TRUST BOARD MEETING IN PUBLIC
AGENDA

1 December 2022 at 9.30am – 12.30pm
Watford Football Club and via zoom (for public and virtual attendees)

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

Time	Item ref	Title	Subcommittee / Purpose	Accountable officer	Paper or verbal
Standing items					
9.30	1	**Opening and welcome**	Information	Chair	Verbal
9.35	2	**Patient story**	Information	Chair	Verbal
9.45	3	**Apologies for absence**	Information	Chair	Verbal
	4	**Declarations of interest**	Information	Chair	Paper
	5	**Minutes of previous meeting 3 November 2022**	Approval	Chair	Paper
	6	**Board decision log**	Information	Chair	Paper
	7	**Board action log**	Information	Chair	Paper
	8	**Board work plan**	Information	Chair	Paper
9.50	9	**Chair's report**	Information	Chair	Paper
9.55	10	**Chief Executive's report**	Information	Chief Executive	Paper
Performance & Committee updates					
10.00	11	**Board Assurance Framework**	QC/ FPC/GPC Approval	Chief Executive	Paper
10.05	12	**Trust Management Committee**	Information and assurance	Chief Executive	Paper
	13	**Finance and Performance Committee** Written report: November 22	Information and assurance	Chair of Committee/ Chief Financial Officer	Paper
	14	**Quality Committee** Written report: October 22 Verbal update: November 22	Information and assurance	Chair of Committee/ Chief Nurse	Paper
	15	**PERC** Written report: October 22	Information and assurance	Chair of Committee/ CPO	Paper
	16	**Great Place Committee** Report: November 22	Information and assurance	Chair of Committee/ CFO	Paper
	17	**Charity Committee**	Information and assurance	Chair of Committee	Verbal

				/Chief Nurse	
10.25	18	**Elective Recovery update**	Information and assurance	Chief Operating Officer	Paper
10.35	19	**Integrated Performance Report** • **Spotlight: Perinatal Quality Surveillance Model**	Information and assurance	Chief Information Officer / Chief Nurse	Paper
Aim 1: Best Care					
10.40	20	**Annual establishment review report – Children's services**	Information and assurance	Chief Nurse	Paper
10.45	21	**Maternity NHSR year 4 update**	Discussion and assurance	Chief Nurse	Paper
10.50	22	**East Kent briefing report**	Information and assurance	Chief Nurse	Paper
10.55	23	**Quality Improvement briefing paper**	Information and assurance	Chief Nurse	Paper
11.00	24	**Annual Report – Infection, Prevention and Control (2021-2022)**	Information and assurance	Chief Nurse	Paper
11.05	25	**Annual Report – Complaints and PALS (2021-2022)**	Information and assurance	Chief Nurse	Paper
11.10	26	**Annual Report – Serious Incidents and Never Events (2021-2022)**	Information and assurance	Chief Medical Officer	Paper
Aim 2: Best Value					
11.15	27	**Finance update (including Business Plan)**	FPC / Information and assurance	Chief Financial Officer	Paper
Aim 3: Great Team					
11.20	28	**People Strategy update**	PERC / Information and assurance	Chief People Officer	Paper
Aim 4: Great Place					
11.25	29	**Better Care Delivered Differently update**	GPC / Information and assurance	Chief Executive Officer	Paper
11.30	30	**Strategic Objectives report**	GPC / Information and assurance	Chief Executive Officer	Paper
11.40	31	**Virtual Hospital Development update**	Information and assurance	Chief Information Officer	Paper
11.45	32	**Use of S.O 6.2 to approve the business case for the Elective Hub**	Information and assurance	Chief Financial Officer	Paper
11.50	33	**ICS update**	Information and assurance	Jane Halpin, CEO, Herts and West Essex ICS	Verbal
Risk and Governance					
12.25	34	**Corporate Risk Register**	QC / Discussion and approval	Chief Medical Officer	Paper

12.25	35	**Items considered in November 22 Private Trust Board**	Information and assurance	Trust Secretary	Paper
Closing Items					
12.30	36	**Any other business previously notified to the Chair**	N/A	Chair	Oral
	37	**Questions from Healthwatch Hertfordshire**	N/A	Chair	Oral
	38	**Questions from our patients and members of the public**	N/A	Chair	Oral
	39	**Date of the next board meeting:** **2 February 2023 at Executive Meeting Room, Watford and via zoom**	Information	Chair	Oral

Acute Respiratory Care Unit: A patients journey

Info about the presentation

Adam Rochester
Non-invasive Ventilation Practitioner

Acute Respiratory Care Unit (ARCU): Specialised unit for the management of acutely unwell respiratory patients requiring increased levels of respiratory support.

2022 to date, ARCU has supported 214 patients requiring non-invasive respiratory support for acute respiratory failure.

Patient X

- 26 year old
- Background: Dilated cardiomyopathy, obstructive sleep apnoea, obese
- Poor compliance with home CPAP therapy for OSA (Under community team)
- Admitted to Emergency Department
  - Difficulty breathing, palpitations and centralized chest pain
  - Needed non-invasive ventilation (NIV) to treat type 2 respiratory failure
  - Transferred to Intensive Care Unit
- Respiratory input on ICU around NIV settings and mask interface
- Day 5 weaned to use of High Flow Nasal Oxygen (HFNO) once type 2 respiratory failure resolved

Acute Respiratory Care Unit

- Day 7
  - Stepdown from ICU to ARCU on HFNO
- Day 8
  - Weaned to nasal cannula oxygen
  - Discussed home CPAP compliance and problems
  - Setup on nocturnal CPAP to support OSA given improved blood gas result
  - Ongoing cardiology input
- Day 9
  - CPAP tolerated well, patient commented ‘sleep was brilliant’ compared to previous quality
  - Patient keen to re-engage with home CPAP therapy
  - Community respiratory nursing team (CLCH) contacted to
  - Re-started on home CPAP + entrained oxygen

Discharge

- Day 12
  - Discharged home with home CPAP and outpatient follow up for respiratory and cardiology

ARCU: Key points

- Importance of maintaining safe staff ratios for management of NIV
- Limited oxygen capacity requires close, daily, monitoring
- Organising regional peer review of service early 2023

Declarations of board members and attendees' interests

1 December 2022

Agenda item: 4

Name	Role	Description of interest
Phil Townsend	Chairman	None
Matthew Coats	Chief Executive	None
Paul Bannister	Chief Information Officer	• Chair of Shared Care Record Programme
Dr Andy Barlow	Divisional Director, Medicine	• Barlow Medical Services Ltd • Director, London & Hertfordshire Respiratory Diagnostics Ltd • Key opinion leader for Masimo Europe Ltd • Medical Advisor to Virtue Health
Tracey Carter	Chief Nurse and Director of Infection Prevention and Control	• Representative for secondary care at the quality committee in the ICB • Trustee of Herts MIND Network
Helen Davis	Associate Non-Executive Director	• Director and shareholder at Brierley Advisory LLP, secondment to NHP finished at end of January 2022. • Partner is senior civil servant at DHSC
Ginny Edwards	Non-Executive Director	• Director of Edwards Consulting Limited • Trustee of *Raise*, West Hertfordshire Hospitals NHS Trust Charity • Trustee of Infection Prevention Society and Vice Chair • NHS Professionals Bank • Community Ambassador for Peace Hospice Care

Last updated: November 2022

Name	Role	Description of interest
		• President Elect of Hertswood Rotary Club • President Bricket Wood WI • Husband is CEO of The Nuffield Trust and a Director Edwards Consulting Ltd
Natalie Edwards	Non-Executive Director	None
William Forson	Divisional Director of WACS	• Private practice at Spire as Forson and Co Medical
Harvey Griffiths	Associate Non-Executive Director	Financial Interests • Director - Anglo Chesham Management Limited • Director - Anglo Industrial Holdings Ltd • Director - Broadgate Freeholds Limited • Director - Energy Capital Advisers Ltd • Secretary – Grip Star Holdings Limited • Director - Horizon (GP) Limited • Director - Horizon Development Capital Limited • Director - Horizon Development Finance Limited • Director - Horizon Housing Reit Plc • Director - Horizon Hudson Holdings • Director - Horizon Infrastructure Partnership Limited • Director - Horizon Investment Holdings (One) Limited • Director - Horizon Investment Holdings (Two) Limited • Director - Horizon Investments (One) Limited • Director - Horizon Investments (Two) Limited • Director - Horizon Scotland (GP) Limited • Director - Housing Investment Finance Limited • LLP Designated Member - Infrastructure Partnership LLP • Non-Executive Director - Inteb Managed Services Ltd • Secretary - Just Property Management Ltd • Director - Sustainable Infrastructure Partnership Ltd • Director – Co-operative Energy Limited • Director – Flow Energy Limited

Last updated: November 2022

Name	Role	Description of interest
		• Director – Co-operative Payroll Giving Limited • Director – The Midcounties WR1 Limited • Director – The Midcounties WR2 Limited • Director – Co-op Travel Services Limited • Director – Co-operative Holidays Limited • Director - Sustainable Infrastructure Partnership Ltd Non-financial Professional Interests • Director - Watford Grammar School for Girls Services Ltd
Ann Griffin	Non-Executive Director	Clinical Professor in Medical Education, UCL. NHS appraisal – occasional employed work Associate revalidation and appeals panel, General Medical Council - occasional employed work
Louise Halfpenny	Director of Communications	None
Edwin Josephs	Non-Executive Director	• Member of the Vine House Health Centre Patient Participation Group
Jonathan Rennison	Non-Executive Director	Financial Interests • Edgecumbe Consulting – Associate • Director of The Yellow Chair Ltd Relevant Consultancy Contracts Held by The Yellow Chair Ltd (Financial Interests): o Kings College London – OD & Learning & Development Activities o In Touch Networks – Coaching Consultant o Government Commercial Function: Role – Subject Matter Expert (SME) delivering training and facilitation o Leadership development role with Mid & South Essex Trust. Professional Interests: • West Hertfordshire Hospitals Trust Charity Committee Chair

Last updated: November 2022

Name	Role	Description of interest
		• Trustee of Rising Tides Ltd
Don Richards	Chief Financial Officer	None
Sally Tucker	Chief Operating Officer	None
Dr Mike van der Watt	Chief Medical Officer	• Owner and Director Heart Consultants Ltd • Work for Hertfordshire and West Essex ICS for one day/week advising on quality and innovation.
Mr Simon West	Divisional Director of Surgery, Anaesthetics and Cancer	• Director Northampton Hip and Knee
Andrew McMenemy	Chief People Officer	Lead for Workforce Modelling and Planning Lead for Temporary Staffing Member of Hertfordshire and West Essex ICS People Board
Barbara Anthony	Trust Secretary	None

Last updated: November 2022

TRUST BOARD MEETING IN PUBLIC
3 November 2022 from 09:30am – 12:30pm
St Albans City Hospital and via Zoom

Chair	**Title**	**Attendance**
Phil Townsend	Chairman	Yes
Voting members		
Matthew Coats	Chief Executive Officer (CEO)	Yes
Tracey Carter	Chief Nurse and Director of Infection Prevention and Control (CNO)	Yes
Don Richards	Chief Financial Officer (CFO)	Yes
Dr Mike van der Watt	Chief Medical Officer (CMO)	Yes
Sally Tucker	Chief Operating Officer (COO)	Yes
Ginny Edwards	Non-Executive Director	Yes
Jonathan Rennison	Non-Executive Director (Vice-Chair)	Yes
Edwin Josephs	Non-Executive Director	Yes
Harvey Griffiths	Non-Executive Director	Yes
Natalie Edwards	Non-Executive Director	Yes
Ann Griffin	Non-Executive Director	Yes
Non-voting members		
Paul Bannister	Chief Information Officer (CIO)	Yes
Andrew McMenemy	Chief People Officer (CPO)	Yes
Helen Davis	Associate Non-Executive Director	Yes
Dr Andy Barlow	Divisional Director for Medicine (DDM)	Yes
Dr Rachel Hoey	Divisional Director for Emergency Medicine (DDEM)	Yes
Mr Simon West	Divisional Director for Surgery, Anaesthetics and Cancer (DDSACs)	Yes
Mr William Forson	Divisional Director for Women's and Children (DDWACs)	Yes
In attendance		
Barbara Anthony	Trust Secretary	Yes
Louise Halfpenny	Director of Communications	Yes
Theresa Maunganidze	Chair, Connect Multicultural Staff Network	Yes
Fiona Smith	Associate Director, Research and Development	Yes
Louise Halahmy	Head of Service Planning, Acute Redevelopment	Yes
Richard Burridge	Guardian of Safer Working	Yes
Tim Duggleby	Associate Director, Redevelopment Programme	Yes
Paddy Hennessy	Director of Environment	Yes

There were 9 members of the public in attendance

MEETING NOTES

Standing items	
1	**Opening and welcome**
1.1	The Chair welcomed everyone to the meeting at St Alban's City Hospital and noted the political change that had occurred since the last meeting. The Trust would continue pressing ahead with its plans for investment and would work to engage with the new government to progress this. It was striving to improve its services and working conditions, which was evidenced today by the business cases on the agenda for approval.
1.2	The meeting would also focus on A&E performance, as well as elective and cancer performance as part of the submission that the Trust was required to make to NHSE on its performance in those areas.
2	**Patient story**
2.1	The Chief Nurse introduced Theresa Maunganidze, Chair of the Connect Multicultural Staff Network, who provided an overview of Black History Month and how Connect had grown over the recent years within the organisation.
2.2	This year's theme for BHM was "Time for change, action not words". During the month, Connect had hosted an educational breakfast morning and a celebratory lunch, attended by 120 people.
2.3	The group's challenge over the next year was how it could change the narrative that staff used when discussing the Trust and create a more inclusive dialogue when discussing actions that the Trust should take to improve equality and diversity. Funding remained a limiting factor. Additional funding would allow guest speakers to visit and more educational events to take place. TM had supported recent discussions with the Trust about an EDI budget and recognised how much the group had developed over recent years with the support of the Trust, and individual champions such as the Chief Nurse and CEO. The Trust's communication department were commended for their work to promote the group's events.
2.4	TM concluded her presentation by explaining that the group's focus was engagement with middle management and promoting EDI within divisional performance review meetings. The Chief People Officer reported that the EDI Steering Group had held its first meeting in September 22 and discussed the overarching EDI budget, which was agreed in principle.
2.5	Jonathan Rennison asked what one thing the Board focus should on to support Connect. TM reiterated the need for middle management to engage with EDI at divisional performance review level on how they would increase the visibility of ethnic minorities within their teams and support staff members with their development.
2.6	Natalie Edwards asked if Connect would hold events throughout the year, not just for Black History Month. TM explained it was important for the Trust to take ownership of Black History Month and be supported by Connect. This had stalled recently, due to the change in the Trust EDI leads. Connect had developed a calendar of events throughout the year which it looked to forward to sharing with the communications team and EDI lead.
2.7	The CEO thanked TM for her reflections and noted the feedback about middle management focusing on EDI within its meetings, which he would discuss with her at their next meeting.
2.8	The Chief Financial Officer asked if Connect should have a role in supporting wider access to Trust services for its diverse population which TM agreed with. She noted that staff were also service users and that a growing number of patients were attending the Trust because of our diversity. She highlighted the Trust's positive work around vaccine engagement and commented that communities would find it reassuring to use services staffed by a representative workforce.
2.9	

	The Chief Nurse thanked TM for her presentation and would progress TM's suggestions around EDI being implemented at Divisional Performance Review level with the Chief People Officer.
3	**Apologies for absence**
3.1	No apologies were received.
4	**Declarations of interest**
4.1	No amendments were needed.
5	**Minutes of previous meeting on**
5.1 5.2	The Chief Operational Officer noted that Stephanie Johnson, Deputy Chief Operational Officer attended the last meeting. The Chief Medical Officer noted that paragraph 10.8 should be amended to show that Niall Keenan is the Associate Medical Officer for Quality and Innovation and the Virtual Hospital had supported 197 patients in total with heart failure.
5.3	**RESOLUTION: The Board approved the minutes of the previous meeting as a true and accurate record, subject to the above amendment.**
6	**Board decision log**
6.1	No amendments were required.
7	**Board action log**
7.1 7.2	The Chief Operational Officer confirmed that the Trust had achieved full compliance status for its core standards for emergency planning. Action two was noted as complete and would be closed.
8	**Board work plan**
8.1	No amendments were required.
9	**Chair's report**
9.1 9.2 9.3	The Chair thanked Clare Parker, Acting Chief Strategy Officer for her work Around the OBC and partnership work with the HPC at the Trust and noted that she had stepped down from her role for personal reasons. In keeping with the national theme on anchor institutions, he highlighted Daisy Peets recent Community Service Award and the engagement work with students from Westfield Academy and noted that these were excellent examples of the Trust being visible and working within its community. He highlighted Daisy Cooper MP's recent visit, who was impressed with the Trust's progress with its Virtual Hospital.
10	**Chief Executive's Report**
10.1 10.2 10.3	The CEO thanked the Chief People Officer for starting the next stage of the Trust's well-being offer which would focus on staff support, recognition & engagement, and environment & facilities. There had never been a more important time for the Trust to demonstrate its commitment to its staff and he was under no doubt the difference between a successful trust and others over the next 5-10 years would be its ability to look after and retain its staff. Assurance was provided that every effort was focused on ensuring proper flow through the emergency and elective pathways, which the Chief Operating Officer would expand on later in the agenda. He thanks staff for working hard to maintain patient flow, often in challenging circumstances.

10.4	He highlighted the increased flow of capital into the Trust and touched on the challenges that this would present and already evidenced in the large number of business cases before the Board for approval. • A significant number of projects for Shrodells, A&E, Community Diagnostic Centre and endoscopy at Hemel were underway. • Enabling funds for the Watford redevelopment programme had been received, with further funds likely to be received for the pathology works. • Bids were also lodged for further elective capacity at St Albans.
10.5	He formally thanked colleagues for the time and attention spent on bringing these projects to fruition. The Trust would increase its rigour and oversight to ensure the funding was spent within this year's budget.
10.6	The wider ICS investment in the St Alban's site, including the reopening of the urgent treatment centre was noted and was a positive indication for the future of the site.
10.7	The Chief Information Officer updated the board about developments within the digital programme. • The Trust had joined the national extend and optimise EPR programme. • Work progressed on embedding and optimising the Trust's use of the EPR system, including further staff training which was already showing positive results. • The implementation programme for pathology was scheduled to start in December 22. • The patient portal was scheduled for launch on February 23 • Work continued to embed an integrate the Virtual Hospital within Cerner.
	The shared care record was also progressing with the anticipated inclusion of pathology data from acute hospitals across the system and the inclusion of providers within Hertfordshire, Essex and Cambridge. A further pilot was commencing with a small number of nursing homes to review whether shared data across care home facilities would help with patient flow.
PERFORMANCE & COMMITTEE REPORTS	
11	**Board Assurance Framework (BAF)**
11.1	The CEO took the report as read. The Trust Secretary highlighted that the BAF had been reviewed by all four committees and highlighted the discussions and changes made by the Quality Committee, PERC and GPC as outlined in the paper.
11.2	The Board noted the discussions and approved the change in wording to BAF risk 14.
11.3	**RESOLUTION: The Board approved the Board Assurance Framework.**
12	**Trust Management Committee**
12.1	The CEO highlighted the strong pipeline of business cases coming through for capital and service development which indicated the volume of work that the Trust needed to undertake.
13	**Finance and Performance Committee**
13.1	Harvey Griffiths, FPC Chair confirmed that the committee had focused on receiving assurance on the Trust's activity and recovery. Demand for services was and the Trust was focused on maintaining those services that were already performing well.
13.2	However, there is the potential that strike action may be taken by staff which will be monitored.
13.3	The Trust was on track with its budget and annual plan, but there was a lot of work to undertake to break even. It was performing well on meeting its capital expenditure target.

14	Quality Committee
14.1	Ginny Edwards, QC Co-Chair, provided a verbal update for the October committee meeting. It received assurance from the perinatal surveillance report on CNST safety action 9. It also received assurance that it was progressing the actions identified in the MBRRACE report and the areas for improvement.
14.2	It received the annual report on medicines optimisation, noted the challenges facing the service and the development of a business case to enhance the service. It received assurance from the ATAIN report that admissions were being reduced and that areas for improvement were being identified and actioned.
14.3	The Chief Nurse added that maternity services had received funding for equality, diversity and inclusion in maternity services which linked well with the signs of safety report from East Kent and the opportunity for developing cultural safety.
15	**PERC**
15.1	Natalie Edwards, PERC Chair, highlighted the agenda items received at PERC committee and noted the staff story from an A&E nurse who described the good experience that she had when joining the Trust and the areas where the Trust could improve.
15.2	The Trust's Flu vaccination programme was progressing well, as was the completion rate for the staff survey. The Trust had also held a successful careers event.
15.3	December Board would receive an updated version of the People Strategy and the committee was assured of the focus on recruitment and retention from an additional paper on the subject. The CPO added that the Board would receive a paper on the findings of the Messenger Review either in December or early next year.
15.4	Positive progress about the progress of the research & development team was received which demonstrated the links being made with local networks.
15.5	The CEO supported the points made on staff retention and noted the positive comments that he had received from recent joiners about their experience in joining the Trust.
15.6	The Board would receive a paper on the Trust's plans to develop it teaching status in the New Year.
16	**GPC**
16.1	Helen Davis, GPC Chair, noted the level of business cases coming through the committee and highlighted the need to ensure that the Estates Department was sufficiently staffed to support this workload and to maintain its operational service.
16.2	The CEO agreed that the Trust needed to separate the workstreams and action would be taken to do this.
17	**Elective Recovery**
17.1	The COO updated the Board on progress with activity and performance, winter initiatives and progress with emergency care.
17.2	Activity remained high for cancer referrals (126%) and urgent referrals. Work was continuing with commissioners and primary care partners to address the trend.
17.3	There was good performance for diagnostic activity, including colonoscopy and non-obstetric ultrasound.
17.4	For RTT, the Trust was ahead of target. No patients were waiting over 104 weeks for treatment and the Trust was meeting the March 23 target for 78 week waits.

17.5	Emergency care was focused on patient flow with additional resources being put into transformation overall, with cross divisional activity to optimize patient flow, both for admissions and for discharging back to the community, with appropriate levels of support. Overall, performance had increased by 5% to 70.2% which benchmarked the Trust in the middle of its peers. There was an increase in type 1 performance to 42.1% and this remained an area of focus for improvement. Urgent treatment centre performance [type 3] had also improved.
17.6	There was a continued focus on ambulance handovers and a winter plan was in place to assist improvement and help the ambulance service meet the demand in the community.
17.7	Jonathan Rennison asked the scale of data quality issues for the PTL and the time scale for the action plan take effect. The CIO estimated that the PTL was overinflated by 25%. The COO confirmed that training on Cerner was ongoing with the staff to address data quality, particularly around clock stops the correct recording by clinical staff. Video learning was proving to be effective at improving data quality validation. The CIO anticipated that significant results would be seen by Jan/Feb.
17.8	Ginny Edwards asked the CMO to outline the process for harm reviews, which were undertaken at divisional performance reviews with a summary being provided to the Quality Committee. To date, only 2 patients had come to moderate harm and no serious or catastrophic harm had occurred. Ginny Edwards confirmed that she was assured that the Quality Committee were able to monitor that the Trust was providing a safe and quality service.
18	**Elective Recovery Self Certification**
18.1	The COO presented the report which sought the Board's approval for the CEO and Chair to certify that the Board discuss and are sighted on 12 fundamental key measures relating to waiting list management, validation, surgical and diagnostic prioritisation, cancer pathway redesign for lower GI, skin and prostate, outpatient transformation and surgical theatre productivity.
18.2	She highlighted each of NHSE's requirements in its letter of 25 October 2022 and, with reference to the self-certification matrix, identified for items A-L within the matrix, how the Trust was fully compliant in the information that came to Board and its sub-committees each month.
18.3	She summarised that, based on the regularity of information that came to the Board and on the dialogue that the board had engaged in today with previous agenda items, it was her assessment that the Trust was fully compliant with the aspects that were referenced in items A – L for which the Chair and the CEO were being asked to provide confirmation.
18.4	The CEO commented added the Trust's historical, excellent performance on long wait patients and collaborative working ensured that no 104-week waiters and that the Trust was on track to eliminate 78-week waiters. He asked the Board to note that the COO had updated it on the three pathways outlined in NHSE's letter as well as the updates on the super September initiative, theatre utilisation and the model health system.
18.5	Jonathan Rennison asked about the process going forward and the COO explained the future process had not been clarified. However, evidence had been gathered should that be required. She added that the Trust was awaiting confirmation from the centre that it would be exiting Tier 1 for cancer performance. Jonathan Rennison noted robust assurance had been provided and he was able to recall the data that he had previously seen for each item within A-L and, as co-chair of the Quality Committee, he had seen it in multiple places as well as at the Board.

18.6	Harvey Griffiths noted the reference in the risk column that further resource may be required to counter the impact of an increased workload and enquired if that risk was likely to materialise. The COO responded that the risk encompassed a combination of issues around operational resource and the ongoing requirement for clinical engagement, which the executive was currently reviewing. She was assured by the gains being made when efforts were focused on the right activity. Indeed, the divisions were now able to focus on the future target of 52 and 65 week waits due to successful management of 104 week and 78 week waits.
18.7	Ginny Edwards asked if the Board had assurance that it would be able to use its outsourcing capacity to help the delivery of the elective recovery. The COO confirmed that outsourcing continued. The operational recovery group received a regular report and we're working closely with the independent sector to maximise outsourcing opportunities in light of the anticipated pressures on emergency care would have on elective care. She confirmed that there is no indication from the independent sector that it would be affected by a lack of workforce.
18.8	Helen Davis asked how the Board could be assured that the Better Care Delivered Differently programme was supporting the elective recovery. The COO explained that it supported the outpatient transformation programme, particularly around PIFU (patient-initiated follow-up) and virtual care. The CMO confirmed that barriers to progress were being actioned, such as improving EPR processes to ensure that virtual referrals were as easy to make. The Trust recognised that it was a learning process which was monitored carefully to pick up issues affecting progress of the programme.
18.9	The Chair asked the COO to elaborate on the work around improvement of DNA rates. This element related to how the Trust engaged with its patients to prevent missed appointments such as texting patients and using telephone reminders. These processes ensured patient safety and optimum utilisation of staff capacity. The element also included how staff safeguarded vulnerable patients who failed to make their appointments and was particularly relevant for paediatric services.
18.10	The Chair asked if Divisional Director comment was required. The COO confirmed that the report was overarching for all divisions and did not require individual divisional comment. Rather, it provided assurance of the Board's oversight, knowledge and management of the Trust's services.
18.11	The CEO summarised that, going forwards, compliance with NHSE's requirements would be explicitly set out within board papers for assurance purposes. In relation to the resourcing point, this connected to theatre utilisation for which he thanked the Divisional Director for SACS for his work in ensuring that extra activity was coming through and how that productivity would be optimised in the coming months. The DDSACs confirmed that he agreed with the conclusions in the report, which was a testament to the hard work of all the Trust's staff.
18.12	The Board approved the report.
18.13	**RESOLUTION: The Board approved the sign-off of the self-certification report to NHSE by the CEO and Chair.**
19	**Integrated Performance report**
19.1	The CIO highlighted the following points from his report: <u>Safety</u>: There was a decreasing trend of patient safety incidents in the past two months. Additionally, all three stroke metrics had improved. <u>ED</u>: All metrics were showing improvement save for 30- and 60-minute ambulance handovers. However, this was against a slightly lower than expected number of attendances. <u>RTT/ Cancer</u>: There was improvement in the breast symptomatic metrics. <u>Workforce</u>: Two new metrics had been added to show workforce trends over the past three years for establishment and staff in post. This data showed the challenges faced by the Trust in relation to its workforce.

19.2	There were no other metrics or themes of concern to draw to the board's attention. Jonathan Rennison asked for assurance on how the Trust was managing and maintaining a safe workplace. The CNO confirmed that templates were used to plan staffing which were reviewed daily against the acuity and dependency of the patients in the Trust's care.
19.3	Daily review ensured that all areas had the best skill mix according to the acuity and dependency of patient including enhanced care support, where there had been an increase in enhanced care support being needed for patients with mental health needs.
19.4	Additionally, the CNO undertook monthly tabletop review with the Heads of Nursing and weekly harm panels reviewed incidents and whether staffing was a contributory factor. The Board received staffing information in the establishment review reports for adults, children services, maternity and other services.
19.5	Jonathan Rennison asked if the triangulation exercise and shown any correlation between staffing ratios and managing harm. The CNO confirmed that there was no correlation, but this was kept under regular review. The Trust was also using QI methodology to improve harm free care and sustainability.
19.6	Ann Griffin thanked the CIO for his comprehensive report and asked about the strategy for reducing attendances at both a Trust level and ICB level in terms of signposting patients to non-hospital services. The CEO summarised that they were working intensively with their partners to reduce admissions and ensure timely discharges. The COO explained the use of social media to signpost patients to alternative services, such as 111.
19.7	Similarly, the ambulance service and CLCH were triaging ambulance calls and offering community-based services rather than hospital conveyance. This initiative had only been in place for a few days and results would be fed into the COO's monthly report. The CIO added that he had attended the recent system leaders meeting where reducing conveyances was discussed at length and was an important issue for the ICS. Ann Griffin also highlighted the London Ambulance initiative where GPs were embedded within ambulance crews to reduce conveyances to hospital.
Aim 1: Best care	
20	**Neonatal Medical and Nursing workforce review**
20.1	The Chief Nurse presented the report which provided an overview of the medical workforce and neonatal unit at Watford and contributed to year four of the maternity incentive scheme. The medical workforce met current requirements and the Divisional Director for WACS would provide assurance on the work to ensure compliance with the neonatal rota for which a business case was being developed by the division.
20.2	She was professionally assured that the neonatal nursing workforce met national guidance but highlighted that allied healthcare professionals also formed part of the workforce. Work was underway with the ICS to resolve the recruitment of speech and language therapists as there was a current shortage.
20.3	The Divisional Director for WACS assured the Board that there was sufficient consultant time for both in hours and out of hours activity. However, the national requirement was for on call ratios was 1:6 rather that 1:5 which was the current level. The team's job plans were currently under review and a business case was being developed to recruit a part time consultant, with a redistribution of daytime activity so that six consultants would be present within the department to meet the specific requirements of the national guidance.
Aim 2: Best Value	
21	**Finance update (including Business Plan)**
	The CFO referred to his slides and highlighted the following points:

21.1	<u>Income and expenditure</u> The deficit of £5.1m was in line with the trajectory to break even at the end of the financial year. However, elective productivity was not yet reaching current national target levels which was currently mitigated by block contract funding. However, this was likely to become an issue during the next financial year if the funding mechanism switched to tariff payments. Increased theatre productivity would resolve the issue, but it was an important consideration for the next financial year.
21.2	The Trust was benefiting from Elective Recovery Funding being paid in full which currently worth £5.8m
21.3	The Trust remained focused on improving its CIP performance. Medical staff spending was overspent and would be addressed with the implementation of a direct engagement model for medic and temporary staffing as well as improved rostering.
21.4	The balance sheet contained a large accrual for annual leave which needed to be reduced without putting pressure on temporary staffing or jeopardising elective productivity.
21.5	COVID spending was reducing which would be maintained whilst ensuring patient safety. Overall, the balance sheet remained healthy and there was a cash balance of £39 million which was lower than last month but remained higher than the start of the financial year. <u>Capital expenditure</u>
21.6	Current spend totalled £4.9 m leaving £37m to be spent on significant projects such as pathology hot labs, CDC and the land redevelopment purchase. <u>Long term financial plan</u>
21.7	The long-term financial plan would be updated on a quarterly basis with the next report due in February 2023.
21.8	The Chair asked about the strategy for managing inflationary pressures, particularly for energy costs. The CFO explained that the Trust currently benefited from the Elective Recovery Fund which was compensating for inflationary pressures. It had started planning for future energy contracts and the outcome of those negotiations would be included in the long-term plan and incorporated within the next ICB contract.
21.9	Natalie Edwards asked if the remaining capital expenditure spend presented any risk. The CFO confirmed that receiving confirmed funding decisions from the centre was problematic and resulted in spending decisions being taken in advance of receipt of final confirmation of national funding. It also impacted the environment team, who faced huge pressures to move ahead and complete schemes quickly before the end of the financial year. This risk was being monitored closely by FPC and GPC to ensure the Trust remained within its annual budget.
21.10	Edwin Josephs asked if the trust had a process whereby it could spend capital monies quickly before the end of the financial year. The CFO confirmed that me trust maintained a reserve list of projects which was able to use residual council expenditure funds. He noted that the CEO had already commented on the difficulty of receiving late funding decisions for national projects and discussions were on-going about using national finance for local projects where previous spending decisions have been taken at risk.
21.11	Ginny Edwards asked how the Trust was mitigating the risks connected with the annual leave accrual. The CPO explained that regular audits were undertaken to ensure correct management of annual leave by managers which supported staff well-being. Additionally, he was working with the Chief Nurse on winter planning for temporary staffing.
Aim 3: Great Team	

22	**Research and development update**
22.1 22.2 22.3	The CMO summarised the report on behalf of the Associate Director, Research and Development. Recruitment into research was positive and the Trust's commercial studies had achieved success. Current challenges were space and the ability to recruit into the Research Nurse post. The Chief Nurse highlighted the positive discussions at PERC around teaching status and how that would be used to support the recruitment of staff and staff retention in this area. The Chief Nurse Fellows Scheme had received funding and would recruit nurses, midwives and allied health professionals to pursue careers in leadership, innovation, research and clinical academia. Jonathan Rennison asked about the Trust's future ambition to develop its Teaching Hospital status. The Associate Director, Research and Development explained that the focus would be on creating joint posts with academic partners. The CPO added that development of department was a key benefit realisation listed in the teaching hospital business case. Both and Natalie Edwards, PERC Chair, were greatly appreciative of the support that Ann Griffin, NED and Teaching Hospital lead had provided. The Board noted the improvements that the department had achieved and positive discussions around feature ambitions.
23	**Gender and Race Pay gap**
23.1	The CPO highlighted that the Trust was under a legal obligation to publish its gender pay gap report and had elected to publish its race pay gap report to promote transparency within its workforce. 77% of the workforce was female with a greater proportion of men in the higher pay bands. BAME staff had a higher representation within the lower pay bands. Overall, the higher pay bands had disproportionate levels of representation for ethnicity and gender.
23.2	44% of the consultant workforce were women against an overall ratio of 77% of the workforce being female and that men were more likely to receive clinical excellence awards. The Trust had changed its system to ensure fairness but acknowledged that fundamental issues remained and would look to its wider strategy for supporting fairness for gender and race.
23.3	Key actions would be to: • Support the findings of proactive reports such as the Sex and Medicine report, led by Rachel Hoey, Divisional Director for Emergency Medicine. • Review leadership development plans and succession plans to see how opportunities could be created across gender and race. • Review recruitment process to ensure values-based recruitment and career development programmes. • Promote the Stepping Up Programme to support the BAME workforce with career opportunities and development.
23.4	The Board was asked to approve the publication of both reports.
23.5	Natalie Edwards, PERC Chair, confirmed that the committee had discussed the findings in depth. She had also met with Rachel Hoey to discuss the findings of her report. Both she and the CPO recommended a board development session to resolve the future action that needed to be taken. The Chair agreed and an action would be taken to review the board development schedule to ensure that priority items were included.
23.6	Ginny Edwards asked how the board could be assured that there was no unconscious bias when deciding banding levels for posts. The CPO explained that banding panels with diverse representation were used. However, these only dealt with a few areas each year and the main focus of improvement work would be on values-based recruitment and training. Unconscious bias was top of the agenda for people strategy.

23.7	The CIO noted the difference in Table 9 between the main and the median numbers for the ethnicity breakdown of the value of bonus pay received which should be considered. Jonathan Rennison asked if the discrepancy in pay gaps was attributable to historical practice or recent practice, particularly in relation to salary negotiation. The CPO the main issue was the lack of progression from a gender or race perspective in the development of both pay scales and promotion. The Trust needed to develop its career coaching, learning opportunities and supporting staff groups to confidently applying for positions. The Chair supported this and noted the recent development of relationships with local schools and colleges to promote diverse recruitment.
23.8	The Chief Nurse added that the Trust should review why women were not taking up senior roles within the Trust and whether this was attributable to how the female workforce was affected by the menopause. The CPO agreed and added that the Trust had recently joined with the council and Watford Football Club to collaborate on how it could provide women with opportunities for development and promotion to achieve women confidently applying for roles knowing that they would receive support with issues affecting their gender such as the menopause or childcare responsibilities.
23.9	Ann Griffin asked how EDI mandatory training could be improved to help with gender and race pay issues. The CPO acknowledged that mandatory training could be improved to include emergent themes and to demonstrate the benefits of improved inclusion and diversity within the workforce, how that would positively impact patient care and cultural awareness. An EDI lead had recently been recruited to support the progress of this work.
23.10	Natalie Edwards concluded that the Trust also needed to decide how it monitored those changes.
23.11	The Board approved the reports for publication on the Trust's website.
23.12	**Action: The board development schedule would be reviewed to ensure that priority items were included.**
23.13	**Resolution: The Board approved the reports for publication on the Trust’s website**
24	**Guardian of Safer Working Annual Report**
24.1	The Guardian of Safer Working presented his annual report which covered the reporting period of August 2021 to August 2022. The report provided a summary of rota gaps and shift fill across the year as well as a summary of the exception reporting.
24.2	On average, there were 15 unfilled shifts per week across the Trust. There were over 250 exception reports across the training year which was a slight increase. These mostly related to additional hours worked, the majority of which were compensated with pay rather than time off in lieu. Due to the clear trend to receive payment, the Guardian also ensured that no junior exceeded their maximum number of permitted working hours to ensure safety.
24.3	The Guardian also monitored the number of reports per trainee for benchmarking purposes. The Trust benchmarked in the middle of its peers, and he was satisfied that there were no issues with reporting levels. Overall, junior doctors had the highest reporting rates, but report were started to be received from higher training grades as the reporting culture became embedded. This would have a positive impact on data quality and would enhance safety as areas of concern were highlighted.
24.4	The Guardian highlighted two significant breaches which had led to a fine being imposed. The first related to the surgery division where a junior doctor, on two separate occasions, had been required to stay on site for 24 hours due to the locum SHO either not turning up or not having the requisite skills to undertake the shift. The guardian praised the division for immediately engaging with each incident, investigating the underlying issues and making prompt payment to the doctor.

24.5	The second fine related to the Medicine division for the number of exception reports received from acute medicine/cardiology. These mainly related to the bed base being used as surge areas, which caused medical outliers leading to multiple ward rounds for junior doctors and delaying their finish times. Again, the Guardian praised the division for engaging with the issue and employing additional doctors. The Guardian noted that the numbers of reports coming from the department had reduced since August 2022.
24.6	Ann Griffin commended the practice of involving junior doctors in resolving many of the issues facing them which research had shown was an effective method in achieving positive change.
24.7	Finally, the Guardian noted that he would be shortly leaving this role and moving into the Chief Clinical Information Officer role. He thanked the Board for their support in resolving issues with the junior doctor workforce over the past six years. Both the Chair and Natalie Edwards, PERC Chair, thanked the Guardian for his hard work, dedication and commitment to the Guardian role.
Aim 4: Great Place	
25	**Community Diagnostic Centre business case**
25.1	Louise Halahmy, Head of Service Planning, Acute Redevelopment presented the report which was part of a five-year national programme to create community diagnostic centres throughout the country.
25.2	Approval was sought to increase capacity for MRI and CT scanning at the St Albans site at a cost of £13.1m, via national funding, over the next two financial years. £5.9 million would be spent this financial year, with the remainder spent in the next financial year. There was a robust plan setting out the spending allocation with preparatory work being undertaken this year, with construction and delivery during the next financial year.
25.3	Harvey Griffiths, FPC chair, confirmed the committee's support for the case.
25.4	The CFO cautioned that he was still awaiting final confirmation of the revenue funding. This created a minimal risk for this financial year for capital expenditure. The revenue costs would be funded through an additional allocation to the ICB which was expected to be confirmed in the next few weeks.
25.5	The Chair asked if preparations had started for ordering the equipment and organising the works. The Head of Service Planning, Acute Redevelopment confirmed that the scanners would be purchased through the NHS supply chain within this financial year. The CFO would liaise with the Chair if action was required to authorise a second scanner.
25.6	Edwin Josephs asked if planning was underway to ensure that services within the site would not be saturated. The Head of Service Planning, Acute Redevelopment confirmed that issues such as car parking and catering were under review.
25.7	Helen Davis checked that there was no duplication of electrical infrastructure costs between this business case and the electrical infrastructure business case, and the CFO confirmed that there was no duplication.
25.8	Ginny Edwards asked if the business case would take into account future innovation. The Head of Service Planning, Acute Redevelopment confirmed that the scanners could be enhanced with future technology. The service would also look to centralise the entire diagnostic department on the St. Albans site to improve access for patients and to create a centralised resource for training and staff development. Future phases would look to include additional services to complement the elective care ambition for the site.

25.9	The COO confirmed that she was assured both from her board visit this morning and from the business case that the co-location of the two scanners would be a more effective way to provide diagnostic services.
25.10	Jonathan Rennison noted the significant patient benefits of the business case which demonstrated how it fitted with the Trust's longer strategic plan and would support its strategic ambition over the next 10 years and longer. The business case was approved by the Board.
25.11	**RESOLUTION: The Board approved the Community Diagnostic Centre business case**
26	**SACH electrical business case**
26.1	The Director of Environment presented the business case which sought approval for an additional £3.9m on top of the £2.8m within the CDC business case. The funding was required due to the 2021 electrical condition survey highlighting compliance and capacity issues with the electrical supply. The improvement works would allow control the main incoming switches, would prevent power outages and would future proof the site for future net zero carbon initiatives.
26.2	Natalie Edwards asked if there was a risk of an overspend given current inflationary pressures. The Director of Environment confirmed that Some works would be undertaken internally in order to save costs. The team were well versed in managing and working on projects of this complexity. He was in the process of receiving tender costs, once those were received, he would be able to revert to the Board with absolute assurance on the risk of an overspend.
26.3	Helen Davis asked if the Watford site was at risk of similar compliance and capacity issues. The Director of Environment confirmed there was no risk for the Watford site as the redevelopment plan included provision for new utilities.
26.4	The Board approved the business case.
26.5	**RESOLUTION: The Board approved the SACH electrical business case.**
27	**LED lighting business case**
27.1	The Director of Environment summarised that approval was sought for £1.086 m following previous investment in LED lighting in key areas of the hospital site although this was not possible in the women's & children's building. The business case anticipated a £98k pay back per month based on current tariffs. Payback was targeted at 11 months. If tariffs increased next year, which was expected, the Trust would see further benefits over a seven-year life cycle or potential savings of £6m.
27.2	Helen Davis asked if the lighting word improve the environment for staff and patients. The Director of Environment confirmed that it would as there would be fewer breakdowns, less maintenance and fewer call outs. The quality of light was better, and the Chief Nurse was supportive of the business case as it improved working conditions for staff and patients receiving care.
27.3	Natalie Edwards asked about the maintenance and replacement programmes. The Director of Environment explained that the maintenance programme was minimal, and the replacement programme would be factored into future investment objectives.
27.4	The Board approved the business case.
27.5	**RESOLUTION: The Board approved the LED lighting business case.**
28	**Essential Services Laboratory business case**
28.1	The CFO summarised that the business case sought approval for £12.1 million pounds, of which £700k had already been spent. The three main objectives behind the business case were to:

	1. Support the hospital redevelopment by clearing the site between PMOK and the visitor's car park. 2. Support the new model of pathology services agreed with the ICS where cold pathology services would be moved to a new hub facility built and managed by an outsourced provider. The full business case for which would be presented to December Board for approval. 3. Allow the relocation of cellular pathology from Hemel Hempstead to SACH.
28.2	Tim Duggleby, Associate Director Redevelopment Programme, highlighted that work on the essential services laboratory and mortuary had been agreed following a tender exercise. He was in dialogue with the provider about inflationary increases to the tender costs. The paper had gone to the Department of Health's investment committee who were supportive, in principle, of the business case provided that the Trust approved it.
28.3	The funding would be provided to carry out the work during this and the following financial year. The CFO added that he had received further communication from NHP last night, confirming that the funding was almost approved subject to confirmation of minor details.
28.4	Helen Davis clarified the timeline for signature of the contract which the Associate Director Redevelopment Programme confirmed was needed by next week at the latest to maintain current agreed prices. Elements of the contract would need to be entered into by the Board for the pathology lab at Watford in order to preserve the current price.
28.5	Helen Davis about the outcome of discussions with NHP about inflationary risks. The CFO indicated that inflationary pressures would remain with the Trust as a risk but there was sufficient contingency within the environment team to cover this. The CEO commented that approval of the business case would be a big step and would evidence the many years of hard work to bring this project to fruition and recommended the Board's support. The business case was approved.
28.6	**RESOLUTION: The Board approved the Essential Services Laboratory business case**
Risk and Governance	
29	**Corporate Risk Register report**
29.1	The Chief Medical Officer presented the report which was discussed at both the Risk Review Group (RRG) and the Quality Committee. There were 18 open risks and little movement in the risks to report. 1 risk was presented for acceptance on the risk register but was not considered to be sufficiently serious for inclusion. The risk related to training for CCG machines. The risk relating to UTC adherence to patient pathways was reduced and removed from the register which reflected the significant work to improve performance.
29.2	1 risk was considered for an increased score regarding the effect of Cerner on DNA CPR but the Chief Nurse and CMO determined that no increase was required.
29.3	**The Board approved the Corporate Risk Register**
30	**Items considered in October Private Trust Board**
30.1	The report was noted.
Closing Items	
31	**Any other business previously notified to the Chair**
31.1	There was no other business for consideration.
32	**Questions from Hertfordshire Healthwatch**
32.1	Meg Carter noted that in relation to attendance at A&E, there was more scope for public information about where they could access treatment. There was scope for patient participation groups to help with that in publishing information in newsletters. She queried if the public health team at the ICB were actioning that. The CEO confirmed that whilst this was

32.2	the ICB's responsibility, the Divisional Director for Emergency Medicine and COO were working hard with the ICB to convey that messaging. She noted the full agenda and appreciated the discussion on elective recovery.
33	**Questions from our patients and members of the public**
33.1 33.2	The Trust Secretary read out three questions which had been received prior to the Board meeting. *1. The Electronic Patient Record system is causing multiple challenges across the Trust and is looking like very poor value for money. Shouldn't there be an external expert review of what has gone wrong to enable the Trust to learn the lessons for future major projects.*
33.3	The CIO responded that every EPR implementation had its challenges, particularly for staff. He thanked the CMO and Chief Nurse for their support in resolving data quality challenges, but these had not resulted in any significant harm to patients or lowering of quality standards. The Trust's implementation programme had largely been successful and there was positive feedback on the improved quality and safety that EPR provided. He was working closely with the CFO to monitor the financial and non-financial benefits of implementation and were undertaking a "lessons learned" exercise with RFL which would also include a post business case implementation review. The CMO added that when there was a power outage some weeks ago, the clinical feedback confirmed the level of appreciation for EPR.
33.4	*2. The Trust plans a big and welcome increase in diagnostic tests, including heart monitoring. But there is already a very long backlog in interpreting such cardiological tests, and there is evidence that very concerning results can be missed for months because no one has looked at the results. How will you ensure that the rising volume of tests is matched by a better-organised system for interpreting and acting on results?*
33.5	The CMO explained that there had been no instances of patients coming to harm. All urgent patients had their tests undertaken and analysed immediately. Diagnostic tests were prioritised. He acknowledged a back log in routine tests for low-risk patients but reassured the Board that teams were reviewing the results prior to allocating outpatient appointments. The department was reviewing whether outsourcing for diagnostics would be appropriate. Overall, risk was managed by prioritising high risk patients and patients with an unknown diagnosis which had prevented patients coming to harm.
33.6	*3. To what extent is the continuing shortfall in elective activity a result of people simply not wishing to be treated at Watford General, and especially in the Princess Michael of Kent building, because of the poor condition of the estate? Have you done any research on this issue?*
33.7	The COO explained the concept of patient choice and confirmed that she was not aware of any cancellations being received due to the condition of the building. She also commented that medical and surgical services and a care quality rating of good and noted the recent theatre refurbishment programme which enhanced the environment for surgical services.
34	**Date of the next Board meeting**
34.1	The next Board meeting would be held on 1 December 2022 in the Watford Football Club and via Zoom.

BOARD AND CORPORATE TRUSTEE DECISION LOG 2022-23			
Board meeting decision date	**Decision reference (from minutes)**	**Item presented to Board for action**	**Comments/outcome**
07 April 2022	22.3	**RFL Partnership arrangements**	The Board approved the extension of the RFL partnership arrangements and would progress a board development session on RFL partnership work.
07 April 2022	24.6	**Draft Business Plan 2022-23**	The Board approved the strategic objectives for 2022/23.
05 May 2022	20.2	**Delegated Authority Request - Quality Account**	The Board approved the delegated authority request for the Quality Committee to approve the Quality Account on behalf of the Board.
05 May 2022	24.3	**PERC Terms of Reference**	The Board approved the PERC terms of reference
05 May 2022	27.2	**Annual statement of actions taken to prevent slavery and human trafficking**	The Board approved the signing of the annual statement by the CEO
05 May 2022	28.2	**Annual self-certification process**	The Board approved the signing of the self certification by the Chair and CEO.
31 May 2022	5.2	**Shortlist review**	The Board approved the recommendation not to reopen the shortlist.
31 May 2022	5.3xv	**Preferred option**	The Board approved option 6 as the preferred option for the emergency site and option 3 as the preferred option for Hemel Hempstead and St Albans.
31 May 2022	20.5	**Business plan**	The Board approved the business subject to the changes in the financial plan.
07 July 2022	25.0	**Approval of the Quality Account by delegated authority.**	The Board ratified the approval of the Quality Account by delegated authority.
07 July 2022	28	**Interventional Radiology business case**	The Board approved the Interventional Radiology business case
01 September 2022	26.2	**Annual Workforce Race Equality Scheme (WRES) report**	The Board approved the publishing of the report.
01 September 2022	27.8	**Annual Workforce Disability Equality Scheme (WDES) report**	The Board approved the findings of the report and approved its publication
06 October 2022	27.9	**Schrodells Business Case**	The Board approved the Schrodells business case
06 October 2022	31.3	**Review of standing orders, standing financial instructions and scheme of delegation**	The Board approved the changes to the standing orders, standing financial instructions and scheme of delegation.
03 November 2022	18	**Elective Recovery Self Certification**	The Board approved the sign-off of the self-certification report to NHSE by the CEO and Chair.
03 November 2022	23	**Gender and Race Pay gap**	The Board approved the reports for publication on the Trust’s website
03 November 2022	25	**Community Diagnostic Centre business case**	The Board approved the Community Diagnostic Centre business case
03 November 2022	26	**SACH electrical business case**	The Board approved the SACH electrical business case.
03 November 2022	27	**LED lighting business case**	The Board approved the LED lighting business case.
03 November 2022	28	**Essential Services Laboratory business case**	The Board approved the Essential Services Laboratory business case

Agenda item: 7

Action log (updated following 3 November 2022)

No.	Date of meeting	Minute ref	Action	Lead for completing the action	Date to be completed	Update
1	3 November 2022	23.12	The board development schedule will be reviewed to ensure that priority items are included.	Chair / Trust Secretary	December 22	

TRUST BOARD WORK PLAN 2022-23: Part 1	Apr-22	May-22	Jun-22	Jul-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Service presentation/patient story	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Trust Chair and Chief Executive's report	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Performance											
Integrated Performance Report	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Aim 1: Best Care											
Seven day services – board assurance framework (suspended)											
Bi-annual establishment review – maternity					✓					✓	
Bi-annual establishment review report – adult inpatient wards				✓							✓
Annual establishment review report – Paediatrics								✓			
Establishment review - neonates							✓				
Perinatal quality surveillance -maternity minimum dataset (quarterly as part of IPR)		✓				✓		✓		✓	
Maternity safety strategy actions and CNST incentive scheme (as required)				✓	✓						
Annual report: infection prevention and control								✓			
Annual report: safeguarding				✓							
Outcome of national patient surveys/progress reports		Reports aligned with the publication of results									
Report on the quality account (ratification of QC approval)				✓							
Annual report: end of life care						✓					
Annual report: complaints and patient advice and liaison								✓			
Annual report: serious incidents and never events						✓					
Quarterly learning from deaths report (Director of Clinical Governance)				✓		✓		✓		✓	
Annual assurance report: emergency preparedness, resilience and response					✓						
Patient Safety Specialist update											
Health inequalities											
Annual report: Legal services								✓			
Aim 2: Best Value											
Outline and final business cases for capital investment more than £1m (as required)	As required										
Ratify proposals for acquisitions, disposals or changes of use and/or buildings (as required)	As required										
Approval to open bank accounts (as required)	As required										
Finance update	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Aim 3: Great Team											
Research and development update							✓				
Public sector equality duty report				✓							✓
EDS3											✓
Gender and race pay gap report							✓				✓
Outcome of national staff survey/progress report											✓
Annual medical appraisal report and statement of compliance					✓						
Annual NHS disability equality standard report					✓						
Annual NHS workforce race equality standard report					✓						
Annual People Strategy update								✓			
People Strategy								✓			
Bi-annual freedom to speak up/whistle blowing report		✓								✓	
Guardian of Safe Working Annual Report							✓				
FPPR Report		✓									
Aim 4: Great Place											

Better Care, Delivered Differently update (bi-monthly)	✓	✓	✓	✓		✓		✓		✓	
Strategic objectives report (quarterly)					✓			✓			✓
Green Plan - annual review											✓
Redevelopment OBC preferred option decision (tbc)						✓					
Development of integrated care partnership update report					✓						
ICS governance proposals											
Progress update on major capital projects (outline business cases/full business cases)	As required										
Risk and governance											
Approval of the corporate aims and objectives	✓										✓
Board assurance framework report	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Corporate risk register report	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Board and committee terms of reference and work plans review		✓									
Annual review of Board and committee effectiveness				✓							
Annual review of corporate governance structure		✓									
Board engagement report						✓					✓
Board and committee meeting schedule					✓						
Regulatory											
Audit Committee annual report				✓							
Annual statement of actions taken to prevent slavery and human trafficking		✓									
Annual self-certification process		✓									
Use of the Trust Seal (*via Audit Committee assurance report)*	✓		✓							✓	✓
Report on standing financial instructions, standing orders and scheme of delegation (*via Audit Committee assurance report)*						✓					
Approval of annual report, annual accounts, annual governance statement and quality account (*via Audit Committee assurance report*)				✓							
Assurance reports from committees											
People, Education and Research Committee		✓	✓	✓		✓		✓		✓	
Audit Committee			✓	✓	✓					✓	✓
Finance and Performance Committee	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Quality Committee	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Trust Management Committee	✓	✓		✓	✓	✓	✓	✓		✓	✓
Great Place Committee	✓	✓		✓	✓	✓	✓	✓		✓	✓
Charity Committee		✓		✓				✓			✓
Charity Committee annual report and accounts		✓									
Questions											
Questions from Hertfordshire Healthwatch	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Questions from the public	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Corporate Trustee meeting - November and May		✓					✓				

Trust Board Meeting
1 December 2022

Title of the paper	**Chair's Report**			
Agenda Item	**9**			
Presenter	**Phil Townsend, Trust Chair**			
Author(s)	**Barbara Anthony, Trust Secretary**			
Purpose	**For approval**	**For discussion**	**For information** ✓	
Executive Summary	This paper provides an update to the Board on items of national and local interest/relevance.			
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1** **Best care** ***Objectives 1-4***	**Aim 2** **Great team** ***Objectives 5-8***	**Aim 3** **Best value** ***Objective 9***	**Aim 4** **Great place** ***Objective 10-12***
	x	x	x	x
Links to well-led key lines of enquiry	✓ Is there the leadership capacity and capability to deliver high quality, sustainable care? ✓ Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ✓ Is there a culture of high quality, sustainable care? ✓ Are there clear responsibilities, roles and systems of accountability to support good governance and management? ✓ 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: 9

Trust Board Meeting – 1 December 2022

Chair's report

Presented by: Phil Townsend, Trust Chair

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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

Virtual hospital team are HSJ finalists

2.1 Well done to our Virtual Hospital team who were finalists in the 2022 Health Service Journal awards, The South and West Herts Health and Care Partnership was nominated for the **Place Based Partnership award** for the ground breaking work of our lung disease and heart failure virtual hospital.

Awareness events

2.2 The Trust has supported a large number of awareness days this month which are so numerous that it is not possible to set out each one in detail. However, I am extremely pleased that we are supporting and highlighting such a wide range of awareness days, including ones that staff can join as a webinar. The awareness days supported this month are as follows:

- World Antibiotic Awareness Day
- National Healthcare Support Workers' day
- Maternity Support Worker Celebration Day webinar
- Nursing Support Workers' Day webinar
- World Radiography Day
- National Stress Awareness Day

2.3 In addition to the above awareness days, I am also pleased that we are celebrating and supporting:

- UK Disability History Month to learn from lived experiences of disabled people and learn how to be as inclusive as possible.
- Diversability Celebration event on 6 December with speakers to mark three years of supporting staff at West Herts.

- Anti-Bullying Week which had the theme of 'reaching out'. Bullying and harassment are completely unacceptable in any organisation. The Trust has Freedom to Speak Up (FTSU) champions and a FTSU Guardian. If you have concerns about bullying in the workplace, please contact the Guardian whose details can be found at https://www.westhertshospitals.nhs.uk/ftsu/
- Occupational Therapy Week - our occupational therapists work across the Trust in various settings and specialties and can help people overcome challenges, gain independence, and encourage their engagement in meaningful activities.

3 Community News

Raise a Smile Christmas Appeal launches

3.1 Raise has launched its annual Raise a Smile Christmas appeal, asking for donations from local businesses and communities so they can buy gifts for patients in hospital over the festive season. Our senior fundraising officer, Emily Theobald is co-ordinating the appeal and can be contacted to receive donations.

Volunteer training to help in ED

3.2 Some of our volunteers have been taught how best to provide support in our emergency department (ED) thanks to a collaborative learning session provided by voluntary services with colleagues in ED. Volunteers currently assist the department by serving refreshments, restocking supplies and providing simple ways to make patients more comfortable. Training was provided on improving patient experience, moving and handling training, learning basic life support and helping patients and visitors to complete the friends and family test. I would like to thank all of our volunteers for the time that they dedicate to the Trust.

Small acts of kindness keep our patients warm

3.3 'Warm in winter' bags are being handed out to our older patients by the emergency department who want to help keep our older patients warm this winter. Each bag contains a blanket, socks, gloves, a hat, a mug and a selection of hot drinks and soup, all packed in a reusable tote bag.

The bags have been supplied by **Small Acts of Kindness**, a local charity based in Watford, which supports older residents in our local area. The bags also contain resources to signpost residents to other local organisations that could support them, as many patients may not have access to a computer.

4 Hertfordshire and West Essex ICS

4.1 The latest edition of the Hertfordshire and West Essex ICB update can found here https://hertsandwestessex.icb.nhs.uk/homepage/24/hertfordshire-and-west-essex-icb-update and demonstrates the work that system partners are undertaking to improve and development services for local communities.

5 BOARD NEWS

Board visit programme:

5.1 As part of the monthly Board visit programme, in November 2022 the Board visited the following departments at St Alban's City Hospital:

- Breast services
- CT scanner and the new site for the diagnostic hub
- Ophthalmology

- Orthopaedic ward

6 Trust Chair's meetings:

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

- Attended bi-weekly Redevelopment Planning Group meetings
- Governance meetings with Trust Secretary
- Pre-Consultant interview meetings with delegates
- Calls with Chairs of other Trusts
- Attendance at EOE Provider and ICS Chair meeting
- Attendance at Official Watford new theatres opening ceremony
- Chaired meeting with Watford Chamber of Commerce
- Chaired Consultant interviews for Emergency Medicine
- Chaired Consultant interviews for Paediatric Emergency Medicine
- Meeting with Dean Russell MP
- Meeting with Mike Penning MP
- Attended NEDs call with CEO
- Chaired Consultant Neurology interviews
- Quality NED discussions
- Visit to CMR Surgical Ltd in Cambridge
- Attended meeting with Paul Burstow & Jane Halpin
- Finance & Performance Committee
- Quality Committee
- Healthwatch Quarterly update meeting with WHTHT
- Realisation of Teaching Hospital status meeting

7 RECOMMENDATION

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

Phil Townsend, Trust Chair

24 November 2022

Trust Board Meeting
1 December 2022

Title of the paper	**Chief Executive's Report**			
Agenda Item	**10**			
Presenter	**Matthew Coats, Chief Executive**			
Author(s)	**Barbara Anthony, Trust Secretary**			
Purpose	**For approval**	**For discussion**	**For information**	
			✓	
Executive Summary	The aim of this paper is to provide an update to the Board on items of national and local interest/relevance since the last meeting. The information in the report is drawn from a variety of sources, including information published by NHS England/Improvement, DHSC, NHS Providers and the CQC.			
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1** **Best care** ***Objectives 1-4***	**Aim 2** **Great team** ***Objectives 5-8***	**Aim 3** **Best value** ***Objective 9***	**Aim 4** **Great place** ***Objective 10-12***
	x	x	x	x
Links to well-led key lines of enquiry	✓ Is there the leadership capacity and capability to deliver high quality, sustainable care? ✓ Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ✓ Is there a culture of high quality, sustainable care? ✓ Are there clear responsibilities, roles and systems of accountability to support good governance and management? ✓ 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		
	N/A			
Action required	The Board is asked to receive the report for information.			

Agenda Item: 10

Trust Board Meeting – 1 December 2022

Chief Executive's report

Presented by: Matthew Coats, Chief Executive Officer

1 PURPOSE

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

2 KEY ISSUES

2.1 On 16 November 2022, the Secretary of State for Health and Social Care set out his intention to focus on the areas that matter most to the patient experience and measures which will make it as easy as possible for frontline NHS and care workers to do their jobs.

The Department's 5 key priorities for the months ahead are:

- supporting the workforce, including through more staff for NHS 111 and 999
- focusing on recovery plans across electives, urgent and emergency care
- tackling the issue of delayed hospital discharge
- improving access to primary care
- ensuring a stronger future for health including maintaining momentum on the New Hospital Programme and investing in technology to improve patient outcomes

2.2 Our board papers for the past few months, and our work with the ICS, demonstrate that we are working hard to focus on these areas and find short, medium and long term solutions to improving our patients' experience and to make our staff's job easier. The key to our long-term success is the redevelopment of our Watford site, quality and innovation and ensuring that we are an excellent employer.

Staff wellbeing and retention

2.3 Last month, I wrote about our intention to increase our attention on our staff wellbeing and retention programme which would focus on the overarching themes of staff support, recognition and engagement and environment and facilities. I am pleased to see that we are already working on these areas with our regular programme of wellbeing support from our wellbeing provider, advice and information on NHS pensions from Isio Group, and support for our international staff through the Shared Professional Decision Making Council.

Winter pressures and elective recovery

2.4 Our services remain under pressure due to the high levels of patients attending A&E. We are working collaboratively with our system partners to reduce these pressures with targeted pieces of work around appropriate conveyances to hospital, quick ambulance handovers and, where possible, arranging our rotas to ensure that senior medics can make rapid decisions to admit or discharge patients.

2.5 We hope that these measures, together with medium term redevelopment projects on our Watford and St Alban's site will help to ease immediate winter pressures and stabilise our services during the early part of 2023. Vaccination remains an important part of our plan and our vaccination service can still help staff who need either a flu or covid vaccine.

2.6 We continue to liaise with our local authority and integrated care colleagues to determine where recently announced health and social care funding should be allocated to support discharges from hospital. I would like to formally thank our Local Authority colleagues for their extremely helpful work in this area.

2.7 We continue to fund our capital programme to use state of the art equipment and technology where the benefit to patients is clearly demonstrated. Our recent purchase of surgical robots, and future purchase of diagnostic equipment for St Albans, will put us in the best position possible to maximise our elective care opportunities and meet our national targets. Our internal and system work on reducing pressures in our emergency care department will help free up capacity for elective work.

2.8 I remain grateful to all of our staff and volunteers for their hard work and dedication over the last month and the quality care that has been provided in difficult circumstances.

3 CHIEF OFFICERS UPDATES

Chief Nurse

Change in statutory status for the Healthcare Safety Investigation Branch

3.1 The Healthcare Safety Investigation Branch confirmed on 10 November 2022 the progress with plans to establish it as a Special Health Authority and continue the Maternity Investigations Programme in England. HSIB currently sits within the Care Quality Commission and will become a Special Health Authority in April 2023. It will be known as the "Maternity and Newborn Safety Investigations Special Health Authority". Maternity investigations will not be affected by this change. I will keep the Board updated when further details are published.

Double win at the 2022 Nursing Times Workforce Awards winners

3.2 I would like to congratulate Suraj Kumar, Junior Charge Nurse at Watford, who won the "Preceptor of the Year" award. A preceptor is a vital position that supports and nurtures new nurses and midwives during their first year following qualification.

3.3 West Herts also won the "Best Employer for Staff Recognition and Engagement Award" for the Trust's superb clinical supervision programme, which provides staff with opportunity for personal growth and professional development through one-to-one and group sessions with skilled supervisors and practitioners.

3.4 I would like to congratulate everyone who was shortlisted as finalists for this year's awards which reflects the dedication and passion or our staff.

Chief Medical Officer

National neonatal audit on reducing risk

3.5 The “Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries” audit for maternity services was recently published and highlighted a number of trusts with mortality rates that were 5% or higher than the average of peer group providers.

3.6 The report reviewed data for 2020 and highlighted significant variation across providers. Average perinatal mortality rates have been falling across England since 2013 but a number of providers are now required to carry out detailed local reviews to see if any of the deaths were avoidable or to find out if there are any local factors that might explain the high rate.

3.7 As the executive officer with responsibility for patient safety, I would like to confirm that the Trust benchmarked favourably amongst its peers for both stillbirths and neonatal mortality and did not have a mortality higher than 5%. We remain committed to providing the safest maternity and neonatal service possible through a transparent and learning culture.

Chief People Officer

Winterfest

3.8 On 18th November we held the first of our festive Fridays at Watford, we had 13 stall holders attend, free massages, and Papa Gee’s hot desserts, Mitie also did Christmas rolls & mince pies. We received extremely high engagement of around 500 staff visit us between 11.30am – 3pm and positive feedback from staff. The annual festival next moved onto St Albans on Friday 25th November and Hemel on Friday 2nd December. The purpose of Winterfest is to bring a little joy to staff , giving them the opportunity to grab some Christmas shopping and get it wrapped (most of the stall holders offered discount and gave a gift to include in a raffle).

Staff Appraisals

3.9 For the first time since January 2020 the compliance rate for staff appraisal has exceeded 90%. This is a great achievement and demonstrates the commitment of our managers and staff to be supportive and provide a listening and compassionate culture at West Herts. This is also good news to hear how we can support staff learning and development especially with our focus on benefits from Teaching Hospital status.

Staff Survey

3.10 In another first for West Herts we have achieved over 50% engagement with our annual staff survey. This demonstrates our improvements with staff engagement. In a year when most NHS organisations are seeing a drop in staff survey engagement, West Herts is providing a positive outcome. The staff survey results are expected in February 2023.

Successful pilot for collaborative health education programme

3.11 I would like to congratulate the graduates of our pilot collaborative health education programme who joined together over five weeks to learn from one another. Five mental health nurses from Herts Partnership University NHS Foundation Trust (HPFT) and five of our adult care nurses shared their knowledge, skills and expertise to better support people's mental and physical health.

3.12 Our nurses were able to learn about suicide prevention, eating disorders and delirium, while HPFT nurses learned from our staff about acute medical management such as echocardiogram interpretations, blood sugars management and physical clinical skills. Both groups of staff learnt though academic learning, simulation and shadowing placements, and the programme received glowing feedback from participants.

Chief Financial Officer

New Hospital Programme visit

3.13 The Trust welcomed a visit from the New Hospital Programme senior leadership team to deepen their understanding of the challenges that our estate presents as well as a chance to learn about our innovative approaches to patient care. They were very interested in our virtual hospital model and were also keen to hear about our work on anticipatory care. We felt that despite the condition of our buildings and infrastructure, the NHP team left encouraged by real evidence of new ways of working that complement a strong case for significant new investment.

3.14 The Trust eagerly awaits more details on the local impact of increased NHS funding announced in the Chancellors Autumn statement. We recognise the challenge related to the costs of inflation which were not taken into account in previous funding announcements. We also recognise the need for the NHS to make further efficiencies and to deliver improved response and waiting times.

4 HCP development update

4.1 We continue working with the HWE ICB in the development of the South West Hertfordshire Health and Care Partnership. The focus of work has been on agreeing a shared performance target that we could deliver jointly as a partnership with shared accountability. The area of focus is envisaged to be Urgent Care and Flow. Work will continue to be progressed through the System Resilience Group with the HCP Board providing support as a strategic sponsor.

4.2 As an HCP Board, we have been consulted by HWE ICB colleagues on the development of an Integrated Care Strategy which will be asked to support. It is expected that the strategy will inform a joint forward plan which will be developed by March 2023 and submitted to NHSE for sign off. All partners must align with the forward plan and understand how they can support its delivery.

4.3 Work continues in Health and Care Partnership to agree priorities for the development path to re-affirm our strategic objectives and agree new ways of working that are owned by all the partners. We continue to progress our transformation projects including Virtual Hospitals, working together with partners in an integrated way.

5 NATIONAL GUIDANCE

New independent review of integrated care systems (ICSs) to improve health outcomes across the country

5.1 The government has announced a new independent review into oversight of ICSs to reduce disparities and improve health outcomes across the country, following record investment in health and social care.

5.2 The review will be led by former Health Secretary, the Rt Hon Patricia Hewitt who is currently chair of NHS Norfolk and Waveney Integrated Care Board, and will explore how to empower local leaders to focus on improving outcomes for their populations. This will include giving them greater control and making them more accountable for performance and spending, reducing the number of national targets, enhancing patient choice and making the healthcare system more transparent.

Consultation launched to protect patients from silent pandemic of antimicrobial resistance

5.3 A new consultation has been launched to inform next stage of tackling antimicrobial resistance or “superbugs”, which are estimated to cause around 7,600 deaths in the UK each year. The government has made significant progress in the past 5 years in tackling AMR by reducing the use of antibiotics in food-producing animals, piloting novel and innovative ways of evaluating and paying for antibiotics on the NHS through a subscription model. Views are sought to inform next 5-year plan to build on the gains made from the previous 20 year strategy.

6 NEWS AND DEVELOPMENTS

Welcome programme supports our newly qualified emergency care nurses

6.1 Newly qualified nurses joining our emergency medicine division have been transitioning into their roles with the help of the division’s new welcome programme. The division recently celebrated the graduation of its first group of students who provided positive feedback about the programme.

6.2 The welcome programme is an induction to emergency medicine where nurses learn practical and focused emergency care knowledge. The division hopes to run this programme for all new nurses who join. I would like to thank all staff members who have supported this programme and our hard-working nurses who took part.

7 RECOMMENDATION

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

Matthew Coats
Chief Executive
24 November 2022

Trust Board Meeting

1 December 2022

Title of the paper	**Board Assurance Framework report**
Agenda Item	**11**
Presenter	**Matthew Coats, Chief Executive Officer**
Author	**Barbara Anthony, Trust Secretary**
Purpose	*For approval* ✓	*For discussion*	*For information*
Executive Summary	The Board approved the corporate aims and objectives for 2022/23 on 7 April 2022. The BAF dashboard and detailed risks are attached for the Board to approve. The risks have been discussed at GPC on 17 November 2022 and FPC and QC on 24 November 2022. There were no material amendments to the BAF risks by the committees. The executive lead for BAF risks 1 and 6 has been changed to Matthew Coats, CEO pending the appointment of the Chief Strategy and Collaboration Officer. BAF risks 2 and 3 have been updated to reflect the progress made on waiting lists and the appointment of the interim Director of Transformation for the Patient Flow improvement programme 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.
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*

	x | x | x | x
Links to well-led key lines of enquiry	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☒Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☒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	• Great Place Committee – 17 November 2022 • Finance and Performance Committee – 24 November 2022 • Quality Committee – 24 November 2022 •
Action required	The Board is asked to consider and approve the latest version of the BAF.

Agenda Item: 11

Trust Board meeting – 3 November 2022

Board Assurance Framework report

Presented by: Matthew Coats, Chief Executive Officer

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.

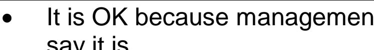
2.2 The BAF forms part of the Trust's overall board assurance and integrated risk management arrangements. It brings together three things:

- The Trust's four aims and 11 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	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

	consistent	information

2.5 The BAF is comprised of the dashboard, which makes reference to the risk statement and risk score matrix, and an in-depth template for each risk. These are dynamic documents and are used by the Board and assurance committees to influence decision making at an individual risk level.

3. Monthly review

3.1 The refreshed BAF will be reviewed monthly by the Board. The risk descriptions, gaps in controls and assurances, areas of challenge and mitigations were reviewed and updated by executive leads in October 2022.

3.2 Elements of the BAF were reviewed on 17 November 2022 by GPC and on 24 November 2022 by Quality Committee and Finance and Performance Committee.

3.3 FPC did not recommend any changes to the BAF.

3.4 The executive lead for BAF risks 1 and 6 has been changed to Matthew Coats, CEO pending the appointment of the Chief Strategy and Collaboration Officer.

3.5 BAF risks 2 and 3 have been updated to reflect the progress made on waiting lists and the appointment of the interim Director of Transformation for the Patient Flow improvement programme.

3.6 There are no areas of extreme risk (red) identified on the BAF. 10 risks are currently assessed as high (amber). Only limited assurance can be gained by the Board for these risks.

4. Risks

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

5. Recommendation

5.1 The Board is asked to consider and approve the revised version of the BAF.

Matthew Coats
Chief Executive Officer

November 2022

BOARD ASSURANCE FRAMEWORK FOR 2022-23													
Trust Board Dashboard													
Strategic Aim/Priority		**Risk no**	**Risk description**	**Executive Lead/ Committee**	**Link to CRR**	Risk Score (L x C)							
						Residual April 22	**Jun/ July 22**	**Aug/ Sep 22**	**Oct /Nov 22**	**Dec/ Jan 23**	**Feb/ Mar 23**	**Target (03/ 2024)**
Best Care	**Resilient Services**	1	If we do not work with acute partners, then we won't be able to strengthen fragile services, recover our acute waiting list and improve patient outcomes.	Clare Parker/ QC		20 (5 x 4) HIGH	20 ↔	20 ↔	20 ↔			12 (3 x 4) Mod
Best Care	**Improving access to care**	2	If the Trust and wider system does not have sufficient elective and diagnostic capacity, then its waiting lists will increase, and patients will be unable to access timely care.	Sally Tucker/ QC	4019 4496 4497	20 (5 x 4) HIGH	20 ↔	20 ↔	20 ↔			9 (3 x 3) Low
Best Care	**Improving access to care**	3	If the number of non-elective patients continues to rise, then this will detrimentally affect the Trust and wider system's ability to treat elective patients and reduce its waiting lists for elective care.	Sally Tucker/ QC	3828 4444	20 (5 x 4) HIGH	20 ↔	20 ↔	20 ↔			9 (3 x 3) Low
Best Care	**Improving access to care**	4	If we have insufficient staff because of low morale, inability to recruit or no enthusiasm for additional work, then we will be unable carry out additional elective work and reduce our waiting lists.	Andrew McMenemy/ QC		20 (5 x 4) HIGH	20 ↔	20 ↔	20 ↔			12 (3 x 4) Mod

	Reducing inequalities	5	If the Trust does not engage collaboratively with its patients and local communities, in the planning and delivery of care and services, then it may not meet the needs of its diverse population resulting in the exacerbation of health inequalities.	Andrew McMenemy/ QC		9 (3 x 3) Mod	9 ↔	9	9			6 (3 x 2) Low
	Transforming our services	6	If we do not work with partners to transform our services, then we will not have sufficient capacity to provide safe and effective care to our patients.	Clare Parker/ QC		20 4 x 5 HIGH	20 ↔	20	20			10 2 x 5 Mod
Best Value	**Ensure we can meet the health needs of our population within our budget on an on-going basis**	7	Failure to agree a plan between the Integrated Care System and the Trust Board to reasonably support the balancing of this year's revenue income with revenue expenditure, when safely responding to expected patient demand.	Don Richards/ FPC		12 (3 x 4) Mod	16 4 x 4 High ↑	12 3 x 4 Mod ↓	12 ↔			8 (2 x 4) Mod
		8	Failure to take corrective action to manage internal/external factors, may result in the trust being unable to adhere to the agreed financial plan.	Don Richards/ FPC		16 (4 x 4) High	16 ↔	16	16			8 (2 x 4) Mod
		9	Failure to agree a realistic long term financial plan that is consistent with ICB long-term allocations compromising the ability to transform the estate and services to meet the longer term needs of the population.	Don Richards/ FPC		12 (3 x 4) Mod	12 ↔	12	12			8 (2 x 4) Mod

Great Team	Culture of inclusion and diversity	10	Engagement and inclusion with staff will be affected negatively where we do not support and celebrate cultural diversity and demonstrate opportunities across all areas of our workforce to ensure it is representative.	AM/ PERC		12 (4 x 3) Mod	12	12	12			6 (3 x 2) Low
Great Team	Improve workforce sustainability	11	Sustainable staffing and improved levels of retention will be affected if we do not invest internally in a positive workplace experience, staff development and externally in local and international candidate opportunities.	AM/ PERC		16 (4 x 4) HIGH	16	16	16			8 4 x 2
Great Team	Develop as a learning organisation	12	The morale and retention of our skilled workforce is at risk if we do not support and prioritise learning and career opportunities for our staff in order to maintain and enhance development and reduce staff turnover.	AM/ PERC		16 (4 x 4) HIGH	16	16	16			8 4 x2
Great Place	Digital and IT innovation	13	If the Trust is unable to secure sufficient funding to support its digital strategy, then its ability to transform its services will be affected.	Paul Bannister / GPC		15 (5 x 3)	15	15	15			6 2 x 3

	Redevelop our hospitals	14	If the confirmation of our capital allocation is delayed, it could lead to increased risk to the safe operation of the existing Watford hospital.	Clare Parker/ GPC		20 (5 x 4)	20	20	20			12 3 x 4
	Environmental Sustainability	15	If we do not minimise the Trust's adverse impact on the environment, then we may suffer reputational damage, cause increased pollution within our local and wider community and lose out on cost saving opportunities.	Clare Parker/ GPC		9 (3 x 3)	9	9	9			4

Risk Matrix					
Likelihood/ Frequency	**Consequence/Impact**				
	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
5 Almost Certain	5 Moderate	10 Moderate	15 High	20 High	25 Extreme
4 Likely	4 Low	8 Moderate	12 Moderate	16 High	20 High
3 Possible	3 Very Low	6 Low	9 Moderate	12 Moderate	15 High
2 Unlikely	2 Very Low	4 Low	6 Low	8 Moderate	10 Moderate
1 Rare	1 Very Low	2 Very Low	3 Very Low	4 Low	5 Moderate

Risk appetite statement

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

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

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

Threshold Matrix

Risk appetite	**What this means**
Very low	The Board is not prepared to accept uncertainty of outcomes for this type of risk.
Low	The Board accepts that a level of uncertainty exists but expects that risks are managed to a level that may not substantially impede the ability to achieve objectives.
Moderate	The Board accepts a moderate level of uncertainty but expects that risks are managed to a level that may only delay or disrupt the achievement of objectives but will not stop their progress.
High	The Board accepts a high level of uncertainty and expects that risks may only be managed to a level that may significantly impede the ability to achieve objectives.

Category	**Risk Appetite**	**Risk Appetite Score**
Quality safety	VERY LOW risk appetite for risks that may compromise safety such as patient harm, infection control, pressure sores and learning lessons.	1 - 5
Affordability	VERY LOW risk appetite for unaffordable items which would affect the financial sustainability of the organisation.	1-5

Quality effectiveness	LOW risk appetite for risks that may compromise the delivery of outcomes for service users such as outcomes, delays, cancellations or operational targets and performance.	6 - 9
Statutory compliance	LOW risk appetite for risks that may affect statutory compliance such as Information Commissioner, CQC, H&S, professional standards and external certifications.	6 - 9
VFM	LOW risk appetite for affordable patient safety items where there is a degree of subjectivity regarding assessment of VFM.	6-9
Workforce recruitment and retention	LOW risk appetite for risks that would affect equal opportunity and diversity and compromise fair recruitment and attractiveness of Trust as employer of choice.	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
Reputation	MODERATE risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the organisation	10 - 12
Quality experience	MODERATE risk appetite for risks that may affect the experience of service users	10 - 12
Workforce innovation	MODERATE risk appetite for actions and decisions taken to improve workforce health and wellbeing and future staffing requirements.	10 - 12
Partnerships	HIGH risk appetite for partnerships which may support and benefit the people the Trust serves	15 - 25
Commercial	HIGH risk appetite for commercial gain whilst ensuring quality and sustainability to service users	15 - 25
Digital innovation	HIGH risk appetite for digital innovation that challenges current working practices in support of digital systems that will produce benefits for the organisation.	15 - 25

BAF Risk 2	If the Trust and wider system does not have sufficient elective and diagnostic capacity, then its waiting lists will increase, and patients will be unable to access timely care.

Strategic Priority	Improving access to care
Review Date	Monthly
Exec Lead	Sally Tucker
Lead Committee	Quality Committee

Risk Score							
Residual	Apr/May	Jun/July	Aug/Sep	Oct/Nov	Dec/Jan	Feb/Mar	Target
20 (5 x 4)	20	20	20	20			9 (3 x 3)

Context
We are in a recovery phase after 2 years of covid-19. The national stand-down directive for elective care and increase in referrals means that we now have a backlog of patients waiting to be treated. Referral rates have increased as more patients access GP care again. However, there is a trend of more complex referrals being received because patients have delayed seeing their GPs. This increased level of clinical complexity has required more diagnostic work up and surgical intervention that is only suitable to be undertaken on the Watford site rather than at St Albans. Our ability to further increase the progress of our recovery program is also affected by the willingness of clinicians to undertake additional work over above their contracted hours. This is due to a combination of factors such as personal fatigue and financial issues related to pensions and taxation which is a national issue. The continued increase in emergency demand and admission rates is creating more outlying patients and increased use of surge areas which is reducing the amount of available ring-fenced elective care beds.

Gaps in Control and Assurance
We are unable to control the level of patient demand and are attempting to mitigate this with the following measures: - Launched recovery plan which links with the submissions made in the annual plan. - Established a monitoring and oversight governance structure. ORG, RTT Programme board, patient access meetings. Availability of monitoring data for divisions' to assess productivity performance & PTL management. - Outsourcing Group provides oversight on private and independent sector capacity and utilisation to maximise activity opportunities. - Outpatient transformation. Non- face to face, PIFU and referral management systems.

Progress		
Positive progress including future opportunities	Current challenges including future risks	How challenges are being managed
Diagnostics – extended the mobile MRI provision at HH to March 23. Established outsourcing criteria – outsourced more complex patients. Proactive reduction of 104 week waiters (55 to 0 for	Increased level of referrals. Lack of uptake of waiting list activity by clinicians. Referral profile has changed - greater volume of urgent / cancer referrals as opposed to routine. Increased complexity of elective procedures Unpicking use of EPR – issues with clock stops, PTL	Continuous review of demand and referral profile. Monitoring of productivity by division/specialty. Increased external performance oversight. EPR – close working with trust's digital leader and participation in digital steering group. Approval of business case of increased validation

end of October 22.) and ahead of 78 week wait improvement plan with reduction from 144 in April to 93 at end of October (plan 121). Complex Orthopaedic surgery recommenced at Watford on 10 October 22.	management, data quality. User knowledge / training	resources.

BAF Risk 3	**If the number of non-elective patients continues to rise, then this will detrimentally affect the Trust and wider system's ability to treat elective patients and reduce its waiting lists for elective care.**

Strategic Priority	**Improving access to care**
Review Date	**Monthly**
Exec Lead	**Sally Tucker**
Lead Committee	**Quality Committee**

Risk Score							
Residual	**Apr/May**	**Jun/July**	**Aug/Sep**	**Oct/Nov**	**Dec/Jan**	**Feb/Mar**	**Target**
20 (5 x 4)	**20**	**20**	**20**	**20**			9 (3 x 3)

Context
Continued increase in emergency care demand. Increased level of ambulance conveyances. Patients are opting to utilise hospital based emergency care services on the basis of a) constraints in accessing primary care or b) not wishing to engage in virtual appointment at GP practice level. The continued increase in emergency demand and admission rates is creating more outlying patients and increased use of surge areas which can reduce the amount of available ring-fenced elective care beds. .

Gaps in Control and Assurance
We are unable to control the level of emergency patient demand and are attempting to mitigate this with the following measures: - On going work with the CCG to audit primary care restoration of services. - Harris ambulance model pending roll out. (ambulance demand & handover) - Assessment of impact of 111 directional service - Maximising our SDEC services associated with admission avoidance.

Progress		
Positive progress including future opportunities	**Current challenges including future risks**	**How challenges are being managed**
Held initial internal summit on 16th June 2022 to review patient flow. Follow up session is scheduled for 17th August. We are exploring the expansion of the Virtual Hospital clinical pathways.	Demand is outside of our control. Continued increase in mental health presentations Ambulance conveyance patterns are resulting in peaks	ICS System working. Participation in ICS Board. Mutual aid support via ICS.

SMART extension to Gastroenterology and Cardiology Expansion of the virtual hospital model, initially to include heart failure and COPD with a roll out for wider use for other conditions eg Frailty Approval of two ED additional consultants and middle grades. Joint working EEAST re ambulance conveyances. Appointment of interim Director of Transformation for Patient Flow improvement programme	in departmental pressure.	Internal review of end to end patient flow i.e. discharges (via HEG). A follow-up summit on 17 August took place to look at Trust initiatives and opportunities of working and improving patient flow.

BAF Risk 7	Failure to agree a plan between the Integrated Care System and the Trust Board to reasonably support the balancing of this year's revenue income with revenue expenditure, when safely responding to expected patient demand.

Strategic Priority	Ensure we can meet the health needs of our population within our budget on an on-going basis.
Review Date	Bi-monthly
Exec Lead	Don Richards
Lead Committee	FPC

Risk Score							
Residual	Apr/May	Jun/July	Aug/Sep	Oct/Nov	Dec/Jan	Feb/Mar	Target
12	16 ↑	16 ↔	12 ↓	12 ↔			8

Context
The current difficult economic climate requires the Trust to work with the ICB to agree a realistic but achievable plan which meets the needs of all stakeholders. A timely agreement of the annual plan increases the ability of the Trust to balance the year's revenue income with revenue expenditure and to make maximum use of capital funds without breaching capital funding limits.

Gaps in Control and Assurance
Inflation forecasts are not stable and the current funding for inflation within contracts and prices does not cover current inflation forecasts. The efficiencies required to support the financial plan are not yet fully developed. The plans for elective activity recovery and hence forecasts for elective recovery funds are ambitious. Data quality necessary to monitor the planned activity plan is not yet fully assured. The forecasts and funding for the growth in emergency care demand are limited, assuming some degree of system working to manage demand. Demand management effects are yet to be assured.

Progress		
Positive progress including future opportunities	Current challenges including future risks	How challenges are being managed
National recognition that plans to balance income with expenditure contain unmitigated inflation risk. Efficiency programme governance in place to support Divisions in developing efficiencies. National work to test resources necessary to respond	Inflation effect manifests the worst case and additional inflation funding is not made available. Efficiency programme governance fails to support delivery of £15m general savings and £2.9m EPR	Frequent dialogue with the ICB highlighting risks/conditions within the plan which must be mitigated/met to deliver financial balance. Internal audit of financial governance planned.

to a 7.5% increase in emergency care demand. Divisions have set out and signed off high level plans for increasing elective activity. Increased support from the Centre for Elective Recovery Funding.	related savings. Demand management fails, emergency care demand exceeds expectation and additional funds not made available.	Stronger ICP governance. Review of inflation forecast by CFO.

BAF Risk 8	**Failure to take corrective action to manage internal/external factors, may result in the trust being unable to adhere to the agreed financial plan.**

Strategic Priority	**Ensure we can meet the health needs of our population within our budget on an on-going basis.**
Review Date	**Bi-monthly**
Exec Lead	**Don Richards**
Lead Committee	**FPC**

Risk Score							
Residual	**Apr/May**	**Jun/July**	**Aug/Sep**	**Oct/Nov**	**Dec/Jan**	**Feb/Mar**	**Target**
16	16 ⟷	16 ⟷	16 ⟷	16 ⟷			8

Context
Monitoring and corrective action planning through Divisional Finance and General Performance Reviews, Trust Management Committee, Finance Committee and Trust Board of the current factors that are most likely to affect the financial plan such as: 1. Inflation experience and procurement actions 2. Costs related to management of pandemic and appropriate adherence to IPC guidance. 3. Maximising ICP contribution to managing ED demand 4. Ensuring achievement of the efficiency programme by replacing any failed interventions with new interventions where necessary. 5. Achievement of elective capacity targets through ensuring planned developments are implemented and deliver anticipated measurable benefits.

Gaps in Control and Assurance
Control of inflation Control of ED demand only partially controlled through local partnership working.

Progress		
Positive progress including future opportunities	**Current challenges including future risks**	**How challenges are being managed**
National dialogue regarding inflation. Pandemic trajectory appears to be reducing overall, despite some spikes in infection rates.	Meeting the elective activity targets and triggering ERF funding will be extremely challenging.	Performance reviews, Committee assurance, individual performance appraisals, regular communication with all divisions regarding targets and actions/resources needed to meet those targets.

BAF Risk 9	Failure to agree a realistic long term financial plan that is consistent with ICB long-term allocations compromising the ability to transform the estate and services to meet the longer term needs of the population.

Strategic Priority	Ensure we can meet the health needs of our population within our budget on an on-going basis.
Review Date	Bi-monthly
Exec Lead	Don Richards
Lead Committee	FPC

Risk Score							
Residual	Apr/May	Jun/July	Aug/Sep	Oct/Nov	Dec/Jan	Feb/Mar	Target
12	12 ↔	12 ↔	12 ↔	12 ↔			8

Context
The long term financial plan gives assurance to the health system and regulators that the Trust can remain financially viable while transforming the estate and the way that services are provided to meet long term demand projections. If the Trusts long term plan is not consistent with ICB allocations and plans, the Trust's transformation plans will not be authorised to go ahead and necessary investment funds will not be made available.

Gaps in Control and Assurance
ICB in its infancy and the lack of a published recognised ICB long term financial plan. Any single capital investment in excess of £15m requires regulator approval. For example, the long term plan includes plans for the major redevelopment of the estate. The Trust is yet to have an outline business case approved.

Progress		
Positive progress including future opportunities	**Current challenges including future risks**	**How challenges are being managed**
The Board receives a regular update on the long term financial projections and assumptions. This will be developed further into a more comprehensive report.	Reliable assumptions in a volatile economy. Developing financial regime.	Transparency of assumptions. Contributions to the development and structure of the health system and financial regime.

BAF Risk 10	Engagement and inclusion with staff will be affected negatively where we do not support and celebrate cultural diversity and demonstrate opportunities across all areas of our workforce to ensure it is representative.

Strategic Priority	Culture of inclusion and diversity
Review Date	
Exec Lead	Andrew McMenemy
Lead Committee	PERC

Risk Score							
Residual	Apr/May	Jun/July	Aug/Sep	Oct/Nov	Dec/Jan	Feb/Mar	Target
12	12	12	12				
	↔						

Context	Gaps in Control and Assurance
The staff survey has demonstrated that we continue to have variations on how staff are treated based on their protected characteristics. The most recent staff survey indicated that a higher proportion of BAME and disabled experience harassment from managers and colleagues while at the same time do not feel as if they have equity of opportunities for development including consideration for more senior roles.	The Trust has working groups that support BAME, LGBT, Disabled and staff with carer responsibilities. However, there is a gap in bring these resources together in order to support the priorities and give greater focus for equality, diversity and inclusion.

Progress		
Positive progress including future opportunities	Current challenges including future risks	How challenges are being managed
A new EDI group has now been established with its first meeting taking place in September 2022. The group will report operationally to TMC to PERC for assurance purposes. The group will bring all collective sub-groups together under one governance arrangement and focus on the Trust strategic direction for Equality, Diversity and Inclusion. A new EDI lead for the Trust has been appointed with the opportunity to refresh priorities and work closely with colleagues in the system. The revised Workforce structure brings EDI within the OD & Culture	A new EDS assessment will be introduced in 2022/23 with oversight of EDI associated to the workforce as well as our services. Ensuring we make improved progress that demonstrates broader diversity across all areas with an emphasis on senior roles. The publication of the report from Sir Gordon Messenger on Leadership for a Collaborative and Inclusive Future provides some fresh insight in	A business case was not approved that would support the EDI agenda going forward. However, the alignment with EDI and the wider OD & Culture team is a positive way forward alongside a new EDI lead and the appointment of the new Director of People who has a strong background and extensive expertise in OD and EDI in the NHS.

framework and therefore sits closely with staff wellbeing, engagement and talent management.	developing our EDI priorities within our senior team.	

BAF Risk 11	Sustainable staffing and improved levels of retention will be affected if we do not invest internally in a positive workplace experience, staff development and externally in local and international candidate opportunities.

Strategic Priority	**Improve workforce sustainability**
Review Date	**Quarterly**
Exec Lead	**Andrew McMenemy**
Lead Committee	**PERC**

Risk Score							
Residual	**Apr/May**	**Jun/July**	**Aug/Sep**	**Oct/Nov**	**Dec/Jan**	**Feb/Mar**	**Target**
16	16	16	16				
	↔	↔	↔				

Context
Staff retention is one of the main challenges facing the NHS with the prediction that staff turnover would increase following the impact of the pandemic. WHHT is now seeing higher rates of turnover but in areas that were different from those demonstrated before the pandemic and for a variety of new reasons. This includes a changing employment market particularly with admin and clerical staff. There continues to be challenged specialities but we are now also seeing a higher proportion of clinical staff leaving with retirement and early retirement more common that prior to the pandemic. The exit feedback we receive is also suggesting a higher proportion of staff leaving the NHS than before and other reasons cited as vertical integration and lack of development opportunities.

Gaps in Control and Assurance
Further review of leadership development programme and alignment across the ICS. Review of organisational values and introduction of behavioural framework. Fully embedded peer to peer support programme following the funding identified for 2022. Effective long term workforce modelling plans across the corporate organisation as well as for services.

Progress		
Positive progress including future opportunities	**Current challenges including future risks**	**How challenges are being managed**
Part of national initiative sponsored by NHSIE on NHS retention. Appointment of People Promise Managers and new Associate Director for recruitment & retention appointed within a new remit in the senior HR team. Plans in place to support identified staff groups and	Increase in turnover with focus being on HCA roles. Main challenges around retention associated with vertical integration, development opportunities and fatigue following the pandemic.	Appointment of People Promise roles to work closely with Divisions and HRBPs. Enhanced and more regular and focused exit interview reports detailing reasons for leaving.

departments with retention and associated recruitment. Introduction of Reaching Out principles to provide positive intervention for those expressing to leave the Trust. In addition a revised induction programme to support new starters in the first 12 months of their employment.		Appointment of new role of Associate Director of HR – Recruitment & Retention. New initiatives associated to new starters with additional support to mitigate the high turnover rates for new staff.

BAF Risk 12	The morale and retention of our skilled workforce is at risk if we do not support and prioritise learning and career opportunities for our staff in order to maintain and enhance development and reduce staff turnover.

Strategic Priority	Develop as a learning organisation
Review Date	
Exec Lead	Andrew McMenemy
Lead Committee	PERC

Risk Score							
Residual	**Apr/May**	**Jun/July**	**Aug/Sep**	**Oct/Nov**	**Dec/Jan**	**Feb/Mar**	**Target**
16	16	16	16				
	↔	↔	↔				

Context
The staff survey has provided clear feedback that the area where we perform least well is within the category of a learning culture. At the same time it should be noted that West Herts benchmarks reasonably favourably alongside other acute Trusts in this area. Taking consideration of the implications on morale, alongside our ambitions with Teaching Hospital status, this is seen as a priority area to support a culture of learning, development and support for our staff.

Gaps in Control and Assurance
Leadership development 3 year rolling plans aligned to divisional and trust strategic and operational priorities. A succession plan that plots staff development with relevant training and leads to progression within the Trust associated to career and skill development. An appraisal process aligned to training needs analysis and training programmes that meets the needs of our staff and supports our objectives.

Progress		
Positive progress including future opportunities	**Current challenges including future risks**	**How challenges are being managed**

We have established a new OD and talent team that will be led by a newly appointed Associate Director of OD & Culture. In addition a newly appointed Associate Director of Learning & Development. Teaching Hospital status will be used as a catalyst to enhance our strategy of developing a learning organisation culture across all staff groups. Divisional plans associated to leadership development and succession planning have commenced but require improvement. The independent review of leadership development in the Trust has now been completed and actions will be developed alongside the L&D team.	Allowing staff and managers quality time to reflect and work with the OD & LD teams on succession plans and supporting the development of their staff. Providing a clear set of development offers across a wide range of staff and also prospective staff that includes work experience, apprenticeships, skill development and leadership development in a cohesive package.	The new OD and Learning structure has placed an emphasis on succession planning and career development. This is now being supported with the two new Associate Director roles that have clear expected objectives and work closely with senior managers to put in place the aims that will support cultural change towards a learning Trust.

BAF Risk 13	**If the Trust is unable to secure sufficient funding to support its digital strategy, then its ability to transform its services will be affected.**

Strategic Priority	Digital and IT innovation
Review Date	Monthly
Exec Lead	Paul Bannister
Lead Committee	GPC

Risk Score							
Residual	Apr/May	Jun/July	Aug/Sep	Oct/Nov	Dec/Jan	Feb/Mar	Target
15	15	15	15				6

Context
The funding required to implement the digital strategy that supports the Trust's longer-term ambitions has not been identified. An on-going commitment to digital investment is required. We have agreed to fund the "digital imperatives" for the new hospital in the acute redevelopment OBC, conversations continue around how we secure the remaining funding. The Digital Programme is funded to the end of March 2022. Digital funding will be clarified by the next round of financial planning or via an update from NHP.

Gaps in Control and Assurance
Inability to have an effective conversation on internal commitment to technology funding. Lack of certainty around national digital requirements for new hospital programme.

Progress		
Positive progress including future opportunities	Current challenges including future risks	How challenges are being managed
SG has fully aligned our recommended digital investment with the national digital blueprint for new hospitals and is currently writing a brief for each recommended piece of functionality that explains the benefit drivers and calculations. Meetings are progressing with whole of executive to go through the rationale for each of the most significant digital benefits commencing with the digital command centre on 21 June 2021.	The Digital Programme is funded to the end of March 2022. Digital funding will be clarified by the next round of financial planning or via an update from NHP.	Addressed within business plan and NHP updates.

BAF Risk 14	If the confirmation of our capital allocation is delayed, it could lead to increased risk to the safe operation of the existing Watford hospital.

Strategic Priority	Redevelop our hospitals
Review Date	Monthly
Exec Lead	Clare Parker
Lead Committee	GPC

Risk Score							
Residual	Apr/May	Jun/July	Aug/Sep	Oct/Nov	Dec/Jan	Feb/Mar	Target
20	20	20	20				

Context
The NHP is responsible for the delivering the hospital build project for approximately 40 hospitals. It has a finite budget and needs to balance the needs of the programme within the budget allocated to it by the Treasury. The redevelopment is needed because of our critical infrastructure issues and for patient safety, patient experience, and capacity issues. We will not be able to transform our services without it.

Gaps in Control and Assurance
Inability to control the scale and timing of the funding.

Progress		
Positive progress including future opportunities	Current challenges including future risks	How challenges are being managed
The Trust Board approved its preferred option for the redevelopment site at its meeting on 31 May 2022. The enabling works business case has been submitted and the pathology element is expected to be approved at the end of September There is increased consensus among key stakeholders that a full rebuild of WGH is necessary.	The new Prime Minister and Secretary of State may have different priorities for the NHP The infrastructure of the trust continues to deteriorate, increasing risk associated with delays The changing economic landscape will impact the NHP's budget. The delay to approval of the enabling works business case will impact the timeline of the overall project.	Close liaison with NHP and ensuring that the Trust is ready to progress to the next phase of the programme.

BAF Risk 15	If we do not minimise the Trust's adverse impact on the environment, then we may suffer reputational damage, cause increased pollution within our local and wider community, and lose out on cost saving opportunities.

Strategic Priority	Environmental sustainability
Review Date	Monthly
Exec Lead	Clare Parker
Lead Committee	GPC

Risk Score							
Residual	**Apr/May**	**Jun/July**	**Aug/Sep**	**Oct/Nov**	**Dec/Jan**	**Feb/Mar**	**Target**
9	9	9	9				4

Context
The NHS has a responsibility to provide high quality health care whilst protecting human health and minimising negative impacts on the environment. The NHS Standard Contract mandates that all healthcare services are required to have (and deliver upon) a Green Plan and there is a requirement for an annual summary of progress to be reported to the ICS's Co-ordinating Commissioner via the Trust's Net Zero Lead. Overall, the NHS is required to reduce its carbon footprint by 80% by 2028 – 2032 and achieve net zero carbon by 2040. Moderate lower score in moderate. Linked to redevelopment – can't do stuff if don't have new buildings. Reducing carbon footprint excluding redevelopment

Gaps in Control and Assurance
Have Green Plan, started to implement, clear governance route through GPC. No current gaps identified.

Progress		
Positive progress including future opportunities	**Current challenges including future risks**	**How challenges are being managed**
The Trust Board approved its Green Plan on 4 February 2022. A Sustainability Steering Group has been formed to help monitor, manage and report on the progress of the Plan's actions. A 'Green Champions' network has been established which will support the implementation of the Green Plan.	Limited resources available to drive change.	Incorporating green plan objectives within current plans and budgets where possible.

Agenda item: 12

Report to:	**Trust Board**
Title of Report:	**Assurance report from Trust Management Committee**
Date of Committee meeting:	**26 October 2022**
Quoracy:	**The meetings were quorate.**
Date of Board meeting:	**1 December 2022**
Recommendation:	**For information and assurance**
Chair:	**Chief Executive Officer**
Purpose:	This report provides an update to the Trust Board on actions and developments since its meetings on 26 October 2022.
Background:	The Committee meets monthly and provides assurance to the Board: • Delivery of the clinical strategy • Revenue investment up to £1m • Operational performance • Operational risk • Safety and business continuity • Information technology • Internal and external communication strategy • Clinical quality • Business planning • Environment
Assurances received and items for update:	**Summary:** Assurance was provided on the monitoring of operational, financial and clinical performance and the development, implementation and monitoring of strategy. **Regular reports received and discussed for assurance:** • Covid-19 update from the Chief Nurse. • Finance update from the Chief Financial Officer.

Additional reports received and discussed for assurance:

- Quality Compliance Programme
- Next steps for Wellbeing Listening Forums
- Access Performance and Activity Report
- Virtual Hospital Development paper
- Patient flow improvement plan
- IPR

The Committee approved:

- Ward clerks business case
- Harm free care business case
- ED consultant replacement business case
- CDC OBC
- Land purchase business case
- Soft FM contract extension
- Outsourced IT managed service
- LED lighting business case
- SACH HV power business case

Oral reports were received from:

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

Any other business:

- Pathology relocation business case (approved)
- Ambulance handover

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

Agenda item:	**13**
Report to:	**Trust Board**
Title of Report:	**Assurance report from the Finance and Performance Committee**
Date of Committee meeting:	**24 November 2022**
Quoracy:	**The meeting was quorate.**
Date of Board meeting:	**1 December 2022**
Recommendation:	**For information and assurance**
Committee Chairperson:	**Harvey Griffiths, Non-Executive Director**
Purpose:	The report summarises the assurances received and documents the approvals of recommendations made to the Finance and Performance Committee at its meeting on 24th November 2022.
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 and the effectiveness of related delivery. The committee provides assurance to the Board on any issues of concern it has with regard to any lack of assurance in respect of any aspect of finance

Summary:

Internal audit reports (BDO) confirm compliance but some areas for improvement in implementation and management

Continued focus on performance – improving trajectory but still below target

Month 7 and some work to do to land the budget

Pathology full business case – key enabler for certainty, improved service levels and new hospital site

The Committee received reports and discussed for information and assurance on the following:

- **Committee Governance:**
  - Workplan
  - Committee register
- **Terms of reference**
  - as currently approved
- **Corporate Risk Register**
  - ongoing review of risk reporting with a refocus on significant / emerging risks only
  - FPC assured on Business Assurance Framework ('BAF') and approved for Trust Board 1st December 22
- **Access Standard Performance and Activity Recovery Overview**
  - month on month demand remains high
  - we are no longer in Tier 1
  - ED activity much higher in the month
  - Improvement plans are in place – a new director has been appointed to look at flow
  - COO explained positives of 'boarding' and change of process
  - CEO stated integrated discharge is critical now
  - CMO highlighted our BMA rates are generous when compared to the system
- **Integrated Performance Report ('IPR')**
  - ED performance down this month but on much higher volumes
  - Chair and CMO explained SHMI performance is very encouraging – significant improvement since 2019

  - overall positive direction and trend
- **Efficiency programme**
  - hitting efficiency targets needs engagement from the divisions
  - CEO suggested another roadshow pre-Christmas to keep momentum up
  - assured on focus and process but need to monitor closely
- **Month 7 finance summary**
  - early signs we are off plan. CFO focused on trajectory to get back to break even
  - careful not to stall during ERF support, need momentum into next year
  - deficit forecast by neighbouring Trusts may put extra pressure on us
- **Contracts and commerce**
  - Tariff value of elective activity significantly behind plan. The variance compared to 2019/20 levels is due to a combination of less activity and reduced data recording.
  - ERF continues to be paid despite performance and relied on to support financial forecasts.
  - see finance summary above
- **Capital programme**
  - substantial capex programme being delivered. CFO provided assurance on resourcing with CEO support to add if needed
- **Full business case evaluation – Outsourcing Pathology**
  1. long planned strategic move to new shared service - all partners must approve
  2. WHTH are the lead contract / party and provided assurance on potential procurement challenge and legal agreement covering contractual back-to-back with partners
  3. Important enabling project for certainty, improved service levels and new hospital site
  4. FPC received assurance on benefits and key contract and procurement risk items
  5. FPC approved the full business case for outsourcing pathology for recommendation to Board 1st December 2022
- **Items for escalation to the Board**
  - Outsourcing pathology full business case with FPC approval as above

Items of note:	**Actions**
Key decisions taken:	None
Risks to refer to risk register:	None
Issues escalated to the Board:	None
Recommendations to the Board:	This report be taken for information and assurance and to aid discussion on other items on the Board’s agenda

Agenda item:	**14**
Report to:	**Trust Board**
Title of Report:	**Assurance report from Quality Committee**
Date of Board meeting:	**1 December 2022**
Quorum:	**The meeting was quorate**
Recommendation:	**For information and assurance**
Chairperson:	**Ginny Edwards, Non-Executive Director**
Purpose:	The report summarises the assurances received and documents the approvals of recommendations made to the Quality Committee at its meeting on 27 October 2022
Background:	The purpose of the Quality Committee is to provide the Board with assurance that high standards of safety and compliance, harm free, high quality, safe and effective services/clinical outcomes are provided by the Trust, and that adequate and appropriate governance structures, processes and controls are in place throughout the Trust.

Summary:

The committee received reports on the following matters:

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

- **Corporate Risk Register and Board Assurance Framework Report**
- **Chair's reports from Risk Review Group and Outsourcing Group**

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

- **Annual self assessment of the effectiveness of the Risk Review Group**
- **Divisional quality assurance report – Medicine**
- **Bi-annual IPC report**
- **IPC BAF update**
- **Perinatal Quality Surveillance Tool report**
- **Cervical Screening Programme Annual Report**
- **National and local safety standards for invasive procedures**
- **Maternal newborn and infant clinical outcome review programme (MBBRACE)**
- **Medicine Optimisation Annual Report (April 21 – March 22)**
- **Avoiding Term Admissions in Neonatal Units (ATAIN)**
- **2021 Inpatient Survey Trust Report**
- **Quality compliance programme report**

- **Maternity Safety Champion Terms of Reference**

The Committee noted the following:

The Corporate Risk Register and the BAF which was approved and recommended to the Board for approval.

The committee took assurance from the evidence provided on the Perinatal Quality Surveillance tool as recommended in Safety Action 09 in the Maternity CNST scheme.

MBBRACE - the committee received information and assurance on the actions being taken to progress the recommendations from MBBRACE and on the identification of areas for improvement.

The committee received the annual report on medicines optimisation and noted the progress and challenges and that a business case is being developed to enhance the service.

Avoiding term admission into the Neonatal Unit (ATAIN) - the committee took assurance on the reduction of admissions and progress with ATAIN and safety action 3 in the maternity CNST scheme.

National and Local Safety Standards for Invasive Procedures/WHO checklist – assurance was received from the CMO that the issue for Watford theatres accessing data from EPR had been resolved and confirmed 100% compliance. A report would be provided to January 23 Quality Committee to provide assurance on the quality aspect of the reporting.

Maternity Safety Champion

The safety champions discussed the ATAIN data and resolved that a further paper would be presented to the committee in December 22 which would update the committee on the overall reviews and data.

NHS Elect are delivering a session in midwifery in December 2022 to support the cultural working as a team. Cultural work would also take place alongside training commissioned with the LMNS.

The safety champions also noted the MDT ward rounds audit on the delivery suite and would receive a further update at its December meeting.

Risks to refer to risk register: None

Items for the Board to note: None

Recommendations to the Board: None

Agenda item:	**15**
Report to:	**Trust Board**
Title of Report:	**Assurance report from People, Education & Research Committee**
Date of Board meeting:	**1 December 2022**
Quorum:	**The meeting was quorate**
Recommendation:	**For information and assurance**
Chairperson:	**Natalie Edwards, Non-Executive Director**
Purpose:	The report summarises the assurances received and documents the approvals of recommendations made to the PERC Committee at its meeting on 27 October 2022
Background:	The purpose of the People, Education and Research Committee is to provide the Board with assurance that the Trust is meeting its requirements in relation to basic workforce metrics and obligations, including whistleblowing and freedom to speak up, meeting the key objectives of the People Strategy that its workforce is fit for purpose, engaged and that it provides a high- quality education provision and excellent research and development opportunities.

Summary:

The committee received reports and had discussions for information and assurance on the following matters.

- **Staff story – A&E nurse**
- **CPO update**
- **Workforce performance report (including flu and staff survey update)**
- **WHTH People Strategy**
- **Recruitment and retention update**
- **BAF**
- **Corporate workforce related risks**
- **Health and social care review – Leadership for a collaborative and inclusive future**
- **Cultural leadership programme**
- **Race and gender pay gap annual report**
- **Children’s Services Establishment Review**
- **Mid-year review (performance and strategy)**
- **Diversability update.**

The Committee noted the following main points:

Staff Story

The staff story from an A&E nurse who described the good experience that she had when joining the Trust and the areas where the Trust could improve.

Chief People Officer Update

The CPO update provided assurance and relevant update to the committee on the following areas:

Industrial Action – An update provided on the latest situation with ballots. In addition the work being undertaken to prepare the Trust in the event of industrial action, actions being taken to mitigate against the effects of any strike action.

Flu Vaccination Campaign – Staff Flu Vaccination is currently taking place with support from our team of peer vaccinators. The uptake from staff has been very positive especially with concerns that this winter could be challenging from a flu perspective.

Staff Survey - The staff survey commenced at the beginning of October and will run until the end of November. The CPO highlighted he was pleased to see improved engagement when compared to this time last year. It noted the work that it could carry out on developing action plans internally before the results were published as well as the overall work on three main areas for wellbeing which would be relevant to the survey results.

Workforce Performance

It noted the improving workforce KPI's in relation to staff turnover, sickness, and use of agency staff. The vacancy rate had risen, and assurance was received that this was due to an increase in the establishment rate. The turnover rate continued to decline and overall workforce performance provided good levels of assurance.

People Strategy

The committee received a further draft of the proposed People Strategy 2023-2028. The strategy was well received with feedback provided at committee. In order to give sufficient time for further feedback it was agreed to extend the consultation period for a further month and therefore the final version would be presented to December Board.

Retention and & Recruitment
The quarterly report, and separate paper on recruitment and retention, provided assurance that there was a focus on this area. This was supported by improvements in staff in post alongside improved performance on retention.

Cultural Leadership
Following the receipt of the Messenger Report the committee received proposals to implement the Cultural Leadership Programme. The associated paper provided assurance that the Trust was taking steps to implement the initiative developed by NHSE. It resolved to monitor the definition of culture to make sure that it was used inclusively.

Race & Gender Pay Gap Report
The Race and Gender Pay Gap report provided assurance on the actions required during 2023 to progress values based recruitment and promote leadership and development opportunities for its staff.

Research & Development Update
Positive progress about the progress of the research & development team was received which demonstrated the links being made with local networks.

Risks to refer to risk register: None

Items for the Board to note: the Board would receive a paper on Cultural Leadership Development early next year.

Recommendations to the Board:

To approve the People Strategy coming to the Board in December 2022.

To approve the Race and Gender Pay Gap Annual Report for publication in November 2022.

Agenda item:	**16**
Report to:	**Trust Board**
Title of Report:	**Assurance report from Great Place Committee**
Date of Committee meeting:	**Thursday 17th November 2022**
Quorum:	**The meeting was quorate**
Chairperson:	**Helen Davis**
Purpose:	The report summarises the assurances received, and documents approvals of recommendations made by Great Place Committee at its meeting on 17th November 2022.
Background:	The Committee meets 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. It is also responsible for the oversight of the Better Care Delivered Differently change programme.

Summary:

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

SRO Programme Update

The Great Place Committee noted that it was positive news that the New Hospital Programme (NHP) team had visited WHTH and had seen the need for WHTH's redevelopment scheme first-hand. Further meetings with the NHP were anticipated during December.

OBC Update

The Committee also noted that further discussion with the NHP team would inform the production of the final OBC and the aim was for this to be completed by Easter 23.

Key Enablers Update

The Great Place Committee were assured that enabling schemes at Watford were progressing well. Work was scheduled to commence to create extra beds in Shrodells, approval had been given for the pathology Essential Services Lab and the land acquisition business case had recently been submitted.

Interim Estates Programme & ED Reconfiguration Update

Dr Hoey and C Galaska attended to provide an update on the interim ED plans. The Great Place Committee noted the work being done to put in place a robust structure to support the

interim estates programme and was also reassured that the ED plans struck an appropriate balance between short term disruption and long-term benefits.

Travel & Access update

It was reported that initial work on travel and access had completed and would inform production of a strategy to be reviewed by the Committee in January 2023.

Better Care Delivered Differently Programme

Of all of the eight (8) programmes under Better Care Delivered Differently (BCDD), the Committee were informed that two (2) were reporting as green, while six (6) programmes were reporting as amber.

Digital Progress Report

The Great Place Committee heard that good progress continued to be made against the majority of projects and recognised that there was a robust plan in place.

Redevelopment Risk Update

The Great Place Committee noted that as part of work on the OBC, a risk workshop had been held. To ensure transparency, the outcomes of this workshop were shared with the committee.

Communications & Engagement Report

The Great Place Committee noted the positive engagement work underway.

Capital Expenditure Report

The Great Place Committee noted the need for careful management of capital expenditure against profile for this financial year, to avoid pressure during 2023/24.

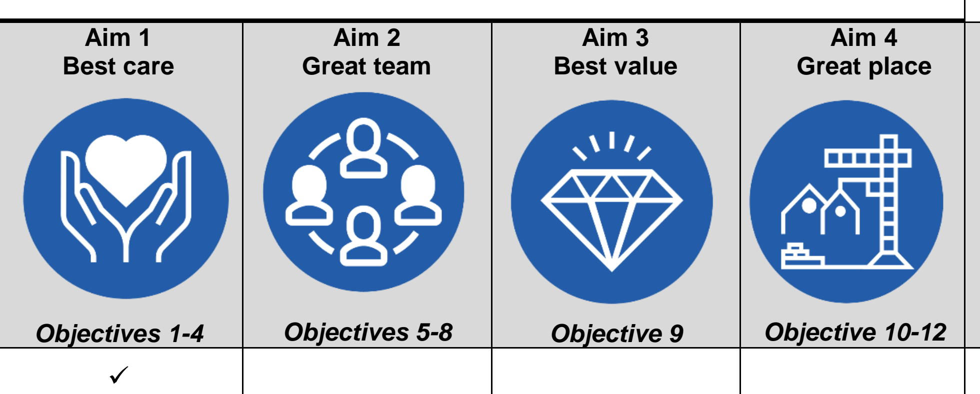
Risks to refer to risk register: No new risks identified.

Items for the Board to note: Positive dialogue with the New Hospital Programme.

Recommendations to the Board: None.

Trust Board
1 December 2022

Title of the paper:	Access Standard Performance & Activity Recovery Overview (October 2022)
Agenda Item:	18
Presenter:	Sally Tucker Chief Operating Officer
Author(s):	Jane Shentall Director of Performance
Purpose:	*Please tick the appropriate box* *For approval*: – / *For discussion*: – / *For information*: ✓
Executive Summary:	Activity rates measured against the 2019/20 baseline are improving but remain below the operational planning/recovery targets. Referral rates are slightly lower than seen in earlier months but remain above the September 2019 baseline at 109%. Cancer referrals have reduced somewhat but urgent referrals remain very high at 112% overall. Outpatient activity has increased somewhat and WACS continue to deliver a high level of activity. Medicine's non-face to face rate is consistently better than the 25% objective and both Surgery and WACS rates have increased this month. Elective (admitted) activity has deteriorated slightly, but there is a better understanding of the impact of changes in reporting activity types which is likely to be influencing rates. Diagnostic activity is lower this month although some modalities are delivering above the 19/20 baseline and colonoscopy has achieved the 120% target. Non-obstetric ultrasound scans (NOUS) have now reached just over 100% of the baseline. Diagnostic waiting times performance continues to improve and a number of modalities are now compliant with the standard. RTT long waits improvement continues. There were no patients over 104 weeks at the end of the month and the forecast for future months remains at zero. There continues to be good improvement in the reduction of 78 week waits and the plan to deliver a zero position by the end of March 2023 remains intact with strong delivery above (better than) plan. There has been a further rise in 52 week waits and divisions have been asked to ensure there is sufficient focus on this cohort as well as those with longer waits. The data quality issues affecting PTL size and clock stops is a significant factor inflating the position. A programme of enhanced validation started in November, supplementing in house validation resources. Further validation (administrative and clinical) will then focus on pathways where application of Access policy rules and processes will be reinforced and clinical decisions made on next steps where there is delay or concern.

	There has been good improvement in cancer performance. Delays in the 2 week wait pathway have affected performance against the 28 day faster diagnosis standard although this is better than last month's position. The current 62 day first performance position is not yet finalised. There has been good improvement in the cancer 62 day backlog, now with 9.3% of pathways over 63 days. The 78 week (by March 23) risk cohort and the 62 day relative PTL backlog were 2 of triggers for the trust's designation by NHS England, as a Tier One provider. Fortnightly oversight meetings are in place with key external stakeholders. These are progressing well and our demonstration of grip and control and improvement delivery has been recognised. Details of the criteria for exit from Tier One are awaited. A 2 day visit by NHS England's Elective Care Improvement Support team (IST) took place on 8 and 9 November, where systems and processes including reporting and oversight of RTT and Cancer were reviewed. The IST report detailing their findings and any recommendations is still awaited. Emergency Department waiting times performance was lower this month, largely due to an increase in attendances and high acuity. Overall performance was 64.5%, type 1 36.9% and type 3 performance also reduced at both UTCs, with 88% at Watford and 96.8% at Hemel Hempstead. Improvement plans are in place across all of these key indicators and the improvement noted above is evidence that some of the key actions are beginning to deliver the required increases in activity and performance.
Trust strategic aims: *(please indicate which of the 4 aims is relevant to the subject of the report)*	 Aim 1: ✓
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?

<table>
<tr><td>Previously considered by:</td><td>
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<tr><th>Committee/Group</th><th>Date</th></tr>
<tr><td>Trust Management Committee</td><td>23 November 2022</td></tr>
<tr><td>Finance & Performance Committee</td><td>24 November 2022</td></tr>
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<tr><td>Action required:</td><td>

- The Board is asked to receive this information for oversight of activity delivery and performance.

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Trust Board
1 December 2022

Access Standard Performance & Activity Recovery Overview – October 2022

Planned Care
- Outpatient Activity
- Inpatient Activity
- RTT performance & long wait reduction
- Diagnostic activity
- Diagnostic (DMO1) performance
- Cancer Waiting Times performance

Urgent & Emergency Care
- ED Performance
- ED Performance Improvement

Jane Shentall
Director of Performance
24 November 2022

Outpatient activity

Referrals				
Oct-22	All refs	Cancer	Urgent	Routine
Surgery	109% ⇧	104% ⇩	146% ⇧	90% ⇧
Medicine	104% ⇩	105% ⇩	79% ⇩	67% ⇧
WACS	141% ⇧	147% ⇧	229% ⇧	65% ⇩
Trust	**109% ⇩**	**108% ⇩**	**115% ⇧**	**55% ⇩**

NB: Total referrals includes A&G. Breakdown is PAS only, excl ERS

Referrals

- Demand appears to have reduced slightly although the new profile of increased cancer and urgent referrals remains unchanged
- WACS activity is currently being investigated as non-elective referrals are potentially distorting the reported position, particularly those prioritised as urgent

Outpatients - 1) 25% reduction in F/U activity 2) 25% virtual/non f2f activity 3) 5% PIFU 4) Advice & Guidance - 16% of 1st OPAs				
Oct-22	New	F/up	Non-F2F	A&G rate
Surgery	97% ⇧	75% ⇧	9% ⇔	52%
Medicine	78% ⇩	85% ⇧	30% ⇔	
WACS	143% ⇧	87% ⇧	9% ⇧	
Trust	**93% ⇧**	**80% ⇔**	**18% ⇧**	

Activity shortfall to baseline & 22/23 planning target - NEW OPAs		
Oct-22	to achieve 19/20 b/line	to achieve 110%
Surgery	656	1239
Medicine	1686	2278
WACS	Achieved	Achieved

Arrows = change from previous month - target achieved / not achieved
NB: Data shows all activity (ie chargeable, non-chargeable)

Outpatient Activity

- WACS new patient activity remains above target.
- Surgery have delivered further improvement.
- Medicine and WACS f/up activity was above the 75% threshold
- Non face to face activity has also increased.
- Although not shown, a break down of non face to face activity is as follows:
  New nf2f 9.2% (Surgery 4%, Medicine 19%, WACS 0)
  Follow up nf2f was 23.5% (Surgery 13%, Medicine 36%, WACS17%)

Elective (inpatient/day case) activity

Electives - 110% of 19/20			
Oct-22	Total	Inpatient	Day Case
Surgery	71% ⇩	96% ⇧	64% ⇩
Medicine	84% ⇩	83% ⇧	84% ⇩
WACS	42% ⇩	42% ⇩	42% ⇩
Trust	**77% ⇩**	**81% ⇩**	**76% ⇩**

Activity shortfall to baseline & 22/23 planning target - ALL INPATIENTS		
Oct-22	to achieve 19/20 b/line	to achieve 110%
Surgery	657	844
Medicine	372	581
WACS	237	276

Total activity

- An additional 1268 episodes would be required to achieve 100% of the 19/20 baseline.
- The majority of the shortfall is within day case activity. To achieve 100% of the inpatient admissions target, 147 additional cases would have been required, compared with 1,176 additional day cases.

Inpatient rates

- Surgery achieved 96% of the baseline activity this month
- WACS rates remain low and further review is required to better understand the underlying factors for low activity. It has been suggested that new ways of recording activity (POD) in EPR has resulted in a lower activity rate for 22/23 as certain types of activity is now included under other descriptors.

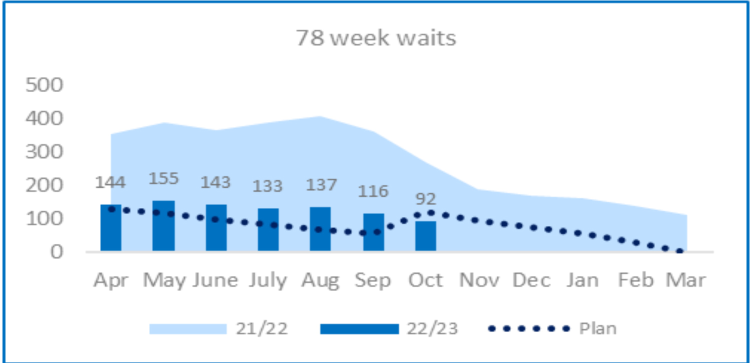
Day Case rates

- Day case rates in Surgery have yet to deliver a significant improvement in activity rates.
- Medicine has not maintained the same level of activity as delivered last month but inpatient admissions did increase.
- As with inpatient activity, WACS rates are low and further review is needed to understand the underlying factors.

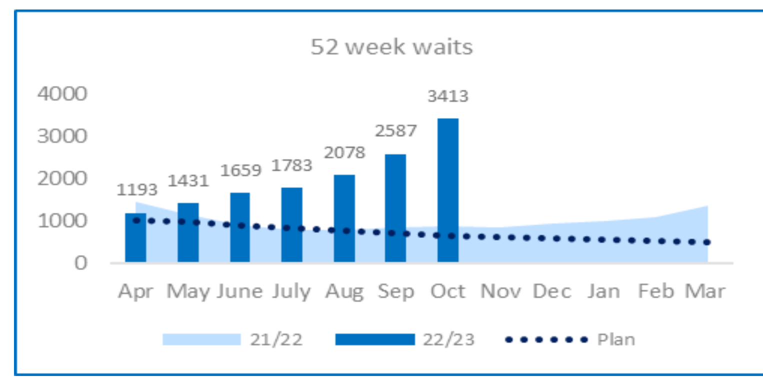
Arrows = change from previous month - target achieved / not achieved
NB: Data shows all activity (ie chargeable, non-chargeable)

NHS West Hertfordshire Teaching Hospitals NHS Trust

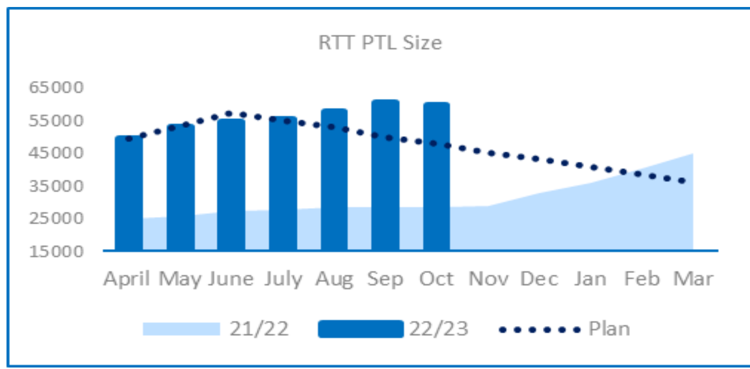
Referral to treatment



78 week waits
The number of patients currently at 78 weeks has improved and is now better than the revised plan (121) submitted in early October.

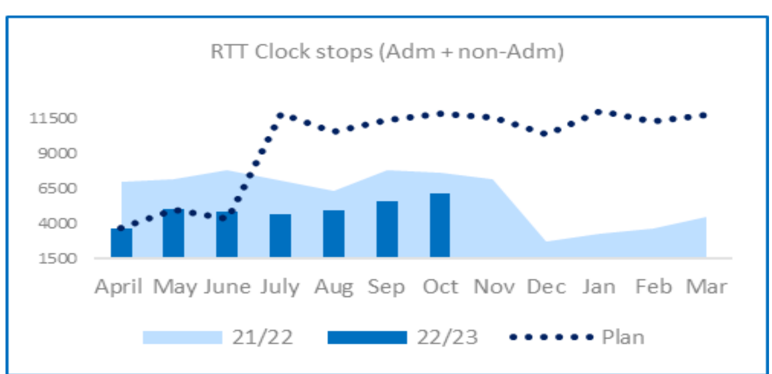


52 week waits
There has been a significant increase in the number of patients waiting over 12 months. In the initial phase of the extensive validation work, focus on this cohort of patients will be prioritised.



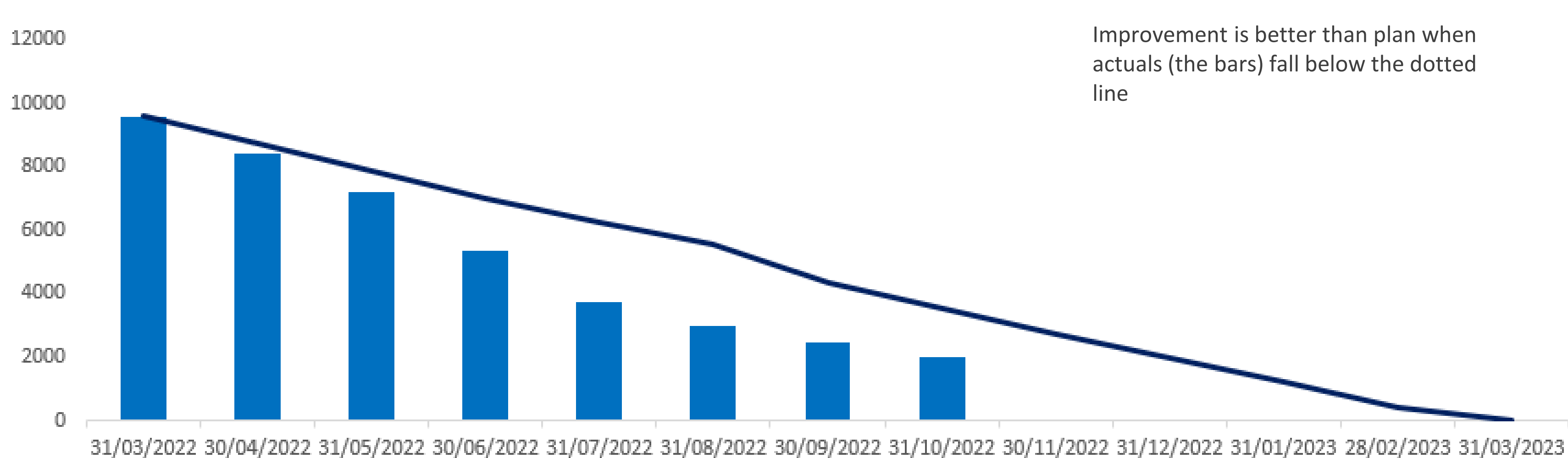
RTT PTL size
The PTL decreased in size in October, with over 1,000 fewer pathways.

This is largely due to the extensive validation work and initial feedback is confirming further evidence of incomplete outcoming of activity.



RTT clock stops
The total number of clock stops remains lower than seen in 19/20 but October's total of 6,116 is the highest since November 2021, and 483 more than September. A significant proportion of these clock stops are linked to the extensive validation work.

78 week waits – at risk pathways



	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Trajectory	9,586	8,743	7,858	6,974	6,278	5,583	4,372	3,561	2,713	1,975	1,201	427	0
Actual	9,586	8,442	7,179	5,377	3,736	2,984	2,463	1,996					

Diagnostic activity

Imaging

- CT activity remains strong although as a % of the baseline, is lower than the previous month.
- MRI activity has become more complex, with many patients requiring longer scanning time. This results in lower activity but similar or increased utilisation.
- NOUS activity is showing good signs of recovery, now just above the baseline. This is largely the result of additional activity being undertaken through outsourcing.

Medicine

- Colonoscopy has achieved the 120% target
- Gastroscopy activity is lower than seen in the last few months and only a small number (40) would have been needed to achieve 100% of the baseline rate. This has been affected by surge in to the Endoscopy Unit during the month. Outsourcing and weekend waiting list initiatives are in place to mitigate for the loss of activity as much as possible.
- Workforce resource challenges within the Echo service continue to impact on recovery.

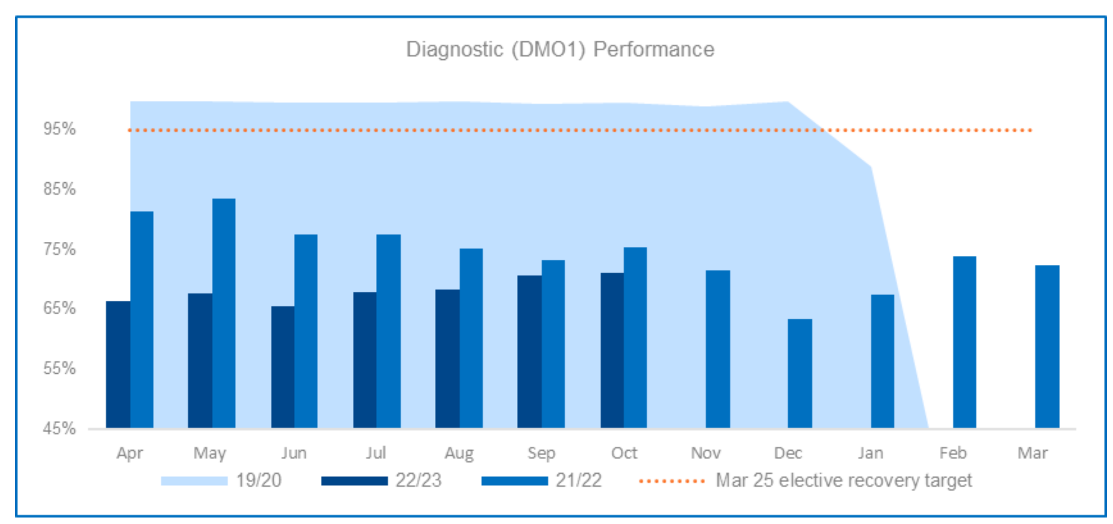
Diagnostics: Clinical Support - 120% of 19/20			
Oct-22	CT	MRI	Non-Obs US
Imaging	104% ⇩	92% ⇩	101% ⇩

Diagnostics: Medicine - 120% of 19/20			
Oct-22	Colonoscopy	Gastroscopy	Echo
Medicine	113% ⇩	75% ⇩	66% ⇩

Activity shortfall to baseline & 22/23 planning target		
Oct-22	to achieve 19/20 b/line	to achieve 120%
CT	Achieved	574
MRI	123	448
NOUS	Achieved	694
Colonoscopy	Achieved	70
Gastroscopy	188	309
Echo	545	805

Arrows = change from previous month - target achieved / not achieved
NB: Data shows all activity (ie chargeable, non-chargeable)

Diagnostic Performance (DMO1)



Performance has improved further, at 71.1% (target 99%). A number of modalities returned to a compliant position, ie at 99% or better :

- MRI
- CT
- NOUS

And the following are close to the 99% target

- Barium enema
- Clinical Neurophysiology
- Colonoscopy
- Flexible Sigmoidoscopy

Colonoscopy and flexible sigmoidoscopy performance is lower than in September due to the loss of capacity during the period of surge in to the unit to support urgent care demand.

Modalities with low performance include:

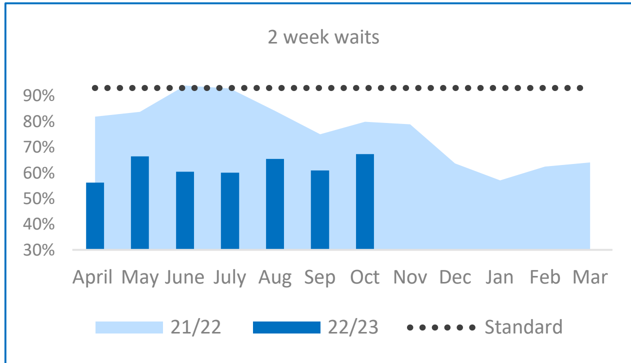
- DEXA
- Echo
- Cystoscopy
- Gastroscopy

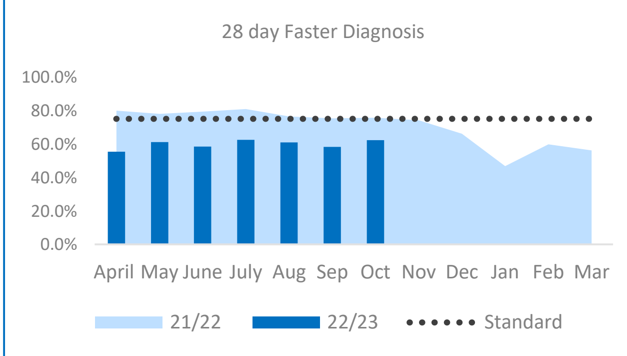
DQ issues associated with implementation of EPR are affecting the position in some modalities. Validation of the Colonoscopy PTL revealed multiple DQ issues including planned/surveillance mixed with active, duplicates etc.

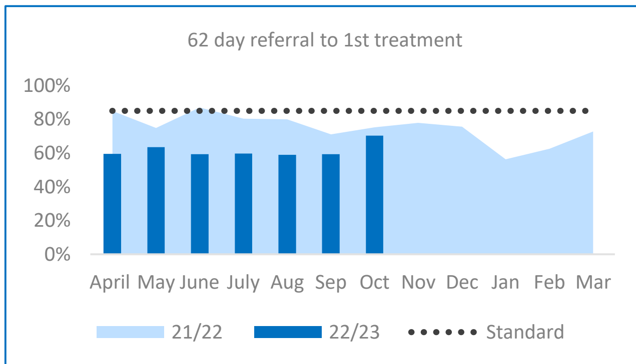
The cystoscopy list is similarly affected and also includes inpatient procedure pathways. Support from the BI team is needed to address this.

Cancer waiting times

West Hertfordshire Teaching Hospitals NHS Trust







2 week waits (target 93%)
Good improvement in October at 67.7% mtd (September 61%, August 65.4%, July 60%).

2week wait Breast Symptomatic (target 93%)
Good recovery continues with an improved performance of 43.8% (September 25%, August 12%, July 9.5%).

28 day Faster Diagnosis Standard (target 75%)
62.3% achieved this month (September 58.3%, August 61.1%, July 62.5%). The 2ww backlog affects performance against this standard.

31 day 1st (target 96%)
Latest position 94.2% (September 94.7%, August 93.8%, July 95.8%).

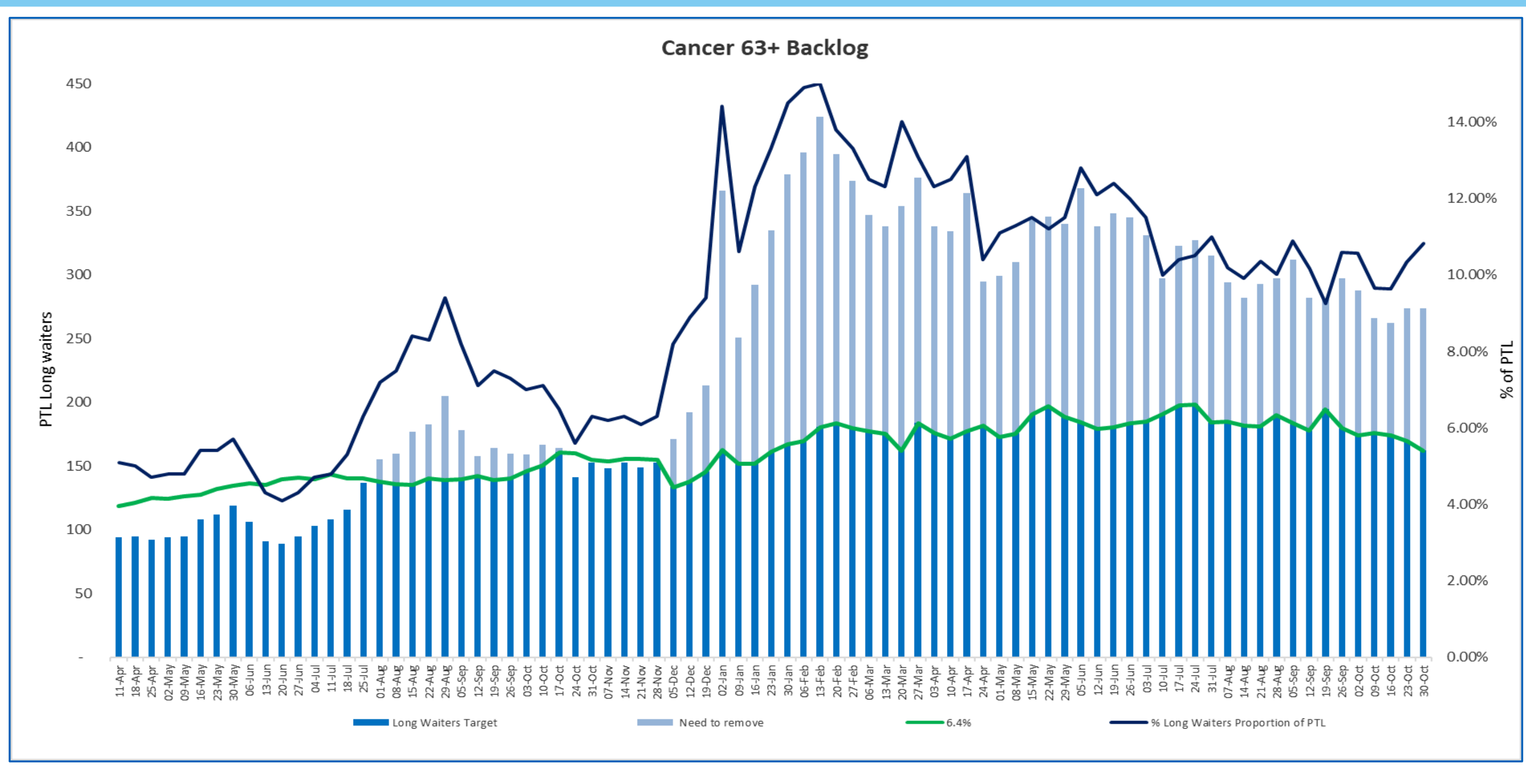
31 day subsequent surgery (target 94%)
Current position 100% (September 92.9%, August 89.3%, July 91.7%).

62 day screening (target 90%)
Only 73.7% this month (September 51.9%, August 74.2%, July 68.8%). 2.5 breaches – 4 Breast, 1 LGI.

62 day (target 85%)
Latest position 68% (September 59.3%, August 59.3%, July 59%). Currently 31.5 breaches (35 patients). 42% of the breaches were in Urology, 17% Lung, 11% Gynae, 8.5% Breast and UGI, LGI, H&N 5%.

Recovery Actions
- Additional consultant posts (substantive and locum) for Upper GI, Breast, Radiology, Urology
- Additional prostate template biopsy capacity created – could do more but insufficient outpatient nursing to support more sessions
- Outsourcing (Gastro/Endoscopy, Breast, additional Prostate MRI capacity)
- Nurse led clinics in Dermatology for imaging to free up consultant capacity
- Increasing straight to test (STT) pathways, eg OP hysteroscopy
- Additional Lower GI theatre capacity
- Trust wide A&C recruitment events (1st in early July)
- Established a cancer long waits (90+ days) review meeting with patient level discussion
- Collaboration with primary care to develop Breast pain clinic in the community.
- Breast 2ww referral form changes made to support demand
- Primary care roll out of dermoscopy underway

Cancer PTL – 62 day backlog



62 day backlog (target 6.4% of total PTL)

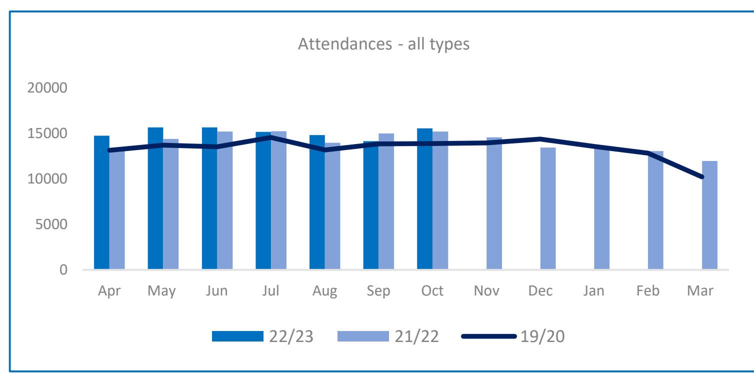
For the week ending 13/11/22 :

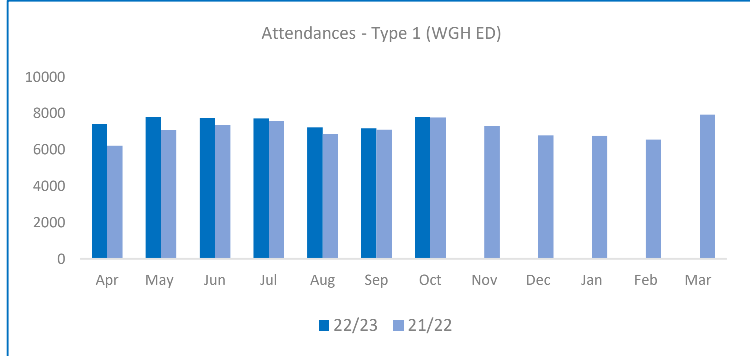
- The total cancer PTL was 2,609
- 9.3% / 243 patients are over 62 days in the backlog
- The EoE Cancer Alliances update for week ending 6/11/22 shows the trust 48th (of 72, with the 72nd having the smallest backlog)
- Removal of 76 more pathways would achieve the 6.4% backlog tolerance.

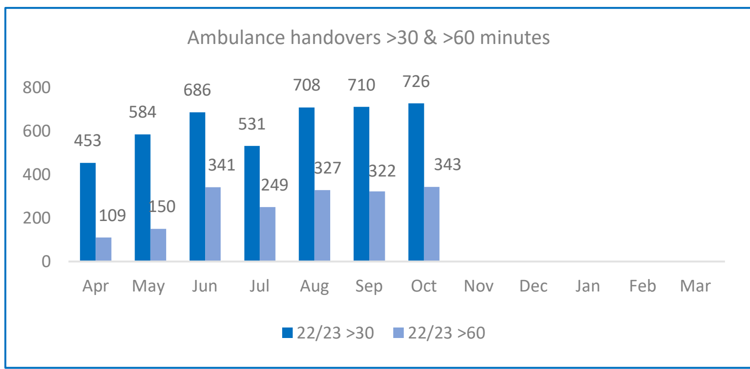
Actions to improve the position include:

- Escalation to Divisional Directors and Clinical Leads as necessary, where previous escalation has been unsuccessful
- Continuation of the spotlight on cancer huddles
- Weekly cancer long waits review meeting
- Renewed focus on delays due to clinical reviews and letter production
- Recruitment to various consultant posts (locum & substantive) in a number of services
- Dermatology advice & guidance service for lesions of diagnostic uncertainty launched

Emergency Department activity







Attendances

Demand has reduced slightly in comparison to the previous month.

- All: 15,609 (Sep 14,136) / Type 1: 7,790 (Sep 7,1642) / Type 3: 7,858 (Sep 6,972)
- Attendances are 12.4% higher than the 19/20 baseline and 2.6% than 21/22
- 4.4%/349 of all type 1 ED attendances related to MH (Sep 4.7%/328)

Ambulance handovers

Demand remains high and is above last month’s conveyances (2,260) with total arrivals to ED by ambulance of 2,313.

Handover delays (as a % of all ambulance arrivals)

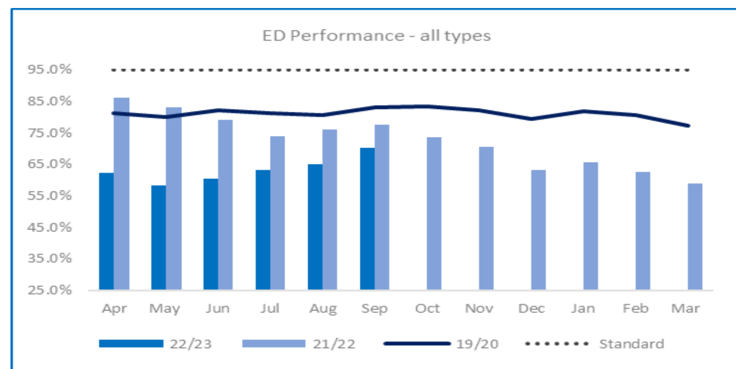
- 31.4% (726) 30 minutes or longer (EEAST: 60.6%)
- 16.5% (383) 30-60 minutes (EEAST do not measure this cohort)
- 14.8% (343) over 60 minutes (EEAST: 28.6%)

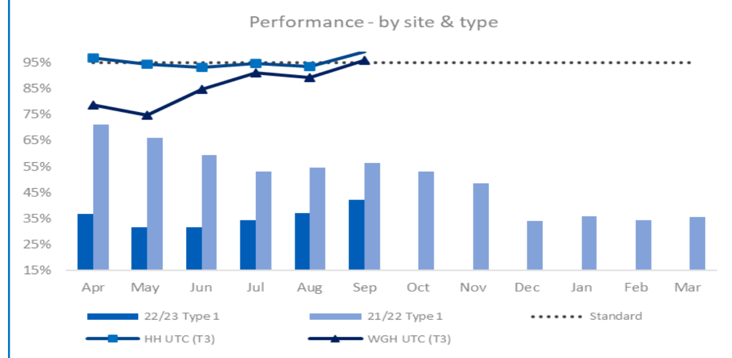
NB: EEAST use the “recording compliance” figure as the denominator, which was only 1370 in September (60.6% of all conveyances), resulting in delays reported at a much higher rate in their performance pack.

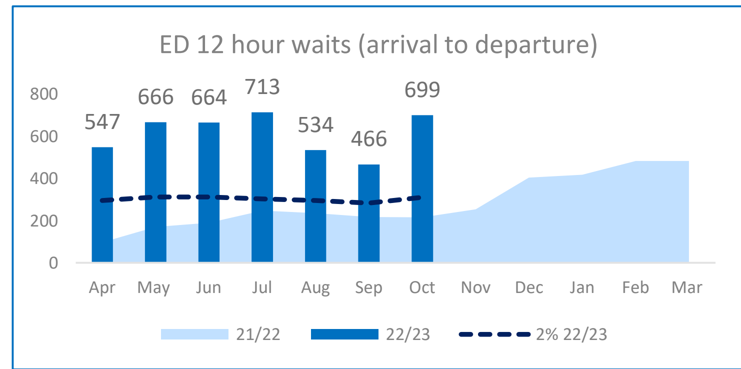
Handover Improvement Actions (system wide)

- Implementation of new boarding policy (from 21/11/22) to support flow
- Full HALO provision
- In/out assessment model
- Supportive of drop and go for Category 1
- Cohorting to enable earlier release of crews utilising Resus corridor
- Harm review of any patient with a 60+ delay
- Utilising old fracture clinic space to increase capacity, decompressing STARR
- Implementation of Fit to Sit
- Increasing referrals to EAU and other SDEC services
- Specialty reviews at front door
- CLCH input in ED/AAU morning rounds to pull patients back to community
- Rapid Response service (CLCH) 7/7
- Early intervention vehicle

Emergency Department Performance







Performance

Drop in performance this month, related to demand increase

- All types 64.5% (September 70.2%, August 65.1%, July 63.2%)
- Type 1 36.9% (September 42.1%, August 37.1%, July 34.4%)
- Watford UTC 88% (September 95.9%, August 89.3%, July 91%)
- HH UTC 96.8% (September 99.3%, August 93.4%, July 94.8%)

12 hour end to end journeys

A significant increase in 12 hour waits seen in October. Totals as a percentage of **all** attendances:

- October 4.5% (699)
- September 3.2% (466)
- August 4% (534)
- July 4.7% (713)
- June 4% (664)
- May 4% (666)
- April 4% (547)

Mental Health

4.5% of all ED attendances related to MH

10.4% (74) of all ED attendances over 12 hours related to MH

20.9% (74) of all ED attendances relating to MH (350) wait 12 hours or more (Sep 17.4%)

Data Sources

Planned Care

- Outpatient Activity – Weekly activity tracker (15/11/2022)
- Inpatient Activity – Weekly activity tracker (15/11/2022)
- RTT performance & long wait reduction – iReporter (15/11/2022)
- Diagnostic activity – Weekly activity tracker (15/11/2022)
- Diagnostic (DMO1) performance – iReporter (15/11/2022)
- Cancer Waiting Times performance – iReporter (17/11/2022)
- Cancer 62 day PTL relative backlog – EoE Cancer Alliances backlog update 6/11/22

Urgent & Emergency Care

- ED Performance – Atts & Waits files (5/9/2022)

Trust Board
1st December 2022

<table>
<tr><td>Title of the paper:</td><td>Integrated Performance Report
(November 2022 reporting period – October 2022 data)</td></tr>
<tr><td>Agenda Item:</td><td>19</td></tr>
<tr><td>Presenter:</td><td>Paul Bannister, Chief Information Officer</td></tr>
<tr><td>Author(s):</td><td>Mark Landau, Director of Business Intelligence
Paul Bannister, Chief Information Officer</td></tr>
<tr><td>Purpose:</td><td>Please tick the appropriate box
For approval:
For discussion: ✓
For information: ✓</td></tr>
<tr><td>Executive Summary:</td><td>
Summary
This cover sheet summarises the contents of the Trust Integrated Performance Report, detailing changes made to the pack and summarising some of the narrative points made and is intended to provide information and assurance to the committee.
Safe Care & Improving Outcomes – Changes to the pack
Theatre Utilisation has been added as a metric in the Activity section of the pack. The metric is measuring Theatre Utilisation (Touch time utilisation on the day hours planned inc. early starts and late finishes), and has been in common cause variation for the last 4 months.
Safe Care & Improving Outcomes - Quality
There are two statistically significant indicators – SHMI continuing to show in improving special cause variation, although Dr Foster class the Trust as being within ‘expected range’.
The second statistically significant change is in Caesarean Section rates for Robson Category 1 (spontaneous labour in women carrying a single baby and giving birth for the first time). The majority of caesarean births in this category were due to lack of progress (36.4%), sub-optimal CTG (40.9%) and unsuccessful instrumental (18.2%)
Safe Care & Improving Outcomes - Safety
There are three exceptions generated - % of nursing hours (shift fill rate) – Unregistered, % of patient safety incidents which were harmful, and Patients admitted to stroke unit within 4 hours of arrival, all three of which were also exceptions in the previous month.
Unregistered fill rate is showing as an exception with the latest data point breaching the upper control limit (for the second consecutive month). This is largely down to enhanced 1:1 care required (largely for mental health inpatients) and to staff exceptional surge.
Caring & Responsive Services – A&E
Eleven exception pages generated – with the only change to exceptions this month being 60 minute ambulance handovers returning to special cause variation
Type 1 Performance continues to be extremely challenged, with WHHT at 37% against the 4 hour target, following 3 months of improvement this has slipped again for October. Worth noting for context is that attendances increased from 14,136 in September to 15,541 in October, with Type 1 attendances (7,855) the highest they have been in 22/23 to date.
Caring & Responsive Services – RTT, Cancer, Outpatients
Twelve Exception pages generated. RTT incomplete performance shows the first improvement against the 18 week target since June 2021
The one metric that has returned to common cause variation is the Outpatient DNA rate (in common cause for the first time since February 2021)
Workforce
</td></tr>
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<table>
<tr><td></td><td colspan="4">

- Six Exception pages generated, all of which were exceptions last month, all of which were exceptions in the previous month's report.

Activity

- Seven Exception pages generated, all of which were also exceptions in the previous month's report.
- Theatre Utilisation added as a new metric

NB: Data correct at the time of reporting
</td></tr>
<tr><td rowspan="2">Trust strategic aims:

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

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

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

Objective 9</td><td>Aim 4
Great place

Objective 10-12</td></tr>
<tr><td>✓</td><td>✓</td><td>✓</td><td>✓</td></tr>
<tr><td>Links to well-led key lines of enquiry:</td><td colspan="4">☒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 colspan="4">

Committee/Group	Date
Trust Management Committee	23/11/2022
Finance & Performance Committee	24/11/2022
</td></tr>
<tr><td>Action required:</td><td colspan="4">The Board are asked to receive this report for information, assurance and discussion</td></tr>
</table>

Integrated Performance Report

November 2022 – October 2022 data

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

Integrated Performance Report

- Trust Management Committee – 26th October 2022
- Finance & Performance Committee – 27th October 2022
- Trust Board – 3rd November 2022

A note on SPC charts

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

High Level Key - Variation

Are we improving declining or staying the same

Variation

Assurance

Special Cause Concerning variation

Special Cause Improving variation

Common Cause

Consistently hit target

Hit and miss target subject to random

Consistently fail target

Orange = significant concern or high pressure

Blue = significant improvement or low pressure

Grey – no significant change

4

High Level Key - Assurance

Can we reliably hit the target

Variation

Special Cause Concerning variation

Special Cause Improving variation

Common Cause

Assurance

Consistently hit target

Hit and miss target subject to random

Consistently fail target

Orange = system change required to hit target

Blue = will reliably hit the target

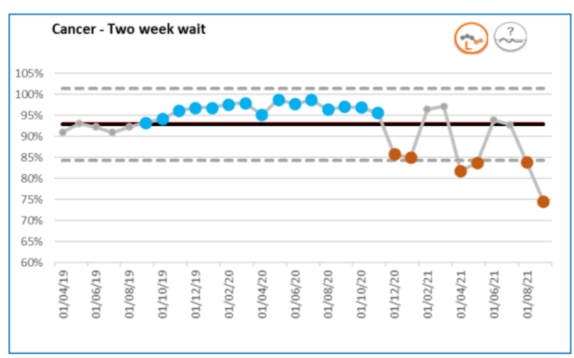
Hit and miss the target

Summary Icon Descriptions

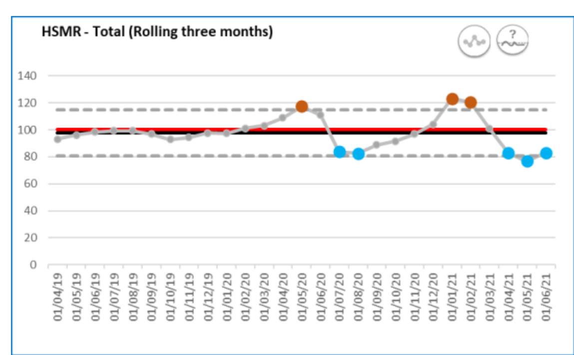
Perform	Assure	Description
		Special cause of a concerning nature where the measure is significantly **HIGHER**. This occurs where there is higher pressure in the system or deteriorating performance. This system is not capable. It will **FAIL** the target without system change.
		Special cause of a concerning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

SPC rules – Special Cause Variation

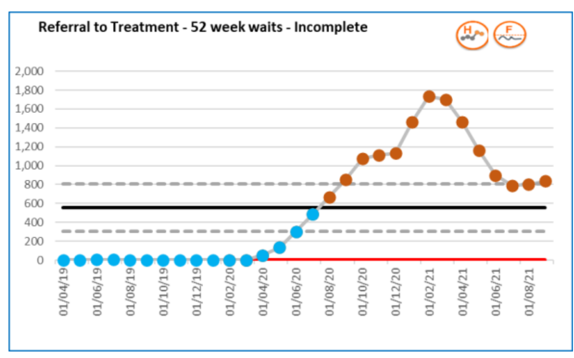
A breach of the upper/lower control limit



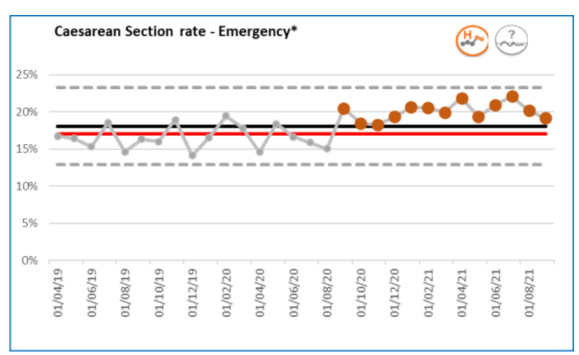
2 out of 3 points close to the control limit



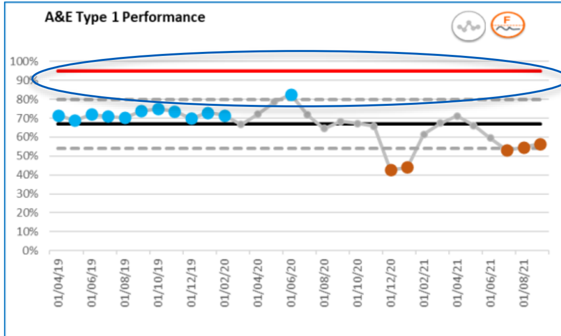
A run of ascending/descending data points



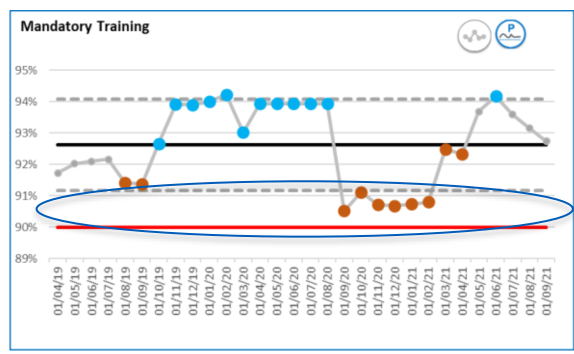
A run of points all one side of the mean



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

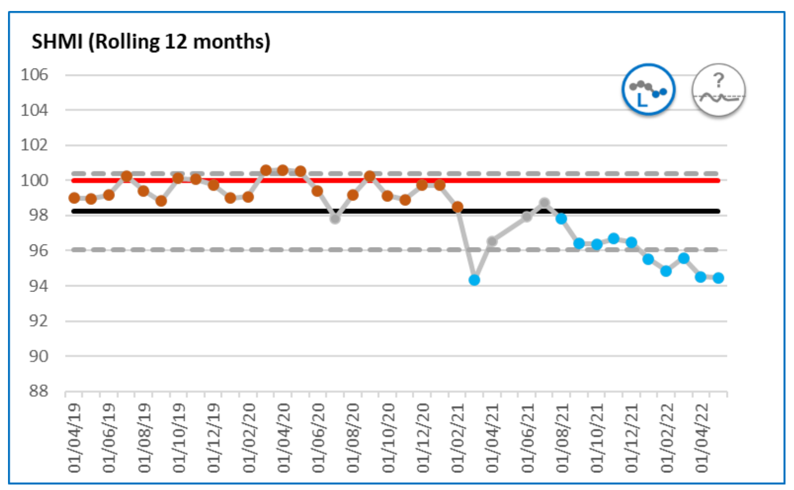


Variation indicating consistently passing the target – target line below lower control limit



KPI	Latest month	Measure	Target	Variation	Assurance	Local or National Metric	Committee	Owner
Safe Care and Improving Outcomes - Quality								
SHMI (Rolling 12 months)	May 22	94	100			National	Quality	CMO
HSMR - Total (Rolling three months)	Jul 22	100	100			National	Quality	CMO
Clostridioides Difficile - Hospital associated (Cat 1)	Oct 22	3	-			Local	Quality	CN
Clostridioides Difficile - Healthcare associated (Cat 2)	Oct 22	1	-			Local	Quality	CN
Clostridioides Difficile - Hospital and Healthcare associated Total	Oct 22	4	3			Local	Quality	CMO
Hand Hygiene Compliance	Oct 22	95%	95%			Local	Quality	CN
30 Day Emergency Readmissions - Elective *	Oct 22	4%	4%			Local	Quality	CMO
30 Day Emergency Readmissions - Emerg *	Oct 22	14%	13%			Local	Quality	CMO
Caesarean Section rate - Robson Category 1	Oct 22	35%	-			Local	Quality	CMO
Caesarean Section rate - Robson Category 2	Oct 22	64%	-			Local	Quality	CMO
Caesarean Section rate - Robson Category 5	Oct 22	85%	-			Local	Quality	CMO

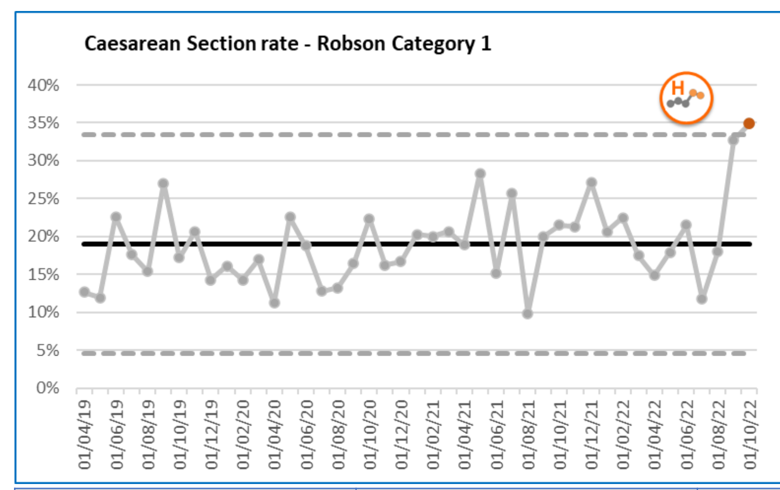
Special Cause Variation – Performance – SHMI (Rolling 12 months)



	Provider	Denominator	Obs	Exp	Obs-Exp	SHMI	Low	High
RC9	Bedfordshire Hospitals NHS Foundation Trust	104,330	2,585	2,400	185	107.62	89.61	111.59
RWH	East And North Hertfordshire NHS Trust	50,485	1,780	1,970	-190	90.38	89.47	111.77
RNQ	Kettering General Hospital NHS Foundation Trust	45,355	1,540	1,395	145	110.47	89.15	112.16
RD8	Milton Keynes University Hospital NHS Foundation Trust	48,580	1,205	1,130	75	106.57	88.91	112.48
RNS	Northampton General Hospital NHS Trust	69,525	1,645	1,800	-155	91.37	89.40	111.86
RWD	United Lincolnshire Hospitals NHS Trust	71,460	3,015	2,900	115	103.97	89.73	111.45
RWE	University Hospitals Of Leicester NHS Trust	137,460	3,655	3,495	160	104.57	89.82	111.33
RWG	West Hertfordshire Teaching Hospitals NHS Trust	61,095	1,830	1,940	-110	94.47	89.46	111.78

Background	What the Data tells us	Issues	Actions	Mitigations
SHMI – (Rolling 12 Months)	Exception triggered due to 7+ data points below the mean (a shift) Exception triggered due to a breach of the lower control limit	SHMI rate is within ‘as expected’ range according to Dr Foster. This is positive performance		

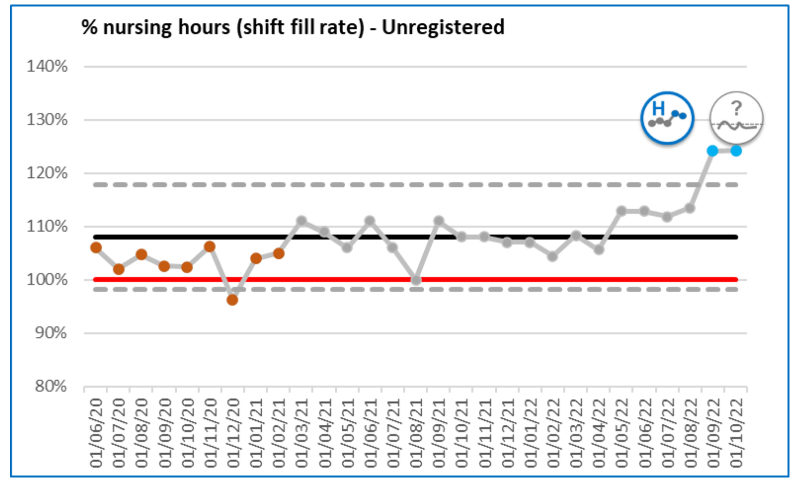
Special Cause Variation – Performance – Caesarean Section Rate – Robson Category 1

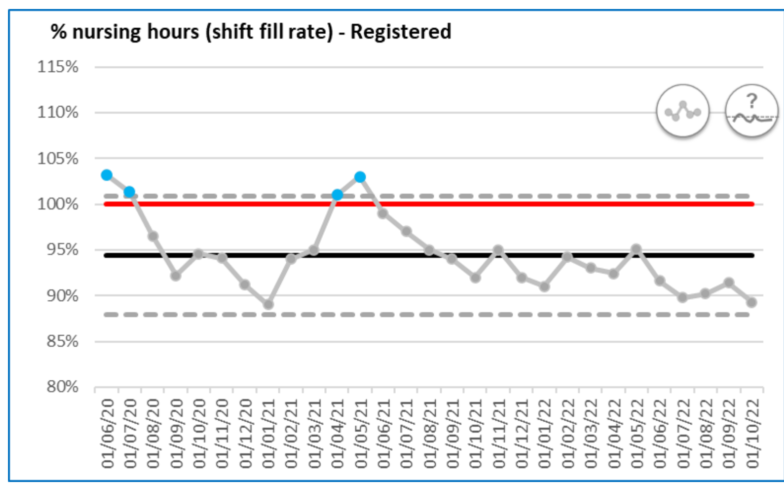


Background	What the Data tells us	Issues	Actions	Mitigations
Caesarean Section Rate – Robson Category 1 • Primiparous woman • singleton pregnancy • cephalic presentation • >37/40 gestation • spontaneous onset of labour.	Of the women in the Robson 1 cohort, 34.9% had a an emergency caesarean birth. This is a statistically significant increase on previous months; average rate is sub 20%.	The distribution of caesarean births is as follows: • 22.7% Category 1 CS • 72.2% Category 2 CS • 4.5% Category 3 CS The primary reason for caesarean birth in this cohort was for • 36.4% Lack of progress • 40.9% Sub-optimal CTG • 18.2% Unsuccessful Instrumental • 4.5% Other • 36% of women had caesarean birth at full dilatation. • 36% of women had caesarean birth at full dilatation.	• CS Robson Category 1 for review by Obstetric leads if continued raised results.	All babies born within this cohort were born with APGAR's >7 at 5 minutes. Although Caesarean birth rate high within this cohort, birth outcomes were positive . Mode of birth should be reviewed in conjunction with neonatal outcomes. 10

KPI	Latest month	Measure	Target	Variation	Assurance	Local or National Metric	Committee	Owner
Safe Care and Improving Outcomes - Safety								
% nursing hours (shift fill rate)	Oct 22	103%	95%			Local	Quality	CN
% nursing hours (shift fill rate) - Registered	Oct 22	89%	100%			Local	Quality	CN
% nursing hours (shift fill rate) - Unregistered	Oct 22	124%	100%			Local	Quality	CN
Serious incidents - number*	Oct 22	4	-			Local	Quality	CMO
Serious incidents - % that are harmful*	Oct 22	50%	0%			Local	Quality	CMO
% of patients safety incidents which are harmful*	Oct 22	13%	0%			Local	Quality	CMO
Never events	Oct 22	1	-			Local	Quality	CMO
Category 4 pressure ulcers - New (Hospital acquired)	Oct 22	0	-			Local	Quality	CN
Category 3 pressure ulcers - New (Hospital acquired)	Oct 22	7	-			Local	Quality	CN
Falls with Harm	Oct 22	19	-			Local	Quality	CMO
VTE risk assessment*	Oct 22	97%	95%			Local	Quality	CMO
Patients admitted to stroke unit within 4 hours of hospital arrival	Oct 22	61%	90%			Local	Quality	CMO
Stroke patients spending 90% of their time on stroke unit	Oct 22	90%	80%			Local	Quality	CMO
% Stroke Patients Thrombolysed within an hour	Oct 22	38%	50%			Local	Quality	CMO

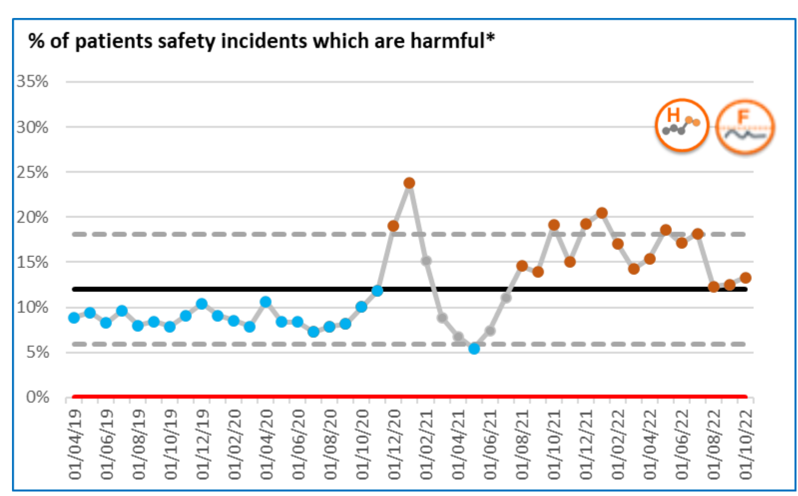
Special Cause Variation – Performance – % Nursing Hours (shift fill rate) - Unregistered





Background	What the Data tells us	Issues	Actions	Mitigations
% Nursing Hours (shift fill rate) - Unregistered	Exception triggered due to a breach of the upper control limit	Unregistered nursing fill rate is high to support not having enough registered nurses and due to providing 1:1 enhanced care.		

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



The Trust recorded 1541 patient safety incidents in October 2022 compared with 1591 in September 2022: a 3.1% decrease.

13.3% (205) of the incidents resulted in patient harm, a 2.5 % increase compared to September data. Of these, 182 incidents were reported as low harm, constituting approximately the same number compared to September's data.

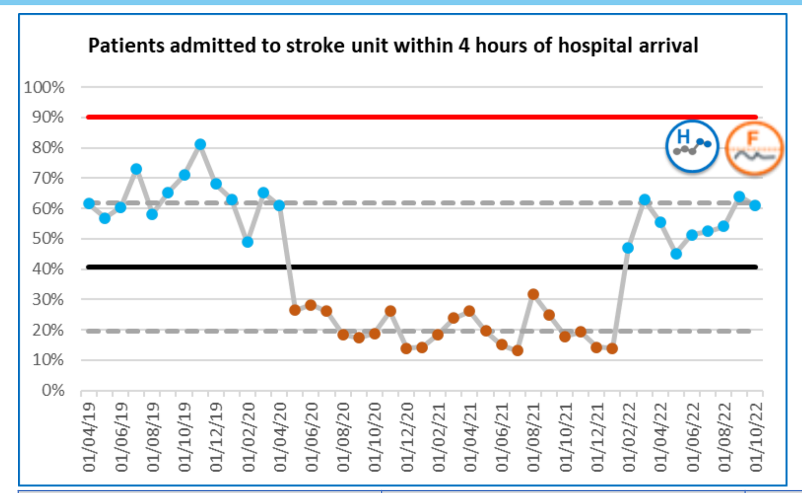
The total number of incidents reported across the divisions trust-wide in October 2022 is comparable with September 2022. A significant difference is the number of deaths (10) reported in October, compared with the average of 3 in the preceding three months.

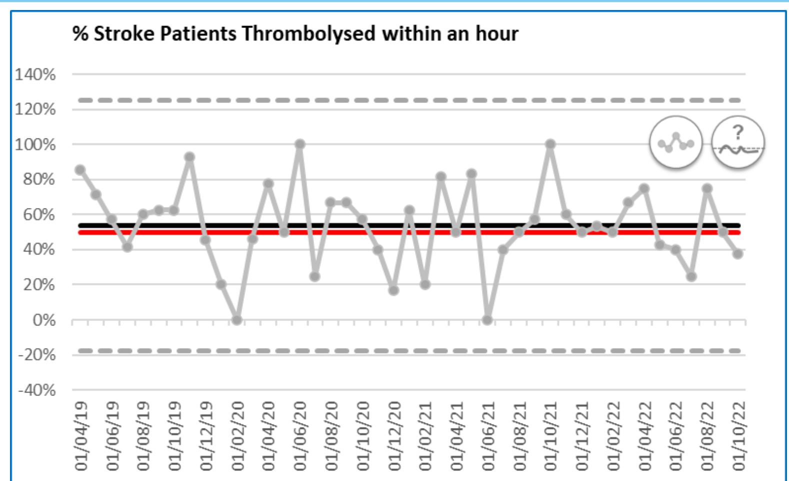
1.9% (29) of the incidents in October 2022 were rated as "moderate or higher" levels of harm; 22 of these are under open investigation. 3 of the incidents rated as Deaths/catastrophic have been reviewed at the SI panel meeting, and 1 has progressed to and been recorded as a serious incident, while the rest are under divisional investigation and review.

The Trust declared 5 SIs in October 2022, including 1 Never Event. The never event relates to a misplaced nasogastric tube.

Background	What the Data tells us	Issues	Actions	Mitigations
% of patient safety incidents which are harmful	Exception triggered due to the target being below the lower control limit Exception triggered due to a run of 7+ data points above the mean (a shift)	In October 2022, 4 incident-type reporting categories contributed to the increased reporting. These are Maternity Care, Neo-natal and perinatal care, Healthcare-associated infections (HCAI), and pressure ulcer. Maternity care, Neonatal/Perinatal care, Pressure Ulcer, and HCAI reported the most more during this period (70, 24, 23, 23), respectively, compared to the preceding month. The number of incidents reported as no harm in October 2022 is relatively lower than September 2022 with no concerning themes	Divisions to continually review incidents promptly and to close them, in order to share and facilitate timely learnings The divisions to ensure lessons learned are embedded. Continue improvement work and organisational shared learning around identified themes and trends to minimise or prevent a recurrence.	Patient safety incident discussions continue in divisional and departmental meetings with an emphasis on lessons learned Identified themes and trends are shared in the monthly Governance Operational Group meeting.

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

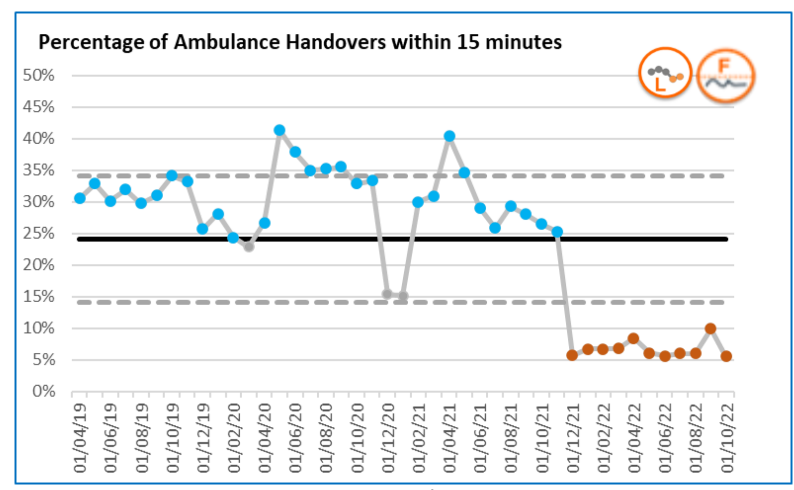




Background	What the Data tells us	Issues	Actions	Mitigations
Patients admitted to stroke unit within 4 hours of hospital arrival	Exception triggered due to target being outside the upper control limit Exception triggered due to a run of 7+ data points above the mean (a shift)	The COVID pandemic pathways for all admitted patients to the Trust required a COVID swab result prior to any planned ward transfers and therefore have to wait for the result , this invariably delayed patients accessing the stroke unit within 4 hours.	The revised process from requiring a COVID PCR swab result to Lateral flow test which takes less time since February has seen an improvement from a preceding months. A review of the noncompliant patients is undertaken to understand if there are themes which need to be addressed. Maintaining ring fenced beds on the HASU and a ring-fenced side room for patients requiring thrombolysis whilst awaiting swab results. Review and validation of the reasons patients were not thrombolysed within the one window, was undertaken which showed clinical factors and as complexity on presentation.	Patients continue to receive Stroke Consultant input and specific recommendations for their care.

KPI	Latest month	Measure	Target	Variation	Assurance	Local or National Metric	Committee	Owner
Caring & Responsive Services - A&E Metrics								
Percentage of Ambulance Handovers within 15 minutes	Oct 22	5.5%	95.0%			National	F&P	COO
Ambulance Turnaround Time between 30 and 60 minutes	Oct 22	383	0			National	F&P	COO
Ambulance Turnaround Time >60 minutes	Oct 22	343	0			National	F&P	COO
Time to Initial assessment, percentage within 15 minutes	Oct 22	80.4%	95.0%			National	F&P	COO
Mean time (minutes) in department (non-admitted)	Oct 22	313.4	-			National	F&P	COO
Mean time (minutes) in department (admitted)	Oct 22	483.7	-			National	F&P	COO
A&E 12 hour waits (arrival to departure)	Oct 22	701	-			National	F&P	COO
A&E 12 hr trolley waits	Oct 22	0	0			National	F&P	COO
ED 4hr waits (Type 1, 2 and 3)	Oct 22	64.6%	95.0%			National	F&P	COO
A&E Type 1 Performance	Oct 22	36.9%	95.0%			Local	F&P	COO
% patients admitted through A&E - 0 LOS	Oct 22	23.2%	-			Local	F&P	COO
Proportion of 12 hour waits in ED	Oct 22	5%	2%			National	F&P	COO

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

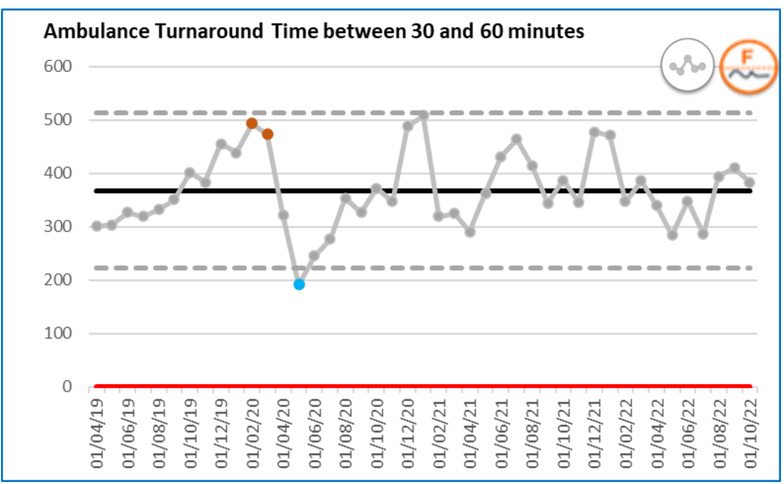


Hospital	% within 15 minutes
Bedford Hospital South Wing	46.72%
Hinchingbrooke Hospital	33.06%
Luton & Dunstable Hospital	28.56%
Addenbrookes Hospital	26.62%
West Suffolk Hospital	24.69%
Broomfield Hospital	20.06%
Ipswich Hospital	15.13%
Basildon & Thurrock Hospital	13.11%
Queen Elizabeth Hospital	12.41%
Southend University Hospital	10.81%
James Paget Hospital	8.09%
Princess Alexandra Hospital	7.06%
Peterborough City Hospital	6.40%
Norfolk & Norwich University Hospital	6.19%
Colchester General Hospital	5.91%
Watford General Hospital	**5.36%**
Lister Hospital	3.11%
Region	**16.81%**

***Latest available benchmarking data – EEAST – October 2022**

Background	What the Data tells us	Issues	Actions	Mitigations
Percentage of ambulance handovers within 15 minutes	Exception triggered due to target being outside the upper control limit Exception triggered due to 7+ data points below the mean (a shift) Exception triggered due to a breach of the lower control limit	ED demand has increased by 19% for adults and 40% for paediatrics Ambulance demand is 22% of overall ED attendances Daily staffing levels for nursing with the Emergency Medicine Division Business Continuity due to capacity pressures mean flow is impeded Assessment area bedded	Ambulance handover project board meetings continue with EEAST and CCG in attendance. Ambulance handover high level actions agreed and submitted to support new trajectory Participate in the #handover at home care coordination programme High level actions included in Trust improvement plan Joint corridor SOP	ED improvement plan developed detailing actions for ED, this is being worked into a Trust flow plan Ambulance handover identified as a focus metric at CEO check-ins All patients assessed by senior decision maker on arrival and treatment commenced if handover delayed. Close partnership working with EEAST including HALO on site Intelligent conveyancing implemented and in agreement with EEAST and ICB as necessary. Rapid release in place to support patients in the community

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

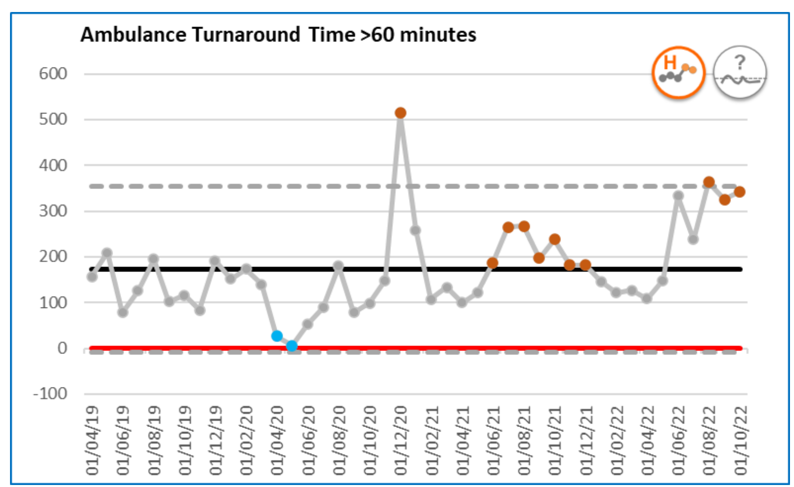


*Latest available benchmarking data – EEAST – October 2022

Hospital	Number over 30 Minutes	% over 30 minutes
Bedford Hospital South Wing	183	12.14%
Hinchingbrooke Hospital	276	25.34%
West Suffolk Hospital	432	29.88%
Luton & Dunstable Hospital	526	31.50%
Addenbrookes Hospital	693	34.36%
Ipswich Hospital	716	47.11%
Broomfield Hospital	861	48.10%
Peterborough City Hospital	755	58.21%
Basildon & Thurrock Hospital	812	60.51%
Watford General Hospital	**736**	**60.73%**
Southend University Hospital	749	62.26%
Colchester General Hospital	844	62.33%
Princess Alexandra Hospital	692	65.16%
Queen Elizabeth Hospital	827	69.32%
James Paget Hospital	901	73.61%
Norfolk & Norwich University Hospital	1,513	78.68%
Lister Hospital	940	81.10%
Region	**12,456**	**51.88%**

Background	What the Data tells us	Issues	Actions	Mitigations
Percentage of ambulance handovers over 30 mins.	Exception triggered due to target being outside the upper control limit	ED demand has increased by 19% for adults and 40% for paediatrics Ambulance demand is 22% of overall ED attendances Daily staffing levels for nursing with the Emergency Medicine Division Business Continuity due to capacity pressures mean flow is impeded Assessment area bedded	Ambulance handover project board meetings continue with EEAST and CCG in attendance. Ambulance handover high level actions agreed and submitted to support new trajectory Participate in the #handover at home care coordination programme High level actions included in Trust improvement plan Joint corridor SOP	ED improvement plan developed detailing actions for ED, this is being worked into a Trust flow plan Ambulance handover identified as a focus metric at CEO check-ins All patients assessed by senior decision maker on arrival and treatment commenced if handover delayed. Close partnership working with EEAST including HALO on site Intelligent conveyancing implemented and in agreement with EEAST and ICB as necessary. Rapid release in place to support

Special Cause Variation – Performance – Ambulance Turnaround Time >60 minutes

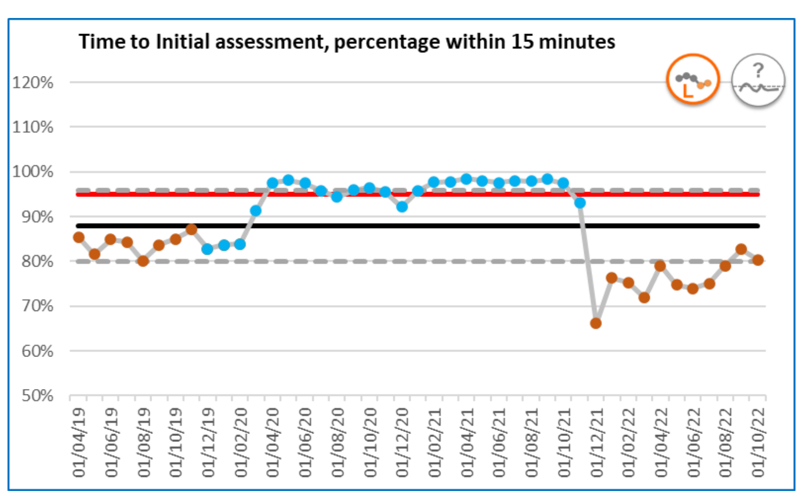


Hospital	Number over 60 minutes	% over 60 minutes
Bedford Hospital South Wing	71	4.71%
Hinchingbrooke Hospital	104	9.55%
West Suffolk Hospital	204	14.11%
Addenbrookes Hospital	334	16.56%
Luton & Dunstable Hospital	281	16.83%
Peterborough City Hospital	339	26.14%
Broomfield Hospital	499	27.88%
Watford General Hospital	**351**	**28.96%**
Ipswich Hospital	442	29.08%
Princess Alexandra Hospital	370	34.84%
Basildon & Thurrock Hospital	514	38.30%
Southend University Hospital	485	40.32%
Colchester General Hospital	546	40.32%
Lister Hospital	609	52.55%
Queen Elizabeth Hospital	669	56.08%
James Paget Hospital	710	58.01%
Norfolk & Norwich University Hospital	1,205	62.66%
Region	**7,733**	**32.21%**

*Latest available benchmarking data – EEAST – October 2022

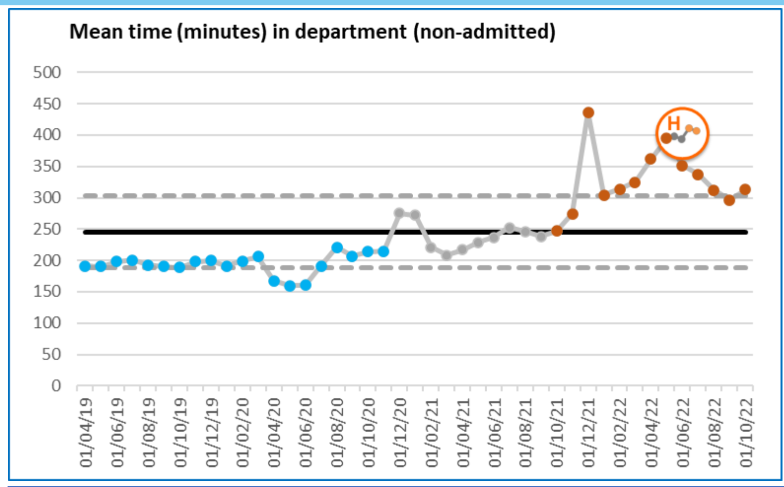
Background	What the Data tells us	Issues	Actions	Mitigations
Ambulance handovers >60 minutes	Exception triggered due to 2 of 3 data points close to the upper control limit	ED demand has increased by 19% for adults and 40% for paediatrics Ambulance demand is 22% of overall ED attendances Daily staffing levels for nursing with the Emergency Medicine Division Business Continuity due to capacity pressures mean flow is impeded Assessment area bedded	Ambulance handover project board meetings continue with EEAST and CCG in attendance. Ambulance handover high level actions agreed and submitted to support new trajectory Participate in the #handover at home care coordination programme High level actions included in Trust improvement plan Joint corridor SOP	ED improvement plan developed detailing actions for ED, this is being worked into a Trust flow plan Ambulance handover identified as a focus metric at CEO check-ins All patients assessed by senior decision maker on arrival and treatment commenced if handover delayed. Close partnership working with EEAST including HALO on site Intelligent conveyancing implemented and in agreement with EEAST and ICB as necessary. Rapid release in place to support patients in the community

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



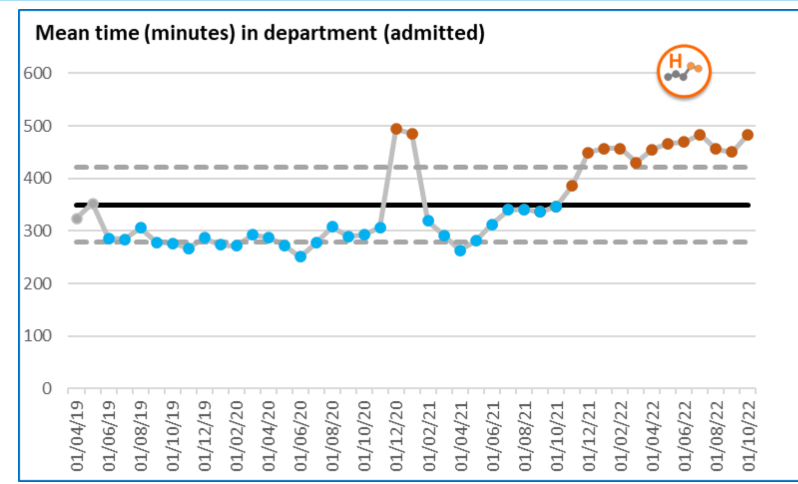
Background	What the Data tells us	Issues	Actions	Mitigations
Time to Initial Assessment – Percentage within 15 minutes	Exception triggered due to 7+ data points below the mean (a shift)	Capacity pressures due to poor flow throughout ED resulted in late assessments. Nursing staffing workforce challenges with workforce at times being RAG rated RED. Business Continuity due to capacity pressures mean flow is impeded Assessment area bedded	Regular check-in meetings with CEO implemented. Walk-in stream separated from ambulance stream to provide clearer visibility across the department and decompress bottleneck areas Additional assessment trolleys created in majors 2. Considering higher acuity ambulatory area to support flow in November Joint corridor SOP	Data shows increase of initial assessment toward 19/20 levels On-going staffing and capacity reviews during shifts and decision taken to open additional areas when safe staffing levels allow Senior decision maker in “STARR” to focus on walk in patients

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



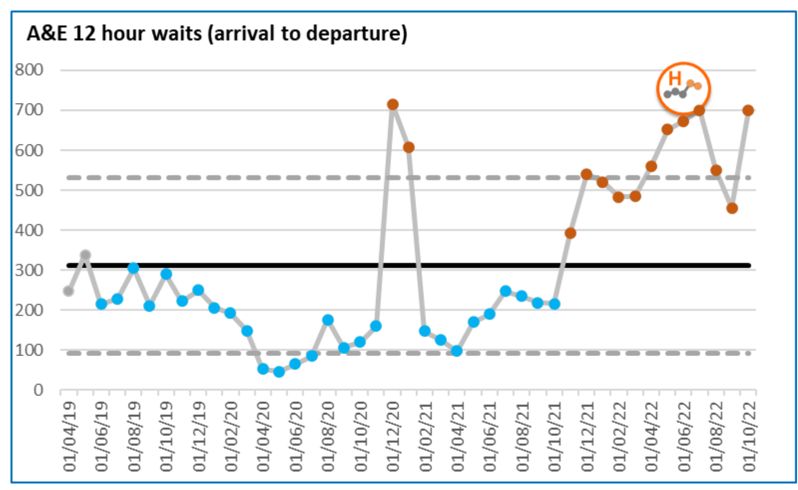
Background	What the Data tells us	Issues	Actions	Mitigations
Mean time (minutes) in department (non-admitted	Exception triggered due to 7 consecutive data points above the mean Exception triggered due to a breach of the upper control limit	Demand for UEC services remains higher than seen in previous years. Patients are treated according to clinical prioritisation although sometimes this may result in less urgent patients experiencing longer waits when the department is under pressure. Patient flow out of department to wards impacts on cubicle capacity for all ED patients Business Continuity due to capacity pressures mean flow is impeded Assessment area bedded	Assessment areas ensure timely assessment of patients for clinical safety. Patients pulled into ACU Senior review/oversight of decisions to admit. Increase usage of SDEC pathways Review EAU usage and pathways in time of surge areas being required Emergency medicine performance meetings focus on improvement plan Regular check-in meetings with CEO implemented	Patients seen and treated in order of clinical priority. Focus on Triage and ambulatory majors area and efficiency through that area ED escalation plan to support dept, including corridor nursing and boarding policy. Prompt senior reviews/post taking. Hourly rounding being undertaken on all patients ensuring comfort If prolonged trolley wait – patients transferred to bed for comfort.

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



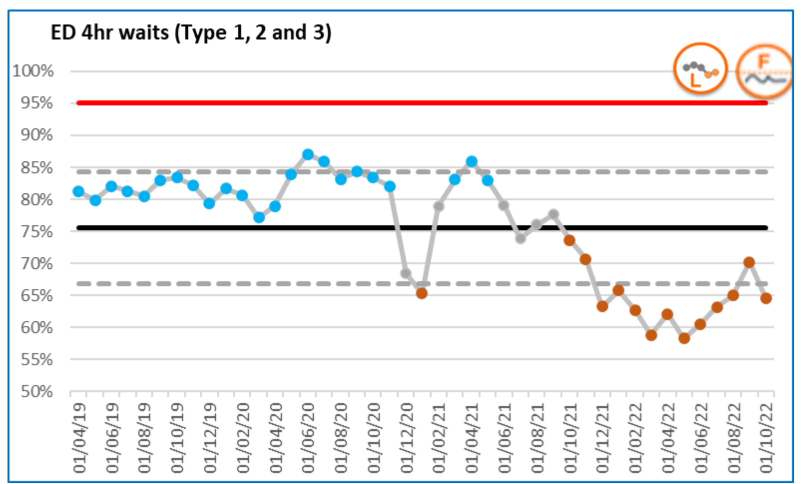
Background	What the Data tells us	Issues	Actions	Mitigations
Mean time (minutes) in department (admitted)	Exception triggered due to a breach of the upper control limit Exception triggered due to 7+ consecutive data points above the mean	Demand for UEC services remains higher than seen in previous years. Patients are treated according to clinical prioritisation although sometimes this may result in less urgent patients experiencing longer waits when the department is under pressure. Patient flow out of department to wards impacts on cubicle capacity for all ED patients Business Continuity due to capacity pressures mean flow is impeded Assessment area bedded	SDEC areas ensure timely assessment of patients for clinical safety Senior review/oversight of decisions to admit. Working with hospital efficiency group focusing on discharge time of day and usage of discharge lounge to make beds available earlier in the day Emergency medicine performance meetings focus on improvement plan Focus on keeping EAU as assessment for ED rather than using as bedded area	Patients seen and treated in order of clinical priority. Focus on Triage and ambulatory majors area and efficiency through that area ED escalation plan to support dept, including corridor nursing and boarding policy. Prompt senior reviews/post taking. Hourly rounding being undertaken on all patients ensuring comfort If prolonged trolley wait – patients transferred to bed for comfort.

Special Cause Variation – Performance – A&E 12 hour waits (arrival to departure)



Background	What the Data tells us	Issues	Actions	Mitigations
A&E 12 hour waits (arrival to departure)	Exception triggered due to a run of data points above the mean (a shift) Exception triggered due to a breach of the upper control limit	Demand for UEC services remains higher than seen in previous years. Patients are treated according to clinical prioritisation although sometimes this may result in less urgent patients experiencing longer waits when the department is under pressure. Patient flow out of department to wards impacts on cubicle capacity for all ED patients Business Continuity due to capacity pressures mean flow is impeded Assessment area bedded	Maintenance of SDEC space to support flow Senior review/oversight of decisions to admit. Increase use of SDEC and SMART services Harm reviews carried out on patients who have waited 12hrs Audit of reasons patients stay in dept, for admitted and non-admitted	Patient safety ensured by ED team with patients seen and treated in timely manner. Increase of patients initially seen within 15mins provides assurance of department safety Standards for speciality reviews in process of being agreed across all specialities Hourly rounding being undertaken on all patients If patient are in cohort assessment undertaken and treatment continues

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

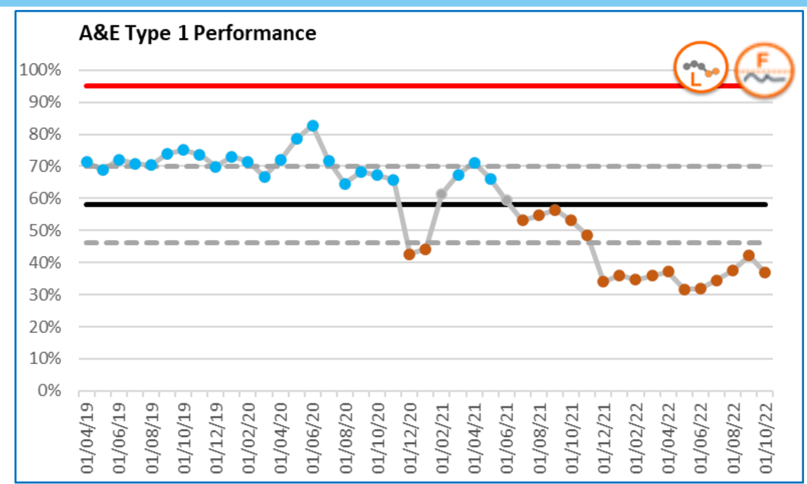


October 2022 - East of England A&E 4hr Wait Performance (Latest Published Data)

Trust	Attendances	Within 4 hours	Performance	Region Rank
Milton Keynes University Hospital NHS Foundation Trust	14,302	11,340	79%	1
Norfolk And Norwich University Hospitals NHS Foundation Trust	20,352	14,221	70%	2
James Paget University Hospitals NHS Foundation Trust	7,693	5,226	68%	3
East Suffolk And North Essex NHS Foundation Trust	25,866	17,437	67%	4
West Hertfordshire Teaching Hospitals NHS Trust	**15,541**	**10,032**	**65%**	**5**
East And North Hertfordshire NHS Trust	15,663	10,083	64%	6
Mid And South Essex NHS Foundation Trust	32,799	20,414	62%	7
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	7,110	4,134	58%	8
North West Anglia NHS Foundation Trust	17,217	9,873	57%	9
The Princess Alexandra Hospital NHS Trust	10,838	5,698	53%	10
Bedfordshire Hospitals NHS Foundation Trust	22,778	-	-	-
Cambridge University Hospitals NHS Foundation Trust	16,435	-	-	-
West Suffolk NHS Foundation Trust	7,840	-	-	-

Background	What the Data tells us	Issues	Actions	Mitigations
ED 4 hour waits for Type 1,2 and 3	Exception triggered due to target being outside the upper control limit Exception due to 7 or more data points below the mean (a shift) Exception triggered due to a breach of the lower control limit	Poor patient flow – primarily late discharges is still a theme Assessment areas being used for exceptional surge compromising flow from ED and impacting negatively on performance Increased number of Mental Health attendances, resulting in long stays in ED impacting on available assessment space. Doctor and nurse staffing levels at Watford UTC .	35 nurses recruited across EM 4 additional consultant posts approved – interviews Nov 22 2 additional MG posts approved CQRM with Greenbrook to review KPIs. Performance monitored through daily reports Workforce model review of UTC Availability of EAU as assessment to divert all GP referrals to EAU - Nov Auditing if pts have attempted to access any service before presenting	Regular Exec to Exec meetings set up with Greenbrook to discuss performance and contractual obligations Fracture clinic opened as additional triage to separate walk-ins and ambulance arrivals Continue to roster additional medical staff rostered to cover times when increased attendance via UTC is anticipated Returner slots at HH reviewed to avoid peak attendance at opening hours

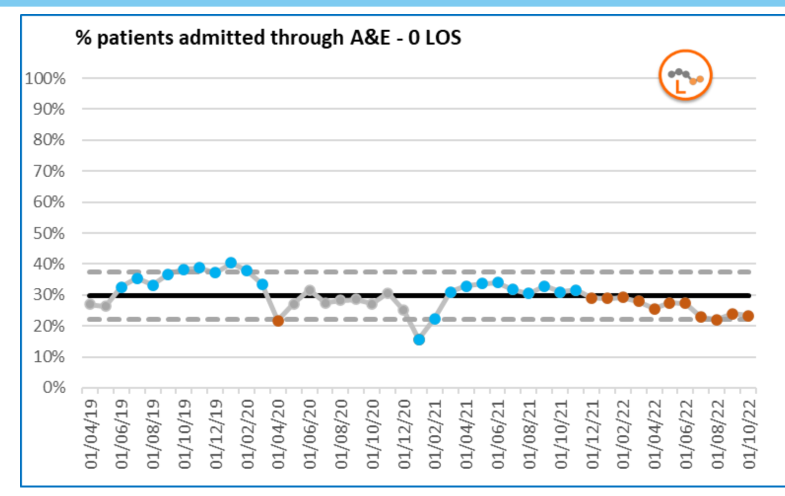
Special Cause Variation – Performance/Assurance – A&E Type 1 Performance



October 2022 - East of England A&E Type 1 4hr Wait Performance (Latest Published Data)				
Trust	**Attendances**	**Within 4 hours**	**Performance**	**Region Rank**
Milton Keynes University Hospital NHS Foundation Trust	8,907	6,105	69%	1
James Paget University Hospitals NHS Foundation Trust	6,525	4,058	62%	2
Mid And South Essex NHS Foundation Trust	30,741	18,626	61%	3
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	7,110	4,134	58%	4
The Princess Alexandra Hospital NHS Trust	10,838	5,698	53%	5
North West Anglia NHS Foundation Trust	12,665	6,412	51%	6
East Suffolk And North Essex NHS Foundation Trust	14,843	6,578	44%	7
East And North Hertfordshire NHS Trust	9,816	4,269	43%	8
Norfolk And Norwich University Hospitals NHS Foundation Trust	10,757	4,627	43%	9
West Hertfordshire Teaching Hospitals NHS Trust	**7,790**	**2,863**	**37%**	**10**
Bedfordshire Hospitals NHS Foundation Trust	16,142	-	-	-
Cambridge University Hospitals NHS Foundation Trust	10,418	-	-	-
West Suffolk NHS Foundation Trust	7,222	-	-	-

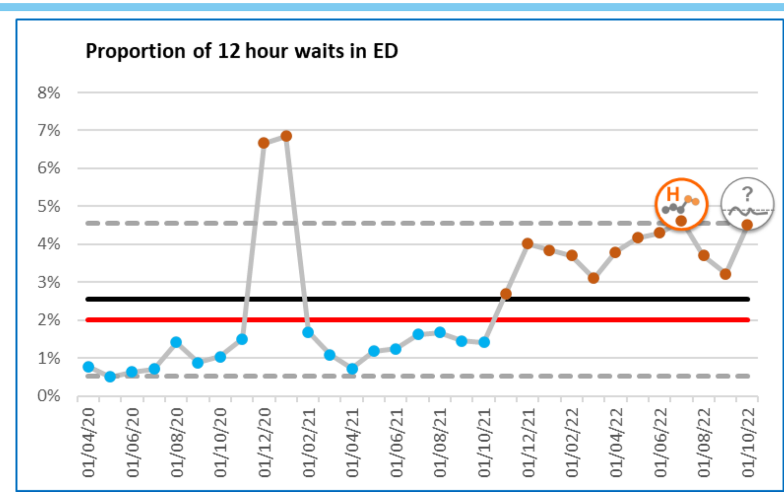
Background	What the Data tells us	Issues	Actions	Mitigations
A&E Type 1 Performance	Exception triggered due to target being outside the upper control limit Exception triggered due to a breach of the lower control limit Exception triggered due to 7+ consecutive data points below the mean (a shift)	Poor patient flow – primarily late discharges is still a theme Assessment areas being used for exceptional surge compromising flow from ED and impacting negatively on performance Increased number of Mental Health attendances, resulting in long stays in ED impacting on available assessment space. Doctor and nurse staffing levels at Watford UTC Number of patients transferred from WGH UTC at closing	Regular ED Access & Performance meetings and HEG meetings Optimising patient flow Regular check in meetings with CEO put in place Validation of “left department time” for each patient Review of performance following high discharge days shows performance does increase slightly when high discharge numbers are achieved	Patient safety ensured by ED team with patients seen and treated in order of clinical priority Prompt senior reviews/post taking in STARR. Hourly rounding being undertaken on all patients ensuring comfort. If prolonged trolley wait – patients transferred to bed for comfort. Joint work with frailty for direct ambulance conveyancing to frailty unit Attendance at ICS level meetings, joint working/learning events

Special Cause Variation – Performance – % patients admitted through A&E – 0 LOS



Background	What the Data tells us	Issues	Actions	Mitigations
% patients admitted through A&E – 0 LOS	Exception triggered due to 7+ data points below the mean (a shift)	Poor patient flow – primarily late discharges is still a theme Assessment areas being used for exceptional surge compromising flow from ED and impacting negatively on performance Increased number of Mental Health attendances, resulting in long stays in ED impacting on available assessment space. Increased attendances of type 3	Emergency medicine/medicine summit Chaired by CEO to identify improvements pathway collaboration Continuous 12 hour end to end audit to identify bottleneck themes Additional staff rostered to cover corridor care at times of high attendance and high DTAs Maximising use of SDEC including ACU	Harm reviews carried out for patients who wait for 12 hrs, so far this has shown no harm caused Patients continue to receive appropriate assessment and treatment whilst incurring the ED department wait

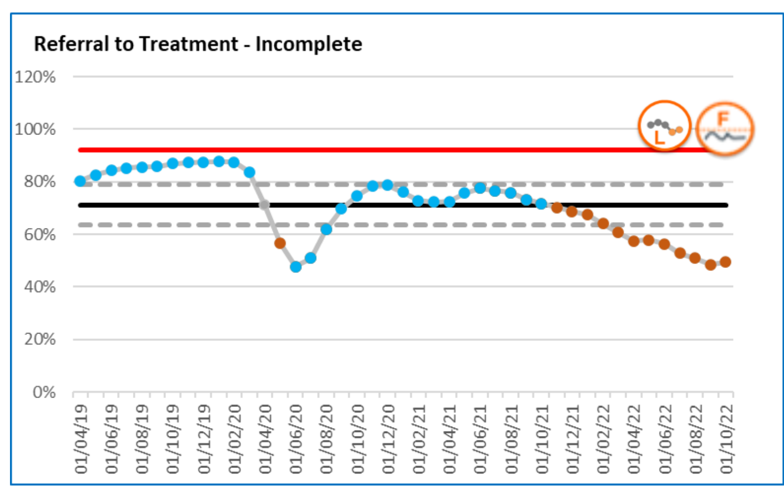
Special Cause Variation – Performance – Proportion of 12 hour waits in ED



Background	What the Data tells us	Issues	Actions	Mitigations
Proportion of 12 hour waits in ED	Exception triggered due to 7+ data points above the mean (a shift) Exception triggered due to a breach of the upper control limit	Poor patient flow – primarily late discharges is still a theme Assessment areas being used for exceptional surge compromising flow from ED and impacting negatively on performance Increased number of Mental Health attendances, resulting in long stays in ED impacting on available assessment space. Increased attendances of type 3	Emergency medicine/medicine summit Chaired by CEO to identify improvements pathway collaboration Continuous 12 hour end to end audit to identify bottleneck themes Additional staff rostered to cover corridor care at times of high attendance and high DTAs Additional Trust actions following escalation procedure enacted at times of extreme capacity pressures	Harm reviews carried out for patients who wait for 12 hrs, so far this has shown no harm caused Patients continue to receive appropriate assessment and treatment whilst incurring the ED department wait

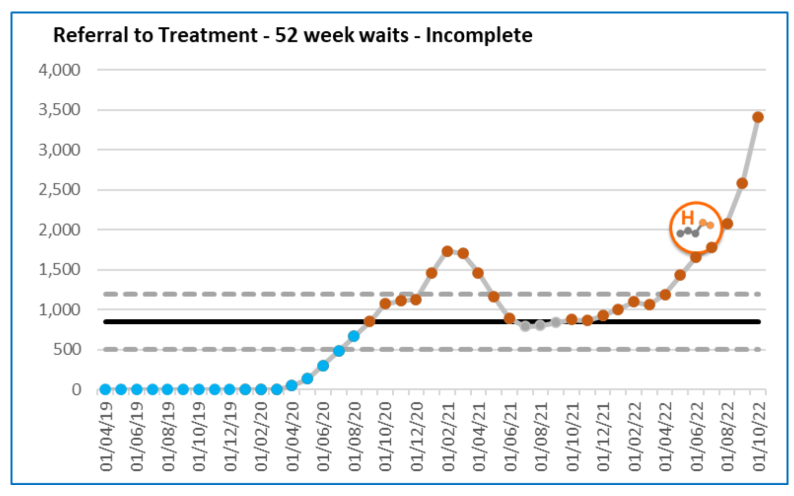
KPI	Latest month	Measure	Target	Variation	Assurance	Local or National Metric	Committee	Owner
Caring & Responsive Services - RTT, Cancer, Outpatients								
Referral to Treatment - Incomplete	Oct 22	49%	92%			National	F&P	COO
Referral to Treatment - 52 week waits - Incomplete	Oct 22	3412	-			Local	F&P	COO
Referral to Treatment - 78 week waits - Incomplete	Oct 22	92	-			Local	F&P	COO
Referral to Treatment - 104 week waits - Incomplete	Oct 22	2	0			National	F&P	COO
Diagnostic (DM01) <6 weeks	Oct 22	71%	99%			National	F&P	COO
Cancer - Two week wait	Oct 22	68%	93%			National	F&P	COO
Cancer - Breast Symptomatic two week wait	Oct 22	44%	93%			National	F&P	COO
Cancer - 28 day waits (faster diagnosis standard)	Oct 22	63%	75%			National	F&P	COO
Cancer - 31 Day First	Oct 22	95%	96%			National	F&P	COO
Cancer - 31 day subsequent drug	Oct 22	100%	98%			National	F&P	COO
Cancer - 31 day subsequent surgery	Oct 22	100%	94%			National	F&P	COO
Cancer - 62 day	Oct 22	69%	85%			National	F&P	COO
Cancer - 62 day screening	Oct 22	74%	90%			Local	F&P	COO
Cancer 104+ day waits	Oct 22	57	-			Local	F&P	COO
Cancer 62+ Day Waits	Oct 22	274	-			Local	F&P	COO
Outpatient cancellation rate within 6 weeks	Oct 22	4%	5%			Local	F&P	CIO
Outpatient DNA rate	Oct 22	9%	8%			Local	F&P	CIO

Special Cause Variation – Assurance – Referral to Treatment - Incomplete

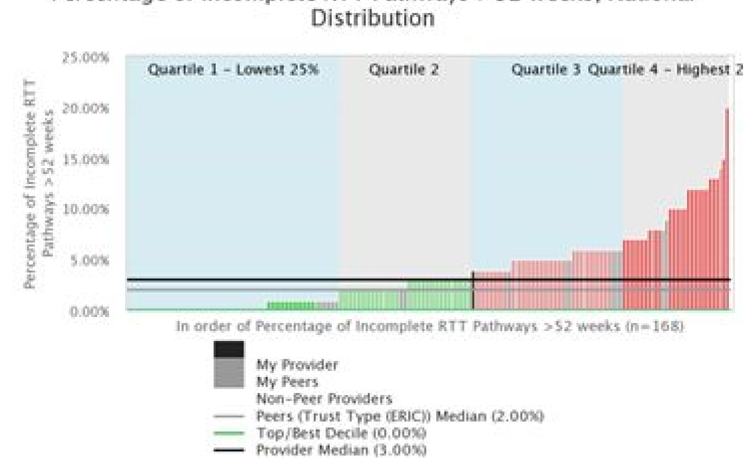


Background	What the Data tells us	Issues	Actions	Mitigations
Referral to Treatment - Incomplete	Exception triggered due to target being outside the upper control limit Exception triggered due to 7+ consecutive data points in one direction (a trend) Exception triggered due to a breach of the lower control limit	A number of factors are influencing open pathway performance, many associated with the quality of pathway data following implementation of the EPR. While staff continue to adjust to new ways of working, errors have increased significantly despite ongoing support and advice, particularly in capturing the correct outcomes following OP attendance, resulting in fewer clock stops and thereby inflating the number of open pathways on the PTL.	Outsourcing programme remains active at a reasonable rate. Additional sessions are being undertaken but there is less uptake than pre COVID. Operational recovery group oversight of activity delivery BI team working with EPR project leads to address issues. External resource to support in house validation of the PTL started on 31/10/22 and is expected to deliver improvement across a range of RTT KPIs	Continuous horizon scanning for additional outsourcing opportunities, with specialty level engagement to ensure quality and safety as well as timely pathways Weekly long wait review meeting in place to drive progress and delivery of improvement plan. Service level tracking with forward look to target deadlines to ensure adequate operational oversight of patient cohorts. Expansion of the Trust's validation team following business case approval, with recruitment underway.

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

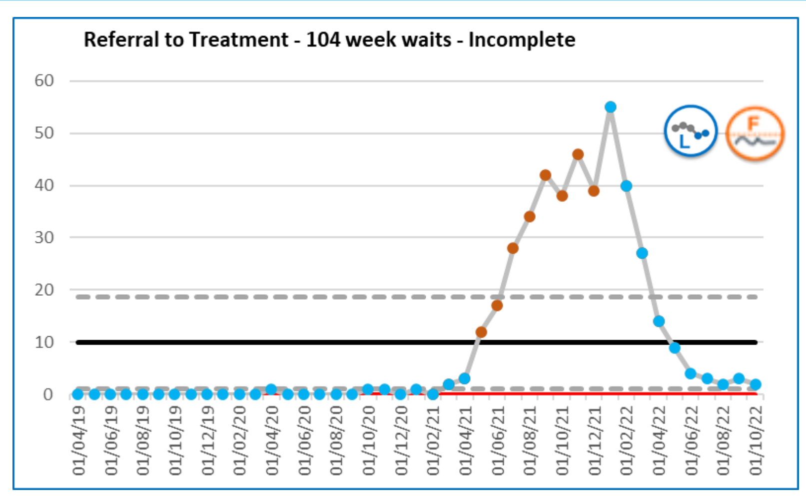


*Latest available benchmarking data – Model Health System – August 2022



Background	What the Data tells us	Issues	Actions	Mitigations
Referral to Treatment – 52 weeks incomplete	Exception triggered due to a run of 7+ data points above the mean (a shift) Exception triggered due to breach of upper control limit	Fewer ad hoc sessions are being undertaken than prior to COVID, reducing the additional capacity that was utilised previously to support improvement. While staff continue to adjust to new ways of working, errors have increased significantly despite ongoing support and advice, particularly in capturing the correct outcomes resulting in fewer clock stops and thereby inflating the number of open pathways on the PTL.	Outsourcing programme remains active at a reasonable rate and additional sessions are being undertaken but there is less uptake than pre COVID. Operational recovery group oversight of activity delivery BI team working with EPR project leads to address multiple DQ issues. Extensive validation commenced 31/10/22 with additional temporary resources supplementing in house capacity. This is expected to have a significant impact on cleansing of the PTL and will improve the position. The weekly access meeting is now incorporating views of patients lower down in the PTL to avoid “tip ins”.	Continuous horizon scanning for additional outsourcing opportunities, with specialty level engagement to ensure quality and safety as well as timely pathways Weekly long wait review meeting in place to drive progress and delivery of improvement plan. Service level tracking with forward look to target deadlines to ensure adequate operational oversight of patient cohorts. Expansion of the Trust’s validation team following business case approval, with recruitment underway.

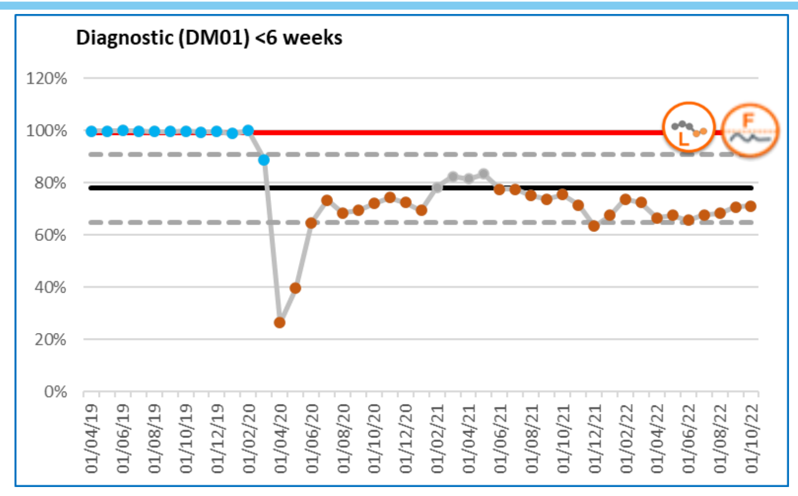
Special Cause Variation – Performance/Assurance – Referral to Treatment – 104 weeks - Incomplete



***Latest available benchmarking data – Model Health System – August 2022**

Background	What the Data tells us	Issues	Actions	Mitigations
Referral to Treatment – 104 weeks incomplete	Exception triggered due to 2 of 3 data points being close to the lower control limit Exception triggered due to target being below the lower control limit	DQ issues post EPR implementation have resulted in a significant increase in the number of pathways on the RTT PTL. There has been a great deal of focus on validation of the longest waits with a pro-active model which has delivered the zero 104 week wait position and this has been maintained since.	Weekly Access and long waits review meetings are maintaining the zero position.	Continuous horizon scanning for additional outsourcing opportunities, with specialty level engagement to ensure quality and safety as well as timely pathways

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

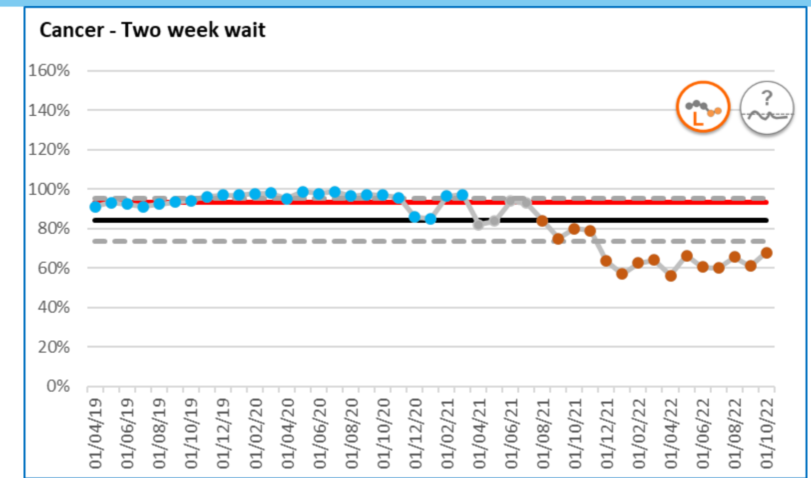


Diagnostics – max 6 weeks wait, National Distribution

125.00%
100.00%
75.00%
50.00%
25.00%
0.00%
Diagnostics – max 6 weeks wait
In order of Diagnostics – max 6 weeks wait (n=120)
My Provider
My Peers
Non-Peer Providers
Benchmark (99.00%)
Peers (Trust Type (ERIC)) Median (74.64%)
Top/Best Decile (92.86%)

Background	What the Data tells us	Issues	Actions	Mitigations
Diagnostic (DM01) < 6 weeks	Exception triggered due to 7 or more data points below the mean (a shift) Exception triggered due to target being outside the upper control limit	Prioritising the most clinically urgent patients results in longer waits for more routine patients. Many requests are for more complex diagnostics which increases demands on capacity. Increased demand (referrals and diagnostic requests). Lower uptake (than pre COVID) of additional sessions to support demand Data quality associated with cutover to Cerner resulting in multiple pathway issues resulting in recording and reporting difficulties	Long waits improvement plan includes: • Outsourcing & insourcing • Additional sessions in place • Operational recovery group oversight of activity delivery BI team working with EPR project leads to address issues with diagnostic pathways	Outsourcing (MRI, DEXA, Cystoscopy, Gastroenterology, NOUS) Additional in house sessions (Audiology, MRI, CT, NOUS, Echo) Mobile, staffed MRI scanner contract extended to end of year.

Special Cause Variation – Performance – Cancer – Two Week Wait

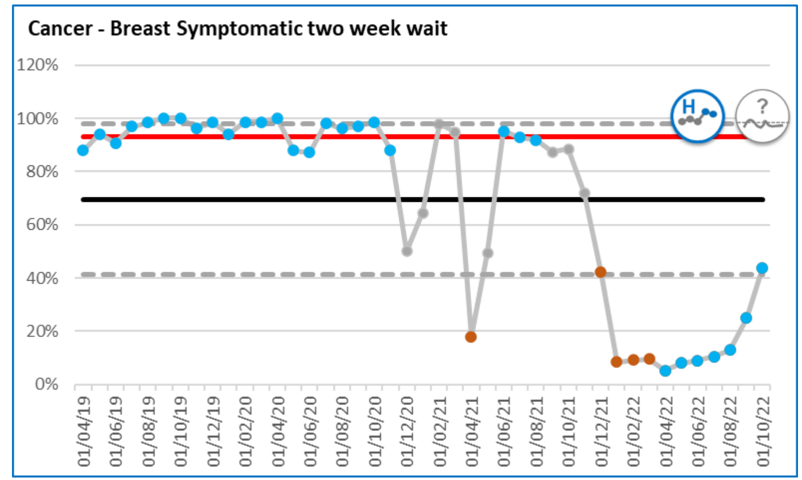


Provider name	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22
EAST AND NORTH HERTFORDSHIRE NHS TRUST	96.4%	97.0%	90.9%	95.8%	93.5%	93.0%	90.6%	92.5%
BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	72.1%	72.7%	71.0%	75.2%	73.8%	81.8%	85.2%	90.1%
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	89.0%	94.3%	91.6%	95.1%	94.9%	91.2%	88.2%	88.2%
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	91.3%	92.1%	91.2%	95.0%	91.6%	88.7%	78.4%	73.1%
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	96.2%	95.5%	93.9%	93.3%	88.7%	88.0%	80.3%	71.5%
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	79.3%	76.8%	74.8%	88.1%	86.1%	75.3%	78.8%	70.8%
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	89.2%	88.0%	79.9%	84.3%	77.4%	73.3%	76.4%	68.9%
WEST SUFFOLK NHS FOUNDATION TRUST	76.2%	67.7%	76.8%	78.8%	61.6%	80.0%	75.0%	67.4%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	**62.2%**	**63.5%**	**55.4%**	**67.0%**	**60.0%**	**57.8%**	**65.0%**	**61.1%**
MID AND SOUTH ESSEX NHS FOUNDATION TRUST	61.6%	52.8%	46.6%	59.6%	51.6%	52.4%	55.4%	54.6%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	61.1%	77.3%	85.0%	88.1%	73.4%	77.4%	68.0%	52.4%
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	79.2%	74.7%	75.2%	75.7%	58.6%	61.6%	67.4%	51.7%
NORTH WEST ANGLIA NHS FOUNDATION TRUST	53.8%	60.9%	61.2%	64.5%	57.3%	60.8%	49.1%	47.9%
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	73.0%	60.7%	83.6%	68.3%	57.2%	44.8%	33.6%	34.8%

***Latest available benchmarking data – Cancer Waiting Times – August 2022**

Background	What the Data tells us	Issues	Actions	Mitigations
Cancer – Two Week Wait	Exception triggered due to this month's performance being below the lower control limit Exception triggered due to a run of 7+ data points below the mean (a shift)	Demand continues to outstrip capacity and it remains a challenge to manage the new demand and backlogs particularly in breast and skin.	All services are actively seeking ways to increase capacity - provision of adhoc clinics, switching routine OPA slots to 2ww slots, outsourcing where possible.	All patients remain on eRS until booked when they are entered onto the Cancer PTL where they are tracked. The Trust has implemented clinical harm reviews for those who had a wait of >28 days who have a cancer diagnosis.

Special Cause Variation – Performance – Cancer – Breast Symptomatic Two Week Wait

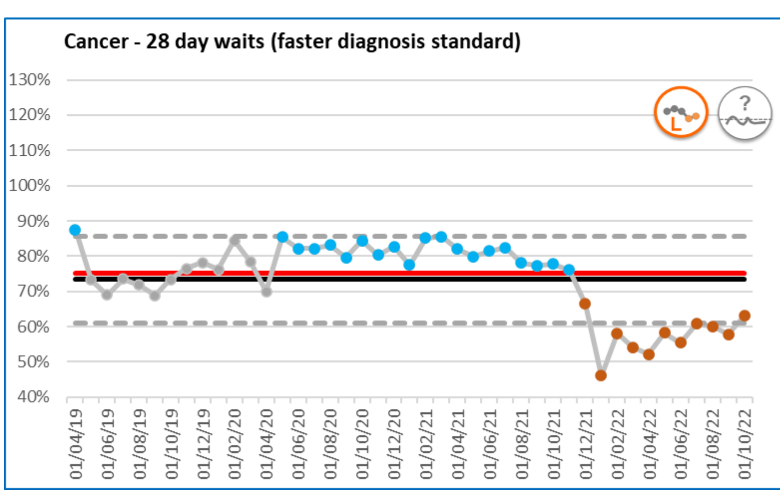


Provider name	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST								
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	100.0%	100.0%	98.1%	100.0%	97.7%	97.9%	98.4%	100.0%
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	99.2%	93.6%	97.0%	98.9%	98.9%	100.0%	98.2%	100.0%
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	73.6%	96.6%	94.3%	100.0%	100.0%	86.7%	76.9%	90.0%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	51.1%	69.3%	89.2%	95.6%	66.9%	82.8%	95.0%	89.1%
EAST AND NORTH HERTFORDSHIRE NHS TRUST	97.6%	92.7%	81.8%	92.0%	97.0%	90.5%	87.1%	87.5%
BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	25.0%	25.0%	22.9%	30.2%	22.1%	44.7%	67.5%	85.3%
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	50.0%	49.1%	68.9%	62.5%	85.1%	100.0%	95.0%	83.3%
NORTH WEST ANGLIA NHS FOUNDATION TRUST	65.1%	82.3%	97.4%	96.8%	87.7%	96.7%	92.3%	80.6%
WEST SUFFOLK NHS FOUNDATION TRUST	18.4%	21.5%	50.0%	75.0%	62.9%	93.4%	79.6%	58.9%
MID AND SOUTH ESSEX NHS FOUNDATION TRUST	8.0%	13.0%	3.5%	2.2%	16.9%	19.5%	59.5%	56.9%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	**10.0%**	**9.3%**	**5.8%**	**6.5%**	**6.7%**	**13.2%**	**12.4%**	**25.0%**
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	29.8%	19.7%	21.7%	73.3%	69.6%	66.7%	31.0%	8.5%
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	96.0%	100.0%	75.0%	100.0%	95.4%	43.4%	0.0%	0.0%

***Latest available benchmarking data – Cancer Waiting Times – September 2022**

Background	What the Data tells us	Issues	Actions	Mitigations
Cancer – Breast Symptomatic Two Week Wait	Exception triggered due to a run of data points below the mean (a shift) Exception triggered due to a run of increasing data points (a trend)	The breast team are facing significant problems on account of the backlog and continued increase in demand. The booking team's staff shortages continued into August which resulted in a challenge to ensure all the capacity is booked into.	The breast service is actively seeking ways to increase capacity - provision of ad hoc clinics, recruitment of locum breast consultant (the post has just been appointed to) outsourcing, switching routine OPA slots to 2ww slots. Work continues to develop a community based Breast Pain Only clinic and further progress is expected in January.	All patients remain on eRS until booked when they are entered onto the Cancer PTL where they are tracked. The Trust has implemented clinical harm reviews for those who had a wait of >28 days who have a cancer diagnosis

Special Cause Variation – Performance – Cancer – 28 Day Wait (Faster Diagnosis Standard)

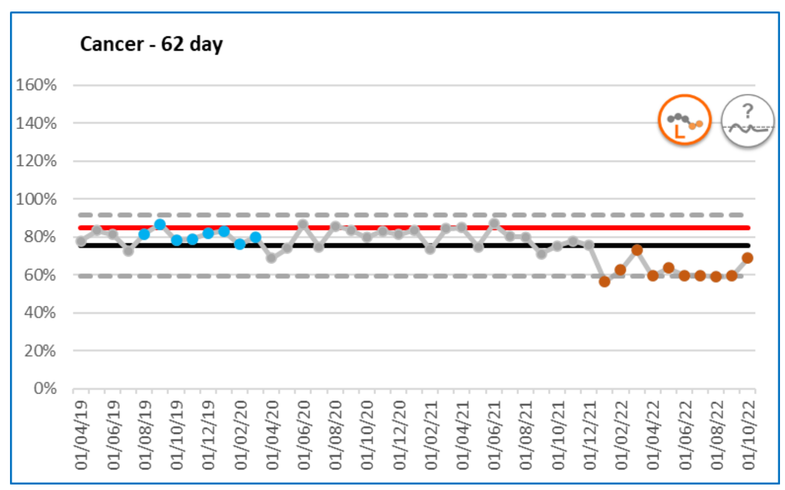


Provider name	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	83.2%	83.5%	80.6%	77.4%	75.4%	75.9%	79.3%	77.0%
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	72.3%	75.2%	73.1%	74.9%	77.6%	79.1%	73.4%	71.9%
BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	70.9%	68.9%	67.9%	62.7%	66.8%	66.8%	70.4%	70.3%
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	70.6%	71.8%	69.0%	69.2%	73.1%	76.9%	71.1%	69.8%
EAST AND NORTH HERTFORDSHIRE NHS TRUST	72.9%	74.6%	68.0%	64.2%	70.6%	71.7%	72.6%	69.7%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	69.4%	69.3%	64.1%	65.9%	74.3%	72.3%	72.8%	68.3%
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	70.8%	69.6%	66.5%	68.5%	73.1%	70.5%	63.0%	66.4%
WEST SUFFOLK NHS FOUNDATION TRUST	71.8%	71.5%	70.9%	72.5%	68.3%	69.5%	67.0%	64.4%
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	69.7%	73.2%	67.3%	72.4%	69.6%	68.7%	67.4%	62.1%
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	65.6%	60.2%	59.0%	62.1%	58.4%	59.2%	60.1%	58.8%
NORTH WEST ANGLIA NHS FOUNDATION TRUST	67.4%	66.3%	66.3%	66.5%	65.7%	65.5%	57.0%	58.6%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	**59.2%**	**54.6%**	**51.3%**	**57.7%**	**55.6%**	**60.3%**	**60.2%**	**57.8%**
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	64.9%	65.4%	65.3%	61.2%	62.6%	61.9%	53.9%	53.8%
MID AND SOUTH ESSEX NHS FOUNDATION TRUST	58.9%	55.5%	49.6%	53.7%	58.0%	61.8%	58.8%	52.5%

***Latest available benchmarking data – Cancer Waiting Times – September 2022**

Background	What the Data tells us	Issues	Actions	Mitigations
Cancer – 28 Day Wait (faster diagnosis standard)	Exception triggered due to this month's performance being below the lower control limit Exception triggered due to a run of 7+ data points below the mean (a shift)	The slow start to the pathway with patients breaching the 2ww standard, leads to frequently missing the 28 day standard	All efforts to regain the 2ww position will contribute to improving the FDS position All services have actions to improve the management of their pathways as part of the Trust's improvement plan. Capacity and demand modelling being completed for all specialties based on FDS pathways.	All patients are on the Cancer PTL and being tracked

Special Cause Variation – Performance – Cancer 62 Day

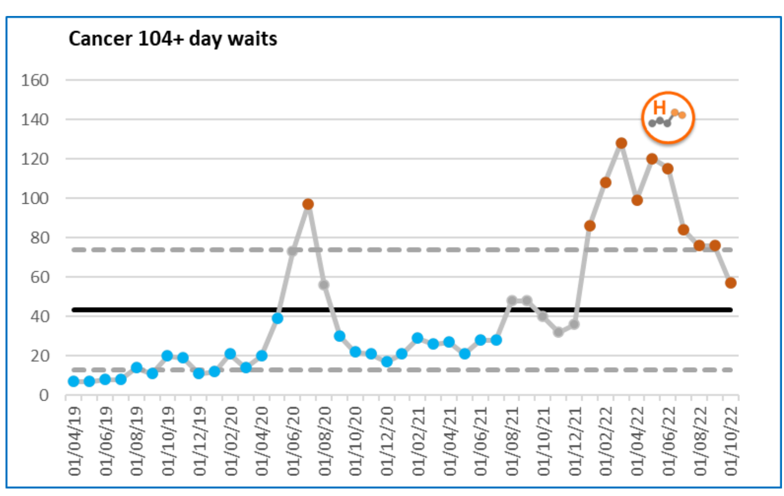


Provider name	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22
EAST AND NORTH HERTFORDSHIRE NHS TRUST	87.6%	84.1%	86.0%	81.1%	82.4%	86.0%	82.6%	81.8%
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	79.6%	65.5%	79.2%	63.6%	70.3%	75.0%	72.0%	81.0%
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	72.8%	77.5%	76.4%	73.0%	75.4%	70.7%	74.2%	70.0%
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	70.8%	70.2%	77.3%	74.4%	67.4%	71.7%	71.8%	67.1%
WEST SUFFOLK NHS FOUNDATION TRUST	60.4%	66.7%	79.6%	70.8%	65.8%	66.9%	64.3%	60.6%
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	65.4%	64.7%	60.2%	70.2%	57.1%	65.0%	70.4%	60.5%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	**62.5%**	**72.6%**	**60.2%**	**61.4%**	**56.1%**	**58.8%**	**59.6%**	**60.2%**
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	58.0%	77.0%	65.3%	72.1%	57.8%	66.7%	56.6%	58.1%
BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	59.4%	71.8%	63.1%	60.7%	51.8%	54.8%	67.4%	57.5%
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	56.6%	55.5%	55.7%	42.0%	46.9%	47.6%	48.1%	53.2%
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	47.0%	70.1%	69.8%	53.6%	48.8%	60.2%	64.1%	51.9%
NORTH WEST ANGLIA NHS FOUNDATION TRUST	48.6%	53.4%	57.7%	50.3%	45.7%	46.5%	45.1%	40.9%
MID AND SOUTH ESSEX NHS FOUNDATION TRUST	45.5%	47.2%	48.3%	40.2%	41.0%	43.8%	40.3%	39.3%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	41.4%	58.1%	61.7%	49.2%	45.0%	46.8%	61.2%	31.9%

***Latest available benchmarking data – Cancer Waiting Times – September 2022**

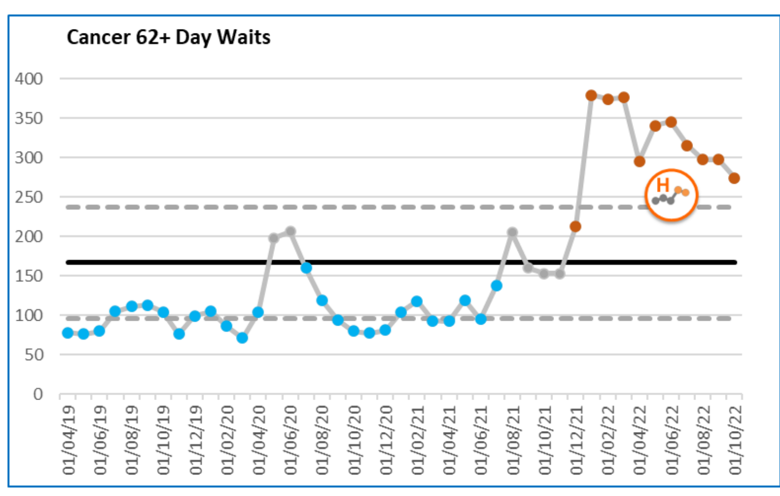
Background	What the Data tells us	Issues	Actions	Mitigations
Cancer – 62 Day Waits – Referral to 1st Treatment	Exception triggered due to this month's performance being below the lower control limit Exception triggered due to 7+ data points below the mean (a shift)	October's performance continues to be non-compliant. A number of factors contribute to non-compliant 62 day performance: increase in demand, slow diagnostic pathways, delays for some OPA appointments, delays in partner providers, delay in availability of letters.	Patients are tracked bi weekly and escalations sent to services twice/ week. Performance reviewed in Access weekly meetings. All services are working on improvements. Long Waiters Reviews now beginning at 49 days across all specialties.	All patients who are treated after Day 62 will be subject to a Clinical Harm Review

Special Cause Variation – Performance – Cancer 104+ Waits



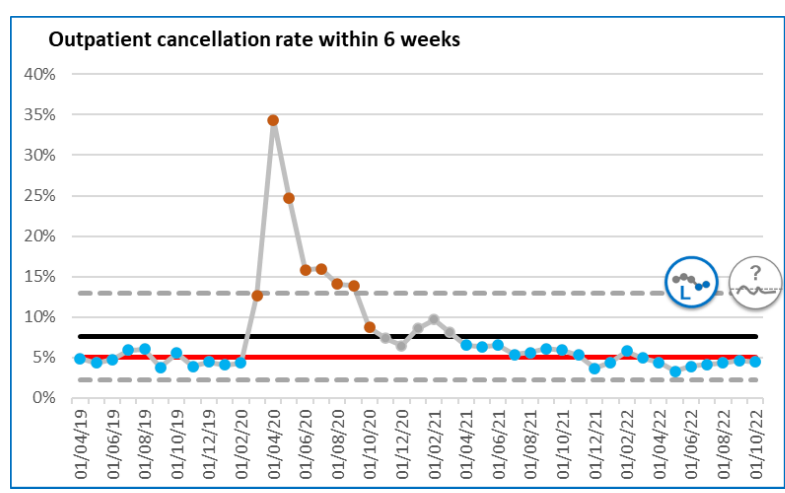
Background	What the Data tells us	Issues	Actions	Mitigations
Cancer – 104 day waits	Exception triggered due to 7+ data points above the mean (a shift)	The number of patients over 104 days on the cancer PTL continues to decrease. Slow diagnostics and some difficulty with patient engagement (making contact and holiday season) are slowing the whole pathway including those waiting over 104 days.	Patient-level scrutiny for all long waiters during the weekly Cancer Long Waiters' meeting has resulted in a reduction of the long waiters. The principles of the "spotlight on cancer" weeks continue in many services. Work is starting to enable services to have a validated PTL to prevent the tip-ins (days 49 to 62)	Clinical review is requested by MDT trackers as they track patients and escalated as necessary Any patient found to have cancer will be subject to a clinical harm review after treatment.

Special Cause Variation – Performance – Cancer 62+ Waits



Background	What the Data tells us	Issues	Actions	Mitigations
Cancer – 62+ day waits	Exception triggered due to this month's performance being above the upper control limit Exception triggered due to 7+ data points above the mean (a shift)	The number of patients over 62 days on the cancer PTL is decreasing but at a slower rate than those over 104 days. Slow diagnostics and some difficulty with patient engagement (making contact and holiday season) are slowing the whole pathway	Patient-level scrutiny for all long waiters during the weekly Cancer Long Waiters' meeting has resulted in a reduction of the long waiters. The principles of the "spotlight on cancer" weeks continue in many services. Work is starting to enable services to have a validated PTL to prevent the tip-ins (days 49 to 62)	Clinical review is requested by MDT trackers as they track patients and escalated as necessary Any patient found to have cancer will be subject to a clinical harm review after treatment.

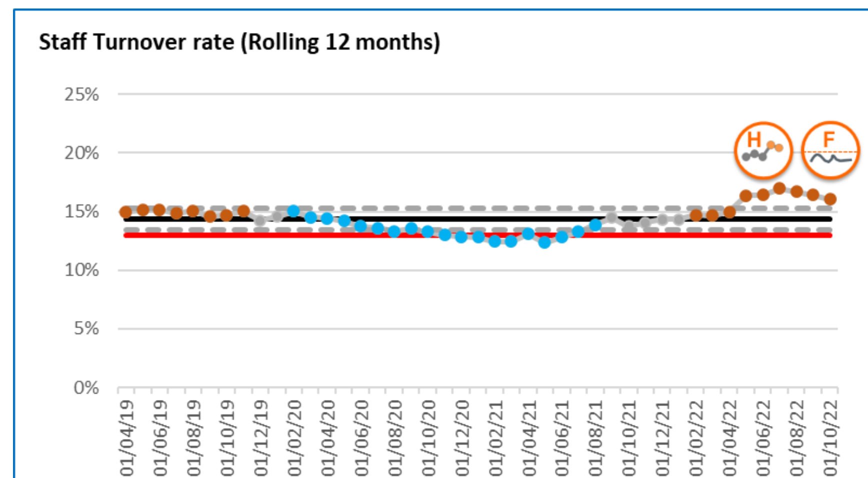
Special Cause Variation – Performance – Outpatient cancellation rate within 6 weeks



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

KPI	Latest month	Measure	Target	Variation	Assurance	Local or National Metric	Committee	Owner
Well-Led Services - Workforce Metrics								
Staff Turnover rate (Rolling 12 months)	Oct 22	16%	13%	H	F	Local	PerC	CPO
% staff leaving within first year (excluding medics and	Oct 22	18%	-	H		Local	PerC	CPO
Vacancy rate	Oct 22	10%	10%		?	Local	PerC	CPO
Sickness rate	Oct 22	5%	4%		?	Local	PerC	CPO
Appraisal rate (Total)	Oct 22	89%	90%	L	F	Local	PerC	CPO
Mandatory Training	Oct 22	90%	90%	L	P	Local	PerC	CPO
% Bank Pay	Oct 22	12%	12%		?	Local	PerC	CPO/CFO
% Agency Pay	Oct 22	6%	5%		?	Local	PerC	CPO/CFO
WTE Workforce Establishment	Oct 22	5445.1	-	H		Local	PerC	CPO
WTE Staff in Post	Oct 22	4925.4	-	H		Local	PerC	CPO

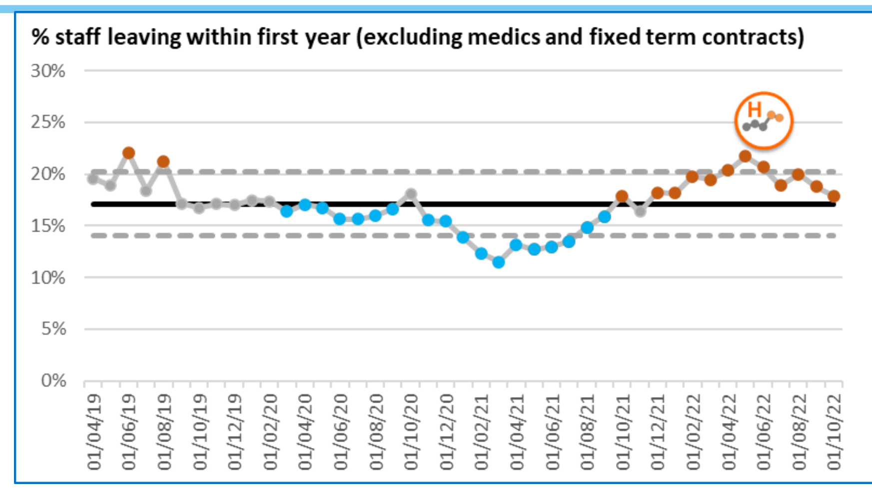
Special Cause Variation – Performance – Staff Turnover rate (rolling 12 months)



TURNOVER RATE							
Trust	Turnover Q1 21/22	Turnover Q2 21/22	Turnover Q3 21/22	Turnover Q4 21/22	Turnover Q1 22/23	Q1 22/23 Ranking (current)	Change Q4 to Q1
Bedford Hospitals	14.9%	14.1%	15.1%	15.1%	16.1%	5	
Herts Community	11.7%	12.9%	17.8%	18.8%	19.4%	12	
WHTH	12.7%	14.5%	14.4%	14.1%	16.4%	6	
East & North Herts	11.2%	12.8%	13.7%	14.1%	13.2%	2	
HPFT	19.7%	19.5%	12.8%	12.8%	13.6%	3	
ELF Bedford MH	16.8%	5.6%	5.6%	4.6%	18.3%	11	
ELF Luton MH	9.4%	6.0%	6.0%	5.2%	17.8%	9	
ELF Bedford Community	12.4%	3.8%	3.8%	3.7%	16.5%	7	
Princess Alexandra	11.0%	12.9%	14.6%	15.8%	17.3%	8	
Essex Partnership UT	9.5%	10.0%	10.0%	10.7%	11.8%	1	
Milton Keynes UFT	7.6%	8.2%	9.3%	11.9%	14.5%	4	
Central North West London FT	14.4%	13.4%	15.6%	17.7%	18.0%	10	
Average	12.6%	11.1%	11.6%	12.0%	16.1%		

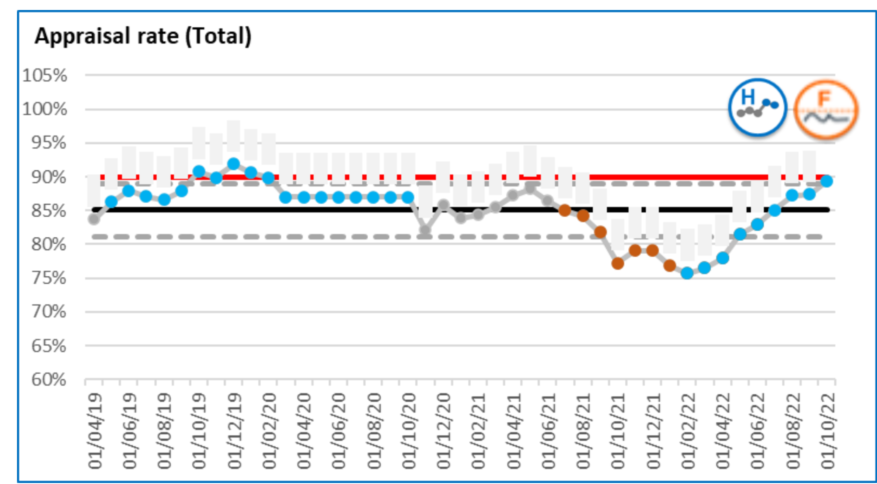
Background	What the Data tells us	Issues	Actions	Mitigations
Staff Turnover rate (Rolling 12 months)	Exception triggered due to a breach of the upper control limit. Exception triggered due to a run of 7+ data points above the mean (a shift)	In common with other NHS organisations the Trust has experienced increased labour turnover. The current rate has decreased over the last three months from 17% to 16.1%. The rates are highest in Clinical Support and WACS areas at 20% and lowest in Medicine and Surgery. Staff Groups with highest rates continue to be HCA's, A&C staff and AHPs. The Trust has relatively high numbers of staff leaving the ICB area compared to other ICB Trusts, this is explained by the proximity to London.	Initiatives such as 'Reaching out' have been launched to help managers mitigate against staff turnover. Initial data has indicated work life balance and relocation are the key drivers. The cost of living crisis is also influencing people to find work closer to home or other sectors. The Trust has introduced initiatives such as the essential hub to help assist retention People Promise managers are reviewing induction process and onboarding experience. Flexible working initiatives are being reviewed too to explore how this may assist retention	Exit interviews and rescue conversation. The 'Reaching Out' programme are priorities for the People Promise managers.

Special Cause Variation – Performance – Staff Leaving within first year (excluding medics and fixed term contracts)



Background	What the Data tells us	Issues	Actions	Mitigations
Staff leaving within first year (excluding medics and fixed term contracts)	Exception triggered due to 2 of 3 data points being around the upper control limit.	Turnover rates for staff leaving within 12 months increased above target and the upper control limit in May 2022. Since then, rates have decreased to 18%, meaning 1 in 6 staff recruited are leaving before working for at least a year. This is the lowest rate since Feb 2022, and there appears to be a downward trend. The rates are highest in clinical support and corporate areas at approx. 22 – 25% respectively. Staff Groups with highest rates are HCA's, A&C staff and AHP.	Corporate and local Induction have been reviewed, particularly A&C staff, where there will be a focus on cohort recruitment to improve the selection of staff. The on-boarding questionnaires data has being analysed or further detail - there is a lot of information to analyse, but issues raised include EPR training, and equipment. Easier access to mandatory training for new starters is being facilitated from November.	People Promise Managers are now in place supporting new starter experience.

Special Cause Variation – Performance/Assurance – Appraisal Rate

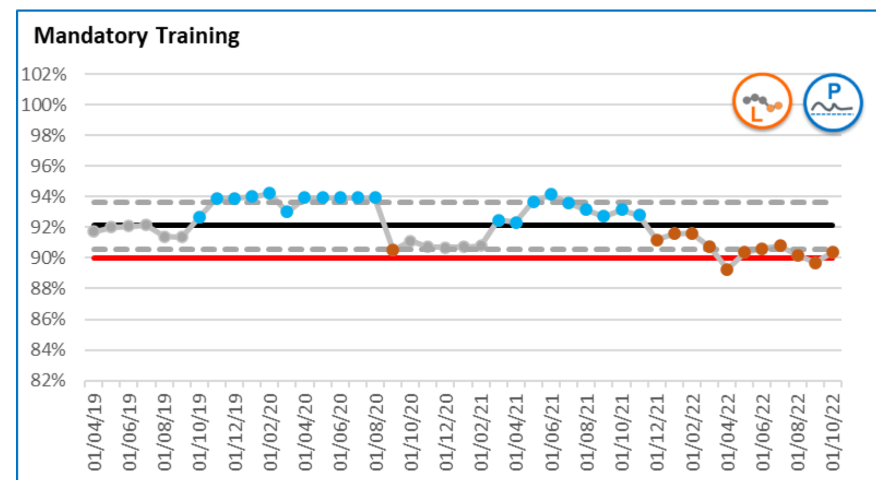


APPRAISAL RATE COMPLIANCE

Trust	Appraisal Rate Q1 21/22	Appraisal Rate Q2 21/22	Appraisal Rate Q3 21/22	Appraisal Rate Q4 21/22	Appraisal Rate Q1 22/23	Q1 22/23 Ranking (current)	Change Q4 to Q1
Bedford Hospitals	67%	67%	67%	67%	67%	7	↗
Herts Community	69%	79%	75%	64%	76%	6	↗
WHHT	86%	82%	79%	79%	83%	4	↗
East & North Herts	63%	61%	55%	46%	37%	10	↘
HPFT	89%	87%	79%	72%	85%	2	↗
ELF Bedford MH	22%	15%	15%	31%	31%	11	→
ELF Luton MH	23%	13%	13%	33%	29%	12	↘
ELF Bedford Community	38%	19%	19%		49%	9	↗
Princess Alexandra	83%	83%	78%	79%	79%	5	→
Essex Partnership UT			78%	59%	59%	8	→
Milton Keynes UFT	92%	91%	91%	92%	88%	1	↘
Central North West London FT	85%	80%	80%	81%	84%	3	↗
Average	65%	62%	61%	64%	64%		↗

Background	What the Data tells us	Issues	Actions	Mitigations
Appraisal Rate	Exception triggered due a run of data points increasing (a trend) Exception triggered due to the target falling below the lower control limit	Following concerted efforts to improve this, the rate is now just under 90%, at 89.4%, just short of the target which is disappointing. The latest reports show a continued increase in compliance over the last 9 months. The Trust is also above average compared to other nearby acute Trusts, ranking 4 / 12 as at Q1 22/23.	Appraisal rates are being reported every week to help monitor performance HRBP's are continuing to agree weekly targets with managers, to achieve compliance, targeting hotspots and helping to set dates for any outstanding appraisals to take place.	Streamlined paperwork has been introduced. The Trust is also looking at further enhancing the way appraisals are completed using better reporting systems.

Special Cause Variation – Performance/Assurance – Mandatory Training



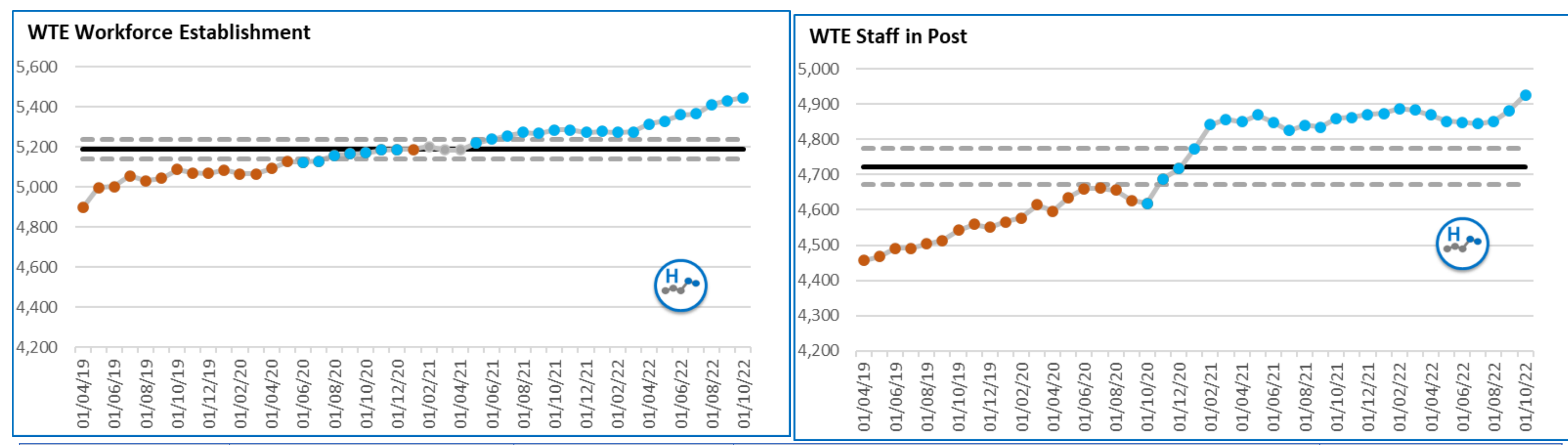
MANDATORY TRAINING COMPLIANCE

Trust	Mandatory Training Rate Q1 21/22	Mandatory Training Rate Q2 21/22	Mandatory Training Rate Q3 21/22	Mandatory Training Rate Q4 21/22	Mandatory Training Rate Q1 22/23	Q1 22/23 Ranking (current)	Change Q4 to Q1
Bedford Hospitals	77%	77%	77%	77%	80%	11	↗
Herts Community	94%	94%	94%	95%	92%	3	↘
WHHT	94%	93%	92%	91%	91%	5	↘
East & North Herts	86%	88%	86%	87%	88%	6	↗
HPFT	91%	90%	89%	89%	91%	4	↗
ELF Bedford MH	88%	86%	86%	85%	82%	9	↘
ELF Luton MH	87%	88%	88%	84%	84%	8	→
ELF Bedford Community	85%	86%	86%	84%	81%	10	↘
Princess Alexandra	88%	87%	87%	86%	86%	7	→
Essex Partnership UT	81%	81%	81%	78%	78%	12	→
Milton Keynes UFT	96%	96%	96%	94%	95%	1	↗
Central North West London F	94%	94%	94%	94%	94%	2	→
Average	88%	88%	88%	87%	87%		↘

The ranking order shows number 1 reflecting the best indicator figure and others in descending order

Background	What the Data tells us	Reasons	Actions	Mitigations
Mandatory Training	Exception triggered due to the target being below the lower control limit Exception triggered due to 7+ data points below the mean Exception triggered due to a breach of the lower control limit	The mandatory training rate continued to consistently achieve 90%, to April 2022.The fall to below the LCL and the 90% compliance rate has occurred twice over the last 8 months, at all other times if has been above the 90% target.	Training team and HRBPs will continue to support Divisions to achieve compliance across staff groups and subjects so that the 90% target is again consistently achieved. Reminders are send to staff who consistently fail to ensure their training is compliant. The Trust is ranked 5 / 12 compared to nearby NHS organisations.	There is a continued focus on specific subjects to maintain compliance and ensure this is above the 90% target.

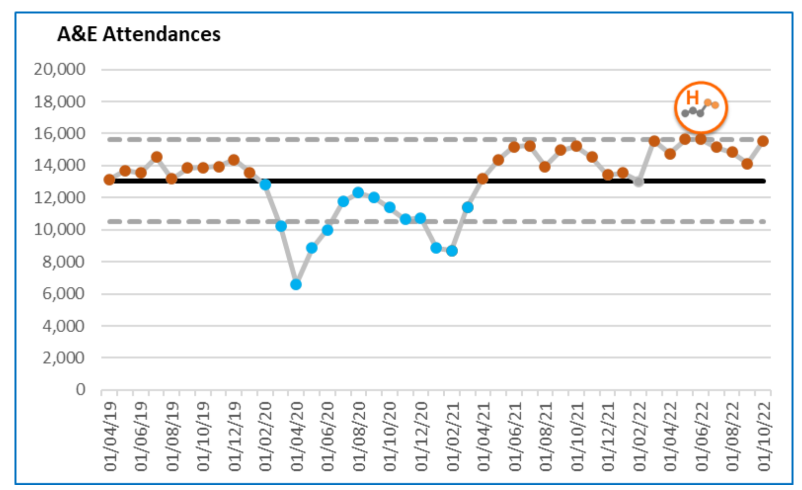
Special Cause Variation – Performance – WTE Staff Establishment/WTE Staff in Post

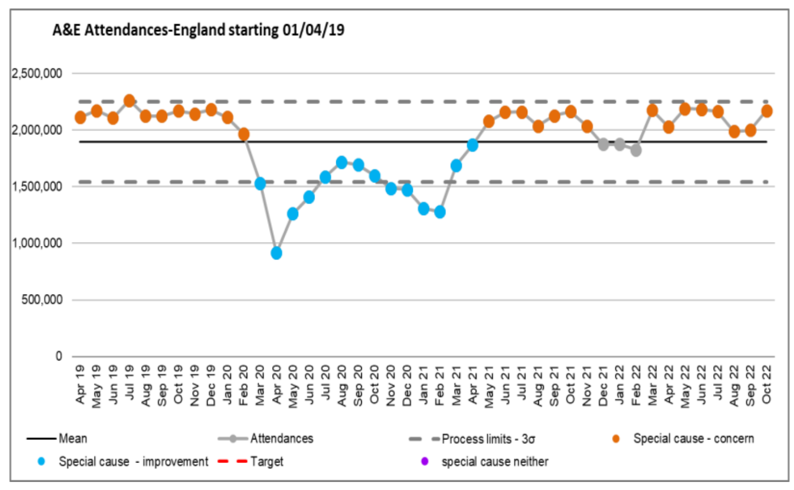


Background	What the Data tells us	Reasons	Actions	Mitigations
WTE Workforce Establishment/WTE Staff in Pot	Exception triggered due to 7+ data points above the mean Exception triggered due to a breach of the upper control limit	The planned business case establishment target is 5,302wte by March 2023. The business case for the wte staff in post figures is 4,890wte in post by March 2023.	The current workforce establishment at Sept at 5,445. The reasons for this being higher than the target are that the financial ledger establishment is adjusted for staffing in a small number of cost centres where there is no funded wte establishment, and to account for the GPVTS medics recharge arrangements. This avoids misleadingly low vacancy rates. The current adjustment is 79wte, so if we adjust the establishment by this figure it is 5,366, much closer to the target. The reason for the remaining variation is that there were more business cases approved for 22/23 than were known about at the time of the plan. There has been a significant upturn in recruitment to help enable staff in post wte to increase, to meet the increased staffing requirements and help offset bank and agency expenditure. This has increased by 55 wte since April 22	Continued recruitment for permanent staff will continue to offset agency usage.

KPI	Latest month	Measure	Target	Variation	Assurance	Local or National Metric	Committee	Owner
Activity Metrics								
GP Referrals Made	Oct 22	6100	-			Local	F&P	COO
A&E Attendances	Oct 22	15541	-			Local	F&P	COO
1st Outpatient Appointments - All	Oct 22	11116	-			Local	F&P	CIO
1st Outpatient Appointments - Face to Face	Oct 22	10089	-			Local	F&P	CIO
Follow Up Outpatient Appointments - All	Oct 22	15224	-			Local	F&P	CIO
Follow Up Outpatient Appointments - Face to Face	Oct 22	11638	-			Local	F&P	CIO
Specific Acute Elective Ordinary Admissions	Oct 22	425	-			Local	F&P	COO
Specific Acute Daycases	Oct 22	2692	-			Local	F&P	COO
Specific Acute Non-Elective Admissions - 0 LOS	Oct 22	1326	-			Local	F&P	COO
Specific Acute Non-Elective Admissions - +1 LOS	Oct 22	2176	-			Local	F&P	COO
Completed Admitted RTT Pathways (Clock Stops)	Oct 22	962	-			Local	F&P	COO
Completed Non-Admitted RTT Pathways (Clock Stops)	Oct 22	5154	-			Local	F&P	COO
New RTT Pathways (Clock Starts)	Oct 22	8952	-			Local	F&P	COO
PTL Volume	Oct 22	59727	-			Local	F&P	COO
Theatre Utilisation (Touch time utilisation on the day h	Oct 22	66%	-			Local	F&P	COO

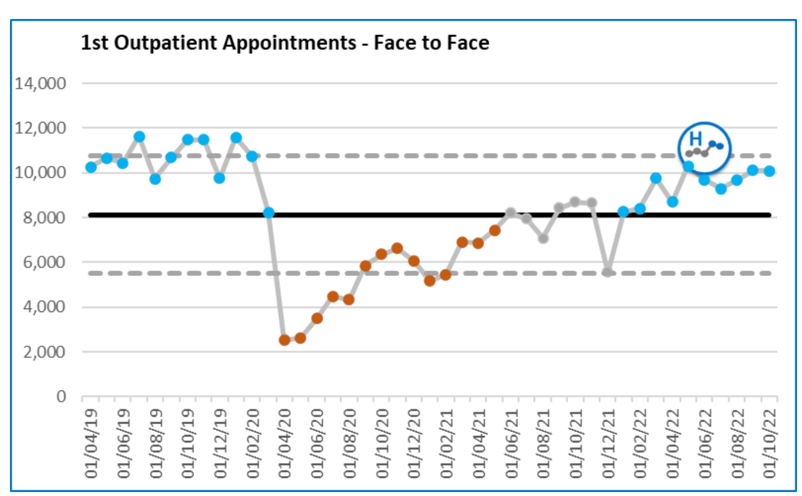
Special Cause Variation – Performance – A&E Attendances

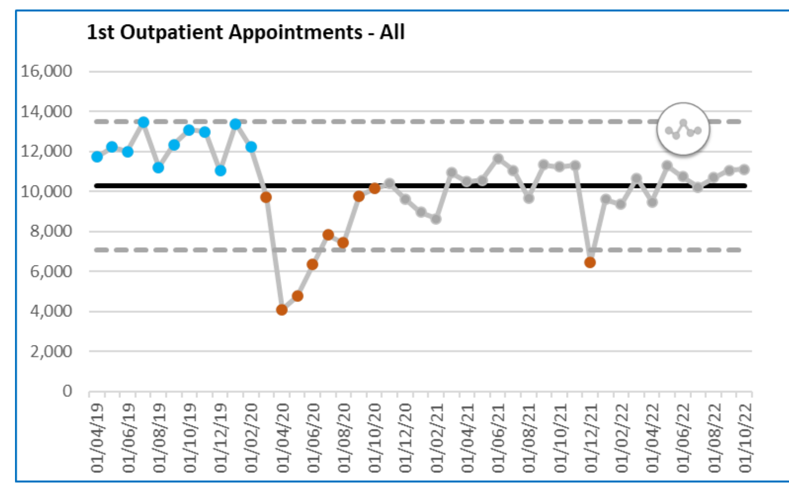




Background	What the Data tells us	Issues	Actions	Mitigations
A&E Attendances	Exception triggered due to 7+ data points above the mean (a shift)	ED demand has increased by 19% for adults and 40% for paediatrics	Working with ICB to review alternative pathways to ED Working closely with UTC providers to ensure patient are streamed early and into the right pathway	The profile observed in A&E attendances at West Herts triggering an exception is equally observed when looking at all A&E attendances in England

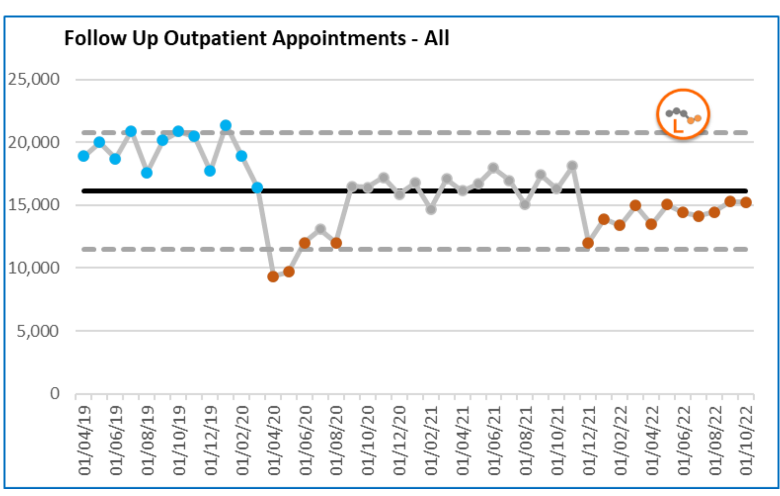
Special Cause Variation – Performance – 1st Outpatient Appointments – Face to Face





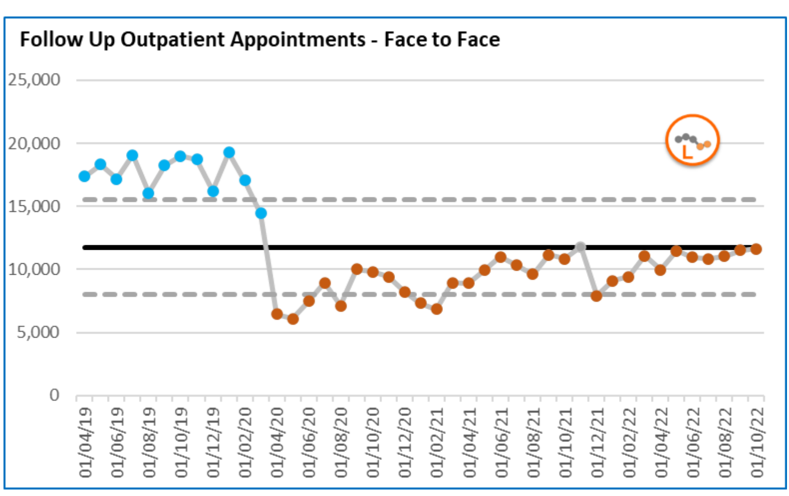
Background	What the Data tells us	Issues	Actions	Mitigations
1st Outpatient Appointments – Face to Face	Exception triggered due to 7+ data points above the mean (a shift)	ED demand has increased by 19% for adults and 40% for paediatrics	Working with ICB to review alternative pathways to ED Working closely with UTC providers to ensure patient are streamed early and into the right pathway	The profile observed in A&E attendances at West Herts triggering an exception is equally observed when looking at all A&E attendances in England

Special Cause Variation – Performance – Follow Up Outpatient Appointments – All



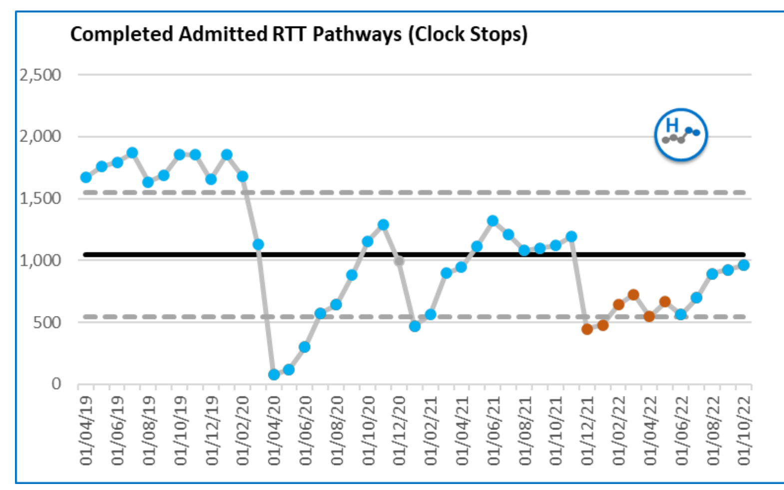
Background	What the Data tells us	Issues	Actions	Mitigations
Follow Up Outpatient Appointments - All	Exception triggered due to 7+ data points below the mean (a shift)	Referral figures beginning to rise but capacity limited towards the end of the financial year due to increased allocation of annual leave. Large number of patients requiring follow up have no order completed by clinicians.	Incomplete order issue highlighted to all ADM and ASMs at OUG meetings.	

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



Background	What the Data tells us	Issues	Actions	Mitigations
Follow Up Outpatient Appointments – Face to Face	Exception triggered due to 7+ data points below the mean (a shift)	Referral figures beginning to rise but capacity limited towards the end of the financial year due to increased allocation of annual leave. Large number of patients requiring follow up have no order completed by clinicians.	Incomplete order issue highlighted to all ADM and ASMs at OUG meetings.	

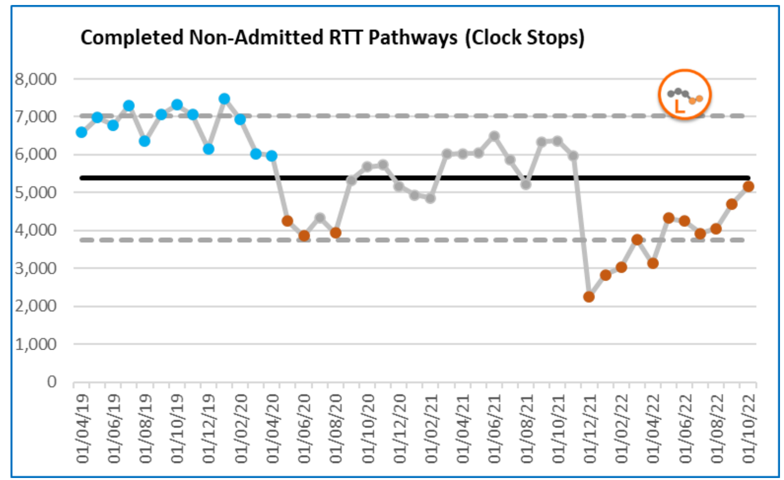
Special Cause Variation – Performance – Completed Admitted RTT Pathways (Clock Stops)



Trust	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Bedfordshire Hospitals NHS Foundation Trust	2,510	2,846	2,471	2,724	2,669	2,581	2,585	2,471
Cambridge University Hospitals NHS Foundation Trust	2,303	2,503	2,154	2,547	2,308	2,453	2,535	2,498
East And North Hertfordshire NHS Trust	1,483	1,639	1,311	1,545	1,639	1,582	1,591	1,666
East Suffolk And North Essex NHS Foundation Trust	1,861	2,082	1,598	2,042	1,884	2,088	2,207	2,221
James Paget University Hospitals NHS Foundation Trust	1,466	1,416	972	1,375	1,211	1,092	1,313	1,317
Mid And South Essex NHS Foundation Trust	3,054	3,162	2,394	3,697	3,319	3,219	3,485	3,595
Milton Keynes University Hospital NHS Foundation Trust	1,236	1,330	1,079	1,437	1,315	1,321	1,586	1,364
Norfolk And Norwich University Hospitals NHS Foundation Trust	2,441	2,695	2,236	2,606	2,415	2,388	2,564	2,706
North West Anglia NHS Foundation Trust	1,636	1,892	1,578	2,014	1,847	1,884	1,862	1,606
The Princess Alexandra Hospital NHS Trust	278	367	341	474	397	386	435	424
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	814	1,049	806	1,109	852	867	956	916
West Hertfordshire Hospitals NHS Trust	**641**	**720**	**547**	**668**	**563**	**696**	**894**	**923**
West Suffolk NHS Foundation Trust	703	836	753	795	795	725	860	781

Background	What the Data tells us	Issues	Actions	Mitigations
Completed Admitted RTT Pathways (Clock Stops)	Exception triggered due to 7+ data points below the mean Exception triggered due to a run of increasing data points (a trend)	Fewer ad hoc sessions are being undertaken than prior to COVID, reducing the additional capacity that was utilised previously to support performance. Prioritising the most clinically urgent patients results in longer waits for more routine patients There are numerous issues with data quality associated with data within the PTL following implementation of the EPR. While staff continue to adjust to new ways of working, errors have increased significantly despite ongoing support and advice.	Outsourcing programme remains active at a reasonable rate and additional sessions are being undertaken but there is less uptake than pre COVID. Operational recovery group oversight of activity delivery BI team working with EPR project leads to address multiple DQ issues. Extensive validation commenced 31/10/22 with additional temporary resources supplementing in house capacity. This is expected to have a significant impact on cleansing of the PTL with many pathways being closed in past months.	Continuous horizon scanning for additional outsourcing opportunities, with specialty level engagement to ensure quality and safety as well as timely pathways Weekly long wait review meeting in place to drive progress and delivery of improvement plan. Service level tracking with forward look to target deadlines to ensure adequate operational oversight of patient cohorts.

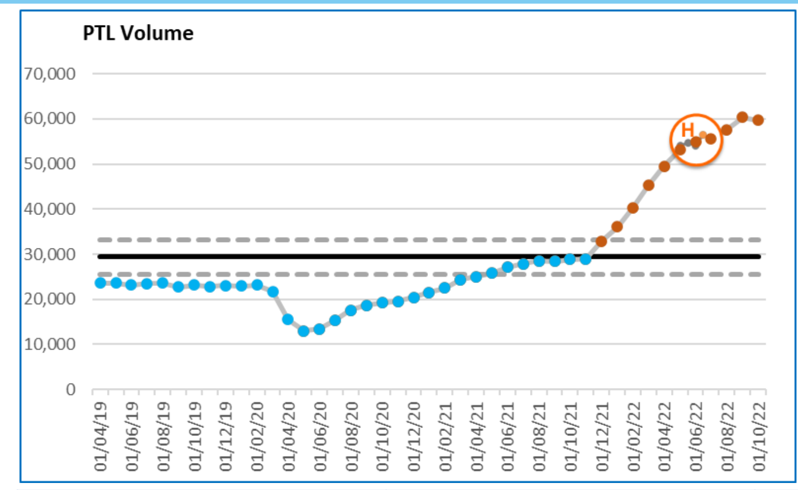
Special Cause Variation – Performance – Completed Non-Admitted RTT Pathways (Clock Stops)



Trust	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Bedfordshire Hospitals NHS Foundation Trust	8,115	8,823	7,481	8,784	7,777	8,020	21,288	8,075
Cambridge University Hospitals NHS Foundation Trust	8,493	9,487	7,870	9,787	8,752	8,467	8,119	9,034
East And North Hertfordshire NHS Trust	7,287	7,829	6,501	7,939	7,497	6,482	1,970	7,681
East Suffolk And North Essex NHS Foundation Trust	12,294	14,031	11,240	13,497	12,551	12,548	5,532	12,595
James Paget University Hospitals NHS Foundation Trust	3,549	3,706	2,533	3,633	3,378	4,241	12,989	3,826
Mid And South Essex NHS Foundation Trust	21,161	23,238	21,015	23,137	20,963	22,095	10,351	23,973
Milton Keynes University Hospital NHS Foundation Trust	5,299	4,924	4,340	5,637	4,765	5,338	3,378	5,610
Norfolk And Norwich University Hospitals NHS Foundation Trust	10,672	12,199	9,191	11,030	9,999	9,424	3,334	10,677
North West Anglia NHS Foundation Trust	10,063	12,088	10,590	12,190	10,802	9,955	8,736	11,512
The Princess Alexandra Hospital NHS Trust	5,477	6,362	4,976	5,614	5,514	5,260	10,684	5,529
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	1,679	1,820	1,602	2,235	2,655	1,760	5,209	1,787
West Hertfordshire Hospitals NHS Trust	**3,025**	**3,772**	**3,129**	**4,329**	**4,251**	**3,918**	**4,052**	**4,701**
West Suffolk NHS Foundation Trust	3,787	4,539	3,280	4,073	3,671	3,216	6,646	3,785

Background	What the Data tells us	Issues	Actions	Mitigations
Completed Non-Admitted RTT Pathways (Clock Stops)	Exception triggered due to 7+ data points below the mean	Fewer ad hoc sessions are being undertaken than prior to COVID, reducing the additional capacity that was utilised previously to support performance. Prioritising the most clinically urgent patients results in longer waits for more routine patients There are numerous issues with data quality associated with data within the PTL following implementation of the EPR. While staff continue to adjust to new ways of working, errors have increased significantly despite ongoing support and advice.	Outsourcing programme remains active at a reasonable rate and additional sessions are being undertaken but there is less uptake than pre COVID. Operational recovery group oversight of activity delivery BI team working with EPR project leads to address multiple DQ issues. Extensive validation commenced 31/10/22 with additional temporary resources supplementing in house capacity. This is expected to have a significant impact on cleansing of the PTL with many pathways being closed in past months	Continuous horizon scanning for additional outsourcing opportunities, with specialty level engagement to ensure quality and safety as well as timely pathways Weekly long wait review meeting in place to drive progress and delivery of improvement plan. Service level tracking with forward look to target deadlines to ensure adequate operational oversight of patient cohorts.

Special Cause Variation – Performance – RTT PTL Volume

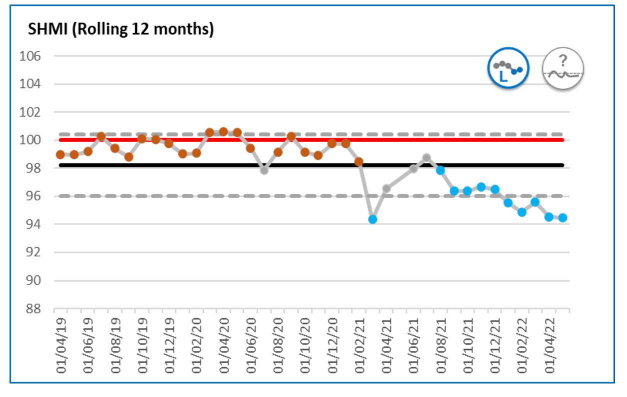


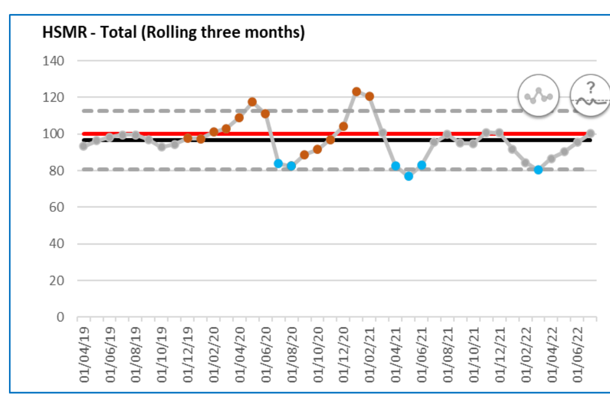
RTT PTL Volume

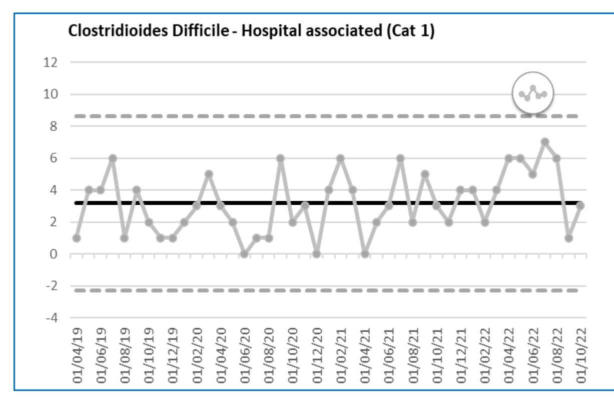
Trust	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Bedfordshire Hospitals NHS Foundation Trust	71,929	74,616	75,763	76,671	78,742	81,852	83,060	83,959
Cambridge University Hospitals NHS Foundation Trust	52,561	53,942	55,097	55,881	56,697	58,203	59,748	59,960
East And North Hertfordshire NHS Trust	47,067	49,147	51,228	52,208	53,957	55,700	59,938	57,971
East Suffolk And North Essex NHS Foundation Trust	66,104	66,618	69,335	71,006	73,392	75,508	75,961	77,357
James Paget University Hospitals NHS Foundation Trust	16,421	16,582	17,309	19,251	20,294	21,950	22,749	22,712
Mid And South Essex NHS Foundation Trust	130,968	137,603	147,324	153,268	155,403	163,485	153,543	158,016
Milton Keynes University Hospital NHS Foundation Trust	32,498	32,122	31,637	31,396	32,400	34,297	36,197	37,818
Norfolk And Norwich University Hospitals NHS Foundation Trust	76,316	77,072	78,635	80,823	82,507	85,523	86,742	87,449
North West Anglia NHS Foundation Trust	58,476	61,243	63,724	64,326	64,643	66,727	68,394	69,875
The Princess Alexandra Hospital NHS Trust	27,444	26,157	25,780	25,862	25,287	25,573	26,759	26,623
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	19,428	19,875	20,195	20,561	20,803	22,142	22,024	21,979
West Hertfordshire Hospitals NHS Trust	**40,188**	**45,024**	**49,466**	**53,090**	**54,562**	**55,456**	**57,539**	**60,250**
West Suffolk NHS Foundation Trust	25,454	25,773	26,492	28,151	29,280	30,708	30,741	31,488

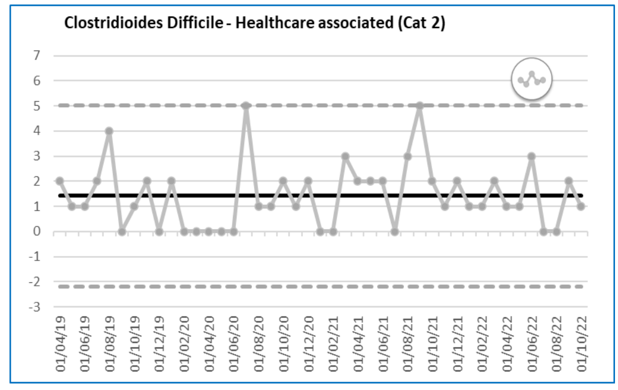
Background	What the Data tells us	Issues	Actions	Mitigations
RTT PTL Volume	Exception triggered due to breach of the upper control limit Exception triggered due to 7+ data points above the mean (a shift)	The most significant factor affecting PTL volume is the substantial number of DQ issues that have arisen following implementation of Cerner. Data quality has deteriorated very significantly with multiple pathway issues as a result of migration problems, some staff not yet being fully competent in pathway management in the new environment. Insufficient resources (capacity & workforce) to re-validate the entire waiting list in a short period of time. Fewer clock stops than clock starts.	BI team working with EPR project leads to address issues. Targeted support with appointment outcoming, to ensure accurate data capture at the time of patient review Weekly meeting with BI team to review actions to improve PTL and pathway issues.BI team working with EPR project leads to address issues. Extensive validation programme commenced 31/10/22 with additional resource in place to support in house team with focused work on several cohorts within the PTL. This will deliver a reduction in PTL size, but only if refresher training is successful and staff follow the correct workflows in EPR.	Joint Performance, BI and EPR team PTL review meeting in place, reviewing all issues to identify issues, themes and solutions.

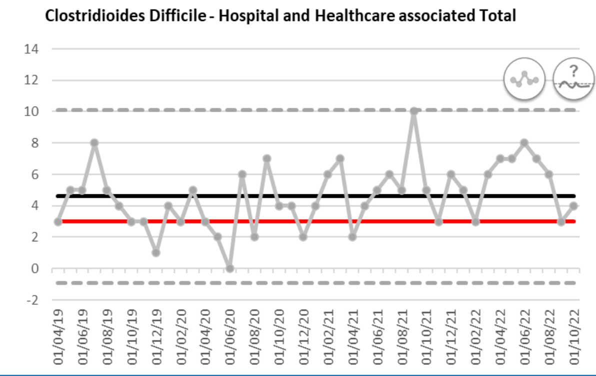
Appendix 1 – Safe Care and Improving Outcomes Metrics - Quality

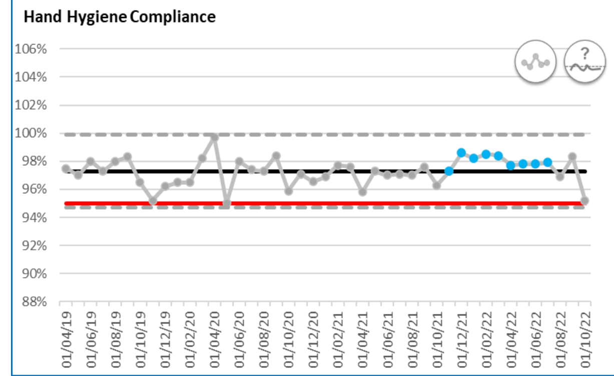




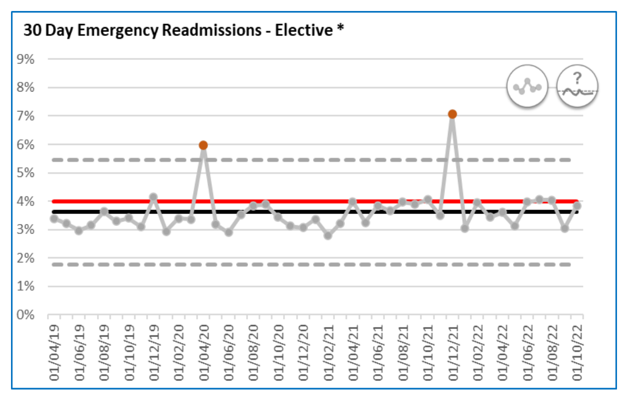


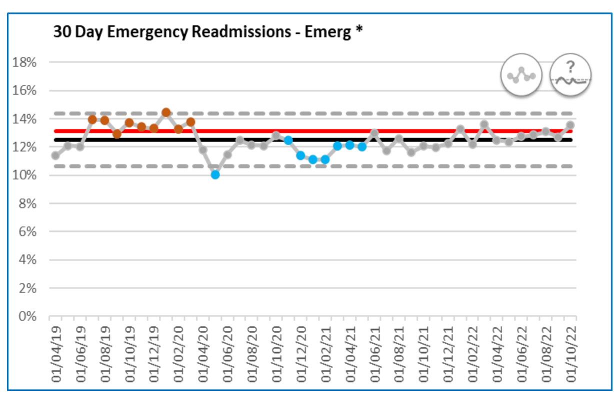


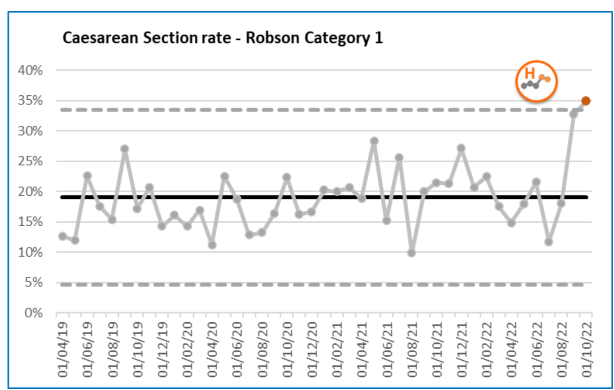


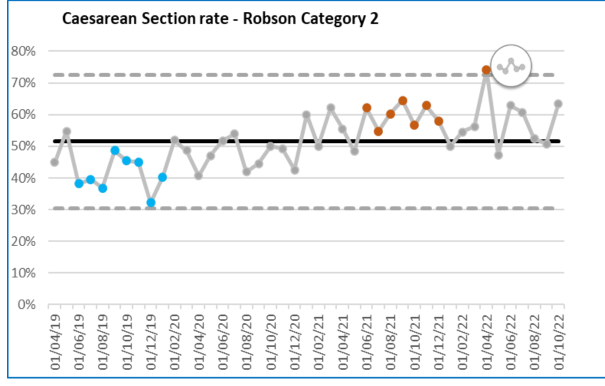


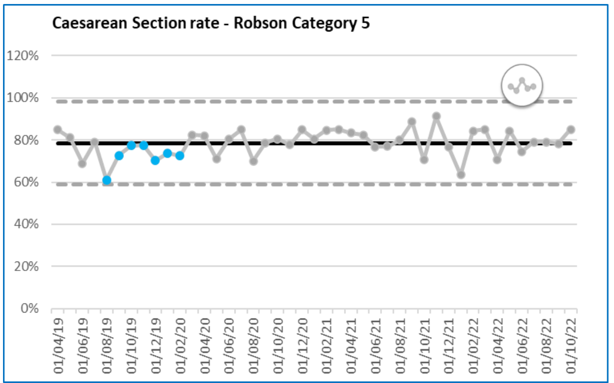
Appendix 1 – Safe Care and Improving Outcomes Metrics - Quality





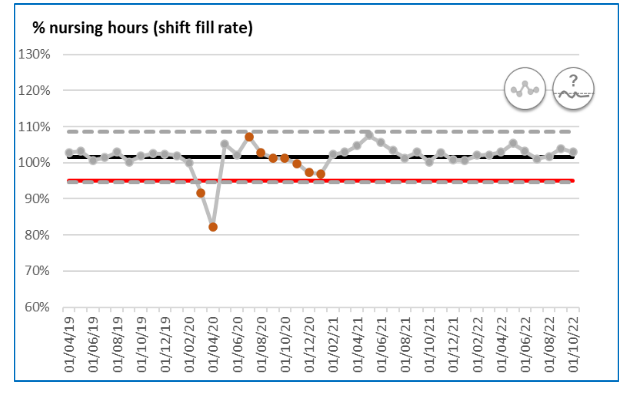


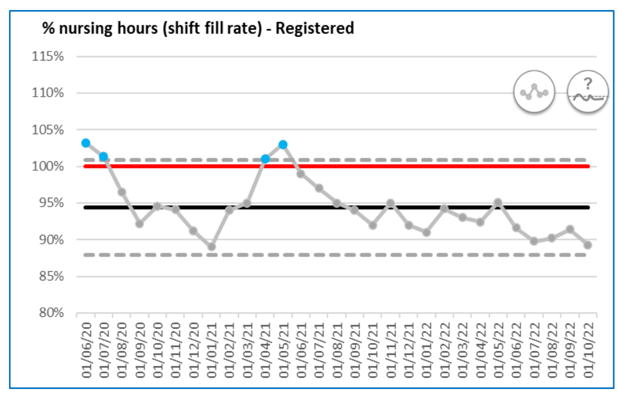


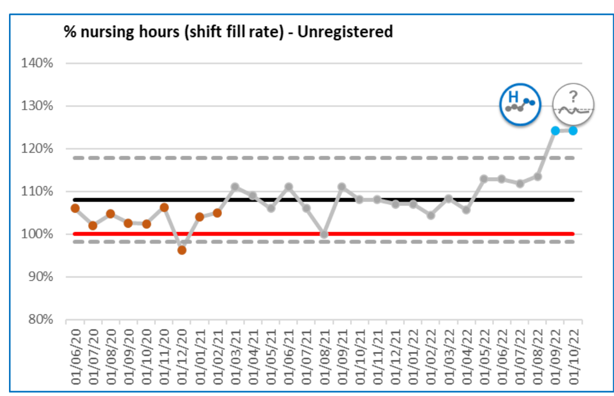


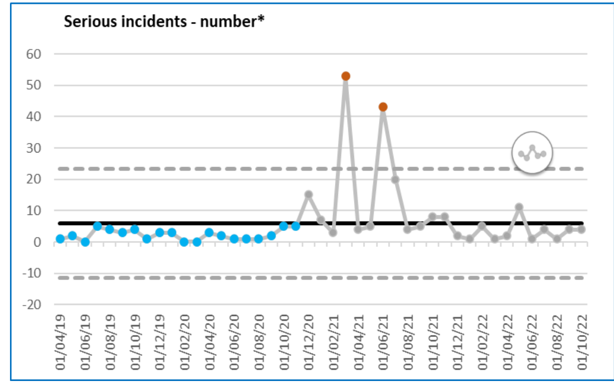
54

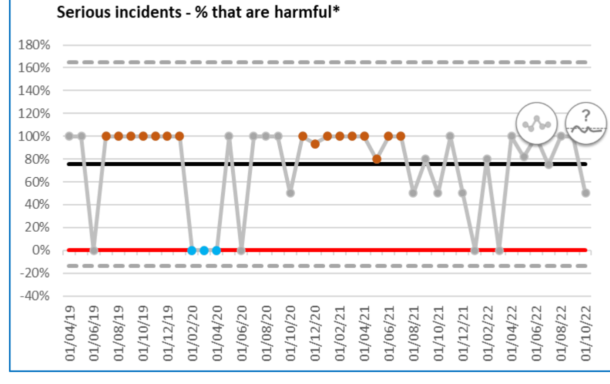
Appendix 1 – Safe Care and Improving Outcomes Metrics - Safety

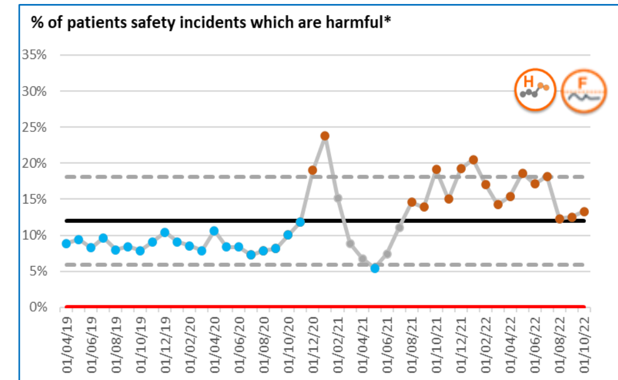




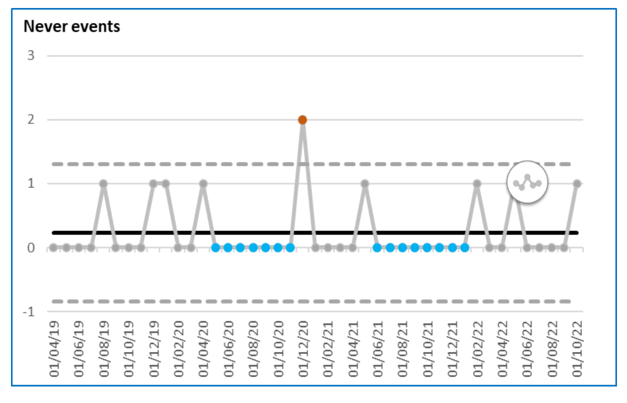


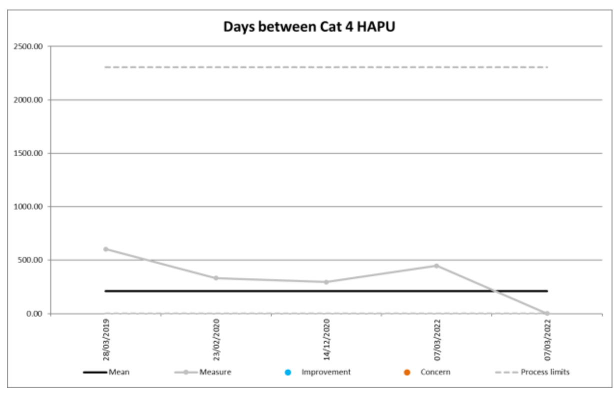


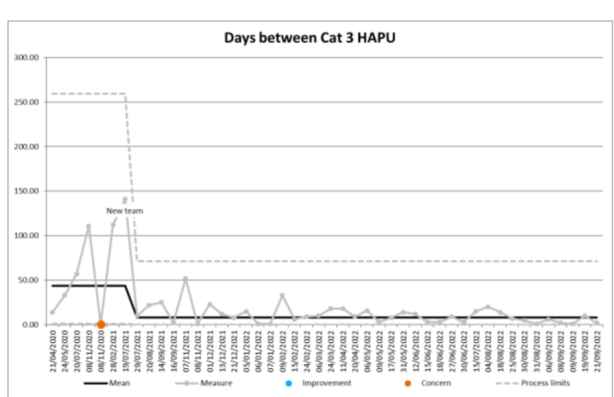


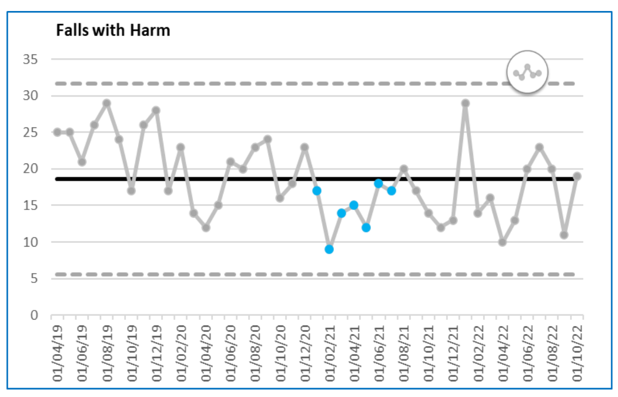


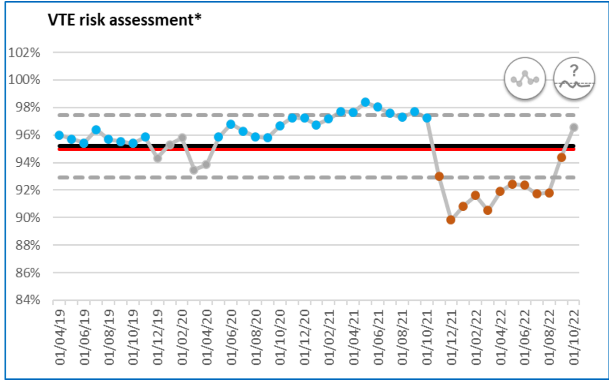
Appendix 1 – Safe Care and Improving Outcomes Metrics - Safety

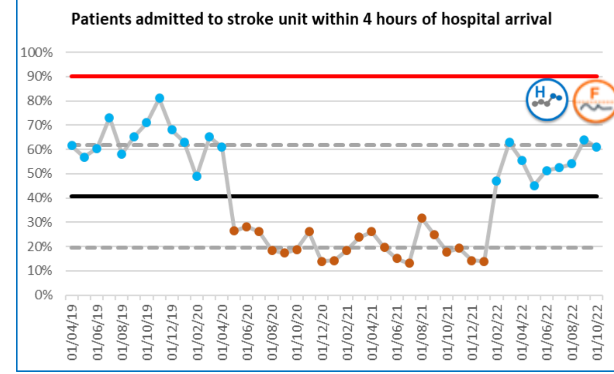












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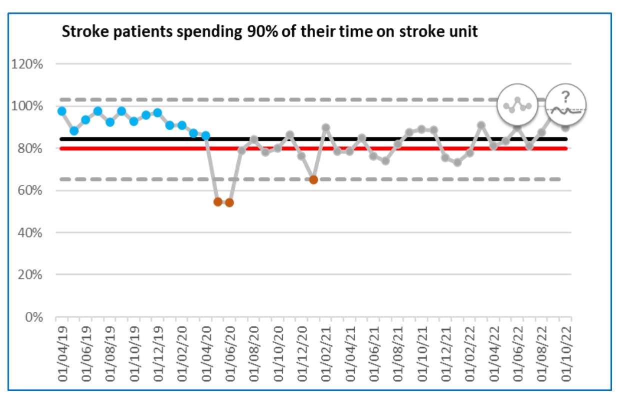
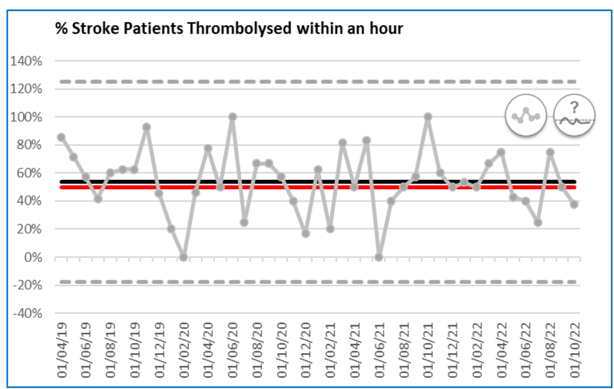
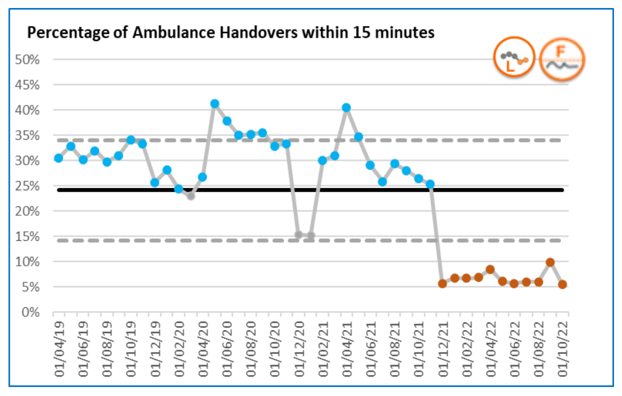
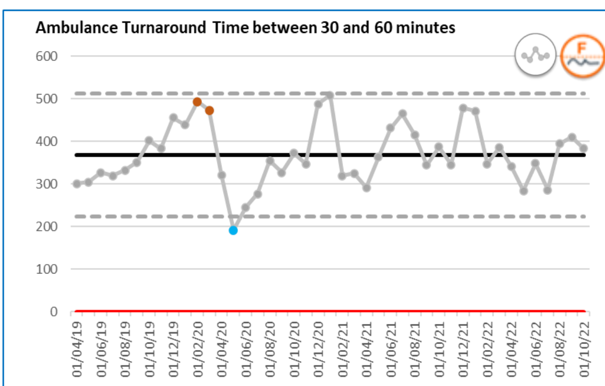
Appendix 1 – Safe Care and Improving Outcomes Metrics - Safety

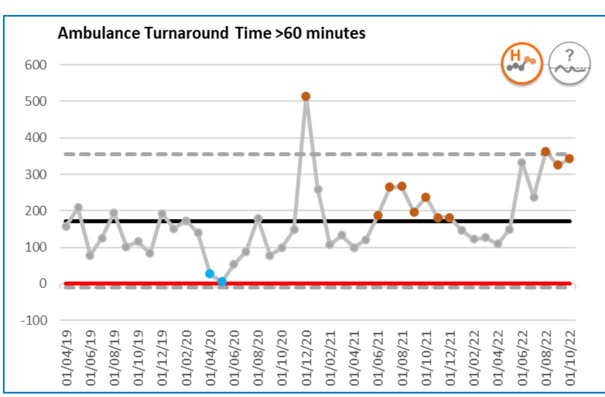


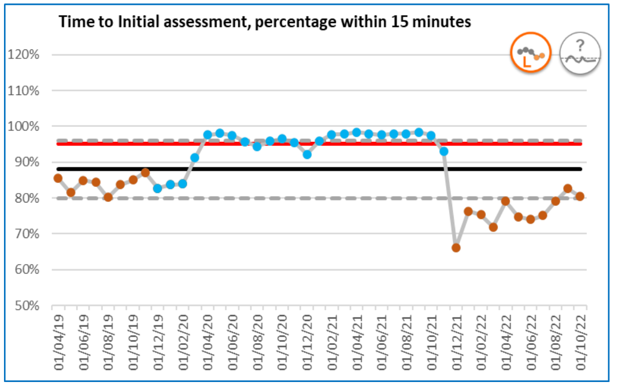


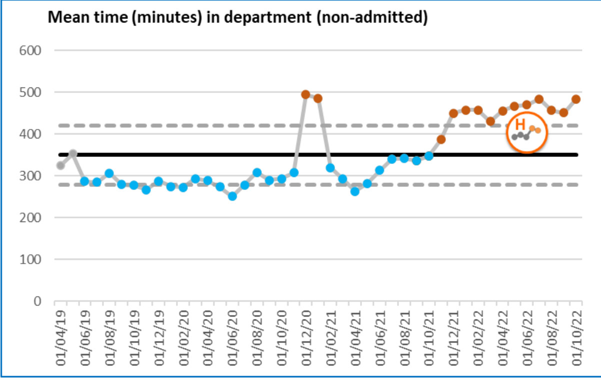
Appendix 2 – A&E Metrics

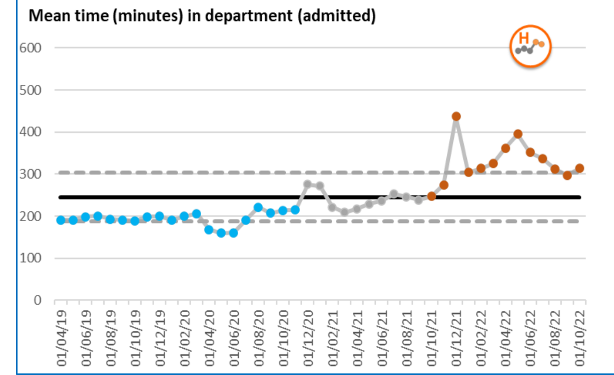




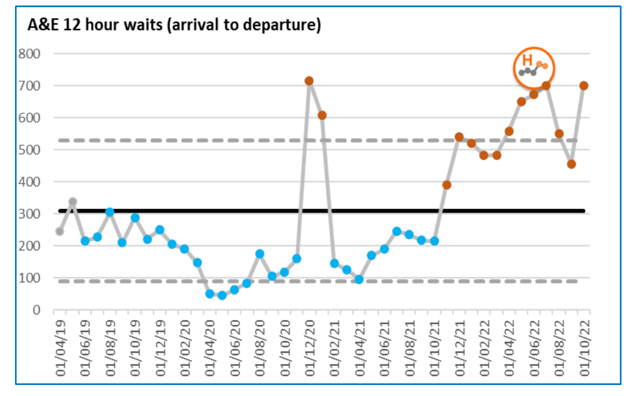


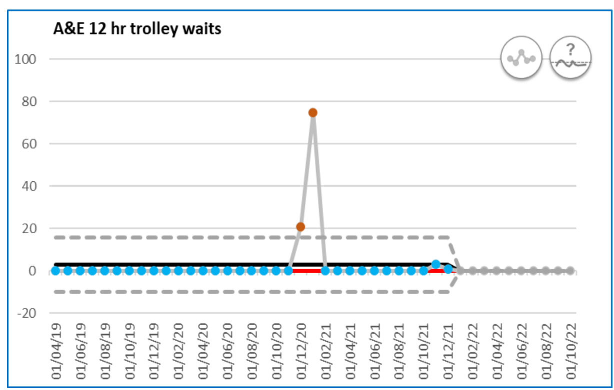


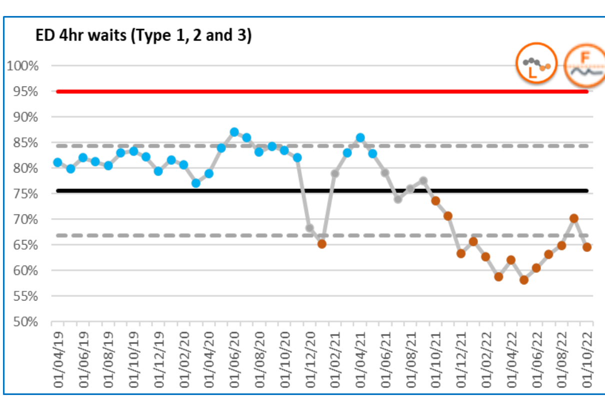


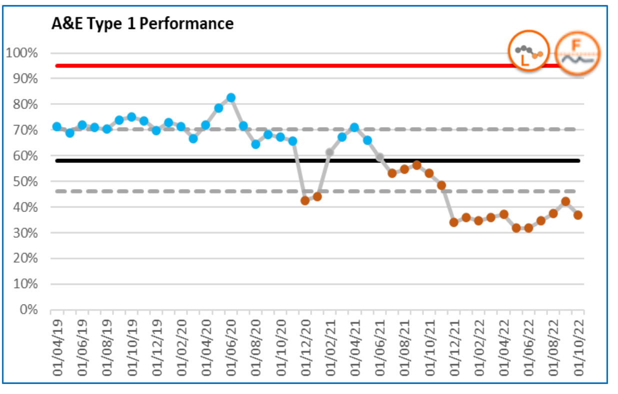


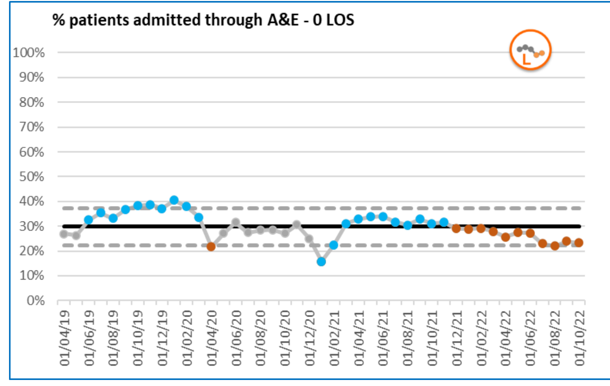
Appendix 2 – A&E Metrics

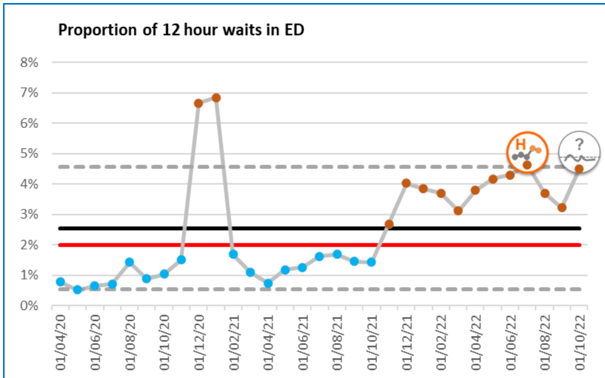




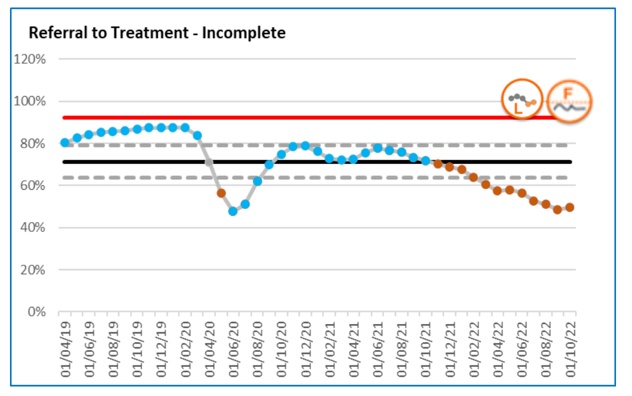


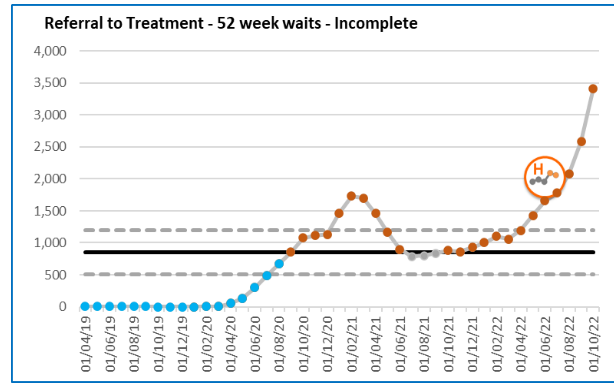


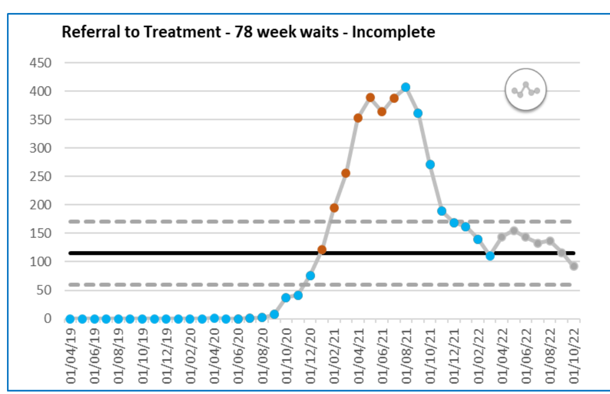


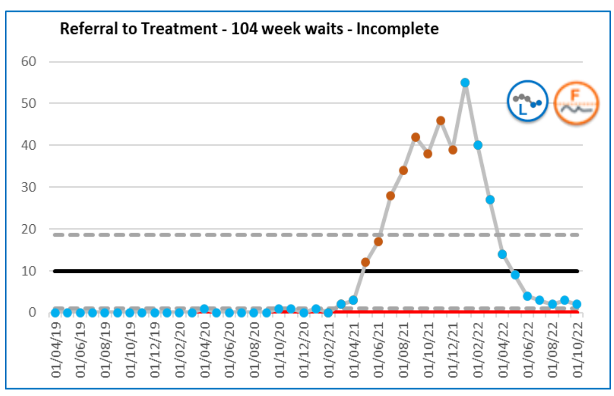


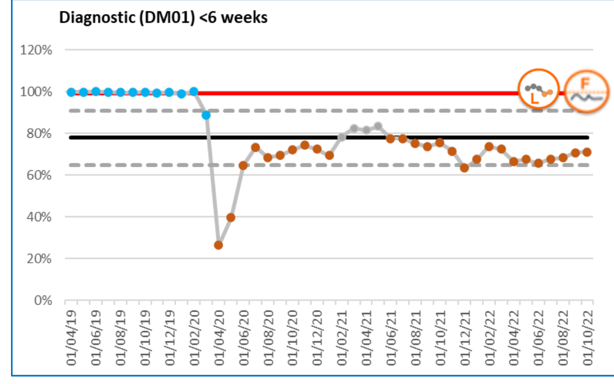
Appendix 3 – RTT, Cancer and Diagnostics Metrics

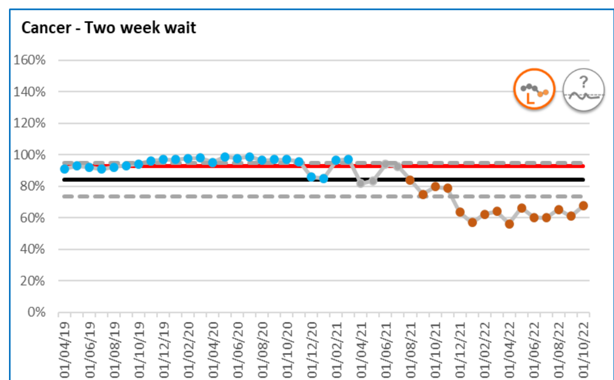




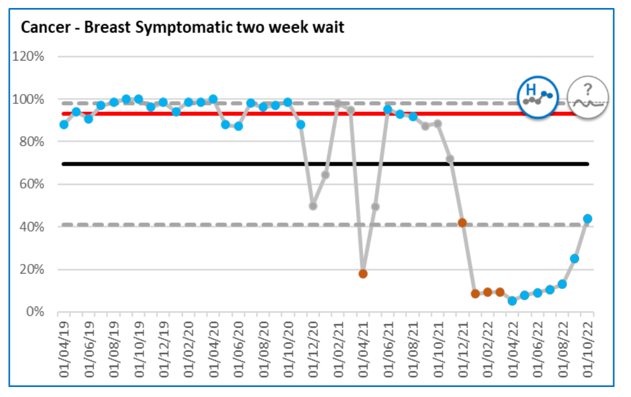


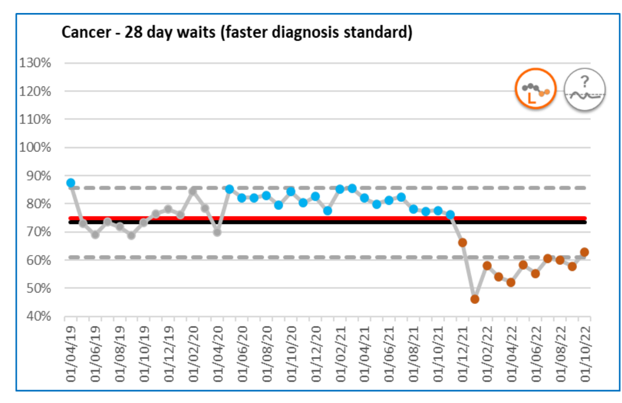


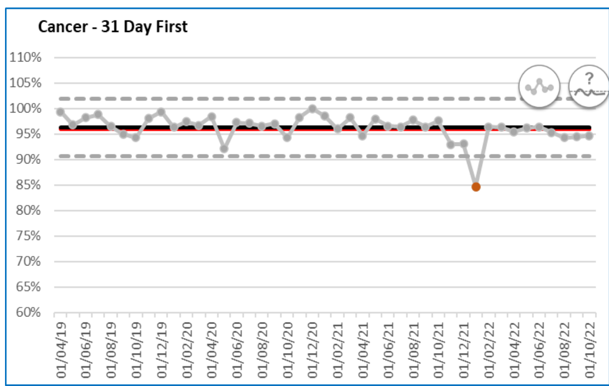


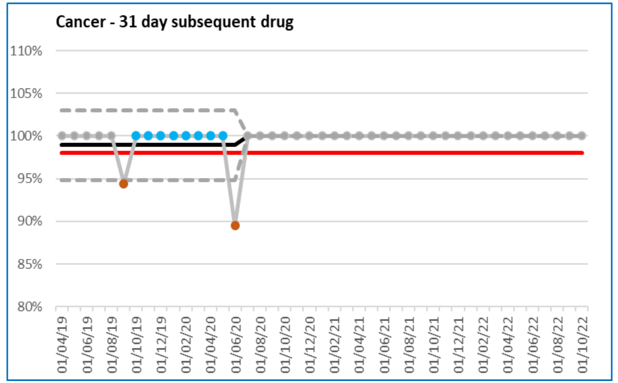


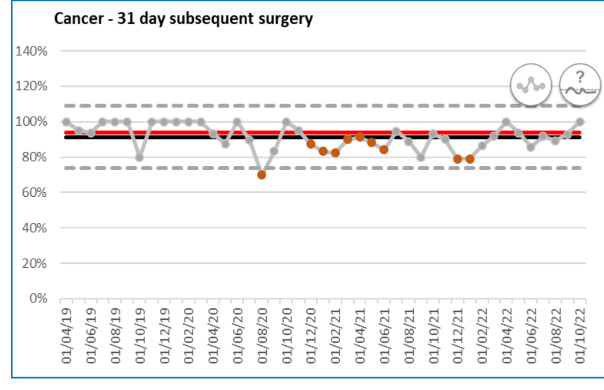
Appendix 3 – RTT, Cancer and Diagnostics Metrics

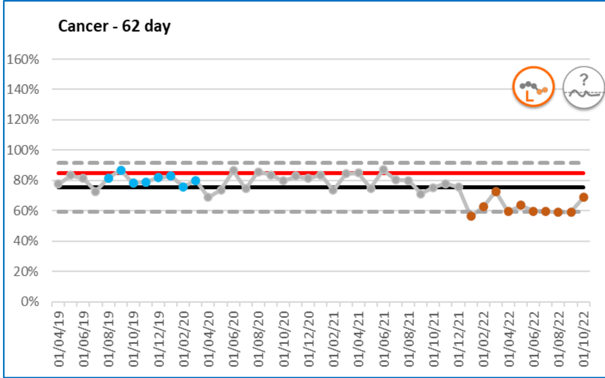




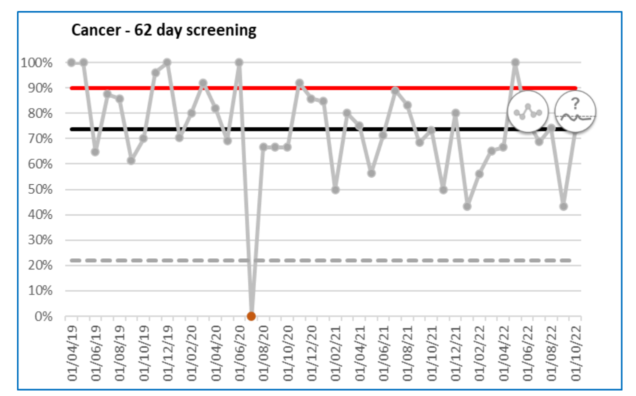


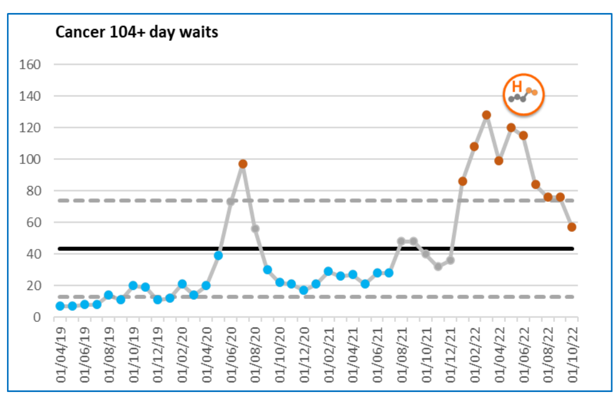


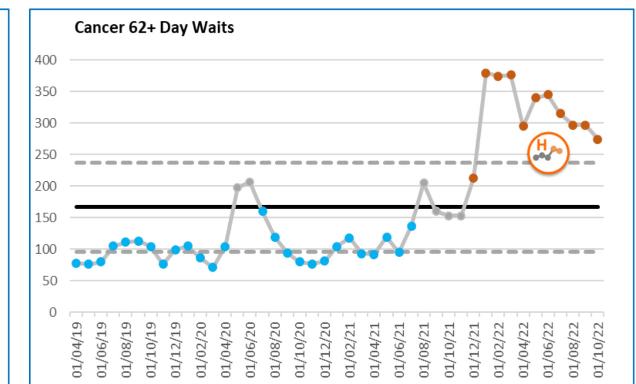


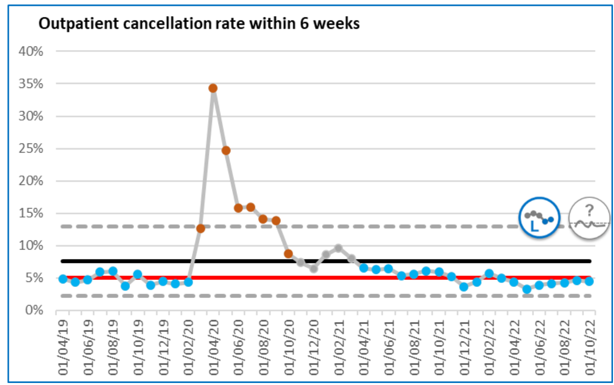


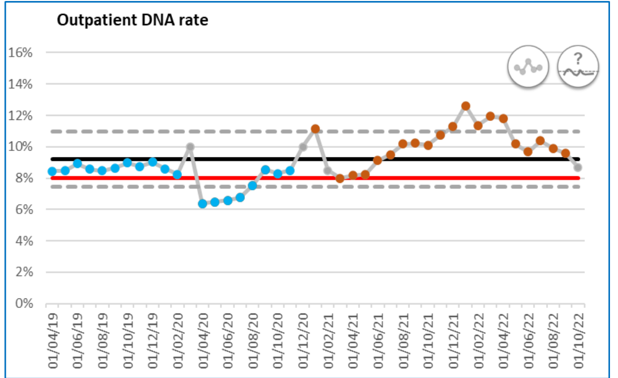
Appendix 3 – RTT, Cancer and Diagnostics Metrics



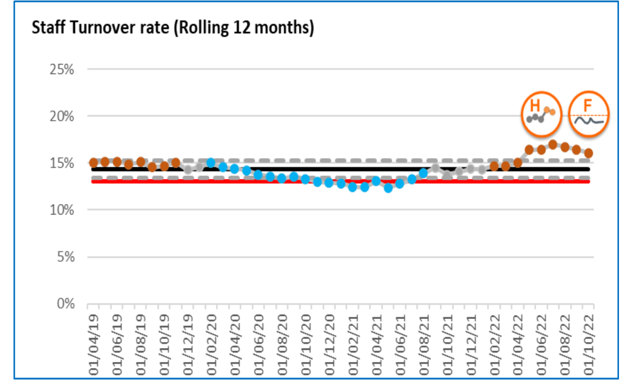


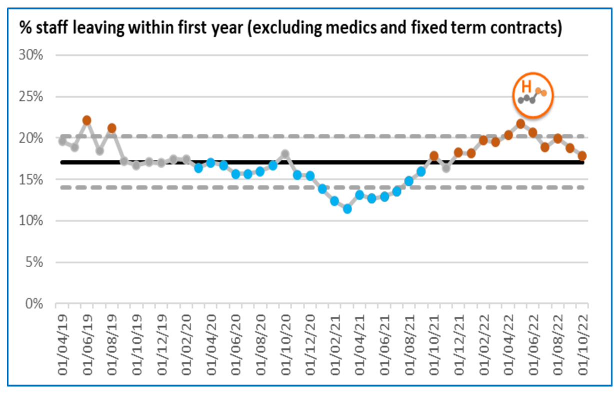


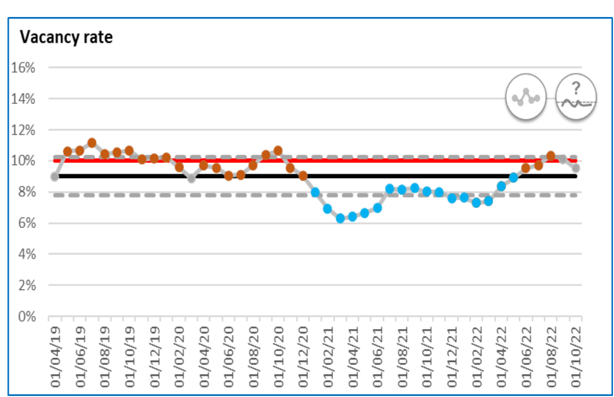


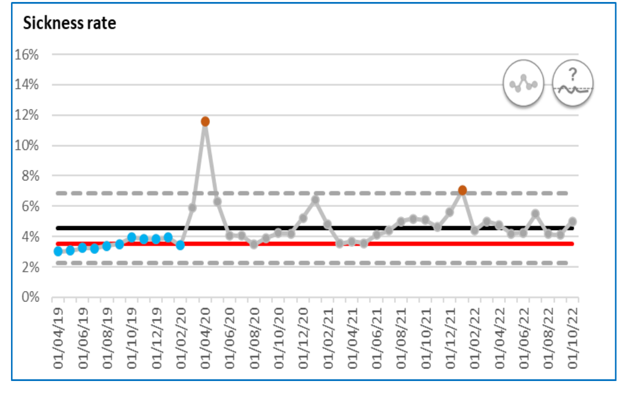


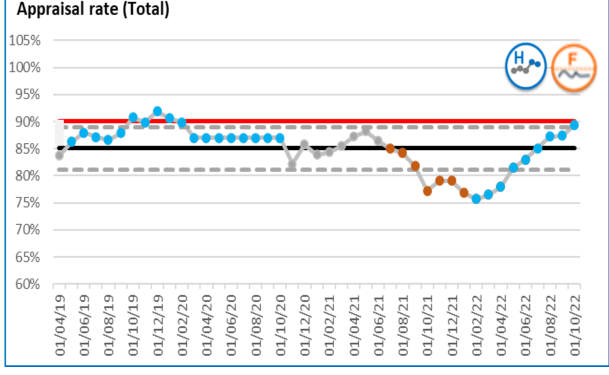
Appendix 4 – Workforce Metrics

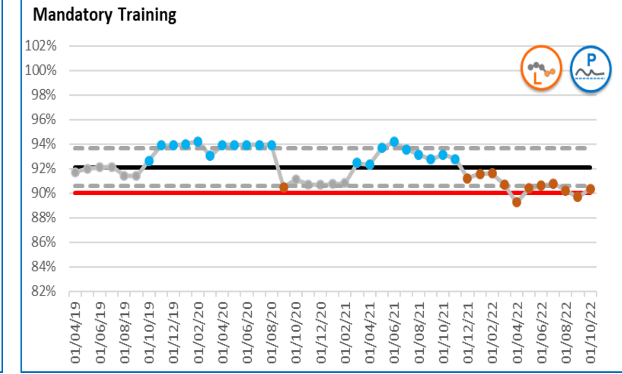




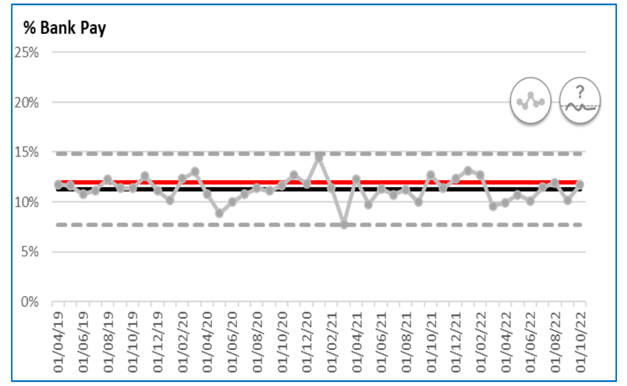


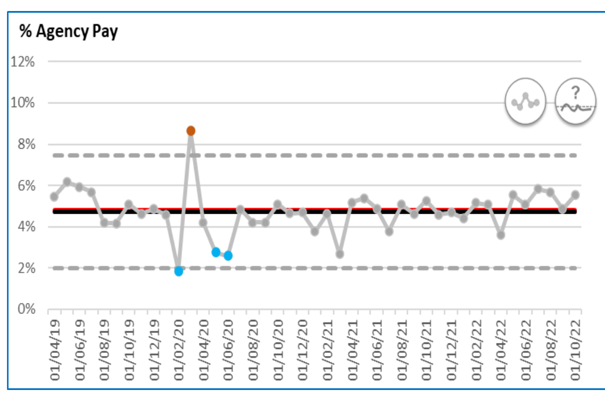


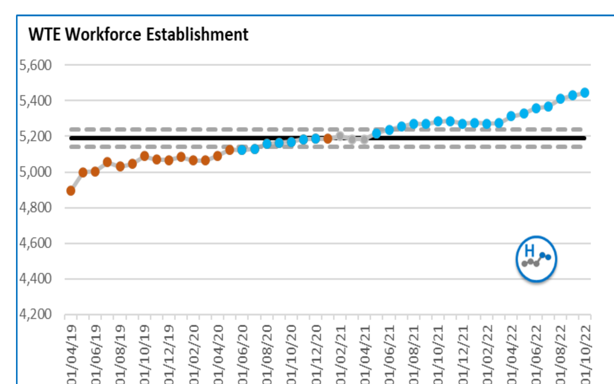


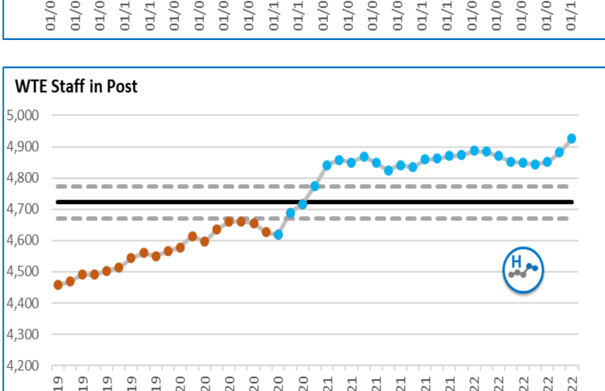


Appendix 4 – Workforce Metrics

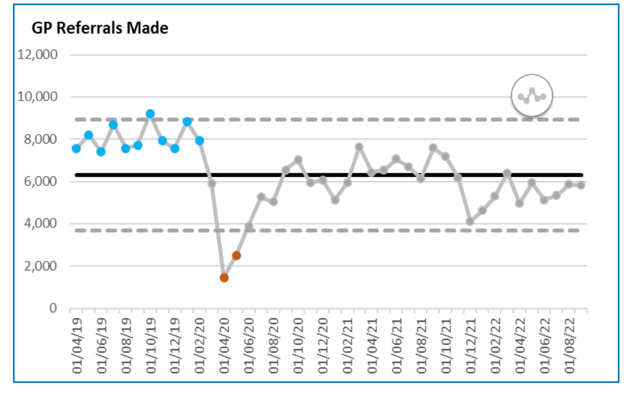


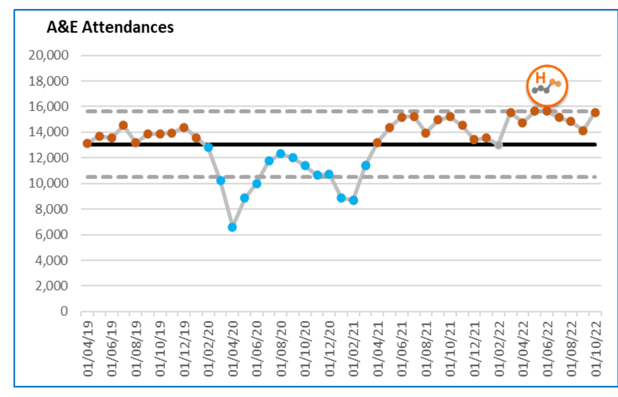


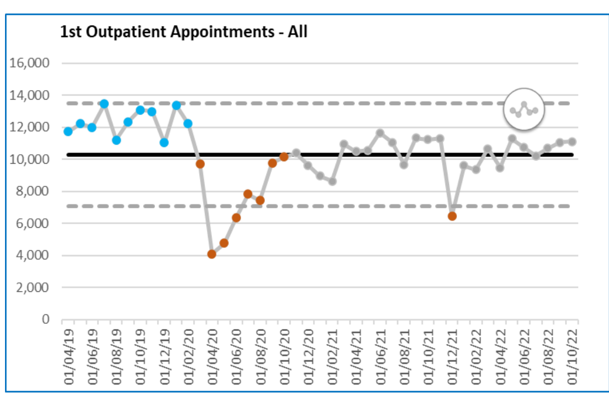


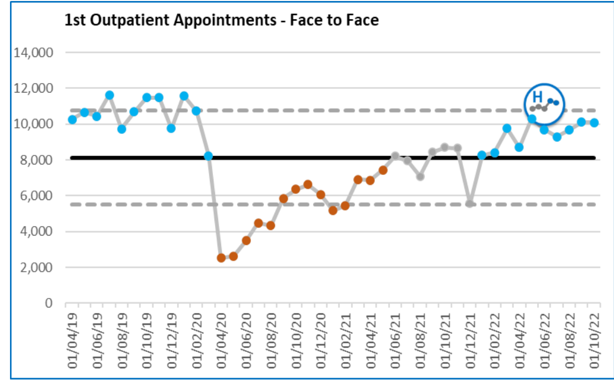


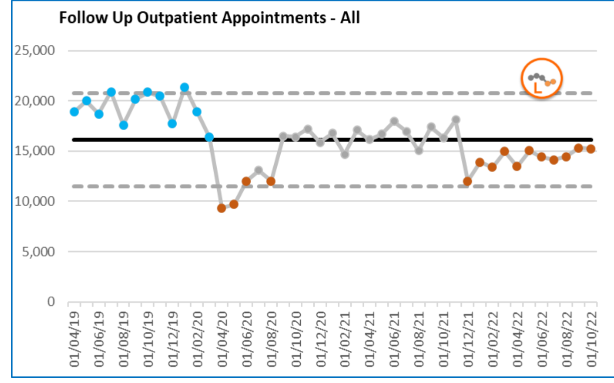
Appendix 5 – Activity Metrics

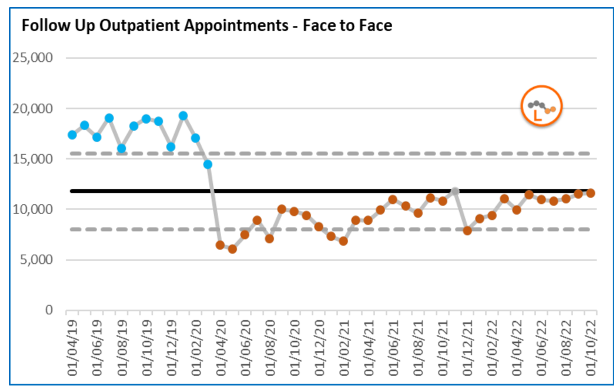




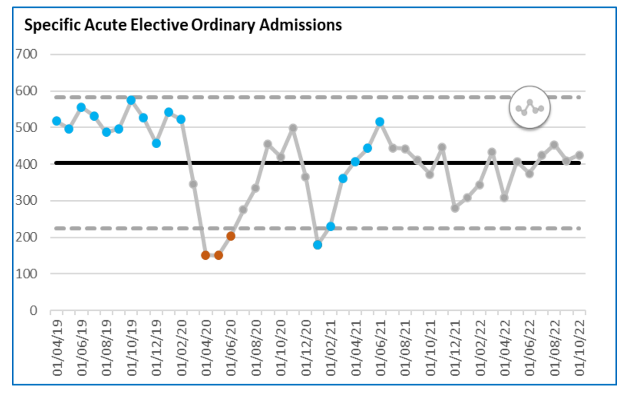


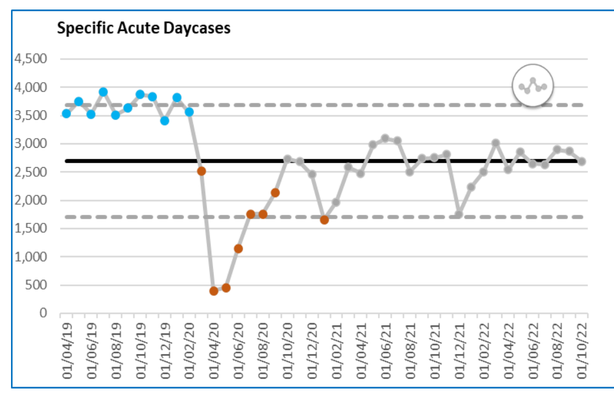


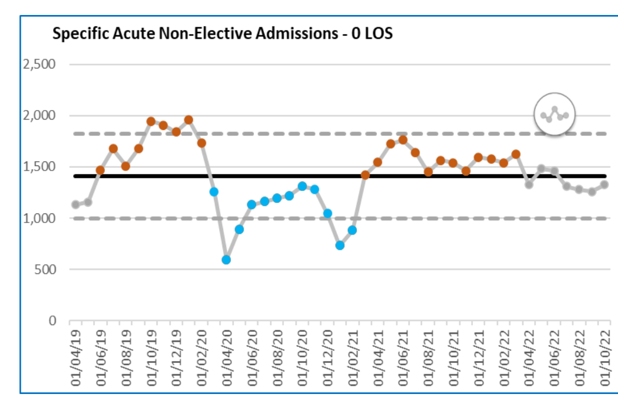


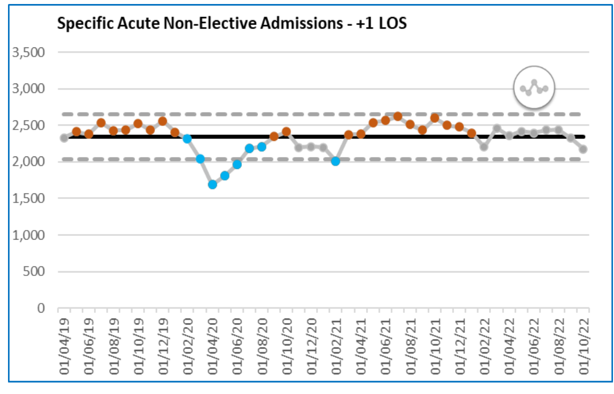


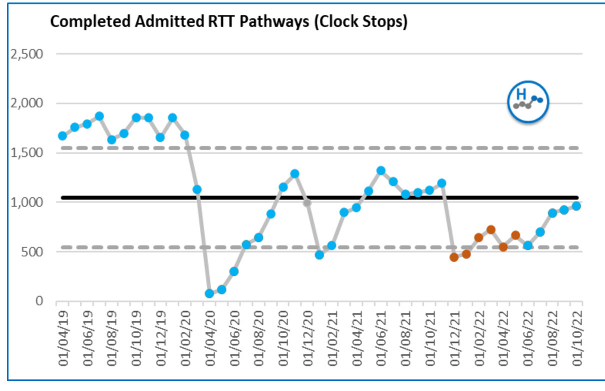
Appendix 5 – Activity Metrics

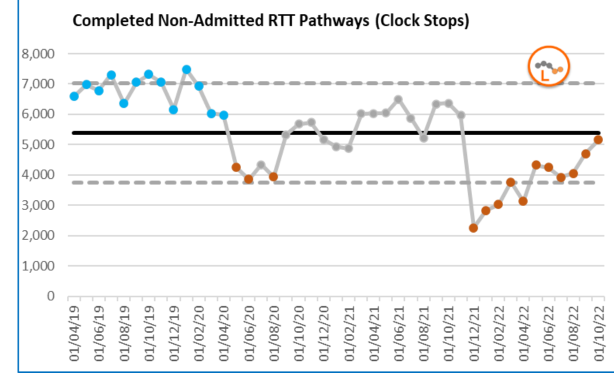




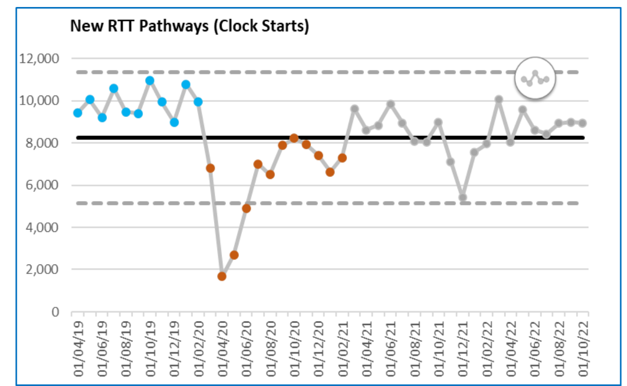


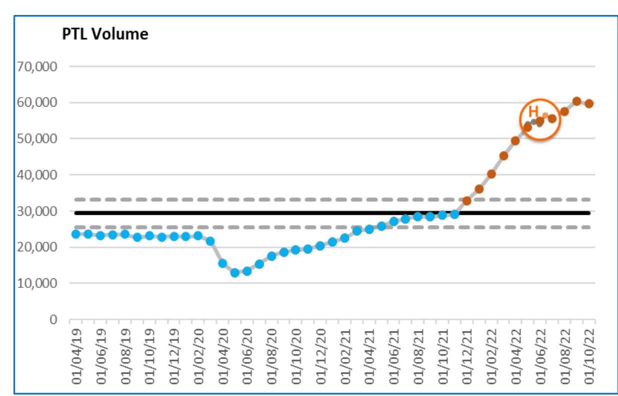


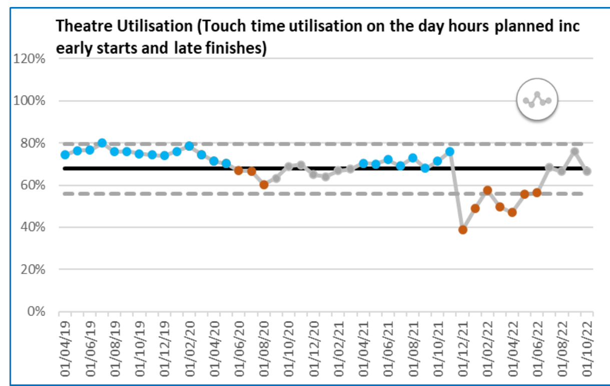




Appendix 5 – Activity Metrics







Thank you

Perinatal Quality Surveillance Model

West Herts – data covering the period April 2021 – September 2022

Mark Landau – Director of Business Intelligence

CQC Maternity Rating

CQC Maternity Rating (last inspection report 2021)	Overall	Safe	Effective	Caring	Well-Led	Responsive
	RI	RI	Good	Good	Good	RI

Maternity Safety Support Programme No

Findings of review of all perinatal deaths using the real time data monitoring tool

April 2021	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021
1. Inappropriate face mask size for a 23 week resuscitation. Appropriate size face masks now available 3. No Bereavement suite	1. Review the national guidance on genetics screening following an IUD / still birth / neonatal death and incorporate into a local guideline 2. Taking a baby home after death, asking about religious or spiritual wishes in the bereavement process to be added to bereavement checklist 3. Education on Aspirin risk assessment at booking for Midwives 4. No Bereavement suite	1. Review of Obstetric Cholestasis guideline. 2. Fetal monitoring during preterm labour guideline to be updated 3. No Bereavement suite	1. Not using the Partogram in the case of an intrauterine death 2. Carbon Monoxide testing at 36 weeks 3. No Bereavement suite	1. Bereavement room out of use. 2. Partogram not used. Routine enquiry not asked 3. No Bereavement suite	1. Importance of discussion of post mortems 2. No Bereavement suite	1. Mothers with poor or no English to have an interpreter at all times 2. CO monitoring 3. No Bereavement suite	1. No Bereavement suite 2. CO monitoring	1. No Bereavement Suite 2. Routine enquiry not discussed 3. No multidisciplinary planning in a woman with low Potassium levels

January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022
1. No Bereavement Suite 2. CO monitoring	1. No Bereavement Suite 2. CO monitoring	1. Delay in diagnosis of a gestational diabetic in a symptomatic woman 2. No Bereavement Suite	1. No Bereavement Suite	1. Symphysis fundal height measurements not performed at correct time intervals 2. No Bereavement Suite				Bereavement Suite not available due to more than one case.

Findings of review of all cases eligible for referral to HSIB

January 2021	February 2021	March 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021
1	0	0	2	0	1	1	1	0	0	0	0

January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022
0	0	0	0	0	0	0	0	1

Perinatal Quality Surveillance Model

KPI	Latest month	Measure	Target	Variation	Assurance
The number of incidents logged graded as moderate or above	Sep 22	5	-		
SBLCBv2 training compliance - Midwives	Sep 22	98%	-		
SBLCBv2 training compliance - Obstetricians	Sep 22	33%	-		
GAP and GROW training compliance - Midwives	Sep 22	98%	-		
GAP and GROW training compliance - Consultant Obstetricians	Sep 22	5%	-		
GAP and GROW training compliance - All other Obstetricians	Sep 22	79%	-		
Fetal Surveillance in Labour training compliance - Midwives	Sep 22	98%	-		
Fetal Surveillance in Labour training compliance - Consultant Obstetricians	Sep 22	5%	-		
Fetal Surveillance in Labour training compliance - All other Obstetricians	Sep 22	79%	-		
Maternity Emergencies and Multiprofessional training compliance - Consultant Obstetricians	Sep 22	67%	-		
Maternity Emergencies and Multiprofessional training compliance - All other Obstetricians	Sep 22	76%	-		
Maternity Emergencies and Multiprofessional training compliance - Anaesthetists	Sep 22	36%	-		
Maternity Emergencies and Multiprofessional training compliance - All other Anaesthetic Doctors	Sep 22	13%	-		
Maternity Emergencies and Multiprofessional training compliance - Midwives	Sep 22	91%	-		
Maternity Emergencies and Multiprofessional training compliance - Maternity Critical Care Staff	Jul 21	95%	-		
Maternity Emergencies and Multiprofessional training compliance - Maternity Support Workers	Sep 22	84%	-		
Personalised Care training compliance - Midwives	Sep 22	98%	-		
Personalised Care training compliance - Obstetricians	Sep 22	33%	-		
Care during Labour and the Immediate Postnatal Period training compliance - Consultant Obstetricians	Sep 22	74%	-		
Care during Labour and the Immediate Postnatal Period training compliance - All other Obstetricians	Sep 22	61%	-		
Care during Labour and the Immediate Postnatal Period training compliance - Anaesthetists	Sep 22	53%	-		
Care during Labour and the Immediate Postnatal Period training compliance - All Other Anaesthetic Doctors	Sep 22	50%	-		
Care during Labour and the Immediate Postnatal Period training compliance - Midwives	Sep 22	99%	-		
Care during Labour and the Immediate Postnatal Period training compliance - Maternity Care Assistants	Sep 22	82%	-		
Care during Labour and the Immediate Postnatal Period training compliance - Maternity Critical Care Workers	Sep 22	82%	-		

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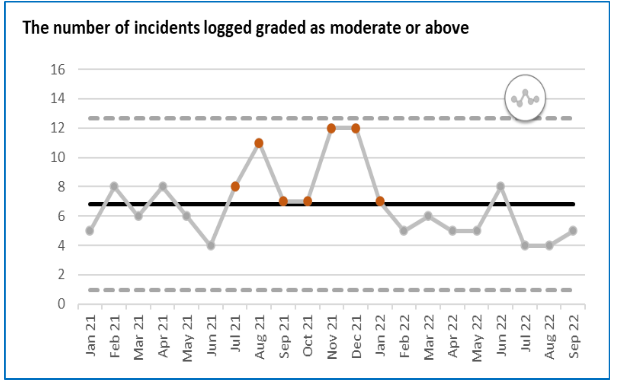
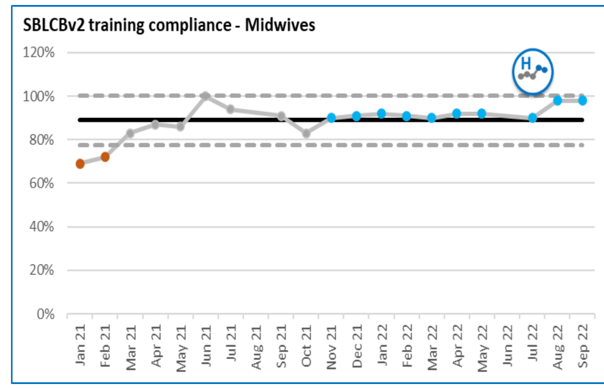
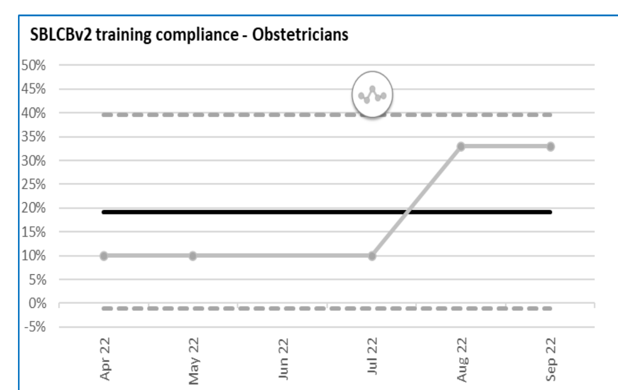
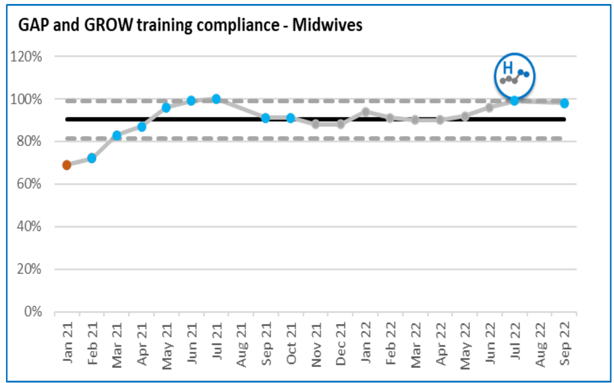
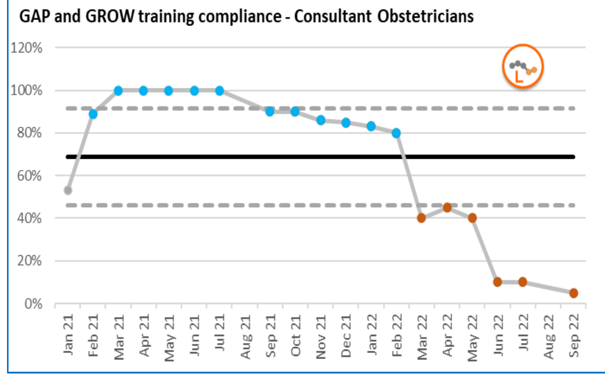
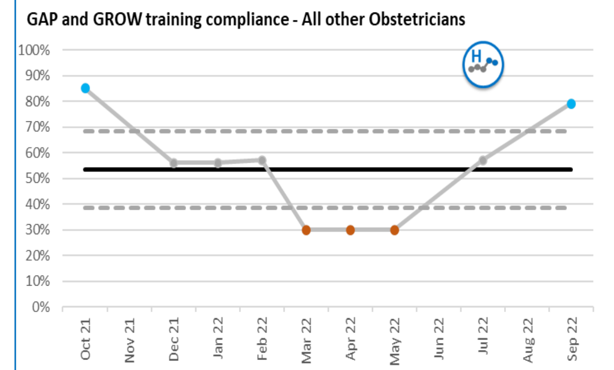

The number of incidents logged graded as moderate or above


SBLCBv2 training compliance - Midwives


SBLCBv2 training compliance - Obstetricians


GAP and GROW training compliance - Midwives


GAP and GROW training compliance - Consultant Obstetricians


GAP and GROW training compliance - All other Obstetricians

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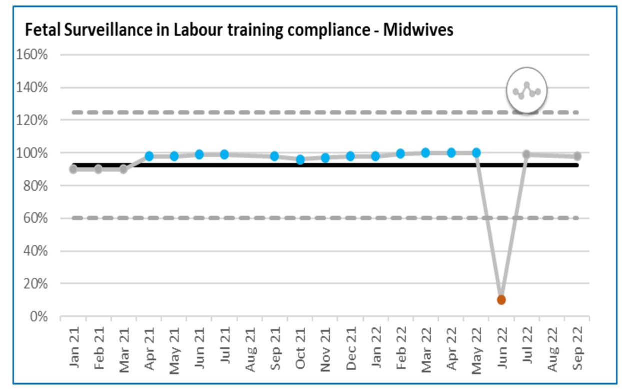
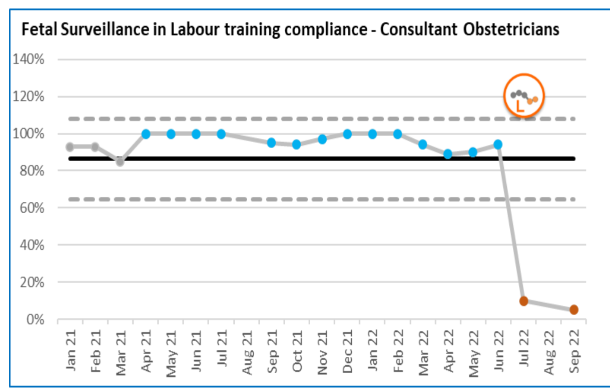
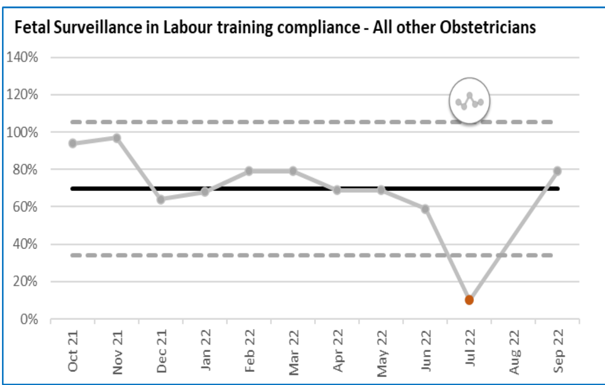
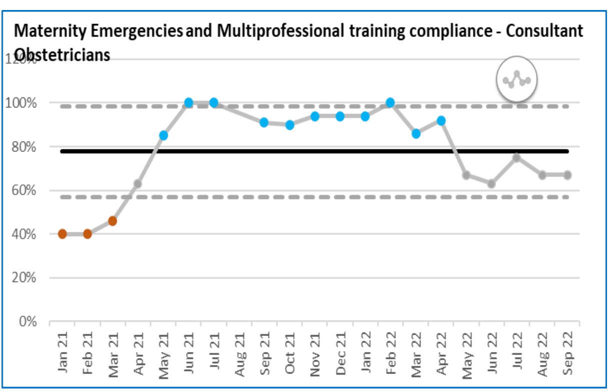

Fetal Surveillance in Labour training compliance - Midwives
160%
140%
120%
100%
80%
60%
40%
20%
0%
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22


Fetal Surveillance in Labour training compliance - Consultant Obstetricians
140%
120%
100%
80%
60%
40%
20%
0%
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22


Fetal Surveillance in Labour training compliance - All other Obstetricians
140%
120%
100%
80%
60%
40%
20%
0%
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22


Maternity Emergencies and Multiprofessional training compliance - Consultant Obstetricians
120%
100%
80%
60%
40%
20%
0%
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
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Jan 22
Feb 22
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Apr 22
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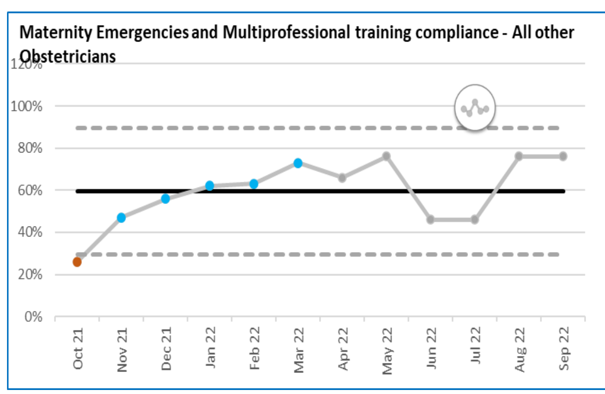
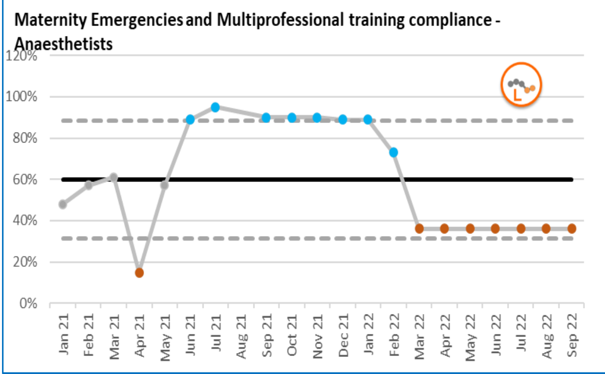
Sep 22


Maternity Emergencies and Multiprofessional training compliance - All other Obstetricians
120%
100%
80%
60%
40%
20%
0%
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22


Maternity Emergencies and Multiprofessional training compliance - Anaesthetists
120%
100%
80%
60%
40%
20%
0%
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
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Aug 22
Sep 22

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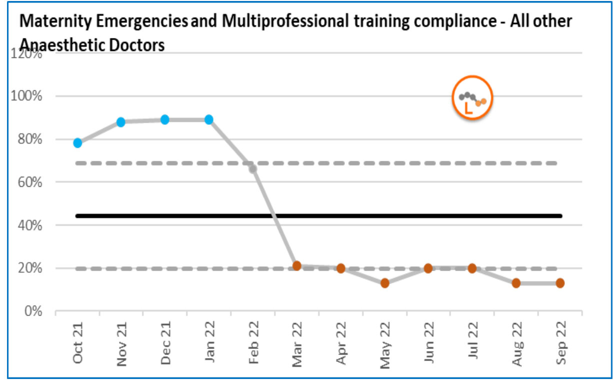
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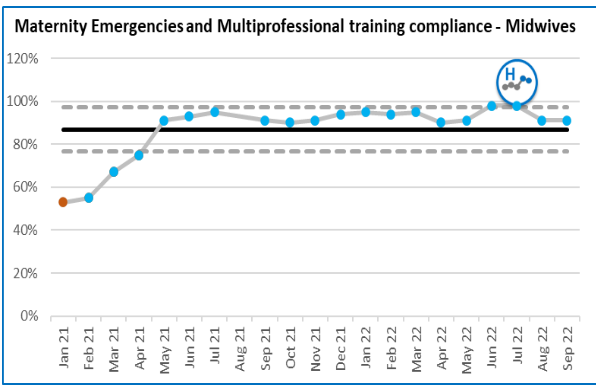
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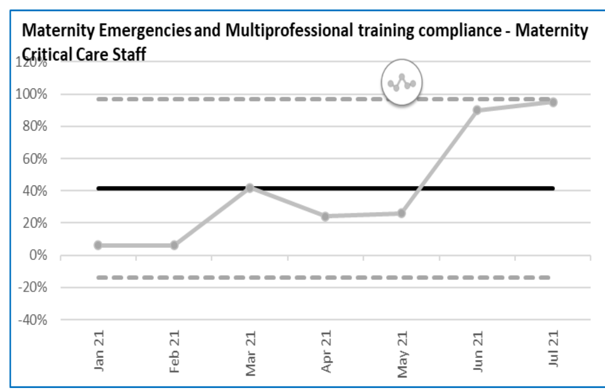
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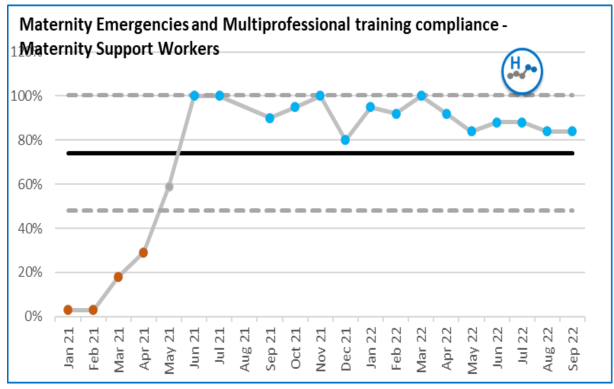
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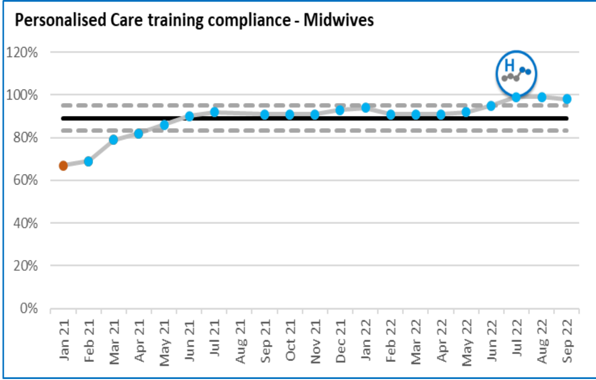
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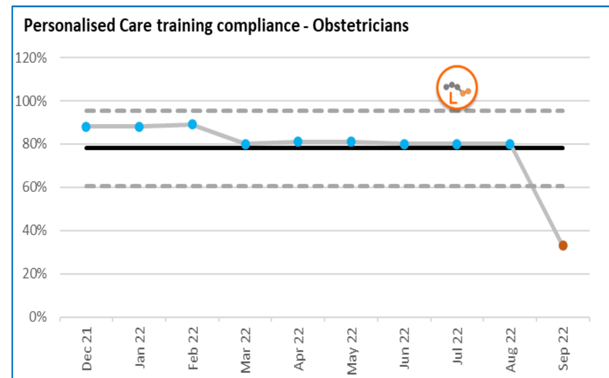
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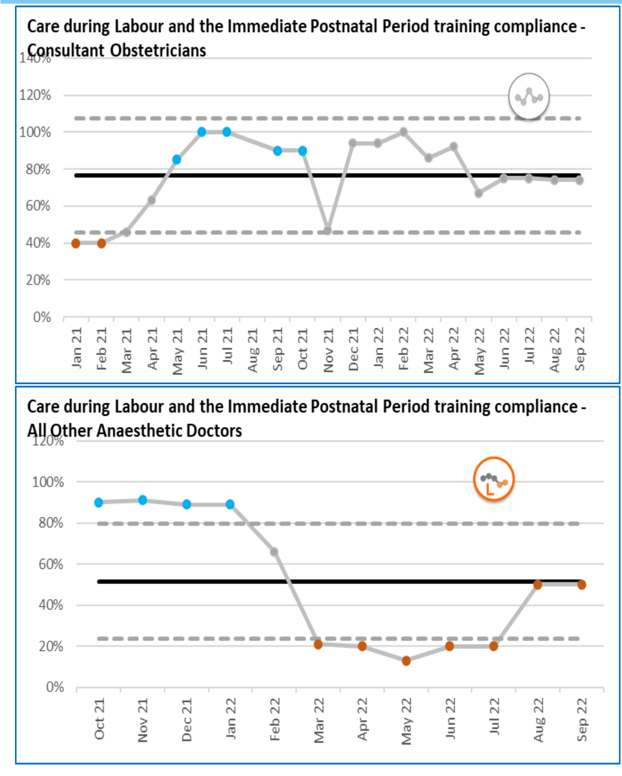
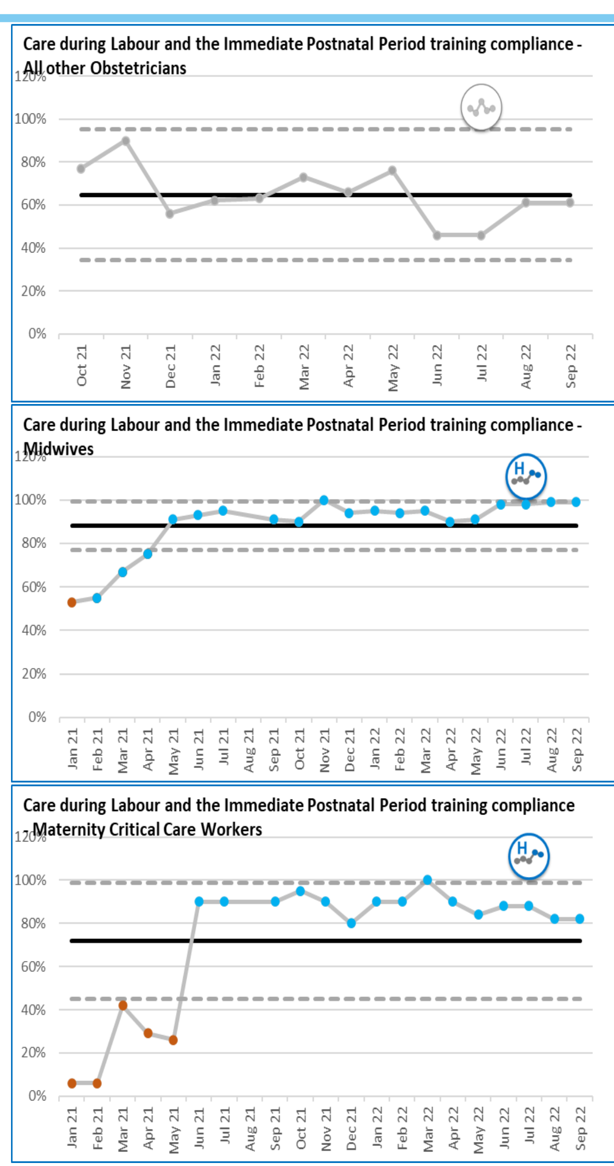
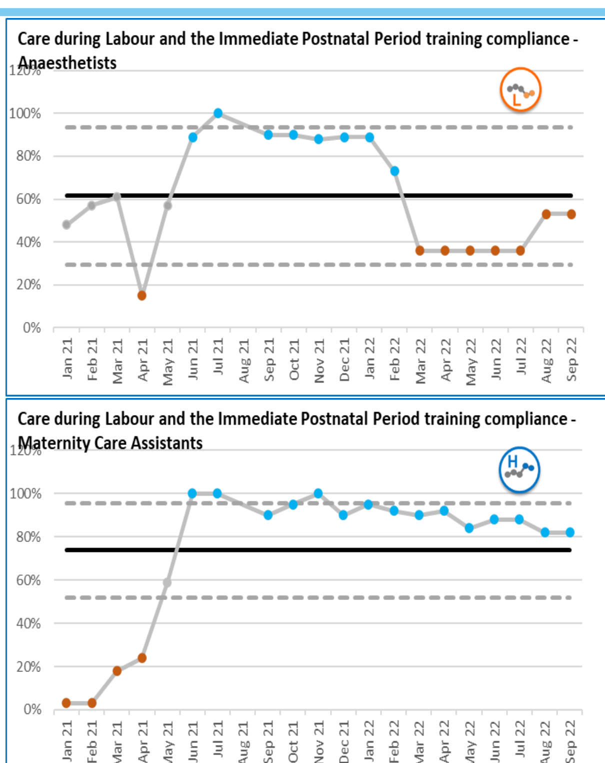

Care during Labour and the Immediate Postnatal Period training compliance - Consultant Obstetricians
Care during Labour and the Immediate Postnatal Period training compliance - All Other Anaesthetic Doctors


Care during Labour and the Immediate Postnatal Period training compliance - All other Obstetricians
Care during Labour and the Immediate Postnatal Period training compliance - Midwives
Care during Labour and the Immediate Postnatal Period training compliance Maternity Critical Care Workers


Care during Labour and the Immediate Postnatal Period training compliance - Anaesthetists
Care during Labour and the Immediate Postnatal Period training compliance - Maternity Care Assistants

Perinatal Quality Surveillance Model

KPI	Latest month	Measure	Target	Variation	Assurance
Newborn Life Support training compliance - Neonatologist	Sep 22	100.0%	-		
Newborn Life Support training compliance - Neonatal Nurses	Sep 22	86.0%	-		
Newborn Life Support training compliance - Advanced Neonatal Nurses	Sep 22	100.0%	-		
Newborn Life Support training compliance - Midwives	Sep 22	91.0%	-		
Minimum safe staffing in maternity services to include Obstetric cover on delivery suite, gaps in rotas (hours)	Sep 22	98	-		
Midwifery Staff Fill Rate	Sep 22	94.0%	-		
Midwifery bank usage	Sep 22	10.7%	-		
Midwifery agency usage	Sep 22	7.0%	-		
Progress in Achievement of CNST	Sep 22	8	-		
Proportion of Midwives responding with 'Agree or Strongly Agree' on whether they would recommend the Trust as a place to work or receive treatment	May 22	59.6%	-		
Proportion of speciality trainees in Obstetrics and Gynaecology responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (National 79.3%, 2019)	May 22	90.0%	-		

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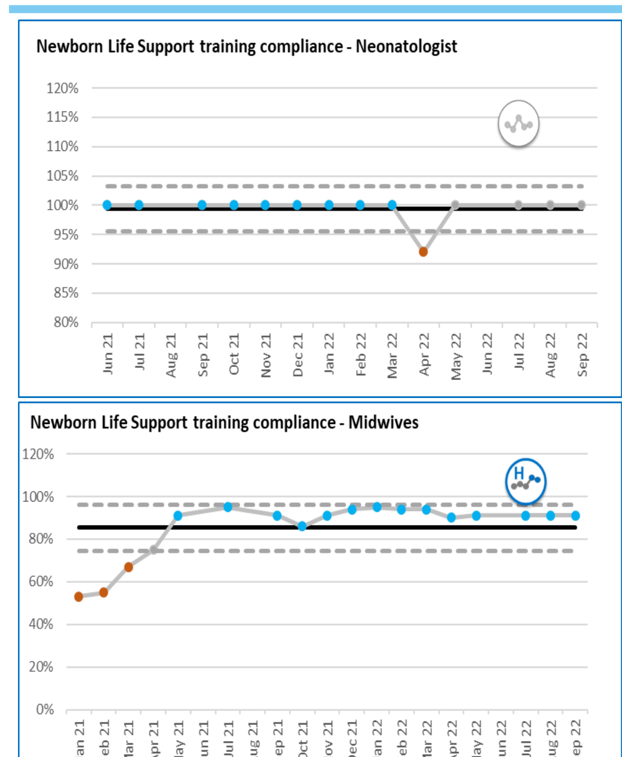
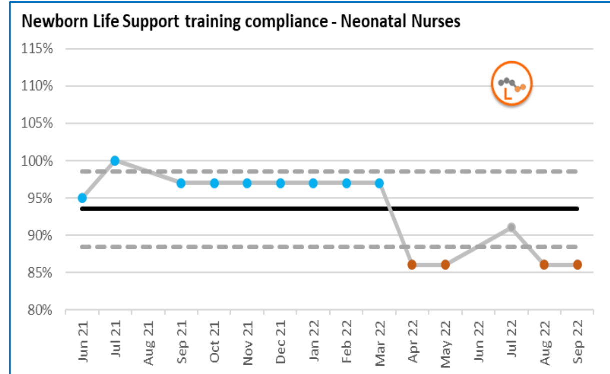
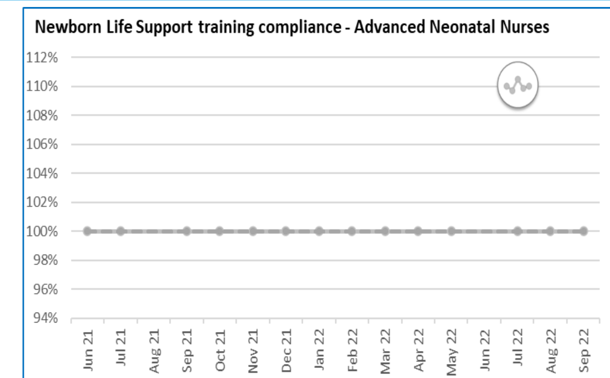
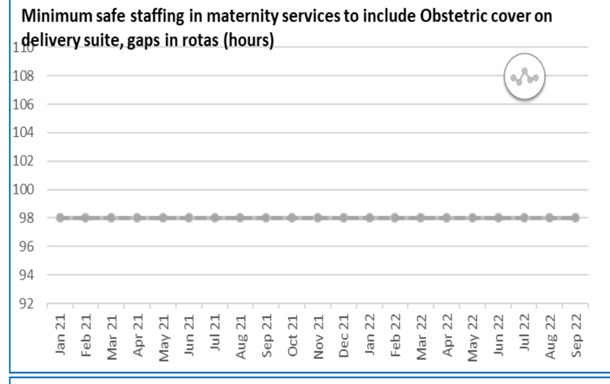
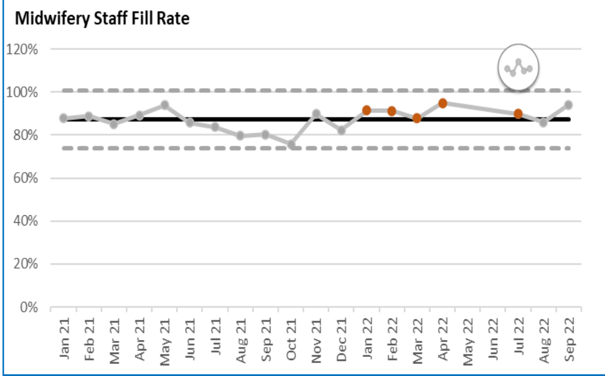
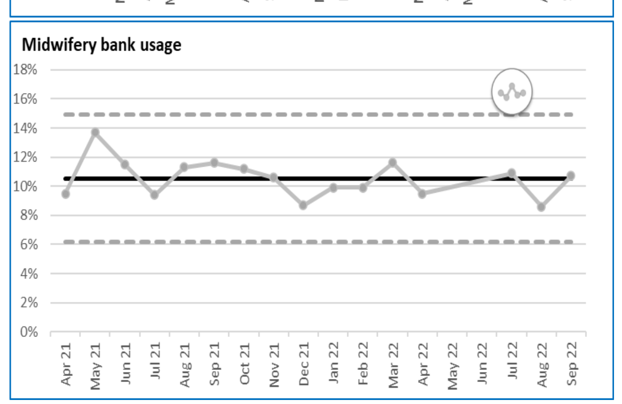

Newborn Life Support training compliance - Neonatologist
Newborn Life Support training compliance - Midwives

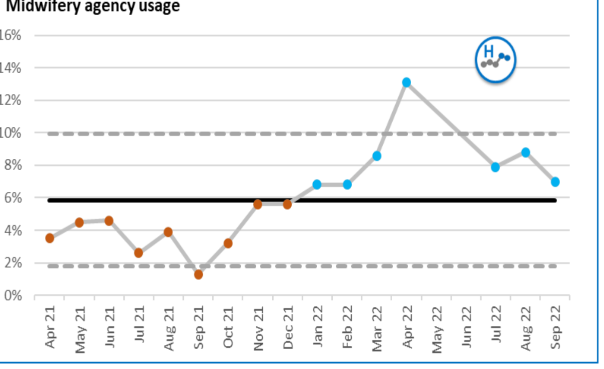

Newborn Life Support training compliance - Neonatal Nurses

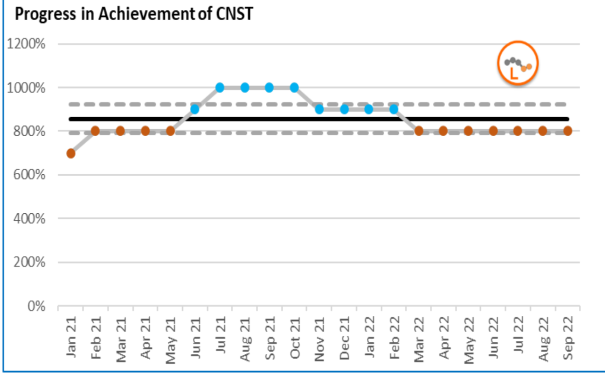

Newborn Life Support training compliance - Advanced Neonatal Nurses


Minimum safe staffing in maternity services to include Obstetric cover on delivery suite, gaps in rotas (hours)


Midwifery Staff Fill Rate


Midwifery bank usage


Midwifery agency usage


Progress in Achievement of CNST

Service User Voice Feedback

January 2021	February 2021	March 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021
1. Visiting times and support partners restrictions 2. Suspension of homebirth service and intermittent closure of the birth centre	1. Visiting times and support partners restrictions 2. Suspension of homebirth service and intermittent closure of the birth centre	1. Visiting times and support partners restrictions 2. Suspension of homebirth service and intermittent closure of the birth centre	1. Visiting times and support partners restrictions 2. Suspension of homebirth service and intermittent closure of the birth centre	1. Visiting times and support partners restrictions 2. Suspension of homebirth service and intermittent closure of the birth centre	1. Visiting times and support partners restrictions 2. Suspension of homebirth service and intermittent closure of the birth centre	1. Visiting times and support partners restrictions 2. Suspension of homebirth service and intermittent closure of the birth centre	1. Visiting times and support partners restrictions 2. Suspension of homebirth service and intermittent closure of the birth centre	1. Cold Rooms 2. Did not feel confident during labour, and did not get treated with dignity and respect 3. More midwives to be available 4. Inconsistent information from midwives regarding care of new born baby (Breastfeeding/swaddling)	1. Slow response and follow up time on basic requests e.g. water. 2. Tests and test results are often significantly delayed or missed. 3. Patients felt they were not given consistent advice about feeding their baby.	1. Very informative, friendly and helpful	1. Low staffing levels and communication. 2.Midwives and other health professionals didn't give active support and encouragement about feeding their baby.

January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022
1. Positive feedback regarding experience.	1. Low response rate. 2. After birth patients were not given information or explanations they needed, did not receive consistent advice, active support and encouragement about feeding their baby.	1. Visiting hours 2. Improved communication when the Birth Centre is closed 3. Visiting hours and how to access LFT and guidance for PCR's	1. Low staffing levels and communication 2. Maternity triage, Bereavement care and Midwives and other health professionals didn't give active support and encouragement about feeding their baby.		1. great feedback from women 2. discharge process 3. noise level	1. environment and privacy	1. MDT attendance at MVP and Obstetrician lead	1. supporting options for birth in general

Staff Feedback from frontline champions and walkabouts

January 2021	February 2021	March 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021
1. Delays with IOL transfer to Delivery Suite, delay with category 3 caesarean sections		1. Number of babies admitted to NICU with thermoregulation problems from Delivery Suite. 2. Pressure on nursing staff due to lack of trained midwives to check IV antibiotics for babies on the postnatal ward 3. Issue with availability of water supply to nurseries in NICU 4. Lack of cot warmers on delivery suite to ensure baby's thermoregulation	1. Staffing of Watford ANC is difficult due to COVID-19 absence, access will be increased after 12th April and how this will be managed. 2. Trying to maintain social distancing in a small waiting area. 3. There is a lot of paperwork to be completed and it is time consuming. 4. Midwives discussed their concerns about skill mix and reduction in shift numbers from 3 to 2 following launch of CoC team. Staff on Victoria may be experienced also. *Concerns about Room 5 in USS as very small and difficult to accommodate partners. Concerns about managing the patient flow during COVID -19 and testing.	1. Ward clerks raised concerns about 2 hourly visiting slots for partners, they are congregating outside the ward with limited social distancing. Also at times they arrive no LFT after 6pm so who is responsible. 2. 3 women & babies on the ward, staff happy and relaxed, some were doing their PROMPT e-learning. They asked for another phone line and a computer. NIPE midwife and student midwives spoke about the process for doing NIPE at the bedside and 1:1 learning opportunities for student midwives.		1. Staff raised issues about the heat wave and challenges of staying cool 2. Staff raised concerns about staffing levels due to COVID-19, the heatwave and the impact of Legionella in water – flow greatly reduced in the Delivery Suite rooms due to filters. Wearing PPE was very hot and uncomfortable in the current weather. 3. Ward clerks raised issues about poor visibility through the Perspex screen so difficult to see who is been admitted to the ward and allowed out. Also issue about who has swipe access to Katherine ward .	Staff raised concerns about staffing levels due to COVID-19, the heatwave and the impact of Legionella in water – flow greatly reduced in the DS rooms due to filters. Wearing PPE was very hot and uncomfortable in the current weather.	A midwife raised the issue of accessing obstetric ultrasound course and lack of available clinical placement at the obstetric scanning department. A third-year student midwife raised concerns that students were stopped taking phlebotomy procedure and worried that it will affect their required competency as its an integral part of the Student Midwife Training	Air conditioning unit is not working in the delivery suite drug room resulting in an increase temperature in the room of up 28 degree censes. Room temperatures during winter session resulting in low temperature on babies in Delivery suite	Community midwife raised issue with lack of access and inadequate rooms in GP surgery to see Antenatal women which is impacting of midwives' ability to do face-to-face booking. This issue affects only community midwives from Watford team. A midwife highlighted some safety concerns with using a mixture of EPR and paper healthcare records. One example was paper copy drug chart and prescription on EPR.	Midwives in MDAU and ANC highlighted concerns with long waiting time for women to be reviewed by doctor due to doctor's Rota. One Registrar is shared between MDAU and Victoria ward. On some occasions women can wait up to 3 hours before a review, this is impacting on patient experience. A Consultant Obstetrician highlighted issues and challenges of poor skill mix due to shortage of band 7 Core Midwives and poor experience of bereaved parents due to lack of bereavement room as room 12 is now used as COVID isolation room.

January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022
Privacy and dignity in triage	Equipment on Victoria Ward	1. Staffing challenges remain and particularly when there are several preceptors on duty which affects the skill mix. PDMs and PMAs are deployed to provide clinical support. 2. Refurbishment is progressing in NICU. Staff looking forward to its completion. Staffing remains a challenge in NICU but under control to maintain safe staffing on shifts.	Equipment on Katherine ward and Delivery Suite	Continuity of carer model, with using Midwives as part of the escalation policy. Midwifery support in Antenatal Clinic	1. review of Triage and BSOT. 2. Application of BSOT for women attending MDAU but requrie transfer to Triage. 3. Review of patient experience in MDAU,		1. discussions around team building, leadership development of staff, three way coaching and trustwide learning and develiopment opportunities.	1. retention and recruitment, reasons for leaving or stayng, sensory feel of the environment and plans for redecoration and reviewing feedback from assurance visit

HSIB/ NHSR/ CQC or other organisation with a concern or request for action made directly with Trust

January 2021	February 2021	March 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021
No	No	No	No	No	No	CQC request regarding midwifery staffing following a whistle-blower	No	No	No	1. IPC practice by Doctor and poor communication 2. Experience from no Bereavement Suite	No
January 2022	**February 2022**	**March 2022**	**April 2022**	**May 2022**	**June 2022**	**July 2022**	**August 2022**	**September 2022**			
No	No	No	No	No	No	No	No	No			

Coroner Regulation 28 made directly Trust

January 2021	February 2021	March 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021
No	No	No	No	No	No	No	No	No	No	No	No
January 2022	**February 2022**	**March 2022**	**April 2022**	**May 2022**	**June 2022**	**July 2022**	**August 2022**	**September 2022**			
No	No	No	No	No	No	No	No	No			

Mortality Rates

	West Herts	National
Stillbirth Rate 2019	3.01 per 1000	3.35 per 1000
Neonatal Death Rate 2019	1.13 per 1000	1.6 per 1000
Perinatal Mortality Rate 2019	4.14 per 1000	4.96 per 1000

Thank you

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Trust Board
1 December 2022

Title of the paper	**Children's Service establishment review 2022**
Agenda Item	**20**
Presenter	**Tracey Carter, Chief Nurse**
Author(s)	**Karen Walker Head of Nursing Children's Services** **Samantha Lee – Paediatric Matron** **Elvira Baker – Neonatal Matron**
Purpose	*Please tick the appropriate box* *For approval*: ☐ *For discussion*: ☐ *For information*: ✓
Executive Summary	The review has been discussed at trust management committee and PERC, assurance was gained to meet the National Quality Board publication 'Safe, sustainable and productive staffing, an improvement resource for children and young people's inpatient wards in acute hospitals' states that **children are not mini adults** (2018). There were a number of national acuity tools and staffing guidelines used for this review. Ward leaders, Matrons, Head of Nursing, Deputy Chief and Chief Nurse have all been involved with this process to enable the following professionally agreed position; **CED** In the last establishment review the safer nursing care tool demonstrated that the current establishment required an uplift of 0.5 WTE to increase band 7 cover across the week which ensured there is appropriate support for the effective running and oversight of CED and PAU. Since implementation there continues to be greater oversight ensuring good patient flow and performance. The Emergency Department Safer Nursing Care Tool (ED SNCT) was utilised for the first time in CED during the month of February 2022. Data was collected each day but at different time intervals so that the acuity, dependency and number of patients could be captured accurately. This tool allows organisations to measure annual attendance, acuity and dependency and therefore set an establishment which is evidence based. No changes to establishment are recommended until at least two cycles of the SNCT have been completed and the second audit will take place in September 2022. **PAU** PAU has been established since 2019 following a successful pilot. A benefits realisation paper outlining the PAU pilot was presented to TMC in March 2022 with recommendations. This paper identified that for the PAU model to function as intended the staffing requirement for a seven-day, 24-hour service to run safely and efficiently the staffing model/establishment should be set at RN: 2 + CSW: 1 for each shift. A business case is required to support this workforce model.

<table>
<tr><td></td><td>Summary overview

There is minimal change within the Paediatric establishment review. Consideration of increasing the staffing levels in PAU is required as per the benefits realisation paper presented to TMC in February 2022.</td></tr>
<tr><td>Trust strategic aims</td><td><table><tr><td>Aim 1
Best care
Objectives 1-4</td><td>Aim 2
Great team
Objectives 5-8</td><td>Aim 3
Best value
Objective 9</td><td>Aim 4
Great place
Objective 10-12</td></tr><tr><td>X</td><td></td><td></td><td></td></tr></table></td></tr>
<tr><td>Links to well-led key lines of enquiry</td><td>☒Is there the leadership capacity and capability to deliver high quality, sustainable care?
☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
☒Is there a culture of high quality, sustainable care?
☒Are there clear responsibilities, roles and systems of accountability to support good governance and management?
☒Are there clear and effective processes for managing risks, issues and performance?
☒Is appropriate and accurate information being effectively processed, challenged and acted on?
☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
☒Are there robust systems and processes for learning, continuous improvement and innovation?
☒How well is the trust using its resources?</td></tr>
<tr><td>Previously considered by</td><td><table><tr><td>Committee/Group</td><td>Date</td></tr><tr><td>Children's governance</td><td>October 22</td></tr><tr><td>TMC</td><td>October 22</td></tr><tr><td>PERC</td><td>October 22</td></tr></table></td></tr>
<tr><td>Action required</td><td>The Trust Board is asked to receive this report for information and assurance of the children's service establishment meeting national guidance.</td></tr>
</table>

Agenda Item: 20

Trust Board – 1 December 2022

Children's Service establishment review 2022

Presented by: Tracey Carter, Chief Nurse

1. Purpose

To provide information, analysis and recommendations following a comprehensive annual nursing establishment review of Paediatric services.

Provide an update and timeline on the recruitment and retention plans for Children's services.

2. Background

It is good practice to regularly review nursing establishments ensuring that the workforce is sufficient in terms of skill and number to meet demand:

- The National Quality Board - Expectations for safe staffing, sustainable and productive staffing, an improvement resource for neonatal care (June 2018)
- The National Quality Board – Safe, sustainable and productive staffing: An improvement resource for children and young people's inpatient wards in acute hospitals (June 2018)
- Royal College of Nursing – Defining staffing levels for children and young peoples' services (June 2013)
- Paediatric Intensive Care Society - Quality Standards for the Critically ill Children (2015)

Additionally, the paediatrics department is managing a number of changes, with the opening of the Paediatric Assessment Unit, redevelopment of the NICU and implementation of the transitional care model, as well as other changes in acuity and activity.

The department has therefore used national staffing tools such as BAPM (2018), Safer Nursing Care (SNCT) (The Shelford Group 2017), Paediatric Intensive Care Society (2015), Royal College of Nursing (2013) and the Dinning tool, which was designed to support the Trent Perinatal and Central Newborn Network peer review programmes, as well as peer review and professional opinion to review its staffing and activity in order to ensure that establishments are fit for purpose and will support the delivery of the very best care for every patient, every day.

3. Analysis/Discussion

3.1 Paediatric Assessment Unit (PAU)

This is a new front line service which is co-located next to the Childrens Emergency Department (CED), providing assessment, investigation, observation and management for acutely presenting infants, children and young people up to the age of 16 years.

A 4-month proof of concept was undertaken and a paper was presented on the outcome of the pilot at TMC in November 2019 where it was agreed that the Division would work towards a Business Case (aiming March 2020) to staff the service appropriately.

3.2 Children's Emergency Department (CED)

CED has a staffing pattern of 5 registered and 1 unregistered childrens nurse (5:1) day and night. This is to allow cover for the different clinical areas within CED: resuscitation, waiting area and cubicles, triage nurse, bay nurse and NIC. This is covered within existing established posts.

Following on from the 2020 establishment review the band 7 senior sister post was increased to provide a 7/7 work pattern which is supernumerary so there is full oversight of both CED & PAU. In addition we have recruited board coordinators within paediatrics to improve patient flow and maintain performance across both areas.

To ensure that we have the correct nursing ratio of staff in CED the newly released ED SNCT was used to review this. To ensure that the quality of data collected was consistent the workforce team and HON for Children's Services attended the training for ED SNCT which was conducted by NHSEI.

In addition, the CED Band 7s and NICs was also trained locally in collecting the data using the ED SNCT. Data checks were undertaken, and scoring was reviewed using check and challenge as part of quality controls and where necessary changes were made.

The data collection was conducted in February 2022 for the twelve days using the ED SNCT evidence-based tool to measure patient acuity and dependency. Data was collected on every patient within the ED to capture acuity and dependency every hour of the day and night by completing a 12-day census. This was achieved by assessing each patient in the department at 00:00 hours and 12:00 hours on day 1, repeat at 01:00 hours and 13:00 hours on day 2 etc. until data collection has covered a full 24 hours /7day period. The patient dependency and acuity census were collected by the nurse in charge or CED Band 7. To provide quality assurance around the reporting, the data was peer reviewed by the Clinical Lead for Safe Care and the analysis showed good knowledge and compliance in using the tool.

A second cycle of SNCT is due to take place in September 2022.

We have been working to remodel our workforce in CED to bridge the gap between medical and nursing and have been successful recruited 2 x Paediatric Advanced Clinical Practitioners following a successful agreed business case that supported this model.

3.3 Starfish Ward

The total bed base is 22 but is currently established and staffed for 20 beds. 18 beds are for acute admissions and 2 are designated High Dependency beds for children who require level 1 & 2 care.

The staffing skill mix for a 2 bed HDU (Lighthouse)

The staffing requirement for the 2 bedded High Dependency Unit is as recommended by the Paediatric Intensive Care Standards (2010), RCPCH (2014), and RCN Standards (2013) is 1:2 nurse: patient ratio, though this will be influenced by a number of factors, including patient diagnosis and complexity, severity of illness (PEWS score), and nursing skill-mix.

Within the remaining 18 beds, Starfish admit a number of children who are newly diagnosed with cancer and in addition the ward also cares for children jointly with other London centres. We have trained oncology nurses to administer infusions of chemotherapy locally to ensure that our patients receive the right care closer to home and in the right place at the right time. Offering a level 2 oncology shared care service can result in those children requiring a higher level of clinical input (often HDU) due to the chemotherapy regimens administered to manage the cancer and more often than not the care would be provided in a side room due to the higher risk of infection and precautions required.

There are often times of peak demand for an admission into an HDU bed and with the increase in the numbers requiring this level of care. We are not requesting staffing to accommodate this increase as we already flex our workforce from other paediatric/NICU clinical areas and use bank if appropriate with clear sign off processes at a senior level. Therefore our establishment review is based on 2 HDU beds at any given time.

Additionally Starfish ward has the ability to manage a deteriorating child who may require level 3 care who we stabilise & then transfer out to an appropriate tertiary centre. This doesn't affect the establishment.

The staffing skill mix for the remaining 18 bed base (Starfish excluding Lighthouse)

Recommended ratios for ward-based care based on RCN standard (2013) are as follows:

< 2 years of age 1:3 registered nurse: child, day and night
> 2 years of age 1:4 registered nurse: child, day and night

Based on the above ratios, an average requirement of 1:3.5 children has been used to assess required establishments.

When setting baseline establishments there are key requirements:

1. An average age of patient population should be considered, as where there are high numbers of children less than two years, an increased registered nurse: patient ratio is required.

2. The ward staffing complement must also have a supervisory senior sister Band 7. Children should also be cared for by staff that have the right knowledge, skills, expertise and competence to meet their needs.

3. In addition to the Band 7 ward sister/charge nurse, a competent, experienced Band 6 is required throughout the 24-hour period to provide the necessary support to the nursing team. This will provide an experienced nurse to advise on clinical nursing issues relating to children across the organisation 24 hours a day.

Accordingly the following staffing has been proposed after adjusting bed numbers for capacity:

Roster variations will be managed tightly by changing the e roster templates, management of annual leave and regular oversight by the matron and Head of nursing. Unexpected surges in acuity or numbers will be mitigated through working across the division and escalations as appropriate. There are also twice daily staffing meetings to review staffing levels.

3.4 Safari Day Unit

The patients that attend Safari Day Unit are a wide range of elective procedures and investigations. They comprise of allergy, oncology, pre assessments, radiology investigations and different surgical speciality procedures.

One of the key test carried out on the day unit are food challenges (allergy). These tests demand a specific nurse/patient ratio 1:2 according to the BASCI guidelines. Activity is scheduled considering staff availability and numbers.

There is no change to establishment required and remains at 10.0 WTE to allow for a staffing pattern that reflects a ratio of 3:1 RN:CSW.

3.5 Summary of changes

The following changes are requested as part of this vacancy review:

Change	WTE
Additional 2.6 RN in PAU	2.6
Additional 0.8 RN in NICU	0.8
Total	**3.4**

In the short term, it is proposed to staff these posts on bank and to offset costs against a long-standing clinical psychologist vacancy which is ongoing and an ANNP training post (which is currently vacant following the accreditation of two nurses).

Longer term, a business case will be prepared to request the additional nurses as part of 23/24 budget setting.

5. Future Plans

- To increase the staffing establishment in PAU to reflect being able to roster 2+1 on each shift to enable the service to run safely 24/7.
- Children’s services will continue to work closely with Human Resources and the recruitment team to ensure that there is a robust plan in place to recruit paediatric nurses (including overseas recruitment).

4. Recommendations

The Trust Board is asked to receive this report for information and assurance of the children’s service establishment meeting national guidance.

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

Date: October 2022

Appendix 1 Safe Staffing Template

Paediatrics

WARD		Current GREEN Template				AMBER Template				RED Template			
		DAY		Night		DAY		Night		DAY		Night	
		RN	RN//NA/NN	RN	RN/NN/NA	RN	RN//NA/NN	RN	RN/NN/NA	Reg Nurse	RN//NA/NN	RN	RN/NN/NA
Starfish inc. iso	HDU (2beds)	1:2		1:2		1:3		1:3		1:4		1:4	
(18beds + 2 HDU)	patients under 2		1:3		1:3		1:4		1:4		1:5		1:5
	over 2 years old		1:4		1:4		1:5		1:5		1:6		1:6
Full ward capacity (Summer template)		4+1		4+1		4+0 or 3+1		4+0 or 3+1		2+1		2+1	

Note:
NN/NA will be included in staffing numbers except for HDU patients
CPAP patients are considered HDU patients
If a child require intubation, staffing needs to be 1:1
EOL patients, staffing needs to be 1:1
If not able to meet, will be RED flag

WARD	Current GREEN Template				AMBER Template				RED Template			
	DAY		Night		DAY		Night		DAY		Night	
	RN	CSW	RN	CSW	RN	CSW	RN	CSW	RN	CSW	RN	CSW
Safari Day unit	2	1			1	1			1	0		

Note:
Staffing dependent on patient acuity and procedures on the day - professional judgement will be added
Food challenges must not run-on staffing ratios less than 1:2

WARD	Current GREEN Template				AMBER Template				RED Template			
	DAY		Night		DAY		Night		DAY		Night	
	Reg Nurse	Unreg Staff	Reg Nurse	Unreg Staff	Reg Nurse	Unreg Staff	Reg Nurse	Unreg Staff	Reg Nurse	Unreg Staff	Reg Nurse	Unreg Staff
CED	5	1	5	1	4	1	4	1	3	1	3	1
PAU	2	1	2	1	1	1	1	1				

Neonates

<table>
<tr><th rowspan="3">Neonatal Unit</th><th colspan="6">Current Budgeted GREEN Template</th><th colspan="6">AMBER Template</th><th colspan="6">RED Template</th></tr>
<tr><th colspan="3">DAY</th><th colspan="3">Night</th><th colspan="3">DAY</th><th colspan="3">Night</th><th colspan="3">DAY</th><th colspan="3">Night</th></tr>
<tr><th>Reg Nurse</th><th>AP</th><th>Unreg Staff</th><th>Reg Nurse</th><th>AP</th><th>Unreg Staff</th><th>Reg Nurse</th><th>AP</th><th>Unreg Staff</th><th>Reg Nurse</th><th>AP</th><th>Unreg Staff</th><th>Reg Nurse</th><th>AP</th><th>Unreg Staff</th><th>Reg Nurse</th><th>AP</th><th></th></tr>
<tr><td>ITU</td><td>1:1</td><td></td><td></td><td>1:1</td><td></td><td></td><td colspan="6" rowspan="5">patient ratio remained the same when GREEN but no admission nure cover</td><td>1:1</td><td></td><td></td><td>1:1</td><td></td><td></td></tr>
<tr><td>HDU</td><td>1:2</td><td></td><td></td><td>1:2</td><td></td><td></td><td>1:3</td><td></td><td></td><td>1:3</td><td></td><td></td></tr>
<tr><td>SCBU</td><td>1:4</td><td></td><td>1</td><td>1:4</td><td></td><td>1</td><td></td><td></td><td>1:4</td><td></td><td></td><td></td></tr>
<tr><td>NIC</td><td colspan="3">1</td><td colspan="3">1</td><td colspan="6" rowspan="2">No NIC and admission nurse cover</td></tr>
<tr><td>Admission Nurse</td><td colspan="3">1</td><td colspan="3">1</td></tr>
</table>

<table>
<tr><th rowspan="3">WARD</th><th colspan="6">Current Budgeted GREEN Template</th><th colspan="6">AMBER Template</th><th colspan="6">RED Template</th></tr>
<tr><th colspan="3">DAY</th><th colspan="3">Night</th><th colspan="3">DAY</th><th colspan="3">Night</th><th colspan="3">DAY</th><th colspan="3">Night</th></tr>
<tr><th>Reg Nurse</th><th>AP</th><th>Unreg Staff</th><th>Reg Nurse</th><th>AP</th><th>Unreg Staff</th><th>Reg Nurse</th><th>AP</th><th>Unreg Staff</th><th>Reg Nurse</th><th>AP</th><th>Unreg Staff</th><th>Reg Nurse</th><th>AP</th><th>Unreg Staff</th><th>Reg Nurse</th><th>AP</th><th></th></tr>
<tr><td rowspan="2">Transitional Care</td><td rowspan="2">1</td><td rowspan="2"></td><td rowspan="2">1</td><td rowspan="2">1</td><td rowspan="2"></td><td rowspan="2">1</td><td colspan="3">1 staff (RN/NN)</td><td colspan="3">1 staff (RN/NN)</td><td colspan="3">1 staff (RN/NN)</td><td colspan="3">1 staff (RN/NN)</td></tr>
<tr><td colspan="6">With ratio of 1:4 and depending on acuity</td><td colspan="6">with ratio of 1:5 (max 6 babies) and depending on acuity</td></tr>
<tr><td>Midwife Support</td><td colspan="6">Midwife in postnatal ward able to support postnatal antibiotics</td><td colspan="6">with no support from the midwife for postnatal antibiotics</td><td colspan="6">with or without support from the midwife for postnatal antibiotics</td></tr>
<tr><td>Cot Capacity</td><td colspan="6">Capacity to admit babies who meet TC criteria</td><td colspan="6">Reduced Capacity to 4 beds</td><td colspan="6">If there is no bed available to admit.</td></tr>
</table>

Note when Staffing is RED:

Team to laisse with other area within division for any mitigation.

1RN might be able to cover 1ITU and HDU patients depending on number of babies, to be discussed with management team.

Consider relocating Transitional care to Neonatal unit after discussion with senior management team.

Consider working with maternity colleagues for any other mitigation that can be put in place.

Trust Board
1 December 2022

<table>
<tr><td>Title of the paper:</td><td>Maternity Incentive Scheme Update– NHS Resolution</td></tr>
<tr><td>Agenda Item:</td><td>21</td></tr>
<tr><td>Presenter:</td><td>Tracey Carter Chief Nurse</td></tr>
<tr><td>Author(s):</td><td>Mitra Bakhtiari - Director of Midwifery, Gynaecology/ Deputy Chief Nurse</td></tr>
<tr><td>Purpose:</td><td>Please tick the appropriate box
For approval:
For discussion: x
For information: </td></tr>
<tr><td>Executive Summary:</td><td>The purpose of this report is to provide the Trust Board with an update on the Trusts' position towards submission of the evidence required against the ten safety actions outlined in the NHS Resolution's year 4 Maternity Incentive Scheme (MIS) for trusts year (Aug 2021, Technical Guidance May 2022).

This is to support the delivery of safer maternity care. The scheme incentivises ten maternity safety actions and the Trust is expected to submit the evidence of compliance by 2nd February 2023.

The Trust Board is asked to note the following key points:
• The Trust is making progress towards submission of the evidence (the list of evidence is in diligent Appendix 1), and this includes areas of partial compliance.
• Maternity digital strategy has been approved and agreed at Local Maternity and Neonatal System (LMNS) board.
• The Trust is compliant with Maternity services Dataset (MSDS) and on track to roll out digital maternity system by 28th March 2023.
• The maternity service compliance with annual multidisciplinary professional training day has improved and will reach above 90% by November 2022.
• In 2023, a refreshed education plan is anticipated to achieve sustained compliance.
• CO monitoring at 36 weeks is currently above 92%. Ongoing audit of performance shows that all eligible women have been offered CO monitoring at 36 weeks.
• The neonatal ward attenders are currently reviewed and will be reported as part of ATTAIN. This is a request as part of the refreshed (MIS) guidance. A further update will be presented to the December Quality Committee.
• The target for Maternity Continuity of Care (MCoC) has been removed. The Trust in line with the national request from NHS</td></tr>
</table>

<table>
<tr><td></td><td colspan="4">England has paused further rollout of MCoC in view of current midwifery vacancies.</td></tr>
<tr><td rowspan="3">Trust strategic aims:

(Please indicate which of the 4 aims is relevant to the subject of the report)</td><td>Aim 1
Best care</td><td>Aim 2
Great team</td><td>Aim 3
Best value</td><td>Aim 4
Great place</td></tr>
<tr><td>Objectives 1-4</td><td>Objectives 5-8</td><td>Objective 9</td><td>Objective 10-12</td></tr>
<tr><td>X</td><td>X</td><td></td><td></td></tr>
<tr><td>Links to well-led key lines of enquiry:</td><td colspan="4">☒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 colspan="4"><table><tr><td>Committee/Group</td><td>Date</td></tr><tr><td>Departmental Governance</td><td>November 2022</td></tr><tr><td>Quality Committee</td><td>24 November 2022</td></tr></table></td></tr>
<tr><td>Action required:</td><td colspan="4">The Trust Board is asked to receive this report for discussion and assurance on progress for the 10 safety actions to meet year 4 of the maternity incentive scheme.</td></tr>
</table>

Agenda Item: 21

Trust Board – 1 December 2022

Title of paper: **Maternity Incentive Scheme Update– NHS Resolution**

Presented by: Tracey Carter Chief Nurse

1. Purpose

1.1 The purpose of this paper is to provide an update on the status of West Hertfordshire Teaching Hospitals NHS Trust compliance with the NHS Resolution (NHSR) Maternity Incentive Scheme (MIS) Year four and to highlight areas of risk with compliance.

2. Background

2.1 NHS Resolution is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.

2.2 The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

2.3 The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

2.4 To be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution (nhsr.mis@nhs.net) by 12 noon on Thursday 2nd February 2023 and must comply with the following conditions:

- Trusts must achieve all ten maternity safety actions.
- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services
- The Board declaration form must be signed and dated by the Trust's Chief Executive Officer (CEO) to confirm that:
- The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.

- There are no reports covering either year 2021/22 or 2022/23 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before Thursday 2 February 2023.

2.5 **For Trusts who have not met all ten safety actions**

Trusts that have not achieved all ten safety actions may be eligible for a small amount of funding to support progress. In order to apply for funding, such Trusts must submit an action plan together with the Board declaration form by 12 noon on 2 February 2023 to NHS Resolution (nhsr.mis@nhs.net). The action plan must be specific to the action(s) not achieved by the Trust and must take the format of the action plan template which will be provided within the Board declaration form. Action plans should not be submitted for achieved safety actions.

2.5 **Requirements for Board for CNST**

3. Discussion

3.1 The trust is making progress in preparing for the MIS submission that includes evidence of board submissions for:

Perinatal Mortality review tool (PMRT)
Perinatal Quality Surveillance model (PQSM)
Maternity dashboard via IPR (all elements of MSDS)
Avoidable Term admissions to the neonatal unit report including ward attenders
Midwifery and medical workforce planning
MBRRACE report
Maternity Safety champion report
HSIB and SI reports

3.2 The areas of focus to ensure full compliance that is currently partially complaint are doctors' attendance at annual update MDT training, sustained compliance for CO monitoring at 36 weeks, ATTAIN report and action plan that includes ward attenders. These are planned to reach compliance by the end of November and will be presented at December quality committee.

3.3 The trust's MHSR update is shared with the LMNS monthly.

4. Risks

4.1 If the Trust does not achieve all ten actions, it will not recover their contribution to the maternity incentive fund but may be eligible for a small discretionary payment from the Scheme to help progress against actions that have not been achieved. This payment would be at a much lower level than the 10% contribution to the incentive fund.

4.2 Areas of focus that remain partially compliant are:

4.2.1 **Safety Action 6:** all eligible women are screened at 36 weeks. The progress to full compliance is on track and in October the compliance has increased to over 92% and expected to achieve full compliance by deadline of MIS submission.

4.2.3 **Safety action 8**: The trust must show evidence that at least 90% of each maternity staff group has attended an 'in house', one day, annual multidisciplinary professional update training day. These include six agreed core modules of the Core Competency Framework included in the Trust training program. The compliance for doctors' training is anticipated to reach compliance by the end of November 2022. Additional sessions are planned in December 2022 to sustain compliance and board assurance in January 2023.

5. Recommendation

5.1 The Trust Board is asked to receive this report for discussion and assurance on progress for the 10 safety actions to meet year 4 of the maternity incentive scheme

Name of Director: Tracey Carter Chief Nurse/ Director of Infection Control

7th November 2022

Trust Board
1 December 2022

<table>
<tr><td>Title of the paper:</td><td>East Kent report: An independent Investigation into East Kent Maternity and Neonatal Services</td></tr>
<tr><td>Agenda Item:</td><td>22</td></tr>
<tr><td>Presenter:</td><td>Tracey Carter Chief Nurse</td></tr>
<tr><td>Author(s):</td><td>Mitra Bakhtiari, Director of Midwifery, Gynaecology/Deputy Chief Nurse</td></tr>
<tr><td>Purpose:</td><td>Please tick the appropriate box
<table><tr><td>For approval</td><td>For discussion</td><td>For information</td></tr><tr><td></td><td></td><td>x</td></tr></table></td></tr>
<tr><td>Executive Summary:</td><td>This report summarises the main findings of the East Kent report, NHSE's requirements in relation to the report and how the Trust will implement these requirements. The full report and letter setting out NHSE's requirements are on Diligent resources.

The East Kent report, published on the 19th October 2022, highlighted a number of failings that resulted in avoidable loss and harm suffered by a number of families out of the total of 202 families between 2009 -2020. This follows the Morecombe Bay investigation in 2015 and the Ockenden review (Shrewsbury and Telford 2020/2021).

NHS England requires the findings of the report to be shared with the Board together with a clear plan outlining how the recommendations will be taken forward.

<u>Key findings</u>

• In 49% of the 202 cases of death and harm, the mother or baby would have had a different outcome if the staff had followed nationally accepted standards of care.
• Of 65 baby deaths, 45 of the newborns might have lived if pregnant women and their babies received the nationally agreed standard of care.
• If care was followed appropriately, twelve of 17 newborns who suffered brain damage may not have done so.
• Similarly, 23 of 32 mothers would not have suffered injury or died while giving birth if they had received good care.
• The key findings from the study highlighted gross failures of teamworking, failures in professionalism, lack compassion, failure to listen to patients and to each other, safety incidents not dealt with properly and failure in the trust's response.

The report identifies four areas which NHS trusts should action to improve outcomes:

• Improving early identification of poorly performing units
• Giving care with compassion and kindness
• Teamworking with a common purpose</td></tr>
</table>

	• Responding to challenge with honesty The Trust has agreed a consolidated action plan against the national reports and regulatory requirements such as Ockenden, Morecombe Bay, CQC and Maternity Incentive Scheme. There is an agreed monthly MDT review of all the actions to meet compliance. The Trust will consider the East Kent findings and recommendations and will include these as part of the overarching maternity and safety actions plans. NHS England is publishing a single delivery plan in 2023, reviewing the recommendations for maternity and neonatal care which will bring together all actions required following this report and emerging Immediate and Essential (IEA) actions from the Ockenden reports, part 1 and 2. This will incorporate NHS Long-Term Plan and Maternity Transformation Programme deliverables. In the mean time NHS trusts are asked to continue their plans to progress full compliance with all IEAs, aiming to improve care for women, babies and their families.
Trust strategic aims: *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1 Best care** – ***Objectives 1-4***: X **Aim 2 Great team** – ***Objectives 5-8***: **Aim 3 Best value** – ***Objective 9***: **Aim 4 Great place** – ***Objective 10-12***:
Links to well-led key lines of enquiry:	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☒Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles and systems of accountability to 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 Divisional Governance – November 2022 Quality Committee – 24 November 2022
Action required:	The Trust Board is asked to receive this report for information and assurance that the maternity services have an agreed process to review this report.

Agenda Item: 22

Trust Board: 1 December 2022

Title of paper: East Kent report: An independent Investigation into East Kent Maternity and Neonatal Services

Presented by: Tracey Carter Chief Nurse

1. Purpose

1.1. This paper provides the Trust Board with an overview of the East Kent report, an independent Investigation into East Kent Maternity and Neonatal Services.

1.2 the trust will review the report and include agreed actions in the consolidated action plans as part of assurance for compliance with national recommendation to improve safety of maternity and neonatal services which will be reviewed on a monthly basis.

2. Background

2.1 In February 2020, following concerns raised about the quality and outcomes of maternity and neonatal care, NHS England and NHS Improvement (NHSEI) commissioned Dr Bill Kirkup to undertake an independent review into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust (the Trust).

2.2 The review examined the maternity services in two hospitals, the Queen Elizabeth, the Queen Mother Hospital (QEQM) at Margate and the William Harvey Hospital (WHH) in Ashford, between 2009 and 2020. East Kent Hospitals University NHS Foundation Trust (the Trust) was responsible for services across these sites.

2.3 The care of 202 families were examined between 2009-2020, some of the care provided was considered suboptimal with evidence that the failings were not discussed with families and recurring patterns of harm was noted. The review highlighted missed opportunities to identify these failings. The report highlighted long-standing deep-rooted problems amongst different professional groups that had an impact on how families were treated as well as lack of transparency regarding actual harm caused with appropriate investigation, ensuring families involvement.

2.4 The report does not have recommendation for change of policy in view of evidence that this approach has not shown prevention of recurrent of similar problems outlined in other reports in to failing of maternity services, such as Morecombe bay and Ockenden.

2.5 the Report identifies four key areas for action to help embed a culture of giving care with compassion and kindness, teamworking with a common purpose, with an honest approach to challenges. These include:

- To get better at identifying poorly performing units
- Giving care with compassion and kindness
- Teamworking with a common purpose
- Responding to challenge with honesty

3. Analysis/Discussion

3.1 The report outlines findings of the investigation of maternity services at East Kent Hospitals University NHS Foundation Trust and how those responsible for the provision of maternity services failed to ensure the safety of women and babies, leading to poor outcomes. It highlights examples of how lack of compassion and kindness within the multidisciplinary team working, impacted on the care of women and their families and missed opportunities to investigate and share the learning.

3.2 The clinical outcome in 97 of 202 cases could have been different if nationally accepted standards were followed. In 69 of the 97 cases, it is predicted the outcome should reasonably have been different - and could have been different in a further 28 cases. Of the 65 baby deaths examined, 45 babies could have lived or may have lived if they had been offered nationally recognised standards of care.

3.3 The report considered different outcomes in 33 of these 45 cases while in a further 12 cases it might have been different. In 17 cases of brain damage, 12 cases could have had a different outcome if good care had been given, of which nine should reasonably have been expected to have had a different outcome.

3.4 The investigation found that in the deaths of mothers, the outcome could have been different in 23 out of 32 cases. In 15 of these 23 cases, the outcome would reasonably have been expected to be different.

3.5 The report found that the trust board Missed eight opportunities during 2009-20 to acknowledge the extent of problems and solve them. They Saw the trust as a "victim" of external factors that were causing its poor maternity care, such as lack of staff and its coastal location, and did not see that the real causes were internal and involved "failures in team-working, professionalism, compassion and listening. This was found to have Compounded families' suffering by not being open and honest and exacerbated by the repeated turnover of staff at many levels, including Chief Executive. Where families brought in concerns, the Trust focused on reputation management, reducing liability through litigation this disrupted patient safety and learning.

3.6 The key findings:

3.6.1 Failures of teamworking: The report identified problems between different staff groups involved in maternity and neonatal services with evidence of a culture of tribalism and lack of mutual trust, and disregard for each other's points of view. This believed to adversely affect timely recognition of problems that led to delayed recognition, escalation and intervention. This was fundamental to the suboptimal care identified in both hospitals.

3.6.2 Failures of professionalism: There were examples noted of staff disrespecting each other and questioning staff capabilities in front of the families and women blamed for poor outcomes. Examples of the Trust replacing staff in key managerial roles who challenged poor behaviour is highlighted in the report as well as weak Human Resources (HR) function. .

3.6.3 Failures of compassion: the report found evidence of many examples of uncompassionate care. Experience of care and effectiveness of interventions were dismissed such as pain relief or signs of labour. Requests for further information was dismissed.

3.6.4 Failures to listen: There were failures to listen, some of which resulted in a different clinical outcome. This included dismissing information and agreed plan of care at hand overs.

3.6.5 Failures after safety incidents: poor culture of team working affected the response by staff after safety incidents, including those incidents that led to death or serious damage. Some staff denied responsibility for adverse outcomes and not even accepting if anything untoward had occurred. Safety investigations were often conducted narrowly and defensively. The trust's response often did not address the root cause and the scale of the nature of the problems associated with a clinical incident.

3.7 Call for action; four areas for action from the findings are outlined in the report.Table below is a summary of the four key action alongside the corresponding recommentations for the trusts to take forward:

Key action Area	Recommendation
1: Monitoring safe performance	The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use.
2: Standards of clinical behaviour	Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning. Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance.
3: effective teamworking	Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how teamworking in maternity and neonatal care can be improved, with particular reference to establishing common purpose, objectives and training from the outset. Relevant bodies, including Health Education England, Royal Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, teamworking and development.
4: Organisational behaviour	The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies. Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards. NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership.

3.8 The report acknowledged that giving care with compassion and kindness, teamworking with a common purpose, and at responding to challenge with honesty are key to any sustained improvement in safety of maternity services. These were identified as not straightforward. The recommended actions provide a catalyst for tackling embedded, deep-rooted problems in teams. The reports highlights the importance of ensuring outcome measures in maternity services are meaningful and risk-sensitive, given that pregnancy and childbirth are physiological in most cases and poor outcomes less common, but this must not become an excuse.

4. Next steps

4.1 The trust will undertake a review of the East Kent report ahead of publication of the single delivery plan in 2023 as recommended by NHS England. Key recommendations are directly linked with an agreed consolidated action plans against the national reports and regulatory requirements such as Ockenden, Morecombe Bay, CQC and Maternity Incentive Scheme.

4.2 The trust will ensure that any immediate actions are taken in respect of the clinical Governance framework and continue to share the learning across East of England Region and the Local Maternity & Neonatal System (LMNS).

4.3 Ongoing review of the immediate actions in line with the recommendations will be monitored at Divisonal level with an oversight from the maternity safety champions, and Quality Committee.

4.4 A report to update on the progress to comply with the IEAs will be brought to the quality committee in February 22 and trust board in March 22. This will incorporate and update on the single delivery plan publication update.

5. Risks

5.1 Recommendations from this report highlights failing in providing safe maternity care and has recommendations for all providers of maternity services. Failure to demonstrate full compliance with the recommendations runs the risk of the trust not being able to withstand internal and external scrutiny and provide assurance that the safety of families is optimised.

6. Recommendation

6.1 The Trust Board is asked to receive this report for information and assurance that the maternity services have an agreed process to review this report.

Name of Director: Tracey Carter, Chief Nurse, and Director of Infection Prevention & Control
Date: 14th November 2022

Trust Board
1 December 2022

Title of the paper:	**Setting the direction for QI & CPG at WHTH**
Agenda Item:	**23**
Presenter:	**Tracey Carter, Chief Nurse**
Author(s):	**Michelle Boot Lead Nurse for Quality Improvement** **Tejal Vaghela, CPG lead**
Purpose:	*For approval*: — / *For discussion*: — / *For information*: ✓
Executive Summary:	This report has been discussed at the Quality Committee and builds on the current position with Quality Improvement and plans for the direction of travel through to the summer of 23. The use of QI methodology brings real benefits to an organisation. The CQC identify that organisations with both top ratings and most improved ratings have QI embedded into the organisational culture (CQC 2018). Research has demonstrated that the Board and executives' teams' understanding of leading improvement is a fundamental factor in the success of an organisation (Lord Darzi 2008). Using a robust QI methodology brings about improved patient safety, outcome and experience. There is also evidence of improvement to staff wellbeing where the use of QI is embedded into an organisation. **Areas for development and Planned milestones** Areas for development have been identified by mapping the Trust' current position against factors that the CQC identify as common elements of successful QI. Areas for development: **Strategic intent** • The development of a QI strategy for the next 3-5 years which aligns with the Trust strategic priorities and organisational risks is a key priority. The strategy will align with the 'Better care delivered differently' using QI and the CPG programme as vehicles to support the delivery. This will require an external resource, with both the engagement work and development of a written strategy, for 3-4 months. **Building leadership capability** • The Trust needs to develop senior leaders QI knowledge and enable them to engage with QI initiatives. Partnering with IHI will support the Trust in its journey to becoming a Trust where continuous improvement is the 'way we do things'. **QI team structure** • Integration of the QI and CPG teams and consistency of QI methodology will help to build the culture of QI across the organisation. **Systems** • The development of the QI Strategy, partnership with the IHI, building Trust capability and creating an integrated QI/CPG team will strengthen our innovation as a partner in the ICS and HCP.
Trust strategic aims:	**Aim 1** **Best care** / **Aim 2** **Great team** / **Aim 3** **Best value** / **Aim 4** **Great place**

	Objectives 1-4	***Objectives 5-8***	***Objective 9***	***Objective 10-12***
	✓			

Links to well-led key lines of enquiry:	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☐Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues and performance? ☒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: Quality Committee — Date: 24 November 22
Action required:	The Trust Board is asked to receive this report for information of the planned direction and development of the QI strategy in 2023.

Committee/Group	Date
Quality Committee	24 November 22

Agenda Item: 23

Trust Board: 1 December 2022

Title of Paper: Setting the direction for QI & CPG at WHTH

Presented by: Tracey Carter Chief Nurse

1. Purpose

The purpose of this report is to provide the Trust Board with an overview of the Trust's current Quality Improvement position and to share plans, recommendations, and options for the direction of travel for QI.

2. Background

The use of QI methodology brings real benefits to an organisation. The CQC identify that organisations with both top ratings and most improved ratings have QI embedded into the organisational culture (CQC 2018). Research has demonstrated that the Board and executives' teams' understanding of leading improvement is a fundamental factor in the success of an organisation (Lord Darzi 2008). Using a robust QI methodology brings about improved patient safety, outcomes, and experience. There is also evidence of improvement to staff wellbeing where the use of QI is embedded into an organisation.

The Institute of Health Improvement (IHI) identifies QI as the science of improvement: 'an applied science that emphasizes innovation, rapid-cycle testing in the field and spread to generate learning about what changes, in which contexts, produce improvements' (IHI nd). This approach is more than a set of tools or methods; it requires a change in the culture of an organisation that is open to learning. It requires a combination of clinical expertise, improvement methods and tools and an MDT approach drawing on systems theory, psychology, and statistics. The Trust along with our partner organisations in the East of England and our clinical partner Royal Free London (RFL) uses the IHI Model for Improvement methodology. The QI and CPG team use the MFI methodology however there is scope to develop a more robust methodology.

3. Analysis/Discussion

3.1 WHTH current QI position

The Trust has invested in building Trust capability and capacity. A QI team was recruited in 2019: a Lead Nurse for QI and two Improvement Lead posts. The team has built the Trust capability offering QI training at both introductory and intermediate QI training

The QI team facilitates teams to undertake QI initiatives supporting the teams with understanding and applying QI methodology. The focus of the team is to support QI initiatives which are aligned with the Trust Quality Priorities. Additionally, the team offer signposting and support to teams, and Junior doctor QIP projects if they use the Model for Improvement for specific initiatives. The QI Faculty is in the early stages of development. Further work to develop how the members work together to further build Trust capability is needed.

QI training 2021-2020 excluding measurement training sessions

Year	QI Awareness	Introduction to QI	Intermediate training
2021	236	94	31 enrolled*
2022	348	28	6 enrolled*

*Not all participants completed the full course

A CPG programme manager was also recruited in 2019. The programme expanded to include a data information officer, CPG programme lead, additional CPG analyst and CPG finance officer. The CPG team have15 pathways in progress.

The CPG programme drives quality by implementing best practice pathways and reduce unwarranted variation in care and outcomes. The pathways, led by clinicians, ensure that care pathways are designed around patient's need and deliver both high quality clinical outcomes and value for money. The aspiration for the CPG programme is to implement 40 clinical pathways over 3 years.

Work is planned to digitalise the CPG pathways as part of our clinical relationship with the Royal Free. The proposed plan:

- an RFL pathway that has not been digitalised will be developed in digitalised format by WHTH
- WHTH will implement a pathway that has been digitalised by RFH.

The timescales for this work are under discussion.

3.2 Areas for development and Planned milestones

Areas for development have been identified by mapping the Trust's current position against factors that the CQC identify as common elements of successful QI:

- Strategic intent
- Leadership for QI
- Building improvement skills
- Building a culture of QI
- Putting the patient at the centre of QI
- Systems view

WHTH have made progress against all these factors. As the Trust moves forward it is reviewing its reviewing its strategic intent to strengthen, leadership for QI, building on the culture of QI and systems view.

3.2i Strategic intent

The development of a QI strategy for the next 3-5 years which aligns with the Trust strategic priorities and organisational risks is a key priority. The strategy will align with the 'Better Care Delivered Differently' (BCDD) strategy. QI and CPG programme are vehicles to support the delivery of the programmes identified in BCDD strategy including the delivery of programme 6; supporting staff development, staff to work innovatively and contribute to WHTH being a great place to work. The CPG programme forms a key part of Consistent care for BCDD strategy programme 4 and reports quarterly.

A series of engagement events will take place between December 2022 and Spring 2023 to facilitate wide participation of all stakeholders including patient representatives in the development of the Strategy.

While acknowledging the experience and skills of the current QI team they will need support from the transformation team, to coordinate the engagement, and external resource with the development of a written strategy. It is anticipated that the required resource would be for approximately 3 months on a part-time basis. This resource will enable the QI team to have a key role in developing the strategy and meet the current demands of their roles; continuing with both training and facilitating teams to lead QI initiatives.

Timeframe:

- Strategic engagement exercise begins end of 2022
- Strategy written, governance review
- Board development April 2023.
- Sign off by Trust Board May/June 2023

3.2ii Building on leadership capability and developing a culture of QI
"The most important determinant of quality of care is leadership. The Trust needs to have a strategic plan for QI which is supported with unwavering commitment from senior leaders who model appropriate improvement focused leadership behaviours and a visible hands-on approach". CQC (2018)

Benchmarking against this CQC standard the Trust needs to continue to build on the senior leaders QI knowledge and importantly enable them to engage with QI initiatives. A culture of continuous improvement will emerge as senior leaders commit to the model for improvement and engage with initiatives. Following the development of the QI strategy a Board development session will be planned for Spring 2023

To build on the established QI foundations the Trust now needs to align the QI activity with Trust Priorities. The QI team will facilitating multiple workstreams focusing on improving discharges during the 2022-23 Winter.

To build on the current training provision a framework to support the transitioning of training into practice needs to be strengthened. Next steps for Spring 2023 will be for the divisions to identify senior team members who will then engage with QI initiatives aligned to Trust priorities to attend the intermediate QI training 'Stepping out with QI', and for an Executive lead to be the SRO for the Trust Priority projects.

Planning for the winter and in response to lower numbers in training sessions the QI will deliver the Introductory training online as lunchtime sessions. The QI team teach on the junior doctor training programme. The Strategic engagement work will include exploring how to embed QI training into the junior doctor's programme.

To support the Trust in developing a culture of QI as the 'way we do things' it is recommended that the Trust partners with the Institute of Health Improvement who are global leaders in QI. The Trust has supported 4 members of the QI and CPG teams to have advance QI training (Improvement Advisor) with the IHI. Identifying the level of engagement with the IHI will be explored as part of the strategic development.

Timeframe:

- Intermediate training for senior divisional staff Summer 2023
- Further training for Board and Executives to have hands on experience with QI initiative Spring/Summer 2023
- IHI partnership 2023-2024

3.iii Systems view:

Aligning QI and CPG

Currently the QI and CPG teams focus on their own workstreams; the QI team focusing on Trust wide initiatives and the CPG team implementing Consultant led clinical pathways (approved by division and clinical decision panel). Strengthening the use of Model for Improvement methodology for Trust priority improvement initiatives and implementation of the CPG pathways will support the Trust to further deliver sustained improvement. Integration of these teams and consistency of QI methodology will help to build the culture of QI across the organisation.

A review of the current QI and CPG structure is needed to enable the Trust to build on its improvement capacity. The overall QI team structure will be reviewed to include a clear reporting structure to a director. Bringing the CPG and QI teams together will support the delivery of the QI

strategy and facilitate the adoption of the model for improvement methodology to continue to strengthen improvement and innovation initiatives across the Trust.

Timeframe:
- Review of QI structure and integration of QI and CPG teams summer 2023

QI will support collaborative working across the ICB and SWHCP

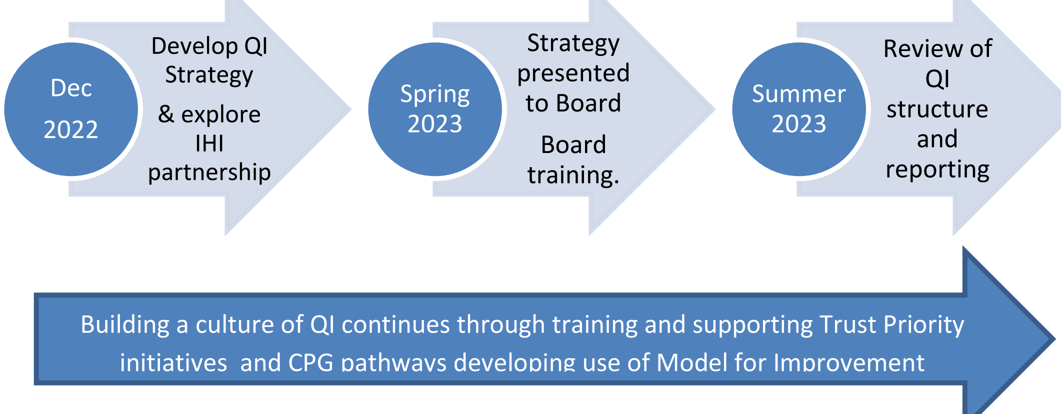
Systems thinking is at the heart of QI. Recognising the complex inter-relationships, connections and dependencies is a fundamental part of QI. The QI approach will facilitate the ICS to use a systems approach to deliver the best care across the ICS footprint.

The Trusts across the East of England network are using the Model for Improvement. This will facilitate learning and will enable Trusts to replicate innovations. This will allow for rapid testing and learning as innovations are scaled up across the ICS footprint.

The development of the QI Strategy, partnership with the IHI, building Trust capability and creating a stronger QI team will support the Trust in developing as a centre of excellence and positioned to be a key innovative partner in the ICS

Timeframe:
- QI network in development Autumn 2022
- Collaborative QI initiative scoping in progress with community partners.

Timeline:



4. Risks

The Trust has made a considerable investment in QI and CPG pathways. The Trust has reached a transition stage where it needs to plan the next steps for building on the foundational work already completed. Without further investment in focus, time, and resources the Trust will miss the opportunity fully realise the benefits of using the Model for Improvement to support the drive for innovation and sustainable change at WHTH.

5. Recommendation

The Trust Board is asked to receive this report for information of the planned direction and development of the QI strategy in 2023.

Name of Director: Tracey Carter Chief Nurse

Date: 24 November 2022

Trust Board
1 December 2022

<table>
<tr><td>Title of the paper:</td><td>IP&C Annual Report – April 2021 – March 2022</td></tr>
<tr><td>Agenda Item:</td><td>24</td></tr>
<tr><td>Presenter:</td><td>Tracey Carter, Chief Nurse & Directors of Infection Prevention & Control</td></tr>
<tr><td>Author(s):</td><td>Glynis Bennett, Deputy Director of Infection Prevention & Control

Dr Prema Singh, Infection Control Doctor, Consultant Microbiologist</td></tr>
<tr><td>Purpose:</td><td>Please tick the appropriate box
For approval:
For discussion:
For information: X</td></tr>
<tr><td>Executive Summary:</td><td>This report has been fully discussed at the quality committee and provided evidence and assurance on the Trusts compliance with the Hygiene code. It also includes information on incidents and actions undertaken to address these. This demonstrates that the Trust is providing a clean and safe environment ensuring infection prevention and control is everybody’s business.

There were 60 cases of Trust apportioned CDI from April 2021 to March 2022 against a trajectory of 41 for the year, however following review with CCG 23 of these cases were identified to have no lapses in care (attributed to WHTH). The Clostrioides difficile Infection (CDI) objectives for 2021/22 are based on NHSE criteria (4 categories) for apportioning of cases; this system commenced on 1 April 2019.

Objectives for acute providers are based on the first 2 categories and the Trust has a trajectory of no more than 41 cases with identified lapses in care for the full year.

There have been 2 cases of MRSAb identified both re admissions within 28 days prior to result, with identified learning identified from both cases.

There has been an increased focus on Gram Negative (organisms) bacteraemia GNBSI with trajectories set as follows:
• E Coli trajectory 105 - total cases for year 64
• Klebsiella trajectory 24 – total cases for year 26
• Pseudomonas aeruginosa trajectory 11 – total cases for year 16

A significant response to the COVID-19 pandemic has challenged the Trust for the whole of this year with a peak in numbers between Nov 21 and April 22. Work on the management and learning from Nosocomial cases has been a focus throughout the year. With joint working to improve/assess environmental risks and patient placement alongside the challenge and emergence of new Variants of Concern (VOCs), that are highly transmittable.

Collaborative working across the Integrated Care System (ICS) has been key this year, with support given to and received from the local system. This has been in the form of peer reviews, the sharing of strategies/policy providing added external assurance and a consistency of IPC standards/ care across the system.</td></tr>
<tr><td>Trust strategic</td><td>Aim 1 | Aim 2 | Aim 3 | Aim 4</td></tr>
</table>

aims: *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Best care** *Objectives 1-4*	**Great team** *Objectives 5-8*	**Best value** *Objective 9*	**Great place** *Objective 10-12*
	X			

Links to well-led key lines of enquiry:	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☒Is there a culture of high quality, sustainable care? ☐Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues and performance? ☐Is appropriate and accurate information being effectively processed, challenged and acted on? ☐Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☒Are there robust systems and processes for learning, continuous improvement and innovation? ☐How well is the trust using its resources?
Previously considered by:	see below
Action required:	The Trust Board is asked to receive this report for information and assurance of the actions taken for the requirements of Hygiene Code (2015) Health and Social Care Act 2008.

Previously considered by:

Committee/Group	Date
IPC Panel	7 October 22
Quality Committee	24 November 22

Agenda Item: 24

Date: 1 December 2022

IP&C Annual Report – April 2021 to March 2022

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

1. Introduction

Preventing infections is a key priority for the Trust. The objective and strategy for IP&C are based on the criteria within the Health & Social Care Act 2008 (H&SC Act) code of practice on the prevention and control of infections and related guidance (DoH 2015) ensuring compliance with the Hygiene Code (appendix 1). In addition, the COVID-19 pandemic has required further assurance and the Board Assurance Framework (BAF) (Section 2.9) for IPC has been developed. Ten criteria and the Hierarchy of controls are reported against, with a repository of evidence to support reporting.

Criteria 1 – Management and Structure for Infection Prevention and Control

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

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

The day-to-day coordination of the IP&C nurses is managed by the Deputy DIPC.

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

2. MANDATORY SURVEILLANCE REPORTING OF Health Care Associated Infection (HCAI)

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

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

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

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

2.1 Trust Assigned *Methicillin Resistant Staphylococcus Aureus* Bacteraemia

Trajectory = none set

For the year 2021/22, the Trust reported 2 cases (re admission within 28 days) MRSAb attributed to the organisation and 1 cases community associated (non-trust apportioned). A comparison within the East of England (Figure 1b) illustrates number of cases per Trust in E of E. A decrease on the previous year's performance from total of 5 cases with 2 of these cases post 48-hour admission (Figure 1a). Learning from all cases has been identified and shared with divisions and clinical areas.

Between April 2021 and March 2022, the Trust has reported 2 cases (both re admissions within 28 days) of MRSAb case 1 in Aug 21:

- A post infection review (PIR) has been undertaken and includes representation from CCG IPC team. The case was a complex case with sample highlighting a Panton-Valentine leucocidin (PVL) strain of MRSA. The patient, a lady, post-surgical C section showed signs of infection in surgical wound and investigation highlighted the source of infection as a Surgical Site Infection (SSI). As a result, C section SSI surveillance has been commenced. The patient recovered well and both her and baby were discharged.
- Case 2 in March 2022 the PIR identified previous admission in last 28 days with pneumonia on re admissions was very unwell and palliative outcome, no identified learning or lapses in care from WHTH.

Work to reduce both MRSAb and MSSAb is focusing on aseptic technique (ANTT) and commenced with a focus on vascular access management. The implementation of new cannulation products to drive best practice has been undertaken.

Figure 1a: MRSAb per year trust and non-trust attributed:

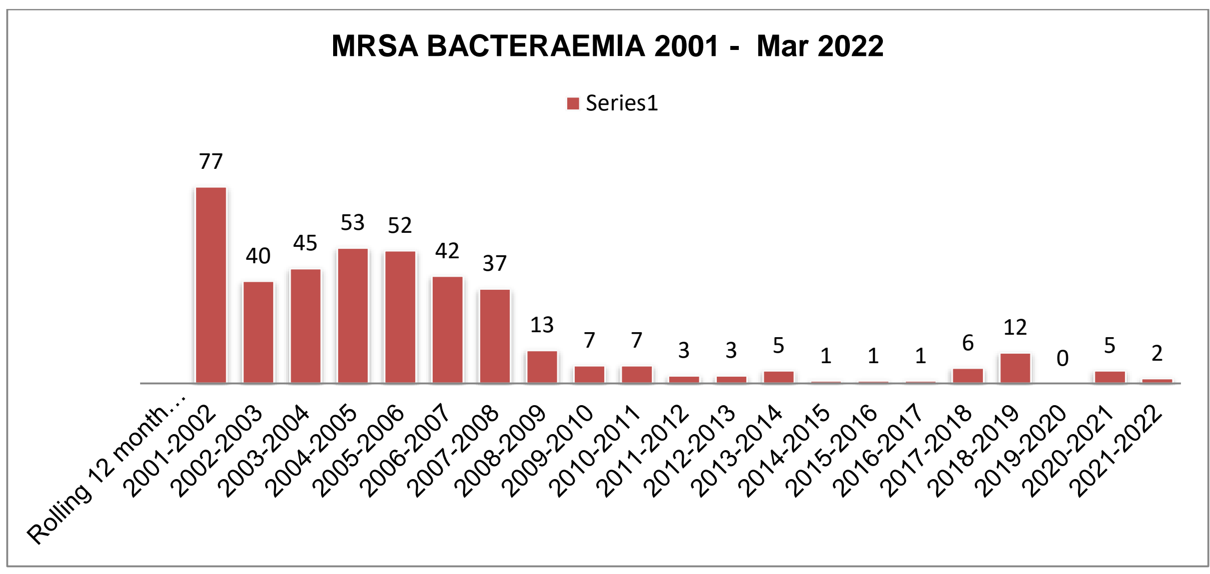
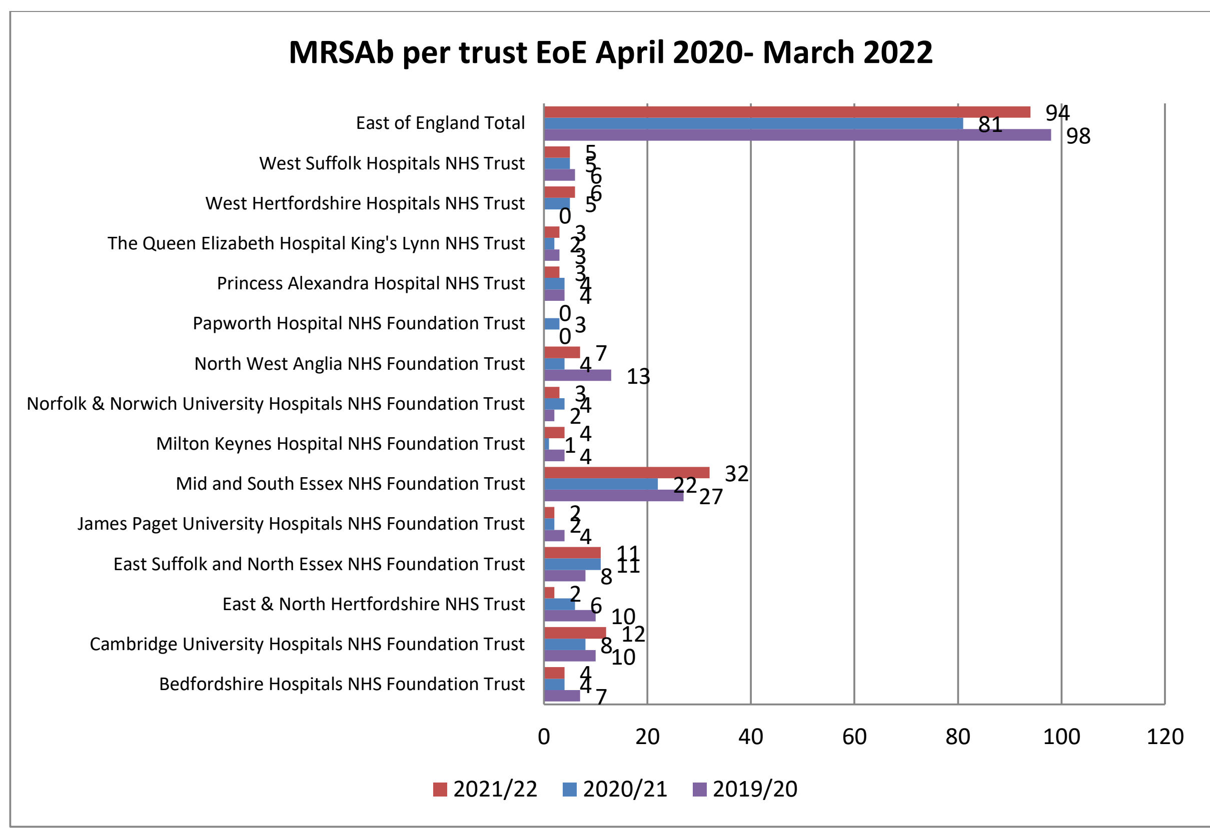


Figure 1b: MRSAb per trust in East of England



2.2 Me*thicillin Sensitive Staphylococcus Aureus Bacteraemia* (MSSAb)

Figure 2 illustrates pre and post 48 hour cases overall. Each case of MSSA is reviewed and findings from thematic analysis such as the presence of an invasive device were addressed.

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

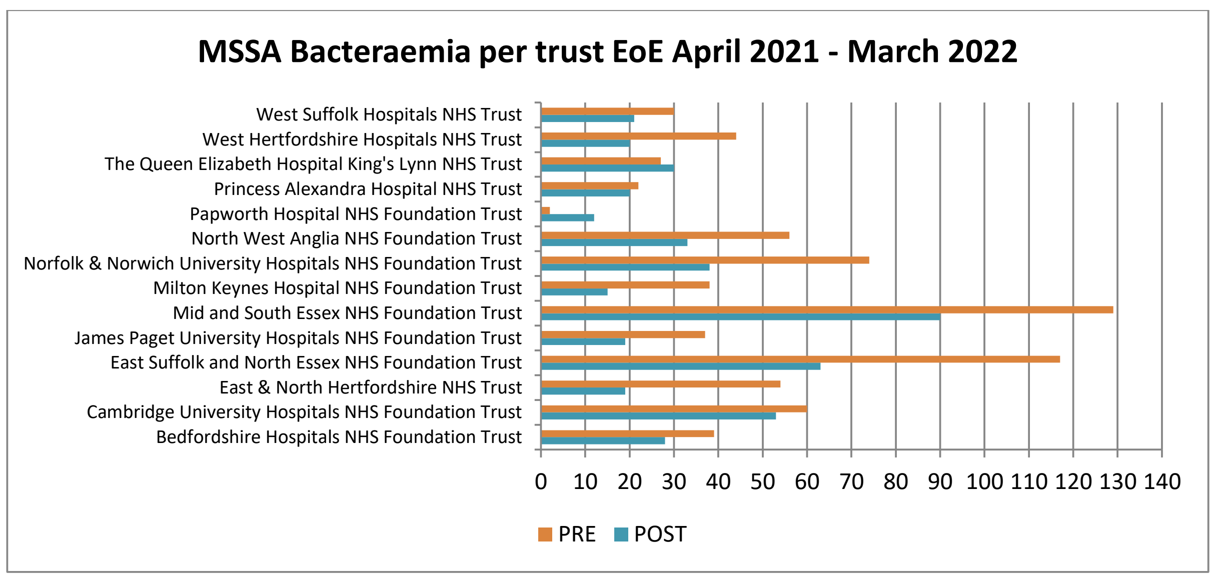
MSSAb Pre & Post Results by Month for 2021-22

10 9 8 7 6 5 4 3 2 1 0

April May June July Aug Sept Oct Nov Dec Jan Feb Mar

Pre Post

The graph above illustrates the number of MSSAb per Trust in Midlands & East of England, 2021/22.



2.3 Gram Negative Blood Stream Infections (GNBSI)

For the year 2021/22 trajectories for GNBSI were set. WHTH trajectories and cases numbers:

Organism	Trajectory	Cases attributed to WHTH 2021/22
E Coli	105	64
Klebsiella	24	26
Pseudomonas Aeruginosa	11	16

Cases were attributed to the Trust within the 2 categories:

1) Blood culture taken post 48 hours of admission
2) Blood culture taken and patient been an inpatient within the previous 28 days

Fig 3 a- c, illustrates each organism pre/post 48 hours.

Work to reduce cases has been on going with community partners and led by CCG IPC team, this includes the management of urinary catheters and communication when patients are discharged with these devices.

There has been a significant reduction in the number of E coli cases this year, however cases of pseudomonas and Klebsiella have breached trajectory. A review of the data has highlighted no links in cases, however a review of the primary source of all GNBSI has highlighted work with Urinary infections (non-catheter related) and hospital/community acquired chest infections. The data has been shared with CCG colleagues and will be included as part of the work in the coming year.

Fig 3a Pseudomonas aeruginosa

Fig 3b Klebsiella

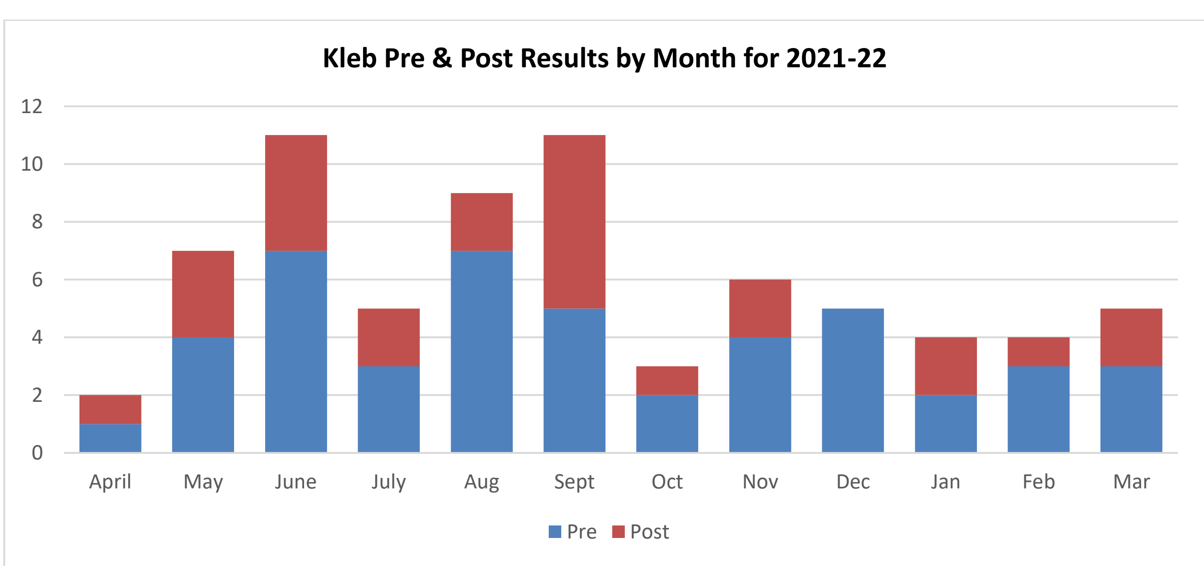
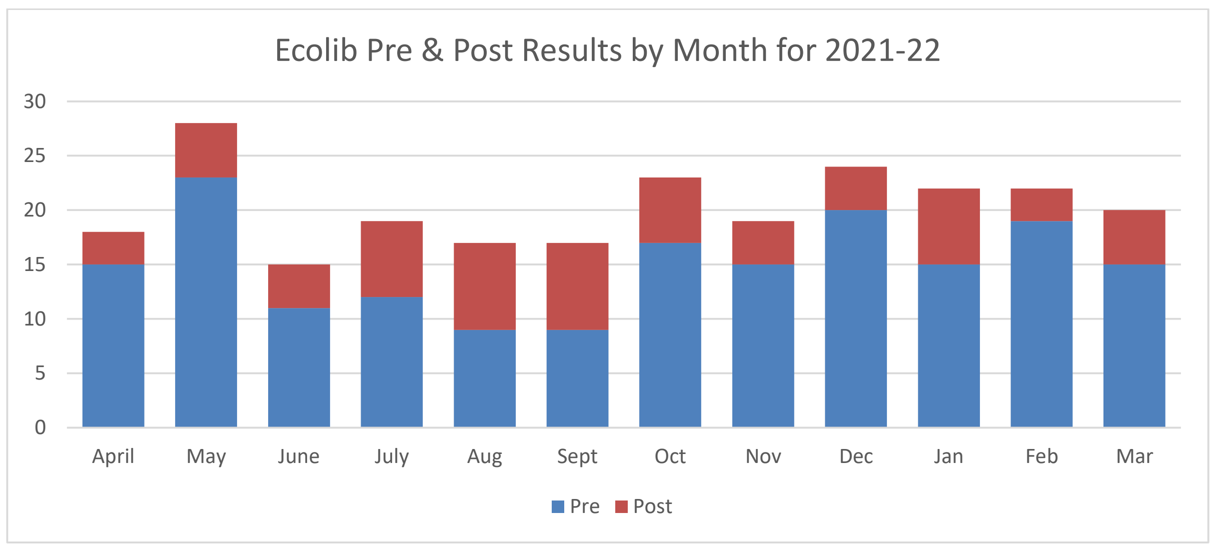


Fig 3c E Coli



2.4 WHHT apportioned CDI cases 2020/21

The Clostrioides difficile Infection (CDI) objectives for 2021/22 are based on the criteria of 4 categories for apportioning of cases; this system commenced on 1 April 2019.

The trust trajectory for this financial year was 4, and Root Cause Analysis (RCA) are required to be completed for all cases.

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

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

The CCG IPCT undertake a full review of all RCA's, involving HOHA and COHA cat 1&2 cases. Those cases with no identified lapses in care remain on the numbers but are not subject to financial penalties. A full review of cases including thematic data and review in lapses in care has now been undertaken also. Of the 60 cases attributed to WHTH (figure 4) 23, have been identified with no lapses in care attributed to WHTH.

Themes from learning from this year's cases are illustrated in fig 4. Missing audit data aligns with peaks in Covid numbers and is largely due to workload, spot check audits were undertaken along with PPE audits to provide assurance in the absence of a formal audit process.

During this time an increase in antibiotic consumptions has been evidenced, again mainly due and aligned with covid surges throughout the year.

Fig 4: RCA themes

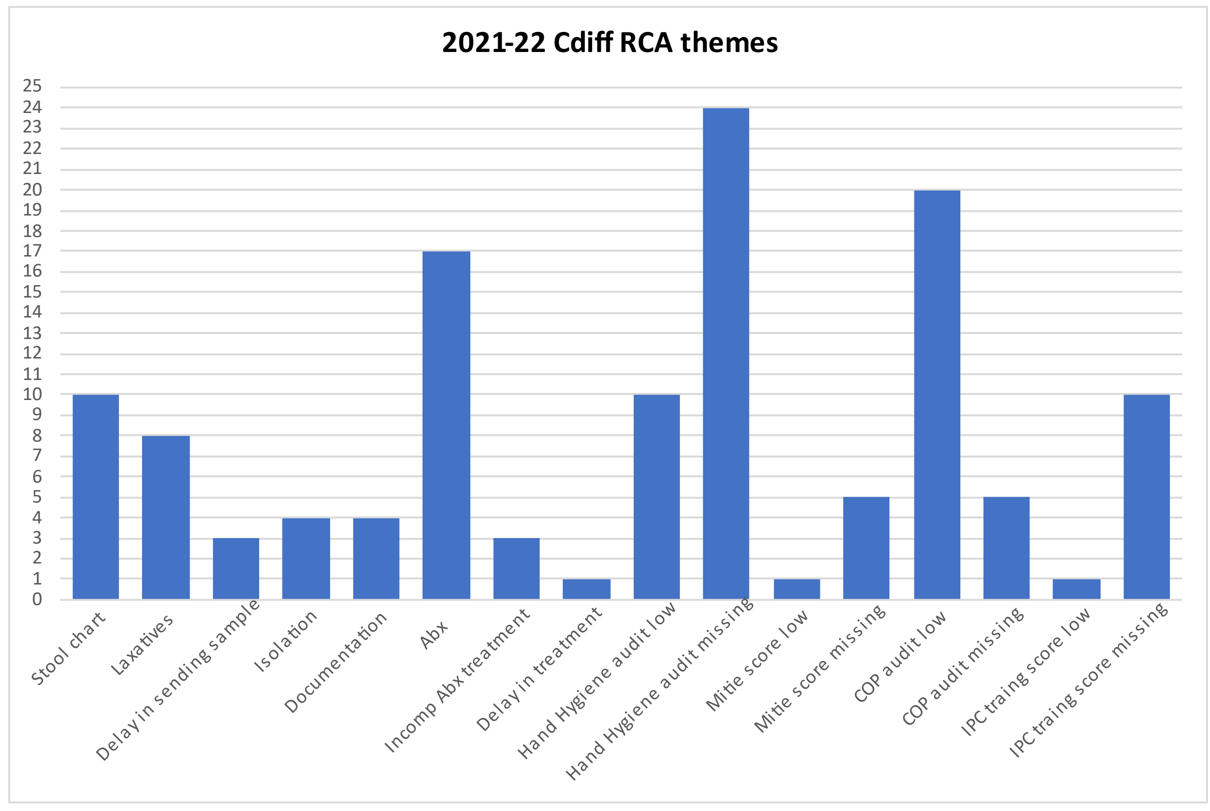
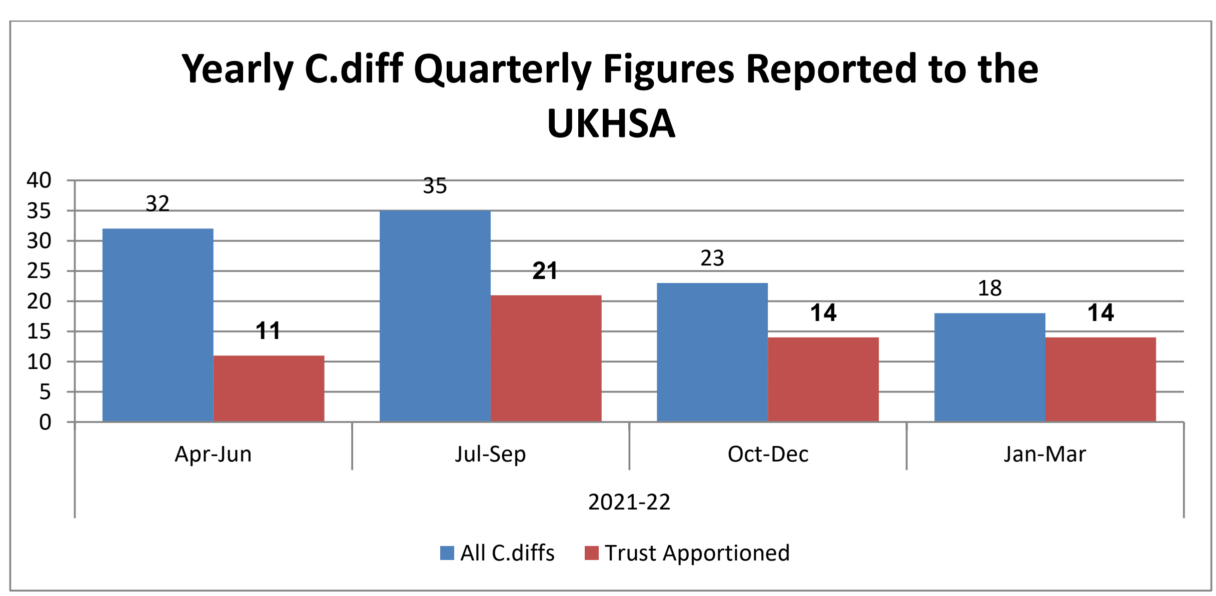


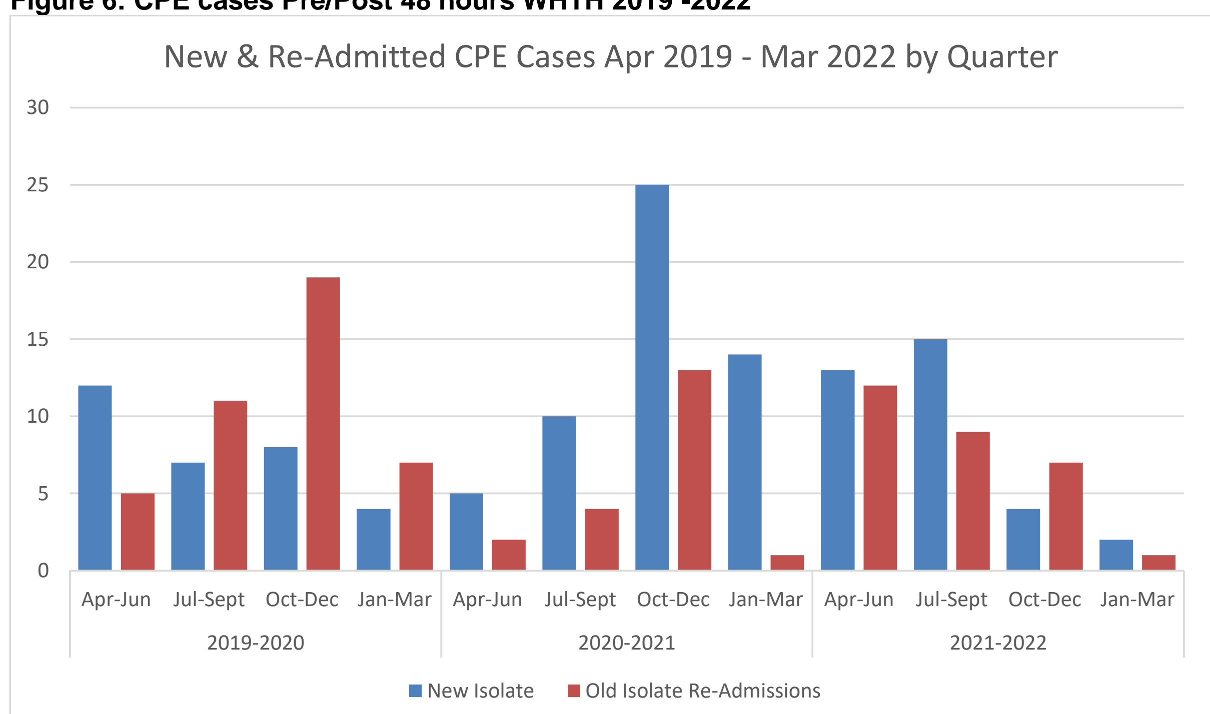
Figure 5: C *difficile* cases apportioned to WHHT 2021-22



2.8 Carbapenemase-Producing Enterobacteriaceae (CPE)

No clusters or outbreaks have been identified during this period. All cases are followed up and contacts screened as per policy. There has been a reduction in cases against last year illustrated in fig 6.

Figure 6: CPE cases Pre/Post 48 hours WHTH 2019 -2022



2.9 COVID – 19

A continued focus on the management of Covid – 19 has been required this year. The continued challenge of peaks in cases numbers and new variants of concern (VOCs) which are more transmissible has been evidenced between Nov 21 and April 22. The sections below outline the management, assurance and interventions undertaken.

IPC Board Assurance Framework IPC BAF:

In June 2020 the IPC BAF was issued by NHSE to provide criteria for board oversight and assurance for standards relating to IPC and the management of COVID-19. Several updates have now been issued (see link below).

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/12/C1501-infection-prevention-control-board-assurance-framework-december-2021.pdf

The Quality Committee is updated via a report on a bimonthly basis and evidence to support the BAF is stored in a repository managed by the IPC team.

Included as part of the BAF the Hierarchy of controls (Figure 7) forms assurance and a governance framework to formulate actions required. Reporting on the BAF is linked to this framework and the 10 key lines of enquriey outlined in the document. A review of the assuracne of data against the BAF was undertaken by an external audit provider and highlighted a good standard of assuracne with no recommendations for any imprvments at that time.

Figure 7: Hierarchy of controls

Clinical pathways and Assessment:

Assessment and Emergency Dept:

During the year screening regimes for covid – 19 have been reviewed and the implementation of rapid Lateral Flow Testing (LFT) on admission in ED. This has facilitated the management of patents to correct bed base. Those patients with symptoms managed separately on admission to ED.

All patients are also screened using PCR laboratory testing on day 3 of admission, a strict monitoring process is in place to ensure that the use of LFT in ED has not resulted in high number of false negative results.

As further information regarding clinical presentation of covid-19 along with the emergence of new variants, updates and learning was disseminated through clinical forums including Clinical Decision Panel (CDP) and Incident Management meetings (IMT). Guidance and pathways were amended.

Inpatient management:

As numbers of cases requiring admission increased the Trust responded by allocating areas of the Hospital as Covid-19 zones. Support by clinical staff to ensure correct allocation of patients depending on acuity .

Improvements to environment:

The estates and IPC Team have worked closely with Microbiology and the Authorising Engineer for ventilation to undertake Risk assessments across all sites. This has included increasing the

numbers of air changes, sourcing extra cleaning of ventilation ducts on Covid-19 specified areas, using HEPA filters to aid air changes, encouraging the opening windows (for short periods) and temperature control to introduce fresh air into clinical area.

In the Shrodells area, the use of wards has been reviewed due to the lack of mechanical and natural ventilation. Learning from nosocomial outbreaks has also included the use of HEPA filters that include UV disinfection also. Ad hoc air testing has shown small improvements to the air quality in this area. The use of the area is now dedicated to specific patient groups, and a risk assessment was shared to safely manage the area with current ventilation systems.

Cleaning and decontamination:

The standards of cleaning and decontamination across the organisation are regularly reviewed. . For further assurance of standards an enhanced cleaning audit and Adenosine Triphosphate (ATP) testing (a reading that gives the organic matter present on a surface) has been introduced by the facilities team.

Clinical practice and IPC

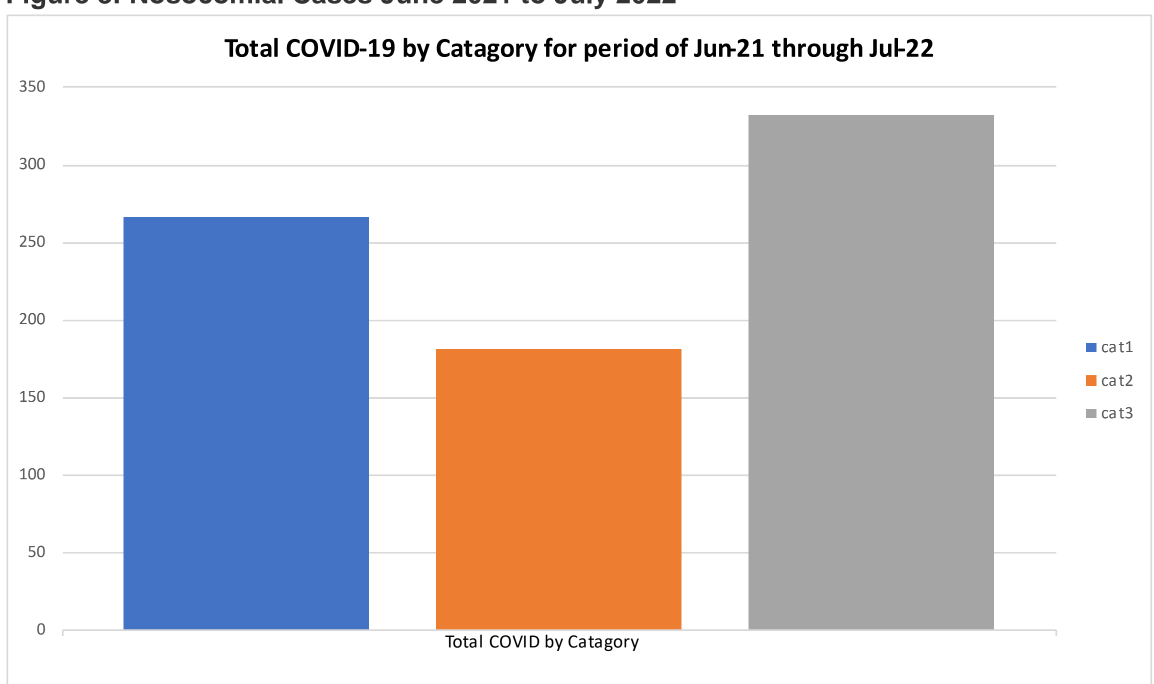
Since the beginning of the pandemic IPC guidance has been frequently updated. The IPC Team has led on the education and support of teams regarding PPE, IPC practice and the placement of patients (isolating and cohorting).

Guidance and pathways have been presented to IMT and where required reviewed by the CDP. UKHSA guidance has been implemented, and included a focus on reduced glove usage, and the importance of removal between care activities

A review of the Risks related (*4375,4300 &4362*)   have been undertaken.

A second thematic review has been undertaken covering the 2021 – 22 period (July 21 – Aug 22). Fig 8 highlights the data for this period

Figure 8: Nosocomial Cases June 2021 to July 2022



Outbreaks and clusters are investigated, and an overarching thematic review has been completed. Learning is outlined in appendix 3.

3.0 Criteria 2 ENVIRONMENTAL CLEANING AND DECONTAMINATION

3.1 Environmental Cleanliness Joint Monitoring

Since April 2018, the cleaning service is provided by Mitie and the contract is monitored by the Facilities team.

Joint working to ensure standards and consistency of standards are met has been on going with the Mitie team, with monthly Director led meetings.

3.2 Informal Monitoring of Cleaning

The Trust has a programme of regular 'walk-about' including the Director of Infection Control (DIPC), Deputy DIPC/IPC, Lead Nurses and the environment and facilities teams. For further assurance ATP testing has been undertaken and enhance cleaning audits implemented.

3.3 Clinical Cleaning Responsibilities

Cleaning of clinical items and patient equipment is undertaken by both the nursing and housekeeping staff with oversight by the matrons. Compliance with policy is monitored through the environmental and IPC audits which are reported on the IPC Dashboard.

3.4 Estates

The aging estate presents challenges for IPC and a continuous maintenance programme is required. The ongoing programme of works has included replacement flooring, bathroom upgrades and theatre maintenance (including a new theatre and recovery in Watford General Hospital).

3.4.1 Water safety

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

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

Higher than normal counts for legionella were identified in both buildings at WGH (PMOK and Maternity) in the previous year due to temperature control following a steam shut down. A programme of works has been developed to rectify identified issues including a thermal disinfection of system, replacement of pipe works and review of outlets. Mitigation for continued management has include the use of point of care (POC) filters and continued testing. A robust action plan for the ongoing management of water is in place with input from the Trust Authorising Engineer (AE).

Within maternity high counts of legionella were detected in a higher number of outlets. Initial thoughts were systemic issues, but further counts and a programme of daily flushing in all areas have highlighted improvements and indicated the issue is confined to individual outlets. POC filters were originally installed on all outlets in maternity, but a large number have now been removed. These are on identified outlets and higher risk areas including SCBU, theatres and Delivery suite. IMT have also been undertaken for this area and an action pan formulated with AE oversight.

3.4.2 Ventilation.

Ventilation has been central in the estates work in management of the COVID-19 pandemic and risk assessments have been undertaken with oversight from the Trust AE, these have been regularly reviewed and updated in line with national guidance and prevalence of covid - 19.

4.0 ANTIBIOTIC USAGE

Antimicrobial Stewardship April 2021 – March 2022

4.1 ANTIMICROBIAL STEWARDSHIP ACTIVITIES

The new NHS contract that came into force in April 2022 require providers to reduce the consumption of Watch and Reserve antibiotics (see table below). The empirical antibiotic guideline was reviewed as part of the Trust's AMS strategy to meet the newly set target and aim to increase use of ACCESS category antibiotics which in turn can help the Trust in achieving a reduction in the consumption of antibiotics from the Watch and Reserve category.

Adapted WHO EML AWaRe List for England — NHS Improvement

Access	Watch	Reserve
Amoxicillin / ampicillin	Amikacin, tobramycin, etc	Aztreonam
Penicillin – all forms	Macrolides	Ceftobiprole,
Co-trimoxazole	Most cefalosporins	Ceftaroline
Doxycycline	Chloramphenicol	Ceftazidime-avibactam
Flucloxacillin	Fluoroquinolones	Ceftolozane-tazobactam
Fosfomycin oral	Clindamycin	Colistin
Fusidate	Co-amoxiclav	Daptomycin
Gentamicin	Other tetracyclines	Carbapenems
Metronidazole	Fidaxomicin	Fosfomycin IV
Nitrofurantoin	Piperacillin-tazobactam, etc	Linezolid / tedizolid
Pivmecillinam	Temocillin	Televancin
Tetracycline	Vancomycin, teicoplanin	Tigecycline
Trimethoprim		

Publications and awards:

The antimicrobial stewardship team has encouraged junior doctors and biomedical scientists to take part in the AMS programme and publish their research in national and international publications.

Antibiotic Guardian Award finalist 2020.

National BAME health and social care award – Dr Hala Kandil (lead for antimicrobial stewardship in the Trust) was the winner of the clinical champion of the year 2021

AMS team led by Dr Hala Kandil have been involved in the published research in a number of areas.

Audits have also been completed looking a number of areas and including junior doctor support and learning

A Poster presentation was also delivered by the AMS team at the 2021 ECCMID conference

4.2 Actions (completed) and Recommendations for 2022/23:

- Assess appropriateness of antimicrobial prescribing for treatment and prophylaxis through AMS ward rounds

- Complete the annual point prevalence audit in November 2022
- Plan, organise and carry out EAAD activities on 18th November 2022
- Continue to engage junior doctors in antimicrobial stewardship audits
- Continue to deliver educational teaching sessions to medical, nursing and pharmacy staff and to re-enforce AMR agenda
- To encourage prompt IV to oral switch in line with the regional action plan for 2022/23

5.0 CRITERIA 4 – PROVIDING INFORMATION TO SERVICE USERS

The Trust provides regular updates on performance related to IPC and mandatory reporting of alert organisms is completed and shared with the wider community. The Trust provides infection rates on Ward information boards which are updated on a monthly basis. Reports for compliance against the BAF are also received by Quality committee on a bimonthly basis and reported to board as part of the Trust BAF.

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

6.1 Identification of patients with infections

The introduction of the Electronic Patient Record (EPR) this year has aided in the management and documentation of microbiology results. The IPCT are working with Informatic consultants to build upon use of EPR for surveillance and monitoring purposes.

6.2 Assessment of patients with risk factors for infections

Thee following are in place

- Diarrhoea & Vomiting (D&V) risk assessment
- Admission IPC assessment

6.3 WHTT Surgical Site Infection Surveillance 2021-2022.

Orthopaedic Surgical Site Infection (SSI) surveillance is a mandatory, with requirement for a three-month module of surveillance in one of the following orthopaedic categories:

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

6.3.1 SSI Surveillance Programme:

During 2021/2022 WHTH continued to participate in continuous UKHSA SSI Surveillance for Total Knee Replacement, Total Hip Replacement and Spinal Surgery across both hospital sites, as well as for Repair of fractured neck of femur surgery at WGH. Additional SSI Surveillance was also undertaken on Breast Surgery at SACH during Oct-Dec 2021. The combined SSI results for 2021/2022 for each surgical category are displayed below in Figure 10

FIGURE10: WHTH SSI Results 2021/2022:

Surgical Category	Hospital Site	Period	Study Population	Total Number of Inpatient/ Readmission SSI's	SSI Rate	National Baseline	UKHSA High/Low outlier alert notice received
TKR	SACH	Apr 21- Mar 22	239	0	0%	0.4%	No
THR	SACH	Apr 21- Mar 22	238	0	0%	0.5%	No
Spinal surgery	SACH	Apr 21- Mar 22	112	0	0%	1%	No
Breast Surgery	**SACH**	**Oct 21 - Dec 21**	**95**	**3**	**3.2%**	**0.8%**	**Yes**
TKR	WGH	Apr 21- Mar 22	1	0	0%	0.4%	No
THR	WGH	Apr 21- Mar 22	22	1	4.5%	0.5%	No (low study population)
Spinal surgery	WGH	Apr 21- Mar 22	8	0	0%	1%	No
Repair of #NOF Surgery	WGH	Apr 21- Mar 22	306	1	0.3%	1%	No

6.3.2 Breast Surgery UKHSA SSI High Outlier Notification

During Oct-Dec 2021 WHTH reported a total of 3 SSI's for breast surgery resulting in a SSI Rate of 3.2% against a national baseline of 0.8%. Subsequently the trust received high outlier notification for Breast Surgery from UKHSA indicating that the SSI risk for this category was above the 90th percentile. All 3 of the SSI cases were identified in implant-based procedures, and all 3 were categorized as Organ/space infections (the most severe type). As per normal protocol, all 3 cases were subject to Root Cause Analysis investigation prior to reporting. Learning/themes identified from these investigations included timing of antibiotic prophylaxis, prevention of intra-operative hypothermia and management of suspected implant infections. An action plan targeting these areas, as well as other improvement strategies has been formulated in collaboration with the SSI Lead Consultant for Breast Surgery

6.4 Vascular Access

This is a Nurse Led service by the CNS Vascular Access and Indwelling Devices, being a part of the wider IPCT.

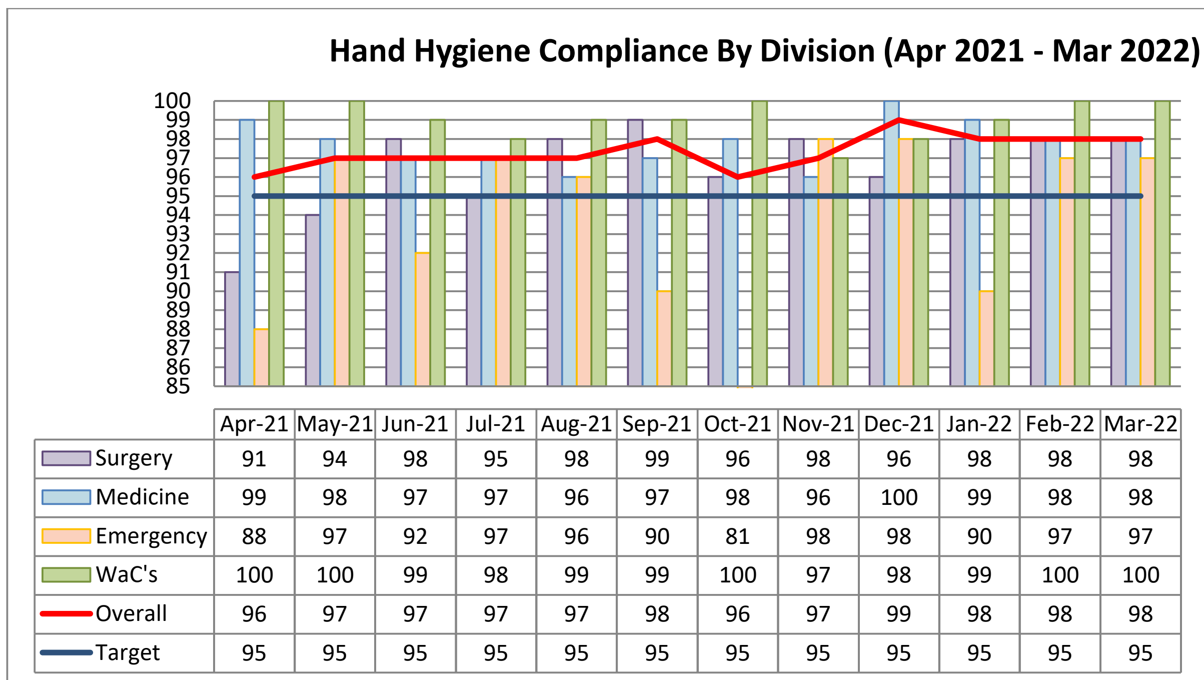
There has been 1 BSI (related to PICC inserted via the Vascular Access service) investigations are undertaken and learning shared with clinical teams as part of the wider asepsis work across the organisation

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

7.1. Hand Hygiene Audits Compliance

Effective hand hygiene remains a key intervention in the reduction of HCAIs. The trust Hand hygiene compliance target is 95%. Fib 11 illustrates Trust compliance

Figure 11 –HH compliance by division WHHT 2021 – 22



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Surgery	91	94	98	95	98	99	96	98	96	98	98	98
Medicine	99	98	97	97	96	97	98	96	100	99	98	98
Emergency	88	97	92	97	96	90	81	98	98	90	97	97
WaC's	100	100	99	98	99	99	100	97	98	99	100	100
Overall	96	97	97	97	97	98	96	97	99	98	98	98
Target	95	95	95	95	95	95	95	95	95	95	95	95

7.2 IPC Audits

Several audits are completed by the IPC team to ensure compliance and highlight areas requiring support these include Code of practice audits, PPE audits and clinical audits

7.3 IPC ACTIVITIES

Several campaigns have been undertaken related to COVID-19, and other alert organisms (including C difficile and CPE). These have been led by the IPC support worker and included “I am a coronavirus get me out of here,” “Clean between” and awareness of glove usage using UV powder to demonstrate contamination to surfaces, patients, and staff.

These campaigns have been shared across the ICS, with excellent feedback on the work and enthusiasm undertaken by the IPC support worker.

A re launch of isolation posters to align with the EPR system have been circulated, with an education and awareness programme to support.

The IPC team have also been working collaboratively across the ICS, with sharing of ideas, policies and undertaking peer review. A poster to highlight the work was submitted for presentation at the Infection Prevention Society (IPS) Conference

8.0 Criteria 7 - Provide adequate isolation facilities

The COVID-19 pandemic has required isolation facilities to be used differently, and the use of Cohort areas for patients with positive results have been implemented. Single room facilities have been used as a protective facility to protect those patients at a higher risk from infection for example those with compromised immunity. The increase in other infections including C *difficile* has required a priority approach to use of these rooms. The IPC team work closely with operational colleagues to assist and assess patients requiring isolation.

Risks related to lack of isolation and associated risks (no ensuite facilities in most rooms) are regularly reviewed.

9.0 Criteria 8 – Microbiology Laboratory Support

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

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

10.0 Criteria 9 - IPC Polices

10.1 Policies and Procedures

There has been a delay in the updating of some of the IPC policies due to COVID-19 repose. A number have been updated throughout the year. A process of checking for updated guidance or procedures is in place to ensure review is undertaken and advice/guidance remains in line with national guidance/policies.

Plans for the coming year include a review and update of all IPC policies

11. CRITERIA 10 - OCCUPATIONAL HEALTH 2021-2022

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

The team have been heavily involved in the management and outbreaks of COVID-19 within staff groups. The team have worked as part of the IMT to develop algorithms for the management and process of staff alongside the COVID hub. The team attend meeting with IPC, Microbiology, COVID hub and EPR to discuss cases of staff identified as part of outbreaks or clusters.

To ensure safe working for both staff and patients, a COVID – 19 assessment process has been in place. A panel approach has been in place for the assessment of staff returning to work if on contact with a covid case or those have symptoms. This has been in the form of a daily review meeting with representation from OH, IPC, covid hub and Microbiology as required. The process has provided support for staff with guidance and screening. The review also looked at staff and patient cases in areas to identify any possible links or high risk areas.

12. RECOMMENDATION

The Trust Board is asked to receive this report for information and assurance of the actions taken for the requirements of Hygiene Code (2015) Health and Social Care Act 2008.

Name of Director: **Tracey Carter, Chief Nurse and Director of Infection Prevention & Control Team**

Date: November 2022

APPENDIX 1

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

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

	provider organisations that will help control infections.	
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	Yes

Appendix 2:

PRIORITIES FOR COMING YEAR

- Strengthen IPCT infrastructure to undertake surveillance and analysis through the extended use of the EPR system.
- Sustain standards, methods, and assurance around all aspects of cleaning working, through partnership with cleaning contractors to provide assurance on standards in all three sites.
- Continue work to improve and sustain clinical standards of IPC across the Trust to ensure consistency in all areas.
- Work with operational and divisional colleagues to safely manage IPC issues, implement pathways and use resources effectively (ie limited numbers of single rooms)
- Manage current estate including plans for refurbishment and updating. Continue with risk assessment for management of water, ventilation, and decontamination.
- Undertake collaborative work with the ICS to reduce numbers of gram-negative BSIs across the region.
- Active role in the recovery planning post COVID-19 and planning for further management of possible further rise in cases
- Contribute to the design and planning of the proposed newly refurbished hospital to design out infections.
- Review the working practices, procedures, and structure of the IPC team to ensure a robust and efficient team for future of WHTH
- Provide consistent leadership and support in IPC across the organisation, engaging staff at all levels to promote the IPC agenda.
- Continue to work collaboratively with partners across ICS to reduce Health Care Acquired Infections and improve IPC practices across the system.
- Work with estates and facilities team to ensure the safe management of water and ventilation systems
- Use IPC surveillance and audit data to target areas of work to improve infection rates and patient safety/experience
- Continue work to improve standards of aseptic practice related to Vascular access and other indwelling devices

Appendix 3: Identified learning and actions – Nosocomial COVID – 19

Identified Learning/Issue	Actions undertaken	Procedures to monitor	IPC BAF Ref No.	Hierarchy of controls ref
Environment: Shared facilities (bathrooms)	Additional cleaning for bathrooms in identified areas of cases, including high touch areas	Contactor audit Facilities audit and ad hoc ATP testing IPC Audit/checks	**2**	**Engineering controls**
Environment:	Risk assessment	HEPA filters with	**2**	**Engineering**

Ventilation systems not at advised air changes	undertaken. Mitigations include use of HEPA filters and window opening	monthly checks. Trail of HEPA filter on Tudor/Castle wards with UV/Filtration machine		**controls**
Environment: Identified continued transmission on Tudor/Castle wards with high-risk patient group (haematology)	Ward(s) used as a covid positive cohort areas and Haematology patients re assigned to another ward	Tudor/Castle continues to be used as Covid cohort designated area	**2**	**Substitution**
Environment: Open bays without doors on some wards resulting in unable to effectively isolate bays	Use of screens at bay entrances where able, continued monitoring of patients for signs/symptoms of covid in both bays if no doors	Continued surveillance in identified areas, and individual risk management for different areas/prevalence. Oxhey ward due to vulnerability of patient's risk assessment in place re admission to ward using LFTs prior to transfer to ward	**2**	**Engineering controls**
Implementation of guidance for management of covid in healthcare settings: Reduced screening regimes Assessment and management of patients in contact with positive cases	Risk assessment undertaken for implementation of guidance and includes clear pathways and assessment processes	Continued surveillance of cases Regular review of Risk – dependent on community and inpatient prevalence	**All**	**All**
Asymptomatic transmission and those admitted while in incubation period: Daily clinical review of patients for signs/symptoms of covid infection. Screening on day 3 and 7 of inpatient stay.	Information and education sessions for new guidance and clear assessment of clinical symptoms. Designed proforma for those who have had contact with a positive case	Surveillance of rates and transmission Compliance with clinical proforma monitored when IPC report results	**1**	**Admin controls**
Environment: Evidence and inconsistency of cleaning clinical equipment	Focused campaign on cleaning of clinical equipment with targeted education days. Frequent COP audits and feedback	IPC COP audit and spot check walk rounds. Monitored via IPC Panel and divisional reporting	**2**	**Admin controls**

21

PPE: Inconsistency of compliance with PPE guidance, specifically change of PPE between patients and care activities	Targeted campaigns and education sessions. Continued PPE audit. Gloves off campaign planned with QI and shared decision-making approach	PPE audits and spot checks Reported as part of IPC Panel and divisional reporting	**6**	**PPE**
PPE: Patient mask wearing compliance	Targeted comms and posters at entrance to encourage mask wearing, Use of mask dispensers at entrances	Spot checks and continued comms. Mask dispensers ordered.	**5**	**PPE**

Trust Board
1 December 2022

Title of the paper	**Annual Complaints and Patient Advice and Liaison Service (PALs) Report 2021-2022**		
Agenda Item	**25**		
Presenter	**Tracey Carter Chief Nurse**		
Author(s)	**Ripa Aziz, Complaints Manager** **Bhavna Katwa, PALS Manager**		
Purpose	*Please tick the appropriate box* *For approval*:	*For discussion*:	*For information*: ✓

Executive Summary

In accordance with the NHS complaints Regulations 2017 this report sets out an analysis of the number and nature of complaints received by the Trust.

This report provides a summary of patient complaints, and compliments received in 2021/2022. It includes details of complaints received during the year, performance in responding to complaints, Parliamentary and Health Service Ombudsman's investigations and actions taken by the Trust in response to complaints.

This also includes a summary of the patient concerns received by PALS and regarding the Trusts performance in resolving these.

Complaints key points to note:

- In 2021/22 452 complaints were received giving an average of 38 complaints per month. This is an increase in comparison to 363 complaints received during the same period in 2020/21
- Acknowledgments were made within the national target of 3 working days 100% of the time.
- The Trust responded to 81% of complaints within the time agreed with the complainant, this is a decline from 85% in 2020/21.
- Improvements in response to complex cases
- Quality of responses

PALS Key points to note:

- PALS information and details added to the WHTH Patient Experience website
- Development and building on the foundation of the Family Liaison line to roll out to all divisions during the pandemic.
- Development of the online portal for interpreting requests throughout the Trust

Trust strategic aims:	**Aim 1** **Best care**	**Aim 2** **Great team**	**Aim 3** **Best value**	**Aim 4** **Great place**

<table>
<tr><td>(please indicate which of the 4 aims is relevant to the subject of the report)</td><td>
<table>
<tr><td>Objectives 1-4</td><td>Objectives 5-8</td><td>Objective 9</td><td>Objective 10-12</td></tr>
<tr><td>X</td><td>X</td><td></td><td>X</td></tr>
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</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><td>Committee/Group</td><td>Date</td></tr>
<tr><td>Quality & Safety Group</td><td>November 22</td></tr>
<tr><td>Quality Committee</td><td>24 November 2022</td></tr>
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<tr><td>Action required</td><td>The Trust Board is asked to receive this report for information and assurance that the Trust is compliant with NHS England Complaints Policy.</td></tr>
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Agenda Item: 25

Trust Board – 1 December 22

Annual Complaints and Patient Advice and Liaison Service (PALs) Report 2021-2022

Presented by: Tracey Carter Chief Nurse

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1. Introduction

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

1.2 Formal complaints, feedback, compliments and contacts are some of the useful tools West Hertfordshire Teaching Hospitals NHS Trust utilises to capture concerns about the care and service provided.

2. Purpose

2.1 This report provides assurance that complaints handling, and management is compliant with our Trust Policy. It presents the findings on complaints and PALS activity and identifies the trends and learning for the period 1 April 2021 to 31 March 2022.

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

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

3. Background

3.1 The Department of Health published the Local Authority Social Services and NHS Complaint Regulations, which was updated in 2017. The policy contains up to date information relating to safeguarding in terms of patients, complainants and staff. Further

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

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

4. Performance 2021/22

4.1 In 2021/22, 452 complaints were received at West Hertfordshire Teaching Hospitals NHS Trust compared to 363 in 2020/2021. In total 370 (81%) complaints were responded to within the agreed timeframes.

4.2 The Trust responded to 81% of all complaints within the Trust set timeframes,; compared to 85% in the preceding year. Of the complaints closed, 222 (49%) were upheld or partially upheld.

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

4.4 The volume of complaints referred and considered for formal investigation to the Parliamentary and Health Service Ombudsman (PHSO) has remained at a low level and as the end of March 2022 there was only one case under review by the PHSO. This has however been impacted by the Covid19 Pandemic, as the PHSO paused any new referrals for a period of seven months. As a result, the PHSO continues to have a significant backlog of cases, which may include complaints relating to WHTH, which are being considered but have not yet reached the Trust.

4.5 All lessons learnt are captured on our Datix system. Specific learning across the Trust is highlighted in the section, 'Learning from Complaints' section of this report.

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

4.7 The Complaints team attend and provide reports for the Patient Experience Group (PEG) meeting. The aim of the report is to offer an update on the delivery of four priorities within the Patient Experience and Care Strategy at Divisional level, and to provide evidence of achievement against key performance indicators agreed for 2021/22.

5. Risks

There is a recognised reputational risk associated with performance against defined targets. Furthermore, there is a risk surrounding the confidence in the Trust and its learning culture if responses are not submitted promptly with clear action plans and set timelines for implementation of these.

6. Overview of compliance with Complaints Policy

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

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

7. Analysis of Complaints Received in 2021/22
(Extracted from Datix Database)

7.1 The chart below records complaints per 10,000 bed days. This is reported monthly via the Integrated Performance Report (IPR) and bi-monthly to the Quality Committee. The Complaints Team continue to work with the divisions and to support their work. The number of complaints the Trust received has increased since in 2020/21, however, it is thought that due to the easing of Covid-19 restrictions and services resuming to usual ways of working this has impacted the level of complaints received.

Fig 1: Number of complaints – rate per 10,000 bed days April 2021 to March 2022.

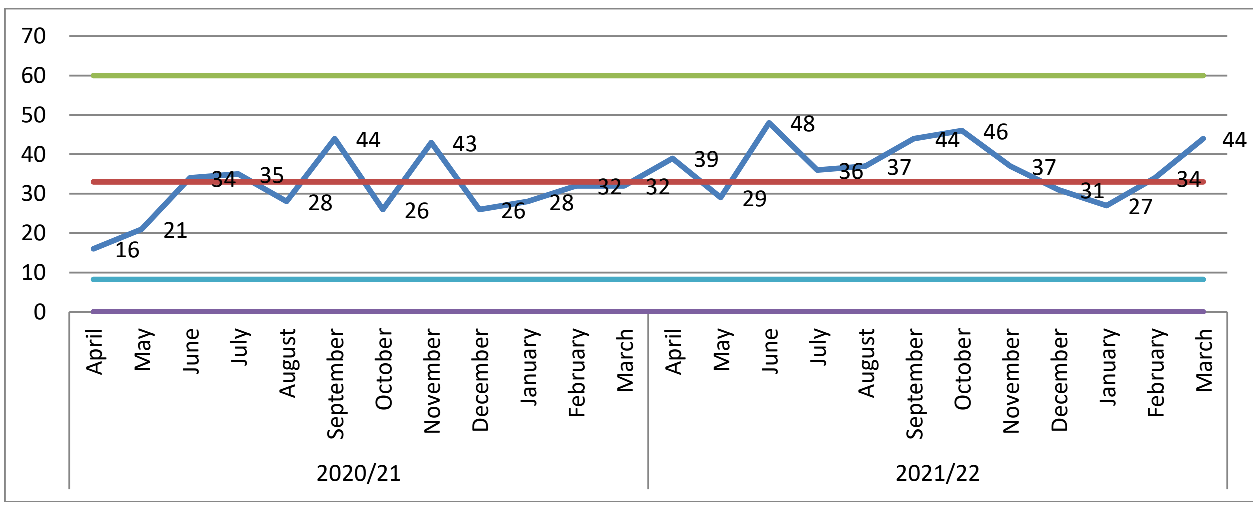


Fig 1

7.2 The Trust received a total of 452 complaints in 2021/22 (up from 363 the previous year) an increase of 89 complaints from 2020/21.

7.3 In 2020/21 complaints received averaged just around 30 complaints a month. In 2021/22 this increased to over 37 a month. April, June and October 2021 saw significant numbers of complaints, above levels seen previously, however no strong correlation could be established to explain the increased numbers for this period of the year.

7.4 40 new complaints had interest of outside organisations: 23 MP (Member of Parliament), 11 CQC (Care Quality Committee) and six for the ICS (Integrated Care System), previously known as CCG (Clinical Commissioning Group).

7.5 The last year has seen continued challenges due to the impact of the pandemic and changes to processes were required, in response to those.

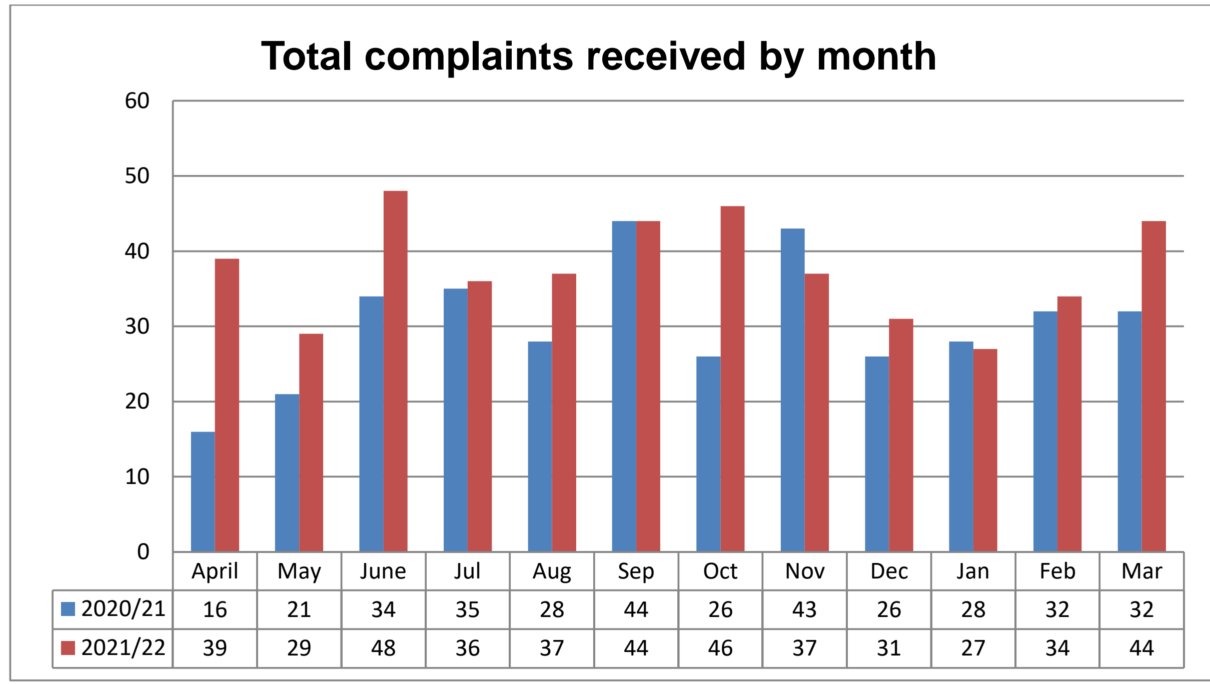
- Complaints are initially triaged by the Complaints team and at this point a decision is made as to whether the concern can be dealt with by the PALS team or Complaints Team. This ensures the concern is appropriately registered on Datix and managed by the most appropriate department depending on a number of factors that include complexity, level of investigation required and others.

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

- Ward staff continue to be proactive in resolving concerns before they escalate to formal complaints, however, there is variability in this practice from Division to Division, and within wards of the same Division. One of the influencing factors highlighted was the staff confident in stepping forward to deal with matters quickly and effectively, avoiding further escalation to PALS or Complaints.

8. Number of new complaints opened per month

Fig 2: breakdown of the complaints received by month.



	April	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2020/21	16	21	34	35	28	44	26	43	26	28	32	32
2021/22	39	29	48	36	37	44	46	37	31	27	34	44

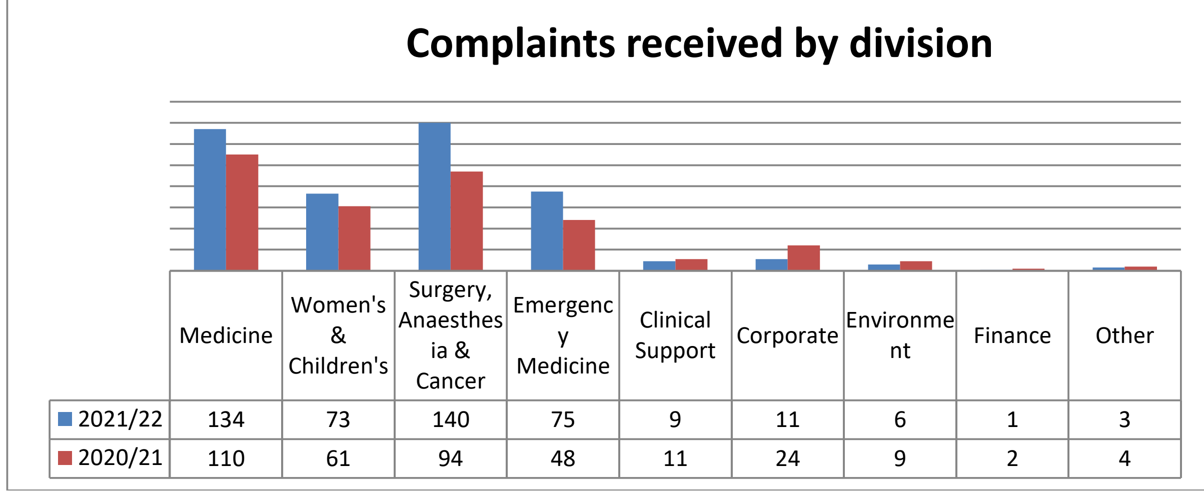
Fig 2

9. Complaints acknowledged within 3 working days

9.1 100% of complaints are acknowledged within 3 working days. This is compliant with the NHS England complaints process.

10. Complaints received by Division by year

Fig 3: *complaints broken down by division FY 2020/21 and 2021/22*



	Medicine	Women's & Children's	Surgery, Anaesthesia & Cancer	Emergency Medicine	Clinical Support	Corporate	Environment	Finance	Other
2021/22	134	73	140	75	9	11	6	1	3
2020/21	110	61	94	48	11	24	9	2	4

Fig 3

10.1 All clinical divisions saw a significant increase in complaints being received during 2021/22, this was inverted in nonclinical Divisions, who saw a decrease

10.2 Surgery, Anaesthetics and Cancer (SAC) complaints increased by 46 complaints, this was linked to surgical procedures being postponed as a result of the Covid19 pandemic.

10.3 The division of Women's and Children's Services (WACS) saw a slight increase in the past year, while Emergency Medicine saw a significant increase. There was a considerable decrease in corporate complaints.

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

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

11.2 As part of the bi-annual publication of Data on Written Complaints, released on 7 July 2022, NHS Digital described plans to review the frequency of both the KO41a collection and subsequent publication. During this review, they engaged with a number of individuals and user groups to understand the impact a move to annual frequency of both elements might have.

11.3 NHS Digital has formally confirmed that we will not be collecting data for 2022-23 quarters 1 and 2 - as per previous year's schedule (originally scheduled for collection in early October 2022). Instead, we will collect data shortly at the end of 2022-23(around April/May) and be asking for data that spans the entire year, moving away from quarterly intervals. This data will then form a combined annual publication with the Primary Care data as collected in the KO41b.

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

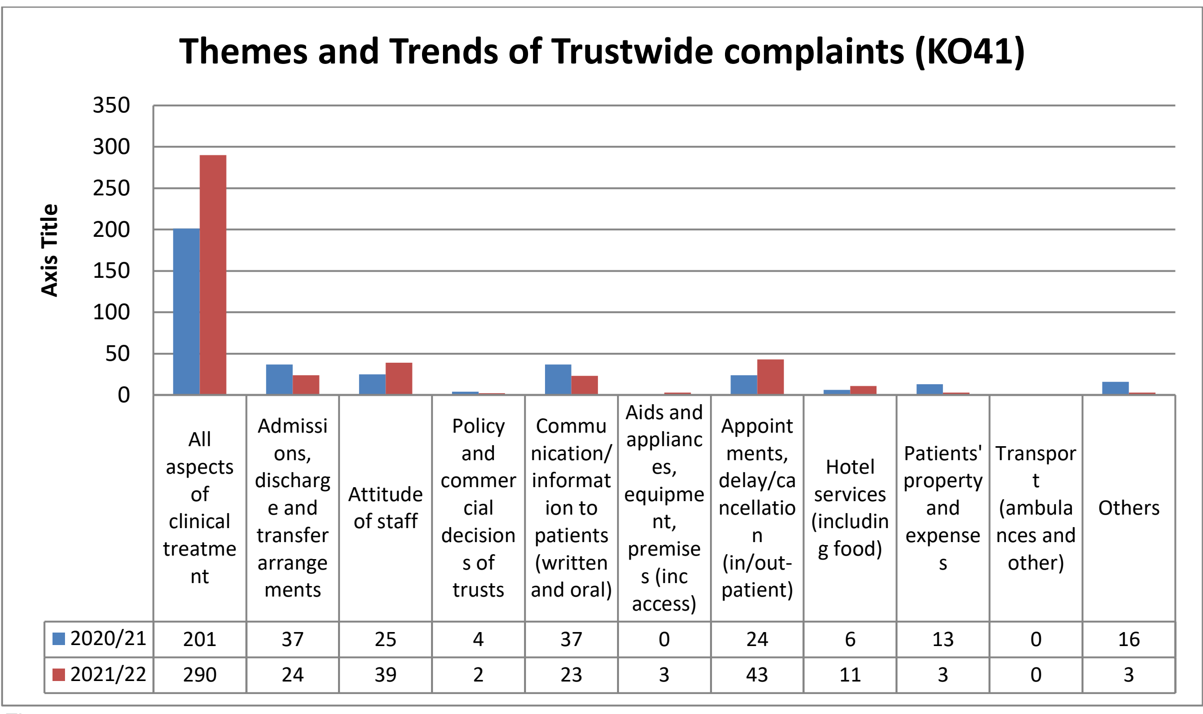


Fig 4

11.4 Complaints received by Support Divisions by month

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

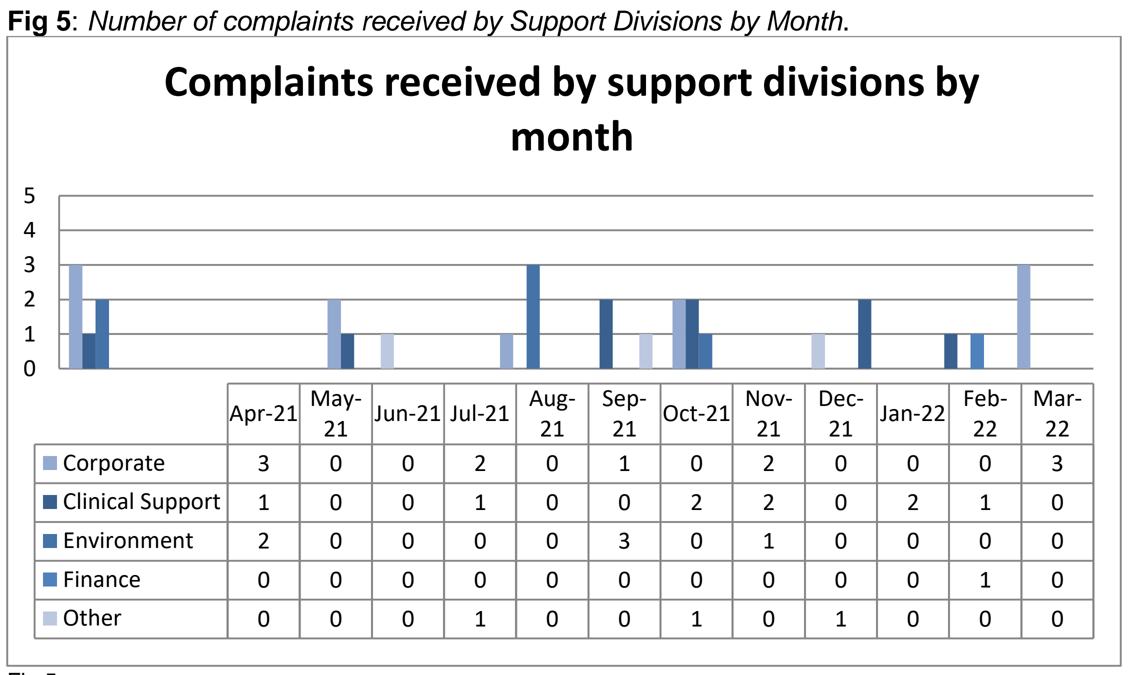


Fig 5

11.5 Themes of complaints received by the Environment Division

Complaints received were very few and primarily around difficulties around car parking, including handling of disputes by security staff.

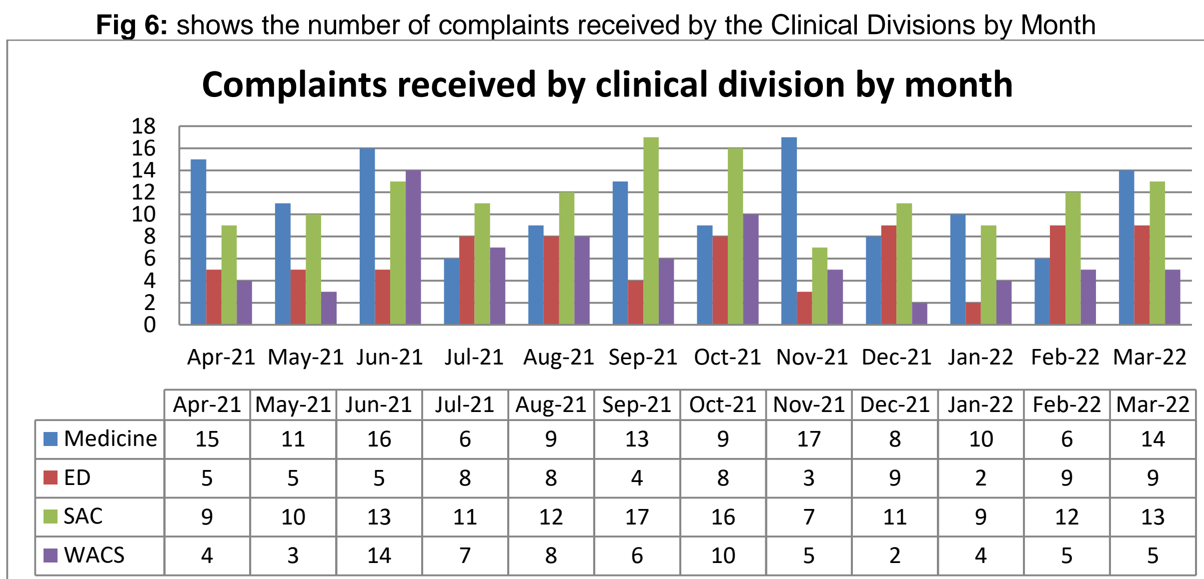
11.6 Themes of complaints received by Clinical Support Services

There were no specific themes identified due to the limited complaints received.

11.7 Themes of complaints received by the Corporate Division
Complaints were around outpatient appointments which included delay in being seen and dissatisfied with outcomes of appointment.

12. Complaints received by Clinical Divisions by Month

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



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Medicine	15	11	16	6	9	13	9	17	8	10	6	14
ED	5	5	5	8	8	4	8	3	9	2	9	9
SAC	9	10	13	11	12	17	16	7	11	9	12	13
WACS	4	3	14	7	8	6	10	5	2	4	5	5

Fig 6

12.1 Themes of complaints received by the Division of Surgery Anaesthetics and Cancer
Trauma and Orthopaedics received the highest number of complaints, 40 (29%) followed by General Surgery, 32 (23%). Complaints related to all aspects of clinical care, including lack of pain relief, poor treatment, incorrect diagnosis, failure to diagnose, missed fractures and delays in treatment and care, cancellations of operations, continuity of care and attitude/communication from staff.

12.2 The Division acknowledge that Trauma and orthopaedics have received the highest number of complaints for the past three years. Complaints continue to be reviewed each month as part of each Divisional Governance meetings.. Through this, learning is achieved from each complaint by means of a case review process, so that learning can be disseminated throughout the teams.

12.3 Themes of complaints received by the Division of Medicine.
Care of the Elderly received the highest number of complaints, 41 (31%) followed by General Medicine 35 (26%). Complaints continued to relate to poor care and treatment, missed diagnosis, communication, and attitude of staff, missed appointments, and concerns regarding nursing care.

12.4 All learning is captured by the division through their governance processes to assist with improvements in service delivery.

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

reviewed or discharged.

12.6 Themes of complaints received by the Division of Women's and Children's
Midwifery received the highest number of complaints 23 (31%) followed by Paediatrics 16 (22%) and Gynaecology 12 (16%). The complaints related to lack of post-operative care, lack of empathy, experiences in the delivery suite and staff attitude.

13. Complaint Outcomes

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

Fig 7: *number of complaint outcomes.*

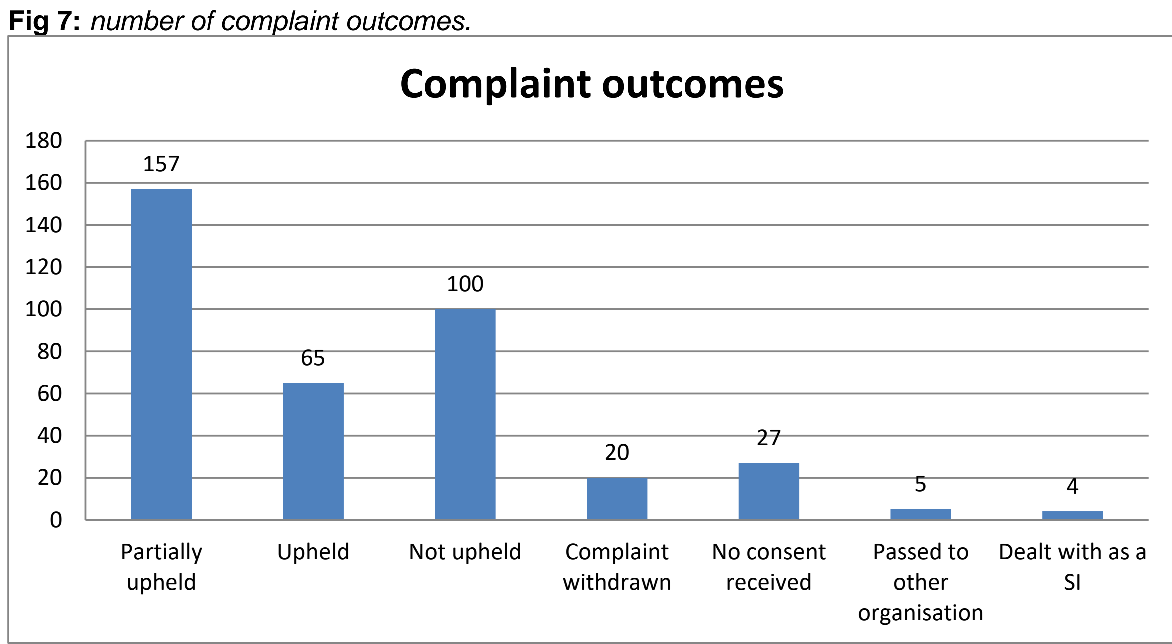


Fig 7

13.2 Not all complaints which are upheld or partially upheld require further actions to be completed. For example, this could be if system improvements/process changes have been internally identified and implemented prior to the receipt of the complaint , or in cases where there were minor issues, requiring no further specific action.

13.3 As part of the continuing review of processes and procedures the Complaints team have engaged with Divisions to ensure learning is captured and shared for all complaints received. This is ongoing as part of the 2022/23 work plan.

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

Surgery, Anaesthetics and Cancer – 64

Medicine – 66
Emergency Department – 43
Women's and Children's – 33
CSS - 7
Environment – 2
Other – 1
Corporate - 6

14. Reopened/Reactivated complaints

14.1 A complaint is categorised as re-opened or reactivated if the complainant is not satisfied with the Trust's first response and requests a further response to the issues raised. A total of 18 (5%) of the 386 complaints that were closed in 2021/22 were reopened for further investigation/response.

14.2 The Trust is committed to understanding why complainants remain dissatisfied with responses for further local resolution and is continually improving the way complaints are investigated and handled, to enhance complainant satisfaction and service user experience. As with previous periods, complainants request that their complaint be reopened as they consider that not all of their questions have been responded to fully; they raise additional issues having received the response to the original complaint and/or they do not agree with the information or findings in the complaint response.

14.3 Although the Trust seeks to resolve complaints and will ensure that in line with good complaint handling; if a complainant remains dissatisfied with the response, the Trust will seek to resolve the matter, however, it is accepted that in some circumstances it is not possible to do so, despite our best attempts and for these cases the matter can be further referred to the PHSO.

15. Complaints Performance

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

15.2 The Trust's target is to respond to 80% of all complaints within agreed timescales. Over the course of the year the number of complaints responded to within the agreed timescale declined from December 2021 although by the end of the period 2021/22 it averaged 81% for the 12-month period.

Fig 10: *Complaint response compliance April 2021 through to March 2022*

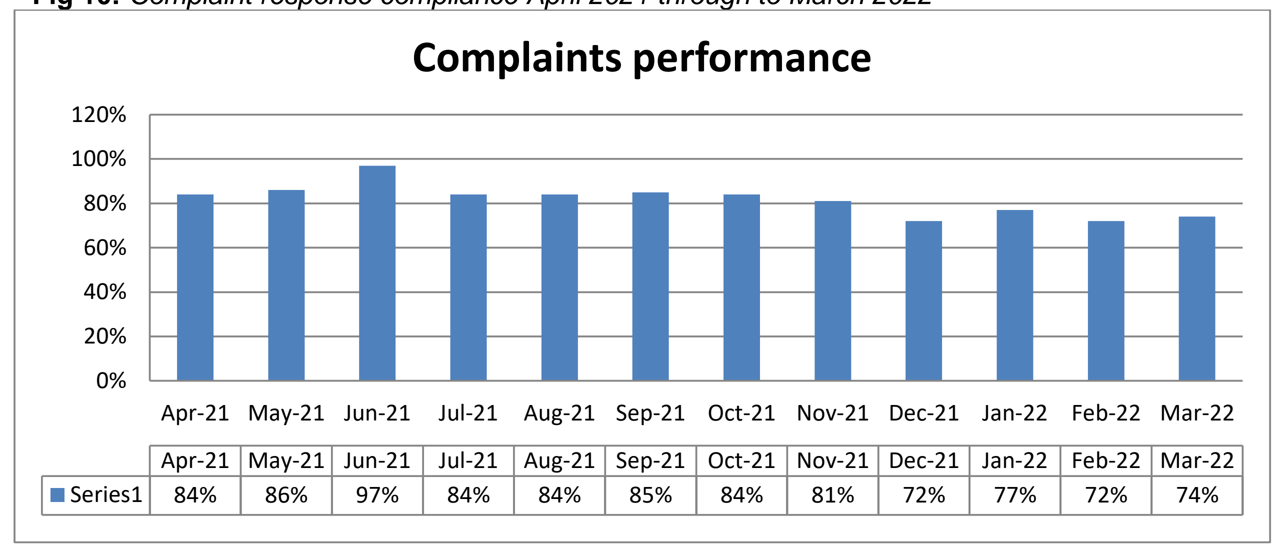


Fig 10

15.3 Divisional complaints performance is monitored weekly via a tracker and the current position regarding live complaints and monthly performance is circulated at the beginning of each week, highlighting key performance data for each Division, including open, received, and overdue complaints, broken down by Division/Department. The tracker is sent to the Divisional Managers, Assistant Divisional Managers, Heads of Nursing, Matrons and other key staff within the organisation. The document provides the Divisional leads with a weekly overview of all open complaints within the organisation and more specifically by Division.

15.4 Corporate Complaint Investigators/Advisors, who are each assigned responsibility over specific divisions, meet on a weekly basis with their divisional colleagues to address the performance of complaint investigations and to support the divisions. Despite the volume of complaints, the Trust receives, the team are implementing resilience pillars within their processes to prevent further backlogs.

16. Parliamentary and Health Service Ombudsman (PHSO)

16.1 During the period of 2021/22 two complaints were formally opened for investigation by the Parliamentary and Health Service Ombudsman (PHSO).

17. Learning from complaints

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

17.2 The action plans are reviewed at the Divisional monthly Quality and Governance meeting and actions are tracked and monitored. Divisions are responsible for ensuring that the learning from complaints and incidents is shared widely with all relevant staff. All Divisions have implemented local communication approaches, which have included the review of how

shared learning can be achieved across the organisation, utilising good practice for established areas. In addition to circulation within the Division, action plans are presented monthly to the Quality and Safety Group.

17.3 As a result of the Covid19 Pandemic, complaint learning events could not be held, however complaints manager attends the monthly Governance meetings for Surgery and Medicine, where learning has been shared.

17.4 At Local Resolution Meetings (LRMs) patients and families have been actively encouraged to share their experiences with staff. This remains a valuable engagement opportunity for staff to discuss concerns with service users and to understand how they experienced their care and treatment.

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

17.6 The Trust is planning to implement a more improved process to track learning against recurring themes, this is something that will be taken forward in collaboration with the Complaints Team and Governance Teams for each division.

17.7 Organisational learning from complaints

Although learning from complaints is recorded on Datix, the capture of how learning is implemented is reliant on Divisional input. Divisional Governance processes are in place however, there continues to be scope for improvement.

All Complaints relating to end-of-life care and treatment are presented to the End-of-Life Compassionate Care Panel. The complaints are reviewed and discussed at the meetings and learning is shared with the wider team and used to inform policy and practice as appropriate.

Summary of Complaint	**Summary of Learning**
ID:15212 Daughter has raised concerns that on discharge her father's chemist was emailed/faxed the incorrect medication information from WGH pharmacy which has meant her father has become very unwell and may need emergency care. Wants to know who made this decision to send the documentation and which doctor gave instructions to stop medication?	Discharge summary was prepared in advance of patients discharge, however, discharge was then delayed until the following day and not updated with further treatment decisions Learning: Any discharge summaries are to be reviewed prior to discharge to ensure that they are updated with the latest correct information especially as there were actions agreed by the team that patient's GP would have been expected to take forward, which also needed to be on the discharge summary.
ID:15112 Patient raised concerns following 2 visits to the UTC at Hemel Hempstead Hospital in July 2021. Following appointments with the physiotherapist at Connect Health she was made aware of a L2 vertebrae fracture.	Acknowledged that early recognition would have provided opportunity for better guidance on the management of pain, and also to explain the reason for its continuation.

Queried why she was not advised during initial visits to UTC	Reviewed at X-ray meeting and used as a learning and reflection for review of this type of X-Ray.
ID: 15195 Concerns from son of patient regarding his elderly mother's discharge and concerns that she was left with a catheter in place.	Acknowledged that there should have been better communication with family re discharge planning., including checking of addresses for referrals/community providers.

18. Complaints Key Achievements for 2021 – 2022

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

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

18.2 Enhanced capture of learning

The complaints team has undertaken discussions with all divisions regarding the capture of learning from complaints. Both Medicine and Surgery Divisions have implemented standing agenda items regarding the sharing of learning from complaints. Further work is being undertaken in respect of this remains ongoing throughout 2022/23

18.3 Review of Current Complaints Policy

There has been no change to the current complaints policy.

18.4 Reduction in overdue complaints

Although there have been challenges to meet compliance in responding to complaints by the agreed timeframe each month, the Trust ensures all overdue complaints are promptly dealt with. The Trust has not had overdue complaints by three months or more, to an average of one or two overdue at any one time.

Patient Advice and Liaison Service (PALS) and Interpreting Service

18.5 The aim of this section of the report is to provide assurance that West Herts Hospital Teaching Trust responded in a timely way to PALS contacts received during 2021-2022 and used the learning identified to improve services.

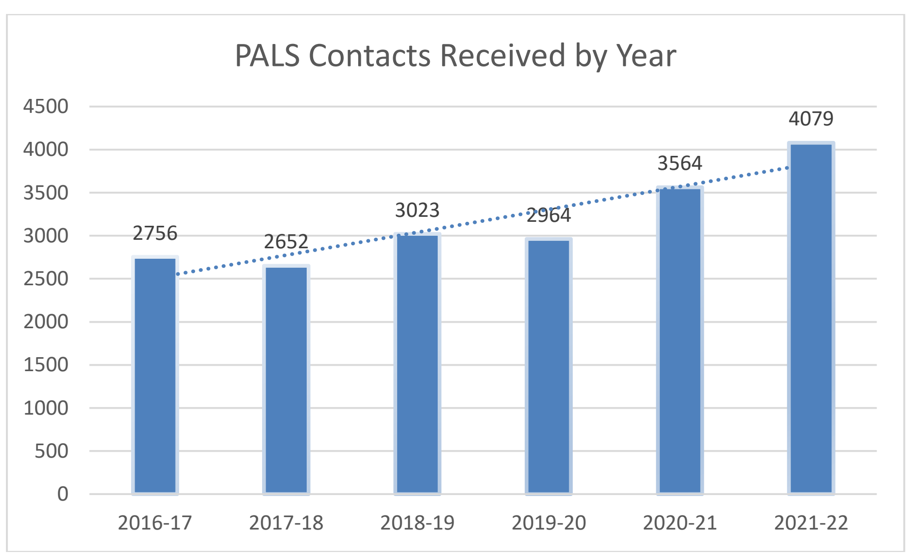
18.6 The PALS team initiated the use of local resolution meetings (LRMs) to help patients, families and staff understand the ramifications of concerns raised, and how seriously these are taken by the Trust, which has proven to be a valuable means of communication. The PALS team did not historically write to complainants followingLRMs, outlining any actions, however this has been reviewed and is now a standard procedure.

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

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

18.9 The data included in this report illustrates PALS overview of queries/contacts raised in the Trust.

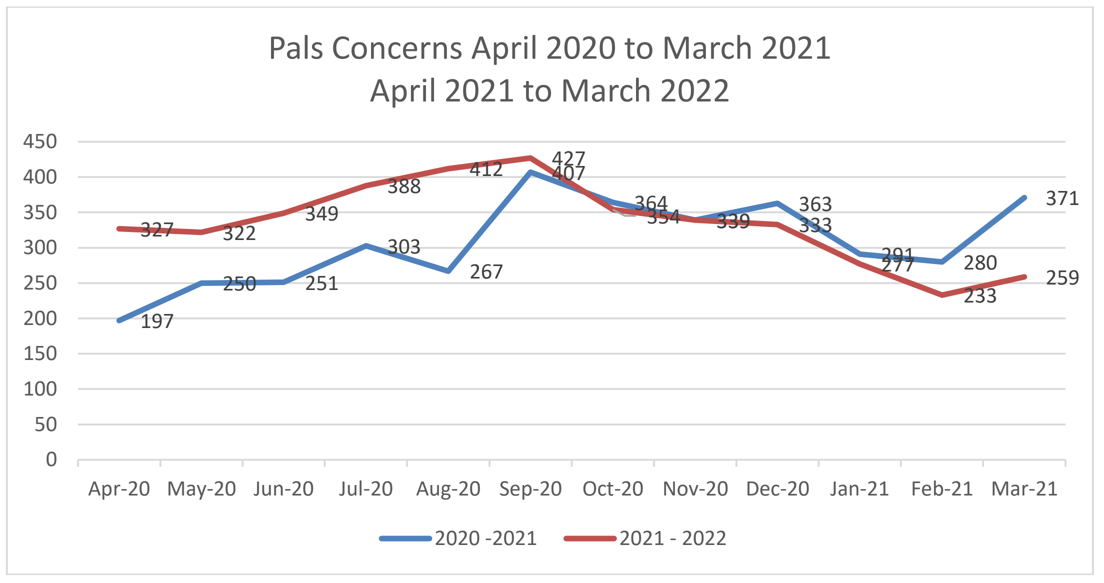
18.10 The following sections outline the activity carried out by the Patient Advice and Liaison Service over 2021-2022, with the number of cases and themes.



19. PALS activity Trust wide

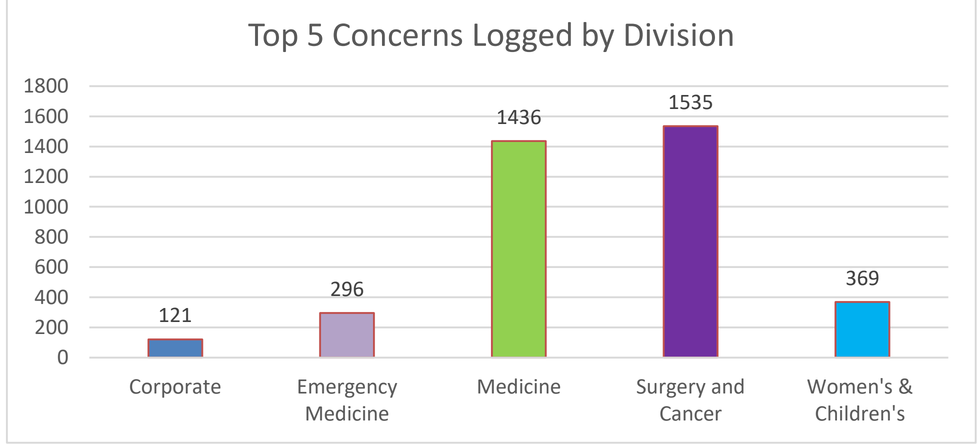
19.1 For the period year ending 31 March 2022 the number of contacts received was 4079; an increase of 1491when compared with 2020/2021.

19.2 The following graphs detail the PALS activity for 2020-21 compared to 2021-22 followed by a breakdown of the concerns by division and subject and the conversion of PALS concerns to formal complaints.



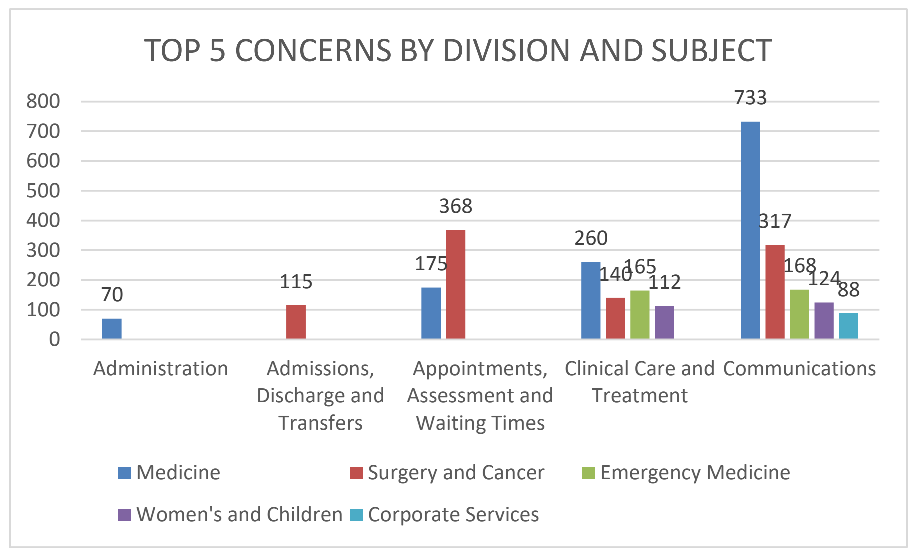
20. PALS top 5 concerns recorded by Division

20.1 The below graph demonstrates the concerns recorded by each Division, which shows Surgery division received the most concerns followed by Medicine which is a switch compared to 2020/2021 where the main division for concerns was Medicine.



21. PALS top 5 concerns recorded by Division and subject

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



22. Themes by Division update

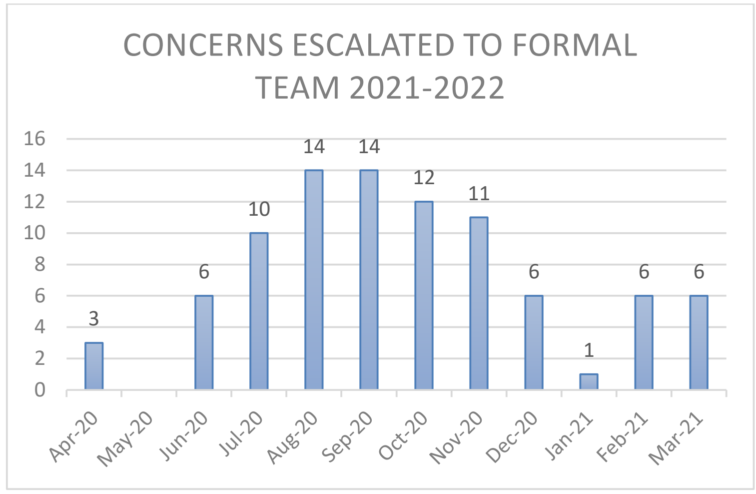
22.1 **Medicine** complaints were related to communication. Due to the pandemic this was more evident despite the instigation of the Family Liaison Line to support covid ward areas, iPads in the clinical.

22.2 **Surgery** the main concerns were regarding delay or lack of appointments. Appointment systems were reviewed and 'online' appointments were implemented. Admissions unable to schedule surgery dates due to waiting lists.

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

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

23. **PALS concerns to formal complaints department: the** PALS service will always aim to resolve concerns in the first instance and prevent patients, relatives, or carers from needing to engage in a lengthy complaint process, however despite early intervention by PALS and the divisional teams responsible for resolving concerns, some cases will progress to formal investigation.



24. Learning from PALS concerns

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

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

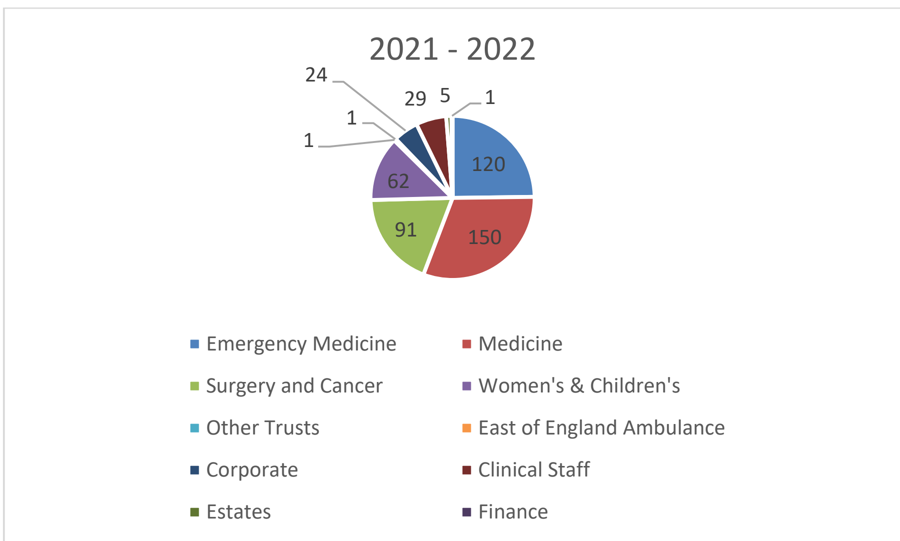
24.2 The PALS Standard Operating Procedure is a Key Performance Indicator (KPI) and reported on monthly as part of the Patient Experience & Carer Strategy dashboard.

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

25. Compliments received

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

25.1 There were 484 compliments logged for 2021-2022.



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

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

26. Interpreting & Translation

The PALS Team are responsible for arranging all requests for interpreters, using the Hertfordshire Interpreting & Translation Service (HITS). The contract with HITS was reviewed and awarded for the year 2021-2022 with an option to extend for 1 further year.

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

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

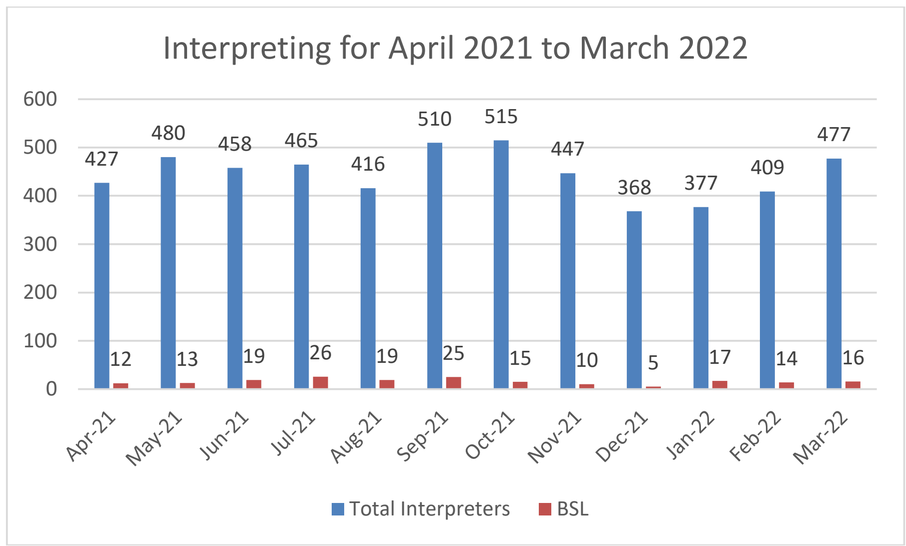
26.3 The PALS team met with Herts Translation & Interpreting Services (HITS) to review the process for requesting interpreters. They have developed an online system which is compatible with the Trust and free to use. This involves staff in ward areas completing a form 'online' and this automatically generates the request to HITs with a copy to PALS. This has been a successful rollout to all Divisions and has decreased the volume of phone calls to and from the PALS department, freeing valuable time in responding to concerns.

26.4 This has made a reduction on late cancellation fees as well as reducing paperwork. We have re-trained staff where they are not making full use of the online portal booking system.

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

26.6 The below graph demonstrates the monthly number of requests for the interpreting service

over the year 2021-2022. The grand total of requests for the Trust for the year is **5540,** which is an increase of 1427 from the previous year of 2020-2021.



27. PALS Key Achievements for 2021-2022

- Maintaining above 95% resolution of concerns within the Standard Operating Procedure (SOP) of 5 working days.
- Development of the online portal for interpreting requests throughout the Trust.
- Producing a Communication Box for all wards. This entails materials to aid patients with communication difficulties, i.e., translation, vision cards, hearing loops, Makaton cards, and other useful aids to help with communicating.
- Filled 2 vacant posts
- Availability of Pocket Talk Translating device for short notice interpreting.

28. Recommendation

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

Name of Director: Tracey Carter Chief Nurse

Date: November 2022

Trust Board
1 December 2022

Title of the paper:	**Annual Report for Serious Incidents and Never Events 2021/2022**
Agenda Item:	**26**
Presenter:	**Dr Mike Van der Watt, Chief Medical Officer**
Author(s):	**Mick Salami, Serious Incident Investigation Lead**
Purpose:	*Please tick the appropriate box* *For approval* | *For discussion* | *For information* √
Executive Summary:	This report presents an overview of the Trust performance against its key performance indicators of all serious incidents (SI) including Never Events (NE) reported between 1st April 2021 and 31st March 2022. The Trust reported **104** serious incidents externally via StEIS. The top five categories of all reported SIs are as follows: • HealthCare Associated Infection (HCAI)/Infection control incidents • Diagnostic incident including delay • Maternity/Obstetric incident: Baby only • Maternity/Obstetric incident meeting SI criteria: Mother only • Suboptimal care of the deteriorating patient Key points to note: • The Trust declared two Never Events during this period. • The Trust achieved 100% compliance against a target of 95% for reporting incidents onto StEIS within 48 hours from the date the decision was made. • The Serious Incident Review Group (SIRG) reviewed 30 completed serious incident investigation reports with new action plans in 2021/2022, including lessons learned and shared. • Key learnings have been identified from SIs reported. These include Diagnostic incidents including delay, Maternity/obstetric incidents and Sub-optimal care of the deteriorating patient. • An overview of COVID-19 Healthcare Associated Infections (HCAI) at West Hertfordshire Teaching Hospitals NHS Trust, and insight into the lessons learned. • The improvement plan for 2022/2023 includes further development of a learning culture across the trust, continuing to review all serious incidents action plans through the SIRG process.
Trust strategic aims: *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1** Best care | **Aim 2** Great team | **Aim 3** Best value | **Aim 4** Great place

	Objectives 1-4	Objectives 5-8	Objective 9	Objective 10-12
	✓			
Links to well-led key lines of enquiry:	☐Is there the leadership capacity and capability to deliver high quality, sustainable care? ☐Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☐Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues and performance? ☐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: Quality Committee Date: 24 November 2022			
Action required:	The Trust Board is asked to receive this report for information and assurance on the management of serious incidents including Never Events.			

Agenda Item: 26

Trust Board: 1 December 2022

Annual Serious Incidents & Never Event Report

Presented by: Dr Mike Van der Watt, Chief Medical Officer

1. Purpose

The purpose of this report is to provide:

1.1 Assurance that each potential serious incident (SI) has undergone a review process in line with NHS England's Serious Incident Framework (March 2015) national requirements and Trust policy.

1.2 An analysis of serious incidents and Never Events declared between 1 April 2021 and 31 March 2022

1.3 An overview of the key learning following serious incident and Never Event investigations.

1.4 An overview of COVID-19 Healthcare Associated Infections (HCAI) at West Hertfordshire Teaching Hospitals NHS Trust.

1.5 Next steps to continue improving organisational learning and ongoing management systems.

1.6 An introduction to the National Patient Safety Strategy, and the role of Patient Safety Specialists in the Trust, in supporting the Trust's transition and contribution towards the Patient Safety Strategy.

2. Background

2.1 Incidents

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

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

The Trust reviews each reported patient safety incident with level of harm rated "moderate or higher" against the NHS England's Serious Incident Framework (SIF) (March 2015). The Framework defines serious incidents as "an event in health care where the learning potential is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response'. Serious incidents can extend beyond incidents that affect

patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare."

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

2.1.1 All potential SIs are discussed in detail at SI panel meetings chaired by the Chief Medical Officer, Chief Nurse, or Associate Chief Nurse - Quality Assurance or the Deputy Chief Nurse. Key stakeholders from the divisions or other specialties are present and a full discussion is undertaken to provide the basis for decision making. This process ensures that a consistent approach to the application of the national SI criteria is achieved. At the end of the presentation of each potential SI, the level of harm, level of investigation and the responsibility for duty of candour are determined. The incident investigation will proceed until completion.

2.1.2 Serious Incident Process - Following completion of the incident investigations using the Root Cause Analysis (RCA) methodology, all serious incidents are reviewed through the Trust's governance arrangements and approved by the Executives. Thereafter, the incident reports are submitted to the Hertfordshire and West Essex Integrated Care Board (HWE-ICB) in accordance with the national SIF requirements. Following the submission, the serious incident investigation reports are made available to the patient or family, following the Duty of Candour Regulation 20 (Health and Social Care Act 2008 (Regulated Activities).

2.2 The Duty of Candour Revised Guidance, March 2021

The Care Quality Commission updated its guidance on the duty of candour in March 2021 to give a more specific explanation of what is defined as a 'notifiable' safety incident. A notifiable safety incident must meet all three of the following criteria:

- It must have been unintended or unexpected.
- It must have occurred during the provision of an activity we regulate.
- In the reasonable opinion of a healthcare professional, already has, or might, result in death, or severe or moderate harm to the person receiving care. This element varies slightly depending on the type of provider.

A crucial part of the duty of candour is the apology. The CQC update of March 2021 re-emphasises that the apology required to fulfil the duty does not mean 'accepting liability'. As noted in the NHS Resolution's 'Saying Sorry' leaflet, apologising will not affect indemnity cover. Thus, "saying sorry is:

- always the right thing to do
- not an admission of liability
- acknowledges that something could have gone better
- the first step to learning from what happened and preventing it recurring."

2.3 **COVID-19 Healthcare Associated Infections (HCAI) at West Hertfordshire Teaching Hospitals NHS Trust**

During the period from July 2020 to May 2021, a "2nd wave" of the COVID-19 pandemic resulted in a high number of admissions to the organisation. As a result, there was an increase in the number of COVID-19 Healthcare Associated Infections (HCAI) at West Hertfordshire Hospitals NHS Trust (the Trust). The peak of these infections occurred in December 2020 and January 2021 and were associated with a new variant identified at that time nationally.

A robust review process identified common themes across all these incidents. As a result, senior managers and Executives agreed it would be appropriate to conduct a thematic review of all nosocomial COVID-19 infections and associated deaths occurring between July 2020 and May 2021. This approach was agreed with the former Clinical

Commissioning Group (CCG) and discussed with NHS England (NHSE) Infection Prevention and Control (IPC) representatives.

There were 650 COVID-19 HCAI cases identified. Of these, 109 were categorised as SIs; these have been declared and reported externally. The review also includes twelve outbreaks and seven clusters identified during this period from July 2020 to May 2021. Of the twelve outbreaks, eight were declared as Serious Incidents (SI).

2.4 **The NHS National Patient Safety Strategy** (the strategy) published in the summer of 2019 and updated periodically to maintain the focus on evolving healthcare landscape and those activities that will have greatest impact on safety improvement with the most recent update in February 2021.

2.5 The role of the Patient Safety Specialist (PSS) was identified as part of the Strategy and the role became a contractual requirement within the NHS Standard Contract 2021/22 Section 33.7 in March 2020, and section 39.11 in the March 2022 guidance. This places a responsibility on NHS organisations to designate one or more PSS in line with the recommendations and a requirement to notify the NHSE/I. In response to this, the Trust has identified and registered 4 Patient Safety Specialists with NHSE/I .

2.6 There is an expectation for the Patient Safety Specialists to support the implementation of the NHS Patient Safety Strategy Improvement programmes and the delivery of the Patient Safety Syllabus during 2022/23.

3. Analysis and Discussion

3.1 **Serious incidents reported in 2021/2022**. A total of 104 serious incidents were reported between 1 April 2021 and 31 March 2022. Of these, HCAI/Infection control incidents (Covid-19) accounted for 53.8 % (56), i.e. 40 in June 2021 and 16 in July 2021.

3.2 The graph below shows the total number of serious incidents (SIs) reported per month in 2021/2022 in comparison with 2020/2021.

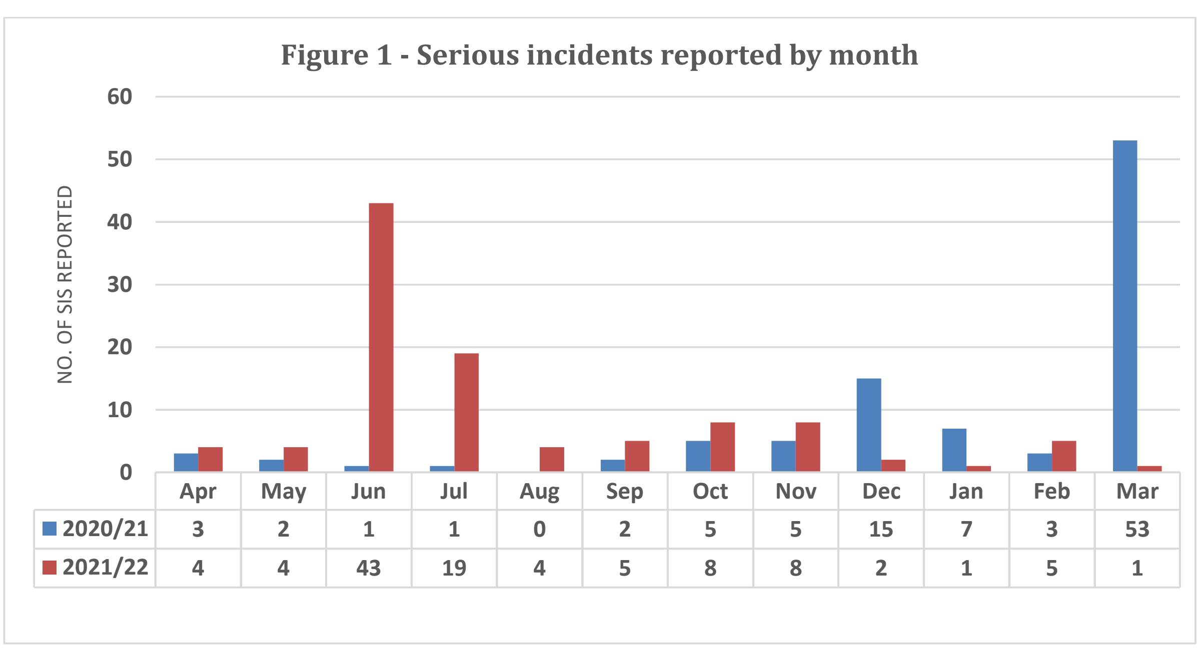


Figure 1 compares the total number of serious incidents (SIs) reported per month in 2021/2022 against 2020/2021.

4.1 Serious Incidents Panel meetings held between 1 April 2021 and 31 March 2022

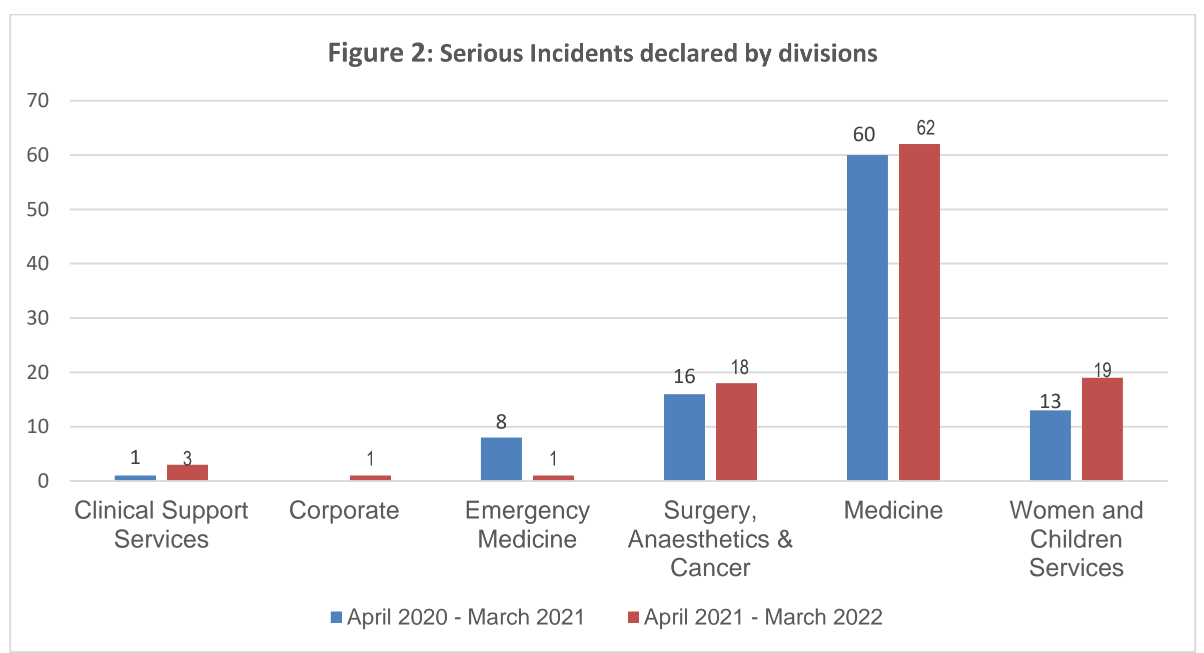
311 potential incidents were presented to SI panel in 2021/2022, compared with 197 in 2020/2021. The increase in total number presented to SI Panel meeting is indicative of prompt reporting of potential SI by all divisions.

Table 1 presents the total number of incidents brought to the SI panel and those confirmed as SIs.

Division	April 2020 – March 2021		April 2021 – March 2022	
	Incidents considered at SI Panel	Number Confirmed as SI	Incidents considered at SI Panel	Number Confirmed as SI
Corporate	1	0	2	1
Emergency Medicine	27	8	23	2
Medicine	60	60	77	62 (incl. 57 Covid-19)
Surgery and Cancer	51	16	51	20 (Incl. 11 Covid-19)
Women's and Children's	52	13	137	20
Clinical Support Services	6	1	9	3
Incidents downgraded				(4)
Total	197	98	311	104 (excluding incidents downgraded)

Table 1. Total Number of SIs including Never Events.

Figure 2 below, shows the number of SIs reported by month. Overall, an average of 8.6 SIs were reported per month in 2021/2022 which is slightly higher than 8.1% of the SIs reported per month in 2020/2021.



The reporting pattern shows a consistent, but comparatively higher number of incidents reported by the Medicine division in 2021/2022 compared with 2020/2021, than other divisions. These relate to HCAI/Infection control (mainly Covid-19) incidents. Medicine division reported 62 SIs in

2021/2022 compared with 60 reported in 2020/2021. The number of incidents reported by Women and Children Services (19) is comparable to Surgery, Anaesthetics and Cancer which reported 18 in the same year under review.

Categories of Serious incidents reported in 2021/2022 by type are summarised below. The top five categories are:

1) HCAI/Infection control incident meeting SI criteria (66)
2) Diagnostic incident including delay (10)
3) Maternity/Obstetric incident: Baby only (8)
4) Maternity/Obstetric incident meeting SI criteria: Mother only (6)
5) Suboptimal care of the deteriorating patient (6)

More details showing the breakdown by categories can be found in Appendix 1

4.2 Never Events Reported between 1 April 2021 – 31 March 2022

Two Never Events were reported by the Trust during the reporting year. Medicine and Women and Children divisions reported one each. Detail of the Never Events by division and StEIS category is shown in **table 2.** These incidents have been submitted to the HWE ICB.

Division	Never Event - Incident Category Criteria	Month Reported	Number reported
Women and Children Services	Retained swab (Maternity/Obstetric incident : Mother only)	May 2021	1
Medicine	Wrong lesion removal (Surgical/invasive procedure incident)	February 2022	1

Table 2 –Never Events Reported by Division and the StEIS category

4.3 Key learning identified and actions implemented as a result of SI investigations in 2021/2022

4.3.1 The Trust continues to strengthen and improve the approaches used to share learnings from SIs and monitor the implementation of all actions arising from investigations. Several learning points from SI actions have led to changes in the Trust's processes and procedures. Some of these can be found below in **table 3.** The corporate team will continue to work with the divisions with a focus on themes of learning which can be applied across the organisation.

4.4 Shared Learnings from Covid-19 serious incidents

4.4.1 Attempts were made to establish engagement with families of deceased patients and directly with the patients where applicable. Individual queries and concerns raised by patients' families were addressed through individual responses or meetings with the patients or their families. The table below shows some of the lessons learned and actions taken from the Covid-19 thematic review.

Table 3: " Extract from the Covid-19 thematic review report July 2020 to May 2021 – The Action plan"

Issues or Recommendations	Actions taken
Ensure there is consistent compliance against standards of IPC practice including PPE compliance in all clinical areas	• Implement IPC Support and education programme • Provide visual posters, intranet updates • Continue and review IPC auditing

	programme
Review allocation of staff to dedicated areas preventing further risk of transmission of COVID-19	Review staffing to ensure staff including enhanced care workers are allocated to designated area
Regularly review ventilation systems and ensure oversight	• Ventilation risk assessments to be undertaken and reviewed at IPC/Estates joint meetings • Oversight from AE and use of technology including HEPA filters to assist with improvements to ventilation
Maintain effective communication with relatives whilst visiting restrictions are in place	• Implementation of 'Family Liaison Line' • Introduction of iPads for use by patients with support of FLT

Table 4 - Key Learnings from classic serious incidents - 1 April 2021 to 31 March 2022

Serious Incidents/ Never event	**Action Taken**
Surgical/invasive procedure incident meeting SI criteria	
Retained Swab - Never Event . DW154189	• All staff completing any invasive surgical procedure for non-theatre cases in maternity, to count all items in the delivery and suture packs before and after the procedure contemporaneously. • The white board must be utilised as part of the procedure for swab counts. • the local procedure should be followed to prevent any errors when counting. It appeared that delivery pack was not removed prior to opening the perineal pack.
Wrong lesion removal - DW168643	• Ensure all Dermatology staff have access to the appropriate applications (including Infoflex) and electronic patient record (EPR) systems with training to be arranged where the need is identified • Medical photography of patients' skin to be taken for uploading to the patients' electronic patient record (EPR) to prevent any potential for a mix up to occur regarding the correct lesion to be excised • Non-consultant Dermatology staff to consult with a consultant colleague prior to performing minor surgical procedures in the absence of adequate clinical information
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	
Discharge on Low sodium - DW140199	• Draft admission summaries should not include any information which is not correct at the time that the draft is prepared and should clearly be marked as draft. • Appropriate action should be taken to contact the patient and/or their family in the event that a patient is discharged in error.
Delayed Surgical Review - DW143790	• Although it is 'common practice' is to make direct referrals between the various specialities, via bleep /telephone system, formal referral processes should be followed in addition to the direct contact method. • General Surgery should accept referrals for surgical sub

Serious Incidents/ Never event	Action Taken
	specialities or provide support for the referral process. The Surgical team could have exercised some degree of flexibility i.e. interim management of sub-speciality conditions, to the point where the Upper GI Surgery Team took over care of the patient.
Sub-optimal care of the deteriorating patient meeting SI criteria	
Fatal PE **Dw137511**	• The need for clear communication between teams • The importance of to give the bolus dose as soon as possible once a diagnosis is confirmed • To ensure the infusion is commenced immediately after bolus • Escalating any barriers to ITU admission • Consider use of thrombolysis to treat a reversible cause during cardiac arrest • Adherence to procedure to notify Patient Affairs after a patient dies in the department.
Maternity/Obstetric incident meeting SI criteria: baby	
Management of Pre-eclampsia (DW150036)	• As early as booking, pregnant women should be given information on when to call the Maternity department for advice • Ambulance crew attending pregnant women should consult with the Maternity Department to discuss observational findings, immediate treatment required and place of arrival. • Early onset severe pre-eclampsia is uncommon but severe hypertension in a pregnant woman from 20 weeks onwards should be treated as pre-eclampsia until proven otherwise.
Delay in Delivery DW149976	• Staff must be reminded of the predisposing factors, signs of symptoms of preterm labour and the associated additional risks caused by of malpresentation. Case to be presented at local governance meetings to share learning. • Junior staff must ensure that the consultant on call is informed of all admissions with malpresentation and threatened preterm labour. • Core midwife on delivery suite should ensure that they accept high risk women without delay when appropriate. • Any patient with a CTG showing bradycardia or where irreversible cause of fetal hypoxia is suspected should be transferred directly to labour ward theatre. If after assessment emergency LSCS if found to not indicated, this can be downgraded.
Medication incident meeting SI criteria	
Adrenaline Overdose **DW150300**	• The administration of intravenous Adrenaline for the management of anaphylaxis should only be administered by a consultant/under the supervision of a consultant or if a member of the ITU is present. • A re-reiteration of the Anaphylaxis guidelines to all doctors in the Trust is required.

4.5 Monitoring Compliance for the implementation of Actions from Serious Incidents.
The Serious Incident Review Group (SIRG) is chaired by the Deputy Chief Medical Officer and meets every two months. The Panel is responsible for ensuring that the actions resulting from investigations have been completed and has valid supporting evidence of learning prior to closure. The divisional teams are invited to attend and present the evidence. **Table 5** provides an overview of the number of serious incident reports submitted and closed SI action plans as received by SIRG during 2021/2022.

Table 5 – Action Plans Presented to SIRG

	Apr-May 2021	June-July 2021	Aug-Sept 2021	Oct-Nov 2021	Dec'21-Jan 2022	Feb-Mar 2022	Total
Serious Incident Reports presented at SIRG for the first time	4	7	1	10	2	6	30
Outstanding actions presented at SIRG	2	4	1	7	2	11	27

There was an increased emphasis to ensure the divisions responded to requests from patient safety department to review all outstanding action and evidence to support the actions.

Thirty incident reports with new set of actions were presented at the SIRG meeting for the first time in 2021/2022, including some which were outstanding from the previous financial year. Actions “outstanding” or “partially completed” are captured within the monitoring arrangements of SIRG. Items with completed actions are removed from the action log, only when all evidence is submitted.

4.6 Performance against Key Performance Indicators (KPI’s) (Serious incidents & NE)

The Commissioners agreed to a target of 95% compliance for reporting a serious incident onto StEIS within 48 hours from the date the decision was made. Compliance with this indicator is monitored every month and reported through the Trust’s governance arrangements. Trust performance was much higher during the reporting year than the previous year as all incidents were raised to StEIS within 48 hours of the incident being confirmed as SI.

However, in the year under review, all the challenges associated with covid-19 pandemic persisted and made it difficult to deliver serious incident investigations timely. Other reasons included limited staff capacity within the serious incident investigation team, and other factors such as trust-wide staff changes and the difficulties in accessing clinicians and other professionals in a timely manner. Since the abatement of the effect of Covid-19 pandemic, the dynamics is beginning to ease off and the serious incident investigation department has begun to look into quality improvement initiatives to enhance the delivery of SI workstreams. The productivity of the serious incident departments has been buoyed by extra support from the senior management and collaborative working with the corporate team, among other things. The expectation is that there will be improved performance against the KPI’s in 2022/2023.

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

	% Target	% Actual performance
Compliance against 48hrs target	95	100
Percentage of SIs submitted to HWE-ICB within 60 days	95	0

4.7 The Duty of Candour – Compliance 2021/2022

All serious incidents reported onto StEIS require the division of origin to allocate a Duty of Candour leads responsible to communicate directly with patients or their families to ensure timeliness, openness and transparency; and to be the Trust's link. The written notification for SI's is undertaken by the SI team in collaboration with the divisional leads.

The compliance against the Duty of Candour during the year of 2021-2022 continues from month to month, i.e. with evidence of 100% compliance, except in October and November 2021. Overall, the Trust achieved 100% compliance in 100 out of 106 cases. This is equivalent to 94.3 % compliance during 2021/2022 compared to 85% compliance in the previous year. The deficit in compliance is due, largely, to the difficulties in accessing appropriate individuals - patients or next of kin to enable the Trust to deliver the Duty of Candour responsibilities. The Quality governance team has continued to work collaboratively with the Divisions and enabled exchange of feedback through the Governance Operational Group meeting that holds monthly.

Table 7 – Serious Incidents - compliance against Duty of Candour.(DoC)

Month	No. of DoC letters*	Percentage compliance with DoC
April 2021	4 (of 4)	100%
May 2021	5 (of 5)	100%
June 2021	43 (of 43)	100%
July 2021	20 (of 20)	100%
August 2021	4 (of 4)	100%
September 2021	5 (of 5)	100%
October 2021	7 (of 8)	87.5%
November 2021	3 (of 8)	37.5%
December 2021	2 (of 2)	100%
January 2022	1 (of 1)	100%
February 2022	5 (of 5)	100%
March 2022	1 (of 1)	100%
Average	100* (of 106)	94.3%

*DoC letters sent in timely manner.

4.8 Quality Improvement Plan for Serious incidents in 2021/2022 and 2022/2023

As part of Quality improvement, the Trust promotes ongoing new initiatives such as weekly harm reviews, both divisionally and trust wide. The Chief Nurse has oversight of serious incident activities through monthly meetings with the Patient safety (SI) team to monitor progress and areas of challenges in order to focus on and clear backlog of overdue RCA investigation reports which had increased during the covid-19 pandemic period. These activities have helped the understanding and review of processes to enhance the management of patient safety incidents and the Trust's involvement in patient and family engagement.

Key Learnings and Actions identified:

- Action plans and organisational wide learning
  - To further develop the learning culture within the Trust; cross-divisional and Trust-wide learning.
  - Patient safety incident discussions occur in governance and departmental meetings.
  - Increased awareness of patient safety incidents, training, and the sharing of lessons learned.

- To promote the take-up of patient safety e-learning during induction activities for all staff trust wide
- To continually review all serious incidents through the SIRG process and ensure lessons are learned, and actions have been implemented.
- To make completed serious incident available through the Trust Intranet for ease of access to all staff
- To continually promote and share identified themes and trends in the weekly harm review meetings chaired by the Chief Nurse to ensure prompt actions

- Duty of Candour – moderate harms and higher
  - There are systems and processes to ensure that moderate harm incidents are managed in accordance with DoC requirements need to be strengthened, particularly documentation of DoC on our incident management system (Datix).
  - Supporting and encouraging staff to attend conferences and seminars on the Duty of candour processes and Family engagement, among other courses.
  - To continue engagement with the divisions to encourage ownership of requisite governance processes.

- National Patient Safety Strategy
  - The Trust has four designated Patient Safety Specialists (PSS) working in collaboration with the regional PSS group. This is led by - led by the Associate Chief Nurse – Quality Assurance.
  - The Patient Safety Specialists will support the implementation of the NHS Patient Safety Strategy Improvement programmes and the delivery of the Patient Safety Syllabus during 2022/23.
  - The Trust has adapted an e-learning programme developed by the Health Education England (HEE),which the Trust has made available to all staff – This is referred to as the Essentials of Patient Safety - Level 1.
  - The Patient Safety Specialist priorities are being planned to ensure that, as a Trust, we benchmark our position against the strategy in readiness for the full implementation anticipated to commence from April 2023 onward.

4.9 Summary and Conclusion

- A total of 104 were confirmed as SIs in 2021/2022, an increase by more than 6% compared with 98 SIs reported in 2020/2021.
- The top five categories of all reported SIs by category were “HCAI/Infection control incident meeting SI criteria”, “Diagnostic incident including delay”, “Maternity/Obstetric incident: Baby only”; “Maternity/Obstetric incident: Mother only" and “Sub-optimal care of the deteriorating patient"
- The Trust declared 2 never events during this period
- The Trust achieved 100% compliance against a target of 95% for reporting incidents onto StEIS within 48 hours from the date the decision was made.
- Key learnings have been identified from incidents such as treatment delays, maternity/obstetric incidents, HCAI/Infection control incidents (Covid-19) and Never Events.
- The Trust has adapted and made available patient safety e-learning level 1, as part of the national patient safety strategy to all staff.

5 Risks

5.1 Risks linked to the serious incident process.

5.2 3950: Failure to comply with duty of candour for all incidents causing moderate harm or above. Current Risk score = 9

Mitigations are in place which include policy available on Trust intranet; provision of training and resources to staff; provision of DoC status reports to divisions; and monitoring of DoC by the corporate governance team.

6 Recommendations

The Trust Board is asked to receive this report for information and assurance on the management of serious incidents including Never Events.

Director: Mike Van der Watt,

Title: Chief Medical Officer

Date: 14, November 2022

APPENDICES:

Appendix 1

Serious Incidents Reported to StEIS by category during 2021/22

SI Category	2020/2021	2021/2022
HCAI/Infection control incident meeting SI criteria	61	66
Diagnostic incidents including delay	6	10
Maternity/Obstetric incident meeting SI criteria: mother and baby	-	8
Maternity/Obstetric incident meeting SI criteria: Mother only	-	6
Suboptimal care of the deteriorating patient	3	6
Surgical/invasive procedure incident meeting SI criteria	5	3
Slips, Trips & Falls meeting SI criteria	3	2
Maternity/Obstetric incident meeting SI criteria: baby only	12	1
Abuse/alleged abuse of adult patient by staff	1	1
Confidential information leak/information governance breach	-	1
Medication incident meeting SI criteria	4	-
Treatment delay meeting SI criteria	1	-
Apparent/actual/suspected self-inflicted harm meeting SI criteria	1	-
Medical equipment/ devices/disposables incident meeting SI criteria	1	-
Total	96	104

Trust Board Meeting
1st December 2022

Title of the paper	Finance update M7
Agenda Item	27
Presenter	Don Richards, Chief Financial Officer
Author(s)	Don Richards, Chief Financial Officer
Purpose	*For approval*: — / *For discussion*: √ / *For information*: √
Executive Summary	The purpose of this report is to provide the Trust Board with information to support short and longer-term financial health assurance. The report covers: - The Trust's revenue, capital and cash flow performance for the first five months of the year. - The income and expenditure forecast to the end of the 2022/23 financial year. - The current value of Trust assets and liabilities. - The approach for longer term financial planning under the new financial regime. After seven months of the financial year the Trust reports total income of £278.7m and costs of £284.4m leading to an increase of the year-to-date deficit to £5.7m (£0.6m larger than last month). This performance is £0.5m adverse to the trajectory set out at the beginning of the year. However, our last report to Finance Committee had anticipated a deficit as high as £5.9m this month. Despite our deficit being £0.5m adverse to the original trajectory we still expect to balance income and expenditure (break-even) by the end of the year. The continued recognition of Elective Recovery Fund (ERF) income has been vital to maintaining acceptable I&E performance. We've accrued for £6.8m of ERF income for the first seven months of the year. This is in line with national confirmation that this income is payable regardless of recovery performance. The payment of ERF income while our elective activity remains behind target has however compensated for additional unfunded inflation pressures. The data suggests the ERF performance shortfall is due to a combination of less activity and a less dependent patients. However a material proportion of the variance will be improved as the quality of our data develops. (Eg recording

	outpatient procedures and outsourced activity appropriately following the introduction of the new electronic patient record system). There are offsetting variances within the year-to-date position despite the overall performance being in line with plan. COVID related costs reached £5.3m compared with year- to-date funding of £5.3m. This level of spend reflects the reduced number of COVID patients seen at the Trust and the concerted efforts to remove additional capacity introduced to support management of the pandemic. However, some of these costs still contribute to an overall medical staff overspend, now reaching £3.7m. Agency costs are an important indicator of financial efficiency. Our agency costs after 7 months totalled £9.5m. We had set ourselves a target to only spend £7.5m at this stage. However, £1.5m of our agency outlay can be directly attributed to changes necessary for managing COVID patients. CIPs continue to fall short of target and when combined with efficiencies expected from the EPR system, CIPs are still only expected to reach £13.6m compared to the total £17.9m expected (£15m general efficiencies and £2.9m EPR related). Additional developments to support capacity over the final 5 months of the year will have to be reviewed to support the break-even ambition. Although the performance remains in line with trajectory, the risk to break-even is heightened this month because of the scale of efficiencies expected to be achieved in the last five months of the year. The analyses show an expected increase in the income trajectory but a relatively large reduction (£6m) in the expenditure trajectory from: non-pay savings, agency cost reductions and a re-assessment of annual leave accruals. The balance sheet remains relatively unchanged, with relatively modest increases in payables and reductions in receivables. Cash balances at £33m are now lower than the £37m at the start of the year but this is in line with expectations. Capital expenditure at £5.5m after 7 months is falling behind the pace of spend needed to make full use of funds. Managers have provided assurance that spending on projects funded by internally generated funds (£20m) will match funding. However, we need to develop revised plans to ensure we fully use an anticipated further £20m of funds targeted for nationally supported priorities. The Trust continues to support the development of the ICS's medium term financial planning financial planning which will ultimately enhance the Trust's own long term financial plan. At this stage important financial variables are yet to be clarified including: the scale of reduction of COVID funds, the recurrent nature of elective recovery funding, the pace of change of ICB allocations to a need- based assessment of funding. This element of the report will be updated on a quarterly basis to support other plans and strategies. Financial management actions will continue to focus on: • Maximising the productive use of revenue funds to treat more elective patients. • Ensuring that funds reserved to manage COVID pandemic pressures are used efficiently.

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Developing general and EPR driven efficiencies to further mitigate the risks of a deficit financial plan.
Ensuring that financial governance is strong enough to minimise the risk of new financial pressures emerging.
Further development of the long-term financial model including supporting the ICS development of a medium term financial plan.

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<tr><td>Trust strategic aims</td><td>
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<tr><td>Aim 1
Best care

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

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

Objective 9</td><td>Aim 4
Great place

Objective 10-12</td></tr>
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☐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?
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<tr><td>Committee/Group</td><td>Date</td></tr>
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<tr><td>Action required</td><td>The Board is asked to note the contents of this report and approve the actions summarised in the cover sheet above.</td></tr>
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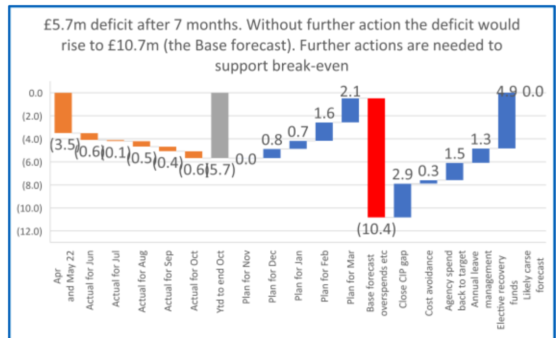
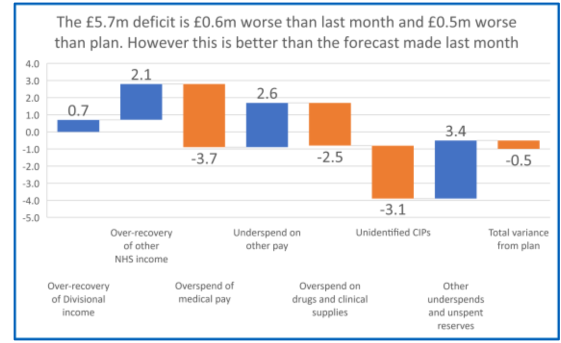
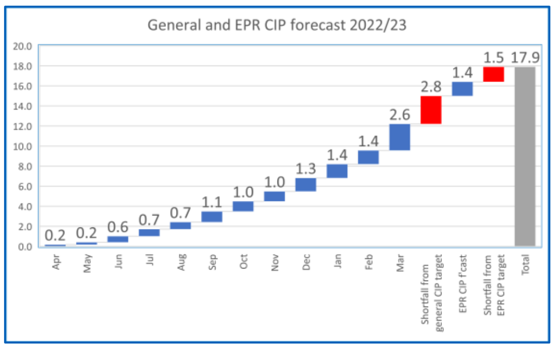
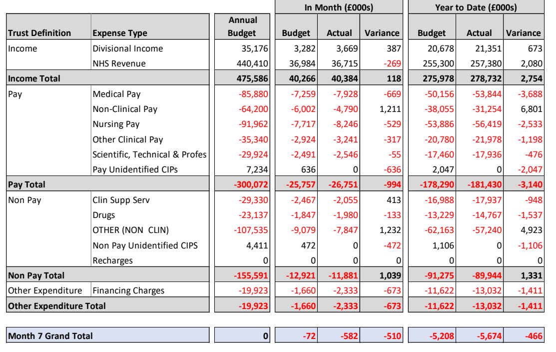
Month 7 Finance Report

The I&E account reports a £5.7m deficit after 7 months, £0.5m adverse to plan but we continue to forecast break-even by year –end.

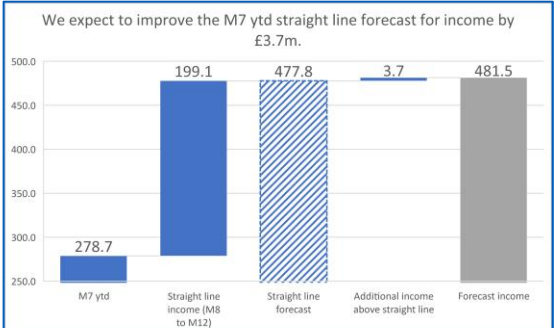


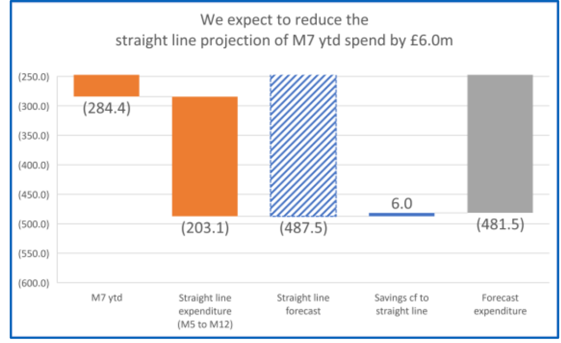






Trust Definition	Expense Type	Annual Budget	In Month (£000s) Budget	In Month (£000s) Actual	In Month (£000s) Variance	Year to Date (£000s) Budget	Year to Date (£000s) Actual	Year to Date (£000s) Variance
Income	Divisional Income	35,176	3,282	3,669	387	20,678	21,351	673
	NHS Revenue	440,410	36,984	36,715	-269	255,300	257,380	2,080
Income Total		**475,586**	**40,266**	**40,384**	**118**	**275,978**	**278,732**	**2,754**
Pay	Medical Pay	-85,880	-7,259	-7,928	-669	-50,156	-53,844	-3,688
	Non-Clinical Pay	-64,200	-6,002	-4,790	1,211	-38,055	-31,254	6,801
	Nursing Pay	-91,962	-7,717	-8,246	-529	-53,886	-56,419	-2,533
	Other Clinical Pay	-35,340	-2,924	-3,241	-317	-20,780	-21,978	-1,198
	Scientific, Technical & Profes	-29,924	-2,491	-2,546	-55	-17,460	-17,936	-476
	Pay Unidentified CIPs	7,234	636	0	-636	2,047	0	-2,047
Pay Total		**-300,072**	**-25,757**	**-26,751**	**-994**	**-178,290**	**-181,430**	**-3,140**
Non Pay	Clin Supp Serv	-29,330	-2,467	-2,055	413	-16,988	-17,937	-948
	Drugs	-23,137	-1,847	-1,980	-133	-13,229	-14,767	-1,537
	OTHER (NON CLIN)	-107,535	-9,079	-7,847	1,232	-62,163	-57,240	4,923
	Non Pay Unidentified CIPS	4,411	472	0	-472	1,106	0	-1,106
	Recharges	0	0	0	0	0	0	0
Non Pay Total		**-155,591**	**-12,921**	**-11,881**	**1,039**	**-91,275**	**-89,944**	**1,331**
Other Expenditure	Financing Charges	-19,923	-1,660	-2,333	-673	-11,622	-13,032	-1,411
Other Expenditure Total		**-19,923**	**-1,660**	**-2,333**	**-673**	**-11,622**	**-13,032**	**-1,411**
Month 7 Grand Total		**0**	**-72**	**-582**	**-510**	**-5,208**	**-5,674**	**-466**





The I&E deficit of £5.7m after 7 months is adverse to the trajectory set at the start of the year and was anticipated when reporting last month. The aggregate of Divisional forecasts leads the Trust to a £10.4m deficit by year end. Actions, including identifying savings up to targeted level, improve the forecast to break-even.

Two graphs at the bottom show a £3.7m improvement needed against a straight line income projection (largely due to winter and SD funds) and a £6m improvement needed against a straight line expenditure forecast (by CIP delivery, agency cost change, COVID cost reductions and improvements to year end liabilities) in order to achieve break-even.

Cost pressures on the Emergency Division increased in October. Recovery of patient care activity remains flat.

Surgery & Anaesthetics

% by month

% of income plan

% of expenditure plan

Environment

% by month

% of income plan

% of expenditure plan

Medicine

% by month

% of income plan

% of expenditure plan

Emergency Medicine

% by month

% of income plan

% of expenditure plan

WACs

% by month

% of income plan

% of expenditure plan

CSS

% by month

% of income plan

% of expenditure plan

The graphs above illustrate each Trust Division's performance against its income plan and expenditure plan. The aim is for each Division to achieve at least 100% of its income plan (blue line) and spend less plan 100% of its expenditure plan (red line). We aim for blue lines to be above red lines. Environment, Medicine and CSS Divisions are achieving. Emergency Division costs and Surgery Division elective activity compromise favourable performance. Hence the main focus of Divisional financial performance management is managing emergency costs and elective throughput.

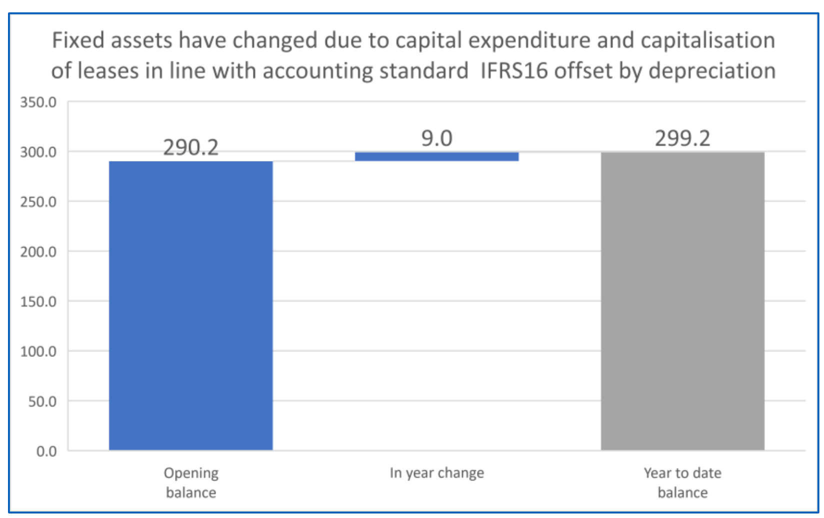
Our forecasts include anticipated inflationary pressures which the Trust plans to mitigate. Inflation estimates are to be refreshed for next month's report.

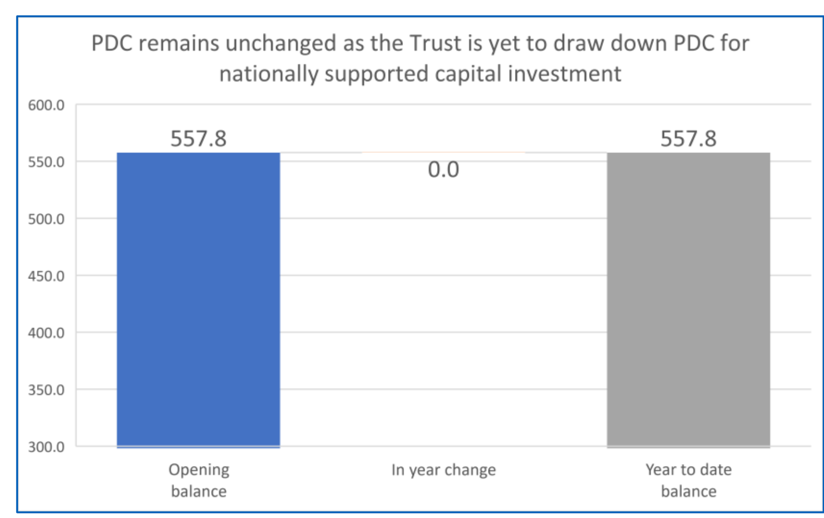
NHS
West Hertfordshire Teaching Hospitals
NHS Trust

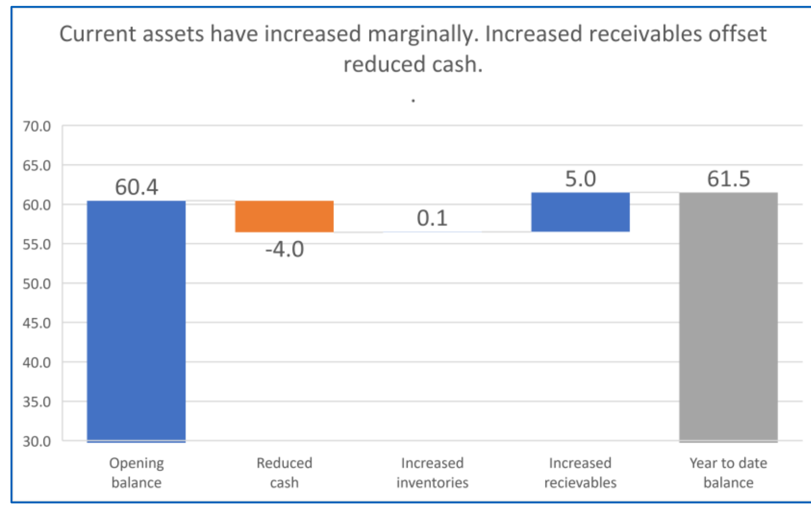
	2021/22 cost base (£m)	% of cost base	Inflation funding: Funding received (Gross of efficiency expectation)	Inflation funding: Funding as % on cost base	Forecast inflation %	Inflation impact	Unfunded inflation: %	Unfunded inflation: £m
Pay (excludes non recurrent pension cont)	280.0	65%	15.5	5.5%	5.6%	3.6%		
Gas	1.3	0%			207.0%	0.6%		
Electricity	2.0	0%			73.5%	0.3%		
Transport	0.5	0%			15.0%	0.0%		
Supplies and services - general	1.9	0%			10.1%	0.0%		
Linen & Laundry	1.9	0%			10.1%	0.0%		
Disposable gowns	3.4	1%			10.1%	0.1%		
Premises - other	5.9	1%			10.1%	0.1%		
Drugs costs (drug inventory consumed and purchase of non-	22.9	5%			10.0%	0.5%		
Purchase of healthcare	4.0	1%			6.6%	0.1%		
Supplies and services – clinical (excluding drugs costs)	30.4	7%			6.6%	0.5%		
Cleaning	2.3	1%			5.5%	0.0%		
Domestic	4.9	1%			5.5%	0.1%		
Portering	1.5	0%			5.5%	0.0%		
Education and training - non-staff	1.6	0%			5.5%	0.0%		
Medical Equipments / Surgical Instruments/ MSSE	0.0	0%			5.4%	0.0%		
Establishment	3.3	1%			5.0%	0.0%		
Maintenance Contract	3.9	1%			5.0%	0.0%		
IT infrastructure contract	4.5	1%			5.0%	0.1%		
IT (software mtce/ computer hardware & software)	6.8	2%			5.0%	0.1%		
Outsourcing Costs	9.8	2%			3.5%	0.1%		
Consultancy	1.5	0%			3.5%	0.0%		
Audit fees and other auditor remuneration	0.1	0%			3.5%	0.0%		
Catering	2.6	1%			3.0%	0.0%		
Premises - business rates payable to local authorities	1.4	0%			0.0%	0.0%		
EPR licence	2.3	1%			0.0%	0.0%		
Clinical negligence	24.5	6%			0.0%	0.0%		
Other	6.3	1%			10.1%	0.1%		
Sub total non pay operating expenses	151.3	35%				3.0%		
PDC Dividend	NA				NA	NA		
Depreciation and other financing	NA				NA	NA		
Sub total non pay	151.3	35%	5.6	3.7%		3.0%		
Total cost base	431.3	100%	**21.1**	4.9%		6.6%	-1.7%	-7.4

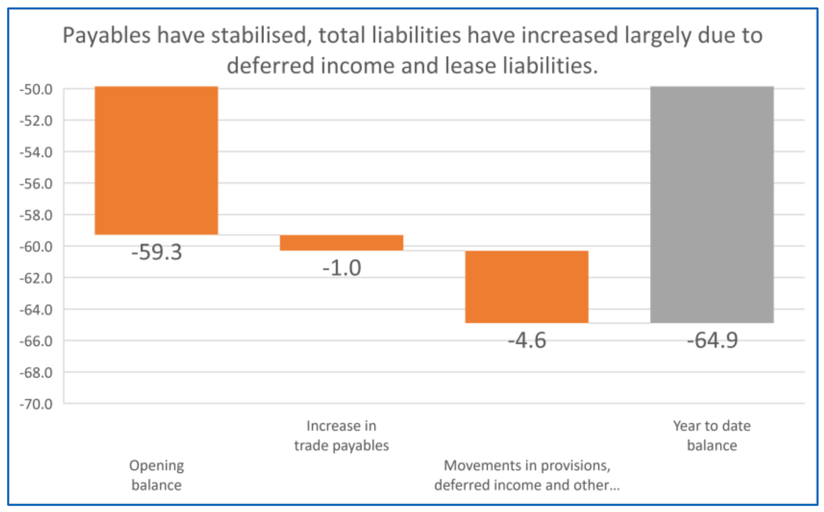
The table to the left compares inflation funding of £21.1m received (4.9% of our cost base) with a forecast inflation experience (including pay costs) of 6.6%. The 1.7% difference is equivalent to £7.4m which the Trust expects to mitigate through measures discussed earlier.

The balance sheet remains relatively stable. Current assets and current liabilities are increasing.

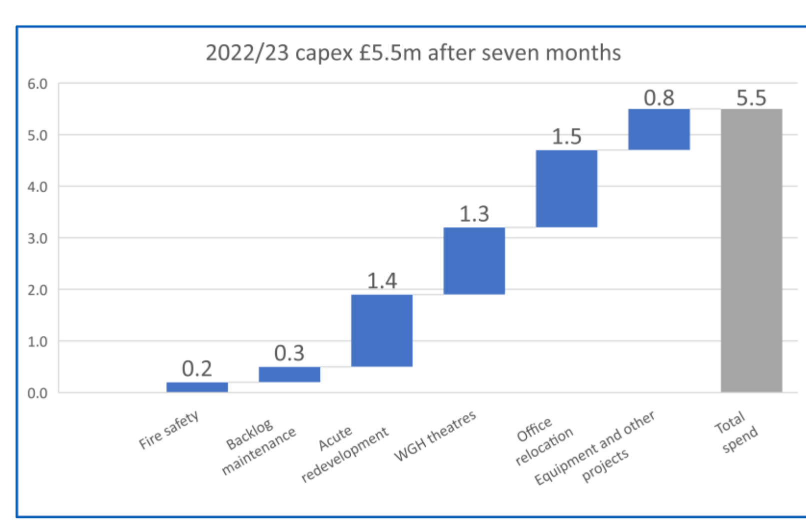


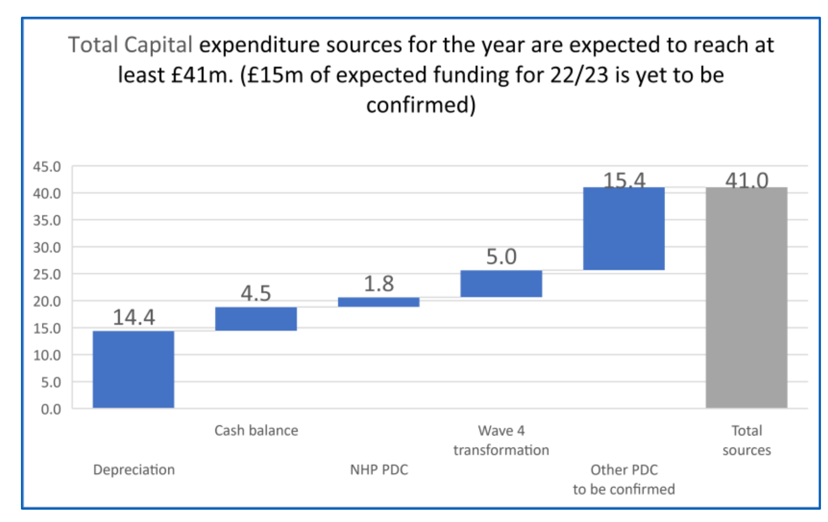


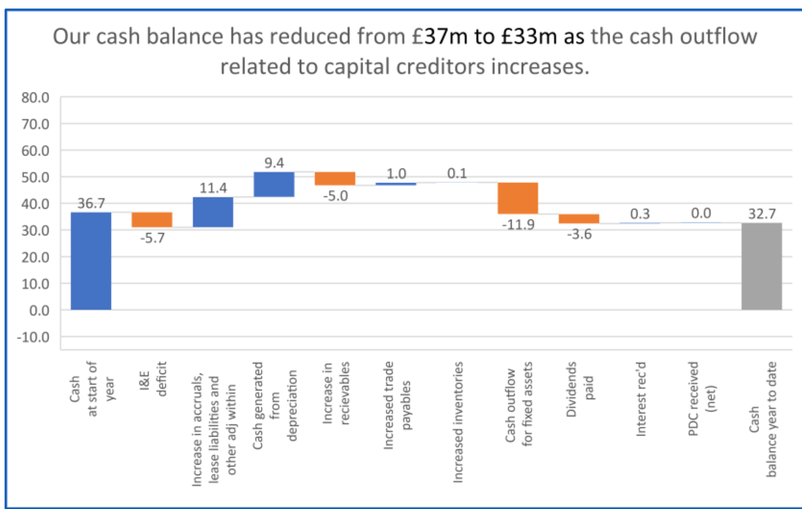




The cash balance at £33m is lower than the start of the year. Capital expenditure totals £5.5m ytd. We await confirmation of bids for funds for nationally supported projects. We expect to spend £41m this year.







After 7 months the Trust spent £5.5m of its current full year confirmed allocation. £25.6m has been confirmed (including funds to improve the ED). However we expect the capital programme to be supplemented by at least another £15m to £41m to support a series of nationally supported projects including the creation of a community diagnostic centre, additional ward capacity, the creation of a replaced essential pathology services laboratory, purchase of land to support options for redevelopment and the possibility of creating an elective centre at St Albans.

The cash balance at the end of October was £33m.

We expect to produce an update on our long-term financial plans each quarter.

Our long term financial modelling will ultimately be influenced by funding allocations to NHS Integrated Care Boards (ICBs) and their consequential financial planning. However it is useful for the Trust to test the impact of scenarios on longer term financial health. For example ICB funding assumptions, service demand, new developments, the withdrawal of COVID funds and efficiency achievements.

The Trust has started to lead the work with the ICB on the development of an ICS medium term financial model which will form the framework for the Trust’s long term financial plan. The imminent publication of a national planning framework will help us to narrow the scenarios currently being modelled.

We will be explicit about the assumptions that we're using for our long-term plan.

This table shows the initial assumptions used to drive the draft output. These are still being refined and will require further engagement / communication (internal and external) to refine

			22/23	23/24	24/25	25/26	26/27	Compound effect
Income	A	GDP deflator	3.5%	2.8%	2.8%	2.8%	2.8%	**15.6%**
	B	National efficiency expectation	(1.1%)	(1.1%)	(1.1%)	(1.1%)	(1.1%)	**(5.4%)**
	C	Convergence allocation	(0.8%)	(0.8%)	(0.8%)	(0.8%)	0.0%	**(3.2%)**
	D	Allocation for growth	2.1%	2.1%	2.1%	2.1%	2.1%	**11.0%**
	E	**Total NHS income growth**	**3.7%**	**3.0%**	**3.0%**	**3.0%**	**3.8%**	**18.0%**
	F	Other income growth	2.0%	2.0%	2.0%	2.0%	2.0%	**10.4%**
	G	**Total Income Growth**	**3.6%**	**2.9%**	**2.9%**	**2.9%**	**3.7%**	**17.1%**
Costs	H	Activity - demographic growth	1.4%	1.4%	1.3%	1.3%	1.2%	**6.8%**
	I	Activity - non demographic growth	1.4%	1.6%	1.5%	1.5%	1.5%	**7.7%**
	J	Service transformation effect	(1.6%)	(1.6%)	(1.6%)	(1.6%)	(1.6%)	**(7.7%)**
	K	**Capacity growth**	**1.2%**	**1.4%**	**1.2%**	**1.2%**	**1.1%**	**6.3%**
	L	Recurrent efficiencies	(3.0%)	(3.2%)	(1.6%)	(1.6%)	(1.6%)	**(10.5%)**
	M	Cost inflation	5.5%	2.8%	2.8%	2.8%	2.8%	**17.8%**
	N	Recurrent cost pressures	0.5%	1.0%	1.0%	1.0%	1.0%	**4.6%**
	O	**Total recurrent cost growth**	**4.2%**	**2.0%**	**3.4%**	**3.4%**	**3.3%**	**17.4%**
	Net Growth		**(0.6%)**	**0.9%**	**(0.5%)**	**(0.5%)**	**0.4%**	**(0.3%)**
Other	P	Non recurrent efficiencies	(1.0%)	(0.5%)	0.0%	0.0%	0.0%	**(1.5%)**
	Q	Non recurrent cost pressures	1.0%	0.5%	0.0%	0.0%	0.0%	**1.5%**
	R	COVID costs (NR) £'m	(11.2)	(5.0)	-	-	-	**-**
	S	COVID funding (NR) £'m	9.2	5.0	-	-	-	**-**
	T	Capacity pressures - costs (NR) £'m	(6.1)	(6.1)	(6.1)	(6.1)	(6.1)	**-**
	U	Capacity pressures - funding (NR) £'m	11.2	-	-	-	-	**-**
	V	SD1 - gross revenue cost pressure	-	-	-	-	-	**-**
	W	SD1 - gross revenue saving	-	-	-	-	-	**-**

- Under the PbR regime, the Trust's long term financial modelling assumed income rising broadly in line with activity, moderated by effective service transformation.
- Our new financial planning approach will involve modelling income based on an understanding of how health system funding is likely to change and modelling expenditure change based on forecast activity growth and cost inflation, moderated by service transformation and efficiency programmes.
- We will also focus on the separate revenue impact of major service developments.

The draft outputs will help set the agenda for more detailed planning rounds

The following table presents the initial output of the LTFM and the impact of some of these key assumptions

			22/23	23/24	24/25	25/26	26/27
I&E		Total operating revenue - normalised	466.7	454.0	462.2	475.8	493.2
		Total operating expenses - normalised	(445.1)	(435.9)	(444.3)	(458.7)	(473.0)
		Total non-operating expenses	(21.5)	(20.9)	(22.5)	(23.0)	(21.0)
		Net surplus/(deficit)	**(0.0)**	**(2.8)**	**(4.5)**	**(5.9)**	**(0.8)**
NR income and costs	U	Capacity pressures funding	11.2	0.0	0.0	0.0	0.0
	S	Covid Costs Funding	9.2	5.0	0.0	0.0	0.0
		Total Non Recurrent Income	**20.3**	**5.0**	**-**	**-**	**-**
		Service transformation investments					
	T	Capacity pressures	(6.1)	(6.1)	(6.1)	(6.1)	(6.1)
	R	Covid Costs	(10.9)	(5.0)	0.0	0.0	0.0
		Total Non Recurrent Costs	**(17.0)**	**(11.1)**	**(6.1)**	**(6.1)**	**(6.1)**
		Total non-recurrent items	**3.4**	**(6.1)**	**(6.1)**	**(6.1)**	**(6.1)**
I&E excl. NR items		**Underlying Deficit**	**(3.4)**	**3.3**	**1.5**	**0.1**	**5.3**
Key drivers of position	C	Convergence allocation %	(0.8%)	(0.8%)	(0.8%)	(0.8%)	0.0%
	C	Convergence allocation £'m	(3.0)	(3.0)	(3.0)	(3.0)	-
	J	Service transformation effect %	(1.6%)	(1.6%)	(1.6%)	(1.6%)	(1.6%)
	J	Service transformation effect £'m	5.0	6.9	6.5	6.5	6.5
	L	Total efficiency required (%)	3.0%	3.1%	1.6%	1.6%	1.5%
	L	Total efficiency required £'m	-	13.7	6.7	6.7	6.7
	A less P	Income inflator (GDP) less cost inflation	(2.0%)	0.0%	0.0%	0.0%	0.0%
	N	Recurrent Cost Pressures £'m	0.5%	1.0%	1.0%	1.0%	1.0%
	N	Recurrent Cost Pressures %	(2.5)	(4.3)	(4.1)	(4.1)	(4.1)

The initial outputs with current assumptions indicate future deficits based on an assumption that the Trust will experience non recurrent capacity pressures in line with historical experience. It is however likely that the Trust will find non-recurrent solutions to ensure break-even in each year.

We will highlight the financial impact of major service developments

Our quarterly report will highlight the impact of our major service developments in terms of capital expenditure in each year and the net revenue pressure or benefit derived from each development.

			22/23	23/24	24/25	25/26	26/27	Compound effect
SD and BAU capex	V	SD1 - gross revenue cost pressure	-	-	-	-	-	-
	W	SD1 - gross revenue savings	-	-	-	-	-	-
	X	SD1 - Capex	-	-	-	-	-	-
	Y	SD2 - gross revenue cost pressure	-	-	-	-	-	-
	Z	SD2 - gross revenue savings	-	-	-	-	-	-
	AA	SD2 - Capex	-	-	-	-	-	-
	AB	BAU - Capex	-	-	-	-	-	-

There are a number of large developments that are at the business case / formal approval stage (e.g. the Trust redevelopment, CDC, additional Shrodells wards, Pathology – enabling works and the land acquisition).

Next steps

- Support the ICB in developing an ICS MTFP which considers the effect of published ICB allocations and planning guidance.
- Refinement of Trust LTFM assumptions based on the ICS MTFP
- Refinement of Trust LTFM assumptions with Trust senior management.
- Update LTFM starting point from 2022/23 plan to 2022/23 forecast
- Refine and incorporate the longer term transformation programme into the Financial Strategy
- Incorporate service developments / capital programmes as they are approved
- Iterate assumptions with the ICB and the wider system

Trust Board
1 December 2022

Title of the paper	**Trust People Strategy**
Agenda Item	**28**
Presenter	**Andrew McMenemy, Chief People Officer**
Author(s)	**Andrew McMenemy, Chief People Officer**
Purpose	*Please tick the appropriate box* *For approval*: X *For discussion*: *For information*:
Executive Summary	The current People Strategy for the Trust was developed in 2019 and ratified by the Trust Board in February 2020. The impact of the pandemic alongside an escalation of activity regarding the Acute Redevelopment has provided an opportunity to reflect and review the existing strategy document and align to some of the changes from a workforce and health care context. In more recent times the drivers for strategic change have become more apparent with the award of Teaching status alongside our continued commitment to inclusion & diversity alongside our focus on staff wellbeing. In addition, the national People Strategy publication and launch of the NHS People Promise has influenced the structure of the Trust strategy and develops a golden thread. This is based on 7 promises and priorities that reflect some of our strategic drivers while focusing on some of the wider strategic workforce challenges. The revised People Strategy has been developed within an inclusive and consultative approach involving a cross section of our workforce. It has also included discussion with system partners and reviewed recently by the Trust Executive team. The enclosure therefore provides the Trust Board with the final version of the revised People Strategy and how this has been aligned with the national People Promise. In support of the enclosed strategy it is proposed that a one page overview of the strategy is developed in order to make it easily accessible to all staff. In addition, the strategy document will be supported with an action plan that will set out measurable objectives for each of the 7 people promise categories. In appendix one of the enclosures an example of the action plan aligned to people promise one has been provided. In terms of governance, it is expected that the action plan will be reviewed at TMC on a twice annual basis with an annual review at PERC/Trust Board in order that assurance alongside progress can be provided.

<table>
<tr><td></td><td colspan="4"></td></tr>
<tr><td rowspan="2">Trust strategic aims

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

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

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

Objective 9</td><td>Aim 4
Great place

Objective 10-12</td></tr>
<tr><td>x</td><td>x</td><td>x</td><td>x</td></tr>
<tr><td>Links to well-led key lines of enquiry</td><td colspan="4">☐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 colspan="4"><table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td>PERC</td><td>Oct 2022</td></tr><tr><td></td><td></td></tr></table></td></tr>
<tr><td>Action required</td><td colspan="4">Trust Board is asked to consider and approve the people strategy document.</td></tr>
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NHS
West Hertfordshire
Teaching Hospitals
NHS Trust
People strategy 23-2028

team
westHerts

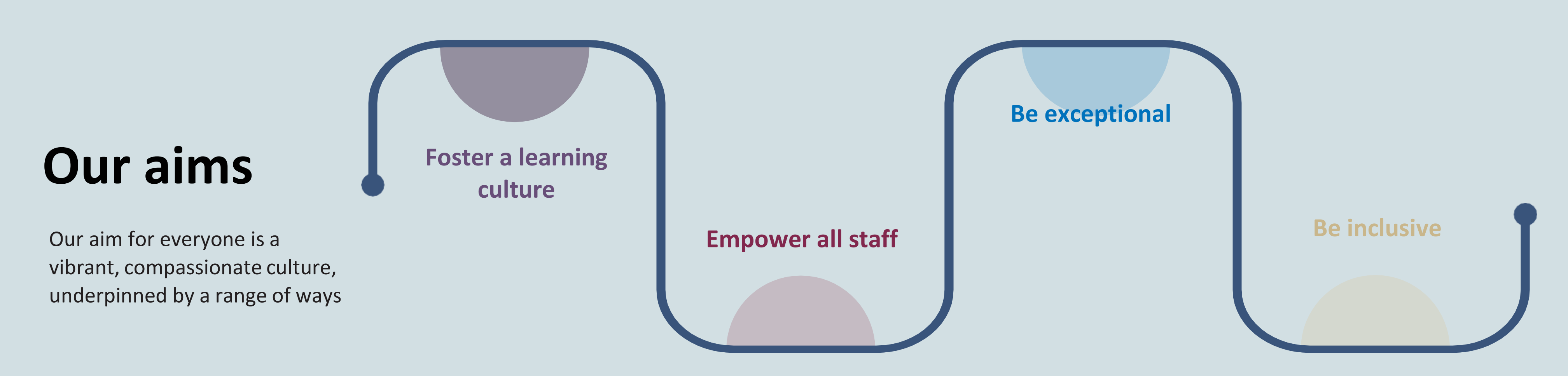
Strategic overview

We will build an exceptional workplace that fosters a learning culture and empowers staff to thrive, enabling high performance. We are dedicated to creating an inclusive workplace that is people focused, celebrates difference and welcomes staff to bring their whole selves to work. We want to be the best place to work for all

- Values and ways of working
- Strategic Drivers
- Data and engagement
- Our approach
- People strategy
- Governance and assurance
- Roles and responsibilities

Our aims

Our aim for everyone is a vibrant, compassionate culture, underpinned by a range of ways



Strategic drivers

Our People strategy has been informed by four key strategic drivers.

Underpinning this strategy will be operational groups supporting the four strategic drivers.

The groups will be led by an HR leader alongside a non-HR leader with broad staff representation involved.

Staff Retention

The recent People Plan and People Promise Plan sets out national expectations of how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as take action to grow our workforce, train our people, and work together differently to deliver the highest standards of patient care.

Staff Engagement & Wellbeing

The staff have provided valuable feedback through various levels of engagement. This includes the annual staff survey, pulse survey, WRES, WDES, Gender and Race Pay Equality Report. We regularly consider workforce indicators around absence, retention, vacancy rates and learning & education.

Teaching Hospital Status

The Trust achieved Teaching Hospital status in December 2021. We have made improvements that led to this achievement with ambitious plans over the lifetime of this strategy to enhance teaching and education further for all our staff to support a highly skilled workforce that enables innovation.

Inclusion and Diversity

The Trust is extremely proud of the diversity of its staff. We have enhanced our support to enhance diversity and equality with an emphasis on our staff.

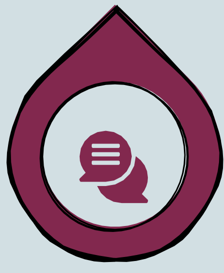
This strategy gives the opportunity to demonstrate excellence in supporting equality and diversity further and providing the support and opportunities for all of our staff while demonstrating compassion, awareness, inclusivity and opportunities at all levels.

Data and engagement

Our People strategy is evidence-led: organisational data and engagement with staff has been central to our approach as it is crucial that we capture and address the issues that are impacting our workforce

Data and engagement

Staff survey

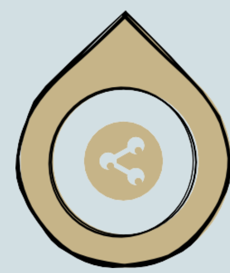


Annual survey which seeks to deep dive on staff experience

Pulse survey

Monthly check in with staff to see how they are feeling and understand any concerns they may have

Regional and directorate engagement

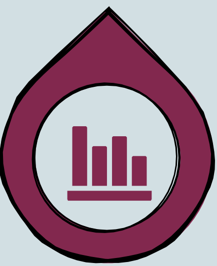


Tailored and leader led local engagement

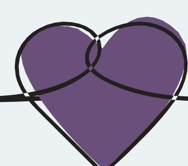
Staff networks

Regular, qualitative feedback provided by members

HR and OD dashboards



Quantitative, organisation wide and near-live data



Promise 1

We are compassionate and inclusive

Year 1-2: Strengthen

- Implement a framework that supports an inclusive culture focusing on compassion & behaviours consistent with Trust values.
- Introduce an inclusive approach to recruiting our staff using values-based approaches. This will support expectations of behaviours associated with staff and patients.
- To support enhanced opportunities for leadership development taking consideration of diversity at all levels.

Year 2-3: Build

- Evaluate the impact of cultural development using our Cultural and leadership programme.
- Evaluate the development of cultural awareness and values-based approaches to the impact of diversity and opportunities across our workforce.

Year 3: Consolidate

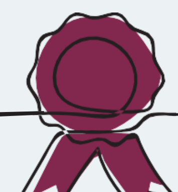
- Cultural change reflected in staff feedback, our appointment process and opportunities for career progression.

Our ambition

Leaders are visible and demonstrating behaviours that are consistent with the values of the Trust. They inspire others to develop with diverse representation at all levels of the Trust.

Measures of impact

- ✓ Improved staff engagement score in the national staff survey.
- ✓ Improved levels of diversity across all pay band that is representative of our diverse workforce.



Promise 2
We are recognised and rewarded

Year 1-2: Strengthen

- Introduce innovative ways to make staff recognition more inclusive and find ways to celebrate those hidden heroes.
- To encourage a culture where staff are supported to be innovative and demonstrate excellence.
- Introduce financial and non-financial rewards that support our staff.

Year 2-3: Build

- Evaluate recognition and rewards strategies for effectiveness.
- Create local strategies for recognition and reward across the Trust that is more inclusive.

Year 3: Consolidate

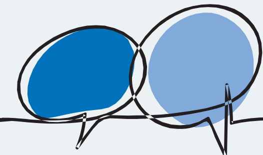
- Staff reward and recognition becomes a recognized and embedded part of Trust culture.

Our ambition

To embed a framework that supports fair and transparent strategies for reward and recognition that supports team and individual behaviours to value our staff and enhance performance

Measures of impact

- ✓ Implementation of clear reward and recognition plan with measurable benefits for staff.
- ✓ Demonstration of greater inclusiveness based on reward and recognition.



Promise 3
We each have a voice that counts

Year 1-2: Strengthen

- Introduce an engagement strategy to enhance 2-way communication with our staff.
- To develop annual plans based on national and local pulse survey and enhance the link between 'You said, we did'.
- To triangulate themes in other areas such as the patient survey and Freedom to Speak up and link these with staff survey feedback.

Year 2-3: Build

- To review best practice staff feedback from within and outside the NHS to determine focused engagement.
- To look at trends in feedback and how we align these with the review of our people strategy.

Year 3: Consolidate

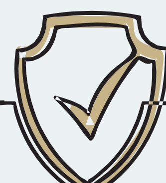
- To continue to review developing technology to support effective mechanisms for staff engagement.

Our ambition

To develop a culture where every voice counts with opportunities and mechanisms to support staff engagement and speaking up to support the staff and patient experience.

Measures of impact

- ✓ Clear improvements in our engagement score consistently above 7.
- ✓ To demonstrate improved levels of engagement across all staff groups.



Promise 4
We are safe and healthy

Year 1-2: Strengthen

- Enhance and improve on our staff wellbeing support to staff.
- To create peer to peer support across the workforce to enable cultural change.
- Review our occupational health and wellbeing function to enhance innovation and support to the staff.

Year 2-3: Build

- Have an established wellbeing platform that is easily accessible.
- To achieve SEQAS accreditation for OH services demonstrating innovation and explore local opportunities to extend service provision.

Year 3: Consolidate

- To continue to develop innovative ways of wellbeing support that aligns to our healthcare services and new technologies.

Our ambition

To continue to develop more effective and innovative ways to support the wellbeing of our staff and create a culture that support and protects

Measures of impact

✓ Positive impact on staff morale measured through retention, engagement and staff absence.

✓ To achieve SEQAS accreditation and create a commercial plan for OH & wellbeing.

Promise 5
We are always learning

Year 1-2: Strengthen

- Develop 3 year plans to support leadership development planning aligned with strategic priorities with focus on middle management development.
- To embed talent management plans across all staff, achieving the benefits provided by Teaching Hospital status.
- Focus on equity of opportunities for development and learning aligned to diversity and inclusion.

Year 2-3: Build

- Develop a range of career pathways supported by our career coaching programmes.
- Effective use of Continuing Professional Development to support and align with other development opportunities.

Year 3: Consolidate

- Develop reputation as a leading provider of leadership and staff development with clear and visible outcomes from Teaching Hospital status demonstrated.

Our ambition

To focus on personal and professional development for all of our staff to enable career development, build skills and generate the capability the Trust needs now and in the future.

Measures of impact

- ✓ Embedded 3 year plans for leadership development for the Trust and each Division that is aligned to strategic and service aims and priorities.
- ✓ Greater levels of equity and opportunities for our diverse workforce to participate in development and learning.

Promise 6
We work flexibly

Year 1-2: Strengthen

- Workforce plans that consider the 5 year forward view focusing on skill mix and priority staff groups.
- Rota management systems for all staff groups that use technology effectively.
- To review our flexible working policies and practices that consider the expectations and wellbeing of staff.

Year 2-3: Build

- .Explore new and alternative job roles and ways of working to meet skills required going forward.
- Develop a talent management and succession planning framework.

Year 3: Consolidate

- Create a culture where engagement, flexible working is seen as a positive.

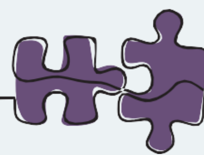
Our ambition

To focus on personal and professional development for all of our staff to enable career development, build skills and generate the capability the Trust needs now and in the future.

Measures of impact

- ✓ Embedded workforce plans that support improved levels of staff satisfaction and retention.
- ✓ Implementation of talent management and succession plans that demonstrate effective career progression and development of our staff.

West Hertfordshire Teaching Hospitals
NHS Trust



Promise 7
We are a team

Year 1: Strengthen

- Improve candidate attraction to enhance recruitment.
- To understand what motivates and retains staff and therefore apply relevant measures.
- To develop more effective and inclusive partnership arrangements that demonstrate a culture of team working.

Year 2-3: Build

- Implementation of effective mentoring and coaching support programmes.
- Implement of our recognized OD & Culture programme and team that focuses on supporting our values.

Year 3: Consolidate

- Create a culture that supports collaboration and team working within the Trust and across the ICS.

Our ambition

WHHT is a place where staff are proud, where they feel valued and recognise the benefits of working as a team to support better outcomes for staff and patients.

Measures of impact

- ✓ Corporate style for marketing the Trust through recruitment that has a positive impact on number and quality of applicants.
- ✓ Measurable outcomes with the use of mentoring and the impact on colleague engagement from the staff survey.

Roles and responsibilities

Collective commitment is needed to help drive change, embed new ways of working and support the delivery of the People Strategy.

Our organisation will…

- Promote our values, behaviours and ways of working.
- Promote and celebrate inclusion, equality and diversity.
- Provide effective performance and development frameworks.
- Provide a comprehensive health and wellbeing package.
- Offer learning and development for all.
- Develop an industry-leading recruitment and deployment model.
- Cultivate a talent reservoir to ensure our teams have the resource they need.
- Provide an induction framework for those joining the organisation.
- Engage with staff on key issues and initiatives.

Individuals will…

- Live our values, behaviours and ways of working.
- Celebrate equality, diversity and inclusion.
- Take an active approach to dynamic conversations.
- Keep yourself updated on matters relating to your role.
- Ask for (and accept) help when needed.
- Take a proactive approach to resolving issues.
- Work collaboratively with others to maximise results.
- Proactively seek out ways to change and improve the organisation for the better.
- Take advantage of learning and development opportunities.
- Look after your own health and wellbeing.

Line managers will…

- Exemplify our values, behaviours and ways of working.
- Promote and celebrate inclusion, equality and diversity.
  Hold dynamic conversations with staff including on health and wellbeing, performance enablement, priorities, aspirations and motivation.
- Address issues in a timely manner.
- Acknowledge and recognise your teams' achievements.
- Celebrate successes and communicate the team's progress.
- Include the team in decision making.
- Promote internal talent.
- Offer a full induction for new team members joining the organisation.
- Encourage collaboration and innovation.

Governance and assurance

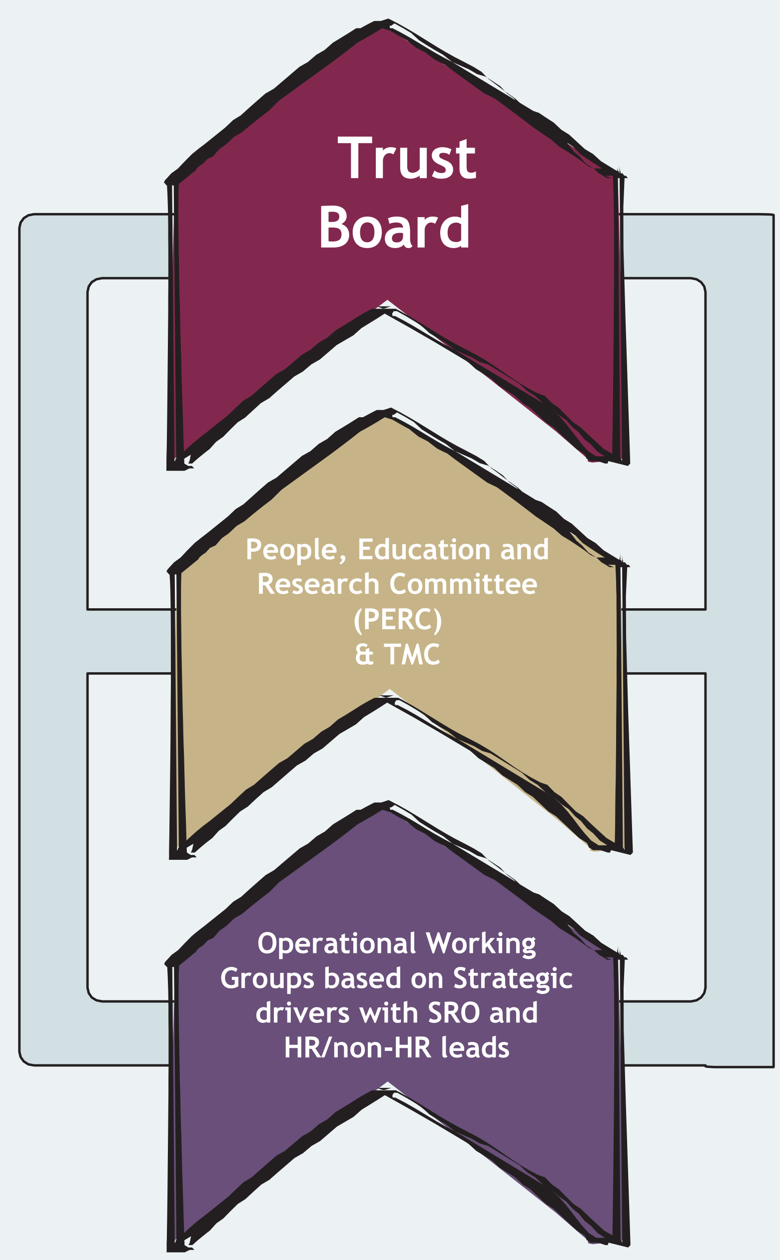
The Chief People Officer will oversee the day-to-day operational development of the People Strategy alongside the workforce team.

There will be four operational working groups that are identified as the strategic drivers. The groups will focus on the following areas:

- Education & Learning (Teaching Hospital);
- Wellbeing & Engagement ;
- Equality, Diversity & Inclusion;
- Retention and Workforce Modelling.

The Chief People Officer alongside the Executive Team colleagues will provide assurance regarding the People Strategy to the People, Education and Research Committee (PERC).

PERC will report with support from the Chief People Officer and the Executive Team to Board providing assurance and annual reports on the strategy.



People Strategy Action Plan – Year 1-2 - Theme: People Promise One – We are compassionate and Inclusive

Ref	Commitment	What success will look like	How we will achieve this	Start date	End date	Responsible
PP 1.1	Implement a framework that supports an inclusive culture focusing on compassion & behaviours consistent with Trust values.	Leaders are visible and demonstrating behaviours that are consistent with the values of the Trust. They inspire others to develop with diverse representation at all levels of the Trust.	• Review of Trust values and implementation of behavioural standards. • Review diversity training for all new and existing staff. • Inclusion of compassionate leadership and reflective behaviours in leadership develop programmes. • Cultural awareness sessions promoted across all staff groups.	Q1 1 23/24 Q4 22/23 Q3 23/24 Q2 23/24	Q2 23/24 Q1 23/24 Q4 24/25 Q2 24/25	Chief people Officer Deputy Chief people Officer Associate Director of People – L&D
PP 1.2	Introduce an inclusive approach to recruiting our staff using values-based approaches. This will support expectations of behaviours associated with staff and patients.		• Introduce a values-based addition to our recruitment process. • Initiate with pilot introduced in consultant and senior posts.	Q2 23/24 Q2 23/24	Q4 23/24 Q4 23/24	Chief people Officer Deputy Chief people Officer Associate Director of People – L&D
PP 1.3	To support enhanced opportunities for leadership development taking consideration of diversity at all levels.		• Introduce new leadership development programme and procurement for senior leaders programme. • Enhance career coaching to support introduction of new leadership development programme.	Q1 23/24 Q3 23/24	Q3 23/24 Q3 24/25	Chief people Officer Deputy Chief people Officer Associate Director of People – L&D

Trust Board
1 December 2022

<table>
<tr><td>Title of the paper</td><td>Better Care Delivered Differently (BCDD) - 2022-23 Priority Project Progress Report – November 2022</td></tr>
<tr><td>Agenda Item</td><td>29</td></tr>
<tr><td>Presenter</td><td>Laura Bell, Director of Strategy & Integration (Interim)</td></tr>
<tr><td>Author(s)</td><td>Strategy Delivery Office</td></tr>
<tr><td>Purpose</td><td><table><tr><th>For approval</th><th>For discussion</th><th>For information</th></tr><tr><td></td><td></td><td>✓</td></tr></table></td></tr>
<tr><td>Executive Summary</td><td>The purpose of the report is to provide an update to the Board on progress being made against key milestones, including those milestones that are at risk of missing the target within the BCDD Programme of works. The report also provides a list of projects that have an overall RAG rating of red, those that are flagging an extreme risk/issue, and includes the Programme SRO summaries and a short summary of the associated priority project highlights.

This report to Trust Board includes updates to specific programmes, and associated priority projects, as discussed at GPPB (9th November) and GPC (17th November). Updates from the following governance forums have been highlighted, for the Board's attention, within the main body of the report. The submitted report is factual and accurate as of projects updates, reported by leads and confirmed by SROs, in October 2022 for reporting to Great Place governance forums in November 2022.

Of the eight programmes within BCDD one programme is reporting an overall RAG rating of GREEN, with five reporting a RAG rating of AMBER. Programme 7 is not RAG rated as part of the report and Programme 3 is noted as under review.

The BCDD Programmes that are currently reporting as AMBER are noted below, alongside accompanying narrative of key highlights, milestone delays, risks, and issues, for associated priority projects, that are contributing to the overall AMBER RAG rating. Additional information, for all programmes is included in the Programme SRO summaries, included in the report.

Programme 1 – Best Care
P1.3 (Development of an elective system hub). It has been confirmed that there is currently no formal confirmation of the expected revenue investment and work is ongoing to escalate this issue across the ICB, and throughout associated partners, to confirm a solution as soon as possible. P1.5 (Remove same day multi-appointment pathways (urology)). The Outline Business Case has been completed but is pending sign off at WHTH governance forums, work is being undertaken during this period to capture benefits realisation and identify the resource and governance structure for the expected programme of</td></tr>
</table>

	works. **Programme 2 – Integrated Care** *P2.1 & P 2.2 (Virtual Hospital & Virtual Ward Expansion).* It has been noted that there will possibly not be sufficient clinical engagement to fully develop the new pathways in line with the expected ICS milestones from the Business Case. To support mitigation the project team have established a weekly task and finish group that has been implemented to ensure sufficient engagement for integration. *P2.5 – Respiratory Transformation.* It has not currently been possible to reach an agreement on the pathways from system partners, however further discussions are scheduled to take place at upcoming Steering Group sessions to confirm. **Programme 4 – Consistent Care** *P4.1 (Clinical Practice Groups).* The reporting schedule has now been revised from quarterly to monthly and the next report is scheduled to be presented next quarter in line with Quality Committee reporting. *P4.2 (Theatre Productivity Improvement Programme).* It has been confirmed that recruitment of an 8c Programme Lead is proving to be a significant challenge and is causing risk to the overall success and completion of the project. The project team have approached agencies to support with recruitment and, as to be noted in December 2022 reporting, a candidate has been offered the position pending confirmation of the agreed rate. *P4.3 – (GIRFT (Getting it Right First Time)).* It has been confirmed that Dr Ajitha Jayaratnan has taken over the clinical leadership of the GIRFT programme from Dr Anna Wood. **Programme 5 – Transforming Outpatients** *P5.2 (Implement PIFU).* There are currently challenges with recording and the overall data quality on EPR and the project team are working to produce guidance to support the clinical and admin teams recording on EPR, alongside the inclusion of data quality spot checks. **Programme 8 – Redevelopment** *P8.2 (Business Case for the Enabling Works).* The overall project RAG rating has been amended from RED to AMBER. This is on the basis that the Pathology ESL and Cellular pathology are approved by the New Hospital Programme (NHP) under a single process, the surge wards have £4.2m allocated from winter funding which will leave a gap of £1.7m initial requested from NHP, and that the Cherry Tree House and VIE investment is to be considered within the overall enabling cost of the new hospital build. Additionally, following the amendment to P8.2s individual RAG rating, the overall RAG rating for Programme 8 (Redevelopment) has been revised from RED to AMBER. *P8.4 (Expansion of Diagnostic Services at SACH).* There has been a delay to the confirmed of the capital and revenue and investment and, as a result, the project's overall RAG rating has been updated from GREEN to AMBER. *P8.5 (Implement the Green Plan).* Following confirmation with the project team and the programme SRO this project will be reported to Great Place governance forums, on a quarterly basis. This will take the form of a standalone report and will no longer be reported directly through the BCDD report.

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

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

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

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

Objective 9</td><td>Aim 4
Great place

Objective 10-12</td></tr><tr><td>✓</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><td>Committee/Group</td><td>Date</td></tr><tr><td>Great Place Programme Board</td><td>9th November 2022</td></tr><tr><td>Great Place Committee</td><td>17th November 2022</td></tr></table></td></tr>
<tr><td>Action required</td><td>The Trust Board is asked to take this report for information on the progress with the priority projects as part of BCDD.</td></tr>
</table>

Better Care Delivered Differently (BCDD)

2022-23 Priority Project Progress Report – November 2022

Introduction

The report is structured to provide an update on the overall RAG rating and project lifecycle stage. It provides a list of projects (slides 6 & 7) that have an overall RAG rating of red or, those that are at risk of missing a current milestone or flagging an extreme risk/issue.

The report also includes the Programme SRO summaries and a short summary of the project highlights.

BCDD Programmes - Overview

Programme		RAG
1	Best Care	AMBER
2	Integrated Care	AMBER
3	Personalised Care	Under review
4	Consistent Care	AMBER
5	Transforming Outpatients	AMBER
6	People/Workforce	GREEN
7	Digital	Reported via Great Place
8	Redevelopment	AMBER

BCDD Programme 8 (Redevelopment) overall RAG rating has been revised from RED to AMBER. This is following the 9th November 2022 GPPB confirmation that P8.2 (Business Case for the Enabling Works) RAG rating is to be revised from RED to AMBER

BCDD Programme and Priority Projects progress updates are true at the point of time of writing, further updates will be provided verbally by respective Programme SROs.

The submitted report is factual and accurate as of project updates reported in October 2022 for reporting to Great Place governance forums in November 2022.

Updates from November GPPB & GPC

Wednesday 9th November 2022 – GPPB Updates

P4.1 – CPGs (Clinical Practice Groups)

- Reporting schedule revised to quarterly in line with reporting to the Quality Committee. Next report due January 2023.

P4.3 – GIRFT (Getting it Right First Time)

- Dr Ajitha Jayaratnan has taken over the clinical leadership of the GIRFT programme from Dr Anna Wood.

P8.2 – Business Case for the Enabling Works

- Overall Programme RAG rating amended from RED to AMBER on the basis that:
  - Pathology ESL and Cellular pathology are approved by NHP under a single process for which we are close to approval.
  - Surge ward have £4.2m allocated from winter funding, leaving a gap of £1.7m requested from NHP.
  - Cherry Tree House and VIE investment to be considered within the overall enabling cost of the New Hospital Programme.
- The estates team are working on a task list with costed actions. It was noted that the focus of effort over the past 12 months has been on the Watford site with great success and now focus will move slightly towards the other two sites, with a series of enabling works that have to happen at SACH, to enable our development to go ahead there. GPPB attention was drawn to the electrical infrastructure work at SACH which is highlighted as essential to progress against other works.

P8.4 - Expansion of Diagnostic Services at SACH

- Dialogue continues with ICB to confirm capital and revenue investment. Delay to confirmation moves the RAG rating from GREEN to AMBER and impacts a hold on submitting the tender for design and infrastructure works.

P8.5 – Implement the Green Plan

- Green plan removed from Programme 8 and now reports separately and directly to GPPB on a quarterly basis.

Thursday 17th November 2022 – GPC Updates

Programme Overview

- The GPC took assurance that of the eight programmes, within BCDD, two programmes are reporting GREEN and five programmes are reporting AMBER.

P8.1 – OBC for the Redevelopment

- The Outline Business Case has been updated and the three remaining cases have been included, alongside refreshing the existing cases.
- Work is ongoing to confirm the route to approval for Business Cases for redevelopment schemes. Redevelopment team pushing for Route 1 approval.

P8.2 – Business Case for the Enabling Works.

- The GPC were assured of the RAG rating changes to P8.2, as noted above, from GPPB updates

BCDD Projects - Project Lifecycle Stage and Overall RAG rating

The tables below and on slide 5 outline the project lifecycle stage and their Overall RAG rating for each project within Better Care Delivered Differently*.

Delivery (10)			
Programme	Ref	Project	Overall RAG rating
Best Care	P1.1a	SMART Cardiology	GREEN
	P1.4	Remove same day multi-site pathways – Breast	GREEN
Integrated Care	P2.1	Virtual Hospital (Phases 1-3) and Virtual Ward Expansion (P2.2)	AMBER
Consistent Care	P4.1	Clinical Practice Group	GREEN
	P4.3	GIRFT (Getting It Right First Time)	GREEN
	P4.5	Multi-Year Efficiency (MYE) Programme	AMBER
Transforming Outpatients	P5.2	Implement patient initiated follow-ups	AMBER
	P5.3	Advice and guidance services	GREEN
	P5.4	Non face to face outpatient attendances	AMBER
Redevelopment	P8.5	Implement the Green Plan	Reported via quarterly programme update

Implementation Planning (6)			
Programme	Ref	Project	Overall RAG rating
Best Care	P1.1b	SMART – Respiratory	AMBER
	P1.6	Improve our services for pregnant women	AMBER
Integrated Care	P2.7	Advanced Care Plans (ACPs)	GREEN
People / Workforce	P6.1	Develop an overarching EDI Group	GREEN
	P6.3	Review of the Learning & Development structure	AMBER
	P6.4	The development of clear action plans with the national staff survey	GREEN

*The tables above excludes the digital programme projects. Digital projects are reported monthly as part of the digital progress report to the GPPB, which includes updates against the most significant projects

BCDD Projects - Project Lifecycle Stage and Overall RAG rating

BCDD projects* would be expected to move out of the scoping and planning phases (tables below) over the coming months and into implementation and delivery (slide 4) with clear benefits realisation demonstrated, ensuring agreed outcomes for each project have been delivered.

Planning (12)			
Programme	Ref	Project	Overall RAG rating
Best Care	P1.3	Development of an elective system hub	AMBER
	P1.5	Remove same day multi-site pathways – Urology	AMBER
Integrated Care	P2.3	Discharge to Assess (DTA)	GREEN
	P2.4	Frailty	GREEN
	P2.5	New model of care for people with Respiratory diseases	AMBER
	P2.6	Proactive management of patients with multiple Long-Term Conditions (LTCs)	GREEN
People / Workforce	P6.2	To support workforce modelling plans across the Trust and at Divisional level	AMBER
	P6.6	Establishment of career coaching	GREEN
Redevelopment	P8.1	Outline business case for the redevelopment	Reported via monthly 'SRO Update'
	P8.2	Business case for enabling works	AMBER
	P8.3	Expand the bed base and reinstate the ringfenced elective beds	Project Closed
	8.4	Expansion of diagnostic services at St Albans City Hospital	AMBER

Project Scoping / Initiation (8)			
Programme	Ref	Project	Overall RAG rating
Best Care	P1.1c	SMART Gastroenterology	AMBER
	P1.2	ICS Acute Services Strategy	GREEN
Personalised care	P3.1	Equality Delivery System (EDS) 2022 Review	Under review
	P3.2	Promote inclusion across our services	Under review
Consistent Care	P4.2	Theatre Productivity Improvement Programme	AMBER
	P4.4	Pre Covid-19 levels of efficiency	AMBER
Transforming Outpatients	P5.1	Modernise our patient communication and booking processes	Currently in the process of appointing a project manager
People/ Workforce	P6.5	Appoint retention lead	In scoping stage

*The tables above excludes the digital programme projects. Digital projects are reported monthly as part of the digital progress report to the GPPB, which includes updates against the most significant projects

BCDD Milestones – highlighted by exception continued

Although the following projects are not Overall RAG rated RED, we are highlighting them for attention, based on **RED milestone RAGS**.

Programme	Ref	Project	Project Lifecycle	Delays in milestones
Best Care	P1.1b	SMART – Respiratory	Implementation	*Milestone 1 (5x Consultants start date).* 3 of 5 consultants have now been recruited, with other posts still out for advert. 3 recruited posts are anticipated to begin in January 2023.
Best Care	P1.5	Remove multi-appointment pathways - Urology	Planning	*Milestone 1 (OBC sign off)*. Currently awaiting final confirmation of OBC.
Integrated Care	P2.1	Virtual Hospital	Delivery	*Milestone 6 (Ensure access for patients in care homes). Meeting with care home lead and developing engagement plan)*
Integrated Care	P2.1	Virtual Hospital	Delivery	*Milestone 7 (Access for people who access acute services in other acute trust). Conversations on-going with Royal Free London NHS FT and via CLCH counterparts.*
Integrated Care	P2.1	Virtual Hospital	Delivery	*Milestone 8 (Develop clinical pathways for virtual frailty ward).* Being developed as part of the wider frailty work with likely completion in October 2022.
Integrated Care	P2.4	Frailty Transformation	Planning	*Milestone 2 (Establishing frailty workstreams).* Workstream identified, leads to be agreed. Workplan has been developed and meeting dates have been set-up.
Integrated Care	P2.5	Respiratory Transformation	Planning	*Milestone 1 (Data mapping for each pathway: Asthma, Bronchiectasis & COPD). Slow progress due to focus on VH Phase 3. Has not yet been possible to get system partners to agree and sign off the pathways. Discussions is scheduled for the 13th October 2022 Steering Group.*
Consistent Care	P4.2	Theatre Productivity Improvement Programme	Scoping	*Milestone 3 (Recruitment of Band 8c programme lead and Band 6 Project Manager).* Offer was made for the 8c position however candidate has withdrawn. Recruitment now to re-commence through the use of an agency.
Consistent Care	P4.4	Pre-Covid-19 levels of efficiency	Scoping	*Milestone 2 (Monthly elective activity to reach 2019/20 levels before the end of the 22/23 FY).* Whilst diagnostic and medicine activity/recovery is on target, overall surgery activity recovery is dependent on theatre productivity focus. Data quality improvement plan to be developed.
Consistent Care	P4.5	Multi-Year Efficiency programme	Delivery	*Milestone 2 (Agree recovery plan for EPR programme).* Additional slippage has been identified as staffing efficiencies have been delayed due to the need for additional support to enable the changes to ERS upload.
Redevelopment	P8.2	Enabling Works Business Case	Planning	*Milestone 2 (Approval of funding)*. Response still awaited from NHP on funding for the Full Enabling Works Business Case, following initial submission in October 2021.
Redevelopment	P8.2	Enabling Works Business Case	Planning	*Milestone 3 (Completion of Pathology/Mortuary).* Design completed, awaiting funding approval.
Redevelopment	P8.4	Expansion of Diagnostic Services at SACH	Planning	*Milestone 1 (Awaiting formal notification of the MoU)*. Dialogue is on-going with the ICB to confirm the capital and revenue investment. This milestone is also imperative to completion of the tender, for the design, and the commence infrastructure works at SACH.

BCDD Risks & Issues – highlighted by exception continued

Although the following projects are not Overall RAG rated RED, we are highlighting them for attention, based on **EXTREME (red) risks/issues indicated, with risk score RAG post-mitigation deemed HIGH (amber).**

Programme	Ref	Project	Project Lifecycle	Extreme (red) Risk indicated; risk score RAG post mitigation deemed High (amber)
Best Care	P1.3	Development of an elective system hub	Planning	*Risk 001 (Currently no formal confirmation of revenue investment).* This has been escalated across the ICB and continues to be escalated throughout the system.
Best Care	P1.3	Development of an elective system hub	Planning	*Risk 003 (Timeframe to deliver additional capacity).* Work to submit SFBC to NHSE/I on time and ensuring a robust programme is in place that has undergone significant engagement.
Best Care	P1.6	Improve our services for pregnant women	Implementation	*Risk 001 (Recruitment & retention).* Live forum and campaigns for recruitment and retention (including international) are on-going.
Integrated Care	P2.3	Discharge to Assess	Planning	*Risk 001 (Risk demand on community services from hospital).* DTA Business Case to review the system need and develop recommendations for a sustainable model. Homecare capacity and efficiency meetings on-going.
Integrated Care	P2.3	Discharge to Assess	Planning	*Risk 002 (Risk the number people NMCTR might outstrip discharge capacity due to growing hospital activity and acuity).* DTA Business Case to review the system need and develop recommendation for a sustainable model. Homecare capacity and efficiency meetings on-going.
Consistent Care	P4.2	Theatre Productivity Improvement Programme	Scoping	*Risk 003 (Recruitment of Programme Lead in challenging market).* Team are currently approaching agencies to support with recruiting.
Consistent Care	P4.5	Multi-Year Efficiency Programme	Delivery	*Risk 003 (Delays to delivery of EPR cash releasing benefits due to unforeseen increases in costs).* Work is currently being undertaken to identify additional benefit opportunities outside those assumed in the Business Case.
Redevelopment	P8.4	Expansion of Diagnostic Services at SACH	Planning	*Risk 001 (Inability to recruit a skilled workforce will impact efficient service delivery).* To explore new roles and ways of working supported by digital transformation and implementing an apprenticeship programme. To expand international recruitment opportunities.
Redevelopment	P8.4	Expansion of Diagnostic Services at SACH	Planning	*Risk 003 (Increase in revenue costs due to inability to recruit radiologists that are able to report on the increases in activity).* Potential increase in costs are being flagged to the relevant forum to raise awareness ahead of time.
Redevelopment	P8.4	Expansion of Diagnostic Services at SACH	Planning	*Issue 001 (WHTH will not have the required time available to spend the allocated investment, if not formally notified of the MoU).* Advanced allocation of funds, through CFPG, are being used to immediately expedite the required surveys. Purchase of the MRI kit will also serve to prevent any potential delays.

BCDD Programme 1 – Best Care	Programme SRO: Sally Tucker	Reporting Month	November 2022

SRO Programme Summary

SMART - Recruitment is ongoing. Three consultants have been recruited (respiratory) and interviews are scheduled for November 2022 (Gastro). Work continues, across all areas of SMART, to agree the informatics/finance project support for KPIs & pull data from Cerner to baseline level.

Acute Services Strategy – Has been agreed, in principle, and is planned to be presented to ICS executives in November 2022.

Development of an elective system hub – Proposal for the SACH solution for elective hub has been completed. Following review, this has been selected as the preferred option and instruction has been provided to progress with the Short Form Business Case & programme implementation.

Remove same day multi-site pathways (breast) – Performance measures, for benefits realisation, to be captured.

Remove same day multi-appointment pathways (urology) – Currently awaiting final confirmation of the OBC. Benefits realisation to be developed.

Improve our services for pregnant women – Work is ongoing to confirm full compliance of Ockenden Report (Dec 20 – Interim & March 22 – Final).

Programme RAG Rating

October 2022	November 2022
A	A

Ref	Project Name	Project RAG Rating	
		Oct 2022	Nov 2022
P1.1	SMART	A	A
P1.2	Acute services strategy	G	G
P1.3	Development of an elective system hub	R	A
P1.4	Remove same day multisite pathways – breast	G	G
P1.5	Remove multisite appointments - urology	A	A
P1.6	Improve our services for pregnant women	A	A

Milestones/Key Achievements

P1.1 - Data capture solution allows SMART intervention to be identified. Locum doctor (respiratory) to start January 2023.
P1.2 – Strategy agreed in principle and work has begun on the development of the delivery plan.
P1.3 – Working group has agreed the programme governance structure and a timeline, to confirm overall NHSE/I sign off, has been developed.
P1.4 – Division is now clear on the original scope and the further work required to achieve aims.
P1.5 – OBC has been completed and signed off by the SACs division.
P1.6 – Funding secured for maternity support worker and Head of Midwifery recruitment is ongoing.

Next Period Planned activities

P1.1 – To agree options appraisal & baseline data (gastro). Cardiology data to be presented to confirm benefits realisation.
P1.2 – To finalise the delivery plan for the ICS Acute Services Strategy.
P1.3 - To confirm leads and resources for the programme and launch task & finish groups.
P1.4 – To identify cross divisional resource on the transfer of sentinel node injections to SACH.
P1.5 – To identify and agree resource and structure for urology centre programme of works,
P1.6 - To review East Kent findings & refresh Equality and Equity action plan for LMNS.

Issues for Escalation

- IEA 5 full compliance of initial **Ockenden report** subject to rollout of digital maternity system by January 2023.

BCDD Programme 2 – Integrated Care	Programme SRO: Laura Bell	Reporting Month	November 2022

SRO Programme Summary

NOTE – As agreed with SWHHCP, project updates will be submitted in arrears and will next be reported in December 2022. P2.3 was updated for November reporting.

Virtual Hospital(VH) & Virtual Ward Expansion - Soft launch of Phase 3 commenced on 26th September. Successfully awarded SDF funding to increase virtual hospital offering to other specialties including Frailty and Diabetes.

Discharge to Assess: Awaiting delivery and decisions around further Health & Social Care winter monies. Range of scheme identified that have been supported or awaiting decisions. Risk mitigations not reduced, as are dependant on system wide agreement, this presents a risk of people delayed in hospital or poor outcomes.

Frailty – Risk register has been developed.

Respiratory Transformation - Dependent on the procurement timeframe and activity set by ICB colleagues, new go live date to be agreed.

Multiple Long-Term Conditions - Workshop planned for 27th September 2022 to determine and agree appropriate pathways.

Advanced Care Plans - Recruitment completed for 12-month pilot commencing in November 2022.

Programme RAG Rating

October 2022	November 2022
A	A

Ref	Project Name	Project RAG Rating	
		Oct 2022	Nov 2022
P2.1	Virtual Hospital (VH): Phases 1-3	A	A
P2.2	Virtual ward expansion	Merged into P2.1	Merged into P2.1
P2.3	Discharge to Assess (DTA)	G	G
P2.4	Frailty	G	G
P2.5	Respiratory Transformation	A	A
P2.6	Multiple Long Term Conditions (LTC)	G	G
P2.7	Advanced Care Plans (ACPs)	G	G

Milestones/Key Achievements

P2.1 & P2.2 - Soft-launch of Phase 3 will commence the week of 26th September. Successfully awarded SDF funding to increase virtual hospital offering to other specialties including Frailty and Diabetes.
P2.3 – Range of schemes identified that have been supported awaiting decisions (winter monies). These provide opportunity to increase resilience and test concepts over winter, however short term nature of funds will make project initiation and recruitment challenging. Contact has been made with patient engagement leads in WHTH and HCC Older People's Co-Production Board.
P2.4 - Framework for Frailty Hotline agreed.
P2.5 - Actions underway to progress workforce changes that are required to mobilise the new pathways.
P2.6 - LTC workshop planned for 27/09/2022 to decide on PCNs, type of LTC to be considered for pilot and developing various pathways.
P2.7 - Governance groups are being refined with an Operational Group and Strategic group scheduled. Representation reviewed to ensure good system partner representation.

Next Period Planned activities

P2.1 & 2.2 - Commence rollout of Phase 3; Develop the workplan for VH transfer from Infoflex, Diabetes clinical pathway sign-off.
P2.3 – Co-production work is still in scoping. Project still to be formulated, but plans are in place to commence patient engagement on information requirements and strength based discharge planning.
P2.4 - Frailty Transformation workstream workshop.
P2.5 - Finalising AS IS demand and capacity work for both CLCH and WHTHT ongoing.
P2.6 - Develop business case, set up working groups, and formulate clinical pathway, operational workforce and IT models.
P2.7 - Induction of recruited staff, identify patient representative to join patient meetings, and drafting of written communications to be completed as part of delivery of communications plan.

Issues for Escalation

- **VH:** Whilst milestones are largely on track – Phase 3 element has been delayed due to Nurse recruitment from original launch date (March 2022) – now due in September 2022. This is key factor impacting the reduced VH activity against plan in the business case.
- **Respiratory:** Procurement process adding uncertainty to project timelines, original implementation date of October 2022 will now need to be reviewed in line with this process. Business case now with ICB for completion.

BCDD Programme 4 – Consistent Care	Programme SRO: Don Richards	Reporting Month	November 2022

SRO Programme Summary

Clinical Practice Group – CPG programme to support the development of the virtual hospital and ensure the pathways are aligned.

Theatre Productivity Improvement Programme - Recruitment is ongoing. Programme team have completed the procurement of the management consultancy firm and meetings are now underway to review the IT solution, agree the programme structure and the programme initiation timeline.

GIRFT - Dr Ajitha Jayaratnan has taken over the clinical leadership of the GIRFT programme from Dr Anna Wood.

Pre-Covid-19 levels of Efficiency – COVID costs reducing. The current forecast spending is only £0.2m higher than target. Elective productivity restoration remains a challenge.

Multi-Year Efficiency – CSS division have successfully identified 90% of the efficiency target at M6. Additionally commercial income generation opportunities (Emergency Medicine) have been identified. Staffing efficiencies have been delayed due to additional support to enable changes to ERS.

Programme RAG Rating

October 2022	November 2022
A	A

Ref	Project Name	Project RAG Rating Oct 2022	Project RAG Rating Nov 2022
P4.1	Clinical Practice Group(CPG)	G	G
P4.2	Theatre Productivity Improvement Programme	A	A
P4.3	GIRFT	G	G
P4.4	Pre-Covid-19 levels of Efficiency	A	A
P4.5	Multi-year Efficiency Programme (MYE)	A	A

Milestones/Key Achievements

P4.1 – Progress made to identify RFL digitalised pathway(s) that can be implemented at WHTH with minimal to no changes. Reporting schedule revised to quarterly in line with reporting to the Quality Committee. Next report due January 2023.
P4.2 – Management consultancy firm procured. Band 6 Project Manager recruited and in post.
P4.3 – Dr Ajitha Jayaratnan has taken over the clinical leadership of the GIRFT programme.
P4.4 – Operational Recovery Group meetings continue and plan to reduce trajectory for COVID spend agreed.
P4.5 - Respiratory work continues with CCG to issue PIN notice to move to direct award.

Next Period Planned activities

P4.1 – To identify a new pathway that can be developed and digitised for WHTH.
P4.2 – Recruitment of Programme Lead (8c) is ongoing. Programme team to create a live theatre dashboard and sign form contract with management consultancy firm.
P4.3 - Dr Ajitha Jayaratnan has taken over the clinical leadership of the GIRFT programme from Dr Anna Wood.
P4.4 – To update the detailed cost projections for COVID testing.
P4.5 – To explore additional opportunities to improve SLR contribution for Gynaecology services.

Issues for Escalation

None

BCDD Programme 5 – Transforming Outpatients	Programme SRO: Paul Bannister	Reporting Month	November 2022

SRO Programme Summary

Implement patient initiated follow-ups (PIFU) – Processes for DNA PIFU working well. Will now look to rapidly roll out to all other specialties
Advice & Guidance (A&G) – 2WW Lesion A&G pathway working well, with positive feedback from primary care.
Non face to face outpatient attendances (NF2F) - Positive work with BI team and CRO for outpatients to agree local definitions for virtual consultation (VC).
Modernise our patient communication and booking processes – Patient portal project manager now appointed. The first meeting of the project group has taken place.

Programme RAG Rating

Oct 2022	Nov 2022
A	A

Ref	Project Name	Project RAG Rating		Ref	Project Name	Project RAG Rating	
		Oct 2022	Nov 2022			Oct 2022	Nov 2022
P5.1	Modernise our patient communication and booking processes	Project in scope		P5.3	Advice and guidance services	G	G
P5.2	Implement PIFU	A	A	P5.4	Non face to face outpatient attendances	A	A

Milestones/Key Achievements	Next Period Planned activities
PIFU: Set up PIFU data on I-Reporter to assist specialties in monitoring implementation – Weekly and monthly reporting against OP metrics by specialty now included within the weekly activity recovery tracker that is sent out to all ADMS and teams weekly.	Complete roll out for Haematology and endocrinology. Review PIFU DNA Pilot and implement findings across other specialties.
Advice & Guidance: New Dermatology skin lesion A&G service set up to reduce pressure on 2WW referrals. All services that are appropriate for a Referral Assessment Service (RAS) are now on a RAS.	
NF2F: Action plan has been developed to agree solutions for key areas that are impacting performance. Key areas include: Cerner Recording, Understanding targets, Defining NFTF activity, Standardising working practices, Understand all the other systems that activity is being recorded on, Demand and capacity review, Promotion of Attend Anywhere and other virtual platforms available to clinicians	Finalise VC SOP and ensure that this is rolled out to all staff. Explore options for setting all FU appointments as a default to NF2F.

Issues for Escalation

None

BCDD Programme 6 – People / Workforce	Programme SRO: Andrew McMenemy	Reporting Month	November 2022

SRO Programme Summary

Develop an EDI Group First meeting undertaken, ToR agreed and devising agenda for the next meeting to ensure all key stakeholders are included. Business case developed for extending EDI establishment & to align with wider OD function.
Support workforce modelling – Westfield Academy work experience event successful, fantastic engagement from colleagues with over 180 young people attending. Appointment of ICS workforce modelling team and drafting local plans to align with business planning process.
Review L&D Structure - Nearly all posts within the L&D and Talent function have been recruited to, initial areas of focus identified but further work to be undertaken to establish some of the finer detail around roles and responsibilities following MoC. Talent team providing support to L&D until final post is recruited to. Associate Directors to work collaboratively to ensure both teams are working in a collaborative and complementary way.
Development of clear action plans for staff survey – Staff survey released 3rd October for 8 weeks. Communication plan devised and incentives in place. Wider wellbeing OD work in progress in order to ensure we have a comprehensive response to feedback and start working on identified areas early in order to have a tangible impact on staff.
Establishment of career coaching - The Head of L&D has arranged for a Coaching for Career Management session on the 6th December. This will train existing Trust Coaches on the specific skills of career coaching. Around 50% of coaching referrals require career coaching so we are commencing an additional upskill programme. This course will be mandatory for all trust coaches.

Programme RAG Rating

Oct 2022	Nov 2022
G	G

Ref	Project Name	Project RAG Rating		Ref	Project Name	Project RAG Rating	
		Oct 2022	Nov 2022			Oct 2022	Nov 2022
P6.1	Develop an overall EDI group	G	G	P6.4	Development of clear action plans for Staff survey	G	G
P6.2	Support workforce modelling	A	A	P6.5	Appoint retention lead	Project in scoping stage	
P6.3	Review of the L&D structure	A	A	P6.6	Establishment of career coaching	No update this month	G

Milestones/Key Achievements	Next Period Planned activities
EDI Group – Initial finance meeting undertaken to discuss funding options to establish a new post that cuts across Wellbeing & EDI teams to enhance inclusion and engagement. Business case for increase in establishment has been drafted and will be sent to corporate finance meeting.	Working with the L&D team to ensure teaching, training and online material are inclusive and accessible.
Establishment of career coaching - All coaching requests are being met. 61 clients have been serviced since October 2022. 29 on-going client interactions at this time. CPD funds identified to train another additional trainer internally to increase capacity.	Develop communication plan around advertising

Issues for Escalation

None.

BCDD Programme 7 – Digital	Programme SRO: Paul Bannister	Reporting Month	November 2022

Reporting Arrangements

BCDD Programme 7 (Digital) is reported separately to the main BCDD Report.

Progress, on associated projects, is reported monthly to the Great Place governance forums (Great Place Programme Board & Great Place Committee), via the Digital Progress Report. The next scheduled version of the report is due to be presented to GPPB on 9th November.

The latest, reported versions, of the Digital Progress Report, are noted in the below table:

Great Place Governance Forum	Date	Report
Great Place Programme Board	9th November 2022	Verbal
Great Place Committee	17th November 2022	Digital Progress Report

BCDD Programme 8 – Redevelopment	Programme SRO: Don Richards	Reporting Month	November 2022

SRO Programme Summary

Outline Business Case (OBC) for the redevelopment – This project is reported monthly, to the GPPB, via the 'SRO Update' paper.

Business Case for Enabling Works - The Enabling Works Business Case was submitted to the New Hospital Programme (NHP) in October 2021, outcome TBC. Short Form Business Case (Pathology) has been submitted and has been reviewed at the NHP Investment Committee (25th October). The case has been approved subject to the production of minor pieces of information. The Trust has secured other sources of funding for all enabling elements except the relocation of the WGH VIE plant and a parcel of land south of the WGH visitors car park.

Expand the bed base and reinstate ringfenced beds – Project closed. Progress reported through P8.2 (Business Case for the Enabling Works)

Expansion of Diagnostic Services at SACH – The OBC has been completed and awaiting review at WHTH internal governance forums. Dialogue continues with ICB to confirm capital and revenue investment. Currently awaiting formal notification of the MoU.

Implement the Green Plan – Following confirmation, P8.5 will no longer be reported through BCDD. P8.5 will now be reported quarterly, to GPPB, in a stand-alone report. The next scheduled report is planned to be presented to the GPPB in December 2022.

Programme RAG Rating

Oct 2022	Nov 2022
A	A

Ref	Project Name	Project RAG Rating		Ref	Project Name	Project RAG Rating	
		Oct 2022	Nov 2022			Oct 2022	Nov 2022
P8.1	OBC for the redevelopment	Reporting arrangements TBC	Reported via 'SRO Update'	P8.4	Expansion of diagnostic services at SACH	G	A
P8.2	Business case for enabling works	R	A	P8.5	Implement the green plan	G	Reported separately
P8.3	Expand the bed base and reinstate ringfenced beds	A	Closed				

Milestones/Key Achievements

P8.1 – This project is reported monthly, to the GPPB, via the 'SRO Update' paper.
P8.2 – Initial design for the VIE has been completed and construction award is in hand. Design for bed expansion (Shrodells) has been completed pending internal approval.
P8.3 – Project closed.
P8.4 – CFPG have approved advanced funds to commence surveys. MRI kit has been ordered with funds internally approved. Ongoing dialogue on the possession of Runcie Wing.
P8.5 - Project reported separately.

Next Period Planned activities

P8.1 - This project is reported monthly, to the GPPB, via the 'SRO Update' paper.
P8.2 - To award the contract for Pathology & Shrodells (pending current approval).
P8.3 – Project closed.
P8.4 – To finalise the Workforce Strategy. To confirm internal sign off of the Operational Policy.
P8.5 – Project reported separately.

Issues for Escalation

N/A

Trust Board
01 December 2022

<table>
<tr><td>Title of the paper</td><td>2022-2024 Strategic Objectives Delivery Report Q2 2022-23</td></tr>
<tr><td>Agenda Item</td><td>30</td></tr>
<tr><td>Presenter</td><td>Laura Bell, Director of Strategy and Integration (Interim)</td></tr>
<tr><td>Author(s)</td><td>Strategy Delivery Office</td></tr>
<tr><td>Purpose</td><td><table><tr><td>For approval</td><td>For discussion</td><td>For information</td></tr><tr><td></td><td></td><td>✓</td></tr></table></td></tr>
<tr><td>Executive Summary</td><td>In May 2022, the Trust Board approved its new two-year strategic objectives. These reflect the unique and ongoing challenges to recover from the Covid-19 pandemic and reduce our waiting lists, while also ensuring that we continue to innovate as we look towards the redevelopment of our three hospital sites and the opportunities that this brings to maximise digital and healthcare innovation to improve care, outcomes and patient experience.

This report sets out the 11 objectives and their delivery progress for Q2 and also includes those success measures that are still in development, providing assurance of the progress being made or not being reported until later in the year.

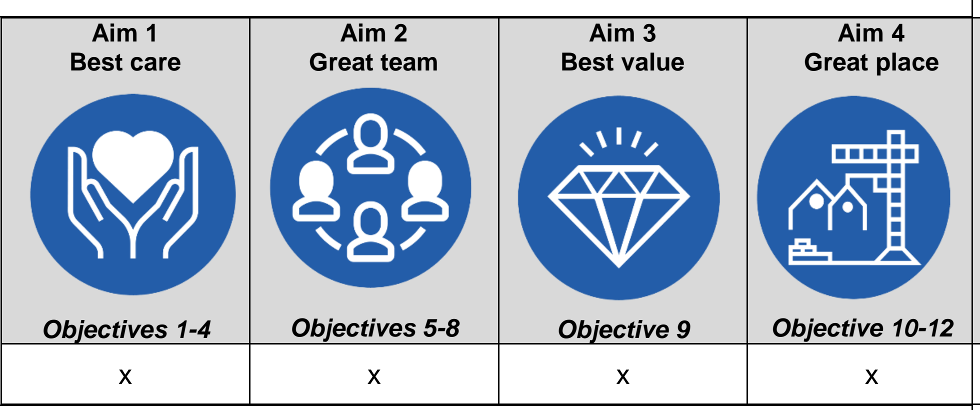
Summary of strategic objectives as at Q2:
3 out of 11 strategic objectives are meeting their targets
5 strategic objectives are not on target and
3 are still in development with delivery expected in Q3 and/or Q4
<u>Strategic Objectives on Target at Q2</u>

Objective 1 – Resilient Services. Green RAG
The ICS Acute Service Strategy has now been agreed in principle and work has begun on developing a delivery plan.

Objective 3 – Reducing Inequalities. Green RAG
The mapping exercise of networks and groups has been completed as part of the Q2 target.

Objective 4 – Transforming our services – Maternity. Amber RAG
The fully funded safe staffing metrics relate to ongoing recruitment and retention issues. There is clear recruitment and retention plan in place. Two international midwives are now in post and a further 10 are expected to join the trust by March 2023.</td></tr>
</table>

	Provisions for listening to families more effectively which relates to the Friends & Family Test, captures intrapartum care. The MVP (Maternity Voices Partnership) has undertaken a site visit and plans are in place for further visits, and they have engaged with women across the community. Training has been positive overall for staff groups with a clear plan for medics to meet the requirements by the end of November in Q3. The team already have plans in place for feedback across all maternity services covering all ethnicities for reporting in Q3. **Strategic Objectives Not yet on Target at Q2** **Objective 2 - Improving Access to Care. Amber RAG** The capture of activity and associated RTT clock status continues to be challenging and recording of outcome information remains under active review. The pressures of urgent and emergency care continue to limit opportunities to restore the elective bed base for orthopaedic surgery. The increase in cancer referrals of 27% is significantly above the 2019/20 baseline noted in the first two quarters of this year. **Objective 4 – Transforming Our Services - Virtual Hospital**. **Amber RAG** The clinical outcomes and patient feedback for the virtual hospital are positive. Work is now underway to increase the number of people being cared for via this model. The rating reflects the need to expand the service in terms of volume. Whilst the target number for people being treated in the virtual hospital or community services has not been met for Q2, there is a rapid development plan to increase medical, nursing and administrative resource to support this. Nurses have been recruited and are due to have completed their training in early December. Staff have been moved to new and more spacious and technology-enabled accommodation to support multi-disciplinary working. A business case to expand the VH pathways to include Frailty, ARI and Diabetes has been developed. **Objective 4 – Transforming our services - Outpatients. Red RAG** Two of the three measures for this objective are not yet on target. Patient initiated Follow Up (PIFU) continues to be under target and active clinical and operational support is required for the further roll out. Remote consultations also remain under target and a comprehensive action plan has been developed to ensure that NFTF (None Face To Face) activity is recorded and captured correctly, as well as ensuring clinicians are considering NFTF for all follow-ups. **Objective 7 – Improve workforce sustainability. Red RAG** The vacancy rate is currently just over the expected measure and vacancies have increased due to staff turnover. However, vacancies are expected to reduce as a result of key recruitment initiatives that are being implemented. Staff turnover rates overall and within the first year of employment remain above the trust target in line with the wider NHS and ICS Providers and have further increased to 18.8%. Retention rates for new starters has been added to the trust Corporate Risk Register as rates are continuing to increase at present. **Objective 8 – Develop as a learning organisation. Amber RAG**

	Diversity in staff involvement in non-mandatory training is just under target, however we continue to publish and drive uptake of non-mandatory training within minority and underrepresented groups. **Objective 10 – New and Refurbished Hospital Buildings. Amber RAG.** The enabling works are on target with funding secured for additional beds in Shrodells and for pathology essential services lab. A business case for the acquisition of land needed for the new hospital at Watford has also been drafted and submitted for initial review. Investment in diagnostic facilities has been welcomed (as part of the national Community Diagnostic Centres programme). **<u>Strategic Objectives not due to report this quarter or in development</u>** **Objective 6 – Culture of inclusion and diversity**. Success measures are due to be achieved Q4 (March 2023), via the Staff Survey. **Objective 9 – Digital IT & innovation.** No change from Q1. The team are focusing on delivering functionality to clinicians; therefore baselines and associated metrics are still to be developed and agreed. **Objective 11 – Reduce our carbon footprint.** Success measures are due in Q3. The delivery plan against Q3 is on track. Completion of success measure 1 has been postponed following agreement to run the Green Plan survey separately from the annual staff survey
Trust strategic aims (please indicate which of the 4 aims is relevant to the subject of the report)	
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?

<table>
<tr><td>Previously considered by</td><td><table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td>TMC</td><td>23 November 2022</td></tr></table></td></tr>
<tr><td>Action required</td><td>The Board is asked to take this report for information on the progress with the strategic objectives for Q2 2022-23.</td></tr>
</table>

2022-2024 Strategic Objectives Delivery Report

Q2 2022-23

Contents

		Slide
1.	Introduction	3
2.	Trust Aims & Strategic Objectives Overview	4
3.	Strategic Objectives Summary Position	5
4.	Strategic Objectives on target at Q2	
	1 Resilient Services	7
	3 Reducing inequalities	
	4 Transforming our Services (Maternity)	12
5.	Strategic Objectives not yet on target at Q2	
	2 Improving access to care	9
	4 Transforming our Services (Virtual Hospital)	10
	4 Transforming our Services (Outpatients)	11
	5 Best Value	13
	7 Improve Workforce Sustainability	14
	8 Develop as a learning organisation	15
	10 New & Refurbished Hospital Buildings	16
1.	Strategic Objectives not due to be reported this quarter or in development	
	6 Culture of Inclusion & Diversity	17
	9 Digital & IT Innovation	18
	11 Environmental and Sustainability	19

Introduction

Our vision is to deliver the very best care for every patient, every day. The five year Trust Strategy set in 2020 describes how we will achieve this, through the delivery of our four ambitions of Best Care, Best Value, Great Team and Great Place.

Every two years the Trust agrees a set of objectives and the priority plans that will help us realise our vision. Refreshed in 2022, this second cycle of strategic objectives reflect a complex and challenging set of circumstances post covid. Delivery of our strategic objectives will ensure we have addressed both the immediate challenges and our long term direction, to give us the confidence that we are taking the right steps towards our new future.

The main body of the report includes the delivery status of objectives, providing assurance of the progress being made.

Over Q3 and Q4, we will engage with leads to further develop the success measures that take us through to successful delivery by 2024, with the ambition of mapping what success will look like by the end of the five year period covered by the Trust Strategy.

Trust Aims and Strategic objectives

We published our five year trust strategy in 2020, which described our four overarching trust aims of best care, best value, great team and great place. We set strategic objectives every two years that describe the specific priorities on which we will focus to help us achieve our ambitions. We have set 11 strategic objectives for 2022-23 and 2023-24 that are summarised below, the delivery of which is detailed on the subsequent pages.

Best Care

- Resilient services
- Improving access to care
- Reducing inequalities
- Transforming our services

Best Value

- Meeting the needs of our population within our budget

Great Team

- Culture of inclusion and diversity
- Improve workforce sustainability
- Develop as a learning organisation

Great Place

- Digital and IT innovation
- Redevelop our hospitals
- Environmental sustainability

Summary slide

Strategic Objectives on Target at Q2

Objective 1 – Resilient Services. Green RAG
ICS Acute Service Strategy agreed in principle, developing delivery plan.

Objective 3 – Reducing Inequalities. Green RAG
Q1 and Q2 success measures have been met. Q3 Partnership arrangements led by ICB leadership are delayed until 2023.

Objective 4 – Transforming our services – Maternity. Amber RAG
The establishment is fully funded safe staffing. In line with the national picture, there are ongoing recruitment/retention issues. However, there is a clear recruitment and retention plan in place. Two international midwives are now in post and a further 10 are expected to commence role by March 2023.
Provisions for listening to families more effectively which relates to the Friends & Family test captures intrapartum care and training has been provided and there is a clear plan for medics to meet the requirements in Q3. MVP has been engaging with local groups and has undertaken site visits with a plan to continue with these. Looking to establish feedback across all maternity services (antenatal, intrapartum, postnatal) covering all ethnicities.

Strategic Objectives Not on Target at Q2

Objective 2 - Improving Access to Care. Amber RAG
Overall activity rates have improved this quarter although the position remains lower than originally anticipated in most areas. All key metrics within the activity plan (OP 1st, OP follow up diagnostic and Inpatient activity rates) are not meeting their target. The capture of activity and the associated RTT clock status continues to be challenging and recording and outcome information remains under active review.
RTT waiting times are under plan with the pressures of urgent and emergency care continuing to limit opportunities to restore the elective bed base at WGH to a pre-pandemic level. This has been particularly impactful for Orthopaedic surgery.
The increase in cancer referrals above the 2019/20 baseline has continued to impact waiting times, with a 27% increase noted in the first 2 quarters of this year compared to last year. The demand for more complex diagnostics has been sustained and additional capacity has been outsourced to mitigate for shortfalls where possible.

Objective 4 – Transforming Our Services -Virtual Hospital. Amber RAG
Phase 1 for COPD and HF are live, together with HF Phase 2, are underperforming, the recruitment of staff and changes to the management of referrals will enable the increase of the number of patients on-boarded into the VH. Recruited three band 6 nurses, two band 7 specialist nurse, a band 8a nurse lead and an administrator. Nurses are now in post and will have completed their training by the first week in December. Phase 3 – An incremental go live of Phase 3 for both COPD and HF pathways commenced in Oct 2022. Staff have been moved into purpose fit accommodation to facilitate multi-disciplinary working.

Objective 4 – Transforming our services - Outpatients. Red RAG
Patient initiated Follow Up (PIFU) and Remote Consultants remain under the Trust target. Active clinical and operational support required for the further roll out and delivery of PIFU and a comprehensive action plan has been developed to ensure that NFTF activity is recorded and captured correctly as well as ensuring clinicians are considering NFTF for all follow-ups. Advice and Guidance performing well.

Summary slide

Strategic Objectives Not on Target at Q2 (continued)

Objective 7 – Improve workforce sustainability. **Red RAG**
The vacancy rate is just over the expected measure and vacancies have increased due to a turnover of 117 staff which is 2.2% of the overall establishment. Staff turnover rates overall and within first year of employment remain above Trust target in line with the wider NHS and ICS Providers and have further increased to 18.8%. Retention has been added to the Trust Corporate Risk Register, as rates are continuing to increase at present.

Objective 8 – Develop as a learning organisation. **Amber RAG**
Diversity in staff involvement in non- mandatory training is just under target, this does not cover non-mandatory training offered by other departments, in particular that offered by Nurse Education and externally funded CPD. We continue to publish and drive uptake of non-mandatory training within minority and under represented Groups. Career coaching is above target.

Objective 10 – New and Refurbished Hospital Buildings. **Amber RAG.**
The enabling works are on target with funding secured for additional beds in Shrodells and for pathology essential services lab. A business case for the acquisition of land needed for the new hospital at Watford has also been drafted and submitted for initial review. The trust awaits further guidance from the New Hospital Programme on its redevelopment plans.

Strategic Objectives not due to report this quarter or in development

Objective 6 – Culture of inclusion and diversity. Success measures are due to be achieved Q4 (March 2023), via the Staff Survey.

Objective 9 – Digital IT & innovation. No change from Q1. The team are focusing on delivering functionality to clinicians, therefore baselines and associated metrics are still to be developed and agreed.

Objective 11 – Reduce our carbon footprint. Success measures due Q3. Delivery plan against Q3 is on track. Completion of success measure 1 has been postponed following agreement to run the Green Plan survey separately from the annual staff survey

Objective 1 Best Care – Resilient Services (On target at Q2)

Identify services where demand, activity or workforce challenges create fragility and strengthen these through internal reorganisation or working with hospital partners, leading to improved patient outcomes

We want to deliver the very best care to every patient, every day, but some of our services are more fragile due to low levels of activity or a small number of consultants, which means that it is harder for us to provide strong out of hours support or to provide services when people are on leave. We want to work in partnership with other local hospitals to strengthen the resilience of our services and improve patient outcomes

Success measures are due to be delivered in Q2 2022-23		Targets				
Success measures	Baseline	Q1 2022-23	Q2 2022-23	Q3 2022-23	Q4 2022-23	RAG
Agreement of acute strategy across three trusts and ICS	-		X			**G**
Set new measures based on actions from the strategy	-		X			**G**
Develop Delivery Plan	-			X		**G**

Progress update for Q2 2022-23:

- The ICS Acute Services Strategy has been agreed in principle.
- Work has begun on the development of a delivery plan, with the first draft anticipated to be presented to ICS Executives in November 2022.

Objective 3 Best Care – Reducing inequalities (On target at Q2)

Reduce health inequalities by completing the Equality Delivery System (EDS) and agreeing an action plan for improvement

We serve a diverse local population and employ a diverse workforce. Evidence at a national level shows that the Covid-19 pandemic has highlighted and worsened existing health inequalities between people from different socio-economic and ethnic backgrounds, as well as for people with disabilities or underlying health conditions. While we understand some of these factors there is more that we need to do to both understand health inequalities and to take actions to reduce them, both on our own and with partners.

Success measures are due to be delivered in Q4 2022-23	Targets				
Success measures	Q1 2022-23	Q2 2022-23	Q3 2022-23	Q4 2022-23	RAG
Detailed measures to be based on action plan	Confirm 2 provided services for review. One from the Core20 plus5 and either: 1. Service where data indicates it is doing well 2. Service data indicates improvements are required. 3. Service performance unknown	Complete mapping exercise of networks and groups	Approval of ICS governance and delivery framework	Publish WHTH review	G

Progress update for Q2 2022-23:

Health inequalities are realised in access, experience and outcome. The EDS will give insight to experience limited to a particular part of a service and some of the barriers to access and poor health outcomes experienced by our stakeholders. How we reduce health inequalities requires system commissioning and delivery across multiple partners and over the course of a long term strategic plan. This Strategic Objective will be revised early 2023. Whilst the ICB have agreed to mirror the service priorities identified by acute providers within the system, they are yet to define the process and governance to support delivery and are not expecting to complete this before the end of the financial year. This will mean that our Q3 target is unmet. Work continues to engage with ICB place director and system colleagues. Next meeting with ICB Health Inequalities lead set for 15th Nov.

2022 is a pilot year for the relaunched and revised Equality Delivery System. In this year, NHSE require service review from a limited list of the core20plus5. We will review maternity services which also compliments the work around the Ockenden Review and transformation work. Integral to the EDS framework is the requirement that a defined group of stakeholders review, validate and score the evidence presented. Our existing ability to engage with a targeted group of service specific stakeholders is limited and will require development through and into 2023. This is a similar experience and position to partners across our ICS. Internal mapping is complete with a list of known staff networks and existing co-production board stakeholders. Outgoing EDI lead met with Network Chairs in Q2 to refamiliarize them with the requirements of EDS. With a vacancy in EDI, the delivery plan has been revised to ensure we complete the EDS review by Feb 24th 2023. A paper will be presented to Jan TMC and TB Feb 2023.

Objective 2 Best Care – Improving access to care (Not yet on target at Q2)

Recover waiting times in line with national standards by increasing diagnostic capacity and elective activity.
Encourage patients and staff to embrace digital technology to help people access healthcare

The Covid-19 pandemic has had a significant impact on elective care, and we have seen an increase in both the number of people on the waiting list and the length of time that those people have to wait for their care. We have also seen an increase of around 20% in the number of people being referred on the cancer two week wait pathway compared to before the pandemic. Continuing infection prevention and control requirements mean that we are less efficient than before and increased emergency demand continues to reduce the capacity we have available to treat elective patients while also increasing waiting times in the emergency department.

Data Source	Success measures		Baseline (Mar22)	Q1 2022-23 Target	Q1 2022-23 Actual	Q1 2022-23 Var	Q1 2022-23 RAG	Q2 2022-23 Target	Q2 2022-23 Actual	Q2 2022-23 Var	Q2 2022-23 RAG
Activity Tracker	**Achieve agreed activity plan** *(set in line with national expectations relating to the recovery of elective activity)*	Outpatient 1st OPA rate	71.2%	110%	73.9%	-36.1%	A	110%	88%	-23%	A
		Outpatient follow up activity reduction	77.9%	by 25%	15.1%	-9.9%	A	75%	75.6%	0.6%	A
		Diagnostic activity rate	95.3%	120%	94.6%	-25.4%	A	120%	96.7%	-23.3%	A
		Inpatient activity rate	75.8%	110%	73.%	-37.0%	A	110%	77.7%	-32.3%	A
IPR	**Reduction in RTT waiting times** (*excl patient choice*)	104 week waits (yr1)	27	0	2	2	A	0	3	3	G
IPR	**Reduction in Cancer waiting times** (*excl patient choice*)	63+ day waits	376	262	345	83	A	286	297	11	A

Progress update for Q2 2022-23:

Activity plan: Activity rates have improved this quarter although the position remains lower than originally anticipated in most areas. The capture of activity and the associated RTT clock status continues to be challenging and recording and outcome information remains under active review. Work is underway to address the issues although progress is slow due to limited support resources. The Trust remains in Tier 1 for both the at risk 78 week wait position and the 62 day cancer waiting list backlog and oversight meetings with key external stakeholders (NHSE national and regional team representatives, the East of England Cancer Alliances and colleagues from the HWE ICB) are going very well. The supporting information used to supplement the discussions is well received and there has been consistent recognition of improvement delivery. RTT waiting times: The pressures of urgent and emergency care continue to limit opportunities to restore the elective bed base at WGH to a pre-pandemic level. This has been particularly impactful for Orthopaedic surgery. Although 3 patients are reported as reaching a wait time of 104 weeks or longer, all have since been treated and none were delayed due to capacity constraints. Cancer waiting times: The increase in cancer referrals above the 2019/20 baseline has continued, with a 27% increase noted in the first 2 quarters of this year compared to last year. The demand for more complex diagnostics has been sustained and additional capacity has been outsourced to mitigate for shortfalls where possible. Although services have had successful business cases to increase consultant posts, some services have been unable to recruit despite a number of incentives, limiting opportunities for improvement. Additional clinics and theatre sessions continue to supplement core capacity and the outsourcing of more routine work to the independent sector frees up in house capacity for more the complex, urgent caseload.

Objective 4 Best Care – Transforming our services (Not yet on target at Q2)

Collaborate with partners in the South and West Herts Health and Care Partnership (SWHHCP) to:

- **provide as much care and support as possible at patients' homes or in community settings, reducing the need for emergency care and reducing lengths of stay and admissions**
- **Reduce the number of different outpatient appointments that people need to attend, which boosts efficiency, respects our patients' time and reduces our carbon footprint**
- **improve maternity services and reduce outcome inequalities between different population groups**

We seek to continually improve our services through innovation and learning from best practice, such as our virtual hospital for Covid patients which was adopted nationally. We will continue to improve and innovate, working on our own or with partners to improve outcomes and patient experience. We will deliver care on our acute sites where patients need to access the facilities but we will increasing look to make our expertise available to people in their own homes or in community settings where possible.

Integrated Care *- Virtual Hospital target to be achieved by January 2024*			Q1 2022-23				Q2 2022-23			
Data source	Success measures	Baseline (April 2022)	Target	Actual	Var	RAG	Target	Actual	Var	RAG
Infoflex	Increase in the number of people treated in the virtual hospital or community services	69	447	105	-342	R	456	77	-379	R
tbc	Increased identification of patients with frailty and reduction in avoidable admissions for patients 65 + with moderate to high frailty scores	tbc	*The framework for metric reporting is being developed.*							

Progress update Q2 2022-23:

Virtual Hospital –
Whilst the target number for people being treated in the virtual hospital or community services has not been met for Q2, there is a rapid development plan to increase medical, nursing and administrative resource to support this is now in place. Nurses have been recruited and would have completed their training the first week in December. Staff have been moved to purpose fit accommodation to enable multi-disciplinary working. A business case to expand the VH pathways to include Frailty, ARI and Diabetes has been developed.
Phase 3 – An incremental go live of Phase 3 for both COPD and HF pathways commenced in Oct 2022. We expect to see a positive impact on success measures in Q3.

The Frailty Transformation Plan is under development and includes the implementation of a frailty virtual hospital. Step up and Step down pathways for the Frailty VH have been developed and are awaiting formal ratification. We expect to see a positive impact on success measures from Q4.

Objective 4 Best Care – Transforming our services continued (Not yet on target at Q2)

Success measures to be achieved by March 2023 (Data source EROC - elective recovery outpatient collection)

Outpatients			Q1 2022-23				Q2 2022-23 **			
Data source	Success measures	Baseline (Mar 22)	Target	Actual	Var	RAG	Target	Actual	Var	RAG
EROC Submission	Patient initiated Follow Up: Moving or discharging 5% of all outpatient attendances to PIFU pathways by March 2023	0.6% (196)	2.5%	0.87%	-1.63%	R	2.5%	0.71%	-1.79%	R
EROC Submission	Specialist Advice Requests: Deliver 16 specialist advice requests, including A&G, per 100 outpatient first attendances by March 2023	4.7% (634)	16%	46.38%	30.38%	G	16%	48.76%	32.76%	G
EROC Submission	Ensure that 25% of all outpatient attendances are carried remotely by March 2023	25%	25%	13.63%	-11.37%	R	25%	13.24%	-11.76%	R

Progress update for Q2 2022-23:

The national and regional ambition is a minimum 25% reduction in outpatient follow ups against 2019-20 activity levels by March 2023, through a personalised approach. The recommendations to providers on how to achieve this includes:

- Moving or discharging 5% of all outpatient attendances to PIFU pathways by March 2023 (reported under BCDD)
- Deliver 16 specialist advice requests, including A&G, per 100 outpatient first attendances by March 2023 (reported under BCDD)
- New : Follow Up Ratio –(NOT reported under BCDD)
- Outpatient Discharges –(NOT reported under BCDD)

The Video & Telephone Consultations (minimum of 25%) is under Measures for additional context (reported under BCDD)

A recognised point across our ICS is that we all had different starting points (e.g.):

1) we already have high performance in first to follow ups;
2) we have already set up Referral Assessment Services to help support a greater use of A&G and straight to test as part of our wider transformation piece;
3) our priority is to discharge whenever clinically appropriate rather than move to PIFU in order to hit the target but completely miss the point and
4) we have multiple enhanced community services that we discharge patients to who would in other ways have been our low hanging PIFU fruit.

We do need consistency and the data supports this and we should not lose site of the stated ask which is the 25% reduction in follow up activity.

*** September figures will not be available from NHS Futures and EROC until the beginning of November, therefore local data for September has been included in the quarterly calculation.*

Objective 4 Best Care – Transforming our services continued (On target at Q2)

Maternity Services				Q1 2022-23				Q2 2022-23			
Ockenden Review Pillar	Data source	Success measures	Baseline (Mar 22)	Target	Actual	Var	RAG	Target	Actual	Var	RAG
1: Fully funded safe staffing	HR	Midwifery vacancies	15.6%	15%	16.1%	1.1%	R	15%	19%	4%	A
	HR	Retention rates	Tbc	13%	18.7%	5.7%	R	13.0%	22.5%	9.5%	R
2: A well trained workforce	HR	MDT training compliance	90.3%	90.30%	Tbc	-	-	90.3%	90.0%	-0.3%	A
3: Learning from incidents	OD	Launch of Digital Maternity System	Target due Q4 2022-23								
	OD	Capacity to complete investigations within timeframes	Target due Q3 2022-23								
4: Provisions for listening to families more effectively	Patient Experience	Responsiveness to Friends and Family Test (FFT) real time survey	>25%	>25%	9.7%*	-15.3%	R	>25%	4.0%*	-21%	A
	MVP	No. Families engaged									A

Progress update for Q2 2022-23:

Ockenden - patient safety specialist identified working collaboratively with corporate staff who sits on SI panel and manages the risk and governance process. This means we are now compliant with the Ockenden requirement.
Discussions are underway with LMNS for WHTH to join a designated Maternal Medicine Network by March 2023.
Digital strategy has been signed of for LMNS. Badgernet system goes live in March 2023.
MVP has been engaging with local groups and has undertaken site visits with a plan to continue with these.
Completed our first divisional MDT route cause analysis training, to optimise the quality of investigation reports and learning.
The first senior midwifery away day is planned for December 2022.
Introduction of nursing within maternity to release midwifery time to care, aiming to improve skill mix.
Senior Bereavement Project midwife recruited, starting in post in January 2023.
Ongoing recruitment/retention - We have 2 international midwives in post and a further 10 are expected to commence role by March 2023. There are plans in place and these are under regular review.
Learning from incidents - review of risk and governance processes, internal audit taken place. Snapshot audits of highly reported incidents undertaken, e.g. Massive Obstetric Haemorrhage.
*FFT based on intrapartum care and training with a clear plan for medics to meet the requirements in Q3. We need to establish feedback across all maternity services (antenatal, intrapartum, post-natal) covering all ethnicities.

Objective 5 Best Value (Not yet on target at Q2)

Ensure we can meet the health needs of our population within our budget on an ongoing basis

The NHS emerges from the pandemic period with revised organisational structures, updated system funding regimes and new provider payment principles. The Trust in response will need to modify its internal financial management to increase elective care capacity, manage demand for emergency care and reduce unit costs for effective patient outcomes. Providing acute healthcare from three ageing sites means that the Trust starts from a financial run rate that is likely to present an affordability challenge to the health system. Plans to modernise the estate will at first present a revenue as well as capital affordability challenge. These challenges will be eased with a relentless focus on finding recurrent efficiencies from 'business as usual' activities as well as transforming models of care.

Best Value			Q1 2022-23				Q2 2022-23			
Data source	Success measures	Baseline	Target	Actual	Variance	RAG	Target	Actual	Variance	RAG
Trust I&E report	Balancing income with expenditure by the end of each financial year	-	Less than 10% adverse variance on budgeted net income	At Q1 the trust is £330k away from plan. This represents an 8% adverse variance.	-8%	A	Less than 10% adverse variance on budgeted net	At Q2 the trust is £44k above plan. This represents a 1% favourable variance	1%	G
Trust Board report	Production of updated 10 year LTFM and assumptions	-	Board report issue	Ongoing	-	N/A	Board report issue	Ongoing	-	N/A
Trust efficiency reports	% of phased efficiency target met by the aggregate of all four efficiency types	-	100%	At Q1 the trust is £469k away from plan. This represents a 41% adverse variance.	-41%	R	100%	At Q2 the trust is £1m away from plan. This represents a 25% adverse variance	-25%	A
Trust efficiency reports	% of monthly phased efficiency target met by recurrent cash release	-	25%	26%	1%	A	25%	38%	13%	G
TMC and FPC reports	Business case evaluations reported to TMC and FPC	-	1	0	-1	G	2	1	-1	A
Trust Board report	% of annual ERF income earned	-	15%	0%	-15%	R	50%	50%	0%	G

Progress update for Q2 2022-23:

Balancing income: At the end of Q2 (M1-6 YTD), the trust reports a £5.1m deficit of income over expenditure. This is £0.04m better than plan.
Production of updated 10 year LTFM: Ongoing.
% of phased efficiency target met by the aggregate of all four efficiency types: Unmet, divisions facing.
% of monthly phased efficiency target met by recurrent cash release: Met for Q1 & Q2.
Business case evaluations reported to TMC and FPC: Delayed due to operational pressures, 2 were due in Q2 however 1 was presented.
% of annual ERF income earned: In line with the construct of our financial plan, 50% of ERF funding has been recognised at the end of Q2.

Objective 7 Great Team (Not yet on target at Q2)

Address the challenge of workforce shortfalls through innovative staffing solutions and effective retention measures as well as proactively marketing the trust as an organisation where careers can be developed and nurtured

The Trust has experienced ongoing issues regarding hard to fill roles and retention in line with the wider NHS. Regular recruitment events and international recruitment campaign help to mitigate the challenge, but the geographical position next to London is also a factor. The impact of the pandemic has also led staff to reconsider some career and life priorities. Therefore this is our opportunity to embrace a new direction for some staff by supporting development opportunities, supporting their wellbeing and experience at work with a focus also on flexibility and work life balance. It is also an opportunity to consider new and innovative ways of developing staff skills and roles to support our services.

Success measures are set for achievement by March 2023.			Q1 2022-23				Q2 2022-23			
Data source	Success measures	Baseline (April 2022)	Target	Actual	Var	RAG	Target	Actual	Var	RAG
ESR BI / Ledger	Continued vacancy rates below 8%	8.4%	10%	9.50%	-0.50%	G	10%	10.1%	0.10%	R
ESR BI	Retention rates overall under 13%	15.0%	13%	16.40%	3.40%	R	13%	16.40%	3.40%	R
ESR BI	Retention rates for new starters (first 12 months) towards 15%	20.4%	15%	20.70%	5.70%	R	15%	18.80%	3.80%	R

Progress update for Q2 2022-23:

Vacancy rate: The vacancy rate as at September 2022 is just over the expected measure. Vacancies have increased due to a turnover of 117 staff which is 2.2% of the overall establishment. Of those, 10.9 wte are additional appointments. Overall the Trust needs to recruit over 800 wte staff each year to fill vacancies gaps. Vacancies are projected to reduce further based on our recruitment pipeline. The following initiatives have been undertaken recently with positive results:

- HCA recruitment day throughout Q2 to fill vacancies across all divisions.
- Rolling adverts for Band 5 A&E Nurses and Band 6 Midwives
- ADM recruitment targeting NHS Graduates for vacancies at Band 6 and 7.

Staff turnover rates overall and within first year of employment remains above Trust target in line with the wider NHS and ICS Providers and has further increased to 18.8%.

Retention has been added to the Trust Corporate Risk Register, as rates are continuing to increase at present. Main reasons for leaving include promotional opportunities in London, proximity to other Trusts and physical moves slightly further North to Aylesbury, Milton Keynes to take advantage of lower house prices.

Objective 8 Great Team (Not yet on target at Q2)

Improve effective development opportunities for our staff to support innovation and enhance our culture as a learning organisation

Staff opportunity to develop and learn is a key priority in retaining and supporting our workforce to equip them with the skills to meet needs of our services and enhance innovation and career development. The staff survey highlights that staff development opportunities being a significant determining factor on morale, productivity and retention. This objective is crucial in supporting effective and sustainable cultural change and is particularly important to us now that we have achieved teaching trust status.

			Q1 2022-23				Q2 2022-23			
Data source	Success measures	Baseline	Target	Actual	Var	RAG	Target	Actual	Var	RAG
Acorn and L&D Records	Improved diversity in staff involvement in non- mandatory training. *(% of BAME staff taking up Acorn- recorded non-mandatory training matches or exceeds % of BAME workforce (45% in March 2022))*	45%	45%	53%	8.0%	G	45%	44.1%	-0.9%	R
Coaching Service Records	Increase in proportion of staff seeking support from new career coaching services. (one client receives 5 coaching sessions) - Coaching Service launched on 22/10/2021 baseline is usage to 1/4/22)	16	25	22	-3	R	50	54	4	G
Staff Survey	The Staff Survey promise on 'We are always learning' to improve from a score of 5.4 to at least 5.6 (*Target set for achievement by March 2023)*	5.4	-	-	-	-	-	-	-	-

Progress update for Q2 2022-23:

Improved Diversity: We continue to publish and drive uptake of non-mandatory training within minority and under represented Groups. This measure covers all non-mandatory training where the registers are known to L&D, e.g. one-off non-mandatory courses and leadership programmes. It does not cover non-mandatory training offered by other departments, in particular that offered by Nurse Education and externally funded CPD, both of which could be incorporated into future reporting (subject to the Talent team's records). Plus numbers do not cover people accessing coaching only (as coaching is not training). Weights each individual as 1, so 1 person accessing 5 courses counts only once.

Coaching: Re-publicised coaching network. The Head of L&D has arranged for a Coaching for Career Management session on the 6th December. This will train existing Trust Coaches on the specific skills of career coaching. Around 50% of coaching referrals require career coaching so we are commencing an additional upskill programme. This course will be mandatory for all Trust coaches. The course looks at various specific career management tools and how coaches can manage them for our clients in a coaching environment.

Staff Survey: Current completion of staff survey stands at 39%. There is a reminder in place for all HRBP's and Medical Staffing personnel to remind their Divisional groups and departments after every meeting with details on the meal voucher for £2 for the staff restaurant or coffee and cake. Plus a prize draw for a days annual leave, the earlier you complete it the more chances you have to win. The team are meeting 7th November to revisit plan and metrics.

Objective 10 Great Place (Not yet on target at Q2)

Deliver new and refurbished hospital buildings in the shortest timescale possible by securing funding for the preferred options for all three hospitals

To deliver the very best care for our patients we need to have fit for purpose, modern buildings from which to provide that care. We have been working for a number of years to secure capital to enable us to redevelop our three hospital sites, with a particular focus on the emergency care site at Watford where most of our clinical buildings need to be replaced. We expect to receive confirmation of the capital allocation available to us during 2022 or early 2023.

		Targets			
Success measures	Baseline	Q1 2022-23	Q2 2022-23	Q3 2022-23	Q4 2022-23
Capital allocation secured (dependent on NHP timelines)	n/a			X	
OBC approved & clear programme for FBC and construction agreed with regulators (dependent on NHP timelines)	n/a				X
Enabling capital agreed and works completed to timetable (dependent on NHP approval)	n/a				

Progress update for Q2 2022-23:

During the last quarter, further work was completed on the outstanding chapters of the OBC and this has been shared with the New Hospital Programme to support the case for WHTH to progress at pace and with a view to securing the capital allocation needed.

There has also been significant progress with regard to enabling schemes, with funding now secured to create additional beds in the Shrodells building and to deliver the pathology essential services lab at Watford. A business case for the acquisition of land needed for the new hospital at Watford has also been drafted and submitted for initial review.

The Trust has also been awarded funding for the development of community diagnostic facilities at St Albans City Hospital. It is beneficial to proceed ahead of the main redevelopment when alternative funding becomes available.

Objective 6 Great Team (Not due to be reported this quarter)

Create and demonstrate a culture of inclusion and diversity where behaviours are consistent with our values and support the well being of our staff.

We are fortunate to have such a diverse group of staff that represents our local communities. It is our aim to celebrate this diversity and support enhanced levels of inclusion and involvement, providing equity of opportunities.

Success measures are due to be achieved in March 2023, via the Staff Survey			Targets				
Data source	Success measures	Baseline	Q1 2022-23	Q2 2022-23	Q3 2022-23	Q4 2022-23	RAG
Staff Survey (*results March 2023*)	WRES Indicator - % of BME staff believing that the organisation provides equal opportunities for career progression or promotion from 50% towards 58% for white staff	50%				X	n/a
Staff Survey (*results March 2023*)	WDES Indicator - % of staff with Long Term condition or illness experiencing harassment, bullying or abuse from other colleagues in last 12 months from 26% towards 18% for those staff without LTC	26%				X	n/a
Staff Survey (*results March 2023*)	Improved Staff Engagement Score in Staff Survey from 6.8 to 7	6.8				7.0	n/a

Progress update for Q2 2022-23:

Staff Survey WRES - Data continues to be collected via the Staff Survey, the results of which will not be available until March 23 and staff encouraged to highlight their ethnicity on all activities throughout the organisation, so that meaningful comparisons can be drawn to accurately identify opportunities and take up in the Trust. New EDI Lead to start in January 2023.

Staff Survey WDES - Data continues to be collected via the Staff Survey, the results of which will not be available until March 23 and staff encouraged to share disability or long term health conditions on all activities throughout the organisation, so that meaningful comparisons can be drawn to accurately identify opportunities and take up in the Trust.

Improving Staff Engagement - Listening events are taking place at all 4 sites and this will be a quarterly occurrence. OD project underway to action feedback from staff with three main themes 1. Staff support, 2. Environment & Facilities 3. Reward & Recognition. This leads into the You Said, We Did piece of work which wraps around the Staff Survey.

The team are meeting on 7th November to revisit plan and metrics.

Objective 9 Great Place (In development)

Maximise the benefits of digital and IT innovation by fully optimising the benefits of EPR and the wider use of data to drive improved patient care

Our vision for 2025 is that digital will underpin every aspect of clinical innovation. We will provide the core digital foundation to empower the population of West Hertfordshire, and support our staff to provide high-quality, safe, consistent and efficient care for every patient, every day. Our digital strategy describes the actions we will take to deliver this vision. Implementing our electronic patient record in November 2021 was a core enabler from which we can build.

Data source	Success measures	Baseline	Q2 2022-23 Target	Q2 2022-23 Actual	Variance	RAG
	Volume of paper used across the organisation (target a % reduction)	Unable to establish a robust baseline.				
	Number of patients accessing the patient portal (need to confirm start date and some usage from other organisation's implementations	The patient portal does not go-live till late February 2023.				
	Number of care staff accessing the Shared Care record (across the ICS) (we only went live in April so we would need to figure out a target)	No targets set for the SCR views, however monthly reporting is available that shows the number of views by organisation by staff group.				
	Number of paper forms digitised within Cerner	We have implemented 53 changes in the live Cerner environment and are working on another 67 – some of these will have an element of reducing paper.				
	% increase in a range of Cerner "lights on" metrics	Not yet effectively using the lights on metrics from Cerner. When this is introduced targets can be set.				

Progress update for Q2 2022-23:

No change from Q1. The team are currently focused on delivering functionality to clinicians.
Baselines and associated metrics are still to be developed and agreed.

Objective 11 Great Place (Not due to be reported this quarter)
Reduce our carbon footprint (excluding redevelopment capital builds)

The NHS is one of the largest employers in Britain and is responsible for ~4% of the nation's carbon emissions. As an NHS Trust, we recognise our responsibility to reduce our emissions and our environmental impact and deliver high quality and sustainable care to the communities we serve. We have identified nine key themes within our net zero action plan to help us deliver on our commitment to become one of the greenest acute hospital Trusts in the NHS.

Baselines and targets to be agreed in Q2		Targets					
Data source	Success measures	Baseline	Q1 2022-23	Q2 2022-23	Q3 2022-23	Q4 2022-23	RAG
Staff survey	1) Increase in the number of staff aware of the Green Plan and their responsibility in achieving the Trust's commitment to become one of the greenest acute hospital trusts in the NHS	TBD at initial staff survey				X	Red
Green dashboard	2) Lead a minimum of 8-10 programmes to reduce the use of single-use items in clinical services and settings	Nil			X	X	Green
Green dashboard	3) By 2025, 100% of appropriate clinical waste to be treated at an energy-from-waste recovery facility	0%			X	X	Green
Green dashboard	4) 5% decrease in energy consumption	N/A				X	Green
Green dashboard	5) To reduce staff driving to work to 55% and patients driving to on of our hospitals to 75%	Staff 61% Patients 79%	Target due 2023-24				

Progress update for Q2 2022-23:

1) The initial survey was due to be undertaken autumn/winter 22/23, however the decision has been made to postpone the survey. This decision was made to avoid a clash with the annual staff survey. **It has been confirmed that this success measure will now be moved to and reported in Q4**. Work is on-going to incorporate the Green Plan into the WHTH induction process.
2) **Achievement of the success measure is on track but will not be completed within the current year**. The 'Gloves Off' campaign has commenced. Additional campaigns, in the pipeline, include 'Walking Aids' & 'Theatre Caps'
3) **Success measure realisation is on track.**
4) The Business Case for replacing all existing WHTH LED lighting, across the building portfolio, is planned to be presented to TMC (26/10/22). **If approved and delivered the electricity savings are anticipated to be over 5%, therefore achieving this noted success measure.** Work is predicted to be underway in Q4, with a 4 month time period of delivery following work commencing.
5) **Draft Travel & Access Strategy anticipated to be presented, for approval, at the November GPPB**.

Trust Board
1 December 2022

Title of the paper	**Virtual Hospital Development Update**
Agenda Item	**31**
Presenter(s)	**Paul Bannister, Chief Information Officer** **Andy Barlow, Divisional Director Medicine** **Mary Bhatti, Divisional Manager Medicine**
Author(s)	**Paul Bannister, Chief Information Officer** **Andy Barlow, Divisional Director Medicine**
Purpose	**For approval**: – **For discussion**: – **For information**: ✓
Executive Summary	This paper provides an update to the Board on the development and expansion of our Virtual Hospital
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1 Best care** – ***Objectives 1-4***: x **Aim 2 Great team** – ***Objectives 5-8***: x **Aim 3 Best value** – ***Objective 9***: x **Aim 4 Great place** – ***Objective 10-12***: x
Links to well-led key lines of enquiry	✓ Is there the leadership capacity and capability to deliver high quality, sustainable care? ✓ Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ✓ Is there a culture of high quality, sustainable care? ✓ Are there clear responsibilities, roles and systems of accountability to support good governance and management? ✓ Are there clear and effective processes for managing risks, issues and performance? ✓ Is appropriate and accurate information being effectively processed, challenged and acted on? ✓ Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ✓ Are there robust systems and processes for learning, continuous improvement and innovation? ✓ How well is the trust using its resources?
Previously considered by	Committee/Group: N/A Date:
Action required	The Board is asked to receive the report for information.

Agenda Item: 31

Trust Board – 1 December 2022

Virtual Hospital Development Update

Presented by: Paul Bannister, Chief Information Officer

1 PURPOSE

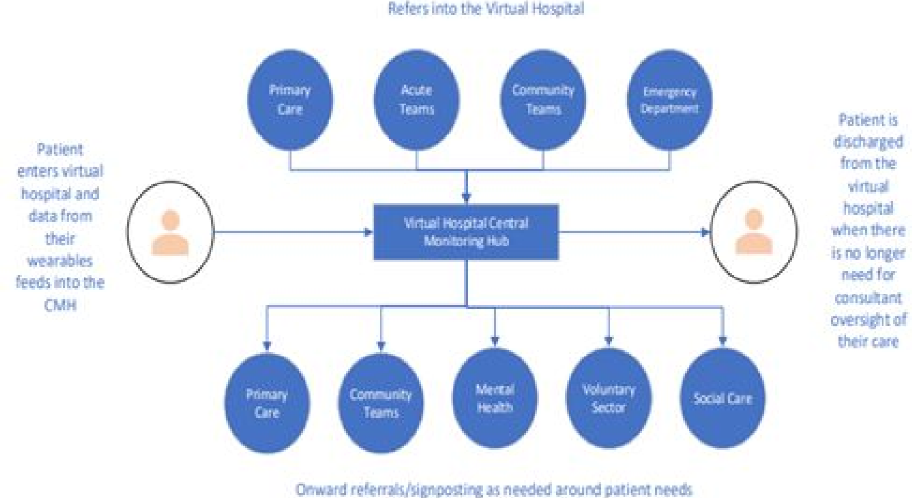
1.1 The aim of this paper is to provide provides an update to the Board on the development and expansion of our Virtual Hospital

2 BACKGROUND AND CONTEXT

2.1 In March 2020 at the height of the COVID pandemic the WHTH respiratory team established the first Virtual Hospital in the NHS, enabling patients to be treated from the comfort of their own home (freeing up hospital beds) whilst being monitored remotely via monitoring devices and application on their mobile phone.

2.2 In December 2021, in collaboration with CLCH, the service was expanded to include COPD and Heart Function.

2.3 The current service has input from a number of partners across the system:



and has the following features:

- Patients have a personalised care plan agreed before being admitted to VH
- Patients have access to a hub support team (clinical and administrative): 9am-6pm
- Care is integrated with support from acute, community, primary care, the voluntary sector and other services
- Clinical responsibility for the patient in the virtual hospital is determined in the care plan.

PLANNED EXPANSION OF VIRTUAL CAPACITY

2.4 In the 2022/23 planning guidance the NHS set a target for a rapid expansion of Virtual Ward capacity. The target is that by Dec 2023 each ICS has been asked to deliver the equivalent 40 to 50 virtual ward "beds" per 100,000 of population. For WHTH this would mean the equivalent to 200 to 250 beds.

2.5 In the latter half of this year the Trust has been trying to support its award winning clinical team to speed up the expansion of the virtual hospital service and we agreed to jointly look at the following:

- An improved physical environment for the Hub team
- More efficient method of identifying potentially eligible patients
- Enhanced staffing to support the onboarding of patients
- Clear processes to support the admission of patients from physical beds into virtual beds
- Merging the Virtual Hospital Record with the EPR
- Agreeing the next stage of expansion across SWHHCP

3 PROGRESS MADE

Physical Environment

3.1 During September we fitted out a new hub room and office for the Virtual Hospital team on the top floor of Cherry Tree House that enabled all the team to sit together in the same location and to expand the size of their team:

We will shortly be converting a 2nd office space to enable more effective multi-disciplinary team meetings.

Patient Identification

3.2 We have created two toolsets to enable the team to more efficiently identify patients who are in the hospital who might be eligible for the Virtual Hospital. The first of these is a download from Cerner of all the patients who are on steroid inhalers and may be suitable for the COPD pathway and the second is a weekly feed of all the patients who have had BNP tests that might indicate suitable candidates for the heart function service.

Recruitment

3.3 The team have recruited three band 6 nurses to run the hub, two band 7 specialist nurses, a band 8A nurse lead and an administrator. The nurses were recruited via secondments to try and speed up the recruitment process and as a proof of concept that the service could be successfully delivered at scale.

The nurses are now in post and will have completed their training by the first week in December. From the 28th November, Respiratory Consultants will provide dedicated morning sessions in the VH M-F, providing early ward rounds to the virtual patients and then to support the review and on-boarding of airways disease patients identified on the outlier wards. Also starting on the 28th November, the ward Respiratory Consultants will provide pm SMART cover M-F, enabling admission prevention work and low DECAF score VH admissions.

Admission Process and Communication

3.4 Referral forms with clear referral criteria have been documented and discussed and shared with the relevant clinical staff groups which can be considered during normal physical ward rounds, helping to improve the interaction between physical and virtual hospitals and capture patients who are not on the specialist respiratory or cardiology wards. Standard Operating Procedures have also been updated.

Conversations have also been held with ED and Acute physicians to clarify the patient on-boarding process, with laminated guidance being produced (see example for COPD in Appendix) for the intranet and ward areas around the correct use of the Virtual Hospital services and there is now a daily process of communication between the Matrons and individual wards to improve knowledge and we are working with our communications team to help promote the service internally

Bringing the Virtual Hospital into Cerner

3.5 The Virtual hospital contains three types of data:

- Administrative (scheduling etc)
- Clinical (Doctor / nurse observations etc)
- Physiological (the data captured outside of hospital by the device)

At present the first two of these data sets are recorded in infoflex and the last of these is stored on the external Massimo web interface.

The EPR team have been working with the VH team and the team at Imperial to develop a range of power-forms which will bring the administrative and clinical data into Cerner, bringing the patient data together and enabling a platform which can be easily rolled out to other services.

The platform has been built and is being tested by the team, we will then need a short period of training with the hope that the data is live in Cerner in Mid December. We are also working with Massimo to build an interface between Massimo and Cerner, though that will not be completed until 2023.

4 PATIENT NUMBERS

Admissions to the Virtual Hospital

4.1 The table below shows the admissions to the Virtual Hospital by service by month:

Service	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Heart Function	3	14	21	30	22	26	22	19	24	19	27
COPD	3	8	14	10	10	6	19	6	5	4	12
Total	**6**	**22**	**35**	**40**	**32**	**32**	**41**	**25**	**29**	**23**	**39**

Volumes have been below the original business case expectations though picked up in October and we would expect them to pick up further in December with the progress noted in the above paragraphs, particularly the increased staffing levels. The average occupancy per day in October was 14 patients, cared for by 1 B6, 1B7 and 1B8 Nurse. This same nurse team was then responsible for reviewing and on-boarding all the HF and COPD patients in the hospital. 1 nurse has to remain in the hub at all times.

The average length of stay of these patients is around 13 days for Heart Function and 7 days for COPD.

The initial aim of the expansion was to try and deliver the equivalent of 40 beds by Christmas 2022, we are still some way off this but with the recent uptick in October, the improved identification of patients and the recent completion of the recruitment we are hopeful that we will get most of the way to the target, with the latest projection being that by Christmas we will have patients equivalent to 20 Heart Function beds and 15 Respiratory beds.

5 PATIENT OUTCOMES

Readmissions and length of stay

- An early look at some of the outcomes from our Virtual Hospital for COPD are encouraging (as taken from the HSJ submission document). For a cohort of 69 Virtual Hospital patients compared to 50 COPD patients who received standard hospital care and a 50 patient comparator group from 2019 the findings were:
    - 30 day Readmission rates were 4% compared to standard of 9.3% and 2019 comparator of 13%
    - 90 day Readmission rates were 6.5% compared to standard of 15.9% and 2019 comparator of 21%
    - Length of Stay 5.3 days compared to standard of 6.3 days and comparator of 5.9 days

Within these findings It's important to emphasise a clear point of difference between the VH model and the 'old standard'; virtual ward care is not substitutional it's additional. The COPD virtual ward extends and enriches the care model by an additional 7 days whilst the patient is at home and provides multiple clinical opportunities to pre-empt and solve unmet needs.

The WH COPD VH appears to demonstrate improvements in lengths of stay, readmission rates at 30 and 90 days, fewer acute admissions and reduced overall bed days used. The program had high patient acceptance scores, low mortality and favourable staff feedback. This is encouraging early data supporting the safety and effectiveness of virtual wards for COPD and will soon be supplemented by the publication of an AHSN rapid evaluation.

6 BUSINESS CASE AND SERVICE EXPANSION

6.1 The *South and West Herts Health and Care Partnership has prepared a business case that seeks funding for the expansion of the Virtual Hospital model across three further pathways, these are:*

- Diabetes
- Acute Respiratory Infection / Pneumonia
- Frailty

Frailty and Pneumonia are expected to go-live shortly after business case approval with Diabetes shortly after that as the pathway needs to be signed off at I-CAG

The new pathways are expecting to refer 292 patients per month (a combination of acute step down, admissions direct from ED and community on boarding) avoid 39 admissions per month and reduce the need for 8 acute beds in the hospital.

Additional staffing will be recruited across acute and community services with the short term funding coming from the Primary Care System Development Funding. At this stage the long term funding of this expansion is unclear. This business case will need to come before Trust Committees to ensure the implications of any decisions are understood.

7 CONCLUSION

7.1 A number of positive steps have been taken to drive the growth in the Virtual Hospital and whilst the activity hasn't increased materially yet we believe all the conditions are now in place to shortly see the desired increase.

8 RECOMMENDATION

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

Name of Director: Paul Bannister, Chief Information Officer
Dr Andy Barlow, Divisional Director Medicine

Date: November 2022

COPD Pathway

For full COPD guidance, refer to published SOP for COPD

In Emergency Department

Triage/Initial Assessment suggestive of COPD exacerbation
Record MRC DS, previous pneumonia/complex microbiology, T2RF, NIV, LTOT, inhalers

INVESTIGATIONS (minimum set): Chest X-Ray, ABG/VBG, FBC,U&E, CRP

No consolidation

CALCULATE DECAF score
continue on COPD management pathway

Consolidation present

STOP. MANAGE ACCORDING TO CAP Pathway
Calculate CURB65 severity score (1 point for each feature present)
Confusion; Urea >7mmol; RR ≥30; BP SBP≤90 or DBP ≤60; Age ≥65

DECAF Score 0-1

1. **DEFAULT CLINICAL DECISION IS TO DISCHARGE. If you're considering admission, this must be justified clinically**
2. **Initiate standard management for COPD** (oral prednisolone (0.5mg/kg daily for 5 days), oral antibiotics if evidence of infective exacerbation)
3. **REFER TO VH HUB Nurse team**
4. **REFER TO SMART CONSULTANT/Respiratory Specialist Nurse**

DECAF Score 2

1. **Initiate standard management for COPD** (oral prednisolone (0.5mg/kg daily for 5 days), oral antibiotics if evidence of infective exacerbation)
2. **REFER IMMEDIATELY TO RESPIRATORY SMART CONSULTANT for consideration of virtual hospital management**
3. **REFER TO VH HUB Nurse team**
4. *** Please refer to inclusion criteria for COPD VH**

DECAF Score >3

1. **Admit via Medical Team**
2. **See COPD management guidelines for specific recommendations:**
   - controlled O2 (target SpO2 88-92%)
   - Oral Prednisolone (0.5mg/kg daily for 5 days)
   - oral antibiotics if infective exac
   - Nebulised therapy
3. **REFER TO ABC MDT**
4. **REFER TO SPECIALIST RESPIRATORY NURSE**
5. **ONCE STABLE, CONSIDER FOR VIRTUAL HOSPITAL TO FACILITATE EARLY DISCHARGE**

*** INCLUSION CRITERIA for COPD Virtual Hospital**
- **COPD diagnosis confirmed**
- **<85**
- **Alert, orientated**
- **No acute type 2 Respiratory Failure**
- **No signs of sepsis**
- **NEWS2 3 or less**
- **willing to give consent/supportive family**
- **Reviewed by VH Nurse team**
- **Reviewed by senior Respiratory Specialist/Referred to ABC MDT**

It is now department policy that ALL patients admitted with airways disease (Asthma, Bronchiectasis, COPD), even if short stay anticipated, are referred to the ABC MDT and the specialist Respiratory Nurse. This is the responsibility of the ward team. ABC MDT referrals are made via the INFOFLEX WEB icon in 'remote clinical Apps' on the intranet front-screen

DECAF 0-2 patients will be referred by the specialist team to the ABD MDT after discharge to facilitate quick discharge

Created by: Dr Andrew Barlow, Jenny Shrestha, Kalpana Girighimire, Nov 2022

Trust Board
1 December 2022

Title of the paper	**Use of emergency powers for the approval of the elective hub business case.**			
Agenda Item	**32**			
Presenter	**Don Richards, Chief Financial Officer**			
Author(s)	**Barbara Anthony, Trust Secretary**			
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: *For information*: X			
Executive Summary	The Board is asked to note the likely use of Standing Order 6.2 – Emergency Powers and urgent decisions prior to the next board meeting on 2 February 2023. The elective hub business case is not ready for approval at this board meeting and needs to be presented to FPC in December 2022. It requires approval prior to the board meeting on 2 February 2022. Standing Order 6.2 allows the Chair and Chief Executive Officer to take emergency or urgent decisions after having consulted two Non-Executive Directors. The exercise of this power to approve the elective hub business case will be reported to the board meeting in February 2023 for ratification.			
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***
			x	
Links to well-led key lines of enquiry	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☐Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☐Is there a culture of high quality, sustainable care? ☐Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues and performance? ☐Is appropriate and accurate information being effectively processed, challenged and acted on?			

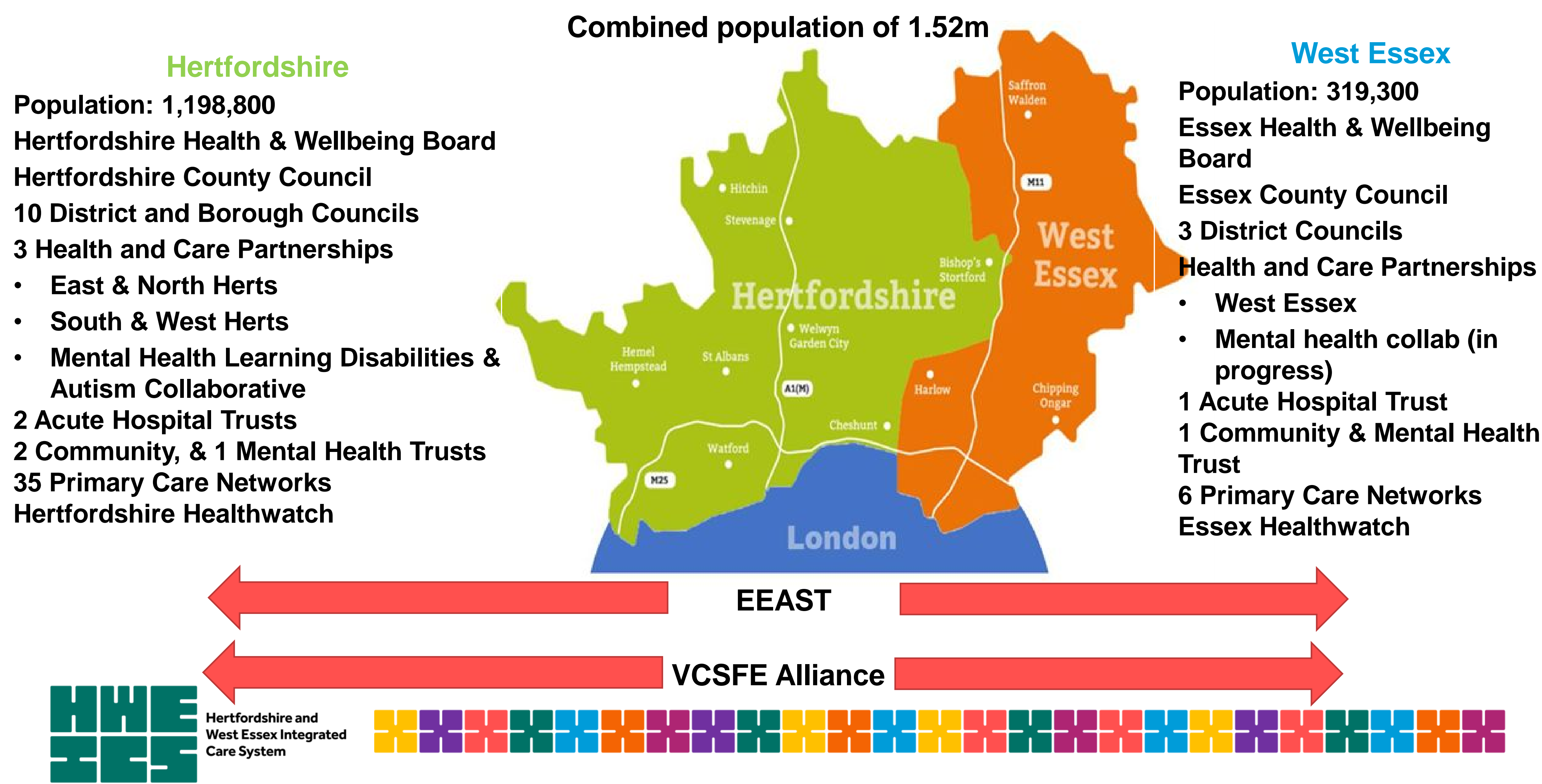
	☐Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☐Are there robust systems and processes for learning, continuous improvement and innovation? ☐How well is the trust using its resources?
Previously considered by	Committee/Group: Finance and Performance Committee — Date: 24 November 2022
Action required	The Board is asked to take this report for information and assurance of the intention to use S.O. 6.2 prior to the next board meeting on 2 February 2023.

Committee/Group	Date
Finance and Performance Committee	24 November 2022

Presentation to **West Hertfordshire Teaching Hospitals NHS Trust**

Thursday 1st December 2022

Working together
for a healthier future


Hertfordshire and West Essex Integrated Care System
Combined population of 1.52m
Hertfordshire
Population: 1,198,800
Hertfordshire Health & Wellbeing Board
Hertfordshire County Council
10 District and Borough Councils
3 Health and Care Partnerships
• East & North Herts
• South & West Herts
• Mental Health Learning Disabilities & Autism Collaborative
2 Acute Hospital Trusts
2 Community, & 1 Mental Health Trusts
35 Primary Care Networks
Hertfordshire Healthwatch
Saffron Walden
M11
Hitchin
Stevenage
West Essex
Bishop's Stortford
Hertfordshire
Welwyn Garden City
Hemel Hempstead
St Albans
A1(M)
Harlow
Chipping Ongar
Cheshunt
Watford
M25
London
West Essex
Population: 319,300
Essex Health & Wellbeing Board
Essex County Council
3 District Councils
Health and Care Partnerships
• West Essex
• Mental health collab (in progress)
1 Acute Hospital Trust
1 Community & Mental Health Trust
6 Primary Care Networks
Essex Healthwatch
EEAST
VCSFE Alliance
Hertfordshire and West Essex Integrated Care System

Hertfordshire and West Essex Strategic Framework 2022-2027

Our mission

Better, healthier and longer lives for all

We will achieve this by

- Improving physical and mental health across our population
- Tackling unequal access, experience and outcomes
- Enhancing productivity and value for money
- Ensuring the NHS supports broader social and economic development.

In the first 3-5 years we will

- Increase healthy life expectancy, and reduce inequality
- Give every child the best start in life
- Improve access to health and care services
- Increase the numbers of citizens taking steps to improve their wellbeing
- Achieve a balanced financial position annually

The ICB will deliver this by:

- Setting direction for the NHS in Hertfordshire and West Essex
- Allocating NHS resources fairly and effectively
- Supporting, equipping, and empowering our people
- Working with and pooling resources with our partners
- Enabling improvement and driving change, with a focus on quality
- Using data and evidence to generate insight and assess impact

Key steps to developing our approach		
Developing the ICP strategy	Range of potential priorities identified, currently in public engagement phase	To be finalised in December 2022
People Strategy	Ready for final approval	Agreed by ICB Board- 18th November
Digital Strategy	Ready for final approval	Agreed by ICB Board- 18th November
VCFSE and its role in the ICB	• Health creation strategy agreed with VCFSE- going to ICP/ICB for approval • Role of VCFSE member on the ICB to be revised	Ongoing Agreed by ICB Board-November 18th
Strategic approach to improving population health	• Kings Fund facilitated workshop- 30th of November • Procurement of BI platform	Ongoing
HCP development	Workshop on the 4th of October-options for future approach being developed	Ongoing

Developing our Operating model (HCPs)

Current approach:

Place:
Three established HCPs at place level – E&NH, S&WH, WE

County:
MH/LD/A: Collaborative for Herts, developing arrangements with Essex ICBs and Essex CC

Children and YP: Networks coming together across two county footprints

System:
Acute Provider Collaborative: in early stages of development
VCSFE Alliance: in place with Chair appointed and linked into ICB governance

Community Services: in early stages of development
Primary Care Board: part of the ICB governance arrangements reporting to ICB Board and strategy in development

Next Steps

HCP Development Network: members from across HCPs and ICB Place Directors driving development of partnerships including recommendations for future delegation

HCP/Collaborative Development Framework and Action Plan to be developed to enable HCPs to progress and demonstrate capability

To support the development of the Framework and Action Plan, the ICB will work on a set of functions deemed as the 'minimal viable product' to support intended development and delegation of ICB responsibilities to our HCPs and Collaborative in April 2023

System Leaders workshops: support from ICS CEOs and HCP Chairs for partnership development direction

Trust Board Meeting
1 December 2022

Title of the paper:	Corporate Risk Register Report
Agenda Item:	34
Presenter:	Mike Van der Watt – Medical Director
Author(s):	Brian Haig – Risk Lead
Purpose:	*Please tick the appropriate box* *For approval* ✓ / *For discussion* ✓ / *For information*
Executive Summary:	The purpose of this report is to provide an update on the status of the Corporate Risk Register (CRR) to the Board. This report captures the decisions made by the Risk Review Group (RRG) on 10 November 2022. **Where applicable, decisions made by the RRG are highlighted in amber under the risk.** The final data for this report was extracted from Datix on 11 November 2022, with some updates made following the RRG meeting; a total of **18** open risks were registered on the Corporate Risk Register (CRR) at that time. In addition, the RRG reviewed all escalated, de-escalated, closed, increased, reduced, and merged risks where applicable. One (1) new risk was presented for consideration for approval and addition to the CRR. **Risk ID 283** Functionality training for all types of CTG machines in use in maternity clinical areas The proposed Risk Score was 15 (3 x 5). The Risk was discussed by the Group, and it was agreed that the risk scoring should be 12 (3 x 4). As such it was decided that the risk would not need be accepted onto the CRR, however it would remain on the Environment Divisional Risk Register. All existing risks on the CRR were reviewed and discussed to ensure that they remained valid and had appropriate controls and mitigation in place.

Trust strategic aims: *(please indicate which of the 4 aims is relevant to the subject of the*	Aim 1 Best care	Aim 2 Great team	Aim 3 Best value	Aim 4 Great place

report)	Objectives 1-4	Objectives 5-8	Objective 9	Objective 10-12
	✓	✓	✓	✓

Links to well-led key lines of enquiry:	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☒Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles, and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues, and performance? ☒Is appropriate and accurate information being effectively processed, challenged, and acted on? ☒Are the people who use services, the public, staff, and external partners engaged and involved to support high quality sustainable services? ☒Are there robust systems and processes for learning, continuous improvement, and innovation? ☒How well is the trust using its resources?
Previously considered by:	Quality Committee – 24 November 2022
Action required:	The Trust Board is asked to discuss and approve the corporate risk register and endorse the changes.

Agenda Item: 34

Trust Board – 1 December 2022

Title of Paper: Corporate Risk Register Report

Presented by: Mike Van der Watt – Chief Medical Officer

1. Purpose

1.1 The purpose of this report is to provide the Trust Board with an update on the status of the Corporate Risk Register (CRR) including current risk scores, new, escalated, de-escalated, merged, increased, reduced, 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 Board's subcommittee, which oversees assurance for risk management arrangements within the Trust.

2.4 The CRR contains all risks rated 15 or above from each of the operational / divisional risk registers. The risk register is a 'live' repository of risks recorded on Datix, and risk owners regularly review and update entries to reflect the current position of the risk.

2.5 Divisions regularly review all their risks rated 12 and under on the risk register and those risks which have been on the register for over two years.

2.6 Risks are closed as appropriate. Any outstanding risks are reported to the Risk Review Group (RRG) for discussion and, where necessary, escalated to this Committee to agree on future action.

3. Corporate Risk Register

3.1 This report captures the decisions made by the RRG on 10 November 2022. Data for this report was extracted on 11 November 2022, with some updates made following the RRG. **Decisions made by the RRG are highlighted in amber under the risk.** A total of **18** open risks were registered on the CRR at that time.

3.2 Appendix 1 details a table representing risks and their associated score movement on the CRR by Division against each month since November 2021.

3.3 Appendix 2 details a full summary of all corporate risks presented to the Risk Review Group on 10 November 2022 and decisions made in respect of these.

3.4 Appendix 3 shows KPI performance in relation to Risk Review status

4. Risk activity

The following provides an overview of risk activity as discussed at the RRG on 10 November 2022:

4.1 **New risks (0)**
No new risks were approved for addition to the CRR

4.2 **Changed Risks (0)**
No changed risks were presented to the RRG meeting

4.3 **De-escalated Risks (0)**
No de-escalated risks were presented to the RRG meeting

4.4 **Escalated Risks (0)**
No risks were presented to the RRG meeting

4.5 **Closed Risks (0)**
No risks were presented to the RRG Meeting

4.6 **Increased risk score (0)**
No risks were presented with an increased risk score

4.7 **Decreased risk score (0)**
No risks were presented with a reduced risk score.

4.8 Merged Risks (0)
No merged risks were presented.

5. Risk

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 approve the corporate risk register and endorse the changes.

Executive Lead Mike Van der Watt
Chief Medical Officer

Date: 25 November 2022

APPENDICES:

Appendix 1 Risks and associated score on the CRR by Division against each month

Appendix 2 Corporate Risk Register (by Division)

Appendix 3 KPI performance regarding KPI Performance for Risk Reviews

Appendix 1 – Risks and associated score movement on the CRR by Division against each month since November 2021

DIVISION	RISK ID	Nov-21		Dec-21		Jan-22		Feb-22		Mar-22		Apr-22		May-22		Jun-22		Jul-22		Aug-22		Sep-22		Oct-22		Nov-22	
CLINICAL INFORMATICS	25	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→
	27	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→
CORPORATE SERVICES	30	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→
	35	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→
	26	15	→	15	→	15	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→
	37									15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→
	97																			16	↑	16	→	16	→	16	→
EMERGENCY MEDICINE	19	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→
	20									16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→
	21									15	→	15	→	15	→	15	→	20	↑	20	→	20	→	20	→	20	→
	22											15	↑	15	→	15	→	15	→	15	→	15	→	15	→	15	→
	113																			15	↑	15	→	15	→	15	→
ENVIRONMENT	32	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→
	33	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→
	34	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→
	31	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→
WOMEN's & CHILDREN	29	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→
	36	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→

APPENDIX 2 – Corporate Risk Register (by Division)

COVID-19 RELATED	RISK ID	OPENED DATE	RISK TITLE	INITIAL RISK RATING SCORE	UPDATE	CURRENT RATING	EXECUTIVE LEAD
CLINICAL INFORMATICS							

No	25	12/06/2017	Trust Bleep System Failure leading to inability to utilise alert systems across the Trust	20	Three independent legacy Blick VHF bleep systems, at Watford, Hemel and St Albans are connected together to enable cross-site bleeping capabilities; providing text and voice group paging to enable rapid response to a range of emergency situations including Fire, Cardiac Arrest, Security Alerts, Medical Emergencies and Trauma Calls. These systems including the VHF transmitters are over 25-years old and consequently, are no longer manufactured and can only be supported on a reasonable endeavours basis. The current risk is that a failure of the bleep system would result in the inability to communicate through the bleep system for rapid response to emergency situations like, Fire, Cardiac Arrest, Security Alerts, Medical Emergencies and Trauma Calls. New UHF transmitters have been installed and temporarily connected to the old bleep system to enable new UHF headsets to run alongside the old system, ahead of cutover to the new system. This also mitigates some of the risk associated with a failed transmitter. Actions we have taken in the last month to manage the risk: • Obtain costs for data sim cards to use as alternative solution to Wi-Fi connectivity • Agree costs for purchasing SIM cards • System testing of the iPhone BlueSky app • Seek clarification on the number of users requiring android and SIM cards from EPRR Actions/activity planned for the following month: • Place order for required SIM cards • Configure Android phone handsets with MDM, ready for circulation • Agree cutover plan from old to new system with EPRR	20	Paul Bannister - Chief Information Officer
<u>NOV 2022 RRG MEETING UPDATE</u> **The comprehensive risk update was noted by the RRG. Risk Score and controls remain appropriate for the Risk at present.** **Current Risk 5 x 4 = 20**							

No	27 (4283)	20/05/2020	Possibility of a Cyber Security Incident arising from vulnerabilities within our network connectivity systems.	15	Although we continue to be vigilant and deal with specific vulnerabilities, the impact on the Trust remains broadly the same as last month. Following the annual independent penetration test we are working to remediate specific vulnerabilities that were identified during the test. The penetration test report identified the risks based on criticality. There were 139 critical, 119 high, 2177 medium and 278 low risk vulnerabilities identified. The majority of the medium and low risk vulnerabilities are related to SSL Certificates and the way they are managed. This is being addressed working with our ITO partner Atos. All critical vulnerabilities have been worked through and either been remediated or have plans in place to remediate. The biggest challenge to the Trust currently is working with third party solution providers to remediate vulnerabilities identified with the systems that they provide and support. Over the next month we will continue to remediate the vulnerabilities reported through the pen test as well as deal with any incidents that occur.	15	Paul Bannister - Chief Information Officer
<u>NOV 2022 RRG MEETING UPDATE</u> **Update noted by RRG and agreed that the risk scoring and controls are in place to manage the ongoing risk.** **Current Score 3 x 5 = 15**							

No	35 (3828)	09/11/2016	Patients may come to harm and have a poor experience due to long waits for elective care	20	As part of the Tier One support package, the NHSE Elective Improvement Support Team (IST) will be undertaking a 2 day visit to meet with key staff to talk to about our approach to managing RTT including our governance structures and processes, reports and information, validation, waiting list management, bookings and associated SOPs, processes in supporting services, clinical prioritisation and harm review processes. The team come on site on 8 and 9 November.	20	Michael Van der Watt, - Medical Director
<u>NOV 2022 RRG MEETING UPDATE</u> **RRG noted the update and actions being taken.** **Current Score 4 x 5 = 20**							

CORPORATE SERVICES							
No	30 (4238)	03/12/2019	Lack of in reach mental health services and tier 4 specialist provision for under 18yrs patients including eating disorders	20	Continued high numbers of CYP accessing services in acute mental health crisis / eating disorder. Update form HPFT - posts currently out for advert for paediatric MH liaison team. Two paediatric nurses attended train the trainer for clinical holding in October - will develop plan in coming months to roll out across key areas. Named Nurse for mental health and complex needs (who supported CYP especially 16 and 17 yr olds) - post funded for 1 year - now finished and post holder moved to a different role - approach made to ICB / HPFT by Chief Nurse to try and secure additional funding to continue this role.	15	Tracey Carter - Chief Nurse and Director of IPC
NOV 2022 RRG MEETING UPDATE **RRG noted update and activity being undertaken. No change to the risk score at this time.** **Current Score 3 x 5 = 15**							

Yes	26 (4280)	28/04/2020	The impact of Covid and Operational Pressures on Workforce wellbeing	16	This risk has evolved against the workforce pressures which have developed since the pandemic. There is a risk that workforce wellbeing will be further impacted on staff retention, sickness, morale and mental wellbeing during a time of national labour shortages and financial crisis. Key updates against this risk include: Effective and collaborative working - Business case approved for additional EDI and Wellbeing support from April 2023 to include a substantive band 4 and band 6 post. EDI and Wellbeing KPI's to measure success and impact - suggestion to include these within Divisional Performance. Wellbeing strategy - strategy in the draft stages Quarterly listening Wellbeing forums across all sites with CEO, CPO and HR teams (dates booked in for 2023). Divisional Wellbeing budget approved.	16	Andrew McMenemy – Chief People Officer
NOV 2022 RRG MEETING UPDATE **RRG noted update and had discussion regarding that the risk had been originally created as a result of the Covid Pandemic, however over time the risk has changed due to new factors impacting on staff welfare, including inflation, cost of living, pressures of waiting lists. Risk to be considered for closure, with a new risk encompassing the new factors, effect on staff welfare and activity. Risk to remain open at present until new risk agreed at RRG.** **Current Score 4x 4 = 16**							

No	37 (4479)	27/01/2022	There is a risk to maintaining Safe staffing levels for Nursing across all Divisions	15	Staffing remains challenged due to number of surge beds open. Staffing reviewed daily by senior leaders and mitigations put in place to make as safe as possible.	20	Tracey Carter – Chief Nurse and Director of IPC
NOV 2022 RRG MEETING UPDATE **RRG reviewed risk and work continues to manage the risk and ensure safe staffing levels.** **Current Score 5 x 4 = 20**							

No	97	11/08/2022	Staff Turnover Rates (overall numbers/turnover within specific staff groups/leavers in first year of employment)	16	Staff turnover has increased steadily year to date from 14.3% in January to 16.1% in October. The turnover rate for staff leaving within their first year of employment has started to decrease in October to 17.9% and staff leaving the Trust is a real area of focus with teams such as Well-being and People Promise looking at Reaching Out, Onboarding and a focused programme of pastoral care for new starters.	16	Andrew McMenemy – Chief People Officer
NOV 2022 RRG MEETING UPDATE **RRG noted update. At present no change to risk or control measures and that there would have to be a sustained period of improvement over several months before consideration could be given to reduce the risk score.** **Current Score 4 x 5 = 20**							

EMERGENCY MEDICINE							
No	19 (4019)	30/04/2018	Ambulance handover delays affecting patient pathway and escalation	20	Offload delays remain prevalent particularly during peak times of activity. The ambulance support team remain in place supporting offloading of crews. Additionally following approval, EEAST crews are undertaking hourly observations to enable early escalation if a patient deteriorates. Senior decision makers remain in place within the STARRing unit to facilitate early identification and treatment of newly arriving patients. EEAST Revised Delayed Handover Protocol in place from 31/10/22 with changes to the Rapid Release of crews and the elimination of Cohorting. A dedicated Ambulance Offload Action plan is in place with revised trajectories for improvement. Regular Ambulance Handover meetings are in place with attendance from EEAST and ICB.	15	Sally Tucker - Chief Operating Officer

<u>NOV 2022 RRG MEETING UPDATE</u>

RRG noted update and the ongoing activity being undertaken to manage the risk. Risk needs to be rewritten to reflect the processes now in place to manage Ambulance offload. Risk Lead will work with Lead Nurse for ED on this and represent at next RRG.

Current Score 5 x 3 = 15

No	20 (4496)	12/04/2022	Reduced patient flow through the Emergency department (ED)	15	Controls mitigation and score remains the same – Patient flow continues to be a challenge with high numbers of patients in ED waiting for an admission bed for long periods. Emergency Medicine continues its focus on utilisation of SDEC services to decompress the Emergency Department including discussions surrounding additional waiting capacity in in EAU. Internal Professional standards are being measured and shared with Divisional leads to improve assessment times. Increased MH attendances impacting on flow and lack of MH capacity resulting in MH patients being admitted to acute beds whilst waiting MH beds.	16	Tracey Carter- Chief Nurse and Director of IPC

<u>NOV 2022 RRG MEETING UPDATE</u>

RRG noted ongoing work in this area. No change to risk or control measures at present.

Current Score 3 x 5 = 15

No	21 (4497)	12/04/2022	Failure to meet performance KPIs within the Emergency Department (ED)	16	Controls mitigation and score remains the same - Performance remains suboptimal against the 4-hour standard. The ED improvement plan remains in place with focus on multiple KPIs. The Triage and Ambulatory Majors (TAM) has heightened focus concentrating on non-admitted performance. Proof of concepts for EAU waiting room to support TAM and type 1 performance, additionally a further proof of concept from 2/11/22 to increased fit to sit capacity. A Trust wide Improvement Plan is in place to focus on patient flow with weekly EM performance meetings in place. The Improvement Plan is monitored through HEG.	20	Sally Tucker – Chief Operating Officer

<u>NOV 2022 RRG MEETING UPDATE</u>

RRG noted update that Trust has improved position, however improvement needs to be maintained and remain consistent before consideration to possibly reduce the risk.

Current Score 5 x 4 = 20

No	22 (4511)	12/04/2022	Challenges in meeting the needs of Mental health Patients within the Emergency Medicine division	16	Current controls mitigation and score remain the same - work continues to establish triggers and actions in response to high number of attendances and high acuity and complexity of patients which if needed will go through the mental health steering group	16	Tracey Carter- Chief Nurse and Director of IPC
NOV 2022 RRG MEETING UPDATE **RRG noted update and work being undertaken. No change to score at present.** **Current Score 4 x 4 = 16**							

No	113	11/08/2022	Impact on Patient Safety / Experience due to need to use fracture clinic as adult ED assessment area, for which it is not designed.	15	Score remains the same as do controls and mitigating, Triage and Ambulance Majors (TAM) remains a key part of the redevelopment of the ED -which is progressing and being monitored through other groups.	15	Tracey Carter, Chief Nurse and DIPC
NOV 2022 RRG MEETING UPDATE **RRG noted that at October RRG, the Division agreed to see if risk could be reduced, as this was now TAM and part of patient flow model. At present the risk score is not able to be changed, however this would be kept under constant review. There is ongoing activity, which needs to be completed before the risk can be considered for reduction.** **Current Score 5 x 3 = 15**							

ENVIRONMENT

No	31 (2795)	15/12/2011	Management and control of - Asbestos Containing Materials (ACMs)	20	Risk has been reviewed and the controls/mitigation remain valid. This is a long-term issue and was discussed at the most recent meeting with regard to reducing the likelihood. It was felt that at this time the risk scoring would remain the same and not be reduced. Deputy Divisional Director for Environment will be undertaking a in depth review over the coming months and the risk will be further reviewed with a view to reducing the risk score.	16	Patrick Hennessy-Director of Environment

NOV 2022 RRG MEETING UPDATE

RRG held discussion regarding the risk and possible reduction, in relation to the likelihood. Division now has head of engineering in place and will be undertaking inspections, as currently the evidence is not available to consider the risk for possible reduction with regard to the score.

Current Score 4 x 4 = 16

No	32 (2883)	13/10/2012	Control of Legionella and Management of water systems	16	Risk has been discussed with Operational Manager, there are no changes to risk or score . Will be discussed again at Divisional Governance Meeting - 20/10/22	20	Patrick Hennessy-Director of Environment

NOV 2022 RRG MEETING UPDATE

RRG noted update. Division has a task and finish group in place.

Current Score 4 x 5 = 20

No	33 (4438)	26/08/2021	Electrical infrastructure risks on the WGH site	15	Risk has been reviewed and at present there is no change in the score, controls or mitigation. This continues to be an ongoing issue. Wwork is being undertaken in relation to the electrical infrastructure. The risk will continue to be monitored through the established Divisional meetings on a monthly basis.	15	Patrick Hennessy-Director of Environment

NOV 2022 RRG MEETING UPDATE

RRG noted no change to Risk Score or Controls. Ongoing work is being undertaken to improve electrical infrastructure.

Current Score 3 x 5 = 15

No	34 (4439)	26/08/2021	Electrical infrastructure risks on the SACH site	15	Risk has been reviewed and at present there is no change in the score, controls or mitigation. This continues to be an ongoing issue. Work is being undertaken in relation to the electrical infrastructure. The risk will continue to be monitored through the established Divisional meetings on a monthly basis.	15	Patrick Hennessy- Director of Environment
NOV 2022 RRG MEETING UPDATE **RRG noted no change to Risk Score or Controls. Ongoing work is being undertaken to improve electrical infrastructure.** **Current Score 3 x 5 = 15**							

No	283	10/10/2022	Management of ventilation across the organisation	16	Differing standards of ventilation across the organisation with minimal air changes, (some with no mechanical systems and some with re circulation of air). Leading to risk of transmission of respiratory viruses (including Covid – 19). Delays in treatments due reduce standards or no ventilation in areas where high risk procedures are undertaken. Specific uses of some areas only due to shared ventilation systems or no mechanical ventilation/re circulated air Effect: Patient and staff exposure to respiratory pathogens due to reduced air changes, no mechanical systems or re circulation or air Dealy in treatments, elective procedures, outpatients appts due to required downtime between patient treatments/procedures Specific patient groups unable to be cared for in areas identified with shared ventilation system, no ventilation/re circulated air or low air changes Impact: Higher risk of transmission of respiratory pathogens including covid – 19 Reduction in elective activities Impact on operational management Risk of transmission to staff	16	Patrick Hennessey – Director of Environment
NOV 2022 RRG MEETING UPDATE **New Risk presented at the meeting. The Risk was discussed by the Group, and it was agreed that the risk scoring should be 12 (3 x 4). As such it was decided that the risk would not be accepted onto the CRR, however it would remain on the Environment Divisional Risk Register.** **Current Score 3 x 4 = 12**							

MEDICINE

SURGERY & CANCER

WOMEN'S AND CHILDREN

No	29 (4339)	20/11/2020	Increased midwifery vacancies leading to lack of appropriate midwifery staffing levels	20	Discussed at Divisional Risk Review meeting 25/10/22. 8A Recruitment and Retention midwife in place since July. Continue robust recruitment and retention strategy with trust wide collaboration. Automatic offers to students who are coming up to qualification. International recruitment. Maternity escalation to review staffing/redeployment of staff/temporary staff use. Monitoring one to one care in labour and supernumerary status of labour ward coordinator. For review at RRG and next Divisional Risk Review meeting	16	Tracey Carter- Chief Nurse and Director of IPC

NOV 2022 RRG MEETING UPDATE

RRG noted no change to Risk Score or Controls and the work being undertaken.

Current Score 4 x 4 = 16

No	36 (4427)	01/04/2019	Delay in the IOL pathway including transfer from the antenatal ward to delivery suite.	16	Discussed at Divisional Risk Review meeting 25/10/22. There are no changes in controls or mitigation regarding this risk. Ongoing audit to monitor obstetric review and ongoing monitoring prioritisation and patient information. For review at trust RRG and next Divisional Risk Review meeting 22/11/22	15	Tracey Carter - Chief Nurse and Director of IPC

NOV 2022 RRG MEETING UPDATE

RRG no change to risk or control measures.

Current Score 3 x 5 = 15

APPENDIX 3 – Current KPI Position for all risks

Target is for all risks to be reviewed by their set review date with 100% completion.

		Risk Score					
Division	Total Risks	1-3	4-6	8-12	15-25	Reviews in date	% in date
WACS	27	0	1	23	3	27	100%
Emergency Medicine	15	1	0	9	5	15	100%
Medicine	12	0	1	11	0	12	100%
SAC	29	2	6	21	0	29	100%
Environment	49	0	2	42	5	48	100%
CSS	40	1	8	30	1	40	100%
Clinical Informatics	27	0	7	18	2	19	70%
Corporate Services	46	2	15	24	5	21	46%
Finance	18	0	5	13	0	18	100%

Trust Board
1 December 2022

<table>
<tr><td>Title of the paper</td><td>Items considered in November 2022 Private Trust Board</td></tr>
<tr><td>Agenda Item</td><td>35</td></tr>
<tr><td>Presenter</td><td>Barbara Anthony, Trust Secretary</td></tr>
<tr><td>Author(s)</td><td>Barbara Anthony, Trust Secretary</td></tr>
<tr><td>Purpose</td><td>Please tick the appropriate box
<table>
<tr><td>For approval</td><td>For discussion</td><td>For information</td></tr>
<tr><td></td><td></td><td>✓</td></tr>
</table></td></tr>
<tr><td>Executive Summary</td><td>To note in the public domain an outline of the matters covered in private, due to their confidential nature, since the last board meeting in public.</td></tr>
<tr><td>Trust strategic aims

(please indicate which of the 4 aims is relevant to the subject of the report)</td><td>
<table>
<tr><td>Aim 1
Best care</td><td>Aim 2
Great team</td><td>Aim 3
Best value</td><td>Aim 4
Great place</td></tr>
<tr><td>Objectives 1-4</td><td>Objectives 5-8</td><td>Objective 9</td><td>Objective 10-12</td></tr>
<tr><td>x</td><td>x</td><td>x</td><td>x</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><td>Committee/Group</td><td>Date</td></tr>
<tr><td>Trust Board part 2</td><td>November 2022</td></tr>
</table></td></tr>
<tr><td>Action required</td><td>The Board is asked to take the report for information of the matters discussed at the last meeting in private (Part 2) session.</td></tr>
</table>

ITEMS FOR DISCUSSION	
1	None
ITEMS FOR INFORMATION AND ASSURANCE	
2	Feedback on Board ward and departmental visits – the Board received feedback from visits by Board members to: • Breast Services, SACH • CT Scanner & new site for diagnostic hub, SACH • Ophthalmology, SACH • Orthopaedic ward, SACH
3	Serious incidents report – the Board received a update from the Chief Medical Officer on serious incidents that had taken place during the reporting period.
4	Strategy update – the Board received an update from the Chief Executive Officer.
5	Redevelopment OBC – The Board received an update from the Chief Financial Officer
ITEMS FOR APPROVAL	
6	ITO full business case – the Board approved the business case for provision of IT services.
7	ARP enabling works – Land acquisition – the Board approved the business case.