West Hertfordshire Teaching Hospitals NHS Trust

TRUST BOARD MEETING IN PUBLIC
AGENDA

1 June 2023 at 9.30am – 12.00pm
Executive Meeting Room and via zoom for virtual attendees.

There is limited space for the public to attend in person – please visit https://www.westhertshospitals.nhs.uk/about/board_meetings/default.asp for more information.
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 focused 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 4 May 2023**	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
10.00	10	**Chief Executive's report**	Information	Chief Executive	Paper
Performance & Committee updates					
10.10	11	**Board Assurance Framework**	Approval	Chief Executive	Paper
10.15	12	**Trust Management Committee**	Information and assurance	Chief Executive	Paper
	13	**Finance and Performance Committee** Written report: April 23 Verbal report: May 23	Information and assurance	Chair of Committee/ Chief Financial Officer	Paper
	14	**Quality Committee** Written report: April 23 Verbal update: May 23	Information and assurance	Chair of Committee/ Chief Nurse	Paper
	15	**People, Education and Research Committee** Written report: April 23	Information and assurance	Chair of Committee/ CPO	Paper
	16	**Great Place Committee** Written report: May 23	Information and assurance	Chair of Committee/CRO	Paper

	17	**Charity Committee** Verbal report: May 23	Information and assurance	Chair of Committee/ACN	Verbal
	18	**Audit Committee** Written report: May 23	Information and assurance	Chair of Committee/CFO	Paper
10.35	19	**Performance, Activity Recovery & High Impact Change Programme updates**	Information and assurance	Director of Operational Performance	Paper
10.45	20	**Integrated performance report** • **Spotlight on perinatal quality surveillance**	Information and assurance	Chief Information Officer	Paper
Aim 1 : Best Care					
10.55	21	**Integrated Maternity Report**	Information and assurance	Acting Chief Nurse	Paper
11.05	22	**Learning from deaths report Q3**	Information and assurance	Deputy Chief Medical Officer	Paper
Aim 2: Best Value					
11.15	23	**Finance update** **-Operating & Financial Plan** **-M1 Finance update**	Information and assurance	Chief Financial Officer	Paper
Aim 4: Great Place					
11.25	24	**Neonatal Intensive Care Unit business case**	Approval	Divisional Director WACS	Paper
Risk and Governance					
11.35	25	**Corporate risk register**	Discussion and approval	Deputy Chief Medical Officer	Paper
11.40	26	**Modern Slavery Act statement**	Approval	Trust Secretary	Paper
11.45	27	**Items considered in May 2023 Private Trust Board**	Information and assurance	Chair	Paper
Closing Items					
11.45	28	**Any other business previously notified to the Chair**	N/A	Chair	Verbal
11.50	29	**Questions from Healthwatch Hertfordshire**	N/A	Chair	Verbal
11.55	30	**Questions from our patients and members of the public**	N/A	Chair	Verbal
12.00	31	**Date of the next board meeting:** **6 July 2023, SACH and via zoom**	Information	Chair	Verbal

West Hertfordshire Teaching Hospitals NHS Trust

Declarations of board members and attendees' interests

1 June 2023

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
Michelle Hope	Acting Chief Nurse and Director of Infection Prevention and Control	Specialist adviser to the CQC
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 • President Elect of Hertswood Rotary Club • President Bricket Wood WI • Husband is CEO of The Nuffield Trust and a Director Edwards Consulting Ltd

Last updated: March 2023

Name	Role	Description of interest
Natalie Edwards	Non-Executive Director	None
Harvey Griffiths	Non-Executive Director	<u>Financial Interests</u> • Director - Anglo Chesham Management Limited • Director - Anglo Industrial Holdings Ltd • Director - Broadgate Freeholds Limited • Director - Energy Capital Advisers Ltd • Secretary – Gripworx 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 • • Secretary - Just Property Management Ltd • Director - Sustainable Infrastructure Partnership Ltd • Director – Co-operative Energy Limited • Director – Flow Energy Limited • 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

Last updated: March 2023

Name	Role	Description of interest
		• Director - Sustainable Infrastructure Partnership Ltd <u>Non-financial Professional Interests</u> • None
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
Edwin Josephs	Non-Executive Director	• Member of the Vine House Health Centre Patient Participation Group
Jonathan Rennison	Non-Executive Director	<u>Financial Interests</u> • Edgecumbe Consulting – Associate • Director of The Yellow Chair Ltd <u>Relevant Consultancy Contracts Held by The Yellow Chair Ltd (Financial Interests):</u> ○ Kings College London – OD & Learning & Development Activities ○ In Touch Networks – Coaching Consultant ○ Government Commercial Function: Role – Subject Matter Expert (SME) delivering training and facilitation ○ Leadership development role with Mid & South Essex Trust. <u>Professional Interests:</u> • West Hertfordshire Hospitals Trust Charity Committee Chair • Trustee of Rising Tides Ltd
Don Richards	Chief Financial Officer	None
Sally Tucker	Chief Operating Officer	None
Dr Mike van der Watt	Chief Medical Officer	• Owner and Director Heart Consultants Ltd • Work for Hertfordshire and West Essex ICS for one day/week advising on quality and innovation.

Last updated: March 2023

Name	Role	Description of interest
Andrew McMenemy	Chief People Officer	Lead for Workforce Modelling and Planning Lead for Temporary Staffing Member of Hertfordshire and West Essex ICS People Board
Alex White	Chief Redevelopment Officer	None
Toby Hyde	Chief Strategy and Collaboration Officer	None
Martin Keble	Divisional Director of Clinical Support Services	None
William Forson	Divisional Director of WACS	• Private practice at Spire as Forson and Co Medical
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
Dr Rachel Hoey	Divisional Director of Emergency Medicine	None
Mr Simon West	Divisional Director of Surgery, Anaesthetics and Cancer	Director Northampton Hip and Knee
Louise Halfpenny	Director of Communications	None
Barbara Anthony	Trust Secretary	None

Last updated: March 2023

West Hertfordshire Teaching Hospitals NHS Trust

TRUST BOARD MEETING IN PUBLIC
Seminar Room, Hemel Hempstead from 09:30am – 12:30pm
via Zoom

Chair	Title	Attendance
Jonathan Rennison	Non-Executive Director (Vice-Chair)	Yes
Voting members		
Phil Townsend	Chair	No
Matthew Coats	Chief Executive Officer (CEO)	Yes
Tracey Carter	Chief Nurse and Director of Infection Prevention and Control	Yes
Don Richards	Chief Financial Officer (CFO)	Yes
Dr Mike van der Watt	Chief Medical Officer (CMO)	Yes
Toby Hyde	Chief Strategy and Collaboration Officer (CSCO)	Yes
Alex White	Chief Redevelopment Officer (CRO)	No
Sally Tucker	Chief Operating Officer	Yes
Ginny Edwards	Non-Executive Director	Yes
Edwin Josephs	Non-Executive Director (Senior Independent 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
Pat Ono	Assistant Trust Secretary	Yes
Louise Halfpenny	Director of Communications	Yes
Michelle Hope	Deputy Chief Nurse	Yes
Mitra Bakhtiari	Director of Midwifery	Yes
Michelle Sorley	Lead Nurse for cancer and palliative care	Yes
Claire Crofts	Cancer Nurse	Yes
Emma Allway	Cancer Nurse	Yes
Joanna Bainbridge	Freedom to Speak Up Guardian	Yes
Jean Hickman	Director of Governance	Yes

There were 5 members of the public in attendance

MEETING NOTES

Standing items	
1	**Opening and welcome**
1.1	The Vice Chair welcomed everyone to the May Trust Board Meeting held in public. He welcomed Toby Hyde, the new Chief Strategy and Collaboration Officer.
1.2	He noted that it was the last board meeting for Tracey Carter, Chief Nurse who was leaving at the end of May to join King's College Hospital as Chief Nurse. He thanked Tracey for her hard work and dedication over the previous 9 years and wished her every success in her new role. He welcomed Michelle Hope, Deputy Chief Nurse who was attending as an observer and in preparation for the Acting Chief Nurse role pending the arrival of Kelly McGovern in July 23.
2	**Patient story**
2.1	Michelle Sorley (MS) – Lead Nurse for Cancer and Palliative Care and cancer nurses Claire Crofts and Emma Allway joined the meeting and provided a short presentation on cancer pathways. They shared a video recorded by Mr L, a 75-year-old patient who had been diagnosed with oesophageal cancer in May 2021 and he described his progress through the cancer pathway. Mr L recounted his treatment and how he had been required to visit three separate hospitals to receive chemotherapy and surgery. He was positive about his experience and thanked the staff at Watford for looking after him.
2.2	The Chief Nurse noted that the role of nurse specialists and the multi-disciplinary team made a real difference in the cohesion of a pathway. She was pleased to see that the pathway was working well.
2.3	Ginny Edwards queried how the Trust was assessing the quality and safety of services where patients were receiving treatment via complex pathways. MS responded that every tumor site had a cancer-specific MDT which took place weekly and discussed each patient's treatment. Following the merger of surgical services to Imperial, a steering group had been set up which monitored patient experience via surveys and used the results to improve care.
2.4	The Vice Chair extended his thanks to Mr L for being willing to share his story.
3	**Apologies for absence**
3.1	Apologies were noted from Alex White, Phil Townsend and Meg Carter.
4	**Declarations of interest**
4.1	There were no changes or amendments to note.
5	**Minutes of previous meeting on**
5.1	The minutes of the meeting held on 6th April 2023 were approved as an accurate record

	of the meeting and signed by the Chair.
5.2	**RESOLUTION: The Board approved the minutes of the previous meeting as a true and accurate record.**
6	**Board decision log**
6.1	The decision log for the 22/23 financial year was noted.
7	**Board action log**
7.1	The actions were noted as complete.
8	**Board work plan**
8.1	No amendments were required.
9	**Chair's report**
9.1	The Vice Chair wished everyone a happy Eid and noted the recent success of the OSCE team who had received national recognition for their work to support the Trust's international nurses to qualify in the UK.
9.2	He also noted the work that the trust had undertaken to install LED lights across the Trust and was pleased that improvements to become energy efficient were being made. He thanked Anytime Fitness for their support of the Trust's hospital charity, Raise.
10	**Chief Executive's Report**
10.1	The CEO thanked all staff for their dedicated patient care and their support of each other in challenging circumstances. He was pleased to report the extension of the Chair's term of office to February 2025.
10.2	He also thanked Tracy Carter for her work at the Trust. During her time at the Trust, she had made a real difference to patient care and had been an excellent colleague. Tracy's successor, Kelly McGovern, would be joining the Trust in July. Kelly is presently Deputy Chief Nurse and Director of Nursing at the Brookfield site for Mid and South Essex Trust. Tracey Carter thanked everyone at the Trust and wished everyone well.
10.3	He also welcomed Toby Hyde, who joined from NHSE where he was the Deputy Director of Strategy. He also noted that the Divisional Director for Surgery, Anaesthetics and Cancer would be leaving following his successful appointment as Deputy Chief Medical Officer of Jersey. He congratulated Simon West on the appointment and noted that recruitment for Mr West's successor was underway.
PERFORMANCE & COMMITTEE REPORTS	
11	**Board Assurance Framework (BAF)**
11.1	The Board Assurance Framework (BAF) had been circulated and was taken as read. The Trust Secretary outlined minor amendments to BAF risks two and three.
11.2	The Vice Chair confirmed that the BAF had gone through the Trust's governance structure and had been approved prior to coming to the Board.
11.3	**RESOLUTION: The Board approved the Board Assurance Framework.**
12	**Trust Management Committee**
12.1	The CEO thanked the divisional directors for their input into the new format for TMC which had changed to ensure that there was an opportunity for engagement and comment from each division at the meeting.
13	**Finance and Performance Committee**

13.1	Harvey Griffiths noted the request from the CMO for the committee to reconsider its corporate finance risks where there were none above nine. The committee would progress this piece of work.
13.2	The 2023/24 financial year would be a challenging. Performance would be key and the COO had provided positive assurance regarding the work with Newton on theatre productivity. There had also been some good progress made around long waits and detailed work was being taken to improve discharges which were starting to show improvement. The COO had updated the committee about the Trust's high impact change plan which the committee would continue to monitor.
13.3	A substantial capital program had been completed at the end of the financial year. The Trust was now working on delivering a number of business cases which would make the best use of the finite capital resources available to it during 23/24.
13.4	The CFO added that he was pleased to report a surplus of £0.32m surplus for month 12 which was the first time in 10 years that the Trust had reported a surplus, excluding Covid.
14	**Quality Committee**
14.1	The Vice Chair reported that the committee had approved the annual NHS self – certification paper and had recommended it for approval to the Board. The clinical audit strategy and NICE report were approved and good assurance had been received on compliance with national audits.
14.2	The first draft of the Quality Account 22/23 was approved. The committee had also received a divisional quality assurance report from clinical support services which had clear action plans in place for areas that required improvement.
14.3	A detailed report was received around maternity services. All of the action plans from the various national reviews such as Ockenden and East Kent had been consolidated into one clear integrated report which made it easier to track the progress of implementation. The plan would be reviewed against the new single delivery plan when the same was published by NHSE. Positive assurance had also been received around gap and grow which would be reported within the maternity consolidated quarterly report along with the perinatal quality surveillance tool.
14.4	A report about the safe use of Entonox gas within the Trust had been received along with a clear plan to monitor the levels of Entonox present within clinical areas. Staff had also been made aware of the potential risks and had been offered support through occupational health. No areas of concern had been found at this point but the Trust was mindful that the matter needed to be monitored and tracked to protect staff. There was good assurance that the Trust was managing the issue and was taking a proactive approach following early warning from the previous year.
14.5	Assurance had also been received around the GIRFT programme and the committee was assured on the reporting around the implementation of actions.
14.6	The Chief Nurse updated the Board that the local maternity and neonatal system were conducting workshops on the single delivery plan over three years, which would be presented to the Board in a few months.

15	**PERC**
15.1	Natalie Edwards presented a verbal update, outlining that there had been a demonstration of the staff recognition portal and the committee was continuing to think about staff recognition.
15.2	The national staff survey analysis had been received which was positive and showed a good response rate.
15.3	The CPO had updated the committee on the teaching hospital. The CPO added that he had put further detail in the Chief Executive's report and would bring a paper back to the Board after the quarterly meeting this month.
15.4	The CEO noted that Katie McGowan and the recruitment team were doing a fantastic job, saying he had received positive feedback on the service during his new staff induction meetings.
16	**Great Place Committee**
16.1	Helen Davis noted the interim building schemes that were progressing whilst the Trust was waiting for confirmation of the next steps and timeline from NHP. She noted the challenges of carrying out improvement works at whilst still maintaining services on busy sites. She also commended the EPR optimization report which would be presented to the board later in the agenda.
16.2	The CFO noted the progress already being made by the Chief Redevelopment Officer and in particular with the development of his team.
17	**Access Standards Performance and Activity Recovery Overview**
17.1	The Chief Operating Officer presented the key highlights from her report, including the development of the two high impact change programs, one associated with patient flow, and the second in relation to performance and productivity.
17.2	During March and April, two forms of industrial action by junior doctor staff occurred which caused a slight reduction in performance when compared to February 2023, but continued improvement with regards to Watford UTC and Hemel UTC performance. Additionally, for the 4 h performance for all types, there was a sustained statistical improvement over the period between November 6th and the weekend in April. This showed that the actions taken by divisions, including the high impact changes associated with first assessments, were starting to show dividends.
17.3	Demand for mental health services had increased significantly during the March period, with 13.5% of all attendances coming from mental health. The ED team was working with EEAS to meet the needs of those patients through the rapid release initiative. Discharges were also changing, with a lot of work done by the medicine and emergence medicine divisions in terms of daily discharges and focus on the weekends. The command and control center had also been improved and the Trust had improved the quality of data available to staff to help them make informed decisions.
17.4	The final impact change on patient flow was connected to the UTC. There had been good joint meetings with Green Brook, who were the provider for the UTC at Watford, and the Trust was working through opportunities to improve the clinical model with the clinical and consultant level oversight by Trust staff. The DDE was heavily involved in these changes.

17.5	The COO highlighted the changes to the elective care recovery programme. Data quality had improved, and meetings had been established with divisions to understand the data, capture data, and record categorization. Training was still available to help with any outstanding issues. FPC was monitoring the performance metrics and the recent uptick for referrals in March 23 was being investigated. Outpatient services were also undergoing transformation, with PIFU being implemented to avoid unnecessary appointments. The metrics for radiology and echo were heading in the right direction.
17.6	High impact changes were being implemented to improve productivity, reduce late starts and early finishes, and add additional cases to individual lists. Productivity had improved to 79% against a target of 85%. Additionally, utilization of some consultants has improved to 79%, whereas the national marker of a productive theatre was 85%. Long waiting patients have been reduced from 104 weeks to 78 weeks. The Trust had made good progress in driving down its long waiting position, but more importantly treating those patients in a timely way.
17.7	The high impact change for cancer had recorded 1.5 breaches and only 8 pathways. Radiology was performing well and progress was being made with a number of key modalities below the 50% position. The RTT Program board and Operational Recovery Group had reviewed those modalities in significant detail.
17.8	The COO highlighted the situation in relation to the April strike. The divisions were able to mobilize their plans to ensure safety and retain a significant proportion of their outpatient and elective services. This effort was commended for preserving the organization, preserving activity, and treating patients during a challenging time.
17.9	Natalie Edwards commended the comprehensive overview and the work done by the team.
17.10	Ann Griffins wondered when the value-weighted activity would be at 103%, also asking what was being done about clock stops. The CFO responded that the financial plan included a trajectory for beyond 103%. However at the moment, there was a gap in performance. He could not guarantee the assurance of 103%, although there was improvement.
17.11	Regarding clock stops, the COO felt it was an opportunity for learning and there was a training programme which divisional managers had committed all assistant divisional managers to attend.
17.12	Ginny Edwards asked the DDEM about the number of mental health patients and whether services were being changed to provide a consistent uptake of demand. The DDED explained that a lot of work was being done with colleagues across the system, with several ongoing projects to enable better access in the community. Additionally, work on two adult rooms and a ligature-free bathroom was almost complete and that training and support for ward staff to look after patients on the wards was happening.
17.13	The COO added that there would be more integration of mental and physical health going forward, nationally and across systems, work would be done with the voluntary sector as well. There had also been work done with children and young people's services on a

	therapeutic model, as well as Bounce Back service for addiction.
17.14	Ginny Edwards raised a question as to whether the high-impact changes were evidence-based to deliver the required results. The COO responded that they were, adding that information associated with high-impact changes had produced data showing that where efforts were focused, was yielding benefit and opportunity.
17.15	The CIO gave examples of where data supported the analysis, including where process and staffing have had an impact, and the period starting to departure.
17.16	The Vice Chair queried, with mental health becoming more integrated with physical health moving forward, how that was factored into the clinical strategy and the stage 3 development. The Chief Nurse responded that there had been discussions around ligature-free spaces, safe havens and sensory rooms.
18	**Integrated Performance report**
18.1	The CIO presented the key highlights.
18.2	Edwin Josephs noted that at PERC, the workforce and levy utilisation had been discussed, suggesting that the CPO share that with the Board.
18.3	The CPO reported on the utilisation of the apprenticeship levy, where work was being conducted with West Herts College. The CPO outlined there was a target of 65% utilisation by the end of this financial year and 80% next year.
18.4	Helen Davis raised a question about falls with harm, wondering what actions were in place to ensure that number continued to decrease. The Chief Nurse responded that there was a harm-free care programme in place which included falls, pressure ulcers and VTE. Harm-free care stewards were present on all wards as part of that programme.
18.5	The Chief Nurse further noted that low-rise beds were being tested and that there was a weekly review of all incidents. West Herts was below the national average on falls with harm, the underpinning data from the IPR showed that there was room for improvement rather than concern.
18.6	The Vice Chair noted that the caesarean-section rate numbers seemed high at 65% and 86%. The DDWACs responded that the numbers continued to fluctuate, assuring that all caesarean-section cases were reviewed, with the review showing nothing that could have been done differently.
18.7	He suggested that the high number of caesarean-section numbers may be due to maternal choice, wondering whether if more help and support was put in place at the beginning of the maternal journey, a different decision might be made. Overall, he felt that the right decisions were being made.
18.8	The CIO noted that categories one and three were relatively stable, however category two was on an overall upward trend, which would trigger an exception.
18.9	The Chief Nurse reported that they had discussed the BAME metric at the PERC meeting, noting it was good to see similar discussions in this meeting.
Aim 1: Best care	

19	**Quality improvement update**
19.1	The Chief Nurse presented the key highlights and noted that the quality improvement strategy would come to the board in Autumn 23. The paper noted key themes that had emerged from the initial work as well as the plans to develop Qi over the summer period which had been agreed with the divisions.
Aim 2: Best Value	
20	**Finance update**
20.1	The CFO presented the key highlights from the paper.
20.2	The Vice Chair thanked the CFO and his team for their work, adding it was good to see they had broken even last year.
20.3	The CPO thanked the CFO for support around temporary staff agency, adding it was pleasing to note there was to be a focus on consultant recruitment and a winter staffing plan which was starting in June.
20.4	Harvey Griffiths wondered about the impact of strike action on finances, further wondering what impact any pay settlement would have. The CFO reported there had been assurance from the Finance Director that costs of any pay settlement would be fully funded, consequently there was a plan for a 2% inflation on pay costs.
Aim 3: Great Team	
21	**Freedom to Speak Up** **Strategy & assurance report** **Summary of the reflection & planning tool**
21.1	The CPO presented the key points from the paper.
21.2	The Freedom to Speak Up Guardian was not concerned that cases had continued to rise in number, which she believed was due to increased staff engagement initiatives as part of the Difference Matters Project.
21.3	This was the first period where a larger number of cases were raised from medical staff, three of the five being the junior doctor workforce. Most cases were linked to bullying and harassment, a trend that had been ongoing for around 18 months.
21.4	There had been a decrease in numbers of cases raised through women's and children's services, the majority of reported cases relating to the midwifery area.
21.5	Natalie Edwards wondered how they could learn from the good work that had been done and replicate that across other divisions. The FTSU Guardian responded that it was about engagement with those areas.
21.6	Regarding data from different sources, Natalie Edwards questioned how that was brought together. The CPO considered that the key was trying to bring data from surveys together to triangulate and form an analysis.
21.7	Ginny Edwards commented that the increase in reported cases should be seen as a positive, as it was showing that people were becoming more confident to speak up. Ginny Edwards outlined that they were now at the point where a separate freedom to speak up

	strategy would be developed.
21.8	She considered that that Freedom to Speak Up was taken seriously, the FTSU Guardian was supported and it was part of the armoury of health and wellbeing for staff. She thanked the FTSU Guardian for her efforts in leading this work.
21.9	The CPO noted there was a Board development session coming up where the national freedom to speak up guardian would be in attendance.
21.10	The Chief Nurse was pleased to see junior doctors raising concerns, which she noted was seen nationally.
Aim 4: Great Place	
22	**Digital Progress Report and EPR Optimisation**
22.1	The CIO noted that the report was slightly different to the usual report and noted the key points.
22.2	Ginny Edwards queried whether there would be an opportunity to see how the voice recognition worked for EPR and the CIO agreed to arrange a demonstration.
22.3	Regarding the voice recognition product, Nuance, Ginny Edwards queried whether that would be able to send information to a patient's GP or system partners. The CIO that initially it would be the clinician improving the speed of noting, the second stage would enable workflows to be triggered verbally.
22.4	Ginny Edwards noted public concern around AI and patient information, and queried whether patient questions could be answered. The CIO thought it was an evolving subject with no clear answers to all questions at the moment. However, they would be able to answer specific questions related to healthcare settings around privacy and workflows. He reported that a thought paper had been published recently regarding the use of AI in healthcare and other protected markets.
22.5	Edwin Josephs asked about the digital roadmap strategy, and queried how much resource was allocated to progress the digital roadmap, that had been previously approved by the Board. The CFO reported that funding from the Frontline Digitisation Fund had provided enough resource for 2023-24, although the longer term may be more uncertain. Further, there was an amount within the redevelopment programme capital budget for digital enhancement.
22.6	The CIO anticipated challenges around the digital model moving towards a revenue software-based model, as well as that, they would probably have a lower proportion of spend than the last three or four years.
22.7	The CEO expressed his support, adding that EPR was a journey and it was important to optimise the products that were in place. He would like to strengthen user feedback into programmes.
22.8	Ann Griffin wondered what would happen if the system was disrupted and whether there was a backup plan. The CIO responded that there were a number of items, including completely backed-up data centres and 24/7 devices to capture the data in the system in the event of a software or network failure. He reassured the Board that they were in a

	fairly good place, but he would like to get all applications into professionally-managed data centers.
23	**Joint BCDD and Strategic Objectives Report**
23.1	The Joint BCDD and Strategic Objectives Report had been submitted and was taken as read. The CSCO presented some of the key highlights.
23.2	Ann Griffin was interested in the outpatient discharge, wondering what was being done in that area. The COO responded that she had made reference to that in her paper around the outpatient transformation programme, noting that the Herts Mind network and patient initiated follow-up (PIFU) as a good example.
23.3	The CIO added that they were conducting a specialty-by-specialty review about the changing activity profile to support waiting lists and the change in follow-up activity.
23.4	Regarding the patient initiated follow-up, Ginny Edwards wondered whether that included other clinical staff than doctors. The CIO felt the same rules would apply, there would be a proactive conversation with the patient.
23.5	The COO clarified that clinical nurse specialists in the Trust were captured and ran their activity in the same way as the clinical body. The opportunities to deliver that service were exactly the same for CNS staff as for clinicians.
23.6	The Divisional Director WACS further clarified that when the PIFU was set up, it was for all of the clinicians and it was about deciding who was the most appropriate person to see them.
23.7	The Chief Nurse queried whether there was a way to capture patient experience, the Divisional Director WACS thought not in West Herts at the moment, however in other areas that used PIFU, there was good patient feedback. He felt there would be opportunities to gather patient feedback in the future.
Risk and Governance	
24	**Corporate Risk Register report**
24.1	The Corporate Risk Register had been circulated and was taken as read. The Chief Medical Officer the presented key highlights.
24.2	**The Board approved the Corporate Risk Register**
25	**Annual self-certification process**
25.1	The Annual self-certification process report had been mentioned by the Vice Chair in the Quality Committee update and was presented to the Board for approval. The Trust Secretary presented the key highlights.
25.2	There were no questions or comments and the report was formally approved by the Board.
25.3	**The Board approved the self-certification process**
26	**Items considered in April 2023 Private Trust Board**
26.1	The paper was noted.
Closing Items	
27	**Any other business previously notified to the Chair**
27.1	There was no other business for consideration.

28	**Questions from Hertfordshire Healthwatch**
28.1	The Trust Secretary confirmed that Meg Carter had received a full pack of papers and would normally send queries through, none had been received.
29	**Questions from our patients and members of the public**
29.1	The Vice Chair noted there had been questions submitted in advance, asking the Trust Secretary to take the Board through them.
29.2	Question 1: On page 5 of item 23 of the May Board papers, there is a sentence which reads, 'Construction work for additional beds in Shrodells, and the essential services pathology lab, is now underway and plans for the potential purchase of the required land continue to be refined.' This appears to suggest that construction work on the new path lab is underway, but that the land has still not been purchased. Could you please clarify whether this sentence refers to that land or another parcel of land at WGH? When are you expecting NHP approval for all of the land purchases required for redevelopment at WGH?
29.3	The CFO responded that the new hot pathology building at Watford was being built on land between the Shrodells building and Willow House. The land is owned by the Trust.
29.4	Question 2: In June 2020, the Second Permanent Secretary at PHFC told the Trust that his department had approved £8.7 million early drawdown of funds to enable the development of the OBC for acute redevelopment, with a further £22.3 million required. Could you please tell me the total expenditure to date, from all sources on development work for the acute redevelopment of OBC? Do you have a forecast of the amount to be spent on the FPC?
29.5	The CFO responded that the costs of the OBC going back to June 2020 was £13.79 million. The breakdown being £5.1 million in the 2020-21 financial year, £5.7 million in the 2021-22 financial year, and £2.87 million in the 2022-23 financial year. With regard to future funding, The CFO was unable to comment until there was more information from the New Hospital Programme team.
30	**Date of the next Board meeting**
30.1	Jonathan Rennison confirmed the date of the next Board Meeting would be on 1st June 2023 at the Executive Meeting Room, Watford General Hospital. The meeting would be via Zoom.

BOARD DECISION LOG

Board meeting/ decision date	Decision reference (from minutes)	Item presented to Board for action	Comments/ outcome
06 April 2023	21	**NHSE Frontline digitisation business case**	The Board approved the business case for the digitisation of frontline services
06 April 2023	25	**Board and committee terms of reference and workplans**	The Board approved its terms of reference and board sub-committee terms of reference and workplans.
04 May 2023	25	**Annual self-certification**	The Board approved the annual self-certification process

West Hertfordshire Teaching Hospitals NHS Trust

Agenda item: 7

Action log (updated following 4 May 2023)

No.	Date of meeting	Minute ref	Action	Lead for completing the action	Date to be completed	Update
1			No actions to report			

TRUST BOARD WORK PLAN 2023/24: Part 1	Apr-23	May-23	Jun-23	Jul-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Service presentation/patient story	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Trust Chair and Chief Executive's report	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Performance											
Access standards performance and activity recovery overview	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Integrated Performance Report	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Aim 1: Best Care											
Seven day services – board assurance framework	✓										
Bi-annual establishment review – maternity					✓						✓
Bi-annual establishment review report – adult inpatient wards				✓						✓	
Annual establishment review report – Paediatrics							✓				
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			✓	✓		✓				✓	✓
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 Annual Report				✓							
Equality and Diversity WRES & WDES annual reports				✓							
EDS3				✓							✓
Gender and race pay gap report							✓				
Outcome of national staff survey/progress report		✓									✓
Annual medical appraisal report and statement of compliance					✓						
Annual People Strategy update					✓						
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 (tbc)											
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		✓									
Review of committee structure/governance to deliver strategic objectives											
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			✓				✓				

West Hertfordshire Teaching Hospitals NHS Trust

Trust Board Meeting
1 June 2023

Title of the paper	**Chair's Report**
Agenda Item	**9**
Presenter	**Phil Townsend, 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	Aim 2 Great team	Aim 3 Best value	Aim 4 Great place
Objectives 1-4	***Objectives 5-8***	***Objective 9***	***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? x☐ 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? x☐ Is appropriate and accurate information being effectively processed, challenged and acted on? x☐ Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☐ Are there robust systems and processes for learning, continuous improvement and innovation? ☐ How well is the trust using its resources?
Previously considered by	Committee/Group: N/A; Date:
Action required	The Board is asked to receive the report for information.

West Hertfordshire Teaching Hospitals NHS Trust

Agenda Item: 9

Trust Board Meeting – 1 June 2023

Chair's report

Presented by: Phil Townsend, Chair

1 PURPOSE

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

2 NEWS AND DEVELOPMENTS

Hospital Redevelopment

2.1 I am very pleased to report the positive news that Steve Barclay MP, the Secretary of State for Health and Social Care, has announced in Parliament on 25 May 2023 his approval for our new hospital at Watford General and confirmation that it will be fully funded. This is one of the schemes being prioritised for a national multi-billion-pound rolling investment, as part of the New Hospital Programme.

East of England Ambulance Service appoints new chair

2.2 Our local ambulance trust, the East of England Ambulance Service Trust (EEAST), has appointed a new chair, Mrunal Sisodia OBE. I would like to congratulate Mrunal on his appointment and look forward to working with him.

Reflecting on Covid-19 experiences to improve care

2.3 Last year, the Trust held a series of sessions for staff to reflect on their Covid-19 experience in a safe, open and creative space. In these sessions, staff explored and reflected on how they could use their learning to improve staff experience at work as well as care for ourselves, each other and our patients. The sessions also explored how we could capture and adopt the good things that came out of the pandemic as well as learn from the more challenging things.

2.4 As a result, a series of reflective posters were produced with words of positivity that came out of the sessions. Tracey Carter, our former chief nurse, unveiled these posters at St Albans City Hospital outpatients area, Hemel Hempstead Hospital, Verulum wing and near reception in PMoK at Watford General Hospital. Thank you to everyone who took

part in the sessions. We hope these posters serve as testament to your commitment and dedication throughout the pandemic.

Brunel medical school student ambassadors visit

2.5 I am pleased to report that we have had the pleasure of hosting five student ambassadors from Brunel Medical School. These students will be undergoing their clinical training in five different hospitals, including Watford General, on their journey towards becoming doctors. The first cohort of students is scheduled to join us from June 2024. The student ambassadors had the chance to explore various departments, including the virtual hospital hub, cardiac catheter lab, CT scan department, simulation suite, outpatient department and several wards. They also had a valuable opportunity to interact with other medical students currently studying at our trust from UCL and St George's University.

2.6 We look forward to the exciting opportunities that lie ahead for our partnership with Brunel Medical School.

Lanyards to help end gender stereotyping

2.7 A selection of lanyards that allow for swift and accurate recognition of medical staff has been made available to the Trust by members of the End Sexism in Medicine Network. This is essential in critical situations such as a cardiac arrest. These lanyards identify different roles, such as ‘consultant’, ‘doctor’ or ‘advanced practitioner’.

2.8 They will also ensure female doctors are easily identified as doctors by staff and patients, an issue which has recently been discussed in the network’s workshops. I would like to thank the network for their support of our clinical staff.

Congratulations to our latest Stars of Herts winners

2.9 Congratulations to Janice Ancheta, Coronary Care Unit (CCU) Ward Manager, and Sarah Puntis, digital midwife in maternity, who are our latest monthly Stars of Herts winners. Janice was nominated for always being flexible and approachable and for being an amazing manager.

2.10 Sarah was nominated for playing a key role in introducing the new paperless patient record system, BadgerNet, into our maternity and neonatal teams.

Celebrating Deaf Awareness Week

2.11 The Trust celebrated Deaf Awarewess week during 1 - 7 May 2023. Celebrations were supported by our Acting Chief Nurse, Michelle Hope, who lives with hearing loss and needs to wear hearing aids at work. Michelle also proudly wears a sunflower lanyard, which is a recognised symbol that the wearer has an invisible disability. Michelle’s story shows that having a hearing impairment is no barrier to achievement.

Celebrating International Nurses Day

2.12 We celebrated International Nurses Day on 12 May 2023 and many nurses and teams across our services took to social media to show how they were marking the occasion. The day was a great opportunity to thank, recognise and praise all our brilliant nursing colleagues at West Herts. Thank you for your service.

Mental Health Awareness Week

2.13 Mental Health Awareness Week (Monday 15 May to Sunday 21 May) was a time for us all to think about mental health, tackle stigma and find out how we can create a society that prevents mental health problems from developing. This year’s theme was anxiety and throughout the week there were webinars available on topics regarding anxiety and

mental health and how activities such as gardening and exercising could improve a person's anxiety.

3 Community News

Kind crocheter helps premature babies

3.1 Thank you to Karen from Homestart Watford, who crocheted and donated beautiful little animals to Raise, our hospitals' charity, which will now be given to our neonatal unit. Crochet items for newborns can have a calming effect on the baby and provide reassurance for concerned parents. The tentacles of crocheted octopuses replicate the umbilical cord, which babies hold onto in the womb. Holding them seems to alleviate some stress for the babies. Karen learnt to crochet during lockdown and began making amigurumi (the Japanese art of knitting or crocheting small, stuffed yarn creatures) for charity, raising £400 over the last two years. My thanks to Karen for supporting our hospital charity.

4 Hertfordshire and West Essex ICS

4.1 On Wednesday 23 May 2023 ,I attended the inaugural meeting of all ICS partners led by Paul Burstow, Chair of the Hertfordshire and West Essex ICS. There was representation from all providers including the voluntary sector, police and housing.

4.2 The SWHHCP continues to make good progress to strengthen relationships within the extended Board membership that now includes GP leaders, District Chief Executives and voluntary sector colleagues in each of the four localities. At the April meeting, the SWHHCP Board signed off the Plan on a Page which outlined the vision and objectives together with a programme of works for 2023/24 onwards. The vision for the SWHHCP is that ' all partners working effectively together to reduce health inequalities and improve the health and wellbeing of people in South and West Hertfordshire. There are three strategic objectives that drive the vision and these are:

- To focus on prevention of ill health and inequalities in access and outcomes
- To understand and respond to the needs of the people we serve
- To ensure the safe and seamless transition of patients and service users from one service to another.

4.3 Work has begun on developing data packs that will provide the evidence of population needs in each locality supported by Population Health Management and Census leads. This work will enable each locality to identify areas of focus for transformation and to prioritise areas of work.

4.4 To support the SWHHCP, the role of Development Director has been created to provide dedicated capacity for the HCP in it's development year. The role will be going out to advert shortly and is funded by WHTH, CLCH and the ICB.

4.5 The Board held a development session in May for members to share views to identifying different and shared goals/ambitions that the development plan for the HCP needs to take account of as we move into delivery mode to then build a clear consensus with shared ambitions and outcomes.

4.6 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, the Board visited the following areas on 4 May 2023:

- Main Outpatient Department
- Radiology Services
- Mortuary Services
- Maternity Outpatient Department

6 Trust Chair's meetings:

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

Board development
ICS chairs event
Trust governance session
Committees
Hosted Chief Nurse leaving event
HCP chairs meeting
ICP event

7 RECOMMENDATION

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

Phil Townsend
Chair

May 2023

West Hertfordshire Teaching Hospitals NHS Trust

Trust Board Meeting
1 June 2023

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, 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	Aim 2 Great team	Aim 3 Best value	Aim 4 Great place
Objectives 1-4	*Objectives 5-8*	*Objective 9*	*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.

West Hertfordshire Teaching Hospitals NHS Trust

Agenda Item: 10

Trust Board Meeting – 1 June 2023

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/ of relevance to the Board

2 KEY ISSUES

Hospital Redevelopment

2.1 I am very pleased to report the positive news that Steve Barclay MP, the Secretary of State for Health and Social Care, has announced in Parliament on 25 May 2023 his approval for our new hospital at Watford General and confirmation that it will be fully funded. This is one of the schemes being prioritised for a national multi-billion-pound rolling investment, as part of the New Hospital Programme. I look forward to working closely with the New Hospital Programme to progress the redevelopment.

Patient care across the Trust

2.2 I would like to express my continued appreciation for all the hard work that staff are undertaking at the moment to look after our patients and to help one another. Because of the outstanding work on discharges, the demand for emergency treatment is modestly declining and I am very grateful to ED staff and ward for their determination to improve processes to facilitate this.

2.3 I remain acutely aware of how tough things are for many people and how hard everyone is working. I am committed to this organisation being one that listens to its staff and acts upon its feedback and am pleased with the number of ways that we do this with out continued health and wellbeing offer, staff recognition and financial workshops. We will strive to build on these improvements and we receive more feedback from our staff.

On-going demand and capacity

2.4 As mentioned above, we are still seeing high levels of demand but there is now a clear trend of fewer patients attending ED. We will work hard to maintain this both internally and with our system colleagues to provide the best care in the right place. In particular, our work to support our ambulance colleagues is bearing fruit with a continued reduction in 30 and 60 minute waits compared to last month. We are further supported with continuing national initiatives to improve access to GPs with the recently announced GP access recovery plan, which will utilise the use of pharmacies to help patients with common, minor ailments as well

as funding to improve technology within GP practices which will help patients make appointments.

2.5 Our focused work on patient flow through our emergency department and high impact change programme to support our elective recovery continues at pace. We are maintaining our early positive results and I would like to extend my thanks again to the operational staff involved in this work. It is crucial work as we face a real challenge to meet NHSE's targets but our preparatory work during the last financial year has given us the best possible chance of meeting those targets.

2.6 The impact of the recent strikes is now starting to show in our data, with reduced activity levels for elective care which will be difficult to recover, and more so, with additional strikes recently announced. We continue to promote a culture of understanding as national bodies seek to resolve disputes over pay.

2.7 I am mindful that the offer of a first or second dose of COVID-19 vaccine will end on 30 June 2023 for most people. I would urge anyone who is eligible to receive a spring booster to take up the offer as it really does make a difference and reduces the need to receive hospital care.

3 CHIEF OFFICERS UPDATES

Chief Operating Officer

3.1 The NHS England Board has announced that they will be stepping down the COVID-19 incident, which was declared a Level 4 incident on 30 January 2020. The World Health Organization has also announced that COVID-19 is no longer a Public Health Emergency of International Concern. This decision will make changes to the way the NHS responds to COVID-19, such as reducing the number of doses of the vaccine given as the threat from Covid-19 diminishes. The Board will be kept informed of any significant changes.

Chief People Officer

Pay Offer

3.2 In recent weeks the NHS Staff Council, constituted of trade unions, staff side representatives and health service management representatives voted to accept the revised pay offer from the government. This will now be paid in June and cover a one-off payment associated to 2022/23 alongside a pay increase for 2023/24.

3.3 The Trust has communicated to all staff the new pay offer and the details of how this will be implemented in June 2023.

3.4 The bodies that accepted the offer include Unison, GMB, Royal College of Midwives and Society of Physiotherapists. However, the offer was rejected by the Royal College of Nursing and Unite.

Industrial Action Update

3.5 The RCN have initiated a new ballot in order to receive a mandate from members for further strike action. The ballot will open on 27 May and close on the 23 June 2023. The ballot for the RCN differs from their previous mandate as its asking members to take action on an aggregated national level whereas previously this was requested at organisational level.

3.6 In addition, the BMA have initiated a ballot for their consultants to vote on taking industrial action. This ballot opened for eligible members on 15 May and will close on 22 June 2023.

3.7 The Trust has started making preparations for further strike action taking consideration of the outstanding ballots as part of our on-going mitigation plans.

Teaching Hospital Status

3.8 Further to the Board development session on 16 February 2023 associated directly with the benefits and aspiration associated to Teaching Hospital status good progress continues on the 5 priority areas.

3.9 This session acted as a catalyst for the enhanced links with the University of Hertfordshire with quarterly meetings established. This has focused on our support to the university regarding their bid for a medical school. In addition, we have commenced discussions on opportunities for visiting lecturer roles for relevant staff at the Trust. The University have also offered opportunities that will align to our leadership development programme.

3.10 In our other priority areas we continue to see developments with clinical fellow roles for digital supporting the virtual hospital with opportunities identified for imaging, simulation and EDI.

3.11 In terms of research there is focus on developing a clinical trials unit with simulation highlighting physical capacity constraints in meeting their ambitions.

Leadership Forum

3.12 The leadership forum has now been set up monthly with full forums that provide a guest speaker, networking sessions and short 30-minute sessions on teams associated to a single agenda item.

3.13 The most recent session for the teams 30-minute presentation associated to the staff survey and next steps priorities. The session was well attended with over 75 senior leaders joining the meeting. The next forum will take place on 22 June with a full in-person meeting taking place at the football club where the theme will be Equality, Diversity and Inclusion.

4 NEWS AND DEVELOPMENTS

New psychological support service for our patients

4.1 A new cancer and palliative care psychological support service is now live which will provide much needed support across the Trust. The service will be delivered by therapists from Essex Partnership University NHS Foundation Trust (EPUT) and is funded by Macmillan Cancer Support until the end of 2024. Clinics will be delivered both face to face and virtually, with provision for inpatient support.

4.2 We are delighted to be able to offer this service to our patients and look forward to working in collaboration with EPUT to deliver it.

Defibrillators installed in multi-storey car park

4.3 The resuscitation service has installed automated external defibrillator (AED) and ligature kits on Level 0, 2 and 5 of the multi-storey car park at Watford. Our security team have received basic life support and AED training to promote early defibrillation, and the AEDs have also been registered with the ambulance service to support our local community to gain early access to a defibrillator.

SHINE portal launched

4.4 The Staff Survey highlighted the importance that recognition and appreciation has on our staff's experience at work. We have partnered with Each Person to launch a new reward and recognition platform to enhance staff recognition and appreciation within the Trust. This platform will enable all staff across departments, staff groups and sites to easily send thanks and appreciation to each other. It will also allow the Trust to recognise Long Service milestones promptly, streamline our monthly Stars of Herts nomination process, recognise and celebrate awareness dates events through the year and allow managers to send personalised happy birthday messages to their team.

5 NATIONAL GUIDANCE

Government invites views on tackling major conditions in England

5.1 A call for evidence has been launched to invite views on how best to prevent, early diagnose, treat and manage the 6 major groups of health conditions which drive ill health and contribute to the burden of disease in the population in England. The 6 major health conditions - cancer, cardiovascular diseases, chronic respiratory diseases, dementia, mental ill health and musculoskeletal disorders - affect millions of people in England with data showing that one in 4 suffer from 2 or more of these major long-term conditions. The government is seeking views on a new strategy to tackle them that will focus not only on treatment but also on prevention. Those suffering from one or more of these conditions are urged to come forward to provide insight into their experiences of managing their health needs. The major conditions strategy signals the government's intention to improve care and outcomes for those living with multiple conditions and an increasing complexity of need. It will seek to reduce care and treatment that are too narrowly focused on specific diseases or organs in the body and consider how to treat people as a whole. Further information can be found here: https://www.gov.uk/government/news/government-invites-views-on-tackling-major-conditions-in-england

6 RECOMMENDATION

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

Matthew Coats
Chief Executive
May 2023

West Hertfordshire Teaching Hospitals NHS Trust

Trust Board Meeting

1 June 2023

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 the Finance and Performance Committee, and the Quality Committee on 27 April 2023. The Quality Committee and Finance and Performance Committee recommended no changes to risks at this time. Changes have been made to the content of BAF risk 1 and BAF risk 6 which are marked in red and provide an update on the progress made with the risks risks for fragile services and transformation of services. 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	Aim 2 Great team	Aim 3 Best value	Aim 4 Great place
Objectives 1-4	*Objectives 5-8*	*Objective 9*	*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	• Finance and Performance Committee – 25 May 2023 • Quality Committee – 25 May 2023
Action required	The Board is asked to consider and approve: • This month's version of the BAF.

West Hertfordshire Teaching Hospitals NHS Trust

Agenda Item: 11

Trust Board meeting – 1 June 2023

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	It is OK because I have reviewed various reliable sources of information, such as: – Independent information source – Evidence of historical progress, outcomes

	– Management explanations are consistent	– Triangulation with other information

2.5 The BAF comprises of a 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 BAF is 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 25 May 2023 by Quality Committee and Finance and Performance Committee.

3.3 The Board approved the reduction in risk scores for BAF 1 (Fragile services), BAF 2 (Sufficient elective and diagnostic capacity) and BAF 4 (Insufficient staffing) at its board meeting on 2 February 2023. No further changes have been made to the risk scores within the BAF this month.

3.4 Changes have been made to the content of BAF risk 1 and BAF risk 6 which are marked in red. These reflect the change in executive lead for the risks to the Chief Strategy and Collaboration Officer. Track changes in blue show minor updates to those risks following an initial review. (See paper 11.2 for further details of QC risks)

3.5 The executive lead for BAF risk 5 has been updated to Michelle Hope, Acting Chief Nurse.

3.6 The Finance and Performance Committee (FPC) does not recommend any changes to the BAF to risk numbers 7, 8 and 9. (S*ee paper 11.3 for further detail of FPC risks*).

3.7 The Board approved the reduction in PERC risk scores for :

- BAF 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),
- BAF 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) and
- 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)

on 2 March 2023 (See paper 11.4 for further detail of PERC risks). No further changes have been made.

3.8 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

May 2023

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	April/ May 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.	Toby Hyde / QC		20 (5 x 4) HIGH	20	20	20	16	16	16	12 (3 x 4) Mod
	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	16	16	16	9 (3 x 3) Low
		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	20	20	20	9 (3 x 3) Low
		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	16	16	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.	Michelle Hope/ QC		9 (3 x 3) Mod	9	9	9	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.	Toby Hyde / QC		20 4 x 5 HIGH	20	20	20	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 ↔	12	12	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	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	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.	Andrew McMenemy / PERC		12 (4 x 3) Mod	12 ↔	12	12	12	9 ↓	9 ↔	6 (3 x 2) Low
	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.	Andrew McMenemy / PERC		16 (4 x 4) HIGH	16 ↔	16	16	16	12 ↓	12 ↔	8 4 x 2
	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.	Andrew McMenemy / PERC		16 (4 x 4) HIGH	16 ↔	16	16	16	12 ↓	12 ↔	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	15	15	12	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.	Alex White/ GPC		20 (5 x 4)	20 ↔	20	20	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.	Toby Hyde/ GPC		9 (3 x 3)	9	9	9	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

West Hertfordshire Teaching Hospitals NHS Trust

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

BOARD ASSURANCE FRAMEWORK FOR 2022-23

Quality Committee Dashboard

Strategic Aim/Priority		Risk no	Risk description	Executive Lead	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	Apr/ May 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.	Toby Hyde		20 (5 x 4) HIGH	20	20	20	16	16	16	12 (3 x 4) Mod
	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	35 (3828) 36	20 (5 x 4) HIGH	20	20	20	16	16	16	9 (3 x 3) Low
		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	19 (4019) 20 (4496) 21(4497) 22 30 23 36 113	20 (5 x 4) HIGH	20	20	20	20	20	20	9 (3 x 3) Low
		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	37	20 (5 x 4) HIGH	20	20	20	16	16	16	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.	Michelle Hope	30	9 (3 x 3) Mod	9	9	9	9	9	9	6 (3 x 2) Low
	Transforming our	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.	Toby Hyde	30	20 4 x 5 HIGH	20	20	20	20	20	20	10 2 x 5 Mod

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

BAF Risk 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.
Strategic Priority	Resilient Services
Review Date	Monthly
Exec Lead	Toby Hyde
Reporting Committee	Quality Committee

Risk Score								
Residual	Apr/May	Jun/July	Aug/Sep	Oct/Nov	Dec/Jan	Feb/Mar	Apr/May	Target (2024)
20 (5 x 4)	20	20	20	20	16	16	16	12 (3 x 4)

Context

The new legislation has an expectation of acute providers improving their collaboration with each other.

The pandemic has significantly impacted the provision of services. Collectively, we have extremely high waiting lists which will ~~only~~ require a coordinated approach across the acute trusts in our Integrated Care System. ~~be able to reduce if we work together.~~

Some of our ~~services are small because they~~more ~~are~~ specialised services ~~and~~ serve ~~reduced~~ relatively low patient numbers which makes it more difficult for them to ~~. They are less able to~~ withstand ~~current~~ increased service pressures, such as staffing and resource issues, which leads to fragility. Pooling our resources with other acute providers would strengthen these services, create greater resilience, and provide better patient experience and outcomes.

Gaps in Control and Assurance

Some services lack a standard operating procedure for out of hours services with no contract in place with a tertiary provider.

Scoring
The risk score has been reduced to 16 (4(L) x 4(C)). I.e., That it is likely that the risk will probably happen/recur, but it is not a persisting issue.
The consequence is assessed as "Major - uncertain delivery of key objective/service due to lack of staff, loss of key staff and very low staff morale if unresolved."

For the risk score to reduce, the likelihood score must reduce "Possible - might happen or recur occasionally" to reach the target likelihood score. The consequence rating would need to reduce to "Moderate - late delivery of key objective/ service due to lack of staff and low staff morale. Presently, the risk score has been reduced to 16 as the risk of not working with acute partners to strengthen fragile services will probably happen but is not a persistent risk that could negatively affect patient outcomes if unresolved.

Progress

Positive progress including future opportunities	Current challenges including future risks	How challenges are being managed
The collaborative surgical hub has been approved and is progressing, which will strengthen our ability to recover elective performance, ~~and~~ reduce the impact of unplanned care demand on surgical activity and ~~demands on fragile services, support the recovery of the acute waiting list and~~ improve patient outcomes. The hub has appointed a Programme Director. The risk score has been reduced to 16 to reflect the approval of the collaborative hub.	Limited resources mean that actions identified in the acute strategy will need to be prioritised. Developing an elective hub, that meets the immediate waiting list needs of the population, within the available capital envelope.	Twice weekly elective hub group meetings attended by all three acutes and ICS. Challenge will be managed by Programme Senior Leadership Team.

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		Risk Score							
Review Date	Monthly	Residual	Apr/May	Jun/July	Aug/Sep	Oct/Nov	Dec/Jan	Feb/Mar	Apr/May	Target
Exec Lead	Sally Tucker	20	20	20	20	20	16	16	16	9
Reporting Committee	Quality Committee	(5 x 4)	←			→	↓	←	→	(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 utilisation to maximise activity opportunities.
- Outpatient transformation. Non- face to face, PIFU and referral management systems.

Scoring

The risk score has been reduced to 16 from 20. (4(L) x 4(C)). I.e. That it is likely that the risk will probably happen/recur but it is not a persisting issue. The consequence is assessed as "Major - non-compliance with national standards with significant risk to patients if unresolved".
For the risk score to reduce, the likelihood score must reduce to "Possible - might happen or recur occasionally" to reach the target likelihood score. The consequence rating would need to reduce to "Moderate - treatment or service has significantly reduced effectiveness."
Presently, the risk score has reduced to 16 to reflect that the risk of insufficient elective and diagnostic capacity will probably happen but is not a persistent issue that will lead to non-compliance with national standards with significant risk to patients if unresolved.

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 end of October 22 which has been maintained in line with the national objective We finished the financial year with ten 78 week breaches, of which 3 were patient choice deferrals to later in the year. Complex Orthopaedic surgery recommenced at Watford on 10 October 22 for a period of 6 weeks. The next planned Orthopaedic focus period has not yet been finalised	Referral profile post COVID has changed, with an increased proportion of urgent and cancer referrals. Lack of uptake of additional waiting list initiatives by clinicians. Unpicking use of EPR – issues with clock stops, PTL management, data quality. User knowledge / training Urgent care demands have increased recently (Dec 22) necessitating surge in to exceptional escalation areas, resulting in decreased capacity for elective activity, particularly affecting Cardiology, Gastroenterology and complex surgical admissions	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 for increased validation resources. Development of RTT and EPR training programme following review of issues leading to poor DQ within the PTL. Roll out commenced in Feb/Mar 23. Launch of high impact change plan with 4 key areas of focus: Data Quality Theatre Productivity Long wait improvement Outpatient transformation & productivity

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
Reporting Committee	Quality Committee

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

Context

Continued increase in emergency care demand.

Upper threshold of ambulance conveyances has continued

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 reduces the amount of available ring-fenced elective care beds. Urgent care demands have increased recently (Dec 22) necessitating surge in to exceptional escalation areas, resulting in decreased capacity for elective activity, particularly affecting Cardiology, Gastroenterology and complex surgical admissions.

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 system partners to audit primary care restoration of services.

  Conveyance prevention initiative pilots, running within partner organisations, have gone live with active monitoring of impact.

- Maximising our SDEC services to enable admission avoidance.

- Ongoing development and expansion of virtual hospital clinical pathways, eg Heart Failure, acute respiratory infection

Scoring

The risk score is currently scored at 20 (5(L) x 4(C)). I.e. That it is almost certain that the risk will undoubtedly happen and/or recur, possibly frequently. The consequence is assessed as "Major - non-compliance with national standards with significant risk to patients if unresolved".
For the risk score to reduce, the likelihood score must reduce to "Likely - will probably happen/recur but it is not a persisting issue" and then to "Possible - might happen or recur occasionally" in order to reach the target likelihood score. The consequence rating would need to reduce to "Moderate - treatment or service has significantly reduced effectiveness."
Presently, the risk score remains at 20 as the risk of insufficient elective capacity and rising waiting lists remains a persistent issue that will lead to non-compliance with national standards with significant risk to patients if unresolved.

Progress

Positive progress including future opportunities	Current challenges including future risks	How challenges are being managed
MADE event held during the week of 3 January 23 with Discharge Summit, attended by CEO & COO in that week, along with senior system partner representatives. 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, with capacity for 40 patients at any time. Robust oversight to support consultant appointments cross divisionally. Joint working EEAST re ambulance conveyances.	Demand is outside of our control. Ongoing increases in mental health demand alongside mental health delays. Ambulance conveyances, when arriving in clusters, result in increased flow pressures to ED alongside the need for rapid handover and release. Urgent care demands continue to rise necessitating surge in to exceptional escalation areas, at times resulting in decreased capacity for elective activity, particularly affecting Cardiology, Gastroenterology and complex surgical admissions	ICS System working. Participation in ICS UEC Board. Mutual aid support via ICB with regard to ambulance conveyance and delayed handovers (intelligent conveyancing). 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. Joint working with HPFT with regard to alternatives to acute hospital attendance for MH patients, focusing on community crisis support initiatives. MADE event to support system partner commitment for patient flow out of hospital. Launch of High Impact Patient Flow initiatives: • Patient assessment • Discharges • Control Centre • Urgent Treatment Centre

BAF Risk 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.
Strategic Priority	Improving access to care
Review Date	Monthly
Exec Lead	Andrew McMenemy
Reporting Committee	Quality

Risk Score								
Residual	Apr/May	Jun/July	Aug/Sep	Oct/Nov	Dec/Jan	Feb/Mar	Apr/May	Target
20 (5 x 4)	20	20	20	20	16	16	16	12 (3 x 4)

Context

There is clearly an element of fatigue and discontent in the workforce that is demonstrated more widely across the NHS with ongoing industrial action. At West Herts the impact of this has been relatively low. In addition, the recruitment levels have been positive with the vacancy rate continuing to fall and stay within our set targets. However, there are areas of risk particularly within some specialities for consultant posts, maternity continues to provide challenges as well as some roles within our allied health professional group.

The elective work in the NHS has historically been supported by staff undertaking additional duties with an emphasis on consultant roles. This has been impacted by pandemic as well as the national changes to the annual allowance on pensions. Therefore we are seeing less staff take these opportunities for additional sessions and therefore having a detrimental impact on our productivity to support the elective recovery.

Gaps in Control and Assurance

The gap that existed was the lack of any national solution to the pension situation, especially for those breaching their annual allowance. This was also exacerbated by no local solution to support those staff reaching the threshold of their annual allowance.

Scoring
The risk score is currently scored at 20 (5(L) x 4(C)). It is proposed that the score change to 16 (4x4) based on the additional mitigations that have been implemented in the recent few weeks alongside continued good progress in recruitment.

Progress

Positive progress including future opportunities	Current challenges including future risks	How challenges are being managed
Continued improvements in recruitment with focus on recruitment and workforce modelling plans in high risk areas such as AHPs, maternity and the medical workforce. The approval and implementation of an alternative pension scheme alongside movement at national level for a solution to be provide from September 2023.	The challenge regarding recruitment remain alongside the continued challenge of retaining the workforce. The indicators and performance has improved over the last 4 months with further improvement required.	The challenges are being overseen by the HR department with good oversight provided at divisional performance meetings. The Trust remuneration committee approved the alternative pension scheme and this is routinely discussed at Medical Staff Committee, TMC and LNC.

BAF Risk 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.									
Strategic Priority	Reducing inequalities		Risk Score							
Review Date	Monthly	Residual	Apr/May	Jun/July	Aug/Sep	Oct/Nov	Dec/Jan	Feb/Mar	Apr/May	Target
Exec Lead	Michelle Hope	9	9	9	9	9	9	9	9	6
Reporting Committee	Quality Committee	(3 x 3)	←						→	(3 x 2)

Context	Gaps in Control and Assurance
There was an emerging focus on health inequalities prior to the pandemic. However, Covid-19 worsened health inequalities and brought the issue into sharp focus. Work has commenced on improving health inequalities within maternity services following the recommendations of the Ockenden report. There is a clear need to build our understanding of health inequalities and take action to improve disparities. Our target is to develop the work being undertaken within maternity services an produce an assessment that better understands the key areas for improvement within the population that we serve.	We do not have a baseline understanding of the health inequalities facing the population that we serve or how our services positively or negatively affect those inequalities.

Scoring
The risk score is currently scored at 9 (3(L) x 3(C)). I.e., That it is possible that the risk might happen or recur occasionally. The consequence is assessed as "Moderate – services have significantly reduced effectiveness if unresolved".
For the risk score to reduce to the target level, the consequence score would need to reduce to "Minor – overall service is suboptimal". Presently, the risk score remains at 9 as there is a possible risk of non-engagement with communities that may affect services not meeting the needs of the population that it serves.

Progress

Positive progress including future opportunities	Current challenges including future risks	How challenges are being managed
Work to improve health inequalities within maternity services has started. We are compliant with Ockenden requirements following identification of patient safety specialist to collaboratively work with corporate staff and to manage the risk and governance process. Work is on-going to develop provisions for listening to friends and families more effectively. And the maternity voice partnership has been engaging with local groups and has undertaken site visit with a plan to continue. We have started work on the EDS3 assessment and we are working with ICS to develop a system wide framework. Internal mapping is complete with a list of non-staff networks and existing co-production board stakeholders.	Lack of knowledge of the baseline. Resources – now have a dedicated EDI champion.	We are working with the ICS to develop a program plan which will go part-way to mitigate the resources issue. Internal – project plan to put structure in place. Following internal mapping, we will develop a robust delivery plan.

BAF Risk 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 over the next five years.
Strategic Priority	Transforming our services
Review Date	Monthly
Exec Lead	Toby Hyde
Reporting Committee	Quality Committee

Risk Score								
Residual	Apr/May	Jun/July	Aug/Sep	Oct/Nov	Dec/Jan	Feb/Mar	Apr/May	Target
20 (4 x 5)	20	20	20	20	20	20	20	12 (2 x 5)

Context

Hospital services are currently under huge strain. Demand is growing and is presently exceeding the capacity available within the hospital. This is impacting on the provision of elective care and emergency care and is at high risk of becoming worse over the next five years.

We have been working with partners to implement transformation projects to mitigate against growth in bed capacity by introducing the new transformation projects which will help manage capacity at home or in the community.

Our ability to transform services in the medium to long term directly depends on a successful outcome for our redevelopment programme.

Gaps in Control and Assurance

Reporting gaps have been addressed with monthly reporting to HCP board. However, we are not yet able to measure the impact on the emergency and elective demand.

Scoring

The risk score is currently scored at 20 (4(L) x 5(C)). I.e., That it is likely that the risk will probably happen/recur but it is not a persisting issue. The consequence is assessed as "Catastrophic - totally unacceptable level or quality of treatment if unresolved."

For the risk score to reduce, the likelihood score must reduce to "Possible - might happen or recur occasionally" and then "Unlikely - Do not expect it to happen/recur but it is possible it may do so to reach the target likelihood score. The consequence rating would remain the same.
Presently, the risk score remains at 20 as the risk of not working with partners to transform services remains a persistent risk that could significantly and negatively affect patient outcomes over the next 5 years if unresolved.

Progress

Positive progress including future opportunities	Current challenges including future risks	How challenges are being managed
Virtual Hospital – we are continuing to develop~~ing~~ the service to facilitate earlier discharge of patients and reduce hospital admissions and on 14th and 15th May had over 50 patients being cared for in the VH. We are seeking to go live with further pathways and expand capacity during 23/24. ~~.~~ The acute collaborative strategy has been agreed with system partners, PAH AND East and north. This will help to inform the delivery plan for the elective system hub which will ~~help in transforming our fragile services.~~ contribute to the recovering our elective activity.	~~We need to increase the number of patients using the Virtual Hospital.~~ We need to do a lot in a relatively short space of time – resourcing capacity and working at pace is challenging. We need to progress our hospital redevelopment programme. We need to develop a process for measuring the impact on elective and emergency demand.	Daily discussions with the health care board as to how to improve patient flow. Assigned resources to programme management. 5-year change programme better care delivered differently HCP change programme We are monitoring the delivery of the programmes to include beds saved as a measure.

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	April/May	Target
12	16 ↑	16 ↔	12 ↓	12 ↔	12 ↔	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 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.	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 related savings. Demand management fails, emergency care demand exceeds expectation and additional funds not made available.	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. 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	April/May	Target
16	16 ↔	16 ↔	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**	**April/May**	**Target**
12	12 ↔	12 ↔	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	February 2023
Exec Lead	Andrew McMenemy
Reporting Committee	PERC

	Risk Score							
Residual	Apr/May	Jun/July	Aug/Sep	Oct/Nov	Dec/Jan	Feb/Mar	Apr/May	Target
12	12	12	12	12	12	9	9	6 (3x2)

Context
The staff survey has demonstrated that we continue to have variations on how staff are treated based on their protected characteristics. The Trust is diverse with 47.2% BAME population. However, our workforce becomes less diverse the more senior the role becomes. Therefore, creating an inclusive and supportive culture with extended opportunities for development and career development is important.

Gaps in Control and Assurance
The main gap is measuring the outcomes from the interventions that have been implemented alongside those being developed such as career coaching, leadership development review, extending staff networks and implementing the EDI Steering Group.

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. 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 framework and therefore sits closely with staff wellbeing, engagement and talent management. Initial priorities will be cultural awareness training, reverse mentoring and values-based recruitment.	A new EDS assessment will be introduced in 2023 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 developing our EDI priorities within our senior team.	The EDI steering group in overseeing the main priorities with TMC receiving new initiatives for agreement. The EDS framework alongside WRES and WDES provide PERC and the Trust with oversight and assurance that the main challenges are understood and being addressed.

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	**February 2023**
Exec Lead	**Andrew McMenemy**
Reporting Committee	**PERC**

	Risk Score							
Residual	**Apr/May**	**Jun/July**	**Aug/Sep**	**Oct/Nov**	**Dec/Jan**	**Feb/Mar**	**Apr/May**	**Target**
16	16	16	16	16	16	12	12	8 (4x2)

Context
Staff retention is one of the main challenges facing the NHS. It was expected that staff turnover would increase following the impact of the pandemic. WHHT is now demonstrating reducing levels of turnover over a sustained period of time. There continues to be challenged specialities and staff groups with relevant mitigations in place.

Gaps in Control and Assurance
Review of organisational values and introduction of behavioural framework. 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 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.	Alongside reductions in the turnover rate and effective recruitment there continue to be areas that require further support such as AHPs, Maternity, Anaesthetics and Critical Care. Main challenges around retention associated with vertical integration, development opportunities and fatigue. Affordable housing is a more common theme that is associated with turnover.	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. New initiatives associated to new starters with additional support to mitigate the turnover rates for new staff. Effective and successful recruitment both locally and internationally. Initial work to support a plan for key worker housing close to the Watford site.

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	**February 2023**
Exec Lead	**Andrew McMenemy**
Reporting Committee	**PERC**

	Risk Score							
Residual	**Apr/May**	**Jun/July**	**Aug/Sep**	**Oct/Nov**	**Dec/Jan**	**Feb/Mar**	**Apr/May**	**Target**
16	16	16	16	16	16	12	12	8 (4x2)

Context
The staff survey has provided clear feedback that the area where we perform least well is within the category of a learning culture. However the 2022 survey has identified this as an area of improvement. 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**
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 with new programme to be launched in September 2023.	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**	**Apr/May**	**Target**
15	15	15	15	15	15	15	15	6 (2 x 3)

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.

Scoring
The risk score is currently scored at 15 (5(L) x 3(C)). I.e. That it is almost certain that the risk will undoubtedly happen and/or recur, possibly frequently. The consequence is assessed as "Moderate- service has significantly reduced effectiveness".
For the risk score to reduce, the likelihood score must reduce to "Likely - will probably happen/recur but it is not a persisting issue", then to "Possible - might happen or recur occasionally" and then "Minor - overall service is suboptimal" to reach the target likelihood score. The consequence rating would remain the same.
Presently, the risk score remains at 15 as the risk of not securing sufficient funding to support the digital strategy remains a persistent issue that may significantly reduce the effectiveness of services if unresolved.

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	Alex White
Lead Committee	GPC

	Risk Score								
Residual	**Apr/May**	**Jun/July**	**Aug/Sep**	**Oct/Nov**	**Dec/Jan**	**Feb/Mar**	**Apr/May**	**Target**
20	20	20	20	20	20	20	20	12 (3 x 4)

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.

Scoring
The risk score is currently scored at 20 (5(L) x 4(C)). I.e., That it is almost certain that the risk will undoubtedly happen and/or recur, possibly frequently. The consequence is assessed as "Major - uncertain delivery of key objective/service due to lack of staff, loss of key staff and very low staff morale if unresolved."

For the risk score to reduce, the likelihood score must reduce to "Likely - will probably happen/recur but it is not a persisting issue" and then to "Possible - might happen or recur occasionally" to reach the target likelihood score. The consequence rating would need to reduce to "Moderate - late delivery of key objective/ service due to lack of staff and low staff morale. Presently, the risk score remains at 20 as the risk of insufficient staffing remains a persistent issue that will affect the recovery of elective services and waiting lists if unresolved.

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	Toby Hyde
Lead Committee	GPC

	Risk Score							
Residual	**Apr/May**	**Jun/July**	**Aug/Sep**	**Oct/Nov**	**Dec/Jan**	**Feb/Mar**	**Apr/May**	**Target**
9	9	9	9	9	9	9	9	4 (2 x 2)

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. The lack of redevelopment impacts the ability of the Trust to mitigate this risk of reducing its carbon footprint within its current

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

estate.	

Scoring
The risk score is currently scored at 9(3(L) x 3(C)). I.e., That it is possible that the risk might happen or recur occasionally. The consequence is assessed as "Moderate- Local media coverage causing a long-term reduction in public confidence".

For the risk score to reduce, the likelihood score must reduce to "Unlikely - Do not expect it to happen/recur but it is possible it may do so. The consequence rating would need to reduce to "Minor - Local media coverage – short-term reduction in public confidence. Presently, the risk score remains at 9 as the risk of the Trust's adverse impact on the environment may lead to a long-term reduction in public confidence.

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. The plan is being implemented and good progress is being made.	Limited resources available to drive change.	Incorporating green plan objectives within current plans and budgets where possible.

West Hertfordshire Teaching Hospitals NHS Trust

Agenda item: 12

Report to:	**Trust Board**
Title of Report:	**Assurance report from Trust Management Committee**
Date of Committee meeting:	**26 April 2023**
Quoracy:	**The meetings were quorate.**
Date of Board meeting:	**1 June 2023**
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 meeting on 26 April 2023
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:

- Finance update from the Chief Financial Officer.
- Integrated Performance Report
- Access Performance and Activity
- Trust Board agendas
- Divisional updates from Divisional Directors and/or Divisional Managers

Additional reports received and discussed for information and assurance:

- Elective care recovery
- Emergency Care High Impact changes
- Quality Priorities for the Quality Account
- National staff survey analysis
- Waiting list initiative
- Car lease scheme
- Elective Care Hub briefing update
- Digital Progress Report and EPR optimisation

Verbal reports were received from:

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

Other reports:

- None

Any other business:

- None

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.

West Hertfordshire Hospitals NHS Trust

Agenda item:	**13**
Report to:	**Trust Board**
Title of Report:	**Assurance report from the Finance and Performance Committee**
Date of Committee meeting:	**27 April 2023**
Quoracy:	**The meeting was quorate.**
Date of Board meeting:	**1 June 2023**
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 27th April 2023.
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:

Majority of substantive items for information and assurance, two papers for approval

Finance risks to be reviewed in light of new financial year, strike action and challenging national, system and trust budgets

ED and Elective performance remains challenging but committee receiving reports and assured on trajectory to improve

Month 12 finance – 22/23 break even budget delivered with £0.32m surplus

Critical we keep momentum into 23/24 to hit target performance, efficiency and budget targets

- **Minutes of last meeting:**
  - Approved with updates noted at 10.1.6 and 10.1.8
- **Summary Finance Risk Register**
  - No finance risks on Corporate Risk Register ('CRR')
  - Performance risks are on the CRR
  - MvDW highlighted majority of finance risks at '9', should this not be higher given strikes and budget pressure. CFO and team to review as we enter new environment
- **Access Standard Performance and Activity Recovery Overview ('ASPARO')**
  - mental health activity remains high
  - cancer performance remains challenging
  - VWA at 92% (would have been higher but for strikes)
  - two good sessions with Newton in last week, utilisation going up 63% in Feb to 71% in March (SACH 79%)
  - formal thanks to team on approach to long waits, SACH is exemplary
  - ongoing work to realign the baseline (£7.6m)
  - ED - progress on discharges last few months, target 100 / day (flow + 7/7 working)
  - Elective – VWA target 103%, 3 days > 76%, 1 > 85%
- **Emergency care high impact change plan**
  - live data feeding into control centre for action (7/7 day working)
  - also being integrated into one report with granular detail
  - focus on delivery

  - dividend is a connected hospital that works better
  - we have a good acute strategy, need a strong community strategy
- **Elective care recovery**
  - Please see ASPARO above
- **Integrated Performance Report ('IPR')**
  - ambulance turnarounds continue to improve since Nov-22
  - workforce positive
  - vacancy rates down at 7%
  - good progress on UTC (complex area)
- **Annual plan and budget**
  - working to national guidance and ICS break even position. WHTH currently at £8.9m deficit. Not yet finalised
  - CFO and COO looking at surge, resourcing and efficiency
  - Need to move from 85% to 103%. Good data quality work in progress to adjust baseline and derisk (£7.5m)
  - finance team looking at risk and will update as part of plan
- **Efficiency programme**
  - £13.2m of the £15m efficiency target met
  - New financial year efficiency target is a further stretch
  - Need to keep momentum up into 23/24. Digital strategy is key
- **Month 12 finance summary**
  - CFO confirmed 22/23 year end surplus of £0.32m
  - first non-coved break even for ten years
  - formal committee thanks to the CFO and his team on a very pleasing result for the Trust
- **Contracts and commerce**
  - Dep CFO reported all major contracts negotiated and settled satisfactorily
  - inflation artificially suppressed at 1.8% (= 2.9% - 1.1% expected efficiency)
- **Capital programme**
  - final capex position for 22/23 £38.2m / £40.3m
  - formal committee thanks to CFO and team for bidding and delivering large, complex capital programme against timing constraints
  - CEO requested tracker to link capex to key objectives for accountability eg laptop investment => health & wellbeing
- **Investment / business cases**
  - Elective care hub briefing
  - £22m of TIF secured against budget of £25m
  - future approval sought from FPC for £3m funding gap
  - 158 WTE needed by Spring 24. CPO assured in process
  - FPC assured on current position and supportive on £3m subject to formal request
- **Items for escalation to the Board**
  - none this month

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

West Hertfordshire Teaching Hospitals NHS Trust

Agenda item:	
Report to:	**Trust Board**
Title of Report:	**Assurance report from Quality Committee**
Date of Board meeting:	**1 June 2023**
Quorum:	**The meeting was quorate**
Recommendation:	**For information and assurance**
Chairperson:	**Jonathan Rennison, Non-Executive Director**
Purpose:	The report summarises the assurances received, and approvals of recommendations made to the Quality Committee at its meeting on 27 April 2023
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

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

- Review and approval of annual NHS self-certification
- Clinical audit strategy and clinical audit and NICE report
- Quality Account 2022 - 2023
- Divisional Quality Assurance Reports (CSS)
- Gap and Grow maternity annual report
- Infection Prevention Control update
- Infection Prevention Control BAF update
- End of Life Care annual strategy bi-annual review
- Maternity Consolidated quarterly report
- Perinatal quality surveillance tool report
- Management of Nitrous Oxide – Entonox across the Trust
- Quality Compliance programme report

- Quality improvement strategy development update
- GIRFT Progress update on Gastroenterology

The Committee noted the following:

The annual NHS self-certification was reviewed and recommended to the Board for approval.

The update on the clinical audit strategy was received, which provided positive assurance on compliance with national audits.

The first draft of the Quality Account was reviewed and the committee noted the further work that needed to be completed.

The Divisional Quality Assurance report from Clinical Support Services highlighted areas of progress and improvement, and areas where improvement was required with action plans setting out the work required to address identified issues.

The Maternity Integrated Report was noted which set out the Trust's compliance with national essential actions and recommendations which had been consolidated into one clear, integrated report. The committee would continue to monitor the report and noted that it would be updated once the national single delivery plan had been published.

The report on the management of nitrous oxide set out the actions that the Trust had take to address national concerns around the potential exposure to nitrous oxide, which is used to manage pain relief in different services. The report provided assurance on the review of all locations, ventilation and extraction, and the monitoring of levels to assess if they were reaching high levels. The report also provided assurance on how staff had been made aware of the potential risks and had been offered support through Occupational Health Service. There was good assurance that the Trust was managing the risk and had been pro-active in managing the risk when the national alert was issued last year.

The committee received the GIRFT progress update for gastroenterology which provided strong assurance on the completion of all the actions and progress, and how the learning coming from GIRFT was being applied to improve both the care for patients and also making services more efficient and effective.

Risks to refer to risk register: None

Items for the Board to note: None

Recommendations to the Board:

- The NHS self-certification process recommended for approval by the Board.

West Hertfordshire Teaching Hospitals NHS Trust

Agenda item:	**15**
Report to:	**Trust Board**
Title of Report:	**Assurance report from People, Education & Research Committee**
Date of Board meeting:	**1 June 2023**
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 April 2023.
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.

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

- CPO update
- Workforce key performance indicator report

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

- Staff recognition portal
- Divisional workforce update – Emergency Medicine
- National staff survey analysis
- People Strategy – Operational update
- Recruitment & Retention update
- Teaching Hospital – benefits realisation update
- FTSU/whistleblowing mid year report
- FTSU – Strategy & assurance report
- FTSU – Summary of the reflection & planning tool

The Committee noted the following main points:

The demonstration of the self recognition portal from the provider, Each Person. The committee noted the benefits of the portal and the importance of recognition to staff well-being and recruitment and retention. A layer would be added to the portal later in the year around diversity and inclusion which would enable trends to be identified.

The CPO update informed the committee about the outcome of the recent strike action and noted that mutual aid would need to be provided to system partners which posed a risk on planned or emergency care. They discussed overseas doctors working as support staff pending registration and resolved that further assurance was required to determine what support was needed.

The need to reduce agency costs within the year was identified. The CPO would provide further assurance on how this would be achieved by reviewing the workforce plan for the clinical and medical workforce. A further paper would come back to TMC and the committee around PAs, medical support workers and MTIs alongside the context of the workforce plan.

Workforce Key Performance Indicators – the committee received assurance on how areas with ongoing issues were being managed through a range of initiatives such as agreeing model employer goals. Further information regarding the breakdown of corporate vacancies would be provided to the committee.

There was discussion around apprenticeship levies and how their use as an indicator would complement the People Strategy. The committee identified that further work was required to support the diversity of the workforce and improving turnover and recruitment rates for support workers, which would improve the quality of patient care.

The divisional work workforce update for the emergency medicine division was discussed. The low appraisal rates were noted, and the committee received assurance about how this was being addressed, but noted the challenge that the department faced with finding time to conduct effective appraisals.

The national staff analysis highlighted five key priority areas for the Trust around staff experience, resources, career development, flexible working, understanding and respect and noted the actions that were being developed to address these areas, particularly around bullying and harassment and training for managers.

The FTSU report was discussed, and the committee noted the low take up of training via Acorn on freedom to speak up. The CPO would review the issue and investigate ways of making the training more accessible to staff.

Risks to refer to risk register:

Items for the Board to note: None

Recommendations to the Board: None

West Hertfordshire Teaching Hospitals NHS Trust

Agenda item:	16
Report to:	**Trust Board**
Title of Report:	**Assurance report from Great Place Committee**
Date of Committee meeting:	**Thursday 18th May 2023**
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 18h May 2023.
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 further information was awaited from the New Hospital Programme as to next steps for the Redevelopment at West Herts.

Clinical Environmental Risk Assessment - The Great Place Committee noted work that was in progress to review environmental risks ahead of the delivery of the redevelopment programme.

Interim Estates & Key Enablers – The Great Place Committee noted the extent of interim and enabling schemes and took assurance that work was continuing to progress. Plans were also being put into place to ensure sufficient resources to support both the redevelopment and the interim schemes.

Digital Update – The Great Place Committee noted the work underway to progress the patient portal, pathology order comms and voice recognition projects, along with the continuing expansion of both the virtual hospital and the use of the surgical robots.

Communications & Engagement Report – The Committee were informed that a proactive approach was being taken in relation to building works being undertaken at SACH and the impact on local residents, following some complaints regarding noise.

Capital Expenditure Report – The Great Place Committee noted the final position for 22/23, which included a planned overspend against the originally allocated budget.

Risks to refer to risk register:	No new risks identified.
Items for the Board to note:	Next steps awaited from New Hospital Programme.
Recommendations to the Board:	None.

West Hertfordshire Teaching Hospitals NHS Trust

Agenda item: **18**

Report to: **Trust Board**

Title of Report: **Assurance report from the Audit Committee**

Date of Committee meeting: **22 May 2023**

Quoracy: **The meeting was quorate.**

Date of Board meeting: **1 June 2023**

Recommendation: **For information and assurance**

Committee Chairperson: **Edwin Josephs, Non-Executive Director**

Purpose: This report provides an update to the Trust Board on matters discussed and assurance received at the Audit Committee meeting on 22 May 2023.

Background: The Committee meets four times a year for regular business and has two additional meeting in relation to the year-end sign off process.

It provides assurance to the Board on all aspects of internal, external audit and counter fraud, integrated governance and internal control and to ensure that effective assurance controls, structures, systems, processes and controls are in place and functioning to support the achievement of the Trust's objectives.

Summary:

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

- **Committee Governance:**
  - Review of Workplan
  - Evidence of Assurances gained by Finance and Performance Committee
- **Financial Focus:**
  - Consideration of draft annual accounts, annual report including annual governance statement and Head of Internal Auditor Annual Opinion
- **Internal Audit:**
  - Progress report on audits in accordance with agreed Annual Plan
  - Outstanding auditor's recommendations
- **Local Counter Fraud:**
  - Review of counter fraud progress against work plan and investigations
  - Review and Annual Return to NHS Counter Fraud Authority
- **Deep dives and 'holding to account':**
  - Waiver/Tender register
  - Conflicts of Interests and Gifts and Hospitality Register
  - Use of Trust Seal

Items of note: **Annual Report –** the number of disclosures and breadth of content in the Annual Report seem to increase each year. The Report is on track for submission before the due date set by NHSE.

Use of the Trust Seal – there have been two occasions when the Trust Seal has been used since the Committee's last report to the Board.

Consecutive Number	Date of Sealing	Description of documents sealed	First signatory	Second signatory	Witness position	Witness signature
8	31.03.23	Commercial in confidence	Matthew Coats (CEO)	Don Richards (CFO)	Trust Secretary	Barbara Anthony
9	31.03.23	Commercial in confidence	Matthew Coats (CEO)	Don Richards (CFO)	Trust Secretary	Barbara Anthony

Recommendations to the Board:	This report be taken for information and assurance and to aid discussion on other items on the Board's agenda.

West Hertfordshire Teaching Hospitals NHS Trust

Trust Board
Thursday 1 June 2023

Title of the paper:	**Performance, Activity Recovery & High Impact Change Plan updates (April 2023)**
Agenda Item:	**19**
Presenter:	**Jane Shentall** **Director of Operational Performance**
Author(s):	**Jane Shentall** **Director of Operational Performance**
Purpose:	*Please tick the appropriate box* *For approval*: ☐ *For discussion*: ✓ *For information*: ✓
Executive Summary:	An overview of performance against the core waiting times standards is included, with previous months for comparison. There has been good improvement in ED performance with the exception of HHGH UTC where, although still above the standard, there was a slight reduction in the number of patients seen within 4 hours. RTT long waits continue to improve although the objective of eradicating 78 week waits has not yet been achieved. There has been a deterioration in two week wait performance and the current position against the faster diagnosis standard is just below target, although better than the ICB objective for Q1. The slides detail progress for each of the Patient Flow Improvement and Elective Care Recovery programmes, with scorecards for both and highlight reports from each of the high impact change SROs, with accompanying data for some. Elective care activity recovery is detailed, with the position against plan provided at trust and divisional level for oversight.
Trust strategic aims: *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1 Best care** — ***Objectives 1-4*** ✓ **Aim 2 Great team** — ***Objectives 5-8*** **Aim 3 Best value** — ***Objective 9*** **Aim 4 Great place** — ***Objective 10-12***
Links to well-led key lines of enquiry:	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☐Is there a culture of high quality, sustainable care?

	☒Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues and performance? ☒Is appropriate and accurate information being effectively processed, challenged and acted on? ☐Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☒Are there robust systems and processes for learning, continuous improvement and innovation? ☒How well is the trust using its resources?
Previously considered by:	Committee/Group: Trust Management Committee — Date: 23 May 2023 Committee/Group: Finance & Performance Committee — Date: 25 May 2023
Action required:	▪ The Committee is asked to receive this information for oversight of activity delivery and performance and progress against the high impact change plans for Patient Flow Improvement and Elective Care Recovery.

West Hertfordshire Teaching Hospitals NHS Trust

Trust Board
1 June 2023

Performance, Activity recovery and High Impact Change Programme updates

April 2023 reporting period

Jane Shentall
Director of Performance
May 2023

NHS
West Hertfordshire Teaching Hospitals
NHS Trust

Performance Overview – April 2023

	Target	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Accident & Emergency															
All types	76%*	69% ✗	68.1% ✗	71.4% ✗											
Type 1	76%*	45% ✗	43.4% ✗	46.9% ✗											
WGH UTC	95%	90% ✗	91.0% ✗	93.8% ✗											
HHGH UTC	95%	99% ✓	99.9% ✓	98.4% ✓											
Diagnostics															
DMo1	99%	64.1% ✗	63.0% ✗	63.8% ✗											
Referral to Treatment															
Open pathways <18 weeks	92%	57.4% ✗	58.2% ✗	56.6% ✗											
78 week waits	0	38 ✗	15 ✗	11** ✗											
65 week waits	0 by Mar 24	607 ↓	548 ↓	495 ↓											
52 week waits	Reducing	2315 ↓	2729 ↓	2695 ↓											
Cancer															
2ww	93%	92.2% ✗	86.5% ✗	74.0% ✗											
2ww breast symptomatic	93%	92.2% ✗	75.2% ✗	79.6% ✗											
28 day faster diagnosis	75%	78.4% ✓	77.2% ✓	74.6% ✗											
31 day first	96%	97% ✓	99.4% ✓	97.4% ✓											
31 day subsequent surgery	94%	100% ✓	96.2% ✓	93.8% ✗											
62 day first	85%	58.2% ✗	57.3% ✗	65.3% ✗											
62 day screening	90%	62.5% ✗	82.4% ✗	90.9% ✓											

All types and Type 1 performance in A&E improved significantly. WGH UTC type 3 performance also improved but there was a small reduction in performance at HHGH UTC.

The second period of junior doctor industrial action significantly affected performance in the 2ww and 2ww breast symptomatic standards. The 28 day faster diagnosis standard was fractionally below target this month. Good improvement was seen in both of the 62 day standards, with compliance achieved for screening referrals.

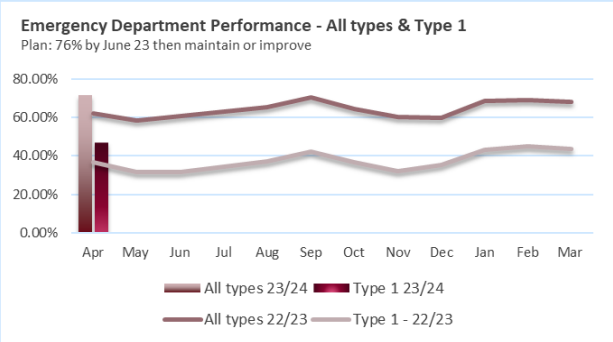
The reported 78 week wait position includes 3 pathways that should be removed and 3 patient choice. The true breaches are the result of complexity with limited capacity to treat before month end, or late decisions following protracted outpatient pathways. All patients have plans in place for May.

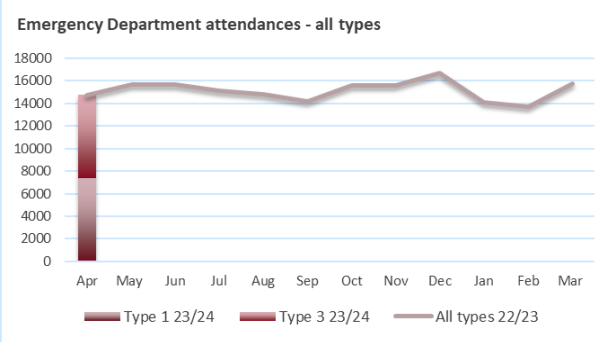
West Hertfordshire Teaching Hospitals NHS Trust

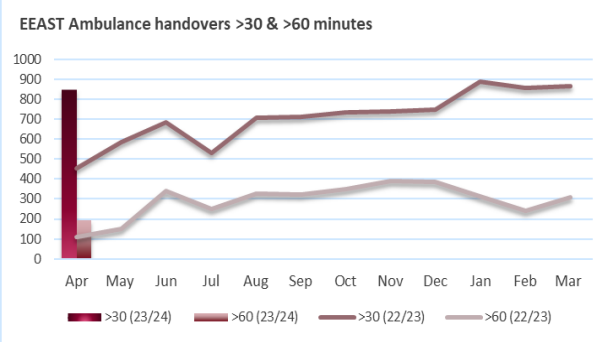
Patient Flow Improvement Programme & Performance

West Hertfordshire Teaching Hospitals NHS Trust

Emergency Department – Performance & Demand







Performance

- All types 71.4% (Mar 68.1%, Feb 69%, Jan 68.4%)
- Type 1 46.9% (Mar 43.4%, Feb 45.2%, Jan 43.2%)
- Watford UTC 93.8% (Mar 91%, Feb 90.4%, Jan 95.9%)
- HH UTC 98.4% (Mar 99.3%, Feb 98.5%, Jan 96.2%)

12 hour end to end journeys

There was a small increase in 12 hour waits (arrival to departure). As there were fewer attendances, the % has increased despite there being fewer 12 hour waits. Totals as a percentage of **all** attendances:

- April 3% (415)
- March 2.9% (458)
- February 3.7% (505)
- January 5.7% (804)
- December 6% (1,002)

Attendances

Demand reduced in April, both types across all sites, but only by a small degree at HHGH UTC.

- All types: 14,755 (Mar 15,736)
- Type 1: 7,388 (Mar 8,225)
- Type 3: 7,367(Mar 7,511)

Mental Health Demand

4.6% (341) of all type 1 ED attendances (7388) related to MH (Mar 4.3%)

14.5% (59) of all ED attendances over 12 hours (48) related to MH (Mar 10.5%)

17.3% of all ED attendances relating to MH (341) wait 12 hours or more (59) (Mar 13.5%)

Ambulance handovers

2,405 patients were brought to ED by ambulance, representing 32.5% of all type 1 attendances.

Handover delays (as a % of all ambulance arrivals) reported by EEAST

- 30+ minutes: 37.3% (851)
  (Mar 41.47% / 866)

- 60+ minutes: 8.39% (191)
  (Mar 14.8% / 309)

Patient Flow Improvement Programme
High Impact Change Plan Scorecard

West Hertfordshire Teaching Hospitals NHS Trust

High Impact Changes Scorecard

WEEK ENDING

Focus Area	Metric	Target	26-Feb	05-Mar	12-Mar	19-Mar	26-Mar	02-Apr	09-Apr	16-Apr	23-Apr	30-Apr	07-May	14-May
HIGH IMPACT CHANGE 1 - Rapid assessment and timely decisions of patients within 1 hour of arrival	All 4 hr Performance	76%	65.4%	67.7% ▲	67.8% ▲	69.6% ▲	66.6% ▼	68.0% ▲	69.3% ▲	73.4% ▲	72.7% ▼	71.0% ▼	69.8% ▼	73.4% ▲
	4 hr Non admitted Performance	80%	49.3%	50.7% ▲	53.8% ▲	53.8% ▲	51.4% ▼	48.9% ▼	52.3% ▲	57.6% ▲	53.7% ▼	50.5% ▼	54.9% ▲	58.5% ▲
	Time to clinical assessment < 1 hour	50%	24.7%	29.3% ▲	31.5% ▲	36.4% ▲	25.3% ▼	25.9% ▲	28.0% ▲	34.1% ▲	40.4% ▲	26.8% ▼	33.6% ▲	34.0% ▲
	Total time in Department - Non admitted	Movement	306	289 ▼	280 ▼	280 =	288 ▲	287 ▼	285 ▼	271 ▼	267 ▼	276 ▲	272 ▼	270 ▼
HIGH IMPACT CHANGE 2 - Improve discharges	IDT Discharges	Movement	137	165 ▲	150 ▼	159 ▲	138 ▼	156 ▲	148 ▼	135 ▼	173 ▲	160 ▼	132 ▼	152 ▲
	WGH Weekday Discharges - weekly totals	Movement	427	429 ▲	438 ▲	417 ▼	453 ▲	465 ▲	444 ▼	394 ▼	455 ▲	454 ▼	385 ▼	421 ▲
	WGH Weekend Discharges - weekly totals	Movement	89	85 ▼	114 ▲	100 ▼	92 ▼	74 ▼	98 ▲	86 ▼	98 ▲	112 ▲	109 ▼	97 ▼
	WGH Total Discharges - weekly totals	Movement	516	514 ▼	552 ▲	517 ▼	545 ▲	539 ▼	542 ▲	480 ▼	553 ▲	566 ▲	494 ▼	518 ▲
	WGH Discharges before 5pm %	Movement	57.8%	56.8% ▼	55.3% ▼	60.7% ▲	58.0% ▼	56.6% ▼	59.0% ▲	58.8% ▼	54.1% ▼	55.7% ▲	55.1% ▼	56.9% ▲
HIGH IMPACT CHANGE 3 - Implement Command and Control Centre	Bed Meeting time freed up for more focused flow management discussions (10mins)	-33%	-3.0%	-6.0% ▼	-6.0% =	-6.0% =	-16.0% ▼	-16.0% =	-16.0% =	-20.0% ▼	-20.0% =	-20.0% =	-20.0% =	-20.0% =
	Transition to Virtual bed meetings for all participants	100%	66.0%	66.0% =	66.0% =	66.0% =	66.0% =	66.0% =	66.0% =	66.0% =	66.0% =	66.0% =	66.0% =	66.0% =
	All participants to share their actual report update on Teams	100%	0.0%	0.0% =	0.0% =	0.0% =	0.0% =	0.0% =	0.0% =	0.0% =	0.0% =	0.0% =	0.0% =	0.0% =
	Complete, accurate, real-time data, visualised in the appropriate level of detail	90%	50.0%	50.0% =	70.0% ▲	70.0% =	70.0% =	70.0% =	70.0% =	70.0% =	70.0% =	70.0% =	70.0% =	90.0% ▲
	Control Room IT/telephony infrastructure reconfigured for usability / resilience	100%	80.0%	80.0% =	80.0% =	80.0% =	80.0% =	80.0% =	80.0% =	80.0% =	80.0% =	80.0% =	80.0% =	100% ▲
HIGH IMPACT CHANGE 4 - Clinical Review of UTC	WGH Type 3 performance	95%	84.7%	88.5% ▲	91.8% ▲	89.9% ▼	87.7% ▼	96.0% ▲	95.2% ▼	93.4% ▼	95.5% ▲	91.5% ▼	86.4% ▼	91.6% ▲
	Number of handovers to ED at close	Movement							29 ▲	14 ▼	22 ▲	37 ▲	48 ▲	
	Referrals to ED at < 2 hours	75%	47.7% ▼			48.6% ▲								

	Performance Levels			
All 4 hr Performance	Above 76%	70%-76%	60%-70%	under 60%
4 hr Non admitted Performance	Above 80%	70%-80%	60%-70%	under 60%
Time to clinical assessment < 1 hour	Above 50%	45%-50%	40%-45%	under 40%
Bed Meeting time freed up for more focused flow management discussions (10mins)	under -30%	-30% to -20%	-20% to -10%	over -10%
Transition to Virtual bed meetings for all participants	Above 90%	70% - 100%	60%-70%	under 60%
All participants to share their actual report update on Teams	Above 90%	60% - 100%	50% - 60%	under 50%
Complete, accurate, real-time data, visualised in the appropriate level of detail	Above 90%	70% -90%	50%-70%	under 50%
Control Room IT/telephony infrastructure reconfigured for usability / resilience	Above 90%	80% - 100%	60%-80%	under 60%
WGH Type 3 performance	Above 95%	85%-95%	75%-85%	under 75%
Referrals to ED at < 2 hours	Above 75%	70%-75%	60%-70%	under 60%

NHS
West Hertfordshire Teaching Hospitals
NHS Trust

Patient Flow Improvement Programme

Workstream: Patient Assessment

High impact change 1

SRO: Rachel Hoey

Objectives: Rapid assessment and timely decisions for patients within one hour of arrival

Reporting month: May 2023

Key updates

Rapid assessment
Performance focus in TAM with the ED juniors
Medical staffing case to C&C – awaiting update
Performance Coordination 24/7 majors and in TAM
Rationalise investigations with Senior Decision Maker oversight
IPS – focus on patients to SDEC
Reviewing streaming guidance from UTC for adults and paeds
Call to arms money extended for 2 weeks pending C&C update

Ambulance offload
Continuing Boarding Policy
Joint working with EEAST and WGH UTC and HH UTC
Corridor Nursing
45 minute rapid release implemented – reviewed 12 May with ICS
Crews accessing stack for UTC
Data accuracy and 'pinning off' a focus
STARR senior nurse cover

Flow
Remove planned care from ACU
Maximising referrals to ACU
EAU chairs for specialty assessment
ED Shift Lead NIC
Focus on weekend discharges

Planned next month actions
Open an additional bay in EAU for assessment
Review of 45 minute Rapid release
Consider increasing CDU chairs and impact on other areas requiring workforce
Options appraisal for UEC dashboard
Consider additional Trust actions to support use of corridor

Decisions required
Support for workforce business cases – medical/ admin/ nursing

Escalations
Call to arms money ended – awaiting outcome of C&C decisions
UEC dashboard - unable to currently use and display adequate performance metrics

Issues and risks affecting performance
Continued bedding of EAU
Lack of workforce to support 'off the clock' activity
Lack of workforce to support seeing patients against KPIs

Milestone plan

Description	Due Date	RAG
Iron Infusions into SACH	28 April 23	R
UTC triage model implementation	August 23	R
Review of 45 minute rapid release	May 23	G
Review of CDU chairs	10 May 23	A
Performance focus and communication	10 May 23	A
Options appraisal UEC dashboard	10 May 23	R

Performance

NHS
West Hertfordshire Teaching Hospitals
NHS Trust

Patient Flow Improvement Programme

Workstream: Improving Discharges

High impact change 2

RO: Mary Bhatti

Objectives: Improve discharges to achieve 100 per day

Reporting month: May 2023

Key updates

The week day discharges continues at the improved numbers, weekend discharges have continued between 45-65. The patient flow manger met with the nursing team to feedback and suggestions to improve weekend discharges.

Board Round and Morning Huddles Criteria agreed and currently being rolled out across the wards. This continues, senior team visiting wards to ensure new crib sheets in use, and feedback if issues using it.

Criteria led discharge (CLD) form finalised and will be added into Cerner this month. This will allow teams to roll out CLD across more wards/divisions

Divisions working with the Control centre/EPR team to confirm content and rollout of the electronic usage of the Whiteboards.

SPOC, IDT and cernet team met to further progress the transfer of the data base. Progress now being made.

A task and finish group has now been set up to review hiring of equipment for discharge. This is a barrier to timely discharges and elongates LOS.

Issues and risks affecting performance

Escalations/decisions needed

None at present

Planned next month actions

The CL for discharges will meet with the discharge teams to update them on feedback and discuss options to improve numbers of discharges at the weekend.

Complex Case Management process agreed and will commence mid May. This will be reviewed September as to benefits realised to determine if it will be impactful (reduce Los) during winter months.

Clinical navigators being trained on CLD.

Progress being made with data base transfer, review process and test on Cerner to determine if all data sources and pathways are able to be followed effectively.

Working with pharmacy team to provide an improved process for administering dosset boxes. (medication)

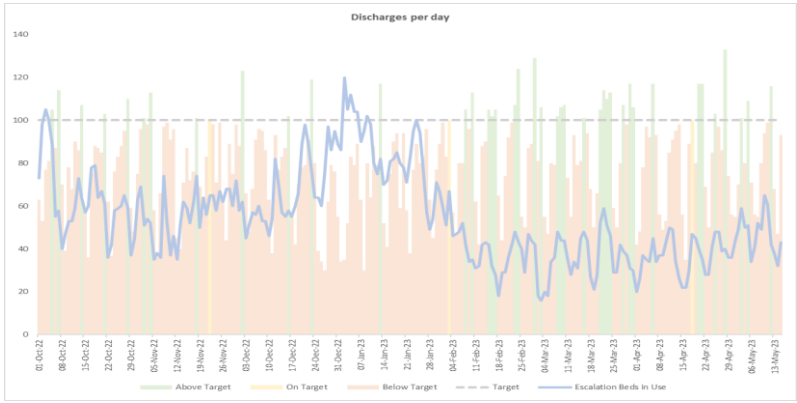
Continue working with CC team to clarify physical boards with the electronic white boards.

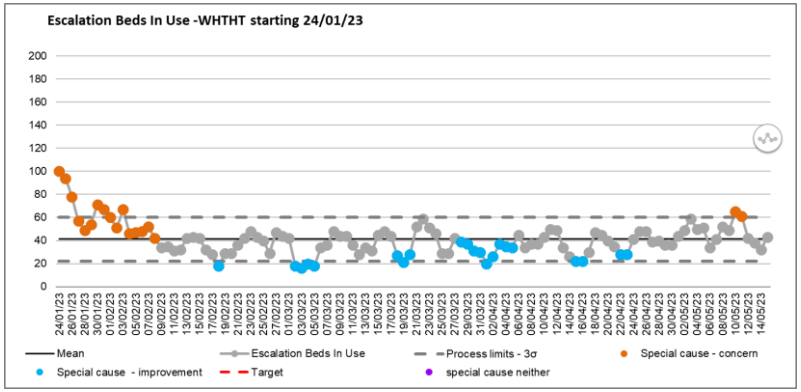
Performance

Chart on this slide shows in green the days when the trust has achieved more than 100 discharges per day. There is a much greater proliferation of such days since mid –February than in the period before

The achievement of 100+ discharges per day correlates nicely with the sustained fall in the usage of escalation beds

Performance





NHS
West Hertfordshire Teaching Hospitals
NHS Trust

Patient Flow Improvement Programme

Workstream: Command & Control Centre

SRO: Paul Bannister

Objectives: Implement a control centre to enable better patient flow and data driven decisions

Reporting month: May 2023

High impact change 3

Key updates

- Bed meeting cycle (changes accepted)
  - minor revision to timings
  - major revision of meeting focus
  - major revision to quality of updates
  - revision to attendee list
  - virtual format commences in May
- Data and systems (changes accepted)
  - screens reconfigured
  - iReporter reports enhanced
  - Cerner reports enhanced
  - IT refinements specified / ticket raised
- Control Centre and Incident Management
  - Estates survey complete – awaiting plan
  - Options to be presented to Estates Committee for Incident Management base
- Multiple Trust Control Centre contacts estab'
  - Cerner and CapMan knowledge shared
- Suggestions presented for further strengthening of patient flow initiatives (to be considered)
- Complementary activity to support the use of electronic whiteboards for reporting (underway)
- Meeting with 'Behavioural Science' Co. took place to inform acceleration of digital adoption

Decisions required

None – HEG has accepted the recommendations

Escalations

None

Planned next month actions

- The virtual Bed Meetings commence on 22 May
- New Bed Meeting guidelines and reporting regime commence on 22 May
- The one outstanding Cerner report enhancement (confirmed discharge) is a 'work ticket' for Cerner
- The IT works is likely to go into June – awaiting Atos
- Finalise dual running of the Ops Room as Control Centre and Incident Management venue; commence estates work to reconfigure desks and equipment

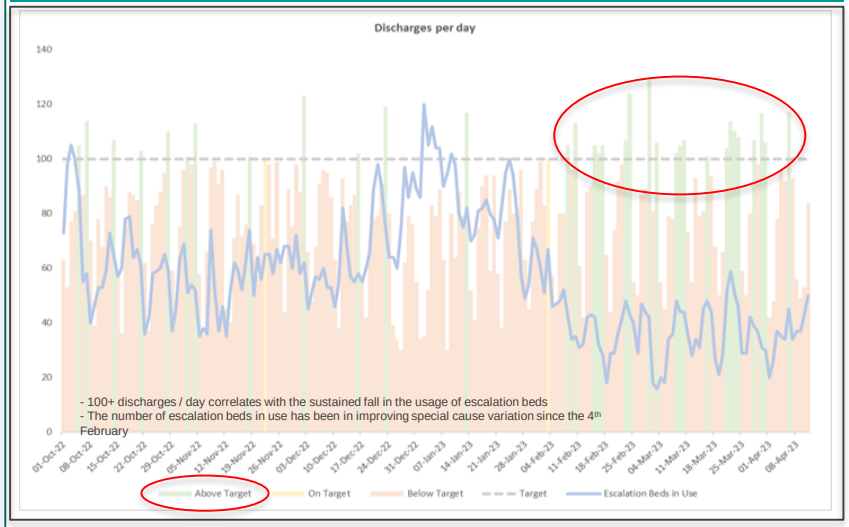
Related work:

- Decision made on a visualisation solution to enhance the use of data for flow management (EPR Team)
- Ward screens to be brought back into use to replace the physical whiteboards and support performance (EPR Team). Formal project, with three pilot wards commences w/c 15/05.
- Process Mining workshop being scheduled
- Second 'behavioural science' meeting arranged

Issues and risks affecting performance

- I - Extremely limited capacity of Ops leads restricts input to the project, resulting in a slower process
- I - Ops Room usage as an Incident Management room impacts timely 'full' Control Centre usage
- R - Data quality and live status for Control Centre usage is dependent upon successful adoption of the CapMan training throughout the Trust
- R - IT & Estates works have uncertain timelines

Performance



Milestone plan

Description	Due Date	RAG
The 'virtual' Bed Meetings commence	22 May	G
New Bed Meeting format and reporting regime commences	22 May	G
Cerner report revisions complete	31 May	A
Estates planning complete	31 May	A

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West Hertfordshire Teaching Hospitals NHS Trust

Patient Flow Improvement Programme

Workstream: Clinical Review of UTC

High impact change 4

SRO: Mike van der Watt

Objectives: Clinical Review of UTC

Reporting month: May 2023

Key updates

- Phased approach agreed for changes within the UTC including those affecting reporting of type 1 and 3 data
- Operational Group convened to discuss the transfer of the initial assessment process to WHTHT
- 2 meetings taken place already
- Process map developed in draft for initial assessment
- Meeting held with BI to discuss change in process, transfer of clinical information and reporting of performance
- Meeting held with HR to discuss next steps for the staff
- Updated contracts team regarding operational process
- DM and project manager meeting weekly to ensure on track with change
- Change date provisional for August
- Audit agreed for utilisation of the waiting room

Escalations

- None this month

Planned next month actions

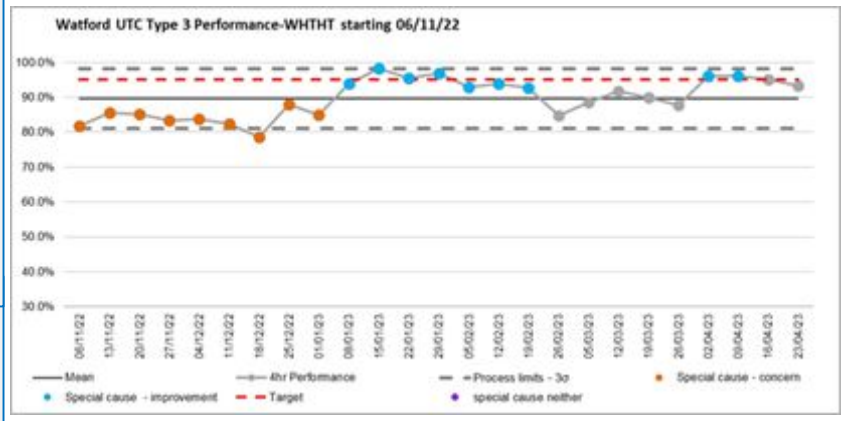
- Audit of utilisation of the waiting room
- Circulate current operational SOP
- Workforce model to be agreed at next meeting on 17 May 2023
- Process map for booked appointments to be agreed
- Process for transfer of clinical information to be agreed
- Reporting of performance to be agreed with WHTHT BI

- Workforce model
- Reporting performance model
- Transferring clinical information from Cerner to Adastra

Issues and risks affecting performance

- Timelines for implementation draft currently until such time as workforce model agreed.
- Workforce changes maybe complicated and may affect timelines

Performance



Milestone plan

Description	Due Date	RAG
UTC triage model implementation	August 23	R
Audit of utilisation of the waiting room	May 23	G
Agree workforce model	May 23	A
Agree clinical SOP	June 23	A

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Elective Care Recovery Programme & Performance

Elective Care Recovery Programme
High Impact Change Plan Scorecard

West Hertfordshire Teaching Hospitals NHS Trust

Elective Care Recovery Programme - High Impact Changes Scorecard

Focus Area	Metric	Target	Jan	Feb	Mar	Apr
HIGH IMPACT CHANGE 1 Improved data quality, capture and recording to enable accurate reporting of activity delivery and value	Value weighted activity	103% of 19/20	87.0%	88.0% ▲	92.0% ▲	86.0% ▼
	RTT PTL size	Reduction	50342	50169 ▼	52995 ▲	57092 ▲
	RTT Clock stops	Improvement	6395	6046 ▼	5856 ▼	5039 ▼
	Outpatient procedures recorded	Improvement	6008	5521 ▼	5696 ▲	4592 ▼
HIGH IMPACT CHANGE 2 Increased theatre productivity with improved utilisation across all sites	Theatre utilisation - WGH & SACH	85%	70.1%	74.5% ▲	75.1% ▲	76.2% ▲
	Time lost to late starts - WGH & SACH	Improvement	225:16	172:27 ▼	186:48 ▲	131:26 ▼
	Time lost to early finishes - WGH & SACH	Improvement	67:21	54:25 ▼	59:06 ▲	51:14 ▼
HIGH IMPACT CHANGE 3 Improve waiting times for RTT, Cancer and Diagnostic pathways	RTT: 78 week wait elimination (excl patient choice)	0 by April 23	69	38 ▼	15 ▼	11 ▼
	RTT: 65 week wait elimination (excl patient choice)	0 by April 24	819	607 ▼	548 ▼	495 ▼
	RTT: 52 week wait reduction	Improvement	2681	2315 ▼	2729 ▲	2924 ▲
	Cancer: 63+ day wait reduction	95*	184	129 ▼	125 ▼	130 ▲
	28 day faster diagnosis performance	75%	68.5%	78.3% ▲	77.2% ▼	74.6% ▼
	DMO1 (diagnostic) performance	99%	62.0%	64.7% ▲	63.1% ▼	63.8% ▲
HIGH IMPACT CHANGE 4 Increase Outpatient productivity with greater uptake of non-face to face models, patient initiated follow up and implementation of the Patient Portal	Outpatient follow up rates vs 19/20	75% of 19/20	87.2%	87.2% ▼	104.6% ▲	77.4% ▼
	Patient initiated follow up rate as a % of all OPAs	2.1%	1.5%	1.7% ▲	2.1% ▲	1.7% ▼
	Non-face to face rate as a % of all OPAs	25%	12.9%	12.8% ▼	12.7% ▼	12.5% ▼
	DNA rates	8%	8.0%	8.1% ▲	7.9% ▼	7.7% ▼

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Elective Care Recovery Programme

High Impact Change 1: Data Quality

SRO: Mark Landau
Objectives: Improved data quality, capture and recording to enable accurate reporting of activity delivery and value

Reporting month: May 2023

Key updates

Data Quality Group established with issues log being worked through in between meeting cycles.

WACS are the most challenged division, with a mix of issues relating to how data is recorded on the front end, how the workflow is currently working and how the build is set up for the division. A number of issues have been solved by Badgernet.

Discussions have concluded with regional and national finance colleagues regarding the adjustment of the Trust's 19/20 baseline which is key to determining VWA performance. The outcomes was an acceptance of baseline adjustments apart from the regular day attenders change, for which the Trust has been instructed to re-code these to daycases for 23/24 recorded activity.

Planned next month actions

Roll out of targeted training.

Rerun reports looking at pre and post EPR clock stops and Outpatient Procedure recording to identify clinicians that may need more help.

Analysis of clock starts and clock stops to identify any specialties/geographic areas that are driving excessive growth (PTL growth through March/April partly due to increased referral numbers.

Decisions required

Decision needed on the Director of Performance's case for re-engaging with the external validation team.

Escalations

Immediate action required to address lack of validation of PTL. Specialist training to be rolled out in May 2023 to reinforce how to outcome appointments and enter correct RTT status.

Issues and risks affecting performance

Lack of expertise/knowledge in terms of outcoming National RTT rules adversely impacting the RTT PTL.

External validation effort has ceased – BAU validation team are too small to address all the incorrect data entry.

Performance

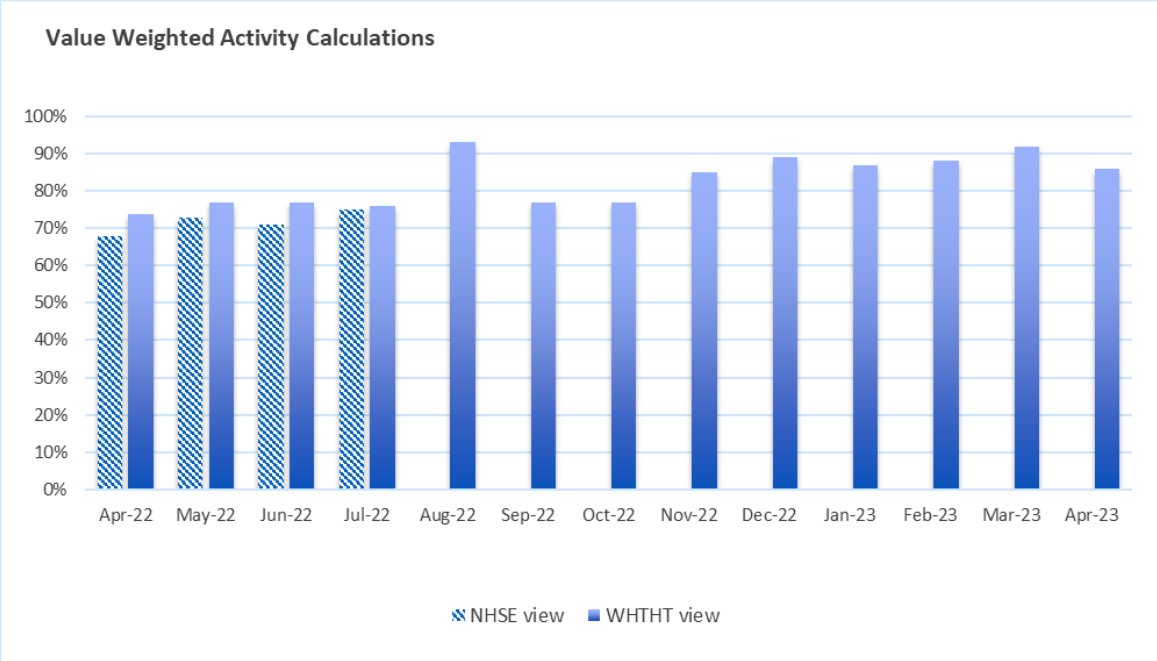
Metric	Target	Jan	Feb	Mar	Apr
Value weighted activity	103% of 19/20	87.0%	88.0% ▲	92.0% ▲	86.0% ▼
RTT PTL size	Reduction	50342	50169 ▼	52995 ▲	56579 ▲
RTT Clock stops	Improvement	6395	6046 ▼	5856 ▼	5038 ▼
Outpatient procedures recorded	Improvement	6008	5521 ▼	5696 ▲	4592 ▼

Milestone plan

Description	Due Date	RAG
WACS recording and Reporting Issues	31/05/2023	A
RTT/Outcoming training	31/05/2023	A
Agree 19/20 baseline with NHSE	30/04/2023	Complete
VWA to hit target	30/06/2023	A

West Hertfordshire Teaching Hospitals NHS Trust

Data Quality - Value Weighted Activity (VWA)



The April position has had additional adjustments to account for the 19/20 baseline and the impact of the junior doctors industrial action.

Baseline changes have now been agreed with NHSE.

The impact of the Junior Doctors Industrial action has been significant. Planned, elective surgery at SACH was stood down and reduced at WGH.

Reluctance to undertake additional waiting list initiatives/ad hoc lists continues to be a challenge and there are far fewer extra sessions provided by clinicians than in the baseline (2019/20) year. Work to quantify this is underway.

The implementation of national policy (evidence based interventions/low priority treatments) has resulted in fewer procedures being undertaken, particularly in Spinal Surgery (injections).

The internal estimation takes in to account improved coding of procedures and capture of ward attender activity.

Internal SLAM reporting has been used as a proxy for VWA while discussions are ongoing with NHSE regarding alignment

NHSE no longer publish the monthly VWA calculations, instead focusing on a rolling weekly estimate of VWA. Dialogue with NHSE continues with regard to understanding and alignment of the weekly estimates.

West Hertfordshire Teaching Hospitals NHS Trust

Elective Care Recovery Programme

Outpatient Activity as a % of the 19/20 baseline month

First OPAs
Overall, 2497 new OPAs below April plan and 3560 adverse variance year to date (Surgery 369, Medicine 2272, WACS 1390)

- **Surgery** 10% behind April plan
- **Medicine** in significant deficit in April at 40% lower than plan
- **WACS** delivered 8% less than April

Follow up OPAs
Overall achieved April's reduction

- **Surgery** achieved April target
- **Medicine** also achieved April target
- **WACS** achieved April target

Non-face to face OPAs Surgery 3%, Medicine 9%, WACS 1%

Outpatients		Month
POD		Apr-23
Outpatient referrals	Plan	16,277
	Actual	14,028
	%var	-14%
OP first attendance	Plan	14,720
	Actual	12,357
	%var	-16%
OP follow-up attendance	Plan	20,275
	Actual	20,923
	%var	3%
Total OP atts	Plan	34,995
	Actual	33,280
	%var	-5%
OP atts with procedures	Plan	6,888
	Actual	5,199
	%var	-25%

Surgery		Apr-23
Outpatient referrals	Plan	5,657
	Actual	5,712
	%var	1%
OP first attendance	Plan	5,408
	Actual	4,891
	%var	-10%
OP follow-up attendance	Plan	7,106
	Actual	6,854
	%var	-4%
Total OP atts	Plan	12,515
	Actual	11,745
	%var	-6%
OP atts with procedures	Plan	2,590
	Actual	2,309
	%var	-11%

Medicine		Apr-23
Outpatient referrals	Plan	7,250
	Actual	4,921
	%var	-32%
OP first attendance	Plan	5,912
	Actual	4,482
	%var	-24%
OP follow-up attendance	Plan	6,142
	Actual	6,124
	%var	0%
Total OP atts	Plan	12,055
	Actual	10,606
	%var	-12%
OP atts with procedures	Plan	3,196
	Actual	1,875
	%var	-41%

WACS		Apr-23
Outpatient referrals	Plan	2,977
	Actual	2,781
	%var	-7%
OP first attendance	Plan	3,236
	Actual	2,523
	%var	-22%
OP follow-up attendance	Plan	6,812
	Actual	6,520
	%var	-4%
Total OP atts	Plan	10,048
	Actual	9,043
	%var	-10%
OP atts with procedures	Plan	1,101
	Actual	1,015
	%var	-8%

West Hertfordshire Teaching Hospitals NHS Trust

Elective Care Recovery Programme

Elective Inpatient Activity as a % of the 19/20 baseline month

Day Cases
Overall April activity was 2% behind plan (only 66 cases below target)

- **Surgery** 30% below plan in April (323 ops)
- **Medicine** delivered 19% (326 cases) more activity than planned
- **WACS 38**% lower (79 d/c admissions) than April plan

Elective Ordinary (inpatients) (contributes to VWA)

- 36% below plan overall (196 cases), with a deficit in all divisions.
- **Surgery** 41% (159) lower than April plan
- **Medicine** delivered 17% less activity than planned in April (4 cases
- **WACS** 28% (42) below plan in April

Total inpatients are 7% (262) below plan in April

POD		Apr-23
Elective Daycase	Plan	3,013
	Actual	2,963
	%var	-2%
Elective Ordinary	Plan	543
	Actual	349
	%var	-36%
Total Elective Inpatients	Plan	3,556
	Actual	3,312
	%var	-7%

Surgery		Apr-23
Elective Daycase	Plan	1,088
	Actual	771
	%var	-29%
Elective Ordinary	Plan	370
	Actual	223
	%var	-40%
Total Elective Inpatients	Plan	1,458
	Actual	994
	%var	-32%

Medicine		Apr-23
Elective Daycase	Plan	1,716
	Actual	2,051
	%var	20%
Elective Ordinary	Plan	22
	Actual	18
	%var	-17%
Total Elective Inpatients	Plan	1,738
	Actual	2,069
	%var	19%

WACS		Apr-23
Elective Daycase	Plan	209
	Actual	131
	%var	-37%
Elective Ordinary	Plan	151
	Actual	108
	%var	-29%
Total Elective Inpatients	Plan	360
	Actual	239
	%var	-34%

West Hertfordshire Teaching Hospitals NHS Trust

Elective Care Recovery Programme

Data Quality – Diagnostic Activity as a % of the 19/20 baseline month

MRI
11% less than plan (200 scan shortfall).
Bank holidays have affected capacity and workforce resources were reduced with annual leave and sickness.

CT
Better than plan by 23% (738 more scans)

Non-obstetric ultrasound (NOUS)
Lower than plan by 1108 scans (30%). A significant amount of activity is undertaken on Monday and Friday and the Easter Bank Holidays have therefore been particularly impactful and there was also a reduction in staff availability due to annual leave. Outsourcing ceased in March.

Colonoscopy
15% better than plan in April with a year to date positive variance of 158 scans.

Flexible sigmoidoscopy
Missed the April plan target by 47% (100 procedures).

Gastroscopy
Achieved plan, with 13 more procedures in April

Echo
Shortfall against plan by 509 scans (39%)

Outsourcing/insourcing is in place for all modalities except NOUS where the backlog has now been cleared.

Modality		Apr-23
MRI	Plan	1,833
	Actual	1,633
	%var	-11%
CT	Plan	3,149
	Actual	3,895
	%var	24%
NOUS	Plan	3,725
	Actual	2,617
	%var	-30%
Colonoscopy	Plan	357
	Actual	412
	%var	15%
Flexi Sig	Plan	214
	Actual	114
	%var	-47%
Gastroscopy	Plan	513
	Actual	529
	%var	3%
Echo	Plan	1,294
	Actual	795
	%var	-39%

West Hertfordshire Teaching Hospitals NHS Trust

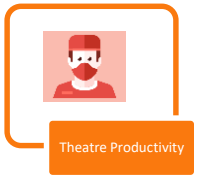
Elective Care Recovery Programme

High Impact Change 2: Theatre Productivity

SRO: Simon West

Objectives: Improve the utilisation and productivity of our operating theatres.

Reporting month: May 2023



Key updates

- Our May utilisation has remained in a good position at 74%. This is expected to grow once trials expand.
- Kevin Swaby is now in post as Programme Lead, Michele Arkwright and Michaela Longman joining over next couple of weeks.
- Adoption of theatre tool in admissions and updates to TAG have resulted in lists which are 10-20% more full.
- In SACH, on-the-day processes trials have resulted in a 40% decrease to late starts for lists following the process.
- In WGH, initial trials are kicking off this week with Urology. Tuesday 16th's list saw a 75% reduction to late starts by communicating golden patient and using recovery as a holding bay.
- V2 theatre tool specification agreed, PO raised and build has started.

Decisions required

Planned next month actions

- Expand on-the-day processes rollout to all elective WGH lists from w/c 29th May.
- Provision of targeted support for those not yet adhering to the new processes.
- Median times trial due to commence across all specialties from w/c 29th May.
- Improvements to theatre tool will enable improvements to number of lists stood down and relet.
- Roll out of divisional comms and engagement strategy for Seamless Surgery programme.
- Continue to develop Theatre Efficiency Meeting (theatres TAG equivalent), and incorporate tool in specialty meetings.

Issues and risks affecting performance

- Anaesthetists do not have job planned admin time to review theatre lists. This may have detrimental impact on the new on-the-day process – escalated to anaesthetic CD for discussion.
- Waiting list card data quality is likely to have a small impact on ability to see if lists are being booked to median times in some cases. This will improve, but will remain the case until Waiting List Cards are moved from Path Point to Cerner.
- While clinician engagement has been very good on the whole, there are a couple of specialties where rollout (inc. median times) may need a little more time.

Performance

(Data from last four weeks)

Theatre Utilisation SACH – 75.8%

Theatre utilisation WGH – 73.8%

Total no. cases completed – 989

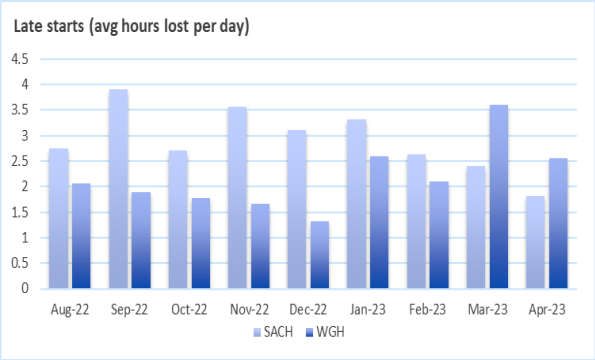
Milestone plan

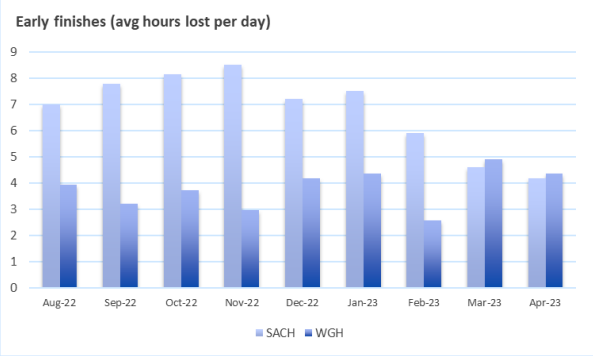
Description	Due Date	RAG
Development of v2 Theatre performance tool starts	15.05.2023	G
WLCs to begin correction of waiting list cards to facilitate median teams change	22.05.2023	G
B7s in post	29.05.2023	G
Begin roll out of new OTD process at WGH	29.05.2023	G
Median times trial	29.05.2023	A

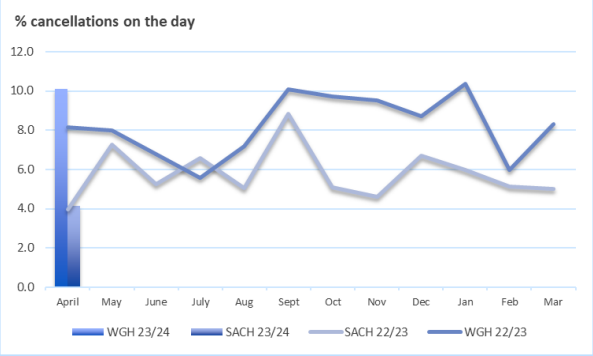
West Hertfordshire Teaching Hospitals NHS Trust

Elective Care Recovery Programme

Theatre Productivity – Late starts & Early finishes







Late Starts
Hours lost to late starts was much improved at SACH with an average of 1.81 hours lost per date (March 2.4)

Similarly, at WGH there was improvement at 2.56 (March 3.6)

It should be noted that some late starts are the result of morning session late finishes.

Early Finishes
The average number of hours lost per day to early finishes improved at both sites

SACH 4.16 (March 4.6)
WGH 4.37 (March 4.9)

On the day cancellations affect this indicator and work on these and scheduling improvement work through the Seamless Surgery programme are expected to contribute to less hours lost.

Cancellations on the day
Cancellations on the day at SACH improved to 4.15% (March 5%) but there was an increase at WGH at 10.1% (March 8.3%)

West Hertfordshire Teaching Hospitals NHS Trust

Elective Care Recovery Programme

Theatre Productivity - Cases, Cases per session & Utilisation

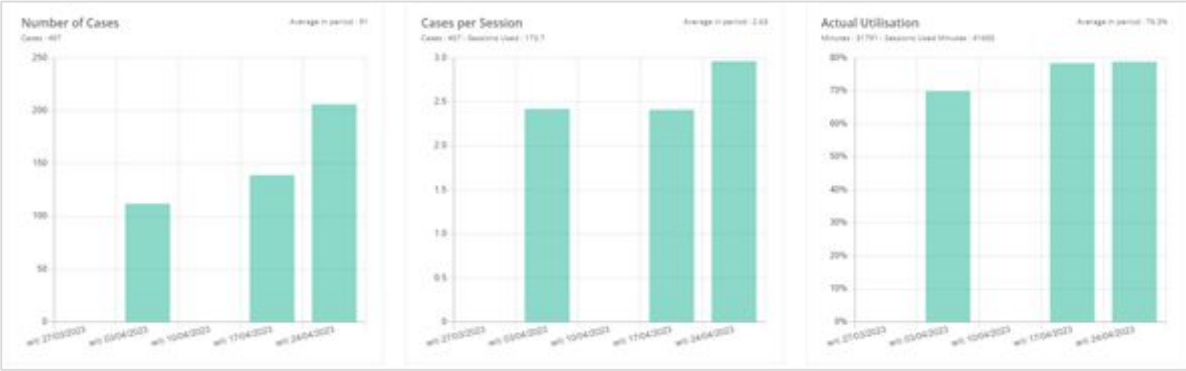
Data has been taken from the new theatre tool, the charts showing the weekly snapshots for April.

The Junior Doctors' Industrial action necessitated a pause in elective surgery at SACH to enable redeployment of staff to urgent care and other priority services. Surgery at WGH was also reduced.

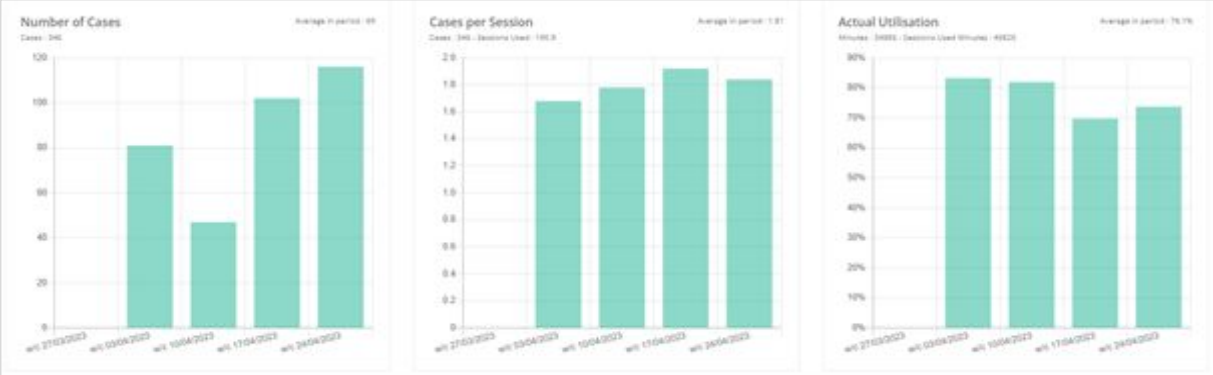
As a result fewer operations were performed;
SACH 457 (March 580)
WGH 346 (March 431).

However, utilisation of planned sessions overall improved at 76.2%.
SACH 76.3% (March 79%)
WGH 76.1 (March 71%)

SACH



WGH (incl Obs & Gynae)



West Hertfordshire Teaching Hospitals NHS Trust

Elective Care Recovery Programme

High Impact Change 3: Long Wait Improvement

SRO: Jane Shentall

Objectives: Eliminate RTT 65WW, reduce 52WW, improvement in Cancer 62 Day & 28 Day FDS

Reporting month: April 2023

Key updates

RTT 78 & 65 week waits
- Services set internal target of reducing waits to 70 weeks by September 2023.
- Administration errors in Cerner continue to create challenges in the management of long wait pathways, often resulting in the need to include additional pathways that had been closed in error previously.
- Cerner/RTT Training commences in May.
- Trajectory development in conjunction with BI underway.

Cancer
- Stretch target (95) in place as NHSE target (143) already achieved.
- Long waits review meeting includes pathways over 40 days
- Cancer Improvement steering group to be established (1st meeting 8 June due to clinical availability)
- 28 day FDS compliance not achieved but above the ICS agreed target for Q1.
- Trajectory development in conjunction with BI underway.

Diagnostics
- 3 modalities have achieved the national standard (99%)
- 3 modalities achieved the NHSE target for March 25 (95%)
- 4 modalities continue to face significant challenges with large backlogs although all have plans in place (insourcing, outsourcing etc) to address these.

Decisions required

None

Escalations

None

Planned next month actions

- Maintain focused approach via long wait meetings with escalations to ADMs as needed
- Launch of trajectories
- Further work with the BI team on improving Data Quality

Issues and risks affecting performance

- In house RTT validation resource significantly depleted as a result of numerous vacancies and long term sickness. This is affecting PTL size, clock stop volume and performance. Additional support from the external provider continues but at a much lower level in order to keep within the financial envelope available.
- Continue to see a high level of errors in pathway status outcomes in EPR which is resulting in late pop ons to the PTL, some at very long waits
- eRS polling ranges are too long, allowing patients to delay 1st OPAs for months, some for more than 1-2 years – exploring contractual options for inclusion of a valid period for referrals
- Some pathways are unnecessarily delayed by junior clinical staff requesting further OPAs for consultant review – particularly in ENT
- Multi-factorial challenges in achieving improvements particularly in Urology

Performance

April:
11 x 78 week waits
- 2 patient choice
- 1 earlier incorrect clock stop
- 6 avoidable delays – multiple hospital and patient initiated cancellations, poor follow up processes
- 2 complex

65 week waits down from 548 in March to 495 in April
52 week waits decreased from 2729 to 2695
28 day faster diagnosis standard 74.6% (ICS target 67.5%, national target 75%)
63+ day waits 161 (internal stretch target 95, ICS allocated target 143)

Milestone plan

Description	Due Date	RAG
No RTT 70 week waits	31/8/23	
No 78 week waits	31/5/23	
No 65 week waits	31/3/24	
Reduction in 52 week waits	31/3/24	
No more than 95 patients over 63 days on the cancer PTL	31/3/24	On track
Achieve the 28 day faster diagnosis standard by Q2	30/6/23	ICS target achieved

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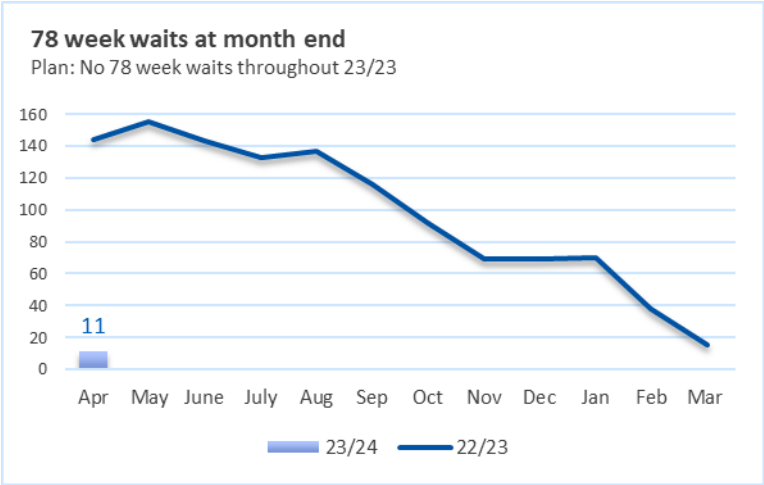
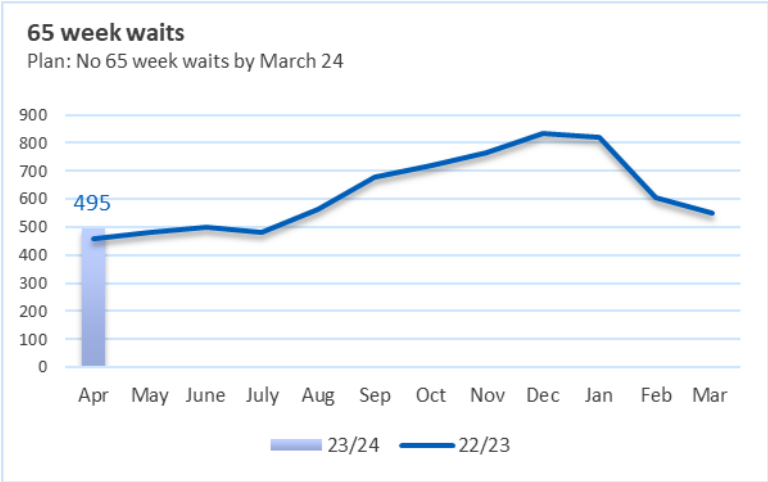
Elective Care Recovery Programme

RTT Long waits Improvement





78 week waits
The position has improved since March (15 reported) with 11 pathways in total of which:

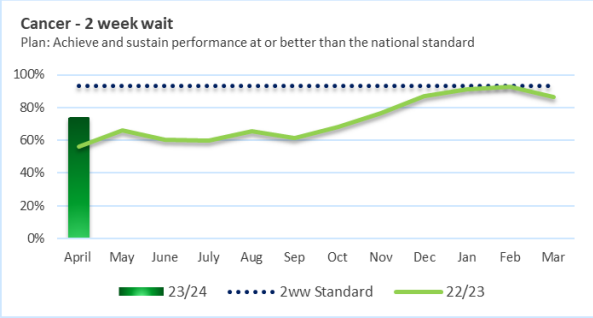
- 2 choice delays (1 dated in May, 1 in June);
- 1 incorrect clock stop applied at start of pathway, corrected and breached as a result (dated in May)
- 1 complex pathway (requires further diagnostics to enable surgical planning)
- 6 pathways with avoidable delays due to multiple hospital and patient initiated cancellation and weak follow up processes

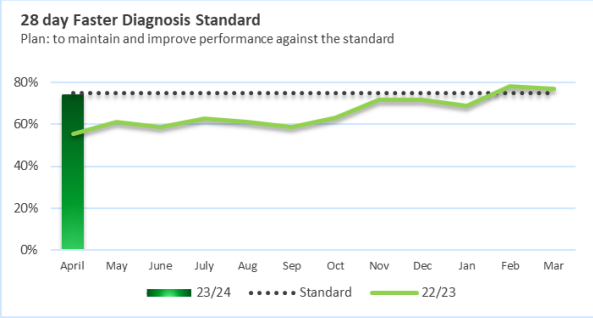
65 weeks:
There has been a further reduction in 65 week wait pathways as a result of widening the focus of the long wait pathway review meetings to include this cohort of patients.

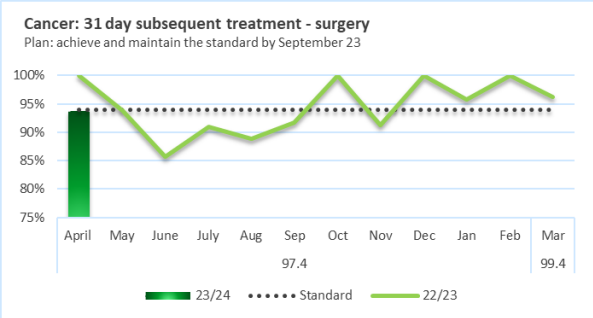
At the end of April there were 495 waits over 65 weeks compared to 548 the previous month.

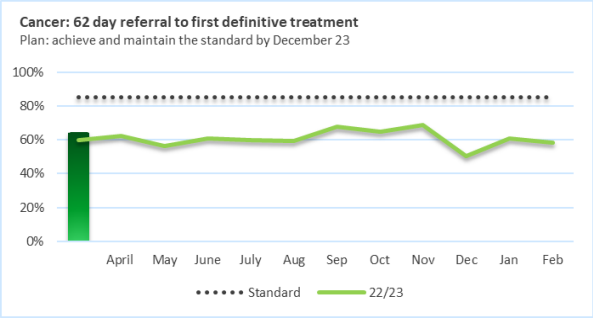
West Hertfordshire Teaching Hospitals NHS Trust

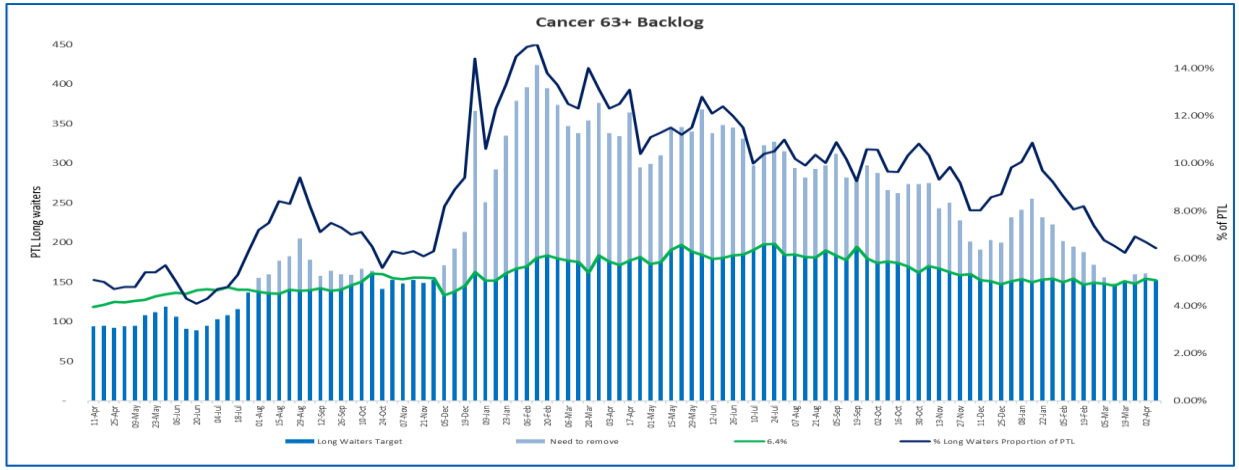
Elective Care Recovery – High Impact Change 3: Cancer waits backlog improvement & performance











2 week waits / breast symptomatic (93%)
The impact of the Junior Doctors' industrial action was significant.
(2ww 74%, 2wwB 79.6%)

28 day Faster Diagnosis Standard (75%)
Compliance with the standard has been maintained (74.6%)

31 day 1st (96%)
(Not shown)
Compliance maintained (97.4%)

31 day subsequent surgery (94%)
Currently just below target (93.8%)

62 day screening (90%) (Not shown)
Compliance with the target achieved (90.9%)

62 day referral to definitive treatment (85%)
Improved performance on last month, but capacity constraints, junior doctor industrial action, complexity and extended pathways have resulted in non-compliance with the standard (65.3%)

63+ day backlog
A stretch target for delivery this year has been agreed internally, set at 95 with an ICS allocated target of 143. At month end there were 130 pathways over 63 days.

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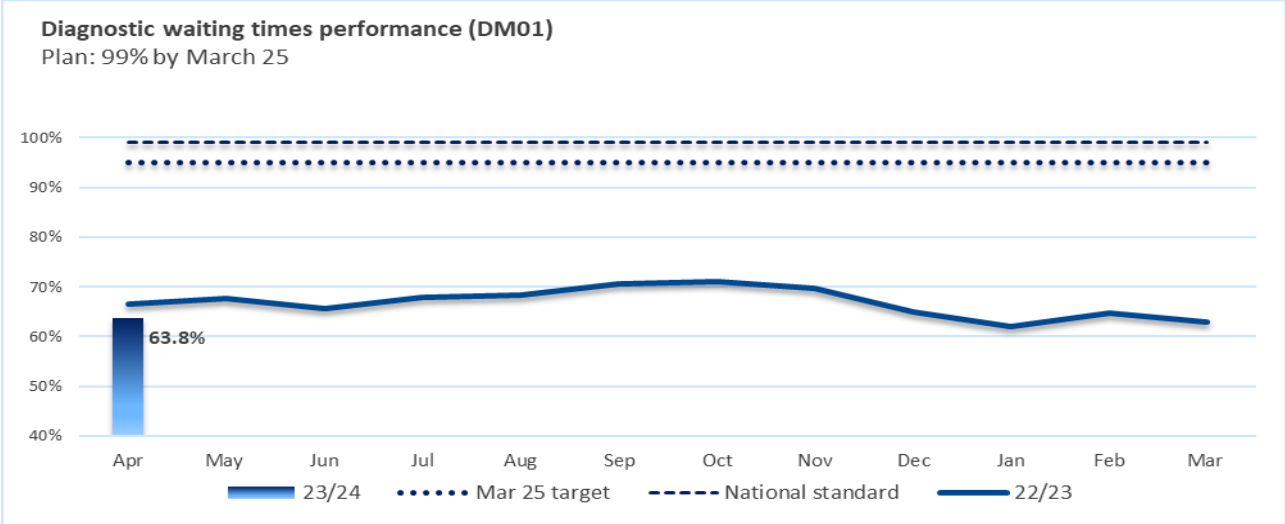
Elective Care Recovery Programme

Diagnostic (DM01) performance improvement



Performance is better than the previous month at 63.8%. The national planning guidance objective for diagnostic performance recovery is to achieve 95% (the red dotted line) by March 2025. The constitutional target is 99%.

3 modalities (CT, Barium enema, flexible sigmoidoscopy) have achieved 99% or better. MRI, clinical neurophysiology and Gynae urodynamics have achieved the March 25 target at 95% or better. Non-obstetric ultrasound, colonoscopy and Gastroscopy have delivered performance between 91 and 94.8%.

Modalities with performance below 50% remain as follows:
Dexa (deterioration on last month due to staff sickness affecting capacity)
Audiology (deteriorated due to loss of capacity at Easter)
Echo (improved)
Cystosocopy (unchanged)

Improvement in all modalities is being supported through additional sessions, outsourcing, insourcing and validation.

DQ issues continue to influence the cystoscopy waiting list. Inclusion of therapeutic procedures is currently under review and a solution is being pursued with the BI team, based on advice from the national team. In addition, this modality and some others have also identified planned/surveillance and duplicate pathways on their waiting lists and this is also being actively pursued with the support of the BI team.

Audiology demand has increased, particularly hearing aid referrals from the community service. Outsourcing plans are advancing, while development of a business case to increase in house capacity progresses.

Dexa performance is improving slowly but workforce constraints have limited the rate of improvement. There are few options for outsourcing. In-house capacity has increased through extended days but more capacity is needed to enable rapid improvement. A former outsourcing provider is expected to be available in the next month or so and this will increase throughput significantly.

The Echo service is constrained by of workforce issues and increased demand. Some activity is outsourced, and plans to insource are progressing. Additional capacity is in place in the form of ad hoc sessions. A new clinical lead is reviewing and validating the waiting list with a view to improving accuracy and thereby reducing the backlog

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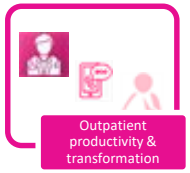
Elective Care Recovery Programme

High Impact Change 4: Outpatient Productivity & Transformation

SROs: Fran Gertler & Jo Wilder

Objectives: The national and regional ambition is a minimum 25% reduction in outpatient follow ups against 2019-20 activity levels by March 2024, through a personalised approach. The recommendations to providers on how to achieve this includes:

Reporting month: May 2023



Key updates

- There is a high performance in first to follow up ratio's and we remain in the top quartile nationally.
- Our priority is to discharge whenever clinically appropriate rather than move to PIFU and inadvertently prolong the care pathway.
- PIFU is being rolled out at pace across specialties who are not currently using it.
- Recording errors on EPR have been rectified and services not reporting on EPR currently have moved over to this system with the exception of Physiotherapy and Virtual Fracture Clinic where active plans are in place to move to EPR and timescales will be made available. This activity has however now been included within the EROC submission and WHTH has now resumed a full EROC submission rather than a partial return. We have multiple enhanced community services that we discharge patients to who would in other ways have been suitable for PIFU.
- Referral Assessment Services are set up in several services to help support a greater use of Advice & Guidance and straight to test as part of our wider transformation piece. Consultant Connect has now been commissioned for a further 3 years by the ICB to support A&G.
- Dermatology have agreed a new advise and referral pathway with Primary Care, With a pilot to launch once governance has been agreed
- Support work started in February 2023 with the regional Digital Elective Care team to increase virtual uptake (Remote Consultations).
- NFTF Divisional Targets that were produced by specialties in March 2023 need to be reviewed to ensure that they contribute to 25% rather that the current proposed position of 14%.
- Work underway with outpatient administrative team to ensure correct set up on EPR on a specialty by specialty basis.
- Ophthalmology FU waiting list has been validated and patients who are suitable for treatment with CHEC are in the process of being transferred over to the community provider. To date c50% of patients being sent for review have been accepted by CHEC.
- New services that have gone live with PIFU include Orthotics, Paediatrics and Gynaecology
- Approval given at ORG to establish a specialty level outpatient sessions and reporting mechanism to ensure Divisional visibility and ownership

Escalations

- None.

Planned next month actions

- Trust wide outpatient plan developed and going through Internal Governance for approval by the end of May 2023.
- Agree and implement protocols for NFTF patient review – use DNA audit to support clinician and patient engagement in relation to PIFU and NFTF plans.
- Expand PIFU for lower risk patient cohorts – Gynaecology, general surgery expansion, additional paediatric sub specialties that have not yet gone live.
- Review divisional level NFTF targets so that they contribute towards 25% rather than the current 14% they have specified
- Re-allocate any freed up capacity to address long wait FU / backlog and 1st OPAs.
- Undertake benefits realisation of patient portal.

Issues and risks affecting performance

- Did not achieve 5% of all patients transferred or discharged to PIFU by 31/03/2023. Local agreement already in place to discharge whenever clinically appropriate and this therefore reduces the pool of potential patients for PIFU. Revised target for 2023-24 across the HWE ICS set at 2.1% (NHSE guidance is 5% or more discharge / transferred to PIFU).
- Maintaining 25% follow up reduction due to workforce constraints and pro-active work to ensure 78+ week waits are cleared.
- Accurate activity capture on EPR of non face to face consultations completed.

Decisions required

- Agreement over proposed key metrics to be included as part of the Elective Care Recovery Programme (OP Follow Up reduction; PIFU; 1st:FU; A&G) others for context (NF2F; DNA Rates).
- Internal governance for outpatient plan to be agreed

Performance

Metric	Target	Jan	Feb	Mar	Apr
Outpatient follow up rates vs 19/20	75% of 19/20	87.2%	87.2% ▼	104.6% ▲	76.7% ▼
Patient initiated follow up rate as a % of all OPAs	2.1%	1.5%	1.7% ▲	2.1% ▲	1.7% ▼
Non-face to face rate as a % of all OPAs	25%	12.9%	12.8% ▼	12.7% ▼	12.5% ▼
DNA rates	8%	8.0%	8.1% ▲	7.9% ▼	7.7% ▼

Patient portal adoption numbers:
As at 17.05.23 - 20,427 against a target at this point of deployment of 19,092.

Milestone plan

Description	Due Date	RAG
Establish a specialty level reporting mechanism to ensure Divisional visibility and ownership of key targets	31/05/2023	G
Review NFTF Divisional Targets that were produced by specialties to ensure that they contribute to 25% rather that the current position of 14%	31/05/2023	G
Complete validation of Ophthalmology follow-ups for patients suitable to be stepped down to Enhanced Community Ophthalmology service	30/06/2023	G
Patient engagement programme to be developed and approved by CAG to encourage patients to enquire about NFTF consultations and PIFU appropriateness	30/6/2023	G

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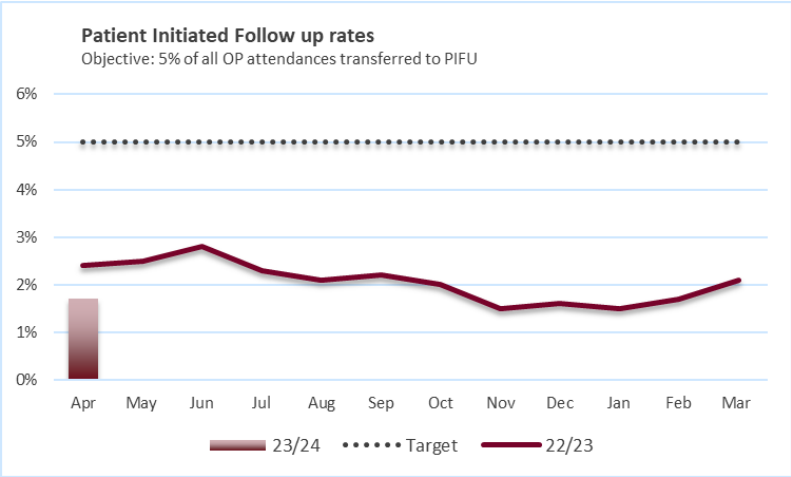
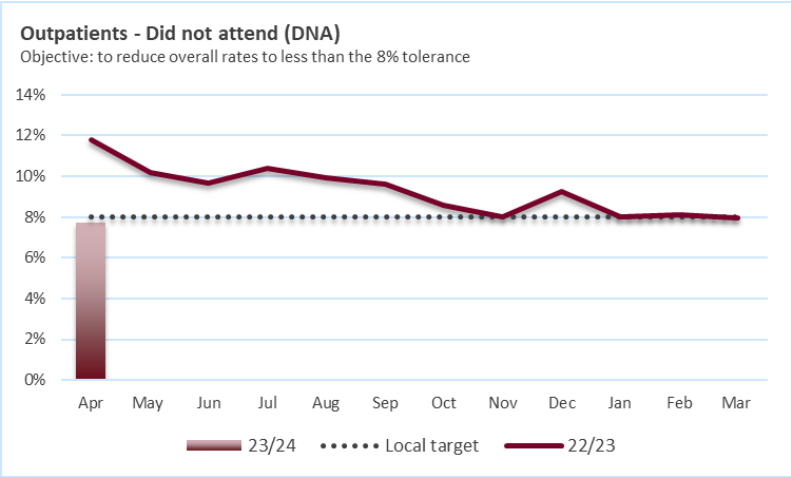
Elective Care Recovery Programme

Outpatient Productivity & Transformation





Patient Initiated Follow up (PIFU)

- Full equality impact assessment completed to ensure patient safety
- Safety netting in place to ensure patients can be tracked
- 15 specialties have gone live with PIFU
  Some services currently working through data recording issues and mitigations are now in place.
- PIFU for DNA Standard operating procedure approved at SWH Clinical Advisory Group – pilot completed in Dermatology and General Surgery with evidence of positive impact. Roll out underway with Endocrinology, Diabetes, Orthopaedics and Neurology.

Non-face to face (NF2F) consultations (target 25% of outpatient activity)

- Principle agreed that where clinically appropriate, all 1st OPAs will be face to face, with non-face to face follow up.
- Agreed areas where NF2F appointments can deliver the greatest patient benefits – eg carers, prison population
- Specialty set and owned targets in place and performance tracked at divisional governance meetings

Outpatient Productivity

- Circa 13,000 patients registered on Patient Portal since February go live
- Monitoring specialty level request lists (for follow up appointments) where backlogs correlate to capacity constraints – Gastroenterology, Ophthalmology and Endocrinology in particular
- Analysis of slot bookings underway to support discussions on improving utilisation
- Outpatient Users Group to commence discussion with services to review DNA rates with a view to supporting development of improvement plans

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Planning Guidance 2023/24 – performance against target/objective

2023/24 Elective Care

1. Eliminate waits of over 65 weeks by March 2024 (except where patients choose to wait longer or in specific specialties).
2. Deliver system specific activity target (agreed through the operational planning process).
3. Continue to reduce the number of patients waiting over 62 days (on the Cancer PTL).
   - The trust specific target to be achieved by March 2024 is 143.
4. Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.
   - Incremental targets per quarter as follows:
   - 67.5% by June 23
   - 70% by September 23
   - 72.5% by December 23
   - 75% by March 24

Urgent & Emergency Care

5. Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
6. Reduce adult general and acute (G&A) bed occupancy to 92% or below

Current position against objectives & actions

	Objective	April 23
1	65 week wait elimination by March 2024	495 (Mar 548)
2	Deliver system specific activity target (103% VWA)	86% (Mar 92%) NB: reported position with internal adjustments.
3	Reduction in patients over 62 days on the Cancer PTL – 143 by March 2024	130 (Mar 105)
4	Meet the Cancer Faster Diagnosis standard of 75% by March 2024 – 67.5% by June 23	74.6% (Mar 77.1%)
7	Improve A&E waiting times to 76% seen within 4 hours by March 2024	71.4% (Mar 68.1%)
8	Reduce adult (G&A) bed occupancy to 92% or below	All sites: 88.8% (Mar 89.3%) WGH only: 93.3% (Mar 93.7%)

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Trust Board
1st June 2023

Title of the paper:	**Integrated Performance Report** ***(May 2023 reporting period – April 2023 data)***
Agenda Item:	**20**
Presenter:	**Paul Bannister, Chief Information Officer**
Author(s):	**Mark Landau, Director of Business Intelligence** **Paul Bannister, Chief Information Officer**
Purpose:	*Please tick the appropriate box* *For approval* [ ] *For discussion* [✓] *For information* [✓]
Executive Summary:	**Summary** • This cover sheet summarises the contents of the Trust Integrated Performance Report, detailing changes made to the pack and summarising some of the narrative points made and is intended to provide information and assurance to the committee. **Changes to the pack** • No changes this month **Safe Care & Improving Outcomes - Quality** • There are three statistically significant indicators – SHMI continuing to show in improving special cause variation, although Dr Foster class the Trust as being within 'expected range'. The SHMI indicator is a rolling 12 month metric. The second statistically significant metric is HSMR, which is now a rolling 12 month metric, and showing improving special cause variation. • Caesarean Section rates for Robson Category 5 (single full-term pregnancy with previous C-section) see a statistically significant change with 100% of women having sections. Feedback from the service suggests that following the Badgernet launch there have been challenges with the historic data. The digital midwife is reviewing the data and will provide an update for the next meetinBoard **Safe Care & Improving Outcomes - Safety** • There are seven exceptions generated, all of which were also exceptions in the previous month - of nursing hours (shift fill rate) – Unregistered, % of nursing hours (shift fill rate) – Registered, Serious Incidents – Number, % of patient safety incidents which were harmful, VTE Risk Assessments and Patients admitted to stroke unit within 4 hours of arrival, and % stroke patients thrombolysed within an hour • Unregistered fill rate is showing as an exception with the latest data point breaching the upper control limit (for the fifth consecutive month). This is largely down to enhanced 1:1 care required (largely for mental health inpatients) and to staff exceptional surge. The unregistered fill rate offsets the low registered fill rate. • Three of the seven exceptions generated reflect improving special cause variation, with four representing concerning special cause variation. **Caring & Responsive Services – A&E** • Nine exception pages generated – all of which were exceptions in the previous month. Worth noting is the fact that whilst still showing concerning special cause variation, there are significant improvements demonstrated in the mean time patients wait in the department as well as with 12 hour journey times **Caring & Responsive Services – RTT, Cancer, Outpatients** • Nine Exception pages generated, eight of which were exceptions in the previous month. The new exception is for Outpatient DNA Rate which demonstrates improving special cause variation • Cancer metrics continue to show improved performance, with only 62 day GP referral generating an exception of the waiting times metrics

	Workforce • Nine Exception pages generated, with six exceptions generated for improving special cause. **Activity** • Six Exception pages generated *NB: Data correct at the time of reporting*
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	Date
Trust Management Committee	23/05/2023
Finance & Performance Committee	25/05/2023

Action required:	• The Committee are asked to receive this report for information, assurance and discussion

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Integrated Performance Report

May 2023 – April 2023 data

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

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Integrated Performance Report

- Trust Management Committee – 23rd May 2023
- Finance & Performance Committee – 25th May 2023
- Trust Board – 1st June 2023

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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

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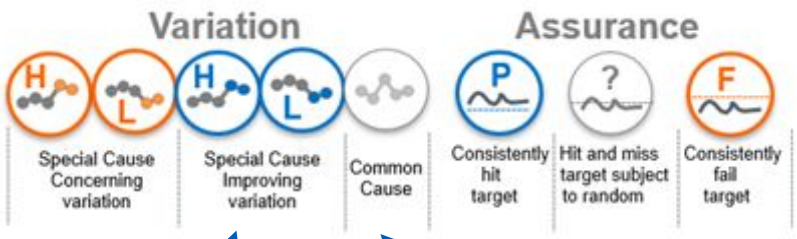
High Level Key - Variation

Are we improving declining or staying the same



Orange = significant concern or high pressure

Blue = significant improvement or low pressure

Grey – no significant change

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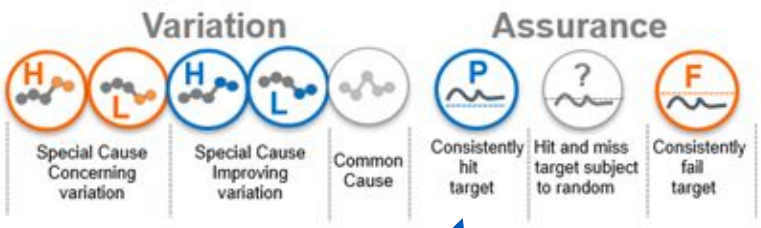
High Level Key - Assurance

Can we reliably hit the target



Orange = system change required to hit target

Blue = will reliably hit the target

Hit and miss the target

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Summary Icon Descriptions

Perform	Assure	*Description*
H	F	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.
H	P	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.
H	?	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).
L	F	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.
L	P	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.
L	?	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).
	F	Common cause variation, no significant change. This system is not reliably capable. It will **FAIL** to consistently meet target without system change.
	P	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).

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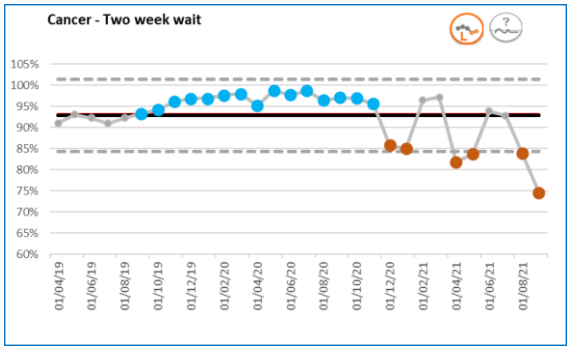
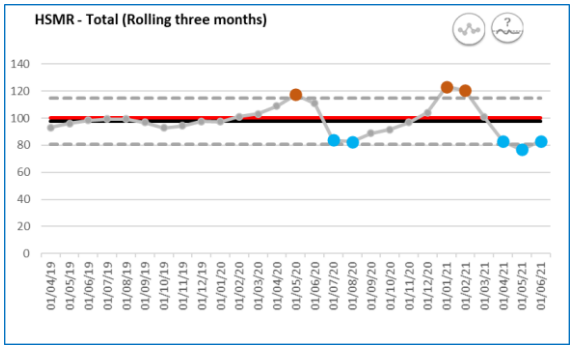
SPC rules – Special Cause Variation

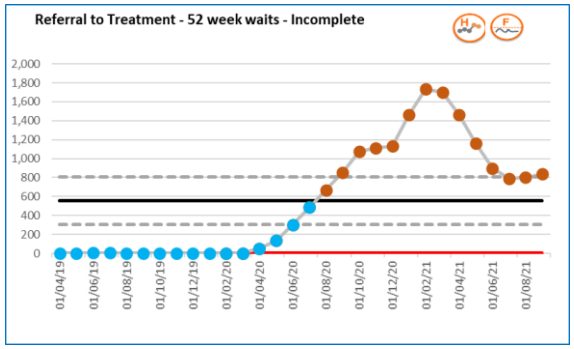
A breach of the upper/lower control limit



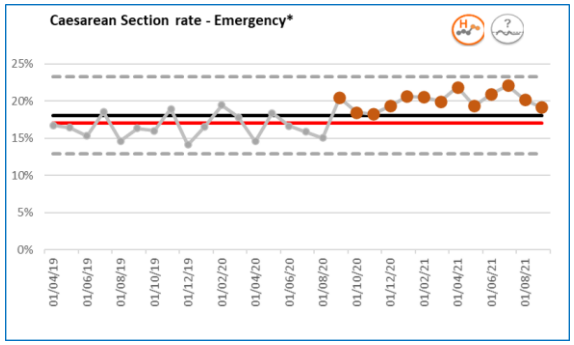
2 out of 3 points close to the control limit



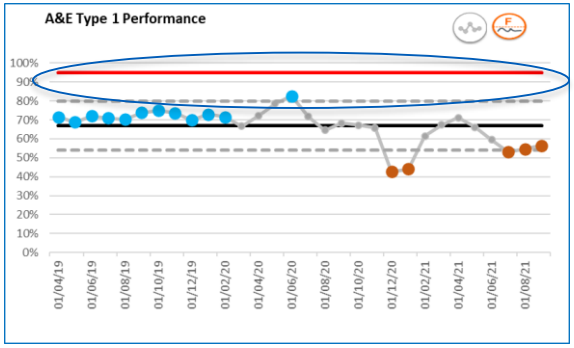
A run of ascending/descending data points



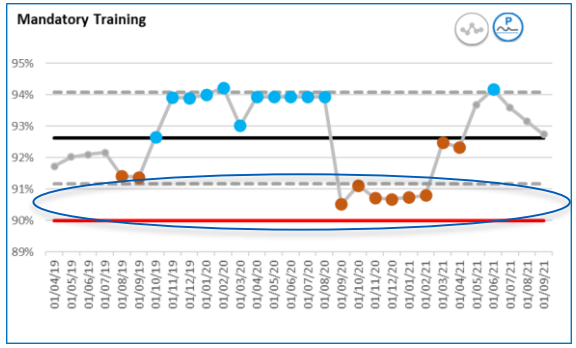
A run of points all one side of the mean



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



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



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KPI	Latest month	Measure	Target	Variation	Assurance	Local or National Metric	Committee	Owner
Safe Care and Improving Outcomes - Quality								
SHMI (Rolling 12 months)	Oct 22	95	100	L	P	National	Quality	CMO
HSMR - Total (Rolling 12 months)	Dec 22	96	100	L	?	National	Quality	CMO
Clostridioides Difficile - Hospital associated (Cat 1)	Apr 23	5	-			Local	Quality	CN
Clostridioides Difficile - Healthcare associated (Cat 2)	Apr 23	2	-			Local	Quality	CN
Clostridioides Difficile - Hospital and Healthcare associated Total	Apr 23	7	3		?	Local	Quality	CMO
Hand Hygiene Compliance	Apr 23	99%	95%		?	Local	Quality	CN
30 Day Emergency Readmissions - Elective *	Apr 23	4%	4%		?	Local	Quality	CMO
30 Day Emergency Readmissions - Emerg *	Apr 23	13%	13%		?	Local	Quality	CMO
Caesarean Section rate - Robson Category 1	Apr 23	13%	-			Local	Quality	CMO
Caesarean Section rate - Robson Category 2	Apr 23	38%	-			Local	Quality	CMO
Caesarean Section rate - Robson Category 5	Apr 23	100%	-	H		Local	Quality	CMO

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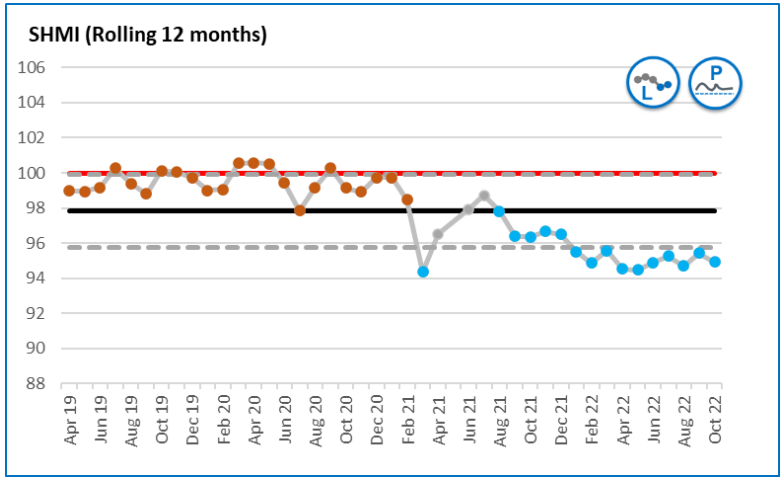
Special Cause Variation – Performance – SHMI (Rolling 12 months)

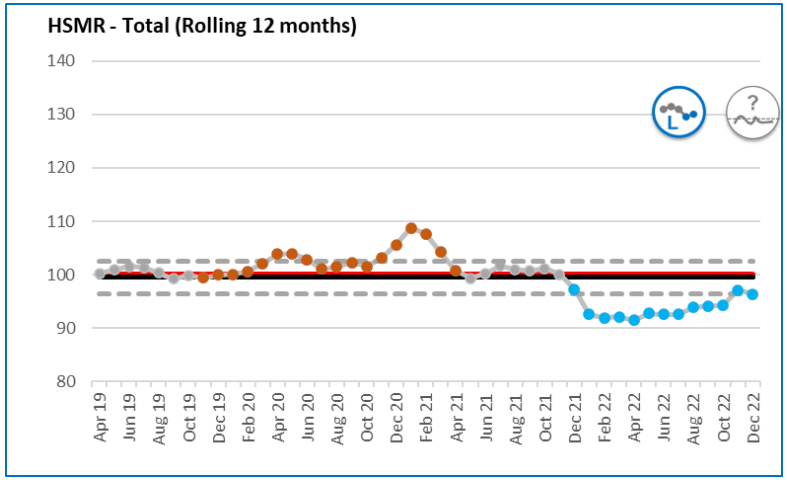


	Provider	Denominator	Obs	Exp	Obs-Exp	SHMI	Low	High
RC9	Bedfordshire Hospitals NHS Foundation Trust	101,040	2,605	2,395	210	108.64	89.74	111.44
RWH	East And North Hertfordshire NHS Trust	49,370	1,725	1,885	-160	91.66	89.56	111.66
RNQ	Kettering General Hospital NHS Foundation Trust	44,925	1,540	1,405	135	109.32	89.28	112.00
RD8	Milton Keynes University Hospital NHS Foundation Trust	47,210	1,230	1,185	45	103.78	89.08	112.26
RNS	Northampton General Hospital NHS Trust	68,615	1,615	1,775	-160	90.81	89.51	111.72
RWD	United Lincolnshire Hospitals NHS Trust	70,455	2,990	2,900	90	103.12	89.85	111.29
RWE	University Hospitals Of Leicester NHS Trust	138,280	3,605	3,465	140	104.02	89.94	111.18
RWG	West Hertfordshire Teaching Hospitals NHS Trust	58,985	1,830	1,920	-90	95.43	89.57	111.64

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		

West Hertfordshire Hospitals NHS Trust

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

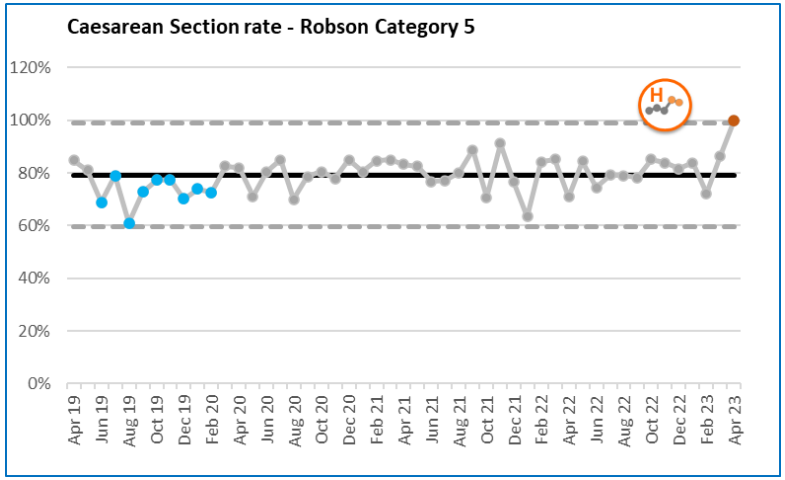


Single-month trend	Super-spells	Spells	Obs.	Crude Rate	Exp.	Exp. Rate	Relative risk	Confidence Intervals	Change	Banding
Nov-21	2604	2606	119	4.57%	117.62	4.52%	101.18	83.81 - 121.07	#N/A	Within
Dec-21	2280	2289	125	5.48%	133.62	5.86%	93.55	77.87 - 111.46	-7.63	Within
Jan-22	2129	2136	97	4.56%	119.25	5.60%	81.34	65.96 - 99.23	-12.20	Lower
Feb-22	2168	2171	95	4.38%	109.80	5.06%	86.52	70 - 105.77	+5.18	Within
Mar-22	2450	2457	103	4.20%	123.97	5.06%	83.08	67.81 - 100.76	-3.44	Within
Apr-22	2141	2149	106	4.95%	123.46	5.77%	85.86	70.29 - 103.84	+2.77	Within
May-22	2366	2372	106	4.48%	109.28	4.62%	96.99	79.41 - 117.31	+11.14	Within
Jun-22	2306	2313	106	4.60%	105.36	4.57%	100.61	82.37 - 121.68	+3.61	Within
Jul-22	2186	2189	87	3.98%	90.77	4.15%	95.85	76.77 - 118.23	-4.76	Within
Aug-22	2278	2285	116	5.09%	106.41	4.67%	109.01	90.08 - 130.75	+13.16	Within
Sep-22	2228	2236	107	4.80%	103.83	4.66%	103.05	84.45 - 124.53	-5.96	Within
Oct-22	2293	2298	112	4.88%	114.43	4.99%	97.88	80.59 - 117.78	-5.17	Within

Background	What the Data tells us	Issues	Actions	Mitigations
HSMR – (Rolling 12 Months)	Exception triggered due to a run of data points below the mean (a shift)			

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance – Caesarean Section Rate – Robson Category 5



Background	What the Data tells us	Issues	Actions	Mitigations
Caesarean Section Rate – Robson Category 5	Exception triggered due to a breach of the upper control limit	Results for Robson 5 are being analysed further; initial results show a low VBAC(Vaginal Birth After Caesarean) rate for April, however this is due to prior birth data being migrated over to Badgernet. Further analysis is required and an updated result will be provided in May.	Further analysis by digital midwife	

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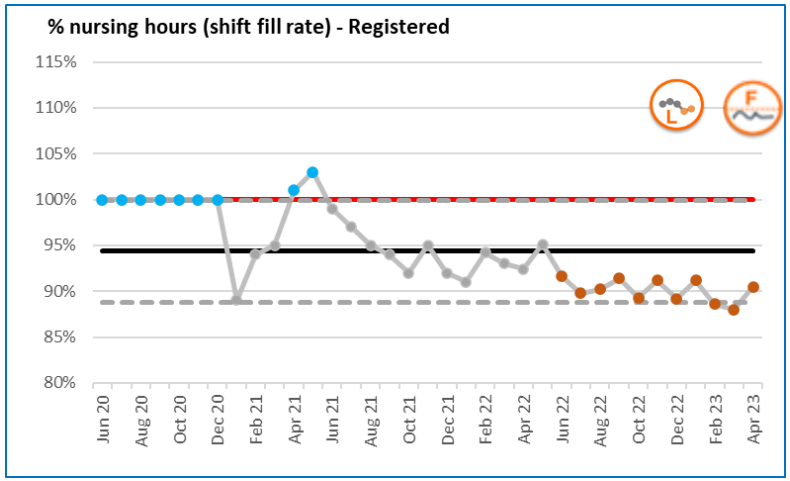
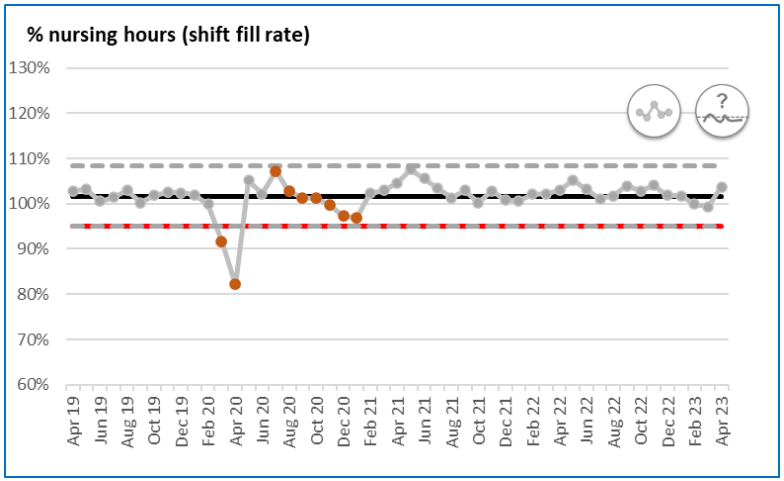
KPI	Latest month	Measure	Target	Variation	Assurance	Local or National Metric	Committee	Owner
Safe Care and Improving Outcomes - Safety								
% nursing hours (shift fill rate)	Apr 23	104%	95%		?	Local	Quality	CN
% nursing hours (shift fill rate) - Registered	Apr 23	91%	100%	L	F	Local	Quality	CN
% nursing hours (shift fill rate) - Unregistered	Apr 23	124%	100%	H	P	Local	Quality	CN
Serious incidents - number*	Apr 23	2	-	L		Local	Quality	CMO
Serious incidents - % that are harmful*	Apr 23	100%	0%		?	Local	Quality	CMO
% of patients safety incidents which are harmful*	Apr 23	11%	0%		F	Local	Quality	CMO
Never events	Apr 23	0	-			Local	Quality	CMO
Category 4 pressure ulcers - New (Hospital acquired)	Apr 23	0	-			Local	Quality	CN
Category 3 pressure ulcers - New (Hospital acquired)	Apr 23	5	-			Local	Quality	CN
Falls with Harm	Apr 23	11	-			Local	Quality	CMO
VTE risk assessment*	Apr 23	97%	95%	H	?	Local	Quality	CMO
Patients admitted to stroke unit within 4 hours of hospital arrival	Apr 23	56%	90%	H	F	Local	Quality	CMO
Stroke patients spending 90% of their time on stroke unit	Apr 23	84%	80%		?	Local	Quality	CMO
% Stroke Patients Thrombolysed within an hour	Apr 23	0%	50%	L	?	Local	Quality	CMO

West Hertfordshire Hospitals NHS Trust

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

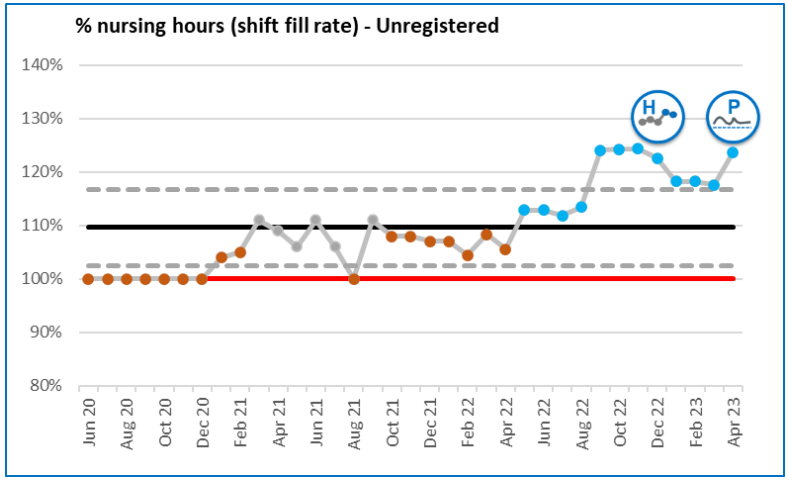


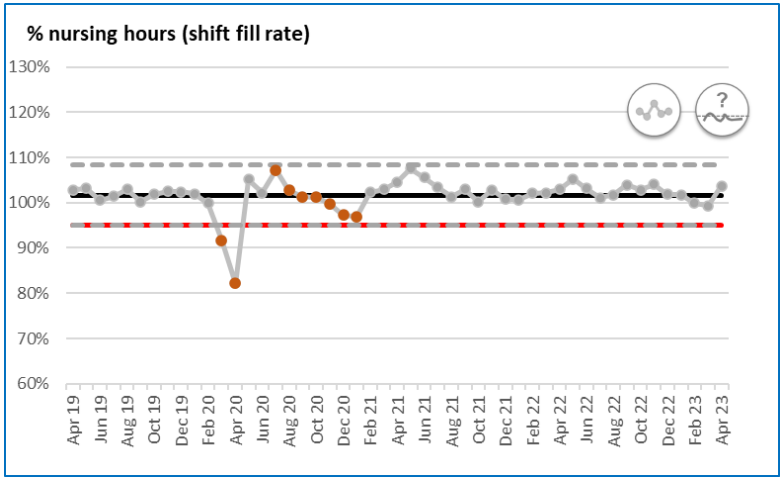


Background	What the Data tells us	Issues	Actions	Mitigations
% Nursing Hours (shift fill rate) - Registered	Exception triggered due to a 7+ data points below the mean (a shift)	Low registered fill rate related to high number of unavailability due to sickness and maternity leave and high vacancy in paediatrics and maternity.	IR Recruitment continues for Nursing and Midwifery Use of Temporary staffing Risk Register # 37	Daily meetings at 8.30 and 14.30 to review safe staffing. Daily Redeployment of staff to support safe staffing Daily reports circulated to indicate Trust and Divisional staffing RAG status. Sign off night staffing by Chief Nurse Senior clinical support out of hours including nights

West Hertfordshire Hospitals NHS Trust

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

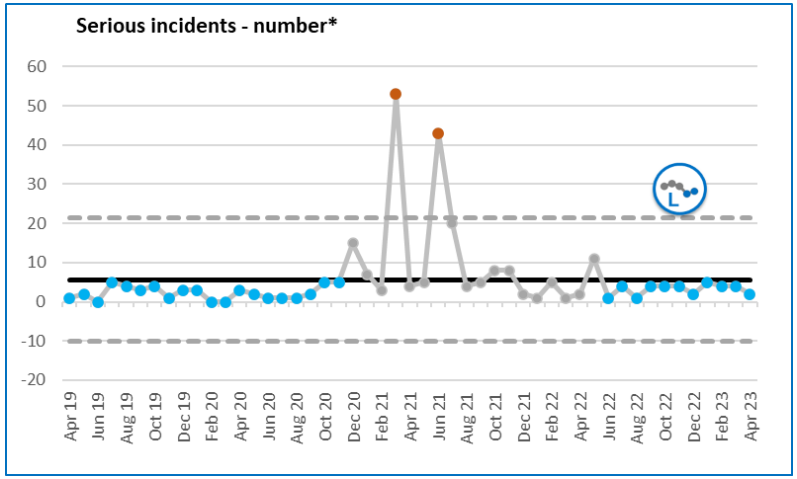




Background	What the Data tells us	Issues	Actions	Mitigations
% Nursing Hours (shift fill rate) - Unregistered	Exception triggered due to a breach of the upper control limit Exception triggered due to 7+ data points above the mean (a shift) Exception triggered due to the target falling below the lower control limit	Increased unregistered demand and fill due to additional shifts related to large number of escalation beds open and increase in ECWs usage.	IR Recruitment continues for Nursing and Midwifery Use of Temporary staffing Risk Register # 37	Daily meetings at 8.30 and 14.30 to review safe staffing. Daily Redeployment of staff to support safe staffing Daily reports circulated to indicate Trust and Divisional staffing RAG status. Sign off night staffing by Chief Nurse Senior clinical support out of hours including nights

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance – Serious Incidents - Number



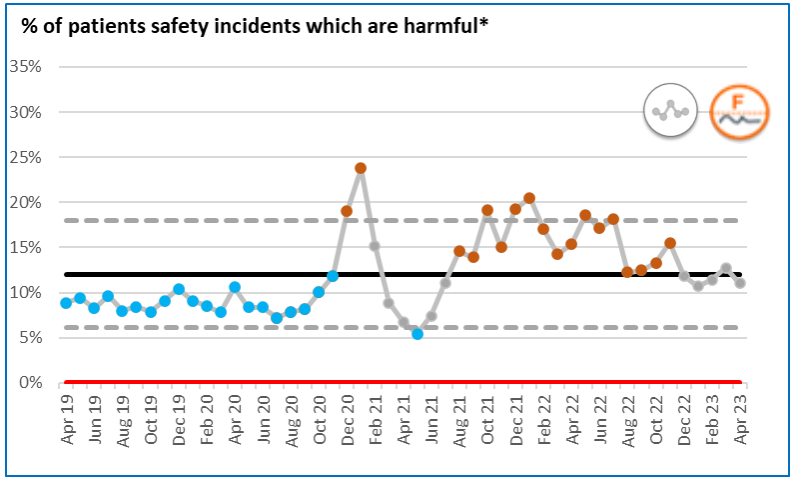
4 serious incidents(SIs) were declared in March 2023. Of these, 2 were reported by Women and Children Services. In comparison, 1 each was reported by Surgery, Anaesthetics and Cancer, and Clinical Support Services.

The trend continues to show a stable number of SIs. Women and Children services reported the highest proportion in comparison with the remaining divisions. In the past six months, from September 2022 to January 2023 inclusive, there have been an average of 1.5 SIs with a range of 1 to 2 incidents each month.

Background	What the Data tells us	Issues	Actions	Mitigations
Serious Incidents - Number	Exception triggered due to a run of 7+ data points below the mean (a shift)	4 serious incidents(SIs) were declared in March 2023 which is comparable to the exact number reported in February 2023 constituting no change in number.. The trend continues to show stable number of SIs	The divisions to continue monitoring incident reporting and put measures in place to support sharing of lessons learned and embed learnings through different forums including their governance meetings and the Serious Incident Panel meetings.	The Trust's Serious incident review group meeting continues to work with the divisions in ensuring learnings from actions are evidenced before incidents are closed.

West Hertfordshire Hospitals NHS Trust

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



The Trust recorded 1406 patient safety incidents in March 2023 compared with 1475 in February 2023: a 4.7% increase.

12.73% (179) of the incidents resulted in patient harm; this is a 5.9% increase compared to February 2023 data. Of these, 161 incidents were reported as low harm, constituting a significant change in comparison with 152 reported in February 2023.

In context, the total number of incidents reported across the divisions trust-wide in March is varied, with no outliers.

1.2 % (17) of the incidents reported in March 2023 were recorded as causing a "moderate or higher" level of patient harm. Of these, 12 are under open investigation, and 3 have been closed.

The Trust declared 4 SIs in March 2023, comparable to the exact number compared to 4 Sis reported in February 2023.

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	In March 2023, 3 incident-type reporting categories were identified in relation to SIs. The categories relate to Maternity/Obstetric incident meeting SI criteria: mother and baby (2), Alleged Abuse of adult patient by third party (1) and Incident affecting patient's body after death (1) Maternity (Midwifery) care (49), Pressure Ulcer (29), Patients Falls (24), Infection Control I (23), Neonatal/Perinatal Care (13) Care, and Diagnostic process (7). The remaining category types reported less than 7. The number of incidents reported as no harm in February is relatively lower than in January, with no concerning themes.	Divisions will continually review incidents promptly and close them, in order to share and facilitate timely learnings and 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.

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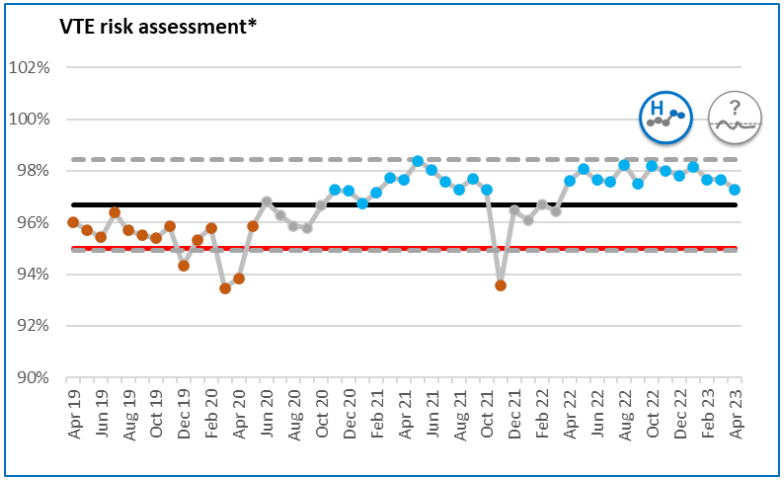
Special Cause Variation – Performance – VTE Risk Assessment



Background	What the Data tells us	Issues	Actions	Mitigations
VTE Risk Assessment	Exception triggered due to a run of 7+ data points above the mean (a shift)	Badgernet data now incorporated for maternity		

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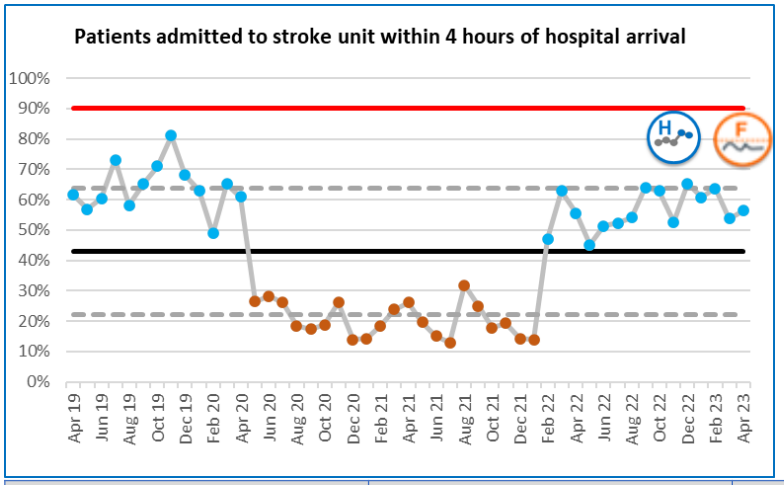
Special Cause Variation – Performance/Assurance – Patients admitted to stroke unit within 4 hours of hospital arrival



Background	What the Data tells us	Issues	Actions	Mitigations
Patients admitted to stroke unit within 4 hours of hospital arrival	Exception triggered due to target being outside the upper control limit Exception triggered due to a run of 7+ data points above the mean (a shift) Exception triggered due to a breach of the upper control limit	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 4 hour to SU % has been consistently good since Feb 22. and reflects how the ward was pre covid. The January to March quarter is currently at 59.7%. The April data is 56.4%	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 Review and validation of the reasons patients were not thrombolysed within the one hour 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.

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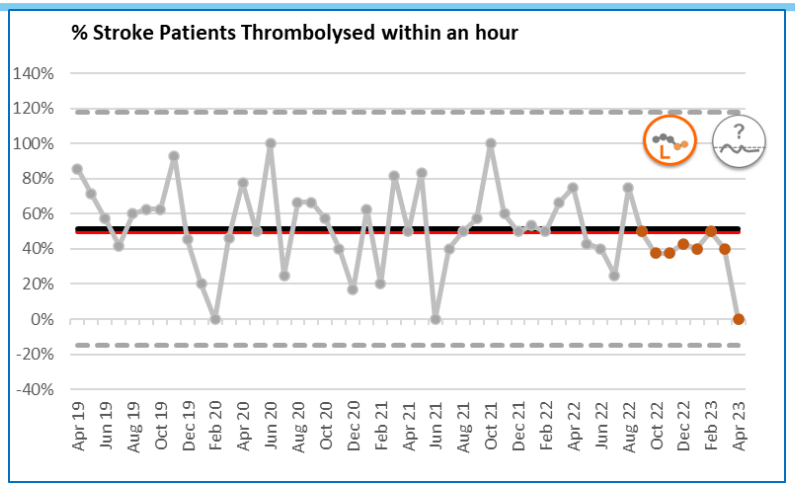
Special Cause Variation – Performance – % Stroke patients thrombolysed within one hour



Background	What the Data tells us	Issues	Actions	Mitigations
% Stroke Patients thrombolysed within one hour	Exception triggered due to a run of 7+ data points below the mean (a shift)	The most common reasons patients are delayed and fail to be thrombolysed within one hour are: • Out of hours telemedicine consultation • Patient requiring a CT perfusion as well as usual CT • Unclear stroke diagnosis when presenting to ED • Patient too unwell for the CT scan or blood pressure too high, need to be stabilised before thrombolysing The % of patients thrombolysed within 1 hour in April was 6 out of those 6, all had failed due to the following reasons: 2 were due to telemedicine/out of hours 1 had a CT perfusion 1 was medically unwell 1 had to have consent/family discussion 1 had an unclear diagnosis	The stroke team and the Clinical lead review the pathway for all thrombolysed patients to ascertain in the delay reasons and make improvements.	Patients continue to receive Stroke Consultant input and specific recommendations for their care

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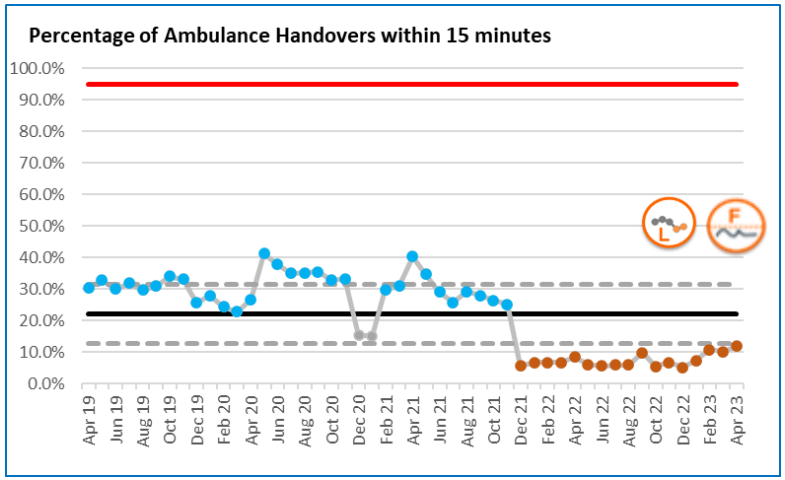
KPI	Latest month	Measure	Target	Variation	Assurance	Local or National Metric	Committee	Owner
Caring & Responsive Services - A&E Metrics								
Percentage of Ambulance Handovers within 15 minutes	Apr 23	12.0%	95.0%	L	F	National	F&P	COO
Ambulance turnaround times >30 mins and <60 mins	Apr 23	681	0	H	F	National	F&P	COO
Ambulance turnaround times >60 mins	Apr 23	304	-	H		National	F&P	COO
A&E Initial Assessment < 15 mins	Apr 23	86.2%	95.0%	L	F	National	F&P	COO
Mean time in department (non-admitted)	Apr 23	276	-	H		National	F&P	COO
Mean time in department (admitted)	Apr 23	403	-	H		National	F&P	COO
12 hour end to end waits for all attendances	Apr 23	414	-	H		Local	F&P	COO
A&E 12hr trolley waits	Apr 23	0	0		?	Local	F&P	COO
A&E 4 Hour Wait - Type 1, 2 & 3	Apr 23	71.4%	95.0%	L	?	National	F&P	COO
A&E 4hr waits – Type 1	Apr 23	46.9%	-	L	F	National	F&P	COO
% Patients admitted through A&E - 0 day LOS	Apr 23	26.6%	-			Local	F&P	COO
Proportion of 12 hour waits in ED	Apr 23	2.8%	2.0%		?	National	F&P	COO

West Hertfordshire Hospitals NHS Trust

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



*Latest available benchmarking data – EEAST – April 2023

Hospital	% within 15 minutes
Bedford Hospital South Wing	73.85%
Addenbrookes Hospital	61.34%
Hinchingbrooke Hospital	51.65%
Broomfield Hospital	48.13%
West Suffolk Hospital	35.31%
James Paget Hospital	34.94%
Queen Elizabeth Hospital	30.92%
Southend University Hospital	29.19%
Basildon & Thurrock Hospital	28.42%
Luton & Dunstable Hospital	26.67%
Ipswich Hospital	26.18%
Princess Alexandra Hospital	23.92%
Norfolk & Norwich University Hospital	23.85%
Colchester General Hospital	21.72%
Lister Hospital	13.69%
Watford General Hospital	**12.78%**
Peterborough City Hospital	9.17%
Region	**31.70%**

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 decreased by 6% for adults and 25% for paediatrics from last month • Ambulance demand is up 4.5% on the previous year and down 8.6% on 20/21 • Daily staffing levels for nursing with the Emergency Medicine Division • Daily medical staffing within ED • Assessment area has 20 bedded patients used as exceptional surge capacity	• Implementation of 45 minute rapid release supported by corridor care and application of the boarding policy (16 April 2023) • HALO on site 12- 12 • Boarding policy in place • Fit to sit area in use to support offload • Joint working with EEAST and WGH UTC to facilitate offload • Corridor nursing in place including a joint Trust and EEAST corridor SOP • 10 x EAU assessment trolleys brought back into use • Ambulance handover project board meetings continue with EEAST and ICS 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 • ED workforce plan submitted as part of confirm and challenge	• ED improvement plan developed detailing actions for ED, this is being worked into a Trust flow plan • All patients assessed by senior decision maker on arrival and treatment commenced if delayed. Close partnership working with EEAST • Increased nursing establishment through winter funding to support timely offloading and release of crews • Intelligent conveyancing implemented and in agreement with EEAST and ICB as necessary. • Rapid release in place to support patients in the community • Winter and call to arms monies utilised to support: Nursing shifts; Medical shifts; Board Controller shifts • Active recruitment to vacancies • Assurance through bed meetings for time to initial assessment and time to offload

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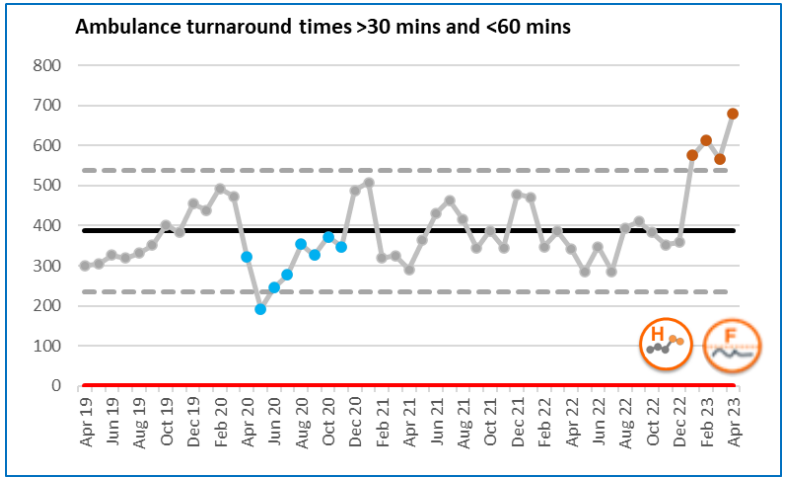
Special Cause Variation – PerformanceAssurance – Ambulance Turnaround Time between 30 and 60 minutes



***Latest available benchmarking data – EEAST – April 2023**

Hospital	Number over 30 Minutes	% over 30 minutes
Bedford Hospital South Wing	45	2.80%
Addenbrookes Hospital	159	6.62%
West Suffolk Hospital	138	8.43%
Broomfield Hospital	258	11.78%
Hinchingbrooke Hospital	151	12.19%
Colchester General Hospital	380	13.89%
Southend University Hospital	556	24.62%
Ipswich Hospital	516	25.39%
Luton & Dunstable Hospital	544	25.95%
Basildon & Thurrock Hospital	557	27.38%
James Paget Hospital	562	31.22%
Queen Elizabeth Hospital	594	35.87%
Watford General Hospital	**851**	**37.37%**
Princess Alexandra Hospital	589	37.56%
Peterborough City Hospital	699	43.02%
Lister Hospital	903	47.18%
Norfolk & Norwich University Hospital	1594	56.56%
Region	**9096**	**26.84%**

Background	What the Data tells us	Issues	Actions	Mitigations
Number of ambulance handovers between 30-60 minutes	Exception triggered due to target being outside the lower control limit Exception triggered due to a breach of the upper control limit	• ED demand has decreased by 6% for adults and 25% for paediatrics from last month • Ambulance demand is up 4.5% on the previous year and down 8.6% on 20/21 • Daily staffing levels for nursing with the Emergency Medicine Division • Daily medical staffing within ED • Assessment area has 20 bedded patients used as exceptional surge capacity	• Implementation of 45 minute rapid release supported by corridor care and application of the boarding policy (16 April 2023) • HALO on site 12- 12 • Boarding policy in place • Fit to sit area in use to support offload • Joint working with EEAST and WGH UTC to facilitate offload • Corridor nursing in place including a joint Trust and EEAST corridor SOP • 10 x EAU assessment trolleys brought back into use • Ambulance handover project board meetings continue with EEAST and ICS 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 • ED workforce plan submitted as part of confirm and challenge	• ED improvement plan developed detailing actions for ED, this is being worked into a Trust flow plan • All patients assessed by senior decision maker on arrival and treatment commenced if delayed. Close partnership working with EEAST • Increased nursing establishment through winter funding to support timely offloading and release of crews • Intelligent conveyancing implemented and in agreement with EEAST and ICB as necessary. • Rapid release in place to support patients in the community • Winter and call to arms monies utilised to support: Nursing shifts; Medical shifts; Board Controller shifts • Active recruitment to vacancies • Assurance through bed meetings for time to initial assessment and time to offload

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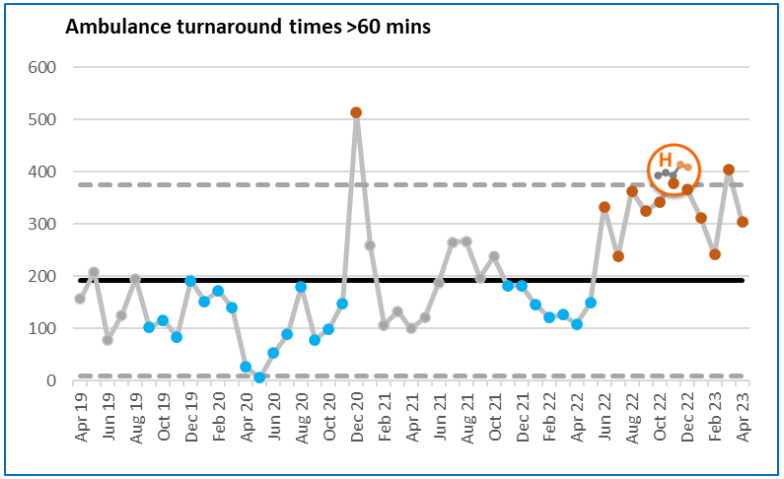
Special Cause Variation – Performance – Ambulance Turnaround Time >60 minutes



***Latest available benchmarking data – EEAST – April 2023**

Hospital	Number over 60 minutes	% over 60 minutes
West Suffolk Hospital	3	0.18%
Bedford Hospital South Wing	15	0.93%
Addenbrookes Hospital	29	1.21%
Colchester General Hospital	72	2.63%
Hinchingbrooke Hospital	51	4.12%
Broomfield Hospital	98	4.47%
Southend University Hospital	138	6.11%
Luton & Dunstable Hospital	165	7.87%
Watford General Hospital	**191**	**8.39%**
Ipswich Hospital	195	9.60%
Basildon & Thurrock Hospital	211	10.37%
Peterborough City Hospital	190	11.69%
Princess Alexandra Hospital	226	14.41%
James Paget Hospital	264	14.67%
Lister Hospital	334	17.45%
Queen Elizabeth Hospital	314	18.96%
Norfolk & Norwich University Hospital	1090	38.68%
Region	**3586**	**10.58%**

Background	What the Data tells us	Issues	Actions	Mitigations
Number of ambulance handovers > 60 minutes	Exception triggered due to 7+ data points above the mean (a shift) Exception triggered due to a breach of the upper control limit	• ED demand has decreased by 6% for adults and 25% for paediatrics from last month • Ambulance demand is up 4.5% on the previous year and down 8.6% on 20/21 • Daily staffing levels for nursing with the Emergency Medicine Division • Daily medical staffing within ED • Assessment area has 20 bedded patients used as exceptional surge capacity	• Implementation of 45 minute rapid release supported by corridor care and application of the boarding policy (16 April 2023) • HALO on site 12- 12 • Boarding policy in place • Fit to sit area in use to support offload • Joint working with EEAST and WGH UTC to facilitate offload • Corridor nursing in place including a joint Trust and EEAST corridor SOP • 10 x EAU assessment trolleys brought back into use • Ambulance handover project board meetings continue with EEAST and ICS 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 • ED workforce plan submitted as part of confirm and challenge	• ED improvement plan developed detailing actions for ED, this is being worked into a Trust flow plan • All patients assessed by senior decision maker on arrival and treatment commenced if delayed. Close partnership working with EEAST • Increased nursing establishment through winter funding to support timely offloading and release of crews • Intelligent conveyancing implemented and in agreement with EEAST and ICB as necessary. • Rapid release in place to support patients in the community • Winter and call to arms monies utilised to support: Nursing shifts; Medical shifts; Board Controller shifts • Active recruitment to vacancies • Assurance through bed meetings for time to initial assessment and time to offload

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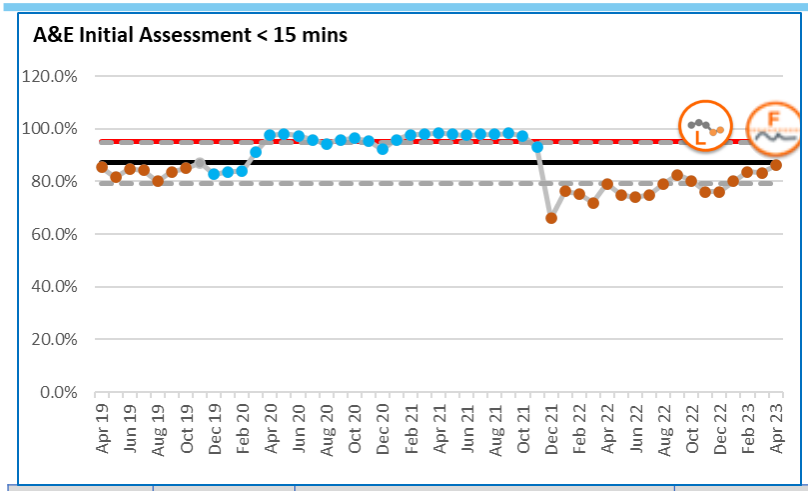
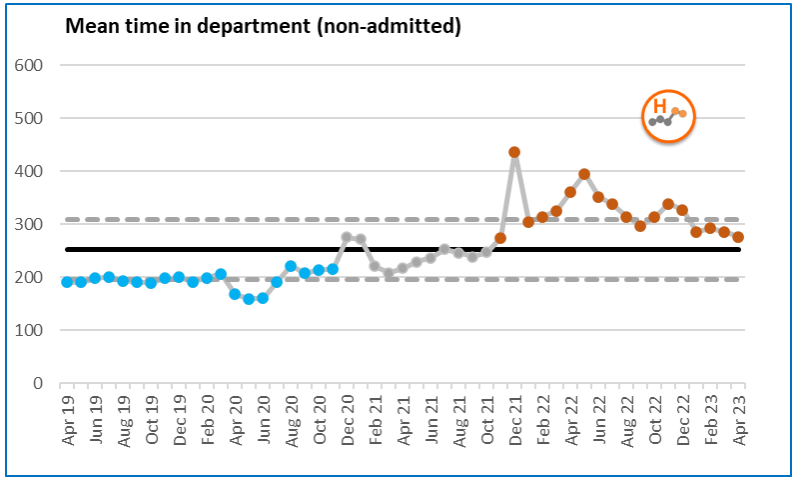
Special Cause Variation – Performance – Time to initial assessment - Percentage within 15 minutes



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. • 20 trolleys in assessment area bedded • ED demand has decreased by 6% for adults and 25% for paediatrics from last month • 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 • WGH UTC flow constraints impact on ED as well as handovers at close.	• Implementation of 45 minute rapid release supported by corridor care and application of the boarding policy (16 April 2023) • Walk-in stream separated from ambulance stream to provide clearer visibility across the department and decompress bottleneck areas. Fit to sit implemented. • Additional assessment trolleys created in majors 2. • Increase use of TAM supported by senior decision makers to support flow • EAU chairs implemented • 10 x assessment spaces released from surge • Increase usage of SDEC pathways including patients actively pulled into ACU. • Phone a friend in place • Emergency medicine performance meetings focus on improvement plan • High Impact Changes work focussing on rapid clinical assessment, and UTC • Focus on weekend discharges, discharge time of day and usage of discharge lounge to enable earlier flow. • Discharge nurse employed on level 1 • Emergency medicine performance meetings focus on improvement plan	• High Impact Changes enabling increasing Senior Decision Makers in ED. • Data shows increase of initial assessment. • 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" and TAM to focus on walk in patients • 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. • 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 • Joint corridor SOP • Senior review/oversight of decisions to admit. • Harm reviews carried out for patients who wait for 12 hrs, so far this has shown no harm caused • Validation SOP in place • Hourly rounding being undertaken on all patients ensuring comfort. • If prolonged trolley wait – patients transferred to bed for comfort.

West Hertfordshire Hospitals NHS Trust

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



Background	What the Data tells us	Issues	Actions	Mitigations
Mean time in department (Non-admitted	Exception triggered due to 7+ data points above 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. • 20 trolleys in assessment area bedded • ED demand has decreased by 6% for adults and 25% for paediatrics from last month • 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 • WGH UTC flow constraints impact on ED as well as handovers at close.	• Implementation of 45 minute rapid release supported by corridor care and application of the boarding policy (16 April 2023) • Walk-in stream separated from ambulance stream to provide clearer visibility across the department and decompress bottleneck areas. Fit to sit implemented. • Additional assessment trolleys created in majors 2. • Increase use of TAM supported by senior decision makers to support flow • EAU chairs implemented • 10 x assessment spaces released from surge • Increase usage of SDEC pathways including patients actively pulled into ACU. • Phone a friend in place • Emergency medicine performance meetings focus on improvement plan • High Impact Changes work focussing on rapid clinical assessment, and UTC • Focus on weekend discharges, discharge time of day and usage of discharge lounge to enable earlier flow. • Discharge nurse employed on level 1 • Emergency medicine performance meetings focus on improvement plan	• High Impact Changes enabling increasing Senior Decision Makers in ED. • Data shows increase of initial assessment. • 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" and TAM to focus on walk in patients • 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. • 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 • Joint corridor SOP • Senior review/oversight of decisions to admit. • Harm reviews carried out for patients who wait for 12 hrs, so far this has shown no harm caused • Validation SOP in place • Hourly rounding being undertaken on all patients ensuring comfort. • If prolonged trolley wait – patients transferred to bed for comfort.

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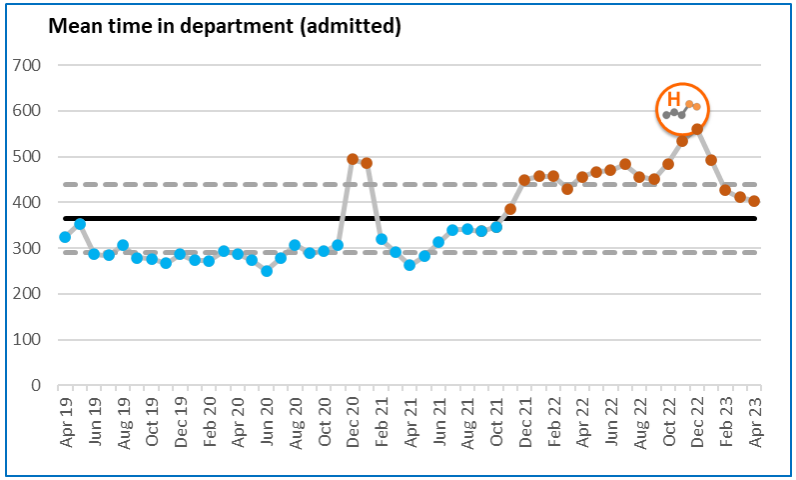
Special Cause Variation – Performance – Mean time (minutes) in department (admitted)



Background	What the Data tells us	Issues	Actions	Mitigations
Mean time in department (admitted	Exception triggered due to 7+ data points above 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. • 20 trolleys in assessment area bedded • ED demand has decreased by 6% for adults and 25% for paediatrics from last month • 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 • WGH UTC flow constraints impact on ED as well as handovers at close.	• Implementation of 45 minute rapid release supported by corridor care and application of the boarding policy (16 April 2023) • Walk-in stream separated from ambulance stream to provide clearer visibility across the department and decompress bottleneck areas. Fit to sit implemented. • Additional assessment trolleys created in majors 2. • Increase use of TAM supported by senior decision makers to support flow • EAU chairs implemented • 10 x assessment spaces released from surge • Increase usage of SDEC pathways including patients actively pulled into ACU. • Phone a friend in place • Emergency medicine performance meetings focus on improvement plan • High Impact Changes work focussing on rapid clinical assessment, and UTC • Focus on weekend discharges, discharge time of day and usage of discharge lounge to enable earlier flow. • Discharge nurse employed on level 1 • Emergency medicine performance meetings focus on improvement plan	• High Impact Changes enabling increasing Senior Decision Makers in ED. • Data shows increase of initial assessment. • 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” and TAM to focus on walk in patients • 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. • 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 • Joint corridor SOP • Senior review/oversight of decisions to admit. • Harm reviews carried out for patients who wait for 12 hrs, so far this has shown no harm caused • Validation SOP in place • Hourly rounding being undertaken on all patients ensuring comfort. • If prolonged trolley wait – patients transferred to bed for comfort.

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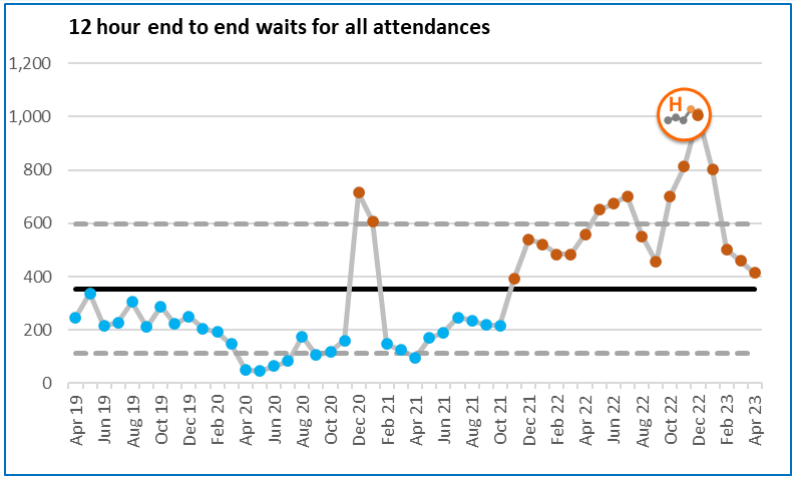
Special Cause Variation – Performance – A&E 12 hour waits (arrival to departure)



Background	What the Data tells us	Issues	Actions	Mitigations
12 Hour end to end waits for all attendances	Exception triggered due to 7+ data points above 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. • 20 trolleys in assessment area bedded • ED demand has decreased by 6% for adults and 25% for paediatrics from last month • 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 • WGH UTC flow constraints impact on ED as well as handovers at close.	• Implementation of 45 minute rapid release supported by corridor care and application of the boarding policy (16 April 2023) • Walk-in stream separated from ambulance stream to provide clearer visibility across the department and decompress bottleneck areas. Fit to sit implemented. • Additional assessment trolleys created in majors 2. • Increase use of TAM supported by senior decision makers to support flow • EAU chairs implemented • 10 x assessment spaces released from surge • Increase usage of SDEC pathways including patients actively pulled into ACU. • Phone a friend in place • Emergency medicine performance meetings focus on improvement plan • High Impact Changes work focussing on rapid clinical assessment, and UTC • Focus on weekend discharges, discharge time of day and usage of discharge lounge to enable earlier flow. • Discharge nurse employed on level 1 • Emergency medicine performance meetings focus on improvement plan	• High Impact Changes enabling increasing Senior Decision Makers in ED. • Data shows increase of initial assessment. • 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" and TAM to focus on walk in patients • 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. • 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 • Joint corridor SOP • Senior review/oversight of decisions to admit. • Harm reviews carried out for patients who wait for 12 hrs, so far this has shown no harm caused • Validation SOP in place • Hourly rounding being undertaken on all patients ensuring comfort. • If prolonged trolley wait – patients transferred to bed for comfort.

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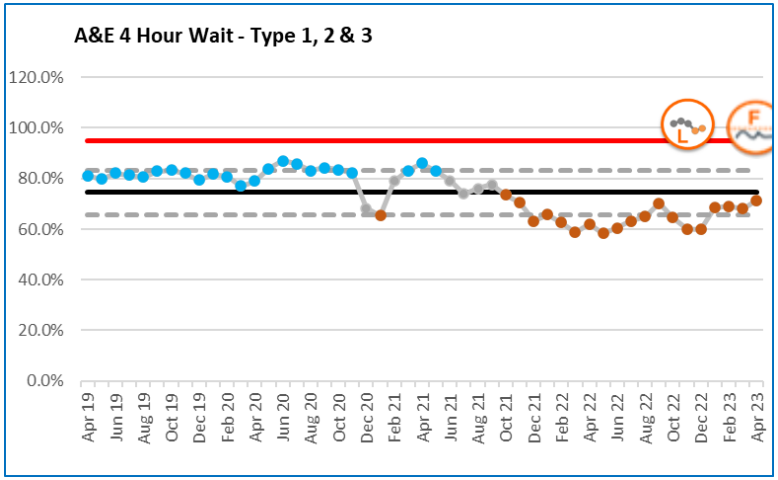
Special Cause Variation – Performance/Assurance – ED 4 hour waits – Type 1,2 and 3



April 2023 - East of England A&E 4hr Wait Performance (Latest Published Data)

Trust	Attendances	Within 4 hours	Performance	Region Rank
Bedfordshire Hospitals NHS Foundation Trust	21,854	-	-	-
Cambridge University Hospitals NHS Foundation Trust	14,739	-	-	-
West Suffolk NHS Foundation Trust	6,892	-	-	-
Norfolk And Norwich University Hospitals NHS Foundation Trust	18,627	14,659	79%	1
East Suffolk And North Essex NHS Foundation Trust	23,848	17,927	75%	2
Milton Keynes University Hospital NHS Foundation Trust	12,485	9,380	75%	3
James Paget University Hospitals NHS Foundation Trust	7,796	5,678	73%	4
West Hertfordshire Teaching Hospitals NHS Trust	**14,755**	**10,538**	**71%**	**5**
Mid And South Essex NHS Foundation Trust	30,449	20,939	69%	6
North West Anglia NHS Foundation Trust	15,804	10,565	67%	7
East And North Hertfordshire NHS Trust	13,813	9,115	66%	8
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	6,953	4,517	65%	9
The Princess Alexandra Hospital NHS Trust	9,664	5,298	55%	10

Background	What the Data tells us	Issues	Actions	Mitigations
A&E 4 Hour Wait – Type 1, 2 & 3	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. • 20 trolleys in assessment area bedded • ED demand has decreased by 6% for adults and 25% for paediatrics from last month • 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 • WGH UTC flow constraints impact on ED as well as handovers at close.	• Implementation of 45 minute rapid release supported by corridor care and application of the boarding policy (16 April 2023) • Walk-in stream separated from ambulance stream to provide clearer visibility across the department and decompress bottleneck areas. Fit to sit implemented. • Additional assessment trolleys created in majors 2. • Increase use of TAM supported by senior decision makers to support flow • EAU chairs implemented • 10 x assessment spaces released from surge • Increase usage of SDEC pathways including patients actively pulled into ACU. • Phone a friend in place • Emergency medicine performance meetings focus on improvement plan • High Impact Changes work focussing on rapid clinical assessment, and UTC • Focus on weekend discharges, discharge time of day and usage of discharge lounge to enable earlier flow. • Discharge nurse employed on level 1 • Emergency medicine performance meetings focus on improvement plan	• High Impact Changes enabling increasing Senior Decision Makers in ED. • Data shows increase of initial assessment. • 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" and TAM to focus on walk in patients • 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. • 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 • Joint corridor SOP • Senior review/oversight of decisions to admit. • Harm reviews carried out for patients who wait for 12 hrs, so far this has shown no harm caused • Validation SOP in place • Hourly rounding being undertaken on all patients ensuring comfort. • If prolonged trolley wait – patients transferred to bed for comfort.

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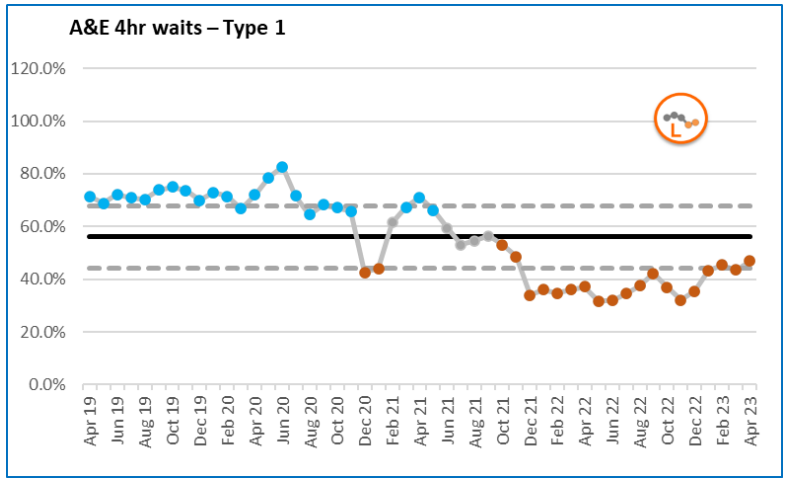
Special Cause Variation – Performance/Assurance – A&E Type 1 Performance



April 2023 - East of England A&E Type 1 4hr Wait Performance (Latest Published Data)

Trust	Attendances	Within 4 hours	Performance	Region Rank
Bedfordshire Hospitals NHS Foundation Trust	14,239	-	-	-
Cambridge University Hospitals NHS Foundation Trust	9,149	-	-	-
West Suffolk NHS Foundation Trust	6,245	-	-	-
Mid And South Essex NHS Foundation Trust	28,358	18,916	67%	1
James Paget University Hospitals NHS Foundation Trust	6,334	4,216	67%	2
Norfolk And Norwich University Hospitals NHS Foundation Trust	10,558	6,594	62%	3
Milton Keynes University Hospital NHS Foundation Trust	7,683	4,770	62%	4
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	6,082	3,646	60%	5
North West Anglia NHS Foundation Trust	11,464	6,735	59%	6
East Suffolk And North Essex NHS Foundation Trust	13,415	7,548	56%	7
The Princess Alexandra Hospital NHS Trust	9,664	5,298	55%	8
West Hertfordshire Teaching Hospitals NHS Trust	**7,388**	**3,465**	**46.9%**	**9**
East And North Hertfordshire NHS Trust	8,629	3,937	46%	10

Background	What the Data tells us	Issues	Actions	Mitigations
A&E 4hr Waits – Type 1	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. • 20 trolleys in assessment area bedded • ED demand has decreased by 6% for adults and 25% for paediatrics from last month • 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 • WGH UTC flow constraints impact on ED as well as handovers at close.	• Implementation of 45 minute rapid release supported by corridor care and application of the boarding policy (16 April 2023) • Walk-in stream separated from ambulance stream to provide clearer visibility across the department and decompress bottleneck areas. Fit to sit implemented. • Additional assessment trolleys created in majors 2. • Increase use of TAM supported by senior decision makers to support flow • EAU chairs implemented • 10 x assessment spaces released from surge • Increase usage of SDEC pathways including patients actively pulled into ACU. • Phone a friend in place • Emergency medicine performance meetings focus on improvement plan • High Impact Changes work focussing on rapid clinical assessment, and UTC • Focus on weekend discharges, discharge time of day and usage of discharge lounge to enable earlier flow. • Discharge nurse employed on level 1 • Emergency medicine performance meetings focus on improvement plan	• High Impact Changes enabling increasing Senior Decision Makers in ED. • Data shows increase of initial assessment. • 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" and TAM to focus on walk in patients • 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. • 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 • Joint corridor SOP • Senior review/oversight of decisions to admit. • Harm reviews carried out for patients who wait for 12 hrs, so far this has shown no harm caused • Validation SOP in place • Hourly rounding being undertaken on all patients ensuring comfort. • If prolonged trolley wait – patients transferred to bed for comfort.

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KPI	Latest month	Measure	Target	Variation	Assurance	Local or National Metric	Committee	Owner
Caring & Responsive Services - RTT, Cancer, Outpatients								
Referral to Treatment - Incomplete	Apr 23	57%	92%	L	F	National	F&P	COO
Referral to Treatment - 52 week waits - Incomplete	Apr 23	2695	-	H		Local	F&P	COO
Referral to Treatment - 65 week waits - Incomplete	Apr 23	529	-	H		Local	F&P	COO
Referral to Treatment - 78 week waits - Incomplete	Apr 23	28	0	L	F	National	F&P	COO
Diagnostic (DM01) <6 weeks	Apr 23	64%	99%	L	F	National	F&P	COO
Cancer - Two week wait	Apr 23	74%	93%		?	National	F&P	COO
Cancer - Breast Symptomatic two week wait	Apr 23	79%	93%		?	National	F&P	COO
Cancer - 28 day waits (faster diagnosis standard)	Apr 23	76%	75%		?	National	F&P	COO
Cancer - 31 Day First	Apr 23	97%	96%		?	National	F&P	COO
Cancer - 31 day subsequent drug	Apr 23	100%	98%		?	National	F&P	COO
Cancer - 31 day subsequent surgery	Apr 23	88%	94%		?	National	F&P	COO
Cancer - 62 day	Apr 23	64%	85%	L	?	National	F&P	COO
Cancer - 62 day screening	Apr 23	90%	90%		?	Local	F&P	COO
Cancer 104+ day waits	Apr 23	46	-	H		Local	F&P	COO
Cancer 62+ Day Waits	Apr 23	172	-			Local	F&P	COO
Outpatient cancellation rate within 6 weeks	Apr 23	6%	5%	L	?	Local	F&P	CIO
Outpatient DNA rate	Apr 23	8%	8%	L	?	Local	F&P	CIO

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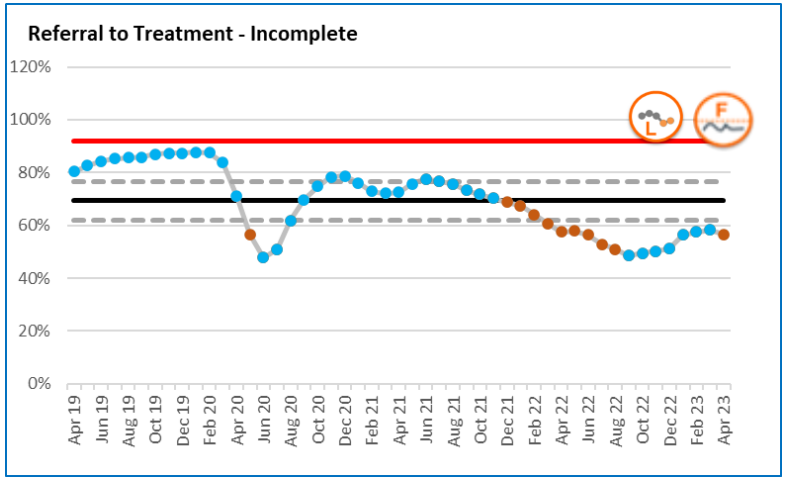
Special Cause Variation – Performance/Assurance – Referral to Treatment - Incomplete



Trust	Nov-21	Dec-21	Jan-22	Nov-22	Jan-23	Feb-23
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	18,435	19,093	19,366	65.0%	64.1%	64.4%
West Suffolk NHS Foundation Trust	24,184	24,641	24,919	64.7%	61.9%	61.0%
East Suffolk And North Essex NHS Foundation Trust	66,916	63,958	65,165	61.3%	58.6%	58.0%
Cambridge University Hospitals NHS Foundation Trust	50,696	51,087	51,370	58.6%	57.5%	57.7%
West Hertfordshire Hospitals NHS Trust	**28,996**	**32,773**	**36,067**	**50.2%**	**56.4%**	**57.5%**
Bedfordshire Hospitals NHS Foundation Trust	66,189	67,922	70,046	57.8%	56.8%	55.2%
North West Anglia NHS Foundation Trust	59,508	59,698	59,235	57.1%	55.1%	54.8%
James Paget University Hospitals NHS Foundation Trust	16,084	16,570	16,544	52.6%	52.6%	53.5%
Mid And South Essex NHS Foundation Trust	119,596	121,464	124,177	54.0%	51.9%	52.7%
East And North Hertfordshire NHS Trust	53,288	49,485	48,229	53.9%	50.9%	50.9%
The Princess Alexandra Hospital NHS Trust	26,196	27,081	27,688	50.5%	50.3%	50.7%
Norfolk And Norwich University Hospitals NHS Foundation Trust	75,221	75,546	75,385	48.2%	48.0%	49.0%
Milton Keynes University Hospital NHS Foundation Trust	33,312	33,004	33,288	48.6%	46.3%	47.4%

***Latest available published RTT data – February 2023**

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 below the mean (a shift) Exception triggered due to a breach of the lower control limit	Although EPR has been in place for over a year, errors to affect the RTT PTL in a number of ways, artificially inflating the PTL size, as capturing the correct outcomes results in fewer clock stops and the number of open pathways on the PTL. Loss of activity as a result of the junior doctors' industrial action, has impacted the number of clock stops. The external validation support that was in place to the end of March has ended. This has coincided with long term sickness within the trust validation team, where a number of posts remain vacant despite several rounds of recruitment.	Outsourcing programme remains active with reasonable patient uptake. Additional sessions are being undertaken but there is less uptake than pre COVID. Operational recovery group oversight of activity delivery DQ steering group established to lead on improvement work. Funds identified to enable a small number of external validators utilising monies from vacancies put in place. There are insufficient validation resources to maintain the pace of validation required to manage the PTL appropriately. A review of the service, with an options appraisal for future form is underway.	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.

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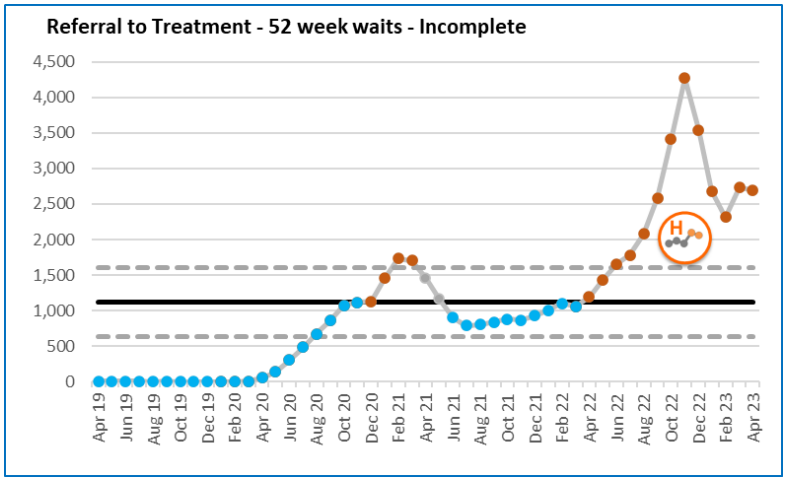
Special Cause Variation – Performance – Referral to Treatment – 52 weeks - Incomplete



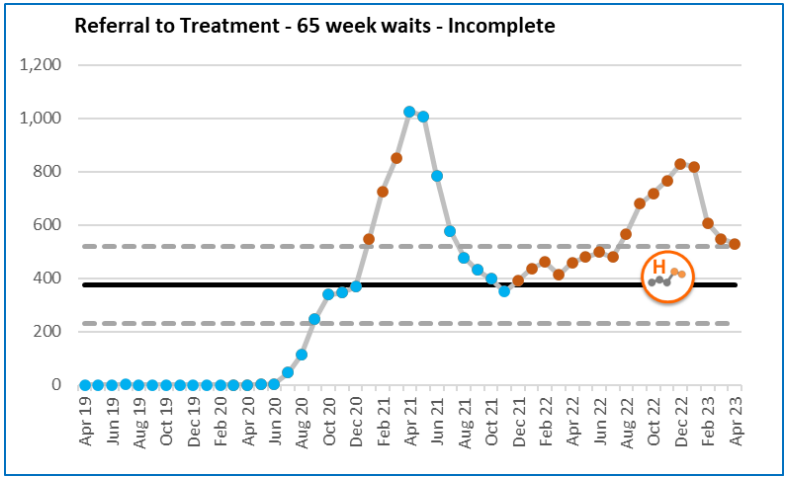
***Latest available published RTT data – March 2023**

52 week waits	
Trust	**Mar-23**
Bedfordshire Hospitals NHS Foundation Trust	4,322
Cambridge University Hospitals NHS Foundation Trust	3,564
East And North Hertfordshire NHS Trust	4,794
East Suffolk And North Essex NHS Foundation Trust	3,801
James Paget University Hospitals NHS Foundation Trust	1,933
Mid And South Essex NHS Foundation Trust	9,985
Milton Keynes University Hospital NHS Foundation Trust	2,119
Norfolk And Norwich University Hospitals NHS Foundation Trust	8,818
North West Anglia NHS Foundation Trust	3,992
The Princess Alexandra Hospital NHS Trust	1,870
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	559
West Hertfordshire Hospitals NHS Trust	**2,721**
West Suffolk NHS Foundation Trust	1,255

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	Although EPR has been in place for over a year, errors to affect the RTT PTL in a number of ways, artificially inflating the PTL size, as capturing the correct outcomes results in fewer clock stops and the number of open pathways on the PTL. The external validation support that was in place to the end of March has ended. This has coincided with long term sickness within the trust validation team, where a number of posts remain vacant despite several rounds of recruitment.	Outsourcing programme remains active with reasonable patient uptake. Additional sessions are being undertaken but there is less uptake than pre COVID. Operational recovery group oversight of activity delivery DQ steering group established to lead on improvement work. Funds identified to enable a small number of external validators utilising monies from vacancies put in place. These validators have continued to focus on long waits. There are insufficient validation resources to maintain the pace of validation required to manage the PTL appropriately. A review of the service, with an options appraisal for future form is underway.	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.

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance – Referral to Treatment – 65 weeks - Incomplete



Background	What the Data tells us	Issues	Actions	Mitigations
Referral to Treatment – 65 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	Although EPR has been in place for over a year, errors to affect the RTT PTL in a number of ways, artificially inflating the PTL size, as capturing the correct outcomes results in fewer clock stops and the number of open pathways on the PTL. The external validation support that was in place to the end of March has ended. This has coincided with long term sickness within the trust validation team, where a number of posts remain vacant despite several rounds of recruitment	Outsourcing programme remains active with reasonable patient uptake. Additional sessions are being undertaken but there is less uptake than pre COVID. Operational recovery group oversight of activity delivery DQ steering group established to lead on improvement work. Funds identified to enable a small number of external validators utilising monies from vacancies put in place. These validators have continued to focus on long waits. There are insufficient validation resources to maintain the pace of validation required to manage the PTL appropriately. A review of the service, with an options appraisal for future form is underway.	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.

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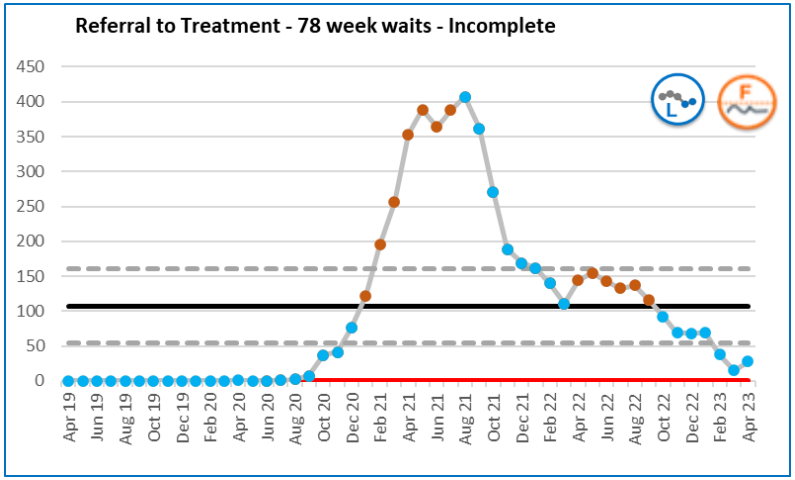
Special Cause Variation – Performance – Referral to Treatment – 78 weeks - Incomplete



*Latest available published RTT data – March 2023

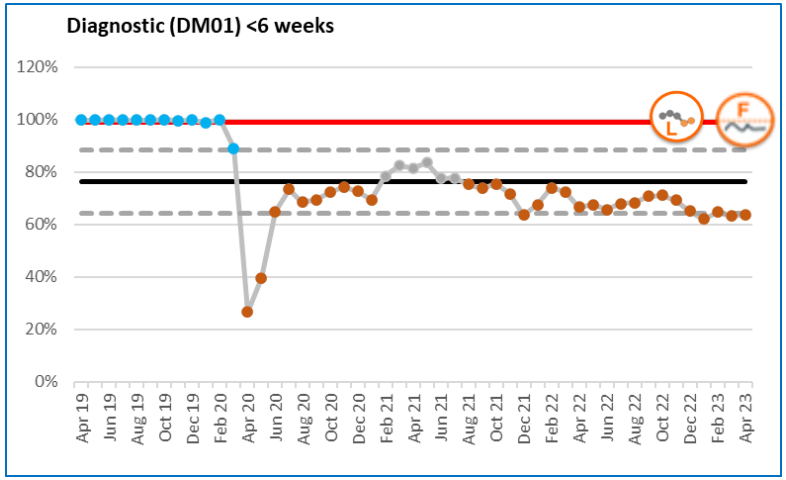
78 Week Waits

Trust	Mar-23
Bedfordshire Hospitals NHS Foundation Trust	7
Cambridge University Hospitals NHS Foundation Trust	100
East And North Hertfordshire NHS Trust	405
East Suffolk And North Essex NHS Foundation Trust	262
James Paget University Hospitals NHS Foundation Trust	135
Mid And South Essex NHS Foundation Trust	20
Milton Keynes University Hospital NHS Foundation Trust	20
Norfolk And Norwich University Hospitals NHS Foundation Trust	175
North West Anglia NHS Foundation Trust	4
The Princess Alexandra Hospital NHS Trust	14
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	5
West Hertfordshire Hospitals NHS Trust	**15**
West Suffolk NHS Foundation Trust	73

Background	What the Data tells us	Issues	Actions	Mitigations
Referral to Treatment – 78 weeks incomplete	Exception triggered due to a breach of the lower control limit Exception triggered due to 7+ data points below the mean (a shift) Exception triggered due to the target being below the lower control limit	Human error with incorrect pathway clock stops is a known factor in PTL management and has resulted in a number of long wait pathway late additions to the waiting list. These have often exceeded the target waiting time at the point of appearing on the waiting list and little can be done to address the wait time, although action is taken to ensure timely treatment under these circumstances. Some outpatient reviews resulted in patients being listed for surgery, with little time to organise treatment before the March deadline.	Weekly Access and long waits review meetings are maintaining the zero forecast position. Daily validation (by the Director of Performance), with support from the RTT validation team to ensure grip and control, with actions to divisions and thematic feedback/lessons learned. Progress for each at risk pathway is tracked at the weekly long wait review meetings. This has ensured robust planning is in place and that all opportunities were taken to offer treatment dates to patients within the desired timeframes.	Continuous horizon scanning for additional outsourcing opportunities, with specialty level engagement to ensure quality and safety as well as timely pathways.

West Hertfordshire Hospitals NHS Trust

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



***Latest available benchmarking data – Diagnostic Wait Times – March 2023**

Trust	Mar-23
East Suffolk And North Essex NHS Foundation Trust	94.4%
Milton Keynes University Hospital NHS Foundation Trust	84.5%
The Princess Alexandra Hospital NHS Trust	76.4%
James Paget University Hospitals NHS Foundation Trust	76.0%
Mid And South Essex NHS Foundation Trust	69.2%
North West Anglia NHS Foundation Trust	67.3%
Bedfordshire Hospitals NHS Foundation Trust	66.2%
Cambridge University Hospitals NHS Foundation Trust	65.6%
West Suffolk NHS Foundation Trust	64.5%
West Hertfordshire Hospitals NHS Trust	**63.1%**
Norfolk And Norwich University Hospitals NHS Foundation Trust	62.7%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	61.6%
East And North Hertfordshire NHS Trust	58.0%

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 Exception triggered due to a breach of the lower control limit	Overall performance is impacted by significant under-performance in 4 modalities – DEXA, Echo, Audiology and Cystoscopy. The cystoscopy PTL includes a number of DQ problems, particularly the inclusion of purely therapeutic procedures, as well as planned and duplicate pathways, the combination having a significant effect on performance. Echo is constrained by workforce issues and increased demand. DEXA also is challenged with workforce issues and loss of capacity from an outsourcing provider who paused activity last year	The cystoscopy PTL is currently under review with the BI team and a solution being pursued based on advice from the national team. Audiology outsourcing to start June/July and DEXA outsourcing capacity to increase when the former provider re-starts activity in June/July Echo ad hoc sessions have been approved by ORG and validation of the waiting list is underway by the new clinical lead.	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.

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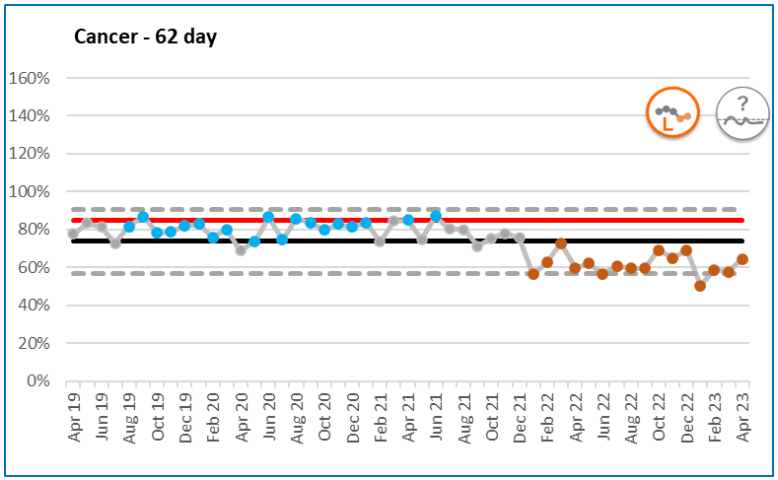
Special Cause Variation – Performance – Cancer 62 Day



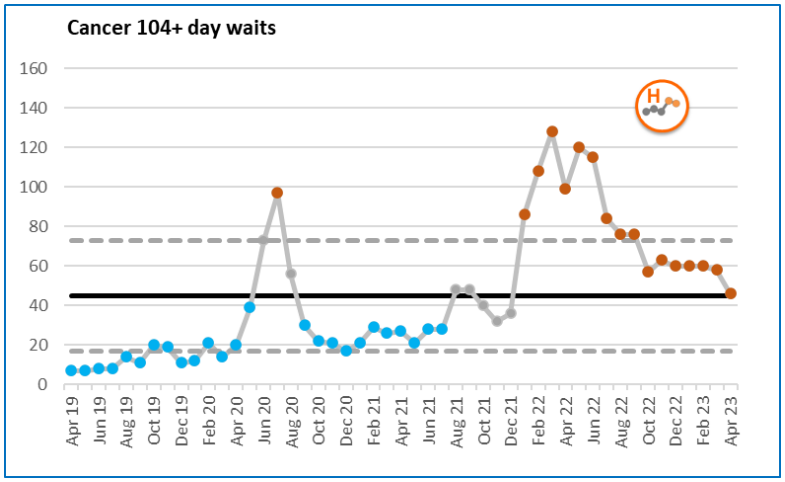
*Latest available benchmarking data – Cancer Waiting Times – March 2023

Provider name	Mar 23
EAST AND NORTH HERTFORDSHIRE NHS TRUST	87.1%
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	76.3%
WEST SUFFOLK NHS FOUNDATION TRUST	74.5%
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	70.3%
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	69.2%
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	64.4%
BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	61.6%
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	60.8%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	**57.0%**
MID AND SOUTH ESSEX NHS FOUNDATION TRUST	54.6%
NORTH WEST ANGLIA NHS FOUNDATION TRUST	53.8%
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	52.7%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	51.8%
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	47.9%

Background	What the Data tells us	Issues	Actions	Mitigations
Cancer – 62 Day Waits – Referral to 1st Treatment	Exception triggered due to 7+ data points below the mean (a shift)	Performance continues to be non-compliant. A number of factors contribute to non-compliant 62 day performance: increase in demand, insufficient capacity for diagnostics owing to a mismatch between increased demand and baseline capacity. Although cancer patients were prioritised during the recent strikes, overall capacity was compromised.	Patients are tracked bi weekly, New escalation process in place and weekly huddle meetings for each tumour type to ensure early sight of issues and improve communication. Performance reviewed in Access weekly meetings. All services are working on improvements – Cancer Improvement Steering Group being established to provide oversight and additional resource for delivery of improvements. Long Waiters Reviews now beginning at 40 days across all specialties. As PTL size decreases this will be reviewed.	All patients who are treated after Day 62 will be subject to a Clinical Harm Review

West Hertfordshire Hospitals NHS Trust

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, complex pathways (where elements are with another provider) and some difficulty with patient engagement (making contact, patient thinking time and diagnostic uncertainty) 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. Weekly huddle meetings in place across all services. Plans in place for every patient >100 – service and clinical lead for each service to own these plans and will be monitored against these separately to reduce this number. Expanding NSS pathway to internal referrals to expedite the diagnosis of patients who have had site specific (e.g. GI) cancer excluded.	Clinical review is requested by MDT trackers as they track patients and escalated as necessary using new escalation process. CNS support requested as needed to support re. patient engagement. Any patient found to have cancer will be subject to a clinical harm review after treatment.

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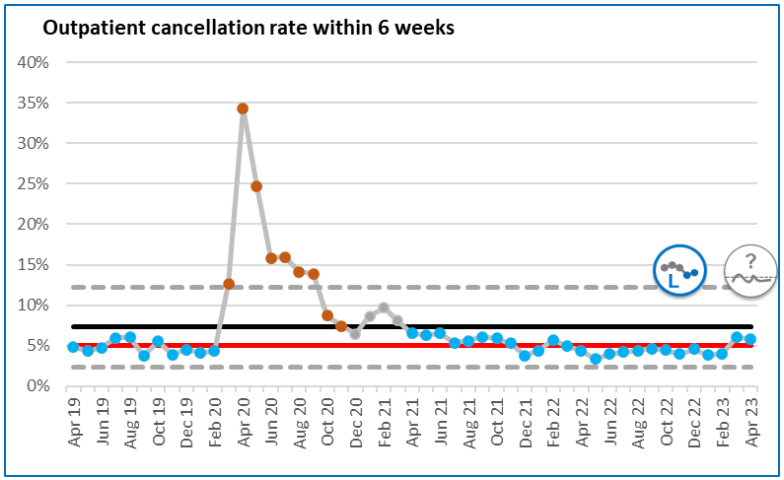
Special Cause Variation – Performance – Outpatient cancellation rate within 6 weeks



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

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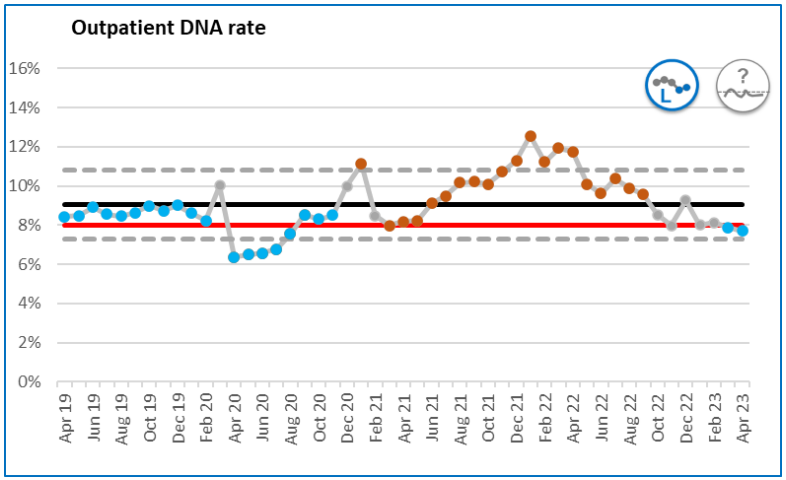
Special Cause Variation – Performance – Outpatient DNA Rate



Background	What the Data tells us	Issues	Actions	Mitigations
Outpatient cancellation rates within 6 weeks	Exception triggered due to 2 of 3 most recent data points being near the lower control limit			

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KPI	Latest month	Measure	Target	Variation	Assurance	Local or National Metric	Committee	Owner
Well-Led Services - Workforce Metrics								
Staff Turnover rate (Rolling 12 months)	Apr 23	14.6%	13.0%	H	F	Local	PerC	CPO
% staff leaving within first year (excluding medics and fixed term contracts)	Apr 23	16.5%	-			Local	PerC	CPO
Vacancy rate	Apr 23	7.4%	10.0%	L	?	Local	PerC	CPO
Sickness rate	Apr 23	3.7%	3.5%		?	Local	PerC	CPO
Appraisal rate (Total)	Apr 23	89.0%	90.0%	L	F	Local	PerC	CPO
Mandatory Training	Apr 23	90.5%	90.0%	L	P	Local	PerC	CPO
% Bank Pay	Apr 23	11.9%	12.0%		?	Local	PerC	CPO/CFO
% Agency Pay	Apr 23	3.8%	3.7%		?	Local	PerC	CPO/CFO
WTE Workforce Establishment	Apr 23	5478.8	5506.0	H	F	Local	PerC	CPO
WTE Staff in Post	Apr 23	5075.0	5152.0	H	F	Local	PerC	CPO
BAME Staff in Post	Apr 23	48%	-	H		Local	PerC	CPO
BAME Staff in Post - Band 8a+	Apr 23	2%	-	H		Local	PerC	CPO
Apprenticeship Levy Spend	Apr 23	33%	65%	H	F	Local	PerC	CPO

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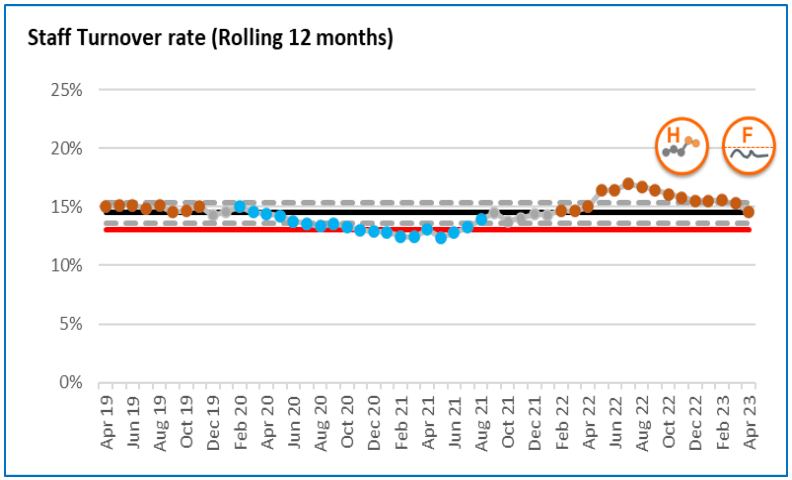
Special Cause Variation – Performance – Staff Turnover rate (rolling 12 months)



TURNOVER RATE

Trust	Turnover Q1 21/22	Turnover Q2 21/22	Turnover Q3 21/22	Turnover Q4 21/22	Turnover Q1 22/23	Turnover Q2 22/23	Q2 22/23 Ranking (current)	Change Q1 to Q2
Bedford Hospitals	14.9%	14.1%	15.1%	15.1%	16.1%	15.9%	7	↘
Herts Community	11.7%	12.9%	17.8%	18.8%	19.4%	15.0%	6	↘
WHTH	12.7%	14.5%	14.4%	14.1%	16.4%	16.4%	8	→
East & North Herts	11.2%	12.8%	13.7%	14.1%	13.2%	12.1%	2	↘
HPFT	19.7%	19.5%	12.8%	12.8%	13.6%	14.3%	5	↗
ELF Bedford MH	16.8%	5.6%	5.6%	4.6%	18.3%	19.6%	12	↗
ELF Luton MH	9.4%	6.0%	6.0%	5.2%	17.8%	12.6%	3	↘
ELF Bedford Community	12.4%	3.8%	3.8%	3.7%	16.5%	14.2%	4	↘
Princess Alexandra	11.0%	12.9%	14.6%	15.8%	17.3%	17.6%	10	↗
Essex Partnership UT	9.5%	10.0%	10.0%	10.7%	11.8%	11.0%	1	↘
Milton Keynes UFT	7.6%	8.2%	9.3%	11.9%	14.5%	16.9%	9	↗
Central North West London FT	14.4%	13.4%	15.6%	17.7%	18.0%	18.4%	11	↗
Average	12.6%	11.1%	11.6%	12.0%	16.1%	15.3%		

Background	What the Data tells us	Issues	Actions	Mitigations
Staff Turnover rate (Rolling 12 months)	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 since early 2022. However, the current rate has decreased over the last four months from 17% to 14.6%, and from 20% to 16.5% for those leaving within the first 12 months The rates are highest in Clinical Support, EM and WACS areas, approaching 20%, and lowest in Medicine and Surgery. Staff Groups with highest rates continue to be HCA's, support staff, 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, in part, by the proximity to London.	The first recruitment and retention meeting group has been held, and will be run every six weeks. The membership includes broad representation across all Divisions, targeting the areas with significant challenges. The People Promise programme has been extended for a 2nd year and whilst we will continue to work on the new joiner experience, there will be significant focus on flexible working, career progression and development, and first line manager support. The wellbeing strategy has been developed collaboratively and will be launched following final feedback is received.	WACS Away day run for senior leads in maternity. Weekly R&R meetings in place EM providing extended local induction and pastoral care for new qualified Band 5 Flexible working task and finish group to be established.

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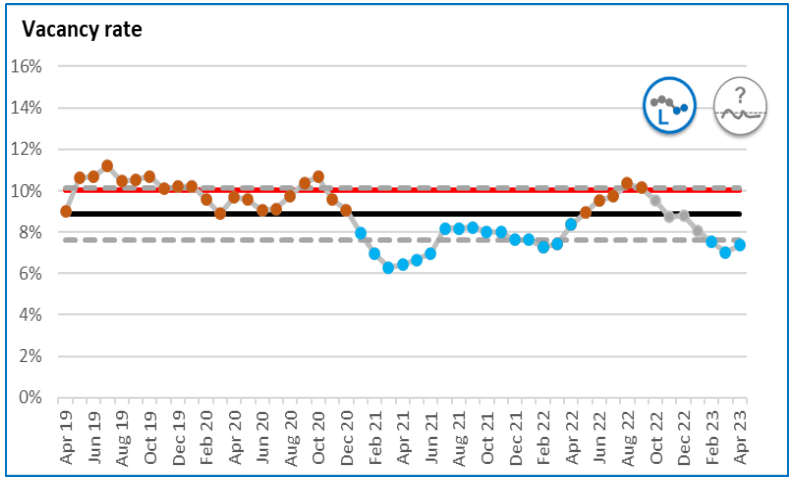
Special Cause Variation – Performance – Vacancy rate



VACANCY RATE

Trust	Vacancy Q4 21/22	Vacancy Q1 22/23	Vacancy Q2 22/23	Vacancy Q3 22/23	Vacancy Q4 22/23	Q3 22/23 Ranking (current)	Q4 22/23 Ranking (current)	Change Q3 to Q4
Bedfordshire Hospitals	9.4%	10.8%	10.9%	9.7%	12.4%	7	9	↗
Herts Community	8.0%	8.3%	8.1%	6.9%	4.6%	2	1	↘
WHTH	7.6%	8.9%	10.1%	8.8%	6.7%	3	2	↘
East & North Herts	6.6%	5.0%	9.5%	9.1%	9.1%	5	4	→
HPFT	14.1%	14.0%	14.1%	14.4%	11.8%	10	8	↘
ELF Bedford MH	11.2%	18.1%	18.5%	16.9%	16.3%	12	12	↘
ELF Luton MH	21.6%	26.2%	18.1%	11.7%	16.0%	9	11	↗
ELF Bedford Community	16.5%	10.7%	10.7%	9.0%	10.9%	4	7	↗
Princess Alexandra	6.1%	9.9%	10.3%	10.4%	9.9%	8	5	↘
Essex Partnership UT	8.5%	10.8%	8.3%	5.0%	10.0%	1	6	↗
Milton Keynes UFT	8.1%	11.1%	10.9%	9.4%	7.4%	6	3	↘
Central North West London FT	14.5%	13.4%	15.6%	14.9%	12.5%	11	10	↘
Average	11.0%	12.3%	12.1%	10.5%	10.6%			↗

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

Background	What the Data tells us	Issues	Actions	Mitigations
Vacancy Rate	Exception triggered due to a breach of the lower control limit.	Vacancies have decreased over 22/23 due to continued recruitment and focus on reducing long term vacant posts and helping to offset agency use. The numbers of vacancies has reduced from 550 to 403 currently (7.4% against a target of 10%). Over the last 12 months, the numbers of staff in post has increased by 223 wte. The funded establishment has increased by 151 wte. Continued recruitment will continue to reduce vacancy levels. The Trust is ranked 2 / 12 in terms of lowest % of vacancies.	Continued recruitment from abroad. Aligning and reviewing establishment across the Trust mapping against long term vacant post with no activity. Winter preparedness meeting scheduled in June looking at key themes such as staffing requirements, surge areas, accurate demand management and how we support nurse redeployments. Candidate attraction recruitment specialist business case developed Proactive management of Consultant recruitment	Oversea recruitment funding Consideration of over establishing Succession planning Ongoing monitoring of all workforce KPIs

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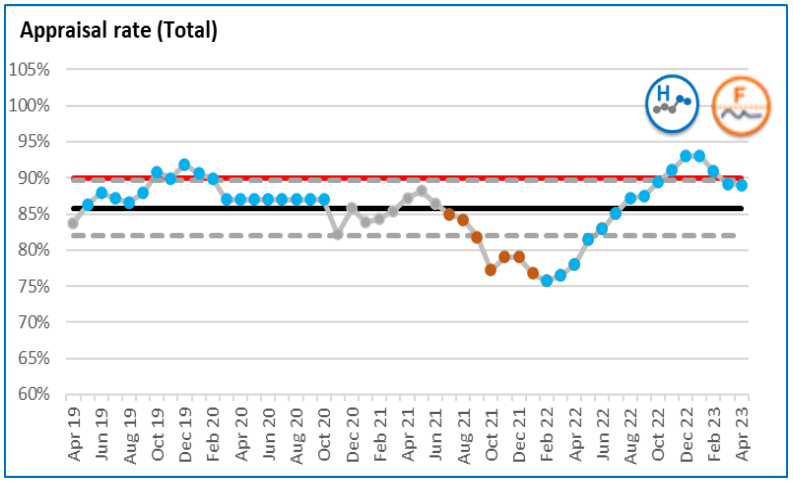
Special Cause Variation – Performance/Assurance – Appraisal Rate



APPRAISAL RATE COMPLIANCE

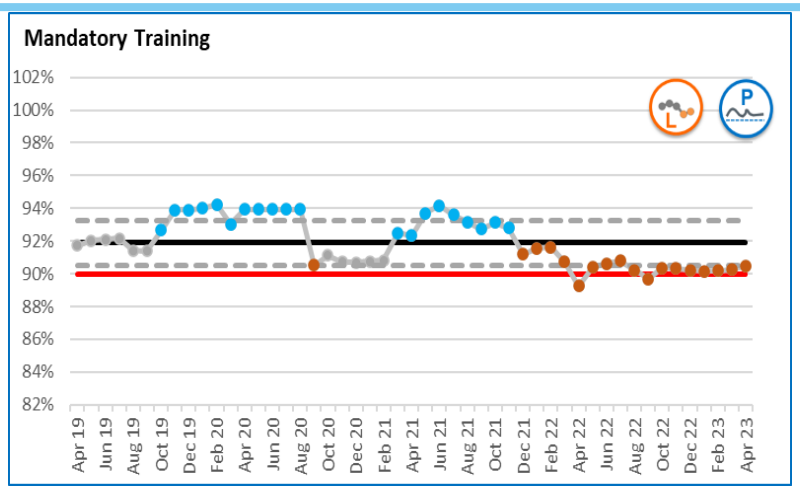
Trust	Appraisal Rate Q4 21/22	Appraisal Rate Q1 22/23	Appraisal Rate Q2 22/23	Appraisal Rate Q3 22/23	Appraisal Rate Q4 22/23	Q3 22/23 Ranking (current)	Q4 22/23 Ranking (current)	Change Q3 to Q4
Bedfordshire Hospitals	67%	67%	69%	70%	70%	8	8	↗
Herts Community	64%	76%	78%	82%	85%	6	5	↗
WHTH	79%	83%	87%	93%	89%	1	2	↘
East & North Herts	46%	37%	57%	64%	66%	9	9	↗
HPFT	72%	85%	84%	85%	86%	3	3	↗
ELF Bedford MH	31%	31%	23%	23%	23%	10	10	→
ELF Luton MH	33%	29%	29%	23%	23%	10	10	→
ELF Bedford Community		49%	49%	23%	23%	10	10	→
Princess Alexandra	79%	79%	80%	83%	84%	5	6	↗
Essex Partnership UT	59%	59%	77%	79%	78%	7	7	↘
Milton Keynes UFT	92%	88%	91%	92%	91%	2	1	↘
Central North West London FT	81%	84%	91%	84%	86%	4	3	↗
Average	64%	64%	68%	67%	67%			↗

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

Background	What the Data tells us	Issues	Actions	Mitigations
Appraisal Rate	Exception triggered due a run of 7+ data points above the mean (a shift) Exception triggered due to the upper control limit being below the target	Following concerted efforts to improve this, the rate rose above 90%, and are now reduced slightly at 89%. This is partly due to recent Industrial Action. 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 2 / 12 as at Q4 22/23, even with the lower rate currently reported	Divisional plans remain in place, and being monitored on a weekly basis to remain above the 90% target. Weekly rates of above 90% have been maintained for over 8 weeks. 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.	Cleansing for ESR data to ensure accuracy Encouraging career development conversations outside the appraisal through out the year. The next priority is to get the appraisal system to be put on acorn to support completion

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance/Assurance – Mandatory Training



MANDATORY TRAINING COMPLIANCE

Trust	Mandatory Training Rate Q4 21/22	Mandatory Training Rate Q1 22/23	Mandatory Training Rate Q2 22/23	Mandatory Training Rate Q3 22/23	Mandatory Training Rate Q4 22/23	Q3 22/23 Ranking (current)	Q4 22/23 Ranking (current)	Change Q3 to Q4
Bedfordshire Hospitals	77%	80%	82%	83%	84%	12	9	↗
Herts Community	95%	92%	95%	94%	95%	1	1	↗
WHTH	91%	91%	90%	90%	91%	5	4	↗
East & North Herts	87%	88%	87%	84%	87%	9	8	↗
HPFT	89%	91%	92%	93%	90%	3	5	↘
ELF Bedford MH	85%	82%	83%	83%	78%	11	12	↘
ELF Luton MH	84%	84%	85%	84%	79%	9	11	↘
ELF Bedford Community	84%	81%	85%	87%	83%	7	10	↘
Princess Alexandra	86%	86%	86%	85%	88%	8	6	↗
Essex Partnership UT	78%	78%	84%	89%	88%	6	6	↘
Milton Keynes UFT	94%	95%	92%	94%	94%	1	2	→
Central North West London FT	94%	94%	93%	92%	93%	4	3	↗
Average	87%	87%	88%	88%	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 above the mean	The mandatory training rate continued to consistently achieve 90%, from 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. Divisions showing rates just below 90% are Surgery, WACS and Emergency Medicine.	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 4 / 12 compared to nearby NHS organisations as at Q4 22/23.	There is a continued focus on specific subjects to maintain compliance and ensure this is above the 90% target. Managers reminded that colleagues have protected time to complete Increase capacity for class room based session across all three sites.

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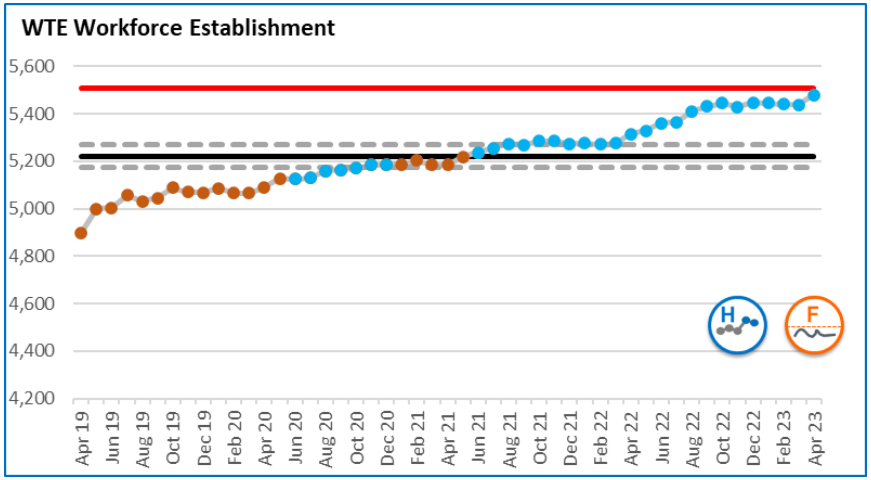
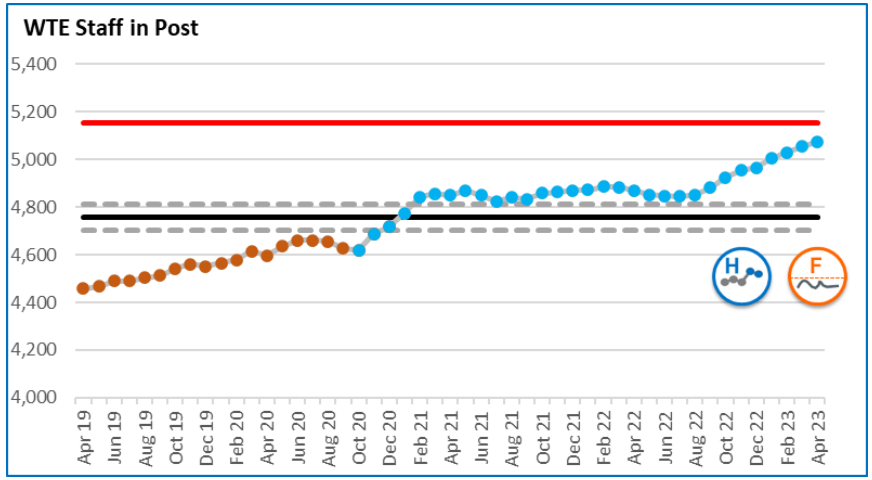
Special Cause Variation – Performance/Assurance – WTE Staff Establishment/WTE Staff in Post





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 5,506 wte by March 2024. The business case for the wte staff in post figures is 5,152 wte in post by March 2024.	The current workforce establishment at is 5,478 wte against a target of 5,506 wte by March 24. The current establishment may increase over the next few months as business cases involving staff are approved. Establishment review to take place, HRBPs to work with divisional finance manager to ensure accuracy of establishment . For staffing wte, the current in post figure is 5,075 against a target of 5,152 wte by March 24. There has been a significant upturn in recruitment over the last year to help enable staff in post wte to increase to meet the increased staffing requirements and help offset bank and agency expenditure, and this will continue.	Continued recruitment for permanent staff will continue to offset agency usage. Divisional finance reviews taking place monthly. Winter preparedness meeting To agree CIPs that may impact

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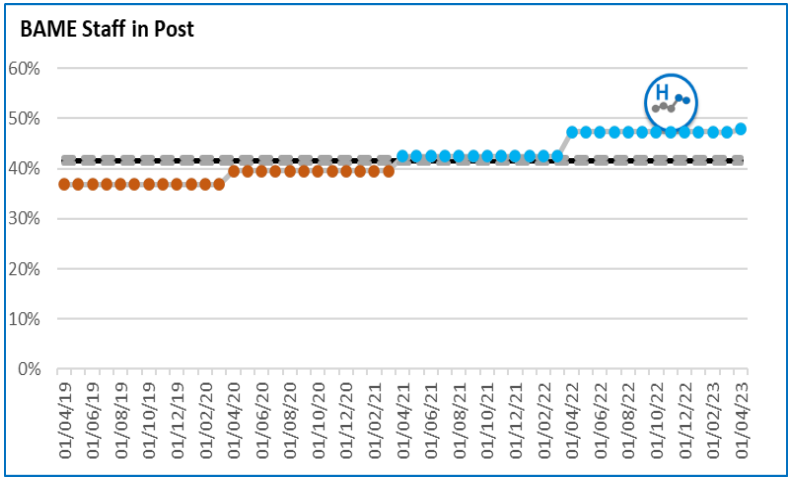
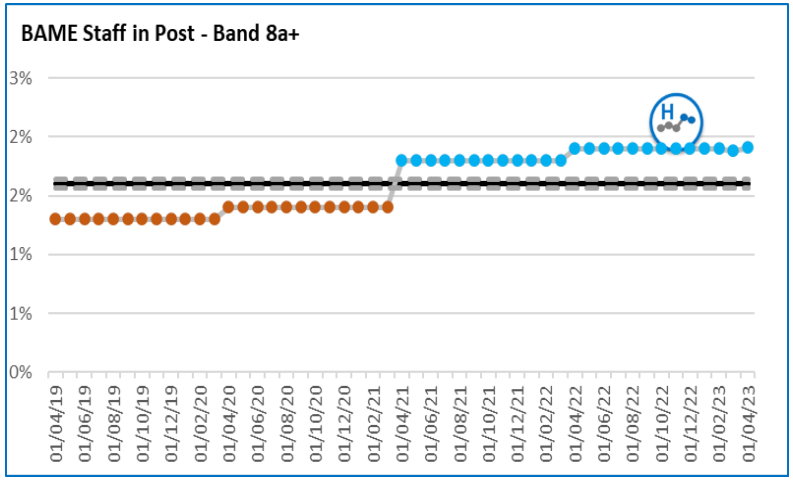
Special Cause Variation – Performance – BAME Staff in Post

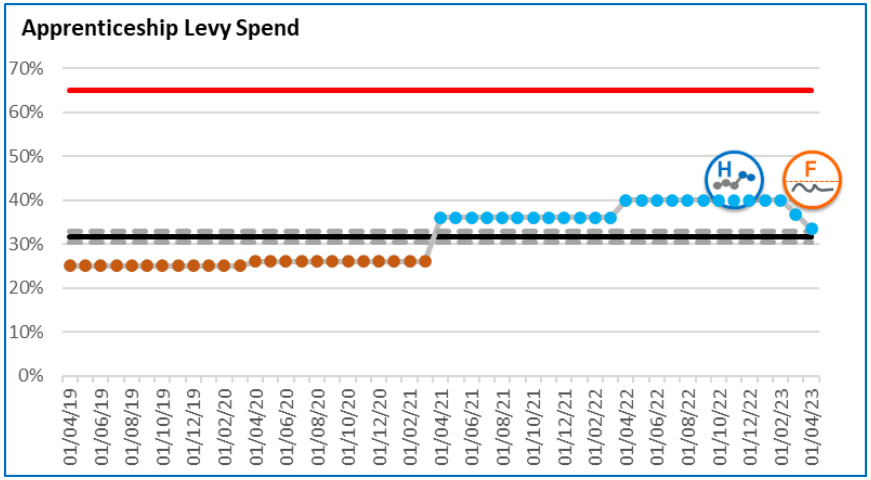




Background	What the Data tells us	Reasons	Actions	Mitigations
BAME staff in post/BAME Staff in post – Band 8a+	Exception triggered due to 7+ data points above the mean Exception triggered due to a breach of the upper control limit	The numbers of BAME staff as a % of the workforce has increased over time due to changing recruitment. In 2019 BAME staff were 36.1% of staff, 39.55 in 2020, The figure for April 23 is 47.9% The % of BAME staff at Band 8A+ is currently 1.9% against 4.3% for White staff.	The Trust has recruited significant numbers of Registered Nursing staff from abroad, and this now reflects the increase proportion of BAME staff. Further development around KPIs relating to the number of BAME colleagues in Senior posts (8a and above) Value based recruitment practices being implemented including mandatory inclusive panel representation All HR processes are being reviewed to ensure fairness, parity of experience and adequate support is provided to all. All Triage panels are now inclusive	Active staff network EDI steering group EDI dashboard developed to track key indicators

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance – Apprenticeship Levy Spend



Background	What the Data tells us	Reasons	Actions	Mitigations
Apprenticeship Levy Spend	Exception triggered due to a run of 7+ data points above the mean Exception triggered due to the target being above the upper control limit	The target for the apprenticeship levy spend is 65% for 23/24.Each financial year resets the % figure and this will increase over 23/24 to achieve the 65% target	- Reinstating the Apprenticeship Oversight Group quarterly - Created a wide stretching engagement plan 2023/24 aligned with the strategic objectives and priorities - New website being designed to act as a 'one stop shop' for career development opportunities and information - Monthly senior leadership bulletins - Engaging with hard to recruit areas such as Estates and IT - Expiration of direct entry apprenticeships - Applications via ICS portal, to enable improved reporting and data capture e.g. EDI - Promoting upcoming Apprenticeships via E-update and bespoke emails/ QR posters e.g. Leadership, Project Management, NHS Data Citizen etc - Currently offer monthly assessments for Maths & English, applicants can register online to complete. - Attending HRBP's Divisional Performance meetings monthly - Attending Staff Network meetings	Academy Portal user guides for managers and applicants created Linked with West Herts College to provide face to face Maths & English (Functional Skills) – The Trust offers an online programme for applicants who require entry level Maths & English for higher apprenticeships.

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KPI	Latest month	Measure	Target	Variation	Assurance	Local or National Metric	Committee	Owner
Activity Metrics								
GP Referrals Made	Apr 23	5809	-			Local	F&P	COO
A&E Attendances	Apr 23	14755	-			Local	F&P	COO
1st Outpatient Appointments - All	Apr 23	10188	-			Local	F&P	CIO
1st Outpatient Appointments - Face to Face	Apr 23	9667	-			Local	F&P	CIO
Follow Up Outpatient Appointments - All	Apr 23	13836	-			Local	F&P	CIO
Follow Up Outpatient Appointments - Face to Face	Apr 23	10400	-			Local	F&P	CIO
Specific Acute Elective Ordinary Admissions	Apr 23	351	-			Local	F&P	COO
Specific Acute Daycases	Apr 23	2950	-			Local	F&P	COO
Specific Acute Non-Elective Admissions - 0 LOS	Apr 23	1424	-			Local	F&P	COO
Specific Acute Non-Elective Admissions - +1 LOS	Apr 23	3065	-			Local	F&P	COO
Completed Admitted RTT Pathways (Clock Stops)	Apr 23	827	-			Local	F&P	COO
Completed Non-Admitted RTT Pathways (Clock Stops)	Apr 23	4212	-			Local	F&P	COO
New RTT Pathways (Clock Starts)	Apr 23	9133	-			Local	F&P	COO
PTL Volume	Apr 23	56959	-			Local	F&P	COO
Theatre Utilisation (Touch time utilisation on the day hours planned inc early starts and late finishes)	Apr 23	76%	85%			Local	F&P	COO

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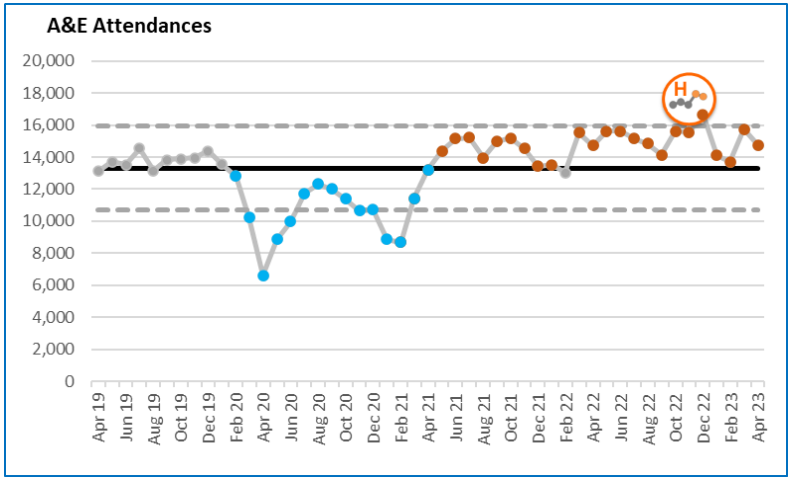
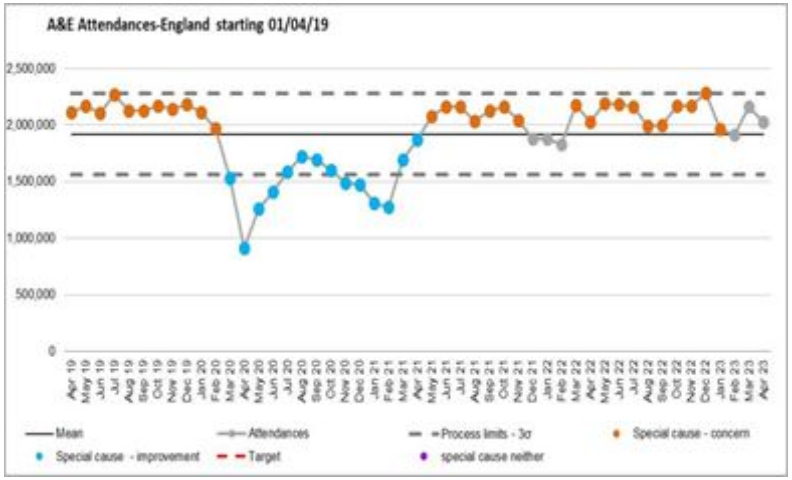
Special Cause Variation – Performance – A&E Attendances





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 ICB have implemented Respiratory HUBs at SACH and HHH receiving patients directly from 111. 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

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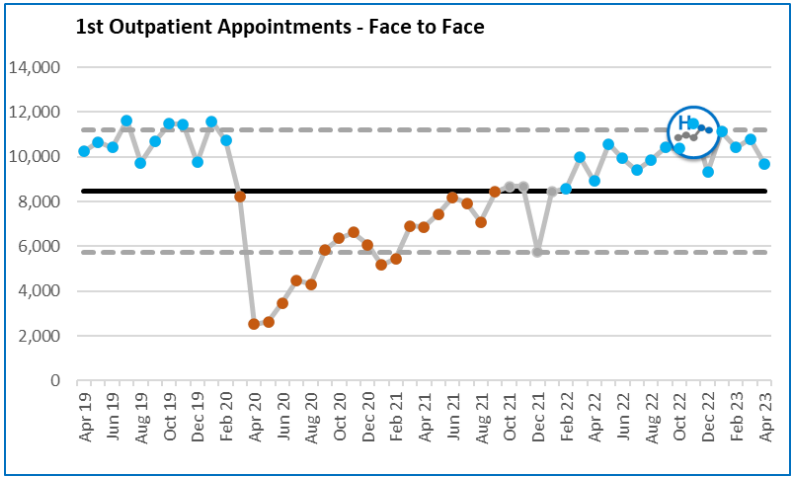
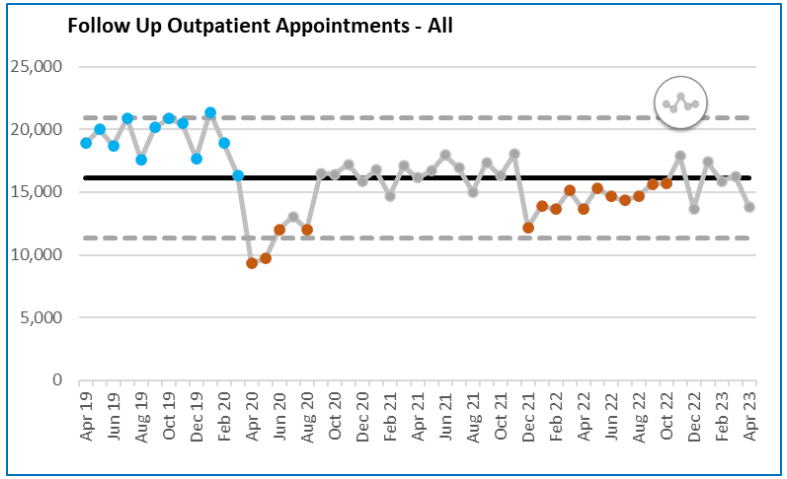
Special Cause Variation – Performance – 1st Outpatient Appointments – Face to Face





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

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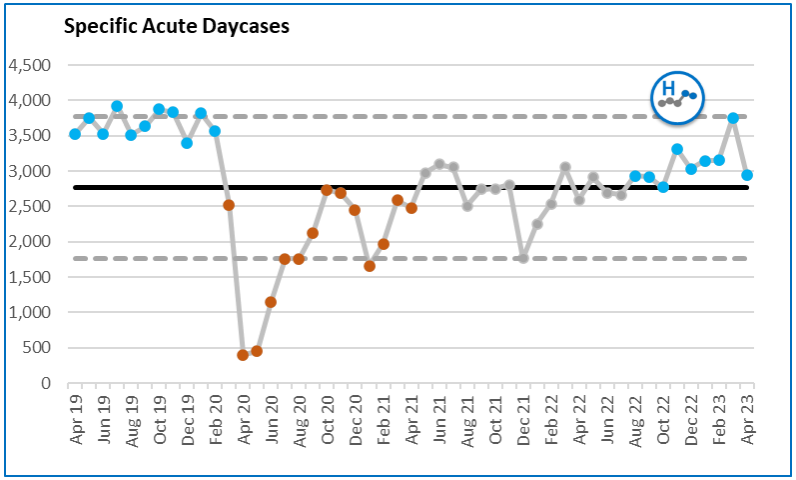
Special Cause Variation – Performance – Specific Acute Daycases



Background	What the Data tells us	Issues	Actions	Mitigations
Specific Acute Daycases	Exception triggered due to 7+ data points above the mean (a shift) Exception triggered due to a breach of the upper control limit	Day case rates were particularly impacted by the loss of capacity due to the Easter Bank Holidays and the subsequent Junior Doctors' Industrial action. The latter resulted in the pause of elective surgical activity at SACH for the duration of the strike. A small amount of activity, undertaken through outsourcing has to be recorded retrospectively and this may have contributed to the overall position. Some ongoing issues with EPR functions remain outstanding but solutions are being pursued.	Seamless Surgery and Elective Care Recovery programmes are in place. The focus on theatre productivity within the Surgical division with particular emphasis on scheduling and utilisation is expected to result in increased volume and improved utilisation in the coming months.	Outsourcing activity contributes to the trust's activity numbers. A new report, with a forward look of activity plans has been developed, and this will assist with oversight and enable a pro-active approach where case numbers appear low.

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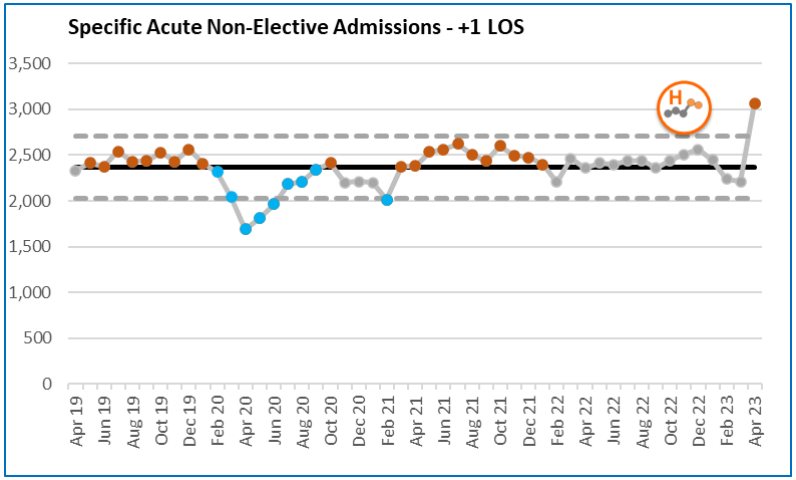
Special Cause Variation – Performance – Specific Acute Non-Elective Admissions – +1 LOS



Background	What the Data tells us	Issues	Actions	Mitigations
Specific Acute Non-Elective Admissions – +1 LOS	Exception triggered due to a breach of the upper control limit			

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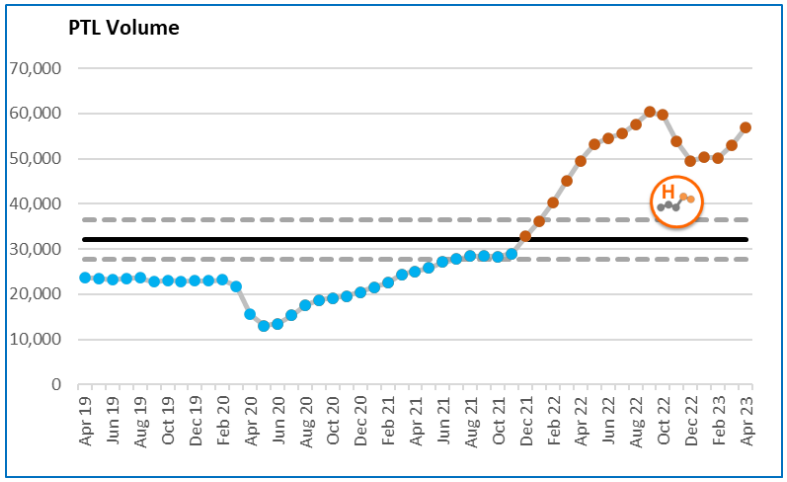
Special Cause Variation – Performance – RTT PTL Volume



***Latest available published RTT data – March 2023**

Trust	Mar-23
Mid And South Essex NHS Foundation Trust	166,335
Bedfordshire Hospitals NHS Foundation Trust	89,195
Norfolk And Norwich University Hospitals NHS Foundation Trust	87,722
East Suffolk And North Essex NHS Foundation Trust	83,070
North West Anglia NHS Foundation Trust	75,646
East And North Hertfordshire NHS Trust	61,738
Cambridge University Hospitals NHS Foundation Trust	60,308
West Hertfordshire Hospitals NHS Trust	**52,944**
Milton Keynes University Hospital NHS Foundation Trust	37,614
West Suffolk NHS Foundation Trust	31,373
The Princess Alexandra Hospital NHS Trust	27,012
James Paget University Hospitals NHS Foundation Trust	24,360
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	21,001

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)	Although EPR has been in place for over a year, errors to affect the RTT PTL in a number of ways, artificially inflating the PTL size, as capturing the correct outcomes results in fewer clock stops and the number of open pathways on the PTL. The external validation support that was in place to the end of March has ended. This has coincided with long term sickness within the trust validation team, where a number of posts remain vacant despite several rounds of recruitment. As a result there is insufficient resource to manage the PTL effectively while the volume of transaction errors continues at the point of entry by Cerner/EPR users.	Outsourcing programme remains active with reasonable patient uptake. Additional sessions are being undertaken but there is less uptake than pre COVID. Operational recovery group oversight of activity delivery DQ steering group established to lead on improvement work. Funds identified to enable a small number of external validators utilising monies from vacancies put in place. These validators have continued to focus on long waits. There are insufficient validation resources to maintain the pace of validation required to manage the PTL appropriately. A review of the service, with an options appraisal for future form is underway.	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.

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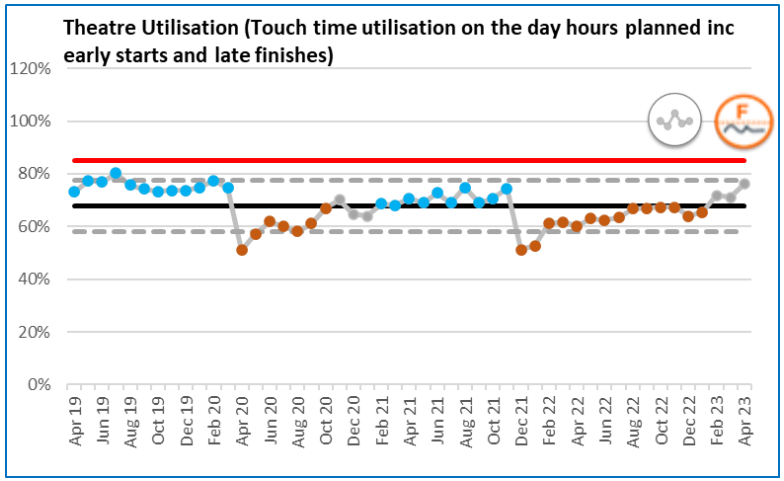
Special Cause Variation – Assurance – Theatre Utilisation (Touch time utilisation on the day hours planned inc early starts and late finishes



Background	What the Data tells us	Issues	Actions	Mitigations
Theatre Utilisation (Touch time utilisation on the day hours planned inc early starts and late finishes	Exception triggered due to target being outside upper control limit	Utilisation has been consistently poor for a period of time which has prompted the implementation of a focused efficiency and productivity programme. Some of the affecting factors have been due to the implementation of Cerner and the recovery challenges following Covid19.	The implementation of the efficiency and productivity programme across both sites with a key aim to maintain this increase in theatre utilisation. Delivery of a new theatre productivity tool which has enabled improved booking practices and changes to on the day processes. Focus on theatre list start times which has seen significant improvement; resulting in utilisation for April increasing to 76%.	Recent recruitment of internal project manager roles in order to bolster the team, focus on key areas that require further improvement and embed new practice to sustain increased utilisation. Introduction of a theatre tool and improvement cycles at TAG and a new Theatre Efficiency Meeting (TEM), give visibility of performance and allows for immediate and easy identification of issues for swift action.

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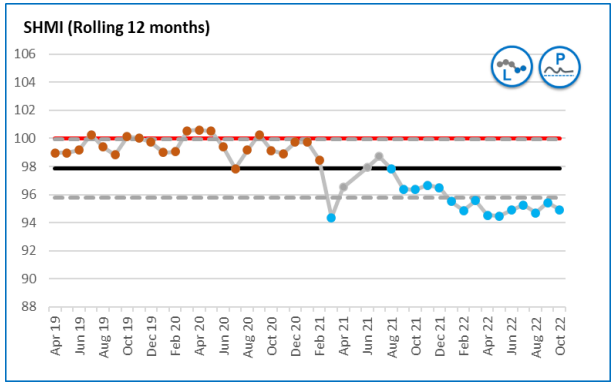
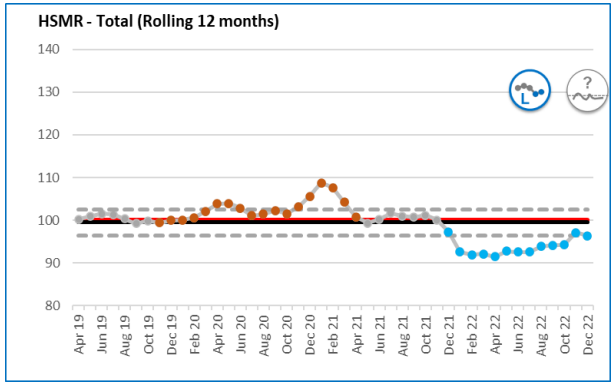
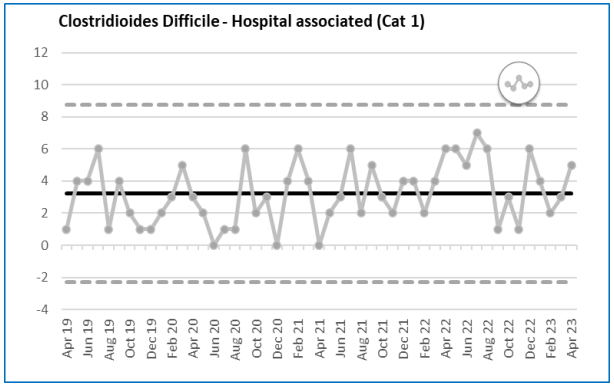
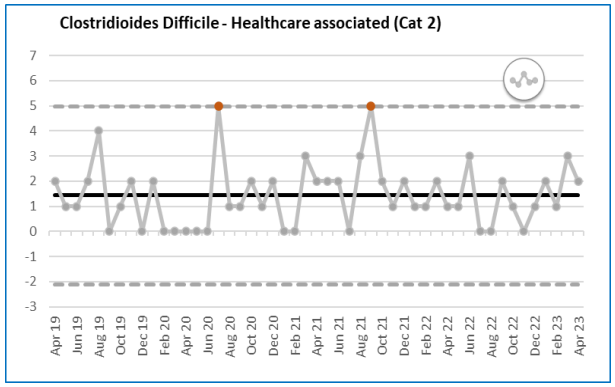
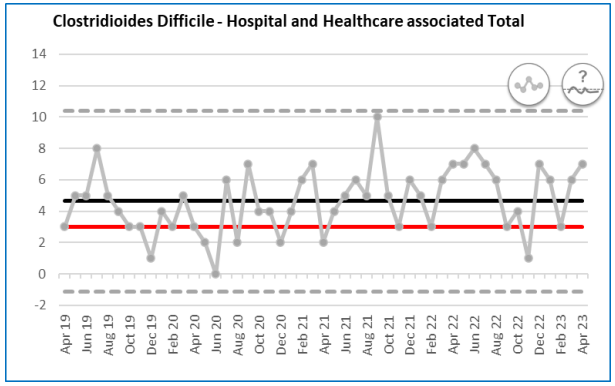
Appendix 1 – Safe Care and Improving Outcomes Metrics - Quality

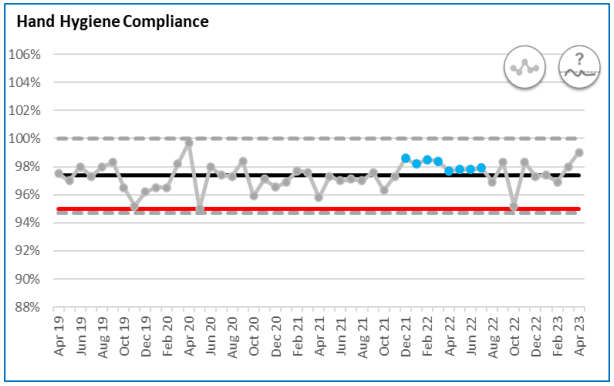












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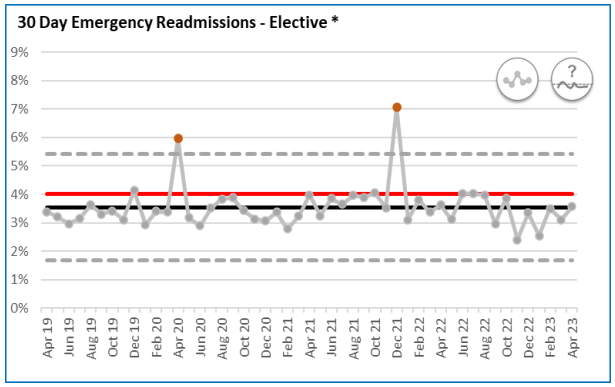

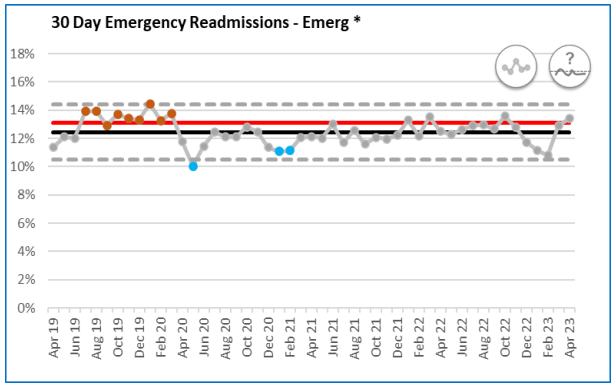

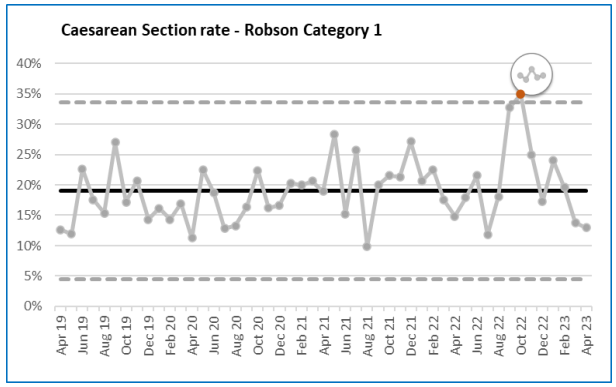

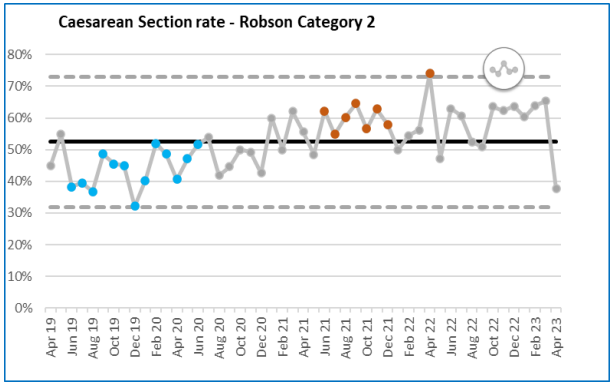

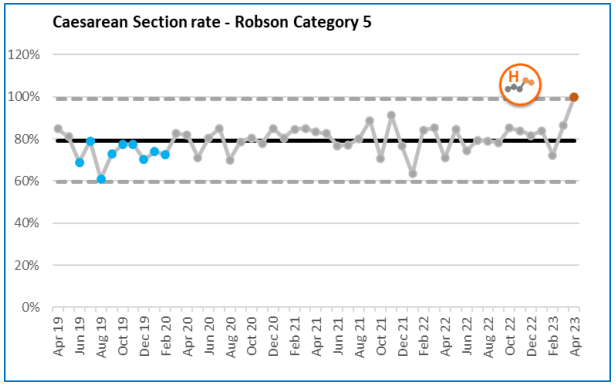

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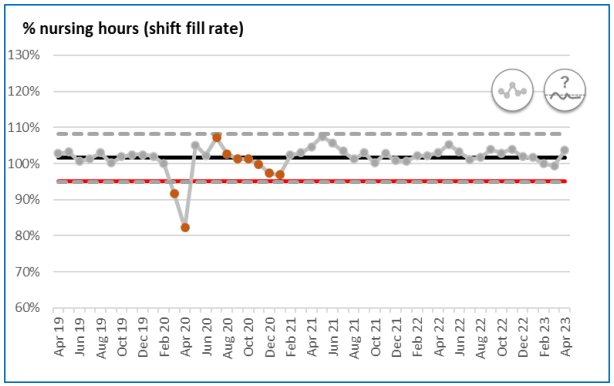
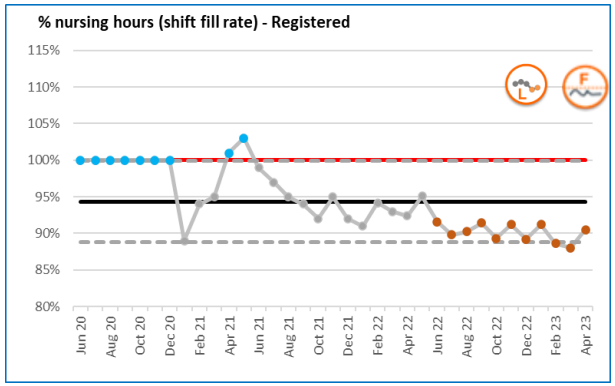
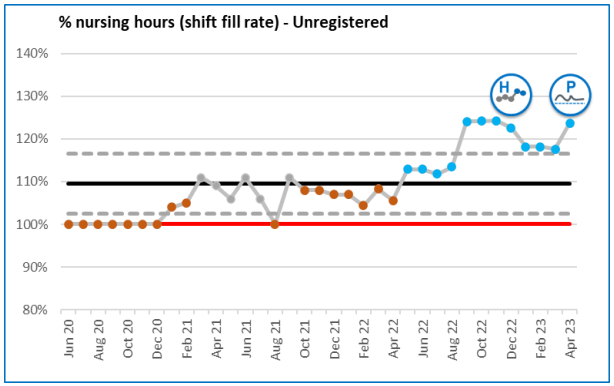
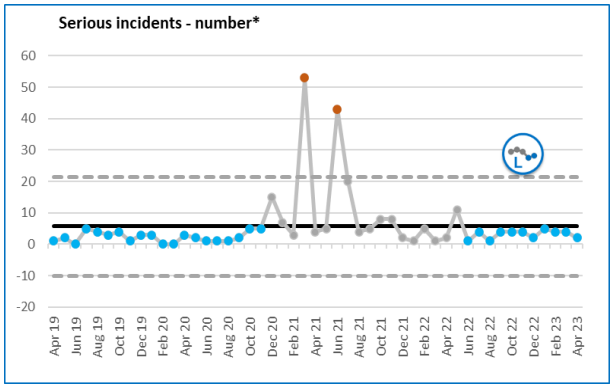
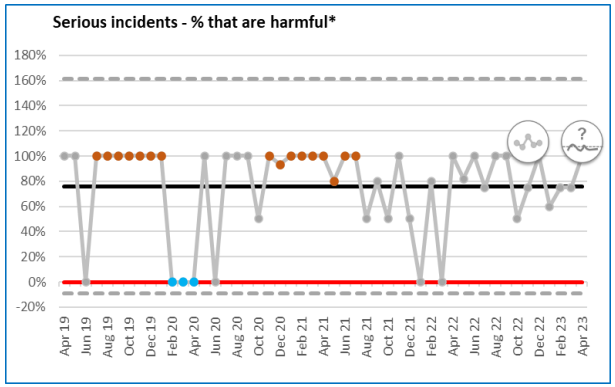
Appendix 1 – Safe Care and Improving Outcomes Metrics - Safety

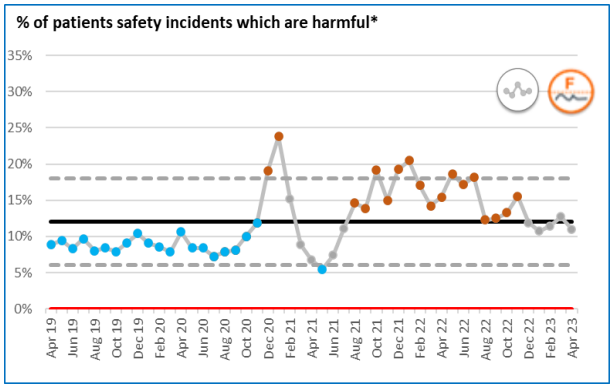












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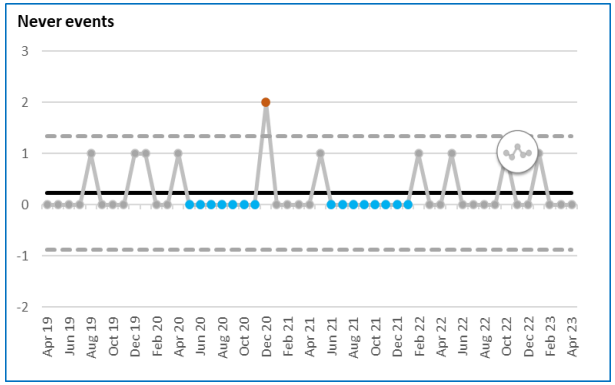

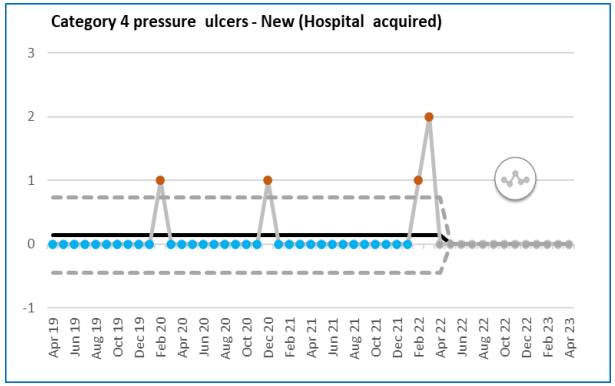

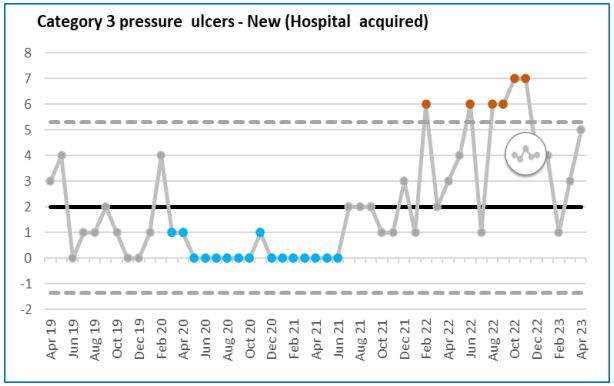

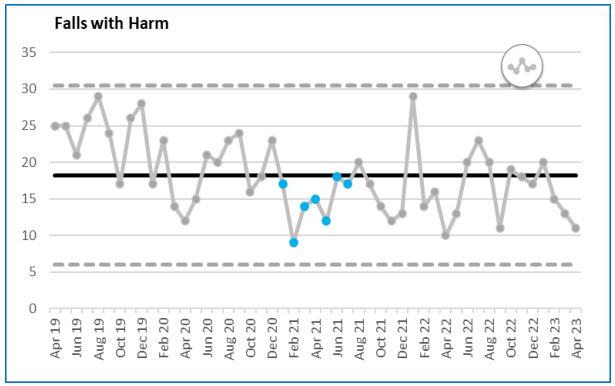

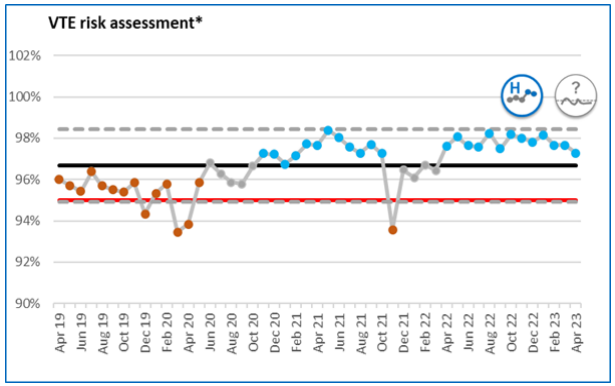

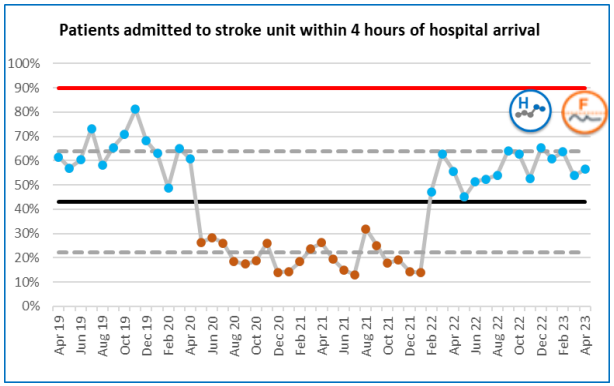

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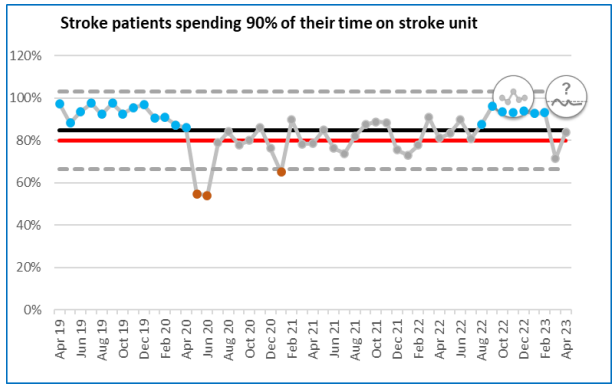
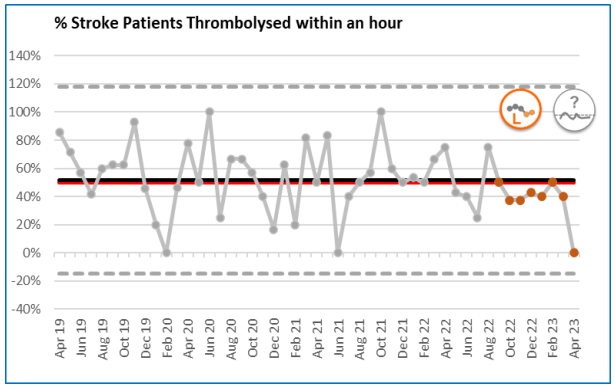
Appendix 1 – Safe Care and Improving Outcomes Metrics - Safety





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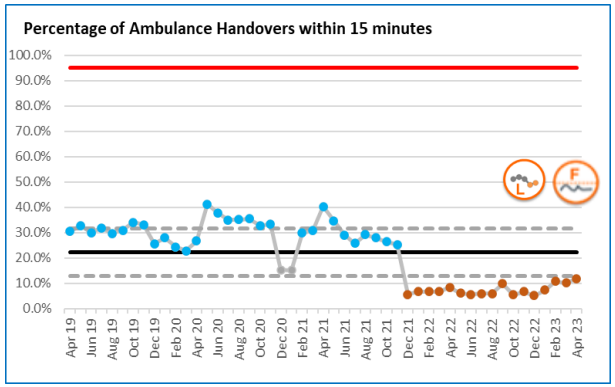
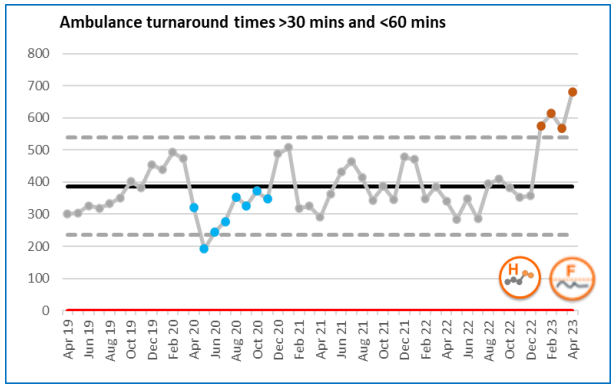
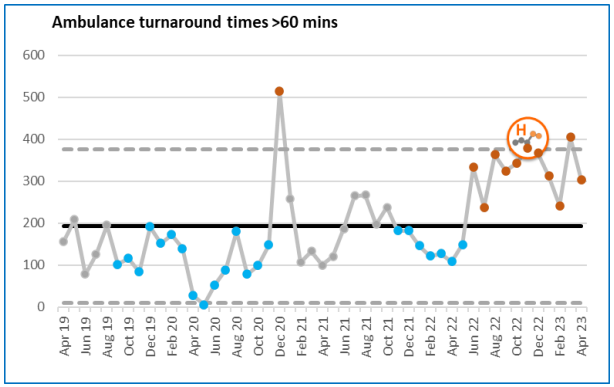
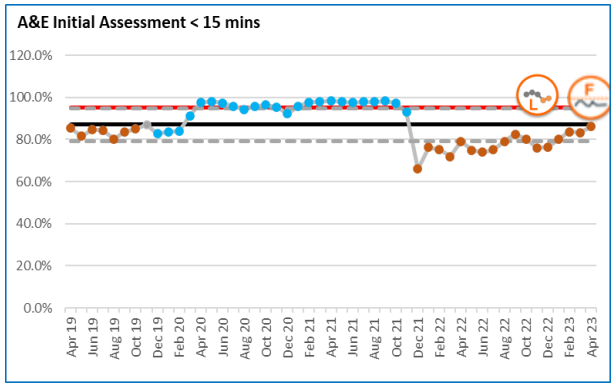
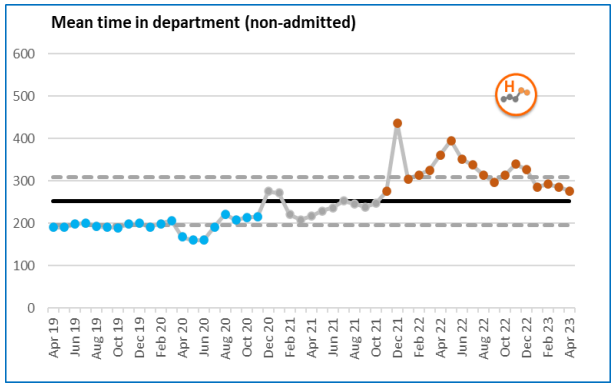
Appendix 2 – A&E Metrics

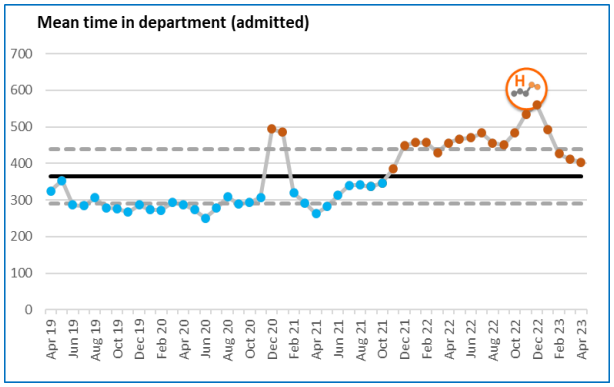












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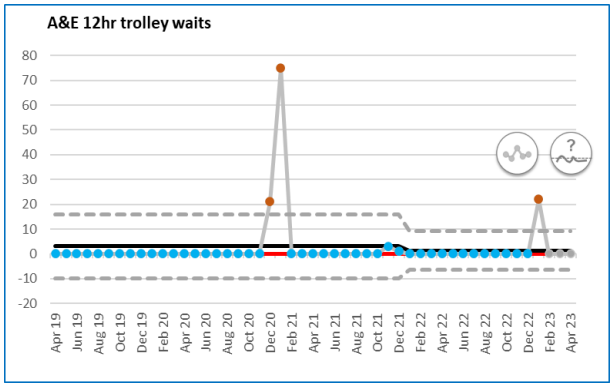
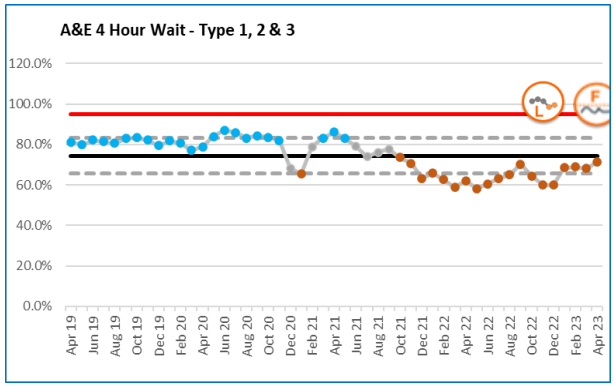
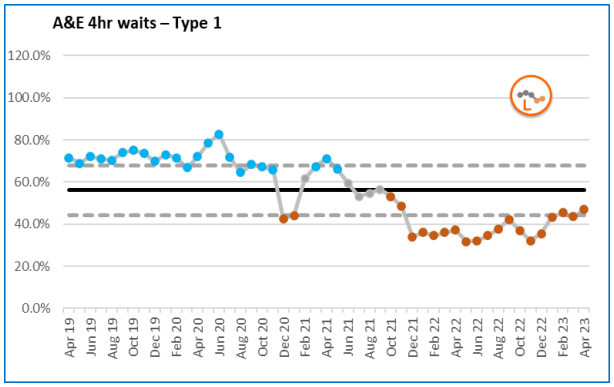
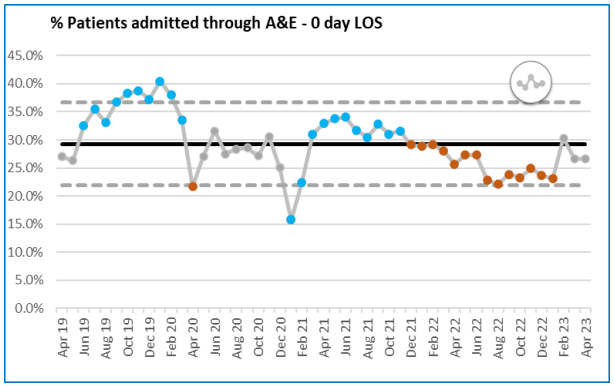
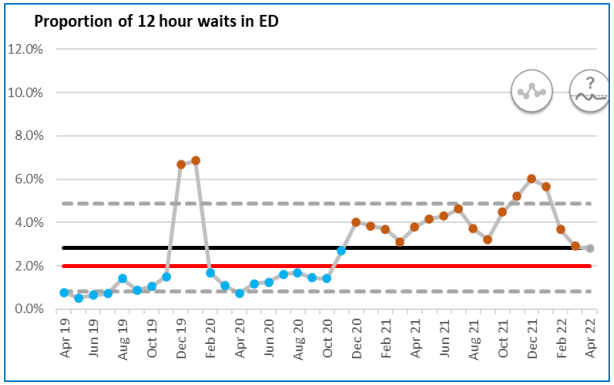
Appendix 2 – A&E Metrics











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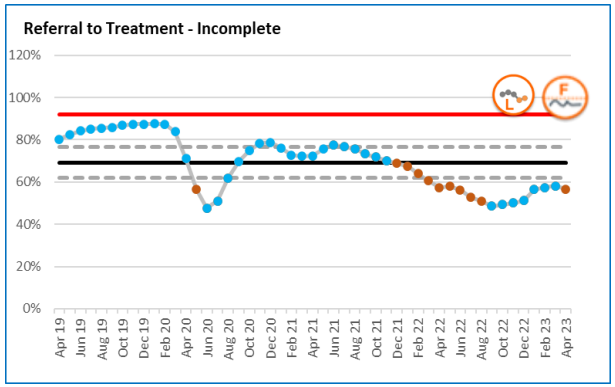
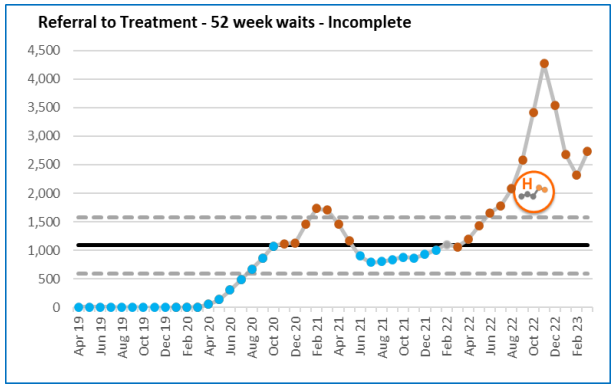
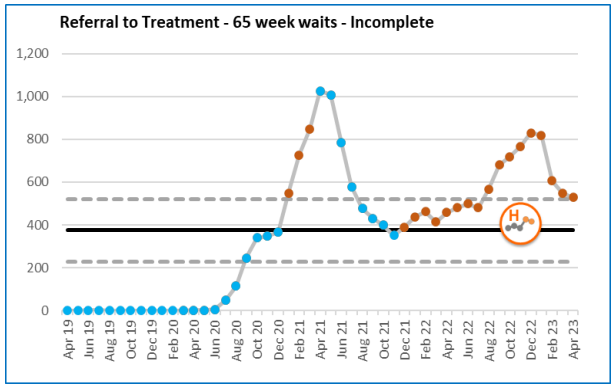
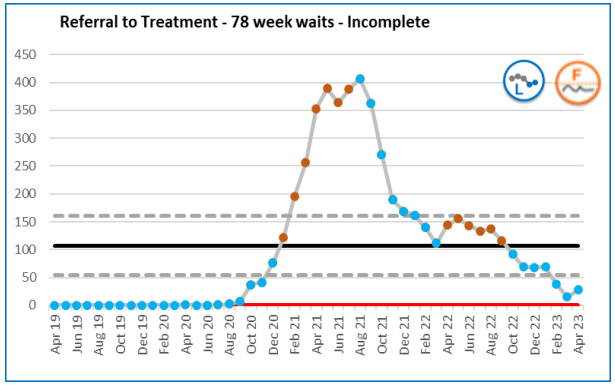
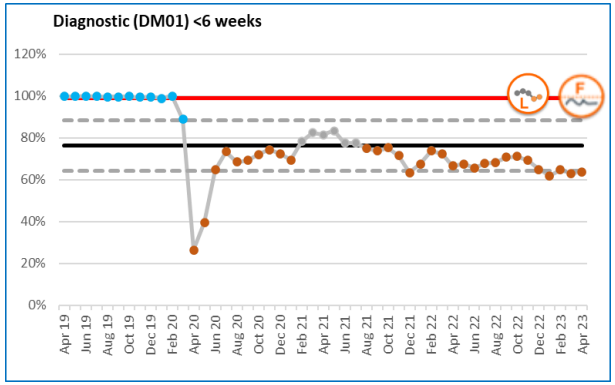
Appendix 3 – RTT, Cancer and Diagnostics Metrics

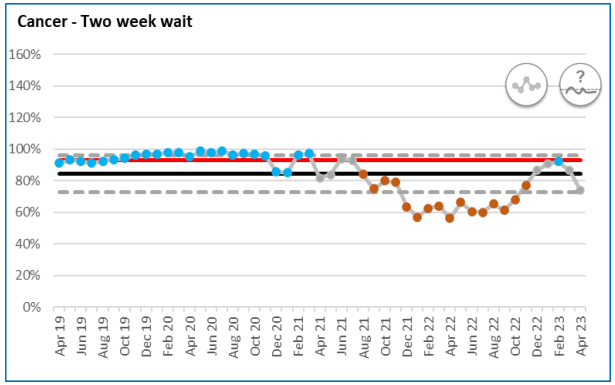












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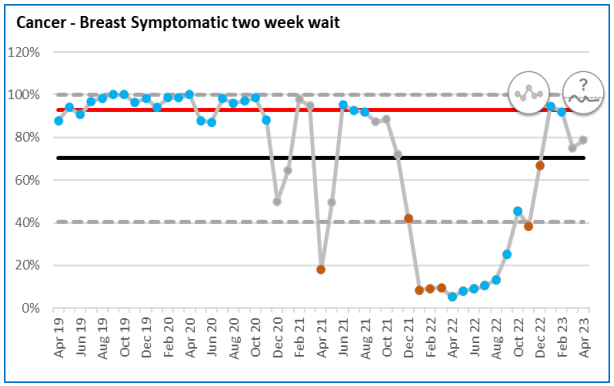

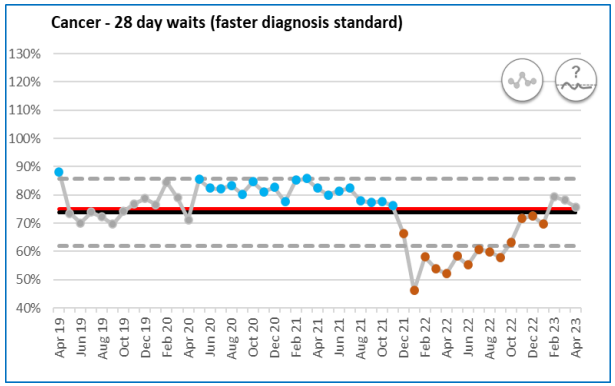

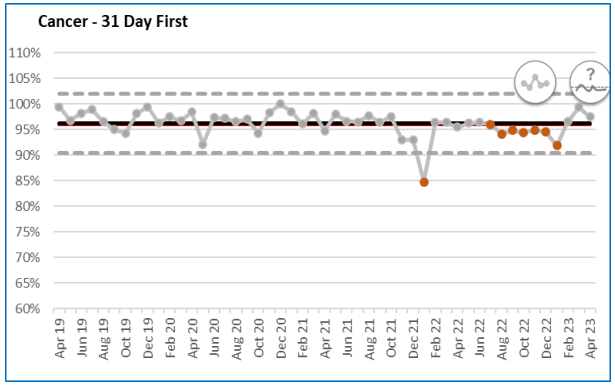

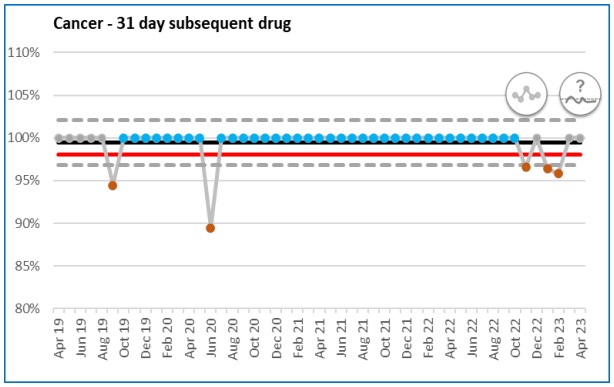

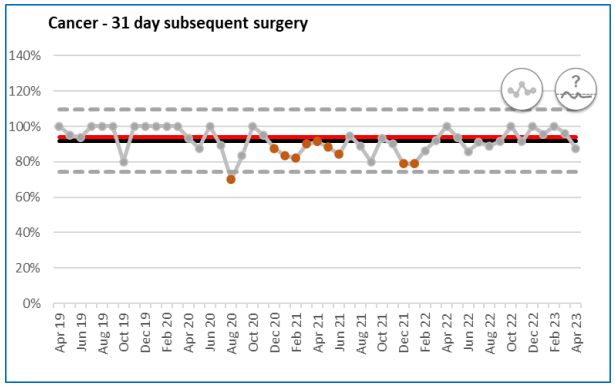

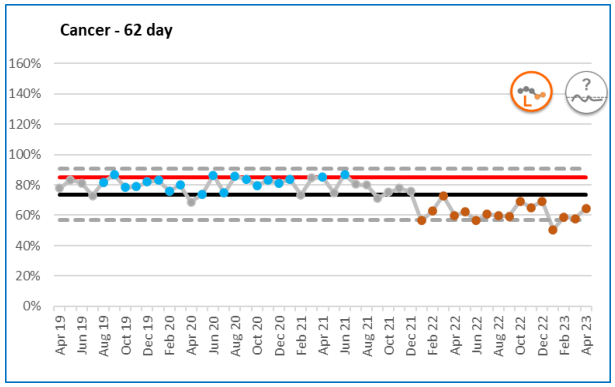

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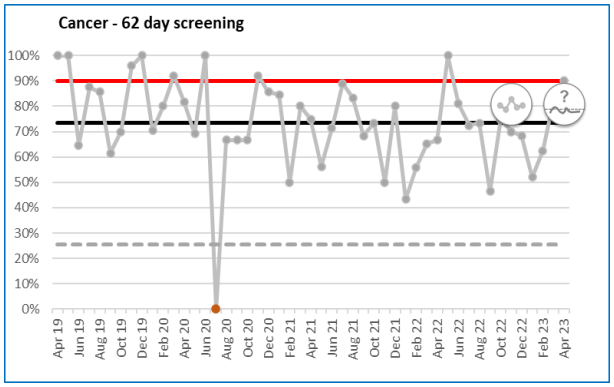
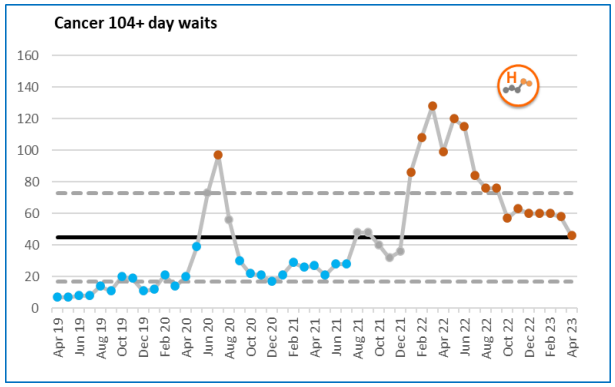
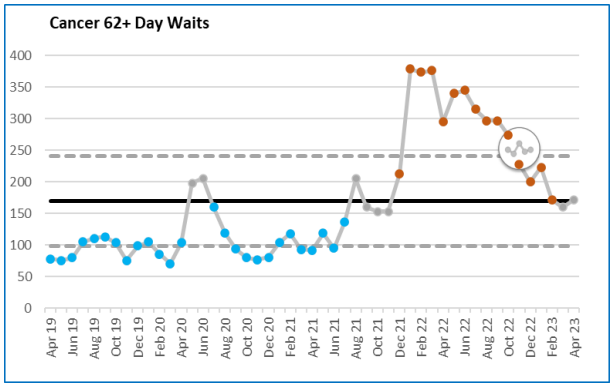
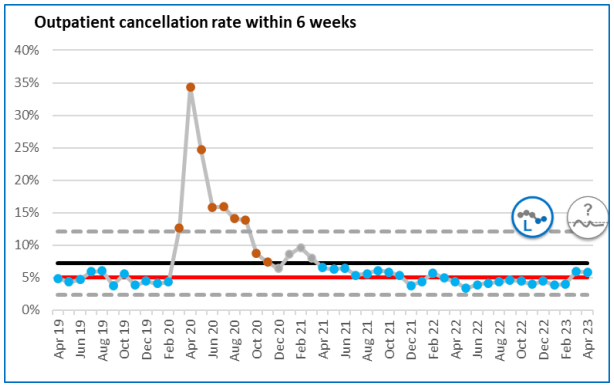
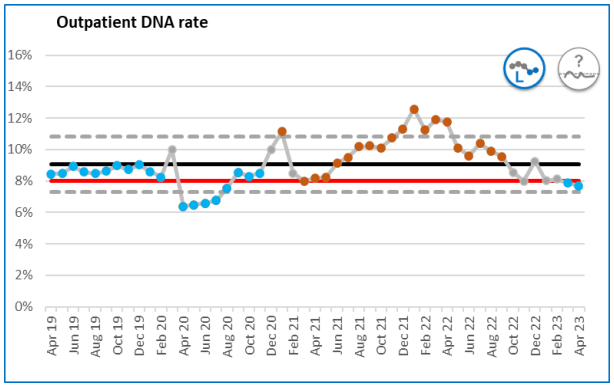
Appendix 3 – RTT, Cancer and Diagnostics Metrics











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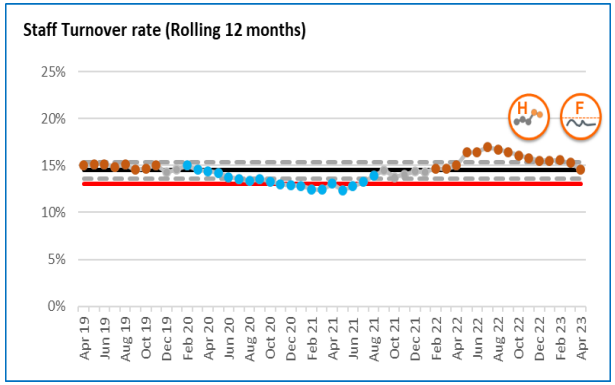
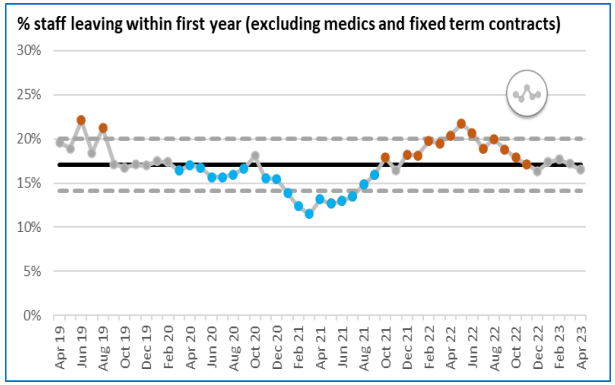
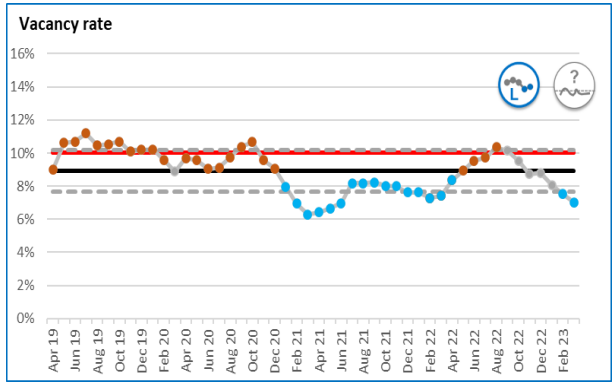
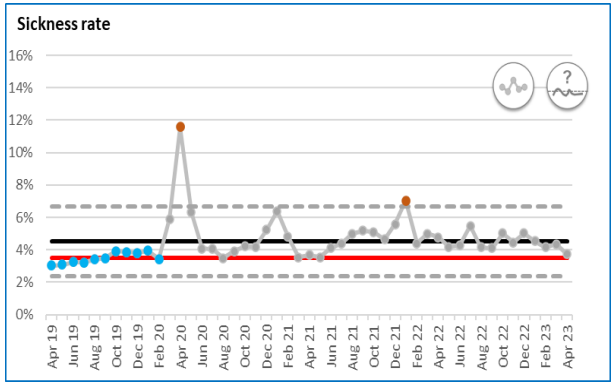
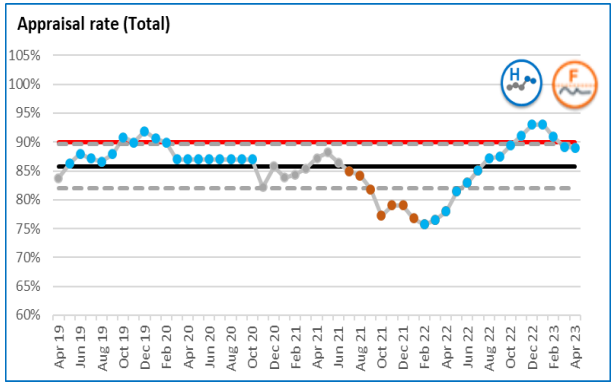
Appendix 4 – Workforce Metrics

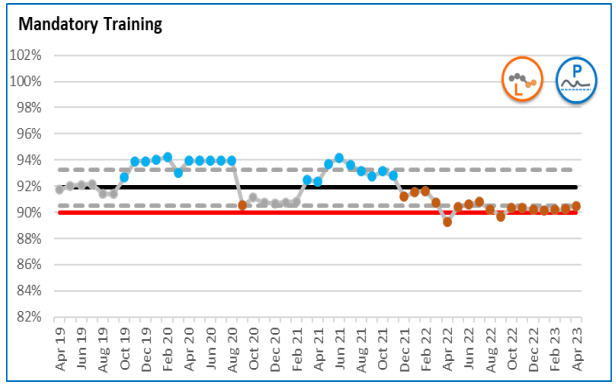












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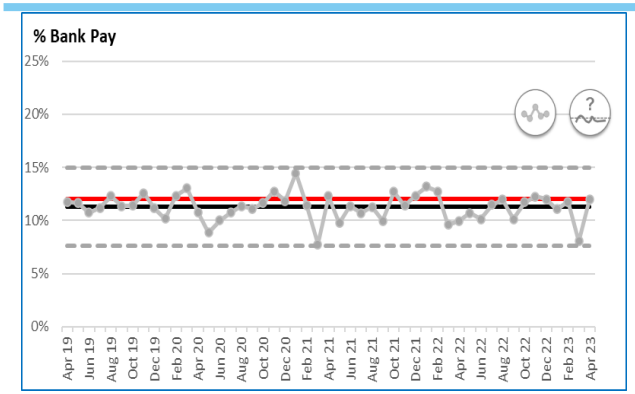
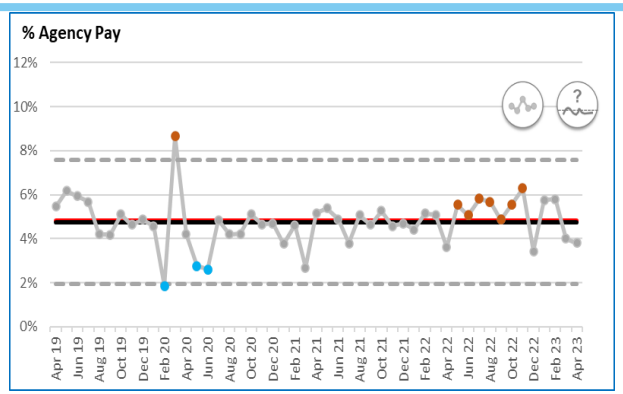
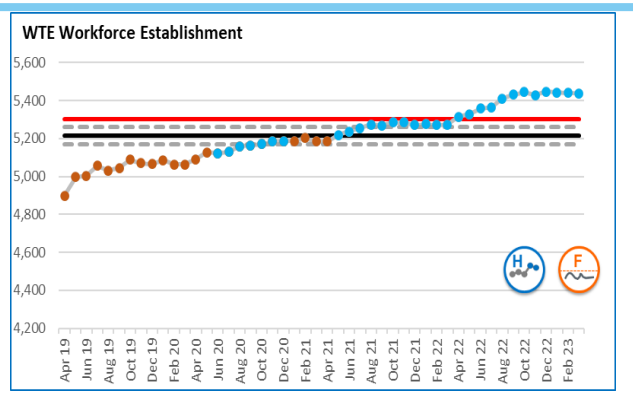
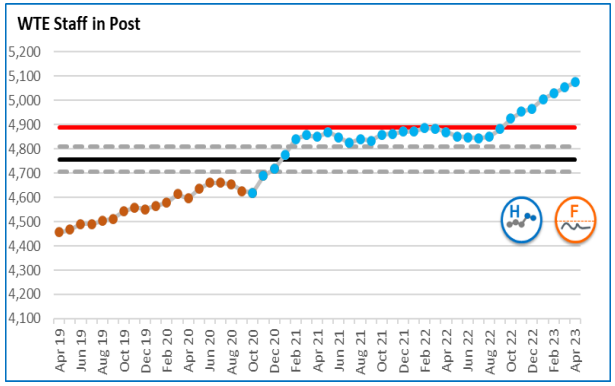
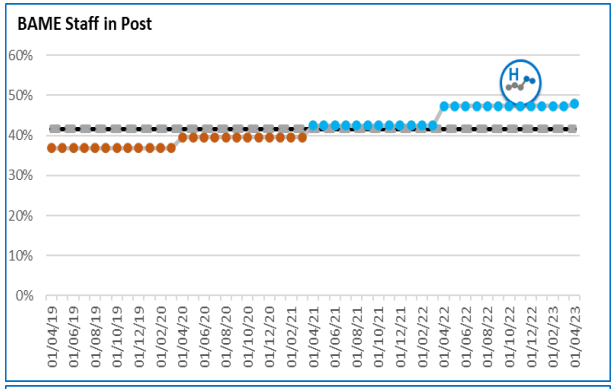
Appendix 4 – Workforce Metrics

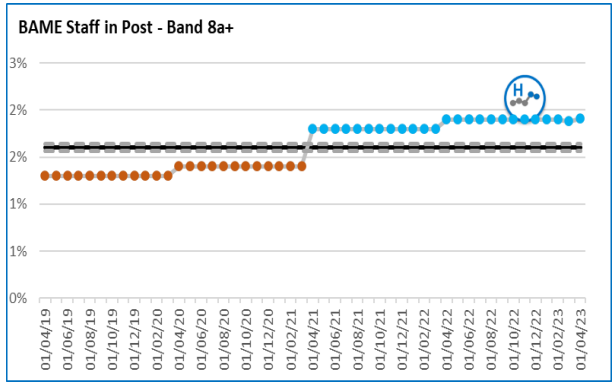


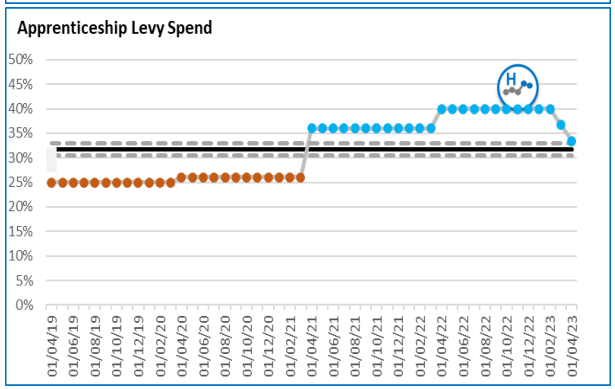












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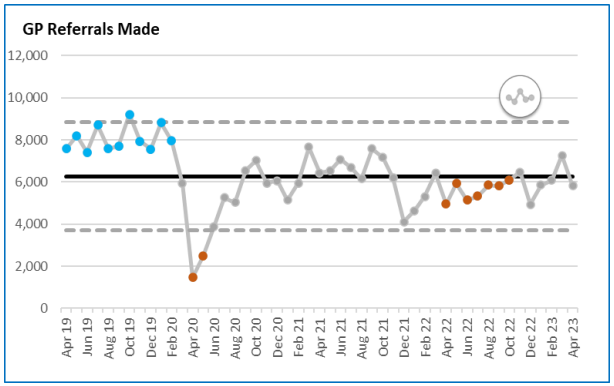
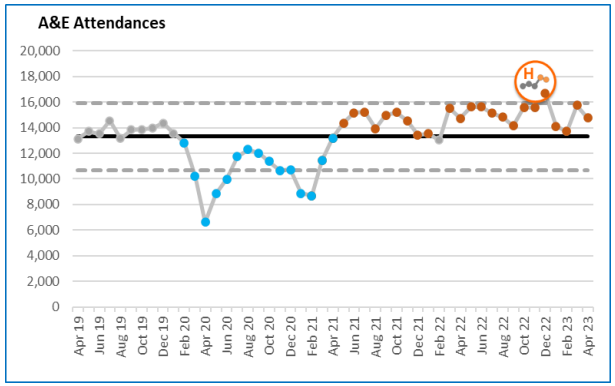
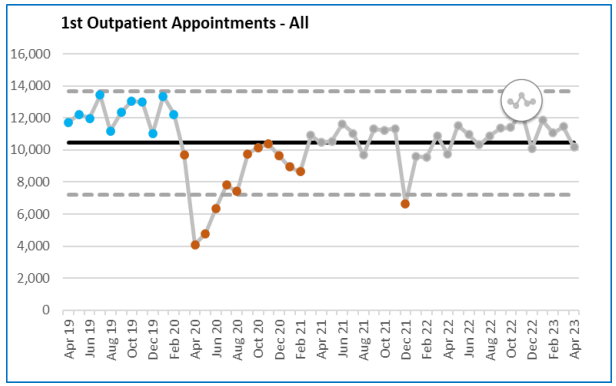
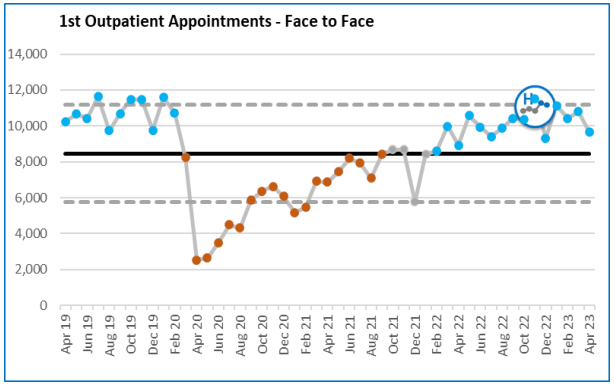
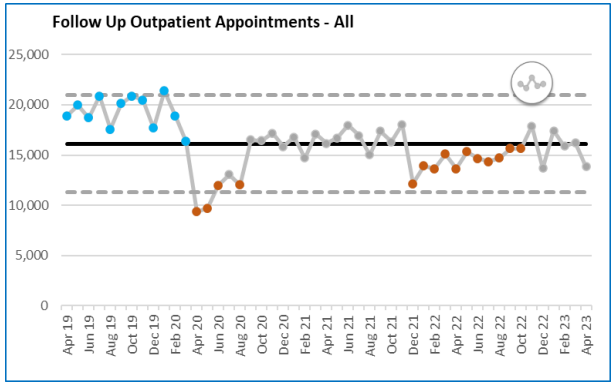
Appendix 5 – Activity Metrics

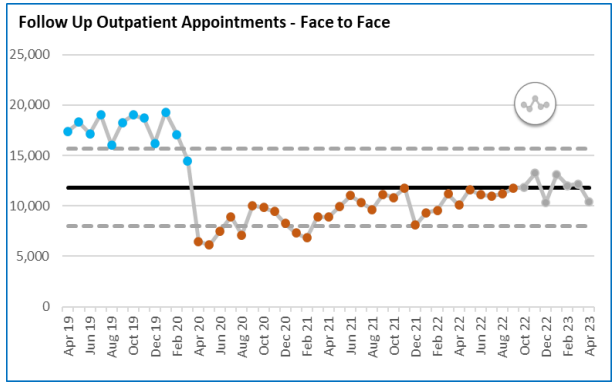












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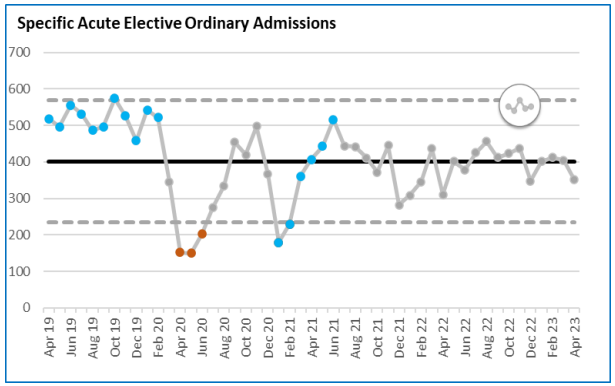
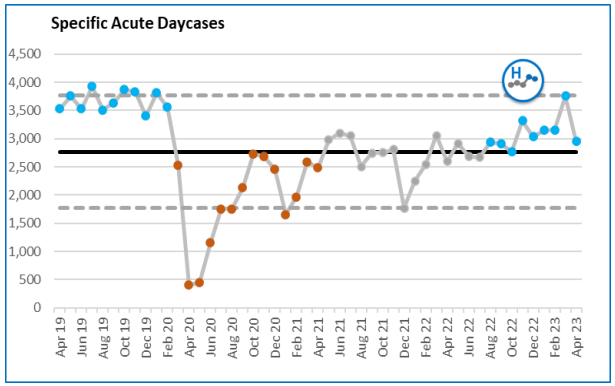
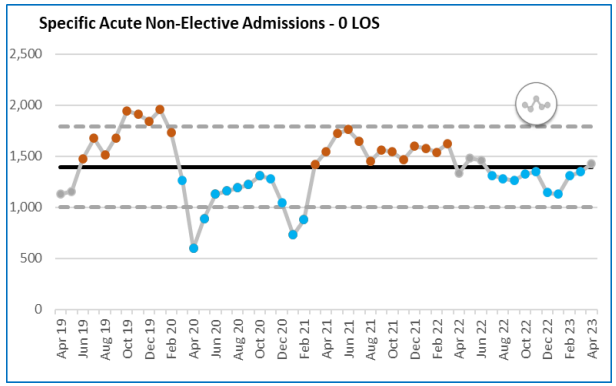
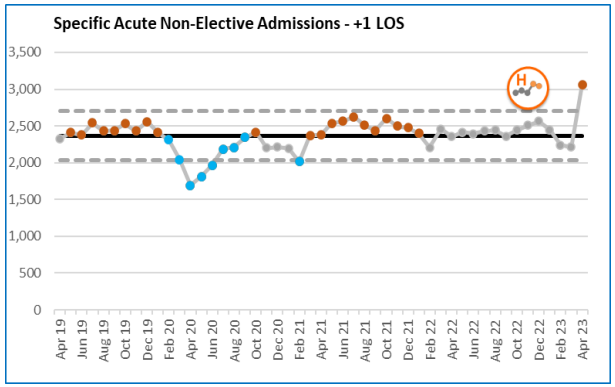
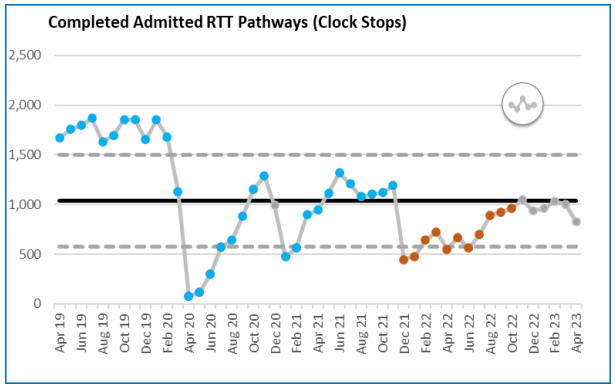
Appendix 5 – Activity Metrics

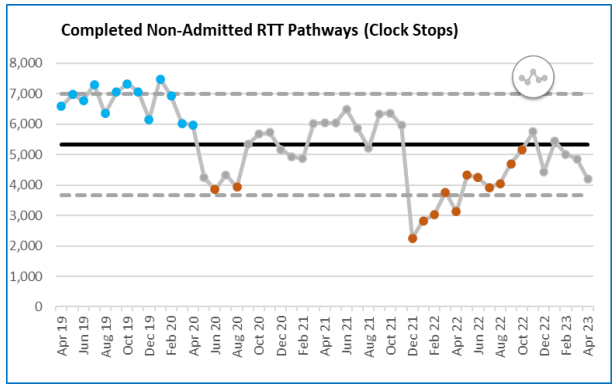












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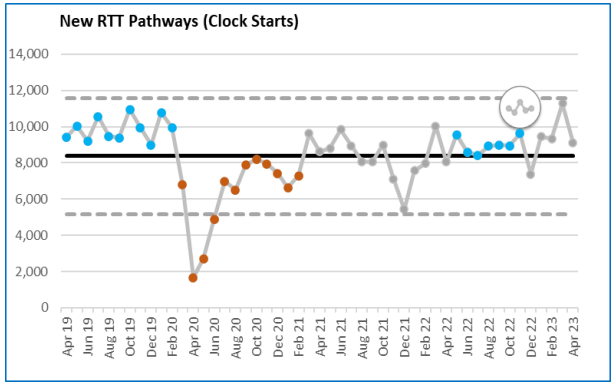
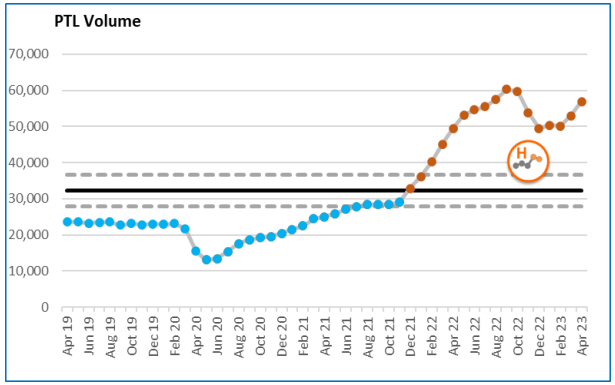
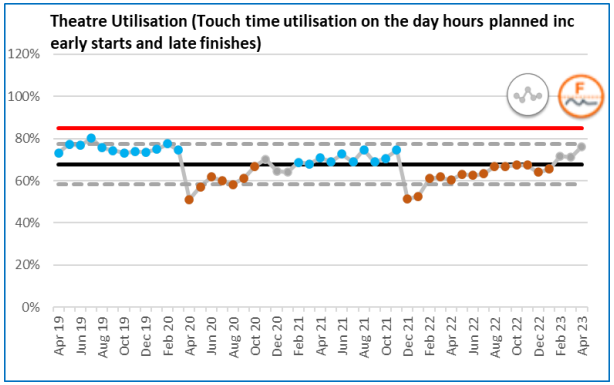
Appendix 5 – Activity Metrics







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Thank you

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OUR VALUES
Commitment
Care Quality

NHS
West Hertfordshire
Teaching Hospitals
NHS Trust

Perinatal Quality Surveillance Model

West Herts – January 2021 – March 2023

Mark Landau – Director of Business Intelligence

Perinatal Quality Surveillance Model 2023

LMNS: HWE	Reporting period: January-March 2023 (Q1)

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	January	February	March
CQC alerts (active alerts & year) /warning notice (29a)	None	Whistleblowing concerns- response provided, CQC relationship meeting held, visit from regional quality lead to provide assurance.	None
HSIB/NHSR concerns or requests for action	None	None	Request to review classification of birth from stillbirth to neonatal death- referred to coroner for review. Coroner accepted medical opinion at the time- learning all cases to be referred when meeting criteria of Chief Coroners guidance 45 (published Feb 2023)
Coroner Regulation made directly to trust (28)	None	None	None

	Maternity Internal divert / Maternity deflect (if applicable)	Divert outside organisation
January	0	6 hours due to chemical spill incident
February	0	0
March	0	0

	WHTH	National
Stillbirth Rate 2022	2.84 per 1000	3.35 per 1000
Neonatal Death Rate 2022	0.96 per 1000	1.6 per 1000
Perinatal Mortality Rate 2022	3.79 per 1000	4.96 per 1000

NHS West Hertfordshire Teaching Hospitals NHS Trust

Safe Staffing, Feedback & Incident reporting

Midwifery Safe Staffing	Fill Rate	Bank usage	Agency usage	Service User Feedback	Staff feedback from frontline champions and walkabouts
January	91.73%	9.8%	13.2%	Updating information on website about visiting hours and sibling visiting Prioritising women who may require side room facilities after birth Further clarification about debrief clinics	Positive feedback regarding the refurbishment work Communication of CPD and funding available Flexible working and self rostering
February	87.19%	13.1%	7.2%	Seamless transfer of care between transitional care unit and postnatal ward How women receive information to prepare them for transitional care	space in ANC and MDAU as further clinic rooms are required as well as office space. There are many small spaces which in their current format are impractical but could potentially be knocked together to make a more usable space
March				Using social media to show case services and facilities at WHTH, Live chat on facebook Identify further opportunities for co-production, SCBU refurbishment and improving the sensory feel of the maternity wards	Review of bereavement services Working towards 7/7 service Collaboration across the regional and national bereavement forum Review of PMRT process

	Datix		Maternity Serious Incidents Declared	Maternity Never Events	PMRT compliant (Ockendon IEA 1.4)	HSIB Cases (new)	Still Births			HIE cases (grade 2 or 3)	Neonatal deaths	Maternal Mortality
	Open	No of incidents logged as moderate harm or above					All	Term	Intrapartum			
January	257	13	2	0	Yes	2	3	0	0	0	0	1 (indirect)
February	223	9	0	0	Yes	1	1	1	1	1 (pre-term)	0	0
March	151	6	2	0	Yes	0	0	0	0	0	0	0

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Training and Compliance

Annual staff Picker survey:

Percentage of Nurses/Midwives recommending WHTH is as a place to work (agree/strongly agree)

53.6% (Trust's average 51.5%)

GMC Survey:

Proportion of speciality trainees in Obstetrics /Gynaecology responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (National 79.3%, 2022) 82%

	SBLCBv2	GAP GROW training	Fetal monitoring in labour	Maternity emergencies/ multi professional training	Personalised Care	Intrapartum care and Immediate PN care	Newborn life support
January	MWs- 99% Consultant obstetricians - 100% Other Obstetric Doctors- 94%	MWs-99% Consultant obstetricians- 95% Other Obstetric Doctors- 94%	MWs-99% Consultant obstetricians- 94% Other Obstetric Doctors- 96%	MWs-97% MSWs/HCAs- 98% Consultant obstetricians- 100% Junior Drs-80% Obstetric Anaesthetic Cons- 100% All other anaesthetic Doctors- 100%	MWs-99% Consultant obstetricians- - 100% Other Obstetric Doctors- 80%	MWs-97% MSWs/HCAs- 98% Consultant Obstetricians- 100% Other Obstetric Doctors- - 80% Obstetric Anaesthetic Consultants- 100% All other anaesthetic Doctors- 100%	MWs 99% Neonatal RNs- 97% ANNPs- 100% Neonatal Consultants- 100% Neonatal Junior Doctors- 100%
February	MWs-99% Consultant obstetricians- 100% Other Obstetric Doctors- 87%	MWs-99% Consultant obstetricians- - 100% Junior Drs- 94%	MWs-99% Consultant obstetricians- 100% Other Obstetric Doctors- 93%	MWs-99% MSWs/HCAs- 99% Consultant obstetricians- - 100% Other Obstetric Doctors- 71% Obstetric Anaesthetic Cons- 100% All other anaesthetic Doctors- 100%	MWs-99% Consultant obstetricians- 100% Other Obstetric Doctors- 71%	MWs-99% MSWs/HCAs- 99% Cons- 100% Other Obstetric Doctors- 71% Obstetric Anaesthetic Cons- 100% All other anaesthetic doctors- 100%	MWs 99% Neonatal RNs- 100% ANNPs- 100% Neonatal Consultants- 100% Neonatal Junior Doctors- 100%
March			MWs-99% Consultant Obstetricians- 100% Other Obstetric Doctors- 97%				

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Perinatal Quality Surveillance Tool

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
The number of incidents logged graded as moderate or ab	Mar 23	6	-			7	0	13
SBLCBv2 Training Compliance - Midwives	Feb 23	99%	-			90%	80%	100%
SBLCBv2 Training Compliance - Obstetricians	Feb 23	100%	-			50%	37%	62%
GAP and GROW trainingcompliance - Midwives	Feb 23	99%	-			91%	84%	99%
GAP and GROW trainingcompliance - Consultant Obstetric	Feb 23	100%	-			73%	52%	94%
GAP and GROW trainingcompliance - All other Obstetricia	Feb 23	94%	-			75%	59%	90%
Fetal Surveillance in Labour training compliance - Midwive	Mar 23	99%	-			98%	95%	100%
Fetal Surveillance in Labour training compliance - Consulta	Mar 23	100%	-			84%	53%	116%
Fetal Surveillance in Labour training compliance - All Othe	Mar 23	97%	-			83%	62%	104%
Maternity Emergencies and Multiprofessional training - Co	Feb 23	100%	-			81%	62%	99%
Maternity Emergencies and Multiprofessional training - Al	Feb 23	71%	-			66%	29%	102%
Maternity Emergencies and Multiprofessional training - Ar	Feb 23	100%	-			65%	38%	91%
Maternity Emergencies and Multiprofessional training - Al	Feb 23	100%	-			55%	33%	77%
Maternity Emergencies and Multiprofessional training - M	Feb 23	99%	-			88%	79%	98%
Maternity Emergencies and Multiprofessional training - M	Jul 21	95%	-			41%	-14%	97%
Maternity Emergencies and Multiprofessional training - M	Feb 23	99%	-			77%	53%	102%
Personalised Care Training Compliance - Midwives	Feb 23	99%	-			90%	85%	96%
Personalised Care Training Compliance - Obstetricians	Feb 23	100%	-			83%	69%	97%
Care During Labour and the Immediate Postnatal Period tr	Feb 23	100%	-			82%	65%	98%
Care During Labour and the Immediate Postnatal Period tr	Feb 23	71%	-			67%	38%	97%
Care During Labour and the Immediate Postnatal Period tr	Feb 23	100%	-			66%	37%	96%
Care During Labour and the Immediate Postnatal Period tr	Feb 23	100%	-			61%	36%	85%
Care During Labour and the Immediate Postnatal Period tr	Feb 23	99%	-			89%	80%	98%
Care During Labour and the Immediate Postnatal Period tr	Feb 23	99%	-			76%	52%	100%
Care During Labour and the Immediate Postnatal Period tr	Dec 22	82%	-			73%	48%	98%

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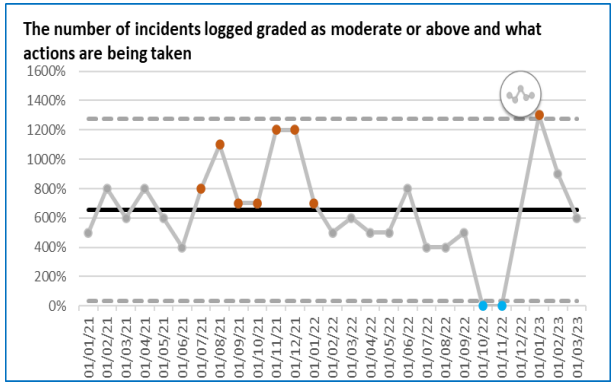

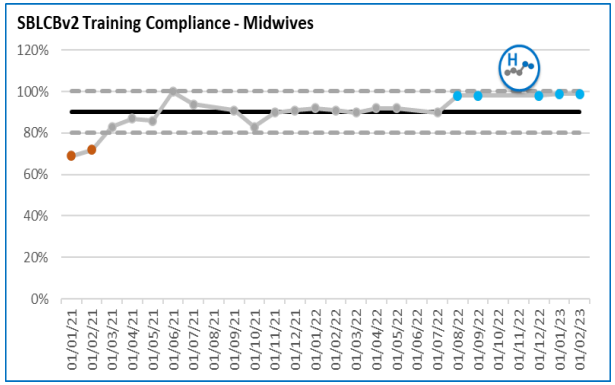

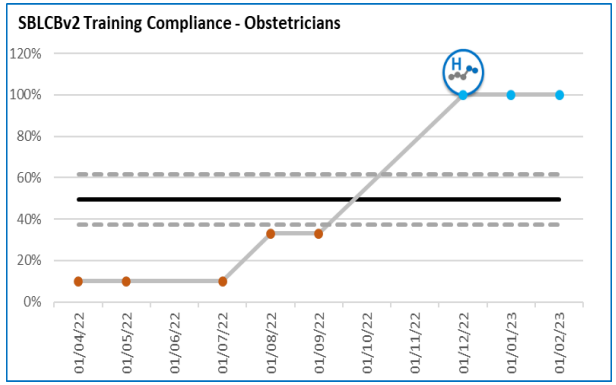

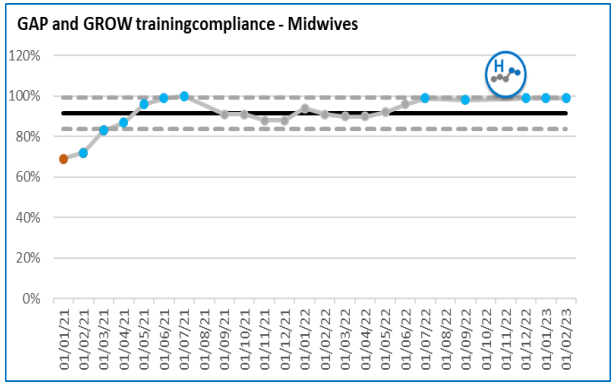

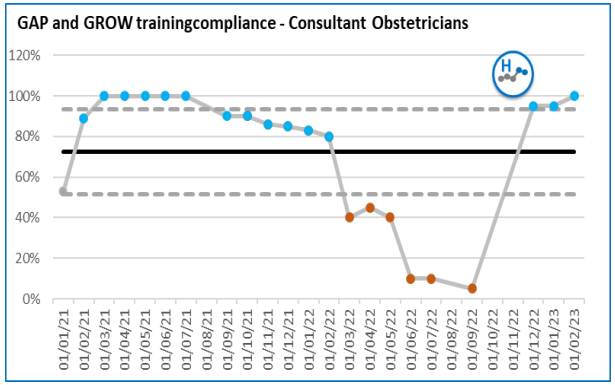

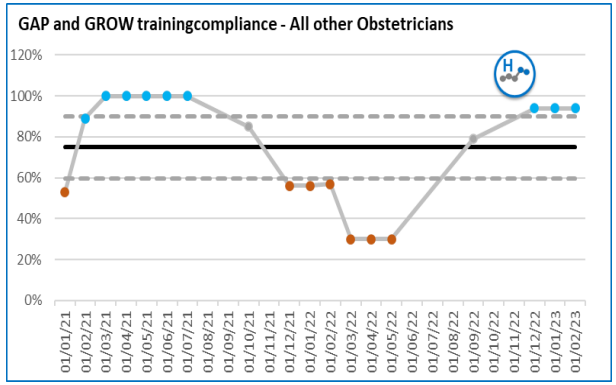

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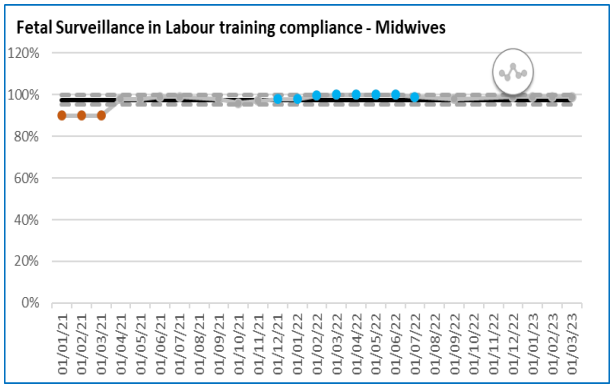

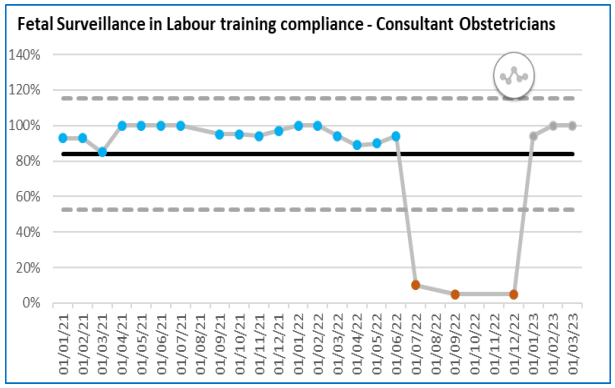

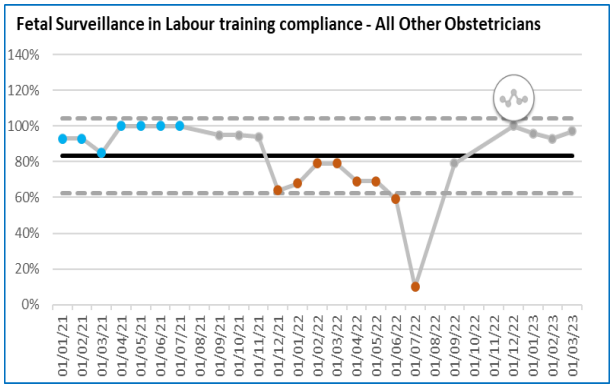

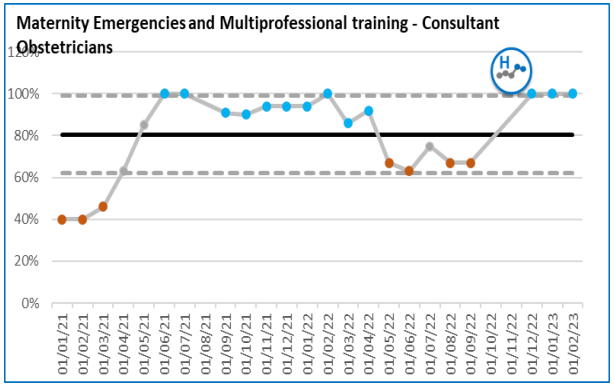

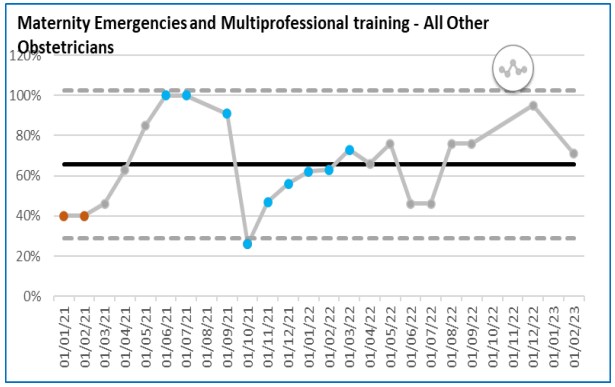

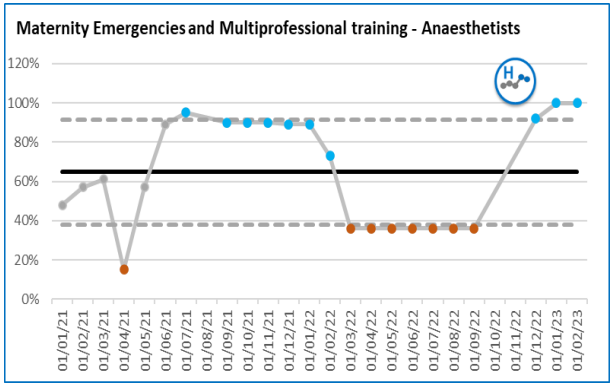

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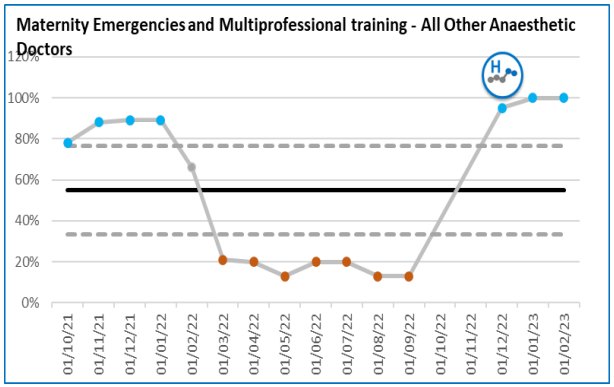

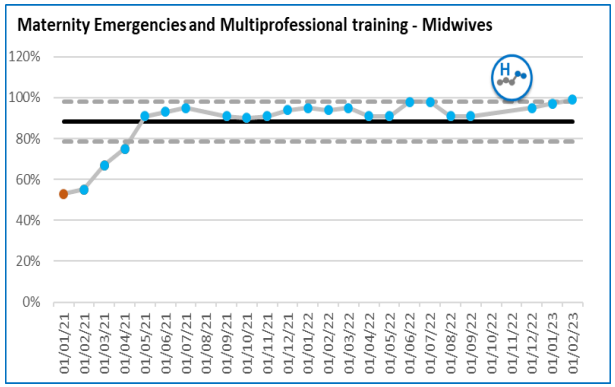

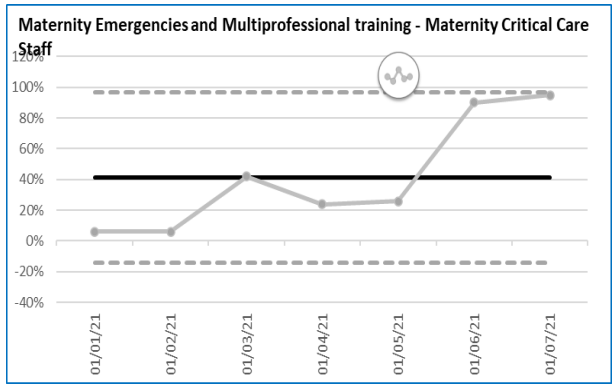

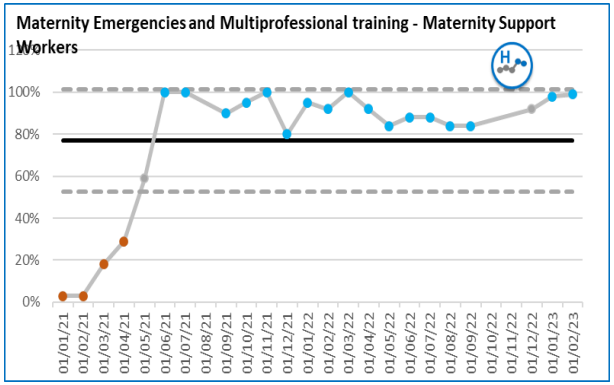

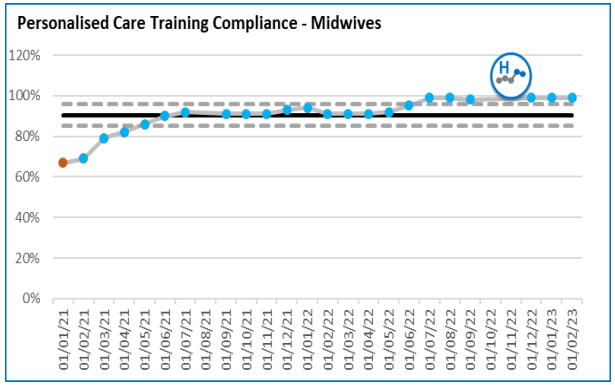

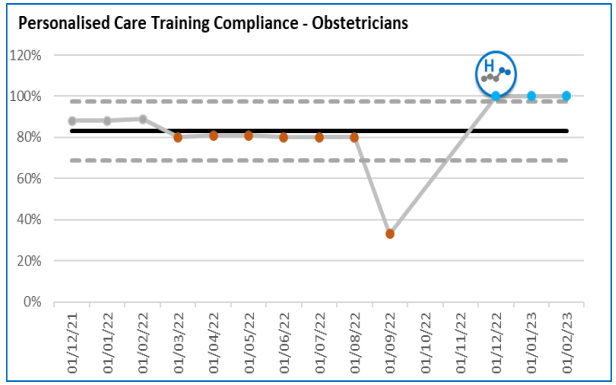

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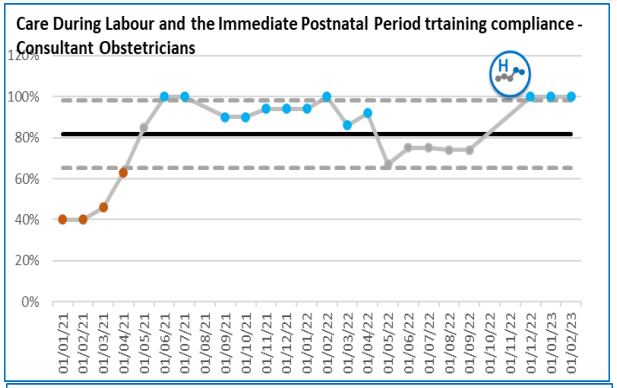

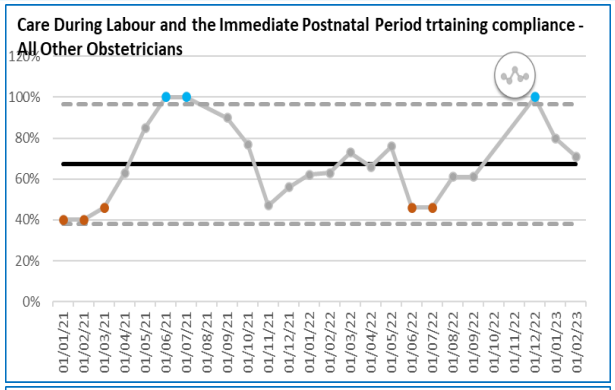

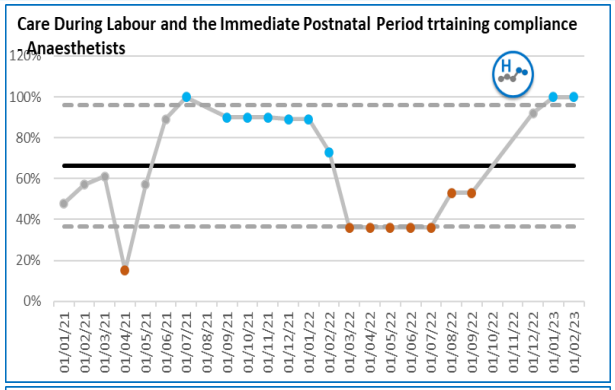

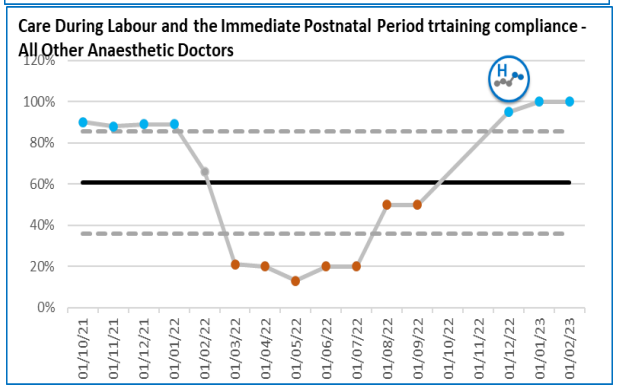

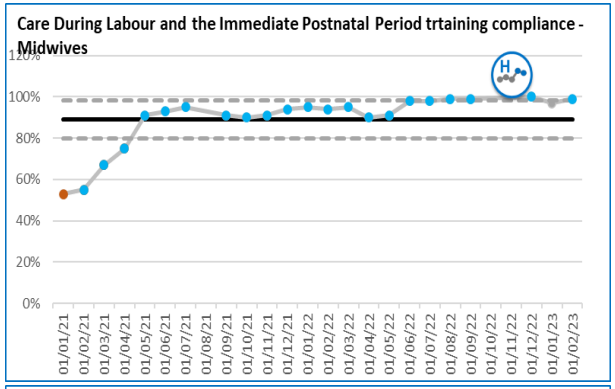

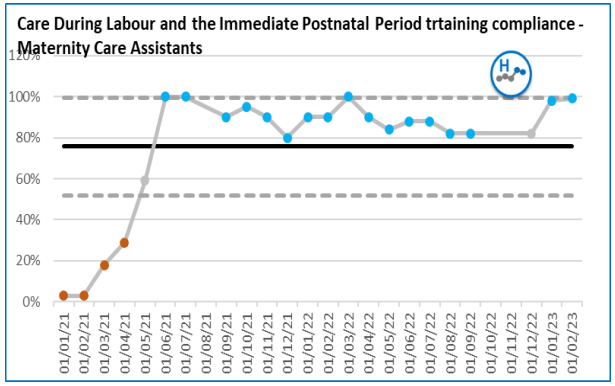

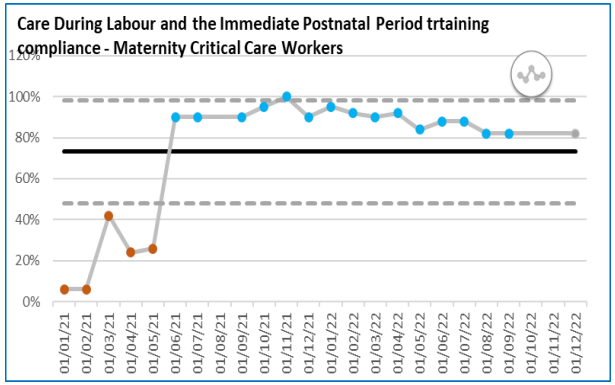

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Perinatal Quality Surveillance Tool

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Newborn Life Support training compliance - Neonatologist	Feb 23	100%	-			100%	96%	103%
Newborn Life Support training compliance - Neonatal Nurses	Feb 23	100%	-			94%	89%	100%
Newborn Life Support training compliance - Advanced Neonatal Nurses	Feb 23	100%	-			100%	99%	100%
Newborn Life Support training compliance - Midwives	Feb 23	99%	-			87%	77%	97%
Minimum safe staffing in maternity services to include Obstetric cover on delivery suite, gaps in rotas (hours)	Mar 23	123	-			106	104	109
Midwifery Staff Fill Rate	Feb 23	87%	-			88%	75%	100%
Midwifery bank usage	Feb 23	13%	-			11%	5%	16%
Midwifery Agency Usage	Feb 23	7%	-			7%	2%	12%
Progress in achievement of CNST	Dec 22	1	-			8	7	10
Proportion of Midwives responding with 'Agree or Stgrongly Agree' on whether they would recommend the Trust as a place to work or receive treatment	Dec 22	6%	-			6%	#N/A	#N/A
Porportion of specialty 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)	Dec 22	90%	-			90%	#N/A	#N/A

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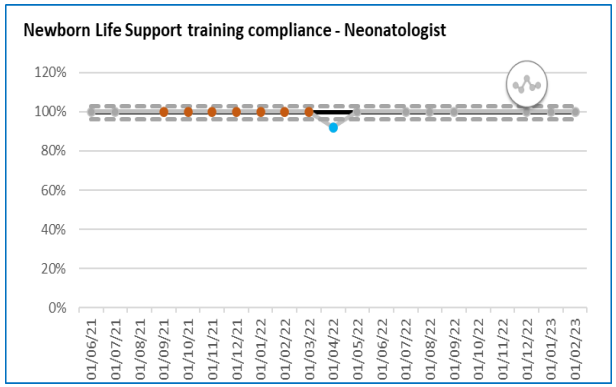

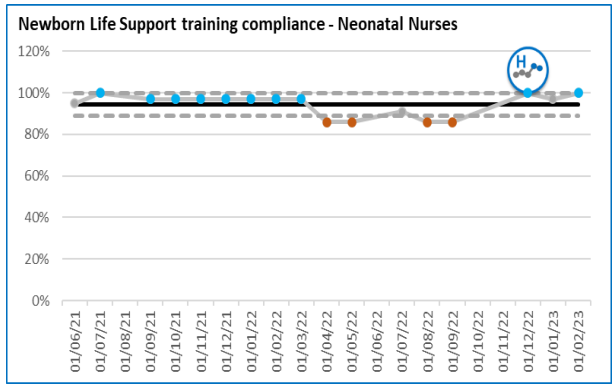

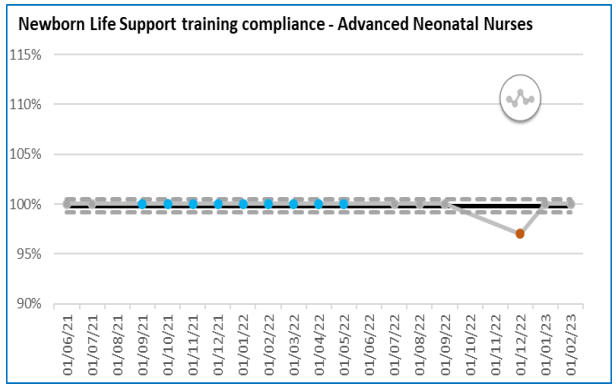

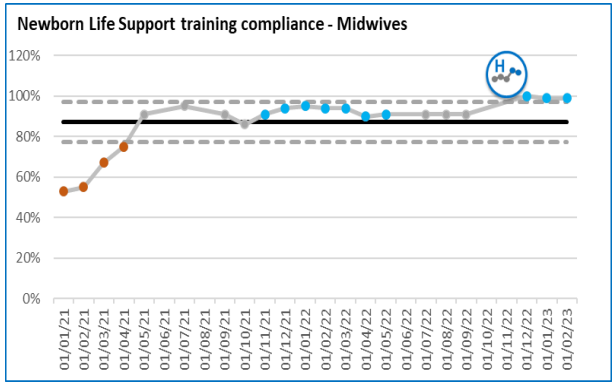

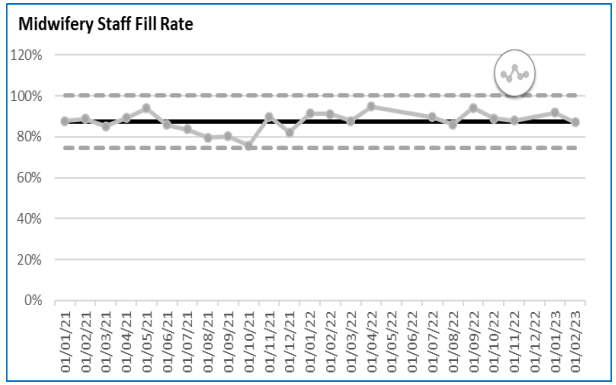

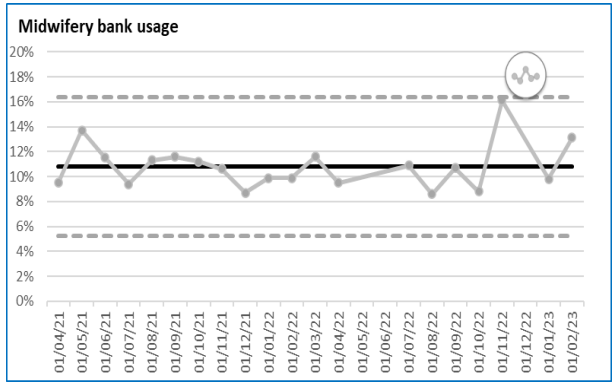

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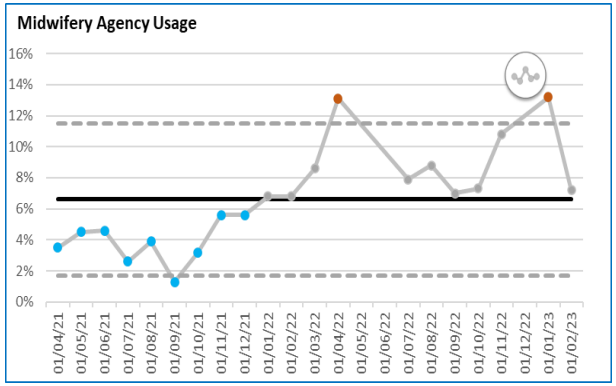

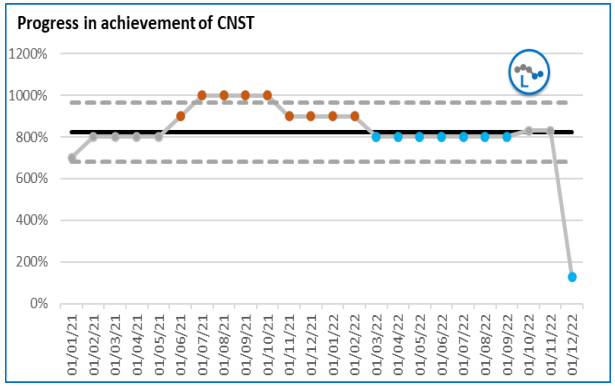

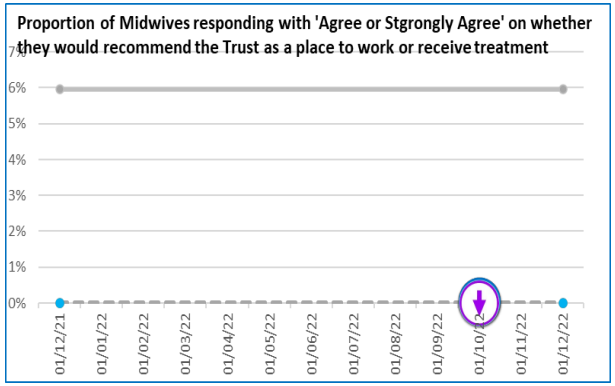

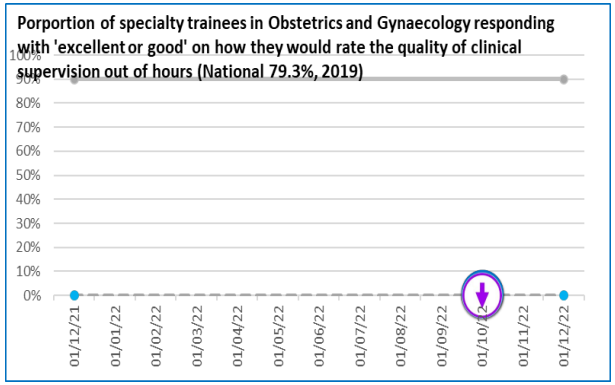

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Thank you

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OUR VALUES
Commitment
Care Quality

West Hertfordshire Teaching Hospitals NHS Trust

Trust Board Meeting
1 June 2023

Title of the paper:	Maternity consolidated report (Jan 2023-March 2023 Q1)
Agenda Item:	21
Presenter:	Michelle Hope, Acting Chief Nurse Mitra Bakhtiari, Director of Midwifery, Gynaecology Nursing/Deputy Chief Nurse
Author(s):	Mitra Bakhtiari, Director of Midwifery, Gynaecology Nursing/Deputy Chief Nurse
Purpose:	*Please tick the appropriate box* *For approval*: [ ] *For discussion*: [ ] *For information*: [x]
Executive Summary:	The purpose of this quarterly report is to provide an overview of quality and safety of maternity services for assurance. This fulfils the quarterly reporting requirements in line with the Ockenden reviews and Maternity Incentive Scheme (Technical guidance October 2022 on diligent resources). This report covers six domains for consistency: • Report on Perinatal mortality review tool • East Kent Kirkup report • Ockendon review update (part 1 & 2) • Maternity Safety Champion Report • Maternity Voices Partnership • Avoiding Term Admissions into Neonatal Units (ATAIN) Key points to note: • The trust is fully compliant with Ockenden first report. • The compliance with Ockenden final report is over 90% and the remaining outstanding actions are on track for completion and impose low risk to the organisation. • The trust has an agreement to join EOE maternal medicine network (MMN) based on a hybrid model with an option for referral to Northwest London MMN. • The trust has completed a Gap analysis against the recommendations from the East Kent report (Appendix 1) based on the LMNS benchmarking tool that will be incorporated in a single action plan following publication of NHS England single delivery plan. • ATAIN performance remain below the 6% national average.
Trust strategic aims: *(please indicate which of the 4*	**Aim 1 Best care** / **Aim 2 Great team** / **Aim 3 Best value** / **Aim 4 Great place**

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aims is relevant to the subject of the report)	***Objectives 1-4***	***Objectives 5-8***	***Objective 9***	***Objective 10-12***
	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: Quality Committee, Divisional Governance Date: April 2023, Maty 2023
Action required:	The Board is asked to receive this report for information and assurance of the evidence of quality safety of maternity services for discussion and assurance.

West Hertfordshire Teaching Hospitals NHS Trust

Agenda Item: 21

Trust Board: 1 June 2023

Title of paper: Maternity consolidated report (Jan2023-March 2023 Q1)

Presented by: Michelle Hope, Acting Chief Nurse
Mitra Bakhtiari, Director of Midwifery, Gynaecology Nursing/Deputy Chief Nurse

1. Purpose

1.1 The report is intended to provide assurance to the Trust that maternity services, in line with national recommendations are focused on improving and sustaining high quality care to families who choose WHTH. The report is based on locally and nationally agreed measures for monitoring maternity and neonatal safety, as outlined in the NHSEI document 'Implementing a revised perinatal quality surveillance model' (December 2020).

1.2 This report includes description of compliance with national reports into safety of maternity services and performance against recommendations, including the quarterly reporting requirement based on MIS year 4. The report aims to highlight any areas of concerns for Ward to Board insight that have been shared across the multi-disciplinary maternity services team.

1.3 The information within the report will reflect actions in line with the Ockenden Independent Maternity Review (2020), and progress made in response to any identified concerns at service level.

1.4 The six domains within the report highlights areas of good practice and those of concern.

2. Background

2.1 In line with the recommendations from the Ockenden Report (March 2022) and Maternity incentive scheme (MIS year 4 on diligent resources October 2022), the Trust is required to systematically review quality and safety of maternity services using a locally agreed Perinatal Quality Surveillance Tool, as well as Perinatal Mortality Review Tool and report to the Trust's quality committee for oversight on a quarterly basis.

2.2 This is to ensure transparency of maternity services and timely escalation of any concerns.

3. Analysis/Discussion

3.1 Perinatal Mortality Review Tool (PMRT)

3.1.1 The aim PMRT is to provide a standard approach comprehensive multi-disciplinary review of all eligible cases and to provide bereaved parents information about why their baby died. A secondary aim is to ensure local and national learning to improve care and ultimately prevent future baby deaths. Eligible cases include:

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- Late fetal losses where the baby is born between 22^{+0} and 23^{+6} weeks of pregnancy showing no signs of life, irrespective of when the death occurred, or if the gestation is not known, where the baby is over 500g.
- All stillbirths where the baby is born from 24+0 weeks gestation showing no signs of life.
- All neonatal deaths where the baby is born alive from 22^{+0} but dies up to 28 days after birth.
- Post-neonatal deaths where the baby is born alive from 22^{+0} but dies after 28 days following neonatal care; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

3.1.2 **WHTH PMRT quarterly report Jan-March 2023:** the trust has continued to use the PMRT tool to review all eligible deaths in the reporting period. In the period Jan- Mar 2023 there were 6 cases reported to MBRRACE within 7 days and the PMRT tool for all eligible 4 cases is on track for completion and one case has been reviewed, see below:

Case	Cause of death
36+5 stillbirth	? secondary to multifocal chronic 'villitis of unknown aetiology' (or 'VUE')
35+5 stillbirth 1 twin	Undetermined
40+6 stillbirth	Undetermined
24+6 stillbirth	Severe early onset IUGR
36+2 stillbirth	In the absence of any other information, it is most likely that the intrauterine death is secondary to the abruption
24+4 stillbirth	Undetermined
22+3 NND	Extreme prematurity and chorioamnionitis
22+2 NND	Extreme prematurity, placental abruption, born outside of hospital environment
29 NND	Tracheal Agenesis

3.1.3 **Summary of the case reviewed (36+5 weeks, Antenatal stillbirth)**

Following the MDT review of this case which considered the information from the post-mortem, placental histology and other investigations, the cause of death of this baby was determined to be VUE (Villitis of an Unknown Etiology). This is a rare manifestation related to maternal-fetal immune interaction. VUE is associated with an adverse pregnancy outcome, including IUGR, prematurity and stillbirth. There was a missed opportunity to act on an abnormal BP at 32 weeks and electronic fetal monitoring. The investigation will be able to determine if this had contributed to the outcome although unlikely. In view of the risk of Thrombosis, low molecular volume Heparin (Clexane) was commenced at 28 weeks, although the dose was incorrect and therefore changed at 35 weeks and 4 days. This however did not make a difference to the outcome. Bereavement care was appropriate including follow up to discuss future pregnancies.

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3.1.4 The trust is on track for completion of PMRT tool within the specified deadline, see below RAG rated summary:

Case details	Date occurred	Date notified to MBRRACE (7 days)	Surveillance completed (within 1 month)	Letter sent to parents/ offered to ask questions	Questions from parents	Tool commenced (within 2 months)
36+5 Stillbirth	05.01.23	06.01.23	20.1.23	16.01.23	No	24.2.23
31+5 Stillbirth	14.01.23	16.01.23	20.1.23	23.01.23	Yes	07.03.23
30+5 Stillbirth	24.1.23	24.1.23	24.1.23	10.02.23	No	23.03.23
41 Stillbirth	26.2.23	28.2.23	28.2.23	27.2.23		26.04.23

3.1.5 Shared learning identified from completed reports in the reporting period that would not have had any impact on the outcome are:

Issue raised
Completion of Domestic Violence questions
Antenatal Aspirin in line with risk factor
Missed information about domestic abuse risk assessment
CTG misinterpretation
Referral to smoking cessation service in view of living with family members who are smokers
Margin of error associated with scans that did not detect IUGR
Failure to act on abnormal BP
Use of the interpreter at every antenatal visit
The opportunity to take their baby home was not offered to the parents
The parents were not provided with written information about practical issues following the death e.g. funeral options and benefits

3.1.6 PMRT is discussed at departmental clinical governance on a quarterly basis led by bereavement lead midwife. In the reporting period all cases reviewed met the following requirements:

1. All cases are reported to MBRRACE within 7 working days
2. for 100% of cases that fit the criteria a PMRT tool have been generated
3. 100% of reported PMRT cases have been reviewed and completed within the 4 months recommendation
4. 100% of reported PMRT cases are on track for a multi-disciplinary team including an external reviewer
5. All parents who fit the criteria for PMRT review were given written information

3.2 **Independent Investigation into East Kent Maternity and Neonatal Services**

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3.2.1 The independent review of 202 families' maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust (*Reading the signals*) was published on 20th October 2022. The report sets out the devastating consequences of failings and the loss and harm suffered by families receiving maternity/neonatal care. The report found that the trust board missed eight opportunities during 2009-2020 to acknowledge the extent of problems and solve them. There was a failure to recognise internal factors compromising safety. In the cases reviewed, the trust failed to demonstrate an open and honest approach, and this was exacerbated by the repeated turnover of staff at senior levels. Where families brought in concerns, the Trust focused on reputation management, reducing liability through litigation that disrupted patient safety and learning.

3.2.2 WHTH has used the LMNS wide benchmarking tool and completed a gap analysis against the recommendations. (Appendix 1) focusing on areas that trusts have been called to action for ongoing improvements. These are:

1. Monitoring safe performance; finding signals amongst the noise
2. Standards of clinical behaviour; technical care is not enough
3. Flawed team working; pulling in different directions
4. Organisational behaviour; looking good while doing badly

3.2.3 WHTH has a maternity consolidated action plan that is reviewed monthly which will incorporate the initial East Kent Gap analysis. This will be used to ensure the trust is taken appropriate steps to improve quality and safety as well as patient experience by actively listening to families and use co-production as a mechanism to individualise care as per recommendations.

3.2.4 **Key successes**:

- Compliance with MIS year 4
- Implementation of Digital maternity system
- Cultural awareness training and development for senior staff
- Effective risk and governance process including shared learning (internal audit nov 2022 demonstrated moderate assurance)
- Human factors training as part of MDT training.
- Agreed training days ahead of implementation of PSIRF (Patient Safety Investigation Response Framework)
- Established staff engagement process including Freedom to speak up for safety guardian service.
- Established shared learning across EOE Local Maternity and Neonatal System (LMNS).
- Regional support visits have been completed with recommendations and no immediate safety concerns. The trust has welcomed the joint ICB/WHTH visits for further transparency and demonstration of continued improvement within maternity.
- Staff awaydays for 2023 have commenced to align vision, purpose, and mission as well as developing strategy and team building.

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3.2.5 **Next steps:** The trust will align the existing consolidated action plan (presented to the quality committee in February 2023) following completion of the LMNS's review of the national maternity single delivery plan published March 2023. The overarching action plan will incorporate the East Kent Gap analysis. Furthermore, the trust is expecting:

- Saving Babies Lives Care Bundle (SBLCB) version 3 is due to publish in early 2023 in line with national ambition to reduce stillbirth rates and perinatal deaths.
- Sixty Supportive Steps to Safety V2 site visits 2023 arranged.
- CNST MIS year 5 is due for publication on 31st May 2023.
- NCST MIS year 4 was published on 19th May and the trust is amongst 38% of trusts in EOE that fully achieved all 10 standards.
- The trust has an agreed maternity Equity, Diversity, Inclusion (EDI) plan in line with the EOE LMNS, this will progress alongside Personalised Care Programme and is entitled 'To Promote Inclusion Across our Services' as part of Better Care Delivered Differently.

3.3 **Ockenden (part 1 & 2)**

3.3.1 The trust is compliant with 7 Ockenden immediate and essential actions (IEA's) from the first report following implementation of digital maternity system.

3.3.2 The trust is over 90% compliant with 15 IEA's from the final report (19 out of 123 actions are amber and the remaining actions are complete). The remaining actions impose a low risk to the trust.

3.3.3 The trust has an agreed plan to join EOE maternal medicine network (one of 17 nationally) that includes training and education. This includes an option to work with NWL to facilitate better access for families living in closer proximity to London. A maternal medicine midwife has been appointed as well as a research midwife. The trust is finalising the referral processes and planned care for women with pre-existing medical conditions, and this includes preconception care and perinatal mental health counselling, and this is in line also with Ockenden final report. The trust is working towards a designated pre- term midwife to support birth optimisation and optimal outcomes for pregnancies at risk.

3.3.4 Active bystander training is planned to be introduced in Summer.

3.3.5 Plans for leadership development of labour ward coordinators are in progress working closely with LMNS and the trust learning and development team.

3.4 **Maternity Safety Champion Report**

3.4.1 In line with MIS safety action 9 Maternity Safety Champions (MSCs) work plan has progressed including monthly visits to the maternity unit and monthly meetings involving board-level maternity safety champion that have acted as a conduit between the board and the service level champions. The role of the maternity safety champions is to support delivering safer outcomes for pregnant women and babies. The Trust Maternity Safety Champions have been meeting monthly to discuss triangulation of information gathered from visiting maternity services, speaking to staff and families.

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3.4.2 Staff have fed back no safety concerns and discussions around the digital system Badgernet received positive feedback.

3.4.3 **Actions progressing in the reporting period includes**:

- Refreshed Perinatal Quality Surveillance model.
- Review of the CQC maternity survey results and action plan
- Review of maternity refurbishment work to include wards, staff areas and office space optimisation.
- Positive feedback from staff regarding the evidence to support improving working environment and staff rest areas.
- Positive feedback regarding the implementation of digital maternity system
- Staff felt supported during training and digital rollout phase.
- There is evidence of established MDT hand over and shared learning from clinical incidents.
- Timely review of families attending Triage is in line with evidence based BSOT model.
- The trust is progressing towards the prestigious Baby Friendly Initiative stage 3 assessment in October 2023 aiming to optimise infant feeding options for families.

3.5 **Maternity Voices Partnership**

3.5.1 The trust has an established process of meeting with service users monthly. The chair of MVP has continued 15 step walkabouts in the maternity unit. The feedback from experiences of a wide range of family groups have been shared with the service via trust MVP and LMNS wide. In the quarter the trust received 2 complaints; the themes are communication of pathways of care. The Maternity Voices Partnership (MVP) service user group provide feedback received via an online padlet available in different languages and during face-to-face interactions in the community. Generally, there is positive feedback about the quality of care and negative comments is related to the anxiety around availability of the low-risk unit. This is being closely monitored and in view of the drop-in midwifery vacancy rates (12.9% down from 13.8%) the number of occasions when the low-risk unit is diverted to delivery suite has decreased. This is closely audited and feedback at the MVP meetings.

3.5.2 **Service User Feedback and engagement with the wider community**

- Introduction of sibling visiting has been received well and further advertisement and updating the website is planned to ensure families are aware.
- Friends and Family Test scores show that over 95% of responses are positive and recommending the service.
- The feedback is reviewed at MVP meetings.
- The last Picker National Maternity Survey data was provided to the Trust in Jan 2023 and banded the trust ‘About the same’ as 2022 and an action plan will be jointly agreed

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with MVP. The key areas of improvements are care after birth, choice of place of birth and infant feeding support.

- 2 complaints raised at MVP meetings in the reporting period, which have been referred to debrief clinics and MVP has reported that all issues have been resolved and therefore they will not progress to formal stage. Key issues were conflicting information, availability of a side room and considering partner staying overnight to enhance psychological support. The trust has been asked to monitor that lessons are learnt. The trust is in the process of reviewing the debrief clinic with revised workforce planning for sustainability and consistency and how the information is shared to encourage referrals and further reducing formal complaints. The service is aiming to ensure families are aware that when they feel ready, they have an opportunity to discuss their care.
- Introduction of live videos on Facebook has been tested led by Head of midwifery to encourage families particularly from Black, Asian, and other minority groups to join for a live interaction and ask any questions relation to maternity care. A video is planned to encourage families to use the badgernet portal that provides information in real time as women progress in tehri pregnancy. This can be initiated at booking.

- Further work is in progress to identify areas of co-production for example review of the behaviour charter in maternity, information and leaflet design focusing on Baby Friendly Initiative and content of the patient facing boards.
- MVP continues to be involved in recruitment of midwifery staff as evidenced in the recruitment audits.
- Current programs on MVP workplan include Birth options re-design, PPH project, digital information on maternity system, Induction of labour infographics and pregnancy scan leaflets.

3.5.3 Next steps

- review of MVP membership and capacity as maternal medicine networks establishes, with focus on disproportionate outcomes for women from Black, Asian and ethnic minority groups. In view of low FFT responses (below 25%), increasing the number of feedbacks received from families and further involvement in complaints management and shared learning.
- Following the publication of CQC maternity survey results, revised action plan will be agreed with MVP to support the trust improve scores.

3.6 Avoiding Term Admissions into Neonatal Units (ATAIN)

62 admissions Jan-Mar 2023 were eligible for ATAIN review (7%) 172 admissions in CY 2022 (4.3%) 235 admissions (5.5%) in 2021
Respiratory distress – most common singular cause – 45% of admissions [28] Jaundice and Hypoglycemia are both equal for the second most common reason (singular diagnosis) at 7% [4 each] Infection was the cause for 5% of admissions [3] 33% of cases the cases that have been reviewed [16/49] were deemed avoidable

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Key Learning points Avoiding term admissions and short stays to neonatal unit reduces preventable harm & improves mother/infant bonding, breastfeeding rates, and long-term outcomes. Sustained reduction in term admission rates well below regional and national average rates – testament to MDT working and culture within the perinatal team. Further improvement hinges on successful reduction of respiratory distress: • Co-ordinated drive to reduce pre labour caesarean sections before 38+6 weeks. • Enhanced pathways to identify at risk infants for jaundice, feeding difficulties. • Normothermia quality improvement project – work on sustainability • Short stay transfers need to monitored more closely – innovative solutions i.e. rapid response team model could reduce such transfers

3.6.1 Avoiding Term Admissions Into Neonatal units (ATAIN) is part of the MatNeoSIP programme that provides the framework for best practice to reduce term admissions. The trust has a weekly multidisciplinary review of all term admissions with a view to understanding reasons and identifying avoidable admissions. Learning is shared locally and LMNS wide aiming to reduce mother/infant separation.

3.6.2 Nationally set target for term admission is < 6 % (< 6 term babies out of 100 births). The trust has achieved sustainable reductions in term admissions the last 4 years (8.4 % to < 4 %).

3.6.3 Newborn respiratory distress, jaundice & feeding problems related readmissions are the most common reasons for admission and consequent mother infant separation.

3.6.4 In line with Maternity Incentive Scheme (MIS) from 18th July 2022 this review has included all admissions regardless of the length of stay.

3.6.5 **Term admissions** (> 4 hours stay in neonatal unit)

Term admissions to the neonatal unit in the reporting period was to 5% in Q4 Jan-Mar 2023 (41/860 live births) compared to 4.3% (172 term admissions/3969 live births) in Jan – Dec 2022. However, 6 out of 41 (15%) of cases were avoidable in the most recent quarter compared to 16.8% (29) of the 172 admissions were deemed avoidable in 2022. The service has been proactive in setting up MDT ATAIN reviews and numerous changes have been embedded to practice (Hypoglycaemia framework for practice, sepsis proforma, respiratory distress guidelines) alongside work to address

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changes to traditional/cultural practices on oxygen weaning and monitoring duration after discontinuation of oxygen. Whilst term admission rates have significantly improved, there has been a recent increase (remaining on target). Current focus is on sustaining these improvements and to look for marginal gains and efficiency in clinical pathways.

3.6.6 **Short stays**: (< 4 hours stay in neonatal unit)
Between 01/01/2023 – 31/03/2023 there were 21 short stay transfers to neonatal unit. The service had 860 live births in this period. Short stay transfers / live births = 2%. There is no nationally available metrics to benchmark this parameter. Reasons for short stay (4 have yet to have reason for admission confirmed):

- Respiratory distress: 7/21 (33.3%)
- Hypoglycemia: 4/21 (19%)

The other avoidable reasons for admission included pain [1], high pitched cry [1], infection [1], and jaundice [1]. Respiratory distress appears to be a predominant cause for short stay observations and consequently mother and infant separation. 10/21 (48%) of short stay cases were avoidable as decided by ATAIN MDT review panel.

3.6.7 **Risks**: higher rates of term admissions and short stay transfers result in poor patient experience, adverse impact of maternal well-being, anxiety, and poor breast-feeding rates. This increases staff workload, can lead to diversion of resources from essential neonatal care. National improvement goals conflict with pricing/tariff for neonatal critical care. Lower rates of term admissions result in reduced care days in Neonatal unit and consequent decline in unit income against budget. In a clinical activity-based payment model this could act as a barrier/threat to adequate resource allocation for neonatal service. (e.g. establishment reviews, workforce plans are largely activity not outcome based. The service will continue to review closely each admission and shared learning to ensure sustainable reduction.

4.0 Conclusion

4.1 The data within this report provides an overview of the process of monitoring quality of safety within maternity services that meets the quarterly regional and local reporting requirements.

4.2 The successful implementation of the digital maternity system on 28th March 2023 will play an important role in enabling transformation and improving efficiency.

4.3 Following the publication of the national single delivery plan, the trust in collaboration with the LMNS will develop a three-year improvement plan as a framework for sustaining high quality maternity service that is able to withstand external assessment.

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4.4 The trust aims to further understand what is required to close the gap in disproportionate outcomes for pregnant people from black Asian and other minority groups, working closely with the maternity medicine networks.

5.0 Recommendation

5.1 The Trust board is asked to receive this report for information and assurance of the evidence of quality safety of maternity services for discussion and assurance.

Name of Director: Michelle Hope, Acting Chief Nurse

Date 25th May 2023

Appendix 1: East Kent gap analysis response

WHTH Gap Analysis East Kent – 'Reading the Signals'

Findings	The Future	Consideration for benchmarking	Trust Position	Evidence	Consideration for LMNS Role
Key Action Area 1: Monitoring Safety Performance					
• No reliable early warning system/mechanism in place to monitor safety in real time and identify relevant signs in relation to perinatal outcomes • No meaning, reliable, risk adjusted, timely outcome measures, often maternity outcome data concealed the truth amongst generic groups, league table and spurious ranking	Identification of early warning signs where action can be taken before problems and behaviours become embedded	**Themes emerging from:** Serious investigations HSIB investigations Datix PMRT Complaints CQC Survey Claims Staff feedback (e.g. staff survey) Governance strategy /process GIRFT Ockenden insight visit MNVP feedback	The Trust is able to demostrate shared learning from the themes emerging from: Serious investigations HSIB investigations Datix PMRT Complaints CQC Survey Claims Staff feedback (e.g. staff survey) Governance strategy /process GIRFT Ockenden insight visit MNVP feedback		The LMNS having a pathway that facilitate co-production with the MNVP Identify Trust that are preforming well or outliers. This will be accomplished by reviewing and benchmarking : maternity dashboard feedback from complaints, review of claims and external reports Staff feedback and use this data to work collaboratively to improve standards or share the process of what is working well
	Regulators can identify units that are outliers and investigate appropriately	**Concerns raised in the last 12 months:** HSIB immediate concerns CQC Sixty Supportive Steps to safety 15 steps Preventions of Future deaths RCM GMC RCOG Health Watch Universities NHSE Ockenden insight visit HEE	In the past 12 months, only one concern has been raised through these channels. This was a case of 'Whislteblowing' to the CQC and the correct process were followed to investigate and respond.		There should be a process in place when internal and external concerns are raised the LMNS is notified and work collaboratively from the onset with Trust.
	All parties can have a conversation based on relevant shared information	**Governance process:** Open and transparent to all Escalation from Ward to Board and Board to Ward Freedom to Speak Up Guardians Collaborative work with local CQC officer Is there an internal process in place when and how to escalate to the LMNS/ICB and the regional maternity team	The trust has a robust ward to board assurance, a local perinatal quality survailance model is followed to triangulate intelligence that informs the board of the safety of the maternity services. A freedom to speak up guardian visits the maternity service regularly and this staff member reports feedback to the board. The Trust's CQC officer keeps in regular contact with the maternity services and arranges mock CQC inspection to monitor the service. LMNS populate a perinatal quality surveillance model which is discussed at the monthly meeting, This feeds into the ICB quality committee.		LMNS to work collaboratively with the Trust governance team - to be the fresh eyes to identify areas of concerns or good practice. This should be accomplished by 1. assurance reviews to look at action plans form national and local reports 2. Assurance and Fresh Eyes visits 3. Regional learning events that are framed from outcomes from adverse events and good practice, QI projects, audits, change in practice

	Measures utilised are meaningful, risk adjustable, available and timely and presented in a way that is relevant	**Measures:** Clinical Audits You said we did Recommendations and from investigations SMART action plans Gap analysis to bench mark and action improvement Risk register reviews Staff updates/feedback Dashboard - accurate data MSDS- compliance Reviewing closed claims - is there a processes in place ? How is the learning shared ?	Maternity has an annual audit plan which reports to a monthly maternity/obstetrics audit meeting. We identify any areas around 'you said we did' at monthly maternity/neonatal safty champion walkabouts and action taken. For example, improvent of the environments. Maternity has a consolidated action plan that includes actions against recent benchmarking. There is an established trust wide risk register review process, chaired by the medical director. There are trust wide mechanism to gather feedback from staff: listening sessions with the exec, staff surveys, 1:1, lead professional midwifery advocate sessions. We have an establish neonatal and maternal dashboards in line with LMNS and MSDS. We are compliant with MSDS The learning from closed claims is monitored through GIRFT. We have to		LMNS/ICB to establish a process to ensure recommendations are actioned and embedded Standardisation of the Dashboard data
	Task Force to be established	Measures: Clinical Audits You said we did Recommendations and from investigations SMART action plans Gap analysis to bench mark and action improvement Risk register reviews Staff updates/feedback Dashboard - accurate data Reviewing closed claims	There is established risk and governance processes and includes designated staff to oversee audit and guidelines, shared learning, and the risk register. Labour ward forum and antenatal/postnatal forums have been established to monitor learning and themes from all workstreams and to monitor that anything identified, or escalated, through the risk and governance processes are adressed to ensure that the teams are following the correct processes. Their work is fed back to the neonatal/maternity safety champion meetings.	AN PN FORUM AGENDA. docx S LW forum minutes 02.09.22 - copy.doc	
Key Action Area 2: Standards of clinical behaviour -technical care is not enough					
• Failure to listen to women affected patient safety; their voices not given regard required • Need for staff to behave professionally and show empathy • Openness and honesty always not evident- institutional defensiveness blame-shifting and punishment • Stubborn and entrenched poor behaviour across all clinical groups was normalised and tolerated • The influence of senior role models impacted on all staff • When issues were highlighted, they were dismissed, challenged or ignored	Compassionate care, listening to women should be re-established and re-emphasised as part of clinical practice	**Themes emerging from:** Complaints - actions Serious Investigations - actions HSIB- actions Social media-actions MVP feedback- actions You said we did - evidence of this	We have established process to gather feedback from the families. This is monitered through the monthly divisional perforamce reviews and features our dashboard. There is a fortnightly meeting with complaints where we identify themes. Comments shared via social media are shared, including compliments and complaints. FFT and matrons monthly survey are both used to gather further feedback and these results are shared at the monthly maternity governance meeting. MVP monthly meetings feedback is shared with the Trust board. The MVP also carry out a regular walkabout of the departments.		LMNS to continue support Trust with training . Already undertaking Mars Lord, Birthrights , Human Factors

Challenged or ignored	Every interaction should be based on kindness and respect, achieved via the attitudes and behaviours of clinicians themselves	**Themes from:** CQC picker survey -how this used to inform learning and frame staff training? Complaints - How are the themes from complaints shared with staff ? Are there actions plans in place? Do not be afraid to ask Is there a process for women and birthing people stories shared? Friends and Family Test Training undertaken by staff, including leadership team eg Mars Lord , Birthright training, Civility Saves Lives Staff Cultural survey	We have an agreed behaviorial charter within maternity and staff are held to these standards through line management processes, and any concerns are address through HR. Staff are bound to the Trust values as part of their employment contract. Any concerns raised via complaints, PALS, survey responses, and FFT, are addressed as above.	Maternity behavioural charter	
	Professional behaviour and compassionate care to be embedded into training and CPD	**Processes:** Staff at all levels understanding duty of candour? Understand what the meaning of birth rights are. How else does your organisation measure this? Equality and equity policy, does it reflect the national requirements and the local needs of the of developing staff (eg was the findings of staff cultural survey used) Human Factors Training? How are employee behaviour concerns dealt with after an escalation? Is staff aware of the aim of the Freedom to Speak Up Guardians and how to use it? Does staff know how the purpose of Freedom to speak up Guardians and how to access this service? How do you know if your staff feel safe to speak up ?	The mandatory annual training for staff includes cultural awareness, how to raise concerns, introduction to freedom to speak up. Duty of candour and consent is covered under mandatory training. And we audit duty of candor compliance. Human factors training is avaliable and all staff are encouraged to attend and we have evidence that many staff members have attend.	Facilitator PROGRAMMEMED 1.07.03.23.docx Facilitator PROGRAMMEMED 2.08.03.23 PROMPT Facilitator programme copy 06.03.23.docx	
	Staff should acknowledge and accept the authority of those in clinical leadership roles (essential for the effective and safe functioning of the service) and they must have time and skills to carry them out	**Consider:** Equality and equity policy, does it reflect the national requirements and the local needs of the of developing staff (eg was the findings of staff cultural survey used) Does staff at all levels feel respected and treated with dignity? What was the finding from staff cultural survey. What has the Trust implemented Training in place for management team? Does staff feel listened to? Are there listening clinics for staff ?	Key members of the leadership team have been allocated to attend cultural awareness training. Maternity hold listening sessions facilitated by HR and the EDI team. Also sessions are facilitated by the executive and non-executive trust board members.	DC044490.msg 5BBED4C3.msg	Facilitate training
	Reasonable and proportionate sanctions are required for employers and regulators to address poor behaviours	**Consider:** How does your organisation review and manage behaviour that is outside of the Trust values? Staff culture survey - what are the themes from this? What actions have been taken to address this?	Managing poor behaviour is carried out in line with the Trust's HR policies. Themes from staff feedback (anonymised and not) are addressed as required.	HR044_Disciplinary_Policy_v10.pdf	
Key action area 3: Flawed teamworking - pulling in different directions					

•Dysfunctional team working • Poor relationships between and within professional groups - teams did not share a common purpose • Toxic and stressful working environments • Arguments occurring in front of women and families • Failure of trust and respect • Different staff groups seen as defenders and inflictors of medicalised care • Clinicians in training felt isolated, exposed and vulnerable - worked unsupervised in complex situations beyond their experience	• Find a stronger basis for teamworking in maternity and neonatal services based on an integrated service & workforce with common goals & a shared understanding of the individual and unique contribution of each team member in achieving them (i.e., no different objectives for a professional group)	**Consider:** Equality and equity policy, does it reflect the national requirements and the local needs of the community it serves, including the needs of staff - eg review the Healthwatch document Making Local Healthcare Equal 2022 Who was engaged in the document's creation? MVP, Black, Asian, and ethnic minority employees The staff culture survey - how has the findings been used to meet the needs of the staff, is there an action plan, has the information been used to frame what are the next steps required to develop a safety culture? How are you monitoring Equality and Equity foe women/pregnant people and staff Debriefs - are debriefs undertaken following emergencies with adverse and good outcomes? Have you consider the introduction of After Actions Reviews (AAR) Are the departmental meetings and Divisional meeting MDT ?	The Equality and equity assessment is part of the trust-wide guideline approval process, and all guidelines must be assessed using this tool. This was created by the EDI committee which is multicultural and inclusive. And action plan has been fomulated on the findings of the cultural survey. For example, from the GMC survey MSDS captures ethnicity data and includes clinical investigations. Risk assessments are carried out at antenatal appointments and between care settings and throughout maternity care. Better care delivered differently also assists with monitoring Equality and Equity. Risk assessments/flexible working assessments are also carried out for staff. Hot debriefs are used to support staff and share learning following an emergency situation. Lead PMA and educational supervisors support with this. As part of the implementation of PSIRF AARs will be introduced. Monthly departmental meetings and Divisional meetings are muli-dicisplinary. These feed into the wider governance structures in the Trust. Staff well-being days are held		To support Trust in getting staff trained in undertaking debriefs, AARs The LMNS equity and equality work to continue to evolve to reflect the needs of the community it service and staff. This should be undertaken by reviews of the process with the action plan, updating and revising as required
	• Teams who train together work better together over and above the use of emergency drills training (from undergraduate training onwards)	**Consider:** Are handovers/huddles representative of all disciplines? Are huddles and handovers reflective of equality and equity? Are departmental and divisional meetings reflective of MDT attendance which facilitate Team work ? MDT training including embedded live stimulations with constructive debriefs in the form of AARs? Feedback from RCOG, Neonatal (BAPM) Deaneries and Universities?			
	• Re-evaluation of the changed patterns of working and training for junior doctors (unintended consequences of fragmentation of work and support given)	**Consider:** Has there been an analysis of the change in junior doctors training and working?	Through the GMC survey we assess the experiences of the juniour doctors training programme and placements. Actions are created to address gaps, and this is monitored through LMNS.		
Key action area 4: Organisational behaviour - looking good while doing badly					
• Reputation management was prioritised to the detriment of being open and straightforward with families, with regulators & with others • Concerns were dismissed and complaints were managed rather than seen as a source of feedback and learning • There was too much effort spent on seeking to challenge and undermine scrutiny from external reports • Pattern of hiring and firing of the senior teams (frequent short-term appointments may be counterproductive) • Ethos of 'heroic leadership' followed by high levels of criticism	• The need for openness, honesty, disclosure and learning must outweigh any perceived benefit of denial, deflection and concealment	**Consider:** Duty of candour - Does all staff have an understanding of this? Is there a process in place to ensure this is undertaken verbally and followed up by a letter where required ? Is the DoC completed when complaints and investigations are signed off? Are women and their families given the opportunity to have a meeting with the clinicians who have completed the complaint response or investigation? Investigation process - Is it MDT as required? Are there external investigators (excluding HSIB)?	The trust board has sight of maternity quality and safety through a structured workplan. Safety champions provide assurance to the quality committee and escalate any isssues to the trust board. Duty of candour is included in mandatory training and is audited and presented at departmental governance forum. Women and families are offerred a debrief sessions to discuss their care and birth option clinics, to facilitate informed choice. There are occassions where the trust may seek external review for SI investigations. The PMRT includes external review for all perinatal deaths reported to EMMBRACE. All SI and HSIB reports are shared with LMNS on a monthly basis.		

	• Need for the introduction of legislation to oblige public bodies and officials to make all of their dealings, with families and with official bodies, honest and open (previously outlined in a public authority bill)	**Consider:** How do does your organisation say sorry?	Apologies are carried out through the duty of candour process, complaint responses, debrief sessions, and in real time where required, for example; managing waiting times.	G003_Duty_of_Candour_Being_Open_P	Feedback the themes from the MVP LMNS reviewing DoC process
	• Organisations have a lasting duty of care	**Consider:** When concerns are raised is there a robust process in place to notify all the relevant parties? Evidence of being open and honest? Maternity representation at Board level? Are responses to complaints and completion of Serious investigations timely? Is there evidence that women and their families are given progress updates ?	Following duty of candour, the family are given contact details to access further updates, to ask questions, or to provide further informations. Families will be informed if there is an unexpected delay in completing investigations. There are agreed deadlines as to when the final report/response must be submitted and compliance with these are monitored.		
	•Review of the regulatory approach to failing organisations by NHSE would identify alternatives to heroic leadership model including the provision of support of trusts in difficulty and incentives for organisations to ask for help rather than conceal the problems	Are you on the a Maternity Safety Support Programme ? Do require further support from the regional team?	The trust is not on the maternity Safety Support Programme. The regional team has been visiting the Trust to support the CQC preparedness and compliance and assurance.	BC31D8AB.msg	LMNS/ICB will assess the mechanism in place to identify Trust that may be experiencing difficulties. The approach should not be designed to provide more loops for the Trust to go through, but rather to engage with the leadership to stabilise and establish transparency.
	•The identification of problems should not be seen as a sign of individual or collective failure but as a sign of readiness to learn.	**Consider:** When care and service delivery concerns are identified is it approached from a system perspective or is there a blame culture ? Are there processes in place for quality improvement , which allow front line staff to lead or involvement ? Are QI methodology used ? What is the Trust progress with the Patient Safety Incident Framework (PSIF)? Has the Trust employed a Patient Safety Specialist?	Care and service delivery problems are reviewed from a system perspective. Staff involved in incidents are supported and are encouraged to lead on QI projects. There is a dedicated QI midwife as part of the risk and governance team. PSIRF is undergoing implementation. We will make the transition for the SI framework soon as part of the Trust plan, The Trust has a link patient Safety Specialist in the corporate team that works directly with the maternity. The Trust also holds a patient safety summit.	CO Monitoring At landscape Poster PC Template Band 8a Quality and Governance Lead Midwife.pdf E3572D7B.msg F28 1B6B7.msg	LMNS to support Trust with Human Factors , with more focus on the systems staff are working in,

West Hertfordshire Teaching Hospitals NHS Trust

Trust Board Meeting
1 June 2023

Title of the paper:	**Mortality and Learning from Deaths Quarter 3 2022/23**
Agenda Item:	**22**
Presenter:	**Dr Tom Galliford, Deputy Chief Medical Officer**
Author(s):	**Deborah Wadsworth, Senior Business Manager**
Purpose:	*Please tick the appropriate box* *For approval* [ ] *For discussion* [ ] *For information* [✓]
Executive Summary:	The purpose of this report is to provide the Quality and Safety Group with an update on Trust mortality and learning from deaths over the quarter 3 period of 2022/3. The latest Dr Foster intelligence report, (January 2023) spans the data period October 2021 to September 2022. Learning from deaths data spans 1 September 2022 – 31 December 2022. HSMR is reported as 94.7, which is within the as expected range. SHMI is also reported as 94.7, which is within the expected range and SMR (all diagnosis) at 92.8 is lower than expected. There are 3 outlying diagnosis groups; • Complication of device implant or graft • Urinary tract infection • Pancreatic disorders (not diabetes) The structured judgement review tier 2 avoidability panel was suspended for the duration of quarter 3 as a consequence of changes to clinical leadership. These meetings are being re-launched in February. Medical examiner scrutiny of cases for both community deaths and trust remains consistently at 100%.
Trust strategic aims: *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1 Best care** — ***Objectives 1-4*** [✓] **Aim 2 Great team** — ***Objectives 5-8*** [ ] **Aim 3 Best value** — ***Objective 9*** [ ] **Aim 4 Great place** — ***Objective 10-12*** [ ]
Links to well-led key lines of enquiry:	☐Is there the leadership capacity and capability to deliver high quality, sustainable care? ☐Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?

	☒Is there a culture of high quality, sustainable care? ☐Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues and performance? ☐Is appropriate and accurate information being effectively processed, challenged and acted on? ☐Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☒Are there robust systems and processes for learning, continuous improvement and innovation? ☐How well is the trust using its resources?
Previously considered by:	Committee/Group: Date:
Action required:	The Board is asked to receive this report for information and assurance on Trust mortality and learning from deaths scrutiny

West Hertfordshire Teaching Hospitals NHS Trust

Agenda Item: 22

Trust Board Meeting – 1 June 2023

Title of paper *Mortality and Learning from Deaths Quarter 3 2022/23*

Presented by: Dr Tom Galliford, Deputy Chief Medical Officer

1. Purpose

1.1 This paper aims to provide a review of trust mortality and related workstreams across quarter 3 2022/23 and to provide an update on current position.

2. Background

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

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

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

3 Mortality metrics

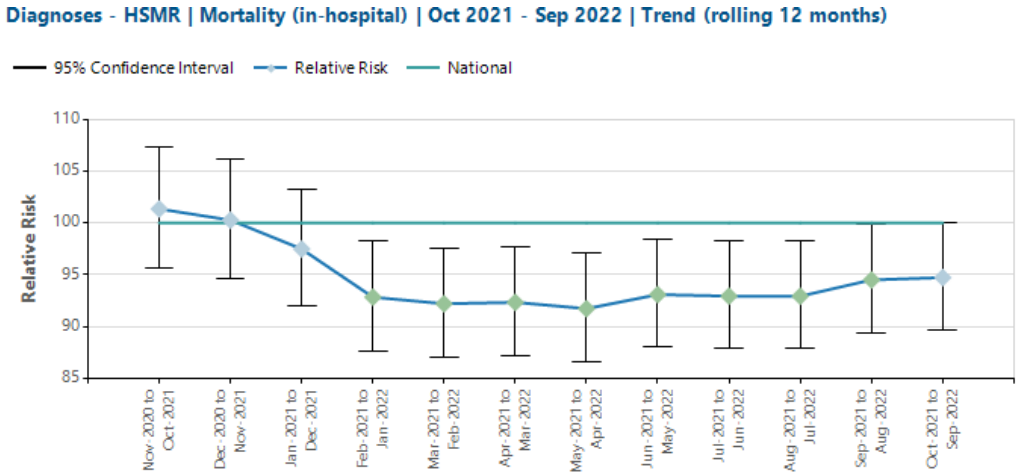
3.1 (Taken from January2022 Dr Foster update which encompasses data from October 2021 – September 2022)

- **HSMR** is 94.7and within the as expected range.
- **SHMI** is 94.7and within the expected range.
- **SMR** is 92.8 and within the lower than expected range

3.2 Overall quantitative performance (the metrics)

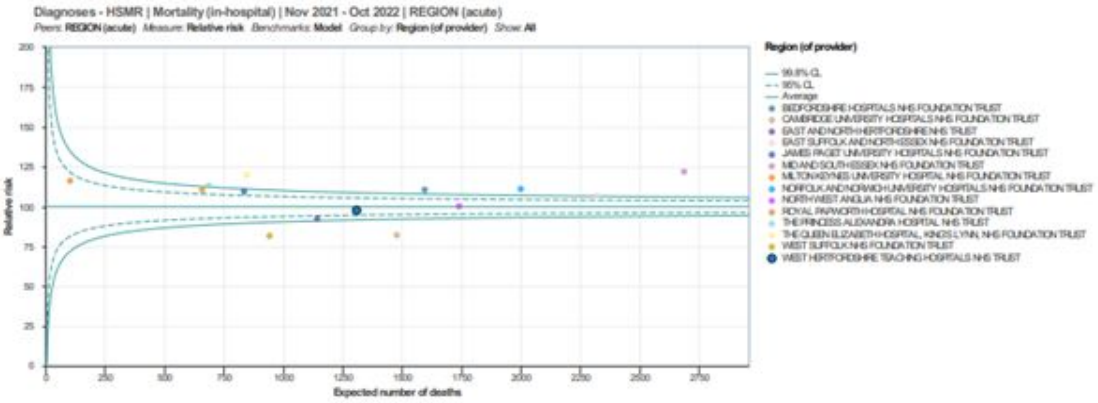
3.2.1 HSMR

a) Chart 1 HSMR rolling 12 months (last point is September 2022)

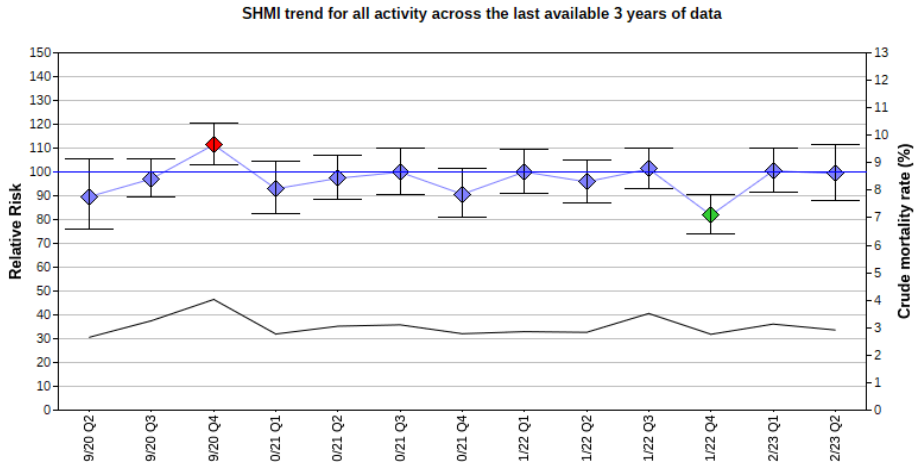


b) Chart 2 Peer comparison

The Trust is 1 of 3 Trusts within the East of England peer group of 14 with an HSMR in the 'as expected' range.



3.2.2 Chart 3 SHMI Last available 3 years (last data point 2021/22)



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

3.3 Outlying SMR and HSMR diagnoses

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

3.3.2 The January Dr Foster report highlighted 3 outlying diagnosis groups:

- **Complication of device, implant or graft** (17 deaths) There have been no new deaths since the most recent consultant coder review. This review of 7 cases led to 1 revision in primary diagnosis.

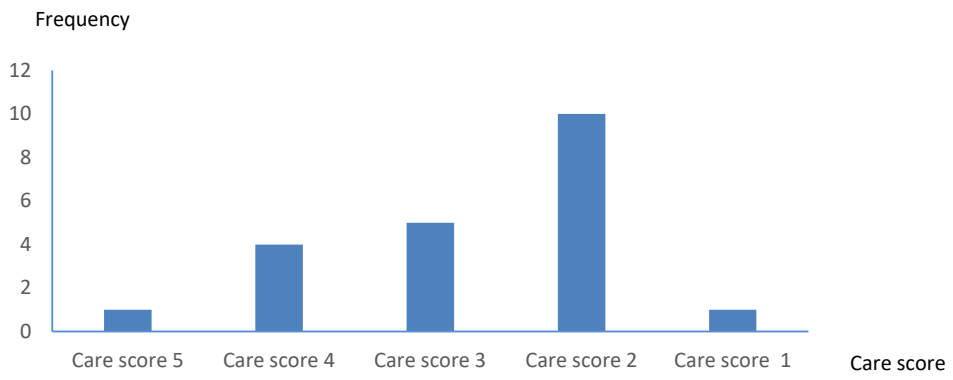
- **Urinary tract infection** (59 deaths). There has been 1 new death since the last consultant coder review of 15 case, which led to 7 changes in primary diagnosis.

- **Pancreatic disorders (not diabetes)** (12 deaths). This is a new alert since the quarter 2 update. 11 cases have already been subject to consultant coder review and 4 cases were subject to a change in primary diagnosis

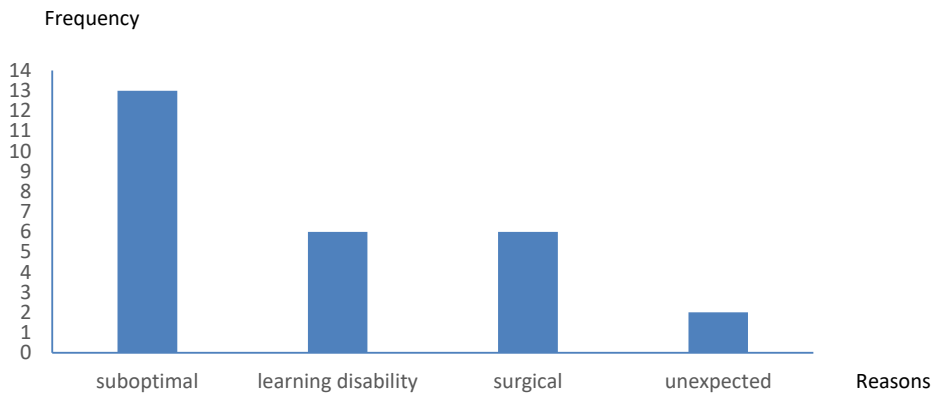
4 Structured judgement review (SJR)

4.1 Between 1 September 2022 and 31 December 2022, 27 referrals for structured judgement review were made. During the quarter, 21 completed reviews were received back from consultant reviewers, with overall care scores ranging from 1 to 5. Of the, 1 scored a (excellent care) 10 scored a (good care), 5 scored a 3 (adequate care), and 4 scored 2 (suboptimal care) and 1 scored 1 (poor care).

4.2 **Chart 4 SJR care scores for quarter 3 2022/23**



2 **Chart 6 reasons stated for SJR referral for quarter 3 2022/23**



4.3 No cases were considered by the avoidability panel during this period. Those scheduled for review will be reflected in the quarter 4 update

4.5 SJR themes and learning

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

4.5.2 No new themes were identified.

5 Medical Examiner Service

5.1 The last quarter has seen a 38% increase in activity as the combined number of trust and community deaths has increased to 793 in total. The vast majority of these are on account of the successful roll out of the Medical Examiner (ME) service to include the scrutiny of community deaths, although there has been a small increase in hospital deaths.

5.2 The Trust is on target to complete the roll out by April 2023 and currently have 86% GP surgeries on- boarded with just 5 more to go.

5.3 2 hospices and 3 rehabilitation units are also on boarded. The Trust will have completed the mandated programme roll out on target.

5.4 The Clinical Director has taken part in the second Integrated Care Service webinar for GP's and community providers in order to help explain how the process has worked in Hertfordshire and to promote sharing of it for GP's and regions which are in earlier implementation stages.

5.5 The scrutiny by Medical Examiners of hospital and community deaths is consistently at 100% and referral for SJR (12 in last quarter) continues despite the increase in work of scrutiny. A recent theme noted by Medical Examiners is antibiotics being inadvertently stopped prematurely due to an EPR process which has been taken forward to the appropriate channels. It is not thought to have caused or been implicated in the deaths of patients but nevertheless of sufficient concern to be flagged.

5.6 Informal verbal feedback from families is encouraging and main areas of positivity are around explanation of terms on the medical certificate of cause of death and kindness and compassion of staff spoken to in the Medical Examiner and patient affairs office. There have been no formal complaints.

5.7 Work has started on the scrutiny of paediatric and neonatal deaths (as mandated by the National Medical Examiner) which has been more challenging as it is more specialised and requires close collaboration with the neonatal team. This is working well however, and 5 deaths were reported in the last quarter, the majority due to extreme prematurity.

5.8 Quarterly meetings continue with the Coroner and Registration service and this is working well as issues are discussed and ironed out in preparation for the statutory ME service deadline of April 2023.

5.9 The Clinical Director for the ME service reports that there are currently two challenges:

A) There are constraints of physical space particularly after the weekend when the ME and MEO rota is skewed to be able to tackle the numbers. This has been taken through the appropriate channels but is unresolved and remains an issue.

B) Another challenge which has been raised and is due for discussion is the retrospective disagreement of wording on the MCCD by consultant teams when discussing patients at their speciality morbidity and mortality meetings. Junior doctors are encouraged to have agreed the cause of death with their seniors prior to attending the ME office and if there is a difference of opinion with the ME after notes scrutiny this can be discussed in a timely way with the consultant.

6 Next steps

6.1 Next steps include:

- Continued implementation of the Community Medical Examiner Service.
- Relaunch of the tier 2 avoidability panel
- Routine review of the learning from deaths policy

7 Risks

7.1 None identified.

8 Recommendation

8.1 The committee is asked to receive this report for information and assurance on Trust mortality and learning from deaths scrutiny.

Name of Director

Dr Tom Galliford, Deputy Chief Medical Officer

Date May 2023

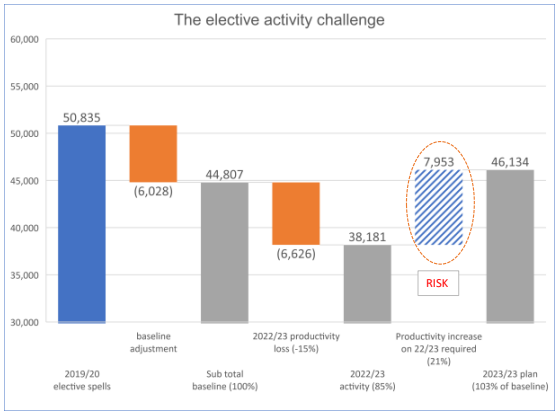
West Hertfordshire Teaching Hospitals NHS Trust

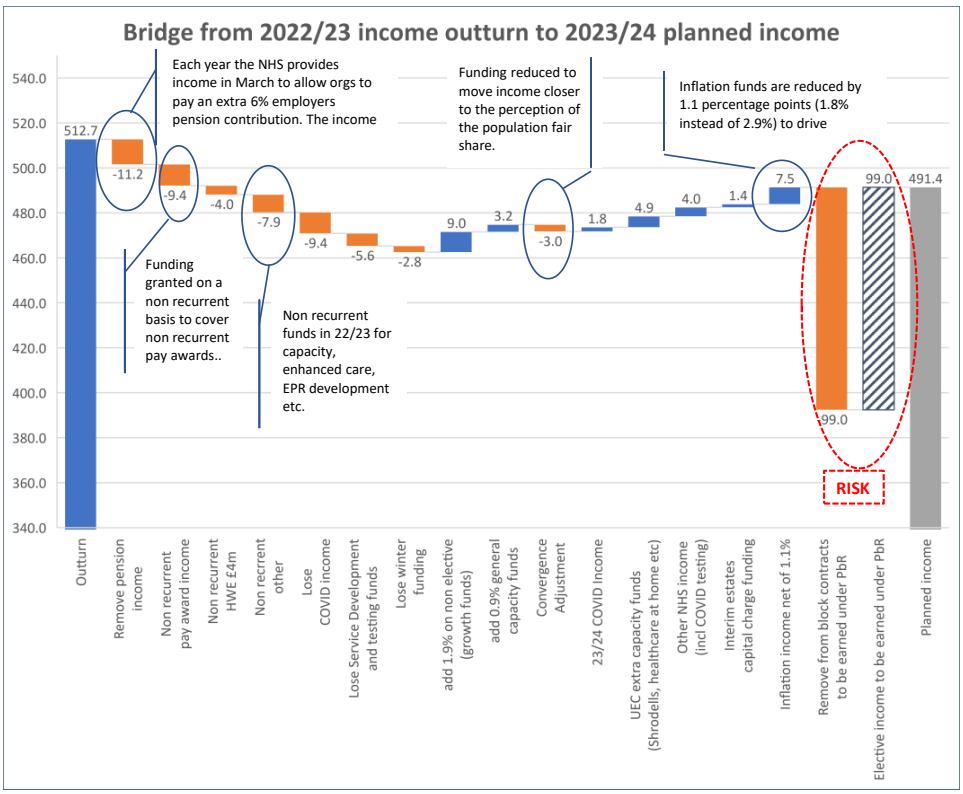
Trust Board Meeting
1st June 2023

Title of the paper	**Operating and Financial Plan**
Agenda Item	**23i**
Presenter	**Don Richards, Chief Financial Officer**
Author(s)	**Don Richards, Chief Financial Officer** **Finance, BI, Operations Teams**
Purpose	*For approval*: ☐ *For discussion*: √ *For information*: √
Executive Summary	**1. Introduction** This purpose of this report is to provide an update on the operating and financial plan for 2023/24 discussed at the May 2023 Part 2 Board and submitted to NHSE via the HWE Integrated Care Board (ICB). **2. Background** The Integrated Care Board (ICB) required final financial plans for the ICS to be submitted by 4th May. Consequently, constituent organisations were asked to submit their financial plans as a subset of the ICS plan by 2nd May. Given this tight deadline, an urgent decision meeting was arranged in line with Standing Order 6.2. The meeting took place on 2nd May with the Vice Chair (standing for the Chair), Chief Executive, two NEDs, and the CFO. The recommendations from that meeting were received at the May 2023 Part 2 Board. The submitted plan summarised by the attached slide deck has considered the recommendations made at the 2nd May meeting. The improvements included the pass through of additional funds from the ICB and an agreement through a Memorandum of Understanding with ICS partners to manage residual financial risks. **4. Revenue Financial Projections** The plan to balance income with expenditure contains considerable risks. The ICS MoU is expected to support enhanced expenditure controls, new cost efficiencies, improved performance review and released funding should it prove to be available within ICS wide allocations.

In order to generate projected income of £491.4m, the Trust must increase the number of elective patient spells by 21% compared to the previous year (2022/23). This is necessary to meet our national target of 103% of 2019/20 spells and to maintain the same level of income earned in 2022/24.

The figure below illustrates the activity bridge from 2019/20 elective activity to the 2023/24 elective activity plan.



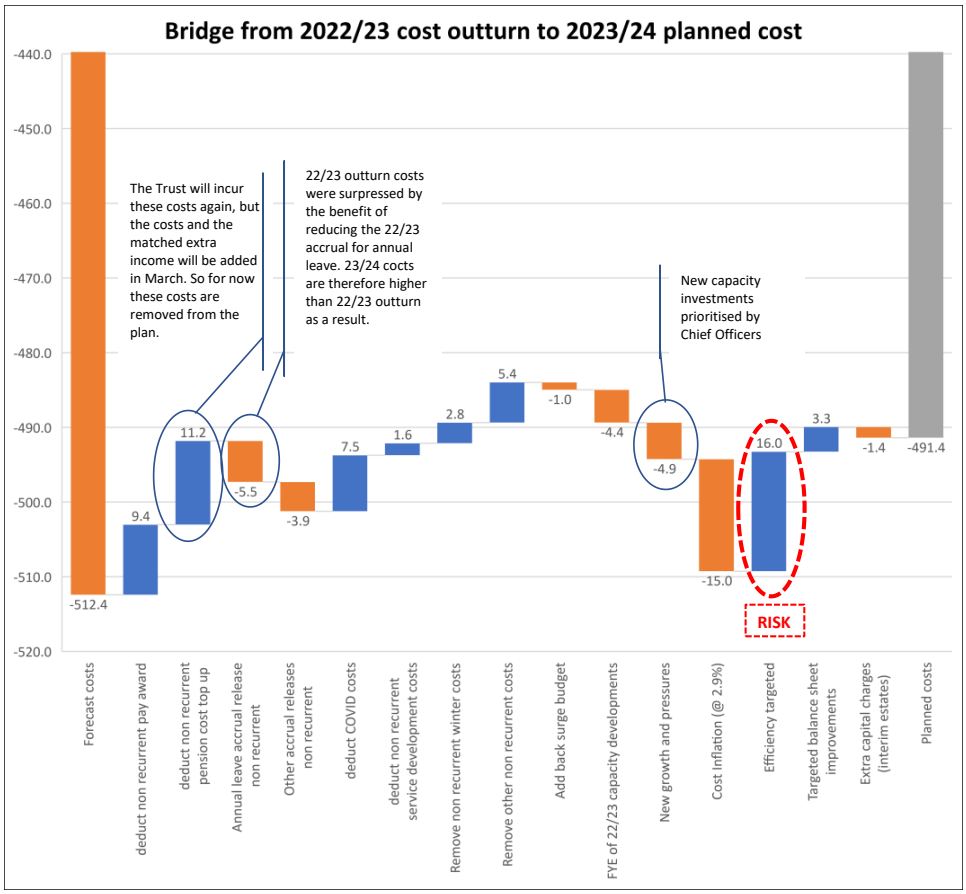


The expenditure plan is to spend no more than £491.4m unless supported by additional income. However, an additional risk to this plan is the need to find £16m of new efficiencies. While the Trust has identified viable themes from which efficiencies could be derived, we need to accelerate efforts to turn these themes into concrete changes in spending patterns.

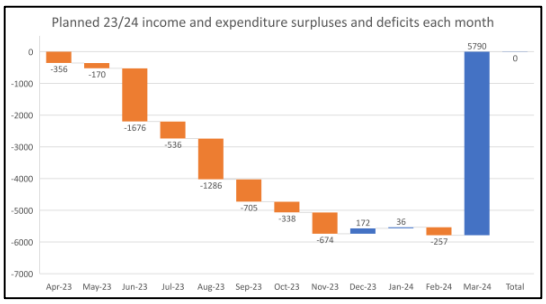
There are two further material risks that could impact the Trust's expenditure plan:

(a) Addressing the costs of inflation within funding. The current funding model assumes a pay cost inflation of 2%. However, if pay inflation exceeds 2%, the national team has advised that extra funding will be made available. Non-pay inflation is funded at 5.5% of non-pay costs. Therefore, any non-pay inflation that exceeds a composite 5.5% will strain the expenditure plan.

(b) Managing emergency care costs within the allotted capacity is another key challenge that needs to be managed by maximising benefits from transformative care to ensure that spending remains within the Trust's plans.



The profiling of income and expenditure in the plan will lead to deficits in the first eight months of the year. However, the benefits anticipated from the actions set out in the MoU are currently profiled to take effect in M12.



The attached slide deck provides details of the income and expenditure plans by Division and subjective heading, including the approved revenue investments to support improved capacity.

5. Capital expenditure

Capital expenditure is restricted to an authorised limit (CRL) regardless of the cash the Trust has available to spend. The CRL allows £18.8m to be spent initially, which is a share of the ICS CRL. Total capital spending could exceed £87m with support for nationally supported projects pending business case approvals. Spending is expected to include: a land purchase to support the new hospital development, elective activity hub for shared use by ICS organisations, the completion of the CDC at St Albans, the pathology hot lab at Watford and continued project fees associated with the wider Trust redevelopment. The attached slide deck provides details on the capital schemes approved with the presentation of an appropriate business case.

5. Operational targets

The primary objective of the plan is to deliver on all operational targets, for the benefit of patients, which includes the demanding goal of achieving 103% of the elective activity performed in 2019/20 and eliminating all 65-week waiters. Consequentially, the Trust must increase its elective activity by 21% above the levels experienced in 2022/23.

In addition to financial risks associated with delivering such an extensive elective activity programme, there is also the risk of managing patient demand with limited emergency care capacity. To mitigate such risks, the plan allows for a modest increase in available beds by making use of surge beds especially over the winter months. (G&A available beds peak in January). Maximising transformations in care such as the Virtual Hospital, Anticipatory Care and using specialist medics in ED will ensure optimal efficiency and minimize the usage of these beds.

6. Risks to successful delivery of the plan

Risk	Mitigations	Progress
(a) To preserve the 2022/23 elective income, the Trust must achieve a 21% increase in elective activity above 2022/23.	The elective care high impact change programme including significant improvements in theatre productivity, data quality and outpatient transformation.	After adjusting for changes to the 2019/20 baseline and allowing for industrial action the Trust elective activity is performing at 85% of target. The Seamless Surgery project will move to improved theatre scheduling in May, data quality improvements continue and new performance monitoring processes are being implemented by Chief Officers.
(b) A £16 million Cost Improvement Program (CIP) must be accomplished, excluding savings in COVID spending.	Cost improvement targets owned by all Divisions, stakeholder engagement. Detailed implementation plans to deliver benefits. Collaboration with ICS partners. Strong leadership, robust CIP governance including SMART objectives, Chief Officer oversight of major themes, alignment with	The Trust wide efficiency meeting was well received. Full efficiency plans demonstrating expected changes to spending will be reviewed in the May and June DFPRs.

	organisation objectives, use of evidence-based methodologies, regular review.	
(c) Maintaining patient experience, safety and performance when providing urgent and emergency care with limited capacity.	The emergency care high impact change programme. Maximising out of hospital care. Maximising benefits and capacity from the virtual hospital and other transformative ways to support emergency care.	A surge bed reserve budget has been set, the virtual hospital continues to increase its occupancy. Anticipatory care and resuming SMART will support manage this risk
(d) Containing costs in a high inflation environment with limited inflation funding. Contracts allow for 2% inflation on pay costs (to be increased in response to final pay settlements) and 5.5% inflation on non-pay costs. The composite 2.9% inflation is top sliced by 1.1% to allow for anticipated efficiencies.	Continuous monitoring of inflation costs. Success with the efficiency programme. Additional funding, savings, non-recurrent benefits.	A number of contracts are being inflated well beyond the composite 5.5% non-pay inflation. For example, IT contracts such as the Cerner EPR contract and soft FM services. The Trust is preparing an inflation analysis schedule to discuss with the ICB and national finance teams.

7. Conclusion

To sum up, while the submitted Annual Plan aims to achieve revenue income and expenditure balance and meet all operational targets, it carries significant risks that require careful management and attention. These risks are to be managed through cost and performance controls and developing new efficiencies.

The capital expenditure plans within authorised limits, do not yet include the construction of a new Watford General Hospital, but the spend projected is still likely to be the largest capital investment in a generation so far.

The targeted operational objectives include eliminating 65-week waiters and increasing elective surgery by 21% compared to 2022/23 levels. The level of inherent risk highlights the need for close partnership and financial coordination between the Trust and the ICS organisations supported by our recent MoU to ensure optimal use of limited resources.

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

Links to well-led key lines of enquiry	☐Is there the leadership capacity and capability to deliver high quality, sustainable care? ☐Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☐Is there a culture of high quality, sustainable care? ☐Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☐Are there clear and effective processes for managing risks, issues and performance? ☐Is appropriate and accurate information being effectively processed, challenged and acted on? ☐Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☐Are there robust systems and processes for learning, continuous improvement and innovation? ☐How well is the trust using its resources?
Previously considered by	Committee/Group: Date:
Action required	The Board is asked to note the contents of this report and approve the final operating and financial plan.

team westHerts

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West Hertfordshire Hospitals
NHS Trust

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Operational Performance

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NHS Trust

Performance metrics

2023/24 Elective Care

1. Eliminate waits of over 65 weeks by March 2024 (except where patients choose to wait longer or in specific specialties).
2. Deliver system specific activity target (agreed through the operational planning process).
3. Continue to reduce the number of patients waiting over 62 days (on the Cancer PTL).
   - The trust specific target to be achieved by March 2024 is 143.
4. Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.
   - Incremental targets per quarter as follows:
   - 67.5% by June 23
   - 70% by September 23
   - 72.5% by December 23
   - 75% by March 24

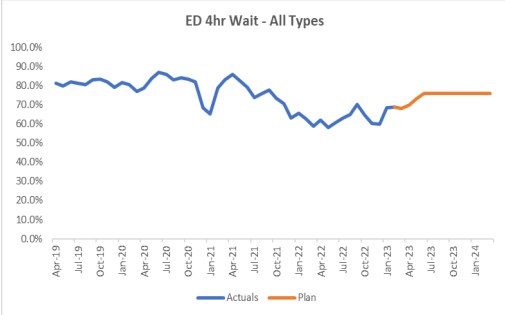
Urgent & Emergency Care

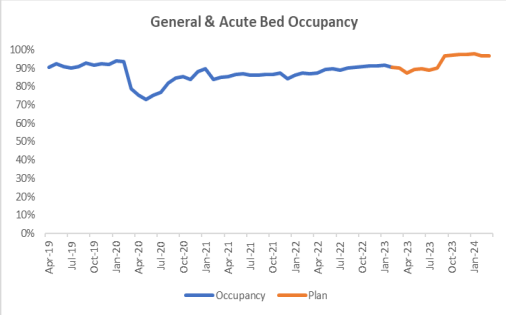
8. Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
9. Reduce adult general and acute (G&A) bed occupancy to 92% or below

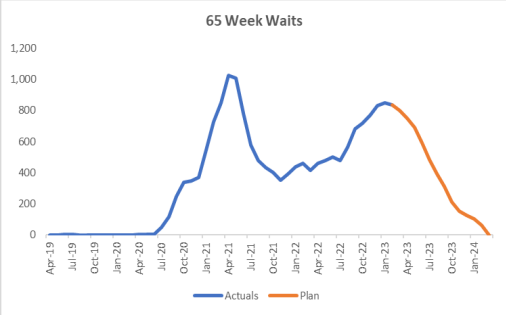
Current position against objectives & actions

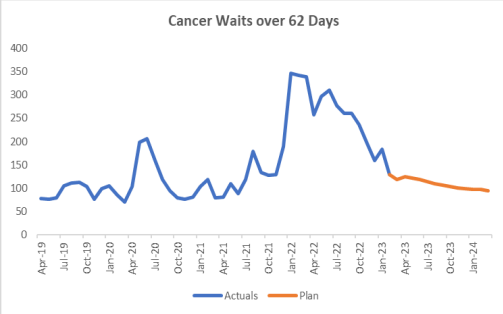
	Objective	April 23
1	65 week wait elimination by March 2024	495
2	Deliver system specific activity target (103% VWA)	86%
3	Reduction in patients over 62 days on the Cancer PTL – 143 by March 2024	130
4	Meet the Cancer Faster Diagnosis standard of 75% by March 2024 – 67.5% by June 23	68.8%
5	All 78 week waiters	11
6	Improve A&E waiting times to 76% seen within 4 hours by March 2024	71.4%
7	Reduce adult (G&A) bed occupancy to 92% or below	All sites: 91.5% WGH only: 96.5%

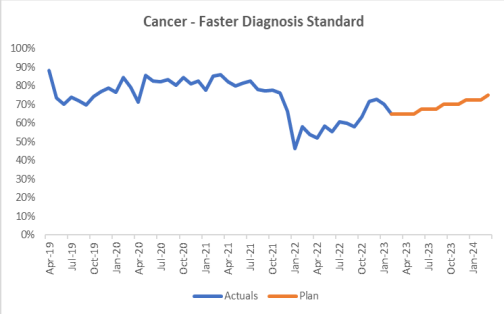
Operational Performance











The charts shows the Trust performance for each of the key performance targets since April 2019 to March 2023.

The orange line highlight the planned trajectory for 2023/24

For A&E, cancer and 65 week wait, the trajectories shown aim to achieve the national operating targets for the next financial year

A proportion of the growth funding received from commissioners is required to underpin these performance trajectories

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Activity planning assumptions and summary at POD level

The proposed plan aims to meet the objectives of elective recovery and eliminating over 65 weeks waits.

The planned care PODs (electives, outpatients, and diagnostics) are based on 2019/20 adjusted baseline to ensure close alignment to the recovery objectives and value weighted activity calculations for 2023/24.

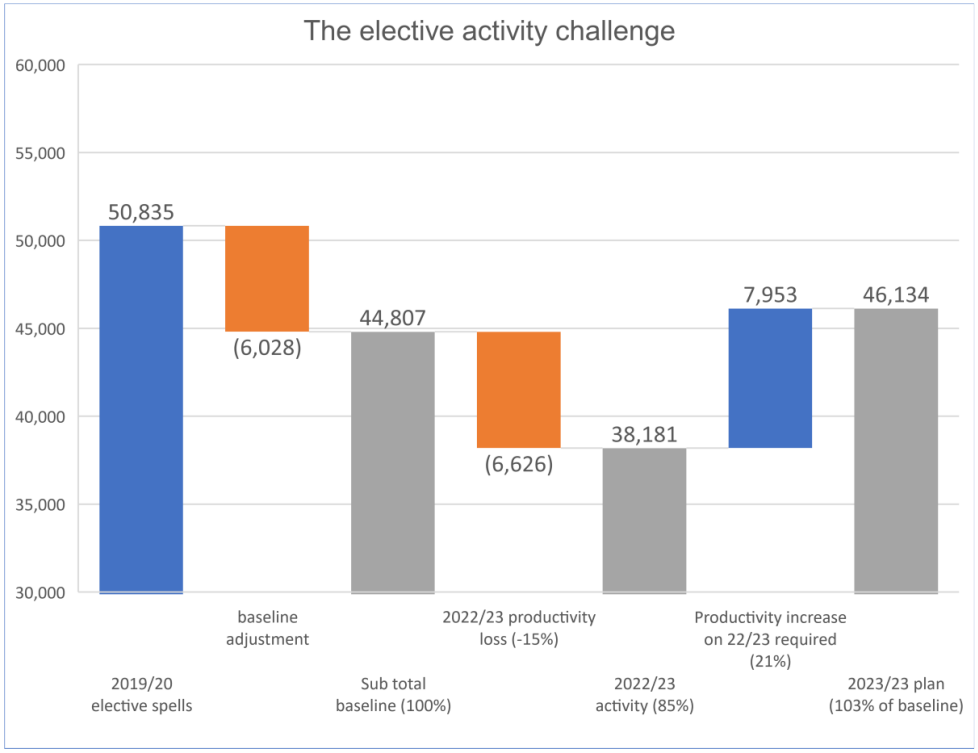
There is a material difference between 2022/23 outturn and the starting baseline for elective and outpatient PODs as shown in the information below

This is a risk for the organisation as planned care activity will be reimbursed in line with payment by results guidance for next year. (See following page).

The '103% elective activity challenge' is a significant financial risk to West Herts

	2019/20 actual	2022/23 actual	2023/24 plan
Elective spells	50,835	33,581	46,134
baseline adjustment	(6,028)		
add RDAs		4,600	
Baseline	44,807	38,181	46,134
% of baseline		85%	103%

The national elective activity target as applied to West Herts is to treat 103% of the 'value weighted activity' of elective patients treated in 2019/20. Because the Trust only treated 85% of the value of patients treated in 2019/20, the Trust has to increase it's elective activity by 21% of the 2022/23 activity levels to secure the same level of elective activity funding as received in 2022/23.



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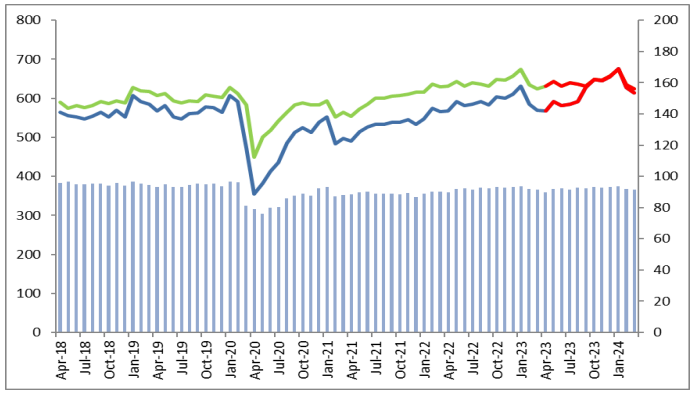
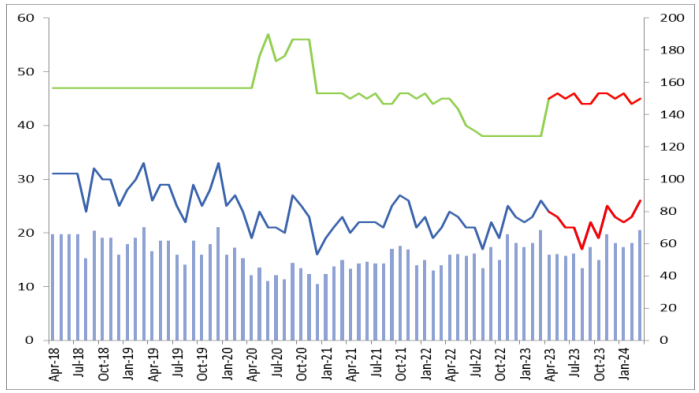
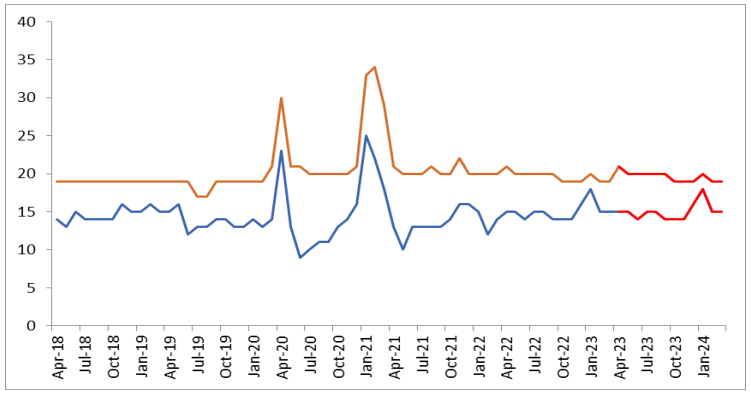
Overnight G&A beds occupied - adult



Overnight G&A beds occupied - paediatrics



Overnight Critical Care beds occupied - adult



Financial Performance

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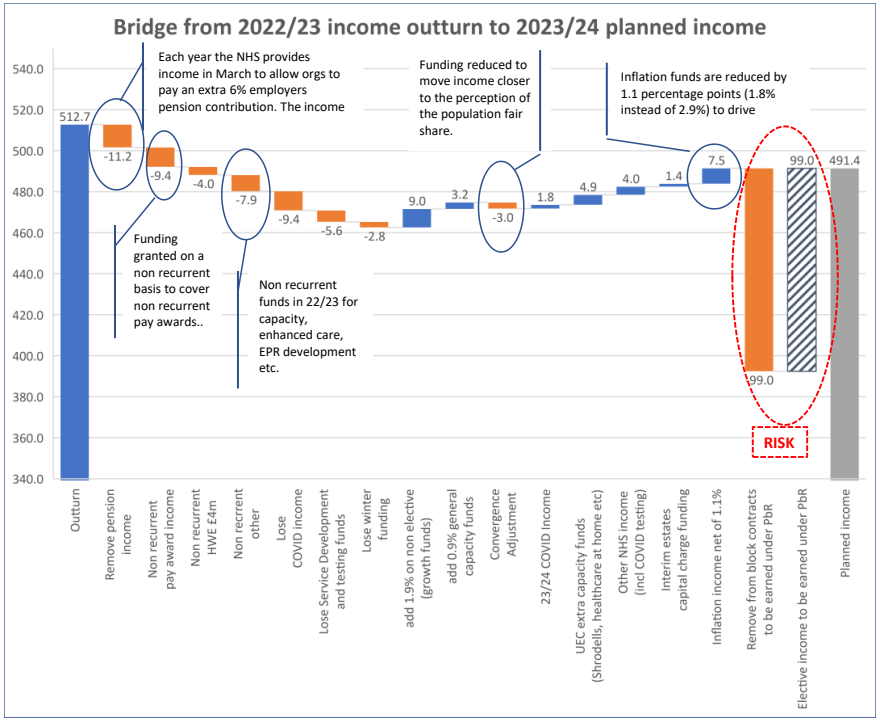
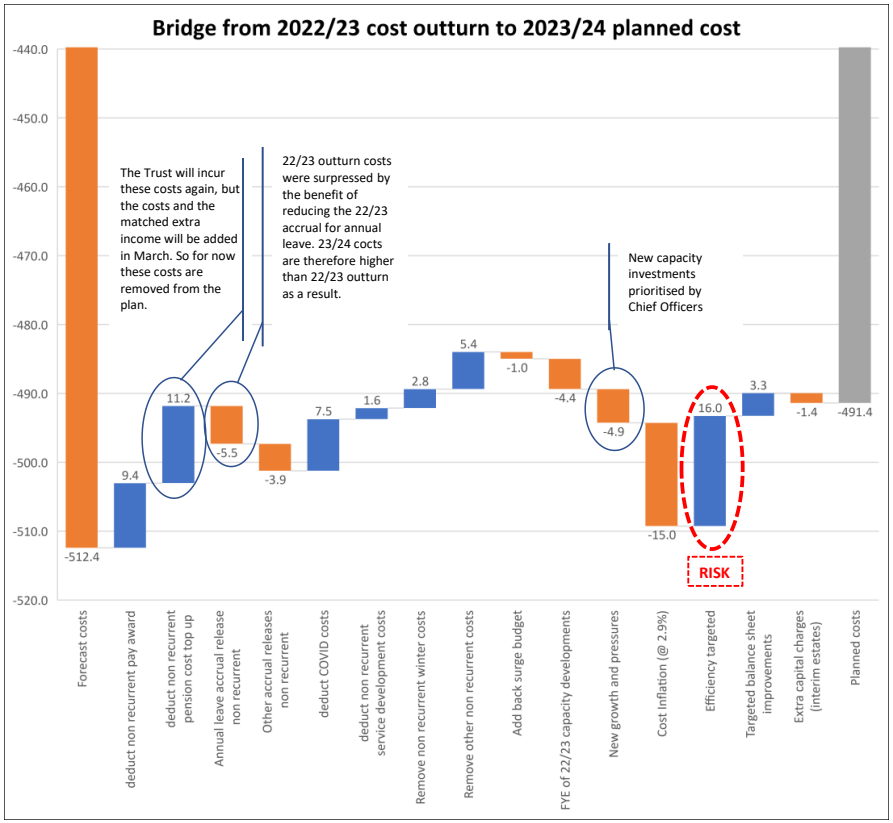
The bridge from 22/23 break even to the 23/24 plan highlights the risks in securing elective income and minimising costs through new efficiencies..





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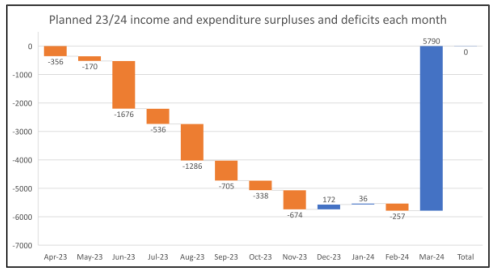
The income and expenditure plan for the year forecasts deficits each month until December. The Trust anticipates a 'year to date' deficit position until benefits as described in the ICS financial MoU yield benefits.

		Apr (M1)	May (M2)	Jun (M3)	Jul (M4)	Aug (M5)	Sep (M6)	Oct (M7)	Nov (M8)	Dec (M9)	Jan (M10)	Feb (M11)	Mar (M12)	Total
Income	Divisional Income	2.79	2.79	2.79	2.79	2.79	2.79	3.03	3.03	3.03	3.03	3.03	4.47	36.38
	NHS Revenue	37.19	38.05	37.94	38.27	37.76	37.83	38.51	38.05	37.50	38.58	37.46	37.93	455.04
Income Total		39.98	40.84	40.73	41.06	40.56	40.62	41.54	41.07	40.52	41.60	40.48	42.40	491.41
Pay	Medical Pay	(7.34)	(7.36)	(7.38)	(7.37)	(7.38)	(7.37)	(7.38)	(7.38)	(7.35)	(7.38)	(7.37)	(7.36)	(88.43)
	Non-Clinical Pay	(5.23)	(5.62)	(5.78)	(5.58)	(5.58)	(5.58)	(5.74)	(5.74)	(5.72)	(5.68)	(5.68)	(2.14)	(64.07)
	Nursing Pay	(7.87)	(7.88)	(7.88)	(7.88)	(7.88)	(7.88)	(7.88)	(7.88)	(7.87)	(7.88)	(7.88)	(7.88)	(94.54)
	Other Clinical Pay	(2.98)	(2.98)	(2.98)	(2.98)	(2.98)	(2.98)	(2.98)	(2.98)	(2.98)	(2.98)	(2.98)	(2.98)	(35.80)
	Scientific, Technical & Profes	(2.57)	(2.57)	(2.58)	(2.57)	(2.58)	(2.57)	(2.58)	(2.58)	(2.57)	(2.58)	(2.57)	(2.57)	(30.88)
	Pay Unidentified CIPs	0.13	0.25	0.38	0.51	0.64	0.76	0.89	1.02	1.15	1.27	1.40	1.53	9.94
Pay Total		(25.87)	(26.16)	(26.22)	(25.88)	(25.77)	(25.62)	(25.66)	(25.54)	(25.35)	(25.23)	(25.08)	(21.40)	(303.78)
Non Pay	Clin Supp Serv	(2.22)	(2.47)	(2.72)	(2.59)	(2.72)	(2.59)	(2.72)	(2.72)	(2.35)	(2.72)	(2.59)	(2.47)	(30.89)
	Drugs	(1.81)	(2.01)	(2.22)	(2.12)	(2.22)	(2.12)	(2.22)	(2.22)	(1.91)	(2.22)	(2.12)	(2.01)	(25.18)
	Other (non clinical costs)	(9.17)	(9.17)	(9.42)	(9.11)	(9.21)	(9.28)	(9.44)	(9.53)	(9.47)	(9.84)	(9.65)	(9.59)	(112.87)
	Non Pay Unidentified CIPS	0.08	0.16	0.23	0.31	0.39	0.47	0.54	0.62	0.70	0.78	0.86	0.93	6.06
Non Pay Total		(13.13)	(13.50)	(14.12)	(13.51)	(13.76)	(13.52)	(13.83)	(13.84)	(13.03)	(13.99)	(13.50)	(13.14)	(162.87)
Depreciation		(0.95)	(0.96)	(1.47)	(1.61)	(1.72)	(1.59)	(1.64)	(1.63)	(1.23)	(1.60)	(1.41)	(1.33)	(17.15)
Depreciation Total		(0.95)	(0.96)	(1.47)	(1.61)	(1.72)	(1.59)	(1.64)	(1.63)	(1.23)	(1.60)	(1.41)	(1.33)	(17.15)
In month (deficit) or surplus		(0.36)	(0.17)	(1.68)	(0.54)	(1.29)	(0.71)	(0.34)	(0.67)	0.17	0.04	(0.26)	5.79	0.00
Cumulative (deficit) or surplus		**(0.36)**	**(0.53)**	**(2.20)**	**(2.74)**	**(4.02)**	**(4.73)**	**(5.07)**	**(5.74)**	**(5.57)**	**(5.53)**	**(5.79)**	**0.00**	



The month of June is anticipated to generate the largest monthly deficit due to the costs of new capacity investments generating additional spend ahead of efficiencies building.

The significant improvement in M12 is linked to as yet unidentified benefits arising from potential balance sheet improvements and the ICS financial MoU.

- *Excludes the impact of approved revenue cost pressures.*
- *Excludes the impact of the 23-24 pay award.*

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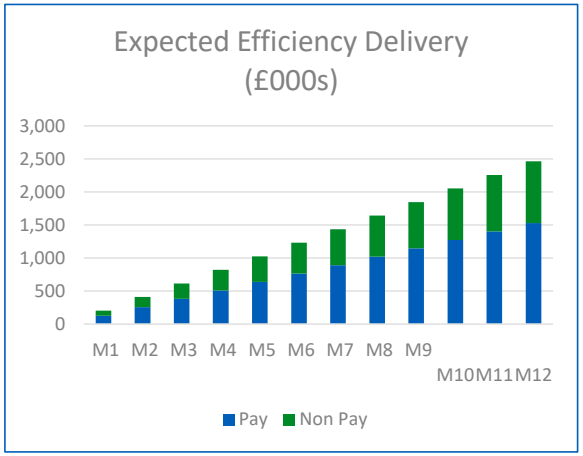
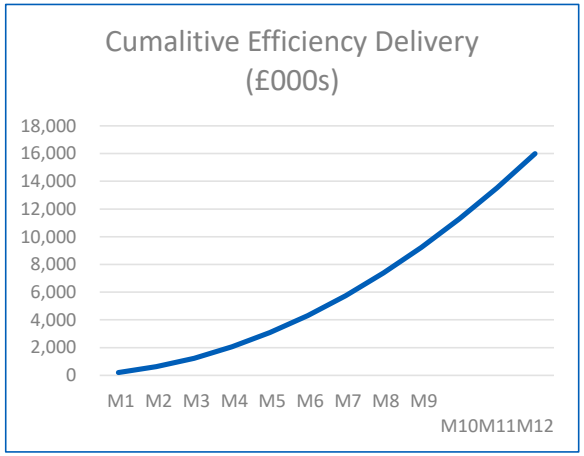
Efficiencies are expected to gather pace as we progress through the year.





Trust Definition	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
Pay	127	255	382	510	637	764	892	1,019	1,146	1,274	1,401	1,529	9,936
Non Pay	78	155	233	311	389	466	544	622	700	777	855	933	6,064
Grand Total	**205**	**410**	**615**	**821**	**1,026**	**1,231**	**1,436**	**1,641**	**1,846**	**2,051**	**2,256**	**2,462**	**16,000**

Theme	Summary of ideas
Theme 1: Workforce	- Increase bank and agency use to fill consultant vacancies - Over-recruit nurses and block book bank staff - Redesign admin workforce with digital investments - Implement voice recognition, self-service for patients, EPR developments, and robotic process automation - Investigate hybrid/flexible work for cost savings - Improve and save through consultant job plan reviews
Theme 2: Commercial and Income	- Repatriate work leveraging ICS strengths - Generate income from solar-powered car charging services - Boost recycling efforts, sell waste for income - Increase income with more pharmacy trials - Capitalize on private healthcare opportunities with shorter wait times
Theme 3: System Transformation	- Empower patients to self-manage their pathways - Overhaul governance around equipment hire - Apply AI for consultant reporting in radiology - Improve understanding of system transformation across the trust to maximise benefits possible
Theme 4: Productivity	- Re-evaluate outsourcing; reduce costs - Implement 7-day work model for increased capacity and reduced inpatient stays - Shift to a 3-session outpatient workday - Revolutionize theatre model with SACH pilot (hybrid, integrated, digital) - Lower DNAs and cancellations through better electronic referral access - Implement team job planning for consultants - Explore opportunities for mutual aid among hospitals
Theme 5: Non pay	- Uniting back office functions for ICS-wide streamlining - Trust-wide work approach standardization - Embracing Robotic Process Automation for optimal efficiency - Contract manager allocation and dedicated contract management enhancements

Accelerated work now needed to turn the themes into tangible changes to spending patterns.

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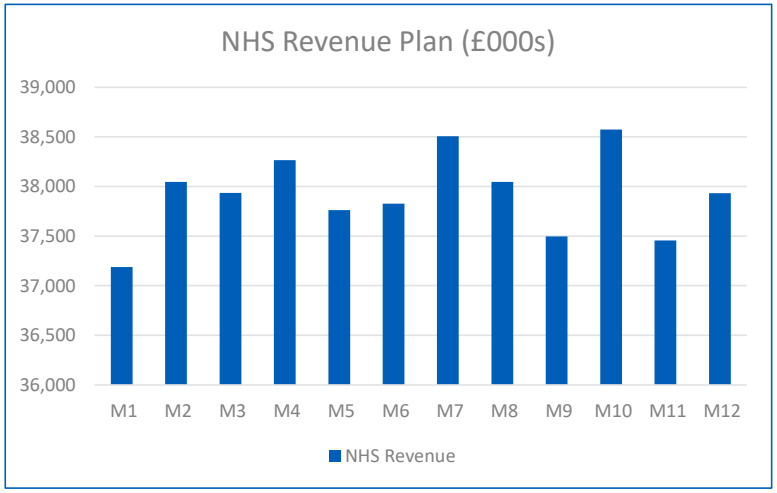
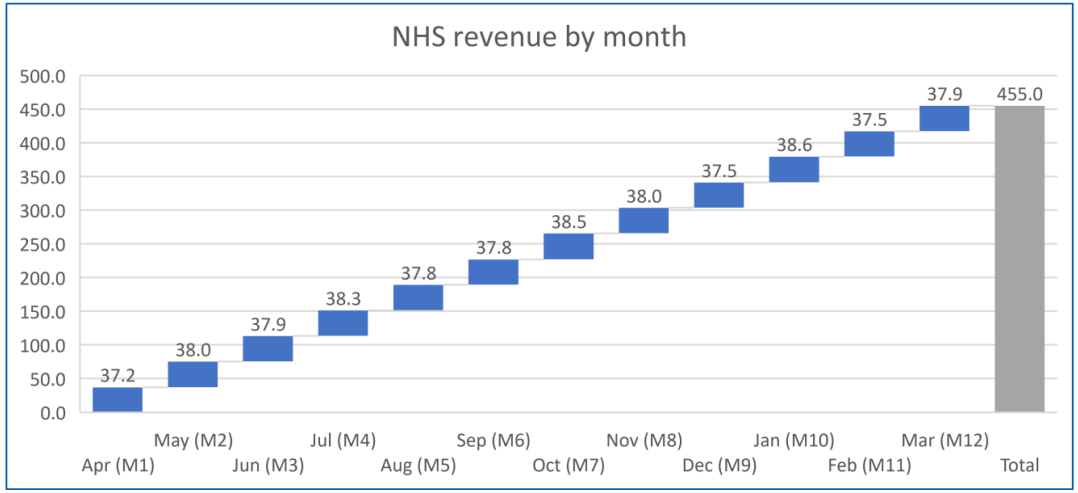
The NHS revenue target varies each month due to the working day impact on elective activity. The target for the month of April is particularly low.





Cumulative NHS income	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
	37,188	75,235	113,171	151,437	189,198	227,024	265,532	303,578	341,075	379,650	417,105	455,037

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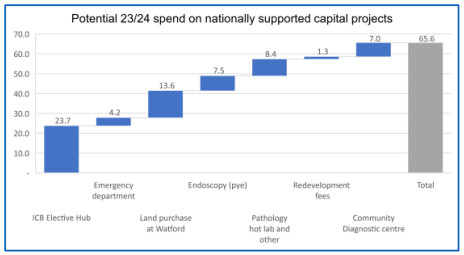
Capital expenditure for 23/24 could exceed £87m pending approval of important business cases.

			ICS allocation (forecast)				National allocation (forecast)						
Sources	Original Plan (£m	Forecast £m	Depreciation	Internal cash	Other funds with CRL cover	Sub total	NHP	NHSE	NHSE CDC	NHSE TIF		Sub total	2023/24 Total
ICS allocation	18.75	18.75	15.00	3.75		18.75						0.00	18.75
ICS elective hub	24.90	24.90		4.10		4.10				20.80		20.80	24.90
Endoscopy	7.49	7.49				0.00			7.49			7.49	7.49
Emergency Department (tba)	4.15	4.15				0.00		4.15				4.15	4.15
Land purchase	13.60	13.60				0.00	13.60					13.60	13.60
Pathology hot lab	11.50	11.50				0.00	11.50					11.50	11.50
Redevelopment (ARP) fees	1.26	1.26				0.00	1.26					1.26	1.26
Community Diagnostic Centre	5.01	5.01				0.00			5.01			5.01	5.01
	86.66	**86.66**	**15.00**	**7.85**	**0.00**	**22.85**	**26.36**	**4.15**	**12.50**	**20.80**	**0.00**	**63.81**	**86.66**

FORECAST Applications													2022/23 Total
B/f	(1.90)	(1.90)	(1.90)			(1.90)						0.00	(1.90)
Backlog maintenance	(3.52)	(3.52)	(3.52)			(3.52)						0.00	(3.52)
Clinical space (incl Urology)	(3.80)	(3.80)	(3.80)			(3.80)						0.00	(3.80)
Equipment	(2.09)	(2.09)	(2.09)			(2.09)						0.00	(2.09)
Green plan	(1.25)	(1.25)	(1.25)			(1.25)						0.00	(1.25)
Digital/ IT	(0.58)	(0.58)	(0.58)			(0.58)						0.00	(0.58)
Other building	(0.53)	(0.53)	(0.53)			(0.53)						0.00	(0.53)
Shrodells wards c/f	(4.48)	(4.48)	(4.48)			(4.48)						0.00	(4.48)
Interventional Radiology c/f	(1.50)	(1.50)		(1.50)		(1.50)						0.00	(1.50)
Community Diagnostic Centre	(7.00)	(7.00)				0.00			(7.00)			(7.00)	(7.00)
Neonatal	(2.00)	(2.00)		(2.00)		(2.00)						0.00	(2.00)
Pathology	(8.40)	(8.40)				0.00	(8.40)					(8.40)	(8.40)
Endoscopy	(7.49)	(7.49)				0.00			(7.49)			(7.49)	(7.49)
Emergency Department (tba)	(4.15)	(4.15)				0.00		(4.15)				(4.15)	(4.15)
ICS Elective hub	(23.70)	(23.70)				0.00				(23.70)		(23.70)	(23.70)
Land purchase	(13.60)	(13.60)				0.00	(13.60)					(13.60)	(13.60)
Redevelopment (ARP) fees	(1.26)	(1.26)				0.00	(1.26)					(1.26)	(1.26)
		0.00										0.00	0.00
Total applications	**(87.25)**	**(87.25)**	**(18.15)**	**(3.50)**	**0.00**	**(21.65)**	**(23.26)**	**(4.15)**	**(14.49)**	**(23.70)**	**0.00**	**(65.60)**	**(87.25)**
Underspend / (Shortfall)	**(0.59)**	**(0.59)**	**(3.15)**	**4.35**	**0.00**	**1.20**	**3.10**	**0.00**	**(1.99)**	**(2.90)**	**0.00**	**(1.79)**	**(0.59)**



The ICS elective hub requires PDC and support from the ICS capital budget.
The land purchase requires NHP approval for the submitted business case.

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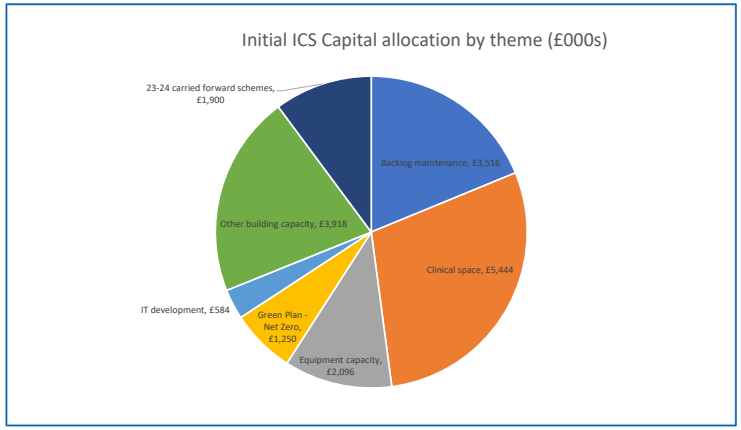
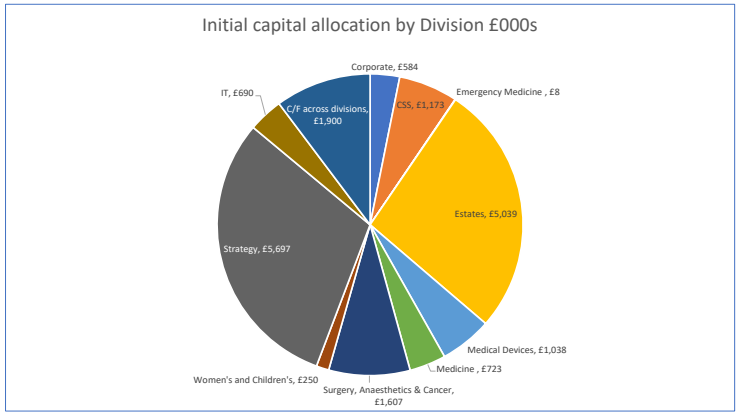
Breakdown by Category

Category	Total
Backlog maintenance	3,516,000
Clinical space	5,444,318
Equipment replacement	1,487,097
Green Plan - Net Zero	1,250,000
IT development	583,550
New equipment	594,097
Other building capacity	3,918,092
Equipment capacity	15,198
23-24 carried forward schemes	1,900,000
Grand Total	**18,708,353**

Breakdown by Division

Directorate	Total
Corporate	583,550
CSS	1,173,189
Emergence Medicine	8,000
Estates	5,039,000
Medical Devices	1,037,675
Medicine	722,741
Surgery, Anaesthetics & Cancer	1,607,198
Women's and Children's	250,000
Strategy	5,697,000
IT	690,000
C/F across divisions	1,900,000
Grand Total	**18,708,353**





£18.7m of indicative capital budget has been allocated to Divisions including sums to fund schemes already started. See the appendix for more detail.

Appendix 1 (Divisional Finance Summaries)

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Income and expenditure budgets are phased to reflect predicted financial influences.

Expense Type	Phasing Methodology
Divisional Income	Phased in equal twelves, except for additional income to cover capital charges for national projects. This element is phased from Month 7 onwards, matched by depreciation and financing charges.
NHS Revenue	Based on calendar days for Non Elective and working days For Elective/Outpatients. Elements of Block contracts are in equal twelfths.
Medical Pay	Substantive pay in equal twelfths. Temporay staffing spend reflects calendar days.
Non-Clinical Pay	Substantive pay in equal twelfths. Temporay staffing spend reflects calendar days.
Nursing Pay	Substantive pay in equal twelfths. Temporay staffing spend reflects calendar days.
Other Clinical Pay	Substantive pay in equal twelfths. Temporay staffing spend reflects calendar days.
Scientific, Technical & Profes	Substantive pay in equal twelfths. Temporay staffing spend reflects calendar days.
Pay Unidentified CIPs	CIP is phased based on delivery in previous years. See next slide for detail.
Clin Supp Serv	Phased based on working days
Drugs	Phased based on working days
OTHER (NON CLIN)	Mostly phased in equal twelfths with gas/electric following a seasonal profile
Non Pay Unidentified CIPS	CIP is phased based on delivery in previous years. See next slide for detail.
Recharges	Phased based on working days
Depreciation	Phased based on a high level profile of capital spend. Also matched by additional income expected from Q3 onwards.
Trust Debt Redemption	Phased based on a high level profile of capital spend. Also matched by additional income expected from Q3 onwards.
Unwinding Discount	Phased based on a high level profile of capital spend. Also matched by additional income expected from Q3 onwards.

3. Phased budget

Medicine Division – Income and Expenditure budget

Trust Definition	Expense Type	Values Sum of M1	Sum of M2	Sum of M3	Sum of M4	Sum of M5	Sum of M6	Sum of M7	Sum of M8	Sum of M9	Sum of M10	Sum of M11	Sum of M12	Sum of Grand Total
Income	Divisional Income	272,445	272,445	272,445	272,445	272,445	272,445	272,445	272,445	272,445	272,445	272,445	272,417	3,269,312
	NHS Revenue	9,856,876	10,561,302	10,607,511	10,701,804	10,416,167	10,564,557	10,862,705	10,706,171	10,292,516	10,923,244	10,488,879	10,557,447	126,539,179
Income Total		**10,129,321**	**10,833,747**	**10,879,956**	**10,974,249**	**10,688,612**	**10,837,002**	**11,135,150**	**10,978,616**	**10,564,961**	**11,195,689**	**10,761,324**	**10,829,864**	**129,808,491**
Pay	Medical Pay	-2,166,835	-2,167,529	-2,168,224	-2,167,876	-2,168,224	-2,167,876	-2,168,224	-2,168,224	-2,167,182	-2,168,224	-2,167,876	-2,167,491	-26,013,785
	Non-Clinical Pay	-642,008	-650,170	-658,330	-654,250	-658,330	-654,250	-658,330	-658,330	-646,090	-658,330	-654,250	-650,143	-7,842,811
	Nursing Pay	-2,193,233	-2,195,173	-2,197,111	-2,196,140	-2,197,111	-2,196,140	-2,197,111	-2,197,111	-2,194,203	-2,197,111	-2,196,140	-2,195,120	-26,351,704
	Other Clinical Pay	-1,010,313	-1,010,435	-1,010,555	-1,010,495	-1,010,555	-1,010,495	-1,010,555	-1,010,555	-1,010,373	-1,010,555	-1,010,495	-1,010,371	-12,125,752
	Scientific, Technical & Profes	-245,599	-247,865	-250,131	-248,998	-250,131	-248,998	-250,131	-250,131	-246,732	-250,131	-248,998	-247,843	-2,985,688
	Pay Unidentified CIPs	23,511	47,023	70,534	94,046	117,557	141,069	164,580	188,092	211,603	235,115	258,626	282,138	1,833,894
Pay Total		**-6,234,477**	**-6,224,149**	**-6,213,817**	**-6,183,713**	**-6,166,794**	**-6,136,690**	**-6,119,771**	**-6,096,259**	**-6,052,977**	**-6,049,236**	**-6,019,133**	**-5,988,830**	**-73,485,846**
Non Pay	Clin Supp Serv	-462,470	-513,862	-565,231	-539,555	-565,231	-539,555	-565,231	-565,231	-488,167	-565,231	-539,555	-513,950	-6,423,269
	Drugs	-984,169	-1,093,518	-1,202,872	-1,148,196	-1,202,872	-1,148,196	-1,202,872	-1,202,872	-1,038,843	-1,202,872	-1,148,196	-1,093,527	-13,669,005
	OTHER (NON CLIN)	-424,742	-424,742	-424,742	-424,742	-424,742	-424,742	-424,742	-424,742	-424,742	-424,742	-424,742	-424,854	-5,097,016
	Non Pay Unidentified CIPS	15,674	31,349	47,023	62,697	78,372	94,046	109,720	125,394	141,069	156,743	172,417	188,092	1,222,596
Non Pay Total		**-1,855,707**	**-2,000,773**	**-2,145,822**	**-2,049,796**	**-2,114,473**	**-2,018,447**	**-2,083,125**	**-2,067,451**	**-1,810,683**	**-2,036,102**	**-1,940,076**	**-1,844,239**	**-23,966,694**
Recharges	Recharges	-550,167	-611,298	-672,426	-641,861	-672,426	-641,861	-672,426	-672,426	-580,731	-672,426	-641,861	-611,295	-7,641,204
Recharges Total		**-550,167**	**-611,298**	**-672,426**	**-641,861**	**-672,426**	**-641,861**	**-672,426**	**-672,426**	**-580,731**	**-672,426**	**-641,861**	**-611,295**	**-7,641,204**
Grand Total		**1,488,970**	**1,997,527**	**1,847,891**	**2,098,879**	**1,734,919**	**2,040,004**	**2,259,828**	**2,142,480**	**2,120,570**	**2,437,925**	**2,160,254**	**2,385,500**	**24,714,747**

- Excludes the impact of approved revenue cost pressures.
- Excludes the impact of the 23-24 pay award.

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Medicine Division – Prioritised revenue capacity investments

Division	Programme / Theme	Short description of project	Finance implications (£'000)	Funding Proposed
Medicine	Pathway and Service improvement	currently the service is across 2 specilities and is disjointed. A lot of the operational activities is sitting with the DM. There needs to be an overall manager that is responsible for manging the VH service, managing budgets, procurement, staffing, governance and recruitment. they also need to be responsible for driving the service forward to increase admissions and work with clinical teams.	63.92	-
		In 2021/2 the neurology service had 3 junior doctors (IMT3, and IMT1) allocated to them to support the ever increasing inpatient review workload. However, 2022 and 2023 the allocation was reduced to one 1 IMT3 which is insufficient. When this doctor is on the acute on call rota, there is indeed no support for the neurology consultant workforce and therefore delay in patients being reviewed in a timely manner. Recruitment to a dedicated neurology Trust Grade doctor with improve the service to inpatient reviews and thereby reduce length of stay for inpatients.	60.00	60.00
		Review staffing levels across all levels	180.98	-
	Utilisation and Productivity Improvements	Increase in referrals and use of biologic treatments (requires funding application, monitoring and management of adverse events: FY 19/20 - 239 FY20/21 - 353 FY/22 - 520 (biologics) FY 20/21 - 5600 FY 21/22 - 6500 FY 22/23 -7900 (referrals Long waiting time for appointment with IBD consultant or nurse clinics which is: Consultant New Routine- 8 months; Consultant Urgent - 6 months; Consultant fol/up 9 months IBD Nurse New Routine- 6 months; IBD Nurse Urgent - 4 months; IBD Nurse fol/up - 9 months;	205.46	205.46
		Increasing Endoscopy capacity by developing a Transnasal endoscopy ((TNE) service using space (urology rooms) adjacent to the Hemel Hempstead endoscopy unit that is not currently JAG compliant for use for standard upper and lower gastrointestinal endoscopy, but would be compliant for use with Transnasal endoscopy. c. £402k Capital funds have already been secured from NHS E to support this proposal in 22/23.	249.59	187.19
		The Stroke nurse consultant will provide reliance to the stroke consultant team. Currently 5.5 WTE in post and 7 WTE consultants posts are required to meet service needs. Stroke Nurse consultant would beinstaed of recruiting an extra medical consultant. teh post holder will work alongside the consultant team to ensure a full SMART Stroke service is provided. The nurse will be able to support and enhance the current service provided by supplementing clinics, faciliate representation at Stroke ICS MDTs (supporting the future virtual clinics) and be able to provide case management across the ICS.	63.92	63.92
	Workforce	This will achieve earlier analysis for outcomes following OPA, RTT compliance, resilance in staffing ing cath lab sessions including cross cover for sickness and leave.maninating levels of elective activity. Review of workforce within the CRM team in order to ensure a stable structure and ensure the efficient running of the department. This will enable resilience in the team whilst maintaing activity. It will enable a structure where there is clear progression and training, making the department more appealing to staff to grown and train within the team. Additional resource will be spread across a range of pay bands, recognising that national shortages make it unrealistic to recruit and accredited, Band 7 level. This workforce review aims to focus on long term planning and ensuring robust recruitment and retention of staff.	146.45	73.22
		To replace locums on Letchmore	180.00	180.00
Grand Total			**1,150.30**	**769.79**

- A total of c. £1.5m Service developments were put forward by the division, of which £770k has been approved.

Medicine Division – Prioritised capital investments

Sum of Ammended value (if ap				
Directorate	Prioritised (Y/N)	Category	Scheme Title	Total
Medicine	Y	Clinical space	Gastroenterology: Renovation of Cysto area at HHGH endoscopy unit	363,318
		Equipment Replacement	Gastroenterology:Endoscopy stacks	359,422
	Y Total			722,741
Medicine Total				722,741
Grand Total				722,741

- Represents approved spend against internally generated schemes and doesn't include PDC schemes.
- Currently excludes ICT related schemes which are still awaiting prioritisation.

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Emergency Medicine Division – Income and Expenditure budget

Trust Definition	Expense Type	Values Sum of M1	Sum of M2	Sum of M3	Sum of M4	Sum of M5	Sum of M6	Sum of M7	Sum of M8	Sum of M9	Sum of M10	Sum of M11	Sum of M12	Sum of Grand Total
Income	Divisional Income	90,188	90,188	90,188	90,188	90,188	90,188	90,188	90,188	90,188	90,188	90,188	90,175	1,082,243
	NHS Revenue	5,175,920	5,347,494	5,187,142	5,351,132	5,348,524	5,189,464	5,356,011	5,193,169	5,350,842	5,359,699	5,031,702	5,357,140	63,248,239
Income Total		**5,266,108**	**5,437,682**	**5,277,330**	**5,441,320**	**5,438,712**	**5,279,652**	**5,446,199**	**5,283,357**	**5,441,030**	**5,449,887**	**5,121,890**	**5,447,315**	**64,330,482**
Pay	Medical Pay	-956,186	-961,161	-966,135	-963,647	-966,135	-963,647	-966,135	-966,135	-958,673	-966,135	-963,647	-961,167	-11,558,803
	Non-Clinical Pay	-264,025	-264,047	-264,069	-264,058	-264,069	-264,058	-264,069	-264,069	-264,036	-264,069	-264,058	-264,016	-3,168,643
	Nursing Pay	-1,221,824	-1,221,824	-1,221,824	-1,221,824	-1,221,824	-1,221,824	-1,221,824	-1,221,824	-1,221,824	-1,221,824	-1,221,824	-1,221,782	-14,661,846
	Other Clinical Pay	-445,384	-445,384	-445,384	-445,384	-445,384	-445,384	-445,384	-445,384	-445,384	-445,384	-445,384	-445,372	-5,344,596
	Scientific, Technical & Profes	-26,031	-26,031	-26,031	-26,031	-26,031	-26,031	-26,031	-26,031	-26,031	-26,031	-26,031	-26,035	-312,376
	Pay Unidentified CIPs	16,572	33,143	49,715	66,286	82,858	99,430	116,001	132,573	149,144	165,716	182,287	198,859	1,292,584
Pay Total		**-2,896,878**	**-2,885,304**	**-2,873,728**	**-2,854,658**	**-2,840,585**	**-2,821,514**	**-2,807,442**	**-2,790,870**	**-2,766,804**	**-2,757,727**	**-2,738,657**	**-2,719,513**	**-33,753,680**
Non Pay	Clin Supp Serv	-150,009	-166,677	-183,347	-175,013	-183,347	-175,013	-183,347	-183,347	-158,339	-183,347	-175,013	-166,692	-2,083,491
	Drugs	-120,893	-134,324	-147,757	-141,039	-147,757	-141,039	-147,757	-147,757	-127,608	-147,757	-141,039	-134,330	-1,679,057
	OTHER (NON CLIN)	-378,215	-378,215	-378,215	-378,215	-378,215	-378,215	-378,215	-378,215	-378,215	-378,215	-378,215	-378,274	-4,538,639
	Non Pay Unidentified CIPS	11,048	22,095	33,143	44,191	55,239	66,286	77,334	88,382	99,430	110,477	121,525	132,573	861,723
Non Pay Total		**-638,069**	**-657,121**	**-676,176**	**-650,076**	**-654,080**	**-627,981**	**-631,985**	**-620,937**	**-564,732**	**-598,842**	**-572,742**	**-546,723**	**-7,439,464**
Recharges	Recharges	-438,356	-487,064	-535,770	-511,418	-535,770	-511,418	-535,770	-535,770	-462,711	-535,770	-511,418	-487,064	-6,088,299
Recharges Total		**-438,356**	**-487,064**	**-535,770**	**-511,418**	**-535,770**	**-511,418**	**-535,770**	**-535,770**	**-462,711**	**-535,770**	**-511,418**	**-487,064**	**-6,088,299**
Grand Total		**1,292,805**	**1,408,193**	**1,191,656**	**1,425,168**	**1,408,277**	**1,318,739**	**1,471,002**	**1,335,780**	**1,646,783**	**1,557,548**	**1,299,073**	**1,694,015**	**17,049,039**

- Excludes the impact of approved revenue cost pressures.
- Excludes the impact of the 23-24 pay award.

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Emergency Medicine Division – Prioritised revenue capacity investments

Division	Short description of project	Sum of Finance implications (£'000)	Sum of Funding Proposed
Emergency Medicine	Aligned to HIGH IMPACT CHANGES Ensure nursing establishment is accurate for division following establishment review. To support flow within the dept in our non admitted TAM area and to support ambulance offload delays.	711.38	490.42
	Aligned to HIGH IMPACT CHANGES of rapid assessment and treatment. Increased workforce within ED as per RCEM and ECIST guidance - as per submitted business case (over 3 years) including 24/7 cover for ACPs	822.00	494.00
	To support flow within the dept within all areas of ED working with the Shift lead, NIC of majors and EPIC.	137.39	137.39
	We need to urgently address the shortfall in APs in acute medicine to ensure all areas within acute med are covered to provide twice daily ward rounds, assessment areas can perform and Virtual hospital can be supported	472.28	236.14
Emergency Medicine Total		**2,143.04**	**1,357.95**
Grand Total		**2,143.04**	**1,357.95**

- A total of c. £3.2m Service developments were put forward by the division, of which £1.4k has been approved.

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Emergency Medicine Division – Prioritised capital investments

Directorate	Prioritised (Y/N)	Category	Scheme Title	Total
Emergence Medicine	Y	Equipment capacity	New Bladder Scanner for AAU Level 1	8,000
Grand Total				8,000

- Represents approved spend against internally generated schemes and doesn't include PDC schemes.
- Currently excludes ICT related schemes which are still awaiting prioritisation.

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Women's and Children's Division – Income and Expenditure budget

Trust Definition	Expense Type	Values Sum of M1	Sum of M2	Sum of M3	Sum of M4	Sum of M5	Sum of M6	Sum of M7	Sum of M8	Sum of M9	Sum of M10	Sum of M11	Sum of M12	Sum of Grand Total
Income	Divisional Income	204,308	204,308	204,308	204,308	204,308	204,308	204,308	204,308	204,308	204,308	204,308	204,300	2,451,688
	NHS Revenue	5,012,684	5,340,965	5,375,393	5,469,088	5,250,140	5,440,116	5,528,167	5,407,869	5,185,489	5,457,781	5,183,701	5,256,996	63,908,389
Income Total		**5,216,992**	**5,545,273**	**5,579,701**	**5,673,396**	**5,454,448**	**5,644,424**	**5,732,475**	**5,612,177**	**5,389,797**	**5,662,089**	**5,388,009**	**5,461,296**	**66,360,077**
Pay	Medical Pay	-1,021,677	-1,022,763	-1,023,849	-1,023,305	-1,023,849	-1,023,305	-1,023,849	-1,023,849	-1,022,220	-1,023,849	-1,023,305	-1,022,745	-12,278,565
	Non-Clinical Pay	-308,484	-308,651	-308,817	-308,734	-308,817	-308,734	-308,817	-308,817	-308,567	-308,817	-308,734	-308,627	-3,704,616
	Nursing Pay	-1,736,335	-1,736,770	-1,737,202	-1,736,983	-1,737,202	-1,736,983	-1,737,202	-1,737,202	-1,736,553	-1,737,202	-1,736,983	-1,736,738	-20,843,355
	Other Clinical Pay	-313,893	-313,893	-313,893	-313,893	-313,893	-313,893	-313,893	-313,893	-313,893	-313,893	-313,893	-313,826	-3,766,649
	Scientific, Technical & Profes	-14,899	-14,899	-14,899	-14,899	-14,899	-14,899	-14,899	-14,899	-14,899	-14,899	-14,899	-14,898	-178,787
	Pay Unidentified CIPs	13,551	27,102	40,653	54,203	67,754	81,305	94,856	108,407	121,958	135,509	149,060	162,610	1,056,968
Pay Total		**-3,381,737**	**-3,369,874**	**-3,358,007**	**-3,343,611**	**-3,330,906**	**-3,316,509**	**-3,303,804**	**-3,290,253**	**-3,274,174**	**-3,263,151**	**-3,248,754**	**-3,234,224**	**-39,715,004**
Non Pay	Clin Supp Serv	-106,183	-117,983	-129,777	-123,876	-129,777	-123,876	-129,777	-129,777	-112,083	-129,777	-123,876	-118,026	-1,474,788
	Drugs	-87,888	-97,654	-107,420	-102,537	-107,420	-102,537	-107,420	-107,420	-92,772	-107,420	-102,537	-97,653	-1,220,678
	OTHER (NON CLIN)	-132,756	-132,756	-132,756	-132,756	-132,756	-132,756	-132,756	-132,756	-132,756	-132,756	-132,756	-132,791	-1,593,107
	Non Pay Unidentified CIPS	9,034	18,068	27,102	36,136	45,170	54,204	63,237	72,271	81,305	90,339	99,373	108,407	704,646
Non Pay Total		**-317,793**	**-330,325**	**-342,851**	**-323,033**	**-324,783**	**-304,965**	**-306,716**	**-297,682**	**-256,306**	**-279,614**	**-259,796**	**-240,063**	**-3,583,927**
Recharges	Recharges	-237,410	-263,791	-290,168	-276,980	-290,168	-276,980	-290,168	-290,168	-250,600	-290,168	-276,980	-263,791	-3,297,372
Recharges Total		**-237,410**	**-263,791**	**-290,168**	**-276,980**	**-290,168**	**-276,980**	**-290,168**	**-290,168**	**-250,600**	**-290,168**	**-276,980**	**-263,791**	**-3,297,372**
Grand Total		**1,280,052**	**1,581,283**	**1,588,675**	**1,729,772**	**1,508,591**	**1,745,970**	**1,831,787**	**1,734,074**	**1,608,717**	**1,829,156**	**1,602,479**	**1,723,218**	**19,763,774**

- Excludes the impact of approved revenue cost pressures.
- Excludes the impact of the 23-24 pay award.

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Women's and Children's Division – Prioritised revenue capacity investments

Division	Short description of project	Sum of Finance implications (£'000)	Sum of Funding Proposed
Women's and Children's	Additional 1 WTE post to support for patients and families in managing cancer and chronic conditions. This is a requirement for diabetes best practice tariff and Level 2 POSCU accreditation. Provides local support within the local community.	63.00	31.50
	Additional staffing to manage the volume and complexity of A&E attendances	171.00	92.00
	Building resilience and sustainable nurse led services within the Gynaecology Team. 1. Investing in future of Gynaecology Nursing and retainment and retention of staff 2. Limitations on Gynaecology Surgical Capacity. With the increase in GACU, this will support Day Cases and late discharges, to reduce cancellations and admissions 3.Supporting patient flow of day cases, and reducing changes of needing admission. 4.Providing additional pharmacy support for Gynaecology (Women's) services reelasing the current provision to enhance the service	152.00	152.00
	Compliance requirements of the BAPM to ensure safe and adequate cover for transitional care, alongside improving staff well being and reduced work related stress. The division is requesting 10PA input and the service is reviewing the team job plan to re-provide an additioanl 2-4PA's to create 2 additional 7PA Consultant posts.	120.00	120.00
	Looking Trust wide there is a lack of equity within the Paediatric Service with a lack of provision of senior nursing roles. A Paediatric Consultant Nurse would be able to take a clinical lead on Digital Health for the service, but also much needed transformational work within the Paediatric team, being supported by the new Clinical Director. The Virtual Hopsital highlights the need for a more multi-disciplinary working model, releasing Consultants but having a senior post holder developing pathways and service efficiencies (LoS). This would also provide career progression for the internal team, and resilience within the service by deputising for the head of Nursing when neeeded. This innovative post would provide equity across the trust, consultant nurse led clinics and new pratices within the service.	73.00	29.20
	Mat-Neo Governance administration support to ensure equity and collaboration between maternity and neonatal services	38.00	-
	WACs currently reviewing the management staffing cross services. The Gynaecology Dept, upon review, have 3 administrative staff under the nursing team. To ensure they are provided the right managerial support we seek to bring them within the administrative team, with a Band 5 Team Leader to support (and also take on the day to day admission support).	38.00	-
Women's and Children's Total		**655.00**	**424.70**
Grand Total		**655.00**	**424.70**

The prioritised funding of £425k represents the full year, total cash envelope.

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Women's and Children's Division – Prioritised capital investments

Directorate	Category	Scheme Title	Total
Women's and Children's	Clinical space	Remodel of rooms and room use - Ambulatory Gynaecology Centre and restructure of rooms for this including Colp and ANC	75,000
		Repurpose current Staff space in to Office space with opportunity to also provide an additional clinic space.	50,000
		Repurpose of current secretarial office for additional outpatient rooms	50,000
	Equipment Replacement	5x Carun Breast Pumps	10,000
		Neonatal Ventilator	35,000
		Point of Care Ultrasound Scanner and Probes	30,000
			250,000
Women's and Children's Total			**250,000**

- Represents approved spend against internally generated schemes and doesn't include PDC schemes.
- Currently excludes ICT relates schemes which are still awaiting prioritisation.

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Clinical Support Services Division – Income and Expenditure budget

Trust Definition	Expense Type	Values Sum of M1	Sum of M2	Sum of M3	Sum of M4	Sum of M5	Sum of M6	Sum of M7	Sum of M8	Sum of M9	Sum of M10	Sum of M11	Sum of M12	Sum of Grand Total
Income	Divisional Income	450,306	450,306	450,306	450,306	450,306	450,306	450,306	450,306	450,306	450,306	450,306	450,338	5,403,704
	NHS Revenue	1,208,398	1,500,329	1,617,404	1,559,753	1,385,530	1,560,904	1,619,790	1,620,364	1,271,400	1,621,606	1,563,904	1,389,763	17,919,145
Income Total		**1,658,704**	**1,950,635**	**2,067,710**	**2,010,059**	**1,835,836**	**2,011,210**	**2,070,096**	**2,070,670**	**1,721,706**	**2,071,912**	**2,014,210**	**1,840,101**	**23,322,849**
Pay	Medical Pay	-585,289	-585,289	-585,289	-585,289	-585,289	-585,289	-585,289	-585,289	-585,289	-585,289	-585,289	-585,287	-7,023,466
	Non-Clinical Pay	-198,061	-198,061	-198,061	-198,061	-198,061	-198,061	-198,061	-198,061	-198,061	-198,061	-198,061	-198,042	-2,376,713
	Nursing Pay	-48,532	-48,532	-48,532	-48,532	-48,532	-48,532	-48,532	-48,532	-48,532	-48,532	-48,532	-48,503	-582,355
	Other Clinical Pay	-429,172	-429,172	-429,172	-429,172	-429,172	-429,172	-429,172	-429,172	-429,172	-429,172	-429,172	-429,135	-5,150,027
	Scientific, Technical & Profes	-1,956,951	-1,957,024	-1,957,097	-1,957,061	-1,957,097	-1,957,061	-1,957,097	-1,957,097	-1,956,988	-1,957,097	-1,957,061	-1,956,969	-23,484,600
	Pay Unidentified CIPs	11,972	23,944	35,916	47,888	59,860	71,832	83,804	95,776	107,748	119,720	131,692	143,664	933,816
Pay Total		**-3,206,033**	**-3,194,134**	**-3,182,235**	**-3,170,227**	**-3,158,291**	**-3,146,283**	**-3,134,347**	**-3,122,375**	**-3,110,294**	**-3,098,431**	**-3,086,423**	**-3,074,272**	**-37,683,345**
Non Pay	Clin Supp Serv	-504,994	-561,105	-617,222	-589,173	-617,222	-589,173	-617,222	-617,222	-533,060	-617,222	-589,173	-561,114	-7,013,902
	Drugs	-276,908	-307,676	-338,445	-323,058	-338,445	-323,058	-338,445	-338,445	-292,292	-338,445	-323,058	-307,659	-3,845,934
	OTHER (NON CLIN)	-600,194	-600,194	-600,194	-600,194	-600,194	-600,194	-600,194	-600,194	-600,194	-600,194	-600,194	-600,057	-7,202,191
	Non Pay Unidentified CIPS	7,981	15,963	23,944	31,925	39,907	47,888	55,869	63,851	71,832	79,813	87,795	95,776	622,544
Non Pay Total		**-1,374,115**	**-1,453,012**	**-1,531,917**	**-1,480,500**	**-1,515,954**	**-1,464,537**	**-1,499,992**	**-1,492,010**	**-1,353,714**	**-1,476,048**	**-1,424,630**	**-1,373,054**	**-17,439,483**
Recharges	Recharges	1,608,414	1,787,127	1,965,839	1,876,483	1,965,839	1,876,483	1,965,839	1,965,839	1,697,771	1,965,839	1,876,483	1,787,125	22,339,081
Recharges Total		**1,608,414**	**1,787,127**	**1,965,839**	**1,876,483**	**1,965,839**	**1,876,483**	**1,965,839**	**1,965,839**	**1,697,771**	**1,965,839**	**1,876,483**	**1,787,125**	**22,339,081**
Grand Total		**-1,313,030**	**-909,384**	**-680,603**	**-764,185**	**-872,570**	**-723,127**	**-598,404**	**-577,876**	**-1,044,531**	**-536,728**	**-620,360**	**-820,100**	**-9,460,898**

- Excludes the impact of approved revenue cost pressures.
- Excludes the impact of the 23-24 pay award.

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Clinical Support Services Division – Prioritised revenue capacity investments

Division	Short description of project	Values Sum of Finance implications (£'000)	Sum of Funding Proposed
CSS	Additional histopathology consultants - to support the Better Cancer Diagnosis pathway (28 day)	129.00	129.00
	Dedicated therapy team for ED - 1.5 B7 OT and 1.5 B7 PT 7/7	191.04	126.08
	MOC Paper - Sonographer workforce - Includes uplift in banding plus a Clinical Practice Educator to support Registrar, Radiographer and Midwifery training	120.00	120.00
	Pharmacy Technical services support	188.98	94.49
	Therapy Patient Flow Co-ordinator	68.43	68.43
CSS Total		**697.45**	**538.01**
Grand Total		**697.45**	**538.01**

The prioritised funding of £538k represents the full year, total cash envelope.

Clinical Support Services Division – Prioritised capital investments

Directorate	Prioritised (Y/N)	Category	Scheme Title	Total
CSS	Y	Backlog maintenance	Remedial Works in Mortuary	250,000
		New equipment	Capital purchase of Blood component tracking system (Haemonetics)	99,097
			Replacement Gamma Camera WGH	495,000
		Other building capacity	Surge capacity for mortuary (Deceased and post mortem management)	329,092
	Y Total			**1,173,189**
CSS Total				**1,173,189**

- Represents approved spend against internally generated schemes and doesn't include PDC schemes.
- Currently excludes ICT relates schemes which are still awaiting prioritisation.

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Surgery and Anaesthetics Division – Income and Expenditure budget

Trust Definition	Expense Type	Values Sum of M1	Sum of M2	Sum of M3	Sum of M4	Sum of M5	Sum of M6	Sum of M7	Sum of M8	Sum of M9	Sum of M10	Sum of M11	Sum of M12	Sum of Grand Total
Income	Divisional Income	230,141	230,141	230,141	230,141	230,141	230,141	230,141	230,141	230,141	230,141	230,141	230,143	2,761,694
	NHS Revenue	8,094,920	8,493,512	8,546,936	8,615,018	8,482,916	8,592,357	8,771,458	8,715,900	8,509,253	8,875,087	8,675,297	8,724,749	103,097,403
Income Total		**8,325,061**	**8,723,653**	**8,777,077**	**8,845,159**	**8,713,057**	**8,822,498**	**9,001,599**	**8,946,041**	**8,739,394**	**9,105,228**	**8,905,438**	**8,954,892**	**105,859,097**
Pay	Medical Pay	-2,506,216	-2,518,160	-2,530,103	-2,524,131	-2,530,103	-2,524,131	-2,530,103	-2,530,103	-2,512,189	-2,530,103	-2,524,131	-2,518,100	-30,277,573
	Non-Clinical Pay	-557,717	-558,228	-558,740	-558,484	-558,740	-558,484	-558,740	-558,740	-557,973	-558,740	-558,484	-558,124	-6,701,194
	Nursing Pay	-2,296,122	-2,298,749	-2,301,376	-2,300,063	-2,301,376	-2,300,063	-2,301,376	-2,301,376	-2,297,436	-2,301,376	-2,300,063	-2,298,664	-27,598,040
	Other Clinical Pay	-613,261	-613,869	-614,477	-614,173	-614,477	-614,173	-614,477	-614,477	-613,566	-614,477	-614,173	-613,841	-7,369,441
	Scientific, Technical & Profes	-157,386	-158,552	-159,718	-159,135	-159,718	-159,135	-159,718	-159,718	-157,970	-159,718	-159,135	-158,540	-1,908,443
	Pay Unidentified CIPs	27,143	54,286	81,429	108,572	135,715	162,858	190,001	217,144	244,287	271,429	298,572	325,714	2,117,150
Pay Total		**-6,103,559**	**-6,093,272**	**-6,082,985**	**-6,047,414**	**-6,028,699**	**-5,993,128**	**-5,974,413**	**-5,947,270**	**-5,894,847**	**-5,892,985**	**-5,857,414**	**-5,821,555**	**-71,737,541**
Non Pay	Clin Supp Serv	-814,578	-905,092	-995,612	-950,366	-995,612	-950,366	-995,612	-995,612	-859,841	-995,612	-950,366	-905,039	-11,313,708
	Drugs	-334,841	-372,049	-409,250	-390,646	-409,250	-390,646	-409,250	-409,250	-353,445	-409,250	-390,646	-372,043	-4,650,566
	OTHER (NON CLIN)	-419,676	-419,676	-419,676	-419,676	-419,676	-419,676	-419,676	-419,676	-419,676	-419,676	-419,676	-419,459	-5,035,895
	Non Pay Unidentified CIPS	18,095	36,191	54,286	72,381	90,476	108,572	126,667	144,762	162,858	180,953	199,048	217,144	1,411,433
Non Pay Total		**-1,551,000**	**-1,660,626**	**-1,770,252**	**-1,688,307**	**-1,734,062**	**-1,652,116**	**-1,697,871**	**-1,679,776**	**-1,470,104**	**-1,643,585**	**-1,561,640**	**-1,479,397**	**-19,588,736**
Recharges	Recharges	-385,394	-428,215	-471,035	-449,627	-471,035	-449,627	-471,035	-471,035	-406,804	-471,035	-449,627	-428,209	-5,352,678
Recharges Total		**-385,394**	**-428,215**	**-471,035**	**-449,627**	**-471,035**	**-449,627**	**-471,035**	**-471,035**	**-406,804**	**-471,035**	**-449,627**	**-428,209**	**-5,352,678**
Grand Total		**285,108**	**541,540**	**452,805**	**659,811**	**479,261**	**727,627**	**858,280**	**847,960**	**967,639**	**1,097,623**	**1,036,757**	**1,225,731**	**9,180,142**

- Excludes the impact of approved revenue cost pressures.
- Excludes the impact of the 23-24 pay award.

Surgery and Anaesthetics Division – Prioritised revenue capacity investments

Programme / T	(All)		
Finance implica	(All)		
Initial Chiefs A	Y		
Division	**Short description of project**	**Values Sum of Finance implications (£'000)**	**Sum of Funding Proposed**
SAC	Create a dedicated urology centre at SACH	206.00	180.00
	Discharge Nursing Team	154.55	154.55
	Expand enhanced care service to a 7 day week model	59.03	59.03
	Expand the multidisciplinary breast team to accommodate rising demand and meet cancer performance standards	464.00	116.00
	Urology consultant of the week	125.68	125.68
SAC Total		**1,009.26**	**635.26**
Grand Total		**1,009.26**	**635.26**

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Surgery and Anaesthetics Division – Prioritised capital investments

Sum of Ammended value (if ap				
Directorate	Prioritised (Y/N)	Category	Scheme Title	Total
Surgery, Anaesthetics & Can	Y	Clinical space	23hr SACH Day Surgery Unit	300,000
			Clinic changes - 1 area into 2 clinic spaces - OMFS	35,000
			One Stop Urology Centre at SACH	1,250,000
		Equipment capacity	I-Stat Alinity Blood gas analyser - Watford Theatres	7,198
		Equipment Replacement	Leonardo mini dual - Urology	15,000
	Y Total			1,607,198
Surgery, Anaesthetics & Cancer Total				1,607,198
Grand Total				1,607,198

- Represents approved spend against internally generated schemes and doesn't include PDC schemes.
- Currently excludes ICT relates schemes which are still awaiting prioritisation.

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Corporate services – Income and Expenditure budget

Trust Definition	Expense Type	Values Sum of M1	Sum of M2	Sum of M3	Sum of M4	Sum of M5	Sum of M6	Sum of M7	Sum of M8	Sum of M9	Sum of M10	Sum of M11	Sum of M12	Sum of Grand Total
Income	Divisional Income	1,078,515	1,078,515	1,078,515	1,078,515	1,078,515	1,078,515	1,078,515	1,078,515	1,078,515	1,078,515	1,078,515	1,078,522	12,942,187
Income Total		**1,078,515**	**1,078,515**	**1,078,515**	**1,078,515**	**1,078,515**	**1,078,515**	**1,078,515**	**1,078,515**	**1,078,515**	**1,078,515**	**1,078,515**	**1,078,522**	**12,942,187**
Pay	Medical Pay	-106,269	-106,269	-106,269	-106,269	-106,269	-106,269	-106,269	-106,269	-106,269	-106,269	-106,269	-106,271	-1,275,230
	Non-Clinical Pay	-2,746,209	-2,746,209	-2,746,209	-2,746,209	-2,746,209	-2,746,209	-2,746,209	-2,746,209	-2,746,209	-2,746,209	-2,746,209	-2,745,976	-32,954,275
	Nursing Pay	-370,236	-370,236	-370,236	-370,236	-370,236	-370,236	-370,236	-370,236	-370,236	-370,236	-370,236	-370,243	-4,442,839
	Other Clinical Pay	-106,773	-106,773	-106,773	-106,773	-106,773	-106,773	-106,773	-106,773	-106,773	-106,773	-106,773	-106,775	-1,281,278
	Scientific, Technical & Profes	-136,761	-136,761	-136,761	-136,761	-136,761	-136,761	-136,761	-136,761	-136,761	-136,761	-136,761	-136,736	-1,641,107
	Pay Unidentified CIPs	19,131	38,259	57,390	76,519	95,649	114,776	133,908	153,037	172,167	191,298	210,426	229,555	1,492,115
Pay Total		**-3,447,117**	**-3,427,989**	**-3,408,858**	**-3,389,729**	**-3,370,599**	**-3,351,472**	**-3,332,340**	**-3,313,211**	**-3,294,081**	**-3,274,950**	**-3,255,822**	**-3,236,446**	**-40,102,614**
Non Pay	Clin Supp Serv	-59,654	-66,283	-72,914	-69,597	-72,914	-69,597	-72,914	-72,914	-62,968	-72,914	-69,597	-66,282	-828,548
	Drugs	-8,187	-9,096	-10,005	-9,552	-10,005	-9,552	-10,005	-10,005	-8,642	-10,005	-9,552	-9,098	-113,704
	OTHER (NON CLIN)	-3,943,886	-3,943,886	-3,943,886	-4,087,886	-4,196,886	-4,065,886	-4,022,886	-4,008,386	-3,613,886	-3,982,886	-3,793,886	-3,722,413	-47,326,659
	Non Pay Unidentified CIPS	5,576	11,152	16,727	22,302	27,878	33,454	39,030	44,605	50,181	55,756	61,332	66,906	434,899
Non Pay Total		**-4,006,151**	**-4,008,113**	**-4,010,078**	**-4,144,733**	**-4,251,927**	**-4,111,581**	**-4,066,775**	**-4,046,700**	**-3,635,315**	**-4,010,049**	**-3,811,703**	**-3,730,887**	**-47,834,012**
Grand Total		**-6,374,753**	**-6,357,587**	**-6,340,421**	**-6,455,947**	**-6,544,011**	**-6,384,538**	**-6,320,600**	**-6,281,396**	**-5,850,881**	**-6,206,484**	**-5,989,010**	**-5,888,811**	**-74,994,439**

- Excludes the impact of approved revenue cost pressures.
- Excludes the impact of the 23-24 pay award.

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Corporate Services Division – Prioritised revenue capacity investments

Division	Specialty	Short description of project	Values Sum of Finance implications (£'000)	Sum of Funding Proposed
Corporate	Communications	Expanding the communications team	150.00	75.00
	Corporate Nusing	Lead AHP for Workforce	70.00	52.50
		Shared Decision making	50.00	25.00
	R&D	Director of Research	134.00	100.00
Corporate Total			**404.00**	**252.50**
Grand Total			**404.00**	**252.50**

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Corporate Services Division – Prioritised capital investments

Directorate	Scheme Title	Total
Corporate	IT across divisions	583,550
Corporate Total		**583,550**
IT	Frontline Digitalisation programme (FLD) EPR (C4041)	690,000
IT Total		**690,000**
Grand Total		**1,273,550**

- Represents approved spend against internally generated schemes and doesn't include PDC schemes.
- Currently excludes ICT relates schemes which are still awaiting prioritisation.

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Environment Division – Income and Expenditure budget

Trust Definition	Expense Type	Values Sum of M1	Sum of M2	Sum of M3	Sum of M4	Sum of M5	Sum of M6	Sum of M7	Sum of M8	Sum of M9	Sum of M10	Sum of M11	Sum of M12	Sum of Grand Total
Income	Divisional Income	326,471	326,471	326,471	326,471	326,471	326,471	326,471	326,471	326,471	326,471	326,471	326,473	3,917,654
Income Total		**326,471**	**326,471**	**326,471**	**326,471**	**326,471**	**326,471**	**326,471**	**326,471**	**326,471**	**326,471**	**326,471**	**326,473**	**3,917,654**
Pay	Non-Clinical Pay	-465,950	-466,054	-466,158	-466,106	-466,158	-466,106	-466,158	-466,158	-466,002	-466,158	-466,106	-466,086	-5,593,200
	Nursing Pay	-4,642	-4,642	-4,642	-4,642	-4,642	-4,642	-4,642	-4,642	-4,642	-4,642	-4,642	-4,643	-55,705
	Other Clinical Pay	-63,674	-63,674	-63,674	-63,674	-63,674	-63,674	-63,674	-63,674	-63,674	-63,674	-63,674	-63,667	-764,081
	Scientific, Technical & Profes	-30,723	-30,723	-30,723	-30,723	-30,723	-30,723	-30,723	-30,723	-30,723	-30,723	-30,723	-30,726	-368,679
	Pay Unidentified CIPs	15,505	31,010	46,515	62,019	77,524	93,029	108,534	124,039	139,544	155,049	170,554	186,058	1,209,380
Pay Total		**-549,484**	**-534,083**	**-518,682**	**-503,126**	**-487,673**	**-472,116**	**-456,663**	**-441,158**	**-425,497**	**-410,148**	**-394,591**	**-379,064**	**-5,572,285**
Non Pay	Clin Supp Serv	-126,118	-140,128	-154,144	-147,138	-154,144	-147,138	-154,144	-154,144	-133,124	-154,144	-147,138	-140,115	-1,751,619
	Drugs	-4	-5	-5	-5	-5	-5	-5	-5	-5	-5	-5	-8	-62
	OTHER (NON CLIN)	-3,267,128	-3,267,128	-3,517,127	-3,065,694	-3,053,196	-3,249,200	-3,453,339	-3,560,656	-3,893,670	-3,893,670	-3,893,670	-3,905,684	-42,020,162
	Non Pay Unidentified CIPS	10,337	20,673	31,010	41,346	51,683	62,020	72,356	82,693	93,029	103,366	113,702	124,039	806,254
Non Pay Total		**-3,382,913**	**-3,386,588**	**-3,640,266**	**-3,171,491**	**-3,155,662**	**-3,334,323**	**-3,535,132**	**-3,632,112**	**-3,933,770**	**-3,944,453**	**-3,927,111**	**-3,921,768**	**-42,965,589**
Grand Total		**-3,605,926**	**-3,594,200**	**-3,832,477**	**-3,348,146**	**-3,316,864**	**-3,479,968**	**-3,665,324**	**-3,746,799**	**-4,032,796**	**-4,028,130**	**-3,995,231**	**-3,974,359**	**-44,620,220**

- Excludes the impact of approved revenue cost pressures.
- Excludes the impact of the 23-24 pay award.

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Environment Division – Prioritised revenue capacity investments

Division	Short description of project	Sum of Finance implications (£'000)	Sum of Funding Proposed
Environment	Medical devices	50.00	50.00
	Medical devices - additional posts	120.00	120.00
	Security contract	250.00	250.00
Environment Total		**420.00**	**420.00**
Grand Total		**420.00**	**420.00**

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Environment Division – Prioritised capital investments

Directorate	Category	Scheme Title	Total
Estates	Backlog maintenance	6-Facet survey	285,000
		Central Infrastructure	270,000
		CHP oil Store modification	65,000
		Fire Safety	750,000
		Lift - Critical spares	150,000
		Lift 9 - Critical spares	76,000
		Pigeon Netting	220,000
		Roof Repair (roof leaks)	350,000
		Water Safety - Legionella	600,000
	Green Plan - Net Zero	CHP Boiler Sequencing Controls Upgrade	750,000
		LED Lighting Upgrade (phase 2)	500,000
	Other building capacity	Critical Ventilation Refurbishment	150,000
		Pressure Systems Safety	50,000
			4,716,000
Estates Total			**4,716,000**
Medical Devices	Equipment Replacement	Anaesthetic machine	400,000
		Faxitron	80,000
		Holmium laser	162,000
		Jundice Meter	23,675
		Oxylog	78,000
		T34 Subcutaneus pump	54,000
		Ultrasound System	240,000
			1,037,675
Medical Devices Total			**1,037,675**
Grand Total			**5,753,675**

Appendix 2
(Detailed operational performance metrics)

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Operational Performance

ED All Types 4 Hr Performance												
Financial Yea	April	May	June	July	August	September	October	November	December	January	February	March
2019/20	81.2%	79.9%	82.1%	81.3%	80.5%	83.0%	83.4%	82.2%	79.4%	81.7%	80.7%	77.1%
2020/21	78.9%	83.9%	87.1%	85.9%	83.1%	84.3%	83.4%	82.1%	68.4%	65.3%	78.9%	83.1%
2021/22	86.0%	82.9%	79.1%	73.9%	76.1%	77.6%	73.6%	70.6%	63.3%	65.7%	62.7%	58.8%
2022/23	62.1%	58.3%	60.5%	63.2%	65.0%	70.2%	64.5%	60.2%	60.0%	68.4%	69.0%	68.1%
2023/24 Plan	70.0%	73.0%	76.0%	76.0%	76.0%	76.0%	76.0%	76.0%	76.0%	76.0%	76.0%	76.0%

G&A Bed Occupancy												
Financial Yea	April	May	June	July	August	September	October	November	December	January	February	March
2019/20	90.4%	92.3%	90.9%	90.1%	91.0%	92.8%	91.8%	92.5%	92.0%	93.8%	93.6%	78.7%
2020/21	75.2%	73.1%	75.4%	76.9%	81.8%	84.5%	85.4%	83.9%	88.1%	89.5%	84.0%	84.9%
2021/22	85.3%	86.7%	87.1%	86.1%	86.2%	86.7%	86.5%	87.2%	84.1%	86.4%	87.2%	87.1%
2022/23	87.4%	89.4%	89.9%	89.1%	90.2%	90.3%	90.8%	91.2%	91.2%	91.7%	90.3%	90.0%
2023/24 Plan	87.4%	89.4%	89.9%	89.1%	90.2%	96.9%	97.2%	97.7%	97.6%	97.9%	96.9%	96.7%

RTT 65 Week Waits												
Financial Yea	April	May	June	July	August	September	October	November	December	January	February	March
2019/20	0	0	1	2	0	0	0	0	0	0	0	0
2020/21	1	2	4	47	114	246	339	347	368	548	726	849
2021/22	1026	1007	783	578	477	431	399	351	390	437	461	413
2022/23	459	480	499	480	566	680	719	767	830	850	834	801
2023/24 Plan	751	693	593	485	393	310	210	152	127	102	61	0

Cancer 62+ Day Waits												
Financial Yea	April	May	June	July	August	September	October	November	December	January	February	March
2019/20	78	76	80	105	111	113	104	76	99	105	86	71
2020/21	104	198	206	160	119	94	80	77	81	104	118	79
2021/22	81	109	88	118	179	133	128	129	189	347	342	339
2022/23	258	297	311	277	261	260	236	195	159	184	129	118
2023/24 Plan	125	122	118	114	110	107	103	100	99	98	97	95

Cancer Faster Diagnosis Standard												
Financial Yea	April	May	June	July	August	September	October	November	December	January	February	March
2019/20	88.3%	73.5%	70.2%	74.0%	72.2%	69.7%	74.2%	76.9%	78.8%	76.6%	84.6%	79.1%
2020/21	71.3%	85.5%	82.5%	82.2%	83.4%	80.3%	84.7%	81.2%	82.7%	77.7%	85.2%	85.9%
2021/22	82.4%	80.0%	81.4%	82.5%	78.1%	77.4%	77.7%	76.2%	66.5%	46.3%	58.2%	54.0%
2022/23	52.1%	58.4%	55.3%	60.8%	59.9%	58.0%	63.3%	71.6%	72.7%	70.2%	65.0%	65.0%
2023/24 Plan	65.0%	65.0%	67.5%	67.5%	67.5%	70.0%	70.0%	70.0%	72.5%	72.5%	72.5%	75.0%

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NHS West Hertfordshire Hospitals NHS Trust

Elective Activity – Baseline (ex ERF baseline adjustment)

	2019-20 Baseline												
Description	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total
Total OP Atts (all TFC; cons and non cons led)	42,297	44,120	41,866	46,719	39,925	43,922	46,428	44,730	39,366	46,765	42,031	43,975	522,144
OP Atts (all TFC; cons and non cons led) - First attendance	15,260	15,788	15,447	17,298	14,628	15,910	16,959	16,643	14,416	17,162	15,851	16,950	192,312
OP Atts (all TFC; cons and non cons led) - Follow-up attendance	27,037	28,332	26,419	29,421	25,297	28,012	29,469	28,087	24,950	29,603	26,180	27,092	329,899
Episodes moved or discharged to PIFU pathway as an outcome of att	-	-	-	-	-	-	-	-	-	-	-	-	-
cons-led first OP atts (Spec acute)	13,180	13,585	13,319	15,011	12,621	13,765	14,557	14,482	12,417	14,831	13,608	14,660	166,036
cons-led first OP atts with procedures (Spec acute)	2,270	2,373	2,444	2,407	2,021	2,147	2,273	2,221	1,953	2,253	2,106	2,324	26,792
Cons-led follow-up OP atts (Spec acute)	18,727	19,863	18,552	20,724	17,492	20,004	20,721	20,335	17,588	21,285	18,778	19,286	233,355
Cons-led follow-up OP atts with procedures (Spec acute)	4,616	4,713	4,679	5,160	4,513	4,823	4,770	4,890	4,486	5,211	4,434	5,064	57,359
Follow Up Outpatient Attendances without procedure (WF sub-chapter HRG)	14,557	15,627	14,316	16,050	13,441	15,595	16,407	15,903	13,455	16,520	14,727	14,582	181,180
Total specific acute EL spells in the period	4,051	4,278	4,116	4,477	4,024	4,143	4,462	4,400	3,891	4,336	4,128	4,529	50,835
Total specific acute EL DC spells in the period	3,544	3,776	3,556	3,943	3,523	3,649	3,898	3,868	3,416	3,831	3,584	4,012	44,600
Total specific acute EL Ord spells in the period	507	502	560	534	501	494	564	532	475	505	544	523	6,241
Total specific acute EL DC spells of which children under 18 years of age	181	206	222	220	203	219	245	285	287	233	193	256	2,750
Total specific acute EL Ord spells of which children under 18 years of age	33	30	41	32	42	30	57	32	33	28	30	23	411
Total GP and other (non-GP) refs made for 1st cons-led OP appts in specific acute TFCs	14,301	15,229	14,038	15,870	14,124	14,403	16,432	15,121	13,931	16,392	14,627	15,819	180,287
Total refs made from GPs for first cons-led OP appts in specific acute TFCs	7,737	8,324	7,385	8,809	7,638	7,688	9,184	7,886	7,589	8,847	7,927	8,711	97,725
Total other (non-GP) refs made for first cons-led OP appts in specific acute TFCs	6,564	6,905	6,653	7,061	6,486	6,715	7,248	7,235	6,342	7,545	6,700	7,101	82,555
Diagnostic Tests - Magnetic Resonance Imaging	1,256	1,366	1,343	1,444	1,374	1,428	1,627	1,491	1,491	1,667	1,397	1,595	17,479
Diagnostic Tests - Computed Tomography	3,189	3,424	3,374	3,804	3,389	3,495	3,688	3,421	3,598	3,545	3,483	3,551	41,961
Diagnostic Tests - Non-Obstetric Ultrasound	3,778	3,088	2,558	2,653	2,338	2,445	2,522	2,634	2,457	2,892	2,408	2,683	32,456
Diagnostic Tests - Colonoscopy	362	438	346	417	378	394	422	409	368	410	404	414	4,762
Diagnostic Tests - Flexi Sigmoidoscopy	565	628	580	664	659	561	591	521	506	627	537	580	7,019
Diagnostic Tests - Gastroscopy	519	616	574	639	532	649	604	614	534	605	607	608	7,101
Diagnostic Tests - Cardiology - Echocardiography	1,312	1,306	1,385	1,390	1,321	1,154	1,301	1,338	1,152	1,302	1,349	1,314	15,624

The table above shows the elective activity delivered in 2019/20 by the Trust and forms the baseline for 2023/24 before any agreed adjustments

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NHS West Hertfordshire Hospitals NHS Trust

Elective Activity – 2022/23 Actual

	2022-23 Actual												
Description	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Total
Total OP Atts (all TFC; cons and non cons led)	32,747	37,374	35,606	34,565	35,954	37,005	37,241	41,612	33,613	41,345	37,178	39,585	435,122
OP Atts (all TFC; cons and non cons led) - First attendance	12,570	14,617	13,697	12,955	13,526	14,055	14,094	15,475	12,444	14,997	13,871	14,446	163,478
OP Atts (all TFC; cons and non cons led) - Follow-up attendance	20,177	22,757	21,910	21,610	22,428	22,950	23,147	26,136	21,169	26,348	23,307	25,139	271,644
Episodes moved or discharged to PIFU pathway as an outcome of att	-	-	-	-	-	-	-	-	-	-	-	-	-
cons-led first OP atts (Spec acute)	9,928	11,768	11,187	10,527	11,117	11,596	11,651	12,704	10,273	12,099	11,294	11,706	133,188
cons-led first OP atts with procedures (Spec acute)	1,874	2,220	2,056	1,936	2,185	2,224	2,414	2,919	1,946	2,408	2,240	2,402	26,298
Cons-led follow-up OP atts (Spec acute)	13,913	15,635	14,941	14,636	14,984	15,971	15,978	18,258	13,971	17,778	16,207	16,590	185,158
Cons-led follow-up OP atts with procedures (Spec acute)	1,568	2,007	1,750	1,871	2,300	2,880	2,998	3,620	3,071	3,720	3,392	3,408	31,946
Follow Up Outpatient Attendances without procedure (WF sub-chapter HRG)	12,592	13,887	13,456	13,040	13,007	13,352	13,266	14,926	11,123	14,368	13,097	13,468	156,452
Total specific acute EL spells in the period	2,527	2,846	2,635	2,702	2,966	2,907	2,769	3,164	2,675	2,755	2,955	3,352	33,581
Total specific acute EL DC spells in the period	2,198	2,459	2,263	2,254	2,518	2,507	2,337	2,732	2,304	2,386	2,533	2,946	28,860
Total specific acute EL Ord spells in the period	328	387	371	448	448	400	432	432	371	369	422	406	4,721
Total specific acute EL DC spells of which children under 18 years of age	70	93	101	108	112	121	113	111	116	122	136	140	1,318
Total specific acute EL Ord spells of which children under 18 years of age	2	3	7	3	17	11	7	6	9	11	13	19	108
Total GP and other (non-GP) refs made for 1st cons-led OP appts in specific acute TFCs	15,155	17,656	16,055	15,481	16,415	15,924	16,216	17,299	13,832	15,477	14,535	15,828	186,151
Total refs made from GPs for first cons-led OP appts in specific acute TFCs	7,657	9,290	8,563	8,651	8,804	8,701	8,592	9,267	7,190	7,966	7,453	8,003	98,173
Total other (non-GP) refs made for first cons-led OP appts in specific acute TFCs	7,498	8,366	7,492	6,830	7,611	7,224	7,623	8,033	6,642	7,511	7,082	7,825	87,978
Diagnostic Tests - Magnetic Resonance Imaging	1,588	1,609	1,483	1,507	1,488	1,427	1,543	1,716	1,490	1,751	1,592	1,824	18,645
Diagnostic Tests - Computed Tomography	3,780	4,139	3,907	3,883	4,162	4,042	4,045	4,491	4,093	4,500	4,113	4,351	48,536
Diagnostic Tests - Non-Obstetric Ultrasound	2,174	2,759	2,612	2,414	2,429	2,679	2,547	3,025	2,311	2,674	2,324	2,823	30,168
Diagnostic Tests - Colonoscopy	384	444	378	461	505	482	440	577	418	451	471	550	5,452
Diagnostic Tests - Flexi Sigmoidoscopy	179	207	154	157	179	166	160	188	169	148	159	172	1,998
Diagnostic Tests - Gastroscopy	609	701	714	626	665	665	481	613	588	519	599	745	7,377
Diagnostic Tests - Cardiology - Echocardiography	1,263	1,346	1,227	1,100	1,163	1,270	979	1,124	824	887	919	1,003	12,848

The table above shows the elective activity delivered in 2022/23 by the Trust

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NHS West Hertfordshire Hospitals NHS Trust

Elective Activity - Plan

Description	Unmitigated 2023/24 Annual Plan													% of 2019 Adj B/L
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total	
Total OP Atts (all TFC; cons and non cons led)	34,996	36,650	34,995	39,207	33,587	37,087	39,324	38,088	33,561	39,985	36,146	38,344	441,970	85%
OP Atts (all TFC; cons and non cons led) - First attendance	14,720	15,404	15,182	17,143	14,616	16,078	17,223	17,023	14,848	17,783	16,512	18,025	194,557	103%
OP Atts (all TFC; cons and non cons led) - Follow-up attendance	20,276	21,246	19,813	22,064	18,971	21,009	22,101	21,065	18,713	22,202	19,634	20,319	247,413	75%
Episodes moved or discharged to PIFU pathway as an outcome of att	52	62	72	82	94	100	100	100	100	100	100	100	1,062	
cons-led first OP atts (Spec acute)	12,666	13,212	13,049	14,833	12,574	13,880	14,743	14,775	12,754	15,324	14,129	15,575	167,514	103%
cons-led first OP atts with procedures (Spec acute)	2,241	2,361	2,450	2,431	2,056	2,201	2,347	2,310	2,046	2,377	2,238	2,486	27,544	103%
Cons-led follow-up OP atts (Spec acute)	14,043	14,894	13,913	15,542	13,117	15,003	15,540	15,251	13,191	15,963	14,082	14,465	175,004	75%
Cons-led follow-up OP atts with procedures (Spec acute)	4,616	4,713	4,679	5,160	4,513	4,823	4,770	4,890	4,486	5,211	4,434	5,064	57,359	100%
Follow Up Outpatient Attendances without procedure (WF sub-chapter HRG)	10,916	11,717	10,736	12,036	10,079	11,696	12,305	11,927	10,091	12,389	11,044	10,936	135,872	75%
Total specific acute EL spells in the period	3,510	3,725	3,553	3,870	3,492	3,735	4,047	4,139	3,610	3,986	3,887	4,580	46,134	103%
Total specific acute EL DC spells in the period	3,013	3,227	2,993	3,331	2,983	3,231	3,465	3,589	3,112	3,456	3,309	4,021	39,730	103%
Total specific acute EL Ord spells in the period	497	498	560	539	509	504	582	550	498	530	578	559	6,404	103%
Total specific acute EL DC spells of which children under 18 years of age	179	205	223	222	207	224	253	296	301	246	205	274	2,835	103%
Total specific acute EL Ord spells of which children under 18 years of age	33	30	41	32	43	31	59	33	35	30	32	24	423	103%
Total GP and other (non-GP) refs made for 1st cons-led OP appts in specific acute TFCs	14,301	15,229	14,038	15,870	14,124	14,403	16,432	15,121	13,931	16,392	14,627	15,812	180,280	100%
Total refs made from GPs for first cons-led OP appts in specific acute TFCs	7,737	8,324	7,385	8,809	7,638	7,688	9,184	7,886	7,589	8,847	7,927	8,711	97,725	100%
Total other (non-GP) refs made for first cons-led OP appts in specific acute TFCs	6,564	6,905	6,653	7,061	6,486	6,715	7,248	7,235	6,342	7,545	6,700	7,101	82,555	100%
Diagnostic Tests - Magnetic Resonance Imaging	1,833	1,976	1,346	1,458	1,398	1,464	1,680	1,551	1,562	1,759	1,484	1,707	19,218	103%
Diagnostic Tests - Computed Tomography	3,149	3,407	3,382	3,842	3,448	3,582	3,808	3,558	3,769	3,740	3,701	3,800	43,186	103%
Diagnostic Tests - Non-Obstetric Ultrasound	3,731	3,073	2,564	2,680	2,379	2,506	2,604	2,739	2,574	3,051	2,559	2,870	33,330	103%
Diagnostic Tests - Colonoscopy	357	436	347	421	385	404	436	425	385	433	429	443	4,901	103%
Diagnostic Tests - Flexi Sigmoidoscopy	214	236	180	190	194	209	200	237	194	202	209	433	2,698	103%
Diagnostic Tests - Gastroscopy	513	613	575	645	541	665	624	639	559	638	645	650	7,307	103%
Diagnostic Tests - Cardiology - Echocardiography	1,296	1,299	1,388	1,404	1,344	1,183	1,343	1,392	1,207	1,374	1,433	1,406	16,069	103%

The table above shows the elective activity plan for 2023/24 before any agreed adjustments derived from the 2019/20 baseline in line with published national guidance.

Non-Elective Activity - Baseline

Line ID	Description	2022-23 Baseline												
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Total
E.M.13n	Number of attendances at all type A&E departments where the patient spent less than 4	9,147	9,103	9,461	9,572	9,635	9,925	10,069	9,356	9,994	9,657	9,669	9,669	115,257
E.M.13d	Number of attendances at all type A&E departments.	14,731	15,630	15,632	15,147	14,834	14,136	15,609	15,554	16,669	14,112	15,445	15,445	182,944
E.M.13	Percentage of attendances at Type 1, 2, 3 A&E departments, excluding planned follow-up	62%	58%	61%	63%	65%	70%	65%	60%	60%	68%	63%	63%	63%
E.M.13an	Number of attendances at type 1 A&E departments where the patient spent less than 4	2,731	2,453	2,434	2,652	2,683	2,932	2,900	2,590	3,021	3,191	2,934	2,934	33,455
E.M.13ad	Number of attendances at type 1 A&E departments.	7,412	7,780	7,737	7,699	7,223	6,972	7,858	8,085	8,539	7,383	8,002	8,002	92,693
E.M.13a	Percentage of attendances at Type 1 A&E departments, excluding planned follow-up	37%	32%	31%	34%	37%	42%	37%	32%	35%	43%	37%	37%	36%
E.M.13bn	Number of attendances at other type A&E departments where the patient spent less than	6,416	6,650	7,027	6,920	6,952	6,993	7,169	6,766	6,973	6,466	6,735	6,735	81,802
E.M.13bd	Number of attendances at other type A&E attendances	7,319	7,850	7,895	7,448	7,611	7,164	7,751	7,469	8,130	6,729	7,443	7,443	90,251
E.M.13b	Percentage of attendances at Type 2 and 3 A&E departments, excluding planned follow-	88%	85%	89%	93%	91%	98%	92%	91%	86%	96%	90%	90%	91%
E.M.11	Specific acute NEL spells in the period	3,864	4,082	3,976	3,895	3,891	3,766	3,931	4,012	3,802	4,012	3,802	4,012	47,045
E.M.11a	Specific acute NEL spells with a LoS of zero days	1,435	1,595	1,564	1,429	1,370	1,341	1,424	1,442	1,222	1,442	1,222	1,442	16,928
E.M.11b	Specific acute NEL spells with a LoS of one or more days	2,429	2,487	2,412	2,466	2,521	2,425	2,507	2,570	2,580	2,570	2,580	2,570	30,117

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NHS West Hertfordshire Hospitals NHS Trust

Non-Elective Activity - Plan

	Unmitigated 2023/24 Annual Plan													
Description	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total	
Number of attendances at all type A&E departments where the patient spent less than 4	10,827	11,980	12,474	12,087	11,838	11,281	12,456	12,412	13,302	11,261	12,325	12,325	144,568	105%
Number of attendances at all type A&E departments.	15,468	16,412	16,414	15,904	15,576	14,843	16,389	16,332	17,502	14,818	16,217	16,217	192,092	105%
Percentage of attendances at Type 1, 2, 3 A&E departments, excluding planned follow-up	70%	73%	76%	76%	76%	76%	76%	76%	76%	76%	76%	76%	75%	
Number of attendances at type 1 A&E departments where the patient spent less than 4	3,527	4,150	4,599	4,658	4,246	4,134	4,724	4,962	5,192	4,549	4,901	4,901	54,543	105%
Number of attendances at type 1 A&E departments.	7,783	8,169	8,124	8,084	7,584	7,321	8,251	8,489	8,966	7,752	8,402	8,402	97,327	105%
Percentage of attendances at Type 1 A&E departments, excluding planned follow-up	45%	51%	57%	58%	56%	56%	57%	58%	58%	59%	58%	58%	56%	
Number of attendances at other type A&E departments where the patient spent less than	7,301	7,830	7,875	7,429	7,592	7,146	7,732	7,450	8,110	6,712	7,424	7,424	90,025	105%
Number of attendances at other type A&E attendances	7,685	8,243	8,290	7,820	7,992	7,522	8,139	7,842	8,537	7,065	7,815	7,815	94,765	105%
Percentage of attendances at Type 2 and 3 A&E departments, excluding planned follow-	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	
Specific acute NEL spells in the period	4,057	4,286	4,175	4,090	4,086	3,954	4,128	4,213	3,992	4,213	3,992	4,213	49,399	105%
Specific acute NEL spells with a LoS of zero days	1,507	1,675	1,642	1,500	1,439	1,408	1,495	1,514	1,283	1,514	1,283	1,514	17,774	105%
Specific acute NEL spells with a LoS of one or more days	2,550	2,611	2,533	2,589	2,647	2,546	2,632	2,699	2,709	2,699	2,709	2,699	31,623	105%

The A&E and NEL activity in based on 2022/23 outturn and adjusted for expected growth of 5%.

Further work is being undertaken to full understand the impact of out of hospital system transformational schemes to the emergency activity pressures

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Bed Capacity – G&A Beds

Average Number of Available G&A Beds	April	May	June	July	August	September	October	November	December	January	February	March
2019/20	655	660	640	635	641	638	656	652	649	675	660	630
2022/23	676	687	671	678	675	669	686	685	695	711	671	662
2023/24	676	687	671	678	675	669	686	685	695	711	671	662

Average Number of Occupied G&A Beds	April	May	June	July	August	September	October	November	December	January	February	March
2019/20	592	609	582	572	583	592	602	603	597	633	618	496
2022/23	591	614	603	604	609	604	623	625	634	652	606	596
2023/24	591	614	603	604	609	648	667	669	678	696	650	640

G&A Beds Occupancy	April	May	June	July	August	September	October	November	December	January	February	March
2019/20	90.4%	92.3%	90.9%	90.1%	91.0%	92.8%	91.8%	92.5%	92.0%	93.8%	93.6%	78.7%
2022/23	87.4%	89.4%	89.9%	89.1%	90.2%	90.3%	90.8%	91.2%	91.2%	91.7%	90.3%	90.0%
2023/24	87.4%	89.4%	89.9%	89.1%	90.2%	96.9%	97.2%	97.7%	97.6%	97.9%	96.9%	96.7%

team westHerts

NHS West Hertfordshire Hospitals NHS Trust

Bed Capacity – Adult Critical Care Beds

Average Number of Available Adult Critical Care Beds	April	May	June	July	August	September	October	November	December	January	February	March
2019/20	19	19	19	17	17	19	19	19	19	19	19	21
2022/23	21	20	20	20	20	20	19	19	19	20	19	19
2023/24	21	20	20	20	20	20	19	19	19	20	19	19

Average Number of Occupied Adult Critical Care Beds	April	May	June	July	August	September	October	November	December	January	February	March
2019/20	15	16	12	13	13	14	14	13	13	14	13	14
2022/23	15	15	14	15	15	14	14	14	16	18	15	15
2023/24	15	15	14	15	15	14	14	14	16	18	15	15

Adult Critical Care Beds Occupancy	April	May	June	July	August	September	October	November	December	January	February	March
2019/20	78.9%	84.2%	63.2%	76.5%	76.5%	73.7%	73.7%	68.4%	68.4%	73.7%	68.4%	66.7%
2022/23	71.4%	75.0%	70.0%	75.0%	75.0%	70.0%	73.7%	73.7%	84.2%	90.0%	78.9%	78.9%
2023/24	71.4%	75.0%	70.0%	75.0%	75.0%	70.0%	73.7%	73.7%	84.2%	90.0%	78.9%	78.9%

West Hertfordshire Teaching Hospitals NHS Trust

Trust Board Meeting
1 June 2023

Title of the paper	**Financial update**
Agenda Item	**23**
Presenter	**Don Richards, Chief Financial Officer**
Author(s)	**Don Richards, Chief Financial Officer**
Purpose	*For approval*: ; *For discussion*: √ ; *For information*: √
Executive Summary	The purpose of this report is to provide assurance to the Board of the Trust's financial stability. This report covers the first month's revenue performance, the capital expenditure plan for the year, and the current status of assets and liabilities. A detailed finance report on which this summary is based, has been reviewed at the May Finance and Performance Committee. **1. Revenue Performance** The plan for the year is to balance projected income of £491.4m with expenditure. For the first month the plan was to earn £40.0m of income and spend £40.4m, hence, to deliver a revenue deficit of £0.4m. The actual results showed a deficit of £1.6m, indicating an adverse variance of £1.2m. The primary cause of this discrepancy is challenges in meeting elective activity targets. National guidance allowed the Trust to moderate a gross deficit of £1.8m to £1.2m due to an estimate that £0.6m of the deficit was due to industrial action in April. Other variances in pay and non-pay costs have been offset by other non-NHS service income. Agency spend, a useful indicator of spending control, was recorded at £1m compared to the targeted £1.2m. Chief Officers have refocussed performance meetings with leaders for six specialties that have contributed most significantly to the income shortfall:

Trauma and orthopaedics, general surgery, dermatology, rheumatology and paediatrics.

We have already seen an increase in weekend working to attempt to make good the shortfall seen in April.

There is early evidence (to be validated after improved coding) that despite the elective activity shortfall, the national tariff value of all Trust April activity, exceeds the block contract value for that period.

2. Savings

At this stage of the year, the Trust has not fully validated the savings that would be included in Month 1 (M1) reports. However, certain savings, such as energy savings, are embedded within the reported expenditure figures.

3. Capital Expenditure Plan

Projected capital expenditure could exceed £87m for the 2023/24 year, depending on support for nationally prioritized initiatives (See Operating and Financial Plan earlier on the agenda). Key spending areas are expected to include:

a) Purchase of a small parcel (0.6 ha) of land
b) The development of the Integrated Care System (ICS) elective hub
c) Completion of the Community Diagnostic Centre
d) The new pathology hot lab at Watford general Hospital

4. Current status of assets and liabilities

The Trust's cash balance at the end of April fell to £29.6m from £35.4m at the end of March. This was linked to a fall in capital payables from £18.0m at the end of March to £13.0m at the end of April. Other balances remained largely unchanged.

5. Risks

At this stage of the year the risks and mitigations as outlined in the Operating and Financial plan paper earlier on the agenda remain.

6. Conclusion

In conclusion, the Trust's financial stability requires ongoing attention to revenue performance, particularly in addressing elective activity targets. As the year progresses, we will continue validating savings and monitoring capital expenditure related to key initiatives. The financial report aims to provide insight supporting the Board to make informed decisions that will ensure the successful and sustainable performance of the Trust.

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: Date:
Action required	The Board is asked to note the contents of this report.

West Hertfordshire Teaching Hospitals NHS Trust

Trust Board Meeting
1 June 2023

Title of the paper	Main Paper: Phase 2 Refurbishment of NICU at WGH – Full Business Case Supporting Document: Neonates Environmental Risk Assessment
Agenda Item	24
Presenter	Mr W Forson, WACS Divisional Director
Author(s)	Rob Emmins, Brian Hargreaves, Vicky Flanagan, Elvira Baker with input / review from the Neonatal Project Team and WACS Divisional Team
Purpose	*Please tick the appropriate box* *For approval*: X *For discussion*: *For information*:
Executive Summary	This business case seeks approval to invest £2,071,652 of capital funding for Phase Two of the refurbishment of the Neonatal Intensive Care Unit (NICU) at Watford General Hospital (WGH). It will improve care quality in line with the Trust's overall clinical strategy, by providing essential infrastructure improvements for NICU, that are needed in advance of the full reprovision of the service when the new Watford Hospital is delivered. The main element of this interim business case is the replacement of the air handling unit and the scheme builds on work already completed to improve administrative, reception and overnight facilities as part of the project's first phase. The specific changes planned are as follows: • Installation of a completely new and compliant air handling unit (AHU) • Upgrade of medical gases and power and new nurse call system • Redecoration (required due to the removal of suspended ceilings and damage caused to existing paintwork) • Upgrade to low emission lighting in new suspended ceiling • Upgrade of wash hand basins • Upgrades to nurse base • Upgrades to fire doors Delivering this project requires the neonatal unit to be vacated, and for neonatal care to be provided elsewhere within the hospital. A detailed options appraisal and transition plan have been completed by the Divisional Team to ensure patient safety, and to allow essential works to be undertaken in a controlled and managed way. In summary, the agreed moves are: • Transitional Care moves to GACU (Level 2) • Intensive Care and High Dependency Units move to Transitional Care (Level 2) • Isolation Beds move to the Rooms 5a and 6a on Katherine Ward (Level 2) • Special Care moves to Bay 5 on Katherine Ward (Level 2) • Offices and storage relocated to external welfare units One of the most significant impacts of the transition plan is the removal of the Gynaecology Ambulatory Care Unit (GACU) on Level 2 from the Trust's surge plan (which details which areas within the hospital are used during times of high demand for admission). With a reduction of 5 beds, it is vital that the impact on the wider organisation and the flow of emergency is accounted for. It has been agreed that the Paediatric Admissions Unit (PAU) will be moved higher within the surge plan while the works are undertaken, to be utilised when needed as part of the adult surge plan.

While there are clinical risks associated with this project, this will be managed in a way that has been given careful consideration and will ultimately result in the service being able to operate from an environment that is compliant with expected standards for ventilation and resilience.

This full business case was presented to Great Place Programme Board (GPPB) on 10th May. As an outcome of that meeting, the project team was asked to review the risks associated with the existing ventilation system and confirm:

1. That the risk resulting from doing nothing exceeded the combined risks arising from undertaking the proposed works project in the neonatal unit.
2. The cost/benefits analysis for the proposal

The project was reviewed by the Ventilation Safety Group on 15th May 2023. After considering the evidence presented in the supporting document *(NICU Environmental Risk Assessment)*, the Ventilation Safety Group confirmed that it supported the Neonatal Business Case and the associated Transition Plan.

The group also recognised the removal or significant reduction of a series of environmental risks that have the potential to impact on patient safety, clinical provision of safe care, and the reputation of the Trust.

Subject to the completion of this review and the feedback given by the Ventilation Safety Group, approval was given for this Full Business Case to proceed for presentation at Finance and Performance Committee and Trust Board. Chief Finance Officer approval was also given to proceed with order for the air handling unit, given the anticipated long lead-in time for this.

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	Date
CFPG (Phase 1 Approved)	January 2022
TMC (Phase 1 Approved)	February 2022
WACS Division Senior Management Team	January 2023
Great Place Programme Board	February 2023
WACS Governance Team	April 2023
Neonatal Team Meeting	May 2023
WACS Divisional Management Team	May 2023
Great Place Programme Board	May 2023
Finance and Performance Committee	May 2023

Note: The outline case for this project was considered by GPPB in February 2023, with approval given to seek full project costs. The case was not taken to Trust Board at that time as the scheme had not yet been confirmed as part of the Trust's capital programme for 2023/24.

Action required	Trust Board is asked to: • Approve this Full Business Case

WEST HERTFORDSHIRE HOSPITALS NHS TRUST

Watford General Hospital NICU Ventilation and Refurbishment Project (Phase 2)

Full Business Case

Authors: Rob Emmins, Brian Hargreaves, Vicky Flanagan, Elvira Baker and Esther Moors, with support of project team

Version No: 1.7

Issue Date: 26th May 2023

REVIEWED	DIVISION	IM&T	ESTATES	CLINICAL	OTHER

BY	BOARD			SUPPORT	
DATE	01.02.2023	01.02.2023	15.05.2023	N/A	GPPB - 10.05.2023

	AMOUNT 2022/23	2023/24	2024/25
CAPITAL FUNDING REQUESTED	COMPLETION OF FULL WORKS FOR £2,071,652, SUBJECT TO APPROVAL AND AVAILABILITY OF FUNDS	NONE	NONE

SOURCE OF FUNDING	SOURCE
REVENUE	N/A
CAPITAL	INTERNAL CAPITAL FUNDS

VERSION HISTORY

Version	Date Issued	Brief Summary of Change	Owner's Name
0.1	01.06.2022	First draft produced for circulation among key stakeholders	Rob Emmins
0.2	01.11.2022	Issued to Divisional Finance Lead for comment	Rob Emmins
0.3	03.11.2022	Updated with feedback from Finance Lead and Inserted updated transition plan visual	Rob Emmins
0.4	26.01.2023	Updated for Divisional Management Team following feedback and review, in preparation for submission to GPPB	Rob Emmins
1.0	01.02.2023	Updated following feedback from Divisional Management Team for submission to GPPB	Rob Emmins
1.1	02.02.2023	Final amendments for GPPB	Rob Emmins
1.2	02.05.2023	Updated to Full Business Case, with confirmed costs in preparation for submission	Rob Emmins
1.3	04.05.2023	Changes for submission to GPPB	Rob Emmins
1.4	05.05.2023	Further changes following review	Rob Emmins
1.5	09.05.2023	Further amendments following feedback on transition plan	Rob Emmins
1.6	19.05.2023	Minor changes to narrative to ensure clarity and internal consistency; Completion and inclusion of environmental risk assessment	Rob Emmins
1.7	26.05.2023	Minor revisions for submission to Trust Board	Rob Emmins

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1. Executive Summary

This full business case seeks approval to invest £2,071,652 of capital funding for Phase Two of the refurbishment of the Neonatal Intensive Care Unit (NICU) at Watford General Hospital (WGH).

Approval of this business case will deliver essential environmental improvements to the unit's clinical environment, building upon work already undertaken to administrative, reception and overnight facilities as part of the project's first phase.

Strategic Case

This business case supports the following of the Trust's strategic aims:

- Best Care
- Great Place

WHTH's Maternity Services offer community and hospital-based care for antenatal, intrapartum, and post-natal pathways. A highly functioning neonatal unit is required to support the high acuity level of the local population and is essential to meet national and local safety standards and commissioning requirements.

There are several service and estates issues with the existing neonatal facilities. Service concerns include limited cot space, non-compliance with best practice estates guidance (NHS England Health Building Notices (HBN)), and compromised patient and staff experience. Most pertinently, there are compliance issues with ventilation systems, medical gases, and power.

Delivering change to ventilation, gases and power is challenging given that it requires the unit to be vacated and for neo-natal care to be provided elsewhere within the Women's & Children's Building. A detailed options appraisal and transition plan have been completed by the Divisional Team to ensure patient safety whilst the works are completed, with the intention that this business case allows essential works to be undertaken in a controlled and managed way.

Economic Case

The economic case sets out the preferred option, which is to proceed to the second phase of improvements works on the neonatal ward. The key benefits of this option include alignment with Trust Strategy, general compliance, and significant overall improvements in the quality of care provided to patients.

The table below shows a summary of the shortlisted options, and of the anticipated benefits that the project would deliver.

Option	Benefits	Outcome
1. Do nothing (do not progress any aspect of scheme further)	• No capital spend	Rejected
2. Proceed with limited second phase based on environmental improvements: • Instillation of a new air handling unit (AHU) • Upgrade of medical gases and power supply • Full redecoration	• Improvement in ventilation and reduced air quality risks • Improved resilience of power and gas supplies • Enhanced environment for patients / parents & staff	Recommended
3. Proceed with original scheme of environmental improvements (as in option two) and significant structural alterations to improve cot sizes and service function	• Improvement in ventilation and reduced air quality risks • Improved resilience of power and gas supplies • Significant improvement in quality of care, environment, and patient flow	Rejected

Commercial Case

The commercial case sets out the design work that has been undertaken by the Trust's capital projects team, and the timeline for implementation.

Tender documentation has already been completed for the second phase of the scheme, and the lowest tender bid for the sum of £1,078,275.00+VAT was recommended by the capital projects team.

Following approval of the outline business case in February 2023, the leading contractor was approached and asked to update their bid. It was not considered necessary to re-tender as there were no changes to the originally tendered scheme. The adjusted tender value has been confirmed as £1,269,700.88+VAT, and the capital projects team has recommended that this bid is accepted.

Financial Case

The financial case modifies the above tendered quote with an estimated 10% contingency, to manage cost increases for any unforeseen circumstances during implementation.

Additional project costs have also been identified, including a dedicated Service Transition Project Manager role (12 months), additional portering, ward clerk and security, and various non-tendered activities such as removals, surveying, and cleaning (as listed in section 6.1).

As a result, the total capital outlay required has been estimated at £2,071,652. This is discussed further in the financial section. There are no anticipated revenue consequences for the capital spend.

Management Case

The project will continue to be managed by a dedicated project group, with operational representation, a project manager and leadership from the Capital Planning Team. This provides strong links with the main redevelopment programme and allows oversight and assurance from the WACS Divisional Management Group and Trust Management Committee.

A detailed transition plan has been created to support the vacation of the neonatal unit to enable the works to proceed. This has been collectively developed through discussion and with representation from all affected services within the WACS Building, and subsequently reviewed and agreed at Divisional Level.
Design work has been overseen by the capital projects team, who will then also oversee all construction works.

Conclusion and Next Steps

This business case recognises the urgency in resolving environmental issues on the NICU and compliments the previous decision to divide the project into two separate phases. Delivery of Phase One was completed in Spring 2022; this business case recommends that the Trust should now proceed with the second phase of the project.

2. Purpose of Business Case

A business case was previously developed to address compliance with best practice, operational resilience and patient experience concerns for the NICU at Watford General Hospital (WGH). Following submission of this case to the Trust Management Committee in November 2019, approval was granted for enabling works (IT/Telephony/Starfish Reception changes) to be completed, with the expectation that further work would then be completed to review the scope of the full scheme.

However, after completion of the enabling works, the full scheme was not delivered during the summer of 2021 as envisaged, due to a combination of factors, including the impact of the COVID19 pandemic across the Trust as whole, a surge in paediatric respiratory admissions and supply chain concerns.

Furthermore, due to the intention (at that time) to use paediatric ward space as a decant facility for neonatal care, construction work in the neonatal unit's clinical areas could only be completed during summer months. As a result, delays to the scheme meant that it could not be delivered in 2021.

On review in late 2021, a decision was made to separate the works on the neonatal unit into two phases. The first phase was approved in December 2021 and was completed in Spring of 2022.

This business case seeks approval for delivery of the second phase of the project. This phase will deliver significant environmental improvements to the NICU and improve both ventilation and the overall resilience of electrical and medical gas systems.

3. Strategic Case

3.1 Strategic Context

Trust Overview

West Hertfordshire Teaching Hospitals NHS Trust (WHTH) is a collection of three hospitals: Watford General Hospital (WGH), St Albans City Hospital (SACH), and Hemel Hempstead Hospital (HHH). The Trust provides healthcare services to a core catchment population of approximately half a million people in West Hertfordshire, and a range of specialist services to the wider population in North London, Bedfordshire, Buckinghamshire, and East Hertfordshire.

WHTH Maternity Services offer community and hospital-based care for antenatal, intrapartum, and post-natal pathways. The demographics of this area, and safety initiatives (such as the Saving Babies Lives Agenda and the MBRRACE-UK Programme) have resulted in a high acuity level for ante natal care and deliveries within our cohort of women. A highly functioning Neonatal Service and Unit is required to support this high acuity level and is essential to meet national and local safety standards and commissioning requirements.

Acute Redevelopment Programme

In all current options (aside from “do nothing” and “do minimum”) for the redevelopment of the WGH site there are plans to replace the Women and Children’s building in its entirety. At the time of writing, this is expected to be delivered c.2030, while there is a need to upgrade and improve the existing environment on the NICU as soon as possible.

Concerns regarding the existing environment have been raised by the CQC and through peer review, in addition to being voiced by Trust staff. These concerns cannot wait several years for the delivery of the Acute Redevelopment Programme before they are addressed.

Environmental Risk Assessment

Following presentation of the Full Business Case at Great Place Programme Board in May 2023, the project team was asked to confirm the following:

a. That the risk resulting from doing nothing exceeds the combined risks arising from undertaking the proposed works project in the neonatal unit
b. The outcome of a cost / benefits analysis

The project was reviewed by the Ventilation Safety Group on 15th May 2023. After considering the evidence presented, the Ventilation Safety Group supported the Neonatal Business Case and the associated transition plan. The group also recognised the removal or significant reduction of a series of environmental risks that

have the potential to impact on patient safety, clinical provision of safe care, and the reputation of the Trust.

Following the completion of this review and the feedback given by the Ventilation Safety Group, approval was given for this Full Business Case to proceed for presentation at Finance and Performance Committee and Trust Board.

The document *NICU Environmental Risk Assessment* is available as a supporting paper with this business case.

3.2 Business Needs

There are several service and estates issues with the existing neonatal facilities. Service concerns include limited cot space, non-compliance with best practice HBN recommendations, compromised patient and staff experience and potential security concerns due to the location of the reception desk.

Furthermore, and most pertinently to this business case, there are compliance issues with ventilation systems, medical gases and power:

High dependency/intensive care areas require a controlled environment using mechanical ventilation with comfort cooling to achieve appropriate ventilation and temperature control. The current ventilation system on the unit is compromised and does not provide variable temperature control, nor dedicated ventilation to different parts of the unit. The unit's ventilation and cooling system should ensure that stable temperatures are variable and maintained and that air movement in the vicinity of the cots/incubators is controlled.

The recent verification report has also highlighted serious concerns regarding infection control, specifically that: *"Use of Badger and Owl as isolation rooms should be reviewed. Both rooms are positive in pressure so must not be used for infectious patients. Former presence of HEPA filters in extract system suggests rooms have been used for infectious patients."*

The deficiencies in the Women's and Children's building have resulted in previous closures of the neonatal unit. For example, due to inadequate temperature control oil heaters were previously used to heat the nurseries during cold weather spells, however these devices are no longer allowed on the unit due to safety concerns and it is almost impossible to keep the nurseries at the appropriate temperature. The unstable temperature conditions and environmental uncertainty also prevent the unit from having a robust process in place to repatriate babies from other hospitals and units.

There is currently a risk recorded within the Trust on the Estates & Environment Divisional Risk Register:

ID	The Risk	Description	Rating (initial)
3698	Failure of Air handling unit (AHU) serving Neo natal unit (NNU)/ leaks in plantroom affect NNU below - 3x separate incidents over last 3x years	Cause: Air handling plant supplying NNU has life expired and has failed on a number of occasions over last 2 years (over 30 years old). Effect: Failure of the plant has impacted on services provided by the neo-natal unit with a requirement to decant on multiple occasions. This has been caused by leaks from the AHU penetrating the plant room floor into the area below. Increased frequency of breakdowns/ leaks Impact: Reduced confidence and operational difficulties when unit fails - clinical spaces taken out of use/ area fully decanted	16

Project Scope

As requested by the Trust Management Committee in January 2021, the Project Team has reviewed and reduced the scope of the previous full business case. The result of this review was that the project team would not seek to increase cot sizes on the unit, due to the disruption that this would cause to both neonatal and paediatric services whilst works were completed and the limited time in which the service would benefit from this prior to delivery of the Acute Redevelopment Programme. The project will instead seek to address the wider compliance issues affecting the unit, specifically replacement of aur handling unit and supply of power and medical gases, as these will still deliver significant service and user benefits.

Further information as to the range of issues and the plan for improvement across both Phase One and Phase Two of the updated scheme is summarised in the table below:

Item	Existing Service Issues in Original Case	In Phase One?	In Phase Two?
Service Concerns:			
Cot size	○ Space around cots is less than <40% of the currently recommended size, leading to infection control risks and limited privacy and dignity	N	N
HBN compliance	○ Non-compliance to wider HBN Guidance, creates infection control risks	N	Y - partly
Staff Experience	○ Limited flexibility caused by current layout ○ Staff required to regularly move heavy equipment around unit ○ Poor 'meet & greet' facilities	Y	Y

Patient Experience	○ Lack of appropriate welcome on arrival ○ Limited privacy and dignity ○ Cramped and unwelcoming spaces	Y – partly (reception)	Y - partly
Facilities	○ Lack of dedicated clean utility and cot wash area on unit means that drugs are prepped in inappropriate areas ○ Limited facilities for preparing and expressing milk ○ No bereavement suite or dedicated area for breaking bad news	N	Y - partly
Security	○ No single point of access ○ Staff base distant from main door ○ No oversight of movement within unit	Y - mainly	N/A
Estates Concerns:			
Ventilation	○ Current ventilation system on the unit is compromised ○ No variable temperature control ○ Repeated failure of air-handling plant	N	Y
Medical Gases	○ Non-compliant – lack of resilience	N	Y
Power	○ Non-compliant – lack of resilience	N	Y

Following on from the completion of Phase One, this Phase Two business case will deliver the following:

- Installation of a completely new and compliant air handling unit (AHU) into the NICU
- Upgrade to full resilience of medical gases and power supplies (to a split/dual zone system for continuity) and new nurse call system
- Full redecoration (required due to the removal of suspended ceilings and damage caused to existing paintwork as a result of the above works)
- Upgrade to low emission LED lighting in new suspended ceiling, adding to Trusts 'Net Zero' target.
- Upgrade of wash basins (to compliant IPS/WHB installations)
- Upgraded nurse base
- Upgrade to fire doors

See Appendix 4 for a paper summarising the scope of the scheme. This paper has been reviewed and agreed at Divisional and Executive level.

4. Economic Case

4.1 Shortlisted Options

The 2019 business case provides further detail regarding the full range of options that have been considered previously to resolve the issues outlined above. This Phase Two business case considers three options for the completion of the full scheme, following the completion of Phase One. These options are as follows:

Option	Benefits	Risks	Outcome
1. Do nothing (do not progress any aspect of scheme further)	• No capital spend • No service disruption	• Failure to deliver benefits identified in full business case • Failure to address safety, environmental and quality concerns • Service failure	Rejected
2. Proceed with reduced scope second phase based on environmental improvements, including: • Instillation of a new air handling unit (AHU) • Upgrade of medical gases and Power/IPS • Full redecoration	• Improvement in ventilation and reduced air quality risks • Improved resilience of power and gas supplies	• Requirement to vacate unit while works are completed • Failure to address space concerns around cots	Recommended
3. Proceed with second phase scheme of environmental improvements and significant structural alterations to improve cot sizes and service function	• Improvement in ventilation and reduced air quality risks • Improved resilience of power and gas supplies • Significant improvement in quality of care, and patient experience	• Lengthy period of vacation from unit • Impending redevelopment programme means that benefits may be short-lived • Increased investment required • Significant impact on other services	Rejected

The preferred option is Option 2, which addresses the most critical environmental concerns facing the unit, minimises disruption, and compliments the longer-term future of the WGH site. This option (and the work already delivered via Phase 1) is consistent with the preferred option in the 2019 Full Business Case, but without the reconfiguration of cot spaces, as agreed through the requested review of project scope.

The proposed new ventilation system has been carefully planned with expert input and will be subject to authorising engineer sign off and ICDC review, along with formal agreement and sign off by the Trust's ventilation group.

4.2 Delivery of Proposed Changes

The Phase One works were all largely contained within rooms off the main corridor and were completed without any significant impact on families and staff using the department. The second phase will be much more disruptive, necessitating a complete withdrawal from the unit for the duration of the project (a minimum of 16 weeks for the main works within the neo-natal unit). See Appendix 2 for a plan of the proposed changes.

Transition Planning

A detailed transition plan has been created to support the vacation of the neonatal unit and can be seen in Appendix 3. This has been collectively developed through discussion and with representation from all affected services within the WACS Building, and subsequently reviewed and agreed at Divisional Level. The options appraisal associated with the transition plans can be seen in Appendix 5. A planning review meeting has also been carried out with members of the executive team to review and agree the transition plan.

In summary, the agreed moves are as follows:

- Transitional Care moves to the Gynaecology Ambulatory Care Unit (GACU) (Level 2)
- Intensive Care and High Dependency Units (ICU/HDU) move to the Transitional Care Bay in Katherine Ward (Level 2)
- Isolation Beds move to the Rooms 5a and 6a on Katherine Ward (Level 2)
- Special Care moves to Bay 5 on Katherine Ward (Level 2)
- Some offices and storage relocated to external welfare units

The following mitigations against project risk have also been identified:

- Reduction in SCBU cot numbers (from 12 to 8), flexible use of cot space on Katherine Ward, and an acceptance that patients may need to be diverted to alternative providers in the case of bed pressures
- Gynaecology Recovery Area to be used as backup in case of ventilation service failure in Transitional Care (noting that this area would only be able to

accommodate four cots, so further mitigation would be required if there were six patients within HDU/ITU)
- Additional cylinders (oxygen, medical air) to be supplied to address the limited number of medical gas ports in Katherine Ward
- Additional staffing in key areas, including security, porters, and ward clerk

Of note, one of the most significant impacts of the transition plan is the removal of the GACU on Level 2 from the Trust's surge plan (which details which areas within the hospital are used during times of high demand for admission). With a reduction of 5 beds for use as surge at peak times, it is vital that the impact on the wider organisation and the flow of emergency care patients is mitigated. It has been agreed that the Paediatric Admissions Unit (PAU) will be moved higher within the surge plan, to be utilised when needed as part of the adult surge plan, for the duration of the works.

4.3 Benefits of Preferred Option

The key benefits of the preferred option are as follows:

Change	Benefits
Environmental	• Installation of a fully compliant ventilation system to deliver environmental compliance, enhancing air quality / heating & cooling on the unit.

Infrastructure	• Upgrade of the medical gases and Power/IPS supplies to ensure full resilience in the event of any system failure.
	• Further improvements to infrastructure, to include:
	  ○ Upgrade to low emission LED light fittings
	  ○ Installation of nurse call system
	  ○ Upgrade to compliant wash basins/fittings
	  ○ Upgrade to internal fire doors

Environmental	• Full redecoration of ceilings, walls and floors to deliver an improved staff, patient and visitor experience • Upgrade of Nurse Base to enhance staff experience and safety

5. Commercial Case

5.1 Procurement & Contract Strategy

Management of the procurement process has been led by the Capital Planning Team via Hertfordshire NHS Procurement.

Tender documentation has previously been completed for the two separate phases of the scheme. The competitive tender of Phase One was tendered on 13th October and returned on 12th November 2021. Phase One works were then delivered in Spring 2022.

Detailed design drawings and other documentation were issued for Phase Two on 26th January 2022 with a return date of Friday 25th February 2022. As described above, the scheme included installation of a completely new fully compliant AHU to the SCBU Clinical area, full resilience to the existing bedhead medical gases and electrical infrastructure, and full redecoration.

Tender documentation was issued to seven potential contractors, and all confirmed in writing their wish to and intention to return a tender. Two bidders withdrew during the tender process and two bidders did not return their bids. Three bidders returned their tender documentation, and the lowest tender bid for the sum of £1,078,275.00+VAT was recommended by the Capital Planning Team.

Following approval of the outline business case in February 2023, the leading contractor was approached and asked to update their bid. It was not considered necessary to re-tender as there were no changes to the originally tendered scheme. The adjusted tender value has been confirmed as £1,269,700.88+VAT, and the Capital Planning Team has recommended that this bid should be accepted.

5.2 Planning and Design

Design work was completed as part of the original 2019 business case. This work has been completed with input from clinical and operational teams at user group level, led by the Capital Projects Team.

There have been no changes to the design since the tender was completed in 2022.

6. Financial Case

6.1 Capital Costs

The capital costs for this project are shown in the table below:

Cost Element	Capital Sum	VAT	Contingency	Totals (Net of est. VAT reclaim)
Main Contract	£1,269,700.88	£152,364	£142,206	£1,564,271
12-months Service Transition Project Manager role – to support service transitions within WACS	£65,000	-	-	£65,000
6-months dedicated porter	£71,269			£71,269
6-months 24/7 security support	£85,936			£85,936
6-month night-time ward clerk	£48,776			£48,776
IT 'lift & shift' to vacate unit for transition period and then to relocate back upon completion	£15,000	£3,000	-	£18,000
Removals to vacate unit and then to return upon completion	£15,000	£3,000	-	£18,000
Revisit plan and final sign-off by trust authorising engineers	£10,000	£2,000	-	£12,000
Asbestos survey during vacation of unit	£5,000	£1,000	-	£6,000
Contingency for unknown asbestos removal after survey	£25,000	£5,000	-	£30,000
Post-works completion chlorination and water sampling	£10,000	£2,000	-	£12,000
Deep clean post-completion	£10,000	£2,000	-	£12,000
Additional MITIE cleaning of surrounding areas whilst works undertaken	£7,000	£1,400	-	£8,400
Completion of Corridor Flooring and Ceiling not carried out during Phase 1 works	£35,000	£7,000	-	£42,000
IEE electrical Regs change to corridor cable trays	£15,000	£3,000	-	£18,000
Making good to temporary IT cabling/trays carried out temporarily in Phase 1 (access with ceiling removed in Phase 2)	£15,000	£3,000	-	£18,000
Sundry Equipment costs not currently within department	£35,000	£7,000	-	£42,000
Totals	**£1,737,682**	**£191,764**	**£142,206**	**£2,071,652**

The totals (net of estimated VAT reclaim) should align to the General Ledger and project control totals used in the monthly Estates Capital Expenditure Reports to the CPFG.

The value of VAT reclaim is calculated at 40% and is an estimate based on discussion with projects as the HM Customs and Excise VAT Inspector is the final arbiter of what is reclaimable.

6.2 Contingency

Although the original tender has been adjusted for inflation with the preferred supplier, the capital projects team has recommended that a 10% contingency of the main building contract with VAT (£142,206k) is retained, to manage the risk of any unforeseen circumstances during implementation.

6.3 Revenue Costs

There are no additional revenue costs anticipated or loss of income associated with this business case.

6.4 Activity and Income

Mitigations will be put in place to ensure that there is no impact on the unit's ability to provide care. The transition plan can be found in Appendix 3.

6.5 Source of Funding

Investment of £2,071,652 is requested from the Trust's internal capital funds.

7. Management Arrangements

7.1 Programme

The delivery of this programme will be overseen by the Head of Capital Projects, supported by the capital projects team. A dedicated project team is already in place, chaired by a member of the capital projects team, with representation from the NICU, the Acute Redevelopment Team, and other relevant stakeholders.

Phase 2 of this scheme represents, as a minimum, a 16-week programme of work. Due to seasonal pressures in Autumn/Winter, it is preferable for the project to take place during summer months. However, given the likelihood of overrun, detailed consideration has been given to how impact avoid negatively impacting the most vulnerable services within the Division. This has resulted in the development of a preferred transition plan, as discussed in section 4.2 above, and available in Appendix 3.

It is anticipated that enabling works will begin in June 2023, subject to approval, with some minor enabling works and general preparation being undertaken in May. A contractor would be expected on site at the end of July, with completion of works in early November, and reoccupation of the unit by the end of November. Delivery of the scheme, in particular the transition and operational aspects, will be supported by a dedicated Service Transition Project Manager role.

A provisional project plan has been developed and is available in Appendix 6. The project timeline will be further refined upon approval of this business case and mobilisation of the preferred contractor.

7.2 Contract Management

Any additions or omissions to the scope of the project or its timetable will be agreed in conjunction with the Head of Capital Projects. Similarly, any variation in the value of the contract up to £10k (excluding VAT) will be authorised by the Capital Planning Project Manager in conjunction with the Head of Capital Projects. Variations in the value of the contract, over £10k (excluding VAT) will be administered by the Head of Capital Projects who will ensure the appropriate authorisation route, dependent on value.

7.3 Contract Monitoring

The contract will be monitored and reviewed against relevant key performance indicators (scope, timetable and cost) on a regular basis at the Capital Team meetings.

7.4 Reporting

General progress on the delivery of the scope, cost and time KPI's set out in the business case will be routinely reported monthly at the Trust's Capital Finance Programme Group meetings.

7.5 Key Project Team Roles

KEY PROJECT TEAM ROLES[1]			
Project Roles	**WHTH Equivalent**	**Name**	**Role Description**
1. The Customer or Executive	SRO	William Forson, Divisional Director	This is the person or organisation that has commissioned the project and will be paying for it. The customer will be the owner of the business case and has ultimate responsibility to ensure that the project delivers on its promise.
2. The Senior User	Clinical Lead(s)	Sankara Narayanan, Consultant Paediatrician	This is the representative of the organisation or people that will be using the product or service supplied by the project: those directly impacted by it. The senior user is responsible for ensuring that the Project Board respects the needs of the user, and that these are specified within the project.
3. The Senior Supplier	Usually the Capital / Estates Lead	Steve Turner, Head of Capital Projects	This is the organisation or person that supplies the expertise required for the project to be successful. He or she will have the knowledge, experience, and expertise to inform the Project Board of what is involved in delivering the finished product and ensuring that appropriate resources are provided for project completion.
4. The Project Manager	Project Manager	Jonathan Turner, Project Manager	The Project Manager organises and controls the project, choosing the team, and ensuring that the project is completed within time, budget, and to the required quality standards. The vital work of project planning is within the project manager's remit.

[1] Role descriptions as per: The Seven Roles in PRINCE2 Projects (yourprojectmanager.com.au)

KEY PROJECT TEAM ROLES[1]			
5. The Team Manager	Project Manager	Jonathan Turner, Project Manager	There may be one or more team managers, depending on the size of the project. It's not unusual for the project manager to assume the role of Team Manager on smaller projects. The team manager manages the day-to-day operational work of the project, ensuring that the product is produced within the agreed tolerance of time, cost and quality.
6. Change Authority	Project Manager	Jonathan Turner, Project Manager	This is an individual or group who will consider any request for changes to project specifications. A change budget will be provided, and the Change Authority has the power to accept or deny change requests. Sometimes, the project manager will assume this responsibility.
7. Project Assurance	Steering Group	Building Better Steering Group	Project Assurance provides an independent view of project progress at agreed intervals. This role must be independent of the Project Manager, and is often assumed by the Project Board. However, an independent Project Assurance team may also be appointed by the Project Board. It is this team's responsibility to ensure that the project remains on track in the three areas of business assurance, user assurance, and supplier assurance.

Other Key Project Roles	WHTH Equivalent		Role Description
N/A	8. Business Case Planning	Rob Emmins, Acute Redevelopment Programme Manager	Leads the production of the business case.
			Liaises with all members of the project team to ensure their requirements are appropriately reflected within the business case.
N/A	9. Ops Lead	Kira Martin, Divisional Manager, with support from WACS QUAD and rest of project membership	Relevant divisional / managerial lead(s).
N/A	10. Finance Lead	Vicky Flanagan	Leads financial analysis for business case / financial input into economic case.
			Monitors expenditure against project budget, for both planning and delivery phases.
N/A	11. IT Lead	Tony Evans	Ensures technology / IT requirements are accurately reflected in the business case, future design and programme plan.
N/A	12. Other (e.g. comms)	See Project Team	As defined for each individual project - there may be further team members or staff with the appropriate expertise that the project team can draw on when needed.

7.6 Wider Project Team Membership

Full Project Team membership may be variable, depending upon the status of the project, but is likely to include the following individuals, in addition to those named above.

Name	Role
Karen Walker	Head of Nursing (Children's Services)
Elvira Baker	Matron for Neonatal Unit
Lauren Petrie	Matron for Maternity
Samantha Lee	Matron for Paediatrics
Mitra Bakhtari	Head of Maternity
Nazim Begum	Assistant Divisional Manager
Patrizia Brown	Assistant Divisional Manager
Emmanuel Quist-Therson	Consultant Paediatrician
Joanne Laker	Theatres
Ann Sunny	Gynaecology
Bhavini Gudka	Pharmacy
Zahida Hassandin	Pharmacy
Anupama Paul	Pharmacy
Wendy Doherty	Facilities
Jan Jonker	Facilities
Anthony McNamara	Estates – Ventilation Lead
David Smart	Fire Safety
Jiovanna Foley	Infection Prevention and Control
Glynis Bennett	Infection Prevention and Control

8. Risk Appraisal

Note: While the tables below provide a demonstration of the main risks associated with this business case, a further detailed and thorough risk assessment will be completed before the project commences in dialogue with the Trust's Risk Team.

8.1 Main Risks Associated with Implementing the Business Case

Key Risks	Risk Assessment:			Mitigation Strategy
	Likeli-hood	Impact	Score	
Ventilation The inadequate ventilation system in the existing Transitional Care area is unsuitable for SCBU and presents a clinical risk to patients cared for there for the duration of works	3	4	12	• Reduction in SCBU cot numbers • Use of gynaecology recovery area as a backup in case of system failure • Acceptance of risk in order to facilitate installation of new and compliant system in Neonatal Unit • Consideration of options to cool TC if required
Patient Care Risk of harm to patients due to care being delivered in unfamiliar locations	3	4	12	• Detailed transition plan developed with relevant services and overseen by project team • Transition plan reviewed and signed off by COO and Chief Nurse • Staffing models reviewed by service area and implemented as required • Recruitment of dedicated project manager and additional staff in place • Detailed programme of capital work with clear timeline
Operational Demands High levels of in maternity activity leads to additional space requirement Both Katherine Ward and Victoria Ward become full	3	4	12	• Surge into alternative locations, such as Elizabeth Ward • Excess gynaecology emergency demand to be diverted to alternative provider • Responsive internal management response, through daily or weekly (as required) MDT meetings to review activity and demand
Funding Capital funding is not made available	3	4	12	• Cancellation of project • Trust assurance that neonatal refurbishment scheme will remain on future capital programme
Failure to address residual estate concerns Non-compliant cot spaces will lead to ongoing suboptimal care	5	2	10	• Acceptance of risk and continuation of current mitigations, pending future Acute Redevelopment of Watford Hospital site
Impact upon activity and income Loss of activity and income during construction and commissioning period	3	3	9	• Comprehensive transitional plans in place for all affected areas • Confirmed no financial impact due to existing funding model

Key Risks	Risk Assessment:			Mitigation Strategy
	Likeli-hood	Impact	Score	
Impact upon paediatric activity Use of PAU for adult care could result in surge into paediatric wards for emergency care, leading to a reduction in scheduled and unscheduled paediatric activity, including surgery	3	3	9	• Ongoing review and refinement of transition and surge plans • Effective communication between adult and paediatric care within ED
Cost Increase in project costs due to inflationary pressures	3	3	9	• Ensure plans for change are the most cost-effective option and assign project manager to continually monitor and report on progress • Tendered costs have already been provided for Phase 2, and the contractor has confirmed the adjusted tender value
Timescales Unforeseen extension of project beyond anticipated delivery date	2	4	8	• Clearly developed project plan with time expectations set out in tender • Capital Projects Team to oversee delivery and prevent delays wherever possible • Decision taken to deliver project during time of least operational impact • Historic transition plan amended to remove reliance on paediatric space
Other Services Impact on other services during construction period (e.g. Maternity/Obstetric and Paediatrics)	2	4	8	• Robust communication strategy to be developed to inform patients, staff and wider stakeholders of temporary change • Development and agreement of transition plan • Delivery of project during less acute period (Summer/Autumn) • Acceptance for PAU to form part of Trust's surge plan
Unforeseen Demand Risk of an increase in demand for neonatal beds during the build period	2	3	6	• Activity has been mapped based on historical data. • Liaison with the neonatal network to reduce activity before and during works • Weekly huddles to monitor activity in maternity/complex births

8.2 Main Risks Associated with NOT Implementing the Business Case

Key Risks	Risk Assessment:			Mitigation Strategy
	Likelihood	Impact	Score	
Impact on patient care Ventilation / poor environmental issues continue, with risk of failure and need to enact this business case on a 'reactive' basis	4	4	16	No viable alternatives Trust assurance that these service developments would be considered at a later date.
Impact upon staff Staff morale adversely affected by not seeing through planned change	3	4	**12**	Maintain dialogue with all staff involved.

9. Handover and Commissioning

The Project Manager and the Capital Projects Manager will accept the works prior to contract handover, ensuring all of the contractually specified requirements have been met.

10. Post-Project Evaluation (PPE)

A PPE report will be produced upon completion of the project and any lessons learned will be recorded, in the form of a register, to help inform future projects.

Delivery of this report would be the responsibility of the following:

- WACs Project Manager
- Estates Senior Project Manager

Progress will be overseen by the Women's and Children's Divisional Management Group and also reported to the Trust's Executive Committee as part of regular progress reporting. Finally, realisation of benefits will be monitored via the Trust Executive Committee, as part of the review of the project.

11. Benefits Realisation

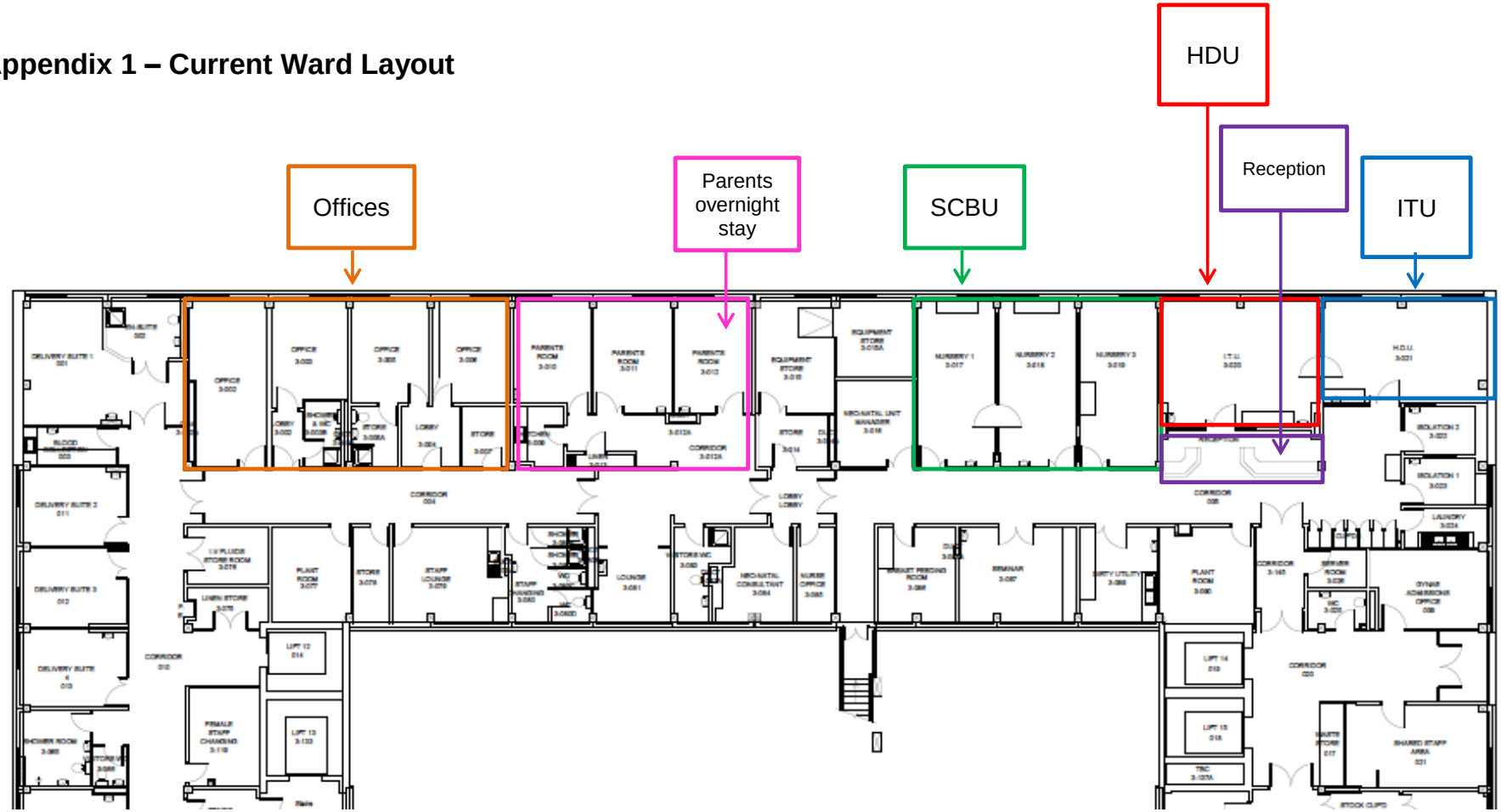
As part of the PPE process, the project outlined in this case will be reviewed to check whether the key benefits have, or will be, realised.

12. Conclusion and Recommendations

This business case recognises the urgency in resolving environmental issues on the Neonatal Unit and compliments the previous decision to divide the project into two separate phases. Delivery of Phase One was completed in Spring 2022 and has significantly increased the likelihood of a successful second phase by reducing the scope and scale of disruption.

This business case recommends that the Trust should proceed with the second phase of the scheme.

Appendix 1 – Current Ward Layout



Appendix 2 – Proposed Refurbishment Plan (Phase 2)

KEY PLAN SCALE 1:250

REFER TO AHP DRAWING A1162-06-P2-112

New areas to be formed.

Existing areas to be refurbished.

DECORATIONS GENERALLY

Doors

PVC door edge/face protection and decoration to existing doors and window frames.
New doors to be PVC encapsulated.

Access controls and video entry systems linked back to new reception area.

Walls

Existing walls to receive paint and wall cladding where indicated on proposed finishes plan A1162-06-P2-103.

Wall cladding to be a combination of plain colours and images to reflect ward identification names.

Floors

New floors generally throughout proposed work area.

Ceilings

New suspended ceiling grid/tiles and new/existing MF plasterboard ceilings to be decorated throughout to suit new ventilation scheme.

IPS

New ONVO IPS systems throughout proposed work area. Existing supply and waste to be adapted to suit new system.

BLINDS

New Roller Blinds throughout proposed work area to windows W1-W9.

Appendix 3 – Transition Plan

Please see the attached document:

WGH Neonatal Unit Transition Plan v1.7

Appendix 4 – Project Scope

Please see the attached document:

Neonatal Unit Project Update - Project Scope

Appendix 5 – Transition Plan Options Appraisal

Please see the attached document:

Neonatal Transition Plan - Options Appraisal v1.3

Appendix 6 – Programme Plan (Provisional)

			May					June				July					August				September				October					November				December			
			01-May	08-May	15-May	22-May	29-May	05-Jun	12-Jun	19-Jun	26-Jun	03-Jul	10-Jul	17-Jul	24-Jul	31-Jul	07-Aug	14-Aug	21-Aug	28-Aug	04-Sep	11-Sep	18-Sep	25-Sep	02-Oct	09-Oct	16-Oct	23-Oct	30-Oct	06-Nov	13-Nov	20-Nov	27-Nov	04-Dec	11-Dec	18-Dec	25-Dec
Enabler	1	Clear Elizabeth Bay 7		GPPB	Preparatory Work			Trust Board																													
	2	Move GACU to Elizabeth Bay 7																																			
	3	Move Transitional Care to GACU																																			
	4	Move ITU / HDU to Transitional Care																																			
	5	Clear Katherine Bay 5 and rooms 5a & 6a																																			
	6	Move SCBU to Katherine Bay 5 and 5 a / 6a available																																			
	7	Prepare contractor's offices (portacabin by entrance)																																			
Main Works	1	Asbestos survey																																			
	2	Actual works commence - 16 week contract																							Works finish												
	3	Air handling unit			Order AHU																AHU delivered				AHU fully fitted												
	4	Commissioning																									Refurbished unit commissioned and prepped										
	5	Move back																											Unit re-opens								
All Risks' Timeline		Contingency timings							Asbestos cleared (if required)			Main works															AHU delay			Works delay / building unpredictability				Works finish	Unit commissioned		Unit re-opens

NICU Environmental Risk Assessment

To confirm:

a. That the risk resulting from doing nothing exceeds the combined risks arising from undertaking the proposed works project in NICU
b. The cost / benefits analysis for the proposed works

Project Objective

To remove the high risk associated with failure of the current ventilation system and address a range of technical non-compliance issues within NICU at Watford General Hospital

Project Scope

The project will remove or mitigate to an acceptable level the risks outlined in the table below:

Risk	Current Situation	Impact	Likelihood	Risk RAG Rating	Planned Resolution
Failure of the air handling unit (AHU)	Current AHU is 30 years old, at least 10 years beyond its design life. It is subject to frequent failure, is increasingly difficult to maintain and will not remain serviceable until the anticipated move of the neonatal unit into the new hospital Fluctuations in temperature in the unit are experienced regularly due to maintenance issues within the AHU, beaching the specified temperature limits for a NICU	Complete failure of the AHU would require closure of the NICU. Services would have to be relocated on site or to other providers. Even if replacement AHU was available the unit would be closed for a minimum 4 months to undertake the replacement work Partial failure (as experienced regularly by the neonatal unit) creates an unsafe environment with temperatures outside mandated limits, reduced air changes in ITU/HDU and 'dirty' water leaking through the ceiling	Complete Failure. Almost certain within next 5 years Partial Failure. Will happen several times each year. Some events will require temporary unplanned relocation of the neonatal unit for period of 1-4 weeks	**Red**	Replacement of AHU by Dec 23. Risk removed
Patient safety	The current ventilation system	The limited number of air	Although babies are in kept	**Red/Amber**	Installation of a new ventilation

impacted by non-compliant ventilation system	is non-compliant It does not provide the required air changes / hour in three areas; **ITU only provides 2.3 air changes / hour against a minimum of requirement of 10**, two of the 3 areas in SCBU only provide 0.0 and 6.2 against a minimum of requirement of 10. A full breakdown is provided at Annex A There are non-compliances in the airflows between rooms, made worse as the unit layout requires room doors to be kept open to provide required clinical oversight. There is only 0.4 air changes / hour in the corridor The ventilation ductwork and heating / cooling coils need urgent remedial work / replacement to reduce risk of critical infrastructure failure	changes/hour in the ITU is placing some of our most clinically vulnerable patients at an increased risk Incorrect airflows across the department and very low air flow rates in the corridor increases the risk of cross infection between rooms	in incubators they are lifted in and out and therefore potentially exposed to infection		system by Dec 23. Risk removed
Medical Gas supply non-compliant and lacks resilience	Current system lacks resilience required for a high dependency unit	The lack of an independent dual system means that a failure within the current system would require temporary replacement (bottled) supply	Low – but system does not comply with current standard requiring the clinical team to understand and manage the risk	**Yellow**	Resilient compliant system to be in place by Dec 23. Risk removed
Power supply non-compliant and lacks resilience	Current system lacks resilience required for a high dependency unit	Without dual independent feeds the supply is dependent on IPS for critical patient safety equipment	Low likelihood of power outage exceeding the capacity of the IPS - but system does not comply with current standard requiring the clinical team to understand and manage the risk	**Yellow**	Resilient compliant system to be in place by Dec 23. Risk removed
Non-compliant water supply and distribution	Following a series of water quality issues a short-term solution was implemented to	Increased likelihood of waterborne infections (legionella / pseudomonas).	Water infrastructure across the WACS building is in poor condition increasing	**Red/Amber**	Installation of new water supply system and IPS wash basins by Dec 23 would significantly reduce the risk

system	create an independent water system in the neonatal unit. This system has proved difficult to operate and maintain to the required standard and it is recommended that an alternative system is installed	Babies being treated in neonatal unit are at particularly high risk from these infections	likelihood that legionella / pseudomonas is present in the supply		
Inadequate nurse call system	Ventilation system requires doors to individual rooms to be closed. A suitable nurse call system is essential to provide safe patient care	Clinical oversight will be compromised if new nurse call system is not installed	High, unless room doors are left open, compromising air quality	**Yellow**	New nurse call system to be in place by Dec 23. Risk removed

Implementation Plan

To complete the works the project team require vacant possession of the NICU area for a minimum of 24 weeks, starting from the date the order for the replacement AHU is placed with the supplier. The timescale is determined by:

- Procurement of AHU (minimum 16 weeks lead time)
- Requirement to undertake asbestos and other pre-commencement surveys after unit is vacated
- Minimum 4-week period for asbestos removal prior to commencement of works
- Main construction phase (3 months)
    - Removal and replacement of existing ceiling, AHU, ventilation ductwork and lighting
    - Upgrade water supply, distribution wash basins
    - Installation of dual systems to improve resilience of medical gas and power systems
    - Upgrade to fire doors and nurse call system
- Installation and commissioning of AHU (4 weeks after arrival of unit)
- Contingency (4 weeks – reflecting uncertainties of working in retained estate)

Assuming the order for the AHU is placed by 26 May 23, and the Trust Board approves the business case and funding on 1 Jun 2023, the target completion date for the works would be 22 Nov 23. The earliest go live date for the new unit would then be 29 Nov 23. This assumes the transition plan is approved and 'get you in' works completed by 15 Jun 23. One week is then allowed to move to the temporary location (16 -21 Jun 23) and one week to move back into new location (29 Nov – 6 Dec 23).

Transition Plan

To deliver the work outlined above the NICU will have to relocate to temporary location for a minimum of 22 weeks. The preferred option identified in the BC is outlined below:

Neonatal Unit Component	Proposed Location	Ventilation	Medical Gas Supply	Water Supply	Power Supply
ITU / HDU	Transitional Care WACS (Level 2)	General vent provides circa 4 air changes / hour against requirement for 10 Ventilation equipment beyond design life **No worse than current facility** Mitigation: The risk would be reduced further with the installation of a temporary ACU to cover the area	Oxygen, suction and medical air available. No resilience (dual supply) **No worse than current facility**	Provided by WACS water supply system. Waterborne infections (legionella / pseudomonas) potentially present – requiring point of use mitigation measures **Worse than current facility** Mitigation: Regular water testing and water quality management processes to be implemented during period area is used as NICU	No IPS in place **Worse than current facility**
SCBU	Katherine Ward Bay 5, Room 5A & 6A	No mechanical ventilation. 0.0 air changes / hour against requirement for 10 No temperature control available **Worse than current facility** Mitigation: Contingency plan required to relocate if temperature go outside clinically acceptable limits	Oxygen and suction available. Medical air not available, but could be supplied from bottles. No resilience (dual supply) **No worse than current facility if bottled supply provided for medical air**	Provided by WACS water supply system. Waterborne infections (legionella / pseudomonas) potentially present – requiring point of use mitigation measures **Worse than current facility** Mitigation: Regular water testing and water quality management processes to be implemented during period area is used as NICU	No IPS in place **Worse than current facility**

Review by Ventilation Safety Group

The project was reviewed by the Ventilation Safety Group on 15 May 23. The review covered:

- The risks associated with the ventilation system in place in the current facility

  Based on the evidence presented the Group agreed that there was a significant risk (4) that the AHU unit in the neonatal unit would fail in the next 5 years and that this failure would (4 / 5) impact on the safety of patients in the unit; warranting a risk score of 16 (minimum) to 20 (maximum). This risk would remain until the AHU was replaced.

- The risks associated with the ventilation arrangements during the period covered by the Transition Plan.

  Based on the evidence presented the Group agreed that there was a risk (4) that the conditions in the Transitional Care and Katherine Ward areas being used under the Transition Plan could (3 / 4) impact on the safety of patients in the unit; warranting a risk score of 12 (minimum) to16 (maximum). This risk would exist for the period the Transition Plan was in place. The risk could, however, be reduced (to a maximum score of 8) if a temporary ACU was installed in the Transitional Care unit for the duration. The risk would be further reduced if a contingency plan was developed by the Division to relocate to the Gynae Theatre, or seek support from an alternative provider, in the event that the temperatures in the temporary facilities created an unacceptable patient safety risk; a very low (1) but high impact (5) scenario.

After considering the evidence presented the Ventilation Safety supported the NICU Business Case and the associated Transition Plan, conditional on:

- WACS Division implementing a temperature monitoring plan which is to be in place throughout the period the Transition Plan is in place;
- Installation of ACU in the Transitional Care unit prior to the move from the current NICU;
- WACS Division produce a contingency plan to cover the possible, but highly unlikely, risk that the temperatures within the Transitional Care unit go outside safe limits;
- WACS Division submit 2 risks for consideration by the June Risk Review Group reflecting the dialogue at the Ventilation Safety Group.

<u>Cost / Benefit Analysis</u>

The key benefit from undertaking this work is the **removal** or **significant reduction** of a series of environmental risks that have the potential to impact on:

- The safety of patients being cared for in the neonatal units
  - A patients outcome affected by failure of the AHU
  - A patients outcome affected by infection attributed to environment in neonatal unit (air or water quality)

- The ability of the clinical teams to deliver safe care to patients in the neonatal unit

  - A patient outcome affected by failure lack of resilience of critical equipment (medical gas, IPS, life support)
  - A patient outcome affected by challenges providing visual oversight due to layout

- The reputational risk for the Trust
  - An SI or incident that adversely impacts on the Trust reputation which could have been avoided if this project had proceeded
  - Conditions in the unit impact on recruitment & retention, increasing dependence on bank / agency

These benefits have not been quantified, but information would be available from the Trust legal team on the likely scale of any claim(s) that may arise from an SI that could be attributed to the failure to address these risks.

Annex A: Extract from Ventilation Survey Reports
Annex B: Ventilation Standards - Extract from HTM 03-01

Annex A

Extract from Ventilation Survey Reports

Extracts from the latest ventilation survey reports are attached for:

1. Current NICU
2. Transitional Care Unit (proposed location for temporary NICU (ITU/HDU)

Building	Area	Plant	Last Validations	AHU Summary Condition	2023-24 Validation Due Dates	2023-24 Proposed Dates	Report Results / Restrictions	HTM Test Requirement
Maternity	Gynae theatre		Completed 26/02/2023	POOR to average	26/02/2024		All air change rates meet HTM recommendations. Room pressures from Theatre to Corridor, Theatre to Anaesthetic and Anaesthetic to Corridor are in correct directions and robust but are below HTM values.	HTM 03-01
Maternity	Gynae Recovery		Completed 26/02/2023	POOR to average	26/02/2024		All air change rates are at least 80% of HTM recommendations. Room pressure from Recovery to Corridor does not meet HTM recommendations. All other room pressures meet HTM recommendations.	HTM 03-01
Maternity	Obs Theatres 1		06/02/2023	Average to poor	Overdue	28/05/2023	Achieves >80% of Original design Upgrade required end of useful life	HTM 2025
Maternity	Obs Theatres 2		06/02/2023	Average to poor	Overdue	28/05/2023	Achieves >80% of Original design Upgrade required end of useful life	HTM 2025
Maternity	Delivery suite 1		N/A	N/A	N/A		No Mechanical Ventilation	
Maternity	Delivery suite 2		N/A	N/A	N/A		No Mechanical Ventilation	
Maternity	SCBU Ward		Completed 01/03/2023	Average to poor	01/03/2024		No mechanical ventilation installed in Hedgehog room. Air change rate below HTM recommendations for extract in Rabbit and Ladybird rooms. All other air change rates are at least 80% of HTM recommendations. Room pressure from Ladybird to Corridor is below HTM recommendations. Room pressures from Rabbit, Squirrel and Bumblebee to Corridor not considered robust. All other room pressures meet HTM recommendations.	HTM 03-01
Maternity	Starfish Beach Hut Iso		31/03/2023	Average	31/03/2024		UPCOMING - No access on planned visit due to COVID positive patients. Awaiting confirmation of access.	HTM 2025
Maternity	Starfish Marina Iso		31/03/2023	Average	31/03/2024		UPCOMING - No access on planned visit due to COVID positive patients. Awaiting confirmation of access.	HTM 2025

Neonatal Unit

Inspection Summary:

Facility	System Component	General Condition	Compliance with Minimum Standard	Maintenance Quality
SCBU	Theatre Suite		Average	Average
SCBU AHU	AHU	End Useful Life	Poor	Poor

Air Change Rates & Room Pressures:

Facility	Room	Air Change Rate				Differential Room Pressure		
		Supply/ Extract	Measured (per hour)	Compliance in relation to: Design	Compliance in relation to: HTM 03-01	Value (Pa)	Compliance in relation to: Design	Compliance in relation to: HTM 03-01
SCBU	Rabbit	Supply	10.4	Unknown	Yes	1	Unknown	Yes*
		Extract	6.2	Unknown	No			
	Squirrel	Supply	15.5	Unknown	Yes	1.5	Unknown	Yes*
		Extract	11.9	Unknown	Yes			
	Hedgehog	Supply	0.0	Unknown	No	0	Unknown	No
		Extract	0.0	Unknown	No			
	Bumblebee	Supply	11.9	Unknown	Yes	1.5	Unknown	Yes*
		Extract	9.0	Unknown	Yes > 80%			
	Ladybird	Supply	10.0	Unknown	Yes	4	Unknown	Yes
		Extract	2.3	Unknown	No			
	Badger	Supply	24.6	Unknown	Yes	5	Unknown	Yes
		Extract	15.3	Unknown	Yes			
	Owl	Supply	28.7	Unknown	Yes	4	Unknown	Yes
		Extract	13.6	Unknown	Yes			
	Corridor	Supply	0.4	Unknown	N/A	-	Unknown	N/A

**Airflow direction between rooms and corridor is correct; however, the pressure differentials are not considered to be sufficiently robust.*

Transitional Care Unit

Inspection Summary:

Facility	System Component	General Condition	Compliance with Minimum Standard	Maintenance Quality
Transitional Care 2-018	Critical Room		Poor	Average
AHU – General Ventilation No1	AHU	End Useful Life	Poor	Poor

Air Change Rates & Room Pressures:

Facility	Room	Air Change Rate				Differential Room Pressure		
		Supply/ Extract	Measured (per hour)	Compliance in relation to:		Value (Pa)	Compliance in relation to:	
				Design	HTM 03-01		Design	HTM 03-01
Transitional Care 2-018	Transitional Care	Supply	**4.10**	**Unknown**	**No**	**0**	**Unknown**	**No**
		Extract	**0.00**	**Unknown**	**No**			

Annex B

Ventilation Standards - Extract from HTM 03-01

Health Technical Memorandum 03-01 Specialised ventilation for healthcare premises Part A

Table 5 Maternity facilities

Application: Obstetrics theatre, delivery rooms, nursery, neonatal intensive care and special care baby units		
Area/zone	**Reason for ventilation**	**Typical design factors**
Obstetrics theatre	Protection of patients from airborne organisms and fungal spores. Control of exposure of staff to waste anaesthetic agents (COSHH Regs)	Ventilation design parameters as for a conventional operating suite. System should normally be at "set back" with a minimum temperature of 18°C and be able to attain full operating conditions within 5 minutes of triggering the system
Delivery room	Control of exposure of staff to waste anaesthetic agents. (COSHH Regs)	Establish a clean airflow path – Supply terminal at high level at foot end of bed and extract terminal at low level at head end of bed. Design parameters: Air change: 10 per hour Pressure regime: Neutral to corridor Noise level: 35 d(B)A Temp range: 20 to 25°C local control Humidity: Floating – max 70%RH Air quality: BS EN 16798 – SUP2
Delivery room with birthing pool	As for standard delivery room above	
Specials delivery room	As for standard delivery room above	
Nursery	Comfort conditions only	
Neonatal intensive care unit or special baby care unit (SCBU)	Protection of neonates from airborne organisms and fungal spores. Neonates are kept in incubators but may be removed for feeding, changing etc. so local temperature control and ensuring a draught-free environment is essential.	Standard supply and extract Design parameters: Air change: 10 per hour Pressure regime: +5 Pa to corridor Noise level: 45 d(B)A Temp range: 20 to 28°C local control Humidity: Floating – max 70%RH Air quality: BS EN 16798 – SUP1 (Filter grade depends on ODA category – see the Specialised Ventilation for Healthcare Society's (2018) SVHSoc.02)
N.B. This is a critical healthcare facility and consideration should be given to system resilience and/or how suitable alternative accommodation may be provided in the event of a ventilation system failure.		

West Hertfordshire Hospitals NHS Trust

Watford General Hospital Neonatal Unit Ventilation and Refurbishment Project (Phase 2)

Transition Plan

Version 1.7

Date: 18th May 2023

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1 Introduction and Aim

The purpose of this document is to provide a detailed summary of the actions required to enable the temporary relocation of the Neonatal Unit at Watford General Hospital from its existing location on Level 3 of the WACS building. This is to enable a major refurbishment of the unit, including installation of a new air handling unit, upgrades to infrastructure, and overall refurbishment of walls and flooring.

2 Development

This document has been developed in collaboration with colleagues from across the Trust, primarily those services within the WACS (Women and Children's Services) Division who will be accommodating the Neonatal Unit for the duration of the works, and the Capital Projects Team, who will be facilitating the relocation and delivering the project itself.

3 Summary and Outline Plan

Subject to approval and mobilisation of the external, contractor, the project is intended to be carried out between May and December 2023. This will require the complete vacation of the existing Neonatal unit, into spaces made available by other services within an already fully occupied building. In summary, the agreed moves are as follows:

- Transitional Care moves to GACU (Level 2)
- ICU/HDU moves to Transitional Care (Level 2)
- Isolation Beds move to the Rooms 5a and 6a on Katherine Ward (Level 2)
- Special Care moves to Bay 5 on Katherine Ward (Level 2)
- Some offices and storage relocated to external welfare units

The following mitigations against project risk have also been identified:

- Reduction in SCBU cot numbers (from 12 to 8)
- Gynaecology Recovery Area to be used as backup in case of ventilation service failure in Transitional Care (noting that this area would only be able to accommodate four cots, so further mitigation would be required if there were six patients within HDU/ITU)
- Additional cylinders (oxygen, medical air) to be supplied to address the limited number of medical gas ports
- Additional staffing in key areas, including security, porters, and ward clerk

Please see below for transition plans by ward area

Note: Some elements below are subject to review and may be altered as plans are developed further.

4 Special Care Babies (SCBU)

Move to: Bay 5 on Katherine Ward, Rooms 5a and 6a on Katherine Ward

- Reduce total special care cot capacity from 12 to 8
- Rooms 5a and 6a to be used flexibly, e.g. for 'rooming in' or for any infection requiring isolation. This room may also be used for any special care admission from CED requiring isolation. There are outlets on the wall for suction and oxygen
- Bay 5 has only one oxygen and suction outlet on the wall. To mitigate for this, portable suction and oxygen cylinders will be used for each cot. Brackets will be installed to secure cylinders to cots/wall
- The neonatal resuscitation trolley from Transitional Care will move to Bay 5
- One resuscitaire will be available for stabilisation for any patient deterioration
- Minimum of 3 staff required per shift; one staff member should be QIS
- A telephone line will be transferred from SCBU to Bay 5
- Freestanding monitors available
- 3 computers on wheels available
- SCBU blood glucose monitoring equipment to be transferred to Katherine Ward with POCT manager support, or use Katherine Ward blood glucose monitoring equipment
- Parents to use the existing facilities on Katherine Ward
- Parents to express at cot side, with screens available for privacy
- Neonatal staff to use a room on GACU as a staff room
- Equipment to be cleaned in the Katherine Ward sluice
- Move SCBU milk fridge to KW milk kitchen
- The freezer in the KW milk kitchen is to be used for any milk that requires freezing
- Allocated space for linens in the store cupboard on Katherine Ward
- Visitation includes parents at any time, but siblings only at visiting times (1530-1800). Extended family visitation will not be possible during the transition period. This policy will be subject to review prior to and during project delivery.
- A security guard will be based within GACU at the start of project. The need for this will be reviewed during project delivery
- As part of the enabling works, additional power supplies will be needed within Bay 5
- Unless a side room is available on Katherine Ward, there will be no capacity to admit babies via CED
- Domestic staff from SCBU will move to Katherine Ward during the transition period

5 Intensive Treatment Unit (ITU) and High Dependency Unit (HDU)

Move to: Transitional Care Bay in Katherine ward

- Reduce total cot capacity from 7 to 6, flexing ITU and HDU
- Short stay observation babies will be admitted to ITU/HDU
- The kitchen on GACU will be used for drug/fluid preparation and storage including controlled drugs
- Katherine Ward treatment room to be used for some drug storage
- Neonatal resuscitation trolley available
- 5 computers on wheels available to support this area
- SCBU small milk freezer to be moved to treatment room
- SCBU Drug fridge move to kitchen on GACU
- POCT manager to support move of blood gas machine to GACU kitchen
- Blood glucose monitoring equipment available
- Freestanding monitors available
- Parents to use Katherine Ward facilities
- Parents to express at cot side, with screens available for privacy
- Space may need to be identified for parents to rest/relax and store items
- Visitation – see section 4, above
- Minimum of 4 nurses per shift, with a minimum of 3 QIS
- Equipment to be cleaned in sluice on Katherine Ward
- Milk preparation and sterilisation of expressing/feeding equipment to be undertaken in the milk kitchen on Katherine Ward
- Allocated space for linens in the store cupboard on Katherine Ward
- Suction, medical air and oxygen outlets available on the wall. Additional portable oxygen cylinders will be required for each cot, with wall brackets installed
- Staff to use temporary staff room on GACU
- Transport incubator and X-ray machine to be located on GACU - additional electrical sockets will be installed to support this
- An external storage unit will be provided directly outside the WACS building for storage of equipment
- SCBU telephone line to be diverted to TC Bay
- Safety huddles to be regularly undertaken, to review capacity and patient flow
- Regular review of staffing (nursing and medical) to ensure cover for all areas
- A security guard will be based within GACU at the start of project. The need for this will be reviewed during project delivery

6 Transitional Care

Move to: Gynaecology Ambulatory Care Unit (GACU)

- Total cot capacity reduced from 6 to 4
- Virtual Transitional Care will be offered (subject to staffing)
- Flexible use of side rooms 5a and 6a will include Transitional Care where appropriate
- One room to be converted to temporary staff room facility
- 2 staff will be required to support this area and postnatal antibiotics
- 2 computers on wheels to be available
- Cupboard available in Bay 5 for stock item storage
- Parents to use Katherine Ward facilities
- TC telephone line to be diverted to GACU telephone line
- Milk kitchen on Katherine Ward to be used for milk preparation and sterilisation of expressing/feeding equipment
- Equipment to be cleaned in the sluice on Katherine Ward
- Blood Glucose monitoring equipment in ITU/HDU to be used
- Visitation – see section 4, above
- Milk fridge in Katherine Ward to be used for milk storage
- One side room to be converted to staff room
- A security guard will be based within GACU at the start of project. The need for this will be reviewed during project delivery
- GACU kitchen to be used for medication storage and preparation; *to review*

7 Gynaecology Ambulatory Care Unit (GACU)

Move to: Bay 7, Elizabeth Ward

- Five beds in EW Bay 7 to be assigned to GACU
- WOWs and essential equipment to be moved to Elizabeth Ward (tbc)
- Desk space in Bay 7 to be used for administrative work
- Treatment Room on EW to be used for MVA and anything else needed, dependent on communication with EW staff
- Staff room can be shared with Elizabeth Ward
- Phone port and Wi-Fi boosters to be added
- Equipment list to confirm which items will move and which will stay in GACU
- Medications will be stored in the EW treatment room
- A box for manual vacuum aspiration (MVA) medications use only will be stored in the EW treatment room
- GACU remains part of Trust’s surge plan, particularly in light of removal of Bay 7 from EW capacity

8 Katherine Ward

Move to: [No move]

- Room 5a and 6a - reduction in 2 beds
- Transitional Care Bay – reduction in four beds
- Bay 5 to Virtual Discharge lounge (old midwives station area) – reduction 4 beds
- New 'Discharge Lounge' (six chairs) to be used as waiting area after discharge
- Removal of Midwives station and creation of Discharge Lounge in same area
- Shift Leader to oversee Discharge Lounge and co-ordinate admissions
- Side rooms reduced from six to four
- Current WOW's on ward to remain for Katherine staff use
- Staffroom and locker room to be for use of KW/VW/Domestic staff
- Visitation policy to be reviewed with SCBU manager/matron
- In the event of Katherine ward meeting full capacity, normal overflow plan of utilising bay in Victoria ward and/or ABC will be followed (if available). TC beds in GACU will also be utilised if not in use.
- Service Efficiency measures include the introducing of the Discharge Lounge on KW, and use of the ELCS enhanced recovery pathway. There will also be a focus on optimising 6-hour discharges
- Current staffing template to remain
- Medication storage, equipment and milk fridge/freezer to remain in place

9 Offices and Administration

- Data administrator will be situated in the Starfish Reception
- Ward clerk to be based in Katherine Ward reception 24/7 to support with visitor access
- Two welfare units outside the WACS building will be used as offices for the following staff: matron, ward manager, infant feeding lead, outreach nurses (2), PDN/CPF, and medical staff
- Benching to be installed in office units, along with Wi-Fi points
- Consultant work schedules will be reviewed to facilitate desking sharing within the welfare units
- Office-based staff to be encouraged to work from home wherever possible
- GACU office to be used for staff handover

10 Key Preparations Prior to Decant

- Risk assessment to be carried out in each area affected (GACU/ Katherine Ward, SCBU & TC)
- IPC and Capital Planning to check ventilation in all areas
- Oxygen, suction and medical air piping to be checked
- Existing stock and non-stock items to be reduced to minimum required levels
- Storage boxes required for decant of SCBU and Transitional Care
- Staffing review to ensure adequate staffing in all phases of the delivery plan

11 Three Phase Transition - Action and Delivery Plan

11.1 Phase 1: Preparation and Decant

Operational

- No changes required for administration of postnatal antibiotics
- ROP outpatient clinic will remain in ophthalmology outpatient clinic
- Safety huddle by NIC/Matron/attending consultant to review capacity/acuity/staffing, equipment and other issues; 3x/day or as necessary (0830, 1200 and 2030)
- Safety huddle by the NIC/Matron/attending consultant with maternity for any potential deliveries, postnatal and paediatric matron to review bed capacity twice daily
- Ensure all areas are fully set up before relocation
- All risk assessments completed, with mitigations in place where required
- Review escalation policy to reflect procedures to follow in each area
- Contact Facilities to ensure all areas are cleaned in preparation for patient moves
- Check that lifts are working for the scheduled date of decanting the area
- Review lift route for retrieval of babies from different floors, with mitigation for when a lift is not working
- Notify Transport, LMNS and Network regarding reduction in cot capacity and for potential issues on repatriation from other hospitals due to capacity issues
- All office-based unit staff (including Matron/ Consultant/ PDN/ CPF/ Community Nurses/ Data Clerk/ Ward Clerk) to create a hot desking schedule

Communication

- Communications Team to assist with letter to parents notifying change of unit location
- All staff to be informed via Red Banner and/or All Users Email
- Liaise with postnatal and GACU matron of the scheduled cleaning so that timely decanting of rooms needed are done
- Project Manager to contact Facilities to organise porter support on the day of transfer to different areas
- Regular communication of consultants/matron with the network/LMNS & maternity (including paediatrics) regarding capacity issues
- Notify Resuscitation Team of service relocation
- Switchboard to be informed of correct telephone lines/number for each area
- Notify CSSD to collect used instruments and deliver sterilised equipment
- Notify Operational Managers to ensure that they are aware of the changes in SCBU/TC operation, including GACU and Katherine ward

Pharmacy / Drug Storage

- Joint risk assessment to be completed for safe transfer and storage of drugs
- Current stocks and storage of surplus pharmaceutical supplies to be reduced
- Portable oxygen requirement in all areas of relocation to be reviewed, including transport incubator
- Surplus consumables and pharmaceutical items to be collected and taken into storage by pharmacist and stores

Consumables/Equipment/IT

- Equipment list to be produced, confirming details of the equipment required in each area
- Advance, twice-weekly review of consumable requirement by NIC and ward manager.
- Ward Manager to prepare list of consumables and equipment needed in each area of relocation
- Storage of equipment for easy access needed such as ventilators, resus trolley, IV pumps, incubators, etc. (to be located in a blue portable cabin outside WACS building and storeroom in Safari)
- Transport incubator and portable x-ray will be located within GACU (temporary electrical sockets to be installed)
- Equipment and boxes that are not needed during the transition period will be taken into storage (proposed location is St Albans)
- Clinical Engineering to be consulted regarding storage of equipment, removing wall mounted monitors and putting in freestanding monitors
- Stores/Procurement to support storage of surplus consumables and reduction of supplies each week
- POCT Lead to support transfer of POCT machines to appropriate areas
- Infection Prevention and Control to be consulted regarding use of shared equipment and general risk assessments
- Facilities/Estates/Porters to support decant and moving equipment, packing, and transfer and collection of specimen samples
- Radiology Manager to be consulted regarding appropriate location for the portable x-ray machine
- Ensure phonelines are working with sufficient provision of computers in each area
- Transfer necessary equipment for each office such as computers, phonelines, etc.
- Ensure adequate freestanding monitors available

Security

- Neonatal staff/ward clerk will make a list of all babies in each area and will be updated regularly. This will be given to the ward clerks on KW (including the Neonatal ward clerks based there) to allow entry to parents who are coming to TC/SCBU
- Visitation includes parents at any time, but siblings only at visiting times (1530-1800). Extended family visitation will not be possible during the transition period. This policy will be subject to review prior to and during project delivery.

Staffing

- Daily review of staffing by Matron/NIC/Consultant. Admission nurse required in each shift to respond to crash calls and supporting transfer of baby safely from delivery suite to ITU/HDU using the transport incubator
- Safety huddle by NIC/Matron/attending consultant to review capacity, acuity, staffing, equipment, and other issues; 3x/day or as necessary

11.2 Phase 2: Transition Period (duration of works)

Communication

- Regular communication by clinical team with the Network/LMNS, transport team, paediatrics and maternity regarding any capacity issues
- Safety huddle by NIC/Matron/attending consultant to review capacity/acuity/staffing, equipment and other issues; 3x/day or as necessary
- Safety huddle by the NIC/Matron/attending consultant with maternity regarding potential deliveries, postnatal and paediatric matron to review bed capacity twice daily
- Daily ward round by consultant/NIC in each service area of relocation
- Daily handover/huddles to communicate issues and changes in current plan
- To follow escalation policy and inform division, operations team and network in the case of capacity or operational issues
- Daily handover to communicate issues and changes in current plan
- Documentation folder to be made available as part of business continuity plan if EPR is down

Security

- Neonatal staff/ward clerk will create and maintain a list of all babies in each area to maintain security
- A security guard will be based within GACU at the start of project.
- The security requirement to be reviewed during project delivery

Staffing

- NIC/Matron/consultant to review staffing levels on a daily basis. Staffing issues to be escalated as per policy

Consumables/Equipment/IT

- NIC/ward manager and HCA to review consumable items in each area 2x per week to ensure enough stock for the week
- NIC and pharmacy to monitor pharmaceutical stock in each area 2x per week
- Neonatal HCA will stock each area daily

11.3 Phase 3: Service Repatriation

Communication

- Parents and staffing to be given advance notification of moving back date(s)
- IPC to be engaged in signing off project completion to support service repatriation
- Facilities to be contacted for clean / deep clean of all areas
  - deep cleaning of the refurbished unit
  - deep cleaning of GACU and Katherine ward after vacation by SCBU
- Inform other services such as CSSD, radiology, maternity, paediatric, etc. that SCBU is back in the neonatal unit
- Inform network / LMNS, transport team and operations team that SCBU is fully operational
- Matron and ward manager to walk around the unit before moving back that all facilities are clean and ready for use
- Safety huddle by NIC/Matron/attending consultant and maternity to update any issues or concerns during and after the move

Staffing

- Ward manager/matron/consultant to review staffing to ensure adequate staff available to support moving back to the neonatal unit.
- Neonatal HCA will support the following key tasks:
  - moving stock back to the Neonatal Unit and ensuring that nurseries are fully stocked before moving patients in
  - unpacking boxes and cleaning all equipment upon return from storage

Consumables/Equipment/IT

- Contact POCT Lead to relocate POCT machines
- Contact Facilities to provide porters to:
  - help move equipment back (including stored items/equipment) to the neonatal unit
  - help return furniture and computers for relocated office staff to their offices
- Liaise with clinical engineering to move freestanding monitors to wall mounted
- Liaise with IT to ensure that telephone lines and other IT requirements are operational
- Contact pharmacy and stores to retrieve consumables and pharmaceutical items in storage and review current stock
- Estates/Project team to support return of stored equipment/boxes stored off site
- Inventory of all equipment to be completed to ensure all equipment is accounted for
- Confirm that lifts are working for the scheduled date of moving back to the area

12 Roles and Responsibilities

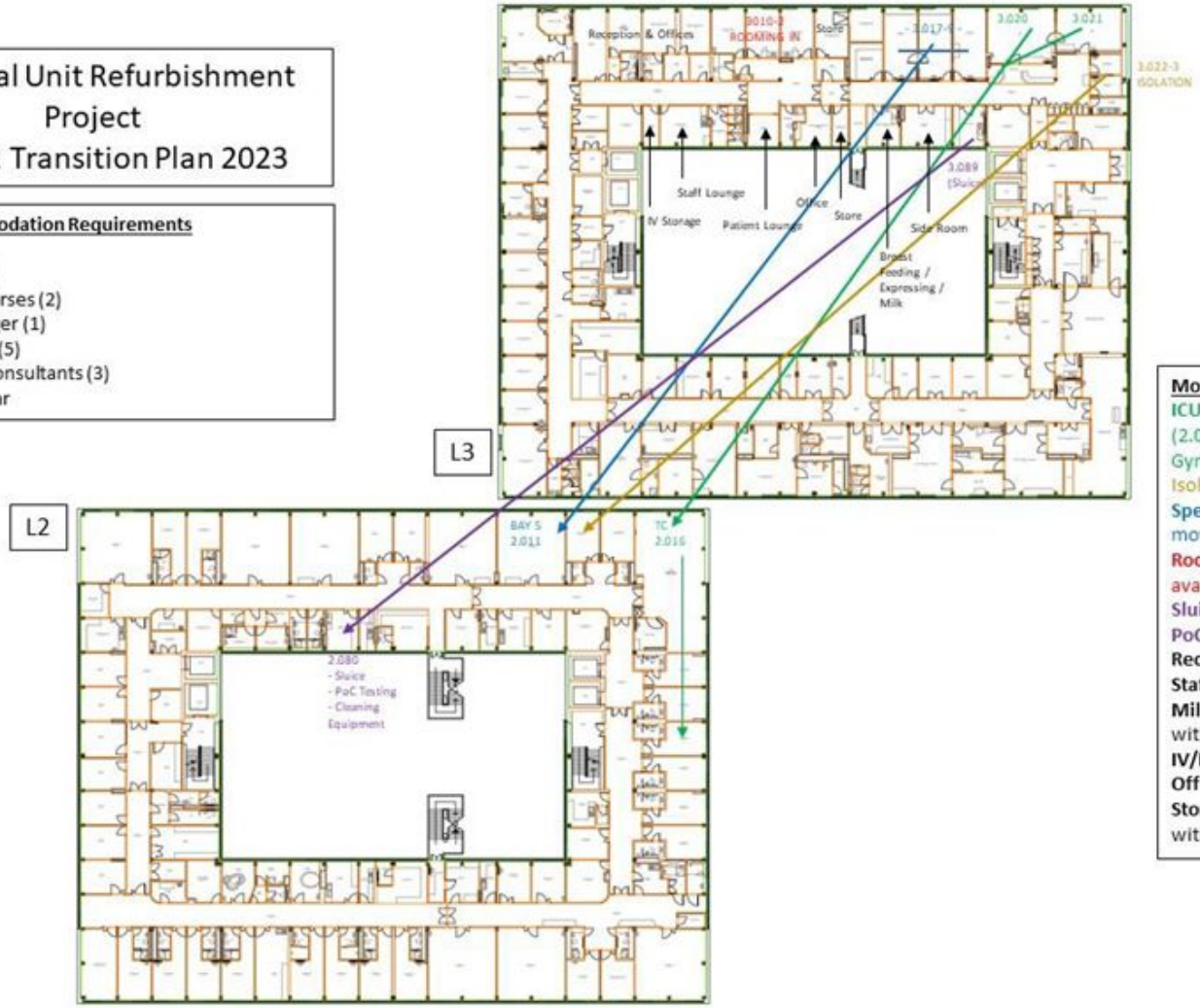
- **Departmental/Ward Matrons**
  - To ensure timely decanting of rooms
  - To review staffing (including medical staffing) on all phases of the project plan
  - To ensure each area's transition plan is appropriate and in place
  - To review patient pathways
- **WACS Project Manager**
  - To oversee the day-to-day details of the project
  - To act as the main point of contact throughout project delivery, working with all stakeholders and supporting services to ensure that the project is delivered with minimal disruption
  - To escalate issues associated with the project, such as change in scope, increase in costs or delays to completion
- **Acute Redevelopment Project Manager**
  - Production and monitoring of the project business case
  - Documentation of initial transition plan
  - Completion of Options Appraisal to support business case
- **Capital Projects Manager**
  - To provide expert planning advice and support delivery of enabling works
- **WACS Quad**
  - To provide senior leadership during project planning and delivery
  - To make key business decisions about the project
  - To approve any increases to the budget and schedule adjustments
  - To regularly communicate with the project manager and members of the team
  - To resolve conflicts among the team members if the project manager cannot
- **IT Project Manager**
  - To work with clinical teams and capital projects to ensure that the IT and telephony requirements for the project are identified and put in place for project delivery
  - To ensure that all IT requirement in SCBU is checked after completion of work
- **All Staff**
  - To comply with and support the transition plan during planning and delivery
  - To notify senior staff of any incidents or risk associated with project delivery
  - To contribute towards overall project objectives
  - To complete required tasks on time
  - To work with other colleagues to establish business needs
  - To provide expertise

Appendix 1 – Neonatal Unit Phase 2 Transition Plan Visual

Neonatal Unit Refurbishment Project
Phase 2 Transition Plan 2023

Office Accommodation Requirements

- Matron (1)
- PDN/CPF (1)
- Outreach Nurses (2)
- Ward Manager (1)
- Consultants (5)
- Paediatric Consultants (3)
- SHO Registrar



Moves

ICU/HDU (3.020/1): Move to Transitional Care (2.013) on KW L2. Transitional Care to move to Gynaecology Ambulatory Care Unit (GACU)
Isolation (3.022-3): Move to Room 5A KW
Special Care (3.017-9): Reduce to 8 beds and move to Bay 5 on Katherine Ward
Rooming In (3.010-2): No location currently available
Sluice (3.089): Use L2 sluice (2.080)
PoC Testing: Use Room 2.080
Reception: Use L2 Reception (KW)
Staff Room/Fridge: Share with KW
Milk Kitchen/Breast Feeding/Expressing: Share with KW
IV/Drug Storage: Shared with Katherine Ward
Offices: Relocate to external container
Storage: Relocate to suitable identified space within WACS, external container, or off site

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Interim Estates Programme

Neonatal Unit Refurbishment

Update on Phase Two Project Scope – November 2022

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1. Purpose

The purpose of this paper is to provide an update on developments relating to the delivery of the project to refurbish and reconfigure the Neonatal Unit at Watford General Hospital (WGH).

2. Context

2.1 Several service and estates issues have been identified with the existing neonatal facilities at WGH. Service concerns include limited cot space, non-compliance with wider HBN guidance, compromised patient and staff experience, and potential security concerns due to the location of the reception desk. Most pertinently, there are compliance issues with ventilation systems, medical gases and power.

2.2 Plans to fully refurbish the unit were drawn up for tendering in Spring 2020, but in March 2020 the country went into Covid 'lockdown' and the scheme was put on hold due to bed pressures/Covid restrictions.

2.3 Following the approval of plans for a new hospital on the Watford Hospital site, the project team was asked by Trust Management Committee to review the scope of the scheme, considering the limited length of time the unit would remain operational before all services moved into the new hospital building.

3. Approach / Outcome

3.1 As requested, the Project Team reviewed and reduced the scope of the previous full business case. The outcome of these discussions was that the new proposal would not seek to increase cot sizes, due to the disruption that this would cause to both neonatal and paediatric services whilst works were completed.

3.2 Other concerns outlined within the previous preferred option would still be addressed, as together they will still deliver significant service and user benefits.

4. Scope

4.1 The revised scope of the project can be seen as outlined in the table below:

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Item	Existing Service Issues in Original FBC	In Phase One?	In Phase Two?
Service Concerns:			
Cot size	○ Space around cots is less than <40% of the currently recommended size, leading to infection control risks and limited privacy and dignity	N	N
HBN compliance	Non-compliance to wider HBN Guidance, creates infection control risks (e.g. lack of dedicated clean utility room and cot wash)	N	Y – partly
Staff Experience	○ Limited flexibility caused by current layout ○ Staff required to regularly move heavy equipment around unit ○ Poor 'meet & greet' facilities	Y	Y
Patient Experience	○ Lack of appropriate welcome on arrival ○ Cramped and unwelcoming spaces ○ Limited privacy and dignity	Y – partly (reception)	Y - partly
Facilities	○ Lack of dedicated clean utility and "cot wash" area on unit means that drugs are prepped in inappropriate areas ○ Limited facilities for preparing and expressing milk ○ No dedicated area for breaking bad news / bereavement suite	N	Y – partly
Security	○ No single point of access ○ Staff base distant from main door ○ No oversight of movement within unit	Y - mainly	N/
Estates Concerns:			
Ventilation	○ Compromised ventilation system ○ No variable temperature control ○ Repeated failure of air-handling plant	N	Y
Medical Gases	○ Non-compliant – lack of resilience	N	Y
Power	○ Non-compliant – lack of resilience	N	Y

5. Conclusion

5.1 Phase One of the business case has been completed already, delivering the refurbishment and minor reconfiguration of administrative, reception and parent overnight facilities.

5.2 Phase Two of the business case will deliver the following:

- 5.2.1 Installation of a completely new and compliant air handling unit (AHU) into the SCBU Clinical area
- 5.2.2 Upgrade to full resilience of medical gases and Power/IPS (to a split/dual zone system for continuity) and new Nurse Call system
- 5.2.3 Full redecoration (required due to the removal of suspended ceilings and damage caused to existing paintwork as a result of the above works)
- 5.2.4 Upgrade to Low emission LED lighting in new suspended ceiling adding to Trusts 'Net Zero' target.
- 5.2.5 Upgrade of Wash basins to compliant IPS/WHB installations
- 5.2.6 Upgraded Nurse Base
- 5.2.7 Upgrade to Fire Doors

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NHS
West Hertfordshire Hospitals
NHS Trust

Watford General Hospital Neonatal Unit Ventilation and Refurbishment Project

Phase 2 Transition Plan Options Appraisal

Version 1.3

Introduction

This paper examines options for the transition plan required to support the vacation of the Trust's Neonatal Unit within the WACS building on the Watford Hospital site. This is required to enable a major refurbishment of the unit, including installation of a new air handling unit, upgrades to infrastructure, and replacement of walls and flooring.

Document Control

Version	Date Issued	Owner	Comments
1.0	17.04.2023	Rob Emmins	Issued to project group
1.1	20.04.2023	Rob Emmins	Updated following discussion and re-issued to project team for comment
1.2	02.05.2023	Rob Emmins	Minor updates
1.3	09.05.2023	Rob Emmins	Updated following feedback on transition plan

Acronyms and Abbreviations

The names of organisations and clinical areas have been abbreviated as follows:

- WHTH = West Hertfordshire Teaching Hospitals NHS Trust
- WGH = Watford General Hospital
- WACS = Women and Childrens Division
- NNU = Neonatal Unit
- TC = Transitional Care
- VW = Victoria Ward
- KW = Katherine Ward
- EW = Elizabeth Ward
- PAU = Paediatric Assessment Unit
- ABC = Alexandra Birthing Centre
- Starfish = Paediatric Inpatient Ward
- Safari = Paediatric Day Case Ward

- GACU – Gynaecology Ambulatory Care Unit
- ED = Emergency Department
- HCA = Health Care Assistant
- CYP = Children & Young People

Principles and Scope

In all scenarios, the following would apply:

- The number of special care beds will be reduced from 12 to 8
- Office accommodation for all staff currently based on the unit will be provided in an external 'container' directly outside the WACS building. Consultant work schedules will be reviewed to facilitate hot desking, and office-based staff will be encouraged to work from home wherever possible
- Storage will be provided through use of existing cupboards and storage facilities within the WACS building, and use of an external container for long-term storage of less frequently required items
- Staff and patients will use facilities (e.g. rest rooms, toilets, milk kitchens, utilities) within the ward space where patients are bedded
- Existing telephone lines will be redirected to new ward spaces
- Computers on wheels will be provided where required
- Existing ward receptions will accommodate the neonatal ward clerk and administrator
- Ventilation and piped gases should be at least equivalent to existing facilities within the unit
- A detailed transition plan will support the preferred option

Longlist

A variety of options have been identified and reviewed by the clinical teams within WACS, including those listed below.

1. 'CYP': Use of space on transitional care and both paediatric wards
2. 'Level 2': Use of space on Katherine Ward
3. 'Victoria': Use of space on Victoria Ward
4. 'Recovery': Use of gynaecology recovering within WACS building
5. Temporary closure of neonatal unit and or moving down to a level 1 unit

As part of the assessment of these options, the Trust's engineering team was asked to review the WACS building and provide information on the provision of medical gases and ventilation within various departments. This can be seen in Appendix 1.

Although Option 4 was appealing due to the presence of compliant ventilation, this option has been rejected on the basis that the impact on emergency gynaecology care and the Trust's operating theatres and recovery areas would be too significant. However, it was recognised that this area would be useful as a backup in the case of critical failure elsewhere.

The partial or full closure of the neonatal unit for the duration of the works (Option 5) was considered but considered too high risk in terms of the impact upon the Trust's obstetrics service, the regional neonatal network, and the reputation of the Trust itself. Again, it was felt that this approach should be considered to be a last resort option rather than as a suitable transitional arrangement.

Options 1-3 were considered appropriate for further consideration as part of the shortlist.

Shortlist

The table below provides details of the three shortlisted options considered most viable within the constraints of the services and the existing clinical accommodation.

	Option 1 – 'CYP'	Option 2 – 'Level 2'	Option 3 – 'Victoria'
ICU/HDU	Move to Transitional Care (Level 2) [*Transitional Care moves to Bay 5 on Katherine Ward*]	Move to Transitional Care (Katherine Ward, Level 2) [*Transitional Care moves to GACU, Level 2; GACU moves to Elizabeth Ward (4 beds)*]	Move to Bay 2 and Side Rooms on Victoria Ward [*Victoria Ward moves to Transitional Care (6 beds) and GACU (5 beds) on Level 2; Transitional Care moves to Bay 3 on Victoria Ward*]
Isolation Beds	Use of cubicle on Paediatric Inpatient Ward (Level 1)	Rooms 5a and 6a on Katherine Ward	Side rooms, Victoria Ward
Special Care	Leopard's Den	Bay 5, Katherine Ward	Bay 1, Victoria Ward

The table below details the review of each option against the service delivery aspects. It should be noted that this table does not provide a summary of all the risks associated with the transition plan and is intended to provide a demonstration of the variation in impact between each of the shortlisted options.

	Option 1 – CYP	Option 2 – GACU	Option 3 – Victoria
Impact on Neonatal Unit			
- Staffing Model	• Service and workforce split across two floors	• Service and workforce based on one floor	• Co-located staffing model retained
- Overall Risk	• Safeguarding concerns regarding access to Safari/Starfish • Non-compliant ventilation in TC	• Security presence required • Non-compliant ventilation in TC	• Security presence required • No medical air supply • No ventilation on VW

Impact on Obstetrics / Maternity			
- General impact	• Reduction (-5 beds) in postnatal capacity	• Reduction (-7 beds) in postnatal capacity • Loss of 2 side rooms on KW - Impact on women requiring side rooms (e.g. readmissions, twins, safeguarding and babies requiring phototherapy)	• -1 antenatal bed • -6 postnatal beds Antenatal ward would need to be relocated to postnatal/TC/GACU (6 beds in TC, 4 in bay 5, 5 from GACU)) • Access to VW via ABC disruptive to women birthing there • Access to VW via KW disruptive as currently no overnight visiting on postnatal ward • Distribution of staffing would impact on ABC as HCAs (and occasionally midwives) are frequently shared with Victoria due to proximity
- General Risk		• If project extends into October/ November/December lack of bed space may become a significant risk to Maternity with forecast of annual rise in numbers over the autumn	• If project extends into October/ November/December lack of bed space may become a significant risk to Maternity with forecast of annual rise in numbers over the autumn

Impact on Paediatrics			
- General Impact	• Reduction of paediatric bed space • Reduced neonatal capacity to support ED admissions for jaundice babies, would require use of Starfish instead	• Reduced neonatal capacity to support ED admissions for jaundice babies, would require use of Starfish instead • PAU would move higher up the Trust's surge plan to support paediatric emergency care	• Reduced neonatal capacity to support ED admissions for jaundice babies, would require use of Starfish instead • PAU would move higher up the Trust's surge plan to support paediatric emergency care
- Overall Risk	• If project extends into October/ November lack of bed space will become a significant risk, particularly if PAU remains unavailable • Will be based next to a mental health ward – priority • Impact on elective surgery	• With PAU moved up higher within the surge plan, and with the decrease in SCBU cots, there is a risk that this will impact on Starfish and Safari	• With PAU moved up higher within the surge plan, and with the decrease in SCBU cots, there is a risk that this will impact on Starfish and Safari
Impact on Gynaecology	• Limited impact unless surge into GACU required.	• Closure of GACU - requires use of EW for ambulatory care	• Closure of GACU - requires use of EW for ambulatory care
Administration	• Night clerk required to service entrance for SCBU	• Would require base on KW • Data clerk based in Starfish Ward	• No reception on VW. Would require base on KW.
Security	• Additional security required for paediatric units	• Security presence required at entrance to KW	• Risk for KW of 'tailgating' at night. • Security required on entrance to KW and VW for safeguarding and baby abduction risk (due to no double door entry system)
Impact on Other Clinical Services	• Impact on elective surgery (CYP)	• Closure of GACU represents bed pressure	• Closure of GACU represents bed pressure
Impact on Non-	• Additional /	• Additional /	• Additional /

Clinical Services	alternative porting support required	alternative porting support required	alternative porting support required

The table below shows a summary of the assessment of each shortlisted option against the Critical Success Factors of the project.

Project	**Option 1 – 'CYP'**	**Option 2 – 'Level 2'**	**Option 3 – 'Victoria'**
Critical Success Factor: Safety	N	Y	Y
Critical Success Factor: Care Quality	Y	Y	Y
Critical Success Factor: Service Resilience	Y	P	N

Rejected Options

Option 1 has been rejected for the following reasons:

- Use of paediatric ward areas is time dependent and the impact of overrun in autumn/winter will lead to unacceptable bed pressures
- The neonatal service would be split between two separate floors, representing an unacceptable service risk

Option 3 has been rejected for the following reasons:

- Victoria Ward does not have mechanical ventilation. It is not considered possible to provide neonatal care without this
- Victoria Ward does not have a medical air supply. Although provision could be made for the use of medical care in tanks, this would not be an ideal approach
- Although it would potentially be possible to install additional piping to provide medical gases, this would not address the lack of mechanical ventilation, and would add significant time and cost to the project

Preferred Option

Option 2 has been identified as the only option that is consistent with all three clinical success factors, safety, care quality, and service resilience.

The ventilation in the transitional care area is non-compliant due to the fact that it runs off the general ventilation system and it does not have any cooling provision. However, and the other limitations identified above, are considered to represent an level of acceptable risk, provided suitable mitigations can be put into place.

These mitigations are likely to include:

- the supply of portable gas cannisters of oxygen and medical air
- portable suction
- relocation to the gynaecology recovery area in the event of service failure in transitional care
- provision of backup generators to address the lack of an isolated/uninterrupted power supply
- Additional staffing (e.g. porter, security, project manager, ward clerk)

It is also noted that with PAU moved up higher within the surge plan, and with the decrease in SCBU cots, there is a risk that this will have an impact on emergency and elective beds on Starfish Ward and Safari Day Unit. The Paediatric Surge SOP is under re-review to assess the impact on the neonatal cot base within the ward area, which could have an impact on elective patient care.

Appendix 1 - Review of existing and proposed facilities for WHTH Neonatal Unit

	Medical Gases			Ventilation	
	Oxygen	Suction	Medical Air		
Neonatal Unit (Existing)					
SCBU	Yes	Yes	Yes	80% Design apart from Hedgehog	
ICU	Yes dual circuits	Yes dual circuits	Yes dual circuits	AHU end of useful life & poor condition	
Isolation Rooms	Yes	Yes	Yes	HTM20-25	
Transitional Care (Level 2)	Yes	Yes	Yes	General vent non compliant for critical care	
Katherine Ward					
Bay 5	Yes 1 x 4	Yes 2 x 4	No	No Mechanical ventilation	
Room 5A	Yes	Yes	No	No Mechanical ventilation	
Room 6A	Yes	Yes	No	No Mechanical ventilation	
Paediatric Wards					
Leopard's Den (Safari)	Yes	Yes	No	No Mechanical ventilation	
Cubicles on Starfish	Yes	Yes	No	No Mechanical ventilation	
Victoria Ward					
Bays 1-3	Yes	Yes	No	No Mechanical ventilation	
Side Rooms 1-4	Yes	Yes	No	No Mechanical ventilation	
Gynaecology & Theatres					
GACU					
Gynae Theatre	Yes	Yes	Yes	80% design HTM2025	End of useful life
Gynae Recovery	Yes	Yes	Yes	80% design HTM2025	End of useful life
Obstetric Theatres	Yes	Yes	Yes	80% design HTM2025	End of useful life
Obstetric Recovery	Yes	Yes	Yes	80% design HTM2025	End of useful life

West Hertfordshire Teaching Hospitals NHS Trust

Trust Board Meeting
1 June 2023

Title of the paper:	Corporate Risk Register Report
Agenda Item:	25
Presenter:	Dr Tom Galliford – Deputy Chief Medical Officer
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. The final data for this report was extracted from Datix on 11 May 2023, with some updates made following the RRG meeting; a total of **22** 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. <u>During this reporting period, the RRG discussed the following</u> **<u>Risk ID 346 (not accepted onto CRR)</u>** Safe fire evacuation when the 'Enabling the flow of urgent and emergency care patients' Standard Operating Procedure is enacted Proposed Risk Score 15 (3 x 5) Accepted Risk Score 10 (2 x 5) This risk was not accepted onto the CRR, as the Group felt that the likelihood of the risk occurring had been mitigated by the significant action undertaken and was therefore currently lower than the proposed score. This was therefore scored with a risk rating of 10 (2 x 5). Therefore, the meeting felt that this risk should not be accepted onto the CRR at present, but would remain on the Divisional Risk Register. **<u>Risk ID 347 (accepted onto CRR)</u>** Inadequate Mortuary facilities for the storage of bodies and post mortem tissue from the deceased Proposed Risk Score 20 (4 x 5) Accepted Risk Score 20 (5 x 4) This risk related to the mortuary facilities for the storage of bodies not being fit for purpose, as such it was deemed that the risk was such that it should be accepted onto the CRR for monitoring through the Group. It had a proposed score of likelihood 4 and a consequence of 5, however after discussion it was decided that the consequence was lower (4), should the risk occur, however the likelihood was increased (5). Accepted onto CRR.

	Risk ID 348 (accepted onto CRR) Insufficient Non-Medical Mortuary Staffing to meet HTA Standards Proposed Risk Score 16 (4 x 4) Accepted Risk Score 16 (4 x 4) Risk was accepted onto the CRR. **Risk ID 349 (accepted onto CRR)** Risk of the Mortuary premises not being fit for purpose. Proposed Risk score 20 (4 x 5) Accepted Risk Score 15 (2 x 5) **Risk ID 351 (accepted onto CRR)** Risk of increased infections arising from the poor and ageing infrastructure within neonatal unit Proposed risk Score 15 (3 x 5) Accepted Risk Score 15 (3 x 5) There was one (1) risk with an increased risk score for consideration, which was approved for addition to the CRR. **Risk ID 119 (accepted onto CRR)** Potential risk to patient safety due to the high vacancy rate across Paediatric Nursing Current Risk rating 9 (3 x 3) Proposed risk rating 15 (5 x 3) During the meeting the following three (3) risks were approved for reduction in risk score and removal from the Corporate Risk Register **Risk ID 32 approved for removal from CRR** Control of Legionella and Management of water systems Current Risk Score 16 (4 x 4) New Risk Score 12 (3 x 4) This risk was considered and given the work undertaken and current position it was agreed that the risk should be reduced and removed from the CRR. To continue to be monitored through the Environment Divisional Risk Register. **Risk 29 approved for removal from CRR** Increased midwifery vacancies leading to lack of appropriate midwifery staffing levels. Current Risk Score 16 (4 x 4) New Risk Score 12 (3 x 4) The Group considered that the risk likelihood had reduced, and the Trust was in a better position. Risk score reduced and removed from the CRR. **Risk 318 approved for removal from CRR** Impact on staff morale, elective and non-elective patient flow and pathways

	due to the use Paediatric Assessment unit as a surge area. Current Risk score 16 (4 x 4) New Risk Score 12 (3 x 4) Group considered that the risk had reduced and therefore could be removed from CRR and continue to be monitored through the Divisional Risk Register. One additional risk was discussed and while not accepted onto the CRR at present it was noted as a risk of note. **<u>Risk ID 356 Workstation on wheels (WOW) electrical faults</u>** Current Risk Score 12 (3 x 4) Group discussed the recent incidents where electrical components on the workstations had overloaded and shorted out, causing a smell of burning and some smoke to come out of them, resulting in Fire brigade attendances. Significant work had been carried out with the provider and inspections undertaken, to replace the components. Anticipated that the work would be completed as soon as possible. Risk to be monitored through RRG, with monthly updates. There were no merged risks for consideration. There were no risks to be considered for closure. 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 report)*	**Aim 1 Best care** — ***Objectives 1-4*** — ✓ **Aim 2 Great team** — ***Objectives 5-8*** — ✓ **Aim 3 Best value** — ***Objective 9*** — ✓ **Aim 4 Great place** — ***Objective 10-12*** — ✓
Links to well-led key lines of enquiry:	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☒Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles, and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues, and performance? ☒Is appropriate and accurate information being effectively processed, challenged, and acted on? ☒Are the people who use services, the public, staff, and external partners engaged and involved to support high quality sustainable services? ☒Are there robust systems and processes for learning, continuous improvement, and innovation? ☒How well is the trust using its resources?

Previously considered by:	Quality Committee – 25 May 2023
Action required:	The Trust Board is asked to discuss and review the corporate risk register and endorse the changes.

West Hertfordshire Teaching Hospitals NHS Trust

Agenda Item: 25

Trust Board – 1 June 2023

Title of Paper: Corporate Risk Register Report

Presented by: Dr Tom Galliford – Deputy 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 Appendix 1 details a table representing risks and their associated score movement on the CRR by Division against each month since June 2022.

3.2 Appendix 2 details a full summary of all corporate risks contained in the papers presented to the Risk Review Group on 11 May 2023.

3.3 Appendix 3 shows KPI performance in relation to Risk Review status

3.4 Appendix 4 Risks scores over the last 12 months (per Division)

4. Risk activity

During this reporting period, there were five new risks (5) presented for discussion and possible approval to add to the CRR, of which four (4) were accepted and one (1) not accepted

4.1 **Risk ID 346 (not accepted onto CRR)**

Safe fire evacuation when the 'Enabling the flow of urgent and emergency care patients' Standard Operating Procedure is enacted

Proposed Risk Score 15 (3 x 5) Accepted Risk Score 10 (2 x 5)

This risk was not accepted onto the CRR, as the Group felt that the likelihood of the risk occurring had been mitigated by the significant action undertaken and was therefore currently lower than the proposed score. This was therefore scored with a risk rating of 10 (2 x 5). Therefore, the meeting felt that this risk should not be accepted onto the CRR at present, but would remain on the Divisional Risk Register.

4.2 **Risk ID 347 (accepted onto CRR)**

Inadequate Mortuary facilities for the storage of bodies and post mortem tissue from the deceased

Proposed Risk Score 20 (4 x 5) Accepted Risk Score 20 (5 x 4)

This risk related to the mortuary facilities for the storage of bodies not being fit for purpose, as such it was deemed that the risk was such that it should be accepted onto the CRR for monitoring through the Group. It had a proposed score of likelihood 4 and a consequence of 5, however after discussion it was decided that the consequence was lower (4), should the risk occur, however the likelihood was increased (5). Accepted onto CRR.

4.3 **Risk ID 348 (accepted onto CRR)**

Insufficient Non-Medical Mortuary Staffing to meet HTA Standards

Proposed Risk Score 16 (4 x 4) Accepted Risk Score 16 (4 x 4)

Risk was accepted onto the CRR.

4.4 **Risk ID 349 (accepted onto CRR)**

Risk of the Mortuary premises not being fit for purpose.

Proposed Risk score 20 (4 x 5) Accepted Risk Score 15 (2 x 5)

Risk was accepted onto the CRR.

4.5 **Risk ID 351 (accepted onto CRR)**

Risk of increased infections arising from the poor and ageing infrastructure within neonatal unit

Proposed risk Score 15 (3 x 5) Accepted Risk Score 15 (3 x 5)
Risk was accepted onto the CRR.

There was one (1) risk with an increased risk score for consideration, which was approved for addition to the CRR.

4.6 **Risk ID 119 (accepted onto CRR)**

Potential risk to patient safety due to the high vacancy rate across Paediatric Nursing

Current Risk rating 9 (3 x 3) Accepted risk rating 16 (4 x 4)

During the meeting the following three (3) risks were approved for reduction in risk score and removal from the Corporate Risk Register

4.7 **Risk ID 32 approved for removal from CRR**

Control of Legionella and Management of water systems

Current Risk Score 16 (4 x 4) New Risk Score 12 (3 x 4)

This risk was considered and given the work undertaken and current position it was agreed that the risk should be reduced and removed from the CRR. To continue to be monitored through the Environment Divisional Risk Register.

4.8 **Risk 29 approved for removal from CRR**

Increased midwifery vacancies leading to lack of appropriate midwifery staffing levels.

Current Risk Score 16 (4 x 4) New Risk Score 12 (3 x 4)

The Group considered that the risk likelihood had reduced, and the Trust was in a better position. Risk score reduced and removed from the CRR.

4.9 **Risk 318 approved for removal from CRR**

Impact on staff morale, elective and non-elective patient flow and pathways due to the use Paediatric Assessment unit as a surge area.

Current Risk score 16 (4 x 4) New Risk Score 12 (3 x 4)

Group considered that the risk had reduced and therefore could be removed from CRR and continue to be monitored through the Divisional Risk Register.

One additional risk was discussed and while not accepted onto the CRR at present it was noted as a risk of note.

4.10 **Risk ID 356 Workstation on wheels (WOW) electrical faults**

Current Risk Score 12 (3 x 4)

Group discussed the recent incidents where electrical components on the workstations had overloaded and shorted out, causing a smell of burning and some smoke to come out of them, resulting in Fire brigade attendances. Significant work had been carried out with the provider and inspections undertaken, to replace the components. Anticipated that the work would be completed as soon as possible.

Risk to be monitored through RRG, with monthly updates.

There were no merged risks for consideration.

There were no risks to be considered for closure.

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 Quality Committee is asked to receive this report for discussion of the corporate risk register and board assurance framework and approve changes made by the Risk Review Group.

Executive Lead Dr Tom Galliford
Deputy Chief Medical Officer

Date: May 2023

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 4 Risks scores over the last 12 months (per Division)

Appendix 1 – Risks and associated score movement on the CRR by Division against each month since February 2022

Division		Jun-22		Jul-22		Aug-22		Sep-22		Oct-22		Nov-22		Dec 22		Jan-23		Feb-23		Mar-23		Apr-23		May-23	
CLINICAL SUPPORT SERVICES	347																							20	↑
	348																							16	↑
	349																							20	↑
CLINICAL INFORMATICS	25	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	→
	35	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→
	37	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→
	97									16	↑	16	→	16	→	16	→	16	→	16		16	→	16	→
	311													16	↑	16	↑	16	→	16		16	→	16	→
	325																	16	↑	16		16	→	16	→
EMERGENCY MEDICINE	19	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→
	20	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→
	21	15	→	15	→	15	→	20	↑	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→
	22					15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→
	23																					16	↑	16	→
	113									15	↑	15	→	15	→	15	→	15	→	15		15	→	15	→
ENVIRONMENT	32	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	16	↓	16	→	16	→	12	
	33	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	→
	344																					20	↑	20	→
MEDICINE																									
SURGERY & CANCER																									
WOMEN's & CHILDREN	29	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	12	
	36	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→
	318															16		16	→	16	→	16	→	12	
	119																							16	↑
	351																							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	Risk remains unchanged. Everything is now ready to go; there is a 4-6 week lead time with the 3rd party (Stanley) to secure resources for the cutover. Cutover takes place over 3 days and there is 0.5 day downtime involved when switching over. The exact date when this cut-over can take place is still being discussed with emergency planning currently.	20	Paul Bannister - Chief Information Officer
RRG MEETING UPDATE **RRG noted update. Risk Score and controls remain appropriate for the Risk at present.** **Current Risk 5 x 4 = 20**							

No	27	20/05/2020	Possibility of a Cyber Security Incident arising from vulnerabilities within our network connectivity systems.	15	The risk is discussed and monitored at Divisional level. There is no change to the score of this risk, which remains appropriate for the level of risk that is being managed at present. Remediation work in progress: Windows 7 device numbers reduced to circa 130 largely within the Pathology, Radiology and Pharmacy departments - work continues to replace these with Windows 10 21H2 Windows 10 build 1909 or earlier - related to third party clinical devices - discussions and agreement on resolutions with third parties required 4 x Windows 2K3 server operating systems remain in the estate because the applications running on these cannot operate on up to date operating systems and the applications need to be replaced these are Charron Path data archive and related terminal server, Maternity CMIS and the Intranet. CMIS Maternity system replaced by Badgernet, legacy CMIS server to be shutdown at the end of May 2023; Way forward agreed for replacing the legacy servers running Charon Path archive; and, Intranet still awaiting agreed way forward for the Intranet replacement.	15	Paul Bannister - Chief Information Officer
RRG MEETING UPDATE **Update noted by RRG. Risk scoring and controls are in place to manage the ongoing risk.** **Current Score 3 x 5 = 15**							

CLINICAL SUPPORT SERVICES

No	347	11/05/2023	Inadequate Mortuary facilities for the storage of bodies and post mortem tissue from the deceased	20	The Human Tissue Authority (HTA) inspected the Mortuary equipment including the available fridge and freezer capacity and the reliance on internal and external surge in March 2023. The inspection report has concluded that there is a critical shortfall under standard PFE2.	20	Sally Tucker – Chief Operating Officer
RRG MEETING UPDATE **RRG accepted Risk onto the CRR.** **Current Score 5 x 4 = 20**							

No	348	11/05/2023	Insufficient Non-Medical Mortuary Staffing to meet HTA Standards	16	The HTA inspection report has concluded that there are insufficient condition checks on deceased and that condition checks are ad hoc, due to the staffing limitations. The inspection report has concluded that there is a major shortfall under standard GQ1. Under HTA standards GQ6 the HTA have concluded that there is a major shortfall as significant risk such as shortage of staff have not been incorporated on to the Trust risk register.	16	Sally Tucker – Chief Operating Officer
RRG MEETING UPDATE **RRG accepted Risk onto the CRR.** **Current Score 4 x 4 = 16**							

No	349	11/05/2023	Risk of the Mortuary premises not being fit for purpose.	16	The Human Tissue Authority (HTA) inspected the Mortuary premises and environment and have reported a Major shortfall under standard PFE1.	16	Michelle Hope – Interim Chief Nurse

RRG MEETING UPDATE

RRG accepted increase in score and addition to CRR.

Current Score 4 x 4 = 16

CORPORATE SERVICES

No	35	09/11/2016	Patients may have a poor experience due to long waits for elective care	20	No further changes to this risk in terms of controls, assurances and mitigations are anticipated. The framework in place to improve patient waiting times is robust, with multiple oversight opportunities and touch points.	20	Michael Van der Watt, - Chief Medical Officer

RRG MEETING UPDATE

RRG noted that risk had been reviewed and updated. RRG asked that risk be rewritten to reflect current position across the Divisions.

Current Score 4 x 5 = 20

No	37	27/01/2022	There is a risk to maintaining Safe staffing levels for Nursing across all Divisions	15	Workforce continues to be challenged, 50+ surge beds in use plus ED corridor. IR recruitment continues pipeline April to November 180 nurses.	15	Michelle Hope – Interim Chief Nurse

RRG MEETING UPDATE

RRG noted ongoing work in this area.

Current Score 5 x 3 = 15

No	97	11/08/2022	Staff Turnover Rates (overall numbers/turnover within specific staff groups/leavers in first year of employment)	16	Turnover is declining and is currently 15.3% overall as of March 2023. The Trust has also seen a reduction in turnover for those leaving within their first 12 months at 17.2%. We continue to work with Divisions supporting localised retention initiatives and the first Recruitment and Retention Steering Group was held in March. The membership includes broad representation across all Divisions, targeting the areas with significant challenges. The People Promise programme has been extended for a 2nd year and whilst we will continue to work on the new joiner experience, there will be significant focus on flexible working, career progression and development, and first line manager support. The first draft of the wellbeing strategy is being development and will be launched as soon as this is completed. Hot spot divisions are WACS with an emphasis on Paediatrics, CSS, and Corporate.	16	Andrew McMenemy – Chief People Officer
RRG MEETING UPDATE **RRG noted risk update and work being undertaken in this area.** **Current Score 4 x 4 = 16**							

No	311	05/12/2023	Effects of Workforce Wellbeing on Operational Services	16	• Wellbeing strategy drafted and shared with stakeholders for feedback prior to a formal publication in June 2023 • Review of all current reasonable adjustment plan/ passports, developing one overarching interactive 'supporting you' passport to launch June 2023 • Wellbeing tab to be included within the ACORN platform to create a centred place for wellbeing training • To support our Together Towards Excellence programme we will ask for staff involved to form a 'change team' • Review of our Employee Assistance Programme, new provide Vivup will be taking over from August 2023 to improve level of support and encourage higher utilisation	16	Michelle Hope - Interim Chief Nurse

RRG MEETING UPDATE

RRG noted update and ongoing activity, which was provided verbally at the meeting.

Current Score 4 x 4 = 16

No	325	04/02/2023	Possible impact on Patient Safety due to need to use Surge Areas within numerous Departments in the Trust	16	The Trust continues to use surge areas as a result of patient numbers. This is constantly reviewed and continues to expand or reduce as demand varies. The risk remains that patient safety/experience will be negatively impacted by the current continued need to utilise surge areas, with areas being utilised which were not designed to have patients. The risk score and the risk itself cannot be reduced at present.	16	Michael Van der Watt, - Chief Medical Officer

RRG MEETING UPDATE

Risk update accepted.

Current Score 4 x 4 = 16

EMERGENCY MEDICINE							
No	19	30/04/2018	Ambulance handover delays affecting patient pathway and escalation	20	The risk score, controls and mitigation remain the same. EEAST have initiated a handover at 45 minutes policy for some patients which has impacted on the turnaround times, which have improved and the division continues to monitor this through the ambulance handover board and will review the risk score when the improvement shows consistency that it has been maintained.	15	Sally Tucker - Chief Operating Officer

RRG MEETING UPDATE

RRG noted update.

Current Score 5 x 3 = 15

No	20	12/04/2022	Reduced patient flow through the Emergency department (ED)	15	Risk score, controls and mitigation remain unchanged. The flow of patients through the department continues to be monitored closely, with the teams actively promoting the use of assessment spaces in EAU, SDEC and ensuring IPS escalations take place. The department RAG rating is discussed throughout the day at operations meetings and patient flow policy is implemented when the department is rated as Red or Black.	15	Michelle Hope- Interim Chief Nurse
RRG MEETING UPDATE **RRG noted update. No change to risk or control measures at present.** **Current Score 3 x 5 = 15**							

No	21	12/04/2022	Failure to meet performance KPIs within the Emergency Department (ED)	16	Risk score, controls and mitigation remain unchanged. The performance against KPIs is monitored closely with the operations team working closely with the ED to ensure where possible patients are not for discharge home from ED are transferred to assessment or ward areas within four hour of arrival. In TAM there is close monitoring of the time patient are in the department and escalation of any causes of delays are made in a timely manner.	20	Sally Tucker – Chief Operating Officer
RRG MEETING UPDATE **RRG noted update. No change at present to risk description, controls etc.** **Current Score 5 x 4 = 20**							

No	22	12/04/2022	Challenges in meeting the needs of Mental health Patients within the Emergency Medicine division	16	Risk score, controls and mitigation remain unchanged. Work on a second Mental health room in ED is in progress and a date to start safe space in AAU Level one is waiting confirmation. A process of the care of patients under a section 136 after 24 hours has been introduced and regular meetings with HPFT take place.	16	Michelle Hope- Interim Chief Nurse
RRG MEETING UPDATE **RRG noted update. No change to score at present.** **Current Score 4 x 4 = 16**							

No	23	11/08/2022	The impact on the Emergency department of the Watford UTC inconsistent adherence to patient pathways, processes and escalation	15	The score was discussed at last RRG and increased. There have been no changes since. Regular meetings are held with the UTC provider at service, divisional and Exec level which monitored and discuss performance, especially against streaming and four hour requirements. Clinical review was commissioned by the WHTHT Medical Director, the recommendations of which are currently being actioned by WHTHT and Greenbrook.	16	Sally Tucker - Chief Operating Officer
RRG MEETING UPDATE **RRG noted update to risk.** **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	The risk score, controls and mitigation remain unchanged. Review of the roles and responsibilities of the staff based in TAM has taken place to ensure early escalation of delays is made, to improve the flow of patients therefore reducing over crowding. Work continues with security and estates to improve the environment and pharmacy in regard the safe and appropriate storage of medications.	15	Michelle Hope, Interim Chief Nurse
RRG MEETING UPDATE **RRG noted update. No change to score at present.** **Current Score 5 x 3 = 15**							

ENVIRONMENT

No	32	13/10/2012	Control of Legionella and Management of water systems	20	Water Safety Manager is in post - March 2023 Recruitment to Water Admin post will commence May 2023 Water Safety meeting continues monthly with minutes and action logs produced	12	David Ambrose – Acting Director of Environment
RRG MEETING UPDATE **RRG reduced Risk score to 12 and removed from CRR, pending any further updates from the Water Safety Officer.** **Current Score 3 x 4 = 12**							

No	33	26/08/2021	Electrical infrastructure risks on the WGH site	15	Work continues with the HV works - Trench/cable/installation to network. The work is running to schedule with each phase rolling into the next one. Generators are in situ from WGH and continue to support the works in terms of resilience for the site whilst works take place. Generators continue to be tested on a monthly basis Score to remain the same Works will continue until late this year	15	David Ambrose – Acting Director of Environment
RRG MEETING UPDATE **RRG noted no change to Risk Score or Controls.** **Current Score 3 x 5 = 15**							

No	34	26/08/2021	Electrical infrastructure risks on the SACH site	15	Risk reviewed with HOE and DDOE Risk score remains the same Monitoring of work being carried out at SACH continues - Work will start to be scheduled as soon as the works at SACH reach an appropriate point of completion. Materials are part of the agreed 22/23 capital program with installation work to be planned for FY 23/24	15	David Ambrose – Acting Director of Environment
RRG MEETING UPDATE **RRG noted no change to Risk Score or Controls.** **Current Score 3 x 5 = 15**							

No	344	09/04/2023	Risk of fire during refurbishment project - Shrodells Building	20	Risk score was discussed by some of the members of the SMT in Environment - agreed score to remain the same until discussed for potential inclusion on the CRR at the May PRG Fire Safety Manager monitoring the on going works along with the Projects Team	20	David Ambrose – Acting Director of Environment
RRG MEETING UPDATE **RRG noted no change to Risk Score or Controls.** **Current Score 3 x 5 = 15**							

SURGERY & CANCER

WOMEN'S AND CHILDREN

No	29	20/11/2020	Increased midwifery vacancies leading to lack of appropriate midwifery staffing levels	20	Review by DOM and head of maternity governance and assurance. There is a reduction in the overall percentage of midwifery vacancy (12.9% in March). Recruitment and retention in progress. RR midwife in post. Re branding project in process, further international recruitment of midwives continues.	12	Michelle Hope-Interim Chief Nurse
RRG MEETING UPDATE **RRG reduced risk score to 12 and removed it from CRR. To continue to be monitored through Divisional Risk Register.** **Current Score 3 x 4 = 12**							

No	36	01/04/2019	Delay in the IOL pathway including transfer from the antenatal ward to delivery suite.	16	Reviewed by DOM and head of maternity governance and assurance- ongoing monitoring of dilapan use to determine effectiveness. Score change as no poor outcomes associated with current delay, in view of improved staffing and reduction in birth rates the frequency of delays has declined. Audit has been undertaken and presented at maternity audit afternoon, to be presented and discussed at Maternity Safety Champions meeting in May.	15	Michelle Hope - Interim Chief Nurse
RRG MEETING UPDATE **RRG noted no change to Risk Score or Controls.** **Current Score 3 x 5 = 15**							

No	318	04/01/2023	Impact on staff morale, elective and non-elective patient flow and pathways due to the use Paediatric Assessment Unit as a surge area	16	02/05/23- still on surge plan. However, occurs less frequently due to winter pressures slowly reducing	12	Mike Van der Watt – Chief Medical Officer
RRG MEETING UPDATE **RRG reduced risk score to 12 and removed it from CRR. To continue to be monitored through Divisional Risk Register.** **Current Score 3 x 4 = 16**							

No	119	11/05/2023	Potential risk to patient safety due to the high vacancy rate across Paediatric Nursing	16	There is currently a high number of vacancies across Children's Services, predominantly in Starfish and Children's Emergency department Cause - Difficulty in recruiting Paediatric Nurses which is a known national issue and is compounded by where we are geographically located (borders of London) - Poor temporary staffing fill rate alongside bank pay rates that do not	16	Michelle Hope - Interim Chief Nurse

					match other local hospitals (ours are lower) Effect / Impact -not able to consistently facilitate having the correct number of staff on each shift. Staff are regularly redeployed to mitigate the risk which has affected staff morale and equally affects our ability to retain staff. - Patient flow between the Children's Emergency Department and Starfish Ward can be impeded if appropriate staffing levels are not appropriate. The risk scoring is based on the likelihood of the risk to patient safety rather than not having enough staff on each shift.		
RRG MEETING UPDATE **RRG accepted increase in risk score and addition to the CRR.** **Current Score 4 x 4 = 16**							

No	351	11/05/2023	Risk of increased infections arising from the poor and ageing infrastructure within neonatal unit	15	The air handling unit within the neonatal unit has reached its end of life and is no longer compliant with the regulatory requirements. As a result there is an increased risk that infection control measures are not effective and there is a significant risk of babies catching infections.	15	Michelle Hope - Interim Chief Nurse
RRG MEETING UPDATE **RRG accepted new risk for addition to the CRR.** **Current Score 3 x 5 = 15**							

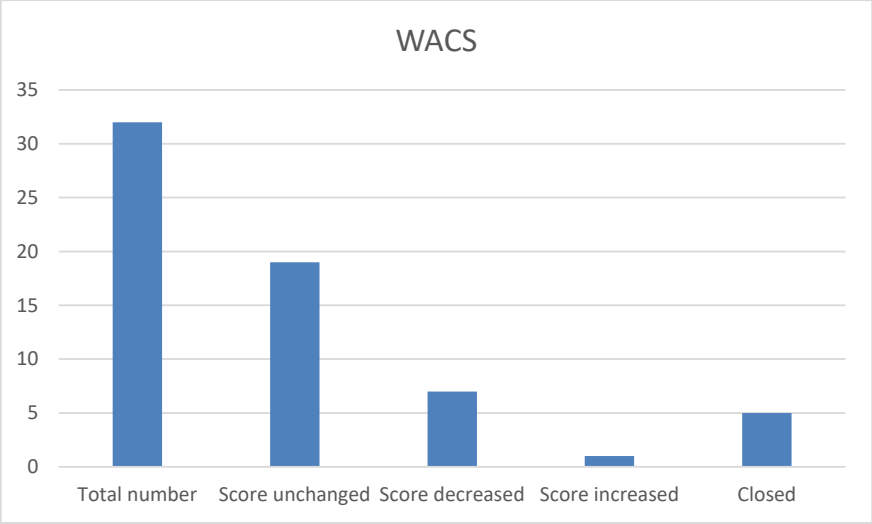
Appendix 3 KPI Performance

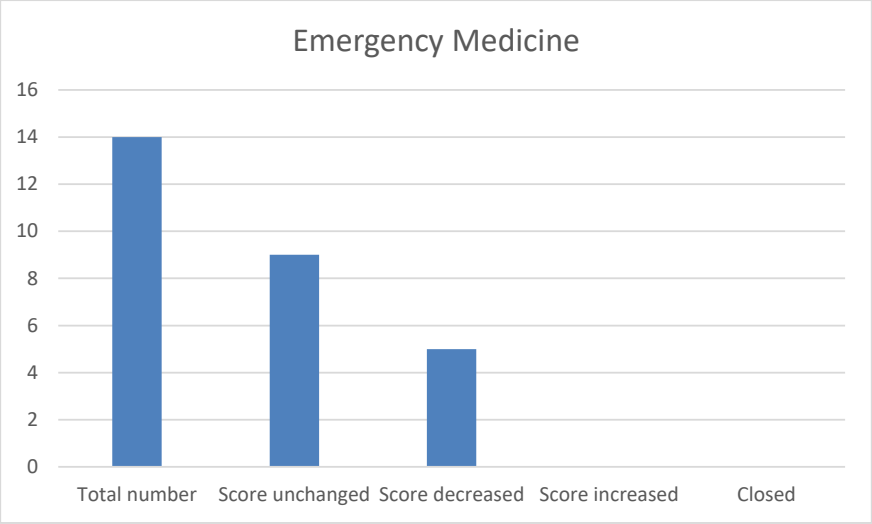
	Risk	

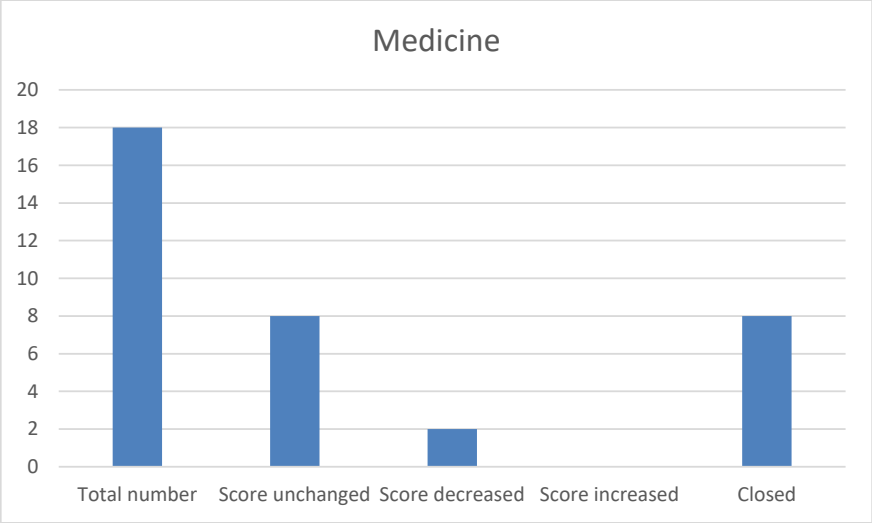
		Score					
Division	Total Risks	1-3	4-6	8-12	15-25	Reviews in date	% in date
WACS	27	0	1	23	3	22	81%
Emergency Medicine	14	1	0	8	6	13	93%
Medicine	8	0	1	7	0	8	100%
SAC	28	3	9	16	0	28	100%
Environment	40	0	4	33	3	40	100%
CSS	52	1	8	42	1	29	44%
Clinical Informatics	26	0	7	17	2	23	88%
Corporate Services	46	3	15	22	6	24	52%
Finance	19	0	5	14	0	1	0%

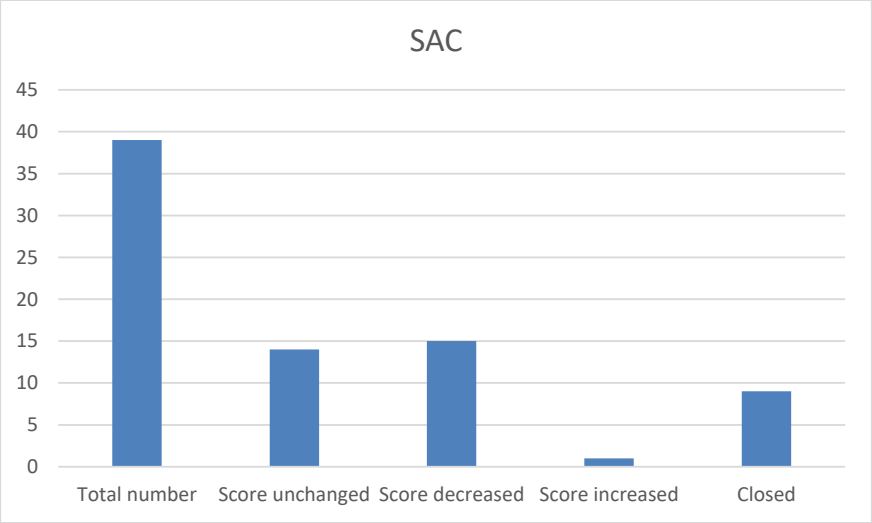
Appendix 4 Direction of Travel

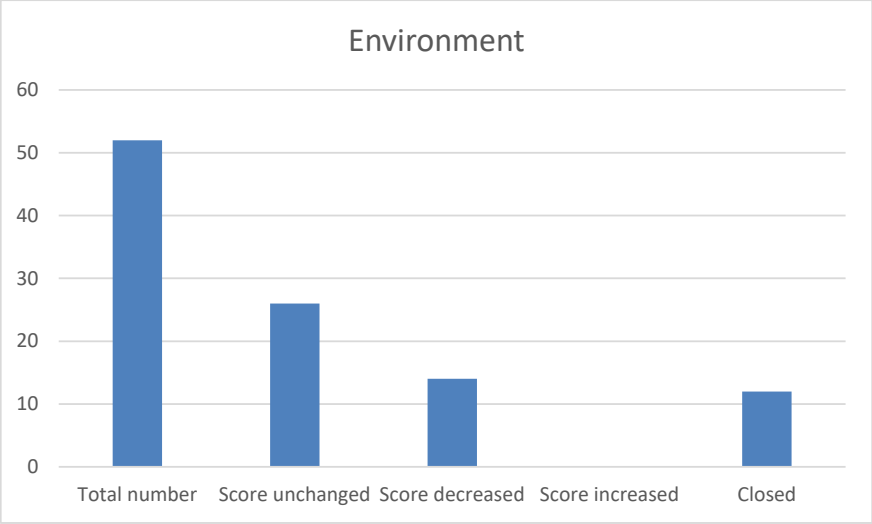
Risks scores over the last 12 months (per Division)

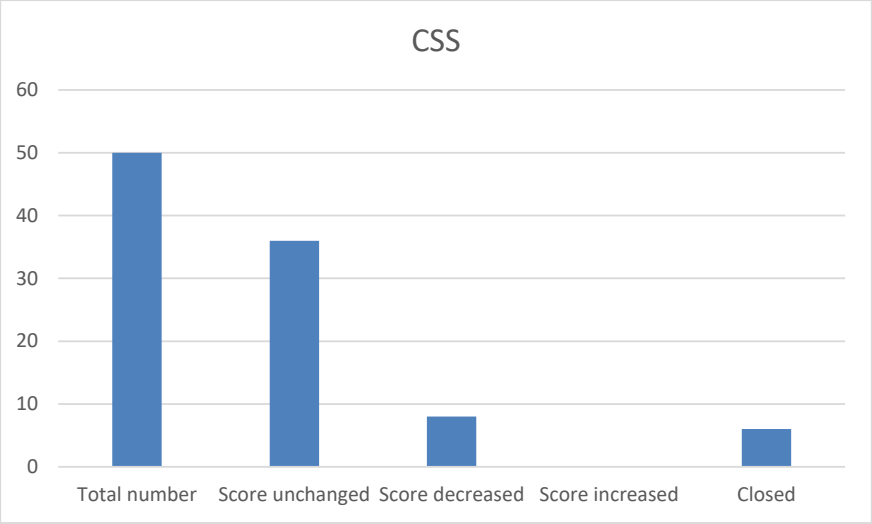

WACS
35
30
25
20
15
10
5
0
Total number
Score unchanged
Score decreased
Score increased
Closed

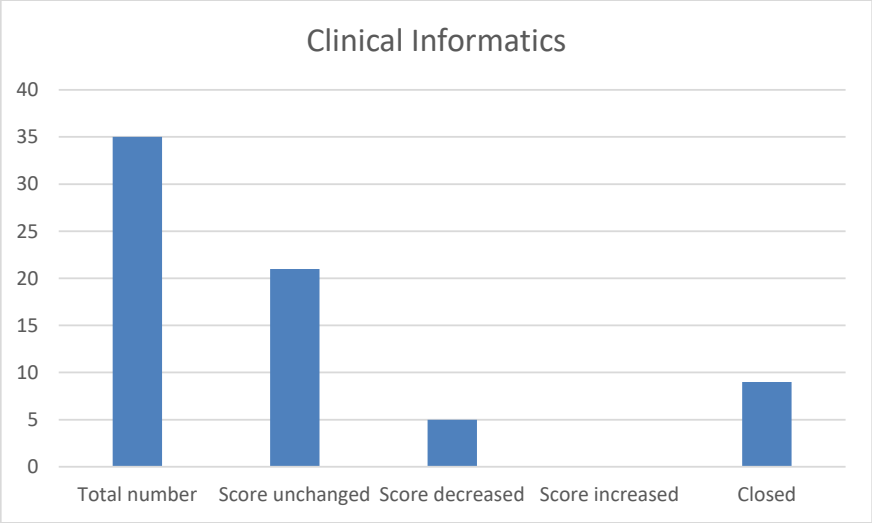

Emergency Medicine
16
14
12
10
8
6
4
2
0
Total number
Score unchanged
Score decreased
Score increased
Closed

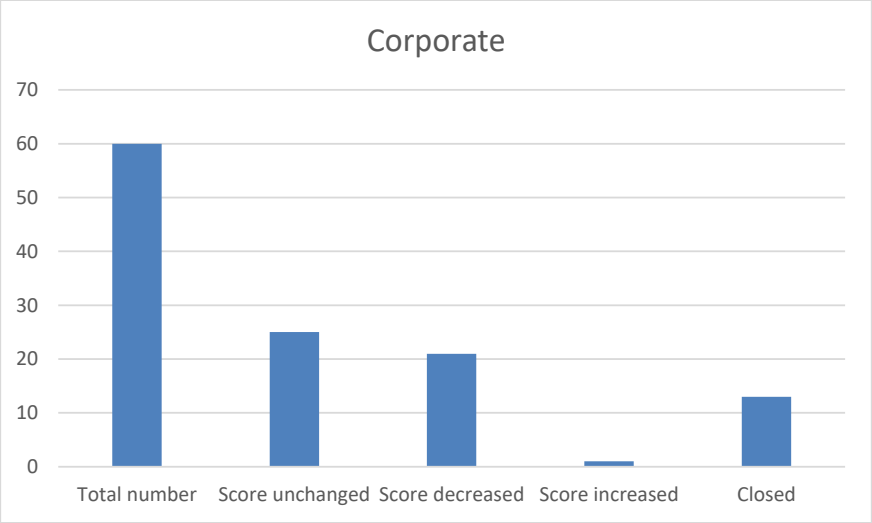

Medicine
20
18
16
14
12
10
8
6
4
2
0
Total number
Score unchanged
Score decreased
Score increased
Closed

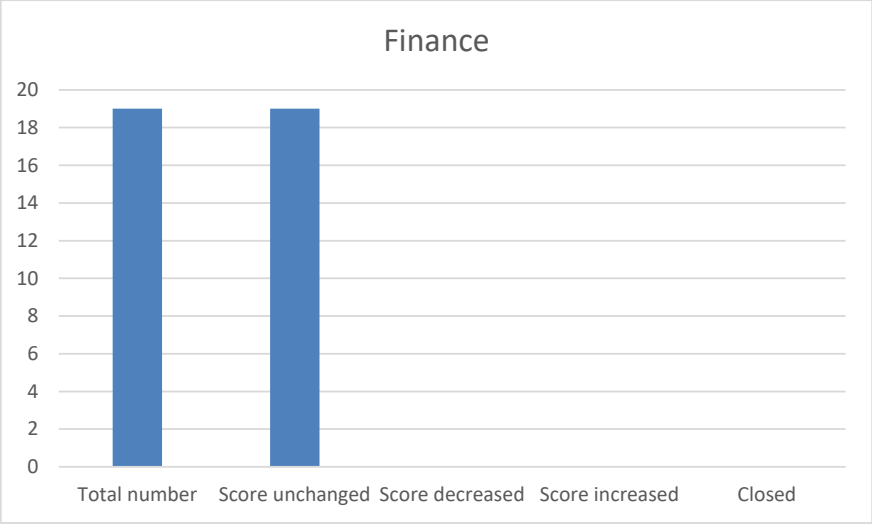

SAC
45
40
35
30
25
20
15
10
5
0
Total number
Score unchanged
Score decreased
Score increased
Closed


Environment
60
50
40
30
20
10
0
Total number
Score unchanged
Score decreased
Score increased
Closed


CSS
60
50
40
30
20
10
0
Total number
Score unchanged
Score decreased
Score increased
Closed


Clinical Informatics
40
35
30
25
20
15
10
5
0
Total number
Score unchanged
Score decreased
Score increased
Closed


Corporate
70
60
50
40
30
20
10
0
Total number
Score unchanged
Score decreased
Score increased
Closed


Finance
20
18
16
14
12
10
8
6
4
2
0
Total number
Score unchanged
Score decreased
Score increased
Closed

25

West Hertfordshire Teaching Hospitals NHS Trust

Trust Board Meeting
1 June 2023

Title of the paper	**Annual statement on actions taken in 2022/23 to prevent slavery and human trafficking**
Agenda Item	**26**
Presenter	**Barbara Anthony, Trust Secretary**
Author(s)	**Barbara Anthony, Trust Secretary**
Executive Summary	Section 54 of the UK Modern Slavery Act (2015) requires commercial organisations operating in the UK with an annual turnover in excess of £36m to produce a Modern Slavery and Human Trafficking Statement for each financial year. The updated Statement outlines the steps taken by the Trust during the last financial year to prevent modern slavery and human trafficking in any of its supply chains, and in any part of its business. It will be displayed on the trust website once approved by the board.
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*
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?
Action required	The Quality Committee is asked to review the draft statement and recommend it to the Board for approval.

West Hertfordshire Teaching Hospitals NHS Trust

Agenda Item: 26

Trust Board Meeting – 1 June 2023

Annual statement on actions taken in 2022/23 to prevent slavery and human trafficking

Presented by: Barbara Anthony, Trust Secretary

1. Purpose

1.1 The purpose of this report is to ask the Board to approve the Modern Slavery and Human Trafficking Statement. The Statement provides an overview of the steps taken by the Trust during the current financial year to ensure that slavery and human trafficking has not taken place in any of its supply chains, and in any part of its own business.

2. Background

2.1 The Modern Slavery Act 2015 introduced changes in UK law, focused on increasing transparency in supply chains. Specifically, large businesses are now required to disclose the steps they have taken to ensure their business and supply chains are free from modern slavery (that is, slavery, servitude, forced and compulsory labour and human trafficking).

2.2 Commercial organisations that supply goods or services and have a minimum turnover of £36m are required to produce a Modern Slavery and Human Trafficking Statement each financial year.

2.3 The Statement must be approved at Board level, signed by a director and published in a prominent place on the organisation's website.

3. Analysis/Discussion

3.1 The 2022/23 Modern Slavery and Human Trafficking Statement has been reviewed by the Herts Procurement Team, the Human Resources Team and the Adult and Children Safeguarding Team.

3.2

3.3 There are no proposed changes to the previous statement in relation to human resources or safeguarding. Procurement changes are marked in red on the attached proposed Statement (appendix A).

3.4 If approved by the Board, the Statement will be signed by the Chief Executive and published on the Trust's website.

4. Risks

4.1 If the Trust fails to publish a Statement for the financial year, the Secretary of State may seek an injunction through the High Course requiring the Trust to comply. If the Trust fails to comply with the injunction, it will be in contempt of a court order, which is punishable by an unlimited fine. As well as posing a financial risk, this would also represent a reputational risk to the Trust.

5. Recommendation

6. The Quality Committee is asked to review the attached draft Statement and recommend it for approval by the Board.

Barbara Anthony
Trust Secretary

May 2023

Appendix A

2022/23 Modern Slavery and Human Trafficking Statement

1. Introduction

Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps they have taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business.

The aim of this Statement is to demonstrate that West Hertfordshire Hospitals NHS Trust follows good practice and all reasonable steps are taken to prevent slavery and human trafficking.

All members of staff have a personal responsibility for the successful prevention of slavery and human trafficking with the procurement department taking responsibility lead for overall compliance.

2. Structure and supply chains

The Trust provides acute healthcare services to a core catchment population of approximately half a million people living in west Hertfordshire and the surrounding area. It also provides a range of more specialist services to a wider population, serving residents of north London, Bedfordshire, Buckinghamshire and east Hertfordshire.

The Trust applies the NHS standard Terms and Conditions for PO's, Goods, Services and the provision of Goods and Services which are used for the majority of procurements and require suppliers to comply with relevant legislation. A large proportion of the goods and services procured are sourced through Government supply frameworks and contracts which also require suppliers to comply with relevant legislation. Social value considerations are also included in specifications and evaluation criteria where this is appropriate and legal to do so. The Trust procures goods and services from a range of providers and while contracts may vary from small one-off purchases to large service contracts, all spend is, with very few exceptions, subject to the NHS Standard terms and conditions which holds the supplier to adhere to the requirements of Modern Slavery, Environmental, social and labour law requirements,

3. Our policy on slavery and human trafficking

The Trust has zero tolerance of slavery and human trafficking and is committed to maintaining and improving systems, processes and policies to avoid complicity in human rights violation and to prevent slavery and human trafficking in its supply chain.

The Trust's policies, procedures, governance and legal arrangements are robust, ensuring that proper checks and due diligence are applied in employment procedures to ensure compliance with this legislation. The Trust also conforms to the NHS employment check standards within its workforce recruitment and selection practices, including through managed service provider contract arrangements.

4. Due diligence

To identify and mitigate the risks of modern slavery and human trafficking in its own business and its supply chain, the Trust:

- Undertakes appropriate pre-employment checks on directly employed staff and agencies on approved frameworks are audited to provide assurance that pre-employment clearance has been obtained for agency staff.
- Implements a range of controls to protect staff from poor treatment and/or exploitation, which complies with all respective laws and regulations. These include provision of fair pay rates, fair terms of conditions of employment and access to training and development opportunities.
- Consults and negotiates with trade unions on proposed changes to employment, work organisation and contractual relations.
- Purchases most of its products from UK or EU based firms, who ~~maybe~~ are also required to comply with the requirements of the UK Modern Slavery Act (2015) or similar legislation in other EU states.
- Purchases a significant number of products through the NHS Supply Chain, whose 'Supplier Code of Conduct' includes a provision around forced labour.
- The Trust requires all suppliers to comply with the provisions of the UK Modern Slavery Act (2015), through its purchase orders and tender specifications.
- Upholds professional codes of conduct and practice relating to procurement and supply, including through its procurement team's membership of the Chartered Institute of Procurement and Supply.
- Where possible and consistent with the Public Contracts Regulations, the Trust builds long-standing relationships with suppliers.

5. Training

The Trust has training in place to ensure frontline staff are vigilant to any potential cases of slavery and human trafficking and are equipped to take the appropriate action. Further information on modern slavery and human trafficking is available through the Trust's safeguarding children and adults policies and procedures and the safeguarding team.

6. Aim

The aim of this Statement is to demonstrate that the Trust follows good practice and all reasonable steps are taken to prevent slavery and human trafficking. All members of staff have a personal responsibility for the successful prevention of slavery and human trafficking with the procurement department taking responsibility lead for compliance in the supply chain.

7. Board approval

The Board has considered and approved this Statement and will continue to support the requirements of the legislation. The Statement has been reviewed in 2023 and it will continue to be reviewed and updated on an annual basis.

Matthew Coats
Chief Executive

Dated:

West Hertfordshire Teaching Hospitals NHS Trust

Trust Board
1 June 2023

Title of the paper	**Items considered in May 2023 Private Trust Board**
Agenda Item	**27**
Presenter	**Phil Townsend, Chair**
Author(s)	**Barbara Anthony, Trust Secretary**
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: *For information*: ✓
Executive Summary	To note in the public domain an outline of the matters covered in private, due to their confidential nature, since the last board meeting in public.
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: Trust Board Part 2 Date: May 2023
Action required	The Board is asked to take the report for information of the matters discussed at the last meeting in private (Part 2) session.

NHS
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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: • Main Outpatients Department • Radiology Services • Mortuary Services • Maternity Outpatients
3	**Perinatal Mortality Review Tool** The Board received an update from the Chief Nurse on the review of cases during the reporting period.
4	**Finance update** The Board received an update from the Chief Financial Officer on the current financial position.
5	**National staff survey- analysis** The Board received an update from the CPO on the analysis from the national staff survey.
6	**Strategy update** The Board received an update from the Chief Executive Officer.
7	**Elective Care Hub Briefing update** The Board received an update from the DDSACs on the progress with the Elective Care Hub.
8	**External Auditor** The Board received an update on the provision of external audit services.