West Hertfordshire Teaching Hospitals NHS Trust

# TRUST BOARD MEETING IN PUBLIC
# AGENDA
## 02 May 2024 at 9.30am – 12.00pm
## Medical Education Centre, Hemel Hempstead
## and via MS Teams for virtual attendees.

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Apologies should be sent to the Director of Governance on jeanhickman@nhs.net

| Time | Item ref | Title | Purpose | Accountable officer | Paper or verbal |
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| **Standing items** | | | | | |
| 09.30 | 1 | **Opening and welcome** | Information | Chair | Verbal |
| | 2 | **Patient story** | Information | Chair | Verbal |
| | 3 | **Apologies for absence** | Information | Chair | Verbal |
| | 4 | **Declarations of interest** | Information | Chair | Paper |
| | 5 | **Minutes of previous meeting 04 April 2024** | Approval | Chair | Paper |
| | 6 | **Board action log** | Information | Chair | Paper |
| | 7 | **Board decision log** | Information | Chair | Paper |
| | 8 | **Board work plan** | Information | Chair | Paper |
| | 9 | **Chair's report** | Information | Chair | Paper |
| | 10 | **Chief Executive's update**<br><br>10.1 **Chief Executive's report**<br>10.2 **Trust Management Committee assurance**<br>- Written report: March 2024<br>- Verbal report: April 2024 | Information | Chief Executive | Paper |
| **Quality and Safety** | | | | | |
| | 11 | **Quality and Safety Committee assurance**<br>- Written report: March 2024<br>- Verbal report: April 2024 | Information and assurance | Committee Chair | Paper |
| | 12 | **Report of the Independent Inquiry into the issues raised by the David Fuller case** | Information and assurance | Chief Nurse | Paper |
| | 13 | **Learning from deaths report** | Information and assurance | Chief Medical Officer | Paper |
| | 14 | **Perinatal quality surveillance report** | Information and assurance | Director of Midwifery | Paper |
| | 15 | **Response to CQC letter regarding paediatric audiology services** | Information and assurance | Director of Midwifery | Paper |
| **Finance and Performance** | | | | | |
| | 16 | **Finance and Performance Committee assurance**<br>- Written report: March 2024<br>- Verbal report: April 2024 | Information and assurance | Committee Chair | Paper |

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| | 17 | **Finance update** | Information and assurance | Acting Chief Financial Officer | Paper |
| | 18 | **Business plan 2024-2025 – Version 3** | Approval | Acting Chief Financial Officer | Paper |
| | 19 | **Performance report** | Information and assurance | Acting Chief Operating Officer | Paper |
| | 20 | **Integrated performance report** | Information and assurance | Chief Information Officer | Paper |
| **People, Education and Research** | | | | | |
| | 21 | **People, Education and Research Committee assurance**<br>- Verbal report: April 2024 | Information and assurance | Committee Chair/ Chief People Officer | Verbal |
| | 22 | **Freedom to Speak Up report** | Information and assurance | Chief People Officer | Paper |
| **Redevelopment** | | | | | |
| | N/A | Next meeting: 23 May 2024 | N/A | N/A | N/A |
| **Audit** | | | | | |
| | N/A | Next meeting: 23 May 2024 | N/A | N/A | N/A |
| **Risk and Governance** | | | | | |
| | 23 | **Board Assurance Framework report** | Approval | Chief Executive | Paper |
| | 24 | **Corporate risk management report** | Approval | Chief Medical Officer | Paper |
| | 25 | **Items considered in the April 2024 Private Board meeting** | Information and assurance | Director of Governance | Paper |
| **Closing Items** | | | | | |
| 11.55 | 26 | **Any other business previously notified to the Chair** | N/A | Chair | Verbal |
| | 27 | **Questions from Healthwatch Hertfordshire** | N/A | Chair | Verbal |
| | 28 | **Questions from patients and members of the public** | N/A | Chair | Verbal |
| | 29 | **Date of the next Board meeting:**<br>06 June 2024,<br>Executive Meeting Room, Watford General Hospital | Information | Chair | Verbal |

West Hertfordshire Teaching Hospitals NHS Trust

# Declarations of Board members and attendees' interests

## May 2024

**Agenda item: 04**

| Name | Role | Description of interest |
|---|---|---|
| **Phil Townsend** | Chairman | • None |
| **Matthew Coats** | Chief Executive | • None |
| **Jonathan Rennison** | Non-Executive Director | • Edgecumbe Consulting – Associate<br>• Director of The Yellow Chair Ltd<br>• Kings College London – OD & Learning & Development Activities<br>• West Hertfordshire Hospitals Trust Charity Committee Chair<br>• Trustee of Rising Tides Ltd |
| **Heather Moulder** | Non-Executive Director | • Managing Director /Owner HM Healthcare Solutions Ltd<br>• Chair NMC Interim Order Hearings<br>• Chair UKCP Complaint Hearings |
| **Harvey Griffiths** | Non-Executive Director | • Director - Anglo Chesham Management Limited<br>• Director - Anglo Industrial Holdings Ltd<br>• Director - Broadgate Freeholds Limited<br>• Director - Energy Capital Advisers Ltd<br>• Secretary – Gripworx Holdings Limited<br>• Director - Horizon (GP) Limited<br>• Director - Horizon Development Capital Limited |

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| | | • Director - Horizon Development Finance Limited<br>• Director - Horizon Housing REIT Plc<br>• Director - Horizon Hudson Holdings<br>• Director - Horizon Infrastructure Partnership Limited<br>• Director - Horizon Investment Holdings (One) Limited<br>• Director - Horizon Investment Holdings (Two) Limited<br>• Director - Horizon Investments (One) Limited<br>• Director - Horizon Investments (Two) Limited<br>• Director - Horizon Scotland (GP) Limited<br>• Director - Housing Investment Finance Limited<br>• LLP Designated Member - Infrastructure Partnership LLP<br>• Secretary - Just Property Management Ltd<br>• Director - Sustainable Infrastructure Partnership Ltd<br>• Director – Co-operative Energy Limited<br>• Director – Flow Energy Limited<br>• Director – Co-operative Payroll Giving Limited<br>• Director – The Midcounties WR1 Limited<br>• Director – The Midcounties WR2 Limited<br>• Director – Co-op Travel Services Limited<br>• Director – Co-operative Holidays Limited<br>• Director - Sustainable Infrastructure Partnership Ltd<br>• Statutory (executive) director of Credit Capital Corporation II Limited |
| **Natalie Edwards** | Non-Executive Director | • None |
| **Edwin Josephs** | Non-Executive Director | • Member of the Vine House Health Centre Patient Participation Group |
| **Helen Davis** | Associate Non-Executive Director | • Director and shareholder at Brierley Advisory LLP, secondment to NHP finished at end of January 2022.<br>• Partner is senior civil servant at DHSC |
| **Prof Ann Griffin** | Non-Executive Director | • Clinical Professor in Medical Education, UCL. |

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| | | • NHS appraisal – occasional employed work<br>• Associate revalidation and appeals panel, General Medical Council - occasional employed work |
| **Catherine Pelley** | Associate Non-Executive Director | • None |
| **Toby Hyde** | Chief Strategy and Collaboration Officer | • None |
| **Paul Bannister** | Chief Information Officer | • Chair of Shared Care Record Programme |
| **Kelly McGovern** | Chief Nurse | • None |
| **Andrew McMenemy** | Chief People Officer | • Lead for Workforce Modelling and Planning<br>• Lead for Temporary Staffing<br>• Member of Hertfordshire and West Essex ICS People Board |
| **Rodney Pindai** | Acting Chief Financial Officer | • Metro Health Network Ltd - Lead Finance Officer<br>• South Vernon Associates Limited |
| **Mary Bhatti** | Acting Chief Operating Officer | • None |
| **Dr Mike van der Watt** | Chief Medical Officer | • Owner and Director Heart Consultants Ltd<br>• Work for Hertfordshire and West Essex ICS for one day/week advising on quality and innovation. |
| **Alex White** | Chief Redevelopment Officer | • None |
| **Dr Niall Kenan** | Divisional Director, Medicine | • Consultant Cardiologist West Herts Teaching Hospitals NHS Trust, Honorary Clinical Senior lecturer, Imperial College London<br>• Wife (Dr Dominique Auger) is locum consultant cardiologist West Herts Teaching Hospitals NHS Trust (until 5/5/23) and Consultant cardiologist, Imperial College Healthcare NHS Trust (from 9/5/23)<br>• Board member and treasurer, BSCMR (British Society of Cardiovascular Magnetic Resonance)<br>• Finance and Investment Committees, BCS (British Cardiovascular Society)<br>• Scientific Documents Committee EACVI (European Association of Cardiovascular Imaging) |

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| | | • NHSE National Steering Group Virtual Wards<br>• Father (Prof Danny Keenan) is associate Medical Director at Manchester University NHS Foundation Trust and Medical Director of HQIP (Healthcare Quality Improvement Partnership)<br>• Shareholder in Mycardium AI (Cardiac Imaging AI company)<br>• Private practice at Spire Bushey Hospital and Chenies Mews Imaging Centre |
| **Mr Drostan Cheetham** | Divisional Director of Surgery, Anaesthetics and Cancer | • None |
| **Mr William Forson** | Divisional Director of WACS | • Private practice at Spire as Forson and Co Medical |
| **Dr Rachel Hoey** | Divisional Director of Emergency Medicine | • None |
| **Martin Keble** | Divisional Director of Clinical Support Services | • None |
| **Jean Hickman** | Interim Director of Governance | • None |

West Hertfordshire Teaching Hospitals NHS Trust

# TRUST BOARD MEETING IN PUBLIC

**04 April 2024 09:30am – 12:00pm**

## Minutes

**Agenda Item: 05**



| Chair | Title | Attendance |
|---|---|---|
| Phil Townsend | Chair | Yes |
| **Board members** | | |
| Matthew Coats | Chief Executive Officer | Yes |
| Jonathan Rennison | Non-Executive Director, Vice Chair | Yes |
| Heather Moulder | 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 |
| Catherine Pelley | Associate Non-Executive Director | No |
| Professor Ann Griffin | Non-Executive Director | Yes |
| Helen Davis | Associate Non-Executive Director | Yes |
| Dr Mike van der Watt | Chief Medical Officer | Yes |
| Kelly McGovern | Chief Nurse and Director of Infection Prevention and Control | Yes |
| Mary Bhatti | Acting Chief Operating Officer | No |
| Rodney Pindai | Acting Chief Financial Officer | Yes |
| Toby Hyde | Chief Strategy and Collaboration Officer | Yes |
| Alex White | Chief Redevelopment Officer | Yes |
| Paul Bannister | Chief Information Officer | Yes |
| Andrew McMenemy | Chief People Officer | Yes |
| **Clinical in attendance** | | |
| Dr Niall Keenan | Divisional Director for Medicine | Yes |
| Dr Rachel Hoey | Divisional Director for Emergency Medicine | No |
| Martin Keeble | Divisional Director for Clinical Support Services | No |
| Mr Drostan Cheetham | Divisional Director for Surgery, Anaesthetics and Cancer | Yes |
| Mr William Forson | Divisional Director for Women's and Children | Yes |
| Penny Snowden | Interim Divisional Director for Midwifery and Gynaecology | Yes |
| **In attendance** | | |
| Jean Hickman | Interim Director of Governance | Yes |
| Nick Foley | Director of Communication | Yes |
| Stephanie Johnson | Deputy Chief Operating Officer | Yes |
| Georgina Theobald | Corporate Governance Manager (minute taker) | Yes |
| Meg Carter | Hertfordshire Healthwatch | No |
| Members of the Public | | 8 |

## MEETING NOTES

| Standing items | |
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| **1** | **Opening and welcome** |
| 1.1 | The Chair welcomed Board members to the meeting, particularly new Associate Non-Executive Director Catherine Pelley, although she was noted to be on leave. He thanked staff for their hard work to improve patient flow at Watford, specifically the Chief Medical Officer, Chief Nurse, and Acting Chief Operating Officer. The Chair asked members to introduce themselves when speaking for the first time. |
| 2 | **Patient Story** |
| 2.1 | The Chief Nurse introduced Lily, a staff member and patient. Lily explained that in February 2023 she had attended the Watford Urgent Treatment Centre (UTC) with chest pain, was sent for an ECG, and was diagnosed with acid reflux. She did not have any blood tests or a chest x-ray and was sent home with medication. When there was no improvement, Lily attended the A&E department and had blood tests and a chest x-ray, however, after another ECG she was informed that she would move over to the Urgent Treatment Centre as it had opened. She became distressed as felt that she had not received the right level of service she would expect from the UTC but was not listened to or given any choice. She believed this was due to age discrimination. Lily was seen by a UTC doctor and after explaining her symptoms, the doctor attributed them to a history of anxiety. The doctor did not ask about her previous medical history and refused to refer Lily to the Acute Cardiac Unit (ACU) for 'anxiety chest pains'. Fortunately, the patient's mother worked in ACU and was able to directly arrange a referral. Lily received a series of tests in the ACU which revealed a mass in her left lung and suspected Hodgkin's Lymphoma, followed by a later diagnosis of Stage 4 metastatic melanoma. It was suggested that Lily's age and history of anxiety had been prejudged causing other diagnoses not to be considered. Lily thanked ACU, haematology, and dermatology services for the swift and potentially life-saving actions. |
| 2.2 | Heather Moulder, Non-Executive Director, thanked Lily for coming forward and asked what learning had been taken from the incident. The Chief Nurse explained that Lily was going to share the story at Emergency Department team meetings, which would include leads from UTC. |
| 2.3 | The Deputy Chief Operating Officer agreed that it was challenging to move patients between the ED and the UTC and that Lily's experience would be taken into account when the delivery of care was discussed. |
| 2.4 | Ann Griffin, Non-Executive Director, wondered how any changes would be embedded when staffing in A&E was fluid. The Chief Nurse assured the Board that a cultural change had begun and the new five-year strategy would help to progress and increase the change. However, she recognised that it would take time to achieve a complete culture change. |
| 2.5 | Harvey Griffiths, Non-Executive Director, asked Lily about her current health and she explained that she had originally been diagnosed with melanoma in 2018 and given the all-clear, however it had started in January 2023. Harvey Griffiths, Non-Executive Director, noted that UTC was an outsourced service and wondered how the cultural change could be carried into a partner organisation. The Chief Nurse confirmed that they were now working in a more integrated manner. |
| **3** | **Apologies for absence** |
| 3.1 | The attendance and apologies are recorded above. |
| **4** | **Declarations of interest** |
| 4.1 | The Chair reminded Board members to ensure they were keeping their electronic declaration of interest record up to date. |
| **5** | **Minutes of the previous meeting on 07 March 2024** |
| 5.1 | The minutes were approved subject to the three points below. |

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| | 1. Minute 5.1 contained an incorrect correction and should read 'replace Heather Moulder', not 'Jonathan Moulder'.<br>2. Minute 14.1 should read 'performance' not 'performance indicator'.<br>3. Minute 24.4 should read 'discrimination' and not 'fear'. |
| **6** | **Board Decision log** |
| 6.1 | The Chair noted the decision register was included for information. |
| **7** | **Board Action log** |
| 7.1 | It was noted that there were no outstanding actions. |
| **8** | **Chair's report** |
| 8.1 | The Chair presented his report and advised that a significant contract was signed with the Integrated Care Board to deliver pathology across a large number of providers, noting that it would take some time and that progress would be reported to the Quality and Safety Committee. The Chair reported that he had recognised through being involved in consultant interviews that the Trust was becoming more attractive to young consultants due to its innovation and future plans. |
| **9** | **Chief Executive Officer's Report** |
| 9.1 | The Chief Executive thanked staff that had worked on the urgent and emergency care pathway, reminding the Board of the importance of patient flow and highlighting a reduction in surge beds. He noted that elective care was also important and good progress was being seen in a reduction in long waiters. The Chief Executive noted that the new strategy would be reviewed later on the Board agenda and congratulated the staff that had worked on it, noting that it set the scene for the next chapter of the Trust and formed a common reference point for themes of partnership and collaboration going forward. He further emphasised the nature of the values of empowerment, compassion, professionalism, and inclusivity. The Chief Executive advised that Rachel Tustin would be taking on the role of Chief Operating Officer from May 2024. |
| **PERFORMANCE & COMMITTEE REPORTS** | |
| **10** | **Board Assurance Framework (BAF)** |
| 10.1 | The Chief Executive reported that the Board Assurance Framework (BAF) continued to be central to the articulation and transparency of risk. He advised that the BAF would be retained within the context of the new strategy and updated over the next few months to ensure it was aligned. The Board approved the BAF. |
| **11** | **Trust Management Committee** |
| 11.1 | The Chief Executive presented the Chair's report from the Trust Management Committee and confirmed that it would remain the key forum for the executive team to interact with divisions. |
| **12** | **Finance and Performance Committee** |
| 12.1 | The Finance and Performance Committee assurance report was presented by Harvey Griffiths, Non-Executive Director. He highlighted a good trajectory with performance, with pockets of excellence, particularly recently in ED, however, he noted some areas of challenge where work was ongoing to address. Harvey Griffiths noted that reducing the deficit would remain a key area of focus by reminding staff to continue being mindful of where efficiencies could be found. The forecast end-of-year deficit was identified at £13.5 million with assistance in the coming months from the Integrated Care System (ICS) and Integrated Care Board (ICB). |
| **13** | **Quality and Safety Committee** |
| 13.1 | Heather Moulder, Non-Executive Director, reported that the Assistant Director of Quality for the ICB had joined the membership of the Quality and Safety Committee. It was noted that the Committee had reviewed the corporate risk register, including ongoing mitigating actions against fourteen open risks, with particular assurance requested around a long-running bleep system risk and issues around the do not attempt to resuscitate (DNA CPR) print-outs. Heather Moulder, Non-Executive Director, stated that the Committee had been updated on the medicines optimisation strategy and on the latest position with regard to infection prevention and control. Privacy, dignity and well-being, dementia and disability |

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| | were identified as areas of issue in the PLACE assessments and it was confirmed that outstanding project timelines for the neonatal refurbishment's repatriation were on track. Internal CQC assessments had highlighted themes, including unsecured medication and out-of-date medication. The Board was informed that the transition to the Patient Safety Incident Response Framework was well underway with the pressure ulcer review. A Getting it Right First Time (GIRFT) action plan for gastroenterology had been reviewed and actions discussed. |
| 13.2 | The Chief Nurse assured the Board that out-of-date medicines were not being dispensed to patients as the issue was with stock not being rotated. |
| 13.3 | Edwin Josephs, Non-Executive Director, enquired to what extent the Trust was tied to the shared electronic patient record system with the Royal Free and whether it would be possible to get enhancements to resolve the DNA CPR printing issue. The Chief Information Officer responded that there was a certain amount the Trust could change at a top level before needing to negotiate and agree changes with the Royal Free London (RFL) NHS Trust however, finding appropriate workarounds required time. Edwin Josephs, Non-Executive Director, further wondered if there was a formal process to implement changes. The Chief Information Officer agreed that there were two Change Boards, one jointly with RFL, and a local Change Board. He noted that there was strong assurance and governance with the Chief Medical Officer and the Chief Nurse often involved in discussions. |
| 13.4 | Helen Davis, Associate Non-Executive Director, enquired what mitigations were in place to mitigate the risk of the bleep and telephony systems suffering a substantial failure. The Chief Information Officer admitted that due to annual leave he was unable to provide an full update on the bleep system pilot, however, he could confirm that it was expected to be completed in March 2024 for immediate rollout across the Watford site. It was reported that a business case was being developed for a telephony solution that balanced future needs and cost. |
| **14** | **People, Education and Research Committee** |
| 14.1 | Natalie Edwards, Non-Executive Director, took the report as read and highlighted promising performance indicators around reductions in staff turnover, with further work being done in emergency and environment, first-year leavers in nursing and midwifery, and vacancy rates. Good discussions were noted to have taken place around papers on the leadership development programme, women as medical leaders, and the staff survey and completion rates, with updates on electronic staff records and the regular reports received by the Committee. The Chief People Officer added that the staff survey report would come to the Board in May 2024, and that a refurbishment to the medical education department had been announced. |
| **15** | **Redevelopment Programme Committee** |
| 15.1 | Helen Davis, Associate Non-Executive Director, confirmed that the Redevelopment Programme Committee had received positive reports on current work at St. Albans and planned digital work to improve the patient journey. It had been noted that additional staff would be required to support ongoing enabling works and a Health and Safety Officer was now in place. |
| **16** | **Audit Committee** |
| 16.1 | Edwin Josephs, Non-Executive Director, advised that the paper was a written version of the verbal report he had given at the previous meeting. He reminded the Board of the Audit Committee's endorsement and recommendation to approve changes to the Standing Orders, which would be discussed under agenda Item 25. |
| **17** | **Performance Report** |
| 17.1 | The Deputy Chief Operating Officer noted that industrial action between 24 February and 28 February 2024 had adversely impacted on activity and performance and that a critical incident had been declared across the system on 7 February and 8 February 2024, when the Trust and several partners had been on Opal 4. Regarding urgent and emergency care, it was confirmed that all types of performance for ED were at 70.8%, an improvement from January 2024. Ambulance handovers remained a priority and were also showing an improvement, with over 60-minute handovers reduced to 5.3% from nearly 10% in January. The agreed trajectory for handover delays had been met and were continuing into March, |

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| | as reported to NHS England. The Emergency Assessment Unit was now supporting flow, with collaboration between emergency medicine and operational services, along with significant work on culture and leadership in the Emergency Medicine division. Performance in March 2024 was reported at 78.2%, and the Board was pleased to be informed that the Trust had been first in the region for ED performance on the first two days in April 2024. The Deputy Chief Operating Officer advised that work was ongoing across the system to support flow. The patient flow improvement programme was reported to be underway. The Deputy Chief Operating Officer explained that elective care had been impacted by industrial action and school holidays, with reduced delivery in February and the VWA slightly down at 90%. New outpatient activity was identified as being 4% lower than plan, with follow-up activity higher, and elective activity 5% better than plan, mainly in day case rates. Diagnostic activity against plan was confirmed to be positive, with performance improved to 90.9%. RTT for February 2024 was highlighted to have reported ten patients waiting over 78 weeks and 353 patients for 65 weeks. March was currently only reporting one complex patient over 78 weeks. It was reported that the main concern for the faster diagnosis cancer standard was within gynaecology services and the Board was assured that actions were being discussed to mitigate this and work was being carried out on the two-week wait pathway, as well as recruitment to address capacity issues. The Deputy Chief Operating Officer concluded her report by informing the Board that new planning guidance had recently been formally published and was now being worked through in terms of its implications. |
| 17.2 | The Chair wondered if an increase in media attention on cancer had increased referrals. The Divisional Director for Women's and Children stated that numbers remained steady, with the Deputy Chief Operating Officer adding that it was sometimes hard to determine any links. |
| 17.3 | Edwin Josephs, Non-Executive Director asked why Watford received 41% of ambulance conveyances compared to 33% in East and North Hertfordshire NHS Trust, and 26% in Princess Alexandra NHS Trust. The Deputy Chief Operating Officer responded that it seemed to be historical, and work was underway within the system to manage attendance and conveyance avoidance. The Chief Nurse suggested that Watford was more appealing due to the speed of the handover. The Chief Executive stated his belief that working partnerships within the system were improving, including work to direct ambulances to the most appropriate place for each patient, however, conveyancing rates were a longstanding issue. |
| 17.4 | Natalie Edwards, Non-Executive Director, queried how increased support and focus on emergency care would be sustained. The Deputy Chief Operating Officer responded that there were opportunities to learn from the changes that had been implemented and advised that the entire Trust should be actively involved, take ownership, and demonstrate leadership. The Chief Nurse added that changing the narrative to be more patient-focused had helped, as well as focusing on the four-hour target. The Chief Executive suggested that sustainability would come from changes in culture, leadership capability, and the use of data. |
| 17.5 | Heather Moulder, Non-Executive Director, referred to the enthusiasm of ED staff and the support felt from the Chief Nurse and the Chief Medical Officer, as well as the shift from corridor care being acceptable. |
| 17.6 | Heather Moulder, Non-Executive Director, asked for an update on the UTC recovery plan. The Deputy Chief Operating Officer responded that a remedial action plan in 2023 had led to improvements, however, performance had now deteriorated, and an additional remedial action plan was now being discussed. The Acting Chief Financial Officer confirmed that a settlement had been reached regarding an activity query notice. |
| 17.7 | Jonathan Rennison, Non-Executive Director asked what actions were being taken to improve weekend discharge performance. The Deputy Chief Operating Officer noted that systems and processes in place during the week were not available at the weekend, however assured that discussions were underway on how this could be improved. |

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| **18** | **Integrated Performance Report** |
| 18.1 | The Chief Information Officer presented the integared performance report. He highlighted that mortality indices continued to increase, with HSMR reaching 105.3, however, this had been based on a provisional report and data including uncoded activity, with the fully coded data now indicating a value of 101.6 that was statistically in normal variation. SHMI was reported to still be an exception due to a run of points above the mean but within the Dr Foster expected rate. It was identified that rates of emergency readmissions for elective patients remained low, with other indicators remaining stable, and nursing fill rates in common cause variation for the second month. It was noted that the Trust was 41st in February for all types of emergency performance, and the third lowest in the region for twelve-hour trolley waits. The Chief Information Officer added that the Trust was second lowest in the region for both 65-week and 78-week waits. The workforce was reported to be stable, with numbers starting to increase. The Chief Information Officer reported a higher number of clock-stops, clock-starts for RTT, and a slightly higher number of referrals. |
| 18.2 | Edwin Josephs, Non-Executive Director asked how long the Trust was expecting to extend a contract on a mobile MRI scanner. The Acting Chief Financial Officer confirmed that it was to March 2025. |
| 18.3 | Edwin Josephs, Non-Executive Director asked for assurance that criteria for business cases for additional staff would include ongoing funding of posts. The Acting Chief Financial Officer confirmed that this was already covered. |
| 18.4 | It was noted that the Trust was between 4% and 6% higher than national values for caesarean section rates. The Divisional Director for Women and Children assured that actions were being taken to address this issue. |
| 18.5 | In response to a question about the drivers for SHMI performance, the Chief Medical Officer reported that there had been an issue with data quality and coding. He advised that improvements would take time to show in the data due to the length of the reporting cycle, and that there had also been an increase in how it was measured nationally. |
| **Aim 1: Best Care** | |
| **19** | **Better Care Delivered Differently final report** |
| 19.1 | The Chief Strategy and Collaboration Officer delivered the final Better Care Delivered Differently report and thanked the strategy team for drafting the report. He noted that the framework would be tied to the new strategy, which would be presented for approval later on the Board agenda. The Chief Strategy and Collaboration Officer reported on progress against elements of the strategy and assured that ongoing actions would be followed through into the new strategy. |
| 19.2 | Ann Griffin, Non-Executive Director, brought attention to a discussion in the medical press concerning the cost-effectiveness of virtual hospitals and inquired about the Trust's confidence in the potential financial savings of its model. The Divisional Director for Medicine responded the cost per bed day in the Trust's virtual ward was highly cost-effective. The Acting Chief Financial Officer agreed and suggested the cost of a virtual ward was around a third of a physical one and advised that this would be reported as part of a benefit realisation exercise. Heather Moulder, Non-Executive Director, reminded the Board on the importance of determining whether patients would otherwise be in a physical bed. The Divisional Director for Medicine confirmed this was the case, and that the acuity of the Trust's virtual ward was at the highest level. It was suggested that the virtual hospital, as part of a strong and successful partnership with Central London Community Healthcare, should be examined in depth by one of the Board's committees. |
| **2: Great Team** | |
| **20** | **Fit and Proper Persons regulations update** |
| 20.1 | The Chief People Officer presented a report on the updated Fit and Proper Persons regulations. It was reported that three Board members had already completed the necessary verifications, including social media screening and disclosure and barring service (DBS) checks. The remaining Board members were scheduled to undergo the process in May 2024, with a full report expected to be presented to the Board in June 2024. |
| **21** | **High-impact change action plan for equality, diversity and inclusion** |
| 21.1 | A report on a high-impact change action plan for equality, diversity and inclusion was presented by the Chief People Officer. He explained that the paper proposed core |

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| | objectives for building into appraisal template reports, with the aim of implementing these from 2025. The process would be monitored by the People, Education and Research Committee and through to the Board. |
| 21.2 | During a discussion about how staff networks could effectively report and escalate actions, as well as ensure accountability of executives and the Board, the Chief People Officer highlighted the need for greater attention to enhance equity across staff networks. The Chief Executive concurred, acknowledging the importance of formalising connections between the Board and staff networks. |
| 21.3 | Natalie Edwards, Non-Executive Director, enquired whether there were any plans for training or a Board development session on equality, diversity and inclusion. The Chief People Officer confirmed that this was being discussed. |
| **Aim 2: Best Value** | |
| **22** | **Finance update** |
| 22.1 | The Acting Chief Financial Officer reported on the latest financial position. He highlighted a £7.24 million surplus in the month, with £15.2 million received from the ICB in February 2024. It was reported that £4.6 million had already been accounted for, with an underlying improvement to of £10.6 million, and a normalised position of £8.3 million deficit, of which the forecast had been £.6 million. The Acting Chief Financial Officer advised that the Trust was £2.7 million away from the forecast in February 2024, of which £1 million was related to industrial action. It was noted that this was an improvement on the underlying position for the month, however, it was not yet a trend, so monitoring and controls would continue. Emergency pressures and surge capacity were identified as drivers, although the latter was acknowledged to be reducing. Excess inflation of roughly £2.6 million was also identified as a key contributor. The Acting Chief Financial Officer stated that the year-end forecast was currently £13.5 million due to winter pressures and under-funding from the emergency pathway. The initial expectation from the ICB was for a £9.3 million forecast, leading to a £4.2 million difference, which was currently being worked out with systems being assessed as systems, resulting in a financial balance across the ICS. Elective work was identified as continuing to improve, with around £2 million of value-weighted over-performance as a result. It was noted that managing the cash balance would remain a key focus. The Acting Chief Financial Officer reported that managing cash and balances would be key through the year, with a £10.9 million cash balance at the end of February likely to out-turn around £4 million, although the unexpected receipt of £15 million meant the cash balance could be as high as £8 million at the end of the year. The year-to-date spend on capital was confirmed to be just under £45 million, with the year's programme totalling £71 million, and the significant pathology contract to have been signed in March. |
| 22.2 | Edwin Josephs, Non-Executive Director enquired why actual divisional income was negative in the month and the Acting Chief Financial Officer responded that it was likely to be due to a re-allocation as £4.6 million of the £15 million settlement had been received in divisional income but the remainder had been part of the NHS revenue. |
| 22.3 | Harvey Griffiths, Non-Executive Director, acknowledged positive forecasts for in-month performance and noted that once assistance had been taken out there remained negatives and associated risks. He wondered why the expected improvements had not been achieved. The Acting Chief Financial Officer explained that the underlying position for the month would have improved if the effects of the industrial action had also been taken out and assured the Board of an emphasis on the sustainability of changes going forward. |
| 22.4 | Heather Moulder, Non-Executive Director, asked how the gap in expected performance was impacting relationships with other organisations in the ICS. The Chief Executive stated that he believed relationships were good with no points of particular tension as all trusts were finding it challenging. |
| 22.5 | Heather Moulder, Non-Executive Director, wondered if there had been progress in understanding the drivers of the underlying structural deficit. The Chief Executive confirmed that work had begun but no updates were available at the current time. |
| 22.6 | Natalie Edwards, Non-Executive Director, questioned what processes were in place to empower lower-level staff to submit requisitions on workforce modelling. The Board was informed that this would be taken into account in the 2024-25 planning, triangulating finances and budget, workforce plan, and activity plan. The training package was confirmed to include elements on managing budgets appropriately. |

| Risk and Governance | |
|---|---|
| **23** | **Strategy 2024 – 2029** |
| | **Vision, values and strategy** |
| 23.1 | The Chief Strategy and Collaboration Officer presented the Trust's 2024-2029 strategy and thanked all those involved in putting the strategy together. He highlighted some of the Trust's successes to date, along with plans, and significant challenges that were expected, explaining the strategy's purpose was a decision-making framework over the next five years. The strategy was developed around three 'whats'; quality and safety of patient services, rebuilding the estate and designing and delivering services in partnership and three 'hows'; embedding improvement in everything, building effective working relationships, across both the Trust and its partnerships and maximising opportunities associated with data and technology. The Chief Strategy and Collaboration Officer added that four new organisation values would support the strategy; empowered, compassionate, professional and inclusive. He concluded his report by emphasising that this was the beginning of this important work which was the start of the Trust's next phase. |
| 23.2 | Heather Moulder, Non-Executive Director, asked how the Board could be ensured that the strategy document was a living document and the Chief Strategy and Collaboration Officer responded that a commitment had been made to a yearly review of progress against the strategy, which would allow for course corrections and updates, with some work outlined in the strategy expected to continue beyond 2029. |
| 23.3 | The Board approved the 2024-2029 Strategy. |
| **23a** | **Accountability framework** |
| 23a.1 | The Board received the Accountability Framework from the Chief Nurse who explained that the framework was intended to set out expectations for how everyday business was run, roles, responsibilities, accountability, and the values lived. She noted that it would go hand-in-hand with the behaviour framework currently being developed and that the quality and safety element would be the first introduced. The Chief Nurse advised that the Board would receive quarterly updates and that responsibility would be passed to the new Chief Operating Officer when she took up the post in May 2024. |
| 23a.2 | Jonathan Rennison, Non-Executive Director, noted the importance of confirming the role of assurance committees and asked for confirmation on the timescale of the behavioural framework. The Chief Strategy and Collaboration Officer confirmed the behaviour framework would be completed by the end of quarter one and the Chief Executive suggested that any changes to the framework would be presented to the Board for approval. The Board was assured that the Accessibility Framework would not impact on the current Board or committee governance structure, and sub-committees would strengthen governance and accountability. The Chief Nurse added that the Terms of Reference for the Quality and Safety Committee would be refreshed to ensure its purpose was clear. |
| 23a.3 | Heather Moulder, Non-Executive Director, thanked the Chief Nurse, the Chief Strategy and Collaboration Officer, and their teams for their work on the Framework and asked for the timeline for a refresh of the clinical strategy. The Chief Strategy and Collaboration Officer responded that the refresh was expected to take around twelve months to complete to ensure proper engagement with clinical teams. Heather Moulder, Non-Executive Director, noted that it should align with the timeline for the redevelopment. |
| 23a.4 | Natalie Edwards, Non-Executive Director, reminded the Board that cultural change took more than a document and a rollout, and wondered what the plan was to measure progress and success. The Chief Executive explained that the behavioural framework was a vehicle to set out the next steps for the new Trust values, what they would mean for different staffing groups, and how they would be embedded, followed up, and measured against. It was suggested that recent work on urgent emergency care had demonstrated the values worked and were being lived already. |
| 23a.5 | The Board approved the Accountability Framework. |
| **24** | **Board and Committee Terms of Reference and work plans 2024-25** |
| 24.1 | The Interim Director of Governance presented a paper which asked the Board to approve the updated Terms of Reference and work plans for the Board, Finance and Performance Committee, Audit Committee, Remuneration Committee, Redevelopment Programme |

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|---|---|
| | Committee, and People Education and Research Committee. It was noted that the Terms of Reference for the Charity Committee would be approved by the Corporate Trustee and Terms of Reference and work plans for the Quality and Safety Committee and Trust Management Committee would be presented to the Board for approval once they had been reviewed against the new Accountability Framework. |
| 24.2 | Harvey Griffiths, Non-Executive Directive highlighted that the Terms of Reference for the Finance and Performance Committee was the only Committee with a provision for a patient panel representative to be part of the membership. He noted that this was a long-standing arrangement and noted the importance of ensuring governance around confidentiality. The Chief Executive suggested that the Board should take a strategic look at patient engagement once the Quality and Safety Committee refresh was complete. |
| 24.3 | The Terms of Reference for the Board, Finance and Performance Committee, Audit Committee, Remuneration Committee, Redevelopment Programme Committee, and People Education and Research Committee were approved. |
| **25** | **Standing Orders update** |
| 25.1 | The Interim Director of Governance presented an amendment to the Trust's Standing Orders to increase the number of vice chairs from one to two. She advised that this amendment would help the Chairman to share responsibilities and support the Board with challenges going forward. The Interim Director of Governance advised that the Audit Committee had considered and recommended the amendment for Board approval. |
| 25.2 | Edwin Joseph, Non-Executive Director suggested that research was needed into item 2.1.6 of the Standing Orders relating to the statutory obligations of Corporate Trustees to ensure all aspects are captured in the statutory framework<br>**Action:** Research item 2.1.6 of the Standing Orders relating to the statutory obligations of Corporate Trustees to ensure all aspects are captured in the statutory framework. |
| 25.3 | The amendment to the Standing Orders to increase the number of vice chairs from one to two was approved by the Board. |
| **26** | **Corporate Risk Register** |
| 26.1 | The Chief Medical Officer presented the Corporate Risk Register (CRR) and identified fourteen open risks. There was one new risk relating to DNA CPR, currently scored at 16, however there were plans to review the scoring. A risk relating to the electrical infrastructure at Watford had been reduced from 15 to 12 and removed from the CRR, although the same risk at St. Albans was unchanged. A risk around the failure of the telephony system had increased and been added to the CRR, however the Chief Medical Officer advised that it was going to be combined with a risk around capacity of the system. It was confirmed that the Head of Patient Risk was now Chairing the Risk Review Group and the Chief Medical Officer would remain accountable. The Board approved the CRR. |
| **27** | **Items considered in the March 2024 Private Board meeting** |
| 27.1 | The Board noted the items discussed at the March 2024 Board meeting in private. |
| **28** | **Any other business previously notified to the Chair** |
| 28.1 | There was no other business previously notified. |
| **29** | **Questions from Healthwatch Hertfordshire** |
| 29.1 | There were no questions from Healthwatch Hertfordshire |
| **30** | **Questions from our patients and members of the public** |
| 30.1 | Q1. What are the dates for the promised public engagement on the Trust's proposals for acute redevelopment?<br>A1. The Chief Redevelopment Officer responded that the Trust had continuously engaged with patients, staff and the public on its redevelopment plans. The Trust remained committed to continuous and meaningful engagement throughout the various phases of its redevelopment programme. Once the Trust had finalised the detailed timetable with colleagues in the New Hospital Programme, it would confirm its engagement timetable for the next phase of the Watford General Hospital redevelopment. |
| 30.2 | Q2. What is the target date for approval of the business case for acute redevelopment?<br>A2. The Chief Redevelopment Officer replied that the Trust was working with the New Hospital Programme to finalise its timetable for business case approval to meet the Secretary of State for Health and Social Care's commitment to the commencement of the main works at Watford General Hospital in 2026. |

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| 30.3 | Q3. One of the major parties has stated that, if elected, and before committing to 'any more money', it would 'make an assessment of all NHS capital projects to make sure money is getting allocated efficiently, that we are eliminating waste, and that we are prioritising the projects that will get the patients the care they deserve faster.'<br>In view of this and other political uncertainties, what contingency plans are in place to make any changes that might become necessary to the Trust's plans for acute redevelopment?<br>A3. The Chief Redevelopment Officer replied that the best way to optimise value for money and accelerate patient access to state-of-the-art healthcare was to progress the Trust's redevelopment programme without delay. To that end, the Trust was working closely with the New Hospital Programme and NHS England to ensure it met the Secretary of State's start date for the new Watford General Hospital in 2026. |
| **31** | **Date of the next Board Meeting** |
| 31.1 | The next meeting was confirmed to be on 2 May 2024, Medical Education Centre, Hemel Hempstead Hospital and MS Teams. |

West Hertfordshire Teaching Hospitals NHS Trust

**Agenda item: 07**

# Trust Board Meeting in Public

## 02 May 2024

## Action log

| No | Date of meeting | Minute ref | Action | Lead for completing the action | Date to be completed | Update |
|---|---|---|---|---|---|---|
| 1 | 04 April 2024 | 25.2 | Research item 2.1.6 of the Standing Orders relating to the statutory obligations of Corporate Trustees to ensure all aspects are captured in the statutory framework. | Interim Director of Governance | June 2024 | |

| Board Decision Log | | | |
|---|---|---|---|
| **Board meeting/ decision date** | **Decision reference (from minutes)** | **Item presented to Board for action** | **Comments/ outcome** |
| 04-Apr-24 | 23.3 | Strategy 2024-2029, including vision, values and strategy | The Board approved the 2024-2029 strategy |
| 04-Apr-24 | 23a.5 | Accountability Framework | The Board approved the Accountability Framework |
| 04-Apr-24 | 24.3 | Board and Committee Terms of Reference and Work Plans<br>Board<br>Audit Commitee<br>Finance and Performance Committee<br>Redevelopment Programme Committee<br>People Education and Research Committee | The Board approved the Committee Terms of Reference and Work Plan |
| 04-Apr-24 | 25.3 | Amendment to Standing Orders to move from one vice-chair to two | The Board approved the amendment |

| TRUST BOARD WORK PLAN 2024/25: Part 1 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Venue** | **WFT** | **Hemel** | **WGH** | **SACH** | **n/a** | **WGH** | **Hemel** | **SACH** | **WGH** | **n/a** | **WGH** | **WGH** |
| Opening and welcome | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Service presentation/patient story | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | | | ✓ | ✓ |
| Apologies for absence | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Declarations of interest | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Minutes of previous meeting | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Board action log | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Board work plan | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Board decision log | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Chair's report | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Chief Executive's report | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| **Performance & Committee updates** | | | | | | | | | | | | |
| People, Education and Research Committee | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Audit Committee | ✓ | | ✓ | ✓ | | | ✓ | ✓ | ✓ | | | ✓ |
| Finance and Performance Committee | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Quality and Safety Committee | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Trust Management Committee | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Redevelopment Programme Committee | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Performance Report | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Integrated Performance Report | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| **Aim 1: Best Care** | | | | | | | | | | | | |
| Board assurance framework | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Quality improvement update | | ✓ | | | | | | | | | | |
| Bi-annual establishment review – maternity | | | | ✓ | | | | | | | | ✓ |
| Bi-annual establishment review report – adult inpatient wards | | | | ✓ | | | | | | | → | ✓ |
| Annual establishment review report – Paediatrics Emergency Department | | | | ✓ | | | | | | | | |
| Establishment review - Neonates | | | | | | | | ✓ | | | | |
| Maternity Quarterly Oversight Report | | | ✓ | | | ✓ | | ✓ | | | ✓ | ✓ |
| Maternity Incentive Scheme (MIS) Year 5 Declaration | | | | | | | | | ✓ | | | |
| Annual report on infection prevention and control | | | | | | | | | ✓ | | | |
| Annual report on 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 on end of life care | | | | | | ✓ | | | | | | |
| Annual report on complaints and patient advice and liaison | | | | ✓ | | | | | | | | |
| Annual report on serious incidents and never events | | | | ✓ | | | | | | | | |
| Quarterly learning from deaths report | | ✓ | | | | ✓ | | | ✓ | | | ✓ |
| Patient engagement strategy | | | ✓ | | | | | | | | | |
| Annual assurance report: emergency preparedness, resilience and response | | | | | | | ✓ | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patient Safety Incident Response Framework (PSIRF) update (rollout) | | | | ✓ | | | | | | | | |
| Annual report on 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 Delivery System | | | | ✓ | | | | | | | | ✓ |
| 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 and strategy | | ✓ | | | | | | | ✓ | | | |
| High impact change action plan for equality, diversity and inclusion | ✓ | | | | | | | | | | | |
| Annual report on Guardian of Safe Working | | | | | | ✓ | | | | | | |
| Teaching Hospital Benefits update | | | | | | | ✓ | | | | | |
| Fit and Proper Persons Compliance Report (FPPR Report) | | ✓ | | | | | | | | | | |
| Fit and Proper Persons Regulation Report (FPPR Report) | ✓ | | | | | | | | | | | |
| **Aim 4: Great Place** | | | | | | | | | | | | |
| Strategy 2024 - 2029, including vision, values and strategy + accountability framework (approval) | ✓ | | | | | | | | | | | |
| Strategy update | ✓ | | ✓ | | | ✓ | | ✓ | | | ✓ | |
| Better Care Delivered Differently report (final) | ✓ | | | | | | | | | | | |
| Green Plan - annual review | | | | | | ✓ | | | | | | |
| Digital progress Report | | | ✓ | | | ✓ | | | ✓ | | | ✓ |
| Progress update on major capital projects (outline business cases/full business cases) | As required | | | | | | | | | | | |
| Redevelopment update | ✓ | | | ✓ | | | ✓ | | | ✓ | | |
| **Risk and governance** | | | | | | | | | | | | |
| Standing orders update | ✓ | | | | | | | | | | | |
| Quality and Safety Committee Refresh | | ✓ | | | | | | | | | | |
| Charity Committee strategy | | ✓ | | | | | | | | | | |
| Accountabilty Framework review/update | | | | ✓ | | | ✓ | | | | ✓ | |
| Corporate risk register report | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Board and committee terms of reference and work plans review | ✓ | ✓ | | | | | | | | | | |
| Annual review of Board and committee effectiveness | | | ✓ | | | | | | | | | |
| Items consider for Private Trust Board | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Board and committee meeting schedule | | | | | | ✓ | | | | | | |
| Audit Committee annual report | | | | ✓ | | | | | | | | |
| Annual statement of actions taken to prevent slavery and human trafficking | | | ✓ | | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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** | | | | | | | | | | | | |
| **Closing** | | | | | | | | | | | | |
| Any other business previsouly notified to the Chair | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Questions from Hertfordshire Healthwatch | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Questions from the public | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Date of next board meeting | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |

West Hertfordshire Teaching Hospitals NHS Trust

**Trust Board Meeting**
**2 May 2024**

| | |
|---|---|
| **Title of the paper** | **Chair's Report** |
| **Agenda Item** | **9** |
| **Presenter** | **Phil Townsend, Chair** |
| **Author(s)** | **Carolyn Greeves, Chief of Staff** |
| **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**<br>*(please indicate which of the 4 aims is relevant to the subject of the report)* | **Aim 1 Best care** — *Objectives 1-4*: x<br>**Aim 2 Great team** — *Objectives 5-8*: x<br>**Aim 3 Best value** — *Objective 9*: x<br>**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?<br>☐ Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?<br>☐ Is there a culture of high quality, sustainable care?<br>x☐ Are there clear responsibilities, roles and systems of accountability to support good governance and management?<br>☐ Are there clear and effective processes for managing risks, issues and performance?<br>x☐ Is appropriate and accurate information being effectively processed, challenged and acted on?<br>x☐ Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?<br>☐ Are there robust systems and processes for learning, continuous improvement and innovation?<br>☐ 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. |

9

West Hertfordshire Teaching Hospitals NHS Trust

**Agenda Item: 9**

**Trust Board Meeting – 2 May 2024**

**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

### Vice Chair Nominations

2.1 As we look ahead to the implementation of the Trust's new strategy, the evolution of our HCP and greater system collaboration, I would like to strengthen the Vice Chair role. To that end, I would like to nominate to the Board that two Non-Executive Directors, Professor Ann Griffin and Edward Joseph be considered for the role. They would both be Vice Chairs. To allow time for other Board members to consider this, I will not finalise the decision until the June Board. Assuming there are no objections, their terms as Vice Chair would start on the 1 July 2024.

### HM Lord-Lieutenant of Hertfordshire Appointed Patron of West Herts Hospital Charity

2.2 The Lord-Lieutenant of Hertfordshire Robert Voss CBE CStJ Hon LLD, the King's personal representative in the county, has been appointed patrol of Raise, the official charity for West Herts Hospitals Charity. As patron the Lord-Lieutenant will reinforce the charity's position as a key partner in the local community and support its growth.

2.3 The Lord-Lieutenant said he was delighted to be appointed to the role and was committed to supporting initiatives that improve healthcare outcomes and enhance the well-being of individuals in the community. Alison Rosen, CEO of Raise, stated that they were immensely grateful for the Lord-Lieutenant for coming on board as the first ever patron.

### Wellbeing Garden Appeal

2.4 The latest appeal for our hospital's charity, Raise, is to fund a new garden for patients and staff. This has started to grow roots after volunteers from the Wickes community programme visited to paint the brickwork which will surround the garden. The Wickes

community programme have also generously donated two pergolas for the garden which will provide a sheltered area. The garden will be a sanctuary nestled within the heart of the women's and children's services building at Watford General and has been designed to provide patients and staff respite from the busy hospital. It will also provide the restorative benefits of the outdoors.

**Passover**

2.5 Passover started on Monday 22 April and ended on the nightfall of 20 April. Passover celebrates the deliverance of the Jewish people from slavery in Egypt, as told in the Bible. Working with Rabbi Yosef Sharfstein from the Bushey Chabad Jewish Community Centre, the Trust marked this by presenting Passover Matzah to our Jewish patients at Watford on Monday 22 April.

**Parkinson's Awareness Day**

2.6 We were reminded that 11 April was World Parkinson's Day and the importance of understanding and supporting patients with Parkinson's disease within our Trust. Our Parkinson's team works hard to support and assist our patients affected by the disease and to offer the best care possible.

## 3 Community News

**Retirement**

3.1 April saw the retirement of two long-servicing members of staff. Firstly, Amanda Jackson, has retired after 45 years of service. An amazing achievement. Mandy's most recent role in the Trust has been as the Parkinson's Disease nurse. Mandy has helped the Trust develop an enhanced service for our patients, for which we are very grateful. Mandy will be greatly missed by her colleagues and patients.



3.2 Secondly we say thank you and goodbye to Hilary Quarman after 30 years at West Herts. Hilary has delivered chemotherapy and many other treatments to patients with great care and compassion, professionalism and kindness. She has also given support to patients' families. Hilary has been a great support to her colleagues and her extensive knowledge and skills have been of countless benefit to student and postgraduate nurses.

**Launch of Solo Parents Network**

3.3 I am pleased to announce the launch of the solo parents' network. The network provides a space for people to meet and discuss the challenges of solo parenting, sharing experiences and advice. The network will run safe space sessions where members and visitors can speak without fear of judgment and gain the perspective of others. The group will also liaise with the staff experience team to ensure everyone knows about the Trust support that is already in place for solo parents.

## 4 Hertfordshire and West Essex ICS

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

## 5 BOARD NEWS

Board visit programme for May:

5.1 Urgent Treatment Centre
Outpatients Department
Endoscopy Unit

## 6 Chair's meetings:

6.1 I have attended the following meetings since the report to the last Board meeting:

- Board preparation
- Trust Board meeting
- Key sub committees
- Governance arrangements
- Consultant / Trust Secretary interviews
- CEO strategy meetings
- ICB Chairs' meeting
- CEO and Chair Session
- Conversations with lead MPs on our strategy
- Chairs and CEO session on ICB medium term plan

## 7 RECOMMENDATION

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

**Phil Townsend**
**Chair**

30 April 2024

West Hertfordshire Teaching Hospitals NHS Trust

**Trust Board Meeting**
**02 May 2024**

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|---|---|
| **Title of the paper** | **Chief Executive's Report** |
| **Agenda Item** | **10** |
| **Presenter** | **Matthew Coats, Chief Executive** |
| **Author(s)** | **Carolyn Greeves, Chief of Staff** |
| **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, Department of Health and Social Care, NHS Providers and the Care and Quality Commission. |

**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 |

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| **Links to well-led key lines of enquiry** | ✓ Is there the leadership capacity and capability to deliver high quality, sustainable care?<br>✓ Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?<br>✓ Is there a culture of high quality, sustainable care?<br>✓ Are there clear responsibilities, roles and systems of accountability to support good governance and management?<br>✓ Are there clear and effective processes for managing risks, issues and performance?<br>✓ Is appropriate and accurate information being effectively processed, challenged and acted on?<br>✓ Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?<br>✓ Are there robust systems and processes for learning, continuous improvement and innovation?<br>✓ 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. |

10.1

West Hertfordshire Teaching Hospitals NHS Trust

**Agenda Item: 10**

**Trust Board Meeting – 02 May 2024**

**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

### Patient Services

2.1 I would like to thank the divisions for their continued hard work and focus on the patients attending hospital through our emergency care pathway. The Trust has achieved the 76% target which was set last year. In fact, the Emergency Department performed at 78.2% for all types and are now the 22nd out of 122 Trusts across the country. The teams are focusing on embedding and sustaining changes made during the last few months. This will continue to improve the patient care and experience when attending our hospital.

### Senior Staffing

2.2 Many thanks to Andrew McMenemy for his 4 years' service at the Trust. He is leaving next week to join Essex Partnership University NHS Foundation Trust. Julie Hull, a very experienced HR Director has joins us as an interim and the permanent recruitment takes place on 14 May. Similarly, many thanks to Mary Bhatti for covering as Interim Chief Operating Officer. Rachel Tustin joins us from The Royal Marsden on 7 May.



## 3 CHIEF OFFICERS UPDATES

### Chief Medical Officer

### NHS England Visit to Maternity

3.1 Thank you to the maternity department who received positive feedback from their recent 6 monthly visit from NHS England in April. Congratulations on the excellent outcome.

### Chief Finance Officer

3.2 For the 2023/24 financial year we will report a £13.8 million deficit (balanced financial position for Herts and West Essex ICS) and a £72 million capital investment in enhancing our estate and equipment infrastructure.

3.3 Moving into the 2024/25 financial year, our goal is to manage our revenue and apital finances economically, efficiently, and effectively. However, we acknowledge the need for a continued productivity increase in elective patient activities to maintain funding levels and reduce waiting times for patients. Our financial management strategy includes achieving £26.6 million in new savings underpinned by enhanced cost control measures on expenditure across the organisation. I would like to thank everyone for their continued support.

**Chief Nurse**

**Feedback from Healthwatch**

3.3 I am delighted to share the news that Healthwatch, Hertfordshire's independent health and social care champion, has been collecting patient feedback over the past six months and they have reported a significant improvement in the overall satisfaction with our care. The feedback is overwhelmingly positive, highlighting the high quality of care our patients are receiving. This is a true testament of the hard work, dedication and commitment to excellence at the Trust. Well done everyone, this is a fantastic achievement.

**First Anniversary of Badgernet**

3.4 In April we celebrated the first anniversary of the implementation of Badgernet, the maternity electronic patient record system which allows patients to view their maternity records via an online portal. Accessed from a smartphone or any device, Badgernet replaces handheld notes through pregnancy and the postnatal period. It has proved a great success.

**Samantha Behagg**

3.5 Congratulations to Samantha Behagg, Bereavement Midwife, who won a special recognition award for Bereavement Midwife of the Year at the Mariposa Awards. These awards recognise excellence in baby bereavement care across the NHS. Thank you Samantha for all your hard work.

**Welcome**

3.6 I would like to welcome Emma Mitchener and Antonio Sierra to the Trust. Emma has joined us in her new role as Head of Midwifery. Antonio has rejoined the team as Consultant Midwife.

**Chief Operating Officer**

3.7 Work continues with system partners focusing on both internal and external reasons for delayed discharges. This collaborative approach has already reduced the patients waiting in our beds who do not meet the criteria to reside by 23% over the last 6 months. Nationally there has been a 2% increase. Thank you to all those that participate in this work for your continued efforts and achievement to date.

3.8 At the beginning of the financial year Dermatology was an area that was struggling with the increase in two week wait referrals, however due to the services hard work and proactive approach they have greatly improved their clinic capacity and are now achieving the 75% Faster Diagnoses Standard. I would like to thank the clinical and operational teams for their continued efforts to improve this even further.

3.9 Having reduced the 78 week waits to one in March 2024, services are now turning their focus on those waiting 65 weeks to produce similar improvements and better care for patients by the end of September 2024

## 4 NEWS AND DEVELOPMENTS

### New Strategy Launch

4.1 At our April Board meeting our new five-year strategy was approved. Thank you to Toby Hyde and his team for all their hard work as we celebrate the launch. Our values of empowerment, compassion, profession and inclusive will drive the right culture and environment for us all to thrive. Our vision of excellent patient care together will highlight our service delivery and work in partnership to provide the best possible care. Thank you to everyone who has worked on the new strategy and will transform services, facilities and care across the region for thousands of people. At the heart of the strategy are our patients, as we continue to develop the best possible care for our communities.

### Tongue Tie Service

4.2 I would like to congratulate and thank the new tongue-tie service who treated their 100th baby this month. This service cares for newborn babies struggling to feed due to a condition with their tongues, providing support for the babies and their families. The tongue-tie procedure is quick and simple and improves feeding. Congratulations to the team for all their hard work.

## 5 RECOMMENDATION

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

**Matthew Coats**
Chief Executive

30 April 2024

West Hertfordshire Teaching Hospitals NHS Trust

**Agenda item: 10.2**

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| **Report to:** | **Trust Board** |
| **Title of Report:** | **Assurance report from Trust Management Committee** |
| **Date of Committee meeting:** | **13 March 2024 – Urgent Matters**<br>**27 March 2024 – Meeting cancelled** |
| **Quoracy:** | **The meeting was quorate** |
| **Date of Board meeting:** | **02 May 2024** |
| **Recommendation:** | **For information and assurance** |
| **Chair:** | **Chief Executive Officer** |
| **Purpose:** | This report provides an update to the Trust Board on actions and developments in March 2024. |
| **Background:** | The Committee meets monthly and provides assurance to the Board:<br>• Delivery of the clinical strategy<br>• Revenue investment up to £1m<br>• Operational performance<br>• Operational risk<br>• Safety and business continuity<br>• Information technology<br>• Internal and external communication strategy<br>• Clinical quality<br>• Business planning<br>• Environment |
| **Assurances received and items for update:** | **Summary:**<br>Assurance was provided on the monitoring of operational, financial and clinical performance and the development, implementation and monitoring of strategy.<br>**Regular reports received and discussed for assurance:**<br>• None |

10.2

**Additional reports and updates were received and discussed for information and assurance:**

- None

**Reports received for approval:**

- Business case to extend the current provision of a mobile MRI scanner at Hemel Hempstead Hospital (approved)

**Verbal reports were received from:**

- None

**Other reports:**

- None

**Any other business:**

- None

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| **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. |

**10.2**

West Hertfordshire Teaching Hospitals NHS Trust

**Agenda item: 11**

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| **Report to:** | **Trust Board** |
| **Title of Report:** | **Assurance report from Quality and Safety Committee** |
| **Date of Committee meeting:** | **28 March 2024** |
| **Quoracy:** | **The meeting was quorate** |
| **Date of Board meeting:** | **02 May 2024** |
| **Recommendation:** | **For information and assurance** |
| **Chair:** | **Heather Moulder, Non-Executive Director** |

**Purpose:**

The report summarises the assurances received, and approvals of recommendations made to the Quality and Safety Committee at its meeting on 28 March 2024.

The purpose of the Quality and Safety 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.

The Committee was joined by Chris Harvey Assistant Director of Nursing and Quality HWE ICB who praised the work of the maternity leadership team in reducing maternity staffing vacancies.

**Background:**

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
- Chair's report from Quality and Safety Group
- Quality Integrated Performance Report (QIPR)

**Additional reports received and discussed for information and assurance:**

- Medicines Optimisation Update Report April 2023 -September 2023)
- Patient-led Assessments of the Care Environment Report (PLACE)
- Neonatal Ventilation Update
- CQC Mock Visits Update
- Pressure Ulcer Update
- PSIRF Update
- GIRFT Gastroenterology Update

- Better Care Delivered Differently Programme Q3 and final report

**Assurances received and items for update:**

**The Committee noted the following:**

The committee received the updates to the Corporate Risk Register including the ongoing mitigating actions against the 14 open risks and progress towards removal. The committee sought particular assurance in relation to the risk regarding Trust bleep system failure including an update on the bleep app pilot as this is a longstanding risk and the pilot is taking time to conclude. The committee discussed the new corporate risk highlighting that currently the EPR system does not permit the full functionality required to ensure that DNACPR documentation can be printed and disseminated during discharge. An EPR solution is hampered by that other providers in SWH are moving to ReSPECT forms and wish there to be a unified approach across the patch – however Royal Free have decided not to go with ReSPECT which creates issues with EPR.

The committee noted the areas of progress against the current Medicines Optimisation Strategy and the current areas of challenge including level of vacancies, operational pressures such as surge, virtual wards and unfunded areas such as homecare services. Improvement methodology is in place to seek to achieve the stretch TTA dispensing target currently 60mins against stretch target of 45 mins.

The Trust maintains compliance with medicine storage requirements and planned assurance audits. Compliance with controlled drug management was high at 97% with ongoing training. Work to improve antimicrobial stewardship continues across the Trust with SPC charts used across the monthly antibiotic measures to help understand variation and improve key measures.

Data collection regarding the prompt switching of IV antimicrobial treatment to oral route as soon as patients meet the switch criteria (data collection not possible in quarters 1 and 2 due to lack of resource).

The committee further notes the collective approach to medicine safety across the ICS.

The panel noted the improved position in relation to complaints being responded to within agreed timescales.

There was robust discussion of the QIPR in particular HCAI (see below) and HMSR/SHMI. The MD gave assurance regarding the data and the committee will be keeping this area under close review.

The committee heard that the Trust has reached its trajectory for C difficile infections and a total of 4 MRSA blood stream infections have been identified The committee noted that to manage HCAI in line with PSIRF. The IPC team are trialling with the divisions a renewed approach to IPC governance as part of April –December 23 HCAI infections review. Divisional progress will be reported back to the IPC Panel.

The committee note the results of the 2023 PLACE assessments in particular the above national average score for cleanliness of 98.64%. However, whilst scores for Privacy, Dignity and Wellbeing Dementia and disability had improved since 2022 they scored well below the national average particularly at WGH.

Whilst many of the failures are due to the current estate the team were challenged to ensure that we were doing all we can to improve, and that advice was being sought and taken from clinical specialists and those with lived experience.

The committee noted the outstanding project timelines for the Neonatal Unit refurbishment to complete for the planned repatriation of services for the first week of May 2024

The committee noted the clinical areas covered by the regular CQC mock inspections since January 2024. The two most common themes of regulatory breaches are expired and unsecured medication. The same themes are reoccurring with minimal divisional engagement, therefore a escalation meeting has been planned with senior leaders on the 9th April to agree actions required to significantly improve compliance – this work will have Chief Nurse oversight

The committee noted the update on the Trust's transition to full implementation of PSIRF. The committee were particularly pleased to see the PSIRF thematic review methodology being applied to Pressure Ulcer incidents in 2024. The themes identified have been developed into an improvement plan with identification of divisional leads to drive the improvements.

The Committee noted the progress that had been made on the completion of the Gastroenterology GIFT action plan. It was a comprehensive report by Dr Mark Fullard. Two out of the three Amber actions are reliant on successful consultant recruitment in order to fully move to green status. For the third amber action ongoing discussions with anaesthetic colleagues should resolve the issue of having anaesthetic supported endoscopy lists. There was an in-depth discussion in relation to lack of access to out of hours interventional radiology service. The CMO and Chief Strategy Officer have been tasked with leading on brokering a potential ICS solution.

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| **Risks to refer to risk register:** | None. |
| **Issues for the Board to note:** | None. |
| **Recommendation to the Board:** | Corporate Risk Register and BAF - approved; Risk Governance Group amended terms of reference – approved. |

West Hertfordshire Teaching Hospitals NHS Trust

# Trust Board Meeting
# 02 May 2024

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| **Title of the paper** | **Phase 1 Report of the Independent Inquiry into the issues raised by the David Fuller case.** |
| **Agenda Item** | **12** |
| **Presenter** | **Kelly McGovern, Chief Nurse** |
| **Author(s)** | **Natalie Whittle, Divisional Manager of Clinical Support Services**<br>**Charlotte Coles, Deputy Divisional Manager of Clinical Support Services** |
| **Purpose** | *For approval*: <br>*For discussion*: <br>*For information*: X |
| **Executive Summary** | The purpose of this report is to provide the Committee with the recommendations that have arisen from Phase 1 of the Independent Inquiry into the issues raised by the David Fuller case.<br><br>In November 2021 the Secretary of State for Health and Social Care announced an independent inquiry into the issues raised by the actions of David Fuller, an electrical supervisor who sexually abused the bodies of 101 women and girls in the mortuaries at Kent and Sussex hospital and Tunbridge Wells hospital between 2005 and 2020.<br><br>Phase 1 of the Independent Inquiry focussed on matters relating to Maidstone and Tunbridge Wells NHS Trust and its system partners and concluded in November 2023. The Phase 1 report includes 17 recommendations that have arisen from the evidence heard during the course of the Inquiry to date.<br><br>Phase 2 of the Independent Inquiry will now focus on considering procedures and practices in NHS hospital settings across England, and a self-assessment return was submitted by West Hertfordshire Teaching Hospitals NHS Trust as requested by the Chair of the Independent Inquiry as this next phase commences.<br><br>In anticipation of Phase 2, a review of the practices at West Hertfordshire Teaching Hospitals NHS Trust against the 17 recommendations has been undertaken – with key areas of focus identified and an action plan developed. |
| **Trust strategic aims**<br><br>*(please indicate which of the 4 aims is relevant to the subject of the report)* | **Aim 1 Best care** – *Objectives 1-4*: √<br>**Aim 2 Great team** – *Objectives 5-8*:<br>**Aim 3 Best value** – *Objective 9*:<br>**Aim 4 Great place** – *Objective 10-12*: |

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| **Links to well-led key lines of enquiry** | ☐Is there the leadership capacity and capability to deliver high quality, sustainable care?<br>☐Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?<br>☐Is there a culture of high quality, sustainable care?<br>☒Are there clear responsibilities, roles and systems of accountability to support good governance and management?<br>☒Are there clear and effective processes for managing risks, issues and performance?<br>☐Is appropriate and accurate information being effectively processed, challenged and acted on?<br>☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?<br>☒Are there robust systems and processes for learning, continuous improvement and innovation?<br>☐How well is the trust using its resources? |
| **Previously considered by** | <table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td>Quality and Safety Committee</td><td>25/04/2024</td></tr></table> |
| **Action required** | The Quality and Safety Committee is asked to receive the recommendations that have arisen from Phase 1 of the Independent Inquiry, alongside our own local areas of focus following self assessment against these recommendations. |

12

West Hertfordshire Teaching Hospitals NHS Trust

**Agenda Item12**

**Public Trust Board – 02 May 2024**

**Phase 1 Report of the Independent Inquiry into the issues raised by the David Fuller case**

**Presented by: Kelly McGovern, Chief Nurse**

## 1. Purpose

1.1 The purpose of this report is to provide the Committee with the recommendations from the Phase 1 report from the Independent Inquiry into the issues raised by the David Fuller case.

1.2 Alongside our own gap analysis undertaken to against these recommendations, we recently completed a self-assessment return relating to existing procedures and practices in West Hertfordshire Teaching Hospitals NHS Trust was submitted to the Chair of the Independent Inquiry as Phase 2 commenced.

## 2. Background

2.1 The mortuary security issues at the Maidstone and Tunbridge Wells NHS Trust have been well documented and a public enquiry announced in November 2021. The Phase 1 report of the Independent Inquiry makes 17 recommendations relating to Mortuary Services:

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| **David Fuller's offending** |
| Recommendation 1: Maidstone and Tunbridge Wells NHS Trust must ensure that non-mortuary staff and contractors, including maintenance staff employed by the Trust's external facilities management provider, are always accompanied by another staff member when they visit the mortuary. For example, maintenance staff should undertake tasks in the mortuary in pairs. |
| Recommendation 2: Maidstone and Tunbridge Wells NHS Trust must assure itself that all regulatory requirements and standards relating to the mortuary are met and that the practice of leaving deceased people out of mortuary fridges overnight, or while maintenance is undertaken, does not happen. |
| **David Fuller's employment and work practices** |
| Recommendation 3: Maidstone and Tunbridge Wells NHS Trust must assure itself that it is compliant with its own current policy on criminal record checks and re-checks for staff. The Trust should ensure that staff who are employed by its facilities management provider or other contractors are subject to the same requirements. |
| **Mortuary management and oversight by Maidstone and Tunbridge Wells NHS Trust** |
| Recommendation 4: Maidstone and Tunbridge Wells NHS Trust must assure itself that its Mortuary Managers are suitably qualified and have relevant anatomical pathology technologist experience. The Mortuary Manager should have a clear line of accountability within the Trust's management structure and must be adequately managed and supported. |
| Recommendation 5: The role of Mortuary Manager at Maidstone and Tunbridge Wells NHS Trust should be protected as a full-time dedicated role, in recognition of the fact that this is a complex regulated service, based across two sites, that requires the appropriate level of management attention. |
| **Security arrangements at Maidstone and Tunbridge Wells NHS Trust** |
| Recommendation 6: Maidstone and Tunbridge Wells NHS Trust must review its policies to ensure that only those with appropriate and legitimate access can enter the mortuary. |

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| Recommendation 7: Maidstone and Tunbridge Wells NHS Trust must audit implementation of any resulting new policy and must regularly monitor access to restricted areas, including the mortuary, by all staff and contractors. |
| Recommendation 8: Maidstone and Tunbridge Wells NHS Trust should treat security as a corporate not a local departmental responsibility. |
| Recommendation 9: Maidstone and Tunbridge Wells NHS Trust must install CCTV cameras in the mortuary, including the post-mortem room, to monitor the security of the deceased and safeguard their privacy and dignity. |
| Recommendation 10: Maidstone and Tunbridge Wells NHS Trust must ensure that footage from the CCTV is reviewed on a regular basis by appropriately trained staff and examined in conjunction with swipe card data to identify trends that might be of concern. |
| **The Wider System** |
| Recommendation 11: Maidstone and Tunbridge Wells NHS Trust must proactively share Human Tissue Authority reports with organisations that rely on Human Tissue Authority licensing for assurance of the service provided by the mortuary. |
| Recommendation 12: Kent County Council and East Sussex County Council should examine their contractual arrangements with Maidstone and Tunbridge Wells NHS Trust to ensure that they are effective in protecting the safety and dignity of the deceased. |
| **Board Assurance** |
| Recommendation 13: We have illustrated throughout this Report how Maidstone and Tunbridge Wells NHS Trust relied on reassurance rather than assurance in monitoring its processes. The Board must review its governance structures and function in light of this. |
| Recommendation 14: Maidstone and Tunbridge Wells NHS Trust Board must have greater oversight of licensed activity in the mortuary. It must ensure that the Designated Individual is actively involved in reporting to the Board and is supported in this. |
| Recommendation 15: Maidstone and Tunbridge Wells NHS Trust should treat compliance with Human Tissue Authority standards as a statutory responsibility for the Trust, notwithstanding the fact that the formal responsibility under the Human Tissue Act 2004 rests with the Designated Individual. The Act will be subject to review in Phase 2 of the Inquiry's work. |
| Recommendation 16: The Chief Nurse should be made explicitly responsible for assuring the Maidstone and Tunbridge Wells NHS Trust Board that mortuary management is delivered in such a way that it protects the security and dignity of the deceased. |
| Recommendation 17: Maidstone and Tunbridge Wells NHS Trust must treat the deceased with the same due regard to dignity and safeguarding as it does its other patients. |

2.2 Sir Johnathan Michael, Chair of the Independent Inquiry, wrote to all Trusts on 29 February 2024 launching Phase 2 of the inquiry. This phase will consider whether procedures and practices in NHS hospital settings across England, where deceased people are kept, are sufficient to safeguard the security and dignity of the deceased and would prevent the inappropriate access and opportunity to abuse the deceased.

2.3 The Independent Inquiry requested a response in the form of an online questionnaire from all NHS Trusts relating to existing procedures and practices. Our self-assessment was returned on 3 April 2024.

2.4 During Phase 2 the Inquiry team will be contacting Trusts to undertake stakeholder interviews, request document supply and/or site visits for the purpose of understanding current arrangements and procedures.

## 3. Analysis/Discussion

3.1 Mortuary Services within West Hertfordshire Teaching Hospitals NHS Trust (WHTHT) are provided across two sites – Watford General Hospital, and Hemel Hempstead General Hospital. Mortuary services sit within the Clinical Support Services Division, with executive oversight provided by the Chief Nurse. Our Designated Individual is Dr Fiona Scott, a Consultant Histopathologist.

3.2 Phase 1 of the Independent Inquiry makes 17 recommendations relating to the Mortuary Services which have been reviewed by the Clinical Support Services divisional leadership team. We have identified the following areas of focus:

- Ensure that all non-mortuary staff are supervised or should undertake tasks in pairs during visits to the Mortuary.
- Confirm compliance with our policy on criminal record checks and rechecks for staff.
- Review policies to ensure that only those with appropriate and legitimate access can enter the Mortuary.
- Review access to restricted areas and upgrade current access control system to enable this.
- Enable greater oversight of licensed activity within the Mortuary and ensure that the Designated Individual is actively involved in reporting to the Board.
- Approach Mortuary security as a corporate, rather than departmental, responsibility.
- Confirm the explicit responsibility of the Chief Nurse in relation to Mortuary Management.
- Treat the deceased with the same due regard to dignity and safeguarding as other patients across all settings.

3.3 We will work with the Chief Nurse to implement our local action plan to address the areas of focus identified from this gap analysis.

## 4. Recommendation

4.1 To note the recommendations that have arisen from Phase 1 of the Independent Inquiry. Additionally, to receive our self-assessed areas of focus in improving Mortuary services at West Hertfordshire Teaching Hospitals NHS Trust. It is proposed to then return, with an update, to the Quality and Safety Committee once Phase 2 of the Independent Inquiry has concluded.

**Kelly McGovern**
**Chief Nurse**

April 2024

**Appendix 1: Conclusions and recommendations of the Phase 1 Report**

# Chapter 10: Conclusions and recommendations

David Fuller was employed by, or worked as a contractor for, the NHS for 31 years, from 1989 to 2020. His employment started only two years after he committed the brutal murders of two young women in Kent, whose deceased bodies he sexually assaulted. There can be no doubt that responsibility for the 140 known offences against deceased women and girls in the mortuaries at Maidstone and Tunbridge Wells NHS Trust (the Trust) lies with David Fuller. The question the Inquiry was set up to examine is how on earth was David Fuller able to commit these offences and remain undetected over such a prolonged period? What went wrong to allow this to happen and what needs to be in place to prevent it ever happening again?

The NHS was and remains a caring organisation, into whose hands millions of people entrust their care each year. During the years of David Fuller's offending, the NHS was subject to legislation, regulation and standards on how to ensure safe care for all patients. These requirements were supported by extensive guidance to organisations on how to deliver best practice. Over the 15 years that David Fuller was known to offend, many of these regulatory requirements increased and evolved, but the basic principle remained that patients admitted under the care of NHS organisations should be able to expect the best treatment the NHS is capable of, provided with care and compassion. The public's reasonable expectation was that the same care and compassion would be shown by the NHS to the deceased as to the living.

However, despite a plethora of regulation, David Fuller was able to offend undetected until his arrest. The idea of a necrophiliac murderer seeking employment in the NHS to be better able to pursue his predilections is such an unlikely scenario that most would consider it incredible. However, it happened. Why did the legislative and regulatory shield not protect the deceased in Maidstone and Tunbridge Wells?

Over the years, the regulatory requirements that should have protected the deceased in the care of Maidstone and Tunbridge Wells NHS Trust were either insufficient or were not followed by those in a position of responsibility. It seems to be an unfortunate fact that gaps in safety or regulatory shields are often only identified and closed after somebody has taken advantage of them. History has shown that this even occurs in the most regulated of environments, such as the airline and nuclear industries. Regulations and their associated standards of policy and practice are designed not only to deliver best practice but also to provide effective discouragement of bad or inappropriate practice whether deliberate or accidental. As well as being effective, regulation needs to be proportionate and to recognise the existence and management of risk.

In making findings and recommendations, the Inquiry identifies gaps in regulation, in governance and in management that together allowed David Fuller to offend. The national regulatory framework and its effectiveness will be reviewed in Phase 2 of the Inquiry.

David Fuller's known offending took place over 15 years, during which time NHS and Trust governance and management structures and responsible personnel changed many times. We received information during the course of the Inquiry that suggested internal controls may have been lacking in the mortuary in one of the predecessor organisations of the Trust seven years before David Fuller's first known offence. The Inquiry has named individuals whom we have identified as being directly involved in the running and management of the Trust, the private facilities management provider and the mortuary service, as well as managing David Fuller himself. We have also named those in senior management or governance positions in these services who had opportunities to identify or correct the systemic weaknesses that allowed David Fuller to commit his crimes.

The recommendations that follow arise from the evidence that we have heard and reviewed in the course of the Inquiry.

## 1. 10.1 David Fuller's offending

David Fuller was able to sexually abuse the bodies of deceased women and girls in the mortuaries of Kent and Sussex Hospital and Tunbridge Wells Hospital because he was allowed unaccompanied access to the mortuaries in his role as an electrical maintenance supervisor. He was most likely to offend between 6pm and 8pm, and second most likely to offend between 4pm and 6pm, when mortuary staff had left for the day.

David Fuller also offended in the mortuary at Tunbridge Wells Hospital during working hours, when staff should have been on duty. The Inquiry has not been able to understand how David Fuller was able to commit his crimes during mortuary working hours when staff were scheduled to be on duty. Despite the potential explanations provided by the mortuary staff, the Inquiry does not consider it likely that staff could have been in the mortuary at these times.

The practice of allowing David Fuller unaccompanied access to the mortuary at the Trust was not compliant with the Human Tissue Authority standard 2017 relating to security, which states: *"Security arrangements should ensure oversight of visitors and contractors who have a legitimate right of access."* It was also not compliant with the conditions of the Kent County Council contract with the Trust for post-mortem services.

### Recommendation 1

- **Maidstone and Tunbridge Wells NHS Trust must ensure that non-mortuary staff and contractors, including maintenance staff employed by the Trust's external facilities management provider, are always accompanied by another staff member when they visit the mortuary. For example, maintenance staff should undertake tasks in the mortuary in pairs.**

The bodies of deceased people were left out of the mortuary fridges overnight at Kent and Sussex Hospital and at Tunbridge Wells Hospital. This practice does not safeguard the dignity of the deceased, and increased David Fuller's opportunities to offend. David Fuller was allowed to undertake maintenance tasks in the post-mortem room while deceased people were out of the fridges: a practice that was entirely inappropriate and contrary to Human Tissue Authority standards.

### Recommendation 2

- **Maidstone and Tunbridge Wells NHS Trust must assure itself that all regulatory requirements and standards relating to the mortuary are met and that the practice of leaving deceased people out of mortuary fridges overnight, or while maintenance is undertaken, does not happen.**

## 2. 10.2 David Fuller's employment and work practices

When David Fuller applied for his first substantive NHS role and when he applied for promotion to the role of supervisor in 2002, he falsely claimed that he had no convictions to declare on his application form.

David Fuller did not disclose his criminal convictions directly to the Trust, and Interserve (Facilities Management) Ltd (Interserve) did not notify the Trust of his convictions when it became aware of them in 2011 and again in 2015. This was in breach of the contract between Interserve and the Special Purpose Vehicle and the agreement with the Trust. There was no process of review in 2011 and 2015 that would have shown David Fuller's previous failure to disclose his convictions when he was appointed to his NHS role in 1989 and promoted in 2002. Although he might not have been barred from continuing his employment, we consider that knowledge of his convictions could have led to questions about his honesty and closer scrutiny of his actions when taken together with his other behaviour.

### Recommendation 3

- **Maidstone and Tunbridge Wells NHS Trust must assure itself that it is compliant with its own current policy on criminal record checks and re-checks for staff. The Trust should ensure that staff who are employed by its facilities management provider or other contractors are subject to the same requirements.**

**The Inquiry will consider the wider issue of the use and effectiveness of criminal record checks for employment that involves access to the deceased in Phase 2 of its work.**

## 3. 10.3 Mortuary management and oversight by Maidstone and Tunbridge Wells NHS Trust

The management and supervision of the mortuary service at the Trust between 2005 and 2020 was woefully inadequate and failed to safeguard or protect the dignity of the deceased.

Problems in the mortuary were known to members of the Trust executive team from as early as 2008. The Inquiry heard that there was virtually no on-site supervision, limited oversight and limited assurance by the management arrangements. A member of the mortuary staff who was strongly criticised in an independent report in 2009 was actually appointed as the lead anatomical pathology technologist to implement the programme of improvement. This was an inexplicable decision. The Inquiry considers that the lack of oversight allowed a culture to develop in the mortuary where Standard Operating Procedures were routinely ignored and security breaches were not thoroughly investigated. This culture created the environment in which David Fuller was able to offend.

Anatomical pathology technologists are not a regulated profession. The leadership of the anatomical pathology technologists at the Trust was inadequate and they adopted working practices that were not in line with recognised good practice or Human Tissue Authority requirements. Mortuary staff felt isolated from the rest of the Trust, received minimal supervision, did not have access to Continuing Professional Development and felt that senior management ignored them.

### Recommendation 4

- **Maidstone and Tunbridge Wells NHS Trust must assure itself that its Mortuary Managers are suitably qualified and have relevant anatomical pathology technologist experience. The Mortuary Manager should have a clear line of accountability within the Trust's management structure and must be adequately managed and supported.**

### Recommendation 5

- **The role of Mortuary Manager at Maidstone and Tunbridge Wells NHS Trust should be protected as a full-time dedicated role, in recognition of the fact that this is a complex regulated service, based across two sites, that requires the appropriate level of management attention.**

**The Inquiry will consider the issue of regulation of mortuary staff in Phase 2 of its work.**

## 4. 10.4 Security arrangements at Maidstone and Tunbridge Wells NHS Trust

The security systems in place at the Trust between 2005 and 2020 were inadequate. The Trust failed to put in place adequate security systems to monitor staff access to restricted areas. David Fuller was given access to a key to the mortuary at Kent and Sussex Hospital from his appointment as an electrical maintenance supervisor in 2002. His access to the mortuary was not monitored as there was no system of monitoring in place for those who had keys. After 2007, there was no system of monitoring access to the mortuary for those who were signing keys out of the switchboard.

From 2011, David Fuller was given full access to the mortuary at the new Tunbridge Wells Hospital site via his individual swipe card. This swipe card enabled him to access the mortuary 444 times in just one year, between December 2019 and December 2020. Data on those accessing the mortuary via their swipe cards was collected but never reviewed. As a result of these inadequate systems, David Fuller was given unchecked and unmonitored access to the mortuary, which allowed him to commit sexual offences against deceased people.

The Trust did not recognise the importance of ensuring the security of its estate, nor the potential safety impact that security lapses might have on those for whom it held responsibility, including the deceased.

### Recommendation 6

- **Maidstone and Tunbridge Wells NHS Trust must review its policies to ensure that only those with appropriate and legitimate access can enter the mortuary.**

### Recommendation 7

- **Maidstone and Tunbridge Wells NHS Trust must audit implementation of any resulting new policy and must regularly monitor access to restricted areas, including the mortuary, by all staff and contractors.**

### Recommendation 8

- **Maidstone and Tunbridge Wells NHS Trust should treat security as a corporate not a local departmental responsibility.**

The Inquiry considers that the Trust senior executives failed to listen to mortuary staff and successive Designated Individuals regarding the necessity of installing CCTV in the mortuary. The Inquiry has identified that discussions about the installation of CCTV in the Kent and Sussex Hospital mortuary took place as early as 2008. Further discussions about the subject continued in 2013/14 and again in 2017/18. We heard that CCTV was not installed in the mortuary until 2020. The delay in installing CCTV was for financial reasons. The Trust failed to prioritise the safety of the mortuary in a way that could have protected deceased people resting in it.

### Recommendation 9

- **Maidstone and Tunbridge Wells NHS Trust must install CCTV cameras in the mortuary, including the post-mortem room, to monitor the security of the deceased and safeguard their privacy and dignity.**

### Recommendation 10

- **Maidstone and Tunbridge Wells NHS Trust must ensure that footage from the CCTV is reviewed on a regular basis by appropriately trained staff and examined in conjunction with swipe card data to identify trends that might be of concern.**

## 5. 10.5 The wider system

There have been many external organisations involved in assessing the Trust's mortuaries over the years. The framework of external oversight did not detect and address serious issues at the Trust's mortuaries, including lax security, non-compliance with policies, and inadequate management arrangements.

NHS trusts are accountable to NHS England for the services they provide. In the case of Maidstone and Tunbridge Wells NHS Trust, NHS England took little interest in the licensed activity that was being undertaken in the mortuary at the Trust. It was easily reassured that all was well.

A variety of organisations assessed and inspected the mortuaries at the Trust during the time that David Fuller was offending, but they did not detect the lack of security and access controls that allowed it to happen, and they did not provide the necessary guidance to rectify these problems.

The Human Tissue Authority's focus is on licensed activity and seemed too ready to accept reassurance about compliance with its requirements rather than assurance. This can be summarised by the difference between 'tell me' and 'show me'.

The fact that the Care Quality Commission inspected the mortuary is unhelpful and confusing, given that its legislative framework does not refer to mortuary services (although its end of life pathway framework does).

The UK Accreditation Service (UKAS) assessments are designed for laboratories not mortuaries, concerned more with the process for handling tissue samples than the wider management of the mortuary.

These organisations did not work together and had no formal mechanism for sharing their reports and any concerns. The fact that three organisations inspected the mortuary gave the impression of effective external regulation, which reassured the Trust and other stakeholders, but none identified or addressed the systemic weaknesses that created the environment in which David Fuller offended.

The Health and Safety Executive did not have a process in place to share with the Human Tissue Authority its concerns about the lack of assessment of risk of injury to staff involved in the manual transfer of the deceased.

The current safeguarding legislation does not extend to the deceased and thus the Trust's safeguarding assessments excluded the mortuary.

### Recommendation 11

- **Maidstone and Tunbridge Wells NHS Trust must proactively share Human Tissue Authority reports with organisations that rely on Human Tissue Authority licensing for assurance of the service provided by the mortuary.**

**The Inquiry will consider the current legislation and system of regulation and oversight of mortuaries, the legislation in relation to safeguarding with regard to the deceased, and the responsibilities of the various regulators charged with ensuring the security and dignity of the deceased in more detail in Phase 2 of its work.**

We understand that at least 79 of David Fuller's victims were under the legal control of the coroner when David Fuller sexually abused them. While coroners have legal control of the body of the deceased until their coronial functions come to an end, they do not have a duty or obligation to safeguard, monitor or otherwise ensure the proper treatment of the deceased in their control. The Inquiry will consider this situation in Phase 2 of its work.

Council officials involved in the placement of coroners' cases at the Trust relied on the Trust and the Human Tissue Authority as regulators of the Trust's mortuary services to ensure that sufficient processes were in place to safeguard the security and dignity of the deceased, and they therefore did not seek assurance on this. The Inquiry intends to consider the role and responsibilities of local authorities in respect of the provision of mortuary services in Phase 2 of its work.

### Recommendation 12

- **Kent County Council and East Sussex County Council should examine their contractual arrangements with Maidstone and Tunbridge Wells NHS Trust to ensure that they are effective in protecting the safety and dignity of the deceased.**

## 6. 10.6 Board assurance

The governance structures in place at the Trust were overly complex. This complexity, lack of effective reporting mechanisms and ineffective delegation arrangements meant that serious issues regarding the mortuary and the Human Tissue Authority requirements received little focus at the Quality Committee and did not reach the Trust Board.

The Board did not consider the requirements of the Human Tissue Authority in sufficient detail. There was an over-reliance on the Designated Individual to ensure the requirements of the Human Tissue Authority were being met.

Concerns about the mortuary management and security outlined in Chapters 4 and 5 did not reach the Trust Board. The Board did not therefore have the opportunity to discuss these or to receive assurance on action to address the concerns. The Board did not receive assurance regarding statutory regulated activity in the mortuary.

### Recommendation 13

- **We have illustrated throughout this Report how Maidstone and Tunbridge Wells NHS Trust relied on reassurance rather than assurance in monitoring its processes. The Board must review its governance structures and function in light of this.**

## Recommendation 14

- **Maidstone and Tunbridge Wells NHS Trust Board must have greater oversight of licensed activity in the mortuary. It must ensure that the Designated Individual is actively involved in reporting to the Board and is supported in this.**

## Recommendation 15

- **Maidstone and Tunbridge Wells NHS Trust should treat compliance with Human Tissue Authority standards as a statutory responsibility for the Trust, notwithstanding the fact that the formal responsibility under the Human Tissue Act 2004 rests with the Designated Individual. The Act will be subject to review in Phase 2 of the Inquiry's work.**

## Recommendation 16

- **The Chief Nurse should be made explicitly responsible for assuring the Maidstone and Tunbridge Wells NHS Trust Board that mortuary management is delivered in such a way that it protects the security and dignity of the deceased.**

## Recommendation 17

- **Maidstone and Tunbridge Wells NHS Trust must treat the deceased with the same due regard to dignity and safeguarding as it does its other patients.**

**Appendix 2: Submission made to Phase 2 of the Independent Inquiry**

# Independent Inquiry into the issues raised by the case of David Fuller

Questionnaire for NHS Trusts.

This questionnaire is to support the Inquiry's work understanding the policies and procedures in place in NHS hospitals that store deceased people. If your Trust does not have either a mortuary or a body store please select no at question 5. This will complete the questionnaire for you and ask you to submit it. Thank you for your assistance with this important work.

## 7. General details about mortuary/body store provision

1. Please tell us the name of your Trust below *

West Hertfordshire Teaching Hospitals NHS Trust

2. Who is the person completing this questionnaire and what is their role? *

Natalie Whittle, Divisional Manager Clinical Support Services

3. Are we able to contact you to discuss this work further? *

- (●) Yes
- ( ) No

4. If yes please complete your contact details below

natalie.whittle3@nhs.net

5. Does your Trust have either a mortuary or a body store that contains deceased persons? *

- (●) Yes
- ( ) No

6. Does your Trust have a mortuary that is licenced by the Human Tissue Authority (HTA) for post-mortems? *

Yes

7. If yes, please list by name all HTA licensed facilities within the Trust

Watford General Hospital, Hemel Hempstead Hospital

8. Does your Trust have a facility to store deceased people that is not licenced by the HTA? *

- ( ) Yes
- (●) No
- ( ) Other

9. If yes, please list all facilities to store deceased people that are not licensed by the HTA

Enter your answer

10. On average how long do the deceased remain in the mortuary/body store at your Trust *

- ( ) 24 hours or less
- ( ) 7 days or less
- (•) More than 7 days
- ( ) Not applicable
- ( ) Other

11. Does the Trust have any teaching or research partnerships with other organisations, such as universities and associated spin-out companies or other private sector organisations for the use of deceased people for purposes such as dissection or demonstration for clinical training or for research? *

- (•) Yes
- ( ) No
- ( ) Other

12. Does the Trust send deceased people to an off-site body storage facility? By offsite facility we mean a facility that is not located on Trust premises *

- ( ) Yes
- (•) No
- ( ) Other

13. If so, please list the off-site facility used by the Trust

Enter your answer

14. On average, how long do the deceased remain in the off-site facilities arranged by your Trust? 24 hours or less

- ○ more than 24 hours but less than 7 days
- ○ More than 7 days
- ○

15. Do you have temporary arrangements to manage surge in capacity? * Yes

- ◉ No
- ○ Other
- ○

16. What are the temporary arrangements to deal with capacity surge *

- ☑ temporary on-site body storage
- ☐ off-site body storage
- ☐ Not applicable
- ☐ Other

12.1

## 8. Management accountability

17. Which Executive Director has accountability for the mortuary/body store service? *

- ○ Chief Operating Officer
- ◉ Chief Nurse
- ○ Medical Director
- ○ Other

18. Has the Trust Board ever received a report such as an HTA report, an internal report or a peer review report about the mortuary since 2014?
*

- ◉ Yes
- ○ No
- ○ Not applicable
- ○ Other

19. If so when did the Trust Board receive this report *

- ○ within the past 6 months
- ◉ within the past 12 months
- ○ more than 12 months ago
- ○ not applicable

20. Has the Phase 1 Report of the Independent Inquiry into the issues raised by the David Fuller case been discussed at Trust Board?

*

- ○ Yes
- ◉ No
- ○ Don't know

21. If so when was this discussed?

Enter your answer

22. If not is this planned for a future meeting?

- ○ Yes
- ○ No
- ◉ To be discussed in June 2024

23. What action has the Trust taken following the NHS England assurance exercise in relation to mortuary security, undertaken in 2021?

1. CCTV in place - Completed March 2022 2. DBS arrangements in place 3. Ac



## 9. Regulation and the mortuary/body store

24. When was the last HTA Inspection of the Trust's mortuary service?

- ○ In the last 12 months

- (●) More than 12 months ago
- ( ) Not applicable

25. How are HTA reports shared within the Trust?

Clinical Support Service Quality Governance meeting, feeding into Trustwide Quali

26. Which Trust governance forums receive HTA inspection reports? *

- [ ] Trust Board
- [ ] Quality Committee (sub-committee of the Trust Board
- [ ] Not applicable
- [x] Quality Governance Group - provided to Quality Committee/Trust Board by exception

27. Does the Trust share HTA inspection reports with any of the following organisations? *

- [ ] CQC
- [ ] NHSE
- [ ] None
- [ ] Not applicable
- [x] HWE ICB

28. Has the CQC inspected the Trust's mortuaries/body stores?

- ( ) Yes

- [x] No
- [ ] Other

29. Please tell us which facility CQC has visited

Enter your answer

## 10. Information about the Designated Individual

30. How long has the Designated Individual been in post? *

- [ ] Less than 12 months
- [x] More than 12 months
- [ ] Not applicable
- [ ] Other

31. What is their professional background *

- [ ] Anatomical Pathology Technician
- [ ] Biomedical scientist
- [x] Consultant pathologist
- [ ] Not applicable Other
- [ ]

32. Has the Designated Individual undertaken any training in relation to their role? *

- [x] Yes
- [ ] No
- [ ] Not applicable
- [ ] Other

33. Please list the training courses that the Designated Individual has attended in relation to their role, in the past three years.

Enter your answer

34. Has the Designated Individual been asked to present to Trust Board in relation to their role in the past 12 months? *

- [ ] Yes
- [ ] No
- [ ] Not applicable
- [x] Represented by CSS Divisional Director

35. How often does the Designated individual meet with the CEO to discuss their responsibilities as DI? *

- [ ] Daily
- [ ] Weekly
- [ ] Monthly

- ○ Quarterly
- ○ Annually
- ◉ As required but no fixed interval
- ○ Never
- ○ Not applicable

36. Does the Designated Individual attend any governance forums specifically in relation to their role as DI? *

- ◉ Yes
- ○ No
- ○ Not applicable
- ○ Other

37. Which Trust governance forums does the Designated Individual attend, specifically in relation to their role as DI? *

- ○ Trust Board
- ○ Quality Committee (sub-committee of the Trust Board)
- ◉ Not applicable
- ○ Other



## 11. Mortuary Service and Management

38. Do you have a mortuary that is managed by a mortuary manager? *

- (●) Yes
- ( ) No, we have a body store only

39. Does the mortuary manager hold an Anatomical Pathology Technician qualification? *

- (●) Yes
- ( ) No
- ( ) Not applicable
- ( ) Other

40. If no, what is their professional background? Biomedical scientist

- ( ) other
- ( )

41. Does the mortuary manager only have the mortuary in their management portfolio? *

- (●) Yes
- ( ) No
- ( ) Not applicable
- ( ) Other

42. If no, what other management responsibilities are in their portfolio

Enter your answer

43. Is the mortuary manager located on the same hospital site as the main mortuary? *

- (●) Yes
- ( ) No
- ( ) Other

44. Has the mortuary manager undertaken any professional training, in relation to their role, in the past 12 months? *

- ( ) Yes
- (●) No
- ( ) Other

45. If so, please list relevant training courses

Enter your answer

46. During what hours is the mortuary/body store staffed?

8-4

47. Are there any staff working alone during this period?

- (●) Yes
- ( ) No

48. Are there standard operating procedures supporting the daily work of the mortuary/body store?

- (●) Yes
- ( ) No
- ( ) Other

49. Has there been an audit to assess compliance with these standard operating procedures in the past 12 months?

- (●) Yes
- ( ) No

50. Who undertakes these audits?

Mortuary Governance Lead

51. Does the mortuary have a governance meeting?

- ( ) Yes
- ( ) No
- (●) Pathology Quality Forum

## 12. Mortuary staffing

If you do not have a mortuary, please go to section 7.

52. How many staff work in the mortuary undertaking mortuary tasks?

8

53. How many of these staff hold APT qualifications?

5

54. How many of the mortuary staff do not hold a APT qualification?

Enter your answer

55. Have the APTs undertaken continuing professional development courses in the last 12 months?

- ○ Yes
- ◉ No

56. Please list the different CPD courses undertaken by APTs in the past 12 months. We do not require this list for individual staff, only the different courses taken overall.

Enter your answer

57. Are all of the APTs registered with the Academy for Healthcare Science or Science Council?

- ○ Yes
- ◉ No

58. Please state how many staff are registered with the Academy for Healthcare Science or Science Council

Enter your answer

## 13. Access to the mortuary and body stores

59. Is the mortuary/body store classed as a restricted area? *

- (●) Yes
- ( ) No

60. How is each facility controlled, eg by key, digital lock, electronic magnetic lock? *

Electronic swipe card and digital locks

61. How do mortuary/body store staff access each individual facility *

- ( ) Electronic swipe card
- ( ) Key
- (●) Digital lock
- ( ) Other

62. Please identify the staff groups, other than mortuary/body store staff, that require access to mortuaries and body stores at your Trust. *

- [x] Porters
- [ ] Maintenance staff
- [x] Domestics
- [ ] Bereavement officers
- [x] Out of hours - site manager

63. Please give details of other staff groups that access the mortuary/body store facilities.

Enter your answer

64. Are any of these staff groups allowed unsupervised access, eg allowed to be in the mortuary on their own? *

- [x] Porters
- [ ] Maintenance staff
- [ ] Bereavement officers
- [ ] Domestic staff
- [ ] Other

65. If you have ticked other, please give details of other staff groups

Enter your answer

66. Do any staff groups access mortuaries and body stores out of office hours? *

- [x] Porters
- [ ] Maintenance staff
- [x] Domestic staff
- [ ] Bereavement staff
- [x] Out of hours - site manager

67. How do non-mortuary staff access the mortuary/body store out of hours? *

- [x] Individual electronic swipe card
- [ ] their own key
- [ ] a shared electronic swipe card
- [ ] a shared key
- [ ] digital lock
- [ ] Other

68. Are audits of access to the mortuary and body store ever carried out? *

- (•) yes
- ( ) no
- ( ) don't know

69. Is there CCTV covering all mortuary entrances?
*

- (•) Yes
- ( ) No
- ( ) Other

70. If not please list mortuary/body stores that do not have CCTV covering an entrance.

Enter your answer

71. Is there CCTV inside the mortuary?
*

- (●) Yes
- ( ) No

72. Is there CCTV covering mortuary/bodystore  fridge doors? *

- (●) Yes
- ( ) No

73. Is there CCTV in the post-mortem room *

- (●) Yes
- ( ) No

74. Is the CCTV covering the mortuary monitored? *

- (●) Yes
- ( ) No
- ( ) Other

75. Who monitors the CCTV?

- ( ) Trust security
- (●) Mortuary staff
- ( )

Other

76. Do you audit CCTV recording of who is accessing the mortuary/body store? * Yes

- (●) No
- ( ) Don't know
- ( )

## 14. Serious incidents in the mortuary

77. Are you aware of any current or historical serious incidents which have taken place in the Trust mortuary/body store? *

- (●) Yes
- ( ) No

78. Have you reported any incidents to the HTA that have not been classified as a HTARI? *

- (●) Yes
- ( ) No
- ( ) Not applicable

79. Have any serious incidents been reported to the Coroner or anyone else, apart from the HTA? *

- ○ Yes
- ◉ No
- ○ Not applicable

80. Have any HTARIs or incidents been reported to the Board or one of its subcommittees? *

- ○ Yes
- ◉ No
- ○ Not applicable

## 15. Relationship with the Local Authority and Coroner

81. Does the Trust meet with the Coroner or the Coroner's staff to discuss arrangements for mortuary services? *

- ◉ Yes
- ○ No
- ○ Not applicable



82. If so, how regular are these meetings?

- ○ Monthly
- ◉ Quarterly
- ○ Yearly

## Appendix 3: WHTHT review against 17 recommendations.

| Recommendations | Review | Actions |
|---|---|---|
| **1. WHTH must ensure that non-mortuary staff and contractors, including maintenance staff employed by the trust's external facilities management provider, are always accompanied by another staff member when they visit the mortuary. For example, maintenance staff should undertake tasks in the mortuary in pairs** | Estates teams often come in pairs, but not always. Estates need to ensure that staff come to the Mortuary in pairs.<br><br>External engineers often come alone; estates need to ensure that engineers are accompanied.<br><br>Mortuary SOP for visitors under review as part of recent incident.<br><br>OOH- guidance notes & online training state that either a bed manager or porter must stay with estates or engineer.<br><br>Porters at Hemel lone work especially OOH. | Estates on-call is a lone working process, how can estates ensure dual attendance for OOH issues? **Mortuary Manager to discuss with Estates Team.**<br><br>Some engineer visits are booked directly with the Mortuary, this needs to be included in the visitor SOP and Mortuary staff will need to stay with the engineer. **Mortuary Manager to update.**<br><br>**Mortuary Manager to discuss with Mitie** |
| **2. WHTH must assure itself that all regulatory requirements and standards relating to the mortuary are met and the practice of leaving deceased people out of the mortuary fridges overnight, or while maintenance is undertaken, does not happen.** | Deceased have never and will never be left out overnight. This forms part of end of day checks completed by Mortuary Staff at both sites.<br><br>Deceased are moved into alternative fridges during maintenance work and never left out. | CCTV camera in the PM room at Hemel is turned on at the end of the day and off before postmortems start, as detailed in SOP.<br><br>Images from CCTV are reviewed as part of the card access and CCTV reviews. |
| **3. WHTH must assure itself that it is compliant with its own current policy on criminal record checks and re-checks for staff. The trust should ensure that staff who are employed by its facilities management provider or other contractors are subject to the same requirements.** | All 4 of new Mortuary staff were recently contacted by HR as they had been employed on basic DBS checks: despite all recruitment forms stating enhanced. HR to review their processes.<br><br>All Mortuary staff now have enhanced DBS checks. | Can the Trust ensure that porters and estates who have regular Mortuary access have enhanced DBS checks? And how often are then re-conducted? **HR to review and confirm.**<br><br>There is nothing within HR policies/ guidance stating how often Mortuary staff should have checks. **To be discussed with HTA/ Colleagues at neighbouring Trusts within the ICB.** |
| **4. WHTH must assure its mortuary managers are suitably qualified and have relevant Anatomical** | Fully qualified highly experienced Diploma holding APT with MSC in Healthcare and Leadership Management. | |

| | | | |
|---|---|---|---|
| | **Pathology Technologist experience. The mortuary manager should have a clear line of accountability with the trust's management structure and must be adequately managed and supported.** | | |
| **5.** | **The role of the mortuary manager at WHTH should be protected as a full-time dedicated role, in recognition of the fact that this is complex regulated service, based across two sites, that requires the appropriate level of management attention** | The Mortuary Manager is a 1WTE admin role that works across both sites and is supported by a Deputy. | Mortuary Manager works predominantly at HHGH. **Presence at WGH to be increased.** |
| **6.** | **WHTH must review its policies to ensure that only those with appropriate and legitimate access can enter the mortuary.** | Was there ever a response from security about ADT having Mortuary access?<br><br>Mortuary reviews card access data and will escalate any person gaining access to the Mortuary who shouldn't and any unusual behaviour as per SOP and competency audits. | **Security to review the Mortuary access and remove any engineers and external contractors that have been given access. Head of Security to confirm.**<br><br>**Security needs to conduct regular reviews to ensure that access has not been granted to anyone who shouldn't have it. Head of Security to confirm.** |
| **7.** | **WHTH must audit any implementation of any resulting new policy and must regularly monitor access to restricted areas, including the mortuary, by all staff and contractors.** | Access data is reviewed by the Mortuary when it is received by security.<br><br>Staff have competency audits in the Mortuary relating directly to the security SOPs and the reviewing of card access data and CCTV images. | **Security Manager to ensure this data is sent weekly.**<br><br>Paxton Net2 access control system installation imminent. |
| **8.** | **WHTH should treat security as a corporate not a local departmental responsibility.** | | **To be discussed with Exec Lead (Chief Nurse) and Head of Security.** |
| **9.** | **WHTH must install CCTV cameras in the mortuary, including the post-mortem room, to monitor the security of the deceased and safeguard their privacy and dignity.** | This was completed in December 2021.<br><br>However recent review has identified a blind spot at HHGH and the RCA will recommend an additional CCTV camera is installed in the lobby area. | Security Manager completed a Security review of HHGH site in Feb 24.<br><br>**Additional cameras to be installed during the refurbishment.**<br>Mortuary Hemel Hempstead Security S |

| | | |
|---|---|---|
| **10. WHTH must ensure that footage from the CCTV is reviewed on a regular basis by appropriately trained staff and examined in conjunction with swipe card data to identify trends that might be of concern.** | Access data is reviewed by the Mortuary when it is received by security.<br><br>Staff have competency audits in the Mortuary relating directly to the security SOPs and the reviewing of card access data and CCTV images. | **Mortuary Team to share weekly audits with Designated Individual and Deputy Divisional Manager.**<br><br>These must be electronic going forwards and not paper audits.<br><br>Paxton Net2 access control system installation imminent. |
| **11. WHTH must proactively share Human Tissue Authority reports with organisations that rely on Human Tissue Authority licensing for assurance provided by the mortuary.** | HTA reports are in the public domain but should be shared with HCC Coroners service. | **Mortuary Manager to ensure these are shared with Coroner.** |
| **12. Herts county council should examine their contractual arrangements with WHTH to ensure they are effective in protecting the safety and dignity of the deceased.** | HCC contract does include that the contractor must ensure dignity, confidentiality and comply with HTA. | Contract negotiations ongoing with Coroners Team. Deputy Divisional Manager leading on this. |
| **13. Board assurance. The David fuller report has illustrated how Maidstone & Tunbridge wells NHS Trust relied on reassurance rather than assurance in monitoring its processes. The board must review its governance structures and function in light of this.** | Paper going to QSC/ following David Fuller recommendations.<br><br>Chief Nurse has visited mortuary sites and attended staff meetings. | **Future Meetings to be agreed.** |
| **14. WHTH must have greater oversight of licensed activity in the mortuary. It must ensure that the designated individual is actively involved in reporting to the board and is supported in this.** | DI has never attended board meetings before, and this will need to be actioned and supported by divisional director.<br><br>DI to meet with CEO as the HTA license holder. | Assurance report to be completed and presented to Quality Safety Committee for discussion in April 2024.<br><br>**DI, DD & DDM must agree who will present.**<br><br>The trust needs to be seen as supportive in this new recommendation for the DI to attend.<br><br>**Committee needs to agree time framework of attendance for DI going forward. (Every 6 months)** |
| **15. WHTH should treat compliance with the Human Tissue Authority** | JD for role of DI? | Review of what DI role encompasses and how the DI & |

| | | |
|---|---|---|
| **standards as a statutory responsibility for the trust, notwithstanding the fact that the formal responsibility under the Human Tissue Act 2004 rest with the designated individual. The Act will be subject to review in phase 2 of the inquiry work.** | | Mortuary Manager ensures the standards are met. |
| **16. The Chief Nurse should be made explicitly responsible for assuring the WHTH that mortuary management is delivered in such a way that it protects the security and dignity of the deceased.** | Evidence of documented meetings, dates and actions.<br><br>Clear agenda items discussed. | **The Mortuary need a clear escalation process that anyone can approach Chief Nurse with concerns.**<br><br>**FTSU Guardian to visit and support the Mortuary staff so they are aware of the process.** |
| **17. WHTH must treat the deceased with the same due regard to dignity and safeguarding as it does its other patients.** | Mortuary staff used to deliver care of the deceased training to ward staff, nurses HCA's and theatre staff. This stopped after the pandemic. | **Mortuary Manager to work with Bereavement Team/ Heads of Nursing to reinstate this.** |

West Hertfordshire Teaching Hospitals NHS Trust

# Trust Board Meeting
# 02 May 2024

| | |
|---|---|
| **Title of the paper:** | **Mortality and Learning from Deaths Quarter 3 2023/24** |
| **Agenda Item:** | **13** |
| **Presenter:** | **Dr Mike van der Watt, Chief Medical Officer** |
| **Author(s):** | **Deborah Wadsworth, Senior Business Manager** |
| **Purpose:** | *Please tick the appropriate box*<br>*For approval*: <br>*For discussion*: <br>*For information*: ✓ |
| **Executive Summary:** | The purpose of this report is to provide the Board with an update on Trust mortality and learning from deaths for quarter 3 2023/4.<br><br>The Dr Foster intelligence report, (March 2024) spans the data period December 2022 – November 2023. Learning from deaths data spans 1 October 2023 – 31 December 2023.<br><br>HSMR is reported as, 101.6 which is as expected. SHMI is also reported as 102.58, which is within the expected range and SMR (all diagnosis) at 97.4 is lower than expected.<br><br>There are 3 outlying diagnosis groups in the Dr Foster intelligence report, 2 of which are new:<br><br>• Cancer of colon (new)<br>• Other injuries and conditions due to external causes (new)<br>• Other perinatal conditions<br><br>The Medical Examiners referred 11 cases for structured judgement review, 2 cases were considered by the avoidability panel and 1 was found to be potentially avoidable.<br><br>Medical Examiners continue to scrutinise all community and trust deaths. |
| **Trust strategic aims:**<br><br>*(please indicate which of the 4 aims is relevant to the subject of the report)* | **Aim 1 Best care** — ***Objectives 1-4*** ✓<br>**Aim 2 Great team** — ***Objectives 5-8***<br>**Aim 3 Best value** — ***Objective 9***<br>**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?<br>☐Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? |

13

<table>
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<tr><td>Action required:</td><td>The Committee is asked to receive this report for assurance on Trust mortality and learning from deaths scrutiny</td></tr>
</table>

**Agenda Item: 13**

**Trust Board Meeting – 02 May 2024**

**Mortality and Learning from Deaths Quarter 3 2023/24**

**Presented by: Dr Mike van der Watt, Chief Medical Officer**

## 1. Purpose

1.1 This paper aims to provide a review of trust mortality and related workstreams across quarter 3 2023/24 and to provide an update on current position

1.2 The last Mortality Review Group meeting was held on 18 March 2024.

## 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

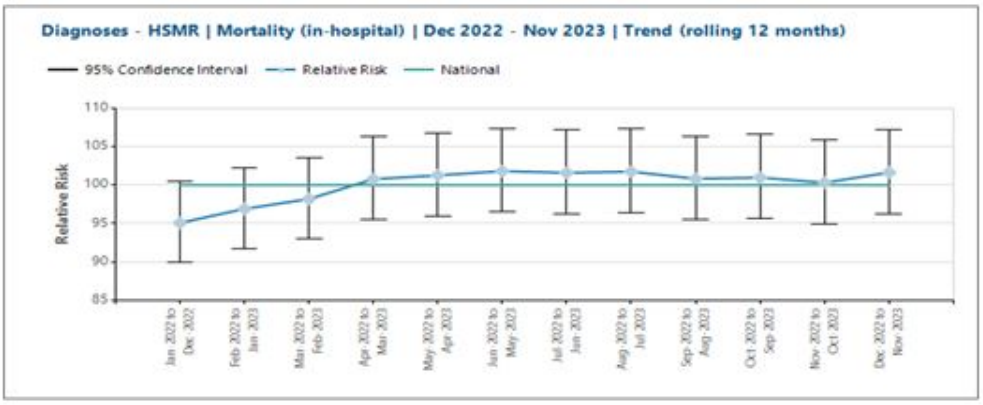
3.1 (Taken from March 2024 Dr Foster update which encompasses data from December 2022 –November 2023)

- **HSMR** is 101.6 and is within the as expected range
- **SHMI** is 102.58 and within the as expected range.
- **SMR** is 97.4 and lower than expected range

### 3.2 Overall quantitative performance (the metrics)

13

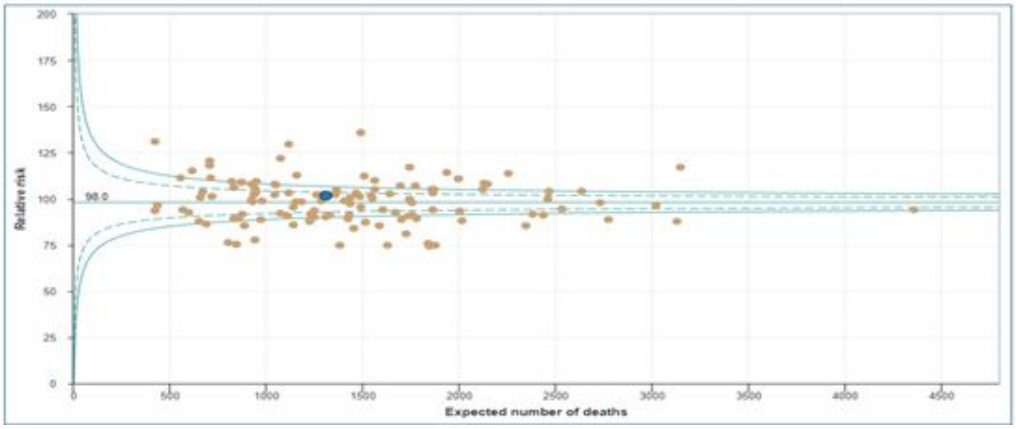
### 3.2.1 Chart 1 HSMR rolling 12 months (last point is November 2023)




### 3.2.2 Chart 2 HSMR 12 month peer comparison (national acute non-specialists) Where West Herts is represented by the blue dot

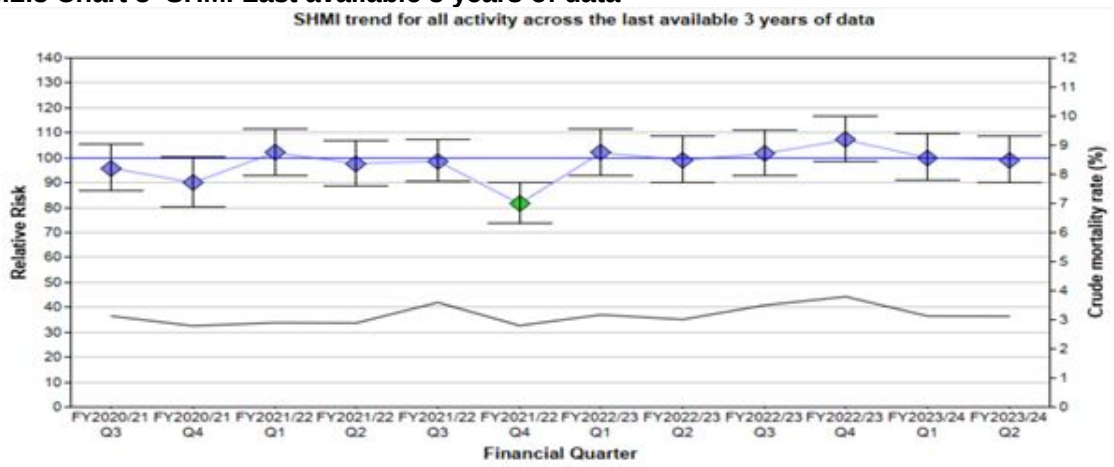
**Figure 3.1 – HSMR 12 Month Peer Comparison: National Peers**

*(National acute non-specialists = brown dots, West Herts = blue dot)*




The Trust is 1 of 4 Trusts within the East of England peer group of 14 with an HSMR in the 'as expected' range. 5 Trusts are in the 'higher than expected' range and 5 in the 'lower than expected' range

### 3.2.3 Chart 3 SHMI Last available 3 years of data



### 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 March Dr Foster report highlighted three outlying diagnosis groups, one of which is an ongoing outlier, *other perinatal conditions*. Other perinatal conditions has been presented previously and the Dr Foster Team has explained that as a diagnosis group, it is not best suited to analysis via HSMR methodology. Advice is that any further analysis should be undertaken with caution. In the last year there were 520 superspells and 12 deaths, but crude rate is improving and there has just been one death reported in the last 7 months of data. These deaths have been reviewed by the Women's and Children's division. The Divisional Director presented the findings to the Mortality Review Group to provide assurance that they were expected. There is an established joint neonatology and maternity mortality and morbidity meeting to regularly review these deaths.

3.3.3 There are also two new outlying groups:

- Cancer of colon
- Other injuries and conditions due to external causes

These 2 new groups will be discussed at the next Mortality Review Group (MRG) meeting on 13 May. *Cancer of the colon* is being reviewed by the division to establish whether there is learning to be shared. The *other injuries due to external causes* group falls within control limits when comparing the Trust to national peers. The clinical coders are reviewing the group and will report findings at the MRG.

3.3.4 Biliary tract disease

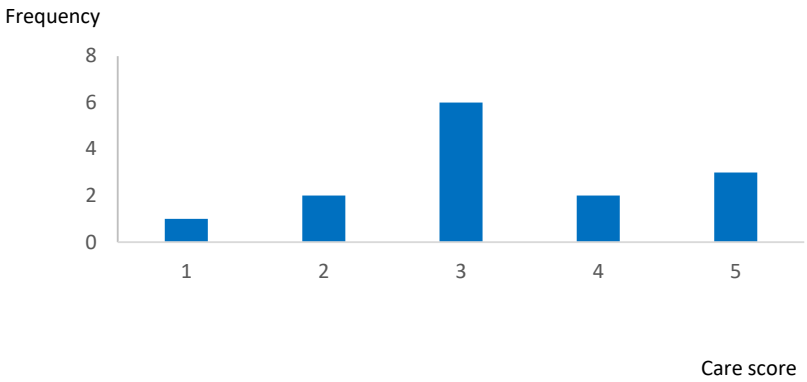
In the quarter 2 update, the Dr Foster Team recommended review of 5 deaths in June 2023. These deaths were reviewed and 1 received a change in primary diagnosis to malignant neoplasm. The other 4 remained unchanged in primary diagnosis.

## 4 Structured judgement review (SJR)

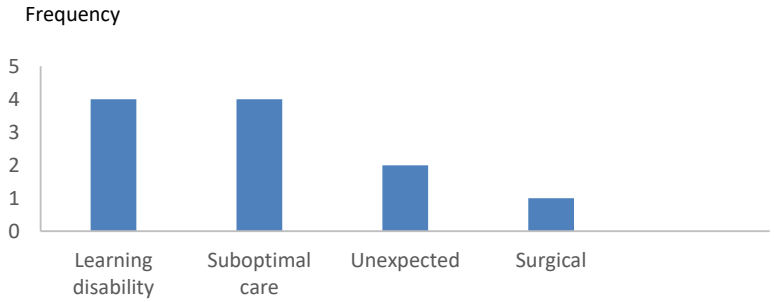
## 5

4.1 Between 1 October 2023 and 31 December 2023, 11 referrals for structured judgement review were made. During the quarter, 14 completed reviews were received back from consultant reviewers, with overall care scores ranging from 1 to 5. Of the 14, 3 scored a 5 (excellent care), 2 scored a 4 (good care), 6 scored a 3 (adequate care), and 2 scored 2 (suboptimal care) and 1 scored 1 (poor care).

4.2 **Chart 4 SJR care scores for quarter 3 2023/24**




4.3 **Chart 5 Reasons stated for SJR referral for quarter 3 2023/24**




4.4 Two cases were reviewed by the avoidability panel during the quarter,1 case scored a 4 and was considered to be possibly avoidable but not likely. The other case scored a 2 and was considered to have strong evidence of avoidability. This case has been referred to ERG as a possible serious incident investigation.

**4.5 SJR themes and learning from deaths**

4.5.1 The SJR process and the more detailed Tier 2 panel reviews of deaths offer opportunities for learning for clinical teams.

All SJR outcomes are fed back to the referrer and the clinical team(s) involved. If there are areas of care where there is potential for learning, the clinical teams are encouraged to discuss at departmental governance meetings for shared learning.

The more detailed Tier 2 reviews are referred from SJRs where care has been identified as poor or where the death has been identified as probably or definitely avoidable. If the panel agrees that the death was probably or definitely avoidable, this leads to referral to the Serious Incident panel.

In addition, if there is specific learning, this is fed back to clinical leads for shared learning in their teams.

4.5.2 The table below provides themes for learning from Tier 2 panel reviews from the last year with corresponding actions.

| Theme | Action |
|---|---|
| Failure to respond to deteriorating patient, leading to delayed referral for to Critical Care Assessment | Liaise with Deteriorating Patient Panel; SJR fed back to clinical team to ensure discussion at Morbidity and Mortality Meeting. |

| | |
|---|---|
| Delayed referral to Palliative Care team | Ongoing feedback to palliative care team; presentation at Medicine Governance meeting by Palliative Care consultant |
| Delayed initiation of Non-Invasive ventilation | Liaison with NIV clinical lead and NIV practitioner – enhanced training in Emergency and Acute Medicine |
| Delayed treatment with antibiotics | Fed back to clinical team to ensure shared learning |

4.6 The service is currently establishing a pathway to assess themes from all SJR reviews and not just Tier 2 panel reviews and to capture both positive negative themes. Themes will be reported upon every 6 months.

## 5 Consultant Coders

5.1 The Trust Coding team provides accurate coding for all patients including patients who have died in the Trust . To provide further assurance on the accuracy of coding for deaths, the Trust has provided an additional coding review by senior clinicians. Previous work has demonstrated that additional consultant coding alters coding outcomes for up to a third of deaths. This leads to more accurate reporting of overall mortality data.

5.2 In recent years the number of appointed consultant coders fell from four to one with the final coder also keen to step down. A recruitment exercise at the end of 2023 led to the appointment of one new starter. The long standing coder however still plans to step down and this will again leave just one consultant coder in post. Options for different operational models are being explored. One possibility is to devolve primary diagnosis reviews for outlying groups to the relevant division.

## 6 Medical Examiner Service

6.1 The Medical Examiners continued to provide 100% scrutiny during quarter three, including fast track cases for both trust and community cases.

6.2 There has been good engagement with the community providers, and the service has reached out to those GP practices yet to make regular referrals in order to offer further support.

6.3 A pilot of out of hours working in order to facilitate rapid release of certificates particularly for faith deaths was conducted over a 12 week period and following its success, the Trust has now commenced an out of hours weekend Medical Examiner Service

6.4 A further internal quality assurance exercise has been undertaken for the purpose of learning, improvement in quality of scrutiny and standardisation. It was noted that there was good concordance with the outcome of scrutinies by different medical examiners regarding the cause of death, coronial referral and clinical governance referrals. The intention is to continue this assurance exercise on a quarterly basis.

6.5 Quarterly meetings continue with the Coroner and Registration service, and this is working well

6.6 The Medical Examiners engage with other nearby Medical Examiner Offices, update the Integrated Care Board (ICB) on activity and share learning. Monthly feedback is shared with the ICB on a monthly basis any governance concerns that are noted by the MEs on scrutiny of community cases.

6.7 There has been participation in the Thirwall enquiry pertaining to questions around the Medical Examiner Service and the Medical Examiners have also met with senior members of the East of England Ambulance Service to agree pathways for raising governance concerns with them.

6.8 A meeting has taken place with a local Rabbi to discuss medical examiner processes and address any concerns, particularly with the statutory commencement and the weekend issue of MCCDs. Attempts are being made to hold a similar meeting with local Muslim leaders.

6.9 Legislative reforms of the process of medical death certification are anticipated but there is not yet a clear timeline for these. At present the Medical Examiner Service is expected to become statutory in April 2024.

## 7 Risks

7.1 None identified

## 8 Recommendation

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

**Dr Mike van der Watt**
**Chief Medical Officer**

15 April 2024

NHS
West Hertfordshire Teaching Hospitals
NHS Trust

# Public Trust Board
# 02 May 2024

| | |
|---|---|
| **Title of the paper:** | **Perinatal Quality Surveillance Report** |
| **Agenda Item:** | **14** |
| **Presenter:** | **Penny Snowden, Director of Midwifery/ Deputy Chief Nurse** |
| **Author(s):** | **Penny Snowden, Director of Midwifery/ Deputy Chief Nurse** |
| **Purpose:** | Please tick the appropriate box<br>For approval: <br>For discussion: X<br>For information: X |
| **Executive Summary:** | The purpose of this report is to provide the Trust Board<br>▪ With robust oversight of Perinatal Services as outlined in the National Perinatal Surveillance Framework and Safety Action 9 of Maternity Incentive Scheme<br>▪ The Report includes clinical outcomes, quarterly Avoiding Term Admissions and other relevant items.<br>▪ The two main areas of current focus include Entonox Monitoring with a revised improvement plan being progressed and compliance with Booking by 9+6 weeks compliance. Both issues are on the risk register for the Department.<br>▪ Midwifery Vacancies has reduced with 17wte vacancies and 40 students qualifying this summer.<br>▪ Maternity Incentive Scheme Year 6 has been published and the team have commenced worked against the new sections in the safety actions.<br>▪ The committee is requested to note the contents of the report and approve future reporting process given the new guidance in Year 6 Maternity Incentive Scheme. |
| **Trust strategic aims:**<br>*(please indicate which of the 4 aims is relevant to the subject of the report)* | **Aim 1 Best care** — *Objectives 1-4*: X<br>**Aim 2 Great team** — *Objectives 5-8*: X<br>**Aim 3 Best value** — *Objective 9*:<br>**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?<br>☐Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? |

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<tr><td>Previously considered by:</td><td><table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td>Maternity Safety Champion Meeting</td><td>17th April 2023</td></tr><tr><td>Quality Committee</td><td>25th April 2023</td></tr></table></td></tr>
<tr><td>Action required:</td><td>The Trust Board is asked to receive this report for assurance on the quality and safety of perinatal services.<br><br>The Committee is recommending future reporting schedules given the latest Maternity Incentive Scheme Guidance. The recommendation is to report monthly to Quality Governance with updates contained in the upward report from the Quality and Safety Committee to Trust Board. A quarterly oversight report is submitted to Trust Board as per current process.</td></tr>
</table>

# Perinatal Quarter 2023/2024 Report

## Perinatal Quality Surveillance Report

**April 2024**

**Penny Snowden, Interim Director of Midwifery on behalf of Kelly McGovern, Chief Nurse**

# Contents



## Purpose of the Report

To comply with the five principles outlined in the national Perinatal Quality Surveillance Report including strengthening Trust Level oversight of the quality of perinatal services which then upwardly reports to the Local Maternity Neonatal System and ICS which in turn to the regional and national quality surveillance meetings

To comply with Safety Action Nine of Year 6 Maternity Incentive Scheme which focuses on demonstrating that there is clear oversight in place to assure the Trust Board of the quality and safety of maternity and neonatal services.

# Executive Summary

| | |
|---|---|
| Successes | • Celebration of the first year of the implementation of BadgerNet.<br>• Samantha Behagg, Bereavement Midwife won a special recognition award for Bereavement Midwife of the Year at the Mariposa Awards. (These awards recognise excellence in Baby Bereavement Care across the NHS).<br>• Celebration event for the Maternity Support Workers who have completed their care certificate.<br>• Emma Mitchener commenced in her role as Head of Midwifery and Antonio Sierra has rejoined the team as Consultant Midwife.<br>• New MNVP chair has been appointed.<br>• Confirmation was received by NHS Resolution of the Trust's successful achievement of Year 5 Maternity Incentive Scheme. |
| Key Themes | • Booking compliance by 9+6 weeks gestation being addressed through additional clinics<br>• 17wte midwifery vacancies with strong student midwife pipeline. Mapping both permanent posts and fixed term to cover maternity leave.<br>• Additional Manual Handling teaching sessions being facilitated to improve training compliance<br>• Improvements made to BadgerNet in recording Duty of Candour which will assist with compliance reporting.<br>• NHS England regional maternity team visited the unit on 16th April to oversee progress against CQC improvement plan with positive feedback received |
| Emerging Issues | • Focus on Entonox monitoring continues with a revised improvement plan in place. On the Risk register (Risk ID 137) score 12. Mitigations in place include retesting staff for VitB12, weekly visits with the Environment team and Entonox monitoring tracker in place.<br>• Live Lock Down on March 4th and a further Lock Down Drill was undertaken 9th April 2024. Closely working with EPPR underway. |

# Women's Views of the Maternity Service- CQC User Survey Report 2024

- On 9th February, the CQC published their findings from their annual Maternity survey which reflected the experiences of maternity service users who had had a live birth between 1st -28th February 2023. 134 women responded at WHTH.

## What women liked included:

- Maternity service users being given information about their own physical recovery after the birth.
- Maternity service users being told who they could contact if they needed advice about any changes they might experience to their mental health after the birth.
- Maternity service users receiving help and advice from health professionals about their baby's health and progress in the six weeks after the birth.
- Maternity service users receiving help and advice from a midwife or health visitor about feeding their baby in the six weeks after giving birth.
- Maternity service users being given information about any changes they might experience to their mental health after having their baby.

# Women's Views of the Maternity Services- CQC User Survey

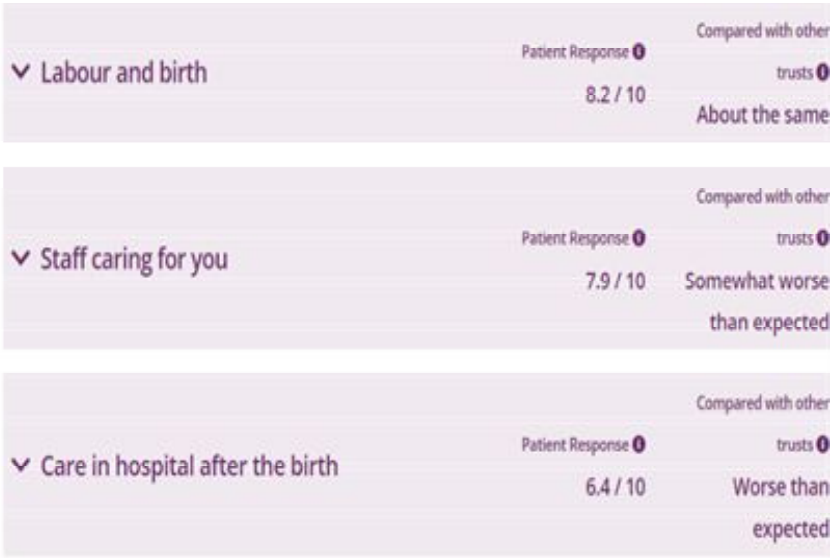
## Women said:

- Want a greater choice about where to have their baby during their antenatal care.
- maternity service wanted information to help decide where to have their baby.
- Maternity service wanted to be treated with kindness and understanding while in hospital after the birth.
- Wanted Partners or someone else involved in the service user's care to be able to stay with them as much as the service user wanted during their stay in the hospital.
- Maternity service users having the opportunity to ask questions about their labour and the birth after the baby was born.

## We did:

- We improved the on-call community rota to support home births, so we have seen more women giving birth at home.
- We have implemented BadgerNet which enables the Trust to send information to women throughout their pregnancy. The Trust holds a birth options clinic for those women with complex pregnancies and we have changed the birthing criteria on the Birthing Centre to support more women opting for the place of birth.. We are also in the process of improving our maternity website.
- We have reinstated partner visiting and staying overnight post COVID and siblings are also able to visit to. We will continue to work to comply with the new NHS Visiting Guidelines.
- We hold a birth reflections clinic for women who wish to discuss and debrief following their birth. There is also a daily consultant ward round in place to also answer questions from women and their families

# Women's Views of the Maternity Services- CQC User Survey Benchmarking




| CQC MATERNITY SURVEY RESULTS (2023 published 2024 ) | | | |
|---|---|---|---|
| Trust | WHTH | ENHT | PAHT |
| CQC Maternity survey overall rating - improvement since previous year (Y/N) | About the same | | Y |
| Survey scores: | | | |
| Start of your care during pregnancy | 4.3 (worse than expected) | 4.0 (worse than expected) | 8.6 (about the same) |
| Antenatal check ups | 8.4 (about the same) | 8.2 (about the same) | 9.1 (better) |
| During your pregnancy | 8.7 (about the same) | 8.4 (about the same) | 8.5 (better) |
| Your labour and birth | 8.2 (about the same) | 8.5 (about the same) | 8.3 (about the same) |
| Staff caring for you | 7.9 (about the same) | 8.3 (about the same) | 6.8 (about the same) |
| Care in hospital after birth | 6.4 (worse than expected) | 6.9 (about the same) | 8.5 (about the same) |
| Feeding your baby | 8.1 (about the same) | 8.1 (about the same) | 8.2 (about the same) |
| Care at home after birth | 7.9 (about the same) | 7.9 (about the same) | 5.8 (about the same) |

# Women's Views of the Maternity Services- CQC User Survey Improvements and Next Steps

The following improvements have been made since the survey:

- Introduction of the Antenatal/Postnatal forum to aid improvement
- Reintroduction of MVP monthly walking the path and new chair appointed
- Induction of the labour leaflet coproduced
- A review of bereavement care pathways in line with the national recommendations has been completed.
- The inpatient wards have been refurbished and the Neonatal Ward will shortly complete their refurbishment.
- Patient Experience Midwife post developed and in the process of being recruited to.
- Infant Feeding Team have expanded to support more women with breastfeeding.
- Vacancy rates have reduced from 18% to 10% enabling midwives to spend more time with women.
- Increase in hours of Environment and infection control audits with direct feedback at the Trust IPC meetings.

## Next Steps include:

- Refreshing the Equality and Diversity improvement Plan
- Improve the response rate for Family and Friends Test (FFT)
- Develop an engagement plan with the new Maternity and Neonatal Voices Partnership (MNVP) chair
- To scope the feasibility of culturally appropriate antenatal classes
- To achieve Level 3 Baby Friendly Initiative accreditation
- To develop and launch a Maternity Helpline which will improve advice and support to women.

# Maternity Clinical Outcomes and Exception Reports

team westHerts

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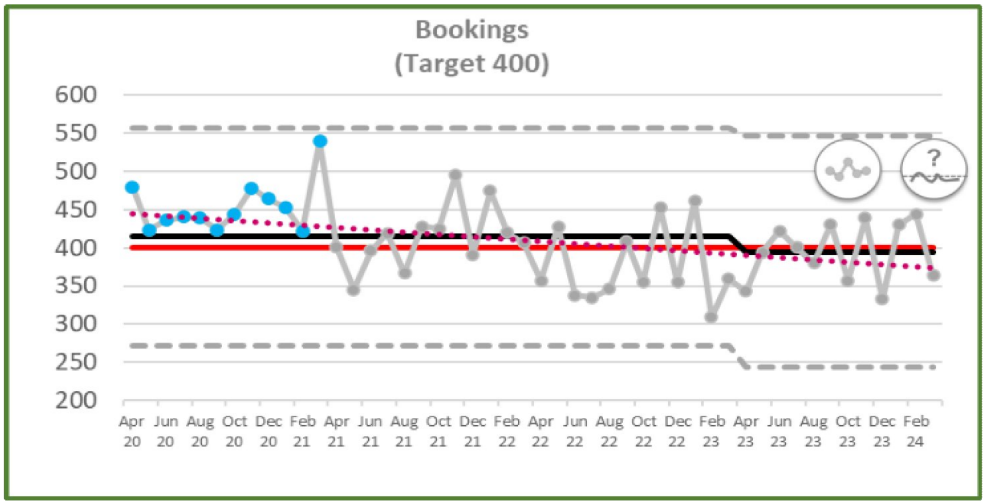
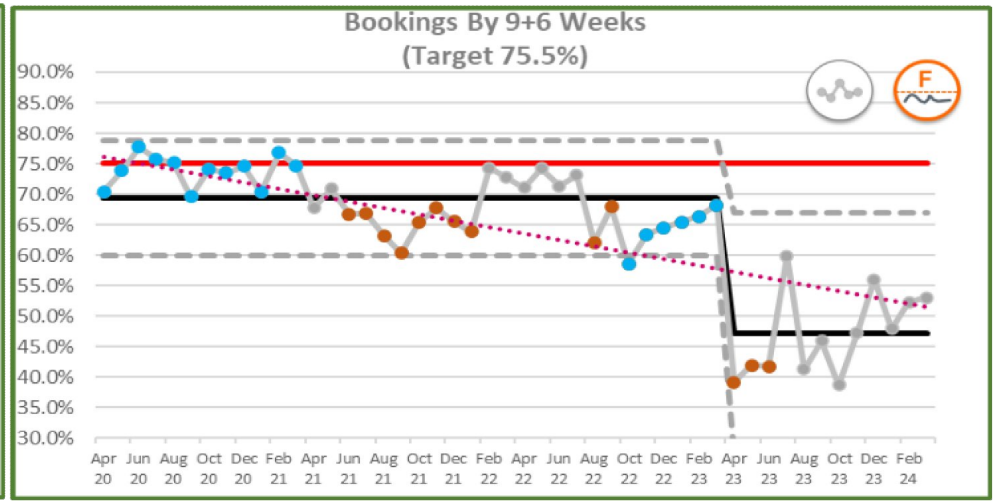
## Maternity Activity Indicators and SBLv2

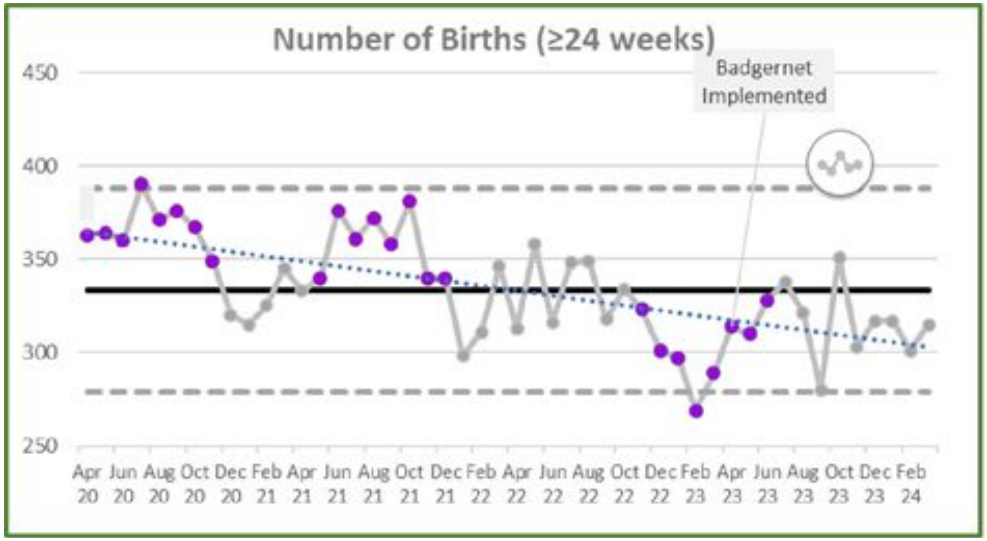
| KPI | Latest month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| Bookings(Target 400) | Mar 24 | 364 | 400 | | | 395 | 244 | 546 |
| Number of Expected Births | Mar 24 | 407 | 400 | | | 414 | 335 | 493 |
| Number of Births | Mar 24 | 315 | 333 | | | 335 | 280 | 389 |
| Number of Births (≥24 weeks) | Mar 24 | 315 | - | | | 334 | 279 | 388 |
| Number of Babies Born ≥24/40 | Mar 24 | 320 | - | | | 337 | 278 | 396 |
| Preterm Births All Outcomes(6% National Ambition, S | Mar 24 | 6.3% | 6.0% | | | 6.9% | 2.4% | 11.3% |
| Attrition Rate | Mar 24 | 23.0% | 20.0% | | | 19.1% | 5.3% | 33.0% |
| Bookings By 9+6 Weeks(Target 75.5%) | Mar 24 | 53.0% | 75.0% | | | 47.1% | 27.2% | 66.9% |
| Bookings By 12+6 Weeks | Mar 24 | 87.4% | 81.3% | | | 86.9% | 79.9% | 94.0% |
| Smoking At Booking(Target -> 12.1%: NMPA Clinical R | Mar 24 | 6.3% | 12.5% | | | 6.6% | 3.0% | 10.2% |
| Smoking At Birth(Target: 6% RPQOG) | Mar 24 | 3.2% | 6.0% | | | 5.2% | 1.4% | 9.0% |
| CO Screening At Booking | Mar 24 | 91.2% | 80.0% | | | 90.6% | 78.1% | 103.1% |
| CO Screening At 36 Weeks | Mar 24 | 64.8% | 80.0% | | | 63.0% | 43.5% | 82.5% |
| | | | 95.0% | | | | | |
| | | | 95.0% | | | | | |
| | | | 95.0% | | | | | |
| Skin To Skin Contact | Mar 24 | 89.7% | 74.7% | | | 87.1% | 79.0% | 95.3% |
| Breastfeeding Initiated(UNiCEF Target: 80%) | Mar 24 | 86.3% | 74.9% | | | 81.0% | 72.5% | 89.4% |
| Breastfeeding At Discharge From Hospital(UNICEF Tar | Mar 24 | 84.4% | 80.0% | | | 81.5% | 71.5% | 91.4% |

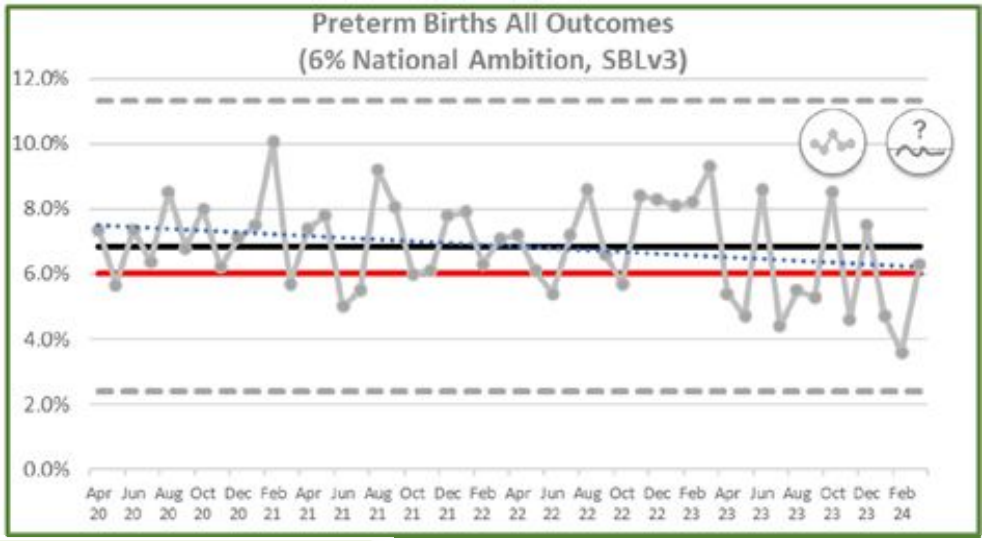



| Activity Indicator | Target | October | November | December | January | February | March | Monthly Average |
|---|---|---|---|---|---|---|---|---|
| All Bookings | >400 | 370 | 439 | 333 | 430 | 444 | 364 | 395 |
| Bookings by 9+$^{6}$ weeks | >75% | 36.8% | 47.2% | 56% | 47.9% | 52.3% | 53.0% | 47% |
| Attrition Rate | >20% | 19% | 22.5% | 14.2% | 8.6% | 20.9% | 23% | 18% |

| Background | What the data tells us | Issues | Actions | Mitigations | Causes & Changes |
|---|---|---|---|---|---|
| This graph looks at the number of bookings into the Maternity Service in February 2024.<br>This is based on 4,100 births for FY 2022/23 -20% attrition. | The number of bookings is below target for the month however, the general trend indicates a decline in booked pregnancies at West Herts on pre pandemic levels. | • The number of women being booked by 9+6/40 has decreased since the return to face-to-face bookings.<br>• Bookings: 364 in total:-<br>63% Referred & Booked by 9+6<br>13% Referred too late to book at 9+6 | • Outpatient Matron reviewing gestation at time of referral and if that is having an impact on booking gestation; action plan to follow.<br>• Additional workforce being allocated to address current vacancy shortfall in community midwifery. | • Referrals are triaged and women are booked in priority order. | Reasons for attrition:<br>• AN Care discontinued<br>• Left the district<br>• Miscarriage<br>• Termination |



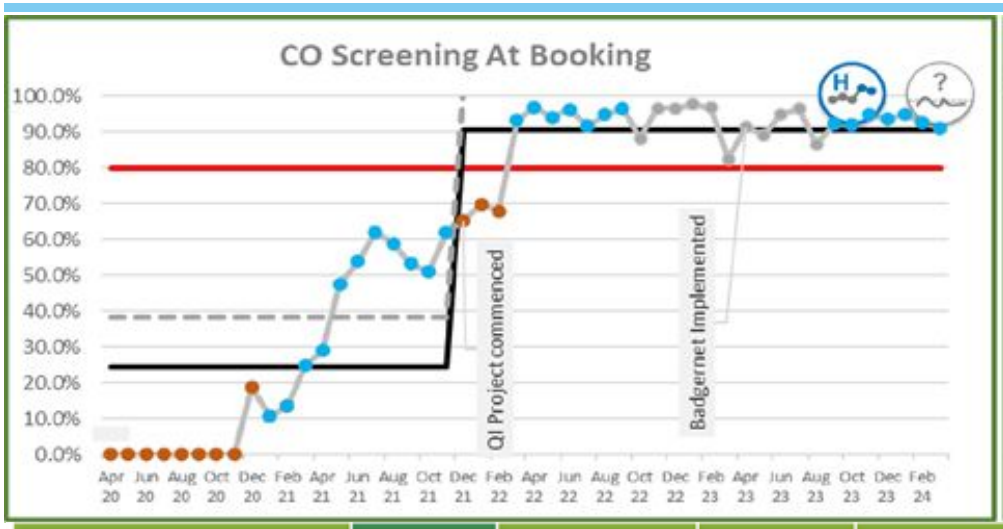



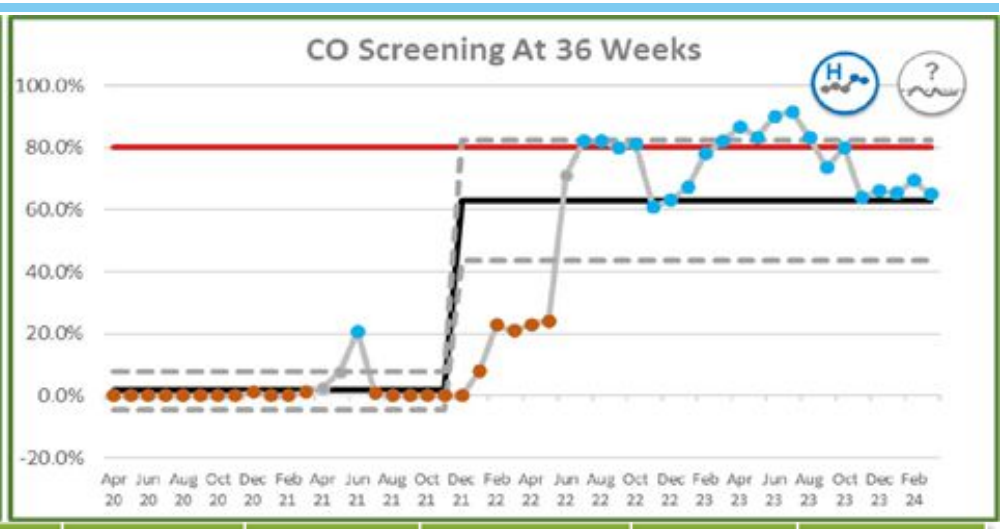

| Activity Indicator | Target | December | January | February | March | YTD |
|---|---|---|---|---|---|---|
| Number of Births ≥24/40 | >333 | 321 | 314 | 301 | 315 | 3477 |
| Pre-Term Births | ≤6% | 7.5% | 4.7% | 3.6% | 6.3% | 5.8% |
| No. of Babies Born ≥24/40 | - | 317 | 317 | 303 | 320 | 3519 |
| In-Utero Transfers (Out) | - | 0 | 2 | 2 | 2 | 9 |

| Background | What the data tells us | Issues | Actions |
|---|---|---|---|
| These graphs represent the total number of births and preterm births (>24/40, all outcomes). | The number of births per month continues to be lower than target and has shown a sustained decline in recent months. Rolling total of births for last 12 months is 3,810. The percentage of preterm births YTD is below benchmark. | • 4 sets of Twins were born<br>• 75% of preterm births were from non-British ethnic group, which was disproportionately high compared to births by ethnic group. | All efforts are made to ensure that women birth in appropriate care settings and are transferred to tertiary units where appropriate. Further trend data regarding ethnicity and preterm birth will be collated to gain baseline prior to improvement activities. |

**Births by Ethnicity**

| | | % of Total Cohort |
|---|---|---|
| Any other ethnic group | 47 | 14.9% |
| Asian-Other | 21 | 6.7% |
| Bangladeshi | 1 | 0.3% |
| Black African | 11 | 3.5% |
| Black Caribbean | 1 | 0.3% |
| British | 124 | 39.4% |
| Chinese | 3 | 1.0% |
| Indian | 24 | 7.6% |
| Irish | 2 | 0.6% |
| Mixed-Other | 5 | 1.6% |
| Pakistani | 25 | 7.9% |
| White and Asian | 2 | 0.6% |
| White and Black Caribbean | 2 | 0.6% |
| White-Other | 47 | 14.9% |




| Saving Babies Lives | Target | October | November | December | January | February | March | YTD | Average |
|---|---|---|---|---|---|---|---|---|---|
| Smoking at Booking | ≤12.1% | 7.8% | 4.7% | 5.4% | 6.8% | 7.4% | 6.3% | 6.1% | |
| Smoking at Birth | ≤6% | 4.2% | 3.0% | 5.3% | 5.0% | 5.3% | 3.2% | 4.8% | |
| CO Screening at Booking | ≥80% | 89.5% | 94.9% | 93.7% | 94.9% | 92.6% | 91.2% | 92.5% | |
| CO Screening at 36 Weeks | ≥80% | 79.9% | 63.94% | 66.0% | 65.2% | 69.4% | 64.8% | 79.8% | |

| Background | What the data tells us | Issues | Actions | Mitigations | Causes & Changes |
|---|---|---|---|---|---|
| SBLv2 target to achieve 80% screening compliance at booking and 36/40. | Special cause variation indicates that there has been a change in the process of capturing screening information; this has been due to the implementation of a QI project commenced in December '21. | Compliance has dropped since September 2023; further work required to understand where the shortfalls in practice. Compliance at 36/40 is challenging because women follow several different pathways and will be seen by a variety of clinicians at this gestation. 327 women were 36-37 weeks pregnant in March, of these only 212 were screened.<br>• 5 women declined<br>• 31 women were not offered | • Action required by Outpatient Matron to investigate areas on non-compliance. Results due to be presented in April Audit meeting. | | Introduction of 'Stop Smoking Service' in October. 2022. |

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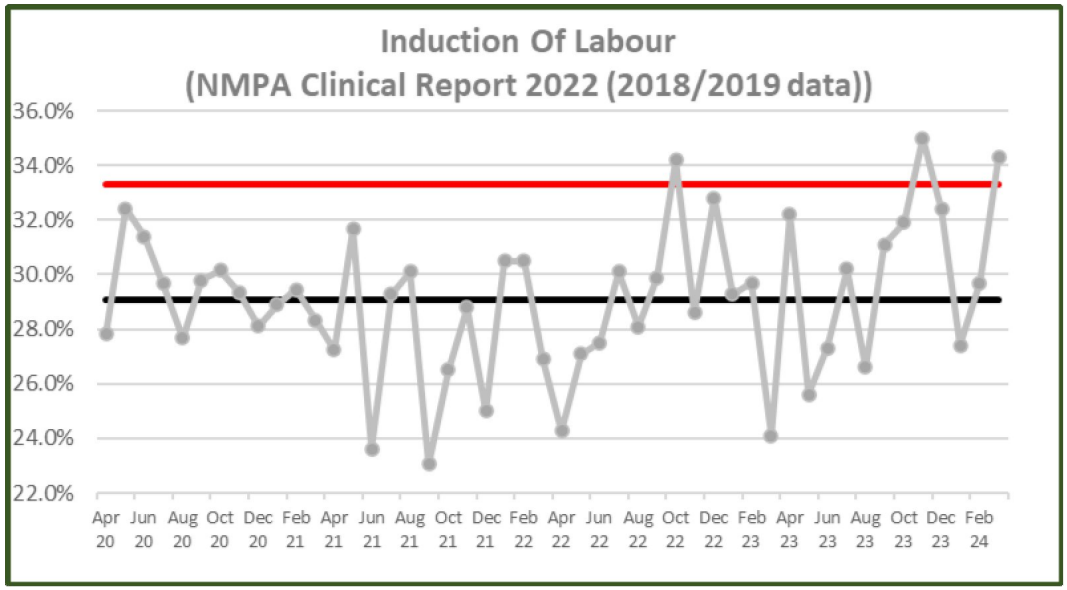
## Birth Place & Birth Outcomes

| KPI | Latest month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| Births On Delivery Suite (Benchmark: NMPA Clinical R | Mar 24 | 86.7% | 85.5% | | | 88.2% | 80.4% | 96.0% |
| Births On Birth Centre(Benchmark: NMPA Clinical Reg | Mar 24 | 12.1% | 12.4% | | | 9.8% | 2.1% | 17.5% |
| BBA((Benchmark: NMPA Clinical Report 2019 (2016/1 | Mar 24 | 1.9% | 0.2% | | | 1.0% | -0.7% | 2.6% |
| Homebirths(Benchmark: NMPA Clinical Report 2019 | Mar 24 | 0.6% | 2.0% | | | 0.8% | -0.6% | 2.3% |
| Induction Of Labour(NMPA Clinical Report 2022 (2018 | Mar 24 | 34.3% | 33.3% | | | 29.1% | 20.9% | 37.2% |
| Total Vaginal Births | Mar 24 | 55.2% | - | | | 61.0% | 53.2% | 68.8% |
| Spontaneous Vaginal Births(Benchmark: NHS Matern | Mar 24 | 45.1% | 0.59.9 | | | 49.3% | 41.9% | 56.7% |
| Instrumental Vaginal Births(Benchmark: NHS Matern | Mar 24 | 10.2% | 12.3% | | | 11.6% | 6.2% | 17.0% |
| | | | - | | | | | |
| | | | - | | | | | |
| | | | - | | | | | |
| | | | - | | | | | |
| LSCS At Full Dilatation | Mar 24 | 1.2% | - | | | 7.2% | -1.5% | 15.9% |
| Vaginal Birth After Caesarean: Suitable | Mar 24 | 12.7% | 22.3% | | | 18.1% | -0.8% | 37.0% |
| Vaginal Birth After Caesarean: Attempted | Mar 24 | 28.0% | 60.9% | | | 48.7% | 13.1% | 84.4% |
| Episiotomies | Mar 24 | 21.3% | - | | | 24.6% | 13.9% | 35.3% |
| Episiotomies: All Vaginal Births(Term, Cephalic, Singl | Mar 24 | 21.4% | 25.1% | | | 24.6% | 12.0% | 37.2% |
| Episiotomies: Spontaneous Vaginal Births (TCS)(Benc | Mar 24 | 7.3% | 9.9% | | | 10.7% | 3.7% | 17.8% |
| Episiotomies: Instrumental Births (TCS)(Benchmark:I | Mar 24 | 83.9% | 88.9% | | | 84.0% | 66.0% | 102.0% |
| 3rd/4th Degree Tears: Total | Mar 24 | 2.9% | - | | | 3.2% | -0.8% | 7.2% |
| 3rd/4th Degree Tears(Term, Cephalic, Singleton) | Mar 24 | 3.0% | 3.2% | | | 3.0% | -1.0% | 7.1% |
| 3rd/4th Degree Tears: Spontaneous Births (TCS)(Benc | Mar 24 | 3.6% | 2.5% | | | 2.4% | -2.2% | 7.0% |
| 3rd/4th Degree Tear: Instrumental Births (TCS)(Benc | Mar 24 | 0.0% | 6.3% | | | 6.8% | -5.3% | 18.8% |
| | | | 0 | | | | | |
| | | | 1 | | | | | |




| Indicator | | Marc | | |
|---|---|---|---|---|
| | | Number | % of total cohort | KPI |
| Induction Of Labour | Any other ethnic group | 22 | 20.4% | 7.0% |
| Induction Of Labour | Asian-Other | 7 | 6.5% | 2.2% |
| Induction Of Labour | Black African | 2 | 1.9% | 0.6% |
| Induction Of Labour | British | 43 | 39.8% | 13.7% |
| Induction Of Labour | Chinese | 1 | 0.9% | 0.3% |
| Induction Of Labour | Indian | 7 | 6.5% | 2.2% |
| Induction Of Labour | Pakistani | 8 | 7.4% | 2.5% |
| Induction Of Labour | White and Asian | 1 | 0.9% | 0.3% |
| Induction Of Labour | White and Black Caribbean | 1 | 0.9% | 0.3% |
| Induction Of Labour | White-Other | 16 | 14.8% | 5.1% |
| Induction Of Labour | | 108 | | 34.3% |

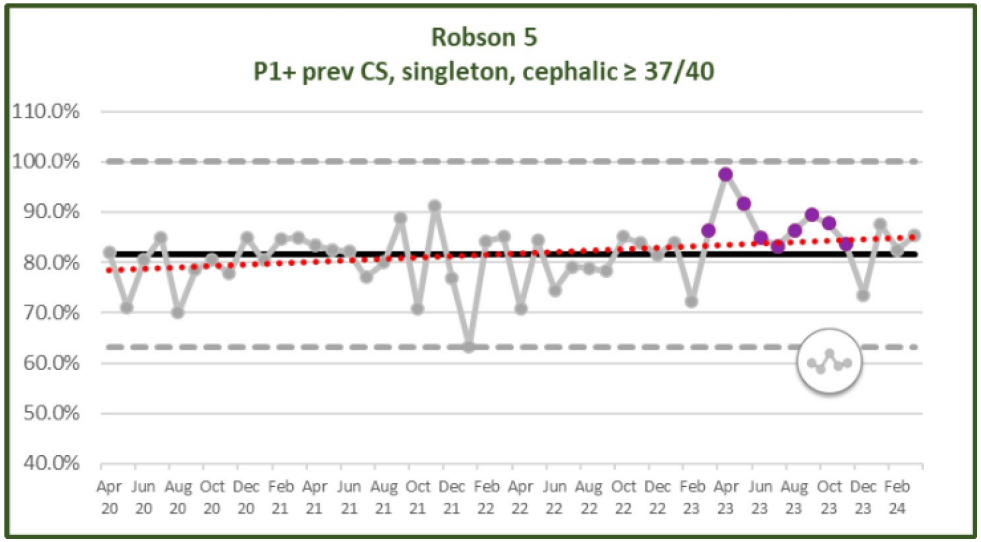
Proportion of Births British Ethnicity: 39.4%

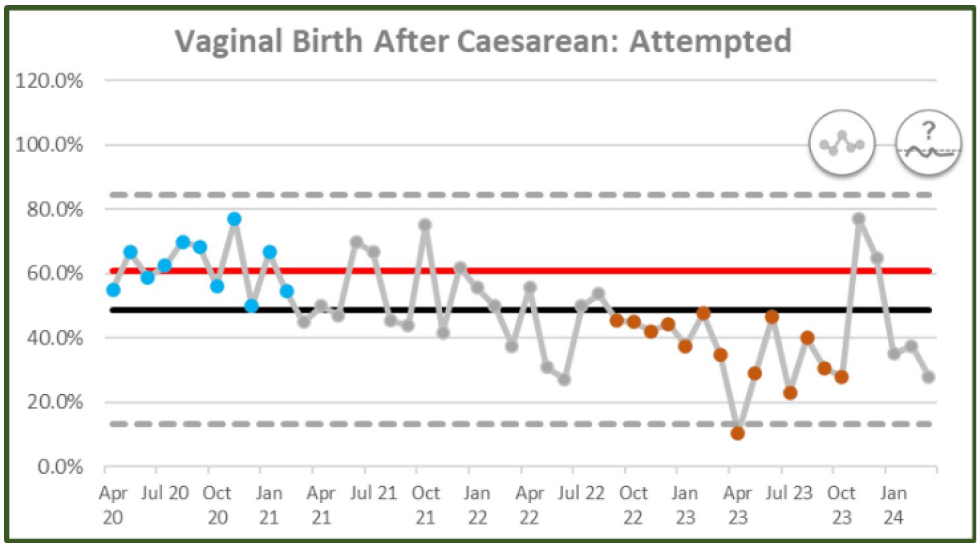
| Birth Outcomes | Target | October | November | December | January | February | March | YTD Ave |
|---|---|---|---|---|---|---|---|---|
| Induction of Labour | ≤33.3% | 31.9% (113) | 35% (106) | 32% (104) | 27.4% (87) | 29.7% (90) | 34.3% (108) | 29.9% (95) |

| Background | What the data tells us | Actions |
|---|---|---|
| The number of women who were induced in the month, including augmentation. | The number of women who labour is below benchmark target of 29.9%. The offer of induction of labour has been extended to all women who reach 41/40 as per NICE guidance.<br>40 women birthed their baby after 41 weeks. 10 women (25%) birthed their baby spontaneously after this gestation.<br>There does not appear to be any ethnic group that is disproportionately more likely to have an induction however, trend analysis will be monitored. | • IOL audit has been completed by Consultant Midwife for Transformation.<br>• Development of IOL pathway by Clinical Pathway Group.<br>• Ongoing review required to determine that all women are offered IOL at 41 weeks. |

## Birth Place & Birth Outcomes

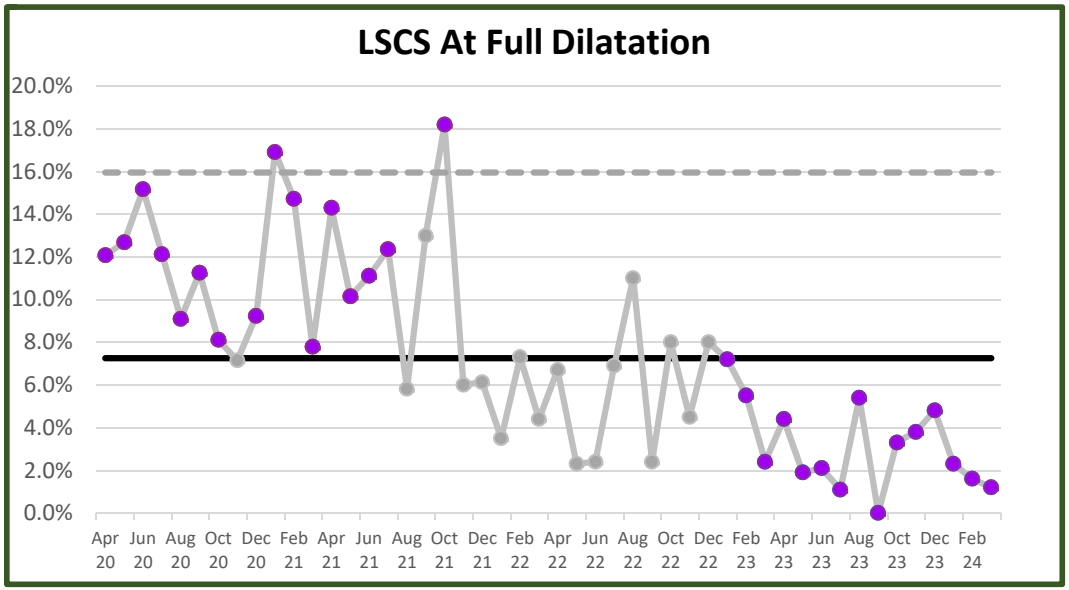
| KPI | Latest month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| Robson 1P0, singleton, cephalic,≥ 37/40 | Mar 24 | 28.2% | 0.0% | | | 19.8% | 5.9% | 33.7% |
| Robson 2aP0, singleton, cephalic, term, induced, del | Mar 24 | 38.6% | 0.0% | | | 41.4% | 6.7% | 76.0% |
| Robson 2bP0, singleton cephalic at term, admitted ar | Mar 24 | 100.0% | 0.0% | | | 98.1% | 87.9% | 108.3% |
| Robson 3P1, prev singleton VB, Term, spontaneous or | Mar 24 | 3.2% | 0.0% | | | 4.6% | -13.3% | 22.5% |
| Robson 4aP1+ Prev vaginal birth, singleton, cephalic, | Mar 24 | 9.5% | 0.0% | | | 6.7% | -5.3% | 18.8% |
| Robson 4bP1+ prev vaginal birth, singleton, cephalic, | Mar 24 | 100.0% | 0.0% | | | 100.0% | 100.0% | 100.0% |
| Robson 5P1+ prev CS, singleton, cephalic ≥ 37/40 | Mar 24 | 85.4% | 0.0% | | | 81.6% | 63.1% | 100.2% |
| Robson 6PO, singelton, breech | Mar 24 | 90.0% | 0.0% | | | 88.8% | 49.6% | 128.0% |
| Robson 7P1, prev CS singleton breech | Mar 24 | 100.0% | 0.0% | | | 82.6% | 15.5% | 149.8% |
| Robson 8All women, multiple pregnancies | Mar 24 | 60.0% | 0.0% | | | 73.8% | 12.4% | 135.3% |
| Robson 9All women, transverse or oblique lie | Mar 24 | 100.0% | 0.0% | | | 59.4% | -83.3% | 202.0% |
| Robson 10All women, singleton, cephalic, preterm | Mar 24 | 72.7% | 0.0% | | | 48.1% | 6.8% | 89.4% |
| | | | 0 | | | | | |




| Birth Outcomes | Target | October | November | December | January | February | March | YTD Average |
|---|---|---|---|---|---|---|---|---|
| VBAC: Suitable | ≥22.3% | 12.3% | 16.7% | 23.2% | 13.5% | 19.4% | 12.7% | 15.8% |
| VBAC: Attempted | ≥60.9% | 28% | 76.9% | 65% | 35% | 37.5% | 28% | 38.4% |

| Background | What the data tells us | Issues | Actions | Mitigations | Causes & Changes |
|---|---|---|---|---|---|
| • The number of women who had a VBAC as a % of all those who attempted a VBAC | • Lower than expected number of women choose to birth vaginally after caesarean section | • 55 women were eligible for a VBAC in March. Of the 55, 30 opted to have an Elective Caesarean. Of the remaining 25 women 7 had a vaginal birth.<br>• Robson 5 Cohort: 48 Women – 29 had a planned caesarean birth, 12 had an unplanned caesarean birth, and 7 had a vaginal birth. | • Introduction of Birth after Caesarean class in 2024. | | |




| Birth Outcomes | Target | October | November | December | January | February | March | YTD Average |
|---|---|---|---|---|---|---|---|---|
| LSCS at Full Dilatation | - | 3.4% | 5.9% | 4.8% | 2.3% | 1.6% | 1.2% | 3.6% |

| Background | What the data tells us | Issues | Actions | Mitigations | Causes & Changes |
|---|---|---|---|---|---|
| • The births as a percentage of all CS that resulted in a CS at full dilatation. | • 3 women had a caesarean birth at full dilatation. | • 2 Delays in second stage of labour<br>• 1 Failed instrumental | • Review in place by Obstetric Lead Consultant to review cases of Failed Instrumental births. | | |

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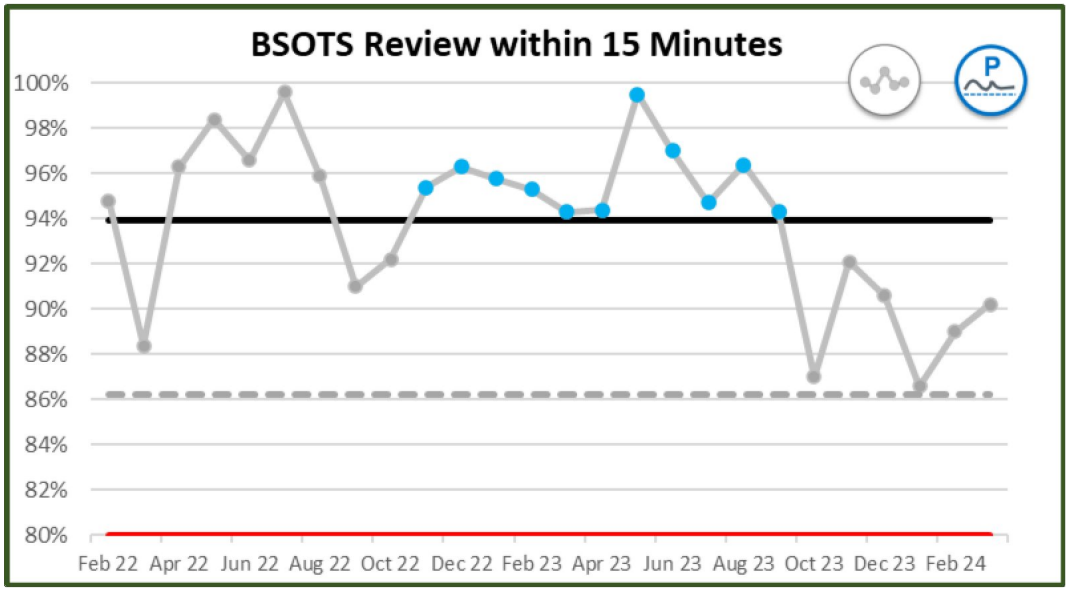
## Maternal Clinical Indicators

| KPI | Latest month | Measure | Target | Variation Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|
| VTE Risk Assessment | Mar 24 | 89.9% | 95.0% | | 93.9% | 87.0% | 100.8% |
| MOH: Blood Loss >1500ml: All(Benchmark: NMPA Clir | Mar 24 | 3.5% | 2.8% | | 2.8% | 0.0% | 5.7% |
| MOH: Blood Loss >1,500ml: TCS(Benchmark: NMPA Cl | Mar 24 | 3.9% | 2.9% | | 2.7% | -0.7% | 6.2% |
| MOH: Blood Loss >1,500ml: Vaginal(Benchmark: NMF | Mar 24 | 4.8% | 2.1% | | 2.5% | -1.0% | 6.0% |
| MOH: Blood Loss >1,500ml: SVB(Benchmark: NMPA Cl | Mar 24 | 2.9% | 0.0% | | 1.5% | -2.1% | 5.2% |
| MOH: Blood Loss >1,500ml: Instrumental(Benchmarl | Mar 24 | 12.9% | 0.0% | | 6.6% | -5.8% | 18.9% |
| MOH: Blood Loss >1,500ml: CS(Benchmark: NMPA Cli | Mar 24 | 1.8% | 3.9% | | 3.0% | -1.7% | 7.7% |
| MOH: Blood Loss >4000ml: All | Mar 24 | 0.0% | 0.0% | | 0.0% | -0.2% | 0.3% |
| BSOTS Review within 15 Minutes | Mar 24 | 90.2% | 80.0% | | 93.9% | 86.2% | 101.6% |
| Eclampsia | Mar 24 | 0 | - | | 0 | 0 | 0 |
| ICU Admissions: Obstetrics | Mar 24 | 0 | - | | 1 | -2 | 3 |
| Post Partum Hysterectomies | Mar 24 | 0 | - | | 0 | 0 | 0 |
| Maternal Death | Mar 24 | 0 | - | | 0 | 0 | 1 |
| Postnatal Maternal Readmissions Within 42 days | Feb 24 | 2.3% | 3.3% | | 2.6% | -3.2% | 8.5% |
| Readmissions Following Caesarean Sections <30 day | Feb 24 | 1.3% | 0.0% | | 1.2% | -0.6% | 3.0% |
| Readmissions for Puerperal Sepsis & Other Puerpera | Feb 24 | 1.3% | 2.0% | | 0.9% | -0.5% | 2.2% |
| | | | - | | | | |




| Total | Abdo Pain | Hyper-tension | SROM | RFM |
|---|---|---|---|---|
| 643 | 74 | 17 | 39 | 264 |
| | 11.5% | 2.6% | 6% | 41.5% |
| ?Labour | AN Bleeding | Unwell | PN | Not Specified |
| 49 | 32 | 97 | 70 | 1 |
| 7.6% | 4.9% | 15% | 10.8% | |

| Maternal Clinical Indicators | Target | October | November | December | January | February | February | YTD Average |
|---|---|---|---|---|---|---|---|---|
| BSOTS: Review within 15 Minutes | ≥80% | 87% | 92.1% | 90.6% | 86% | 89% | 90% | 92.9% |

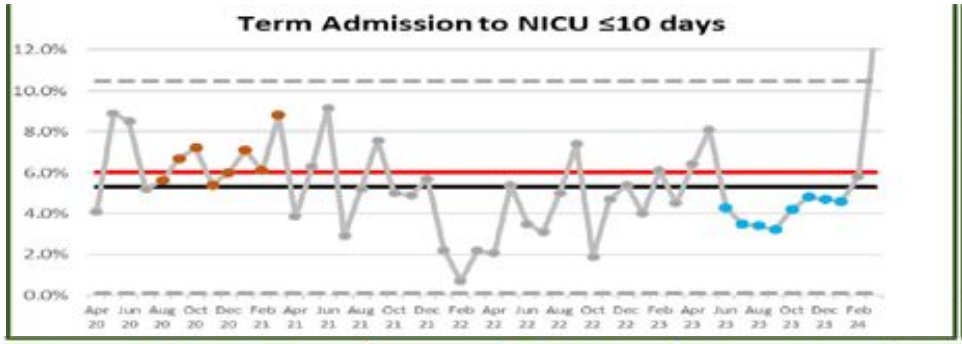
| Background | What the data tells us | Issues | Actions | Mitigations | Causes & Changes |
|---|---|---|---|---|---|
| The number of women assessed in Triage with 15 minutes of arrival. | | There were 643 triage attendances in March. 90% of women were reviewed within 15 minutes. | Lead Midwife for Triage has been appointed. Review of current Triage workflow to be undertaken.<br>QI project planned to address documentation issues on admission and transfer. | | |

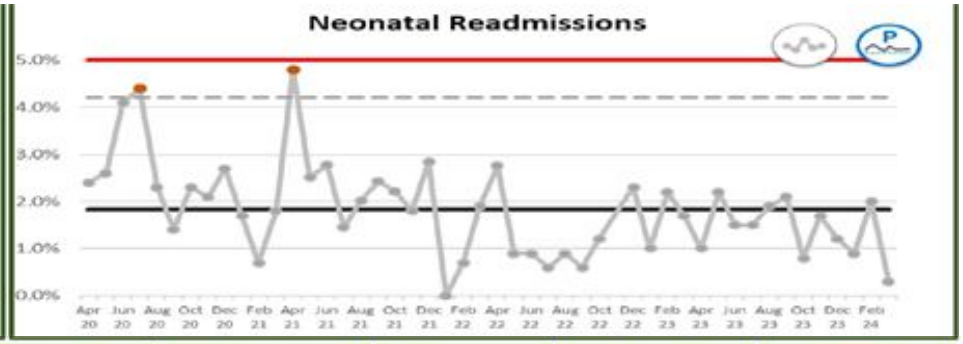
# Neonatal Clinical Outcomes and Exception Reports

## Neonatal Clinical Indicators

| KPI | Latest month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| Apgar Score <7 (term) | Mar 24 | 1.0% | 1.0% | | | 1.0% | -0.8% | 2.7% |
| Birth Weight <2500g (term) | Jul 23 | 3.8% | 3.0% | | | 2.6% | 0.1% | 5.1% |
| GAP & GROW <10th centile reported (quarterly) | Jun 23 | 11.5% | 10.0% | | | 12.5% | #N/A | #N/A |
| Term Admission to NICU ≤10 days | Mar 24 | 4.4% | 6.0% | | | 5.1% | 0.3% | 10.0% |
| Neonatal Readmissions | Mar 24 | 0.3% | 5.0% | | | 1.8% | -0.5% | 4.2% |
| Meconium Aspiration | Mar 24 | 0 | 0 | | | 1 | -2 | 3 |
| Hypoxic Encephalopathy ≥37/40 | Mar 24 | 1 | 0 | | | 0 | #N/A | #N/A |
| Shoulder Dystocia Resulting in Neonatal Injury | Mar 24 | 0 | 0 | | | 0 | 0 | 0 |
| Intrapartum Stillbirth | Mar 24 | 0.0% | - | | | 0.0% | -0.1% | 0.1% |
| Antepartum Stillbirth | Mar 24 | 0.0% | - | | | 0.4% | -0.6% | 1.3% |
| TOP >24/40 | Mar 24 | 0 | - | | | 0 | 0 | 1 |
| Early Neonatal Death (>24 weeks) | Mar 24 | 0.0% | - | | | 0.0% | -0.1% | 0.1% |
| Late Neonatal Death | Mar 24 | 0.0% | - | | | 0.0% | 0.0% | 0.1% |
| | | | - | | | | | |

# Avoiding Term Admissions into Neonatal Units (ATAIN)




| Neonatal Clinical Indicators | Target | October | November | December | January | February | March | YTD Average |
|---|---|---|---|---|---|---|---|---|
| Term Admission to NICU | <6% | 4.2% | 4.8% | 4.7% | 4.6% | 5.8% | 4.4% | 4.8% |
| ATAIN | | | 14 (100%) | 2 (14.3%) | 2 (14.3%) | 1 (5.9%) | 2 (15.4%) | |
| Neonatal Readmission | ≤5% | 0.8% | 1.7% | 1.2% | 0.9% | 0.9% | 0.3% | 1.5% |

| Background | What the data tells us | Issues | Actions | Mitigations | Causes & Changes |
|---|---|---|---|---|---|
| These charts look at the number of term babies admitted to NICU, the rate of avoidable term admissions and the rate of neonatal admissions. | The data reflects common cause variation and does not reflect any deterioration or improvement in results. | There were 13 term admissions in March, two of which was avoidable. There were seven term admissions born at 37/40 and 38/40 (53%) weeks gestation. All seven births were either induced or had a caesarean birth before labour. | • Community and Outpatient Matron monitoring all readmissions for Jaundice. | | • Pilot scheme in progress on Katherine Ward to perform transcutaneous bilirubin checks on babies at risk of developing jaundice prior to discharge. The rate of readmissions appears to have decreased. |

# Avoiding Term Admissions into Neonatal Units (ATAIN) Quarter 4

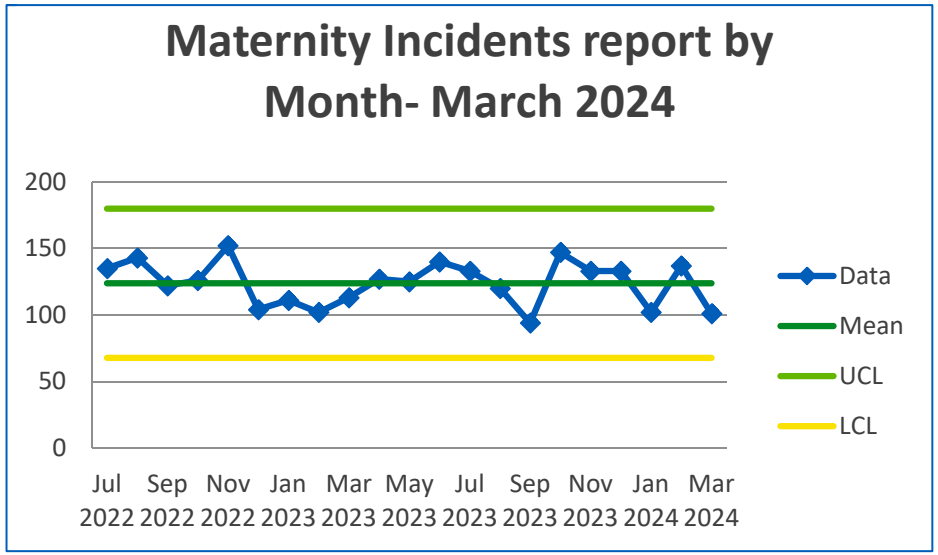
- This program is part of the Maternity and Neonatal safety Improvement plan (MatNeoSip) that provides the framework for best practice to reduce term admissions hence mother and baby separation. The trust has weekly multidisciplinary review of all term admissions (regardless of the length of stay) with a view to understanding reasons and identifying avoidable admissions. Learning is shared locally and LMNS wide aiming to reduce mother/infant separation.
- Nationally set target for term admission is < 6 %. The trust has achieved sustainable reductions in term admissions in the last 4 years (8.4 % to 5.6%). Whilst compared to the previous quarter, we saw a decrease in admissions appropriate for ATAIN review with a total of 43, the number of avoidable admissions however increased in the reporting period, 11.6%.

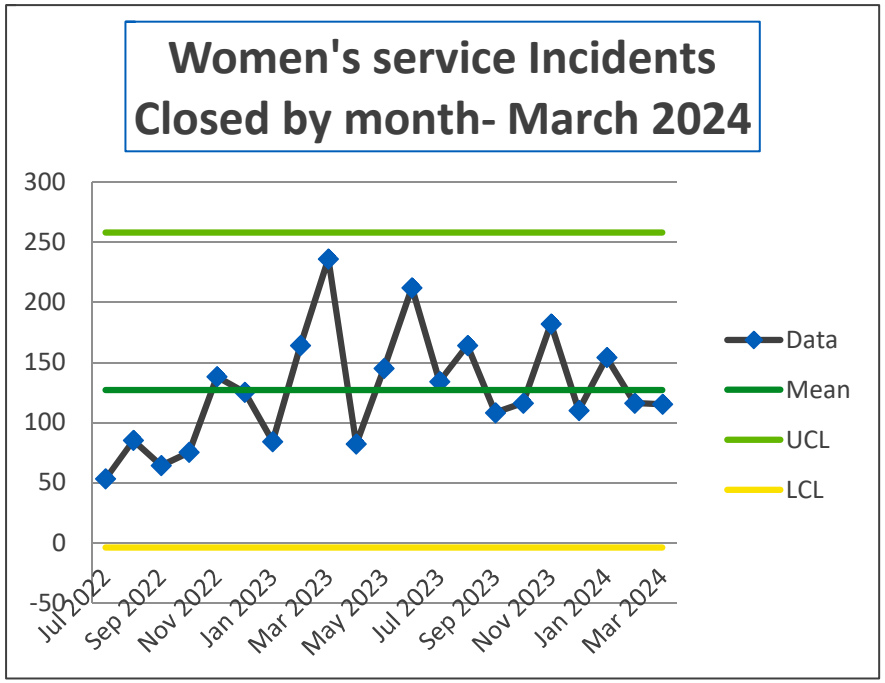
| Number of admissions | QTR 4 2023/2024 | QTR 3 2023/2024 |
|---|---|---|
| Admissions | 4.6% | 5.2% |
| Admissions >4hours | 3.1% (2 out of 20 cases avoidable) | 3.59% |
| Admissions <4hours | 1.4% (3 of the cases avoidable) | |
| Respiratory distress Syndrome (RDS) | 51% (22) | 55% |
| Observations | 9% (4) | 6% |
| Jaundice | 4.6% (2) | 20% |
| Hypoglycaemia | 4.6% (2) | 2% |
| Hypothermia | 6.9% (3) | 4% |
| Feed Tolerance | None | 6% |
| NAS | 4.6% (2) | None |
| Suspected sepsis | 4.6% (2) | None |
| HIE (MRI confirmed neither baby had HIE) | 4.6% (2) | None |
| Other | 4.6% (2) | 8% |

## Lessons learnt

- Review of the Hypoglycaemia framework
- Audit of the Sepsis Proforma
- Review of the Respiratory distress pathway
- To audit use of pulse oximetry
- To monitor administration of oxygen levels as part of the newborn assessment.

# Clinical Incidents Reporting




There are 134 (decrease of 12) open incidents (as at 27/03/2024) of which 38 (decrease of 19) are overdue incidents (open longer than 30 days) and 115 closed incident reports in March 2024.

Incidents open are reviewed at the end of patient safety meeting. Support meetings have been put in place to support incident handlers to close incident reports in real time to enable learning.

# Clinical Incidents Reporting

| | No Harm | Low Harm | Moderate Harm | Severe Harm | Death/ Catastrophic | Total |
|---|---|---|---|---|---|---|
| Community | 5 | 44 | 0 | 0 | 0 | 49 |
| Fetal Medicine | 3 | 6 | 0 | 0 | 0 | 9 |
| Antenatal Care | 9 | 10 | 0 | 0 | 1 | 20 |
| Midwifery | 45 | 88 | 17 | 0 | 1 | 151 |
| Obstetrics | 17 | 42 | 4 | 1 | 3 | 67 |
| Total | 79 | 190 | 21 | 1 | 5 | 296 |

All maternity incidents reviewed at patient safety meetings weekly and harm level reviewed. If moderate harm and above then duty of candour carried out, critical incident review discussion and potentially present to trust panel to consider the level of investigation.

Duty of Candour was 100% for both January and February. In March 100% compliance was not achieved and changes have been made to the monitoring processes as discrepancies in recording on DATIX was found which impacted on compliance data,

Of the 5 deaths reported 4 cases were stillbirths and one case was a 17-week miscarriage. All families are being supported by the Bereavement Team

# Patient Safety Incident Investigations

As the Trust is transferring to the new Patient Safety Incident Response Framework (PSIRF) both declared Serious Incidents and Patient Safety Incidents reporting will be reported.

No cases met the criteria to be reported to Maternity Neonatal Safety Investigation (MNSI) and there are no ongoing MNSI investigations

No never events were reported

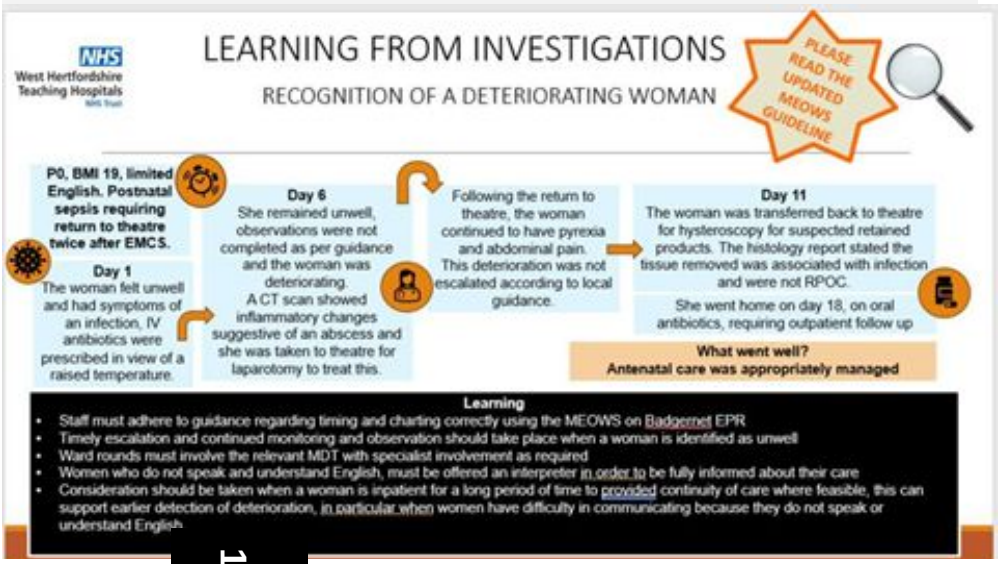
| Month | Type of Investigation | Subject | Externally Reported |
|---|---|---|---|
| March 24 | Serious Incident | NND of Twin 2 following preterm birth at 34+6/40 | Reported by the Tertiary Unit |
| January 24 | Serious Incident | Eclamptic seizure. | |
| December 23 | Serious Incident | Preterm birth NND at 21+4/40 | |
| June 23 | Serious Incident | Neonatal jaundice readmission- upgraded as abnormal MRI and hearing loss. (Neonatal led investigation with Maternity input). | |

# Patient Safety Incidents –Ongoing Root Cause Analysis

| Type of Investigation | Subject | Externally Reported |
|---|---|---|
| Root Cause Analysis | 17/40 miscarriage then MOH 2 litres | |
| Root Cause Analysis | Transfer to tertiary unit for therapeutic cooling. | Referred to MNSI however parents declined |
| Root Cause Analysis | Uterine rupture, neonatal transfer to tertiary unit for therapeutic cooling. | Referred to MNSI, not accepted as MRI normal. |
| Root Cause Analysis | Neonatal transfer for therapeutic cooling. | Not accepted by MNSI as MRI normal |
| Root Cause Analysis | Management of labour and undiagnosed transverse lie. | |
| After Action Review | Patient declined blood products | |

As we progress with PSIRF, the root cause analysis will fade out as we move to thematic reviews and after-action reviews.

# Learning from Patient Safety Incidents




Learning from incidents is disseminated through a variety of channels including:

- Maternity Teams Channel
- Padlet
- Newsletter
- Message of the Week
- Patient Safety Midwives attending Handovers
- Communication Boards
- Weekly safety alerts
- Team Meetings
- Posters

# Regulatory Compliance

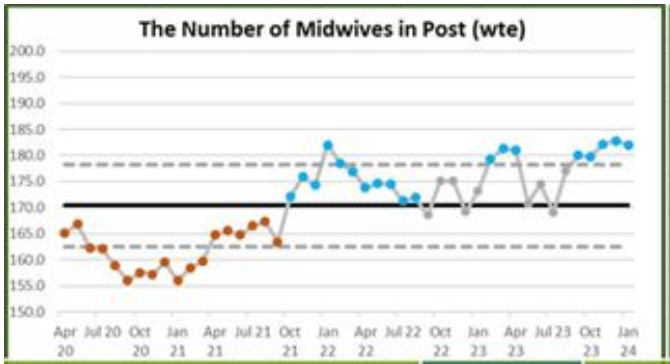
## Regulatory Bodies

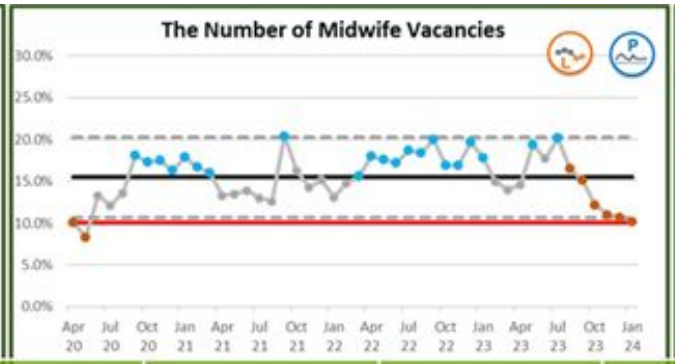
| | | CQC Domains | | | | | |
|---|---|---|---|---|---|---|---|
| CQC Rating | Date of Inspection | Safe | Effective | Caring | Responsive | Well-Led | Action Plan Status |
| RI | Oct 2021 | | | | | | Open |
| CQC Alerts(active alerts and year) | | None | | | | | |
| CQC Warning Notices | | None | | | | | |
| Regulatory Letters from the Coroner (29A) | | None | | | | | |
| NMC Concerns | | None | | | | | |
| GMC Concerns | | None | | | | | |
| RCM Concerns | | None | | | | | |
| HEE Concerns | | None | | | | | |
| HSIB/ MNSI concerns | | None | | | | | |

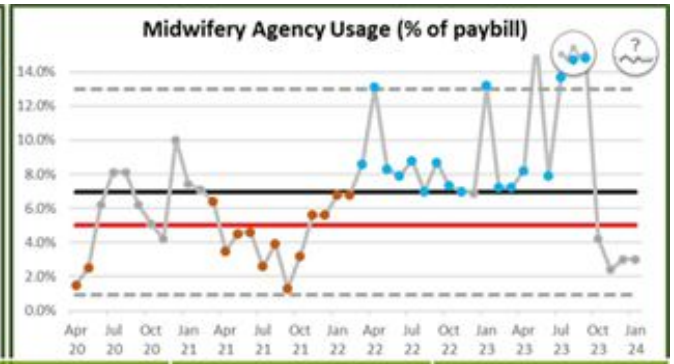
team westHerts

NHS West Hertfordshire Teaching Hospitals NHS Trust

# Safer Staffing- Midwifery




| Birthplace | Target | August | September | October | November | December | January |
|---|---|---|---|---|---|---|---|
| Establishment | ≤85.5% | 212 | 212 | 204.8 | 204.8 | 204.8 | 204.8 |
| Number of Midwives in Post | ≥15% | 177.1 | 180 | 179.8 | 182.2 | 182.8 | 184.6 |
| Number of Midwife Vacancies | <.02% | 16.5% | 15.1% | 12.2% | 11% | 10.7% | 10.2% |
| Maternity Leave | ≥2% | 3.8% | 4% | 3.9% | 3.7% | 3.6% | 3.6% |
| Midwife Absence Related to Sickness | ≤3.5% | 5.5% | 4.9% | 6.2% | 5.1% | 6.3% | 6.7% |
| Midwifery Bank Usage | ≤12% | 14.3% | 14.3% | 9.2% | 10.2% | 11.9% | 11.9% |
| Midwifery Agency Usage | ≤5% | 14.7% | 14.8% | 4.2% | 2.4% | 3.0% | 3.0% |
| Staff Fill Rate | ≥95% | 87.40% | 89.1% | 89.1% | 91.6% | 91.5% | |
| Midwife: Birth Ratio | ≤1:26 | 1:26 | 1:26 | 1:25 | 1:28 | 1:22 | 1:28 |

| Background | What the data tells us | Issues | Actions | Mitigations | Causes & Changes |
|---|---|---|---|---|---|
| Workforce KPI's.<br>Data is provided a month in arrears. | • The number of midwives in post increased in January. | • The number of midwifery vacancies has decreased, and associated agency expenses. | • Enhanced bank rates reviewed in light of lower vacancy rates in the unit so now only apply to Community Shifts | • Specialist midwives and operational team redeployed to support clinical areas when staffing challenging. | |

# Training and Education

| | SBLCBv3 | GAP GROW training | Fetal Surveillance in labour | Maternity emergencies and multi professional training | Personalised Care | Intrapartum care and Immediate PN care | Newborn life support |
|---|---|---|---|---|---|---|---|
| Jan | MWs 99%-Consultant obstetricians - 88% Other Obstetric Doctors- 74% | MWs 99%-Consultant obstetricians - 88% Other Obstetric Doctors- 74% | MWs 98%-Consultant obstetricians- 94% Other Obstetric Doctors- 100% | MWs- 99% MSWs/HCAs- 100% Consultant obstetricians- 88% Junior Drs- 96% Obstetric Anaesthetic Cons- 94% All other anaesthetic Doctors- 75% | MWs 99%-Consultant obstetricians - 88% Other Obstetric Doctors- 74% | MWs- 99% MSWs/HCAs- 100% Consultant obstetricians- 88% Junior Drs- 96% Obstetric Anaesthetic Cons- 94% All other anaesthetic Doctors- 75% | MWs- 100% Neonatal RNs- 99% ANNPs- 100% Neonatal Consultants- 100% Neonatal Junior Doctors- 100% |
| Feb | MWs- 99% Consultant obstetricians -94% Other Obstetric Doctors- 75% | MWs- 99% Consultant obstetricians -94% Other Obstetric Doctors- 75% | MWs 98%-Consultant obstetricians- 94% Other Obstetric Doctors- 95% | MWs- 98% MSWs/HCAs- 95% Consultant obstetricians- 94% Junior Drs- 96% Obstetric Anaesthetic Cons- 94% All other anaesthetic Doctors- 83% | MWs- 99% Consultant obstetricians-94% Other Obstetric Doctors- 75% | MWs- 98% MSWs/HCAs- 95% Consultant obstetricians- 94% Junior Drs- 96% Obstetric Anaesthetic Cons- 94% All other anaesthetic Doctors- 83% | MWs- 99% Neonatal RNs- 100% ANNPs- 100% Neonatal Consultants- 100% Neonatal Junior Doctors- 100% |
| March | MWs- 99% Consultant obstetricians - 100% Other Obstetric Doctors- 96% | MWs- 99% Consultant obstetricians - 100% Other Obstetric Doctors- 96% | MWs 99%-Consultant Obstetricians- 98% Other Obstetric Doctors- 100% | MWs- 98% MSWs/HCAs- 93% Consultant obstetricians- 94% Other Obstetric Doctors- 96% Obstetric Anaesthetic Cons- 100% All other anaesthetic Doctors-92% | MWs- 99% Consultant obstetricians- 100% Other Obstetric Doctors- 96% | MWs- 98% MSWs/HCAs- 93% Consultant obstetricians- 94% Other Obstetric Doctors- 96% Obstetric Anaesthetic Cons- 100% All other anaesthetic Doctors-92% | MWs- 98% Neonatal RNs- 100% ANNPs- 100% Neonatal Consultants- 100% Neonatal Junior Doctors- 100% |

# Maternity Incentive Scheme Year 6

- Trust received formal notice of a successful year 5 submission.
- Results have now been released. 92 of the 120 Maternity Units successfully achieved Year 5
- Year 6 was published in April 2024 and baseline assessment is shown
- Several requirements have been removed which in essence suggests that current compliance needs sustaining
- Safety Action 3 and 6 require quality improvement projects

| Safety Action | Topic | RAG | Comments |
|---|---|---|---|
| 1 | PMRT | On Track | To sustain current performance |
| 2 | MSDS | Partial Compliance Jan 2024 | Smoking at delivery and ethnicity data quality requires improvement |
| 3 | ATAIN | On Track | Quality Improvement Project to be completed |
| 4 | Clinical staffing | On Track | To sustain current performance and comply with latest BAPM standards for Neonatal Staffing |
| 5 | Midwifery Staffing | On Track | To sustain current performance |
| 6 | Saving Babies Lives | On Track | Quarterly meetings with ICB arranged. Quality Improvements to be undertaken |
| 7 | Engagement with Women | On Track | To ensure the MNVP lead is a key member of Trust Safety and Governance Meetings |
| 8 | MDT education | On Track | |
| 9 | Board Assurance | On Track | Maternity needs to be on every Trust Board and Quality Governance Committee |
| 10 | MNSI | On Track | |

NHS
West Hertfordshire Teaching Hospitals
NHS Trust

# Public Trust Board
# 02 May 2024

| | |
|---|---|
| **Title of the paper:** | Response to CQC Letter regarding Paediatric Audiology |
| **Agenda Item:** | 15 |
| **Presenter:** | Penny Snowden, Director of Midwifery /Deputy Chief Nurse |
| **Author(s):** | Penny Snowden, Director of Midwifery /Deputy Chief Nurse |
| **Purpose:** | Please tick the appropriate box<br>For approval: X<br>For discussion:<br>For information: X |
| **Executive Summary:** | The purpose of this report is to provide the Quality Committee<br>▪ To summarise the CQC letter received by the Organisation 16th April 2024 and the associated action required to be undertaken.<br>▪ Whilst the Trust does not provide Paediatric Audiology services, the Trust does undertake Newborn Hearing Screening.<br>▪ Accreditation in relation to Newborn Screening was discussed with the Screening Quality Assurance Service as it was a recommendation in the 2022 Antenatal and Newborn Screening Quality Assurance Visit.<br>▪ It was confirmed that the Improving Quality in Physiological Services (IQIPS) only applies to Paediatric Audiology which does not include Newborn Hearing Screening.<br>▪ Paediatric Audiology Services are currently provided by Hertfordshire Community Trust which according to their latest Public Board Papers (March 2024) are reporting significant pressures in waiting times (555 children with a wait over 40 weeks, 255 waiting over 52 weeks) |
| **Trust strategic aims:**<br>*(please indicate which of the 4 aims is relevant to the subject of the report)* | **Aim 1 Best care** — ***Objectives 1-4*** — X<br>**Aim 2 Great team** — ***Objectives 5-8***<br>**Aim 3 Best value** — ***Objective 9***<br>**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?<br>☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?<br>☒Is there a culture of high quality, sustainable care?<br>☒Are there clear responsibilities, roles, and systems of accountability to |

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<table>
<tr><td></td><td>support good governance and management?<br>☒Are there clear and effective processes for managing risks, issues, and performance?<br>☒Is appropriate and accurate information being effectively processed, challenged, and acted on?<br>☒Are the people who use services, the public, staff, and external partners engaged and involved to support high quality sustainable services?<br>☒Are there robust systems and processes for learning, continuous improvement, and innovation?<br>☒How well is the trust using its resources?</td></tr>
<tr><td>Previously considered by:</td><td><table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td>None</td><td></td></tr></table></td></tr>
<tr><td>Action required:</td><td>The Board is asked to:<br><br>▪ To review the contents of the CQC letter and requested action to be taken by Trusts.<br>▪ To gain assurance that all relevant action has been completed by the Trust.<br>▪ To note that our response needs to be returned to the CQC.</td></tr>
</table>

West Hertfordshire Teaching Hospitals NHS Trust

**Agenda Item: 15**

**Public Trust Board meeting – 02 May 2024**

***CQC Letter regarding Paediatric Audiology***

**Presented by: Penny Snowden, Director of Midwifery/Deputy Chief Nurse**

## 1. Purpose

1.1 The purpose of this report is to assure the Board that the Trust has considered the letter received by the CQC regarding Paediatric Audiology (see appendix one) and that any action required by the Trust has been received. As requested by the CQC, the Trust Board is required to consider the contents of the letter at the next full board meeting and that an initial response is sent to the CQC by the 30th June 2024.

## 2. Background

2.1 The background to the letter being sent to Trusts by the CQC follows an expert review undertaken by NHS Lothian. That review reported failings in the standard of paediatric audiology services that resulted in delayed identification and missed treatment of children with hearing loss. For some children this resulted in permanent avoidable deafness.

2.2 Subsequent to the Scottish review, a review in England was undertaken of which 4 NHS Trusts were found to have similar failings. A Paediatric Hearing Services Improvement Programme was established by NHS England to support providers and Integrated Care Boards (ICB'S) to improve the quality of these services. The programme is undertaking work to understand the scale of the problem and the number of children who have been affected and to develop the strategic tools and interventions to support sustainable improvements.

2.3 The main themes identified by providers in the same survey were long waiting lists, staffing issues, increasing demands on services, barriers to Improve Quality in Physiological Services (IQIPS) accreditation and the resource of funding issues.

2.4 CQC are working closely with NHS England to understand the assurance boards have about the quality of hearing services for children that they commission or provide.

2.5 Trust Boards are being requested to consider the assurance that they have about the safety, quality and accessibility of children hearing services. Following that consideration, the Trust Board has to submit a report to the CQC that clarifies the Trust's position.

## 3. Analysis/Discussion

3.1 West Hertfordshire Teaching Hospitals NHS Trust (WHTHT) does not provide Paediatric Audiology

3.2 Paediatric Audiology is provided by Hertfordshire Community Service for West Hertfordshire children.

3.3 In the Public Trust Board Papers for Hertfordshire Community NHS Trust held in March 2024, significant pressures on paediatric audiology services were noted with 255 children waiting over 52 weeks and 55 waiting over 40 weeks. A shortfall in substantive staff to meet the demand was also reported. As such, paediatric audiology is recorded on their high-level risk register.

3.4 Hertfordshire Community NHS Trust is currently progressing improvement work against the IQIPS standards and hopes to achieve compliance withing 2 years.

3.5 The position for Hertfordshire Community NHS Trust is included in this report as many of the children who access WHTHT's paediatric services may also be referred to audiology. Additionally, the information provides the Trust Board of the challenges being experienced by system partners.

3.6 WHTHT does provide Newborn Hearing Screening Services, and this is part of the Maternity Services.

3.7 Newborn Hearing Screening is part of the national Antenatal and Newborn Screening Programme. Key Performance indicators are reported monthly internally and externally to the screening quality assurance service (SQAS). Assurance also includes external quality assurance visits to assess performance against the programme standards.

3.8 In 2022, an external quality assurance visit was undertaken and recommended that IQIPS accreditation should be achieved for the Newborn Hearing Screening. However, since then, the issue has been discussed further with SQAS who have confirmed that IQIPS does not include Newborn Screening and is only applicable to paediatric audiology.

3.9 Therefore, there is no further action for WHTHT with regards to the Letter received by the CQC

## 4. Risks

4.1 The risk to WHTHT is that children who are under the care of the Trust's Paediatric Services are also waiting for audiology services.

4.2 There is a risk that those babies who are referred to Paediatric audiology from the Newborn Hearing Screening Programme who may face delays. This is monitored monthly, and the Paediatric Audiology Lead from Hertfordshire Community NHS Trust does attend internal and system screening oversight meetings to discuss referrals and ongoing improvements. Currently, 2-3 babies are not seen in the required timeframe, and this is due to families out of the country or do not attend.

4.3 There is system risk to the health and wellbeing of local children given the current performance at Hertfordshire Community NHS Trust.

## 5. Recommendation

5.1 To consider including performance data on the Antenatal and Newborn Screening programme in the perinatal quality surveillance report to provide assurance of Newborn Hearing Programme.

**Kelly McGovern**
**Chief Nurse**

22 April 2024

**APPENDICES:**

**Appendix One: Letter from the CQC regarding Paediatric Audiology**

The independent regulator of health and social care in England

**8 April 2024**

Dear colleague,io

**Re: Paediatric audiology services**

As you may be aware, an expert review undertaken by NHS Lothian in Scotland found failings in the standard of paediatric audiology services that resulted in delayed identification and missed treatment of children with hearing loss. This resulted in permanent, avoidable deafness for some children.

These findings led to a review of the service provided by 4 NHS trusts in England which found similar failing. A Paediatric Hearing Services Improvement Programme has been established by NHS England to support providers and integrated care boards (ICBs) to improve the quality of these services. The programme is undertaking work to understand the scale of the problem and the number of children who have been affected, and to develop the strategic tools and interventions to support sustainable improvements.

Childhood deafness is a significant health and developmental risk. A National Deaf Children's Society survey in 2023 showed that:

- 527,898 children are known to the hearing services.
- In 2022 there were an estimated 8,405 children not supported by a hearing service.
- Ninety-four percent of children referred to ear nose and throat (ENT) services were missing the six-week initial appointment target, with an average waiting time of 141 days.
- More than half of respondents (52%) reported that their trusts were missing the 126-day target for grommets surgery. This was a rise of 23% since 2019. The average waiting time was now 178 days, with a maximum wait of 540 days.
- Most paediatric audiology services (79%) did not offer wax removal, and most of them referred children to ear nose and throat (ENT) services for this, leading to lengthy delays.
- Thirty-nine percent of services failed to meet the 42-day waiting list target for an initial hearing assessment for babies and children who were not referred via newborn hearing screening.
- Only 26 services (23%) reported that they were currently accredited by Improving Quality in Physiological Services (IQIPs).

The main themes identified by providers in the same survey were long waiting lists, staffing issues, increasing demands on services, barriers to gaining Improving Quality in Physiological Services (IQIPs) accreditation and other resource or funding issues.

The total number of children with permanent deafness reported to be on services' caseloads has decreased by more than 7% since 2019. The incidence of permanent deafness generally remains stable, so this may suggest that some children have not yet been identified.

CQC are working closely with NHS England to help understand the current situation across the country regarding the level of assurance boards have about the quality of hearing services for children that they commission or provide.

The UKAS IQIPS (Improving quality in physiological services) is the only recognised accreditation standard for physiological science services inclusive of audiology services. Whilst accreditation cannot be mandated by CQC, we strongly encourage participation in UKAS diagnostic accreditation schemes, including IQIPS. Participation and performance in such schemes are evidence of good practice that is used to inform CQC's judgements about the safety and quality of care. ICB's should ensure there are plans in place so that trusts can

implement, achieve, and maintain accreditation using the available tools, and that there is oversight of quality management systems.

Services that are not IQIPs accredited should formally register this as a quality risk in their quality reporting system.

Please can I ask that at the next full board meeting, the board considers the assurance that they have about the safety, quality, and accessibility of your children's hearing services. Following that consideration, the board should submit a report to CQC that makes clear:

- Whether you have achieved IQUIPS accreditation, including whether there were any improvement recommendations made.
- Whether you are working towards IQIPS accreditation.
- What stage that work has reached and the assurance the board has about paediatric audiology, using the IQIPS standards as a guide for the areas to tell us about.
- The expected timeline for gaining accreditation.
- The number and severity of incidents where a child has suffered detriment due to delayed or missed diagnosis or treatment or not received timely follow up care and support.

NHS England have asked that where services that are **not** UKAS IQIPS accredited, heads of services should provide an external evidence-based assessment of their provision. If your services are not UKAS IQIPS accredited, we would like you to include a copy of that assessment report when responding to this letter.

Boards may be aware that UKAS have a benchmarking tool for provider of audiology services considering accreditation to help them understand what stage they are at and where the focus of work may need to be. Please can you supply a copy of the completed tool if you have used it.

We are keen to understand the progress made towards accreditation and how the service across the county is improving over time. We would therefore ask that further to your initial report to CQC (as outlined above), an additional review of assurance is conducted at a subsequent board meeting and a further follow up report on progress is provided to us.

The intent of this letter is information gathering and to gain a picture of service provision and the speed with which improvements are being made across the country. We are wanting to collaborate with other stakeholders to do our part in bringing about improvements in the care and treatment of this cohort of children.

Information returns from providers will be shared with operational colleagues to add to the wider information held about providers. It may be used to assist in the determination of risk levels within services for children and young people, but at this point it is not the intent to undertake stand-alone site visits based on what we are told about the service in your trust. That does not mean we will not conduct a thematic review or bespoke assessment process in the future, but rather to reiterate that we want to focus on getting a clear picture about what is happening at provider level now.

For clarity, we require consideration by the full board at the next meeting. An initial response should be sent to CQC no later than 30 June 2024. A subsequent response should follow after the next full board meeting. If there is any reason this cannot be achieved, please do come back to us with the reasons and when you consider you might be able to tell us about your service.

Please send your responses to Terri Salt, the lead senior specialist for this work, by email to terri.salt@cqc.org.uk. Terri can also be contacted if you have any questions or queries about this letter.

Yours sincerely,

Prem Premachandran MBE
Medical Director
Care Quality Commission



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| | |
|---|---|
| **Agenda item:** | **16** |
| **Report to:** | **Trust Board** |
| **Title of Report:** | **Assurance report from the Finance and Performance Committee** |
| **Date of Committee meeting:** | **28 March 2024** |
| **Quoracy:** | **The meeting was quorate.** |
| **Date of Board meeting:** | **2 May 2024** |
| **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 28th March 2024. |
| **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.<br>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:**

- Committee approved the Draft Terms of Reference and workplan 2024-25 subject to reported changes.
- Committee approved the BAF
- Improvement in A&E performance, including Type1, positive progress on ambulance handover plan
- Committee recognised the effort and performance to exceed the mandated 76% target and thanked CMO, CNO and COO
- VWA expected to finish year at 102% - provides assurance for 24-25
- CFO reported in month surplus of £7.24m, YTD deficit £13.6m. The in-month movement was driven by receipt of £15.2 million distribution of ICB money, resulting in a net improvement of £10.6 million.
- YEF would likely show a deficit of £9.3 million, which was £4.2 million away from the expected forecast
- grip and control on spend being strengthened into the new financial year
- CIPS cost avoidance element has room for improvement and work to improve and avoid repeat
- work on cultural change and accountability via engagement with the divisions
- draft business plan submitted 21 March as part of the Integrated Care System's submission to NHS England. next submission due 02 May
- Capex for year c£50 million with £15 million that needed to be receipted off taking total to c£65 million
- Committee approved £10m Chairs Action for new surgical robot
- Committee Chair concerned the Trust was operating on capex as cash was low

- **Declarations of interest**
  - No changes notified. New online software system in place to live update / record
- **Minutes of last meeting**
  - Approved as circulated
- **Action log**
  - In progress and ongoing with two live actions (1 and 2)
- **Decision register**
  - Noted for information as an accurate record
- **Work plan and committee register**
  - Noted for information as an accurate record. Acting CFO advised current work may impact the

work plan – details to follow as they arise

- **Draft Terms of Reference**
  - The Draft Terms of Reference and workplan 2024-25 were approved subject to the reported changes.
- **BAF Finance Risk Register incl review of Corporate Risk Register**
  - BAF risks 7 and 8 interrelated – risk re balancing the position to year end
  - BAF risk 7 – increased from 12 to 16 with Acting CFO affirming more assured
  - Committee approved the BAF
- **Access Standard Performance and Activity Recovery Overview ('ASPARO')**
  - Improvement in A&E performance, including Type1
  - Positive progress on ambulance handover plan
  - Committee recognised the effort and performance to exceed the mandated 76% target and thanked CMO, CNO and COO
  - VWA expected to finish the year at 102% - another good effort and outcome and provides assurance for 24-25
  - Theatre utilisation flat
  - Work continues with High Impact Change Plan ('HICP')
- **Integrated Performance Report ('IPR')**
  - mortality metrics for SHMI and HSMR showing a significant increase in the rolling twelve-month metrics, however, Doctor Foster report was not included in the latest data and would be reviewed when available through the Mortality Review Group
  - Trust had improved to 99th out of 122 for type 1 performance and in March it was at 77% for all types and 59.3% for type 1
  - Discussion and clarification around mortality
  - CSO and CMO to check the strategy wording on expectations relating to mortality
  - UTC run by a PSP and will change in Sept 24
- **Month 11 finance summary**
  - CFO reported in month surplus of £7.24m, YTD deficit £13.6m. The in-month movement was driven by receipt of £15.2 million distribution of ICB money, resulting in a net improvement of £10.6 million.
  - YEF would likely show a deficit position of £9.3 million, which was £4.2 million away from the expected forecast
  - Associate Director of Operational Finance assured the Committee that as of 28 March Trust on track to hit the likely case deficit of £13.6 million.
  - Acting CFO reported shoots of recovery in the underlying position, and controls were being maintained to sustain the position into 2024-25
  - Committee Chair concerned the Trust was operating on capex as cash was low. Acting CFO assured monitoring closely with proactive borrowing plan if and when needed
- **Financial recovery plan - Month 11**
  - Acting CFO advised grip and control being strengthened into the new financial year
  - key elements of the recovery plan were being split into four actions, including doubling down and strengthening workforce controls, increasing the levels of authorisation, and cost improvements with associated plans were being stripped out
- **Efficiency programme**
  - Acting CFO advised cost avoidance element has room for improvement and is working to improve and avoid repeat
  - work on cultural change and accountability via engagement with the divisions
- **Contracts and commerce**
  - Committee noted contracts and commerce generally on track
  - Income has not been our problem
- **Business planning**
  - draft business plan submitted 21 March as part of the Integrated Care System's submission to NHS England
  - next submission due 02 May
  - fuller paper at the next committee meeting, noting that there may need to be prior committee governance sign-off

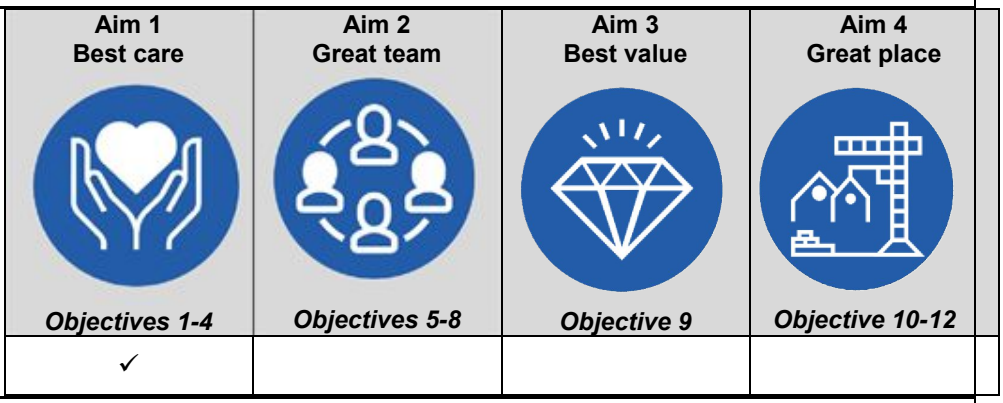
- **Capital programme**
  - Acting CFO reported £71.6 million to month 11 had been spent, £27 million in the last few weeks of the year, which included brokerage and the slippage of the national schemes into local schemes.
  - the Trust was at around £50 million with £15 million open commitments that needed to be receipted off, which got closer to £65 million.
  - Committee Chair concern using capex cash for opex and will need to be unwound
- **Business case to purchase robotics equipment**
  - Divisional Director of Surgery, Anaesthetic and Cancer presented a business case to purchase new robotic equipment.
  - Committee reminded this had been approved by Chair's action on 14 March 2024.
  - Committee heard the £10 million capital had been discussed by the Quality and Safety Committee and the Chair's Action meeting where a full discussion had been undertaken.
  - the Committee Chair suggested that data on the two existing robots was the most important piece of information and should have been more prominent in the business case. It was suggested that the paper could have been more commercial and important to see the longer-term strategy and the expected benefits realisation.
  - the business case was approved retrospectively

- **Items for escalation to the Board**
  - Business plan approvals

| **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 |

# Trust Board
# 2 May 2024

| | |
|---|---|
| **Title of the paper:** | **Performance & Activity Recovery (March 2024)** |
| **Agenda Item:** | **19** |
| **Presenter:** | **Mary Bhatti, Acting Chief Operating Officer** |
| **Author(s):** | **Jane Shentall, Director of Operational Performance** |
| **Purpose:** | *Please tick the appropriate box*<br>*For approval*: <br>*For discussion*: ✓<br>*For information*: ✓ |
| **Executive Summary:** | This paper provides an overview of activity and performance delivery against national objectives and waiting times targets.<br><br>Scorecards detailing progress against the high impact change plans for both the Patient Flow Improvement and Elective Care Recovery programmes, are included.<br><br>**Urgent & Emergency Care (UEC)**<br>There was further improvement in A&E performance, supported by increased focus with executive leadership and focus on patient flow. A&E performance (all types) was 78.2% and type 1 61.5%, delivering on the NHSE improvement objective of achieving 78% by March 2024. There were 44 x 12 hour (from decision to admit) breaches, which was higher than the previous month. HHGH UTC maintained performance above the 95% standard and there was improvement at WGH UTC at 90.8%, where a recovery plan owned by the service provider, is in place. Despite increases in ambulance conveyances and associated handover delays, performance against the recovery trajectory remains positive and is better than plan.<br><br>Discharges, particularly at the weekend have not yet reached a sustainable level to support flow from ED in to the wards, despite implementation of the full capacity protocol and boarding. However there was improvement in the time of day discharge profile. The work to drive improvement has been aligned with the trust strategy and high level details are included in the pack,<br><br>**Elective, planned care**<br>High rates of annual leave affected the volumes of activity delivered this month, but the value of that activity was better than the previous month. March's VWA was 101%, which was also the position for the full year.<br><br>Delivery of activity plans is variable, with a 6% shortfall against the new outpatient appointment plan year to date and a much higher rate of follow up activity than planned. Elective inpatient activity was 3% better than plan for all |

| | |
|---|---|
| | activity types in the month. Overnight admissions remain below plan year to date.<br><br>Delivery of the diagnostic activity plan remains positive, although there are shortfalls against plan in three modalities this month, one of which (flexible sigmoidoscopy) is not expected to improve due to coding changes.<br><br>There was just 1 x 78 week wait at the end of the month and 65 week wait reduction continues with 245 at month end. ENT remains a high risk specialty along with Dermatology, in terms of long waits elimination, but both services have plans in place which are delivering improvement.<br><br>Two of the three consolidated cancer waiting time standards have been achieved; 28 day faster diagnosis performance was 77.9% (target 75%) and 62 day performance was 72.5% (target 70%). The relative backlog (as a percentage of the cancer waiting list) was 5.7%, better than the NHSE target of 6.4% and the actual number of pathways in the backlog (86) was better than the fair share allocation (143) given to the trust.<br><br>Diagnostic performance improvement was not sustained in March, reducing to 88.3%, with deterioration across most modalities. Staffing availability issues were a major factor with high annual leave rates. Twelve modalities are compliant with the 95% national recovery target and 6 are better than the national 99% target. |
| **Trust strategic aims:**<br><br>*(please indicate which of the 4 aims is relevant to the subject of the report)* |  |
| **Links to well-led key lines of enquiry:** | ☒Is there the leadership capacity and capability to deliver high quality, sustainable care?<br>☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?<br>☐Is there a culture of high quality, sustainable care?<br>☒Are there clear responsibilities, roles and systems of accountability to support good governance and management?<br>☒Are there clear and effective processes for managing risks, issues and performance?<br>☒Is appropriate and accurate information being effectively processed, challenged and acted on?<br>☐Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?<br>☒Are there robust systems and processes for learning, continuous improvement and innovation?<br>☒How well is the trust using its resources? |

| | |
|---|---|
| **Previously considered by:** | <table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td>Trust Management Committee</td><td>24 April 2024</td></tr><tr><td>Finance & Performance Committee</td><td>25 April 2024</td></tr></table> |
| **Action required:** | ▪ The Board 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. |

NHS
West Hertfordshire Teaching Hospitals
NHS Trust

# Trust Board

# 2 May 2024

## Performance & Activity recovery

## March 2024 reporting period

**Jane Shentall**
**Director of Operational Performance**
**16 April 2024**

# Core KPI overview – reporting month & year to date

West Hertfordshire Teaching Hospitals NHS Trust

## Urgent & Emergency Care

**4 hour performance: A&E all types**
Mar: 78.2% ↑
YTD: 71.5%
Trust stretch target: 80%
Interim national target: 76%

**4 hour performance: Type 1 (WGH)**
Mar: 61.5% ↑
YTD: 46%
Trust target: tbc

**A&E Non-admitted performance:**
Mar: 66.7% ↑
YTD: 53%
Trust target: 80%

**Ambulance handovers: hours lost over 30 minutes**
51
Trust plan: 108 (weekly)

## Planned Care

**RTT 78 week waits**
Mar: 1 ↓
National target: 0

**RTT 65 week waits**
Mar: 245 ↓
National target: 0 by April 24

**Cancer 28 day faster diagnosis**
Mar: 77.9% ↑
YTD: 73.3%
National target: 75%

**Cancer 62 day 1st**
Mar: 72.5% ↑
YTD: 68.2%
National target: 70% (recovery target)

**Diagnostic wait times**
Mar: 88.1% ↓
National target: 95% (recovery target, monthly)

## Activity delivery

**Value weighted activity**
Mar: 101% ↑
YTD: 101%
National target: 101%

**Theatre Utilisation**
Mar: 78.5% ↓
National target: 85%

**1st OPA rate variance to plan**
Mar: -23% ↓
YTD: -6%
Trust activity plan vs 19/20

**Total Elective Inpatients variance to plan**
Mar: -14% ↓
YTD: +3%
Trust activity plan vs 19/20

↓/↑ worse than previous month
↑/↓ better than previous month

West Hertfordshire Teaching Hospitals NHS Trust

# Patient Flow Improvement & Performance

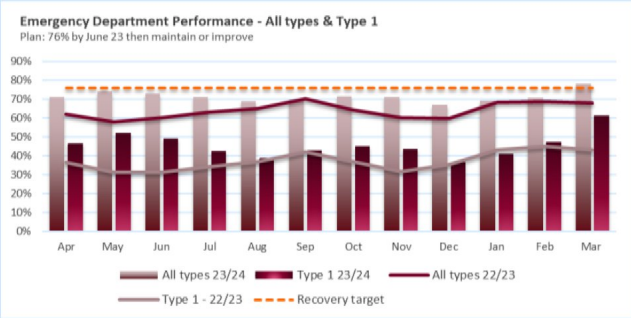
# Patient Flow Improvement Programme
# High Impact Change Plan Scorecard

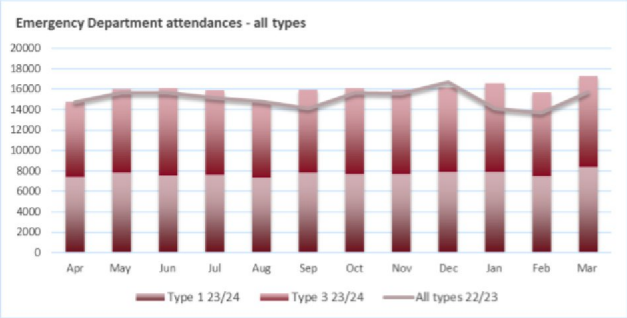
West Hertfordshire Teaching Hospitals NHS Trust

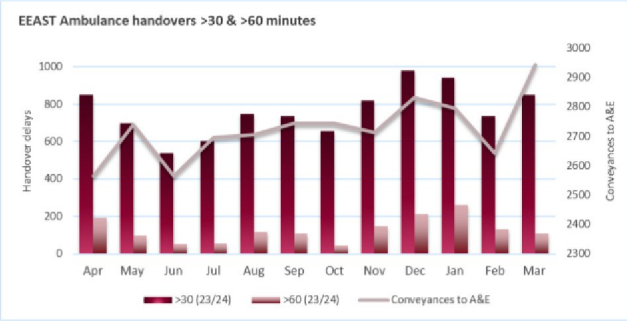
| Focus Area | Metric | Target | 14-Jan | 21-Jan | 28-Jan | 04-Feb | 11-Feb | 18-Feb | 25-Feb | 03-Mar | 10-Mar | 17-Mar | 24-Mar | 31-Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HIGH IMPACT CHANGE 1 - Rapid assessment and timely decisions of patients within 1 hour of arrival | All 4 hr Performance | 76% | 75.1% | 67.7% ▼ | 64.5% ▼ | 69.2% ▲ | 64.7% ▼ | 69.0% ▲ | 76.8% ▲ | 76.7% ▼ | 77.0% ▲ | 75.8% ▼ | 79.2% ▲ | 82.1% ▲ |
| | 4 hr Non admitted Performance | 80% | 56.7% | 41.0% ▼ | 43.7% ▲ | 52.8% ▲ | 44.8% ▼ | 51.2% ▲ | 62.5% ▲ | 66.2% ▲ | 65.9% ▼ | 62.7% ▼ | 68.4% ▲ | 72.7% ▲ |
| | Time to clinical assessment < 1 hour | 50% | 36.3% | 24.3% ▼ | 25.4% ▲ | 30.0% ▲ | 20.7% ▼ | 25.0% ▲ | 34.6% ▲ | 45.7% ▲ | 34.7% ▼ | 23.5% ▼ | 34.1% ▲ | 36.0% ▲ |
| | Total time in Department - Non admitted | 240 | 284 | 340 ▲ | 352 ▲ | 306 ▼ | 363 ▲ | 310 ▼ | 322 ▲ | 256 ▼ | 279 ▲ | 291 ▲ | 265 ▼ | 252 ▼ |
| HIGH IMPACT CHANGE 2 - Improve discharges | IDT Discharges | Movement | 173 | 175 ▲ | 174 ▼ | 190 ▲ | 182 ▼ | 163 ▼ | 164 ▲ | 178 ▲ | 152 ▼ | 180 ▲ | 181 ▲ | 179 ▼ |
| | WGH Weekday Discharges - weekly totals | Movement | 407 | 418 ▲ | 399 ▼ | 430 ▲ | 415 ▼ | 416 ▲ | 354 ▼ | 407 ▲ | 410 ▲ | 388 ▼ | 425 ▲ | 452 ▲ |
| | WGH Weekend Discharges - weekly totals | Movement | 111 | 80 ▼ | 101 ▲ | 107 ▲ | 93 ▼ | 97 ▲ | 127 ▲ | 101 ▼ | 103 ▲ | 85 ▼ | 103 ▲ | 137 ▲ |
| | WGH Total Discharges - weekly totals | Movement | 518 | 498 ▼ | 500 ▲ | 537 ▲ | 508 ▼ | 513 ▲ | 481 ▼ | 508 ▲ | 513 ▲ | 473 ▼ | 528 ▲ | 589 ▲ |
| | WGH Discharges before 5pm % | Movement | 62.0% | 60.8% ▼ | 63.0% ▲ | 59.8% ▼ | 59.8% ▲ | 60.0% ▲ | 61.3% ▲ | 58.7% ▼ | 63.7% ▲ | 65.5% ▲ | 63.4% ▼ | 62.1% ▼ |
| HIGH IMPACT CHANGE 3 - Implement Command and Control Centre | Bed Meeting time freed up for more focused flow management discussions (10mins) | -33% | -33.0% | -33.0% = | -33.0% = | -33.0% = | -33.0% = | -33.0% = | -33.0% = | -33.0% = | -33.0% = | -33.0% = | -33.0% = | -33.0% = |
| | Transition to Virtual bed meetings for all participants | 100% | 100% | 100% = | 100% = | 100% = | 100% = | 100% = | 100% = | 100% = | 100% = | 100% = | 100% = | 100% = |
| | All participants to share their actual report update on Teams | 100% | 100% | 100% = | 100% = | 100% = | 100% = | 100% = | 100% = | 100% = | 100% = | 100% = | 100% = | 100% = |
| | Complete, accurate, real-time data, visualised in the appropriate level of detail | 90% | 90.0% | 90.0% = | 90.0% = | 90.0% = | 90.0% = | 90.0% = | 90.0% = | 90.0% = | 90.0% = | 90.0% = | 90.0% = | 90.0% = |
| | Control Room IT/telephony infrastructure reconfigured for usability / resilience | 100% | 100% | 100% = | 100% = | 100% = | 100% = | 100% = | 100% = | 100% = | 100% = | 100% = | 100% = | 100% = |
| HIGH IMPACT CHANGE 4 - Clinical Review of UTC | WGH Type 3 performance | 95% | 95.2% | 95.5% ▲ | 86.8% ▼ | 84.3% ▼ | 80.8% ▼ | 86.9% ▲ | 99.6% ▲ | 89.9% ▼ | 92.3% ▲ | 89.1% ▼ | 90.8% ▲ | 90.8% ▼ |
| | Number of handovers to ED at close | 0 | 0 | 6 ▲ | 21 ▲ | 11 ▼ | 33 ▲ | 12 ▼ | 0 ▼ | 1 ▲ | 1 = | 6 ▲ | | |
| | Referrals to ED at < 2 hours | 75% | 64.3% ▼ | | | | 57.4% ▼ | | | | | | | |

| | 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% |

# Emergency Department – Performance & Demand




**Performance**
The NHSE recovery standard for A&E 4 hour performance was achieved, despite it being the month with highest demand.

- **All types 78.2%** (Feb 70.8%, Jan 69.5%, Dec 67.1%)
- **Type 1 61.6%** (Feb 47.7%, Jan 44.1%, Dec 37%)
- **Watford UTC 90.8%** (Feb 88%, Jan 93.8%, Dec 93.5%)
- **HH UTC 97.1%** (Feb 96.8%, Jan 98.8%, Dec 98.5%)

Non-admitted performance was much improved at 66.7% (Feb 54.5%).

Same day emergency care (SDEC) activity increased, with 1,494 patients seen in this care setting (Feb 1,125) and admissions to other wards also increased (Mar 2,563 vs Feb 2,335)

There were **44 x 12 hour breaches** from decision to admit to admission in the month (Feb 38)

**12 hour end to end journeys**
The improvements in flow also resulted in fewer 12 hour waits (arrival to departure) with 786 delays over 12 hours, down from 841 the previous month.

**Attendances (demand)**
March saw the highest number of attendances in the year.

- **All types: 17,289** (Feb 15,642, Jan 16,592, Dec 16,156)
- **Type 1: 8,393** (Feb 7,476, Jan 7,892, Dec 7,900)
- **Type 3: 8,896** (Feb 8,166, Jan 8,700, Dec 8,256)

**Mental Health Demand**
5.3% (441) of all type 1 ED attendances (8,393) related to MH. Last month 4.8% (362) of attendances were MH related.

Of the 12 hour waits (786), 10.1% (79) related to MH. In the previous month 10% (84) related to MH.

Within the MH attendance cohort (441), 17.9% (79) waited 12 hours or more in comparison with the previous month where 23.2% of all ED attendances relating to MH (362) wait 12 hours or more (84).

**Ambulance handovers**
2,942 patients were brought to ED by EEAST. Of these 2,707 were fully data compliant (all data recorded by EEAST, ie "pinned off").

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

- **30+ minutes: 30.8% / 853**
  (Feb 29.6%/739, Jan 35.7%/942, Dec 37.5%/983)
- **60+ minutes: 3.94% / 109**
  (Feb 5.3%/133, Jan 9.9%/261, Dec 8%/210)

Data provided by EEAST shows that WHTH delays are significantly lower than elsewhere in the ICS. WHTH received 42% of EEAST conveyances, E&NH 33% and PAH 25%.

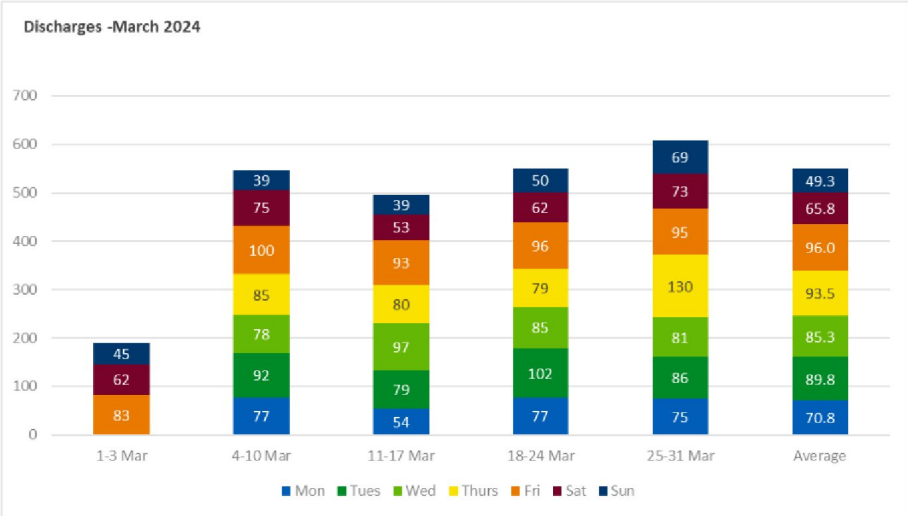
- 30+ minutes: PAH 35.1%/51, E&NH 32.6%/767
- 60+ minutes: PAH 10.1%/265, E&NH 7.6%/274
- Conveyances: PAH 1,751 / E&NH 2,302

Trajectories to measure improvement against hours lost over 30 minutes, have been agreed. WHTHT has agreed a trajectory improvement plan to deliver no greater than 108 hours lost over 30 minutes per week by March 2024.

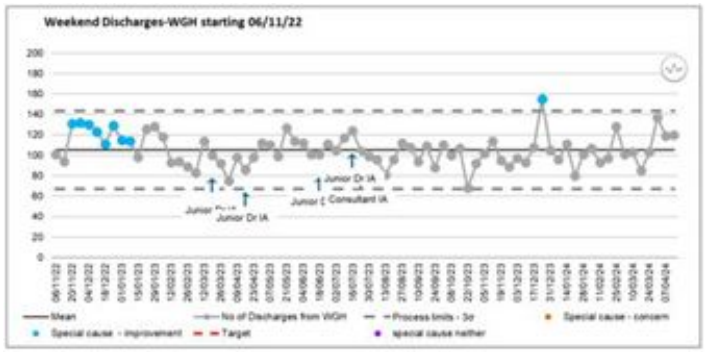
This month's hours lost over 30 minutes per week was 51 against the trajectory plan of 108.

West Hertfordshire Teaching Hospitals NHS Trust

# Patient Flow - Discharges








There was a prolonged period of special cause variation for improvement in discharges before 5pm during the month. However, weekend discharges remains static (bottom chart).

A new Patient Flow programme mandate has been agreed, with the Chief Nurse as SRO, confirming a patient centred systems thinking approach. The programme is supported by a plan for transitioning current work in to the new programme with a more structured suite of linked projects, clear terms of reference for key roles and governance structure.

The Hospital Efficiency Group (HEG) will be replaced by a focused Programme Board, supported by the programme support team. Wider stakeholder engagement will move from HEG and Optimising Patient Flow (OPFG) to a new Stakeholder Advisory Group to ensure engagement in co-design and focused project support.

The programme has been aligned to the HWE ICB Discharge Improvement Programme.

The first programme board meeting will take place on 22 May.

West Hertfordshire Teaching Hospitals NHS Trust

# Elective Care Recovery & Performance improvement

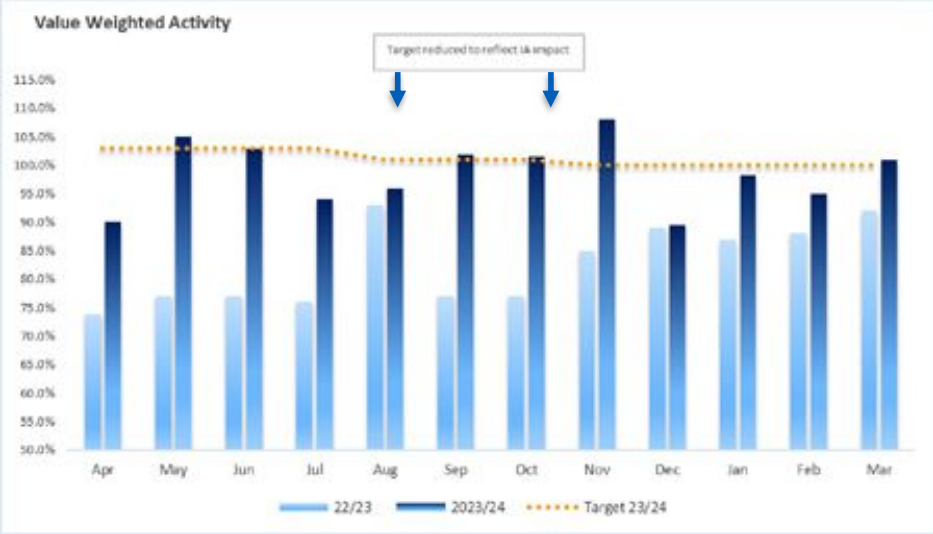
# Elective Care Recovery Programme
# High Impact Change Plan Scorecard

West Hertfordshire Teaching Hospitals NHS Trust

| Focus Area | Metric | Target | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **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 | 86.0% | 101.0% ▲ | 102.4% ▲ | 94.0% ▼ | 96.0% ▲ | 102.0% ▲ | 101.7% ▼ | 108.0% ▲ | 90.0% ▼ | 98.3% ▲ | 95.0% ▼ | 101.0% ▲ |
| | RTT PTL size | Reduction | 56,574 | 57,933 ▲ | 60,626 ▲ | 62,689 ▲ | 64,384 ▲ | 62,966 ▼ | 63,054 ▲ | 60,236 ▼ | 58,731 ▼ | 58,220 ▼ | 58,693 ▲ | 58,599 ▲ |
| | RTT Clock stops | Improvement | 5,039 | 6,382 ▲ | 6,519 ▲ | 6,272 ▼ | 6,481 ▲ | 6,443 ▼ | 6,559 ▲ | 7,383 ▲ | 5,551 ▼ | 7,003 ▲ | 6,420 ▼ | 6,328 ▼ |
| | Outpatient procedures recorded | Improvement | 5,562 | 6,645 ▲ | 6,582 ▼ | 6,306 ▼ | 6,467 ▲ | 6,463 ▼ | 6,520 ▲ | 6,541 ▲ | 5,219 ▼ | 6,473 ▲ | 6,067 ▼ | 5,624 ▼ |
| **HIGH IMPACT CHANGE 2** Increased theatre productivity with improved utilisation across all sites | Theatre utilisation - WGH & SACH | 85% | 76.2% | 75.1% ▼ | 78.5% ▲ | 79.5% ▲ | 75.2% ▼ | 82.1% ▲ | 78.0% ▼ | 82.0% ▲ | 79.0% ▼ | 77.6% ▼ | 81.2% ▲ | 78.5% ▼ |
| | Time lost to late starts - WGH & SACH | Improvement | 127:11 | 146:17 ▲ | 164:10 ▲ | 183:32 ▲ | 141:33 ▼ | 135:58 ▼ | 154:44 ▲ | 151:32 ▼ | 143:08 ▼ | 159:54 ▲ | 141:29 ▼ | 145:36 ▲ |
| | Time lost to early finishes - WGH & SACH | Improvement | 256:08 | 382:01 ▲ | 341:21 ▼ | 274:26 ▼ | 369:42 ▲ | 271:34 ▼ | 309:00 ▲ | 269:19 ▼ | 209:23 ▼ | 301:10 ▲ | 222:18 ▼ | 261:48 ▲ |
| **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 | 11 | 9 ▼ | 7 ▼ | 8 ▲ | 6 ▼ | 8 ▲ | 9 ▲ | 7 ▼ | 8 ▲ | 14 ▲ | 10 ▼ | 1 ▼ |
| | RTT: 65 week wait elimination (excl patient choice) | 0 by April 24 | 495 | 504 ▲ | 524 ▲ | 455 ▼ | 569 ▲ | 636 ▲ | 621 ▼ | 466 ▼ | 434 ▼ | 402 ▼ | 353 ▼ | 245 ▼ |
| | RTT: 52 week wait reduction | Improvement | 2,694 | 2,439 ▼ | 2,504 ▲ | 2,440 ▼ | 2,769 ▲ | 2,982 ▲ | 3,039 ▲ | 2,488 ▼ | 2,246 ▼ | 2,407 ▲ | 2,420 ▲ | 2,751 ▲ |
| | Cancer: 63+ day wait reduction | 95* | 130 | 159 ▲ | 149 ▼ | 135 ▼ | 139 ▲ | 101 ▼ | 119 ▲ | 121 ▲ | 148 ▲ | 142 ▼ | 136 ▼ | 86 ▼ |
| | 28 day faster diagnosis performance | 75% | 74.5% | 66.0% ▼ | 72.9% ▲ | 66.7% ▼ | 67.0% ▲ | 68.0% ▲ | 66.0% ▼ | 68.7% ▲ | 74.7% ▲ | 74.2% ▼ | 79.8% ▲ | 78.0% ▼ |
| | DMO1 (diagnostic) performance | 99% | 63.8% | 65.8% ▲ | 67.3% ▲ | 69.5% ▲ | 68.5% ▼ | 70.8% ▲ | 78.3% ▲ | 83.3% ▲ | 84.1% ▲ | 85.2% ▲ | 90.9% ▲ | 88.1% ▼ |
| **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 | 82.9% | 95.1% ▲ | 101.8% ▲ | 86.4% ▼ | 99.4% ▲ | 91.1% ▼ | 93.6% ▲ | 103.7% ▲ | 94.3% ▼ | 98.8% ▲ | 98.8% ▲ | 105.8% ▲ |
| | Patient initiated follow up rate as a % of all OPAs | 2.1% | 1.70% | 1.77% ▲ | 1.76% ▼ | 2.02% ▲ | 1.93% ▼ | 2.25% ▲ | 2.08% ▼ | 1.89% ▼ | 2.23% ▲ | 2.11% ▼ | 2.02% ▼ | 2.31% ▲ |
| | Non-face to face rate as a % of all OPAs | 25% | 12.2% | 12.6% ▲ | 12.7% ▲ | 12.5% ▼ | 12.5% ▲ | 12.5% ▼ | 12.6% ▲ | 12.7% ▲ | 13.0% ▲ | 13.0% ▼ | 13.5% ▲ | 13.3% ▼ |
| | DNA rates | 8% | 7.7% | 7.6% ▼ | 8.0% ▲ | 7.5% ▼ | 7.5% ▲ | 7.5% ▲ | 7.3% ▼ | 7.7% ▲ | 7.5% ▼ | 7.5% ▲ | 7.7% ▲ | 8.9% ▲ |

West Hertfordshire Teaching Hospitals NHS Trust

# Data Quality - Value Weighted Activity (VWA)




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.

Activity was lower than plan across a number of points of delivery in the month. However, the value of activity delivered was higher than in recent months.

VWA for March was 101%

The full year position was also 101%, with £2.9m over-performance.

The expectation for 2024/25 has been set at 110% (of the 2019/20 baseline)

## Industrial action – activity impact

| | Impact of Industrial action on all elective activity | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 11-15 April | 14-17 June | 13-18 July JD | 20-21 July (Cons) | 25-27 July (Rad) | 11-15 August JD | 24-25 August Cons | 19-22 Sept JD/Cons | 2-4 Oct Cons | 20-22 Dec JD | 3-9 Jan JD | 24-28 Feb JD |
| Total booked | 7941 | 6269 | 6402 | 3762 | 4566 | 3980 | 3542 | 7759 | 5862 | 5798 | 9152 | 7459 |
| Total cancelled & rebooked | 909 | 497 | 487 | 231 | 24 | 290 | 210 | 605 | 773 | 374 | 518 | 416 |
| % activity rescheduled | 11.4% | 7.9% | 7.6% | 6.1% | 0.5% | 7.3% | 5.9% | 7.8% | 13.2% | 6.5% | 5.7% | 5.5% |

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

| OUTPATIENTS | | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Outpatient referrals | Plan | 16,277 | 17,168 | 15,915 | 17,810 | 15,912 | 16,374 | 18,534 | 17,055 | 15,756 | 18,609 | 16,573 | 17,860 | 203,841 |
| | Actual | 17,401 | 19,849 | 20,525 | 19,135 | 18,980 | 18,683 | 19,749 | 19,772 | 16,206 | 20,134 | 18,157 | 14,857 | 223,448 |
| | %var | 7% | 16% | 29% | 7% | 19% | 14% | 7% | 16% | 3% | 8% | 10% | -17% | 10% |
| OP first attendance | Plan | 14,720 | 15,403 | 15,182 | 17,143 | 14,616 | 16,078 | 17,223 | 17,023 | 14,848 | 17,783 | 16,512 | 18,025 | 194,555 |
| | Actual | 12,827 | 15,651 | 15,938 | 15,354 | 15,128 | 15,574 | 16,288 | 17,269 | 12,991 | 16,432 | 15,249 | 13,797 | 182,498 |
| | %var | -13% | 2% | 5% | -10% | 4% | -3% | -5% | 1% | -13% | -8% | -8% | -23% | -6% |
| OP follow-up attendance | Plan | 20,275 | 21,246 | 19,813 | 22,064 | 18,970 | 21,009 | 22,101 | 21,065 | 18,712 | 22,201 | 19,633 | 20,319 | 247,408 |
| | Actual | 22,423 | 26,937 | 26,900 | 25,410 | 25,142 | 25,525 | 27,583 | 29,127 | 23,537 | 29,218 | 25,794 | 23,607 | 311,203 |
| | %var | 11% | 27% | 36% | 15% | 33% | 21% | 25% | 38% | 26% | 32% | 31% | 16% | 26% |
| Total OP atts | Plan | 34,995 | 36,649 | 34,994 | 39,207 | 33,587 | 37,087 | 39,324 | 38,088 | 33,560 | 39,984 | 36,145 | 38,344 | 441,963 |
| | Actual | 35,250 | 42,588 | 42,838 | 40,764 | 40,270 | 41,099 | 43,871 | 46,396 | 36,528 | 45,650 | 41,043 | 37,404 | 493,701 |
| | %var | 1% | 16% | 22% | 4% | 20% | 11% | 12% | 22% | 9% | 14% | 14% | -2% | 12% |
| OP atts with procedures | Plan | 6,888 | 7,120 | 7,162 | 7,631 | 6,597 | 7,048 | 7,154 | 7,220 | 6,558 | 7,621 | 6,695 | 7,565 | 85,259 |
| | Actual | 5,630 | 6,733 | 6,669 | 6,402 | 6,588 | 6,750 | 6,869 | 6,911 | 5,512 | 6,864 | 6,387 | 5,897 | 77,212 |
| | %var | -18% | -5% | -7% | -16% | 0% | -4% | -4% | -4% | -16% | -10% | -5% | -22% | -9% |

**First OPAs**
The shortfall between plan and new OPA activity remains 4% lower than plan year to date with a gap of 12,057 appointments.

**Follow up OPAs**
Follow up activity remains above the 75% threshold month on month and year to date. Divisions have been asked to review their plans to address this position.

**Patient Initiated Follow up (PIFU)**
There has been no significant change in the % of patients moved to a PIFU pathway with only 2.0% moved on this follow up pathway.

**Non-face to face OPAs**
Surgery 10%, Medicine 25%, WACS 4%

| Surgery | | Jan-24 | Feb-24 | Mar-24 | YTD |
|---|---|---|---|---|---|
| Outpatient referrals | Plan | 6,386 | 5,639 | 6,048 | 72,099 |
| | Actual | 7,509 | 6,716 | 5,619 | 82,097 |
| | %var | 18% | 19% | -7% | 14% |
| OP first attendance | Plan | 6,849 | 6,038 | 6,412 | 73,098 |
| | Actual | 6,085 | 5,447 | 4,999 | 69,022 |
| | %var | -11% | -10% | -22% | -6% |
| OP follow-up attendance | Plan | 7,969 | 7,133 | 6,693 | 88,222 |
| | Actual | 8,949 | 7,870 | 7,550 | 98,221 |
| | %var | 12% | 10% | 13% | 11% |
| Total OP atts | Plan | 14,818 | 13,171 | 13,106 | 161,320 |
| | Actual | 15,034 | 13,317 | 12,549 | 167,243 |
| | %var | 1% | 1% | -4% | 4% |
| OP atts with procedures | Plan | 3,163 | 2,819 | 2,807 | 34,272 |
| | Actual | 2,538 | 2,278 | 2,423 | 31,265 |
| | %var | -20% | -19% | -14% | -9% |

| Medicine | | Jan-24 | Feb-24 | Mar-24 | YTD |
|---|---|---|---|---|---|
| Outpatient referrals | Plan | 8,597 | 7,608 | 8,136 | 91,312 |
| | Actual | 8,028 | 7,293 | 5,740 | 90,339 |
| | %var | -7% | -4% | -29% | -1% |
| OP first attendance | Plan | 7,053 | 6,846 | 7,670 | 78,706 |
| | Actual | 6,491 | 6,281 | 5,698 | 70,340 |
| | %var | -8% | -8% | -26% | -11% |
| OP follow-up attendance | Plan | 7,106 | 6,093 | 6,798 | 76,914 |
| | Actual | 8,819 | 7,982 | 7,334 | 92,658 |
| | %var | 24% | 31% | 8% | 20% |
| Total OP atts | Plan | 14,159 | 12,939 | 14,469 | 155,620 |
| | Actual | 15,310 | 14,263 | 13,032 | 162,998 |
| | %var | 8% | 10% | -10% | 5% |
| OP atts with procedures | Plan | 3,230 | 2,786 | 3,483 | 37,660 |
| | Actual | 2,938 | 2,898 | 2,418 | 32,173 |
| | %var | -9% | 4% | -31% | -15% |

| WACS | | Jan-24 | Feb-24 | Mar-24 | YTD |
|---|---|---|---|---|---|
| Outpatient referrals | Plan | 1,547 | 1,505 | 1,691 | 17,917 |
| | Actual | 1,973 | 1,830 | 1,536 | 22,591 |
| | %var | 28% | 22% | -9% | 26% |
| OP first attendance | Plan | 2,008 | 1,927 | 2,166 | 22,391 |
| | Actual | 1,865 | 1,693 | 1,504 | 21,029 |
| | %var | -7% | -12% | -31% | -6% |
| OP follow-up attendance | Plan | 1,549 | 1,411 | 1,394 | 16,891 |
| | Actual | 1,875 | 1,694 | 1,418 | 19,389 |
| | %var | 21% | 20% | 2% | 15% |
| Total OP atts | Plan | 3,556 | 3,339 | 3,560 | 39,282 |
| | Actual | 3,740 | 3,387 | 2,922 | 40,418 |
| | %var | 5% | 1% | -18% | 3% |
| Total OP atts with | Plan | 1,228 | 1,096 | 1,324 | 13,181 |
| | Actual | 1,255 | 1,123 | 951 | 12,724 |
| | %var | 2% | 2% | -28% | -3% |

**Surgery**
- Referrals have increased by 14% year to date.
- The full year position for 1st OPAs was 6% behind plan activity and 22% adverse to the monthly plan.
- Follow ups are 13% worse than plan in month and 11% worse year to date.

**Medicine**
- Referrals are relatively stable.
- New appointments were 11% below the full year plan year and 26% lower for the month.
- Follow up activity is 20% above the year to date plan, and 8% worse than plan for the month.

**WACS**
- Referrals have increased by 26%
- Year to date 1st OPAs are worse than plan by 6% and 31% adverse to the monthly plan
- Year to date, follow up activity is 15% over plan but only 2% over for the month

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

| INPATIENTS | | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Elective | Plan | 3,013 | 3,228 | 2,993 | 3,333 | 2,983 | 3,231 | 3,465 | 3,590 | 3,113 | 3,456 | 3,309 | 4,021 | 39,735 |
| Daycase | Actual | 3,039 | 3,685 | 3,669 | 3,367 | 3,603 | 3,590 | 3,654 | 3,939 | 3,248 | 3,893 | 3,706 | 3,559 | 42,952 |
| | %var | 1% | 14% | 23% | 1% | 21% | 11% | 5% | 10% | 4% | 13% | 12% | -11% | 8% |
| Elective | Plan | 543 | 536 | 607 | 589 | 551 | 565 | 632 | 596 | 535 | 569 | 628 | 591 | 6,942 |
| Ordinary | Actual | 350 | 439 | 441 | 465 | 433 | 460 | 445 | 493 | 417 | 416 | 406 | 396 | 5,161 |
| | %var | -36% | -18% | -27% | -21% | -21% | -19% | -30% | -17% | -22% | -27% | -35% | -33% | -26% |
| Total | Plan | 3,556 | 3,764 | 3,600 | 3,922 | 3,535 | 3,796 | 4,097 | 4,186 | 3,648 | 4,025 | 3,937 | 4,612 | 46,677 |
| Elective | Actual | 3,389 | 4,124 | 4,110 | 3,832 | 4,036 | 4,050 | 4,099 | 4,432 | 3,665 | 4,309 | 4,112 | 3,955 | 48,113 |
| | %var | -5% | 10% | 14% | -2% | 14% | 7% | 0% | 6% | 0% | 7% | 4% | -14% | 3% |

**All admission types**
The full year's activity was 3% better than plan but 14% under the monthly plan.

**Day Cases**
Year to date 8% better than plan but 11% behind the monthly plan.

**Overnight admissions (elective ordinary)**
Continue to underperform against plan with a 26% deficit year to date and 33% behind plan for the month.

| Surgery | | Jan-24 | Feb-24 | Mar-24 | YTD |
|---|---|---|---|---|---|
| Elective | Plan | 1,249 | 1,141 | 1,349 | 14,235 |
| Daycase | Actual | 1,007 | 971 | 929 | 11,543 |
| | %var | -19% | -15% | -31% | -19% |
| Elective | Plan | 382 | 403 | 390 | 4,645 |
| Ordinary | Actual | 267 | 255 | 247 | 3,477 |
| | %var | -30% | -37% | -37% | -25% |
| Total Elective | Plan | 1,631 | 1,544 | 1,739 | 18,880 |
| Inpatients | Actual | 1,274 | 1,226 | 1,176 | 15,020 |
| | %var | -22% | -21% | -32% | -20% |

| Medicine | | Jan-24 | Feb-24 | Mar-24 | YTD |
|---|---|---|---|---|---|
| Elective | Plan | 1,833 | 1,828 | 2,305 | 21,311 |
| Daycase | Actual | 2,396 | 2,281 | 2,232 | 25,381 |
| | %var | 31% | 25% | -3% | 19% |
| Elective | Plan | 18 | 29 | 16 | 212 |
| Ordinary | Actual | 12 | 12 | 20 | 146 |
| | %var | -33% | -58% | 24% | -31% |
| Total Elective | Plan | 1,851 | 1,857 | 2,321 | 21,523 |
| Inpatients | Actual | 2,408 | 2,293 | 2,252 | 25,527 |
| | %var | 30% | 23% | -3% | 19% |

| WACS | | Jan-24 | Feb-24 | Mar-24 | YTD |
|---|---|---|---|---|---|
| Elective | Plan | 252 | 216 | 191 | 2,775 |
| Daycase | Actual | 222 | 218 | 199 | 2,432 |
| | %var | -12% | 1% | 4% | -12% |
| Elective | Plan | 111 | 126 | 134 | 1,385 |
| Ordinary | Actual | 60 | 70 | 64 | 760 |
| | %var | -46% | -45% | -52% | -45% |
| Total Elective | Plan | 363 | 342 | 326 | 4,161 |
| Inpatients | Actual | 282 | 288 | 263 | 3,192 |
| | %var | -22% | -16% | -19% | -23% |

**Surgery**
- Year to date shortfall against the overall plan by 20% and 32% below plan for the month.
- Overnight admissions are 25% behind plan year to date and 37% below plan for the month.
- Day case admissions are also behind plan, 19% year to date and 31% for the month.

**Medicine**
- Day cases are 19% above the year to date plan and 3% lower than plan for the month.
- Overnight admissions are 31% behind plan year to date, but 21% above the month

**WACS**
- 12% adverse variance to the day case plan year to date but 4% better than plan in the month.
- Year to date overnight admissions 45% below plan with a deficit of and 52% short of plan for the month.
- The overall position year to date is 23% short of plan and 19% behind plan in month.

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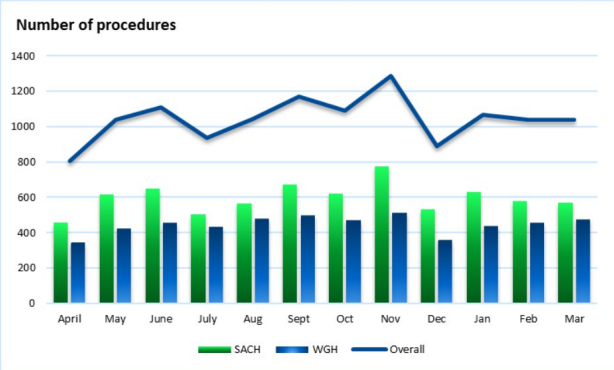
# Diagnostic Activity as a % of the 19/20 baseline month

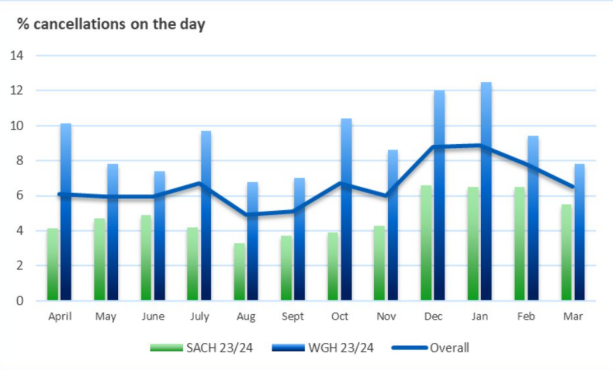
| DIAGNOSTICS | | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MRI | Plan | 1,833 | 1,977 | 1,346 | 1,458 | 1,398 | 1,465 | 1,680 | 1,551 | 1,562 | 1,759 | 1,484 | 1,707 | 19,219 |
| | Actual | 1,655 | 1,731 | 1,802 | 1,620 | 1,783 | 1,583 | 1,732 | 1,832 | 1,476 | 1,869 | 1,743 | 1,719 | 20,545 |
| | %var | -10% | -12% | 34% | 11% | 28% | 8% | 3% | 18% | -5% | 6% | 17% | 1% | 7% |
| CT | Plan | 3,149 | 3,409 | 3,382 | 3,842 | 3,448 | 3,582 | 3,808 | 3,558 | 3,769 | 3,740 | 3,701 | 3,800 | 43,188 |
| | Actual | 4,102 | 4,389 | 4,538 | 4,454 | 4,431 | 4,437 | 4,518 | 4,727 | 4,366 | 4,625 | 4,152 | 4,438 | 53,177 |
| | %var | 30% | 29% | 34% | 16% | 28% | 24% | 19% | 33% | 16% | 24% | 12% | 17% | 23% |
| NOUS | Plan | 3,725 | 3,055 | 2,572 | 2,712 | 2,385 | 2,530 | 2,601 | 2,721 | 2,545 | 3,046 | 2,574 | 2,862 | 33,328 |
| | Actual | 2,616 | 2,924 | 3,393 | 2,986 | 3,122 | 2,921 | 2,921 | 3,145 | 2,613 | 3,216 | 2,946 | 2,476 | 35,279 |
| | %var | -30% | -4% | 32% | 10% | 31% | 15% | 12% | 16% | 3% | 6% | 14% | -13% | 6% |
| Colonoscopy | Plan | 357 | 436 | 347 | 421 | 385 | 404 | 436 | 425 | 385 | 433 | 429 | 443 | 4,901 |
| | Actual | 460 | 633 | 673 | 586 | 596 | 605 | 655 | 667 | 561 | 682 | 499 | 415 | 7,032 |
| | %var | 29% | 45% | 94% | 39% | 55% | 50% | 50% | 57% | 46% | 58% | 16% | -6% | 43% |
| Flexi Sig | Plan | 214 | 236 | 180 | 190 | 194 | 209 | 200 | 237 | 194 | 202 | 209 | 433 | 2,698 |
| | Actual | 107 | 26 | 35 | 24 | 5 | 17 | 21 | 32 | 16 | 29 | 91 | 98 | 501 |
| | %var | -50% | -89% | -81% | -87% | -97% | -92% | -90% | -86% | -92% | -86% | -57% | -77% | -81% |
| Gastroscopy | Plan | 513 | 613 | 575 | 645 | 541 | 665 | 624 | 639 | 559 | 638 | 645 | 650 | 7,309 |
| | Actual | 620 | 705 | 729 | 700 | 664 | 673 | 624 | 650 | 546 | 656 | 561 | 570 | 7,698 |
| | %var | 21% | 15% | 27% | 8% | 23% | 1% | 0% | 2% | -2% | 3% | -13% | -12% | 5% |
| Echo | Plan | 1,294 | 1,296 | 1,385 | 1,401 | 1,341 | 1,180 | 1,347 | 1,398 | 1,204 | 1,376 | 1,438 | 1,410 | 16,069 |
| | Actual | 1,101 | 1,232 | 1,316 | 1,181 | 1,283 | 1,406 | 1,461 | 1,523 | 1,172 | 1,333 | 1,133 | 889 | 15,030 |
| | %var | -15% | -5% | -5% | -16% | -4% | 19% | 8% | 9% | -3% | -3% | -21% | -37% | -6% |

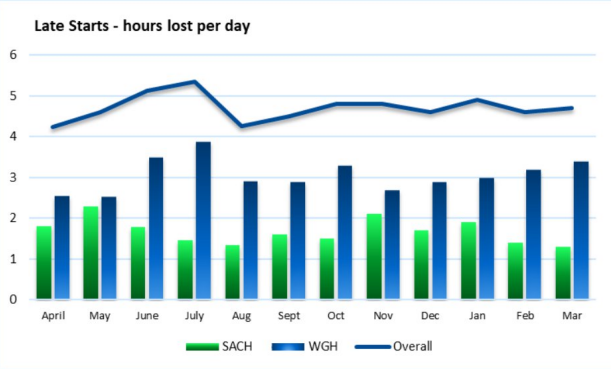
The full year plan has been achieved by all but 2 modalities, namely Flexible Sigmoidoscopy and Echo.

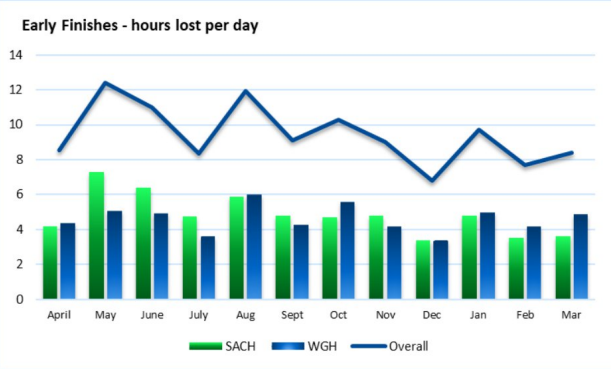
- Changes to procedure coding have affected flexible sigmoidoscopy activity rates, as many of these procedures are now included in the colonoscopy activity line. On that basis, the activity delivery reported for this modality will not increase.
- Echo activity remains below plan. Recovery actions for this modality are in place, with additional capacity provided through ad hoc sessions.
- Delivery of the monthly planned activity numbers was not achieved by many of the modalities.

# Theatre Productivity & Utilisation


**Utilisation:** There was a fall in overall utilisation, the result of WGH reducing to 75.5% (from 80%), while SACH utilisation was similar to the previous month (82.6%) at 82.1%.

**Number of procedures:** Procedure numbers were unchanged this month. Within this indicator however, there were fewer undertaken at SACH and more performed at WGH. SACH 567 (prev 581) WGH 474 (prev 459)

**Cancellations on the day:** The percentage of cancellations on the day improved at both sites, with 7.8% at WGH (Feb 9.4%) and 5.5% at SACH (prev 6.5%)

**Hours lost to late starts/early finishes:** There was little change to late start hours lost, with both sites more or less the same as the previous month (WGH 3.4, SACH 1.3) and early finishes were also similar, WGH 4.2 (prev 4.9) and SACH 3.6 (Feb 3.5)

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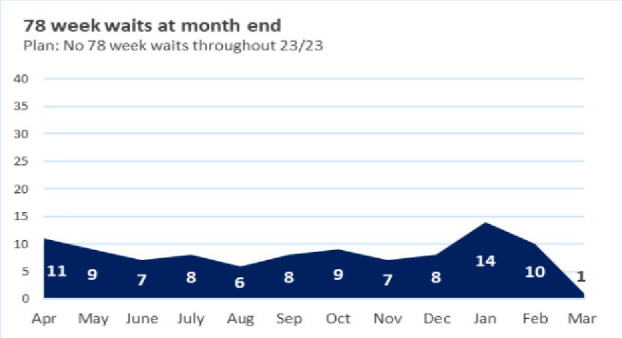
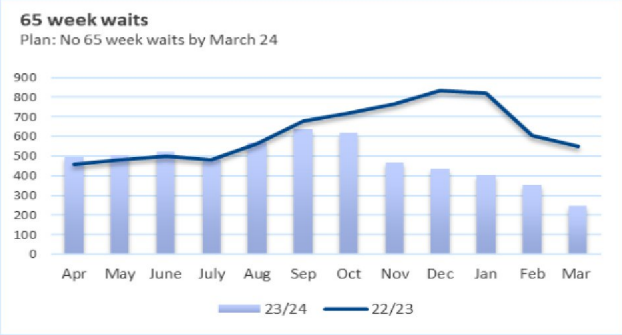
# RTT Long waits Improvement


**RTT PTL Size**
The ongoing focus on correcting errors at source, combined with targeted validation and the weekly long wait review and Access meetings, are all intended to support reduction in PTL size. However, the rise in clock starts first noted in January, has continued and this is significant as it is a major factor in PTL size.

The PTL at the end of March was at 58,599, in comparison with 58,693 the previous month.

**78 week waits**
There was one 78 week wait pathway at the end of the month, originating in Dermatology with referral to Vascular Surgery for onward investigation and management.

There has been further focus on elimination of very long waits with support provided to a number of services where there is ongoing risk of 78 week waits in the coming months.

**65 week waits**
The weekly meetings reviewing long wait pathways has ensured continuous oversight within the divisions and as a result these continue to reduce month on month.

At the end of the month there were 245 x 65 week waits (a reduction of 108 since last month).

There has been some slippage of the date Trusts were expected to achieve elimination of 65 week waits, from the end of March to September 2024. There are 4,895 pathways in the risk cohort requiring action (confirmed OPA or TCI date, bringing forward or clinical review).

**52 week waits**
This long wait cohort has increased for the second month, now at 2,751 (February 2,420).

**Clock stops vs clock starts**
The trend of higher clock starts, first noted in January, has continued with 9,437 new starts in March (10,236 February, 10,212 January, 7408 December).
Clock stops were lower in the month, at 6,328 (February 6,420, January (7,003). However, a higher number of long wait pathways were closed.

- 607 pathways over 52 weeks were closed, of which
- 245 pathways were over 65 weeks and
- 31 pathways were over 78 weeks.

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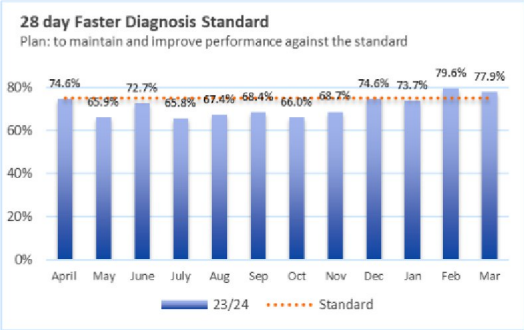
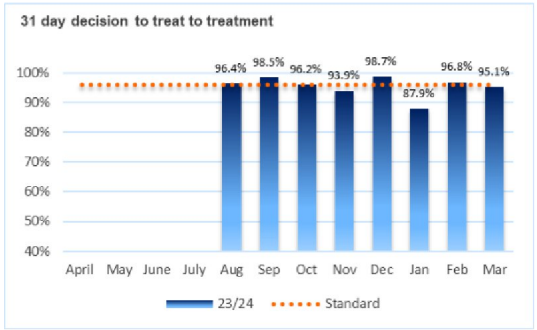
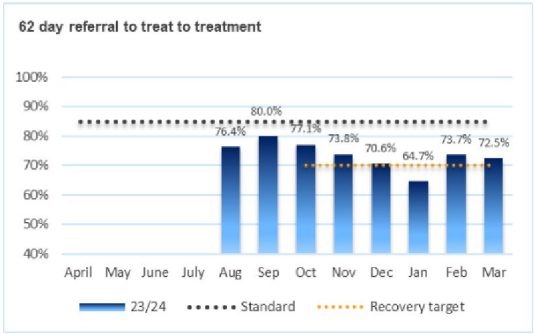
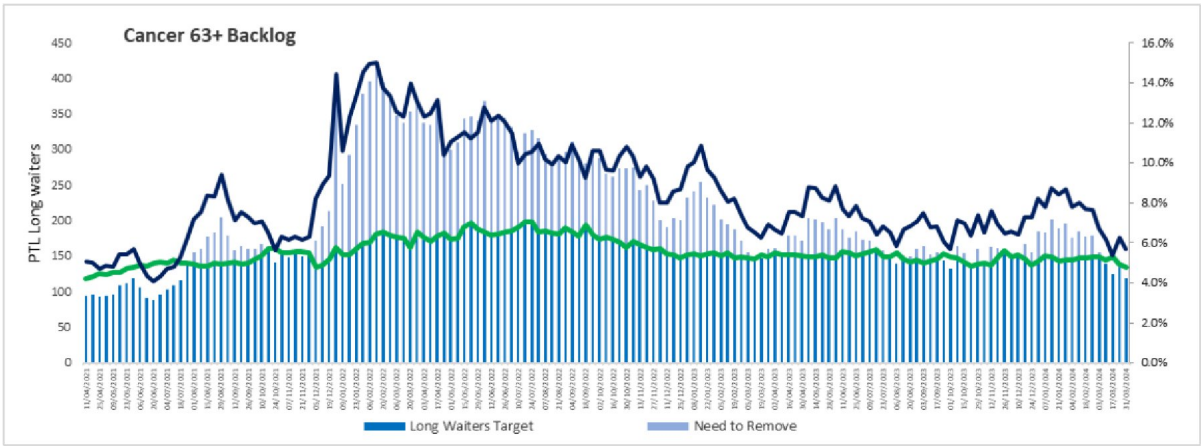
# Cancer waits backlog improvement & performance




**28 day Faster Diagnosis Standard (75%)**
Performance is compliant with the standard this month at 77.9%. However, Gynaecology continues to experience challenges with this pathway, reporting the greatest proportion of breaches. The impact of recent capacity increases is awaited.

Internally, oversight of performance against the 2ww measure is being maintained as this is fundamental to achievement of the 28 day FDS target.

**31 day decision to treat to treatment (96%)**
Performance is not currently compliant with the standard at 95.1%. Breach numbers are very low (9 breaches in total, across Urology, Skin, LGI and Breast).

**62 day referral to definitive treatment (75% / 85%)**
Performance against this standard was compliant (with the recovery target) at 72.5%. Breaches were incurred in Haematology, Lung, LGI, UGI and Urology. Further focus in the Cancer Improvement Steering group will be given to these services to ensure support is provided to deliver sustainable improvement.

**63+ day backlog**
At month end there were 86 (5.7%) pathways over 63 days with a PTL of 2,098 patients. The NHSE objective is to have a backlog of no more than 6.4%.

The ICB was set a target for reduction, with a “fair share” allocation to each acute provider. The WHTH target was to have no more than 143 pathways over 62 days by 31 March 2024.

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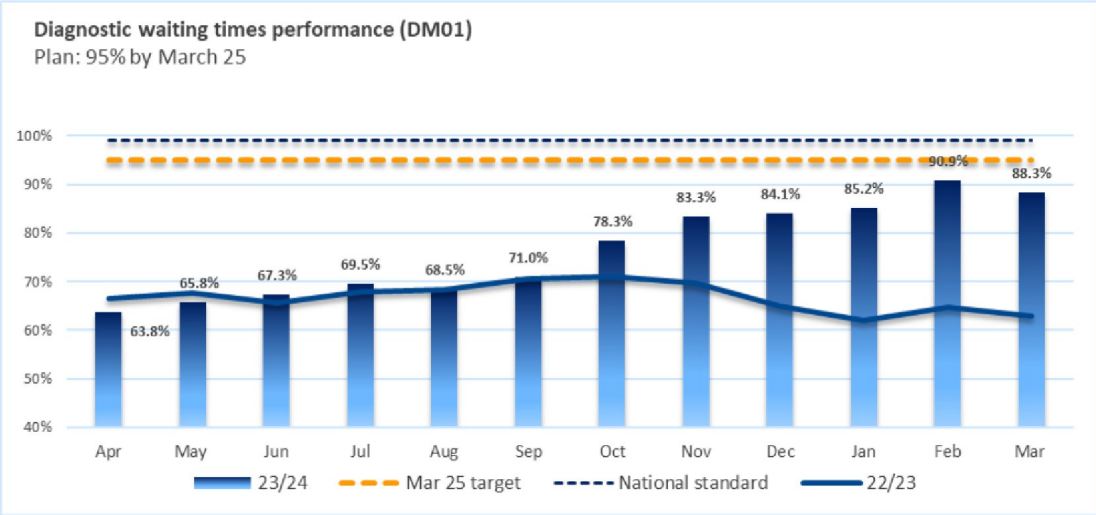
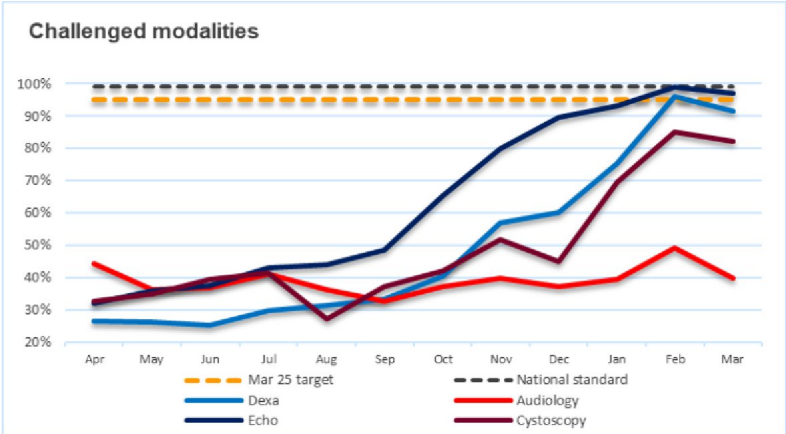
# Diagnostic (DM01) performance improvement




Performance against the 95% recovery target was lower than last month (90.9%) at 88.3%. (The national planning guidance objective for diagnostic performance recovery is to achieve 95% (the orange dotted line) by March 2025. The constitutional target is 99%.

Staff availability was a major factor, with impact on capacity in a number of modalities, particularly MRI.

12 are above the 95% target and 6 are at 99% or better.

The second chart shows the performance of the four most challenged modalities; Audiology, Cystoscopy, DEXA and Echo. Work to improve data quality within the Uro-Gynae Cystoscopy list is well underway and performance improvement expected in the next month or two.

Performance also decreased in all four of the challenged modalities.

The activity delivered through the Community Diagnostic Centre (hub at HHGH, spoke at SACH) will further support improvement when modalities go live.

# 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 | March 24 | Achieved/ not achieved |
|---|---|---|---|---|
| 1 | 65 week wait elimination by March 2024 | 495 | 246 (Feb 353) | Deadline moved to Sep 24 |
| 2 | Deliver system specific activity target (103% VWA – revised down to 101% due to IA impact) | 90% | 101% (Feb 98.3%)<br>101% ytd<br>NB: reported position with internal adjustments. | ✓ |
| 3 | Reduction in patients over 62 days on the Cancer PTL – 143 by March 2024 | 130 | 86 (Feb 142) | ✓ |
| 4 | Meet the Cancer Faster Diagnosis standard of 75% by March 2024 – 67.5% by June 23 | 74.5% | 78% (Feb 79.6%)<br>73.3% ytd | ✓ |
| 5 | Improve A&E waiting times to 76% seen within 4 hours by March 2024 | 71.4% | 78.2% (Feb 70.8%) | ✓ |
| 6 | Reduce adult (G&A) bed occupancy to 92% or below | All sites: 88%<br><br>WGH only: 93.3% | All sites: 91% (Feb 91.9%)<br>WGH only: 95.9% (Feb 95.7%) | ✓ |

West Hertfordshire Teaching Hospitals NHS Trust

# Trust Board
# 02 May 2024

20

| | |
|---|---|
| **Title of the paper:** | **Integrated Performance Report**<br>***(April 2024 reporting period – March 2024 data)*** |
| **Agenda Item:** | **20** |
| **Presenter:** | **Paul Bannister, Chief Information Officer** |
| **Author(s):** | **Mark Landau, Director of Business Intelligence**<br>**Paul Bannister, Chief Information Officer** |
| **Purpose:** | *Please tick the appropriate box*<br>*For approval* [ ] *For discussion* [✓] *For information* [✓] |
| **Executive Summary:** | **Summary**<br>• 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.<br>**Changes to the pack**<br>• CHPPD (Care Hours per Patient Day) has been added in the Safety section – currently in common cause variation<br>**Safe Care & Improving Outcomes - Quality**<br>• Both Mortality metrics (SHMI and HSMR) are showing concerning special cause variation. However both are within expected ranges.<br>• Improvement is expected once new consultant coders are embedded, although this will take some time to feed through given the 12 month rolling nature of the metrics,<br>**Safe Care & Improving Outcomes - Safety**<br>• There are six exceptions generated, all of which were exceptions in the previous month<br>• Registered fill rate, whilst still an exception for assurance is in common cause variation for Performance, likewise both the Trust overall fill rate and the unregistered fill rate.<br>• The other exceptions are the % of patient safety incidents which are harmful which is in concerning special cause variation for both performance and assurance, VTE Risk Assessments and Patients admitted to stroke unit within 4 hours with continuing improving special cause variation<br>**Caring & Responsive Services – A&E**<br>• Eight exception pages generated – all of which were exceptions in the previous month. Of particular note is that both All Types and Type 1 4hr performance are in common cause variation for performance, following much improved performance in March 2024, which meant that the Trust was 22nd of Type 1 Acute trusts for All Types A&E Performance.<br>• There was an increase in 12 hour trolley waits in March 2024 to 44, which was 5th fewest regionally<br>**Caring & Responsive Services – RTT, Cancer, Outpatients** |

| | |
|---|---|
| | • Eight Exception pages generated, 5 of which are showing improving special cause variation for performance: RTT 65 week waits, RTT 78+ week waits, Diagnostic – 6 Week Waits and Outpatient cancellation rates<br>• West Herts have the second fewest 65 week waiters in the region, and the second fewest 78 week waiters<br>• In January 2024 (latest nationally published data), West Herts were the second best performers in the region against the Diagnostic 6 week wait target<br>• Against the 3 cancer waiting times metrics, the Trust met the target for both the FDS and the 31 Day metric, and were 4th regionally against all 3 targets.<br>**Workforce**<br>• Eleven Exception pages generated, with nine exceptions generated for improving special cause. Mandatory Training and Appraisal rates generate concerning special cause variation, although appraisal rates are in common cause for performance.<br>**Activity**<br>• Nine Exception pages generated, four of which are for improving special cause variation (1st Outpatient Appointments – Face to Face, Specific Acute Daycases, Theatre Utilisation, and Theatre cases per session).<br>*NB: Data correct at the time of reporting* |
| | |
| **Trust strategic aims:**<br>*(please indicate which of the 4 aims is relevant to the subject of the report)* | **Aim 1 Best care** — ***Objectives 1-4*** — ✓<br>**Aim 2 Great team** — ***Objectives 5-8*** — ✓<br>**Aim 3 Best value** — ***Objective 9*** — ✓<br>**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?<br>☐Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?<br>☐Is there a culture of high quality, sustainable care?<br>☒Are there clear responsibilities, roles and systems of accountability to support good governance and management?<br>☒Are there clear and effective processes for managing risks, issues and performance?<br>☒Is appropriate and accurate information being effectively processed, challenged and acted on?<br>☐Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?<br>☒Are there robust systems and processes for learning, continuous improvement and innovation?<br>☒How well is the trust using its resources? |

| | |
|---|---|
| **Previously considered by:** | <table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td>Trust Management Committee</td><td>24/04/2024</td></tr><tr><td>Finance & Performance Committee</td><td>25/04/2024</td></tr></table> |
| **Action required:** | The Board is asked to receive this report for information, assurance and discussion |

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# Integrated Performance Report

## April 2024 – March 2024 data

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

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# Integrated Performance Report

- Trust Management Committee – 24th April 2024
- Finance & Performance Committee – 25th April 2024
- Trust Board – 2nd May 2024

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# A note on SPC charts

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

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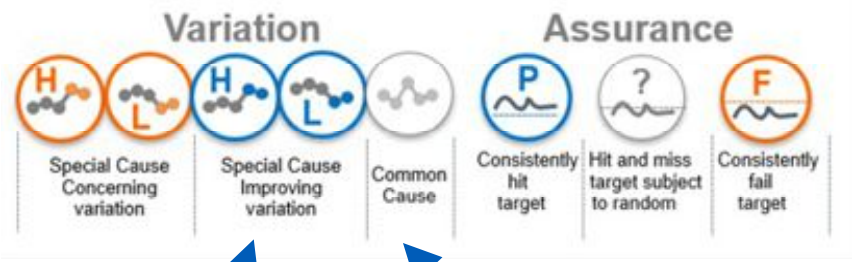
# High Level Key - Variation

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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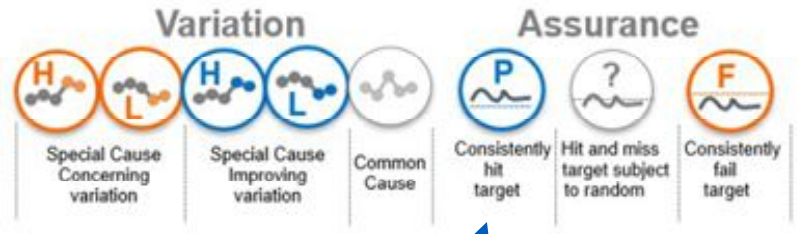
# High Level Key - Assurance

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

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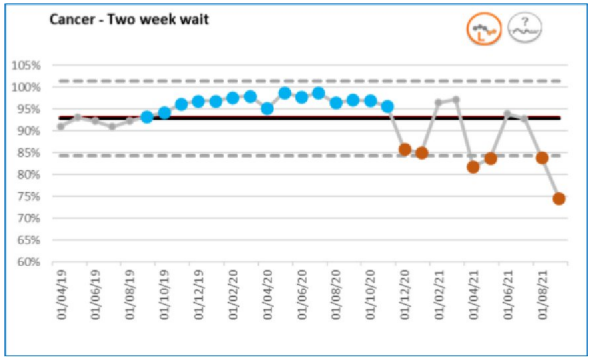
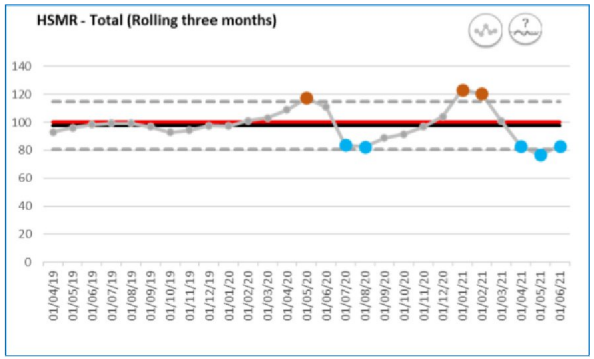
# SPC rules – Special Cause Variation

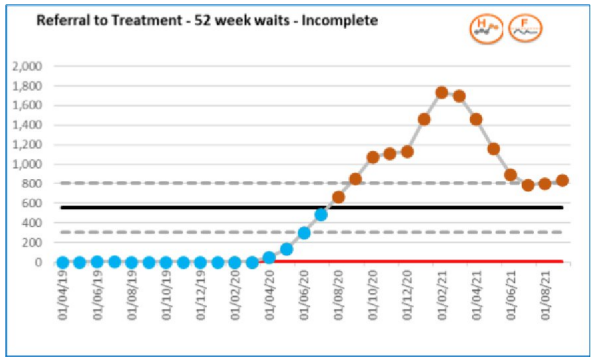
**A breach of the upper/lower control limit**



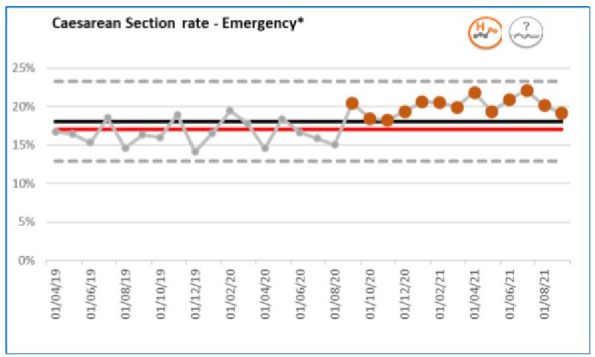

**2 out of 3 points close to the control limit**



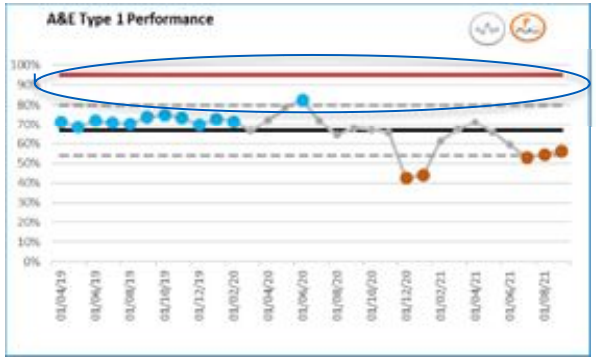

**A run of ascending/descending data points**



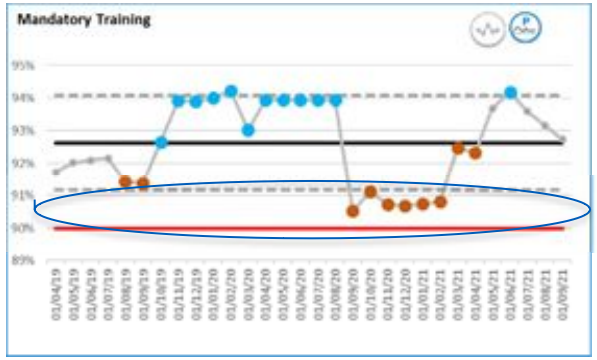

**A run of points all one side of the mean**




**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 23 | 103 | 100 | | | National | Quality | CMO |
| HSMR - Total (Rolling 12 months) | Nov 23 | 102 | 100 | | | National | Quality | CMO |
| Clostridioides Difficile - Hospital associated (Cat 1) | Mar 24 | 5 | - | | | Local | Quality | CN |
| Clostridioides Difficile - Healthcare associated (Cat 2) | Mar 24 | 1 | - | | | Local | Quality | CN |
| Clostridioides Difficile - Hospital and Healthcare associated Total | Mar 24 | 6 | 3 | | | Local | Quality | CMO |
| Hand Hygiene Compliance | Feb 24 | 97% | 95% | | | Local | Quality | CN |
| 30 Day Emergency Readmissions - Elective * | Mar 24 | 4% | 4% | | | Local | Quality | CMO |
| 30 Day Emergency Readmissions - Emerg * | Mar 24 | 13% | 13% | | | Local | Quality | CMO |
| Caesarean Section rate - Robson Category 1 | Mar 24 | 28% | - | | | Local | Quality | CMO |
| Caesarean Section rate - Robson Category 2 | Mar 24 | 57% | - | | | Local | Quality | CMO |
| Caesarean Section rate - Robson Category 5 | Mar 24 | 85% | - | | | Local | Quality | CMO |

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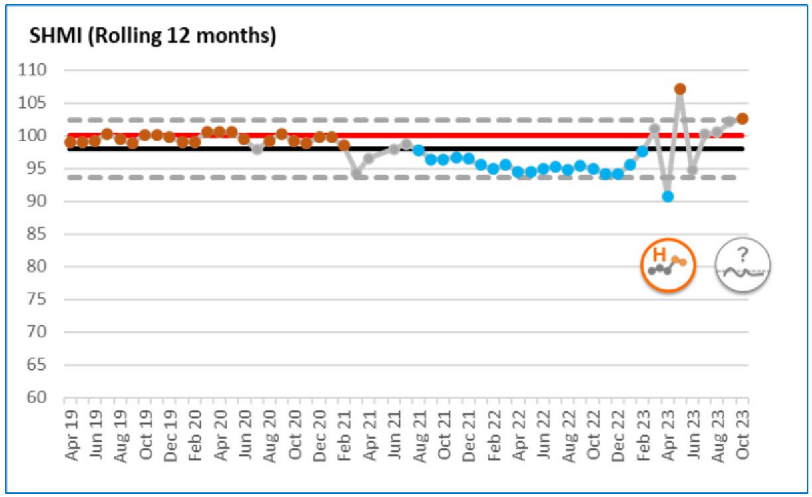
## Special Cause Variation –Assurance – SHMI (Rolling 12 months)




| | Provider | Denominator | Obs | Exp | Obs-Exp | SHMI | Low | High |
|---|---|---|---|---|---|---|---|---|
| RC9 | Bedfordshire Hospitals NHS Foundation Trust | 116,265 | 2,865 | 2,835 | 30 | 101.00 | 89.29 | 111.99 |
| RWH | East And North Hertfordshire NHS Trust | 49,595 | 1,790 | 1,970 | -180 | 90.75 | 89.06 | 112.28 |
| RNQ | Kettering General Hospital NHS Foundation Trust | 46,785 | 1,690 | 1,580 | 110 | 107.08 | 88.88 | 112.52 |
| RD8 | Milton Keynes University Hospital NHS Foundation Trust | 55,610 | 1,295 | 1,365 | -70 | 94.72 | 88.74 | 112.69 |
| RNS | Northampton General Hospital NHS Trust | 75,170 | 1,780 | 2,080 | -300 | 85.71 | 89.10 | 112.23 |
| RWD | United Lincolnshire Hospitals NHS Trust | 76,310 | 3,210 | 3,110 | 100 | 103.19 | 89.34 | 111.93 |
| RWE | University Hospitals Of Leicester NHS Trust | 153,260 | 3,885 | 3,820 | 65 | 101.74 | 89.43 | 111.82 |
| RWG | West Hertfordshire Teaching Hospitals NHS Trust | 58,750 | 1,980 | 1,930 | 50 | 102.58 | 89.05 | 112.30 |

| Background | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| SHMI – (Rolling 12 Months) | Exception triggered due to a breach of the upper control limit | SHMI rate is within 'as expected' range according to Dr Foster. | Consultant coders are being recruited to improve mortality coding | |

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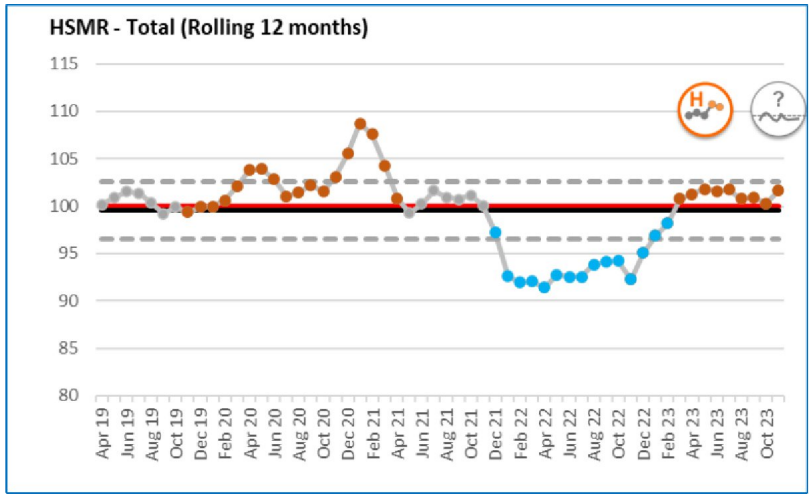
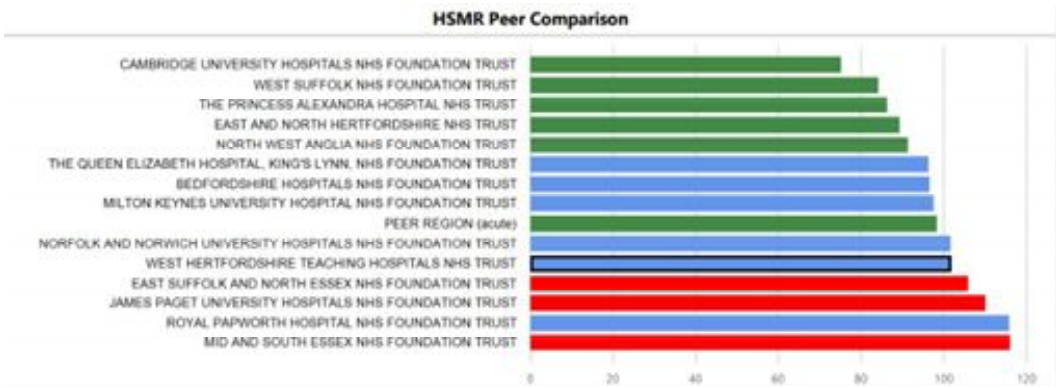
## Special Cause Variation –Assurance – HSMR (Rolling 12 months)




| Background | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| HSMR Total – (Rolling 12 Months) | Exception triggered due to a run of data points above the mean | HSMR rate is within 'as expected' range according to Dr Foster. | Consultant coders are being recruited to improve mortality coding | |

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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) | Mar 24 | 103% | 95% | | P | Local | Quality | CN |
| % nursing hours (shift fill rate) - Registered | Mar 24 | 99% | 100% | | F | Local | Quality | CN |
| % nursing hours (shift fill rate) - Unregistered | Mar 24 | 110% | 100% | | P | Local | Quality | CN |
| Serious incidents - number* | Mar 24 | 1 | - | | | Local | Quality | CMO |
| Serious incidents - % that are harmful* | Mar 24 | 100% | 0% | | ? | Local | Quality | CMO |
| % of patients safety incidents which are harmful* | Mar 24 | 15% | 0% | H | F | Local | Quality | CMO |
| Never events | Mar 24 | 0 | - | | | Local | Quality | CMO |
| Category 4 pressure ulcers - New (Hospital acquired) | Mar 24 | 0 | - | | | Local | Quality | CN |
| Category 3 pressure ulcers - New (Hospital acquired) | Mar 24 | 1 | - | | | Local | Quality | CN |
| Falls with Harm | Mar 24 | 16 | - | | | Local | Quality | CMO |
| VTE risk assessment* | Mar 24 | 98% | 95% | H | P | Local | Quality | CMO |
| Patients admitted to stroke unit within 4 hours of hospital arrival | Mar 24 | 64% | 90% | H | F | Local | Quality | CMO |
| Stroke patients spending 90% of their time on stroke unit | Mar 24 | 96% | 80% | | ? | Local | Quality | CMO |
| % Stroke Patients Thrombolysed within an hour | Mar 24 | 75% | 50% | | ? | Local | Quality | CMO |
| CHPPD (Care Hours Per Patient Day) | Mar 24 | 7.9 | - | | | Local | Quality | CN |

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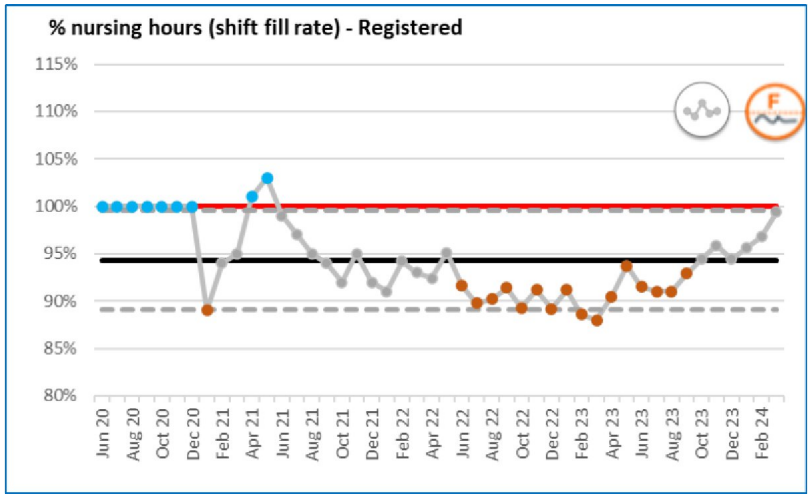
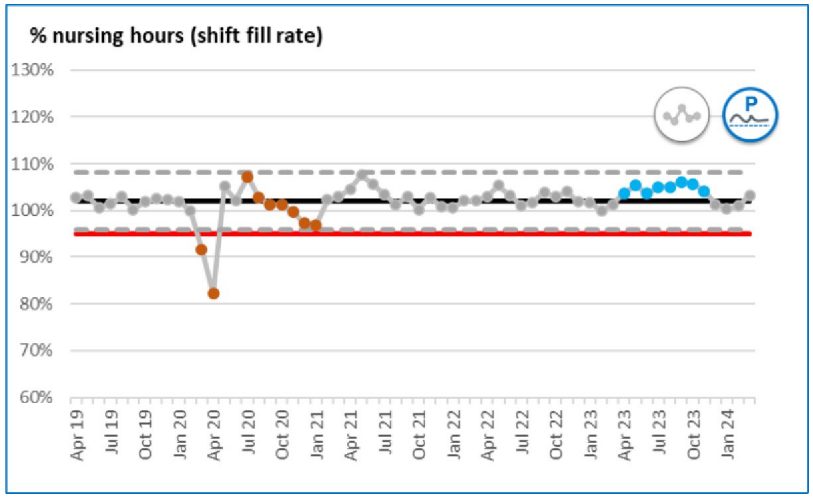
# Special Cause Variation – Assurance – % Nursing Hours (shift fill rate) - Registered




| Background | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| % Nursing Hours (shift fill rate) - Registered | Exception triggered due to the target being above the upper control limit | The Registered fill rate has significantly improved to 99% this is influenced by the numbers of overseas nurses no getting the NMC PIN.<br><br>However when surge beds open (March this was 1260) that requires staff redeployment this reduces to 96%<br><br>Temporary staff fill rate demand has decreased, with an overall un fill of 10% | Continue to monitor fill rates and unavailability<br><br>Monitor number of surge beds open including use of temporary staffing.<br>Use of Temporary staffing<br><br>**Ref # 37** Maintaining safe staffing nursing **(**Score 20) Risk has closed and moved to the Corporate Services Issues log as an ongoing issue. | Daily meetings at 8.30 and 14.30 to review safe staffing.<br><br>Daily Redeployment of staff to support safe staffing<br><br>Daily reports circulated to indicate Trust and Divisional staffing RAG status.<br><br>Sign off night staffing by Chief Nurse /Deputy<br><br>Senior clinical support out of hours including nights |

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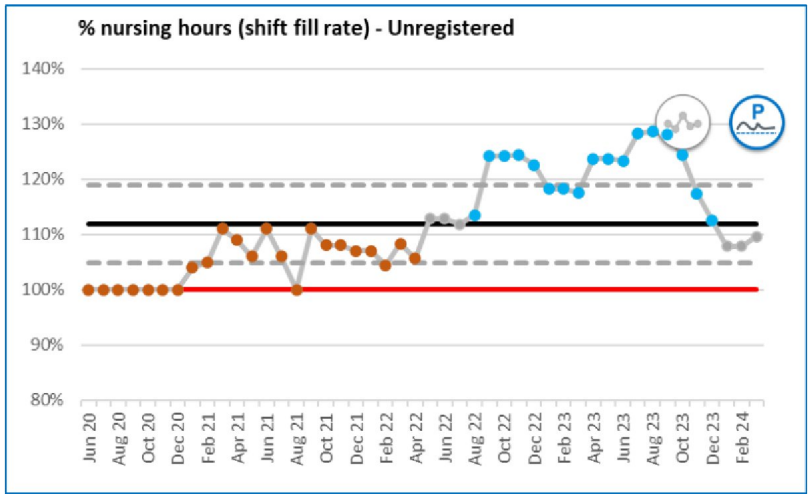
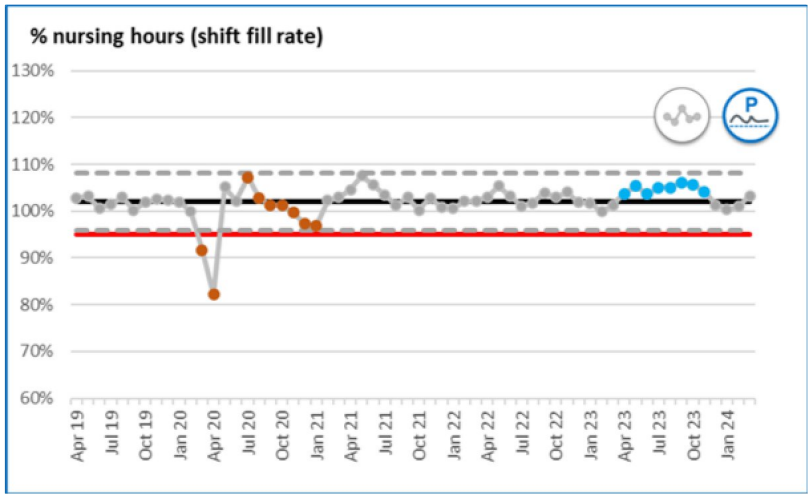
## Special Cause Variation –Assurance – % Nursing Hours (shift fill rate) - Unregistered




| Background | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| % Nursing Hours (shift fill rate) - Unregistered | Exception triggered due to the target falling below the lower control limit | Increased unregistered demand and fill due to additional shifts related to number of escalation beds open enhanced care workers usage | Continue to report monthly on use of HCSW and surge demand.<br><br>Monitor HCSW vacancies and Turnover<br><br>. | Daily meetings at 8.30 and 14.30 to review safe staffing.<br><br>Daily Redeployment of staff to support safe staffing<br><br>Daily reports circulated to indicate Trust and Divisional staffing RAG status.<br><br>Sign off night staffing by Chief Nurse<br><br>Senior clinical support out of hours including nights |

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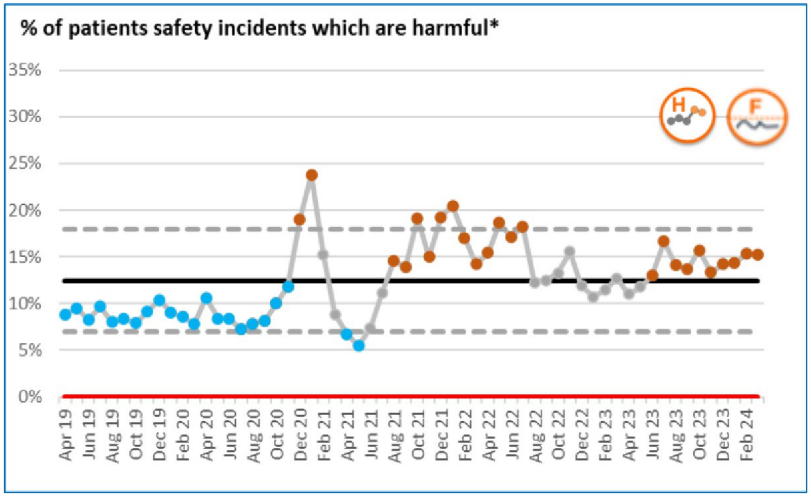
# Special Cause Variation – Assurance – % of patient safety incidents which are harmful




The Trust recorded 1799 patient safety incidents in March 2024, compared with 1668 in February 2024: a 7.8% increase.

15.2% (273) of the incidents resulted in patient harm; This is comparable to 15.3% (256) reported in February 2024.

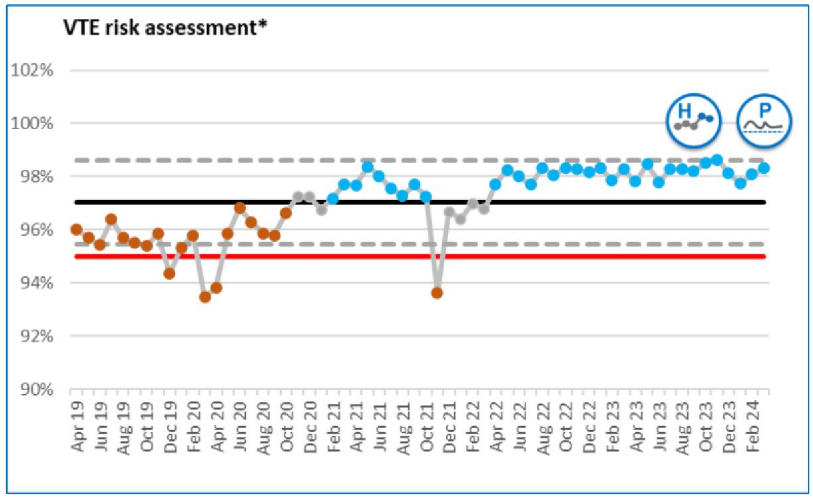
In context, the types of incidents reported across the divisions in March 2024 are varied. Pressure Ulcers and Maternity Care, fall outside the range as outliers, reporting 84 and 79 respectively. Accidents and Falls accounted for 32 incidents.

2.2 % (41) of the incidents reported in March 2024 were recorded as causing a "moderate or higher" level of harm to patients. Of these, 17 are under open investigation and 18 have been closed.

| Background | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| % of patient safety incidents which are harmful | Exception triggered due to a run of data points above the mean<br><br>Exception triggered due to the target being below the lower control limit | In March 2024, the incident-type reporting categories were varied with no discernible theme. Incident types include Pressure ulcers, Maternity (Midwifery) care, and Patient Falls.<br><br>The proportion of incidents reported with no harm in March 2024 is 84.1% (1513) which is favourably higher in proportion when compared with February 2024. | Divisions will continue to share and facilitate timely learning and ensure lessons learned are embedded.<br><br>Continue improvement, and organisational shared learning around identified themes and trends to minimise or prevent a recurrence. | Patient safety incident discussions continue, during meetings in the divisions and the Executive Review Group meetings.<br><br>The Trust has commenced the implementation of the Patient Safety Incident Response Framework (PSIRF) following the Go-Live date at the end of January 2024. PSIRF embraces proactive use of data, collaborative working, improved engagement, focus on lessons learned, and quality improvement. |

## Special Cause Variation – Performance/Assurance – VTE Risk Assessment

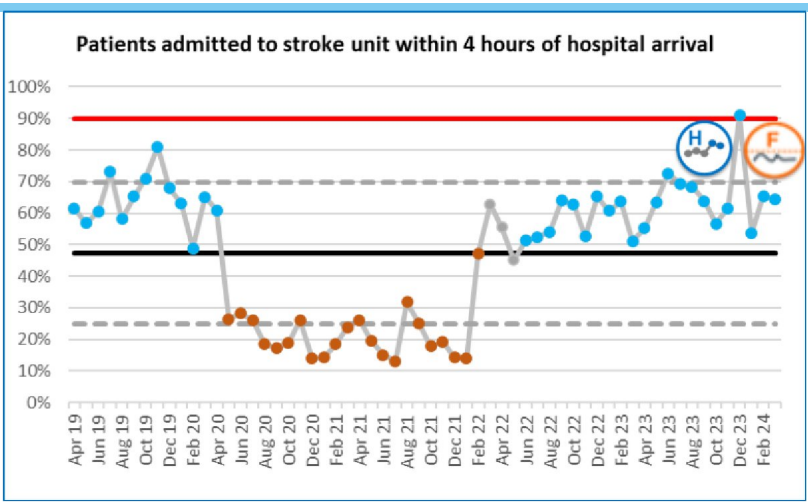
West Hertfordshire Hospitals NHS Trust




| Background | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| VTE Risk Assessment | Exception triggered due to the target being below the lower control limit<br><br>Exception triggered due to a breach of the upper control limit<br><br>Exception triggered due to a run of data points above the mean (a shift) | Badgernet data now incorporated for maternity | | |

West Hertfordshire Hospitals NHS Trust

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



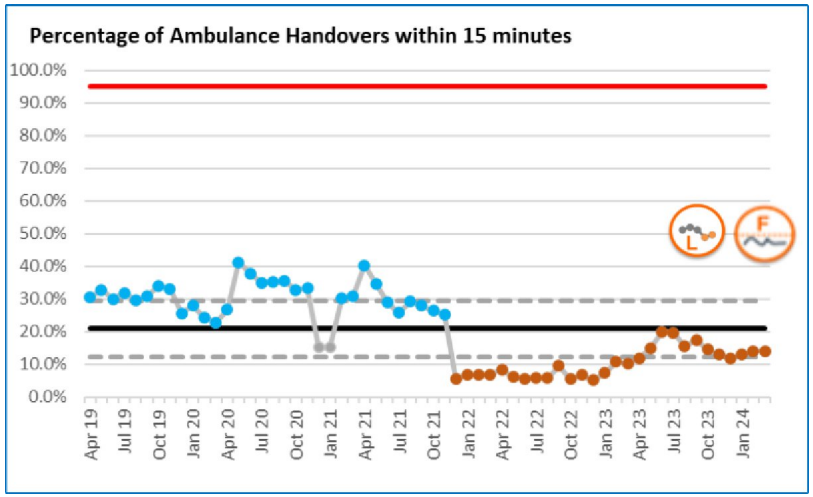

| Background | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| Patients admitted to stroke unit within 4 hours of hospital arrival | Exception triggered due to target being outside the upper control limit<br><br>Exception triggered due to a run of 7+ data points above the mean (a shift) | Changes to Covid testing guidance have enabled the service to improve the standard and consistently maintain it above the national average (49.5%). Also, to note, this performance is back to pre-pandemic ranges.<br><br>**Total number of admissions** : 34<br>**Already an inpatient** : 6<br>**Admissions achieved** : 21<br>**Admissions not achieved:** 12<br><br>The July–September quarter for Watford was 67%; in comparison the EoE average was 51.8%. Local Trusts were recorded as follows: Lister 37.4%, L&D 60.5%, Milton Keynes 52.5% | A review of the noncompliant patients is undertaken to understand if there are themes which need to be addressed.<br><br>Maintaining ring fenced beds on the HASU and a ring-fenced side room for patients requiring thrombolysis | The reasons for not meeting the national set target are not within the service gift to influence. These encompass late referrals, capacity and patients admitted to another ward before Stroke unit due to an unclear diagnosis.<br><br>Patients continue to receive Stroke Consultant input and specific recommendations for their care. |

NHS
West Hertfordshire Hospitals
NHS Trust

| 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 | Mar 24 | 14.1% | 95.0% | | | National | F&P | COO |
| Ambulance turnaround times >30 mins and <60 mins | Mar 24 | 746 | - | | | National | F&P | COO |
| Ambulance turnaround times >60 mins | Mar 24 | 113 | - | | | National | F&P | COO |
| A&E Initial Assessment < 15 mins | Mar 24 | 75.6% | 95.0% | | | National | F&P | COO |
| Mean time in department (non-admitted) | Mar 24 | 274 | - | | | National | F&P | COO |
| Mean time in department (admitted) | Mar 24 | 391 | - | | | National | F&P | COO |
| 12 hour end to end waits for all attendances | Mar 24 | 784 | - | | | Local | F&P | COO |
| A&E 12hr trolley waits | Mar 24 | 44 | 0 | | | Local | F&P | COO |
| A&E 4 Hour Wait - Type 1, 2 & 3 | Mar 24 | 78.2% | 76.0% | | | National | F&P | COO |
| A&E 4hr waits – Type 1 | Mar 24 | 61.5% | - | | | National | F&P | COO |
| % Patients admitted through A&E - 0 day LOS | Mar 24 | 34.0% | - | | | Local | F&P | COO |
| Proportion of 12 hour waits in ED | Mar 24 | 4.5% | 2.0% | | | National | F&P | COO |

West Hertfordshire Hospitals NHS Trust

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



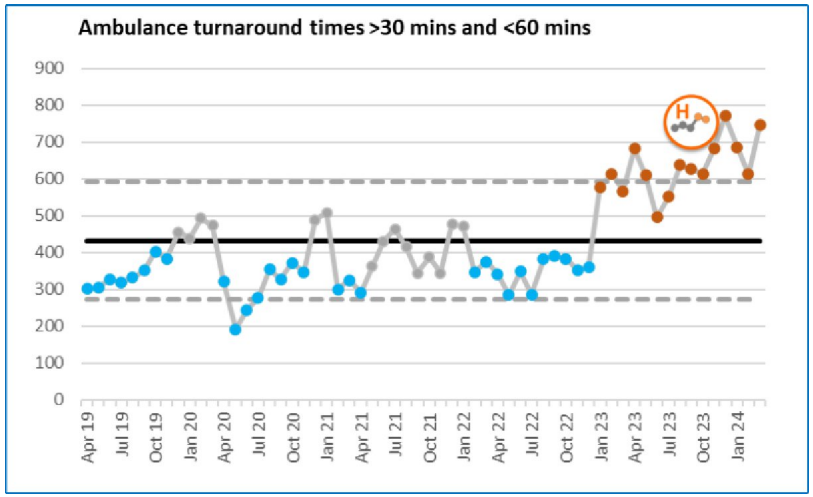

*Latest available benchmarking data – EEAST – March 2024

| Hospital | % within 15 minutes |
|---|---|
| Bedford Hospital South Wing | 64.88% |
| Addenbrookes Hospital | 56.36% |
| Hinchingbrooke Hospital | 51.16% |
| Norfolk & Norwich University Hospital | 48.67% |
| Broomfield Hospital | 45.55% |
| Basildon & Thurrock Hospital | 39.77% |
| West Suffolk Hospital | 35.82% |
| Southend University Hospital | 34.14% |
| Queen Elizabeth Hospital | 32.72% |
| Princess Alexandra Hospital | 27.63% |
| Ipswich Hospital | 24.52% |
| James Paget Hospital | 20.86% |
| Luton & Dunstable Hospital | 19.93% |
| Peterborough City Hospital | 17.70% |
| Lister Hospital | 15.04% |
| Colchester General Hospital | 14.77% |
| **Watford General Hospital** | **14.06%** |
| **Region** | **32.82%** |

| 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<br><br>Exception triggered due to 7+ data points below the mean (a shift) | Ambulance demand is up 7.9% on the previous year and down 9.1% on 20/21<br><br>Daily staffing levels for nursing with the Emergency Medicine Division Daily medical staffing within ED<br><br>Assessment areas bedded and used as exceptional surge capacity | • The implementation of 45 minute 'rapid release' supported by corridor care and application of the boarding policy (16 April 2023) has continued through September to decompress ED<br>• HALO on site 12- 12<br>• Fit to sit area in use to support offload<br>• Joint working with EEAST and WGH UTC to facilitate offload<br>• Senior nurse in STARR<br>• Shift lead in charge of ED (as well as nurse in charge of majors)<br>• ED escalation policy in place<br>• Improved pathways and staffing in TAM<br>• Increased chair capacity in EAU<br>• Assurance on performance and plans/actions at bed meetings<br>• Corridor nursing in place including a joint Trust and EEAST corridor SOP<br>• SOP to be agreed with AP and EEAST for call before convey programme<br>• Ambulance handover project board meetings continue with EEAST and ICS in attendance.<br><br>Ambulance handover high level actions agreed (being revised alongside trajectory for lost hours by Mar 24)<br><br>High level actions included in Trust improvement plan | ED improvement plan developed detailing actions for ED, this is being worked into a Trust flow plan<br><br>All patients assessed by senior decision maker on arrival and treatment commenced if delayed. Close partnership working with EEAST<br><br>Intelligent conveyancing implemented and in agreement with EEAST and ICB as necessary.<br><br>Rapid release in place to support patients in the community<br><br>Workforce Business Plans being submitted to TMC July 23 to support:<br>Nursing workforce<br>Medical workforce<br>Performance Co-Ordinator shifts<br><br>Active recruitment to vacancies<br><br>Assurance through bed meetings for time to initial assessment and time to offload |

West Hertfordshire Hospitals NHS Trust

# Special Cause Variation – Performance/Assurance – Ambulance Turnaround Times >30 mins and <60 mins



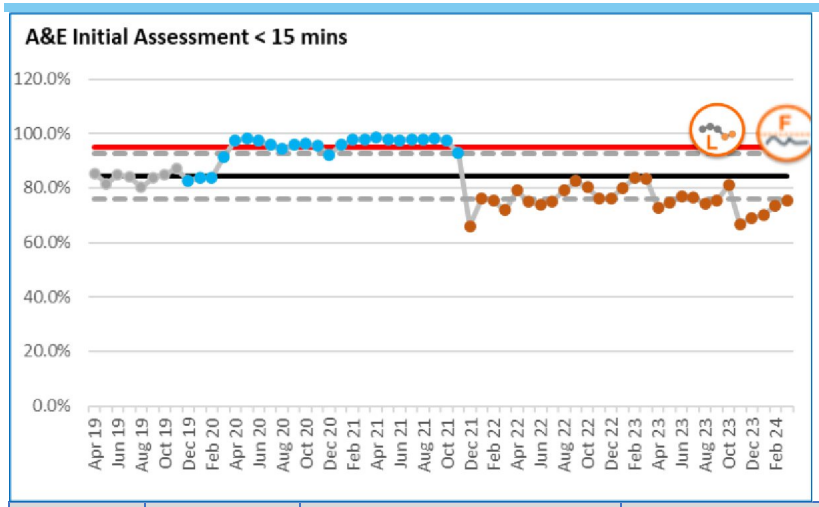

*Latest available benchmarking data – EEAST – March 2024

| Hospital | Number over 30 Minutes | % over 30 minutes |
|---|---|---|
| Bedford Hospital South Wing | 103 | 6.26% |
| Hinchingbrooke Hospital | 153 | 11.46% |
| West Suffolk Hospital | 252 | 12.97% |
| Addenbrookes Hospital | 361 | 14.17% |
| Southend University Hospital | 393 | 15.04% |
| Basildon & Thurrock Hospital | 359 | 16.28% |
| Broomfield Hospital | 461 | 18.58% |
| Colchester General Hospital | 747 | 25.30% |
| Ipswich Hospital | 618 | 26.26% |
| Queen Elizabeth Hospital | 585 | 30.63% |
| **Watford General Hospital** | **853** | **30.83%** |
| Princess Alexandra Hospital | 551 | 32.60% |
| Norfolk & Norwich University Hospital | 1,225 | 32.94% |
| Luton & Dunstable Hospital | 783 | 33.35% |
| Lister Hospital | 767 | 35.07% |
| Peterborough City Hospital | 656 | 36.16% |
| James Paget Hospital | 942 | 51.03% |
| **Region** | **9,809** | **25.57%** |

| Background | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| Ambulance turnaround times >30 mins and <60 mins | Exception triggered due to a breach of the upper control limit<br><br>Exception triggered due to 7+ data points above the mean (a shift) | Ambulance demand is up 7.9% on the previous year and down 9.1% on 20/21<br><br>Daily staffing levels for nursing with the Emergency Medicine Division Daily medical staffing within ED<br><br>Assessment areas bedded and used as exceptional surge capacity | • The implementation of 45 minute 'rapid release' supported by corridor care and application of the boarding policy (16 April 2023) has continued through September to decompress ED<br>• HALO on site 12- 12<br>• Fit to sit area in use to support offload<br>• Joint working with EEAST and WGH UTC to facilitate offload<br>• Senior nurse in STARR<br>• Shift lead in charge of ED (as well as nurse in charge of majors)<br>• ED escalation policy in place<br>• Improved pathways and staffing in TAM<br>• Increased chair capacity in EAU<br>• Assurance on performance and plans/actions at bed meetings<br>• Corridor nursing in place including a joint Trust and EEAST corridor SOP<br>• SOP to be agreed with AP and EEAST for call before convey programme<br>• Ambulance handover project board meetings continue with EEAST and ICS in attendance.<br><br>Ambulance handover high level actions agreed (being revised alongside trajectory for lost hours by Mar 24)<br><br>High level actions included in Trust improvement plan | ED improvement plan developed detailing actions for ED, this is being worked into a Trust flow plan<br><br>All patients assessed by senior decision maker on arrival and treatment commenced if delayed. Close partnership working with EEAST<br><br>Intelligent conveyancing implemented and in agreement with EEAST and ICB as necessary.<br><br>Rapid release in place to support patients in the community<br><br>Workforce Business Plans being submitted to TMC July 23 to support:<br>Nursing workforce<br>Medical workforce<br>Performance Co-Ordinator shifts<br><br>Active recruitment to vacancies<br><br>Assurance through bed meetings for time to initial assessment and time to offload |

West Hertfordshire Hospitals NHS Trust

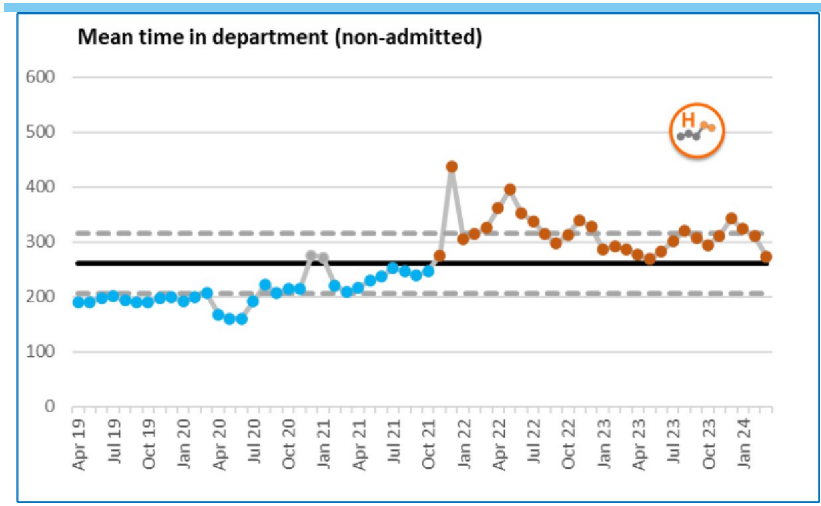
# Special Cause Variation – Performance – Time to initial assessment - Percentage within 15 minutes




| 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)<br><br>Exception triggered due to a breach of the lower control limit<br><br>Exception triggered due to the target being above the upper control limit | • Capacity pressures due to poor flow throughout ED resulted in late assessments.<br>• Nursing staffing workforce challenges with workforce at times being RAG rated RED.<br>• Assessment area bedded further compounded by Castle Ward closure<br>• Mental Health attendances, resulting in long stays in ED impacting on available assessment space.<br>• Doctor and nurse staffing levels at Watford UTC<br>• 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)<br>• Walk-in stream separated from ambulance stream to provide clearer visibility across the department and decompress bottleneck areas. Fit to sit implemented.<br>• Additional assessment trolleys created in majors 2.Increase use of TAM supported by senior decision makers to support flow and non admitted performance<br>• Senior oversight of CT & Diagnostic requests to reduce LOS in dept to improve flow and implementation of boarding policy<br>• EAU chairs implemented<br>• 10 x assessment spaces released from surge<br>• Increase usage of SDEC pathways including patients actively pulled into ACU.<br>• Emergency medicine performance meetings focus on improvement plan<br>• High Impact Changes work focussing on rapid clinical assessment, and UTC<br>• Focus on weekend discharges, discharge time of day and usage of discharge lounge to enable earlier flow. | • High Impact Changes enabling increasing Senior Decision Makers in ED.<br>• Data shows continued increase of initial assessment.<br>• On-going staffing and capacity reviews during shifts and decision taken to open additional areas when safe staffing levels allow<br>• Senior decision maker in “STARR” and TAM to focus on non-admitted patients<br>• 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.<br>• Additional staff rostered to cover corridor care at times of high attendance and high DTAs<br>• Additional Trust actions following escalation procedure enacted at times of extreme capacity pressures<br>• Joint corridor SOP and increased use of corridor due to Castle Ward closure<br>• Senior review/oversight of decisions to admit.<br>• Harm reviews carried out for patients who wait for 12 hrs, so far this has shown no harm caused<br>• Validation SOP in place<br>• Hourly rounding being undertaken on all patients ensuring comfort.<br>• If prolonged trolley wait – patients transferred to bed for comfort. |

West Hertfordshire Hospitals NHS Trust

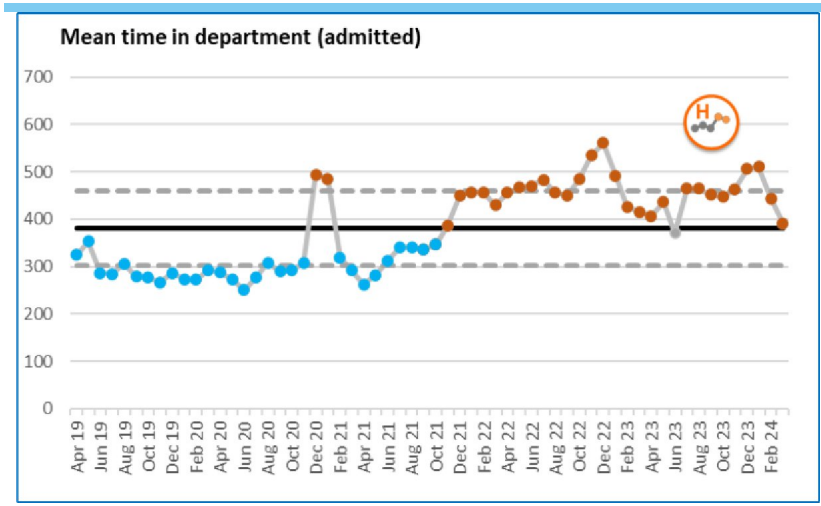
# Special Cause Variation – Performance – Mean time (minutes) in department (non-admitted)




| 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.<br>• Nursing staffing workforce challenges with workforce at times being RAG rated RED.<br>• Assessment area bedded<br>• Increased number of Mental Health attendances, resulting in long stays in ED impacting on available assessment space.<br>• Doctor and nurse staffing levels at Watford UTC<br>• WGH UTC flow constraints impact on ED as well as handovers at close.<br>• Increased LOS due to Castle Ward closure | • Implementation of 45 minute rapid release supported by corridor care and application of the boarding policy (16 April 2023)<br>• Walk-in stream separated from ambulance stream to provide clearer visibility across the department and decompress bottleneck areas. Fit to sit implemented.<br>• Additional assessment trolleys created in majors 2.Increase use of TAM supported by senior decision makers to support flow<br>• Senior oversight of CT and diagnostic tests to reduce unnecessary time in department<br>• EAU chairs implemented<br>• 10 x assessment spaces released from surge<br>• Increase usage of SDEC pathways including patients actively pulled into ACU.<br>• Phone a friend in place<br>• Emergency medicine performance meetings focus on improvement plan<br>• High Impact Changes work focussing on rapid clinical assessment, and UTC<br>• Focus on weekend discharges, discharge time of day and usage of discharge lounge to enable earlier flow. | • High Impact Changes enabling increasing Senior Decision Makers in ED.<br>• Data shows increase of initial assessment due to lack of flow<br>• On-going staffing and capacity reviews during shifts and decision taken to open additional areas when safe staffing levels allow<br>• Senior decision maker in “STARR” and TAM to focus on walk in patients and increase utilisation of CDU<br>• 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.<br>• Additional staff rostered to cover corridor care at times of high attendance with increased focus on flow<br>• Additional Trust actions following escalation procedure enacted at times of extreme capacity pressures<br>• Joint corridor SOP due to increased usage of corridor<br>• Senior review/oversight of decisions to admit.<br>• Harm reviews carried out for patients who wait for 12 hrs, so far this has shown no harm caused<br>• Validation SOP in place<br>• Hourly rounding being undertaken on all patients ensuring comfort.<br>• If prolonged trolley wait – patients transferred to bed for comfort. |

West Hertfordshire Hospitals NHS Trust

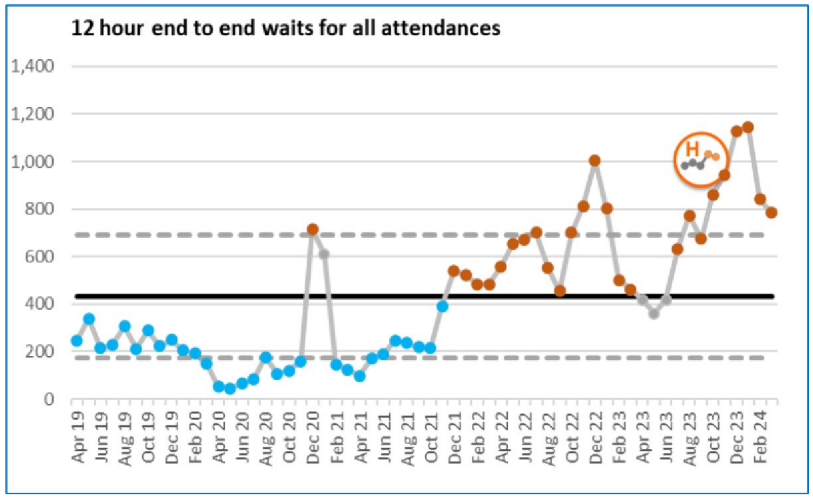
# Special Cause Variation – Performance – Mean time (minutes) in department (admitted)

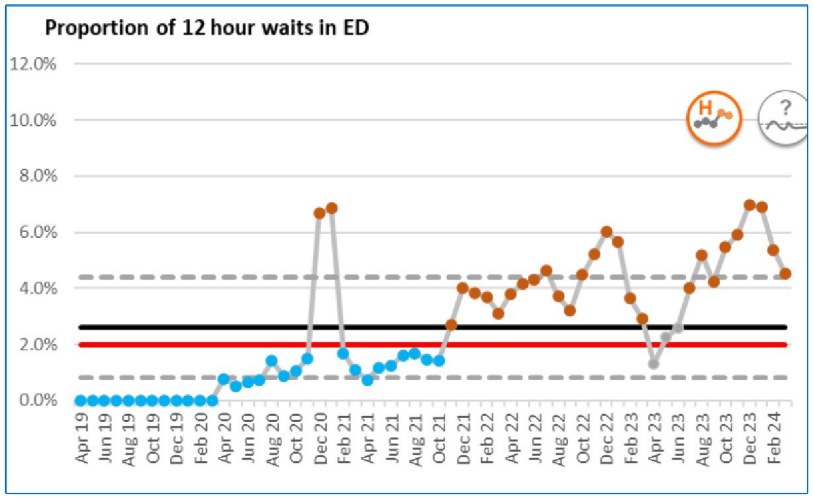



| Background | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| Mean time in department (Non-admitted | Exception triggered due to a run of data points above the mean (a shift) | • Capacity pressures due to poor flow throughout ED resulted in late assessments.<br>• Nursing staffing workforce challenges with workforce at times being RAG rated RED.<br>• Assessment area bedded<br>• Increased number of Mental Health attendances, resulting in long stays in ED impacting on available assessment space.<br>• Doctor and nurse staffing levels at Watford UTC<br>• WGH UTC flow constraints impact on ED as well as handovers at close.<br>• Increased LOS due to Castle Ward closure | • Implementation of 45 minute rapid release supported by corridor care and application of the boarding policy (16 April 2023)<br>• Walk-in stream separated from ambulance stream to provide clearer visibility across the department and decompress bottleneck areas. Fit to sit implemented.<br>• Additional assessment trolleys created in majors 2.Increase use of TAM supported by senior decision makers to support flow<br>• Senior oversight of CT and diagnostic tests to reduce unnecessary time in department<br>• EAU chairs implemented<br>• 10 x assessment spaces released from surge<br>• Increase usage of SDEC pathways including patients actively pulled into ACU.<br>• Phone a friend in place<br>• Emergency medicine performance meetings focus on improvement plan<br>• High Impact Changes work focussing on rapid clinical assessment, and UTC<br>• Focus on weekend discharges, discharge time of day and usage of discharge lounge to enable earlier flow. | • High Impact Changes enabling increasing Senior Decision Makers in ED.<br>• Data shows increase of initial assessment due to lack of flow<br>• On-going staffing and capacity reviews during shifts and decision taken to open additional areas when safe staffing levels allow<br>• Senior decision maker in “STARR” and TAM to focus on walk in patients and increase utilisation of CDU<br>• 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.<br>• Additional staff rostered to cover corridor care at times of high attendance with increased focus on flow<br>• Additional Trust actions following escalation procedure enacted at times of extreme capacity pressures<br>• Joint corridor SOP due to increased usage of corridor<br>• Senior review/oversight of decisions to admit.<br>• Harm reviews carried out for patients who wait for 12 hrs, so far this has shown no harm caused<br>• Validation SOP in place<br>• Hourly rounding being undertaken on all patients ensuring comfort.<br>• If prolonged trolley wait – patients transferred to bed for comfort. |

West Hertfordshire Hospitals NHS Trust

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

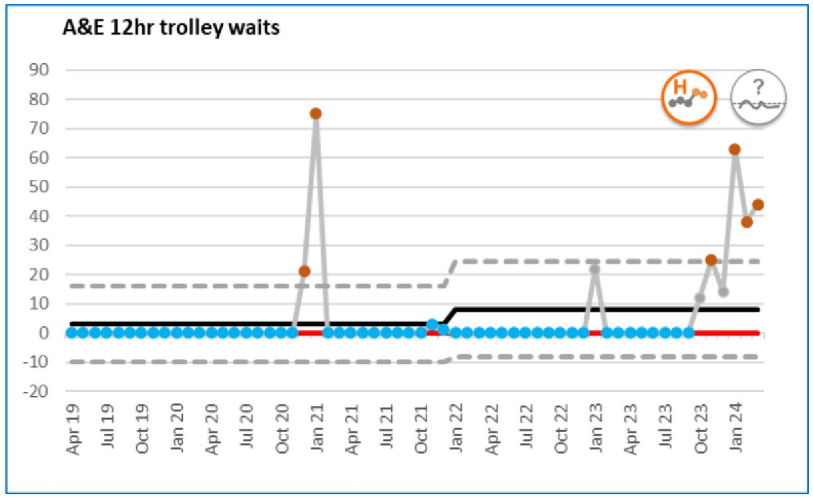



| Background | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| 12 Hour end to end waits for all attendances | Exception triggered due to a breach of the upper control limit<br><br>Exception triggered due to a run of data points above the mean (a shift) | • Capacity pressures due to poor flow throughout ED resulted in late assessments.<br>• Nursing staffing workforce challenges with workforce at times being RAG rated RED.<br>• Assessment area bedded<br>• Increased number of Mental Health attendances, resulting in long stays in ED impacting on available assessment space.<br>• Doctor and nurse staffing levels at Watford UTC<br>• WGH UTC flow constraints impact on ED as well as handovers at close.<br>• Industrial action impacting on LOS in department<br>• IPS response times slightly higher in the month of September | • Implementation of 45 minute rapid release supported by corridor care and application of the boarding policy (16 April 2023)<br>• Walk-in stream separated from ambulance stream to provide clearer visibility across the department and decompress bottleneck areas. Fit to sit implemented.<br>• Additional assessment trolleys created in majors 2.<br>• Increase use of TAM supported by senior decision makers to support flow<br>• Senior oversight of CT & Diagnostic requests in TAM<br>• EAU chairs implemented<br>• 10 x assessment spaces released from surge<br>• Increase usage of SDEC pathways including patients actively pulled into ACU.<br>• Increased focus on use of CDU through board rounds<br>• Phone a friend in place<br>• Emergency medicine performance meetings focus on improvement plan<br>• High Impact Changes work focussing on rapid clinical assessment, and UTC<br>• Focus on weekend discharges, discharge time of day and usage of discharge lounge to enable earlier flow. | • High Impact Changes enabling increasing Senior Decision Makers in ED.<br>• Data shows increase of initial assessment.<br>• On-going staffing and capacity reviews during shifts and decision taken to open additional areas when safe staffing levels allow<br>• Senior decision maker in “STARR” and TAM to focus on walk in patients<br>• 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.<br>• Use of CDU promoted through TAM and EPIC role.<br>• Additional staff rostered to cover corridor care at times of high attendance and high DTAs<br>• Additional Trust actions following escalation procedure enacted at times of extreme capacity pressures<br>• Joint corridor SOP<br>• Senior review/oversight of decisions to admit.<br>• Harm reviews carried out for patients who wait for 12 hrs, so far this has shown no harm caused<br>• Validation SOP in place<br>• Hourly rounding being undertaken on all patients ensuring comfort.<br>• If prolonged trolley wait – patients transferred to bed for comfort. |

West Hertfordshire Hospitals NHS Trust

# Special Cause Variation – Performance – A&E 12 hour trolley waits




**March 2024 - East of England A&E 12 Hour Trolley Waits (Latest Published Data)**

| Trust | Attendances | 12 Hour Trolley Waits | Region Rank |
|---|---|---|---|
| Milton Keynes University Hospital NHS Foundation Trust | 14,753 | 0 | 1 |
| Bedfordshire Hospitals NHS Foundation Trust | 25,443 | 6 | 2 |
| Mid And South Essex NHS Foundation Trust | 37,872 | 7 | 3 |
| East And North Hertfordshire NHS Trust | 17,353 | 37 | 4 |
| **West Hertfordshire Teaching Hospitals NHS Trust** | **17,289** | **44** | **5** |
| The Princess Alexandra Hospital NHS Trust | 11,663 | 101 | 6 |
| Norfolk And Norwich University Hospitals NHS Foundation Trust | 22,302 | 151 | 7 |
| The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust | 8,059 | 161 | 8 |
| James Paget University Hospitals NHS Foundation Trust | 8,859 | 370 | 9 |
| West Suffolk NHS Foundation Trust | 8,773 | 398 | 10 |
| East Suffolk And North Essex NHS Foundation Trust | 30,387 | 408 | 11 |
| North West Anglia NHS Foundation Trust | 19,476 | 614 | 12 |
| Cambridge University Hospitals NHS Foundation Trust | 17,607 | 616 | 13 |

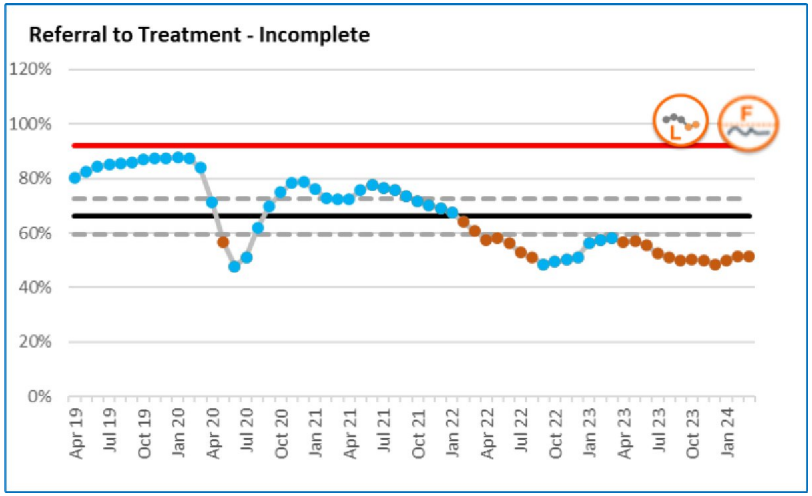
| Background | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| 12 Hour trolley Waits | Exception triggered due to a breach of the upper control limit | | | |

West Hertfordshire Hospitals NHS Trust

| KPI | Latest month | Measure | Target | Variation | Assurance | Local or National Metric | Committee | Owner |
|---|---|---|---|---|---|---|---|---|
| **Caring & Responsive Services - RTT, Cancer, Outpatients** | | | | | | | | |
| Referral to Treatment - Incomplete | Mar 24 | 51% | 92% | L | F | National | F&P | COO |
| Referral to Treatment - 52 week waits - Incomplete | Mar 24 | 2657 | 0 | H | F | Local | F&P | COO |
| Referral to Treatment - 65 week waits - Incomplete | Mar 24 | 245 | 0 | L | F | Local | F&P | COO |
| Referral to Treatment - 78 week waits - Incomplete | Mar 24 | 1 | 0 | L | F | National | F&P | COO |
| Diagnostic (DM01) <6 weeks | Mar 24 | 88% | 99% | H | F | National | F&P | COO |
| New Cancer Metric - 28 Day Faster Diagnosis Standard | Mar 24 | 78% | 75% | H | ? | National | F&P | COO |
| New Cancer Metric - 31 Day Combined | Mar 24 | 95% | 96% | | ? | National | F&P | COO |
| New Cancer Metric - 62 Day Combined | Mar 24 | 71% | 85% | | ? | National | F&P | COO |
| Cancer 104+ day waits | Mar 24 | 37 | - | | | Local | F&P | COO |
| Outpatient cancellation rate within 6 weeks | Mar 24 | 4% | 5% | L | ? | Local | F&P | CIO |
| Outpatient DNA rate | Mar 24 | 9% | 8% | | ? | Local | F&P | CIO |

West Hertfordshire Hospitals NHS Trust

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



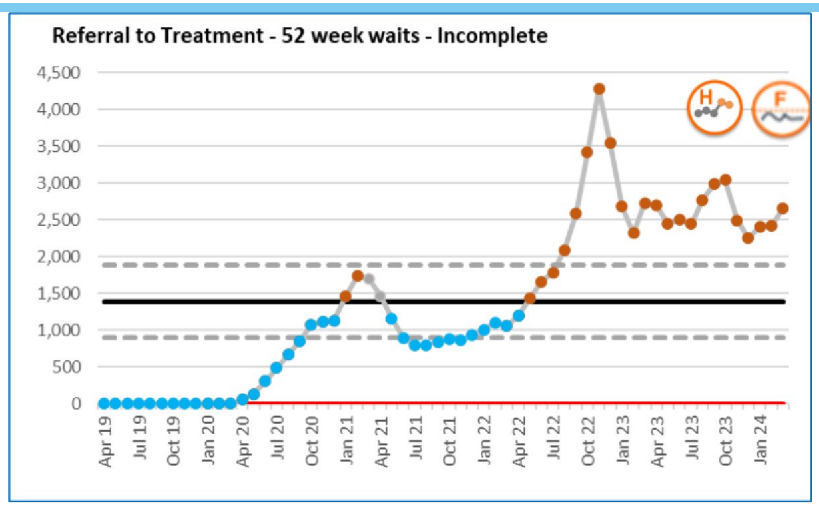

| Trust | Feb-24 |
|---|---|
| The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust | 60.7% |
| Cambridge University Hospitals NHS Foundation Trust | 58.8% |
| East Suffolk And North Essex NHS Foundation Trust | 56.5% |
| East And North Hertfordshire NHS Trust | 54.2% |
| West Suffolk NHS Foundation Trust | 53.6% |
| The Princess Alexandra Hospital NHS Trust | 52.7% |
| Bedfordshire Hospitals NHS Foundation Trust | 52.3% |
| Mid And South Essex NHS Foundation Trust | 51.7% |
| **West Hertfordshire Hospitals NHS Trust** | **51.4%** |
| Norfolk And Norwich University Hospitals NHS Foundation Trust | 50.8% |
| North West Anglia NHS Foundation Trust | 49.3% |
| James Paget University Hospitals NHS Foundation Trust | 43.8% |
| Milton Keynes University Hospital NHS Foundation Trust | 34.8% |

***Latest available published RTT data – February 2024**

| Background | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| Referral to Treatment - Incomplete | Exception triggered due to target being outside the upper control limit<br><br>Exception triggered due to 7+ consecutive data points below the mean (a shift)<br><br>Exception triggered due to a breach of the lower control limit | Although EPR has been in place for 2 years, errors continue to affect the RTT PTL in a number of ways. Incorrect outcoming at appointments results in fewer clock stops and adversely affects PTL size with more open pathways on the PTL.<br><br>Loss of activity as a result of industrial action also continues to impact activity and associated clock stops.<br><br>The external validation support that was in place at the end of 2022/23 was fundamental in delivering comprehensive validation. Although there has been agreement to invest in expanding the validation service in house, staff are not yet in post. | Outsourcing programme remains active with reasonable patient uptake.<br><br>Additional sessions are being undertaken but there is less uptake than pre COVID.<br><br>Elective Activity Oversight group monitoring and supporting activity delivery<br><br>DQ steering group established to lead on improvement work.<br><br>Validation team recruitment is underway with some posts appointed to and others out to advert. A small amount of external resource remains in place, to increase validation activity | Continuous horizon scanning for additional outsourcing opportunities, with specialty level engagement to ensure quality and safety as well as timely pathways<br><br>Weekly long wait review meeting in place to drive progress and delivery of improvement plan.<br><br>Service level tracking with forward look to target deadlines to ensure adequate operational oversight of patient cohorts. |

West Hertfordshire Hospitals NHS Trust

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



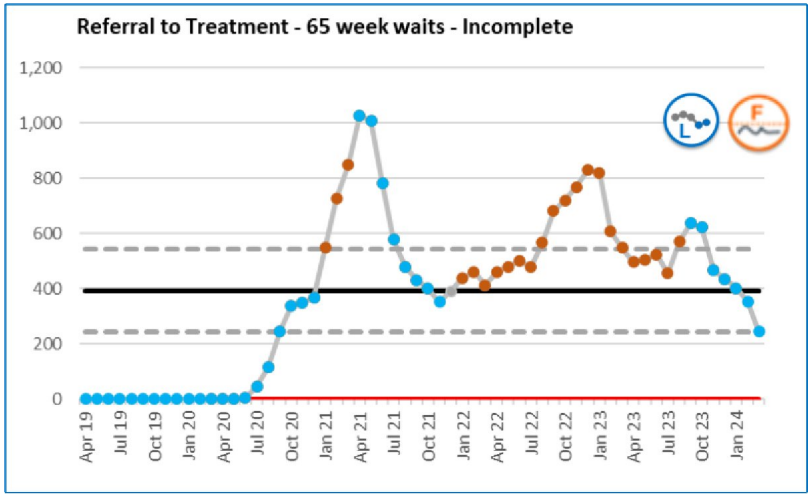

| Trust | Feb-24 |
|---|---|
| The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust | 399 |
| West Suffolk NHS Foundation Trust | 1,797 |
| The Princess Alexandra Hospital NHS Trust | 1,959 |
| **West Hertfordshire Hospitals NHS Trust** | **2,420** |
| East And North Hertfordshire NHS Trust | 2,905 |
| Cambridge University Hospitals NHS Foundation Trust | 3,030 |
| James Paget University Hospitals NHS Foundation Trust | 3,612 |
| East Suffolk And North Essex NHS Foundation Trust | 3,887 |
| Milton Keynes University Hospital NHS Foundation Trust | 4,385 |
| Bedfordshire Hospitals NHS Foundation Trust | 4,485 |
| North West Anglia NHS Foundation Trust | 6,644 |
| Norfolk And Norwich University Hospitals NHS Foundation Trust | 6,951 |
| Mid And South Essex NHS Foundation Trust | 7,797 |

*Latest available published RTT data – February 2024

| 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)<br><br>Exception triggered due to breach of upper control limit<br><br>Exception triggered due to the target being below the lower control limit | Although EPR has been in place for 2 years, errors continue to affect the RTT PTL in a number of ways, with incorrect outcomes which results in fewer clock stops and more open pathways on the PTL.<br><br>The external validation support that was in place at the end of 2022/23 was fundamental in delivering comprehensive validation and this continues at a lower level. Recruitment is underway, with some posts appointed to. Until all staff are in post external validation support will remain in place. | Outsourcing programme remains active with reasonable patient uptake, although tighter controls are in place to support financial recovery plans.<br><br>Additional sessions are being undertaken but there is significantly less uptake than pre COVID.<br><br>Elective Activity Oversight Group supporting divisions with activity delivery against plan.<br><br>DQ steering group established to lead on improvement work.<br><br>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. | Continuous horizon scanning for additional outsourcing opportunities, with specialty level engagement to ensure quality and safety as well as timely pathways<br><br>Weekly long wait review meeting in place to drive progress and delivery of improvement plan.<br><br>Service level tracking with forward look to target deadlines to ensure adequate operational oversight of patient cohorts. |

West Hertfordshire Hospitals NHS Trust

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



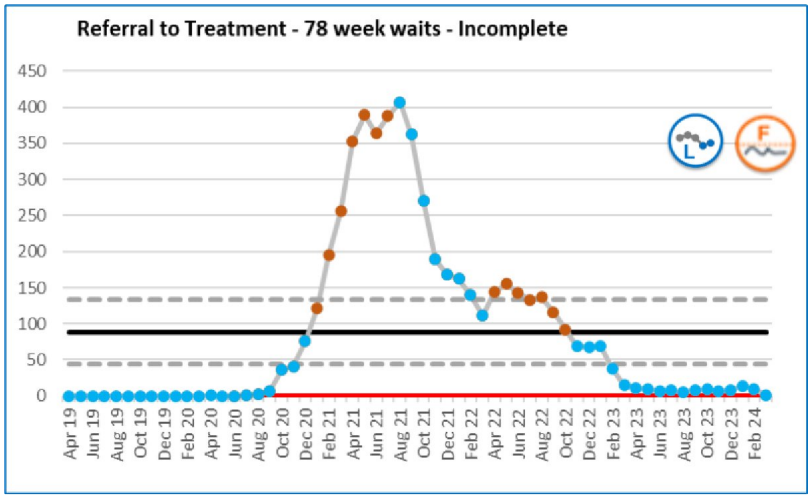

| Trust | Feb-24 |
|---|---|
| The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust | 69 |
| **West Hertfordshire Hospitals NHS Trust** | **353** |
| East And North Hertfordshire NHS Trust | 499 |
| West Suffolk NHS Foundation Trust | 580 |
| The Princess Alexandra Hospital NHS Trust | 655 |
| East Suffolk And North Essex NHS Foundation Trust | 747 |
| Cambridge University Hospitals NHS Foundation Trust | 748 |
| Bedfordshire Hospitals NHS Foundation Trust | 874 |
| Milton Keynes University Hospital NHS Foundation Trust | 1,305 |
| James Paget University Hospitals NHS Foundation Trust | 1,444 |
| North West Anglia NHS Foundation Trust | 2,091 |
| Mid And South Essex NHS Foundation Trust | 2,187 |
| Norfolk And Norwich University Hospitals NHS Foundation Trust | 2,838 |

*Latest available published RTT data – February 2024

| Background | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| Referral to Treatment – 65 weeks incomplete | Exception triggered due to the target being below the lower control limit<br><br>Exception triggered due to a breach of the lower control limit<br><br>Exception triggered due to a run of data points in the same direction (a trend) | Although EPR has been in place just over 2 years, errors continue to affect the RTT PTL and the number of long waits.<br><br>The external validation support that was in place at the end of 2022/23 was fundamental in delivering comprehensive validation. Although there has been agreement to invest in expanding the validation service in house, staff are not yet in post, so this resource remains in place at a lower level.<br><br>Services are working on delivery of this task but DQ issues are creating additional challenges. Capacity constraints (ENT, Dermatology, Orthopaedics) require services to consider additional actions to ensure long wait elimination. | Outsourcing programme remains active with reasonable patient uptake, although tighter controls are in place to support financial recovery plans.<br><br>Additional sessions are being undertaken but there is significantly less uptake than pre COVID.<br><br>Elective Activity Oversight Group supporting divisions with activity delivery against plan.<br><br>DQ steering group established to lead on improvement work.<br><br>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. | Continuous horizon scanning for additional outsourcing opportunities, with specialty level engagement to ensure quality and safety as well as timely pathways<br><br>Weekly long wait review meeting in place to drive progress and delivery of improvement plan.<br><br>Service level tracking with forward look to target deadlines to ensure adequate operational oversight of patient cohorts. |

West Hertfordshire Hospitals NHS Trust

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



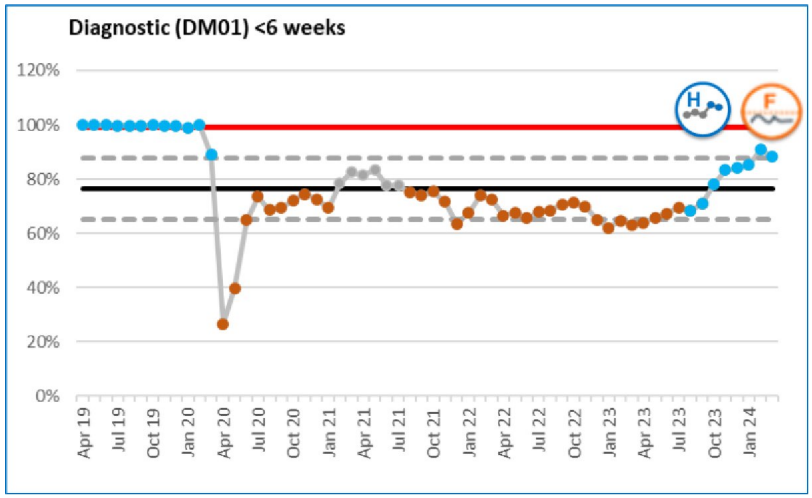

| Trust | Feb-24 |
|---|---|
| The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust | 2 |
| **West Hertfordshire Hospitals NHS Trust** | **10** |
| East And North Hertfordshire NHS Trust | 30 |
| East Suffolk And North Essex NHS Foundation Trust | 32 |
| West Suffolk NHS Foundation Trust | 61 |
| Bedfordshire Hospitals NHS Foundation Trust | 66 |
| The Princess Alexandra Hospital NHS Trust | 84 |
| Cambridge University Hospitals NHS Foundation Trust | 111 |
| Milton Keynes University Hospital NHS Foundation Trust | 136 |
| North West Anglia NHS Foundation Trust | 233 |
| Mid And South Essex NHS Foundation Trust | 292 |
| James Paget University Hospitals NHS Foundation Trust | 303 |
| Norfolk And Norwich University Hospitals NHS Foundation Trust | 703 |

***Latest available published RTT data – February 2024**

| 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<br><br>Exception triggered due to 7+ data points below the mean (a shift)<br><br>Exception triggered due to the target being below the lower control limit | Complexity and unexpected diagnostic outcomes, patient choice delays and fitness to proceed are all risks to delivery of this long wait target.<br><br>Capacity constraints in some services continue to limit opportunities to improve routine wait times as clinically urgent cases are always prioritised. | Weekly Access and long waits review meetings are fundamental to delivery of this target.<br><br>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.<br><br>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



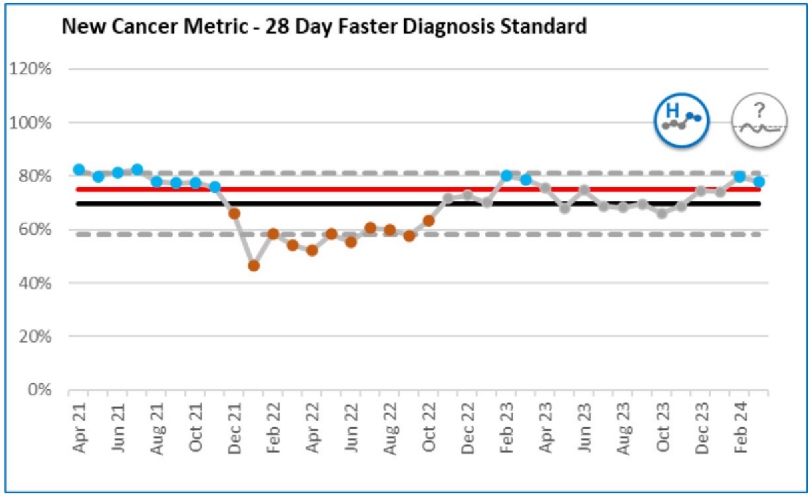

| Trust | Jan-24 | Feb-24 |
|---|---|---|
| East Suffolk And North Essex NHS Foundation Trust | 87.5% | 92.6% |
| **West Hertfordshire Hospitals NHS Trust** | **85.2%** | **90.9%** |
| James Paget University Hospitals NHS Foundation Trust | 84.7% | 88.7% |
| The Princess Alexandra Hospital NHS Trust | 65.3% | 75.2% |
| The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust | 65.6% | 72.7% |
| Mid And South Essex NHS Foundation Trust | 69.5% | 71.9% |
| West Suffolk NHS Foundation Trust | 60.7% | 68.8% |
| Cambridge University Hospitals NHS Foundation Trust | 59.8% | 64.8% |
| North West Anglia NHS Foundation Trust | 55.4% | 64.7% |
| Milton Keynes University Hospital NHS Foundation Trust | 61.1% | 64.7% |
| Norfolk And Norwich University Hospitals NHS Foundation Trust | 57.4% | 64.2% |
| Bedfordshire Hospitals NHS Foundation Trust | 55.1% | 59.4% |
| East And North Hertfordshire NHS Trust | 49.2% | 55.3% |

***Latest available benchmarking data – Diagnostic Wait Times – February 2024**

| Background | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| Diagnostic (DM01) < 6 weeks | Exception triggered due to a run of improving data points (a trend)<br><br>Exception triggered due to target being outside the upper control limit | Capacity constraints have affected the rate of recovery and backlog clearance in some modalities (Dexa, Cystoscopy and Audiology)<br><br>All of the challenged modalities (excluding Audiology) have plans in place that are delivering month on month improvement. | Work on the cystoscopy PTL with the BI team has completed and lessons learned are being applied to the uro-gynae (which sits within WACS) element of the waiting list.<br><br>DEXA outsourcing has ceased now that in house capacity is sufficient to manage demand.<br><br>Echo ad hoc sessions have been approved by the Elective Activity Oversight group and are underway | Additional in house sessions (Audiology, MRI, CT, NOUS, Echo)<br><br>Mobile, staffed MRI scanner contract extended to end of year. |

West Hertfordshire Hospitals NHS Trust

# Special Cause Variation – Performance – New Cancer Metric – 28 Day Faster Diagnosis Standard

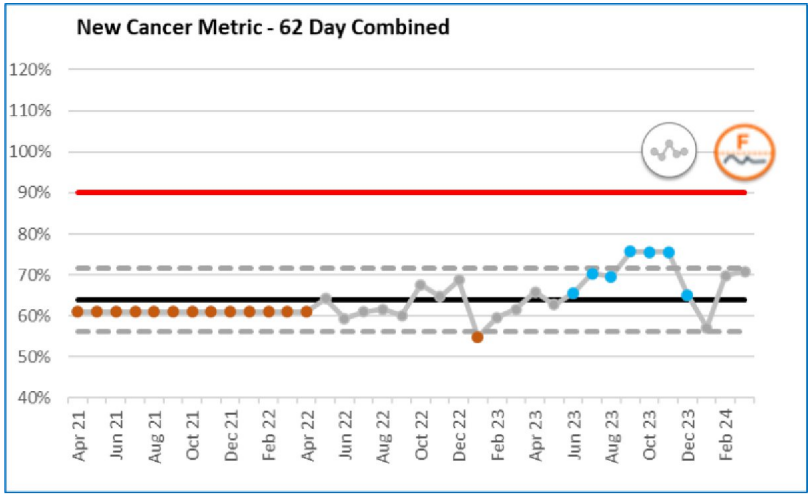



| Provider Name | Jan 24 | Feb 24 |
|---|---|---|
| CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST | 79.9% | 84.9% |
| EAST AND NORTH HERTFORDSHIRE NHS TRUST | 76.1% | 83.4% |
| THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST | 74.5% | 80.3% |
| **WEST HERTFORDSHIRE TEACHING HOSPITALS NHS TRUST** | 74.1% | 79.8% |
| WEST SUFFOLK NHS FOUNDATION TRUST | 66.9% | 76.7% |
| NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST | 61.1% | 75.9% |
| EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST | 70.2% | 75.3% |
| MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST | 71.6% | 74.2% |
| BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST | 67.1% | 74.0% |
| JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST | 62.7% | 72.5% |
| MID AND SOUTH ESSEX NHS FOUNDATION TRUST | 57.9% | 71.1% |
| NORTH WEST ANGLIA NHS FOUNDATION TRUST | 59.6% | 70.6% |
| THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST | 60.0% | 70.4% |

| Background | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| New Cancer Metric – 62 Day Combined | Exception triggered due to 2 of 3 most recent data points being close to the upper control limit | | | |

West Hertfordshire Hospitals NHS Trust

# Special Cause Variation – Assurance – New Cancer Metric – 62 Day Combined

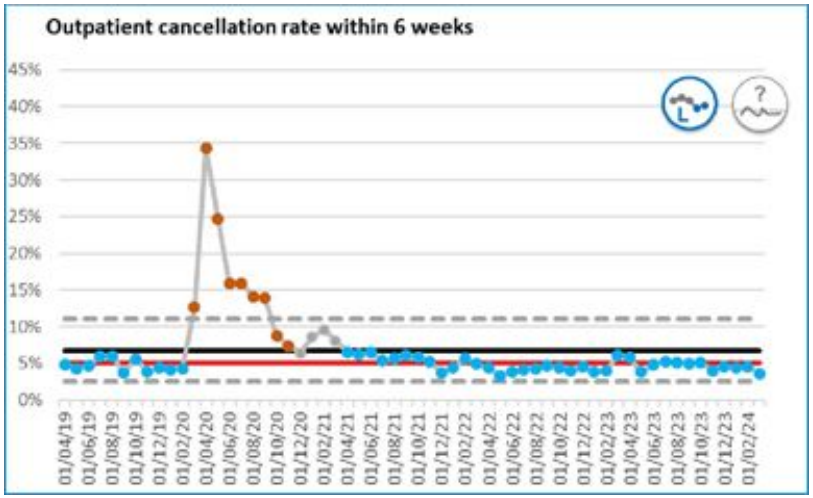



| Provider Name | Jan 24 | Feb 24 |
|---|---|---|
| EAST AND NORTH HERTFORDSHIRE NHS TRUST | 86.1% | 83.6% |
| WEST SUFFOLK NHS FOUNDATION TRUST | 74.0% | 81.7% |
| CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST | 73.0% | 73.9% |
| **WEST HERTFORDSHIRE TEACHING HOSPITALS NHS TRUST** | 62.6% | 72.7% |
| MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST | 63.6% | 71.0% |
| EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST | 67.8% | 70.6% |
| BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST | 67.7% | 63.2% |
| JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST | 57.6% | 62.3% |
| THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST | 63.4% | 61.1% |
| NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST | 44.9% | 49.5% |
| THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST | 44.2% | 48.8% |
| NORTH WEST ANGLIA NHS FOUNDATION TRUST | 45.8% | 48.4% |
| MID AND SOUTH ESSEX NHS FOUNDATION TRUST | 47.4% | 48.3% |

| Background | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| New Cancer Metric – 62 Day Combined | Exception triggered due to a breach of the upper control limit<br><br>Exception triggered due to target being outside the upper control limit | | | |

West Hertfordshire Hospitals NHS Trust

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




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

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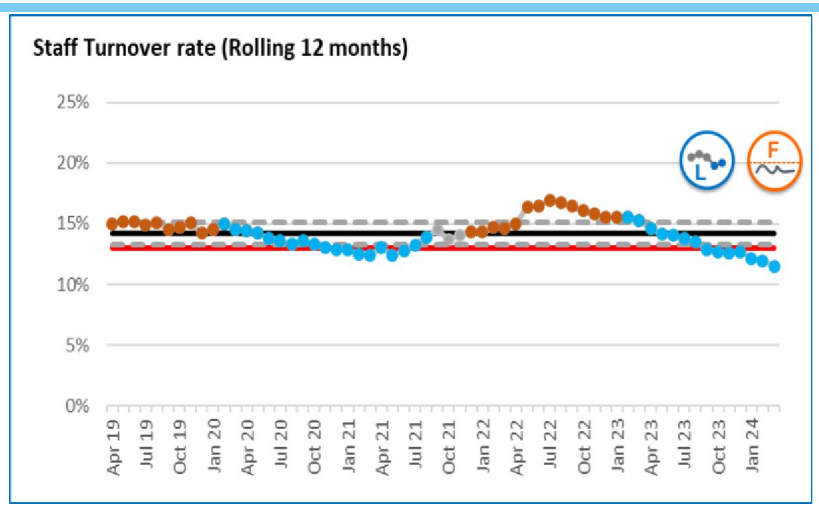
| KPI | Latest month | Measure | Target | Variation | Assurance | Local or National Metric | Committee | Owner |
|---|---|---|---|---|---|---|---|---|
| **Well-Led Services - Workforce Metrics** | | | | | | | | |
| Staff Turnover rate (Rolling 12 months) | Mar 24 | 11.5% | 13.0% | | | Local | PerC | CPO |
| % staff leaving within first year (excluding medics and fixed term contracts) | Mar 24 | 13.5% | - | | | Local | PerC | CPO |
| Vacancy rate | Mar 24 | 5.0% | 10.0% | | | Local | PerC | CPO |
| Sickness rate | Mar 24 | 3.8% | 3.5% | | | Local | PerC | CPO |
| Appraisal rate (Total) | Mar 24 | 79.0% | 90.0% | | | Local | PerC | CPO |
| Mandatory Training | Mar 24 | 90.4% | 90.0% | | | Local | PerC | CPO |
| % Bank Pay | Mar 24 | 7.6% | 12.0% | | | Local | PerC | CPO/CFO |
| % Agency Pay | Mar 24 | 2.1% | 3.7% | | | Local | PerC | CPO/CFO |
| WTE Workforce Establishment | Mar 24 | 5626.7 | 5506.0 | | | Local | PerC | CPO |
| WTE Staff in Post | Mar 24 | 5345.8 | 5152.0 | | | Local | PerC | CPO |
| BAME Staff in Post | Mar 24 | 51% | - | | | Local | PerC | CPO |
| BAME Staff at Band 8a+ | Mar 24 | 28% | - | | | Local | PerC | CPO |
| Apprenticeship Levy Utilisation | Mar 24 | 42% | 65% | | | Local | PerC | CPO |

West Hertfordshire Hospitals NHS Trust

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



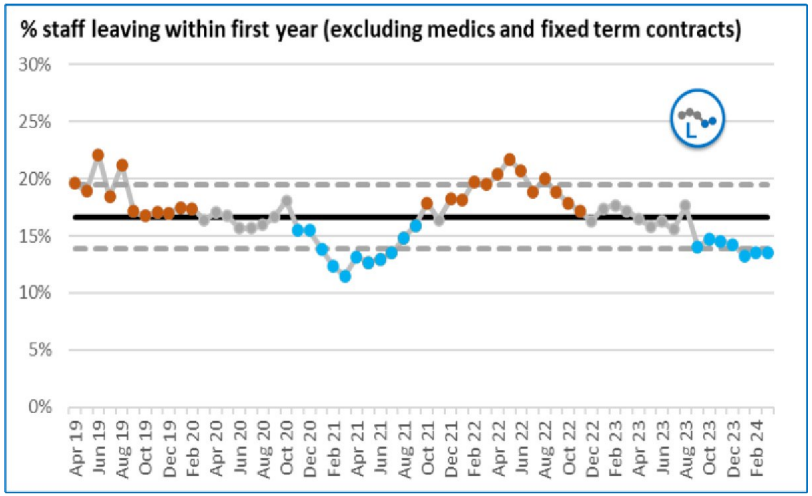

**TURNOVER RATE**

| Trust | Turnover Q4 22/23 | Turnover Q1 23/24 | Turnover Q2 23/24 | Turnover Q3 23/24 | Q2 23/24 Ranking (current) | Q3 23/24 Ranking (current) | Change Q1 to Q2 | Change Q2 to Q3 |
|---|---|---|---|---|---|---|---|---|
| Bedfordshire Hospitals | 15.0% | 14.4% | 13.8% | 13.5% | 8 | 8 | ↘ | ↘ |
| Herts Community | 14.4% | 14.1% | 13.5% | 12.4% | 7 | 4 | ↘ | ↘ |
| WHTH | 14.6% | 14.0% | 12.9% | 12.7% | 6 | 6 | ↘ | ↘ |
| East & North Herts | 11.5% | 11.7% | 11.1% | 10.4% | 2 | 2 | ↘ | ↘ |
| HPFT | 11.8% | 11.7% | 11.1% | 10.5% | 2 | 3 | ↘ | ↘ |
| ELF Bedford MH | 18.3% | 16.7% | 14.2% | 15.5% | 9 | 12 | ↘ | ↗ |
| ELF Luton MH | 19.6% | 17.2% | 17.2% | 13.7% | 12 | 9 | → | ↘ |
| ELF Bedford Community | 15.1% | 12.9% | 12.8% | 14.3% | 4 | 11 | ↘ | ↗ |
| Princess Alexandra | 16.3% | 15.1% | 12.8% | 12.5% | 4 | 5 | ↘ | ↘ |
| Essex Partnership UT | 10.6% | 10.2% | 9.4% | 9.3% | 1 | 1 | ↘ | ↘ |
| Milton Keynes UFT | 16.9% | 15.7% | 14.4% | 13.3% | 10 | 7 | ↘ | ↘ |
| Central North West London FT | 19.2% | 19.9% | 16.9% | 13.9% | 11 | 10 | ↘ | ↘ |
| Average | 15.3% | 14.5% | 13.3% | 12.7% | | | ↘ | ↘ |

| Background | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| Staff Turnover rate (Rolling 12 months) | Exception triggered as the target is below the lower control limit<br><br>Exception triggered due to a run of descending data points (a trend)<br><br>Exception triggered due to a breach of the lower control limit | Staff turnover has further declined from 16.1% October 22 to 12.7% in December, 2023.<br><br>The rate of staff leaving the organisation with under one year service has increased slightly to 14.7%.This compares with a rate of nearly 18% in Oct 22. However, HCA turnover has reduced from 21% to 16%.<br><br>EM, CSS and WACS are above the target of 13%.<br><br>Relatively high agency use, vacancies and turnover in CS and WACS has contributed to lower engagement levels in these divisions | • Leaver policy has been updated to incorporate reaching out process and revision of 'rescue conversation template' for managers.<br><br>• Flexible Working event linked to the 'People Promise' launched in between 22- 26 January 2024<br><br>• WACs – turnover significantly improved from 19-14% over last 12 month – continue to hold reaching out interviews and weekly walkabouts and visible leadership | To share findings of recent staff survey which closed in December to support action plans in response to staff feedback<br><br>Focus of launch of events across People Promise focus themes.<br><br>Further develop engagement on work on culture, values and behaviours to support new corporate strategy. |

West Hertfordshire Hospitals NHS Trust

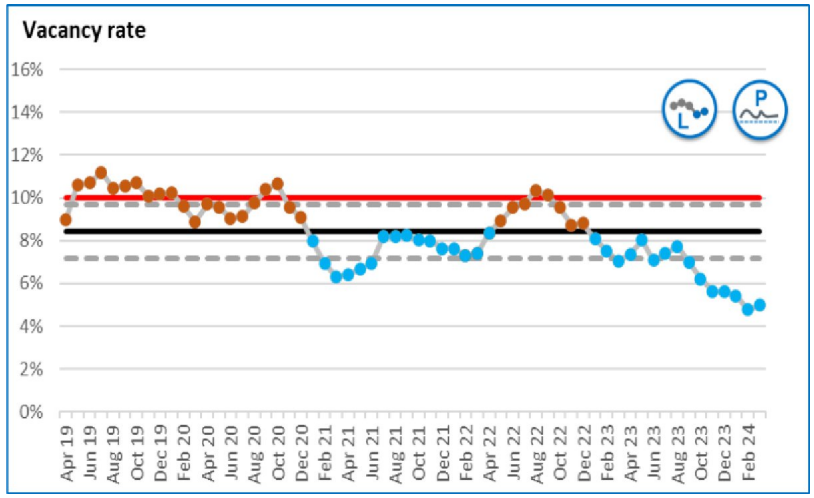
## Special Cause Variation – Performance – % staff leaving within first year (excluding medics and fixed term contracts)




| Background | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| % staff leaving within first year (excluding medics and fixed term contracts) | Exception triggered due to two of three most recent data points being close to the lower control limit | Turnover rates for staff leaving within 12 months has decreased over the last 18 months and the current rate is 14.2% reduced from well over 20% in May 2022.<br><br>WACs – CED – high vacancy rate with increased leavers | Reconnection sessions continue and are held at months, 1 3 and 7 post recruitment. Quality feedback has been received which is being used to improve the new starter experience. This is reflected in reduction in turnover.<br><br>Ongoing analysis and feedback on on-boarding questionnaires and data emerging from the New starter app to enhance.<br><br>WACS: Recruitment event held, staff leaving due to promotion or moving closer to home – encouraging career conversation and organisational opportunities as they arise such as secondment and acting up opportunities. | Exit interviews and rescue conversations will also assist with a better understanding of leaver reasons and will assist interventions and future recruitment. The Reaching Out programme and feedback informs priorities for the People Promise managers |

West Hertfordshire Hospitals NHS Trust

# Special Cause Variation – Performance – Vacancy rate




**VACANCY RATE**

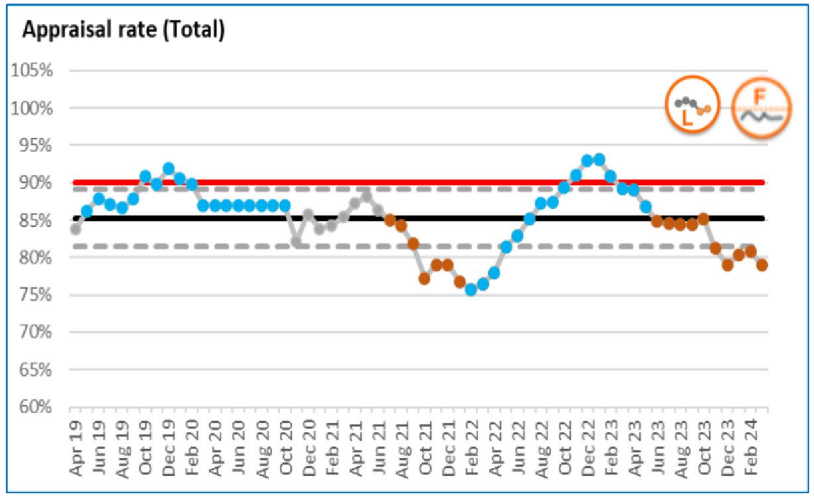
| Trust | Vacancy Q4 22/23 | Vacancy Q1 23/24 | Vacancy Q2 23/24 | Vacancy Q3 23/24 | Q2 23/24 Ranking (current) | Q3 23/24 Ranking (current) | Change Q1 to Q2 | Change Q2 to Q3 |
|---|---|---|---|---|---|---|---|---|
| Bedfordshire Hospitals | 12.4% | 12.6% | 8.8% | 6.4% | 4 | 3 | ↘ | ↘ |
| Herts Community | 4.6% | 11.3% | 12.1% | 9.0% | 9 | 7 | ↗ | ↘ |
| WHTH | 6.7% | 7.1% | 7.0% | 5.6% | 2 | 2 | ↘ | ↘ |
| East & North Herts | 9.1% | 8.1% | 8.5% | 8.1% | 3 | 4 | ↗ | ↘ |
| HPFT | 11.8% | 12.2% | 12.6% | 11.0% | 10 | 10 | ↗ | ↘ |
| ELF Bedford MH | 16.3% | 16.6% | 10.7% | 16.1% | 6 | 12 | ↘ | ↗ |
| ELF Luton MH | 16.0% | 14.8% | 18.1% | 12.3% | 11 | 11 | ↗ | ↘ |
| ELF Bedford Community | 10.9% | 8.1% | 18.5% | 8.6% | 12 | 5 | ↗ | ↘ |
| Princess Alexandra | 9.9% | 12.4% | 10.4% | 8.9% | 5 | 6 | ↘ | ↘ |
| Essex Partnership UT | 10.0% | 12.0% | 12.0% | 9.0% | 8 | 7 | → | ↘ |
| Milton Keynes UFT | 7.4% | 6.2% | 5.1% | 4.4% | 1 | 1 | ↘ | ↘ |
| Central North West London FT | 12.5% | 12.6% | 11.2% | 10.2% | 7 | 9 | ↘ | ↘ |
| Average | 10.6% | 11.2% | 11.3% | 9.1% | | | ↗ | ↘ |

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

| Back ground | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| Vacancy Rate | Exception triggered due to a breach of the lower control limit.<br><br>Exception triggered due to a run of data points below the mean (a shift) | Vacancies have decreased last month, continuing a trend since Summer 2022 of steady reduction. The rate is currently 5.6% the lowest rate since May 2021. The Trust ranks 3/5 ICS organisations (Q2 23/24). It should be noted that the trust is now over-established for B5 nursing staff and this has contributed to the low overall vacancy levels.<br><br>Higher levels of vacancies and cover across WACS; paediatric nurses and medical locum rates<br><br>Consultant recruitment vacancies and high locum spend remain challenging particularly across hard to recruit specialities. | Vacancies are projected to reduce further based on our recruitment pipeline.<br><br>Strengthening the Consultant recruitment process including formulating plans for all roles to reduce vacancy factors.<br><br>Improved process to support redeployment of nursing staff to cover gaps/surge.<br><br>WACS: Divisional review of cover and rates to develop action to address current issues.<br><br>Nurse international recruitment is currently on pause, whilst a review of demand and supply takes. Nevertheless, the Trust will continue recruitment of candidates in the pipeline. | Winter preparedness actions in place to secure supply of staff.<br><br>Extended workforce KPIs<br><br>Ongoing push for managers to actively recruit to vacancies, with a review on corporate areas and disestablishing any posts no longer required.<br><br>Undertaking an establishment review to identify vacant roles that are no longer required |

West Hertfordshire Hospitals NHS Trust

# Special Cause Variation – Performance/Assurance – Appraisal Rate



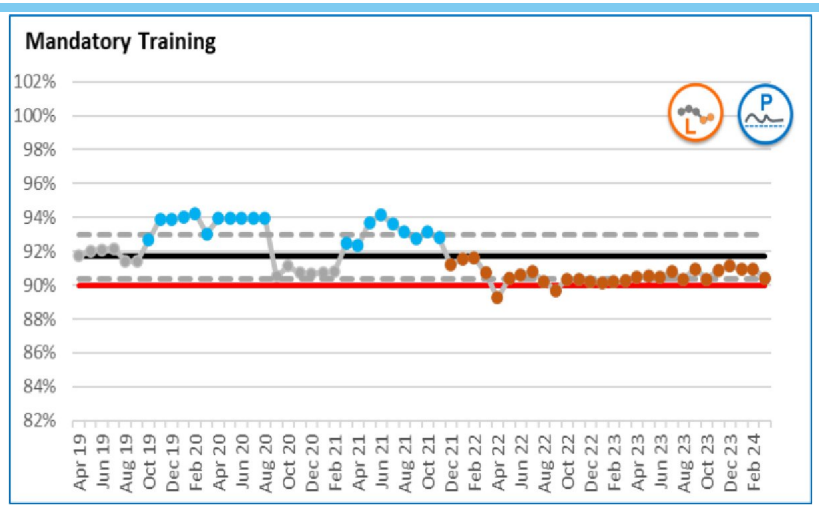

**APPRAISAL RATE COMPLIANCE**

| Trust | Appraisal Rate Q4 22/23 | Appraisal Rate Q1 23/24 | Appraisal Rate Q2 23/24 | Appraisal Rate Q3 23/24 | Q2 23/24 Ranking (current) | Q3 23/24 Ranking (current) | Change Q1 to Q2 | Change Q2 to Q3 |
|---|---|---|---|---|---|---|---|---|
| Bedfordshire Hospitals | 70% | 71% | 73% | 74% | 8 | 8 | ↗ | ↗ |
| Herts Community | 85% | 83% | 92% | 81% | 2 | 6 | ↗ | ↘ |
| WHTH | 89% | 85% | 84% | 79% | 5 | 7 | ↘ | ↘ |
| East & North Herts | 66% | 68% | 78% | 82% | 7 | 4 | ↗ | ↗ |
| HPFT | 86% | 86% | 94% | 96% | 1 | 1 | ↗ | ↗ |
| ELF Bedford MH | 23% | 23% | 23% | 23% | 9 | 10 | → | → |
| ELF Luton MH | 23% | 23% | 23% | 23% | 9 | 10 | → | → |
| ELF Bedford Community | 23% | 23% | 23% | 23% | 9 | 10 | → | → |
| Princess Alexandra | 84% | 70% | | 55% | | 9 | | ↗ |
| Essex Partnership UT | 78% | 70% | 81% | 82% | 6 | 4 | ↗ | ↗ |
| Milton Keynes UFT | 91% | 93% | 90% | 90% | 3 | 3 | ↘ | → |
| Central North West London FT | 86% | 90% | 89% | 92% | 4 | 2 | ↘ | ↗ |
| Average | 67% | 65% | 68% | 67% | | | ↗ | ↘ |

| Background | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| Appraisal Rate | Exception triggered due to the upper control limit being below the target<br><br>Exception triggered due to a breach of the lower control limit | Appraisal compliance continues its downward trajectory, currently 79.1%.<br><br>All Divisions except Environment are below trust KPI<br><br>The Trust is above average compared to other nearby acute Trusts, ranking 5 / 12 as at Q2 23/24, even with the lower rates currently reported | Appraisals continue to be managed in collaboration with divisions by HRBPs with a focus on hotspots, occupational groups and routine monitoring.<br><br>Large numbers staff due for appraisal at the same time. This is being managed across division. | Encouraging career development conversations and access to training opportunities to inform PDPs.<br><br>HRBP identifying key hotspots, sending weekly appraisal reminders and meeting with managers bi-weekly.<br><br>Appraisal policy has been refreshed. |

West Hertfordshire Hospitals NHS Trust

# Special Cause Variation – Performance/Assurance – Mandatory Training




**MANDATORY TRAINING COMPLIANCE**

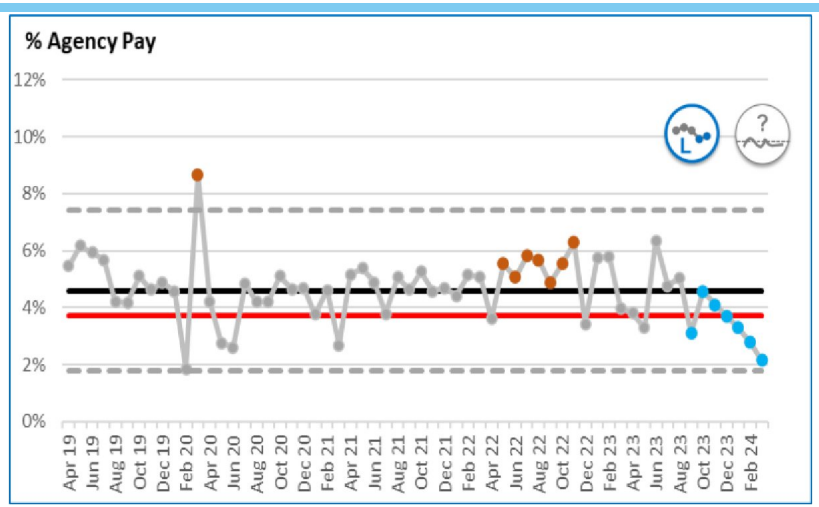
| Trust | Mandatory Training Rate Q4 22/23 | Mandatory Training Rate Q1 23/24 | Mandatory Training Rate Q2 23/24 | Mandatory Training Rate Q3 23/24 | Q2 23/24 Ranking (current) | Q3 23/24 Ranking (current) | Change Q1 to Q2 | Change Q2 to Q3 |
|---|---|---|---|---|---|---|---|---|
| Bedfordshire Hospitals | 84% | 84% | 88% | 87% | 7 | 10 | ↗ | ↘ |
| Herts Community | 95% | 93% | 93% | 95% | 3 | 2 | → | ↗ |
| WHTH | 91% | 91% | 90% | 92% | 5 | 5 | ↘ | ↗ |
| East & North Herts | 87% | 88% | 90% | 91% | 5 | 6 | ↗ | ↗ |
| HPFT | 90% | 91% | 93% | 90% | 3 | 7 | ↗ | ↘ |
| ELF Bedford MH | 78% | 81% | 85% | 88% | 8 | 8 | ↗ | ↗ |
| ELF Luton MH | 79% | 82% | 85% | 88% | 8 | 8 | ↗ | ↗ |
| ELF Bedford Community | 83% | 89% | 83% | 92% | 11 | 4 | ↘ | ↗ |
| Princess Alexandra | 88% | 78% | 78% | 80% | 12 | 12 | → | ↗ |
| Essex Partnership UT | 88% | 89% | 85% | 85% | 8 | 11 | ↘ | → |
| Milton Keynes UFT | 94% | 95% | 95% | 96% | 2 | 1 | → | ↗ |
| Central North West London FT | 93% | 95% | 96% | 95% | 1 | 2 | ↗ | ↘ |
| Average | 87% | 88% | 88% | 90% | | | ↗ | ↗ |

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<br><br>Exception triggered due to 7+ data points below the mean | Mandatory training is at 91.1% remains above the Trust target of 90%<br><br>Environment, Surgery and WACs Divisions are below the Trust KPI.<br>. | • HRBPs continue to support Divisions to maximise compliance opportunities including sending reminders to staff.<br><br>• A review of reporting of medical devices training. Update data reporting processes for fire training.<br><br>• In Q2, the Trust is ranked 5/12 when benchmarked against local NHS employers | There is a continued focus on specific subjects to maintain compliance and ensure this is above the 90% target, Surgery Division have been actively working on training and trajectory and have seen an increase in compliance to 89.6%<br><br>Managers reminded that colleagues have protected time to undertake mandatory training.<br><br>Recruitment underway for fire training role. |

West Hertfordshire Hospitals NHS Trust

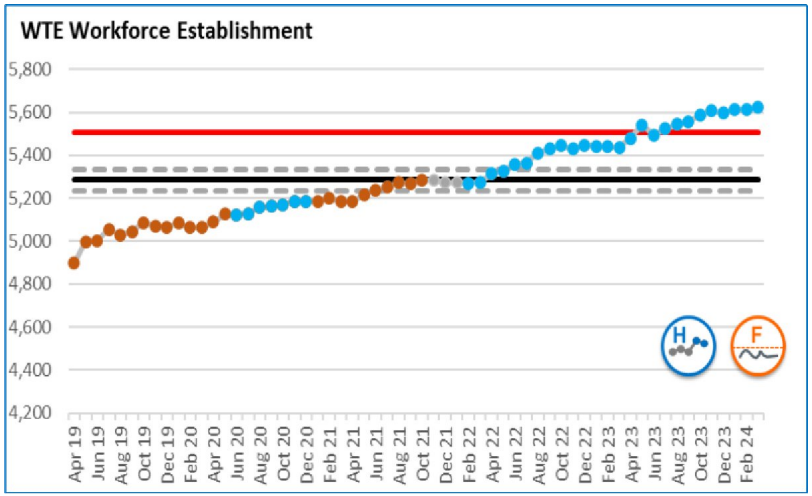
## Special Cause Variation – Performance/Assurance – % Agency Pay

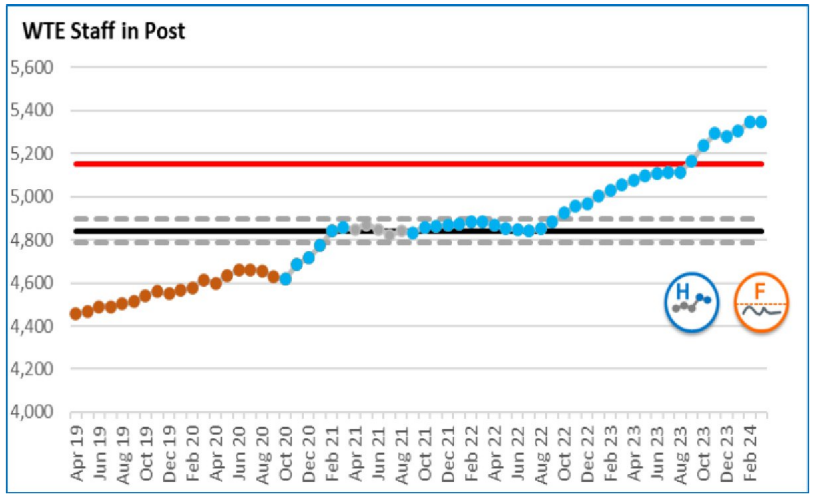



| Background | What the Data tells us | Reasons | Actions | Mitigations |
|---|---|---|---|---|
| % Agency Pay | Exception triggered due to a run of data points in one direction (a trend) | | | |

West Hertfordshire Hospitals NHS Trust

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

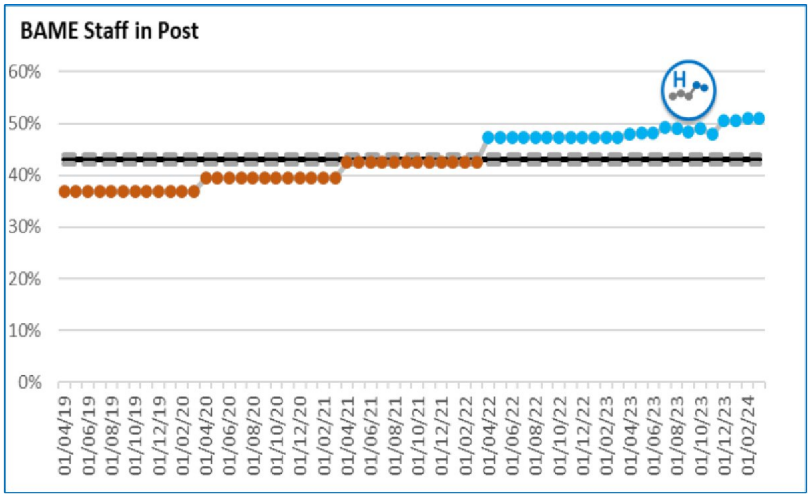


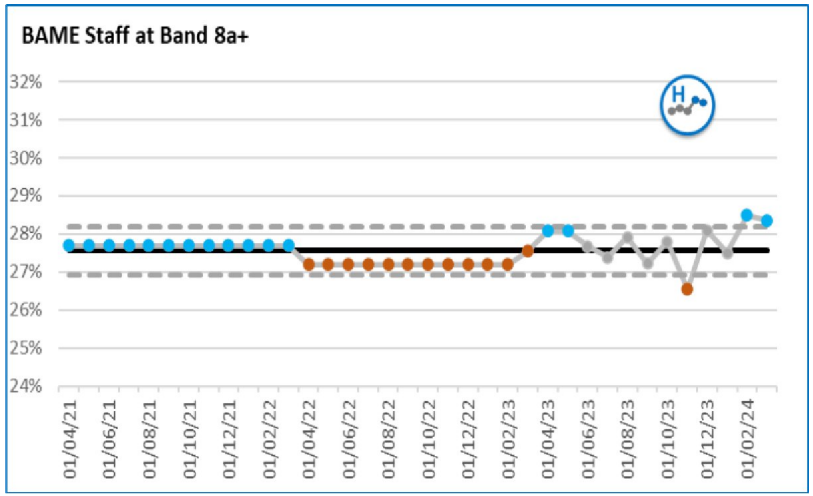




| Background | What the Data tells us | Reasons | Actions | Mitigations |
|---|---|---|---|---|
| WTE Workforce Establishment/ WTE Staff in Post | Exception triggered due to 7+ data points above the mean<br><br>Exception triggered due to a breach of the upper control limit | The planned business case establishment target is 5,506 wte by March 2024.<br><br>The business case for the wte staff in post figures is 5,152 wte in post by March 2024. | • The current staff wte figure is 5,282 and continued recruitment including IR nurses has enabled the target of 5,152wte by March 2024 to be reached. There is a current oversupply of Band 5 nurses due to IR recruitment which has inflated the wte figures. The International recruitment of nurses is paused whilst nursing establishment review is undertaken.<br>• The establishment is adjusted slightly for staffing in a small number of cost centres where there is no funded establishment, and to account for the GPVTS medics. This avoids misleadingly low vacancy rates.<br>• Establishment review for Corporate are underway to disestablish roles no longer required.<br>• The establishment has increased over 23/24 as approved business cases have been added to the funded establishment. | Establishment review and recruitment of permanent staff to vacancies will help offset agency usage.<br><br>Focus on Consultant recruitment<br><br>Corporate establishment review ongoing.<br><br>Business planning cycle for 24/25 commenced<br><br>Workforce Efficiency Group monitoring and measuring workforce CIPs. |

West Hertfordshire Hospitals NHS Trust

# Special Cause Variation – Performance – BAME Staff in Post/BAME staff at Band 8a+

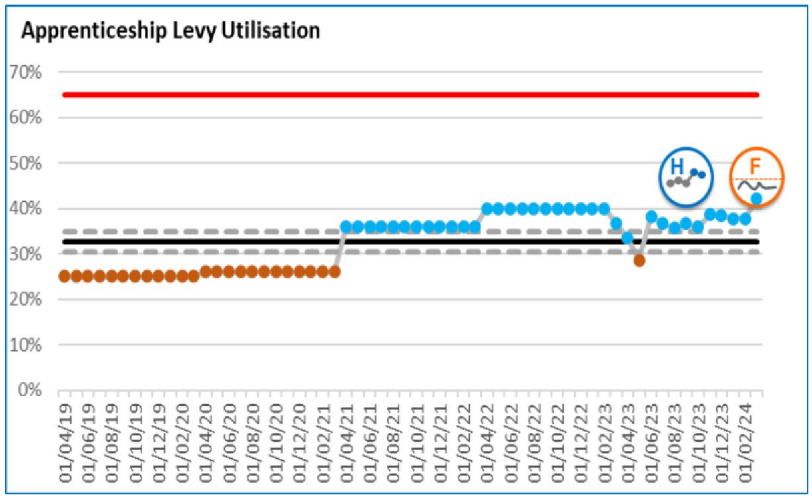



| Background | What the Data tells us | Reasons | Actions | Mitigations |
|---|---|---|---|---|
| BAME staff in post/BAME Staff in post – Band 8a+ | Exception triggered due to 7+ data points above the mean<br><br>Exception triggered due to a breach of the upper control limit<br><br>BAME Staff at Band 8a+ - breach of the lower control limit | These charts show Black Asian Minority Ethnic (BAME) staff as a percentage of staff in post, and BAME staff at Agenda for Change Band 8A or higher as a percentage of staff in post in these bands<br><br>The percentage of BAME staff in post has increased over the last 4 years to 49.1% currently. | • Currently, the percentage of BAME staff in post increased to 51.1%. The percentage of White staff is 43.8%, with 7.1% not stated.<br>• Band 8A staff –The proportion of these staff who are BAME is increased slightly to 28%. The percentage of White staff who are employed on Bands 8A and above is 65.4%.<br>• cultural awareness training to be launched March 2024 and included with in emerging leadership programme<br>• Anti Racism pledge signed at a Trust level, staff experience team to work with divisions to get local ownership and buy in<br>• Anti Racism policy is being developed to help ensure zero tolerance toward racist behaviour | Active Staff Network<br><br>EDI steering group<br><br>EDI divisional dashboard proposed to commence in April 2024<br><br>Reciprocal mentoring scheme ongoing |

West Hertfordshire Hospitals NHS Trust

# Special Cause Variation – Performance – Apprenticeship Levy Utilisation




| Background | What the Data tells us | Reasons | Actions | Mitigations |
|---|---|---|---|---|
| Apprenticeship Levy Utilisation | Exception triggered due to a breach of the upper control limit<br><br>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. The current utilisation is 38%.<br><br>This chart show the percentage of apprenticeship levy expenditure over time.<br><br>Emergency Medicine (43%) and Medicine divisions (53%) report levy utilisation above Trust average. | • The current apprenticeship levy utilisation figure is 38% (42% including gifting levy) against an end of year target of 65%.<br>• Apprenticeship First programme for HCSWs and non-clinical (Band 2's and 3's) to be launched April 2024.<br>• Commenced bi-weekly walkabouts in hotspot areas<br>• Continue to work with CSS, WACS Environment on department trajectories. Environment Division utilisation increased from 1%-9% with new starts from April 2024.<br>• Developing more robust divisional trajectories for greater transparency on utilisation.<br>• Apprenticeship audit not yet finalised however work plans and associated actions are being developed with a focus on communication. | 42 apprenticeship scheduled to start between Jan - March 2024.<br><br>Design of an apprenticeship one-stop website Feb 2024.<br><br>The Trust offers an online programme for applicants who require entry level Maths & English. |

NHS
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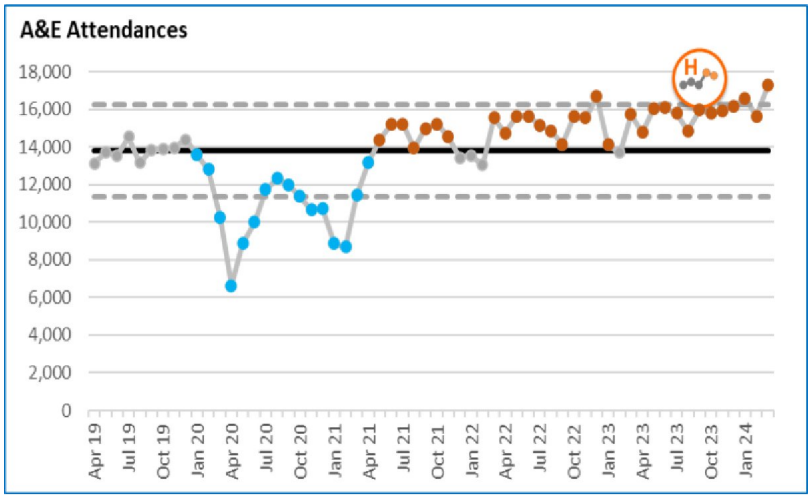
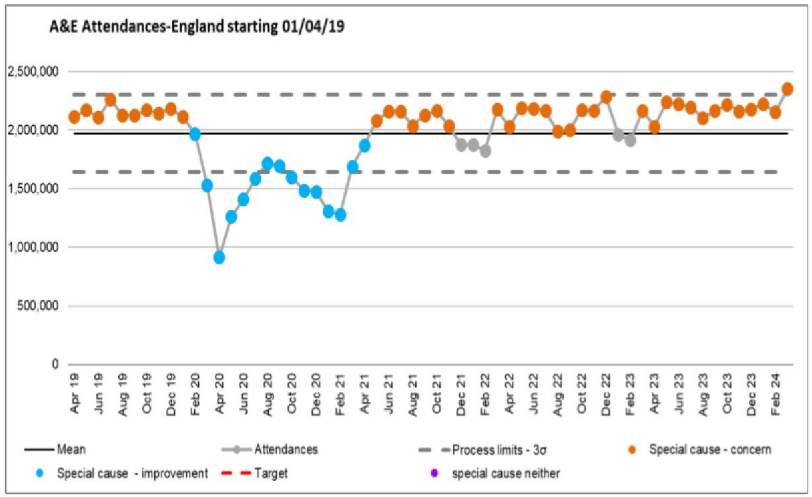
NHS Trust

| KPI | Latest month | Measure | Target | Variation | Assurance | Local or National Metric | Committee | Owner |
|---|---|---|---|---|---|---|---|---|
| **Activity Metrics** | | | | | | | | |
| GP Referrals Made | Mar 24 | 6455 | - | | | Local | F&P | COO |
| A&E Attendances | Mar 24 | 17289 | - | | | Local | F&P | COO |
| 1st Outpatient Appointments - All | Mar 24 | 11652 | - | | | Local | F&P | CIO |
| 1st Outpatient Appointments - Face to Face | Mar 24 | 10839 | - | | | Local | F&P | CIO |
| Follow Up Outpatient Appointments - All | Mar 24 | 15925 | - | | | Local | F&P | CIO |
| Follow Up Outpatient Appointments - Face to Face | Mar 24 | 11879 | - | | | Local | F&P | CIO |
| Specific Acute Elective Ordinary Admissions | Mar 24 | 341 | - | | | Local | F&P | COO |
| Specific Acute Daycases | Mar 24 | 3595 | - | | | Local | F&P | COO |
| Specific Acute Non-Elective Admissions - 0 LOS | Mar 24 | 1864 | - | | | Local | F&P | COO |
| Specific Acute Non-Elective Admissions - +1 LOS | Mar 24 | 2824 | - | | | Local | F&P | COO |
| Completed Admitted RTT Pathways (Clock Stops) | Mar 24 | 815 | - | | | Local | F&P | COO |
| Completed Non-Admitted RTT Pathways (Clock Stops) | Mar 24 | 5477 | - | | | Local | F&P | COO |
| New RTT Pathways (Clock Starts) | Mar 24 | 9437 | - | | | Local | F&P | COO |
| PTL Volume | Mar 24 | 58599 | - | | | Local | F&P | COO |
| Theatre Utilisation (Touch time utilisation on the day hours planned inc early starts and late finishes) | Mar 24 | 79% | 85% | | | Local | F&P | COO |
| Theatre Cases | Mar 24 | 1041 | - | | | Local | F&P | COO |
| Theatre Cases per Session | Mar 24 | 2.4 | - | | | Local | F&P | COO |

West Hertfordshire Hospitals NHS Trust

# Special Cause Variation – Performance – A&E Attendances

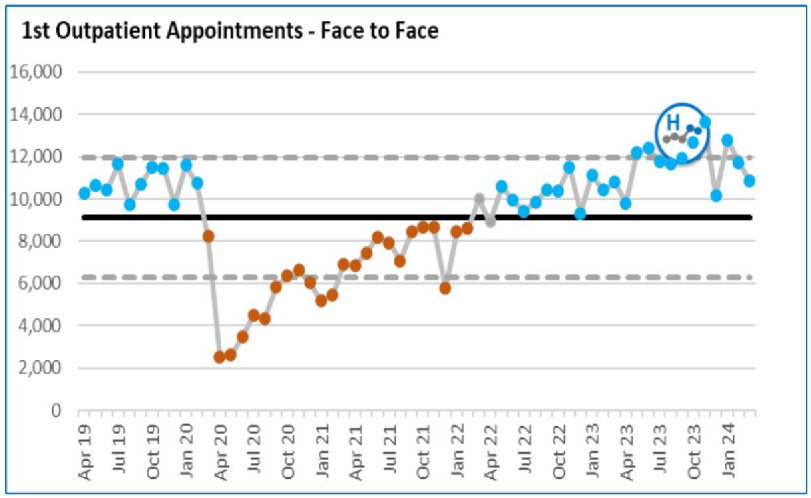


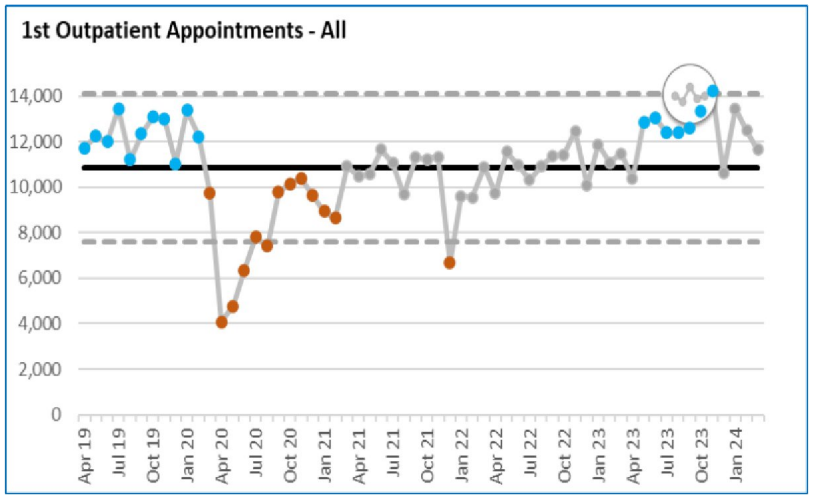




| Background | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| A&E Attendances | Exception triggered due to 7+ data points above the mean (a shift)<br><br>Exception triggered due to a breach of the upper control limit | ED demand has increased by 19% for adults and 40% for paediatrics | Working with ICB to review alternative pathways to ED<br><br>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.<br>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 |

West Hertfordshire Hospitals NHS Trust

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

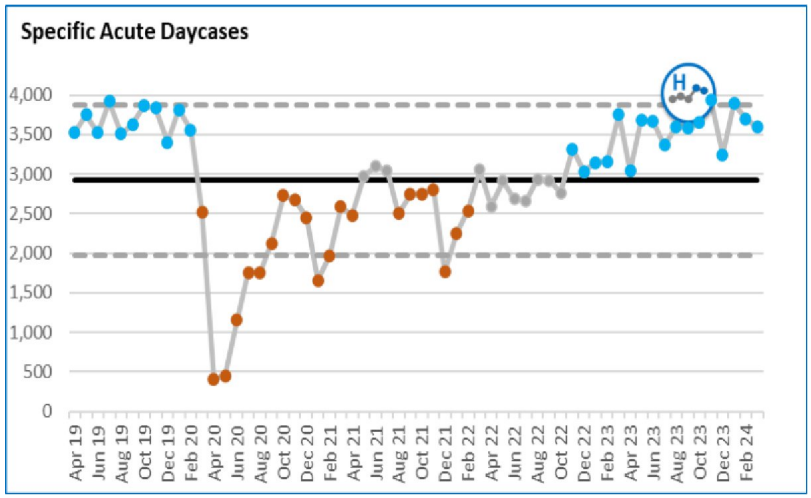



| Background | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| 1st Outpatient Appointments – Face to Face | Exception triggered due to 7+ data points above the mean (a shift) | | | |

West Hertfordshire Hospitals NHS Trust

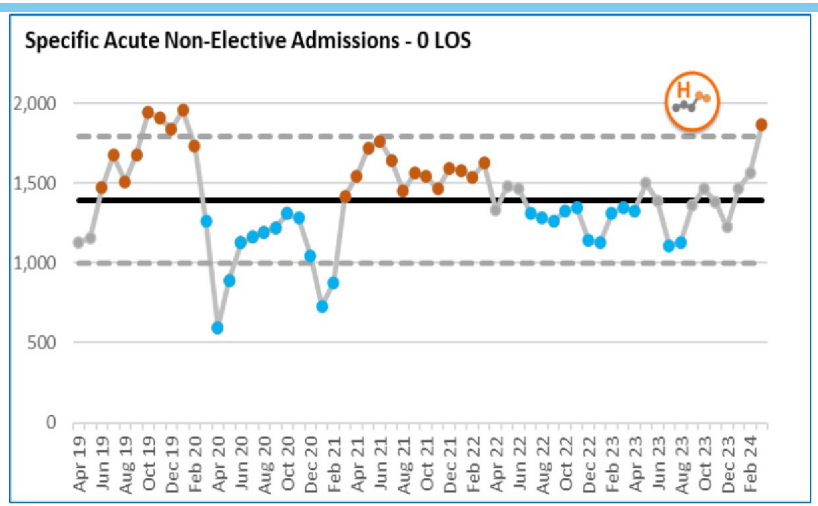
## Special Cause Variation – Performance – Specific Acute Daycases




| Background | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| Specific Acute Daycases | Exception triggered due to 7+ data points above the mean (a shift) | | | |

West Hertfordshire Hospitals NHS Trust

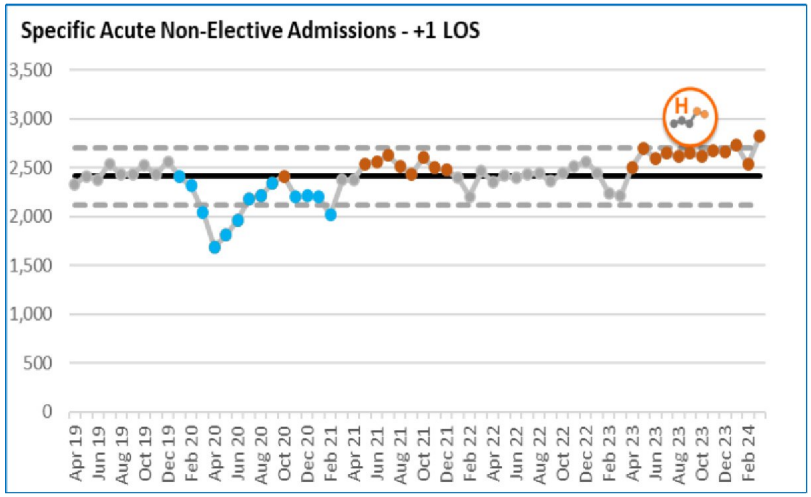
## Special Cause Variation – Performance – Specific Acute Non-Elective Admissions - 0 LOS




| Background | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| Specific Acute Non-Elective Admissions - 0 LOS | Exception triggered due to a breach of the upper control limit | | | |

West Hertfordshire Hospitals NHS Trust

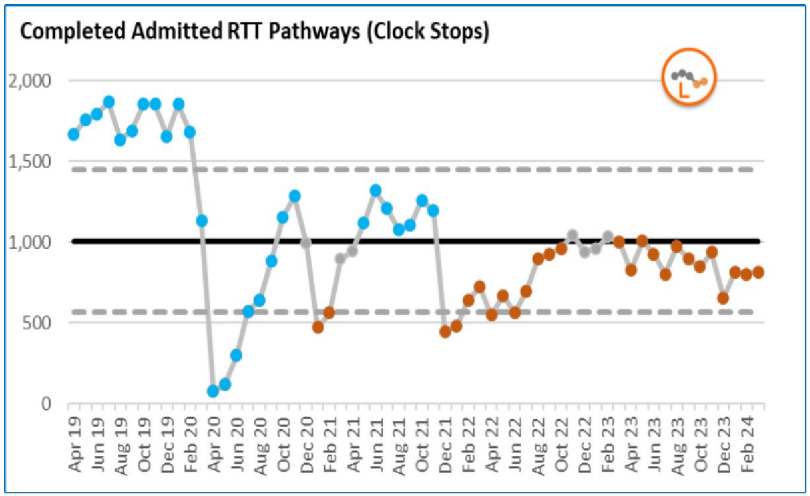
# Special Cause Variation – Performance – Specific Acute Non-Elective Admissions - +1 LOS




| 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<br><br>Exception triggered due to a run of 7+ data points above the mean | | | |

West Hertfordshire Hospitals NHS Trust

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



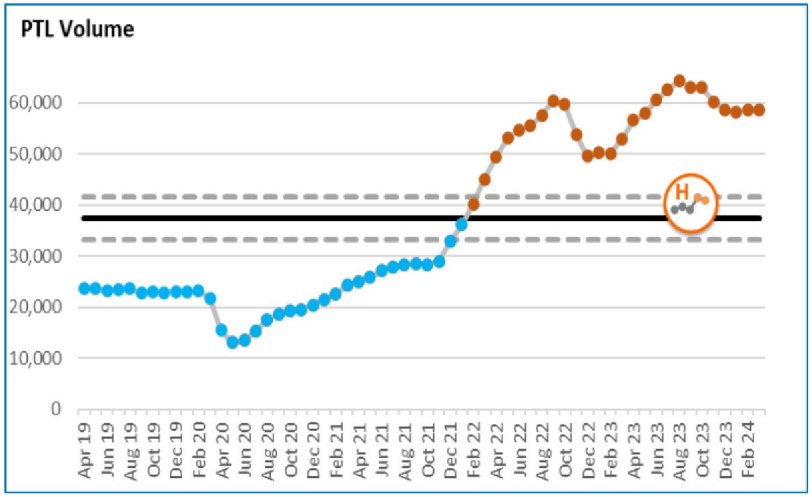

| Trust | Jan-24 | Feb-24 |
|---|---|---|
| Mid And South Essex NHS Foundation Trust | 3,644 | 3,798 |
| Cambridge University Hospitals NHS Foundation Trust | 2,726 | 2,777 |
| Norfolk And Norwich University Hospitals NHS Foundation Trust | 2,746 | 2,604 |
| Bedfordshire Hospitals NHS Foundation Trust | 2,606 | 2,558 |
| East Suffolk And North Essex NHS Foundation Trust | 2,057 | 2,137 |
| North West Anglia NHS Foundation Trust | 2,141 | 2,136 |
| Milton Keynes University Hospital NHS Foundation Trust | 1,689 | 1,751 |
| East And North Hertfordshire NHS Trust | 1,945 | 1,719 |
| James Paget University Hospitals NHS Foundation Trust | 1,516 | 1,680 |
| The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust | 1,106 | 1,106 |
| West Suffolk NHS Foundation Trust | 797 | 812 |
| **West Hertfordshire Hospitals NHS Trust** | **812** | **801** |
| The Princess Alexandra Hospital NHS Trust | 470 | 500 |

***Latest available published RTT data – February 2024**

| Background | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| Completed Admitted RTT Pathways (Clock Stops) | Exception triggered due to a run of 7+ data points below the mean | The latest month's activity was lower than plan and as a result there were fewer clock stops. A degree of human error continues to affect clock stops, with incorrect or absent outcoming after patient contact events.<br><br>The external validation support that was in place at the end of 2022/23 was fundamental in delivering comprehensive validation. Although there has been agreement to invest in expanding the validation service in house, staff are not yet in post. This resource will therefore continue, albeit at a lower level, until all staff have been recruited. | DQ steering group established to lead on improvement work within divisions, with divisional plans in development to address key factors including regular drop in training sessions which are targeted to the error themes identified through validation.<br><br>Funds identified to enable a small number of external validators utilising monies from vacancies put in place.<br><br>Validation team recruitment is underway and external resource remains in place, to increase validation activity | Additional training (a weekly drop in session) is in place to ensure staff receive adequate support in the correct use of Cerner.<br><br>Weekly long wait review meeting in place to drive progress and delivery of improvement plan.<br><br>Service level tracking with forward look to target deadlines to ensure adequate operational oversight of patient cohorts. |

West Hertfordshire Hospitals NHS Trust

# Special Cause Variation – Performance – RTT PTL Volume



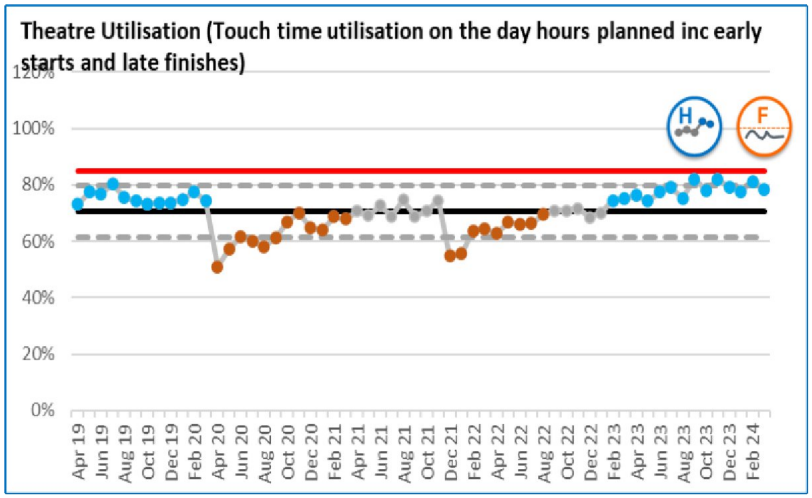

| Trust | Jan-24 | Feb-24 |
|---|---|---|
| Mid And South Essex NHS Foundation Trust | 160,364 | 163,659 |
| Bedfordshire Hospitals NHS Foundation Trust | 95,679 | 97,012 |
| East Suffolk And North Essex NHS Foundation Trust | 87,453 | 87,906 |
| Norfolk And Norwich University Hospitals NHS Foundation Trust | 85,884 | 85,694 |
| North West Anglia NHS Foundation Trust | 81,593 | 81,773 |
| Cambridge University Hospitals NHS Foundation Trust | 61,531 | 62,392 |
| **West Hertfordshire Hospitals NHS Trust** | **58,212** | **58,686** |
| East And North Hertfordshire NHS Trust | 59,757 | 55,075 |
| West Suffolk NHS Foundation Trust | 35,340 | 35,441 |
| Milton Keynes University Hospital NHS Foundation Trust | 35,045 | 34,623 |
| James Paget University Hospitals NHS Foundation Trust | 33,555 | 32,306 |
| The Princess Alexandra Hospital NHS Trust | 25,767 | 25,715 |
| The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust | 25,272 | 25,531 |

*Latest available published RTT data – February 2024

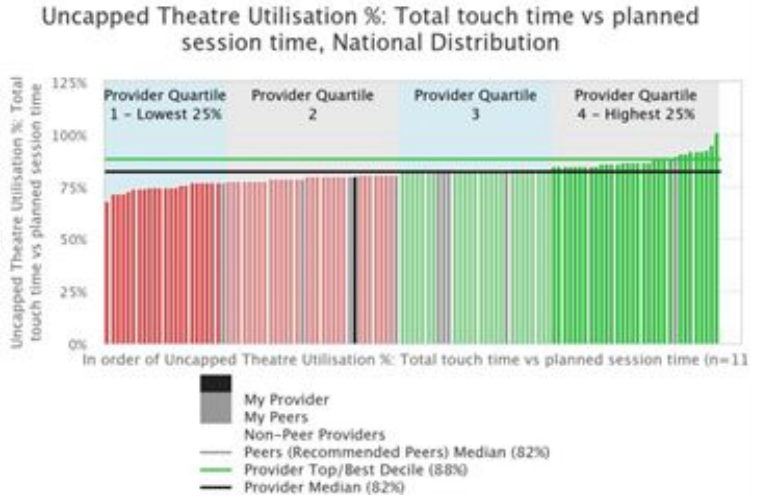
| Background | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| RTT PTL Volume | Exception triggered due to breach of the upper control limit<br><br>Exception triggered due to 7+ data points above the mean (a shift) | Although EPR has been in place for over a year, errors continue to affect the RTT PTL in a number of ways, with incorrect RTT status captured at outcoming.<br><br>The external validation support that was in place at the end of 2022/23 was fundamental in delivering comprehensive validation. Although there has been agreement to invest in expanding the validation service in house, staff are not yet in post. | Divisional plans in development to address some of the key data quality issues arising from current practice within Cerner with regard to pathway management workflows.<br><br>DQ steering group established to lead on improvement work.<br><br>A trial of electronic patient validation questionnaires via the patient portal, has proved very successful with a high response rate in a very short period of time. Up to 10% of patients contacted in some services have indicated that their referral is no longer required. This validation exercise will now be rolled out across all services over the next quarter. | Continuous horizon scanning for additional outsourcing opportunities, with specialty level engagement to ensure quality and safety as well as timely pathways, to facilitate additional capacity for patients on the PTL.<br><br>Weekly long wait review meeting in place to drive progress and delivery of improvement plan.<br><br>Service level tracking with forward look to target deadlines to ensure adequate operational oversight of patient cohorts. |

West Hertfordshire Hospitals NHS Trust

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




***Latest available published Theatre Utilisation – Model Hospital – w/e 7th Apri 2024**




| Background | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| Theatre Utilisation (Touch time utilisation on the day hours planned including early starts and late finishes | Exception triggered due to target being outside upper control limit<br><br>Exception triggered due to a run of 7+ data points above the mean | Theatre utilisation in December averaged 79.8% across all specialities, compared to 82% for the previous month.<br><br>Work continues in order to drive up utilisation, further towards and beyond 85%, and sustain this improvement.<br><br>Late starts increased to 34mins on average per list (29 mins in Nov), whereas early finishes fell to an average of 35 mins compared to Nov of 48 mins.<br><br>Disruption due to industrial action and winter pressures had an adverse effect on services and overall activity in December, resulting in 14 theatre lists being stood down. | The division will continue to drive adherence to the established processes, including median time use and golden patient until at least the end of the financial year to ensure these are embedded.<br><br>High priority continues to focus on the reduction of late starts and early finishes – an audit is scheduled to take place in SACH to further integrate real-time data and identify opportunities to make further improvements.<br><br>Reiterating the support pathway process to drive adherence for planning, booking and on-the-day processes, to increase compliance.<br><br>There will be an overall increased focus on data quality to ensure performance figures provide accurate reflection of activity within theatres. | Continued high levels of clinical engagement.<br><br>Data quality actions to address discrepancies of information recorded on cerner.<br><br>Complete service review of POA underway to triangulate avoidable short notice and on-the-day cancellations with opportunities to book patients at short notice and increase utilisation and productivity. |

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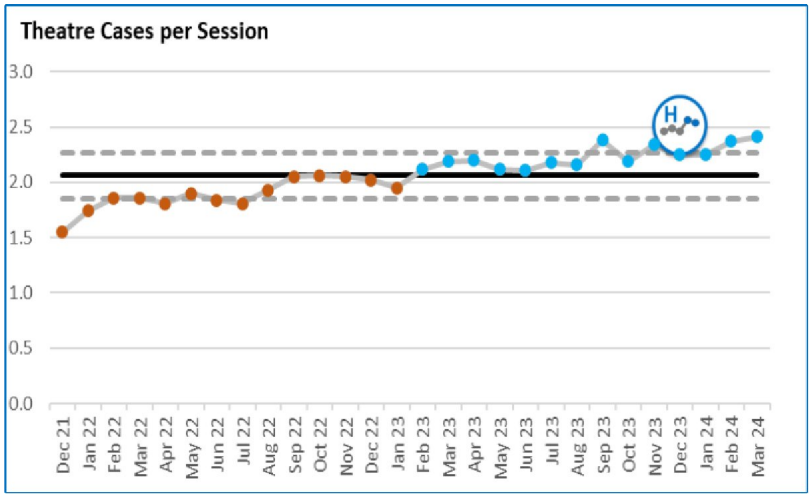
## Special Cause Variation – Assurance – Theatre Cases per session




| Background | What the Data tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| Theatre Cases per Session | Exception triggered due to a run of 7+ data points above the mean (a shift)<br><br>Exception triggered due a breach of the upper control limit | Cases per session in December reached 2.25 against the overall target of 2.4.<br><br>It is expected that this will increase further in subsequent months due to stated actions.<br><br>With cases per session, case mix is also is an important consideration.<br><br>Winter pressures & industrial action meant prioritising cancer, urgent and long waiting patients only – reducing the number of patients booked.<br><br>Median times usage requires more work and attention in order to produce median times for use with all cases that also are available via Cerner. | Continue to use median times where possible to realistically ensure there are sufficient volumes of patients booked.<br><br>Project manager continues to support the admissions team to define, and roll out, a clear booking process to backfill short notice cancellations.<br><br>Additional patients being added to lists where early finishes are a consistent theme.<br><br>Focus on reallocating lists and reducing number of fallow lists, following the demolition of SACH theatre 5. Established a tracker to monitor those specialties most affected and to disperse the impact. | Median times embedded.<br><br>Complete service review of POA underway to triangulate avoidable short notice and on-the-day cancellations with opportunities to book patients at short notice and increase utilisation and productivity. |

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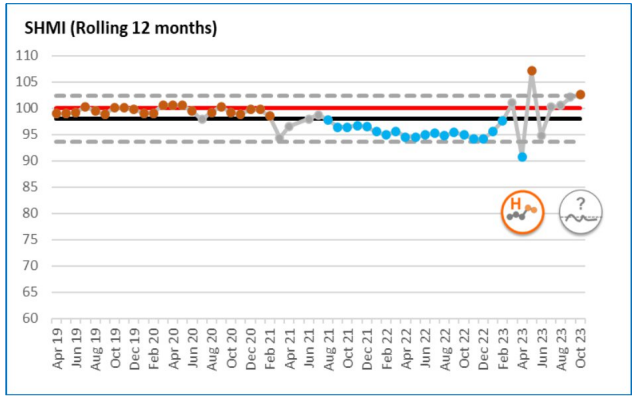
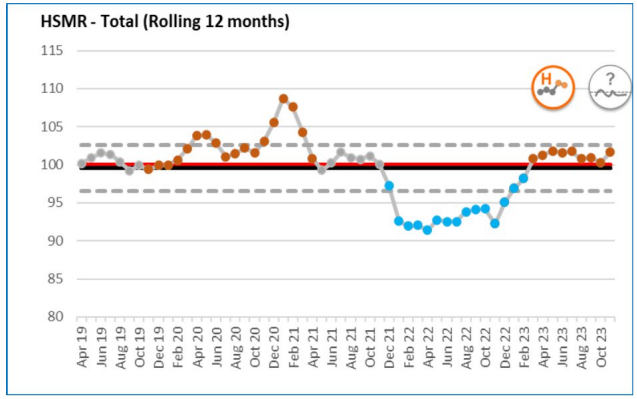
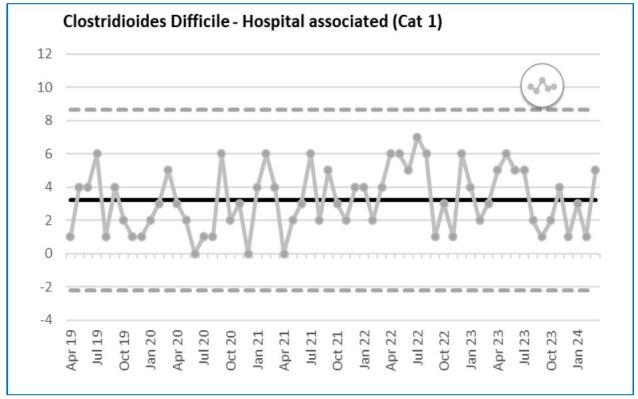
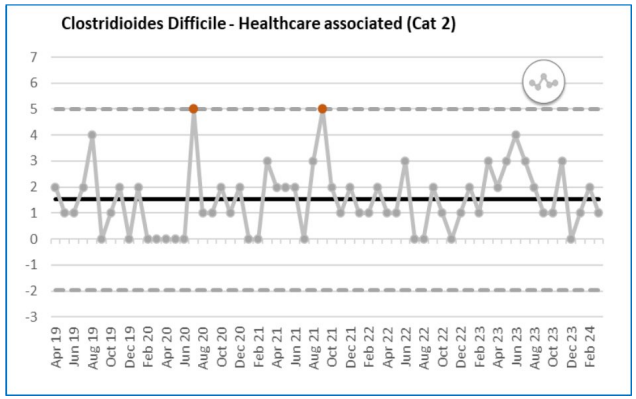
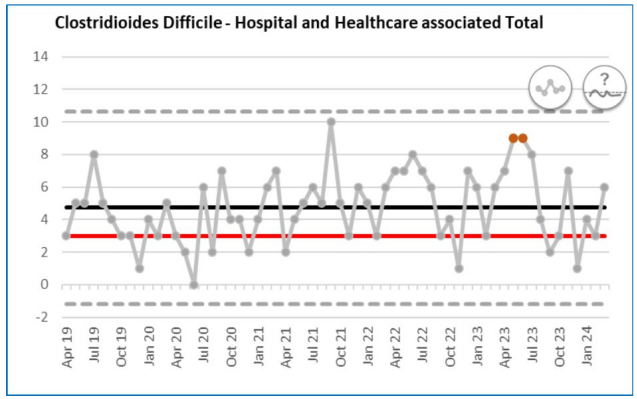
# Appendix 1 – Safe Care and Improving Outcomes Metrics - Quality

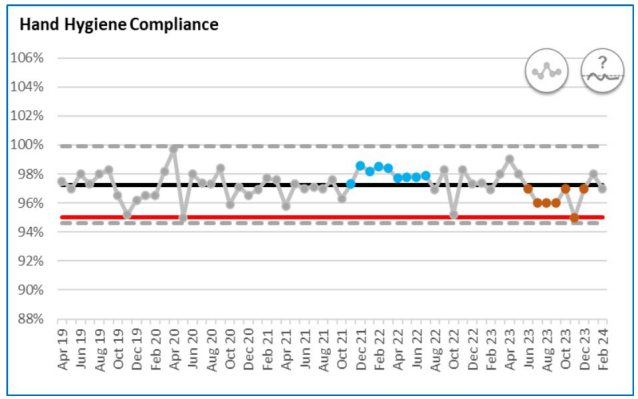


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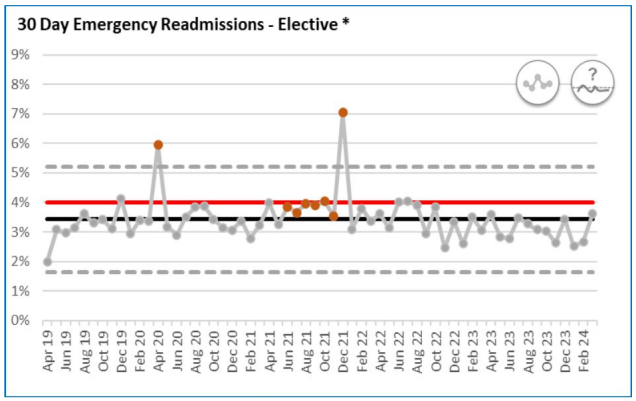
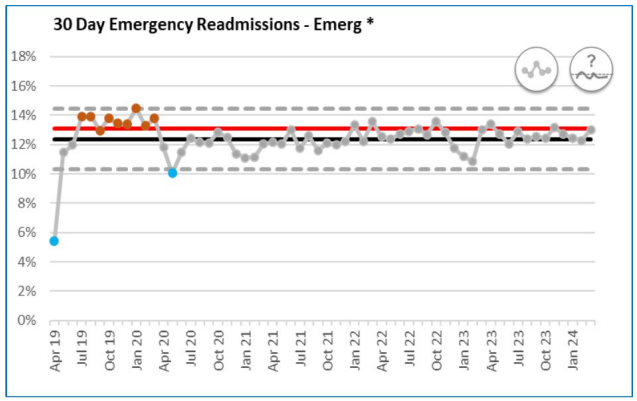
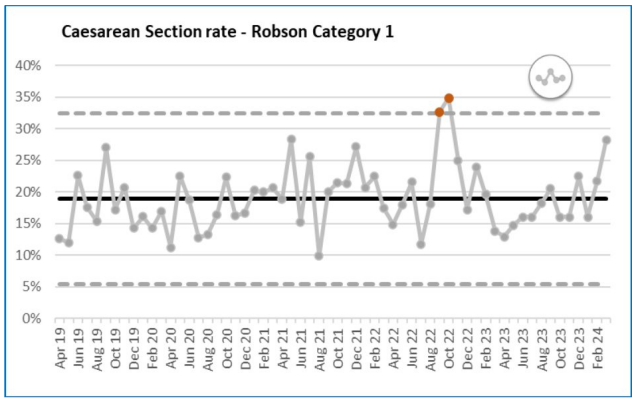
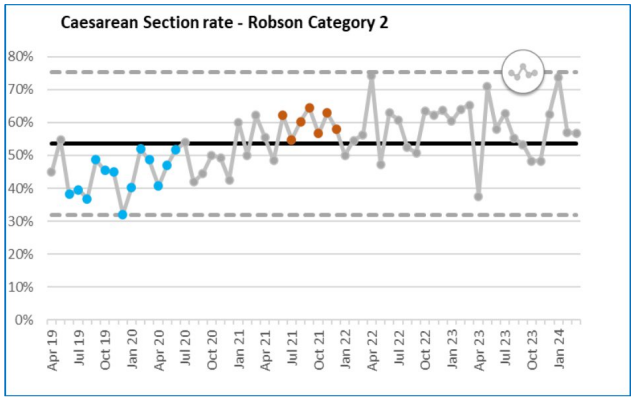
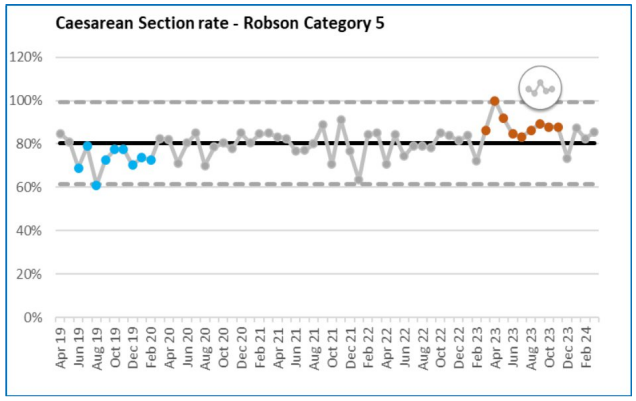
# Appendix 1 – Safe Care and Improving Outcomes Metrics - Quality



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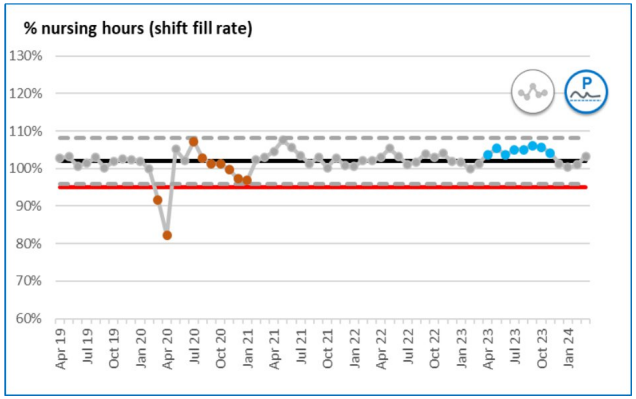
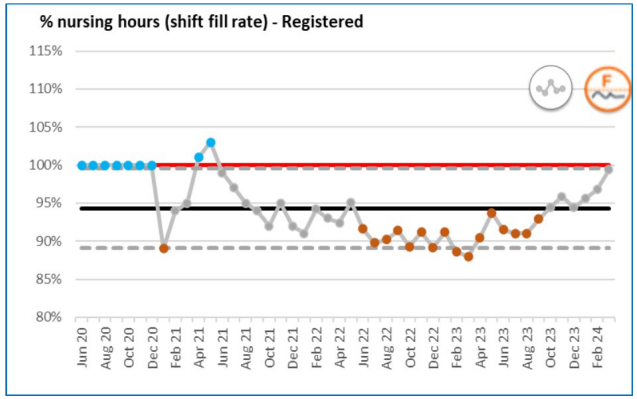
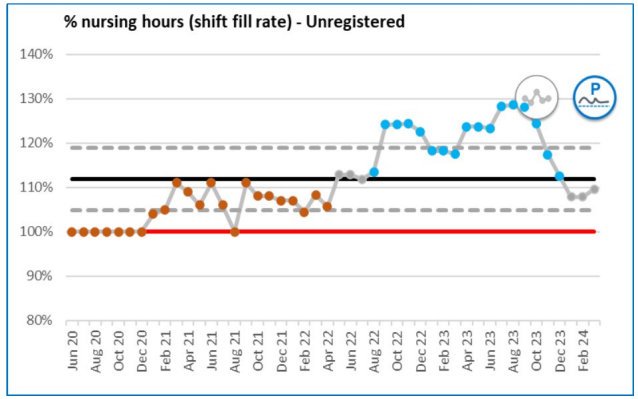
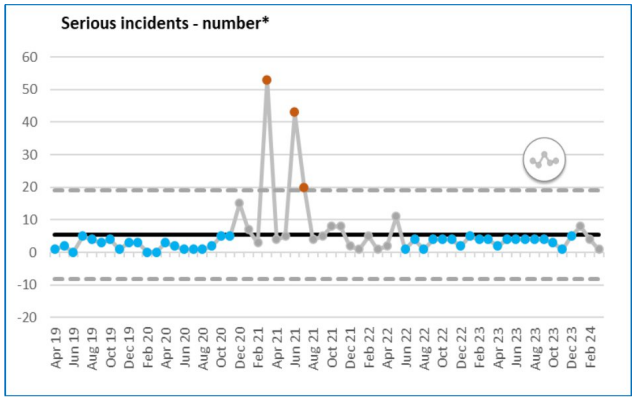
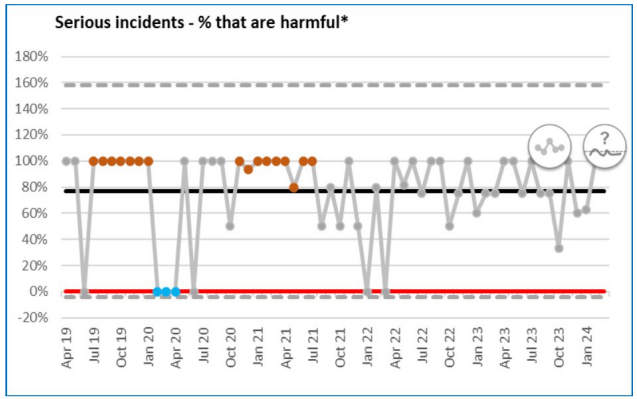
# Appendix 1 – Safe Care and Improving Outcomes Metrics - Safety

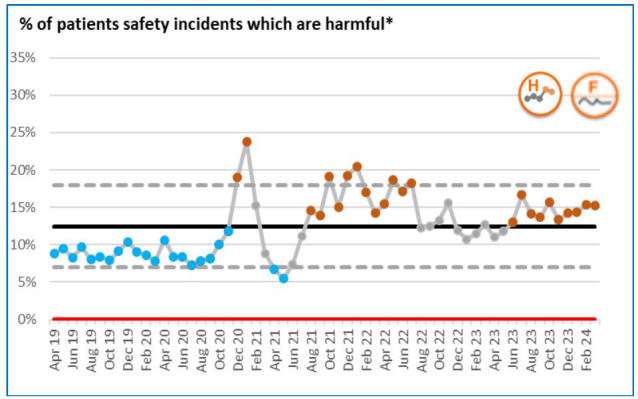


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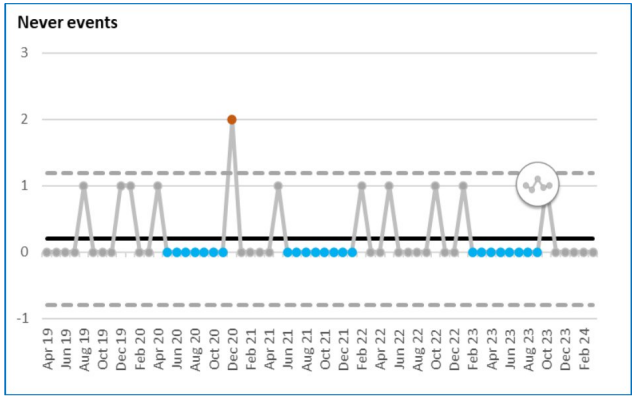
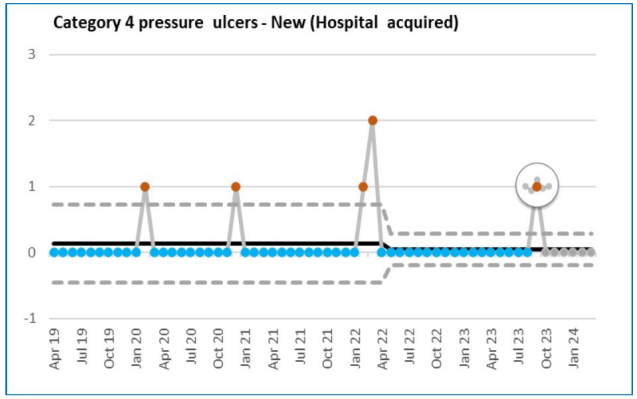
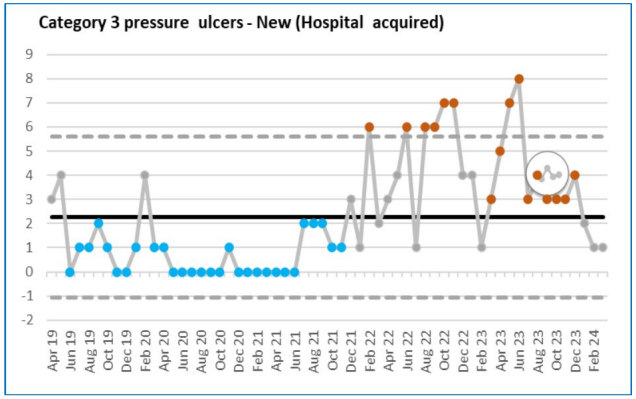
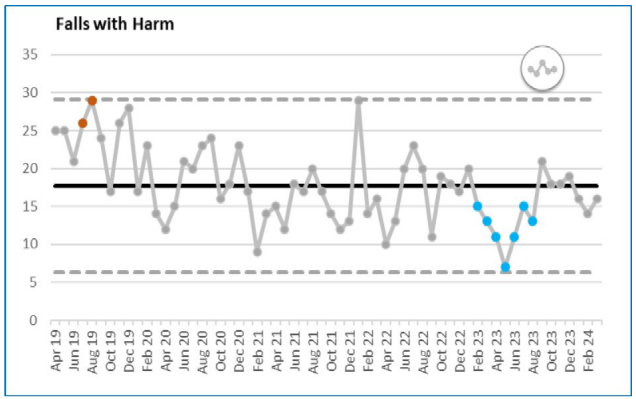
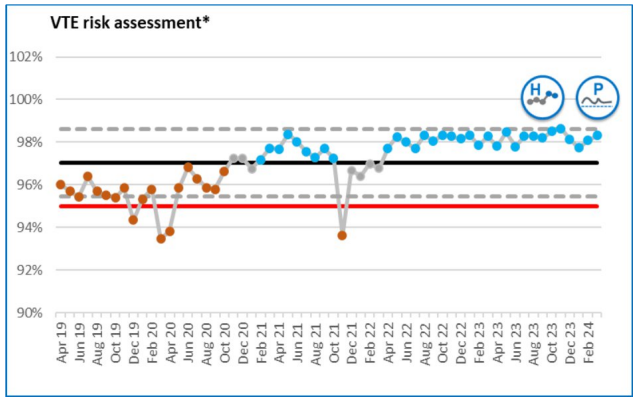
# Appendix 1 – Safe Care and Improving Outcomes Metrics - Safety

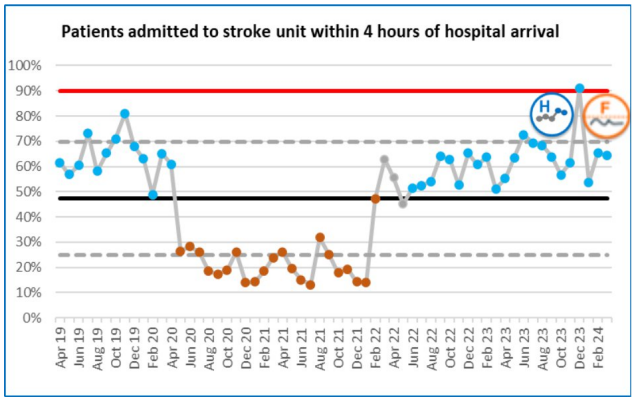


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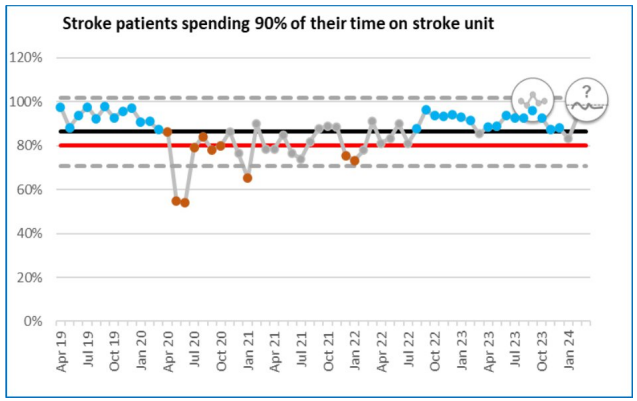
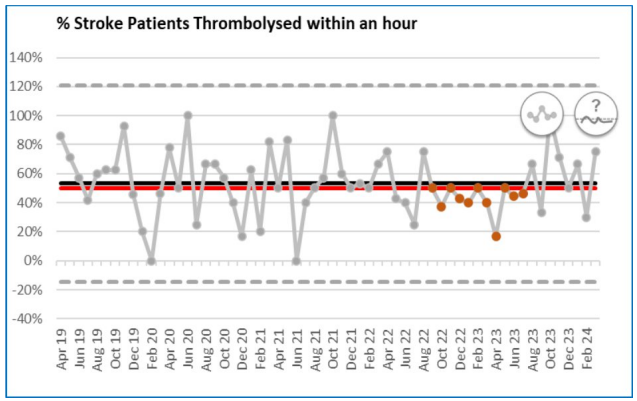
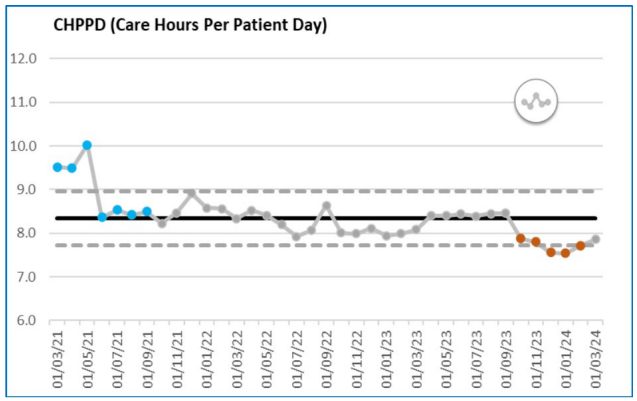
# Appendix 1 – Safe Care and Improving Outcomes Metrics - Safety



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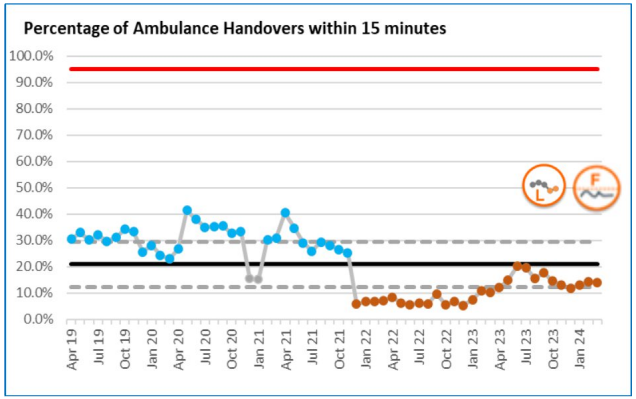
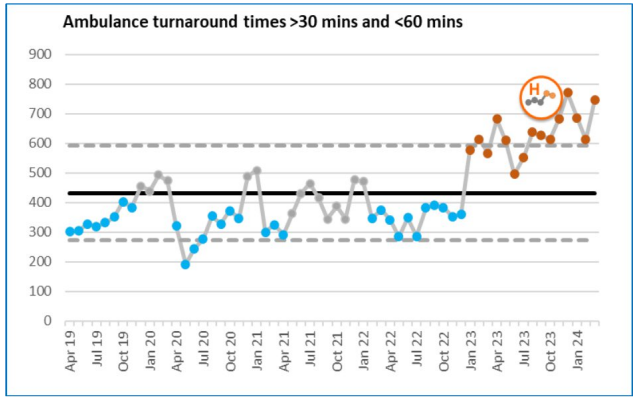
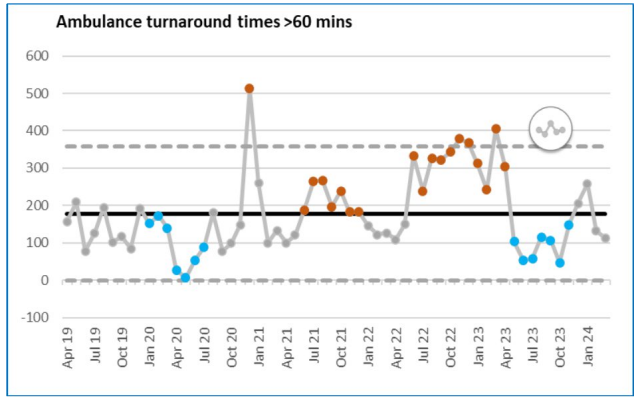
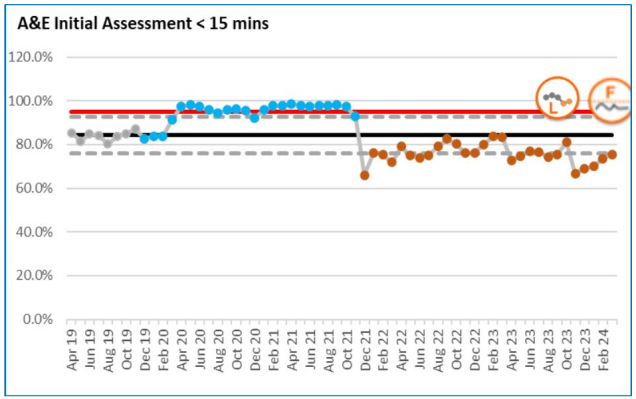
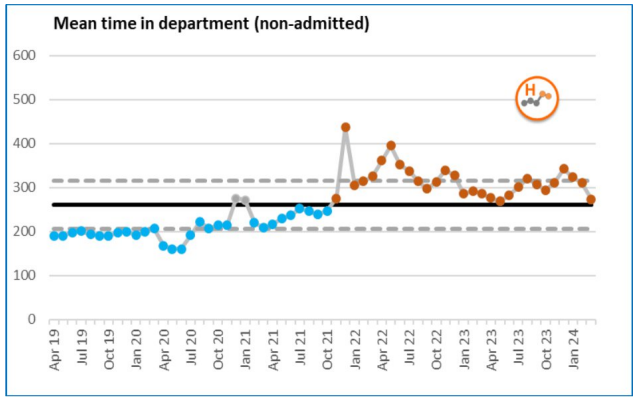
# Appendix 2 – A&E Metrics

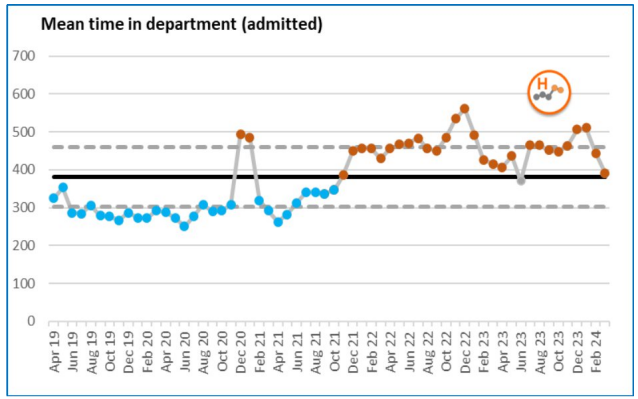


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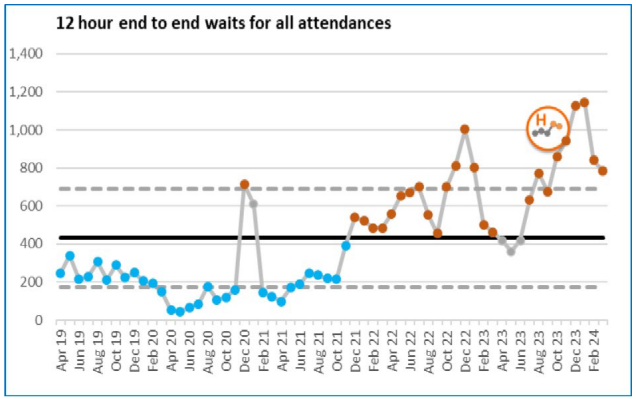
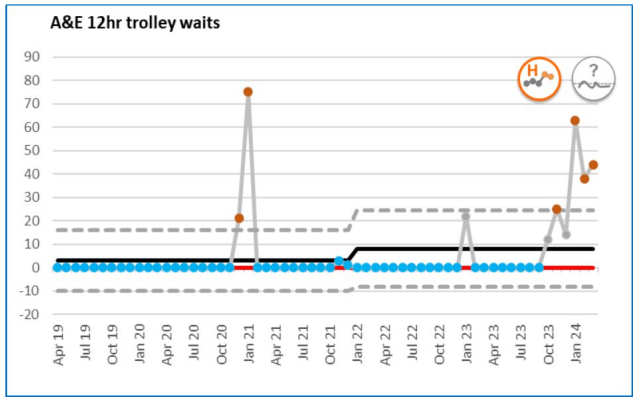
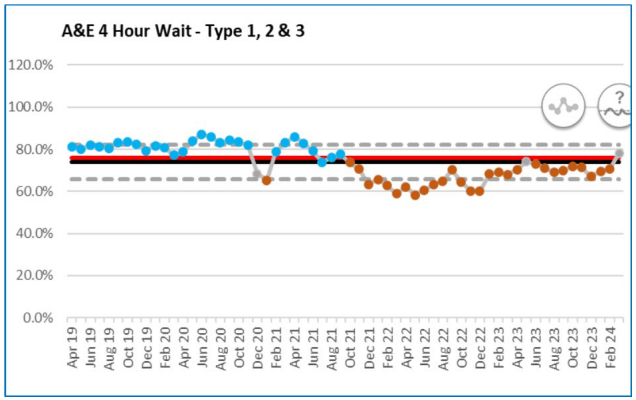
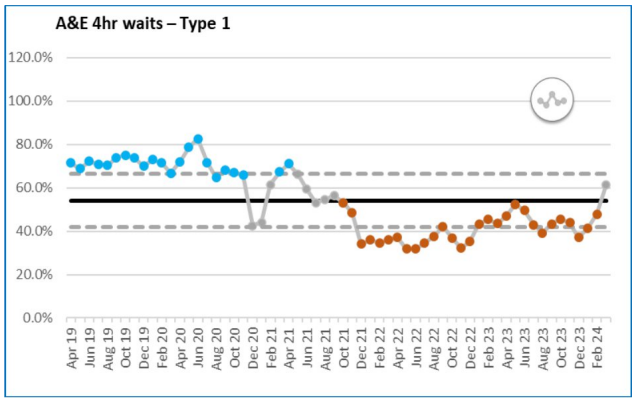
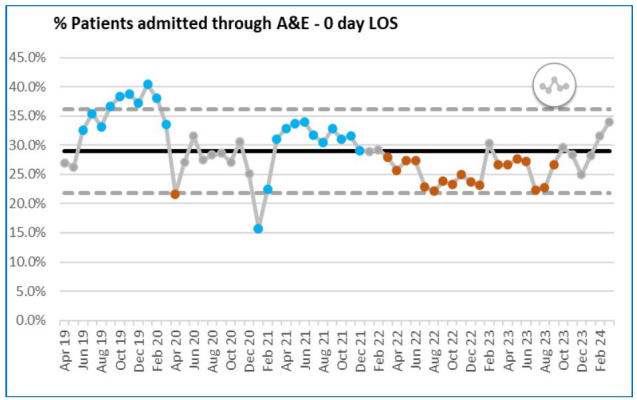
# Appendix 2 – A&E Metrics

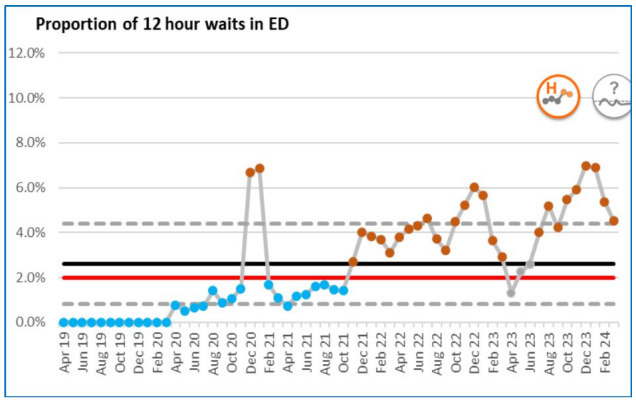


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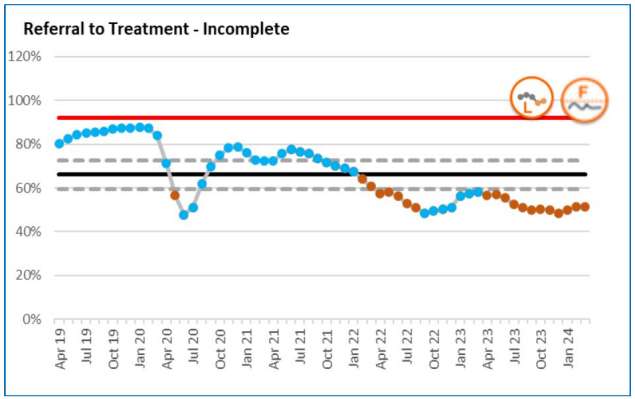
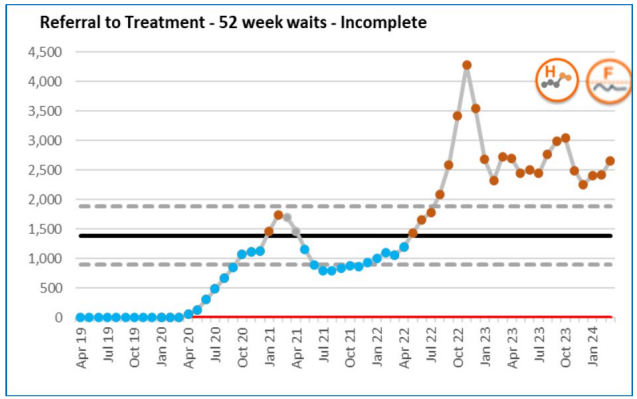
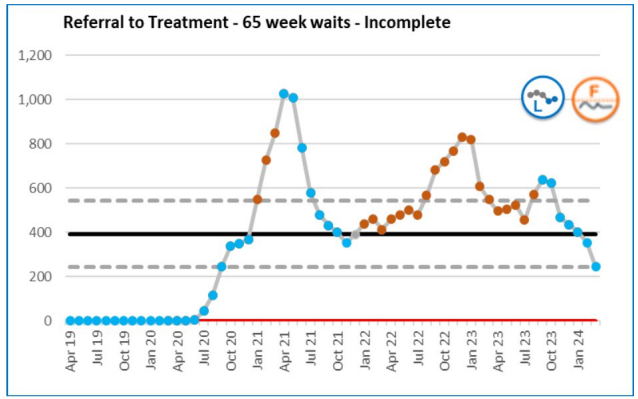
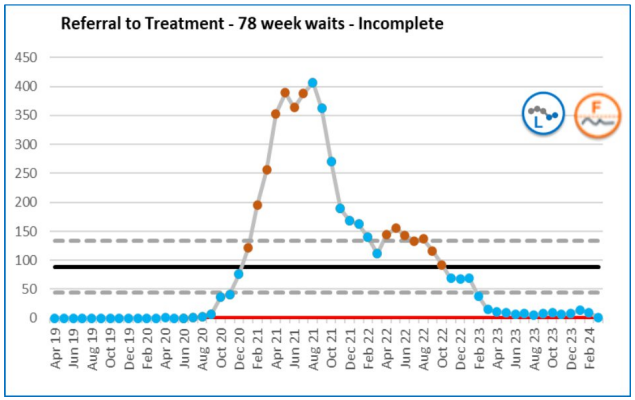
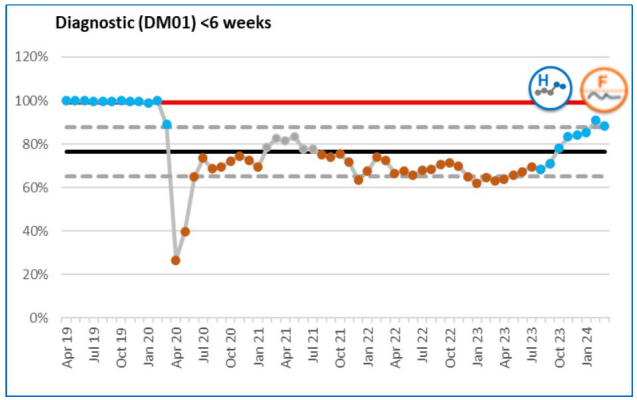
# Appendix 3 – RTT, Cancer and Diagnostics Metrics

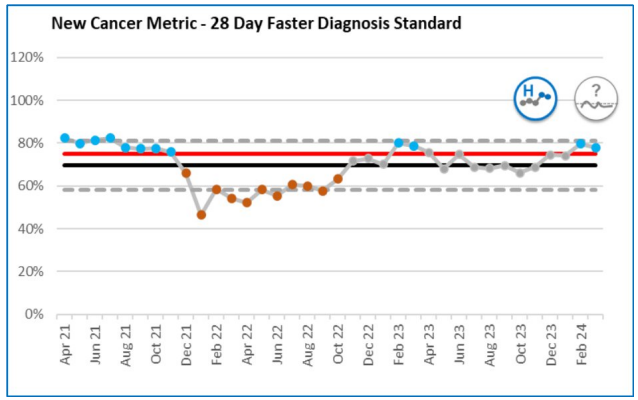


# Appendix 3 – RTT, Cancer and Diagnostics Metrics

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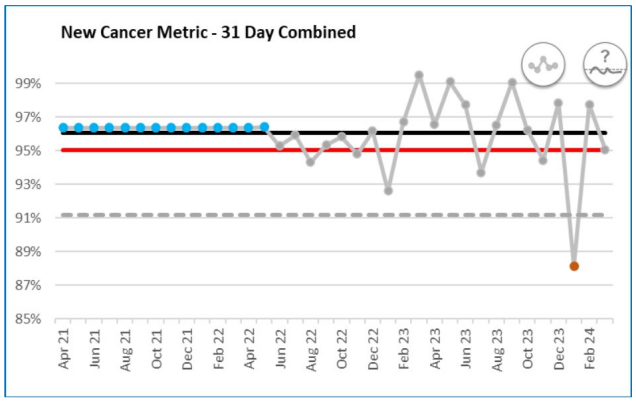


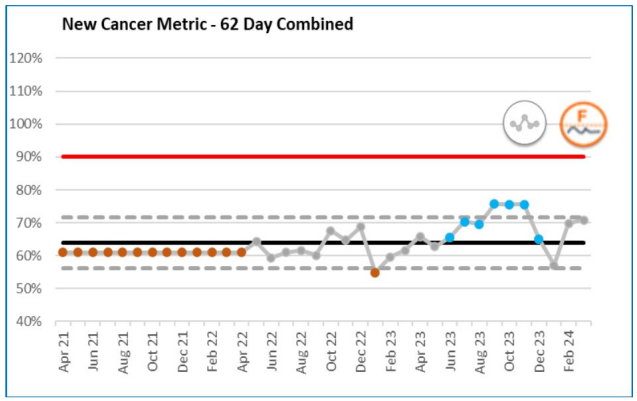


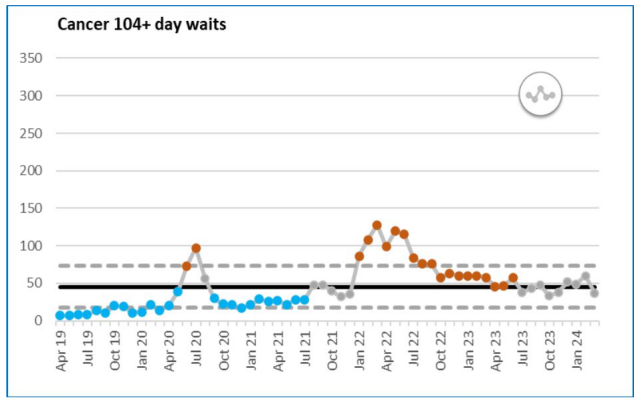


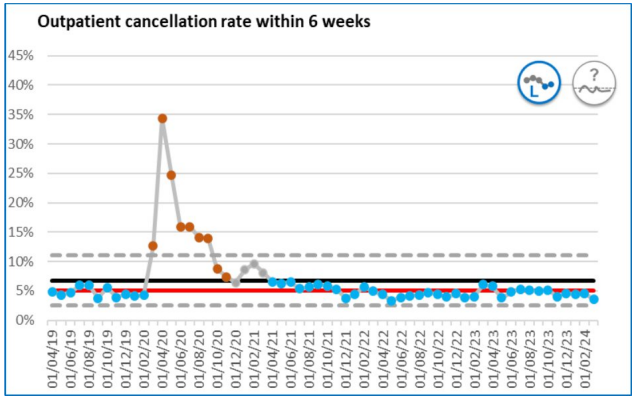


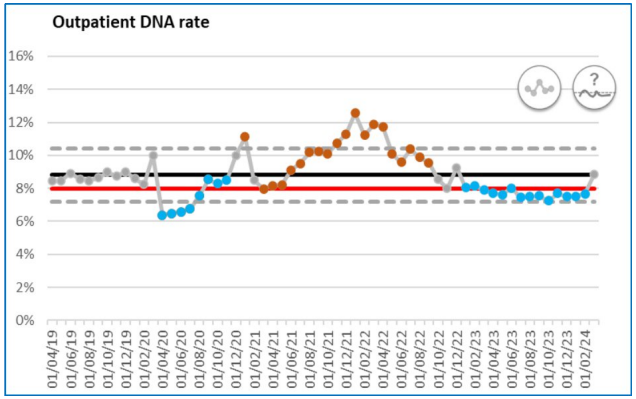

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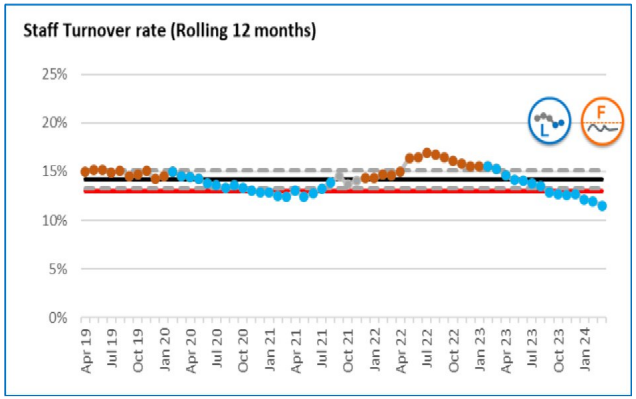
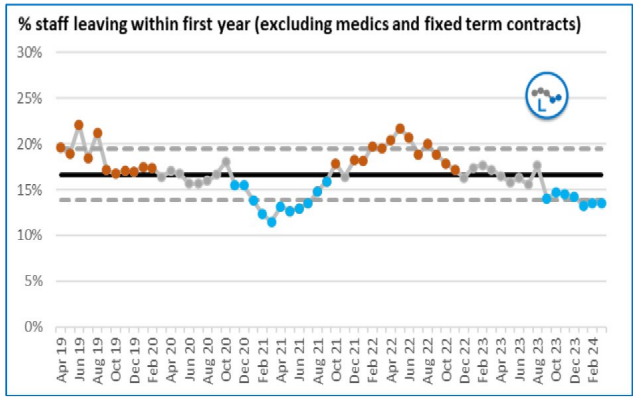
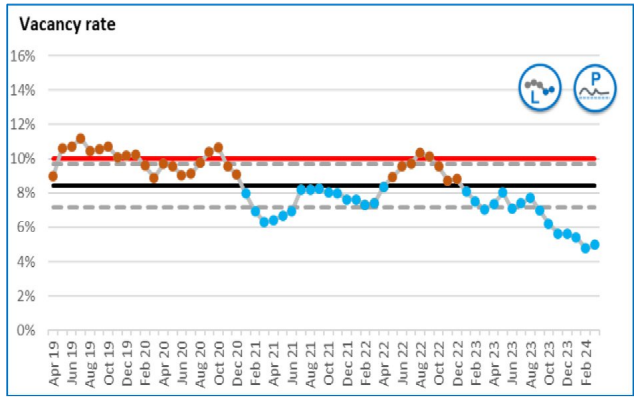
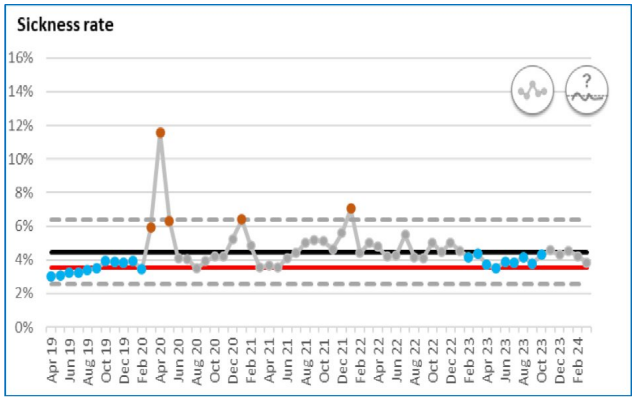
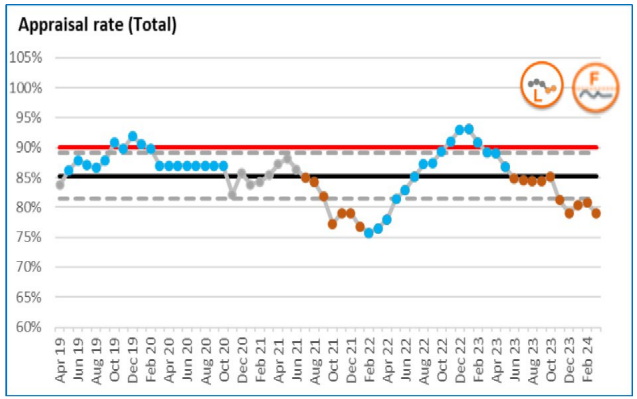
# Appendix 4 – Workforce Metrics

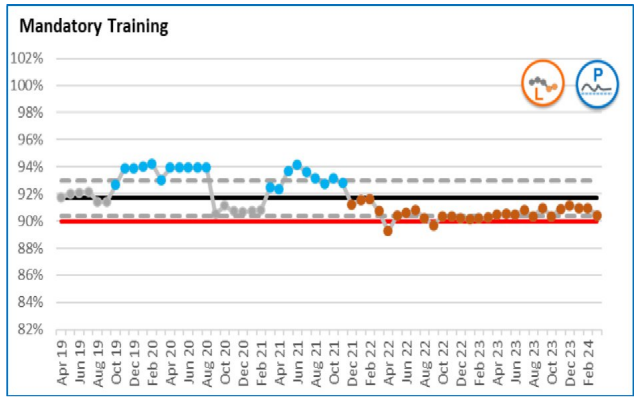


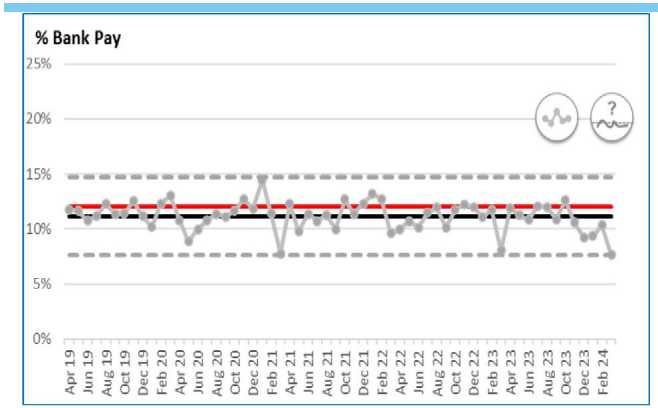



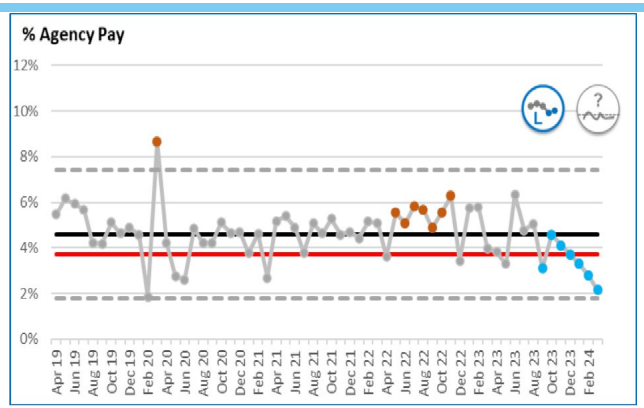



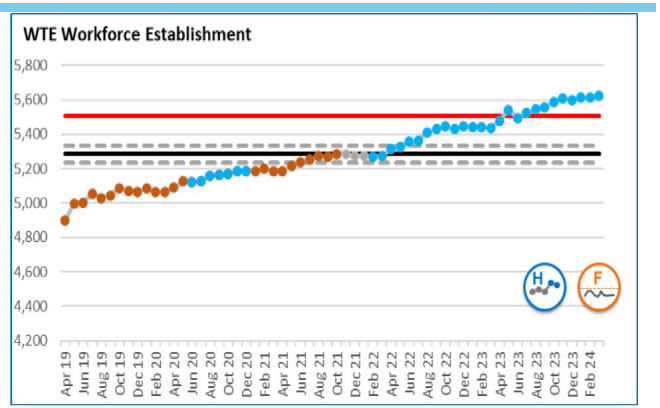



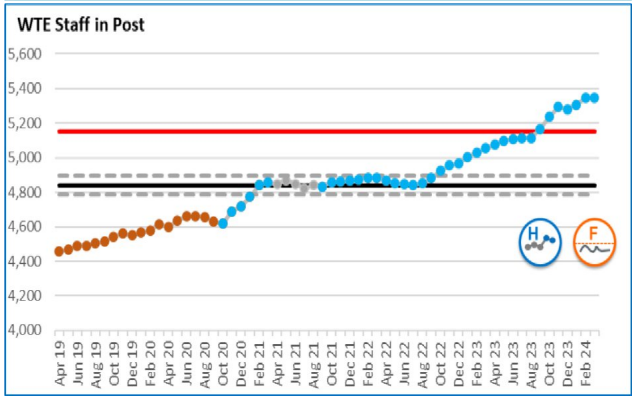
West Hertfordshire Hospitals NHS Trust

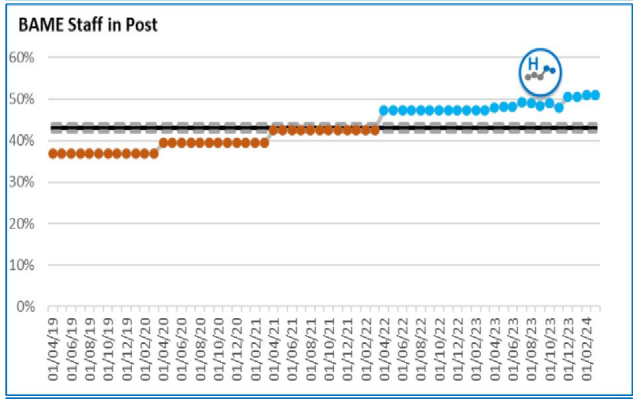
# Appendix 4 – Workforce Metrics

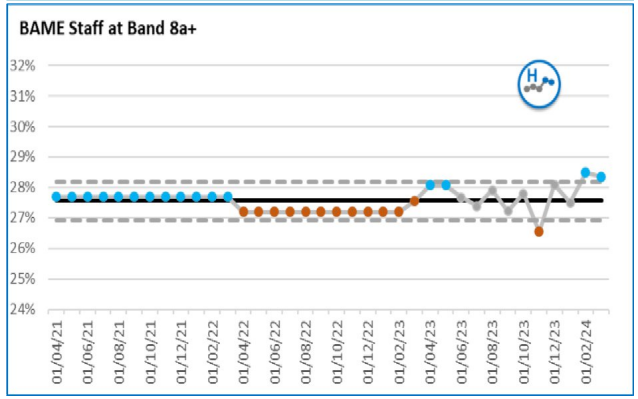


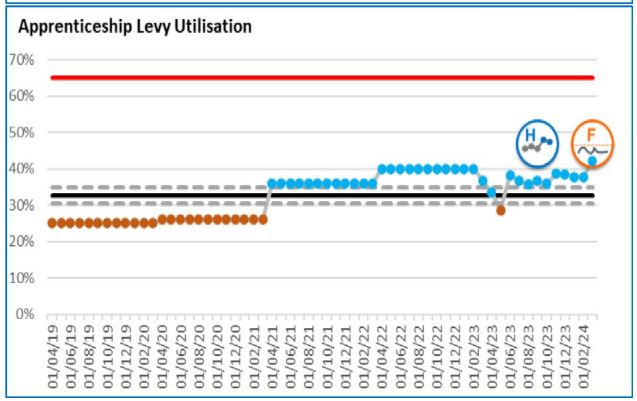



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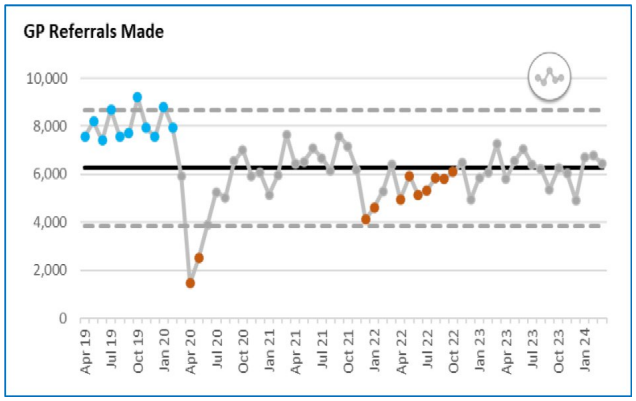
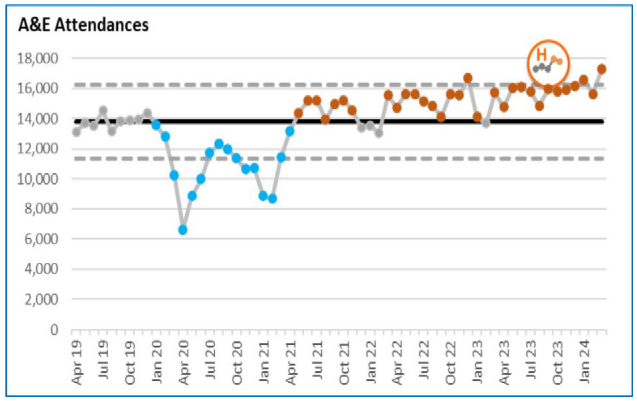
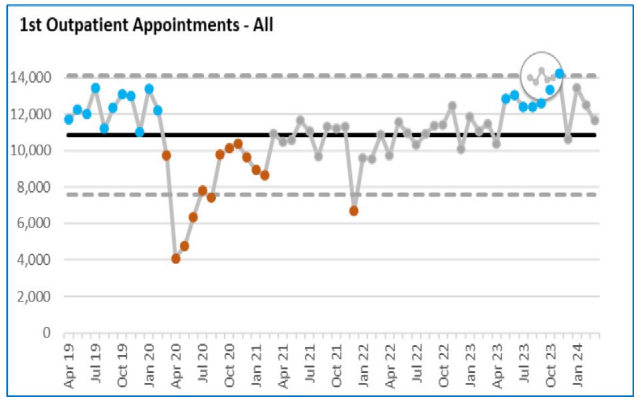
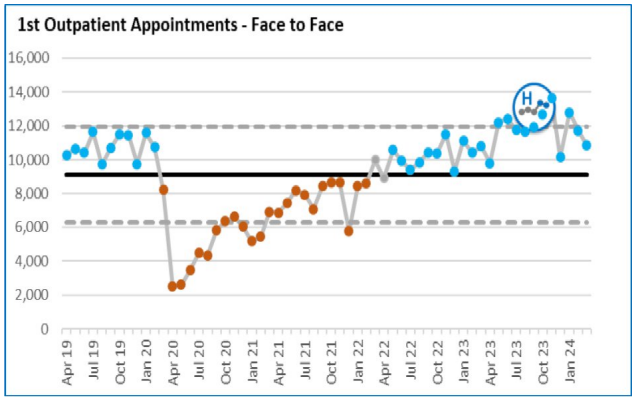
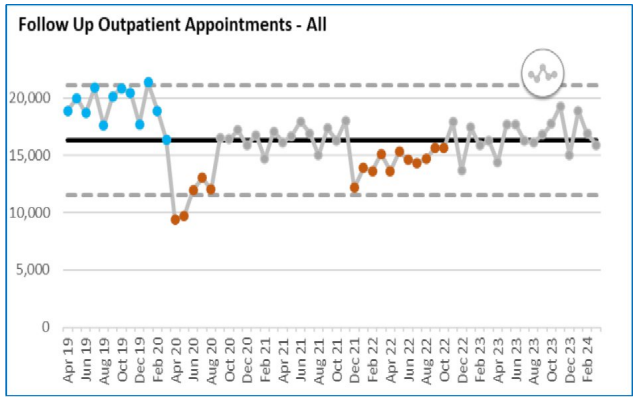
# Appendix 5 – Activity Metrics

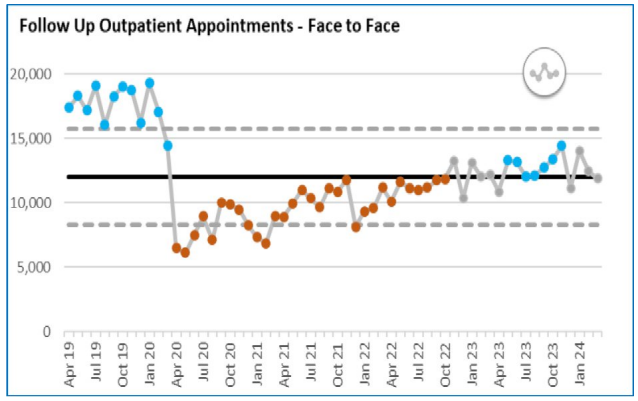


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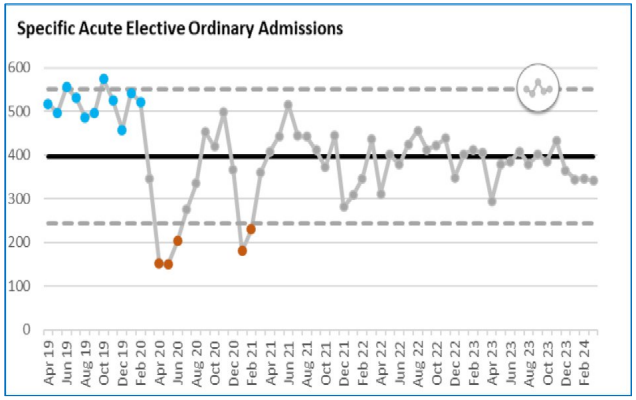


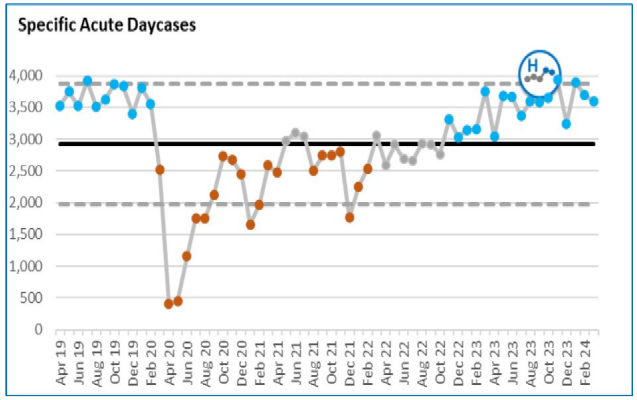


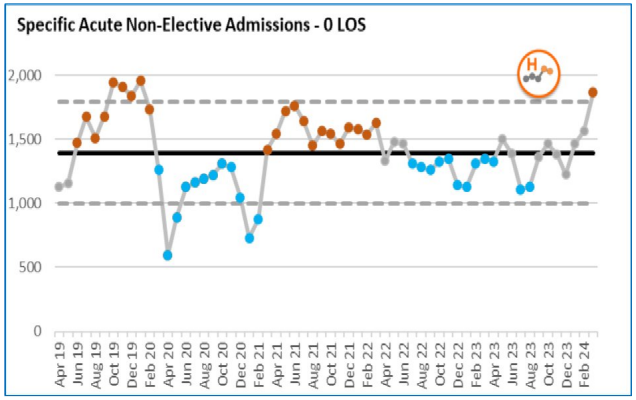


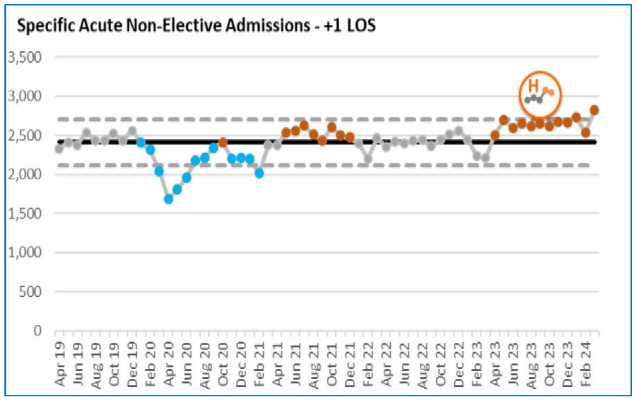


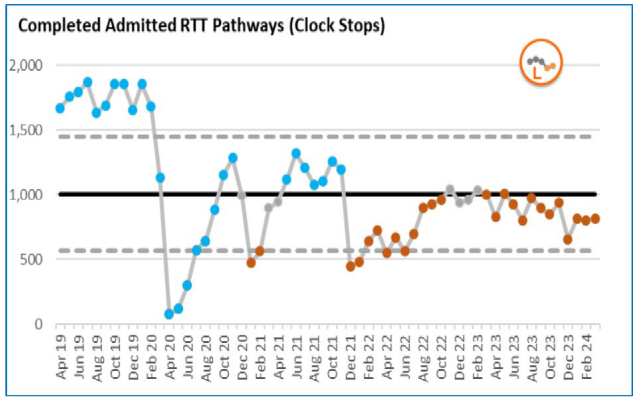


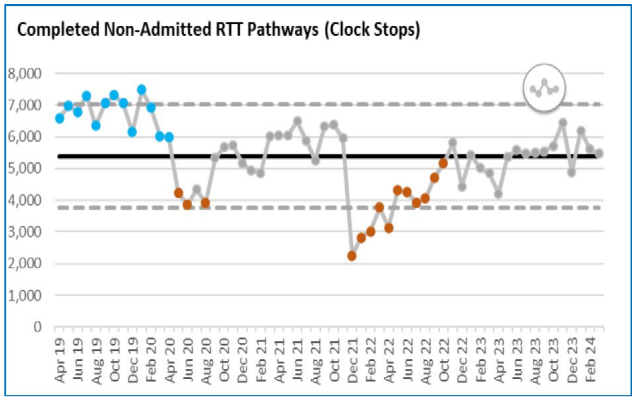

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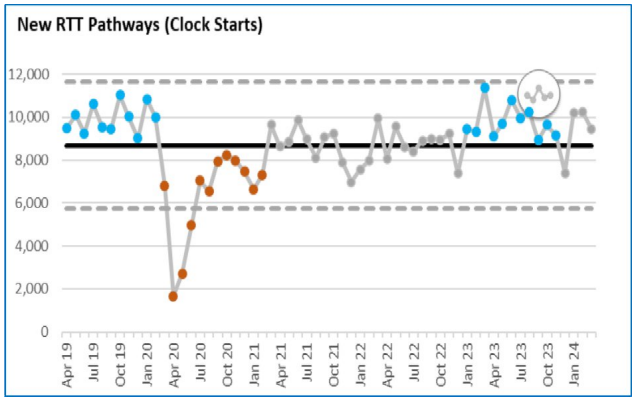


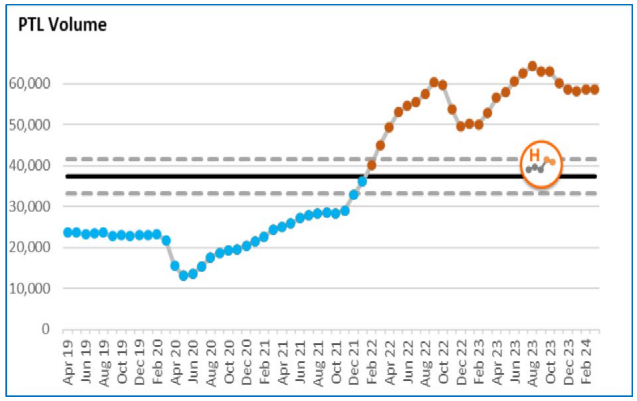


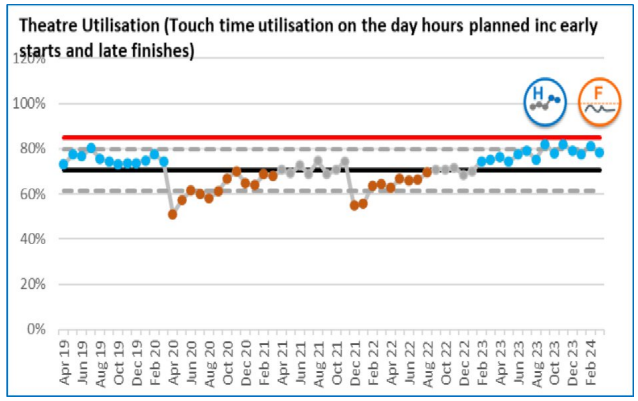


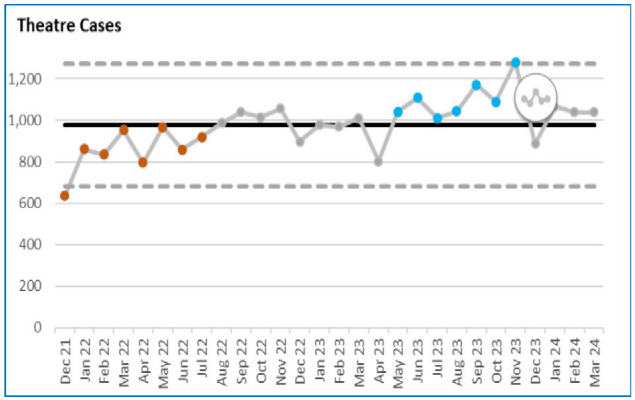


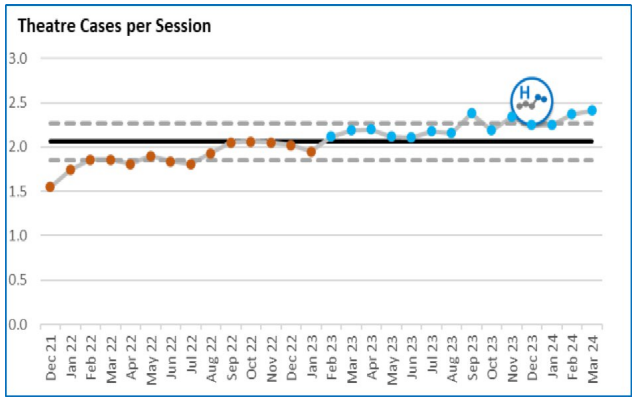

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OUR VALUES
Commitment
Care Quality

West Hertfordshire Teaching Hospitals NHS Trust

# Trust Board Meeting
# 02 May 2024



| | |
|---|---|
| **Title of the paper:** | **Freedom to Speak up update** |
| **Agenda Item:** | **22** |
| **Presenter:** | **Andrew McMenemy, Chief People Officer** |
| **Author(s):** | **Joanna Bainbridge, Freedom to Speak Up Guardian** |
| **Purpose:** | *Please tick the appropriate box*<br>*For approval*: <br>*For discussion*: X<br>*For information*: X |
| **Executive Summary:** | The purpose of this paper is to give an overview of the progress, development, themes, and trends from the FtSU casework and activity delivered at West Herts during the period 1st October 2023 and 31st March 2024.<br><br>The purpose of creating a speaking up culture is to keep our patients safe, improve the working environment of staff, promote learning and improvement, and ensure that the Trust has a safe culture.<br><br>The report provides assurance to the Board that the FtSU team continues to provide an effective service in line with requirements and the expectations of the National Guardian's Office.<br><br>This report also considers areas for focus over the coming 6 months. |
| **Trust strategic aims:**<br><br>*(please indicate which of the 4 aims is relevant to the subject of the report)* | **Aim 1 Best care** — ***Objectives 1-4***<br>**Aim 2 Great team** — ***Objectives 5-8***<br>**Aim 3 Best value** — ***Objective 9***<br>**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?<br>☒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?<br>☒Are there clear responsibilities, roles and systems of accountability to support good governance and management?<br>☒Are there clear and effective processes for managing risks, issues and performance?<br>☒Is appropriate and accurate information being effectively processed, challenged and acted on?<br>☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?<br>☒Are there robust systems and processes for learning, continuous improvement and innovation?<br>☒How well is the trust using its resources? |
| **Previously considered by:** | <table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td>People, Education and Research Committee</td><td>25.04.24</td></tr></table> |
| **Action required:** | The Board is asked to receive this report for assurance on the progress that has been made over the 6 months between the 1st October 2023 and 31st March 2024 and to endorse the actions planned for the coming 6 months. In support of this, the Committee is asked to receive this report for information and relevant discussion. |

West Hertfordshire Teaching Hospitals NHS Trust

**Agenda Item: 22**

**Public Board Meeting - 02 May 2024**

**Freedom to Speak Up (FtSU) update**

**Presented by: Andrew McMenemy, Chief People Officer**

22

## 1 Purpose

1.1 This report provides an overview of the activity that took place during the period 1st October 2023 to 31st March 2024, across the Trust to deliver our commitment to Freedom to Speak Up, including actions taken to improve speaking up at West Herts and an assessment of the number and themes of concerns raised, learning and recommendations.

## 2 Background

2.1 The standard NHS contract requires that all trusts and foundation trusts employ a Freedom to Speak up Guardian (FtSUG). FtSU Guardians are employed across the health and care sector, including in primary care, health charities, independent providers and arm's length bodies including health regulators. The FtSU Guardian's role is to ensure patient safety and staff wellbeing by providing a mechanism for staff to speak up when they see or hear something that is not right. The FtSUG also provides support to staff who raise concerns and supports the Board to develop a 'positive, compassionate, and inclusive' workplace culture in line with the vision set out in the NHS People Plan. Regular meetings are held between the FtSUG and the Chief Executive Officer and the Non-Executive lead for FtSU to ensure themes of concerns are discussed and relevant actions are taken and followed up.

## 3 Analysis/Discussion

### 3.1 Cases

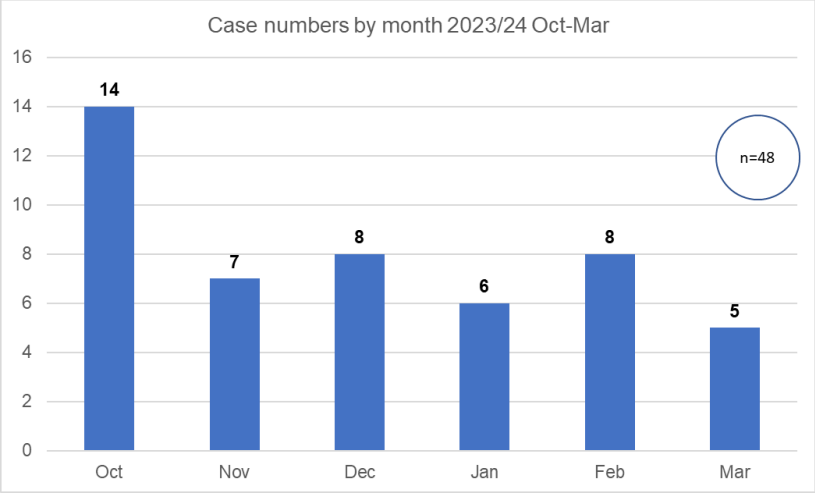


**Figure 1: Case numbers by month 2023/24 Oct-Mar**

3.2 Figure 1 shows that the total number of FtSU cases raised over the 6-month reporting period was 48. This represents the highest number of cases raised to-date, over a 6-month period. 14 cases were raised in October, during national FtSU month and this saw the highest number of cases raised in any one month to-date.

3.3 All 48 cases were responded to by the Guardian, with all staff receiving a first response within the agreed timeframe, of a maximum of 48 hours. Case numbers over this period show an increase of 24 cases, compared with the same 6-month period from 2022/23.

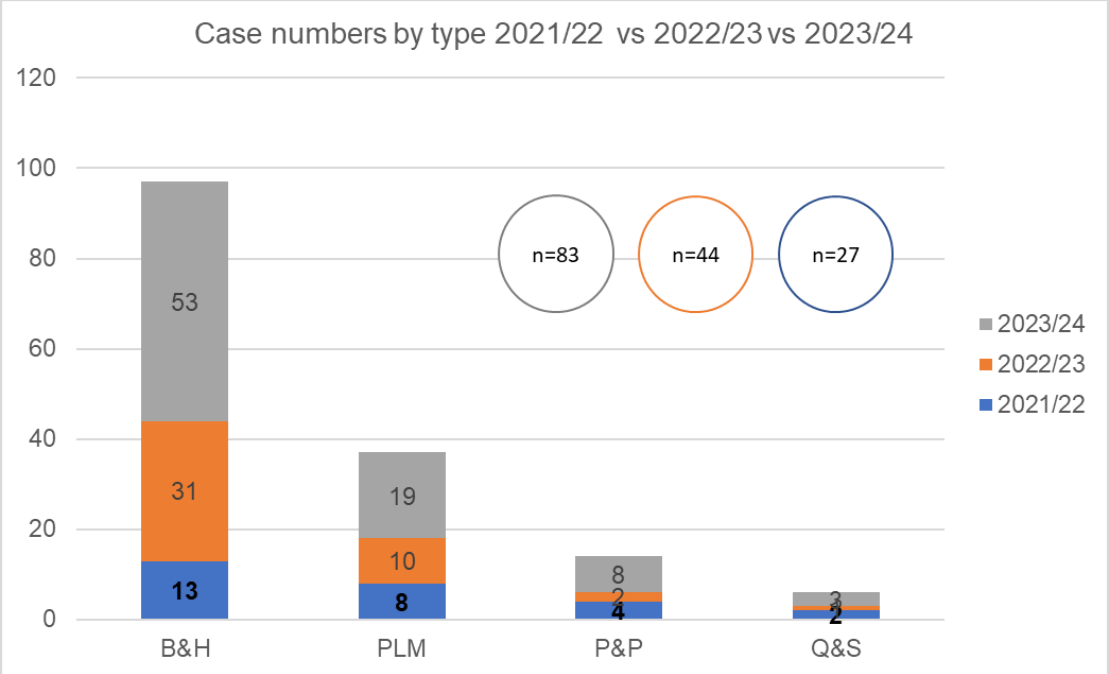


**Figure 2: Case numbers by type 2021/22 vs 2022/23 vs 2023/24**

3.4 Figure 2 shows and compares all FtSU cases raised over the past 3 years. The year-on-year increase has been significant. Case numbers have more than trebled in number between April 2021 and March 2023.

3.5 83 FtSU cases have been raised over the 12-month period ending 31st March 2024. This compares with 44 cases over the same period in the previous year, an increase of 57%.

3.6 From the national perspective, FtSU cases increased by 25% over quarter 3 of 2023/24 compared with the same quarter from 2022/23. National figures are not currently available for the year 2023/24, but it is anticipated, based on trend, that the raise in numbers of cases at West Herts will exceed any national increase.

3.7 There were no cases reported anonymously over the 6-month reporting period. This continues to show on-going trust from our staff through a willingness to escalate concerns openly rather than anonymously.

3.8 The average time from a FtSU case opening and closing during the reporting period decreased from 18 days during the last period, to 12 days. Most cases continue to be resolved informally. There is however a growing trend of cases being escalated to the Guardian due to the member of staff raising the concern not getting a response from the person who they raised the concern with. A response is normally forthcoming once the Guardian intercepts.

3.9 39 of the FtSU cases have been closed during the reporting period. Of the cases closed, 29 of those raising the cases have completed and returned review forms. 29 responders indicated that given their experience of speaking up, they would feel safe to raise a concern again through the FtSU service. None of the staff who responded to the review form stated that they had suffered detriment because of raising a concern. This indicator should not be seen as 100% assurance that detriment is not suffered by staff because of raising concerns at West Herts. Indicators taken from the Difference Matters project show that some staff do fear raising a concern due to the fear of potential detriment from a line manager or colleague.

3.10 From the national perspective, 1 in every 25 cases raised are reported by staff who experienced some level of detriment because of speaking up.

3.11 Figure 3 shows the trend in cases by case type, over the six-month period.

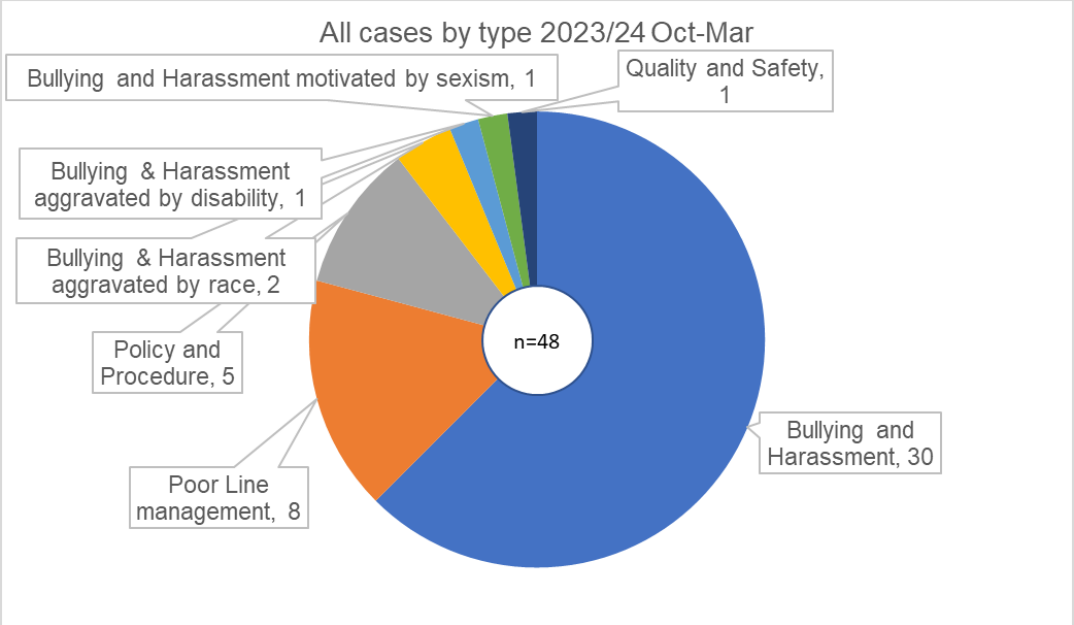


**Figure 3: All cases by type 2023/24**

3.12 This period saw a record number of bullying and harassment cases reported, at 34. This shows an increase of 11 cases (33%) compared with the previous reporting period. 4 of the cases raised were aggravated by race (3), Sexism (1) and Disability (1). Bullying and harassment cases represents 70% of the overall cases reported.

3.13 Bullying and Harassment themes that can be taken from the cases over this reporting period are, use of inappropriate language, belittling, undervaluing work, persistent and unjustified criticism, ignoring, favouritism and nepotism. Most of this case type are resolved within 7 days, as most cases are escalated to the FTSUG when local escalation to the immediate line manager fails, or a response has not been given to the member of staff. Often, staff raising this this type of concern need support to escalate their concern to the senior manager, the FtSUG provides this support where needed.

3.14 The trust remains an outlier compared with the national picture on bullying and harassment cases, the national picture for cases of this type is 39% (quarter 3 2023/24) with an element of Bullying and Harassment, a variance of + 31%.

3.15 There has been a reduction in cases of Poor Line Management compared with the previous 6-month reporting period, from 11 cases to 8. 100% of this case type were resolved within less than 7 days, as many either require an additional conversation with the line manager or a prompt to the line manager to provide a response to the member of staff who has raised the concern. Themes from these cases included lack of appropriate workplace training, secondment posts being appointed without being open for applications from all staff and workplace tensions between staff remaining unresolved and unmanaged.

3.16 Policies or Processes represented 5 cases (10%), one more case than reported in the previous reporting period. Cases in this category included a report of unresolved infestation and graffiti and a discrepancy in shift patterns applied across hospital sites. All cases were successfully resolved.

3.17 Quality and Safety represented 1 case (2%); this is a reduction of 1 case compared with the previous reporting period. It is important to note, that once again, no serious patient safety concerns have been raised during this period through FtSU. It is also important to note that there were no cases raised under the Whistleblowing provisions during this period.



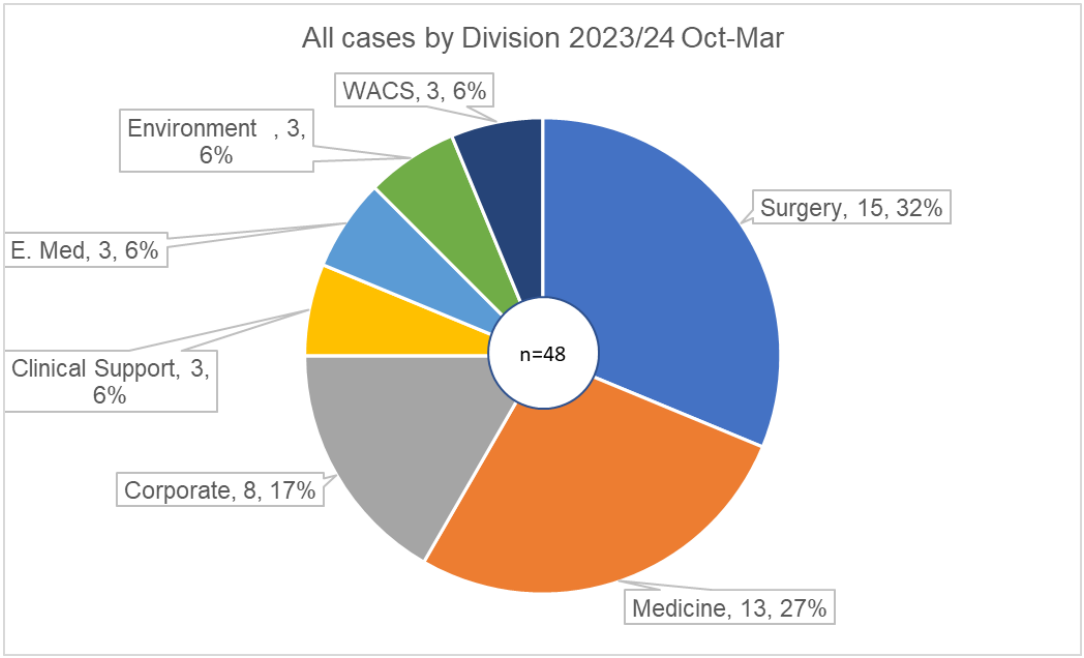


**Figure 4 cases by Division 2023/24 M7-12**

3.18 Figure 4 shows that Surgery had the highest number of cases at divisional level within the reporting period, at 15 cases (32%). 8 of these cases came from Theatres (53% of the total cases). Theatres represents 22% of the headcount within the surgery division, the proportion of cases is therefore high as a % of the headcount. In the previous reporting period Surgery reported 6 cases at 15% of the overall FtSU cases. Proportionally cases within Surgery have increased by over 50% comparing the two reporting periods.

3.19 Case themes from Theatres include, reports of a toxic working environment, staff not receiving a response when a concern is raised, bullying from band 7 staff and concerns relating to service changes and car parking changes. This position has been escalated to all the relevant senior staff at service and divisional level. The remaining 7 cases from this division have shown themes of bulling from members of the management team and 2 cases where flexible working arrangements have been unfairly applied or used as a tool for bullying.

3.20 The division of Medicine reported 13 cases over the reporting period (27%), these came from a range of clinical areas across the division, however 4 of the 13 cases came from multi-disciplinary members of the Respiratory team. Case numbers from Medicine from the previous reporting period were 9 cases at 22% of the overall case numbers.

3.21 Case themes from the division of Medicine included, flexible working requests being rejected, 1 case of a senior nurse experiencing upward bullying and 2 cases of senior nurses experiencing sideways bullying. Both senior nurses who raised the bullying cases previously mentioned have resigned. Both these cases have been escalated to the divisional Head of Nursing. Case numbers are in line with the proportion of headcount within this division.

3.22 The Corporate areas reported 8 cases during the reporting period. Themes included concerns relating to unfair recruitment processes and concerns relating to flexible working being unfairly applied across teams.

3.23 The division of Woman and Childrens Services reported 3 cases. This represents a downward trend compared with the previous reporting period, where 10 cases were reported. Cases reported by midwives have been on a down trend for the past 12 months.

3.24 The Divisions of Environment, Clinical Support and Emergency Medicine reported 3 cases each, all were bullying and harassment. The downward trend in cases from Environment continues for the 3rd reporting period, however as a % of headcount the % of cases are proportionally higher (2% v 6%).



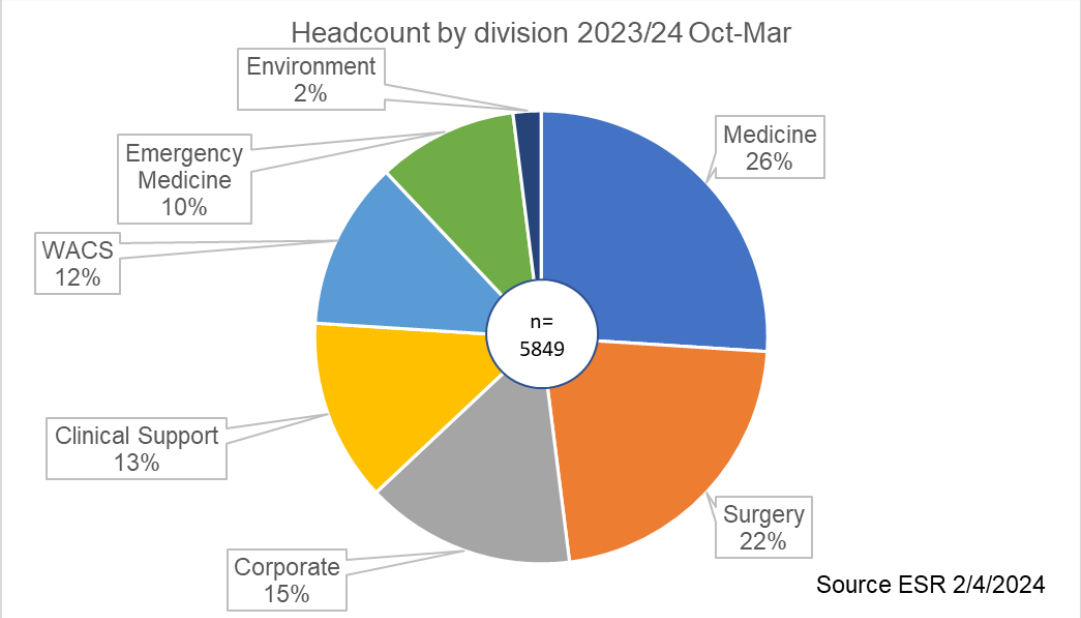


**Figure 5a Headcount by division 2023/24 Oct-Mar**

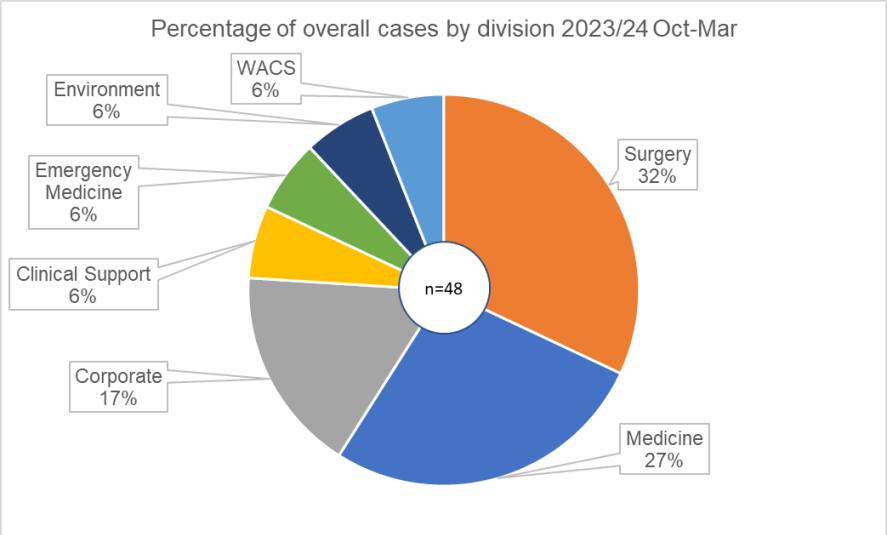


**Figure 5b Percentage of overall cases by division 2023/24 Oct-Mar**



3.25 Figure 5b shows the % of cases by division, which can be compared with figure 5a showing the % of headcount from within each division. The greatest exceptions are shown for Surgery where 22% of the trust's headcount sit and where 32% of cases were reported over the period. Environment where 2% of the trust's headcount sit and where 6% of FtSU cases were reported over the period. Corporate areas where 15% of the trust's headcount sit and where 17% of FtSU cases were reported over the period and Medicine where 26% of the trust's headcount sit and where 27% of FtSU cases were reported over the period.

3.26 Within the divisions of Women and Childrens Clinical Services and Emergency Medicine FtSU case numbers represent a lower proportion compared with % of headcount.

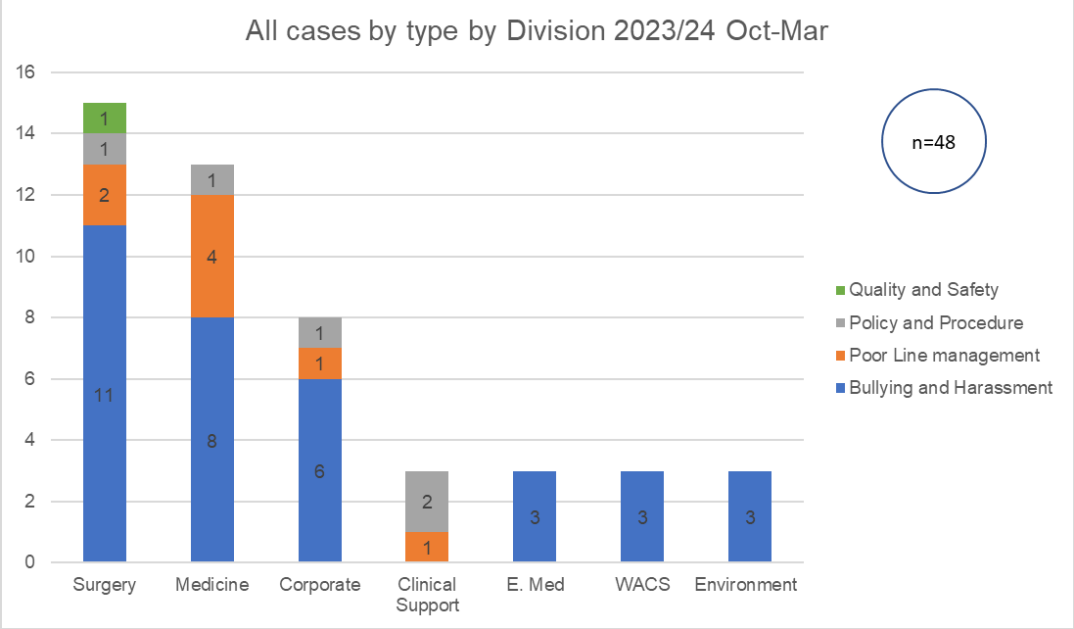


**Figure 6 All cases by types by division 2023/24 Oct-Mar**

3.27 Figure 6 is an additional data set for this bi-annual report and shows type of FtSU case by Divison over the reporting period. This data set adds further detail to the information shown in fig 5a. Types of bullying and harassemnt within this case type have been merged to one descriptor, this is to preserve annonimity. Bullying and Harassment represents 75% of total cases in the Corporate Division, 73% of total cases in Surgery, 61% in Medicine.

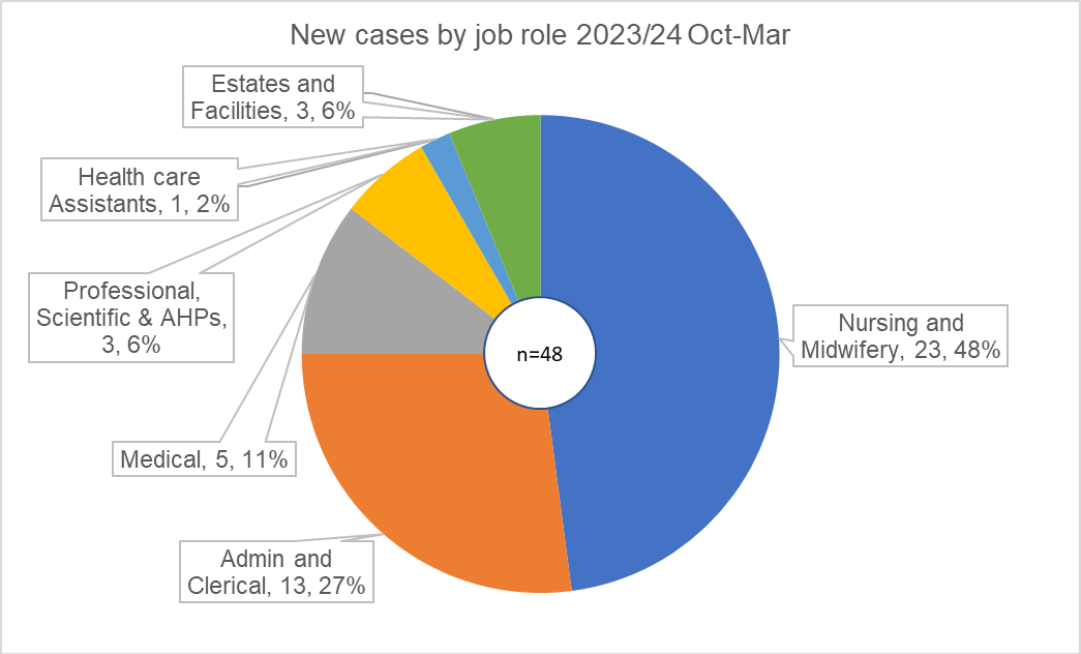


**Figure 7 New cases by staff group 2023/24 Oct-Mar**



3.28 Nursing and Midwifery represented the highest number of cases within a staff group, at 23 cases. Most of these cases were raised by nurses rather than midwives. Numbers of cases reported in the previous period were 20, this shows a slight increase compared with the period covered by this report. However, the change seen here, is that the majority of cases reported by this staff group came from the divisions of Surgery and Medicine contrasting with the higher numbers being reported from the Women and Children's Services division over the previous period.

3.29 The Administration and Clerical staff group reported 13 cases over the reporting period, the same number reported over the previous period.

3.30 Medical staff represented 5 cases, compared with 4 over the previous reporting period. Most cases this time have come from Consultants rather than from our Junior Doctor workforce. Most of the FtSU cases from Consultants involved themes of bulling and harassment and were not resolved through the immediate line manager, but required intervention, or escalation to a more senior clinical leader.

3.31 The Professional, Scientific and AHP staff group reported slightly higher case numbers for this reporting period this, with Health Care Assistants and Estates and Facilities staff group showing slight reductions in case numbers.

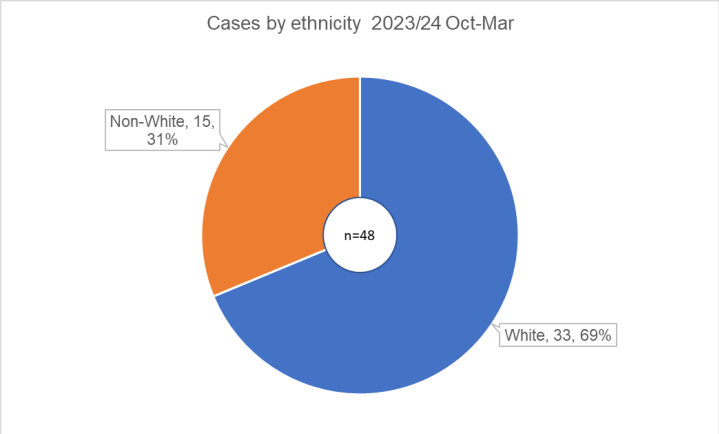

**Figure 8: cases by ethnicity 2023/24 Oct-Mar**

3.32 Figure 8 shows a breakdown of staff by ethnicity who raised concerns over the period. The pattern of reporting by ethnicity has shifted for the second reporting period from a 50/50 split shown for the previous 12-month period to a higher number of cases being raised by staff identifying as white UK. A 12-month period has expired since any direct engagement has been made from the FTSU service with staff who do not identify as UK White. A plan will be put in place to address this gap over the coming 6-month period, aimed at continuing to raise awareness with staff who find it more difficult to speak up.

## 4 Highlights from the activity over the reporting Period

4.1 The reporting period covered by this report has seen a significant rise in FtSU case numbers, which mirrors the trend over the past 12 and 36 month periods. The work currently being carried out by the team led by the Associate Director of Organisational Development refreshing the trusts values, coupled with the accountability framework will have a positive impact on improving this picture as our values become front-and-centre of the way we do things at West Herts and the basis of the FtSU strategy. One of the trust's main aims for the coming period is to empower our workforce and enhance our ability to provide a supportive and inclusive culture, where our staff feel safe to speak up, this will in turn enable the delivery of high-quality patient services. The success of our FtSU strategy and service will play a significant role in delivering this ambition.



4.2 Direct staff engagement has continued in the form of direct messaging from the Guardian and through the Freedom to Speak Up Champions who are now carrying out their revised role, focused on delivering the FtSU service within their own work areas.

4.3 A new project has been launched designed to carry out a 'deep dive' into the factors that lie behind the bullying and harassment (B&H) cases, this project is known as 'Respect Me'. The plan is to roll this out to all staff within the trust, by staff group, continuing until the end of June 2024. This involves staff responding to a number of questions within a confidential questionnaire which poses questions and statements regarding whether they have experienced bullying and harassment and if they have, the form it took, how long ago it was and from whom they sought support. The questionnaire was rolled out to just over 2,000 nurses and midwifes in January of this year and to 750 medical staff at the beginning of February.

4.4 The Respect Me project closed for the nursing and midwifery staff at the end of February and the data/results have been committed to a report which showed, amongst other things that the type of bullying and harassment that has taken place from those who have been bullied and harassed, fits into five main behaviours, persistent attempts to belittle, constant undervaluing, persistent and unjustified criticism, freezing out and ignoring, destructive inuendo and sarcasm. Affirmative responses to these types of bullying and harassment accounted for 74% of the total responses to this question, these five 'types', by their nature are intrinsically linked by behaviour type and mirror the main types of B&H reported through the FtSU cases.

4.5 A further question explores the participants knowledge of where they can raise a concern regarding bullying and harassment. The majority of responders from the nursing and midwifery group indicated that FtSU is the most popular choice as a potential support for bullying The main themes gathered from the project so far have been fed into the work being carried out on the accountability framework and the development of leadership training. The outcome report from the Respect Me project for Nurses and Midwifes has been shared with the Chief Nurse, and the Divisional Heads of Nursing.

4.6 The revised and refreshed Champion team was formally launched during January through our communications team and individual messages and information were provided for the senior divisional team leaders to advise on who their local Champions are. Recruitment to the FtSU Champion team has continued, and this has successfully increased numbers of Champions within Emergency Medicine, Medicine and Women and Childrens Services.

4.7 A support pack has been developed for the Champions and includes support material to assist Champions with local presentations and initiatives and hints on conversation topics for group discussions. Support sessions were also run for those requiring further information on how best to utilise the pack.

4.8 The FtSUG carried out several walkarounds between January and March covering the majority of areas within the divisions of Surgery and Medicine, on all 3 hospital sites. Before the most recent Guardian walkarounds took place the Guardian emailed all staff directly within each area to advise of the visit in advance. This approach led to the recruitment of an additional Consultant Champion from the Breast Service.

## 5 Planned activity for next 6 months.

5.1 The next 6 months will produce further opportunities for a continued focus on our activity but will include a higher emphasis on the objectives and actions identified through our FtSU Strategy. With the conclusion of the Respect Me project due at the end of June, further work will be carried out to explore and understand the themes that arise from this project and relevant recommendations will be made, as needed.



5.2 In line with the expected outcomes from the FtSU Strategy work will continue to identify where detriment may occur for members of staff who speak up and continuing to work on identifying and tackling barriers to speaking up at West Herts.

5.3 Our plan over the following 6 months will include continuing to reach out with the FtSU service to all our ethnic minority staff. The Champion's training has been developed to include a section on conscious and unconscious bias. We have already seen that from previous direct engagement with this staff group, we have already closed the case reporting gap all our staff. Plans going forward will include building on the quality and outcomes from the conversations that Champions are having with their colleagues and increasing direct engagement between our ethnic minority staff and the Guardian.

5.4 The Champions will be tasked with gaining an understanding of the opportunities that can be accessed to improve speaking up within their local area and target specific interventions to improve behaviour linked to bullying and harassment, understand the diversity within their local area.

5.5 A further programme of FTSUG walkarounds will continue over the next period, aimed at continuing to develop regular engagement with staff across all departments and wards. Guardian walkarounds will continue and will be focussed on FtSU themes and trends that are identified, as the next 6-month period progresses.

5.6 Work on the Respect Me project will continue and conclude in June with relevant reports and recommendations being made and shared.

## 6 Risks

6.1 Organisations should have a culture where staff feel able to voice their concerns safely. Not having this culture can create potential impacts on patient safety, clinical effectiveness and patient and staff experience, as well as possible reputational risks and regulatory impact. It is therefore critical that the organisation continues to support the FtSU service at West Herts. There are no concerns about the support that has been provided to the Guardian during the reporting period.

## 7. Recommendations

6.2 Whist the number of FtSU cases has been increasing, a trend has been identified that has seen members of staff raising concerns with the Guardian because they have not received a timely response from the person/manager with whom the concern has been raised. We must recognise that managers play a vital role in supporting staff who raise concerns in order that we set the right cultural tone for speaking up and for handling speaking up matters effectively. Leaders at every level of our organisation need to role-model the speaking-up principles as this helps workers feel safe, valued, and confident to speak up and workers are likely to emulate the values and behaviours they see in their more senior colleagues. The recommendation made is that we should review our leadership development training to consider whether the importance of establishing a speaking-up culture is being sufficiently addressed at first line management level.

6.3 The Board are asked to note the content of this report for information.



**Andrew McMenemy**
**Chief People Officer**

**25 April 2024**

West Hertfordshire Teaching Hospitals NHS Trust

# Trust Board Meeting
# 02 May 2024

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Title of the paper** | **Board Assurance Framework report** | | | | | | |
| **Agenda Item** | **23** | | | | | | |
| **Presenter** | **Matthew Coats, Chief Executive Officer** | | | | | | |
| **Author** | **Jean Hickman, Interim Director of Governance** | | | | | | |
| **Purpose** | | *For approval* | | *For discussion* | | *For information* | |
| | | ✓ | | | | | |
| **Executive Summary** | This report is to provide the Board with assurance that risks to achieving the Trust's strategic objectives are being appropriately mitigated, to consider those elements that report directly to the Board and any recommendations of changes from assurance committees.<br><br>The BAF dashboard and detailed risks are attached for the Board to approve.<br><br>The risks were discussed by the Finance and Performance Committee and Quality and Safety Committee on 25 April 2024 and no changes are recommended.<br><br>On 25 April 2024, the Patient Education and Research Committee reviewed an assessment of BAF risks 10 - 12 associated with the strategic priorities for the workforce. The supporting narrative of all three risks has been updated and the score of BAF risks 11 and 12 is recommended to change as outlined below:<br><br>**BAF 11** – the risk score is reduced to the target score of 8 (4 x 2) based on positive progress associated with sustainable staffing and retention.<br><br>**BAF 12** - the risk score is reduced to the target score of 8 based on work undertaken to support teaching hospital status with an emphasis on leadership development. The rationale for reducing the score for this risk is based on the priority actions from national staff survey results.<br><br>The BAF is currently being reviewed against the Trust's new strategy and the refreshed BAF will be shared with Committees in May 2024 and presented to the Board in June 2024 for approval. | | | | | | |
| **Trust strategic aims** | **Aim 1**<br>**Best care**<br>***Objectives 1-4*** | **Aim 2**<br>**Great team**<br>***Objectives 5-8*** | **Aim 3**<br>**Best value**<br>***Objective 9*** | **Aim 4**<br>**Great place**<br>***Objective 10-12*** | | | |

23

| | |
|---|---|
| | <table><tr><td>x</td><td>x</td><td>x</td><td>x</td></tr></table> |
| **Links to well-led key lines of enquiry** | ☒Is there the leadership capacity and capability to deliver high quality, sustainable care?<br>☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?<br>☒Is there a culture of high quality, sustainable care?<br>☒Are there clear responsibilities, roles and systems of accountability to support good governance and management?<br>☒Are there clear and effective processes for managing risks, issues and performance?<br>☒Is appropriate and accurate information being effectively processed, challenged and acted on?<br>☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?<br>☒Are there robust systems and processes for learning, continuous improvement and innovation?<br>☒How well is the trust using its resources? |
| **Previously considered by** | • Finance and Performance Committee on 28 March 2024<br>• Quality & Safety Committee on 28 March 2024 |
| **Action required** | The Board is asked to review the latest version of the BAF and approve it. |

West Hertfordshire Teaching Hospitals NHS Trust

**Agenda Item: 23**

**Trust Board meeting – 02 May 2024**

**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<br>• Strong management personalities may dominate<br>• Track record of success<br>• Professional background or expertise<br>• No contradictory evidence | • It is OK because how management have responded to questions from the Board has given me confidence by:<br>– Clear and logical explanations from Board members | It is OK because I have reviewed various reliable sources of information, such as:<br>– Independent information source<br>– Evidence of historical progress, outcomes |

| | | |
|---|---|---|
| | – What has happened; why it has happened and what is the response<br>– Management explanations are consistent | – Triangulation with other information |

2.5 The BAF comprises of a dashboard, which refers 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 March 2024.

3.2 Elements of the BAF were reviewed on 25 April 2024 by the Quality and Safety Committee and Finance and Performance Committee and no changes are recommended.

3.3 On 25 April 2024, the Patient Education and Research Committee reviewed an assessment of BAF risks 10 - 12 associated with the strategic priorities for the workforce. The supporting narrative of all three risks has been updated and the score of BAF risks 11 and 12 is recommended to change as outlined below:

**BAF 11** – the risk score is reduced to the target score of 8 (4 x 2) based on positive progress associated with sustainable staffing and retention.

**BAF 12** - the risk score is reduced to the target score of 8 based on work undertaken to support teaching hospital status with an emphasis on leadership development. The rationale for reducing the score for this risk is based on the priority actions from national staff survey results.

3.4 There are no areas of extreme risk (red) identified on the BAF. 12 risks are currently assessed as high (amber). Only limited assurance can be gained by the Board for these risks.

**4. Next Steps**

4.1 The BAF is currently being reviewed against the Trust's new strategy and the refreshed BAF will be shared with Committees in May 2024 and presented to the Board in June 2024 for approval.

**5. Risks**

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

**6. Recommendation**

6.1 The Board is asked to review and approve the latest version of the BAF.

**Matthew Coats**
**Chief Executive Officer**

May 2024

**BOARD ASSURANCE FRAMEWORK FOR 2023-24**

**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/ Jul 22 | Aug/ Sep 22 | Oct/ Nov 22 | Dec/ Jan 23 | Feb/ Mar 23 | April/ May 23 | June/ Jul 23 | Aug/ Sep 23 | Oct/ Nov 23 | Dec/ Jan 23/24 | Feb/ Mar 23/24 | 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 / QSC | | 20 (5 x 4) HIGH | 20 | 20 | 20 | 16 | 16 | 16 | 16 | 16 | 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. | Mary Bhatti/ QSC | 4019 4496 4497 | 20 (5 x 4) HIGH | 20 | 20 | 20 | 16 | 16 | 16 | 16 | 16 | 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. | Mary Bhatti/ QSC | 3828 4444 | 20 (5 x 4) HIGH | 20 | 20 | 20 | 20 | 20 | 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/ QSC | | 20 (5 x 4) HIGH | 20 | 20 | 20 | 16 | 16 | 16 | 16 | 16 | 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. | Kelly McGovern/ QSC | | 9 (3 x 3) Mod | 9 | 9 | 9 | 9 | 9 | 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 / QSC | | 20 4 x 5 HIGH | 20 | 20 | 20 | 20 | 20 | 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. | Rodney Pindai/ FPC | | 12 (3 x 4) Mod | 16 4 x 4 High | 12 3 x 4 Mod | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 16 | 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. | Rodney Pindai / FPC | | 16 (4 x 4) High | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 20 | 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. | Rodney Pindai / FPC | | 12 (3 x 4) Mod | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 16 | 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 | 9 | 9 | 9 | 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 | 12 | 12 | 12 | 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 | 12 | 12 | 12 | 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/ RPC | | 15 (5 x 3) | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 6 2 x 3 |
| | Redevelop our hospitals | 14 | If the confirmation of our capital allocation is delayed, it could lead to increased risk to the safe operation of the existing Watford hospital. | Alex White/ RPC | | 20 (5 x 4) | 20 | 20 | 20 | 20 | 20 | 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/ RPC | | 9 (3 x 3) | 9 | 9 | 9 | 9 | 9 | 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 |

| 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 | June/July | Aug/Sept | Oct/Nov | Dec/Jan | Feb/Mar | Target (2024) |
| 20 (5 x 4) | 20 | 20 | 20 | 20 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 12 (3 x 4) |

| Context | Gaps in Control and Assurance |
|---|---|
| The new legislation has an expectation of acute providers improving their collaboration with each other.<br><br>The pandemic has significantly impacted the provision of services. Collectively, we have extremely high waiting lists which will require a coordinated approach across the acute trusts in our Integrated Care System.<br><br>Some of our more specialised services serve relatively low patient numbers which makes it more difficult for them to withstand 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. | 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, reduce the impact of unplanned care demand on surgical activity and improve patient outcomes. The hub has appointed a Programme Director.<br><br>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.<br><br>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.<br><br>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** |
| **Review Date** | **Monthly** |
| **Exec Lead** | **Mary Bhatti** |
| **Reporting Committee** | **Quality Committee** |

**Risk Score**

| Residual | Apr/May | Jun/July | Aug/Sep | Oct/Nov | Dec/Jan | Feb/Mar | Apr/May | June/July | Aug/Sep | Oct/Nov | Dec/Jan | Feb/Mar | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 20 (5 x 4) | 20 | 20 | 20 | 20 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 9 (3 x 3) |

**Context**

We are in a recovery phase after 2 years of covid-19. The national stand-down directive for elective care and increase in referrals means that we now have a backlog of patients waiting to be treated.

Referral rates have increased as more patients access GP care again. However, there is a trend of more complex referrals being received because patients have delayed seeing their GPs. This increased level of clinical complexity has required more diagnostic work up and surgical intervention that is only suitable to be undertaken on the Watford site rather than at St Albans.

Our ability to further increase the progress of our recovery program is also affected by the willingness of clinicians to undertake additional work over above their contracted hours. This is due to a combination of factors such as personal fatigue and financial issues related to pensions and taxation which is a national issue.

The continued increase in emergency demand and admission rates is creating more outlying patients and increased use of surge areas which is reducing the amount of available ring-fenced elective care beds.

**Gaps in Control and Assurance**

We are unable to control the level of patient demand and are attempting to mitigate this with the following measures:

- Launched recovery plan which links with the submissions made in the annual plan.
- Established a monitoring and oversight governance structure. Elective activity meeting, 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, Patient portal 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 |
|---|---|---|
| Established outsourcing criteria – outsourced more complex patients.<br>Proactive reduction of 104 week waiters<br>Work on reducing long waits continues, with a small number of 78 week waits due to complexity and/or capacity remaining.<br>Focused work on delivering a reduction of 65 +week waits is delivering month on month improvements. | Referral profile post COVID has changed, with an increased proportion of urgent and cancer referrals.<br>There has been some uptake on additional and elective activity by the clinicians to support recovery.<br>EPR Review has highlighted a number of gaps in User knowledge therefore a training pack and process has been provided for existing staff and new starters.<br><br>urgent care pressures have resulted in a reduced elective bed base at WGH, limiting capacity for complex, WGH only cases.<br><br>Industrial action has necessitated the cancellation of routine procedures when consultant or junior doctor cover necessitates the prioritisation of other urgent activities. | Continuous review of demand and referral profile.<br>Monitoring of productivity by division/specialty.<br>Increased external performance oversight.<br>EPR – close working with trust's digital leader and participation in digital steering group.<br>Approval of business case for increased validation resources.<br>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.<br>Refreshed High impact patient flow actions to reduce use of surge to facilitate more elective activity in WGH.<br>Monitoring the rebooks following IA through The RTT programme board.<br><br>Launch of high impact change plan with 4 key areas of focus:<br>Data Quality<br>Theatre Productivity<br>Long wait improvement<br>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 | Mary Bhatti |
| Reporting Committee | Quality Committee |

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

| Context | Gaps in Control and Assurance |
|---|---|
| Continued increase in emergency care demand.<br><br>Upper threshold of ambulance conveyances has continued<br><br>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.<br><br>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 into exceptional escalation areas, resulting in decreased capacity for elective activity, particularly affecting Cardiology, Gastroenterology and complex surgical admissions. | We are unable to control the level of emergency patient demand and are attempting to mitigate this with the following measures:<br><br>- On going work with system partners to audit primary care restoration of services.<br><br>Conveyance prevention initiative pilots, running within partner organisations, have gone live with active monitoring of impact.<br><br>- Maximising our SDEC services to enable admission avoidance.<br><br>- 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 |
|---|---|---|
| • Patient Summit with system partners held September 2023, actions highlighted and follow up meeting booked for mid October.<br>• Urgent case review in Medicine has started, this will add another SDEC pathway to support emergency flow.<br>• Elective activity will be removed from Ambulatory care unit (ACU) by the beginning of October to allow more SDEC work go through ACU.<br>• Joint working with Radiology has reduced variation and number of CT requests.<br>• Expansion of the virtual hospital model to Acute Respiratory Infections and Frailty. Capacity in VH expanded to 75.<br>• Endoscopy removed from surge policy.<br>• Reduction of average surge beds in use over the last few months.<br>• Boarding policy reviewed, Triumphant relaunching usage across the bed base.<br>• Joint working EEAST re ambulance conveyances. | • Demand is outside of our control.<br>• Ongoing increases in mental health demand alongside mental health delays.<br>• Ambulance conveyances, when arriving in clusters, result in increased flow pressures to ED alongside the need for rapid handover and release.<br>• Increased in the number of ambulance conveyances this month. | • Participation in ICS UEC Board.<br>• Mutual aid support via ICB with regard to ambulance conveyance and delayed handovers (intelligent conveyancing).<br>• Joint working with HPFT to review KPIs for assessment and alternatives to acute hospital attendance for MH patients, focusing on community crisis support initiatives.<br>• A consultant has been placed in TAM to support senior decision making and improved use of the SDEC pathways.<br>• Ongoing work with CLCH and EAST to increase the usage of Call before Convey and reducing conveyances to ED, better use of SDEC and community pathways.<br>• Ops team using data and the control centre to provide live bed data to improve discharge planning 48 hours ahead and improved percentage earlier in the day.<br>• Implementing Boarding policy and improving discharge numbers to further reduce surge bed usage.<br>• Reenergising of the High Impact Patient Flow initiatives:<br>Patient assessment<br>Discharges<br>Control Centre<br>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 | June/July | Aug/Sept | Oct/Nov | Dec/Jan | Feb/Mar | Target |
| 20 (5 x 4) | 20 | 20 | 20 | 20 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 12 (3 x 4) |

| Context | Gaps in Control and Assurance |
|---|---|
| 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.<br><br>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. | 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.<br><br>The approval and implementation of an alternative pension scheme alongside movement at national level for a solution to be provided 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.<br><br>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 |
| Review Date | Monthly |
| Exec Lead | Kelly McGovern |
| Reporting Committee | Quality Committee |

| Risk Score | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Residual | Apr/May | Jun/July | Aug/Sep | Oct/Nov | Dec/Jan | Feb/Mar | Apr/May | June/July | Aug/Sept | Oct/Nov | Dec/Jan | Feb/Mar | Target |
| 9 (3 x 3) | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 6 (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.<br><br>Work has commenced on improving health inequalities within maternity services following the recommendations of the Ockenden report.<br><br>There is a clear need to build our understanding of health inequalities and take action to improve disparities.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>Internal – project plan to put structure in place.<br><br>Following internal mapping, we will develop a robust delivery plan.<br><br>A Promoting Inclusion project has commenced seeking to reduce inequalities and promote inclusion across our services.<br><br>The group have reviewed EDI data captured on EPR and identified gaps for improvement. The group are exploring research opportunities to understand how accessible our complaints and interpreting services are for patients from black, Asian and minority ethnic groups and the incidents which they are more likely to experience. |

| 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 | | Risk Score | | | | | | | | | | | | |
| Review Date | Monthly | | Residual | Apr/May | Jun/July | Aug/Sep | Oct/Nov | Dec/Jan | Feb/Mar | Apr/May | June/July | Aug/Sept | Oct/Nov | Dec/Jan | Feb/Mar | Target |
| Exec Lead | Toby Hyde | | 20 (4 x 5) | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 10 (2 x 5) |
| Reporting Committee | Quality Committee | | | | | | | | | | | | | | | |

| Context | Gaps in Control and Assurance |
|---|---|
| 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.<br><br>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.<br><br>Our ability to transform services in the medium to long term directly depends on a successful outcome for our redevelopment programme. | 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 the service to facilitate earlier discharge of patients and reduce hospital admissions. We are seeking to go live with further pathways and expand capacity during 23/24 in line with our revised trajectory submitted to HWE ICB.<br><br>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 contribute to the recovering our elective activity. | We need to do a lot in a relatively short space of time – resourcing capacity and working at pace is challenging.<br><br>We will need to manage within varying G&A bed stock through 2023/24, placing additional emphasis on the need to reduce demand through system-wide initiatives. | Daily discussions within the trust and across HWE ICS on how we can improve flow through the system and provide safe, high quality care to our patients.<br><br>Updated VH strategy and expansion to include frailty pathway (which went live in July 2023). Ongoing monitoring to ensure we are tracking throughput, capacity and impact of the VH model. |

| 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 | Rodney Pindai |
| Lead Committee | Finance and Performance Commitee |

**Risk Score**

| Residual | Apr/May | Jun/July | Aug/Sep | Oct/Nov | Dec/Jan | Feb/Mar | April/May | June/July | Aug/Sept | Oct/Nov | Dec/Jan | Feb/Mar | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12 | 16 ↑ | 16 ↔ | 12 ↓ | 12 ← | 12 | 12 | 12 | 12 | 12 | 12 | 12 → | 16 ↑ | 8 (2x4) |

**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.<br>Efficiency programme governance in place to support Divisions in developing efficiencies.<br>National work to test resources necessary to respond to a 7.5% increase in emergency care demand.<br><br>Divisions have set out and signed off high level plans for increasing elective activity.<br><br>Increased support from the Centre for Elective Recovery Funding. | Inflation effect manifests the worst case and additional inflation funding is not made available.<br><br>Efficiency programme governance fails to support delivery of £15m general savings and £2.9m EPR related savings.<br><br>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.<br><br>Internal audit of financial governance planned.<br><br>Stronger ICP governance.<br><br>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** | **Rodney Pindai** |
| **Lead Committee** | **Finance and Performance Commitee** |

**Risk Score**

| Residual | Apr/May | Jun/July | Aug/Sep | Oct/Nov | Dec/Jan | Feb/Mar | April/May | June/July | Aug/Sept | Oct/Nov | Dec/Jan | Feb/Mar | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 20 | 20 | 20 | 8 (2x4) |

**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 emergency demand only partially controlled through local partnership working.
Control of workforce within agreed establishments
Costs of industrial action
Achievement of efficiencies on the context of the above pressures

**Progress**

| Positive progress including future opportunities | Current challenges including future risks | How challenges are being managed |
|---|---|---|
| National dialogue regarding inflation.<br>Pandemic trajectory appears to be reducing overall, despite some spikes in infection rates.<br>National dialogue regarding industrial action costs<br>Recovery plan developed | Meeting the elective activity targets and triggering ERF funding will be extremely challenging.<br>Management of emergency demand including mental health | Performance reviews, Committee assurance, individual performance appraisals, regular communication with all divisions regarding targets and actions/resources needed to meet those targets.<br>Recovery plan<br>National dialogues |

| 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 | Rodney Pindai |
| Lead Committee | Finance and Performance Commitee |

**Risk Score**

| Residual | Apr/May | Jun/July | Aug/Sep | Oct/Nov | Dec/Jan | Feb/Mar | April/May | June/July | Aug/Sept | Oct/Nov | Dec/Jan | Feb/Mar | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 16 | 8 |

| Context | Gaps in Control and Assurance |
|---|---|
| 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. | ICB in its infancy and the lack of a published recognised ICB long term financial plan.<br><br>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.<br>Developing financial regime. | Transparency of assumptions.<br>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 | October 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 | June/July | Aug/Sept | Oct/Nov | Dec/Jan | Feb/Mar | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12 | 12 | 12 | 12 | 12 | 12 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 6 (3x2) |

| Context | Gaps in Control and Assurance |
|---|---|
| The staff survey has demonstrated that we continue to have variations on how staff are treated based on their protected characteristics. The Trust is diverse with nearly 50% 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. | The main gap was measuring the outcomes from the interventions that have been implemented. In addition, there are gaps recently developed such as career coaching and an extensive leadership development programme alongside the Kings Fund. |

| Progress | | |
|---|---|---|
| **Positive progress including future opportunities** | **Current challenges including future risks** | **How challenges are being managed** |
| The EDI steering group is now well established and has successfully overseen strategic developments. This includes annual reports associated to WRES/WDES, EDS, Pay Gap analysis and PSED provided to Board in March. There has been good progress in priority areas including reciprocal mentoring in May 2024 and values-based recruitment. New networks established for Veterans, vegans and Women's network. In addition, the programme of cultural awareness | Ensuring we make improved progress that demonstrates broader diversity across all areas with an emphasis on senior roles and demonstrating equity of opportunities for learning and education, particularly with the introduction of the Kings Fund programme. | The EDI steering group in overseeing the main priorities alongside TMC on an operational basis and PERC for strategic assurance. |

| | | |
|---|---|---|
| sessions commenced in June 2024 and Trust wide cultural and interpersonal awareness incorporated as part of internal leadership development programmes. | | |

| **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** | **October 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 | June/July | Aug/Sept | Oct/Nov | Dec/Jan | Feb/Mar | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 16 | 16 ← | 16 | 16 | 16 | 16 → | 12 ↓ | 12 ← | 12 | 12 | 12 | 12 → | 8 ↓ | 8 (4x2) |

| **Context** | **Gaps in Control and Assurance** |
|---|---|
| Staff retention is one of the main challenges facing the NHS. WHHT is now demonstrating continued reduction in levels of turnover over a sustained period of time. There continues to be challenged specialities and staff groups with relevant mitigations in place. The focus has moved to hotspot areas and mitigations to support positive cultural changes. | Effective long term workforce modelling plans across the corporate organisation as well as for divisional teams and clinical services. |

| **Progress** | | |
|---|---|---|
| **Positive progress including future opportunities** | **Current challenges including future risks** | **How challenges are being managed** |
| The new induction programme to support new starters in the first 12 months of their employment has been particularly successful with continued improvements in turnover rates.<br><br>The new framework for staff development and education is a key area based on feedback from our staff survey in terms of supporting career development and therefore assist in retaining staff. | Alongside reductions in the turnover rate and effective recruitment there continue to be areas that require further support such as AHPs, Maternity & paediatrics. However there have been improvements.<br><br>Main challenges around retention associated with vertical integration and career development opportunities. | Enhanced and more regular and focused exit interview reports detailing reasons for leaving.<br>New initiatives associated to new starters with additional support to mitigate the turnover rates for new staff.<br>Effective and successful recruitment both locally to address the aspirations of financial efficiencies, productivity and the NHS new long term workforce plan. |

| **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** | **October 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 | June/July | Aug/Sept | Oct/Nov | Dec/Jan | Feb/Mar | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 16 | 16 | 16 | 16 | 16 | 16 | 12 | 12 | 12 | 12 | 12 | 12 | 8 | 8 (4x2) |

| **Context** |
|---|
| The staff survey has provided clear feedback on priority area where we will focus over the next 12 months. These include:<br>1. **Getting the basics right for our staff** – staff rooms/ rest areas, working toilets, water, access to nutritious/affordable food.<br>2. **Bullying & harassment** – addressing unwanted behaviours and setting expectations.<br>3. **Learning and development** – improving promotion/ awareness of career progression & training opportunities.<br>4. **Flexible working** –improving promotion of opportunities, engaging with managers. |

| **Gaps in Control and Assurance** |
|---|
| Leadership development 3 year rolling plans aligned to divisional and Trust strategic and operational priorities.<br>A succession plan that plots staff development with relevant training and leads to progression within the Trust associated to career and skill development.<br>An appraisal process, within a designated appraisal window that is 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 has been used as a catalyst to enhance our strategy of developing a learning organisation culture across all staff groups.<br>Divisional plans associated to leadership development and succession planning have commenced with new programme to be launched in June 2024. The values and behaviours launched in March 2024. | 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.<br>Providing a clear set of development offers across a wide range of staff and also prospective staff that includes work experience, apprenticeships, skill | The Education and Learning group aligned to the People Strategy reports operationally to TMC and with strategic assurance to PERC. |

| | | |
|---|---|---|
| | development and leadership development in a cohesive package. | |

| **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 | **Risk Score** | | | | | | | | | | | | |
| **Review Date** | Monthly | **Residual** | **Apr/May** | **Jun/July** | **Aug/Sep** | **Oct/Nov** | **Dec/Jan** | **Feb/Mar** | **Apr/May** | **June/July** | **Aug/Sept** | **Oct/Nov** | **Dec/Jan** | **Feb/Mar** | **Target** |
| **Exec Lead** | Paul Bannister | **15** | **15** | **15** | **15** | **15** | **15** | **15** | **15** | **15** | **15** | **15** | **15** | **15** | **6 (2 x 3)** |
| **Lead Committee** | Redevelopment Programme | | ← | | | | | | | | | | | → | |

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

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.

| **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.<br><br>Meetings are progressing with whole of executive to go through the rationale for each of the most significant digital benefits commencing with the digital command centre on 21 June 2021. | The Digital Programme is funded to the end of March 2022. Digital funding will be clarified by the next round of financial planning or via an update from NHP. | Addressed within business plan and NHP updates. |

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

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Strategic Priority** | Redevelop our hospitals | | | | | **Risk Score** | | | | | | | | | |
| **Review Date** | Monthly | **Residual** | **Apr/May** | **Jun/July** | **Aug/Sep** | **Oct/Nov** | **Dec/Jan** | **Feb/Mar** | **Apr/May** | **June/Jul** | **Aug/Sep** | **Oct/Nov** | **Dec/Jan** | **Feb/Mar** | **Target** |
| **Exec Lead** | Alex White | **20** | **20** | **20** | **20** | **20** | **20** | **20** | **20** | **20** | **20** | **20** | **20** | **20** | **12 (3x4)** |
| **Lead Committee** | Redevelopment Programme | | ← | | | | | | | | | | | → | |

| **Context** | **Gaps in Control and Assurance** |
|---|---|
| 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.<br><br>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. | 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.<br><br>The enabling works business case has been submitted and the pathology element is expected to be approved at the end of September<br><br>There is increased consensus among key stakeholders that a full rebuild of WGH is necessary.<br><br>The Secretary of State for Health & Social Care has confirmed that the new hospital at Watford will be fully funded. This was confirmed by the Prime Minister when he visited site in the summer of 2023. | The infrastructure of the trust continues to deteriorate, increasing risk associated with delays<br><br>The delay to approval of the enabling works business case will impact the timeline of the overall project.<br><br>The Outline Business Case is being updated ready for submission to the NHP. | 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.** |
|---|---|

| | | Risk Score | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Strategic Priority** | Environmental sustainability | | | | | | | | | | | | | |
| **Review Date** | Monthly | **Residual** | **Apr/May** | **Jun/July** | **Aug/Sep** | **Oct/Nov** | **Dec/Jan** | **Feb/Mar** | **Apr/May** | **June/July** | **Aug/Sep** | **Oct/Nov** | **Dec/Jan** | **Feb/Mar** | **Target** |
| **Exec Lead** | Toby Hyde | **9** | **9** | **9** | **9** | **9** | **9** | **9** | **9** | **9** | **9** | **9** | **9** | **9** | **4 (2 x 2)** |
| **Lead Committee** | Redevelopment Programme | | ← | | | | | | | | | | | → | |

| **Context** | **Gaps in Control and Assurance** |
|---|---|
| The NHS has a responsibility to provide high quality health care whilst protecting human health and minimising negative impacts on the environment.<br><br>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.<br><br>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 estate. | Have Green Plan, started to implement, clear governance route through GPC.<br><br>No current gaps identified. |

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.<br><br>A Sustainability Steering Group has been formed to help monitor, manage, and report on the progress of the Plan's actions.<br>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

# Trust Board
# 02 May 2024

| | |
|---|---|
| **Title of the Paper** | **Risk Management Report** |
| **Agenda Item** | **24** |
| **Presenter** | **Dr Mike van der Watt, Chief Medical Officer** |
| **Author** | **Brian Haig – Head of Patient Safety & Risk** |
| **PURPOSE** | *Please tick the appropriate box*<br>*For approval*: x; *For discussion*: x; *For information*: |
| **EXECUTIVE SUMMARY** | The purpose of this report is to update the Risk Governance Group on matters the Group is required to note or respond to with actions to facilitate service improvement and / or compliance with legislative and regulatory requirements in relation to Risk Management. The Group should assure itself that the Risks presented are accurate, up to date and are being effectively managed.<br><br>All risks should be continually updated with comprehensive reviews detailing the Action taken since the risk was identified/or last reviewed. This should include the following as a minimum:<br>1. What activity/actions have been undertaken since the last review<br>2. What impact has this had on the likelihood and consequence.<br>3. What activity/action is planned to be undertaken going forward<br><br>As of 5 April 2024 the Trust had 148 risks on the risk register. Of these 14 Risks were on the Corporate Risk Register, i.e. those with a risk score of 15 or above.<br><br>Risks by Division - 5 Apr 2024.xlsx<br><br>No new risks were presented for discussion.<br><br>No risks were presented with reduced risk scores.<br><br>No risks with increased scores were considered.<br><br>No merged risks were considered.<br><br>No risks were considered for closure. |

24

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|---|---|
| | For the purposes of this report, any updates added to the Risk Register on or before 11 April 2024 have been included.<br><br>All risks on the Corporate Risk Register were updated with a current review.<br><br>The Group discussed the current position of risks within the Trust and examined the risks on the Corporate Risk Register with each Division providing oversight of ongoing activity to manage the risk. |
| **TRUST STRATEGIC AIMS**<br><br>*(Please indicate which of the four aims is relevant to the subject of the report)* | **Aim 1 Best care** — ***Objectives 1-4*** — ✓<br>**Aim 2 Great team** — ***Objectives 5-8*** — ✓<br>**Aim 3 Best value** — ***Objective 9*** — ✓<br>**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?<br>☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people and robust plans to deliver?<br>☒Is there a culture of high quality, sustainable care?<br>☒Are there clear responsibilities, roles, and systems of accountability to support good governance and management?<br>☒Are there clear and effective processes for managing risks, issues, and performance?<br>☒Is appropriate and accurate information being effectively processed, challenged, and acted on?<br>☒Are the people who use services, the public, staff, and external partners engaged and involved to support high-quality, sustainable services?<br>☒Are there robust systems and processes for learning, continuous improvement, and innovation?<br>☒How well is the Trust using its resources? |
| **PREVIOUSLY CONSIDERED BY** | Committee/Group — Date<br>Risk Governance Group — 11/04/2024<br>Quality and Safety Committee — 25/04/2024 |
| **ACTION REQUIRED** | The Board is asked to receive this report for discussion of the corporate risk register and Trust risks |

24

West Hertfordshire Teaching Hospitals NHS Trust

**Agenda Item 24**

**Trust Board – 02 May 2024**

**Corporate Risk Report**

**Presented by: Dr Mike van der Watt, Chief Medical Officer**

## Purpose

The purpose of this report is to update the Board on matters the Risk Governance Group was required to note or respond to with actions to facilitate service improvement and / or compliance with legislative and regulatory requirements in relation to Risk Management. The Group assured itself that the Risks presented were accurate, up to date and are being effectively managed.

Of note is that all risks should be continually updated with comprehensive reviews detailing the action taken since the risk was identified/or last reviewed. This should include the following:

1. What activity/actions have been undertaken since the last review
2. What impact has this had on the likelihood and consequence
3. What activity/action is planned to be undertaken going forward

As of the date of extraction the Trust had one hundred and forty-eight (148) risks on the risk register. Of these fourteen (14) Risks were approved on the Corporate Risk Register, i.e. those with a risk score of 15 or above.

For the purposes of this report, any updates added to the Risk Register on or before 5 April 2024 have been included and the discussions arising from the Risk Governance Meeting have been included.

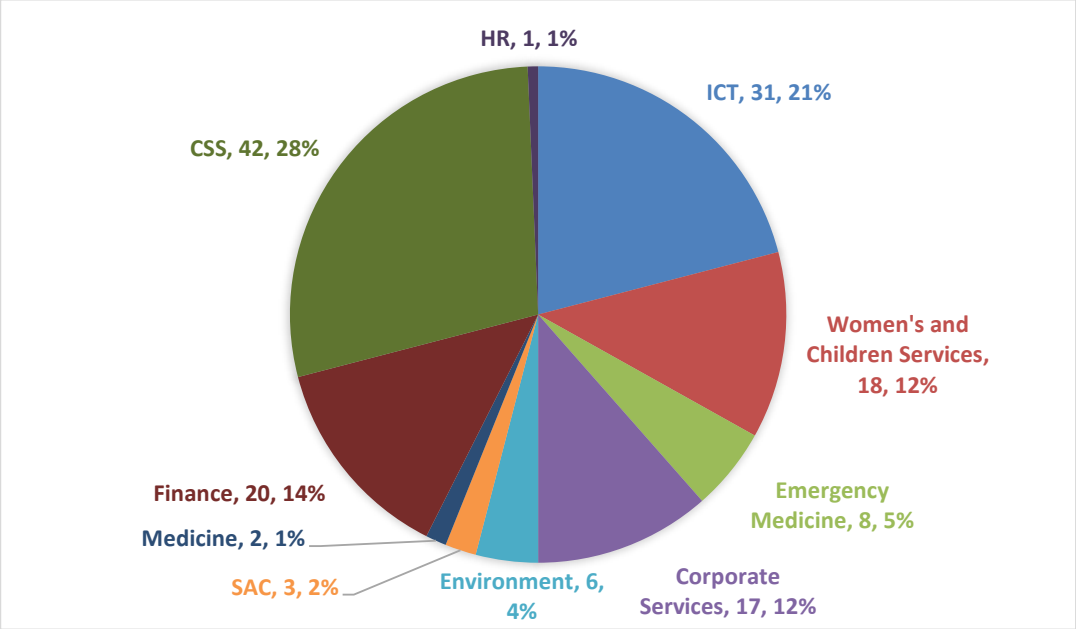
## Key Points for Action/Noting

| Section | | Key points for action/noting |
|---|---|---|
| 1.1 | Risk Status and KPI | Overall Risks are updated in a timely manner and overall 97% of all risks have reviews which are in date. |
| 1.2 | Overdue Risks | 4 risks are overdue and require an update – these will be chased up with the Risk Owners to be updated within the next 5 working days |
| 1.3 | Qualitative Risk overview | Qualitive overview of Risks currently show the following:<br>• 32 of risks describe existing issues rather than future risks<br>• 95% of all risks lack a structured SMART action plan to manage the risk<br>• 69 risks are less than 2 years old<br>• 43 risks are over 2 years old (up to 4 years 11 months) |

| | | |
|---|---|---|
| | | • 32 risks are over 5 years old (up to 9 years 11 months)<br>• 4 risks are over 10 years old<br>• 104 risks with no updated Controls<br>• 82 risks lack effective Assurances<br>• 11 risks do not have a Target Rating |
| 1.4 | New Risk(s) | None presented |
| 1.5 | Escalated/Increased/Decreased/Merged Risks | None presented |
| 1.6 | Risks for discussion | None presented |
| **1.7** | Risks for closure | None presented |
| **1.8** | Current CRR | No escalation of risks |

## 1.0 Risk Overview

There are a total of 148 open risks within the Trust. This is an increase of one (1) since the last report.




All current risks are shown within the embedded spreadsheet. These can be filtered by any column as required. Please contact the Corporate Governance Team if you wish to view the embedded document below.

Comprehensive
Risk Register - Oper

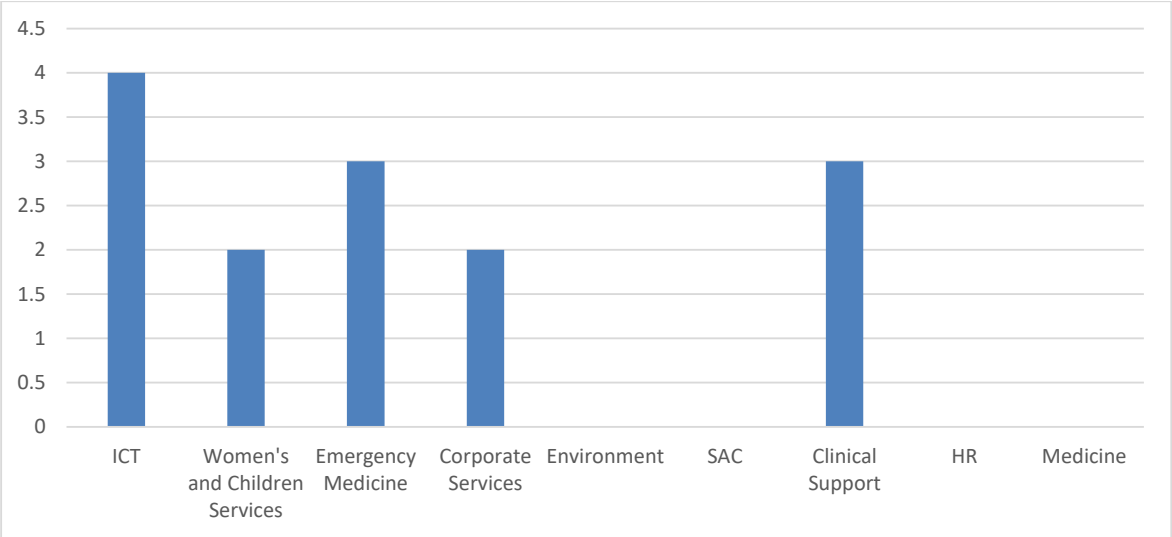
## 1.1 Risk Status, KPI and overall stats.

KPI performance shows that against a target of all risks being updated within their review timeframes 97% were compliant with only 4 being overdue. Corporate services have significantly improved since the last reporting period.

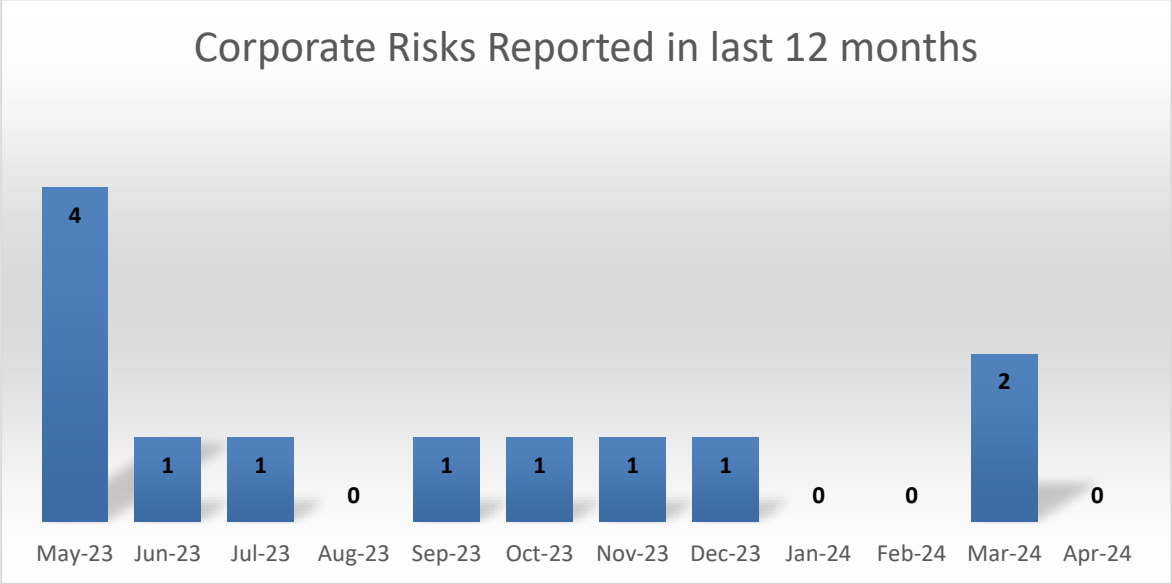
| | | Risk Score | | | | | |
|---|---|---|---|---|---|---|---|
| Division | Total Risks | 1-3 | 4-6 | 8-12 | 15-25 | Reviews in date | % in date |
| WACS | 18 | 0 | 2 | 14 | 2 | 18 | 100% |
| Emergency Medicine | 8 | 0 | 1 | 4 | 3 | 8 | 100% |
| Medicine | 2 | 0 | 1 | 1 | 0 | 2 | 100% |
| SAC | 3 | 0 | 2 | 1 | 0 | 3 | 100% |
| Environment | 6 | 0 | 0 | 6 | 0 | 6 | 100% |
| CSS | 42 | 1 | 4 | 34 | 3 | 42 | 100% |
| ICT | 31 | 0 | 7 | 20 | 4 | 30 | 98% |
| HR | 1 | 0 | 0 | 1 | 0 | 1 | 100% |
| Corporate Services | 17 | 1 | 7 | 7 | 2 | 14 | 82% |
| Finance | 20 | 0 | 6 | 14 | 0 | 20 | 100% |

The Corporate Risk Register made up 9.45% of all open risks on the Trust's risk register.

The graph below demonstrates the distribution of the corporate risk register risks by division.




Since May 2023, 12 risks have been added to the CRR with the highest number of 4 being added in May 2023.




## 1.2 Overdue Risks

On the date of the RGG meeting only 4 risks had passed their review date, one (1) for ICT and three (3) for Corporate Services. It was recommended that these risks were updated within the next 5 working days.

Frequency of reviews as per Trust policy:
Risks scored 1 – 3 must be reviewed every 12 months,
Risks scored 4 – 6 Six monthly.
Risks scored 8 – 12 every 1 to 3 months.
Risks scored 15 or above must be reviewed monthly.

## 1.3 Risk Register Qualitive overview.

*Risks on the risk registers should be kept up to date and be accurate, to ensure there is effective oversight of risks within the Trust.*

Qualitive overview of Risks currently show the following:

- 32 number of risks describe existing issues rather than future risks.
- 95% of all risks lack a structured SMART action plan to manage the risk.
- 69 risks are less than 2 years old.
- 43 risks are over 2 years old (up to 4 years 11 months)
- 32 risks are over 5 years old (up to 9 years 11 months)
- 4 risks are over 10 years old.
- 104 risks with no updated Controls
- 82 risks lack effective Assurances.
- 11 risks do not have a Target Rating

Risks continue to present a mixture of issues and risks and would greatly benefit from fresh reviews to reflect their accuracy and whether the original description remains accurate.

Actions on risks should be regularly reviewed and closed when complete with an update. The current focus should be on ensuring all risks have actions documented to evidence how a risk is being progressed/mitigated.

Actions do not need to cover each individual task required, but should provide the high-level work required, have a lead assigned and a planned completion date.

All Risks should have SMART actions detailed.

SAC, Environment, Medicine, and Emergency Medicine have undertaken reviews with the Head of Patient Safety & Risk and their risks are now much improved with issues having been transferred to their Issues log. CSS have had a review and are in the process of reviewing their risks and have 28 of their risks which are over 2 years old. WACS have reviewed their risks, and these have been reduced.

ICT risks are increasing and currently have 17 risks which are over 2 years old.

The Head of Patient Safety & Risk continues to undertake significant work to improve the highlighted areas above through education and guidance. The Trust has improved their processes and work in this area of risk management; however this needs to be maintained and continue to improve, especially in the area of SMART action planning.

## 1.4 New Risks

*Risks should be discussed at divisional governance meetings and approved by the Divisional Triumvirate before being added to the risk register to ensure multidisciplinary and senior review. This review of all new risks is in line with best practice to deliver a consistent approach and provide assurance that the risk narrative including controls, assurance and risk rating are appropriate.*

No new risks were presented for discussion to be added to the Corporate Risk Register

## 1.5 Risks for reduction/closure/increased/merged risk score.

No risks were presented for closure/reduction or increase in Risk Score

## 1.6 Risks for Discussion

No risks were being presented for discussion.

## 1.7 Possible Emerging Risks (Horizon Scanning)

The Trust found itself in the position of having a significant overspend at the end of the last financial year. Therefore, it is likely that there is a possibility that Divisions may in this financial year find themselves overspending their budget.

As such this presents a risk to operational services that unless the possibility of an overspend is effectively managed these may be negatively impacted towards the latter half of 2024/25. Controls and mitigation should be implemented against a risk to ensure that such an overspend is either prevented or minimised.

**RGG Comment:** Discussion took place with regard to ensuring that the Divisions considered this as part of a forward-looking risk, as there exists a possibility of an overspend for this financial year. Finance were present and will link in with Head of Patient Safety & Risk to ensure an overarching risk is created and which the Divisions will feed into. This should detail the work being undertaken and provide a oversight of all divisional activity to ensure that assurance can be given that this is effectively managed. Consideration will be given as to whether this needs to be added to the Corporate Risk Register in due course.

## 1.8 Current Corporate Risk Register

*All Risks on the Corporate Risk Register should be reviewed to ensure that the rating is accurate, controls are up to date and assurances are effective. All Risks should be discussed at the Divisional/Departmental Governance Meetings and updated monthly.*

There are 14 Risks on the Corporate Risk Register. All risks have been updated with a current review. RGG comments are shown in Amber.

| Risk ID | Risk Title | Risk Register | Risk opened | Current Rating (L x C) | Date Next Review Due | Risk Owner | Executive Lead |
|---|---|---|---|---|---|---|---|
| 20 | Reduced patient flow through the Emergency department (ED) | Emergency Medicine | 15/03/2022 | 15 (3 x 5) | 03/05/2024 | Ms Sarah Cato | Kelly McGovern – Chief Nurse |
| **Risk Description:**<br>At time patient flow through the ED is reduced. this can be for a variety of reasons which impact on each other and exacerbate the situation. causes include<br>High numbers of patients referred from the Urgent treatment Centre (UTC) Reduced capacity / opening / staffing of the UTC<br>Capacity pressures within the Trust, including bed closure due to IPC constraints, number of admissions exceeding number of discharges, discharged occurring later in the day<br><br>The reduced flow through the ED results in the department becoming overcrowded, insufficient assessment spaces to see patients high number of patients waiting to be transferred to other areas of the trust - assessment and inpatient areas. overcrowding and excessive times spent in the ED can have a detrimental effect on the patient's clinical care, mortality, and experience. | | | | | | | |
| **Risk Review:** Score, mitigation, and controls remain unchanged. Trust full capacity protocol has been agreed and implemented as needed. If patients are identified as suitable for the patient lounge the bed becomes available to the operational teams for use. The patient lounge is now open earlier to facilitate early discharges. Wards are encouraged and continue to identify patients suitable for reverse boarding. Focus within the trust/division on prompt discharges/discharge planning which is reviewed at multiple forums including divisional performance review, OPFG and patient flow summit. Considerable work is taking place within the division supported by ops and specialties to ensure flow is maintained through EAU and AAU ensuring that short stay patients remain in the AAU and those patients requiring specialty / longer stays are moved to PMOK which will also support a reduced length of stay. EAU is working well as an assessment unit utilising chair spaces as much as possible which in turn is having a positive impact on the flow from ED and it is also enabling Frailty to assess more patients. | | | | | | | |
| **RGG Comment:** ED were able to provide a comprehensive update on the risk and the activity that has been undertaken and the Chief Nurse is working with ED as part of improvements projects. No change to Risk score or mitigation at present and this will be continually kept under review by senior management in the Trust, including Executive level. | | | | | | | |

| Risk ID | Risk Title | Risk Register | Risk opened | Current Rating (L x C) | Date Next Review Due | Risk Owner | Executive Lead |
|---|---|---|---|---|---|---|---|
| 21 | Failure to meet performance KPIs within the Emergency Department (ED | Emergency Medicine | 15/03/2022 | 16 (4 x 5) | 03/05/2024 | Ms Sarah Cato | Kelly McGovern – Chief Nurse |

**Risk Description:**
There is a national need to improve ambulance response times within the community, particularly category 1 and 2 patients. There is a direct correlation between ambulance delays within emergency departments and ambulances inability to meet their response times, which could lead to significant patient harm and risk of death. The focus to improve ambulance offload times with the acute Trust has increased and a updated trajectory has been agreed.

There is a risk that this trajectory will not be met. There may be financial and reputational consequences as a result.
The ability to release ambulance crews has been severely hindered by the capacity and flow challenges faced by the ED, meaning that there frequently delays more than one hour to release crews. Various work streams are in place to support improved flow and performance against the KPI's in addition to controls and mitigation's for this specific risk.

**Risk Review:** Risk score, controls and assurances remain the same and have been reviewed. A full capacity protocol/policy is in place, with the aim of providing early flow from ED to the wards this enables a more effective management of the department with adequate assessment spaces to see/treat patients. This is also supported by improving the flow of patients through the department which is impacted significantly by continued flow of patients though EAU and AAU and onto specialty wards. Continual review of pathways and processes is undertaken within ED to enable early assessment and decision making in relation to patients. There was a national focus on the four-hour KPI for the month of March with additional senior presence supporting this within the ED, this enabled the trust to meet the target in the month of March and work is now in place to continue/maintain this level of performance for 24/25.

**RGG comment:** ED were able to provide a comprehensive update on the risk and the activity that has been undertaken and the Chief Nurse is working with ED as part of improvements projects. No change to Risk score or mitigation. There is improvement and it may be that if this is sustained the risk can be reduced, however at present this is not the case.

| Risk ID | Risk Title | Risk Register | Risk opened | Current Rating (L x C) | Date Next Review Due | Risk Owner | Executive Lead |
|---|---|---|---|---|---|---|---|
| 22 | Challenges in meeting the needs of Mental health Patients within the Emergency Medicine division | Emergency Medicine Risk Register | 04/05/2022 | 15 (3 x 5) | 03/05/2024 | Jennifer Windle Mercy Vincent | Kelly McGovern – Chief Nurse |

**Risk Description:**
The Trust is experiencing a significant increase in Mental Health patients attending the Emergency Department, some of whom require admission to AAU/EAU awaiting placement/service provision. Decrease support in community, limited bed capacity, limited 136 suite capacity, less support resource at weekends.

EFFECT :- This patient group spend more time in ED due to their complexity and the requirement for multi - agency contribution these patients can be in the department a very long time. Patients requiring a mental health bed can wait up to 72 or longer hours for a bed to be identified. If they need medical admission or Hertfordshire Partnership Foundation Trust (HPFT) is unable to find a MH bed for them within 12 hours of patients' admission. The nursing team in Emergency Medicine are not trained in managing the patients with mental health challenges.

IMPACT :- The ED is not the best place for this group of patients. It is a busy noisy environment and lots of movement may create increased anxiety for these patients. There is only 1 mental health room and at times there are several patients waiting for MH beds. This means that the patients are nursed in other areas of the department impacting the overall capacity, meaning that the ability to see all patients within an acceptable period is affected. When patients go out of the building for example to smoke there is an increased risk of absconding from the hospital or inflicting self-harm. This poses a risk to patients' safety, increased complaints and incidents and trust reputation may be compromised.

**Risk Review:** Risk score, controls and mitigation remain unchanged. Both MH rooms with toilet facilities in ED have been refurbished and are in use. SR 18 in AAU level 1 has been completed, risk assessment to be reviewed by Chief Nurse. The pilot for the Right place right care process (RPRC) for patients under the care of Section 136 is now completed. The trust is liaising with HPFT regarding RPRC and how this can be safely implemented and HPFT are in the process of appointing a designated RMN to support this. The trust is currently advertising for a mental health matron to support pathways/care for MH patients across the trust. Daily reporting of MH within the department and escalation of MH bed requests continues. Ongoing work with Security, Police and MHLT to try to maintain safety of patients and staff. ED are regularly meeting with Police +- Security. MH is one of the priorities within the trust PSIRF framework, initial mapping and follow up meetings have taken place and an action plan will be developed. MHSG has not met since last risk review as per previous update, next meeting planned and risk to be discussed with potential de-escalation from Corporate register.

**RGG Comment:** ED are progressing activity and it is hoped that the improvements can result in the risk score being reduced. At present the risk remains the same with no changes.

| Risk ID | Risk Title | Risk Register | Risk opened | Current Rating (L x C) | Date Next Review Due | Risk Owner | Executive Lead |
|---|---|---|---|---|---|---|---|
| 25 | Trust Bleep System Failure leading to inability to utilise alert systems across the Trust | ICT Risk Register | 12/06/2017 | 16 (4 x 4) | 03/05/2024 | Charlie Hawkridge<br>Jo Brown | Paul Bannister – Chief Information Officer |

**Risk Description:**
Cause: Equipment damage or failure due to: age of equipment, inadequate environmental controls, and capacity limitations and "supportability" of legacy infrastructure (single supplier). Failure of the PABX system.
Effect: Bleep System Service available.
Impact: Patient or staff harm as the Trust will be unable to communicate or raise alerts rapidly to support:
•crash teams in the event of an emergency
•site alert in the event of a fire alarm activation
•alert staff in the event of a lift entrapment
•security in the event of a security emergency

**Risk Review:**

• Increase stock of new frequency pocket bleeps based on the results from the validation exercise.
o 125 old devices need to be replaced, we have 50 available that can be issued now, which Switchboard are contacting the bleep holders to swap out now. Order has been placed with Daisy for additional 80 pocket bleeps – awaiting a delivery date which has been chased again today.

• Replace old bleeps still in use for all those on the critical cascade groups
o Full deployment is relying on the delivery of the additional pocket bleeps, they will be issued to Switchboard who will bleep the holders of the devices needing to be replaced.

• Provide assurance to operational, clinical, and executive teams that the three issues preventing the November go-live have been addressed.
o Meeting in diary 17/4/2024 with Richard Burridge, Sol Brown, and Sean to agree go-live can proceed.

• Go live at St Albans City Hospital and Hemel Hempstead roll over the pilot into live – complete.
o Feedback from pilot has been positive.
o St Albans City Hospital and Hemel Hempstead have continued to use the Android mobile and Bleep App and is complete except for outstanding element of the telephony changes, which cannot be done until Watford is cutover.

• Finalise dates with the supplier for enabling works and switchover at Watford
o Assuming go ahead to proceed is given at the meeting on 17/4/2024 and that we have received the delivery of additional pocket bleeps in the next 2-weeks, the expected project completion date will be 31st May 2024.

**RGG Comment:** Comprehensive update noted. No final timeframe can be given for completion and it was noted that at the last QSC concerns were raised that this risk had been created in 2017 and that progress was slow. Discussion took place which highlighted that as the project progressed new challenges were identified which had caused delays as each was resolved in turn. It was stated that Chief Information Officer for the Trust is providing additional updates to the Board.

| Risk ID | Risk Title | Risk Register | Risk opened | Current Rating (L x C) | Date Next Review Due | Risk Owner | Executive Lead |
|---|---|---|---|---|---|---|---|
| 27 | Possibility of a Cyber Security Incident arising from vulnerabilities within our network-connected systems | ICT Risk Register | 20/05/2020 | 15 (3 x 5) | 03/05/2024 | Luke Drewer Jo Brown | Paul Bannister – Chief Information Officer |

**Risk Description:**
Cause: An internal, external malicious or unintentional act will exploit vulnerabilities (a weakness or flaw) in the Trust clinical and/or information systems, software, hardware, or organisational processes.

Effect: Loss of, or disruption to, Information and Communication Technology (ICT) services, network-connected systems, data, or both.

Impact: Delays or disruption to patient workflows, information flows, communications, or both. Reduce productivity leading to patient pathway delays and backlogs. Potential for Financial and Reputational Damage.

Any cyber or cybersecurity threat seeks to damage data, steal data, delete data, or disrupt digital life in general. Cyber threats include computer viruses, data breaches, Denial of Service (DoS) attacks, ransomware, phishing/spear-phishing attacks, man-in-the-middle attacks, etc.

**Risk Review:**
What activity have we undertaken since the last review?
Changes implemented to remove vulnerabilities TLS 1.0 and 1.1 across the estate. Majority have been successful (13) however, follow up scans identified 4 outstanding servers – these are being investigated and plans drawn up to remediate.
All Windows 7 desktop operating systems removed on the managed device estate.
SSL certificate vulnerabilities under investigation as to what can safely be done to either mitigate or remove.

2 (out of 13) Windows 10 third party managed devices have been upgraded to supported operating system versions
Changes drawn up for 10 (out of 13) Windows 10 third party managed devices to be upgraded to supported operating system versions over the next 2-weeks.
1 (out of 13) Windows 10 third party managed devices still seeking agreement from the Radiology department to be upgraded to a supported operating system version.
Communications department have procured a new Intranet service provider at the end of March 2024, which will at a point in time tba.
Remove the last remaining Windows 2003 server.
Procured a Commercially off the Shelf (COTS) software patching solution.

What has the impact of the activity been on the risk and risk score? If there is no change in the score, then state that and explain why.
The score remains unchanged. There are several vulnerabilities that have been identified particularly in the clinical device space, where earlier discussions with third party suppliers and departments responsible for these devices are taking place. Plans to begin address these will follow.
There are legacy protocols such as SMB1 which cannot be removed or mitigated for, as the applications using these, cannot function using up to date versions. (i.e. Intranet, WinPath)
There is no patching solution in place to address the many Commercially off the Shelf (COTS) software products in use in the Trust that are out of date and therefore have associated vulnerabilities.

What is the plan going forward (what activities are planned for the next period)?
Investigate and plans drawn up to remediate TLS 1.0 and 1.1 vulnerabilities on 4 outstanding servers identified.
Complete investigation on SSL certificate vulnerabilities and draw up plans for any changes that can safely be done to either mitigate or remove.
Implement changes for the 10 (out of 13) Windows 10 third party managed devices to be upgraded to supported operating system versions over the next 2-weeks.
Get agreement and a date from the Radiology department to upgraded to a supported operating system version 1 (out of 13) Windows 10 third party managed devices.
Identify with Comms department the timeline for delivery of their new Intranet and therefore, a date for removal of the last Windows 2003 server.
Pilot Commercially off the Shelf (COTS) software patching solution.

**RGG comment:** Very comprehensive update and this will continue to be a major risk for the Trust, worldwide cyber incidents are increasing and the Trust remains vulnerable to such an attack in future.

| Risk ID | Risk Title | Risk Register | Risk opened | Current Rating (L x C) | Date Next Review Due | Risk Owner | Executive Lead |
|---|---|---|---|---|---|---|---|

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|---|---|---|---|---|---|---|---|
| 331 | Failure of Telephone Services infrastructure leading to a complete loss of telephony per site | ICT Risk Register | 13/03/2024 | 16 (4 x 4) | 03/05/2024 | Luke Drewer Jo Brown | Paul Bannister – Chief Information Officer |

**Risk Description:**
Cause: All three telephony platforms providing telecommunications service across the Trust have reached end of life. The ISDX's in WGH and SACH went out of manufacturer support in 2016. As of 31st November 2023, the Avaya Telephony system used for HHGH, Unit 11 and Jacketts Field will be no longer under manufacturer support and will be on best endeavours.

Effect: Telecommunication service (crash calls, 2222, incoming and outgoing calls) failure impacting multiple sites. Delays in sourcing replacement/repair parts. We are at capacity in WGH and HHGH. This will impact future projects such as Civic Centre, Pathology. Adding extra hardware to Watford ISDX puts extra load onto an already struggling infrastructure. There may be a need to increase power to the system which has already suffered power unit failures INC30092 (INC003814059). Extra load would add the risk of failure (see risk 391).

Impact: Potential delays to time-sensitive (emergency) patient pathways leading to serious harm or death. Significant damage to Trust Credibility, financial loss or both. IF we have a complete failure of the PABX's in either WGH or SACH that site will lose ALL telephony capabilities, including bleeps and emergency phones. As a like for like replacement is not available due to the age of the equipment a new solution would be needed. After conversations with our current providers this would take a minimum of 4 months after receipt of a PO just to get back basic telephony.

**Risk Review:**

Additional information on the risks.
Ensuring all components are covered under a maintenance agreements
Roadmap identifies short term and long term plans
Telephony platforms have some capabilities to provide resilience between sites.

**RGG Comment:** ICT apologised for the limited review update and this will be more comprehensive in future. Project work is ongoing to provide assurance to the Trust that telephone capacity issues and failure of the system are addressed/prevented. No change to risk score and mitigation at present.

| Risk ID | Risk Title | Risk Register | Risk opened | Current Rating (L x C) | Date Next Review Due | Risk Owner | Executive Lead |
|---|---|---|---|---|---|---|---|

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 398 | Unexpected instability, failure or comprise of Wi-Fi services | ICT Risk Register | 01/12/2023 | 16 (4 x 4) | 03/05/2024 | Sean Gilchrist Jo Brown | Paul Bannister – Chief Information Officer |
| **Risk Description:** Cause: 50% (approx. 600) Cisco Aironet 1702i Wi-Fi Access Points (APs) will reach end of manufacturer support by April 2024 at which point, they will not receive manufacturer updates for known security vulnerabilities and the Cisco Wi-Fi controllers (WLC), which manage and control these APs, cannot be upgraded to the latest supported software version because the current version 17.3.x is the only available version that is compatible 1702i APs.<br><br>Impact: Wi-Fi services may become unstable, insecure and/or fail to operate. Delays or disruption to patient workflows, information flows, communications, or both. Reduced productivity leading to patient pathway delays and backlogs. Potential for financial and reputational Damage. Consequence: Wi-Fi devices dependent on the Wi-Fi for connectivity to critical services such as EPR like the WoW's, tablets and some patient monitors etc. may not be able to connect these services in some areas of the hospital. | | | | | | | |
| **Risk Review:**<br>1) What activity have we undertaken since the last review? a) Capital funding was made available in March, and an order for replacement AP equipment raised. b) Equipment delivered.<br><br>2) What has the impact of the activity been on the risk and risk score? If there is no change in the score, then state that and explain why. a) The risk score remains the same currently.<br><br>3) What is the plan going forward (what activities are planned for the next period)? a) Deployment plans for the replace of the approx. 600 AP's across the Trust is being drawn up | | | | | | | |
| **RGG comment:** This is a fairly new risk on the CRR and work is ongoing to improve resilience and capacity of the system. Further updates will follow as it progresses and the risk is being mitigated as much as possible. | | | | | | | |

| Risk ID | Risk Title | Risk Register | Risk opened | Current Rating (L x C) | Date Next Review Due | Risk Owner | Executive Lead |
|---|---|---|---|---|---|---|---|
| 347 | Inadequate Mortuary facilities for the storage of bodies and post mortem tissue from the deceased | CSS Risk Register | 04/05/2023 | 20 (5 x 4) | 03/05/2024 | Katie Tomkins Charlotte Coles | Mary Bhatti – Acting Chief Operating Officer |
| **Risk Description:** | | | | | | | |

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| 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. |
| **Risk Review:**<br>Remedial work start date in March has been delayed to possibly May/June. Regular meeting continue with project team led by deputy divisional manager and mortuary manager. continues to be standing item for discussion at monthly divisional governance meetings. |
| **RGG comment:** The work may be further delayed and while it is still planned for completion this year, until it commences and is concluded the risk remains. |

| Risk ID | Risk Title | Risk Register | Risk opened | Current Rating (L x C) | Date Next Review Due | Risk Owner | Executive Lead |
|---|---|---|---|---|---|---|---|
| 349 | Risk of the Mortuary premises not being fit for purpose. | CSS Risk Register | 04/05/2023 | 20<br>(4 x 5) | 03/05/2024 | Katie Tomkins<br>Charlotte Coles | Mary Bhatti – Acting Chief Operating Officer |

**Risk Description:**
The Human Tissue Authority (HTA) inspected the Mortuary premises and environment and have reported a Major shortfall under standard PFE1.

Cause:
Age of premises and environment.
Insufficient maintenance programs on all areas of the Mortuary buildings.
Prolonged use of the water and chemicals Post Mortem room.
Extensive moving of deceased on heavy trollies.
Quick fix repairs by estates.

Effect:
Infection control risk.
Inability to clean and disinfect the fridge rooms to the required standard.
Inability to clean and disinfect the Post Mortem room to the required standard.

Slip trip and fall risks in fridge room.
Slip trip and fall risks in the Post Mortem room.
Potential for security breaches.
Potential for sharps injuries from wooden splinters and damaged walls.

Impact:
Risk to staff and visitors to the Mortuary.
Risk to staff working in the Post Mortem room.
Risk to staff and visitors in the fridge rooms.
Failure to comply with infection control.
Failure to comply with Health and Safety regulations HSG283.
Major shortfalls in compliance with HTA standards and codes of practice.
Adverse publicity.
Reputational damage to the Trust.

**Risk Review:**
Remedial works at HHGH delayed to May/June. new mortuary service at WGH on track to be operational in June 2024

**RGG comment:** Update was noted in line with information provided for risk 347

| Risk ID | Risk Title | Risk Register | Risk opened | Current Rating (L x C) | Date Next Review Due | Risk Owner | Executive Lead |
|---|---|---|---|---|---|---|---|
| 379 | No identified area for urology nephrostomy patients who require a day case bed post intervention of semi urgent procedures. | CSS Risk Register | 04/05/2023 | 16 (4 x 4) | 03/05/2024 | Ben Thorn | Mike Van der Watt – Chief Medical Officer |

**Risk Description:**
Unable to accommodate Nephrostomy patients, who are often older frail patients with cancer, who require semi urgent planned interventional procedures. This represents a future Patient safety risk.
Patients who require interventional radiology procedures such as RIG's, Nephrostomies, vascular angiography/embolisations, lung, renal and liver biospies require a recovery inpatient bed post procedure. This ensures patients receive the required care and monitoring post procedure.

**Risk Review:**
Risk remains as per previous review.
Current demand is:
2 x AMLs,

7 x varicocele embolisations,
5 x nephrostomy exchanges due now,
2 x nephrostomy exchanges due in April,
6 x nephrostomy exchanges due in May,
4 x nephrostomy exchanges due in June.

Recovery bed capacity remains less than demand.

**RGG Comment:** No change at present, however work continues to try to increase capacity and ensure risk is mitigated.

| Risk ID | Risk Title | Risk Register | Risk opened | Current Rating (L x C) | Date Next Review Due | Risk Owner | Executive Lead |
|---|---|---|---|---|---|---|---|
| 388 | Risk that Deteriorating Patients may not be identified due to lack of effective processes/procedures/IT | Corporate Risk Register | 06/10/2023 | 20 (4 x 5) | 03/05/2024 | Brian Haig | Kelly McGovern – Chief Nurse |

**Risk Description:**
Unable to accommodate Nephrostomy patients, who are often older frail patients with cancer, who require semi urgent planned interventional procedures. This represents a future Patient safety risk.
Patients who require interventional radiology procedures such as RIG's, Nephrostomies, vascular angiography/embolisations, lung, renal and liver biospies require a recovery inpatient bed post procedure. This ensures patients receive the required care and monitoring post procedure.

**Risk Review:**
Work continues on the following and the scope of work is extensive. Deteriorating Patient Panel restarting and will take on activity so that the Task and finish group can focus on specific areas to complete.

To merge the following teams to make a deteriorating patient team: Resus, CCOT, sepsis and hospital at night. (Ongoing activity) To introduce Care Aware, Connect Mesenger with handheld devises for specialist teams to have complete oversight of the deteriorating patient. Total licences required 4000, with 105 devices cost: £268,451.52 for 36 months, under capital costs. (Further quotes being obtained from other providers at present as Cerner quoted 300k implementation and ongoing costs per year, looking at Alertive App)

Introduce all wards with the e-whiteboards to display the ward NEWS2 scores, allowing easy identification of the deteriorating patient. Implement a deteriorating patient introduction alongside NEWS2 training for all staff and must be mandatory. All medical reviews of patients must be taken face to face. This will reduce the risk to late uploading of NEWS2 scores. Improvement will be embedded to deliver safer care for deteriorating patients Restart the deteriorating patient group and ensure medical lead attends Ensure that all

policies and procedures are up to date. Reintroduce sepsis 6 awareness Review staff understanding of the EPR systems and documentation requirements and implement training if required.

Ensure that all vital signs equipment is compliant with the EPR system and configurated to show the NEWS2 score and warning if high Review Critical Care staffing levels to ensure that there is adequate staff, so CCOT stop getting pulled back into the unit Increasing staff support in sepsis high-risk areas such as ED To introduce Call 4 Concern 24 hours/ 7 days a week, implementing Martha's Law Audit compliance with NEWS2 to identify a baseline on six wards with highest number of deteriorating patients to identify themes and issues Introduce a named deteriorating patient bleep holder on all inpatient wards and audit compliance. Address any barriers to deteriorating patients, especially at night. Audit inclusion of deteriorating patient in ward safety huddles Audit time from escalation to response and identify areas requiring further education and input.

Roll out sepsis and deteriorating patient awareness week, with a rolling yearly programme Achieve 60% of all unplanned Critical Care admissions from non-critical care wards of patients 18+, having a NEWS2 score, time of escalation and time of clinical response recorded. Achieve 60% of all unplanned paediatric ICU admissions from non-critical wards of children up to their 16th birthday, having bedside Paediatric Early Warning score (BPEWS) score, time of escalation and time of clinical response recorded. Achieve 60% of all unplanned maternity Critical Care admissions from the birth centre or labour wards, having Maternity Early Warning Score (MEWS) completed, time of escalation and time of clinical response recorded. Discuss and implement the sepsis risk assessment not being allowed to be skipped

**RGG Comment:** Task and Finish group continues and this is overseen by Chief Nurse. Comprehensive update noted.

| Risk ID | Risk Title | Risk Register | Risk opened | Current Rating (L x C) | Date Next Review Due | Risk Owner | Executive Lead |
|---|---|---|---|---|---|---|---|
| 404 | Risk to Patient Safety due to inability to utilise EPR system with regard to DNACPR documentation and processes | Corporate Risk Register | 07/03/2024 | 16 (4 x 4) | 03/05/2024 | Fran Regal | Kelly McGovern – Chief Nurse |

**Risk Description:**
Unable to accommodate Nephrostomy patients, who are often older frail patients with cancer, who require semi urgent planned interventional procedures. This represents a future Patient safety risk.
Patients who require interventional radiology procedures such as RIG's, Nephrostomies, vascular angiography/embolisations, lung, renal and liver biospies require a recovery inpatient bed post procedure. This ensures patients receive the required care and monitoring post procedure.

**Risk Review:**
Discussions undertaken with deputy CMO and Chief Nurse. Communication to go out with regard to transcribing all DNACPR/TEP at transfer. Work is continuing with regard to the following: Richard Burridge is exploring if the details of the digital DNACPR form can be automatically transferred to an alternative EPR form which is printable. This may take some time. Richard is talking to Cerner to explore if it possible for us to have an independent process for DNACPR/TEP and move to ReSPECT. It will be possible to print the ReSPECT form. We (Resus, Palliative care and EPR) are attending ICB ReSPECT meetings to follow the progress of the ReSPECT rollout across the ICB. Their timeline to rollout is April 2024. We are advising clinicians during induction and training to complete a hard copy for every new DNACPR decision if it is likely the patient may be discharged.

Currently Controls and Assurances remain appropriate to the risk. Risk score to be reviewed as work progresses as CMO has expressed view that this may be scored lower, given the controls and mitigation in place.

**RGG Comment:** Update noted. CMO was going to discuss level of scoring as this may be reduced. At present however no change to the risk score or mitigation in place.

| Risk ID | Risk Title | Risk Register | Risk opened | Current Rating (L x C) | Date Next Review Due | Risk Owner | Executive Lead |
|---|---|---|---|---|---|---|---|
| 119 | Potential risk to patient safety due to the high vacancy rate across Paediatric Nursing | WACS Risk Register | 06/10/2023 | 16 (4 x 4) | 03/05/2024 | Karen Walker | Kelly McGovern – Chief Nurse |

**Risk Description:**
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 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.

**Risk Review:**
The challenges in recruitment persist and initiatives continue to be undertaken to recruit staff to the positions. However, this has not been successful and while the inability to recruit staff is an issue, there is a risk to patient safety that any gaps or continued reliance on agency staff presents.

This risk is discussed regularly at Divisional Governance meetings and escalations are undertaken where necessary. The controls and mitigation remain appropriate in order to ensure that Patient Safety is not affected, however there is a possibility that in future an incident may occur, hence the risk being recorded here.

**RGG comment:** Update noted. No change at present and until full staffing is achieved there remains a risk.

| Risk ID | Risk Title | Risk Register | Risk opened | Current Rating (L x C) | Date Next Review Due | Risk Owner | Executive Lead |
|---|---|---|---|---|---|---|---|
| 351 | Relocating Special Care Baby Unit and Transitional Care due to renovation works required to address the poor and ageing infrastructure of the current unit | WACS Risk Register | 04/05/2023 | 15 (3 x 5) | 03/05/2024 | Karen Walker | David Ambrose _ Director of Environment |

**Risk Description:**
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 this will need to be replaced and the unit will need to move to level 2 resulting in a complete change to working practices. This may result in an increase in outbreaks of babies catching infections as in the new location air changes from the air management system are not HTM complaint (recommended 10 changes/hour). Also, potentially if babies have to be transferred out that could result in a financial loss to the service.

**Risk Review:**
There is now a delayed reopening date for our neonatal unit following planned ventilation system upgrade works.

Estates department, building contractors and neonatal staff, have worked to achieve the opening of the unit, However IPC inspection of the unit revealed that further works are required. The amended deadline for this is now end of April.

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| In order to ensure that IPC standards are met, the original works have been extended to include ventilation adaptions to two side rooms within the neonatal unit.<br><br>Level 3 of the neonatal unit is now strictly out of bounds to all but essential staff and this has possible wider implications across some services in Women's and Children's. The project steering group is currently working with relevant leads on plans for the proposed new project requirements. |
| **RGG comment:** Planned completion is now 29 April, and it is hoped that the risk will then be presented for closure at May RGG |

Full details of all previous reviews are available in the attached Document. Please contact the Corporate Governance Team if you wish to have full access. Please contact the Corporate Governance Team if you wish to view the embedded document below.

Risks with reviews - 5 Apr 2024.xlsx

## 1.9 New Risks added across the Trust.

New risks added since last RGG.

| Risk ID | Title | Risk Register | Risk Opened Date | Current Risk Grading | Target Risk Grading | Location | Risk owner |
|---|---|---|---|---|---|---|---|
| 408 | Trust SBC's which connect our telephony system to the PSTN are out of support | ICT Risk Register | 03-04-2024 | 10 | 2 | Hemel Hempstead, St Albans, Watford | Charlie Hawkridge |

| Risk ID | Title | Risk Register | Risk Opened Date | Current Risk Grading | Target Risk Grading | Location | Risk owner |
|---|---|---|---|---|---|---|---|
| 409 | Lack of ICT project managers and project resource | ICT Risk Register | 04-04-2024 | 12 | 2 | Trust wide | Richard Smith |

## 2.0 Closed Risks across the Trust

| ID | Title | Risk Register | Risk Opened Date | Current Risk Grading | Target Risk Grading | Risk owner |
|---|---|---|---|---|---|---|
| 243 | Potential for nosocomial infection or outbreaks as a result of cross infection within the ward or environment from COVID-19 | Corporate Services Risk Register | 23-07-2020 | 9 | 6 | Hannah BYSOUTH |
| 249 | IPC and PPE during hot weather | Corporate Services Risk Register | 17-06-2021 | 3 | 3 | Hannah BYSOUTH |

West Hertfordshire Teaching Hospitals NHS Trust

# Trust Board
# 02 May 2024

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|---|---|
| **Title of the paper** | **Items considered at the Trust Board meeting in private on 04 April 2024** |
| **Agenda Item** | **25** |
| **Presenter** | **Phil Townsend, Chair** |
| **Author(s)** | **Jean Hickman, Interim Director of Governance** |
| **Purpose** | *Please tick the appropriate box*<br>*For approval*: <br>*For discussion*: <br>*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**<br>*(please indicate which of the 4 aims is relevant to the subject of the report)* | **Aim 1 Best care** — ***Objectives 1-4*** — x<br>**Aim 2 Great team** — ***Objectives 5-8*** — x<br>**Aim 3 Best value** — ***Objective 9*** — x<br>**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?<br>☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?<br>☒Is there a culture of high quality, sustainable care?<br>☒Are there clear responsibilities, roles and systems of accountability to support good governance and management?<br>☒Are there clear and effective processes for managing risks, issues and performance?<br>☒Is appropriate and accurate information being effectively processed, challenged and acted on?<br>☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?<br>☒Are there robust systems and processes for learning, continuous improvement and innovation?<br>☒How well is the trust using its resources? |
| **Previously considered by** | Committee/Group: Trust Board Part 2 — Date: April 2024 |
| **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. |

25

West Hertfordshire Teaching Hospitals NHS Trust

**ITEMS FOR DISCUSSION**

Feedback on Board engagement visits

**ITEMS FOR INFORMATION AND ASSURANCE**

**Incident Reporting**
The Board received an update from the Chief Medical Officer regarding the Serious Incident Report and the Patient Safety Incident Response Framework report.

**Finance update, including financial recovery plan**
The Board received an update from the Acting Chief Financial Officer

**Employee tribunals and maintaining high professional standards**
The Board received an update from the Chief People Officer

**Strategy update, including Health and Care Partnership**
The Board received an update from the Chief Strategy and Collaboration Officer

**ITEMS FOR APPROVAL**

**Business Case for Redevelopment Recruitment**
The Board received a business case from the Chief Redevelopment Officer