NHS
West Hertfordshire Teaching Hospitals
NHS Trust

TRUST BOARD MEETING IN PUBLIC
31 May 2022 from 09:00am – 12:15pm
Executive Meeting Room and via Zoom

Chair	**Title**	**Attendance**
Phil Townsend	Chairman	Yes
Voting members		
Christine Allen	Chief Executive Officer (CEO)	No
Helen Brown	Deputy Chief Executive (Deputy CEO)	Yes
Tracey Carter	Chief Nurse and Director of Infection Prevention and Control	Yes
Don Richards	Chief Financial Officer (CFO)	Yes
Dr Mike van der Watt	Chief Medical Officer (CMO)	No
Ginny Edwards	Non-Executive Director (Vice-Chair)	No
Jonathan Rennison	Non-Executive Director (Senior Independent Director)	Yes
Edwin Josephs	Non-Executive Director	Yes
Paul Cartwright	Non-Executive Director	Yes
Natalie Edwards	Non-Executive Director	Yes
Non-voting members		
Paul Bannister	Chief Information Officer (CIO)	Yes
Sally Tucker	Chief Operating Officer (COO)	No
Andrew McMenemy	Chief People Officer (CPO)	Yes
Helen Davis	Associate Non-Executive Director	Yes
Dr Andy Barlow	Divisional Director for Medicine (DDM)	No
Dr Rachel Hoey	Divisional Director for Emergency Medicine (DDEM)	Yes
Dr Anna Wood	Director of Clinical Governance (DoCG)	No
Mr Simon West	Divisional Director for Surgery, Anaesthetics and Cancer (DDSACs)	Yes
Mr William Forson	Divisional Director for Women's and Children (DDWACs)	Yes
In attendance		
Dr Tom Galliford	Deputy Chief Medical Director (Deputy CMO)	Yes
Dominique Auger	Locum Consultant Cardiologist (DA)	Yes
Duane Passman	Acute Redevelopment Programme Director (DP)	Yes
Mr Freddie Banks	Associate Medical Director for Strategy and Consultant Urologist	Yes
Paddy Hennessy	Director of Estates	Yes
Barbara Anthony	Trust Secretary	Yes
Louise Halfpenny	Director of Communications	Yes
Clare Parker	Director of Strategy and Integration	Yes
Meg Carter	Hertfordshire Healthwatch	Yes
Mitra Bakhtiari	Director of Midwifery	Yes

There were 23 members of the public in attendance

MEETING NOTES

Standing items	
1	**Opening and welcome**
1.1 1.2 1.3 1.4	The Chair welcomed everyone to June board meeting which was being held two days early due to the Queen's Jubilee bank holiday. The first part of the meeting would focus on the redevelopment papers and would then continue with normal business. The Chair reminded everyone that the meeting was a "meeting in public" rather than a "public meeting". Securing investment in buildings represented a critical priority for the board and today's decision on the preferred options for emergency and planned care was an important milestone in the redevelopment business case. The Chair appreciated that there were strong views on the choice of site for the redevelopment and this was evident from the feedback process when the draft board papers were published on 6 May 2022. He noted the view expressed within some of the feedback that the board should not consider the matter until the new chief executive was in place. He disagreed with this suggestion and explained that the board was greater than one person. It was comprised of a group of highly experienced people who were able to make a collective decision. The Board would first consider the recommendation within the shortlisting paper not to re-open the shortlisting process. If approved, the Board would go on to consider the draft outline business case chapters, the strategic economic and financial cases and would discuss the preferred option recommendations. The Board recognised that the discussion was very important and had allocated a significant amount of time for a full discussion.
2	**Apologies**
2.1	Apologies were received from Christine Allen, Ginny Edwards, Mike Van der Watt and Sally Tucker
3	**Declarations of interest**
3.1	No changes to declarations
4	**Patient story**
4.1 4.2 4.3	The Deputy Chief Medical Director introduced the video on the Virtual Hospital which provided best care to patients during the pandemic by managing patients at home. The Virtual Hospital platform had since been extended and was recognised both regionally and nationally as a leader in its field. Within the video, Dominique Auger (DA), Locum Consultant Cardiologist described the benefits that patients received from being cared for by the Virtual Hospital and how the technology, hospital and community staff came together in a virtual hub to support and monitor patients at home. Patients described feeling calmer and more reassured in their home environment which also helped their recuperation. The Virtual Hospital team were proud of their achievement of developing an innovative model

	of care which used technology to transform and provide integrated care which improved patient experience.
4.4	The Chair asked about the future plans for the Virtual Hospital. DA explained that the team were exploring the provision of a virtual frailty service to support caring for the elderly at home. Services supporting the treatment of liver disease, pneumonia and the monitoring of patients post-operatively were also being actively reviewed.
4.5	Jonathan Rennison asked what the biggest impact of the Virtual Hospital could be across the ICS. DA explained that the team's ambition was to reduce unnecessary admissions for community patients who were identified as being more unstable. She envisaged a service where the community team would visit the patient at home, with the hospital team reviewing the patient remotely. There would need to be resources in place but it would prevent unnecessary admissions.
4.6	The CIO confirmed that he was working with the team to incorporate virtual ward activity with the electronic patient record (EPR). He was also discussing with his ICS partners how digital healthcare records should be created to enable any clinician within the system to review a patient including the use of monitoring tools and digital care plans.
4.7	The Director of Strategy and Integration added that one of the key contributory reasons for the success of the Virtual Hospital was the ability of acute and community partners to collaborate and work together. She commended the work which has built relationships and is critical to the success of integrated care which the Chair agreed was important.
Acute Redevelopment Programme – shortlist review and preferred options	
5.1	**Stakeholder engagement and communications update**
5.1i	The Director of Communications summarised the paper which set out the Trust's engagement on the redevelopment. The responses were varied and the Trust would continue to engage with its stakeholders despite differences of opinion being expressed. She highlighted the following points:
5.1ii	- The engagement papers were different to previous engagement exercises as the draft board papers were shared to ensure transparency. These papers complied with HM Treasury Green Book guidance to enable the Board, who were habituated in considering papers of this nature, to make an informed decision. They had not been designed for public consumption, which had generated negative feedback about their complexity and length of time given for understanding the papers.
5.1iii	- a better phrase than "fresh eyes" could have been used to describe the process and explained that the purpose the board meeting was to take a fresh look at the 2020 decision, in the context of factors that had emerged since 2020, before moving on to the next step.
5.1iv	- Following publication of the paper, Dacorum Borough Council had asked for it to be made clear that they supported the green field site option and were not neutral. Ron Glatter's feedback had been updated to include his whole submission. She thanked him for providing his edited version and apologized for the last 60 words being inadvertently removed.
5.1v	- Letters from Councillor Bhinder, Sir Mike Penning and the Chair's response had also been published.

5.1vi	- Negative feedback had been received about the engagement information being presented in summary form, which was the custom and practice within the Trust. She considered that the commentary in the paper was evenhanded.
5.1vii	Overall, the engagement had produced a divergent range of views and had highlighted the difference between staff and some members of the public. She assured the Board that the Trust had complied with its duty to involve the public which had been confirmed by the Trust's legal advisors.
5.1viii	Paul Cartwright asked how assured the Trust was that it had met its statutory duty to engage the public in decisions so far as well as for the current decision. The Director of Communications explained that the Trust needed to demonstrate that the public had a reasonable opportunity to engage in the detail and discussion around the decision. She considered that sharing the board papers in draft had created an opportunity for people to do that. Previously, the Trust had also reached out to community groups which had generated informative feedback. It would be concerning if no feedback had been received but that was not the case.
5.1ix	The Deputy CEO explained that the current decision was one in a process that spanned a number of years. The review of the shortlist was not being undertaken in isolation and did not represent a new decision; rather it built on previous decisions. The Trust's legal advisors were clear that the feedback needed to have the possibility of influencing the board, who would take everything into account including wide ranging factors affecting the community. Regrettably, the Board would not be able to please everybody. The Trust had been transparent and open through out the process, which had been previously tested in 2019 when the Trust was judicially reviewed and found to have met the standard required for engagement.
5.1x	Edwin Josephs asked if the Trust had made any previous changes to its plans due to feedback received. The Deputy CEO explained that examples were not straightforward as a range of views always fed into the decision making process. However, the Trust had changed its view on the provision of diagnostics at Hemel Hempstead following feedback from residents. It had also diverged from its strategy to consolidate medical services to two sites and had will retain gastroenterology outpatient services at Hemel Hempstead as well as at St Albans.
5.1xi	Helen Davis noted that concerns had been received about travelling between sites and asked about the Trust's response. The Deputy CEO recognised the concerns around congestion at the Watford site and the difficulty in using public transport east to west. The Trust was committed to improving the issue by minimising the need to travel between sites and working with Herts County Council to improve public transport for its patients where possible. Watford Borough Council had published its sustainable travel plans. Whilst there were no quick solutions, there was a clear plan of action. Concerns around the lack of parking at Watford had been removed with the addition of the new car park and the Trust had also worked with voluntary driver services and the Arriva click bus service in Watford to increase use of the virtual bus stops at WGH.
5.1xii	The Deputy Chief Medical Officer added that the clinical body had been involved in discussions about clinical models from an early stage and the best way to deliver care which had also been influenced by the pandemic. The medical and nursing workforce had been

	engaged throughout the process via the Clinical Advisory Group. The Chair agreed that it was important to remember that staff were also stakeholders.
5.2	**Shortlist review**
5.2i	The Deputy CEO summarised that the purpose of the paper was to check in on the Board's previous decision in 2020. She accepted that whilst the paper was not an external review of the decision, it did set out the rationale for not reopening the short list decision at this point.
5.2ii	There was an opportunity for the Board to test and challenge the rationale of the 2020 decision. Jonathan Rennison asked what expertise the Board had draw upon as there had not been an external review undertaken within the "fresh eyes" process. The Deputy CEO explained that such a review would have taken time and resources that were not warranted at this point, although she acknowledged that the Board could ask for such an approach. The current "check-in" drew on the experience of the Deputy CEO and the Acute Redevelopment Programme Director as well as the Trust's external specialist advisors for planning, commerce and delivery elements which was reflected in the steps to be taken and timescales indicated.
5.2iii	The need to progress the redevelopment was very urgent and a new site option would delay matters. Mr Freddie Banks, Associate Medical Director for Strategy agreed that urgency was key due to the daily struggle with the Trust's existing estate. Any delay in the redevelopment would have a negative impact. The Chief Nurse agreed that the Trust's buildings currently did not allow for the provision of good quality clinical care with privacy and dignity. Further, they did not allow for good infection, prevention and control practices due to ventilation and space in clinical areas which were lacking. The Trust needed to progress its case for redevelopment based on the shortlisted options.
5.2iv	The Director of Environment explained that in 2017/18, the Trust had undertaken a 6 facet survey which confirmed that 57% of the overall estate was below the minimum required standard and Watford's estate was assessed as poor. Since then, the estate had deteriorated. Mechanical and electrical services had expired and the estate could not comply with modern standards. This meant that new services and/or equipment could not be added. He also highlighted that the sites were steam driven, which was outdated and often broke down. Water hygiene was an issue, there were lots of leaks and a significant of money needed to be spent on maintaining water hygiene. Space was also an issue, patients were currently accommodated in six bed bays that are smaller than the current standards for four bed bays and compromised patient safety and patient experience. The whole estate needed to be brought up to modern building standards.
5.2v	Jonathan Rennison noted the reasons for no independent review but that the Trust had received external advice. He asked if other schemes existed which had used a greenfield site and had that option been faster and cheaper. The Acute Redevelopment Programme Director set out that only one hospital within cohort 1 and 2 was considering a new site option. Only one scheme within cohort 4 had used a new site, the Midland and Metropolitan Hospital site. Project planning had started in 2002/03 and construction had started in 2015. He summarised that less than one-quarter of the programme were considering new sites. He added that construction on new sites was not straightforward. Site remediation was costly, transport links were complicated and costly and the unit costs were not cheaper.
5.2vi	The Deputy CEO commented that the project would be cheaper if the proposed hospital was smaller, which had been considered in 2017. At this time, there was a strong clinical view that this option was not the right model.

5.2vii	Natalie Edwards asked why the team had not commissioned a more detailed study. The Deputy CEO explained that producing such a piece of work would not be quick as there would be a need to review the clinical model, m2 requirements and what would be needed on each site. All of these elements would be hypothetical because there was no identified site. Consequently, it would not be value for money carry out such a piece of work.
5.2viii	Helen Davis commented that in her 35 years' experience, she only knew of two hospitals that had been built on new sites. She confirmed to the Board, as Chair of the Great Place Committee, that a shortlist review had been undertaken which aligned with HM Treasury's approach. The committee had been assured by level of internal and external expertise involved in the review. She was satisfied that all processes had been followed and were robust.
5.2ix	The Deputy Chief Medical Officer reflected that staff received several red banners each day about estate issues. The Corporate Risk Register also contained a number of risks about the estate. Finally, patient experience was not good, particularly for pregnant mothers. It was hard for staff to provide care in the current environment. He confirmed his view that the Trust needed to make a decision soon.
5.2x	Mr Freddie Banks added that the staff glued the organisation together. It did not follow that a single site model would be staffed by Hemel Hempstead or St Alban's staff. The three site model maintained links with staff local to these areas which was a huge advantage in staffing the three hospital sites. The DCEO commented that there were a range of options other than three site model. The priorities were urgency, poor estate, heating and cooling all of which were significantly compromised. The Divisional Director for SACS agreed with Freddie Banks's views on staffing the three site model and reminded the Board that it was helping the Trust's recovery from the pandemic. A new hospital at Watford would greatly help the Trust with surgical patients and the Trust needed to come to a decision.
5.2xi	The Board approved the recommendation not to reopen the short list.
5.2	**RESOLUTION: The Board approved the recommendation not to reopen the short list.**
5.3	**Preferred option**
5.3i	The Acute Programme Redevelopment Director presented the navigator paper which summarised the draft strategic, economic and financial case. It set out the whole redevelopment process – the SOC, OBC and FBC and the five chapters within the HM Treasury Green book and where the Trust currently was in the redevelopment timeline. The current papers asked the Board to review the draft strategic, economic and financial cases and approve the preferred options which would then inform the remaining cases within the outline business case. Draft strategic case
5.3ii	The Director for Strategy and Integration summarised the draft strategic case which set out the rationale for the redevelopment which was based on three key themes of Better Care, Better Buildings and Care that is integrated and digitally enabled.
5.3iii	The strategic case built on the strategic outline case presented in 2019 which identified Watford's use as a emergency site with planned care services at St Albans and Hemel Hempstead. She summarised the case for change which developed the three themes of

	Better Care, Better Buildings and integrated and digitally enabled. She emphasised the negative experience of the current estate on patient experience.
5.3iv	The strategic case set out the discussion around the size of the new hospital which needed to meet future demand and use its space efficiently. Growth in demand for unplanned admissions will be offset by delivering more services that keep people well at home (system transformation) while bed occupancy will reduce to 85% which will increase the number of beds and enable that Trust to manage performance more effectively.
5.3v	The strategic case also considered the scope of the programme which had changed since the SOC in 2019 when capital was restricted. At that point only a partial solution was proposed which would have necessitated a further development in the future. Today's case considered full redevelopment of the Watford site in a single phase and set out key risks and dependencies. She highlighted the need to relocate the pathology service as a key enabler, for which a business case had been submitted. Finally, she highlighted the engagement work that had also been undertaken.
	<u>Draft economic and draft financial case</u>
5.3vi	The CFO confirmed that the draft economic and financial case had been reviewed at the Finance and Performance Committee. The draft economic case set out which of the shortlisted options gave the best economic value and explained the appraisal process. Professional advice had been received to support the production of a demand and capacity model, the economic assessment and the affordability assessment. The capital costs for the six options were set out, they ranged from the minimum required to meet core investment objectives through to the ideal scenario. The "do minimum" option had been assessed at costing £326m. The ideal scenario of an emergency site at Watford had been estimated at £1.1bn with an additional amount of £61m and £93m being needed for necessary improvements at Hemel Hempstead and St Alban's respectively.
5.3vii	The economic and financial cases reviewed the business as usual revenue and capital costs and changes to those costs caused by the redevelopment. It identified the changes in benefits for each option which were categorised into cash releasing, non cash releasing and societal benefits. It was estimated that there will be £89m per annum of economic benefit when the redevelopment reached its full potential and included £45m of cash releasing benefits per annum which needed to be taken in account when considering affordability. For the purpose of the decision that needed to taken today, the case summarised the benefits and costs of each option and set out the option which provided the best combination of benefit and cost, which was option 6 for Watford. The case further tested the option to analyse its affordability to the Trust and the health system and found that the option would produce £11.7m of cumulative surplus to 2036/37. He highlighted that each option had different effects for each year. Option 6 would produce a deficit in early years but was projected to make in year surpluses within three years of the new facility opening. He recommended option 6 as the preferred option for Watford and option 3, the enhanced options as best for Hemel Hempstead and St Albans.
5.3viii	Natalie Edwards asked about the confidence around the demand and capacity planning, whether it was supported by the ICS and the Trust's ability to increase capacity if this were needed. The Director of Strategy and Integration confirmed that detailed modelling had been undertaken including population projections, historical trends and national expectations of growth in diagnostics. The Trust had maintained existing capacity for children against a

	forecast reduction in population but had been prudent in other areas. The models had been tested with the ICS and PAH and included assumptions for system transformation. There was no expectation that total activity would be reduced but it would be managed differently with new models of care such as the Virtual Hospital. The Director of Strategy and Integration was confident that the assumptions were reasonable but if the actual experience is different then the risk could be mitigated by bringing forward bed plans, having a higher bed occupancy rate and ensuring that future system work delivered the required reductions for in-patient stays.
5.3ix	Harvey Griffiths accepted that the case for PMOK was clear but involved substantial cost. He asked if there was a more economical approach. The Acute Redevelopment Programme Director explained that a number of permutations had been considered. The key priority was patient privacy and dignity. The paper included a range of options to address these needs from the minimum through to a new build the costs of which ranged from £800m to the most expensive. He set out the difficulty of keeping PMOK operational during a refurbishment programme and highlighted that a refurbishment programme would not be able to deliver temperature regulation unless it was gutted or rebuilt. The Director of Environment added that full refurbishment could only be done through a phased approach which would involve risk and would not deliver the government's net zero ambition. The building itself only had 10-20 years of life left and was not worth the refurbishment investment.
5.3x	Harvey Griffiths asked about confidence levels for securing the funding. The Deputy CEO explained that the position was presently uncertain and it was hoped that it would become clearer towards the end of the year. In the meantime, the Trust needed to be ready with its preferred solution and work hard to secure the funding for it. Substantial work had been undertaken to evidence why any refurbishment of PMOK would be difficult to achieve. There was no middle option available and the Trust could not struggle on with it in its present state, it needed to be replaced. If sufficient funding could not be secured then the Trust would need to source alternative funding from the diagnostic or recovery fund for planned care at Hemel Hempstead and St Albans and would need to consider reducing the size of the redevelopment and/or retaining existing estate. These options would create a higher level of risk, and any changes to national requirements would have to be agreed with NHP. Phased development would also need to be considered but would be less viable as time passed because of the challenging site logistics.
5.3xi	Natalie Edwards asked the CIO how technological investment would take place. The CIO explained the redevelopment digital plan was a subset of the digital strategy. The areas of focus would be items that allowed future enablement of patient safety and patient experience such as clinical grade wifi, clinical monitoring, smart beds and digital signage amongst others.
5.3xii	Edwin Josephs shared that whilst he was not a member of the Board in October 2020, he had read the papers and would probably have reached the same decision. He hoped that HM Treasury would take a long term view as the project represented £ 50-80m benefit per year over the long term. He asked if reduced funding for the national programme would impact the OBC timetable. The Deputy CEO anticipated that it would but would wait to receive information from NHP. The Director of Strategy and Integration added that once the Trust received confirmation of funding it would aim to complete its stage 2 design within 6 months or less and then complete the financial and economic case and governance. In meantime, work continues to progress on a range of areas including the digital plan.
5.3xiii	The Chair asked the Board to approve option 6 as the preferred option for the emergency site and option 3 for Hemel Hempstead and St Albans. The Board confirmed its approval.

5.3xiv	The Director of Communications confirmed to the Chair that a question had been asked by a member of public on why Appendix A had not been made public on 26 May 2022. The Deputy CEO explained that the stage 1 report had been made available but Appendix A had not been ready to publish on 6 May 2022 as financial due diligence was still required. There was no expectation for the Board to undertake due diligence on Appendix A because assurance would be received from professional advisors. Further, all papers presented today were in draft and could change before the full business case stage. They had been published in order to be transparent.
5.3xv	**RESOLUTION – The Board approved Option 6 as the preferred option for the emergency site and Option 3 as the preferred option for Hemel Hempstead and St Albans.**
6	**Minutes of the previous meeting on 5 May 2022**
6.1	No amendments were required.
7	**Board decision log**
7.1	No amendments were required.
8	**Board action log**
8.1	No actions due.
9	**Board work plan**
9.1	No amendments required
10	**Chair's report**
10.1	The Chair welcomed Harvey Griffiths as a substantive NED to the Board and thanked Paul Cartwright for all of his hard work as his term of office came to a close. The Chair was also pleased to announce that Professor Ann Griffin, Deputy Dean of Education at UCL had been appointed as the Teaching NED.
11	**Chief Executive's Report**
11.1	The Deputy CEO presented the report and noted that it was her last board meeting before she joined Whittington Hospital NHS Trust as its CEO. Whilst she looked forward to her role, she set out her it had a privilege and a pleasure to work for the Trust.
11.2	The report set out that Covid-19 patients were reducing and the Trust was in the process of reducing the number of beds allocated to Covid-19. However, the hospital remained busy and it was hoped that the number of patients would reduce over the next few months. The Deputy CEO thanked the staff for all of their hard work.
11.3	It was noted that the pandemic had had a significant impact on elective pathways and access to care. The report set out the national documents that had been published to assist recovery.
11.4	Finally, May 22 was Well-Fest month. The Deputy CEO thanked the CPO and his team for all of their hard work in organising the festival and the Staff Network days on 11 May 2022.
PERFORMANCE & COMMITTEE REPORTS	
12	**Board Assurance Framework (BAF)**
12.1	The Deputy CEO confirmed that there had been no changes during the month. The Board would receive the revised BAF at its next meeting which would reflect the new strategic priorities.
	RESOLUTION: The Board approved the Board Assurance Framework.
13	**Finance and Performance Committee**
13.1	Paul Cartwright reported that FPC had received and discussed the new BAF risks in draft and

	looked forward to receiving the finalised BAF at the next meeting.
13.2	It had reviewed the IPR and noted that both cancer and ED performance were below target. The committee discussed the action plan for UTC and ED and were happy with the management proposals.
13.3	The committee received a helpful presentation about all the issues that the ED faced. It noted that the targets would not be reached in the foreseeable future which was clearly demoralising for the team. The Trust needed to assess what was within its control to change and improve. It approved the interventional radiology business case which would be presented to the Board in July 22.
13.4	The business plan would be covered later on in the agenda. However, the committee noted the draft deficit of £15m, which had been reduced to £10m with national adjustment. The route to breakeven still needed to be established.
13.5	The committee received the Divisional Medicine review. The division were grappling with some difficult issues and he was confident that they would be addressed. He wished Harvey Griffiths all the best in his new role.
14	**Quality Committee**
14.1	There were no questions about the written report for the April 22 meeting chaired by Jonathan Rennison.
14.2	The May meeting had considered the update for the CNST scheme. The Trust would need to submit its report on compliance with the deadline by 5 January 2023. The committee received a high degree of assurance that it was on track to achieve compliance with eight of the safety actions. It was expected to achieve compliance with safety action six (carbon monoxide screening) by January 2023. It was assured by the Quality Improvement programme in place to achieve recovery of the safety action.
14.3	The committee noted the issue with safety action eight (multi professional day training). There was an issue with GP rotational doctors and whether they should be included within the safety action. Inclusion would affect the Trust's compliance even thought these clinicians would not be involved in assessing gap and grow. It was unlikely that the Trust would be compliant with the actions would make it ineligible to receive the maternity incentive premium of £1.1m.
14.4	The plan for Entonox management in the delivery suite was received. The committee noted the CQC inspections, action plan and the high degree of assurance that there was a robust management of the issues.
14.5	The Mortuary risk assessment was reviewed in full and there was a high degree of assurance that the timeline for the remaining actions would be met. The committee was assured that there was appropriate management of the mortuary within the Trust.
15	**PERC**
15.1	The written report was taken as read and there were no questions.
16	**Audit Committee**
16.1	Edwin Josephs reported that Paul Cartwright and the CFO had attended the committee on behalf of FPC to provide assurance that the committee was meeting its terms of reference. The committee was impressed with FPC's work and transparency about areas of improvement. The committee also received confirmation from the internal auditors that the legacy outstanding actions had either been completed or superseded. He also highlighted that the safeguarding audit had received outstanding in both design and performance. He congratulated the Chief Nurse on this achievement.

17	**Integrated Performance report**
17.1	The CIO highlighted that the paper had been discussed at FP with a focus on A&E and cancer services.
17.2	Quality: The Robson 2 caesarean section data had spiked, which the CIO was investigating and would report back on the following month.
17.3	Safety: There was continued improvement in the stroke and VTE metrics. He anticipated the VTE being removed as an exception soon.
17.4	A&E: ED – There was a small improvement in the metrics despite an increase in mean time and number of 12 hour journeys. The Trust remained an outlier for type 1 performance. A new metric on proportion of 12 hour waits in the department had been introduced from the planning guidance. There was a now a 2% target for stays beyond 12 hours. Presently, the Trust was just under 4% and had started an improvement plan with its suppliers to improve performance. The ED team would report back to the committee on its progress at the next meeting, but it had been acknowledged that the target would be difficult to achieve.
17.5	RTT/cancer: There was a downward trend in performance with 52 week waits increasing. The Trust was benchmarking in the middle of its peers and 104 week waits were decreasing, with an expectation of being cleared in the next month. 2 week wait performance had dipped, with the breast and skin services being particularly challenged. This reflected the increase in referrals.
17.6	Activity – Elective activity was low for the month, contributed to by April only having 19 working days. The PTL continued to increase and work was needed to understand the increase. Validation had cleared 3000 patients from the list. Discussion
17.7	The Divisional Director for Emergency Medicine explained that the ED department continued to work with EEAS on ambulance attendances and new ways of working. Space was limited within the department and the team were working to utilise space effectively to meet their targets. Work was also underway on the same day emergency care pathways to increase flow in that area to meet performance metrics. The team were waiting for formal acknowledgement that the metrics were in force.
17.8	Jonathan Rennison asked why the maternity data for the Robson criteria was 20% higher than the national average. The CIO confirmed that the Trust was investigating the uptick and would analyse why it was above the national average. The Chief Nurse added that the Director of Midwifery had undertaken a deep dive and was researching the coding categories used which had also been the subject of an internal audit process. The Chief Nurse confirmed that the results would be fed back via the maternity safety champions and Quality Committtee.
17.9	Jonathan Rennison asked how the low breast cancer performance and high DNA rate would be managed. The Divisional Director for Surgery, Anaesthetics and Cancer explained that DNAs were a wider issue which was being managed by contacting patients to ensure attendance. Harm reviews were being conducted on an on-going process. On performance, a locum breast consultant and a radiologist had been appointed to target performance. Further appointments were needed in the longer term.
Aim 1: Best care	
18	**Patient Safety Specialist update**
18.1	The Deputy CMO reminded the Board of the patient safety strategy introduced in 2019 and which was subsequently disrupted by the pandemic. The strategy was being re-implemented

	by the National Director for Patient Safety, who had recently requested board oversight from each provider.
18.2	The paper set out the nine key deliverables and the request for boards to support the patient safety specialist role, of which the Trust had four, and a team who were working through the priorities and focusing on embedding the strategy going forwards. There would be a presentation to the July board meeting with further information.
18.3	Edwin Josephs asked if it was usual to have four patient safety specialists. The Deputy CMO confirmed that there was a specific Head of Patient Safety who was being supported the patient safety specialists. NHSE were aware that the Trust had four patient safety specialists and received regular updates from the Trust.
18.4	Jonathan Rennison asked what support was required for the strategy to become embedded within the Trust. The Deputy CMO explained that visibility would be important. The Board would also need to provide assurance that it was aware of the requirement. Jonathan Rennison asked how visibility was being raised across the Trust. The Deputy CMO explained that mandatory training would be incorporated into the training programme and work would progress with the Medical Education centre to raise visibility. It was important to note that lots of good practice had already been embedded and the Trust was ahead on achieving compliance with the nine key priorities. It now needed to evidence its progress.
Aim 2: Best Value	
19	**Finance update**
19.1	The CFO reported the submission of the plan which set out a projected deficit of £15m caused by inflationary pressures over and above the level built into the contract. The NHSE Finance Director had subsequently communicated plans to release funds to tackle inflationary pressures which required a further re-submission of the plan by 20 June 2022.
19.2	The draft plan was discussed at FPC which now projected a deficit of £10m. NHSE were aware that April's activity was lower nationally and had asked for the activity plans to be stretched whilst remaining realistic. Further information would be received about ERF funding. Following receipt of the M1 data, work was underway with the divisions to resubmit a refreshed plan and the Board would be updated once the mechanism for ERF was released.
19.3	He highlighted that the further submission of a deficit plan would incur increased oversight from NHSE for the system and for the Trust, whose ability to access capital funds would be reduced. There would also be a requirement to articulate workforce changes. Going forwards, the plan would need to be carefully considered.
19.4	The Board confirmed that the Chief Officers would have delegated authority to submit the plan on 20 June 2022 on behalf of the Board. M1 update
19.5	The CFO reported a M1 deficit of £1.4m due to inflationary pressures linked to pay awards, energy and contract uplifts. The deficit was in line with the current plan but the lower activity had meant a shortfall against the ERF target. Covid costs were in line with the budget and were anticipated to fall. The plan was underpinned by the elective recovery, reduction in covid costs and being able to deliver the savings plan.
20	**Business plan**

20.1	The Director of Strategy and Integration introduced the business plan which had previously been approved in draft by the Board in March 2022.
20.2	The plan included the success measures for the strategic objectives for the next two years. Additional slides set out the governance arrangements for the change programme which would be monitored by GPC.
20.3	The Chair about the visibility of the document internally. The Director of Strategy and Integration explained that a number of confirm and challenge sessions had taken place with the divisions and the document had been reviewed twice at TMC. It would be circulated to the consultants once it had been finalised with the divisions.
20.4	Paul Cartwright asked if the divisions had agreed the targets and the Director of Strategy and Integration confirmed that reciprocal conversations had taken place. The document was linked to the clinical strategy which had been developed with significant clinical involvement. Detailed confirm and challenge meetings had taken place for the activity plans for each division, which would be refreshed as the plan changed. The CFO added that the activity plan would be further refined due to April's activity performance and would need final agreement with the ICS and ICB to ensure that the plan was tolerable within the system submission to NHSEI. The Divisional Director for SACs confirmed that the division were sighted on the plan. Whilst it was ambitious, there was a 3 month rolling programme with clinical directors in place to ensure that they were sighted on progress with the targets. He added that there was also a 3 year and 5 year cycle in place to give greater oversight.
20.5	**RESOLUTION:** The Board approved the business plan subject to the changes in the financial plan.
Aim 4: Great Place	
22	**Strategic Priorities Update**
22.1	The Director of Strategy and Integration presented the paper which demonstrated the work undertaken during the past year. A new report would come to the Board on a quarterly basis and to GPC on a monthly basis. She noted Paul Cartwright's request for the report to include whether projects were on time and on budget.
Risk and Governance	
23	**Corporate Risk Register report**
23.1	The Deputy CMO presented the report which had been discussed at the Risk Review Group on 12 May 2022 and at Quality Committee on 28 May 2022. The report included two new risks, one of which was an amalgamation of two risks for the management of mental health patients in trust. The other new risk concerned the adherence of patient pathways and work in UTC.
23.2	Three risks had been closed relating to mental health and the management of mothers in the obstetric observation bay. One risk had been re-classified following analysis of coding for surgical waiting and surgical procedures.
23.3	The Chair asked the Divisional Director for Emergency Medicine for more information about the risk relating to mental health patients. The DDEM explained the space across the whole of ED was unsuitable for providing care to mental health patients and linked with the lack of community beds available to mental health patients and s136 provision. There was also a need to support staff who looked after mental health patients on wards and provide adequate training to staff. The Trust had seen a huge rise in eating disorders for children there was presently no adequate facilities to treat them, which was a national issue. The Chief Nurse added that the Trust was working at PLACE and system level for solutions with the ICS autism and learning disabilities collaborative and funding had been agreed for the Children

	and Young People's Liaison Service. There was also psychological support for staff and a programme of work on safe spaces within the Acute Admissions Unit. The safeguarding team had also developed pathways with the mental health liaison team.
26.3	**RESOLUTION: The Board approved the Corporate Risk Register**
27	**Items considered in May Private Trust Board**
27.1	The report was noted.
Closing Items	
28	**Any other business previously notified to the Chair**
28.1	There was no other business for consideration.
29	**Questions from Hertfordshire Healthwatch**
29.1	There were no questions from Meg Carter.
30	**Questions from our patients and members of the public**
30.1 30.2	There were no questions. The Chair thanked Helen Brown for all of her hard work and her contribution to the organisation.
31	**Date of the next Board meeting**
31.1	The next Board meeting would be held on 7 July 2022 in the Executive Meeting Room and via Zoom.