West Hertfordshire Teaching Hospitals NHS Trust

TRUST BOARD MEETING IN PUBLIC
AGENDA

4 May 2023 at 9.30am – 12.00pm
Jubilee Seminar Room, Hemel Hempstead and via zoom (for public and virtual attendees)

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

Time	Item ref	Title	Subcommittee / Purpose	Accountable officer	Paper or verbal
Standing items					
9.30	1	**Opening and welcome**	Information	Vice Chair	Verbal
9.35	2	**Patient focused story**	Information	Vice Chair	Verbal
9.45	3	**Apologies for absence**	Information	Vice Chair	Verbal
	4	**Declarations of interest**	Information	Vice Chair	Paper
	5	**Minutes of previous meeting 6 April 2023**	Approval	Vice Chair	Paper
	6	**Board decision log**	Information	Vice Chair	Paper
	7	**Board action log**	Information	Vice Chair	Paper
	8	**Board work plan**	Information	Vice Chair	Paper
9.50	9	**Chair's report**	Information	Vice Chair	Paper
10.00	10	**Chief Executive's report**	Information	Chief Executive	Paper
Performance & Committee updates					
10.10	11	**Board Assurance Framework**	Approval	Chief Executive	Paper
10.15	12	**Trust Management Committee**	Information and assurance	Chief Executive	Paper
	13	**Finance and Performance Committee** Verbal report: April 23	Information and assurance	Chair of Committee/ Chief Financial Officer	Verbal
	14	**Quality Committee** Written report: March 23 Verbal update: April 23	Information and assurance	Chair of Committee/ Chief Nurse	Paper
	15	**People, Education and Research Committee** Verbal report: April 23	Information and assurance	Chair of Committee/ CPO	Verbal
	16	**Great Place Committee** Written report: April 23 Written report: March 23	Information and assurance	Chair of Committee/CRO	Paper
10.35	17	**Access standards performance and activity recovery overview**	Information and assurance	Chief Operating Officer	Paper

10.45	18	**Integrated performance report**	Information and assurance	Chief Information Officer	Paper
Aim 1 : Best Care					
11.05	19	**Quality improvement update**	Information and assurance	Chief Nurse	Paper
Aim 2: Best Value					
11.15	20	**Finance update**	Information and assurance	Chief Financial Officer	Paper
Aim 3: Great Team					
11.25	21	**Freedom to Speak Up** • **Strategy & assurance report** • **Summary of the reflection & planning tool**	Approval	Chief People Officer / Freedom to Speak Up Guardian	Paper
Aim 4: Great Place					
11.30	22	**Digital Progress Report and EPR optimisation**	Information and assurance	Chief Information Officer	Paper
11.35	23	**Joint BCDD and Strategic Objectives report**	Information and assurance	Chief Strategy and Collaboration Officer	Paper
Risk and Governance					
11.40	24	**Corporate risk register**	Discussion and approval	Chief Medical Officer	Paper
11.45	25	**Annual self-certification process**	Approval	Trust Secretary	Paper
11.50	26	**Items considered in April 2023 Private Trust Board**	Information and assurance	Vice Chair	Paper
Closing Items					
11.50	27	**Any other business previously notified to the Chair**	N/A	Vice Chair	Verbal
12.00	28	**Questions from Healthwatch Hertfordshire**	N/A	Vice Chair	Verbal
	29	**Questions from our patients and members of the public**	N/A	Vice Chair	Verbal
12.00	30	**Date of the next board meeting:** **1 June 2023, Executive Meeting Room, Watford General Hospital and via zoom**	Information	Vice Chair	Verbal

West Hertfordshire Teaching Hospitals NHS Trust

Declarations of board members and attendees' interests

4 May 2023

Agenda item: 4

Name	Role	Description of interest
Phil Townsend	Chairman	None
Matthew Coats	Chief Executive	None
Paul Bannister	Chief Information Officer	• Chair of Shared Care Record Programme
Tracey Carter	Chief Nurse and Director of Infection Prevention and Control	• Representative for secondary care at the quality committee in the ICB • Trustee of Herts MIND Network
Helen Davis	Associate Non-Executive Director	• Director and shareholder at Brierley Advisory LLP, secondment to NHP finished at end of January 2022. • Partner is senior civil servant at DHSC
Ginny Edwards	Non-Executive Director	• Director of Edwards Consulting Limited • Trustee of *Raise*, West Hertfordshire Hospitals NHS Trust Charity • Trustee of Infection Prevention Society and Vice Chair • NHS Professionals Bank • Community Ambassador for Peace Hospice Care • President Elect of Hertswood Rotary Club • President Bricket Wood WI • Husband is CEO of The Nuffield Trust and a Director Edwards Consulting Ltd

Last updated: March 2023

Name	Role	Description of interest
Natalie Edwards	Non-Executive Director	None
Harvey Griffiths	Non-Executive Director	<u>Financial Interests</u> • Director - Anglo Chesham Management Limited • Director - Anglo Industrial Holdings Ltd • Director - Broadgate Freeholds Limited • Director - Energy Capital Advisers Ltd • Secretary – Gripworx Holdings Limited • Director - Horizon (GP) Limited • Director - Horizon Development Capital Limited • Director - Horizon Development Finance Limited • Director - Horizon Housing REIT Plc • Director - Horizon Hudson Holdings • Director - Horizon Infrastructure Partnership Limited • Director - Horizon Investment Holdings (One) Limited • Director - Horizon Investment Holdings (Two) Limited • Director - Horizon Investments (One) Limited • Director - Horizon Investments (Two) Limited • Director - Horizon Scotland (GP) Limited • Director - Housing Investment Finance Limited • LLP Designated Member - Infrastructure Partnership LLP • • Secretary - Just Property Management Ltd • Director - Sustainable Infrastructure Partnership Ltd • Director – Co-operative Energy Limited • Director – Flow Energy Limited • Director – Co-operative Payroll Giving Limited • Director – The Midcounties WR1 Limited • Director – The Midcounties WR2 Limited • Director – Co-op Travel Services Limited • Director – Co-operative Holidays Limited

Last updated: March 2023

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

Last updated: March 2023

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

Last updated: March 2023

TRUST BOARD MEETING IN PUBLIC
6 April 2023 from 09:30am – 12:30pm
via Zoom

Chair	Title	Attendance
Phil Townsend	Chairman	Yes
Voting members		
Matthew Coats	Chief Executive Officer (CEO)	Yes
Tracey Carter	Chief Nurse and Director of Infection Prevention and Control	Yes
Don Richards	Chief Financial Officer (CFO)	Yes
Dr Mike van der Watt	Chief Medical Officer (CMO)	Yes
Sally Tucker	Chief Operating Officer (COO)	Yes
Ginny Edwards	Non-Executive Director	Yes
Jonathan Rennison	Non-Executive Director (Vice-Chair)	Yes
Edwin Josephs	Non-Executive Director (Senior Independent Director)	Yes
Harvey Griffiths	Non-Executive Director	Yes
Natalie Edwards	Non-Executive Director	No
Ann Griffin	Non-Executive Director	Yes
Non-voting members		
Paul Bannister	Chief Information Officer (CIO)	Yes
Andrew McMenemy	Chief People Officer (CPO)	Yes
Alex White	Chief Redevelopment Officer (CRO)	Yes
Helen Davis	Associate Non-Executive Director	No
Dr Andy Barlow	Divisional Director for Medicine (DDM)	Yes
Dr Rachel Hoey	Divisional Director for Emergency Medicine (DDEM)	No
Mr Simon West	Divisional Director for Surgery, Anaesthetics and Cancer (DDSACs)	Yes
Mr William Forson	Divisional Director for Women's and Children (DDWACs)	No
Mr Martin Keble	Divisional Director for Clinical Support Services (DDCSS)	No
In attendance		
Barbara Anthony	Trust Secretary	No
Louise Halfpenny	Director of Communications	Yes
Jean Hickman	Corporate Governance	Yes
Heidi Buckell	Diversability Lead	Yes
Michelle Hope	Deputy Chief Nurse	Yes

MEETING NOTES

Standing items	
1	**Opening and welcome**
1.1	The Chair opened the April Board Meeting and highlighted the visit from Oliver Dowden, Secretary of State in the Cabinet Office, who had spent time experiencing patient technology, particularly in the Virtual Hospital and was hugely appreciative of the technology and patient care displayed.
1.2	He outlined that the performance data on operational performance and transformation work would be considered today, including investment in IT and endoscopy.
2	**Patient and staff focus on disability awareness**
2.1	The Chief Nurse introduced Heidi Buckell, Diversability Lead and Michelle Hope, Deputy Chief Nurse who provided a presentation on the perspective from staff and patients around the work for diversability across the organisation, including the story of a patient, Eddie Lucas who shared his experience of using one of the disabled toilets in his wheelchair. He highlighted that the emergency cord was not accessible if someone had fallen on the floor or needed help whilst on the toilet. The toilet seat was loose and it was hard to reach the toilet paper from the toilet.
2.2	The Deputy Chief Nurse shared that since Eddie had given feedback, repairs had been done and the cord had been repositioned. She would invite Eddie to join the co-production work on changing places.
2.3	The Chair thanked HB for her presentation and opened the floor for questions and observations.
2.4	Ginny Edwards asked about the Trust's HR policies and whether HB was looking at how staff with disabilities were recruited. HB confirmed that they were and that there had been a job fair for people with learning disabilities. She would be reviewing the Trust's recruitment processes further.
2.5	The CPO noted the development of values-based recruitment processes to create inclusion, as well as training for recruiting managers to create an inclusive approach to shortlisting and interview panels. There were also discussions taking place around unconscious bias which HB was involved in.
2.6	The CFO asked HB whether she was getting all the representation she needed on the diversability group, such as from Estates and Procurement. HB confirmed that she was.
2.7	Jonathan Rennison sought assurance from executive colleagues that the appropriate resourcing would continue to be in place to continue with improvements, recalling that Eddie had been raising the same concerns for at least nine years. The CEO felt it was not a financial resources issue and that processes could be improved. The CPO added that there were a variety of areas that HB was leading on to make improvements.

3	**Apologies for absence**
3.1	Apologies were received from Helen Davis, Natalie Edwards, Rachel Hoey, Martin Keble and William Forson.
4	**Declarations of interest**
4.1	No amendments were needed.
5	**Minutes of previous meeting on 2 March 2023**
5.1	Page 1 - Jonathan Rennison noted that he should be recorded as Vice Chair, Edwin Josephs should be noted as Independent Director.
5.2	Page 5, Section 15 - the CPO noted that the reference to discrimination and sexual harassment issues was in the context of freedom to speak up. He would also provide updated wording for page 9 in relation to EDS and Covid
5.3	The minutes were approved subject to the above changes.
5.4	**RESOLUTION: The Board approved the minutes of the previous meeting as a true and accurate record, subject to the above amendment.**
6	**Board decision log**
6.1	No amendments were required.
7	**Board action log**
7.1	The action was noted as complete.
8	**Board work plan**
8.1	No amendments were required.
9	**Chair's report**
9.1	The report was taken as read and the Chair welcomed Alex White to the Board. He thanked Tom Cleverly from Watford Football Club for promoting the Trust's Raise charity and was hoping to report positive news about fundraising activities next month.
10	**Chief Executive's Report**
10.1	The report was taken as read and the CEO thanked all Trust staff for all their hard work during the winter, adding that demand was easing. He thanked staff for their work around the organisation in covering the industrial action for junior doctors, which would be taking place next week.
10.2	He welcomed Alex White, Chief Redevelopment Officer, to the organisation, along with Toby Hyde who would be joining the Trust later this month as Chief Collaboration and Strategy Officer.
10.3	He thanked Tracey Carter, Chief Nurse for her outstanding work for the Trust, adding they were in the process of recruiting to the Chief Nurse and hoped to report positive news at the next Board.
10.4	He was pleased to report positive news for consultant recruitment to the Trust with the recruitment of two upper GI surgeons. The CMO added that high-level interventions had continued to attract superb candidates and the recent surgical robot procurement was part of that, as well as providing consultants with the ability to undertake procedures normally reserved for tertiary centres.

10.5	24 substantive appointments had been made in the last year along with a further 19 locum appointments, many of whom were anticipated to become substantive. The Trust was fortunate to have a high level of talent who wished to join the Trust.
10.6	The Chief Nurse responded to Jonathan Rennison's question around how staff were responding to BadgerNet. She reported that the launch had gone well, midwives were reporting the benefits of the system. The CIO added that it was the most successful big system launch he had ever seen, giving credit to the midwives and the team who were engaged from the start.
PERFORMANCE & COMMITTEE REPORTS	
11	**Board Assurance Framework (BAF)**
11.1	The BAF report was taken as read and the Chief Nurse outlined the following changes:
11.2	BAF risks 1 and 6 had been updated to reflect the appointment of the new programme director to support the progress of the hub.
11.3	BAF risk 6 had also been updated to reflect some reporting aspects which had now been addressed.
	RESOLUTION: The Board approved the Board Assurance Framework.
12	**Trust Management Committee**
12.1	The report was taken as read.
13	**Finance and Performance Committee**
13.1	The report was taken as read. Harvey Griffiths highlighted the continued focus on performance.
13.2	The NHSE Frontline digitisation bid had been approved, which reflected an investment of £3.5m into innovation around frontline services.
13.3	The Trust would achieve its budget this year and work had begun on efficiencies for the new financial year.
14	**Quality Committee**
14.1	Ginny Edwards verbally updated the Board about the meeting in March which reviewed the Trust's CQC registration, with changes to the covid testing hub.
14.2	The terms of reference were recommended to the Board for approval. The committee received the Medical Devices Annual Report and were assured about the plan and actions. It also reviewed the Corporate Risk Register, 7-day BAF, Quality IPR and proposals for the Quality Account priorities. There were no matters to escalate to the Board.
15	**PERC**
15.1	The report was taken as read and the CPO confirmed that the detail of the five working groups to support the People Strategy were up and running. Progress from the meetings would be reported to PERC at its next meeting as well as discussion around the staff survey. There was ongoing work following the Teaching Hospital Board around the leadership review. His team were making links with local education establishments and setting up working groups. There would be further updates after the first quarterly meetings for the five areas with updates anticipated in approximately two months.

16	**Charity Committee**
16.1	The report was taken as read.
17	**Audit Committee**
17.1	The report was taken as read. Edwin Josephs added that the Trust had benchmarked positively against its peers within the HFMA Financial Sustainability Benchmarking Report.
18	**Great Place Committee**
18.1	The CFO reported that GPC had met on 18th March 2023. The committee had discussed the development of the draft OBC and the impact of all rooms being single rooms for patients, which was achievable within the current design footprint. The committee also received updates on the interim and enabling projects currently underway.
19	**Access standards performance and activity recovery overview**
19.1	The COO highlighted the insight within the report on the patient flow high impact change programme and elective recovery high impact change programme. Both plans had been reviewed at TMC, with the divisions confirming their commitment to the high impact changes.
19.2	The patient flow improvement plan included a scorecard which provided assurance on the following areas. a) Rapid assessment, timely assessments and decisions regarding further hospital services or discharge. b) Discharge, with daily discharge information being emailed for the first time today. c) Control centre development, giving key staff business intelligence to understand how efficient the Trust is functioning. d) Clinical review of the UTC service run by Greenbrook.
19.3	The elective recovery programme focused on four high impact changes, those being: a) Outpatients, both in service delivery and in core national transformation requirements. b) Theatre productivity, the theatre tool having gone live. c) Waiting times, ensuring the right patients are treated in time order and reducing waiting times in line with national directives. d) Data quality capture and recording, which the COO reported that a meeting to consider this area had been well attended with representation from across the organisation.
19.4	Regarding activity and recovery, the COO noted the following: a) Referrals for cancer and urgent referrals remained high, with cancer being 119% by comparison to previous year and 135% increase in the proportion of urgent referrals. b) Follow-up rates remained above 75% tolerance across all divisions. c) Surgery delivering 95% of the activity baseline for new outpatient appointments.
19.5	Reporting on electives, the COO reported that, in comparison to previous month's activity, baseline was higher with medicine achieving the required targets.
19.6	On theatre productivity, a snapshot from the new tool demonstrated some of the new data. Improvements with regard to theatre utilisation were noted, along with a reduction in late starts and early finishes.
19.7	For diagnostics, MRI continues to be positive, 115% against the 120% 2019/20 baseline, and increased levels of traction could be seen with non-obstetric ultrasound.

19.8	There was evidence of improvements compliance for Echo in particular, with staff showing willingness to undertake additional ad hoc activity.
19.9	The A&E department saw the lowest number of attendances in February 23, however 4.6% of all Type 1 attendances related to mental health.
19.10	Ambulance conveyances represented 34.3% of all Type 1 patients treated, but the Trust had seen improvements in 30- and 60-minute ambulance handover, compared favourably on this against its peers.
19.11	Regarding performance overall, the COO noted the following: a) Performance continues to improve, however challenges remained around sustainability. b) Small improvements could be seen in all types performance compared to January. c) UTC performance had deteriorated by comparison to January, predominantly focused on staffing constraints. d) Hemel UTC achieved 98.5% compared to 96% in the previous month. e) There was good reduction in end-to-end 12-hour waits, which were the lowest since September 2022.
19.12	RTT performance showed the following: a) Extensive validation is ongoing; the COO felt the eradication of all 78-week waiters by 31st March had been recognised as a significant challenge and was not helped by the strike action. Guidance was now to reschedule all patients who were displaced in March by the end of April. b) There were seven patients where the 78-week position had been breached, and the aim was to schedule and treat those during April. c) Cancer was a continuing success story, with good performance being noted for two-week waits, being 92.7% against 93%. There was a focus on the management of long waits, with a 42-day tracking target. d) The PTL was at 6.2% and next year's target had already been achieved.
19.13	Planning guidance for 2023/24 was presented as a reminder to all colleagues.
19.14	Ginny Edwards asked if the actions underpinning the high impact changes could be grouped to achieve a greater impact. The COO responded that the Hospital Efficiency Group were overseeing high impact changes for patient flow, with an action plan that was reviewed on a fortnightly basis alongside the monitoring of metrics. The CIO added that work was also starting on a more scientific data analysis to identify which changes were having the greatest impact. The COO added that a similar process was in place for the elective high impact changes through the ORG, which was also fortnightly. The four measures monitored by the score card had been identified as those most likely to deliver the greatest change.
19.15	Jonathan Rennison noted that on the high impact change on elective recovery, there was an increase of around 3% and queried where that fitted within the reported decrease. The COO confirmed that it was attributable to the strike action.
19.16	Jonathan Rennison asked about the data generated by the theatre reporting tool. The DDSACs responded that the tool was part of the booking procedure and was used on a

	weekly basis. Booking procedures had been changed consequently, with surgeons interrogating their own lists and adding cases.
19.17	The DDSACs had received an update yesterday, reporting that orthopaedics list utilisation had increased by 7% from February 23 to March 23. He felt that the tool was being used by surgeons, bookers and waiting list co-ordinators and would become embedded across all surgical specialities.
19.18	THE COO reported that there was a pilot programme being run by CLCH working jointly with East Ambulance Service, with a screening process to establish whether primary care and community care services can respond to a patient's needs as opposed to a hospital. The aim was to have a 20% impact on the level of conveyances.
19.19	There was continued supportive work on enabling East to be able to respond to 999 calls more efficiently, with rapid release and staying at hospital for no longer than 45 minutes being confirmed this week as a business-as-usual process. The Chair urged caution that problems were not moved from one place to another.
20	**Integrated Performance report**
20.1	The CIO highlighted the following points:
20.2	I) The mortality metric had been amended to a 12-month rolling average.
20.3	II) There were no changes in any exceptions other than the percentage of nursing hours field.
20.4	III) The mean time in A&E was the lowest for 14 months.
20.5	IV) The national benchmark of the four-hour performance had improved, with all types of performance moving from 55th out of 110 nationally to 53rd, with Type 1 performance moving from 106th to 98th.
20.6	V) 12 of 17 metrics for cancer had improved in the month, which the CIO felt was promising.
20.7	VI) There was one change in workforce exceptions where the vacancy rate had moved to a positive acceptance, better than statistically expected. A couple of new metrics had been added for reporting of staffing volumes and ratios for BAME.
20.8	The Chair noted the amount of movement around staff turnover relative to other organisations.
20.9	Ginny Edwards noted the sustained improvement for stroke patients. She felt it would be helpful to know how the quality and safety for patients was being upheld when registered nurse numbers were being reduced. The Chief Nurse provided reassurance that staffing was reviewed several times a day, senior nurse cover was on-site 24/7 as well, this was triangulated with ward accreditation and weekly panels to review incidents. There was also positive feedback from the friends and family test. Additionally, there were no vacancies in adult nursing, it was more the unavailability of nurses and a number of international nurses awaiting registration. She felt staff were carefully managed with a view to the acuity of patients across the sites.

Aim 2: Best Value	
20	**Finance update**
20.1	The CFO highlighted the following:
20.2	There was a deficit of £5.5 million after 11 months, next month was expected to report a break-even position.
20.3	There had been a benefit this year from elective income being block funded, which would lead to a challenge next year.
20.4	Surgery performance and the pattern of income showed steady improvement.
20.5	Overall income for the Trust had been higher than planned because of funds to support areas of activity such as the Virtual Hospital, extra funding for education, winter capacity funding, COVID testing costs and IT funding.
20.6	There had been a shortfall in CIPs this year, compensated by non-recurrent measures.
20.7	Agency costs across all staff types totalled £15.2 million after 11 months, which was higher than the original plan.
20.8	COVID related costs were noted as being a success, with £6.4 million being spent after 11 months, with the original allowance being £8.4 million.
20.9	A more dynamic annual leave management system was being developed. There had been a high amount of outstanding annual leave at the beginning of the year which had been reduced and would give a benefit of potentially £3 million for year-end figures.
20.10	The balance sheet remained healthy, with the cash balance at the end of February 2023 being £50.2 million. The public dividend capital had been drawn down and had been approved for spending on nationally funded schemes.
20.11	The CFO anticipated a significant reduction of the cash balance as invoices were paid, expecting a drop to around £35 million by the end of year.
20.12	Capital expenditure was £15 million, which demonstrated the challenging year in terms of the number of projects worked on. The latest projection was for full use of capital allocation by the end of the year.
20.13	Regarding the financial plan for next year, there were further national discussions scheduled. However, all organisations in the NHS were being asked to treat plans as draft plans while the national finance team reviews every system's plan.
20.14	The Chair asked for clarification of whether reports were to be finalised by the end of April 2023. The CFO confirmed they were, adding that agreement had been reached with commissioners for interim funding to allow the Trust to continue to provide services until the plan is finalised.
20.15	Harvey Griffiths noted the substantial cost item of clinical negligence, being £24.5 million, and queried whether this could be reduced. The CFO explained that it was an accumulated clinical

	negligence bill which took a long time to reduce. The Chief Nurse added that it was about how to learn from incidents and change processes and management of patients which would reduce claims. She added that obstetrics was a high part of insurance premiums and advised that an element of that would always be there.
20.16	Harvey Griffiths asked whether there was a point where this would begin to reduce, the Chief Nurse referred to the NHS resolution scorecard where a difference could be seen with improvements over a period of five to ten years.
20.17	It was noted that in the past five years there had been a number of individual large obstetric claims which was affecting the premium rate, improvements made now would not result in a reduction in premium until the next 5-10 years.
Aim 4: Great Place	
21	**NHSE Frontline Digitisation business case**
21.1	The CIO highlighted the following points:
21.2	£3 million of additional funding over two years had been secured in February 2023 from the NHS England Frontline digitisation bid and they were now asking for approval to complete the current four programmes, those being: a) They were looking to implement Nuance, the most advanced digital dictation voice recognition system that works with integrated EPRs, which would enable direct voice noting. b) The launch of CapMan tool, to give the most accurate bed state in the organisation. Training had been done across wards and an audit was currently being conducted. c) The continuation of the pathology communications programme. d) Advanced technology to join up back-end services with EPR.
21.3	The CIO confirmed that completion of the four programmes had been discussed at TMC, at Finance and Performance Committee and Capital Finance Group and had been supported at all of those meetings.
21.4	Ann Griffin asked about the impact on staffing. The CIO explained that they had never been able to self-fund digitisation because they had not been able to agree on the impact on administrative staff and it was now being implemented due to the external funding. The CIO considered that there would be some impact, however that would be managed in a productive way, possibly through redeployment into other administrative roles. The CPO added that digitisation would allow for a review of staff skill sets. The Chief Nurse highlighted how EPR had improved the role of ward clerks, who were now able to undertake more patient facing work which improved patient experience.
21.5	**RESOLUTION: The Board approved the business case.**
Risk and Governance	
22	**Corporate Risk Register report**
22.1	The CMO reported that the Risk Review Group had been cancelled last month due to industrial action, consequently there was no formal changes to the Risk Register which had been approved by RRG. There were two new proposed risks but a desktop review had determined that it was safe to leave those for the next meeting in April 23.

22.2	The Chair asked if there was anything that the CMO or Chief Nurse wanted to verbally report. The risk posed by the industrial action was noted with the Chief Nurse confirming that a full risk assessment had been undertaken.
22.3	The CMO also raised the issue of the roof of Shrodells had been recently assessed as posing a risk and mitigating action was being undertaken. The COO noted that conversion works had commenced on the top floor of Shrodells with a longer-term plan to bring 40 additional beds into the organisation. The fire officer's advice in respect of compartmentation opportunities in the event of a fire was a firm recommendation that there was a need to alter the arrangement of those works to make the building safe. This would involve an increased level of financial investment and a seven-week delay in delivery of those beds. The COO reported that there had been an urgent Chief's Meeting where the recommendations of the fire officer had been acknowledged and accepted. This information would feed through to the Board through the next meeting of the quality committee.
22.4	The Chair asked about the financial impact, which was reported at around £250,000.
22.5	**ACTION: The risk regarding the roof of Shrodells would be added to the Risk Register.**
22.6	**The Risk Register was approved by the Board with the addition of the two verbal items.**
23	**External Well Led review**
23.1	The CEO reported that as part of ongoing improvement and reflection within the organisation, an external well-led review had been commissioned which had commended the Trust's culture and digital maturity. Visibility and engagement had been highlighted in the review as things to be worked on.
23.2	The CEO asked that the Board note the paper and agree to prepare an action plan accordingly.
23.3	The Chair confirmed that the report and action planning would be considered by the Board in private, later in the meeting.
24	**Board Engagement Report**
24.1	The paper was taken as read and the Chief Nurse outlined the following: a) Refurbishment work in WACs to make a more sensory environment was ongoing. b) Refurbishment work was ongoing with staff rooms. c) There had been health and wellbeing events, a celebration of Black History Month and aspects of patient engagement.
24.2	Ginny Edwards queried whether staff could request a Board visit. The CPO confirmed that they were made available but there could be better ways of engaging with the workforce.
24.3	The CEO added that he had drafted a fortnightly staff email which had highlighted that staff could request a visit. However, he agreed that there should be a more structured process. He suggested an action to consider how this could be implemented.
24.4	**ACTION: A structured way for staff to request Board visits would be developed.**
25	**Board and committee terms of reference and work plan reviews**
25.1	The Chief Nurse outlined the six committees, noting changes in the review of the strategy and the terms of reference. She confirmed Great Place Committee had elected not to review its terms of reference until the strategy refresh was completed.

25.2	Jonathan Rennison queried whether there should be consistency in the number of non-executives attending the committees. The Chief Nurse confirmed that there would be an amendment, although PERC was slightly different.
25.3	A minor amendment to the FPC was suggested, where the Exec lead would be the CFO.
25.4	Harvey Griffiths asked if the terms of reference were in line with other trusts. The Chair considered that other trusts would have a similar format. Ginny Edwards added that they had a lot of committees compared to some trusts but not all trust were working on a major redevelopment project.
25.5	**Resolution: The Board approved the current set of terms of reference subject to the Strategy Review.**
26	**Items considered in March 2023 Private Trust Board**
26.1	The report was noted.
Closing Items	
27	**Any other business previously notified to the Chair**
	There was no other business for consideration.
28	**Questions from Hertfordshire Healthwatch**
28.1	There were no questions put forward.
29	**Questions from our patients and members of the public**
29.1	Q1. There is no mention of unscheduled and unannounced visits to hospital departments by non-executive directors in the Board engagement paper. How can non-execs get a full and independent picture of performance if all their visits are scheduled and announced?
29.2	The Chief Nurse responded that we are very fortunate to have a Chair and NEDs who live locally and have friends and family who experience our services and share their experiences. All NEDs are free to visit any service, within reason, unannounced.
29.3	There is a comprehensive programme of visits every month where our Board splits into groups of three or four and go to different areas to meet staff. The visits are informal by nature and provide an opportunity to understand more about our services and also the experience of our staff. The feedback is discussed at length in part 2 of the board meeting. The discursive nature of the visits, when added to the range of performance data presented to the Board provides a rounded picture for NEDs and executive directors alike.
29.4	We also have a series of ‘night walks’ to meet teams who are a valued part of our 24-hour service. These are unannounced visits and NEDs participate. In addition, many of our NEDs are chairs of Board sub-committees and this enables them to gain a very rich and detailed view of our organisation.
29.5	Q2. Watford Hospital wards have been given a 1 out of 5 food safety rating again, despite solemn promises to improve after a similar rating two years ago. Why has there been no Board discussion of this serious failure to maintain basic standards and protect patients? Will the Board review the situation soon?
29.6	The CFO responded that we have refurbished the ward kitchens since the inspection and have addressed the concerns raised. We have updated our processes and are providing

	enhanced training to ensure our food handling environment is safe and that there are strong food management procedures in place. The Board is kept informed of progress.
29.7	Q3. There are some welcome improvements to the figures for A&E performance, but the Dispatches programme revealed weaknesses in ED management of mental illness and in speed of reporting of vital test results. Could you tell us what is being done to strengthen the Trust's performance in those areas?
29.8	The COO responded that we saw unprecedented demand for urgent and emergency services over the winter, seeing around 500 patients daily. Like many NHS hospitals, the pressures were compounded by a peak in flu as well as still managing Covid cases. We were caring for many seriously ill patients at the time of filming.
29.9	The programme highlighted pressures on our capacity, which can be limited for patients experiencing severe mental health issues. As we have seen from other papers, we are working hard with partners across the NHS and the wider care system to improve the flow through our hospitals. This includes developing appropriate care solutions for patients with severe mental health issues with the aim of finding alternatives to hospital and, if they do come to our ED, speeding up the time it takes for them to have a specialist assessment and the right onward care.
29.10	The care of patients featured in the documentary has been fully reviewed. Whilst some experienced longer waits than we would like, we are satisfied that the care they received was safe.
29.11	Q4. Last month's private Board meeting discussed a review of mortuary security arrangements. Was this review prompted by any specific incident? How will security be assured during the planned move of the mortuary?
29.12	The Chief Nurse responded that the review of the mortuary security review was prompted by a criminal case at another trust. Such was the seriousness of the case that that all hospital mortuaries were required to carry out a review. As you would expect, we will make careful plans for the planned move of the mortuary, and these will include security.
29.13	Q5. Last month's private Board meeting approved a business case for a mobile MRI scanner at Hemel. How will this fit in with plans to provide new permanent premises for scanners at Hemel? When will the business case be brought forward for that?
29.14	The COO responded that the new mobile scanner will help us increase access to diagnostics for local people. It will be in place until the end of 2023/24, during which time we will finalise our plans for permanent diagnostic facilities in Hemel Hempstead.
29.15	Q6. The Trust claims to have broken even at the end of the financial year, despite being adrift on both income and expenditure very late in the year. Has this been achieved by pushing spending into the next financial year, or by other short-term financial engineering? How are the underlying problems caused by shortfalls in elective income and failure to meet CIP targets being tackled?
29.16	The CFO responded that our response to a similar question last month explained that movements of income and expenditure can happen late in the financial year. We haven't yet

	balanced income with expenditure, but we expect to report a break-even position when we report the end of year position, which will be subject to audit as usual. We have not pushed spending into the next financial year or used short-term financial engineering.
29.17	We hold 'confirm and challenge' meetings to help manage our CIPs. In terms of elective income, we are focusing on improving our data quality and theatre productivity, both of which will help in the current regime of payment per elective activity.
29.18	Q7. The last-minute shelving of last week's planned announcement on new hospital funding suggests, among other things, that the Trust is having serious problems persuading the Treasury to back its £1.1 bn plus preferred Watford option. The likely outcome is that we will have to endure decades more of the shabby Princess Michael of Kent building. Isn't this failure (long predicted by the New Hospital Campaign) a direct result of the refusal of the Trust to properly assess new site options and seek value for the patient and the taxpayer?
29.19	The Chief Redevelopment Officer responded that we can't comment on the timings of government announcements. All we can say is that we remain in active dialogue with the New Hospital Programme.
30	**Date of the next Board meeting**
30.1	The next Board meeting would be held on 4 May 2023 at Hemel Hempstead Hospital and via Zoom.

BOARD DECISION LOG

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

West Hertfordshire Teaching Hospitals NHS Trust

Agenda item: 7

Action log (updated following 6 April 2023)

No.	Date of meeting	Minute ref	Action	Lead for completing the action	Date to be completed	Update
1	6 April 2023	22.5	The risk regarding the roof of Shrodells would be added to the Risk Register.	Chief Nurse	May 2023	Complete
2	6 April 2023	24.4	A structured way for staff to request Board visits will be developed.	CEO	May 2023	Complete

TRUST BOARD WORK PLAN 2023/24: Part 1	Apr-23	May-23	Jun-23	Jul-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Service presentation/patient story	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Trust Chair and Chief Executive's report	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Performance											
Access standards performance and activity recovery overview	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Integrated Performance Report	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Aim 1: Best Care											
Seven day services – board assurance framework	✓										
Bi-annual establishment review – maternity					✓						✓
Bi-annual establishment review report – adult inpatient wards				✓						✓	
Annual establishment review report – Paediatrics							✓				
Establishment review - neonates							✓				
Perinatal quality surveillance -maternity minimum dataset (quarterly as part of IPR)			✓		✓		✓			✓	
Maternity safety strategy actions and CNST incentive scheme (as required)			✓		✓			✓			
Annual report: infection prevention and control								✓			
Annual report: safeguarding				✓							
Outcome of national patient surveys/progress reports		Reports aligned with the publication of results									
Report on the quality account (ratification of QC approval)				✓							
Annual report: end of life care						✓					
Annual report: complaints and patient advice and liaison								✓			
Annual report: serious incidents and never events						✓					
Quarterly learning from deaths report				✓		✓				✓	✓
Annual assurance report: emergency preparedness, resilience and response					✓						
Patient Safety Specialist update											
Health inequalities											
Annual report: Legal services								✓			
Aim 2: Best Value											
Outline and final business cases for capital investment more than £1m (as required)	As required										
Ratify proposals for acquisitions, disposals or changes of use and/or buildings (as required)	As required										
Approval to open bank accounts (as required)	As required										
Finance update	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Aim 3: Great Team											
Research and development update							✓				
Public Sector Equality Annual Report				✓							
Equality and Diversity WRES & WDES annual reports				✓							
EDS3				✓							✓
Gender and race pay gap report							✓				
Outcome of national staff survey/progress report		✓									✓
Annual medical appraisal report and statement of compliance					✓						
Annual People Strategy update					✓						
Bi-annual freedom to speak up/whistle blowing report		✓					✓				
Guardian of Safe Working Annual Report					✓						✓
FPPR Report		✓									
Aim 4: Great Place											

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

West Hertfordshire Teaching Hospitals NHS Trust

Trust Board Meeting
4 May 2023

Title of the paper	**Chair's Report**
Agenda Item	**9**
Presenter	**Jonathan Rennison, Vice Chair**
Author(s)	**Barbara Anthony, Trust Secretary**
Purpose	**For approval** ☐ **For discussion** ☐ **For information** ☐
Executive Summary	This paper provides an update to the Board on items of national and local interest/relevance.
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1 Best care** — *Objectives 1-4*: x **Aim 2 Great team** — *Objectives 5-8*: x **Aim 3 Best value** — *Objective 9*: x **Aim 4 Great place** — *Objective 10-12*: x
Links to well-led key lines of enquiry	☐ Is there the leadership capacity and capability to deliver high quality, sustainable care? ☐ Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☐ Is there a culture of high quality, sustainable care? x☐ Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☐ Are there clear and effective processes for managing risks, issues and performance? x☐ Is appropriate and accurate information being effectively processed, challenged and acted on? x☐ Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☐ Are there robust systems and processes for learning, continuous improvement and innovation? ☐ How well is the trust using its resources?
Previously considered by	Committee/Group: N/A — Date:
Action required	The Board is asked to receive the report for information.

West Hertfordshire Teaching Hospitals NHS Trust

Agenda Item: 9

Trust Board Meeting – 4 May 2023

Chair's report

Presented by: Jonathan Rennison, Vice 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

Wishing everyone a Happy Eid

2.1 I would like to wish everyone a very warm and Happy Eid Mubarak and hope that everyone who celebrates Eid was able to do so with their family and friends.

West Herts leads the way with support for international nurses

2.2 I am delighted that West Herts has been recognised as a leader in supporting international nurses to qualify and prepare for life as a nurse in the UK. The Objective Structured Clinical Examination (OSCE) training team and international nurses have worked hard to make West Herts' pass rates much higher than the national average. West Herts has an incredible pass rate of 86% against a national average of 79%. The OSCE team have trained more than 700 nurses since 2016 and recently received a letter from NHS England which showed appreciation for the support they provide to international nurses. My thanks to the OSCE training team for supporting our international nurses so well.

George cross to tour the nation to mark NHS 75th birthday

2.3 The George Cross medal, awarded to the NHS in England last year by the late Queen, is set to tour the nation from July. It was bestowed on staff for their exceptional efforts, particularly during the pandemic, and was only the third time in British history the medal has been granted to an organisation for an act of great heroism. The medal will be on display at the iconic Science Museum in London as a temporary addition to Medicine: The Wellcome Galleries, the world's largest museum devoted to the history of medical healthcare. It will then visit the South West in 2025, with the venue to be confirmed in due

course. The award recognises the courage, compassion and dedication of NHS staff and volunteers, as well as the work of the NHS since it was established in 1948.

Installation of LED lighting across the Trust

2.4 The Trust is committed to being energy efficient and I am pleased to see that the project to install LED lighting across the Trust is making great progress and has the potential to save 877 tonnes of carbon and over £1 million on energy costs every year.

3 Community News

Local quilting group's cushion-a-thon for West Herts

3.1 Mead Quilters, a friendly quilt guild based in Wheathampstead, have been busy sewing up a storm to create beautiful little cushions for the breast clinic at St Albans. These cushions are given out to patients at the breast clinic every year and are used under the arm for comfort following surgery and placed under a seat belt to protect the surgical area. Chief nurse Tracey Carter and the breast care nursing team met with members from Mead Quilters to receive the cushions and say thank you for their incredible efforts. I am grateful to the Mead Quilters for their on-going support and kindness.

Anytime Fitness Easter egg donation to Raise

3.2 I would like to thank Anytime Fitness for their kind donation of 300 Easter eggs to the hospital charity Raise's Easter egg appeal. The special chocolate treats helped bring smiles to young patients staying in hospital over the bank holiday weekend. I know that Starfish ward were extremely grateful for the donation as it made a real difference to children staying in hospital over the Easter holidays.

4 Hertfordshire and West Essex ICS

Hewitt Review of integrated care systems

4.1 The Rt Hon Patricia Hewitt was commissioned to lead an independent review of integrated care systems (ICSs) in November 2022. Each ICS has an integrated care board (ICB), which includes representatives from local authorities, primary care and NHS trusts and foundation trusts. The review covered ICSs in England and the NHS targets and priorities for which ICBs are accountable, including those set out in the government's mandate to NHS England.

4.2 The review concluded that ICSs represent the best opportunity for a transformation in our health and care system. However they require collaboration and limited shared priorities, should allow local leaders the space and time to lead, balancing freedom with accountability and enabling access to timely, transparent and high-quality data. DHSC should incentivise the flow and quality of data between providers and systems while the CQC and NHS England should complement each other. Finally the review recommended that work should be done to design a new framework for GP primary care contracts, recruit and train more specialists, and reset the approach to finance to create health value.

4.3 The government is now considering the recommendations made by the review.

4.4 The latest edition of the Hertfordshire and West Essex ICB update can found here https://hertsandwestessex.icb.nhs.uk/homepage/24/hertfordshire-and-west-essex-icb-

update and demonstrates the work that system partners are undertaking to improve and development services for local communities.

5 BOARD NEWS

Board visit programme:

5.1 As part of the monthly Board visit programme, the Board visited the following areas on 6 April 2023:

- Emergency Department
- Pastoral Care
- Intensive Care Unit (ICU)
- Estates

6 Trust Chair's meetings:

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

- Herts Chairs – 6 weekly call
- Meeting with NEDs on ward discussion
- Consultant Interviews – Dermatology
- Star of Herts award category discussion.
- Annual leave: 17 April – 7 May 2023

7 RECOMMENDATION

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

Jonathan Rennison
Vice Chair

April 2023

West Hertfordshire Teaching Hospitals NHS Trust

Trust Board Meeting
4 May 2023

Title of the paper	**Chief Executive's Report**
Agenda Item	**10**
Presenter	**Matthew Coats, Chief Executive**
Author(s)	**Barbara Anthony, Trust Secretary**
Purpose	**For approval** ☐ **For discussion** ☐ **For information** ✓
Executive Summary	The aim of this paper is to provide an update to the Board on items of national and local interest/relevance since the last meeting. The information in the report is drawn from a variety of sources, including information published by NHS England/Improvement, DHSC, NHS Providers and the CQC.

Trust strategic aims

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

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

Links to well-led key lines of enquiry

✓ Is there the leadership capacity and capability to deliver high quality, sustainable care?
✓ Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
✓ Is there a culture of high quality, sustainable care?
✓ Are there clear responsibilities, roles and systems of accountability to support good governance and management?
✓ Are there clear and effective processes for managing risks, issues and performance?
✓ Is appropriate and accurate information being effectively processed, challenged and acted on?
✓ Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
✓ Are there robust systems and processes for learning, continuous improvement and innovation?
✓ How well is the trust using its resources?

Previously considered by	Committee/Group	Date
	N/A	
Action required	The Board is asked to receive the report for information.	

West Hertfordshire Teaching Hospitals NHS Trust

Agenda Item: 10

Trust Board Meeting – 4 May 2023

Chief Executive's report

Presented by: Matthew Coats, Chief Executive Officer

1 PURPOSE

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

2 KEY ISSUES

Patient care across the Trust

2.1 I want to express my gratitude to all of our employees for their remarkable effort over the last month, which has not always been simple due to recent strikes in the NHS and other parts of the public sector. I am aware that we are asking a lot from our staff, many of whom took on extra shifts and planning responsibilities to ensure that our services ran as smoothly as possible. I want to thank everyone for working together and treating one another with kindness and professionalism and respecting our co-workers' decisions to participate in or abstain from industrial action.

2.2 I want to express my gratitude again to the ward nursing and outpatient nursing team for their commitment to our patients throughout this time. We worked hard to prepare for industrial action and minimise the effects of the strikes and we should be proud that we were able to provide a reduced, but safe service. I am hopeful that a national resolution will be achieved soon.

On-going demand and capacity

2.3 The demand on services remains high, but the trend of gradually diminishing attendances is continuing. This is welcome and evidence of a strong culture to work with our system colleagues to provide the best care in the right place. Colleagues will also be pleased to see that whilst demand from patients with mental health issues remains high, we are also starting a see a slight reduction in both the numbers attending our emergency department and needing to remain there for over 12 hours. We will continue to work with our mental health and community colleagues to ensure this trend continues to reduce.

2.4 Our focused work on patient flow through our emergency department and our elective recovery continues at pace. Our early results continue to remain positive, and I would like to thanks the operational staff involved in this work for all of their efforts. However, we must be mindful that the recent strikes have had an impact on our elective care performance and waiting time lists, as appointments for planned care have needed to be rescheduled. This impact will become more evident as the data becomes available over the next few months.

Chair re-appointed for further two years

2.5 Congratulations to Phil Townsend who has been reappointed as Chair until 2025. Phil has used his skills and expertise from a long career in industry to help steer the Trust through a period of sustained improvement. He has taken a strong interest in our redevelopment plans and has chaired board meetings and consultant recruitment panels, as well as maintaining great working relationships with MPs, business leaders and partners in the local health system. He is well known to staff for his regular visits across the Trust and for awarding our monthly and annual Star of Herts staff awards. I am delighted with this news and look forward to working with Phil over the next two years.

Farewell to Tracey Carter, Chief Nurse

2.6 I would like to thank Tracey Carter for her dedicated service to this Trust over the past 8.5 years. I know from conversations with colleagues that the Trust faced many challenges when Tracey joined. During her time here, she has put patients and their carers at the heart of the Trust's work, implemented high standards, and provided outstanding leadership during the pandemic. She leaves us in an extremely strong position for which I know everyone in the Trust is sincerely grateful. We wish Tracey the very best for her future career at Kings Hospital.

Appointment of our new Chief Nurse

2.7 I am delighted to announce the appointment of Kelly McGovern as Chief Nurse at the Trust, who will replace Tracey Carter when she leaves on 19 May 2023 to take up her post as Chief Nurse at Kings Hospital. Kelly is the Deputy Chief Nurse and Director of Nursing of the Broomfield site for Mid and South Essex NHS Foundation Trust. Our Deputy Chief Nurse, Michelle Hope will be Acting Chief Nurse until Kelly's arrival on 24 July 2023.

Welcome to Toby Hyde, Chief Strategy and Collaboration Officer

2.8 Toby Hyde, Chief Strategy and Collaboration Officer joined the Trust on 24 April 2023 and will be leading on the strategy refresh going forwards. Over the past few months, we have held strategy refresh engagement sessions across the Trust and I am grateful to those who have given up their time to participate in them. As part of the next stage of engagement, the leadership team have created a survey that describes the eight strategic themes in more detail and asks participants to share any additional suggestions on the Trust's proposed priorities.

Appointment of Simon West as Deputy Medical Officer Health for Jersey

2.9 Congratulations to Simon West, Divisional Director of Surgery, Anaesthetics and Cancer who has been appointed as Deputy Medical Officer Health for Jersey. We have started the process to recruit Simon's successor and anticipate updating the Board in the next few months.

3 CHIEF OFFICERS UPDATES

Chief Financial Officer

3.1 For the 2022/23 financial year, we will report a balanced budget, with revenue income exceeding spend by £0.3m and a £39 million capital investment in enhancing our estate and equipment infrastructure.

3.2 Moving into the 2023/24 financial year, our goal is to manage our revenue and capital finances just as effectively. However, we acknowledge the need for a significant boost in elective patient activities to maintain funding levels and reduce waiting times for patients. Our financial management strategy includes achieving £16 million in new savings while eliminating our reliance on the £9.4 million in COVID funding received during the 2022/23 financial year.

Chief Medical Officer

3.3 West Herts is demonstrating its commitment to patient safety by hosting the first of four patient safety learning summits on 26 April 2023. There will be four summits throughout the year focusing on corporate and clinical governance (26 April 2023), infection prevention and control and antimicrobial resistance stewardship (6 June 2023), deteriorating patients (5 September 2023) and enhanced care needs (10 January 2024). All summits will be held at Watford FC and streamed live, with a British Sign Language interpreter, induction loops and captions available. Attendees will gain over 30 continuing professional development (CPD) points by attending all four events.

3.4 Dr Alan Fletcher, National Medical Examiner for England and Wales and his team visited Watford General Hospital last week in recognition of our successful rollout of the medical examiner's office service to the local community. He met members of the West Herts' team who have been instrumental in the success of the service, including Dr Malini Bhular, Dr Anna Wood, medical examiners and officers from the team, and Amy Faulkner, Patient Affairs Manager. The medical examiner service independently scrutinises deaths in hospital settings and has asked Watford General Hospital to help other acute trusts follow suit. My thanks to the team for all their hard work, and congratulations on this national recognition.

Chief Information Officer

3.5 The Hertfordshire and West Essex Shared Care Record now contains information from all five hospices in Hertfordshire and West Essex. Endoscopy reports have also been added to the information available from The Princess Alexandra Hospital NHS Trust (PAHT) and East North and Herts NHS Trust. An initial set of data from University College London Hospitals NHS FT (UCLH) is now available as part of our connection to the London Care Record. These additions demonstrate our progress in working as a system for the benefit of our patients.

Chief Nurse

3.6 The preceptorship team at the Trust have been awarded the Quality Mark, a gold standard recognition, for their amazing preceptorship programme. We are the first trust in the country and the first in the East of England region to have been awarded the Quality Mark, which was developed to recognize organisations who go above and beyond in supporting newly qualified staff in their transition to their clinical roles. Thank you and congratulations to the preceptorship team for their brilliant work.

Chief People Officer

Industrial Action Update

3.7 We have recently had the further action undertaken by junior doctors leading to approximately 200 staff taking part in industrial action. This was more challenging than the previous occasion as a result of the bank holiday and Easter period.

3.8 There has been an announcement of further action by the RCN. This action is based on the mandate from their original ballot and therefore will not have a direct impact on West Herts. However, we are engaging with partners directly affected to offer support.

Teaching Hospital Status

3.9 On 16 February the Board held a development session associated directly with the benefits and aspiration associated to Teaching Hospital status. The papers today provide some update associated to our commitment on priorities.

3.10 In the last few weeks we have continued developing our relationships with University of Hertfordshire with an emphasis on their process to having a medical school. The university has been successful at stage 1 of 8 in the process with an expectation that the first students will be enrolled in 4 years time.

3.11 We are also pleased with our partnership arrangements with West Herts college. In particular we have agreed opportunities for our staff to provide teaching. This will support the college and the students with better context alongside the NHS while at the same time support professional development of some of our staff.

3.12 In addition, we are also looking forward to engage in virtual reality training opportunities facilitated by the college for a cohort of relevant staff at the Trust. It is also proposed a future Board Development session that aligns EDI and VR training and for this to take place at the college facilities.

Medical Support Workers

3.13 Following the recent announcement that funding for Medical Support Workers would be removed for 2023/24 we are pleased to announce that funding has been restored for the opportunity of up to 240 MSW across the East of England region. David and Katie will be working together alongside Divisions to identify opportunities for West Herts and how this can support some of our winter plans and the shortfall in our medical workforce.

Project Choice

3.14 We have commenced initial discussions with Project Choice in order to provide opportunities for students with learning needs or autism to undertake work experience at West Herts. We are hoping that we can provide this alongside our partners at Westfield Academy and integrate with our wider work experience programme and hopefully develop this further into internships.

4 NATIONAL GUIDANCE

10-year vision for adult social care system

4.1 The government is committed to the 10-year vision for adult social care set out in the People at the Heart of Care white paper. This 'Next steps to put People at the Heart of Care' plan details how £700 million will be spent to continue the transformation of the adult social care system in England, including investment in improved access to care and support, recognising skills for careers in care, driving digitisation and technology adoption, data and local authority oversight, support to enable people to remain independent at home, encouraging innovation and improvement, joining up services to support people and carers.

4.2 Alongside this plan, the government has also launched the call for evidence for the care workforce pathway, published the Better Care Fund policy framework 2023 to 2025, published guidance and conditions for the Market Sustainability and Improvement Fund (MSIF), provided £27 million to local authorities through a grant to streamline local authority adult social care assessment processes, and launched an expression of interest for year 2 funding of the Adult Social Care Technology Fund. We look forward to working with our local authority partners to make the best use of this funding.

Health Education England and NHS England complete merger

4.3 NHS England and Health Education England have legally merged to create a new, single organisation to lead the NHS in England. This follows the merger of NHS Digital and NHS England on the 1 February 2023, and brings the NHS' people, skills, digital, data and technology expertise together into one national organisation to deliver high-quality services for all in England.

4.4 Health Education England has played a critical role in improving the quality of health and care services and growing the number of staff working in the NHS over the last decade. The new organisation will build on the strengths and expertise of its legacy organisations, while avoiding duplicate activities, enabling it to be even more responsive to changing demand and to the biggest challenges, priorities and opportunities of the health system. It is expected that by the end of 2023/24, the new organisation will be between 30-40% smaller than the current combined size of NHS England, Health Education England and NHS Digital.

Spring Covid jabs

4.5 The NHS Covid-19 Vaccination Programme has opened up its spring offer to all those eligible. More than 320,000 people have already booked an appointment and the first of these will begin receiving their vaccinations from today. Around five million people are eligible in line with JCVI advice, including over 75s, those aged five and over with a weakened immune system, and older adult care home residents.

4.6 The NHS has issued 1.25 million invites so far and a further one million people will be asked to book a vaccine appointment this week. The health service has administered more than 144.5 million covid jabs over several vaccination campaigns since Maggie Keenan became the first in the world outside of a clinical trial to receive the vaccination in December 2020.

5 RECOMMENDATION

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

Matthew Coats
Chief Executive
April 2023

Trust Board Meeting

4 May 2023

Title of the paper	**Board Assurance Framework report**
Agenda Item	**11**
Presenter	**Matthew Coats, Chief Executive Officer**
Author	**Barbara Anthony, Trust Secretary**
Purpose	*For approval* ✓ / *For discussion* / *For information*
Executive Summary	The Board approved the corporate aims and objectives for 2022/23 on 7 April 2022. The BAF dashboard and detailed risks are attached for the Board to approve. The risks have been discussed at the Finance and Performance Committee, and the Quality Committee on 27 April 2023. The Quality Committee and Finance and Performance Committee recommended no changes to risks at this time. Changes have been made to the content of BAF risk 2 and BAF risk 3 which are marked in red and provide an update on the progress made with elective and non-elective capacity. This report is to provide the Board with assurance that risks to achieving the Trust's strategic objectives are being appropriately mitigated, to consider those elements that report direct to Board and any recommendations of changes from assurance committees.

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

Links to well-led key lines of enquiry	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☒Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues and performance? ☒Is appropriate and accurate information being effectively processed, challenged and acted on? ☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☒Are there robust systems and processes for learning, continuous improvement and innovation? ☒How well is the trust using its resources?
Previously considered by	• Finance and Performance Committee – 27 April 2023 • Quality Committee – 27 April 2023
Action required	The Board is asked to consider and approve: • This month's version of the BAF.

West Hertfordshire Teaching Hospitals NHS Trust

Agenda Item: 11

Trust Board meeting – 4 May 2023

Board Assurance Framework report

Presented by: Matthew Coats, Chief Executive Officer

1. Purpose

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

2. Background

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

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

- The Trust's four aims and 11 underpinning strategic objectives
- A headline summary of all the issues (risks) that might get in the way of achieving those objectives.
- A headline summary of what the Trust is doing about those issues, along with a concise description of how the Board can be assured that what is being doing is working.

2.3 Where appropriate the BAF is cross-referenced against operational risks on the corporate risk register. It should be noted that the BAF and corporate risk register are complementary but not the same thing.

2.4 The difference between 'assurance' and 'reassurance' is vital to make the BAF work. Reassurance is when someone tells you all's well; assurance is when they tell you what's happening, show you the evidence and you can judge for yourself if all's well. The diagram below demonstrates this in more detail.

Reassurance **Assurance**

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

	– Management explanations are consistent	– Triangulation with other information

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

3. Monthly review

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

3.2 Elements of the BAF were reviewed on 27 April 2023 by Quality Committee and Finance and Performance Committee.

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

3.4 Changes have been made to the content of BAF risk 2 and BAF risk 3 which are marked in red. (See paper 11.2 for further details of QC risks)

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

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

- BAF 10 (engagement and inclusion with staff will be affected negatively where we do not support and celebrate cultural diversity and demonstrate opportunities across all areas of our workforce to ensure it is representative),
- BAF 11 (sustainable staffing and improved levels of retention will be affected if we do not invest internally in a positive workplace experience, staff development and externally in local and international candidate opportunities) and
- BAF risk 12 (the morale and retention of our skilled workforce is at risk if we do not support and prioritise learning and career opportunities for our staff in order to maintain and enhance development and reduce staff turnover)

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

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

4. Risks

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

5. Recommendation

5.1 The Board is asked to consider and approve:

- the revised version of the BAF.

Matthew Coats
Chief Executive Officer

April 2023

	BOARD ASSURANCE FRAMEWORK FOR 2022-23													
	Trust Board Dashboard													
Strategic Aim/Priority		**Risk no**	**Risk description**	**Executive Lead/ Committee**	**Link to CRR**		Risk Score (L x C)							
						Residual April 22	**Jun/ July 22**	**Aug/ Sep 22**	**Oct /Nov 22**	**Dec/ Jan 23**	**Feb/ Mar 23**	**April/ May 23**	**Target (03/ 2024)**
Best Care	**Resilient Services**	1	If we do not work with acute partners, then we won't be able to strengthen fragile services, recover our acute waiting list and improve patient outcomes.	Matthew Coats / QC		20 (5 x 4) HIGH	20	20	20	16	16	16	12 (3 x 4) Mod
	Improving access to care	2	If the Trust and wider system does not have sufficient elective and diagnostic capacity, then its waiting lists will increase, and patients will be unable to access timely care.	Sally Tucker/ QC	4019 4496 4497	20 (5 x 4) HIGH	20	20	20	16	16	16	9 (3 x 3) Low
		3	If the number of non-elective patients continues to rise, then this will detrimentally affect the Trust and wider system's ability to treat elective patients and reduce its waiting lists for elective care.	Sally Tucker/ QC	3828 4444	20 (5 x 4) HIGH	20	20	20	20	20	20	9 (3 x 3) Low
		4	If we have insufficient staff because of low morale, inability to recruit or no enthusiasm for additional work, then we will be unable carry out additional elective work and reduce our waiting lists.	Andrew McMenemy / QC		20 (5 x 4) HIGH	20	20	20	16	16	20	12 (3 x 4) Mod
	Reducing inequalities	5	If the Trust does not engage collaboratively with its patients and local communities, in the planning and delivery of care and services, then it may not meet the needs of its diverse population resulting in the exacerbation of health inequalities.	Tracey Carter/ QC		9 (3 x 3) Mod	9	9	9	9	9	9	6 (3 x 2) Low
	Transforming our services	6	If we do not work with partners to transform our services, then we will not have sufficient capacity to provide safe and effective care to our patients.	Matthew Coats / QC		20 4 x 5 HIGH	20	20	20	20	20	20	10 2 x 5 Mod

Best Value	Ensure we can meet the health needs of our population within our budget on an on-going basis	7	Failure to agree a plan between the Integrated Care System and the Trust Board to reasonably support the balancing of this year's revenue income with revenue expenditure, when safely responding to expected patient demand.	Don Richards/ FPC		12 (3 x 4) Mod	16 4 x 4 High ↑	12 3 x 4 Mod ↓	12 ↔	12 ↔	12 ↔	12 ↔	8 (2 x 4) Mod
		8	Failure to take corrective action to manage internal/external factors, may result in the trust being unable to adhere to the agreed financial plan.	Don Richards/ FPC		16 (4 x 4) High	16 ↔	16 ↔	16 ↔	16 ↔	16 ↔	16 ↔	8 (2 x 4) Mod
		9	Failure to agree a realistic long term financial plan that is consistent with ICB long-term allocations compromising the ability to transform the estate and services to meet the longer term needs of the population.	Don Richards/ FPC		12 (3 x 4) Mod	12 ↔	12 ↔	12 ↔	12 ↔	12 ↔	12 ↔	8 (2 x 4) Mod
Great Team	Culture of inclusion and diversity	10	Engagement and inclusion with staff will be affected negatively where we do not support and celebrate cultural diversity and demonstrate opportunities across all areas of our workforce to ensure it is representative.	Andrew McMenemy / PERC		12 (4 x 3) Mod	12 ↔	12 ↔	12 ↔	12 ↔	9 ↓	9 ↔	6 (3 x 2) Low
	Improve workforce sustainability	11	Sustainable staffing and improved levels of retention will be affected if we do not invest internally in a positive workplace experience, staff development and externally in local and international candidate opportunities.	Andrew McMenemy / PERC		16 (4 x 4) HIGH	16 ↔	16 ↔	16 ↔	16 ↔	12 ↓	12 ↔	8 4 x 2
	Develop as a learning organisation	12	The morale and retention of our skilled workforce is at risk if we do not support and prioritise learning and career opportunities for our staff in order to maintain and enhance development and reduce staff turnover.	Andrew McMenemy / PERC		16 (4 x 4) HIGH	16 ↔	16 ↔	16 ↔	16 ↔	12 ↓	12 ↔	8 4 x2
Great Place	Digital and IT innovation	13	If the Trust is unable to secure sufficient funding to support its digital strategy, then its ability to transform its services will be affected.	Paul Bannister / GPC		15 (5 x 3)	15 ↔	15 ↔	15 ↔	15 ↔	15 ↔	12 ↔	6 2 x 3
	Redevelop our hospitals	14	If the confirmation of our capital allocation is delayed, it could lead to increased risk to the safe operation of the existing Watford hospital.	Don Richards/ GPC		20 (5 x 4)	20 ↔	20 ↔	20 ↔	20 ↔	20 ↔	20 ↔	12 3 x 4

	Environmental Sustainability	15	If we do not minimise the Trust's adverse impact on the environment, then we may suffer reputational damage, cause increased pollution within our local and wider community and lose out on cost saving opportunities.	Don Richards/ GPC		9 (3 x 3)	9	9	9	9	9	9	4

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

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

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

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

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

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

Progress		
Positive progress including future opportunities	Current challenges including future risks	How challenges are being managed
National recognition that plans to balance income with expenditure contain unmitigated inflation risk. Efficiency programme governance in place to support Divisions in developing efficiencies.	Inflation effect manifests the worst case and additional inflation funding is not made available. Efficiency programme governance fails to support	Frequent dialogue with the ICB highlighting risks/conditions within the plan which must be mitigated/met to deliver financial balance.

National work to test resources necessary to respond to a 7.5% increase in emergency care demand. Divisions have set out and signed off high level plans for increasing elective activity. Increased support from the Centre for Elective Recovery Funding.	delivery of £15m general savings and £2.9m EPR related savings. Demand management fails, emergency care demand exceeds expectation and additional funds not made available.	Internal audit of financial governance planned. Stronger ICP governance. Review of inflation forecast by CFO.

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

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

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

Context

Monitoring and corrective action planning through Divisional Finance and General Performance Reviews, Trust Management Committee, Finance Committee and Trust Board of the current factors that are most likely to affect the financial plan such as:

1. Inflation experience and procurement actions
2. Costs related to management of pandemic and appropriate adherence to IPC guidance.
3. Maximising ICP contribution to managing ED demand
4. Ensuring achievement of the efficiency programme by replacing any failed interventions with new interventions where necessary.
5. Achievement of elective capacity targets through ensuring planned developments are implemented and deliver anticipated measurable benefits.

Gaps in Control and Assurance

Control of inflation
Control of ED demand only partially controlled through local partnership working.

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

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

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

Risk Score

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

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

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

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

BOARD ASSURANCE FRAMEWORK FOR 2022-23

Quality Committee Dashboard

Strategic Aim/Priority		Risk no	Risk description	Executive Lead	Link to CRR	Risk Score (L x C)							
						Residual April 22	Jun/ July 22	Aug/ Sep 22	Oct/ Nov 22	Dec/ Jan 23	Feb/ Mar 23	Apr/ May 23	Target (03/ 2024)
Best Care	Resilient Services	1	If we do not work with acute partners, then we won't be able to strengthen fragile services, recover our acute waiting list and improve patient outcomes.	Matthew Coats		20 (5 x 4) HIGH	20	20	20	16	16	16	12 (3 x 4) Mod
	Improving access to care	2	If the Trust and wider system does not have sufficient elective and diagnostic capacity, then its waiting lists will increase, and patients will be unable to access timely care.	Sally Tucker	35 (3828) 36	20 (5 x 4) HIGH	20	20	20	16	16	16	9 (3 x 3) Low
		3	If the number of non-elective patients continues to rise, then this will detrimentally affect the Trust and wider system's ability to treat elective patients and reduce its waiting lists for elective care.	Sally Tucker	19 (4019) 20 (4496) 21(4497) 22 30 23 36 113	20 (5 x 4) HIGH	20	20	20	20	20	20	9 (3 x 3) Low
		4	If we have insufficient staff because of low morale, inability to recruit or no enthusiasm for additional work, then we will be unable carry out additional elective work and reduce our waiting lists.	Andrew McMenemy	37	20 (5 x 4) HIGH	20	20	20	16	16	16	12 (3 x 4) Mod
	Reducing inequalities	5	If the Trust does not engage collaboratively with its patients and local communities, in the planning and delivery of care and services, then it may not meet the needs of its diverse population resulting in the exacerbation of health inequalities.	Tracey Carter	30	9 (3 x 3) Mod	9	9	9	9	9	9	6 (3 x 2) Low
	Transforming our	6	If we do not work with partners to transform our services, then we will not have sufficient capacity to provide safe and effective care to our patients.	Matthew Coats	30	20 4 x 5 HIGH	20	20	20	20	20	20	10 2 x 5 Mod

Risk Matrix

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

BAF Risk 1	If we do not work with acute partners, then we won't be able to strengthen fragile services, recover our acute waiting list and improve patient outcomes.
Strategic Priority	Resilient Services
Review Date	Monthly
Exec Lead	Matthew Coats
Reporting Committee	Quality Committee

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

Context

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

The pandemic has significantly impacted the provision of services. Collectively, we have extremely high waiting lists which we will only be able to reduce if we work together.

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

Gaps in Control and Assurance

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

Scoring

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

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

Progress

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

BAF Risk 2	If the Trust and wider system does not have sufficient elective and diagnostic capacity, then its waiting lists will increase, and patients will be unable to access timely care.
Strategic Priority	Improving access to care
Review Date	Monthly
Exec Lead	Sally Tucker
Reporting Committee	Quality Committee

	Risk Score							
Residual	Apr/May	Jun/July	Aug/Sep	Oct/Nov	Dec/Jan	Feb/Mar	Apr/May	Target
20 (5 x 4)	20	20	20	20	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. ORG, RTT Programme board, patient access meetings. Availability of monitoring data for divisions' to assess productivity performance & PTL management.
- Outsourcing Group provides oversight on private and independent sector capacity utilisation to maximise activity opportunities.
- Outpatient transformation. Non- face to face, PIFU and referral management systems.

Scoring

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

Progress

Positive progress including future opportunities	Current challenges including future risks	How challenges are being managed
Diagnostics – extended the mobile MRI provision at HH to March 23. Established outsourcing criteria – outsourced more complex patients. Proactive reduction of 104 week waiters (55 to 0 for end of October 22 which has been maintained in line with the national objective.) ~~and ahead of 78 week wait improvement plan with reduction from 144 in April to 74at end of December (plan 78).~~ We finished the financial year with ten 78 week breaches, of which 3 were patient choice deferrals to later in the year. Complex Orthopaedic surgery recommenced at Watford on 10 October 22 for a period of 6 weeks. The next planned Orthopaedic focus period has not yet been finalised ~~is scheduled for Feb/Mar 23.~~	Referral profile post COVID has changed, with an increased proportion of urgent and cancer referrals. Lack of uptake of additional waiting list initiatives by clinicians. Unpicking use of EPR – issues with clock stops, PTL management, data quality. User knowledge / training Urgent care demands have increased recently (Dec 22) necessitating surge in to exceptional escalation areas, resulting in decreased capacity for elective activity, particularly affecting Cardiology, Gastroenterology and complex surgical admissions	Continuous review of demand and referral profile. Monitoring of productivity by division/specialty. Increased external performance oversight. EPR – close working with trust's digital leader and participation in digital steering group. Approval of business case for increased validation resources. Development of RTT and EPR training programme following review of issues leading to poor DQ within the PTL. Roll out ~~expected to~~ commenced in Feb/Mar 23. Launch of high impact change plan with 4 key areas of focus: Data Quality Theatre Productivity Long wait improvement Outpatient transformation & productivity

BAF Risk 3	If the number of non-elective patients continues to rise, then this will detrimentally affect the Trust and wider system's ability to treat elective patients and reduce its waiting lists for elective care.
Strategic Priority	Improving access to care
Review Date	Monthly
Exec Lead	Sally Tucker
Reporting Committee	Quality Committee

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

Context

Continued increase in emergency care demand.

Upper threshold of ambulance conveyances has continued

Patients are opting to utilise hospital based emergency care services on the basis of a) constraints in accessing primary care or b) not wishing to engage in virtual appointment at GP practice level.

The continued increase in emergency demand and admission rates is creating more outlying patients and increased use of surge areas which reduces the amount of available ring-fenced elective care beds. Urgent care demands have increased recently (Dec 22) necessitating surge in to exceptional escalation areas, resulting in decreased capacity for elective activity, particularly affecting Cardiology, Gastroenterology and complex surgical admissions.

Gaps in Control and Assurance

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

- On going work with system partners to audit primary care restoration of services.

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

- Maximising our SDEC services to enable admission avoidance.

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

Scoring

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

Progress

Positive progress including future opportunities	Current challenges including future risks	How challenges are being managed
MADE event held during the week of 3 January 23 with Discharge Summit, attended by CEO & COO in that week, along with senior system partner representatives. SMART extension to Gastroenterology and Cardiology Expansion of the virtual hospital model, initially to include heart failure and COPD with a roll out for wider use for other conditions eg Frailty, with capacity for 40 patients at any time. Robust oversight to support consultant appointments cross divisionally. Joint working EEAST re ambulance conveyances. ~~Programme Interim Director of Transformation overseeing launch and delivery of patient flow initiatives~~	Demand is outside of our control. Ongoing increases in mental health demand alongside mental health delays. Ambulance conveyances, when arriving in clusters, result in increased flow pressures to ED alongside the need for rapid handover and release. Urgent care demands continue to rise, ~~have increased recently (Dec 22)~~ necessitating surge in to exceptional escalation areas, at times resulting in decreased capacity for elective activity, particularly affecting Cardiology, Gastroenterology and complex surgical admissions	ICS System working. Participation in ICS UEC Board. Mutual aid support via ICB with regard to ambulance conveyance and delayed handovers (intelligent conveyancing). Internal review of end to end patient flow i.e. discharges (via HEG). A follow-up summit on 17 August took place to look at Trust initiatives and opportunities of working and improving patient flow. Joint working with HPFT with regard to alternatives to acute hospital attendance for MH patients, focusing on community crisis support initiatives. MADE event to support system partner commitment for patient flow out of hospital. Launch of High Impact Patient Flow initiatives: • Patient assessment • Discharges • Control Centre • Urgent Treatment Centre

BAF Risk 4	If we have insufficient staff because of low morale, inability to recruit or no enthusiasm for additional work, then we will be unable carry out additional elective work and reduce our waiting lists.
Strategic Priority	Improving access to care
Review Date	Monthly
Exec Lead	Andrew McMenemy
Reporting Committee	Quality

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

Context

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

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

Gaps in Control and Assurance

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

Scoring

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

Progress

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

BAF Risk 5	If the Trust does not engage collaboratively with its patients and local communities, in the planning and delivery of care and services, then it may not meet the needs of its diverse population resulting in the exacerbation of health inequalities.
Strategic Priority	Reducing inequalities
Review Date	Monthly
Exec Lead	Tracey Carter
Reporting Committee	Quality Committee

	Risk Score							
Residual	Apr/May	Jun/July	Aug/Sep	Oct/Nov	Dec/Jan	Feb/Mar	Apr/May	Target
9 (3 x 3)	9	9	9	9	9	9	9	6 (3 x 2)

Context

There was an emerging focus on health inequalities prior to the pandemic. However, Covid-19 worsened health inequalities and brought the issue into sharp focus.

Work has commenced on improving health inequalities within maternity services following the recommendations of the Ockenden report.

There is a clear need to build our understanding of health inequalities and take action to improve disparities.

Our target is to develop the work being undertaken within maternity services an produce an assessment that better understands the key areas for improvement within the population that we serve.

Gaps in Control and Assurance

We do not have a baseline understanding of the health inequalities facing the population that we serve or how our services positively or negatively affect those inequalities.

Scoring

The risk score is currently scored at 9 (3(L) x 3(C)). I.e., That it is possible that the risk might happen or recur occasionally. The consequence is assessed as "Moderate – services have significantly reduced effectiveness if unresolved".

For the risk score to reduce to the target level, the consequence score would need to reduce to "Minor – overall service is suboptimal". Presently, the risk score remains at 9 as there is a possible risk of non-engagement with communities that may affect services not meeting the needs of the population that it serves.

Progress

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

BAF Risk 6	If we do not work with partners to transform our services, then we will not have sufficient capacity to provide safe and effective care to our patients over the next five years.
Strategic Priority	Transforming our services
Review Date	Monthly
Exec Lead	Matthew Coats
Reporting Committee	Quality Committee

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

Context

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

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

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

Gaps in Control and Assurance

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

Scoring

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

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

Progress

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

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

Strategic Priority	Culture of inclusion and diversity
Review Date	February 2023
Exec Lead	Andrew McMenemy
Reporting Committee	PERC

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

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

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

Progress		
Positive progress including future opportunities	**Current challenges including future risks**	**How challenges are being managed**
A new EDI group has now been established with its first meeting taking place in September 2022. The group will report operationally to TMC to PERC for assurance purposes. A new EDI lead for the Trust has been appointed with the opportunity to refresh priorities and work closely with colleagues in the system. The revised Workforce structure brings EDI within the OD & Culture framework and therefore sits closely with staff wellbeing, engagement and talent management. Initial priorities will be cultural awareness training, reverse mentoring and values-based recruitment.	A new EDS assessment will be introduced in 2023 with oversight of EDI associated to the workforce as well as our services. Ensuring we make improved progress that demonstrates broader diversity across all areas with an emphasis on senior roles. The publication of the report from Sir Gordon Messenger on Leadership for a Collaborative and Inclusive Future provides some fresh insight in developing our EDI priorities within our senior team.	The EDI steering group in overseeing the main priorities with TMC receiving new initiatives for agreement. The EDS framework alongside WRES and WDES provide PERC and the Trust with oversight and assurance that the main challenges are understood and being addressed.

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

Strategic Priority	Improve workforce sustainability
Review Date	February 2023
Exec Lead	Andrew McMenemy
Reporting Committee	PERC

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

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

Gaps in Control and Assurance
Review of organisational values and introduction of behavioural framework. Effective long term workforce modelling plans across the corporate organisation as well as for services.

Progress		
Positive progress including future opportunities	**Current challenges including future risks**	**How challenges are being managed**
Part of national initiative sponsored by NHSIE on NHS retention. Appointment of People Promise Managers and new Associate Director for recruitment & retention appointed within a new remit in the senior HR team. Plans in place to support identified staff groups and departments with retention and associated recruitment. Introduction of Reaching Out principles to provide positive intervention for those expressing to leave the Trust. In addition a revised induction programme to support new starters in the first 12 months of their employment.	Alongside reductions in the turnover rate and effective recruitment there continue to be areas that require further support such as AHPs, Maternity, Anaesthetics and Critical Care. Main challenges around retention associated with vertical integration, development opportunities and fatigue. Affordable housing is a more common theme that is associated with turnover.	Appointment of People Promise roles to work closely with Divisions and HRBPs. Enhanced and more regular and focused exit interview reports detailing reasons for leaving. New initiatives associated to new starters with additional support to mitigate the turnover rates for new staff. Effective and successful recruitment both locally and internationally. Initial work to support a plan for key worker housing close to the Watford site.

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

Strategic Priority	**Develop as a learning organisation**
Review Date	**February 2023**
Exec Lead	**Andrew McMenemy**
Reporting Committee	**PERC**

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

Context
The staff survey has provided clear feedback that the area where we perform least well is within the category of a learning culture. However the 2022 survey has identified this as an area of improvement. It should be noted that West Herts benchmarks reasonably favourably alongside other acute Trusts in this area. Taking consideration of the implications on morale, alongside our ambitions with Teaching Hospital status, this is seen as a priority area to support a culture of learning, development and support for our staff.

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

Progress		
Positive progress including future opportunities	**Current challenges including future risks**	**How challenges are being managed**
Teaching Hospital status will be used as a catalyst to enhance our strategy of developing a learning organisation culture across all staff groups. Divisional plans associated to leadership development and succession planning have commenced with new programme to be launched in September 2023.	Allowing staff and managers quality time to reflect and work with the OD & LD teams on succession plans and supporting the development of their staff. Providing a clear set of development offers across a wide range of staff and also prospective staff that includes work experience, apprenticeships, skill development and leadership development in a cohesive package.	The new OD and Learning structure has placed an emphasis on succession planning and career development. This is now being supported with the two new Associate Director roles that have clear expected objectives and work closely with senior managers to put in place the aims that will support cultural change towards a learning Trust.

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

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

	Risk Score							
Residual	**Apr/May**	**Jun/July**	**Aug/Sep**	**Oct/Nov**	**Dec/Jan**	**Feb/Mar**	**Apr/May**	**Target**
15	15	15	15	15	15	15	15	6 (2 x 3)

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

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

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

Scoring

The risk score is currently scored at 15 (5(L) x 3(C)). I.e. That it is almost certain that the risk will undoubtedly happen and/or recur, possibly frequently. The consequence is assessed as "Moderate- service has significantly reduced effectiveness".

For the risk score to reduce, the likelihood score must reduce to "Likely - will probably happen/recur but it is not a persisting issue", then to "Possible - might happen or recur occasionally" and then "Minor - overall service is suboptimal" to reach the target likelihood score. The consequence rating would remain the same.

Presently, the risk score remains at 15 as the risk of not securing sufficient funding to support the digital strategy remains a persistent issue that may significantly reduce the effectiveness of services if unresolved.

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

Strategic Priority	Redevelop our hospitals
Review Date	Monthly
Exec Lead	Matthew Coats
Lead Committee	GPC

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

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

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

Scoring

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

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

Progress

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

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

Strategic Priority	Environmental sustainability
Review Date	Monthly
Exec Lead	Matthew Coats
Lead Committee	GPC

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

Context
The NHS has a responsibility to provide high quality health care whilst protecting human health and minimising negative impacts on the environment. The NHS Standard Contract mandates that all healthcare services are required to have (and deliver upon) a Green Plan and there is a requirement for an annual summary of progress to be reported to the ICS's Co-ordinating Commissioner via the Trust's Net Zero Lead. Overall, the NHS is required to reduce its carbon footprint by 80% by 2028 – 2032 and achieve net zero carbon by 2040. The lack of redevelopment impacts the ability of the Trust to mitigate this risk of reducing its carbon footprint within its current

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

estate.	

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

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

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

West Hertfordshire Teaching Hospitals NHS Trust

Agenda item: 12

Report to:	**Trust Board**
Title of Report:	**Assurance report from Trust Management Committee**
Date of Committee meeting:	**29 March 2023**
Quoracy:	**The meetings were quorate.**
Date of Board meeting:	**4 May 2023**
Recommendation:	**For information and assurance**
Chair:	**Chief Executive Officer**
Purpose:	This report provides an update to the Trust Board on actions and developments since its meeting on 29 March 2023
Background:	The Committee meets monthly and provides assurance to the Board: • Delivery of the clinical strategy • Revenue investment up to £1m • Operational performance • Operational risk • Safety and business continuity • Information technology • Internal and external communication strategy • Clinical quality • Business planning • Environment
Assurances received and items for update:	**Summary:** Assurance was provided on the monitoring of operational, financial and clinical performance and the development, implementation and monitoring of strategy. **Regular reports received and discussed for assurance:** • Covid-19 update from the Chief Nurse. • Finance update from the Chief Financial Officer. • Integrated Performance Report • Access Performance and Activity • Trust Board agendas • Divisional updates from Divisional Directors and/or Divisional Managers

Additional reports received and discussed for information and assurance:

- Elective care recovery
- Internal audit
- Maternity Patient Survey results
- Quality Compliance Programme
- Staff survey update
- NHSE Frontline digitisation bid

The Committee approved:

- Terms of reference and workplan

Verbal reports were received from:

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

Other reports:

- None

Any other business:

- None

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

West Hertfordshire Teaching Hospitals NHS Trust

Agenda item: 14

Report to:	**Trust Board**
Title of Report:	**Assurance report from Quality Committee**
Date of Board meeting:	**4 May 2023**
Quorum:	**The meeting was quorate**
Recommendation:	**For information and assurance**
Chairperson:	**Ginny Edwards, Non-Executive Director**
Purpose:	The report summarises the assurances received, and approvals of recommendations made to the Quality Committee at its meeting on 30 March 2023
Background:	The purpose of the Quality Committee is to provide the Board with assurance that high standards of safety and compliance, harm free, high quality, safe and effective services/clinical outcomes are provided by the Trust, and that adequate and appropriate governance structures, processes and controls are in place throughout the Trust.

Summary:

The Committee received reports on the following matters:

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

- Corporate Risk Register and Board Assurance Framework Report
- Chair's reports from Risk Review Group
- Chair's report from Clinical Decision Panel Group
- Chair's report from Quality and Safety Group

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

- CQC Registration
- Terms of reference review
- Annual self-assessment of the effectiveness of the committee
- Medical Devices Annual Report
- 7 Day Board Assurance Framework
- Quality Integrated Performance Report
- Quality Account Priority Proposals 2023 to 2024
- Quality Account Q3 review against 2022 to 2023
- Co-production update

- Medicines Optimisation update report
- Microbiology Laboratory Health and Safety Inspection response.
- Patient Consent Annual Report 2021 – 2022
- Quality Assurance Framework and Process for WHTH Outsourced Service Providers
- GIRFT Progress update on Radiology
- Patient Safety Learning Summit posters
- EHO – Food Hygiene.

The Committee noted the following:

The Committee received a report providing an update on changes to the Trust's registration with the Care Quality Commission (CQC), This includes the change of the nominated person to the new Chief Executive Office

The Committee received and recommended the terms of reference to the Board for approval.

The Committee received the Medical Devices annual report and are assured on the plan and actions. The Committee were provided with assurance around the Trust performance in meeting the priority clinical standards for 7-day service provision and this also on the agenda.

The Committee received the quality Integrated performance report and formally noted the quality account priorities for financial year 2023 to 2024.

Maternity Safety Champions

MDT handovers audits show embedding within the unit.

Saving babies lives bundle version 2 continues with good compliance, and we await the publication of version 3.

The recently published single delivery plan is being reviewed with the integrated action plan and will be presented to June quality committee and July trust board.

Risks to refer to risk register: None

Items for the Board to note: None

Recommendations to the Board:

- The 2023/24 terms of reference recommended for approval by the Board.
- 7 Day Board Assurance Framework recommended for approval by the Board

Agenda item:	**16**
Report to:	**Trust Board**
Title of Report:	**Assurance report from Great Place Committee**
Date of Committee meeting:	**Thursday 16th March 2023**
Quorum:	**The meeting was quorate**
Chairperson:	**Helen Davis**
Purpose:	The report summarises the assurances received, and documents approvals of recommendations made by Great Place Committee at its meeting on 16th March 2023.
Background:	The Committee meets monthly and gains assurance on the delivery of the objectives of the hospital redevelopment and digital infrastructure programmes and provides senior-level leadership to shape and drive the implementation of these key elements of the Trust's strategy. It is also responsible for the oversight of the Better Care Delivered Differently change programme.

Summary:

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

SRO Programme Update – The Great Place Committee noted the delay in the OBC being completed and that it wouldn't now be finalised with NHP requirements by Spring 23 as previously hoped. A timetable would be developed following discussions with the NHP, which should lead to confirmation of the ultimate timetable for the West Herts Redevelopment.

Single Room & Ward Layouts – The Great Place Committee noted the current status of standardised ward designs and the potential impact of 100% single rooms on the design of the new Watford hospital. GPC would await information on the approach to standardisation adopted by NHP.

Interim Estates & Key Enablers – The Great Place Committee took note of the challenges of resources surrounding the multiple ongoing projects and the need to ensure that staff, patients and visitors were informed across all sites.

Digital Progress Report – The Great Place Committee heard that good progress continued to be made against the majority of projects and recognised that there was a robust plan in place. It was agreed that EPR optimisation would be a future standing agenda item for GPC.

Redevelopment Risk Update – The Great Place Committee took assurance that an updated risk structure was being developed and that this would be a key priority when additional project management resources were acquired.

Communications & Engagement Report - The Great Place Committee noted the engagement work underway. During March, there had been positive engagement with the residents at St. Albans about the elective care building works and the model of care that would be provided.

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

Risks to refer to risk register:	No new risks identified.
Items for the Board to note:	Positive dialogue with the New Hospital Programme.
Recommendations to the Board:	None.

West Hertfordshire Teaching Hospitals NHS Trust

Agenda item:	**16**
Report to:	**Trust Board**
Title of Report:	**Assurance report from Great Place Committee**
Date of Committee meeting:	**Thursday 20th April 2023**
Quorum:	**The meeting was quorate**
Chairperson:	**Helen Davis**
Purpose:	The report summarises the assurances received, and documents approvals of recommendations made by Great Place Committee at its meeting on 16th March 2023.
Background:	The Committee meets monthly and gains assurance on the delivery of the objectives of the hospital redevelopment and digital infrastructure programmes and provides senior-level leadership to shape and drive the implementation of these key elements of the Trust's strategy. It is also responsible for the oversight of the Better Care Delivered Differently change programme.

Summary:

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

SRO Programme Update – The Great Place Committee welcomed Alex White as the new Chief Redevelopment Officer and thanked Don Richards for leading this work in the interim. The anticipated challenges in the OBC being completed was noted, along with the expectation that further guidance would be needed from the New Hospital Programme (NHP) to confirm next steps.

Interim Estates & Key Enablers – Members were told that further guidance would be needed from the New Hospital Programme (NHP) to confirm next steps, including the development of the OBC. Progress was being made in progressing interim schemes but there were challenges to overcome in progressing construction projects whilst maintaining services on busy hospital sites.

Digital Progress Report – The Great Place Committee received a report on EPR optimisation and the important role of further training ahead of recent strikes. The extensive work being undertaken by the digital team was highlighted, with EPR optimisation remaining a future agenda item for the committee.

Communications & Engagement Report - The Great Place Committee noted the engagement with the residents of St. Albans in relation to existing construction works and the plan for further staff engagement too.

Capital Expenditure Report - The Great Place Committee noted the anticipated 2022 – 23 out-turn position for the redevelopment programme and for other major capital schemes.

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

Items for the Board to note: Positive progress with EPR optimisation.

Recommendations to the Board: None.

NHS
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NHS Trust

Trust Board
Thursday 4 May 2023

Title of the paper:	**Performance, Activity Recovery & High Impact Change Plan updates (March 2023)**
Agenda Item:	**17**
Presenter:	**Sally Tucker** **Chief Operating Officer**
Author(s):	**Jane Shentall** **Director of Operational Performance**
Purpose:	*Please tick the appropriate box* *For approval*: *For discussion*: ✓ *For information*: ✓
Executive Summary:	The slides detail progress for each of the high impact change plans – Patient Flow Improvement and Elective Care Recovery, and include updated scorecards and further detail for the core key performance indicators. Updates against all of the mandated access (waiting time) standards is provided for March and shadow reporting against the 2023/24 planning guidance is included, showing March position. Activity is measured against the 2019/20 baseline. The March 2020 activity levels were low, as a result of the onset of COVID wave 1. As a result activity rates as reported for 2022/23 are exceptionally high. A summary of activity affected by the Junior Doctors' Industrial Action in March and April is included.
Trust strategic aims: *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1 Best care** — ***Objectives 1-4*** — ✓ **Aim 2 Great team** — ***Objectives 5-8*** **Aim 3 Best value** — ***Objective 9*** **Aim 4 Great place** — ***Objective 10-12***
Links to well-led key lines of enquiry:	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☐Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles and systems of accountability to support good governance and management?

<table>
<tr><td></td><td>☒Are there clear and effective processes for managing risks, issues and performance?
☒Is appropriate and accurate information being effectively processed, challenged and acted on?
☐Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
☒Are there robust systems and processes for learning, continuous improvement and innovation?
☒How well is the trust using its resources?</td></tr>
<tr><td>Previously considered by:</td><td><table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td>Trust Management Committee</td><td>26 April 2023</td></tr><tr><td>Finance & Performance Committee</td><td>27 April 2023</td></tr></table></td></tr>
<tr><td>Action required:</td><td>The Board is asked to receive this information for oversight of activity delivery and performance.</td></tr>
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West Hertfordshire Teaching Hospitals NHS Trust

Trust Board
4 May 2023

Performance, Activity recovery and High Impact Change Programme updates

March 2023 reporting period

Jane Shentall
Director of Performance
April 2023

NHS
West Hertfordshire Teaching Hospitals
NHS Trust

Patient Flow Improvement

- High Impact Change Scorecard
- Emergency Department demand & performance
- Clinical assessment
- Improving Discharges
- Implementation of Control Centre
- Clinical Review of the Urgent Treatment Centre

Patient Flow Improvement Programme
High Impact Change Plan Scorecard

West Hertfordshire Teaching Hospitals NHS Trust

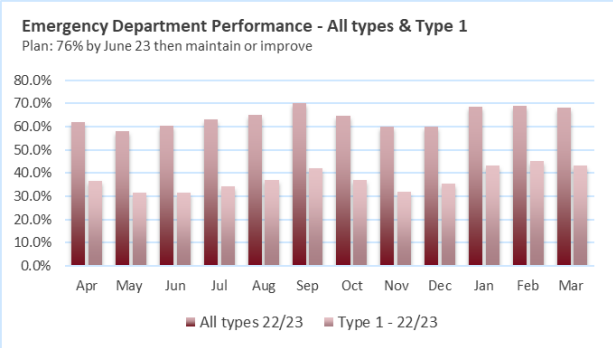
High Impact Changes Scorecard

Focus Area	Metric	Target	WEEK ENDING 29-Jan	05-Feb	12-Feb	19-Feb	26-Feb	05-Mar	12-Mar	19-Mar	26-Mar	02-Apr	09-Apr	16-Apr
HIGH IMPACT CHANGE 1 - Rapid assessment and timely decisions of patients within 1 hour of arrival	All 4 hr Performance	76%	69.4%	68.6% ▼	74.6% ▲	69.1% ▼	65.4% ▼	67.7% ▲	67.8% ▲	69.6% ▲	66.6% ▼	68.0% ▲	69.3% ▲	73.4% ▲
	4 hr Non admitted Performance	80%	56.8%	52.3% ▼	65.1% ▲	48.7% ▼	49.3% ▲	50.7% ▲	53.8% ▲	53.8% ▲	51.4% ▼	48.9% ▼	52.4% ▲	57.6% ▲
	Time to clinical assessment < 1 hour	50%	44.2%	42.1% ▼	39.4% ▼	37.1% ▼	24.7% ▼	29.3% ▲	31.5% ▲	36.4% ▲	25.3% ▼	25.9% ▲	28.0% ▲	34.7% ▲
	Total time in Department - Non admitted	Movement	284	292 ▲	258 ▼	301 ▲	306 ▲	289 ▼	281 ▼	280 ▼	288 ▲	287 ▼	285 ▼	266 ▼
HIGH IMPACT CHANGE 2 - Improve discharges	IDT Discharges	Movement	155	175 ▲	145 ▼	150 ▲	137 ▼	165 ▲	150 ▼	159 ▲	138 ▼	156 ▲	148 ▼	135 ▼
	WGH Weekday Discharges - weekly totals	Movement	374	396 ▲	414 ▲	420 ▲	418 ▼	427 ▲	426 ▼	413 ▼	441 ▲	458 ▲	435 ▼	385 ▼
	WGH Weekend Discharges - weekly totals	Movement	101	91 ▼	90 ▼	94 ▲	89 ▼	83 ▼	114 ▲	100 ▼	92 ▼	74 ▼	98 ▲	85 ▼
	WGH Total Discharges - weekly totals	Movement	475	487 ▲	504 ▲	514 ▲	507 ▼	510 ▲	540 ▲	513 ▼	533 ▲	532 ▼	533 ▲	470 ▼
	WGH Discharges before 5pm %	Movement	59.2%	56.7% ▼	59.9% ▲	57.6% ▼	58.4% ▲	57.1% ▼	56.1% ▼	61.2% ▲	58.9% ▼	57.3% ▼	59.8% ▲	59.1% ▼
HIGH IMPACT CHANGE 3 - Implement Command and Control Centre	Bed Meeting time freed up for more focused flow management discussions (10mins)	-33%	0.0%	0.0% =	-3.0% ▼	-3.0% =	-3.0% =	-6.0% ▼	-6.0% =	-6.0% =	-16.0% ▼	-16.0% =	-16.0% =	-20.0% ▼
	Transition to Virtual bed meetings for all participants	100%	66.0%	66.0% =	66.0% =	66.0% =	66.0% =	66.0% =	66.0% =	66.0% =	66.0% =	66.0% =	66.0% =	66.0% =
	All participants to share their actual report update on Teams	100%	0.0%	0.0% =	0.0% =	0.0% =	0.0% =	0.0% =	0.0% =	0.0% =	0.0% =	0.0% =	0.0% =	0.0% =
	Complete, accurate, real-time data, visualised in the appropriate level of detail	90%	50.0%	50.0% =	50.0% =	50.0% =	50.0% =	50.0% =	70.0% ▲	70.0% =	70.0% =	70.0% =	70.0% =	70.0% =
	Control Room IT/telephony infrastructure reconfigured for usability / resilience	100%	80.0%	80.0% =	80.0% =	80.0% =	80.0% =	80.0% =	80.0% =	80.0% =	80.0% =	80.0% =	80.0% =	80.0% =
HIGH IMPACT CHANGE 4 - Clinical Review of UTC	WGH Type 3 performance	95%	96.8%	93.0% ▼	93.9% ▲	92.8% ▼	84.7% ▼	88.5% ▲	91.8% ▲	89.9% ▼	87.7% ▼	96.0% ▲	95.2% ▼	93.4% ▼
	Number of handovers to ED at close	Movement												
	Referrals to ED at < 2 hours	75%	71.4% ▲	47.7% ▼				48.6% ▲						

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

West Hertfordshire Teaching Hospitals NHS Trust

Emergency Department – Performance & Demand



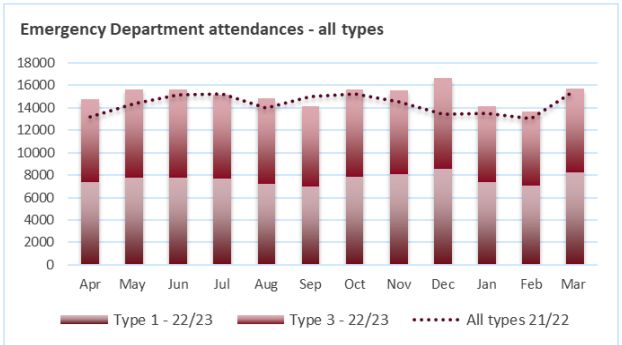
Performance

- All types 68.1% (Feb 69%, Jan 68.4%, Dec 60%)
- Type 1 43.4% (Feb 45.2%, Jan 43.2%, Dec 35.4%)
- Watford UTC 91% (Feb 90.4%, Jan 95.9%, Dec 83.2%)
- HH UTC 99.3% (Feb 98.5%, Jan 96.2%, Dec 88.5%)

12 hour end to end journeys

There was further improvement in 12 hour waits (arrival to departure) with the lowest % since September. Totals as a percentage of **all** attendances:

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



Attendances

Demand increased in March, both types at levels only surpassed by attendances in December 2022 (16,669).

- All types: 15,736 (Feb 13,027)
- Type 1: 8,225 (Feb 7,076)
- Type 3: 7,511 (Feb 6,625)

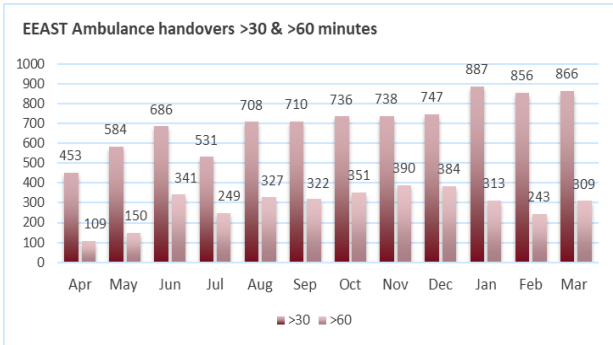
This was an extraordinary level of demand, with only December 22 seeing higher attendances. There was an exceptional number of attendances in the days during the junior doctor industrial action mid-month.

Mental Health Demand

4.3% (355) of all type 1 ED attendances (8225) related to MH
(Feb 4.6%, Jan 5%)

10.5% (48) of all ED attendances over 12 hours (48) related to MH
(Feb 10.5%, Jan 6.9%)

13.5% of all ED attendances relating to MH (355) wait 12 hours or more (48) (Feb 16.4%, Jan 19.4%)



Ambulance handovers

2,557 patients were brought to ED by ambulance, representing 31% of all type 1 attendances.

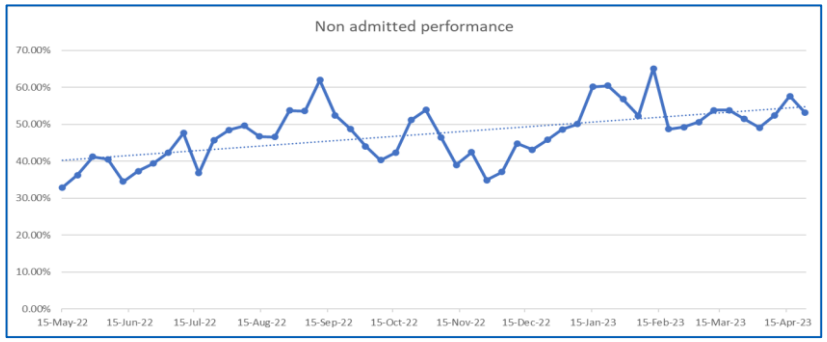
Handover delays (as a % of all ambulance arrivals) reported by EEAST

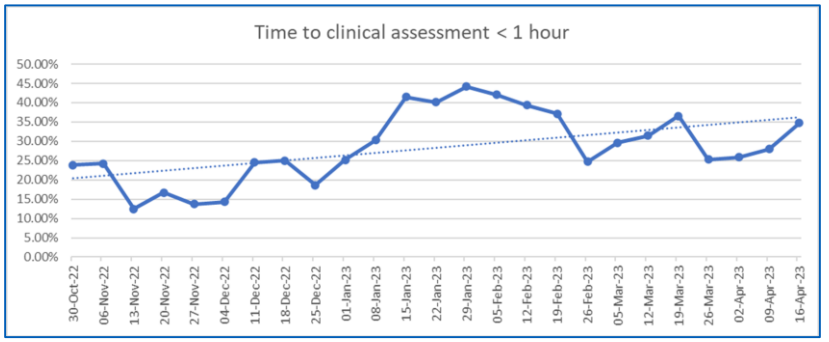
- 30+ minutes: 41.4% (866)
  (Feb 43.7% / 857)

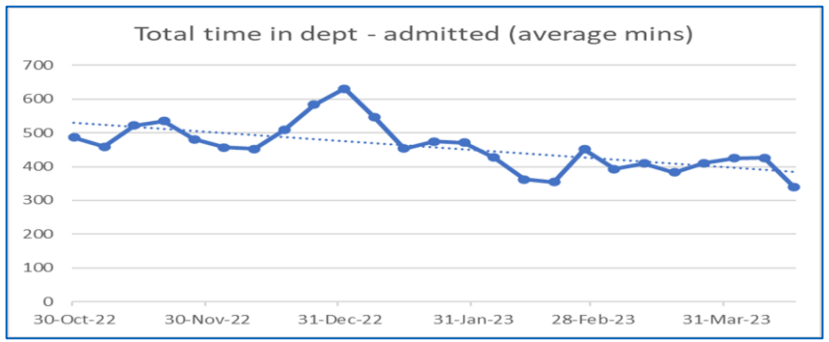
- 60+ minutes: 14.8% (309)
  (Feb 12.4% / 313)

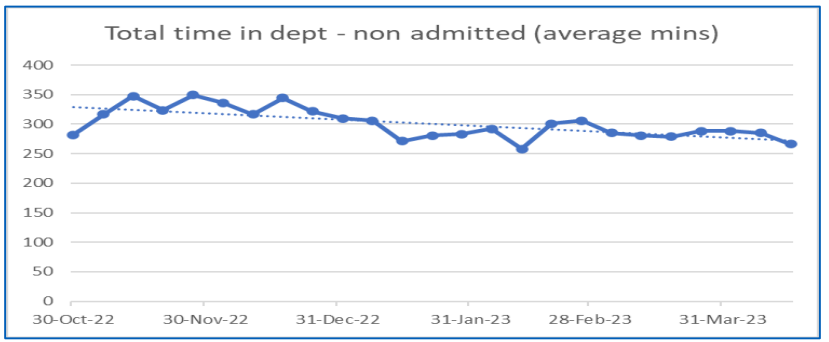
West Hertfordshire Teaching Hospitals NHS Trust

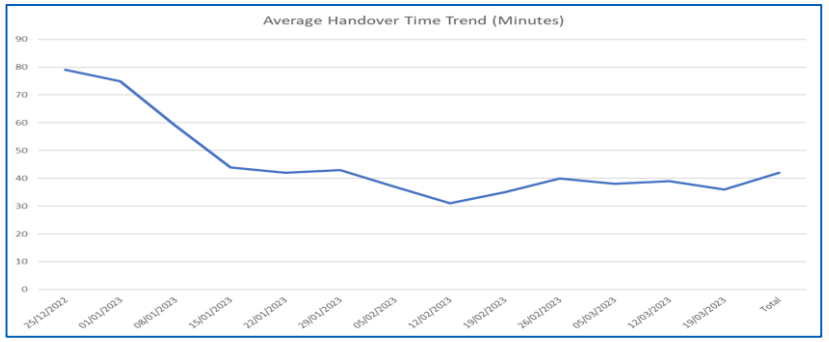
Patient Flow Improvement - High Impact change 1: Clinical assessments

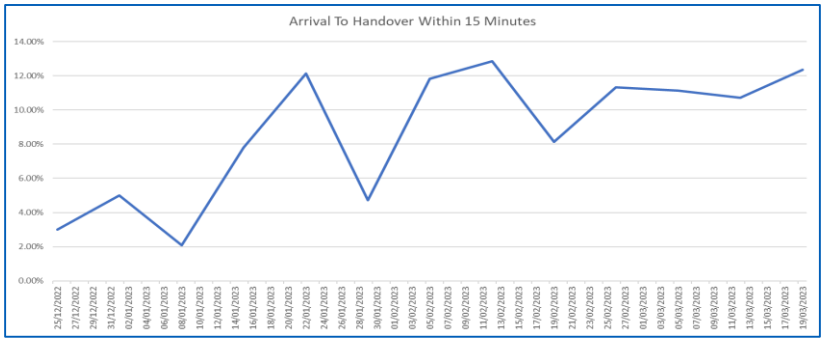












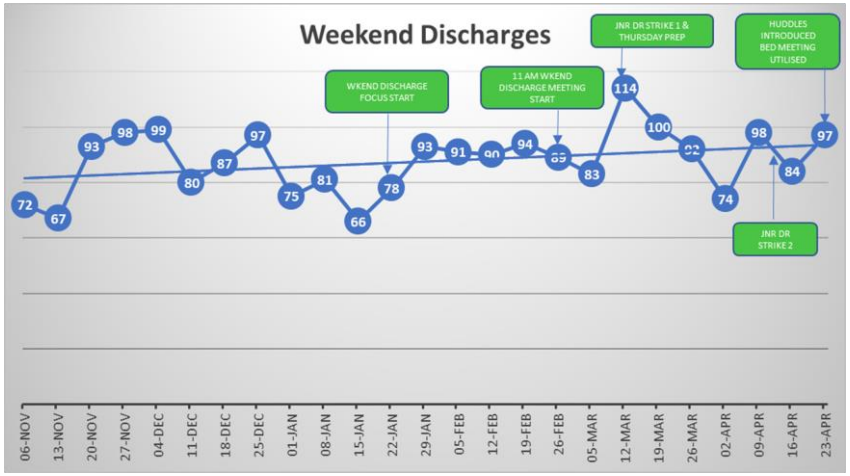
Patient Flow Improvement -High Impact Change 2: Improving Discharges

West Hertfordshire Teaching Hospitals NHS Trust

Objective: 100 discharges per day

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
1-5 Mar			116	74	99	52	38
6-12 Mar	75	73	100	100	102	67	51
13-19 Mar	88	77	79	96	88	63	45
20-26 Mar	62	98	104	108	108	58	45
27-31 Mar	75	104	95	102	102		

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
1-2 Apr						40	44
3-9 Apr	75	94	86	116	6	52	47
10-16 Apr	51	78	79	92	87	53	31
17-23 Apr	80	99	79	111	105	68	43
24-30 Apr							



Weekend Discharge Focus

Focused work started 22/1/23 across Divisions and system

Weekend band 7 SAC (same Sat/Sun)

Joined up weekend discharge Consultant with band 7s on AAU

Cerner list being utilised across divisions

11am weekend discharge meeting with IDT, Senior Nurse, SSM, Band 7s, pharmacy, SMOC – focus on issues/prep

Weekend discharge process starts on Thursdays

Assurance through bed meetings from Thursday

Additional IDT staffing on at weekends

ADM and ASM for patient flow communicating with doctors on wards and discharge teams

Divisional teams focussing on discharges

During JD strike – extra Consultant on weekend in pm

9am and 12.45pm huddles

Bed meeting utilised for discharge focus

Patient Flow Improvement – High Impact Change 3: Implementation of a Command & Control Centre

West Hertfordshire Teaching Hospitals NHS Trust

Bed Meeting time freed up for more focused flow management discussions (10mins)

- A gradual change of approach by the Chair over the last 2m has reduced (but not eliminated) time spent on non-value adding updates (e.g. listing all 'green' Estates updates).
- Consistency of approach will be in place following sign-off of the recommendations in the HEG paper, and the implementation of the Virtual meeting with new format and expectations
- Virtual meeting planned for mid to end of May.

Transition to Virtual bed meetings for all participants

- The % reflected in the scorecard simply indicates the proportion of those who attend in person and those on Teams.
- The move on 15 May to go 100% virtual, following all the re-work of agendas, meetings focus and approach, will complete this.

All participants to share their actual report update on Teams

- The move on 15 May to go 100% virtual (recorded with documented actions) will complete this.
- A requirement will be to produce daily, documented updates on key KPIs, VH metrics etc. for the Division, shared with all on the meeting.
- Handwritten, verbalised updates with poor audio will cease.

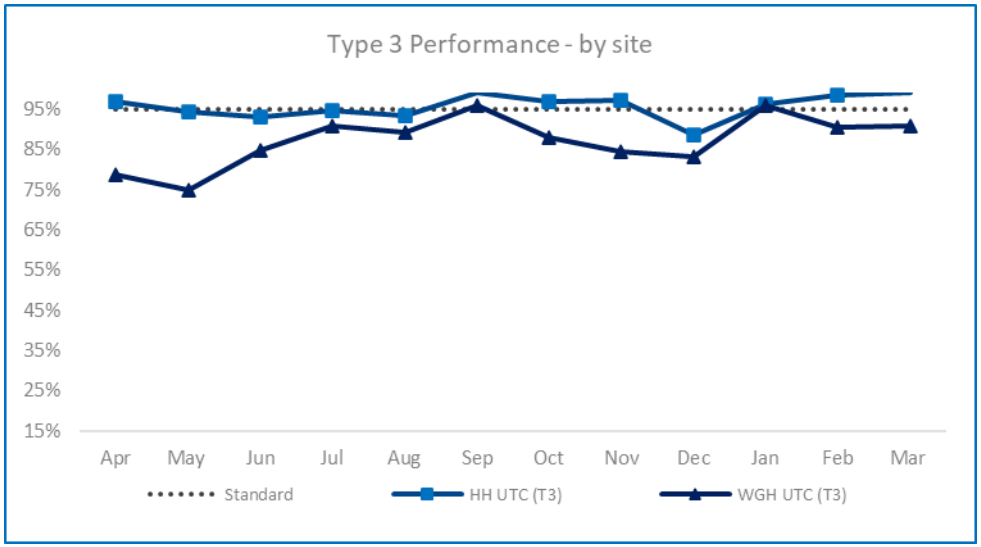
Complete, accurate, real-time data, visualised in the appropriate level of detail

- The increase in performance in mid-March reflects the BI Team making requested changes for the Ops Team in iReporter.
- The complete set of revisions will not be complete until mid-May, when it is estimated the Cerner report revisions will have been enacted via Cerner in collaboration with the CapMan team. This is considered to be stage 1.
- The ongoing CapMan rollout will increase the entry and completeness of data available for accurate reporting over time, and further visualisation enhancements for the Ops/Control Centre team will take place as we develop the capability.

Control Room IT/telephony infrastructure reconfigured for usability / resilience

- The IT refinements (80>100%) specification was worked through with IT, in conjunction with Atos and we are awaiting a final price with installation date.
- Current expectation is that we will see this in place in mid-May, but this is to be confirmed.

Patient Flow Improvement – High Impact Change 4: Clinical Review of Urgent Treatment Centre



Streaming & Triage

- Initial assessment model changes – implementation planned for August 2023
- Operational translation underway, including processes, timelines and prioritisation of actions
- Pathways to be developed for paediatric and adult attendances
- Data flows to be agreed
- Contractual elements to be finalised

West Hertfordshire Teaching Hospitals NHS Trust

Elective Care Recovery

- High Impact Change Scorecard
- Access Standards performance overview
- Shadow reporting against 2023/24 priorities
- Data Quality – value weighted activity, PTL size, activity tracking
- Theatre Productivity
- Long Wait Improvement – RTT & Cancer (including performance)
- Outpatient productivity

West Hertfordshire Teaching Hospitals NHS Trust

Performance Overview – March 2023

	Target	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Accident & Emergency															
All types	95%	69% ✗	68.1% ✗												
Type 1	95%	45% ✗	43.4% ✗												
WGH UTC	95%	90% ✗	91.0% ✗												
HHGH UTC	95%	99% ✓	99.9% ✓												
Diagnostics															
DMo1	99%	64.1% ✗	63.0% ✗												
Referral to Treatment															
Open pathways <18 weeks	92%	57.4% ✗	58.2% ✗												
78 week waits	0	38 ✗	15* ✗												
65 week waits	0 by Mar 24	607 ↓	548 ↓												
52 week waits	Reducing	2315 ↓	2729 ↑												
Cancer															
2ww	93%	92.2% ✗	86.5% ✗												
2ww breast symptomatic	93%	92.2% ✗	77.1% ✗												
28 day faster diagnosis	75%	78.4% ✓	77.1% ✓												
31 day first	96%	97% ✓	99.3% ✓												
31 day subsequent surgery	94%	100% ✓	86.0% ✓												
62 day first	85%	58.2% ✗	56.8% ✗												
62 day screening	90%	62.5% ✗	81.3% ✗												

* includes 5 pathways already closed through validation

ED demand during the March Junior Doctor industrial action period was exceptionally high and maintaining good patient flow was challenging.

The strike also impacted some of the cancer standards, particularly early on in the pathway, ie 2ww and Faster diagnosis standard as patients were moved to appointments beyond the maximum waiting time standards. 4 RTT Long wait patient bookings were deferred.

The reported 78 week wait position includes 5 pathways that should be removed and 3 patient choice. The true breaches are the result of complexity with limited capacity to treat before month end, or late decisions following protracted outpatient pathways. All patients have plans in place for April.

Planning Guidance 2023/24 – shadow reporting

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

Elective Actions for the 78 week cohort
12/1/2023 Letter from Sir James Mackey & Professor Tim Briggs

5. All patients in the 78 week cohort without a decision to admit must have a next appointment booked by the end of January 2023.

6. All patients in the 78 week cohort with a decision to admit must have a recorded TCI date by the end of January 2023, with the treatment scheduled before the end of March 2023

Urgent & Emergency Care

7. 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
8. Reduce adult general and acute (G&A) bed occupancy to 92% or below

Current position against objectives & actions

	Objective	March 23
1	65 week wait elimination by March 2024	548 (Feb 626)
2	Deliver system specific activity target (103% VWA)	92% (Feb 88%) NB: reported position with internal adjustments
3	Reduction in patients over 62 days on the Cancer PTL – 143 by March 2024	105 (Feb 120)
4	Meet the Cancer Faster Diagnosis standard of 75% by March 2024 – 67.5% by June 23	77.1% (Feb 78.3%)
5	All 78 week wait cohort patients without a DTA must have an appointment booked by 31/3/23	3 pathways at month end; • 1 complex • 2 patient initiated delays
6	All 78 week wait cohort patients with a DTA must have a TCI by 31/3/23 with treatment by 31/3/23	7 pathways at month end; • 3 patient choice • 3 historic clock stop errors • 1 complex
7	Improve A&E waiting times to 76% seen within 4 hours by March 2024	68.1% (Feb 69%)
8	Reduce adult (G&A) bed occupancy to 92% or below	All sites: 89.3% (Feb 90.3%) WGH only: 93.7% (Feb 94.8%)

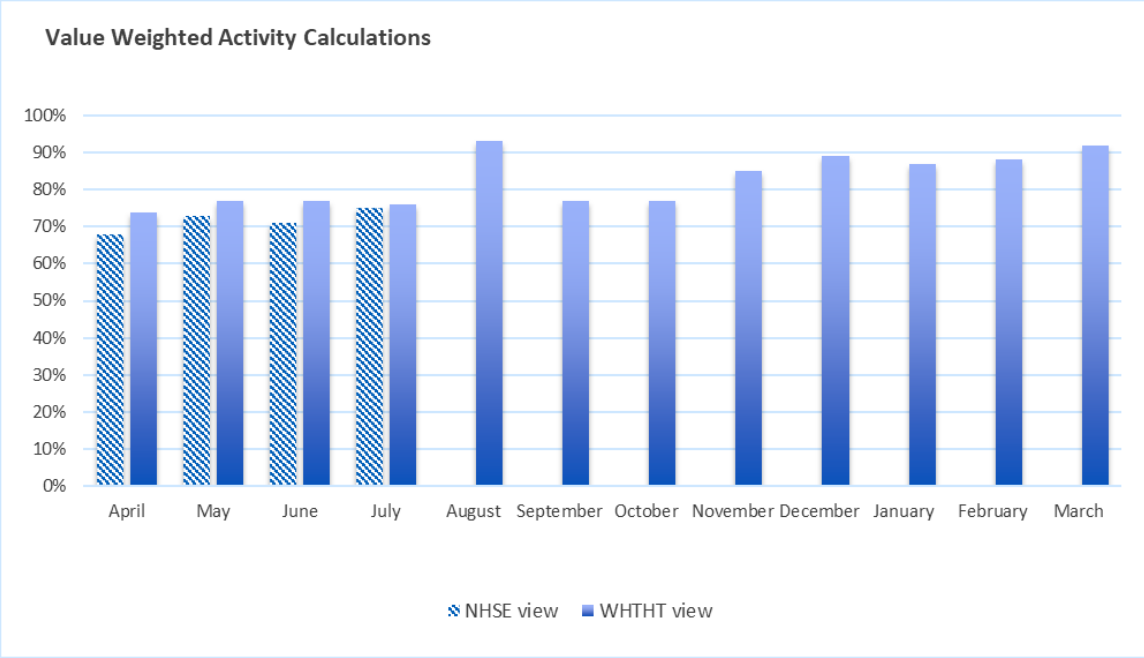
Elective Care Recovery Programme
High Impact Change Plan Scorecard

West Hertfordshire Teaching Hospitals NHS Trust

Elective Care Recovery Programme - High Impact Changes Scorecard

Focus Area	Metric	Target	Jan	Feb	Mar
HIGH IMPACT CHANGE 1 Improved data quality, capture and recording to enable accurate reporting of activity delivery and value	Value weighted activity	103% of 19/20	87.0%	88.0% ▲	92.0% ▲
	RTT PTL size	Reduction	50342	50169 ▼	52995 ▲
	RTT Clock stops	Improvement	6395	6046 ▼	5856 ▼
	Outpatient procedures recorded	Improvement	7284	6862 ▼	7158 ▲
HIGH IMPACT CHANGE 2 Increased theatre productivity with improved utilisation across all sites	Theatre utilisation - WGH & SACH	85%	70.1%	74.5% ▲	75.1% ▲
	Time lost to late starts - WGH & SACH	Improvement	225:16	172:27 ▼	186:48 ▲
	Time lost to early finishes - WGH & SACH	Improvement	67:21	54:25 ▼	59:06 ▲
HIGH IMPACT CHANGE 3 Improve waiting times for RTT, Cancer and Diagnostic pathways	RTT: 78 week wait elimination (excl patient choice)	0 by April 23	69	38 ▼	15 ▼
	RTT: 65 week wait elimination (excl patient choice)	0 by April 24	819	607 ▼	548 ▼
	RTT: 52 week wait reduction	Improvement	2681	2315 ▼	2729 ▲
	Cancer: 63+ day wait reduction	95*	178	120 ▼	105 ▼
	28 day faster diagnosis performance	75%	68.5%	78.4% ▲	77.1% ▼
	DMO1 (diagnostic) performance	99%	62.0%	64.7% ▲	63.1% ▼
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	85.2%	83.6% ▼	92.0% ▲
	Patient initiated follow up rate as a % of all OPAs	2.1%	1.5%	1.7% ▲	2.1% ▲
	Non-face to face rate as a % of all OPAs	25%	17.2%	16.6% ▼	16.5% ▼
	DNA rates	8%	8.0%	8.1% ▲	8.0% ▼

Elective Care Recovery - High Impact Change 1: 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. Dialogue with NHSE continues with regard to understanding and alignment of the weekly estimates.

The March position has had additional adjustments to account for the 19/20 baseline which was very low following the onset of COVID wave 1.

Negotiation with NHSE continues regarding baseline changes.

Circa £7.5m changes were proposed and to date £2-3m agreed.

Further discussion on outstanding areas for agreement to take place 19/4/23 with a view to ensuring alignment with baseline adjustments agreed for other ICS members.

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Elective Care Recovery - High Impact Change 1: Data Quality - Activity as a % of the 19/20 baseline month

Activity baseline month is March 20, at start of COVID wave 1 and therefore activity levels were low, resulting in high activity percentage rates for March 23.

Referrals			
Mar-23	Cancer	Urgent	Routine
Surgery	167% ⇧	188% ⇧	123% ⇧
Medicine	147% ⇧	130% ⇧	70% ⇧
WACS	204% ⇧	210% ⇧	75% ⇧
Trust	**163% ⇧**	**158% ⇧**	**91% ⇧**

Outpatients - 1) 25% reduction in F/U activity 2) 25% virtual/non f2f activity 3) 5% PIFU 4) Advice & Guidance - 16% of 1st OPAs				
Mar-23	New	F/up	Non-F2F	A&G rate
Surgery	122% ⇧	98% ⇧	11% ⇧	66%
Medicine	91% ⇧	86% ⇔	25% ⇔	
WACS	159% ⇧	93% ⇧	11% ⇧	
Trust	**111% ⇧**	**92% ⇧**	**16.5% ⇔**	

Activity shortfall to baseline & 22/23 planning target - NEW OPAs		
Mar-23	to achieve 19/20 b/line	to achieve 110%
Surgery	Achieved	Achieved
Medicine	219	694
WACS	Achieved	Achieved

Diagnostics: Clinical Support - 120% of 19/20			
Mar-23	CT	MRI	Non-Obs US
Imaging	**140% ⇧**	**150% ⇧**	**141% ⇧**

Activity shortfall to baseline & 22/23 planning target - Diagnostics		
Mar-23	to achieve 19/20 b/line	to achieve 120%
CT	Achieved	Achieved
MRI	Achieved	Achieved
NOUS	Achieved	Achieved
Colonoscopy	Achieved	Achieved
Gastroscopy	Achieved	Achieved
Echo	99	270

Diagnostics: Medicine - 120% of 19/20			
Mar-23	Colonoscopy	Gastroscopy	Echo
Medicine	**175% ⇧**	**184% ⇧**	**88% ⇧**

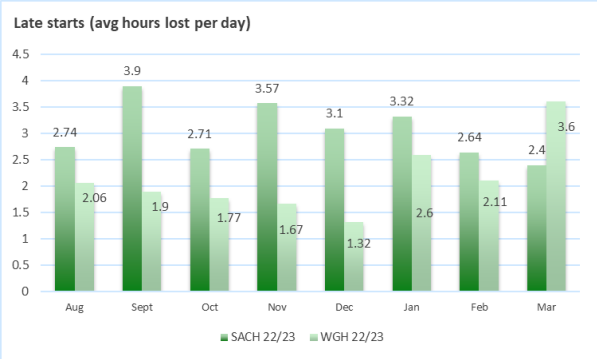
Electives - 110% of 19/20				
Mar-23	Total	Inpatient	Day Case	% as day case
Surgery	109% ⇧	123% ⇧	106% ⇧	75.4% ⇧
Medicine	145% ⇧	143% ⇧	145% ⇧	99% ⇔
WACS	116% ⇧	82% ⇧	143% ⇧	69.3% ⇧
Trust	**139% ⇧**	**112% ⇧**	**142% ⇧**	**90% ***

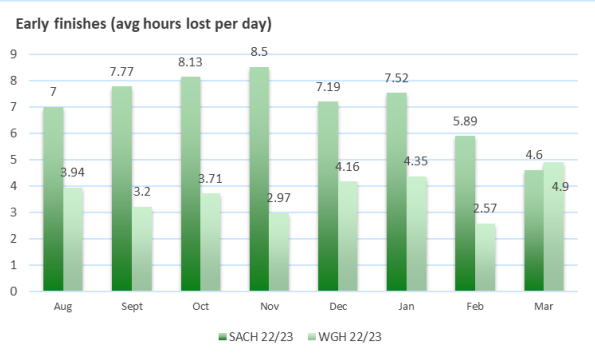
* inc reg day attenders

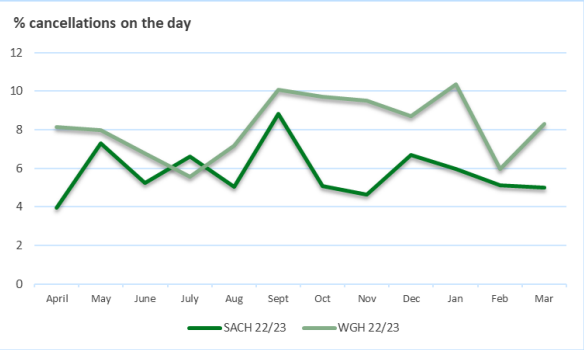
Activity shortfall to baseline & 22/23 planning target - ALL INPATIENTS		
Mar-23	to achieve 19/20 b/line	to achieve 110%
Surgery	Achieved	Achieved
Medicine	Achieved	Achieved
WACS	119	151

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

Elective Care Recovery – High Impact Change 2: Theatre Productivity – Late starts & Early finishes







Late Starts
Hours lost to late starts improved slightly at SACH when compared with February.

At WGH it was much worse, rising from 2.11 to 3.6 hours lost.

However, it should be noted that some late starts are the result of morning session late finishes.

Early Finishes
The number of hours lost to early finishes increased at both sites, more than doubling at WGH to 4.9, with 4.6 hours lost at SACH.

Cancellations on the day
Cancellations on the day (not shown) at SACH were relatively unchanged at 5% (from 5.1%) but deteriorated at WGH, at 8.3% (from 6%).

Elective Care Recovery – High Impact Change 2: Theatre Productivity - Cases, Cases per session & Utilisation

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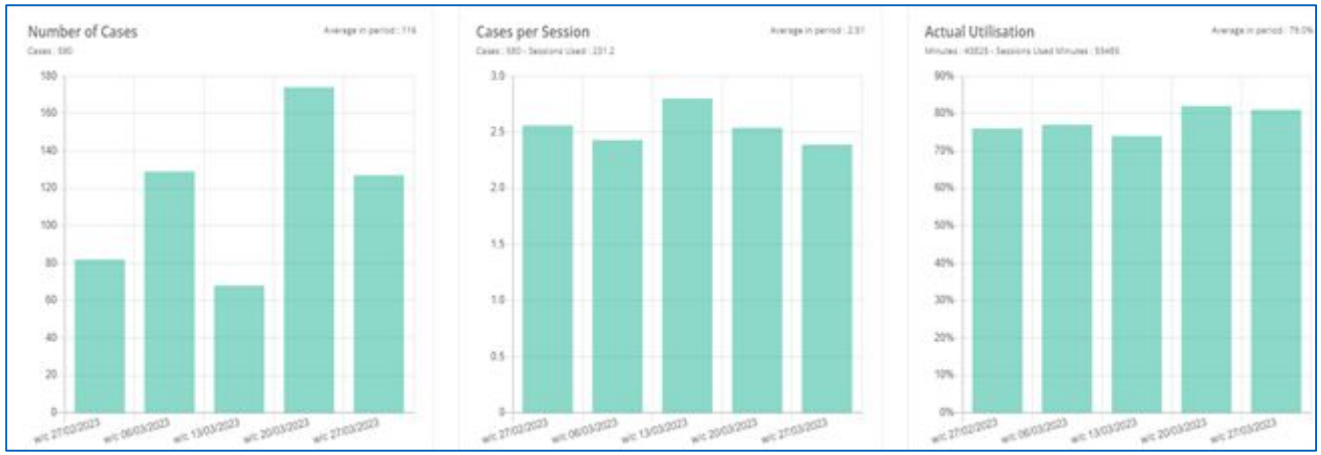
Data has been taken from the new theatre tool, the charts showing the weekly snapshots for March.

Although more cases were undertaken in March, the total number of operations performed at SACH (580) was marginally lower than February (594). However, throughput was significantly better at WGH (Feb 268) at 431.

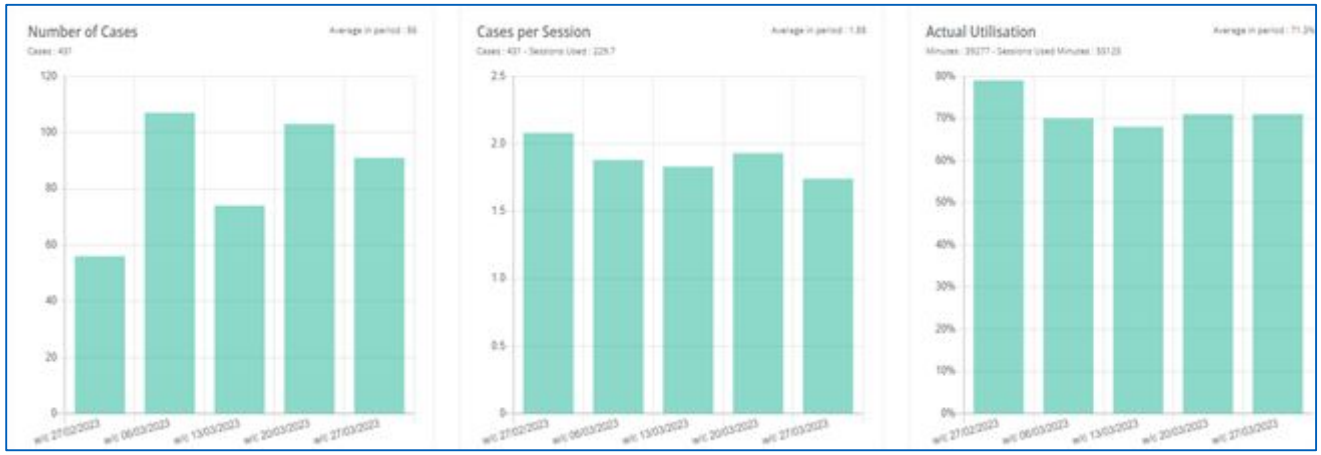
Utilisation at SACH has improved, now at 79% for March. Although WGH (incl Obs & Gynae) utilisation was lower, this has improved from 63% in February, to 71%.

Cancellations on the day (not shown) at SACH were relatively unchanged at 5% (from 5.1%) but deteriorated at WGH to 8.3% (from 6%).

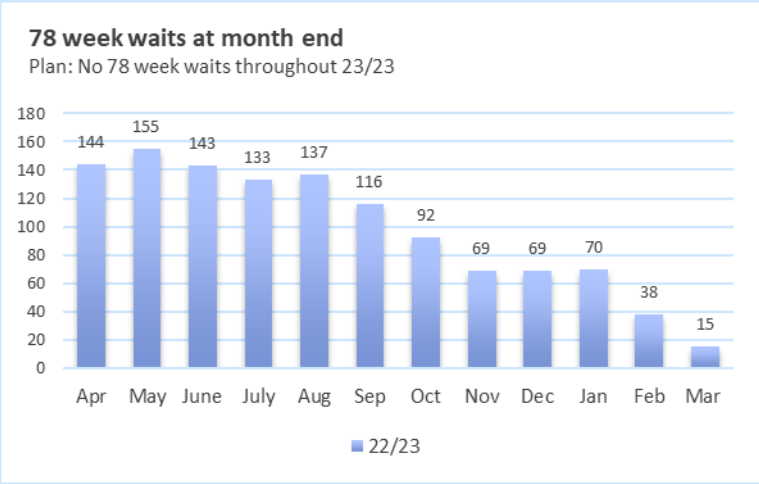
SACH

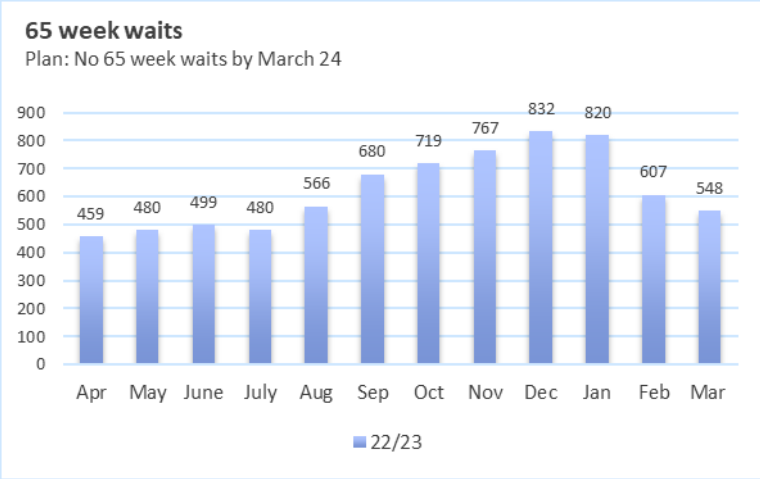


WGH (incl Obs & Gynae)



Elective Care Recovery – High Impact Change 3: RTT Long waits Improvement



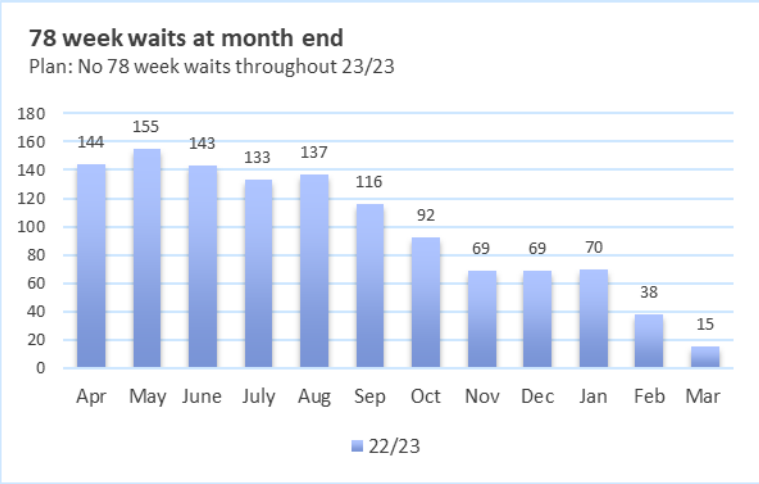


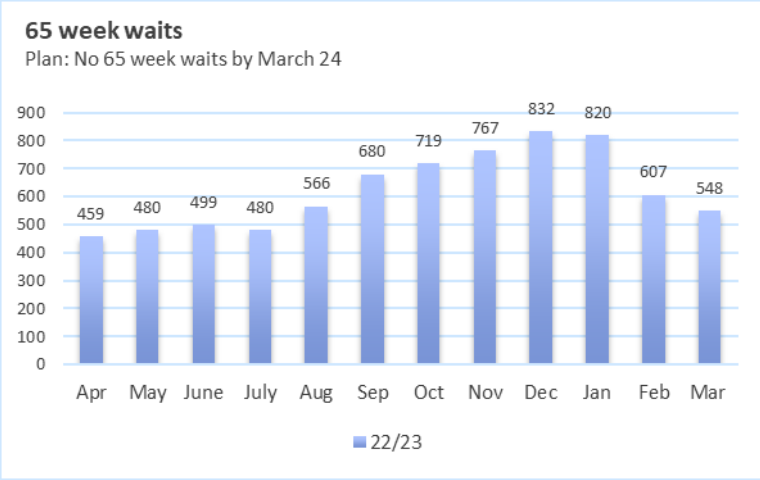
78 week waits
Excluding the pathways that are known to be open in error, there are 10 pathways over 78 weeks for reporting, as follows:

- 3 choice pathways (all dated in April);
- 3 incorrect clock stops applied at start of pathway, corrected and breached as a result (both dated in April)
- 2 complex pathways (1 dated in April, 1 subsequently closed)
- 2 pathways have been delayed due to multiple patient initiated cancellation resulting in extensive delay (1subsequently closed, 1 with service for review)

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

Elective Care Recovery – High Impact Change 3: RTT Long waits Improvement





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

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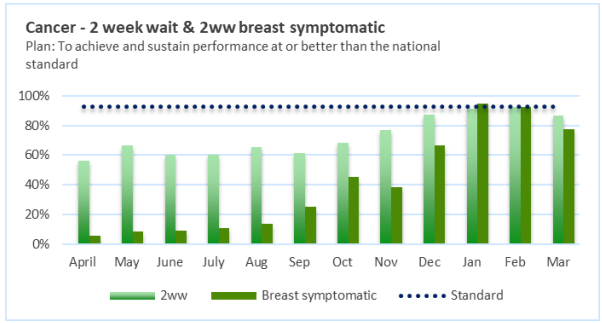
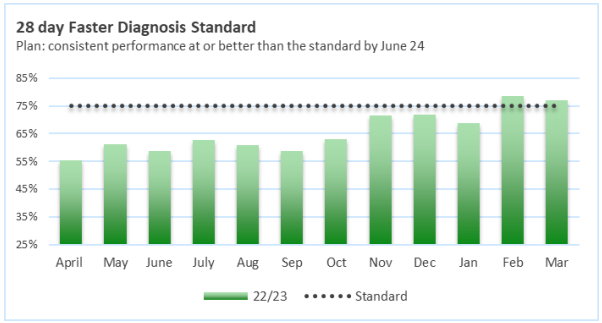
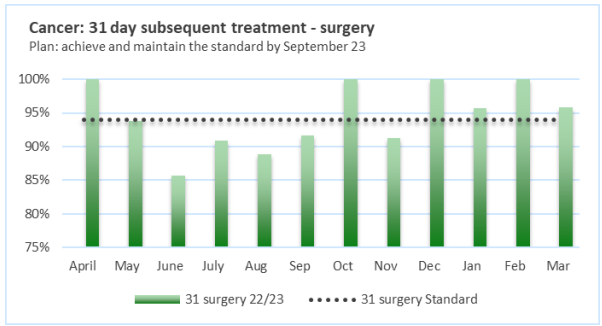
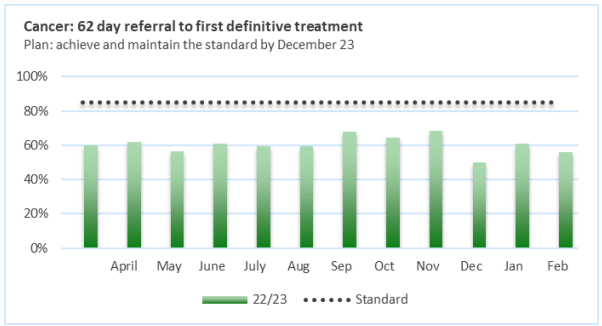
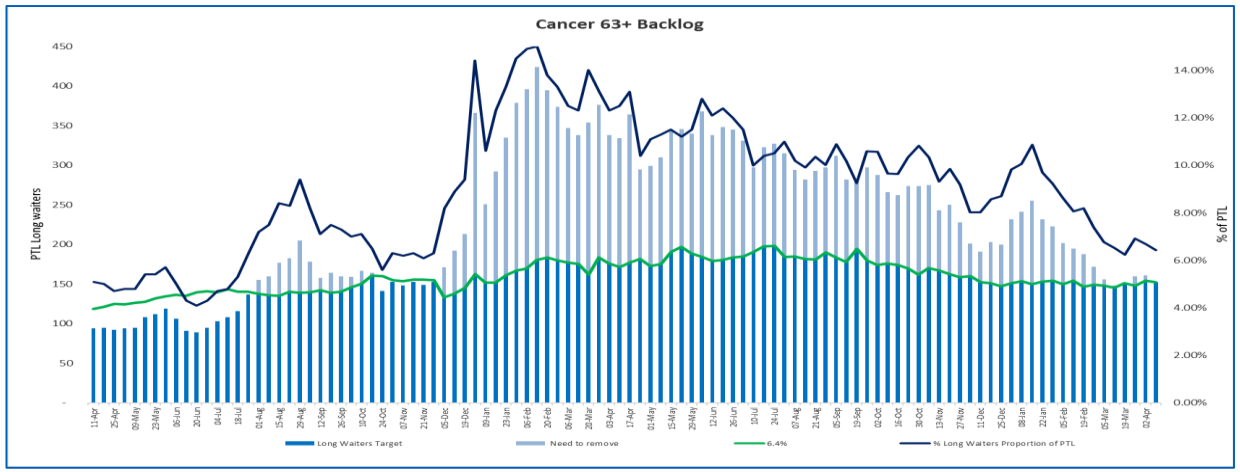
Elective Care Recovery – High Impact Change 3: Cancer waits backlog improvement & performance











2 week waits / breast symptomatic (93%)
The impact of the Junior Doctors' industrial action was significant. Referrals were slightly above the monthly average
(2ww 86/4%, 2wwB 77.4%)

28 day Faster Diagnosis Standard (75%)
Compliance with the standard has been maintained (76.9%)

31 day 1st (96%)
(Not shown)
Compliance maintained (99.3%)

31 day subsequent surgery (94%)
Compliance maintained (96%)

62 day screening (90%)
(Not shown)
1.5 breaches incurred but only 8 pathways in total, resulting in non-compliance at 81.3%)

62 day referral to definitive treatment (85%)
Fewer pathways and fewer breaches this month, but capacity constraints, junior doctor industrial action, complexity and extended pathways have resulted in non-compliance with the standard (58%)

63+ day backlog
Improvement plans have been very successful and the month end position (105) is better than the target set for 2023/24. A stretch target for delivery this year has been agreed internally, set at 95.

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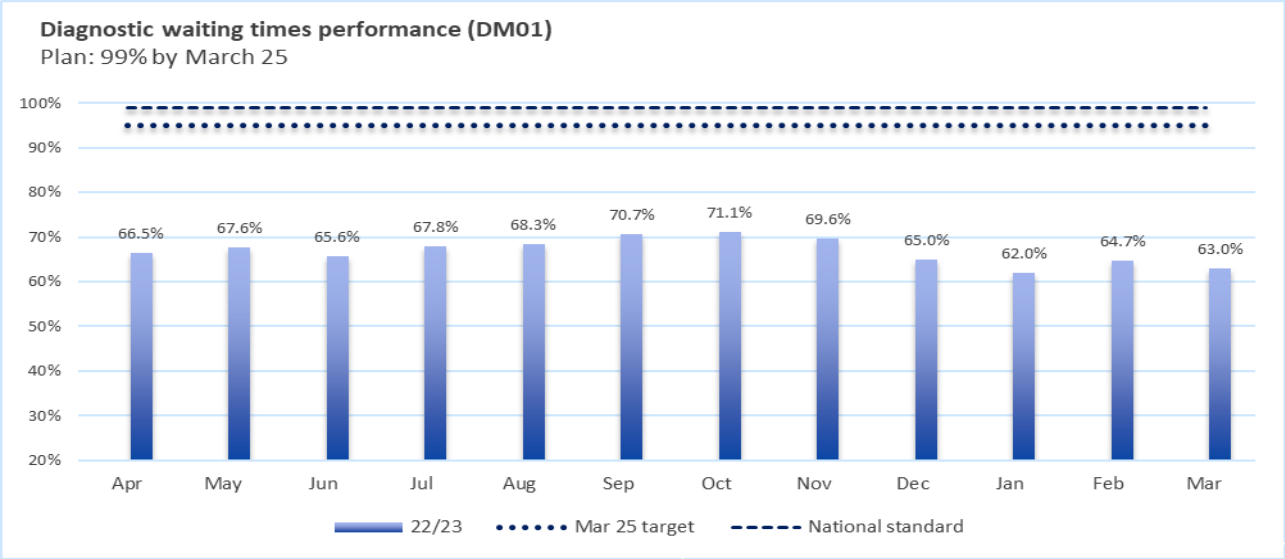
Elective Care Recovery – High Impact Change 3: Diagnostic (DM01) performance improvement



Performance continues to fluctuate, with only 63% of diagnostics performed within 6 weeks in March. The national planning guidance objective for diagnostic performance recovery is to achieve 95% (the red dotted line) by March 2025. The constitutional target is 99%.

Five modalities (MRI, CT, Barium enema, colonoscopy and flexible sigmoidoscopy) achieved 99% or better. NOUS, clinical neurophysiology, and urodynamics were all just below the 99% target.

Modalities with performance below 50% include:
Dexa (very slowly improving)
Audiology (showing month on month improvement)
Echo (deteriorated)
Cystosocopy (deteriorated)

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

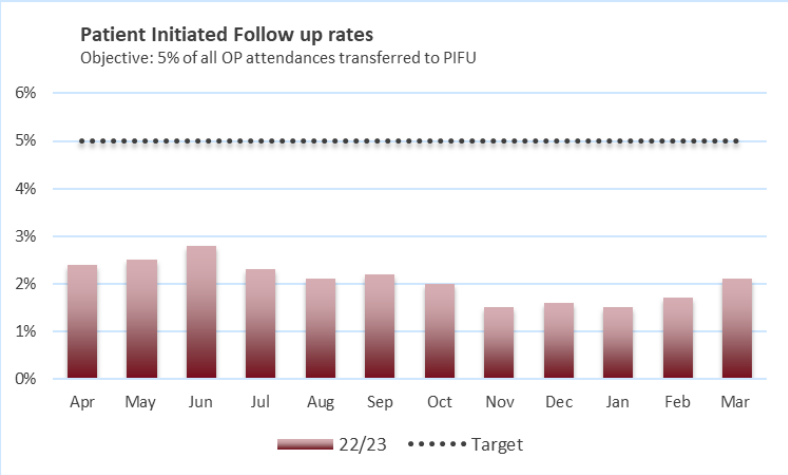
DQ issues continue to influence the cystoscopy waiting list, with incorrect inclusion of planned/surveillance and duplicate pathways. A solution is being actively pursued with the support of the BI team.

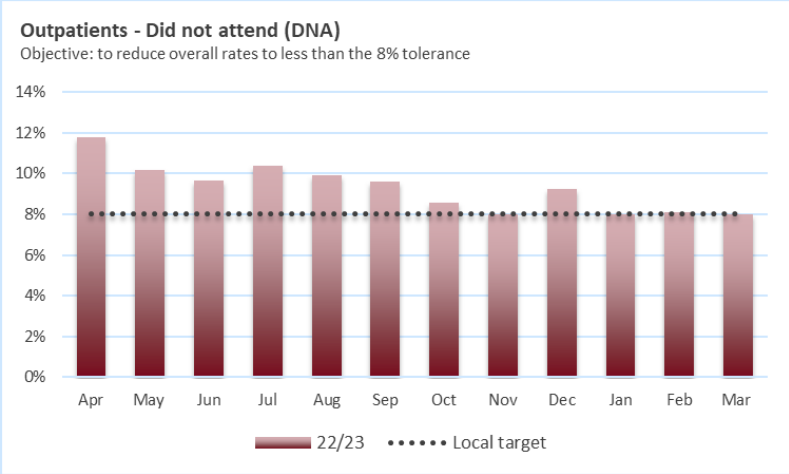
Audiology demand has increased, particularly hearing aid referrals from the community service. Outsourcing plans are advancing, while development of a business case to increase in house capacity progresses.

Dexa performance is improving slowly but workforce constraints have limited the rate of improvement. There are few options for outsourcing. In-house capacity has increased through extended days but more capacity is needed to enable rapid improvement.

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

Elective Care Recovery – High Impact Change 4: Outpatient Productivity & Transformation





Patient Initiated Follow up (PIFU)

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

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

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

Outpatient Productivity

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

Junior Doctors' Industrial action - impact

Staggered approach to cancellation

		Industrial action period			
		11/04/2023	12/04/2023	13/04/2023	14/04/2023
Date cancellations start	05/04/2023	✓			
	06/04/2023		✓		
	11/04/2023			✓	
	12/04/2023				✓

Activity booked during industrial action period

	Outpatient		Inpatient		
	Preserved	Cancelled*	Preserved	Cancelled*	Total
Medicine	1772	310	232	76	2390
Surgery	1797	440	79	153	2469
WACS	1266	81	41	28	1416
CSS	441	0	4	0	445
Total	5276	831	356	257	6720

Outpatient Activity preserved

	Industrial action period				
	11/04/2023	12/04/2023	13/04/2023	14/04/2023	Total
Medicine	494	530	397	351	**1772**
Surgery	509	443	436	409	**1797**
WACS	293	389	341	243	**1266**
CSS	113	107	108	113	**441**
Total	**1409**	**1469**	**1282**	**1116**	**5276**

Inpatient Activity preserved

	Industrial action period				
	11/04/2023	12/04/2023	13/04/2023	14/04/2023	Total
Medicine	43	63	63	63	**232**
Surgery	20	17	23	19	**79**
WACS	15	11	5	10	**41**
CSS	1	0	0	3	**4**
Total	**79**	**91**	**91**	**95**	**356**

*Activity cancelled using specified code - other cancelled activity excluded, eg patient initiated

Approach to cancellation
Divisions provided with patient lists detailing clinical priority status, waiting time, appointment type and clinical review of all bookings undertaken to identify bookings that could safely be deferred.

A rolling cancellation model was implemented, to minimise activity losses in the event that the strike was stood down at the last minute or at any point during the period of industrial action.

Activity
13-15 March – of the 6,029 OP appointments booked during the period, as a result of the strike, 804 were rescheduled. There were 476 admissions booked, of which 144 were deferred.

11-14 April - 7,447 appointments and admissions booked during the period. A number have been excluded from tracking as these were cancelled or deferred for other, non-related reasons (eg patient request). 831 OPAs were rescheduled and 257 admissions, as a result of the industrial action.

Rebooking was undertaken at the time of cancellation where possible. The Operational Recovery Group has oversight of rescheduling, tracking progress with each division to ensure all patients cancelled receive new dates. The BI team and the Divisional Manager for Outpatients have supported divisions with provision of patient lists to enable divisional oversight.

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Trust Board
4th May 2023

Title of the paper:	**Integrated Performance Report** ***(April 2023 reporting period – March 2023 data)***
Agenda Item:	**18**
Presenter:	**Paul Bannister, Chief Information Officer**
Author(s):	**Mark Landau, Director of Business Intelligence** **Paul Bannister, Chief Information Officer**
Purpose:	*Please tick the appropriate box* *For approval*: *For discussion*: ✓ *For information*: ✓
Executive Summary:	**Summary** • This cover sheet summarises the contents of the Trust Integrated Performance Report, detailing changes made to the pack and summarising some of the narrative points made and is intended to provide information and assurance to the committee. **Changes to the pack** • BAME staff in post and BAME staff in post – 8a+ added to Workforce section – historic data added • Apprenticeship levy spend added as a metric in the workforce section **Safe Care & Improving Outcomes - Quality** • There are two statistically significant indicators – SHMI continuing to show in improving special cause variation, although Dr Foster class the Trust as being within 'expected range'. The SHMI indicator is a rolling 12 month metric. The second statistically significant metric is HSMR, which is now a rolling 12 month metric, and showing improving special cause variation. **Safe Care & Improving Outcomes - Safety** • There are seven exceptions generated, six of which were also exceptions in the previous month - of nursing hours (shift fill rate) – Unregistered, % of nursing hours (shift fill rate) – Registered, Serious Incidents – Number, % of patient safety incidents which were harmful, VTE Risk Assessments and Patients admitted to stroke unit within 4 hours of arrival. • The new exception is for Stroke patients thrombolysed within an hour. • Unregistered fill rate is showing as an exception with the latest data point breaching the upper control limit (for the fifth consecutive month). This is largely down to enhanced 1:1 care required (largely for mental health inpatients) and to staff exceptional surge. The unregistered fill rate offsets the low registered fill rate. • Four of the seven exceptions generated reflect improving special cause variation, with three representing concerning special cause variation. **Caring & Responsive Services – A&E** • Ten exception pages generated – all of which were exceptions in the previous month. Worth noting is the fact that whilst still showing concerning special cause variation, there are significant improvements demonstrated in the mean time patients wait in the department as well as with 12 hour journey times • Attendances were high in March with 15,736 attendances the second highest single month we have experienced (after December 2022) **Caring & Responsive Services – RTT, Cancer, Outpatients** • Eight Exception pages generated, all of which were exceptions in the previous month. At time of producing this report the RTT position for March had not been submitted • Cancer metrics continue to show improved performance, with only 62 day GP referral generating an exception of the waiting times metrics

	Workforce • Six Exception pages generated, all of which were exceptions last month, with four exceptions generated for improving special cause. **Activity** • Six Exception pages generated, with one new exception *NB: Data correct at the time of reporting*
Trust strategic aims: *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1 Best care** — ***Objectives 1-4*** — ✓ **Aim 2 Great team** — ***Objectives 5-8*** — ✓ **Aim 3 Best value** — ***Objective 9*** — ✓ **Aim 4 Great place** — ***Objective 10-12*** — ✓
Links to well-led key lines of enquiry:	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☐Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☐Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues and performance? ☒Is appropriate and accurate information being effectively processed, challenged and acted on? ☐Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☒Are there robust systems and processes for learning, continuous improvement and innovation? ☒How well is the trust using its resources?
Previously considered by:	Committee/Group: Trust Management Committee — Date: 26/04/2023 Committee/Group: Finance & Performance Committee — Date: 27/04/2023
Action required:	• The Committee are asked to receive this report for information, assurance and discussion

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Integrated Performance Report

April 2023 – March 2023 data

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

West Hertfordshire Hospitals NHS Trust

Integrated Performance Report

- Trust Management Committee – 26th April 2023
- Finance & Performance Committee – 27th April 2023
- Trust Board – 4th May 2023

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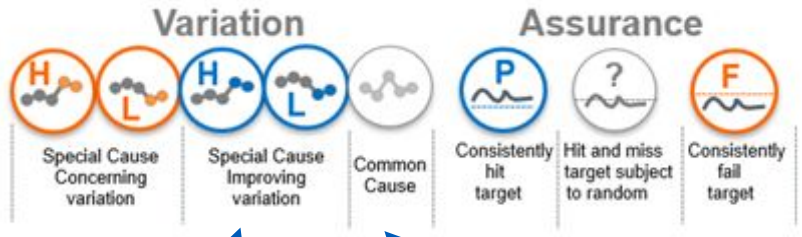
A note on SPC charts

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

West Hertfordshire Hospitals NHS Trust

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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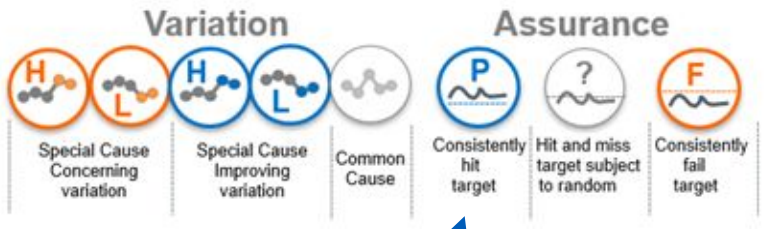
High Level Key - Assurance

Can we reliably hit the target



Orange = system change required to hit target

Blue = will reliably hit the target

Hit and miss the target

5

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

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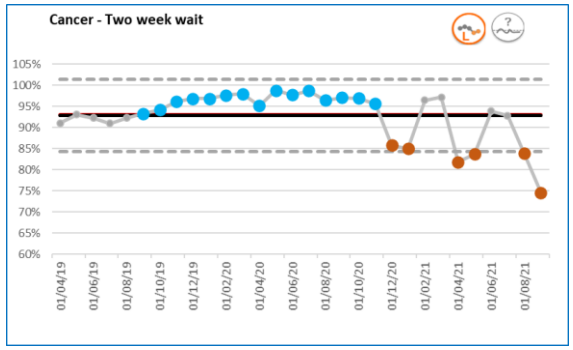
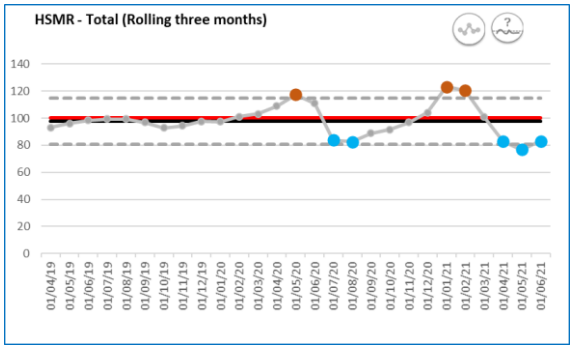
SPC rules – Special Cause Variation

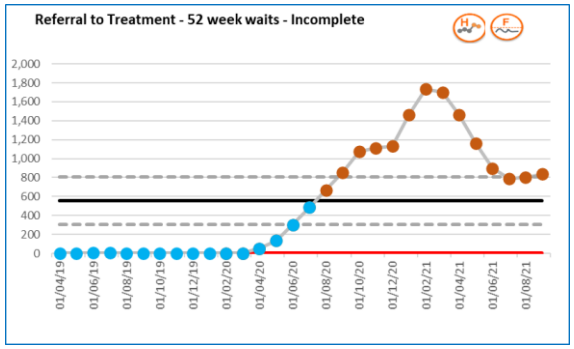
A breach of the upper/lower control limit



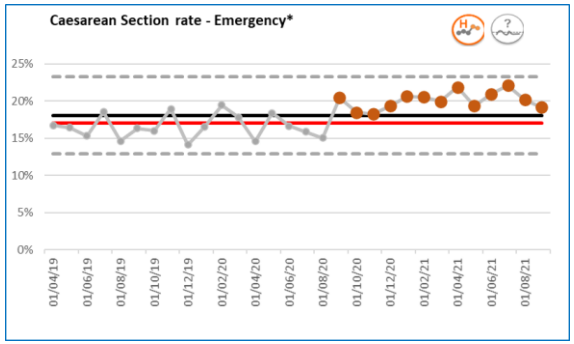
2 out of 3 points close to the control limit



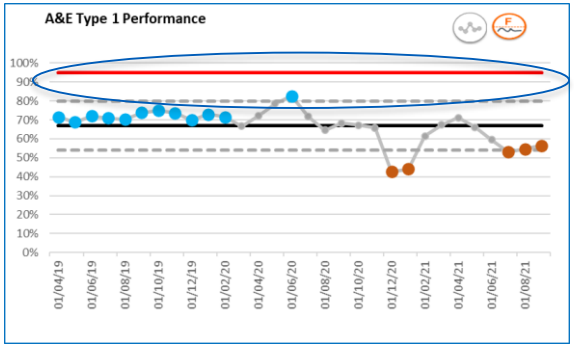
A run of ascending/descending data points



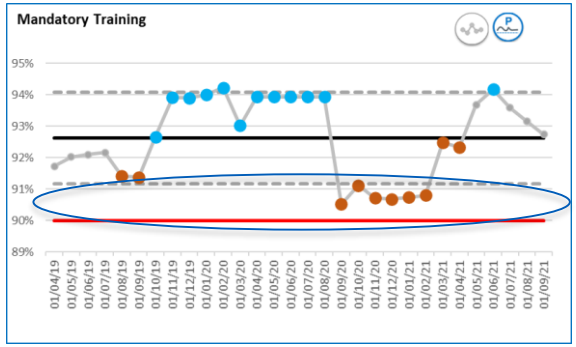
A run of points all one side of the mean



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



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



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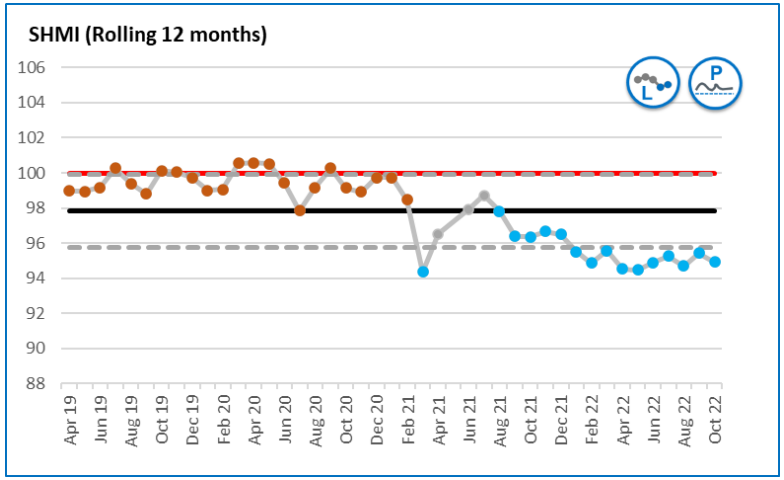
KPI	Latest month	Measure	Target	Variation	Assurance	Local or National Metric	Committee	Owner
Safe Care and Improving Outcomes - Quality								
SHMI (Rolling 12 months)	Oct 22	95	100			National	Quality	CMO
HSMR - Total (Rolling 12 months)	Dec 22	96	100			National	Quality	CMO
Clostridioides Difficile - Hospital associated (Cat 1)	Mar 23	3	-			Local	Quality	CN
Clostridioides Difficile - Healthcare associated (Cat 2)	Mar 23	3	-			Local	Quality	CN
Clostridioides Difficile - Hospital and Healthcare associated Total	Mar 23	6	3			Local	Quality	CMO
Hand Hygiene Compliance	Mar 23	98%	95%			Local	Quality	CN
30 Day Emergency Readmissions - Elective *	Mar 23	3%	4%			Local	Quality	CMO
30 Day Emergency Readmissions - Emerg *	Mar 23	13%	13%			Local	Quality	CMO
Caesarean Section rate - Robson Category 1	Mar 23	14%	-			Local	Quality	CMO
Caesarean Section rate - Robson Category 2	Mar 23	65%	-			Local	Quality	CMO
Caesarean Section rate - Robson Category 5	Mar 23	86%	-			Local	Quality	CMO

West Hertfordshire Hospitals NHS Trust

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

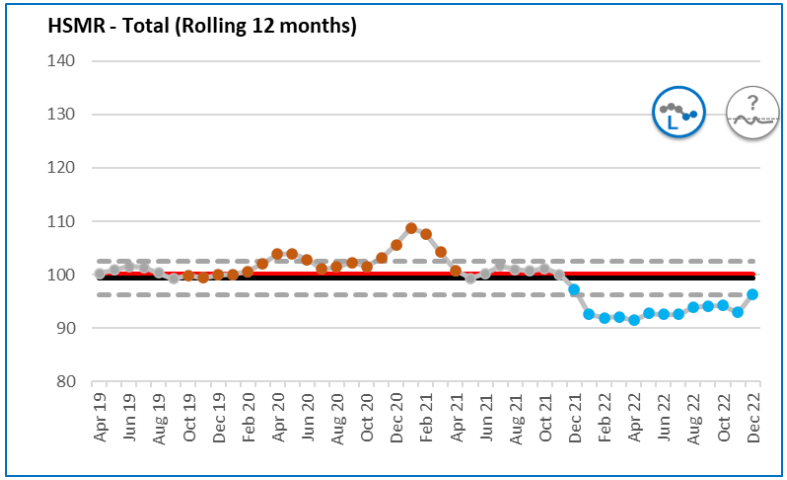


	Provider	Denominator	Obs	Exp	Obs-Exp	SHMI	Low	High
RC9	Bedfordshire Hospitals NHS Foundation Trust	101,040	2,605	2,395	210	108.64	89.74	111.44
RWH	East And North Hertfordshire NHS Trust	49,370	1,725	1,885	-160	91.66	89.56	111.66
RNQ	Kettering General Hospital NHS Foundation Trust	44,925	1,540	1,405	135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

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

West Hertfordshire Hospitals NHS Trust

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



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

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

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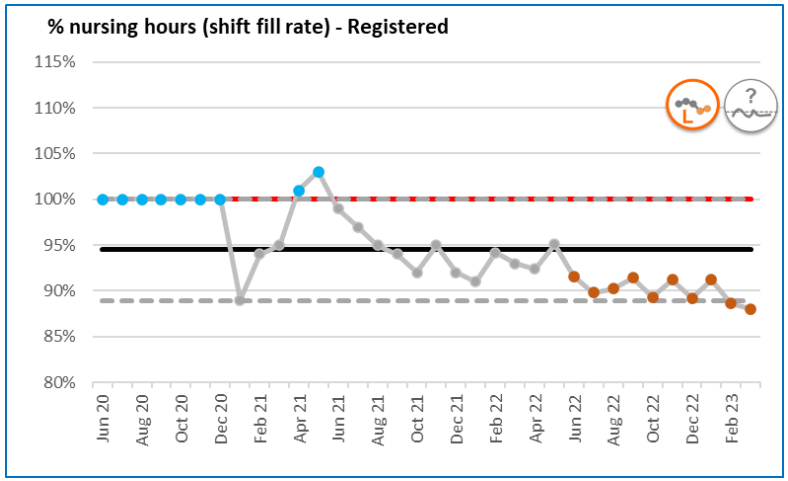
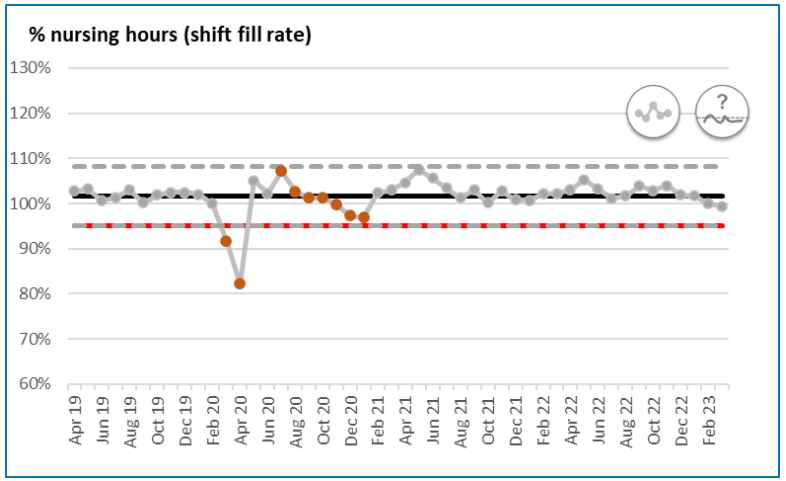
KPI	Latest month	Measure	Target	Variation	Assurance	Local or National Metric	Committee	Owner
Safe Care and Improving Outcomes - Safety								
% nursing hours (shift fill rate)	Mar 23	99%	95%			Local	Quality	CN
% nursing hours (shift fill rate) - Registered	Mar 23	88%	100%	L		Local	Quality	CN
% nursing hours (shift fill rate) - Unregistered	Mar 23	118%	100%	H	P	Local	Quality	CN
Serious incidents - number*	Mar 23	4	-	L		Local	Quality	CMO
Serious incidents - % that are harmful*	Mar 23	75%	0%			Local	Quality	CMO
% of patients safety incidents which are harmful*	Mar 23	13%	0%		F	Local	Quality	CMO
Never events	Mar 23	0	-			Local	Quality	CMO
Category 4 pressure ulcers - New (Hospital acquired)	Mar 23	0	-			Local	Quality	CN
Category 3 pressure ulcers - New (Hospital acquired)	Mar 23	3	-			Local	Quality	CN
Falls with Harm	Mar 23	13	-			Local	Quality	CMO
VTE risk assessment*	Mar 23	98%	95%	H		Local	Quality	CMO
Patients admitted to stroke unit within 4 hours of hospital arrival	Mar 23	54%	90%	H	F	Local	Quality	CMO
Stroke patients spending 90% of their time on stroke unit	Mar 23	71%	80%			Local	Quality	CMO
% Stroke Patients Thrombolysed within an hour	Mar 23	40%	50%	L		Local	Quality	CMO

West Hertfordshire Hospitals NHS Trust

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

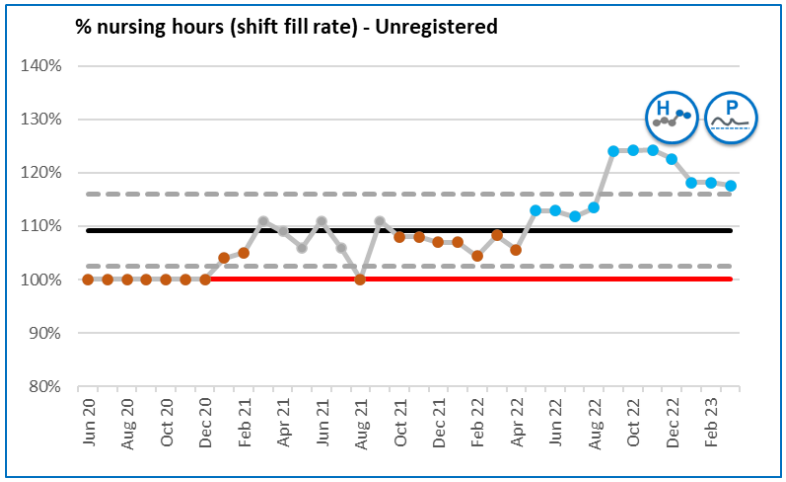


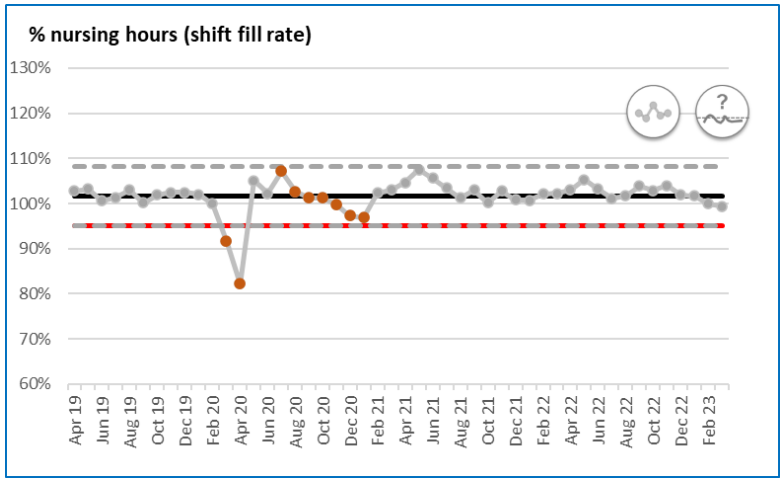


Background	What the Data tells us	Issues	Actions	Mitigations
% Nursing Hours (shift fill rate) - Registered	Exception triggered due to a 7+ data points below the mean (a shift)	Low registered fill rate related to high number of unavailability due to sickness, vacancy and maternity leave, especially in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

West Hertfordshire Hospitals NHS Trust

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

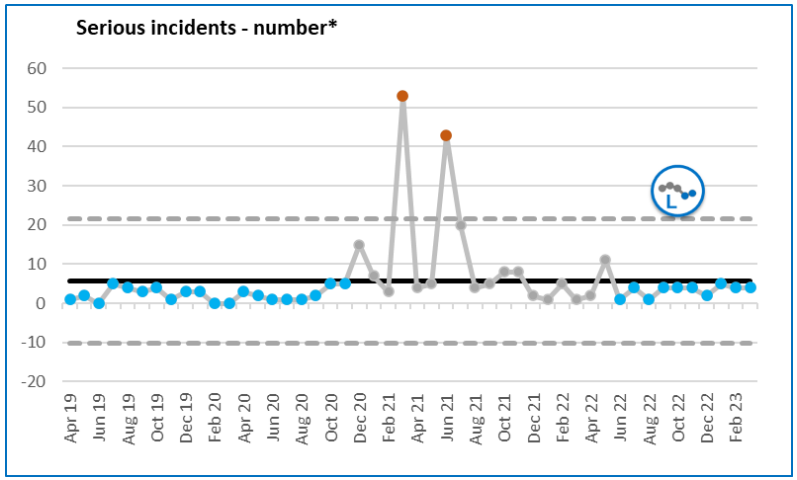




Background	What the Data tells us	Issues	Actions	Mitigations
% Nursing Hours (shift fill rate) - Unregistered	Exception triggered due to a breach of the upper control limit Exception triggered due to 7+ data points above the mean (a shift) Exception triggered due to the target falling below the lower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

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance – Serious Incidents - Number



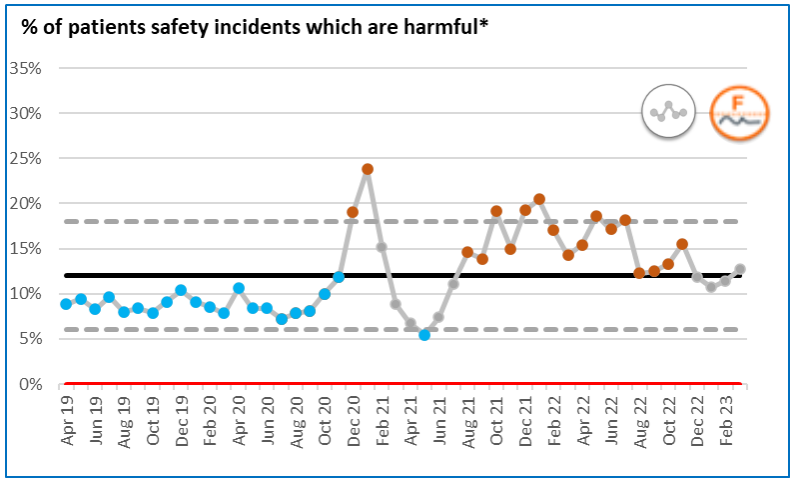
4 serious incidents(SIs) were declared in March 2023. Of these, 2 were reported by Women and Children Services. In comparison, 1 each was reported by Surgery, Anaesthetics and Cancer, and Clinical Support Services.

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

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

West Hertfordshire Hospitals NHS Trust

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



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

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

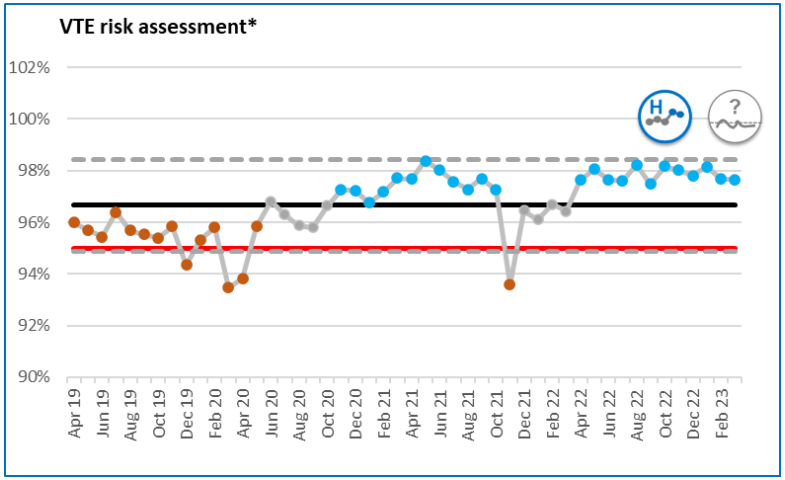
In context, the total number of incidents reported across the divisions trust-wide in March is varied, with no outliers.

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

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

Background	What the Data tells us	Issues	Actions	Mitigations
% of patient safety incidents which are harmful	Exception triggered due to the target being below the lower control limit	In March 2023, 3 incident-type reporting categories were identified in relation to SIs. The categories relate to Maternity/Obstetric incident meeting SI criteria: mother and baby (2), Alleged Abuse of adult patient by third party (1) and Incident affecting patient's body after death (1) Maternity (Midwifery) care (49), Pressure Ulcer (29), Patients Falls (24), Infection Control I (23), Neonatal/Perinatal Care (13) Care, and Diagnostic process (7). The remaining category types reported less than 7. The number of incidents reported as no harm in February is relatively lower than in January, with no concerning themes.	Divisions will continually review incidents promptly and close them, in order to share and facilitate timely learnings and ensure lessons learned are embedded. Continue improvement work and organisational shared learning around identified themes and trends to minimise or prevent a recurrence.	Patient safety incident discussions continue in divisional and departmental meetings with an emphasis on lessons learned Identified themes and trends are shared in the monthly Governance Operational Group meeting.

Special Cause Variation – Performance – VTE Risk Assessment

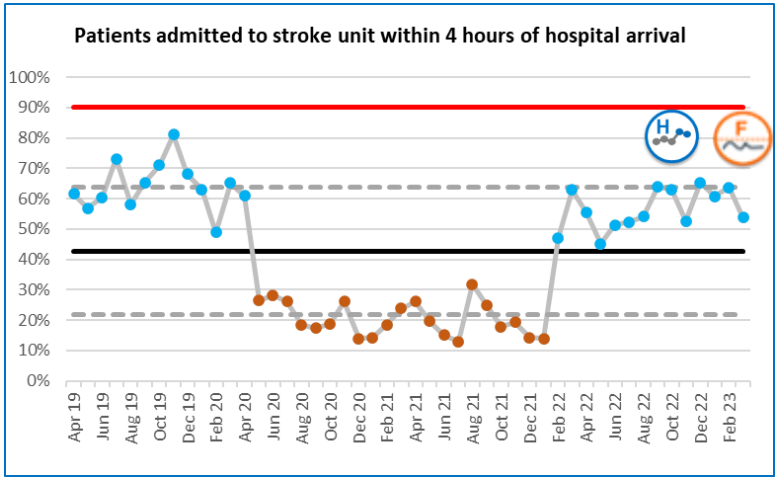


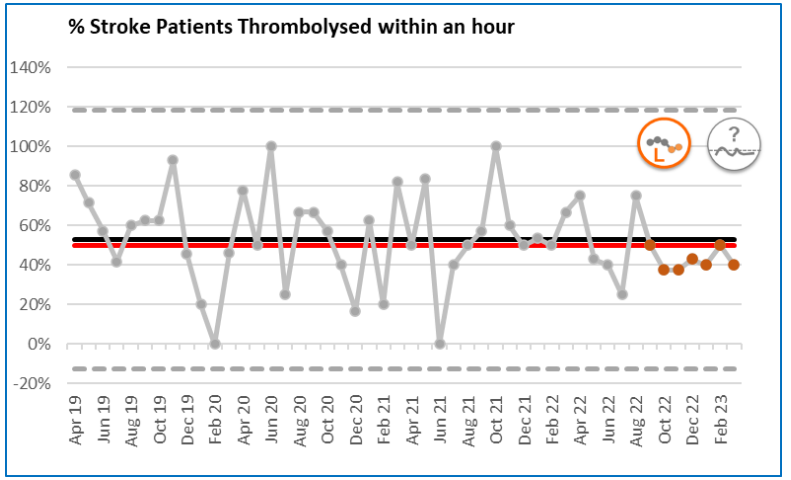
Background	What the Data tells us	Issues	Actions	Mitigations
VTE Risk Assessment	Exception triggered due to a run of 7+ data points above the mean (a shift)			

16

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 Exception triggered due to a run of 7+ data points above the mean (a shift) Exception triggered due to a breach of the upper control limit	The COVID pandemic pathways for all admitted patients to the Trust required a COVID swab result prior to any planned ward transfers and therefore have to wait for the result , this invariably delayed patients accessing the stroke unit within 4 hours. The 4 hour to SU % has been consistently good since Feb 22. and reflects how the ward was pre covid. The January to March quarter is currently at 59.7%	The revised process from requiring a COVID PCR swab result to Lateral flow test which takes less time since February has seen an improvement from a preceding months. A review of the noncompliant patients is undertaken to understand if there are themes which need to be addressed. Maintaining ring fenced beds on the HASU and a ring-fenced side room for patients requiring thrombolysis Review and validation of the reasons patients were not thrombolysed within the one hour window, was undertaken which showed clinical factors and as complexity on presentation.	Patients continue to receive Stroke Consultant input and specific recommendations for their care.

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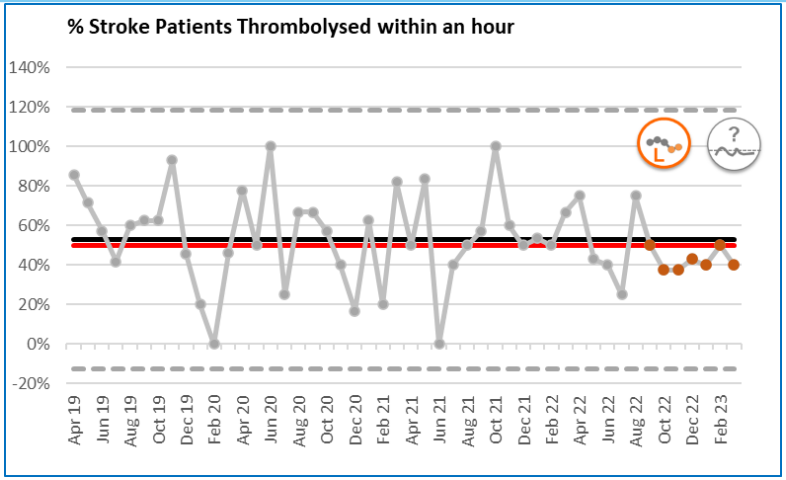
Special Cause Variation – Performance – % Stroke patients thrombolysed within one hour



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

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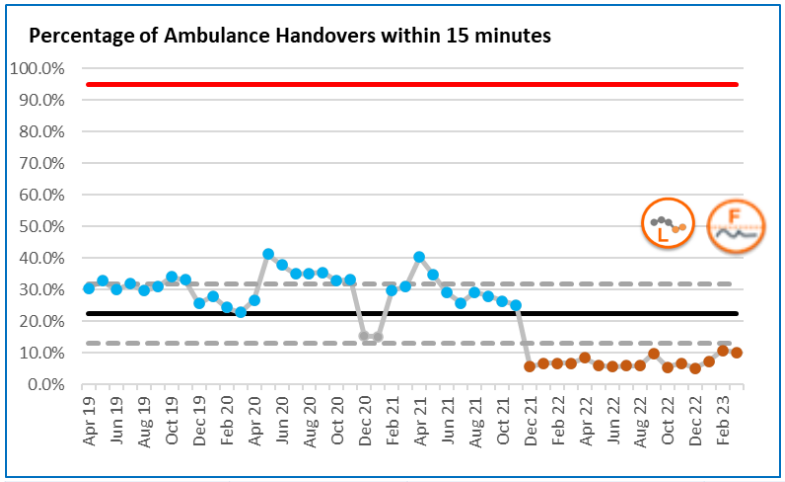
KPI	Latest month	Measure	Target	Variation	Assurance	Local or National Metric	Committee	Owner
Caring & Responsive Services - A&E Metrics								
Percentage of Ambulance Handovers within 15 minutes	Mar 23	10.2%	95.0%	L	F	National	F&P	COO
Ambulance turnaround times >30 mins and <60 mins	Mar 23	567	0	H	F	National	F&P	COO
Ambulance turnaround times >60 mins	Mar 23	405	-	H		National	F&P	COO
A&E Initial Assessment < 15 mins	Mar 23	83.2%	95.0%	L	F	National	F&P	COO
Mean time in department (non-admitted)	Mar 23	286	-	H		National	F&P	COO
Mean time in department (admitted)	Mar 23	399	-	H		National	F&P	COO
12 hour end to end waits for all attendances	Mar 23	455	-	H		Local	F&P	COO
A&E 12hr trolley waits	Mar 23	0	0		?	Local	F&P	COO
A&E 4 Hour Wait - Type 1, 2 & 3	Mar 23	68.1%	95.0%	L	?	National	F&P	COO
A&E 4hr waits – Type 1	Mar 23	43.6%	-	L	F	National	F&P	COO
% Patients admitted through A&E - 0 day LOS	Mar 23	26.7%	-			Local	F&P	COO
Proportion of 12 hour waits in ED	Mar 23	2.9%	2.0%	H	?	National	F&P	COO

West Hertfordshire Hospitals NHS Trust

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



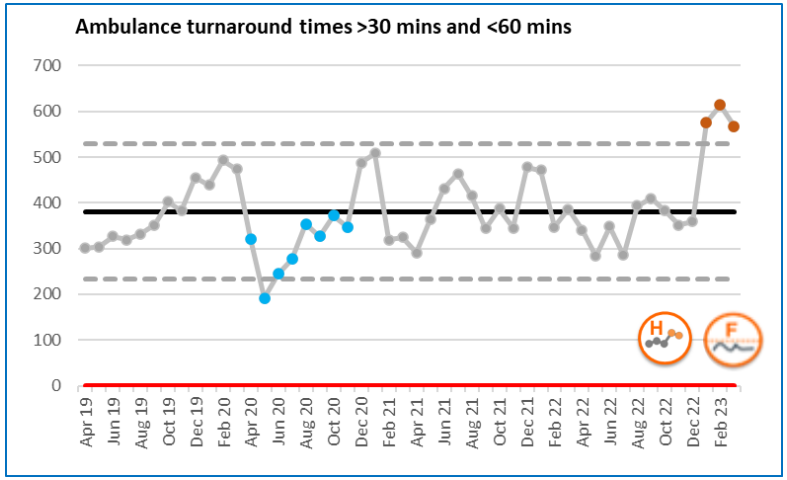
*Latest available benchmarking data – EEAST – March 2023

Hospital	% within 15 minutes
Bedford Hospital South Wing	60.11%
Addenbrookes Hospital	51.63%
Hinchingbrooke Hospital	39.01%
Broomfield Hospital	30.33%
Basildon & Thurrock Hospital	23.87%
West Suffolk Hospital	23.77%
Luton & Dunstable Hospital	23.55%
Ipswich Hospital	22.90%
Southend University Hospital	22.70%
James Paget Hospital	18.49%
Queen Elizabeth Hospital	17.74%
Princess Alexandra Hospital	14.55%
Norfolk & Norwich University Hospital	12.60%
Colchester General Hospital	10.86%
Watford General Hospital	**10.67%**
Lister Hospital	10.20%
Peterborough City Hospital	6.86%
Region	**23.49%**

Background	What the Data tells us	Issues	Actions	Mitigations
Percentage of ambulance handovers within 15 minutes	Exception triggered due to target being outside the upper control limit Exception triggered due to 7+ data points below the mean (a shift) Exception triggered due to a breach of the lower control limit	ED demand has increased by 8% for adults and 15.5% for paediatrics Ambulance demand is down 13.7% on the previous year and 8.6% on 20/21 Daily staffing levels for nursing with the Emergency Medicine Division Daily medical staffing within ED Assessment area has 20 bedded patients used as exceptional surge capacity	• HALO on site 12- 12 • Boarding policy in place • Fit to sit area in use to support offload • Joint working with EEAST and WGH UTC to facilitate offload • Corridor nursing in place including a joint Trust and EEAST corridor SOP • 10 x EAU assessment trolleys brought back into use • Ambulance handover project board meetings continue with EEAST and ICS in attendance. • Ambulance handover high level actions agreed and submitted to support new trajectory • Participate in the #handover at home care coordination programme • High level actions included in Trust improvement plan • ED workforce plan submitted as part of confirm and challenge	• ED improvement plan developed detailing actions for ED, this is being worked into a Trust flow plan • All patients assessed by senior decision maker on arrival and treatment commenced if delayed. Close partnership working with EEAST • Increased nursing establishment through winter funding to support timely offloading and release of crews • Intelligent conveyancing implemented and in agreement with EEAST and ICB as necessary. • Rapid release in place to support patients in the community • Winter and call to arms monies utilised to support: • Nursing shifts • Medical shifts • Board Controller shifts • Active recruitment to vacancies • Assurance through bed meetings for time to initial assessment and time to offload

West Hertfordshire Hospitals NHS Trust

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



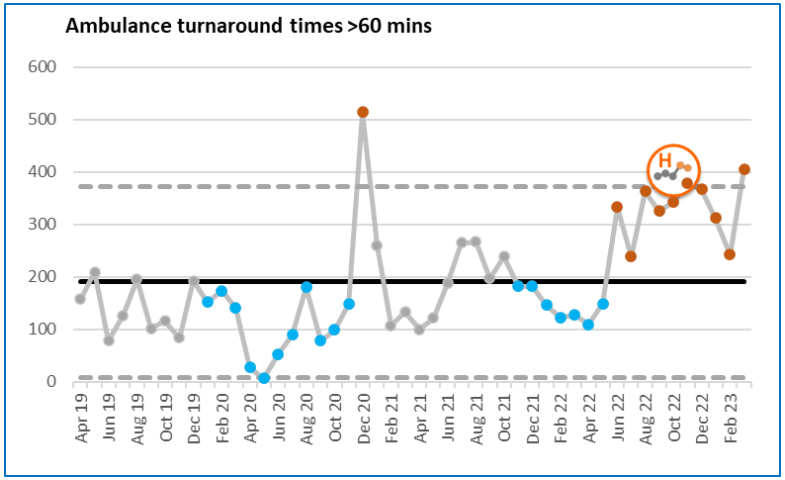
***Latest available benchmarking data – EEAST – March 2023**

Hospital	Number over 30 Minutes	% over 30 minutes
Bedford Hospital South Wing	168	10.39%
Addenbrookes Hospital	315	12.85%
Hinchingbrooke Hospital	260	21.40%
Broomfield Hospital	588	26.08%
West Suffolk Hospital	472	29.14%
Ipswich Hospital	689	33.79%
Luton & Dunstable Hospital	727	33.97%
Southend University Hospital	781	34.90%
Basildon & Thurrock Hospital	738	38.80%
Watford General Hospital	**866**	**41.44%**
Colchester General Hospital	866	42.94%
Peterborough City Hospital	819	49.28%
James Paget Hospital	949	55.17%
Queen Elizabeth Hospital	866	56.27%
Princess Alexandra Hospital	822	60.71%
Lister Hospital	1104	60.86%
Norfolk & Norwich University Hospital	1856	74.45%
Region	**12886**	**40.06%**

Background	What the Data tells us	Issues	Actions	Mitigations
Number of ambulance handovers between 30-60 minutes	Exception triggered due to target being outside the lower control limit Exception triggered due to a breach of the upper control limit	ED demand has increased by 8% for adults and 15.5% for paediatrics Ambulance demand is down 13.7% on the previous year and 8.6% on 20/21 Daily staffing levels for nursing with the Emergency Medicine Division Daily medical staffing within ED Assessment area has 20 bedded patients used as exceptional surge capacity	• HALO on site 12- 12 • Boarding policy in place • Fit to sit area in use to support offload • Joint working with EEAST and WGH UTC to facilitate offload • Corridor nursing in place including a joint Trust and EEAST corridor SOP • 10 x EAU assessment trolleys brought back into use • Ambulance handover project board meetings continue with EEAST and ICS in attendance. • Ambulance handover high level actions agreed and submitted to support new trajectory • Participate in the #handover at home care coordination programme • High level actions included in Trust improvement plan • ED workforce plan submitted as part of confirm and challenge	• ED improvement plan developed detailing actions for ED, this is being worked into a Trust flow plan • All patients assessed by senior decision maker on arrival and treatment commenced if delayed. Close partnership working with EEAST • Increased nursing establishment through winter funding to support timely offloading and release of crews • Intelligent conveyancing implemented and in agreement with EEAST and ICB as necessary. • Rapid release in place to support patients in the community • Winter and call to arms monies utilised to support: • Nursing shifts • Medical shifts • Board Controller shifts • Active recruitment to vacancies • Assurance through bed meetings for time to initial assessment and time to offload

West Hertfordshire Hospitals NHS Trust

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



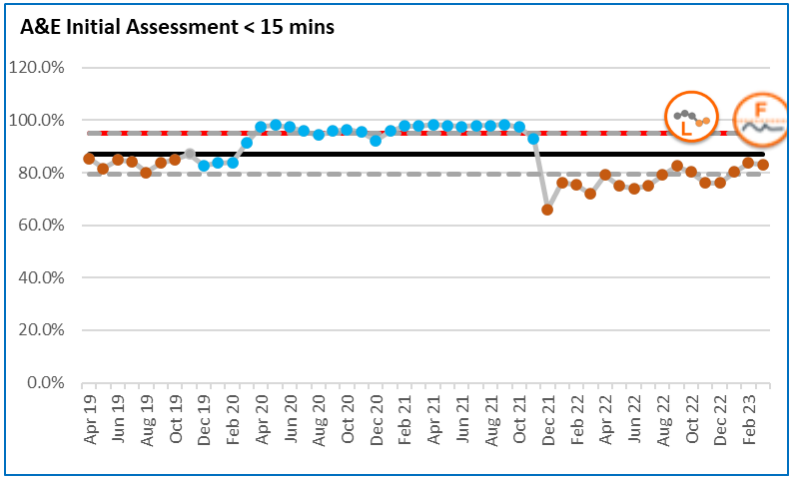
***Latest available benchmarking data – EEAST – March 2023**

Hospital	Number over 60 minutes	% over 60 minutes
Addenbrookes Hospital	92	3.75%
Bedford Hospital South Wing	95	5.88%
Broomfield Hospital	165	7.32%
Hinchingbrooke Hospital	135	11.11%
Southend University Hospital	269	12.02%
West Suffolk Hospital	210	12.96%
Watford General Hospital	**309**	**14.78%**
Peterborough City Hospital	269	16.19%
Ipswich Hospital	333	16.33%
Luton & Dunstable Hospital	350	16.36%
Basildon & Thurrock Hospital	397	20.87%
Colchester General Hospital	495	24.54%
Lister Hospital	575	31.70%
James Paget Hospital	575	33.43%
Princess Alexandra Hospital	511	37.74%
Queen Elizabeth Hospital	616	40.03%
Norfolk & Norwich University Hospital	1474	59.13%
Region	**6870**	**21.36%**

Background	What the Data tells us	Issues	Actions	Mitigations
Number of ambulance handovers > 60 minutes	Exception triggered due to 7+ data points above the mean (a shift) Exception triggered due to a breach of the upper control limit	ED demand has increased by 8% for adults and 15.5% for paediatrics Ambulance demand is down 13.7% on the previous year and 8.6% on 20/21 Daily staffing levels for nursing with the Emergency Medicine Division Daily medical staffing within ED Assessment area has 20 bedded patients used as exceptional surge capacity	• HALO on site 12- 12 • Boarding policy in place • Fit to sit area in use to support offload • Joint working with EEAST and WGH UTC to facilitate offload • Corridor nursing in place including a joint Trust and EEAST corridor SOP • 10 x EAU assessment trolleys brought back into use • Ambulance handover project board meetings continue with EEAST and ICS in attendance. • Ambulance handover high level actions agreed and submitted to support new trajectory • Participate in the #handover at home care coordination programme • High level actions included in Trust improvement plan • ED workforce plan submitted as part of confirm and challenge	• ED improvement plan developed detailing actions for ED, this is being worked into a Trust flow plan • All patients assessed by senior decision maker on arrival and treatment commenced if delayed. Close partnership working with EEAST • Increased nursing establishment through winter funding to support timely offloading and release of crews • Intelligent conveyancing implemented and in agreement with EEAST and ICB as necessary. • Rapid release in place to support patients in the community • Winter and call to arms monies utilised to support: • Nursing shifts • Medical shifts • Board Controller shifts • Active recruitment to vacancies • Assurance through bed meetings for time to initial assessment and time to offload

West Hertfordshire Hospitals NHS Trust

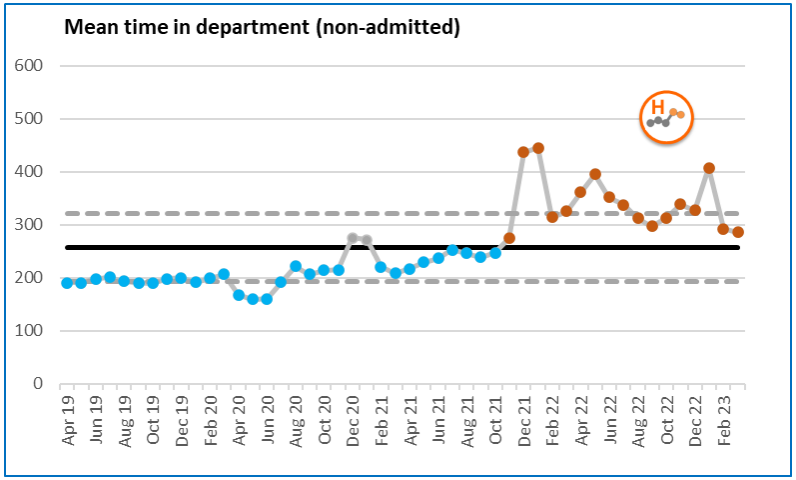
Special Cause Variation – Performance – Time to initial assessment - Percentage within 15 minutes



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)	• Capacity pressures due to poor flow throughout ED resulted in late assessments. • Nursing staffing workforce challenges with workforce at times being RAG rated RED. • 20 trolleys in assessment area bedded • ED demand has increased by 8% for adults and 15.5% for paediatrics • Increased number of Mental Health attendances, resulting in long stays in ED impacting on available assessment space. • Doctor and nurse staffing levels at Watford UTC • WGH UTC flow constraints impact on ED as well as handovers at close. • 3% increase in type 3attendances from last year	• Walk-in stream separated from ambulance stream to provide clearer visibility across the department and decompress bottleneck areas. Fit to sit implemented. • Additional assessment trolleys created in majors 2. • Increase use of TAM supported by senior decision makers to support flow • EAU chairs implemented • 10 x assessment spaces released from surge • Increase usage of SDEC pathways including patients actively pulled into ACU. • Phone a friend in place • Emergency medicine performance meetings focus on improvement plan • High Impact Changes work focussing on rapid clinical assessment, and UTC • Focus on weekend discharges, discharge time of day and usage of discharge lounge to enable earlier flow. • Discharge nurse employed on level 1 • Emergency medicine performance meetings focus on improvement plan	• High Impact Changes enabling increasing Senior Decision Makers in ED. • Data shows increase of initial assessment. • On-going staffing and capacity reviews during shifts and decision taken to open additional areas when safe staffing levels allow • Senior decision maker in “STARR” and TAM to focus on walk in patients • Patients are treated according to clinical prioritisation although sometimes this may result in less urgent patients experiencing longer waits when the department is under pressure. • Additional staff rostered to cover corridor care at times of high attendance and high DTAs • Additional Trust actions following escalation procedure enacted at times of extreme capacity pressures • Joint corridor SOP • Senior review/oversight of decisions to admit. • Harm reviews carried out for patients who wait for 12 hrs, so far this has shown no harm caused • Validation SOP in place • Hourly rounding being undertaken on all patients ensuring comfort. • If prolonged trolley wait – patients transferred to bed for comfort.

West Hertfordshire Hospitals NHS Trust

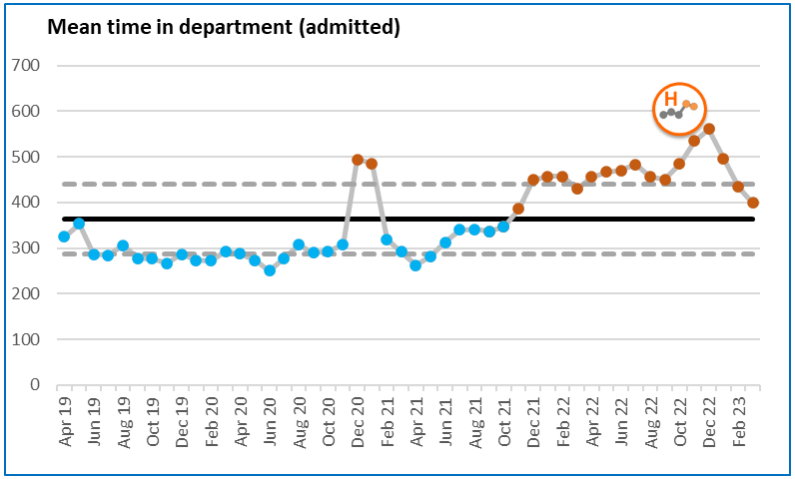
Special Cause Variation – Performance – Mean time (minutes) in department (non-admitted)



Background	What the Data tells us	Issues	Actions	Mitigations
Mean time in department (Non-admitted	Exception triggered due to 7+ data points above the mean (a shift)	• Capacity pressures due to poor flow throughout ED resulted in late assessments. • Nursing staffing workforce challenges with workforce at times being RAG rated RED. • 20 trolleys in assessment area bedded • ED demand has increased by 8% for adults and 15.5% for paediatrics • Increased number of Mental Health attendances, resulting in long stays in ED impacting on available assessment space. • Doctor and nurse staffing levels at Watford UTC • WGH UTC flow constraints impact on ED as well as handovers at close. • 3% increase in type 3attendances from last year	• Walk-in stream separated from ambulance stream to provide clearer visibility across the department and decompress bottleneck areas. Fit to sit implemented. • Additional assessment trolleys created in majors 2. • Increase use of TAM supported by senior decision makers to support flow • EAU chairs implemented • 10 x assessment spaces released from surge • Increase usage of SDEC pathways including patients actively pulled into ACU. • Phone a friend in place • Emergency medicine performance meetings focus on improvement plan • High Impact Changes work focussing on rapid clinical assessment, and UTC • Focus on weekend discharges, discharge time of day and usage of discharge lounge to enable earlier flow. • Discharge nurse employed on level 1 • Emergency medicine performance meetings focus on improvement plan	• High Impact Changes enabling increasing Senior Decision Makers in ED. • Data shows increase of initial assessment. • On-going staffing and capacity reviews during shifts and decision taken to open additional areas when safe staffing levels allow • Senior decision maker in “STARR” and TAM to focus on walk in patients • Patients are treated according to clinical prioritisation although sometimes this may result in less urgent patients experiencing longer waits when the department is under pressure. • Additional staff rostered to cover corridor care at times of high attendance and high DTAs • Additional Trust actions following escalation procedure enacted at times of extreme capacity pressures • Joint corridor SOP • Senior review/oversight of decisions to admit. • Harm reviews carried out for patients who wait for 12 hrs, so far this has shown no harm caused • Validation SOP in place • Hourly rounding being undertaken on all patients ensuring comfort. • If prolonged trolley wait – patients transferred to bed for comfort.

West Hertfordshire Hospitals NHS Trust

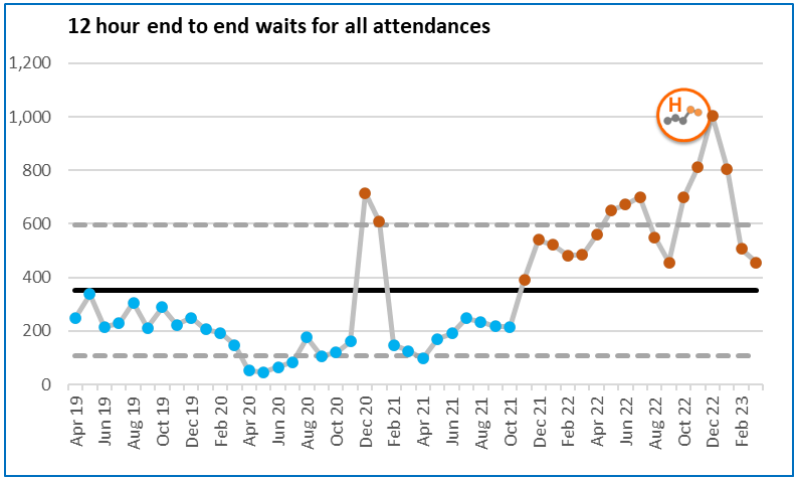
Special Cause Variation – Performance – Mean time (minutes) in department (admitted)



Background	What the Data tells us	Issues	Actions	Mitigations
Mean time in department (admitted	Exception triggered due to 7+ data points above the mean (a shift)	• Capacity pressures due to poor flow throughout ED resulted in late assessments. • Nursing staffing workforce challenges with workforce at times being RAG rated RED. • 20 trolleys in assessment area bedded • ED demand has increased by 8% for adults and 15.5% for paediatrics • Increased number of Mental Health attendances, resulting in long stays in ED impacting on available assessment space. • Doctor and nurse staffing levels at Watford UTC • WGH UTC flow constraints impact on ED as well as handovers at close. • 3% increase in type 3attendances from last year	• Walk-in stream separated from ambulance stream to provide clearer visibility across the department and decompress bottleneck areas. Fit to sit implemented. • Additional assessment trolleys created in majors 2. • Increase use of TAM supported by senior decision makers to support flow • EAU chairs implemented • 10 x assessment spaces released from surge • Increase usage of SDEC pathways including patients actively pulled into ACU. • Phone a friend in place • Emergency medicine performance meetings focus on improvement plan • High Impact Changes work focussing on rapid clinical assessment, and UTC • Focus on weekend discharges, discharge time of day and usage of discharge lounge to enable earlier flow. • Discharge nurse employed on level 1 • Emergency medicine performance meetings focus on improvement plan	• High Impact Changes enabling increasing Senior Decision Makers in ED. • Data shows increase of initial assessment. • On-going staffing and capacity reviews during shifts and decision taken to open additional areas when safe staffing levels allow • Senior decision maker in “STARR” and TAM to focus on walk in patients • Patients are treated according to clinical prioritisation although sometimes this may result in less urgent patients experiencing longer waits when the department is under pressure. • Additional staff rostered to cover corridor care at times of high attendance and high DTAs • Additional Trust actions following escalation procedure enacted at times of extreme capacity pressures • Joint corridor SOP • Senior review/oversight of decisions to admit. • Harm reviews carried out for patients who wait for 12 hrs, so far this has shown no harm caused • Validation SOP in place • Hourly rounding being undertaken on all patients ensuring comfort. • If prolonged trolley wait – patients transferred to bed for comfort.

West Hertfordshire Hospitals NHS Trust

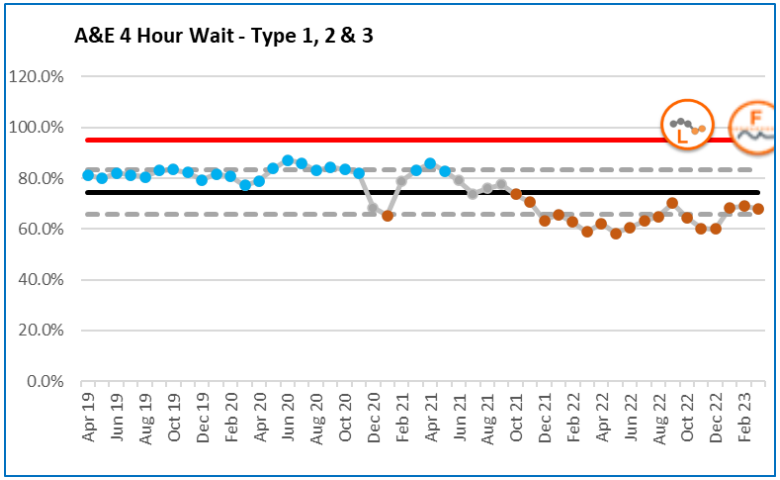
Special Cause Variation – Performance – A&E 12 hour waits (arrival to departure)



Background	What the Data tells us	Issues	Actions	Mitigations
12 Hour end to end waits for all attendances	Exception triggered due to 7+ data points above the mean (a shift)	• Capacity pressures due to poor flow throughout ED resulted in late assessments. • Nursing staffing workforce challenges with workforce at times being RAG rated RED. • 20 trolleys in assessment area bedded • ED demand has increased by 8% for adults and 15.5% for paediatrics • Increased number of Mental Health attendances, resulting in long stays in ED impacting on available assessment space. • Doctor and nurse staffing levels at Watford UTC • WGH UTC flow constraints impact on ED as well as handovers at close. • 3% increase in type 3attendances from last year	• Walk-in stream separated from ambulance stream to provide clearer visibility across the department and decompress bottleneck areas. Fit to sit implemented. • Additional assessment trolleys created in majors 2. • Increase use of TAM supported by senior decision makers to support flow • EAU chairs implemented • 10 x assessment spaces released from surge • Increase usage of SDEC pathways including patients actively pulled into ACU. • Phone a friend in place • Emergency medicine performance meetings focus on improvement plan • High Impact Changes work focussing on rapid clinical assessment, and UTC • Focus on weekend discharges, discharge time of day and usage of discharge lounge to enable earlier flow. • Discharge nurse employed on level 1 • Emergency medicine performance meetings focus on improvement plan	• High Impact Changes enabling increasing Senior Decision Makers in ED. • Data shows increase of initial assessment. • On-going staffing and capacity reviews during shifts and decision taken to open additional areas when safe staffing levels allow • Senior decision maker in “STARR” and TAM to focus on walk in patients • Patients are treated according to clinical prioritisation although sometimes this may result in less urgent patients experiencing longer waits when the department is under pressure. • Additional staff rostered to cover corridor care at times of high attendance and high DTAs • Additional Trust actions following escalation procedure enacted at times of extreme capacity pressures • Joint corridor SOP • Senior review/oversight of decisions to admit. • Harm reviews carried out for patients who wait for 12 hrs, so far this has shown no harm caused • Validation SOP in place • Hourly rounding being undertaken on all patients ensuring comfort. • If prolonged trolley wait – patients transferred to bed for comfort.

West Hertfordshire Hospitals NHS Trust

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



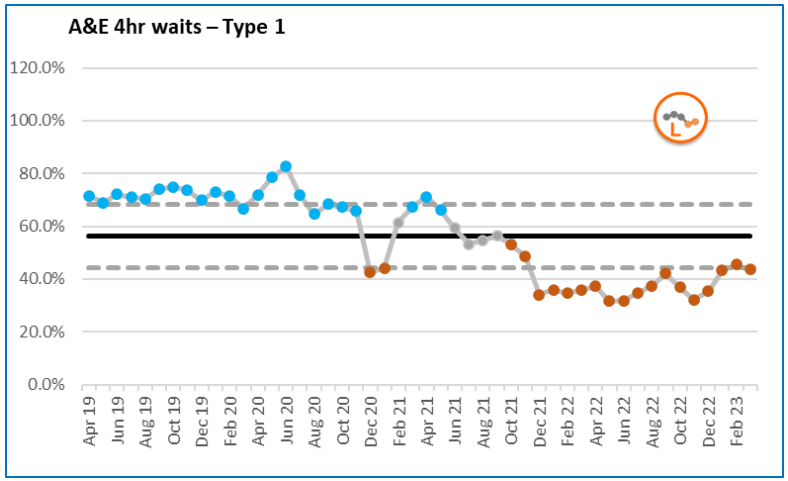
March 2023 - East of England A&E 4hr Wait Performance (Latest Published Data)

Trust	Attendances	Within 4 hours	Performance	Region Rank
Bedfordshire Hospitals NHS Foundation Trust	24,666	-	-	-
Cambridge University Hospitals NHS Foundation Trust	16,373	-	-	-
West Suffolk NHS Foundation Trust	7,525	-	-	-
Milton Keynes University Hospital NHS Foundation Trust	13,498	10,677	79%	1
Norfolk And Norwich University Hospitals NHS Foundation Trust	19,474	14,802	76%	2
East Suffolk And North Essex NHS Foundation Trust	25,220	17,329	69%	3
West Hertfordshire Teaching Hospitals NHS Trust	**15,736**	**10,715**	**68%**	**4**
James Paget University Hospitals NHS Foundation Trust	8,187	5,452	67%	5
North West Anglia NHS Foundation Trust	17,471	11,063	63%	6
Mid And South Essex NHS Foundation Trust	33,294	21,063	63%	7
East And North Hertfordshire NHS Trust	15,281	9,607	63%	8
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	7,341	4,578	62%	9
The Princess Alexandra Hospital NHS Trust	10,412	5,376	52%	10

Background	What the Data tells us	Issues	Actions	Mitigations
A&E 4 Hour Wait – Type 1, 2 & 3	Exception triggered due to 7+ data points below the mean (a shift)	• Capacity pressures due to poor flow throughout ED resulted in late assessments. • Nursing staffing workforce challenges with workforce at times being RAG rated RED. • 20 trolleys in assessment area bedded • ED demand has increased by 8% for adults and 15.5% for paediatrics • Increased number of Mental Health attendances, resulting in long stays in ED impacting on available assessment space. • Doctor and nurse staffing levels at Watford UTC • WGH UTC flow constraints impact on ED as well as handovers at close. • 3% increase in type 3attendances from last year	• Walk-in stream separated from ambulance stream to provide clearer visibility across the department and decompress bottleneck areas. Fit to sit implemented. • Additional assessment trolleys created in majors 2. • Increase use of TAM supported by senior decision makers to support flow • EAU chairs implemented • 10 x assessment spaces released from surge • Increase usage of SDEC pathways including patients actively pulled into ACU. • Phone a friend in place • Emergency medicine performance meetings focus on improvement plan • High Impact Changes work focussing on rapid clinical assessment, and UTC • Focus on weekend discharges, discharge time of day and usage of discharge lounge to enable earlier flow. • Discharge nurse employed on level 1 • Emergency medicine performance meetings focus on improvement plan	• High Impact Changes enabling increasing Senior Decision Makers in ED. • Data shows increase of initial assessment. • On-going staffing and capacity reviews during shifts and decision taken to open additional areas when safe staffing levels allow • Senior decision maker in “STARR” and TAM to focus on walk in patients • Patients are treated according to clinical prioritisation although sometimes this may result in less urgent patients experiencing longer waits when the department is under pressure. • Additional staff rostered to cover corridor care at times of high attendance and high DTAs • Additional Trust actions following escalation procedure enacted at times of extreme capacity pressures • Joint corridor SOP • Senior review/oversight of decisions to admit. • Harm reviews carried out for patients who wait for 12 hrs, so far this has shown no harm caused • Validation SOP in place • Hourly rounding being undertaken on all patients ensuring comfort. • If prolonged trolley wait – patients transferred to bed for comfort.

West Hertfordshire Hospitals NHS Trust

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



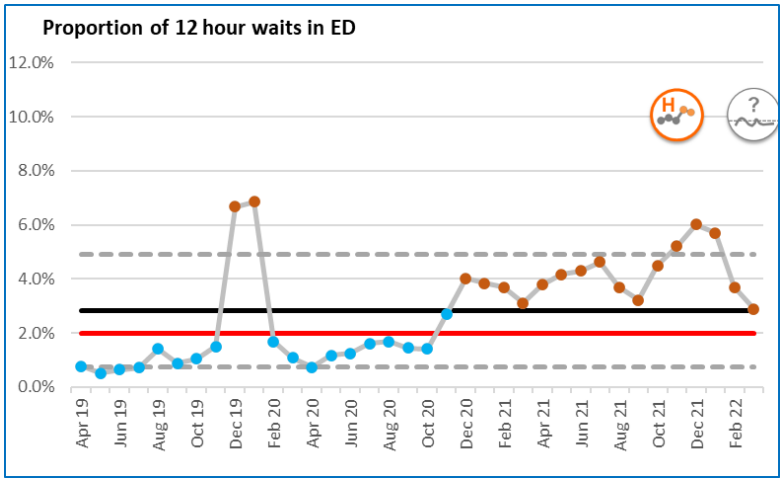
March 2023 - East of England A&E Type 1 4hr Wait Performance (Latest Published Data)

Trust	Attendances	Within 4 hours	Performance	Region Rank
Bedfordshire Hospitals NHS Foundation Trust	16,144	-	-	-
Cambridge University Hospitals NHS Foundation Trust	10,361	-	-	-
West Suffolk NHS Foundation Trust	6,752	-	-	-
Milton Keynes University Hospital NHS Foundation Trust	8,357	5,737	69%	1
Mid And South Essex NHS Foundation Trust	31,125	18,997	61%	2
James Paget University Hospitals NHS Foundation Trust	6,774	4,039	60%	3
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	6,479	3,716	57%	4
Norfolk And Norwich University Hospitals NHS Foundation Trust	10,828	6,157	57%	5
North West Anglia NHS Foundation Trust	12,393	6,591	53%	6
The Princess Alexandra Hospital NHS Trust	10,412	5,376	52%	7
East Suffolk And North Essex NHS Foundation Trust	14,239	6,533	46%	8
West Hertfordshire Teaching Hospitals NHS Trust	**8,225**	**3,571**	**43%**	**9**
East And North Hertfordshire NHS Trust	9,719	4,049	42%	10

Background	What the Data tells us	Issues	Actions	Mitigations
A&E 4hr Waits – Type 1	Exception triggered due to 7+ data points below the mean (a shift)	• Capacity pressures due to poor flow throughout ED resulted in late assessments. • Nursing staffing workforce challenges with workforce at times being RAG rated RED. • 20 trolleys in assessment area bedded • ED demand has increased by 8% for adults and 15.5% for paediatrics • Increased number of Mental Health attendances, resulting in long stays in ED impacting on available assessment space. • Doctor and nurse staffing levels at Watford UTC • WGH UTC flow constraints impact on ED as well as handovers at close. • 3% increase in type 3attendances from last year	• Walk-in stream separated from ambulance stream to provide clearer visibility across the department and decompress bottleneck areas. Fit to sit implemented. • Additional assessment trolleys created in majors 2. • Increase use of TAM supported by senior decision makers to support flow • EAU chairs implemented • 10 x assessment spaces released from surge • Increase usage of SDEC pathways including patients actively pulled into ACU. • Phone a friend in place • Emergency medicine performance meetings focus on improvement plan • High Impact Changes work focussing on rapid clinical assessment, and UTC • Focus on weekend discharges, discharge time of day and usage of discharge lounge to enable earlier flow. • Discharge nurse employed on level 1 • Emergency medicine performance meetings focus on improvement plan	• High Impact Changes enabling increasing Senior Decision Makers in ED. • Data shows increase of initial assessment. • On-going staffing and capacity reviews during shifts and decision taken to open additional areas when safe staffing levels allow • Senior decision maker in “STARR” and TAM to focus on walk in patients • Patients are treated according to clinical prioritisation although sometimes this may result in less urgent patients experiencing longer waits when the department is under pressure. • Additional staff rostered to cover corridor care at times of high attendance and high DTAs • Additional Trust actions following escalation procedure enacted at times of extreme capacity pressures • Joint corridor SOP • Senior review/oversight of decisions to admit. • Harm reviews carried out for patients who wait for 12 hrs, so far this has shown no harm caused • Validation SOP in place • Hourly rounding being undertaken on all patients ensuring comfort. • If prolonged trolley wait – patients transferred to bed for comfort.

West Hertfordshire Hospitals NHS Trust

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



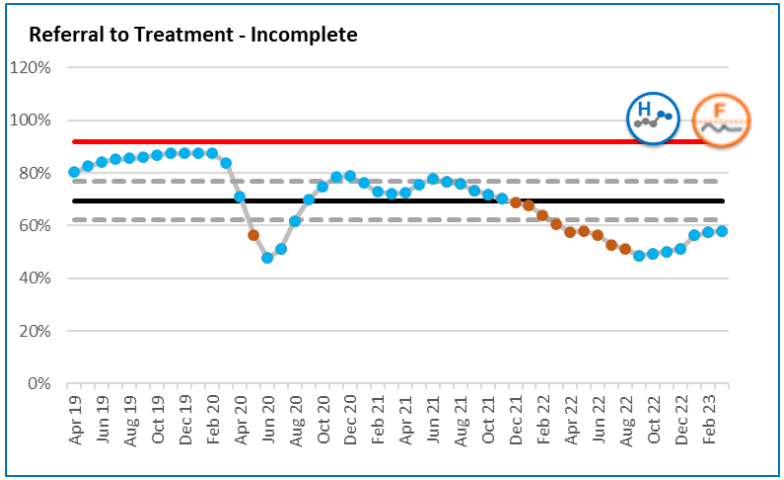
Background	What the Data tells us	Issues	Actions	Mitigations
Proportion of 12 hour waits in ED	Exception triggered due to 7+ data points above the mean (a shift)	• Capacity pressures due to poor flow throughout ED resulted in late assessments. • Nursing staffing workforce challenges with workforce at times being RAG rated RED. • 20 trolleys in assessment area bedded • ED demand has increased by 8% for adults and 15.5% for paediatrics • Increased number of Mental Health attendances, resulting in long stays in ED impacting on available assessment space. • Doctor and nurse staffing levels at Watford UTC • WGH UTC flow constraints impact on ED as well as handovers at close. • 3% increase in type 3attendances from last year	• Walk-in stream separated from ambulance stream to provide clearer visibility across the department and decompress bottleneck areas. Fit to sit implemented. • Additional assessment trolleys created in majors 2. • Increase use of TAM supported by senior decision makers to support flow • EAU chairs implemented • 10 x assessment spaces released from surge • Increase usage of SDEC pathways including patients actively pulled into ACU. • Phone a friend in place • Emergency medicine performance meetings focus on improvement plan • High Impact Changes work focussing on rapid clinical assessment, and UTC • Focus on weekend discharges, discharge time of day and usage of discharge lounge to enable earlier flow. • Discharge nurse employed on level 1 • Emergency medicine performance meetings focus on improvement plan	• High Impact Changes enabling increasing Senior Decision Makers in ED. • Data shows increase of initial assessment. • On-going staffing and capacity reviews during shifts and decision taken to open additional areas when safe staffing levels allow • Senior decision maker in “STARR” and TAM to focus on walk in patients • Patients are treated according to clinical prioritisation although sometimes this may result in less urgent patients experiencing longer waits when the department is under pressure. • Additional staff rostered to cover corridor care at times of high attendance and high DTAs • Additional Trust actions following escalation procedure enacted at times of extreme capacity pressures • Joint corridor SOP • Senior review/oversight of decisions to admit. • Harm reviews carried out for patients who wait for 12 hrs, so far this has shown no harm caused • Validation SOP in place • Hourly rounding being undertaken on all patients ensuring comfort. • If prolonged trolley wait – patients transferred to bed for comfort.

NHS
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 23	58%	92%	H	F	National	F&P	COO
Referral to Treatment - 52 week waits - Incomplete	Mar 23	2767	-	H		Local	F&P	COO
Referral to Treatment - 65 week waits - Incomplete	Mar 23	585	-	H		Local	F&P	COO
Referral to Treatment - 78 week waits - Incomplete	Mar 23	24	0	L	F	National	F&P	COO
Diagnostic (DM01) <6 weeks	Mar 23	63%	99%	L	F	National	F&P	COO
Cancer - Two week wait	Mar 23	86%	93%		?	National	F&P	COO
Cancer - Breast Symptomatic two week wait	Mar 23	77%	93%		?	National	F&P	COO
Cancer - 28 day waits (faster diagnosis standard)	Mar 23	78%	75%		?	National	F&P	COO
Cancer - 31 Day First	Mar 23	99%	96%		?	National	F&P	COO
Cancer - 31 day subsequent drug	Mar 23	100%	98%		?	National	F&P	COO
Cancer - 31 day subsequent surgery	Mar 23	92%	94%		?	National	F&P	COO
Cancer - 62 day	Mar 23	58%	85%	L	?	National	F&P	COO
Cancer - 62 day screening	Mar 23	81%	90%		?	Local	F&P	COO
Cancer 104+ day waits	Mar 23	58	-	H		Local	F&P	COO
Cancer 62+ Day Waits	Mar 23	160	-			Local	F&P	COO
Outpatient cancellation rate within 6 weeks	Mar 23	6%	5%	L	?	Local	F&P	CIO
Outpatient DNA rate	Mar 23	8%	8%		?	Local	F&P	CIO

West Hertfordshire Hospitals NHS Trust

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



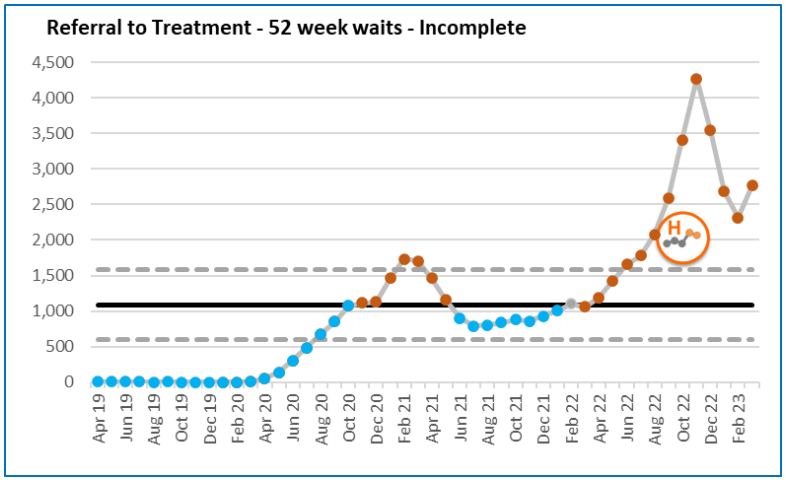
Trust	Nov-21	Dec-21	Jan-22	Nov-22	Jan-23	Feb-23
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	18,435	19,093	19,366	65.0%	64.1%	64.4%
West Suffolk NHS Foundation Trust	24,184	24,641	24,919	64.7%	61.9%	61.0%
East Suffolk And North Essex NHS Foundation Trust	66,916	63,958	65,165	61.3%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

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

Background	What the Data tells us	Issues	Actions	Mitigations
Referral to Treatment - Incomplete	Exception triggered due to target being outside the upper control limit Exception triggered due to 7+ consecutive data points in one direction (a trend) Exception triggered due to a breach of the lower control limit	Although EPR has been in place for over a year, errors continue (albeit at a lower level) to affect the RTT PTL in a number of ways, artificially inflating the PTL size, as capturing the correct outcomes results in fewer clock stops and the number of open pathways on the PTL. Loss of activity as a result of the junior doctors' industrial action, has impacted the number of clock stops.	Outsourcing programme remains active with reasonable patient uptake. Additional sessions are being undertaken but there is less uptake than pre COVID. Operational recovery group oversight of activity delivery BI team working with EPR project leads to address issues. DQ steering group established to oversee this work. The contract with the external provider delivery extensive validation wasextended until year end. This is expected to have a significant impact on PTL management. RTT/EPR training programme sponsored by Director of Performance has commenced.	Continuous horizon scanning for additional outsourcing opportunities, with specialty level engagement to ensure quality and safety as well as timely pathways Weekly long wait review meeting in place to drive progress and delivery of improvement plan. Service level tracking with forward look to target deadlines to ensure adequate operational oversight of patient cohorts.

West Hertfordshire Hospitals NHS Trust

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



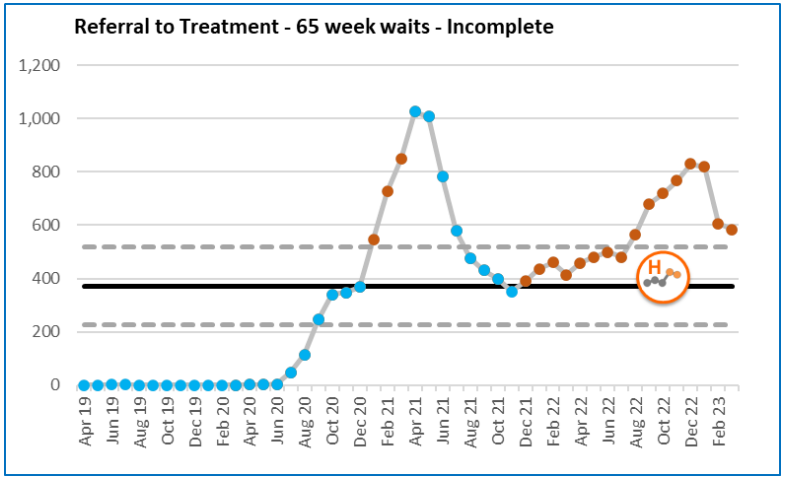
*Latest available published RTT data – February 2023

Trust	Feb-23
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	491
West Suffolk NHS Foundation Trust	1,235
James Paget University Hospitals NHS Foundation Trust	1,800
The Princess Alexandra Hospital NHS Trust	1,814
West Hertfordshire Hospitals NHS Trust	**2,309**
Milton Keynes University Hospital NHS Foundation Trust	2,322
Cambridge University Hospitals NHS Foundation Trust	3,556
East Suffolk And North Essex NHS Foundation Trust	3,890
Bedfordshire Hospitals NHS Foundation Trust	4,038
North West Anglia NHS Foundation Trust	4,117
East And North Hertfordshire NHS Trust	4,615
Norfolk And Norwich University Hospitals NHS Foundation Trust	9,240
Mid And South Essex NHS Foundation Trust	9,865

Background	What the Data tells us	Issues	Actions	Mitigations
Referral to Treatment – 52 weeks incomplete	Exception triggered due to a run of 7+ data points above the mean (a shift) Exception triggered due to breach of upper control limit	Although EPR has been in place for over a year, errors continue (albeit at a lower level) to affect the RTT PTL in a number of ways, artificially inflating the number of long waits as capturing the correct outcomes results in fewer clock stops and the number of open pathways on the PTL. This resulted in a significant increase in in November 2022 (the one year anniversary of EPR go live). Clock stop rates reduced in March, in part due to the junior doctor industrial action and this has impacted waiting times.	Outsourcing programme remains active at a reasonable rate and additional sessions are being undertaken but there is less uptake than pre COVID. Operational recovery group oversight of activity delivery BI team working with EPR project leads to address multiple DQ issues and a DQ steering group has been established to oversee this work. The contract with the external provider delivery extensive validation was extended until year end. This had a significant impact on cleansing of the PTL and the number of long waits. The weekly access meeting is now incorporating views of patients lower down in the PTL to avoid “tip ins” (pathways reaching the specific waiting time milestone, in this case 52 weeks) RTT/EPR training programme sponsored by Director of Performance has commenced.	Continuous horizon scanning for additional outsourcing opportunities, with specialty level engagement to ensure quality and safety as well as timely pathways Weekly long wait review meeting in place to drive progress and delivery of improvement plan. Service level tracking with forward look to target deadlines to ensure adequate operational oversight of patient cohorts. Expansion of the Trust’s validation team following business case approval, with recruitment underway.

West Hertfordshire Hospitals NHS Trust

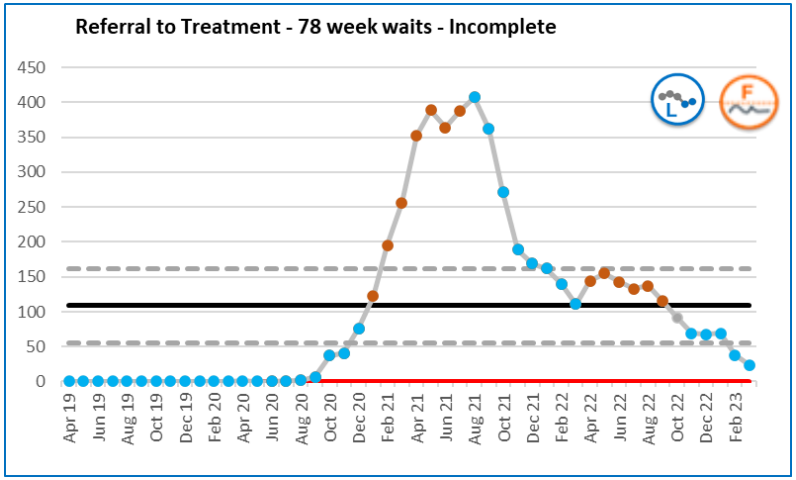
Special Cause Variation – Performance – Referral to Treatment – 65 weeks - Incomplete



Background	What the Data tells us	Issues	Actions	Mitigations
Referral to Treatment – 65 weeks incomplete	Exception triggered due to a run of 7+ data points above the mean (a shift) Exception triggered due to breach of upper control limit	Although EPR has been in place for over a year, errors continue (albeit at a lower level) to affect the RTT PTL in a number of ways, artificially inflating the number of long waits as capturing the correct outcomes results in fewer clock stops and the number of open pathways on the PTL.	Outsourcing programme remains active at a reasonable rate and additional sessions are being undertaken but there is less uptake than pre COVID. Operational recovery group oversight of activity delivery BI team working with EPR project leads to address multiple DQ issues. A steering group has been established to oversee this work. Extensive validation commenced 31/10/22 with additional temporary resources supplementing in house capacity. This had a significant impact on cleansing of the PTL and the number of long wait pathways. The weekly long waits review meetings now include pathways lower down in the PTL to avoid “tip ins” (pathways reaching the specific waiting time milestone, in this case 65 weeks) RTT/EPR training programme sponsored by Director of Performance has commenced.	Continuous horizon scanning for additional outsourcing opportunities, with specialty level engagement to ensure quality and safety as well as timely pathways Weekly long wait review meeting in place to drive progress and delivery of improvement plan. Service level tracking with forward look to target deadlines to ensure adequate operational oversight of patient cohorts.

West Hertfordshire Hospitals NHS Trust

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



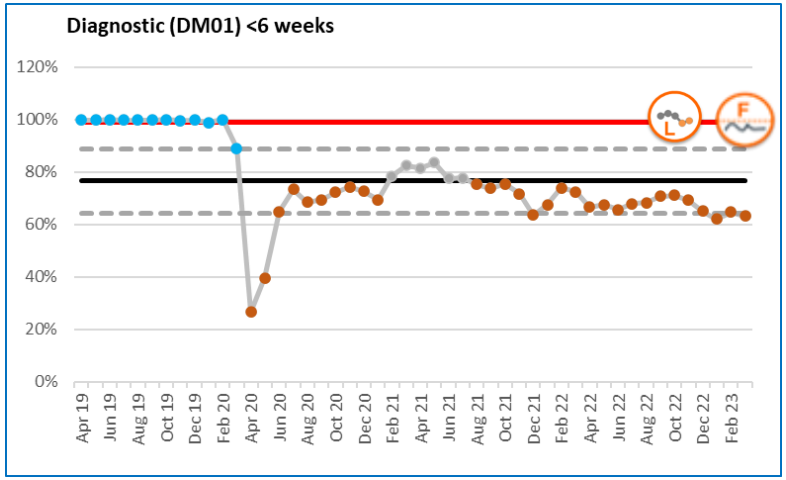
***Latest available published RTT data – February 2023**

Trust	Feb-23
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	15
West Hertfordshire Hospitals NHS Trust	**38**
Bedfordshire Hospitals NHS Foundation Trust	90
The Princess Alexandra Hospital NHS Trust	95
Milton Keynes University Hospital NHS Foundation Trust	107
West Suffolk NHS Foundation Trust	140
James Paget University Hospitals NHS Foundation Trust	213
Cambridge University Hospitals NHS Foundation Trust	225
North West Anglia NHS Foundation Trust	274
Mid And South Essex NHS Foundation Trust	501
East Suffolk And North Essex NHS Foundation Trust	503
East And North Hertfordshire NHS Trust	515
Norfolk And Norwich University Hospitals NHS Foundation Trust	718

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

West Hertfordshire Hospitals NHS Trust

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



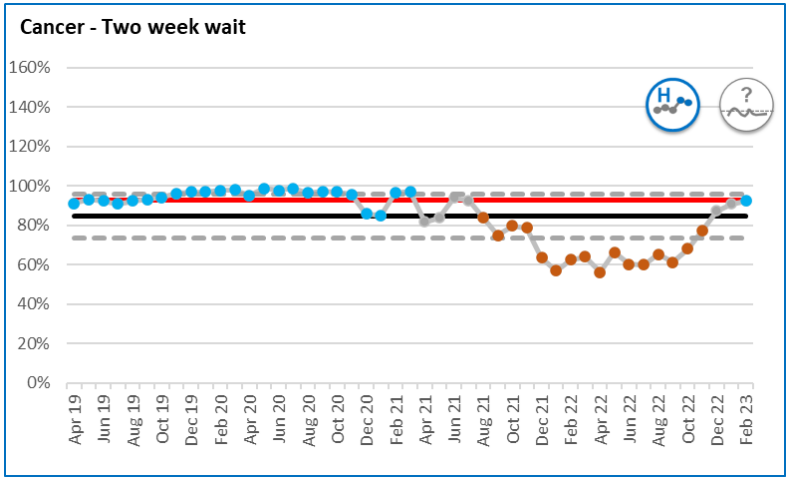
***Latest available benchmarking data – Diagnostic Wait Times – February 2023**

Trust	Feb-23
East Suffolk And North Essex NHS Foundation Trust	94.3%
Milton Keynes University Hospital NHS Foundation Trust	86.8%
James Paget University Hospitals NHS Foundation Trust	78.6%
The Princess Alexandra Hospital NHS Trust	74.6%
Mid And South Essex NHS Foundation Trust	67.2%
Bedfordshire Hospitals NHS Foundation Trust	67.0%
Norfolk And Norwich University Hospitals NHS Foundation Trust	66.3%
North West Anglia NHS Foundation Trust	65.9%
West Hertfordshire Hospitals NHS Trust	**64.7%**
Cambridge University Hospitals NHS Foundation Trust	62.8%
East And North Hertfordshire NHS Trust	61.8%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	60.4%
West Suffolk NHS Foundation Trust	58.8%

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

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance – Cancer – Two Week Wait



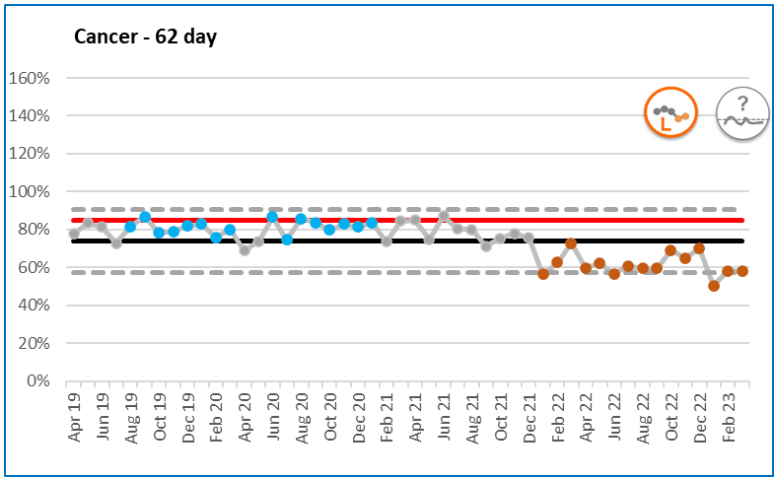
Provider name	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23
EAST AND NORTH HERTFORDSHIRE NHS TRUST	93.5%	97.1%	94.5%	96.0%	96.3%
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	83.9%	76.4%	94.4%	96.2%	95.3%
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	90.6%	94.2%	93.2%	92.7%	95.3%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	**67.8%**	**77.0%**	**87.2%**	**91.0%**	**92.7%**
BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	89.8%	92.0%	91.1%	90.5%	89.9%
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	72.7%	72.5%	78.4%	82.9%	89.0%
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	93.7%	96.2%	79.7%	81.9%	84.7%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	67.9%	78.4%	72.6%	76.8%	81.0%
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	48.1%	51.6%	51.5%	69.0%	79.0%
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	79.1%	80.3%	79.6%	76.6%	77.8%
MID AND SOUTH ESSEX NHS FOUNDATION TRUST	65.8%	51.1%	60.9%	68.7%	75.1%
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	72.0%	73.5%	73.1%	67.5%	74.0%
WEST SUFFOLK NHS FOUNDATION TRUST	69.9%	73.5%	72.2%	66.0%	73.9%
NORTH WEST ANGLIA NHS FOUNDATION TRUST	56.4%	46.5%	48.5%	56.1%	65.3%

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

Background	What the Data tells us	Issues	Actions	Mitigations
Cancer – Two Week Wait	Exception triggered due to 2 of 3 data points close to the upper control limit			

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance – Cancer 62 Day



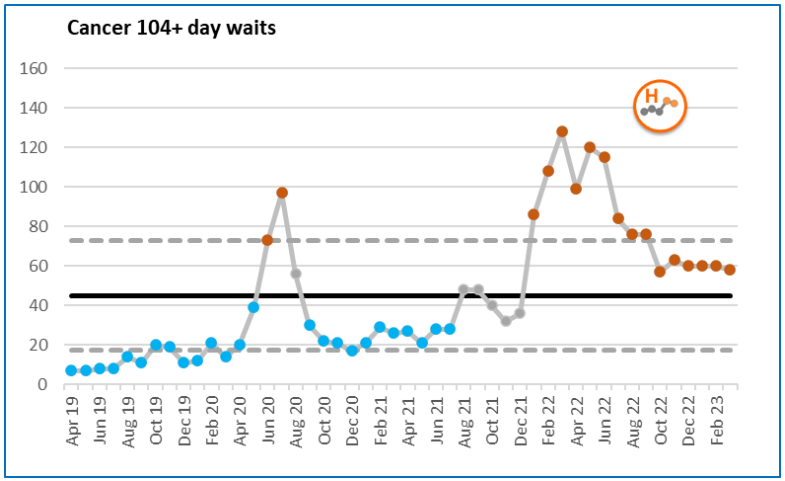
Provider name	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23
EAST AND NORTH HERTFORDSHIRE NHS TRUST	80.7%	69.0%	91.0%	78.6%	81.8%
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	74.5%	76.8%	66.3%	67.8%	73.4%
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	68.4%	61.5%	74.0%	63.7%	68.7%
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	62.4%	67.6%	63.5%	65.3%	67.9%
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	46.0%	47.5%	52.2%	55.0%	67.1%
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	66.2%	58.3%	73.2%	61.5%	62.6%
WEST SUFFOLK NHS FOUNDATION TRUST	72.5%	72.4%	66.7%	61.9%	62.5%
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	59.0%	65.5%	63.5%	50.3%	60.0%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	**68.7%**	**58.3%**	**69.5%**	**51.2%**	**58.6%**
BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	65.4%	67.7%	68.5%	53.5%	57.2%
NORTH WEST ANGLIA NHS FOUNDATION TRUST	17.7%	43.4%	52.4%	33.7%	49.8%
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	64.5%	55.2%	57.8%	52.1%	48.4%
MID AND SOUTH ESSEX NHS FOUNDATION TRUST	29.8%	39.3%	43.4%	36.3%	47.6%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	65.3%	38.5%	47.4%	32.1%	44.9%

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

Background	What the Data tells us	Issues	Actions	Mitigations
Cancer – 62 Day Waits – Referral to 1st Treatment	Exception triggered due to 7+ data points below the mean (a shift) Exception triggered due to a breach of the lower control limit	January performance continues to be non-compliant. A number of factors contribute to non-compliant 62 day performance: increase in demand, insufficient capacity for diagnostics owing to a mismatch between increased demand and baseline capacity. Surgical capacity was impacted during the business continuity period as a result of winter pressures.	Patients are tracked bi weekly, New escalation process in place and weekly huddle meetings for each tumour type to ensure early sight of issues and improve communication. Performance reviewed in Access weekly meetings. All services are working on improvements. Long Waiters Reviews now beginning at 49 days across all specialties. As PTL size decreases this will be reviewed.	All patients who are treated after Day 62 will be subject to a Clinical Harm Review

West Hertfordshire Hospitals NHS Trust

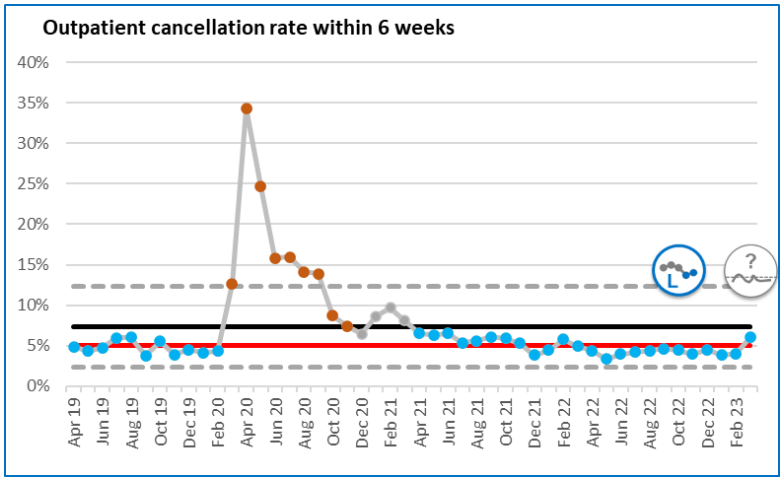
Special Cause Variation – Performance – Cancer 104+ Waits



Background	What the Data tells us	Issues	Actions	Mitigations
Cancer – 104 day waits	Exception triggered due to 7+ data points above the mean (a shift)	The number of patients over 104 days on the cancer PTL continues to decrease. Slow diagnostics, complex pathways (where elements are with another provider) and some difficulty with patient engagement (making contact, patient thinking time and diagnostic uncertainty) are slowing the whole pathway including those waiting over 104 days.	Patient-level scrutiny for all long waiters during the weekly Cancer Long Waiters' meeting has resulted in a reduction of the long waiters. Weekly huddle meetings in place across all services. Plans in place for every patient >104 days. Expanding NSS pathway to internal referrals to expedite the diagnosis of patients who have had site specific (e.g. GI) cancer excluded.	Clinical review is requested by MDT trackers as they track patients and escalated as necessary using new escalation process. CNS support requested as needed to support re. patient engagement. Any patient found to have cancer will be subject to a clinical harm review after treatment.

West Hertfordshire Hospitals NHS Trust

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



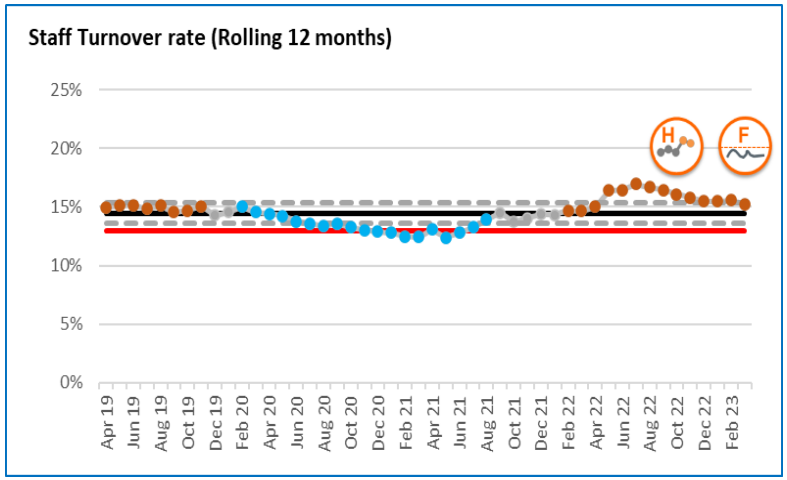
Background	What the Data tells us	Issues	Actions	Mitigations
Outpatient cancellation rates within 6 weeks	Exception triggered due to a run of 7+ data points below the mean (a shift)	This is positive performance and is the outcome of renewed BAU practises and processes within the cancellation PAS Clinic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

NHS
West Hertfordshire Hospitals
NHS Trust

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 23	15.3%	13.0%	H	F	Local	PerC	CPO
% staff leaving within first year (excluding medics and fixed term contracts)	Mar 23	17.2%	-			Local	PerC	CPO
Vacancy rate	Mar 23	7.0%	10.0%	L	?	Local	PerC	CPO
Sickness rate	Mar 23	4.3%	3.5%		?	Local	PerC	CPO
Appraisal rate (Total)	Mar 23	89.2%	90.0%	L	F	Local	PerC	CPO
Mandatory Training	Mar 23	90.3%	90.0%	L	P	Local	PerC	CPO
% Bank Pay	Mar 23	8.0%	12.0%		?	Local	PerC	CPO/CFO
% Agency Pay	Mar 23	4.0%	4.8%		?	Local	PerC	CPO/CFO
WTE Workforce Establishment	Mar 23	5438.5	5302.0	H	F	Local	PerC	CPO
WTE Staff in Post	Mar 23	5054.8	4890.0	H	F	Local	PerC	CPO
BAME Staff in Post	Mar 23	47%	-	H		Local	PerC	CPO
BAME Staff in Post - Band 8a+	Mar 23	2%	-	H		Local	PerC	CPO
Apprenticeship Levy Spend	Mar 23	37%	-	H		Local	PerC	CPO

West Hertfordshire Hospitals NHS Trust

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



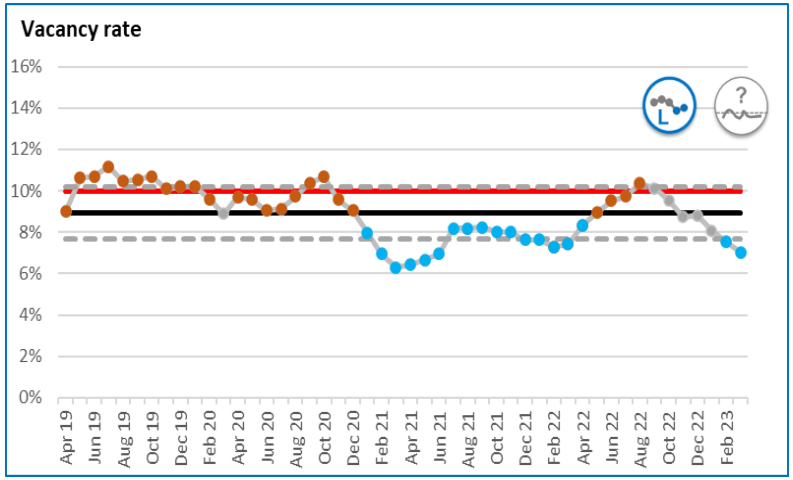
TURNOVER RATE

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

Background	What the Data tells us	Issues	Actions	Mitigations
Staff Turnover rate (Rolling 12 months)	Exception triggered due to a run of 7+ data points above the mean (a shift)	In common with other NHS organisations the Trust has experienced increased labour turnover since early 2022. However, the current rate has decreased over the last four months from 17% to 15.5%. The rates are highest in Clinical Support, EM and WACS areas, approaching 20%, and lowest in Medicine and Surgery. Staff Groups with highest rates continue to be HCA's, support staff, A&C staff and AHPs. The Trust has relatively high numbers of staff leaving the ICB area compared to other ICB Trusts, this is explained, in part, by the proximity to London.	New corporate induction launched in January 2023 to incorporate a new joiner buddy system to assist with site tours and day one welcome, extended on-boarding with themed new joiner support programmes. Introduction of new flexible working policy Free blue light card to be launched for all staff "Wellfest" held in December and a schedule of events being planned for the year ahead, including long service awards.	Exit interviews and rescue conversation. The 'Reaching Out' programme are priorities for the People Promise managers.

West Hertfordshire Hospitals NHS Trust

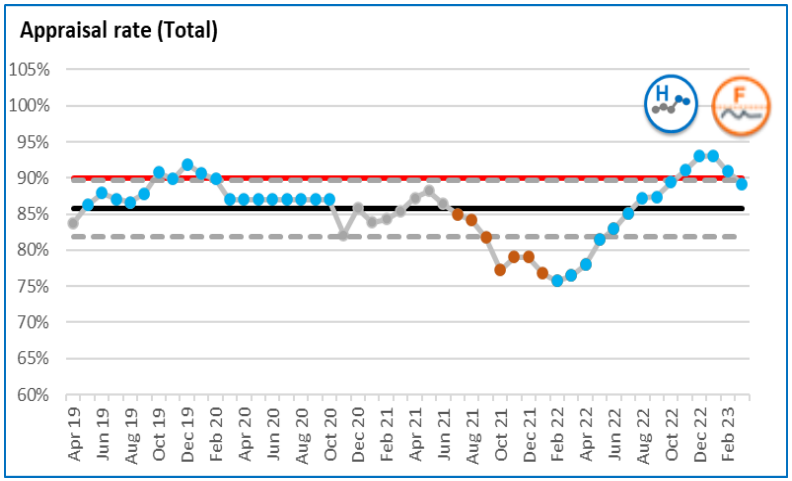
Special Cause Variation – Performance – Vacancy rate



Background	What the Data tells us	Issues	Actions	Mitigations
Vacancy Rate	Exception triggered due to a breach of the lower control limit.			

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance/Assurance – Appraisal Rate



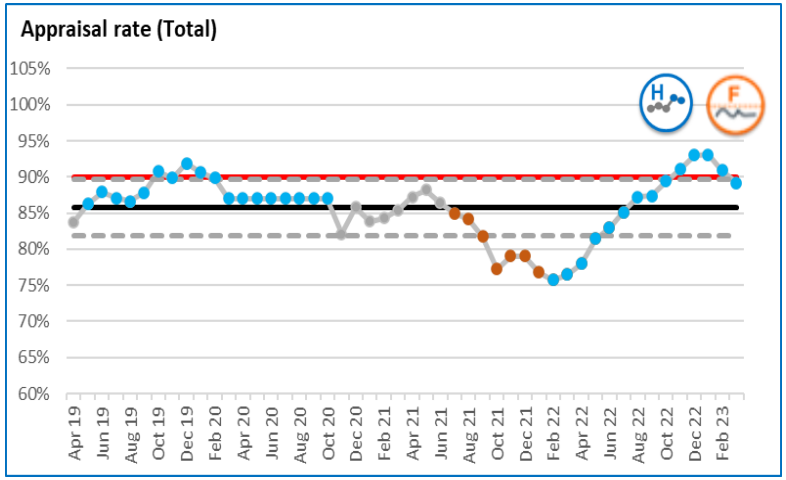
APPRAISAL RATE COMPLIANCE

Trust	Appraisal Rate Q1 21/22	Appraisal Rate Q2 21/22	Appraisal Rate Q3 21/22	Appraisal Rate Q4 21/22	Appraisal Rate Q1 22/23	Appraisal Rate Q2 22/23	Q2 22/23 Ranking (current)	Change Q1 to Q2
Bedford Hospitals	67%	67%	67%	67%	67%	69%	8	↗
Herts Community	69%	79%	75%	64%	76%	78%	6	↗
WHHT	86%	82%	79%	79%	83%	87%	3	↗
East & North Herts	63%	61%	55%	46%	37%	57%	9	↗
HPFT	89%	87%	79%	72%	85%	84%	4	↘
ELF Bedford MH	22%	15%	15%	31%	31%	23%	12	↘
ELF Luton MH	23%	13%	13%	33%	29%	29%	11	→
ELF Bedford Community	38%	19%	19%		49%	49%	10	→
Princess Alexandra	83%	83%	78%	79%	79%	80%	5	↗
Essex Partnership UT			78%	59%	59%	77%	7	↗
Milton Keynes UFT	92%	91%	91%	92%	88%	91%	1	↗
Central North West London FT	85%	80%	80%	81%	84%	91%	1	↗
Average	65%	62%	61%	64%	64%	68%		

Background	What the Data tells us	Issues	Actions	Mitigations
Appraisal Rate	Exception triggered due a run of 7+ data points above the mean (a shift) Exception triggered due to the upper control limit being below the target	Following concerted efforts to improve this, the rate is now above 90%, at 93%. The latest reports show a continued increase in compliance over the last 9 months. The Trust is also above average compared to other nearby acute Trusts, ranking 3 / 12 as at Q2 22/23, even with the lower rate reported at Q2.	Divisional plans remain in place, and being monitored on a weekly basis to remain above the 90% target. Weekly rates of above 90% have been maintained for over 8 weeks. HRBP's are continuing to agree weekly targets with managers, to achieve compliance, targeting hotspots and helping to set dates for any outstanding appraisals to take place.	Streamlined paperwork has been introduced. The next priority is utilising the information from appraisals to inform our staff development priorities and support retention.

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance/Assurance – Mandatory Training



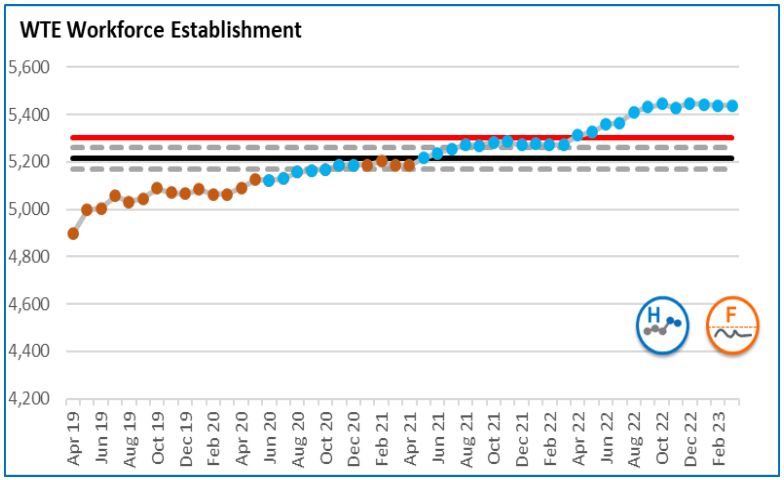
MANDATORY TRAINING COMPLIANCE

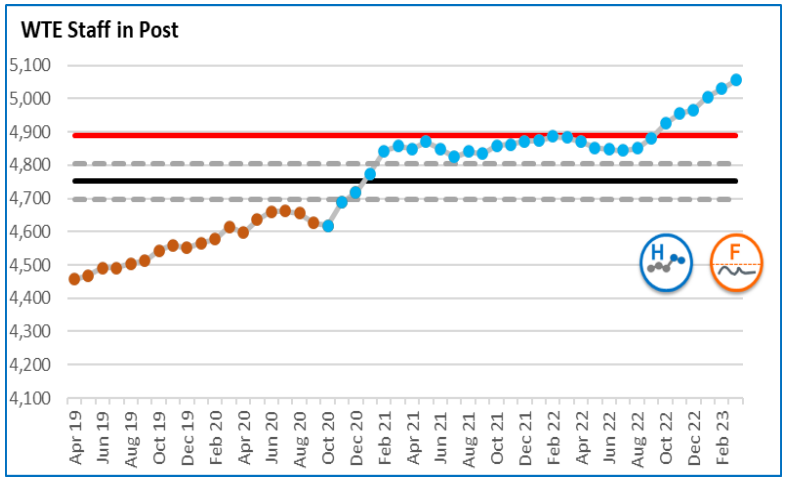
Trust	Mandatory Training Rate Q1 21/22	Mandatory Training Rate Q2 21/22	Mandatory Training Rate Q3 21/22	Mandatory Training Rate Q4 21/22	Mandatory Training Rate Q1 22/23	Mandatory Training Rate Q2 22/23	Q2 22/23 Ranking (current)	Change Q1 to Q2
Bedford Hospitals	77%	77%	77%	77%	80%	82%	12	↗
Herts Community	94%	94%	94%	95%	92%	95%	1	↗
WHHT	94%	93%	92%	91%	91%	90%	5	↘
East & North Herts	86%	88%	86%	87%	88%	87%	6	↘
HPFT	91%	90%	89%	89%	91%	92%	3	↗
ELF Bedford MH	88%	86%	86%	85%	82%	83%	11	↗
ELF Luton MH	87%	88%	88%	84%	84%	85%	8	↗
ELF Bedford Community	85%	86%	86%	84%	81%	85%	8	↗
Princess Alexandra	88%	87%	87%	86%	86%	86%	7	→
Essex Partnership UT	81%	81%	81%	78%	78%	84%	10	↗
Milton Keynes UFT	96%	96%	96%	94%	95%	92%	3	↘
Central North West London FT	94%	94%	94%	94%	94%	93%	2	↘
Average	88%	88%	88%	87%	87%	88%		

Background	What the Data tells us	Reasons	Actions	Mitigations
Mandatory Training	Exception triggered due to the target being below the lower control limit Exception triggered due to 7+ data points above the mean	The mandatory training rate continued to consistently achieve 90%, to April 2022.The fall to below the LCL and the 90% compliance rate has occurred twice over the last 8 months, at all other times if has been above the 90% target.	Training team and HRBPs will continue to support Divisions to achieve compliance across staff groups and subjects so that the 90% target is again consistently achieved. Reminders are send to staff who consistently fail to ensure their training is compliant. The Trust is ranked 5 / 12 compared to nearby NHS organisations as at Q2 22/23	There is a continued focus on specific subjects to maintain compliance and ensure this is above the 90% target. Divisions showing rates below 90% are Corporate, Surgery, WACS and Emergency Medicine. These are just below 90%.

West Hertfordshire Hospitals NHS Trust

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

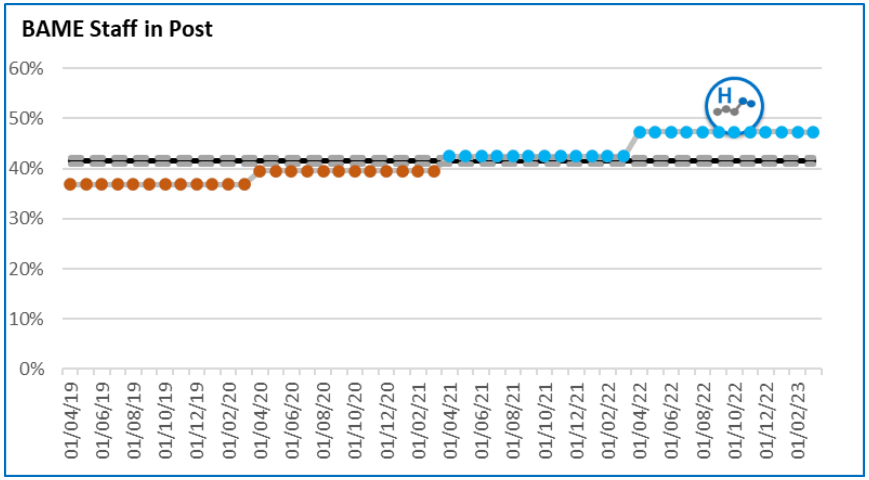


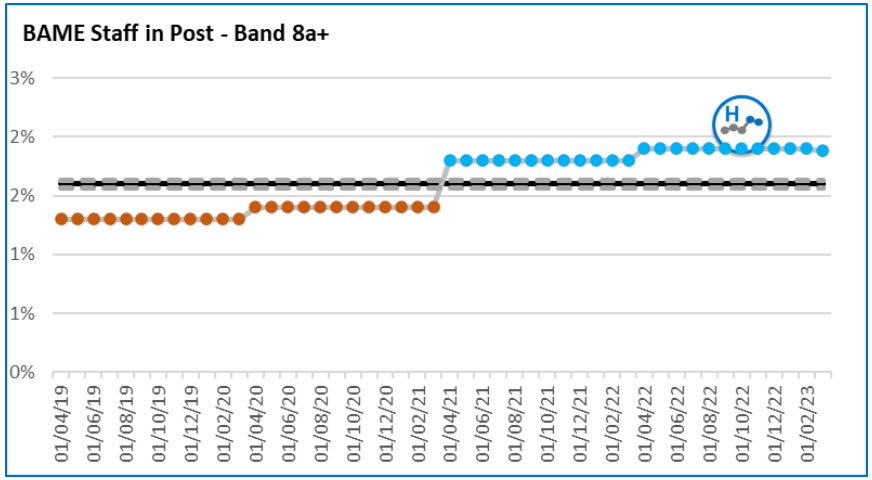


Background	What the Data tells us	Reasons	Actions	Mitigations
WTE Workforce Establishment/WTE Staff in Pot	Exception triggered due to 7+ data points above the mean Exception triggered due to a breach of the upper control limit	The planned business case establishment target is 5,302wte by March 2023. The business case for the wte staff in post figures is 4,890wte in post by March 2023.	The current workforce establishment at Dec is 5,447. The reasons for this being higher than the target are adjustments to the ledger. The current adjustment is 70wte, so it is 5,366 and far closer to the target. The reason for the remaining variation is that there were more business cases approved for 22/23 than were known about at the time of the plan. For staffing wte, there has been a significant upturn in recruitment to help enable staff in post wte to increase to meet the increased staffing requirements and help offset bank and agency expenditure. This has increased by 93 wte over the last 12 months.	Continued recruitment for permanent staff will continue to offset agency usage.

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance – BAME Staff in Post

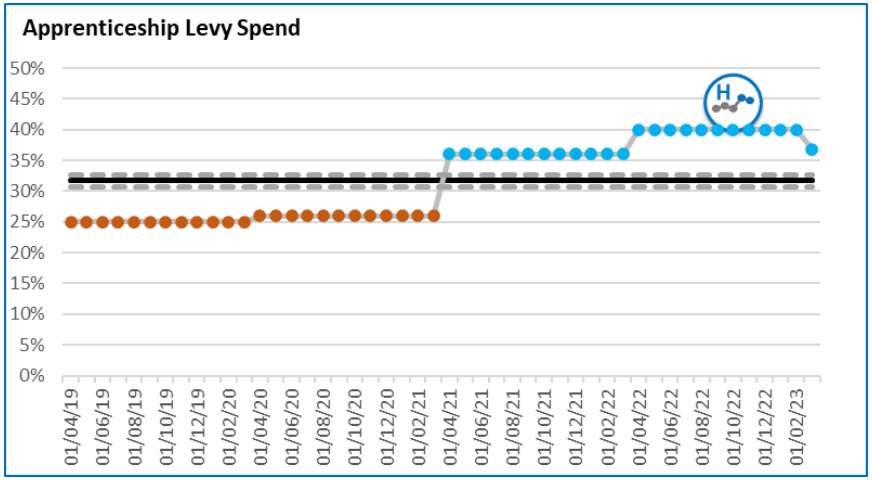




Background	What the Data tells us	Reasons	Actions	Mitigations
BAME staff in post/BAME Staff in post – Band 8a+	Exception triggered due to 7+ data points above the mean Exception triggered due to a breach of the upper control limit			

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance – Apprenticeship Levy Spend



Background	What the Data tells us	Reasons	Actions	Mitigations
Apprenticeship Levy Spend	Exception triggered due to 7+ data points above the mean Exception triggered due to a breach of the upper control limit			

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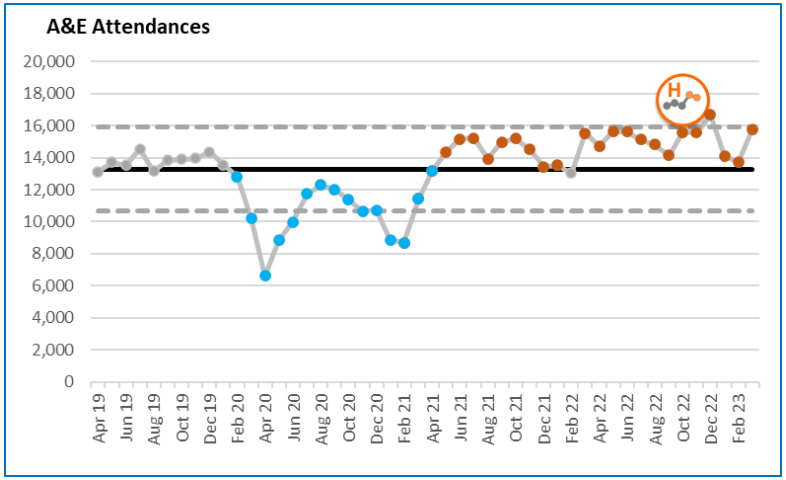
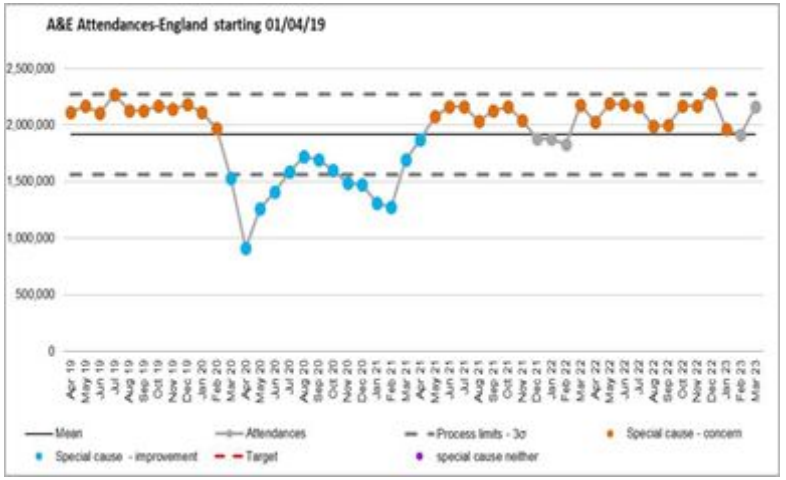
KPI	Latest month	Measure	Target	Variation	Assurance	Local or National Metric	Committee	Owner
Activity Metrics								
GP Referrals Made	Feb 23	6080	-			Local	F&P	COO
A&E Attendances	Mar 23	15736	-	H		Local	F&P	COO
1st Outpatient Appointments - All	Mar 23	11289	-			Local	F&P	CIO
1st Outpatient Appointments - Face to Face	Mar 23	10604	-	H		Local	F&P	CIO
Follow Up Outpatient Appointments - All	Mar 23	15739	-			Local	F&P	CIO
Follow Up Outpatient Appointments - Face to Face	Mar 23	11958	-			Local	F&P	CIO
Specific Acute Elective Ordinary Admissions	Mar 23	405	-			Local	F&P	COO
Specific Acute Daycases	Mar 23	3757	-	H		Local	F&P	COO
Specific Acute Non-Elective Admissions - 0 LOS	Mar 23	1348	-	L		Local	F&P	COO
Specific Acute Non-Elective Admissions - +1 LOS	Mar 23	2212	-			Local	F&P	COO
Completed Admitted RTT Pathways (Clock Stops)	Mar 23	1003	-			Local	F&P	COO
Completed Non-Admitted RTT Pathways (Clock Stops)	Mar 23	4853	-			Local	F&P	COO
New RTT Pathways (Clock Starts)	Mar 23	11279	-			Local	F&P	COO
PTL Volume	Mar 23	53019	-	H		Local	F&P	COO
Theatre Utilisation (Touch time utilisation on the day hours planned inc early starts and late finishes)	Mar 23	71%	85%		F	Local	F&P	COO

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance – A&E Attendances

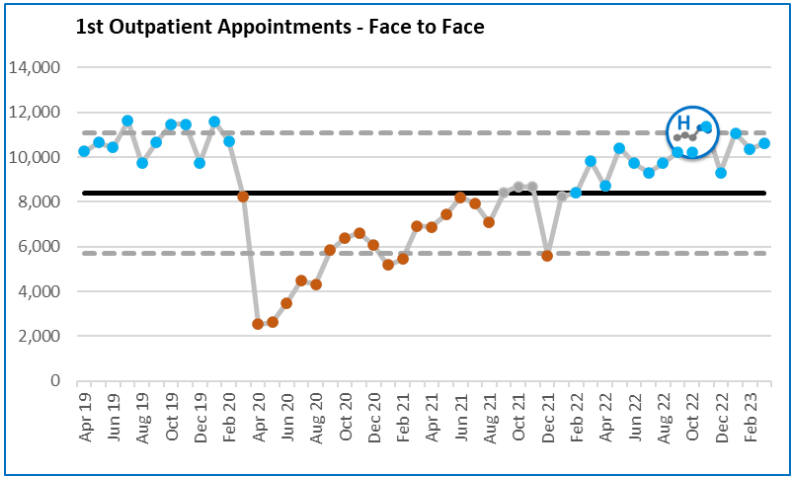


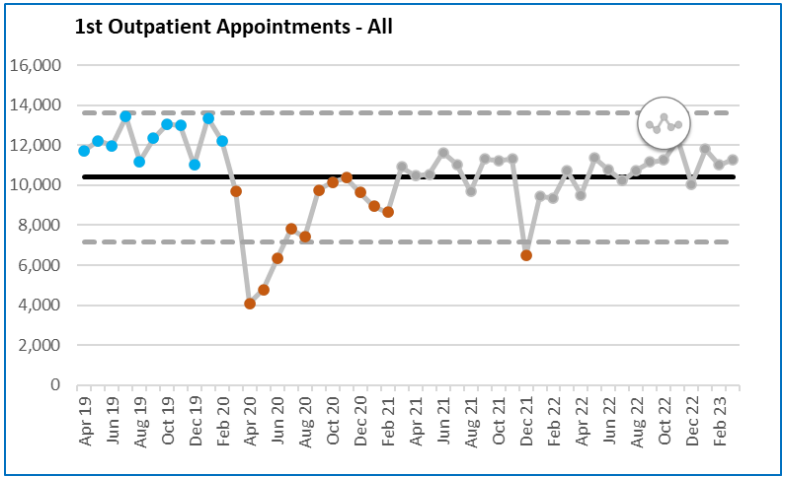


Background	What the Data tells us	Issues	Actions	Mitigations
A&E Attendances	Exception triggered due to 7+ data points above the mean (a shift)	ED demand has increased by 19% for adults and 40% for paediatrics	Working with ICB to review alternative pathways to ED Working closely with UTC providers to ensure patient are streamed early and into the right pathway	The ICB have implemented Respiratory HUBs at SACH and HHH receiving patients directly from 111. The profile observed in A&E attendances at West Herts triggering an exception is equally observed when looking at all A&E attendances in England

West Hertfordshire Hospitals NHS Trust

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

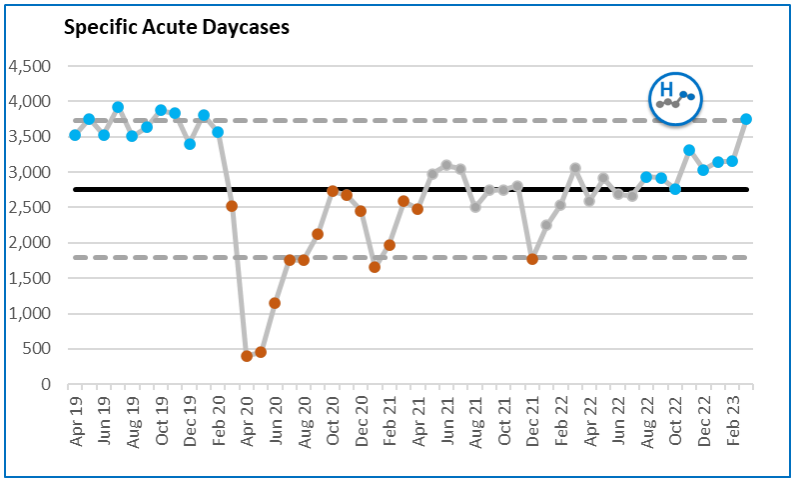




Background	What the Data tells us	Issues	Actions	Mitigations
1st Outpatient Appointments – Face to Face	Exception triggered due to 7+ data points above the mean (a shift)	ED demand has increased by 19% for adults and 40% for paediatrics	Working with ICB to review alternative pathways to ED Working closely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

West Hertfordshire Hospitals NHS Trust

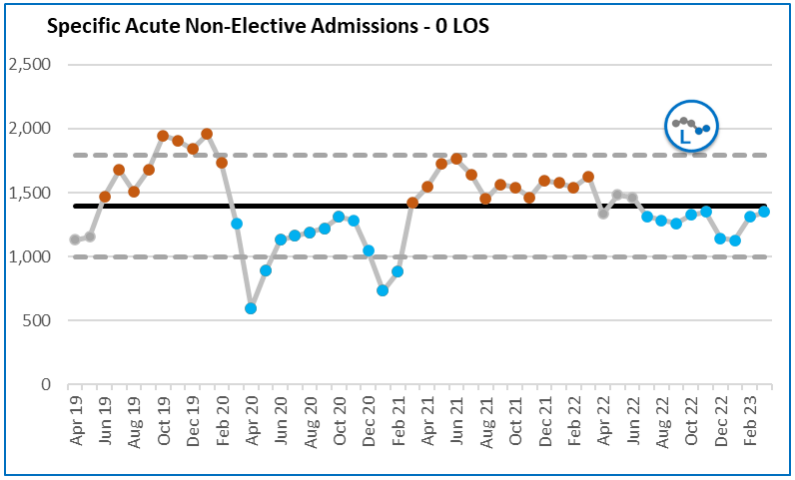
Special Cause Variation – Performance – Specific Acute Daycases



Background	What the Data tells us	Issues	Actions	Mitigations
Specific Acute Daycases	Exception triggered due to 7+ data points above the mean (a shift) Exception triggered due to a breach of the upper control limit			

West Hertfordshire Hospitals NHS Trust

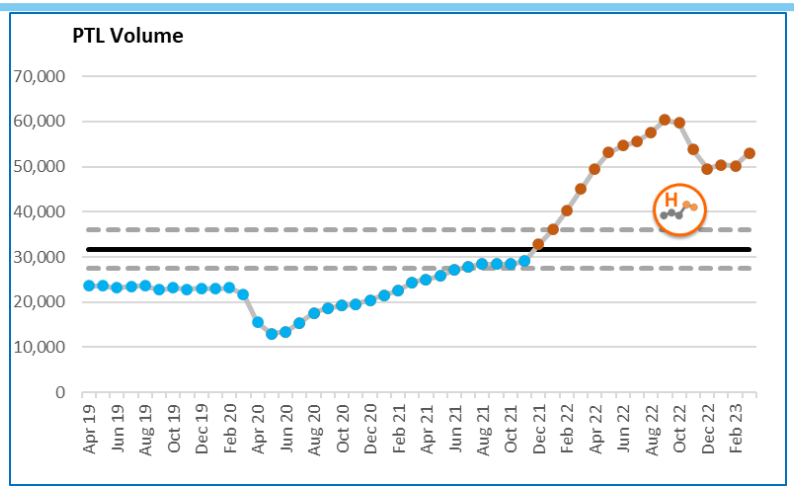
Special Cause Variation – Performance – Specific Acute Non-Elective Admissions – 0 LOS



Background	What the Data tells us	Issues	Actions	Mitigations
Specific Acute Non-Elective Admissions – 0 LOS	Exception triggered due to 7+ data points below the mean (a shift)			

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance – RTT PTL Volume



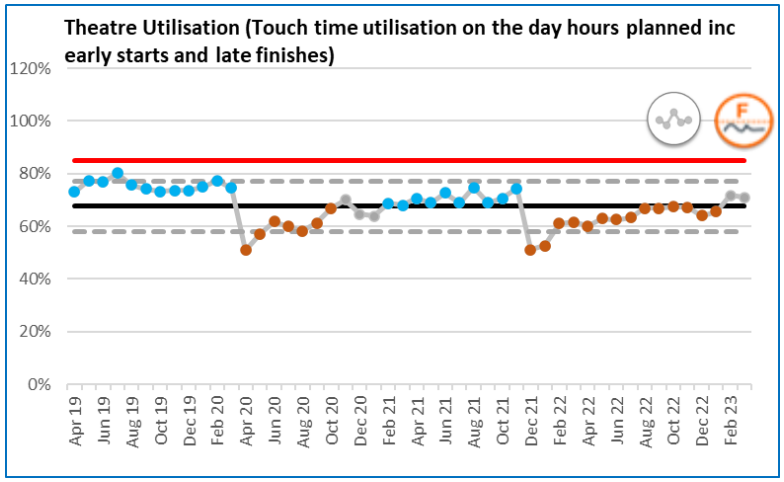
***Latest available published RTT data – January 2023**

Trust	Jan-23
Mid And South Essex NHS Foundation Trust	155,957
Bedfordshire Hospitals NHS Foundation Trust	86,494
Norfolk And Norwich University Hospitals NHS Foundation Trust	85,795
East Suffolk And North Essex NHS Foundation Trust	80,402
North West Anglia NHS Foundation Trust	73,867
East And North Hertfordshire NHS Trust	60,444
Cambridge University Hospitals NHS Foundation Trust	58,708
West Hertfordshire Hospitals NHS Trust	**50,279**
Milton Keynes University Hospital NHS Foundation Trust	37,945
West Suffolk NHS Foundation Trust	30,300
The Princess Alexandra Hospital NHS Trust	27,408
James Paget University Hospitals NHS Foundation Trust	23,269
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	20,931

Background	What the Data tells us	Issues	Actions	Mitigations
RTT PTL Volume	Exception triggered due to breach of the upper control limit Exception triggered due to 7+ data points above the mean (a shift)	Although EPR has been in place for over a year, errors continue (albeit at a lower level) to affect the RTT PTL in a number of ways, artificially inflating the size of the waiting list, as capturing the correct outcomes results in fewer clock stops and the number of open pathways on the PTL. Clock starts in March were very high, much greater than seen in a number of years. Loss of activity as a result of the junior doctors' industrial action, has impacted the number of clock stops. Both of these are major factors in PTL growth.	Outsourcing programme remains active at a reasonable rate and additional sessions are being undertaken but there is less uptake than pre COVID. Operational recovery group oversight of activity delivery BI team working with EPR project leads to address multiple DQ issues and a DQ steering group is to be established to oversee this work. The contract with the external provider delivery extensive validation was extended until year end. This had a significant impact on cleansing of the PTL. The weekly access meeting is now incorporating views of patients lower down in the PTL to avoid "tip ins" (pathways reaching the specific waiting time milestones) RTT/EPR training programme sponsored by Director of Performance commenced in February	Continuous horizon scanning for additional outsourcing opportunities, with specialty level engagement to ensure quality and safety as well as timely pathways Weekly long wait review meeting in place to drive progress and delivery of improvement plan. Service level tracking with forward look to target deadlines to ensure adequate operational oversight of patient cohorts. Expansion of the Trust's validation team following business case approval, with recruitment underway.

West Hertfordshire Hospitals NHS Trust

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

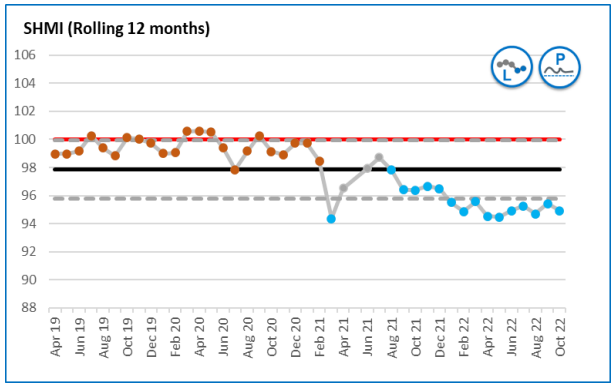


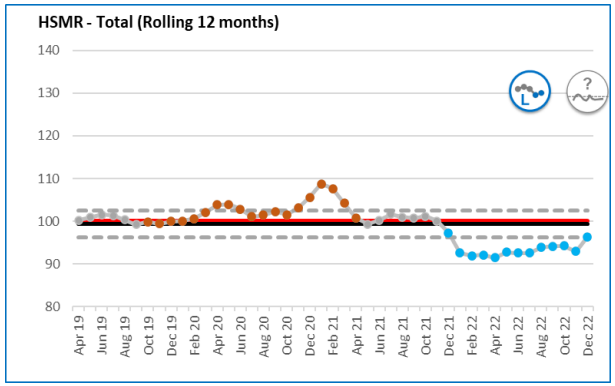
Background	What the Data tells us	Issues	Actions	Mitigations
Theatre Utilisation (Touch time utilisation on the day hours planned inc early starts and late finishes	Exception triggered due to target being outside upper control limit			

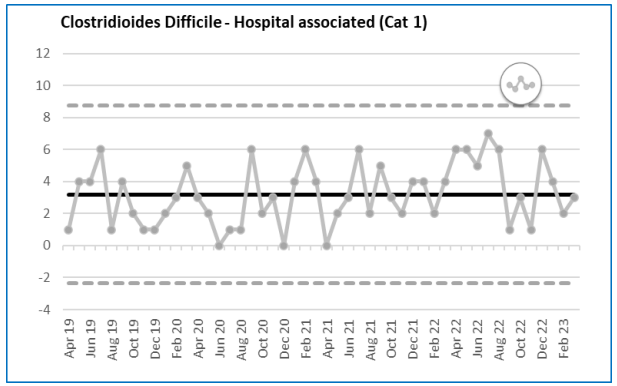
54

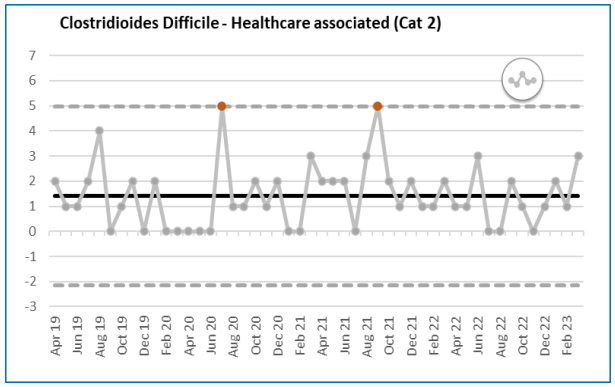
West Hertfordshire Hospitals NHS Trust

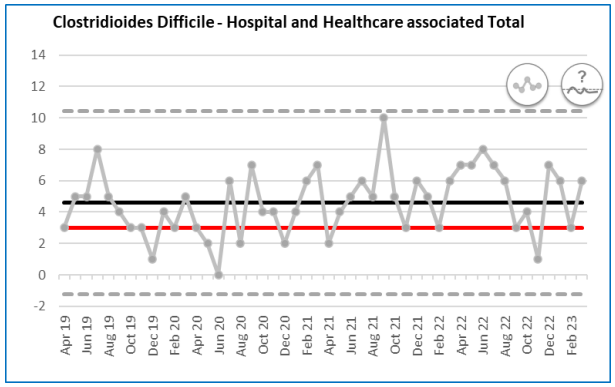
Appendix 1 – Safe Care and Improving Outcomes Metrics - Quality

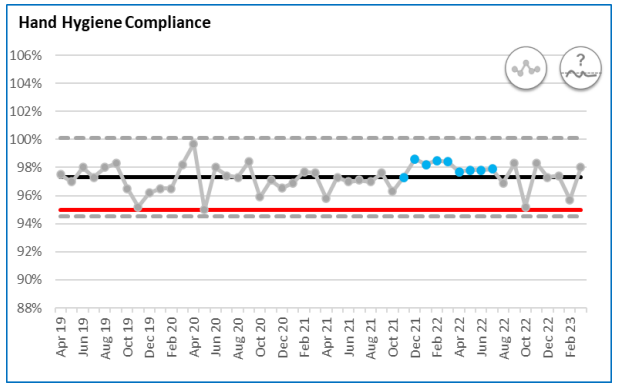






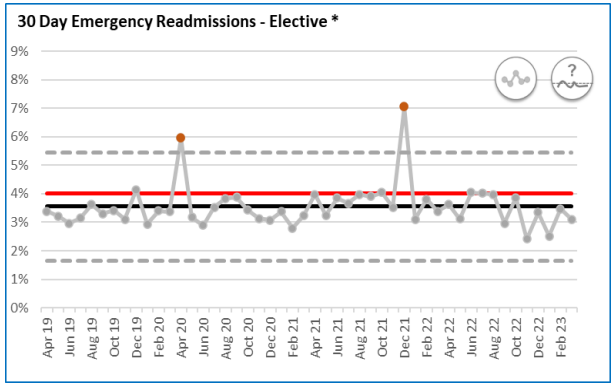


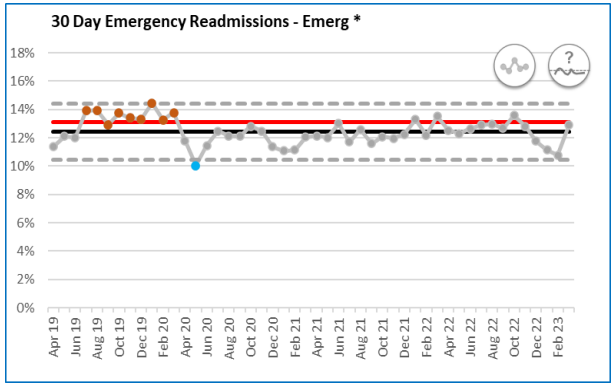


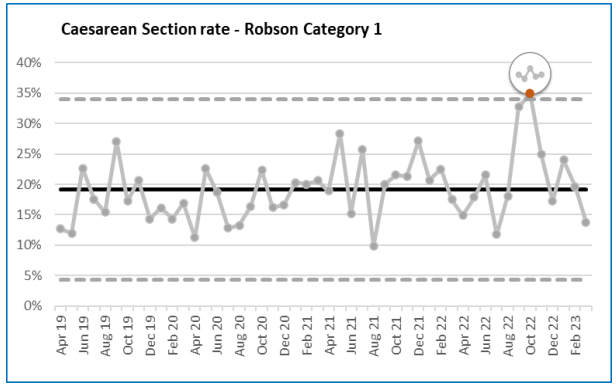


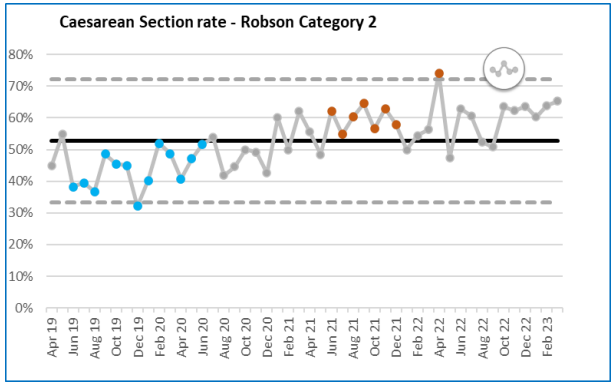
West Hertfordshire Hospitals NHS Trust

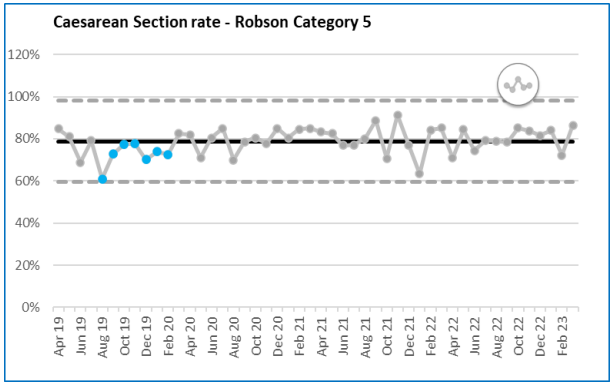
Appendix 1 – Safe Care and Improving Outcomes Metrics - Quality





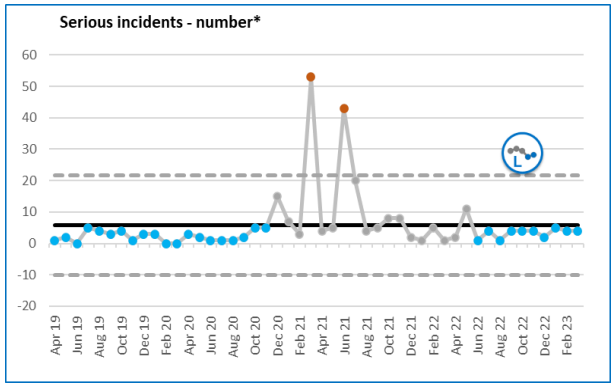


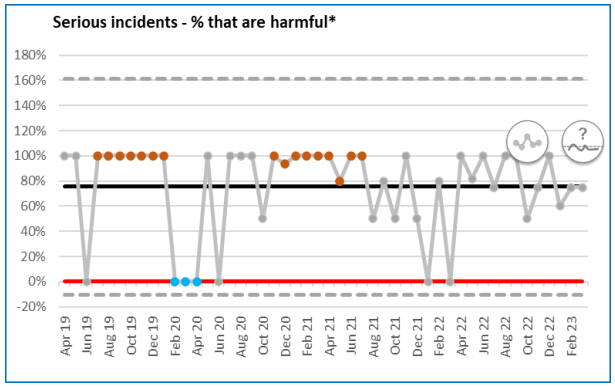


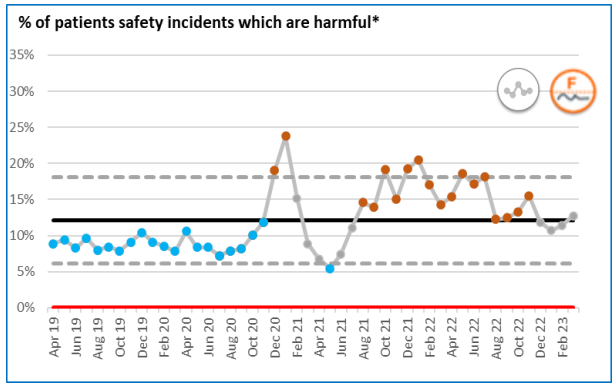


West Hertfordshire Hospitals NHS Trust

Appendix 1 – Safe Care and Improving Outcomes Metrics - Safety

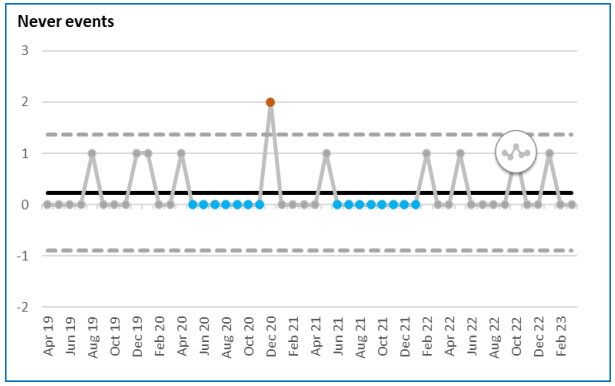


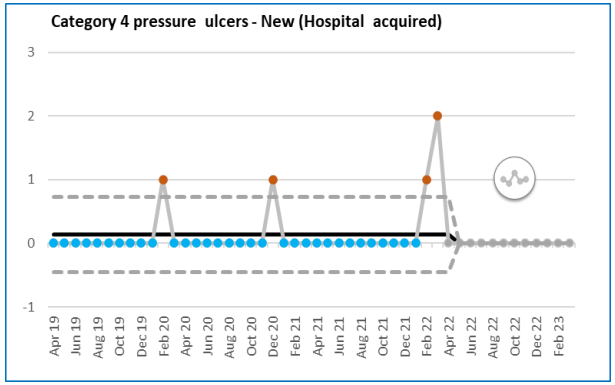


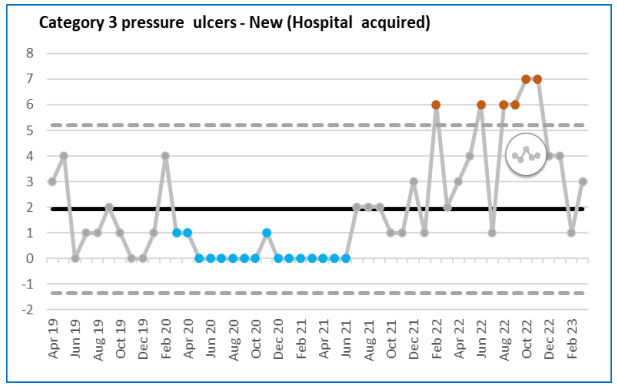


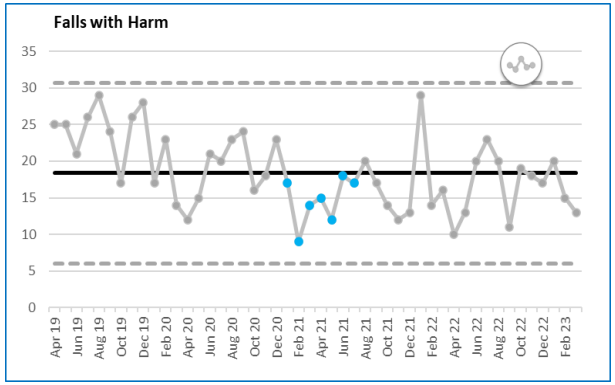
West Hertfordshire Hospitals NHS Trust

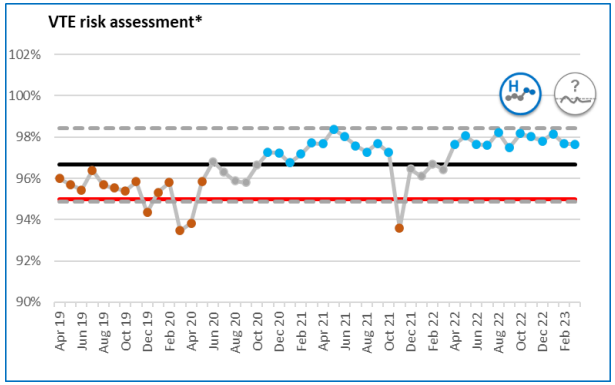
Appendix 1 – Safe Care and Improving Outcomes Metrics - Safety

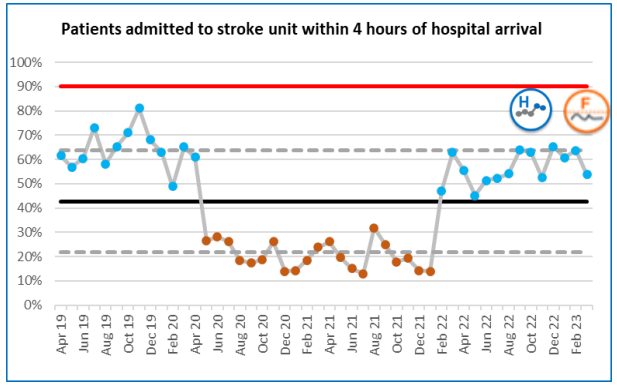






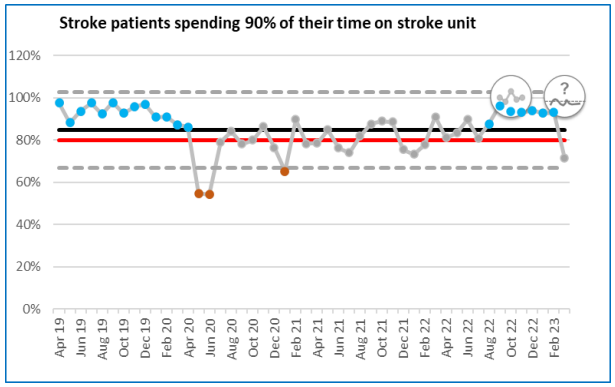


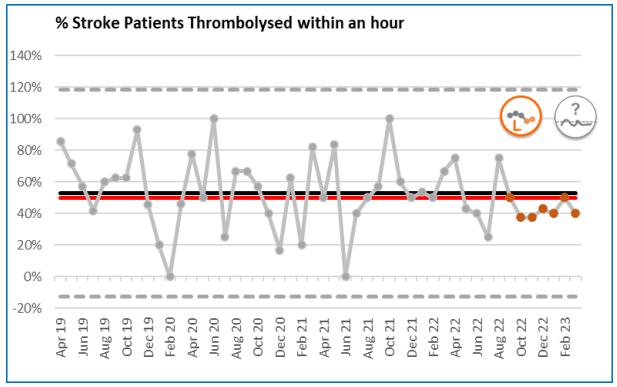




West Hertfordshire Hospitals NHS Trust

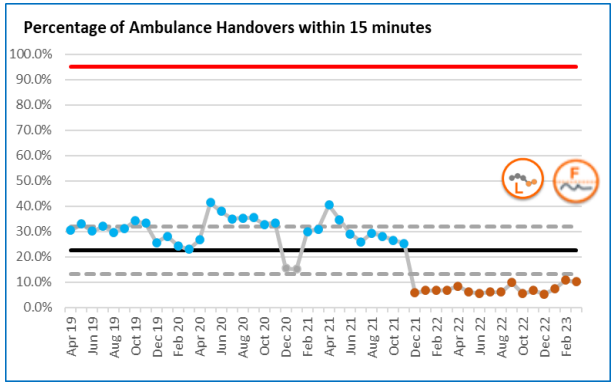
Appendix 1 – Safe Care and Improving Outcomes Metrics - Safety

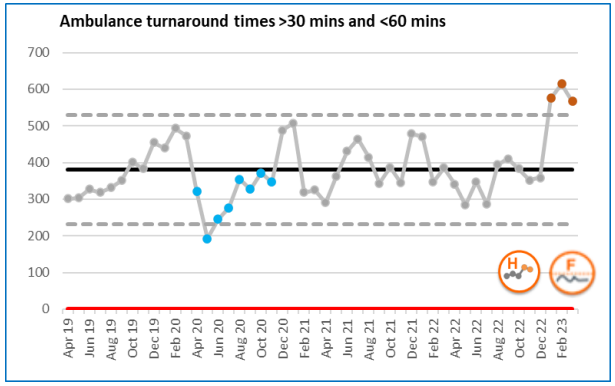


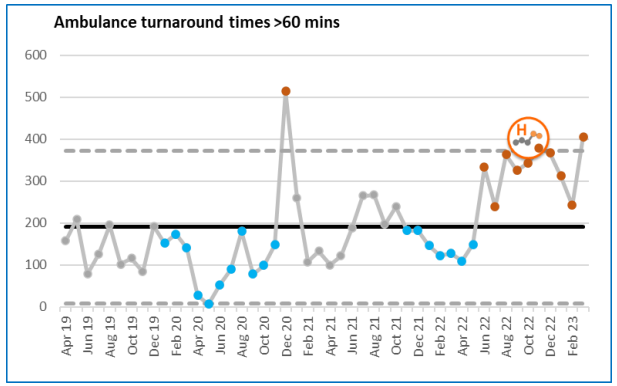


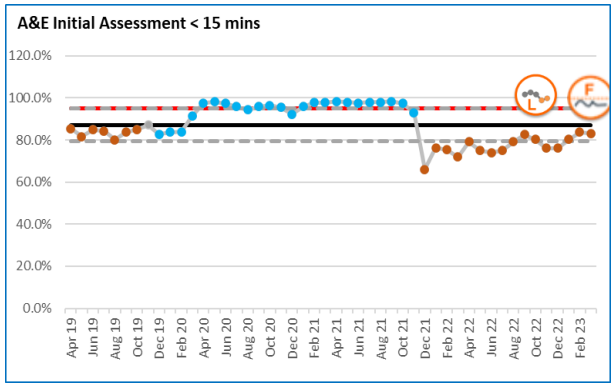
West Hertfordshire Hospitals NHS Trust

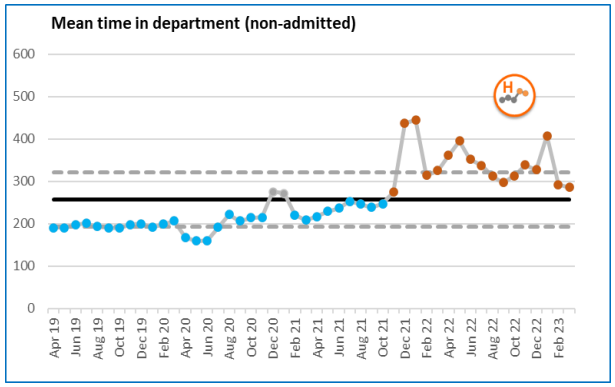
Appendix 2 – A&E Metrics

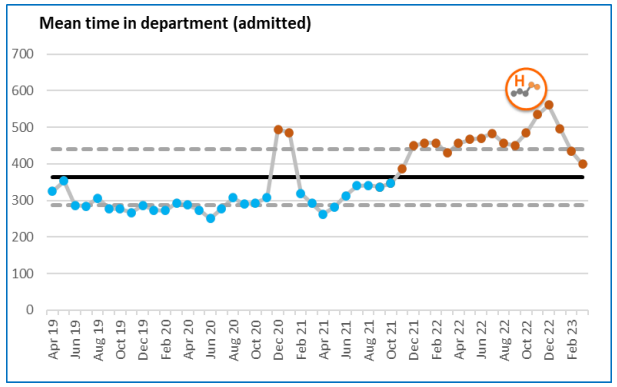












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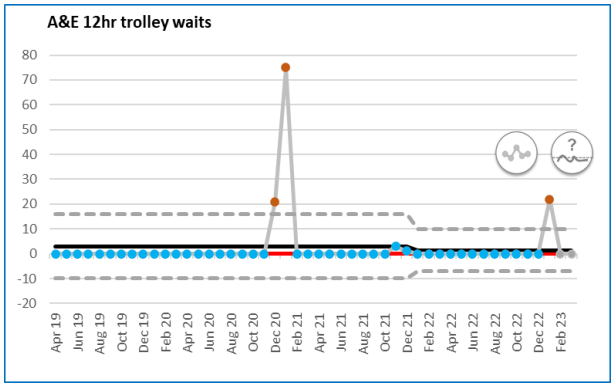
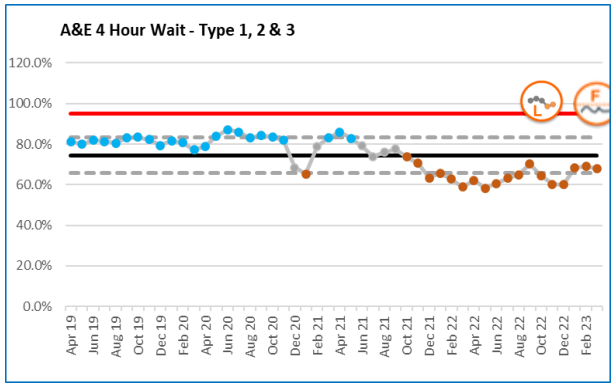
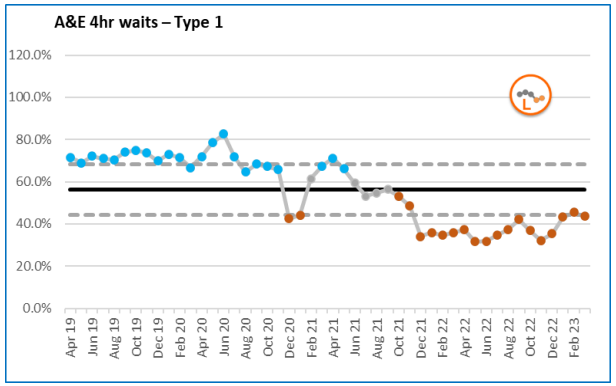
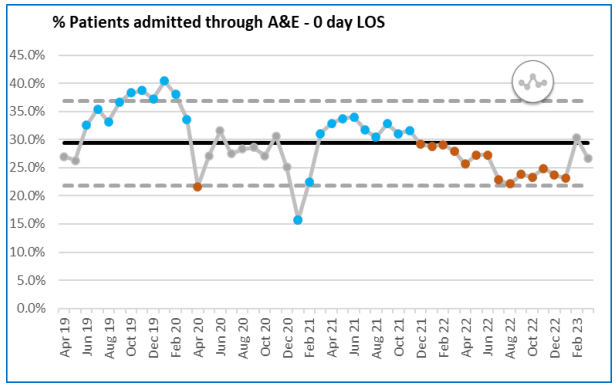
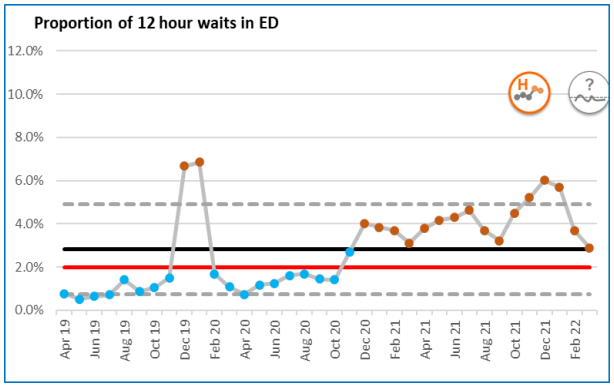
Appendix 2 – A&E Metrics





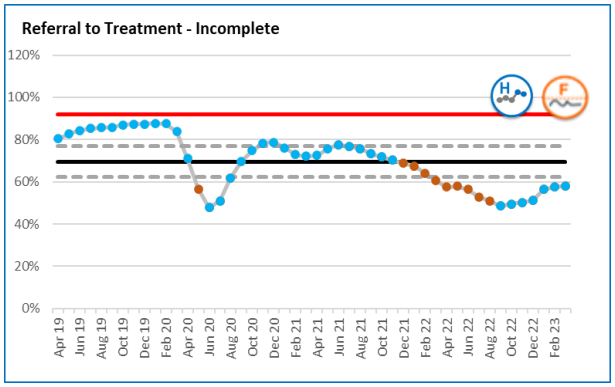


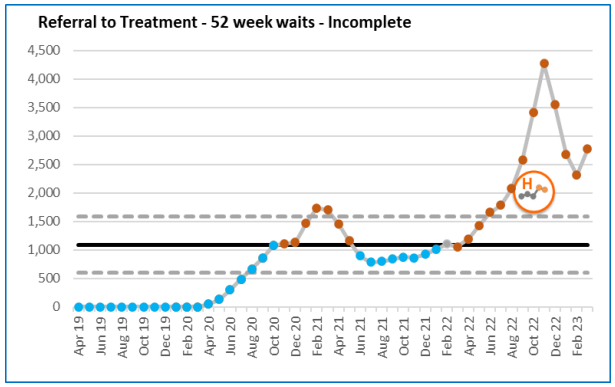


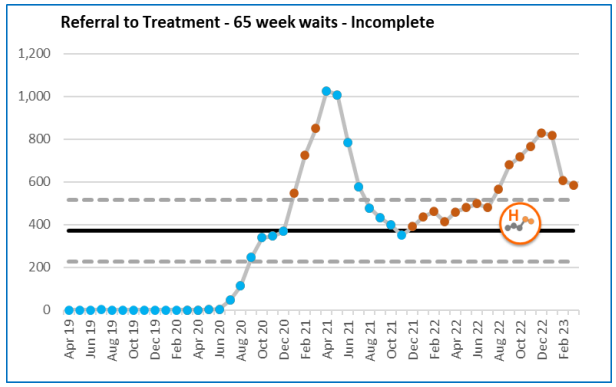


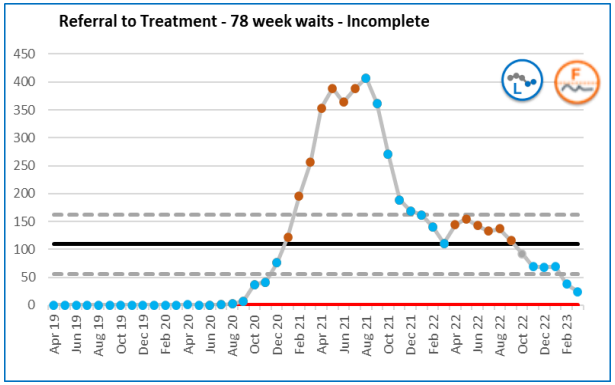
West Hertfordshire Hospitals NHS Trust

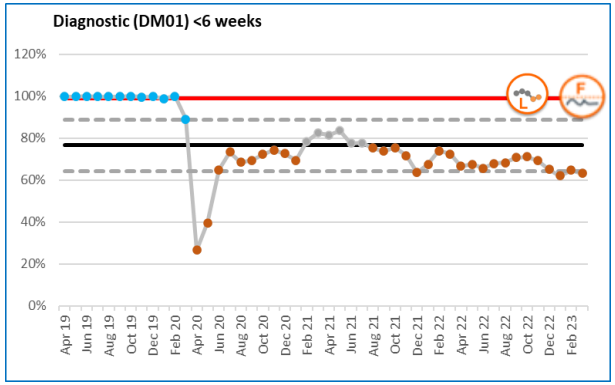
Appendix 3 – RTT, Cancer and Diagnostics Metrics

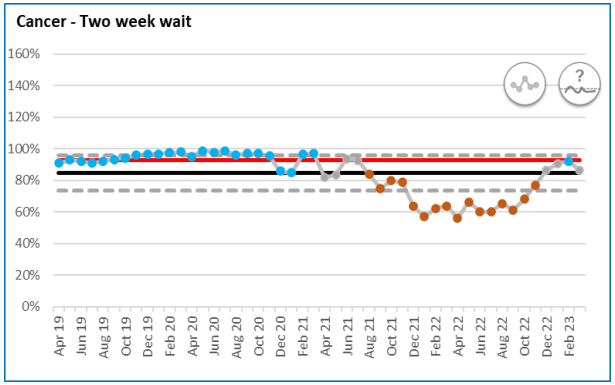






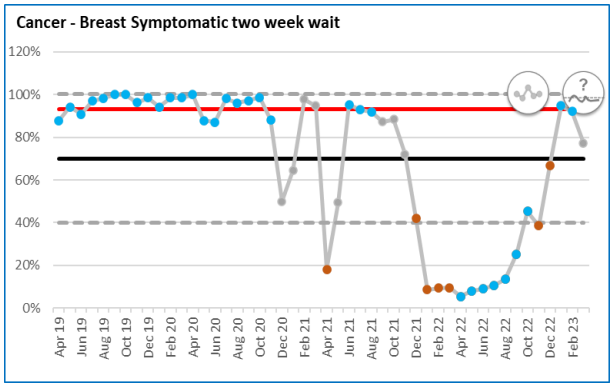


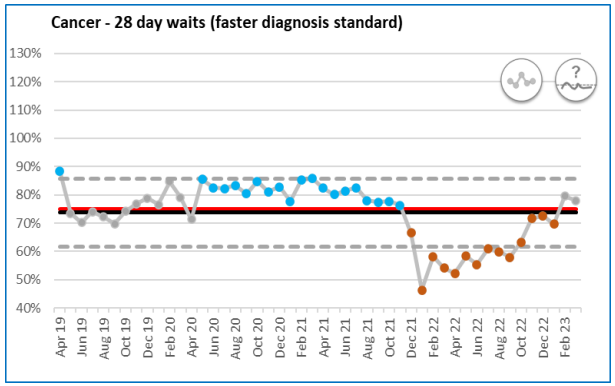


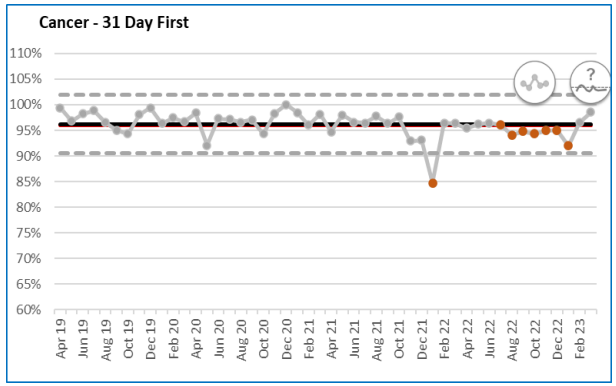


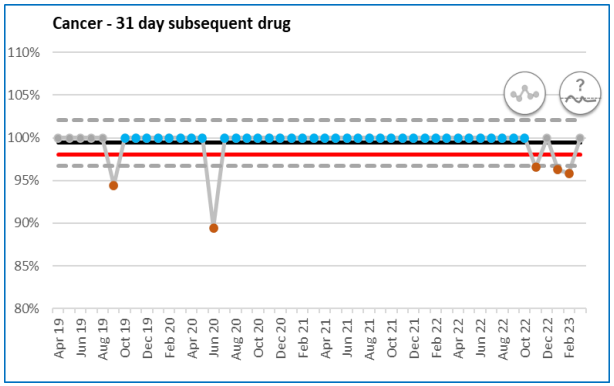
West Hertfordshire Hospitals NHS Trust

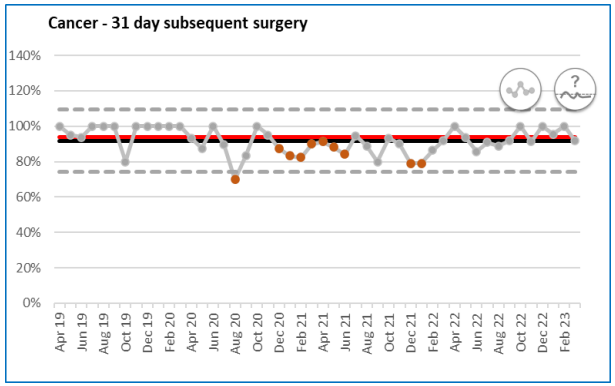
Appendix 3 – RTT, Cancer and Diagnostics Metrics

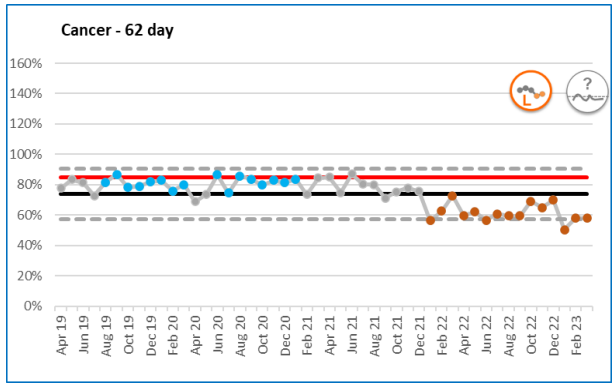






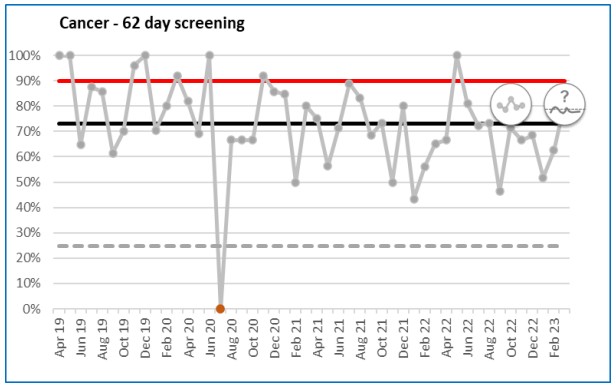


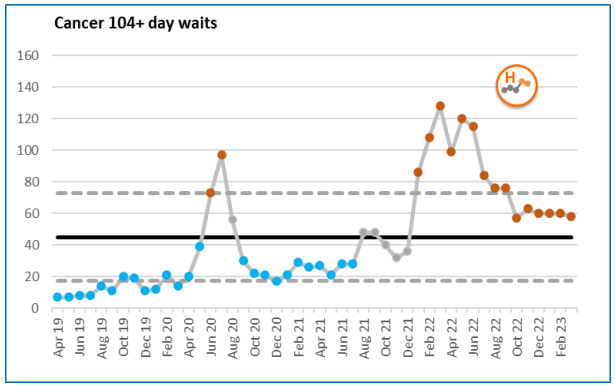


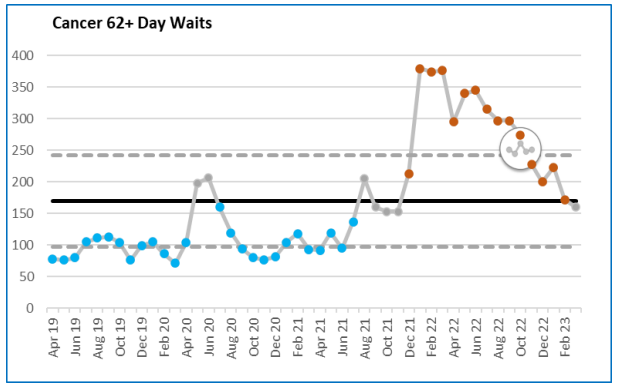


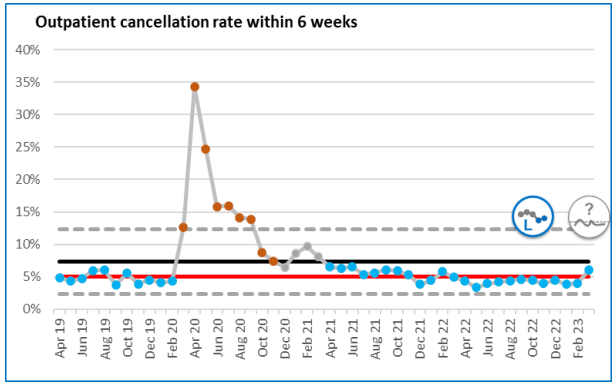
West Hertfordshire Hospitals NHS Trust

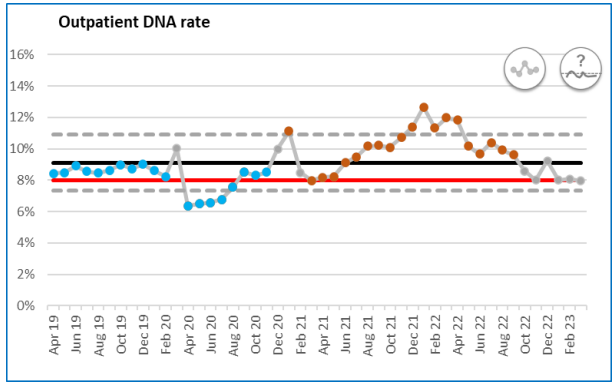
Appendix 3 – RTT, Cancer and Diagnostics Metrics





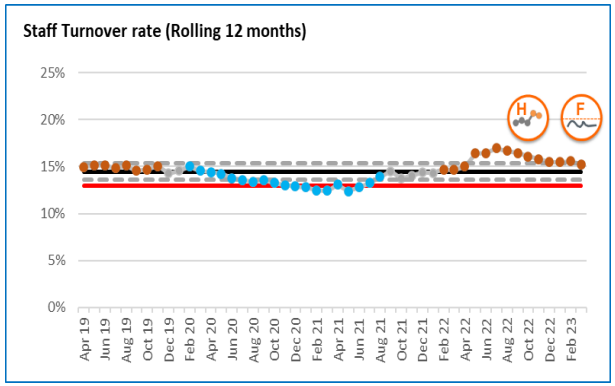


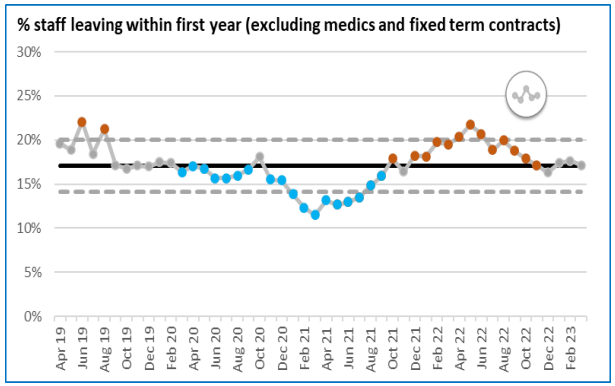


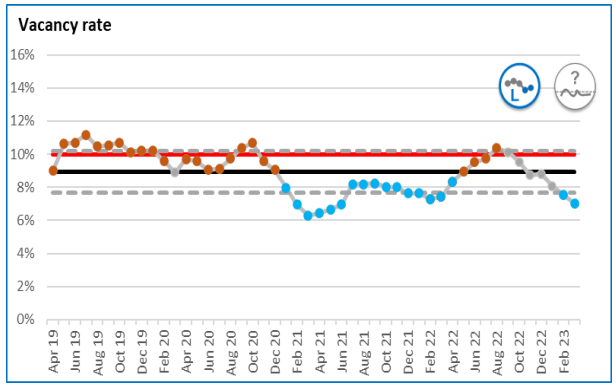


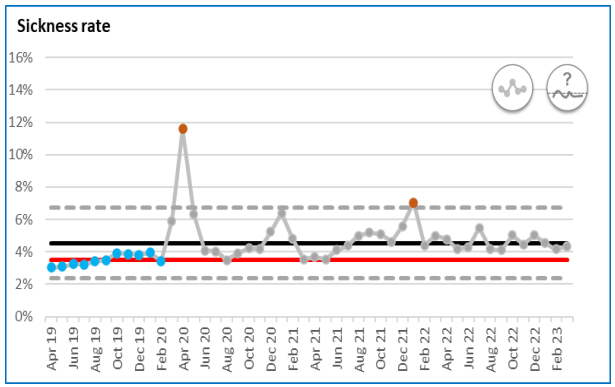
West Hertfordshire Hospitals NHS Trust

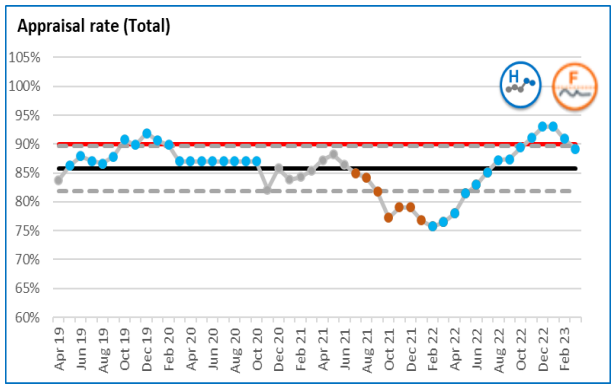
Appendix 4 – Workforce Metrics

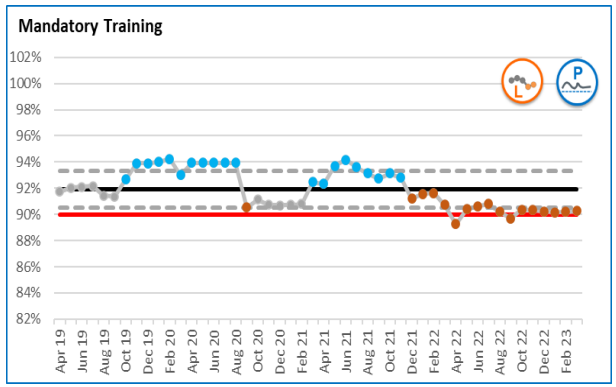






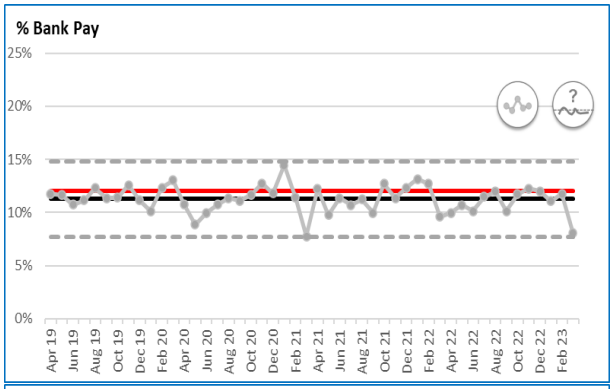


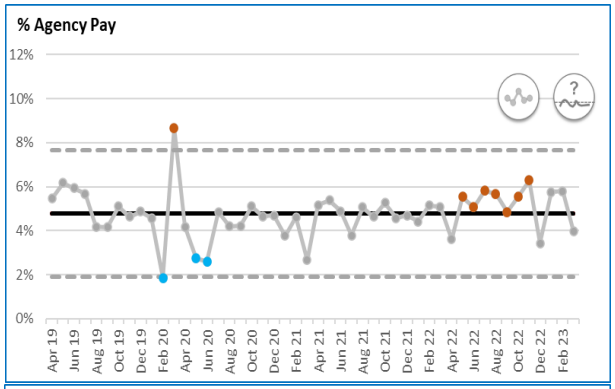


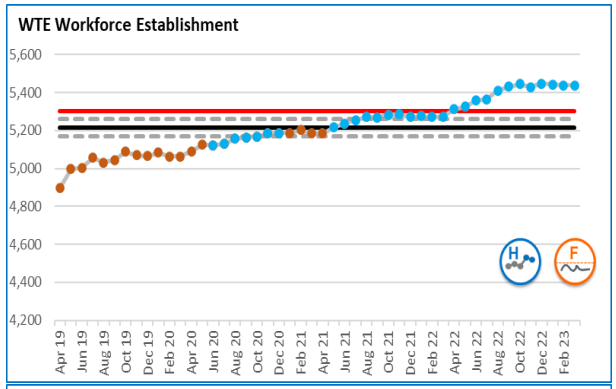


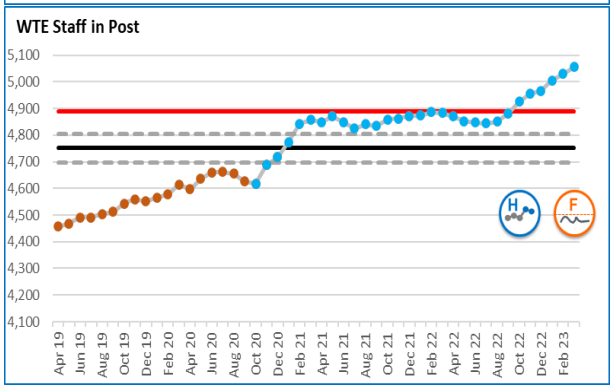
West Hertfordshire Hospitals NHS Trust

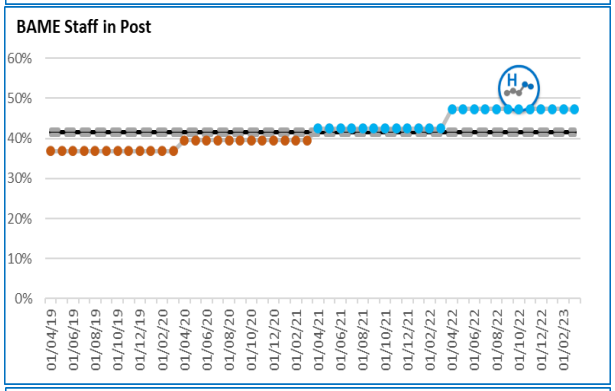
Appendix 4 – Workforce Metrics

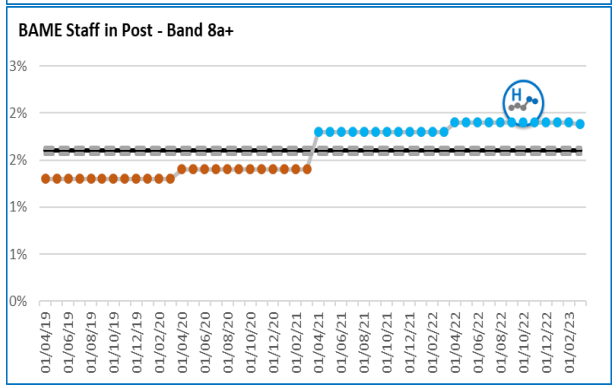


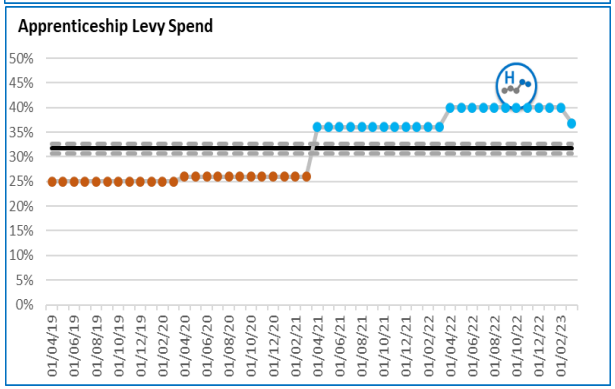






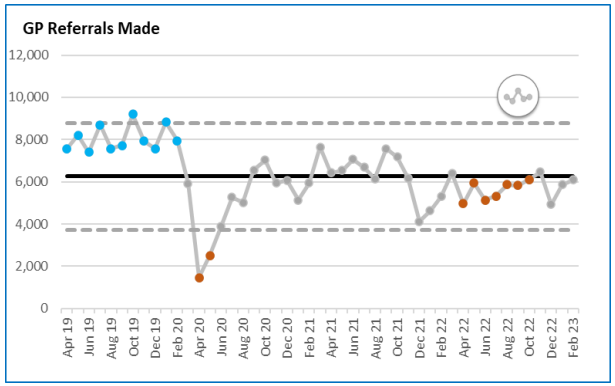


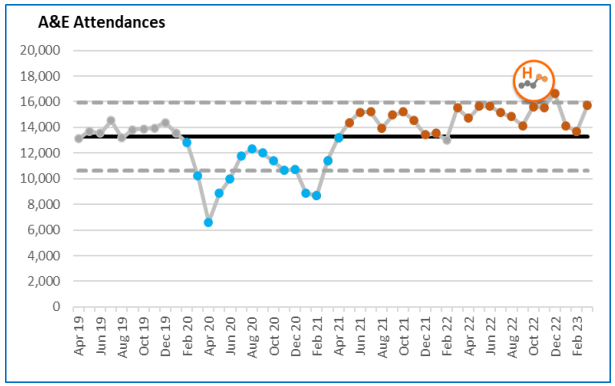


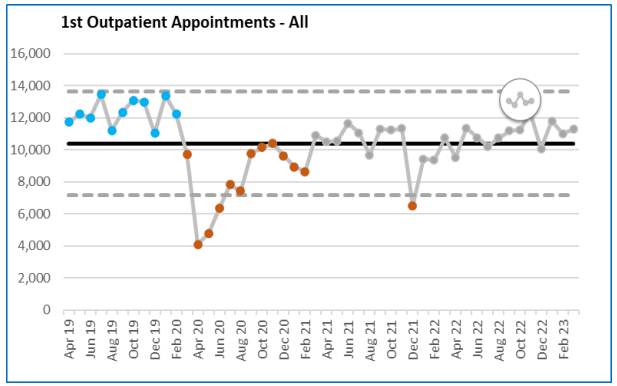


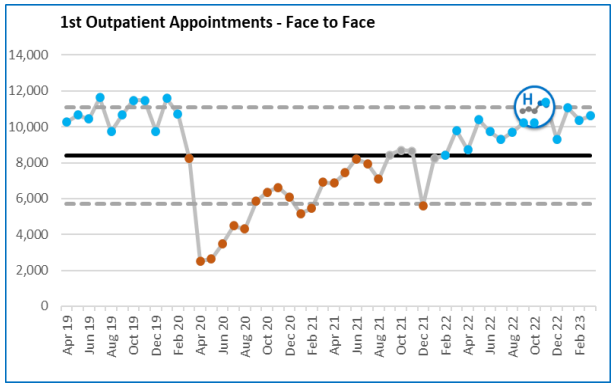
West Hertfordshire Hospitals NHS Trust

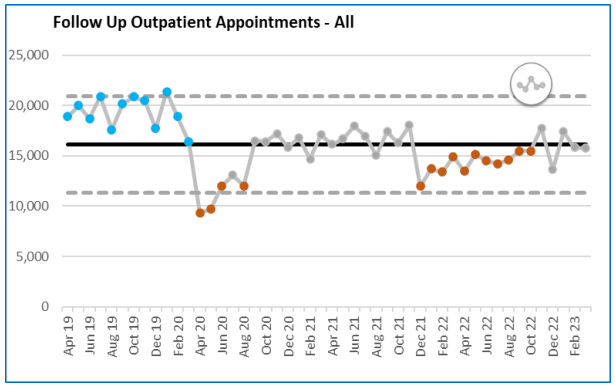
Appendix 5 – Activity Metrics

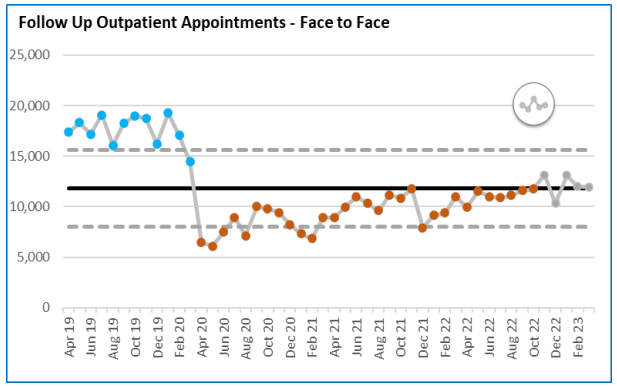






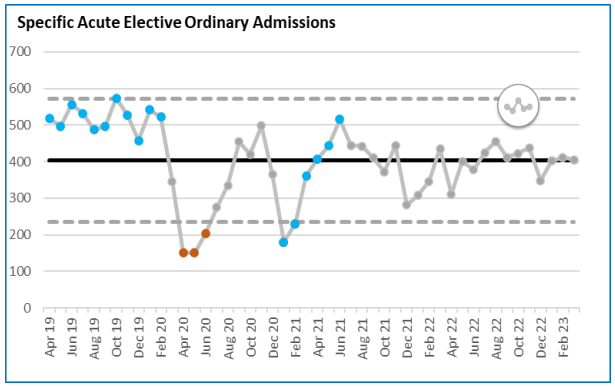


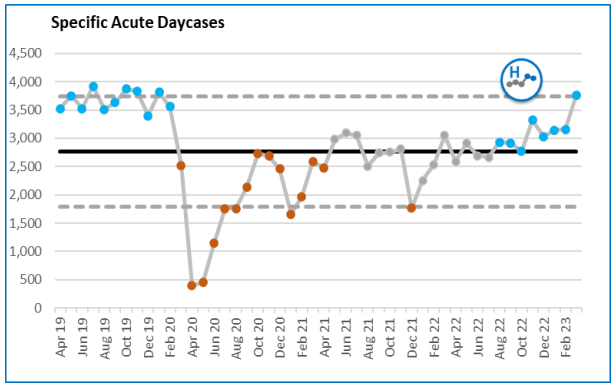


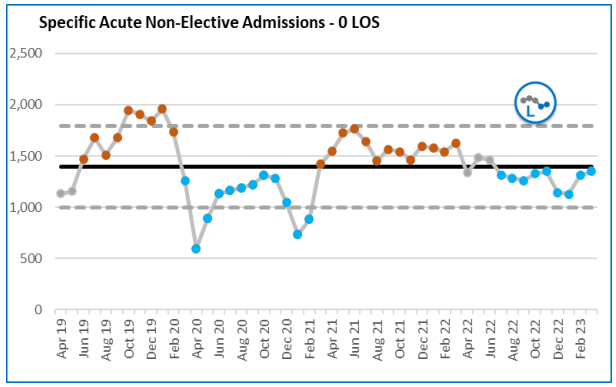


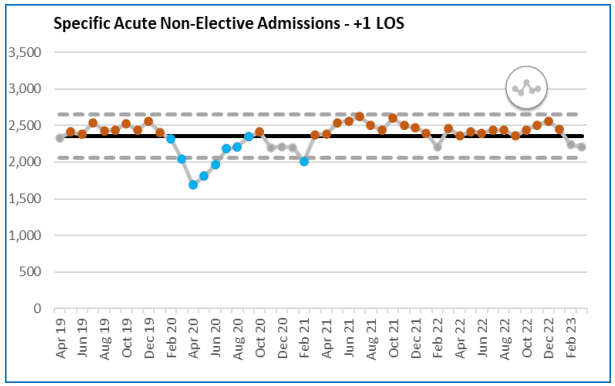
West Hertfordshire Hospitals NHS Trust

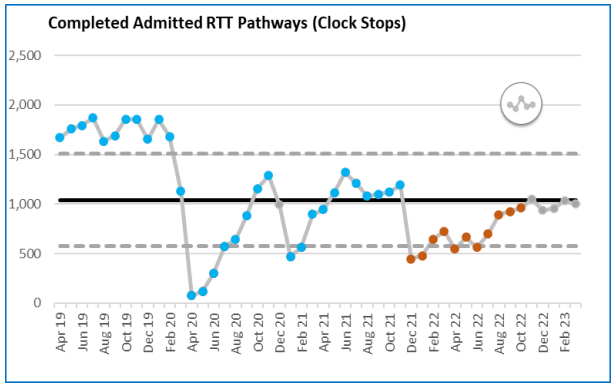
Appendix 5 – Activity Metrics

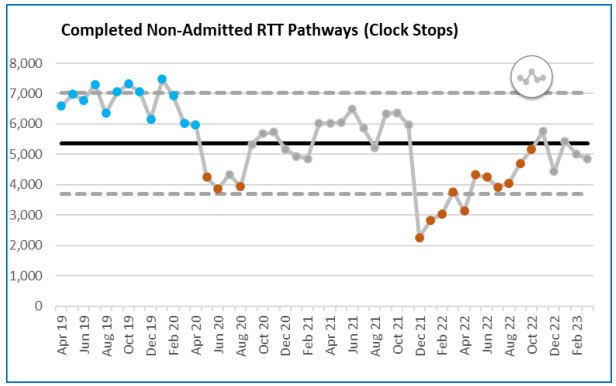












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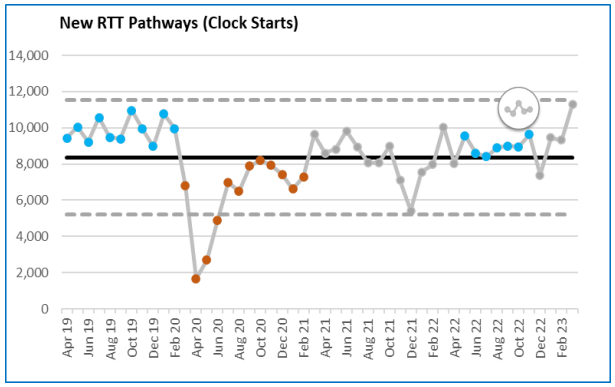
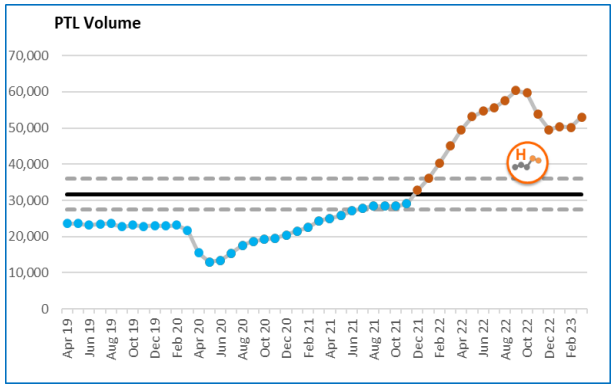
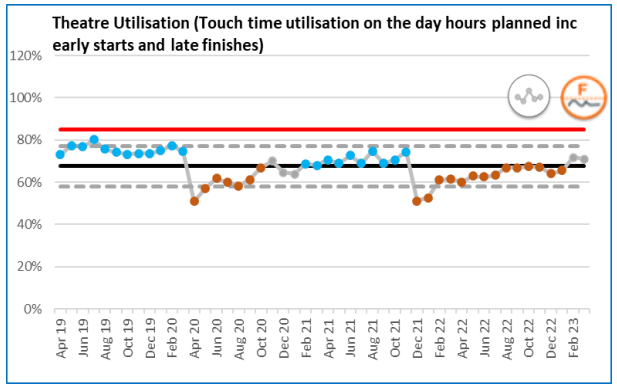
Appendix 5 – Activity Metrics







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OUR VALUES
Commitment
Care Quality

West Hertfordshire Teaching Hospitals NHS Trust

Trust Board
4 May 2023

Title of the paper:	**Quality Improvement Strategy development update**
Agenda Item:	**19**
Presenter:	**Tracey Carter, Chief Nurse**
Author(s):	**Michelle Boot, Lead Nurse QI**
Purpose:	*Please tick the appropriate box* *For approval*: *For discussion*: x *For information*:
Executive Summary:	QI engagement events took place between December 2022 and February 2023. Key themes emerging from the engagement events were: o Developing an organisational culture to support QI. o Leadership to support the adoption of QI culture and methodology. o Building capability o Creating capacity o Digital as an enabler/ QI enabling digital improvement. o Insight and sharing- insight into what is happening in the Trust and ICB and sharing learning across the ICB These themes are enablers which will enable the Trust to deliver improvement on key priorities through QI methodology. These enablers reflect CQC and research evidence of key requirements for successfully embedding QI into and organisation. **QI plan until December 2023** It is anticipated that the final version of the QI Strategy will be presented to Board between September and December following the appointment of the Chief Nurse (CNO) and Chief Strategy & Partnerships Officer (CSPO). The QI and CPG team have identified priorities for the remainder of 2023 QI priorities: The QI team will facilitate work to improve patient flow across the Trust, patient safety initiatives and support the teams working to improve theatre utilisation. CPG priorities: The CPG project management team will focus on implementing 15 approved CPG pathways aligned to Trust priorities, develop, and implement costing strategy for three pathways, the digitalisation of 4-6 pathways and facilitate two patient co-production focus groups. **Aligned with the Trust Strategy** The QI strategy will be a subsection of the Trust strategy and the current work shared. The new CNO/CSPO/CIO will collaborate to develop the agreed way forward for QI and CPG workstreams. **Measuring outcomes** The success in creating a QI culture will be measured through process, qualitative and ultimately outcome measures. The success of the delivery of the strategy will be measured by improved outcomes related to the Trust and divisional objectives and a reduction in patient safety incidents. The draft strategy has been reviewed by quality committee.
Trust strategic aims: *(please indicate which of the 4 aims is relevant to the subject of the*	**Aim 1 Best care** | **Aim 2 Great team** | **Aim 3 Best value** | **Aim 4 Great place**

report)	 ***Objectives 1-4***  ***Objectives 5-8***  ***Objective 9***  ***Objective 10-12***
	x | x | x |
Links to well-led key lines of enquiry:	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☒Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues and performance? ☐Is appropriate and accurate information being effectively processed, challenged and acted on? ☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☒Are there robust systems and processes for learning, continuous improvement and innovation? ☒How well is the trust using its resources?
Previously considered by:	Committee/Group: Quality Committee — Date: 27 April 2023
Action required:	The Trust Board is asked to receive this report for information and assurance on the progress of the QI strategy and interim plan for 2023.

West Hertfordshire Teaching Hospitals NHS Trust

Agenda Item: 19

Trust Board: 4 May 2023

Title: Quality Improvement Strategy development update

Presented by: Tracey Carter, Chief Nurse

1. Purpose

1.1 The purpose of this report is to inform the Board on progress in developing the QI strategy and the interim plan.

2. Background

2.1 The Trust is in the process of developing a QI strategy which will support the Trust to deliver the best care, best value and to be the best place to work. The Trust initially invested in the development of QI in 2019 with the appointment of a Lead nurse for QI, 2 Improvement Leads and a CPG project manager. These posts have facilitated improvement workstreams and building of QI capability. The strategy will facilitate the development of QI across the Trust both in terms of developing a culture that supports QI and building capacity and capability to use QI methodology to drive improvement across the Trust.

3. Analysis/Discussion

3.1 **Engagement to develop the QI strategy.**
Between December and February 2022-2023 Divisional triumvirates were invited to attend initial discussions to explore divisional need and planning for divisional QI engagement events. Each division hosted an engagement event. 170 people attended engagement events and were given the opportunity to contribute to the development of the strategy though online workshops, completing a written survey or through a one-to- one discussion with the Lead Nurse for QI.

Key themes

3.2 Key themes emerging from the engagement are:

- Developing an organisational culture to support QI
- Leadership
- Building capability
- Creating capacity
- Digital as an enabler/ QI enabling digital improvement.
- Insight and sharing- insight into what is happening in the Trust and ICS and sharing learning across the ICS

These themes are enablers which will enable the Trust to deliver improvement through QI methodology. These enablers reflect CQC and research evidence of key requirements for successfully embedding QI into and organisation.

It is anticipated that the final draft for the QI Strategy will be presented to the Trust Board between September and December following the appointment of the Chief Nurse (CNO) and Chief Strategy & Partnerships Officer (CSPO). The section ‘Bringing our QI strategy to life’ will identify the Trust’s priorities and provides a plan of action this section will be agreed in conjunction with the CN and the CSPO.

3.3 **QI team and CPG team plans until December 2023**

The QI and CPG team have identified priorities for the remainder of 2023

QI priorities:

- To facilitate the teams working to improve flow across the Trust.
- To facilitate the Harm free care team with improvement work to reduce harm from falls.
- Facilitate training and QI methodology for the theatre productivity improvement programme.
- To work with the divisions building capability of key staff who will use a QI approach to drive improvement with divisional priorities.

CPG priorities:

- To implement up to 15 approved CPG pathways aligned to Trust priorities
- To develop and implement costing strategy for three pathways working in conjunction with our clinical partners.
- To implement digitalisation of 4-6 pathways
- To facilitate two patient co-production focus groups

3.4 **Proposed three-year plan**

In Year 1 the board and senior leaders will have a key role in developing the organisational culture that creates the conditions for QI to flourish. Engagement at a senior level is needed to ensure buy in by senior clinical leaders and middle managers. The focus of QI training will target key individuals who will support QI initiatives at divisional level. The QI team will work closely with teams working to improve performance of Trust priority initiatives. QI initiatives will adopt a systems approach with teams working with our Health Care Partners building on existing improvement work in progress with our Health Care Partners. Mechanisms for sharing learning within the Trust and the ICB will be established.

Across the three years the workstreams will align with the co-production boards priorities. 2023-2024 priorities are: outpatients, discharge planning and mental health. QI will be used to facilitate new working practices that emerge from co-production.

Year 2 progress will depend on the success of engaging staff, creating a QI culture and building capacity in year 1. Trust and divisional QI initiatives from year 1 will demonstrate sustained improvement and the number of initiatives expanded. Success will be measured by the number of initiatives demonstrating sustained improvement rather than the number of initiatives.

Year 3 will see the embedding of the work of the QI enablers from the previous years. Each division will have QI coaches supporting the improvement aligned with divisional priorities. QI methodology will be used to support national KPIs such as GIRFT. The Trust will have established links with partner Universities.
and will have the infrastructure to support a QI fellowship programme.

CPG Specific 3-year plan

The clinical pathways 3-year plan will focus on the implementation and digitalisation of the pathways. The CPG programme aims to implement 20 approved pathways aligned to Trust priorities each year (incorporating sustainability in each pathway) and continue to have oversights on already established sustained pathways. The programme will develop a costing strategy, digitalisation proposal, dashboards and explore research capabilities in year 1 and will continue to embed these workstreams in year 2 and 3. The CPG programme will facilitate three patient co-production projects for the clinical pathways in year 1, a further 6 in year 2 and a further 12 co-production pathways in year 3.

3.5 **Aligned with the Trust strategy:**

QI is a key theme of the Trust strategy. It is anticipated that the QI strategy will be a subsection of the Trust strategy. The QI strategy will support the delivery of the clinical strategy ‘Better care delivered differently’. All the programmes within the clinical strategy will benefit from the QI culture and using QI methodology to facilitate improvement.

3.6 **Measuring outcomes**

The success of the development and deployment of the QI strategy will be measured by the presentation of the completed strategy in the Autumn of 2023, the delivery of Board training in relation to the Strategy by December 2023 and the QI teams and CPG teams facilitating the priority workstreams identified for 2023 and improvements on these workstreams.

The priority workstreams identified by the divisions for 2023 will be monitored through the divisional governance meetings and as part of the strategy PRMs. Reporting will also be within the QSG divisional reports and to the quality committee as part of the workplan for assurance of progress being made.

The longer-term measurement of success will include: The success in creating a QI culture will be measured through process, qualitive and ultimately outcome measures. A culture of QI will be evidenced by the quality committee reviewing progress on improvement workstreams and analysing data using improvement metrics in the quality IPR, the Trust risk register linking to improvement workstreams, and qualitative data supporting staff engagement and improved wellbeing scores. The success of the delivery of the strategy will be measured by improved outcomes related to the Trust and divisional objectives and a reduction in patient safety incidents.

The quality committee will report to the trust board on progress.

4. Risks

4.1 Failing to act will limit the opportunities for improvement at WHTH, and the associated benefits including improved patient safety, reduced cost, improved patient experience and outcomes, enhanced reputation, and improved staff wellbeing.

5. Recommendation

5.1 The Trust Board is asked to receive this report for information and assurance on the progress of the QI strategy and interim plan for 2023.

Name of Director Tracey Carter
Title Chief Nurse

Date: April 2023

Trust Board Meeting
4 May 2023

Title of the paper	**Finance update M12**
Agenda Item	**20**
Presenter	**Don Richards, Chief Financial Officer**
Author(s)	**Don Richards, Chief Financial Officer**
Purpose	*For approval*: *For discussion*: *For information*: √
Executive Summary	The purpose of this report is to provide the Board with pertinent data to support assurance of the short and longer term financial stability. The report encompasses the Trust's income, revenue expenditure, capital investments, cash flow and year end valuations of Trust assets and liabilities. At the end of the year the financial year the Trust reports total income of £511.8m and costs of £511.5m leading to a year end surplus of £0.3m. This performance is in line with the Trust's objective to balance income with expenditure. The performance is the third consecutive year that the Trust has recorded a surplus. The continued recognition of Elective Recovery Fund (ERF) income has been vital to maintaining acceptable I&E performance. We've accrued for £11.2m of ERF income for the year. This is in line with national confirmation that this income is payable regardless of recovery performance. The payment of ERF income, while our elective activity was below target, has compensated for additional unfunded inflation pressures (estimated to create a c£7.5m cost pressure). The data suggests that our elective activity performance deficit results from a combination of reduced activity levels and fewer highly dependent patients. However, a significant proportion of the deficit is expected to improve as our data quality improves. This includes appropriately documenting outpatient procedures and outsourced activity as required in the newly introduced electronic patient record (EPR) system. As reported throughout the year, there are offsetting variances within the year-to-date position despite the overall performance being better than plan. COVID related costs reached £6.8m compared with funding of £9.4m. This level of

	spend reflects the reduced number of COVID patients seen at the Trust and the concerted efforts to remove additional capacity introduced to support management of the pandemic. However, some of these costs still contribute to an overall medical staff overspend. Agency costs remain a significant measure of financial efficiency. Our agency costs for the year amounted to £16.6m, exceeding our initial target of £12.8m. Notably £1.5m of these costs can be directly connected to alterations needed for handling COVID-19 patients. CIPs fell short of target and when combined with efficiencies expected from the EPR system, CIPs reached £13.3m compared to the total £17.9m expected (£15m general efficiencies and £2.9m EPR related). Transformation projects including the virtual hospital for COPD and heart failure help the Trust to manage demand with limited capacity. The break-even position was supported by the year-end review of appropriate accruals for outstanding annual leave. Data gathered at the end of the year allowed the Trust to reduce its accrual to £1.4m from £6.9m on the balance sheet at the start of the year. The balance sheet shows a £41m increase in non-current assets due to the capital programme and the annual revaluation of the Trust estate. Current assets have increased to £69m including a cash balance of £35m and a £9m increase in receivables. Capital expenditure totalled £39.4m by the end of the year with significant investments in new diagnostic equipment, refurbishment of clinical areas and general estate infrastructure. The Trust submitted its draft annual accounts on 27 April. These will be discussed and analysed at the next Audit Committee in preparation for an external audit agreed with NHSE to start later in the year than usual. The Trust continues the development of the ICS's medium term financial planning financial planning until the 23/24 plan has been finalised. The plan will ultimately enhance the Trust's own long term financial plan. Financial management actions will continue to focus on: • Maximising the productive use of revenue funds to treat more elective patients. The financial regime for 23/24 requires the Trust to significantly increase elective activity to maintain elective care funding received in 22/23. • Ensuring that funds reserved to manage COVID pandemic pressures are now reduced in view of the falling risks. • Developing general and EPR driven efficiencies to further mitigate the risks of a deficit financial plan. • Ensuring that financial governance is strong enough to minimise the risk of new financial pressures emerging. • Further development of the short and long-term financial plans including supporting the ICS development of a medium-term financial plan.

<table>
<tr><td></td><td></td></tr>
<tr><td>Trust strategic aims</td><td>
<table>
<tr><th>Aim 1
Best care</th><th>Aim 2
Great team</th><th>Aim 3
Best value</th><th>Aim 4
Great place</th></tr>
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<tr><th>Committee/Group</th><th>Date</th></tr>
<tr><td>TMC
FPC</td><td>26 April
27 April</td></tr>
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<tr><td>Action required</td><td>The Board is asked to note the contents of this report.</td></tr>
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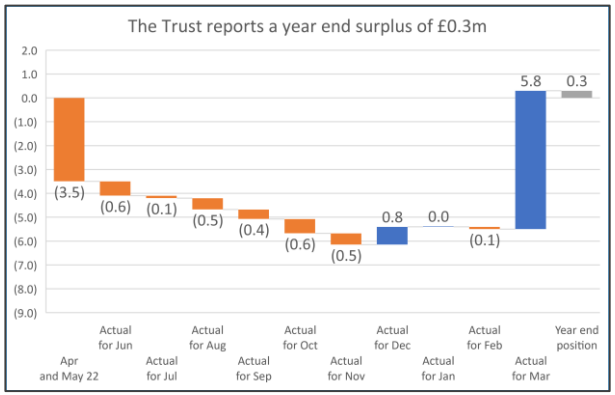
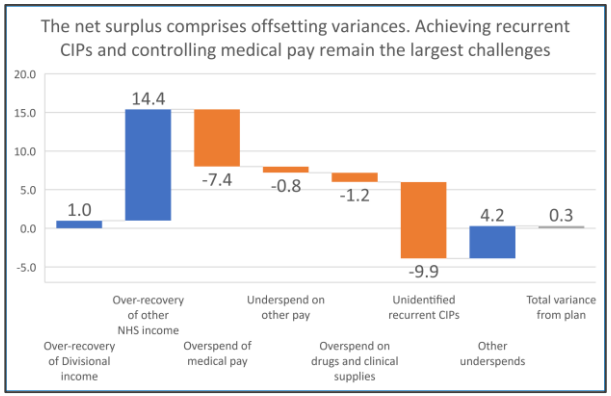
NHS
West Hertfordshire Teaching Hospitals
NHS Trust

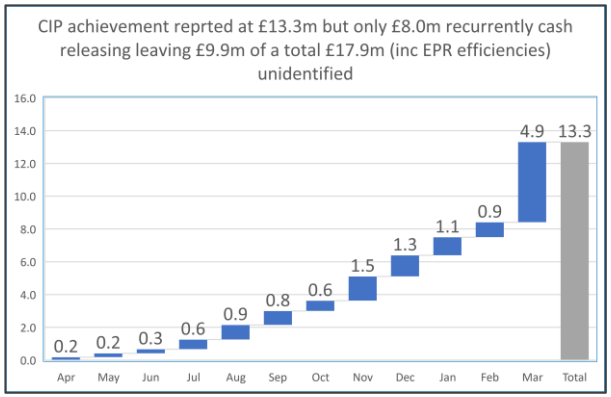
Month 12 Finance Report

The I&E account reports a £0.3m surplus for the year. This is £0.3m better than the plan.

West Hertfordshire Teaching Hospitals NHS Trust



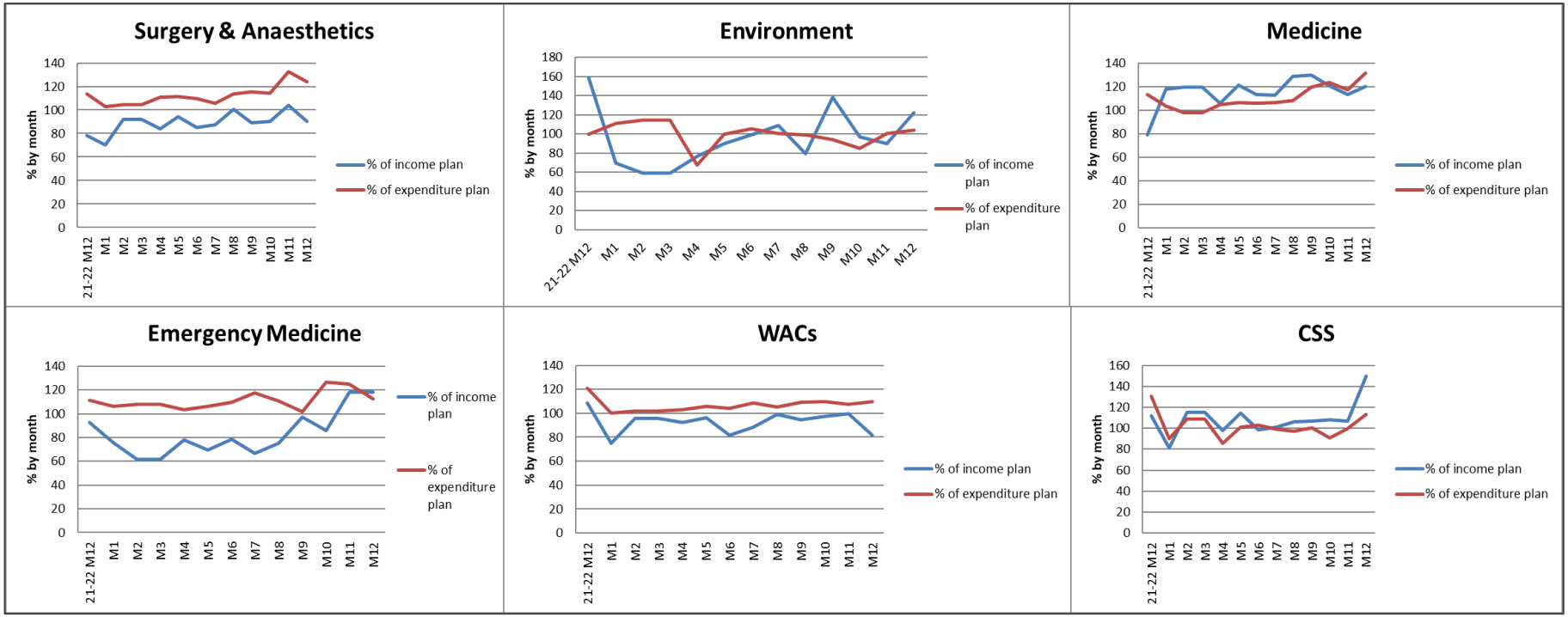




			In Month (£000s)			Year to Date (£000s)		
Trust Definition	Expense Type	Annual Budget	Budget	Actual	Variance	Budget	Actual	Variance
Income	Divisional Income	35,831	3,371	-368	-3,738	35,831	36,850	1,019
	NHS Revenue	460,540	57,704	66,335	8,631	460,540	474,950	14,409
Income Total		496,371	61,074	65,967	4,893	496,371	511,799	15,428
Pay	Medical Pay	-89,580	-10,826	-13,127	-2,301	-89,580	-96,956	-7,375
	Non-Clinical Pay	-74,618	-15,437	-8,476	6,961	-74,618	-59,253	15,365
	Nursing Pay	-95,902	-11,151	-11,969	-818	-95,902	-102,182	-6,280
	Other Clinical Pay	-36,706	-4,216	-4,372	-156	-36,706	-38,946	-2,240
	Scientific, Technical & Profes	-30,895	-3,516	-3,825	-309	-30,895	-32,073	-1,177
	Pay Unidentified CIPs	6,504	1,109	0	-1,109	6,504	0	-6,504
Pay Total		-321,198	-44,036	-41,769	2,268	-321,198	-329,408	-8,211
Non Pay	Clin Supp Serv	-29,247	-2,647	-2,705	-58	-29,247	-31,415	-2,168
	Drugs	-22,688	-2,117	-2,387	-270	-22,688	-26,056	-3,368
	OTHER (NON CLIN)	-106,681	-8,941	-10,195	-1,253	-106,681	-100,997	5,685
	Non Pay Unidentified CIPS	3,366	429	0	-429	3,366	0	-3,366
	Recharges	0	0	0	0	0	0	0
Non Pay Total		-155,251	-13,277	-15,287	-2,010	-155,251	-158,468	-3,217
Other Expenditure	Financing Charges	-19,923	-1,660	-3,055	-1,395	-19,923	-23,602	-3,680
Other Expenditure Total		-19,923	-1,660	-3,055	-1,395	-19,923	-23,602	-3,680
Month 12 Grand Total		0	2,101	5,856	3,755	0	321	321

The Trust reported a year-end surplus of £0.32m, achieving its breakeven forecast. The improvement from the M11 position was largely due to updating accruals for outstanding annual leave as anticipated. The change in national guidance allowed the Trust to fully accrue for £11.2m of Elective Recovery Fund income. The surplus in elective income supported the Trust in managing unfunded inflation pressures. Efficiencies totalled £13.3m for the year. NHS income is reported here as £14m more than the original plan. This includes the usual year end central funding of an additional 6% employers pension contribution.

Surgery, WACS and Emergency Divisional spend remained higher than plan while activity remained lower than plan through most of 22/23.



The graphs provided illustrate the performance of each Trust Division concerning their income and expenditure plans. The target is for each division to achieve at least 100% of its planned income (blue line), while simultaneously maintaining expenditure below 100% of their planned expenditure (red line). In the ideal situation, blue lines should be above red lines. The CSS Division has consistently shown strong performance in this regard. Although all divisions have experienced a steady rise in activity levels, and subsequently income, cost control remains an ongoing challenge. This is particularly notable within the Surgery, Emergency Medicine and WACS divisions.

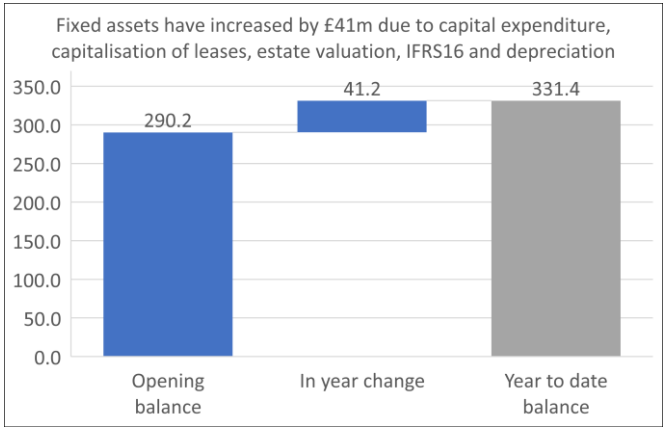
Our outturn includes inflationary pressures totalling £7.4m

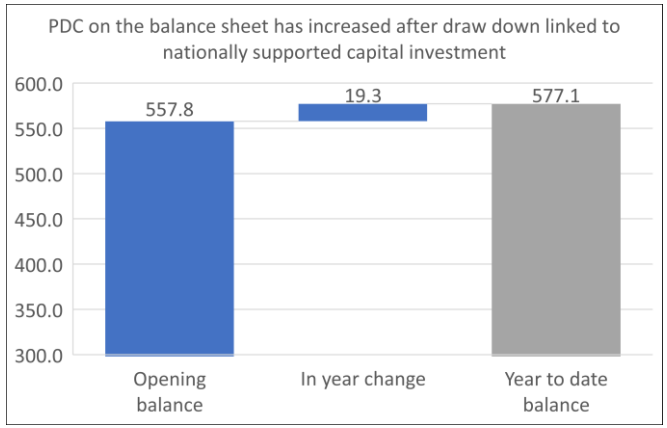
West Hertfordshire Teaching Hospitals NHS Trust

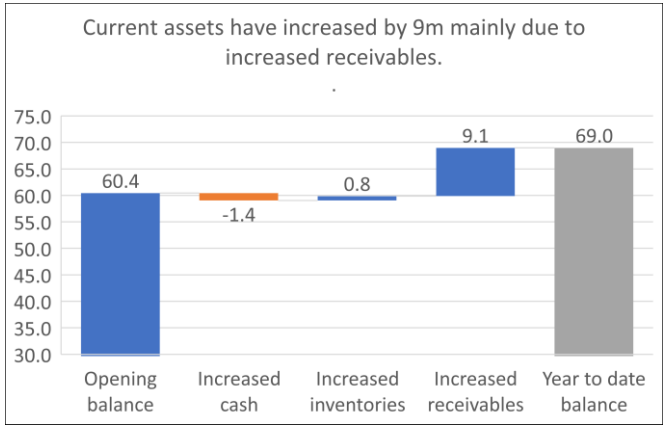
			Inflation funding				Unfunded inflation	
	2021/22 cost base (£m)	% of cost base	Funding received (Gross of efficiency expectation)	Funding as % on cost base	Forecast inflation %	Inflation impact	%	£m
Pay (excludes non recurrent pension cont)	280.0	65%	15.5	5.5%	5.6%	3.6%		
Gas	1.3	0%			207.0%	0.6%		
Electricity	2.0	0%			73.5%	0.3%		
Transport	0.5	0%			15.0%	0.0%		
Supplies and services - general	1.9	0%			10.1%	0.0%		
Linen & Laundry	1.9	0%			10.1%	0.0%		
Disposable gowns	3.4	1%			10.1%	0.1%		
Premises - other	5.9	1%			10.1%	0.1%		
Drugs costs (drug inventory consumed and purchase of non-	22.9	5%			10.0%	0.5%		
Purchase of healthcare	4.0	1%			6.6%	0.1%		
Supplies and services – clinical (excluding drugs costs)	30.4	7%			6.6%	0.5%		
Cleaning	2.3	1%			5.5%	0.0%		
Domestic	4.9	1%			5.5%	0.1%		
Portering	1.5	0%			5.5%	0.0%		
Education and training - non-staff	1.6	0%			5.5%	0.0%		
Medical Equipments / Surgical Instruments/ MSSE	0.0	0%			5.4%	0.0%		
Establishment	3.3	1%			5.0%	0.0%		
Maintenance Contract	3.9	1%			5.0%	0.0%		
IT infrastructure contract	4.5	1%			5.0%	0.1%		
IT (software mtce/ computer hardware & software)	6.8	2%			5.0%	0.1%		
Outsourcing Costs	9.8	2%			3.5%	0.1%		
Consultancy	1.5	0%			3.5%	0.0%		
Audit fees and other auditor remuneration	0.1	0%			3.5%	0.0%		
Catering	2.6	1%			3.0%	0.0%		
Premises - business rates payable to local authorities	1.4	0%			0.0%	0.0%		
EPR licence	2.3	1%			0.0%	0.0%		
Clinical negligence	24.5	6%			0.0%	0.0%		
Other	6.3	1%			10.1%	0.1%		
Sub total non pay operating expenses	151.3	35%				3.0%		
PDC Dividend	NA				NA	NA		
Depreciation and other financing	NA				NA	NA		
Sub total non pay	151.3	35%	5.6	3.7%		3.0%		
Total cost base	431.3	100%	**21.1**	4.9%		6.6%	-1.7%	-7.4

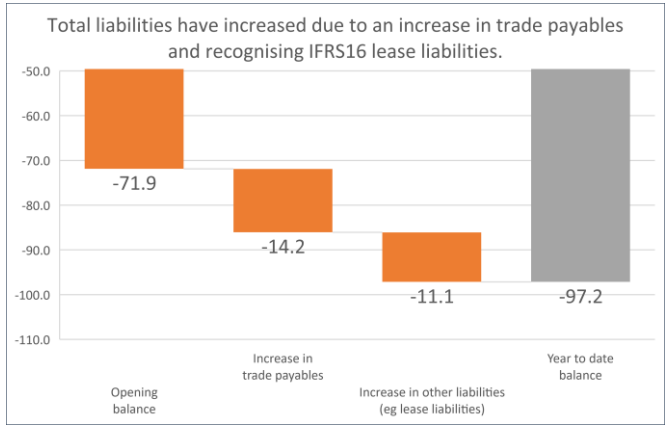
The table to the left compares inflation funding of £21.1m received (4.9% of our cost base) with a inflation experience which includes pay costs at 6.6%. This 1.7% difference is equivalent to £7.4m. While this inflationary pressure is partially offset in 22/23 through one off income, it continues to contribute to the Trust's core deficit.

Assets values are enhanced though capital spend and revaluations. Current assets are higher due to increased receivables. Creditor balances are higher mainly due to creditors on leases.





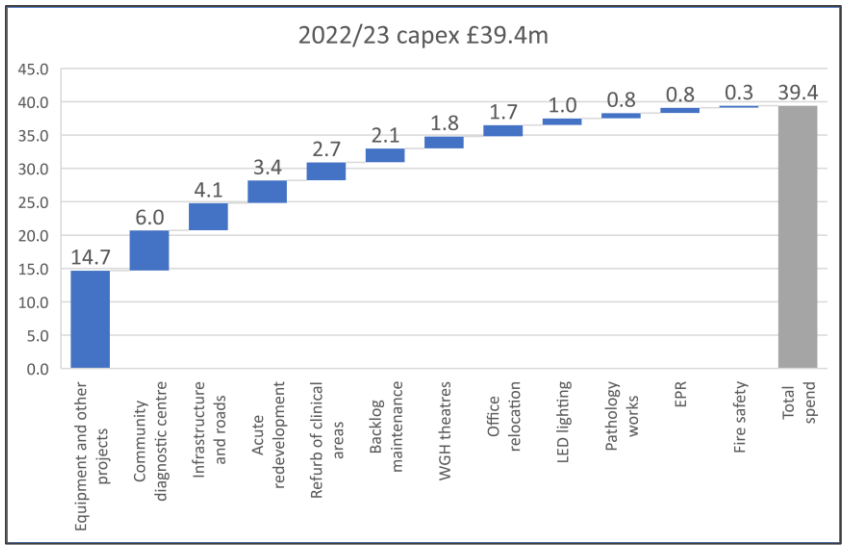


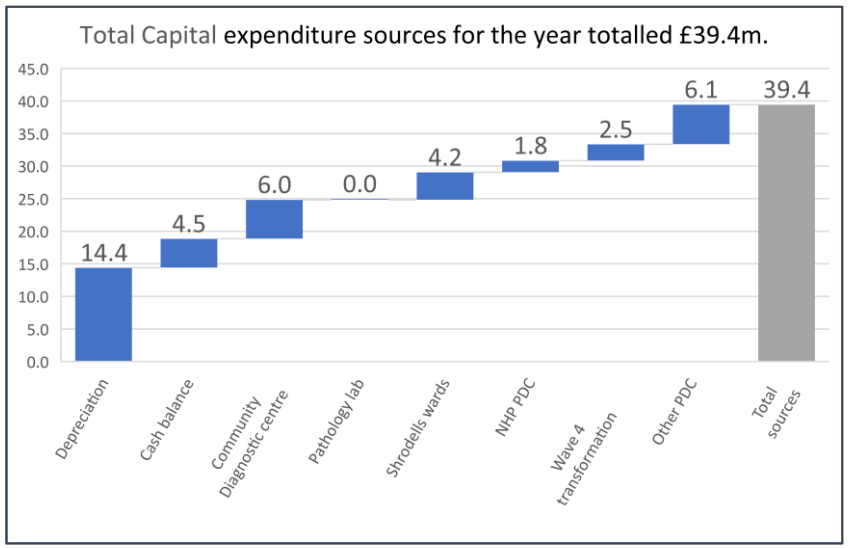


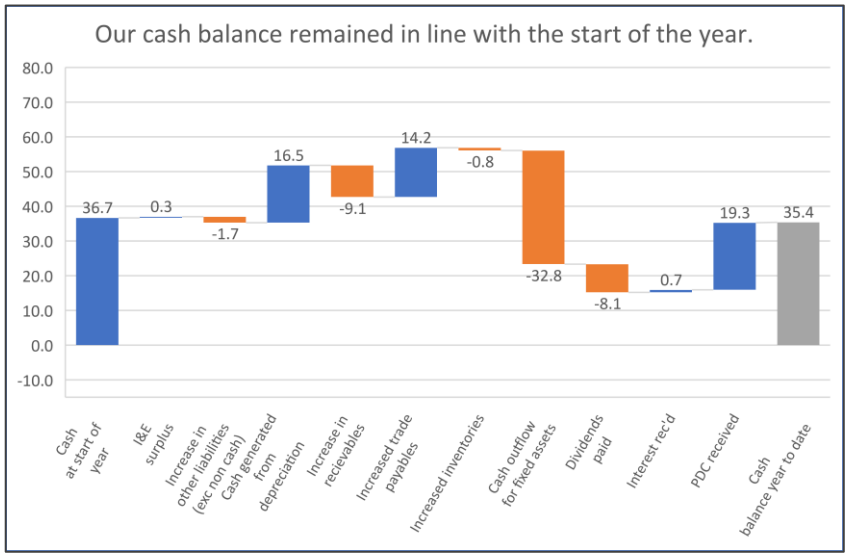
Right of use assets capitalisation, new capital spending and asset revaluations have raised the fixed assets' book value to £331m. As at month 12 the Trust has obtained an additional £19m in PDC to finance capital expenditure supported at the national level. The cash balance has dropped by £1m compared to th estart of the year but an increase in receivables has pushed the value of current assets up to £69m. Liabilities have risen to £97m due to lease liabilities and increased payables.

Cash balance £35m broadly matches the balance at the start of the year. Capital expenditure totalled £39m ytd.

West Hertfordshire Teaching Hospitals NHS Trust







The Trust spent up to it's full allocation of £39.4m by the end of the financial year. The capital programme was supplemented by over £20m of nationally supported projects including the creation of a community diagnostic centre, additional ward capacity. The cash balance at the end of March was £35.4m.

Draft Annual Accounts will be presented and analysed at the Audit Committee this month

West Hertfordshire Teaching Hospitals NHS Trust

Statement of Comprehensive Income			
		2022/23	2021/22
	Note	£000	£000
Operating income from patient care activities	3	480,149	452,359
Other operating income	4	32,598	28,777
Operating expenses	7, 9	(513,814)	(484,663)
Operating surplus/(deficit) from continuing operations		**(1,067)**	**(3,527)**
Finance income	11	836	28
Finance expenses	12	(500)	41
PDC dividends payable		(7,894)	(6,828)
Net finance costs		**(7,558)**	**(6,759)**
Other gains / (losses)	13	-	(41)
Surplus / (deficit) for the year from continuing operations		**(8,625)**	**(10,327)**
Surplus / (deficit) for the year		**(8,625)**	**(10,327)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(788)	(5,667)
Revaluations	17	14,670	8,097
Total comprehensive income / (expense) for the period		**5,257**	**(7,897)**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		(8,625)	(10,327)
Remove net impairments not scoring to the Departmental expenditure limit		8,485	10,160
Remove I&E impact of capital grants and donations		432	363
Remove net impact of inventories received from DHSC group bodies for COVID response		29	452
Remove loss recognised on return of donated COVID assets to		-	41
Adjusted financial performance surplus / (deficit)		**321**	**689**

The adjusted retained surplus of £321,000 is after excluding impairments, net of donated income and depreciation and net of inventories received and consumed from Department of Health and Social Care centrally purchased Personal Protective Equipment (PPE) free of charge to the Trust. The Trust financial performance is measured on the adjusted Breakeven duty surplus of £321,000 as described in note 44.

Statement of Financial Position			
		31 March 2023	31 March 2022
	Note	£000	£000
Non-current assets			
Intangible assets	14	21,363	21,794
Property, plant and equipment	15	294,247	265,269
Right of use assets	18	12,761	-
Receivables	18	3,033	3,148
Total non-current assets		**331,404**	**290,211**
Current assets			
Inventories	17	5,800	5,004
Receivables	18	27,906	18,755
Cash and cash equivalents	20	35,393	36,688
Total current assets		**69,099**	**60,447**
Current liabilities			
Trade and other payables	21	(69,065)	(54,896)
Borrowings	23	(1,467)	-
Provisions	25	(1,129)	(1,604)
Other liabilities	22	(1,166)	(2,833)
Total current liabilities		**(72,827)**	**(59,333)**
Total assets less current liabilities		**327,676**	**291,325**
Non-current liabilities			
Borrowings	23	(13,232)	(2,000)
Provisions	25	(7,461)	(6,882)
Other liabilities	22	(3,641)	(3,704)
Total non-current liabilities		**(24,334)**	**(12,586)**
Total assets employed		**303,342**	**278,739**
Financed by			
Public dividend capital		577,106	557,760
Revaluation reserve		76,560	62,678
Income and expenditure reserve		(350,324)	(341,699)
Total taxpayers' equity		**303,342**	**278,739**

	Surplus/ (Deficit)
2018/19	(49,641)
2019/20	(22,471)
2020/21	257
2021/22	689
2022/23	321

The Trust reports at least break even for the last 3 years.

We expect to produce an update on our long-term financial plans.

NHS
West Hertfordshire Teaching Hospitals
NHS Trust

The long-term financial forecasting for our Trust will be significantly impacted by funding allocations to ICBs and their subsequent financial planning strategies. Nonetheless, it is beneficial for the Trust to examine the consequences of various scenarios on our financial sustainability in the long run. Such scenarios may include ICB funding assumptions, service demand fluctuations, the implementation of new initiatives, the cessation of COVID-19 funding and the realisation of efficiency gains.

The Trust has taken a leading role in collaborating with the ICB to establish an ICS medium term financial model, which will serve as a foundation for the Trust's long-term financial planning. Finalising the 2023/24 plans will be instrumental in refining the range of scenarios currently under analysis.

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NHS Trust

Trust Board Meeting
4th May 2023

Title of the paper:	Freedom to Speak Up Reflection and Planning Tool, outcomes and action plan for West Herts.
Agenda Item:	21
Presenter:	Andrew McMenemy, Chief People Officer
Author(s):	Joanna Bainbridge, Freedom to Speak Up Guardian
Purpose:	*Please tick the appropriate box* *For approval*: x *For discussion*: *For information*: x
Executive Summary:	The purpose of this report is to update the committee on the outcomes from a review of the Freedom to Speak Up service at West Herts, in conjunction with the Reflection and Planning Tool, which has been developed through NHS England and provided to all NHS organisations through the National Guardian Office. All NHS organisations are required to complete this exercise and keep the plan under review. Completing this improvement tool has demonstrated, for our trust, the progress that we have made in developing our Freedom to Speak Up arrangements, together with identifying gaps where further focus will be required going forward, this has enabled an action plan to be developed and included as part of this work. The actions from the plan will be reflected within the FtSU strategy and workplan. A more detailed version of the completed tool was presented to the People, Education and Research Committee on 27th April 2023.
Trust strategic aims: *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1 Best care** — ***Objectives 1-4*** **Aim 2 Great team** — ***Objectives 5-8*** **Aim 3 Best value** — ***Objective 9*** **Aim 4 Great place** — ***Objective 10-12***
Links to well-led key lines of enquiry:	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☒Is there a culture of high quality, sustainable care?

	☒Are there clear responsibilities, roles, and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues, and performance? ☒Is appropriate and accurate information being effectively processed, challenged and acted on? ☒Are the people who use services, the public, staff, and external partners engaged and involved to support high quality sustainable services? ☒Are there robust systems and processes for learning, continuous improvement, and innovation? ☒How well is the trust using its resources?
Previously considered by:	

Committee/Group	Date
People, Education and Research Committee (PERC)	27th April 2023

Action required:	The Board is provided with this report as assurance on the progress FtSU has made, so far at West Herts and to approve the formation of the related action plan, which will be focussed on the activity required to close the gaps identified for the service through the tool. The actions identified from this exercise will form part of the FtSU strategy and associated workplan.

West Hertfordshire Teaching Hospitals NHS Trust

Agenda Item: 21

Trust Board Meeting, 4th May 2023

Freedom to Speak Up (FtSU) Reflection and Planning Tool, outcomes, and actions for the service at West Herts.

Presented by: Andrew McMenemy, Chief People Officer

1. Purpose

1.1 The guidance provided through the Reflection and Planning tool is designed to help senior leaders, in NHS organisations who provide services to the NHS, develop a culture where:

- leaders and managers encourage workers to speak up, without the fear of repercussion
- where concerns are raised by workers, this should drive learning and improvement.

1.2 The purpose of this report is to illustrate the position for West Herts against the expectations of the Reflection and Planning tool.

1.3 Trust Board members are invited to review this paper and the blank copy of the Reflection and Planning tool at appendix 1. The Board is asked to receive a further Freedom to Speak Up report on this topic later in the year.

2. Background

2.1 Introduced nationally in the summer of 2022, the Reflection and Planning tool and Guidance is designed to help the board to reflect on its current position and the improvement needed to meet the expectations of NHS England, NHS Improvement, and the National Guardian's Office.

2.2 It is recommended that this exercise be repeated at regular intervals and in the spirit of transparency the review and any accompanying action plan should be discussed in the public part of the board meeting. The Executive lead for FtSU should provide updates on progress to the Board at least every six months.

2.3 This exercise has been completed at West Herts and the remainder of this report provides a high-level summary of the process and the outcomes from this exercise.

2.4 A copy of the Reflection and Planning tool used in this exercise is attached to this report, at appendix one, for information. The completed version of this document will be reserved for internal purposes, as a tool to maintain the good standards achieved to date and to improve any standard that does not meet with the requirements prescribed.

3. Analysis/Discussion

3.1 The Refection and Planning tool is designed to analyse Freedom to Speak Up performance, at organisational level, across the following 8 principals:

Principle 1: Value speaking up
Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture
Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so
Principle 4: When someone speaks up, thank them, listen, and follow up
Principle 5: Use speaking up as an opportunity to learn and improve
Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements
Principle 7: Identify and tackle barriers to speaking up
Principle 8: Continually improve our speaking up culture

3.2 The first part of the framework allows the organisation to review their position against each of the statements, detailed under each principle and add supporting evidence and score this position between 1-5, 5 representing the highest performance score. Any scores awarded for performance between 3-1 are identified for further commentary regarding actions needed to improve the score.

3.3 The second part of the framework involves the organisation summarising the high-level actions to be taken over the next 6–24 months to develop their Freedom to Speak Up arrangements. These actions are broadly based on the areas within each principal where scores were between 3 and 1. Some of these findings for our trust will be elements included within the FtSU Strategy and associated Workplan.

3.4 The third part of the framework enables the organisation to summarise the high-level actions needed to promote and share strengths, both within the organisation and the wider system. One action has been identified for our trust within this section and relates to sharing, across the East of England the best practice initiative from the Difference Matters project and the outcomes from the questionnaire.

3.5 A summary of the outcomes from this reflection and planning exercise demonstrate that the trust has made good progress against all 8 principals and much of this progress has formed the content of the twice-yearly reports to PERC and Public Board.

3.6 It will be important to ensure that good progress achieved, so far, against the 8 principles is maintained going forward. It should also be noted that there are 5 key areas identified and detailed within the attached document where additional focus and activity will be required to meet the requirements of all 8 principals, they are:

- Identifying where detriment may occur for members of staff who speak up and addressing this where it exists, through education and increasing awareness amongst our staff
- Improved working links for FtSU up with the trust's Organisational Development and Diversity, leads, agendas and workplans.
- Improving communication, particularly in relation to sharing good news stories and learning, regularly with all our staff.
- Increasing the trust's participation rate with the 3 national training modules, Speak Up, Listen Up and Follow Up.
- Identifying and overcoming the barriers that stop staff from speaking up.

4. Risks

4.1 It is considered that the FTSU arrangements are within the existing risk appetite and no specific risks need to be acknowledged or captured on the risk register.

5. Recommendation

5.1 The Board is provided with this report as assurance on the progress FtSU has made, so far at West Herts and to approve the formation of the related action plan, which will be focussed on the activity required to close the gaps identified for the service through the tool. The actions identified from this exercise will form part of the FtSU strategy and associated workplan.

Name of Director Andrew McMenemy, Chief People Officer

Date: 4th May 2023

APPENDICES:

Appendix one – Blank copy of Reflection and Planning tool

National Guardian
Freedom to Speak Up

NHS

Freedom to Speak up

A reflection and planning tool

Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable othersin your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide

What to do

- Using the scoring below, mark the statements to indicate the current situation.

  1 = significant concern or risk which requires addressing within weeks

  2 = concern or risk which warrants discussion to evaluate and consider options

  3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

  4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

  5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	
I have led a review of our speaking-up arrangements at least every two years	
I am assured that our guardian(s) was recruited through fair and open competition	
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	
I am regularly briefed by our guardian(s)	
I provide effective support to our guardian(s)	
Enter summarised commentary to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	
I am confident that the board displays behaviours that help, rather than hinder, speaking up	
I effectively monitor progress in board-level engagement with the speaking-up agenda	
I challenge the board to develop and improve its speaking-up arrangements	
I am confident that our guardian(s) is recruited through an open selection process	
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	
I am involved in overseeing investigations that relate to the board	
I provide effective support to our guardian(s)	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	
We regularly and clearly articulate our vision for speaking up	
We can evidence how we demonstrate that we welcome speaking up	
We can evidence how we have communicated that we will not accept detriment	
We are confident that we have clear processes for identifying and addressing detriment	
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	
We regular discuss speaking-up matters in detail	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)	
1	
2	

Statements for the person responsible for organisational development	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	
We support our guardian(s) to make effective links with our staff networks	
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about how much time the guardian(s) has to carry out their role	Score 1–5 or yes/no
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	
We have reviewed the ringfenced time our Guardian has in light of any significant events	
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	
We can evidence that our staff know how to find the speaking-up policy	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about how speaking up is promoted	Score 1–5 or yes/no
We have used clear and effective communications to publicise our guardian(s)	
We have an annual plan to raise the profile of Freedom to Speak Up	
We tell positive stories about speaking up and the changes it can bring	
We measure the effectiveness of our communications strategy for Freedom to Speak Up	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office and Health Education England training	
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	
Our HR and OD teams measure the impact of speaking-up training	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	
All managers and senior leaders have received training on Freedom to Speak Up	
We have enabled managers to respond to speaking-up matters in a timely way	
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	
We use triangulated data to inform our overall cultural and safety improvement programmes	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about learning for improvement	Score 1–5 or yes/no
We regularly identify good practice from others – for example, through self-assessment or gap analysis	
We use this information to add to our Freedom to Speak Up improvement plan	
We share the good practice we have generated both internally and externally to enable others to learn	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	
Our guardian(s) has been trained and registered with the National Guardian Office	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	
Our guardian(s) has access to a confidential source of emotional support or supervision	
There is an effective plan in place to cover the guardian's absence	
Our guardian(s) provides data quarterly to the National Guardian's Office	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about our speaking up process	Score 1–5 or yes/no
Our speaking-up case-handling procedures are documented	
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	
We are assured that confidentiality is maintained effectively	
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	
We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	
We know who isn't speaking up and why	
We are confident that our Freedom to Speak Up champions are clear on their role	
We have evaluated the impact of actions taken to reduce barriers?	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about detriment	Score 1–5 or yes/no
We have carried out work to understand what detriment for speaking up looks and feels like	
We monitor whether workers feel they have suffered detriment after they have spoken up	
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	
Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	
We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	
Our improvement plan is up to date and on track	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	
Our plan follows a recognised 'plan, do, study, act' or other quality improvement approach	
Our speaking-up arrangements have been evaluated within the last two years	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about assurance	Score 1–5 or yes/no
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	
We have we evaluated the content of our guardian report against the suggestions in the guide	
Our guardian(s) provides us with a report in person at least twice a year	
We receive a variety of assurance that relates to speaking up	
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Stage 2: Summarise your high-level development actions for the next 6 – 24 months

Development areas to address in the next 6–12 months	Target date	Action owner
1		
2		
3		
4		
5		
6		
7		
8		

Development areas to address in the next 12–24 months	Target date	Action owner
1		
2		
3		
4		
5		
6		
7		
8		

Stage 3: Summary of areas of strength to share and promote

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner
1		
2		
3		
4		
5		
6		
7		
8		

West Hertfordshire Teaching Hospitals NHS Trust

Trust Board Meeting
4 May 2023

Title of the paper	**EPR optimization**
Agenda Item	**22**
Presenter	**Paul Bannister, Chief Information Officer**
Author(s)	**Paul Bannister, Chief Information Officer** **Sean Gilchrist,Director of Digital Transformation**
Purpose	For approval: For discussion: For information: X
Executive Summary	This paper summarizes the current and future activities in the EPR optimization program.
Trust strategic aims: *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1 Best care** — ***Objectives 1-4*** **Aim 2 Great team** — ***Objectives 5-8*** **Aim 3 Best value** — ***Objective 9*** **Aim 4 Great place** — ***Objective 10-12*** Aim 1: Aim 2: Aim 3: X Aim 4: X
Links to well-led key lines of enquiry	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☒Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues and performance? ☒Is appropriate and accurate information being effectively processed, challenged and acted on? ☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☒Are there robust systems and processes for learning, continuous improvement and innovation? ☒How well is the trust using its resources?

Previously considered by	

Committee/Group	Date
GPC	20 April 2023
TMC	27 April 2023

Action required:	For information only

West Hertfordshire Teaching Hospitals NHS Trust

Agenda item: 22

Trust Board Meeting – 20 April 2023

EPR optimization report

Presented by: Paul Bannister, Chief Information Officer

1. Purpose

1.1 The purpose of this report is to update the committee on Electronic Patient Record (EPR) improvement and optimization programme.

2. History & Context

2.1 On the 23rd December 2020 the Trust signed a ten year contract with Cerner Limited for the provision of an EPR solution (Cerner Millenium)

2.2 The solution incorporated a shared instance with the Royal Free London, enabling the Trust to reduce its implementation time and reduce cost. The Trust procured the following functionality:

Solution Scope	Royal Free			West Hertfordshire		
	CFH	BH	RFH	WGH	HHH	SACH
Patient Administration System (PAS)						
Clinical Documentation – IP (doctors, nurses, AHPs)						
Clinical Documentation – OP (doctors, nurses, AHPs)						
FirstNet (ED Solution)						
Critical Care						
Maternity						
Fetalink						
Electronic Prescribing and Medications Administration						
Theatres						
Anaesthesia						
Order communications						
Powerchart ECG						
Integrated devices						
Capacity Management						
Powertrials (research)						
Patient Portal						
Health Information Exchange (HIE)						

2.3 Post the Contract signing, the Trust decided not to deploy Maternity and Fetal link, instead deciding to opt for the Badgernet solution, however we managed to re-negotiate elements of the contract to purchase additional solutions, including critical care and digital dictation.

2.4 Cerner Millenium went live in the Trust on 28th November 2021 with all solutions implemented other than integrated ECGs and pathology Order Communications. Integrated ECGs are now love and we decided to delay the go-live of Patient Portal until the enhanced Zesty portal was available, this is also now live.

3.0 Why did we implement an EPR

3.1. The EPR Full Business Case (FBC) highlighted a compelling rational for implementing an EPR, including:

- Improving the safety and quality of patient care with greater visibility of clinical information in one place at the point of care
- Improving the safety and quality of patient care by enabling tracking of pathways and reducing unwarranted variation in provision of care and associated outcomes
- Developing new models of care by enabling clinicians, patients and service users to interact with their health information and care in a way that paper systems don't allow
- Alignment with the Trust's digital strategy and Acute Redevelopment plans

- Alignment with the National minimum Digital foundations
- Alignment with the Greener NHS Programme
- Improved patient experience
- Enabling the Trust to have a greater understanding of its operational efficiency
- Providing better data driven decision making tools for clinical staff

4.0 What do we mean by EPR optimization

4.1 A well implemented and optimised EPR improves patient safety, staff satisfaction, patient flow and data quality. But this can only be achieved with continuous optimisation and investment. A poor EPR implementation, followed by a lack of investment in its ongoing development, can frustrate staff and create disillusionment. This in turn leads to poor usage and unsafe workarounds. In time this will negatively impact productivity and result in substandard data informing clinical decision making.

4.2 The promised benefits set out in the initial business case will only be achieved if a concerted effort is sustained to optimise the EPR over the life cycle of the contract. Other organisations who implemented an EPR before WHTH have said that the real benefits of an EPR may take five years or more to be fully realized, we are only 1 year into this journey.

4.3 Optimisation is a continuous process which improves an EPR's usability and functionality over time. This may include adding features to the EPR. But it is just as likely to mean removing features, making it simpler and easier to use. Whatever changes we make optimisation is ultimately about a usable system that makes the lives of staff easier and helps manage change on the basis of data insights.

4.4 Rather than thinking of optimisation in terms of functions and features, it may be more helpful to think of it through the lens of quality and improvement. Improving the EPR means improving the experience of those who use it every day.

4.0 What does good optimization look like

4.1 Effective optimisation has a number of features and will incorporate small tweaks and large changes, it will be about fixing errors and scaling what works but typically it will incorporate:

- Commitment to change and leadership from the board down
- An organizational development mechanism that promotes digitally enabled change and integrated Cerner first solutions
- A clear change process, allied to good decision making governance
- Significant engagement of and leadership from the clincal workforce
- Joint teams of clinical, operational and digital staff

- Good supplier relationships
- Sufficient resources in place to deliver the change
- Increasingly standardised ways of working

5. What is the current focus of the optimization team

5.1 There are a large number of EPR projects / change requests in flight, including but not limited to:

- Pathology Order Communications
- Re-launch of Capacity Management / live bed state (and the control centre)
- Launch of Digital Dictation / Voice recognition
- Virtual hospital physiological monitoring
- Infusion pump integration
- Point of Care Device Integration (Blood Gas analysers)
- Wifi blackspot troubleshooting
- Correct data capture at source

6. Longer term optimization

6.1 Longer term optimization is about reaching the full potential of what an EPR is able to deliver for high quality and safe clinical care while making the EPR as easy as possible to use. This will likely incorporate building cross profession improvement teams rather than the current project delivery and will include the following features:

- Greater integration with the patient portal (and the therefore the NHS app) enabling patients to access more information and communicate more effectively with their healthcare team driving more self care, education and prevention
- A more systematic approach to understanding and utilizing the increased depth of data captured in the system, both to aid performance and efficiency but also to support clinical initiatives, research and learning
- Increased sharing of WHTH clinical information with system partners via the Health Information Exchange (another Cerner platform)
- Increased standardization of administration processes, including automation and robotics to reduce the human time requirement
- Increased standardizarion of clinical pathways with the digitization of Clinical Practice

Groups

7. Further considerations

7.1 The Trust is becoming increasingly reliant on digital solutions. This means we need to think differently about how we manage certain activities and crucially how we manage change.

7.2 We are in the process of reviewing our digital road map and strategy and governance ensuring this is all correctly aligned with the resources available and the culture and training available in the organization to ensure we extract the most value out of the EPR but also the other digital investments we have made in recent times and the new hospital on the horizon.

7.3 This review will be incorporated into the upcoming strategy refresh.

8. Conclusion / Recommendation

8.1 The committee is asked to note the report for information

NHS
West Hertfordshire Teaching Hospitals
NHS Trust

Trust Board
4 May 2023

Title of the paper	**Combined Strategic Objectives Q4 and Better Care Delivered Differently Priority Projects Year-End Review Report**
Agenda Item	**23**
Presenter	**Toby Hyde, Chief Strategy and Collaboration Officer**
Author(s)	**Laura Bell, Director of Strategy & Integration (Interim)** **Strategy Delivery Office**
Purpose	For approval: For discussion: X For information:
Executive Summary	The purpose of the report is to provide an update to the Board on progress being made on the Strategic Objectives as evidenced by the supporting priority projects in the Better Care Delivered Differently Programme (BCDD). The report outlines the delivery of the Trust's eleven strategic objectives for Q4, and also provides the year-end position for priority projects currently reported through the BCDD programme. **WHTH Board Recommendations** Slide 8 outlines recommendations for priority projects to continue to be reported, through BCDD, into FY23/24. These initial recommendations only incorporate priority projects that are already reported through BCDD and do not include additional projects that are identified through the FY23/24 business planning process, those that were identified in the Clinical Strategy, or additional priorities emerging from the engagement around the strategy refresh. Slide 9 outlines recommendations for priority projects, currently reported through BCDD, which are suggested to be assumed into divisional BAU and reported through their appropriate governance forums moving forward. These identified projects are therefore no longer recommended to be reported as part of BCDD, as they originally have been throughout FY22/23. **The key, strategic objective, highlights in the report are as follows**: Three strategic objectives are on target, and these are reducing inequalities, best value, develop as a learning organisation, and reduce our carbon footprint. One objective is not due to report this quarter (Digital IT & Innovation). The strategic objectives that are not on target are summarised below with supporting detail contained in the main report: **Objective 1 - Resilient Services** • Whilst the ICS Acute Services Strategy has formally agreed by all provider representative CEOs, the overall scope of the Acute Service Strategy project has extended to encompass the development of a delivery model and an associated governance structure. • Our registration to join the NHSE Provider Collaborative Innovators scheme was not accepted. • Work is now ongoing to finalise the delivery plan and governance framework. This was initially delayed due to a lack of supporting programme resource; however additional resource has now been identified. **Objective 2 - Improving Access to care.** • Although the metrics that align to the achievement of the activity plan are below target for Q4 improvements continue to be seen. • There has been a continued improvement in activity rates and the gap between plan and the delivered activity for the 1st OPA and inpatient activity has reduced.

	• Progress has been made on reducing the number of cancer pathways over 62 days and improvement continues month on month. • Despite challenging recruitment for key consultant posts, services have increased utilisation of alternative roles and pursued other initiatives to mitigate this where possible. **Objective 4 - Transforming Services- Virtual Hospital** • The number of patients being onboarded into our VH beds has increased but the activity levels in the VH trajectory have not yet been achieved. • Additional nursing staff have been appointed and training which will allow for more screening, onboarding and monitoring to take place. • A live activity dashboard has been developed and daily occupancy levels are circulated to all VH leads to ensure closer monitoring. **Objective 4 - Transforming Services- Maternity Services.** • Maternity turnover rates have improved from the rates noted in Q3 but midwifery vacancies still remains behind target. Friends & Family Test response rate has seen an overall drop for Q4 but work in ongoing, utilising the ethnicity breakdown data established in Q3, to focus on relevant feedback and achieve the 25% response rate across all patient groups. • WHTH is fully compliant the with recommendations made in Ockenden 1 and are over 90% compliant with Ockenden 2 recommendations. The remaining IEA are on track for completion and impose a low overall risk to the service. • All CQC must and should do's are on track for completion. **Objective 4- Transforming Services- Outpatients** • We currently remain in the national top quartile for follow up ratios. • Patient Initiated Follow Ups (PIFU) remains under target. However, it is noted that our priority is to discharge whenever clinically appropriate rather than move to PIFU to achieve the target. • Referral Assessment services have been set up in several services which are helping to support a greater use of Advice &Guidance services and straight to test. This forms an integral part of our wider transformation work. **Objective 6 – Culture of Inclusion & Diversity** • Our % of BME staff believing that the organisation provides equal opportunities for career progression is currently performing under target. This score has been recorded as higher than the national average but is lower compared to the % of white staff. Work is ongoing to remedy this with leadership programmes being developed with involvement from the EDI lead. • Our WDES indicator score is constant with last year's result but remains below the national average. Work is underway to develop a civility and respect policy, alongside an antibullying toolkit. **Objective 7- Improve Workforce Sustainability.** • Turnover for individuals who leave within their first months has seen a 17.2% reduction by March. Hot spot areas have been identified as HCSW, AHP, Nursing & Midwifery, Clinical Support, Corporate and Women's and Children's. • The new People Plan has officially launched in Q4 and operational groups have been established to focus on recruitment, retention, equality, diversity, inclusion, learning & development, and workforce modelling. • Positive feedback has been received from the new joiner support programme and career development workshops, for all bands, has now commenced. **Objective 10 – New & Refurbished Hospitals** • The potential funding allocation for WHTH is still awaited following the Trust's submission of the Outline Business Case to the New Hospital Programme. • The Pathology and Shrodells enabling schemes are now underway, with the plans for the potential purchase of land continuing to be refined. The land purchase is currently anticipated to be secured during 2023-24.
Trust strategic aims (please indicate which	**Aim 1** **Best care** | **Aim 2** **Great team** | **Aim 3** **Best value** | **Aim 4** **Great place**

of the 4 aims is relevant to the subject of the report)	 **Objectives 1-4** ✓  **Objectives 5-8** ✓  **Objective 9** ✓  **Objective 10-12** ✓
Links to well-led key lines of enquiry	☐Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☐Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues and performance? ☐Is appropriate and accurate information being effectively processed, challenged and acted on? ☐Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☐Are there robust systems and processes for learning, continuous improvement and innovation? ☒How well is the trust using its resources?
Previously considered by	Committee/Group: — Date: Committee/Group: — Date:
Action required	The Board is asked to note the progress made in the delivery of the Trust's strategic objectives and the year-end position of BCDD priority projects. The Board is asked to discuss the recommendations made to ongoing BCDD priority projects reporting into FY23/24.

Combined Better Care Delivered Differently Year-End & Strategic Objectives Q4 Report

The sequencing of this report is strategic objectives delivery, followed by year-end review of the supporting priority projects (Better Care Delivery Differently)

Contents

Introduction

Our vision is to deliver the very best care for every patient, every day. The five year Trust Strategy set in 2020 describes how we will achieve this, through the delivery of our four ambitions of Best Care, Best Value, Great Team and Great Place.

Every two years the Trust agrees a set of objectives and the priority plans that will help us realise our vision. Refreshed in 2022, this second cycle of strategic objectives reflect a complex and challenging set of circumstances post covid. Delivery of our strategic objectives will ensure we have addressed both the immediate challenges and our long term direction, to give us the confidence that we are taking the right steps towards our new future.

The main body of the report includes the delivery status of the trust's strategic objectives and the year-end review of priority projects under Better Care Delivered Differently (BCDD) programme, providing assurance of the progress being made. The following report provides a concise summary of all year-end review returns, the full year-end review reports can be found in Appendix 1.The overall RAG ratings for our strategic objectives are noted below:

Strategic Objective		RAG
1	Resilient Services	AMBER
2	Improving Access to Care	AMBER
3	Reducing Inequalities	GREEN
4	Transforming our Services (VH)	AMBER
	Transforming our Services (Maternity)	AMBER
	Transforming our Services (Outpatients)	AMBER
5	Best Value	GREEN
6	Culture of Inclusion & Diversity	AMBER
7	Improve Workforce Sustainability	AMBER
8	Develop as a Learning Organisation	GREEN
9	Digital IT & Innovation	N/A – MEASURES NOT REPORTING IN Q4
10	New & Refurbished Hospital Buildings	RED
11	Reduce our Carbon Footprint	GREEN

Strategic Objectives - Summary

The summary below provides highlights of progress against delivery plan for each strategic objective

Objective 1 – Resilient Services. **Green RAG**
The ICS Acute Services Strategy has been formally agreed by all representative organisation CEOs. Work is ongoing to finalise the delivery plan and the associated governance framework. Additional programme resource has been identified from East and North Hertfordshire NHS Trust to support the additional work required. A formal Acute Provider Collaboration Governance Group has been established.

Objective 2 - Improving Access to Care. **Amber RAG**
There has been continued improvements in Q4 activity rates and the gap between plan and delivered activity for 1st OPA and inpatient activity has reduced. The Trust exited the NHSE tiering structure, for cancer, in Q3 and was de-escalated from Tier 1 for elective activity. The increase in cancer referrals above the 2019/20 baseline has continued, as has the demand for more complex diagnostics. Progress has been made on reducing the number of cancer pathways and progress continues month on month. Recruitment to some key consultant posts remains challenging but services have increased utilisation of alternative roles and pursued other initiatives to mitigate wherever possible.

Objective 3 – Reducing Inequalities. **Green RAG**
EDS Domain 1 (Commissioned Services): This was not submitted alongside the report for Domain 2 & 3, in line with national guidance for 23/24. EDS is a contractual requirement and for Domain 1, three services will be reviewed noting that we need to do this in partnership with ICB colleagues as part of a system delivery. EDS Domain 2 (Workforce, Health and Wellbeing) and EDS Domain 3 (Inclusive Leadership): The full EDS outcome report was developed and shared at TMC, PERC and Board. The full report is uploaded onto the WHTH website. Co-Production: A meeting of the Co-Production Board took place on 23rd February and work is ongoing to develop a stakeholder reference group and associated workstreams.

Objective 4 – Transforming Our Services -Virtual Hospital (VH). **Amber RAG**
Have increased the number of patients being onboarded into VH beds but we have not achieved the activity levels in the VH activity trajectory, which was approved in January 2023. A communications plan has been created to increase the level of referrals to VH from primary care and a VH Operational Plan is planned to be approved in April 2023 and implemented immediately to increase overall VH activity in SWH. The COPD and HF pathways are increasing their capacity usage and have their highest number of patients in VH since commencement. The Frailty VH pathways is in its implementation stage and the Diabetes VH pathways Business Case is currently in its' final stages of completion. In addition, other VH pathways are also in development, which include Gallbladder and Children and Young People.

Objective 4 – Transforming our services – Maternity. **Amber RAG**
All improvement roles, as recommended by the national team and Ockenden have been recruited into. There is ongoing strong collaboration with the ICB, LMNS and WHTH. WHTH is fully compliant with Ockenden 1 and are currently over 90% compliant with Ockenden 2. The remaining IEA are on track for completion and impose a low risk to the service. All noted CQC must and should do's are on track for completion, as well as all overdue reports and all opened Datix requests.

Objective 4 – Transforming our services - Outpatients. **Amber RAG**
Our current priority is to discharge whenever clinically appropriate rather than move to PIFU to 'hit the target but miss the point'. PIFU is currently being rolled out at pace across the specialties who are not currently using it. Recording errors on EPR have been rectified and services not reporting on EPR have now moved over to this system, except for Physiotherapy and Virtual Fracture Clinic. Support work has begun (February 2023) with the regional Digital Elective Care team to increase virtual uptake. Additionally, opportunities are being explored for patient engagement in the outpatient transformation work to manage expectations around face-to-face appointments.

Strategic Objectives – Summary (continued)

Objective 5 – Best Value. Green RAG

The trust is reporting a break-even position of income over expenditure at the end of Q4, which was in line with the forecast position. Due to operational pressures, there has been a delay to the number of business case evaluations reported to TMC and FPC. The % of monthly phased efficiency targets met by recurrent cash release has been met for all reported quarters.

Objective 6 – Culture of inclusion and diversity. Amber RAG

We have achieved our highest response rate of 50.3% (2.612 responders), with a 1.3% increase from 2021. Work is underway to implement a recognition platform for the Trust to enable more positive feedback, peer to peer support, messages from senior leadership, and notification of key events. We have seen a 4% drop, from 2021, in 'would you recommend your organisation as a place to work' this is an area of concern as it relates to overall staff experience and therefore influences our staff recruitment and retention.

Objective 7 – Improve workforce sustainability. Amber RAG

Turnover for those who leave within their first 12 months increased slightly in February but a reduction of 17.2% has been seen in March. The new People Plan was launched in Q4, aligned to the People Promise themes and informed by the four key strategic drivers. Flexible working and career development and progression will be priorities in the coming year, as well as continuing to improve the new joiner experience. There is a continued emphasis on staff well-being with events planned throughout the year.

Objective 8 – Develop as a learning organisation. Green RAG

An overhaul of the leadership programme content has commenced. The number of available coaches has not increased as intended as it was necessary to cancel the coach training session in Q1 due to winter pressures. There are three coach sessions now scheduled in Q1 23/24 to remedy the shortfall.

Objective 9 – Digital IT & innovation. No RAG, Measures not reporting in Q4

No update.

Objective 10 – New and Refurbished Hospital Buildings. Red RAG.

WHTH still awaits feedback from the New Hospital Programme (NHP). The redevelopment team, in the interim, have supported work by NHP to inform their overall approach and continue to host site visits with a variety of key stakeholders. Construction work for additional beds in Shrodells and the essential services Pathology lab is now underway, and plans for the potential purchase of the required land continue to be refined. Additionally, as part of the Planned Care sites, work is progressing well to provide additional surgical capacity at St Albans and work is well underway to temporarily relocate the fracture clinic at St Albans to support the Community Diagnostic Centre.

Objective 11 – Reduce our carbon footprint. Green RAG

Three projects to reduce single use items are well underway which include the reduction of non-sterile gloves, a return and reuse walking aids scheme and the move to reusable theatre caps. The LED lighting project official began in January 2023 and the project anticipates conclusion in Q1 23/24. The communication plan, to support awareness of the WHTH Green Plan, continues to be rolled out however, due to funding constraints, the previously considered 'Big Green Week' did not proceed but remains in consideration for late Q1 23/24.

BCDD Projects - Project Lifecycle Stage and End of Year RAG

The tables below and on slide 7 outline the project lifecycle stage and their Overall RAG rating for each project within Better Care Delivered Differently*.

Completed/Not Reported (7)			
Programme	**Ref**	**Project**	**Overall RAG rating**
Best Care	P1.2	ICS Acute Services Strategy	**COMPLETED**
	P1.4	Remove same day multi-site pathways – Breast	**COMPLETED**
Personalised Care	P3.1	Equality Delivery System Review	**COMPLETED**
Transforming Outpatients	P5.1	Modernise our patient communication and booking process	**COMPLETED**
Redevelopment	P8.1	Outline Business Case for the Redevelopment	**Reported separately to GPPB monthly, via SRO update**
	P8.3	Expand the bed base and reinstate ringfenced beds	**Closed – Reported through P8.2 (Business Case for Enabling Works)**
	P8.5	Implement the Green Plan	**Reported separately to GPPB quarterly, via programme update**

Delivery (15)			
Programme	**Ref**	**Project**	**Overall RAG rating**
Best Care	P1.1a	SMART Cardiology	**GREEN**
	P1.1b	SMART Respiratory	**AMBER**
Integrated Care	P2.1	Virtual Hospital (Phases 1-3) and Virtual Ward Expansion (P2.2)	**AMBER**
	P2.3	Discharge to Assess	**GREEN**
	P2.5	Respiratory Transformation	**AMBER**
	P2.7	Advanced Care Plans	**GREEN**
Consistent Care	P4.1	Clinical Practice Group	**GREEN**
	P4.3	GIRFT (Getting It Right First Time)	**GREEN**
	P4.5	Multi-Year Efficiency (MYE) Programme	**AMBER**
Transforming Outpatients	P5.2	Implement patient initiated follow-ups	**AMBER**
	P5.3	Advice and guidance services	**GREEN**
	P5.4	Non face to face outpatient attendances	**AMBER**
People/Workforce	P6.6	Establishment of Career Coaching Service	**GREEN**
Redevelopment	P8.2	Business Case for the Enabling Works	**GREEN**
	P8.4	Expansion of Diagnostic Services at SACH	**GREEN**

*The tables above excludes the digital programme projects. Digital projects are reported monthly as part of the digital progress report to the GPPB, which includes updates against the most significant projects

BCDD Projects - Project Lifecycle Stage and End of Year RAG

The tables below and on slide 6 outline the project lifecycle stage and their Overall RAG rating for each project within Better Care Delivered Differently*.

Implementation Planning (6)			
Programme	**Ref**	**Project**	**Overall RAG rating**
Best Care	P1.6	Improve our services for pregnant women	**AMBER**
Consistent Care	P4.4	Pre-Covid Levels of Efficiency	**AMBER**
People / Workforce	P6.1	Develop an overarching EDI Group	**GREEN**
	P6.2	To support workforce modelling plans across the trust and at a divisional level	**AMBER**
	P6.3	Review of the Learning & Development structure	**AMBER**
	P6.4	The development of clear action plans with the national staff survey	**GREEN**

Project Scoping / Initiation (2)			
Programme	**Ref**	**Project**	**Overall RAG rating**
Personalised Care	P3.2	Promote inclusion across our services	**GREEN**
People/ Workforce	P6.5	Appoint retention lead	**In scoping stage**

Planning (6)			
Programme	**Ref**	**Project**	**Overall RAG rating**
Best Care	P1.1c	SMART Gastroenterology	**AMBER**
	P1.3	Development of an elective system hub	**GREEN**
	P1.5	Remove same day multi-site pathways (Urology)	**AMBER**
Integrated Care	P2.4	Frailty	**GREEN**
	P2.6	Proactive management of patients with multiple Long-Term Conditions (LTCs)	**AMBER**
Consistent Care	P4.2	Theatre Productivity Improvement Programme	**AMBER**

*The tables above excludes the digital programme projects. Digital projects are reported monthly as part of the digital progress report to the GPPB, which includes updates against the most significant projects

BCDD Projects – FY23/24 Recommendations 1 of 2

Priorities reporting to GPPB will include those that carry forward, those that are identified to deliver refreshed strategic objectives, those that were in plan from the Clinical Strategy (years 3-5) and any emerging from business planning.

Priority Projects to Continue into FY23/24	Recommendation
• P1.2: Acute Services Strategy	P1.2: Initial deliverables completed; scope of project increased
• P1.3: Elective System Hub	P1.3: To continue
• P1.5: Remove Same Day Multi-Site Pathways (Urology)	P1.5: To continue
• P1.6: Improve our Services for Pregnant Women	P1.6: Project description to be reviewed with SRO
• P2.1/2.2: Virtual Hospital & Virtual Ward Expansion	P2.1/2.2: To continue
• P2.4: Frailty Transformation	P2.4: To continue
• P2.5: Respiratory Transformation	P2.5: To continue
• P2.6: Multiple Long-Term Conditions	P2.6: To continue
• P3.1: Equality Delivery System	P3.1: To continue
• P3.2: Promote Inclusion Across our Services	P3.2: Project description and scope to be reviewed with SRO
• P4.1: Clinical Practice Groups	P4.1: To continue
• P4.2: Theatre Productivity Programme	P4.2: To continue
• P8.2: Business Case for the Enabling Works	P8.2: To continue
• P8.4: Expansion of Diagnostic Services at SACH	P8.4: To continue
• P8.5: Implement the Green Plan	P8.5: Project scope and reporting to be reviewed with SRO

BCDD Projects – FY23/24 Recommendations 2 of 2

At the time of writing, and noting for the Board's attention, the following priority projects are suggested to be assumed into divisional BAU and reported through appropriate governance. Please note that this is an initial recommendation is pending discussion and agreement with associated SROs.

Programme 1: Best Care
P1.1: SMART
P1.4: Remove Same Day Multi-Site (Breast)

Programme 2: Integrated Care
P2.4: Frailty Transformation
P2.5: Respiratory Transformation
P2.6: Long Term Conditions

Programme 4: Consistent Care
P4:1 Clinical Practice Groups
P4.2: Theatre Productivity Improvement

Programme 5: Transforming Outpatients
P5.1: Modernise our Patient Communications
P5.2: Implement PIFU
P5.3: Advice & Guidance Services
P5.4: Non F2F Outpatient Attendances

Programme 6: People/Workforce
P6.1: Develop an Overall EDI Group
P6.2: Support Workforce Modelling
P6.3: Review of L&D Structure
P6.4: Clear Action Plans for Staff Survey
P6.5: Appoint Retention Lead
P6.6: Establishment of Career Coaching

Strategic Objective 1: Best Care – Resilient Services (Q4 2022-23)

A

Objective 1
Identify services where demand, activity or workforce challenges create fragility and strengthen these through internal reorganisation or working with hospital partners, leading to improved patient outcomes

		Targets				
Success measures	Baseline	Q1 2022-23	Q2 2022-23	Q3 2022-23	Q4 2022-23	RAG
Agreement of acute strategy across three trusts and ICS	-		X			C
Set new measures based on actions from the strategy	-		X			A
Develop Delivery Plan	-			X		A

Q4 Narrative

Agreement of acute strategy across three trusts and ICS: ICS Acute Services Strategy has been formally agreed by all CEOs (November 2022). The overall scope of the project was extended, following submission of the strategy, to encompass the development of a delivery model and associated governance structure. Progress is formally noted under SM3 'Develop Delivery Plan'.

Set new measures based on actions from the strategy: Our registration of interest was submitted to join NHSE Provider Collaborative Innovators Scheme (December 2022). The registration of interest was not accepted.

Develop Delivery Plan: Work is ongoing to finalise the delivery plan and the governance framework. Additional programme resource has been identified from East and North Hertfordshire NHS Trust to support the additional work on the delivery plan. A formal Acute Provider Collaboration Governance Group has been established to support the development of the governance piece.

Strategic Objective 1: Best Care – Resilient Services
BCDD Delivery (FY22/23 Year-End Narrative)

How we will deliver it	BCDD programme
• Develop & agree an ICS Acute Services Strategy which identifies priority areas for action	Programme 1 – Best Care
• Implement the agreed action plan	Programme 1 – Best Care
• Implement high priority actions defined through Getting it Right First Time (GIRFT) report	Programme 4 – Consistent Care

Ref.	Project Name	RAG
P1.2	Acute Services Strategy	C
P4.3	GIRFT (Getting It Right First Time) Reviews	G

FY22/23 Year-End Narrative

Acute Services Strategy

This project is complete in the literal sense in that the strategy document has been delivered and fully ratified. However, the scope of the project has now been extended to develop a delivery model and governance structure. There is clearly appetite to work together to deliver the outcomes, with the delivery of the agreed strategy being a strong outcome and evidence of this. Relationships have developed across the 3 acute teams. Lessons learned include a willingness to work together in a supportive way, multiple opportunities for collaboration exist that will deliver improved outcomes, and that dedicated resource is needed to deliver the overall strategy and continue positive work.

GIRFT

New GIRFT clinical lead in post. Regular team meetings scheduled to take work forward.

Strategic Objective 2: Best Care – Improving access to care (Q4 2022-23)

A

Objective 2
Recover waiting times in line with national standards by increasing diagnostic capacity and elective activity
Encourage patients and staff to embrace digital technology to help people access healthcare

				Q1 2022-23				Q2 2022-23				Q3 2022-23				Q4 2022-23			
Data Source	Success measures		Baseline (Mar22)	Target	Act	Var	RAG	Tar	Act	Var	RAG	Tar	Act	Var	RAG	Tar	Act	Var	RAG
Activity Tracker	**Achieve agreed activity plan** *(set in line with national expectations relating to the recovery of elective activity)*	Outpatient 1st OPA rate	71.2%	110%	73.9%	-36.1%	A	110%	88%	-23%	A	110%	94%	-16%	A	110%	97%	-13%	A
		Outpatient follow up activity reduction	77.9%	by 25%	15.1%	-9.9%	A	75%	75.6%	0.6%	A	75%	81.5%	6.5%	A	75%	86.4%	11%	A
		Diagnostic activity rate	95.3%	120%	94.6%	-25.4%	A	120%	96.7%	-23.3%	A	120%	94.6%	-25.4%	A	120%	105.7%	-14%	A
		Inpatient activity rate	75.8%	110%	73.%	-37.0%	A	110%	77.7%	-32.3%	A	110%	81.7%	-28.3%	A	110%	99.7%	-10%	A
IPR	**Reduction in RTT waiting times** (*excl patient choice*)	104 week waits	27	0	2	2	A	0	3	3	G	0	0	0	G	0	1	1	A
IPR		78 week waits	111	143	143	0	G	116	116	0	G	78	68	-10	G	0	12	12	A
IPR	**Reduction in Cancer waiting times**	63+ day waits (*excl patient choice*)	376	262	345	83	A	286	297	11	A	244	200	-44	G	202	160	-42	G

Q4 Narrative

Activity plan: There has been continued improvement in activity rates Q4 and the gap between plan and delivered activity for 1st OPA and inpatient activity has reduced. Service changes including commissioning decisions mean that activity included in the baseline is no longer being undertaken, e.g. simple cataract extraction, flexible sigmoidoscopy, and some activity is now recorded differently, but correctly in Cerner and as a result is excluded. However, the position remains lower than plan in most areas. Work to resolve issues with capture of activity has progressed well and most issues are now resolved - with the Trust having established a Data Quality Group to address any further issues.

RTT & Cancer Waiting times: The Trust exited the NHSE Tiering structure altogether for cancer in Q3 and was de-escalated from Tier 1 for elective activity. The pressures of urgent and emergency care increases experienced towards the end of Q3 have continued into Q4 and have been further exacerbated by Junior Doctor Industrial Activity. Good progress has been made on validation of the RTT PTL, supported by an external provider, although in March 2023 the Trust experienced a large increase in the number of RTT Clock Starts. One patient was reported with a waiting time over 104 weeks, the result of an incorrect clock stop much earlier in the pathway, which on correction resulted in a very long wait time being reported. Of the 12 pathways reported (excl patient choice) over 78 weeks, 5 can be excluded as these are incorrect and will be removed. Patient initiated delays and case complexity have influenced 5 pathway wait times and as described for the 104 week wait, 2 further pathways had clock stop corrections resulting in a wait in excess of 78 weeks.

Cancer waiting times: The increase in cancer referrals above the 2019/20 baseline has continued, as has demand for more complex diagnostics. Excellent progress has been made on reducing the number of cancer pathways over 62 days and improvement continues month on month. Recruitment to some key consultant posts remains challenging but services have increased utilisation of alternative roles and pursued other initiatives to mitigate this wherever possible. Additional clinics and theatre sessions continue to supplement core capacity although at a lower level than pre-COVID and the outsourcing of more routine work to the independent sector frees up in house capacity for more the complex, urgent caseload.

Strategic Objective 2: Best Care – Improving access to care
BCDD Delivery (FY22/23 Year-End Narrative)

How we will deliver it	BCDD programme
• Implement the recommendations from the Attain report to increase theatre utilisation	Programme 4 – Consistent Care
• Deliver our outpatient transformation programme	Programme 5 – Transforming Outpatients
• Increase the diagnostics capacity at SACH and HHH in line with the national community diagnostics centre programme	Programme 1 – Best Care

Ref.	Project Name	RAG
P1.3	Development of an elective system hub	G
P4.2	Theatre Productivity Improvement Programme	A
P4.3	GIRFT (Getting It Right First Time) Reviews	G
P4.4	Pre-Covid-19 levels of Efficiency	A

Ref.	Project Name	RAG
P5.1	Modernise our patient communication and booking processes	G
P5.2	Implement patient initiated follow-ups	A
P5.3	Advice and guidance services	G
P5.4	Non face to face outpatient attendances	A

FY22/23 Year-End Narrative

Development of an elective system hub

Stage 2 design complete. Short Form Business Case has been submitted to NHSE/I and further Key Lines of Enquiry have been responded to. Contractor appointments and PCSA have commenced, and the planning application has been compiled and submitted to the town council.

Theatre Productivity Improvement Programme

Have completed four workshops and draft implementation plans across 6 workstreams. All workstream clinical leads have now been identified and have signed up to chair their respective working groups. One working group has now commenced with its first session and a follow up workshop is diarised. Four of the workstreams currently remain in the planning phase due to a reconfiguration of the original project plan and resourcing. Further workshops and working group launches are being planned for mobilisation in the upcoming months.

Pre-Covid 19 levels of Efficiency

Covid expenditure to not exceed the 22/23 funding envelope has been achieved. Elective activity to reach 19/20 level by the end of 22/23 is within the implementation/delivery range. Agreement of the plan for zero Covid funding is currently within the implementation/delivery range. There is a YTD underspend of £2.1m as at M11 reporting 22/23, this has been achieved through robust budgetary management and expenditure control mechanism. Covid expenditure control mechanisms have been a success and have ensured YTD successful delivery of this project element.

Modernise our patient communication and booking process

The patient portal went live on 1st March 2023. There have been over 10,000 users that have registered for the patient portal within four weeks of go live. This project is now under BAY support and the review of the benefits realisation will commence in due course.

Implement PIFU

Good progress has been made on PIFU implementation, but WHTH will not achieve the 5% target by March 2023. The trust is achieving an overall reduction of 25% of follow up activity, which is that target that we are measured against as part of ERF. The current priority is to discharge whenever clinically appropriate rather than move to PIFU. Have implement a full EQIA for PIFU, WHTH are currently live with PIFU in 15 major specialities, WHTH have processes in place that allow patients to be placed on PIFU following a non-F2F attendance, safety netting procedures have been implemented, a WHTH Outpatient Oversight Group has been established, and GIRFT has been used to support the roll out of PIFU.

Advice and Guidance Services

WHTH has consistently achieved above the 16% target for A&G during 22/23. Job planning work is completed in some specialities, a well-established tele-derm service is in place, Straight To Test pathways are in place for several services, currently looking to further expand local SWH pathways on DXS, and there are ongoing educational sessions through GP webinars and locality training events.

Non Face-to-Face Outpatient Attendance

The WHTH VC position has been agreed at an executive level as clinically appropriate. Scoping work has taken place to understand the reasoning behind the F2F attendances at WHTH, clinic templates have been reviewed and amended, patient portal implementation is in progress, areas where non F2F appointments will have the greatest benefit have been agreed, and WHTH attend Anywhere user guides have been developed.

Strategic Objective 3: Best Care – Reducing Inequalities (Q4 2022-23)

G

Objective 3
Reduce health inequalities by completing the Equality Delivery System (EDS) and agreeing an action plan for improvement

	Targets				
Success measures	Q1 2022-23	Q2 2022-23	Q3 2022-23	Q4 2022-23	RAG
Detailed measures to be based on the action plan	Confirm 2 provided services for review. One from the Core20 plus5 and either: 1. Service where data indicates it is doing well 2. Service data indicates improvements are required. 3. Service performance unknown	Complete mapping exercise of networks and groups	Approval of ICS governance and delivery framework	Publish WHTH review in line with the national guidance	G

Q4 Narrative

EDS Domain 1 (Commissioned Services)
This was not submitted alongside the report for Domain 2 & 3, in line with national guidance for 23/24. EDS is a contractual requirement and for Domain 1, three services will be reviewed noting that we need to do this in partnership with ICB colleagues as part of a system delivery.

EDS Domains 2 (Workforce, Health & Wellbeing) & 3 (Inclusive Leadership)
Following review of the collated evidence packs, scores have been obtained by key stakeholders for Domain 2+ 3 along with extensive qualitative feedback that provided further insight. A Trust was identified to 'Peer Review' Domain 3 (Milton Keynes) and was completed. Action plans collaboratively developed with key stakeholders, utilising feedback and comments, and all developments regularly shared at EDI steering group for input and comment. The full EDS outcome report was developed and shared at TMC, PERC and Board. The full report was uploaded on the Trust Website along with the NHS England as per the guidance.

Promoting Inclusion
Co-Production Board meeting took place on 23rd February with key actions noting that additional engagement groups have been identified. Following initial completion of the Project Initiation Document work is ongoing to develop a stakeholder reference group.

Strategic Objective 3: Best Care – Reducing Inequalities
BCDD Delivery (FY22/23 Year-End Narrative)

How we will deliver it	BCDD programme
• Complete and publish EDS3 assessment by January 2023 and set out action plan	Programme 3 – Personalised Care
• Use co-production methodology and increase engagement activity to promote inclusion	Programme 3 – Personalised Care

Ref.	Project Name	RAG
P3.1	Equality Delivery System (EDS) 3 assessment	C
P3.2	Promote inclusion across our services	G

FY22/23 Year-End Narrative

EDS Assessment

The report has been completed and published. From 2023/2024 the contractual requirement in line with NHSE guidance is that all domains are reviewed and scored by all relevant stakeholders and for their feedback to be used to develop action plans. For 2022/23 the report only contained the stakeholder scores for Domain 2 + 3 with proposed scores for Domain 1. EDS is a contractual requirement and for Domain 1, three services will be reviewed noting that we need to do this in partnership with ICB colleagues as part of a system delivery. The report provided a framework to review and develop our services, workforce and leadership. Enabling the development and implementation of meaningful equality objectives, enacting tangible change in an incremental and sustainable way, to produce better experiences and outcomes for those who utilise the service and those who deliver it. It has provided focus and direction to action plan formation and next steps regarding key areas of staff experience as well as increasing engagement with key stakeholders and for them to have the opportunity to shape practices moving forward.

Promote inclusion across our services

Whilst the project is still in the scoping phase of works, significant planning and work has taken place to begin to develop and design the deliverables of the project. The project has been in scoping stage since its inception, during the development of BCDD, however is now close to moving into the planning stage following approval and finalisation of the PID. Key achievements in period include the development of the PID and WHTH representation at the Co-Production Board. Next steps, following finalisation of the PID and project plan, include the development of an overarching stakeholder reference group and associated workstreams that will focus on each of the protected characteristics as identified in the Equality Act (2010).

Strategic Objective 4: Best Care – Transforming our Services (Q4 2022-23)

A

Objective 4
Collaborate with partners in the South and West Herts Health and Care Partnership (SWHHCP) to:

- **Provide as much care and support as possible at patients' homes or in community settings, reducing the need for emergency care and reducing lengths of stay and admissions**
- **Reduce the number of different outpatient appointments that people need to attend, which boosts efficiency, respects our patients' time and reduces our carbon footprint**
- **Improve maternity services and reduce outcome inequalities between different population groups**

***Integrated Care** - Virtual Hospital target to be achieved by January 2024*

			Q1 2022-23				Q2 2022-23				Q3 2022-23				Q4 2022-23			
Data source	Success measures	Baseline (April 2022)	Tar	Act	Var	RAG	Tar	Act	Var	RAG	Tar	Act	Var	RAG	Tar	Act	Var	RAG
Infofl ex	Increase in the number of people treated in the virtual hospital or community services	69	447	105	-342	R	456	77	-379	A	*No longer reported – replaced by below metric*							
Infofl ex	Increase the number of VH beds utilised - to be measured against target in new approved VH activity Trajectory	-									115*	73*	-42	A	176	81.5	-94.5	A
tbc	Increased identification of patients with frailty and reduction in avoidable admissions for patients 65 + with moderate to high frailty scores	tbc	*The framework for metric reporting is being developed.*															

Q4 Narrative

We have increased the number of patients being onboarded into our VH beds, however we have not achieved the activity levels in the VH activity Trajectory approved in January 2023. **VH Status update**: The COPD and HF pathways are increasing capacity usage and have their highest numbers of patients in VH since commencement. Acute Respiratory Infection (ARI) VH step down pathway commenced in March. ARI step up pathway is in implementation stage. Frailty VH Pathway is in implementation stage. Diabetes VH pathway Business Case is in its' final stages of completion. Other VH pathways in development, scoping and planning: Gallbladder, CYP (Children and Young People). Actions taken/planned to increase VH activity in line with VH activity Trajectory approved in January 2023. **VH HUB procedures have been streamlined (e.g.):** ED attendance list is screened in the HUB to increase number of patients identified for admission to VH. Additional nursing staff have been appointed and trained, allowing more screening, onboarding and monitoring to take place. High intensity and Low intensity patients monitoring responsibilities allocated to different staff within VH HUB team to increase monitoring and onboarding capacity also. **Increased monitoring of VH activity:** Development of live activity dashboard. Daily occupancy levels circulated to all VH leads to ensure closer monitoring. **To support the delivery of all pathways in the two approved business cases, 63 roles were identified. Progress:** 28 in post, 5 appointed and 30 advertised, in job 'matching' / JD being finalised.

Comms plan created to increase level of referrals to VH from Primary Care. VH Operational Plan to be approved in April 2023 and implemented immediately to increase VH activity in SWH

Strategic Objective 4: Best Care – Transforming our services (Virtual Hospital)
BCDD Delivery (FY22/23 Year-End Narrative)

How we will deliver it:	BCDD programme
• Deliver the SWHHCP transformation plan and achieve the intended outcomes • Deliver our outpatient transformation programme • Deliver the actions from the Ockenden review and the Better Births report	Programme 2 – Integrated Care Programme 5 – Transforming Outpatients Programme 1 – Best Care

Ref.	Project Name	RAG
P2.1	Virtual Hospital (VH) & Virtual Ward Expansion	A
P2.4	Frailty Transformation	G
P2.5	Respiratory Transformation	A

Ref.	Project Name	RAG
P2.6	Multiple Long Term-Conditions	G
P2.7	Advanced Care Planning	G

FY22/23 Year-End Narrative

Virtual Hospital & Virtual Ward Expansion

COPD VH and Heart Function VH met their planned commencement dates and are operational. Acute Respiratory Infection step down pathway commenced in May and the ARI step up pathway is now in the implementation stage. The Frailty VH pathway is in its implementation stage and the Diabetes VH pathway Business Case is in the final stages of completion. There are additional VH pathways in development, scoping and planning (Gallbladder and Children & Young People). Overall VH activity levels are below planned levels and additional staffing has been recruited to increase overall VH capacity.

Frailty Transformation

The project has moved from initiation to planning, the project scope has been refined in the PID and a detailed project schedule has been completed. Project objectives are aligned to the ICS/ICB plan, the Business Case for Frailty @ Home has been developed and signed off, the governance for the frailty projects/workstreams has been established, the communication plan and strategy document has been developed, and the expected go live for Frailty @ Home is scheduled for May 2023.

Respiratory Transformation

There has been a redesign of the Integrated Respiratory pathways which includes airways, hospital at home and advice line, obstructive sleep apnoea, pulmonary rehabilitation, chest physio, home oxygen service and review, non-invasive ventilation, and TB nursing & BCD vaccination. An overall workforce redesign has been completed and the demand and capacity review has also been completed.

Multiple Long Term-Conditions

Governance for the project has been established, the clinical pathway has been developed, 4 PCNS to participate in the pilot have been identified and selected, patient cohort data has been finalised and consolidated, and work has begun on the development of the business case. This project has moved from initiation to planning.

Advanced Care Planning

The business case has been approved, recruitment has been completed to a dedicated team to undertake ACP in care homes, key performance metrics have been agreed by the HCP Quality Group, 212 ACPS have been completed to date, and an overall evaluation is due to be completed by July 2023. The project is currently delivering against agreed milestones.

Strategic Objective 4: Best Care – Transforming our Services (Q4 2022-23)

A

Objective 4
Collaborate with partners in the South and West Herts Health and Care Partnership (SWHHCP) to:

- **Provide as much care and support as possible at patients' homes or in community settings, reducing the need for emergency care and reducing lengths of stay and admissions**
- **Reduce the number of different outpatient appointments that people need to attend, which boosts efficiency, respects our patients' time and reduces our carbon footprint**
- **Improve maternity services and reduce outcome inequalities between different population groups**

Maternity Services - 4 pillars of Ockenden review ensure sustained continuous safety improvements in Maternity services are effectively monitored.				Q1 2022-23				Q2 2022-23				Q3 2022-23				Q4 2022-23			
Ockenden Review Pillar	Data source	Success measures	Baseline (Mar 22)	Target	Actual	Var	RAG	Target	Actual	Var	RAG	Target	Actual	Var	RAG	Tar	Act	Var	RAG
1: Fully funded safe staffing	HR	Midwifery vacancies	15.6%	15%	16.1%	1.1%	A	15%	19%	4%	A	15%	18%	3%	A	15%	12.6%	-3.4%	A
	HR	Turnover rates (Maternity)	13%	13%	-	-	-	13%	19%	6%	A	13%	19%	6%	A	17%	16.5%	-0.5%	G
2: A well trained workforce	HR	MDT training compliance	90.0%	90.0%	N/A	N/A	N/A	90.0%	90.0%	0%	G	90.0%	94.0%	4.0%	G	90%	90-100%	0%	G
3: Learning from incidents	OD	Launch of Digital Maternity System	Target due Q4 2022-23													**Implemented**			G
	OD	Capacity to complete investigations within timeframes	Target due Q3 2022-23									Metric being developed							
4: Provisions for listening to families more effectively	Patient Experience	Responsiveness to Friends and Family Test (FFT) real time survey	>25% (Survey collection rate)	>25%	9.7%	-15.3 %	A	>25 %	4.0 %	-21%	A	>25 %	13.0 %	-12.0 %	A	>25%	4.7 %	-21. 3%	A
	MVP	No. Families engaged	TBC	In development				In development				In development				In development			

Q4 Narrative

Fully funded safe staffing
All improvement roles as recommended by the national team and Ockenden have been recruited to. This includes a senior project bereavement midwife commenced in January 2023, this post focuses on bereavement services. Both a Maternal Medicine Midwife and a Research Midwife have also been successfully recruited into the team. The Senior Management Team currently has 1wte vacancy (out to advert) and remaining posts have been substantively recruited to. The recruitment process began for an EDI specialist to work cross the LMNS as well as recruitment to an LMNS wide role that encompasses patient safety.

A well trained workforce
There is ongoing strong collaboration with the ICB, LMNS and WHTH. The trust is fully compliant with Ockenden 1 and are currently over 90% compliant with all recommendations that have been made in Ockenden 2. The remaining IEA on track for completion and impose low risk to the service. The maternal medicine network has now been agreed and there is an overarching agreement in place to join a dedicated maternal medicine network. Work is currently ongoing to ensure the service is mapped against the current LMNS equity and equality plan. To support more integrated and digital working a digital maternity system has been fully implemented and working is ongoing, in collaboration with the communications team, to refresh the maternity website.

Learning from incidents
Currently on track with the completion of all CQC must and should do's and on track with the completion of all overdue reports, as well as all opened Datix requests being noted as on track for completion.

FFT
FFT has seen an overall drop for Q4. Work is ongoing, in line with the ethnicity breakdown developed in Q3, to focus on the relevant feedback and to achieve the 25% response rate across all patient groups.

Strategic Objective 4: Best Care – Transforming our services (Maternity)
BCDD Delivery (FY22/23 Year-End Narrative)

How we will deliver it:	BCDD programme
• Deliver the SWHHCP transformation plan and achieve the intended outcomes • Deliver our outpatient transformation programme • Deliver the actions from the Ockenden review and the Better Births report	Programme 2 – Integrated Care Programme 5 – Transforming Outpatients Programme 1 – Best Care

Ref.	Project Name	RAG
P1.6	Improve our services for pregnant women	A

FY22/23 Year-End Narrative

Improve our Services for Pregnant Women

This is an ongoing clinical transformation project, in line with the national maternity agenda. There is currently a strong collaboration between the ICB, LMNS and WHTH. Have implemented immediate and essential actions and we are fully compliant with recommendations from Ockenden 1 and 90% compliant with Ockenden 2. Currently in the process of mapping the service against the LMNS equity and equality plan. The maternal medicine network has been agreed and there is an additional agreement in place to join a dedicated maternal medicine network. Ongoing recruitment has taken place in the team and a maternal medicine midwife, and a research midwife have both been successfully recruited into the team. The digital maternity system has been fully implemented and work is ongoing to refresh the maternity website. On track for the completion of CQC must and should dos and overall refurbishment works have begun.

Strategic Objective 4: Best Care – Transforming our Services (Q4 2022-23)

A

Objective 4
Collaborate with partners in the South and West Herts Health and Care Partnership (SWHHCP) to:

- **Provide as much care and support as possible at patients' homes or in community settings, reducing the need for emergency care and reducing lengths of stay and admissions**
- **Reduce the number of different outpatient appointments that people need to attend, which boosts efficiency, respects our patients' time and reduces our carbon footprint**
- **Improve maternity services and reduce outcome inequalities between different population groups**

			Q1 2022-23				Q2 2022-23				Q3 2022-23				Q4 2022-23			
Data source	Success measures	Baseline (Mar 22)	Target	Actual	Var	RAG	Target	Actual	Var	RAG	Target	Actual	Var	RAG	Tar	Act	Var	RAG
Activity Tracker	Outpatient follow up activity reduction	77.9%	by 25%	15.1%	-9.9%	A	75%	75.6%	0.6%	A	75%	81.5%	6.5%	A	Provided as part of improving access to care metrics			
SUS	Outpatients Discharged After 1st Attendance **	-	-	41.3%	-	G	-	41.6%	-	G	-	39.5%	-	G	-	40.3%	-	G
SUS	Outpatients Follow-Up Ratio **	-	-	1.31	-	G	-	1.34	-	A	-	1.31	-	A	-	1.33	-	A
EROC Submission	Patient initiated Follow Up: Moving or discharging 5% of all outpatient attendances to PIFU pathways by March 2023	0.6% (196)	2.5%	0.87%	-1.63%	R	2.5%	0.71%	-1.79%	R	2.5%	0.19%	-2.31%	R	5%	1.72%	-3.28%	R
EROC Submission	Specialist Advice Requests: Deliver 16 specialist advice requests, including A&G, per 100 outpatient first attendances by March 2023	4.7% (634)	16%	46.38%	30.38%	G	16%	48.76%	32.76%	G	16%	54.32%	38.32%	G	16%	57.04%	41.04%	G
EROC Submission	Ensure that 25% of all outpatient attendances are carried out remotely by March 2023	25%	25%	13.63%	-11.37%	R	25%	13.24%	-11.76%	R	25%	13.62 %	-11.38 %	R	25%	12.89 %	-12.11%	A

Q4 Narrative

There is a high performance in first to follow up ratio's and we remain in the top quartile nationally.
Our priority is to discharge whenever clinically appropriate rather than move to PIFU in order to 'hit the target, but completely miss the point'. PIFU is being rolled out at pace across specialties who are not currently using it. Recording errors on EPR have been rectified and services not reporting on EPR currently have moved over to this system except for Physiotherapy and Virtual Fracture Clinic. This activity has however now been included within the EROC submission for the whole of 2022-23 hence the change in reporting position above for Q1-3. WHTH has now resumed a full EROC submission rather than a partial return. We have multiple enhanced community services that we discharge patients to who would in other ways have been suitable for PIFU.
Referral Assessment Services are set up in several services to help support a greater use of Advice & Guidance and straight to test as part of our wider transformation piece. Consultant Connect has now been commissioned for a further 3 years by the ICB to support A&G. Support work started in February 2023 with the regional Digital Elective Care team to increase virtual uptake (Remote Consultations). Also exploring opportunities for patient engagement in outpatient transformation work to manage patient expectation around face-to-face appointments due to patient fatigue with virtual process. Work underway with outpatient administrative team to ensure correct set up on EPR on a specialty-by-specialty basis.** No national targets set. Monitored internally against ICS HWE providers.

Strategic Objective 4: Best Care – Transforming our services (Outpatients)
BCDD Delivery (FY22/23 Year-End Narrative)

How we will deliver it:	BCDD programme
• Deliver the SWHHCP transformation plan and achieve the intended outcomes • Deliver our outpatient transformation programme • Deliver the actions from the Ockenden review and the Better Births report	Programme 2 – Integrated Care Programme 5 – Transforming Outpatients Programme 1 – Best Care

Ref.	Project Name	RAG
P1.1	SMART	A
P1.4	Remove Same Day Multi-Site Pathways (Breast)	C
P1.5	Remove Same Day Multi-Site Pathways (Urology)	A
P1.6	Improve our services for pregnant women	A

Ref.	Project Name	RAG
P2.3	Discharge to Assess	G

FY22/23 Year-End Narrative

SMART

Respiratory SMART need to identify additional staff into the AM shift. Respiratory SMART is built into job planning and is proposed to be managed as BAU moving forward. Gastro SMART is still ongoing and is proposed to stay open and continue to be managed outside of BAU processes that other SMART services will be moving towards.

Remove Same Day Multi-Site Pathways (Breast)

Breast list is now running at SACH (Tuesday AM) weekly. This enables more patients to engage in the same site pathway and was achieved through a theatre swap with general surgery and the creation of increased theatre capacity through the procedure room at Watford. This project has been noted as completed and all associated benefits have been achieved (reducing patient travel and increase theatre capacity at Watford for colorectal cancer services)

Remove Same Day Multi-Site Pathways (Urology)

This scheme is currently being re-tendered to obtain updated delivery costs. Following updated delivery costs being confirmed the Full Business Case will then be taken to TMC for approval in June 2023 and then to Trust Board for approval in July 2023. Following this approval, the project will then move to mobilisation and delivery, with the expectation that the scheme will be completed inmid-2024. The design of a new clinical unit and adjacent administrative unit has been completed, alongside the completion of the Outline Business Case.

Discharge to Assess

Have set up monthly IDG meetings with partners agreeing workstream priorities. There are currently five ongoing workstreams overseeing specific areas of work rather than a focus on one particular project. These workstreams were agreed at the September 2022 IDG and all are at various stages of delivery. There has been a steady increase in the number of discharges managed by SPOC, a regular DTA Dashboard has been created, and a DTA Model Work Programme has been created to implement a sustainable DTA model over the next 5 years.

Strategic Objective 5: Best Value (Q4 2022-23)

G

Objective 5
Ensure we can meet the health needs of our population within our budget on an ongoing basis.

			Q1 2022-23				Q2 2022-23				Q3 2022-23				Q4 2022-23			
Data	Success measures	Baseline	Tar	Act	Var	RAG	Tar	Act	Var	RAG	Tar	Act	Var	RAG	Tar	Act	Var	RAG
Trust I&E report	Balancing income with expenditure by the end of each financial year	-	Less than 10% adverse variance on budgeted net income	At Q1 the trust is £330k away from plan. This represents an 8% adverse variance.	-8%	A	Less than 10% adverse variance on budgeted net	At Q2 the trust is £44k above plan. This represents a 1% favourable variance	1%	G	Less than 10% adverse variance on budgeted net	At Q3 the trust is £1m away from plan. This represents a 23% adverse variance	-23%	A	Less than 10% adverse var on budgeted net	Break even achieved	£0,3m	G
Trust Board report	Production of updated 10 year LTFM and assumptions	-	Board report issue	Ongoing	-	N/A	Board report issue	Ongoing	-	N/A	Board report issue	Ongoing	-	N/A	Board report issue	Ongoing	Ongoing	N/A
Trust efficiency reports	% of phased efficiency target met by the aggregate of all four efficiency types	-	100%	At Q1 the trust is £469k away from plan. This represents a 41% adverse variance.	-41%	R	100%	At Q2 the trust is £1m away from plan. This represents a 25% adverse variance	-25%	A	100%	At Q3 the trust is £2.3m away from plan. This represents a 26% adverse variance	-26%	A	100%	£2m away from plan. 13% adverse var	£2m	A
Trust efficiency reports	% of monthly phased efficiency target met by recurrent cash release	-	25%	26%	1%	A	25%	38%	13%	G	25%	29%	6%	G	25%	30%	5%	G
TMC and FPC reports	Business case evaluations reported to TMC and FPC	-	1	0	-1	G	2	1	-1	A	2	1	-1	A	2	1	-1	A
Trust Board report	% of annual ERF income earned	-	15%	0%	-15%	R	50%	50%	0%	G	75%	75%	0%	G	100%	100%	0%	G

Q4 Narrative

Balancing income: At the end of Q4 (M12), the trust reports a break-even position of income over expenditure. This was in-line with the forecast expectation.
Production of updated 10 year LFTM: Ongoing.
% of phased efficiency target met by the aggregate of all four efficiency types: Unmet, 87% overall achievement.
% of monthly phased efficiency target met by recurrent cash release: Met for Q1, Q2, Q3 and Q4.
Business case evaluations reported to TMC and FPC: Delayed due to operational pressures, 2 were due in Q3 however 1 was presented.
% of annual ERF income earned: In line with the construct of our financial plan: 75% of ERF funding has been recognised at the end of Q3.

Strategic Objective 5: Best Value
BCDD Delivery (FY22/23 Year-End Narrative 2023)

How we will deliver it	BCDD programme
• A continued focus on a rolling 10 year financial plan • Ensuring that approved funding is accompanied by agreement to measurable benefits and agreement to when benefits take effect • An improved focus on rolling efficiency programme with clarity over whether efficiency interventions deliver: a) recurrent savings compared to base plan, b) non recurrent savings against plan, c) avoidance of otherwise unplanned costs, d) non cash releasing productivity • Continuous evaluation of investment decisions	All programmes will contribute to best value

Ref.	Project Name	RAG
P4.1	Clinical Practice Group (CPG)	G
P4.2	Theatre Productivity Improvement Programme	A
P4.3	GIRFT (Getting It Right First Time) Reviews	G
P4.4	Pre-Covid-19 levels of Efficiency	A

Ref.	Project Name	RAG
P4.5	Multi-year efficiency programme	A
P8.5	Implement the Green Plan	N/A

FY22/23 Year-End Narrative

Clinical Practice Group

9 clinical pathways have been implemented to date (financial year 2022/2023). 3 more pathways are due to be implemented -SDEC DVT, SDEC Headache by April 2023 and CS by May 2023. Two further pathways (Gynae Cancer and CED flow) have been scoped and are undergoing governance process for approval in April 2023. Digitalised one pathway and work in progress to digitalise a further 8 pathways. Facilitated two patient co-production projects -Early pregnancy and Miscarriage. Data migration post Cerner implementation completed ahead of schedule (Legacy pathway redesigning, redevelopment and revalidation). Development of costing strategy in progress. QI strategy refresh-Led with QI lead nurse in engagement and development of QI strategy. Developed patient co-production templates which are now Trust templates for co-production workstreams. Established patient cohort post Cerner implementation for all legacy and new pathways.

Multi-Year Efficiency Programme

The 2022/23 element of the multi-year efficiency programme is forecast to deliver £13.2 million pounds against a planned target of £15 million. This represents 12% under performance. Divisions which struggled to achieve their targets include Women & Children, Surgery and Anaesthetics and Corporate division. These divisions expect to achieve the allocated savings targets for 2024/25. The 2022/23 programme has been an overall success. Key lessons include early engagement to influence behaviours which bring about changes in spend as well as improved links with HCP programmes in order to ensure delivery of cost avoidance schemes.

Strategic Objective 6: Great Team – Culture of Inclusion & Diversity (Q4 2022-23)

A

Objective 6
Create and demonstrate a culture of inclusion and diversity where behaviours are consistent with our values and support the well being of our staff

Success measures reported in Q4, following analysis and completion of the staff survey. No data available for previous quarters.

Data source	Success measures	Baseline	Targets Q1 2022-23	Q2 2022-23	Q3 2022-23	Q4 2022-23	RAG
Staff Survey (*results March 2023*)	WRES Indicator - % of BME staff believing that the organisation provides equal opportunities for career progression or promotion from 50% towards 58% for white staff	50%	n/a	n/a	n/a	48%	R
Staff Survey (*results March 2023*)	WDES Indicator - % of staff with Long Term condition or illness experiencing harassment, bullying or abuse from other colleagues in last 12 months from 26% towards 18% for those staff without LTC	26%	n/a	n/a	n/a	26.1%	G
Staff Survey (*results March 2023*)	Improved Staff Engagement Score in Staff Survey from 6.8 to 7	6.8	n/a	n/a	n/a	6.7	A

Q4 Narrative

Staff & Survey Engagement

- We hit our highest response rate of 50.3% (2,612 responders), with a 1.3% increase from 2021
- There has been an increase in the number of Black, Asian and minority ethnic respondents and from staff with long term conditions or illness
- Our Staff Engagement score was below the sector average of 6.8 and has dipped this year compared to 2021 reflecting the wider trend across all NHS trusts. The staff engagement score is based on 9 questions equally spilt across motivation, involvement, and advocacy. Looking at the sub themes there was a statistically significant difference in Advocacy (recommending our Trust to others). A key question where we saw a significant drop of 4% from 2021 was 'would you recommend your organisation as a place to work' this is an area of concern as it relates to overall staff experience and therefore influences our staff recruitment and retention. This is 5.6% lower than the sector score. In order to help respond to these findings to further develop staff experience 5 priority areas have been identified, each with three specific actions and outcomes along with a 6-point plan to take them forward. Papers drafted for TMC/PERC/Board/ ICB Quality for presentation in April and May.
- Alongside this the wellbeing and engagement programme of events have been enhanced for 2023/2024, work is underway to implement a recognition platform into the Trust to enable more positive feedback, peer to per support, messages from senior leaderships, notification of key events etc.
- Wellbeing strategy drafted and engagement from the wider trust will be sort to ensure it reflects the thought and needs of the whole organisation.

Staff Survey WDES

Score for this indicator is 26.1% which while it remains relatively constant with last year's results it is below the national average. Nevertheless, bullying and harassment findings have also been analysed and incorporated in staff survey response plans (i.e. behavioural frameworks, new values etc) . Work has begun in developing a civility and respect policy, an antibullying 'toolkit', sharing staff stores through Schwartz rounds, board and PERC meetings and closer working with staff networks.

Staff Survey WRES

'We are always learning' was highlighted as a key strength in our staff survey as we scored significantly higher than the sector average, appraisals drove good scores however scores could be improved on development and career conversations. % of staff with from other ethnic groups believe that their organisation acts fairly with regard to career progression/ promotion was 48%, higher than the 47% sector benchmark average, however lower compared to 58.3% of white staff. Leadership programmes are in development, divisional planning meetings have taken place and EDI lead involved.

Strategic Objective 6: Great Team – Culture of inclusion and diversity
BCDD Delivery (FY22/23 Year-End Narrative)

How we will deliver it	BCDD programme
• Develop an overarching EDI Group bringing together representatives across all protected characteristics with the aim to enhance inclusion and engagement and take forward the inclusion priorities within our People Strategy	Programme 6 – People/Workforce

Ref.	Project Name	RAG
P6.1	Develop an overarching EDI Group	G
P6.4	The development of clear action plans with the national staff survey	G

FY22/23 Year-End Narrative

Develop an overarching EDI Group

While the project to develop an overarching EDI Group has been completed, a new project needs to be created to discuss developing a compassionate and inclusive culture to track the progress of the wider EDI priorities/ workstreams. An EDI steering group implemented which has been established to provide the Trust with an overarching group that enables a collective focus on EDI priorities, to further advance the delivery of our inclusive ambitions, as well as representing all protected characteristics. To ensure a comprehensive approach, the focus of the agenda alternates between workforce related matters and the consideration of health inequalities in terms of our patients and services. The composition of the membership enables a collaborative and inclusive approach as well as ensuring relevant insight and lived experience are recognised and considered. Secured places and contributing to facilitation of ICS career development programmes for BAME and Disabled staff across a range of bands. Supported the facilitation of the in-house Career development workshops ensuing an EDI lens has been taken in the recruiting and running of the sessions. Events for 2023 have been identified and plans for delivery in place. Staff networks stalls including neurodiversity awareness sessions being run. Continued work with Operational HR to review Polices e.g. Transgender policy. Working collaboratively with estates on ensuring a EDI lens is taken e.g. suitability of car park for disabled users. Continued collaboratively working with Carer's network to establish how to support further

Development of clear action plans with the national staff survey

The project has moved through to the delivery phase with most of the milestones completed or on track. This is an annual project, every year we review the Staff Survey data and set new milestones based on feedback. We will look to set new objectives following the 2022 Staff Survey data. Our 2022 events Well Fest and Winterfest saw over 1000 staff members (10% of the organisation at each) engaging with activities including Here for You, Massages, and health checks. Our 2022 Stars of Herts awards night allowed 600 staff members to share a memorable night of reward and recognition (with nearly 500 nominations). The People Promise manager came in post to help deliver the NHS People Promise commitments to develop a compassionate and inclusive workforce. We have established a new post that works across Wellbeing & EDI to enhance staff inclusion and engagement. A business case was approved, job description developed and post holder starting 1st April 2023. We have enhanced staff engagement across sites with quarterly listening walk arounds including the CEO, CPO, Wellbeing guardian, Wellbeing Lead and AD of Culture. Three themed working groups have been identified to respond to staff feedback through these listening walk arounds and the staff survey results. The Trust's event planner for 2023 has been improved to include more recognition events (Long Service Awards, All-stars week, Stars of Herts Awards night).

Strategic Objective 7: Great Team – Improve Workforce Sustainability (Q4 2022-23) A

Objective 7
Address the challenge of workforce shortfalls through innovative staffing solutions and effective retention measures as well as proactively marketing the trust as an organisation where careers can be developed and nurtured

Success measures are set for achievement by March 2023.			Q1 2022-23				Q2 2022-23				Q3 2022-23				Q4 2022-23			
Data source	Success measures	Baseline (April 2022)	Tar	Act	Var	RAG	Tar	Act	Var	RAG	Tar	Act	Var	RAG	Tar	Act	Var	RAG
ESR BI / Ledger	Continued vacancy rates below 8%	8.4%	10%	9.50%	-0.50%	G	10%	10.1%	0.10%	A	10%	8.80%	-1.20%	G	10%	7%	-3%	G
ESR BI	Staff turnover rates overall under 13%	15.0%	13%	16.40%	3.40%	A	13%	16.40%	3.40%	A	13%	15.50%	2.50%	A	13%	15.3%	2.3%	A
ESR BI	Turnover rate for new starters (first 12 months) towards 15%	20.4%	15%	20.70%	5.70%	A	15%	18.80%	3.80%	A	15%	16.30%	1.30%	A	15%	17.2%	2.2%	A

Q4 Narrative

Across Q4 turnover for those who leave within their first 12 months increased slightly in February but we have seen a reduction to 17.2% in March. Hot spot areas are HCSWs, AHPs, and Nursing and Midwifery and across Divisions it is Clinical Support, Corporate and WACS. The Trust's new People Plan was launched in Q4, aligned to the People Promise themes and informed by 4 key strategic drivers. Operational groups have been created to take forward workstreams in the following areas, recruitment & retention, equality diversity & inclusion, learning and development, and workforce modelling.

The People Promise initiative has been extended for a further year. Flexible working and career development and progression will be priorities as well as continuing to improve the new joiner experience. The new joiner support programmes has already received positive feedback. The Trust's first Leadership forum was held with a 2nd event planned for May, and career development workshops for all bands have now commenced. The survey results have been received and work is underway to analyse in detail and communicate with the wider trust and this will heavily inform staff wellbeing and retention. Continued emphasis on staff well-being with events planned throughout the year, and staff engagement and listening forums, supported by a staff recognition and engagement working group.

Strategic Objective 7: Great Team – Improve workforce sustainability
BCDD Delivery (FY22/23 Year-End Narrative)

How we will deliver it	BCDD programme
• To support workforce modelling plans across the Trust and Divisional level that highlights different ways of working alongside supporting effective recruitment. Alongside a particular focus on retention with the appointment of a People Promise Manager for 12 months, based on a national initiative	Programme 6 – People/Workforce

Ref.	Project Name	RAG
P6.2	To support workforce modelling plans	A
P6.5	Appoint retention lead	N/A

FY22/23 Year-End Narrative

To support workforce modelling plans

ICS workforce planning training for HR Business Partners to be delivered (May 2023). ICS to share system wide workforce plan templates (May 2023). Divisional workforce plans drafted but still need to be fully aligned to system plans (May/June 2023). Work is currently ongoing to scope the 2-5 year long term workforce plan for the trust. Work continues to finalise the divisional workforce plans and to ensure they are aligned with the system plans. The annual business planning process has been completed to the agreed timescales outlined for the ICS and NHSE. A new flexible working policy has been launched and work is ongoing to divisions to embed the adoption of flexible working throughout the trust. January 2023 saw the launch of 'Corporate Induction' this initiative incorporated the buddy system and also extended to boarding.

Appoint retention lead

Project currently in scoping stage no additional information noted as part of the year-end review process.

Strategic Objective 8: Great Team – Develop as a learning organisation (Q4 2022-23) G

Objective 8
Improve effective development opportunities for our staff to support innovation and enhance our culture as a learning organisation

			Q1 2022-23				Q2 2022-23				Q3 2022-23				Q4 2022-23			
Data source	Success measures	Baseline	Tar	Act	Var	RAG	Tar	Act	Var	RAG	Tar	Act	Var	RAG	Tar	Act	Var	RAG
Acorn and L&D Records	Improved diversity in staff involvement in non-mandatory training. *(% of BAME staff taking up Acorn- recorded non-mandatory training matches or exceeds % of BAME workforce (45% in March 2022))*	45%	45%	53%	8%	G	45%	44.1%	-0.9%	A	45%	53%	8%	G	45%	50%	5%	G
Coaching Service Records	Increase in proportion of staff seeking support from new career coaching services. (one client receives 5 coaching sessions) - Coaching Service launched on 22/10/2021 baseline is usage to 1/4/22)	16	25	22	-3	A	50	54	4	G	75	76	1	G	75	87	13	G
Staff Survey	The Staff Survey promise on 'We are always learning' to improve from a score of 5.4 to at least 5.6	5.4	*Target set for achievement by March 2023*								5.6	5.62	0.02	G	5.6	5.6	0	G

Q4 Narrative

Improved Diversity: Whilst the success measure of BAME has been met overall trust compliance with mandatory training in Q4 was less than planned at the start of the year due to industrial action and frequent suspension on non-mandatory training combined with a planned reduction in activity scheduled in this time due to major programmes normally starting in Q1 to avoid winter pressures little of non-mandatory training took place in Q4 due to We have, however, commenced the overhaul of leadership programme content.

Coaching: It was necessary to cancel the coach training session in Q1 due to winter pressures, as such the number of available coaches has not increased as intended, however three such sessions are scheduled in Q1 23/24 to make up for this. The intended advanced coaching courses are now confirmed to be introduced in Q3 23/24.

Staff Survey: Staff survey results published and the score for we are always learning was 5.6 and above the national average.

Strategic Objective 8: Great Team – Develop as a learning organisation
BCDD Delivery (FY22/23 Year-End Narrative)

How we will deliver it	BCDD programme
• The review of the Learning & Development structure with a focus on going forward on leadership development, career coaching, talent management (succession planning) and organisational development	Programme 6 –People/Workforce

Ref.	Project Name	RAG
P6.3	Review of the Learning & Development Structure	A
P6.6	Establishment of Career Coaching	G

FY22/23 Year-End Narrative

Review of the Learning & Development Structure

Induction processes have been revised and were implemented in January (including new welcome slides). Induction support sessions have been designed and begun to be delivered to support new starters embed into the Trust within the first six months (1 – recruitment, 2 – wellbeing and EDI + 3 – Career development. The CPD process has been refined and developed to ensure equity across staff and provide transparency on spend. The workstreams have been spread across the roles to avoid a single point of failure. Career development programmes for all staff launched in March 2023. Second cohorts will commence in September 2023. Divisional leadership requirement reviews all but completed (Corporate outstanding). Existing Leadership programmes have been completed with current cohorts. Succession planning meetings held with key Execs to ensure succession planning is a key discussion going forward. Training needs requirements of succession planning identified and will be shared with the Editorial Group. Work experience governance processes being finalised to enable more placements to be facilitated. Apprenticeship information presentations have taken place with divisions – follow up sessions and further socialisation is required. Relationship meeting held with West Herts College with a focus on developing career pathways into the local NHS, work experience placements, apprenticeships and shared experience around leadership development. These key workstreams have been allocated to Senior Staff to lead on via partnership groups.

Establishment of Career Coaching

Definitive methodology to identify Career Coaching (as opposed to other types of coaching provided by the Trust Coaching Service) was agreed upon in April 2022, and reportable without subjectivity from September 2022. Career Coaching was available on demand and provided since before the start of the project. A specialist Career Coaching course for existing Trust Coaches was commissioned from the Forton Group (the Trust's coach development delivery partners) in August 2022 and is now licensed by the Trust for internal delivery. It has run twice to date. 21 of the Trust's 39 coaches have been trained by the above specialist course as of March 2023. Since the start of the Trust's Coaching Service (in October 2021) 38 of the service's 87 clients to date have received career coaching, with a further 5 paired with coaches (as of 31/3/23) and awaiting the start of their coaching. This represents 47% of all clients of the service to date. The Trust is providing the coach development aspects of two career development programmes being run at ICB level, one for Bands 2-4 and one for Band 5-7. The Trust's Coaching Service is additionally providing the result client coaching of the delegates that results from this (7 individual client referrals from these programmes to date). 2023/2024 will see additional coach training courses laid on, the training of the remaining 18 Trust coaches who are not already careers coach trained, and more advanced coach development that will create a cadre of 10 more senior coaches who can supervise the anticipated increase in numbers of both coaches and clients.

Strategic Objective 9: Great Place – Digital & IT Innovation (Q4 2022-23)

N/A

Objective 9
Maximise the benefits of digital and IT innovation by fully optimising the benefits of EPR and the wider use of data to drive improved patient care

Data source	Success measures	Baseline	Q4 2022-23 Target	Q4 2022-23 Actual	Variance	RAG
	Volume of paper used across the organisation (target a % reduction)					
	Number of patients accessing the patient portal (need to confirm start date and some usage from other organisation's implementations					
	Number of care staff accessing the Shared Care record (across the ICS) (we only went live in April so we would need to figure out a target)					
	Number of paper forms digitised within Cerner					
	% increase in a range of Cerner "lights on" metrics					

Q4 Narrative

Q1 & Q2 : The team are currently focused on delivering functionality to clinicians. Baselines and associated metrics are still to be developed and agreed.

No update for Q3.

No update for Q4.

Strategic Objective 9: Great Team – Digital & IT Innovation
BCDD Delivery (FY22/23 Year-End Narrative)

How we will deliver it	BCDD programme
•Leverage WHHT's relationship with the RFL and other Trusts re best practice and work with the Divisional teams to build this into our practice •Use Cerner training and coaching tools to drive targeted adoption training. Strengthen WHHT training offering •Implement Infusion Suite & integrated ECG monitors, actively encourage the use of barcode scanning •Digitise paper forms •Implement the enhanced patient portal •Roll out the use of the ICS Health Information Exchange •Work with operational teams to deliver insightful reporting and analytics	Programme 7 - Digital

FY22/23 Year-End Narrative

All 20+ Digital Transformation projects are reported through the monthly Digital Progress Report to Great Place governance forums.

Strategic Objective 10: Great Place – New & Refurbished Hospital Buildings (Q4 2022-23) R

Objective 10
Deliver new and refurbished hospital buildings in the shortest timescale possible by securing funding for the preferred options for all three hospitals

		Targets				
Success measures	Baseline	Q1 2022-23	Q2 2022-23	Q3 2022-23	Q4 2022-23	RAG
Capital allocation secured (dependent on NHP timelines)	-			X		R
OBC approved & clear programme for FBC and construction agreed with regulators (dependent on NHP timelines)	-				X	R
Enabling capital agreed and works completed to timetable (dependent on NHP approval)	-		X			A

Q4 Narrative

Overall Programme: Confirmation of funding and completion of the OBC are noted as RED, due to the originally anticipated target dates being missed, whilst WHTH awaits feedback from the New Hospital Programme (NHP). We have supported work by the NHP to inform their overall approach were invited to do so and are also continuing to host site visits with a variety of key stakeholders to provide further information regarding our scheme and the growing risk that is presented by aging estate.

Watford Hospital / Emergency Care Enabling Schemes: Following the approval of funding to create additional beds in the Shrodells building and to deliver the pathology essential services lab at Watford, construction work for both schemes is now underway. Plans for the potential purchase of land continue to be refined, with a view to securing the purchase during 2023-24.

Planned Care: To provide sufficient capacity to meet local demand, bids have been submitted for alternative funding for planned care services, where this is available. The future for St Albans lend themselves readily to these individual service bids, whereas the focus at Hemel Hempstead is on developing care pathways ahead of significant investment to consolidate the site. Enabling work on the electrical infrastructure and to temporarily relocate the fracture clinic at St Albans to support the Community Diagnostic Centre, is well underway ahead of the main works commencing. Plans to provide additional surgical capacity at St Albans on behalf of the Integrated Care System are progressing well and an updated planning application to reflect this is being prepared for submission in April 23.

Strategic Objective 10: Great Place – Redevelop our Hospitals
BCDD Delivery (FY22/23 Year-End Narrative)

How we will deliver it	BCDD programme
• Acute Redevelopment Programme sets out clear programme and delivery resources, with robust governance framework	Programme 8 - Redevelopment

Ref.	Project Name	RAG
P8.1	Outline business case for the redevelopment	N/A
P8.2	Business case for enabling works	G

FY 22/23 Year-End Narrative

Outline business case for the redevelopment

Progress on this project is no longer reported through BCDD. An SRO Progress Report is submitted separately to the monthly Great Place Programme Board meeting to outline progress.

Business Case for the Enabling works

Pathology: Essential Service Lab under construction and is due for completion in December 2023, this expected completion date is in line with the required programme, for pathology, ICS projects. Demolition of the current facility is planned for mid-2024. *Shrodells Beds*: Under construction and due for completion by August/September 2023. Vacation of surge units will depend on hospital new build programme but is expected to be late 2024. *Medical Gas:* Design and planning complete, awaiting New Hospital Programme (NHP) funding to undertake construction in late 2023. *Land Transaction:* Business Case submitted to NHP, the final contract documentation is being prepared. Funding approved and expect transition in FY23/24. There is an ongoing potential for delay due to a possible lack of funding from NHP.

Strategic Objective 11: Great Place – Reduce our carbon footprint(Q4 2022-23) G

Objective 11
Reduce our carbon footprint (excluding redevelopment capital bids)

		Targets					
Data source	Success measures	Baseline	Q1 2022-23	Q2 2022-23	Q3 2022-23	Q4 2022-23	RAG
Staff survey	1) Increase in the number of staff aware of the Green Plan and their responsibility in achieving the Trust's commitment to become one of the greenest acute hospital trusts in the NHS	TBD at initial staff survey				X	G
Green dashboard	2) Lead a minimum of 8-10 programmes to reduce the use of single-use items in clinical services and settings	Nil				Not due this FY	G
Green dashboard	3) By 2025, 100% of appropriate clinical waste to be treated at an energy-from-waste recovery facility	0%				Not due this FY	G
Green dashboard	4) 5% decrease in energy consumption	N/A				X	G
Green dashboard	5) To reduce staff driving to work to 55% and patients driving to on of our hospitals to 75%	Staff 61% Patients 79%				X	A

Q4 Narrative

1) The communications plan continues to be rolled out; this includes regular articles in e-update. The second green staff survey has now been drafted however the arrival of the Trust's new Chief Strategy Officer in Q1. Due to funding constraints, the previously considered 'Big Green Week' did not proceed however this remains under consideration for late Q1 (possibly June). A slide on Sustainability & Green Plan Awareness has been developed for inclusion within the induction process for new starters.

2) Three projects to reduce single use items are well underway. These include the reduction of non-sterile gloves, a return and reuse walking aids scheme and the move to reusable theatre caps. Other single-use reduction projects are currently being investigated.

3) Actions on track for 100% of appropriate clinical waste to be treated at an energy-from-waste recovery facility by 2025.

4) The LED lighting project began in early January 2023. The retrofit works at HHGH & SACH are now complete and work has recently begun at WGH. The project programme anticipates conclusion in Q1, pending any unforeseen access issues for the installation teams.

5) It is understood that the WHTH Travel & Access Strategy will be submitted for Board approval until Q1. Following its approval, it will be difficult to achieve the targets set out in the associated success measure (reduce staff driving to work to 55% and patients driving to one of our hospitals to 75%). It is therefore recommended that achievement of this success measure is extended, for completion, into Q4 FY23/24.

Strategic Objective 11: Great Place – Reduce our carbon footprint
BCDD Delivery (FY22/23 Year-End Narrative)

How we will deliver it	BCDD programme
• A Green Plan co-Ordinator will be recruited in 2022 and a clear delivery plan developed	Programme 8 - Redevelopment
• A sustainability steering group has been established, reporting through GPPB to the GPSC	Programme 8 – Redevelopment

Ref.	Project Name	RAG
P8.5	Implement the Green Plan	N/A

FY22/23 Year-End Narrative

Implement the Green Plan

Progress on this project is not reported through BCDD. An quarterly stand-alone report is submitted separately to the monthly Great Place Programme Board meeting to outline progress.

Appendix 1: BCDD Year-End Reviews 1 of 2

Programme 1: Best Care	
P1.1: SMART	P1.1: Year-End
P1.2: Acute Service Strategy	P1.2: Year-End
P1.3: Elective System Hub	P1.3: Year-End
P1.4: Remove Same Day Multi-Site (Breast)	P1.4: Year-End
P1.5: Remove Multi-Site Appointments (Urology)	P1.5: Year-End
P1.6: Improve services for pregnant women	P1.6: Year-End

Programme 2: Integrated Care	
P2.1/2.2: Virtual Hospital & Virtual Ward Expansion	P2.1: Year-End
P2.3: Discharge to Assess	P2.3: Year-End
P2.4: Frailty Transformation	P2.4: Year-End
P2.5: Respiratory Transformation	P2.5: Year-End
P2.6: Long Term Conditions	P2.6: Year-End
P2.7: Advanced Care Plans	P2.7: Year-End

Programme 3: Personalised Care	
P3.1: Equality Delivery System	P3.1: Year-End
P3:2 Promote Inclusion Across Our Services	P3.2: Year-End

Appendix 1: BCDD Year-End Reviews 2 of 2

Programme 4: Consistent Care	
P4:1 Clinical Practice Groups	P4.1: Year-End
P4.2: Theatre Productivity Improvement	P4.2: Year-End
P4.3: GIRFT	N/A
P4.4: Pre-Covid Levels of Efficiency	P4.4: Year-End
P4.5: Multi-Year Efficiency Programme	P4.5: Year-End

Programme 5: Transforming Outpatients	
P5.1: Modernise our Patient Communications	P5.1: Year-End
P5.2: Implement PIFU	P5.2: Year-End
P5.3: Advice & Guidance Services	P5.3: Year-End
P5.4: Non F2F Outpatient Attendances	P5.4: Year-End

Programme 6: People/Workforce	
P6.1: Develop an Overall EDI Group	P6.1: Year-End
P6.2: Support Workforce Modelling	P6.2 Year-End
P6.3: Review of L&D Structure	P6.3: Year-End
P6.4: Clear Action Plans for Staff Survey	P6.4: Year-End
P6.5: Appoint Retention Lead	N/A
P6.6: Establishment of Career Coaching	P6.6: Year-End

Programme 8: Redevelopment	
P8.1: OBC for the Redevelopment	N/A
P8.2: Business Case for Enabling Works	P8.2: Year-End
P8.3: Expand the Bed Base	N/A
P8.4: Expansion of Diagnostic Services at SACH	P8.4: Year-End
P8.5: Implement the Green Plan	N/A

Thank you

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West Hertfordshire Teaching Hospitals NHS Trust

Trust Board Meeting
4 May 2023

Title of the paper:	Corporate Risk Register Report
Agenda Item:	24
Presenter:	Dr Mike Van der Watt – Chief Medical Officer
Author(s):	Brian Haig – Risk Lead
Purpose:	*Please tick the appropriate box* *For approval* [ ] *For discussion* [✓] *For information* [ ]
Executive Summary:	This report provides an update on the Corporate Risk Register (CRR) risks, including changes to current risks scores, new, escalated, emerging, escalated, de-escalated, re-opened and closed risks. The Risk Review Group is asked to note that the risk management update report discusses risks on the CRR as of 13 April 2023. There are a total of 20 open risks on the Corporate Risk Register which have been approved, with a risk score of 15 or above. <u>During this reporting period, there were three new risks (3) presented for discussion and possible approval to add to the CRR.</u> **<u>Risk ID 329</u> (not accepted onto CRR)** Risk of Wrong Blood in Tube (WBIT) Proposed Risk Score 15 (3 x 5) This risk was not accepted, as the risk is already covered sufficiently by Risk ID 179, held by CSS on their register, and which is applicable for this risk across the entire Trust. This existing risk had been considered and discussed extensively by the RRG meeting at the time it was presented. This was scored with a risk score of 10 (2 x 5). Therefore, the meeting felt that this risk should not be accepted onto the CRR at present. **<u>Risk ID 336</u> (not accepted onto CRR)** Inability to meet national turnaround time standards due to a lack of reporting resource. Proposed Risk Score 15 (5 x 3) At the meeting it was decided that further GAP analysis, which is being undertaken by CSS at present, should be awaited before further considering the risk. To be presented back to the RRG next month, once further data has been obtained.

	Risk ID 344 (approved and added to CRR) Risk of fire during refurbishment project - Shrodells Building Agreed Risk score 20 (4 x 5) This risk was due to be presented at the RRG, however was not ready to do so. As a result risk was subsequently approved by the chair of the RRG outside of the meeting to be added to the CRR and the minutes of the meeting reflect this decision. Two (2) risks were presented with an increased score. **Risk ID 43** Breach of Food Hygiene Regs at WGH - Ward Kitchens Current Risk Score 12 (3 x 4) Proposed Risk Score 16 (4 x 4) It was requested that further work be undertaken to clarify the risks and score by Environment, regarding aspects of infection control and activity undertaken. This would then be represented to the group. **Risk ID 23** The impact on the Emergency department of the Watford UTC inconsistent adherence to patient pathways, processes and escalation Previous risk score 12 (3 x 4) New agreed Risk Score 16 (4 x 4) Within the service provided by UTC, the risk likelihood has increased. The RRG discussed and agreed the increased risk score and acceptance on to the CRR. One (1) risk was presented with a reduced score and this was accepted and removed from the CRR **Risk ID 30** Lack of in reach mental health services and tier 4 specialist provision for under 18yrs patients including eating disorders Current Risk rating 15 (3 x 5) Agreed risk rating 12 (3 x 4) Risk reduction in score and removal from CRR was agreed, as significant work has been undertaken in mitigation and control of this risk. There were no merged risks for consideration. There were no risks to be considered for closure. **March RRG meeting** Meeting was not held due to Junior Doctors Strike. Papers were accepted as having been read and all updates were accepted. New risks were to be carried over and discussed at April meeting as none were urgent or critical

Trust strategic aims: *(please indicate which of the 4*	**Aim 1** **Best care**	**Aim 2** **Great team**	**Aim 3** **Best value**	**Aim 4** **Great place**

<table>
<tr><td>aims is relevant to the subject of the report)</td><td>
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<tr><td> 
Objectives 1-4</td><td> 
Objectives 5-8</td><td> 
Objective 9</td><td> 
Objective 10-12</td></tr>
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<tr><td>Links to well-led key lines of enquiry:</td><td>☒Is there the leadership capacity and capability to deliver high quality, sustainable care?
☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
☒Is there a culture of high quality, sustainable care?
☒Are there clear responsibilities, roles, and systems of accountability to support good governance and management?
☒Are there clear and effective processes for managing risks, issues, and performance?
☒Is appropriate and accurate information being effectively processed, challenged, and acted on?
☒Are the people who use services, the public, staff, and external partners engaged and involved to support high quality sustainable services?
☒Are there robust systems and processes for learning, continuous improvement, and innovation?
☒How well is the trust using its resources?</td></tr>
<tr><td>Previously considered by:</td><td>
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<tr><th>Committee/Group</th><th>Date</th></tr>
<tr><td>Quality Committee</td><td>27 April 2023</td></tr>
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<tr><td>Action required:</td><td>The Trust Board is asked to receive this report for discussion of the corporate risk register and board assurance framework.</td></tr>
</table>

West Hertfordshire Teaching Hospitals NHS Trust

Agenda Item: 24

Trust Board Meeting – 4 May 2023

Title of Paper: Corporate Risk Register Report

Presented by: Dr Mike Van der Watt – Chief Medical Officer

1. Purpose

1.1 The purpose of this report is to provide the Quality Committee with an update on the status of the Corporate Risk Register (CRR) including current risk scores, new, escalated, de-escalated, merged, increased, reduced, and closed risks.

1.2 The final data for this report was extracted from Datix on 18 April 2023, a total of **19** open risks were registered on the Corporate Risk Register (CRR) at that time.

2. Background

2.1 The CRR forms part of the Trust's overall board assurance and integrated risk management arrangements.

2.2 The Chief Medical Officer is the Trust's delegated lead executive for risk management.

2.3 The Quality Committee is the Board's subcommittee, which oversees assurance for risk management arrangements within the Trust.

2.4 The CRR contains all risks rated 15 or above from each of the operational / divisional risk registers. The risk register is a 'live' repository of risks recorded on Datix, and risk owners regularly review and update entries to reflect the current position of the risk.

2.5 Divisions regularly review all their risks rated 12 and under on the risk register and those risks which have been on the register for over two years.

2.6 Risks are closed as appropriate. Any outstanding risks are reported to the Risk Review Group (RRG) for discussion and, where necessary, escalated to this Committee to agree on future action.

3. Corporate Risk Register

3.1 Appendix 1 details a table representing risks and their associated score movement on the CRR by Division against each month since April 2022.

3.2 Appendix 2 details a full summary of all corporate risks contained in the papers presented to the Risk Review Group on 18 April 2023.

3.3 Appendix 3 shows KPI performance in relation to Risk Review status

3.4 Appendix 4 Risks scores over the last 12 months (per Division)

4. Risk activity

4.1 **During this reporting period, there were three risks (3) presented for discussion and possible approval to add to the CRR.**

Risk ID 329 (not accepted onto CRR)

Risk of Wrong Blood in Tube (WBIT)

Proposed Risk Score 15 (3 x 5)

This risk was not accepted, as the risk is already covered sufficiently by Risk ID 179, held by CSS on their register, and which is applicable for this risk across the entire Trust. This existing risk had been considered and discussed extensively by the RRG meeting at the time it was presented. This was scored with a risk score of 10 (2 x 5). Therefore, the meeting felt that this risk should not be accepted onto the CRR at present.

Risk ID 336 (not accepted onto CRR)

Inability to meet national turnaround time standards due to a lack of reporting resource.

Proposed Risk Score 15 (5 x 3)

At the meeting it was decided that further GAP analysis, which is being undertaken by CSS at present, should be awaited before further considering the risk. To be presented back to the RRG next month, once further data has been obtained.

Risk ID 344 (approved and added to CRR)

Risk of fire during refurbishment project - Shrodells Building

Agreed Risk score 20 (4 x 5)

This risk was due to be presented at the RRG, however was not ready to do so. As a result risk was subsequently approved by the chair of the RRG outside of the meeting to be added to the CRR and the minutes of the meeting reflect this decision.

Additionally, the CEO has directed the following actions to be taken:

1. On-going active risk management of the assessment of the risk.
2. Certification of the solution for certifying the works and management of the risk to be separately assured by the CEO.
3. Final Fire certification to be submitted to Quality Committee for information and assurance.

Two (2) risks were presented with an increased score.

Risk ID 43

Breach of Food Hygiene Regs at WGH - Ward Kitchens

Current Risk Score 12 (3 x 4) Proposed Risk Score 16 (4 x 4)

It was requested that further work be undertaken to clarify the risks and score by Environment, regarding aspects of infection control and activity undertaken. This would then be represented to the group.

One risk was discussed as an agenda item and a decision was made to increase the risk score and accept it onto the CRR.

Risk ID 23

The impact on the Emergency department of the Watford UTC inconsistent adherence to patient pathways, processes and escalation

Previous risk score 12 (3 x 4) New accepted Risk Score 16 (4 x 4)

Within the service provided by UTC, the risk likelihood has increased. The RRG discussed and agreed the increased risk score and acceptance on to the CRR.

One (1) risk was presented with a reduced score and this was accepted and removed from the CRR

Risk ID 30

Lack of in reach mental health services and tier 4 specialist provision for under 18yrs patients including eating disorders

Current Risk rating 15 (3 x 5) Proposed risk rating 12 (3 x 4)

Risk reduction in score and removal from CRR was agreed, as significant work has been undertaken in mitigation and control of this risk.

There were no merged risks for consideration.

There were no risks to be considered for closure.

5. Risk

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

6. Recommendation

6.1 The Trust Board is asked to receive this report for discussion of the corporate risk register and board assurance framework.

Executive Lead Dr Mike Van der Watt
CMO

Date: 27 April 2023

APPENDICES:

Appendix 1 Risks and associated score on the CRR by Division against each month

Appendix 2 Corporate Risk Register (by Division)

Appendix 3 KPI performance regarding KPI Performance for Risk Reviews

Appendix 4 Risks scores over the last 12 months (per Division)

Appendix 1 – Risks and associated score movement on the CRR by Division against each month since April 2022

Division		Apr-22		May-22		Jun-22		Jul-22		Aug-22		Sep-22		Oct-22		Nov 22		Dec 22		Jan 23		Feb 23		Mar 23		Apr 23	
CLINICAL SUPPORT SERVICES																											
CLINICAL INFORMATICS	25	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→
	27	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→
CORPORATE SERVICES	30	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	12	↓
	35	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→
	37			15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→
	97													16	↑	16	→	16	→	16	→	16	→	16		16	→
	311																	16	↑	16	→	16	→	16		16	→
	325																					16	↑	16		16	→
EMERGENCY MEDICINE	19	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→
	20			16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→
	21			15	→	15	→	15	→	15	→	20	↑	20	→	20	→	20	→	20	→	20	→	20	→	20	→
	22					15	↑	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→
	113													15	↑	15	→	15	→	15	→	15	→	15		15	→
	23																									16	↑
ENVIRONMENT	32	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	16	↓	16	→	16	→
	33	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→
	34	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→
	344																									16	↑
MEDICINE																											
SURGERY & CANCER																											
WACS	29	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→
	36	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→
	318																			16	↑	16	→	16		16	→

APPENDIX 2 – Corporate Risk Register (by Division)

COVID-19 RELATED	RISK ID	OPENED DATE	RISK TITLE	INITIAL RISK RATING SCORE	UPDATE	CURRENT RATING	EXECUTIVE LEAD
CLINICAL INFORMATICS							
No	25	12/06/2017	Trust Bleep System Failure leading to inability to utilise alert systems across the Trust	20	Risk remains unchanged. Everything is now ready to go; there is a 4-6 week lead time with the 3rd party (Stanley) to secure resources for the cutover. Cutover takes place over 3 days and there is 0.5 day downtime involved when switching over. The exact date when this cut-over can take place is being discussed with emergency planning currently.	20	Paul Bannister - Chief Information Officer
RRG MEETING UPDATE **RRG noted update. Risk Score and controls remain appropriate for the Risk at present.** **Current Risk 5 x 4 = 20**							
No	27	20/05/2020	Possibility of a Cyber Security Incident arising from vulnerabilities within our network connectivity systems.	15	There is no change to the score of this risk, which remains appropriate for the level of risk that is being managed at present.	15	Paul Bannister - Chief Information Officer
RRG MEETING UPDATE **Update noted by RRG. Risk scoring and controls are in place to manage the ongoing risk.** **Current Score 3 x 5 = 15**							

CORPORATE SERVICES							
No	30	03/12/2019	Lack of in reach mental health services and tier 4 specialist provision for under 18yrs patients including eating disorders	20	Risk reviewed - score reduced to 12. New MHLT for CYP now onsite and supporting patients with mental health needs who are not in crisis providing additional support. Multi agency escalation process being developed around CYP presenting with non acute / behavioural issues where there is a breakdown in placement. Clinical holding training being delivered across paediatrics. Work due to commence on safe space room in Starfish and AAUL1.	12	Tracey Carter - Chief Nurse and Director of IPC
RRG MEETING UPDATE **RRG approved reduction in Risk Score from 15 to 12 (3 x 4) and removal from the CRR.** **Current Score 3 x 4 = 12**							

No	35	09/11/2016	Patients may come to harm and have a poor experience due to long waits for elective care	20	Risk score and controls remain the same with no changes at present.	20	Michael Van der Watt, - Chief Medical Officer
RRG MEETING UPDATE **RRG noted that risk had been reviewed and updated.** **Current Score 4 x 5 = 20**							

No	37	27/01/2022	There is a risk to maintaining Safe staffing levels for Nursing across all Divisions	15	Staffing continues to be challenged due to staff unavailability and surge open	15	Tracey Carter – Chief Nurse and Director of IPC

RRG MEETING UPDATE **Risk Management review paper accepted, detailing the update on the risk.** **Current Score 5 x 3 = 15**

No	97	11/08/2022	Staff Turnover Rates (overall numbers/turnover within specific staff groups/leavers in first year of employment)	16	Turnover reducing slowly within the Trust for those leaving in first year, however remains at present above the target figure. Localised initiatives and a integrated people plan in place to continue work to reduce turnover. Areas affected primarily remain the same throughout the Trust and work is ongoing within those Divisions.	16	Andrew McMenemy – Chief People Officer
RRG MEETING UPDATE **RRG noted risk update, which was provided verbally at the meeting.** **Current Score 4 x 4 = 16**							

No	311	05/12/2023	Effects of Workforce Wellbeing on Operational Services	16	Updates for April 2023: - New post holder (Engagement & Inclusion Advisor) started in April 2023 to improve collaborative working between EDI & Wellbeing - 2022 Staff Survey results analysed to inform next steps at both Trust and divisional , full report and presentation going to relevant stakeholder meetings in April & May (including PERC, TMC & Board) - Quarterly pulse survey used for temperature checks (January, April & July 2023) - Each Person - peer to peer recognition, recognition from managers/ senior leaders , milestone celebrations for birthdays and work anniversary & nominations - Each Person to include a rewards and benefits platform for further discounts and savings (ability to provide incentives , gift cards & vouchers) - Ward based massages - free of charge for staff - A local benefits brochure drafted	16	Tracey Carter - Chief Nurse and Director of IPC

RRG MEETING UPDATE **RRG noted update and ongoing activity.** **Current Score 4 x 4 = 16**

No	325	04/02/2023	Possible impact on Patient Safety due to need to use Surge Areas within numerous Departments in the Trust	16	The Trust still has levels of patients which necessitate the use of surge areas and this could expand or reduce as demand varies. The impact varies and the risk remains that patient safety/experience will be negatively impacted by the current continued need to utilise surge areas, with facilities etc not designed to have patients. Until such time as the Trust returns to a position whereby the use of surge areas are not required, the risk cannot be reduced at present.	16	Michael Van der Watt, - Chief Medical Officer
RRG MEETING UPDATE **Risk Management review paper accepted, detailing the update on the risk.** **Current Score 4 x 4 = 16**							

EMERGENCY MEDICINE							
No	19	30/04/2018	Ambulance handover delays affecting patient pathway and escalation	20	Risk score, controls and mitigation remain unchanged. Nursing support for the ED corridor continues as does the focus on timely assessment in STARR. HALO has been allocated to Hemel UTC where possible to identify any potential patients who could have been conveyed to Hemel rather than Watford. Work continues within the department to ensure ambulances are released as quickly as possible, working closely with the HALO. KPIs are discussed at service, divisional meetings and as part of the Ambulance handover meeting attended by EEAST and ICB	15	Sally Tucker - Chief Operating Officer
RRG MEETING UPDATE **RRG noted update.** **Current Score 5 x 3 = 15**							

No	20	12/04/2022	Reduced patient flow through the Emergency department (ED)	15	Risk score, Controls and mitigation remain unchanged. The division continues to focus on the performance and flow of patients through the ED. This is supported by continuing to utilise assessment spaces both within the ED and EAU with regular reporting as to RAG rating of the department.	15	Tracey Carter- Chief Nurse and Director of IPC
RRG MEETING UPDATE **RRG noted update. No change to risk or control measures at present.** **Current Score 3 x 5 = 15**							

No	21	12/04/2022	Failure to meet performance KPIs within the Emergency Department (ED)	16	Controls, mitigations and scoring to remain the same - Performance remains sub-optimal against the 4 hour standard, however a slight improvement in overall performance is noticeable. The month of January has seen the highest Non Admitted performance this reporting year. Once this improvement has been sustained the scoring of the risk will be further reviewed. The Emergency Department continues to focus on improvements in wait times and patient pathways, with a Divisional improvement plan in place to support any changes. Targets continued to be monitored through the relevant groups such as HEG, OPFG and CEO check in meetings.	20	Sally Tucker – Chief Operating Officer
RRG MEETING UPDATE **RRG noted update. No change at present to risk description, controls etc.** **Current Score 5 x 4 = 20**							

No	22	12/04/2022	Challenges in meeting the needs of Mental health Patients within the Emergency Medicine division	16	Risk score, controls and mitigation remain unchanged. Work has started on additional MH room in ED and there has been agreement for the risk assessment of patients have been under a Section 136 in excess of 24 hours and the police need to leave. Daily reporting of MH within the department and escalation of MH bed requests continues	16	Tracey Carter- Chief Nurse and Director of IPC

RRG MEETING UPDATE **RRG noted update. No change to score at present.** **Current Score 4 x 4 = 16**							
No	113	11/08/2022	Impact on Patient Safety / Experience due to need to use fracture clinic as adult ED assessment area, for which it is not designed.	15	Risk score, controls and mitigation remain unchanged. KPIs for TAM focusing on non admitted patients including triage time, time to clinical assessment and IPS are reported through the divisional manager of the day for assurance and escalation raised directly and through the operations meetings. On going review of the environment in place including the storage of medications and security.	15	Tracey Carter, Chief Nurse and DIPC
RRG MEETING UPDATE **RRG noted update. No change to score at present.** **Current Score 5 x 3 = 15**							
No	23	11/08/2022	Impact on Patient Safety / Experience due to need to use fracture clinic as adult ED assessment area, for which it is not designed.	15	The division of Emergency medicine would like RRG to approve increasing the risk score to 16 This is because there has not been a sustained improvement in performance which regarding streaming is a clinical safety risk as well as reputational. This is occurring most days. We continue to work closely with Greenbrook in monitoring and supporting their KPIs and following a clinical review commissioned by Dr Mike Van De Watt recommendations for the future processes and pathways are being operationalised by the senior teams.	16	Sally Tucker - Chief Operating Officer
RRG MEETING UPDATE **RRG agreed increase in Risk Score and accepted onto CRR** **Current Score 4 x 4 = 16**							

ENVIRONMENT

No	32	13/10/2012	Control of Legionella and Management of water systems	20	Risk score remains the same Flushing and testing regime in place Water Safety Manager now in post March 2023 Water Safety Group continues to meet monthly - Chaired by Deputy Director Operations (Environment)	15	David Ambrose – Acting Director of Environment
RRG MEETING UPDATE **RRG noted update. No change to score at present.** **Current Score 3 x 4 = 15**							

No	33	26/08/2021	Electrical infrastructure risks on the WGH site	15	Work continues with the HV works - Trench/cable/installation to network. The work is running to schedule with each phase rolling into the next one. Generators are in situ from WGH and continue to support the works in terms of resilience for the site whilst works take place. Generators tested on a monthly basis Score to remain the same Works will continue until late this year	15	David Ambrose – Acting Director of Environment

RRG MEETING UPDATE **RRG noted no change to Risk Score or Controls.** **Current Score 3 x 5 = 15**

No	34	26/08/2021	Electrical infrastructure risks on the SACH site	15	Risk score remains the same Monitoring of work being carried out at SACH continues - Work will start to be scheduled as soon as the works at SACH reach an appropriate point of completion. Materials are part of the agreed 22/23 capital programme with installation work to be planned for FY 23/24	15	David Ambrose – Acting Director of Environment
RRG MEETING UPDATE **RRG noted no change to Risk Score or Controls.** **Current Score 3 x 5 = 15**							

SURGERY & CANCER

WOMEN'S AND CHILDREN

No	29	20/11/2020	Increased midwifery vacancies leading to lack of appropriate midwifery staffing levels	20	05/04/2023 Review by DOM and head of maternity governance and assurance. There is a reduction in the overall percentage of midwifery vacancy (13.8%). Recruitment and retention in progress. RR midwife in post. Re branding project in process, further international recruitment of midwives continues. Risk level remains the same.	16	Tracey Carter- Chief Nurse and Director of IPC
RRG MEETING UPDATE **RRG noted no change to Risk Score or Controls.** **Current Score 4 x 4 = 16**							

No	36	01/04/2019	Delay in the IOL pathway including transfer from the antenatal ward to delivery suite.	16	05/04/2023 Reviewed by DOM and head of maternity governance and assurance- ongoing monitoring of dilapan use to determine effectiveness. Score change as no poor outcomes associated with current delay, in view of improved staffing and reduction in birth rates the frequency of delays has declined.	15	Tracey Carter - Chief Nurse and Director of IPC
RRG MEETING UPDATE **RRG noted no change to Risk Score or Controls.** **Current Score 3 x 5 = 15**							

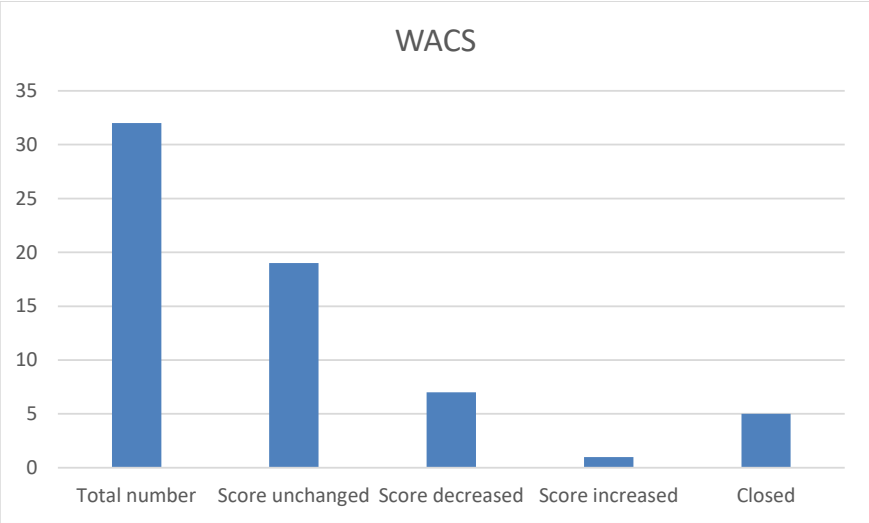
No	318	04/01/2023	Impact on staff morale, elective and non-elective patient flow and pathways due to the use Paediatric Assessment Unit as a surge area	16	Still working on options appraisal, still risk as resources patient flow in CED. Paeds don't have capacity to expand footprint.	16	Mike Van der Watt – Chief Medical Officer
RRG MEETING UPDATE **RRG noted no change to Risk Score or Controls.** **Current Score 4 x 4 = 16**							

Appendix 3 KPI Performance

		Risk Score					
Division	Total Risks	1-3	4-6	8-12	15-25	Reviews in date	% in date
WACS	28	0	1	23	4	16	57%
Emergency Medicine	14	1	0	8	5	11	79%
Medicine	8	0	1	7	0	8	100%
SAC	28	3	9	16	0	28	100%
Environment	40	0	4	33	3	8	20%
CSS	49	1	8	39	1	45	92%
Clinical Informatics	26	0	7	17	2	24	92%
Corporate Services	46	3	15	22	6	24	52%
Finance	19	0	5	13	0	0	0%

Appendix 4 Direction of Travel

Risks scores over the last 12 months (per Division)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Score decreased
Score increased
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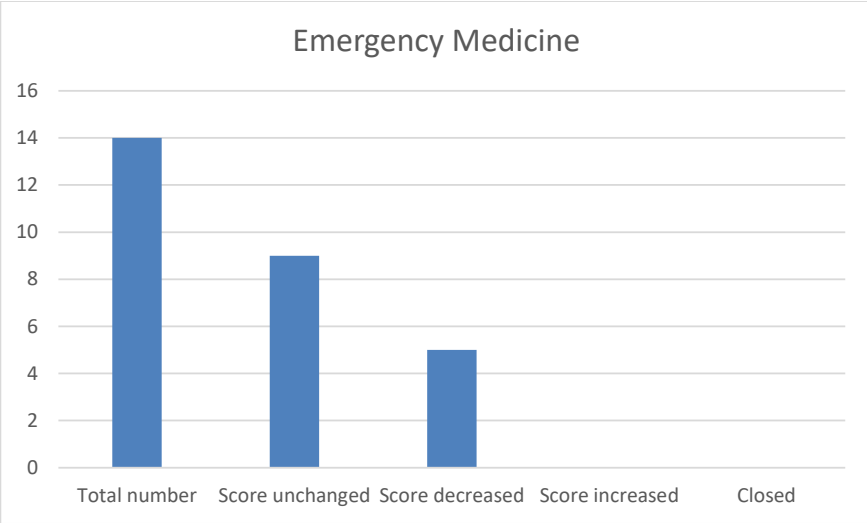
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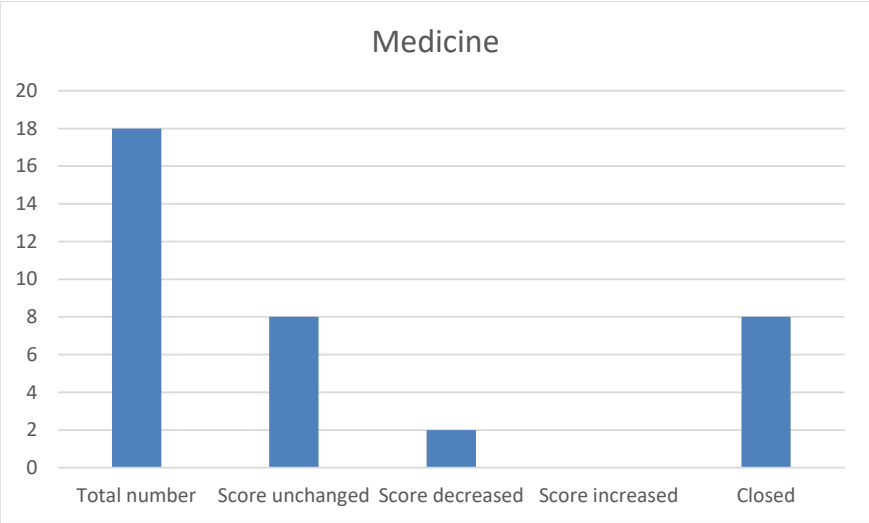
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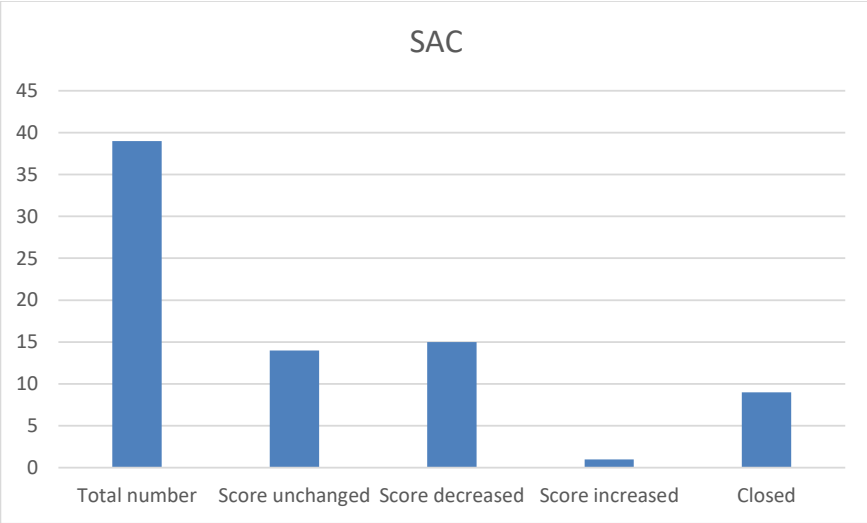
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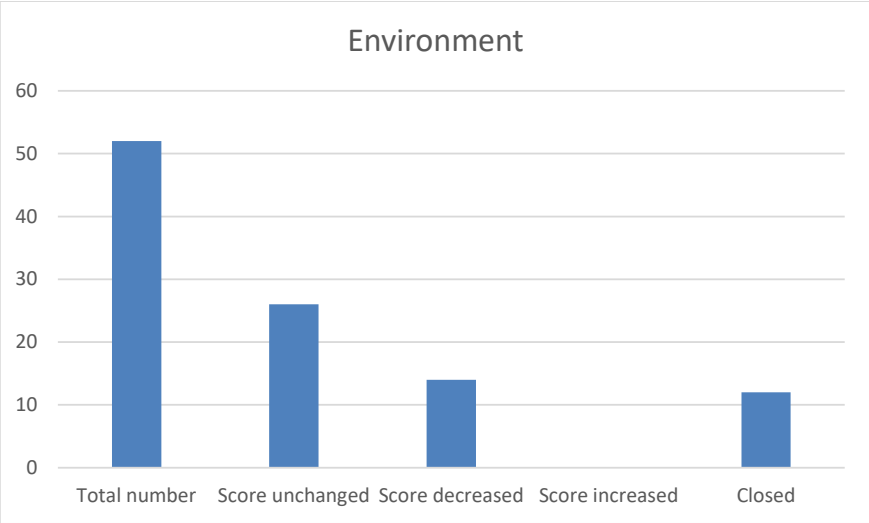
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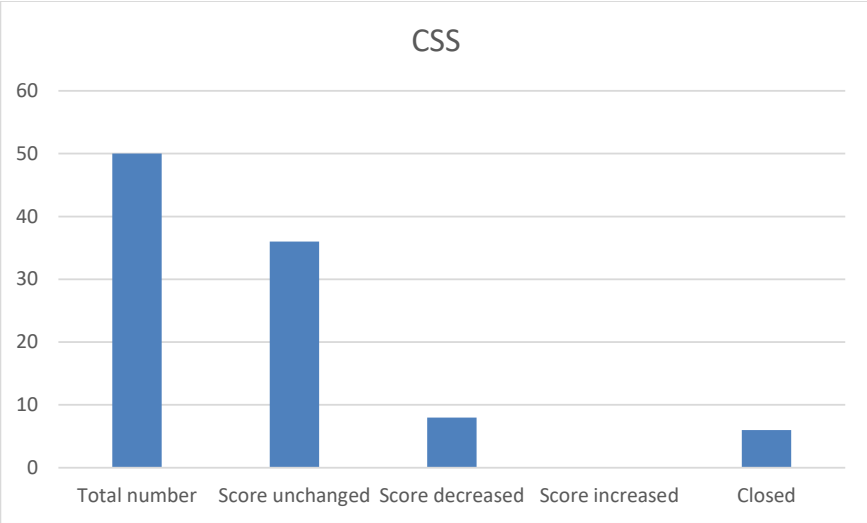
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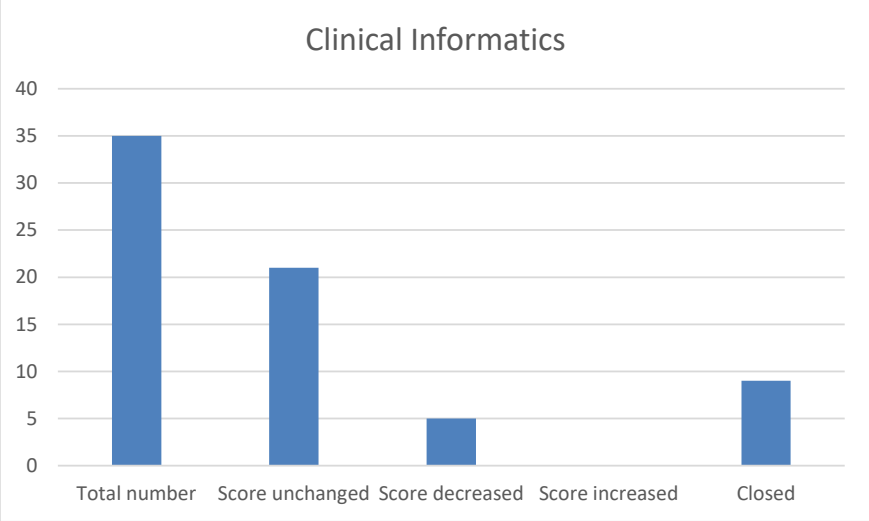
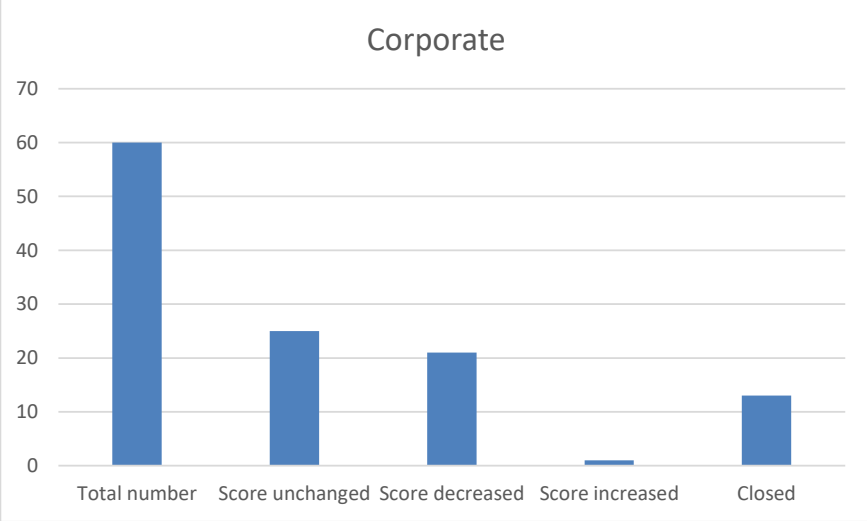
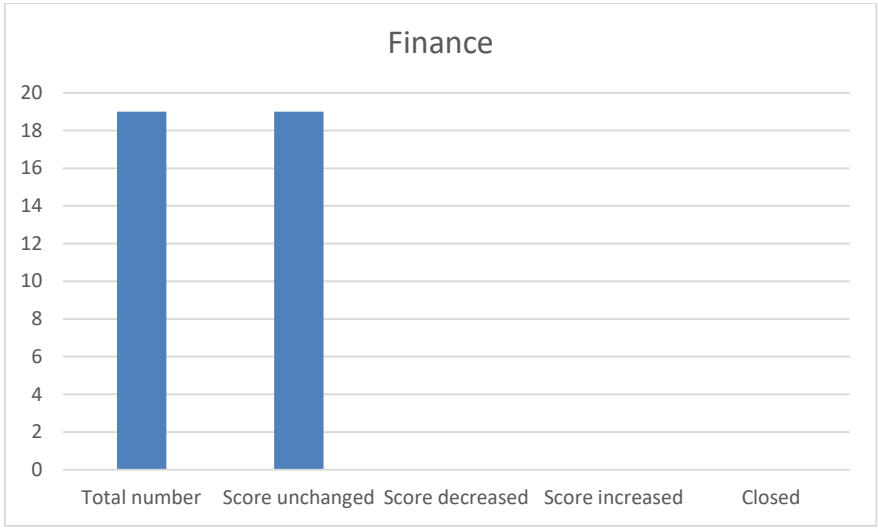
Score increased
Closed


Clinical Informatics
40
35
30
25
20
15
10
5
0
Total number
Score unchanged
Score decreased
Score increased
Closed


Corporate
70
60
50
40
30
20
10
0
Total number
Score unchanged
Score decreased
Score increased
Closed


Finance
20
18
16
14
12
10
8
6
4
2
0
Total number
Score unchanged
Score decreased
Score increased
Closed

20

West Hertfordshire Teaching Hospitals NHS Trust

Trust Board
4 May 2023

Title of the paper:	**2022/23 NHS self-certification**
Agenda Item:	**7**
Presenter:	**Barbara Anthony, Trust Secretary**
Author(s):	**Barbara Anthony, Trust Secretary** **Jean Hickman, Corporate Governance**
Purpose:	*Please tick the appropriate box* *For approval*: x *For discussion*: *For information*:
Executive Summary:	Although NHS trusts are exempt from holding a provider licence, they are required to comply with conditions equivalent to the licence that NHS England has deemed appropriate. The single oversight framework uses the NHS provider licence as a basis for oversight. Therefore, all NHS trusts are legally subject to the equivalent of certain licence conditions and, in light of this, have to self-certify. The Board is required to sign-off that it is satisfied with compliance; Condition G6 by 31 May 2023 and Condition FT4 by 30 June 2023. Both Conditions must be published on the Trust's website no later than 30 June 2023. If the Trust is unable to confirm that it is compliant with the Conditions it must explain why. NHS England retains the option of contacting a select number of NHS trusts and foundation trusts to ask for evidence that they have self-certified, either by providing the completed or relevant board minutes and papers recording sign-off. --- **Condition G6(3) – Providers must certify that their board has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution**. This Condition requires NHS trust to have processes and systems that: Identify risks to compliance and take reasonable mitigating actions to prevent those risks and a failure to comply from occurring. **<u>Recommendation</u>** **Following a review of actions taken throughout the year to comply with the NHS Provider licence, NHS Acts and the NHS Constitution, it is concluded that the Trust has met Condition G6 (3) and it is**

	recommended that the self-certification is signed by the Chair and Chief Executive. **Condition FT4(8) – Providers must certify compliance with required governance standards and objectives.** There is no set approach to meeting this Condition; however it is expected that any approach should involve effective board and committee structures, reporting lines and performance and risk management systems. **<u>Recommendation</u>** **Following a review of compliance against the required governance standards and objectives, it is concluded that the Trust has met Condition FT4 (8) and it is recommended that the self-certification is signed by the Chair and Chief Executive.** See appendix A – Proposed statement for G6 See appendix B – Proposed statement for FT4
Trust strategic aims: *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1 Best care**  ***Objectives 1-4*** x **Aim 2 Great team**  ***Objectives 5-8*** x **Aim 3 Best value**  ***Objective 9*** x **Aim 4 Great place**  ***Objective 10-12*** x
Links to well-led key lines of enquiry:	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☒Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues and performance? ☒Is appropriate and accurate information being effectively processed, challenged and acted on? ☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☒Are there robust systems and processes for learning, continuous improvement and innovation? ☒How well is the trust using its resources?
Previously considered by:	Committee/Group: Quality Committee — Date: 27 April 2023
Action required:	The Committee is asked to consider and recommend the self-certification of Condition G6 and FT4 for signature for approval to the Board.

West Hertfordshire Teaching Hospitals NHS Trust

Agenda Item: 7

Trust Board meeting – 27 April 2023

2022/23 NHS self-certification

Presented by: Barbara Anthony, Trust Secretary

1. Purpose

1.1 The report informs the committee about the requirement to self-certify compliance with the NHS provider licence, NHS legislation and the NHS Constitution and asks the committee to recommend the report to the Board for approval.

2. Background

2.1 NHSE requires NHS providers to self-certify that they have effective systems to ensure compliance with the conditions of their NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution.

2.2 NHS trusts are not required to hold a provider licence, but directions from the Secretary of State require NHSE to ensure that NHS trusts comply with conditions equivalent to those in the licence as it deems appropriate. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions for the 22/23 financial year.

2.3 New provider licences have been issued to NHS trusts for the 23/24 financial year and there is no requirement to self-certify compliance with these new licences going forwards.

3. Analysis/Discussion

3.1 A template is provided to record the self-certifications, but it is not necessary to submit this template to NHSE unless requested. The template has been completed for record keeping purposes and in case the Trust receives a request for further information from NHSE.

3.2 NHSE's self-certification requirements and deadlines are set out in the table below.

Condition	Description	National Deadline
Condition G6 (3)	The provider has taken all precautions to comply with the licence, NHS acts and NHS Constitution.	31 May 2023
Condition G6 (4)	Publication of condition G6 (3) self-certification	30th June 2023
Condition FT4(8)	The provider has complied	30th June 2023

	with required governance arrangements.	

Condition G6

3.3 Condition G6(2) requires NHS providers to have processes and systems that:

- identify risks to compliance with the licence, NHS acts and the NHS Constitution

- guard against those risks occurring.

3.4 Providers must complete a self-certification after reviewing whether their processes and systems were implemented in the previous financial year and were effective (condition G6(3)).

3.5 Providers must publish their self-certification by 30 June (condition G6(4)).

3.6 A self-certification has been completed using the recommended template (provided in Appendix A) which confirms that processes and systems were implemented in the previous financial year and were effective (condition G6(3)).

3.7 On the basis that the Trust is compliant with its provider licence, is not subject to any imposed requirements under the NHS Acts, has regard to the NHS Constitution in delivering NHS services and has received positive assurance on its processes and systems from internal auditors, it is reasonable for the Trust to confirm it is compliance with Condition G6(3) in its self-certification this year.

3.8 Providers must publish their self-certification by 30 June (condition G6(4)).

3.9 This assurance report will be presented to the public Trust Board on 4 May 2023 and will be available on the Trust's website within the Board paper pack.

Condition FT4

3.10 Condition FT4 is about systems and processes for good governance. NHS providers must make a corporate governance statement under condition FT4(8) as to current and future compliance with condition FT4 (see Appendix B).

Evidence of Compliance

3.11 The compliance declarations above have been made on a range of evidence listed in Appendix C.

4. Risks

4.1 The Trust will be in breach of its regulatory obligations if it does not comply with the self-certification requirements set out above.

5. Recommendation

5.1 The Committee is asked to consider and recommend the self-certification of Condition G6 and FT4 for signature for approval to the Board.

Name of Director: Tracey Carter
Title: **Chief Nurse and Director of Infection, Prevention and Control.**

Date: 20 April 2023
APPENDICES: A - C

Appendix C: Evidence of compliance

In making the above declarations the following additional assurance can be provided to the Board.

• The Trust has Standing Orders, Standing Financial Instructions, and a Scheme of Delegation, which together describe how the Board of Directors discharge their duties through the Trust's governance structure.

• A risk management strategy which sets the standards for staff regarding the management and responsibility for risk throughout the Trust, describes the Trust's risk appetite and defines the framework and structure for risk management in the Trust.

• There is a Corporate Risk Register (CRR) and subsidiary risk registers (i.e. risk assessment, counter fraud, local and directorate risk registers) as well as a Board Assurance Framework (BAF). Quality Committee and the Board reviews the CRR and BAF each month.

• A risk based internal audit programme has been delivered that includes an advisory opinion of risk maturity across the Trust to help ensure an effective risk management culture becomes embedded across the Trust. It concluded that the Trust scored above average against the key indicators included within the report and that there were no areas of significant concern.

• The Head of Internal Audit Opinion provided moderate assurance (it's second highest assurance rating) that there is a sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently.

• An external well led review against the CQC's 'well-led' domain.

• An Annual Governance Statement which reflects the Trust's governance structures and internal control arrangements.

Worksheet "G6"

Financial Year to which self-certification relates 2022/23

Declarations required by General condition 6 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed OK

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Trust's financial strategy and annual financial plan set out details of resource requirements and efficiencies approved by the Board. The accounts have been prepared on a going concern basis. The Trust has systems and processes in place to ensure it complies with current compliance requirements which is coordinated by the Chief Nurse and the Corporate Governance Team. Risks to the Trust's priorities and the compliance requirements of the CQC and the SOF are considered by the Board in the corporate risk register, board assurance framework and robust performance reporting. A robust governance structure is in place as part of the system of internal control that maintains oversight and provides the Board with assurance.

Signed on behalf of the board of directors.

Signature		**Signature**	
Name	Phil Townsend	**Name**	Matthew Coats
Capacity	Chair	**Capacity**	Chief Executive Officer
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

Not required.

Worksheet "FT4 declaration" | **Financial Year to which self-certification relates** | 2022/23

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Trust has well developed systems of corporate and financial governance as evidenced by its Annual Governance Statement, Head of Internal Audit Opinion, internal and external audit reports, robust financial planning, and regular review of risks by the Executive, board sub-committees and the Board itself. The Trust has recently commissioned an external well led review which was positive about the Trust's corporate governance arrangements with recommendations for minor changes.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Trust responds to guidance issued by NHSE. Submissions and information provided to NHSE are approved through relevant and appropriate authorisation processes. Recent examples are (1) the Trust's response to the Ockenden Report and the subsequent recommendations and (2) compliance with the guidance on external well-led reviews.
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The Trust has a well developed committee structure with approved terms of reference and clearly defined responsibilities, reporting arrangements and accountability. Each board sub-committee provides verbal and written assurance reports to the Board which also escalates any matters of concern and actions to be taken.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	The Trust has sound systems of governance in place which are underpinned by an internal audit programme, external audit, and clinical audit programme. A monthly performance report is reviewed at Trust Board and FPC and quality performance report is reviewed at Quality Committee bi-monthly. The Trust has systems and processes in place to ensure it complies with current compliance and reporting requirements. Quality Committee has a robust system of oversight to ensure compliance with healthcare standards which is underpinned by a strong, central quality governance function and sound divisional governance. The Trust has robust and comprehensive corporate and financial governance arrangements in place. Amendments to these processes due to the Covid-19 pandemic have been in line with DHSC guidance. Corporate and financial governance arrangements remain subject to internal audit. All audit plans are agreed by the Audit Committee and similarly all audit reports are received and reviewed at the Audit Committee. The Trust responds to guidance and requests from NHSE. Information provided is approved through the relevant and appropriate authorisation processes. The Trust's accounting systems and processes ensure appropriate recording of cost information. The Trust has in place the services of external firms providing, external and internal audit and counter-fraud assurance.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	The Trust has robust appraisal and performance review arrangements throughout the organisation. The executive team are supported by several corporate directors and there are uniform senior leadership models within each division. The Quality Committee receives assurance on issues of patient safety and quality of care, patient experience and patient outcomes and promotes involvement of service users, carers and the public. In addition, quality summits or thematic reviews of any indicators or areas of concern are commissioned and reported to the Quality Committee as they arise. The committee also receives bi-monthly quality performance metrics which is linked to the Quality Account. The Board receive a patient focused story at each meeting and undertakes board visits each month. The Board receives a range of quality reports including reports on serious incidents, PALS, complaints and CQC regulatory compliance. There is clear accountability for quality of care throughout the Trust and systems of governance allow for appropriate escalation to the Board. Quality Committee receives assurance from a number of operational committees that the Trust is delivering safe, caring, responsive, effective, and well led services and scrutinises clinical quality issues, particularly related to best practice and national guidance. It monitors risks to patient safety and quality and ensures that plans are developed and monitored to manage or mitigate risks, escalating risks to the Board as appropriate.
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The composition of the Board is reviewed on an ongoing basis by the Chair and CEO to ensure that there is sufficient capacity, capability and the requisite skills and experience to deliver the Trust's objectives and plans and to provide effective leadership at an organisation and system level.

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Signature** _____

Name Phil Townsend **Name** Matthew Coats

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A Not required.

OK

West Hertfordshire Teaching Hospitals NHS Trust

Trust Board
4 May 2023

Title of the paper	**Items considered in April 2023 Private Trust Board**
Agenda Item	**26**
Presenter	**Jonathan Rennison, Vice Chair**
Author(s)	**Barbara Anthony, Trust Secretary**
Purpose	*Please tick the appropriate box* *For approval*: *For discussion*: *For information*: ✓
Executive Summary	To note in the public domain an outline of the matters covered in private, due to their confidential nature, since the last board meeting in public.
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1 Best care** — ***Objectives 1-4*** — x **Aim 2 Great team** — ***Objectives 5-8*** — x **Aim 3 Best value** — ***Objective 9*** — x **Aim 4 Great place** — ***Objective 10-12*** — x
Links to well-led key lines of enquiry	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☒Is there a culture of high quality, sustainable care? ☒Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☒Are there clear and effective processes for managing risks, issues and performance? ☒Is appropriate and accurate information being effectively processed, challenged and acted on? ☒Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☒Are there robust systems and processes for learning, continuous improvement and innovation? ☒How well is the trust using its resources?
Previously considered by	Committee/Group: Trust Board Part 2 — Date: April 2023
Action required	The Board is asked to take the report for information of the matters discussed at the last meeting in private (Part 2) session.

West Hertfordshire Teaching Hospitals NHS Trust

ITEMS FOR DISCUSSION	
1	None
ITEMS FOR INFORMATION AND ASSURANCE	
2	**Feedback on Board ward and departmental visits** The Board received feedback from visits by Board members to: • Emergency Department • Pastoral Care • ICU • Estates
3	**Serious Incidents Report** The Board received an update on the serious incidents that had taken place during the reporting period.
4	**7 – day services board assurance framework** The Board received an update on the progress in meeting 7 days services targets.
5	**Finance update** The Board received an update from the Chief Financial Officer on the current financial position.
7	**Strategy update** The Board received an update from the Chief Executive Officer.
	External Well Led Review The Board received an update about the outcome of the review.
	Planning for AGM The Board discussed the planning for this year's AGM.