West Hertfordshire Teaching Hospitals NHS Trust

TRUST BOARD MEETING IN PUBLIC
AGENDA
04 April 2024 at 9.30am – 12.00pm
Sir Elton John Suite, Watford Football Club and via MS Teams for virtual attendees.

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

Time	Item ref	Title	Subcommittee / Purpose	Accountable officer	Paper or verbal
Standing items					
09.30	1	**Opening and welcome**	Information	Chair	Verbal
	2	**Patient story**	Information	Chair	Verbal
	3	**Apologies for absence**	Information	Chair	Verbal
	4	**Declarations of interest**	Information	Chair	Paper
	5	**Minutes of previous meeting 07 March 2024**	Approval	Chair	Paper
	6	**Board action log –** no outstanding actions	Information	Chair	Paper
	7	**Board decision log**	Information	Chair	Paper
	8	**Chair's report**	Information	Chair	Paper
	9	**Chief Executive's report**	Information	Chief Executive	Paper
Performance & Committee updates					
09.45	10	**Board Assurance Framework**	Approval	Chief Executive	Paper
	11	**Trust Management Committee** Written report: February 2024 Verbal report: March 2024	Information and assurance	Chief Executive	Paper
	12	**Finance and Performance Committee** Written report: February 2024 Verbal report: March 2024	Information and assurance	Chair of Committee/ Chief Financial Officer	Paper
	13	**Quality and Safety Committee** Written report: February 2024 Verbal report: March 2024	Information and assurance	Chair of Committee/ Chief Nurse	Paper
	14	**People, Education and Research Committee** Written report: February 2024	Information and assurance	Chair of Committee/ Chief People Officer	Paper
	15	**Redevelopment Programme Committee** Written report: March 2024	Information and assurance	Chair of Committee/ Chief Redevelopment Officer	Paper
	16	**Audit Committee** Written Report: March 2024	Information and assurance	Chair of Committee/ Acting Chief Financial Officer	Paper

	17	**Performance report**	Information and assurance	Acting Chief Operating Officer	Paper
	18	**Integrated performance report**	Information and assurance	Chief Information Officer	Paper
Aim 1: Best Care					
10.55	19	**Better Care Delivered Differently final report**	Information and assurance	Chief Strategy and Collaboration Officer	Paper
Aim 2: Great Team					
11.00	20	**Fit and Proper Persons regulations update**	Information and assurance	Chief People Officer	Paper
	21	**High-impact change action plan for equality, diversity and inclusion**	Information and assurance	Chief People Officer	Paper
Aim 3: Best Value					
11.20	22	**Finance update**	Information and assurance	Acting Chief Financial Officer	Paper
Risk and Governance					
11.30	23	**Strategy 2024 – 2029** **a. Vision, values and strategy** **b. Accountability framework**	Approval	Chief Strategy and Collaboration Officer/Chief Nurse	Paper
	24	**Board and Committee Terms of Reference and work plans 2024-25** 24.1 Board 24.2 Audit 24.3 Remuneration 24.4 Finance and Performance 24.5 Redevelopment Programme 24.6 People, Education and Research	Approval	Interim Director of Governance	Paper
	25	**Standing Orders update**	Approval	Interim Director of Governance	Paper
	26	**Corporate risk register**	Approval	Chief Medical Officer	Paper
	27	**Items considered in the March 2024 Private Board meeting**	Information and assurance	Interim Director of Governance	Paper
Closing Items					
11.50	28	**Any other business previously notified to the Chair**	N/A	Chair	Verbal
	29	**Questions from Healthwatch Hertfordshire**	N/A	Chair	Verbal
	30	**Questions from patients and members of the public**	N/A	Chair	Verbal
	31	**Date of the next Board meeting:** 02 May 2024, **Medical Education Centre, Hemel Hempstead**	Information	Chair	Verbal

West Hertfordshire Teaching Hospitals NHS Trust

Declarations of Board members and attendees' interests

April 2024

Agenda item: 03

Name	Role	Description of interest
Phil Townsend	Chairman	None
Matthew Coats	Chief Executive	None
Jonathan Rennison	Non-Executive Director	Financial Interests Edgecumbe Consulting – Associate Director of The Yellow Chair Ltd Relevant Consultancy Contracts Held by The Yellow Chair Ltd (Financial Interests): Kings College London – OD & Learning & Development Activities Professional Interests: West Hertfordshire Hospitals Trust Charity Committee Chair Trustee of Rising Tides Ltd
Heather Moulder	Non-Executive Director	Managing Director /Owner HM Healthcare Solutions Ltd Chair NMC Interim Order Hearings Chair UKCP Complaint Hearings
Harvey Griffiths	Non-Executive Director	Financial Interests Director - Anglo Chesham Management Limited Director - Anglo Industrial Holdings Ltd Director - Broadgate Freeholds Limited Director - Energy Capital Advisers Ltd Secretary – 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 Director - Sustainable Infrastructure Partnership Ltd Statutory (executive) director of Credit Capital Corporation II Limited <u>Non-financial Professional Interests</u> None
Natalie Edwards	Non-Executive Director	None
Edwin Josephs	Non-Executive Director	Member of the Vine House Health Centre Patient Participation Group
Helen Davis	Associate Non-Executive Director	Director and shareholder at Brierley Advisory LLP, secondment to NHP finished at end of January 2022. Partner is senior civil servant at DHSC
Prof 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

Catherine Pelley	Associate Non-Executive Director	TBC
Toby Hyde	Chief Strategy and Collaboration Officer	None
Paul Bannister	Chief Information Officer	Chair of Shared Care Record Programme
Kelly McGovern	Chief Nurse	None
Andrew McMenemy	Chief People Officer	Lead for Workforce Modelling and Planning Lead for Temporary Staffing Member of Hertfordshire and West Essex ICS People Board
Rodney Pindai	Acting Chief Financial Officer	Metro Health Network Ltd - Lead Finance Officer South Vernon Associates Limited
Mary Bhatti	Acting Chief Operating Officer	None
Dr Mike van der Watt	Chief Medical Officer	Owner and Director Heart Consultants Ltd Work for Hertfordshire and West Essex ICS for one day/week advising on quality and innovation.
Alex White	Chief Redevelopment Officer	None
Dr Niall Kenan	Divisional Director, Medicine	TBC
Mr Drostan Cheetham	Divisional Director of Surgery, Anaesthetics and Cancer	None
Mr William Forson	Divisional Director of WACS	Private practice at Spire as Forson and Co Medical
Dr Rachel Hoey	Divisional Director of Emergency Medicine	None
Martin Keble	Divisional Director of Clinical Support Services	None
Jean Hickman	Director of Governance	None

West Hertfordshire Teaching Hospitals NHS Trust

TRUST BOARD MEETING IN PUBLIC

07 March 2024 09:40am – 12:00pm

Minutes

Agenda Item: 05

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Chair	Title	Attendance
Phil Townsend	Chair	Yes
Board members		
Matthew Coats	Chief Executive Officer	Yes
Jonathan Rennison	Non-Executive Director, Vice Chair	Yes
Kelly McGovern	Chief Nurse and Director of Infection Prevention and Control	Yes
Mary Bhatti	Interim Chief Operating Officer	No
Rodney Pindai	Acting Chief Financial Officer	Yes
Dr Mike van der Watt	Chief Medical Officer	Yes
Toby Hyde	Chief Strategy and Collaboration Officer	Yes
Alex White	Chief Redevelopment Officer	Yes
Heather Moulder	Non-Executive Director	Yes
Edwin Josephs	Non-Executive Director (Senior Independent Director)	Yes
Harvey Griffiths	Non-Executive Director	Yes
Natalie Edwards	Non-Executive Director	Yes
Martin Keble	Divisional Director, Clinical Support Services	Yes
Paul Bannister	Chief Information Officer	Yes
Professor Ann Griffin	Non-Executive Director	No
Paul Bannister	Chief Information Officer	Yes
Andrew McMenemy	Chief People Officer	Yes
Helen Davis	Associate Non-Executive Director	Yes
Clinical in attendance		
Dr Andy Barlow	Divisional Director for Medicine	Yes
Dr Rachel Hoey	Divisional Director for Emergency Medicine	Yes
Martin Keeble	Divisional Director for Clinical Support Services	Yes
Mr Drostan Cheetham	Divisional Director for Surgery, Anaesthetics and Cancer	No
Mr William Forson	Divisional Director for Women's and Children	Yes
In attendance		
Mark Landau	Director of Business Intelligence	Yes
Jean Hickman	Interim Director of Governance	Yes
Catherine Pelley	Associate Non-Executive Director	Yes
Tom Stevenson	Interim Director of Communication	Yes
Stephanie Johnson	Deputy Chief Operating Officer	Yes
Georgina Theobald	Corporate Governance Manager	Yes
Meg Carter	Hertfordshire Healthwatch	No
Members of the Public		8

MEETING NOTES

Standing items	
1	**Opening and welcome**
1.1	The Chair welcomed attendees to the meeting and apologised for the delayed start. He expressed his admiration for the work on embedding the patient flow methodology into the business, highlighting the efforts of the Chief Nurse, Chief Medical Officer, the Acting Chief Operating Officer and their Deputies. The Interim Director of Governance was also thanked for her work. The Chair reported that the Chair of East of England had visited and been very impressed with both staff and the changes being made, seeing the Trust as an exemplar in ambulance handling. The Board expressed its condolences to the family and friends of Steve Palmer, the Chair of Healthwatch Hertfordshire, noting that he had been both a colleague and supporter of the Trust.
1.2	The Chair stated that the meeting would look at performance, assurance from each of the non-executives and committees, and seek to approve a paper on nursing establishment
2	**Patient Story**
2.1	The Chief Nurse explained that unfortunately, the nominated patient was unable to attend in person due to health issues. She advised that the patient had a cancer diagnosis and was in palliative care with some complications in her treatment pathway. The Chief Nurse confirmed that the patient would attend a future meeting to share her experience once she was well enough to do so.
3	**Apologies for absence**
3.1	Attendance and apologies are reported above.
4	**Declarations of interest**
4.1	The Chair reminded Board members to ensure they were keeping their electronic Declaration of Interest record up to date.
5	**Minutes of the previous meeting on 01 February 2024**
5.1	The minutes were approved subject to the noted below. 14.1 – Replace Helen Moulder, not Jonathan Rennison 15.1 - Edwin Joseph gave the report, not Natalie Edwards, Non-Executive Director 15.1 - 'NMC' should be 'National Medical Council' 15.1 - The penultimate line should read 'education partners' not 'education departments' 17.1 – Jonathan Rennison had been misattributed as giving the report 18.5 – Heather Moulder, not Heather Davis
6	**Board Decision log**
6.1	The Chair noted the decision register was included for information.
7	**Board Action log**
7.1	Action 1. The Director of Governance advised that she had contacted Meg Carter from Healthwatch who had confirmed that her current focus was on regularly attending Redevelopment Programme Committee meetings. The Chair requested for the agenda item to remain on the Board agenda and Healthwatch was welcome to submit questions for answering as required. Action closed.
8	**Board work plan**
	The Chair noted the work plan was included for information.
9	**Chair's report**
9.1	The Chair presented his report and highlighted the ongoing implementation of Martha's Law, which the Chief Nurse confirmed was taking place over the next six months. The Board was reminded that the Long Service Awards ceremony had been held, which had seen 3,600 years of NHS service between all attendees. The Chair added that East and North Herts NHS Trust had appointed a new Chair, Anita Day and he expressed the hope that there would be a level of collaboration between them going forward.
10	**Chief Executive Officer's Report**
10.1	The Chief Executive thanked staff for their hard work, particularly during industrial action and around patient flow. He noted that it was the last Board Meeting for the Interim Director

	of Communication, thanking him for his work over the past eight months, and wishing him well in the future.
PERFORMANCE & COMMITTEE REPORTS	
11	**Board Assurance Framework (BAF)**
11.1	The Chief Executive explained that some more work needed to be done to describe the next chapter at the start of the new strategic period, and that he felt it had been a good, robust piece of assurance that had served the Board well in terms of maintaining focus. He stated that the only changes had been recommended by the Finance and Performance Committee, with risks 7 and 9 increased from 12 to 16. The BAF in its current form was approved.
12	**Trust Management Committee**
12.1	The Chief Executive took the paper as read and there were no comments or questions raised.
13	**Finance and Performance Committee**
13.1	Harvey Griffiths, Non-Executive Director expressed his thanks to the operations team regarding patient flow. He noted that December 2023 had been challenging, with spikes and a reverse in trajectory which was hoped to be back on track soon. It was reported that VWA was down to 90% with the impact of holidays and industrial action, but the high-impact change plan was working. Regarding finance, Harvey Griffiths, Non-Executive Director, mentioned the month 9 forecast of £19 million deficit and the continued efforts to reduce it, adding that the finance risks in the BAF numbers 7, 8, and 9, were at 16, 20, and 16 respectively, which demonstrated that work was needed in those areas. It was confirmed that block income was ahead of forecast and that spending was a challenge. The importance of rapid turnaround was highlighted, along with the need for patient safety, quality, and care to remain priorities. He concluded that assurance would continually be sought regarding finances during the year.
14	**Quality and Safety Committee**
14.1	Heather Moulder, Non-Executive Director, stated that the Committee was receiving very good quality papers, expressing her thanks to the Chief Medical Officer, and the Chief Nurse. She highlighted a detailed report around deteriorating patients and safeguarding, including the actions being taken to mitigate risks and improve staff awareness, presentations around insulin incidents and mitigations, and GIRFT stroke progress, emphasising the continued issue with the use of the stroke gym as a surge area. Heather Moulder noted discussions around Martha's Law and its implementation, the independent sexual violence advisor impact, challenges around interpreting CT angiograms out of hours, updates on the asbestos incident and improvements to the mortuary service. It was identified that the patient safety incident response framework (PSIRF) would be helpful in future in identifying where deeper dives were needed. There had been robust discussions and challenges around the assumptions and recommendations of the nursing establishment report, following which the Committee fully endorsed it. The Non-Executive Director referred to increased work at colonoscopy clinics in St. Albans, explaining that key point indicators were still being met and treatment failures were within targets, with staffing, particularly laboratory staff and consultants, identified as an area of challenge. The requirement for the Quality Account to be delivered and ready for publication by 13 June 2024 was confirmed to have been noted.
14.2	The Chair wondered if PSIRF language was understood by patients. The Chief Nurse admitted that it would take a while to embed, but there were a lot of publications on it, and work was ongoing to update the intranet and website.
15	**People, Education and Research Committee**
15.1	Natalie Edwards, Non-Executive Director, explained that the Committee's previous meeting had covered areas in HR aligning with the People Strategy, the Education Strategy, and the Leadership Development Programme. She noted that work on the Medical Education Centre had been completed and papers had been received on Women as Medical Leaders, Guardian of Safe Working, equality and delivery, public sector equality, and the nursing establishment review. Discussions had been held concerning the initial results of the staff survey, including concerns regarding the drop-in completion rates. The Non-Executive Director confirmed the Committee had received a report on the progress of the electronic

	staff record (ESR), in particular regarding self-service project plans. Workforce performance was also seen to be showing encouraging trends. The Chief People Officer added that there had been a good piece of work linking up the ESR with the digital strategy and thanked the team.
16	**Redevelopment Programme Committee**
16.1	Helen Davis, Non-Executive Director highlighted that a meeting had been held to discuss Phase 2 of the redevelopment programme and this would be followed up in the private section of the Board meeting. She congratulated the team on a successful market engagement event, which had been co-arranged with the National New Hospital Programme.
17	**Charity Committee**
17.1	Jonathan Rennison, Non-Executive Director, pointed out that the charity's income had decreased over the past year. This was partly due to a delay in the start of the lottery, as well as some bids being pulled and other timing issues with income. However, it was emphasised that the overall trend was still upwards. He reported that a new strategy and budget for the next couple of years would be presented to the Corporate Trustee for approval, with a focus on managing the charity's cash flow. The Board was informed that there would be recommendations for bringing finance for the charity back in-house.
18	**Audit Committee**
18.1	Edwin Josephs, Non-Executive Director, reported that in addition to the regular items, the Audit Committee had received updates from the Chair of the Charity Committee and the Chief Executive of the Charity regarding changes that had been made and proposed for the operation of the Charity. These changes would be further discussed at a meeting of the Corporate Trustee later that day. The Committee reviewed and approved an updated Conflicts of Interest Policy, agreed on a proposed timetable for the Annual Report and Accounts, and scrutinised the external auditors' Audit Planning Report. Additionally, it was noted that a motion to change standing orders had been proposed and approved, and this would be presented to the next Board meeting for ratification.
19	**Performance Report**
19.1	The Deputy Chief Operating Officer presented a comprehensive summary of performance and activity in January 2024 and highlighted improvements in the emergency department, noting performance at 69.5% which was fifth in the region and adding that although 63 x 12-hour waits had incurred, the Trust was third in the region for trolley waits and was indicative of the pressure faced. Ambulance delays were better than elsewhere in the Integrated Care System and lost hours over 30 minutes was on trajectory for the end of March 2024. Concerning the improvement programme supporting patient flow, a multi-agency discharge event was run for three days at the end of January 2024 which had achieved its goals of reducing surge and resetting the emergency assessment unit, however, this was followed by the whole system suffering a critical incident and reaching OPAL 4 status for two days at the beginning of February 2024. The Deputy Chief Operating Officer advised that actions to improve flow included continuing to work on attendance avoidance with Central London Community Healthcare, and on pathways from primary care into emergency care services. The command-and-control centre was managing flow from the front door to discharge, working to a suite of key performance indicators. It was confirmed that the Trust was performing second best in the region for 65 weeks, 78 weeks, and diagnostics, with VWA in January at 98.3%, up from 90% in December.
19.2	Edwin Josephs, Non-Executive Director, asked why the activities of flexible sigmoidoscopy and colonoscopy were not reported together. The Deputy Chief Operating Officer explained that there was a change in the coding, and the Acting Chief Financial Officer agreed that the reporting method could be reviewed in the future, but it would have to align with the guidelines.
19.2	The Deputy Chief Operating Officer was asked to explain how they were addressing the issue of uneven discharge numbers over the weekend. The Deputy Chief Operating Officer acknowledged that discharging patients at certain times of the day and on weekends was a problem. She then explained that they were using a criteria-led discharge programme on Tudor Ward, which included weekly meetings. She expressed her hope that this programme could be implemented on a wider scale and emphasised the importance of

	medical and nursing staff taking responsibility for the programme, which was part of the optimising patient flow programme.
19.3	The Board was advised that more hysteroscopy capacity was being considered, with additional capacity being made available, however, there was an issue in terms of pathways for menopausal patients and some work to do with primary care on referrals. It was further wondered what follow-up, if any, there was regarding unnecessary referrals. The Chief Strategy and Collaboration Officer explained that the primary-secondary care interface group fed back on issues of that nature and that there was an opportunity to consider whether the community gynaecology service could pick up some of the issues.
20	**Integrated Performance Report**
20.1	The Chief Information Officer presented the integrated performance report and reported a slight increase in the Summary Hospital-level Mortality Indicator (SHMI) related to quality. It was noted that the increase was just above the upper control limit, but it was not considered a cause for concern as it was close to the national benchmark. It was mentioned that it would be monitored in the future. Regarding safety, the main change reported was continued improvements in nursing fill rates, with the number of registered nurses in common cause variation for fill rates and trending back towards one hundred. The Chief Information Officer reported improvements for all performance types and the Trust had moved from 55th to 44th out of 102 trusts. It was noted that there had been a slight decrease in appraisal compliance, however, establishment and staffing post numbers had increased slightly in January following a decrease in December. Activity numbers were confirmed to be consistent and as expected, with high clock starts for referral to treatment (RTT) leading to a slowdown in the reduction of the patient tracking list (PTL), although this was suggested to be a catch-up on a lower number in December.
20.2	The Chair asked if there were any important matters that the Board needed to focus on over the next six months. In response, the Chief Information Officer brought up the topic of mortality rates. The Chief Medical Officer explained that this rate was being closely monitored by the Mortality Review Group. Moreover, he mentioned that the slight increase in the rate was partially due to a nationwide reset of the statistic, which was not limited to the Trust. He also informed the Board that a new consultant coder had been hired to help address coding issues. The Chief Executive informed the Board that the four-hour A&E performance of all types was the focus of national attention.
Aim 1: Best Care	
21	**Bi-Annual nursing establishment review**
21.1	A paper on a bi-annual nursing establishment review was presented by the Chief Nurse. She explained that the review was a national requirement and noted that for completeness she had included nursing roles in safety and quality, and clinical posts and that these were also included in the finance figures for clarity. The Chief Nurse went on to highlight that some changes were to adjust skill mixes and not just the addition of more staff, and that there were some proposed reductions in costs that could be challenging, but it would balance out the cost being recommended, including a reduction in supernumerary sisters and the enhanced care budget. The Chief Nurse clarified that the proposal to reduce the enhanced care budget was to keep half of the budget for mental health one-to-ones and high-risk patients, with the reduction enabled by moving staff into ward areas and adding extra staff only where there was a high rate of one-to-one being used.
21.2	The Chair acknowledged that both the Quality and Safety and the People, Education and Research Committees had discussed and endorsed the paper. The Acting Chief Financial Officer agreed that it was also endorsed from a financial perspective, and it had been included in indicative plans for 2024/25. The Chief Executive added his support for the paper, recognising the importance of correct ward establishments in the overall picture.
21.3	Heather Moulder, Non-Executive Director confirmed the paper had been subjected to strong scrutiny by the Quality and Safety Committee and advised it was recommended for approval by the Board. The Chief Nurse was praised for her mature approach and move from surge to establishment.
22.2	Jonathan Rennison, Non-Executive Director, asked how the impact would be calculated and reported in terms of performance and quality. The Chief Nurse responded that the new accountability framework would hold staff to account and a new nursing auditing system would help to work out how key performance indicators could be captured both for the

	Board and for nursing staff to take into account. She expressed confidence that bank and agency spending would continue to reduce, and that there would be changes in the rate at which patients scored higher getting into ITU, along with drops around deteriorating patients and ward metrics, such as falls and pressure sores.
22.3	The Chair understood the reasons why the paper was delayed for completeness and wondered how soon changes would be evident. The Chief Nurse suggested that she planned to take until April 2024 to determine the appropriate metrics, and would report on initial trajectories a couple of months after that.
22.5	The Board approved the recommended nursing establishment.
22	**Mortuary update**
22.1	The Director of Clinical Support Services presented a report on mortuary services and highlighted that since the last update, three staff had been employed and were working well. It was noted that a 19-bay mortuary surge unit had been established at Watford, as was a 46-bay unit at Hemel with bariatric and super-bariatric capacity. Remedial works were identified as the next phase due to start in April 2024, with the programme expected to last for three to six months. Thanks were expressed to the coroner and partner trusts for their support in the intervening period, with Watford being used for postmortems. A new essential services lab, including a new mortuary, was confirmed to be due to open in Summer 2024.
22.2	Further thanks were expressed to staff, managers, and executives for work and support through the changes. It was noted that the service had been re-inspected and feedback had been positive towards the plans with a further visit arranged for July 2024. A plan for a CT scanner was stated to be on hold, but a plan to move from paper to an electronic system was reported as progressing well.
22.3	It was suggested that staff morale in the mortuary service was improving due to a new IT system, additional staff, and other investments, however, it was acknowledged that there was more work to be done. The Divisional Manager for Clinical Support was praised for her excellent leadership and the importance of talent management and succession planning was agreed.
22.4	Jonathan Rennison, Non-Executive Director, inquired about the strategy and ambition of the mortuary. The response highlighted that postmortems were identified as challenging, and the availability of histopathologists was a concern. CT scanning was suggested as a potential solution that could provide benefits and be a way forward.
Aim 2: Best Value	
23	**Finance update**
23.1	The Acting Chief Financial Officer reported a deficit of £2.6 million up to January 2024, and a deficit of £20.8 million against the year-to-date plan of £5.5 million at the end of the tenth month. He reported that the main reasons for the deficit were ongoing emergency pressures and industrial action in the last three months. The revised forecast for the tenth month was £18.5 million, with elective recovery continuing to improve and supported by savings of £9.6 million, which was below the target of £13.3 million. It was highlighted that divisional oversight and enhanced control were crucial to achieving the forecast out-turn for the year. The capital plan was noted to be just under £60 million, and work was ongoing with divisions to finalise the remaining capital programme schemes to be delivered in the current financial year.
23.2	The Chair was concerned about the clarity of the numbers with the system and the wider Integrated Care Board. The Acting Chief Financial Officer confirmed that the numbers were fully visible, although some areas still needed to be completed in the next week or so.
23.3	Harvey Griffiths, Non-Executive Director, highlighted the efficiency programme as a key area of risk. The Acting Chief Financial Officer added that the February industrial action had not been included in the numbers.
24.4	The Chief Medical Officer thanked divisions for work on the finalisation of the capital programme.
Aim 3: Great Team	
24	**Public sector equality duty workforce report**
24.1	The Chief People Officer confirmed that a paper on the public sector equality duty workforce had been presented to the People, Education and Research Committee on 29 February 2024, and explained the national requirement to publish equality objectives,

	demonstration of compliance, and workforce demographic information, all of which were referenced in the report. The Chief People Officer reported that national staff survey results had shown 'compassionate and inclusive' as green, but it was below average, that the sub-theme of 'advocacy and thinking of leaving' had been graded significantly worse, and that over half the respondents did not think career progression and promotion was fair. The Chief People Officer acknowledged they were important points, together with equality, diversity and inclusion which would be a priority for discussion at the inaugural staff survey meeting.
24.2	Jonathan Rennison, Non-Executive Director asked about the goals and targets of the survey results. He wanted to know if the activities carried out were aligned with those goals. The Chief People Officer agreed that the goals needed to be more specific, and activities should be linked to those ambitions.
24.3	The Chief Nurse suggested that continuous feedback needed to be considered, with the Chief People Officer stating that quarterly surveys were already carried out.
24.4	Heather Moulder, Non-Executive Director raised concern about the survey results including the colour green being used for compassion but was below average. She noted that when staff were leaving, over half did not think the Trust acted fairly and asked whether the right actions were being put in place as there were clear links to fear, and career progression of band 5s and above. The Chief People Officer said this would be considered as part of the staff survey action plan.
24.5	The Board expressed concern about how the Trust was capturing continuous data since the survey and the Chief People Officer said a quarterly pulse staff survey was used to collate real-time feedback.
24.6	The Chief Executive the importance of the Board receiving a good response to the staff survey rather than a quick response and provided assurance that a small working group led by the Chief Executive and divisional leaders would be examining the results in detail and would report back to the People Education and Research Committee.
24.7	The Board approved the publication of the report on the Trust website
Risk and Governance	
25	**Corporate Risk Register**
25.1	The Chief Medical Officer presented the corporate risk register, identifying that it had been reviewed by the Risk Review Group on 08 February 2024 and the Quality and Safety Committee on 29 February 2024. He advised that the register had thirteen open risks and no new risks. Two risks had been removed; one regarding staff turnover rates that had been reassessed and reduced to a risk score of twelve, and one regarding JAG accreditation that would be removed at the next meeting. The Chief Medical Officer advised that the Risk Review Group would be chaired by the Risk Manager, with the Chief Medical Officer remaining the Executive Lead. The Board was informed that the risk report would be presented in a new form from April 2024.
25.1	The Board approved the paper.
26	**Items considered in February 2024 Private Trust Board**
26.1	The Board noted the list of items for information.
27	**Any other business previously notified to the Chair**
27.1	No items of business had been previously notified.
27.2	The Chair acknowledged that it was the last meeting for the Divisional Director for Medicine and the Board expressed its gratitude for his excellent work. The Chief Executive and Chief Medical Officer also extended their thanks for the Divisional Director's seven years of outstanding leadership during the Covid-19 pandemic and for his contributions in establishing the virtual hospital.
28	**Questions from Healthwatch Hertfordshire**
28.1	The Interim Director of Governance confirmed there no questions had been received from Healthwatch Hertfordshire.
29	**Questions from our patients and members of the public**
29.1	**Question 1.** In answer to the question submitted to the February Board meeting it was stated that the Trust's recent purchase of land was subject to "a special purchase valuation " Could the Trust explain precisely what such a valuation is, how it is certified and whether its

	application resulted in a purchase price lower or higher than might have been expected in an open market transaction not deemed to be "special. " The Acting Chief Financial Officer responded that the Trust had instructed external advisers (Montague Evans) to advise on the value of the site (including a red book valuation). The valuation derived and the price paid were certified and within the reasonable range based on the independent advice.
29.3	**Question 2.** The answer also declared that the price paid for the land was "commercial in confidence " yet Tab 24 (p.241) of the February board papers contains 2 bar charts each showing a sum of £13.1m. for "land purchase" and p.232 states that the price of the land was part of the PDC drawing of £36m. Assuming these amounts are accurate, how can the purchase price be considered commercial in confidence? (In fact, more than one set of Board papers have contained similar figures (£12.9m. - £13.6m.) for the land purchase since the May 2022 papers facilitated a similar calculation. Was that calculation wholly incorrect? The Acting Chief Financial Officer replied that the purchase price was within the range of indicative budget figures included in previous reports. The exact amount remained commercial in confidence. The PDC drawdown of £36m included funding for a range of other investment within the Trust.
29.4	**Question 3.** Is the legal dispute over pathology contracts holding up the provision of a new temporary hot pathology lab at Watford? When are the proposed pathology/mortuary facilities expected to be fully operational and will the required temporary closure of facilities at Hemel Hempstead necessitate that the old mortuary at Watford continues to operate during their refurbishment? The Director of Clinical Support Services responded that building work continued on a new pathology lab at Watford (the essential services laboratory) and a new mortuary unit. The essential services laboratory building works remained on target for completion in summer 2024. Remedial works for the Hemel Hempstead mortuary were scheduled to start in April 2024 (and last for three to four months). The Trust has an agreement with the coroner and East and North Herts and Princess Alexandra Trusts to manage capacity during the works. The mortuary at Watford would be used for postmortems only in the intervening period.
29.5	**Question 4.** In November 2022 the Chief Financial Officer warned the Board that any annual deficit would ‘undermine the long-term plan that supported the redevelopment.’ When do you expect to be able to agree with Government an approved outline business case for redevelopment, given the probability of a £36m structural deficit this year and a £30m structural deficit for 2024-25? The Chief Redevelopment Officer replied that the Trust continued to work closely with the New Hospital Programme to agree on a business case approval timeline to meet the Secretary of State for Health & Social Care’s commitment to starting the main works in 2026. Alongside the redevelopment programme, the Trust continued working across its hospitals and with colleagues at the Integrated Care Board to manage the deficit position.
29.6	**Question 5.** The East and North Herts NHS Trust are forecasting a deficit of c £3m this year against an equivalent figure of £19m for West Herts. What explains this substantial difference in performance, and are there lessons to be learned from the experience of East and North Herts? The Acting Chief Financial Officer responded that every NHS hospital trust had a unique position reflecting the population it cared for, the range of services provided, and alignment with other local health and care services. All of which affect operational and financial performance. The Trust actively works with partners in the local Integrated Care System to share information on best practice and improvement. The Trust also looks at national benchmarks and reviews good practice examples across the country.

29.7	**Question 6.** Following recent enquiries into the premature deaths of disabled individuals and those with learning disabilities does the board condone the haranguing and emotional blackmail of parents of children with disabilities to sign DNR orders for their children? If not, can the board confirm what processes they have in place to ensure that complaints about such behaviours are fully and competently investigated in a timely manner to ensure that staff who may be demonstrating prejudiced and discriminatory attitudes to children with protected characteristics are properly held to account. Can the board confirm that should such a complaint be raised it would be incumbent on the individual investigating the complaint to interview all the witnesses to the events and to not determine the outcome of the investigation by relying solely on the response of the accused. The Chief Nurse responded that the Board did not condone any behaviour that resulted in patients, families or carers feeling pressured into making specific decisions on any course of treatment. The Trust follows national NHS procedures for investigating complaints and would be happy to discuss any concerns about specific cases outside of the Board meeting.
30	**Date of the next Board Meeting**
30.1	The next Board meeting will be held on 04 April 2024 at the Elton John Suite at Watford Football Club and via MS Teams.
31	**Close**
31.1	The Chair thanked everybody for their input and closed the meeting.

Board Decision Log

Board meeting/ decision date	Decision reference (from minutes)	Item presented to Board for action	Comments/ outcome
06-Apr-23	21	NHS England Frontline digitisation business case	The Board approved the business case for the digitisation of frontline services
06-Apr-23	25	Board and committee terms of reference and workplans	The Board approved its terms of reference and board sub-committee terms of reference and workplans.
04-May-23	25	Annual self-certification	The Board approved the annual self-certification process
01-Jun-23	24	Neonatal Intensive Care Unit business case	The Board approved the Neonatal Intensive Care Unit business case
01-Jun-23	26	Modern Slavery Act statement	The Board approved the Modern Slavery Act statement and its publishing on the Trust website
06-Jul-23	22	Quality Report	The Board ratified the report.
06-Jul-23	28	Domestic and Clinical Waste Contract	The Board approved the Domestic and Clinical Waste contract
06-Jul-23	29	Award of Compliant Courier Contract for Pathology and Pharmacy Services	The Board approved the Award of Compliant Courier Contract for Pathology and Pharmacy Services
07-Sep-23	25	Patient Safety Incident Response Framework Policy	The Board approved the PSIRF policy
07-Sep-23	20A	Self Certification, Protecting and Expanding Elective Capacity	The Board approved the signature and submission of the self-certification document to NHSE.
07-Sep-23	29	Medical Appraisal Annual Organisational Audit 2022/23 Statement of Compliance	The Board approved the Medical Appraisal Annual Organisational Audit 2022/23 Statement of Compliance.
05-Oct-23	25	Obstetric, neonatal and anaesthetic clinical workforce planning report	The Board approved the report.
05-Oct-23	29	Workforce race equality standard and workforce disability equality standard report	The Board approved the report for publication.
02-Nov-23	22	Gender and race pay gap report	The Board approved the report.
02-Nov-23	32	Updated standing orders, standing financial instructions and scheme of delegation	The Board approved the annual documents.
07-Dec-23	20	Maternity incentive scheme Year 5 declaration	The Board approved the declaration.
01-Feb-24	27	Equality Delivery System	The Board approved for publication.
07-Mar-24	21	Bi-annual nursing establishment	The Board approved the nursing establishment.

West Hertfordshire Teaching Hospitals NHS Trust

Trust Board Meeting
4 April 2024

Title of the paper	**Chair's Report**
Agenda Item	**8**
Presenter	**Phil Townsend, Chair**
Author(s)	**Carolyn Greeves, Chief of Staff**
Purpose	**For approval** ☐ **For discussion** ☐ **For information** ☐
Executive Summary	This paper provides an update to the Board on items of national and local interest/relevance.

Trust strategic aims

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

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

Links to well-led key lines of enquiry

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

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

8

West Hertfordshire Teaching Hospitals NHS Trust

Agenda Item: 8

Trust Board Meeting – 4 April 2024

Chair's Report

Presented by: Phil Townsend, Chair

1 PURPOSE

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

2 NEWS AND DEVELOPMENTS

NHS Covid Waiting List Continues to Fall

2.1 NHS England announced in March that the NHS covid backlog fell for the fourth month in a row in January, despite the longest period of industrial action in NHS history. January data showed a fall of 27,761 patients on December's data. Work continues to focus on the longest waits and the number of those waiting over 65 weeks down by 60% when compared to the peak in June 2021.

Pathology Update

2.2 As part of our commitment to work in close collaboration with our partners to further improve services across the region, our pathology team will be joining a shared pathology network in early 2025 with East and North Herts, and the Princess Alexandra Hospital NHS Trusts, the Trusts in the Herts and West Essex ICB. The single shared pathology service will support our hospitals, community services, GPs and the patients we care for. This move will bring many benefits including significant financial investment in state-of-the-art equipment, new laboratories and staffing resilience. However, we recognise these changes will be unsettling for some colleagues. We will continue to work closely with those directly impacted and support them with the new arrangements.

Celebrating Healthcare Science Week

2.3 11 – 15 March was Healthcare Science Week, celebrating over 50 scientific specialisms and professional groups and raising awareness of this diverse and highly qualified NHS

workforce. Our pathology team currently comprises 267 healthcare science colleagues. Thank you to all who work at West Herts providing services for our patients.

Shared Care Record Update – Additional Trusts Added

2.4 Tavistock and Portman NHS Foundation Trust, North Middlesex University Hospital NHS Trust and Moorfields Eye Hospital NHS Foundation Trust are the latest to join the considerable list of partners in the capital thanks to our connection to the London Care Record. The Shared Care Record brings together information from the electronic record held by the different places patients receive their care. This allows health and care professionals to access a real-time summary of key information, safely and securely as the deliver their care.

Nutrition and Hydration Week

2.5 The week commencing 11 March also saw the Nutrition and Hydration Week which highlights the importance of eating and drinking well to maintain health and wellbeing. Good nutrition is key for our patients in aiding wound healing, helping fight infection and reducing length of stay in hospital. It is important to remember that the same principles apply to us, so that we have a well-functioning and healthy workforce.

Understanding ADHD and Low Self-esteem Webinar

2.6 As part of the Neurodiversity Celebration week, 18 – 24 March, the NHS Talking Therapies Hertfordshire hosted a webinar called "Understanding ADHD and low self-esteem'. This was open to all staff. Staff are also welcome to join the staff network Diversibility which has a neurodiversity subgroup. This offers a safe space to talk.

3 Community News

West Herts Support for Charities' Fundraiser

3.1 We were delighted to have supported a charity event called "Sleep Out" held at Watford Foodball Club. The event helped homelessness charities in Hertfordshire raise over £50,000. Almost 300 people slept out at the Stadium for the night to experience what it was like to sleep rough. We helped by supporting the charities with free overnight parking in Watford General's car park.

New Armed Forces Network

3.2 I am pleased to announce our newly formed Armed Forces Network. The network is dedicated to bringing together members of all the Armed Forces, veterans and their family and friends in a welcoming and inclusive environment within our Trust. On Tuesday 26 March the network hosted a stall in the dining room to help promote this worthy cause.

Introducing Revd. Christian Damanka

3.3 I would like to wish a very warm welcome to Revd, Christian Damanka, who joins us as our new spiritual and pastoral care lead. Revd Damanka brings a wealth of experience in NHS chaplaincy from Guys and St Thomas', Barts Health and Kings College Hospital. Revd. Damana and his team are dedicated to making spiritual care and pastoral support readily available to all individuals at West Herts.

David Taylor, Labour Parliamentary Candidate for Hemel Hempstead Visit to Watford

3.4 On 13 March we welcomed David Taylor, Labour Parliamentary Candidate for Hemel Hempstead, to Watford General Hospital. The visit also included Pete Hannell, Labour Councillor for Bennetts End. We were able to show David and Pete around our Control Centre, Accident and Emergency Department, as well as the model of our new hospital, situation by the Executive Meeting Room. The visit ended with a tour of our Virtual Hospital.

Star of Herts Walkarounds

3.5 March saw this year's initial Star of Herts winners during the first of hopefully many walkarounds. Congratulations to all those amazing members of staff who are nominated.

4 Hertfordshire and West Essex ICS

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

5 BOARD NEWS

5.1 April Board visit programme:

- Emergency Department/Emergency Assessment Unit
- Shrodells Unit
- Michael Clements Diabetes Centre
- Clinical Engineering

6 Chair's meetings:

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

- Board preparation
- Trust Board meeting
- Key sub committees
- Governance arrangements
- Consultant / NED interviews
- CEO strategy meetings
- ICB Chairs' meeting
- CEO and Chair Session
- Labour Candidate for Hemel Hempstead and Councillor Tour of Watford General Hospital
- Lord Richard Harrington Tour of Watford General Hospital

7 RECOMMENDATION

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

Phil Townsend
Chair

28 March 2024

West Hertfordshire Teaching Hospitals NHS Trust

Trust Board Meeting
4 April 2024

Title of the paper	**Chief Executive's Report**
Agenda Item	**9**
Presenter	**Matthew Coats, Chief Executive**
Author(s)	**Carolyn Greeves, Chief of Staff**
Purpose	**For approval** | **For discussion** | **For information** ✓
Executive Summary	The aim of this paper is to provide an update to the Board on items of national and local interest/relevance since the last meeting. The information in the report is drawn from a variety of sources, including information published by NHS England, Department of Health and Social Care, NHS Providers and the Care and Quality Commission.

Trust strategic aims

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

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

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

9

West Hertfordshire Teaching Hospitals NHS Trust

Agenda Item: 9

Trust Board Meeting – 04 April 2024

Chief Executive's Report

Presented by: Matthew Coats, Chief Executive Officer

1 PURPOSE

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

2 KEY ISSUES

Performance

2.1 Great focus has been given to improving the timeliness of care of patients who are on the Emergency and Urgent Care pathway. The nursing, medical and operational teams across all divisions are working collaboratively and making good progress with our patient flow. I would like to thank the staff for all their hard work and offer my continued support.

2.2 Another area the divisions have been working on are the patients receiving care through our elective services. We are working hard on improving our patients' experience by reducing waiting times for treatments. Thank you to everyone involved for everything they are doing.

3 CHIEF OFFICERS UPDATES

Chief Medical Officer

New Ward at Watford General Hospital

3.1 Thank you to all the staff at the Trust who have worked so hard to open our new ward in on Level 2 of the Shrodells Unit. The ward is home to 44 general medical beds and has improved ventilation and updated features with the capacity to act as a surge ward. Staff and patients alike will benefit from the air conditioning and brand-new IT equipment.

Chief Finance Officer

3.2 In February 2024 the Trust's financial position delivered a £7.24m surplus against the in-month target of a £0.25m planned deficit. Year to date, after 11 months of the financial year, the Trust is reporting an actual deficit of £13.6m against a planned deficit of £5.8m. The in-month position was vastly improved by distribution of funding from the ICB resulting in an in-month improvement of £10.6m. The adjusted forecast for the financial year is £13.5m. Further information regarding the financial situation is available in the Finance report.

Chief Nurse

Emma Willis: Delivering Babies

3.3 A big thank you to the maternity department for welcoming Emma Willis to the Trust. During filming of Emma Willis: Delivering Babies, Emma has been working as a maternity support worker while capturing stories and experiences of new families and our amazing staff who bring new life into the world. In a recorded message Emma thanked our dedicated staff and the incredible individuals she has had the privilege to meet and work with.

Director of Midwifery Announcement

3.4 I am delighted to announce that Penny Snowden joined the Trust as Interim Director of Midwifery at the beginning of March. Penny is an experienced midwife and has over 30 years nursing experience in the NHS. We are excited to have Penny as part of the team to continue the work already embedded in our maternity unit.

Brilliant Basics

3.5 Brilliant Basics continues with an early Spring clean. The work includes checking for out-of-date drugs and equipment as well as posters and leaflets. Thank you to all staff for their hard work with this clean up programme.

Chief Operating Officer

3.6 In line with our plans to incorporate improvement methodology into our refreshed strategy I would like to thank Tudor ward staff and the Quality Improvement (QI) team for their work on capturing real time data, improving board rounds and criteria led discharge. This has allowed the operational teams to gather more accurate information, manage the hospital flow more efficiently and overall improve patient care.

4 NEWS AND DEVELOPMENTS

Chief Operating Officer Appointment

4.1 I am delighted to announce the appointment of Rachel Tustin as Chief Operating Officer. Rachel will be joining us from 6 May and brings a wealth of experience in NHS operational leadership. Rachel has been at the Royal Marsden Hospital since 2020 where she ran the internationally renowned private patient division before leading the delivery of their new Digital Health Record trust wide. Prior to this Rachel led the Division of Medicine and Emergency Care at Hillingdon Hospital as well as working with a range of trusts in consultancy roles.

4.2 I am sure you will join me in thanking Mary Bhatti for all her hard work whilst covering this role. Mary has made a big contribution to our patient flow during a time of significant operational challenges, including winter pressures and industrial action.

New Outpatient Entrance at Watford General Hospital

4.3 I would like to thank all the outpatients' team for their support and involvement during the changes to the access to outpatients at Watford. The access to the department has been changed due to the building work for the new fracture unit. New signage leads patients to a brand-new reception area. The work also includes a new room in outpatients which can house a hospital bed, previously unachievable due to the door size.

Shared Care Record Shortlisted for a National Award

4.4 I'm pleased to announce that the Hertfordshire and West Essex (HWE) Shared Care Record has been shortlisted as a finalised in this year's HSJ Digital Awards. These awards recognise digital innovations which transform care delivery and enhance efficiency and improve patient outcomes.

Plans for a New Temporary Car Park at St Albans City Hospital

4.5 Thank you to all our staff at St Albans City Hospital for their co-operation and understanding as enabling works for our exciting plans to increase the volume and range of services at St Albans City Hospital continue. These works are putting pressure on parking spaces, so plans to use some of the park next to the hospital, known as Oysterfields, as a temporary car park are underway.

5 RECOMMENDATION

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

Matthew Coats
Chief Executive

28 March 2024

West Hertfordshire Teaching Hospitals NHS Trust

Trust Board Meeting in Public
04 April 2024

Title of the paper	**Board Assurance Framework report**
Agenda Item	**10**
Presenter	**Matthew Coats, Chief Executive Officer**
Author	**Jean Hickman, Interim Director of Governance**
Purpose	*For approval* ✓ / *For discussion* / *For information*
Executive Summary	This report is to provide the Board with assurance that risks to achieving the Trust's strategic objectives are being appropriately mitigated, to consider those elements that report direct to Board and any recommendations of changes from assurance committees. The BAF dashboard and detailed risks are attached for the Board to approve. The risks were discussed at the Finance and Performance Committee and Quality and Safety Committee on 27 March 2024 and no changes are recommended. The BAF will be reviewed against the Trust's new strategy in April and the refreshed BAF will be presented to the Board in May 2024.
Trust strategic aims	**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?

10

Previously considered by	• Finance and Performance Committee on 28 March 2024 • Quality & Safety Committee on 28 March 2024
Action required	The Board is asked to review the latest version of the BAF and approve.

West Hertfordshire Teaching Hospitals NHS Trust

Agenda Item: 10

Trust Board meeting – 04 April 2024

Board Assurance Framework report

Presented by: Matthew Coats, Chief Executive Officer

1. Purpose

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

2. Background

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

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

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

10

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

	– What has happened; why it has happened and what is the response – 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 March 2024.

3.2 Elements of the BAF were reviewed on 28 March 2024 by the Quality and Safety Committee and Finance and Performance Committee and no changes are recommended.

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

4. Next Steps

4.1 The BAF will be reviewed against the Trust's new strategy in April and the refreshed BAF will be presented to the Board in May 2024.

5. Risks

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

6. Recommendation

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

Matthew Coats
Chief Executive Officer

April 2024

		BOARD ASSURANCE FRAMEWORK FOR 2023-24																		
		Trust Board Dashboard																		
Strategic Aim/Priority		Risk no	Risk description	Executive Lead/ Committee	Link to CRR	Risk Score (L x C)														
						Residual April 22	Jun/ Jul 22	Aug/ Sep 22	Oct/ Nov 22	Dec/ Jan 23	Feb/ Mar 23	April/ May 23	June/ Jul 23	Aug/ Sep 23	Oct/ Nov 23	Dec/ Jan 23/24	Feb/ Mar 23/24	Target (03/ 2024)			
Best Care	Resilient Services	1	If we do not work with acute partners, then we won't be able to strengthen fragile services, recover our acute waiting list and improve patient outcomes.	Toby Hyde / QSC		20 (5 x 4) HIGH	20	20	20	16	16	16	16	16	16	16	16	12 (3 x 4) Mod		
	Improving access to care	2	If the Trust and wider system does not have sufficient elective and diagnostic capacity, then its waiting lists will increase, and patients will be unable to access timely care.	Mary Bhatti/ QSC	4019 4496 4497	20 (5 x 4) HIGH	20	20	20	16	16	16	16	16	16	16	16	9 (3 x 3) Low		
		3	If the number of non-elective patients continues to rise, then this will detrimentally affect the Trust and wider system's ability to treat elective patients and reduce its waiting lists for elective care.	Mary Bhatti/ QSC	3828 4444	20 (5 x 4) HIGH	20	20	20	20	20	20	20	20	20	20	20	9 (3 x 3) Low		
		4	If we have insufficient staff because of low morale, inability to recruit or no enthusiasm for additional work, then we will be unable carry out additional elective work and reduce our waiting lists.	Andrew McMenemy/ QSC		20 (5 x 4) HIGH	20	20	20	16	16	16	16	16	16	16	16	12 (3 x 4) Mod		
	Reducing inequalities	5	If the Trust does not engage collaboratively with its patients and local communities, in the planning and delivery of care and services, then it may not meet the needs of its diverse population resulting in the exacerbation of health inequalities.	Kelly McGovern/ QSC		9 (3 x 3) Mod	9	9	9	9	9	9	9	9	9	9	9	6 (3 x 2) Low		
	Transforming our services	6	If we do not work with partners to transform our services, then we will not have sufficient capacity to provide safe and effective care to our patients.	Toby Hyde / QSC		20 4 x 5 HIGH	20	20	20	20	20	20	20	20	20	20	20	10 2 x 5 Mod		
Best Value	Ensure we can meet the health needs of our population within our budget on an on-going basis	7	Failure to agree a plan between the Integrated Care System and the Trust Board to reasonably support the balancing of this year's revenue income with revenue expenditure, when safely responding to expected patient demand.	Don Richards/ FPC		12 (3 x 4) Mod	16 4 x 4 High	12 3 x 4 Mod	12	12	12	12	12	12	12	12	16	8 (2 x 4) Mod		
		8	Failure to take corrective action to manage internal/external factors, may result in the trust being unable to adhere to the agreed financial plan.	Don Richards/ FPC		16 (4 x 4) High	16	16	16	16	16	16	16	16	16	16	20	8 (2 x 4) Mod		

		9	Failure to agree a realistic long term financial plan that is consistent with ICB long-term allocations compromising the ability to transform the estate and services to meet the longer term needs of the population.	Don Richards/ FPC		12 (3 x 4) Mod	12	12	12	12	12	12	12	12	12	12	16	8 (2 x 4) Mod
Great Team	Culture of inclusion and diversity	10	Engagement and inclusion with staff will be affected negatively where we do not support and celebrate cultural diversity and demonstrate opportunities across all areas of our workforce to ensure it is representative.	Andrew McMenemy/ PERC		12 (4 x 3) Mod	12	12	12	12	9	9	9	9	9	9	9	6 (3 x 2) Low
	Improve workforce sustainability	11	Sustainable staffing and improved levels of retention will be affected if we do not invest internally in a positive workplace experience, staff development and externally in local and international candidate opportunities.	Andrew McMenemy/ PERC		16 (4 x 4) HIGH	16	16	16	16	12	12	12	12	12	12	12	8 4 x 2
	Develop as a learning organisation	12	The morale and retention of our skilled workforce is at risk if we do not support and prioritise learning and career opportunities for our staff in order to maintain and enhance development and reduce staff turnover.	Andrew McMenemy/ PERC		16 (4 x 4) HIGH	16	16	16	16	12	12	12	12	12	12	12	8 4 x2
Great Place	Digital and IT innovation	13	If the Trust is unable to secure sufficient funding to support its digital strategy, then its ability to transform its services will be affected.	Paul Bannister/ RPC		15 (5 x 3)	15	15	15	15	15	15	15	15	15	15	15	6 2 x 3
	Redevelop our hospitals	14	If the confirmation of our capital allocation is delayed, it could lead to increased risk to the safe operation of the existing Watford hospital.	Alex White/ RPC		20 (5 x 4)	20	20	20	20	20	20	20	20	20	20	20	12 3 x 4
	Environmental Sustainability	15	If we do not minimise the Trust's adverse impact on the environment, then we may suffer reputational damage, cause increased pollution within our local and wider community and lose out on cost saving opportunities.	Toby Hyde/ RPC		9 (3 x 3)	9	9	9	9	9	9	9	9	9	9	9	4

Risk Matrix

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

Risk appetite statement

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

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

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

Threshold Matrix

Risk appetite	**What this means**	
Very low	The Board is not prepared to accept uncertainty of outcomes for this type of risk.	
Low	The Board accepts that a level of uncertainty exists but expects that risks are managed to a level that may not substantially impede the ability to achieve objectives.	
Moderate	The Board accepts a moderate level of uncertainty but expects that risks are managed to a level that may only delay or disrupt the achievement of objectives but will not stop their progress.	
High	The Board accepts a high level of uncertainty and expects that risks may only be managed to a level that may significantly impede the ability to achieve objectives.	
Category	**Risk Appetite**	**Risk Appetite Score**
Quality safety	VERY LOW risk appetite for risks that may compromise safety such as patient harm, infection control, pressure sores and learning lessons.	1 - 5
Affordability	VERY LOW risk appetite for unaffordable items which would affect the financial sustainability of the organisation.	1-5

Quality effectiveness	LOW risk appetite for risks that may compromise the delivery of outcomes for service users such as outcomes, delays, cancellations or operational targets and performance.	6 - 9
Statutory compliance	LOW risk appetite for risks that may affect statutory compliance such as Information Commissioner, CQC, H&S, professional standards and external certifications.	6 - 9
VFM	LOW risk appetite for affordable patient safety items where there is a degree of subjectivity regarding assessment of VFM.	6-9
Workforce recruitment and retention	LOW risk appetite for risks that would affect equal opportunity and diversity and compromise fair recruitment and attractiveness of Trust as employer of choice.	6-9
Clinical innovation	MODERATE risk appetite for clinical innovation that does not compromise quality of care	10 - 12
Compliance/regulatory	MODERATE risk appetite for compliance/regulatory risks ***where there are no risks or compromise in quality safety***	10 - 12
Reputation	MODERATE risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the organisation	10 - 12
Quality experience	MODERATE risk appetite for risks that may affect the experience of service users	10 - 12
Workforce innovation	MODERATE risk appetite for actions and decisions taken to improve workforce health and wellbeing and future staffing requirements.	10 - 12
Partnerships	HIGH risk appetite for partnerships which may support and benefit the people the Trust serves	15 - 25
Commercial	HIGH risk appetite for commercial gain whilst ensuring quality and sustainability to service users	15 - 25
Digital innovation	HIGH risk appetite for digital innovation that challenges current working practices in support of digital systems that will produce benefits for the organisation.	15 - 25

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

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

Context	Gaps in Control and Assurance
The new legislation has an expectation of acute providers improving their collaboration with each other. The pandemic has significantly impacted the provision of services. Collectively, we have extremely high waiting lists which will require a coordinated approach across the acute trusts in our Integrated Care System. Some of our more specialised services serve relatively low patient numbers which makes it more difficult for them to withstand increased service pressures, such as staffing and resource issues, which leads to fragility. Pooling our resources with other acute providers would strengthen these services, create greater resilience, and provide better patient experience and outcomes.	Some services lack a standard operating procedure for out of hours services with no contract in place with a tertiary provider.

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

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

Progress		
Positive progress including future opportunities	Current challenges including future risks	How challenges are being managed
The collaborative surgical hub has been approved and is progressing, which will strengthen our ability to recover elective performance, reduce the impact of unplanned care demand on surgical activity and improve patient outcomes. The hub has appointed a Programme Director. 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	Mary Bhatti
Reporting Committee	Quality Committee

Risk Score

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

Context

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

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

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

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

Gaps in Control and Assurance

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

- Launched recovery plan which links with the submissions made in the annual plan.
- Established a monitoring and oversight governance structure. Elective activity meeting, RTT Programme board, patient access meetings. Availability of monitoring data for divisions' to assess productivity performance & PTL management.
- Outsourcing Group provides oversight on private and independent sector capacity utilisation to maximise activity opportunities.
- Outpatient transformation. Non- face to face, PIFU, Patient portal and referral management systems.

Scoring

The risk score has been reduced to 16 from 20. (4(L) x 4(C)). I.e. That it is likely that the risk will probably happen/recur but it is not a persisting issue. The consequence is assessed as "Major - non-compliance with national standards with significant risk to patients if unresolved".

For the risk score to reduce, the likelihood score must reduce to "Possible - might happen or recur occasionally" to reach the target likelihood score. The consequence rating would need to reduce to "Moderate - treatment or service has significantly reduced effectiveness."

Presently, the risk score has reduced to 16 to reflect that the risk of insufficient elective and diagnostic capacity will probably happen but is not a persistent issue that will lead to non-compliance with national standards with significant risk to patients if unresolved.

Progress

Positive progress including future opportunities	Current challenges including future risks	How challenges are being managed
Established outsourcing criteria – outsourced more complex patients. Proactive reduction of 104 week waiters Work on reducing long waits continues, with a small number of 78 week waits due to complexity and/or capacity remaining. Focused work on delivering a reduction of 65 +week waits is delivering month on month improvements.	Referral profile post COVID has changed, with an increased proportion of urgent and cancer referrals. There has been some uptake on additional and elective activity by the clinicians to support recovery. EPR Review has highlighted a number of gaps in User knowledge therefore a training pack and process has been provided for existing staff and new starters. urgent care pressures have resulted in a reduced elective bed base at WGH, limiting capacity for complex, WGH only cases. Industrial action has necessitated the cancellation of routine procedures when consultant or junior doctor cover necessitates the prioritisation of other urgent activities.	Continuous review of demand and referral profile. Monitoring of productivity by division/specialty. Increased external performance oversight. EPR – close working with trust's digital leader and participation in digital steering group. Approval of business case for increased validation resources. Development of RTT and EPR training programme following review of issues leading to poor DQ within the PTL. Roll out commenced in Feb/Mar 23. Refreshed High impact patient flow actions to reduce use of surge to facilitate more elective activity in WGH. Monitoring the rebooks following IA through The RTT programme board. 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	Mary Bhatti
Reporting Committee	Quality Committee

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

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

Context	Gaps in Control and Assurance
There is clearly an element of fatigue and discontent in the workforce that is demonstrated more widely across the NHS with ongoing industrial action. At West Herts the impact of this has been relatively low. In addition, the recruitment levels have been positive with the vacancy rate continuing to fall and stay within our set targets. However, there are areas of risk particularly within some specialities for consultant posts, maternity continues to provide challenges as well as some roles within our allied health professional group. The elective work in the NHS has historically been supported by staff undertaking additional duties with an emphasis on consultant roles. This has been impacted by pandemic as well as the national changes to the annual allowance on pensions. Therefore we are seeing less staff take these opportunities for additional sessions and therefore having a detrimental impact on our productivity to support the elective recovery.	The gap that existed was the lack of any national solution to the pension situation, especially for those breaching their annual allowance. This was also exacerbated by no local solution to support those staff reaching the threshold of their annual allowance.

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

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

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

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

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

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

Progress		
Positive progress including future opportunities	Current challenges including future risks	How challenges are being managed
Work to improve health inequalities within maternity services has started. We are compliant with Ockenden requirements following identification of patient safety specialist to collaboratively work with corporate staff and to manage the risk and governance process. Work is on-going to develop provisions for listening to friends and families more effectively. And the maternity voice partnership has been engaging with local groups and has undertaken site visit with a plan to continue. We have started work on the EDS3 assessment and we are working with ICS to develop a system wide framework. Internal mapping is complete with a list of non-staff networks and existing co-production board stakeholders.	Lack of knowledge of the baseline. Resources – now have a dedicated EDI champion.	We are working with the ICS to develop a program plan which will go part-way to mitigate the resources issue. Internal – project plan to put structure in place. Following internal mapping, we will develop a robust delivery plan. A Promoting Inclusion project has commenced seeking to reduce inequalities and promote inclusion across our services. The group have reviewed EDI data captured on EPR and identified gaps for improvement. The group are exploring research opportunities to understand how accessible our complaints and interpreting services are for patients from black, Asian and minority ethnic groups and the incidents which they are more likely to experience.

BAF Risk 6	If we do not work with partners to transform our services, then we will not have sufficient capacity to provide safe and effective care to our patients over the next five years.														
Strategic Priority	Transforming our services		Risk Score												
Review Date	Monthly		Residual	Apr/May	Jun/July	Aug/Sep	Oct/Nov	Dec/Jan	Feb/Mar	Apr/May	June/July	Aug/Sept	Oct/Nov	Dec/Jan	Feb/Mar	Target
Exec Lead	Toby Hyde		20 (4 x 5)	20	20	20	20	20	20	20	20	20	20	20	20	10 (2 x 5)
Reporting Committee	Quality Committee														

Context	Gaps in Control and Assurance
Hospital services are currently under huge strain. Demand is growing and is presently exceeding the capacity available within the hospital. This is impacting on the provision of elective care and emergency care and is at high risk of becoming worse over the next five years. 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.	Reporting gaps have been addressed with monthly reporting to HCP board. However, we are not yet able to measure the impact on the emergency and elective demand.

Scoring

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

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

Progress		
Positive progress including future opportunities	Current challenges including future risks	How challenges are being managed
Virtual Hospital – we are continuing to develop the service to facilitate earlier discharge of patients and reduce hospital admissions. We are seeking to go live with further pathways and expand capacity during 23/24 in line with our revised trajectory submitted to HWE ICB. The acute collaborative strategy has been agreed with system partners, PAH AND East and north. This will help to inform the delivery plan for the elective system hub which will contribute to the recovering our elective activity.	We need to do a lot in a relatively short space of time – resourcing capacity and working at pace is challenging. We will need to manage within varying G&A bed stock through 2023/24, placing additional emphasis on the need to reduce demand through system-wide initiatives.	Daily discussions within the trust and across HWE ICS on how we can improve flow through the system and provide safe, high quality care to our patients. Updated VH strategy and expansion to include frailty pathway (which went live in July 2023). Ongoing monitoring to ensure we are tracking throughput, capacity and impact of the VH model.

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

Strategic Priority	Ensure we can meet the health needs of our population within our budget on an on-going basis.
Review Date	Bi-monthly
Exec Lead	Rodney Pindai
Lead Committee	Finance and Performance Commitee

Risk Score

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

Context

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

Gaps in Control and Assurance

Inflation forecasts are not stable and the current funding for inflation within contracts and prices does not cover current inflation forecasts.

The efficiencies required to support the financial plan are not yet fully developed.

The plans for elective activity recovery and hence forecasts for elective recovery funds are ambitious.

Data quality necessary to monitor the planned activity plan is not yet fully assured.

The forecasts and funding for the growth in emergency care demand are limited, assuming some degree of system working to manage demand. Demand management effects are yet to be assured.

Progress

Positive progress including future opportunities	Current challenges including future risks	How challenges are being managed
National recognition that plans to balance income with expenditure contain unmitigated inflation risk. Efficiency programme governance in place to support Divisions in developing efficiencies. National work to test resources necessary to respond to a 7.5% increase in emergency care demand. Divisions have set out and signed off high level plans for increasing elective activity. Increased support from the Centre for Elective Recovery Funding.	Inflation effect manifests the worst case and additional inflation funding is not made available. Efficiency programme governance fails to support delivery of £15m general savings and £2.9m EPR related savings. Demand management fails, emergency care demand exceeds expectation and additional funds not made available.	Frequent dialogue with the ICB highlighting risks/conditions within the plan which must be mitigated/met to deliver financial balance. Internal audit of financial governance planned. Stronger ICP governance. Review of inflation forecast by CFO.

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

Strategic Priority	Ensure we can meet the health needs of our population within our budget on an on-going basis.
Review Date	Bi-monthly
Exec Lead	Rodney Pindai
Lead Committee	Finance and Performance Commitee

Risk Score

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

Context

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

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

Gaps in Control and Assurance

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

Progress

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

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

Strategic Priority	Ensure we can meet the health needs of our population within our budget on an on-going basis.
Review Date	Bi-monthly
Exec Lead	Rodney Pindai
Lead Committee	Finance and Performance Commitee

Risk Score

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

Context	Gaps in Control and Assurance
The long term financial plan gives assurance to the health system and regulators that the Trust can remain financially viable while transforming the estate and the way that services are provided to meet long term demand projections. If the Trusts long term plan is not consistent with ICB allocations and plans, the Trust's transformation plans will not be authorised to go ahead and necessary investment funds will not be made available.	ICB in its infancy and the lack of a published recognised ICB long term financial plan. Any single capital investment in excess of £15m requires regulator approval. For example, the long term plan includes plans for the major redevelopment of the estate. The Trust is yet to have an outline business case approved.

Progress

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

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

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

Risk Score

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

Context	Gaps in Control and Assurance
The staff survey has demonstrated that we continue to have variations on how staff are treated based on their protected characteristics. The Trust is diverse with nearly 50% BAME population. However, our workforce becomes less diverse the more senior the role becomes. Therefore, creating an inclusive and supportive culture with extended opportunities for development and career development is important.	The main gap was measuring the outcomes from the interventions that have been implemented. In addition, there are gaps being developed such as career coaching, leadership development review and a talent management strategy.

Progress

Positive progress including future opportunities	Current challenges including future risks	How challenges are being managed
The EDI steering group is now well established and has successfully overseen reports and recommendations associated to WRES and WDES actions that were presented to Board in October 2023. There has been good progress in priority areas including reciprocal mentoring and values-based recruitment. In addition the programme of cultural awareness sessions commenced in October 2023.	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 alongside TMC. The WRES and WDES recently provided 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	October 2023
Exec Lead	Andrew McMenemy
Reporting Committee	PERC

Risk Score

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

Context	Gaps in Control and Assurance
Staff retention is one of the main challenges facing the NHS. WHHT is now demonstrating continued reduction in levels of turnover over a sustained period of time. There continues to be challenged specialities and staff groups with relevant mitigations in place. The focus has moved to hotspot areas and mitigations to support positive cultural changes.	Review of organisational values and introduction of behavioural framework that is currently being discussed across the Trust in a bottom up approach. 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
The new induction programme to support new starters in the first 12 months of their employment has been particularly successful with continued improvements in turnover rates. The new framework for staff development and education is a key area based on feedback from our staff survey in terms of supporting career development and therefore assist in retaining staff.	Alongside reductions in the turnover rate and effective recruitment there continue to be areas that require further support such as AHPs, Maternity & paediatrics. Main challenges around retention associated with vertical integration, development opportunities with our HCA workforce most affected by high rates. Affordable housing is also a more common theme that is associated with turnover.	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	**October 2023**
Exec Lead	**Andrew McMenemy**
Reporting Committee	**PERC**

Risk Score

Residual	Apr/May	Jun/July	Aug/Sep	Oct/Nov	Dec/Jan	Feb/Mar	Apr/May	June/July	Aug/Sept	Oct/Nov	Dec/Jan	Feb/Mar	Target
16	16	16	16	16	16	12	12	12	12	12	12	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 alongside supporting pulse survey feedback 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 January 2024 with some interim initiatives in place from Autumn 2023. Effective partnership has been identified with the Kings Fund, University of Hertfordshire and West Herts College.	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.

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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	Redevelopment Programme

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

Context	**Gaps in Control and Assurance**
The funding required to implement the digital strategy that supports the Trust's longer-term ambitions has not been identified. An on-going commitment to digital investment is required. We have agreed to fund the "digital imperatives" for the new hospital in the acute redevelopment OBC, conversations continue around how we secure the remaining funding.	Inability to have an effective conversation on internal commitment to technology 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.	Lack of certainty around national digital requirements for new hospital programme.

Scoring

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

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

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

Progress

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

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

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

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

Scoring

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

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

Progress

Positive progress including future opportunities	**Current challenges including future risks**	**How challenges are being managed**
The Trust Board approved its preferred option for the redevelopment site at its meeting on 31 May 2022. 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 Secretary of State for Health & Social Care has confirmed that the new hospital at Watford will be fully funded. This was confirmed by the Prime Minister when he visited site in the summer of 2023.	The infrastructure of the trust continues to deteriorate, increasing risk associated with delays The delay to approval of the enabling works business case will impact the timeline of the overall project. The Outline Business Case is being updated ready for submission to the NHP.	Close liaison with NHP and ensuring that the Trust is ready to progress to the next phase of the programme.

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

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

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

Scoring

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

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

Progress		
Positive progress including future opportunities	**Current challenges including future risks**	**How challenges are being managed**
The Trust Board approved its Green Plan on 4 February 2022. 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: 11

Report to:	**Trust Board**
Title of Report:	**Assurance report from Trust Management Committee**
Date of Committee meeting:	**28 February 2024**
Quoracy:	**The meetings were quorate**
Date of Board meeting:	**04 April 2024**
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 28 February 2024 2024
Background:	The Committee meets monthly and provides assurance to the Board: • Delivery of the clinical strategy • Revenue investment up to £1m • Operational performance • Operational risk • Safety and business continuity • Information technology • Internal and external communication strategy • Clinical quality • Business planning • Environment
Assurances received and items for update:	**Summary:** Assurance was provided on the monitoring of operational, financial and clinical performance and the development, implementation and monitoring of strategy. **Regular reports received and discussed for assurance:** • Finance update • Integrated performance report • Performance report

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- Divisional updates from Divisional Directors and/or Divisional Managers

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

- St Albans programme update

Reports received for approval:

- Mutually agreed resignation scheme (approved)
- Apprenticeship First Scheme (approved)
- Business case for the relocation of admin staff to Civic Centre
- Business case for the relocation of SACH staff

Verbal reports were received from:

- The Chief Medical Officer provided feedback from the Clinical Advisory Group and Hospital Efficiency Group
- The Chief Nursing Officer provided feedback from the Professional Advisory Council
- The Interim Director of Governance provided a verbal update on the annual review of the Terms of Reference and committee work plan for 2024/25

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.

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NHS
West Hertfordshire Teaching Hospitals
NHS Trust

Agenda item:	**12**
Report to:	**Trust Board**
Title of Report:	**Assurance report from the Finance and Performance Committee**
Date of Committee meeting:	**29 February 2024**
Quoracy:	**The meeting was quorate.**
Date of Board meeting:	**4 April 2024**
Recommendation:	**For information and assurance**
Committee Chairperson:	**Harvey Griffiths, Non-Executive Director**
Purpose:	The report summarises the assurances received and documents the approvals of recommendations made to the Finance and Performance Committee at its meeting on 29th February 2024.
Background:	The Committee meets monthly and provides assurance on scheduled reports from all Trust operational committees with a finance, investment and access performance brief according to established work programmes and the effectiveness of related delivery. The committee provides assurance to the Board on any issues of concern it has with regard to any lack of assurance in respect of any aspect of finance

Summary:

- Another challenging month in terms of emergency care and patient flow
- VWA up slightly at 98.3% in month
- ENT has emerged as a high risk.
- Diagnostic performance improves, now at 85.2%. Strong performance on 65 and 78 week waits and cancer metrics.
- CNO reviewing workforce data in detail M9 forecast at £19m deficit with continued efforts to reduce this.
- BAF risk 8 - delivering the budget / plan remains at 20 – **major risk.**
- CIPS programme £9.6m to month 10, cash releasing element £7.4m. Committee Chair noted behind with high risks attached, critical we accelerate the run rate.
- CFO reported in month deficit of £2.6m and reduction in HICP. Forecast scenarios at month 10 indicated a base of £27m and a likely scenario of £18.5m
- Business planning on time but national guidance delayed and £30m budget deficit not acceptable. Cost reduction target increasing from 3% to 4% (some trusts at 8%)
- Committee Chair concerned the Trust was operating on capex as cash was low and continues to seek further detailed assurance on actions to reduce the deficit by month 12 and roll the all-important momentum into the next financial year 24/25 and beyond.

- **Declarations of interest**
  - No changes notified but new software system in place to notify.

- **Minutes of last meeting**
  - Approved as circulated.

- **Action log**
  - In progress and ongoing with two live actions (1 and 3)

- **Decision register**
  - Noted for information as an accurate record.

- **Work plan and committee register**
  - Noted for information as an accurate record.

- **Draft Terms of Reference**
  - More work required; approval deferred to March FPC then up to April Board

- **BAF Finance Risk Register incl review of Corporate Risk Register**
  - BAF risks 7 and 9 – both increased from 12 to 16.
  - BAF risk 8 - delivering the budget / plan remains major risk at 20 and has now materialised.

- **Access Standard Performance and Activity Recovery Overview ('ASPARO')**
  - Another challenging month in terms of emergency care and patient flow
  - Business continuity incident in month in response to capacity pressures.
  - VWA up slightly at 98.3% in month
  - Work continues with High Impact Change Plan ('HICP')
  - ENT has emerged as a high risk.
  - Diagnostic performance strengthens, now at 85.2%.

- **Integrated Performance Report ('IPR')**
  - much of the IPR reported and discussed in detail above.
  - SHMI showing negative variation for performance, although it is still within expected values according to Dr Foster
  - 1,891 patient safety incidents, 271 had resulted in harm which the patient representative found concerning. Patients spending over twelve hours in ED was reported to be another area of concern.
  - Strong performance on 65 and 78 week waits and cancer metrics.
  - CNO reviewing workforce data in detail.

- **Month 10 finance summary**
  - CFO reported in month deficit of £2.6m and reduction in HICP.
  - forecasted scenarios at month 10 gave a base of £27m and a likely scenario of £18.5m
  - the £18.5m was partly predicated on arriving at a settlement on high-cost drugs with the system.
  - In seeking assurance on the £18.5m YEF, Deputy CFO responded that months 11 and 12 were likely to be in line with the forecast as some overspend had already been allowed and a benefit in month 12 was expected due to paybacks.
  - Committee Chair concerned the Trust was operating on capex as cash was low.
  - Committee Chair continuing to seek further detailed assurance on actions to reduce the deficit by month 12.

- **Contracts and commerce**
  - Committee noted contracts and commerce generally on track and noted that month 9 had been discussed in detail.
  - Income has not been the problem.

- **Financial recovery plan - Month 10**
  - Committee Chair concerned with momentum and impact of HICP.

- **Efficiency programme**
  - £9.6m to month 10, cash releasing element £7.4 m
  - forecast based on £12 m and schemes established up to £12.2 m

  - £18.5m YEF did not take into account the impact of industrial action in February 2024. Deputy CFO hoped this would be offset by national funding.
  - Committee Chair noted behind with high risks attached, critical we accelerate the run rate.

- **Business planning**
  - CFO reported work on second version of the 24/25 business plan.
  - scoping work indicating £30m deficit for next year 2024 net of 3% cost reduction target. Not an acceptable budget position
  - Trust wide cost reduction target of 3% may be going to 4% (some trusts at 8%)
  - Nursing establishment under detailed review and will be critical.
  - Committee Chair stressed again Trust must not wait for delayed national guidance and must be bolder and quicker with NHP and other imminent transformational changes to tackle.

- **Capital programme**
  - 23/24 capital programme to month 10 was £38.7 m out £60m (down from £85.5m) with some deferrals into next year.
  - Committee Chair concern using capex cash for opex.

- **Procurement update and Cabinet Office spend controls**
  - Director of Procurement updated on procurement - plans on track.
  - Also reported savings for the ICS and the Trust were above the business case baseline targets and operational KPIs were strong.
  - One red KPI related to invoicing matching to purchase orders, but not a major concern.

- **Items for escalation to the Board**
  - Budget deficit and finances remain the major risk.

Items of note:	**Actions**
Key decisions taken:	None
Risks to refer to risk register:	Committee seeking further assurance on budget deficit and finances given BAF risk 8 delivering plan (Risk rating 20 – Major Risk)
Issues escalated to the Board:	None
Recommendations to the Board:	This report be taken for information and assurance and to aid discussion on other items on the Board's agenda

West Hertfordshire Teaching Hospitals NHS Trust

Agenda item: 13

Report to:	**Trust Board**
Title of Report:	**Assurance report from Quality and Safety Committee**
Date of Committee meeting:	**29 February 2024**
Quoracy:	**The meeting was quorate**
Date of Board meeting:	**04 April 2024**
Recommendation:	**For information and assurance**
Chair:	**Heather Moulder, Non-Executive Director**
Purpose:	The report summarises the assurances received, and approvals of recommendations made to the Quality and Safety Committee at its meeting on 25 January 2024. The purpose of the Quality and Safety Committee is to provide the Board with assurance that high standards of safety and compliance, harm free, high quality, safe and effective services/clinical outcomes are provided by the Trust, and that adequate and appropriate governance structures, processes and controls are in place throughout the Trust.
Background:	The Committee received reports on the following matters: **Standard reports received and discussed/noted for information and assurance:** • Corporate Risk Register and Board Assurance Framework report • Chair's reports from Risk Review Group **Additional reports received and discussed/noted for information and assurance:** • Quality Account timeline update • Diabetes Incidents Report • Nursing Establishment Review • Cervical Screening programme update • Deteriorating Patient Report • Bi-annual Safeguarding Report • GIRFT programme update for stroke services

- Health Records Management Report
- Mortuary Update Report

Assurances received and items for update:

The Committee noted the following:

The very detailed report describing the work that has been completed since the last Committee to ensure that there is appropriate and timely identification of deteriorating patents. The report outlined the key areas of challenge and risk and required mitigations and actions. These were clearly set out with the associated revenue implications; implementation plans and completion timelines. Plans for the introduction of Martha's Law were set out. The committee endorsed the proposed actions and will be receiving regular updates on progress.

Work undertaken in response to an increase in insulin incidents. The main cause of which are prescribing errors in large part due to the variety of insulins now available to prescribe with more becoming available in the near future.

The Chief Nurse presented the Nursing Establishment Review setting which gave details of the recommended increase in staffing levels within adult inpatient wards, emergency medicine and ITU. The paper fully set out the governance and assurance process for setting the establishments. There was robust discussion and challenge to test both the assumptions and recommendations. Following which the Committee endorsed the review findings in their entirety.

The increased workload of both the colposcopy clinics at St Albans City Hospital and Watford General Hospital however all key performance indicators are being met with treatment failures within target. The main challenge for the service being staffing, particularly laboratory staff and consultants.

The timeline of actions to ensure that the final version of the Trust's Quality Account 2023/2024 is ready for publication on 30 June 2024.

The Committee had a good discussion on the work presented within the very thorough Bi-annual Safeguarding Report. The team were thanked for the amount of work undertaken including:

- ongoing work with social care to meet out statutory obligations to protect our patients from harm, high levels of training compliance with clinical patient facing staff at band 5 now undertaking Level 3 training.
- mental capacity training for senior nurses and ward managers,
- continued focus for improving care for patients with a learning disability.

An area noted for improvement is the Oliver McGowan eLearning training currently at 50%.

The Hospital Independent Sexual Violence Advisor (ISVA) continues to develop with high referrals and positive patient feedback and evaluation. Following work with the police and crime commissioner, the Trust now has 3 sexual and domestic violence workers on site and we have recently appointed a further lead post to support the service in the Trust and also at the Lister Hospital.

The team were congratulated on winning a 'Star of Herts' award in September for outstanding demonstration of innovation and development. The team were also finalists in the national Nursing Times awards in the category of integrated approaches to care.

The Committee discussed the four safeguarding risks on the Trust risk register:

- ongoing county wide issues with the DoLS process,
- the risk that the acute trust environment provides challenges for providing safe care for patients experiencing mental illness,
- challenges with the recording of mental capacity on EPR,
- and the lack of in-reach mental health services and tier 4 specialist provision for under 18-year-old patients including eating disorders.

Progress is being made in each of these areas to mitigate and reduce the risk and the Committee will receive a further progress update in the next report.

The Committee noted that the referral rates to social care were appropriate and proportionate for an acute provider organisation of our size.

The Committee was provided with an update regarding the drafting of the new soft FM services specifications with initial drafts for review and timeline for any proposed changes.

The Committee was provided with an update following the recent asbestos incident at St Albans City Hospital involving an IT server cabinet, update included details of the actions taken to date and the future actions required. The committee was confident that all the apparent necessary actions were being progressed appropriately.

The progress that has been made with the mortuary improvement plan including:

- The risk for staffing being removed from the corporate register as all posts have been recruited to.
- Two new units commissioned to meet winter demands. A 19 bay surge unit at Watford General Hospital operational as of December 23 and a 46 bay unit at Hemel Hempstead General Hospital operational as of 05 January 2024.

Remedial works at Hemel Hempstead General Hospital planned to start April 2024. Capital Projects team will confirm exact start date following completion of surveys, Programme of works will last 3- 6 months and will bring a full closure to Hemel Mortuary. The Committee noted that the Coroner's Office is supportive of these plans and will redirect to other Trusts within the ICB during this time. The Coroners Team have led on mutual aid discussions and plans have been agreed and circulated.

Presentation from Dr Tolu Adesina on the progress against GIRFT stroke service recommendations. Staffing remains an issue with particular challenges in the recruitment of permanent consultants. The Committee also noted the ongoing issue of the gym area being used to bed surge patients. The Chief Nurse working with the interim Chief Operating Officer is treating this as an

area of priority to resolve. The committee strongly endorsed removing the stroke gym as an area of surge and that finding a solution is a key priority.

The key issue discussed was that of **outside normal working hours** there is a challenge as to the interpretation timeframes of CT angiograms. Ideally this timeframe should be 30mins. However, radiologists are not reporting CT angiograms within this timeframe, the earliest is c. 90 mins. This is due to in part workforce shortfalls and the delay in them electronically receiving the images taking 20mins to arrive.

To mitigate this issue a pilot collaboration is in place between the Trust and Charing Cross Hospital using AI software to make the radiological diagnosis for appropriate stroke patients potentially requiring transfer for thrombectomy. This negates the need to wait for the formal radiology report as Charing Cross team will review the AI images and see if the patient is suitable for a thrombectomy. Work is ongoing for new IT integration system and roll out of a new portal which may help with the radiologist reporting delay. There will be a report back to the Committee in 3 months.

Risks to refer to risk register:	None.
Issues for the Board to note:	None
Recommendation to the Board:	Corporate Risk Register and BAF - approved; Endorsement of Nursing Establishment Review.

Agenda Item:	**14**
Report to:	**Trust Board**
Title of Report:	**Assurance report from People, Education & Research Committee**
Date of Committee meeting:	**29 February 2024**
Quoracy:	**The meeting was quorate.**
Date of Board meeting:	**04 April 2024**
Recommendation:	**For information and assurance**
Committee Chairperson:	**Natalie Edwards, Non-Executive Director**
Purpose:	This report provides an update to the Trust Board on matters discussed and assurance received at the People, Education and Research Committee (PERC) at its meeting on 29 February 2024.
Background:	The purpose of PERC is to provide the Board with assurance that the Trust is meeting its requirements in relation to workforce metrics and obligations, including whistleblowing and freedom to speak up, meeting the key objectives of the People Strategy that its workforce is fit for purpose, engaged and that it provides a high- quality education provision and excellent research and development opportunities.

Summary:

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

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

- Chief People Officer update
- Core workforce Key Performance Indicators
- Annual review of terms of reference and action plan

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

- Leadership Development Programme
- Women as Medical Leaders
- Staff survey 2023 – Initial results
- Electronic Staff Record – Self Services Project Plan
- Guardian of Safe Working quarterly report
- Equality Delivery System 2 (EDS2) annual report
- Public Sector Equality Duty
- Nursing Establishment Review

Additional reports received and discussed/noted for approval:

- Education Strategy

Items to note:

The Committee considered areas in HR aligning with the People Strategy, the Education Strategy, and the Leadership Development Programme.

It was noted that work on the Medical Education Centre had been completed and papers had been received on Women as Medical Leaders, Guardian of Safe Working, equality and delivery, public sector equality, and the nursing establishment review.

Discussions had been held concerning the initial results of the staff survey, including concerns regarding the drop-in completion rates.

The Committee had received a report on the progress of the electronic staff record (ESR), in particular regarding self-service project plans. Workforce performance was seen to be showing encouraging trends with a good piece of work linking up the ESR with the digital strategy.

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

Agenda item:	**15**
Report to:	**Trust Board**
Title of Report:	**Assurance report from Redevelopment Programme Committee**
Date of Committee meeting:	**Thursday 21 March 2024**
Quorum:	**The meeting was quorate**
Chairperson:	**Helen Davis**
Purpose:	The report summarises the assurances received, and documents approvals of recommendations made by the Redevelopment Programme Committee at its meeting on 21 March 2024.
Background:	The Committee meets monthly and gains assurance on the delivery of the objectives of the redevelopment programme and the digital strategy. It provides senior-level leadership to shape and drive the implementation of these key elements of the Trust's future plan.

Summary:

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

CRO Report - The Redevelopment Programme Committee noted the progress being made.

For Watford, work with the New Hospital Programme (NHP) on demand & capacity was continuing, alongside further review of service pathways in readiness for the next design phase. A regional contractor engagement event would also be convened by NHP in the next few weeks.

Demolition of the existing 'theatre 5' at St Albans City Hospital had now completed to vacate space needed for the Elective Care Hub and the target completion date for the Community Diagnostic Centre at St Albans was confirmed as December 2024.

For Hemel Hempstead, work was taking place with partners to further consider the potential Hemel Market Square Health Hub option.

Redevelopment Phase One Recruitment - The Redevelopment Programme Committee noted the need to recruit additional staff, both to support the more detailed planning required for the new Watford Hospital and to deliver the significant interim capital programme. It was agreed that the Business Case for 'Phase 1' recruitment to the team would be submitted to April 24 Trust Board (Part 2).

Clinical & Digital Transformation Programme Board Update - The Redevelopment Programme Committee noted the planned digital improvements for the coming months, which included use of artificial intelligence to inform diagnostic reporting, use of the patient portal to verify if patients still required an appointment and use of the national federated data platform to support elective care recovery.

Communications & Engagement Strategy Update - The Redevelopment Programme Committee welcomed the staff engagement underway to support recruitment for the Elective Care Hub. Meetings had also been held with local residents in St Albans in relation to the planning application for a temporary staff carpark on nearby land.

Capital Expenditure Report - The Redevelopment Programme Committee noted the current underspent financial position for the Watford redevelopment project and the major projects programme, against nationally allocated capital funds for 2023-24.

Redevelopment Health and Safety Report - The Redevelopment Programme Committee received the Health & Safety report, noting that this would be a standing agenda item in future. There had been no reportable incidents during February 2024 and regular inspection continued for all active construction sites.

Items for the Board to note:

- Redevelopment Phase 1 Recruitment Business Case (Part 2)

Recommendations to the Board: None.

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Report to:	**Trust Board**	**Agenda item: 16**
Title of Report:	**Assurance report from the Audit Committee (written report of oral update given at Board meeting 7 March 2024)**	
Date of Committee meeting:	**5 March 2024**	
Quoracy:	**The meeting was quorate.**	
Date of Board meeting:	**4 April 2024**	
Recommendation:	**For information and assurance**	
Committee Chairperson:	**Edwin Josephs, Non-Executive Director**	
Purpose:	This report provides an update to the Trust Board on matters discussed and assurance received at the Audit Committee meeting on 5 March 2024.	
Background:	The Committee meets four times a year for regular business and has two additional meetings in relation to the year-end scrutiny and sign off process of the Trust's Annual Report and Accounts. It provides assurance to the Board on all aspects of internal and external audit, counter fraud, integrated governance, and internal controls and to ensure that effective assurance controls, structures, systems, processes, and controls are in place and functioning to support the achievement of the Trust's objectives.	

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

- **Committee Governance:**
  - Schedule of items to be included at future meetings as detailed in the Workplan
  - Scrutiny of the Charity Committee to seek assurance on how it was discharging its responsibilities, the impact it was making, and whether there were any changes to how it operates, or areas of focus that it needed to make.
  - Revision to Trust Standing Orders
  - Review of timetable for Annual Report and Accounts production
  - Review of Conflicts of Interests Policy
- **Financial Focus:**
  - The current financial position of the Trust and forecasts
- **Internal Audit:**
  - Progress report on audits in accordance with agreed Annual Plan
  - Progress on outstanding auditor's recommendations
- **Local Counter Fraud:**
  - Review of counter fraud progress against work plan and investigations
- **External Audit:**
  - Review of Annual Audit Planning Report including key dates
- **In-depth reviews and 'holding to account':**
  - Review of losses and compensations payments
  - Waiver/Tender register
  - Review of salary overpayments and progress in recouping funds
  - Conflicts of Interests and Gifts and Hospitality Register
  - Use of Trust Seal

Items of note:

- **Use of the Trust Seal-** there has been one occasion when the Trust Seal has been used since the Committee's last report to the Board
- **Review of Conflicts of Interests Policy-** the Committee had previously agreed a three month extension to allow a more complete review of the policy. This had now been carried out and updated taking into account some comments from the Trust's Counter Fraud auditors. The Committee endorsed the changes and the policy and would now go to the next part of the Trust's policy review group process.
- **Revision to Trust Standing Orders-** the Committee had reviewed the proposed revisions and fully endorsed the changes. These would be presented as a separate agenda item at the April Board meeting.

Recommendations to the Board:

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

The Committee fully endorsed changes to the Trust Standing Orders and recommend that these be approved by the Board.

West Hertfordshire Teaching Hospitals NHS Trust

Trust Board
04 April 2024

Title of the paper:	**Performance & Activity Recovery (February 2024)**
Agenda Item:	17
Presenter:	Mary Bhatti Acting 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:	An overview of performance against the core waiting times standards is included, with previous months for comparison. The junior doctor industrial action in late February has adversely affected activity delivery and performance this month. The scorecards detailing progress against the high impact change plans for both the Patient Flow Improvement and Elective Care Recovery programmes, are included. **Urgent & Emergency Care (UEC)** Performance has improved this month with an increase in support and focus on emergency care and patient flow. A&E performance (all types) was 70.8% and type 1 at 47.7%. Although there were 38 x 12 hour (from decision to admit) breaches, this was an improvement on the previous month. HHGH UTC maintained performance above the 95% standard but WGH UTC was well below at 88% and a recovery plan has been drafted by the service provider. Despite increases in ambulance handover delays, performance against the recovery trajectory remains positive. A business continuity incident was declared in the month in response to capacity pressures. Discharges, particularly at the weekend, continue at an insufficient level to support flow from ED in to the wards, despite implementation of the full capacity protocol and boarding. The work to drive improvement has been aligned with the trust strategy and high level details are included in the pack, **Elective, planned care** Industrial action and half term have resulted in reduced activity delivery in the month, with VWA currently at 95%. Delivery of activity plans is variable, with a 4% shortfall against the new outpatient appointment plan year to date and a much higher rate of follow up activity than planned. Elective inpatient activity was 5% better than plan for all activity types in the month. Overnight admissions remain below plan year to date. Delivery of the diagnostic activity plan remains positive, although there are shortfalls against plan in three modalities this month, one of which (flexible sigmoidoscopy) is not expected to improve due to coding changes.

There were 10 x 78 week waits at the end of the month and 65 week waits continue to reduce with 353 at month end. ENT remains a high risk specialty along with Dermatology, in terms of long waits elimination, but both services have plans in place which are delivering improvement.

All three of the consolidated cancer waiting time standards have been achieved. Gynaecology report the highest number of breaches against the 28 day Faster Diagnosis Standard (FDS) but a plan to increase capacity commenced in March with the arrival of a new consultant. Gynaecology and Urology account for 50% of the 62 day referral to first treatment breaches, both affected by capacity shortfalls, case complexity and patient availability (unfit and choice). The relative backlog (as a percentage of the cancer waiting list) is just above the NHSE target but the number of pathways over 62 days is better than the fair share allocation given to the trust.

Diagnostic performance improvement continues to improve, now at 90.9%, with improvement in Echo, DEXA, Cystoscopy and Audiology. Echo is compliant with the 99% standard, one of 7 modalities to do so. Thirteen modalities are compliant with the 95% national recovery target.

Trust strategic aims:

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

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

Links to well-led key lines of enquiry:

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

Previously considered by:

Committee/Group	Date
Trust Management Committee	27 March 2024
Finance & Performance Committee	28 March 2024

Action required:

- The Board is asked to receive this information for oversight of activity delivery and performance and progress against the high impact change plans for Patient Flow Improvement and Elective Care Recovery.

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Trust Board

4 April 2024

Performance & Activity recovery

February 2024 reporting period

Jane Shentall
Director of Operational Performance
19 March 2024

Core KPI overview – reporting month & year to date

West Hertfordshire Teaching Hospitals NHS Trust

Urgent & Emergency Care

4 hour performance: A&E all types
Feb: 70.8%% ↑
YTD: 70.8%
Trust stretch target: 80%
Interim national target: 76%

4 hour performance: Type 1 (WGH)
Feb: 47.7% ↑
YTD: 44%
Trust target: tbc

A&E Non-admitted performance:
Feb: 54.5% ↑
YTD: 51.7%
Trust target: 80%

Ambulance handovers: hours lost over 30 minutes
58
Trust plan: 120 (weekly)

Planned Care

RTT 78 week waits
Feb: 10 ↓
National target: 0

RTT 65 week waits
Feb: 353 ↓
National target: 0 by April 24

Cancer 28 day faster diagnosis
Feb: 79.6% ↑
YTD: 72.6%
National target: 75%

Cancer 62 day 1st
Feb: 73.7% ↑
YTD: 71.8%
National target: 70% (recovery target)

Diagnostic wait times
Feb: 90.9% ↑
National target: 95% (recovery target, monthly)

Activity delivery

Value weighted activity
Feb: 95% ↑
YTD: 99.3%
National target: 101%

Theatre Utilisation
Jan: 81% ↑
National target: 85%

1st OPA rate variance to plan
Feb: -8% ↔
YTD: -4%
Trust activity plan vs 19/20

Total Elective Inpatients variance to plan
Jan: +4% ↓
YTD: +5%
Trust activity plan vs 19/20

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

West Hertfordshire Teaching Hospitals NHS Trust

Patient Flow Improvement & Performance

Patient Flow Improvement Programme
High Impact Change Plan Scorecard

West Hertfordshire Teaching Hospitals NHS Trust

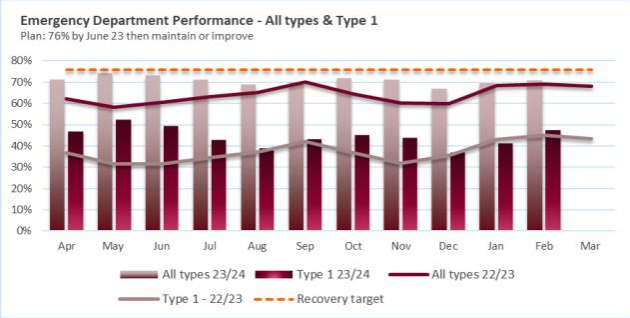
High Impact Changes Scorecard

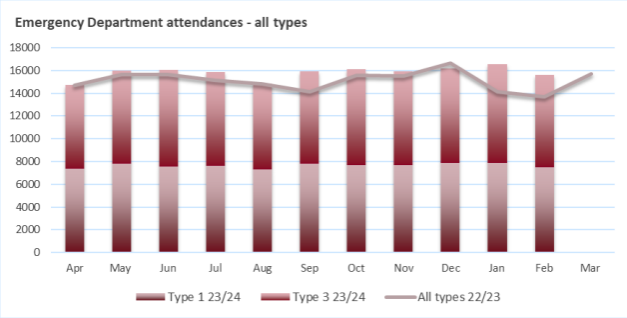
Focus Area	Metric	Target	WEEK ENDING 17-Dec	24-Dec	31-Dec	07-Jan	14-Jan	21-Jan	28-Jan	04-Feb	11-Feb	18-Feb	25-Feb	03-Mar
HIGH IMPACT CHANGE 1 - Rapid assessment and timely decisions of patients within 1 hour of arrival	All 4 hr Performance	76%	65.3%	72.4% ▲	66.4% ▼	70.6% ▲	75.1% ▲	67.7% ▼	64.5% ▼	69.2% ▲	64.7% ▼	69.0% ▲	76.8% ▲	76.7% ▼
	4 hr Non admitted Performance	80%	43.5%	56.4% ▲	40.6% ▼	52.7% ▲	56.7% ▲	41.0% ▼	43.7% ▲	52.9% ▲	44.9% ▼	51.2% ▲	62.5% ▲	66.2% ▲
	Time to clinical assessment < 1 hour	50%	27.8%	35.5% ▲	18.0% ▼	42.7% ▲	36.3% ▼	24.3% ▼	25.4% ▲	30.0% ▲	20.7% ▼	25.0% ▲	34.6% ▲	45.7% ▲
	Total time in Department - Non admitted	240	346	289 ▼	346 ▲	322 ▼	284 ▼	340 ▲	352 ▲	306 ▼	362 ▲	310 ▼	275 ▼	256 ▼
HIGH IMPACT CHANGE 2 - Improve discharges	IDT Discharges	Movement	141	182 ▲	137 ▼	174 ▲	172 ▼	176 ▲	173 ▼	189 ▲	180 ▼	161 ▼	162 ▲	177 ▲
	WGH Weekday Discharges - weekly totals	Movement	421	447 ▲	299 ▼	362 ▲	406 ▲	419 ▲	399 ▼	431 ▲	413 ▼	416 ▲	350 ▼	406 ▲
	WGH Weekend Discharges - weekly totals	Movement	108	155 ▲	105 ▼	96 ▼	111 ▲	80 ▼	101 ▲	106 ▲	92 ▼	97 ▲	128 ▲	100 ▼
	WGH Total Discharges - weekly totals	Movement	529	602 ▲	404 ▼	458 ▲	517 ▲	499 ▼	500 ▲	537 ▲	505 ▼	513 ▲	478 ▼	506 ▲
	WGH Discharges before 5pm %	Movement	57.7%	56.8% ▼	61.1% ▲	63.8% ▲	62.1% ▼	60.9% ▼	63.0% ▲	59.8% ▼	60.0% ▲	60.2% ▲	61.1% ▲	58.9% ▼
HIGH IMPACT CHANGE 3 - Implement Command and Control Centre	Bed Meeting time freed up for more focused flow management discussions (10mins)	-33%	-33.0% =	-33.0% =	-33.0% =	-33.0% =	-33.0% =	-33.0% =	-33.0% =	-33.0% =	-33.0% =	-33.0% =	-33.0% =	-33.0% =
	Transition to Virtual bed meetings for all participants	100%	100% =	100% =	100% =	100% =	100% =	100% =	100% =	100% =	100% =	100% =	100% =	100% =
	All participants to share their actual report update on Teams	100%	100% =	100% =	100% =	100% =	100% =	100% =	100% =	100% =	100% =	100% =	100% =	100% =
	Complete, accurate, real-time data, visualised in the appropriate level of detail	90%	90.0% =	90.0% =	90.0% =	90.0% =	90.0% =	90.0% =	90.0% =	90.0% =	90.0% =	90.0% =	90.0% =	90.0% =
	Control Room IT/telephony infrastructure reconfigured for usability / resilience	100%	100% =	100% =	100% =	100% =	100% =	100% =	100% =	100% =	100% =	100% =	100% =	100% =
HIGH IMPACT CHANGE 4 - Clinical Review of UTC	WGH Type 3 performance	95%	93.9%	95.4% ▲	95.9% ▲	94.5% ▼	95.2% ▲	95.5% ▲	86.8% ▼	84.3% ▼	80.8% ▼	86.9% ▲	99.6% ▲	89.9% ▼
	Number of handovers to ED at close	0			5	0 ▼	0 =	6 ▲	21 ▲	11 ▼	33 ▲	12 ▼	0 ▼	
	Referrals to ED at < 2 hours	75%	68.3% ▲			64.3% ▼								

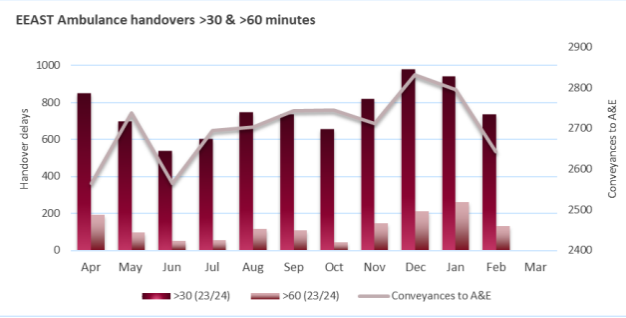
	Performance Levels			
All 4 hr Performance	Above 76%	70%-76%	60%-70%	under 60%
4 hr Non admitted Performance	Above 80%	70%-80%	60%-70%	under 60%
Time to clinical assessment < 1 hour	Above 50%	45%-50%	40%-45%	under 40%
Bed Meeting time freed up for more focused flow management discussions (10mins)	under -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
Performance improved with renewed focus on delivering the 4 hour target, particularly towards the end of the month.

- **All types 70.8%** (Jan 69.5%, Dec 67.1%, Nov 71.4%)
- **Type 1 47.7%** (Jan 44.1%, Dec 37%, Nov 43.8%)
- **Watford UTC 88%** (Jan 93.8%, Dec 93.5%, Nov 95.4%)
- **HH UTC 96.8%** (Jan 98.8%, Dec 98.5%, Nov 99.6%)

Non-admitted performance was much improved at 54.5% (January 49%).

There were more bed requests in February (1169) in comparison to the previous month (1023).

There were **38 x 12 hour breaches** from decision to admit to admission in the month (Jan: 63)

12 hour end to end journeys
12 hour waits (arrival to departure) also improved, with 841 delays over 12 hours, down from 1,150 the previous month.

Attendances (demand)
There were fewer attendances in the month, across both types.

- **All types: 15,642** (Jan 16,592, Dec 16,156, Nov 15,931)
- **Type 1: 7,476** (Jan 7,892, Dec 7,900, Nov 7,712)
- **Type 3: 8,166** (Jan 8,700, Dec 8,256, Nov 8,219)

Mental Health Demand
4.8% (362) of all type 1 ED attendances (7,476) related to MH. Last month 4.7% (370) of attendances were MH related.

Of the 12 hour waits (841), 10% (84) related to MH. In the previous month 6% (69) related to MH.

Within the MH attendance cohort (362), 23.2% (84) waited 12 hours or more in comparison with the previous month where 18.6% of all ED attendances relating to MH (370) wait 12 hours or more (69).

Ambulance handovers
2,642 patients were brought to ED by EEAST. Of these 2,494 were fully data compliant (all data recorded by EEAST, ie "pinned off").

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

- **30+ minutes: 29.6% / 739**
  (Jan 35.7%/942, Dec 37.5%/983, Nov 33.2%/822)
- **60+ minutes: 5.3% / 133**
  (Jan 9.9%/261, Dec 8%/210, Nov 5.9%/148)

Data provided by EEAST shows that WHTH delays are significantly lower than elsewhere in the ICS. WHTH received 41% of EEAST conveyances, E&NH 33%% and PAH 26%.

- 30+ minutes: PAH 53.8%/834, E&NH 45.7%/904
- 60+ minutes: PAH 27.4%/425, E&NH 17.5%/425
- Conveyances: PAH 1,623 / E&NH 2,118

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

This month's hours lost over 30 minutes per week was 58 against the trajectory plan of 120.

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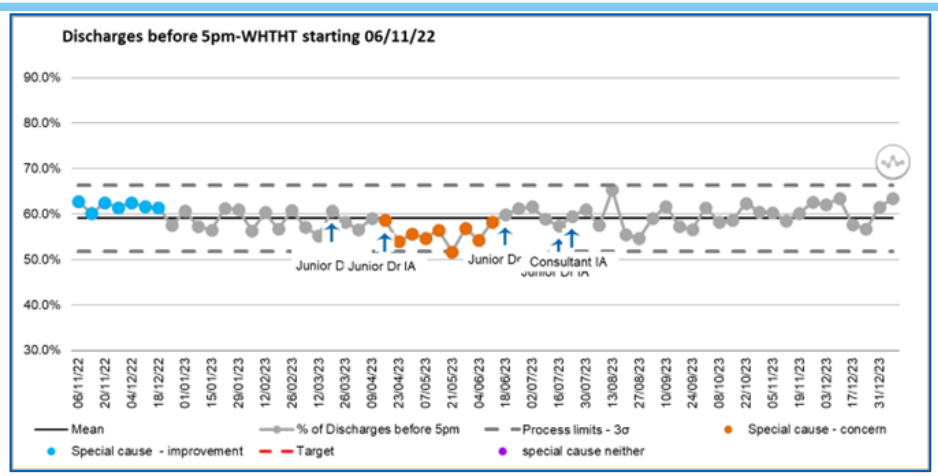
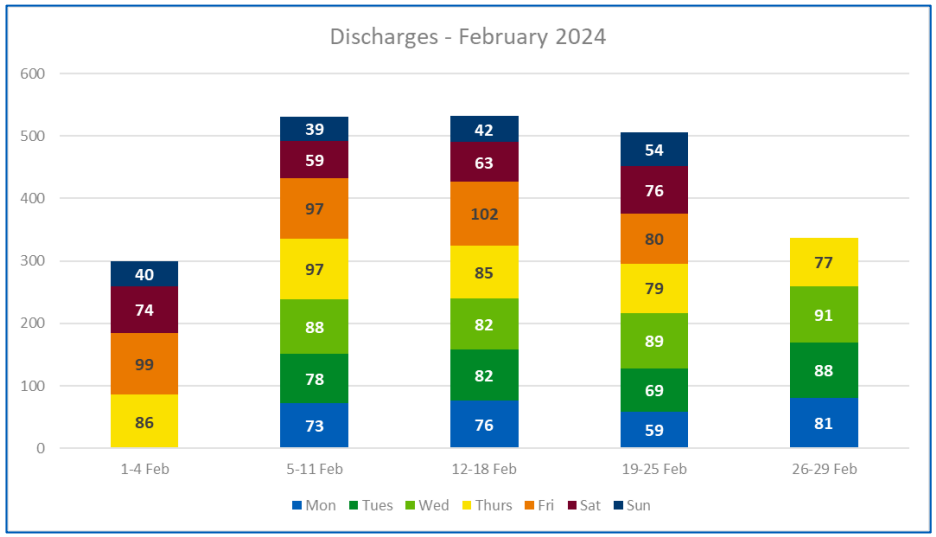
Patient Flow - Discharges





The volume of weekend discharges remains static. Significant changes to the process are required and divisions will be expected to report updates through the Hospital Efficiency Group chaired by the Chief Medical Officer.

There will be a relaunch of the Patient Flow Improvement Programme in April 2024, aligned to the trust's strategy. This will be led by the Deputy Chief Operating Officer operationally, supporting all divisions including Emergency Medicine, in the development and delivery of their action plans.

Key areas of focus will be:

- Improving length of stay (LOS) through initiatives including early discharge planning, criteria led discharge, system partner working particularly with frailty, mental health and dementia patients.
- Improving attendance avoidance initiatives, working with system partners
- Expansion of the virtual hospital with increased utilisation (patient "pull" from wards, A&E) and development of new pathways
- Implement phase 2 of the command centre

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Elective Care Recovery & Performance improvement

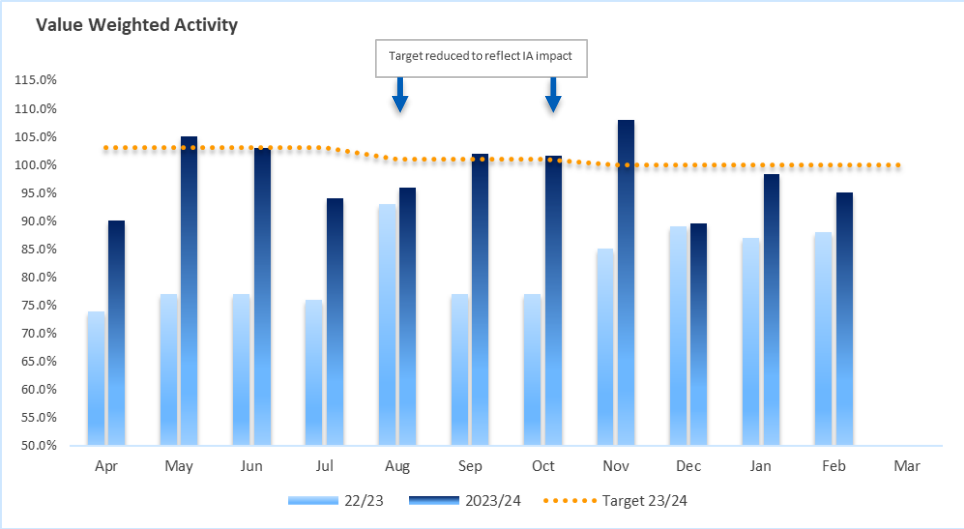
Elective Care Recovery Programme
High Impact Change Plan Scorecard

West Hertfordshire Teaching Hospitals NHS Trust

Elective Care Recovery Programme - High Impact Changes Scorecard

Focus Area	Metric	Target	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
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	92.0%	86.0% ▼	101.0% ▲	102.4% ▲	94.0% ▼	96.0% ▲	102.0% ▲	101.7% ▼	108.0% ▲	90.0% ▼	98.3% ▲	95.0% ▼
	RTT PTL size	Reduction	52,995	56,574 ▲	57,933 ▲	60,626 ▲	62,689 ▲	64,384 ▲	62,966 ▼	63,054 ▲	60,236 ▼	58,731 ▼	58,220 ▼	58,940 ▲
	RTT Clock stops	Improvement	5,856	5,039 ▼	6,382 ▲	6,519 ▲	6,272 ▼	6,481 ▲	6,443 ▼	6,559 ▲	7,383 ▲	5,551 ▼	7,003 ▲	6,422 ▼
	Outpatient procedures recorded	Improvement	5,789	5,562 ▼	6,645 ▲	6,582 ▼	6,306 ▼	6,467 ▲	6,463 ▼	6,521 ▲	6,541 ▲	5,209 ▼	6,436 ▲	6,019 ▼
HIGH IMPACT CHANGE 2 Increased theatre productivity with improved utilisation across all sites	Theatre utilisation - WGH & SACH	85%	75.1%	76.2% ▲	75.1% ▼	78.5% ▲	79.5% ▲	75.2% ▼	82.1% ▲	78.0% ▼	82.0% ▲	79.0% ▼	77.6% ▼	81.2% ▲
	Time lost to late starts - WGH & SACH	Improvement	187:27	127:11 ▼	146:17 ▲	164:10 ▲	183:32 ▲	141:33 ▼	135:58 ▼	154:44 ▲	151:32 ▼	143:08 ▼	159:54 ▲	141:29 ▼
	Time lost to early finishes - WGH & SACH	Improvement	295:32	256:08 ▼	382:01 ▲	341:21 ▼	274:26 ▼	369:42 ▲	271:34 ▼	309:00 ▲	269:19 ▼	209:23 ▼	301:10 ▲	222:18 ▼
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	15	11 ▼	9 ▼	7 ▼	8 ▲	6 ▼	8 ▲	9 ▲	7 ▼	8 ▲	14 ▲	20 ▲
	RTT: 65 week wait elimination (excl patient choice)	0 by April 24	548	495 ▼	504 ▲	524 ▲	455 ▼	569 ▲	636 ▲	621 ▼	466 ▼	434 ▼	402 ▼	374 ▼
	RTT: 52 week wait reduction	Improvement	2,729	2,694 ▼	2,439 ▼	2,504 ▲	2,440 ▼	2,769 ▲	2,982 ▲	3,039 ▲	2,488 ▼	2,246 ▼	2,407 ▲	2,545 ▲
	Cancer: 63+ day wait reduction	95*	125	130 ▲	159 ▲	149 ▼	135 ▼	139 ▲	101 ▼	119 ▲	121 ▲	148 ▲	142 ▼	136 ▼
	28 day faster diagnosis performance	75%	76.7%	74.5% ▼	66.0% ▼	72.9% ▲	66.7% ▼	67.0% ▲	68.0% ▲	66.0% ▼	68.6% ▲	74.7% ▲	74.2% ▼	79.6% ▲
	DMO1 (diagnostic) performance	99%	63.1%	63.8% ▲	65.8% ▲	67.3% ▲	69.5% ▲	68.5% ▼	70.8% ▲	78.3% ▲	83.3% ▲	84.1% ▲	85.2% ▲	90.8% ▲
HIGH IMPACT CHANGE 4 Increase Outpatient productivity with greater uptake of non-face to face models, patient initiated follow up and implementation of the Patient Portal	Outpatient follow up rates vs 19/20	75% of 19/20	105.6%	82.9% ▼	95.1% ▲	101.8% ▲	86.4% ▼	99.4% ▲	91.1% ▼	93.6% ▲	103.7% ▲	94.2% ▼	98.5% ▲	97.1% ▼
	Patient initiated follow up rate as a % of all OPAs	2.1%	2.10%	1.70% ▼	1.77% ▲	1.76% ▼	2.02% ▲	1.93% ▼	2.25% ▲	2.08% ▼	1.89% ▼	2.23% ▲	2.12% ▼	2.05% ▼
	Non-face to face rate as a % of all OPAs	25%	12.7%	12.2% ▼	12.6% ▲	12.7% ▲	12.5% ▼	12.5% ▲	12.5% ▼	12.6% ▲	12.7% ▲	13.0% ▲	13.0% ▼	13.5% ▲
	DNA rates	8%	7.9%	7.7% ▼	7.6% ▼	8.0% ▲	7.5% ▼	7.5% ▲	7.5% ▲	7.3% ▼	7.7% ▲	7.5% ▼	7.5% ▲	7.7% ▲

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.

As in previous months where there were periods of industrial action, February's activity value has been adversely impacted.

VWA for the month is currently at 95%

Industrial action – activity impact

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

West Hertfordshire Teaching Hospitals NHS Trust

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

Trust		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	YTD
Outpatient referrals	Plan	16,277	17,168	15,915	17,810	15,912	16,374	18,534	17,055	15,756	18,609	16,573	185,981
	Actual	17,371	19,837	20,516	19,110	18,920	18,691	19,694	19,730	16,131	19,969	17,833	207,802
	%var	7%	16%	29%	7%	19%	14%	6%	16%	2%	7%	8%	12%
OP first attendance	Plan	14,720	15,403	15,182	17,143	14,616	16,078	17,223	17,023	14,848	17,783	16,512	176,530
	Actual	12,827	15,651	15,938	15,354	15,128	15,574	16,288	17,269	12,990	16,428	15,166	168,613
	%var	-13%	2%	5%	-10%	4%	-3%	-5%	1%	-13%	-8%	-8%	-4%
OP follow-up	Plan	20,275	21,246	19,813	22,064	18,970	21,009	22,101	21,065	18,712	22,201	19,633	227,089
	Actual	22,424	26,937	26,901	25,410	25,140	25,523	27,579	29,122	23,514	29,174	25,564	287,288
	%var	11%	27%	36%	15%	33%	21%	25%	38%	26%	31%	30%	27%
Total OP atts	Plan	34,995	36,649	34,994	39,207	33,587	37,087	39,324	38,088	33,560	39,984	36,145	403,619
	Actual	35,251	42,588	42,839	40,764	40,268	41,097	43,867	46,391	36,504	45,602	40,730	455,901
	%var	1%	16%	22%	4%	20%	11%	12%	22%	9%	14%	13%	13%
OP atts with procedures	Plan	6,888	7,120	7,162	7,631	6,597	7,048	7,154	7,220	6,558	7,621	6,695	77,694
	Actual	5,630	6,733	6,669	6,402	6,588	6,750	6,869	6,911	5,502	6,853	6,385	71,292
	%var	-18%	-5%	-7%	-16%	0%	-4%	-4%	-4%	-16%	-10%	-5%	-8%

First OPAs
The shortfall between plan and new OPA activity remains 4% lower than plan year to date with a gap of 7917 appointments.

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

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

Non-face to face OPAs
Surgery 11%, Medicine 25%, WACS 5%

Surgery		Dec-23	Jan-24	Feb-24	YTD
Outpatient referrals	Plan	5,243	6,386	5,639	66,051
	Actual	5,661	7,428	6,716	76,407
	%var	8%	16%	19%	16%
OP first attendance	Plan	5,688	6,849	6,038	66,685
	Actual	4,799	6,086	5,446	64,023
	%var	-16%	-11%	-10%	-4%
OP follow-up	Plan	6,638	7,969	7,133	81,529
	Actual	7,141	8,934	7,843	90,613
	%var	8%	12%	10%	11%
Total OP atts	Plan	12,326	14,818	13,171	148,214
	Actual	11,940	15,020	13,289	154,636
	%var	-3%	1%	1%	4%
OP atts with procedures	Plan	2,800	3,163	2,819	31,465
	Actual	2,249	2,527	2,279	28,822
	%var	-20%	-20%	-19%	-8%

Medicine		Dec-23	Jan-24	Feb-24	YTD
Outpatient referrals	Plan	7,410	8,597	7,608	83,176
	Actual	6,601	7,955	7,018	84,006
	%var	-11%	-7%	-8%	1%
OP first attendance	Plan	5,830	7,053	6,846	71,036
	Actual	5,030	6,490	6,233	64,592
	%var	-14%	-8%	-9%	-9%
OP follow-up	Plan	5,786	7,106	6,093	70,116
	Actual	7,014	8,815	7,972	85,310
	%var	21%	24%	31%	22%
Total OP atts	Plan	11,616	14,159	12,939	141,152
	Actual	12,044	15,305	14,205	149,902
	%var	4%	8%	10%	6%
OP atts with procedures	Plan	2,742	3,230	2,786	34,176
	Actual	2,240	2,938	2,895	29,752
	%var	-18%	-9%	4%	-13%

WACS		Dec-23	Jan-24	Feb-24	YTD
Outpatient referrals	Plan	1,342	1,547	1,505	16,226
	Actual	1,708	1,973	1,822	20,999
	%var	27%	28%	21%	29%
OP first attendance	Plan	1,666	2,008	1,927	20,224
	Actual	1,525	1,861	1,693	19,522
	%var	-8%	-7%	-12%	-3%
OP follow-up	Plan	1,237	1,549	1,411	15,497
	Actual	1,367	1,876	1,666	17,944
	%var	10%	21%	18%	16%
Total OP atts	Plan	2,903	3,556	3,339	35,721
	Actual	2,892	3,737	3,359	37,466
	%var	0%	5%	1%	5%
Total OP atts with	Plan	1,014	1,228	1,096	11,857
	Actual	915	1,255	1,123	11,773
	%var	-10%	2%	2%	-1%

Surgery
- Referrals have increased by 16% year to date.
- Year to date 1st OPAs remain 4% behind plan activity and 10% adverse to the monthly plan.
- Follow ups are 10% worse than plan in month and 11% worse year to date.

Medicine
- Referrals are 1% higher year to date
- New appointments were 9% below plan year to date and for the month.
- Follow up activity is 22% above the year to date plan, and 31% worse than plan for the month.

WACS
- Referrals have increased by 29%
- Year to date 1st OPAs remain 3% worse than plan and 12% adverse to the monthly plan
- Year to date, follow up activity is 16% over plan and also 16% for the month

West Hertfordshire Teaching Hospitals NHS Trust

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

Trust level		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	YTD
Elective	Plan	3,013	3,228	2,993	3,333	2,983	3,231	3,465	3,590	3,113	3,456	3,309	35,714
Daycase	Actual	3,039	3,685	3,669	3,368	3,603	3,590	3,655	3,940	3,248	3,895	3,703	39,395
	%var	1%	14%	23%	1%	21%	11%	5%	10%	4%	13%	12%	10%
Elective	Plan	543	536	607	589	551	565	632	596	535	569	628	6,351
Ordinary	Actual	350	439	441	466	431	460	444	493	417	416	407	4,764
	%var	-36%	-18%	-27%	-21%	-22%	-19%	-30%	-17%	-22%	-27%	-35%	-25%
Total	Plan	3,556	3,764	3,600	3,922	3,535	3,796	4,097	4,186	3,648	4,025	3,937	42,065
Elective	Actual	3,389	4,124	4,110	3,834	4,034	4,050	4,099	4,433	3,665	4,311	4,110	44,159
	%var	-5%	10%	14%	-2%	14%	7%	0%	6%	0%	7%	4%	5%

All admission types
Year to date activity remains 5% better than plan and 4% better than the monthly plan.

Day Cases
Year to date 10% better than plan and 12% ahead of the monthly plan.

Overnight admissions (elective ordinary)
Continue to underperform against plan with a 25% deficit year to date and 35% behind plan in February.

Surgery		Dec-23	Jan-24	Feb-24	YTD
Elective	Plan	1,145	1,249	1,141	12,886
Daycase	Actual	824	1,007	970	10,614
	%var	-28%	-19%	-15%	-18%
Elective	Plan	365	382	403	4,255
Ordinary	Actual	274	267	255	3,230
	%var	-25%	-30%	-37%	-24%
Total	Plan	1,510	1,631	1,544	17,142
Elective	Actual	1,098	1,274	1,225	13,844
	%var	-27%	-22%	-21%	-19%

Surgery
- Year to date shortfall against the overall plan by 19% behind plan and 21% below plan for the month.
- Overnight admissions are 24% behind plan year to date and 37% below plan for the month.
- Day case admissions are also behind plan, 18% year to date and 15% for the month.

Medicine		Dec-23	Jan-24	Feb-24	YTD
Elective	Plan	1,583	1,833	1,828	19,006
Daycase	Actual	1,921	2,397	2,280	23,150
	%var	21%	31%	25%	22%
Elective	Plan	19	18	29	195
Ordinary	Actual	18	12	12	125
	%var	-5%	-33%	-58%	-36%
Total	Plan	1,602	1,851	1,857	19,202
Elective	Actual	1,939	2,409	2,292	23,275
	%var	21%	30%	23%	21%

Medicine
- Day cases are 22% above the year to date plan and 25% above plan for the month.
- Overnight admissions are 38% behind plan year to date, and 58% adverse for the month but it should be recognised that the activity numbers are low in any event.

WACS		Dec-23	Jan-24	Feb-24	YTD
Elective	Plan	264	252	216	2,584
Daycase	Actual	195	223	218	2,235
	%var	-26%	-12%	1%	-14%
Elective	Plan	105	111	126	1,251
Ordinary	Actual	55	60	70	695
	%var	-47%	-46%	-45%	-44%
Total	Plan	369	363	342	3,835
Elective	Actual	250	283	288	2,930
	%var	-32%	-22%	-16%	-24%

WACS
- 14% adverse variance to the day case plan year to date but 1% better than plan in the month.
- Year to date overnight admissions 44% below plan with a deficit of and 45% short of plan for the month.
- The overall position year to date is 24% short of plan and 16% behind plan in month.

West Hertfordshire Teaching Hospitals NHS Trust

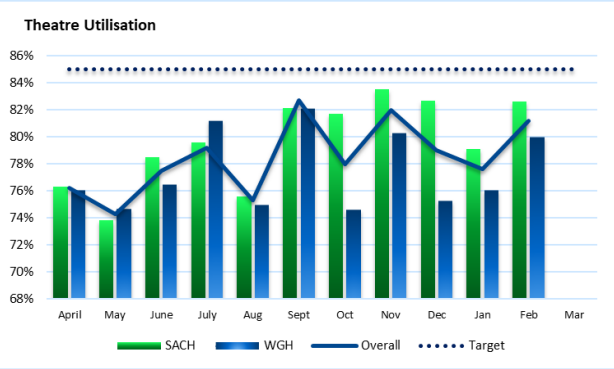
Diagnostic Activity as a % of the 19/20 baseline month

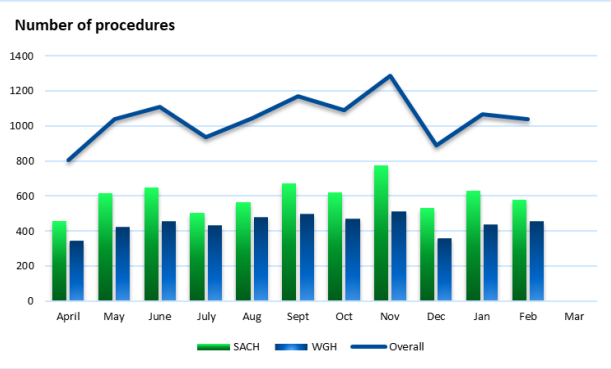
Diagnostics		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	YTD
MRI	Plan	1,833	1,977	1,346	1,458	1,398	1,465	1,680	1,551	1,562	1,759	1,484	17,513
	Actual	1,655	1,731	1,802	1,620	1,783	1,583	1,732	1,832	1,476	1,869	1,735	18,818
	%var	-10%	-12%	34%	11%	28%	8%	3%	18%	-5%	6%	17%	7%
CT	Plan	3,149	3,409	3,382	3,842	3,448	3,582	3,808	3,558	3,769	3,740	3,701	39,388
	Actual	4,102	4,389	4,538	4,454	4,431	4,437	4,518	4,726	4,361	4,579	4,072	48,607
	%var	30%	29%	34%	16%	28%	24%	19%	33%	16%	22%	10%	23%
NOUS	Plan	3,725	3,055	2,572	2,712	2,385	2,530	2,601	2,721	2,545	3,046	2,574	30,467
	Actual	2,616	2,924	3,393	2,986	3,122	2,919	2,921	3,145	2,613	3,217	2,943	32,799
	%var	-30%	-4%	32%	10%	31%	15%	12%	16%	3%	6%	14%	8%
Colonoscopy	Plan	357	436	347	421	385	404	436	425	385	433	429	4,458
	Actual	460	633	673	586	596	605	655	667	561	674	484	6,594
	%var	29%	45%	94%	39%	55%	50%	50%	57%	46%	56%	13%	48%
Flexi Sig	Plan	214	236	180	190	194	209	200	237	194	202	209	2,265
	Actual	107	26	35	24	5	17	21	32	16	29	94	406
	%var	-50%	-89%	-81%	-87%	-97%	-92%	-90%	-86%	-92%	-86%	-55%	-82%
Gastroscopy	Plan	513	613	575	645	541	665	624	639	559	638	645	6,659
	Actual	620	705	729	700	664	673	623	650	546	646	536	7,092
	%var	21%	15%	27%	8%	23%	1%	0%	2%	-2%	1%	-17%	7%
Echo	Plan	1,294	1,296	1,385	1,401	1,341	1,180	1,347	1,398	1,204	1,376	1,438	14,659
	Actual	1,101	1,232	1,316	1,181	1,283	1,387	1,461	1,523	1,169	1,290	1,056	13,999
	%var	-15%	-5%	-5%	-16%	-4%	18%	8%	9%	-3%	-6%	-27%	-5%

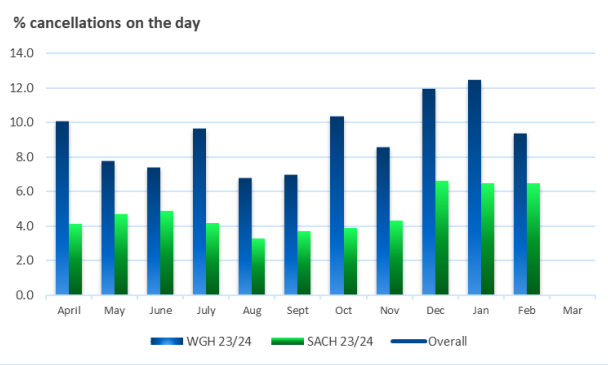
Most modalities are delivering activity above plan year to date, although there are 3 exceptions:

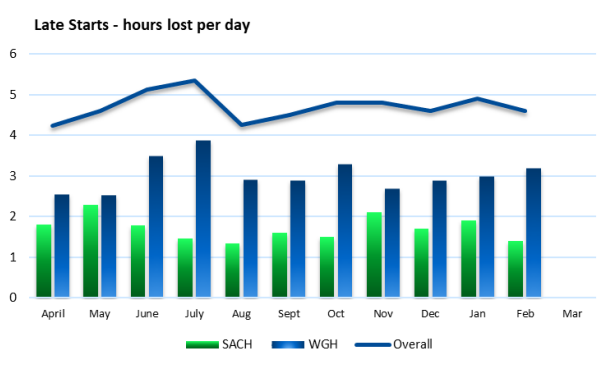
- Changes to procedure coding have affected flexible sigmoidoscopy activity rates, as many of these procedures are now included in the colonoscopy activity line. On that basis, the activity delivery reported for this modality will not increase.
- Echo activity remains below plan. Recovery actions for this modality are in place, with additional capacity provided through ad hoc sessions.
- Gastroscopy is 10% behind plan for the month but with 7% positive variance year to date.

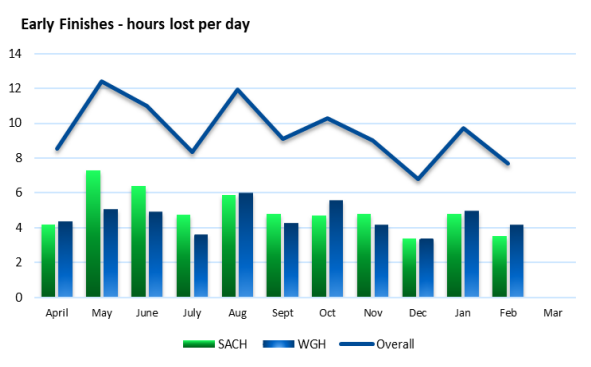
Theatre Productivity & Utilisation











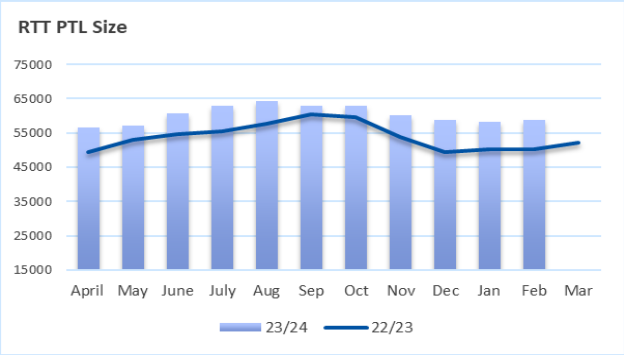
Utilisation: This improved in February at 81% overall (target 85%) , and 82.6% at SACH and 80% at WGH.

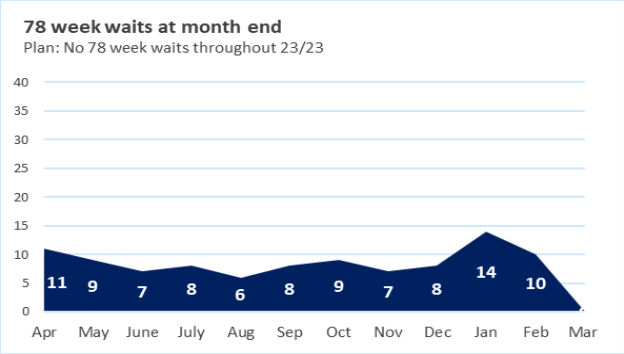
Number of procedures: Fewer procedures were undertaken overall). This was the result of a reduction at SACH, at 581 (from 631). 459 procedures were performed at WGH (438 January).

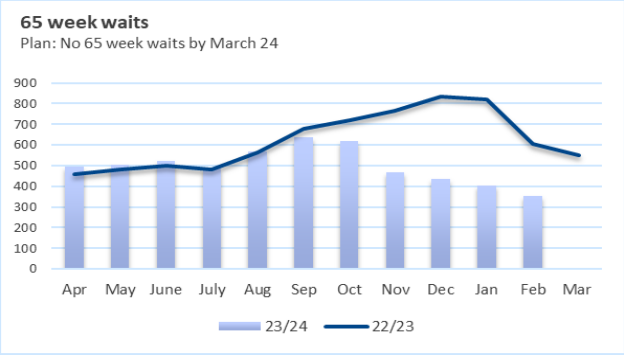
Cancellations on the day: The percentage of cancellations on the day decreased, again driven by improvement at WGH at 9.4% (January 12.5%). The position at SACH was unchanged at 6.5%

Hours lost to late starts/early finishes: Late starts improved slightly, with SACH improvement to an average of 1.4 hours lost per day. However there was an increase at WGH from 3 to 3.2. Early finishes improvement at both sites, with 3.5 hours lost on average per day at SACH and 4.2 hours at WGH.

RTT Long waits Improvement







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

78 week waits
There were 10 x 78 week waiters at the end of the month as follows:
2 x Dermatology
7 x ENT
1 x Cardiology

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

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

At the end of the month there were 353 x 65 week waits (a reduction of 51 since last month).

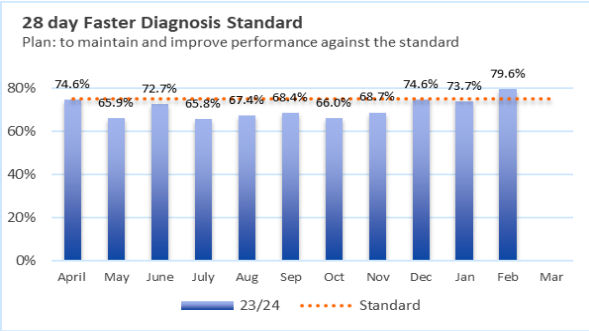
There are just under 361 (January 669) patients in the risk (of reaching 65 weeks by 31/3/24) cohort which require action to avoid breaching the target for the end of the financial year. ENT, Dermatology and General Surgery are the most at risk of not achieving this objective. Outsourcing is in place for Dermatology mainly although there is a small amount of ENT activity undertaken externally. Definitive plans are awaited from Rheumatology and ENT. Cardiology is challenged but there is good engagement and flexibility in response to requests to support improvement.

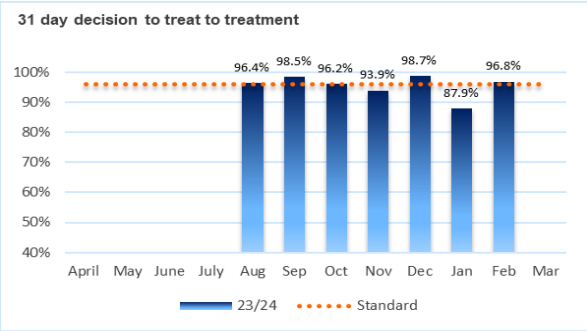
52 week waits
There has been a very small increase on the previous month, now at 2,420 (January 2,407).

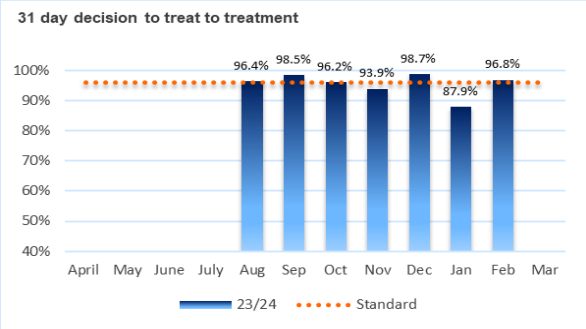
Clock stops vs clock starts
For the second consecutive month clock starts have been much higher than usual, with 10,236 new starts in February (10,212 January, 7408 December).
There were fewer clock stops in the month, 6,420, compared to January (7,003)
- 570 pathways over 52 weeks were closed, of which
- 208 pathways were over 65 weeks and
- 20 pathways were over 78 weeks.

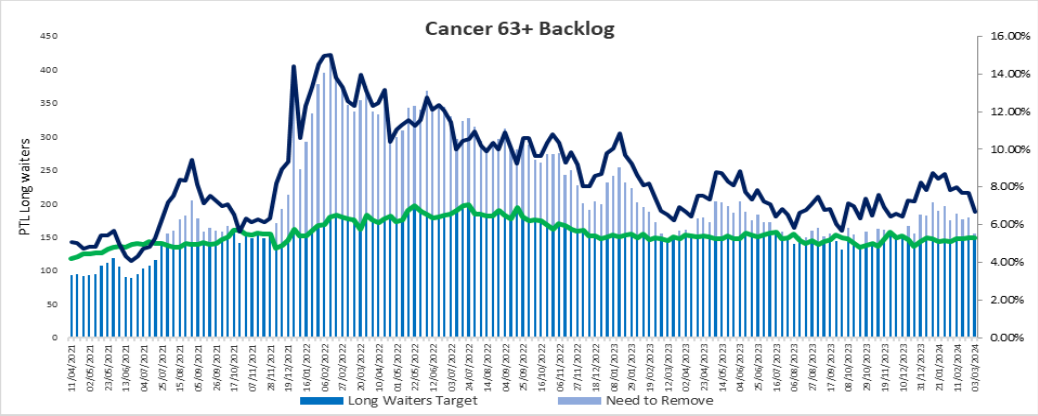
West Hertfordshire Teaching Hospitals NHS Trust

Cancer waits backlog improvement & performance









28 day Faster Diagnosis Standard (75%)
Performance is compliant with the standard this month at 79.6%. However, Gynaecology continues to experience challenges with this pathway, reporting the greatest proportion of breaches. Additional capacity is now in place to address this and improvement is expected imminently.

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

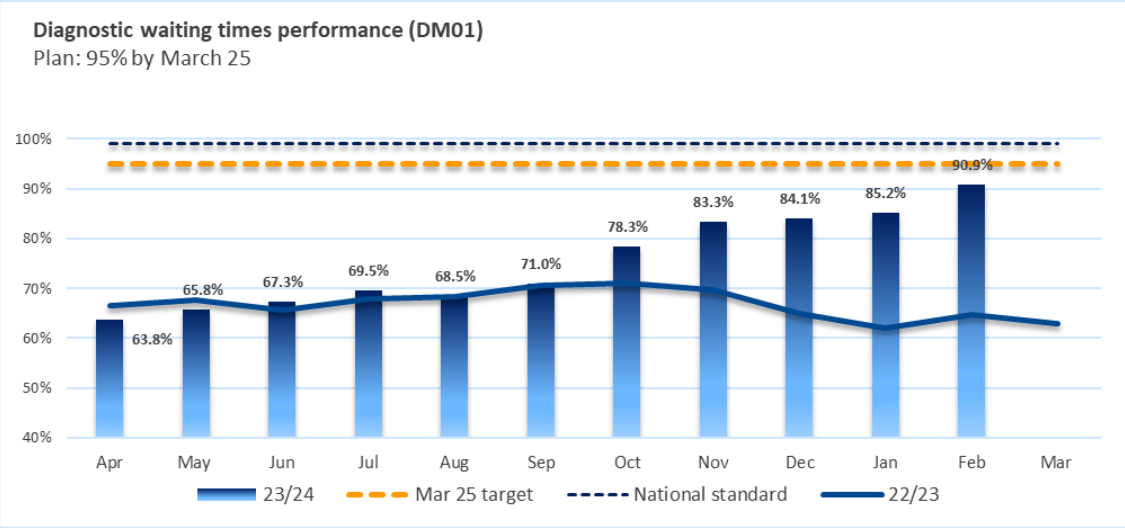
31 day decision to treat to treatment (96%)
Performance was compliant with the standard at 96.8%. Breach numbers are very low (6 breaches in total, of which 2 were Gynaecology).

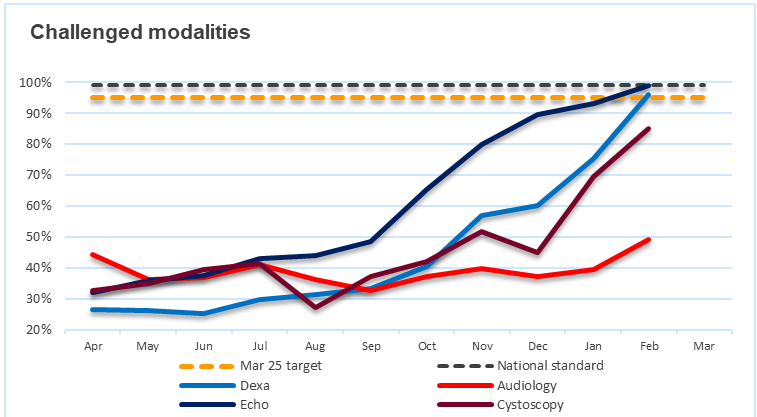
62 day referral to definitive treatment (75% / 85%)
Performance against this standard was also compliant (with the recovery target) at 73.7%. There were 42 breaches (70.5 in January), Urology and Lung accounting for 50% of these. Further focus in the Cancer Improvement Steering group will be given to these services to ensure support is provided to deliver sustainable improvement.

63+ day backlog
At month end there were 118 (6.7%) pathways over 63 days with a PTL of 2,331 patients. The NHSE objective is to have a backlog of no more than 6.4%.

The ICB has been set a target for reduction, with a "fair share" target allocated to each acute provider. The WHTH target is to have no more than 143 pathways over 62 days by 31 March 2024.

Diagnostic (DM01) performance improvement





There was very significant improvement across most modalities in February and 90.9% achieved against the 95% recovery target. (The national planning guidance objective for diagnostic performance recovery is to achieve 95% (the orange dotted line) by March 2025. The constitutional target is 99%.

13 are above the 95% target and 7 are at 99% or better.

The second chart shows the performance of the four most challenged modalities; Audiology, Cystoscopy, DEXA and Echo. Work to improve data quality within the Uro-Gynae Cystoscopy list is well underway and performance improvement expected in the next month or two. Urology Cystoscopy performance is now at 85.1%.

The delivery of numerous additional sessions in Echo, supplemented with outsourcing, have supported a rapid improvement in the service, with a significant reduction in waits over 6 weeks and this month the service achieved the 99% target.

Dexa performance is also improving as a result of increased internal capacity and outsourcing has now ceased. Performance in February was better than the recovery target (95%) at 96.1%.

Audiology demand has increased, particularly hearing aid referrals from the community service. Outsourcing plans are advancing slowly, while development of a business case to increase in house capacity progresses. Nonetheless, there continues to be month on month improvement in performance, this month at 49.1%, 10 percentage points better than the previous month.

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

Planning Guidance 2023/24 – performance against target/objective

2023/24 Elective Care

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

Urgent & Emergency Care

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

Current position against objectives & actions

	Objective	January 24
1	65 week wait elimination by March 2024	353 (January 402)
2	Deliver system specific activity target (103% VWA – revised down to 101% due to IA impact)	98.3% (Dec 89.6%) NB: reported position with internal adjustments.
3	Reduction in patients over 62 days on the Cancer PTL – 143 by March 2024	142 (Dec 148)
4	Meet the Cancer Faster Diagnosis standard of 75% by March 2024 – 67.5% by June 23	79.6% (January 74.2%)
5	Improve A&E waiting times to 76% seen within 4 hours by March 2024	70.8% (Jan 69.5%)
6	Reduce adult (G&A) bed occupancy to 92% or below	All sites: 91% (Jan 91.9%) WGH only: 95.7% (Jan 96.3%)

18

West Hertfordshire Teaching Hospitals NHS Trust

Trust Board
04 April 2024

Title of the paper:	**Integrated Performance Report** ***(March 2024 reporting period – February 2024 data)***
Agenda Item:	**18**
Presenter:	**Mark Landau, Director of Business Intelligence**
Author(s):	**Mark Landau, Director of Business Intelligence** **Paul Bannister, Chief Information Officer**
Purpose:	*Please tick the appropriate box* *For approval*: *For discussion*: ✓ *For information*: ✓
Executive Summary:	**Summary** • This cover sheet summarises the contents of the Trust Integrated Performance Report, detailing changes made to the pack and summarising some of the narrative points made and is intended to provide information and assurance to the committee. **Changes to the pack** • No changes to the pack this month **Safe Care & Improving Outcomes - Quality** • Both Mortality metrics (SHMI and HSMR) are showing concerning special cause variation. SHMI is in the as expected range according to Dr Foster for the period to September 2023 • There is improving special cause variation in 30 Day Emergency Readmissions – Elective, with 7 consecutive data points below the mean. **Safe Care & Improving Outcomes - Safety** • There are six exceptions generated • Registered fill rate, whilst still an exception for assurance is in common cause variation for Performance, likewise both the Trust overall fill rate and the unregistered fill rate. • The other exceptions are the % of patient safety incidents which are harmful which is in concerning special cause variation for both performance and assurance, VTE Risk Assessments (at it's highest level of compliance in the observed period (since April 2019) and Patients admitted to stroke unit within 4 hours with continuing improving special cause variation **Caring & Responsive Services – A&E** • Nine exception pages generated – all of which were exceptions in the previous month. All Types A&E Performance whilst showing a relatively small improvement on January 2024 data has seen a good improvement in relative position amongst other acute trusts (41st in February 2024 as compared to 44th in January 2024) . **Caring & Responsive Services – RTT, Cancer, Outpatients** • Eight Exception pages generated, 5 of which are showing improving special cause variation for performance: RTT 78+ week waits, Diagnostic – 6 Week Waits, Outpatient cancellation rates and Outpatient DNA rates. • West Herts have the second fewest 65 week waiters in the region, and the second fewest 78 week waiters • In January 2024 (latest nationally published data), West Herts were the second best performers in the region against the Diagnostic 6 week wait target • The historic data for the new consolidated cancer metrics have been added. Regionally in January 2024, West Herts are 4th of 13 against the FDS metric, 6th of 13 against the 31 Day metric, and 8th of 13 against the 62 Day metric **Workforce** • Ten Exception pages generated, with eight exceptions generated for improving special cause. Mandatory Training and Appraisal rates generate concerning special cause variation, although appraisal rates are in common cause for performance.

	Activity • Nine Exception pages generated, four of which are for improving special cause variation (1st Outpatient Appointments – Face to Face, Specific Acute Daycases, Theatre Utilisation, and Theatre cases per session). *NB: Data correct at the time of reporting*
	[redacted]
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: Finance and Performance Committee — Date: 28 March 2024
Action required:	• The Committee are asked to receive this report for information, assurance and discussion

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Integrated Performance Report

March 2024 – February 2024 data

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

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Integrated Performance Report

- Trust Management Committee – 27th March 2024
- Finance & Performance Committee – 28th March 2024
- Trust Board – 4th April 2024

West Hertfordshire Hospitals NHS Trust

A note on SPC charts

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

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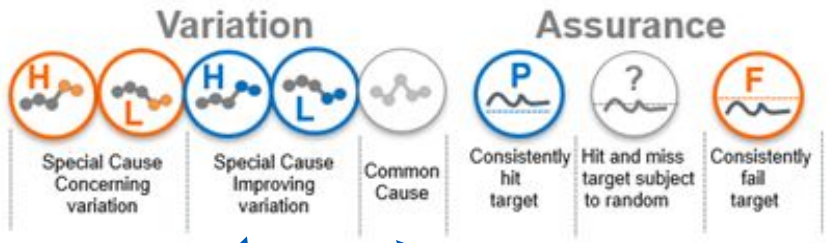
High Level Key - Variation

Are we improving declining or staying the same



Orange = significant concern or high pressure

Blue = significant improvement or low pressure

Grey – no significant change

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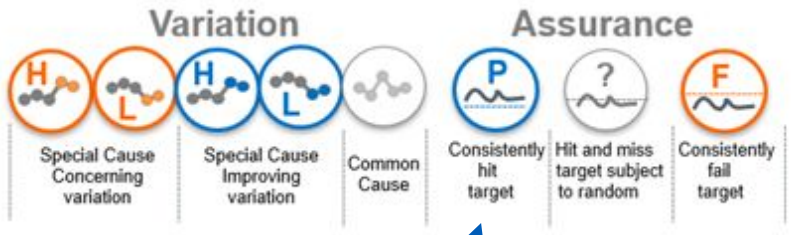
High Level Key - Assurance

Can we reliably hit the target



Orange = system change required to hit target

Blue = will reliably hit the target

Hit and miss the target

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Summary Icon Descriptions

Perform	Assure	Description
		Special cause of a concerning nature where the measure is significantly **HIGHER**. This occurs where there is higher pressure in the system or deteriorating performance. 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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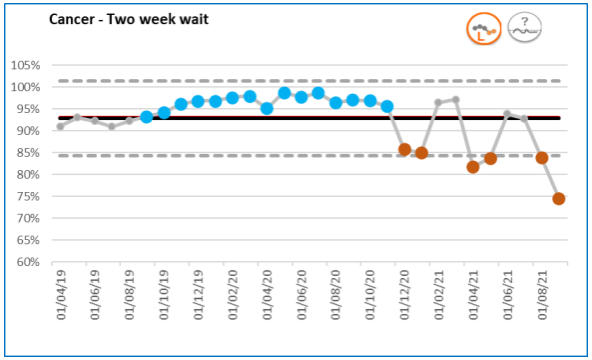
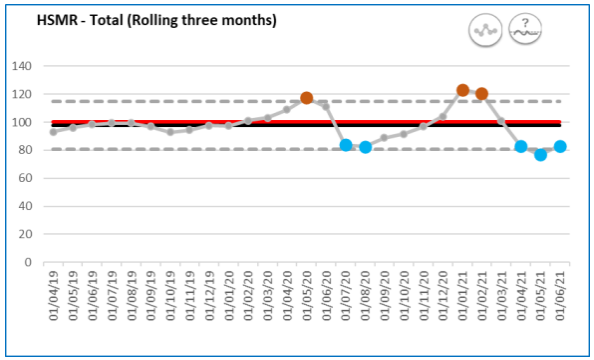
SPC rules – Special Cause Variation

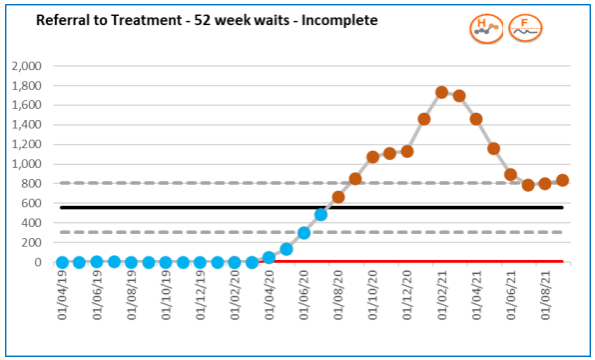
A breach of the upper/lower control limit



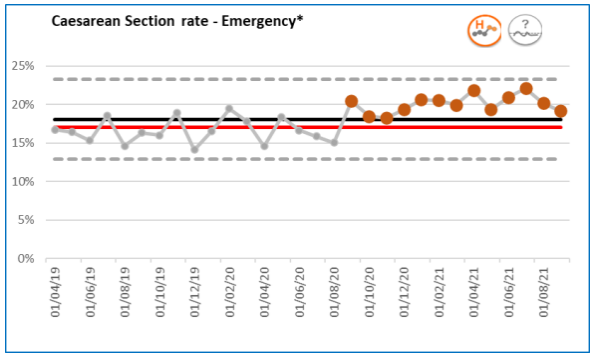
2 out of 3 points close to the control limit



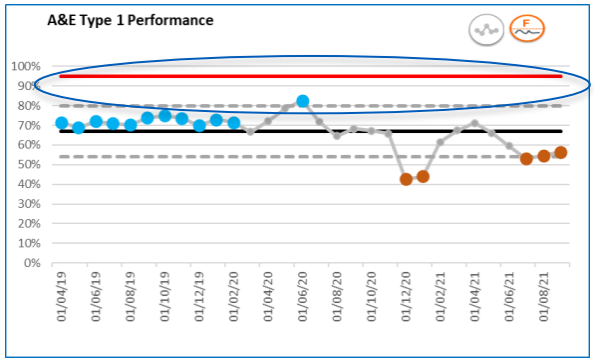
A run of ascending/descending data points



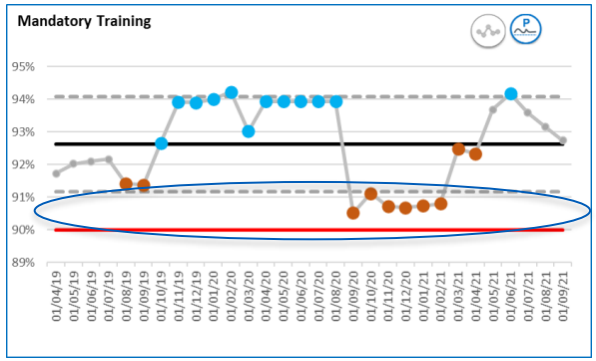
A run of points all one side of the mean



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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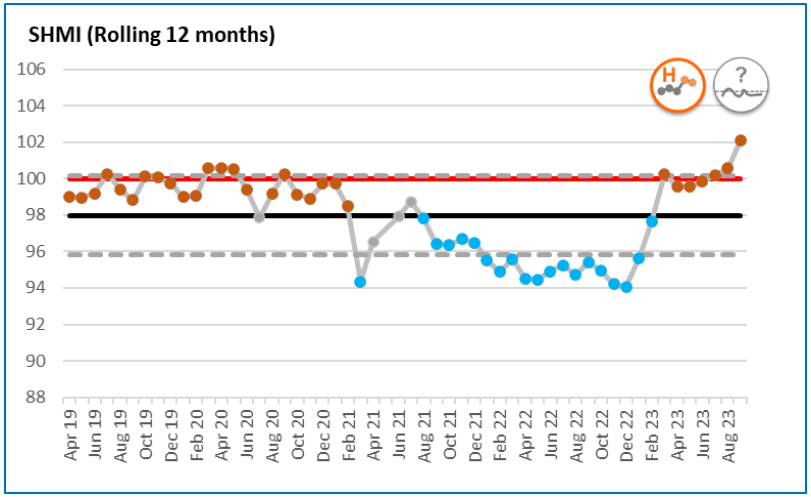
KPI	Latest month	Measure	Target	Variation	Assurance	Local or National Metric	Committee	Owner
Safe Care and Improving Outcomes - Quality								
SHMI (Rolling 12 months)	Oct 23	103	100	H	?	National	Quality	CMO
HSMR - Total (Rolling 12 months)	Nov 23	102	100		?	National	Quality	CMO
Clostridioides Difficile - Hospital associated (Cat 1)	Feb 24	1	-			Local	Quality	CN
Clostridioides Difficile - Healthcare associated (Cat 2)	Feb 24	2	-			Local	Quality	CN
Clostridioides Difficile - Hospital and Healthcare associated Total	Feb 24	3	3		?	Local	Quality	CMO
Hand Hygiene Compliance	Jan 24	98%	95%		?	Local	Quality	CN
30 Day Emergency Readmissions - Elective *	Feb 24	3%	4%	L	?	Local	Quality	CMO
30 Day Emergency Readmissions - Emerg *	Feb 24	12%	13%		?	Local	Quality	CMO
Caesarean Section rate - Robson Category 1	Feb 24	22%	-			Local	Quality	CMO
Caesarean Section rate - Robson Category 2	Feb 24	57%	-			Local	Quality	CMO
Caesarean Section rate - Robson Category 5	Feb 24	82%	-			Local	Quality	CMO

West Hertfordshire Hospitals NHS Trust

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



	Provider	Denominator	Obs	Exp	Obs-Exp	SHMI	Low	High
RC9	Bedfordshire Hospitals NHS Foundation Trust	114,725	2,875	2,800	75	102.79	89.22	112.08
RWH	East And North Hertfordshire NHS Trust	48,490	1,790	1,835	-45	97.48	88.94	112.43
RNQ	Kettering General Hospital NHS Foundation Trust	46,585	1,695	1,585	110	107.06	88.82	112.59
RD8	Milton Keynes University Hospital NHS Foundation Trust	54,445	1,310	1,330	-20	98.62	88.65	112.81
RNS	Northampton General Hospital NHS Trust	74,780	1,780	2,065	-285	86.11	89.03	112.32
RWD	United Lincolnshire Hospitals NHS Trust	75,945	3,175	3,065	110	103.48	89.27	112.02
RWE	University Hospitals Of Leicester NHS Trust	151,825	3,865	3,795	70	101.87	89.36	111.90
RWG	West Hertfordshire Teaching Hospitals NHS Trust	58,440	1,975	1,935	40	102.08	88.99	112.38

Background	What the Data tells us	Issues	Actions	Mitigations
SHMI – (Rolling 12 Months)	Exception triggered due to the target being above the upper control limit Exception triggered due to 2 of 3 most recent data points being close to the upper control limit	SHMI rate is within 'as expected' range according to Dr Foster.		

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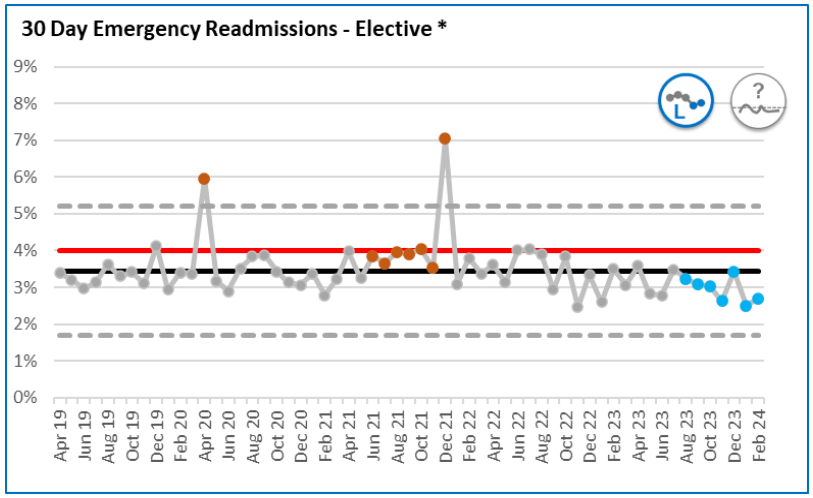
Special Cause Variation –Assurance – 30 Day Emergency Readmissions - Elective



Background	What the Data tells us	Issues	Actions	Mitigations
30 Day Emergency Readmissions - Elective	Exception triggered due to a run of data points below the mean (a shift)			

West Hertfordshire Hospitals NHS Trust

KPI	Latest month	Measure	Target	Variation	Assurance	Local or National Metric	Committee	Owner
Safe Care and Improving Outcomes - Safety								
% nursing hours (shift fill rate)	Feb 24	101%	95%		P	Local	Quality	CN
% nursing hours (shift fill rate) - Registered	Feb 24	97%	100%		F	Local	Quality	CN
% nursing hours (shift fill rate) - Unregistered	Feb 24	108%	100%		P	Local	Quality	CN
Serious incidents - number*	Feb 24	4	-			Local	Quality	CMO
Serious incidents - % that are harmful*	Feb 24	100%	0%		?	Local	Quality	CMO
% of patients safety incidents which are harmful*	Feb 24	15%	0%	H	F	Local	Quality	CMO
Never events	Feb 24	0	-			Local	Quality	CMO
Category 4 pressure ulcers - New (Hospital acquired)	Feb 24	0	-			Local	Quality	CN
Category 3 pressure ulcers - New (Hospital acquired)	Feb 24	1	-			Local	Quality	CN
Falls with Harm	Feb 24	14	-			Local	Quality	CMO
VTE risk assessment*	Feb 24	99%	95%	H	P	Local	Quality	CMO
Patients admitted to stroke unit within 4 hours of hospital arrival	Feb 24	65%	90%	H	F	Local	Quality	CMO
Stroke patients spending 90% of their time on stroke unit	Feb 24	94%	80%		?	Local	Quality	CMO
% Stroke Patients Thrombolysed within an hour	Feb 24	30%	50%		?	Local	Quality	CMO

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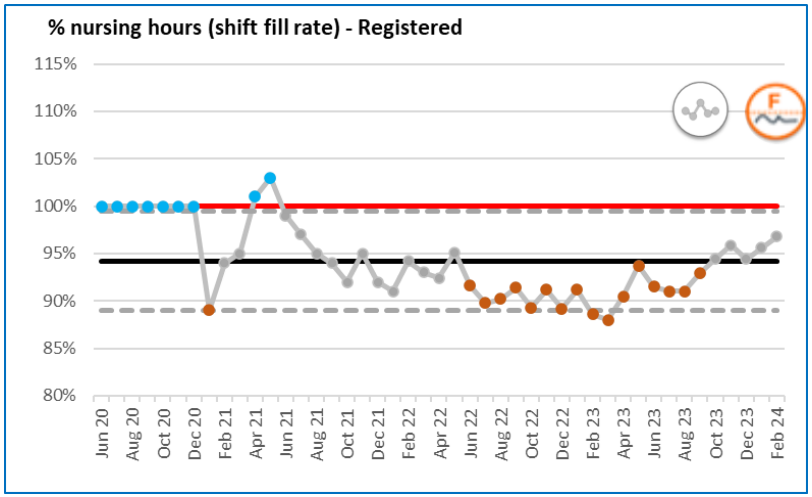
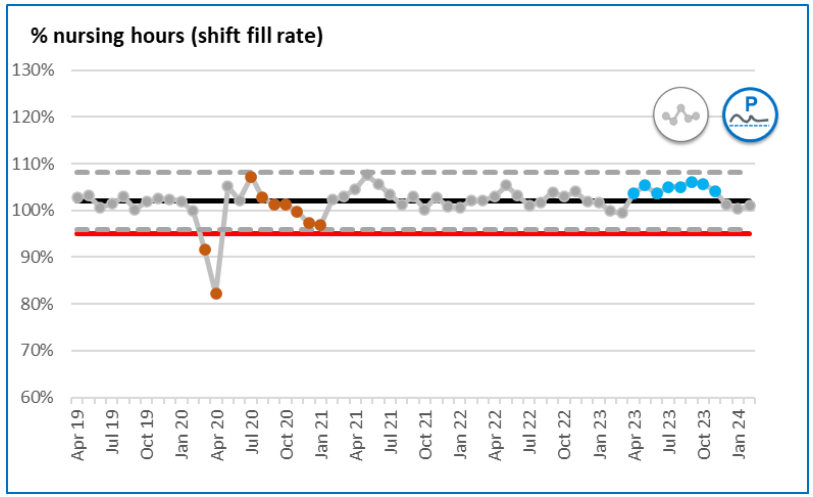
Special Cause Variation – Assurance – % Nursing Hours (shift fill rate) - Registered

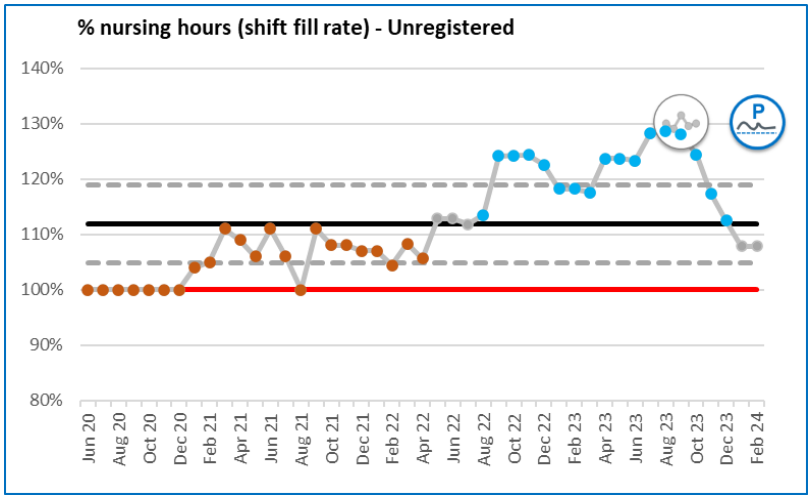


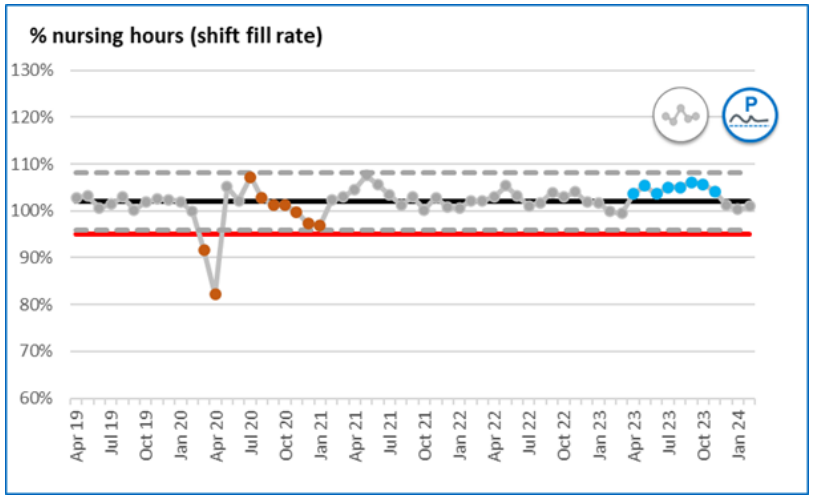


Background	What the Data tells us	Issues	Actions	Mitigations
% Nursing Hours (shift fill rate) - Registered	Exception triggered due to the target being above the upper control limit	The Registered fill rate has slightly improved but remains below 95% target. The cause is multifactorial, 1. number of escalation beds open (1119). 2. staff redeployment to cover surge and unavailability, total sickness for inpatient areas was **7.5%** against **3.5%** target (7.2% RNs and 7.8% HCSWs). 3. Temporary staffing **14%** unfilled shifts 4. Vacancy in Paediatrics and maternity Overseas nurses are reported as unregistered until they have received their NMC PIN.	Continue to monitor fill rates and unavailability Monitor number of surge beds open including use of temporary staffing. Use of Temporary staffing **Ref # 37** Maintaining safe staffing nursing **(**Score 20) Risk has closed and moved to the Corporate Services Issues log as an ongoing issue.	Daily meetings at 8.30 and 14.30 to review safe staffing. 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 /Deputy Senior clinical support out of hours including nights

West Hertfordshire Hospitals NHS Trust

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

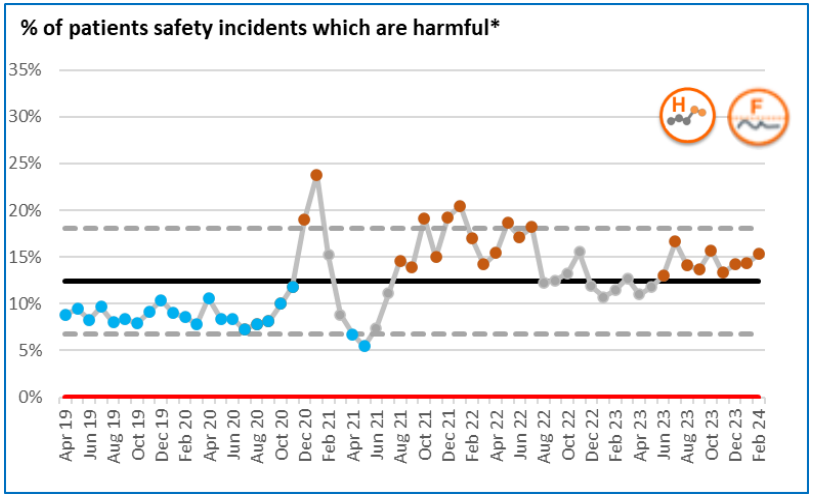




Background	What the Data tells us	Issues	Actions	Mitigations
% Nursing Hours (shift fill rate) - Unregistered	Exception triggered due to the target falling below the lower control limit	Increased unregistered demand and fill due to additional shifts related to number of escalation beds open enhanced care workers usage Overseas nurses are reported as unregistered until they have received their NMC PIN	Continue to report monthly on use of ECSW and surge demand. Monitor HCSW vacancies and Turnover Care Support Worker Development programme has commenced.	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 – Assurance – % of patient safety incidents which are harmful



The Trust recorded 1891 patient safety incidents in January 2024, compared with 1832 in December 2023: a 3.2% increase.

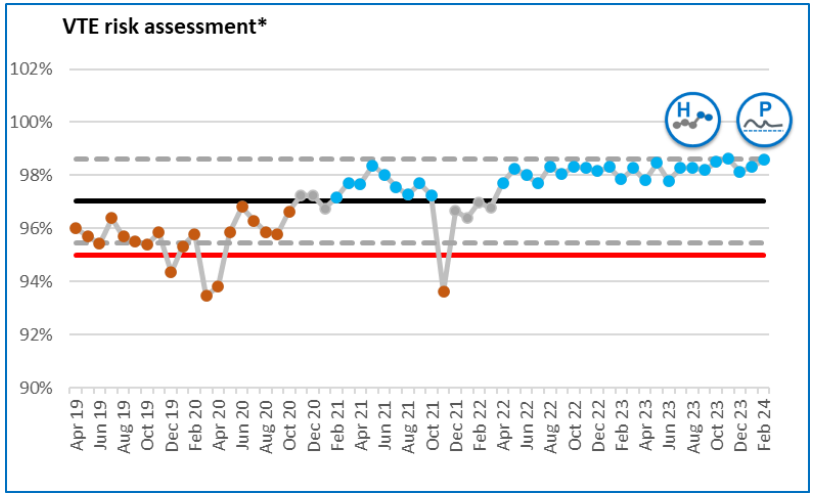
14.33% (271) of the incidents resulted in patient harm; This is similar to the 14.32% reported in December 2023.

In context, the types of incidents reported across the divisions in January 2024 are varied. Pressure Ulcers and Maternity Care, fall outside the range as outliers, reporting 116 and 56 respectively. Accidents and Falls accounted for 23 incidents.

1.69% (32) of the incidents reported in January 2024 were recorded as causing a “moderate or higher” level of harm to patients. Of these, 19 are under open investigation and 12 have been closed.

Background	What the Data tells us	Issues	Actions	Mitigations
% of patient safety incidents which are harmful	Exception triggered due to a run of data points above the mean Exception triggered due to the target being below the lower control limit	In January 2024, the incident-type reporting categories were varied concerning patient safety incident investigation (formerly known as Serious Incident) with no discernible theme. Incident types include Pressure Ulcer, Maternity (Midwifery) care, and Patient Falls as listed above. The proportion of incidents reported with no harm in January 2024 is 83.5% (1580) which is similar to the proportion in December 2023.	Divisions will continue to share and facilitate timely learning and ensure lessons learned are embedded. Continue improvement, and organisational shared learning around identified themes and trends to minimise or prevent a recurrence.	Patient safety incident discussions continue, through meetings in the division and the Executive Review Group meetings. The Trust has a Go-Live date to begin the process of transitioning to the new Patient Safety Incident Response Framework (PSIRF), which embraces proactive use of data, collaborative working, improved engagement, and emphasizes lessons learned.

Special Cause Variation – Performance/Assurance – VTE Risk Assessment



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

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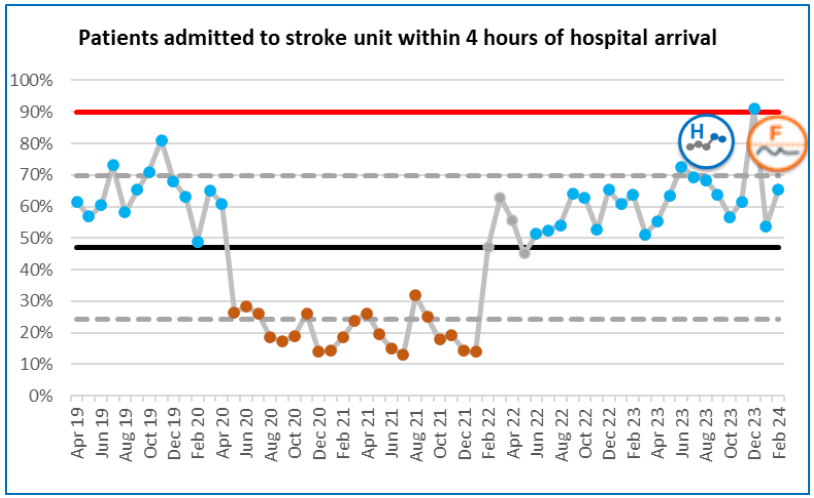
Special Cause Variation – Performance/Assurance – Patients admitted to stroke unit within 4 hours of hospital arrival



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

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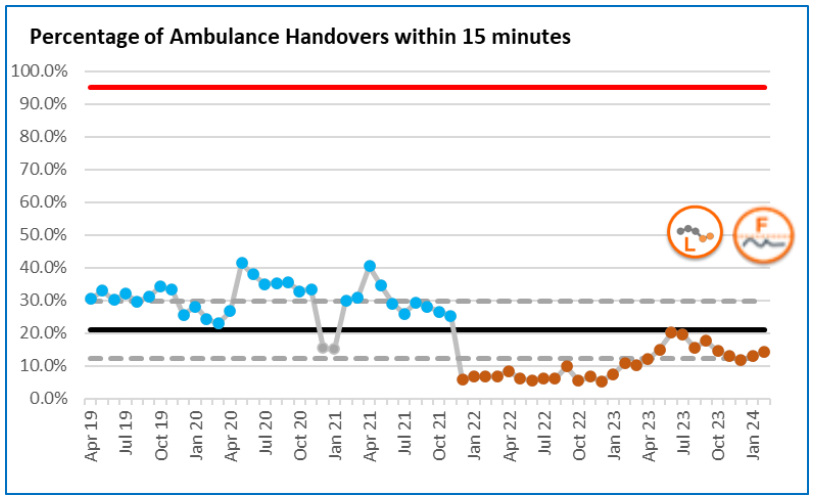
KPI	Latest month	Measure	Target	Variation	Assurance	Local or National Metric	Committee	Owner
Caring & Responsive Services - A&E Metrics								
Percentage of Ambulance Handovers within 15 minutes	Feb 24	14.2%	95.0%	L	F	National	F&P	COO
Ambulance turnaround times >30 mins and <60 mins	Feb 24	612	-	H		National	F&P	COO
Ambulance turnaround times >60 mins	Feb 24	132	-			National	F&P	COO
A&E Initial Assessment < 15 mins	Feb 24	73.6%	95.0%	L	F	National	F&P	COO
Mean time in department (non-admitted)	Feb 24	310	-	H		National	F&P	COO
Mean time in department (admitted)	Feb 24	443	-	H		National	F&P	COO
12 hour end to end waits for all attendances	Feb 24	841	-	H		Local	F&P	COO
A&E 12hr trolley waits	Feb 24	38	0	H	?	Local	F&P	COO
A&E 4 Hour Wait - Type 1, 2 & 3	Feb 24	70.8%	76.0%	L	?	National	F&P	COO
A&E 4hr waits – Type 1	Feb 24	47.9%	-	L	?	National	F&P	COO
% Patients admitted through A&E - 0 day LOS	Feb 24	31.4%	-			Local	F&P	COO
Proportion of 12 hour waits in ED	Feb 24	5.4%	2.0%	H	?	National	F&P	COO

West Hertfordshire Hospitals NHS Trust

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



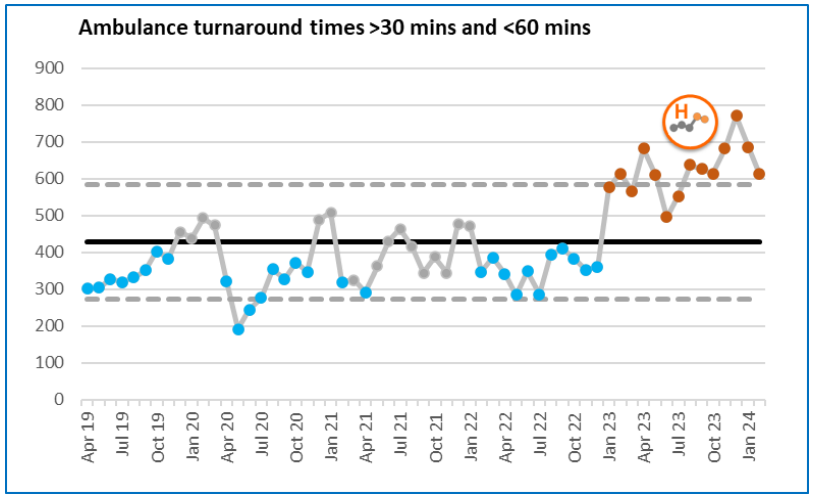
*Latest available benchmarking data – EEAST – February 2024

Hospital	% within 15 minutes
Bedford Hospital South Wing	64.34%
Hinchingbrooke Hospital	49.55%
Addenbrookes Hospital	47.78%
Norfolk & Norwich University Hospital	39.15%
Broomfield Hospital	37.52%
Basildon & Thurrock Hospital	36.80%
Queen Elizabeth Hospital	35.30%
Southend University Hospital	34.70%
West Suffolk Hospital	30.72%
James Paget Hospital	24.62%
Princess Alexandra Hospital	17.30%
Luton & Dunstable Hospital	16.77%
Peterborough City Hospital	16.37%
Ipswich Hospital	14.51%
Watford General Hospital	**14.19%**
Lister Hospital	11.52%
Colchester General Hospital	10.24%
Region	**28.79%**

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



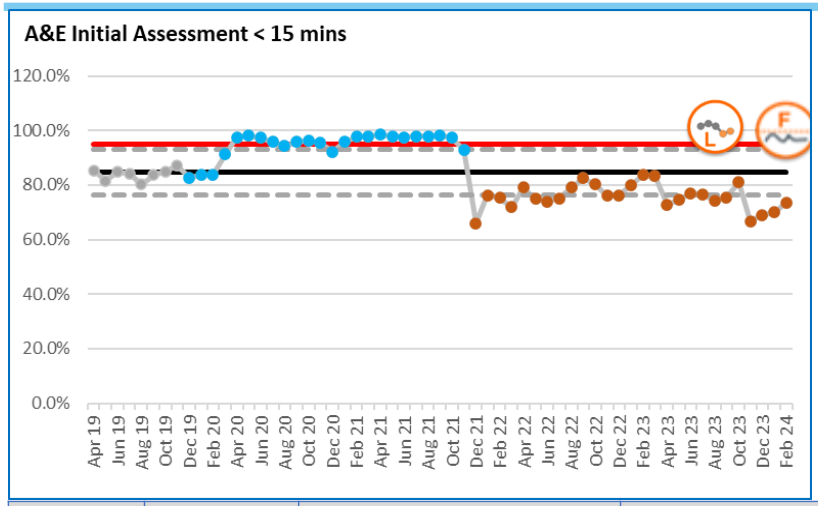
***Latest available benchmarking data – EEAST – February 2024**

Hospital	Number over 30 Minutes	% over 30 minutes
Bedford Hospital South Wing	116	7.58%
Hinchingbrooke Hospital	151	12.43%
Basildon & Thurrock Hospital	290	14.17%
Southend University Hospital	430	18.13%
West Suffolk Hospital	326	18.68%
Broomfield Hospital	477	20.74%
Addenbrookes Hospital	531	23.07%
Queen Elizabeth Hospital	483	28.23%
Watford General Hospital	**739**	**29.63%**
Colchester General Hospital	924	34.66%
Luton & Dunstable Hospital	934	40.57%
Peterborough City Hospital	698	42.64%
James Paget Hospital	712	43.60%
Norfolk & Norwich University Hospital	1,492	44.90%
Lister Hospital	904	45.68%
Ipswich Hospital	1,039	49.10%
Princess Alexandra Hospital	834	53.84%
Region	**11,080**	**31.73%**

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

West Hertfordshire Hospitals NHS Trust

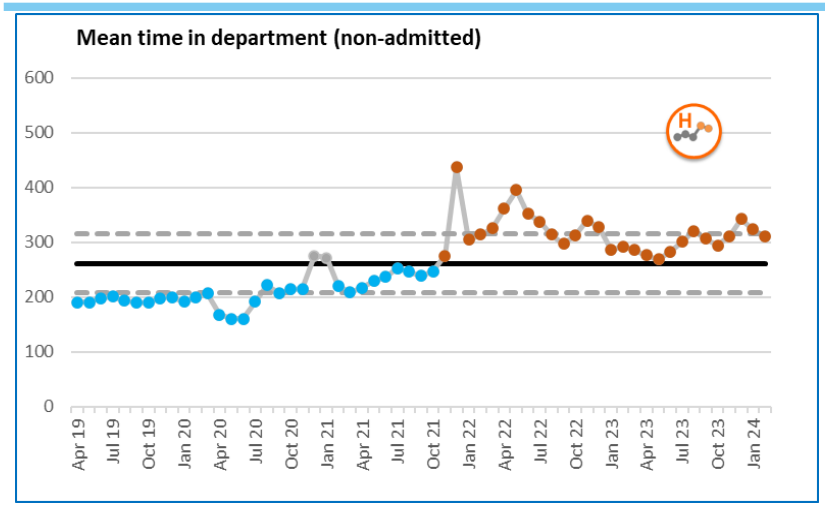
Special Cause Variation – Performance – Time to initial assessment - Percentage within 15 minutes



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) Exception triggered due to a breach of the lower control limit Exception triggered due to the target being above the upper control limit	• Capacity pressures due to poor flow throughout ED resulted in late assessments. • Nursing staffing workforce challenges with workforce at times being RAG rated RED. • Assessment area bedded further compounded by Castle Ward closure • Mental Health attendances, resulting in long stays in ED impacting on available assessment space. • Doctor and nurse staffing levels at Watford UTC • WGH UTC flow constraints impact on ED as well as handovers at close.	• Implementation of 45 minute rapid release supported by corridor care and application of the boarding policy (16 April 2023) • Walk-in stream separated from ambulance stream to provide clearer visibility across the department and decompress bottleneck areas. Fit to sit implemented. • Additional assessment trolleys created in majors 2.Increase use of TAM supported by senior decision makers to support flow and non admitted performance • Senior oversight of CT & Diagnostic requests to reduce LOS in dept to improve flow and implementation of boarding policy • EAU chairs implemented • 10 x assessment spaces released from surge • Increase usage of SDEC pathways including patients actively pulled into ACU. • 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.	• High Impact Changes enabling increasing Senior Decision Makers in ED. • Data shows continued 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 non-admitted 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 and increased use of corridor due to Castle Ward closure • 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

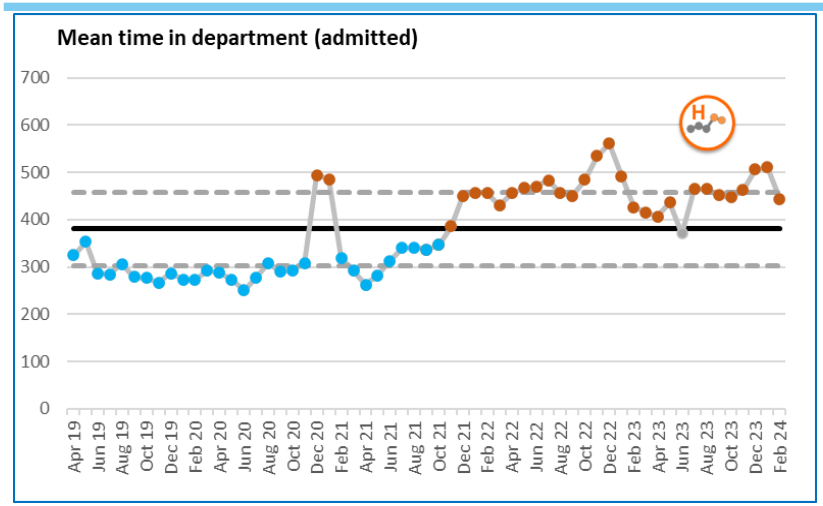
Special Cause Variation – Performance – Mean time (minutes) in department (non-admitted)



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. • Assessment area bedded • 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. • Increased LOS due to Castle Ward closure	• Implementation of 45 minute rapid release supported by corridor care and application of the boarding policy (16 April 2023) • 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 • Senior oversight of CT and diagnostic tests to reduce unnecessary time in department • 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.	• High Impact Changes enabling increasing Senior Decision Makers in ED. • Data shows increase of initial assessment due to lack of flow • 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 and increase utilisation of CDU • 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 with increased focus on flow • Additional Trust actions following escalation procedure enacted at times of extreme capacity pressures • Joint corridor SOP due to increased usage of corridor • 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

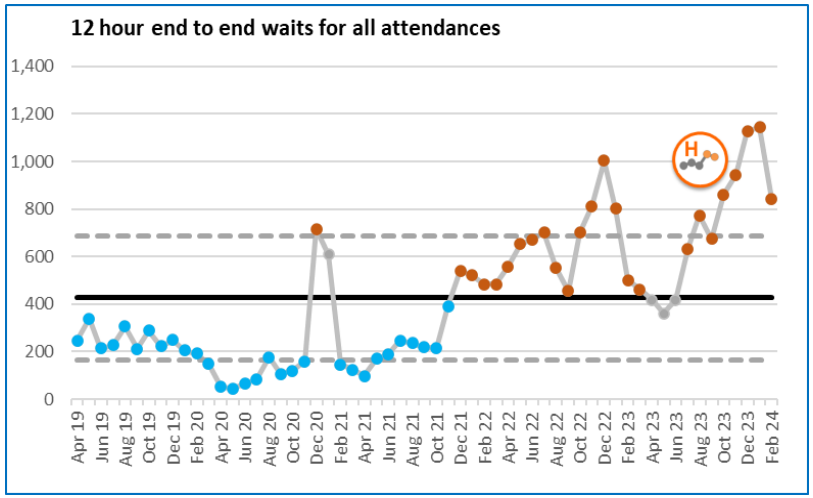
Special Cause Variation – Performance – Mean time (minutes) in department (admitted)

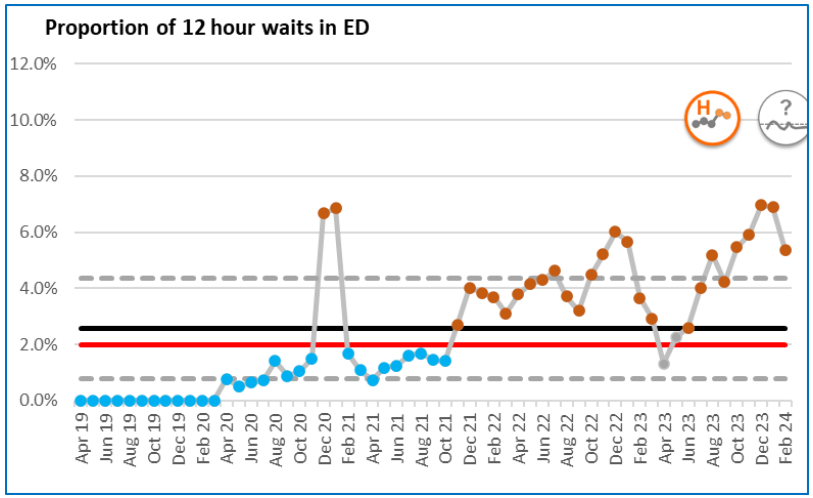


Background	What the Data tells us	Issues	Actions	Mitigations
Mean time in department (Non-admitted	Exception triggered due to a run of data points above the mean (a shift)	• Capacity pressures due to poor flow throughout ED resulted in late assessments. • Nursing staffing workforce challenges with workforce at times being RAG rated RED. • Assessment area bedded • 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. • Increased LOS due to Castle Ward closure	• Implementation of 45 minute rapid release supported by corridor care and application of the boarding policy (16 April 2023) • 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 • Senior oversight of CT and diagnostic tests to reduce unnecessary time in department • 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.	• High Impact Changes enabling increasing Senior Decision Makers in ED. • Data shows increase of initial assessment due to lack of flow • 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 and increase utilisation of CDU • 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 with increased focus on flow • Additional Trust actions following escalation procedure enacted at times of extreme capacity pressures • Joint corridor SOP due to increased usage of corridor • 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)

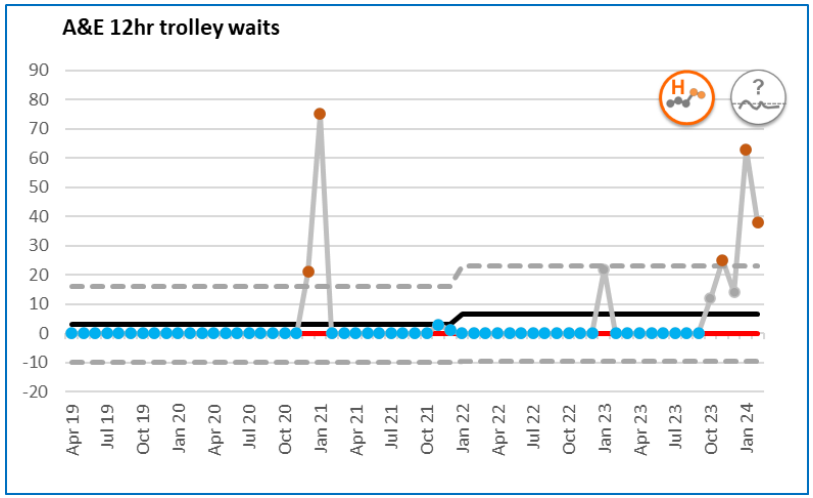




Background	What the Data tells us	Issues	Actions	Mitigations
12 Hour end to end waits for all attendances	Exception triggered due to a breach of the upper control limit Exception triggered due to a run of data points above the mean (a shift)	• Capacity pressures due to poor flow throughout ED resulted in late assessments. • Nursing staffing workforce challenges with workforce at times being RAG rated RED. • Assessment area bedded • 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. • Industrial action impacting on LOS in department • IPS response times slightly higher in the month of September	• Implementation of 45 minute rapid release supported by corridor care and application of the boarding policy (16 April 2023) • 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 • Senior oversight of CT & Diagnostic requests in TAM • EAU chairs implemented • 10 x assessment spaces released from surge • Increase usage of SDEC pathways including patients actively pulled into ACU. • Increased focus on use of CDU through board rounds • 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.	• 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. • Use of CDU promoted through TAM and EPIC role. • 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 trolley waits



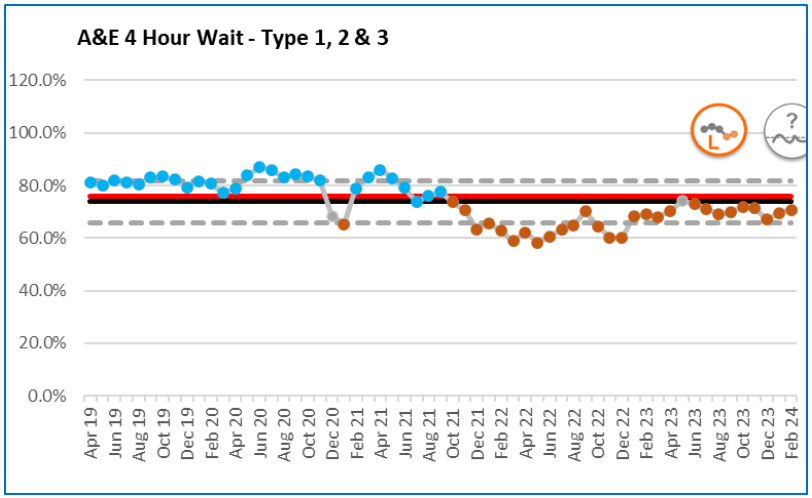
February 2024 - East of England A&E 12 Hour Trolley Waits (Latest Published Data)

Trust	Attendances	12 Hour Trolley Waits	Region Rank
Milton Keynes University Hospital NHS Foundation Trust	13,721	0	1
Bedfordshire Hospitals NHS Foundation Trust	23,683	6	2
West Hertfordshire Teaching Hospitals NHS Trust	**15,642**	**38**	**3**
Mid And South Essex NHS Foundation Trust	32,586	38	3
East And North Hertfordshire NHS Trust	15,693	108	5
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	7,224	125	6
The Princess Alexandra Hospital NHS Trust	10,766	167	7
James Paget University Hospitals NHS Foundation Trust	7,845	262	8
Norfolk And Norwich University Hospitals NHS Foundation Trust	20,141	325	9
West Suffolk NHS Foundation Trust	7,690	351	10
East Suffolk And North Essex NHS Foundation Trust	27,412	504	11
North West Anglia NHS Foundation Trust	17,253	644	12
Cambridge University Hospitals NHS Foundation Trust	16,760	711	13

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

West Hertfordshire Hospitals NHS Trust

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



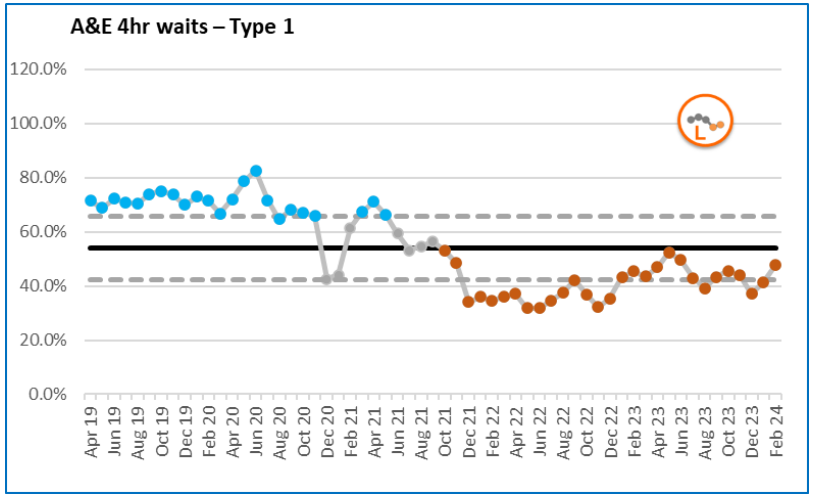
February 2024 - East of England A&E 4hr Wait Performance (Latest Published Data)

Trust	Attendances	Within 4 hours	Performance	Region Rank
Norfolk And Norwich University Hospitals NHS Foundation Trust	20,141	16,025	79.6%	1
Milton Keynes University Hospital NHS Foundation Trust	13,721	10,554	76.9%	2
Bedfordshire Hospitals NHS Foundation Trust	23,683	17,513	73.9%	3
East Suffolk And North Essex NHS Foundation Trust	27,412	19,787	72.2%	4
West Hertfordshire Teaching Hospitals NHS Trust	**15,642**	**11,081**	**70.8%**	**5**
East And North Hertfordshire NHS Trust	15,693	10,808	68.9%	6
Mid And South Essex NHS Foundation Trust	32,586	22,180	68.1%	7
West Suffolk NHS Foundation Trust	7,690	4,933	64.1%	8
Cambridge University Hospitals NHS Foundation Trust	16,760	10,640	63.5%	9
James Paget University Hospitals NHS Foundation Trust	7,845	4,856	61.9%	10
North West Anglia NHS Foundation Trust	17,253	10,613	61.5%	11
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	7,224	4,428	61.3%	12
The Princess Alexandra Hospital NHS Trust	10,766	6,447	59.9%	13

Background	What the Data tells us	Issues	Actions	Mitigations
A&E 4 Hour Wait – Type 1, 2 & 3	Exception triggered due to a run of data points below the mean	• Capacity pressures due to poor flow throughout ED resulted in late assessments. • Nursing staffing workforce challenges with workforce at times being RAG rated RED. • Assessment area bedded • 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. • Industrial action impacting on LOS in department • IPS response times slightly higher in the month of September	• Implementation of 45 minute rapid release supported by corridor care and application of the boarding policy (16 April 2023) • 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. Senior oversight of CT & diagnostic requests to reduce LOS in Department and improve 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.	• 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



February 2024 - East of England A&E Type 1 4hr Wait Performance (Latest Published Data)

Trust	Attendances	Within 4 hours	Performance	Region Rank
Mid And South Essex NHS Foundation Trust	29,467	19,127	64.9%	1
Milton Keynes University Hospital NHS Foundation Trust	8,376	5,405	64.5%	2
Norfolk And Norwich University Hospitals NHS Foundation Trust	11,270	7,156	63.5%	3
Bedfordshire Hospitals NHS Foundation Trust	15,577	9,407	60.4%	4
West Suffolk NHS Foundation Trust	6,908	4,151	60.1%	5
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	6,156	3,360	54.6%	6
North West Anglia NHS Foundation Trust	12,648	6,744	53.3%	7
James Paget University Hospitals NHS Foundation Trust	6,346	3,357	52.9%	8
East Suffolk And North Essex NHS Foundation Trust	14,429	7,186	49.8%	9
West Hertfordshire Teaching Hospitals NHS Trust	**7,476**	**3,567**	**47.7%**	**10**
East And North Hertfordshire NHS Trust	8,896	4,024	45.2%	11
The Princess Alexandra Hospital NHS Trust	7,745	3,426	44.2%	12
Cambridge University Hospitals NHS Foundation Trust	10,431	4,455	42.7%	13

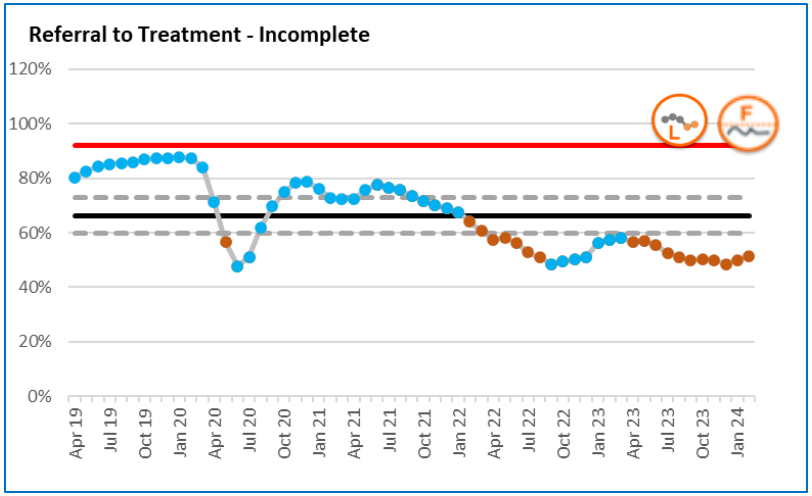
Background	What the Data tells us	Issues	Actions	Mitigations
A&E 4hr Waits – Type 1	Exception triggered due to 7+ data points below the mean (a shift)	• Increase in Type 1 attendances compared to August 2023 • Capacity pressures due to poor flow throughout ED resulted in late assessments. • Nursing staffing workforce challenges with workforce at times being RAG rated RED. • Assessment area bedded • 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. • Industrial action impacting on department • IPS response times slightly higher in the month of September • Increased use of corridor	• Implementation of 45 minute rapid release supported by corridor care and application of the boarding policy (16 April 2023) • Walk-in stream separated from ambulance stream to provide clearer visibility across the department and decompress bottleneck areas. Fit to sit implemented. • Additional assessment trolleys created in majors 2.Increase use of TAM supported by senior decision makers to support flow. Senior oversight on CT & diagnostic requests to support improved performance and 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.	• 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. • Flexing of staff across Emergency Floor to support peaks in attendances

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	Feb 24	51%	92%	L	F	National	F&P	COO
Referral to Treatment - 52 week waits - Incomplete	Feb 24	2420	0	H	F	Local	F&P	COO
Referral to Treatment - 65 week waits - Incomplete	Feb 24	353	0		F	Local	F&P	COO
Referral to Treatment - 78 week waits - Incomplete	Feb 24	10	0	L	F	National	F&P	COO
Diagnostic (DM01) <6 weeks	Feb 24	91%	99%	H	F	National	F&P	COO
New Cancer Metric - 28 Day Faster Diagnosis Standard	Feb 24	80%	76%		?	National	F&P	COO
New Cancer Metric - 31 Day Combined	Feb 24	97%	96%		?	National	F&P	COO
New Cancer Metric - 62 Day Combined	Feb 24	72%	85%	H	?	National	F&P	COO
Cancer 104+ day waits	Feb 24	60	-			Local	F&P	COO
Outpatient cancellation rate within 6 weeks	Feb 24	4%	5%	L	?	Local	F&P	CIO
Outpatient DNA rate	Feb 24	8%	8%	L	?	Local	F&P	CIO

West Hertfordshire Hospitals NHS Trust

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



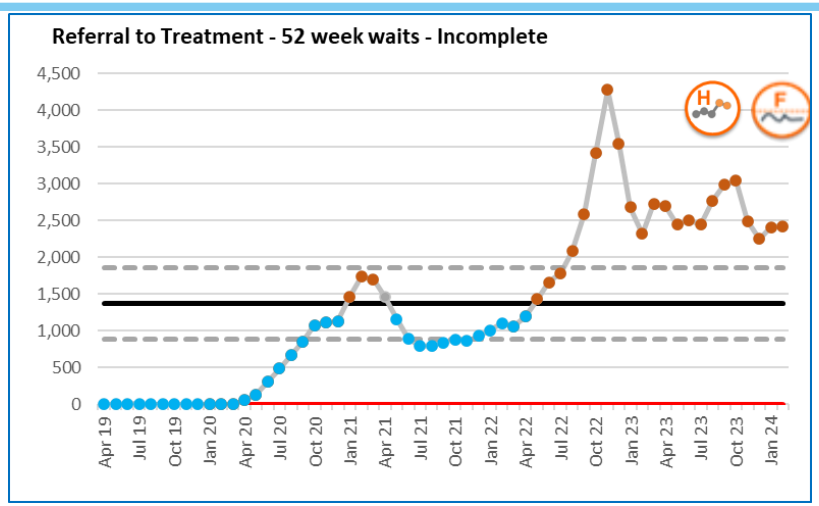
Trust	Jan-24
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	60.3%
Cambridge University Hospitals NHS Foundation Trust	58.0%
East Suffolk And North Essex NHS Foundation Trust	56.8%
West Suffolk NHS Foundation Trust	54.2%
Mid And South Essex NHS Foundation Trust	52.0%
Bedfordshire Hospitals NHS Foundation Trust	51.5%
The Princess Alexandra Hospital NHS Trust	51.1%
West Hertfordshire Hospitals NHS Trust	**50.0%**
East And North Hertfordshire NHS Trust	50.0%
Norfolk And Norwich University Hospitals NHS Foundation Trust	49.9%
North West Anglia NHS Foundation Trust	49.1%
James Paget University Hospitals NHS Foundation Trust	41.4%
Milton Keynes University Hospital NHS Foundation Trust	34.5%

*Latest available published RTT data – January 2024

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



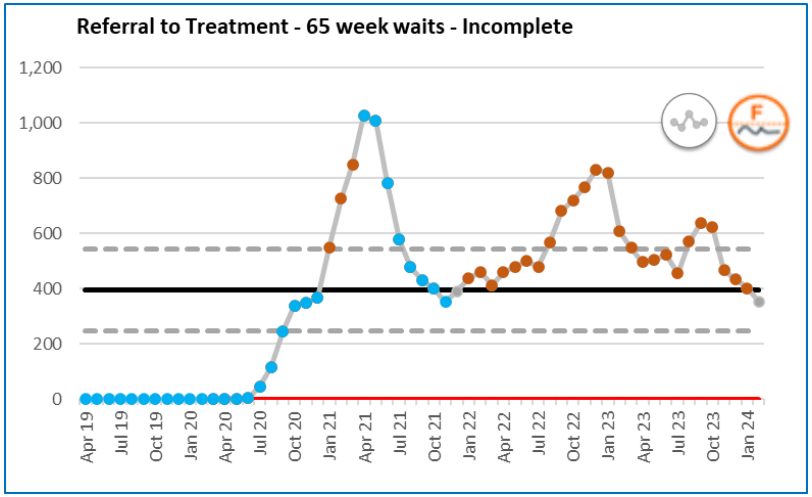
Trust	Jan-24
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	492
The Princess Alexandra Hospital NHS Trust	1,941
West Suffolk NHS Foundation Trust	1,954
West Hertfordshire Hospitals NHS Trust	**2,407**
Cambridge University Hospitals NHS Foundation Trust	3,000
East Suffolk And North Essex NHS Foundation Trust	3,758
James Paget University Hospitals NHS Foundation Trust	3,850
Milton Keynes University Hospital NHS Foundation Trust	4,207
Bedfordshire Hospitals NHS Foundation Trust	4,409
East And North Hertfordshire NHS Trust	5,347
North West Anglia NHS Foundation Trust	6,986
Norfolk And Norwich University Hospitals NHS Foundation Trust	7,076
Mid And South Essex NHS Foundation Trust	7,952

*Latest available published RTT data – January 2024

Background	What the Data tells us	Issues	Actions	Mitigations
Referral to Treatment – 52 weeks incomplete	Exception triggered due to a run of 7+ data points above the mean (a shift) Exception triggered due to breach of upper control limit Exception triggered due to the target being below the lower control limit	Although EPR has been in place for 2 years, errors continue to affect the RTT PTL in a number of ways, with incorrect outcomes which results in fewer clock stops and more open pathways on the PTL. The external validation support that was in place at the end of 2022/23 was fundamental in delivering comprehensive validation and this continues at a lower level. Recruitment is underway, with some posts appointed to. Until all staff are in post external validation support will remain in place.	Outsourcing programme remains active with reasonable patient uptake, although tighter controls are in place to support financial recovery plans. Additional sessions are being undertaken but there is significantly less uptake than pre COVID. Elective Activity Oversight Group supporting divisions with activity delivery against plan. DQ steering group established to lead on improvement work. Funds identified to enable a small number of external validators utilising monies from vacancies put in place. These validators have continued to focus on long waits.	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 – 65 weeks - Incomplete



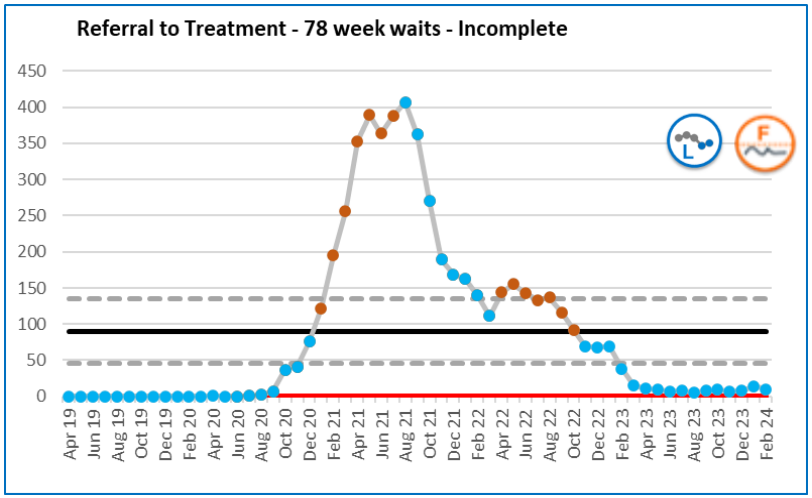
Trust	Jan-24
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	91
West Hertfordshire Hospitals NHS Trust	**402**
West Suffolk NHS Foundation Trust	665
The Princess Alexandra Hospital NHS Trust	718
Cambridge University Hospitals NHS Foundation Trust	815
East Suffolk And North Essex NHS Foundation Trust	863
Bedfordshire Hospitals NHS Foundation Trust	1,047
Milton Keynes University Hospital NHS Foundation Trust	1,367
James Paget University Hospitals NHS Foundation Trust	1,456
North West Anglia NHS Foundation Trust	2,376
East And North Hertfordshire NHS Trust	2,425
Mid And South Essex NHS Foundation Trust	2,643
Norfolk And Norwich University Hospitals NHS Foundation Trust	3,101

*Latest available published RTT data – January 2024

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

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

West Hertfordshire Hospitals NHS Trust



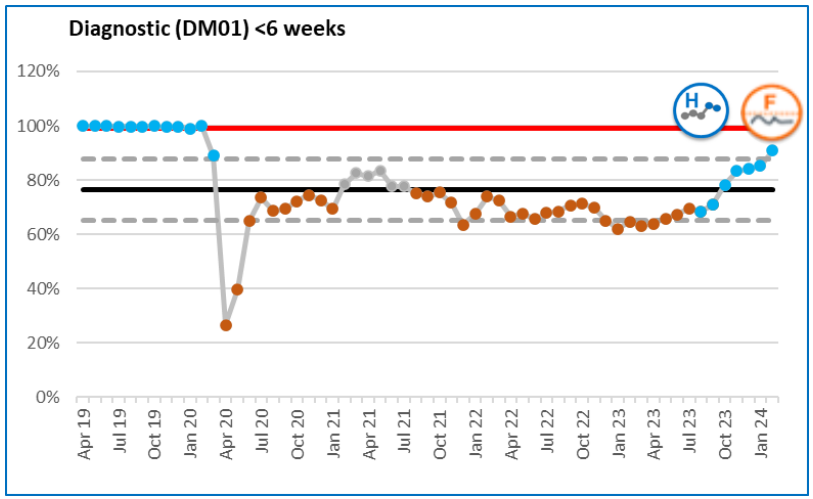
Trust	Jan-24
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	2
West Hertfordshire Hospitals NHS Trust	**14**
East Suffolk And North Essex NHS Foundation Trust	41
West Suffolk NHS Foundation Trust	59
Bedfordshire Hospitals NHS Foundation Trust	69
The Princess Alexandra Hospital NHS Trust	99
Milton Keynes University Hospital NHS Foundation Trust	109
Cambridge University Hospitals NHS Foundation Trust	130
James Paget University Hospitals NHS Foundation Trust	311
North West Anglia NHS Foundation Trust	317
Mid And South Essex NHS Foundation Trust	341
Norfolk And Norwich University Hospitals NHS Foundation Trust	865
East And North Hertfordshire NHS Trust	1,357

*Latest available published RTT data – January 2024

Background	What the Data tells us	Issues	Actions	Mitigations
Referral to Treatment – 78 weeks incomplete	Exception triggered due to a breach of the lower control limit Exception triggered due to 7+ data points below the mean (a shift) Exception triggered due to the target being below the lower control limit	Patient availability (choice and fitness) remains a challenge, with variability in the application of national choice guidance. Capacity in some services (ENT, Dermatology, Cardiology) is constrained and clinical prioritisation dictates which patients are booked, although long waits are accommodated on most occasions. Services are working on improving DQ issues.	Weekly Access and long waits review meetings are fundamental to delivery of this target. 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

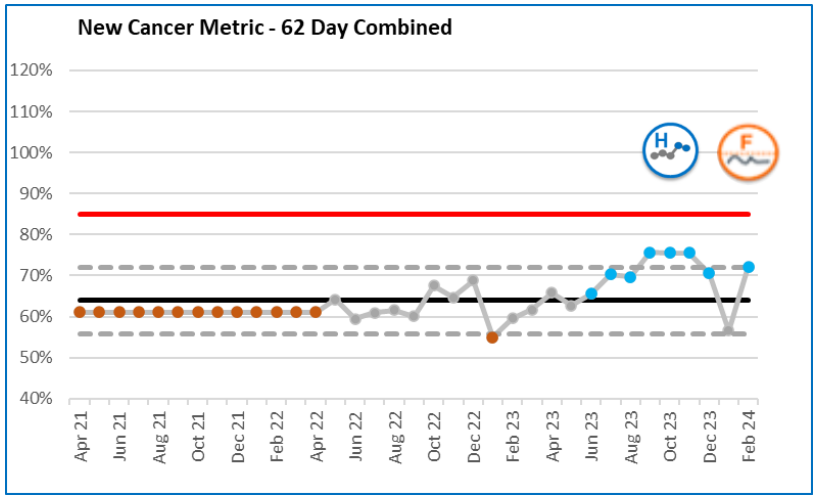


Trust	Jan-24
East Suffolk And North Essex NHS Foundation Trust	87.5%
West Hertfordshire Hospitals NHS Trust	**85.2%**
James Paget University Hospitals NHS Foundation Trust	84.7%
Mid And South Essex NHS Foundation Trust	69.5%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	65.6%
The Princess Alexandra Hospital NHS Trust	65.3%
Milton Keynes University Hospital NHS Foundation Trust	61.1%
West Suffolk NHS Foundation Trust	60.7%
Cambridge University Hospitals NHS Foundation Trust	59.8%
Norfolk And Norwich University Hospitals NHS Foundation Trust	57.4%
North West Anglia NHS Foundation Trust	55.4%
Bedfordshire Hospitals NHS Foundation Trust	55.1%
East And North Hertfordshire NHS Trust	49.2%

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

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

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

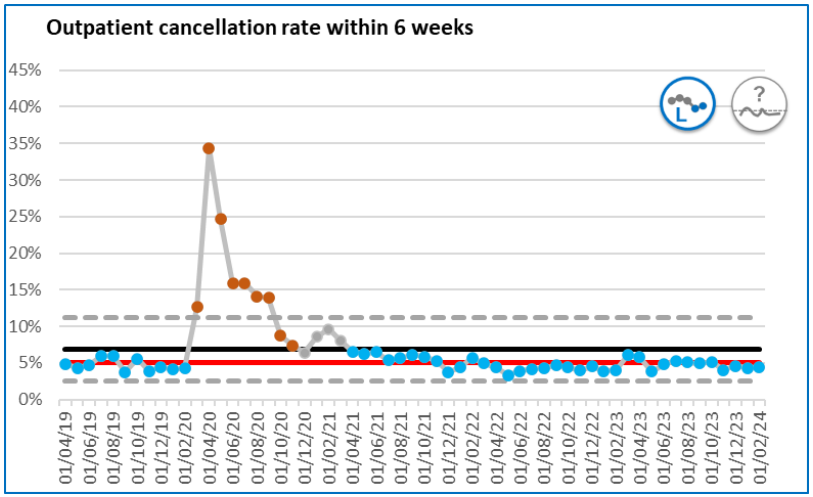


Provider Name	Jan 24
EAST AND NORTH HERTFORDSHIRE NHS TRUST	86.1%
WEST SUFFOLK NHS FOUNDATION TRUST	74.0%
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	73.0%
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	67.8%
BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	67.7%
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	63.6%
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	63.4%
WEST HERTFORDSHIRE TEACHING HOSPITALS NHS TRUST	62.6%
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	57.6%
MID AND SOUTH ESSEX NHS FOUNDATION TRUST	47.4%
NORTH WEST ANGLIA NHS FOUNDATION TRUST	45.8%
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	44.9%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	44.2%

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

West Hertfordshire Hospitals NHS Trust

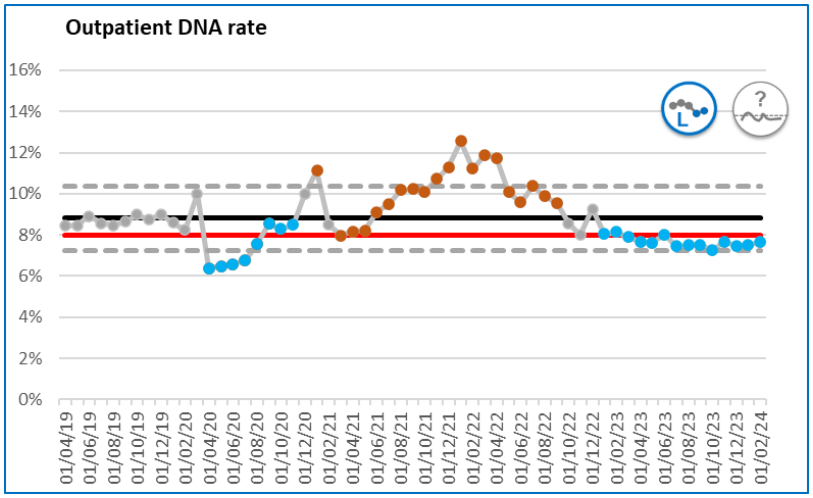
Special Cause Variation – Performance – Outpatient cancellation rate within 6 weeks



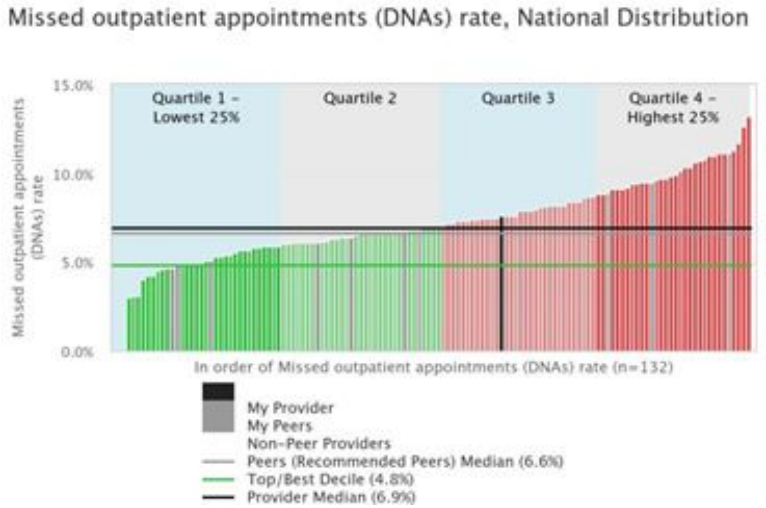
Background	What the Data tells us	Issues	Actions	Mitigations
Outpatient cancellation rates within 6 weeks	Exception triggered due to a run of 7+ data points below the mean (a shift)	This is positive performance and is the outcome of renewed BAU practises and processes within the cancellation PAS Clinic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

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance – Outpatient DNA Rate



Latest Benchmarking data – January 2024 (source – Model Hospital



Background	What the Data tells us	Issues	Actions	Mitigations
Outpatient DNA Rate	Exception triggered due to 2 of 3 most recent data points being near the lower control limit Exception triggered due to a run of data points below the mean (a shift)	Still heavily reliant on Text messaging for short notice bookings and need more information to be released as part of that communication Bookings being made more than 6 months in advance	In line with OP plan working on targeted approach to our patient demographic Trying to influence expanding patient portal functionality and correspondence assurance with stake holders	Calling patients where possible adopting partial booking approach to telephone appointments and advertising Patient portal uptake to ensure patients have real time appointments letters for short notice and routine bookings that are made more than 6 months. Text now changed to 5 and 2 days in advance ofexpected attendance

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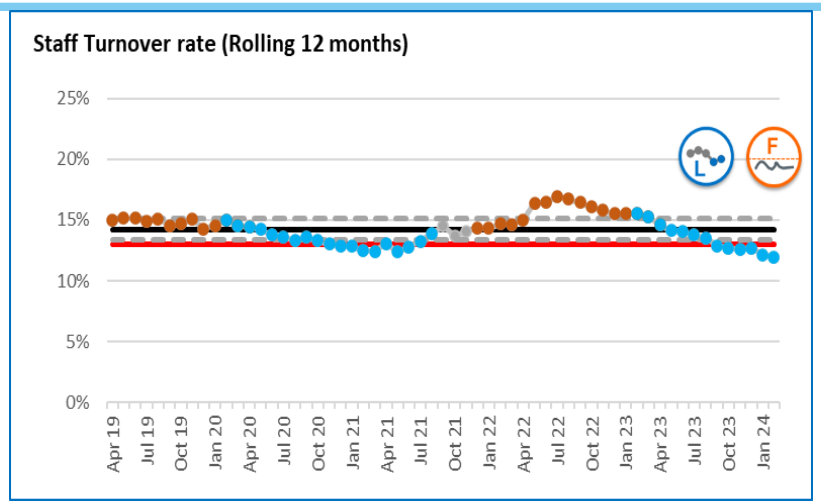
KPI	Latest month	Measure	Target	Variation	Assurance	Local or National Metric	Committee	Owner
Well-Led Services - Workforce Metrics								
Staff Turnover rate (Rolling 12 months)	Feb 24	12.0%	13.0%			Local	PerC	CPO
% staff leaving within first year (excluding medics and fixed term contracts)	Feb 24	13.5%	-			Local	PerC	CPO
Vacancy rate	Feb 24	4.8%	10.0%			Local	PerC	CPO
Sickness rate	Feb 24	4.2%	3.5%			Local	PerC	CPO
Appraisal rate (Total)	Feb 24	80.8%	90.0%			Local	PerC	CPO
Mandatory Training	Feb 24	91.0%	90.0%			Local	PerC	CPO
% Bank Pay	Feb 24	10.3%	12.0%			Local	PerC	CPO/CFO
% Agency Pay	Feb 24	2.8%	3.7%			Local	PerC	CPO/CFO
WTE Workforce Establishment	Feb 24	5612.9	5506.0			Local	PerC	CPO
WTE Staff in Post	Feb 24	5345.5	5152.0			Local	PerC	CPO
BAME Staff in Post	Feb 24	51%	-			Local	PerC	CPO
BAME Staff at Band 8a+	Feb 24	28%	-			Local	PerC	CPO
Apprenticeship Levy Utilisation	Feb 24	38%	65%			Local	PerC	CPO

West Hertfordshire Hospitals NHS Trust

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



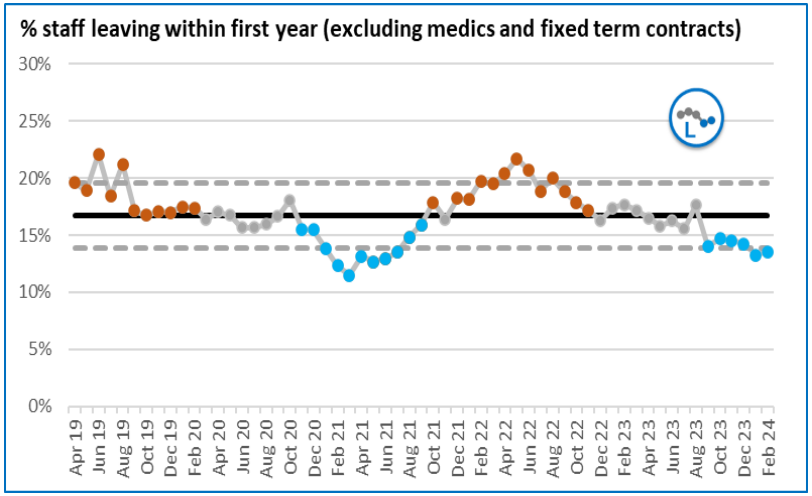
TURNOVER RATE

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

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

West Hertfordshire Hospitals NHS Trust

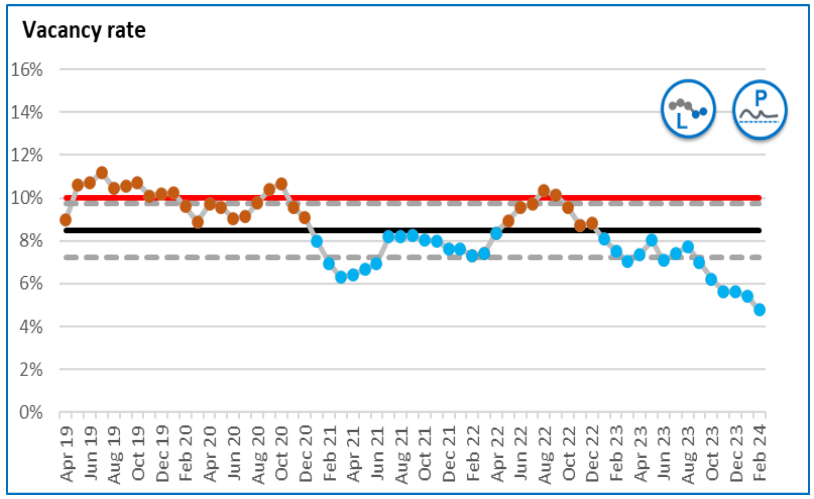
Special Cause Variation – Performance – % staff leaving within first year (excluding medics and fixed term contracts)



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

Special Cause Variation – Performance – Vacancy rate

West Hertfordshire Hospitals NHS Trust



VACANCY RATE

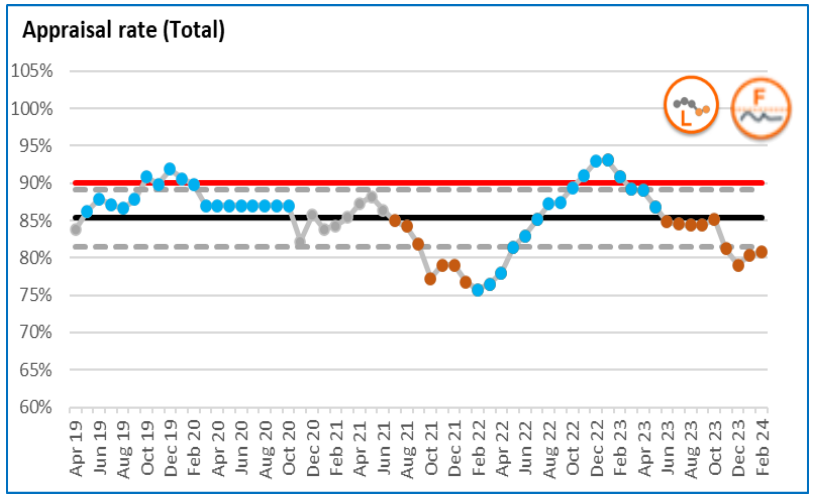
Trust	Vacancy Q4 22/23	Vacancy Q1 23/24	Vacancy Q2 23/24	Vacancy Q3 23/24	Q2 23/24 Ranking (current)	Q3 23/24 Ranking (current)	Change Q1 to Q2	Change Q2 to Q3
Bedfordshire Hospitals	12.4%	12.6%	8.8%	6.4%	4	3	↘	↘
Herts Community	4.6%	11.3%	12.1%	9.0%	9	7	↗	↘
WHTH	6.7%	7.1%	7.0%	5.6%	2	2	↘	↘
East & North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

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

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

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance/Assurance – Appraisal Rate



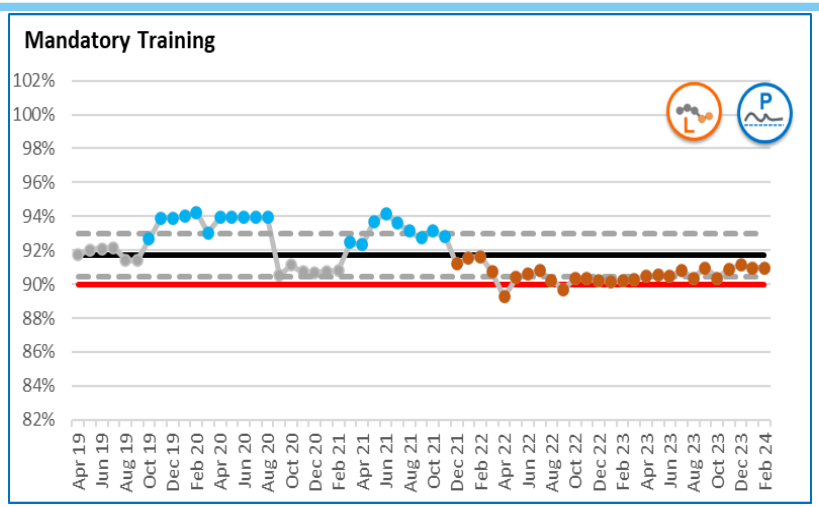
APPRAISAL RATE COMPLIANCE

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

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

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance/Assurance – Mandatory Training



MANDATORY TRAINING COMPLIANCE

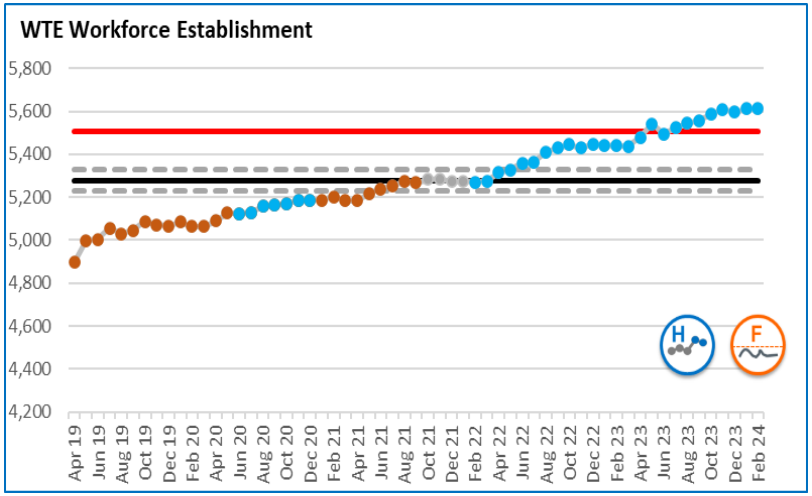
Trust	Mandatory Training Rate Q4 22/23	Mandatory Training Rate Q1 23/24	Mandatory Training Rate Q2 23/24	Mandatory Training Rate Q3 23/24	Q2 23/24 Ranking (current)	Q3 23/24 Ranking (current)	Change Q1 to Q2	Change Q2 to Q3
Bedfordshire Hospitals	84%	84%	88%	87%	7	10	↗	↘
Herts Community	95%	93%	93%	95%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

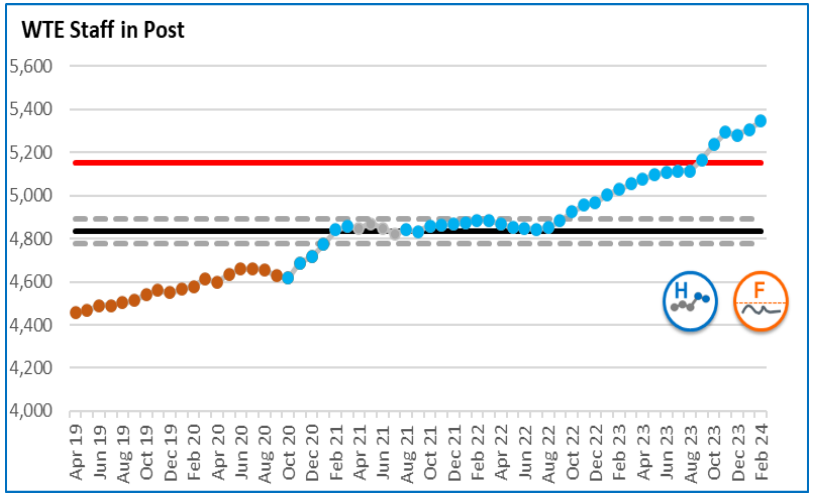
The ranking order shows number 1 reflecting the best indicator figure and others in descending order

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

West Hertfordshire Hospitals NHS Trust

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

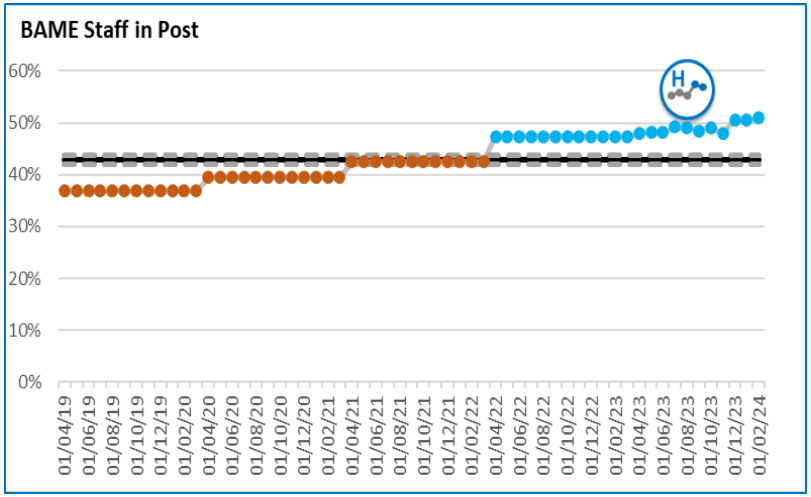


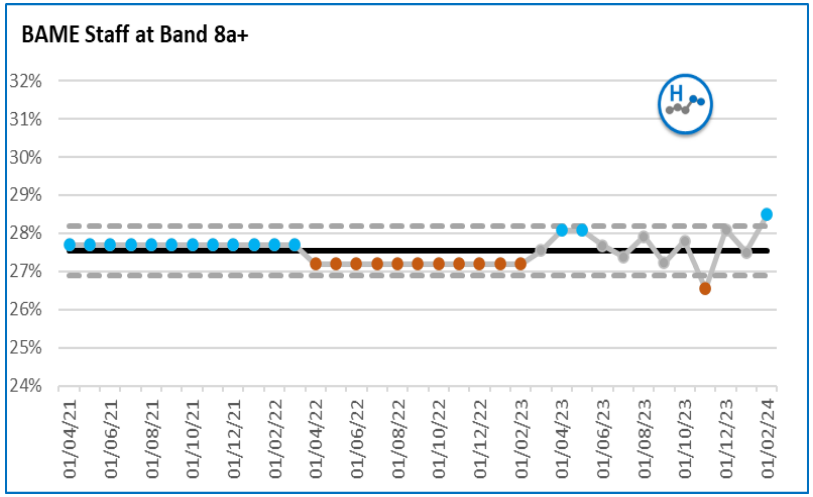


Background	What the Data tells us	Reasons	Actions	Mitigations
WTE Workforce Establishment/ WTE Staff in Post	Exception triggered due to 7+ data points above the mean Exception triggered due to a breach of the upper control limit	The planned business case establishment target is 5,506 wte by March 2024.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

West Hertfordshire Hospitals NHS Trust

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

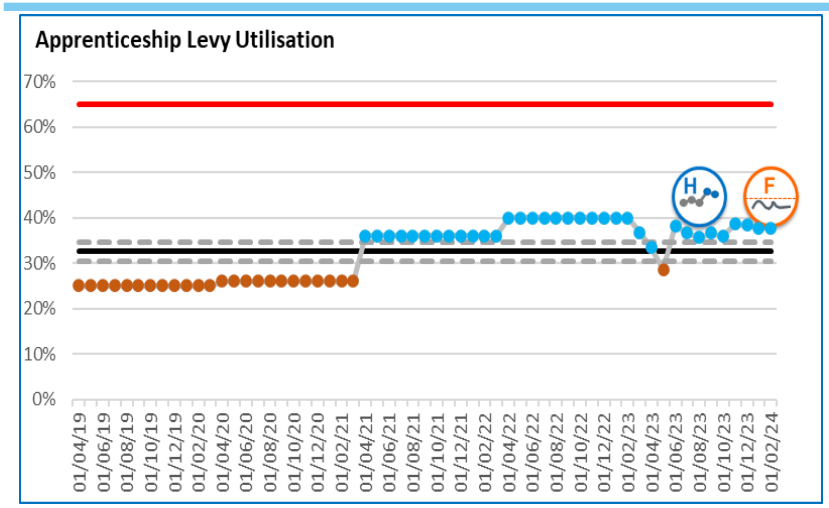




Background	What the Data tells us	Reasons	Actions	Mitigations
BAME staff in post/BAME Staff in post – Band 8a+	Exception triggered due to 7+ data points above the mean Exception triggered due to a breach of the upper control limit BAME Staff at Band 8a+ - breach of the lower control limit	These charts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

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance – Apprenticeship Levy Utilisation



Background	What the Data tells us	Reasons	Actions	Mitigations
Apprenticeship Levy Utilisation	Exception triggered due to a breach of the upper control limit Exception triggered due to the target being above the upper control limit	The target for the apprenticeship levy spend is 65% for 23/24.Each financial year resets the % figure and this will increase over 23/24 to achieve the 65% target. The current utilisation is 38%. This chart show the percentage of apprenticeship levy expenditure over time. Emergency Medicine (43%) and Medicine divisions (53%) report levy utilisation above Trust average.	• The current apprenticeship levy utilisation figure is 38% (42% including gifting levy) against an end of year target of 65%. • Apprenticeship First programme for HCSWs and non-clinical (Band 2's and 3's) to be launched April 2024. • Commenced bi-weekly walkabouts in hotspot areas • Continue to work with CSS, WACS Environment on department trajectories. Environment Division utilisation increased from 1%-9% with new starts from April 2024. • Developing more robust divisional trajectories for greater transparency on utilisation. • Apprenticeship audit not yet finalised however work plans and associated actions are being developed with a focus on communication.	42 apprenticeship scheduled to start between Jan - March 2024. Design of an apprenticeship one-stop website Feb 2024. The Trust offers an online programme for applicants who require entry level Maths & English.

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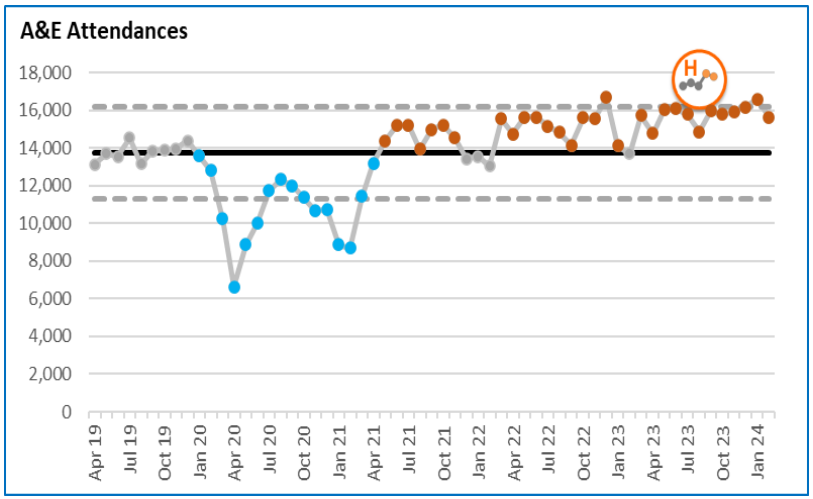
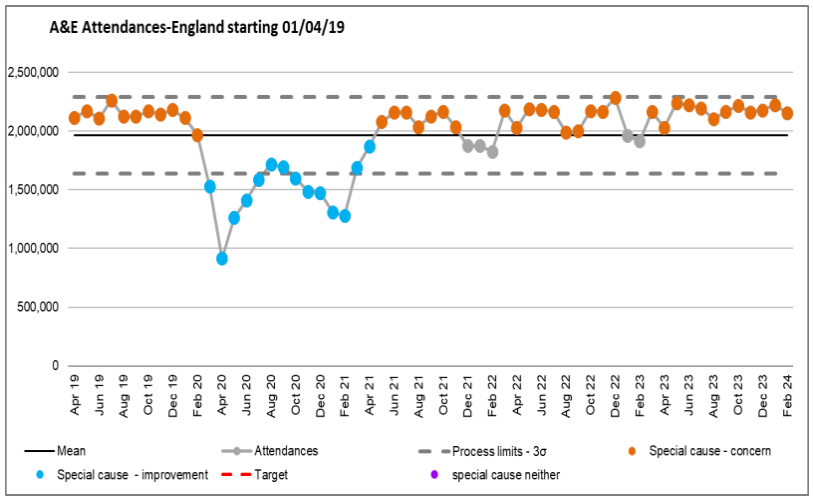
KPI	Latest month	Measure	Target	Variation	Assurance	Local or National Metric	Committee	Owner
Activity Metrics								
GP Referrals Made	Feb 24	6779	-			Local	F&P	COO
A&E Attendances	Feb 24	15642	-	H		Local	F&P	COO
1st Outpatient Appointments - All	Feb 24	12389	-			Local	F&P	CIO
1st Outpatient Appointments - Face to Face	Feb 24	11630	-	H		Local	F&P	CIO
Follow Up Outpatient Appointments - All	Feb 24	16824	-			Local	F&P	CIO
Follow Up Outpatient Appointments - Face to Face	Feb 24	12429	-			Local	F&P	CIO
Specific Acute Elective Ordinary Admissions	Feb 24	345	-			Local	F&P	COO
Specific Acute Daycases	Feb 24	3703	-	H		Local	F&P	COO
Specific Acute Non-Elective Admissions - 0 LOS	Feb 24	1561	-			Local	F&P	COO
Specific Acute Non-Elective Admissions - +1 LOS	Feb 24	2535	-	H		Local	F&P	COO
Completed Admitted RTT Pathways (Clock Stops)	Feb 24	801	-	L		Local	F&P	COO
Completed Non-Admitted RTT Pathways (Clock Stops)	Feb 24	5619	-			Local	F&P	COO
New RTT Pathways (Clock Starts)	Feb 24	10236	-			Local	F&P	COO
PTL Volume	Feb 24	58695	-	H		Local	F&P	COO
Theatre Utilisation (Touch time utilisation on the day hours planned inc early starts and late finishes)	Feb 24	81%	85%	H	F	Local	F&P	COO
Theatre Cases	Feb 24	1040	-			Local	F&P	COO
Theatre Cases per Session	Feb 24	2.4	-	H		Local	F&P	COO

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Performance – A&E Attendances

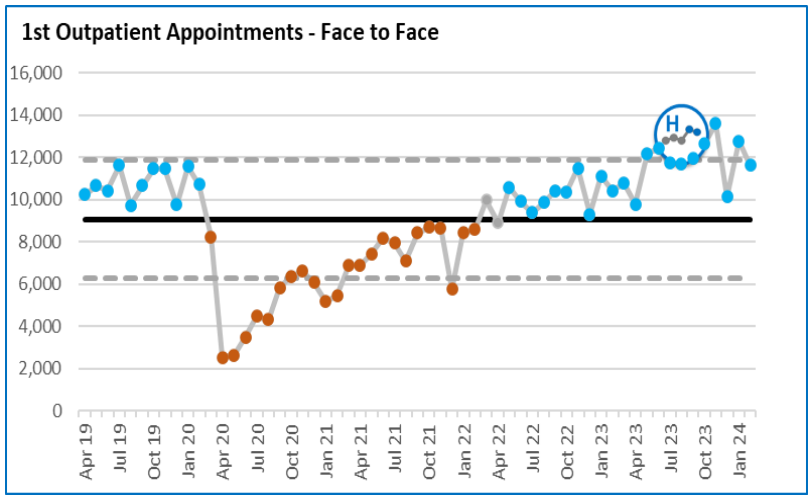


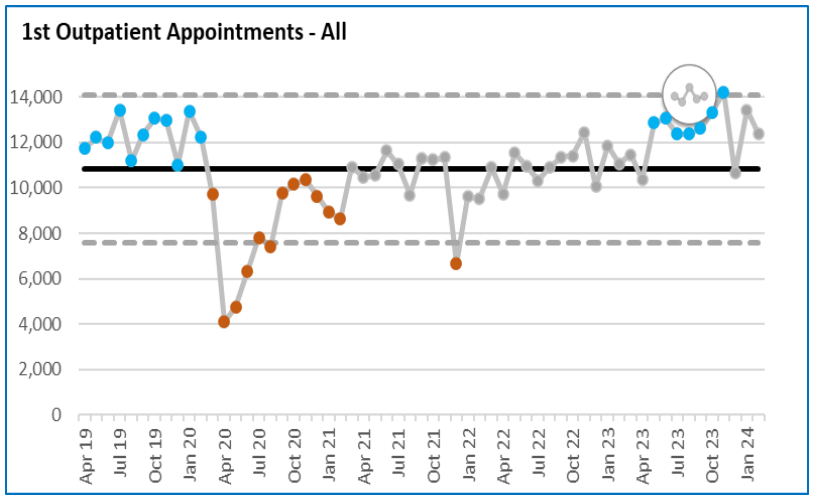


Background	What the Data tells us	Issues	Actions	Mitigations
A&E Attendances	Exception triggered due to 7+ data points above the mean (a shift)	ED demand has increased by 19% for adults and 40% for paediatrics	Working with ICB to review alternative pathways to ED Working closely with UTC providers to 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

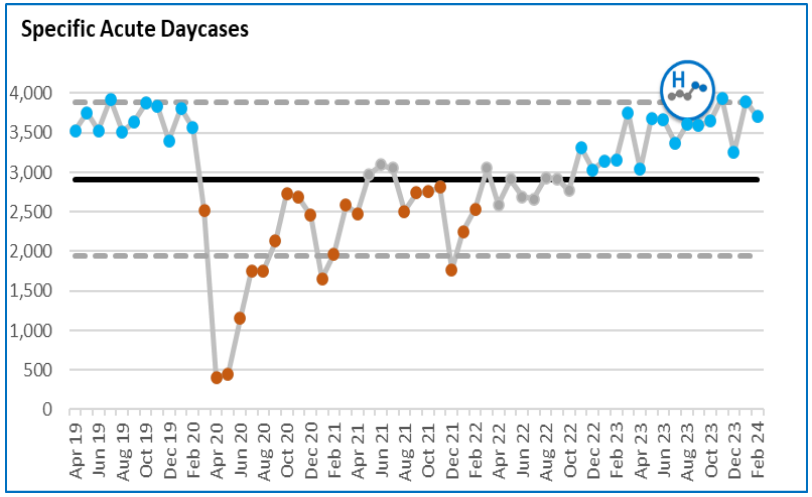




Background	What the Data tells us	Issues	Actions	Mitigations
1st Outpatient Appointments – Face to Face	Exception triggered due to 7+ data points above the mean (a shift)			

West Hertfordshire Hospitals NHS Trust

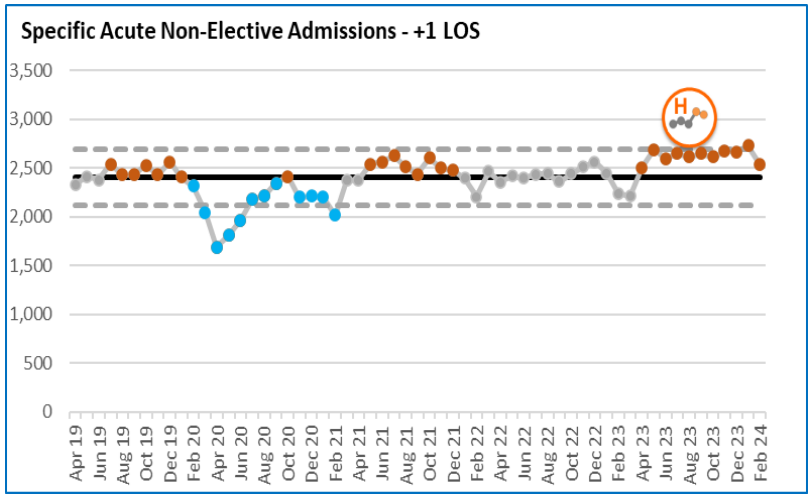
Special Cause Variation – Performance – Specific Acute Daycases



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

West Hertfordshire Hospitals NHS Trust

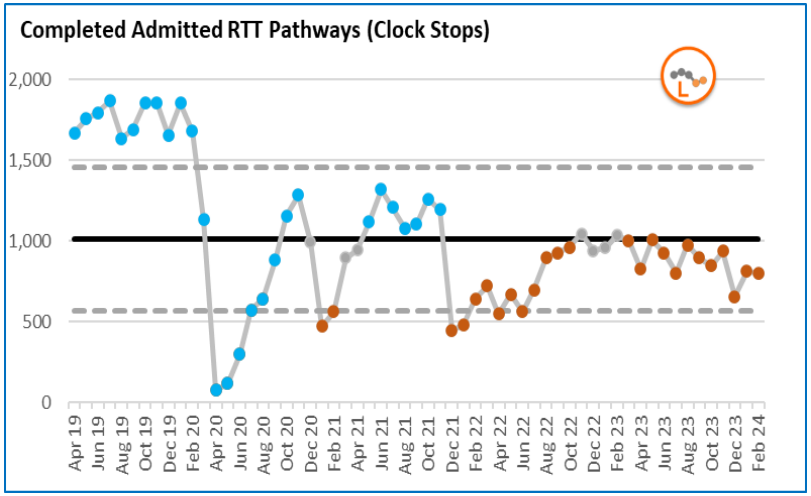
Special Cause Variation – Performance – Specific Acute Non-Elective Admissions - +1 LOS



Background	What the Data tells us	Issues	Actions	Mitigations
Specific Acute Non-Elective Admissions - +1 LOS	Exception triggered due to 2 of 3 most recent data points being close to the upper control limit Exception triggered due to a run of 7+ data points above the mean			

West Hertfordshire Hospitals NHS Trust

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



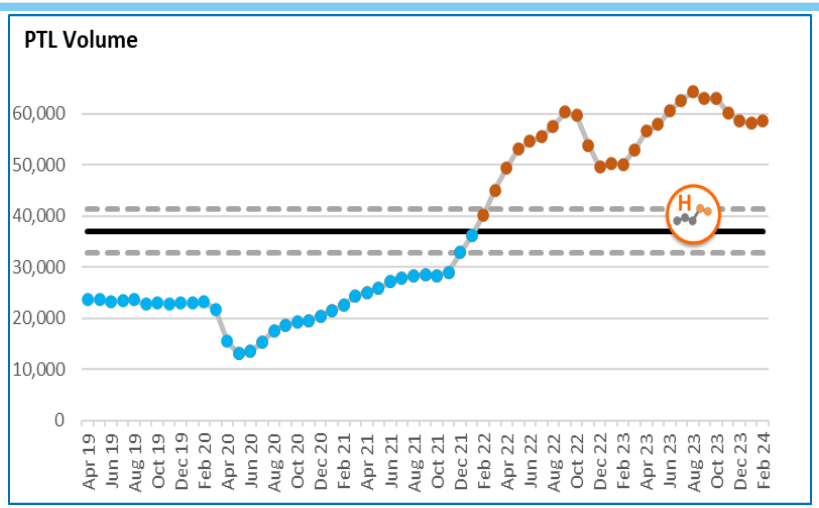
Trust	Dec-23
Mid And South Essex NHS Foundation Trust	3,338
Cambridge University Hospitals NHS Foundation Trust	2,505
Bedfordshire Hospitals NHS Foundation Trust	2,363
Norfolk And Norwich University Hospitals NHS Foundation Trust	2,209
East Suffolk And North Essex NHS Foundation Trust	1,564
North West Anglia NHS Foundation Trust	1,539
East And North Hertfordshire NHS Trust	1,533
Milton Keynes University Hospital NHS Foundation Trust	1,422
James Paget University Hospitals NHS Foundation Trust	1,362
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	950
West Suffolk NHS Foundation Trust	689
West Hertfordshire Hospitals NHS Trust	**656**
The Princess Alexandra Hospital NHS Trust	399

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

Background	What the Data tells us	Issues	Actions	Mitigations
Completed Admitted RTT Pathways (Clock Stops)	Exception triggered due to a run of 7+ data points below the mean	Loss of activity as a result of industrial action, continues to impact activity and associated clock stops. The external validation support that was in place at the end of 2022/23 was fundamental in delivering comprehensive validation. Although there has been agreement to invest in expanding the validation service in house, staff are not yet in post. This resource will therefore continue, albeit at a lower level, until all staff have been recruited.	DQ steering group established to lead on improvement work within divisions, with divisional plans in development to address key factors. Funds identified to enable a small number of external validators utilising monies from vacancies put in place. Validation team recruitment is underway and external resource remains in place, to increase validation activity	Additional training (a weekly drop in session) is in place to ensure staff receive adequate support in the correct use of Cerner. 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 – RTT PTL Volume



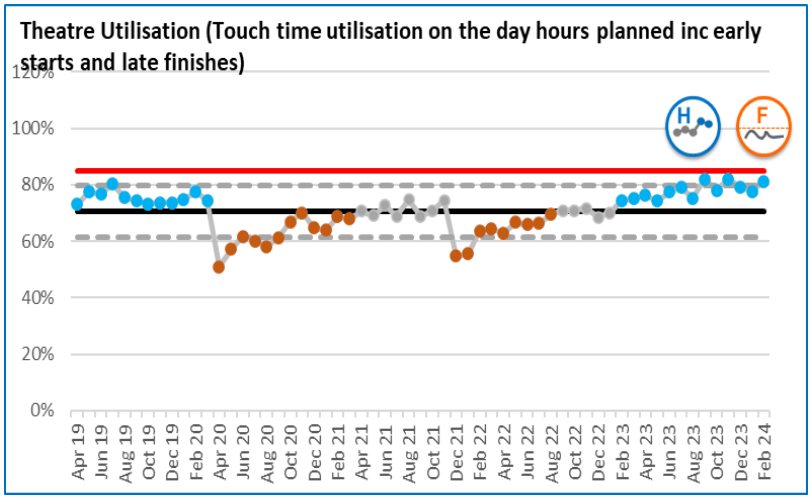
Trust	Dec-23
Mid And South Essex NHS Foundation Trust	160,322
Bedfordshire Hospitals NHS Foundation Trust	95,117
Norfolk And Norwich University Hospitals NHS Foundation Trust	86,655
East Suffolk And North Essex NHS Foundation Trust	86,561
North West Anglia NHS Foundation Trust	82,145
Cambridge University Hospitals NHS Foundation Trust	61,529
East And North Hertfordshire NHS Trust	61,163
West Hertfordshire Hospitals NHS Trust	**58,720**
Milton Keynes University Hospital NHS Foundation Trust	35,357
West Suffolk NHS Foundation Trust	35,176
James Paget University Hospitals NHS Foundation Trust	34,231
The Princess Alexandra Hospital NHS Trust	25,991
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	24,660

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

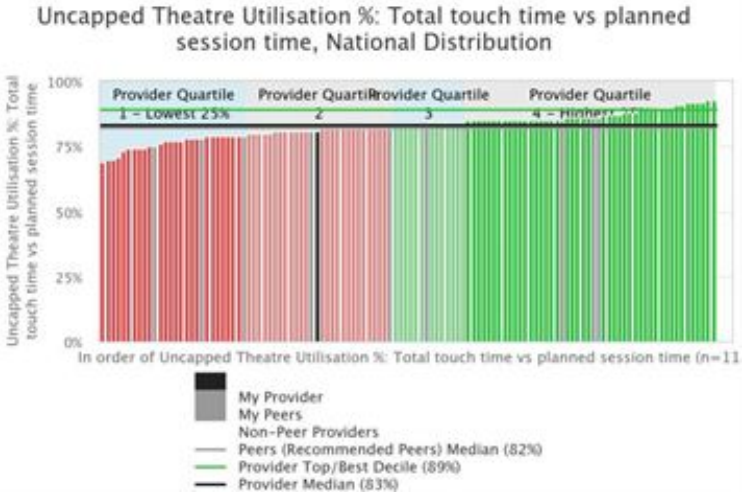
Background	What the Data tells us	Issues	Actions	Mitigations
RTT PTL Volume	Exception triggered due to breach of the upper control limit Exception triggered due to 7+ data points above the mean (a shift)	Although EPR has been in place for over a year, errors continue to affect the RTT PTL in a number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



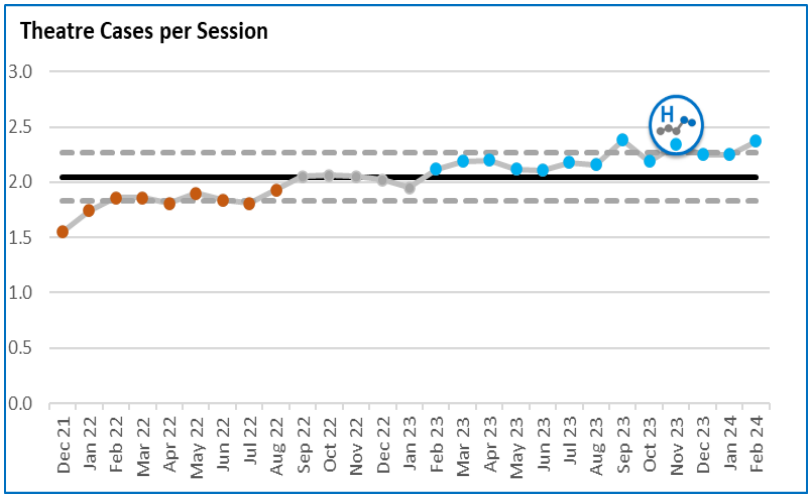
*Latest available published Theatre Utilisation – Model Hospital – w/e 25th February 2024



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

West Hertfordshire Hospitals NHS Trust

Special Cause Variation – Assurance – Theatre Cases per session



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

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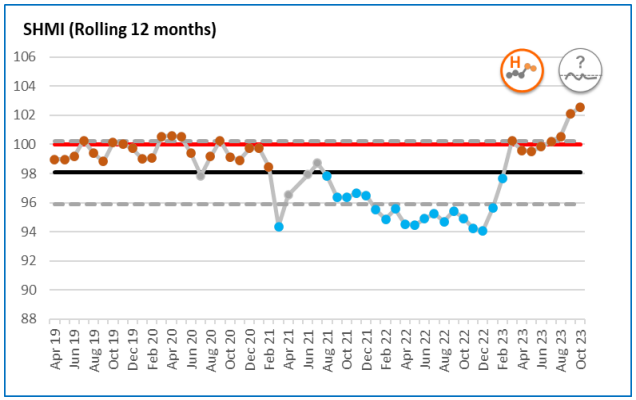
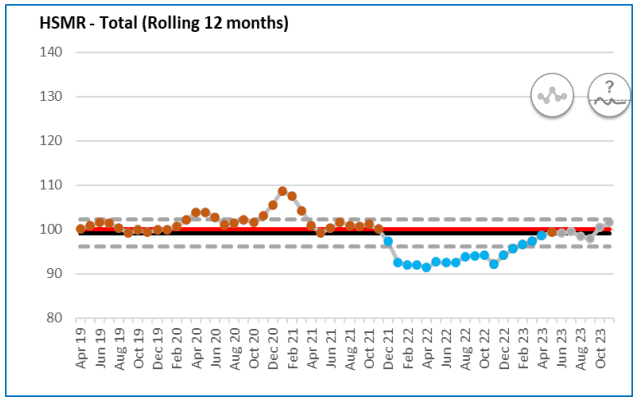
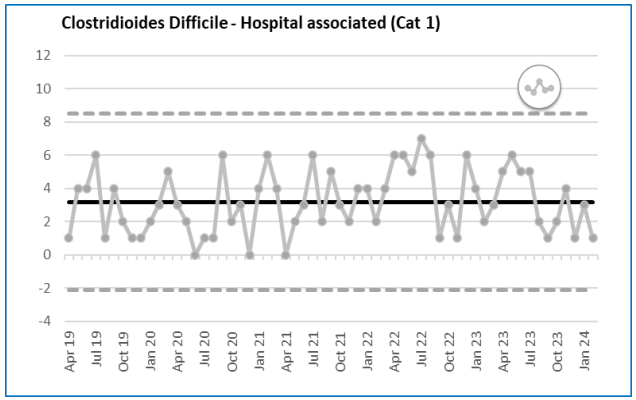
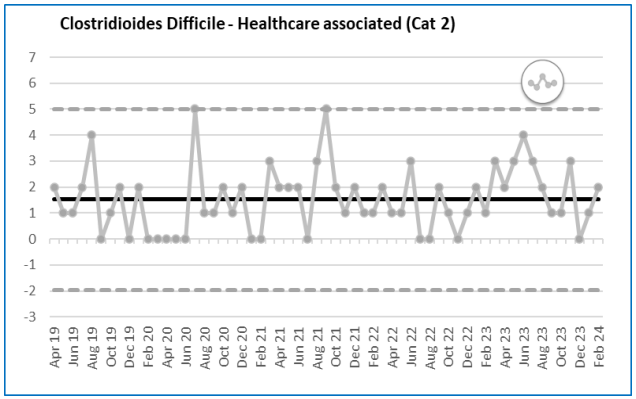
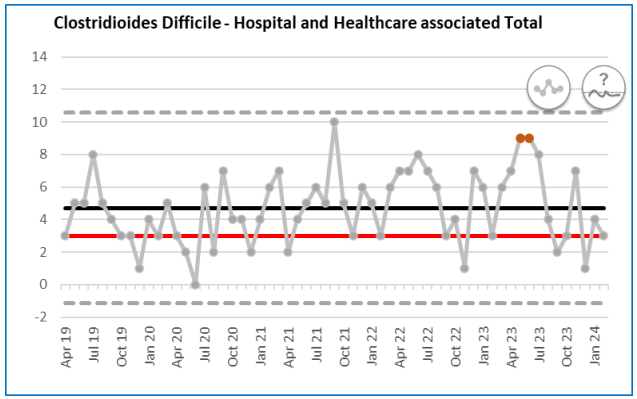
Appendix 1 – Safe Care and Improving Outcomes Metrics - Quality

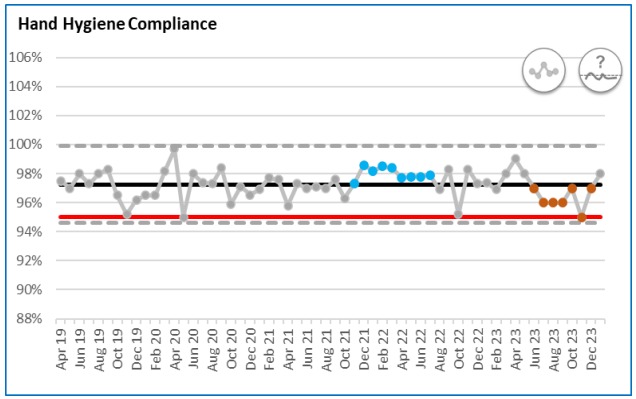












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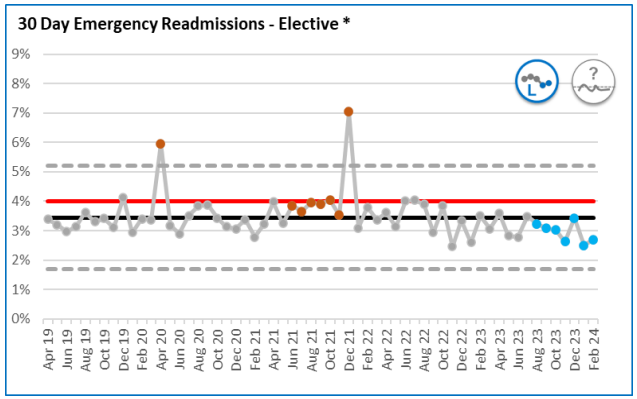
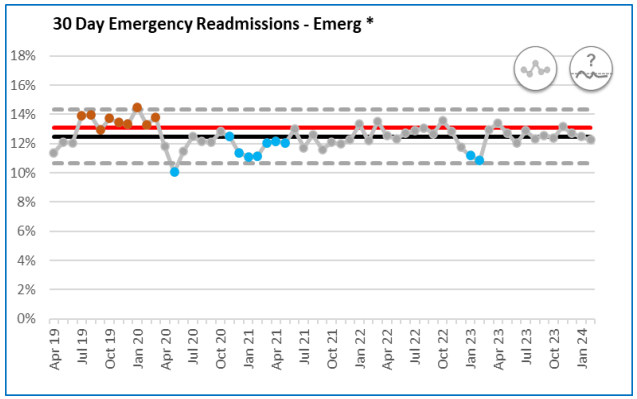
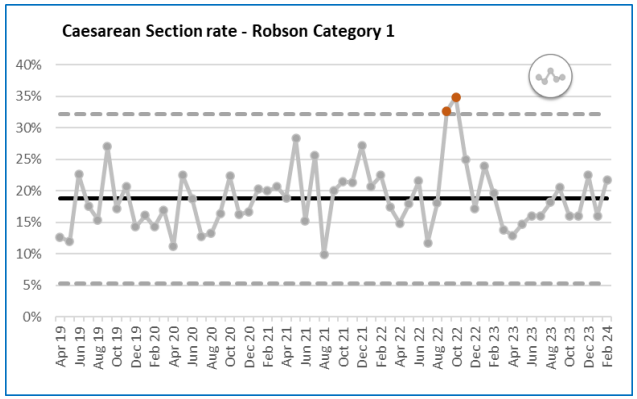
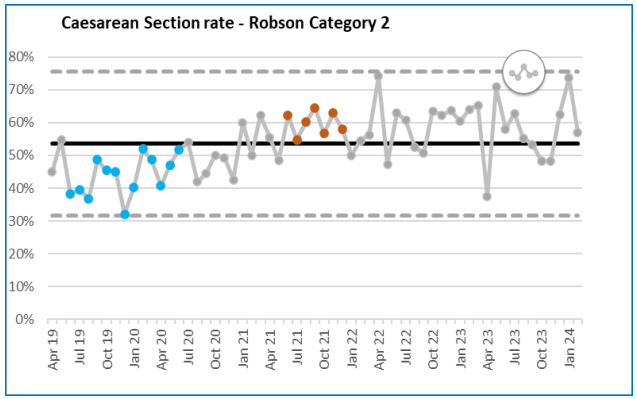
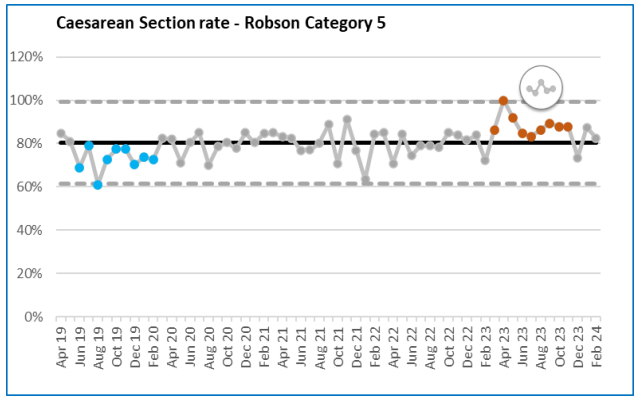
Appendix 1 – Safe Care and Improving Outcomes Metrics - Quality











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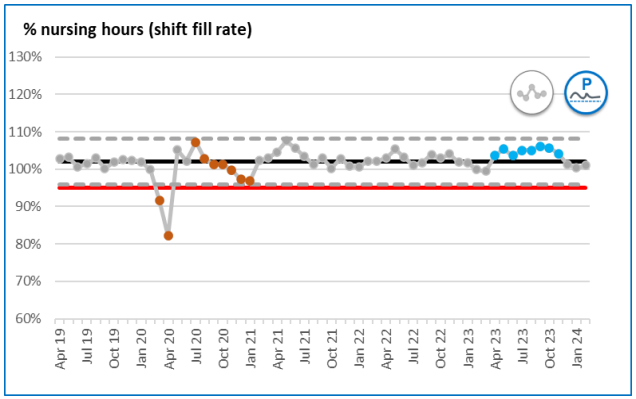
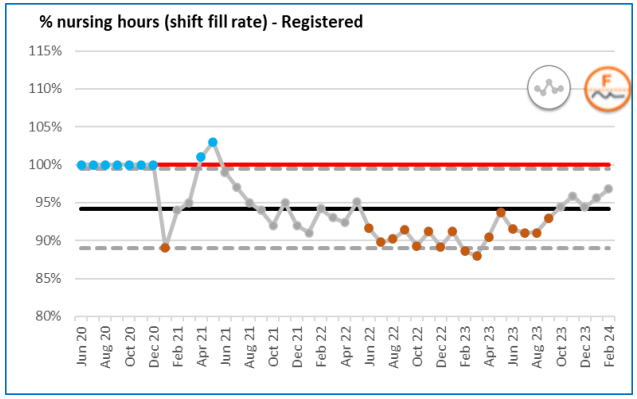
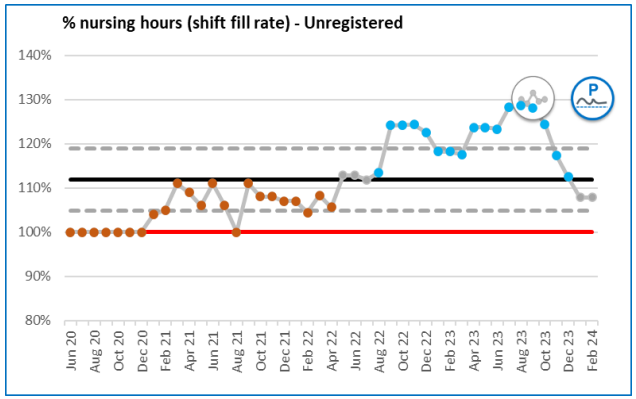
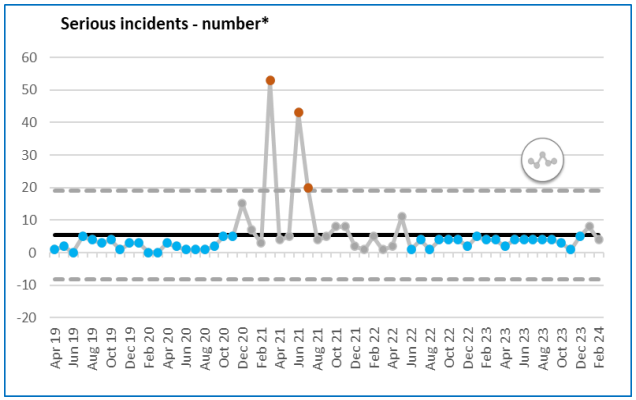
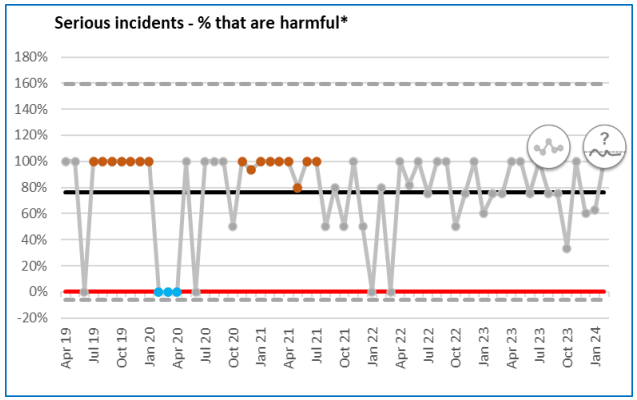
Appendix 1 – Safe Care and Improving Outcomes Metrics - Safety

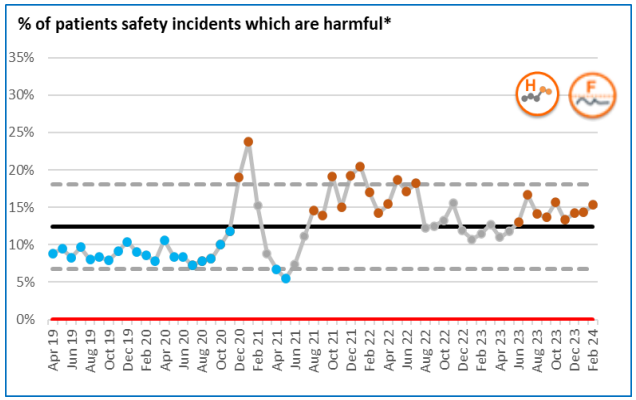












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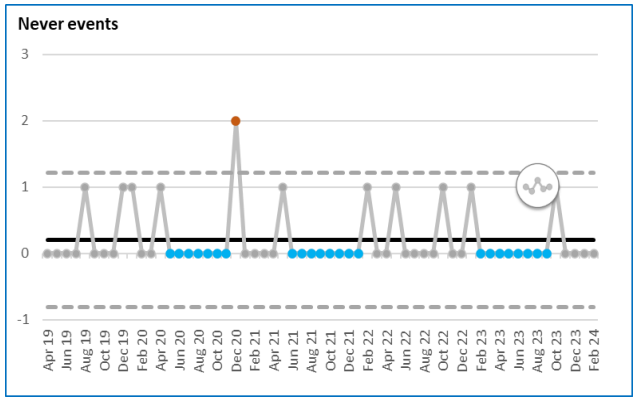
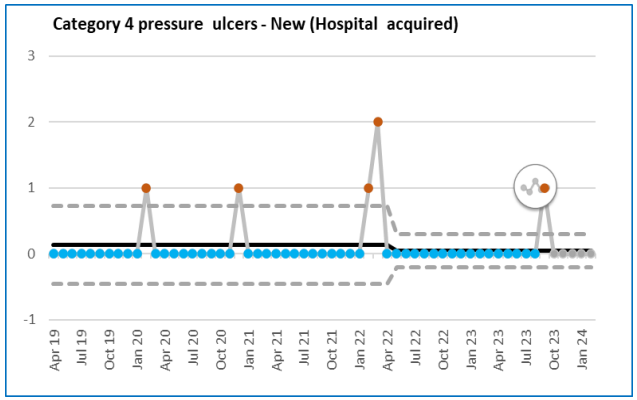
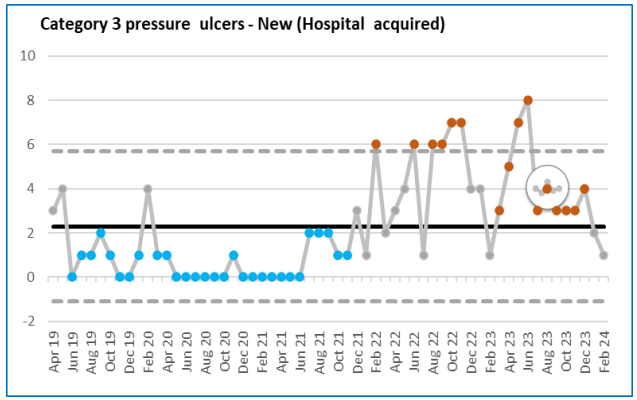
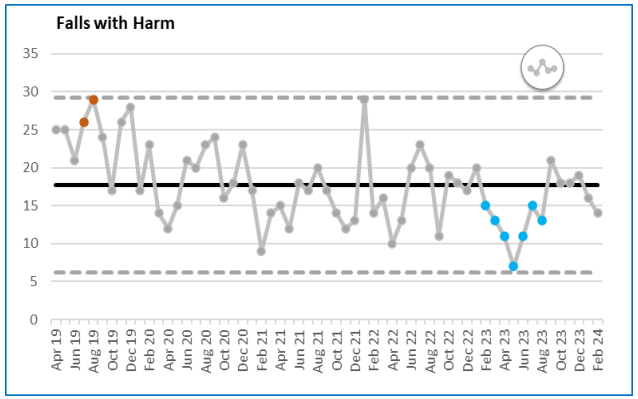
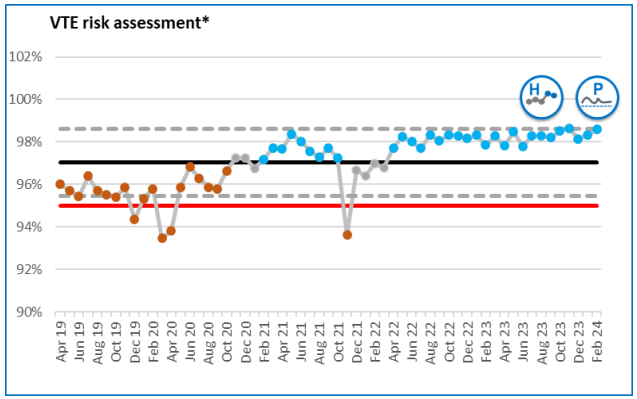
Appendix 1 – Safe Care and Improving Outcomes Metrics - Safety

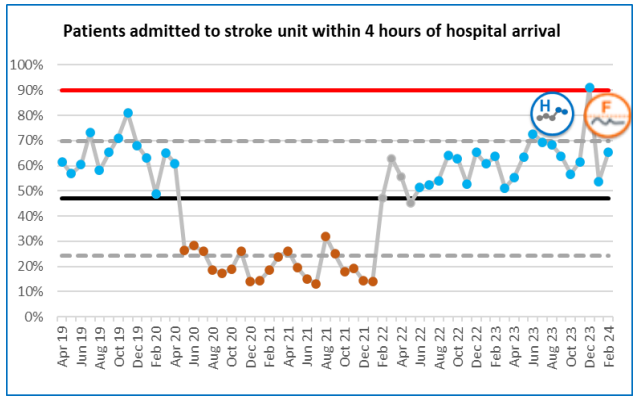












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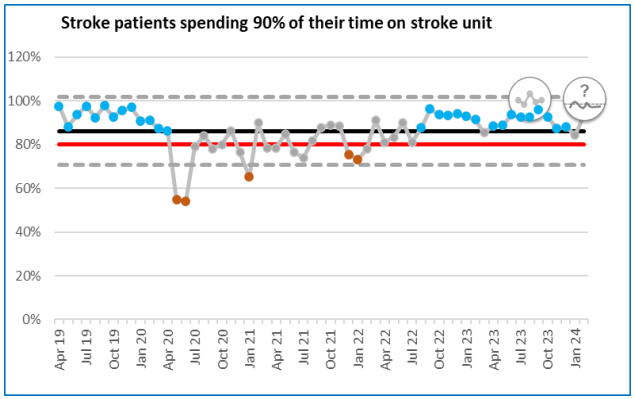
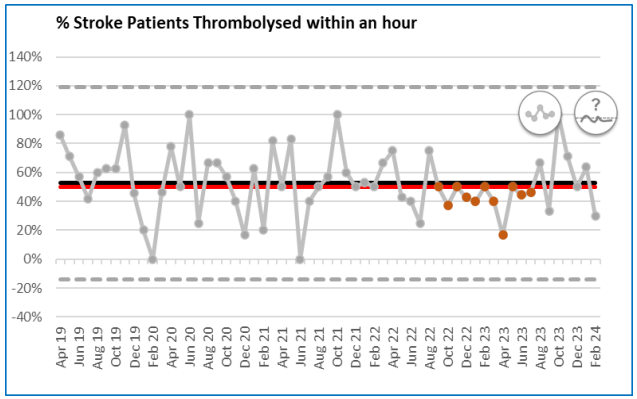
Appendix 1 – Safe Care and Improving Outcomes Metrics - Safety





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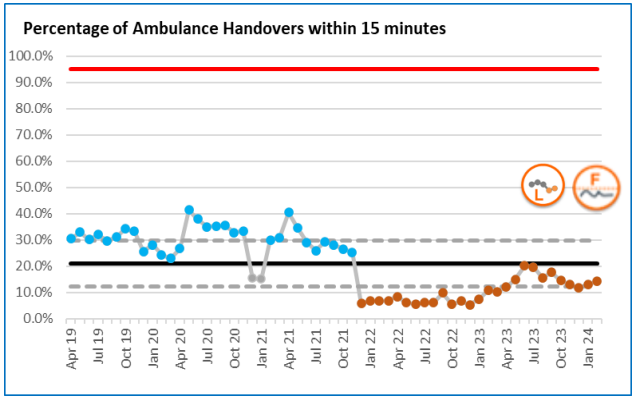
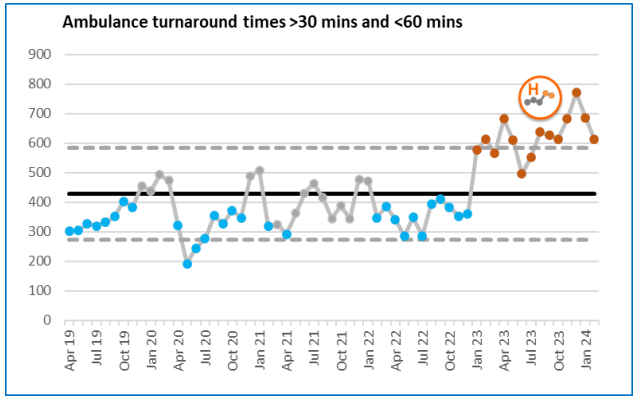
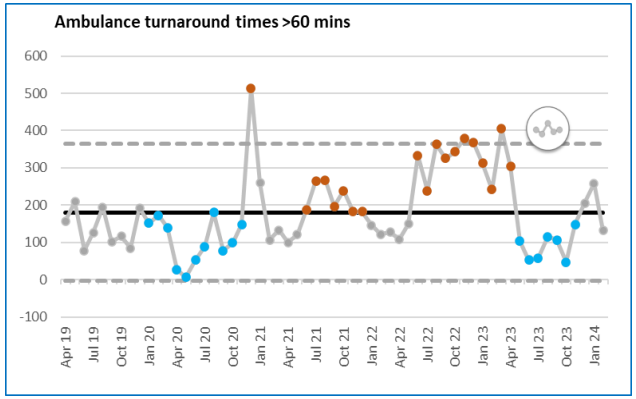
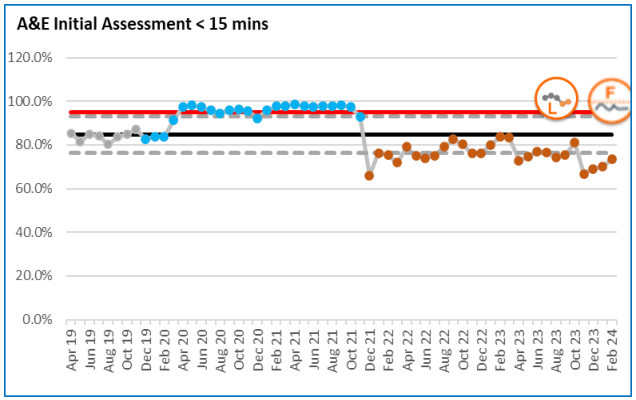
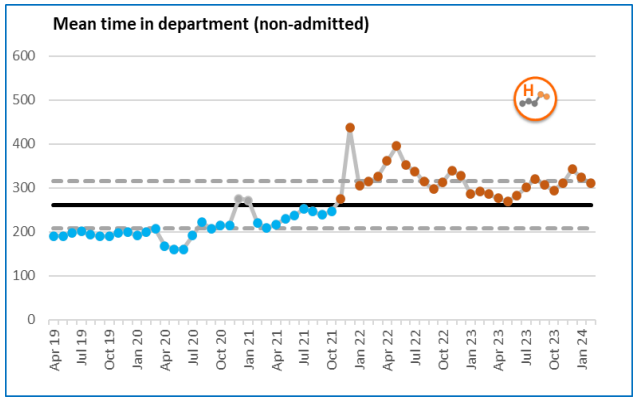
Appendix 2 – A&E Metrics

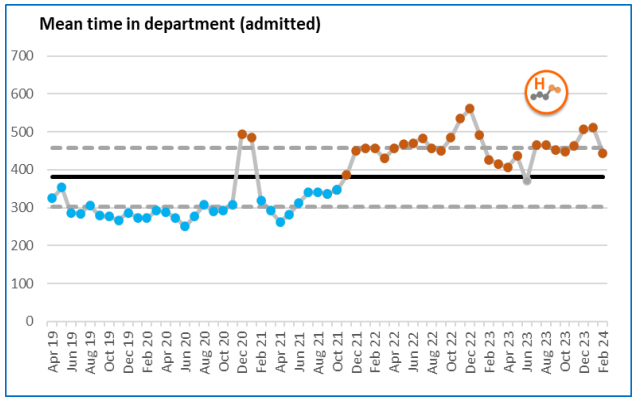












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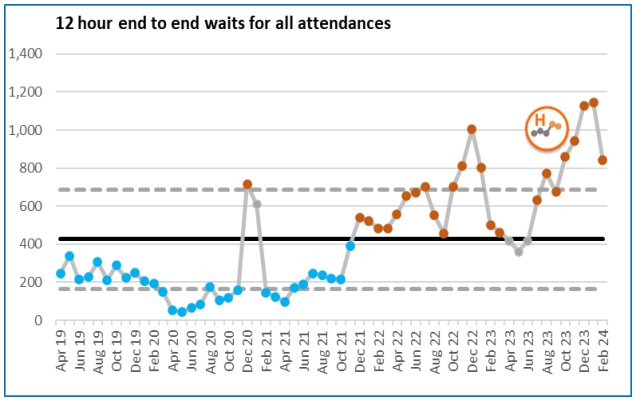
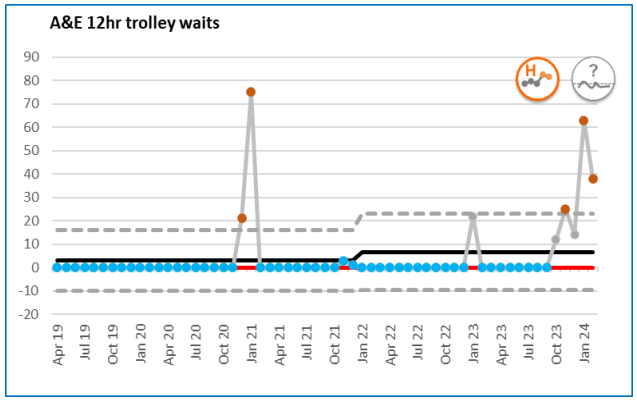
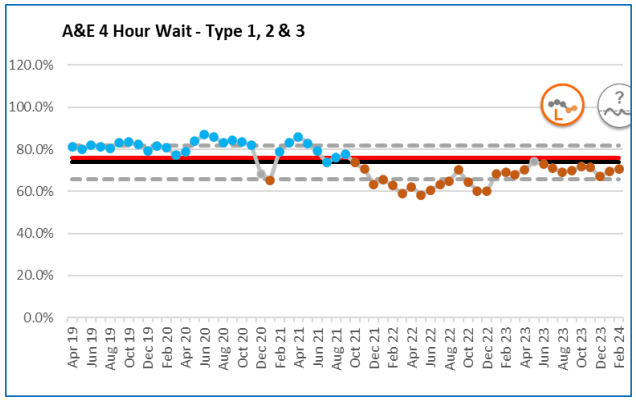
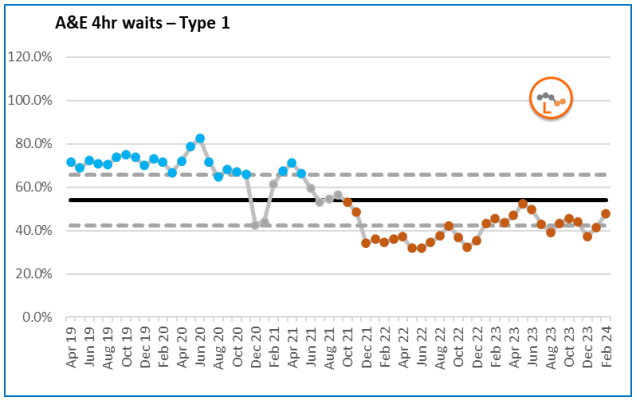
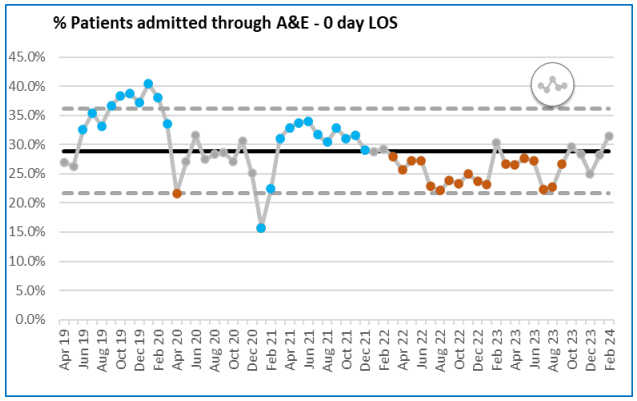
Appendix 2 – A&E Metrics

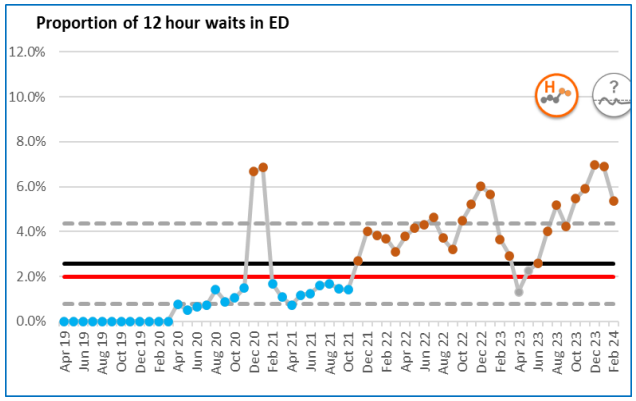












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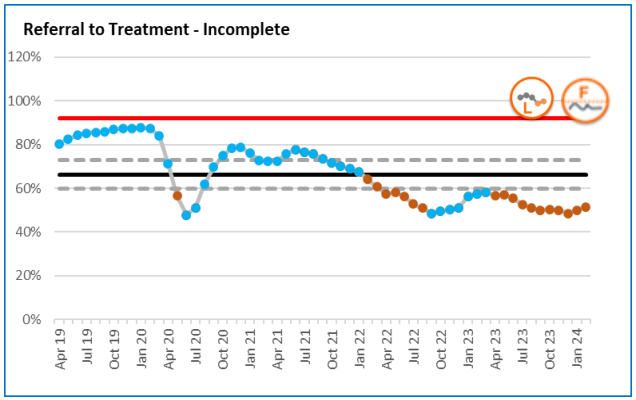
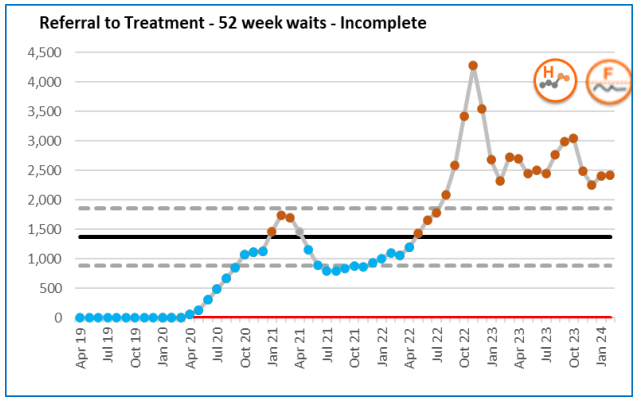
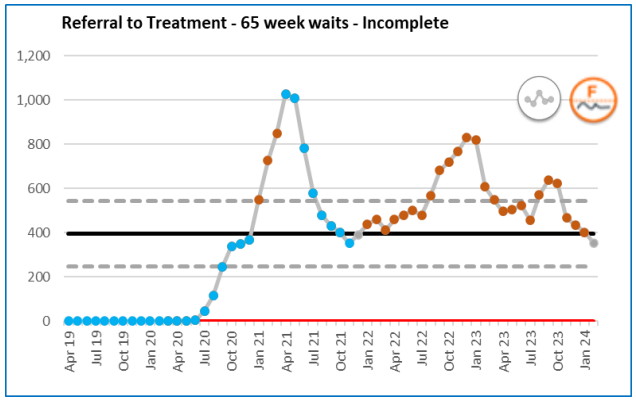
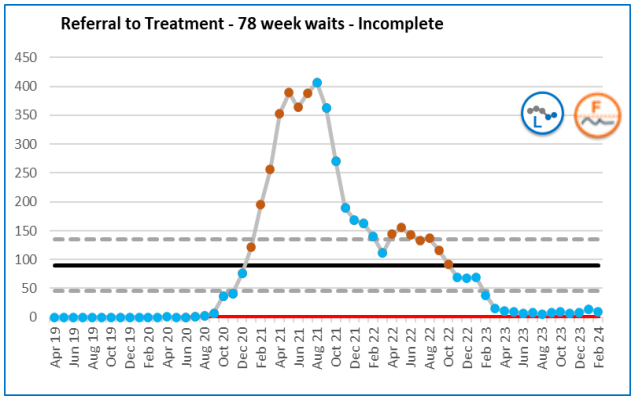
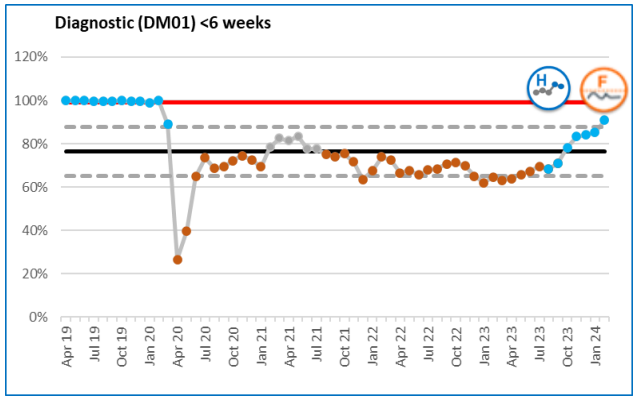
Appendix 3 – RTT, Cancer and Diagnostics Metrics

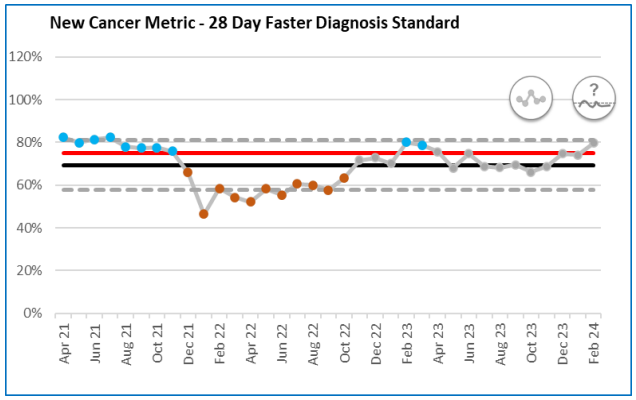












Appendix 3 – RTT, Cancer and Diagnostics Metrics

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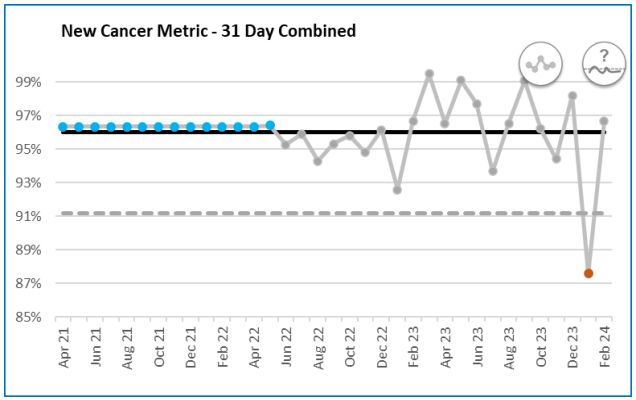

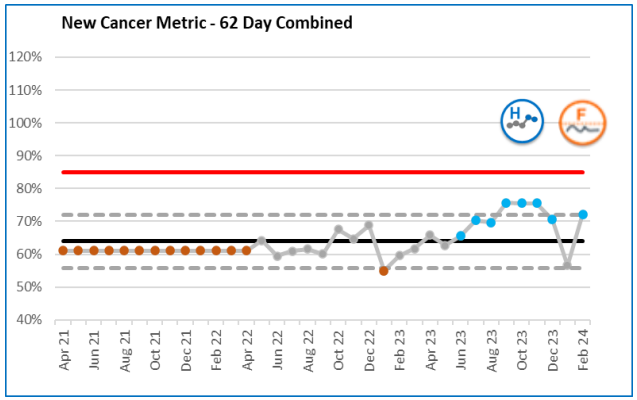

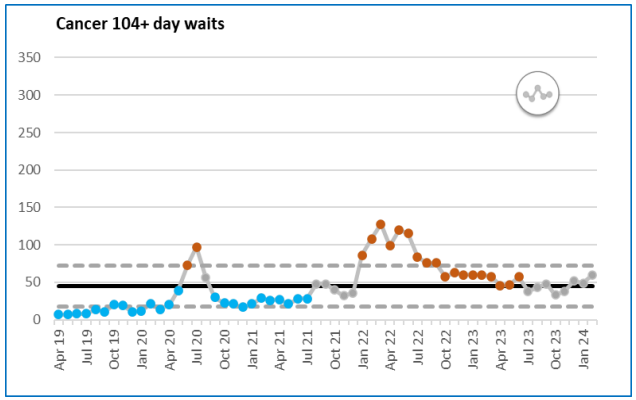

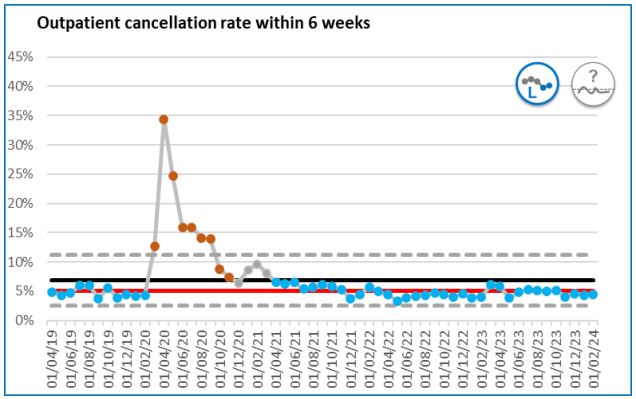

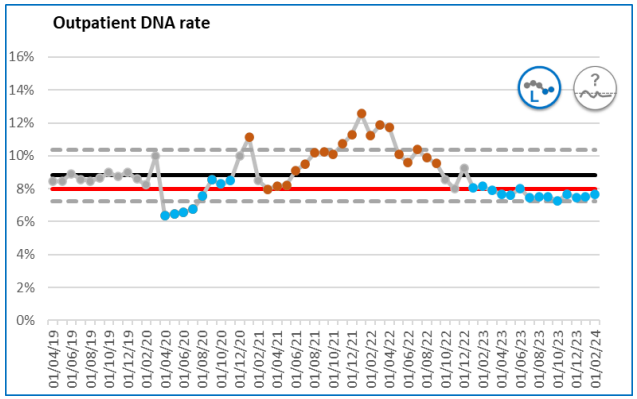

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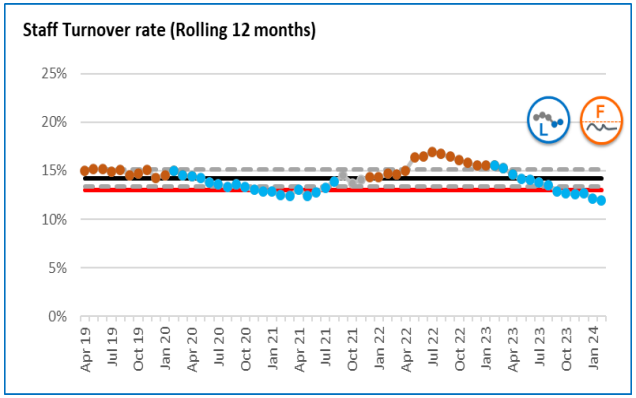
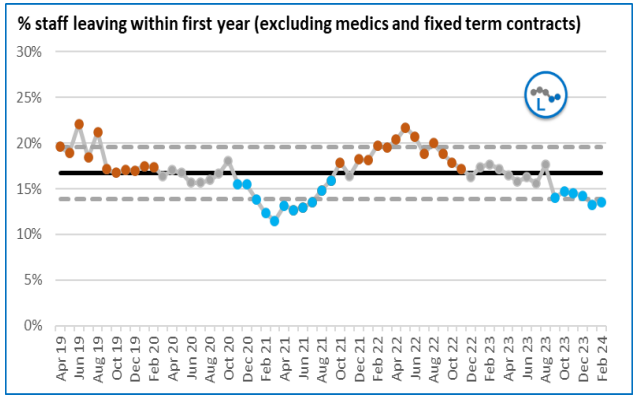
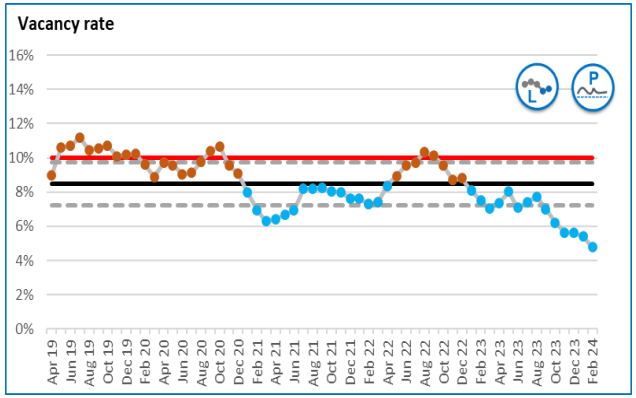
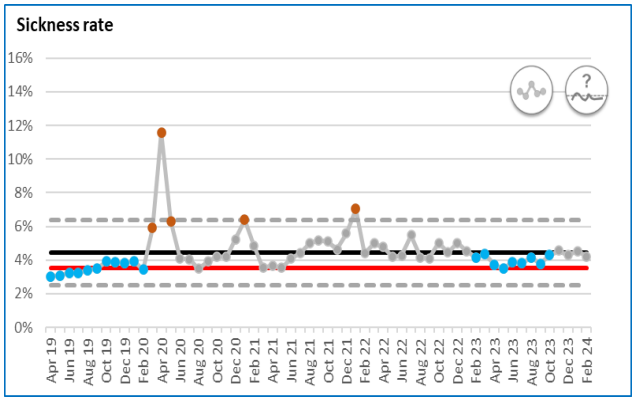
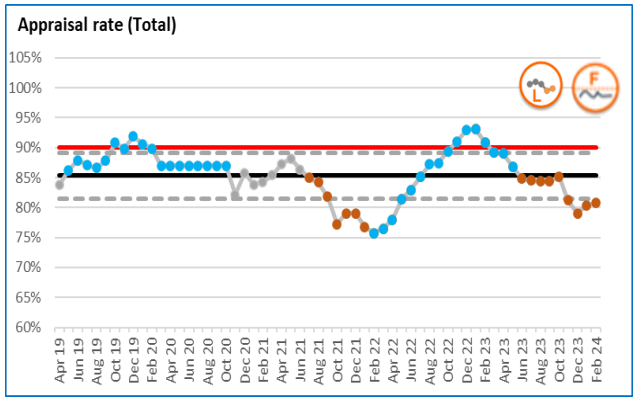
Appendix 4 – Workforce Metrics

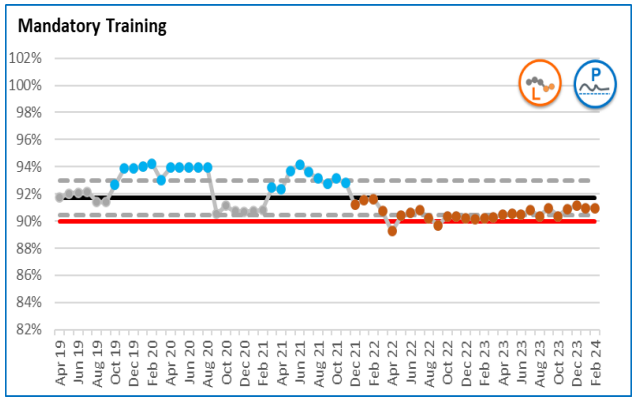












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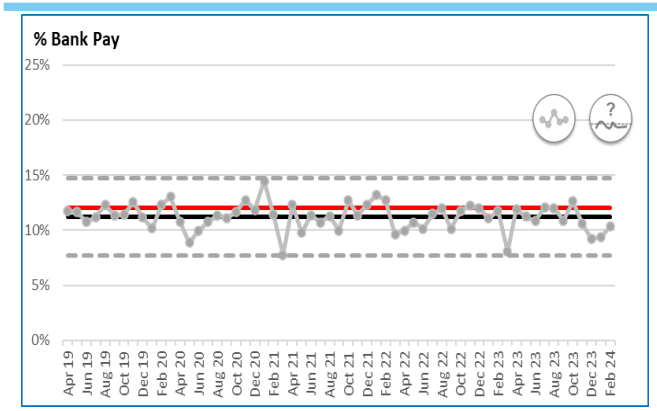

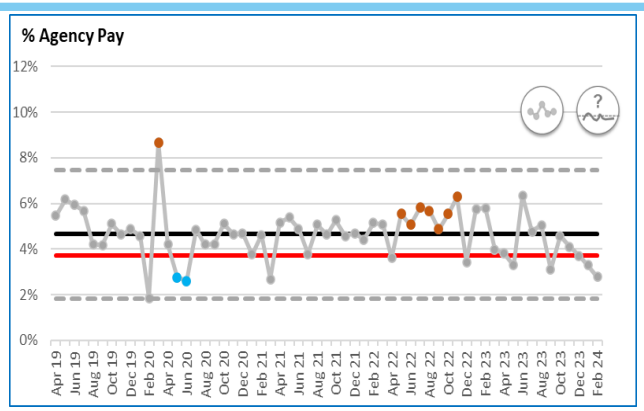

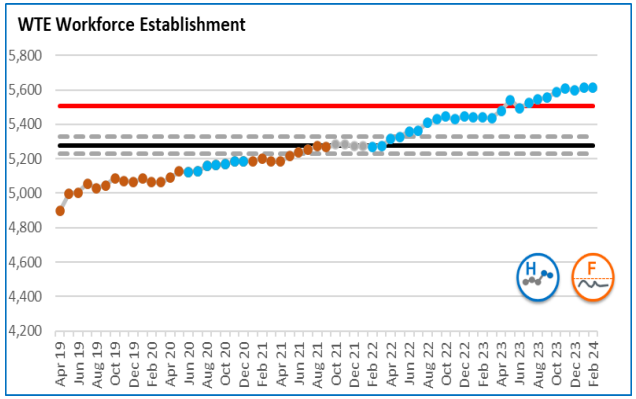

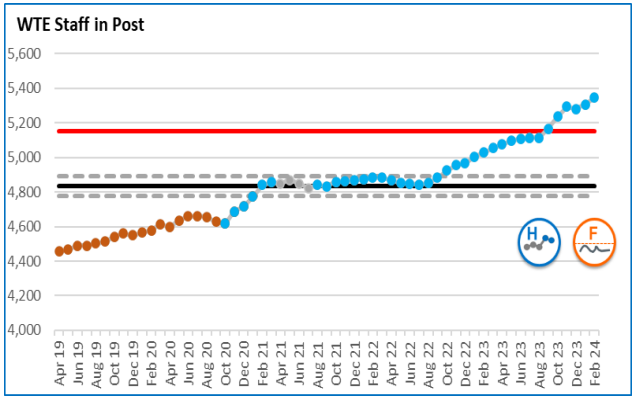

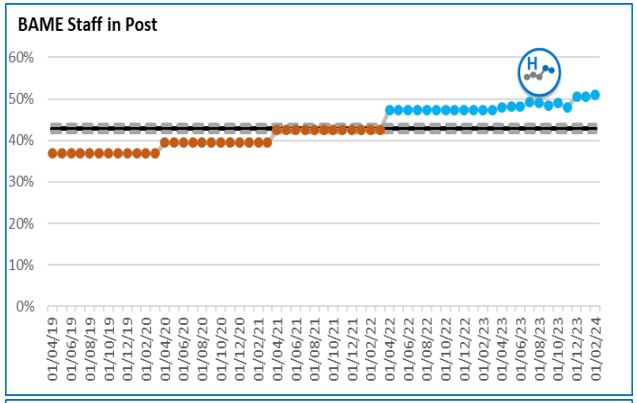

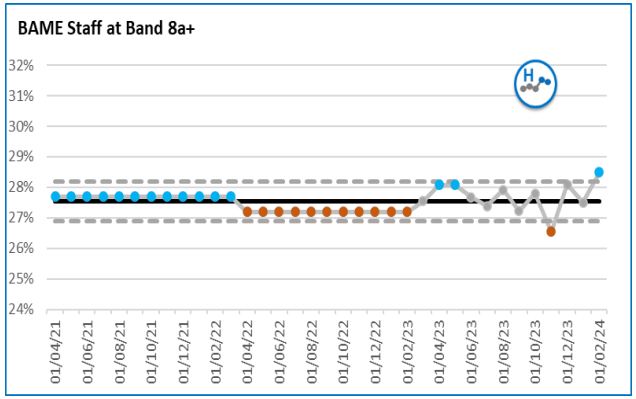

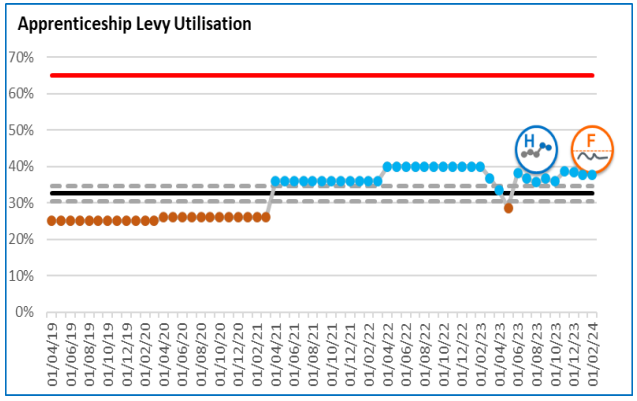

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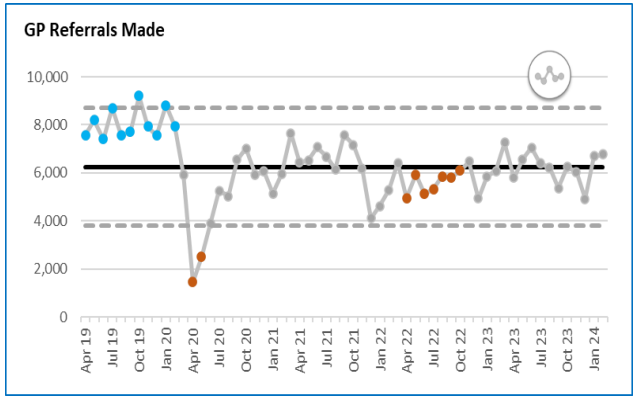
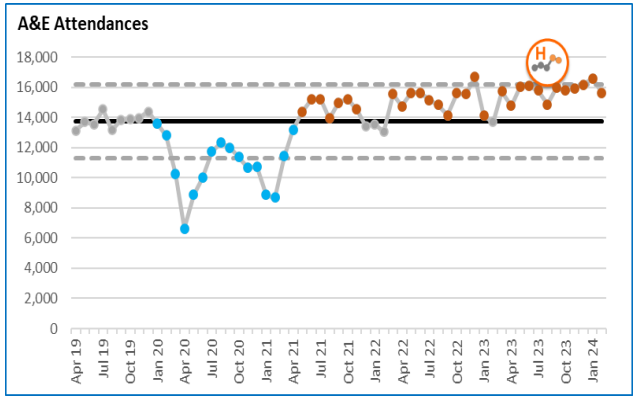
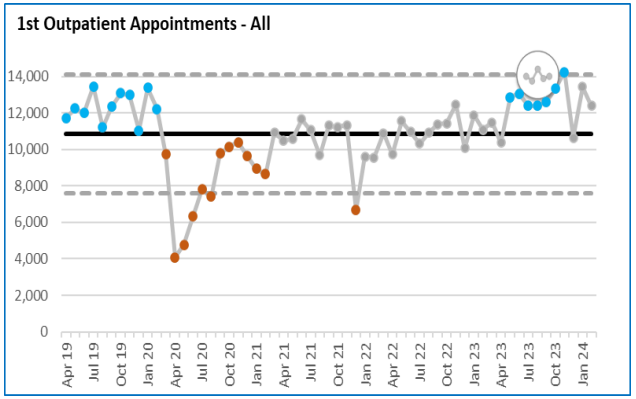
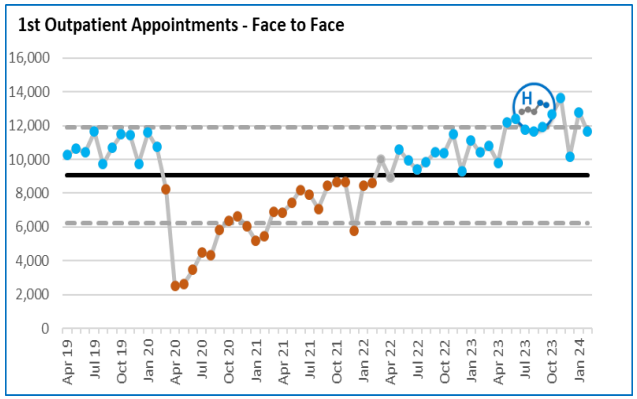
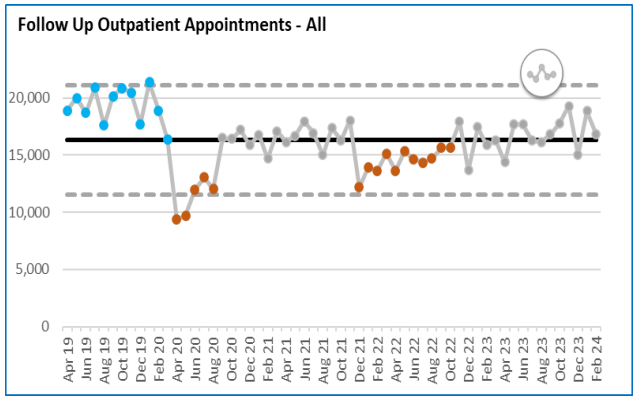
Appendix 5 – Activity Metrics

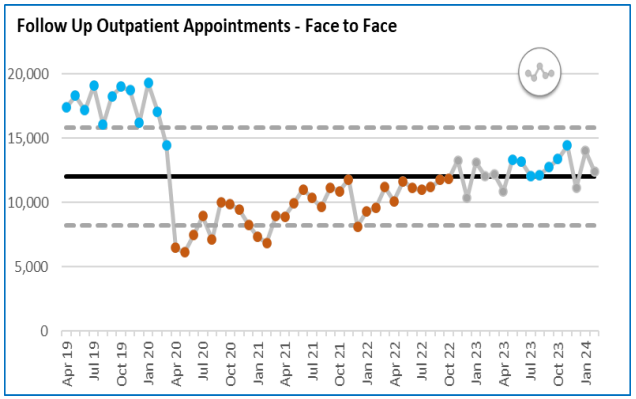












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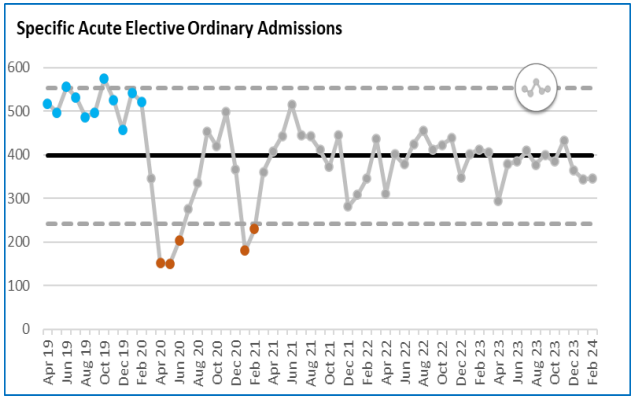

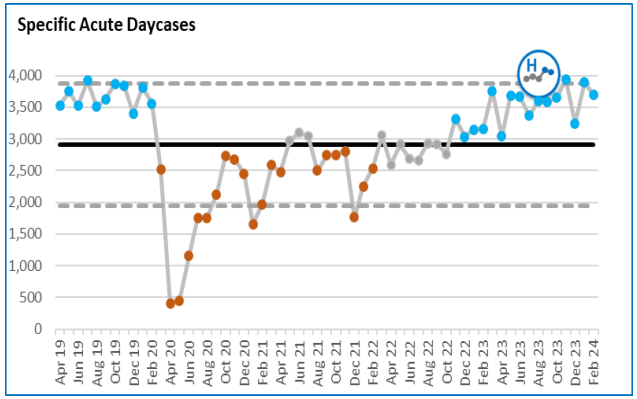

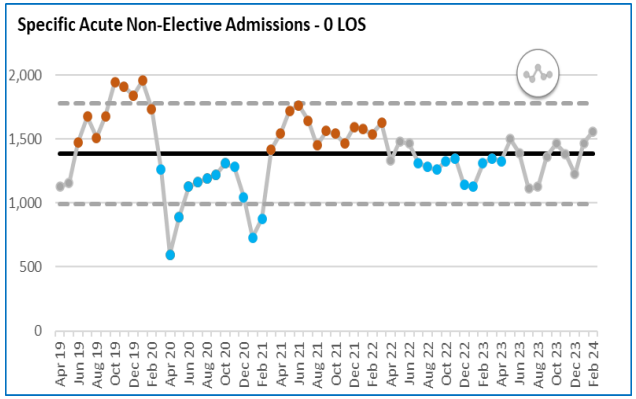

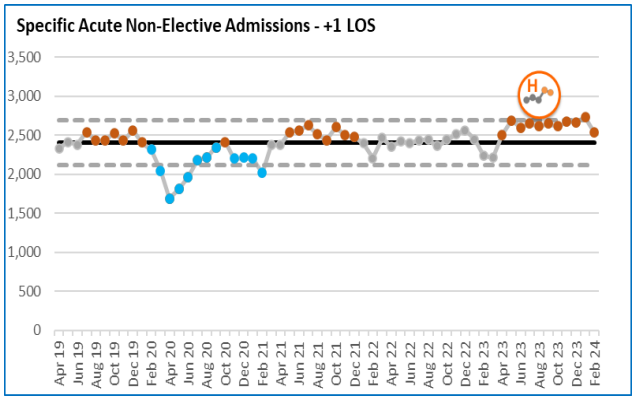

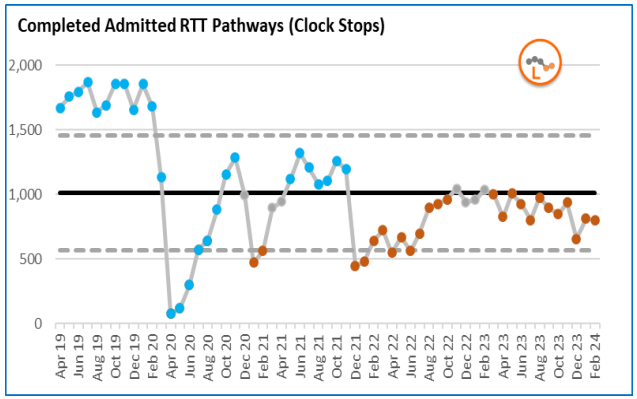

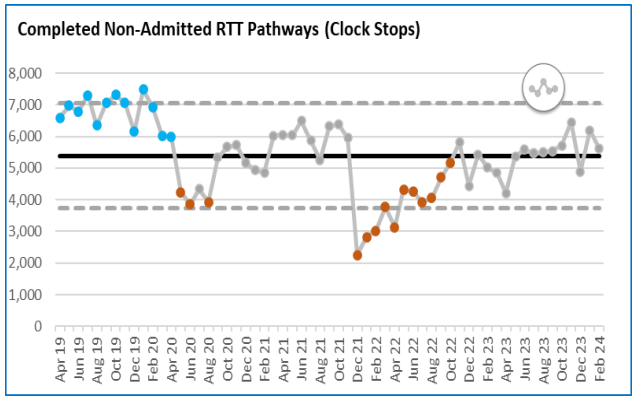

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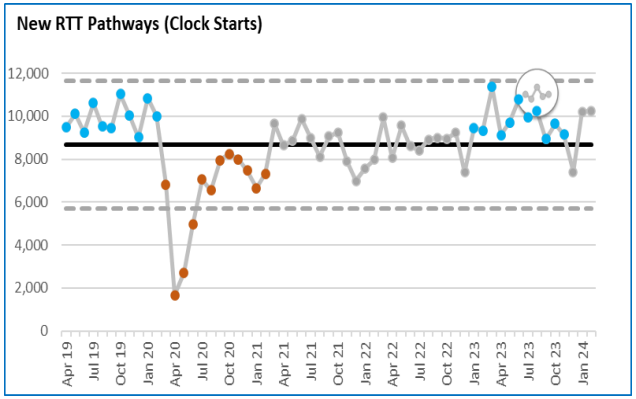

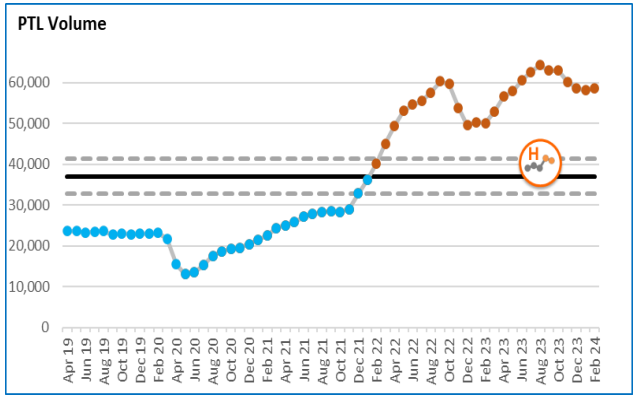

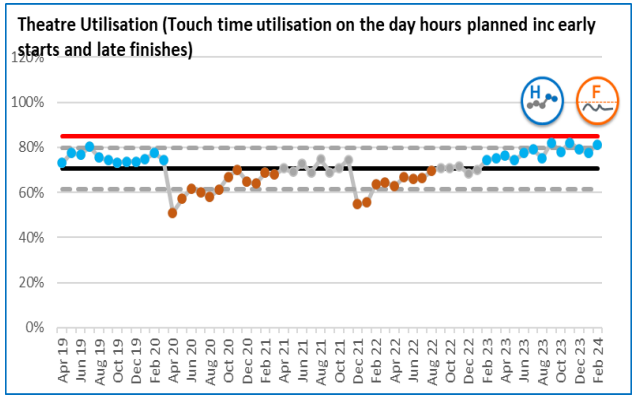

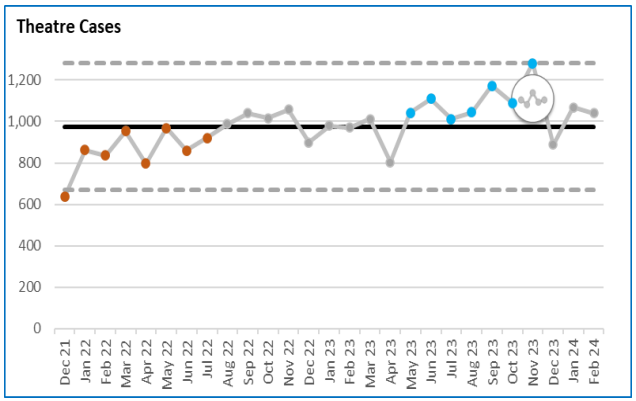

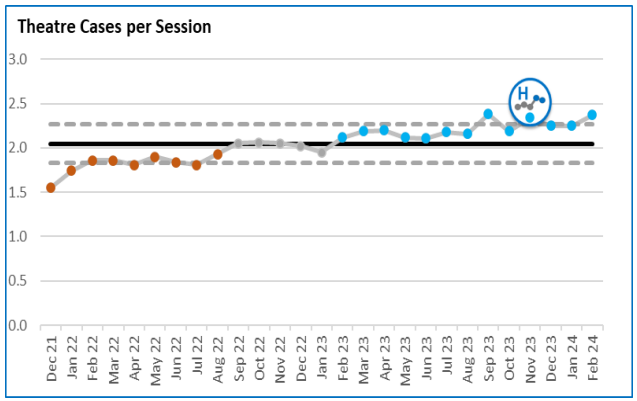

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Thank you

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Care Quality

West Hertfordshire Teaching Hospitals NHS Trust

19

Trust Board
04 April 2024

Title of the paper	**Strategic Objectives Q3 (23/24) and Better Care Delivered Differently Priority Projects Review Report**
Agenda Item	19
Presenter	Toby Hyde, Chief Strategy and Collaboration Officer
Author(s)	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 Q3 progress being made on the Strategic Objectives as evidenced by the supporting priority projects in the Better Care Delivered Differently Programme (BCDD). The main body of the report includes the delivery status of the trust's strategic objectives and the status of priority projects under the Better Care Delivered Differently (BCDD) programme, providing assurance of the progress being made. **The key, strategic objective, highlights in the report are as follows**: As at Q3, five strategic objectives are on target, and these are improving access to care, reducing inequalities, improve workforce sustainability, develop as a learning organisation and environmental sustainability. Culture of inclusion and diversity is not RAG rated for this quarter and Digital and IT innovation is reported elsewhere. 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 strategy itself was finished there has been no real momentum across the system to take this forward. This work forms part of the 24/25 Trust Strategy, particularly in relation to fragile services and repatriation of activity, WHTH leadership will continue to work with ICB Executive to provide a way forward. **Objective 4 - Transforming Services- Virtual Hospital** • VH activity alongside the phasing trajectory continues to increase, with bed occupancy increasing each month but currently remaining off target. • A new pathway for Surgical has been launched, with low activity numbers (as expected, due to being funded within existing resource). This pathway is working well and will be considered for expansion. **Objective 4 - Transforming Services- Maternity Services.** • The remaining actions on the Ockenden 2 Action Plan impose a low risk to the Trust and is ongoing related to leadership development. • Currently on track with the completion of all CQC must and should do's • Q3 numbers are from IQVIA. Numbers remain low but plan in action to increase by having QR code on flyers in room, on lockers so women can download on phone. **Objective 4- Transforming Services- Outpatients** • There is high performance in first to follow up ratio's and we remain in the top quartile nationally. There are a few specialty areas that fall in the bottom quartile and work is commencing with these services to improve ratios. **Objective 5 – Best Value** • At the end of Q3 (M9), the trust reported a £18.2m deficit position of income over expenditure. This was £12.6m away from the plan expectation.

- As at the current position the Trust is forecasting a £9.3m deficit position where expenditure is in-excess of income, risks have been highlighted and mitigations are currently being worked through alongside the ICB.

Objective 10 – New & Refurbished Hospitals

- The Trusts redevelopment team confirm the OBC for the Watford site has been updated and was submitted to Part 2 of the December 2023 Trust Board where approval was granted to send the draft OBC to the New Hospital Programme (NHP) for information and to initiate the finalisation of the OBC ahead of formal submission.
- Progressing enabling schemes remains a key priority and business cases are being developed with a view to clearing the site and commencing demolitions in 2024, completing civil engineering works in 2025 and starting the main build in 2026.

The key, BCDD, highlights in the report are as follows:

GREEN RAG: Integrated Care. Consistent Care.
AMBER RAG: Best Care. Redevelopment.
RED RAG: Personalised Care.

The BCDD Programme that is currently reporting as RED is noted below:

Programme 3 – Personalised Care

P3.1 – Equality Delivery System

- Overall, including Domain 1 scores and stakeholder scores from Domain 2 and 3, the Trust is working at a 'Developing activity level'.
- EDS report is published to the Trust website.

P3.2 – Promote Inclusion across our services.

- It was agreed that the Promote Inclusion Stakeholder Group was paused to allow focus on the EDS submission, resulting in agreed milestones falling behind schedule and altering the RAG rating of the project to RED. Additionally, the Project SRO and Project Lead will no longer be leading this project and project deliverables are TBC until new ownership is agreed.

The BCDD Programme that is currently reporting as AMBER is noted below:

Programme 1 – Best Care

P1.3 – Development of an elective system hub

- Construction works are progressing with BAM construction.
- A regular update to an 8-week lookahead plan was issued by BAM construction to the clinical team, to allow for effective planning.

P1.5 – Remove multi appointment pathways (Urology)

- GMP was returned in November.
- The scheme has now been reissued externally for competitive tender.

Programme 8 – Redevelopment.

P8.2 – Business case for enabling works.

- Work has commenced on site and is now scheduled to complete on 10th June 2024. The original completion date, noted as 23rd February 2024, has been delayed.

P8.4 – Expansion of diagnostic services at SACH.

- Trust team currently reviewing a full range of options for the CDC project.
- Cost and programme will be confirmed once an option is selected to progress.

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**
✓	✓	✓	✓

<table>
<tr><td>Links to well-led key lines of enquiry</td><td>☐Is there the leadership capacity and capability to deliver high quality, sustainable care?
☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
☐Is there a culture of high quality, sustainable care?
☒Are there clear responsibilities, roles and systems of accountability to support good governance and management?
☒Are there clear and effective processes for managing risks, issues and performance?
☐Is appropriate and accurate information being effectively processed, challenged and acted on?
☐Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
☐Are there robust systems and processes for learning, continuous improvement and innovation?
☒How well is the trust using its resources?</td></tr>
<tr><td>Previously considered by</td><td><table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td>Quality and Safety Committee</td><td>28 March 2024</td></tr><tr><td></td><td></td></tr></table></td></tr>
<tr><td>Action required</td><td>The Board is asked to note the progress made in the delivery of the Trust’s strategic objectives and the position of BCDD priority projects.</td></tr>
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West Hertfordshire Teaching Hospitals NHS Trust

Agenda Item: 19

Trust Board Meeting in Public – 04 April 2024

Q3 Better Care Delivered Differently Report

Presented by: Toby Hyde, Chief Strategy & Collaboration Officer

1. Purpose

1.1 The purpose of this paper is to provide the Quality Committee with a Q3 progress update on the clinical and quality focussed projects of the Better Care Delivered Differently (BCDD) programme.

2. Background

2.1 The 2022-23 Trust Business Plan was approved by the Trust Board (May 2022) and set out the details of the Trust's five-year change programme, known as Better Care Delivered Differently. (BCDD).

2.2 Following the submission of the BCDD FY22/23 Year-End review, to the May 2023 Trust Board, it was agreed that BCDD would continue reporting throughout FY23/24 with a reduced number of supporting projects. 15 BCDD projects were agreed to carry forward into FY23/24 with the remaining projects agreed to be assumed into divisional BAU and reported through appropriate governance forums.

2.3 BCDD is made up of five transformation programmes, of which the first four are clinically focussed. Each one is supported by a range of priority projects which are in various stages of development and delivery. Project aims are found in Appendix 1.

3. BCDD Programme Overview

3.1 The table below sets out the first four clinical transformation programmes that form BCDD and the RAG ratings in Q3 (data period = Jan 24).

Programmes		RAG
1	Best Care	A
2	Integrated Care	G
3	Personalised Care	A
4	Consistent Care	G

4. Programme Update

4.1 The tables below outline the project lifecycle stage and overall Q3 RAG rating for each project within Better Care Delivered Differently (including the non-clinical programmes).

Delivery (7)			
Programme	Ref	Project	Overall RAG rating
Best Care	P1.2	ICS Acute Services Strategy	A
Integrated Care	P2.1	Virtual Hospital (Phases 1-3)	A
Personalised Care	P3.1	Equality Delivery System	A
Consistent Care	P4.1	Clinical Practice Group	G
Redevelopment	P8.2	Business Case for Enabling Works	A
	P8.4	Expansion of Diagnostic Services at SACH	A
	P8.5	Implement the Green Plan	G

Planning (6)			
Programme	Ref	Project	Overall RAG rating
Best Care	P1.3	Development of an elective system hub	A
	P1.5	Removal of same day multi site pathways - Urology	G
Integrated Care	P2.4	Frailty Transformation	G
	P2.5	Respiratory Transformaton	G
	P2.6	Proactive management of patients with multiple long term conditions (LTC's)	G
Consistent Care	P4.2	Theatre Productivity Improvement	A

Project scoping/Initiation (1)			
Programme	Ref	Project	Overall RAG rating
Personalised Care	P3.2	Promote inclusion across our services	A

Closed (Assumed into BAU)			
Programme	Ref	Project	Overall RAG rating
Best Care	P1.6	Improve our services for pregnant women	Project closed and assumed into divisional BAU

5. Programme 1: Best Care - Delivering the best care to the local population, with areas of excellence and partnerships with other acute providers.

5.1 Q3 Update - P1.3 Development of an elective system hub is reported as AMBER RAG.

Theatre 5 handed over to BAM Construction on 15th December 2023 and demolition progressing well.

As at March 2024/Year End Summary. Onward reporting via Redevelopment Programme Committee.

Construction works are progressing with BAM construction. This includes drainage diversion works, underpinning of the existing day unit foundations, further demolition of the level 2 Moynihan building balcony, re-location of some existing services. Works have also started within the courtyard which includes clearing of soil from the existing planter for demolition to make space for the new changing room facilities. Noise and vibration are closely monitored during the demolition. 8-week lookahead plan issued by the BAM construction to the clinical team to allow for effective planning. These will be updated regularly.

5.2 Q3 Update - P1.5 Remove multisite appointments (urology) is reported as AMBER RAG.

GMP was returned in November. The scheme has now been reissued externally for competitive tender. While awaiting final project costs the BC is being refreshed by the service to align with divisional strategy, CDC, business plans and to include demand-capacity and growth models, as well as financial benefits.

As at March 2024/Year End Summary. Onward reporting via Redevelopment Programme Committee.

The Urology Unit Project Team has been focussed in the past year on the work-up of a full business case, with the intention of securing funding for the construction of a new and dedicated unit for the provision of streamlined urology care at St Albans City Hospital. This would enable the service to offer single-site and one-stop appointments to patients in a streamlined manner, similar to that of the orthopaedic unit already in place on the SACH site. The design for the unit has now been fully tendered, with confirmed costs to be included in the FBC. This is supported by a refreshed capacity and remand review, and proposals for the new clinical pathways that could be implemented with a new unit in place. The business case will be submitted for approval soon, once it has been finalised and signed off by the Division.

5.3 Q3 Update - P1.6 Improve our services is closed and reported as divisional BAU.

6. Programme 2: Integrated Care - Delivering integrated care, in partnership with South and West Herts Health & Care partners.

6.1 Q3 Update - P2.1 Virtual Hospital is reported as AMBER RAG.

VH activity continues to increase as does the phasing trajectory. Bed occupancy increases monthly; however, we remain off target across VH. Differing calculation of bed occupancy will be taken to VH Partnership Board in Jan 2024 and the recommendation that bed occupancy is calculated in the same way as our neighbouring providers from Jan 2024 onwards. We would expect to see a higher bed occupancy rate going forward.

As at March 2024/Year End Summary. Onward reporting via Finance & Performance Committee. & VH Partnership Board

ICB have confirmed current funding will continue for 24/25. Developing and expanding the community step-up Frailty pathway will be a key focus for 24/25 and beyond. Following the full development of a business case, an alternative funding mechanism will need to be identified. Performance in Feb 24 was 309 delivered against a target of 325 which is a result of a combination of increased utilisation and realignment of data calculations which reflects reporting methodology of other system providers.

7. Programme 3: Personalised Care - Delivering personalised care and shared decision making.

7.1 Q3 Update - P3.1 Equality Delivery System (EDS) is reported as AMBER RAG.

Overall, including Domain 1 scores and stakeholder scores from Domain 2 and 3, the Trust is working at a 'Developing activity level'. EDS report is ready for publication to the Trust website.

As at March 2024/Year End Summary. Onward reporting via PERC and Quality Committee.

Overall, including Domain 1, 2 and 3, the Trust is reporting that it is working at a 'Developing' activity level. EDS report was published to the Trust website in February. 2024-2025 EDS will be completed with system partners and include validation from an independent assessor and union representative, consistent with the NHSE Framework.

7.2 Q3 Update P3.2 Promote inclusion across our services is reported as RED RAG.

Promote Inclusion Stakeholder Group has been paused until further notice for the project team to focus on the 2023/24 EDS submission. The pause of this group has resulted in several of the noted and agreed milestones falling behind schedule and altering the RAG rating of the project to RED. Additionally, the Project SRO and Project Lead will no longer be leading this project come the new year and the project deliverables are TBC until new ownership is agreed.

As at March 2024/Year End Summary. Onward reporting via Quality Committee.

8. Programme 4: Consistent Care - Delivering consistent best practice and best value care.

8.1 Q3 Update - P4.2 Theatre Productivity Improvement is reported as AMBER RAG.

The key focus on two workstreams continues, with a focus on booking and planning the on the day processes. Clinical engagement has been successful and average utilisation is currently over 80% across the trust. Programme lead and surgical support services ADM working to integrate process and policy as BAU with plans for regular stakeholder engagement and accountability of utilisation of productivity improvements. This is planned to be monitored through the divisional theatre activity group (TAG).

As at March 2024/Year End Summary. Onward reporting via Divisional BAU and Theatre Activity Group.

The work to integrate the theatre productivity programme components into 'business as usual' has concluded. All relevant teams, including clinicians, theatre staff and ADMs et al, work together to ensure processes and policies are embedded and maintained. Factors such as the use of median times to more accurately plan operating lists and theatre start times continues. Comms and engagement are supporting elements of the programme. The continuation of the weekly Theatre Activity Group meetings, along with separate regular stakeholder engagement, enables processes and progress to be closely monitored. The organisation continues to utilise theatre productivity in excess of 80%.

9. Governance Arrangements

9.1 The BCDD programme exists to provide assurance that projects are on track to achieve their agreed objectives and ambitions, have identified risks and mitigating actions in place for identified issues.

9.2 Each of the BCDD programmes and associated priority projects have an assigned project governance structure which includes a Senior Responsible Officer (SRO) (for the overall Programme), a Clinical Responsible Officer (CRO), an SRO (for each Project) and a Project Lead.

9.3 BCDD reported bi-monthly to the Trust Board and the Quality Committee.

10. Recommendation

10.1 The Board is asked to note the BCDD report for information and assurance.

Toby Hyde
Chief Strategy & Collaboration Officer
28th March 2024

APPENDIX 1: Clinical Transformation Project Aims

Prog	Project Name	Project Aim
P1.2	Acute Services Strategy	Develop an ICS acute services strategy document to maximise the opportunities of working in partnership with other local providers (East & North Herts Trust and Princess Alexandra Hospital Trust).
P1.3	Development of an elective system hub	Ensuring the fastest possible recovery of elective waiting times including the development of a system hub to increase capacity should capital be available to support it.
P1.5	Remove same day multi-appointment pathways (urology)	Remove multi-appointment pathways in Urology as quickly as it is clinically safe to do so.
P1.6	Improve our service for pregnant women	Improve our services for pregnant women by learning from and implementing the actions from the Ockenden report and the recommendations of the national strategy Better Births, to ensure all pregnant women and new-born babies receive the best possible care.

Prog	Project Name	Project Aim
P2.1 P2.2	Virtual Hospital & Virtual Ward Expansion	Develop and expand our virtual hospital model as our best practice standard (Phases 1-3). Improving access for patients with SMI/LD & Social Care Packages or resident in care homes to promote equitable access to VH. Extending the VH model to new pathways including respiratory, Frailty & Diabetes.
P2.4	Frailty	The Frailty Transformation workstream will review existing services, designing an integrated service that supports the frail population of South and West Hertfordshire. This will include looking at all levels of care such as primary, community, secondary and voluntary services.
P2.5	Respiratory Transformation	The Integrated Respiratory Service Transformation will be led by a Joint Working Project Group to develop an Enhanced Integrated Respiratory Service across South West Herts.
P2.6	Multiple Long-Term Conditions	Develop a new model of care for people with multiple long-term conditions, delivering multi-disciplinary proactive support to enable them to stay well in their own homes and prevent unplanned admissions. This project will act as a pilot that will inform the ICS plan for the proactive management of patients with multiple LTCs. The overarching aim of the project is to proactively support the health and wellbeing of local people with multiple long-term conditions to help keep them well, closer to home

Prog	Project Name	Project Aim
P3.1	Equality Delivery System 2022 Review	Complete and publish the Trusts Equality Delivery System review by 28th February 2023 and set out the action plan to address the issues identified through the assessment.
P3.2	Promote inclusions across our services	Use the co-production methodology and increase engagement activity to promote inclusion across our services, including priority areas of transformation.

Prog	Project Name	Project Aim
P4.1	Clinical Practice Groups (CPGs)	To implement 15 new pathways this year (Financial year 2022/23) in a phased approach
P4.2	Theatre Productivity Improvement Programme	Large scale culture and process improvement programme to radically increase the productivity of elective theatre lists at both SACH and WGH, including gynae theatres

Q3 2023-2024 Strategic Objectives & Better Care Delivered Differently Programme Closure Report.

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 strategic 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 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 Q3 delivery status of the trust's strategic objectives and the status of priority projects under the Better Care Delivered Differently (BCDD) programme, providing assurance of the progress being made. True at the time of writing, the overall Q3 RAG ratings for our strategic objectives and BCDD priority projects are noted below.

This is the final Strategic Objective and BCDD report showing the Q3 position, which is a retrospective view of performance and delivery. This report includes an end of year summary for each scheme. The new Trust Strategy, launches in April 2024.

Strategic Objective		Q2 23-24	Q3 23-24
1	Resilient Services	A	A
2	Improving Access to Care	G	G
3	Reducing Inequalities	G	G
4	Transforming our Services (VH)	A	A
	Transforming our Services (Maternity)	A	A
	Transforming our Services (Outpatients)	A	A
5	Best Value	A	A
6	Culture of Inclusion & Diversity	Not due	Not due
7	Improve Workforce Sustainability	G	G
8	Develop as a Learning Organisation	G	G
9	Digital IT & Innovation	N/A	N/A
10	New & Refurbished Hospital Buildings	A	A
11	Reduce our Carbon Footprint	G	G

BCDD Programme		Nov 23	Jan 24
1	Best Care	A	A
2	Integrated Care	G	G
3	Personalised Care	R	R
4	Consistent Care	G	G
8	Redevelopment	G	A

Strategic Objectives – Q3 Summary

The summary below provides Q3 highlights of progress against the delivery plan for each strategic objective

Objective 1 – Resilient Services. Amber RAG

The meeting with E&N colleagues has yet to take place, however this work will form part of the 24/25 strategy particularly in relation to fragile services and repatriation of activity . In the meantime, a stock take of the current position of the other providers and the ICB will be undertaken in readiness.

Objective 2 - Improving Access to Care. Green RAG

Overall delivery has been closer to plan for 1st OP appointments with a relatively small shortfall. Continued industrial activity has caused difficulties in achieving plan and achievement of the follow up reduction target has been challenging, particularly since the drive to eradicate long waits increases demand for follow up reviews. Focus on increasing patient initiated follow up to reduce demand has delivered better uptake, but rates are below requirement. Diagnostic and elective inpatient activity plans have been achieved. Reduction of cancer long waits has continued with the closing number of patients over 63+ days being 148 (against a target of 143).

Objective 3 – Reducing Inequalities. Green RAG

Overall, including Domain 1 scores and stakeholder scores from Domain 2 and 3, the Trust is working at a 'Developing activity level'.

EDS report is ready for publication to the Trust website.

Objective 4 – Transforming Our Services -Virtual Hospital (VH). Amber RAG

VH activity continues to increase ,as does the phasing trajectory. Bed occupancy increases monthly but remains off target across VH as a whole. We have had conversations with neighbouring providers within our ICB and other divisions in CLCH (our community provider for VH). Currently, SWH HCP is calculating bed occupancy differently to these other providers. This will be taken to VH Partnership Board in Jan 2024, and the recommendation will be that bed occupancy is calculated in the same way as our neighbouring providers from Jan 2024 onwards, therefore we would expect to see a higher bed occupancy rate going forward, with our activity being represented in the same way as other VH services . A new pathway for Surgical has been launched, with low activity numbers (as expected, due to being funded within existing resource). This pathway is working well and will be considered for expansion. Work continues with the Diabetes pilot with an expected launch date in Q4.

Objective 4 – Transforming our services – Maternity. Amber RAG

The NHS single delivery plan and action plan was agreed by Trust Board as part of the maternity oversight paper. Phase 2 entrance renovations are on-going and the refresh of the reception area has been completed. The remaining actions on the Ockenden 2 Action Plan impose a low risk to the Trust and is ongoing related to leadership development. 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. Risk assessments, in maternity, are captured in the maternity digital system. this system is audited and is currently noted at 100%. Q3 numbers are from IQVIA. Numbers remain low but plan in action to increase by having QR code on flyers in room, on lockers so women can download on phone.

Objective 4 – Transforming our services - Outpatients. Amber RAG

Trust wide outpatient plan developed and approved through Internal Governance. The plan was approved at the beginning of August 2023 and spans up until March 2024. On-the-whole, there is high performance in first to follow up ratio's and we remain in the top quartile nationally. There are a few specialty areas that fall in the bottom quartile and work is commencing with these services to improve ratios. Our priority is to discharge whenever clinically appropriate rather than move to PIFU which has been rolled out to the majority of specialties and plans in place to engage with those specialties yet to go live. Work is underway with outpatient administrative team to ensure correct set up on EPR on a specialty-by-specialty basis.

Strategic Objectives – Q3 Summary (continued)

Objective 5 – Best Value. Amber RAG

At the end of Q3 (M9), the trust reported a £18.2m deficit position of income over expenditure. This was £12.6m away from the plan expectation. Business case evaluations reported to TMC and FPC were delayed due to operational pressures and of two expected to be presented zero were presented. Our % of annual ERF income earned is in line with the construct of our financial plan and 50% of ERF funding has been recognised at the end of Q2.

Objective 6 – Culture of inclusion and diversity. No RAG, Measures not due

The staff survey noted a 40% completion rate which is a 10% decrease from last year despite an increase in divisional engagement, walk around and incentives. Initial high-level results have been received from the survey provider which has indicated an increase in 6 out of 7 People Promise themes being seen. The areas where we have seen slight decreases include culture, leadership and learning and aligns with the findings that have arisen from the staff survey. Full results are unavailable at this time and are due early March (hence no updated figures for all metrics). Launched Trust wide anti racism pledge with work commencing to get this adopted locally and to start implementing associated actions.

Objective 7 – Improve workforce sustainability. Green RAG

The Trust is working to improve the uptake of apprenticeships targeting band 2 HCWs and non-clinical roles providing several different pathway options for internal staff and new recruits. Staff survey results have been received and show an overall positive improvement in several areas including engagement score. Motivation, improvement and advocacy have all increased. **Recommendations**- colleagues have scored both recommending the trust as a place to work and friends or family receiving care at our hospitals, higher than in 2022 (improving by 5% and 4% respectively.) **Bullying and harassment,** - the percentage of staff stating they have never experienced bullying or harassment, by a colleague or manager has also improved. The people promise programme continues to focus on a variety of flexible working options for all staff and a road show style event will be taking place to raise awareness across all sites. HRBPs continue to work closely with divisions on localised initiative to tackle themes.

Objective 8 – Develop as a learning organisation. Green RAG

Turnover of **coaches** during Q3, meant that total available coaches remains static at 54, however up to 22 currently in training and due to complete mid-Q4. First part of new advanced coaching course took place in November with second part due in March. This will create 9 additional senior coaches which will allow coach numbers to grow to match large anticipated increase in clients due to coaching being offered to delegates of new leadership programmes, which will start from Q4 23/24 and progress through Q's1-3 of 24/25. Re improved diversity in mandatory training, we have ensured equality of representation on Cohort 7 of the ADDS programme (50% of final nominations were of BAME staff) and Cultural Awareness has commenced roll-out on Leadership Development Programmes, the first dates for which are in Q4. The staff survey 'We are always learning' has risen to 5.58, just 0.02 short of the 5.6 target.

Objective 9 – Digital IT & innovation. No RAG, Measures reported separately

No update.

Objective 10 – New and Refurbished Hospital Buildings. Amber RAG

The Trusts redevelopment team confirm the OBC for the Watford site has been updated and was submitted to Part 2 of the December 2023 Trust Board where approval was granted to send the draft OBC to the New Hospital Programme (NHP) for information and to initiate the finalisation of the OBC ahead of formal submission. Progressing enabling schemes remains a key priority and business cases are being developed with a view to clearing the site and commencing demolitions in 2024, completing civil engineering works in 2025 and starting the main build in 2026. Enabling schemes currently underway to create additional beds in the Shrodells building and a pathology essential services lab are progressing well. Of note is that the land transfer at Watford completed in December 2023. The Elective Care Hub guaranteed maximum price has now been agreed and the Full Business Case submitted to the Trust Board. Works will take place during 2024, with this new regional facility opening at the end of the year.

Objective 11 – Reduce our carbon footprint. Green RAG

Planning is underway with the communications team to run events/promotions on a variety of Environmental/Sustainability related topics throughout the year. January's Quarterly Pulse survey contained the addition of the following two questions:- To what extent are you aware of the Trusts Green Plan to help reach Net Zero carbon emissions by 2040? How could your department operate more sustainably? The survey results are not yet known. Ongoing projects are still taking place. It is understood that the draft Travel and Access Strategy is yet to be presented to Board and therefore the KPI's associated with this metric are yet to be ratified.

BCDD Projects – FY24/25 Recommendations

Listed here are the BCDD priorities that remain live and recommended to carry forward and report through appropriate governance. Please note that this is an initial recommendation and pending agreement.

Priority Projects to Continue into FY24/25	Recommendation
• P1.2: Acute Services Strategy	P1.2: Trust Management Committee
• P1.3: Elective System Hub	P1.3: Redevelopment Programme Committee
• P1.5: Remove Same Day Multi-Site Pathways (Urology)	P1.5: Redevelopment Programme Committee
• P1.6: Improve our Services for Pregnant Women	P1.6: Assumed to Divisional BAU
• P2.1 Virtual Hospital	P2.1 Finance and Performance Committee & VH Partnership Board
• P2.4: Frailty Transformation	P2.4: Clinical and Digital Transformation Board & Partnership Board
• P2.5: Respiratory Transformation	P2.5: Clinical and Digital Transformation Board & Partnership Board
• P2.6: Multiple Long-Term Conditions	P2.6: Clinical and Digital Transformation Board & Partnership Board
• P3.1: Equality Delivery System	P3.1: Quality Committee and PERC
• P3.2: Promote Inclusion Across our Services	P3.2: Quality Committee and PERC
• P4.1: Clinical Practice Groups	P4.1: Quality Committee and Clinical & Digital Transformation Board
• P4.2: Theatre Productivity Programme	P4.2: Assumed BAU (Divisional theatre activity group (TAG)
• P8.2: Business Case for the Enabling Works	P8.2: Redevelopment Programme Board
• P8.4: Expansion of Diagnostic Services at SACH	P8.4: Redevelopment Programme Committee
• P8.5: Implement the Green Plan	P8.5: Trust Management Committee

Strategic Objective 1: Best Care – Resilient Services (Q3 2023-24)

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	Q2 2023-24	RAG	Q3 2023-24	RAG
Agreement of acute strategy across three trusts and ICS	-		C		C
Set new measures based on actions from the strategy	-		A		A
Develop Delivery Plan	-		A	X	G

Q3 23/24 - Narrative

The meeting with E&N colleagues has yet to take place, however this work will form part of the 24/25 strategy particularly in relation to fragile services and repatriation of activity . In the meantime, a stock take of the current position of the other providers and the ICB will be undertaken in readiness.

Supporting BCDD Projects:
P1.2 – Acute Services Strategy

Strategic Objective 2: Best Care – Improving access to care (Q3 2023-24)

G

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

				Q2 2023 – 24				Q3 2023 -24			
Data Source	Success measures		Baseline (Mar22)	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%	47,836	45,905	-1,931	A	49,094	46,378	-2,716	A
		Outpatient follow up activity reduction	77.9%	123,377	151,923	28,546	R	185,255	232,228	46,973	R
		Diagnostic activity rate	95.3%	62,293	69,650	7,357	G	93,736	104,477	10,741	G
		Inpatient activity rate	75.8%	22,172	23,510	1,338	G	34,103	35,726	1,623	G
IPR	**Reduction in RTT waiting times** (*excl patient choice*)	104 week waits	27	0	0	0	G	0	0	0	G
IPR		78 week waits	111	0	8	8	A	0	8	8	A
IPR	**Reduction in Cancer waiting times**	63+ day waits (*excl patient choice*)	376	132	132	0	G	143	142	-1	G

Q3 23/24 - Narrative

Activity plan: Delivery has been closer to plan for 1st OP appointments with a relatively small shortfall. Continued industrial activity has caused difficulties in achieving plan. Achievement of the follow up reduction target has been challenging, particularly since the drive to eradicate long waits increases demand for follow up reviews. Focus on increasing patient initiated follow up to reduce demand has delivered better uptake, but rates are below requirement. Diagnostic and elective inpatient activity plans have been achieved.

RTT & Cancer waiting times: There were 0 x 104 week waiters in this period. There were 8 x 78 week waiters which is the same position as in Q2 but this position is the lowest in the ICS and all patients have plans in place. Reduction of cancer long waits has continued with the closing number of patients over 63+ days being 148 (against a target of 143.

Supporting BCDD Projects:
P1.3 – Development of an elective system hub, P4.2 – Theatre Productivity Improvement Programme, P8.4 – Expansion of Diagnostic Services at SACH

Strategic Objective 3: Best Care – Reducing Inequalities (Q3 2023-24)

G

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

	Targets			
Success measures	Q2 2023-24	RAG	Q3 2023-24	RAG
Detailed measures to be based on the action plan	Development of the EDS 23/24 submission	**G**	Publish EDS by Feb 26th 2024	**G**

Q3 23/24 - Narrative

Overall, including our **Domain 1** scores and stakeholder scores from Domain 2 and 3 the Trust is working at an 'Developing activity level'.
For Domain 1, three services were selected, one which is doing well, one which requires improvement, and one where we don't know. These were selected as follows:
• Service 1 – maternity services doing well (excelling activity)
• Service 2 – diabetes services – needs improvement (achieving activity)
• Service 3 – gypsy and traveller empowerment (GATE) – not enough data. (underdeveloped activity)
Overall feedback from stakeholders under **Domain 2** was that good progress has been made and, the Trust is meeting the level required across this domain. This was reflected in the scoring whereby 'developing activity was
attained for Domain 2. **Domain 3**, stakeholders indicated that there is varying perception of senior leadership involvement and engagement across the networks. Elements of good practice were noted but feedback indicated this was not consistent across the networks. Consequently, the 'Developing Activity' score was provided across the majority of the outcomes.
To achieve and monitor the progress of the gaps highlighted in the report, we will;
• Align action plans for each domain with the WDES, WRES, and EDI improvement plan 6 high impact actions.
• Put working groups in place for the EDI high impact actions & Staff Experience.
• Track and monitor actions through both the EDI Steering Group and the Wellbeing and Engagement steering group.

Supporting BCDD Projects:
P3.1 – Equality Delivery System, P3.2 – Promote Inclusion Across our Services

Strategic Objective 4: Best Care – Transforming our Services (Q3 2023-24)

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*			Q2 2023-24				Q3 2023-24			
Data source	Success measures	Baseline (April 2022)	Tar	Act	Var	RAG	Tar	Act	Var	RAG
Infoflex	Increase in the number of people treated in the virtual hospital or community services	69	*No longer reported – replaced by below metric*				*No longer reported – replaced by below metric*			
Infoflex	Increase the number of VH beds utilised - to be measured against target in new approved VH activity Trajectory	-	386	233	-153	**A**	449	299	-150	**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				The framework for metric reporting is being developed			

Q3 23/24 - Narrative

VH activity continues to increase, ,as does the phasing trajectory. Our bed occupancy increased each month, however, we remain off target across VH as a whole. We have had conversations with neighbouring providers within our ICB and other divisions in CLCH (our community provider for VH). Currently, SWH HCP is calculating bed occupancy differently to these other providers. This will be taken to VH Partnership Board in Jan 2024, and the recommendation will be that bed occupancy is calculated in the same way as our neighbouring providers from Jan 2024 onwards, therefore we would expect to see a higher bed occupancy rate going forward, with our activity being represented in the same way as other VH services . A new pathway for Surgical has been launched, with low activity numbers (as expected, due to being funded within existing resource). This pathway is working well and will be considered for expansion. Work continues with the Diabetes pilot with an expected launch date in Q4

Supporting BCDD Projects:
P2.1 – Virtual Hospital, P2.4 – Frailty Transformation, P2.5 – Respiratory Transformation, P2.6 – Multiple Long Term Conditions

Strategic Objective 4: Best Care – Transforming our Services (Q3 2023-24)

A

Outpatients			Q2 2023-24				Q3 2023-24			
Data source	Success measures	Baseline (Mar 22)	Tar	Act	Var	RAG	Tar	Act	Var	RAG
Activity Tracker	Outpatient follow up activity reduction	77.9%	Provided as part of improving access to care metrics							
SUS	Outpatients Discharged After 1st Attendance **	-	-	42.62%	-	G	-	40.00%	-	G
SUS	Outpatients Follow-Up Ratio **	-	-	1.28	-	A	-	1.32	-	A
EROC Submission	Patient initiated Follow Up: Moving or discharging 5% of all outpatient attendances to PIFU pathways by March 2023	0.6% (196)	5%	2.08%	-2.92%	R	5%	2.07%	-2.93%	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%	49.95%	33.95%	G	16%	52.60%	36.60%	G
EROC Submission	Ensure that 25% of all outpatient attendances are carried out remotely by March 2023	25%	25%	12.51%	-12.49%	R	25%	12.75%	-12.25%	R

Q3 23/24 - Narrative

Trust wide **outpatient plan** developed and approved through Internal Governance. The plan was approved at the beginning of August 2023 and spans up until March 2024. Specialty level outpatient review meetings are facilitated, and actions tracked monthly. OP scorecard metrics reviewed monthly, with specific service concerns reviewed twice a month. On-the-whole, there is high performance in first to follow up ratio's and we remain in the top quartile nationally. There are a few specialty areas that fall in the bottom quartile and work is commencing with these services to improve ratios. Our priority is to discharge whenever clinically appropriate rather than move to **PIFU.** PIFU has been rolled out to the majority of specialties and plans in place to engage with those specialties yet to go live. 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 are still providing A&G. **Patient awareness campaign** around non face to face appointments and patient initiated follow up to raise patient awareness and encourage patients to ask about alternatives to traditional outpatient appointments has been developed. This will be signed off at CAG prior to implementation. Work is 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.

Supporting BCDD Projects:
P1.5 – Remove Same Day Multi Site Pathways (Urology)

Strategic Objective 4: Best Care – Transforming our Services (Q3 2023-24)

A

Maternity Services				Q2 2023-24				Q3 2023-24			
Ockenden Review Pillar	**Data source**	**Success measures**	**Baseline (March 2022)**	Target	Actual	Variance	RAG	Target	Actual	Variance	RAG
1: Fully funded safe staffing	HR	Midwifery vacancies	15.6%	15%	17%	2%	A	15%	11%	-4%	G
	HR	Turnover rates	13%	13%	15.20%	2.20%	A	13%	16%	3%	A
2: A well trained workforce	HR	MDT training compliance	90.3%	90%	89%	-1%	A	90%	89%	-1%	A
3: Learning from incidents	OD	Launch of Digital Maternity System	Target due Q4 2022-23	Implemented							
		Capacity to complete investigations within timeframes	Target due Q3 2022-23	Metric being developed				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%	Transferred to IQVIA	Transferred to IQVIA	N/A	>25%	2%	-23%	A
	MVP	No. Families engaged	TBC	In development				In development			

Q3 23/24 - Narrative

Fully funded safe staffing
The NHS single delivery plan and action plan was agreed by Trust Board as part of the maternity oversight paper. Phase 2 entrance renovations are ongoing and the refresh of the reception area has been completed. The remaining actions on the Ockenden 2 Action Plan impose a low risk to the Trust and is ongoing related to leadership development.

A well trained workforce
A Senior Midwife away day took place on 10th January 2024.

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. Risk assessments, in maternity, are captured in the maternity digital system. this system is audited and is currently noted at 100%.

FFT
Q3 numbers are from IQVIA. Numbers remain low but plan in action to increase by having QR code on flyers in room, on lockers so women can download on phone.

Supporting BCDD Projects:
P1.6 – Improve our Services for Pregnant Women

Strategic Objective 5: Best Value (Q3 2023-24)

A

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

			Q2 2023-24				Q3 2023-24			
Data	Success measures	Baseline	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	£16.1m adverse	£11.3m adverse	R	Less than 10% adverse variance on budgeted net	£18.2m adverse	£12.6m adverse	R
Trust Board report	Production of updated 10 year LTFM and assumptions	-	Board report issue	Ongoing	-	N/A	Board report issue	Ongoing	-	N/A
Trust efficiency reports	% of phased efficiency target met by the aggregate of all four efficiency types	-	100%	121%	21%	G	100%	93%	-7%	A
Trust efficiency reports	% of monthly phased efficiency target met by recurrent cash release	-	25%	58%	33%	G	25%	58%	33%	G
TMC and FPC reports	Business case evaluations reported to TMC and FPC	-	2	0	-2	R	2	0	-2	R
Trust Board report	% of annual ERF income earned	-	25%	25%	0%	G	25%	25%	0%	G

Q3 23/24 - Narrative

Balancing income: At the end of Q3 (M9), the trust reported a £18.2m deficit position of income over expenditure. This was £12.6m away from the plan expectation.
Production of updated 10-year LFTM: Ongoing.
% of phased efficiency target met by the aggregate of all four efficiency types: 93% overall achievement.
% of monthly phased efficiency target met by recurrent cash release: 58% overall achievement.
Business case evaluations reported to TMC and FPC: Delayed due to operational pressures, 2 were due in Q3 however 0 were presented.
% of annual ERF income earned: In line with the construct of our financial plan: 50% of ERF funding has been recognised at the end of Q2.

Supporting BCDD Projects:
P4.1 – Clinical Practice Groups

Strategic Objective 6: Great Team – Culture of Inclusion & Diversity (Q3 2023-24)

N/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 last reported in Q4, following analysis and completion of the staff survey. No further data available until new staff survey analysis.

Data source	Success measures	Baseline	Targets Q2 2023-24	RAG	Q3 2023-24	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	**N/A**
Staff Survey (*results March 2023*)	WDES Indicator - % of staff with Long Term condition or illness experiencing harassment, bullying or abuse from other colleagues in last 12 months from 26% towards 18% for those staff without LTC	26%	N/A	**N/A**	N/A	**N/A**
Staff Survey (*results March 2023*)	Improved Staff Engagement Score in Staff Survey from 6.8 to 7	6.8	N/A	**N/A**	6.77	**A**

Q3 23/24 - Narrative

Staff Survey. 40% completion rate was seen during the recent staff survey, this is a 10% decrease from last year despite an increase in divisional engagement, walk around and incentives. Initial high-level results have been received from the survey provider which has indicated :an increase in 6 out of 7 People Promise themes being seen; improvement to our staff engagement score (increase from 6.69 to 6.77); Bullying & harassment scores have improved; 'Would you recommend' scores have improved. The areas where we have seen slight decreases include culture, leadership and learning and aligns with the findings that have arisen from the staff survey. Full results are unavailable at this time and are due early March (hence no updated figures for all metrics).
Improved staff engagement - All wellbeing offering have been well received with the majority of events and session being fully booked. Menopause and nutritional webinars were well received, and we are looking to offer these again in 2024. Well fest and Winterfest weeks took place across all sites and had positive uptake. Monthly star of Herts part of the shine recognition platform which continues to see good utilisation. First phase of Value and Behaviours work completed with over 700 staff members taking part.
EDI: Launched Trust wide anti racism pledge with work commencing to get this adopted locally and to start implementing associated actions; Cultural competency sessions have been delivered by an external facilitator, developing in house content to make a provision more sustainable; EDI 'mandatory' module to be developed and launched April 24; EDI celebration events will be incorporated to a wider staff experience calendar to make it truly inclusive and will be developed in a more accessible format.
-Staff networks continue to build in terms of membership and types of networks. Further focus will be on developing LGBT provisions while supporting achieving the carer confident. We are launching the EDI high improvement working group to support the completion of key actions that transect across the HR directorate.

Supporting BCDD Projects:
N/A – Supporting BCDD Projects subsumed into Divisional BAU in May 2023

Strategic Objective 7: Great Team – Improve Workforce Sustainability (Q3 2023-24)

G

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.			Q2 2023-24				Q3 2023-24			
Data source	Success measures	Baseline (April 2022)	Tar	Act	Var	RAG	Tar	Act	Var	RAG
ESR BI / Ledger	Continued vacancy rates below 8%	8.4%	10%	7.00%	-3.00%	G	10%	6%	-4.4%	G
ESR BI	Staff turnover rates overall under 13%	15.0%	13%	12.90%	-0.10%	G	13%	12%	-0.9%	G
ESR BI	Turnover rate for new starters (first 12 months) towards 15%	20.4%	15%	14.10%	0.90%	G	15%	14%	-0.8%	G

Q3 23/24 - Narrative

All indicators are now below target for the first time this year. All divisional vacancy rates are below target except for Environment. Apprenticeships are being explored to support and a recruitment open day is planned for November. Turnover has continued to reduce and is now below target both overall and for those leaving within their first 12 months. Whilst CSS, EM and WACS remain above turnover target, we are seeing reductions. Notable improvement is with HCSWs. The Trust is holding a recruitment open day in November to target hotspot areas such as Paediatrics, Midwifery and AHPs. The Trust is working to improve the uptake of apprenticeships targeting band 2 HCSWs and Non-clinical roles providing several different pathway options for internal staff and new recruits. Staff survey is to be launched in October and will be open for 9 weeks, results of this are expected early 2024. The people promise programme continues to focus on a variety of flexible working options for all staff and a road show style event will be taking place to raise awareness across all sites. HRBP continue to work closely with divisions on localised initiatives to tackle themes.

Supporting BCDD Projects:
N/A – Supporting BCDD Projects subsumed into Divisional BAU in May 2023

Strategic Objective 8: Great Team – Develop as a learning organisation (Q3 2023-24)

G

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

			Q2 2023-24				Q3 2023-24			
Data source	Success measures	Baseline	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%	49%	4%	G	45%	46%	+1%	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	125	125	0	G	125	138	+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	Awaiting new staff survey	Awaiting new staff survey	Awaiting new staff survey	N/A	5.6	5.58	-0.02	G

Q3 23/24 - Narrative

Coaching: Some turnover of coaches during Q3, meaning that total available coaches remains static at 54, however up to 22 currently in training and due to complete mid-Q4. First part of new advanced coaching course took place in November with second part due in March. This will create 9 additional senior coaches which will allow coach numbers to grow to match large anticipated increase in clients due to coaching being offered to delegates of new leadership programmes, which will start from Q4 23/24 and progress through Q's1-3 of 24/25.

Improved Diversity: We have ensured equality of representation on Cohort 7 of the ADDS programme (50% of final nominations were of BAME staff) and Cultural Awareness has commenced roll-out on Leadership Development Programmes, the first dates for which are in Q4.

Staff Survey: The promise has risen to 5.58, just 0.02 short of the 5.6 target.

Supporting BCDD Projects:
N/A – Supporting BCDD Projects subsumed into Divisional BAU in May 2023

Strategic Objective 9: Great Place – Digital & IT Innovation (Q3 2023-24)

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	Q3 2023-24 Target	Q3 2023-24 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					

Q3 23/24 - Narrative

No update for Q3 2023-24

Supporting BCDD Projects:
N/A – Supporting BCDD Projects reported elsewhere

Strategic Objective 10: Great Place – New & Refurbished Hospital Buildings (Q3 2023-24) A

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	Q2 2023-24	RAG	Q3 2023-24	RAG
Capital allocation secured (dependent on NHP timelines)	-		A		A
OBC approved & clear programme for FBC and construction agreed with regulators (dependent on NHP timelines)	-		R		R
Enabling capital agreed and works completed to timetable (dependent on NHP approval)	-		A		A

Q3 23/24 - Narrative

Work is continuing to progress plans for each of the Trust's sites, as summarised below.
Watford: > The draft OBC for the Watford site has been updated and was submitted to Part 2 of the December 2023 Trust Board where approval was granted to send the draft OBC to the New Hospital Programme (NHP) for information and to initiate the finalisation of the OBC ahead of formal submission. > Next key steps to finalise the OBC are 1) to align the demand and capacity modelling methodology with that of the recently completed NHP centralised model and 2) to update our design - this is a crucial stage in the project where we will be finalising the design of the new hospital for West Hertfordshire's next generation. > Progressing enabling schemes is also a key priority and business cases are being developed with a view to clearing the site and commencing demolitions in 2024, completing civil engineering works in 2025 and starting the main build in 2026. Enabling schemes currently underway to create additional beds in the Shrodells building and a pathology essential services lab are progressing well. Of particular note, is that the land transfer at Watford completed in December 2023.
Hemel:> Dacorum Borough Council, in partnership with West Hertfordshire Teaching Hospitals NHS Trust and the NHS Hertfordshire and West Essex Integrated Care Board (ICB), is exploring the future viability of an Integrated Health Campus at Market Square in Hemel Hempstead. > The decision to progress this potential option further follows initial exploration work, which has highlighted the advantages to the healthcare offer for local people and the wider regeneration of the town centre.> The intention is that the HWE ICB and DBC will play the leading role in sponsoring the scheme, with the Trust being a partner for its design, delivery and operation.
St Albans:> Elective Care Hub - a guaranteed maximum price for this scheme has now been agreed and the Full Business Case submitted to the Trust Board. Works will take place during 2024, with this new regional facility opening at the end of the year.> Community Diagnostic Centre - the CDC design is currently being amended to align with budget and site constraints. The work will be tendered in March 2024 and the target completion date is December 2024.
> Endoscopy Unit - work has continued to develop the design and the Outline Business Case for the new endoscopy unit. The target works completion date is March 2025.

Supporting BCDD Projects:
P8.2 – Business Case for the Enabling Works

Strategic Objective 11: Great Place – Reduce our carbon footprint (Q3 2023-24)

G

Objective 11
Reduce our carbon footprint (excluding redevelopment capital bids)

		Targets				
Data source	Success measures	Baseline	Q2 2023-24	RAG	Q3 2023-24	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	Q3/Q4 survey	A	Q3/Q4 survey	A
Green dashboard	2) Lead a minimum of 8-10 programmes to reduce the use of single-use items in clinical services and settings	Nil	Ongoing	G	Ongoing	G
Green dashboard	3) By 2025, 100% of appropriate clinical waste to be treated at an energy-from-waste recovery facility	0%		C		C
Green dashboard	4) 5% decrease in energy consumption	N/A	Q4	G	Q4	G
Green dashboard	5) To reduce staff driving to work to 55% and patients driving to our hospitals to 75%	Staff 61% Patients 79%	Q2	R	Q2	R

Q3 23/24 - Narrative

Planning is underway with the communications team to run events/promotions on a variety of Environmental/Sustainability - related topics throughout the year. January's Quarterly Pulse survey contained the addition of the following two questions:- To what extent are you aware of the Trusts Green Plan to help reach Net Zero carbon emissions by 2040? How could your department operate more sustainably? The survey results are not yet known.

Ongoing projects are still taking place. From 1st October 23 the law has changed, and single use plastic is now banned. This will impact ongoing milestones for eliminating single use products through the Trust. Work is on-going to support.

As noted in the Q2 updates, all appropriate waste is now going to a green energy waste facility.

The installation of LED lights in WACS building is due to be completed at the end of January. A grant funding application of £521k has been made for the installation of photovoltaic solar panels on Gloucester Wing, SACH and Verulum building, HH. The outcome of this is anticipated shortly but if successful, these works are to be completed during FY23-24.
It is understood that the draft Travel and Access Strategy is yet to be presented to Board and therefore the KPI's associated with this metric are yet to be ratified.

RED RAG to Green dashboard - At the time the Green Plan was produced we anticipated having ANPR at each of our 3 acute sites within a few months and therefore the ability to understand the number of vehicles visiting our hospitals and (in-time) to establish an idea of the proportional split between staff and non-staff. However, to the best of my knowledge the ANPR technology still hasn't been installed anywhere other than the MSCP at WGH and therefore this metric remains unmeasurable.

Supporting BCDD Projects:
P8.5 – Implement the Green Plan

BCDD Projects - Project Lifecycle Stage and Overall RAG rating

The tables below outlines the project lifecycle stage and their Overall RAG rating for each project within Better Care Delivered Differently programmes.

Delivery			
Programme	**Ref**	**Project**	**Overall RAG rating**
Best Care	P1.2	ICS Acute Services Strategy	**A**
Integrated Care	P2.1	Virtual Hospital (Phases 1-3)	**A**
Personalised Care	P3.1	Equality Delivery System	**A**
Consistent Care	P4.1	Clinical Practice Group	**G**
Redevelopment	P8.2	Business case for enabling works	**G**
	P8.4	Expansion of Diagnostic Services at SACH	**A**
	P8.5	Implement the Green Plan	**G**

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

Implementation Planning			
Programme	**Ref**	**Project**	**Overall RAG rating**
Best Care	P1.6	Improve our services for pregnant women	**Project to be closed and assumed into divisional BAU**

Project Scoping / Initiation			
Programme	**Ref**	**Project**	**Overall RAG rating**
Personalised Care	P3.2	Promote Inclusion across our services	**R**

BCDD Milestones – highlighted by exception

Overall RAG Rated **RED** projects.

Programme	Ref	Project	Project Lifecycle	Delays in milestones and extreme (red) risk identified
3. Personalised Care	P3.2	Promote Inclusion Across our Services	Scoping	Milestone 1: Set up and confirm membership for internal stakeholder group Group ToR and PID not signed off. Milestone 2: Set up the initial internal workstream (Race) to focus on the recommendations outlined in the Making Local Healthcare Equal (MLHE) report It has been agreed that stakeholder meetings will be paused until the EDS submission for 2023/24. This also results in the outputs and recommendations made from the Healthwatch report being put on hold until further notice and until the stakeholder group reconvenes. Milestone 3: Review existing research on patients and their experience of accessing services Limited EDI data has been received from Michelle Creese (EPR) and it was planned, for the November Stakeholder Group, that colleagues from around the Trust would join the meeting to present on captured EDI data. As noted, this meeting has now been stood down and is awaiting confirmation of next steps following the EDS submission (23/24). Milestone 4: Undertake/Source external support for new research on patient engagement Project SRO and Project Support will no longer be leading the project come the new year and deliverables of the project will be TBC as new ownership is agreed. Risk 004: Unable to respond to recommendations made in MLHE Stakeholder group has now been stood down until further notice and method for responding to Making Local Healthcare is currently unclear

BCDD Milestones – highlighted by exception

Although the following projects are not overall RAG rated RED, we are highlighting them for attention, based on **RED milestone RAGS**.

Programme	Ref	Project	Project Lifecycle	Delays in milestones
8. Redevelopment	P8.5	Implement the Green Plan	Delivery	*Milestone 5 (Development of the Green Travel & Access Strategy).* Noted that the Travel & Access work is incorporated into the redevelopment workstream and will be dependent on progress made within the redevelopment. An upcoming meeting is taking place between Toby Hyde, Alex White, Green Plan Team and the Redevelopment team to confirm the route forward for this work. .

BCDD Risks & Issues – highlighted by exception

Although the following projects are not Overall RAG rated RED, we are highlighting them for attention, based on **HIGH (red) risks/issues indicated, with risk score RAG post-mitigation deemed MEDIUM (amber).**

Programme	Ref	Project	Project Lifecycle	High (red) Risk indicated; risk score RAG post mitigation deemed Medium (amber)
1. Best Care	P1.3	Development of an elective surgical hub for the system	Planning	*Risk: Currently no formal confirmation of the revenue investment.* Mitigation: This has been escalated across the ICB and will be reviewed as part of the OBC submission.
	P1.3	Development of an elective surgical hub for the system	Planning	*Risk: The timeline to deliver additional capacity.* Mitigation: Submitting OBC to NHSE/I on time and ensuring a robust programme that has undergone significant engagement.
	P1.5	Remove multi-site appointments (Urology)	Planning	*Risk: The Trust financial position can no longer support funding for this programme for the current FY and upcoming* Mitigation: Project will be included in FY25 divisional business plans – to seek approval for funding to deliver in FY25. Business case updates will demonstrate robust rationale and benefits (qualitative, quantitative and monetise).
4. Consistent Care	P4.1	Clinical Practice Groups	Delivery	*Risk: Implementation of 10 pathways by March 2024 risk of not achieving due to ongoing industrial actions, CPG team staffing capacity, EPR processes delay, ongoing internal surge incidents and delays in divisional approvals* Mitigation: Develop strategy for business-as-usual pathways to be handed over to appropriate division for long term sustainability with provision of periodic oversight by CPG team.

BCDD Risks & Issues – highlighted by exception (continued)

Although the following projects are not Overall RAG rated RED, we are highlighting them for attention, based on **HIGH (red) risks/issues indicated, with risk score RAG post-mitigation deemed MEDIUM (amber).**

Programme	Ref	Project	Project Lifecycle	High (red) Risk indicated; risk score RAG post mitigation deemed Medium (amber)
8. Redevelopment	P8.2	Business Case for the Enabling Works	Delivery	*Risk: Trust to confirm the release of 44 beds (August 2024) to enable the removal of the surge units.* Mitigation: Ongoing service transformation activity to reduce the overall demand on beds at WGH.
	P8.2	Business Case for the Enabling Works	Delivery	*Risk: Inflation and uncertainty in the contractor and supply chain market is leading to cost increase and programme delay across much of the trust's internal capital programmes and enabling works for the redevelopment* Mitigation: Engage with the marketplace to try and mitigate the excessive risk into project costs. Continue to investigate alternative procurement routes to ensure VFM
	P8.4	Expansion of Diagnostic Services at SACH	Delivery	*Risk: Inability to recruit a skilled workforce will impact efficient service delivery.* Mitigation: To explore new roles and new ways of working, supported by digital transformation, and implementing an apprenticeship programme. To expand international recruitment to include Radiographers and to explore opportunities via volunteer pools.
	P8.4	Expansion of Diagnostic Services at SACH	Delivery	*Risk: An increase in revenue costs, due to the inability to recruit radiologists that are able to report on the increases in activity.* Mitigation: Potential increase in costs are being flagged, to relevant forum, ahead of time to raise awareness.
	P8.4	Expansion of Diagnostic Services at SACH	Delivery	*Risk : Parking on SACH site.* Mitigation: Reviewing various on and off-site parking solutions. Will also work closely with the main contractor to minimise parking disruption.

BCDD Programme 1 – Best Care

Programme SRO: Mary Bhatti

Reporting Month January 2023

SRO Programme Summary

Acute Services Strategy – The meeting with E&N colleagues has yet to take place, however this work will form part of the 24/25 strategy particularly in relation to fragile services and repatriation of activity . In the meantime, a stock take of the current position of the other providers and the ICB will be undertaken in readiness.

Development of an elective system hub – Theatre 5 handed over to BAM Construction on 15th December 2023 and demolition progressing well.

Remove same day multi-appointment pathways (urology) – GMP was returned in November. The scheme has now been reissued externally for competitive tender. While awaiting final project costs the BC is being refreshed by the service to align with divisional strategy, CDC, business plans and to include demand-capacity and growth models, as well as financial benefits.

Improve our services for pregnant women – *Following a recommendation from the WHTH Strategy Team the Project SRO, Mitra Bakhtiari, has confirmed that following submission of the November 2023 update P1.6 will no longer be reported via BCDD and will be assumed into divisional BAU and reported through divisional governance forums.*

Programme RAG Rating

Nov 2023	Jan 2024
A	A

Ref	Project Name	Project RAG Rating	
		Nov 2023	Jan 24
P1.2	Acute services strategy	G	A
P1.3	Development of an elective system hub	A	A

Ref	Project Name	Project RAG Rating	
		Nov 23	Jan 2024
P1.5	Remove multisite appointments - urology	A	A
P1.6	Improve our services for pregnant women	G	BAU

Milestones/Key Achievements

P1.2 – The meeting with E&N colleagues has yet to take place, however, this work will form part of the 24/25 strategy particularly in relation to fragile services and repatriation of activity .

P1.3 – SACs division have completed an impact assessment which indicates c.300-400 cases might be lost over the 12-month construction period, despite work and mitigation planned to prevent this. TMC endorsed the plans and divisional TAG will monitor this weekly and report accordingly

P1.5 – Business case is being updated by the clinical service to align with the trust strategic objectives and future needs of the service, Plan for completion end of FY23/24. Confirmation of inclusion of revenue required from programme SRO and CFO

Next Period Planned activities

P1.2 – A stock take of the current position of the other providers and the ICB will be undertaken in readiness

P1.3 - To monitor impact assessment progress and report this through SAC divisional finance and performance group monthly meetings. - Construction work to start within the internal courtyard.

P1.5 – To finalise financial case based on updated activity and demand models and further potential to increase income through additional procedures. Confirm best option for admin teams within the project scope and costs

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Issues for Escalation

- N/A

BCDD Programme 2 – Integrated Care	Programme SRO: Toby Hyde	Reporting Month	January 2024

Virtual Hospital (VH) – VH activity continues to increase, ,as does the phasing trajectory. Bed occupancy increases monthly, however, we remain off target across VH. Differing calculation of bed occupancy will be taken to VH Partnership Board in Jan 2024 and the recommendation that bed occupancy is calculated in the same way as our neighbouring providers from Jan 2024 onwards. We would expect to see a higher bed occupancy rate going forward.

Frailty – Noting the current financial situation, any schemes requiring additional investment are on hold which means that the Business Case is also on hold. Many of the supporting workstreams do not require additional investment.

Respiratory Transformation – Contract has now been extended until 31/05/24. It was agreed on 21st November that WHTH will review a wider set of respiratory activity (including breathlessness and chronic cough) to identify the full financial envelope. Integrated contract and MOU are in development and joint alliance performance meetings are due to start Q4 24.

Multiple Long-Term Conditions – Workforce modelling / staffing review is taking place to identify gaps and possible alternative staffing options. The high-level clinical model has now been agreed and a design group has been established which is led by Steve Laitner. Work is now underway with finance to develop an investment model that will support the programme. Some funding has already been allocated. Contract has now been extended until 31/05/24. It was agreed on 21st November that WHTH will review a wider set of respiratory activity (including breathlessness and chronic cough) to identify the full financial envelope. Integrated contract and MOU are in development and joint alliance performance meetings are due to start Q4 24.

Programme RAG Rating

November 2023	January 2024
A	G

Ref	Project Name	Project RAG Rating		Ref	Project Name	Project RAG Rating	
		Nov 2023	Jan 2024			Nov 2023	Jan 2024
P2.1	Virtual Hospital (VH): Phases 1-3	A	A	P2.5	Respiratory Transformation	G	G
P2.4	Frailty	G	G	P2.6	Multiple Long-Term Conditions (LTC)	G	G

Milestones/Key Achievements	Next Period Planned activities
P2.1 – A new pathway for Surgical has been launched, with low activity numbers (as expected, due to being funded within existing resource). This pathway is working well and will be considered for expansion. Work continues, on the Diabetes pilot with an expected launch date in Q4. **P2.4 –** Work continues to identify cohort of patients for initial phase of Pro Active/Anticipatory Care Programme - task and finish group has been established. Frailty H@H showcase took place - very well received. Framework and process for re scoping of wider Frailty Transformation Programme agreed **P2.5 –** Demand and capacity modelling has been completed and pathways have been agreed. The current submission exceeds the financial envelope. **P2.6 –** Task and finish Groups in place for Data and identification of cohort, together with Outcome Framework. Funding agreed with finance for development work. Principles of programme agreed. Continued work to finalise programme and operational model.	**P2.1 –**To adjust the internal meeting/reporting structure to move to a BAU model with teams presenting on performance. Significant work is ongoing with Primary Care colleagues to promote 'set up' aspects of VH pathways. **P2.4 –** To identify cohort of patients for the initial phase of proactive / anticipatory care programme and write up a concise proposal for the Finance Group. To agree the framework and process for re-scoping of the wider Frailty Transformation Programme. **P2.5 –** Several options are being considered in terms of next steps and teams will be working together to agree a way forward. **P2.6 –** To finalise the revised programme plan and to identify a cohort of patients to be included in the initial programme.

Issues for Escalation

N/A

BCDD Programme 3 – Personalised Care	Programme SRO: Kelly McGovern	Reporting Month	January 2024

SRO Programme Summary

Equality Delivery System (EDS) 23-24 Review – Overall, including our **Domain 1** scores and stakeholder scores from Domain 2 and 3 the Trust deems it to be working at a 'Developing activity level'. For Domain 1, three services were selected, one which is doing well, one which requires improvement, and one where we don't know. These were selected as follows:• Service 1 – maternity services doing well (excelling activity)• Service 2 – diabetes services – needs improvement (achieving activity)• Service 3 – gypsy and traveller empowerment (GATE) – not enough data. (underdeveloped activity)
Overall feedback from stakeholders under **Domain 2** was that good progress has been made and, the Trust is meeting the level required across this domain. This was reflected in the scoring whereby 'developing activity was attained for Domain 2. **Domain 3**, stakeholders indicated that there is varying perception of senior leadership involvement and engagement across the networks. Elements of good practice were noted but feedback indicated this was not consistent across the networks. Consequently, the 'Developing Activity' score was provided across the majority of the outcomes.
To achieve and monitor the progress of the gaps highlighted in the report, we will; • Align action plans for each domain with the WDES, WRES, and EDI improvement plan 6 high impact actions. • Put working groups in place for the EDI high impact actions & Staff Experience. • Track and monitor actions through both the EDI Steering Group and the Wellbeing and Engagement steering group.
Promote inclusion across our services – Following discussion between Michelle Hope and Alex Paice it was agreed that the Promote Inclusion Stakeholder Group is to be paused until further notice for the project team to focus on the 2023/24 EDS submission. The pause of this group has resulted in several of the noted and agreed milestones falling behind schedule and altering the RAG rating of the project to RED. Additionally, the Project SRO and Project Lead will no longer be leading this project come the new year and the project deliverables are TBC until new ownership is agreed.

Programme RAG Rating

Nov 2023	Jan 2024
R	A

Ref	Project Name	Project RAG Rating	
		Nov 2023	Jan 2024
P3.1	Equality Delivery System 2023-24 Review	A	A
P3.2	Promote inclusion across our services	R	R

Milestones/Key Achievements	Next Period Planned activities
P3.1 - EDS paper submitted to Feb PERC ahead of publication to Trust website. An EDI improvement plan for 2024 is in development to support the 2024-25 EDS delivery. **P3.2** – Work has paused pending further review.	**P3.1 –** Work continues to progress the actions and work is ongoing with staff networks to provide support with their comments and scoring. It is required that EDS is completed as part of a system approach and that domain 3 requires independent review with Union representative. **P3.2** – Chief Nurse to review and make recommendation for next steps.

Issues for Escalation

N/A

BCDD Programme 4 – Consistent Care	Programme SRO: Don Richards	Reporting Month	November 2023

SRO Programme Summary

Clinical Practice Group: CPG Finance Officer to develop and implement costing strategy for three pathways: Induction of labour, Pulmonary Embolism and Frailty. Frailty cost avoidance based on one day admission completed. Costing for comparison of correct and incorrect pathway flow completed. Induction of labour, Pulmonary Embolism, Community Acquired Pneumonia, Enhanced Recovery and Right Upper Quadrant Pain completed and a further 3 pathways (Chest pain, Anaemia and Cellulitis) in progress. Opportunity for cost improvements identified some for the pathways and discussed with efficiency team for approval.
Nine pathway digitalisation in progress: (6 pathways completed). Limiting factor for digitising the 3 remaining pathways is capacity of EPR builder Scoping for Children's Emergency Department (CED) Clinical lead requested delay (to April 2024) until after implementation of step-down plan for wheezy child and Emergency department to be discussed with division triumvirate by 31st January 2024.

Theatre Productivity Improvement Programme: The key focus on two workstreams continues, with a focus on booking and planning the on the day processes. Clinical engagement has been successful and average utilisation is currently over 80% across the trust. Programme lead and surgical support services ADM working to integrate process and policy as BAU with plans for regular stakeholder engagement and accountability of utilisation of productivity improvements. This is planned to be monitored through the divisional theatre activity group (TAG)

Programme RAG Rating

Sep 2023	Nov 2023
A	G

Ref	Project Name	Project RAG Rating	
		Sep 2023	Nov 2023
P4.1	Clinical Practice Group(CPG)	G	G
P4.2	Theatre Productivity Improvement Programme	A	A

Milestones/Key Achievements	Next Period Planned activities
P4.1 – Cellulitis digitalisation completed. Pulmonary Embolism, Heart failure, Deep Vein Thrombosis and Paediatric allergy digitalisation of pathways in progress.-Intranet CPG page updated ;Attended joint meeting (RFL & WHTH) for developing BAU process for pathways;-CPG leads meeting held in Nov 2023 for Medicine and Emergency Medicine;-Miscarriage audits posters presented at national conference in November 2023;-Costing for all pathways in progress; QI modules training delivered as part of QI faculty **P4.2 –** Programme realigning focus to achieve financial recovery action plans. Business as usual transitional approach to theatre improvement incorporating regular speciality-based review of performance. Performance against plan: • Increase average cases per list to 2.9. SACH, currently at 2.38 for November. • Early finishes 31.5 minutes • Late starts 27 mins • Utilisation 83.5%	**P4.1** – Initiate Inpatient Diabetes pathway meetings with clinical lead in early 2024 to understand the workload prioritisation and timeframe. Exploring options with clinical lead for co-production work on Frailty and Right Upper Quadrant pain pathway. Explore and scope new pathways which have shown beneficial improvement at RFL for implementation in 2023/2024 and 2024/2025. **P4.2** To further embed median times across all clinical services. Roll-out further comms and engagement . Undergo engagement clinical engagement session. BAU approach to theatre lists that continue to underperform via Theatre Activity Group meetings and regular speciality review.

Issues for Escalation

None

BCDD Programme 8 – Redevelopment

Programme SRO: Alex White

Reporting Month January 2024

SRO Programme Summary

Business Case for Enabling Works -Work has commenced on site and is now scheduled to complete on 10th June 2024. The original completion date, noted as 23rd February 2024, has been delayed. The Business Case is due to be submitted to the New Hospital Programme (mid-December 2023) and expecting work to take place on site during the first half of 2024 (January 2024 – June 2024). The work has now been split into two phases and the last noted completion date (12th January 2024) will not be achieved. The first phase (top floor) is scheduled to complete on 20th December 2023. The second phase (first floor) is due to complete on 28th February 2024.

Expansion of Diagnostic Services at SACH – GMP returned by BAM construction over budget for the CDC project. Trust team currently reviewing a full range of options for the CDC project. Cost and programme will be confirmed once an option is selected to progress. The installation of IT equipment is currently still awaited to relocate fracture. Cost and programme will be confirmed once an option is selected to progress.

Implement the Green Plan – From 1st October 2023 the law has changed and single use plastic is now banned. Discussions are still ongoing about providing plant-based meals as standard although this is unlikely to be adopted prior to the start of the next Soft FM Contract. The WHTH Vegan Network has now been established; the development of this Network will hopefully support the further development of the initiative of plant based meals provided as standard. The Sustainable Procurement Specialist has now started and has been in post for 3 months. Already, an initiative to remove couch-roll throughout the Trust has been implemented; this will generate annual savings in excess of £50k for WHTH.

Programme RAG Rating

Nov 2023	Jan 2024
A	A

Ref	Project Name	Project RAG Rating	
		Nov 2023	Jan 2024
P8.2	Business case for enabling works	G	A
P8.4	Expansion of diagnostic services at SACH	A	A
P8.5	Implement the green plan	G	G

Milestones/Key Achievements

P8.2 – There is a member of the New Hospital Programme embedded two days a week within the redevelopment team to support the ongoing enabling works programmes. Unconditional outline planning consent (land transfer) has been received for the main development.

P8.4 – The Trust team are currently reviewing the alternative options for the CDC project.

P8.5 - A Green Plan update was incorporated within the Trust Strategy Development Update to the Trust Board in December 2023. The planned update will note that there is currently reduced support in team and the potential to increase resourcing to support the ongoing work. This associated report will also cover the governance and reporting processes for the programme.

Next Period Planned activities

P8.2 - New Hospital Programme expecting work to take place on site during the first half of 2024 (January 2024 – June 2024).
P8.4 – Decision on option to progress once the full range of options for the CDC project have been assessed on cost, programme and deliverability.
P8.5 – Work is ongoing to develop supporting capital projects that are being developed for later this year specifically around photovoltaic solar panels and upgrades to the Trust's Building Management System. Good priorities on the medicine optimisation with regard to anaesthetic gases and continued progress for meter dose inhalers. No further update has been noted on these projects following the previous update. A Communications Plan to be agreed with the Communications Team to run events/promotions on a variety of Environmental/Sustainability-related topics through 2024.

Issues for Escalation

N/A

Strategic Objectives – Closing Summary at March 2024.

The summary below provides closing statements for each strategic objective

Objective 1 – Resilient Services.

This is now on hold. Whilst the strategy itself was finished , there has been no real momentum across the system to take this forward. WHTH leadership will continue to work with the ICB Executive to provide a way forward and next steps.

Objective 2 - Improving Access to Care.

Overall delivery has been closer to plan for 1st OP appointments with a relatively small shortfall. Continued industrial activity has caused difficulties in achieving plan and achievement of the follow up reduction target has been challenging, particularly since the drive to eradicate long waits increases demand for follow up reviews. The Trust continues to perform well against trajectory for RTT long waiters. Focus on increasing patient initiated follow up to reduce demand has delivered better uptake, but rates are below requirement. Diagnostic and elective inpatient activity plans have been achieved, with significant improvement in diagnostic waiting times. Reduction of cancer long waits has also been successful, with the target for number of waiters over 62 days having been met.

Objective 3 – Reducing Inequalities.

Overall, including Domain 1 , 2 and 3, the Trust is reporting to be working at a 'Developing' activity level. Equality Delivery System report is published to the Trust website. Going forward the 2024-2025 report will comply with the technical guidance of the EDS framework. The future years EDS must be completed with system partners and include validation from an independent assessor and union representative.

Objective 4 – Transforming Our Services -Virtual Hospital (VH).

ICB have confirmed current funding will continue for 24/25. Developing and expanding the community step up Frailty pathway will be a key focus for 24/25 and beyond. Following the full development of a business case an alternative funding mechanism will need to be identified. Performance in Feb 24 was 309 delivered against a target of 325 which is a result of a combination of increased utilisation and realignment of data calculations which reflects reporting methodology of other system providers.

Objective 4 – Transforming our services – Maternity.

The NHS single delivery plan and action plan was agreed by Trust Board as part of the maternity oversight paper. The Trust remains 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. Risk assessments, in maternity, are captured in the maternity digital system. this system is audited and is currently noted at 100%.

Strategic Objectives – Closing Summary at March 2024

The summary below provides closing statements for each strategic objective

Objective 4 – Transforming our services - Outpatients. Specialty level outpatient review facilitated meetings actions are tracked monthly. OP scorecard metrics reviewed monthly, if there are specific services concerns, they will be reviewed twice a month. Work is underway with Clinical Teams to review clinic templates to ensure that they reflect a 25% reduction in f/u activity. On the whole, there is a high performance in first to follow up ratio's and we remain in the top quartile nationally. There are a few specialty areas that fall in the bottom quartile and work is commencing with these services to improve ratios. Our priority is to discharge whenever clinically appropriate rather than move to PIFU. **PIFU** has been rolled out, to the majority of specialties, and plans are in place to engage with those specialties yet to go live. 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 are still providing A&G. Patient awareness campaign around **non face to face appointments** and patient initiated follow up to raise patient awareness and encourage patients to ask about alternatives to traditional outpatient appointments launched at the end of Jan 24. Work underway with outpatient administrative team to ensure correct set up on EPR on a specialty-by-specialty basis.

Objective 5 – Best Value. As at the current position the Trust is forecasting a £9.3m deficit position where expenditure is in-excess of income, risks have been highlighted and mitigations are currently being worked through alongside the ICB. Efficiency: FOT efficiency delivery is £12.6m as at M11 February, of which £7.9m is of a cash releasing nature and £4.7m relating to cost avoidance and recovery of overspend initiatives.

Objective 6 – Culture of inclusion and diversity. While acknowledging the achievements highlighted in the staff survey it is important to emphasise that substantial efforts are still required to accomplish the Trust's strategic objectives and fully integrate Equality, Diversity, and Inclusion across the organisation. Advancing the aspects outlined in the People Strategy, coupled with enhancing values-based recruitment and HR practices, will play a pivotal role in fostering the extensive cultural transformation necessary to establish the Trust as a genuinely inclusive and favourable workplace. To support in achieving and monitoring progress of the gaps highlighted within the national reports and staff survey we have; Developed an EDI Improvement plan mapped against the 6 high impact actions which aligns the, previously separate, WRES,WDES, Pay gap and EDS action plans in a more cohesive and robust manner Working groups ae now in place for the EDI high impact actions & as well as for Staff Experience. Senior leadership engagement of staff survey has commenced, and more data profiles are being developed to provide further insight. We will track and monitor actions through both the EDI Steering Group

Objective 7 – Improve workforce sustainability The apprenticeship first scheme will launch on 1st April 2024, targeting band 2 HCSW's, non-clinical admin and clerical roles across the organisation to make better use of the levy and improve career progression. Lots of improvements are being made to the recruitment policy that will support protected secondments and job trials with an emphasis on internal recruitment to support staff retention and better utilisation of skills and talent.

Strategic Objectives – Closing Summary at March 2024.

Objective 8 – Develop as a learning organisation.

The number of coaches, though unchanged in Q3, will increase in Q4 and Q1 24/25. 9 new senior coaches will qualify in Q4 allowing greater service capacity. For diversity in non-mandatory training, there was equality of representation for the latest ADDS programme, and cultural awareness courses now run on all leadership programmes. Staff survey metric "we are always learning" is up at 5.58.

Objective 9 – Digital IT & innovation. **No RAG, Measures reported separately**

No update.

Objective 10 – New and Refurbished Hospital Buildings.

The Trust's redevelopment team has continued to work closely with the New Hospital Programme and to further develop work as part of the Outline Business Case process. During the course of the year, outline planning permission for the new Watford Hospital has been granted and the additional land to optimise the site also purchased. The Outline Business Case narrative has been updated and submitted in draft to the New Hospital Programme team. Enabling schemes are also progressing well, with work to create a new Pathology Essential Services Lab and to provide further inpatients beds in the Shrodells' building, with both completed by the autumn. These enabling schemes create new capacity so that existing buildings on the site of the new hospital can be demolished. Key priorities for the coming year are: progress the overall design and complete supporting technical work; clear all buildings on the new hospital site ready for demolition; finalise the Target Operating Model.

Objective 11 – Reduce our carbon footprint.

Since board-ratification in February 2022 good progress has been made on the actions within our Green Plan across the majority of our 9 key themes. Beyond what's been reported previously, work is now being undertaken in establishing a multi-organisational working group to create a climate-related Adaptation Plan. Alongside our EPRR colleagues, we are looking to work with the Public Health Team from Herts County Council as well as the ICB and Greener NHS Regional Team; this will enable the inclusion of regional, local and organisational perspectives. Further, plans are now in place for the creation of a "Green Speak-Up Challenge" which will ask WHTH staff to communicate opportunities for improved environmentally-sustainable practice. This is to interact with a Green Champions Network that will be suitably motivated, empowered and (possibly) incentivised to support the progression of this agenda.

BCDD Projects – Closing statements at March 2024.

P1.2: Acute Services Strategy This is now on hold. Whilst the strategy itself was finished , there has been no real momentum across the system to take forward. WHTH leadership will continue to work with the ICB Executive to provide a way forward and next steps.

P1.3: Elective System Hub Construction works are progressing with BAM construction. This includes drainage diversion works, underpinning of the existing day unit foundations, further demolition of the level 2 Moynihan building balcony, re-location of some existing services. Works have also started within the courtyard which includes clearing of soil from the existing planter for demolition to make space for the new changing room facilities. Noise and vibration are closely monitored during the demolition. 8-week lookahead plan issued by the BAM construction to the clinical team to allow for effective planning. These will be updated regularly

P1.5: Remove Same Day Multi-Site Appointments (Urology) The Urology Unit Project Team has been focussed in the past year on the work-up of a full business case, with the intention of securing funding for the construction of a new and dedicated unit for the provision of streamlined urology care at St Albans City Hospital. This would enable the service to offer single-site and one-stop appointments to patients in a streamlined manner, similar to that of the orthopaedic unit already in place on the SACH site. The design for the unit has now been fully tendered, with confirmed costs to be included in the FBC. This is supported by a refreshed capacity and remand review, and proposals for the new clinical pathways that could be implemented with a new unit in place. The business case will be submitted for approval soon, once it has been finalised and signed off by the Division.

P2.1 Virtual Hospital ICB have confirmed current funding will continue for 24/25. Developing and expanding the community step up Frailty pathway will be a key focus for 24/25 and beyond. Following the full development of a business case an alternative funding mechanism will need to be identified.

P2.4: Frailty Transformation Frailty hospital at home service has seen over 400 patients. Outcomes and feedback continue to be very positive. Plans are being developed to increase capacity and activity particularly for step up pathways in the community, this is aligned to Frailty Transformation being a priority for our HCP.

P2.5: Respiratory Transformation There is a funding gap of £1.1m which the ICB have confirmed they are not able to fund. However, the 3 partners WHTH, CLCH and ICB are considering how they might 'risk share' this gap. An initial meeting has taken place, further meeting Thursday 28th March to discuss each organisations contribution. Plan is to still go live on 1st June.

P6: Multiple Long-Term Conditions Clinical design work is now complete and initial patient cohort has been identified. Lists are in review by participating PCNs. A pilot model is being costed as part of the business case development progress. Work continues to identify potential funding model.

P3.1: Equality Delivery System Overall, including Domain 1 , 2 and 3, the Trust is working at a 'Developing' activity level. EDS report is published to the Trust website. 2024-2025 process and report will comply with the technical guidance of the EDS framework. The future years EDS must be completed with system partners and include validation from an independent assessor and union representative.

P3.2: Promote Inclusion Across our Services Co Production/Co design is seen in differing pieces of work through the Trust as is the promotion of inclusion. More will be done to highlight this good work and promote the opportunity to engage, listen and learn from our patients.

BCDD Projects – Closing statements at MARCH 2024.

P4.1: Clinical Practice Groups Six new pathways have been implemented to date. There are several factors that might hinder the achievement of implementing 10 new pathways by March 2024. These include ongoing industrial action, staffing capacity within the CPG team, delays in the EPR (Electronic Patient Record) process, internal surge incidents, and delays in divisional approval. Digitalization processes have been completed for 6 out of 9 pathways planned for year one pathways. For the remaining three pathways, the digitalized processes have been approved or are in the approval stage, with one of them scheduled to go live in April 2024. Patient co-production has been completed for the wheezy child pathway, and the engagement process is ongoing for the wheezy child discharge leaflet. Additionally, plans are in place to initiate a frailty co-production project in May 2024. A costing strategy has been completed and costing data for 18 pathways have been finalised. In summary, progress has been made in various aspects, including pathway implementation, digitalization, patient co-production, and costing strategy. Following the Hugh McCaughey Feb visit, 2024-2025 will see QI methodologies fully implemented into new and existing pathways.

P4.2: Theatre Productivity Programme The work to integrate the theatre productivity programme components into 'business as usual' has concluded. All relevant teams, including clinicians, theatre staff and ADMs et al, work together to ensure processes and policies are embedded and maintained. Factors such as the use of median times to more accurately plan operating lists and theatre start times continues. Comms and engagement are supporting elements of the programme. The continuation of the weekly Theatre Activity Group meetings, along with separate regular stakeholder engagement, enables processes and progress to be closely monitored. The organisation continues to utilise theatre productivity in excess of 80%.

P8.2: Business Case for the Enabling Works The Trust's redevelopment team has continued to work closely with the New Hospital Programme and to further develop work as part of the Outline Business Case process. During the course of the year, outline planning permission for the new Watford Hospital has been granted and the additional land to optimise the site also purchased. The Outline Business Case narrative has been updated and submitted in draft to the New Hospital Programme team. Enabling schemes are also progressing well, with work to create a new Pathology Essential Services Lab and to provide further inpatients beds in the Shrodells' building, with both completed by the autumn. These enabling schemes create new capacity so that existing buildings on the site of the new hospital can be demolished. Key priorities for the coming year will be: progress the overall design and complete supporting technical work; clear all buildings on the new hospital site ready for demolition; finalise the Target Operating Model.

P8.4: Expansion of Diagnostic Services at SACH On the St Albans site, work has commenced to deliver the regional Elective Care Hub with planning also well progressed to create additional diagnostic and endoscopy capacity. For Hemel Hempstead, an important feasibility study has been completed in partnership with the ICB and Dacorum Borough Council, as a result of which a new potential option to develop an Integrated Health Campus on the Market Square site will now be assessed in further detail, with this work being led by the ICB.

P8.5: Implement the Green Plan Since board-ratification in February 2022 good progress has been made on the actions within our Green Plan across the majority of our 9 key themes. Beyond what's been reported previously, work is now being undertaken in establishing a multi-organisational working group to create a climate-related Adaptation Plan. Alongside our EPRR colleagues, we are looking to work with the Public Health Team from Herts County Council as well as the ICB and Greener NHS Regional Team; this will enable the inclusion of regional, local and organisational perspectives. Further, plans are now in place for the creation of a "Green Speak-Up Challenge" which will ask WHTH staff to communicate opportunities for improved environmentally-sustainable practice. This is to interact with a Green Champions Network that will be suitably motivated, empowered and (possibly) incentivised to support the progression of this agenda.

West Hertfordshire Teaching Hospitals NHS Trust

Trust Board Meeting
04 April 2024

Title of the paper:	Fit and Proper Persons Test – new regulation implementation
Agenda Item:	20
Presenter:	Andrew McMenemy, Chief People Officer
Author(s):	Katie McGowan, Associate Director of People - Recruitment & Retention
Purpose:	*Please tick the appropriate box* *For approval*: *For discussion*: x *For information*: x
Executive Summary:	The purpose of this paper is to provide the board with an update regarding the new FPP regulation implementation. Following the Kark review 2019, NHS England have released a new framework which will introduce new elements to the Fit and Proper Persons testing compliance as of 31 March 2024. The Trust currently have 18 Board members who fall within the remit of the FPPT and remain complaint. Three Board members are newly appointed and are compliant with the new requirements. The remaining 15 Board members are due to renew their FPPT declaration in April, this will include the new requirements which is a DBS renewal, employment tribunal check and social medial check, in addition to the standard declaration and disqualified director checks. As part of the FPPT annual compliance, the Chair is required to countersign all declarations and submit a compliance report to NHS England. This report will be prepared by the Associate Director of People, Recruitment & Retention for submission early May 2024. This will continue annually. To support the changes to the FPPT regulation, the existing policy is being amended and there are set templates to support the compliance and reporting going forward. The new Leadership and Competency Framework was released 31 March 2024 outlining 6 domains all board members must follow, and this also forms part of annual appraisals. It is recommended an appraisal window is set that falls in line with the FPPT annual renewals and is included in the compliance report to NHSE. This paper therefore outlines the actions taken so far and to provide assurance of ongoing compliance with the new FPPT regulations.

Trust strategic aims: *(Please indicate which of the 4 aims is relevant to the subject of the report)*	<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><tr><td>  ***Objectives 1-4***</td><td>  ***Objectives 5-8***</td><td>  ***Objective 9***</td><td>  ***Objective 10-12***</td></tr><tr><td></td><td>*X*</td><td></td><td>*X*</td></tr></table>
Links to well-led key lines of enquiry:	☒Is there the leadership capacity and capability to deliver high quality, sustainable care? ☐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:	<table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td></td><td></td></tr></table>
Action required:	The Board is asked to receive this paper for information and assurance the Trust has implemented the required changes to remain compliant with the Fit and Proper Persons Test.

West Hertfordshire Teaching Hospitals NHS Trust

Agenda Item: 20

Trust Board Meeting 4 April 2024

Fit and Proper Persons Test – new regulation requirements

Presented by: Andrew McMenemy, Chief People Officer

1. Purpose

1.1 To update the board regarding the implementation of the new Fit and Proper Persons Test regulation.

1.2 To provide assurance regarding ongoing Fit and Proper Persons compliance.

2. Background

2.1 On 2 August 2023 NHS England released a new FPPT framework as a result of the recommendations made following the Kark review.

2.2 A report was presented to Board in September 2023 outlining the staged implementation of the new FPPT framework that is to be in place from 31 March 2024. This applies to all board members executive and non-executive:

- New appointments
- Acting / interim arrangements for 6 weeks or more
- Existing board members through an annual renewal
- Board member leavers.

2.3 New guidance and FPPT templates have been issued to support NHS organisations implement the process and a new FPPT policy is being created which is aligned to that of the ICB policy.

2.4 The last element of the FPPT framework has been released in March which is the new Leadership and Competency Framework for all board members.

3. Analysis/Discussion

3.1 The Trust currently has 18 Board members, 3 of which are new appointments and have been subject to the new requirements for the FPPT and are compliant. The remaining 15 Board members are complaint against the old framework but will commence the annual FPPT renewal under the new requirements from 1st April.

3.2 The Associate Director of People Recruitment & Retention will write to all board members by 1 April 2024 with instructions to complete the FPPT, which will include new elements:

- DBS renewal (NEW renewable every 3 years)
- Annual Employment Tribunal check (NEW)
- Annual Social Media checks (NEW)
- Annual FPPT Declaration (NEW proforma)
- Annual Disqualified Director check

3.3 In addition to annual FPPT checks, a compliance report will be provided to Board in May 2024 with a follow up compliance report submitted to NHSE in May 2024, as per new regulations.

3.4 The Chair is required to countersign all FPPT declarations and approve the compliance report for submission. This is co-ordinated by the Associate Director of People Recruitment & Retention.

3.5 The new Leadership Competency Framework (LCF) has now been released and all Board members must be assessed against this, and it must form part of the annual appraisal. NHSE recommend that an appraisal window should be set at the time of FPPT annual renewals in order to record compliance as part of this process.

4. Actions to Support Compliance

4.1 All relevant additions to the framework have been implemented to the selection process for any new board level appointments.

4.2 All existing Board members will be notified to complete their FPPT renewal with a deadline of mid-April.

4.3 A revised FPPT policy is being implemented to include all relevant templates.

4.4 Continued annual board reports outlining compliance plus a report submitted to NHSE using a set template signed off by the Chair.

5. Risks

5.1 The Trust risk being non-compliant if implementation of the new FPPT framework as set out in the regulation is not completed appropriately. This forms part of the “Well Led” domain under CQC.

6. Recommendation

6.1 The Board is asked to receive this paper for information and assurance the Trust will continue to act on the new regulation to remain compliant with the Fit and Proper Persons Test.

6.2 The FPPT annual renewal window will continue to take place every April, with a compliance report submitted to Board and NHSE every May.

6.3 The regulation recommends that appraisals are conducted as part of the FPPT annual renewal process as this forms part of the compliance report submitted to NHSE.

Andrew McMenemy
Chief People Officer

March 2024

NHS
West Hertfordshire Teaching Hospitals
NHS Trust

Trust Board in Public
04 April 2024

Title of the paper:	**NHS EDI Improvement Plan – High Impact Action 1**
Agenda Item:	21
Presenter:	**Andrew McMenemy, Chief People Officer**
Author(s):	**Kayleigh Rockett – Head of Staff Experience**
Purpose:	*Please tick the appropriate box* *For approval*: X *For discussion*: *For information*: X
Executive Summary:	The purpose of this paper is to provide assurance of work being done to achieve High Impact Action 1 from the NHS EDI improvement plan. This paper also seeks approval on the outlined objectives and actions. The paper includes, - Summary of High impact Action 1 - Actions, updates, and next steps The NHS EDI improvement plan builds on the People Promise and the People plan, using the latest data and evidence to identify six high-impact actions organisations across the NHS can take to considerably improve. To achieve and strengthen this objective, we have identified EDI objectives for the Board and actions, these will be taken forward by collaborative working with the director of governance to be measured by the Board Assurance Framework.
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*** — X **Aim 3 Best value** — ***Objective 9*** — **Aim 4 Great place** — ***Objective 10-12*** — X
Links to well-led key lines of enquiry:	☐Is there the leadership capacity and capability to deliver high quality, sustainable care? ☐Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☐Is there a culture of high quality, sustainable care? ☐Are there clear responsibilities, roles and systems of accountability to support good governance and management? ☐Are there clear and effective processes for managing risks, issues and performance?

	☐Is appropriate and accurate information being effectively processed, challenged and acted on? ☐Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☐Are there robust systems and processes for learning, continuous improvement and innovation? ☐How well is the Trust using its resources?
Previously considered by:	<table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td></td><td></td></tr></table>
Action required:	The Board is asked to receive this report for information and assurance of work being done to achieve High Impact Action 1 from the NHS EDI improvement plan. This paper also seeks approval on the outlined objectives and actions.

West Hertfordshire Teaching Hospitals NHS Trust

Agenda Item: 21

Trust Board

NHS EDI Improvement Plan – High Impact Action 1

Presented by: Andrew McMenemy, Chief People Officer

1. Purpose

The purpose of this paper is to provide assurance of work being done to achieve High Impact Action 1 from the NHS EDI improvement plan. The paper includes,

- Summary of High impact Action 1
- Actions, updates, and next steps

2. Background

The NHS EDI improvement plan builds on the People Promise and the People plan, using the latest data and evidence to identify six high-impact actions organisations across the NHS can take to considerably improve.

This improvement plan sets out targeted actions to address the prejudice and discrimination – direct and indirect – that exists through behaviour, policies, practices, and cultures against certain groups and individuals across the NHS workforce.

It has been co-produced through engagement with staff networks and senior leaders.

The plan:

- Sets out why equality, diversity, and inclusion are a key foundation for creating a caring, efficient, productive, and safe NHS
- Explains the actions required to make the changes that NHS staff and patients expect and deserve, and who is accountable and responsible for their delivery
- Describes how NHS England will support implementation
- Provides a framework for integrated care boards to produce their own local plans.

3. NHS EDI Improvement Plan

3.1 Summary

The EDI improvement plan supports the long-term workforce plan by improving the culture of our workplaces and the experiences of our workforce, including wellbeing, to boost staff retention and attract diverse new talent to the Trust.

1. Measurable objectives on EDI for Chairs Chief Executives and Board members
2. Overhaul recruitment processes and embed talent management processes

3. Eliminate total pay gaps with respect to race, disability, and gender
4. Address Health Inequalities within their workforce
5. Comprehensive induction and onboarding programme for international recruitment staff
6. Eliminate conditions and environment in which bullying, harassment and physical harassment occurs

All high-impact actions and success metrics can be seen below.

Following a self-analysis of the EDI improvement plan, we have created our own local improvement plan which aligns actions across reports including, WRES, WDES, and EDS. We have broken the improvement plan down into tangible actions that sit across the wider HR directorate. As a result, we have set up a High Impact action working group to remain on track and accountable for all actions. The updates against these actions will report to the EDI Steering Group.

3.2 High impact action 1

High-impact action 1 is measurable objectives on EDI for Chairs Chief Executives and board members. It is expected that all Trusts achieve their success metrics under this action by March 24.

Our proposed objectives on EDI for Board members divided between Executives and shared areas are:

Executive Board Members only objectives:

1. To act as a Staff Network Guardian/ sponsor for at least one Staff Network.
2. To commit to attending cultural celebration events throughout the year.
3. To participate in the Trust reciprocal mentoring programme.

Executive and Non-Executive shared objectives:

1. All are to complete mandatory EDI training and attend cultural awareness training.
2. All board members commit and demonstrate the Trust values and behaviours that enhance Equality, Diversity, and Inclusion.

To achieve and strengthen this objective, we have identified some initial actions as below, these will be taken forward by collaborative working with the director of governance to be measured by the Board Assurance Framework

Action	Update	Next steps
Objectives on EDI for Executives and Board members	Proposed objectives sent to CPO for review and comments.	Paper going to Board in April to discuss proposed objectives and seek approval.
CEO and CPO to have dedicated Staff Network meetings to create parity across network experience	To schedule with CEO and CPO to agree next steps.	
All staff network chairs are to be invited to an annual meeting with all board members to discuss the wider EDI agenda and support needed for their network		To agree / organise this with Director of Governance
Staff networks are to be periodically invited to present at PERC as part of staff stories, sharing experiences and updates from the network		
Develop roles and responsibilities for the Staff Network executive guardian	Roles and responsibilities of the staff network guardian have been included within the new Staff Network TOR and shared with network chairs.	To share with the board and any current/ new network guardians.

Trust Board Meeting
04 April 2024

Title of the paper	**Financial update M11 February**
Agenda Item	**22**
Presenter	**Rodney Pindai, Acting Chief Financial Officer**
Author(s)	**Rodney Pindai, Acting Chief Financial Officer**
Purpose	This report provides an overview of the Trust's financial performance after eleven months of the financial year
Executive Summary	**Introduction** This report provides an overview of the Trust's financial performance after eleven months of the financial year. It includes key information from detailed reports presented at the Trust's Finance and Performance Committee, summarising the performance against the initial plan and a revised forecast for the year. This revised forecast takes into account ongoing trends, the implementation of over 80 actions as part of a high impact financial change plan, and the effects of the Trust's £4.2m share of the £800 million allocated to the NHS to cover the costs of industrial action and changes to the Elective Recovery Fund (ERF) mechanism. Additionally, the report updates the Board on £15.2m change to the HWE ICB income and key elements of the Trust's balance sheet and the Trust's financial planning. **Deficit Drivers** In February 2024, the Trust's financial position delivered a £7.24m surplus against the in-month target of a £0.26m planned deficit. Therefore, actual performance was £7.5m better than plan. Year to date, after 11 months of the financial year, the Trust is reporting an actual deficit of £13.6m against a planned deficit of £5.8m. The in-month position was significantly improved by distribution of funding from the ICB. £15.2m was distributed in month of which £4.6m was already within the year-to-date position. This resulted in an in-month improvement of £10.6m. After allowing for the £10.6m in month improvement, the Trust would have delivered a £3.3m deficit in month (£7.24m actual surplus in month less £10.6m). The forecast in month position was to have a deficit of £0.6m. Therefore, on a like for like basis, the month 11 position was £2.7m away from forecast. £2.7m adverse movement to forecast is comprised of: 1. £1m worth of cost related to unplanned Industrial action 2. £1.4m slippage against CIP delivery (schemes identified were not cash releasing) 3. £0.1m slippage against the high impact change

4. elements of non-recurrent costs netting to £0.2m after being partially offset by a HEE income benefit.

Revenue Spending Analysis
Analysis of the I&E account shows that the drivers of excess spending have manifested in overspends in various areas, with year to date medical staff pay (£8m), nursing and healthcare assistant costs (£9.8m), and unidentified savings (£8.1m) being the major drivers of the overspend.

Agency spending has now totalled £12.9m which is above the year-to-date target of £11.4m at M11. There is now an increased focus on temporary staffing spend and retention and is a primary focus of WEG (workforce efficiency group).

Revised forecast and industrial action effects
The receipt of funding from the ICB consisted of national support for the industrial action costs and regional support for ICB providers. The receipt of funding meant that the trust was required to reduce its year end forecast by a similar amount, this has resulted in a revised projected 2023/24 forecast of £9.3m at year end based on the H2 plans submitted in November 2023.

The Trust has highlighted a £4.2m risk to the forecast position at M11 resulting from pressures noted above. Mitigations are currently being worked through alongside the HWE ICB and system partners.

Elective income
The ERF qualifying elective income after month 11 is valued at 98% of the adjusted value of our activity in 2019/20. The Trust had downturn in ERF performance in December and January due to industrial action but the year to date trend has been an improvement on the previous financial year. The forecast ERF over performance is £2.0m for the year.

Cost Improvement Programme
The Trust aimed to reduce gross budgets by £13.5m over the eleven months to February of 2023/24. Efficiency delivery for this period was £11m, of which £6.8m was cash releasing and £4.2m cost avoidance and recovery of overspends.

The Trust aimed to develop savings projected to reach £13.5m boosted by the High Impact Financial Change Programme. One of the challenges experienced by the Trust from December through to the current month February was the anticipation that all cost avoidance work will improve forecasts.

There is therefore a risk that the introduced cost avoidance measure does not contribute to slowing spend as expected and contributes to the forecast risk noted above.

Divisional Oversight
Overspending issues are primarily concentrated in three divisions, with the Surgery Division, Medicine Division, and Emergency Division exceeding their planned costs.

The Emergency Division has committed to limit their overspend, although challenged by increased ED attendances and the need to maintain patient access performance targets. The Medicine and Surgery Divisions requested

adjustments to reflect additional costs expected over the second half of the year. Discussions continue to ensure that the Trust's agreed year end forecast is met.

Enhanced controls

In light of the ongoing financial challenges, Chief Officers addressed all managers to emphasise the necessity of introducing additional financial controls beyond those we had already put in place this year via the High Impact Change Programme.

Chief Officers commended the commitment and hard work shown in working to make our Trust as efficient as possible and the efforts in safeguarding the well-being of patients while striving for efficiency have been noticed and applauded.

However, at this juncture, Chief Officers and all staff have intensified efforts to tighten financial controls.

For example:

- The default for the non-clinical vacancy control panel will be to not recruit to fill vacancies with substantive, bank, or agency staff.
- Junior doctor deployment by area will be regularised.
- The Chief and Deputy Chief Nurses review all bank bookings every day.
- The Chief Nurse and Chief Financial Officer will review bank bookings every week.
- Ward nurses' recruitment will be added to the clinical vacancy control panel and chaired by the Chief Operating Officer

Balance Sheet and capital expenditure

At the end of the eleventh month, the Trust's cash balance is £10.9m, boosted by PDC drawn down to support approved nationally supported capital schemes including the purchase of a land plot to support the new hospital development. The Trust has enhanced its cash flow forecasting building in the timing if the effects of the financial recovery programme to test cash flow management options.

The total capital expenditure for the year 2023/2024 is expected to exceed £71.2m, with funds coming from a variety of sources including depreciation charges, the Trust's internal cash balance, and additional funds from nationally approved business cases. However, inflationary pressure and costing delays have led to changes in the original plans, necessitating discussions about adjusting the timetable and distribution of spending between 2023/24 and 2024/25 for various schemes. Additionally, schemes that were started in 2022/2023 and were expected to be funded by local capital are facing inflationary and regulatory cost pressures, leading the Trust's capital finance planning group to revise the programme for local schemes and defer some schemes until additional capital funds become available.

Financial Plan and Business Plan

The Divisional Business Planning Meetings Phase 1 for all the Divisions for the ensuing financial years have now been completed. The Phase 2 of the Business Planning Meetings with the Divisions are scheduled for March and April 2024.

Full details of the 2024/25 business plan will be included in the business planning paper for this Board next month.

Conclusion/ Summary

This report provides an overview of the financial performance of the Trust after eleven months of the financial year. It includes key information from detailed reports presented at the Trust's Finance and Performance Committee, summarising the performance against the initial plan and a revised forecast for the year.

Year to date, after 11 months of the financial year, the Trust is reporting an actual deficit of £13.6m against a planned deficit of £5.8m. This deviation from the initial plan is attributed to several factors, including emergency pressures, extra costs of industrial action, mental health patient management, unfunded pay and non-pay inflation, delayed cost improvements, higher expenditure on theatre support staff, and increased outsourcing of care.

Highlighted areas of overspending include medical staff pay, nursing and healthcare assistant costs, and unidentified cost improvement programmes. The report also addresses the effects of industrial action on elective income and the challenges faced by the Trust in reducing gross budgets during industrial action.

The report reveals that overspending issues are primarily concentrated in three divisions - Surgery, Medicine, and Emergency. However, discussions are ongoing to ensure the Trust's agreed year-end forecast is met. The report notes a change to the HWE ICB contract to support these pressures.

Considering the financial challenges, Chief Officers have called for enhanced financial controls, including additional measures to control non-clinical vacancies, regularise junior doctor deployment, and review bank bookings.

The Trust's cash balance is reported to be £10.9m, with total capital expenditure for the year expected in the region of £71.2m. The financial plan aims to establish a system-wide approach, with assumptions for activity projections, performance targets, funding mechanisms, inflation costs, and capital expenditure.

9Trust strategic aims

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

Links to well-led key lines of enquiry

☐Is there the leadership capacity and capability to deliver high quality, sustainable care?
☐Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
☐Is there a culture of high quality, sustainable care?
☐Are there clear responsibilities, roles and systems of accountability to support good governance and management?
☐Are there clear and effective processes for managing risks, issues and performance?
☐Is appropriate and accurate information being effectively processed, challenged and acted on?

	☐Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☐Are there robust systems and processes for learning, continuous improvement and innovation? ☐How well is the trust using its resources?
Previously considered by	<table><tr><th>Committee/Group</th><th>Date</th></tr><tr><td></td><td></td></tr></table>
Action required	The Board is asked to note the contents of this report.

NHS
West Hertfordshire Teaching Hospitals
NHS Trust

Month 11 Finance Report

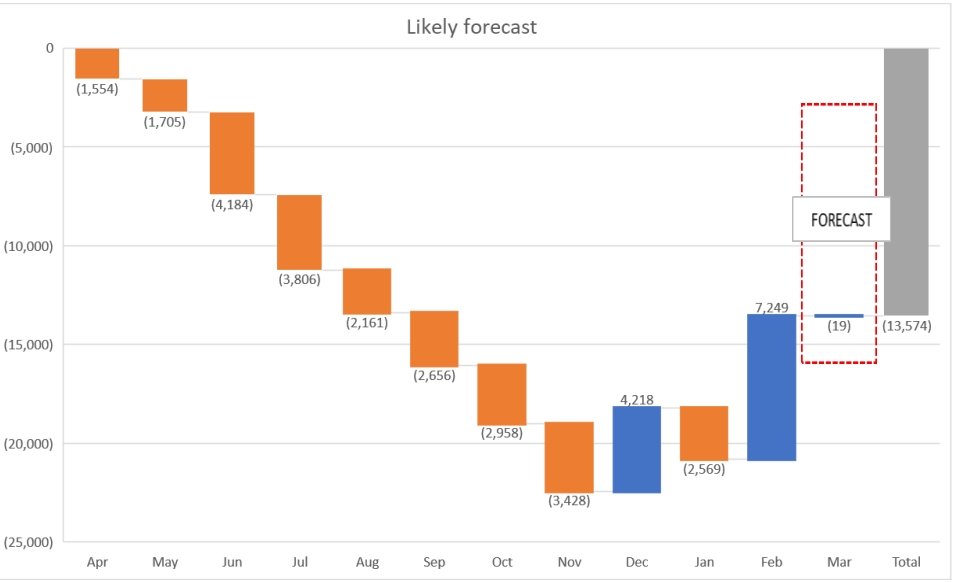
February 2024

Rodney Pindai – Acting Chief Financial Officer

February 2024 - The I&E account reports an £13.6m YTD deficit, however there is increased underlying pressure.

West Hertfordshire Teaching Hospitals NHS Trust

Trust Definition	Expense Type	Annual Budget	In Month (£000s) Budget	In Month (£000s) Actual	In Month (£000s) Variance	Year to Date (£000s) Budget	Year to Date (£000s) Actual	Year to Date (£000s) Variance
Income	Divisional Income	43,359	3,626	-420	-4,046	38,118	44,204	6,086
	NHS Revenue	462,982	38,114	55,323	17,209	424,388	449,027	24,639
Income Total		**506,341**	**41,740**	**54,903**	**13,163**	**462,506**	**493,231**	**30,725**
Pay	Medical Pay	-95,394	-8,099	-9,069	-970	-87,425	-95,441	-8,016
	Non-Clinical Pay	-60,577	-5,129	-5,163	-33	-58,780	-56,725	2,054
	Nursing Pay	-99,398	-8,348	-9,145	-797	-91,143	-98,114	-6,972
	Other Clinical Pay	-37,410	-3,151	-3,159	-8	-34,289	-37,209	-2,920
	Scientific, Technical & Profes	-31,977	-2,733	-2,766	-33	-29,340	-30,276	-937
	Pay Unidentified CIPs	6,027	1,047	0	-1,047	5,200	0	-5,200
Pay Total		**-318,729**	**-26,413**	**-29,301**	**-2,888**	**-295,776**	**-317,767**	**-21,991**
Non Pay	Clin Supp Serv	-30,667	-2,571	-3,112	-541	-28,208	-32,239	-4,032
	Drugs	-25,953	-2,207	-2,439	-232	-23,869	-26,873	-3,004
	OTHER (NON CLIN)	-110,049	-9,386	-10,014	-628	-100,723	-104,889	-4,165
	Non Pay Unidentified CIPS	3,763	730	0	-730	2,920	0	-2,920
	Recharges	0	0	0	0	0	0	0
Non Pay Total		**-162,907**	**-13,436**	**-15,566**	**-2,130**	**-149,881**	**-164,001**	**-14,120**
Other Expenditure	Financing Charges	-24,706	-2,149	-2,787	-638	-22,639	-25,018	-2,378
Other Expenditure Total		**-24,706**	**-2,149**	**-2,787**	**-638**	**-22,639**	**-25,018**	**-2,378**
Month 11 Grand Total		**0**	**-257**	**7,249**	**7,506**	**-5,790**	**-13,554**	**-7,764**



February 24 saw the Trust's financial position deliver a £7.24m surplus against the in-month target of a £0.26m planned deficit. Therefore, actual performance was £7.5m better than plan.

- Year to date, after 11 months of the financial year, the Trust is reporting an actual deficit of £13.6m against a planned deficit of £5.8m. The in-month position was vastly improved by distribution of funding from the ICB.
- £15.2m was distributed in month of which £4.6m was already within the year-to-date position. This resulted in an in-month improvement of £10.6m.
- After allowing for the £10.6m in month improvement, the Trust would have delivered a £3.3m deficit in month (£7.24m actual surplus in month less £10.6m).
- The forecast in month position was to have a deficit of £0.6m. Therefore, on a like for like basis, the month 11 position was £2.7m away from forecast.
- £2.7m adverse movement to forecast is comprised of: £1m worth of cost related to unplanned Industrial action, £1.4m slippage against CIP delivery (schemes identified were not cash releasing), £0.1m slippage against the HICP, and elements of non-recurrent costs netting to £0.2m after being partially offset by a HEE income benefit.

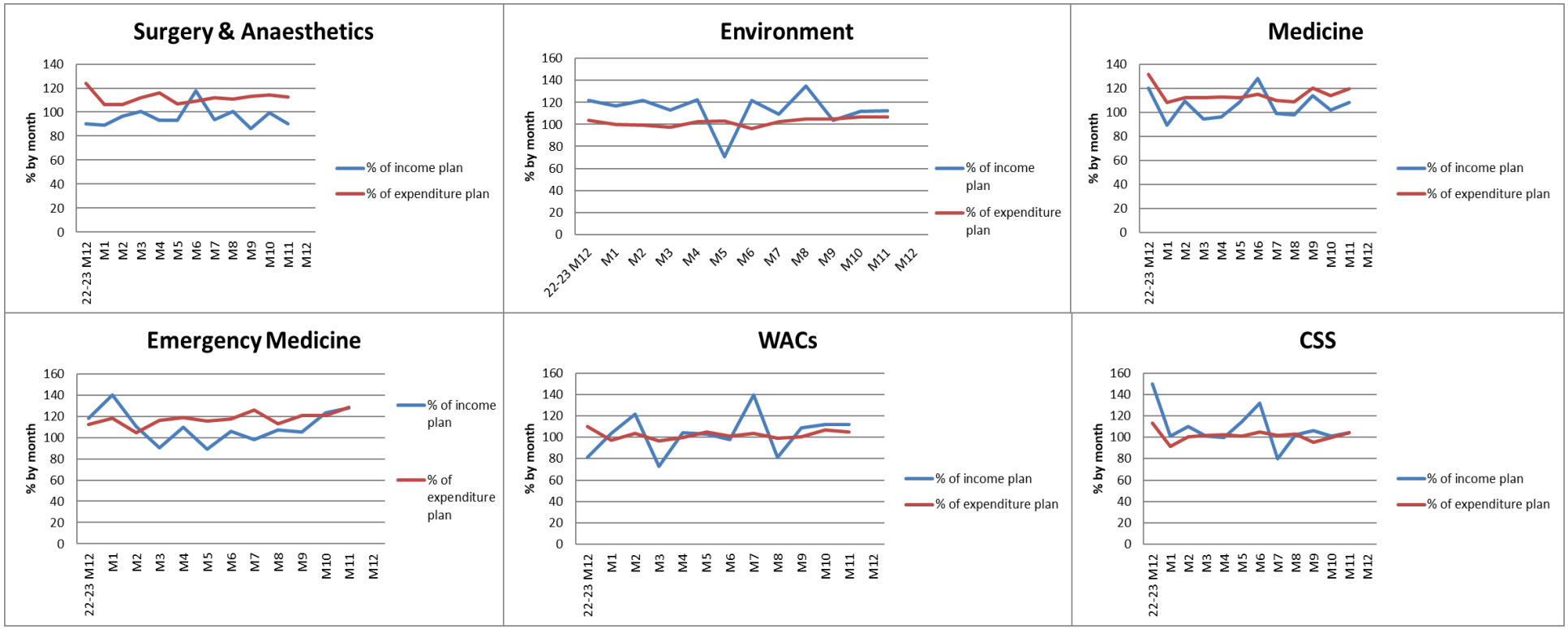
Year End Forecast: The receipt of funding from the ICB consisted of national support for the industrial action costs and regional support for ICB providers.

The receipt of funding meant that the trust was required to reduce its forecast outturn by a similar amount, **this has resulted in a revised forecast outturn of £9.3m at year end**.

The Trust has highlighted a £4.2m risk to the forecast outturn position at M11. Mitigations are currently being worked through alongside the ICB

All Divisions are challenged to ensure expenditure does not exceed plan and patient activities match plan.

West Hertfordshire Teaching Hospitals NHS Trust



Year to date – February 2024.

The graphs summarise Trust Divisions' income and expenditure targets, striving for income at 100% of plans and spending below 100%.

Ideally, income exceeds expenditure. Environment CSS, and WACS Divisions largely meet these criteria.

Medicine, Emergency Medicine and Surgery Divisions are not meeting these criteria and have been set overspending limits based on recovery actions as a result.

All Divisions are challenged to ensure expenditure does not exceed plan and patient activities match plan.

West Hertfordshire Teaching Hospitals NHS Trust

Month 11 Divisional position - in-month and year to date

		In Month (£000s)			Year to Date (£000s)		
Division	Annual Budget	In Month Budget	In Month Actual	In Month Variance	YTD Budget	YTD Actual	YTD Variance
Surgery & Anaesthetics	4,958	663	-1,246	-1,909	4,121	-9,492	-13,613
Medicine	21,257	1,674	722	-951	19,183	10,740	-8,443
Womens & Children	19,158	1,545	1,982	437	17,496	20,461	2,965
Corporate	-78,200	-6,304	-5,660	644	-71,996	-71,498	498
Environment	-45,792	-4,104	-4,355	-251	-41,714	-42,286	-572
Emergency Medicine	15,826	1,208	1,533	325	14,218	11,709	-2,509
Clinical Support	-9,959	-655	-676	-21	-9,115	-8,474	641
All non-divisional (Capital/Reserves/Trust Income/ICS Pathology)	72,753	5,716	14,948	9,232	62,018	75,286	13,269
Grand Total	**0**	**-257**	**7,249**	**7,506**	**-5,790**	**-13,554**	**-7,764**

Expenditure run-rate (Pay & Non-Pay)

	In Month Actual (£000s)											YTD Actual (£000s)
Division	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M1-11
Surgery & Anaesthetics	-8,169	-8,335	-9,442	-9,243	-8,550	-9,471	-9,023	-8,841	-8,647	-9,009	-8,755	**-97,485**
Medicine	-8,713	-9,527	-10,101	-9,946	-9,637	-10,528	-10,536	-9,442	-10,123	-9,890	-10,503	**-108,947**
Womens & Children	-3,587	-3,830	-3,810	-3,763	-3,911	-4,070	-3,864	-3,619	-3,689	-3,878	-3,824	**-41,846**
Corporate	-7,532	-7,260	-8,402	-8,171	-8,168	-7,812	-8,370	-8,070	-7,464	-7,573	-7,384	**-86,206**
Environment	-3,933	-3,906	-4,276	-3,900	-4,040	-3,805	-4,231	-4,420	-4,730	-4,810	-4,781	**-46,833**
Emergency Medicine	-4,159	-4,111	-4,605	-4,345	-4,328	-4,658	-4,511	-4,067	-4,001	-4,304	-4,545	**-47,634**
Clinical Support	-4,486	-4,885	-5,284	-4,752	-4,811	-5,156	-5,004	-4,902	-5,110	-5,104	-5,029	**-54,523**
All non-divisional (Capital/Reserves/Trust Income/ICS Pathology)	528	-926	1,423	38	126	-106	316	93	134	124	-45	**1,707**
Expenditure Total	**-40,050**	**-42,781**	**-44,498**	**-44,082**	**-43,319**	**-45,605**	**-45,223**	**-43,269**	**-43,629**	**-44,445**	**-44,867**	**-481,767**

The Trust will experience an inflation pressure of c.6.5% compared to the 4.8% funding received in year - (weighted estimate of the cost uplift factor).

West Hertfordshire Teaching Hospitals NHS Trust

Cost type	*% of cost base*	Forecast Inflation %		Funded Inflation %		Unfunded Inflation (%)
		Inflation	Weighted inflation	Inflation	Weighted inflation	
Gas	*2%*	61%	1.40%	5.50%	0.10%	1.30%
Electricity	*3%*	44%	1.30%	5.50%	0.20%	1.10%
Facilities	*9%*	12%	1.00%	5.50%	0.50%	0.60%
IT / EPR	*8%*	8%	0.70%	5.50%	0.40%	0.20%
Drugs	*17%*	1.60%	0.30%	1.30%	0.20%	0.10%
Other Non-pay	*61%*	3%	1.80%	5.50%	3.30%	-1.50%
Total Non-pay	***100%***		**6.50%**		**4.80%**	**1.70%**

The table provides a granular analysis of the key drivers of the inflationary pressures identified by key cost category.

It compares a forecast for inflation (based on actual cost pressures identified by the Trust) to the formula inherent in funding the Trust's cost inflation.

Please note given pay pressures are known and are generally totally funded, the main risk lies with non-pay inflation (as such pay inflation has been excluded from this).

See the appendix (**slide 6**) for a detailed breakdown of the unfunded inflation %

Inflation of 6.5% will create an unfunded cost pressure of 1.7% which equates to c.£2.6m.

West Hertfordshire Teaching Hospitals NHS Trust

Appendix – Analysis of the inflationary pressures

Detailed Operating Expenditure (excluding Pay)	% of Cost base	Forecast inflation	Detailed Weighted Inflation	Funding received based on Cost Uplift factor in tariff	Weighted Funded Inflation	Unfunded Inflation	Source of Forecast Inflation rate assumed
Gas	**2.30%**	**61%**	**1.40%**	5.50%	0.10%	**1.30%**	Inflation rate based on price projections supplied
Electricity	**3.00%**	**44.00%**	**1.30%**	5.50%	0.20%	**1.10%**	by Crown Commercial Services, the trust's
Facilities	**9%**	**11.80%**	**1.00%**	**5.50%**	**0.50%**	**0.60%**	
Linen & Laundry	1.30%	11.40%	0.20%	5.50%	0.10%	0.10%	Analysis of Mitie contract provided by HOF (VF)
Cleaning Domestic	3.70%	11.40%	0.40%	5.50%	0.20%	0.20%	Analysis of Mitie contract provided by HOF (VF)
Cleaning - IHSS	1.10%	13.80%	0.10%	5.50%	0.10%	0.10%	Based on contract
Portering	1.00%	11.40%	0.10%	5.50%	0.10%	0.10%	Analysis of Mitie contract provided by HOF (VF)
Catering	1.70%	11.40%	0.20%	5.50%	0.10%	0.10%	Analysis of Mitie contract provided by HOF (VF)
IT / EPR	**8.10%**	**8.20%**	**0.70%**	**5.50%**	**0.40%**	**0.20%**	
IT Infrastructure contract	2.90%	5.00%	0.10%	5.50%	0.20%	0.00%	Discussion with HOF, Review of Contract
IT (Software/ Computer hardware & software)	3.50%	10.00%	0.40%	5.50%	0.20%	0.20%	Discussion with HOF, Review of Contract
EPR Licence	1.70%	10.00%	0.20%	5.50%	0.10%	0.10%	Analysis of Cerner Contract
Drugs	**17.00%**	**1.60%**	**0.30%**	**1.30%**	**0.20%**	**0.10%**	
Other Non-pay	**61%**	**3%**	**1.80%**	**5.50%**	**3.30%**	**-1.50%**	
Transport	0.30%	1.50%	0.00%	5.50%	0.00%	0.00%	As per published CPI Analysis
Premises - other	2.60%	4.00%	0.10%	5.50%	0.10%	0.00%	Discussion with HOF & review of contracts
Premises - BR	1.00%	0.00%	0.00%	5.50%	0.10%	-0.10%	Review of invoice received in 2023/24
Education & Training - Non Staff	1.40%	3.20%	0.00%	5.50%	0.10%	0.00%	Official National Statistics
Maintenance Contract	3.40%	5.50%	0.20%	5.50%	0.20%	0.00%	Discussion with HOF & review of contracts
Outsourcing Costs	6.10%	1.80%	0.10%	5.50%	0.30%	-0.20%	PBR
Supplies & services Clinical	21.20%	3.00%	0.60%	5.50%	1.20%	-0.50%	Based on report provided by procurement
Purchase of Healthcare from NHS Services	1.90%	1.80%	0.00%	5.50%	0.10%	-0.10%	PBR
Consultancy	1.10%	5.70%	0.10%	5.50%	0.10%	0.00%	Discussion with HOF & review of contracts
Audit fees & Other Remuneration	0.10%	0.00%	0.00%	5.50%	0.00%	0.00%	
Clinical negligence	14.50%	1.80%	0.30%	5.50%	0.80%	-0.50%	As per letter received from NHS Resolution
Other Costs	7.20%	7.60%	0.50%	5.50%	0.40%	0.10%	Weighted average inflation rate uplift
Total Non Pay (including drugs)	**100.00%**		**6.50%**		**4.80%**	**1.70%**	

M11 February 2024 – Balance Sheet

West Herts NHS Trust

As at 29th February 2024

Statement of financial position	Opening Bal £'000	YTD £'000	FOT £'000
Non-current assets			
Intangible assets	21,363	19,657	19,657
Property, plant and equipment: other	294,247	343,290	355,359
ROU Assets	12,761	11,604	11,604
Receivables: due from non-NHS/DHSC group bodies	3,033	3,075	3,075
Total non-current assets	**331,404**	**377,626**	**389,695**
Current assets			
Inventories	5,800	5,910	5,910
Receivables: due from NHS and DHSC group bodies	15,532	27,457	27,457
Receivables: due from non-NHS/DHSC group bodies	12,374	12,675	12,675
Cash and cash equivalents: GBS/NLF	35,372	10,907	3,983
Cash and cash equivalents: commercial / in hand / other	21	67	17
Total current assets	**69,099**	**57,016**	**50,042**
Current liabilities	0		
Trade and other payables: capital	(17,974)	(4,406)	(4,406)
Trade and other payables: non-capital	(51,123)	(51,613)	(31,086)
Provisions	(1,129)	(1,090)	(1,090)
Other liabilities: deferred income including contract liabilities	(1,134)	(2,919)	(2,919)
ROU Lease Liability	(1,467)	(1,349)	(1,349)
Total current liabilities	**(72,827)**	**(61,377)**	**(40,850)**
Total assets less current liabilities	**327,676**	**373,265**	**398,887**
Non-current liabilities			
Provisions	(7,461)	(7,669)	(7,215)
Borrowings	(2,000)	(2,000)	(2,000)
Other liabilities: deferred income including contract liabilities	(3,641)	(3,594)	(3,594)
ROU Lease Liability	(11,232)	(10,382)	(10,382)
Total non-current liabilities	(24,334)	(23,645)	(23,191)
Total net assets employed	**303,342**	**349,620**	**375,696**

Financed by	Opening Bal £'000	YTD £'000	YTD £'000
Public dividend capital	577,106	618,545	627,139
Revaluation reserve	76,560	72,647	72,647
Income and expenditure reserve	(350,324)	(341,572)	(324,090)
Total taxpayers' and others' equity	**303,342**	**349,620**	**375,696**

The key changes to the balance sheet involve payment of capital creditors outstanding at the end of the 22/23 year and a reduction in cash balances.

At Month 11 February the Trust's cash balance is £10.9m

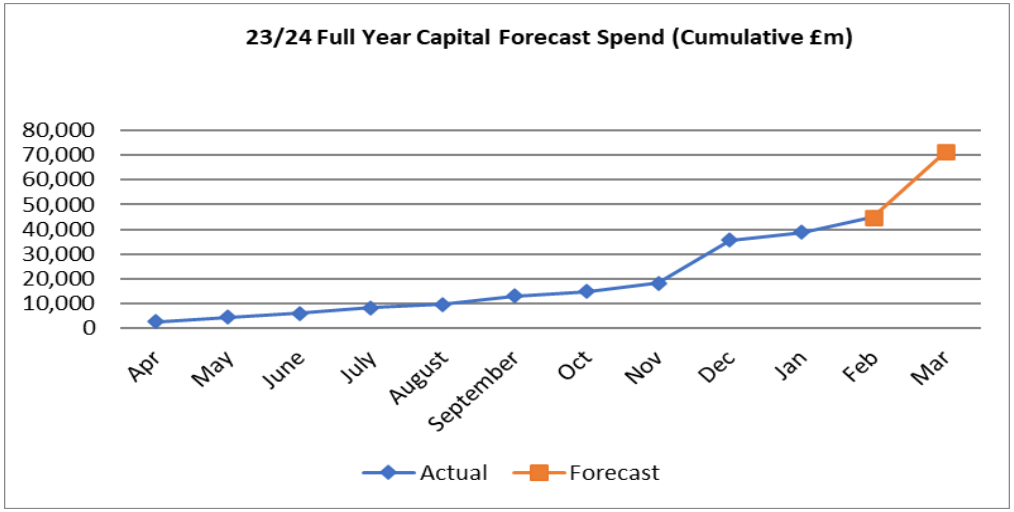
Key impacts to the cash balance position include payments made to large creditors, and the deficit in income and expenditure accumulated over the year.

Current assets have reduced because of cash used to settle capital creditors and fund the revenue deficit. The decrease in capital creditors has resulted in reduced liabilities.

The increase in fixed assets is due to capital expenditure, offset by depreciation.

Success with the high-impact financial change plan should help the Trust avoid borrowing as we progress into 24/25.

2023/2024 Capital Expenditure



The total capital expenditure sources for the year 2023/2024 are expected to be circa £71.2m.

This includes £18.8m plus £2.9m for the elective care hub that has been authorised by the ICS to be spent from depreciation charges and the Trust's internal cash balance. The remaining balance of the will come from additional funds (PDC) that are made available through nationally approved business cases.

Inflationary pressure on the capital programme and costing delays have caused changes in the original plans. The sums of money that were initially expected to be sufficient and spent in accordance with national expectations will now need to be adjusted.

The Trust is currently in discussions regarding the timetable and distribution of spending between 2023/2024 and 2024/2025 for schemes such as the endoscopy suite at St Albans, and the community diagnostic centre SACH.

Year to date capital expenditure is £44.8m with the aim to spend up to £71m for the financial year.

Schemes that were started in **2022/2023** and were expected to be funded by local capital are also facing inflationary and regulatory cost pressures.

This means that only the schemes that have already started are expected to fully utilise the local capital programme.

The Trust's capital finance planning group, which includes representatives from all divisions, has agreed to revise the programme for local schemes and has identified the schemes that should be deferred until additional capital funds become available.

West Hertfordshire Teaching Hospitals NHS Trust

Trust Board Meeting
04 April 2024

Title of the paper:	The new WHTH Strategy 2024-2029 and Accountability Framework
Agenda Item:	23
Presenter:	Toby Hyde, Chief Strategy & Collaboration Officer Kelly McGovern, Chief Nurse
Author(s):	Toby Hyde, Chief Strategy & Collaboration Officer Kelly McGovern, Chief Nurse
Purpose:	*Please tick the appropriate box* *For approval*: X *For discussion*: *For information*:
Executive Summary:	This paper presents Board our new five-year Strategy and the new Accountability Framework for approval. **Strategy:** The document builds on the paper presented to board in December 2023 outlining the proposed future direction for the organisation. The following document now sets out an overarching vision for the organisation of 'Excellent patient care, together', a new set of values and a more detailed strategy document incorporating a wealth of feedback from staff, partners and patients, and a detailed measurement framework to track progress on delivery. The new strategy outlines the three strategic aims (the 'whats') 1. Provide safe, high quality, timely and sustainable care 2. Redevelop our hospitals for patients and staff 3. Design and deliver services with our local partners And three ways we intend to achieve them (the 'hows') 1. Embed improvement in everything we do 2. Clinical and wider collaboration across teams and organisations 3. Maximise data and technology opportunities The full strategy document is included in this paper. **Accountability framework:** This document sets out the overarching accountability framework to drive and assure delivery of organisational strategy and performance goals at West Hertfordshire Teaching Hospitals NHS Trust. This accountability framework is a key component of Trust's management system, which comprises of the systems, processes, structures and supporting arrangements in place to ensure appropriate oversight and engagement in all areas of performance, to support the achievement of the Trust's strategic priorities and meeting regulatory standards. Our accountability framework will support us in achieving our vision of delivering 'excellent patient care, together' and will set the foundations to enable the organisation to:

	• Provide safe, high quality and sustainable care • Prepare and empower staff when they transfer into our newly developed hospitals • Enable our workforce to design and deliver services with our local partners. The framework describes how a tiered process will be utilised to ensure that a rigorous, supportive and consistent accountability approach is achieved at all levels of the organisation. The full accountability framework is included in this paper.
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 — Date: 7 December 2023
Action required:	The Trust Board is asked to: • Review and approve the Trust's Strategy 2024-2029 • Review and approve the Accountability Framework

23

NHS
West Hertfordshire Teaching Hospitals
NHS Trust

Our strategy

2024-2029

Excellent patient care, together

Empowered Compassionate Professional Inclusive

Contents page

Introduction from the Chair and Chief Executive

It is a privilege to lead the West Hertfordshire Teaching Hospital NHS Trust. We are surrounded by talented, committed and compassionate colleagues who strive every day to provide excellent care to the patients we serve.

This strategy sets the Trust's ambition for improving everything we do with, and for, our patients, colleagues and partners. We are setting ourselves high expectations with major projects, including building a brand-new hospital at Watford. But we are also focusing on the everyday care for individual patients and delivering brilliant basics in everything we do.

Thank you to everyone who helped shape the strategy and the refresh of our vision and values; which we are launching alongside the strategy. Hundreds of people have contributed thousands of ideas, and our plans are better for it.

Our simple new vision is **Excellent patient care, together**. And our new values are to be **empowered, compassionate, professional and inclusive.** They capture an important balance across what we must all do as individuals and to support others.

Delivering this strategy will be a team effort, and in doing so, we must pay attention to strengthening a culture where everyone feels empowered to drive change; feels pride in what they deliver; and feels able to share their views and express their true self.

We are confident that we will rise to the challenges across strategy and culture, because we see the amazing work our colleagues do every day and how they are continuously improving how we care for patients, how we support colleagues and how we work with partners. Examples of our achievements include the award-winning work on virtual hospitals; our rapid progress on robotic surgery; the successful roll-out of a new electronic patient record; achieving Teaching Hospital status; improving patient journeys through our hospitals; and supporting staff wellbeing.

We could list many more examples of the positive difference our West Herts teams make every single day, but we will close by saying thank you to everyone for your continued commitment and we look forward to working with you on this exciting new chapter in the Trust's story.

Our vision, values and priorities

Excellent patient care, together

Empowered

We are all listened to and are accountable for what we do. We achieve our potential through continuous learning, teaching and education.

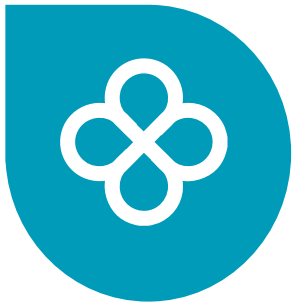
Compassionate

We care about patients and colleagues. We always support each other and show kindness by considering the impact of our actions and decisions.

Professional

We set high standards for ourselves and others, delivering brilliant basics every day. We are calm, measured, fair and respectful; and commit to continuous improvement.

Inclusive



We value diversity and individuality in all its forms. We actively seek contributions from patients, partners, and colleagues. We speak out against discrimination.

What we need to do

- Provide safe, high quality, timely and sustainable care
- Redevelop our hospitals for patients and staff
- Design and deliver services with our local partners

How we need to do it

- Embed improvement in everything we do
- Clinical and wider collaboration across teams and organisations
- Maximise data and technology opportunities

Who we are

About us

West Hertfordshire Teaching Hospitals NHS Trust has over 5,800 staff and volunteers working across four locations to provide care for over 600,000 people living in and around Watford, Three Rivers, St Albans, Harpenden, Dacorum and Hertsmere. We provide emergency and planned care across more than 50 specialities. A range of more specialist services also support people living in North London, Bedfordshire, Buckinghamshire and East Hertfordshire.

We gained Teaching Hospital status in 2021 and have bold ambitions to deliver training and education for the next generation of clinicians.

Key facts and statistics

Over 5,800 staff

600,000 people

More than 50 specialities

We are part of the New Hospital Programme and will be building a new Watford General Hospital during the life of this strategy.

23.1

Every day we take care of **500** people through our urgent and emergency care services, see **1,900** people in our outpatient clinics and undertake **70** operations across all of our sites.

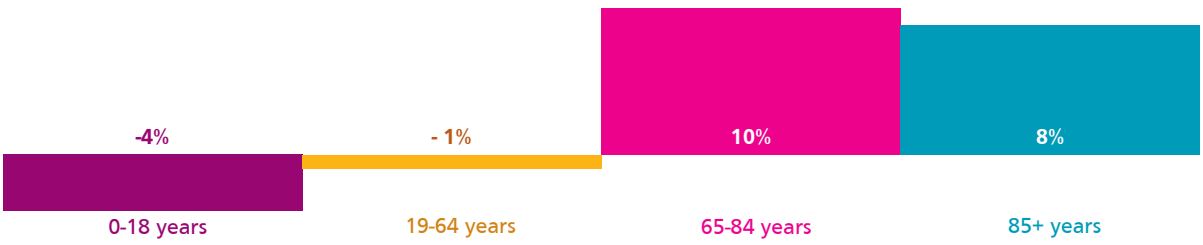
The population we serve

West Hertfordshire Teaching Hospitals NHS Trust is part of a wider health and care system covering Hertfordshire and West Essex, our Integrated Care System (ICS) covering around 1.6 million people.

Over 90% of the services we provide are for our local catchment population of 600,000, which broadly sits within the Dacorum, Hertsmere, St Albans, Three Rivers, and Watford district boundaries. In developing our strategy, we are grateful for the expert advice of our public health colleagues at Hertfordshire County Council who have shared insights on our local population profile and how that is expected to change:

- The population is slightly younger and more diverse that other areas of Hertfordshire and West Essex Integrated Care System.
- The deprivation levels are low on average, with some more affluent areas and some areas with higher levels of deprivation, contributing to poorer health outcomes. For example, women in the most deprived areas live 5.25 years fewer compared to the least deprived. For men the difference is even greater at 6.95 years. This is primarily caused by deaths from cancer and cardiovascular diseases.
- The population will become more ethnically diverse over time and increasingly better at using digital tools.
- There will be a significant shift to a higher proportion of people aged over 65 (graph below) and the number of people living in more deprived areas. These two trends will lead to increased demand for health services, especially for urgent and emergency care.

Population forecast by age group in our catchment area (2024–2029), % growth



The district boundaries

What we have learnt

Our priorities for 2024-2029 build on the many successes from our previous strategy, as well as insights from our teams, patients and partners about how we might need to adapt to the shifting context within health and care both locally and nationally.

Building on solid foundations

We look to the future with confidence as we build on significant successes in recent years.

Approved a clinical model in May 2022, outlining how services will be delivered across Watford, St Albans and Hemel Hempstead, after which we have:

- Secured the Government's commitment to funding a new hospital in Watford.
- Progressed proposals for an Elective Care Hub at St Albans in partnership with other acute hospitals in Hertfordshire.
- Explored options in Hemel Hempstead, working across NHS and council services to deliver improved services and regenerate the town centre.

Improved services within the Trust and in partnership with other NHS providers, including:

- Introduced a new virtual hospital service at the height of the pandemic in 2020 that has grown to be a nationally recognised and an award-winning example of best practice.
- Successfully introduced robotic surgery in 2022, becoming one of the fastest growing robotic surgery centres in the UK and a specialist centre for training the surgeons of the future.
- Transformed how we manage patient journeys through the hospital to improve both patient care and staff wellbeing, reducing unnecessary delays.
- Improved theatre utilisation and productivity from 65% to 84%, enabling us to treat more of the patients on our waiting list with the same resources.

Investment in our workforce and our learning and development offer, including:

- Reduced vacancies across medical, nursing and support roles.
- Developed a work experience pilot and enhanced volunteering opportunities.
- Introduced a new leadership development programme and wider career development initiatives.
- Improved support for staff wellbeing and a greater focus on equality, diversity and inclusion.

Invested in our workforce and our learning and development offer, including:

- Introduced an Electronic Patient Record in 2021.
- Launched an online patient portal and online notes for our maternity service in 2023.
- Upgrades of all computers to improve performance and security.

Greater collaboration with patients to drive service improvement, including:

- Established a sensory experience group in 2021.
- Continued work to expand the diversity of our patient panel.
- Launched a Caring for Carers service in 2022.
- Expanded the use of patient surveys and focus groups.

Progressed our Green Plan as we work towards net zero, including:

- Adopted alternatives to an environmentally harmful anaesthetic gas.
- Upgraded LED lighting across our sites.
- Adopted the Green Kitchen Standard.

Developing our strategy together

To develop this strategy, we worked closely with patients, carers and families, along with our own staff and partners. This helps set a strategic direction that will more effectively meet the needs of the population we serve and create a sense of shared ownership and accountability for delivery. The following strategy reflects what we have heard:

Listening to our patients and the public:
We reviewed service user feedback (friends and family test, patient experience surveys, feedback from carers partnership group) as well as discussed priorities with Healthwatch and other groups representing patients and the public.

Service users put emphasis on:

- Communications between patients and staff: providing sufficient information, considering cultural sensitivity, courtesy and respect, being transparent about waiting times and managing expectations of patients and carers.
- Inpatient experience: a pleasant ward environment, timely discharge, working with carers, wider family and out of hospital services.
- Caring staff: sufficient support, highly skilled and capable workforce.
- Transport / access to sites: location of services and parking availability including drop-off and disabled spaces.
- Digital access / use of shared care records: positivity on modernisation and use of technology, alongside caution on not excluding those without digital access and security of personal information.
- Equitable access to care, particularly for people from ethnic minority backgrounds.
- Integration between physical and mental health care offers.

Listening to our staff:
We engaged our staff through online sessions, face-to-face drop-ins at all sites, and surveys. We collected views from more than 500 staff. In addition, we held diagnostic sessions with each division to understand the problems we need to address strategically. Finally, we established a Strategy Advisory Group with representatives from various departments across the Trust to review the feedback received and to sense check the consistency of the new strategy with wider staff experiences.

Our staff highlighted:

- The fundamental importance of investing in supporting our staff, recognising the pressure our colleagues have been under over recent years and the impact the pandemic has had on staff wellbeing, including their physical and mental health.
- The impact of sustained demand for urgent and emergency care, which has led to more frequent enactment of surge policies which negatively impacts our ability to provide best care and can result in staff being moved between departments to keep our patients safe.
- The importance of staff finding time to identify and work together on sustainable improvements to address our challenges.

- The difficulties associated with under investment in our estate and the challenges that poses to staff providing care to our patients. As we progress with our redevelopment plans, we need to ensure we manage current issues with our estate to enable our services to continue to deliver for patients.
- The need to work with system partners to deliver integrated services which are fit for future demands – our organisation should demonstrate leadership, facilitate sharing of best practice and help establish clear responsibilities.

Listening to our system partners:
As we work towards an increasingly joined-up way of providing health and care across the system, we must align our strategy with our partners. The priorities in this strategy reflect challenges we must address in partnership. They rely on joint working for strategic decision making, on issues like our redevelopment programme, and operational delivery, on issues like patient journeys through the hospital and developing more community-based services.

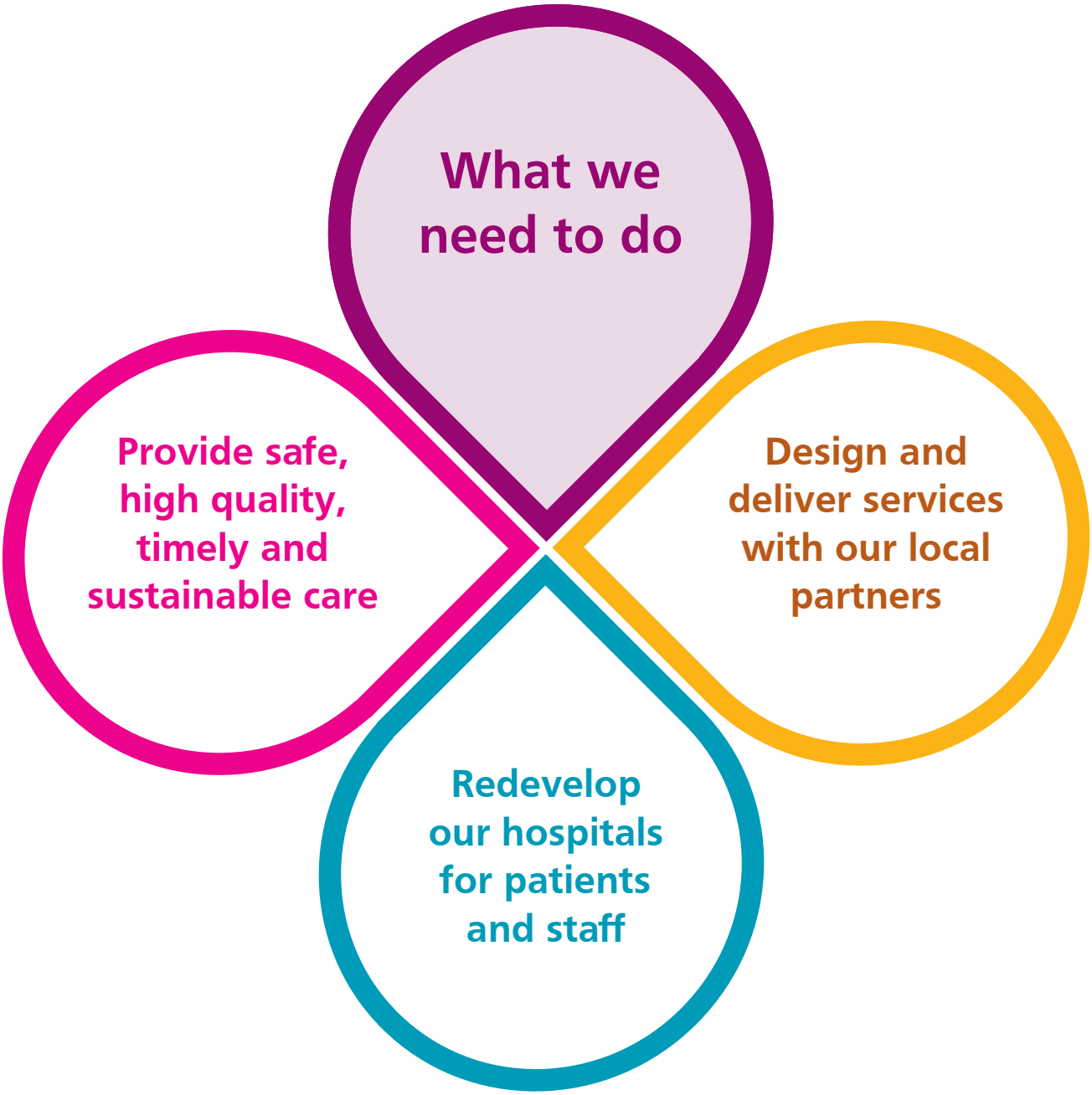
In developing this strategy, we met with a wide range of partners across Hertfordshire and West Essex to share our emerging ideas, discuss priorities and seek feedback. Our partners highlighted:

- That we have continued to improve how we work together with partners in the local system to support our patients, for example working with our colleagues in adult social care to help our patients get home as soon as they have finished treatment in hospital.
- Our continued efforts with our colleagues in the education sector to help develop the workforce of the future, for example through our partnership with West Herts College.
- The importance of working effectively with partners across the system, and with our local community, to address the wider determinants of health and to understand and respond to inequitable outcomes, for example in different ethnic groups, more deprived communities, or people with learning disabilities.
- The importance of continuing to invest in our joint work with primary care colleagues through the primary-secondary care partnership group, enabling us to work together to fix issues affecting our patients as they move between different parts of the health and care system.
- The need to be ambitious in working with District Council and Voluntary Sector partners on prevention, helping to keep people well and reducing the need for future reliance on hospital services.

Considering our opportunities over the next five years:
Besides these challenges, there are also opportunities we should capitalise on:

- We know our greatest asset are the 5,800 colleagues working across our services. Attracting, retaining and developing people with the passion, skills and experience to provide excellent care to our patients will need to be a fundamental strand of our strategy over the next five years.
- The announcement that our proposals for the rebuild of Watford General Hospital will be fully funded represents a huge opportunity for the Trust, our staff and most importantly for our local community.
- We are starting to see major shifts in the application of data and technology to the delivery of health care, from predictive algorithms enabling us to intervene and support patients before they become acutely unwell to robotic surgery that minimises complications and promotes speedy recovery.
- We are fortunate to work with a range of fantastic partner organisations, within the Hertfordshire and West Essex Integrated Care System and further afield. In particular, we have close working relationships with our colleagues at the Royal Free, University College London, Guys and St Thomas, Imperial Healthcare and Great Ormond Street Hospitals. This enables our patients to access world-leading specialist care and provides training and education opportunities for our staff. Harnessing the benefits these relationships can have for our patients and staff is an important consideration for our strategy.

Our strategic priorities



Priority 1

Provide safe, high quality, timely and sustainable care

Strategic objectives

❶ Develop a safety and learning environment where staff are empowered to share their concerns and feel reassured that organisation will respond.	❷ Support our staff to excel in their role and provide excellent care to patients.	❸ Improve the journeys of patients through our urgent and emergency care services and our productivity of planned care services.	❹ Continue to develop and run sustainable services – financially, clinically and environmentally.

We will seek to deliver the best possible outcomes for our patients by providing services that our staff are proud of. This means creating the culture and environment where our teams are supported to achieve our vision of Excellent patient care, together.

❶ Develop a safety and learning environment

We want to drive higher standards of care for our patients. We recognise that a strong safety and learning culture is fundamental in pursuing this. We have many examples of excellence, but like the rest of the NHS, we sometimes see examples of poor culture and behaviour. As a Trust we must acknowledge that and focus on making improvements.

Over the duration of this strategy, we will:

Embed a Quality Improvement (QI) approach across all levels of the organisation, in line with the national priority to adopt the NHS IMPACT[1] approach .
This means:

- Adopting a consistent methodology that works for West Herts.
- Utilising data and observations generated through tests of change and pilots.
- Leadership demonstrating unwavering commitment to safety and visible support for improvement initiatives.
- Developing clear, well-defined protocols for common procedures and processes, ensuring consistency and accuracy in care delivery.
- Supporting the delivery of QI through a core team, improvement leads, QI coaches and fellows.

[1]Improving Patient Care Together (NHS England, 2023)

Case study:
Frailty pathway

Evidence shows that the longer patients spend in hospital, the more likely they are to become deconditioned, making recovery and regaining independence more difficult. This especially applies to older, frail patients. We have introduced a multi-disciplinary team to help identify these patients as soon as they arrive and help them get home as quickly as possible by fast tracking key test results, timely transportation and referral to the Frailty at Home service. The multidisciplinary frailty team now reviews over 200 patients a month, and discharges almost 70% of the patients on the same day with appropriate care packages back to their normal place of residence. In the first three quarters of 2023/24 the frailty service reduced occupied bed days at Watford General Hospital by 4,761 days.

Empowering teams to make decisions and improve the care they deliver, supported by a clearer Accountability Framework. This means:

- Delegating accountability and responsibility to divisional and service teams alongside the support to deliver.
- Nurse leadership setting standards for patient safety and creating an environment of trust.
- Moving away from a command-and-control approach towards a Management System that works for us at West Herts.

Adopt the Patient Safety Incident Reporting Framework. This means:

- Demonstrating compassionate engagement and involvement of those affected by patient safety incidents.
- Applying a system-based approach to learning from patient safety incidents.
- Responding proportionately and considerably to patient safety incidents.
- Ensuring early detection and intervention for deteriorating patients to improve outcomes and reduce avoidable harm.
- Providing supportive oversight.

Embed the principles of speaking up, listening up and following up. This means:

- Promoting an environment where all staff feel empowered to report concerns and incidents without fear of reprisal.
- Fostering transparent and open communication enabling us to identify areas for improvement and prevent future errors.

Foster collaboration amongst all staff groups – support services, allied health professionals, nurses, midwives and doctors. This means:

- Promoting interdisciplinary working and shared accountability for patient safety.

❷ Support our staff

Evidence shows that investing in our colleagues and creating a positive working environment improves services for patients[2]. To deliver the wider ambitions of this strategy, we must attract, develop and retain a talented workforce. This will mean developing a culture that is inclusive and committed to the wellbeing of all colleagues, supports innovation and improvement and contributes to the highest standards of care.

Over the duration of this strategy, we will:

Use our refreshed values and behaviours to create a more inclusive and compassionate environment that actively supports improved staff wellbeing. This means:

- Demonstrating our values at all levels of our organisation, making them visible in the way we work together and communicate and being honest when we fall short.
- Embedding the refreshed values and behaviours in organisational processes from recruitment to appraisals and talent management.

Attract and retain the best local talent and further develop our reputation as a centre of excellence for development. This means:

- Working with University of Hertfordshire, West Herts College and other prominent partners in education, and system partners, on attracting local residents into training and roles in health and care services.
- Realising the benefits associated with our Teaching Hospital status. This will be driven by our Education Strategy, focusing on becoming a true learning organisation, empowering staff, embracing innovation and developing our talent.
- Introducing a new clinical research facility with protected time for research activities and develop joint roles with universities and colleges. In the later years of this strategy, we will consider when and how to progress with our ambition to gain University Hospital status.
- Implementing digital development passports that can be utilised across the system to support broader staff development and seamless work of teams across organisational boundaries.
- Adopting new roles which extend across traditional professional boundaries, e.g. clinical associates, advanced care practitioners.
- Implementing succession planning for key roles in the Trust and developing our pipeline of future leaders across clinical and non-clinical roles.
- Strengthening career opportunities for advanced data and analytical roles reflecting the importance of harnessing the potential of artificial intelligence to improve how we plan, target and deliver health care for our population.

[2]The relationship between leader support, staff influence over decision making, work pressure and patient satisfaction: A cross-sectional analysis of NHS datasets in England. (West, T.H.R.; Daher, P.; Dawson, J.F. et al., 2022).

Case study:
End Sexism in Medicine

We believe that creating a great place to work is one of the best ways to ensure that we look after our employees, and our staff networks are critical in helping us to achieve this. The End Sexism in Medicine Network provides support and practical solutions to tackle sexism affecting predominantly female doctors.

One way we have reduced instances of staff being misidentified and not having their role or seniority recognised is through the use of a colour-coded lanyards. After the introduction of the lanyard scheme, 65% of female doctors at our Trust reported improvement in how they were addressed. Since then, the British Medical Association has recommended the adoption of the colour-coded lanyard scheme to other trusts across the NHS.

Continuously strive to ensure everyone feels welcome, included and supported in achieving their full potential. We will address discrimination – direct and indirect – through behaviour, policies, practices and cultures. This means:

- Demonstrating inclusive and compassionate leadership behaviours, proactively advocating the inclusion agenda and challenging unwanted behaviours.
- Building an inclusive, anti-discriminatory workplace by combatting racism, bullying, discrimination and harassment.
- Improving proportional representation of ethnicity, gender, disability and sexual orientation in all roles and bands.
- Debiasing recruitment and access to development to drive career progression, leadership, and promote diversity of thought.
- Continuing to invest in staff health and wellbeing to reduce health inequalities, increase resilience, and engagement.
- Fostering collaborative relationships across the Trust.

Support teams through change and difficult times. This means:

- Offering a comprehensive physical and mental health support package, focusing on psychological safety.
- Working with the West Herts Hospitals Charity to grow our workforce wellbeing initiatives.
- Building digital literacy skills to adapt to the new ways of working.
- Developing estates, environment and IT capabilities to align with future requirements of the new hospitals.

Engage our staff and listen to them. This means:

- Strengthening our approach to staff engagement with more visibility, transparency and more innovative and accessible ways to share information and receive feedback.
- Improving our transparency of decision-making.

❸ Improve patient journeys through our urgent and emergency care services and our productivity of planned care services

In recent years we have seen higher levels of activity, traditionally associated with winter, become the norm throughout the year. This has meant sustained pressure on services which has a negative impact on patient care and staff wellbeing. Looking at population changes alone, by 2030, annual visits to our emergency department are expected to rise by 2,500, the emergency admissions by 1,500 and emergency bed days by 15,000. We are building more capacity with our new hospital, but we must also change how we work to ensure efficiency in planned and unplanned care across our services.

We have made good progress, with new approaches helping to shift our response from using surge beds to focussing on improving patient journeys through our hospitals.

This is fundamental to addressing issues raised by our patients and staff, helps to ensure our services are safe, and provides an excellent patient experience. It also means we have the capacity we need in our hospitals to deliver planned care services and tackle the backlog that now exists after the pandemic.

What are the different stages involved in improving patient journeys through our hospitals?

23.1

Over the duration of this strategy, we will:

Deliver excellent services within the available capacity. This means:

- Continuously improving patient journeys through our hospital by adopting national best practice and using a patient-centred approach where all involved in a patient's care understand their contribution to the patient journey.
- Working with system partners to continue to transform services outside of the hospital, in line with available capacity before and after the opening of the new Watford General Hospital.
- Developing our Stage 3 Control Centre with real-time patient tracking and prescriptive response planning capabilities – linked with partner organisations within the ICS.
- Adopting sophisticated demand-capacity modelling approaches to inform strategic and tactical resource allocation decisions.
- Work with our partners at Hertfordshire Partnership NHS Foundation Trust and the wider system to support people suffering from a mental health crisis, combining our expertise to ensure we are addressing the physical and mental health needs of the population that we serve.

Deliver excellent services consistently seven days a week. This means:

- Enhancing weekend capacity, with a particular focus on patient pathway bottlenecks.
- Embedding increasing levels of consistency in the way we run our services during the week and at weekends.

Achieve and sustain improved productivity, especially in our planned care pathways. This means:

- Ringfencing elective capacity to limit disruptions to elective pathway, including through our new elective care hub at St Albans.
- Maximising our elective capacity through improved scheduling of theatre sessions and outpatient clinics, high session /clinic utilisation, reduced cancellations, and reduced length of stay through innovations such as same-day discharges for orthopaedic procedures.
- Utilising AI tools in diagnostic imaging and administrative processes to free up capacity to treat our patients.

Maximise opportunities offered by digital tools. This means:

- Maintaining the country-leading status of the Virtual Hospital by continuously expanding the scale and impact of our Virtual Hospital offer and adopting increasingly advanced remote monitoring tools.
- Coordinating the majority of patient interactions through the patient portal: booking, rescheduling, cancelling, tracking appointments, accessing health information, interacting with care team through direct chat.
- Deliver care virtually as the first option, where both appropriate and requested by the patient.

Case study:
Control Centre

Within the last six months, the Trust has created a centralised operational hub, allowing for better patient journeys throughout the hospital using live data.

This hub provides coordination of data, co-located operational staff, better prediction of upcoming pressures and the ability to enact faster decision making. This operational hub facilitates the management of emergency and electives admissions, ward movements and discharges. Staff have access to real time data of where patients are, highlighting outliers, surge and bed capacity to improve patient safety.

This enables efficient capacity management to get the right patient, to the right bed, at the right time.

"The establishment of the Control Centre enables 24/7 control and observation of patient flow in, around and out of hospital in a timely, efficient and safe manner. The Control Centre is pivotal in the ability of the Trust to provide the best experience for our patients and staff on a daily basis"
– Control centre staff

❹ Develop and run sustainable services

Sustainable services are firstly about delivering great service quality and excellent patient safety. We can only provide that if we deploy our resources effectively, develop the right service offer at appropriate scale, and create a predictable environment for our teams to work within for the long-term. For the five years of this strategy, we need to re-look at how we maximise the value of our limited resources and deliver services that are financially, clinically, and environmentally sustainable.

The Trust has a good track record of consistently delivering efficiency improvements since 2020. At the time of publication, we are on track to deliver £12m through our efficiency programme in 2023/24. We must build on this as we face an extremely challenging medium-term financial outlook for the NHS, both nationally and locally.

We will have to work with our system partners to tackle our clinical sustainability challenges by looking for shared solutions to address the most challenged specialties and seek to repatriate services from outside of our system where it improves access and quality for our patients.

We are also committed to improving environmental sustainability and continue to strive to meet the NHS's national decarbonisation commitments of achieving net zero by 2040 for the emissions we control and by 2045 by those associated with our wider supply chain.

Over the duration of this strategy, we will:

Operate financially sustainable services. This means:

- Setting budgets informed by demand-capacity modelling.
- Managing budgets effectively at all levels of the organisation, enabled by the integration of finance and workforce data into high quality management information, supported by robust governance processes.
- Implementing a rolling 3-5-year business planning produced in collaboration with system partners.
- Maximise efficiency opportunities offered by digital technologies, for example using voice recognition to support note taking within clinical settings.
- Maximising value for money of our non-pay procurement activities through collaboration with ICS partners.

Operate clinically sustainable services that meet the demand of our local population, are consistently delivered at excellent quality, and are supported with required staffing. This means:

- Working with ICS partners to address unsustainable services where we cannot achieve consistency.
- Seeking to repatriate services that our patients have to travel further afield for, where it works better for the patients and the system.
- Achieving a well-balanced mix of generalist and specialist skillsets and empowering all clinical roles to act at the top of their license.

Operate environmentally sustainable service by minimising our carbon footprint. This means:

- Incorporating sustainable practices and social-value/ net-zero requirements in our tenders.
- Redeveloping our hospitals with net-zero, green space and biodiversity-duty commitments.
- Delivering of our Green Plan including decarbonising our fleet, increasing our capacity for onsite energy generation, decarbonising our heating systems, decommissioning piped nitrous-oxide infrastructure, minimising medication wastage, challenging and re-evaluating habitual practices that are wasteful.

Priority 2

Redevelop our hospitals for our patients and staff

Strategic objectives

❶ Redevelop Watford General Hospital into a new state of the art acute and specialist care facility.	❷ Redevelop St Albans City Hospital to focus on planned surgery and diagnostics.	❸ Redevelop Hemel Hempstead services to provide chronic and complex care to our population, working alongside partners.	❹ Continue to ensure we maintain our current estate across all sites.

We confirmed our future clinical model in May 2022 and are progressing with our redevelopment plans across each of our major sites, at Watford General Hospital, St Albans City Hospital and Hemel Hempstead.

The three streams will be active projects throughout the period of this strategy. The complexity of the programmes and dependencies on national and local policy decisions will influence our delivery plans.

Up-to-date information on progress will be provided on our website.

❶ Redevelop Watford General Hospital

The new Watford site will act as a catalyst for the redesign of services across our local health and care system. It is central to our wider Watford Health Campus vision, where we will seek to co-locate services that will benefit our local population, offer improved key worker accommodation, develop bioscience infrastructure and offer excellent training and education facilities.

Over the duration of this strategy, we will:

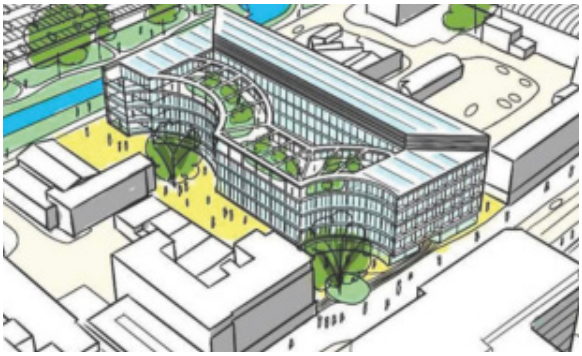
Bring the construction of the new Watford General Hospital close to completion. This includes:

- Entering the commissioning phase of the programme.
- Implementing decant plans – clearing the site for construction and relocating affected services.

Prepare our staff to maximise the benefits of the new site. This means:

- Develop and prepare to deliver the new operating model associated with / enabled by the new hospital, including new ways of working, improved patient pathways, clinical and digital innovation.

Develop and deliver our plans for the remainder of the Watford site.



❷ Redevelop St Albans City Hospital

St Albans City Hospital will be the focus for our planned surgery and diagnostics. This will improve patient experience through better access and reduce elective waiting lists and cancellations.

Over the duration of this strategy, we will:

Build a system-wide facility for elective surgery (Elective Care Hub) and diagnostics (Community Diagnostics Centre).

Expand endoscopy services offered in St Albans.

Consolidate urology services on the St Albans site.

❸ Redevelop Hemel Hempstead services

Hemel Hempstead will become a focal point for chronic and complex care, working alongside partners in other NHS and social care services as an example of the benefits the maturing Health and Care Partnership offers.

Over the duration of this strategy, we will:

Work with Dacorum Borough Council and other partners to find the best long-term solution between the current site and the town centre.

Progress with the redevelopment planning, develop the Final Business Case (FBC) and agree funding mechanisms.

❹ Maintaining our current estate

Before the redevelopment schemes are complete, we must continue to manage our current estate to ensure services continue to run smoothly.

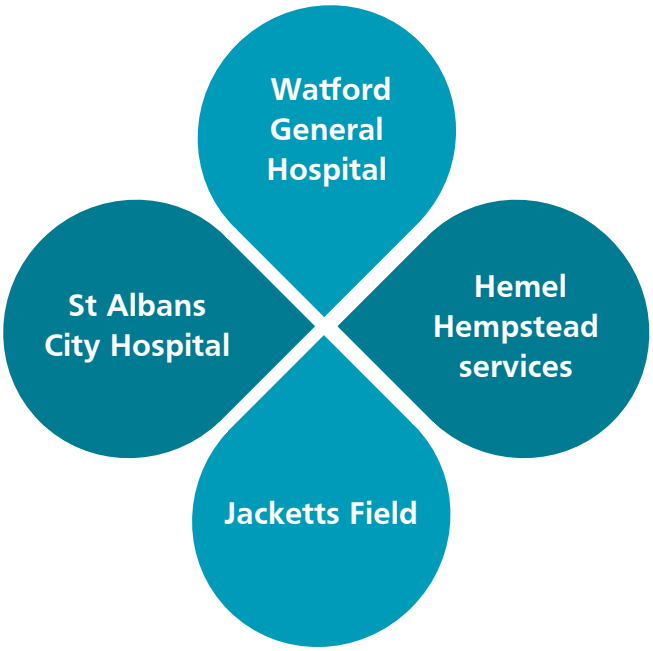
Over the duration of this strategy, we will:

Develop and implement our Estate Strategy.
This means:

- Comprehensively assessing our current assets.
- Establish a long-term vision for the configuration of our estate, which reflects and supports the clinical strategy.
- Making strategic decisions to invest, maintain or close down parts of our estate, informed by a clear focus on patient and staff wellbeing and with reference to the redevelopment timelines.

Maintain a proactive maintenance approach which minimises urgent incidents, improves staff experience and quality of care.

Work with West Herts Hospitals Charity to improve the environment we work in, including wellbeing spaces, green spaces, arts and comforts for staff.



Priority 3

Design and deliver services with our local partners

Strategic objectives

❶ Develop and deliver our vision for place-based care.	❷ Devolve decision making.	❸ Shift to preventative and proactive model of care.

Responding to changes in underlying population need, capitalising on new technologies and treatments, developing the workforce of the future and addressing underlying health inequalities.These are all major challenges for health and care services and can only be tackled through working together with our community and partners across the local system.

We have developed a Health and Care Partnership (HCP) serving local people living in and around Watford, Three Rivers, St Albans, Harpenden, Dacorum and Hertsmere. The HCP builds on successful collaborations with our partner organisations including the Integrated Care Board (ICB), Central London Community Healthcare NHS Trust (CLCH), Hertfordshire Community Trust (HCT), primary care, District and Borough Councils and the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector. This has enabled the HCP to establish successful integrated working through new and innovative models of care such as the Integrated Discharge Teams and the Virtual Hospital. The HCP Board has been expanded to include primary care and District Council partners in recognition of their essential role in supporting population-based health and care and addressing the wider determinants of health.

We have agreed an ambitious vision to become **'a single team, responsible for planning, improving and delivering population-based health and care services for the population of South and West Hertfordshire, delivered through a locality working model'.**

We will also contribute to the delivery the ambition outlined in the ICS Joint Forward Plan 2024-2029[3] - reduced health inequalities, integration of services and preventative care.

❶ Develop and deliver our vision for place-based care

We have made significant progress on improving services, driven by previous clinical strategies that lifted the Trust out of special measures and moved many of our services to a Good Care Quality Commission rating. As we look ahead to the challenges we face over the next 5-10 years, we know success will depend on continuing leadership by clinical and care professionals and working in collaboration; both across our own services and in partnership with other health and care providers.

Over the duration of this strategy, we will:

Co-develop and co-deliver the HCP's clinical and care strategy with system partners and our patients. This means:

- Detailing services delivered across the HCP and by each partner organisation (number of patient contacts by method of delivery and service).
- Working closely with system partners to identify opportunities for transforming primary and community services to enhance proactive and preventative care, including providing care within and close to home.
- Supporting the HCP in describing and delivering its future clinical and care operating model and working together to achieve this agreed model over the duration of this strategy.
- Agreeing how we collectively resource the change required to delivery our vision of a population-based health and care services and initiate delivery through an annual, shared planning cycle.
- Engaging our patients, hearing what is important to them in our new clinical model and addressing drivers of health inequalities – all building on the foundations of the co-production board.
- Working with West Herts Hospitals Charity to build community partnerships and raise money for HCP-wide programmes that improve the quality of care.

[3]Hertfordshire and West Essex Joint Forward Plan 2024-2029 [DRAFT]

Case study:
Virtual Hospital

In 2020, we opened the first Virtual Hospital in the UK to care for patients with COVID-19. Since then, this service has been successfully extended to heart and respiratory conditions and is considered a national exemplar. Patients who would have otherwise been admitted are instead monitored remotely and receive at home care if required.

Treating patients in the Virtual Hospital has clinical benefits such as, decreased risk of deconditioning, fewer hospital-acquired infections and maintaining a safe and familiar environment for the patient. Between April 2023 and February 2024, we treated almost 5,000 patients, saved an estimated 4,500 bed days and scored on average 9/10 on patient experience questionnaires. Our Virtual Hospital is delivered with our partners Central London Community Health Care (CLCH) and is an example of how innovative clinical collaboration can be used to support patients to deliver fantastic results.

'I am writing to thank you all for the support, dedication and care that I have been given. The nursing staff all go that extra mile to make this experience a positive one. They are friendly, helpful and carry out their responsibilities with much humour. I get the privilege to talk every day to them or one of the doctors. Time is never rushed and their listening skills are superb. Through all of this I get to be at home where recovery is, in my opinion, easier. Thank you, thank you, thank you. You are fantastic.' – Patient feedback to PALS

'I don't know how long the virtual hospital has been going for but for me I could not praise it enough, I could recover in my own home comforts, at the same time knowing I would have the nurse and or doctor call me daily and my readings were being kept an eye on. This must be more cost- effective way of doing things than having a stay in hospital and for me the healing process is quicker.'
– Patient feedback to PALS

Introduce a single service planning approach within the HCP. This means:

- Understand population health needs for each locality.
- Understand available resources and capacity to meet current population health needs and identify gaps in capacity and opportunities for transformation.
- Sharing safety, quality, performance and business information with our partners.
- Working towards shared goals with aligned incentives.
- Leveraging our network of partnerships to deliver coherent, joined up clinical services that meet our population's needs. This will include continuing our strong collaborative working with HCP partners to deliver services in the most appropriate settings.

Embed population health management approach and use of data. This means:

- Identifying gaps in service provision and health inequalities, and designing interventions to close these shortfalls, including those addressing wider determinants of health.
- Understanding the impact of our services and that of our partners to health outcomes of our local population. This will include indirect impacts and long-term impact on health and care outcomes.

❷ Devolve decision making

The Hertfordshire and West Essex ICB has agreed that HCPs will be more effective in identifying opportunities, solving problems and improving health and care outcomes for our residents than single organisations working alone. As a result, the ICB operating model is changing to break down barriers between commissioners and providers, working together in new ways to share responsibility for improving services and outcomes. The HCP is evolving its operating model to promote collaboration in problem solving and improving health and care outcomes.

Over the duration of this strategy, we will:

Work with the Hertfordshire and West Essex NHS Integrated Care Board to enable the devolution of decision-making and associated resources to our Health and Care Partnership. This means:

- Working through our localities and empowering front-line teams to work across organisational boundaries.
- Balancing the implementation of ICS-wide models of care with local interventions identified at HCP and locality-level to ensure we are responsive to our local population's health and care needs.

Establish our Trust as a host provider for health and care services in the HCP. This means:

- Supporting the Health and Care Partnership Board to take on delegated formal accountability for quality, safety, operational and financial performance of health services for our population.
- Establishing the underlying relationships, ways of working and enabling contracting agreements to facilitate a move to place-based working.

Support the establishment of Integrated Neighbourhood Teams (INTs) within each of our localities, providing same-day access, chronic and complex care and preventative care with our partners in the HCP. This will mean enabling INTs to identify and deliver local priorities for transformation alongside acting as the delivery arm for system-wide priorities.

Proactively sharing information on safety, quality, performance and finance to enable the HCP to identify opportunities for collaboration and improvement across the HCP.

❸ Shift to preventative and proactive model of care

There is overwhelming evidence showing that if we invest in supporting people to live healthy lives and access early support when they do become unwell, we can significantly reduce the chances of repeated and unplanned visits to hospital, and the impact that has on individuals, their family and on the services we provide.

National guidance such as the Fuller stocktake[4] provides a blueprint for how we can move to a more holistic, joined up health and care system, as well as a wealth of good practice examples from across the NHS in England.

Over the duration of this strategy, we will:

Seek to become an exemplar site for this more proactive, preventative way of working. This means:

- Delivering health and care services that build on proactive outreach into communities.
- Working with partner organisations, including District and Borough Councils and the VCFSE sector to improve access and experience to underserved citizens.
- Delivering better care within the physical and workforce constraints within the HCP.

Work with partners across the HCP to support the development of communities and environments that promote healthy lifestyles.

Use data and digital tools to manage population health. This means:

- Maximising the value of the Hertfordshire and West Essex Shared Care Record and improving our demand management capabilities (improved workflow, automated alerts, population risk segmentation, etc.).
- Expanding our patient portal functionality to include digital care plans and a suite of self-care tools.
- Establishing a single, integrated health and care platform for our Health and Care Partnership, providing seamless access to patients, carers and care teams to enable joined up services and improved patient outcomes and experience.

[4] Next steps for integrating primary care: Fuller stocktake report (NHS England, May 2022)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Electronic Staff Record – view your payslip
Our people promise
Information for new starters
Developing you (training)
Occupational Health
Freedom to Speak Up
HR Toolkits for Managers and Employees
Staff networks
Freenshare
Key documents
Document / Policy / Guideline Search
Policy and guideline information
Trust Board Papers
Communications portal
Communications home page
Live for Five
Staff app
e-update
Chief Executive Emails
Latest news and media releases
Tools and templates
DynaMed
BMJ Best Practice
QlikView
Shared Care Record

How we will deliver our strategy

In publishing this strategy, we are setting out the three main components of our approach to strategy delivery which we believe will make the biggest difference – our three 'Hows'.

1 Embed improvement in everything we do

We will apply quality improvement (QI) methodology to tackle the challenges we face and unlock the opportunities we have. This is a scientific method which utilises data and an iterative approach to identify improvements that will make a difference in practice. It is the best way to achieve sustainable, positive change.

Our QI approach will build on the Institute of Health Improvement (IHI) methodology[5] we have already begun to roll out which includes defining clear aims for improvement, promoting idea generation, using data to measure the outcomes and testing. Plan-Do-Study-Act cycles will be used to accelerate and embed change in a consistent way.

At the heart of our approach is empowering our teams to improve, recognising that the people who do the work every day are best placed to identify improvement opportunities that make the biggest difference to patients. To make that happen, we will upskill our staff ranging from core QI knowledge for everyone to advanced delivery methodology for our QI leaders. We will also work on our culture. We want to empower people to take ownership of their departments, for everyone to be involved in improvement and know that they have permission to do so.

An important part of embedding this change is to re-look at our systems and processes that enable effective decision-making across the organisation. Therefore, alongside publication of the strategy will be launching a refreshed Accountability Framework. It will improve the way we work together to tackle issues, simplify our processes and clarify responsibilities. The framework will help to coordinate our efforts through more distributed decision-making, promote individual ownership over goals and standards, and a more balanced approach between supporting autonomy within our teams and ensuring we are all working together to deliver the organisational strategy. We will continue to review and improve our Accountability Framework over the course of the strategy in response to feedback from teams across the Trust.

[5]How to Improve: Model for Improvement (Institute for Healthcare Improvement)

2 Clinical and wider collaboration across teams and organisations

To deliver excellent services to our patients, it is essential to continue our development as a clinically-led organisation and strengthen our clinical partnerships.

We will work with community and primary care providers, District and County Councils and the VCFSE sector to design and deliver services that meet the current and future needs of the population that we serve. We will utilise a population health approach where we use data to identify the needs of the population, trends in health outcomes and gaps in service delivery. It also means working with partners to impact the wider determinants of health.

We will also ensure we hear and respond to the patient voice. We will work with patients to review and co-produce the elements of our clinical collaboration plans which are most important to them and reduce barriers to accessibility and inclusion.

To set this on the right track, we will develop a new clinical strategy which outlines a clear vision and plan to achieve it for each service. The strategy will build on the lessons from the pandemic, our new status as a Teaching Hospital and the increasing opportunities offered by technology to deliver better care within hospitals and in patient's homes. It will also inform the design decisions of our new redevelopment programmes to capitalise on the potentials leaps in service delivery offered by the new builds. In line with our commitment to designing and delivering services with local partners, our clinical strategy will be co-produced with our local community and our partners in the Health and Care Partnership and designed specifically to meet the needs of the population we serve.

3 Maximise data and technology opportunities

We will use data and technology to improve patient access their health information, to improve the quality our services and capture opportunities to be more efficient as an organisation.

We have made significant progress with our Patient Portal. By 2024, more than 50,000 people had registered,

and our maternity services are making appointment and other information available through a dedicated app. We will continue to expand these services, making it easier for patients to book, change and cancel appointments, access personalised advice on their health conditions, and interact with their care team. Priority developments include enabling emergency department patients to register on the portal, radiology appointments, integration with remote video consultation software, waiting list validation, and integration with the NHS App. We also recognise the need to make clear concise information easily accessible for patients and carers using our services and to support staff to work safely and efficiently. We will update the Trust's public website and intranet as part of improvements in this area.

We have also expanded our use of virtual consultations, adopting new approaches pioneered during the pandemic. Video and telephone consultations for appropriate conditions offer greater convenience and reduce unnecessary travel onto hospital sites. They can also support improving work-life balance for our staff and reduces emissions associated with travelling into our hospital sites. We will continue to improve our use of these technologies whilst recognising that digital solutions are not suitable for all patients and must be combined with alternatives to avoid exclusion.

We have pioneered the use of remote monitoring technology through our Virtual Hospital, working in collaboration with Central London Community Healthcare NHS Trust, to provide a range of convenient and user-friendly remote monitoring devices. We will continue to develop our use of these technologies, including use of devices to help track routine chronic conditions and enabling patients, carers and teams across the Health and Care Partnership to recognise and respond to any deteriorations in health status earlier.

We have made excellent progress in adopting robotic-assisted surgery at record pace, improving care outcomes and helping the Trust to attract talented clinical professionals. We will continue to invest in this technology to expand our offer to more patients.

The development of our Control Centre at Watford General Hospital is increasingly allowing us to respond in real-time to pressures across our local health and care system and ensure that patients are seen quickly by the most appropriate professional to meet their needs. The next phase will see the same methodology rolled out across all our wards, digitising key operational processes and reducing the use of analogue and outdated systems. We will seek to expand this approach to incorporate datasets from across the health and care system, enabling our teams to track the movement of patients through clinical pathways, and to plan for and respond to fluctuations in demand.

We will seek to automate processes using AI technology where we can help our staff excel at their roles. We will focus on standardised administrative tasks, clinical aids in radiology and predictive capabilities in our Control Centre.

Maximising the use of data and digital technology within the design of our hospitals will also be a key part of our redevelopment programme. We will seek to learn from the emerging international evidence base on digitally-enabled health care and capitalise on the opportunity associated with the redevelopment programme to affect a step-change in our use of technology to support our patients.

Case study:
Robotic-assisted surgery

West Hertfordshire Teaching Hospitals Trust was the first in the country to install two Versius robots to assist with surgical operations. Robotic-assisted surgery brings major benefits to patients including reduced post-operative pain and faster recovery. The patient experiences less pain as the robot creates a virtual pivot point around the small incisions through which the robotic instruments are inserted, minimising trauma, and putting less strain on the patient. Since July 2022, we have performed approximately 340 robotic-assisted surgeries, and we are further expanding our robotics programme to include an aquablation and orthopaedic robot to treat even more patients.

We are the first NHS trust to have a robotic surgical training programme for specialist trainees in colorectal and upper gastrointestinal surgery and we are an international reference site for our robotics programme, surgeons from the rest of the UK, Europe and globally visit to see our achievements in RAS. This training was shortlisted for a prize at the annual Association for Surgeons in Training (ASIT) conference this year to recognise it's achievements.

How we will know if we have achieved our aims

Alongside qualitative feedback from our staff, patients and partners, we will measure our success using data. We have set out groups of metrics that we will use to understand our progress and identify areas of improvement. The specific metrics selected demonstrate the areas that are most important to us and where we want to push ourselves every day to seek the very best for our patients and staff. Achieving what we aspire to may take more than the period of this strategy, but we aim to see sustained and material improvement over the duration of the strategy.

True North metrics

These goals reflect where we want to get to as an organisation. They are rightly aspirational and will require a sustained effort across the organisation and local system to achieve. It will take time to achieve these ambitions, but it is right that we set goals that give us clear direction.

Driver metrics

These are goals that inform our day-to-day work in the organisation, helping us to move toward the True North. These metrics are more responsive to individual interventions and are reported more frequently. If we improve our driver metrics, we can be more confident that we will see improvements in our True North.

Watch metrics

These are measures that help us to understand what is happening across all of the services and teams we are responsible for. We watch them to ensure we understand trends, identify new issues or unintended consequences of our efforts. Having visibility across the Trust means we need a large number of watch metrics and review them by exception.

Our aspiration under each metric include:

- specific values where it is linked to a national standard.
- tracking to agreed delivery plans where target values change over time.
- relative performance where we seek to see sustained improvement and a positive change in our relative position against other acute providers.

In addition to the above, we will track and report on the delivery of our Year 1 programmes. We will focus on hitting the specific milestones agreed at the launch of each programme.

Measurement framework

Provide safe, high quality, timely and sustainable care

Strategic objective	True North metrics with aspiration	Driver metrics with aspiration	Watch metrics (list not exhaustive)
Develop a safety and learning environment Selection rationale: We seek to reduce hospital-linked mortality and ensure our staff and regulators see our service as safe and high-quality. In the short term, we aim to minimise the number of patient safety incidents and respond to them effectively.	Summary Hospital-level Mortality Indicator (SHMI) **[<100 and 'as expected' for all diagnosis groups]**. Staff survey: If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation **[Sustained absolute and relative improvement]**. CQC rating: Safe and Caring **[Outstanding]**.	Proportion of national patient safety alerts actioned **[100%]**. Serious incidents closed within 60 days **[Sustained absolute and relative improvement]**. Moderate and above incidents count **[Sustained absolute and relative improvement]**.	Never events count. Patient safety incidents count. Formal complaints per £100m income. VTE risk assessment rates. Healthcare acquired infections: • MRSA bacteraemia count • C. Difficile infection count • E. Coli bacteraemia count • Klebsiella bacteraemia count • Pseudomonas bacteraemia count Proportion of patients with harm from fall.
Support our staff Selection rationale: We seek for our staff to feel motivated, included and proud to belong in our organisation. In the short term, we aim to create positive experiences at work, strengthen our training offer and progress with our ED&I agenda.	Staff survey: I would recommend my organisation as a place to work **[Sustained absolute and relative improvement]**. Staff survey: In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public? **[Sustained absolute and relative improvement]**. Pay gap across different staff groups **[Sustained absolute and relative improvement]**.	Global majority representation at senior bands (8A and above) **[>40%]**. Reasons for leaving: • Incompatible working relationships • Work-life balance **[Sustained absolute and relative improvement]**. Apprenticeship levy utilisation by staff groups **[>65%]**. Uptake of Apprenticeship First Scheme **[>100]**.	EDS activities. Vacancy rate. Voluntary turnover rate. Sickness-absence rate (both long-term and short-term). Appraisal compliance rate. Staff survey: Staff engagement score. Staff survey: Morale theme score. Staff survey: We are always learning theme score.
Improve our urgent and emergency care and planned care services Selection rationale: We seek to demonstrate improvement in line key with national standards. In the short term, we aim for timely discharge, reduced waits our Emergency Department and improved patient journeys through the hospital.	ED 4-hour target **[In line with national standards towards 95%]**. RTT 52-weeks waiters **[0]**. Cancer 62d waiting time target **[Consistent with national standards]**.	Adult G&A bed occupancy in Watford General **[Consistent with national standards]**. Average non-elective length of stay (1+ days) **[Sustained absolute and relative improvement]**. Mean time in ED for admitted patients **[Sustained absolute and relative improvement]**. Proportion of discharges by 12:00 **[33%]**. Virtual hospital utilisation **[On track compared to plan]**. Value-weighted activity **[On track compared to plan]**. Outpatients follow up ratio **[Sustained absolute and relative improvement]**.	Surge bed days. Emergency ambulance handover delays. Delayed discharge. Ratio between admissions and discharge per day. Case-mix standardised length of stay. ED conversion rate. Proportion of >7-day patients reviewed by MDT. Proportion of ward patients reviewed by senior clinician by 10:00. Theatre utilisation. Waiting list clearance rate.

Provide safe, high quality, timely and sustainable care

Strategic objective	True North metrics with aspiration	Driver metrics with aspiration	Watch metrics (list not exhaustive)
Develop and run sustainable services Selection rationale: We seek to be sustainable as system as move towards shared accountability. In the short term, it is important we improve our financial position where it is in our control.	System financial sustainability **[Achieved]**. Acute service productivity compared to 2019/20 **[Sustained absolute and relative improvement]**. Total clinical waste carbon emissions **[Sustained absolute and relative improvement]**.	Trust's in-year financial performance **[Breakeven]**. Cost-weighted out of area activity **[On track compared to plan]**.	Trust's financial performance against budget at divisional level. Temporary staff spend. Cost Improvement Plan delivery %.

Redevelop our hospitals for our patients and staff

Strategic objective	True North metrics with aspiration	Driver metrics with aspiration	Watch metrics (list not exhaustive)
All Selection rationale: Our focus is to successfully deliver the redevelopment programme. In the short term, we aim to improve our responsiveness to maintenance issues and environmental sustainability.	Redevelopment programme timeline **[On schedule]**. Redevelopment programme costs **[Consistent with projections]**.	Proportion of proactive maintenance **[>60%]**.	Estates and facilities related incidents. Clinical service incidents caused by estates and infrastructure failures. Critical infrastructure risk. Thermal energy consumption. Electrical energy consumption.

Design and deliver services with our local partners

How we measure success will be limited to driver metrics for Year 1. As part of the delegation agreement with the ICB, we will be working up a set of metrics to capture the success of the partnership in a more comprehensive way. This must be approved by the ICB and the Trust board by Q4 of next year and there will be incorporated in the Year 2-5 of the strategy.

Strategic objective	Driver metrics (aspiration will be aligned with wider HCP ambition for 2024/25)
All Selection rationale: Our focus with our system partners will be on citizens with frailty and multimorbidity. It is for us important to minimise emergency admissions to hospitals where it is preventable.	• Rate of emergency admissions for people living with frailty or on End-of-Life Register. • Readmission rate within 7 and 30 days for people living with frailty. • Emergency admissions from care homes. • Average length of stay for people living with frailty. • Rate of emergency admissions for falls within the community for people aged 65+

Our next steps

We will embed strategy delivery into our daily activities, utilising the teams and structures that are already working to improve the way we operate. In practice it means hardwiring strategic delivery into annual business planning and transacting the strategy through our new Accountability Framework. The things people are doing daily should all contribute to the delivery of our strategic priorities.

In circumstances where we identify that the mechanisms within our business-as-usual processes are insufficient to achieve the aims described in the strategy, we will put in place supplementary programmes to support this, that help to assure the Board that we will deliver on our priorities.

The Measurement Framework will cascade from delivery into our oversight frameworks and into teams across the organisation. Our implementation approach gives a clear and agreed understanding of how the metrics that we are using on a day to day, will drive us towards the True North metrics, agreed in the Strategy.

We have agreed the following principles that will guide our approach to delivery:

- Integration with business planning process.
- Executive level sponsorship of strategic programmes to build momentum, provide oversight and equip the teams with the right tools.
- Distributed leadership where the wider Trust's leadership team will have the opportunity to lead on strategic programmes.
- Central allocation of transformation and improvement capacity to support key programmes.
- Embedding our QI approach in programmes to ensure we use data, iterate and develop improvement skills across the organisation.
- Working collaboratively with system partners – from information sharing to co-delivery.
- Reinforcing our new values in the way we deliver our strategy.

Strategy delivery will also be supported by Trust plans in individual service areas, operating in harmony with the overall direction of travel we set out here. We will ensure alignment between our strategy and the priorities we set with our teams.

This strategy sets out our vision, values and priorities for the next five years. Whilst this describes our overall destination, it is important that we commit to reviewing our strategic priorities and delivery programmes on an annual basis, reflecting progress to date and requirements to 'course correct' in response to shifts in national and local strategic context and the resources we have available to support delivery.

23.1

Excellent patient care, together

Empowered Compassionate Professional Inclusive

West Hertfordshire Teaching Hospitals NHS Trust

Accountability Framework

Current Document Information	
Version:	2.0
Document Lead:	Chief Nurse
Approving Group:	Trust Management Committee
Date Approved:	
Date Due for Review:	
Target Audience:	All staff

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All employees must adhere to the requirements set out within this document. Any specific responsibilities or actions for particular staff or staff groups will be outlined within the main body of the document and their duties cascaded to them as required.

Promoting equality and addressing health inequalities are at the heart of West Hertfordshire Teaching Hospitals NHS Trust's values. Throughout the processes detailed within this document the Trust has given due regard to the need to eliminate discrimination, harassment and victimisation to advance equality of opportunity and to foster good relations between people who share a relevant protected characteristic, as cited under the Equality Act 2010, and those who do not.

Contents

1. Introduction

1.1 This document sets out the overarching accountability framework to drive and assure delivery of organisational strategy and performance goals at West Hertfordshire Teaching Hospitals NHS Trust.

1.2 This accountability framework is a key component of the Trust's management system, which comprises of the systems, processes, structures and supporting arrangements in place to ensure appropriate oversight and engagement in all areas of performance, to support the achievement of the Trust's strategic priorities (see WHTH Our Strategy 2024-2029) and meeting regulatory standards. Our accountability framework will support us in achieving our vision of delivering 'Excellent patient care, together' and will set the foundations to enable the organisation to:

- Provide safe, high quality and sustainable care
- Prepare and empower staff when they transfer into our newly developed hospitals
- Enable our workforce to design and deliver services with our local partners.

1.3 The framework describes how the Trust's tiered organisational structure will be utilised to ensure that a rigorous, supportive and consistent accountability approach is achieved at all levels of the organisation.

1.4 The accountability framework and its component parts are underpinned by the Trust's Values and Behaviours Framework. The framework has been developed against a set of guiding principles (see section 5. Accountability Framework Guiding Principles). The components of the Accountability Framework are:

- **Leadership roles** (and their associated areas of accountability and responsibility)
- **Oversight meeting structure** (including terms of references)
- **Measurement and data** (including performance reporting and KPIs)
- **Expectation setting for reporting** (including reporting rules and reporting templates that are grounded in improvement methodology)
- **Escalation and de-escalation** (utilising the Trust's Oversight Framework).

2. Abbreviations

2.1 Table 1 explains the meaning of any abbreviations used within this document.

Abbreviation	Meaning
AHP	Allied Health Professional
BAF	Board Assurance Framework
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CMO	Chief Medical Officer
CN	Chief Nurse
COO	Chief Operating Officer
CPO	Chief People Officer
CQC	Care Quality Commission
DIPRM	Division Integrated Performance Review Meeting
ER	Exception Report
HR	Human Resources
ICS	Integrated Care System
IPR	Integrated Performance Report
KLOE	Key Line of Enquiry
KPI	Key performance indicator
NHSE	NHS England
OD	Organisational development
PSIRF	Patient Safety Incident Response Framework
SFI	Standing Financial Instructions
SMART	Specific, Measurable, Actionable, Realistic, Time bound
SOP	Standard Operating Procedure
SPC	Statistical Process Control
SVU	Structured Verbal Update
TMC	Trust Management Committee
WHT	West Hertfordshire Teaching Hospitals Trust

Table 1 Abbreviations and their meaning

3. Purpose

3.1 The purpose of this accountability framework is to ensure that the organisation has a comprehensive and clear system in place for the monitoring and management of all elements of performance. It's ultimate aim is to achieve the following goals:

- To enable agile and distributed decision-making
- To establish clear individual ownership over performance standards
- To maintain the balance between local autonomy and alignment with organisational strategy.

4. Leading change through our values and behaviour

4.1 The way this accountability framework is used will be consistent with our organisational values – to be empowered, professional, compassionate and inclusive – and our associated behavioural framework. Values and behaviours reflections will be embedded into all future meetings and a set of draft behaviours has been developed to support the 'Values and Behaviours Observer' meeting role in their reflections. See Appendix A. These will be updated following co-design of a Trust-wide behaviours framework by the end of quarter 1 2024/25.

Our Trust Values

5. Accountability Framework Guiding Principles

5.1 This accountability framework, and all components of it, have been developed with five guiding principles in mind. Figure 1 below highlights these five guiding principles and their supporting descriptions.

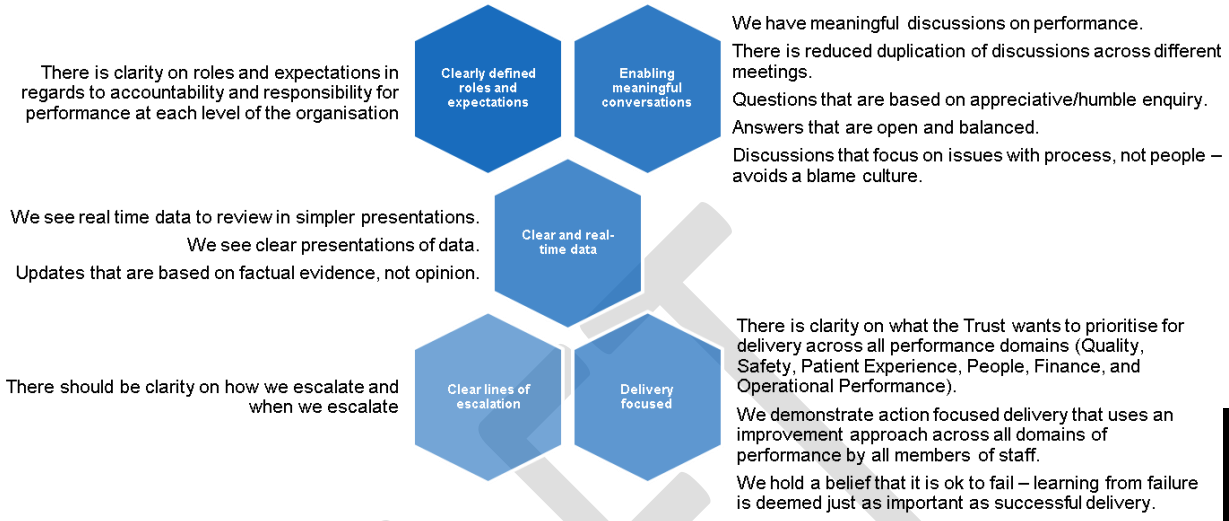


Figure 1 WHT Accountability Framework Guiding Principles

6. Roles, Accountability and Responsibilities

6.1 The first component of the accountability framework is to have clearly defined roles and expectations in regard to accountability and responsibility for performance at each level of the organisation. An overview of individual and team accountabilities and responsibilities from Board to Specialty level are detailed below. A more detailed description by role can be found in Appendix C, tables 1, 2 and 3.

6.2 For reference, Appendix B depicts the Trust's current (January 2024) Executive and Senior Management organisational structure.

Trust Board

6.3 The Board functions as a unitary decision-making body; Chief Officers and Non-Executive Directors are full and equal members. Their role as members of the Board will be to consider key strategic and managerial issues facing the Trust in carrying out its statutory and other functions. It is accountable, through our Chair of the Board, to NHS England (NHSE), the Care Quality Commission (CQC) and the Secretary of State for Health.

Chair of the Board

6.4 The Chair of the Board leads the Board and ensures that it successfully discharges its overall responsibility for the Trust as a whole. The Chair is responsible for the operation of the Board, and has certain delegated executive powers. The Chair works in close harmony with the Chief Executive and ensures that key and appropriate issues are discussed by the Board in a timely manner.

Non-Executive Directors

6.5 Non-Executive Directors are selected by the Chair of the Board and appointed by NHSE. Their key role is to constructively seek assurance from the Executives on plans and actions laid before the Board. They are not granted any individual executive powers on behalf of the Trust. The Board has a set of Committees, some of which are mandatory, that are chaired by Non-Executive Directors and they may exercise collective authority when acting as members of or when chairing a Committee of the Trust which has delegated powers.

Chief Executive Officer

6.6 The Chief Executive Officer is the Accountable Officer, responsible for the overall running of the organisation. This includes ensuring that the Trust meets all quality, safety, people, operational performance and financial requirements.

Executive Team

6.7 The Executive Team supports the CEO in delivering the Trust's strategic objectives and has overall responsibility for the approval, and implementation, of the Accountability Framework.

6.8 The Executive Team will be responsible for ensuring appropriate oversight mechanisms and appropriate processes for the management of performance, including application of corrective actions in relation to:

- Ensuring high standards of quality and safety first and foremost,
- Delivery of strategic priorities, including all programmes and projects that support delivery of the priorities,
- People, operational and financial performance,
- Organisational capability and capacity to deliver the priorities, including an appropriately skilled and supported workforce,
- Compliance with statutory, mandatory and regulatory requirements.

Chief Nurse

6.9 The Chief Nurse leads the development of the Accountability Framework. This includes ensuring there is alignment with the Trust's Governance Framework and that there are robust systems in place for the monitoring and management of national, local and internal targets.

Chief Operating Officer

6.10 The Chief Operating Officer leads the implementation of the Accountability Framework. This includes ensuring divisions adhere to the standards set out in the framework.

Divisional Directors and Corporate Directors

6.11 Directors are accountable to the Chief Operating Officer for all elements of performance within their area of responsibility.

Divisional Leadership Team

6.12 Under the leadership of the Divisional Director, the Divisional Leadership Team are collectively responsible for ensuring the provisions of safe, effective and high quality care, for complying with all local and national standards (clinical, operational and financial) and for identifying the strategic development of services within their divisions. They are also responsible for establishing and maintaining processes to manage performance at divisional and organisational level, and to have appropriate oversight of performance for their respective specialties/services. They are also jointly responsible for approving the budget delegated to the Division and, by doing so, accept the responsibilities for delivering the financial plan and associated cost improvements and activity levels within the delegated budget (further detailed description can be found in paragraph 7.43 under the section *Financial Accountability Framework* and Monthly Reporting Cycle).

6.13 It is also the responsibility of the Divisional Leadership Teams to ensure that:

- Trust strategic objectives are cascaded down to teams within their Division, ensuring strategic alignment of quality, safety, people, operational and financial objectives to that of the Trust where applicable,
- There are appropriate governance arrangements in place to underpin the accountability framework across the whole Division,
- Targets for key indicators are agreed, communicated and delivered,
- Performance information is scrutinised to understand variances, trends, discrepancies and gaps,
- Off-track or deterioration in performance is identified, analysed using our improvement methodology and corrective change actions are put in place to ensure performance is restored in as short a timescale as possible, and
- Suitable time is available for the review of performance information at Specialty/Service level and actions in relation to their performance are agreed and monitored appropriately.

Specialty Leadership Teams

6.14 The Specialty Leadership Teams (consisting of Clinical Lead, Assistant Divisional Manager, and Matron) are jointly responsible for performance within their Specialty/Services. They are collectively responsible for ensuring the provisions of safe, effective and high quality care, for complying with all local and national standards (clinical, operational and financial) and leading on service development and delivery. This includes maintaining a system whereby performance reviews take place at specialty, department, service or individual level as appropriate.

6.15 It is also the responsibility of the Specialty Leadership Teams to ensure that:

- Trust strategic objectives are cascaded down to teams within their Specialty, ensuring strategic alignment of quality, safety, people, operational and financial objectives to that of the Trust where applicable,
- There is an appropriate balance of organisational and local priorities,
- KPIs and SMART goals are set against each objective for the Specialty and their reporting teams,
- All staff understand the importance and scientific approach to data collection and analysis and its role within the organisation,
- Policies such as the Patient Access Policy are adhered to within their Specialty(s), and that data is accurately entered into all other relevant electronic systems within the appropriate timescales,
- Monitoring processes are in place for any action plans to improve performance, and that the Trust's improvement methodology is used to understand root causes to under-performance and develop sustainable change actions,
- Issues that cannot be resolved locally are escalated to the Divisional Leadership Team and any associated risk is appropriately captured on the risk register.

All staff

6.16 It is everyone's responsibility to ensure that high standards of quality and safe care are delivered first and foremost. Everyone can contribute to improvement and will be encouraged and supported to identify improvement opportunities and to take the required action. It is important all individuals own the data relating to their service and understand how it translates to the overall performance of the organisation.

7. The system for delivering excellent performance

An Effective Trust Management System

7.1 A Trust Management System provides the framework to support the organisation, our divisions, specialties, front line and corporate teams in identifying, agreeing and delivering on their objectives.

7.2 An effective management system is more than just meetings. An effective management system should aim to:

- Set and deploy organisational strategy and priorities
- Align teams and resource to organisational strategy and local priorities
- Have a clear framework in place to manage and monitor delivery of priorities (i.e. an accountability framework)
- Embed improvement methodology into ways of working, systems and processes

7.3 For each of these aims, there are tools and routines that can help teams to ensure they have the right toolsets, skillsets and behaviours to enable them to deliver on improvement initiatives that support the achievement of the Trust's True North and strategic priorities (see Measurement Framework within WHTH Our Strategy 2024-2029). The figure below (figure 2) depicts how a WHT management system could look in the future.

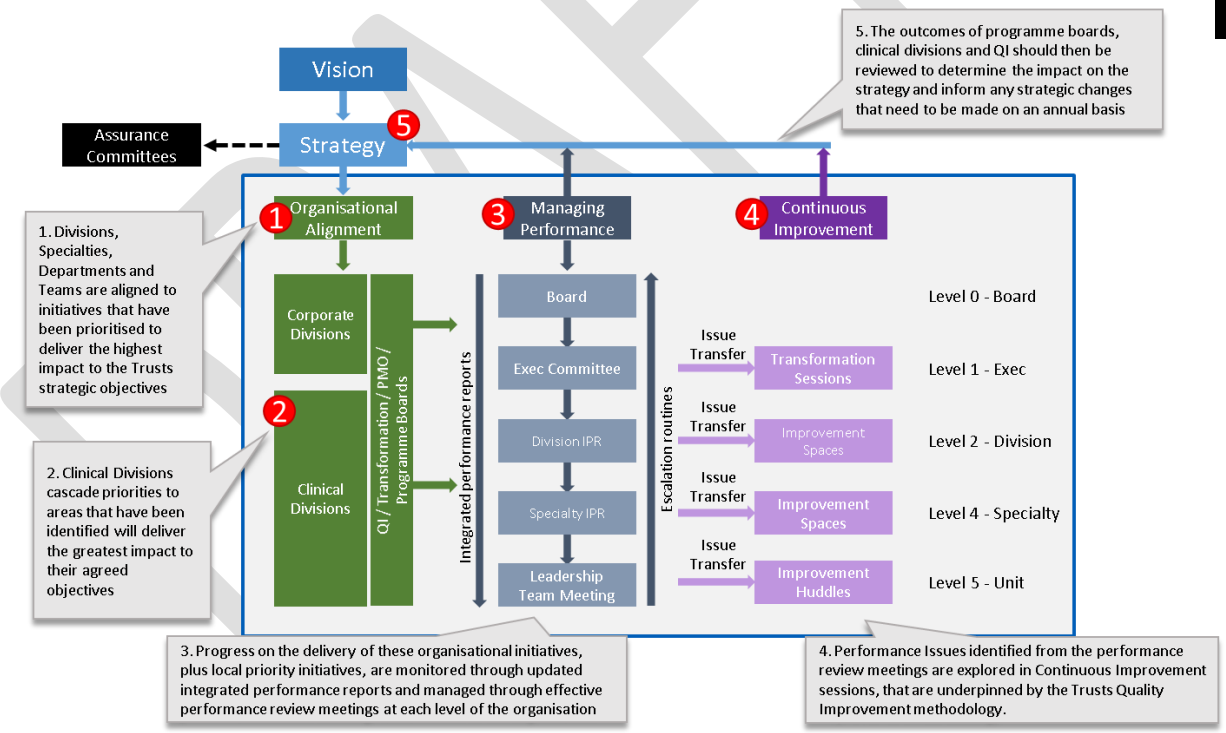


Figure 2 Future WHT Management System

Board and Executive Governance Frameworks

7.4 Figure 3 shows the Trust Board and Board Committee governance meeting structure as per the Trust's governance framework, and Figure 4 shows the current (As of January 2024) Executive governance meeting structure that supports the Accountability Framework.

7.5 Figure 5 shows a proposed future state of the Executive governance meeting structure, which introduces three Executive sub-committees and act as sub-committees to the Trust Management Committee. The proposed introduction of these Executive sub-committees, which would be chaired by the appropriate Executive(s) who hold devolved accountabilities for each statutory duty and performance domain, would support:

- Streamlining of Executive groups that currently report into the TMC with the aim of reducing the number of reporting meetings into TMC, reducing duplication of conversation, and reducing the number of reporting papers,
- Ensure more holistic oversight of performance standards and statutory duties that relate to the 6 domains of performance, and other organisational statutory duties,
- Free up Executive capacity as it is proposed that the chairing of groups that report up into the Executive sub-committees are delegated to executive deputies, which also provides development opportunities and allows for delegation of responsibility and ownership.

7.6 The purpose of each of the Executive level meeting is described below. The terms of reference for the current Board and Executive level committees are available on the Trust intranet or on request from the Trust Secretariat.

7.7 The Trust Board and Board Committees, Executive and Divisional meetings are categorised by 4 different types of meetings:

- **Assurance**: meetings where information and evidence is presented and triangulated to provide confidence and assurance to leadership in meeting, sustaining or improvement against statutory and performance standards
- **Scrutiny of Delivery**: Oversight meetings where delivery actions to meet, sustain or improve statutory and performance standard are discussed in greater detail and act as a point of escalation
- **Transformation:** meetings that discuss the Trusts Transformation programmes, including milestone progress, benefits tracking and risk management.
- **Advisory:** bodies or groups that are consulted with to elicit recommendations and engagement, but do not necessarily take action against them.

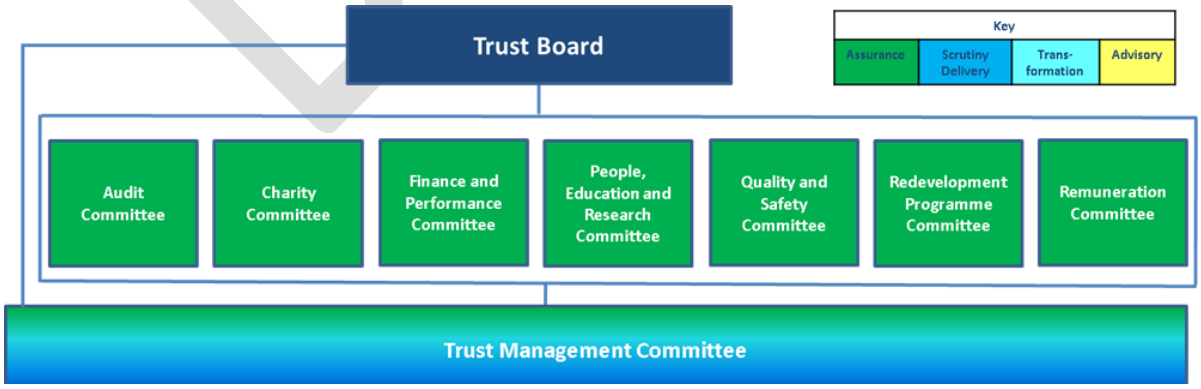


Figure 3 Trust Board and Committee Structure (January 2024)

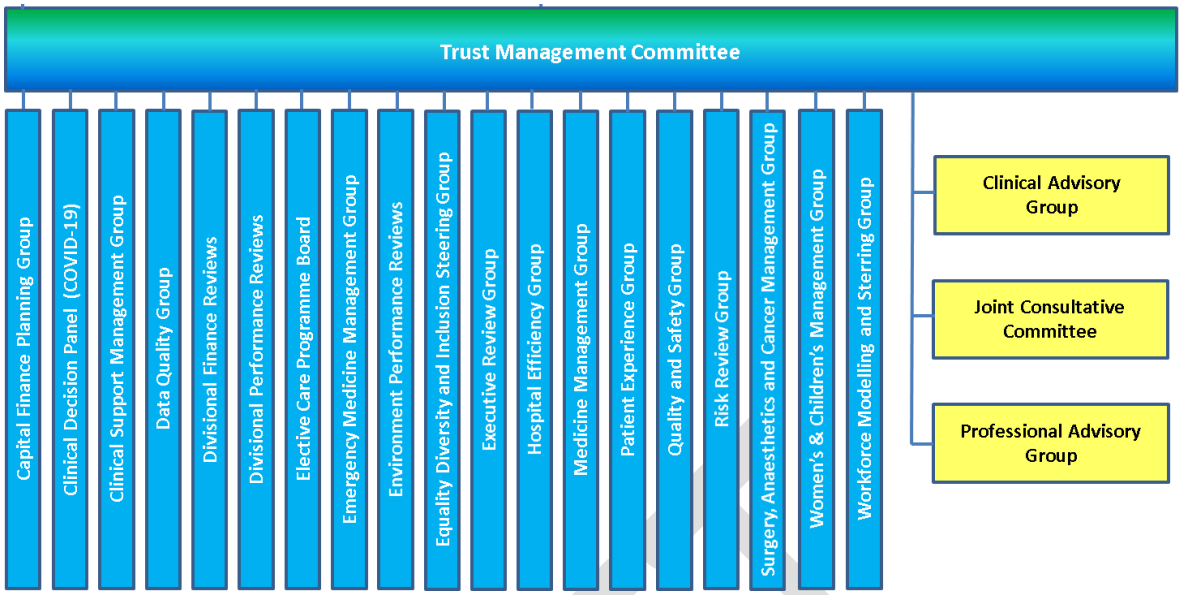


Figure 4 Trust Executive Governance Framework - Current Jan 2024

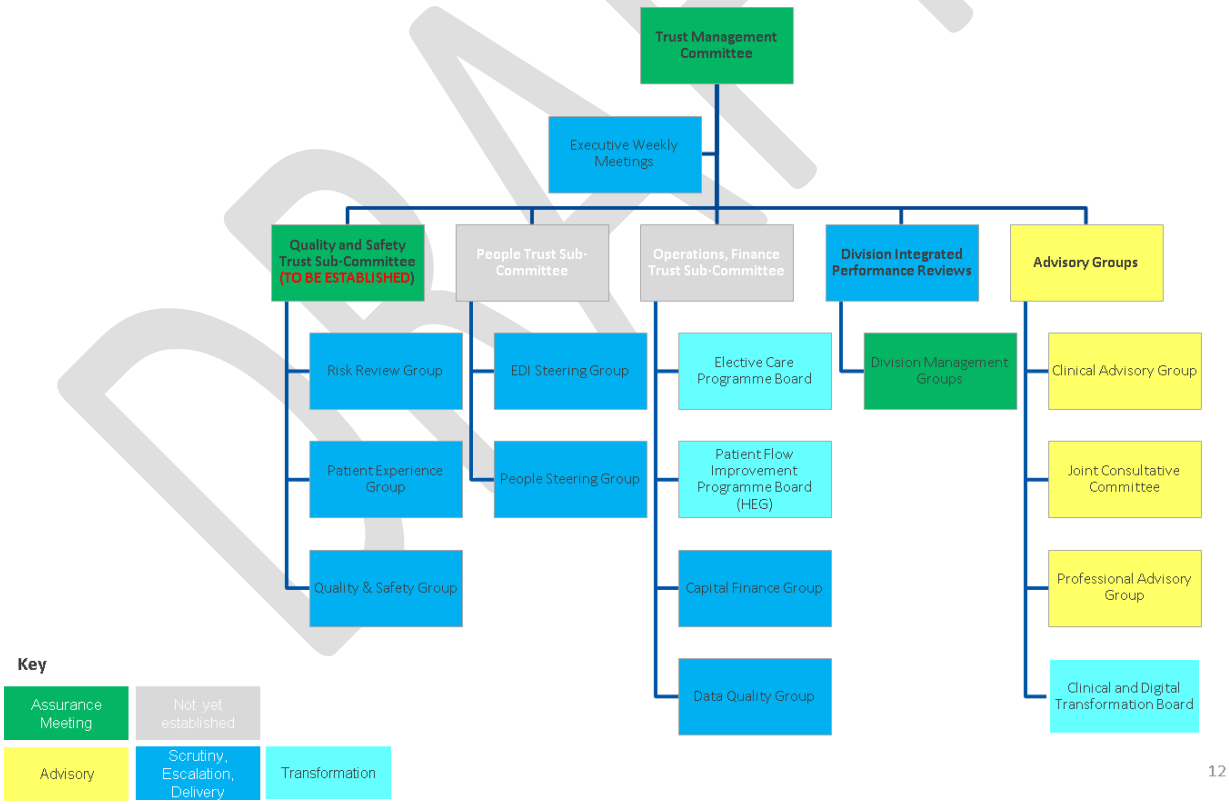


Figure 5 Proposed Trust Executive Governance Framework (DRAFT TBC FROM April 2024)

Trust Management Committee (TMC)

7.8 The TMC is the executive decision-making body in the Trust. As such, it will approve financial commitments and business cases for investment in line with the limits for Executive approval set out in the Trust scheme of delegated authority. This authority

may be delegated to an Executive Team meeting in specifically defined circumstance. The TMC will have oversight of performance and agree appropriate corrective action in relation to all areas of performance. TMC will also act as the Trust's Executive Risk Committee. Executive level operational groups and the Divisional Integrated Performance Review Meetings will support it. TMC will agree recommendations to the Trust Board and agree risks and issues for escalation.

Quality and Safety Trust Sub-Committee – TO BE ESTABLISHED FROM APRIL 2024

7.9 The Quality, Safety and Patient Experience Trust Sub-Committee, chaired by the Chief Nurse and Chief Medical Officer, ensures oversight of Trust-level quality, safety and patient experience related performance KPIs and will agree appropriate corrective actions in relation to these areas of performance. The sub-committee will agree recommendations to the TMC and agree risks and issues for escalation. The overall purpose of the sub-committee is to review all areas of quality performance across the Trust that are adverse to performance targets or trajectories, ensure improvement plans are developed and then tracked until they reach improved and sustained levels, providing assurance to the TMC. The sub-committee will ensure that learning from all aspects of our quality risk and clinical effectiveness systems is shared and used to improve the quality of care, and the safety of our patients and staff.

People & OD Trust Sub-Committee – NOT YET ESTABLISHED

7.10 The POD Trust Sub-Committee, chaired by the Chief People Officer, ensures oversight of Trust-level people related performance KPIs and will agree appropriate corrective actions in relation to these areas of performance. The sub-committee will agree recommendations to the TMC and agree risks and issues for escalation. The overall purpose of the sub-committee is to ensure the Trust recruits and retains staff with the skills to meet current and future requirements and to develop and retain a culture that enables, motivates and empowers our staff to provide the best care to patients possible within our resources.

Operations and Finance Trust Sub-Committee – NOT YET ESTABLISHED

7.11 The Operations and Finance Trust Sub-Committee, chaired by the Chief Operating Officer and Chief Finance Officer, ensures oversight of Trust-level operational, finance related performance KPIs, and will agree appropriate corrective actions in relation to these areas of performance. The sub-committee will agree recommendations to the TMC and agree risks and issues for escalation. The overall purpose of the sub-committee is to review all areas of operational and financial performance across the Trust that are adverse to performance targets or trajectories, ensure improvement plans are developed and then tracked until they reach improved and sustained levels, providing assurance to the TMC.

Divisional Integrated Performance Review Meetings

7.12 The Divisional Integrated Performance Review Meetings are the mechanism through which the Executive exercises oversight on divisional level performance, celebrating success and discussing key areas of risk or concern, and to receive assurance that exceptions identified at specialty level are being addressed. (See Appendix D for the detailed terms of reference for the Divisional Integrated Performance Review Meetings (DIPRMs)).

7.13 These meetings are chaired by the Chief Operating Officer and will cover all performance domains: Quality, Safety, People, Operations and Finance. These meetings also provide an opportunity for Divisions to present a summary of their strategic initiatives / developments, some of which are cascaded down from the Executive strategic priorities and others that are locally set. The meetings also provide an opportunity for Divisions and the Executive Team to identify specific areas where

additional support is required from corporate divisions, aligned with the Trust business planning cycle.

7.14 Performance is managed via an integrated performance report and reporting is governed by a set of reporting rules. The outcome of the DIRPMs will be reported to the Trust Management Committee. At the end of the DIPRMs, the Executive will agree which oversight category the Division falls into, see Section 9. Oversight Framework for detail on the oversight categories.

Divisional Quarterly Operating Reviews

7.15 Once a quarter, the CEO will chair and Operating Review with each Division, which will replace the usual Divisional Integrated Performance Review Meeting. Wider executive team members will also attend this.

7.16 The purpose of the meeting is a review of progress over the previous quarter against each of the performance domains (Quality, Safety, People, Operations and Finance). The meeting provide an opportunity for the CEO, and wider Executive team, to ask questions using an appreciate enquiry approach and identify specific areas where additional support is required.

Governance and Accountability meeting structures for Divisions and Specialties

7.17 Figure 6 sets out the advised cascade of accountability meetings from Division to Service/Ward level and the supporting governance meetings that might oversee the data and reporting information flows prior to formal performance review.

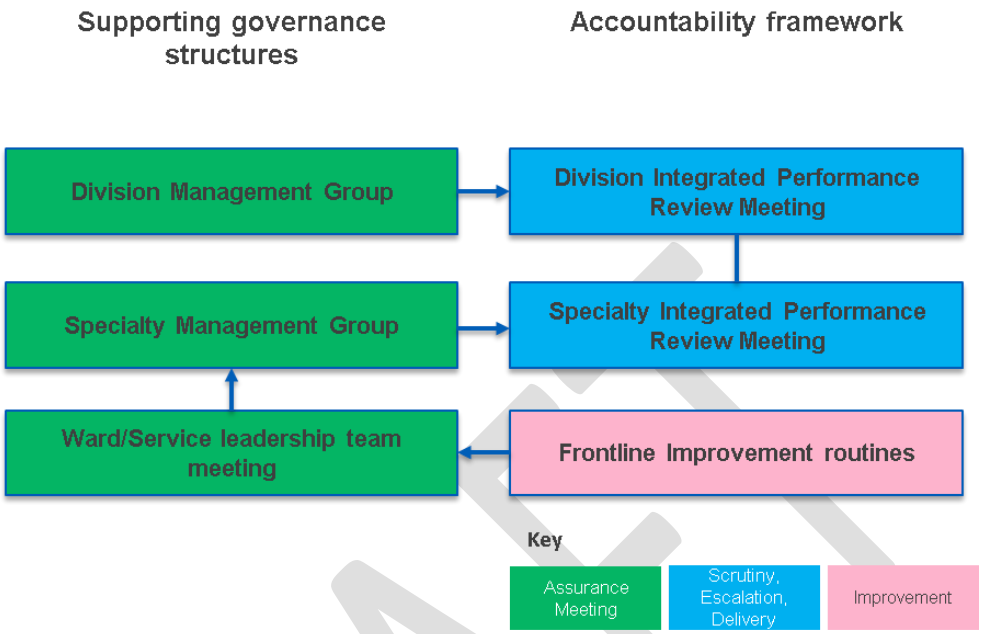


Figure 6 Example cascade of performance management meetings from Division to Ward/Service level

7.18 All Integrated Performance Review Meetings should follow a structured format in terms of agenda and content. Appendix E sets out the proposed meeting standard agenda for Integrated Performance Review meetings.

7.19 Table 2 sets out the accountability meeting framework at Division and Specialty level.

	Specialty Performance Review	Division Performance Review
Purpose	Division-led review of specialty performance	Executive-led review of Divisional performance
Frequency	Minimum bi-monthly	Minimum monthly
Minimum attendance	Chair (Divisional Director) Division Leadership Team Specialty Leadership Team (Head of Specialty or Clinical Lead, Matron or Senior Nurse(s), Assistant Divisional Managers) Finance HR	Chair (Chief Operating Officer) Core Executive Leadership (CFO, CPO, CN, CMO) Division Leadership Team Finance Business Partner Associate Director of People & OD or HR Business Partner equivalent ICT Business Partner or equivalent
Agenda items	• Areas of good performance for celebration and sharing of best practice • Review of integrated performance specialty report, with an focus on exception reporting, governed by the Trusts reporting rules and Division established KLOEs, against previously agreed improvement plans and trajectories	• Areas of good performance for celebration and sharing of best practice • Review of integrated performance division report, with an focus on exception reporting, governed by the Trusts reporting rules and Executive established KLOEs, against previously agreed improvement plans and trajectories • Financial performance and business plan delivery • Progress with specialty review plans and
Reporting & escalation	Actions and interventions are agreed and documented with clearly identified named leads and timescales for delivery. Where a significant risk to performance is identified, an exception report is completed by the Specialty and submitted to the Divisional team for review.	Action and decision must be formally recorded. Formal minutes are advised. Papers and exception reports are prepared by the Divisional team and circulated in advance of the meeting. Actions and interventions are agreed and documented with clearly identified named leads and timescales for delivery. Where a significant risk to performance is identified by the Division, the risk must be escalated and discussed with the Executive team for review and noted in the minutes, actions or decisions.

Table 2 Division and Specialty Accountability Meeting Framework

Integrated Performance Report

7.20 The integrated performance report (IPR) will track and monitor the delivery of strategic and operational objectives, whilst continuing to maintain oversight of statutory national standards. It serves to monitor strategic goals relative to KPIs and to make decisions on a larger scale. Trust KPIs will be cascaded to each level of the organisation to ensure alignment to organisational priorities and will provide a quick, but comprehensive, picture of the organisation's health.

7.21 The KPIs on the integrated performance report covers the domains of patient experience, quality and safety, people, operational performance and finance. It will provide a snapshot of current performance against KPIs across these domains, compared to their set SMART goals.

7.22 The integrated performance report will support strategic decision making on what the priorities should be at each level of the organisation based on the distance between current and historical performance and the goal.

7.23 Management information dashboards can be used to access more real-time, stratified data to support day-to-day operational management, where applicable.

7.24 The integrated performance report is used to identify reporting requirements to the appropriate integrated performance review meeting. Reporting against KPIs are governed by the Trust's reporting rules. See section *Reporting Rules and Reporting Templates, table 3.*

7.25 The report will, where possible, provide performance updates to support reporting against the month prior to when it is published. At the time of publishing this framework, the monthly reporting cycle publishes latest performance data for Trust Board through the overall integrated performance report (IPR), Board Committees, Trust Management Committee, Executive groups and Divisional Integrated Performance Review Meetings.

Key performance indicators

7.26 The set of Trust key performance indicators (KPIs) that make up the accountability framework are reviewed each financial year to ensure alignment to the annual NHS operating planning guidance and changes to national oversight frameworks. The KPIs may also be changed throughout the year as new guidance and trust programmes and projects come into place.

7.27 The KPIs identified for monitoring in any one year are documented in the Trust integrated performance report, rather than within this document, to ensure that the list is flexible and can be adapted to reflect new requirements as they arise. Where national definitions exist, KPIs will be constructed in line with these to allow for benchmarking. Where these are not available, KPIs will be defined locally.

Reporting rules and reporting templates

7.28 Reporting rules govern how teams report on performance of KPIs and initiatives. These rules are based on statistical rules for identifying deteriorating, improving or sustained control of a process. Reporting rules related to task and finish projects or programmes of work are based on milestone achievement as per the set out project or programme plan.

7.29 Table 3 below sets out the Trust's Reporting Rules.

7.30 The reporting rules are embedded in the integrated performance reports, which are circulated prior to the committee cycle. This will ensure that teams do not have to remember the rules verbatim and reporting is an automated indicator.

7.31 To ensure meetings are as effective and efficient as possible, the rules identify that if there are more than 6 'Driver' metrics that are red for 2 or more reporting months, then a discussion should take place with the chairperson in advance of the meeting to determine which ones should be formally reported on. The basis of this decision could be due to high risk of delivery and/or a requirement to escalate a request for support. It is at the chairpersons discretion which performance reports they deem the most important to be presented for assurance and risk mitigation purposes.

	Metric	Action	Reporting expectation
'Driver' metrics	Metric is **green** for current reporting month	Share success	No action required
	Metric is **green** for 6+ reporting months	Discuss changing to a 'Watch' metric	Make 'Watch' metric if agreed
	Metric is **red** for current reporting month	Share the top contributing reason for this and summary if action is required	Structured verbal update
	Metric is **red** for 2+ reporting months	1. Demonstrate understanding of the problem 2. Provide action plan	Present Exception Report
	More than 6 driver metrics are **red** for 2+ reporting months	Discuss with the meeting chair in advance which Exception Reports to present	
'Watch ' metrics	'Watch' metric is **green** for current reporting period	No action required	No action required
	'Watch' metric is **red** for current reporting period	Note metric performance and move on – unless linked to statutory standard	If statutory standard provide structured verbal update
	'Watch' is **red** for 4+ months reporting	Discuss making it a driver metric	If agreed, make driver metrics

Table 3 the Trusts Reporting Rules

7.32 Operational metrics in the integrated performance report are further distinguished to support the reporting process, between 'Driver' and 'Watch' metrics.

- **'Driver' metrics** include metrics that are consistently not performing against target / trajectory and where we want to align resources via a specific project to drive

improvement. This helps to prioritise resources for key improvement projects where they are needed.

- **'Watch' metrics** acknowledges business as usual activities to maintain performance in other areas. 'Watch' metrics include metrics that are consistently performing and this is expected to be reliably maintained through business as usual activities or where we are not currently able to directly influence performance.

7.33 In order to identify which metrics should be deemed a 'Driver' or 'Watch' metric, management teams should review historical performance against targets to determine which performance metrics have the largest gaps and pose the greatest risks to patient care, staff well-being, service delivery and financial efficiency.

7.34 Improvement trajectories should be developed for 'Driver' metrics, which can be embedded into the integrated performance report.

7.35 Risk thresholds, or tolerance levels, can be set for 'Watch' metrics that fluctuate, due to common cause variation, around the target. To identify appropriate thresholds, statistical process control (SPC) charts should be used to support the threshold setting request. Once approved, these thresholds can be embedded into the integrated performance scorecard.

Key Lines of Enquiry

7.36 One week prior to the Division Integrated Performance Review Meetings, the core executive team (COO, CPO, CFO, CMO, CN) will meet and review early drafts of the Divisional Integrated Performance Reports. In this meeting, they will agree a set of Key Lines of Enquiries (KLOEs) that will be shared with the Division in advance of the DIPRMs to ensure there is adequate discussion on the key areas of concern or where further updates or information is required.

7.37 These KLOEs will be circulated no less than 24 hours after the meeting to the divisional teams. See Appendix F for the meeting standard work for the Executive Pre-Meet.

Reporting templates

7.38 The reporting rules inform the type of update required for a particular metric or project milestone, dependent on recent performance against target or trajectory or signals from statistical process control. The rules are driven by 'by exception' principles and updates may include:

- sharing successes
- structured verbal update (SVU)
- full exception report (ER) with trend, root causes and improvement actions.

7.39 The exception report template is visual in nature and builds in improvement and structure problem solving methodology to provide greater assurance that the solution to mitigate off-track performance is based on identifying the root cause of the. The exception report comprises of the following structure: historical performance, top contributor, root cause analysis, immediate action plan.

7.40 Appendix G and H provide the template for the exception report and a guide of how to complete the exception. Appendix I provides an example template for the structured verbal update.

7.41 An overarching divisional summary report is produced each month for submission to the Trust Management Committee. This summary report highlights the monthly exceptions from the divisional integrated performance report, positive highlights, top risks and mitigations and key actions and any decisions for escalation as agreed from the

Divisional Integrated Performance Review Meetings. The exception reports are added to the appendices to this report. This report can be used for specialty performance review meetings for consistency. See Appendix J for a copy of the template.

Considerations to other Trust statutory duties

7.42 Health and safety is also a Trust statutory responsibility, of which the Chief Financial Officer has delegated overall responsibility for ensuring the Trust meets its statutory duties in this regard. Therefore, the application of this accountability framework also applies the Environment Function with the Director of Environment responsible for the delivery of all health and safety performance standards for the Trust, providing assurance of functions activities to improve adherence to standards.

Financial Accountability Framework and Monthly Reporting Cycle

7.43 The *Financial Accountability Framework* describes the framework under which the Trust's financial plan and budgets will be set, leading to clear delegation of budgets and budgetary responsibility to facilitate optimum use of resources.

- Budget setting principles will be clear and transparent with sign off of the divisional budgets by the triumvirates. Each Divisional Triumvirate (Divisional Director, Divisional Head of Nursing, and Divisional Manager) will formally approve the budget delegated to it, and by doing so, accept the responsibilities for delivering the financial plan and associated cost improvements and activity levels within the delegated budget. The Divisional Director will be ultimately accountable for the delivery of the budget and cost improvement plans.
- Budgets will be triangulated with workforce and activity plans to enable deliverability. The activity plan will outline the levels of work divisions are expecting to perform in the next year and as a by-product will also inform the level of income associated with that work while the workforce plan will be a robust assessment of the workforce required to perform the said level of activity. The budget will then detail the level of resource required to perform the activity required. Divisional planning arrangements must ensure that any risks associated with delivery are understood and must set out how those risks will be mitigated in practice throughout the year.
- Budgets will be set net of the cost improvement targets with approved schemes being accompanied by project initiation documents (PIDs) and quality impact assessments (QIAs) signed off by the appropriate chief officers.
- Appropriate training will be provided to managers in the application the principles to be adopted. This will be provided as part of the Trust's Leadership and Management Development programme. It is important that where a failure in standards of conduct or performance occurs because of a weakness in the Trust's systems or processes, learning takes place across the Trust. This will take place at several different levels: individual, departmental, Divisional level and Trust-wide. Guidelines for managers and staff will therefore be continually improved in the light of operational practice and experience.

7.44 The monthly finance reporting cycle, that supports the Accountability Framework and Financial Accountability Framework is detailed as follows:

- Day 1 to Day 4 - finance department complete month end reporting
- Day 5 - Divisional draft numbers shared with teams and queries addressed
- Day 6 - CFO sign off and draft submission to ICS and NHSE
- Day 7 - Capital, cash, productivity (ERF/VWA) and savings numbers signed off
- Day 8 - WD8 divisional finance meeting (monthly KLOEs determined)
- Day 9 - CEO report shared with CEO and Chief Officers
- Day 10 - FPC agenda meeting and monthly meeting with FPC Chair
- Day 11 - Full divisional reports with KLOEs shared with divisions
- Day 12 to 17 - Monthly Divisional Finance Review Meetings

Other supporting policies, procedures and frameworks

7.45 The *Patient Access Policy* describes in detail the arrangements for managing performance of national elective patient access standards and waiting list processes.

7.46 The *Patient Safety Incidents under the Patient Safety Incident Response Framework (PSIRF) Policy* details the Trust's approach to responding to patient safety incidents for the purpose of learning and improving patient safety. This policy details the governance framework and plan for implementing the Trust-wide approach and should be given due consideration in all integrated performance review meetings. This is to ensure the Trust is developing a culture of learning and improvement.

7.47 The St*anding Financial Instruction* (SFI) policy sets out the budget setting process, delegation of budget management process, levels of budgetary delegation and spend limits. This policy should be adhered to and observed when considering degrees of autonomy and escalation as referenced in table 4 in Section 9. Oversight Framework.

8. Risk management

8.1 This accountability framework aligns with the Trust Risk Management Strategy by ensuring that there is a forum at each level in the organisation where key risks can be identified, reviewed, challenged and monitored through the relevant risk register as required. The Trust risk appetite links with the Trust's performance KPIs and reporting rules and provides clear guidance and advice on what type of assessment should be undertaken to determine if there is a risk to the service and when action is needed.

8.2 Risk registers are reviewed at specialty, divisional, executive and Board level meetings. This allows for connected consideration and conversation around performance and supports arrangements for reporting and escalating risks.

8.3 The *Board Assurance Framework* (BAF) describes the Trusts risk appetite against key performance indicators and strategic risks that might hinder the Trusts ability to deliver its aims and objectives as set out in the Trust Strategy. It aims to help our staff and stakeholders understand the level of risk that we are prepared to accept in any given area and reduces the likelihood of erratic and inopportune risk taking, which could expose the organisation to a risk that it cannot tolerate, or prevent it from exploiting opportunities it should take. It also helps with prioritising resource allocation when there are competing priorities. Any tolerances detailed in the Board Assurance Framework should be cascaded down throughout the organisation via the Integrated Performance Reports and Risk Registers.

9. Oversight Framework: Degrees of Autonomy and Escalation

9.1 It is important to recognise positive demonstrations of improvement and sustainable performance across all performance domains, as well as having in place appropriate levels of escalation where support is required. At the end of each performance review meeting, the Executive team will agree which category the Division falls into based on their performance across all domains and the level of autonomy over decision-making or escalation support/intervention is required. Table 4 sets out a proposed framework that is subject to co-design with divisional leadership teams. Updates will be in published version 2 of this accountability framework.

9.2 The Executive Team may consider:

- The oversight category the division falls into;
- The degree to which the division understands what is driving the issue(s);
- The credibility of existing plans to address the issue(s); and
- Progress made meeting the trajectory for recovery.

9.3 If a Specialty requires special measures, a set of specific interventions will be agreed with the respective division to address the issues of concern as quickly as possible. The division will oversee the delivery of the recovery plan, providing appropriate assurance to the Executive Team.

9.4 If a division requires special measures, a set of specific interventions will be agreed with relevant executive team members to address the issues of concern as quickly as possible. This will include the development of a clear trajectory for recovery. The Executive Team will oversee the delivery of the recovery plan.

	Category	Trigger	Support	Degree of Autonomy	Review
1	**Business as usual/Maximum Autonomy:** No requirement for additional support	No material concerns	**Universal** (e.g. tools, guidance & benchmark information routinely made available to divisions)	Division/Specialty are empowered to make decisions to direct resources (people and financial within agreed delegated budgetary and spend limits) to invest/improve services within the division.	Monthly review via Division or Specialty Integrated Performance Review Meetings No additional escalation meetings required.
2	**Targeted support:** Additional support needed in one area	Moderate concern in one area	**Targeted** (defined by the Divisional Leadership Team and agreed with the Executive Team)	Division/Specialty are encouraged to direct and collaborate with Corporate resources to address the area of concern. Division/Specialty are empowered to make decisions and direct resources (people and finance as above) to invest/improve services within other areas of the division.	Monthly review via Division or Specialty Integrated Performance Review Meetings Additional meetings as required (format defined by and agreed with the Divisional Triumvirate) Ad-hoc intervention from Transformation and/or QI to help address the area of underperformance
3	**Intense support:** Mandated support in place	Moderate concern in two areas, or significant concern in one area	**Intense** (mandated by the Executive Team)	Division/Specialty must seek approval from Executive team for any proposed required investment in resources to improve services within the Division/Specialty until improvement is observed in the areas of concern.	Monthly review via Division or Specialty Integrated Performance Review Meetings Additional meetings as required and frequency to be determined e.g. fortnightly (format defined by and agreed with the Divisional Leadership Team) Structured intervention from Transformation and/or QI to help address the area of underperformance

4	**Special measures:** Direct support from the Executive Team to agree and deliver the recovery plan	Moderate concern in >2 areas and/or significant concern in 2 areas	**Special** (mandated by the Executive Team)	Division/Specialty will lose all decision making powers of authority in relation to the use of resources to the Executive until there is observed improvement in the areas of concern.	Fortnightly review via extraordinary meetings as appropriate. Additional meetings as required and frequency to be determined e.g. once a week (format mandated by the Executive Team). Potential 1:1 mentoring support to local management to direct and ensure mitigating actions.

Table 4 Proposed framework for performance support

10. Monitoring and Review

10.1 The Chief Nurse, Chief Operating Officer and Director of Corporate Governance will lead an annual review of the Performance and Accountability Framework. The review will coincide with the annual refresh of the indicators that make up the Integrated Quality and Performance report.

10.2 The Trust Management Committee will approve any proposed changes to the Performance and Accountability Framework.

Appendices

Appendix A. Living our values – value and behaviour observers:

This tool is designed to assist a nominated meeting observer to reflect on how we live our values during meetings. Feedback against expectations will help us bring our values to life and contribute to improving our culture.

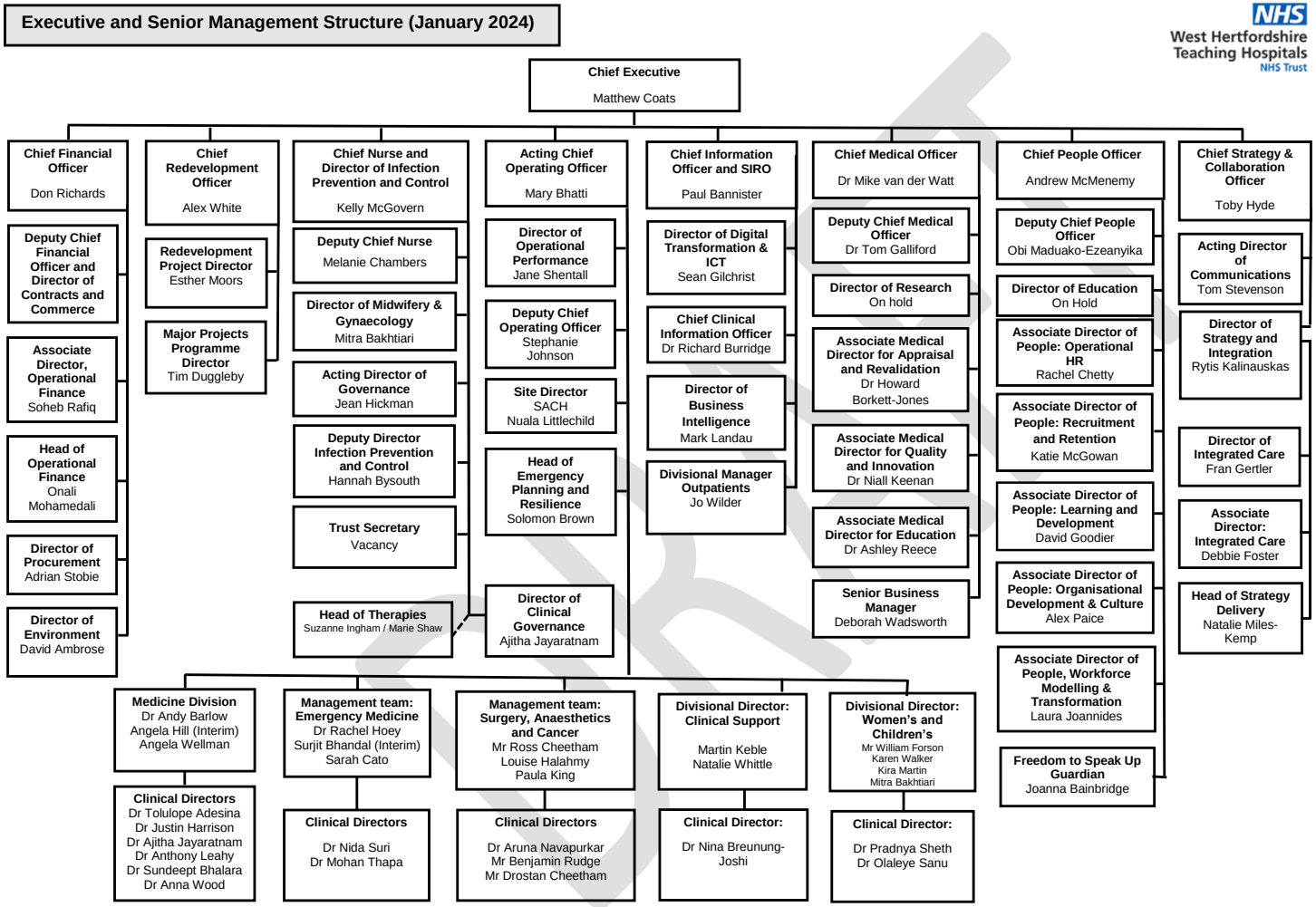
Empowered - behaviours to observe	Yes	No
Did we have an agenda and provide updates on actions from previous meeting?		
Did we acknowledge successes as part of the meeting?		
Were there opportunities during the meeting able to talk openly, share ideas and concerns?		
Was the meeting helpful and provide us opportunities to learn and build on our knowledge?		
Was an action owner assigned and recorded as part of the meeting minutes		

Compassionate - behaviours to observe	Yes	No
Was everyone kind and respectful towards each other throughout the meeting?		
Did we communicate clearly, and did we check if everyone understood the messages?		
Did everyone in the meeting actively listen and participate?		
Did we allow everyone to speak		
Did we speak over each other?		

Professional - behaviours to observe	Yes	No
Were we all prepared for the meeting?		
Did everyone turn up on time?		
Were actions distributed fairly?		
Did we take pride in our work and services by tracking impact and measures against KPIs?		
Did we discuss openly about a better way to do things?		
Was improvement methodology used? Did we mention the plan, do, act and study approach?		
Did we consider lessons learnt from previous experience or review any previous mistakes?		

Inclusive - behaviours to observe	Yes	No
Did collaboration take place during the meeting?		
Was everyone able to provide constructive feedback?		
Did the meeting ensure that everyone was included and listened to?		
Were different views and perspectives considered?		
Was compassionate leadership demonstrated, allowing quieter members to participate?		

Appendix B. Trust Executive and Senior Management Organisational Structure (January 2024)



Appendix C. Breakdown of Accountability and Responsibility Roles

Table 1. Accountability and Responsibility Roles breakdown from Chair to Specialty Leadership Team

	Accountability	Responsibility
Chair of the Board	The **Chair of the Board** is **accountable** to NHSE, ensuring the Board successfully discharges its overall responsibility for the Trust as a whole.	The **Chair** has overall **responsibility** for the operation of the Board, and has certain delegated executive powers. The Chair works in close harmony with the Chief Executive and ensures that key and appropriate issues are discussed by the Board in a timely manner.
Non-Executive Directors	**Non-Executive Directors** are **accountable** to the Chair of the Board and are not granted any individual executive powers on behalf of the Trust.	The **Non-Executive Directors** have **responsibility** to exercise collective authority when acting as members of or when chairing a Committee of the Trust which has delegated powers.
Chief Executive	The **CEO** is **accountable** to the *Board of Directors* for the effective overall management of the organisation, and for conformity with policies agreed upon by the Board.	Has overall **responsibility** for the delivery of WHT's business in accordance with the organisation's strategic goals and current year integrated performance priorities (including Quality & Safety, Operations, Finance, People and Patient Experience) and has defined levels of authority for decision-making
Executive team	Has devolved **accountability** for the management of organisational performance standards across 6 domains (Patient Experience, Quality, Safety, People, Finance, Operations) Are **accountable** to the *Chief Executive* and *Board of Directors* for the effective management of devolved accountable areas.	Has devolved **responsibility** for the delivery of strategic programmes and projects that align to the organisations strategic goals and current year integrated performance priorities and have defined levels of authority for decision-making.
Division Leadership Team	The **Divisional Director** is **accountable** for the management of performance standards across the 6 domains for the Division. Is **accountable** to the *Chief Operating Officer and Chief Medical Officer* for the effective management of performance and clinical standards for the Division.	The **Divisional triumvirate** (Divisional Director, Divisional Manager, and Divisional Head of Nursing) are **responsible** for the overall delivery of performance standards for the Division. Ensuring joint decision making that is consistently applied across the Division in all areas of policy and procedure, and that consideration is given to all aspects of service delivery. This includes the commitment to the application of QI methodology and capability building. Have joint responsibility for engaging in and communicating the impact of Redevelopment changes within the Division
Specialty Leadership Team	The **Clinical Lead** is **accountable** for the management of performance standards across the 6 domains for the Specialty. Is **accountable** to the *Divisional Triumvirate* for the effective management of performance standards for the Specialty.	The **Specialty triumvirate** (Clinical Lead, Assistant Divisional Manager, and Matron) are **responsible** for the overall delivery of performance standards for the Specialty.

Table 2. Accountability and Responsibility Roles breakdown by Executive Team member

	Accountability	Responsibility
Chief Financial Officer	Is **accountable** to the *Chief Executive* and *Board of Directors* for the effective management of statutory duties in relation to finance and health and safety.	Has overall **responsibility** for ensuring the Trust meets its statutory duties in relation to finance and health and safety. Has joint **responsibility** for ensuring the Trust delivers safe care to its patients and population.
Chief Nurse and Director of Infection, Prevention and Control	Is **accountable** to the *Chief Executive* and *Board of Directors* for the effective management of statutory duties in relation to Quality and Corporate and Clinical Governance.	Has overall **responsibility** for ensuring the Trust meets its statutory duties in relation to Quality and Corporate and Clinical Governance. Has joint **responsibility** for ensuring the Trust delivers safe care to its patients and population.
Chief Medical Officer	Is **accountable** to the *Chief Executive* and *Board of Directors* for the effective management of statutory duties in relation to Patient Safety and Medical Education, Training and Compliance.	Has overall **responsibility** for ensuring the Trust meets its statutory duties in relation to Patient Safety and Medical Education, Training and Compliance. Has joint **responsibility** for ensuring the Trust delivers safe care to its patients and population.
Chief People Officer	Is **accountable** to the *Chief Executive* and *Board of Directors* for the effective management of statutory duties in relation to Human Resources standards, Organisational Development and Culture, and Equality, Diversity and Inclusion.	Has overall **responsibility** for ensuring the Trust meets its statutory duties in relation to Human Resources standards, Organisational Development and Culture, and Equality, Diversity and Inclusion. Has joint **responsibility** for ensuring the Trust delivers safe care to its patients and population.
Chief Operating Officer	Is **accountable** to the *Chief Executive* and *Board of Directors* for the effective management of statutory duties in relation to Operational Performance.	Has overall **responsibility** for ensuring the Trust meets its statutory duties in relation to Operational Performance. Has joint **responsibility** for ensuring the Trust delivers safe care to its patients and population.
Chief Information officer	Is **accountable** to the *Chief Executive* and *Board of Directors* for the effective management of statutory duties in relation to reporting and intelligence across all organisational performance standards.	Has overall **responsibility** for ensuring the Trust meets its statutory duties in relation to reporting and intelligence across all organisational performance standards. Has joint **responsibility** for ensuring the Trust delivers safe care to its patients and population.

Table 3. Accountability and Responsibility Roles breakdown by Divisional Leadership Team member

	Accountability	Responsibility
Divisional Director	The **Divisional Director** is **accountable** for the overall management of performance standards across the 6 domains for the Division, providing assurance of Divisional activities to improve adherence to standards. The **Divisional Director** is **accountable** for the overall strategic plans for the division, providing assurance of Divisional alignment to organisation strategy. Is **accountable** to the *Chief Operating Officer* for the effective management of performance and *Chief Medical Officer* for clinical standards for the Division.	The **Divisional Director** is **responsible** for the delivery of all clinical quality and safety performance standards for the Division, providing assurance of Divisional activities to improve adherence to standards. Has joint **responsibility** for ensuring the Trust delivers safe care to its patients and population.
Divisional Manager	The **Divisional Manager** is **accountable** to the *Divisional Director* for the management of operational, divisional workforce and financial performance standards for the Division.	The **Divisional Manager** is **responsible** for the delivery of all operational, divisional workforce and financial performance standards for the Division, providing assurance of Divisional activities to improve adherence to standards. Has joint **responsibility** for ensuring the Trust delivers safe care to its patients and population.
Division Head of Nursing/ Midwifery/ AHP	The **Divisional Head of Nursing** is **accountable** to the *Divisional Director* and *Chief Nurse* for the management of quality, safety, nursing/midwifery/AHP workforce, finance, patient experience standards, and governance for the Division.	The **Divisional Head of Nursing** is **responsible** for the delivery of quality, safety, nursing/midwifery/AHP workforce, health and wellbeing, finance, patient experience standards, and governance for the Division, providing assurance of Divisional activities to improve adherence to standards. Has joint **responsibility** for ensuring the Trust delivers safe care to its patients and population.

Appendix D. Division Integrated Performance Review Meeting Terms of Reference

West Hertfordshire Teaching Hospitals NHS Trust

Division Integrated Performance Review Meeting – Terms of Reference

Definitions
"the Trust" refers to West Hertfordshire Teaching Hospitals NHS Trust
"the Board" refers to the Trust Board.
"the Division" refers collectively to the clinical divisions of the Trust
"the Specialty" refers collectively to the clinical specialties of the Trust
"Specialty Performance Review Meeting" refers to the performance meeting where the division holds the specialty to account for performance and improvement

1. **Purpose:**
   1.1. The Division Integrated Performance Review Meeting is a monthly oversight, escalation and engagement meeting, covering all domains of performance / regulatory compliance, as well as any specialty level strategic developments. The approach is one of shared accountability and joint ownership of problems impacting on performance, where performance improvement is as much about the support and accountability of corporate services on that issue as it is about the division themselves.
   1.2. This approach should also drive the planning and priorities of corporate services so the Executive agree the best use of available resources to maximise performance.
   1.3. In regards to its role in the process of business cases and financial approval, the Division Integrated Performance Review Meeting has no delegated authority in financial decision making. However, the division can raise the state of a business case and use the Division Integrated Performance Review Meeting to request support or escalate risks associated with the development or approval of a business case, in order to obtain guidance and support.
   1.4. Note the Standing Financial Instructions sets out in more detail the Trust's approach to financial decision making.
   1.5. Divisional performance is tracked via an integrated performance report, and reporting is governed by a set of reporting rules. Should priorities need to change as indicated on the report, prioritisation of initiatives against divisional capacity can be undertaken in either the Division Integrated Performance Review Meetings or the Divisional Management Committee. This ensures any change supports the Trust's overall promise of 'excellent patient care, together', and aligns with our clinical and corporate strategies and the Hertfordshire and West Essex Integrated Care System.
   1.6. Division Integrated Performance Review Meetings will be paper light and documentation will include the integrated performance report and a set of exception reports.
   1.7. Update on actions and mitigations will be provided with any issues escalated where appropriate.
   1.8. A member of the executive team will present a Trust and ICS update to the Divisional team with an opportunity for questions. This will provide timely information and transparency regarding the priorities of the organisation.
   1.9. The Division will provide a summary report to the Trust Management Committee, as part of its routine divisional management report, including any issues for escalation arising from directorate oversight meetings held in the last period.

2. **Membership**

2.1. The Chief Operating Officer will chair the Division Integrated Performance Review Meeting. In the absence of the chair and/or nominated deputy, the remaining members present shall elect one of themselves to chair the meeting.
2.2. Members are expected to attend each meeting of the Division Integrated Performance Review Meetings unless on leave or in exceptional circumstances; when members are unable to attend, deputy representation should be arranged.
2.3. The Division Integrated Performance Review Meeting membership will comprise the following:

Divisional Leadership team:
- Divisional Director
- Divisional Manager
- Divisional Head of Nursing
- clinical or non-clinical leaders as invited by triumvirate
- People and OD business partner
- Finance business partner

Executive Team:
- Chief Operating Officer
- Chief Financial Officer
- Chief People Officer
- Chief Nurse
- Chief Medical Officer
- Divisional Director for Medicine
- Divisional Director of Surgery and Cancer
- Divisional Director of Women's & Children's
- Divisional Director of Clinical Services

3. **Quorum**

3.1. A quorum requires the presence of not less than one half of members present, with at least one representative from each team. A duly convened meeting of the Division Integrated Performance Review Meeting at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by Executive or Division present.

4. **Secretary**

4.1. The office of the director of corporate governance and trust company secretary will provide secretariat support to the Division Integrated Performance Review Meeting, including the schedule of meetings and noting actions.
4.2. The format of the meetings is designed to be paper-lite, the report (web-link) and accompanying exception reports will be circulated by the respective Divisional Director ahead of each meeting.

5. **Frequency of meetings, format and attendance requirements**

5.1. The Division Integrated Performance Review Meetings will meet monthly for a period of 75 minutes.
5.2. The Division Integrated Performance Review Meeting members should aim to attend all scheduled meetings as set out in Section 3.

6. **Notice of meetings**

6.1. Unless otherwise agreed, notice of each meeting confirming the venue, time and date shall be forwarded to each member of Division Integrated Performance Review Meeting and any other person required to attend, no later than two working days before the date

of the meeting. Supporting papers shall be sent to members and to other attendees as appropriate, at the same time. Papers will be uploaded to an appropriate MS Teams channel.

7. **Actions of meetings**
   7.1. The corporate governance team will record actions of all meetings of the Division Integrated Performance Review Meetings.
   7.2. A note of actions will be agreed following each meeting and will be shared with all members promptly. Progress against agreed actions will be reported at the next meeting. All actions will be saved in a MS team's folder that everyone can easily access.

8. **Reporting responsibilities**
   8.1. The Divisional Directors will provide a divisional report to the Trust Management Committee covering any key messages and exceptions arising from these review meetings.

9. **Other matters**
   9.1. The Division Integrated Performance Review Meeting and its members should:
   - Act in accordance with the values and behaviours of the Trust in all undertakings.
   - Read all papers prior to the meeting to aid effectiveness
   - Each meeting will conclude with a review of values and behaviours exhibited at the meeting.
   - Have access to sufficient resources in order to carry out its duties
   - Give due consideration to laws and regulations
   - Review its own performance and terms of reference, on an annual basis, to ensure it is operating at maximum effectiveness and recommend to the Trust Management Committee for approval, any changes it considers necessary.

10. **Monitoring and Review**
   10.1. The Chief Operating Officer and Chief Financial Officer will monitor the effectiveness of, and appropriateness of, the terms of reference of the Division Integrated Performance Review Meeting, via the Trust Management Committee.
   10.2. The annual cycle approach will be maintained by the Trust Secretariat and Division Integrated Performance Review Meetings will be referred to in the Trust forward planner.

Appendix E. Division Integrated Performance Review Meeting Standard Agenda

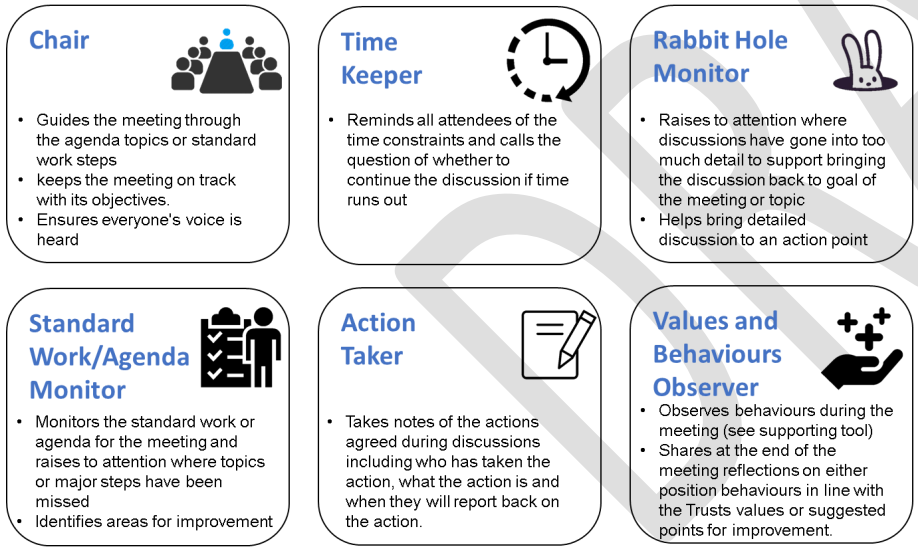
Division Integrated Performance Review Meeting standard Agenda					
Last updated:	01/03/2024	Owner:	Kelly McGovern	Performed by	Various
Meeting length:	75 minutes	Revised by:	Sophie Massie (interim consultancy support)	Revision #: 1	1

Purpose: The Division Integrated Performance Review meetings form part of our formal governance process. Once a month the executive team will meet with the Division in an oversight and engagement meeting. They are intended to provide a view of performance from the past month, celebrate successes, understand current state, issues blocking progress and agree solutions or actions. The meetings are paper light with a focus on dialogue, appreciative enquiry and clear actions with owners. Time is dedicated at the end of the meeting for reflection so that we can continuously improve on the process.

Supporting documentation: This meeting is paper light with a set of exception reports and the integrated performance report. These documents should be accessible on MS Teams and shared on screen. Actions will be tracked in an action log, also stored in MS teams.

#	Major Steps	Details	Time
1.	**Welcome and introduction**	1. Welcome and apologies 2. Confirm meetings roles (see descriptions on following page): a) Chair b) Time keeper c) Rabbit hole monitor and standard work monitor d) Action taker e) Values and behaviours observer (uses supporting tool)	2 minutes
2.	**Actions**	Review the action log	3 minutes
3.	**Risk Register**	1. Review the risk register 2. Division raises any risks they need to escalate	5 minutes
4	**KLOE summary**	KLOEs reviewed and a response provided upfront or signposted to where the response will be provided	5 minutes
5.	**Performance review (repeat for each domain)**	1. Response to KLOEs as required 2. Division provides a review of performance (Quality, Safety, People, Operations, Finance). Responses provided following reporting rules. 3. Summary of actions in relation to performance domain Agree next steps and any escalations for specialty deep dive (3 min)	Approx. 40 minutes total

6.	**Share highlights**	Share your top highlights, key achievements, local innovation and/or improvement projects and learnings for the past month.	5 minutes
7.	**Deep dive summary and next steps**	1. Review the agreed escalations for Division/Specialty deep dive	5 minutes
8.	**Division oversight category**	Agree the oversight category that the division is in following the performance and accountability escalation guidance	2 minutes
9.	**AOB**	Division presents or raises any other business they wish to discuss	3 minutes
10.	**Confirm actions**	The action taker/scribe reviews recorded actions and owners for agreement.	2 minutes
11.	**Review effectiveness of the meeting**	1. Reflect on the meeting standard work A. Observations from the values and behaviours observer B. General feedback from all in the meeting C. What would we do differently in our next meeting? Confirm next time/date	2 minutes



Meeting Roles Descriptions

Appendix F. Executive Pre-Meet for Division Integrated Performance Review Meeting Standard Work

Executive Pre-Meet Meeting Standard Work					
Last updated:	01/03/2024	Owner:	Kelly McGovern	Performed by	Various
Cycle time:	60 minutes	Revised by:	Sophie Massie (interim consultancy support)	Revision #:	1
Trigger:	Start of the meeting	Done:	Close of meeting		

Purpose: The executive pre-meet is a preparatory step for the Division Integrated Performance Review meetings. During the meeting, divisional performance will be reviewed and key lines of enquiry will be established for KPIs that are off track against improvement trajectory. The KLOEs will be provided to the divisions to support them in preparing for the Division Performance and Accountability Review Meeting.

#	Major Steps	Details (if applicable)	Diagram, Work flow, Picture, Time, Grid
1.	**TMC consolidation**	3. TMC feedback / key issues – establish any questions or follow up required	15 minutes TMC division reports
2.	**Integrated performance report review**	4. Integrated performance report review across the each domain of performance	10 minutes per division Division and directorate integrated performance scorecard
3.	**Additional considerations**	5. Are there any other KLOEs that need to be considered outside of the integrated performance reports	10 minutes
4.	**Summary and agreement**	6. Summarise KLOEs to be communicated to the division in preparation for the Division Integrated Performance Review Meeting	5 minutes

Appendix G. Exception Report Template

Exception Report: [Title of the metric]

Problem Statement: *[Include:*

- *the current state of performance and the gap with the target*
- *The impact performance has on patients, e.g. quality, safety, experience*
- *The impact performance has on the business, e.g. staff, finances*
- *Any trends we currently know of*

Aim to keep the problem statement objective, avoiding potential causes and blame]

Performance Domain: e.g. Quality, Safety, Finance

Metric: XX

Desired Trend: ↓ or ↑

Narrative:

What is the data telling us?

- XX
- XX

What is driving it, what are the underlying causes?

- XX
- XX

What are we doing about it?

- XX
- XX

What do we expect to see change (and when)?

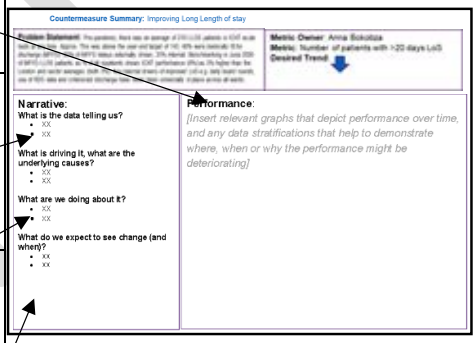
- XX
- XX

Performance:

[Insert relevant graphs that depict performance over time, and any data stratifications that help to demonstrate where, when or why the performance might be deteriorating]

Appendix H. Exception Report Template Guidance

Exception Report Template Guidance standard work					
Last updated:	1 March 2024	Owner:	Kelly McGovern	Performed by	Presenter
Cycle time:	6-8 minutes	Revised by:	Sophie Massie	Revision #:	1
Trigger:	Reporting Rules	Done:	Questions complete		

#	Major Steps	Time	Diagram, Work flow, Picture, Time, Grid
1.	Share following information from header of the Exception Report: • Current problem statement • What you are measuring • An additional description of the measure (if needed) • The performance domain of the metric • The target • Desired trend (up or down)	30 sec	
2.	**Summarise Main Performance Graph (historical data)** by answering the following 3 questions: • Are you at target? • Are you improving? • Are you consistent?	1 min	
3.	**Summarise What is the Data Telling Us (Stratification of Data)** by answering the following 2 questions: • How have you stratified the data? • What did the stratification tell you about better understanding your problem statement?	1 min	
4.	**Summarise What is Driving the Problem (Top Contributors / RCA)** by answering the following questions: • How have you carried out your root cause/top contributors analysis? • How did you further stratify the data? • What did the stratification tell you? • How do you validate the data? • How much do you expect to improve performance if you alleviate a particular top contributor?	1.5 mins	
5.	**Summarise What are we doing about it (Action Plan);** describe what you will do in the next 30 days to improve performance by briefly answering the following questions line-by-line: • What are the improvement actions? • What is your hypothesis about why these actions will improve performance? • Who owns the action? • What is the completion date?	1.5 mins	
6.	Answer questions from team/audience	2 mins	

Appendix I. Structured Verbal Update Guide Structure

Metric: [Title of the metric]

Metric Performance	Sep	Oct	Nov

The target for the metric is:

The current status of the metric is: RED / GREEN

The current metric performance is:

Is the improvement plan on track and meeting the agreed milestones? YES / NO

The top contributory factors for off-track performance are:

The recovery plan is:

The forecast risks ahead the need mitigating are:

The help or support I need is:

To celebrate success we are / we can:

Questions or comment?

Appendix J. Division Summary Report to TMC template

Report to Trust Management Committee

Division report from ……. [Insert e.g. Medicine]

Oversight Category: …….

[*Integrated Performance Report and Exception reports from Division Integrated Performance Review meetings added to the appendices for reference*]

1. Exceptions/outliers from Integrated Performance Report

1.1. Performance Summary

High-level summary bullets of observations from the performance report and what have been the key priorities for the division over the last month

- …
- …
- …

2. Positive highlights

AREA	HIGHLIGHT	COMMUNICATION PLAN

3. Top risks and mitigations

DATIX ID	TITLE	DESCRIPTION	CONTROLS IN PLACE	RATING (INITIAL)	LIKELIHOOD (CURRENT)	CONSEQUENCE (CURRENT)	RATING (CURRENT)	RATING (TARGET)	TARGET RISK SCORE DATE	DATE RISK REVIEWED

4. Key actions from Division Integrated Performance Review Meeting and decisions for escalation

AREA	ACTION OR DECISION REQUIRED

Author (name and position)
Date

NHS
West Hertfordshire Teaching Hospitals
NHS Trust

Trust Board
04 April 2024

Title of the paper	**Board and Committee Governance: 2023/24 Terms of Reference and work plans**
Agenda Item	**24**
Presenter	**Jean Hickman, Director of Governance**
Author(s)	**Georgina Theobald, Corporate Governance Manager**
Purpose	*Please tick the appropriate box* *For approval*: x *For discussion*: *For information*:
Executive Summary	The attached papers provide updated terms of reference and work plans for the Board and the following committees: 1. Audit Committee 2. Renumeration Committee 3. Finance and Performance Committee 4. Redevelopment Programme Committee 5. People, Education and Research Committee Each of the above committees has reviewed its terms of reference and work plan for 2024/25 and recommended them to the Board for approval.
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?

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	☒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	The committees set out above have approved their terms of reference and work plans.
Action required	The Board is asked to approve the terms of reference and work plans for 2024/25 for Board meetings and for the sub-committees,

West Hertfordshire Teaching Hospitals NHS Trust

TRUST BOARD

TERMS OF REFERENCE

Chair: Trust Chair

Clerk: Trust Secretary

Frequency of Meetings: 10 meetings per year

Quorum: Three Non-Executive Directors (one must chair the Board) and three Executive Directors

1. Constitution

1.1 The West Hertfordshire Hospitals Teaching NHS Trust Board (the Board) is the managing body of the Trust and is responsible for exercising all the powers of the Trust.

1.2 The constitution of the Board conforms to the requirements laid down in the Health Act 2006, with a Chair, Chief Executive, Executive and Non-Executive Directors.

1.3 The Chair of the Trust is responsible for leading the Board.

1.4 The Board will function as a corporate decision-making body, considering the key strategic issues facing the Trust in carrying out its statutory and other functions.

1.5 The Board may delegate any of its powers to a committee of the Board or an Executive Director. Arrangements for the reservation and delegation of powers are set out in the Trust's Standing Orders and Standing Financial Instructions.

2. Purpose

2.1 The purpose of the Board is to govern the organisation effectively and in doing so to build public and stakeholder confidence that their health and healthcare is in safe hands and ensure that the Trust is providing safe, high-quality, patient-centred care.

2.2 The Board's fundamental role is therefore, to establish the vision, strategic direction and corporate objectives for the organisation, to ensure accountability for that strategy and to shape the culture of the organisation.

3. Membership

3.1 The membership will comprise of:

- Trust Chair
- Non-Executive Directors

- Chief Executive
- Chief Operating Officer
- Chief Medical Officer and Director of Patient Safety
- Chief Nurse and Director of Infection Prevention and Control
- Chief Financial Officer

3.2 The Trust Chair will be the Chair of the Board.

3.3 A Vice Chair of the Board will act in the absence of the Chair.

3.4 Other Executive Directors will be invited to attend the Board meetings to present specific items on the agenda as required.

3.5 In the absence of a quorum, meetings will continue to be held and any decisions made will be ratified at the next quorate meeting of the Board for actions to be acted upon.

4. Duties

4.1 The Board will:

4.1.1 Determine and keep under review the Trust's strategic direction, within the overall policies' and priorities' framework of the Government and the NHS.

4.1.2 Agree and maintain the Trust's vision, aims and objectives, ensuring that the necessary financial, physical and human resources are in place for it to meet the objectives.

4.1.3 Support the aims of the Integrated Care Partnership.

4.1.4 Exercise its functions as Corporate Trustee of Raise (West Hertfordshire Hospitals NHS Trust Charity).

4.1.5 Formulate the Trust's strategy to deliver safe, high quality, patient-centred care.

4.1.6 Agree the annual business plan for the Trust, including the annual financial plan, as a means of taking forward the strategy.

4.1.7 Agree and maintain the Trust's operational plan.

4.1.8 Take decisions on significant service changes, investment/disinvestment opportunities and other strategic matters as expressly reserved to the Board.

4.1.9 Hold the organisation to account for its performance in the delivery of the Trust's strategy and the achievement of the Trust's strategic objectives.

4.1.10 Receive regular reports on performance against objectives, business plans and budgets in respect of:

- Finance
- Hospital redevelopment
- Digital transformation
- Operational performance
- Quality (safety, clinical effectiveness and patient experience)
- Workforce
- Risk management and internal control
- Matters that may materially affect the reputation of the Trust.

4.1.11 Ensure effective financial stewardship through effective value for money, financial control and financial planning and strategy.

4.1.12 Seek assurance that the systems of governance, risk management and internal control operating in the Trust are robust, reliable, support the delivery of the annual plan and comply with Care Quality Commission and any other registration requirements.

4.1.13 Approve and keep under review the Trust's arrangements for the management of risk.

4.1.14 Approve joint ventures, new business ventures, partnerships and strategic alliances that are material in terms of the business of the Trust.

4.1.15 Approve acquisitions and disposals of assets that are material in terms of the business of the Trust.

4.1.16 Establish Committees and approve their Terms of Reference.

4.1.17 Approve the appointments of Chairs and members of Board Committees.

4.1.18 Approve the appointment of the Senior Independent Director and the Vice Chair from among the Non-Executive Directors of the Board.

4.1.19 Receive and consider assurance reports from Board committees.

4.1.20 Carry out the duties of the Trust's role as Corporate Trustee for the Raise Charity.

4.1.21 Take collective responsibility for adding value to the organisation by promoting its success through the direction and supervision of its affairs.

4.1.22 Provide active leadership within a framework of prudent and effective controls which enable risk to be assessed and managed.

4.1.23 Set the organisation's values and standards, while ensuring its obligations to patients, the local community and the Secretary of State are understood and met.

5. Required Attendance

5.1 Board members should aim to attend all scheduled meetings and must attend at least 70% of all meetings each financial year.

6. Frequency of Meetings

6.1 The Board will meet monthly, with at least ten meetings a year held in public or virtually (with public access) according to national requirements.

6.2 Only matters which are confidential on the grounds of commercial sensitivity or involving staff issues will be discussed in a separate closed session which will not be attended by members of the public. The preference is for all matters to be discussed in open sessions where possible.

6.3 The Board will hold regular informal seminars/board development workshops.

6.4 The Board will hold an Annual General Meeting each year to receive the annual report and accounts of the Trust.

7. Reporting Arrangements

7.1 The minutes of all meetings will be formally recorded and submitted to the Board at the next possible opportunity. The minutes of the meetings held in public will be published on the Trust website.

8. Monitoring Effectiveness and Compliance with Terms of Reference

8.1 The Board will carry out an annual review of its effectiveness.

Terms of reference ratified by: Trust Board

Date of ratification:

Date of review:

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

Patient Safety Incident Response Framework (PSIRF) update (rollout)				✓								
Annual report on legal services									→		✓	
Aim 2: Best Value												
Outline and final business cases for capital investment more than £1m (as required)	As required											
Ratify proposals for acquisitions, disposals or changes of use and/or buildings (as required)	As required											
Approval to open bank accounts (as required)	As required											
Finance update	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Aim 3: Great Team												
Research and development update								✓				
Public Sector Equality Annual Report												✓
Equality Delivery System				✓								✓
Gender and race pay gap report								✓				
Outcome of national staff survey/progress report		✓										
Annual medical appraisal report and statement of compliance						✓						
Annual People Strategy update							✓					
Bi-annual freedom to speak up/whistle blowing report and strategy		✓							✓			
High impact change action plan for equality, diversity and inclusion	✓											
Annual report on Guardian of Safe Working						✓						
Teaching Hospital Benefits update							✓					
Fit and Proper Persons Compliance Report (FPPR Report)		✓										
Fit and Proper Persons Regulation Report (FPPR Report)	✓											
Aim 4: Great Place												
Strategy 2024 - 2029, including vision, values and strategy + accountability framework (approval)	✓											
Strategy update	✓		✓			✓		✓			✓	
Better Care Delivered Differently report (final)	✓											
Green Plan - annual review						✓						
Digital progress Report			✓			✓			✓			✓
Progress update on major capital projects (outline business cases/full business cases)	As required											
Redevelopment update	✓			✓			✓			✓		
Risk and governance												
Standing orders update	✓											
Quality and Safety Committee Refresh		✓										
Charity Committee strategy		✓										
Accountabilty Framework review/update				✓			✓				✓	
Corporate risk register report	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Board and committee terms of reference and work plans review	✓	✓										
Annual review of Board and committee effectiveness			✓									
Items consider for Private Trust Board	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Board and committee meeting schedule						✓						
Audit Committee annual report				✓								
Annual statement of actions taken to prevent slavery and human trafficking			✓									

Annual self-certification process		✓										
Use of the Trust Seal (*via Audit Committee assurance report)*	✓		✓				✓		✓			✓
Report on standing financial instructions, standing orders and scheme of delegation (*via Audit Committee assurance report)*							✓					
Approval of annual report, annual accounts, annual governance statement and quality account (*via Audit Committee assurance report*)								✓				
Assurance reports from committees												
Closing												
Any other business previsouly notified to the Chair	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Questions from Hertfordshire Healthwatch	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Questions from the public	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Date of next board meeting	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓

AUDIT COMMITTEE

TERMS OF REFERENCE

Status:	Board committee
Committee Chair	Non-Executive Director
Clerk	Trust Secretary
Frequency of Meetings	Quarterly (plus one informal and one extra-ordinary meeting to consider and approve the annual accounts, annual report (including the governance statement).
Quorum	The committee shall be quorate with two Non-Executive Directors (one being the Committee Chair)

1. Constitution

1.1. The Board hereby resolves to establish a committee of the Board to be known as the Audit committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference.

2. Purpose

2.1. The purpose of the Committee is to provide the Board with assurance concerning all aspects of internal and external audit, integrated governance and internal control and to ensure that they are in place and functioning to support the achievement of the Trust's objectives.

2.2. To assure the Board that, where there are issues of internal control that may jeopardise the Trust's ability to deliver its objectives, that these are being managed in a controlled way through the Trust Management Committee.

2.3. To exercise the functions set out in part 3, section 9 of the Local Audit and Accountability Act 2014.

3. Membership

3.1. The Committee shall be appointed by the Board from amongst its independent, Non-Executive Directors and shall consist of no less than three members. A quorum shall be two of the three independent members. One of the members will be appointed Committee Chair by the Board.

3.2. The Trust Chair shall not be a member of the Committee.

4. Attendance at meetings

4.1. The members of the executive team listed below will be invited to meetings of the

Committee on a regular basis and other executive directors/senior managers should be invited to attend, particularly when the committee is discussing areas of risk or operation that are the responsibility of that director/manager.

- Chief Financial Officer
- Clinical Director of Clinical Governance
- Chief Nurse
- Chief Executive

4.2. Members of the executive team listed may nominate an appropriate deputy to attend in their absence. However, they shall not routinely allocate attendance at the Committee to their nominated deputy and this shall only happen as a result of planned or unforeseen absence. The Chief Nurse's deputy is not required to attend if the Director of Clinical Governance is in attendance and vice versa.

4.3. In the absence of a quorum, meetings will continue to be held and any decisions made will be ratified at the next quorate meeting of the Committee in order for actions to be acted upon.

4.4. Non-Executive Directors have a standing open invitation to attend any meetings of the Committee and to have access to the agenda and papers on request from the Trust Secretary. Any Non-Executive Director asked to attend the meeting will count towards the quorum save for the Trust Chair.

4.5. Representatives from the following bodies shall be required to attend each formal meeting of the Committee:

- Internal audit
- External audit
- Local counter fraud specialist

4.6. In the absence of the Committee Chair, a Non-Executive member will chair the meeting.

4.7.

4.8. Representatives from other bodies and other individuals may be invited to attend on occasion.

4.9. The Trust Secretary shall be secretary to the Committee and shall be responsible for the taking of minutes of the meeting and provide appropriate support to the Committee Chair and Committee members.

4.10. At least annually, the Committee should meet privately with the external and internal auditors.

4.11. The Head of Internal Audit and representatives of external audit have a right of direct access to the Committee Chair.

5. Frequency of meetings

5.1. The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.

5.2. The Board, Committee Chair, Chief Executive Officer, external auditors or Head of Internal Audit may request an additional meeting if they consider that it is necessary.

6. Authority

6.1. The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information required from any employee and all employees are directed to cooperate with any request made by the Committee.

6.2. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of others with relevant experience and expertise if it considers this necessary.

7. Responsibilities

7.1. The Committee's duties/responsibilities can be categorised as follows:

Integrated governance, risk management and internal control

7.2. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activity (clinical and non-clinical), that supports the achievement of the Trust's objectives.

7.3. In particular, the Committee will review the adequacy and effectiveness of:-

- all risk and control related disclosure statements (in particular, the annual governance statement), together with an accompanying head of internal audit opinion, external audit opinion or other appropriate independent insurances, prior to submission to the Board
- the underlying assurance processes that indicate the degree of achievement of the Trust's objectives, effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- the policies for ensuring compliance with relevant regulatory legal, code of conduct requirements and any related reporting and self-certification
- the policies and procedures for all work related to counter fraud, bribery and corruption, as required by NHS Counter Fraud Authority (NHSCFA)

7.4. In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions. However, it will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

7.5. This will be evidenced through the permitted use of an effective assurance framework to guide its work and the audit and insurance functions that report to it.

7.6. As part of this integrated approach, the Committee will have effective relationships with other key committees (e.g. the Quality and Safety Committee) so that it understands processes and linkages. However, the other committees must not usurp the Audit Committee's role.

Internal audit

7.7. The Committee shall ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards 2017 and provide appropriate independent insurers to the Committee, Chief Executive Officer and the Board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved.

- Reviewing and approving the annual internal audit plan and more detailed program of work, ensuring that this is consistent with the audit needs of the Trust's as identified in the assurance framework.
- Considering the major findings of internal audit work (and management response), and ensuring coordination between the internal and external auditors to optimise the use of audit resources.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the Trust.
- Monitoring the effectiveness of internal audit and carrying out an annual review.

External audit

7.8. The Committee shall review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications of management response to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the Board when appropriate).
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan.
- Discussing with the external auditors the evaluation of audit risks and assessment of the Trust and the impact on the audit fee.
- Reviewing all external audit reports, including the report to those charged with governance (before the submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of the management responses.
- Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

Other assurance functions

7.9. The Committee shall review the findings of other significant assurance functions, internal and external to the Trust, and to consider the implications for the governance of the Trust. These will include, but not limited to, any reviews by the Department of Health and Social Care arm's length bodies for regulators/inspectors, e.g. the Care Quality Commission, NHS Resolution, etc. and professional bodies with responsibility for the performance of staff or functions, e.g., Royal colleges, accreditation bodies, etc.

7.10. In addition, the Committee will review the work of all the committees within the Trust, whose work can provide relevant assurance to the Audit Committee's own area of responsibility. In particular, this would include any clinical governance, risk management or quality committees that are established.

7.11. The Audit Committee will satisfy itself on the assurance that can be gained from the clinical audit function.

Counter fraud

7.12. The Committee shall satisfy itself that the Trust has adequate arrangements in place for counter fraud, bribery and corruption that meet NHS Counter Fraud Authority's (NHSCFA) standards and shall review the outcomes of work in these areas.

7.13. The Committee will refer any suspicions of fraud, bribery and corruption to the NHSCFA.

Management

7.14. The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

7.15. The Committee may request specific reports from individual functions within the Trust, e.g. clinical audit.

Financial reporting

7.16. The Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- The wording in the annual governance statement and other documents relevant to the terms of reference of the committee.
- Changes in, and compliance with, accounting policies, practising and estimation techniques.
- Adjusted misstatements in the financial statements.
- Significant judgements in preparation of financial statements.
- Significant adjustments resulting from the audit.
- Letters of representation.
- Explanations of significant variances.

Whistle-blowing

7.17. The Committee shall review the effectiveness of arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently. The Committee shall ensure, via assurance from the People, Education and Research Committee, that these arrangements allow proportionate and independent investigation of such matters and appropriate follow-up action.

8. Reporting

8.1. The Committee shall report to the Board on how it discharges its responsibilities.

8.2. The minutes of the committee meetings shall be formally recorded and submitted to the next Audit Committee meeting for approval.

8.3. The Committee Chair will draw attention of the Board to any issues that require disclosure to the Board, or require executive action.

8.4. The Committee will report to the Board at least annually on its work in support of the annual governance statement, specifically commenting on:

- The fitness for purpose of the assurance framework.
- The completeness and 'embeddedness' of risk management in the Trust.
- The integration of governance arrangements.

- The appropriateness of the evidence that shows the Trust is fulfilling regulatory requirements relating to its existence as a functioning business.
- The robustness of the processes behind the quality account.

8.5. This annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

9. Administrative support

9.1. The Committee should be supported administratively by the Trust Secretary or governance lead. His or her duties in this respect will include:

- Agreement of agendas with the Committee Chair and attendees.
- Preparation, collation and circulation of papers in good time.
- Ensuring that those invited to each meeting attend.
- Ensuring accurate, quality minutes are taken and provided to the Committee Cahir within three weekd of each meeting.
- Helping the Committee Chair to prepare an assurance report to the Board.
- Keeping a record of matters arising and issues to be carried forward.
- Arranging meetings for the Committee Chair, e.g. with the internal and external auditors or
  local counter fraud specialist.
- Maintaining records of members' appointments and renewal dates, etc.
- Advising the Committee on personal issues/areas of interest/policy developments.
- Ensuring action points are taken forward between meetings.
- Ensuring that committee members receive the development and training they need.

10. Review and monitoring

10.1. The Committee shall undertake and evidence an annual review of its performance against the NHS Audit Committee Handbook's self-assessment checklist in order to evaluate its effectiveness, the fulfilment of its functions in connection with its terms of reference and achievement of duties. This report will be provided to the Board as part of its audit committee annual report.

10.2. Terms of reference will be reviewed annually and approved by the Board.

Terms of reference ratified by: Trust Board

Date of ratification

Date of review **November 2023**

AUDIT COMMITTEE WORK PLAN 2024-25

		11 April 2024 (informal)	21 May 2024	17 June 2024 *(extra-ordinary)*	17 September 2024	19 November 2024	4 March 2025
1.							
1.1	Apologies for absence	√	√	√	√	√	√
1.2	Declaration of Interests	√	√	√	√	√	√
1.3	Minutes of the last meeting		√		√	√	√
1.4	Matters arising/action log		√		√	√	√
1.5	Review agenda against agreed work plan		√		√	√	√
2.							
2.1	Review Audit Committee terms of reference and work plan for forthcoming year for Board adoption					√	
2.2	Audit Committee self-assessment (commence process for next year after March 24 meeting)		√				Start process
2.3	Review Audit Committee annual report		√				
3.							
3.1	Receive Chief Financial Officer overview (verbal)		√		√	√	√
3.2	Review timetable for the production of annual accounts (including accounting policies and significant judgements) and annual report and annual governance statement.						√
3.3	Consideration of draft annual accounts, annual report and the annual governance statement	√					
3.4	Approve annual accounts (including unadjusted and adjustments), annual report and the annual governance statement and recommend Board adoption			√			
4.							
4.1	Receive internal audit progress report		√		√	√	√
4.2	Receive internal audit annual report and Head of Internal Audit Opinion	√					
4.3	Review outstanding auditors recommendation		√		√	√	√
4.4	Review and approve internal audit annual plan for forthcoming year						√

November 2023

5.							
5.1	Receive counter fraud progress report		√		√	√	√
5.2	Review counter fraud self-assessment prior to submission to NHS Protect						√
5.3	Review counter fraud annual plan for forthcoming year						√
6.							
6.1	Receive external audit progress report	√	√				√
6.2	Receive annual audit findings			√			
6.3	Receive annual audit letter			√			
6.4	Review external audit plan						√
7.							
7.1	Committee assurance programme		√ (FPC PERC)		√ (QSC RPC)	√ (RC)	√ (Charity TMC)
7.2	Review and approval of updated standing orders, standing financial instructions and scheme of delegation				√		
7.3	Review annual clinical audit plan				√		
7.4	Review insurance policy compliance					√	
7.5	Review internal audit and external audit performance						√
7.6	Review of quality compliance framework						√
8.							
8.1	Review losses and compensation register				√ (review)	√	√
8.2	Review waiver/tender register (Inform Director of Procurement of any changes/workplan update)		√		√	√ (review)	√
8.3	Review staff salary overpayments				√	√	(review) √
8.4	Review conflicts of interest register		√		√	√	√
8.5	Review use of the Trust seal		√		√	√	√
9.							
9.1	Review of Terms of Reference and annual work plan				√		
10.							

10.1	Meeting with internal and external auditors				√		
11.							
11.1	Draft agenda for the next meeting	√	√		√	√	√
11.2	Items for escalation to the Board	√	√	√	√	√	√
11.3	Any other business	√	√		√	√	√

West Hertfordshire Teaching Hospitals NHS Trust

REMUNERATION COMMITTEE

TERMS OF REFERENCE

Status:	Committee of the Trust Board
Chair:	Non-Executive Director
Secretary:	Chief People Officer
Frequency of Meetings:	At least 2 times per year
Quorum:	Three members of the Committee (including the Chair)

1. Authority

1.1 The Remuneration Committee is constituted as a standing committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference. Its constitution and terms of reference are set out below and can only be amended with the approval of the Trust Board.

1.2 The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee of the Trust and all employees are directed to cooperate with any request made by the Committee.

1.3 The Committee is authorised by the Trust Board to obtain outside legal, remuneration or other independent professional advice and to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

2. Purpose

2.1 The Remuneration Committee shall have delegated authority from the Trust Board to set the remuneration, allowances and other terms and conditions of office for the Trust's Executive Directors covered by Very Senior Managers (VSM) terms and conditions. In addition to recommend and monitor the structure of remuneration, including setting pay ranges and receiving at least annual reports for VSM Directors.

The Committee will also be responsible for succession planning for the role of the Trust's Chief Executive and receiving assurances that adequate succession planning processes are in place for VSM roles and other organisationally critical roles.

3. Membership

3.1 The Committee shall be appointed by the Trust Board and comprise the Trust Chair and all Non-Executive Directors of the Trust. One member of the Non-Executive will be appointed as the Chair of the Remuneration Committee.

3.2 A quorum shall be three members (including the Chair of the Committee who must be a NED)

3.3 Members should make every effort to attend as many meetings of the Committee as possible. The Committee Secretary will monitor attendance by members and report this to the Chair of the Committee on a regular basis.

3.4 Should the quoracy not be met, the meeting will go ahead on the understanding that no key decisions can be made or significant actions taken.

4. Attendance

4.1 The Chief Executive and the Chief People Officer shall normally be in attendance except when issues regarding their own positions are discussed.

4.2 Other directors or any other individual deemed appropriate by the Committee may be invited to attend by the Chair of the Committee for specific items.

4.3 The Chief People Officer shall act as Secretary to the Committee and provide appropriate administrative support to the Chair and Committee. This will include agreement of the agenda with the Chair, collation of papers, taking the minutes and keeping a record of matters arising and issues to be carried forward and advising the Committee as appropriate.

5. Frequency of meetings

5.1 Meetings of the Remuneration Committee shall be held as deemed necessary by the Chair but not less than twice a year with four meetings scheduled annually.

5.2 Where it is necessary for decisions to be taken between meetings of the Remuneration Committee, these decisions shall be taken by the Chair of the Committee after consultation with a quorate number of committee members, and ratified and minuted at the next meeting of the Committee to ensure an effective audit trail.

6. Reporting

6.1 The approved minutes of the Remuneration Committee's meetings will be circulated to the Trust Chairman, all Non-Executive Directors, the Chief Executive and the Chief People Officer. The minutes will not be shared with executive directors unless agreed on a case-by-case basis by the Chair of the Committee.

6.2 The Chair of the Committee will provide the Trust Chair with relevant items, with particular attention to any issues that require disclosure to the full Board or require Board approval or ratification. This will be presented as part of the Trust Chair report to part 2 of Trust Board after each Committee meeting or within a separate paper to Part 2 of the Board where this is required.

These items will have due regard for the sensitive nature of some of the Committee's discussions, which for clarity means that they would not under normal circumstances report upon individual remuneration.

6.3 The Trust's Annual Report, which is approved by the Trust Board, shall include a statement of the Trust's broad remuneration policy.

7. Review

7.1 The Terms of Reference shall be reviewed by the Committee and approved by the Trust Board at least every two years.

8. Duties

8.1 To agree and keep under review the overall remuneration policy of the Trust.

8.2 To set the individual remuneration, allowances and other terms and conditions of office (including termination arrangements) for the Trust's Executive Directors.

8.3 To recommend and monitor the structure of remuneration, including setting pay ranges and receiving at least annual reports, for VSM.

8.4 To ensure that appropriate and robust processes are in place to provide appropriate performance management of the Trust's Chief Executive and Executive Directors against objectives for the previous year and note forward objectives. Performance of other senior managers will be monitored and evaluated by their line managers

8.5 To ratify decisions taken between meetings by the Chair of the Committee providing they have been taken in accordance with point 5.2.

8.6 In determining remuneration policy and packages, to have due regard to the policies and recommendations of the Department of Health, NHSIE, CQC and to adhere to all relevant laws, codes and regulations. Where required the Committee will have the ability to seek external legal advice.

8.7 To keep abreast of executive level remuneration policy and practice and market developments elsewhere in the NHS and in other relevant organisations, drawing on external advice as required.

8.8 To agree those Settlement Agreements, Redundancy Payments and MARS agreements which require final approval by NHSI/HM Treasury as well as any proposed termination payment to the Chief Executive or an Executive Director.

8.9 To receive regular reports on other Settlement Agreements, Redundancies and MARS agreements to be approved in accordance with Trust policies.

8.10 To receive an annual report on the outcome of the employer-based (local) Clinical Excellence Awards round for Consultants and SAS doctors.

8.11 To undertake any other duties as directed by the Trust Board.

8.12 To ensure good succession planning in relation to the role of the Trust’s Chief Executive. In addition the committee should also assure itself that adequate processes exist in relation to success planning for other executive level and key senior organisational roles.

8.13 To annually gain assurance that due process is being followed and value for money achieved in relation to ‘top earners’ across the organisation by grade and job type.

Terms of Reference ratified by: **Trust Board**

Date of Ratification:

Date of Review:

FINANCE & PERFORMANCE COMMITTEE
TERMS OF REFERENCE

Status:	Committee of the Trust Board
Chair:	Non-Executive Director
Clerk:	Business Co-ordinator to the Chief Financial Officer
Frequency of Meetings:	Monthly
Quorum:	Two Non-Executive Directors (one must chair the committee) and two Executives

1. Constitution:

1.1 The Trust Board (the Board) hereby resolves to establish a committee of the Board to be known as the Finance and Performance Committee. The committee has no executive powers, other than those specifically delegated in these terms of reference. The terms of reference can only be amended with the approval of the Trust Board.

1.2 The committee is authorised by the Board to investigate any activities within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the committee. The committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experiences and expertise if it considers this necessary.

2. Purpose:

2.1 The Finance and Performance Committee shall make recommendations to the Trust Board about those matters detailed below in Section 4, and the effectiveness of related delivery.

3. Membership:

3.1 The committee will be appointed by the Board and its membership will comprise of:

- Three Non-Executive Directors (one is the Chair of the Trust)
- Chief Financial Officer
- Chief Executive Officer
- Chief Operating Officer
- Chief Medical Officer and Director of Patient Safety
- Chief Nurse and Director of Infection Prevention and Control
- Chief Information Officer
- Chief Strategy and Collaboration Officer
- Chief Redevelopment Officer

3.2 The following key staff will attend on a regular basis. However, they will not count against the quorum:

- Divisional Director of Surgery, Anaesthetics & Cancer
- Divisional Director of Medicine
- Deputy Chief Financial Officer and Director of Contracts and Commerce
- Associate Director of Operational Finance.
- Patient Representative

3.3 Executive Directors will nominate an appropriate deputy if they are unable to attend a meeting. A deputy must be able to make decisions on behalf of the Executive and will be recognised as part of the quorum.

3.4 In the absence of a quorum, meetings will continue to be held and any decisions made will be ratified at the next quorate meeting of the committee in order for actions to be acted upon.

3.5 All Non-Executive Directors have a standing open invitation to attend any meetings of the committee and to have access to the agenda and papers on request from the committee clerk or the Trust Secretary. Any Non-Executive Director asked to attend the meeting will count towards the quorum.

3.6 The committee may request attendance by relevant staff at any meeting.

4. Duties:

4.1 The Finance and Performance Committee will:

<u>Strategy & Policy</u>

4.1.1 Consider and shape the Trust's financial strategy and its strategic financial plans to ensure long term financial viability.

4.1.2 Assess the impact of key policy changes and ensure these are addressed in the Trust's financial plans.

4.1.3 Review and recommend to the Board for the approval the annual business plan for the Trust.

<u>Risk</u>

4.1.4 Assess financial and all relevant risks and risk management arrangements.

<u>Operational Performance</u>

4.1.5 Review the Trust's performance against constitutional and contracted waiting times performance standards.

4.1.6 Maintain oversight of the recovery of elective care services and escalate any significant variations to the Board.

4.1.7 Review Trust performance against key core performance standard indicators (as presented in the integrated performance report) and provide assurance and appropriate escalation to the Board for any significant variations.

4.1.8 Review, monitor and provide assurance to the Board on the effectiveness of the Trust's integrated performance reporting arrangements and recommend any changes.

4.1.9 The committee will promote accountability, encourage continuous improvement and support the delivery of local and national performance objectives and targets.

4.1.10 Support the development and delivery of recovery plans in the event of sustained non-compliance against key performance indicators, providing assurance and escalation to the Board as appropriate.

Financial Performance

4.1.11 Assess the Trust's overall revenue income and expenditure performance.

4.1.12 Assess the Trust's treasury and cash management arrangements and liquidity so that appropriate levels of cash and funding and liquidity can be achieved to meet best practice requirements.

4.1.13 Monitor the overall performance against NHS service line agreements and contracts

4.1.14 Review spending against the capital programme and ensure that there is robust control of expenditure and of variations to the agreed plan.

4.1.15 Review the realisation of benefits from agreed investment.

4.1.16 Coordinate with the Great Place Committee (GPC) on the monitoring of the capital programme and benefit realisation.

4.1.17 Review annual savings programmes, ensure sound governance arrangements are in place, monitor progress in delivering agreed savings and any remedial action taken to deal with variances.

4.1.18 Provide assurance to the Board for business cases for investment as outlined in the Trust's Standing Financial Instructions (SFIs).

4.1.19 Provide assurance to the Board regarding the development and utilisation of Service Line Reporting (SLR) information and the transition to Service Line Management (SLM).

4.1.20 Provide assurance to the Board regarding the performance of the ICS Procurement Service in terms of financial position, contracts renewals, strategic and transformational activities, progress against national procurement standards and associated corporate risks.

4.1.21 Monitor performance under the Trust's Pathology outsourcing contract.

5. Accountability and Reporting arrangements:

5.1 The committee shall be directly accountable to the Board.

5.2 The Chair of the committee shall prepare an assurance report to the Board detailing items discussed, actions agreed and issues to be referred to the Board.

5.3 The minutes of Finance & Performance Committee meetings shall be formally recorded.

5.4 The committee shall refer to the Board any issues of concern it has with regard to any lack of assurance in respect of any aspect of finance.

6. Review and Monitoring:

6.1 The committee will undertake and evidence an annual review of its performance against the agreed committee assurance framework in order to evaluate its effectiveness, the fulfilment of its functions in connection with the terms of reference and achievement of duties. This report will be provided to the Audit Committee as part of an annual assurance review.

6.2 Terms of reference will be reviewed annually and approved by the Board.

Terms of reference ratified by: Trust Board
Date of ratification:
Date of review:

NHS
West Hertfordshire Teaching Hospitals
NHS Trust

Finance and Performance Committee Workplan – 2024-2025

		25 April	30 May	27 Jun	25 Jul	29 Aug	26 Sep	31 Oct	28 Nov	19 Dec	30 Jan	27 Feb	27 Mar
1.0	**Administration**												
1.01	Opening, welcome and apologies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
1.02	Declarations of interest	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
1.03	Minutes of the last meeting and matters arising	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
1.04	Action log	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
1.05	Decision register	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
1.06	BAF (for reference only)	✓		✓	✓		✓	✓		✓	✓		✓
2.0	**Quality, Governance and Compliance**												
2.01	Terms of reference and workplan annual review		✓									✓	
2.02	Committee workplan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2.03	Committee register	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2.04	BAF update	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2.05	Summary finance risk register including review of corporate risks (*quarterly*, *other than by exception*)	✓		✓			✓		✓			✓	
2.06	Review of finance policies		✓										
3.0	**Access Performance**												
3.01	Integrated Performance Report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
3.02	Access performance and recovery			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
4.0	**Financial Assurance**												
4.01	Annual plan and budget	✓								✓	✓	✓	✓
4.02	Monthly finance report, forecast overview and actions including cash and funding, risk and management	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
4.03	Efficiency programme project highlight report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
4.04	Divisional finance review	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
4.05	Contracts and commerce	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
4.06	Service line reporting				✓			✓					
4.07	Capital programme expenditure, planning, capital control schedule and risks	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
4.08	Internal audit update	✓		✓			✓			✓		✓	✓

Finance and Performance Committee Workplan – 2024-2025

		25 April	30 May	27 Jun	25 Jul	29 Aug	26 Sep	31 Oct	28 Nov	19 Dec	30 Jan	27 Feb	27 Mar
5.0	**Investment**												
5.01	Procurement update quarterly (including review of Trust contracts coming up for renewal)		✓			✓			✓			✓	
5.02	Business cases and strategy papers											✓	
5.03	Business case evaluation	✓		✓		✓		✓		✓		✓	
6.0	**Closing**												
6.01	Any other business	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
6.02	Items for escalation to the Board	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
6.03	Meeting evaluation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
6.04	Date and time of next meeting	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
6.05	Draft agenda for next meeting	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

West Hertfordshire Teaching Hospitals NHS Trust

Redevelopment Programme Committee
Terms of Reference

Status:	Committee of the Trust Board
Chair:	Non-Executive Director
Executive Lead:	Chief Redevelopment Officer
Clerk:	Trust Secretary
Frequency of meetings:	Monthly
Quorum:	Two Non-Executive Directors (one of which must chair the committee) and two Executives

Introduction

In Summer 2023, the government confirmed that the new hospital at Watford General would be “fully funded” with a substantial funding envelope. It is currently anticipated that the new hospital will open in 2030.

In addition and in parallel, the Trust has a significant redevelopment programme across its sites at St Albans and Hemel Hempstead, including the creation of a centre for high volume low complexity elective care for the health system and a community diagnostics centre.at St Albans City Hospital and the provision of community based medical care in Hemel Hempstead.

This Redevelopment Programme represents the most significant capital investment in healthcare in our region for a generation.

The redevelopment programme will be clinically-led and digitally-driven. The programme will reflect and adapt to local and national strategies, with digital innovation forming a pillar of our models of care and facility design.

The Redevelopment Programme Committee is established to assure the Trust Board of all decisions related to the Redevelopment Programme.

1. Constitution

1.1. The Trust Board (the Board) hereby resolves to establish a Committee of the Board to be known as the Redevelopment Programme Committee (the Committee). The Committee has no powers, other than those specifically delegated in these Terms of Reference. The Terms of Reference can only be amended with the approval of the Trust Board.

1.2. The Committee is authorised by the Board to investigate any activities within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experiences and expertise if it considers this necessary.

2. Purpose

2.1. The purpose of the Committee is to gain assurance on the delivery of the objectives of the Redevelopment Programme and the Trust's digital strategy.

3. Membership

3.1. The Committee will be appointed by the Board and its membership will consist of:

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy)
- Trust Chair
- Chief Executive Officer
- Chief Redevelopment Officer (Lead)
- Chief Information Officer & SIRO (Deputy Lead)
- Chief Medical Officer
- Chief Nurse and Director of Infection Prevention and Control
- Chief Operating Officer
- Chief People Officer
- Chief Financial Officer
- Associate Medical Director, Clinical Strategy

3.2. The following will attend the Committee on a regular basis:

- Representative of Healthwatch Hertfordshire
- Acute Redevelopment Programme Director
- Director of Environment
- Acute Redevelopment Programme management team as required

3.3. Executive Directors will nominate an appropriate deputy if they are unable to attend a meeting. A deputy must be able to make decisions on behalf of the Executive and will be recognised as part of the quorum.

3.4. All Non-Executive Directors have a standing open invitation to attend any meetings of the Committee and to have access to the agenda and papers on request from the Committee Clerk or the Trust Secretary. They will count against the quorum.

3.5. Should the quoracy not be met, the meeting will go ahead on the understanding that no key decisions can be made, or significant actions taken.

4. Duties and Responsibilities

4.1. To seek assurance that good governance arrangements are in place for the Redevelopment Programme, ensuring that strong, compelling recommendations are made to the Trust Board.

4.2. To seek assurance that redevelopment proposals and business cases reflect, include and allow for digital strategy, investment and innovation.

4.3. To seek assurance that the right structures, leadership, and capability are in place to deliver the projects comprising the Redevelopment Programme on time and within budget.

4.4. To review the Redevelopment Programme business cases prior to making recommendations to the Trust Board, in association with the Finance and Performance Committee.

4.5. To review options appraisals, procurement strategies and other relevant proposals prior to making recommendations to the Trust Board.

4.6. To assure the Trust Board of the management and implementation of health and safety arrangements for the projects comprising the Redevelopment Programme.

4.7. To monitor the progress of the Redevelopment Programme and achievement of core aims and objectives within agreed timescales, ensuring any potential variances are highlighted in a timely way.

4.8. To seek assurance on the alignment of key programmes to the Trust strategy, ensuring opportunities for cross-organisational projects are identified and enabled, utilising the Board Assurance Framework and Corporate Risk Register.

4.9. To receive regular reports from the Watford General Hospital Redevelopment Board, the St Albans City Hospital Redevelopment Board, the Hemel Hempstead Redevelopment Board and the Clinical and Digital Transformation Board on the actions being taken to mitigate the principal risks and monitor controls and assurance sources. Areas of work that cut across the geographical location will be handled on a case-by-case basis. For example, workforce will be handled by the People, Education and Research Committee.

4.10. To seek assurance of communication within the Trust, across the health and care system and with all stakeholders is strong and in line agreed communications objectives across the ICP and ICS.

5. Accountability and Reporting Arrangements

5.1. The Committee will be directly accountable to the Trust Board.

5.2. The Chair of the Committee will prepare an assurance report to the Board detailing items discussed, actions agreed, and issues referred to the Board.

5.3. The Committee will escalate to the Board any issues of concern through identified unresolved risks arising from the scope of these terms of reference, that require executive action or that pose significant threats to the operation, resources of reputation of the Trust.

5.4. Members of the Committee should act in the interests of the Trust as a whole and should not confine focus to representing or advocating for their respective department, division or service area. This will ensure the focus of the Committee is maintained on Trust wide governance.

5.5. The Committee will report annually to the Audit Committee as part of the Board's assurance programme. This report will review the work of the Committee to ensure it is working efficiently and meeting the terms of reference.

6. Administration

6.1. The Trust Secretary, supported by the Acute Redevelopment Project/Business Coordinator, will be responsible for arranging meetings, circulating and uploading papers, minuting meetings, updating action logs, and maintaining files on the WHTH network.

6.2. Committee agenda and papers will be circulated at least 5 working days prior to the meeting.

7. Review and Monitoring

7.1. The Committee will undertake and evidence an annual self-assessment review of its performance to evaluate its effectiveness, the fulfilment of its functions in connection with the terms of reference and achievement duties. This report will be provided to the Audit Committee as part of the Annual Assurance Report.

7.2. Terms of reference will be reviewed annually and approved by the Board.

Ratified by: Trust Board
Date of ratification:
Date of review:

Redevelopment Programme Committee 2024-2025

Agenda item	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
ADMINISTRATIVE												
Apologies for absence	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of the previous meeting	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Action log	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Review of work plan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
GPC ToR Refresh & Review		✓										
KLOE 2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?												
SRO Update	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
OBC Update	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
OBC Approval										tbc		
Interim Estates Report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Digital Progress Report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Travel & Access Strategy			✓			✓			✓			
Land Acquisition	✓					✓						
KLOE 3. Are there clear and effective processes in place for managing risks, issues and performance?												
Quarterly Risks & Issues Update			✓			✓			✓			✓
BAF Risks Review	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
KLOE 7 Are the people who use the services, the public, staff and external partners engaged and involved to support high quality sustainable services												
Communications & Engagement Report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
KLOE 8. Are there robust systems and processes for learning, continuous improvement and innovation?												
Digital Schemes - Post Implementation Benefits Review (eg Virtual Hospital / Robots / EPR)		✓			✓			✓				
KLOE 9. How well is the trust using its resources?												
Capital Expenditure Report (Including Acute Redevelopment Programme Fees)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Board reporting												
Any other business	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Key points to report to the Board (verbal)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Date of next meeting	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

PEOPLE, EDUCATION AND RESEARCH COMMITTEE TERMS OF REFERENCE

Status:	Committee of the Trust Board
Chair:	Non-Executive Director
Executive Lead:	Chief People Officer
Clerk:	Corporate Governance Manager
Frequency of Meetings:	Every 2 months
Quorum:	Two Non-Executive Directors (one of which must be the Chair of the Committee) and two Executive Directors

1 Constitution:

1.1 The Trust Board (the Board) hereby resolves to establish a committee of the Board to be known as the People, Education and Research Committee. The committee is a Non-Executive committee and has no executive powers, other than those specifically delegated in these terms of reference. The Terms of Reference can only be amended with the approval of the Trust Board.

1.2 The committee is authorised by the Board to investigate any activities within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the committee. The committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experiences and expertise if it considers this necessary.

2. Purpose:

2.1 The purpose of the committee is to provide the Board with assurance that the Trust is delivering against its mission to be a great place to work and learn by ensuring its workforce is fit for purpose and that it provides a high quality education, excellent research opportunities and development opportunities for staff.

2.2 To assure the Board that we have tools, processes and measures in place to ensure we are communicating with, listening to and involving our staff and volunteers in our ambition to deliver *the very best care for every patient every day.*

2.3 To assure the Board that the Trust is meeting its requirements in relation to basic workforce metrics and obligations, including whistleblowing and freedom to speak up.

2.4 To assure the Board that it is developing its Teaching Strategy to maximise the benefits of being appointed a Teaching Hospital.

2.5 To assure the Board that the Trust is meeting its key objectives as set out in the 5 year People Strategy.

3. Membership:

3.1 The committee will be appointed by the Board and its membership shall consist of:

- a minimum of two Non-Executives Directors, one of whom should be the Chair of the Committee;
- Chief People Officer;
- Chief Nurse/Deputy Chief Nurse;
- Chief Medical Officer/Deputy Chief Medical Officer;
- Director of People / Deputy Chief People Officer;
- Or one further Executive Director.

3.2 The committee also benefits from the specialist support and attendance of the following people who do not however count against the quorum:

- Associate Director of People: Operational Human Resources;
- Associate Director of People: Learning & Education;
- Associate Director of People: Organisational Development;
- Associate Director of People: Recruitment & Retention;
- Chair of Staff Side (for the JCC and LNC);
- Directors of Research and Development;
- Associate Medical Director for appraisal and revalidation;

3.3 All Non-Executive Directors have a standing open invitation to have access to the agenda and papers on request from the committee clerk. Any Non-Executive Director asked to attend the meeting will count towards the quorum.

3.4 Should the quoracy not be met, the meeting will go ahead on the understanding that no key decisions can be made or significant actions taken.

4. Frequency of attendance:

4.1 The committee members will be required to attend at least four out of six meetings, which are held every 2 months.

4.2 The committee may request attendance by relevant staff at any meeting.

5 Duties and responsibilities:

5.1 The committee will:

i. Review the work programmes underpinning the Trust's People strategy and assure itself that these will support the Trust's ability to recruit, retain and develop its workforce adequately. It will ensure that Research and Development is being undertaken as per the Trust's requirements.

ii. Seek assurance that the activities set out in the strategic work programmes are being progressed in line with agreed priorities, that they are contributing to the agreed Trust objectives and are in line with all national and local policies to ensure adequate evaluation and monitoring within the Trust.

iii. Seek assurance that the development and implementation of the Trust's Teaching strategy is being progressed and is in line with the Trust's overall strategy on workforce development. Ensure the Trust is setting and meeting high standards and expectations in relation to its status as a Teaching Hospital.

iv. Seek assurance that all relevant policies and procedures are in place that ensures the Trust is compliant with all national and local requirements and that the Trust is compliant with all aspects of current employment legislation and best practice. The committee shall assure itself that the processes for monitoring, reviewing and ratification of relevant policies is robust and fit for purpose.

v. Assure itself that high level risks and impacts to the achievement of Trust objectives and organisation performance in relation to staff experience and education are captured on the risk register and that appropriate mitigations are in place. The committee should assure itself that the items on the risk register are correctly documented on the Corporate Risk Register.

vi. Ensure that the Trust is setting and meeting high standards and expectations as we work towards the new national standards for health & wellbeing, to improve the support available to NHS staff in order for them to remain healthy and well. Also the committee will be responsible for gaining assurance that we are meeting our requirements under the Public Sector Equality Duty, Workforce Race Equality Scheme and Workforce Disability Equality Scheme.

vii. Ensure that the there is a robust Research and Development strategy in place which is line with the Trust's strategic requirements.

viii. Assure itself that there are proactive and robust approaches in place to ensure that the Trust is meeting its organisational and contractual requirement to provide high quality education and training.

ix. Ensure that the Trust is working at a system level to ensure that it is meeting all its key workforce metrics.

x. Consider reports from appropriate groups and committees referred to it from the Trust Management Committee and ask the Trust Management Committee to provide it with appropriate levels of assurance relating to any aspect of the terms of reference.

6. Accountability and Reporting arrangements

6.1 The committee shall be directly accountable to the Trust Board.

6.2 Assurance reports from the People, Education and Research Committee meetings will be submitted and reported to the Board following each Committee.

6.3 The committee shall refer to the Board any issues of concern it has with regard to any lack of assurance in respect of any aspect of staff experience.

7. Review and Monitoring

7.1 The committee will undertake and evidence an annual review of its performance against the agreed Board Assurance Framework in order to evaluate its effectiveness, the fulfilment of its functions in connection with the terms of reference and achievement of duties. This report will be provided to the Trust Board.

7.2 The committee will report to the Audit Committee via the committee assurance programme and will include assurance on the effectiveness of the whistleblowing and freedom to speak up processes.

7.3 Terms of Reference will be reviewed annually by PERC and approved by the Board.

Terms of Reference ratified by: **Trust Board**

Date of Ratification:

Date of Review:

People, Education and Research Committee Workplan 2024-2025

West Hertfordshire Teaching Hospitals NHS Trust

Agenda item:	Purpose	KLOEs:	April 2024	June 2024	Aug 2024	Oct 2024	Dec 2024	Feb 2025
Administration:								
Apologies for absence	To note		✓	✓	✓	✓	✓	✓
Declarations of interest	To note		✓	✓	✓	✓	✓	✓
Minutes of last meeting	To approve		✓	✓	✓	✓	✓	✓
Review of action log	To note		✓	✓	✓	✓	✓	✓
Review of work plan	For approval							✓
Annual review of terms of reference and work plan	For approval							✓
Self-assessment of the effectiveness of the committee	For approval		✓					
Staff Story	For information and assurance		✓	✓	✓	✓	✓	✓
CPO Update	For information and assurance		✓	✓	✓	✓	✓	✓
Workforce Performance:								
People Strategy								
People Strategy Assurance Report				✓		✓		✓
Education & Research								
Education Strategy Review								✓
Education Strategy Assurance Report (To include): • Teaching Hospital Benefits Realisation • Leadership Development Programme			✓		✓		✓	
Research Strategy Update (To Include) • Clinical Trials Unit Progress Report				✓		✓		✓
OD & Culture								
Staff Experience Assurance Report (To include) • Equality, Diversity & Inclusion Assurance Report • Staff well-being			✓		✓		✓	

People, Education and Research Committee Workplan 2024-2025

Agenda item:	Purpose	KLOEs:	April 2024	June 2024	Aug 2024	Oct 2024	Dec 2024	Feb 2025
• Staff engagement.								
Values & Behaviours Framework Assurance Report			✓		✓		✓	
Talent Assurance Report (To Include) • Work Experience • Apprenticeship Levy • Appraisal Framework				✓		✓		✓
Staff Survey Assurance Report			✓					✓
Workforce Modelling & Transformation								
Business Planning Assurance Report (To include) • New models of working • Annual Plans • Five-year plans • Alignment with Redevelopment.				✓		✓		✓
Workforce Digitisation Assurance Report (To include) • ESR Self Service • Future Innovations.			✓		✓		✓	
Recruitment & Retention Assurance Report • Recruitment initiatives • People Promise.				✓		✓		✓
Workforce Efficiency Assurance Report			✓		✓		✓	
Workforce Performance								
Workforce Key Performance indicators (To include) • Core workforce performance • Extended workforce performance • Alignment to non-workforce performance.	For information and assurance		✓	✓	✓	✓	✓	✓

People, Education and Research Committee Workplan 2024-2025

West Hertfordshire Teaching Hospitals NHS Trust

Agenda item:	Purpose	KLOEs:	April 2024	June 2024	Aug 2024	Oct 2024	Dec 2024	Feb 2025
Workforce Governance:								
Board Assurance Framework	For approval			✓		✓		✓
Corporate workforce-related risks	For information and assurance		✓	✓	✓	✓	✓	✓
Review of workforce-related internal audit reports	For information and assurance							✓
Guardian of Safe Working quarterly and annual reports	For approval							
Annual reporting:								
Freedom to speak up annual and mid-year review	For approval		✓			✓		
WRES & WDES annual reports	For approval				✓		✓	
Gender Pay and Race Pay Gap annual report	For approval					✓		
Public Sector Equality annual report	For approval							✓
Revalidation update annual report – Nursing & Midwifery	For approval							
Revalidation update annual report – Medical	For approval							
Occupational Health annual report	For approval							
Equality Delivery System (EDS) annual report	For approval						✓	
Adult Bi-annual Establishment Review	For approval							
Maternity Bi-annual Establishment Review	For approval							
Annual Children's Establishment Review	For approval							
Annual ED Services Establishment Review	For approval							
GMC survey report	For information and assurance							
Other reporting:								
Key points to report to the Board (verbal)	To note		✓	✓	✓	✓	✓	✓

NHS
West Hertfordshire Teaching Hospitals
NHS Trust

Trust Board
04 April 2024

Title of the paper	**Revision to Standing Orders**
Agenda Item	**25**
Presenter	**Jean Hickman, Interim Director of Governance**
Author(s)	**Jean Hickman, Interim Director of Governance**
Purpose	*Please tick the appropriate box* *For approval*: X *For discussion*: *For information*:
Executive Summary	To offer opportunities for further sharing of responsibilities and support the Board to better prepare for the challenges ahead, it is recommended that the Standing Orders be amended to increase the provision of the vice-chair role from one to two. The updated Standing Orders are shown in appendix 1. The Audit Committee has considered this change and recommends it for approval by the Board.
Trust strategic aims *(please indicate which of the 4 aims is relevant to the subject of the report)*	**Aim 1 Best care** – ***Objectives 1-4*** – X **Aim 2 Great team** – ***Objectives 5-8*** – X **Aim 3 Best value** – ***Objective 9*** – X **Aim 4 Great place** – ***Objective 10-12*** – X
Links to well-led key lines of enquiry	☐Is there the leadership capacity and capability to deliver high quality, sustainable care? ☐Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? ☐Is there a culture of high quality, sustainable care? ☐Are there clear responsibilities, roles and systems of accountability to support good governance and management? ✓Are there clear and effective processes for managing risks, issues and performance? ☐Is appropriate and accurate information being effectively processed, challenged and acted on? ☐Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? ☐Are there robust systems and processes for learning, continuous improvement and innovation? ☐How well is the trust using its resources?
Previously considered by	Committee/Group: N/A Date:

25

Action required	The Board is asked to approve the recommended amendments to the Standing Orders to allow two vice-chairs to be appointed.	

SO/ Version 2.8
Ratified by: Trust Board
Date of Ratification:05 October 2023
Date of Review: August 2024

NHS
West Hertfordshire
Teaching Hospitals
NHS Trust

STANDING ORDERS

Change History

Version 1.0	SOs ratified by Audit Committee June 2010
Version 1.1	SO No. 5 updated for Bribery Act ratified by audit Committee March 2011
Version 1.2	SO No. 5, 6 and 8 updated to include Capsticks (legal) advisors comments re Bribery Act. Cross references within the document amended.
Version 1.3	Version 1.2 reviewed no material changes made.
Version 1.4	Update to reflect recent legislation and to include Interpretation and Definitions
Version 2.0	Complete review of Standing Orders
Version 2.1	Complete review and minor changes made
Version 2.2	Minor changes made to reflect changes to the committee structure
Version 2.3	Document reviewed and no changes made
Version 2.4	Narrative added to highlight the Trust's responsibilities with regard to the Modern Slavery Act, updating of the voting executive directors, reflecting changes to the committee structure and a section added on the standards of business conduct.
Version 2.5	Annual review
Version 2.6	Annual review and minor changes made.
Version 2.7	Annual review and minor changes made.
Version 2.8	Annual review and minor changes made.
Version 2.9	Update reflecting the ability of the Trust to appoint up to two Vice-Chairs

ID Number	Version 2.9
Author's name	Jean Hickman
Author's job title	Trust Secretary
Division	Corporate
Version number	Version 2.9
Ratifying Committee	Board
Ratified date	5 October 2023
Review date	August 2024
Name of manager responsible for review	Jean Hickman
Job title of manager responsible for review	Interim Director of Governance
Email address for this manager	jeanhickman@nhs.net
Referenced (Yes/No)	Yes
Key words (to aid searching)	Membership, quorum, duties, delegated
User Group	All Staff
Equality Impact Assessment Completed	Yes

The Trust is committed to promoting an environment that values diversity. All staff are responsible for ensuring that all patients and their carers are treated equally and fairly and not discriminated against on the grounds of race, sex, disability, religion, age, sexual orientation or any other unjustifiable reason in the application of this policy, and recognising the need to work in partnership with and seek guidance from other agencies and services to ensure that special needs are met.

Index

Foreword to Standing Orders

NHS Trusts are required by law to make Standing Orders, which regulate the way in which the proceedings and business of the Trust will be conducted. Regulation 19 of the NHS Trusts (Membership and Procedure) Regulations, 1990 (as amended) requires the meetings and proceedings of an NHS trust to be conducted in accordance with the rules set out in the Schedule to those Regulations and with Standing Orders made under Regulation 19(2).

These Standing Orders and associated documents are extremely important. High standards of corporate and personal conduct are essential in the NHS. As the NHS is publicly funded, it is accountable to Parliament for the services it provides and for the effective and economical use of taxpayers' money. The Standing Orders, Standing Financial Instructions, procedures and the rules and instructions made under them provide a framework and support for the public service values which are essential to the work of the NHS of:

- Accountability – the ability to stand the test of Parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
- Probity – an absolute standard of honesty in dealing with the assets of the Trust; integrity in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties.
- Openness – transparency about NHS activities to promote confidence between the organisation and its staff, patients and the public.

Additional documents, which form part of these "extended" Standing Orders are:

- Standing Financial Instructions, which detail the financial responsibilities, policies and procedures to be maintained by the Trust.
- Reservation of Powers and Schedule of Delegation, which are designed to facilitate devolved decision making and personal accountability and set out delegated levels of authority and responsibility.

These extended Standing Orders set out the ground rules within which Board, Chief Officers and staff must operate in conducting the business of the Trust. Observance of them is mandatory. Such observance will mean that the business of the Trust will be carried out in accordance with the law, Government policy, the Trust's statutory duties and public service values.

As well as protecting the Trust's interests, Standing Orders, Standing Financial Instructions and Reservation of Powers and Schedule of Delegation protect staff from any possible accusation of having acted less than properly. All Chief Officers and Non-Executive Directors and senior staff are expected to be aware of the existence of these documents, understand when they should be referred to and, where necessary and appropriate to their role, make themselves familiar with the detailed provisions.

1. Interpretation and Definitions

1.1. Save as otherwise permitted by law, at any meeting the Chair of the Board of the Trust shall be the final authority on the interpretation of the Standing Orders (on which they should be advised by the Chief Executive).

1.2. In these Standing Orders, words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa. References to any statutory body shall be deemed to include any successor body or bodies which may from time to time assume all or substantially all of the functions of that original statutory body.

1.3. References to any statute or statutory provision shall be deemed to include any instrument, order, regulation or direction issued under it and shall be construed to include a reference to the same as it may have been, or may from time to time be, amended, modified, consolidated, re-enacted or replaced.

1.4. Any expression to which a meaning is given in the National Health Service Acts 1977 and 2006, National Health Service and Community Care Act 1990, Health and Social Care Act 2012, Health and Care Act 2022 and other Acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Orders and in addition:

a) **"Accounting Officer"** means the Chief Executive and Accountable Officer who is responsible and accountable for funds entrusted to the Trust. The Accounting Officer is responsible for ensuring the proper stewardship of public funds and assets.

b) **"Board"** means the Chair, Chief Officers and Non-Executive Directors of the Trust, collectively as a body.

c) **"Budget"** means a resource, expressed in financial terms, proposed by the Trust for the purpose of carrying out, for a specific period, any or all of its functions.

d) **"Budget holder"** means the Chief Officer or employee with delegated authority to manage finances (income and expenditure) for a specific area of the organisation's budget.

e) **"Chair of the Board (or Trust)"** is the person appointed by NHSE on behalf of the Secretary of State for Health & Social Care to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Vice Chair(s) of the Trust, if the Chair is absent from the meeting or is otherwise unavailable.

f) **"Commissioning"** means the process for determining the need for and for obtaining the supply of healthcare and related services for the Trust within available resources.

g) **"Committee"** means a Committee or sub-Committee created and appointed by the Board.

h) **"Committee members"** means persons formally appointed by the Board to sit on or to chair specific Committees**.**

i) **"Contracting and procuring"** means the systems for obtaining the supply of good, materials, manufacturing items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

j) **"Chief Financial Officer"** means the Chief Officer with responsibility for ensuring the Trust meets its statutory duties in relation to finance

k) **"Employee"** means an employee of the Trust or any other person holding a paid appointment or office with the Trust.

l) **"Chief Officer r"** means an executive member of the Board who is either an executive member of the Board or is to be treated as such by virtue of regulation 1(3) (i.e. the Chair of the Trust or any person nominated by such a Committee for appointment as a Trust member).

m) **"Funds held on trust"** shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, and now contained under Schedule 2, paragraph 12; Schedule 6, paragraph 8; and Schedule 5, paragraph 8 of the NHS Act 2006, as amended. Such funds may or may not be charitable.

n) **"HSCA 2012"** means the Health and Social Care Act 2012.

o) **"Member"** means a Chief Officer or non-executive member of the Board as the context permits. Member in relation to the Board does not include its Chair.

p) **"Membership and Procedure Regulations"** means National Health Service Trusts (Membership and Procedure) Regulations (SI 1990/2024) and subsequent amendments.

q) **"Motion"** means a formal proposition to be discussed and voted on during the course of the meeting.

r) **"Nominated officer"** means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

s) **"Non-Executive Director"** means a member of the Board who is not an officer of the Trust.

t) **"Officer"** means employee of the Trust or any other person holding a paid appointment or office with the Trust.

u) **"Officer member"** means a member of the Trust who is either an officer of the Trust or is to be treated as an officer by virtue of regulation 1(3) (i.e. the Chair of the Trust or any person nominated by such a Committee for appointment as a Trust member).

v) **"SFIs"** means Standing Financial Instructions.

w) **"Trust"** means West Hertfordshire Teaching Hospitals NHS Trust.

x) **"Trust Secretary"** means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with the law, Standing Orders, Department of Health and Social Care or other regulatory body governance.

y) **"Vice Chair(s)"** means a non-officer member or members appointed by the Board to take on the Chair's duties if the Chair is absent for any reason.

2. INTRODUCTION

2.1 Statutory Framework

2.1.1 The West Hertfordshire Hospitals NHS Trust is a statutory body that came into existence on 23 March 2000 under West Hertfordshire Hospitals NHS Trust (Establishment) Order SI 2000/732 (the Establishment Order).

2.1.2 The name was subsequently changed on 1 December 2021 to The West Hertfordshire Teaching Hospitals NHS Trust (the Trust) under The West Hertfordshire Hospitals National Health Service Trust (Establishment) (Amendment) Order SI 2021/1314 (the Teaching Establishment Order).

2.1.3 The principal places of business of the Trust are Watford General Hospital, Vicarage Road, Watford, Hertfordshire, WD18 0HB; Hemel Hempstead Hospital, Hillfield Road, Hemel Hempstead Herts, HP2 4AD and St Albans City Hospital, Waverley Road, St Albans Hertfordshire AL3 5PN.

~~2.1.4~~ NHS Trusts are governed by Act of Parliament, mainly the National Health Service Act 1977 (NHS Act 1977), the National Health Service and Community Care Act 1990 (NHS & CC Act 1990) as amended by the Health Authorities Act 1995, the Health Act 1999, the National Health Service Act 2006 (including amendments by the Health and Social Care Act 2012) and the Health and Care Act 2022.

2.1.5 The functions of the Trust are conferred by the above legislation.

2.1.6 As a statutory body, the Trust has specified powers to contract in its own name and to act as a Corporate Trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State.

2.1.7 The Trust also has statutory powers under Section 28A of the NHS Act 1977, as amended by the Health Act 1999 and as now contained under Sections 256 and 257 of the NHS Act 2006, to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

2.1.8 The NHS Membership and Procedure Regulations 1990 requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions as an integral part of Standing Orders setting out the responsibilities of individuals.

2.1.9 The Trust will also be bound by such other statutes and legal provisions that govern the conduct of its affairs.

2.1.10 Should any difficulties arise regarding the interpretation or application of any of the Standing Orders, advice should be sought from the Trust Secretary before acting. The user of these Standing Orders should also be familiar with and comply with the provisions of the Trust's SFIs. Note in particular procedures for tendering, quotations and contracts and the Schedule of Powers Reserved to the Board.

2.1.11 Failure to comply with the Standing Orders, Standing Financial Instructions or Scheme of Delegation can, in certain circumstances, be regarded as a disciplinary matter that could result in dismissal.

2.1.12 All members of the Board and employees have a duty to disclose any non-compliance with these Standing Orders to the Trust Secretary as soon as possible.

2.2 Equality and Human Rights

2.2.1 The Trust recognises that all sections of society may experience prejudice and discrimination. This can be true for service delivery and employment. The Trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The Trust believes that all people have rights to be treated with dignity and respect. The Trust is working towards and is committed to the elimination of unfair and unlawful discriminatory practices. All employees have responsibility for the effective implementation of the policy. They will be made fully aware of this policy and without exception must adhere to its requirements.

2.2.2 The Trust is also aware of its legal duties under the Human Rights Act 1998 and the Modern Slavery Act 2015.

2.2.3. The Trust is committed to carrying out its functions and service delivery in line with the Human Rights FREDA principles (i.e. **F**airness, **R**espect, **E**quality, **D**ignity and **A**utonomy).

2.3 NHS Framework

2.3.1 In addition to the statutory requirements the Secretary of State, through the Department of Health & Social Care, issues further directions and guidance. These are normally issued under cover of a Department Circular or Departmental Letter.

2.3.2 The Code of Accountability requires that, inter alia, Boards draw up a schedule of decisions reserved to the Board and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives. These are contained within the document 'Reservation of Powers and Scheme of Delegation'. The Code of Accountability also requires the establishment of Audit and Remuneration Committees with formally agreed terms of reference.

2.3.3 The Code of Conduct makes various requirements concerning possible conflicts of interests of Board Members.

2.3.4 The Code of Practice on Openness in the NHS sets out the requirements for public access to information on the NHS. As from 1 January 2005, this was superseded by the Freedom of Information Act 2000.

2.4 Delegation of Powers

2.4.1 The Trust has powers to delegate and make arrangements for delegation. These Standing Orders set out the detail of these arrangements.

2.4.2 Under the Standing Order relating to the Arrangements for the Exercise of Functions (Standing Order 6) the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 5 or by an officer of the Trust. In each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State may direct.

2.4.3 Delegated Powers are covered in a separate document (Reservation of Powers and Scheme of Delegation), this document has effect as if incorporated into the Standing Orders.

2.5 Integrated Governance

2.5.1 The Trust is committed to integrated governance which ensures that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, information and research governance. Integrated governance better enables the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives.

3. THE TRUST BOARD: COMPOSITION OF MEMBERSHIP

3.1 Introduction

3.1.1 All business shall be conducted in the name of the Trust. All funds received in trust shall be held in the name of the Trust as a Corporate Trustee. In relation to funds held on trust, powers exercised by the Trust as a Corporate Trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

3.1.2 The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in Standing Order 5. Directors acting on behalf of the Trust as a Corporate Trustee are acting as quasi-trustees. Accountability for charitable funds held on trust is to the Charity Commission and to the Secretary of State for Health. Accountability for non-charitable funds held on trust is only to the Secretary to State for Health.

3.1.3 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in the Scheme of Delegation of powers and have effect as if incorporated into the Standing Orders.

3.2 Composition of the Membership of the Board

3.2.1 In accordance with the Teaching Establishment Order and Membership and Procedure Regulations, the composition of the Board shall be:

3.2.1.1 The Chair of the Board (appointed by NHSE);

3.2.1.2 Up to 6 Non-Executive Directors (appointed by NHSE);

3.2.1.3 Up to 5 Chief Officers (but not exceeding the number of Non-Executive Directors) including:

a) the Chief Executive
b) the Chief Medical Officer
c) the Chief Financial Officer
d) the Chief Nurse

3.2.1.4 The Trust shall have no more than twelve and not less than eight members (unless otherwise determined by the Secretary of State and set out in the Trust's Teaching Establishment Order or such other communication from the Secretary of State).

3.3 Appointment and tenure of the Chair and Members of the Board

3.3.1 The appointment of the Chair and members are set out in the NHS Membership and Procedure Regulations 2014.

3.3.2 Regulation 7 of the Membership and Procedure Regulations sets out the period of tenure of office of the Chair and members and Regulations 8 and 9 of the Members and Procedure Regulations set out provisions for the termination or suspension of office of the Chair and Members.

3.4 Appointment and Powers of Vice-Chair

3.4.1 For the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chair, the Chair and members of the Board may appoint up to two members, who are not a Chief Officer , to be a Vice-Chair for such a period, not exceeding the remainder of their term as a Non-Executive Director of the Board, as they may specify on appointing them.

3.4.2 Any Non-Executive Director so appointed may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The Chair and Board of Directors may thereupon appoint another Non-Executive Director as a Vice-Chair.

3.4.3 In order to appoint Vice-Chairs, nominations will be invited. Where there are more than two nominations a written vote will be conducted, and the results will be announced at the subsequent meeting of the Board. In the event of there being only up two nominations and this is being acceptable to the Directors present; the Board will be requested to confirm those persons as Vice-Chairs at the meeting in which the nomination is made.

3.4.4 Where the Chair of the Board has died or has ceased to hold office, or where he has been unable to perform his duties as Chair owing to illness or any other cause, one of the Vice-Chairs shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform those duties, be taken to include references to the Vice-Chair.

3.5 Joint Members

3.5.1. Where the office of a member of the Board is shared jointly by more than one person:

a) Either or both of those persons may attend or take part in meetings of the Board;
b) If both are present at a meeting they should cast one vote if they agree;
c) In the case of disagreements no vote should be cast;
d) The presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 4.11 Quorum;
e) If only one person attends the meeting, they shall be entitled to cast a vote.

3.6 Roles of Board Members

3.6.1 The Board will function as a corporate decision-making body; Chief Officers and Non-Executive Directors will be full and equal members. Their role as members of the Board will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

a) Non-Executive Directors

i. The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a Committee of the Trust which has delegated powers.

b) Chair

i. The Chair shall be responsible for the operation of the Board and chair all Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of appointment and with these Standing Orders.

ii. The Chair shall liaise with NHSE over the appointment of the Non-Executive Board members and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments and their performance.

iii. The Chair shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform and debate and ultimate resolutions.

c) Chief Officer

i. Chief Officers shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Reservation of Powers and Scheme of Delegation.

d) Chief Executive

i. The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. They are the Accountable Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

e) Chief Financial Officer

i. The Chief Financial Officer shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. They shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

3.7 Corporate role of the Board

3.7.1 All business shall be conducted in the name of the Trust.

3.7.2 All funds received in trust shall be held in the name of the Trust as Corporate Trustee.

3.7.3 The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in Standing Order No. 2.

3.7.4 The Board shall define and regularly review the functions it exercises on behalf of the Secretary of State.

3.7.5 The Board should undertake a formal and rigorous annual evaluation of its own performance and that of its Committees and individual directors.

3.8 Schedule of Matters Reserved to the Board and Scheme of Delegation

3.8.1 The Board has resolved that it may only exercise certain powers and decisions in formal session. These powers and decisions are set out in the 'Reservation of Powers and Scheme of Delegation' and shall have effect as if incorporated into the Standing Orders. Those powers that it has delegated to officers and other bodies are contained within this document.

3.9 Lead Roles for Board Members

3.9.1 The Chair will ensure that the designation of lead roles or appointments of Board members as required by the Department of Health and Social Care and NHS England or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Member with responsibilities for Infection Control or Child Protection Services etc.).

4. MEETINGS OF THE TRUST

4.1 Calling meetings

4.1.1 Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine.

4.1.2 The Chair may call a meeting of the Board at any time.

4.1.3 One third or more members of the Board may requisition a meeting in writing. If the Chair refuses, or fails to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

4.2 Notice of Meetings and the Business to be transacted

4.2.1 Before each meeting of the Board a written notice specifying the business proposed to be transacted shall be delivered to every member either by hand, by electronic means or post, so as to be available to members at least three clear days before the meeting. The notice shall be authorised by the Chair and may be issued by an officer authorised by the Chair.

4.2.2 In the case of a meeting called by members in default of the Chair calling the meeting, the notice shall be signed by those members.

4.2.3 No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 4.6.

4.2.4 A member desiring a matter to be included on an agenda shall make their request in writing to the Chair at least 14 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 14 days before a meeting may be included on the agenda at the discretion of the Chair.

4.2.5 Before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's principal offices at least three clear days before the meeting, (required by the Public Bodies (Admission to Meetings) Act 1960 Section 1 (4) (a)).

4.3 Agenda and Supporting Papers

4.3.1 The agenda will be sent to members six days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three clear days before the meeting, save in emergency.

4.3.2 Requests made less than eleven days before a meeting may be included on the agenda at the discretion of the Chair.

4.3.3 In the event of a petition (i.e. a letter or form of request submitted by a member or section of the public) being received by the Trust, the petition will be forwarded to the Trust Secretary for advice as to the appropriateness of that request being included in any part of the agenda for the Trust's next Board meeting.

4.4 Petitions

4.4.1 Where a petition has been received by the Trust the Chair shall include the petition as an item for the agenda of the next meeting.

4.5 Notice of Motion

4.5.1 Subject to the provision of Standing Orders 4.7, a member of the Board wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chair.

4.5.2 The notice shall be delivered at least fourteen clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations.

This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

4.6 Emergency Motions

4.6.2 Subject to the agreement of the Chair, and subject also to the provision of Standing Order 4.7, a member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

4.7 Motions: Procedure at and during a meeting

4.7.1 Who may propose

a. The Chair of the meeting or any member of the Board present may propose a motion. Another member of the Board must second it.

4.7.2 Contents of motions

a) The Chair may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

i. The reception of a report;
ii. Consideration of any item of business before the Board;
iii. The accuracy of minutes;
iv. That the Board proceed to next business;
v. That the Board adjourn;
vi. That the question be now put.

4.73 Amendments to motions

a. A motion for amendment shall not be discussed unless it has been proposed and seconded.

b. Amendments to motions shall be moved relevant to the motion and shall not have the effect of negating the motion before the Board.

c. If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

4.7.4 Rights of reply to motions

a. Amendments

i. The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

b. Substantive/original motion

i. The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

4.7.5 Withdrawing a motion

a. A motion, or an amendment to a motion, may be withdrawn at any point of the proceedings of the Board.

4.7.6 Motions once under debate

a. When a motion is under debate, no motion may be moved other than:
   i. An amendment to the motion;
   ii. The adjournment of the discussion, or the meeting;
   iii. That the meeting proceeds to the next business;
   iv. That the question should be now put;
   v. The appointment of an 'ad hoc' Committee to deal with a specific item of business;
   vi. That a member/director be not further heard;
   vii. A motion under Section l (2) or Section l (8) of the Public Bodies (Admissions to Meetings) Act l960 resolving to exclude the public, including the press (see Standing Order 2.17).

b. In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a member of the Board who has not taken part in the debate.

c. If a motion to proceed to the next business or that the question be now put, is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

4.8 Motion to Rescind a Resolution

4.8.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member of the Board who gives it and also the signature of three other members of the Board, and before considering any such motion of which notice shall have been given, the Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

4.8.2 When any such motion has been dealt with by the Board, it shall not be permitted for any member of the Board other than the Chair to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

4.9 Chair of meeting

4.9.1 At any meeting of the Board the Chair, if present, shall preside. If the Chair is absent from the meeting, one of the Vice-Chairs, if present, shall preside.

4.9.2 If the Chair and both Vice-Chairs are absent, a Non-Executive Director member present shall preside. A Chief Officer may not chair.

4.9.3 The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and his interpretation of the Standing Orders shall be final. In this interpretation he shall be advised by the Chief Executive and the Trust Secretary and in the case of Standing Financial Instructions he shall be advised by the Chief Financial Officer.

4.10 Chair's ruling

4.10 The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

4.11 Quorum

4.11.1 No business shall be transacted at a meeting unless the agreed quorum in the terms of reference is in place.

4.11.2 An officer in attendance for a Chief Officer on the Board but without formal acting up status will not count towards the quorum.

4.11.3 If the Chair or a member of the Board has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.8) that person shall no longer count towards the quorum.

4.11.4 If a quorum is not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

4.12 Voting

4.12.1 Every question put to a vote at a meeting shall be determined by a majority of the votes of members of the Board present and voting on the question. In the case of an equal vote, the person presiding (i.e. the Chair of the meeting) shall have a second, and casting vote.

4.12.2 At the discretion of the Chair all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

4.12.3 If at least one third of the members of the Board present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

4.12.4 If a member of the Board so requests, their vote shall be recorded by name.

4.12.5 In no circumstances may an absent member of the Board vote by proxy. Absence is defined as being absent at the time of the vote.

4.12.6 A manager who has been formally appointed to act up for a Chief Officer on the Board during a period of incapacity or temporarily to fill a Chief Officer's vacancy shall be entitled to exercise the voting rights of the Chief Officer of the Board.

4.12.7 A manager attending the Trust Board meeting to represent a Chief Officer of the Board during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Chief Officer member of the Board of Directors.

4.12.8 For the voting rules relating to joint members see Standing Order 3.5.

4.13 Suspension of Standing Orders

4.13.1 Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum (SO 4.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the Board of Directors are present (including at least one Non Executive Director and one Chief Officer member of the Board) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Board's minutes.

4.13.2 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and members of the Board.

4.13.3 No formal business may be transacted while Standing Orders are suspended.

4.13.4 The Audit Committee shall review every decision to suspend Standing Orders.

4.14 Variation and Amendment of Standing Orders

4.14.1 These Standing Orders shall not be varied except in the following circumstances:

a. Upon a notice of motion under Standing Order 4.7;
b. Upon a recommendation of the Chair or Chief Executive included on the agenda for a meeting;
c. That two thirds of Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Non-Executive Directors vote in favour of the amendment;
d. Providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

4.15 Record of Attendance

4.15.1 The names of the Chair and Non-Executive Directors, Chief Officers on the Board, Chief Officers without voting rights and Officers in attendance present at the meeting shall be recorded.

4.16 Minutes

4.16.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next meeting where the person presiding at it shall sign them.

4.16.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate.

4.16.3 Any amendment to the minutes as to their accuracy shall be agreed and recorded at the next meeting and the amended minutes shall be regarded as the formal record of the meeting.

4.17 Admission of public and the press

4.17.1 Admission and exclusion on grounds of confidentiality of business to be transacted

a. The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw at the point at which the Chair declares:

   i. 'that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1 (2), Public Bodies (Admission to Meetings) Act l960.

   ii. Guidance should be sought from Trust's Freedom of Information Lead to ensure correct procedure is followed on matters to be included in the exclusion.

4.17.2 General disturbances

a. The Chair, or one of Vice Chairs presiding over the meeting shall give such directions as they think fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted. The public will be required to withdraw upon the Board resolving as follows:

   i. *'That in the interests of public order the meeting adjourns for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public'. Section 1(8) Public Bodies (Admissions to Meetings) Act l960*'

4.17.3 Business proposed to be transacted when the press and public have been excluded from a meeting

a. Matters to be dealt with by the Board following the exclusion of representatives of the press, and other members of the public, as provided in (i) and (ii) above, shall be confidential to the members of the Board.

b. Non-Executive Directors, Chief Officers and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Chair. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

4.17.4 Use of mechanical or electrical equipment for recording or transmission of meetings

a. Nothing in these Standing Orders shall be construed as permitting the introduction by the public or press representatives, of recording, transmitting, videoing or similar apparatus into meetings of the Board or Committee. Such permission shall be granted only upon resolution of the Board.

4.17.5 Observers at Trust meetings

a) The Board will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

4.18 Annual General Meeting

4.1.8.1 The Trust will publicise and hold an Annual General Meeting in accordance with the NHS Trust's (Public Meetings) Regulations 1991 (SI (1991) 482). The meeting shall take place no later than 30 September each year. The Annual Report and Annual Accounts of the preceding year shall be presented at that meeting. The Trust is precluded from holding an AGM after this date if there is a delay to the production of audited accounts which is outside of the Trust's control.

5. APPOINTMENT OF COMMITTEES

5.1 Appointment of Committees

5.1.1 Subject to such directions as may be given by the Secretary of State for Health & Social Care, the Board may appoint Committees of the Trust

5.1.2 The Board shall determine the membership and terms of reference of Committees and sub-Committees and shall if it requires to, receive and consider reports of such Committees.

5.1.3 The Standing Orders, as far as they are applicable, shall apply with appropriate alternation to meetings of any Committees or sub-Committees established by the Board. Each such Committee shall have terms of reference and powers and be subject to such conditions (such as reporting back to the Board), as the Board shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.1.4 The Board may elect to change the Committees, sub-Committees and joint-Committees of the Trust, as necessary, without requirement to amend these Standing Orders.

5.1.5 Any Committee or sub-Committee appointed under this Standing Order may, subject to such directions as may be given by the Secretary of State or the Board or other health bodies in question, appoint sub-Committees consisting wholly or partly of members of the Committees or joint Committee (whether or not they are members of the Trust or health bodies in question) or wholly of persons who are not members of the Trust or health bodies in question or the Committee of the Trust or health bodies in question.

5.1.6 Committees may not delegate their executive powers to a sub-Committee unless expressly authorised by the Board.

5.2 Joint Committees

5.2.1 Joint Committees may be appointed by the Trust by joining together with other Trusts consisting of, wholly or partly of the Chair and Board members. Any joint

Committee appointed under this standing order, subject to such directions as may be given by the Secretary of State or the Board or other health bodies in question, appoint sub-Committees consisting wholly or partly of members of the Committees or joint Committees.

5.3 Confidentiality

5.3.1. A member of a Committee or sub-Committee shall not disclose a matter dealt with by, or brought before, the Committee without its permission until the Committee shall have reported to the Board or shall otherwise have concluded on that matter.

5.3.2 A Chief Officer of the Trust or member of a Committee or sub-Committee shall not disclose any matter reported to the Board or otherwise dealt with by the Committee or sub-Committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or Committee shall resolve that it is confidential.

5.4 Applicability of Standing Orders and Standing Financial Instructions to Committees

5.4.1 The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any Committees established by the Board. In which case the term “Chair” is to be read as a reference to the Chair of the other Committees as the context permits, and the term “member” is to be read as a reference to a member of other Committees also as the context permits. (There is no requirement to hold meetings of Committees established by the Board in public.)

5.5 Terms of Reference

5.5.1 Each Committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.6 Delegation of Powers by Committees to Sub-Committees

5.6.1 Where Committees are authorised to establish Sub-Committees they may not delegate executive powers to the Sub-Committee unless expressly authorised by the Board.

5.7 Approval of Appointments to Committees

5.7.1 The Board shall approve the appointments to each of the Committees that it has formally constituted.

5.7.2 Where the Board determines, and regulations permit, that persons, who are neither Non-Executive Directors, Chief Officers or otherwise an employee of the Trust, shall be appointed to a Committee the terms of such appointment shall be within the powers of the Board as defined by the Secretary of State.

5.7.3 The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.8 Appointments for Statutory functions

5.8.1 Where the Board is required to appoint persons to a Committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Board such appointment shall be made in accordance with the Regulations and Directions made by the Secretary of State.

5.9 Committees established by the Trust Board

5.9.1. The assurance Committees established by the Board are:

a. Audit Committee

i. In line with the requirements of the NHS Audit Committee Handbook, NHS Codes of Conduct and Accountability, and the Higgs report, an Audit Committee will be established and constituted to provide the Board with an independent and objective review of its financial systems, financial information, organisational governance and compliance with laws, guidance, and regulations governing the NHS. The terms of reference will be approved by the Board and reviewed on an annual basis.

ii. The Higgs report recommends a minimum of three Non-Executive Directors be appointed, unless the Board decides otherwise, of which one must have significant, recent and relevant financial experience.

b. Remuneration Committee

i. In line with the requirements of the NHS Codes of Conduct and Accountability, and the Higgs report, a Remuneration Committee will be established and constituted.

ii. The Higgs report recommends the Committee be comprised exclusively of Non-Executive Directors, a minimum of three, who are independent of management.

iii. The purpose of the Committee will be to advise the Board on appropriate remuneration and terms of service for the Chief Executive, Chief Officers and other Directors of the Trust, including:

- Agree and review the overall remuneration policy of the Trust
- Set the individual remuneration for Chief Officers
- Ensure that appropriate and robust processes are in place to provide appropriate performance management of the Chief Executive
- Agree compromise agreements, settlements and redundancy payments which require final approval by NHS Improvement/HM Treasury and any proposed termination payments to very senior management

iv. The Committee shall report to the Board on the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Chief Officers and senior employees.

v. Minutes of the Board's meetings should record such decisions.

c. Charity Committee

In line with its role as a Corporate Trustee for any funds held in trust, either as charitable or non-charitable funds, the Board will establish a Charitable Funds Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission.

d. Quality and Safety Committee

The purpose of the Quality and Safety Committee is to provide the Board with assurance that high standards of safety and compliance, harm free, high quality, safe and effective services/clinical outcomes that are provided by the Trust and in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust.

e. People, Education and Research Committee

A Committee of the Board which provides assurance on all aspects of the workforce, organisational development and learning development and research.

f. Finance and Performance Committee

A Committee of the Board established to provide the Board with assurance on the financial strategy and plan to ensure long term financial viability and performance against the access standards.

g. Redevelopment Programme Committee

A Committee of the Board established to gain assurance on the delivery of the objectives of the hospital redevelopment and digital infrastructure programmes and to provide senior level leadership to shape and drive the implementation of the “Great Place” elements of the Trust’s strategy.

5.10 Other Committees

5.10.1 The Board may also establish such other Committees as required to discharge the Trust's responsibilities.

5.11 Confidentiality

5.11.1 A member of a Committee will not disclose a matter dealt with by, or brought before, the Committee without its permission until the Committee will have reported to the Board or will otherwise have concluded on that matter.

5.11.2 A Board or Committee member, or anybody attending a Committee meeting, will not disclose any matter reported to the Board or otherwise dealt with by the Committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or Committee will resolve that it is confidential.

6. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

6.1 Delegation of Functions to Committees, Officers or Other Bodies

6.1.1 Subject to such directions as may be given by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a Committee, Sub-Committee appointed by virtue of SO 5, or by an Officer of the Trust, or by another body as defined in SO 6, in each case subject to such restrictions and conditions as the Board thinks fit.

6.1.2 Paragraph 18 of Schedule 4 of the NHS Act 2006 (as amended0 allows the functions of the Trust to be carried out jointly with any one or more of the following: NHS Trusts, NHSE or any other body or individual.

6.1.3. Regulation 16 of the NHS Membership and Procedure Regulations 2014 permits the Trust to make arrangements for the exercise of behalf of the Trust of any of its functions by a Committee appointed pursuant to Regulation 15 of the membership and Procedure Regulations.

6.2 Emergency Powers and Urgent Decisions

6.2.1 The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 3) may in an emergency or for an urgent decision, be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Board in public session for formal ratification, unless the decision is confidential or concerns sensitive information in which case it will be reported to the next formal meeting of the Board in private.

6.3 Delegation to Committees

6.3.1 The Board shall agree from time to time to the delegation of executive powers to be exercised by other Committees or joint Committees, which it has formally constituted in accordance with Regulation 15 of the NHS Membership and Procedure Regulations 2014. The terms of reference of these Committees or joint Committees, and their specific executive powers shall be approved by the Board.

6.3.2 When the Board is not meeting in public session, it shall operate as a Committee and may only exercise such powers as may have been delegated to it by the Board in public session.

6.4 Delegation to Officers

6.4.1 Those functions of the Trust which have not been retained as reserved by the Board or delegated to Committee or joint Committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Trust.

6.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying their proposals, which shall be considered and approved by the Board. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board.

6.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Chief Financial Officer to provide information and advise the Board in accordance with statutory or Department of Health and Social Care requirements. Outside these statutory requirements the roles of the Chief Financial Officer shall be accountable to the Chief Executive for operational matters.

6.5 Reservation of Powers and Scheme of Delegation

6.5.1 The arrangements made by the Board as set out in the Reservation of Powers and Scheme of Delegation document shall have effect as if incorporated into these Standing Orders.

6.6 Duty to Report Non-Compliance with Standing Orders and Standing Financial Instructions

6.6.1 If for any reason the SO and SFIs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All members of the Board and employees of the Trust have a duty to disclose any non-compliance with the Standing Orders and SFIs to the Chief Executive as soon as possible.

7. OVERLAP WITH OTHER TRUST POLICY, STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

7.1 Policy Statements: general principles

7.1.1 The Board will from time to time agree and approve Policy Statements/ procedures, which will apply to all, or specific groups of staff employed by the Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders
and SFIs. The Board may delegate the approval of specific policies to its Committees.

7.2 Specific Policy Statements

7.2.1 Notwithstanding the application of SO 7, the Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy Statements:

- Conflicts of interest policy
- Anti-bribery policy;
- The staff Disciplinary and Appeals Procedures adopted by the Trust both of which shall have effect as if incorporated in these Standing Orders.

7.3 Standing Financial Instructions

7.3.1 Standing Financial Instructions adopted by the Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

7.4 Specific Guidance

7.4.1 Notwithstanding the application of SO 7, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

- Caldicott Guardian 1997;
- Human Rights Act 1998;
- Freedom of Information Act 2000;
- The Public Contracts Regulations 2006;
- Confidentiality: NHS Code of Practice 2003;
- Standards of Business Conduct for NHS Staff;
- The NHS Constitution for England 2013.

8. DUTIES AND OBLIGATIONS OF BOARD MEMBERS/DIRECTORS AND SENIOR MANAGERS AND ALL STAFF UNDER THESE STANDING ORDERS

8.1 Conflicts of Interests

8.1.1 Requirements for Declaring Conflicts of Interests and applicability to Board Members

8.1.1.1 In addition to the statutory requirements relating to pecuniary interests dealt with in Standing Order 9, under the Trust's Conflicts of Interests policy directors are required to declare interests which are relevant and material to the Board. All existing directors and any senior officers who may act up into a Chief Officer post should declare such interests on an annual basis, or as otherwise recommended in the Policy. Any directors and senior officers appointed subsequently should declare these interests on appointment.

8.1.2 Declarable interests –

8.1.2.1 Interests that should be declared are:

- Financial interests: Where an individual may get direct financial benefit from the consequences of a decision they are involved in making.

- Non-financial professional interests: Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.

- Non-financial personal interests: Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.

- Indirect interests: Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

8.1.2.2 Any member of the Board who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 8 and elsewhere) has any pecuniary interest, direct or indirect, the Board member shall declare his/her interest by giving notice in writing of such fact to the Trust as soon as practicable.

8.1.2.3 It is important to ensure that all declarations are submitted and up to date, to ensure the Trust has a robust system to prevent bribery. Trust employees should refer to the Trust's Counter Fraud Policy and Anti-Bribery Policy for further information in relation to fraud and bribery offences. Failure to adhere to these policies could, depending upon the circumstances, amount to a criminal offence and lead to the individual(s) being subject to disciplinary action and/or criminal investigation.

8.1.3 Advice on Interests

8.1.3.1 Membership and Procedure regulations require that the pecuniary interest of directors' spouses and cohabiting partners, in contracts should be declared. Any members of the Board who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her has pecuniary interest, direct or indirect, the Board member shall declare his/her interest by giving notice in writing of such fact to the Trust as soon as practicable.

8.1.3.2 If Directors have any doubts about the relevance of an interest, this should be discussed with the Chair of the Trust or with the Trust Secretary. Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that the potential level of influence, rather than the immediacy of the relationship is more important in assessing the relevance of an interest.

8.1.4 Recording of interests in Board minutes

8.1.4.1 At the time Board members' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring and recorded in the minutes of that meeting.

8.1.5 Publication of declared interests in Annual Report

8.1.5.1 Board members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

8.1.6 Conflicts of interest that arise during the course of a meeting

8.1.6.1 During the course of a Board meeting, if a conflict of interest is established, the Board member should declare such likely conflict of interest and withdraw from the meeting, unless requested to remain by the Board members present. The Director should play no part in the relevant discussion or decision.

8.2 Register of Interests

8.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board or Committee members. In particular the Register will include details of all directorships and other relevant and material interests that have been declared by both Non-Executive and Chief Officers .

8.2.2 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

8.2.3 The Register will be made available to the public.

8.3 **Standards of Business Conduct**

8.3.1 All staff must comply with the 'Standards of Business Conduct for NHS staff', 'Code of Conduct for NHS Managers' 2002 and the seven principles set out by the Committee on Standards in Public Life, published by the Professional Standards Authority, November 2012.

8.3.2 All staff must declare any relevant and material interest, such as those described in Standing Order 8. The declaration should be made on appointment or, if the interest is acquired, or recognised subsequently, at that time to the Chief Officer , clinical director, or senior manager to whom they are accountable. Such director or senior manager shall ensure that such interests are entered in a Register of Interests, kept for that purpose.

8.3.4 Officers who are involved in, have responsibility for, or are able by virtue of their role or functions to influence the placing of contracts by the Trust, may be required by the Trust to give statements from time to time, or in connection with particular contracts, confirming that they have no relevant or material interest to declare.

8.3.5 If an officer becomes aware of a potential or actual contract in which he has an interest, he shall immediately advise the Trust Secretary. This requirement applies whether or not the officer is likely to be involved in administering the proposed, or awarded contract to which he has an interest.

8.3.6 Gifts and hospitality shall only be accepted in accordance with the Trust's Conflicts of Interest policy. Officers of the Trust shall not ask for any rewards or gifts; nor shall they accept any rewards or gifts of significant value.

9. EXCLUSION OF CHAIR AND DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUINARY INTEREST

9.1.1. Subject to the following provisions of this SO, if the Chair or a member of the Board of Directors, non-voting Chief Officer or Trust employee has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after it's commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question concerning it.

9.1.2. The Secretary of State may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this SO in any case in which it appears to him/her in the interests of the National Health Service that the disability should be removed.

9.1.3. The Board may exclude the Chair member of the Board of Directors, non-voting Chief Officer or employee of the Trust from a meeting of the Board while any

contract, proposed contract or other matter in which he/she has a pecuniary interest is under consideration.

9.1.4. Any remuneration, compensation or allowance payable to the Chair or a Member by virtue of Schedule 4 National Health Service Act 2006 shall not be treated as a pecuniary interest for the purpose of this Standing Order.

9.1.5. This Standing Order applies to a Committee, Sub-Committee, Joint Committee or Joint Sub-Committee as it applies to the Board and applies to a member of any such Committee or Sub-Committee (whether or not he/she is also a member of the Board) as it applies to a member of the Board.

9.2 Powers of the Secretary of State for Health & Social Care

a. Power of the Secretary of State to remove disability

i. Under Regulation 20(2) of the NHS Membership and Procedure Regulations 2014, there is a power for the Secretary of State to, subject to any conditions the Secretary of State may think fit to impose, remove any disability imposed by Regulation 20, in any case in which it appears to the Secretary of State in the interests of the health service that the disability (which prevents a Chair or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he has a pecuniary interest) should be removed.

9.3 Interest of Officers in Contracts

a. Any officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 8) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or Trust Secretary as soon as practicable.

b. An Officer should also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

c. The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

d. The Trust is required to disclose in its Annual Report and Annual Financial Accounts, material related party transactions in compliance with Financial Reporting Standards (FRS) 8: Related Party Disclosures.

9.4 Tendering and contract procedure

9.4.1. The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders is applied).

9.4.2 Full information on the Trust's tendering and contract procedures can be found in the Standing Financial Instructions.

9.5 Canvassing of and Recommendations by Members in Relation to Appointments

a. Canvassing of members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the SO shall be included in application forms or otherwise brought to the attention of candidates.

b. Members of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this SO shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

c. Informal discussions outside appointment panels or Committees, whether solicited or unsolicited should be declared to the panel or Committee

9.6 Relatives of Members or Officers

a. Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

b. The Chair and every member and officer of the Trust shall disclose to the Trust Board any relationship between themselves and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

c. On appointment, members (and prior to acceptance of an appointment in the case of Chief Officers) should disclose to the Trust whether they are related to any other member or holder of any office under the Trust.

d. Where the relationship to a member of the Board is disclosed, the Standing Order headed Exclusion of Chair and Board Members in proceedings on account of pecuniary interest shall apply. (SO 9)

9.7. Canvassing of and Recommendations by Board Members in Relation to Appointments

a. Canvassing of a member of the Board or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

b. Members of the Board shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

10. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

10.1 Custody of Seal

10.1.1 The Chief Executive shall keep the Common Seal of the Trust, or a person nominated by them such as the Trust Secretary, in a secure place.

10.2 Sealing of Documents

10.2.1 Where it is necessary that a document shall be sealed, the seal shall be affixed by the Chief Executive or his/her nominated representative and witnessed by a Chief Officer or Officer duly authorised by the Chief Executive. The witness cannot be from the originating department.

10.2.2 Before any building, engineer, property or capital document is sealed, it must be approved and signed by the Chief Financial Officer (or an officer nominated by him/her) and authorised and countersigned by the Chief Executive (or an officer nominated by him/her who shall not be within the originating directorate)

10.3 Register of Sealing

10.3.1 The Chief Executive shall keep a Register in which they, or a Chief Officer or Officer of the Trust authorised by them, shall enter a record of the sealing of every document.

10.3.2 An entry of every sealing shall be made and number consecutively in a book provided for that purpose, and shall be signed by the person who shall have approved and authorised the document and those who witnessed the seal. A report of all sealings shall be made to the Board via the Audit Committee on a quarterly basis. The report shall contain details of the seal number, the description of the document and date of sealing.

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10.4 Signature of documents

10.4.1 **Delegated Authority in Legal Proceedings**

10.4.1.1Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Chief Officer on the Board.

10.4.1.2In land transactions, where the signing of certain supporting documents may be required these will also be signed by the Chief Executive or Chief Officer Board.

11. MISCELLANEOUS

11.1 Joint Finance Arrangements

11.1.1 The Board may confirm contracts to purchase from a voluntary organisation or a Local Authority using its powers under Section 28A of the NHS Act 1977. The Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 28A of the NHS Act

1977, as amended by section 29 of the Health Act 1999. All transactions must comply with the Trust's Anti-Bribery Policy.

11.2 Standing Orders to be given to Board Members and Officers

11.2.1 It is the duty of the Chief Executive to ensure that existing Board Members and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions. Updated copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of Standing Orders.

11.3 Documents having the standing of Standing Orders

11.3.1 Standing Financial Instructions and Reservation of Powers to the Board and Delegation of Powers and the Detailed Scheme of Delegation shall have effect as if incorporated into Standing Orders.

11.4 Review of Standing Orders

11.4.1 Standing Orders shall be reviewed annually by the Audit Committee and recommended to the Board for approval. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

NHS
West Hertfordshire Teaching Hospitals
NHS Trust

Trust Board meeting
04 April 2024

Title of the paper:	**Corporate Risk Register Report**
Agenda Item:	**26**
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:	The purpose of this report is to provide an update on the status of the Corporate Risk Register (CRR) to the Board. This report captures the decisions made by the Risk Review Group (RRG) on 14 March 2024. Where applicable, decisions made by the Group are highlighted in amber under the risk. The final data for this report was extracted from the Trusts Risk Management System (DCIQ) on 15 February 2024. A total of 14 open risks were registered on the Corporate Risk Register (CRR) at that time. The RRG reviewed any escalated, de-escalated, closed, increased, reduced, and merged risks where applicable. <u>There was one (1) new risk for discussion, and which was accepted onto the CRR.</u> **Risk ID 404** Risk to Patient Safety due to inability to utilise EPR system with regard to DNACPR documentation and processes. Agreed Risk Score 16 (4 x 4) This risk related to numerous aspects of EPR being unable to capture/print out DNACPR documentation, representing a Patient Safety risk. Although controls were in place to manage the risk, there was still a possibility that incorrect information could be in place regarding a patient relating to DNACPR. Agreed that this should be accepted onto the CRR at present, which further mitigation and work is being undertaken. <u>There was one (1) risk with a decreased score, which was agreed and removed from the CRR.</u> **Risk ID 34** Electrical infrastructure risks on the WGH site

	Current Risk Score 15 (3 x 5) Agreed new Risk Score 12 (3 x 4) This risk could be reduced due to the ongoing work that had been undertaken on the Watford site. Although it could not be closed, due to the fact that there is still a possibility of power outages affecting the whole site, the work undertaken had resulted in reduced levels of risk. Agreed to be reduced to 12 and removed from the CRR. To be monitored and managed by the Environment Division on their risk register. <u>There were two (2) risks with increased scores to be considered.</u> **Risk ID 331** Failure of Telephone Services infrastructure leading to a complete loss of telephony per site. Previous Risk Score 12 (3 x 4) Agreed new Score 16 (4 x 4) The telephone services infrastructure is under significant pressure at present and failures are now becoming more prevalent. There exists a increased risk that the entire system will fail, representing a major risk to the Trust. While ongoing work is seeking to mitigate the risk, this will take time. Agreed to be added to the CRR. **Risk ID 391** Insufficient capacity on WHG and HHGH Telephony exchanges to add new extensions. Previous Risk Score 12 (3 x 4) Proposed new Score 16 (4 x 4) This risk was not accepted onto the CRR, as this is an ongoing issue rather than a risk and ICT will review and incorporate this into Risk ID 331 in due course as a contributing factor for that risk. Not accepted onto the CRR, to remain on ICT Divisional Risk Register with a risk score of 12 (3 x 4) <u>There were no merged risks for consideration.</u> <u>There were no risks to be considered for closure.</u> The meeting also confirmed that the updated template for the Corporate Risk report will be implemented in April 2024. As stated in the previous February report this is designed to present a more qualitative oversight of all risks, not just those on the Corporate Risk Register (CRR) and allows for more effective escalation of risks, as it now allows for risks, which do not reach the level of possible inclusion within the CRR to be raised for discussion at each monthly meeting rather than being presented by Divisions on a separate report every three months on a rota basis. The amended ToR is re-presented for approval to reflect the change of Chair from CMO to Head of Patient Safety & Risk.

<table>
<tr><td>Trust strategic aims:

(please indicate which of the 4 aims is relevant to the subject of the report)</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>
<tr><td>  </td><td>  </td><td>  </td><td>  </td></tr>
<tr><td>Objectives 1-4</td><td>Objectives 5-8</td><td>Objective 9</td><td>Objective 10-12</td></tr>
<tr><td>✓</td><td>✓</td><td>✓</td><td>✓</td></tr>
</table>
</td></tr>
<tr><td>Links to well-led key lines of enquiry:</td><td>☒Is there the leadership capacity and capability to deliver high quality, sustainable care?
☒Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
☒Is there a culture of high quality, sustainable care?
☒Are there clear responsibilities, roles, and systems of accountability to support good governance and management?
☒Are there clear and effective processes for managing risks, issues, and performance?
☒Is appropriate and accurate information being effectively processed, challenged, and acted on?
☒Are the people who use services, the public, staff, and external partners engaged and involved to support high quality sustainable services?
☒Are there robust systems and processes for learning, continuous improvement, and innovation?
☒How well is the trust using its resources?</td></tr>
<tr><td>Previously considered by:</td><td>
<table>
<tr><th>Committee/Group</th><th>Date</th></tr>
<tr><td>Quality and Safety Committee</td><td>28 March 2024</td></tr>
</table>
</td></tr>
<tr><td>Action required:</td><td>The Board is asked to receive this report for discussion of the corporate risk register.</td></tr>
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West Hertfordshire Teaching Hospitals NHS Trust

Agenda Item: 26

Trust Board – 04 April 2024

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 Board with an update on the status of the Corporate Risk Register (CRR) including current risk scores, new, escalated, de-escalated, merged, increased, reduced, and closed risks.

1.2 The final data for this report was extracted from the Trusts Risk Management system (DCIQ) on 15 March 2024, a total of **14** 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, while the Risk Lead/Head of Patient Safety manages and chairs the Risk Review Group.

2.3 The Quality Safety 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 the Trust Risk Management system, 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 2023.

3.2 Appendix 2 details a full summary of all corporate risks contained in the paper presented to the Chair of the Risk Review Group on 14 March 2024.

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 There was one (1) new risk for discussion and which was accepted onto the CRR.

Risk ID 404

Risk to Patient Safety due to inability to utilise EPR system with regard to DNACPR documentation and processes

Agreed Risk Score 16 (4 x 4)

This risk related to numerous aspects of EPR being unable to capture/print out DNACPR documentation, representing a Patient Safety risk. Although controls were in place to manage the risk, there was still a possibility that incorrect information could be in place regarding a patient relating to DNACPR. Agreed that this should be accepted onto the CRR at present, which further mitigation and work is being undertaken.

There was one (1) risk with a decreased score, which was agreed and removed from the CRR.

Risk ID 34

Electrical infrastructure risks on the WGH site

Current Risk Score 15 (3 x 5) Agreed new Risk Score 12 (3 x 4)

This risk could be reduced due to the ongoing work that had been undertaken on the Watford site. Although it could not be closed, due to the fact that there is still a possibility of power outages affecting the whole site, the work undertaken had resulted in reduced levels of risk. Agreed to be reduced to 12 and removed from the CRR. To be monitored and managed by the Environment Division on their risk register.

There were two (2) risks with increased scores to be considered.

Risk ID 331

Failure of Telephone Services infrastructure leading to a complete loss of telephony per site.

Previous Risk Score 12 (3 x 4) Agreed new Score 16 (4 x 4)

The telephone services infrastructure is under significant pressure at present and failures are now becoming more prevalent. There exists a increased risk that the entire system will fail, representing a major risk to the Trust. While ongoing work is seeking to mitigate the risk, this will take time. Agreed to be added to the CRR.

Risk ID 391

Insufficient capacity on WHG and HHGH Telephony exchanges to add new extensions.

Previous Risk Score 12 (3 x 4) Proposed new Score 16 (4 x 4)

This risk was not accepted onto the CRR, as this is an ongoing issue rather than a risk and ICT will review and incorporate this into Risk ID 331 in due course as a contributing factor for that risk. Not accepted onto the CRR, to remain on ICT Divisional Risk Register with a risk score of 12 (3 x 4)

There were no merged risks for consideration.

There were no risks to be considered for closure.

The meeting also confirmed that the updated template for the Corporate Risk report will be implemented in April 2024.

5. Risk

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

The 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
Chief Medical Officer

Date: 18 March 2024

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 – Summary of the risk score movement of Risks currently on the Corporate Risk Register. New/Increased risks are shown in Amber. Reduced in Blue

Division		Apr-23		May-23		Jun-23		Jul-23		Aug-23		Sep-23		Oct-23		Nov-23		Dec-23		Jan-24		Feb-24		Mar-24	
CLINICAL SUPPORT SERVICES	347			20	↑	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→
	349			15	↑	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→
	379											16	↑	16	→	16	→	16	→	16	→	16	→	16	→
ICT	25	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→
	27	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→
	331																							16	↑
	391																							16	↑
	398																	16	↑	16	→	16	→	16	→
CORPORATE SERVICES	404																							16	↑
	344			20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→	20	→
EMERGENCY MEDICINE	20	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→
	21	20	→	20	→	16	↓	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→
	22	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→
ENVIRONMENT	34	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	12	↓
MEDICINE																									
SURGERY & CANCER																									
WOMEN's & CHILDREN	351			16	↑	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→	16	→
	119			15	↑	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→	15	→

APPENDIX 2 – Corporate Risk Register (by Division)

RISK ID	OPENED DATE	RISK TITLE	INITIAL RISK RATING SCORE	UPDATE	CURRENT RATING	EXECUTIVE LEAD
25	12/06/2017	Trust Bleep System Failure leading to inability to utilise alert systems across the Trust	20	Pilot of the Bleep app is being run in HHGH and SACH. This will help define numbers of devices. Feedback and configuration of the app is ongoing Update on the Bleep app pilot	15	Paul Bannister - Chief Information Officer
RRG MEETING UPDATE **Risk update noted. The pilot continues, as does work in improving the bleep system.** **No change to the risk score at present and further updates will be provided as the work progresses.** **Current Risk 3 x 5 = 15**						
27	20/05/2020	Possibility of a Cyber Security Incident arising from vulnerabilities within our network connectivity systems.	15	Work continues to remediate vulnerabilities reported through the annual penetration test. Changes are being prepared to remove the following vulnerabilities from the environment: SSL RC4 Cipher Suites Supported (Bar Mitzvah)-Port (3389-443) TLS Version 1.0 Protocol Detection-Port (3389-443) TLS Version 1.1 Protocol Deprecated-Port (3389-443)	15	Paul Bannister - Chief Information Officer

				There are 13 Windows 10 devices which are owned by third party vendors that are below the supported version. The Trust are working with the 3rd parties to upgrade these devices to the latest supported version. There is currently 1 Windows 7 desktop and 1 Windows 2003 server on the domain. Work continues to remediate these end of life operating systems.		

RRG MEETING UPDATE

RRG noted the update on the risk. There remains a risk that our security could be breached due to existing vulnerabilities in the systems that are used. ICT continue to work across the entire Trust to minimise and reduce the risk.

No change to the Risk score.

Current Risk 3 x 5 = 15

398	04/12/2023	Unexpected instability, failure or compromise of Wi-Fi services	16	1) What activity have we undertaken a) Impact assessment of disabling the affected APs is complete. 2) What has the impact of the activity been on the risk a) The risk score remains the same currently. 3) What is the plan going forward Options and rough order of magnitude (ROM)costs for implementation identified. These are 1) a full replacement of Cisco 1702's circa £800K or, 2) redistribute the Access Points such that no clinical area has greater than 50% coverage provided by 1702s circa £150K. Develop business case to seek invest capital is required to address this. This has been put on the department capital wish list and is in discussion.	16	Paul Bannister - Chief Information Officer

RRG MEETING UPDATE

Risk update noted. Risk score remains and no change to mitigation at present.

Current Risk 4 x 4 = 16

331	13/03/2023	Failure of Telephone Services infrastructure leading to a complete loss of telephony per site	16	Telephone Services infrastructure leading to a complete loss of telephony per site Cause: All three telephony platforms providing telecommunications service across the Trust have reached end of life. The ISDX's in WGH and SACH went out of manufacturer support in 2016. As of 31st November 2023, the Avaya Telephony system used for HHGH, Unit 11 and Jacketts Field will be no longer under manufacturer support and will be on best endeavours. Effect: Telecommunication service (crash calls, 2222, incoming and outgoing calls) failure impacting multiple sites. Delays in sourcing replacement/repair parts. We are at capacity in WGH and HHGH. This will impact future projects such as Civic Centre, Pathology. Adding extra hardware to Watford ISDX puts extra load onto an already struggling infrastructure. There may be a need to increase power to the system which has already suffered power unit failures INC30092 (INC003814059). Extra load would add the risk of failure (see risk 391). Impact: Potential delays to time-sensitive (emergency) patient pathways leading to serious harm or death. Significant damage to Trust Credibility, financial loss or both. IF we have a complete failure of the PABX's in either WGH or SACH that site will lose ALL telephony capabilities, including bleeps and emergency phones. As a like for like replacement is not available due to the age of the equipment a new solution would be needed. After conversations with our current providers this would take a minimum of 4 months after receipt of a PO just to get back basic telephony.	15	Paul Bannister - Chief Information Officer

10

RRG MEETING UPDATE

New Risk. The telephone services infrastructure is under significant pressure at present and failures are now becoming more prevalent. There exists a increased risk that the entire system will fail, representing a major risk to the Trust. While ongoing work is seeking to mitigate the risk, this will take time. Agreed to be added to the CRR.

Current Risk 4 x 4 = 16

CLINICAL SUPPORT SERVICES

347	11/05/2023	Inadequate Mortuary facilities for the storage of bodies and postmortem tissue from the deceased	20	Full scheme of remedial works at HHGH starts March 2024. Watford Mortuary is scheduled to be operational in June 24. At present the risk score, controls and mitigation as well as assurance is appropriate to the risk level. This is discussed at Divisional Governance and assurance is given that the risk is managed effectively.	20	Mary Bhatti – Acting Chief Operating Officer

RRG MEETING UPDATE

RRG noted the update on the risk. Work is underway. In the meantime the risk and mitigation remain the same.

Current Risk 4 x 5 = 20

349	11/05/2023	Risk of the Mortuary premises not being fit for purpose.	25	As per risk 347 Full scheme of remedial works at HHGH starts on March 10th. Watford Mortuary in WGH expected to be operational in June 24.	20	Mary Bhatti – Acting Chief Operating Officer
RRG MEETING UPDATE **RRG noted the update on the risk. Work is progressing as with risk 347.** **Current Risk 4 x 5 = 20**						

379	17/08/2023	No identified area for urology nephrostomy patients who require a day case bed post intervention of semi urgent procedures.	20	The challenges in mitigating risk remain ongoing. Work has commenced in the build of the new IR suite which will include day case recovery beds following procedures.	16	Mary Bhatti – Acting Chief Operating Officer
RRG MEETING UPDATE **Risk update noted. No change at present.**						

Current Risk 4 x 4 = 16

CORPORATE SERVICES

388	03/10/2023	Risk that Deteriorating Patients may not be identified due to lack of effective processes/procedures/IT	20	Recommendations for next 6 months: To merge the following teams to make a deteriorating patient team: Resus, CCOT, sepsis and hospital at night. To introduce Care Aware, Connect Mesenger with handheld devises for specialist teams to have complete oversight of the deteriorating patient. Total licences required 4000, with 105 devises cost: £268,451.52 for 36 months, under capital costs. Introduce all wards with the e-whiteboards to display the ward NEWS2 scores, allowing easy identification of the deteriorating patient. Implement a deteriorating patient introduction alongside NEWS2 training for all staff and must be mandatory. All medical reviews of patients must be taken face to face. This will reduce the risk to late uploading of NEWS2 scores. Improvement will be embedded to deliver safer care for deteriorating patients Restart the deteriorating patient group and ensure medical lead attends Ensure that all policies and procedures are up to date. Reintroduce sepsis 6 awareness Review staff understanding of the EPR systems and documentation requirements and implement training if required. Ensure that all vital signs equipment is compliant with the EPR system and configurated to show the NEWS2 score and warning if high Review Critical Care staffing levels to ensure that there is adequate staff, so CCOT stop getting pulled back into the unit Increasing staff support in sepsis high-risk areas such as ED To introduce Call 4 Concern 24 hours/ 7 days a week, implementing Martha's Law Audit compliance with NEWS2 to	20	Kelly McGovern – Chief Nurse

				identify a baseline on six wards with highest number of deteriorating patients to identify themes and issues Introduce a named deteriorating patient bleep holder on all inpatient wards and audit compliance. Address any barriers to deteriorating patients, especially at night. Audit inclusion of deteriorating patient in ward safety huddles Audit time from escalation to response and identify areas requiring further education and input. Roll out sepsis and deteriorating patient awareness week, with a rolling yearly programme Achieve 60% of all unplanned Critical Care admissions from non-critical care wards of patients 18+, having a NEWS2 score, time of escalation and time of clinical response recorded. Achieve 60% of all unplanned paediatric ICU admissions from non-critical wards of children up to their 16th birthday, having bedside Paediatric Early Warning score (BPEWS) score, time of escalation and time of clinical response recorded. Achieve 60% of all unplanned maternity Critical Care admissions from the birth centre or labour wards, having Maternity Early Warning Score (MEWS) completed, time of escalation and time of clinical response recorded. Discuss and implement the sepsis risk assessment not being allowed to be skipped		
RRG MEETING UPDATE **RRG noted update and ongoing work being undertaken to improve the identification of deteriorating patients. Bi weekly task and finish group remains to discuss. Risk score remains high at this time and unchanged.** **Current Risk 4 x 5 = 20**						

404	13/03/2024	Risk to Patient Safety due to inability to utilise EPR system with regard to DNACPR documentation and processes	16	Currently the EPR system does not permit the full functionality required to ensure DNACPR documentation can be printed and disseminated during discharges. As a result staff were required to transcribe the information onto hard copies. This carries a risk of errors occurring and these could lead to patient safety incidents occurring. The factors below outline the concerns that this raises as well as the fact that we are unable	16	Kelly McGovern – Chief Nurse

				to resolve and prevent the risk from occurring due to Royal Free, our partner organisation with respect to EPR, not wishing to move to ReSPECT. • The DNACPR/TEP form is not currently printable from EPR in a form that is acceptable to the ambulance transport teams or as a valid document for any community destination. • Doctors were transcribing the details onto the original hard copy form in preparation for discharge. • A transcription error was made which led to a complaint from a relative • Doctors are now being advised not to transcribe forms if they are not the original decision maker to protect themselves and prevent errors. • The transport service will only accept original hard copy forms or photocopies if the original copy can be viewed. • This has led to delayed discharges and crews refusing to take patients (despite some doctors advising to resuscitate in transit if not comfortable with the documentation) • The SWH ICB are moving to the ReSPECT form and are encouraging WHHT to move with them so there is a unified form across the ICB. • The Royal Free have decided not to move to ReSPECT which creates issues with EPR. • There is currently no lead allocated to take the project forward at WHHT and in addition to this we have been asked to identify leads for education, communications, and digital transformation.		

RRG MEETING UPDATE

New Risk. This risk related to numerous aspects of EPR being unable to capture/print out DNACPR documentation, representing a Patient Safety risk. Although controls were in place to manage the risk, there was still a possibility that incorrect information could be in place regarding a patient relating to DNACPR. Agreed that this should be accepted onto the CRR at present, which further mitigation and work is being undertaken.

Current Risk 4 x 4 = 16

EMERGENCY MEDICINE						
20	12/04/2022	Reduced patient flow through the Emergency department (ED)	15	Score, mitigation and controls remain unchanged. Trust full capacity protocol has been agreed and implemented as needed. If patients are identified as suitable for the patient lounge the bed becomes available to the operational teams for use. The patient lounge is now open earlier to facilitate early discharges. Wards are encouraged and continue to identify patients suitable for reverse boarding. Direct ambulance admissions to ACU pilot continues following the move from planned care. Focus within the trust/division on prompt discharges/discharge planning which is reviewed at multiple forums including divisional performance review, OPFG and patient flow summit. Considerable work is taking place within the division supported by ops and specialties to ensure flow is maintained through EAU and AAU ensuring that short stay patients remain in the AAU and those patients requiring specialty / longer stays are moved to PMOK which will also support a reduced length of stay.	15	Kelly McGovern – Chief Nurse
RRG MEETING UPDATE **Risk update noted. This risk remains and no change to risk score at present.** **Current Risk 3 x 5 = 15**						

21	12/04/2022	Failure to meet performance KPIs within the Emergency Department (ED)	20	Risk score, controls and assurances remain the same and have been reviewed. A full capacity protocol/policy is in place, with the aim of providing early flow from ED to the wards this enables a more effective management of the department with adequate assessment spaces to see/treat patients. Continual review of pathways and processes is undertaken within ED to enable early assessment and decision making in relation to patients, STARR/Corridor SOP have been merged and updated to include escalation and actions when there is a need for patients to return to the ambulance after initial assessment. The location codes on Cerner have been changed to give better clarity if patients are waiting in STARR, the Corridor or in the ambulance. There is a national focus on the four-hour KPI for the month of March with additional senior presence supporting this within the ED. This is also supported by improving the flow of patients through the department which is impacted significantly by continued flow of patients though EAU and AAU and onto specialty wards.	16	Mary Bhatti – Acting Chief Operating Officer
RRG MEETING UPDATE **Risk update noted. Long standing risk with no changes at present to the Risk Score.** **Current Risk score 4 x 4 = 16**						

22	12/04/2022	Challenges in meeting the needs of Mental health Patients within the Emergency Medicine division	15	Risk score, controls and mitigation remain unchanged. Both MH rooms with toilet facilities in ED have been refurbished and are in use. SR 18 in AAU level 1 is nearing completion. There has been a pilot for the Right place right Care process for patients under the care of Section 136. Daily reporting of MH within the department and escalation of MH bed requests continues. Ongoing work with Security, Police and MHLT to try to maintain safety of patients and staff. ED are regularly meeting with Police +- Security. MH is one of the priorities within the trust PSIRF framework, initial mapping and follow up meetings have taken place and an action plan will be developed. MHSG has not met since last risk review as per previous update, next meeting planned and risk to be discussed with potential de-escalation from Corporate register.	15	Kelly McGovern – Chief Nurse
RRG MEETING UPDATE						

Risk update noted. Until discussed at Mental Health Steering Group this risk cannot be considered for removal from the CRR.

Current risk 3 x 5 = 15

ENVIRONMENT

34	26/08/2021	Electrical infrastructure risks on the SACH site	15	This risk has remained on the risk register. However, following discussion with the HOE around our risks and potential transfer of this risk to our issues log. It was agreed to reduce the score to a 12 and request a transfer to the issues log. The rationale for this is that the project works continue at SACH, monitoring of this programme of work has resulted in the works at WGH being aligned to this progress. Works at WGH have progressed to the extent that after discussion with the HOE it was agreed that the score can be reduced to a 12 .	12	David Ambrose – Director of Environment

RRG MEETING UPDATE

This risk could be reduced due to the ongoing work that had been undertaken on the Watford site. Although it could not be closed, due to the fact that there is still a possibility of power outages affecting the whole site, the work undertaken had resulted in reduced levels of risk. Agreed to be reduced to 12 and removed from the CRR. To be monitored and managed by the Environment Division on their risk register.

Current Risk 3 x 4 = 12

MEDICINE

SURGERY & CANCER

WOMEN'S AND CHILDREN

119	**WACS**	Potential risk to patient safety due to the high vacancy rate across Paediatric Nursing	20	The challenges in recruitment persist and initiatives continue to be undertaken to recruit staff to the positions. However this has not been successful and while the inability to revcruit staff is an issue, there is a risk to patient safety that any gaps or continued reliance on agency staff presents. This risk is discussed regularly at Divisional Governance meetings and escalations are undertaken where necessary. The controls and mitigation remain appropriate in order to ensure that Patient Safety is not affected, however there is a possibility that in future an incident may occur, hence the risk being recorded here.	15	Kelly McGovern – Chief Nurse
<u>RRG MEETING UPDATE</u> **Risk update noted. No changes at present.** **Current risk 3 x 5 = 15**						

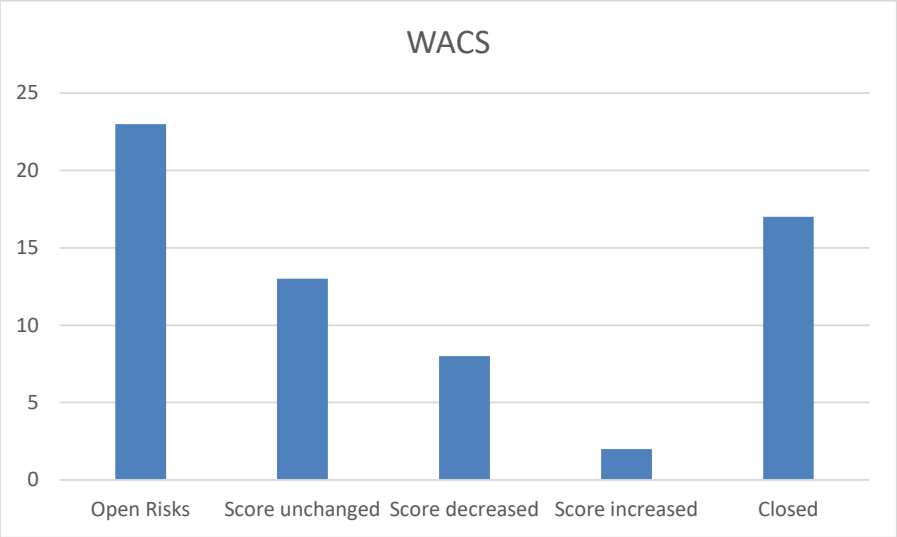
351	**WACS ENVIRONMENT**	Relocating Special Care Baby Unit and Transitional Care due to renovation works required to address the poor and ageing infrastructure of the current unit	20	There is now a delayed reopening date for our neonatal unit following planned ventilation system upgrade works. Estates department, building contractors and neonatal staff, have worked to achieve the opening of the unit, However IPC inspection of the unit revealed that further works are required. The amended deadline for this is now end of April. In order to ensure that IPC standards are met, the original works have been extended to include ventilation adaptions to two side rooms within the neonatal unit. Level 3 of the neonatal unit is now strictly out of bounds to all but essential staff and this has possible wider implications across some services in Women's and Children's. The project steering group is currently working with relevant leads on plans for the proposed new project requirements.	15	David Ambrose – Director of Environment
RRG MEETING UPDATE **Risk update noted. No change to risk at present.** **Current risk 3 x 5 = 15**						

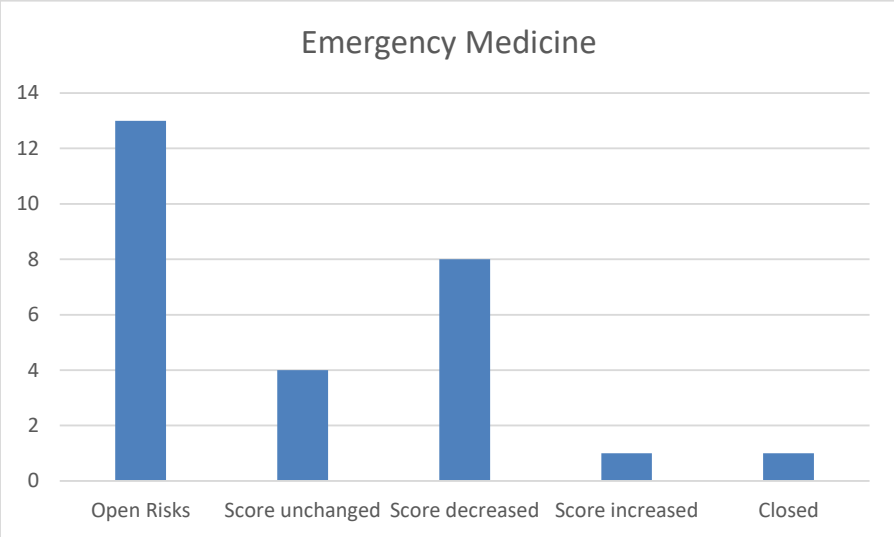
Appendix 3 KPI Performance

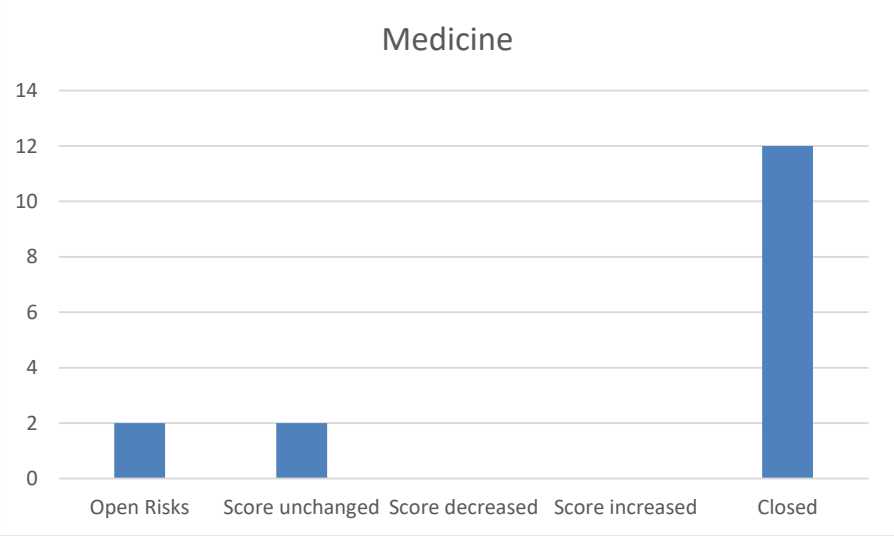
		Risk Score					
Division	Total Risks	1-3	4-6	8-12	15-25	Reviews in date	% in date
WACS	18	0	2	14	2	18	100%
Emergency Medicine	8	0	1	4	3	7	88%
Medicine	2	0	1	1	0	1	50%
SAC	3	0	2	1	0	3	100%
Environment	7	0	0	7	0	7	100%
CSS	41	1	4	33	3	24	56%
ICT	28	0	7	16	5	28	100%
HR	1	0	0	1	0	1	100%
Corporate Services	19	2	6	9	2	10	52%
Finance	20	0	6	14	0	20	100%

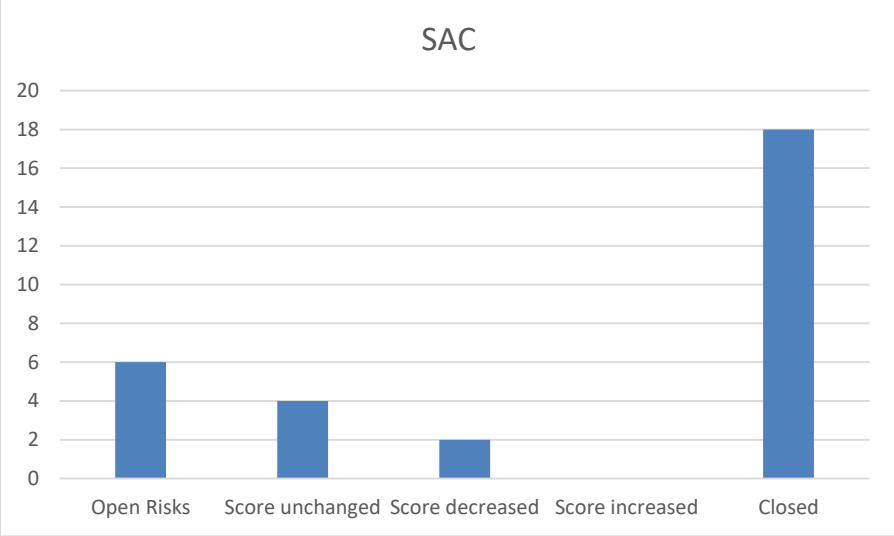
Appendix 4 Direction of Travel

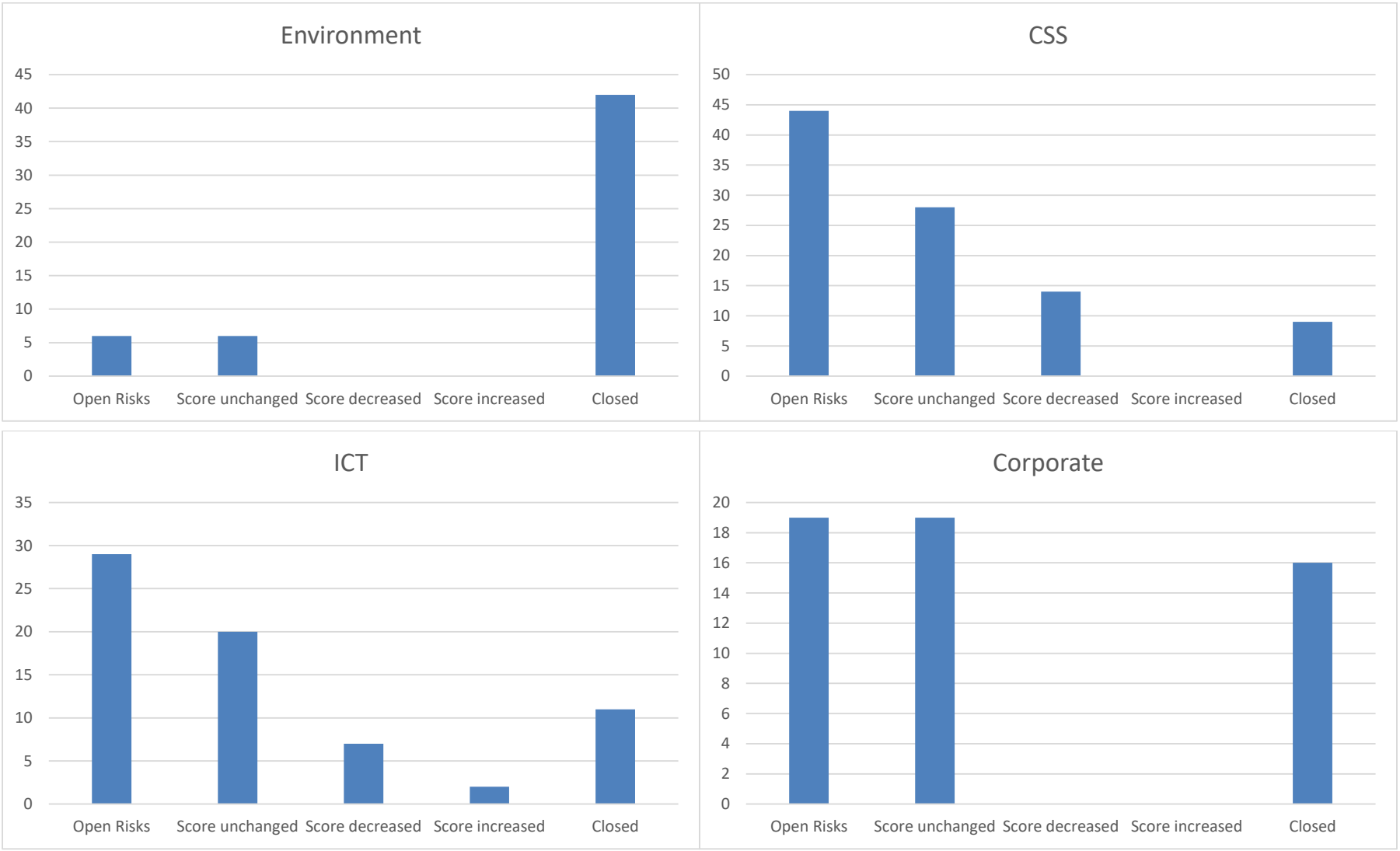
Risks scores over the last 12 months (per Division) Total number of Risks open, Risk score unchanged, Risk score decreased, score increased and number closed

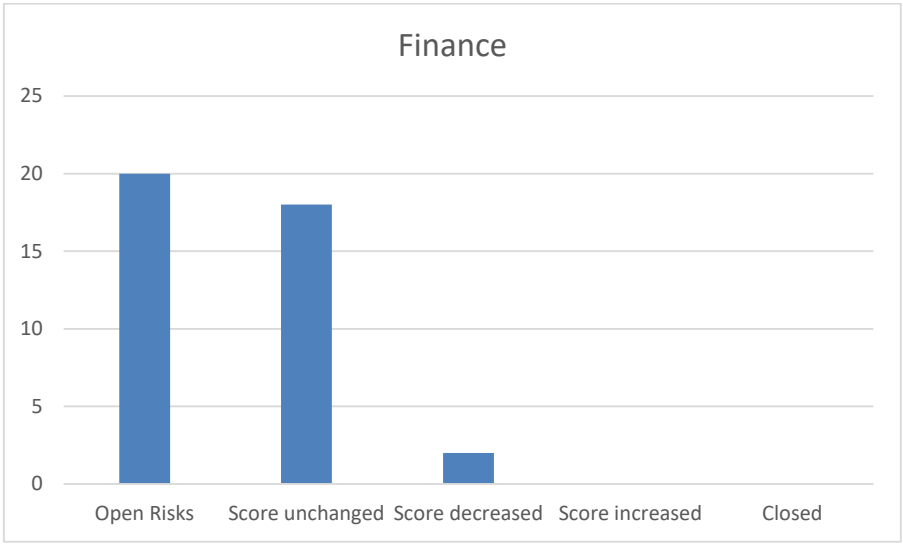

WACS
25
20
15
10
5
0
Open Risks
Score unchanged
Score decreased
Score increased
Closed


Emergency Medicine
14
12
10
8
6
4
2
0
Open Risks
Score unchanged
Score decreased
Score increased
Closed


Medicine
14
12
10
8
6
4
2
0
Open Risks
Score unchanged
Score decreased
Score increased
Closed


SAC
20
18
16
14
12
10
8
6
4
2
0
Open Risks
Score unchanged
Score decreased
Score increased
Closed


Environment
45
40
35
30
25
20
15
10
5
0
Open Risks
Score unchanged
Score decreased
Score increased
Closed
CSS
50
45
40
35
30
25
20
15
10
5
0
Open Risks
Score unchanged
Score decreased
Score increased
Closed
ICT
35
30
25
20
15
10
5
0
Open Risks
Score unchanged
Score decreased
Score increased
Closed
Corporate
20
18
16
14
12
10
8
6
4
2
0
Open Risks
Score unchanged
Score decreased
Score increased
Closed


Finance
25
20
15
10
5
0
Open Risks
Score unchanged
Score decreased
Score increased
Closed

Risk Governance Group

Terms of Reference

Chair Head of Patient Safety

Membership

- Head of Patient Safety (Chair)
- Chief Medical Officer
- Director of Governance
- Chief Nurse
- Chief Operating Officer
- Director of ICT
- Director of Performance
- Director of Environment
- Director of Finance
- A representative from each Divisional Triumvirate for Medicine, SAC, Emergency Medicine, WACS.
- Deputy Director of Nursing – Quality and Safety
- Chief People Person
- Divisional Quality Governance Facilitators

Or nominated Deputy.

Frequency of meetings Monthly

Quorum One member of each Divisional Triumvirate or equivalent, a representative for each of the following Divisions: CSS and Environment and the Head of Patient Safety or nominated deputy.

West Hertfordshire Teaching Hospitals NHS Trust

1. Constitution

1.1 The Quality & Safety Committee has resolved to establish a Group known as the Risk Governance Group (RGG). The group is an executive group and has responsibilities as set out below. These terms of reference can only be amended with the approval of the Quality & Safety Committee.

2. Purpose

2.1 The purpose of the RGG is to provide executive responsibility for establishing a proactive strategic approach to risk management across the organisation. The RGG is also responsible for the overall co-ordination of risk management activity within the Trust, including a positive culture of risk awareness and embedded risk management processes to achieve compliance with statutory requirements and to protect the Trusts' patients, staff, and assets.

3. Frequency of attendance

3.1 All RGG members are expected to attend the meetings. If a member is unable to attend a meeting, they must provide an appropriate deputy who is able to discuss and update the group for the relevant risks they are attending to represent.

3.2 The RGG may request attendance by relevant staff at any meeting.

4. Accountability and reporting arrangements

4.1 The RGG will be directly accountable to the Quality & Safety Committee.

4.2 The Chair of the RRG will prepare a summary report detailing items discussed, actions agreed and issues to be referred to the Quality & Safety Committee.

4.3 The RGG will escalate any issues of concern to the relevant board sub-committee aligned to risks scored 15 or above.

4.4 The RGG will escalate any issues of concern related to risks 12 and below to the divisional triumvirate.

4.5 The RGG will refer any issues of concern to the Quality & Safety Committee it has with regard to any gaps in controls or for any aspect of Risk Management.

5. Responsibilities

5.1 The RGG will provide scrutiny of the Corporate Risk Register (CRR) and will review all new, escalated, deescalated and closed risks.

5.2 The RGG will provide an on-going 'Check and Challenge' for the risks contained on the Corporate Risk Register to ensure they are accurately described, scored and that the controls and assurances are adequate.

5.3 The RGG will also review the requirement for further action at either divisional/directorate level or where additional actions are required at a corporate level. It will also track delivery of actions to mitigate risk.

5.4 For each risk included on the CRR the RGG will ensure that a lead executive has been identified.

5.5 The RGG will provide assurance to the Quality & Safey Committee of appropriate levels of scrutiny of risk register content alongside assurances of controls and mitigations.

5.6 Provide advice to divisions and support the process of escalation from local risk registers.

5.7 To oversee the development and implementation of a process for target risk score and a mechanism to track delivery.

5.8 To monitor and support the implementation of the timetable for the delivery of the risk maturity self-assessment tool.

5.9 The RGG will oversee the development and monitoring of the risk appetite within the Trust. This will be, as a minimum, a quarterly agenda item for discussion.

5.10 Receive and scrutinise the divisional risks and provide assurance to Quality & Safety Committee of functioning risk management processes at a divisional level.

5.11 Receive and monitor the accepted risks in the Trust with a risk score of 15 – 25.

5.12 The RGG will review risks 12 and below for divisions to provide assurance that all risks are relevant and up to date.

5.13 The RGG will review all divisional risks on the risk register to ensure that they remain relevant and up to date.

5.14 The RGG will direct any amendments to Divisional Risks as required to ensure that they are current, accurate and have effective SMART actions and plans in place to manage the risk.

5.15 Oversee the development and provision of support and training for Risk Management across the Trust

5.16 The RGG will develop a mechanism to horizon scan risk and assess these. This will include any risks related to national guidance, alerts and NHSI updates.

6. Participation

6.1 It is expected that all members of the group and those attending on an ad hoc basis are able to take an active part in expressing their views as part of the Group in relation to all Risks.

6.2 Where virtual meetings are utilised, staff should ensure they have their cameras turned on (unless not available) throughout the meeting. This is to ensure that staff remain engaged as part of the meeting.

7. Review and monitoring

7.1 The RGG will undertake and evidence, an annual review of its performance against these Terms of Reference in order to evaluate the effectiveness of the group. This report will be provided to the Quality & Safety Committee.

7.2 Terms of Reference will be reviewed annually and approved by the Quality & Safety Committee. (Appendix 1)

7.3 An Annual Work plan for the RGG will be developed and agreed by the Quality & Safety Committee.

Terms of Reference ratified by:	Quality & Safety Committee
Date of ratification	April 2024
Date of next review	March 2025

Appendix 1 – Risk Review Group Terms of Reference

West Hertfordshire Teaching Hospitals NHS Trust

Trust Board
04 April 2024

Title of the paper	**Items considered at the Trust Board meeting in private on 07 March 2024**
Agenda Item	**27**
Presenter	**Phil Townsend, Chair**
Author(s)	**Jean Hickman, Interim Director of Governance**
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: March 2024
Action required	The Board is asked to take the report for information of the matters discussed at the last meeting in private (Part 2) session.

27

West Hertfordshire Teaching Hospitals NHS Trust

ITEMS FOR DISCUSSION

Feedback on Board engagement visits

ITEMS FOR INFORMATION AND ASSURANCE

Draft Business Plan
The Board received an update from the Acting Chief Financial Officer

Finance update, including financial recovery plan
The Board received an update from the Acting Chief Financial Officer

Strategy update, including Health and Care Partnership
The Board received an update from the Chief Strategy and Collaboration Officer

Redevelopment update
The Board received an update from the Chief Redevelopment Officer

Market Engagement Report
The Board received an update from the Chief Redevelopment Officer

Estates improvement programme update
The Board received an update from the Director of Environment

ITEMS FOR APPROVAL

Market Engagement Report
The Board received a report from the Chief Redevelopment Officer

Business Case for WGH Phase Two Redevelopment Enabling Works
The Board received a business case from the Chief Redevelopment Officer