Agenda

East and North Hertfordshire NHS Trust

Meeting: Public Trust Board

Date: Wednesday 2 November 2022 – 10.30am – 12.30pm

Venue: Lister Education Centre, Lister Hospital, Stevenage

Standing Items				
Time	**Item Number**	**Item**	**Item owner**	**Purpose**
10.30	**1**	**Chair's Opening Remarks**	Trust Chair	For noting
	2	**Apologies for Absence**	Trust Chair	For noting
	3	**Declarations of Interests**	Trust Chair	For noting
	4	**Minutes of Previous Meeting**	Trust Chair	For approval
	5	**Actions Log**	Trust Chair	For noting
10.35	**6**	**Questions from the Public**	Head of Corporate Governance	For noting
10.40	**7**	**Patient Story**	Chief Nurse	For discussion
10.50	**8**	**Chief Executive's Report**	Chief Executive	For discussion
11.00	**9**	**Board Assurance Framework**	Head of Corporate Governance	For discussion
11.05	**10**	**Integrated Performance Report**	All Directors	For discussion
Strategy Items				
11.35	**11**	**System Working and Provider Collaboration (ICS & HCP) Updates**	Deputy CEO	For discussion
11.45	**12**	**Strategic Portfolio Update**	Director of Improvement	For discussion
Assurance and Governance Items				
11.55	**13**	**Charity Annual Accounts and Report**	Chief People Officer	For approval
12.05	**14**	**Learning from Deaths Report**	Medical Director	For noting
12.10	**15**	**Responsible Officer Annual Review**	Medical Director	For noting

12.15	**16**	**MVCC Wards 10/11 Assurance Report**	Director of Estates & Facilities	For discussion
12.20	**17**	**Patient Safety and Incident Report**	Chief Nurse	For discussion
Committee Reports				
12.25	**18**	**Finance, Performance and Planning Committee Report to Board** 27th September 2022 25th October 2022	Chair of FPPC	For noting
	19	**Quality and Safety Committee Report to Board** 28th September 2022 26th October 2022	Chair of QSC	For noting
	20	**Charity Trustee Committee Report to Board** 12th September 2022	Chair of CTC	For noting
	21	**People Committee Report to Board** 20th September 2022	Chair of People	For noting
	22	**Audit Committee Report to Board** 11th October 2022	Chair of Audit	For noting
Other Items				
	23	**Annual Cycle**	Trust Chair	For noting
	24	**Any Other Business**	Trust Chair	For noting
	25	**Date of Next Meeting**	Trust Chair	For noting
12.30	**26**	**Close**		

East and North Hertfordshire NHS Trust

Agenda item: 4

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday 7 September 2022 at 10.30am at the Lister Education Training Centre

Present:	Mrs Ellen Schroder	Trust Chair
	Mrs Karen McConnell	Deputy Trust Chair and Non-Executive Director
	Dr Peter Carter	Non-Executive Director
	Mr Jonathan Silver	Non-Executive Director
	Ms Val Moore	Non-Executive Director
	Dr David Buckle	Non-Executive Director
	Mr Adam Sewell-Jones	Chief Executive Officer
	Mr Martin Armstrong	Director of Finance & Deputy Chief Executive Officer
	Mrs Rachael Corser	Chief Nurse
	Ms Lucy Davies	Chief Operating Officer
	Ms Theresa Murphy	Chief Nurse
From the Trust:	Mr Thomas Pounds	Chief People Officer
	Mr Mark Stanton	Chief Information Officer
	Mr Kevin O'Hart	Director of Transformation
	Ms Marie Lyons	Divisional Medical Director Planned Care
Also in attendance:	Mr Stuart Dalton	Head of Corporate Governance
	Ms Bridget Saunders	Medical Programme Director (Item 22/)
	Ms Julia Seez	People Business Partner (Item 22/)
	Ms Silvia Gomez	Freedom to Speak Up Guardian (Item 22/)
	Ms Julia Smith	Assistant Trust Secretary (Minutes)
Members of the Public:	No members of the public were present	

No	Sub-No	Item	Action
22/105		**CHAIR'S OPENING REMARKS**	
	22/105.1	The Chair welcomed the Board to the meeting and explained Mr Parmar had decided to step down from his role as Non-Executive Director effective immediately. Mrs Schroder commented that he would be missed for his wise and measured advice. She said he commenced with the Trust in March 2020 which had been a challenging time. He had championed the equality and diversity agenda including the setting up of the committee; supported initiatives such as the staff networks; input into key appointments including the CEO and Chief Operating Officer. Mrs Schroder wished Mr Parmar well for the future.	

22/105.2 Mrs Schroder informed the Board that Dr Buckle would step-up to the full Non-Executive Director role following Mar Parmar's departure, and the Board would look to recruit at least one Associate Board member as well as another NeXT Director.

22/105.3 Mrs Schroder informed the Board that the Chief Nurse would leave the Trust at the end of the week and thanked her for her commitment and support to the Nurses, Midwives, and the Board. Mrs Schroder said her hard work at the Quality and Safety Committee, through the pandemic and care and compassion she had demonstrated for everyone would be missed. On behalf of the Board Mrs Schroder wished the Chief Nurse every success in her new role.

22/105.4 Mrs Schroder welcomed the new Chief Nurse to the Board and the Trust and said she was looking forward to working with her.

22/105.5 Mrs Schroder informed the Board that the Managing Director of Unplanned Care would be leaving the Trust at the end of the following week. She said the Managing Director of Unplanned Care had worked hard with ever increasing demands in the Emergency Department and many other departments across Unplanned Care. Mrs Schroder thanked the Managing Director for Unplanned Care for her work through the pandemic including the colour coding patient streams and ward reconfigurations. Mrs Schroder wished her well in her new role.

22/106 APOLOGIES FOR ABSENCE

22/106.1 Apologies were received from:

Mr Biraj Parmar – Non-Executive Director

Dr Michael Chilvers – Medical Director

Mr Kevin Howell – Director of Estates and Facilities

22/107 DECLARATIONS OF INTEREST

22/107.1 There were no new declarations of interest made.

22/108 MINUTES OF PREVIOUS MEETING

22/108.1 The minutes of the previous meeting held on 6 July 2022 were **APPROVED** as an accurate record of the meeting subject to some minor changes from Mrs Schroder.

22/109 ACTION LOG

22/109.1 The Board **NOTED** the current Action Log.

22/110 QUESTIONS FROM THE PUBLIC

22/110.1 There were no questions from the public.

East and North Hertfordshire NHS Trust

22/111 STAFF STORY – CIVILITY MATTERS

22/111.1 The Chief People Officer introduced the Medical Programme Director, the People Business Partner, and the Freedom to Speak Up Guardian. He explained to the Board that the video that would be shown was part of the broader staff story and thanked them for their time.

22/111.2 The Medical Programme Director explained to the Board that the GMC and staff survey results had highlighted issues around how staff treated each other and that the idea for the film had come from an MDT group.

22/111.3 The Board viewed the video and the People Business Partner asked for their feedback.

22/111.4 Mrs Schroder commented that the video was interesting and asked how it would be communicated to all Trust employees because it would be important for all to be able to access it. The People Business Partner explained to the Board that along with the Medical Programme Director, they were part of a national group that the video would be circulated to as well as uploaded onto the website. She said implementation across the Trust was being planned for inclusion at “team-talks” and listening events.

22/111.5 Mrs Schroder commented it could complement the work underway around bullying and harassment. She asked how the Trust could ensure that all staff were included. The Freedom to Speak Up Guardian confirmed it should form part of all team meetings. She said work was underway to understand how teams were making the cultural change and that staff should be challenging each other to role model the correct behaviours. The Freedom to Speak Up Guardian informed the Board that September was Speak-Up month when additional messaging would be circulated.

22/111.6 The Chief Operating Officer informed the Board that it had been presented to the Leadership Briefing and had been well received. She said it could be a foundation for culture change. The Chief Operating Officer commented that bullying and harassment was at all levels and the Board shouldn’t lose sight of responsibilities.

22/111.7 The Chief Executive commented on the value of the video and it was positive recognition for the team that it had been identified by the national team. He said it would be important for everyone to be able to acknowledge when they had been uncivil.

22/111.8 The Divisional Medical Director Planned Care informed the Board that Theatres would be recording work to understand behaviours, how they can be changed and interventions for poor behaviours.

22/111.9 The Chief People Officer thanked the Board for viewing the video and it would support the work underway to underpin the Trust values. The Chief People Officer explained to the Board that it would be important to get the messaging right first time and to recruit new staff who believed and demonstrated the value. He said the video would be shown at all Trust inductions.

22/112 CHIEF EXECUTIVE'S REPORT

22/112.1 The Chief Executive explained to the Board that in relation to winter planning and the NHS being more prepared it would be important to understand the challenge against all the metrics, especially those that were not achieving target. The Chief Executive confirmed to the Board that it would be the ICB metrics that would be monitored. He said work had been undertaken around some of the metrics during reset week and a number of positive changes embedded within the organisation. He highlighted one change around culture and staff feeling empowered to make suggestions for change.

22/112.2 The Chief Executive informed the Board that the Trust had received full accreditation for the Pathways to Excellence of which the Trust were the first to receive designation. He said the accreditation would be an important building block for the Trust.

22/112.3 The Chief Executive explained to the Board that on 18th September 2022 the Trust would be celebrating its 50th birthday with an open day and invited the Board to bring their family and friends to enjoy the celebrations. He commented that the Communications team had been asked to model key metrics for the past 50 years which would be presented in a summary of the annual report. Mrs Schroder asked that the Board be sighted on the metrics.

22/112.5 The Board **RECEIVED** and **NOTED** the Chief Executive Officer's report.

22/113 BOARD ASSURANCE FRAMEWORK

22/113.1 The Head of Corporate Governance informed the Board that three key risk points had changed and highlighted a change in the clinical engagement risk score.

22/113.2 Mrs Schroder commented that some of the risks were repetitive and said there was an overlap of mitigations. She recognised the new format needed to embed and asked if there were different ways to change and present the risks.

22/113.3 The Chief Executive commented that People was a common theme throughout the risks and that reflected the workforce as the Trusts biggest challenge. He explained to the Board that by getting the approach to People accurate the Trust would flourish and if it was

incorrect it would be detrimental to the Trust.

22/113.4 Mrs McConnell commented that culture and leadership was more of a Board responsibility than that of the People Committee. Mrs Schroder commented that Place and System collaboratives was a Board responsibility more than that of Quality and Safety Committee.

22/113.5 The Chief Executive explained to the Board that the Board Committees would undertake the work to provide assurance to the Board on the risks The Board discussed the placement, responsibility and articulation of the risks and it was agreed the new Board Assurance Framework required further work before it was presented to the Board in November. **Head of Corporate Governance**

22/113.6 The Board **RECEIVED** and **NOTED** the Board Assurance Framework.

22/114 INTEGRATED PERFORMANCE REPORT

22/114.1 The Deputy Chief Executive and Director of Finance introduced the Month 4 Integrated Performance Report and noted the new format.

22/114.2 **Safe, Caring and Effective**

The Chief Nurse assured the Board that the Quality and Safety committee were sighted on the deteriorating position of the observations and explained that the position was in part due to the reliability of the electronic devices. She explained to the Board that the team had undertaken a considerable amount of work to determine the issue was with medical equipment and support would be sought. The Chief Nurse continued that it remained an area of focus for the wards and that they would be held to account. She informed the Board that September was patient safety month, and the slogan was “if in doubt, shout”.

The Chief Nurse highlighted the positive position relating to Sepsis and explained to the Board that although the average hadn’t increased, Sepsis was not tracking as an outlier against the target. The Chief Nurse informed the Board that the Sepsis 6 measures continued to be followed and the training would increase.

The Chief Nurse explained to the Board that it had been previously reported that there was an expectation the VTE performance would deteriorate. She said the teams were examining how to achieve improved compliance with the newly recruited VTE medical lead. The Chief Nurse informed the Board that it was an area of focus for the CQC.

Mr Silver asked about the percentage of hospital acquired Covid and whether the change of testing regime had impacted and whether there was an expectation it would increase through the winter. The

Chief Nurse explained to the Board that the Trust continued with a robust testing process. She said there were limited bed closures, ring-fenced capacity and the cohorting of patients. The Chief Nurse explained that all asymptomatic testing had been paused nationally but that may change through the winter period.

Mrs McConnell asked whether there were identifiable themes from complaints to the PALS team. The Chief Nurse informed the Board that a proportionate number of PALS complaints according to the levels of activity. She said the work hadn't been started on the trends but when this work was complete the information would be available on the dashboards.

22/114.3 The Medical Director informed the Board that in terms of crude mortality the summary Hospital-Level Hospital Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR) were stable. He said the Trust was an outlier for Coronary Atherosclerosis which would continue to be monitored by Cardiology and the Head of Coding.

22/114.4 **Responsive**

The Chief Operating Officer informed the Board that the Trust would remain in Tier 1 for the 78-week and 62-day standards. She said the fortnightly meetings with the national team would continue as they supported the Trust to improve the position. The Chief Operating Officer explained to the Board that the Patient Tracking List (PTL) would be challenging but significant improvement was expected over the coming months. Preparation was underway for a Tier 1 visit later in September.

The Chief Operating Officer informed the Board that a new MRI vehicle had been in position at the Trust since 22 August 2022 and demand continued to increase, she said there was a lot of work being done but it would be some time until the position changed for Diagnostics.

The Chief Operating Officer informed the Board that discussions were underway in relation to the recruitment of specialist Therapists for Stroke, the ring fencing of beds and direct admission to improve the Stroke rating.

Mr Silver commented on the falling number of ambulance arrivals and asked f they were being diverted to other hospitals. The Chief Operating Officer explained to the Board that ambulance arrivals were offset by patient presentations and when ambulances were delayed elsewhere, patients were self-presenting.

The Board discussed the patients presenting with mental health issues and Mrs Schroder asked if Hertfordshire Partnership

Foundation Trust (HPFT) still had staff in the ED. The Chief Nurse explained to the Board that to move HPFT staff to the Trust ED had negative impacts on their staffing and workforce remained an issue for them.

22/114.5 **Well-Led**

The Chief People Officer highlighted:

- Recruitment and retention target of 5% was being achieved.
- A plan to recruit to three-to-six-month bank placements and move those staff onto apprenticeships was underway.
- There had been additional support and increased levels of attainment for rostering which had provided improved monitoring. Medical staffing had transferred and there had been early success in job planning.
- Work was underway with Finance on temporary staffing. There was also a piece of system work being done on the alignment of pay rates to open opportunities for staff to work shifts from across the system.
- The Grow Together target wouldn't be achieved but a lot of work would be done to recover the position through September.

22/114.6 Mrs Schroder commented on the overspend on medical staffing and asked if there was an understanding of the areas of concern.

The Chief People Officer informed the Board that additional bank staff were being booked with the drive in activity which were premium high-cost solutions. The Chief People Officer explained to the Board that converting temporary rates into substantive posts provided better value. He said there were areas of long-term sickness.

22/114.7 Mrs McConnell asked for a medical staffing deep dive to be undertaken at the next Finance, Performance and Planning Committee meeting. Director of Finance

22/114.8 Mrs McConnell asked if there were specific areas in the Trust with high levels of sickness and whether any issues with those department had been identified. She asked if work was planned to reduce sickness rates and commented that understanding why sickness rates were high was important.
The Chief People Officer explained to the Board that the increase in July 2022 was predominantly Covid related. He said long-term sickness was stable, but work was underway to understand early intervention with mental health and musculoskeletal issues.
The Chief People Officer informed the Board that the ED was an

area of concern and work was underway to support staff health and well-being.

22/114.9 **Sustainability**

The Deputy Chief Executive and Director of Finance highlighted:

- Finance and productivity would be an area of focus as the Trust had 10% to 15% more staff than pre-Covid and a slowly recovering activity level.
- The Trust was reporting a £3.8m deficit with significant pressures. The medical staffing over spend and CIP programme were contributing factors. Delivering the financial plan would be challenging and a balanced and responsive plan would be required.

22/114.10 The Board **RECEIVED** and **NOTED** the Month 4 Integrated Performance Report

STRATEGY AND CULTURE REPORTS

22/115 INTEGRATED CARE SYSTEM (ICS) BRIEFING AND SYSTEM WORKING

22/115.1 The Deputy CEO and Director of Finance informed the Board that the ICS was formalised in July 2022 and have released their priorities. He said the Board will continue to be informed of progress.

22/115.2 The Board **RECEIVED** and **NOTED** the Integrated Care System (ICS) Briefing and system Working report.

22/116 RESET WEEK DEBRIEF

22/116.1 The Chief Operating Officer explained to the Board that following a difficult period in July it had been agreed to implement a reset week. This was supported by the ICB who provided a GP, HPFT who located a number of their staff within the Trust ED. She said there was a focus on what could be done to improve flow with discharges and tough target were set which included:

- 100 discharges per day
- 3 discharges per ward before 11am
- SDEC to remain un-bedded

The Chief Operating Officer reported that the actions proved successful and for the last three days 100 discharges per day were achieve and, SDEC had been un-bedded within the first 24-hours.

22/116.2 The Chief Operating Officer informed the Board that as a result of the actions taken the number of patients waiting 12-hours reduced, the average ambulance handover time reduced, She said the Trust

had maintained SDEC as un-bedded and the 12-hour ED wait had stabilised as well as the discharge lounge had been un-bedded.

22/116.3 Mr Silver commented that 100 discharges per day was a significant achievement and asked what had influenced the improvement.

The Chief Operating Officer explained to the Board that the senior nurses role modelled the push for discharges, use of hospital at home and other mechanisms. She said having non-essential meetings stood down provided time and staff feeling empowered to make suggestions, decisions, and challenge.

22/116.4 Mr Silver commented on the 4-hour wait metric and said he had expected the backlog to have been cleared. He said the lack of assessment space was impactful on outcome.

The Chief Operating Officer explained to the Board that the focus of the week had been on admitting patients. She agreed the number had been disappointing and said this was an area of concentration.

The Chief Operating Officer and Mr Silver agreed to continue the conversation moving in relation to the use of space in the ED.

22/116.5 Mrs McConnell congratulated the Chief Operating Officer on the reset week. She asked if there was a plan to make the actions sustainable.

The Chief Operating Officer informed the Board that there would be a video as part of flow-Friday to ensure momentum continued and the messages were communicated.

22/116.6 The Chief Executive explained to the Board that there was a requirement to achieve a balance. He said movement would be made slowly due to the complicated admissions as well as patients in the wrong locations. He said rethinking the front of the hospital would be more of a mind-set change.

22/116.9 The Board **RECEIVED** and **NOTED** the Reset Week Debrief.

ASSURANCE AND GOVERNANCE REPORTS

22/117 VALUE FOR MONEY REPORT

22/117.1 The Board **RECEIVED**, **NOTED** the Value for Money report.

22/118 INFECTION PREVENTION AND CONTROL (IPC) ANNUAL REPORT

22/118.1 The Chief Nurse informed the Board the IPC Annual Report had been discussed in detail at the Quality and Safety Committee.

22/118.2 The Board **RECEIVED** and **NOTED** the Infection Prevention and Control Annual Report.

East and North Hertfordshire NHS Trust

22/119 WORKFORCE RACE EQUALITY STANDARD (WRES) UPDATE

22/119.1 The Chief People Officer informed the Board that the report had been discussed at the People Committee and the data uploaded onto the national system.

22/119.2 Mrs Schroder commented it was encouraging to see the medical workforce had been included.

22/119.3 The Chief People Officer explained to the Board that the standards had been in place for six to seven years and were to improve the experiences of BAME members of staff.

22/119.4 The Chief People Officer informed the Board that staff with a BAME background were more likely to have a less positive staff experience. He said the improvements the Trust has made over the last two years included the use of inclusion ambassadors, different approaches to recruitment and advertising.

22/119.5 The Chief People Officer explained to the Board that the WRES indicators in the staff survey highlighted difference experience of BAME and white staff and that bullying, and harassment impacted BAME staff more. He said there had been improvements in harassment from managers.

22/119.6 The Chief People Officer discussed the model employer data and informed the Board that 22% of the organisation should have a BAME background and be seen at all levels of the organisation. He said there was work to be done to encourage different backgrounds to apply for Trust roles.

22/119.7 Ms Moore commented that the link between experience and ethnicity had changed over the last three years and agreed more work was required.

22/119.8 The Board **RECEIVED** and **APPROVED** the Workforce Race Equality Standard update.

22/120 TREASURY MANAGEMENT POLICY

22/120.1 The Deputy CEO and Director of Finance informed the Board that the Treasury Management Policy had been approved by the Audit Committee.

22/120.2 The Board **RECEIVED** and **NOTED** the Treasury Management Policy.

22/121 AUDIT COMMITTEE BECOMING AUDIT AND RISK COMMITTEE

22/121.1 The Board **APPROVED** the recommendation for the Audit Committee to manage the Corporate Risk and become the Audit and Risk Committee.

East and North Hertfordshire NHS Trust

SUB-COMMITTEE REPORTS:

22/122 **FINANCE, PERFORMANCE AND PLANNING COMMITTEE REPORT TO BOARD**

22/122.1 The Board **RECEIVED** and **NOTED** the summary report from the Finance, Performance and Planning Committee meetings held on 26 July 2022.

22/123 **QUALITY AND SAFETY COMMITTEE REPORT TO BOARD**

22/123.1 The Board **RECEIVED** and **NOTED** the summary report from the Quality and Safety Committee meetings held on 27 July 2022.

22/124 **STRATEGY COMMITTEE REPORT TO BOARD**

22/124.1 The Board **RECEIVED** and **NOTED** the summary report from the Strategy Committee meeting held on 11 July 2022.

22/125 **PEOPLE COMMITTEE REPORT TO BOARD**

22/125.1 The Board **RECEIVED** and **NOTED** the summary report of the People Committee meeting held on 19 July 2022.

22/126 **AUDIT COMMITTEE REPORT TO BOARD**

22/126.1 The Board **RECEIVED** and **NOTED** the summary report from the Audit Committee meeting held on 12 July 2022.

22/127 **ANNUAL CYCLE**

22/127.1 The Board **RECEIVED** and **NOTED** the latest version of the Annual Cycle.

22/128 **ANY OTHER BUSINESS**

22/128.1 Dr Buckle informed the Board that the MVCC fun run and family day out would be held on 2nd October 2022.

22/128.2 The Head of Corporate Governance informed the Board that the independent well-led review would commence in September and the team would be observing meetings and would be talking to all Board members.

22/128.3 The Chief Operating Officer informed the Board that the Deputy Director of Unplanned Care would act-up to the position of Managing Director of Unplanned Care.

22/129 **DATE OF NEXT MEETING**

22/129.1 The next meeting of the Trust Board will be on 2 November 2022.

Ellen Schroder
Trust Chair
September 2022

	Action has slipped
	Action is not yet complete but on track
	Action completed
*	Moved with agreement

Agenda item: 5

EAST AND NORTH HERTFORDSHIRE NHS TRUST
TRUST BOARD ACTIONS LOG TO 2 NOVEMBER 2021

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
4 May 2022	22/057.5	Question from the Public re smoking within Trust grounds	Review the smoking policy with a task and finish group to include Dr Alex Wilkinson, Occupational Health, expert opinions, staff and patient representatives, Mental Health team and the Ambulance Service	August 2022 update: Medical Director on leave for September Board but will provide an update to the Board in November November 2022: this will be an ongoing project as all the groups work together. The Medical Director will provide a verbal update.	Medical Director	Ongoing
6 July 2022	22/088.9	IPR	Undertake a Harm Free Care deep dive at the Quality and Safety committee and report any escalations to Board	November 2022: This will be completed at the 30 November Quality and Safety meeting.	Chief Nurse	November 2022
7 September 2022	22/113.5	BAF	Review the articulation and placement of risks and update the BAF.	October – Risks have been reallocated to correct Committees.	Head of Corporate Governance	November 2022
7 September 2022	22/114.7	IPR	Undertake a Medical Staffing deep dive at the September FPPC meeting.	October – Action complete	Deputy CEO & Director of Finance	September 2022

East and North Hertfordshire NHS Trust

Briefing paper - Patient & Carer story – Trust Board

Date of meeting	2nd November
Committee Title	Public Trust Board
Presenter	Sarah Leigh

Carer's Story – Trust Board

Background

Sarah is a parent- carer to a 7yr old son, Nate, who is autistic and has a severe learning disability. They have attended the hospital for outpatient appointments, procedures and attendances to the Accident and Emergency Department. She gives her voice and shares her experience having had negative experiences when trying to secure accessible and equitable healthcare for her son. From her experience she has often felt that her son's life isn't as valued as a typical child's life.

Story

An overview of Sarah's journey so far with Nate and the experiences they have had within the hospital. Sarah is currently developing a Healthcare Passports alongside Specialist Complex Care Children's nurse, Eleanor Willis

Actions taken

Children's hospital passports
Presenting at the co-production shared learning council
Meeting with the Trusts CEO
Member of the PACE committee

Further actions to consider

Making it common practice to ask the question to everyone if they have any access requirements/reasonable adjustments
Read the passport / training

East and North Hertfordshire NHS Trust

Learning Disability liaison for children – sedation is offered to adults at home, why can't children have the same service Digital flags for learning disabilities to include children (they currently don't) Reasonable adjustment flags 'Changing Places' toilet – fully accessible disabled toilet within the hospital All clinicians / departments involved in a child's care to share information and communicate (also communicate with school specialist nursing teams

East and North Hertfordshire NHS Trust

Chief Executive's Report

November 2022

Corporate Update

The Trust welcomed the Care Quality Commission (CQC) during the first week in October where they inspected our maternity services as part of a national programme. This included a significant response from users of the service, for which we are grateful. A further update on the visit will be provided once the formal report is received.

Staff Survey

The National NHS Staff Survey for 2022 launched on Thursday 22nd September and will end on Friday 25th November 2022.

This year the survey will be electronic only with emails going out to all active staff. The questions are based on the 7 dimensions of the NHS People Promise and are an important measure for how successfully we are delivering the people strategy and to enable continuous improvement in staff experience.

Since the last survey there has been greater ownership locally to discuss the results and develop improvement plans as part of the 'team talk' discussions and we hope that this will improve the level of engagement with the staff survey this year.

Board Development

As part of our routine development sessions, the board had an extensive discussion relating to organisation culture. One of the key themes was how we embed a culture of civility and respect and the importance of the board modelling these behaviours while holding ourselves to the highest standards.

This follows the launch of the Civility Matters video, created by the Trust, which is now starting to be used as part of the Trust training and induction programmes as well as being shared nationally. This led to an exercise on the new Trust values: Include, Respect, Improve, where we collectively developed our compact as part of the behaviour framework.

Operational Update

There has been a rise in the Covid Incident Rate (IR) for Hertfordshire, 98.7 per 100,000; an increase from 87.6 seven days previously. This IR increase is reflected in the rise in Covid-19 positive in-patients at the Trust; at the time of writing there were 80 Covid positive inpatients. This is in line with the predicted modelling.

Activity within urgent and emergency care continues to put the Trust and our system partners under pressure. The Trust continues to work with the East of England Ambulance Service to ensure the safety of patients who are conveyed to the hospital as well as those waiting for an ambulance in the community, and this remains a priority.

The paediatric Emergency department and children's assessment unit successfully moved into their new environment on 19 October. This will enable the Same Day Emergency Care unit to reopen next month seeing new pathways for direct access from GPs and ambulances being rolled out.

The volume of elective activity has improved gradually in recent months as planned additional capacity has come on-line. Two procedure rooms opened in late September which gives additional capacity for low complexity procedures. This additional capacity will support delivery for the rest of 22/23 (winter permitting). The Trust continues to make progress towards the national target of a maximum wait of 18 months (78 weeks) by 31st March 2023.

National Recognition for our Rheumatology Team

Finally, congratulations to our Rheumatology Team who have been named 'Rheumatology Team Champion' in this year's National Rheumatoid Arthritis Society (NRAS) Champions.

The awards recognise best practice in rheumatology and those that have gone above and beyond.

The team were nominated by two different patients who praised the team for the care they received, for meeting their needs and involving them in their care. The team collected their award at an awards ceremony in Windsor.

Adam Sewell-Jones
Chief Executive

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	9
Report title	**Board Assurance Framework (BAF) Risks**			**Meeting Date**	02.11.22
Presenter	Stuart Dalton, Head of Corporate Governance				
Author	Stuart Dalton, Head of Corporate Governance				
Responsible Director	Martin Armstrong, Deputy CEO			**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**	☐	
	Discussion	☒	**Decision**	☐	

Report Summary:

The BAF risks are enclosed for review, including a Risks Summary; a Heat Map and the Trust's strategic priorities. The following key risk points or changes are highlighted:

- Two BAF risk scores are proposed to reduce from 16 to 12 (Risk 10 Technology, systems and processes to support change and Risk 12 clinical engagement). The Board is asked to sense-check it agrees these three risk score reductions are justified. If the Board agrees, this reduces the number of red-flagged BAF risks from seven to four since the production of the revised BAF, which suggests encouraging progress.

- People Committee considered the September Board's feedback for the desire to combine overlapping people risks and reduce duplication. People Committee supported combining Risk 5 (Culture and leadership) with Risk 6 (Engagement and listening) where they both relate to mitigating the risk to delivering the same strategic priority. Therefore, the wording for the combined risk will be presented at January Board for agreement once People Committee has agreed the combined wording at the next People Committee meeting.

- Risk 3 (Financial constraints): Risk 3 is the highest scored risk on the BAF at 20 and therefore warrants particular attention from the Board. A new Financial Reset Steering Group commences in November.

- For the remaining three red-scored risks i.e. Risk 3 financial constraints, Risks 5 & 6 combined culture, leadership and engagement and Risk 7 system collaboration, it should be noted that the current risk scores match the inherent score. This suggests current controls are not significantly mitigating these risks (if inherent and current risk scores are accurate). This indicates the lead committees for each of these risks need to particularly focus on assuring themselves that the proposed actions to address gaps in controls will be effective in reducing down the risk score and the actions to address gaps in assurance will provide the committee with robust and timely assurance given the risk level. For example, the committees may wish to consider prioritising deep dives relating to these three risks.

A BAF training and review session is planned at December's Board Seminar, which will allow for further reflection space on getting the most from the BAF.

Impact: where significant implication(s) need highlighting

Covered above

Risk: *Please specify any links to the BAF or Risk Register*

N/A - BAF

Report previously considered by & date(s):

Since the BAF was reviewed at September Board, all the BAF risks have been reviewed by their respective lead committees.	
Recommendation	The Board is asked to **NOTE** the BAF

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East and North Hertfordshire NHS Trust

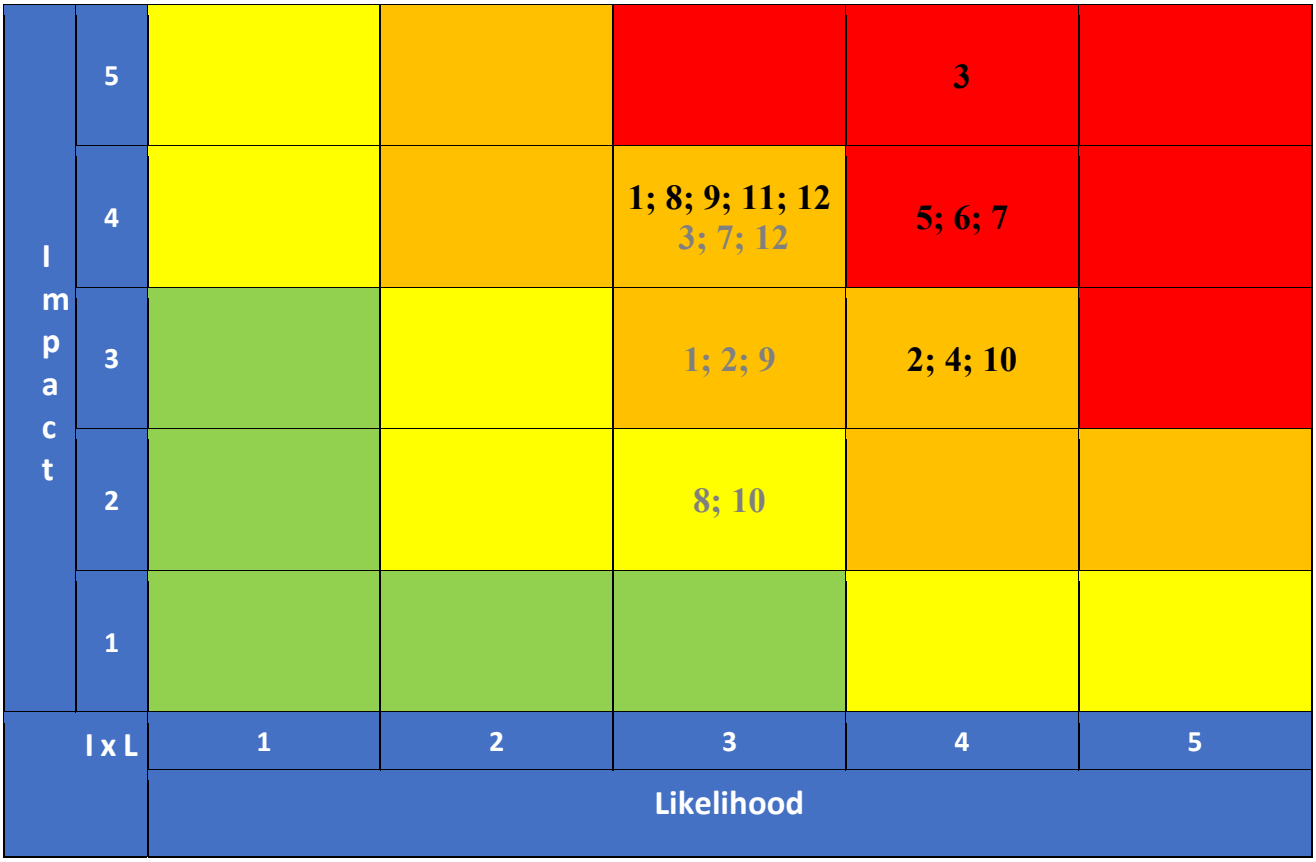
BOARD ASSURANCE FRAMEWORK REPORT

Section 1 - Summary

Risk no	Strategic Risk	Lead(s) for this risk	Assurance committee(s)	Current score	Trajectory
Consistently deliver quality standards, targeting health inequalities and involving patients in their care					
1.	**Workforce requirements**	Chief Nurse Medical Director Chief People Officer	Quality & Safety	12	⟷
2.	**Population/stakeholder expectations**	Chief Nurse Medical Officer	Quality & Safety	12	⟷
3.	**Financial constraints**	Chief Financial Officer	Finance, Performance & Planning	20	⟷
Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability					
4.	**Workforce shortages and skills mix**	Chief People Officer	People	12	⟷
5.	***Culture and leadership*** *[People Committee has asked for risks 5 & 6 to be combined]*	Chief People Officer	People	16	⟷
6.	***Engagement and listening*** *[People Committee combining risks 5 & 6]*	Chief People Officer	People	16	⟷
Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners					
7.	**Immature place and system collaborative processes and culture**	Deputy Chief Executive (CFO)	Finance, Performance & Planning	16	⟷
8.	**Improving performance and flow**	Chief Operating Officer	Finance, Performance & Planning	12	↓
9.	**Trust and system financial flows and efficiency**	Chief Financial Officer	Finance, Performance & Planning	12	⟷
Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities					
10.	**Technology, systems and processes to support change**	Director of Transformation	Quality & Safety	12	↓
11.	**Enabling Innovation**	Director of Transformation	People	12	⟷
12.	**Clinical engagement with change**	Medical Director Chief Nurse	Quality & Safety	12	↓

Section 2 Strategic Risk Heat Map

Current risk scores in **black**
Target risk scores in ***grey***



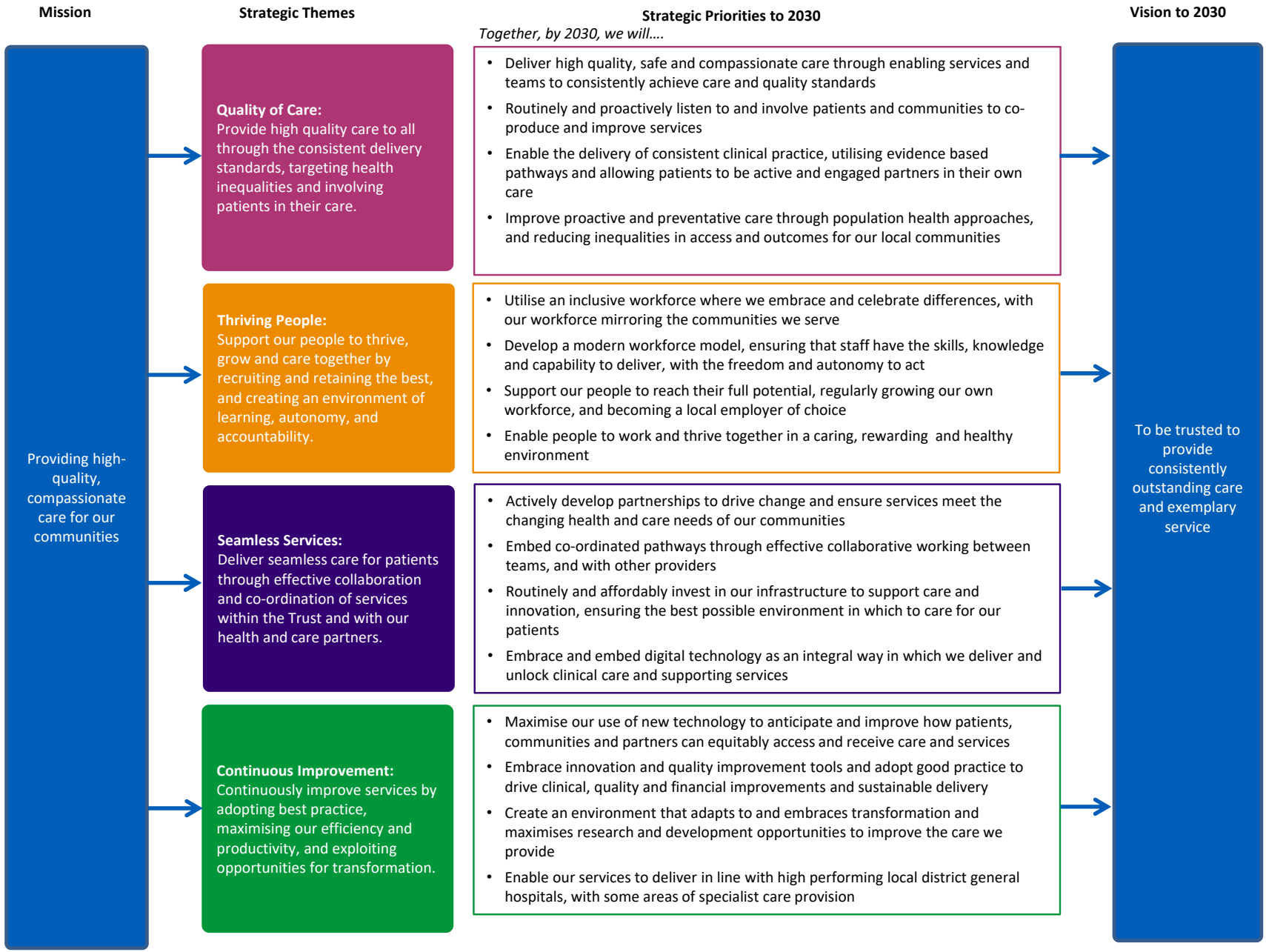
Risk Scoring Guide

Risks included in the Risk Assurance Framework (RAF) are assessed as extremely high, high, medium and low based on an Impact/Consequence X Likelihood matrix. Impact/Consequence – The descriptors below are used to score the impact or the consequence of the risk occurring. If the risk covers more than one column, the highest scoring column is used to grade the risk.

Impact Level	Impact Description	Safe	Effective	Well-led/Reputation	Financial
1	**Negligible**	No injuries or injury requiring no treatment or intervention	Service Disruption that does not affect patient care	Rumours	Less than £10,000
2	**Minor**	Minor injury or illness requiring minor intervention	Short disruption to services affecting patient care or intermittent breach of key target	Local media coverage	Loss of between £10,000 and £100,000
		<3 days off work, if staff			
3	**Moderate**	Moderate injury requiring professional intervention	Sustained period of disruption to services / sustained breach key target	Local media coverage with reduction of public confidence	Loss of between £101,000 and £500,000
		RIDDOR reportable incident			
4	**Major**	Major injury leading to long term incapacity requiring significant increased length of stay	Intermittent failures in a critical service	National media coverage and increased level of political / public scrutiny. Total loss of public confidence	Loss of between £501,000 and £5m
			Significant underperformance of a range of key targets		
5	**Extreme**	Incident leading to death	Permanent closure / loss of a service	Long term or repeated adverse national publicity	Loss of >£5m
		Serious incident involving a large number of patients			

Likelihood	**1 Rare (Annual)**	**2 Unlikely (Quarterly)**	**3 Possible (Monthly)**	**4 Likely (Weekly)**	**5 Certain (Daily)**
Death / Catastrophe 5	5	10	15	20	25
Major 4	4	8	12	16	20
Moderate 3	3	6	9	12	15
Minor 2	2	4	6	8	10
None /Insignificant 1	1	2	3	4	5

Risk Assessment	Grading
15 – 25	**Extreme**
8 – 12	**High**
4 – 6	**Medium**
1 – 3	**Low**


Mission
Strategic Themes
Strategic Priorities to 2030
Together, by 2030, we will….
Vision to 2030
Providing high-quality, compassionate care for our communities
Quality of Care:
Provide high quality care to all through the consistent delivery standards, targeting health inequalities and involving patients in their care.
Deliver high quality, safe and compassionate care through enabling services and teams to consistently achieve care and quality standards
Routinely and proactively listen to and involve patients and communities to co-produce and improve services
Enable the delivery of consistent clinical practice, utilising evidence based pathways and allowing patients to be active and engaged partners in their own care
Improve proactive and preventative care through population health approaches, and reducing inequalities in access and outcomes for our local communities
Thriving People:
Support our people to thrive, grow and care together by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability.
Utilise an inclusive workforce where we embrace and celebrate differences, with our workforce mirroring the communities we serve
Develop a modern workforce model, ensuring that staff have the skills, knowledge and capability to deliver, with the freedom and autonomy to act
Support our people to reach their full potential, regularly growing our own workforce, and becoming a local employer of choice
Enable people to work and thrive together in a caring, rewarding and healthy environment
Seamless Services:
Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our health and care partners.
Actively develop partnerships to drive change and ensure services meet the changing health and care needs of our communities
Embed co-ordinated pathways through effective collaborative working between teams, and with other providers
Routinely and affordably invest in our infrastructure to support care and innovation, ensuring the best possible environment in which to care for our patients
Embrace and embed digital technology as an integral way in which we deliver and unlock clinical care and supporting services
Continuous Improvement:
Continuously improve services by adopting best practice, maximising our efficiency and productivity, and exploiting opportunities for transformation.
Maximise our use of new technology to anticipate and improve how patients, communities and partners can equitably access and receive care and services
Embrace innovation and quality improvement tools and adopt good practice to drive clinical, quality and financial improvements and sustainable delivery
Create an environment that adapts to and embraces transformation and maximises research and development opportunities to improve the care we provide
Enable our services to deliver in line with high performing local district general hospitals, with some areas of specialist care provision
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Section 3 –Strategic Risks

Strategic Priority: **Consistently deliver quality standards, targeting health inequalities and involving patients in their care**			Risk score 12
Strategic Risk No.1: **Workforce requirements**			
If we fail to recruit and retain sufficient high-quality staff in the right places	***Then*** we will not be able to deliver the needs of the population and standard of care that are required	***Resulting in*** poor performance, poor patient experience; failure to ensure the best possible health outcomes and quality of life; and a loss of trust	

	Impact	Likelihood	Score	Risk Trend
Inherent	4	3	12	*Future editions of this report will include a trend line showing the evolution of the risk score from month to month*
Current	4	3	12	
Target	3	3	9	

Risk Lead	Chief Nurse Medical Director Chief People Officer	Assurance committee	Quality and Safety

Controls	Assurances reported to Board and committees
Strategies and Plans • Clinical Strategy 2022-2030 • People Strategy • Annual Divisional workforce plans • Thematic review of complaints relating to staffing **Operational Systems and Resources** • Local recruitment and retention plans • International recruitment plans • Training needs analysis reviews (capability building) • Fill rates and reviews • GROW appraisal and talent system • Apprenticeship schemes • Change policy and toolkit • Pre and post reg training programs **Governance & Performance Management Structures** • Accountability and Review Meetings (ARM) • People Committee	**Internal Committee-level assurances** • Integrated performance report key indicators • Deep Dive recruitment briefs and reviews reports • Freedom to Speak up prevalence thematic analysis reports • Board members walk rounds • Deep dives for each division to establish staffing plans/budgeted WTE **Third line (external) assurances** • Staff survey results • External benchmarking with Integrated Care Partnership, Integrated Care Board and other partners • Ad hoc feedback: Health Education England / Professional Bodies / Academic body (pre and post reg) partners feedback • Care Quality Commission engagements session feedback reports
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
No substantive care support worker development programme	Redesign of service delivery pathways and development of new roles including 'grow your own' skills/talent - *by end of Q4 2022/23*
• Recruitment and retention plans required for professional groups with identified high vacancy rates, e.g. pharmacy, administration	• Review of establishment in Electronic Staff record to confirm baseline staffing position - *by end of Q4 2022/23* • Specialty specific Recruitment and retention plans - *by end of Q4 2022/23* • CPO and CNO supporting deep dives in safer staffing across October 2022
National and local cost of living and employment picture, which may make recruitment more challenging	To be confirmed

Current Performance - Highlights
The following points are highlighted from the Integrated Performance Report: • Transformation programmes delivering structure and people team changes are planned for delivery in 2022/23 • Vacancy rate overall has decreased slightly from 6.7% to 6.6% (414 vacancies). • Candidate experience rating remains high at 4.7 out of and time to hire is at 11 weeks (against a target of 10 weeks)

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
	To be added once Corporate Risk Register work is complete (this applies to all the BAF risks)	

Strategic Priority: **Consistently deliver quality standards, targeting health inequalities and involving patients in their care**		Risk score 12
Strategic Risk No.2: **Population/stakeholder expectations**		
If we do not meet the expectations of patients and other stakeholders, in the context of unprecedented backlogs	***Then*** population/stakeholder dissatisfaction will grow	***Resulting in*** loss of trust, loss of funding opportunities and regulatory censure, poorer outcomes

	Impact	Likelihood	Score	Risk Trend
Inherent	3	4	12	*Future editions of this report will include a trend line showing the evolution of the risk score from month to month*
Current	3	4	12	
Target	3	3	9	

Risk Lead	Chief Medical Officer/Chief Nurse	Assurance committee	Quality & Safety Committee

Controls	Assurances reported to Board and committees
Partnership Arrangements • NHSE/I Recovery operational plan • Integrated Care Board agreements • Health watch • Provider collaborative • Elective HUB development / Community diagnostic HUB • Maternity Voices Partnership **Strategies and Plans** • Quality Strategy • National Patient Safety Strategy • National patient Experience Strategy **Systems and Resources** • QlikView Quality dashboards • Quality Oversight System 'EnHance' **Governance and Performance Management Structures** • Accountability review meetings • Patient and Carer Experience Committee • Patient initiated Follow Up programme • Risk management group **Quality Management Processes** • Clinical harm reviews - cancer and non-cancer • Learning from incidents • Triangulation of incidents and complaints at divisional level • Model hospital information on service line and specialty standards **Sharing best practice** Transformation programmes, specifically: • Discharge collaborative • Complaints transformation • Outpatient and theatre transformation • ICS transformation programme	**Internal Committee-level assurances** • Elective recovery programme escalation reports • Cancer board escalation reports • Accountability Review Meetings escalation reports • Integrated performance reports to Board/ Committees • Executive Programme board escalation reports Sub Board Committees – assurance reports to board: • Patient and Carer Experience • Finance and Performance Committee • Audit and Risk Committee **Third line (external) assurances** • NHS Annual specialty patient surveys (ED, cancer) reports • NHS Friends and Family survey results • Care Quality Commission assessment reports • HSIB reviews/reports • NHSE regulator review meeting escalation reports • Peer reviews of selected services
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
Poor timelines in responding to concerns	Complaints transformation programme – *already in progress*

• Unwarranted variation across specialty booking Follow Up processes	• Establish safety improvement learning collaborative - *by end of Q3 2022/23* • Transition to new a learning from incidents framework - *by end of Q4 2022/23* • Pro-active Communication plan with public and partners – *already in progress* • Moving beyond safe programme for clinical matrons 2022
Unwarranted variation on Clinical Harm Review – non-cancer backlogs	Business case for a digital solution - *in progress for >52weeks incidents*
Clearer processes required for harm reviews relating to time waited for procedure	Implement and embed quality assurance framework - *by end of Q4 2022/23*
Delayed in patient information of non-cancer diagnosis	Improvement priorities focusing on clinical outcome letter processes, to be imbedded by end of *Q4 2021/22*
RTT TIER 1 rating due to long waiting times status	Implementation of intensive recovery plan by end of Q4 2021/22

Current Performance - Highlights
The following points are highlighted from the IPR most recent Board report: • On average 94% of complaints are acknowledged within 3 working days • On average 75% of complaint responses are responded to within agreed timeframe • Progress made with patient experience programme and co-design plans

Strategic Priority: **Consistently deliver quality standards, targeting health inequalities and involving patients in their care**		**Risk score 20**
Strategic Risk No.3: **Financial constraints and efficiencies**		
If costs increase significantly and/or far-reaching financial savings are required, and we do not deliver greater efficiencies	***Then*** we will need to make difficult decisions that could have a negative impact on quality and delivery	***Resulting in*** poorer patient outcomes, longer waiting times; reduced staff morale and reputational damage

	Impact	Likelihood	Score	Risk Trend
Inherent	5	4	20	*Future editions of this report will include a trend line showing the evolution of the risk score from month to month*
Current	5	4	20	
Target	4	3	12	

Risk Lead	Chief Financial Officer	Assurance committee	FPPC

Controls	Assurances reported to Board and committees
Strategies and Plans • Approved 22/23 Revenue, Capital, CIP & Activity Plan **Operational Systems and Resources** • Financial Reporting Systems – Finance Qlikview Universe • Detailed monthly CIP performance reporting **Governance & Performance Management Structures** • Monthly FPPC & Exec Committee Reporting • Monthly Divisional Finance Boards meetings • Monthly Capital Review Group • Financial Reset Steering Group – commences Nov-22 • Monthly cost ~~-~~centre / budget holder meetings • Bi-weekly ICS Director of Finance meetings • Ratified SFI's and SO's, Counter Fraud Policy • Consolidated ICS Procurement Service & Governance	**First and second line (internal) assurances)** • Monthly Finance Report / Key Metrics to FPPC • Financial Reset Programme proposed to and supported by the Trust Board (07/09/22). Monitoring through Board, FPPC-, TMG & Financial Reset Steering Group. **Third line (external) assurances** • Financial plan submitted to and approved by NHSE • Monthly financial reporting to NHSE & HWE System • External / Internal audit review of key financial systems and processes • National review of financial sustainability performance (complete in Q3) • Model Hospital / GIRFT / Use of Resources benchmarking
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Failure to deliver CIP savings at the level planned, placing financial pressure on the Trust and its system partners	• Implementation of additional CIP project managers within divisions. (Aug) • Review of outlying specialties to identify opportunities for delivery improvement/cost reduction. • Financial Reset recommendations to bolster PMO support to support savings delivery • Monthly financial reset meetings with divisions and Financial Reset Steering Group
• Gap in delivering ERF planned income and activity levels, creating the risk of revenue claw back	• Financial Reset workstream to review and bolster ERF delivery arrangements
• Significant overspend against elements of the Trust's workforce establishment.	• Financial Reset – 'Medical Staffing' review to focus on this significant overspending area
~~• Significant overspends against some elements of the Trusts 22/23 capital programme~~	~~• Governance and controls review of Capital Programme to be undertaken in Q3 with recommendations to FPPC.~~
• Ratification of Medium-Term financial plan (MTFP) and assumptions – both Trust & ICS, triangulation with clinical strategy and improvement / transformation projects.	• ~~Validation of MTFP~~Development and implementation of MTFP planning framework with ICS partner organisations

Current Performance - Highlights
The following points are highlighted from the Integrated Performance Report: • Year to date deficit of £3.~~9m~~2m • Reliance upon non recurrent reserves to support plan achievement year to date • £2.~~5m~~8m YTD slippage against agreed CIP programme • Medical staffing budgets overspend of £1.~~9m~~5m YTD

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score

Strategic Priority: **Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability**		Risk score 12
Strategic Risk No.4: **Workforce shortages and skill mix**		
If global and local workforce shortages in certain staff groups persist or increase combined with not having the right skill mix	***Then*** the Trust may not have the required number of staff with the right skills in the right locations	***Resulting in*** a negative work experience for staff due to increased work burden

	Impact	Likelihood	Score	Risk Trend
Inherent	3	4	12	*Future editions of this report will include a trend line showing the evolution of the risk score from month to month*
Current	3	4	12	
Target				

Risk Lead	Chief People Officer	Assurance committee	People Committee

Controls	Assurances reported to Board and committees
Strategies and Plans • Clinical Strategy 2022-2030 • People Strategy • Annual Divisional workforce plans and local Skill mix reviews • GROW and Succession plans • Tailored approach to nursing and medical and administration hotspots, with UK based campaigns supported by international recruitment plans **Learning and Development** • Apprenticeship schemes • Leader and Manager Development programmes **Recruitment and Retention** • Workforce Plans • NHSP and international recruitment • Various return to work schemes e.g. retire and return **Staff Engagement & Wellbeing** • Thank you and engagement interventions • Staff Survey • Absence and referral rates • Take up of wellbeing services **Governance & Performance Management Structures** • Medical establishment oversight working group • Clinical oversight working group • Recruitment and retention group • Workforce reports – time to hire, pipeline reports	**First and second line (internal) assurance** • IPR – to board and People Committee, including vacancy and turnover rates • WDES/WRES reports - to board and People Committee • Recruitment and Retention deep dives and reports – People Committee, ARM, Divisional Boards **Third Line (external) assurances** • Equality data for workforce (WRES/WDES) • Staff survey results
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Capacity to deliver scale of changes alongside day to day service delivery	• Prioritization of programmes through board and agreed by executives

Current Performance - Highlights
The following key performance indicators are highlighted from Integrated Performance Report: • Plans to continue collaboration with the ICS for international nurse recruitment for 22/23 • Virtual training sessions and drop in events continue to take place in April and are set to continue during the appraisal cycle to support GROW conversations

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
6359	Risk that the failure to achieve the Trust target for staff appraisals of 90% compliance will have an adverse impact on staff engagement and on the effective line management of staff.	12
6848	There is a risk that the Trust will fail to develop an effective workforce plan and workforce model for each service that takes account of new/different ways of working and will also fail to make best use of the existing talent pool through developing staff to their full potential and enabling flexible working arrangements.	16

Strategic Priority: **Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability**		Risk score 16
Strategic Risk No.5: **Culture and leadership**		
If the culture and leadership is hierarchical and not empowering and not compassionate and inclusive	***Then*** staff experience relating to stress, bullying, harassment and discrimination will perpetuate	***Resulting in*** poorer staff morale and retention and ultimately poorer quality of services and patient outcomes and CQC ratings

	Impact	Likelihood	Score	Risk Trend
Inherent	4	4	16	*Future editions of this report will include a trend line showing the evolution of the risk score from month to month*
Current	4	4	16	
Target				

Risk Lead	Chief People Officer	Assurance committee	People Committee

Controls	Assurances reported to Board and committees
Strategies and Plans • People Strategy • ENHT Values • People policy reviews • Speak Up approaches **Learning and Development** • Core skill and knowledge programmes (management and Leadership) • Healthy Leadership programme of work • Civility Matters programme of work • Mentoring and coaching programmes **Recruitment and Retention** • Values assessment undertaken at application stage for senior roles and in shortlisting criteria **Staff Engagement & Wellbeing** • Core offer of support available linked to financial, physical, mental, spiritual and social wellbeing for all staff • Annual days to focus on and raise awareness of specific topics • Staff networks **Governance & Performance Management Structures** • People Committee, staff side, Local Negotiating Committee • divisional boards • Grow together reviews and talent forums	**First and second line (internal) assurance** • Regular reports on progress against People Strategy • IPR **Third Line (external) assurances** • National staff survey results
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Capacity to undertake support and development in identified areas to improve leadership practice and engagement	• Prioritise approaches for service areas and deliver development work by end of Q4. • We have submitted our SEQOHS application for Health@Work services

Current Performance - Highlights
The following key performance indicators are highlighted from Integrated Performance Report:

- Staff team talks have launched linked to staff survey results and actions collated in early June for monitoring progress later in the Autumn

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
6092	There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered or enabled, impacting on the Trust's ability to deliver the required improvements and transformation, and impacting on the delivery of quality and compassionate care to the community.	16

Strategic Priority: **Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability**			Risk score 16
Strategic Risk No.6: **Engagement and listening**			
If we do not engage with and listen effectively to our staff and prioritise listening and do not provide clear message prioritization and co-ordination	***Then*** staff will suffer information fatigue and overload or ambiguity	***Resulting in*** staff disengagement, confused priorities, loss of purpose and low morale	

	Impact	Likelihood	Score	Risk Trend
Inherent	4	4	16	*Future editions of this report will include a trend line showing the evolution of the risk score from month to month*
Current	4	4	16	
Target				

Risk Lead	Chief People Officer	Assurance committee	People Committee

Controls	Assurances reported to Board and committees
Strategies and Plans • People Strategy • EDI Strategy • Leadership Development Plans **Learning and Development** • Civility Matters • Mandatory learning around inclusion, management and development of people • Healthy leadership, care support pyramid • Speak up training **Recruitment and Retention** • Pulse surveys • Feedback through local induction processes • grievance and raising concerns policy and guidance **Staff Engagement & Wellbeing** • Internal communications - all staff briefing, in brief and newsletter • Annual days to focus on and raise awareness of specific topics • Staff networks /Freedom To Speak Up/ Meet the Chief Executive **Governance & Performance Management Structures** • People Committee • Staff networks • Staff side, Local Negotiating Committee	**First and second line (internal) assurance** • IPR **Third Line (external) assurances** • WRES/WDES • Published equality data
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Capacity to release staff and leaders to participate in development alongside day to day priorities	• Creative delivery and support to enable release and participation e.g. protected time; forward planned events and team talks
• Ability to resolve staff complaints quickly and easily	• Policy reviews and training for managers in investigation, reports and hosting challenging conversations

Current Performance - Highlights
The following key performance indicators are highlighted from Integrated Performance Report: • The increase in time to resolve disciplinaries is in part due to availability of investigation officers time and resource capacity in the system • The time to resolve grievances continues to improve as a direct result of the ERAS team continuing to follow up and encourage early resolution

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
6092	There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered or enabled, impacting on the Trust's ability to deliver the required improvements and transformation, and impacting on the delivery of quality and compassionate care to the community.	16

Strategic Aim: **Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners**		**Risk score 16**
Strategic Risk No.7: **Immature place and system collaborative processes and culture**		
If the emerging ICS and place-based models do not develop at pace and we are unable to develop mutually collaborative approaches with partners throughout the system	***Then*** collaboration will stall, and partners will not trust us and vice versa	***Resulting in*** not delivering improved ways of working, missing the opportunities to improve health services and patient outcomes system-working offers; regulatory accountability and not achieving the system financial envelope.

	Impact	Likelihood	Score	Risk Trend
Inherent	4	4	16	*Future editions of this report will include a trend line showing the evolution of the risk score from month to month*
Current	**4**	**4**	**16**	
Target	4	3	12	

Risk Lead	Deputy Chief Executive	Assurance committee	FPPC

Controls	Assurances reported **to Board and committees**
Strategies and Plans • Clinical Strategy and Trust objectives • Joint strategic needs assessment **Financial Controls** • Cross System pathway transformation commissioning priorities at PLACE/ICB/ICS **Governance & Performance Management Structures** • ICB Board • ICS Board • Place Board • Scrutiny committee • Health and wellbeing board **Relationships** • Strong networks *[specifics to be clarified - requires a wider Exec discussion around how this could be achieved]*	**First and second line (internal) assurances** • Escalation reports to: Quality and Safety Committee; People Committee: Clinical Audit & Effectiveness sub-committee • Integrated performance reports to Board/ Committees • Well led framework assessment and review reports • Elective recovery programme escalation reports **Third line (external) assurances** • NHSE Board feedback forums

Gaps in Controls and Assurances	Actions and mitigations to address control / assurance gaps
• Defined governance frameworks	• ICB/ICS/Place leadership strategy group reports
• Missed opportunities to influence joint strategic needs assessment	• Influencing policy design at ICB and HCP level
• Developing role, responsibilities, and relationships	• Participation in System and Place development groups
• Developing cross systems agreed values and behaviours	• Participation in System and Place development groups

Current Performance - Highlights
The following key performance indicators are highlighted from the Integrated Performance Report: • the IPR does not include any measures that specifically highlight the effectiveness or not of collaborative arrangements

Associated Risks on the Board Risk Register

Risk no.	Description	Current score

Strategic Aim: **Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners**		Risk score 16
Strategic Risk No.8: **Performance and flow**		
If we do not achieve the improvements in flow within the Trust and wider system	***Then*** the Trust's key performance targets will not be met	***Resulting in*** increased avoidable Serious Incidents, wider health improvements not being delivered and regulatory censure

	Impact	Likelihood	Score	Risk Trend
Inherent	4	4	16	*Future editions of this report will include a trend line showing the evolution of the risk score from month to month*
Current	4	4	16	
Target	4	2	8	

Risk Lead	Chief Operating Officer	Assurance committee	FPPC

Controls	Assurances reported to Board and committees
Strategies and Plans • Recovery plans (Elective, cancer, stroke) • Cancer Strategy and Cancer recovery plan • Stroke recovery plan • System UEC strategy (incl ambulance and discharge flow) • UEC rapid action event (Sept 22), with resulting action plan monitored weekly by Execs • Support from ECIST (Emergency Care Improvement Support Team) – improvement actions and plan agreed **Performance Information Controls** • IPR • Deep dives • Qlikview dashboards – used to provide immediate access to data across a number of domains to enable effective management of performance **Governance & Performance Management Structures** • Operational restructure underway to further develop clinical and operational leadership, clear accountabilities, shared learning, QI approach • Transformation programmes at the Exec Programme Board • ARMs – includes exception reports • Divisional Board meetings • Regular tumour group meetings and improvement workstreams • System-wide Cancer Board chaired by COO • Specialty exception meetings	**First and second line (internal) assurances** • Board (IPR; transformation reports) • FPPC (IPR & deep dives) • Board Seminars (e.g. elective recovery Feb 22) **Third line (external) assurances** • Quality & Performance Review Meeting (chaired by ICS with CQC) • Herts & West Essex ICS UEC Board • ENH performance meeting (chaired by ICS Director of Performance)
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• New NHSE performance metrics (62 days cancer and 78 weeks waits)	• Further development of IPR – reviewing what metrics are focused on (including use of bed occupancy as a metric) – by Quarter 4 • ARM meetings – revised format from ~~September~~ October 2022
• Scope of validation of Patient Tracking Lists	• Increasing validation of Patient Tracking Lists – by Quarter 4

• Ambulance intelligent conveyancing lack of proactiveness	• System solution to intelligent conveyancing/ambulance intelligence - ongoing
• Lack of social care and community capacity to support discharge • Utilisation of Hospital at Home not yet optimal – further work being undertaken to increase uptake.	• Extending scope of hospitals at home – not matching what we need (taking patients who are awaiting packages of care) - ongoing
• Capacity to increase referrals to cancer pathways	• Review of ARM meetings to ensure effectiveness – by Quarter 4
• Clinical and administrative processes for progressing patients through their pathways	• Increasing MRI insourcing capacity – Additional mobile capacity onsite by quarter 3, further capacity planned for quarter • System being implemented to speed up the process of informing patients they do not have cancer – Quarter 4
• Diagnostic wait times – Access Board, Cancer Board	• Demand and capacity analysis – Quarter 3 • Additional capacity in plan: CT, echo, ultrasound, DEXA, MRI and plain film

Current Performance - Highlights
The following key performance indicators are highlighted from the Integrated Performance Report: • % of 62 day PTL over 62 days • 62-day/ 31-day cancer performance • 78 weeks RTT • Ambulance handovers • ED 4 and 12 hour performance • Diagnostic waits • 2 week waits • Stroke performance

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score

Strategic Aim: **Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners**		**Risk score 12**
Strategic Risk No.9: Trust and system **financial flows and efficiency**		
If finances do not move around the system in recognition of costs incurred in new models of care	***Then*** our and our partner financial positions will deteriorate	***Resulting*** in the inability to fund planned service delivery and regulatory scrutiny

	Impact	Likelihood	Score	Risk Trend
Inherent	4	4	16	*Future editions of this report will include a trend line showing the evolution of the risk score from month to month*
Current	4	3	12	
Target	3	3	9	

Risk Lead	Chief Financial Officer	Assurance committee	FPPC

Controls	Assurances reported to Board and committees
Strategies and Plans • Signed SLA contracts with ICS commissioners for 22/23 – embedding finance and associated plans. • Clinical Strategy and associated prioritisiation and development framework. Linked to place priorities **Financial Controls** • Monthly ERF & SLA activity reporting schedules **Governance & Performance Management Structures** • Establishment of SFA team to provide strategic finance transformation evaluation support • Bi-weekly ICS System Leaders meeting • Bi-weekly ICS DoFs and DDOFs meeting • Monthly E&N Herts Partnership Board & associated meetings • Elective Surgical Hub, Community Diagnostic Hub, Virtual Hospital and Heart Failure local and regional governance arrangements • PHM reporting mechanism to track changes in patient flows and associated costs and income • PHM steering and development group and link to place and system PHM development activity	**First and second line (internal) assurances** • System and Provider Collaboration reports to Trust Board advising on activity • Monthly project review sessions between Finance & Transformation Team. Transformation activity updates included in FPPC business cycle **Third line (external) assurances** • Consolidated ICS financial performance reports • Share further ICS performance reports as circulated by ICS.

Gaps in Controls and Assurances	Actions and mitigations to address control / assurance gaps
• Establishment of transparent financial reporting environment across ICS partners	• Q3 – ICS DoFs to work together to develop ICS financial framework for implementation
• Development of ICS financial risk management strategy	• Q3 – ICS DoFs to work together to develop ICS financial framework for implementation
• Determination of place based financial responsibilities	• Q3 – ICS DoFs to work together to develop ICS financial framework for implementation
• Development of long-term financial plan for ICS	• Q3 – ICS DoFs to work together to develop ICS financial framework for implementation
• Acute Provider Collaborative and associated business rules	• ~~Proposal shared with and approved~~Approved by ~~TB – 07/09/~~Trust CEO's – Sep 22. To be reviewed System Leaders Group – ~~Sept~~Oct 22. Move to implementation phase

• Further Board dialogue to be facilitated to help develop further metrics that can support assurance	• To be addressed through future Kings Fund and Board Development Sessions

Current Performance - Highlights
The following key performance indicators are highlighted from the Integrated Performance Report: • Performance against ERF income and activity targets • Delivery of CDH activity levels

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score

Strategic Aim: **Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities**			Risk score ~~16~~12
Strategic Risk No.10: **Technology, systems and processes to support change**			
If staff do not have the technology, systems and processes in place to support change and staff do not engage with or understand new continuous improvement processes and methodologies	***Then*** the pace of transformation delivery will falter	***Resulting in*** failing to improve productivity, deliver efficiencies and performance targets and ultimately the Trust being unable to deliver our strategic ambitions to timescale	

	Impact	Likelihood	Score	Risk Trend
Inherent	4	4	16	*Future editions of this report will include a trend line showing the evolution of the risk score from month to month*
Current	~~4~~3	4	~~16~~12	
Target	2	3	6	

Risk Lead	Director of Transformation	Assurance committee	QSC

Controls	Assurances reported to Board and committees
Strategies and Plans • Board approved 22/23 Strategic Objectives • 10 Year Integrated Business Plan • Digital Roadmap • Front Line Digitisation **Systems and Resources** • QlikVIew dashboards/ deployment of SPC methodology **Governance & Performance Management Structures** • Executive Programme Board • Clinical Digital Design Authority • GIRFT Board • Programme and project delivery framework • ENH HCP Transformation Delivery Group • Provider collaborative Programme Board **Quality Management Processes** • Here to improve model **Training and Sharing Best Practice** • Trust-wide training and development programme • Learning events, safety huddles and debriefs	**First and second line (internal) assurances** • Monthly Divisional Board and Transformation meetings • Monthly programme reports • Digital programme boards • Key performance metric reporting to Board/Committees • Board and Committee transformation update reports • External /internal audit review of key programmes i.e., transformation portfolio, efficiency and productivity, strategic projects **Third line (external) assurances** • Annual and Pulse staff surveys • National benchmarking reports • NHS Model Hospital Portal • GIRFT programme
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
Control gaps • Single improvement methodology not established across the organisation • Consistency with engagement across all staff groups to support improvement projects • Ongoing number of trust projects require cultural change and formal organisational redesign approaches • Variation in business-as-usual systems and processes • Improvement training compliance is variable across staff groups and levels of seniority • Benchmarking data comparisons not routinely understood to inform improvement priorities **Assurance gaps** • Need to embed culture of improvement and learning • Compliance with project management principles	**Control treatments** • Engagement exercise to identify an improvement partner to roll-out a Quality Management System • Roll-out strategic objectives aligned with Grow Together conversations and new Trust values and behaviors • Formalisation of an organisational development change model and engagement programme • Adoption of lean thinking in pathway redesign model • Review of the current dosing model for improvement skills and training • Development of a new annual benchmarking programme to monitor and evaluate performance and priorities **Assurance treatments** • Review of current processes and gap analysis plan • New strategic project management governance

• Engagement in the design and adoption of digital systems • Alignment of new transformation portfolio digital requirements with overarching Digital Roadmap	framework established. External audit scheduled Q4 22/23. • Review of mechanisms to ensure stakeholders have adequate time to engage in design and transformation. • Executive Programme Board to provide oversight and leadership regarding alignment resourcing and decisions

Current Performance - Highlights
• A series of departmental Values Charter pilot sessions have been conducted, cumulating in feedback and agreement of next steps at the Board Development Session on 5 October 2022. • As part of a wider programme of work the Leadership briefing on 18 October explored through a series of breakout discussions how individual senior leaders would take forward specific pledges to improve speaking up in their areas. • The Improvement Partner tender specification has been shared with the executive team for comment with an NHSE consultancy business case scheduled for completion by 28 October 2022. • The first two internal Audits of the Executive Programme Board governance processes and strategic programmes commenced this month; this involves CDC and Hospital at Home. • The Director of Improvement continues to work with the Speaking Up Guardian to design a corporate speaking up strategy and framework.

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
6092	There is a risk our staff do not feel fully engaged which prevents the organisation maximising efforts to deliver quality care.	16

Strategic Aim: **Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities**		Risk score 12
Strategic Risk No.11: **Enabling innovation**		
If we do not foster a learning culture where experimentation and questions are encouraged and staff are supported to innovate and do the right thing when mistakes happen	***Then*** there is the risk staff will become disempowered, will not identify solutions, not challenge without fear, not learn from mistakes and managers will hide issues and the culture will be psychologically unsafe.	***Resulting in*** avoidable harm to patients, missed opportunities for improvement and potential regulatory intervention and a culture of uncivil behaviour and lack of trust amongst staff

	Impact	Likelihood	Score	Risk Trend
Inherent	5	4	20	*Future editions of this report will include a trend line showing the evolution of the risk score from month to month*
Current	4	3	12	
Target	3	3	9	

Risk Lead	Director of Transformation	Assurance committee	People

Controls	Assurances reported to Board and committees
Strategies and Plans • Quality / Patient Safety Strategy • EDI strategy **Systems and Resources** • QlikView Quality dashboards • Quality Oversight System 'EnHance' • Change Toolkit and Policy **Governance and Performance Management Structures** • Patient Safety Forum(s) • Collaborative(s) (harm free care/ deteriorating patient) • A just culture guide for evaluating patient safety incidents • Freedom to speak up guardian / network • Mortality review process • Clinical audit programme **Learning from Incidents** • Clinical and serious incident review panels • Schwartz rounds/ quality huddles/ Here for You sessions • After Action Review debriefs **Quality Management Processes** • CQC and compliance preparedness framework • Incident management KPIs • Patient safety specialist role (s) **Training and sharing best practice** • RCN Clinical Leadership Programme • QI Bite size, masterclass & coaching sessions • PDSA / quality improvement in action • Leadership rhythm / bite-size sessions • Human factors simulation training	**First and second line (internal) assurances** • Divisional quality meetings/ structures • Accountability Review Meetings • Key performance metric reporting to Board/Committees • External/ internal audit review programme i.e., BAF & Risk Management, MHPS • CQC peer/ ICB review assessments **Third line (external) assurances** • Annual and Pulse staff survey results • Care Quality Commission assessment process • ICB / Place Quality Surveillance Group • NHS patient survey results • NHS clinical incident reporting benchmarking
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
Control gaps • Single improvement methodology not established across the organisation	**Control treatments** • Develop and roll-out a Quality Management System •

• Freedom to Speak up Strategy not launched or imbedded	• Develop leadership and management framework to support freedom to speak up processes as part of BAU
• Variation in ward to Board quality governance structures and operational procedures	• Good Governance Institute review. • National Safety Incident Framework launch
Assurance gaps • Improving evidence of learning from incidents, complaints, audit and wider performance issues	**Assurance treatments** • Review of systems to capture and share learning • Develop and launch a refreshed vision for learning and improvement, closely linked to strategic objectives and Trust values
• Level of absence and grievances for staff	• Review of ward/specialty MDT governance processes - develop MDT ward leadership model • Development of ICB / Place learning network

Current Performance - Highlights
• Discussions commenced with agreement to develop HCP improvement and learning network; at ICB level current agreement between ENHT and PAH to explore. • Engagement exercise supported by Procurement Services with Improvement Partner draft tender specification to be complete by end August. This will be a competitive process with a capability assessment at outset. • Improvement support allocated to FTSU and work commenced to develop a leadership and management speaking up framework as part of BAU service delivery • RESET week in August incorporated new agile, PDSA and behavioral change approach, deliberately moving away from historical command and control model, focusing on license to act. AAR feedback demonstrated significant positivity amongst all staff involved toward feelings of trust and empowerment. Work is underway to maintain this momentum.

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
6092	There is a risk our staff do not feel fully engaged which prevents the organisation maximising efforts to deliver quality care.	16

Strategic Aim: **Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities**		Risk score 12
Strategic Risk No.12: **Clinical engagement with change**		
If the conditions for clinical engagement with change and best practice are not created and fostered	***Then*** we will be unable to make the transformation changes needed at the pace needed	***Resulting in*** not delivering our recovery targets or improved clinical outcomes; not building a financially sustainable business model; and being unable to contribute fully to system-wide improvements

	Impact	Likelihood	Score	Risk Trend
Inherent	4	4	16	*Future editions of this report will include a trend line showing the evolution of the risk score from month to month*
Current	4	3	12	
Target	4	3	12	

Risk Lead	Medical Director/Chief Nurse	Assurance committee	QSC

Controls	Assurances reported to Board and committees
Strategies and Plans • Clinical Strategy • Quality Strategy **Information systems and resources** • QlikView Quality dashboards • Life QI • Datix / 'ENHance' **Governance and Performance Management Structures** • Operational committees e.g. Patient Safety ForumMortality surveillance committee **Learning from Incidents** Key performance SOPs e.g. Incident learning responses: serious incident reports, round tables, restorative culture framework **Quality Management Processes** • CQC and compliance preparedness framework • Safety Incident management framework • Quality Improvement service • Transformation service • Reward and recognition **Training and sharing best practice** • Royal College of Nursing Clinical Leadership Programme • Clinical Directors development Programme • New Consultants development programme • Improvement and transformation capability sessions • Quality Improvement coaching • Leadership and human factors development programmes • Research programmes **Staff engagement and well being** • Here for you health at Work • Values and behaviour programmes • Freedom to speak up guardian / network	**Internal Committee-level assurances** **Sub Board Committees** • Quality and safety Committee report • Education committee escalation report • Clinical Audit and Effectiveness Committee escalation report Safety Culture survey **Third line (external) assurances** • Annual and Pulse staff survey results • Care Quality Commission assessment process • ICB / Place Quality Surveillance Group escalation report • NHS patient survey results • Peer assessment review report and action plan • External/ internal audit programme reports and action trackers • Getting it Right First Time national programme
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**

Control gaps Skills and knowledge within clinical workforce to learn how to drive change	• Combined efforts to drive skills and knowledge by people team, transformation team, quality improvement team and business information's analysts in progress • Engage with and improvement partner end of Q3 2023/24
Capacity within clinical roles to apply change methodology	Agreed job planning and rostered time demonstrated through Roster on PA allocation
Unwarranted variation in quality assurance framework	Redesign quality assurance framework by end of Q3
Current national safety Incident framework	New safety incident framework implements by end of Q4
No allocated Medical lead Quality Improvement	Agreed job planning and rostered time demonstrated through Roster on PA allocation
Operational pressures, especially throughout Q3 and Q4	Risk based approach to quality improvement and prioritising
Assurance gaps Improving evidence of imbedded sustainable changes following learning from incidents, complaints, audit, and wider performance issues	

Current Performance - Highlights
The following are highlighted from the most recent Integrated Performance Report: • Sustained improvement in recognition and management of sepsis • Sustained improvement in incident reporting • Sustained improvements in learning form deaths and mortality outcomes

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score

East and North Hertfordshire NHS Trust

Integrated Performance Report

Month 06 | 2022-23

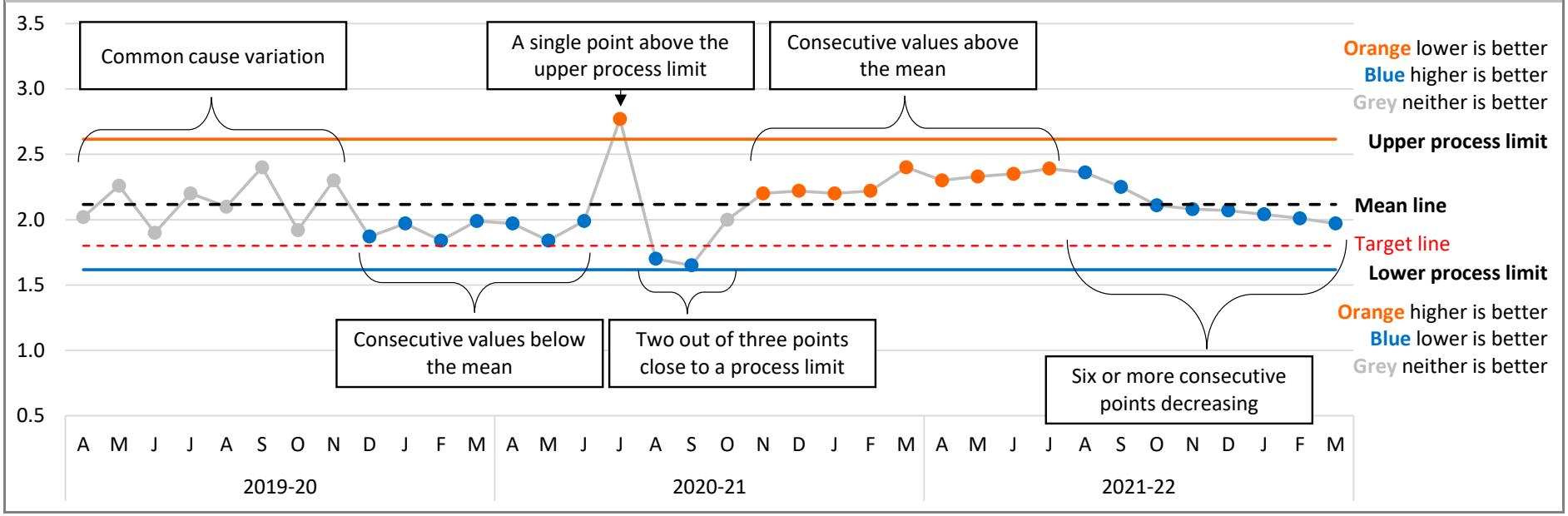
	P	?	F
H / L	0	5	3
	4	36	2
H / L	5	14	10

Data correct as at 21/10/2022

Integrated Performance Report

East and North Hertfordshire NHS Trust

How to interpret a Statistical Process Control (SPC) Chart



Variation

H L	Special cause variation of **concerning** nature due to **H**igher or **L**ower values
H L	Special cause variation of **improving** nature due to **H**igher or **L**ower values
	Common cause variation No significant change

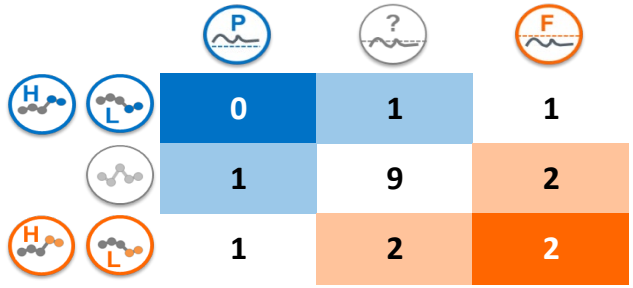
Assurance

F	Consistent Failing of the target Upper / lower process limit is above / below target line
P	Consistent Passing of target Upper / lower process limit is above / below target line
?	Inconsistent passing and failing of the target

East and North Hertfordshire NHS Trust

Safe Services

Month 06 | 2022-23



Safe Services

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Safety Incidents	Total incidents reported in-month	Sep-22	n/a	1,448			Common cause variation No target
	Serious incidents in-month	Sep-22	0	5		?	Common cause variation Metric will inconsistently pass and fail the target
Infection Prevention and Control	Hospital-acquired MRSA Number of incidences in-month	Sep-22	0	0		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired c.difficile Number of incidences in-month	Sep-22	0	9		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired e.coli Number of incidences in-month	Sep-22	0	7		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired MSSA Number of incidences in-month	Sep-22	0	4		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired klebsiella Number of incidences in-month	Sep-22	0	2		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired pseudomonas aeruginosa Number of incidences in-month	Sep-22	0	1		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired CPOs Number of incidences in-month	Sep-22	0	0		?	Common cause variation Metric will inconsistently pass and fail the target
	Hand hygiene audit score	Sep-22	80%	90.8%		P	Common cause variation Metric will consistently pass the target
Safer Staffing	Overall fill rate	Sep-22	n/a	79.0%			Common cause variation No target
	Staff shortage incidents	Sep-22	n/a	35			Common cause variation No target

Safe Services

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cardiac Arrests	Number of cardiac arrest calls per 1,000 admissions	Sep-22	n/a	0.60			Common cause variation No target
	Number of deteriorting patient calls per 1,000 admissions	Sep-22	n/a	0.74			Common cause variation No target
Deteriorating Patients	Reliability of observations (4-hour)	Sep-22	n/a	69.5%	L		Ten points below the mean No target
	Reliability of observations (1-hour)	Sep-22	50%	36.0%	L	F	One point below the lower process limit Metric will consistently fail the target
Sepsis Screening and Management	Inpatients receiving IVABs within 1-hour of red flag	Sep-22	95%	100.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Inpatients Sepsis Six bundle compliance	Sep-22	95%	58.3%		F	Common cause variation Metric will consistently fail the target
	ED attendances receiving IVABs within 1-hour of red flag	Sep-22	95%	93.8%		?	Common cause variation Metric will inconsistently pass and fail the target
	ED attendance Sepsis Six bundle compliance	Sep-22	95%	82.0%	H	F	Two consecutive points above upper process limit Metric will consistently fail the target
VTE Risk Assessment	VTE risk assessment stage 1 completed	Sep-22	85%	63.6%	L	?	Seven points below the mean Metric will inconsistently pass and fail the target
	VTE risk assessment for stage 2, 3 and / or 4	Sep-22	85%	43.1%	L	F	Seven points below the mean Metric will consistently fail the target
	Correct low molecular weight heparin prescribed and documented administration	Sep-22	85%	90.2%	L	P	Seven points below the lower process limit Metric will consistently pass the target
	TED stockings correctly prescribed and documentation of fitted	Sep-22	85%	58.1%	L	?	Seven points below the mean Metric will inconsistently pass and fail the target

Safe Services

Summary

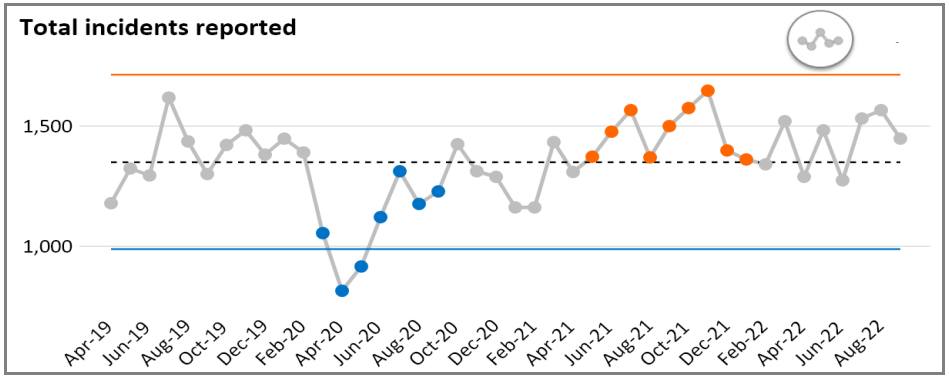
East and North Hertfordshire NHS Trust

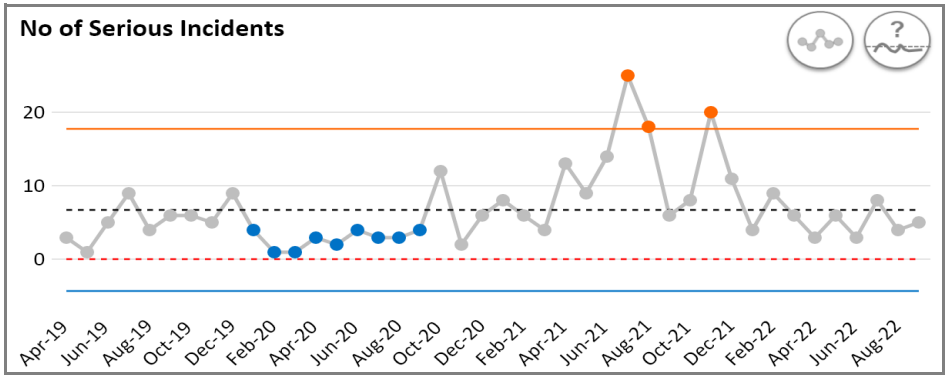
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
HATs	Number of HAT RCAs in progress	Sep-22	n/a	80	H		Seven points above the mean No target
	Number of HAT RCAs completed	Sep-22	n/a	25			Common cause variation No target
	HATs confirmed potentially preventable	Sep-22	n/a	2			Common cause variation No target
PU	Pressure ulcers All category ≥2	Sep-22	0	10		F	Common cause variation Metric will consistently fail the target
Patient Falls	Rate of patient falls per 1,000 overnight stays	Sep-22	n/a	4.0			Common cause variation No target
	Proportion of patient falls resulting in serious harm	Sep-22	n/a	1.7%			Common cause variation No target
Other	National Patient Safety Alerts not completed by deadline	Aug-22	0	0			Metric unsuitable for SPC analysis
	Potential under-reporting of patient safety incidents	Jul-22	6.2%	4.6%			Metric unsuitable for SPC analysis

Safe Services

Patient Safety Incidents

East and North Hertfordshire NHS Trust





Key Issues and Executive Response

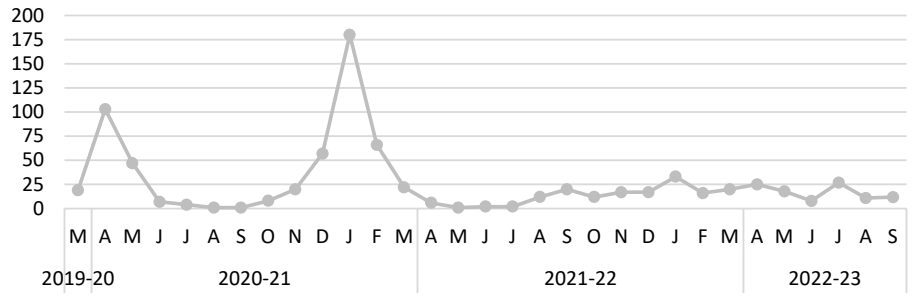
- Common cause variation seen in the number of incidents reported.
- Approximately 98% of incidents reported resulted in no or low harm (this is in-line with previous months).
- Common cause variation in the number of SIs declared each month.
- Improvement in overdue SIs noted over July and August with ongoing commitment from Divisions to support timely approvals.
- Ongoing close engagement with CCG to ensure alignment of data and provide updates as to progress with overdue SIs.
- Two ongoing thematic reviews; care of patients with mental health needs in ED and Ophthalmology follow up processes.

Safe Services

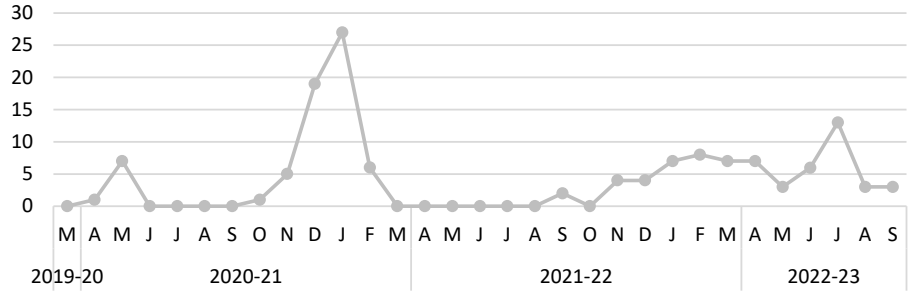
COVID-19

East and North Hertfordshire NHS Trust

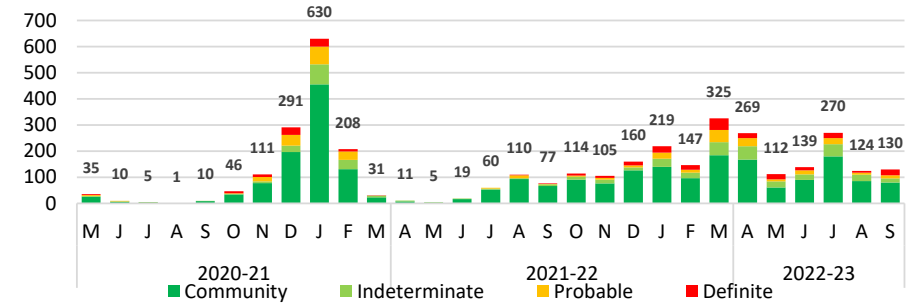
Number of deaths from COVID-19



Number of deaths from hospital-acquired COVID-19



COVID-19 cases by category



Key Issues and Executive Response

- A slight decrease in COVID cases were seen in September, the total number was 130. Of these cases 35 were contributed to probable or definite hospital-onset COVID.
- Sadly 12 patients died with a diagnosis of COVID in September, and 3 of these cases were related to hospital-onset COVID.
- Structured reviews are undertaken locally to capture learning where a hospital acquired infection has been identified. Where any potential harmful impacts are identified cases shall be represented to serious incident review panel.
- One ward area experienced a COVID 19 outbreak in September, other wards have seen increased incidences and local bay closures to manage the risk of spreading COVID 19 infection.
- The trust continues to deliver a clinical specialist COVID advisory group where all new national and local guidance is reviewed, and plans agreed to implement accordingly.

Safe Services

Infection Prevention and Control

East and North Hertfordshire NHS Trust

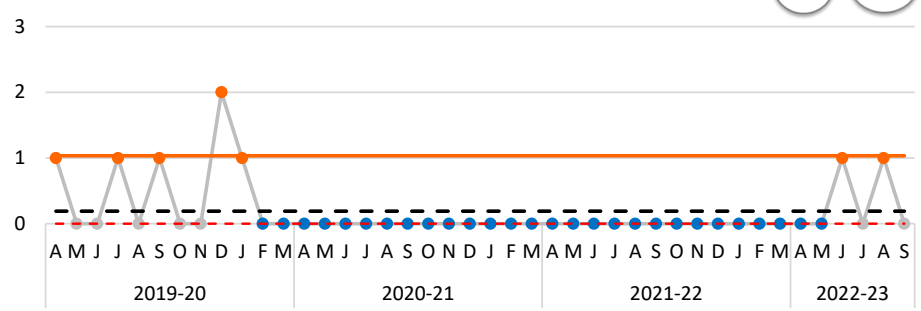
Measure	Site	Assurance		Narrative
Water Safety	Lister Site		**Reasonable assurance**	• Policy in place with Water Safety Plan procedures currently in draft. • An Authorising Engineer [Water] and an Authorised Person [Water] have been appointed. • Competent Persons training has been completed in readiness for formal appointments. • Water Safety Group & operational sub-groups established. • Water safety risk assessments are up to date. • Control schemes documented at all Trust sites. • The programme of planned maintenance & monitoring at Lister Hospital is ongoing and up to date and demonstrates high levels of compliance with the control scheme. • The Trust has some very old water distribution infrastructure. There is a programme of works (backlog maintenance programme 22-23) in the process of being commissioned to target the most high-risk areas, this will further enhance the microbiological management of the water across the site. Circa £533,000 is being invested into site infrastructure - including water remedial works site-wide, phased programme of water temp and flow monitoring. • Work continues to engage with our colleagues & partners at each of the satellite premises to provide assurance that the relevant processes & procedures are in place for water safety. However there does continue to be concerns over the water management at Mount Vernon Hospital,
	Satellite premises		**Limited assurance**	
Ventilation	Lister Site		**Limited assurance**	• Current policy is now due for review / update to reflect the 2021 rewrite of the HTM. • Limited procedure documents, 3 x pending, including develop and implement permission to isolate / permit to work. All SOPs across all critical function areas will be incorporated into the finalised Contractor Control Policy. • An Authorising Engineer [Ventilation] and an Authorised Person [Ventilation] have been appointed. An additional AP has now attended ventilation training and is awaiting formal assessment by the AE. • Competent Persons training has been completed in readiness for formal appointments by AP • Ventilation Safety Group [VSG] meetings are now scheduled on a quarterly basis. • Critical ventilation systems are verified annually; inspection findings are reported to the VSG; • The Trust has some very old assets/AHU in poor condition. A risk-based back-log maintenance programme 22-23 captures higher-risk items including Theatre (3-8) plant replacement. Funding approved to proceed in 22-23 financial year. • Satellite premises have not been assessed separately from the Lister site at this time, however a workplan and approach has been agreed and work
	Satellite premises		**To be confirmed**	
Decontamination	Lister Site		**Limited assurance**	• A Trust Decontamination Group [TDG] has scheduled quarterly meetings. Meeting terms of reference, membership and agenda has been updated and due for sign-off at the next TDG meeting in October (delayed from September). • An Authorising Engineer [Decontamination] has been appointed. • An Estates Manager (Decontamination) role has been employed to undertake the Authorised Person [Decontamination] duties, however this role has yet to be formally appointed by the AE[D]. AP completed and passed final Decontamination Training in August, now awaiting AE assessment and sign-off. • The AE[D] has completed an audit / gap analysis which identified opportunities for improvement. This action plan continues to be worked on, one key concern highlighted was the poor governance / reporting mechanism for Trust Decontamination. This assurance gap has now been filled with appointment of TDL and updated ToR for TDG. • The AE[D] has completed the JAG IHEEM audit for endoscope decontamination facilities, which identified the lack of a permit to work system. A permit-to-work system has been devised and documented ready for implementation. • Backlog maintenance programme 22-23 includes Reverse Osmosis (RO) plant replacement in HSSD and replacement of 8 x Endoscopy Washers (end
	Satellite premises		**To be confirmed**	

Safe Services

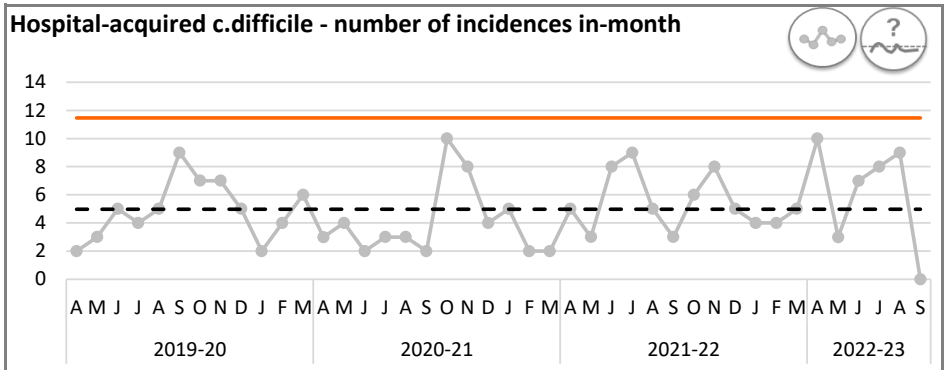
Infection Prevention and Control

East and North Hertfordshire NHS Trust

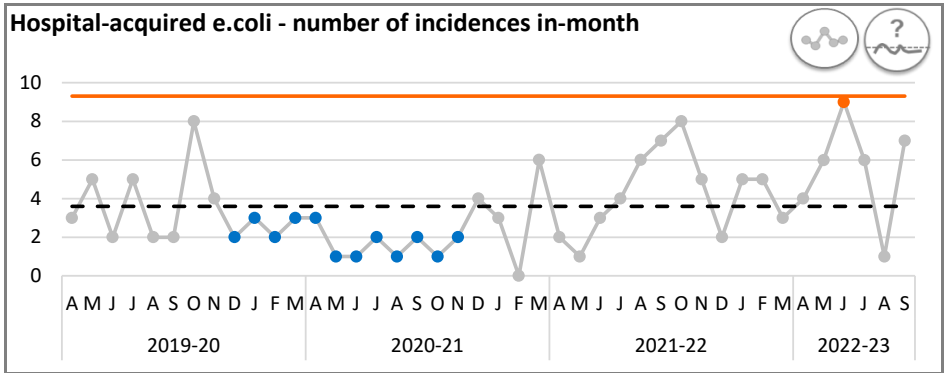
Hospital-acquired MRSA - number of incidences in-month



Hospital-acquired c.difficile - number of incidences in-month



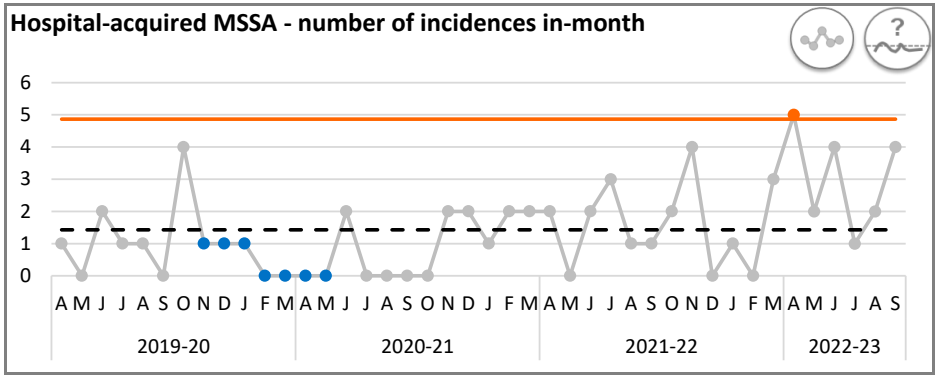
Hospital-acquired e.coli - number of incidences in-month



Key Issues and Executive Response

- The Trust reported 0 hospital acquired MRSA blood stream infection (BSI) in September 2022 against the annual target of 0. The Trust has reported a total of 1 hospital-acquired MRSA BSIs in 2022 - 2023 to date against the annual target of 0, which is above trajectory.
- The 1 hospital-acquired MRSA BSI that occurred in August at Mount Vernon Cancer Centre (MVCC) site has been reviewed and it was identified not MRSA, rather a Methicillin Sensitive Staphylococccus Aureus (MSSA).
- The Trust has reported 0 hospital acquired Clostridioides difficile infections (CDI) in September 2022. This is partly due to the ongoing Trust support the IPC team provide when an incident occurs through visiting wards, reviewing practices, and implementing the learning from the post infection reviews (PIR).
- The Trust has reported 37 hospital acquired Clostridioides difficile infections (CDI) in 2022-23 to date against the annual target of 59, which is slightly above trajectory.
- The Trust has reported a total of 28 hospital acquired E. coli BSIs in 2022-23 to date against the annual target of 46, which is slightly above trajectory.
- The IPC team continue to review all agreed gram-negative and gram-positive infections through the PIRs.
- The Trust has reported a total of 18 hospital acquired MSSA infection in 2022-23 to date. No target has been set for MSSA.

Hospital-acquired MSSA - number of incidences in-month

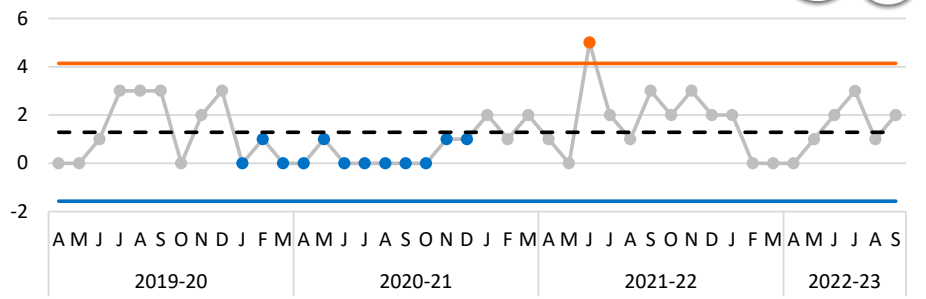


Safe Services

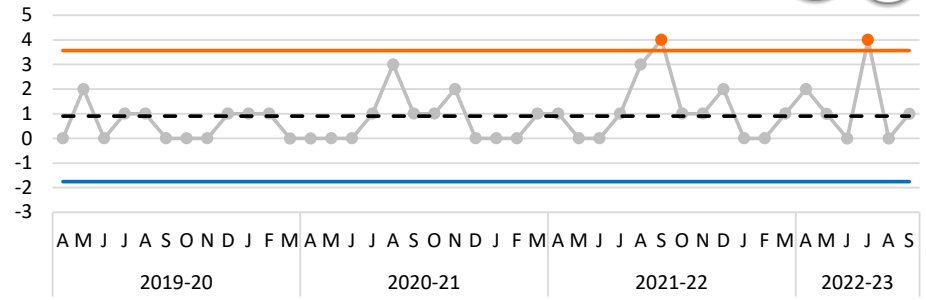
Infection Prevention and Control

East and North Hertfordshire NHS Trust

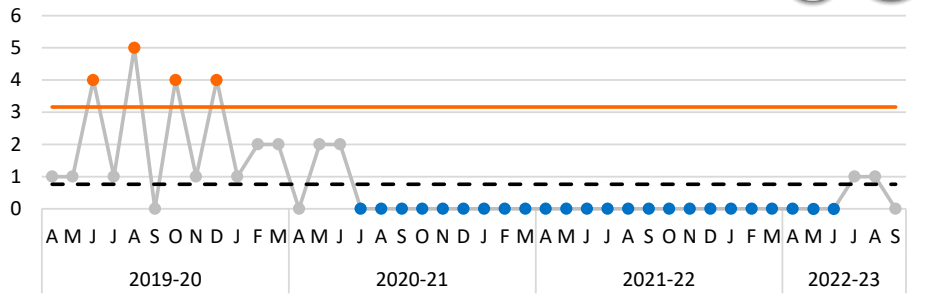
Hospital-acquired klebsiella - number of incidences in-month



Hospital-acquired pseudomonas aeruginosa - no. incidences in-month



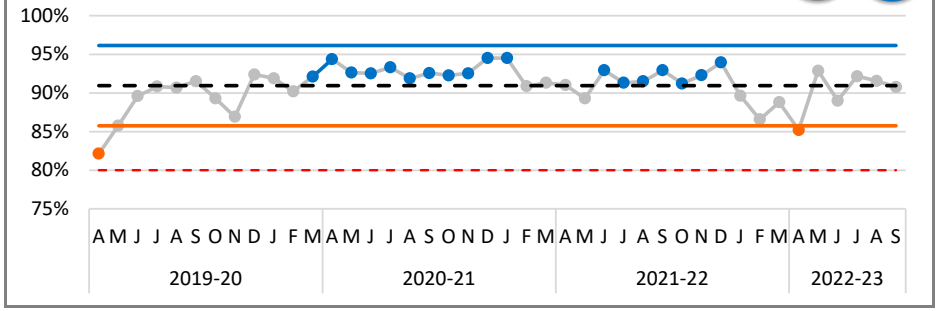
Hospital-acquired Carbapenemase Producing Organisms (CPOs)



Key Issues and Executive Response

- The IPC team continue to review all agreed gram-negative and gram-positive infections through the PIRs.
- The Trust has seen a notable reduction in hospital acquired BSIs in the month of September 2022.
- As part of the greater aseptic technique work of the Trust, BBraun (an external company who supply the Trust with intravascular devices such as cannulas) will carry out observational audits during October on aseptic practice within the Trust.
- The Trust has identified 5 hospital acquired CPO infections in 2022 - 2023 to date.
- An Incident Management Team (IMT) chaired by the IPC Deputy DIPC was convened and met with 8A North (where the incident occurred) throughout September to review, discuss, and identify the learning and improve practices.
- External colleagues from the ICB visited 8A North observe the gaps identified in the IMT to ensure the mitigations discussed are in place.
- IPC continue to carry out monthly hand hygiene competency training and support the wards throughout the year by delivering bespoke training.

Hand hygiene audit score

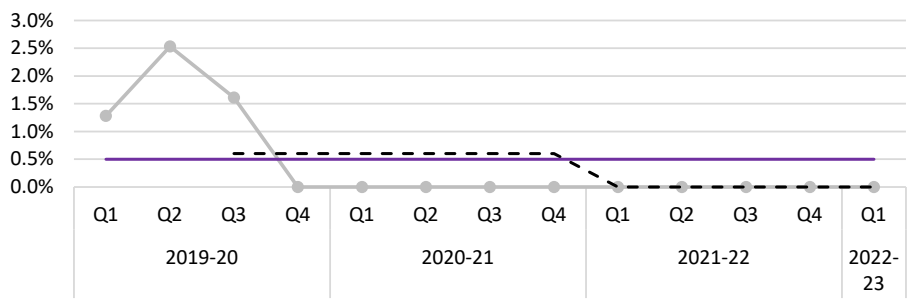


Safe Services

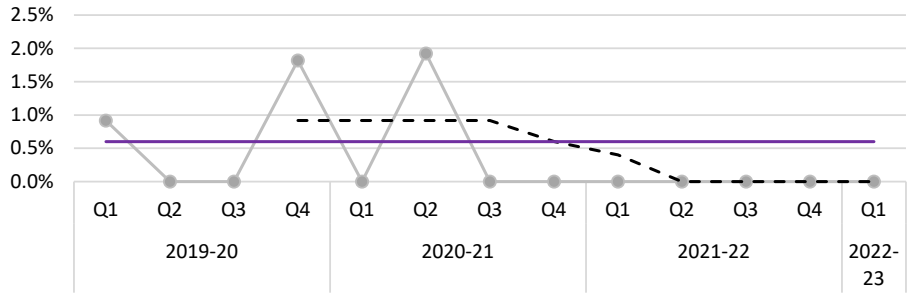
Infection Prevention and Control

East and North Hertfordshire NHS Trust

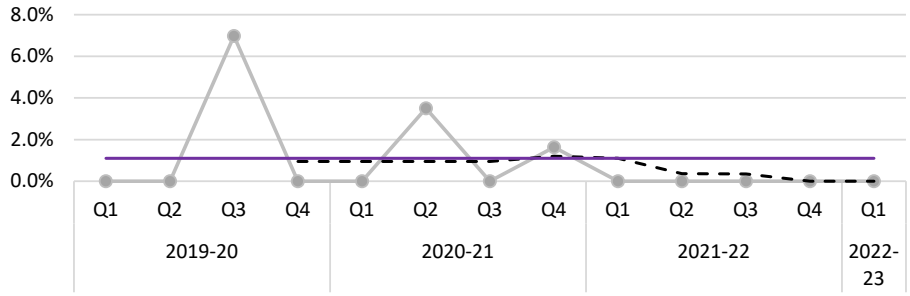
Surgical Site Infections - Total Knee Replacements



Surgical Site Infections - Total Hip Replacements



Surgical Site Infections - Fractured Neck of Femur



Key Issues and Executive Response

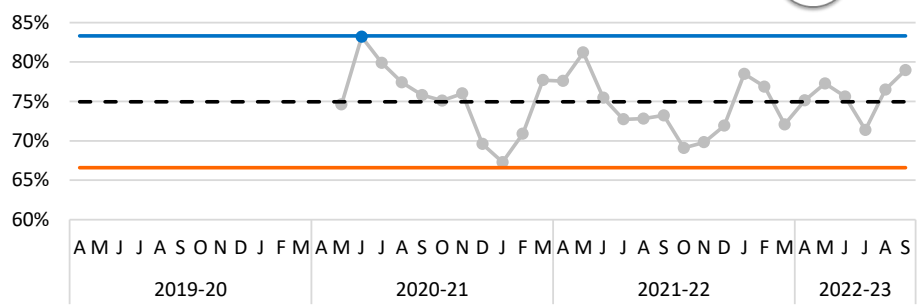
- SSI figures over the last 4 periods (July 2021 – June 2022) show an overall reduction in infection rates in all three categories monitored (Total Knee Replacement (TKR), Total Hip Replacement (THR) & Repair of Fractured Neck of Femur (NOF), compared to the 2014 - 2019 figures.
- The TKR infection rate remains at 0.0% in April - June 22 and the overall rate for the past 4 periods (July 2021 – June 2022) remains at 0.0%. This is below the national benchmark of 0.5%.
- There were 0 THR infections in April - June 22, which gives an infection rate of 0%. The THR rate over the last 4 quarters (July 2021 – June 2022) has remained at 0.0%, which is below the national benchmark of 0.6%.
- The NOF infection rate for April - June 22 remains at 0.0% and the rate for the last 4 quarters (July 2021 – June 2022) remains at 0.0%, which is below the national benchmark of 1.1%.
- A quality improvement project, led by the Planned Care Division, has commenced and is ongoing with the support from the Trust QI team.
- Thus far, the most common causative organism is Staphylococcus aureus. The Planned Care Division has been asked to review the MSSA pre-operative screening process and eradication therapy for all patients to run in parallel with our MRSA detection.
- The pre-operative skin preparation agent of choice will be presented at the product selection group by the Pre-Operative Assessment team.

Safe Services

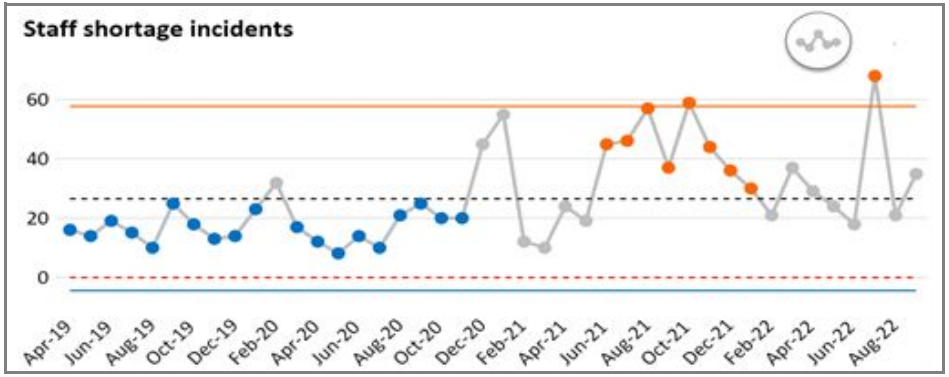
Safer Staffing

East and North Hertfordshire NHS Trust

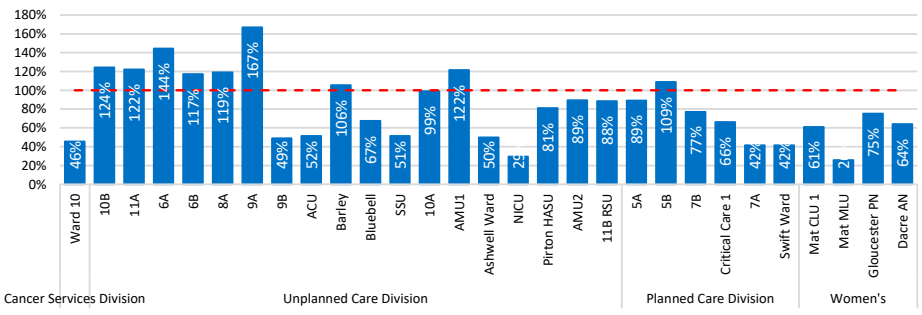
Safer Staffing - Overall fill rate



Staff shortage incidents



Safer Staffing - Supervisory Shift Report - Sep-22



Key Issues and Executive Response

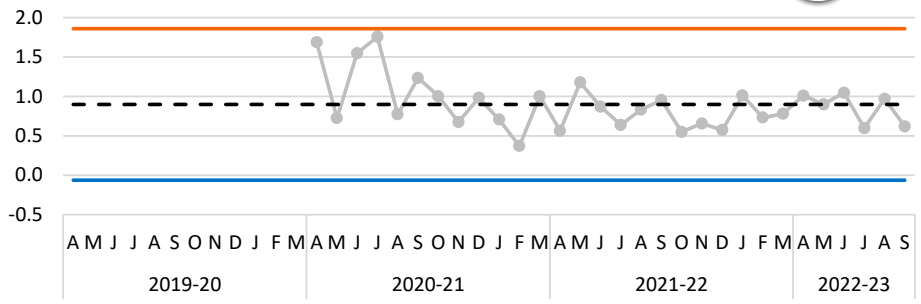
- Temporary staffing demand remained high due to annual leave at 16.4% and sickness levels at 7%. Overall CHPPD has increased from 7.3 in August to 7.4 in September, however Registered fill rates decreased, and Unregistered fill increased thereby reducing the skill mix on the wards.
- The number of staffing shortage Datix has increased for the month of September. The top 3 departments raising Datix were Emergency department, Children's Emergency Department, and Maternity. All staffing Datix are reviewed by a manager.
- There are still challenges around RN and CSW vacancies. Ongoing international recruitment continues for registered nurses and focused recruitment days for CSWs.
- Flexible Pool and Rapid Response pools were utilised to support short notice sickness and drop out. If unable to cover all the shortfalls shifts are then released to agency on agreement by the head of nursing at the safer staffing meetings.
- Ward managers are rostered 75% supervisory time to provide adequate leadership and support for their department. As part of the safer staffing mitigation ward managers are utilised if supervisory and moved into the clinical numbers when shortfalls happen, or acuity increases. The supervisory shift report shows the amount of supervisory time each department delivered for the month; the supervisory time managers have taken for the month of September has fluctuated in areas where they have been supporting in a clinical shift.

Safe Services

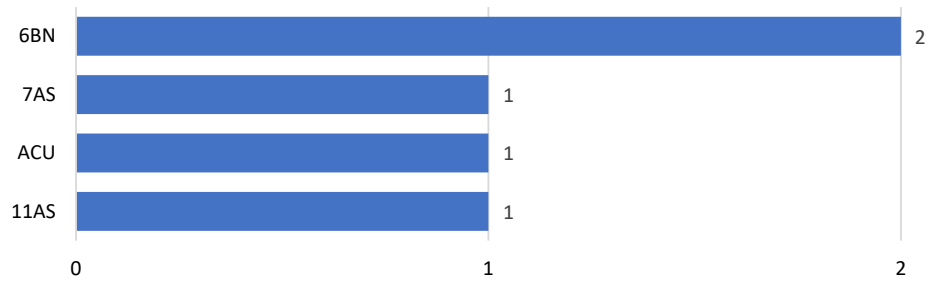
Cardiac Arrests

East and North Hertfordshire NHS Trust

Number of cardiac arrest calls per 1,000 admissions



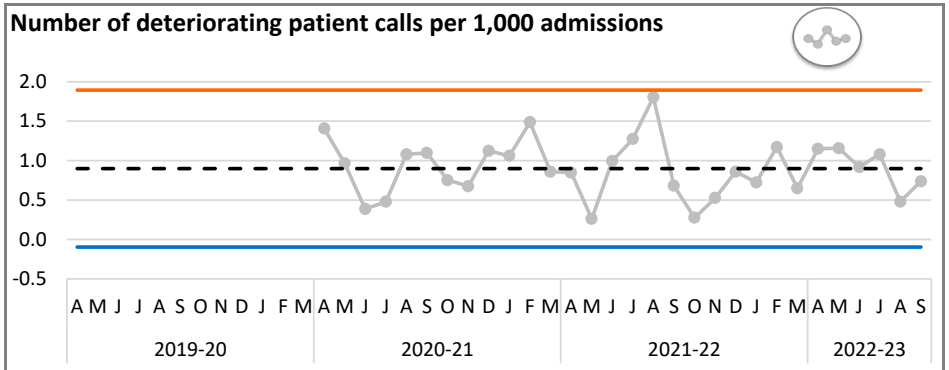
Number of cardiac arrest calls by location - Sep-22



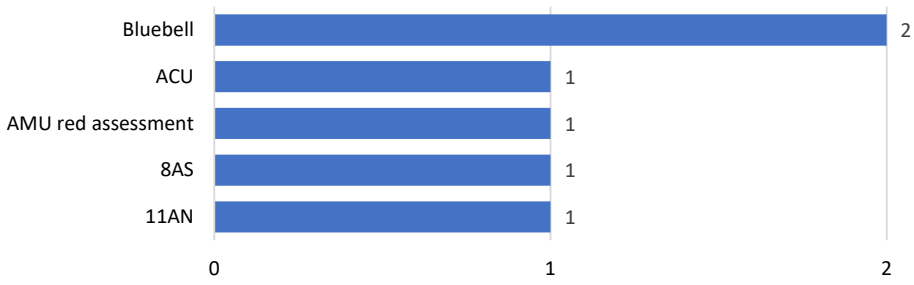
Key Issues and Executive Response

- The trust's cardiac arrest rate per 1000 admissions remains steady.
- Human Factors project launched in July, examining the influencing factors that affect the recognition and management of the deteriorating patient and cardiac arrest. Strategies are in development to examine the data and share the learning.
- ReSPECT Launched in collaboration with palliative care teams, to support the quality of recognising and supporting end of life clinical presentations.
- Plan to launch in situ simulation training, to imbed real time simulation training across the Trust by January 2023. This aims to examine and support staff in the recognition and management of the deteriorating patient and examine the current systemic response to 2222 calls.
- Funding and approval have been granted to deliver increased education and skills to clinical support workers, in a nationally recognised course. This is due to begin in January 2023.

Number of deteriorating patient calls per 1,000 admissions



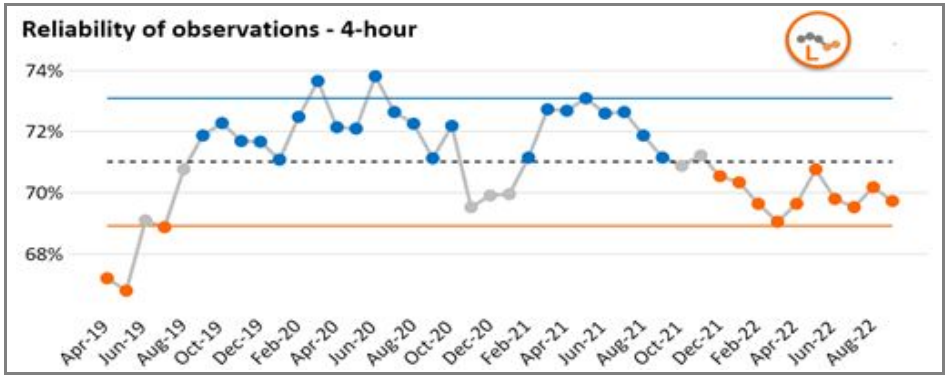
Number of deteriorating patient calls by location - Sep-22

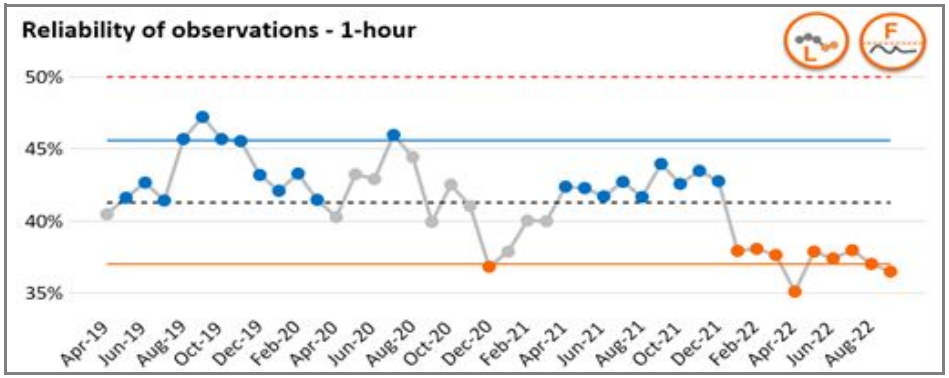


Safe Services

Deteriorating Patients

East and North Hertfordshire NHS Trust





Key Issues and Executive Response

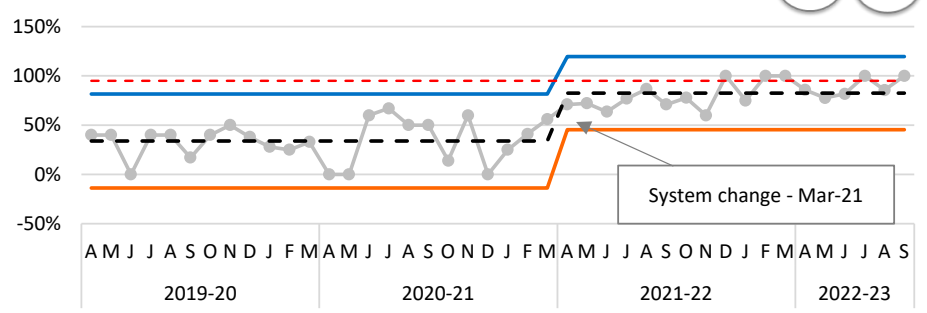
- Continued theme around short staffing versus increased acuity of patients/OPEL statuses causing pressure on discharges and flow onwards.
- Work ongoing with CCOT and QI to review and support improved equipment (observation machines, tympanics) on wards to undertake timely observations. Includes a review of repair /procurement and improving these processes. Working with ward managers to understand their shortfalls.
- Audit paper presented at Medical Devices Committee with various actions arising for ongoing Quality Improvement work happening as a result. CSW's being given shadowing opportunities to shadow CCOT.
- Deteriorating Patient Roadshow launched in September with this month's theme being 'reliability of observations' and 'escalations.' Feedback so far from ward staff raising themes to be discussed and actioned from the Deteriorating Patient Committee.

Safe Services

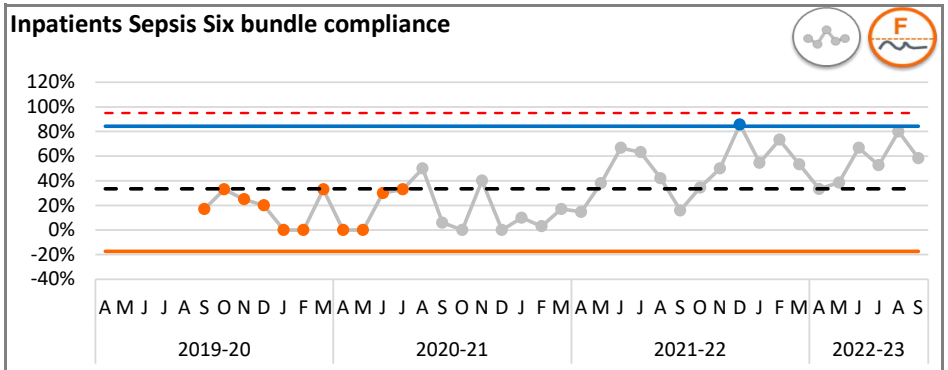
Sepsis Screening and Management | Inpatients

East and North Hertfordshire NHS Trust

Inpatients receiving IVABs within 1-hour of red flag



Inpatients Sepsis Six bundle compliance



Themes

Sepsis IP	2021-22							2022-23				
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Oxygen	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Blood cultures	54%	54%	85%	70%	79%	75%	55%	93%	82%	89%	92%	86%
IV antibiotics	72%	72%	100%	75%	100%	100%	86%	83%	82%	92%	86%	92%
IV fluids	60%	60%	100%	71%	67%	80%	50%	90%	86%	50%	100%	75%
Lactate	52%	52%	85%	70%	62%	55%	50%	86%	76%	67%	89%	70%
Urine measure	59%	59%	82%	67%	58%	50%	42%	60%	74%	73%	87%	76%

Key Issues and Executive Response

Themes

- Concentrated work for adults on improving fluid balance charts, including digitalisation of fluid balance charts. Raising awareness, real time feedback to clinical team, sepsis team visibly in ED and reaching out to ambulances. Sepsis team undertaking training and analysis in inpatient ward areas, supporting clinical skills. Paediatrics have set a trajectory to improve the timely recognition and treatment of sepsis in children. (Audit on children's sepsis performance was presented at the quality committee, which demonstrated the need for improvement in compliance).
- This was the final month for the Sepsis Team to cover weekend shifts from 08:00 to 18:00 to support a 7-day cover and assist the ED and IP areas in the delivery of Sepsis 6. From October 2022, it resumes to a Mon-Fri 08:00-18:00 service.

Response

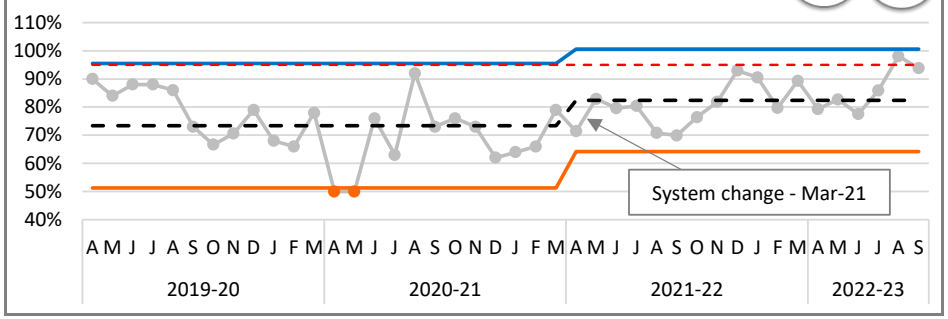
- The Sepsis Team continues to run Sepsis teaching sessions via Teams to IP areas. Continued virtual Sepsis Teaching has been delivered to 5A, 8A, 8B, and 10A.
- Sepsis E-Learning has now gone live on the ENH Academy, requiring all clinical staff in the trust (Nurses, CSW's, TNA's etc.) to complete the videos and E-Assessment. Many staff have already begun completing this and it will be promoted on the trust Newsletter WC 16/10.
- The team continues on a journey of collaborative work with DPC, CCOT, Resus, AKI, and allocated Practice Development Teams for both planned and unplanned care to improve fluid balance monitoring and documentation.
- The team begins to plan a Fluid balance E-Learning in collaboration with the AKI team (still very early stages). In the meantime, we are incorporating extra fluid balance teaching into some TEAMS teaching sessions where extra time is available.

Safe Services

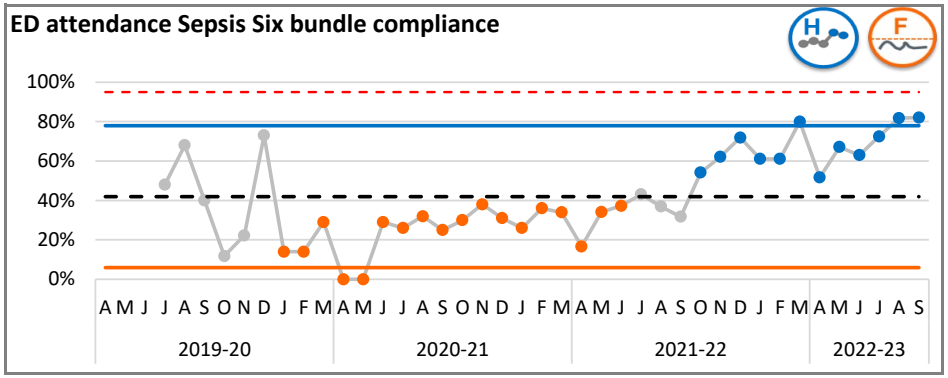
Sepsis Screening and Management | Emergency Department

East and North Hertfordshire NHS Trust

ED attendances receiving IVABs within 1-hour of red flag



ED attendance Sepsis Six bundle compliance



Themes

Sepsis ED	2021-22							2022-23				
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Oxygen	95%	94%	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%
Blood cultures	88%	93%	95%	88%	93%	90%	86%	89%	91%	87%	98%	93%
IV antibiotics	76%	82%	93%	91%	80%	89%	79%	83%	76%	86%	98%	92%
IV fluids	85%	98%	98%	98%	86%	90%	95%	86%	80%	93%	96%	96%
Lactate	80%	76%	93%	100%	87%	98%	87%	97%	95%	67%	98%	97%
Urine measure	64%	71%	76%	61%	76%	90%	69%	79%	77%	84%	81%	84%

Key Issues and Executive Response

Themes

- Normal variation in compliance of blood culture collection.
- Administration of Oxygen within the 1-hour target remains at 100%.
- Noted 6% decrease in IV antibiotic administration within 60 minutes, dropping from 98% in August to 92% in September.
- IV fluids administration within the 1-hour target remains at 96% and has been improving in ED since June.
- Noted increase in urine output measurement by 3%.
- Slight improvement in overall Sepsis 6 compliance in ED.

Response

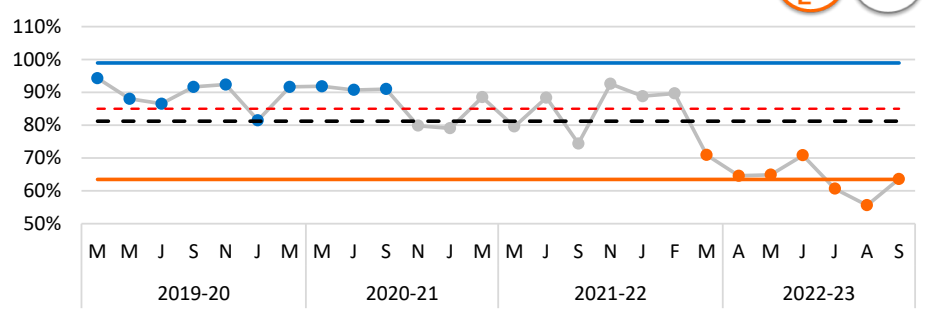
- The team is in communication with Practice Development Nurse (PDN) of ED and trainings are in place for newly qualified staff. The team is still waiting for confirmation from the ED Practice Development Team regarding training.
- In the meantime, the Sepsis E-Learning has gone live on ENH Academy for all staff (Nurses, EMT's, CSW's, TNA's etc.) in ED to access, some of which have already taken and passed the E-Assessment. The Sepsis Team continues to encourage all staff to participate in the new role-essential Academy training.
- The Sepsis Team has been continuously supporting ED by being clinically visible when a Septic patient is identified.
- The team assists the staff in completing the Sepsis 6 within an hour where possible.

Safe Services

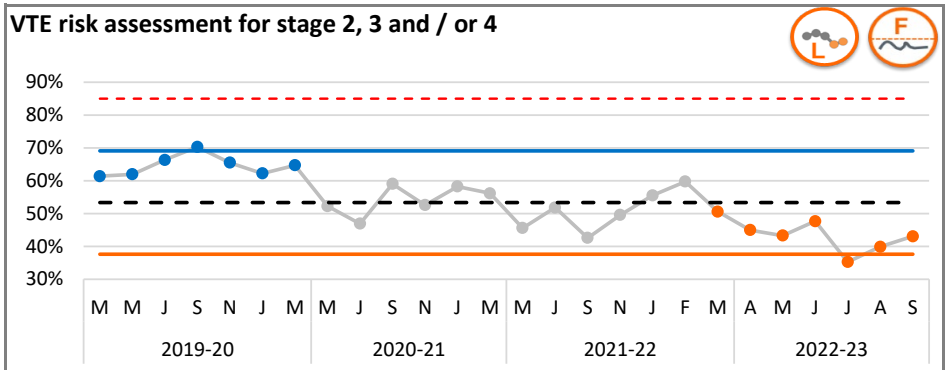
VTE Risk Assessment

East and North Hertfordshire NHS Trust

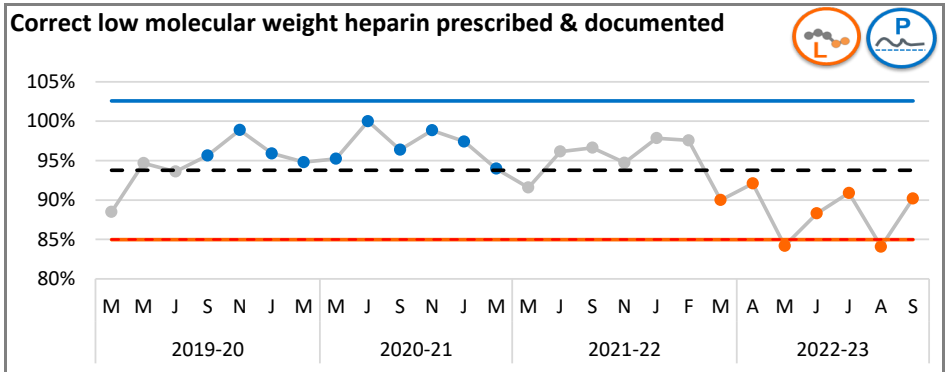
VTE risk assessment stage 1 completed



VTE risk assessment for stage 2, 3 and / or 4



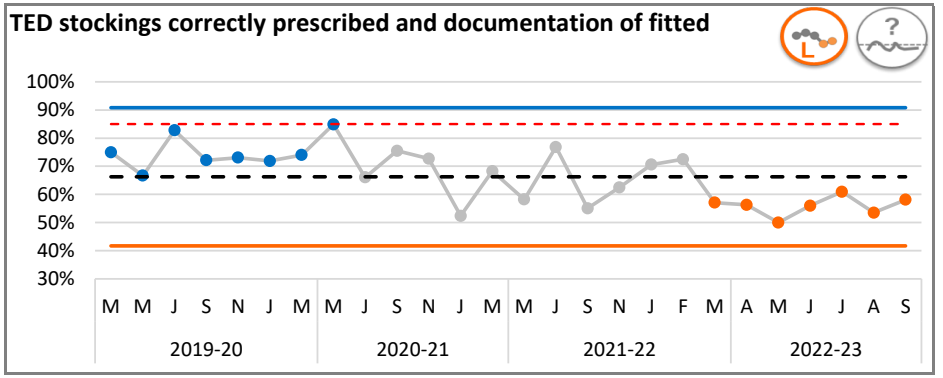
Correct low molecular weight heparin prescribed & documented



Key Issues and Executive Response

- ePMA rolled out across all adult in-patient medical and surgical wards during March 2022. From April 2022 data demonstrates full impact of the roll out on VTE risk assessments and prescribing.
- VTE digital options appraisal has been drafted, approved at KOPS and is in the beginning stages of planning.
- Established that retrospective data capture from Lorenzo is possible, in beginning stages of identifying parameters to improve audit data.
- Progression towards the appointment of a VTE consultant - strengthen clinical leadership.
- Obtained a consultant for VTE in Planned care.
- To organise regular HAT case sessions with FY1/FY2.
- Continue regular clinical engagement to share VTE data, improvement work and learning from HATs.
- Continue to monitor training figures for VTE and report the results at Thrombosis Action Group.
- Continue the on-going ward focused quality improvement work.
- Continue to improve patient engagement and review VTE patient information during admission and on discharge.

TED stockings correctly prescribed and documentation of fitted

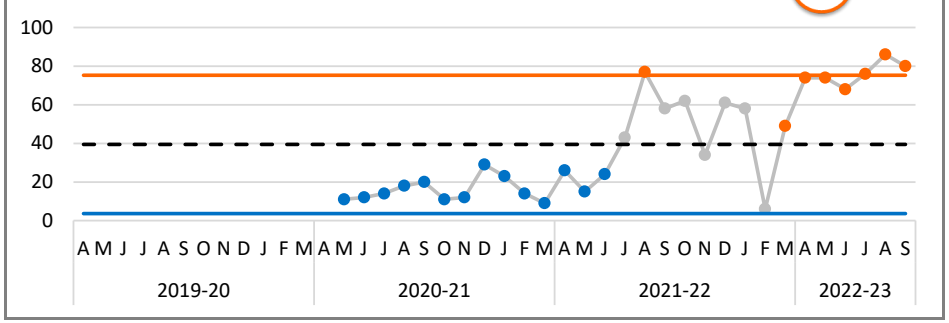


Safe Services

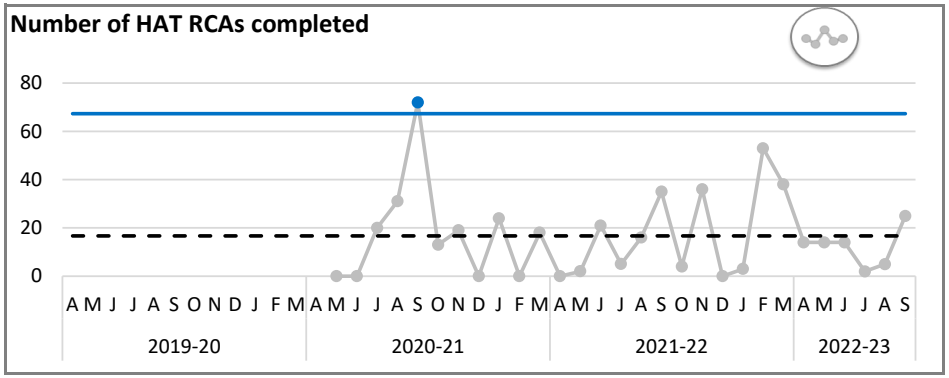
Hospital-Acquired Thrombosis (HAT)

East and North Hertfordshire NHS Trust

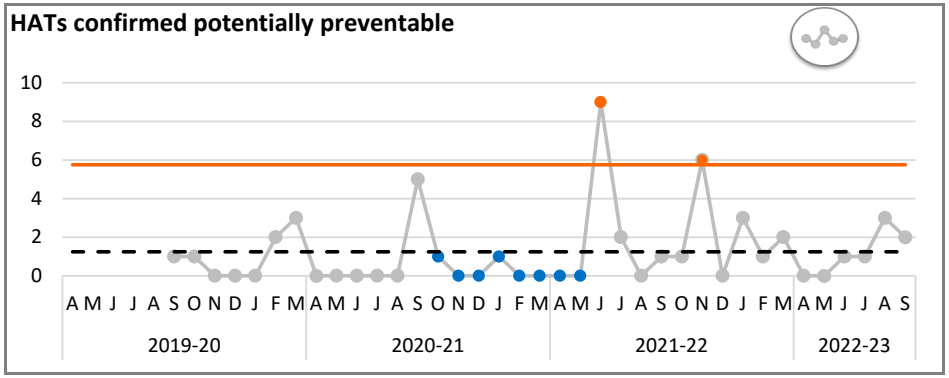
Number of HAT RCAs in progress



Number of HAT RCAs completed



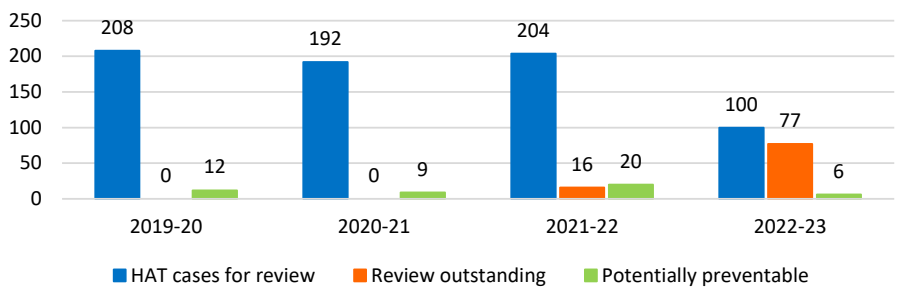
HATs confirmed potentially preventable



Key Issues and Executive Response

- Slight increase in number of HAT RCAs due to annual leave - in process of clearing backlog.
- Rapid review of HATs has allowed learning to be identified quicker and actions implemented in a timelier manner - to review this process in the coming months to identify additional pitfalls and streamline the process even more.
- HATs that are discussed at SIRP are shared at Thrombosis Action Group (TAG) to ensure the learning and associated actions have been completed.
- Organise FY1/FY2 training sessions to share learning from HATs.
- Identified Trust-wide consultant engagement with QI work.
- Planned Care consultant to help QI project and dissemination of learning from HATs to Planned Care Division.
- Continue regular clinical engagement to share VTE data, improvement work and learning from HATs.
- Continue progression towards a VTE/Thrombosis consultant - strengthen clinical leadership.

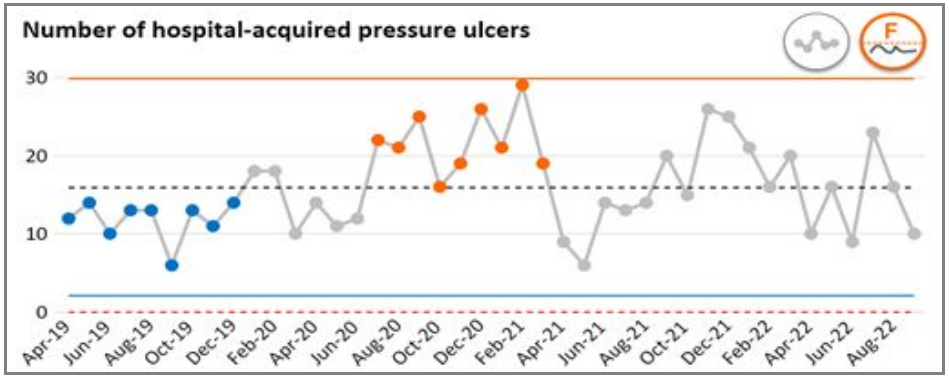
Annual HAT review prevalence

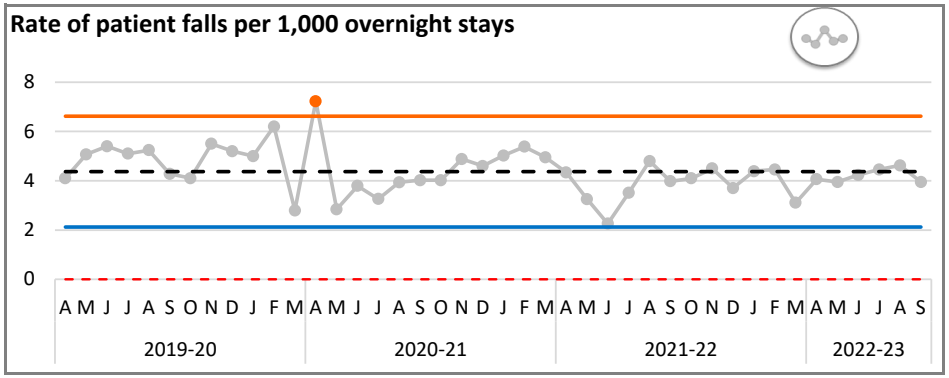


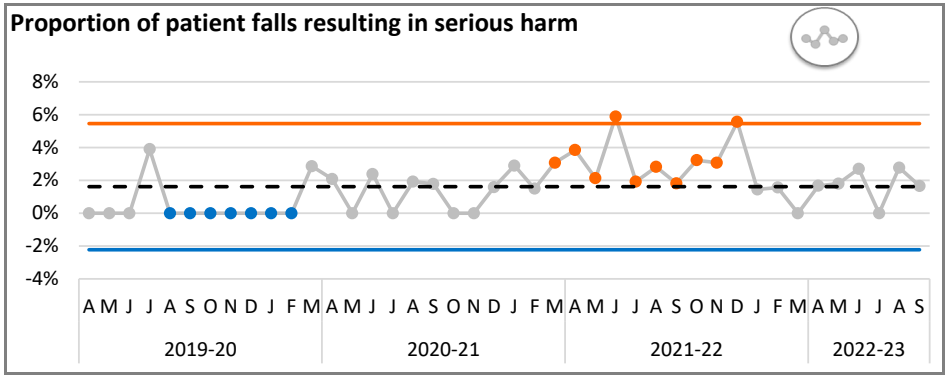
Safe Services

Pressure Ulcers | Falls

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

- 66 days since last category 4 as at 21/10/2022.
- Pressure ulcer themes:
  - Reposition = 3
  - None = 3
  - Device Care = 2
  - Awaiting root cause analysis = 1
  - Skin inspection = 1
- Completion of digital waterlow assessment within 6 hours of admission is an improvement priority - improvement is starting to happen.
- Lack of skin inspection and repositioning as main themes of learning reviews. Tissue Viability Nurse (TVN) to work on improving skin inspection and repositioning regimes following digitisation. TVN able to review assessment dashboard and focus training on areas showing red.
- TVN related assessments and care plans now live in NC and across all adult inpatient areas. this alongside increased use of WABA app allows for TVN to have greater oversight of skin issues within ward areas.
- TVN auditing staff knowledge check of PU prevention, focusing on wards with highest number and then expanding to other areas. - work ongoing to address gaps in knowledge.
- TVN attending ward team time focusing on some of the issues identified.
- Inpatient falls data continues to show common cause variation.
- Trust compliance for falls risk assessment completion on nerve centre has improved. We are currently averaging from 63% to 87% on our September/October Audit.
- Trust compliance in completing Enhanced Care Plan on Nerve Centre has improved from 54% to 61%. Still a lot of work to do to support clinical areas in improving their compliance.
- Medical staff teaching is planned in November to build will and engagement from medical doctors to share learning from delays in medical reviews post falls and encourage multidisciplinary working in Improvement work.
- QI Project in ED to reduce falls incidence has started.

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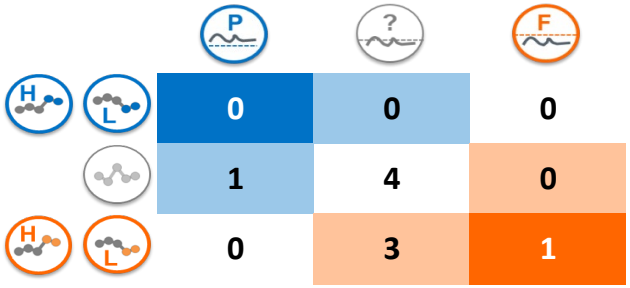
Caring Services

Month 06 | 2022-23



Caring Services

Summary

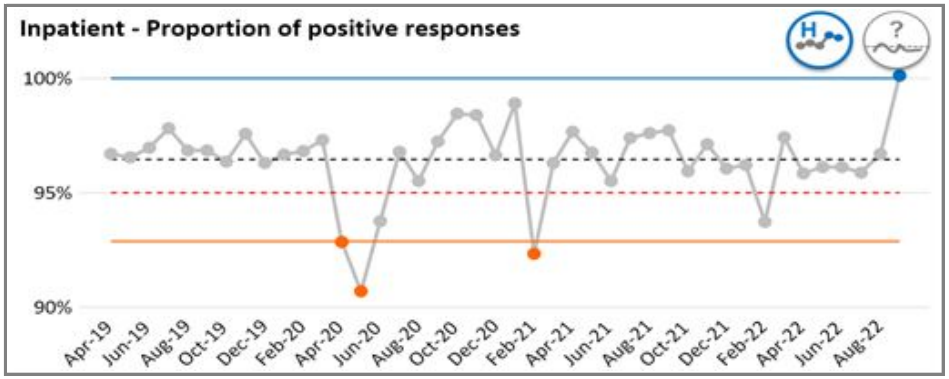
East and North Hertfordshire NHS Trust

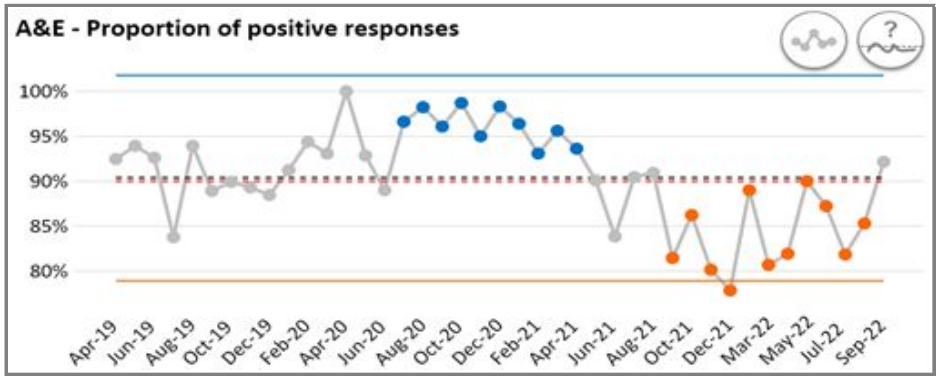
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Friends and Family Test	Inpatients positive feedback	Sep-22	95%	100.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	A&E positive feedback	Sep-22	90%	92.2%		?	Common cause variation Metric will inconsistently pass and fail the target
	Maternity Antenatal positive feedback	Sep-22	93%	0.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Maternity Birth positive feedback	Sep-22	93%	0.0%	L	?	Two points below the lower process limit Metric will inconsistently pass and fail the target
	Maternity Postnatal positive feedback	Sep-22	93%	0.0%	L	?	Two points below the lower process limit Metric will inconsistently pass and fail the target
	Maternity Community positive feedback	Sep-22	93%	87.5%		F	Common cause variation Metric will consistently fail the target
	Outpatients FFT positive feedback	Sep-22	95.0%	96.3%		?	Common cause variation Metric will inconsistently pass and fail the target
PALS	Number of PALS referrals received in-month	Sep-22		199			Common cause variation No target
Complaints	Number of written complaints received in-month	Sep-22		66			Common cause variation No target
	Number of complaints closed in-month	Sep-22		30			Common cause variation No target
	Proportion of complaints acknowledged within 3 working days	Sep-22	75%	100.0%		P	Common cause variation Metric will consistently pass the target
	Proportion of complaints responded to within agreed timeframe	Sep-22	80%	55.6%	L	?	Ten points below the mean Metric will inconsistently pass and fail the target

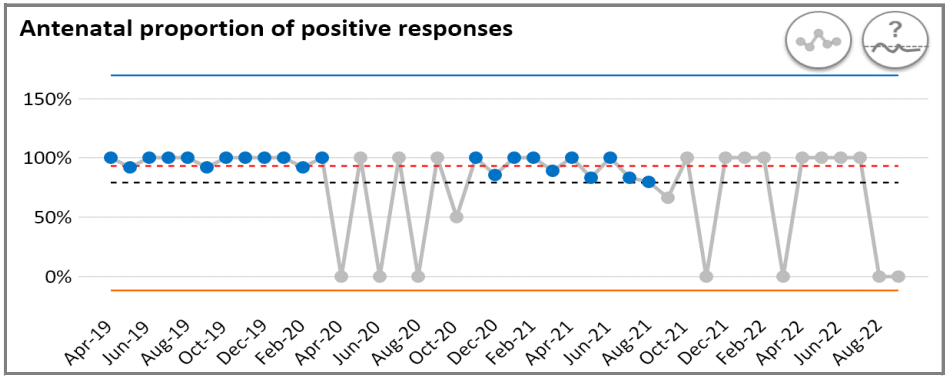
Caring Services

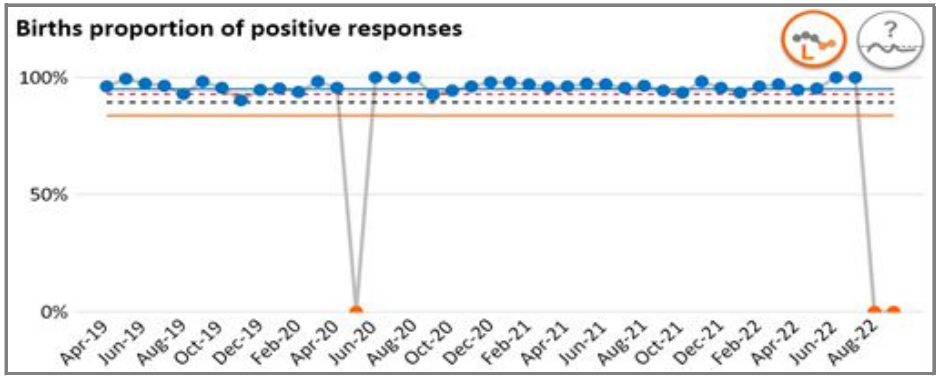
Friends and Family Test

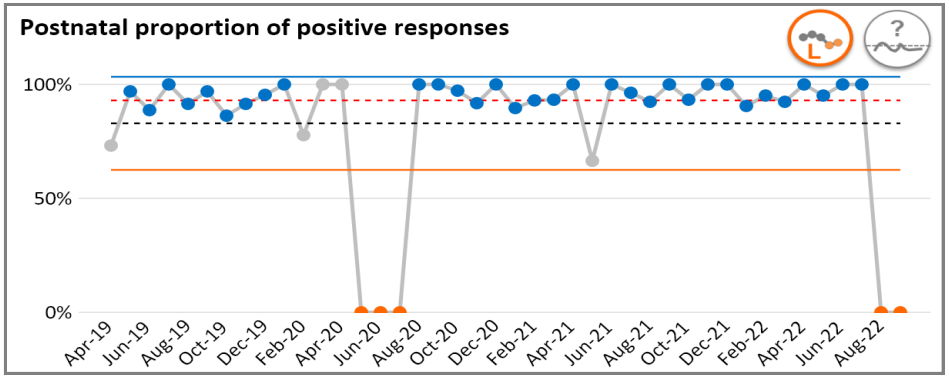
East and North Hertfordshire NHS Trust

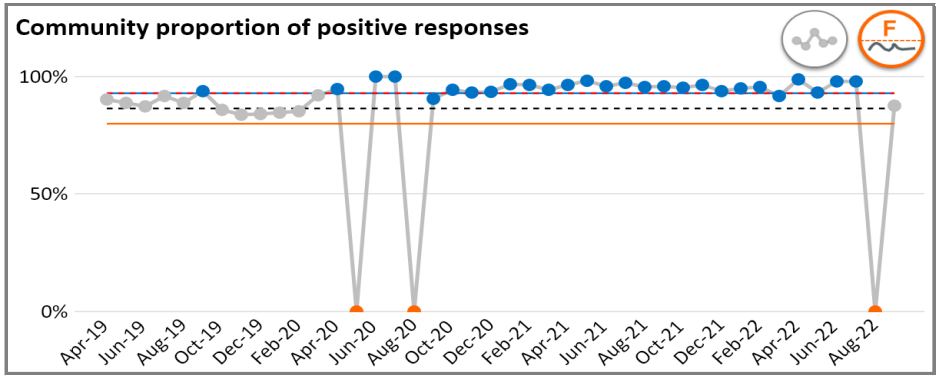








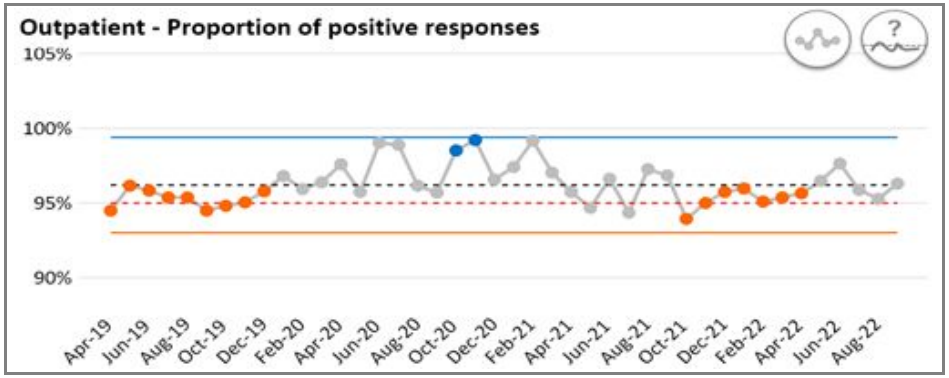


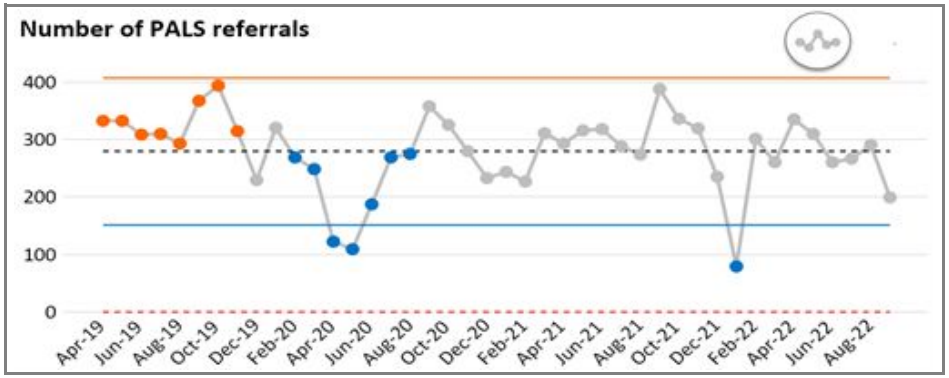


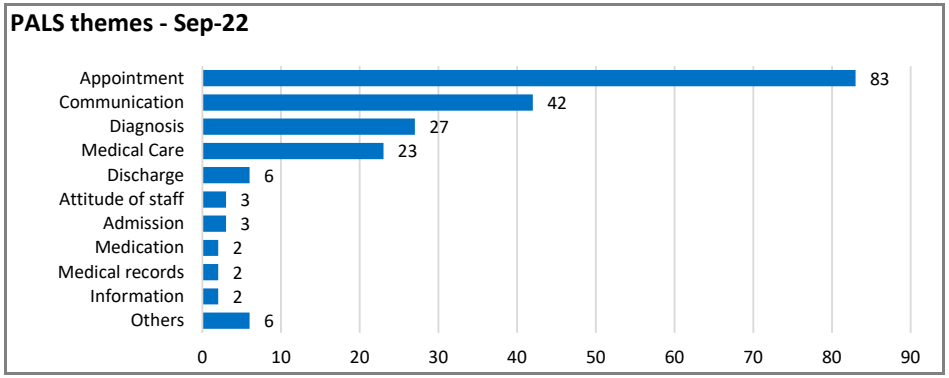
Caring Services

Friends and Family Test | Patient Advice and Liaison Service

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

Friends and Family Test

Excellence

- Inpatient and outpatient positive responses have increased past the monthly target.

Challenges

- No app has been created yet so iPads still can't be used to complete surveys

Actions

- Maternity leads have been contacted to review and comment on the significant decrease on the birth and postnatal positive response rate,
- Continue to work with ENHance to ensure that all functions and reporting systems are in place.

Patient Advice and Liaison Service

Excellence

Challenges

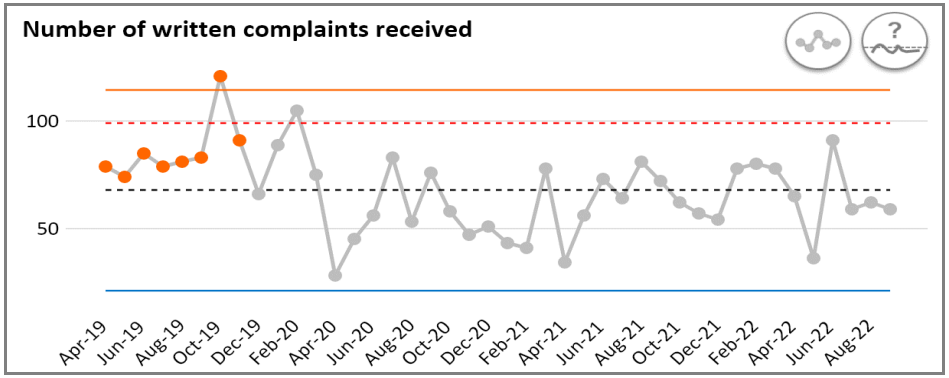
Actions

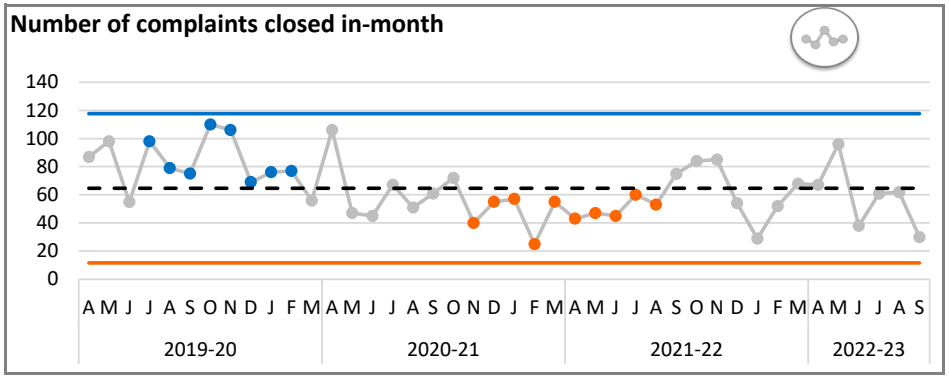
- Continue to work towards to Complaints & PALS transformation programme.
- Review of times office is open - longer opening times
- Working with services with long waiting times to look if there are any voluntary services they could use in the meantime. Signposting information needed.

Caring Services

Complaints

East and North Hertfordshire NHS Trust





Key Issues and Executive Response

Excellence

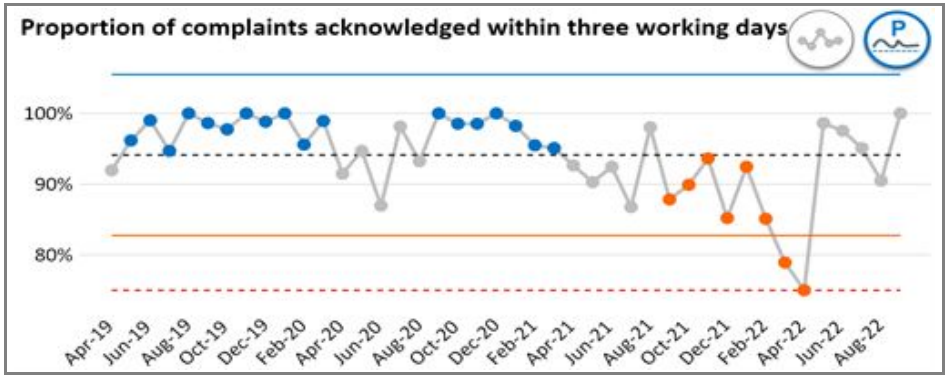
- Achieving 100% on acknowledging complaints within 3 days
- Responding to complaints within allocated timeframe has increased, we hope that this is linked to the ongoing complaints and PALS transformation project and making the Trust more aware of the current status.

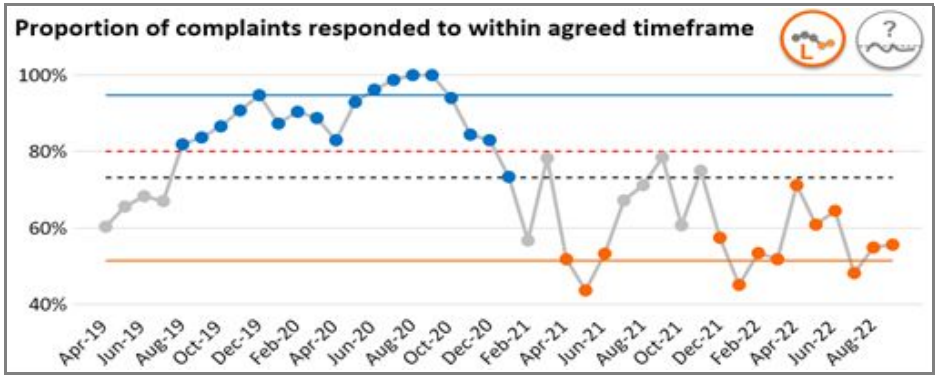
Challenges

- Number of complaints being closed has decreased due to volume of complaints coming in and no additional capacity to draft letters. Backlog of letters to draft within the team.

Actions

- Continue to work towards to Complaints & PALS transformation programme.





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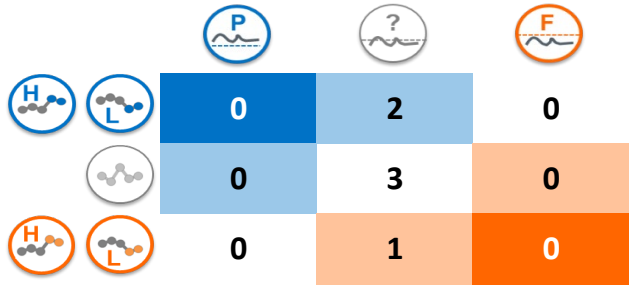
Effective Services

Month 06 | 2022-23



Effective Services

Summary

East and North Hertfordshire NHS Trust

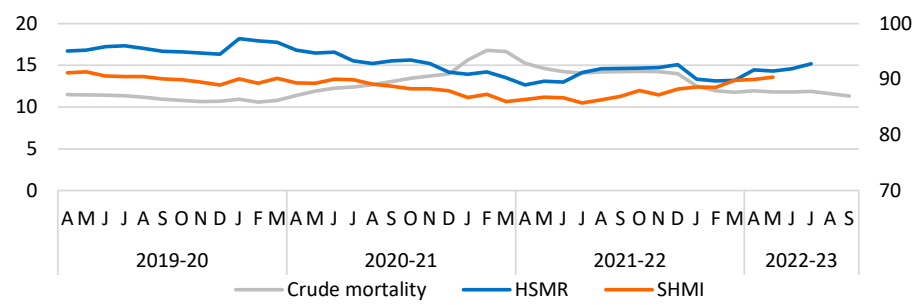
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Mortality	Crude mortality per 1,000 admissions In-month	Sep-22	12.8	9.9			Eight consecutive points below the mean Metric will inconsistently pass and fail the target
	Crude mortality per 1,000 admissions Rolling 12-months	Sep-22	12.8	11.3			Rolling 12-months - unsuitable for SPC
	HSMR In-month	Jul-22	100	106.3			Common cause variation Metric will inconsistently pass and fail the target
	HSMR Rolling 12-months	Jul-22	100	92.8			Rolling 12-months - unsuitable for SPC
	SHMI In-month	Apr-22	100	87.2			Common cause variation Metric will inconsistently pass and fail the target
	SHMI Rolling 12-months	May-22	100	90.4			Rolling 12-months - unsuitable for SPC
Re-admissions	Number of emergency re-admissions within 30 days of discharge	Jul-22	n/a	669			12 consecutive points below the mean No target
	Rate of emergency re-admissions within 30 days of discharge	Jul-22	9.0%	6.6%			14 consecutive points below the mean Metric will inconsistently pass and fail the target
Length of Stay	Average elective length of stay	Sep-22	2.8	2.1			Common cause variation Metric will inconsistently pass and fail the target
	Average non-elective length of stay	Sep-22	4.6	4.9			15 consecutive points above the mean Metric will inconsistently pass and fail the target
Palliative Care	Proportion of patients with whom their preferred place of death was discussed	Sep-22	n/a	80.6%			Common cause variation No target
	Individualised care pathways	Sep-22	n/a	29			Common cause variation No target

Effective Services

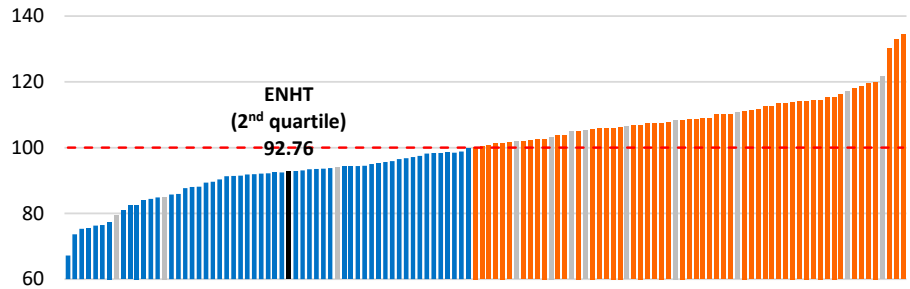
Mortality Summary

East and North Hertfordshire NHS Trust

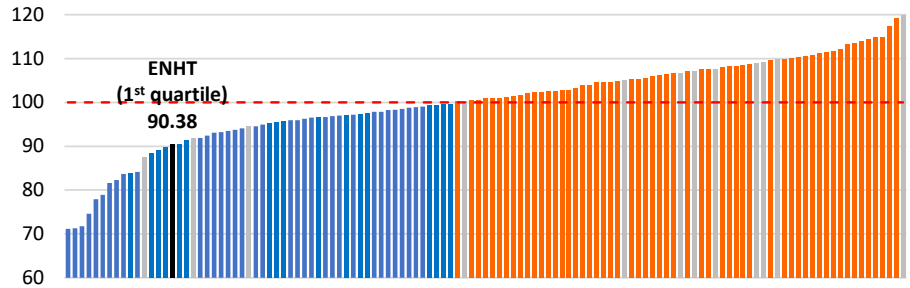
Mortality metric comparison - rolling 12-months



HSMR peer distribution - Jul-22



SHMI peer distribution - May-22



Key Issues and Executive Response

COVID-19

- To date CHKS analysis of our COVID-19 mortality has shown the Trust to well-placed in comparison to the national peer group with mortality tracking below the national trend.
- COVID-19 activity continues to be excluded from the SHMI by NHS Digital.

Learning from Deaths

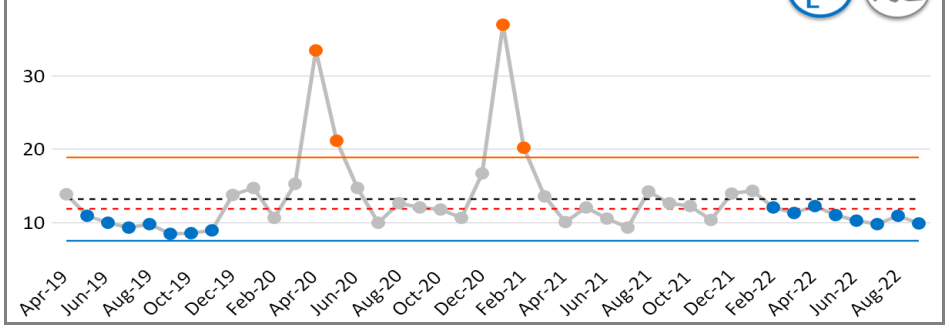
- Reforms continue regarding the Trust's learning from deaths framework, including the adoption of a SJR Plus Review format, developed by NHSE/I's 'Better Tomorrow' platform which commenced on 1 July 2022. Reforms will include the reduction in the number of reviews undertaken, with the focus being on gaining richer learning from the process.
- The SJR Plus review format, adopted by the Trust in July, is very different to our existing review tool. Its adoption provides an opportunity to revisit our broader learning from deaths processes, to take into account recent and imminent changes in the fields of scrutiny, quality and governance, including the introduction of the Medical Examiner function and the forthcoming introduction of the new PSIRF approach to patient safety.
- To provide additional clarity and focus, a Learning from Deaths Strategy has been developed which will align with the Trust's overarching strategy and the Quality strategy.

Effective Services

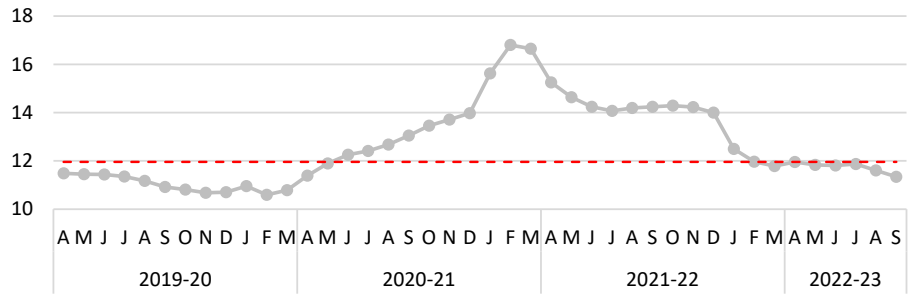
Crude Mortality

East and North Hertfordshire NHS Trust

Crude mortality per 1,000 discharges



Crude mortality per 1,000 admissions - rolling 12-months



Key Issues and Executive Response

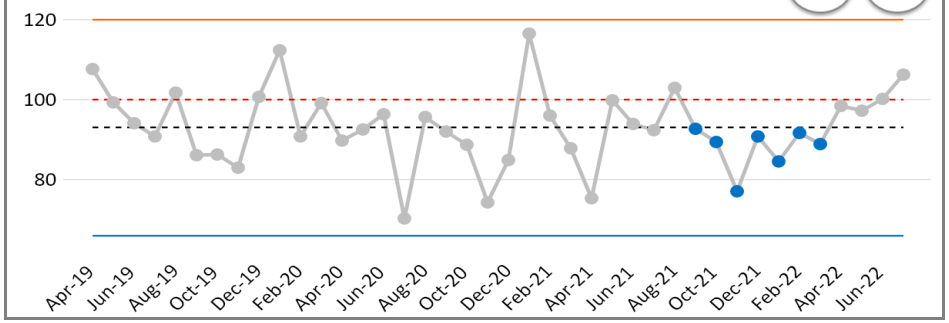
- Crude mortality is the factor with the most significant impact on HSMR. The exception was during the COVID pandemic, when the usual correlation was weakened by the partial exclusion of COVID-19 patients from the HSMR metric.
- The general improvements in mortality prior to the COVID-19 resulted from corporate level initiatives such as the learning from deaths process, focussed clinical improvement work. Of particular importance has been the continued drive to improve the quality of our coding.
- While the COVID-19 pandemic saw peaks in April 2020 and January 2021, most of the intervening and subsequent periods have seen us positioned below, or in line with, the national average, with rolling 12-month crude consistently tracking below national.

Effective Services

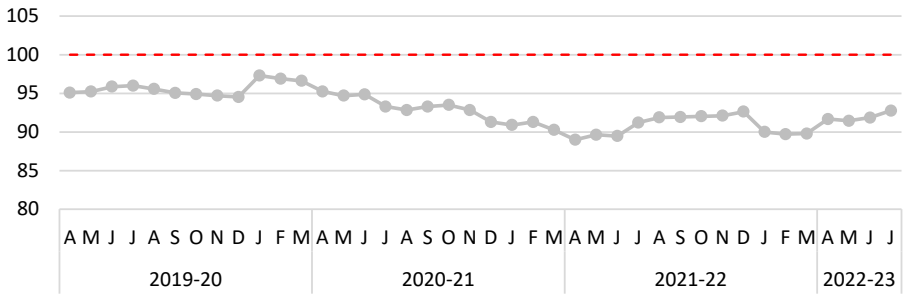
Hospital Standardised Mortality Ratio (HSMR)

East and North Hertfordshire NHS Trust

HSMR - Hospital Standardised Mortality Ratio



HSMR - rolling 12-months



HSMR - mortality alerts Aug-21 to Jul-22

CCS Group	Deaths	Value	Alert
No HSMR red (3-sigma) alerts in the 12 months to July			

Key Issues and Executive Response

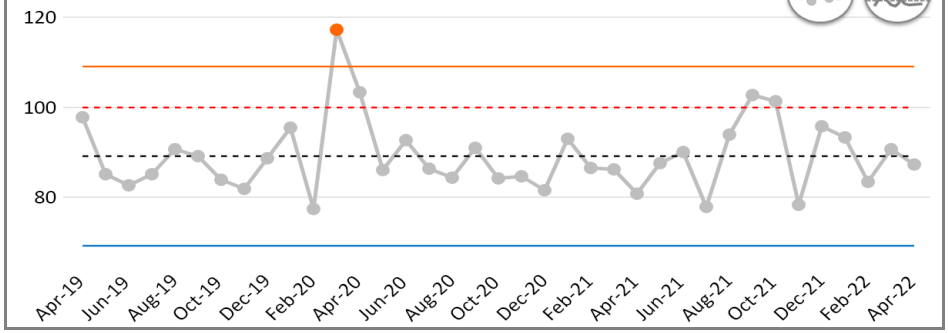
- There has been an upward trend in in-month HSMR since December 2021. This contrasts with a downward trend in crude mortality for the same period, which is unusual as HSRM tends to follow the crude metric. The reason for this is not clear but is being monitored.
- Despite this, our rolling 12-month HSMR data to July 2022 shows the Trust has remained well positioned with regard to our national and Model Hospital Peer groups.
- Following the National Hip Fracture Database 3SD outlier alert for #NOF mortality (for the period Jan-Dec 2020) work has continued on the remedial action. The Service reports that a key remaining impediment to improvement is timely access to theatre. The Medical Director is leading continuing discussions regarding how to address this issue.
- The long-awaited update to 30-day mortality according to the National Hip Fracture Database has taken place. The last reported data to December 2020, saw the Trust showing 12.3% against the national average of 8.2%. The latest data to June 2022 now sees the Trust at 7.3% vs the national average of 5.7%. Although still above the national average this represents a significant improvement.

Effective Services

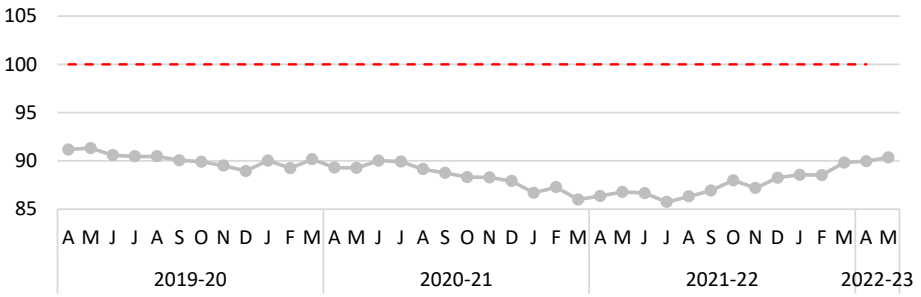
Summary Hospital-level Mortality Index (SHMI)

East and North Hertfordshire NHS Trust

SHMI - Summary Hospital-level Mortality Indicator



SHMI - rolling 12-months



SHMI - mortality alerts May-21 to Apr-22

SHMI Group	Deaths	Value	Alert
91 - 142, 148: Appendiceal conditions, Peritonitis & intestinal abscess	12	238.8	R
107 - 197: Skin and subcutaneous tissue infections	30	190.6	R
108 - 198, 199, 200: Skin disorders	30	268.3	R

Key Issues and Executive Response

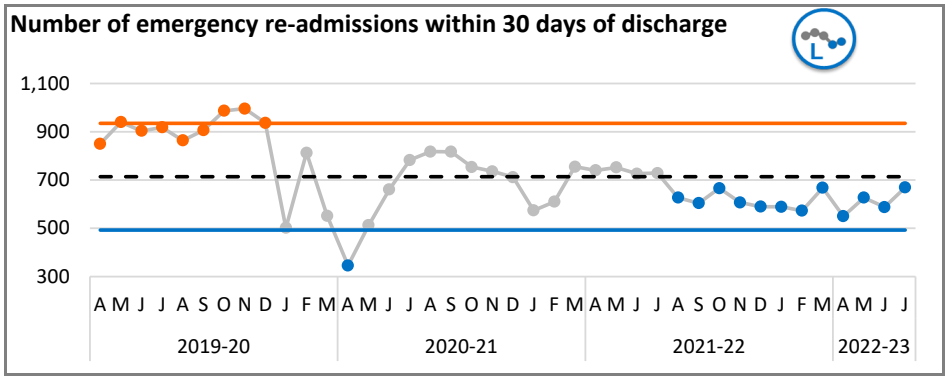
Please note: SHMI data was not updated on CHKS at the time of writing.

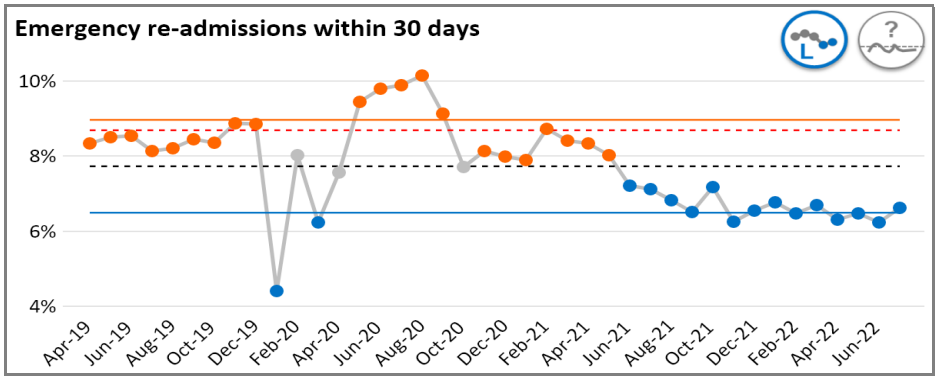
- The latest in-month position for March 2022 reported by CHKS shows common cause variation.
- Latest published rolling 12-month SHMI to May 2022 increased slightly to 90.38.
- This positions the Trust just outside the 'lower than expected' band.
- SHMI alerts are routinely discussed by the Mortality Surveillance Committee.
- Alerts are considered in conjunction with other metrics and current performance information.
- Where further review is deemed appropriate, this starts with a Coding review. The detail of this is used to determine the need for further action, potentially involving a clinical review of the deaths underpinning the alert, or joint remedial work between coding and the clinical specialty.
- The 3 SHMI alerts were discussed at October Mortality Surveillance Committee. Outputs from a coding review of the Appendiceal conditions alert showed a number of coding errors which have been corrected. Coding reviews of the deaths underpinning the remaining 2 skin associated alerts were agreed.

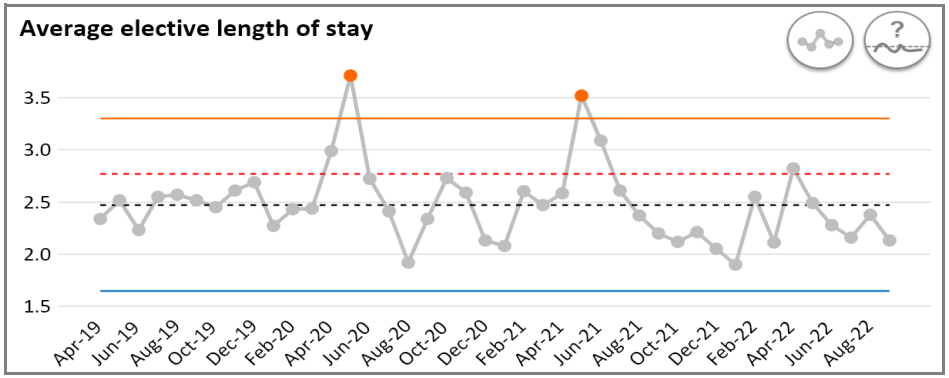
Effective Services

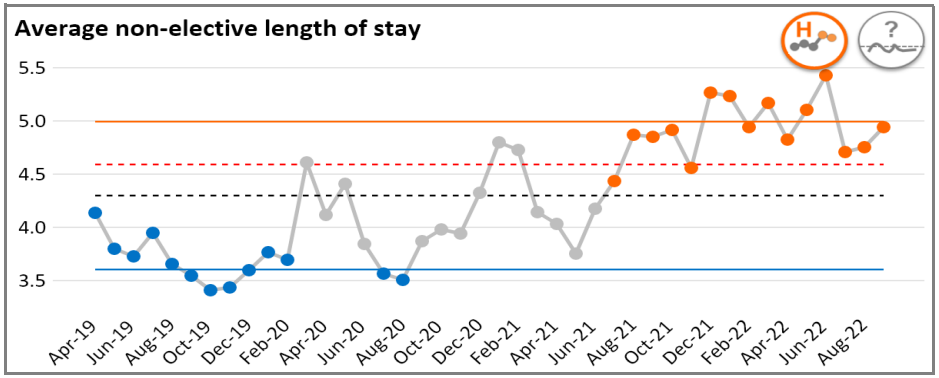
Emergency Re-admissions | Length of Stay

East and North Hertfordshire NHS Trust









Key Issues and Executive Response

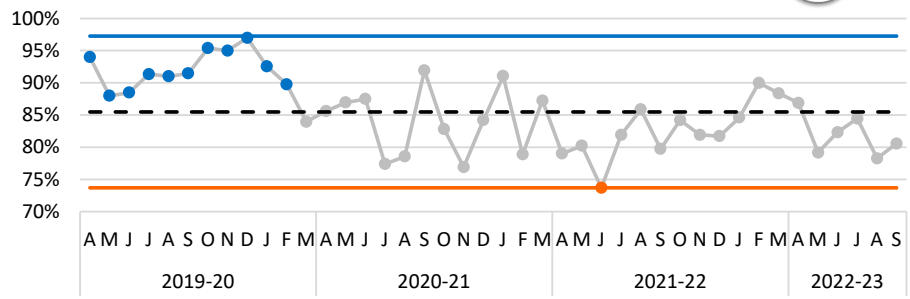
- Recent months have seen re-admissions performance improve, with the Trust consistently tracking below the national average.
- The Trust's performance is well positioned in comparison to our Model Hospital peer group.
- Recent months have seen a consistent upward trend in average non-elective length of stay (LoS).
- A review was undertaken to look at the deaths of Medically Optimised (MO) patients whose discharges were delayed and who subsequently died in hospital between January-June 2022. At October Mortality Surveillance Committee, it was agreed the cohort of patients reviewed should be expanded to cover those whose MO status had reversed prior to death. Outputs of both will be reported together.

Effective Services

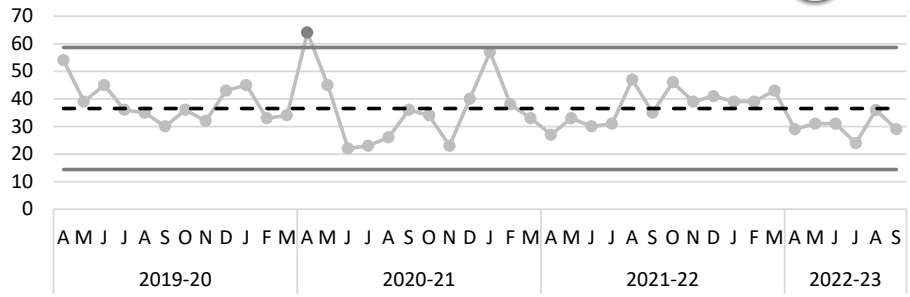
Palliative Care

East and North Hertfordshire NHS Trust

Patients with whom their preferred place of death was discussed



Individualised care pathways



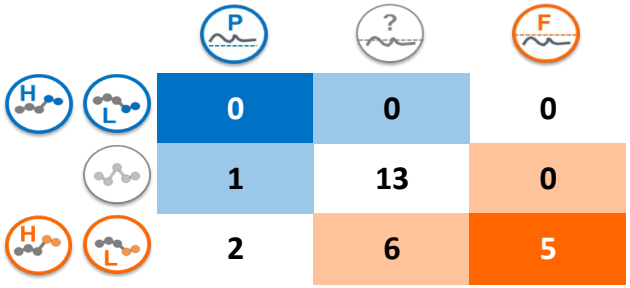
Key Issues and Executive Response

- The data provided shows the portion of patients with whom their preferred place of death has been discussed. While the last 12 months have seen periods of improvement, these have yet to be sustained. The rate currently stands at 80.6%.
- It should be noted that currently only the Palliative Care team collect preferred place of death data, meaning that this figure does not represent the Trust as a whole. Work is on-going to address this.
- The incidence of individualised care pathways has remained relatively stable but has recently dipped below the mean.
- From 5 September the current Do No Attempt CPR (DNACPR) form has been replaced with the ReSPECT form. The new form provides an individualised summary of emergency care that puts the patient at the centre of a shared decision-making process. It focuses on treatments to be given and not just on the withdrawal of one (CPR).

East and North Hertfordshire NHS Trust

Responsive Services

Month 06 | 2022-23



Responsive Services

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Emergency Department	Patients waiting no more than four hours from arrival to admission, transfer or discharge	Sep-22	95%	66.4%	L	F	13 consecutive points below the lower process limit Metric will consistently fail the target
	Patients waiting more than 12 hours from arrival to admission, transfer or discharge	Sep-22	2%	9.2%	H	?	12 consecutive points above the upper process limit Metric will inconsistently pass and fail the target
	Percentage of ambulance handovers within 15-minutes	Sep-22	65%	3.4%	L	F	14 consecutive points below the lower process limit Metric will consistently fail the target
	Time to initial assessment - percentage within 15-minutes	Sep-22	80%	54.6%	L	F	17 consecutive points below the mean Metric will consistently fail the target
	Average (mean) time in department - non-admitted patients	Sep-22	240	201.8	H	P	8 consecutive points above the upper process limit Metric will consistently pass the target
	Average (mean) time in department - admitted patients	Sep-22	tbc	605.1	H		12 consecutive points above the upper process limit No target
	Average minutes from clinically ready to proceed to departure	Sep-22	tbc	452			Insufficient data points for SPC analysis
	Critical time standards	Sep-22	tbc				Pending data
RTT & Diagnostics	Patients on incomplete pathways waiting no more than 18 weeks from referral	Sep-22	92%	52.5%	L	F	Twenty consecutive points below the mean Metric will consistently fail the target
	Patients waiting more than six weeks for diagnostics	Sep-22	0%	53.7%	H	F	10 consecutive points above the upper process limit Metric will consistently fail the target

Responsive Services

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cancer Waiting Times	Two week waits for suspected cancer	Aug-22	93%	90.6%	L	?	One point below lower process limit Metric will inconsistently pass and fail the target
	Two week waits for breast symptoms	Aug-22	93%	87.1%		?	Common cause variation Metric will inconsistently pass and fail the target
	28-day faster diagnosis	Aug-22	75%	72.60%	L	?	Ten consecutive points below the mean Metric will inconsistently pass and fail the target
	31-days from diagnosis to first definitive treatment	Aug-22	96%	96.10%		?	Common cause variation Metric will inconsistently pass and fail the target
	31-days for subsequent treatment - anti-cancer drugs	Aug-22	98%	98.90%		P	Common cause variation Metric will consistently pass the target
	31-days for subsequent treatment - radiotherapy	Aug-22	94%	95.40%	L	P	One point below the lower process limit Metric will consistently pass the target
	31-days for subsequent treatment - surgery	Aug-22	94%	77.80%		?	Common cause variation Metric will inconsistently pass and fail the target
	62-days from urgent GP referral to first definitive treatment	Aug-22	85%	82.60%		?	Common cause variation Metric will inconsistently pass and fail the target
	Patients waiting more than 104-days from urgent GP referral to first definitive treatment	Aug-22	0	13.5	H	?	One point above the upper process limit Metric will inconsistently pass and fail the target
	62-days from referral from an NHS screening service to first definitive treatment	Aug-22	90%	83.3%		?	Common cause variation Metric will inconsistently pass and fail the target
	62-days from consultant upgrade to first definitive treatment	Aug-22	n/a	83.3%			Common cause variation No target

Responsive Services

Summary

East and North Hertfordshire NHS Trust

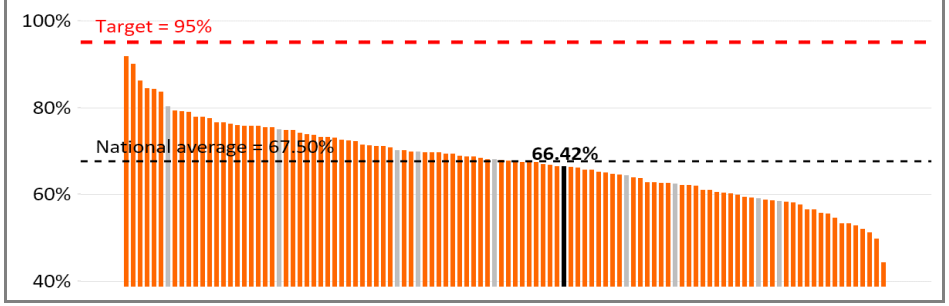
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Stroke Services	Trust SSNAP grade	Q1 2022-23	A	D			
	% of patients discharged with a diagnosis of Atrial Fibrillation and commenced on anticoagulants	Sep-22	80%	83.3%			Common cause variation Metric will inconsistently hit and miss the target
	4-hours direct to Stroke unit from ED	Sep-22	63%	14.3%			3 consecutive points below the lower process limit Metric will inconsistently hit and miss the target
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	Sep-22	63%	13.5%			6 consecutive points below the lower process limit Metric will inconsistently hit and miss the target
	Number of confirmed Strokes in-month on SSNAP	Sep-22	n/a	63			Common cause variation No target
	If applicable at least 90% of patients' stay is spent on a stroke unit	Sep-22	80%	92.1%			Common cause variation Metric will inconsistently hit and miss the target
	Urgent brain imaging within 60 minutes of hospital arrival for suspected acute stroke	Sep-22	50%	49.2%			Common cause variation Metric will inconsistently hit and miss the target
	Scanned within 12-hours - all Strokes	Sep-22	100%	100.0%			Common cause variation Metric will inconsistently hit and miss the target
	% of all stroke patients who receive thrombolysis	Sep-22	11%	4.7%			Common cause variation Metric will inconsistently hit and miss the target
	% of patients eligible for thrombolysis to receive the intervention within 60 minutes of arrival at A&E (door to needle time)	Sep-22	70%	66.7%			Common cause variation Metric will inconsistently hit and miss the target
	Discharged with JCP	Sep-22	80%	81.0%			Common cause variation Metric will inconsistently hit and miss the target
	Discharged with ESD	Sep-22	40%	58.5%			Common cause variation Metric will inconsistently hit and miss the target

Responsive Services

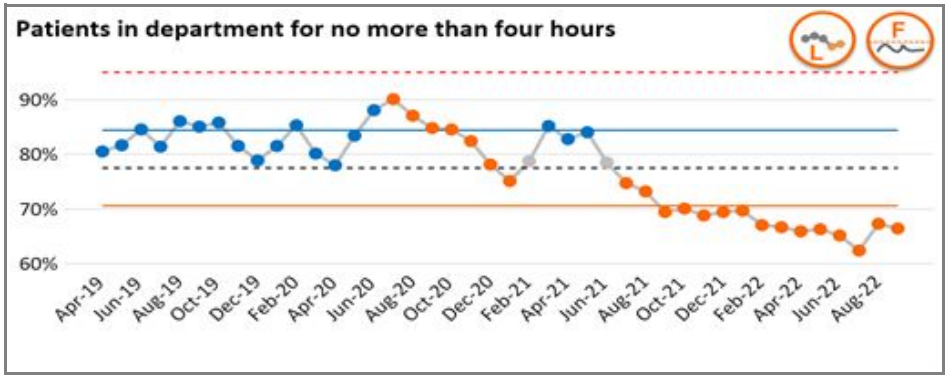
Emergency Department

East and North Hertfordshire NHS Trust

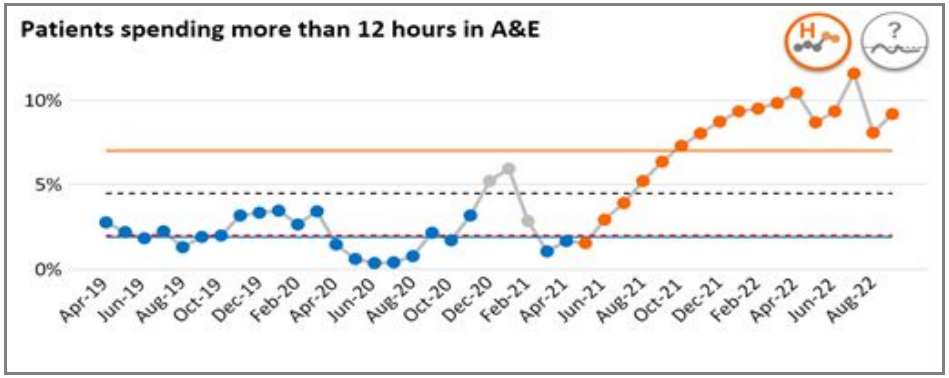
Patients waiting no more than 4-hours in ED peer distribution - Sep-22



Patients in department for no more than four hours



Patients spending more than 12 hours in A&E



Key Issues and Executive Response

Actions

- The Trust held a UEC workshop from which a rapid UEC action plan has been created. Some of the key actions include UTC style working at Adult ED by mid to late November and increasing SDEC productivity across both planned and unplanned specialities once children's ED vacates their temporary location towards the end of October. In addition, ophthalmology and the early pregnancy unit have introduced new pathways for the patients to reduce footfall via adult ED.
- Where possible senior medical support has been introduced at ED Streaming (formally known as Hello) to maximise redirection.

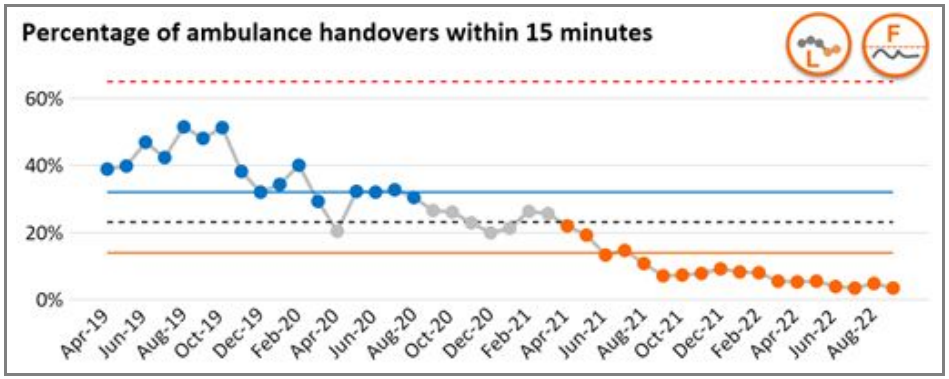
Challenges

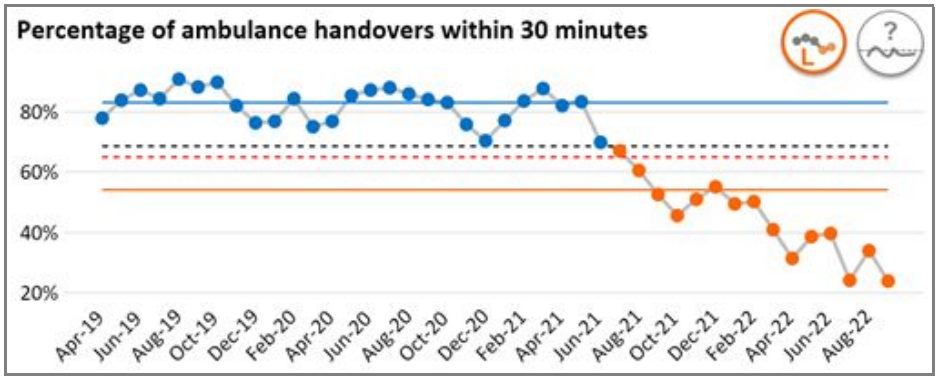
- Attendances remain well above the pre-pandemic mean. Whilst the number of ambulance arrivals appear to be reducing month on month, average daily attendances and average monthly attendances remain relatively static with walk-ins replacing ambulance arrivals.
- Surge ED cubicles were required, and the 2 triage assessment rooms were often converted to cubicle spaces.
- Admission conversion rates remained low despite an increase for the 4th consecutive month.
- The number of patients who don't meet the criteria to reside remains between 70 to 80 patients on average per day. There has been a considerable amount of work to ensure accurate capture of data. Further work is required on weekend data, which is linked with the ward round and discharge project. After being declared Medically Optimised (MO), patients have on average an additional length of stay of about 1.6 days, based on data from April to September 2022. The reasons are split between external factors and internal factors. The teams will continue to work on improving this position through identification of those factors that are within the Trust's gift to improve, such as medicine management.

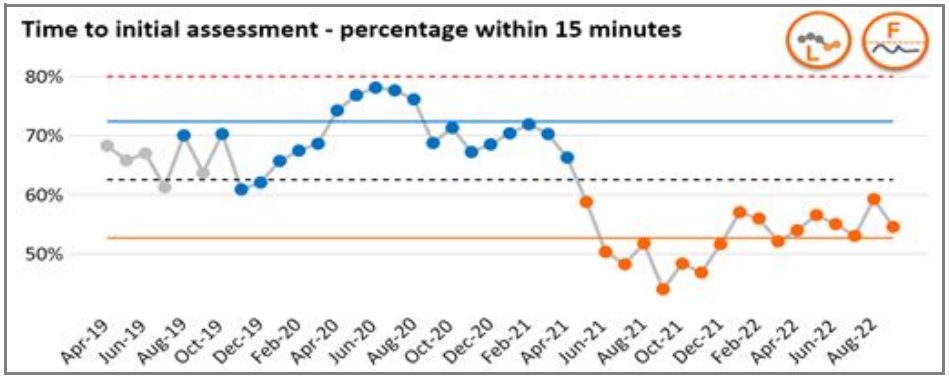
Responsive Services

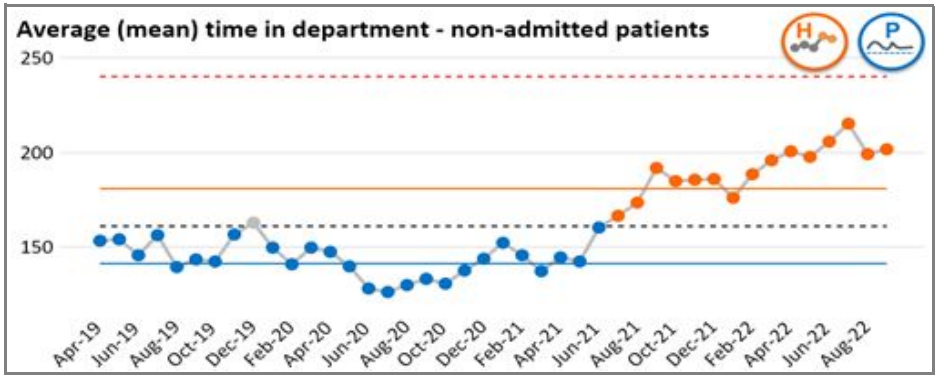
Emergency Department New Standards

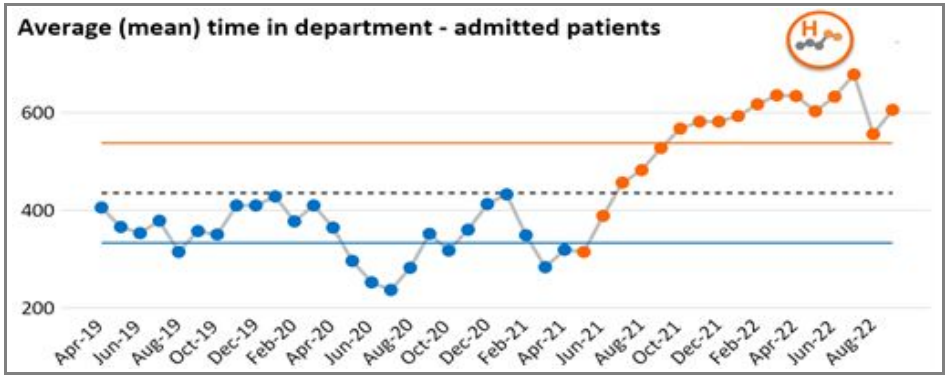
East and North Hertfordshire NHS Trust

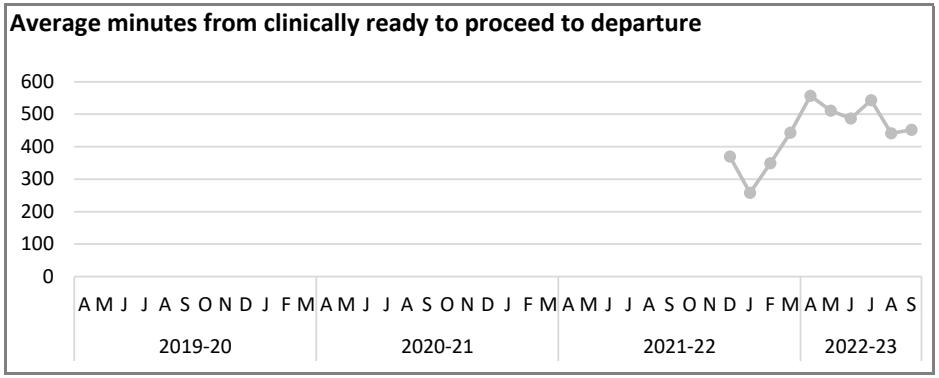










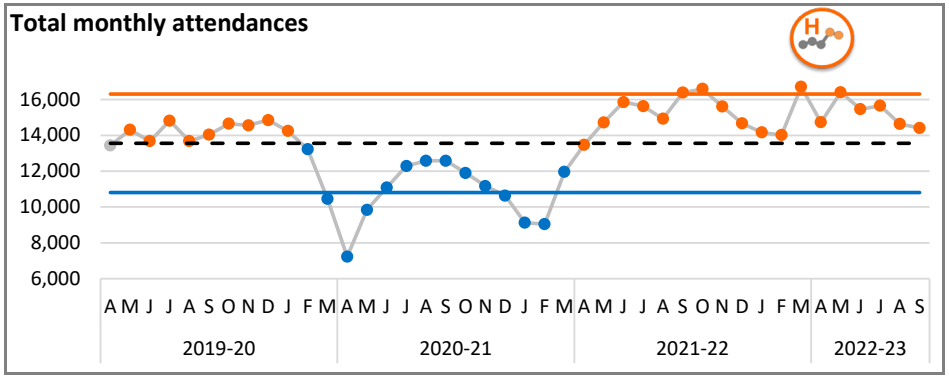


Responsive Services

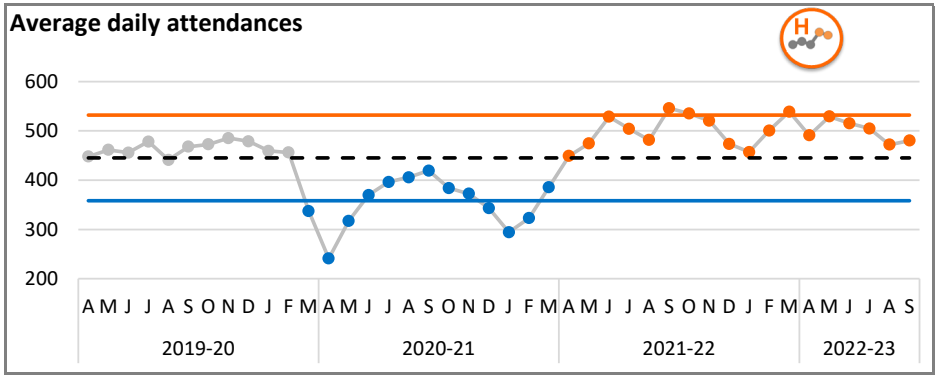
Emergency Department Supporting Metrics

East and North Hertfordshire NHS Trust

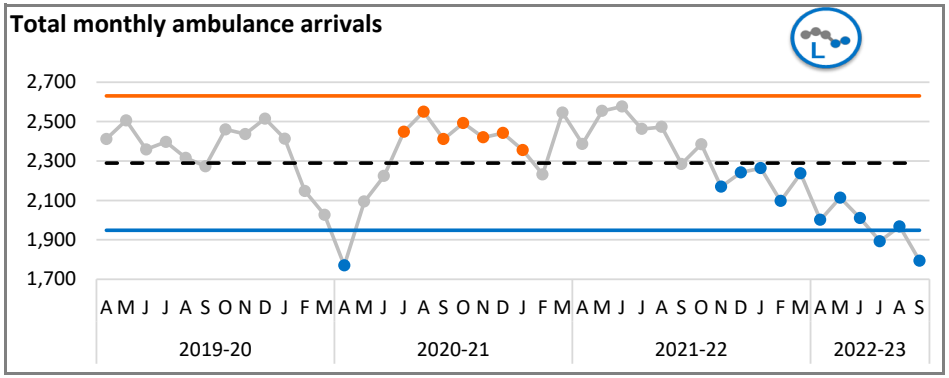
Total monthly attendances



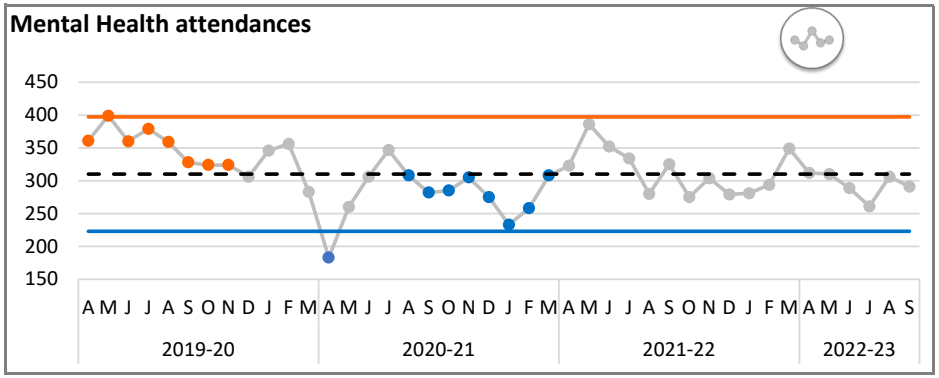
Average daily attendances



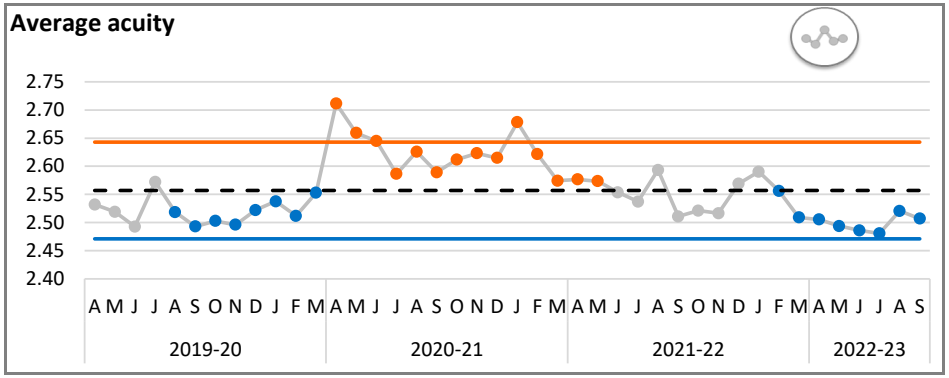
Total monthly ambulance arrivals



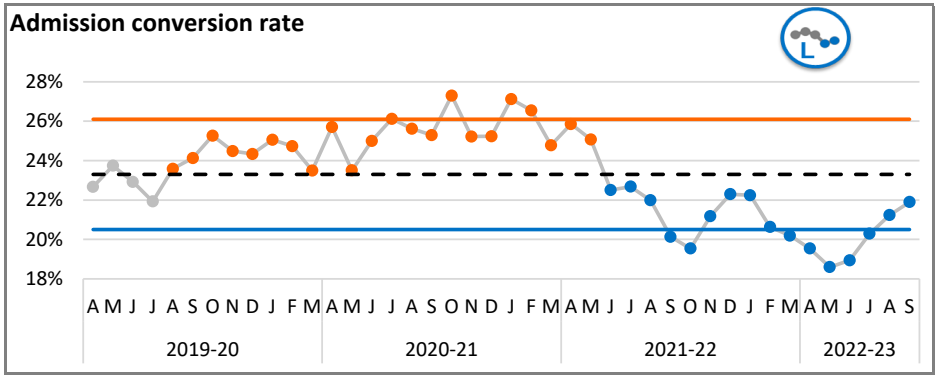
Mental Health attendances



Average acuity



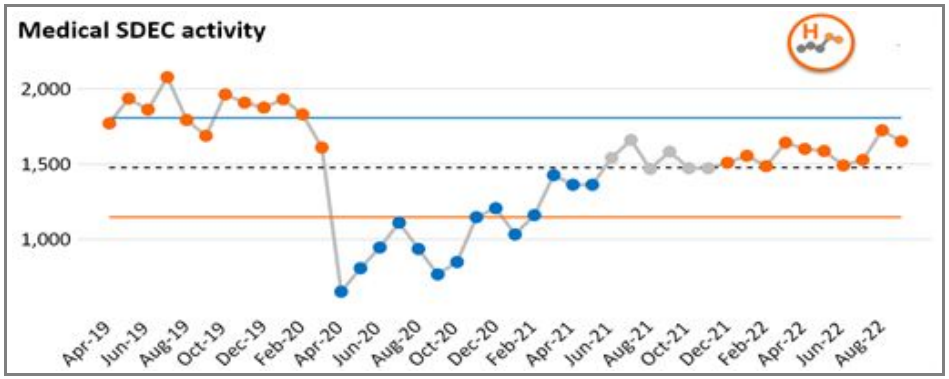
Admission conversion rate

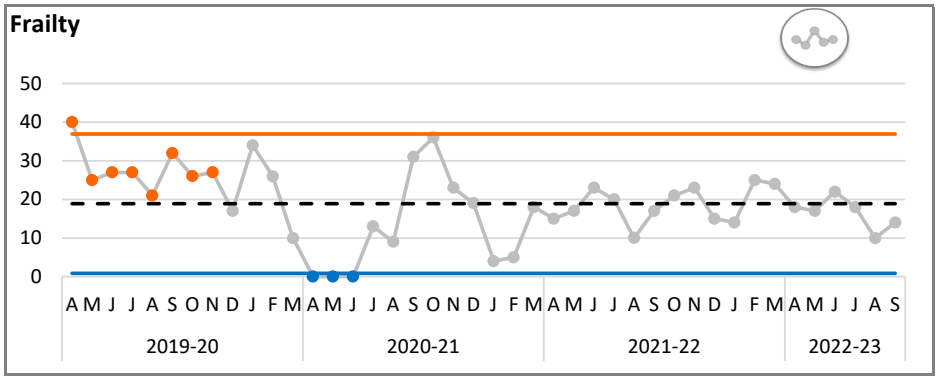


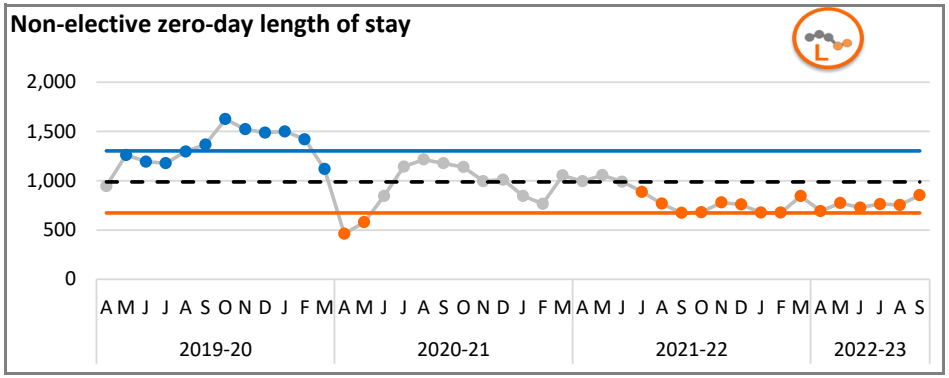
Responsive Services

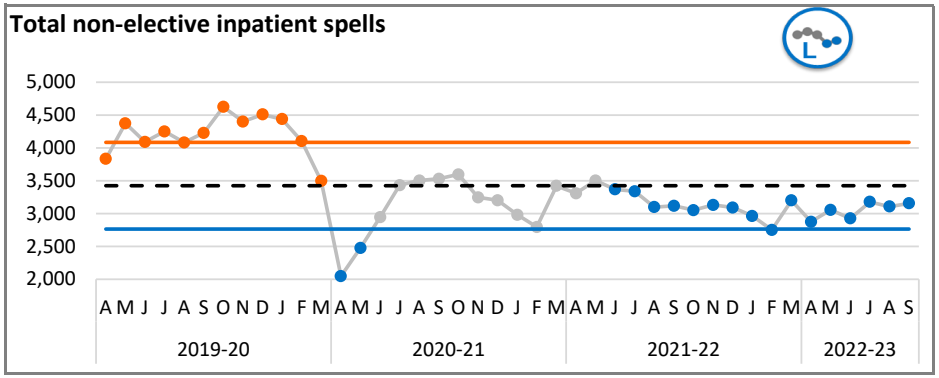
Emergency Department Supporting Metrics

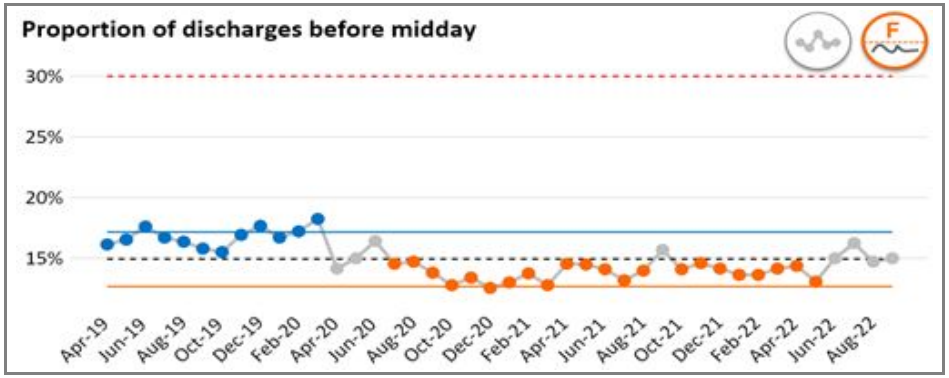
East and North Hertfordshire NHS Trust

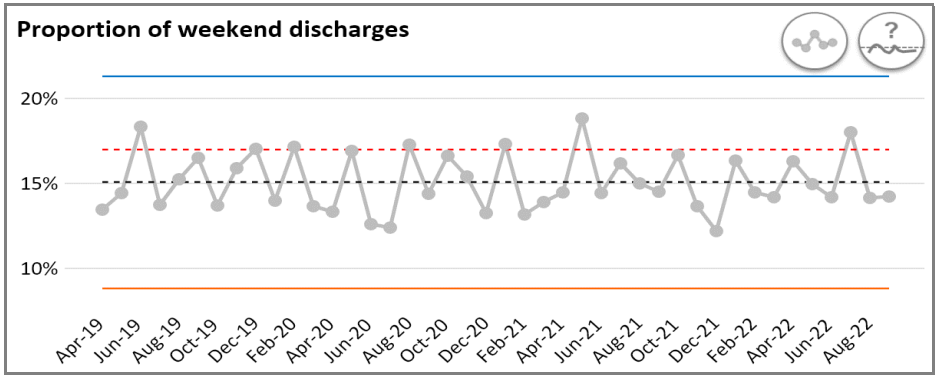








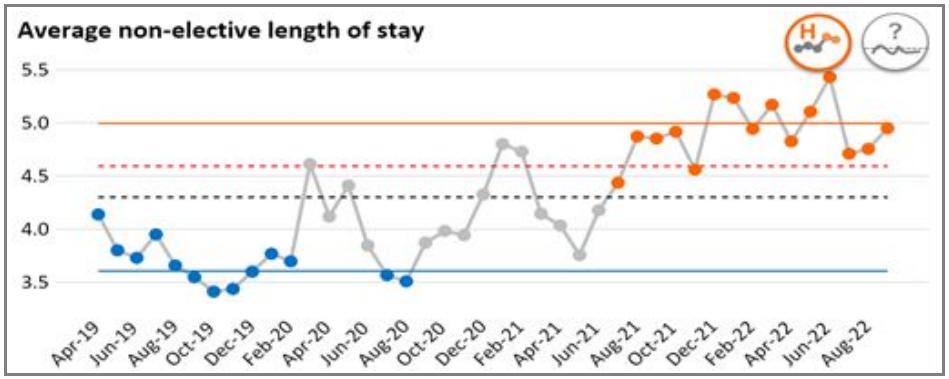


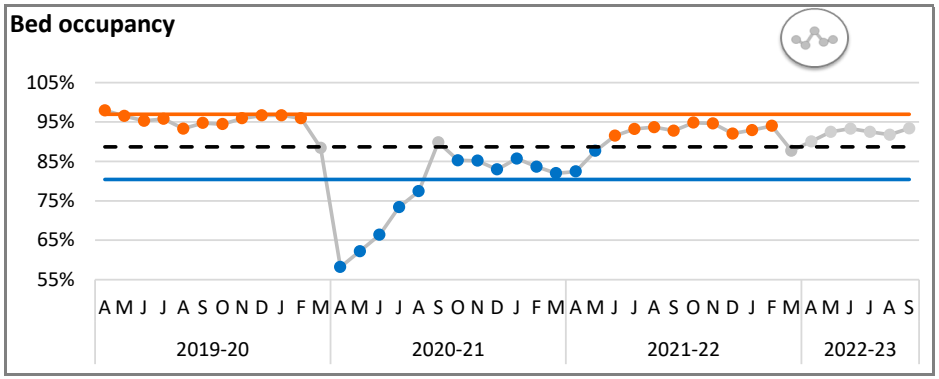


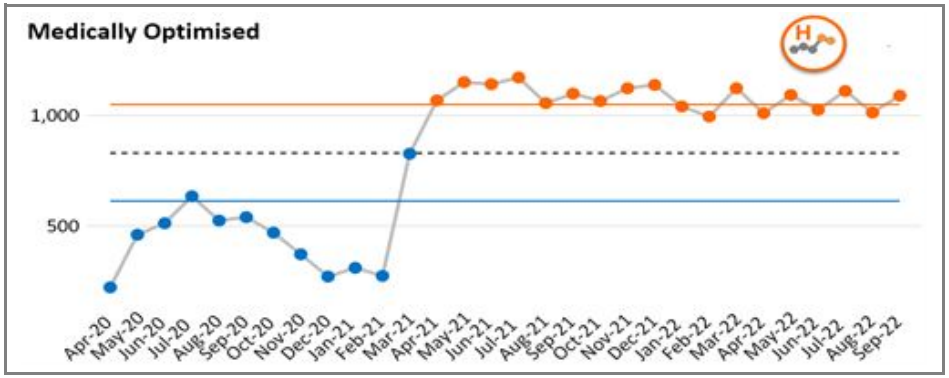
Responsive Services

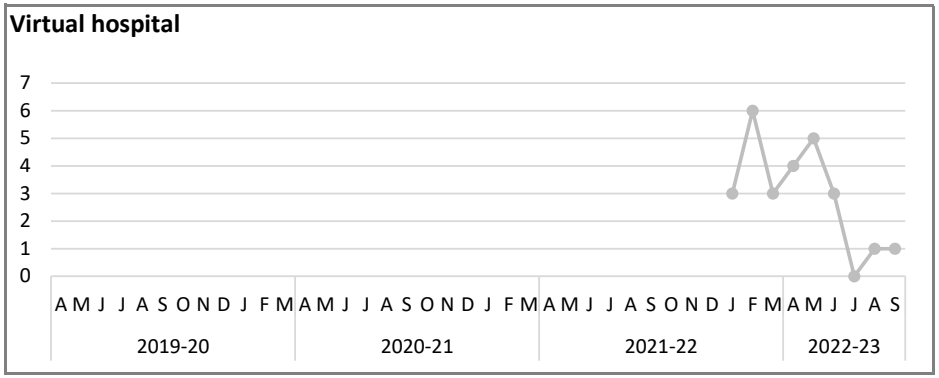
Emergency Department Supporting Metrics

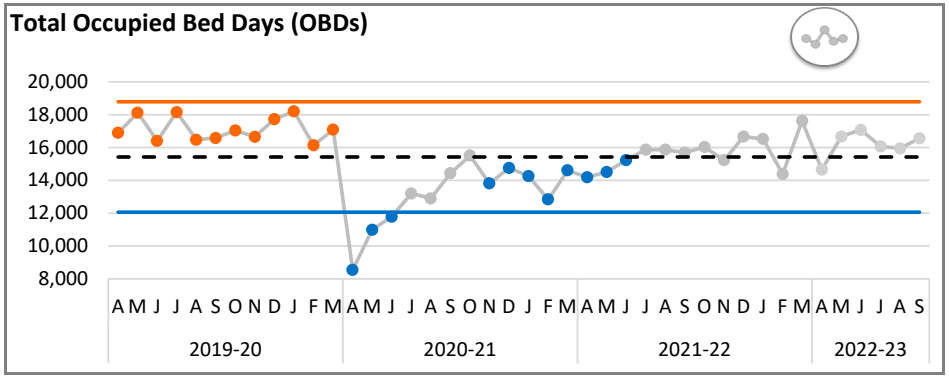
East and North Hertfordshire NHS Trust

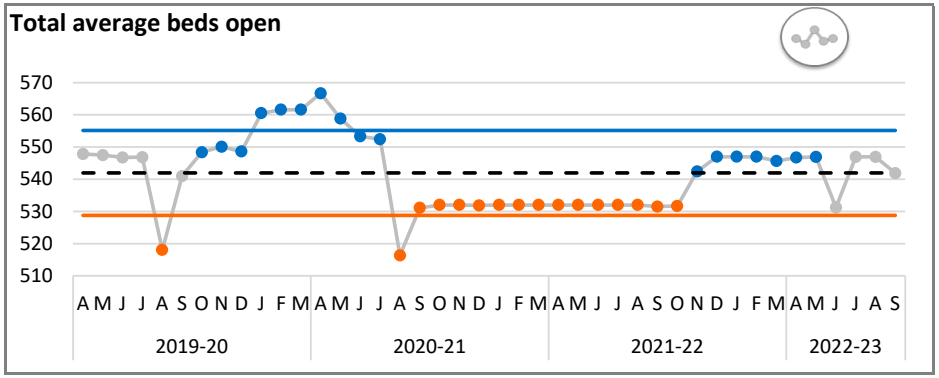








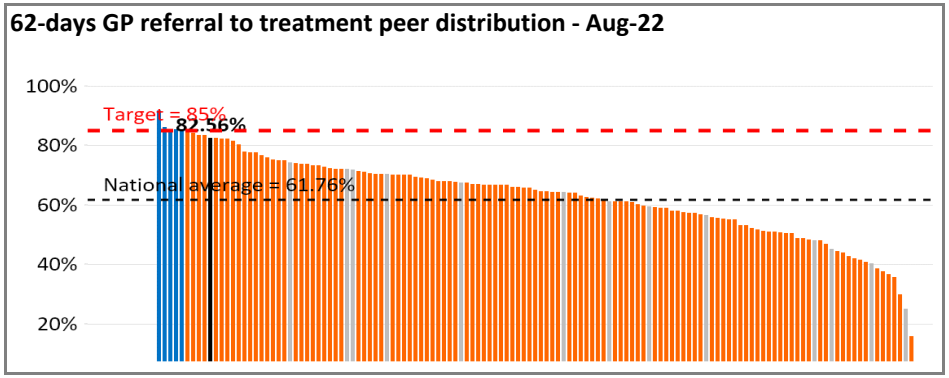


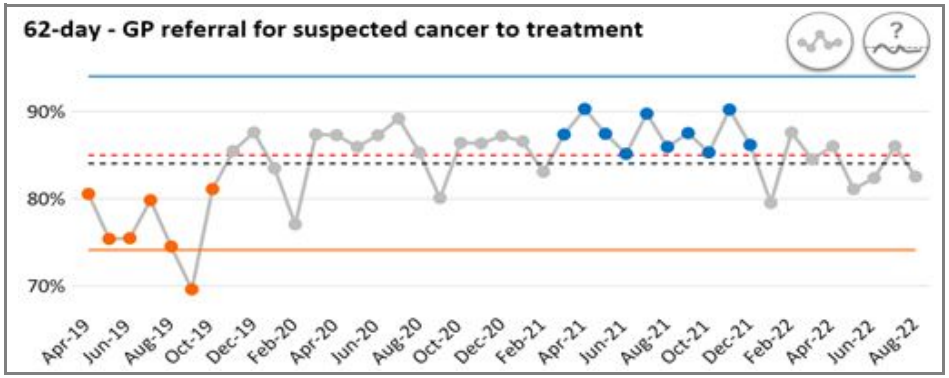


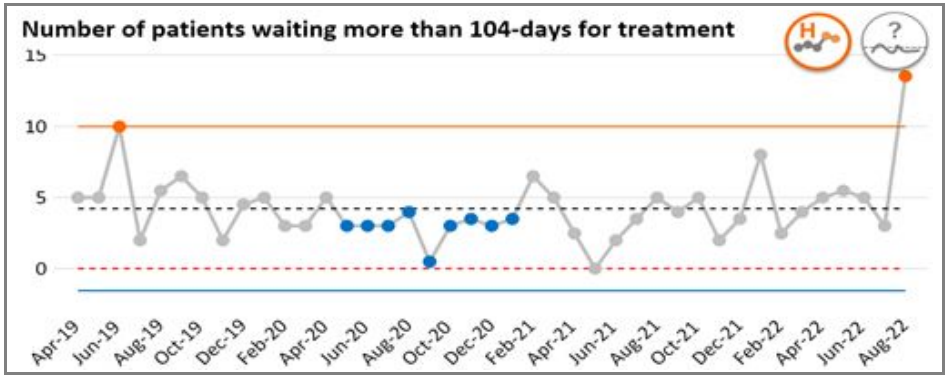
Responsive Services

Cancer Waiting Times

East and North Hertfordshire NHS Trust







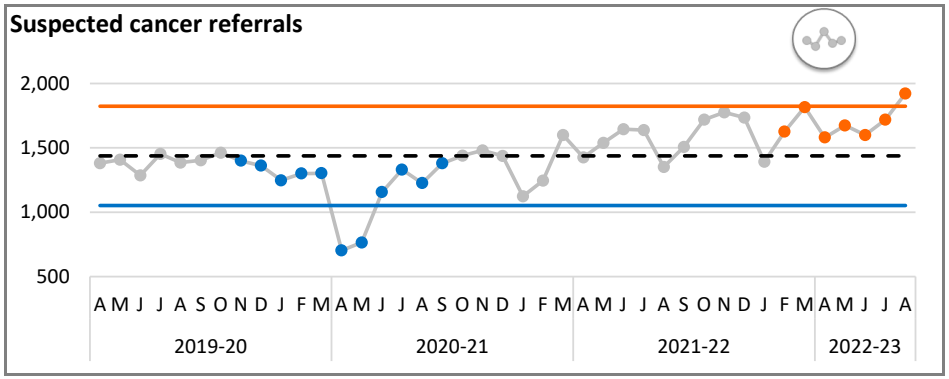
Key Issues and Executive Response

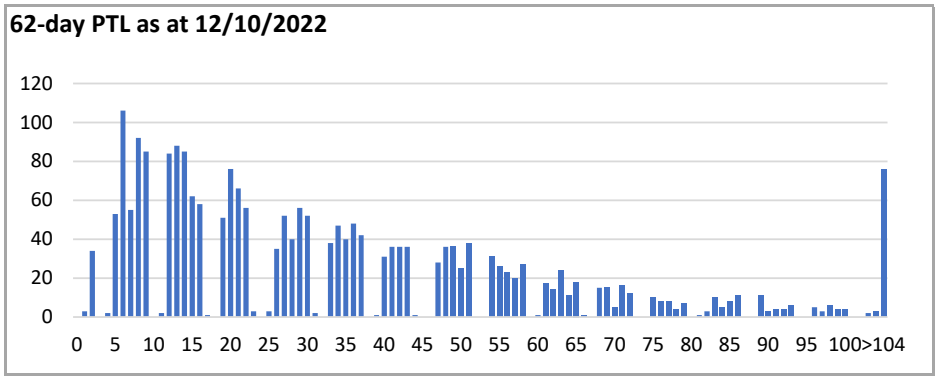
- The Trust has been placed in Tier 1 nationally for elevated support due to rising number and proportion of patients waiting over 62 days on the cancer PTL. Percentage had risen from 6.5% to 16% in last 12 months. Now down to 11.9%.
- Tier 1 Action plan with Skin, UGI, LGI, MDT Tracking team, Histopathology and Radiology to improve MDT follow-up, reporting and more timely communication of diagnosis and next steps, particularly for patients who after diagnosis do not have cancer.
- However, Radiology and Histopathology continue to face major issues with capacity and staffing, likely to affect 62-day cancer performance and backlog for coming months.
- Deep dives for tumour sites continue. Additional scrutiny and support leading to improved performance.
- Timed pathways now in place for all Tumour sites to improve and sustain 62-day standard. Work continues to improve and deliver the Faster Diagnosis Standard performance.
- Achieved 3 of the 8 national targets in August: 31-day first treatment, 31-day second or subsequent treatment for chemotherapy and radiotherapy.
- 31-day performance for Radiotherapy will be affected in September and October due to staffing issue: unable to recruit Band 6 staff.
- The Trust has not achieved the 31-day subsequent for Surgery, 2ww GP referral, 2ww Breast symptoms, 62-day referral to treatment for Screening and all cancers for August due to radiology and histopathology delays, capacity issues and patient delaying the diagnostic pathway or 1st appointment.
- Radiology and histopathology continue to prioritise cancer patients to avoid delays; offering WLI work to increase capacity.
- The team will continue to analyse all breaches by Tumour Site to identify issues and resolve pathway delays.

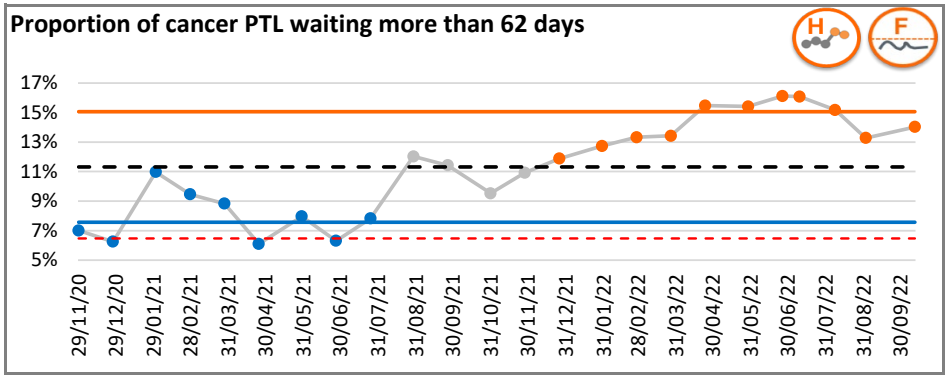
Responsive Services

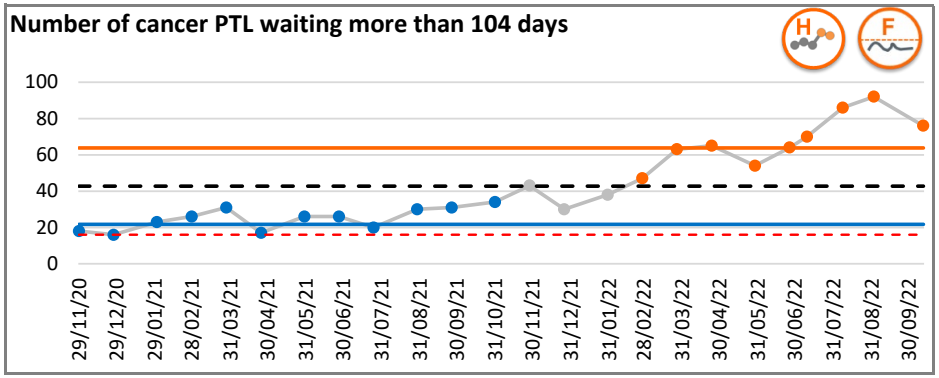
Cancer Waiting Times | Supporting Metrics

East and North Hertfordshire NHS Trust



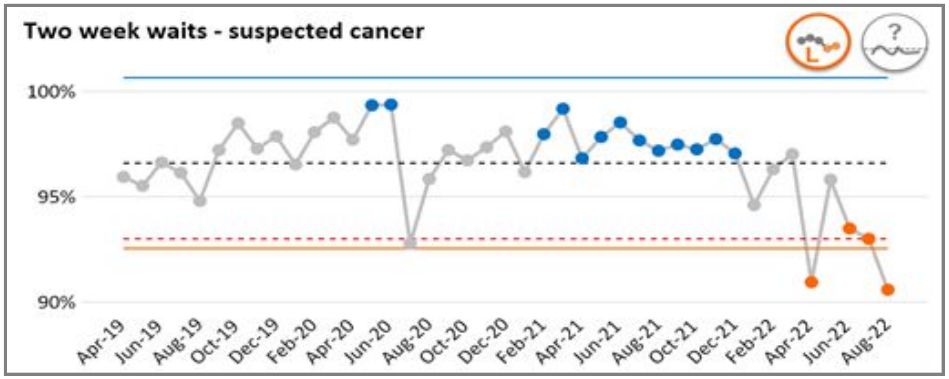


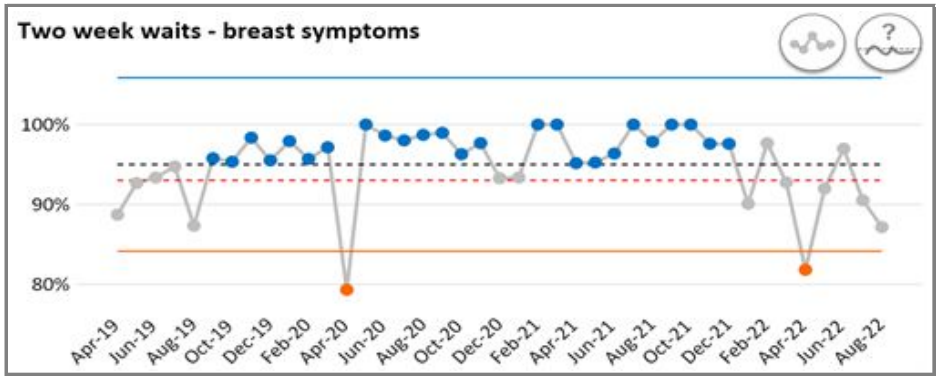


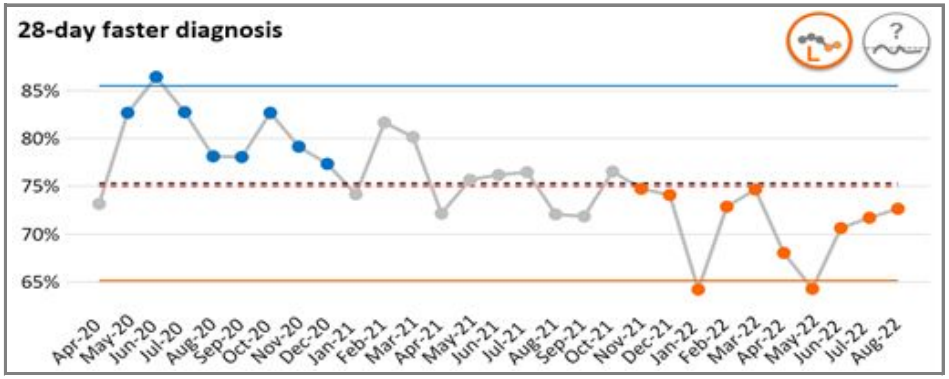


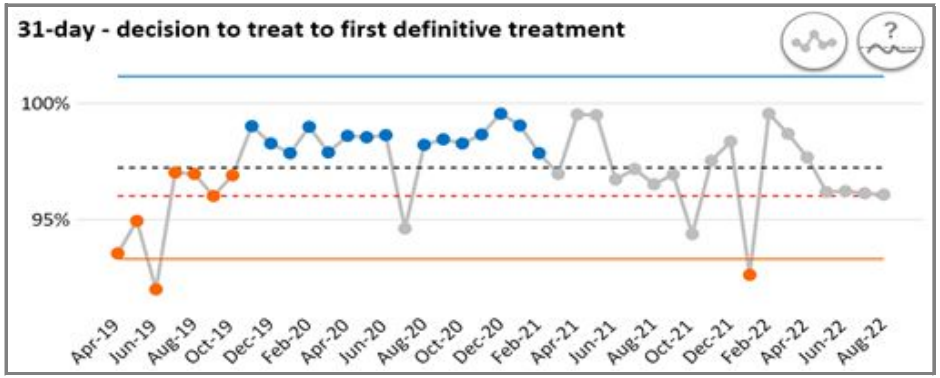
Responsive Services

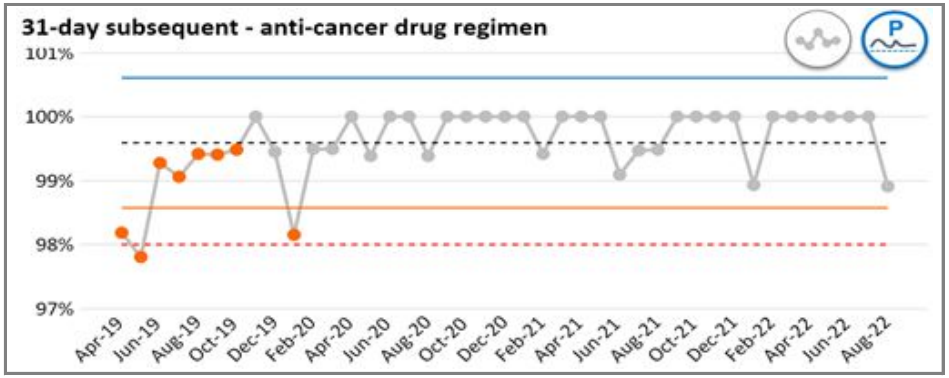
Cancer Waiting Times

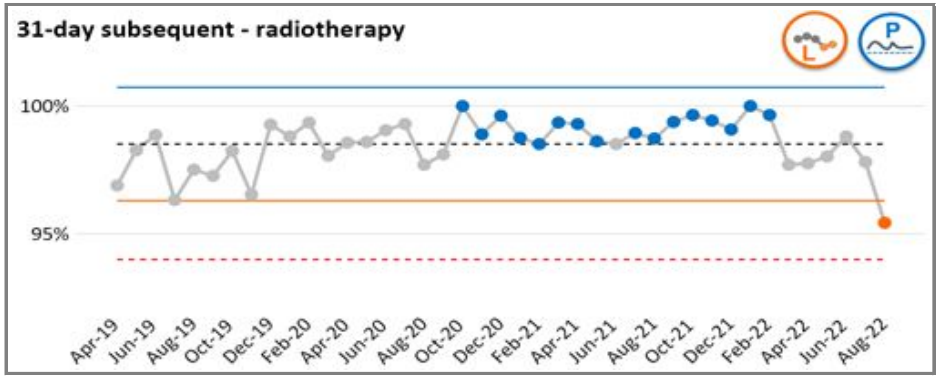








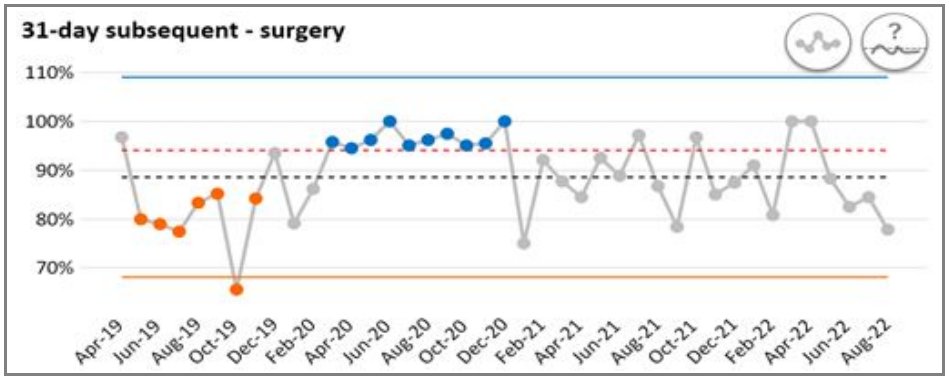


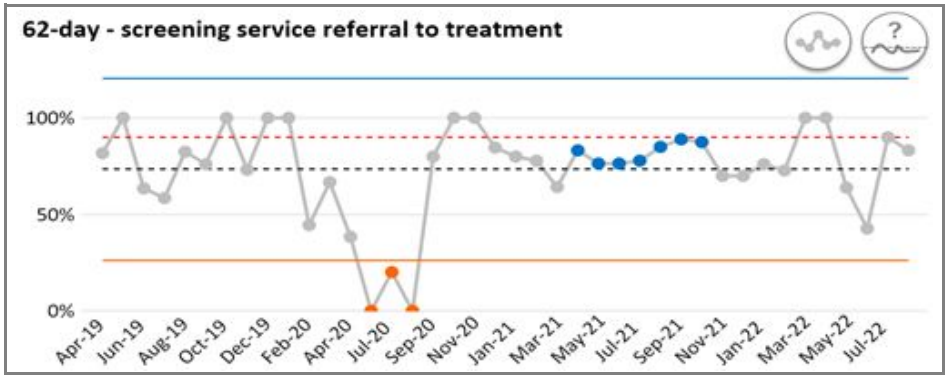


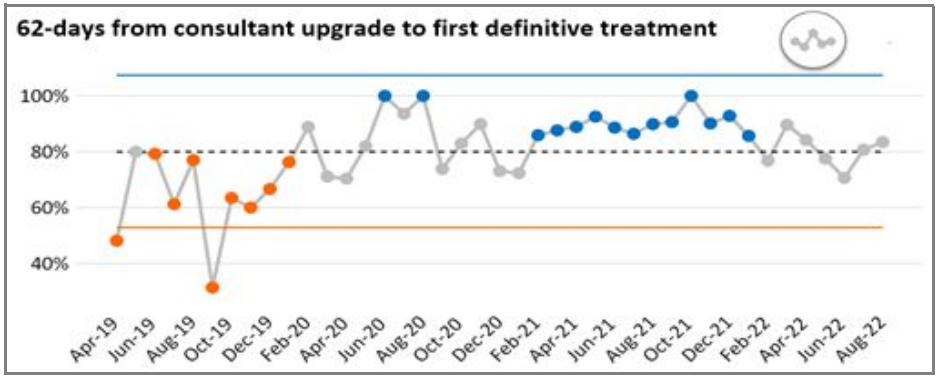
Responsive Services

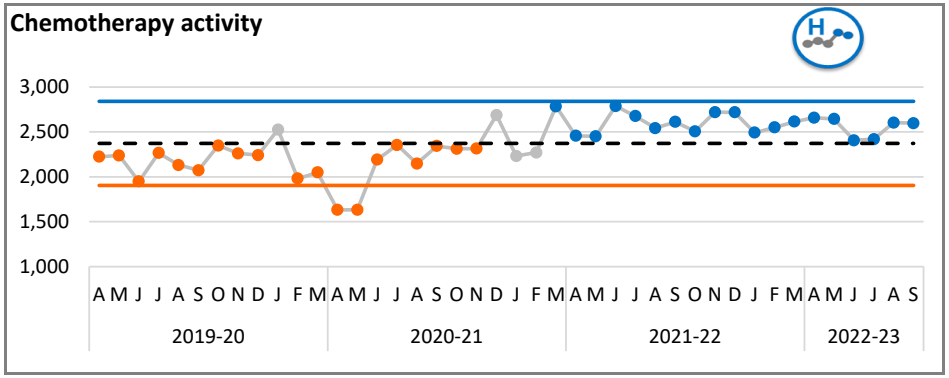
Cancer Waiting Times

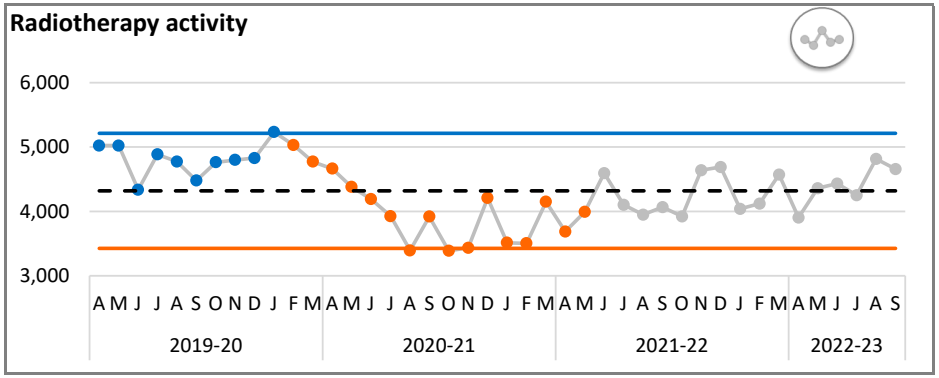
East and North Hertfordshire NHS Trust









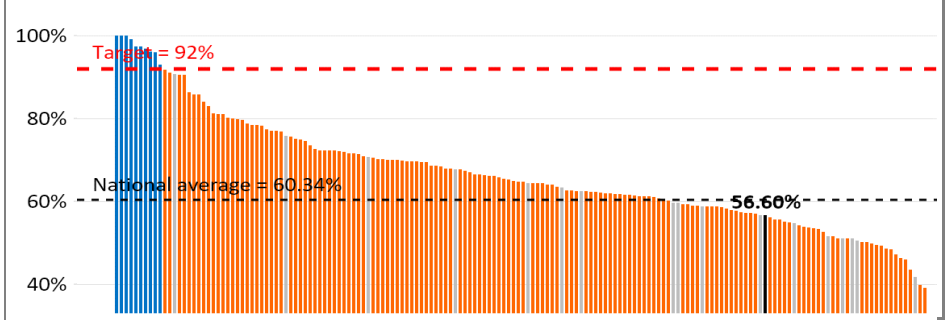


Responsive Services

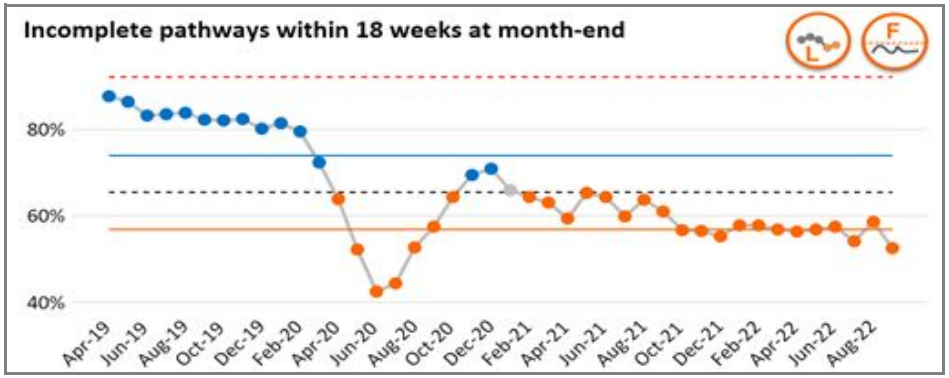
RTT 18 Weeks

East and North Hertfordshire NHS Trust

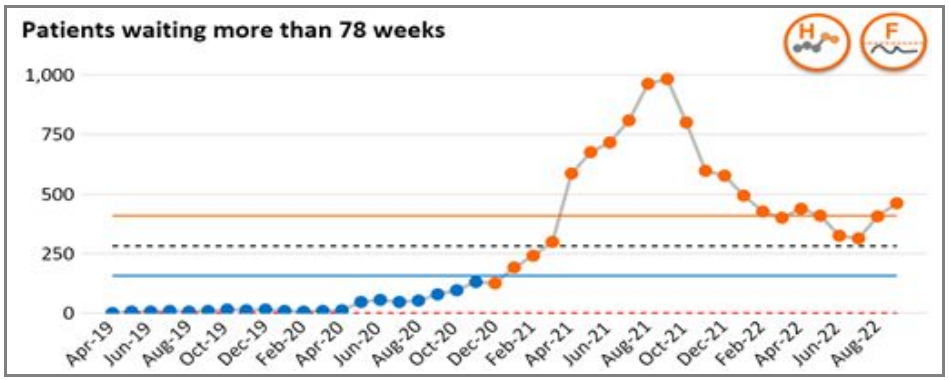
Incomplete pathways peer distribution - Aug-22



Incomplete pathways within 18 weeks at month-end



Patients waiting more than 78 weeks



Key Issues and Executive Response

RTT Performance

- **78+ week waiters:** The number of patients waiting 78+ weeks for an appointment is 0.79% of total RTT PTL.
- There are currently 4,165 patients on the incomplete PTL who will need to be treated by the end of March 2023 to meet the 78-week target. 85% non-admitted; 15% admitted; a 20% reduction from last month (1,029 patients).
- Services have completed forecast trajectories to ensure capacity is available and performance is being monitored and managed.
- **104+ week waiters:** 2 patients were waiting more than 2 years at the end of September - 1 patient was treated at the beginning of October, the other patient is awaiting delivery of cutting blocks, as there is a national shortage.

Data Quality

- In addition to validating all patients waiting over 38 weeks on the incomplete PTL, validation resource was reallocated to the front end of the pathway to try and address the higher number of potential DQ errors and reduce the overall PTL size. This has reduced the PTL and has impacted performance.
- All patients waiting 78 weeks+ are validated and actively managed; enhanced focus on 52–78-week waiters.

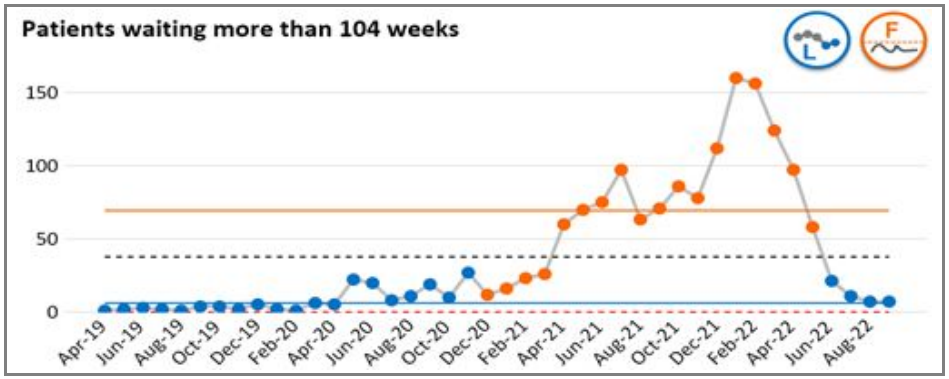
Activity

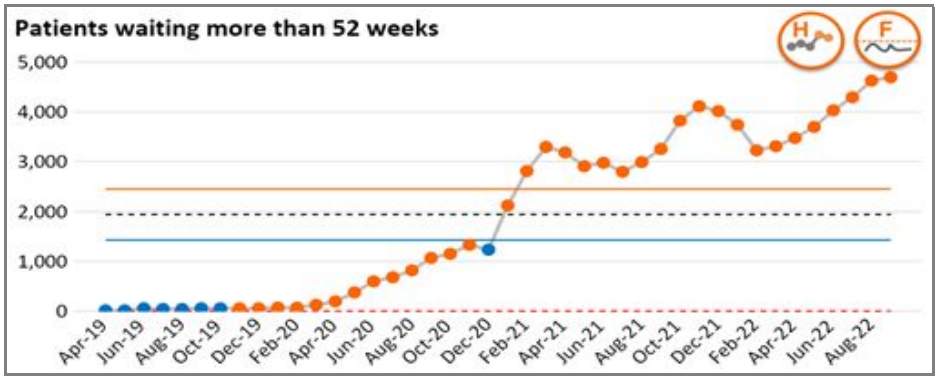
- Referrals have remained stable around the mean.
- Outpatient, Day case and inpatient activity has remained stable.
- PIFU episodes have continued to increase in month above the UCL
- Advice and Guidance remains stable on the UCL.
- Theatre cases per list have remained stable and above average.
- DNA rate has increased this month.

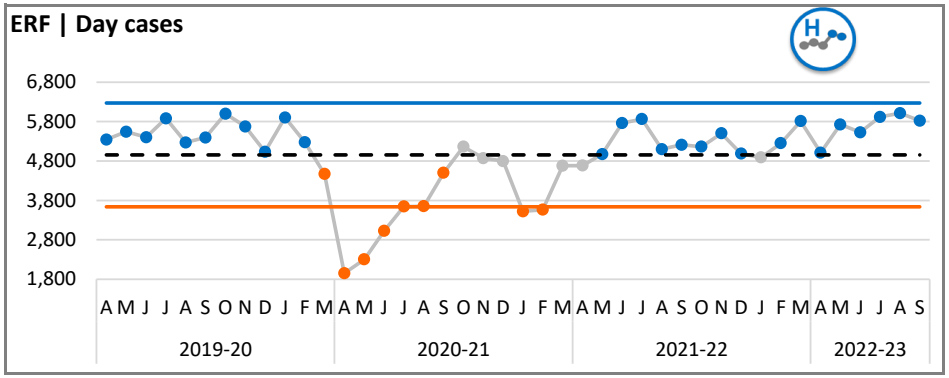
Responsive Services

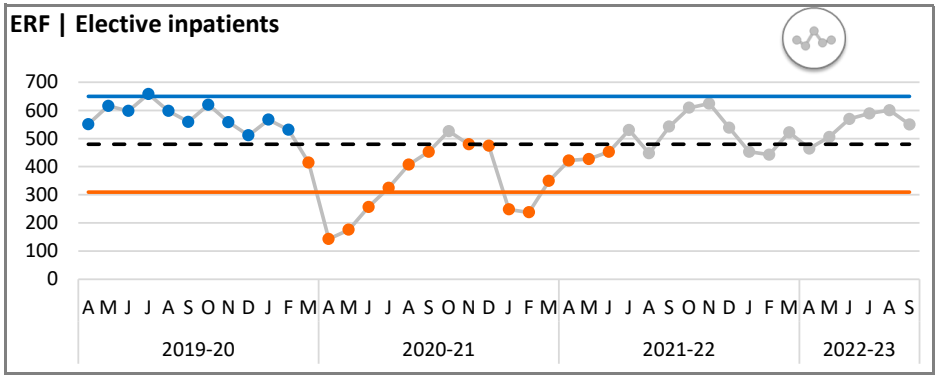
RTT 18 Weeks Supporting Metrics

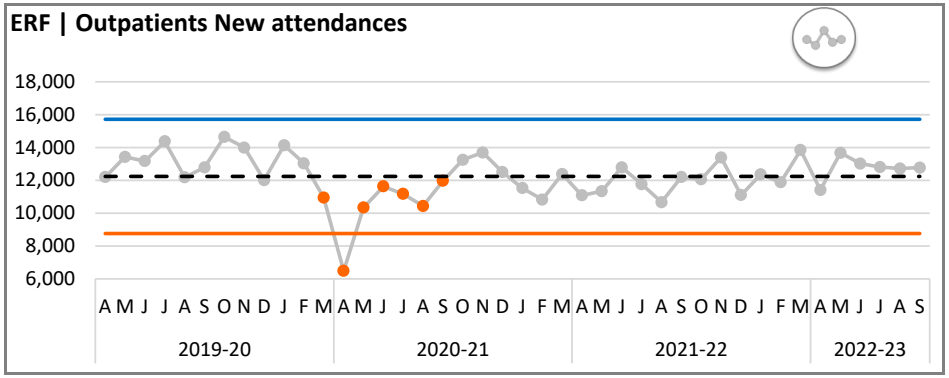
East and North Hertfordshire NHS Trust

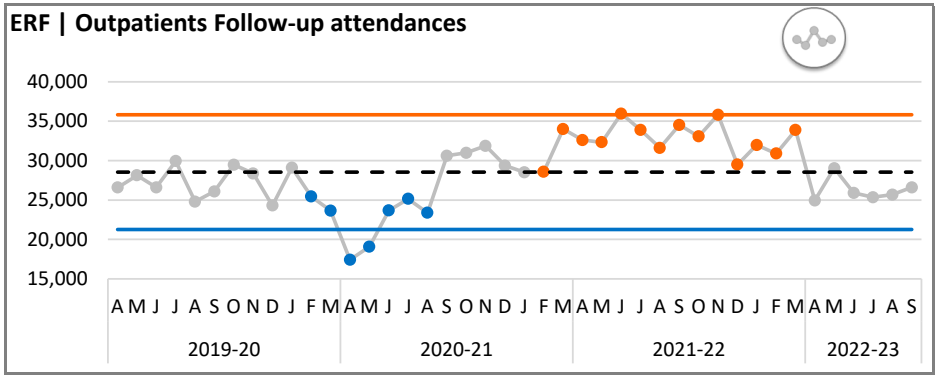








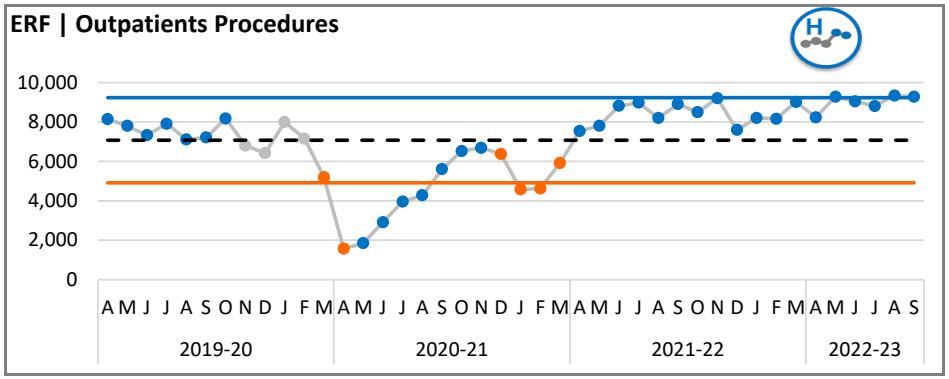


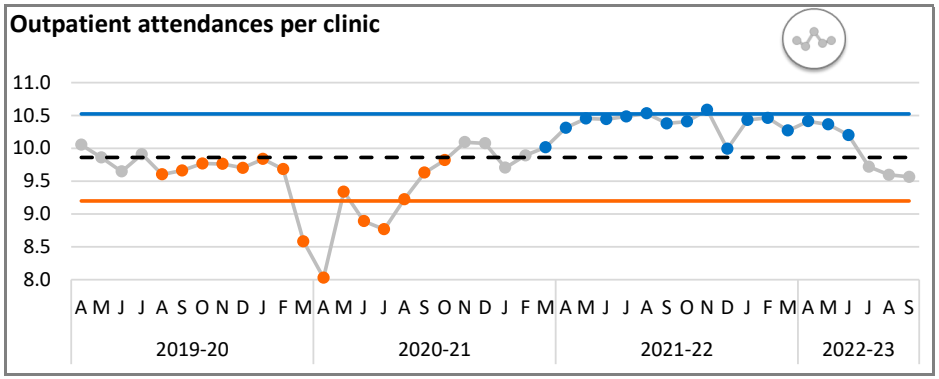


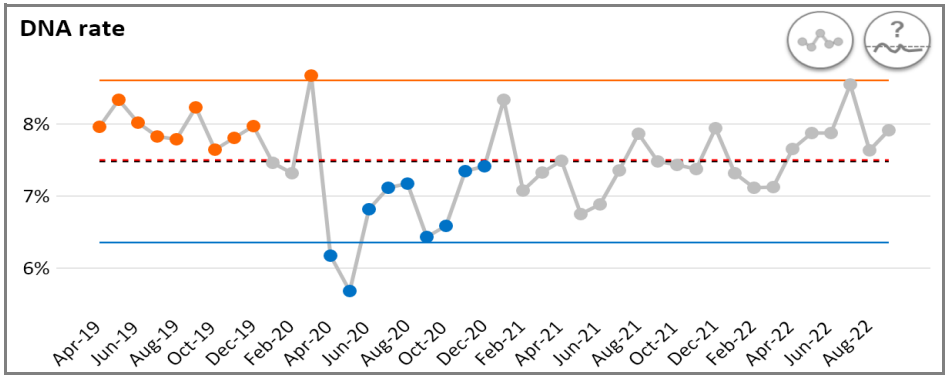
Responsive Services

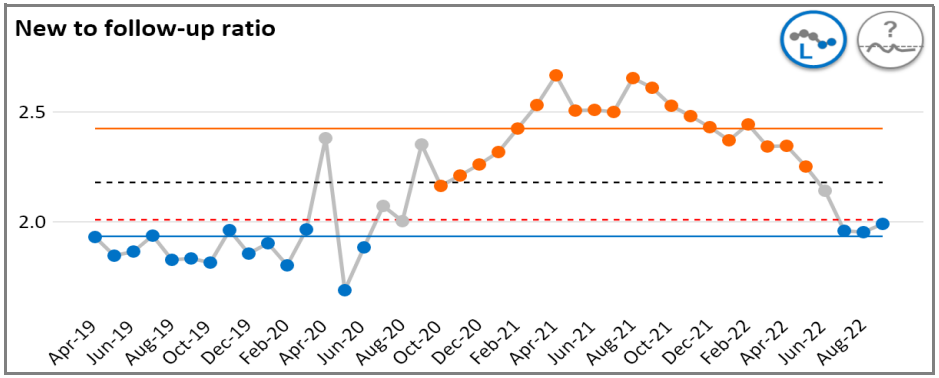
RTT 18 Weeks Supporting Metrics | Elective Recovery Fund

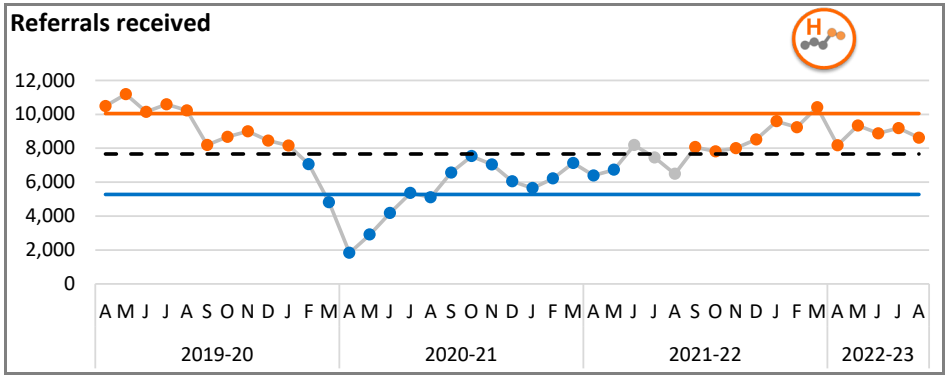
East and North Hertfordshire NHS Trust

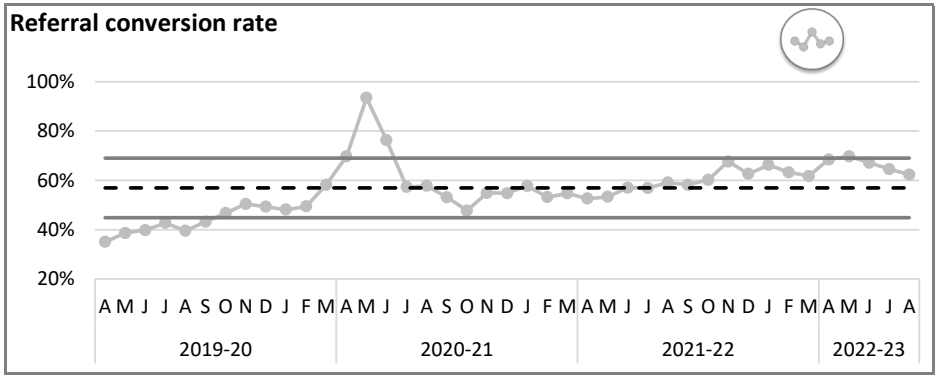








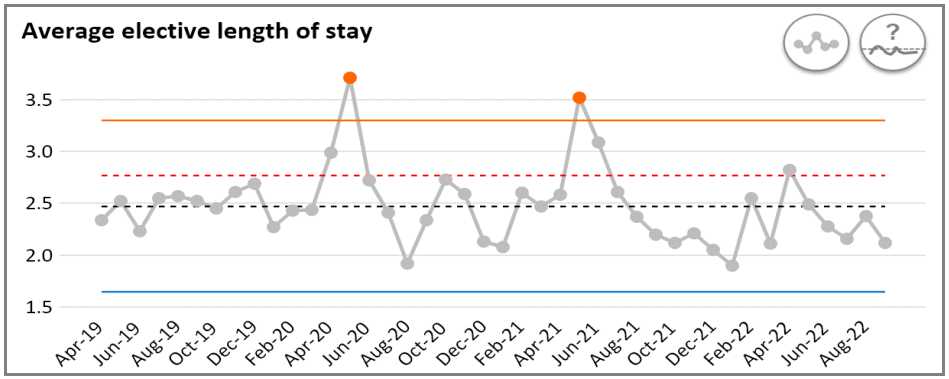


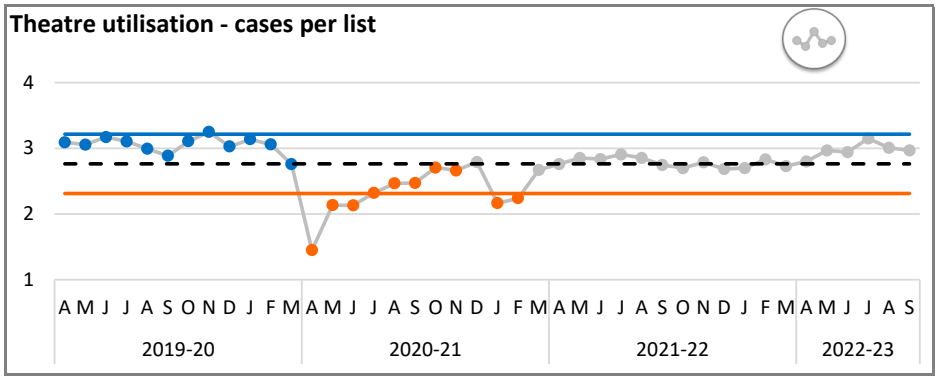


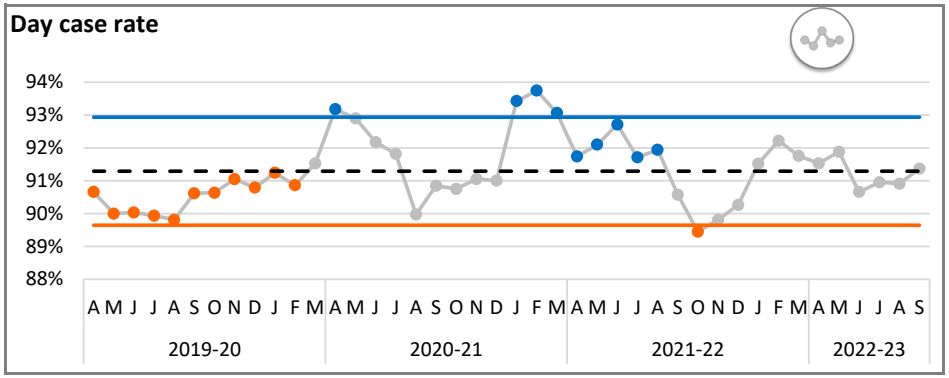
Responsive Services

RTT 18 Weeks Supporting Metrics | Outpatients | Inpatients

East and North Hertfordshire NHS Trust





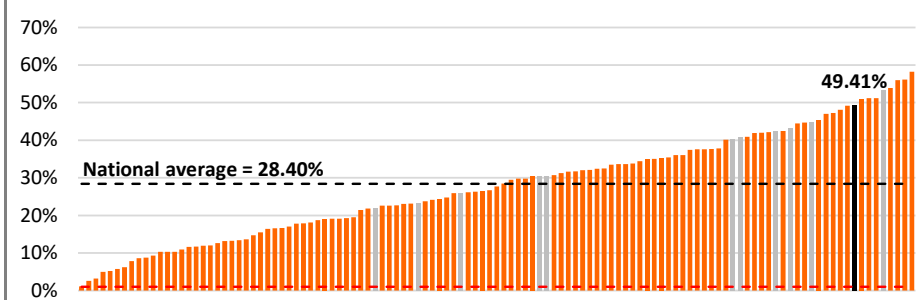


Responsive Services

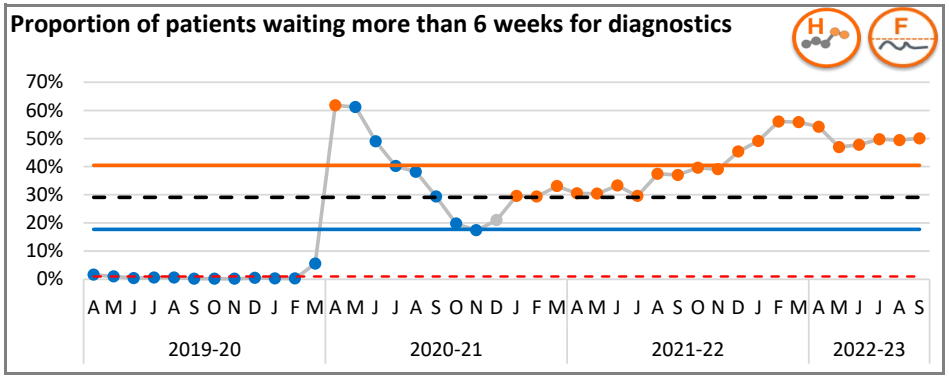
Diagnostics Waiting Times

East and North Hertfordshire NHS Trust

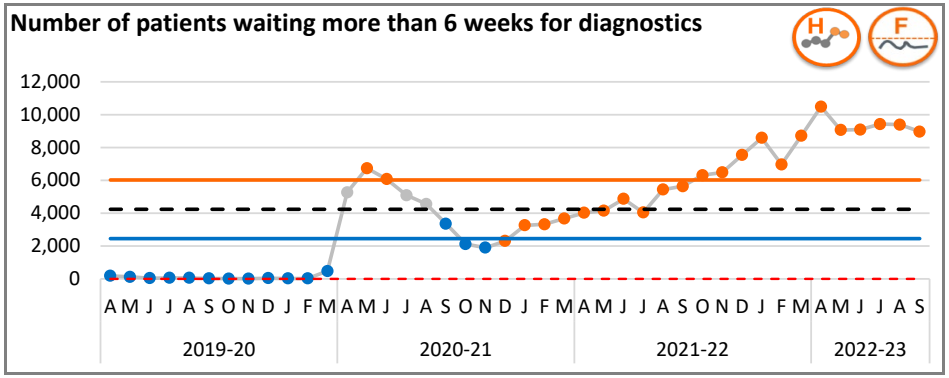
Diagnostics waiting times peer distribution - Aug-22



Proportion of patients waiting more than 6 weeks for diagnostics



Number of patients waiting more than 6 weeks for diagnostics



Key Issues and Executive Response

Improvements

- Imaging position marginally improved overall.
- Continued improvement with MRI position (despite increase in demand) over 6 weeks linked to additional van capacity.
- Improved position with 13+ weeks.
- Two additional Gastroenterology Consultants starting Autumn 2022.
- ECHO Backlog position reduced from 1637 to 574 as of 20/10/2022 based on number of patients booked- trajectory on track for compliance by end of December 2022.
- CDH ECHO activity commenced for backlog management.

Challenges

- Continued sustained increase in cancer demand for CT, MRI & US, impacting ability to regain compliance with diagnostic waits within 6 weeks (DM01).
- Increased CT demand for acute patients in Sept.
- Lost elective sessions due to additional bank holiday.
- Significant MRI and CT equipment downtime due to equipment failure.
- Delay in Gastroenterology recruitment and extended period of supernumerary working.
- Risk to echo compliance due to insourcing capacity and long term implementation of 7 day services.

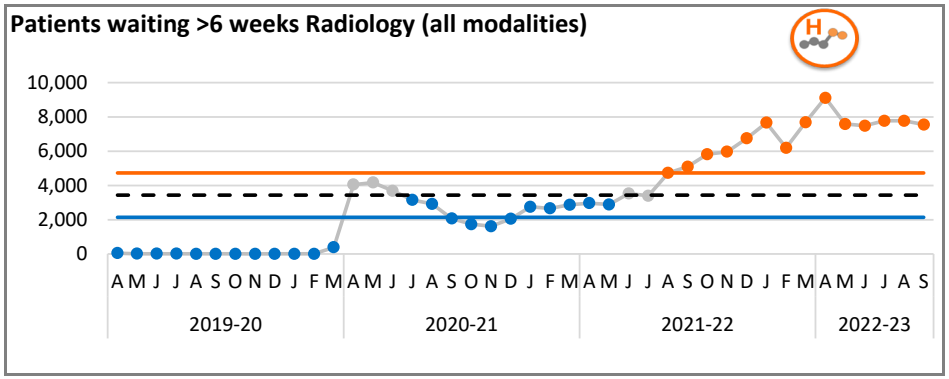
Actions

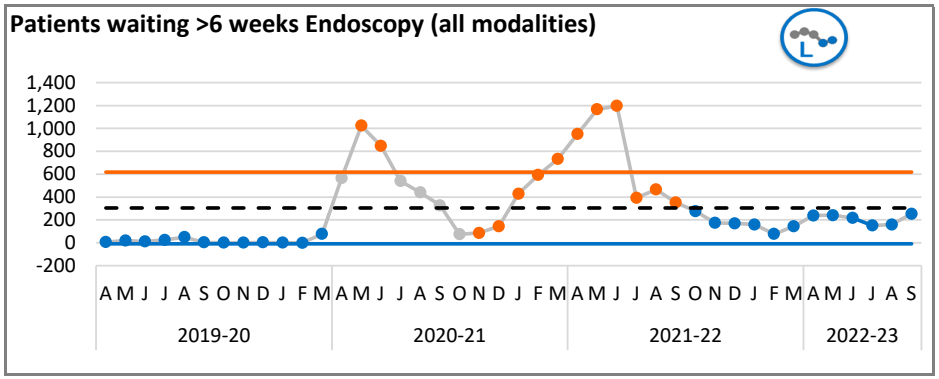
- Demand and capacity review at sub-speciality level and for reporting underway in imaging.
- Engagement with ED and Stroke re. increase in CT and MRI demand and ways to address this.
- Private partners being explored to reduce Endoscopy wait times.
- Implementation of Direct Access ECHO aims for December 2022 once backlog is in a clinically safe positon for DM01 and Planned.

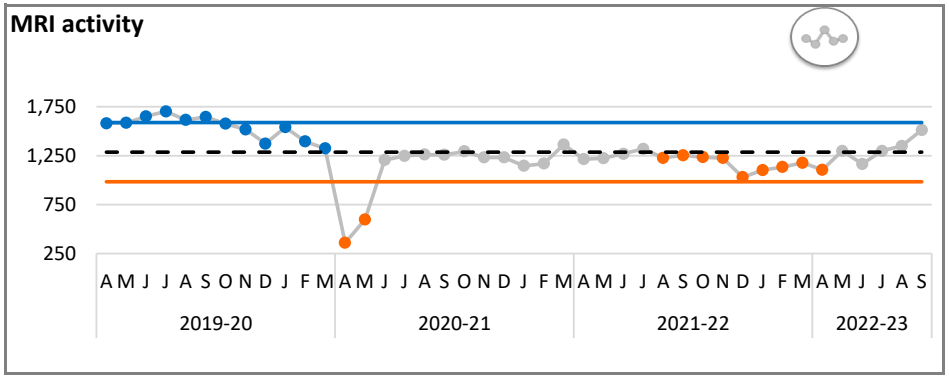
Responsive Services

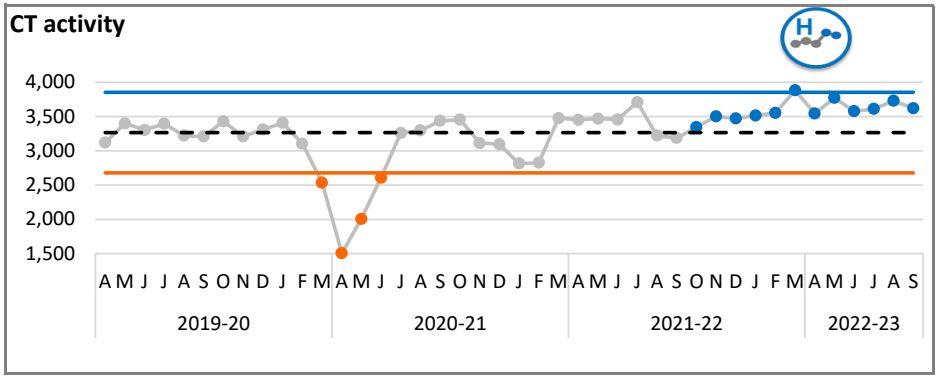
Diagnostics Waiting Times Supporting Metrics

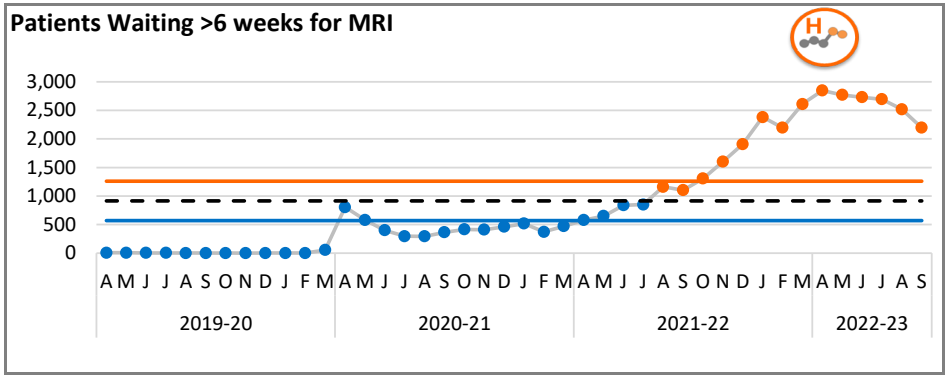
East and North Hertfordshire NHS Trust

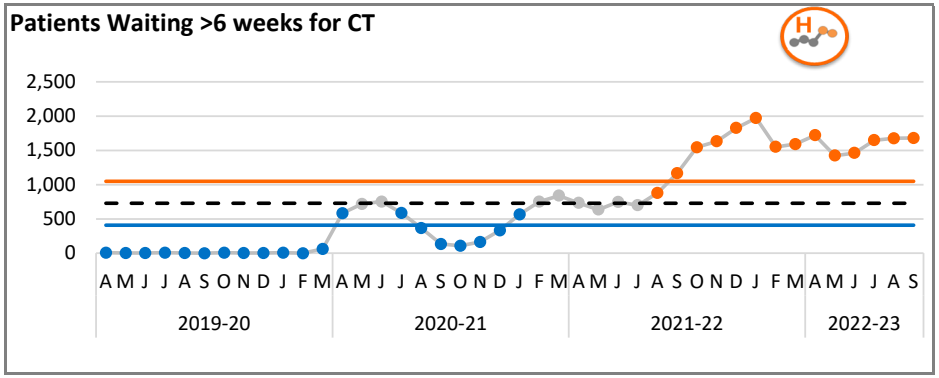






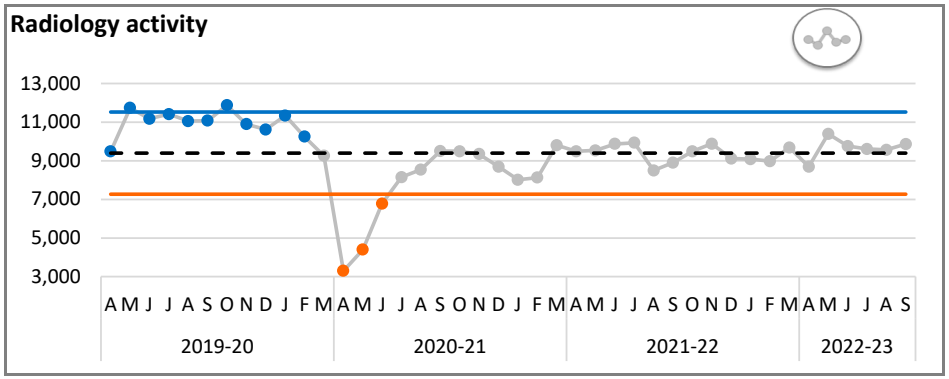


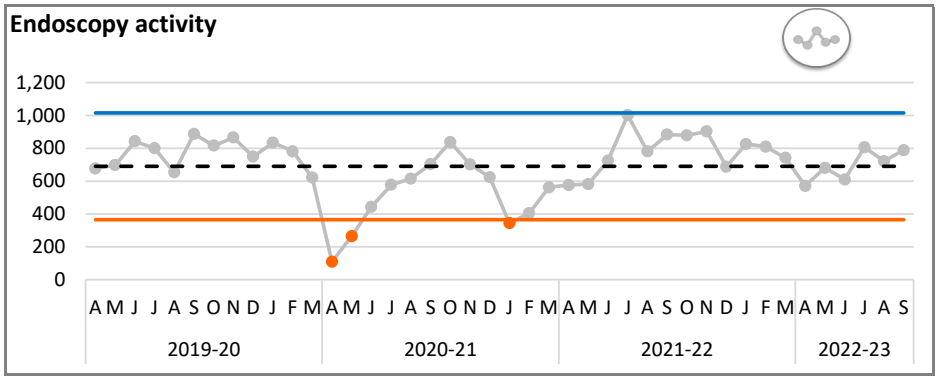


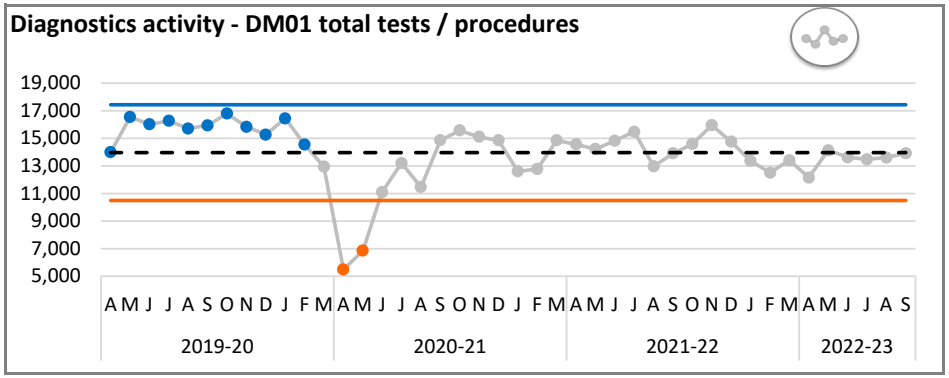


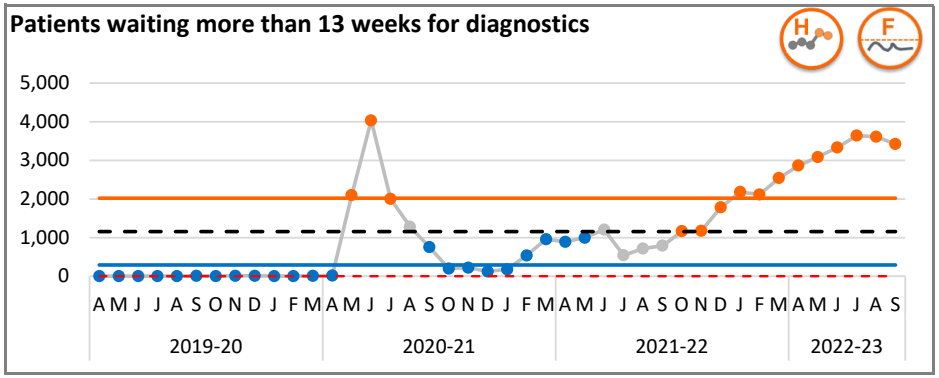
Responsive Services

Diagnostics Waiting Times Supporting Metrics









Responsive Services

Stroke Services

East and North Hertfordshire NHS Trust

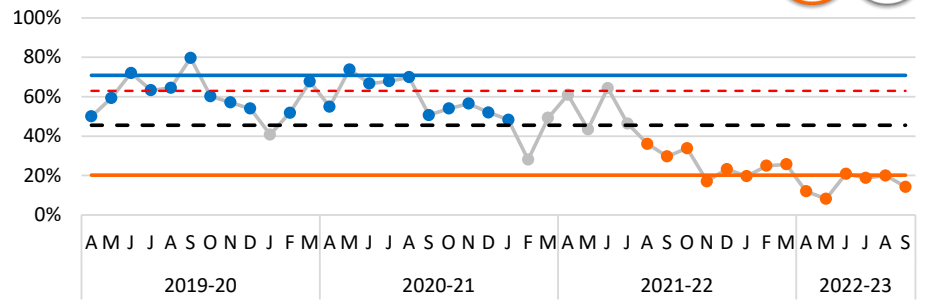
Trust SSNAP grade	Q1 2022-23	D

Breach reasons

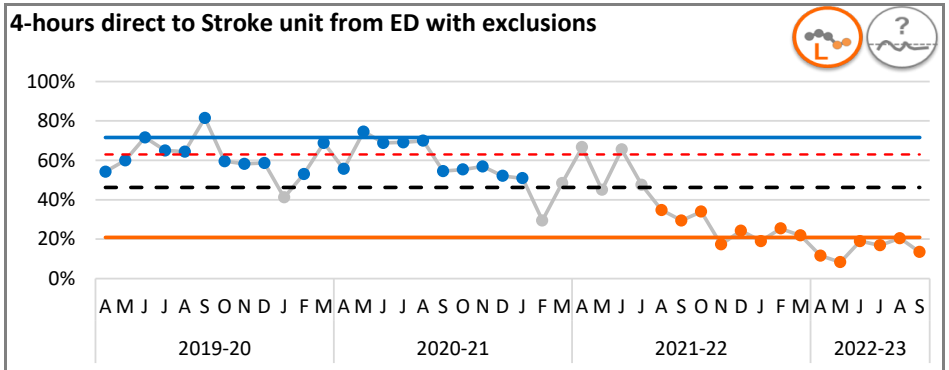
In-hours	24
Challenging Diagnosis/Complex Patient pathway/Clinical Need	8
Late Referral	6
Share Care Transfers	1
Pathway (ED Delays)	9

Out-of-hours	28
Bed Capacity	17
Inpatient Stroke	2
COVID POC	9
Other	0

4-hours direct to Stroke unit from ED



4-hours direct to Stroke unit from ED with exclusions



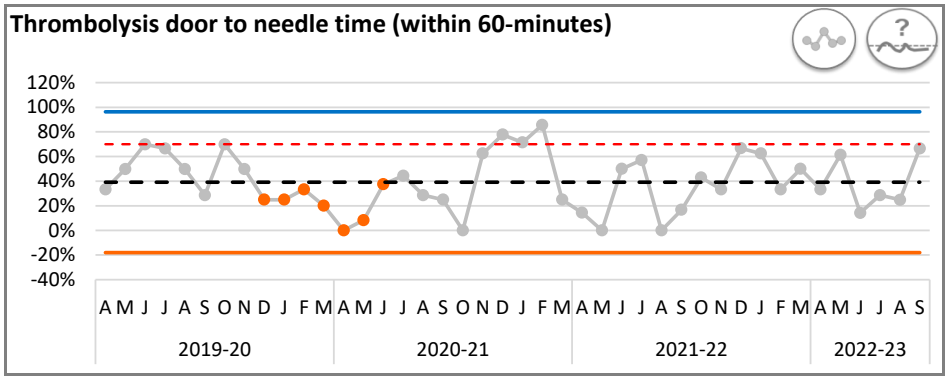
Key Issues and Executive Response

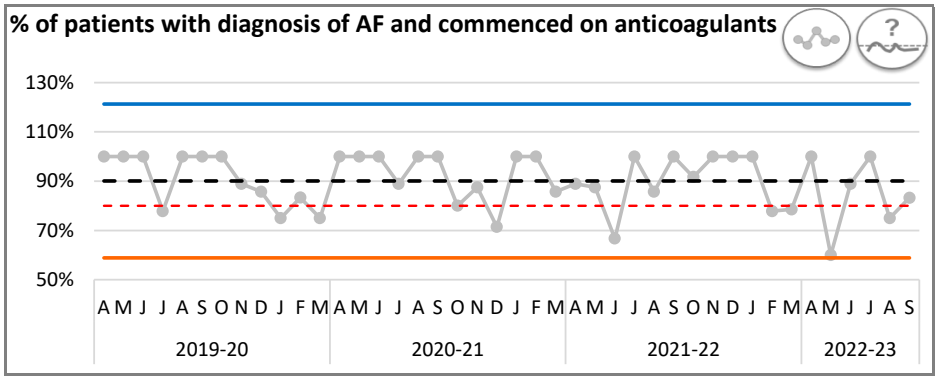
- SSNAP rating for Q2 2022-23 not yet released
- As per the SPC chart, the areas of ongoing concern are: Direct to Stroke unit within 4 hours, due to Covid swab delays and capacity issues; and Thrombolysis performance.
- Direct to Stroke Unit within 4 hours. Due to recent outbreaks within the Stroke unit impacting on the service, re-review of the swabbing pathway for Stroke patients with IPC.
- High number of breaches due to heavy trust wide prolonged operational pressures, particularly ambulance handover delays, despite stroke nurses assessing patients whilst still in the ambulance. Action: Stroke working with ED and external ICS working group on pathway review to support Stroke pathway from admission to discharge.
- Ringfencing of Stroke bed capacity increased from 3 to 4 beds. Daily monitoring of adherence and monthly analysis of bed utilisation.
- Door to Needle performance for September has improved from previous months, but still challenged in regards to ED demands.
- Ongoing discussions and monthly meetings with Radiology to support straight to CT and in-patient MRI capacity.
- Other domains have stable systems and processes, but ongoing monthly review for all domains supported with improvement plans.

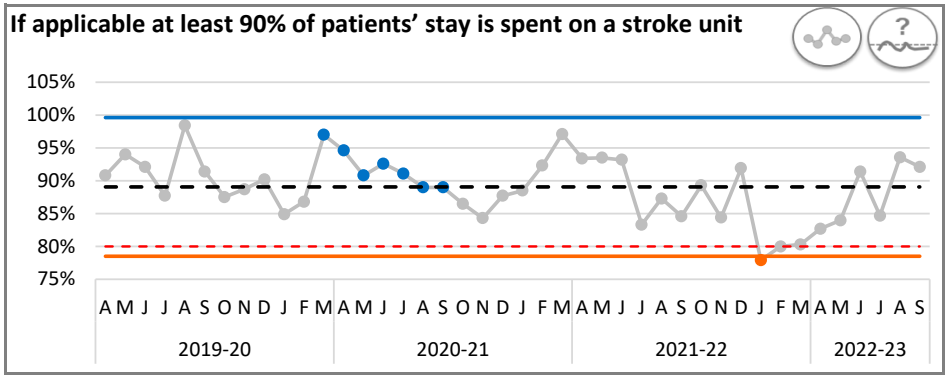
Responsive Services

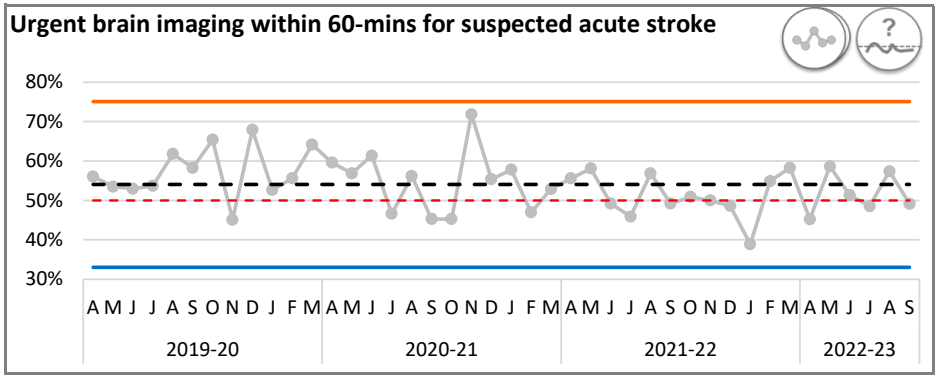
Stroke Services Supporting Metrics

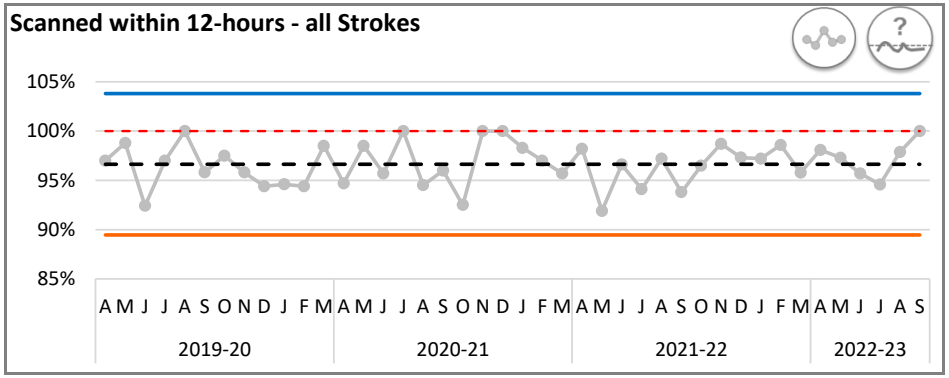
East and North Hertfordshire NHS Trust

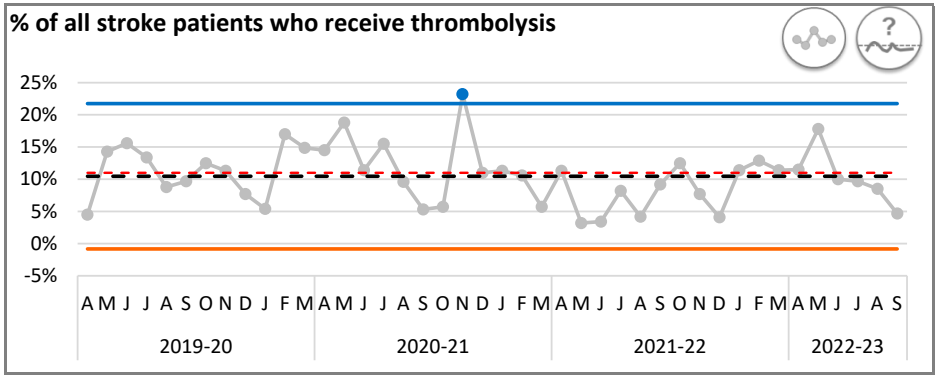








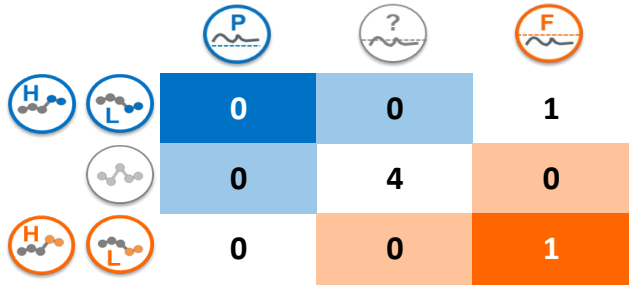




NHS
East and North Hertfordshire
NHS Trust

People

Month 06 | 2022-23



People

Summary

East and North Hertfordshire NHS Trust

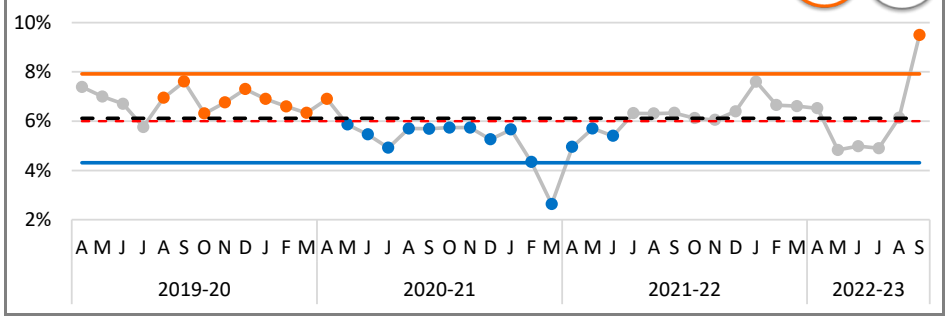
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Work	Vacancy rate	Sep-22	6%	9.5%		?	One point above upper process limit Metric will inconsistently pass and fail the target
	Bank spend as a proportion of WTE	Sep-22	10%	9.8%		?	Common cause variation Metric will inconsistently pass and fail the target
	Agency spend as a proportion of WTE	Sep-22	4%	2.9%		?	Common cause variation Metric will inconsistently pass and fail the target
Grow	Statutory and mandatory training compliance rate	Sep-22	90%	87.4%	H	F	Eight points above the mean Metric will consistently fail the target
	Appraisal rate	Sep-22	90%	57.0%	L	F	26 consecutive points below the mean Metric will consistently fail the target
Thrive	Turnover rate	Sep-22	12%	10.7%			Metric unsuitable for SPC analysis
Care	Sickness rate	Sep-22	3.8%	5.4%		?	Common cause variation Metric will inconsistently pass and fail the target

People

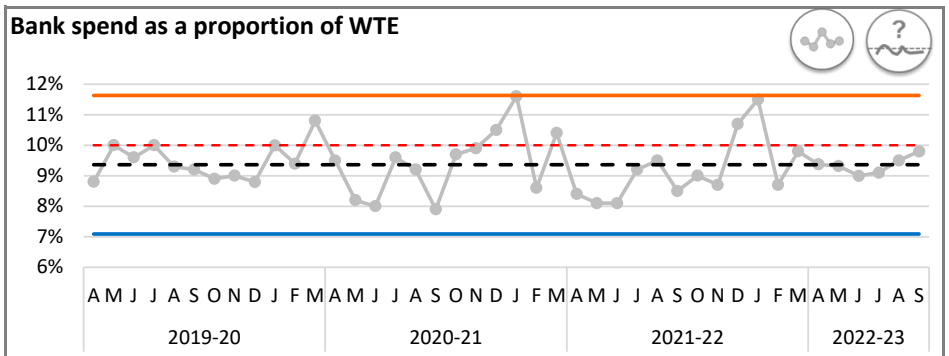
Work Together

East and North Hertfordshire NHS Trust

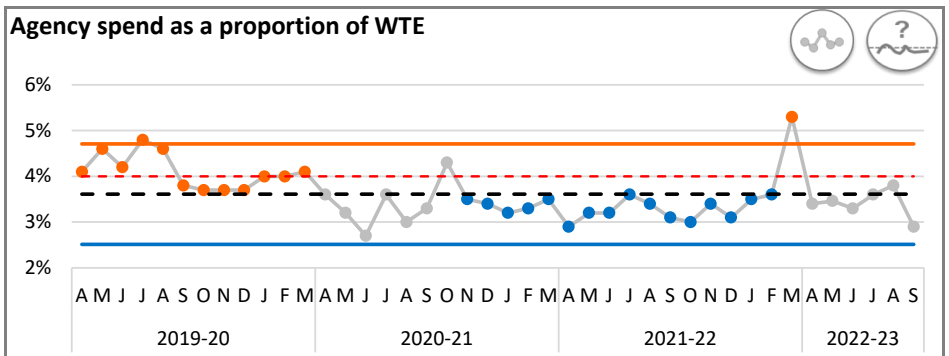
Vacancy rate



Bank spend as a proportion of WTE



Agency spend as a proportion of WTE



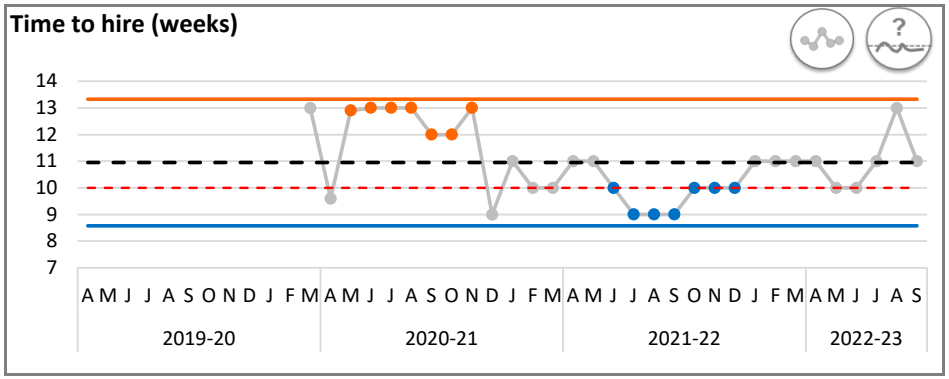
Key Issues and Executive Response

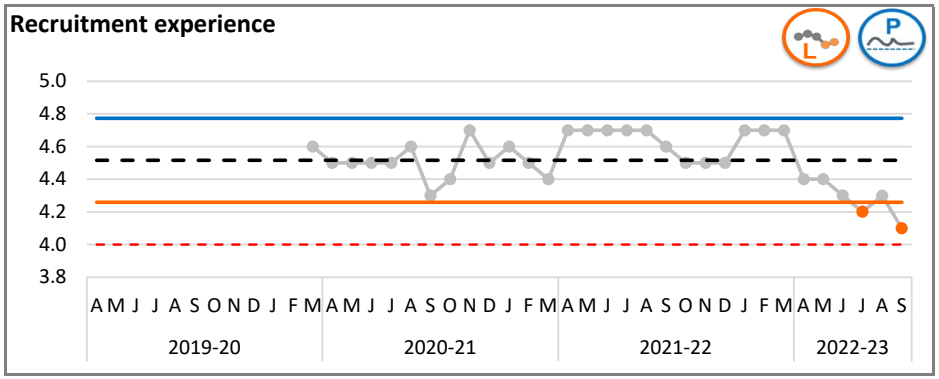
- Overall vacancy rate increased by 261 WTE in M6 due to the agreed uplift in recruitable headroom (up to 22%) which now includes bank and agency. There are now 236 vacancies across the Trust due to the changes.
- 8 CSWs started in month, with 50 in pipeline – vacancy rate for this staff group has reduced to 9.9% (65 vacancies) – work is ongoing here with a number of local initiatives with Job Centre Plus and other local recruitment events, both independently and ICS-wide.
- 68 student nurses issued offers to remain in the Trust upon qualifying plus 16 student midwives. 376 candidates in the pipeline including 55 doctors, 144 nurses & midwives and 27 AHPs.
- Medical WTE recruitable increased by 14 posts, rotations across August and September continued to have an impact on numbers of medics in post - we expect this to even out in the coming months.
- 5 from 27 recruitment experience responses were 3 or below - 3 were interview experience which has been addressed and used for learning, feedback will also be used to generate the recruitment and selection policy which is in progress.
- International recruitment continues – 12 nurses arrived in month, bringing the total since April 2022 to 50. A number of AHPS (Radiographers and OTs) are in the pipeline arriving in October. Additional, 4 Cardiac Physiologists are in the pipeline, as well as a further 8 midwives (no confirmed start dates as yet)
- Agency Spend reduced in M6 which was inconsistent with actual filled activity (increase of 400 worked shifts) however consistent with numbers of agency price cap breaches falling by 83.
- E-Roster roll out for Clinical Staff remains at 84% (6% off national target) and on track to deliver as per project plan. Team based rostering pilot in progress with Barley and 5B. Self-rostering pilot for Dialysis On-calls with the aim to improve staff satisfaction and promote flexible working.

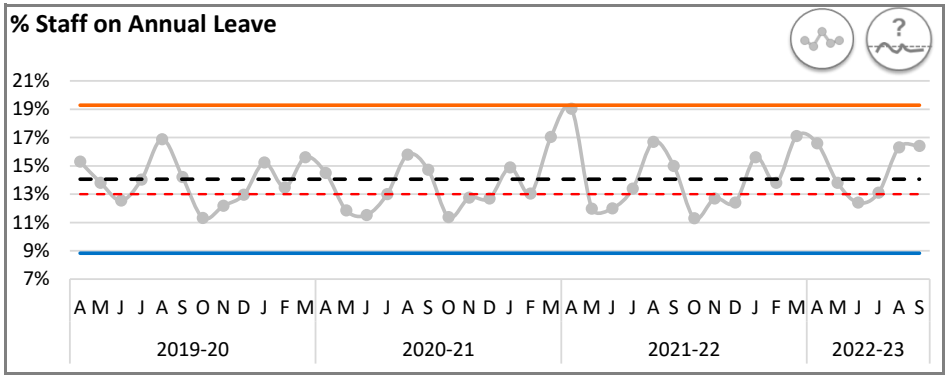
People

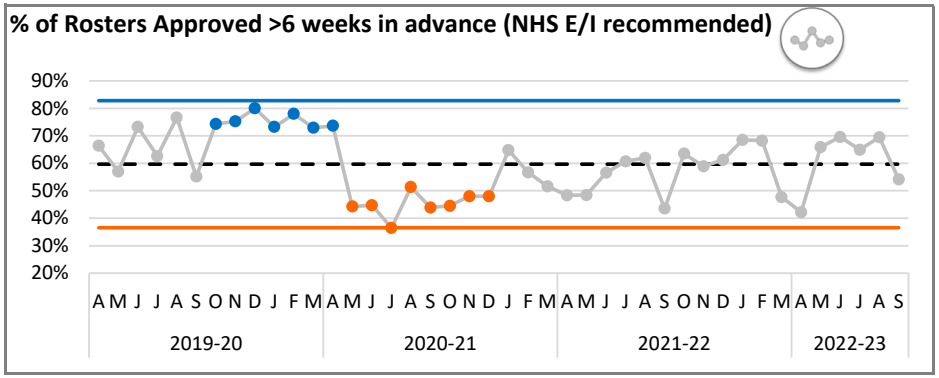
Work Together

East and North Hertfordshire NHS Trust





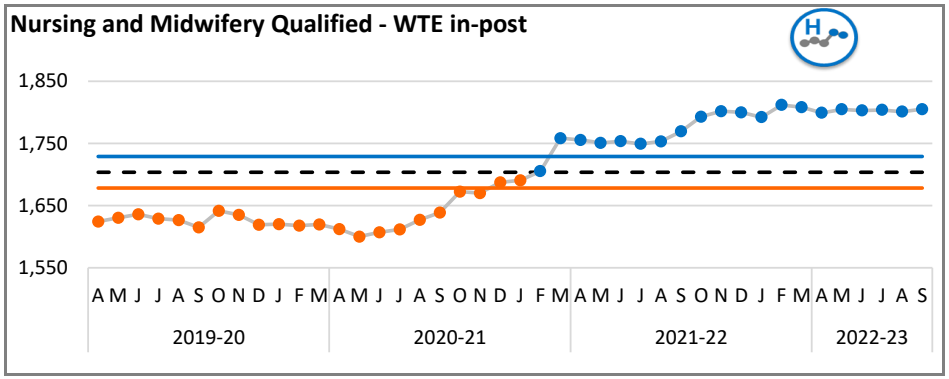


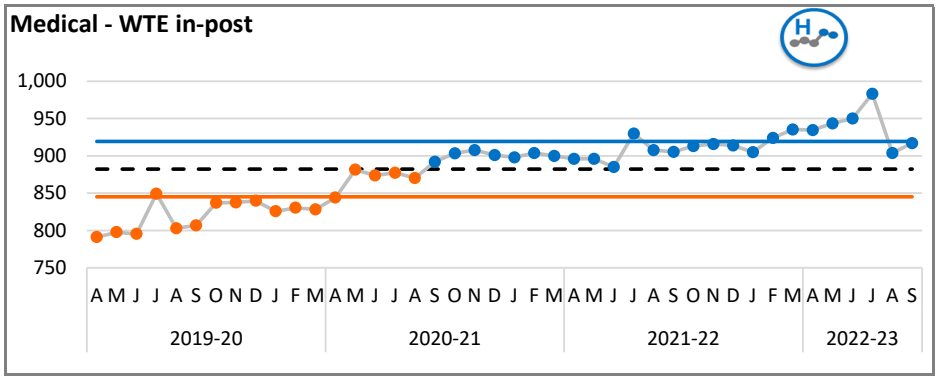


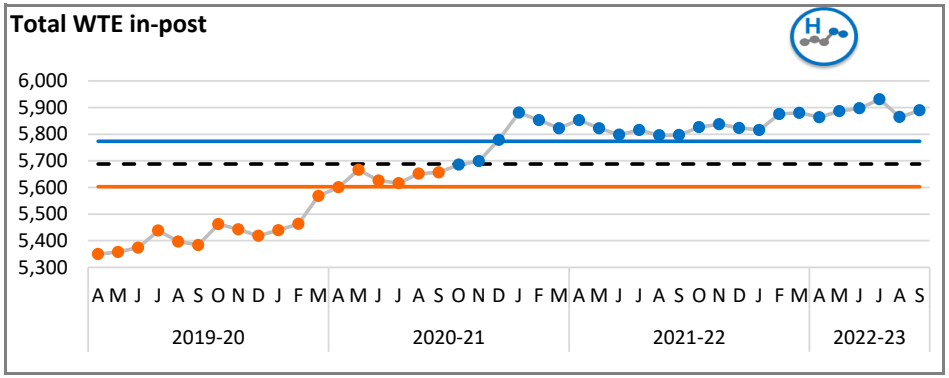
People

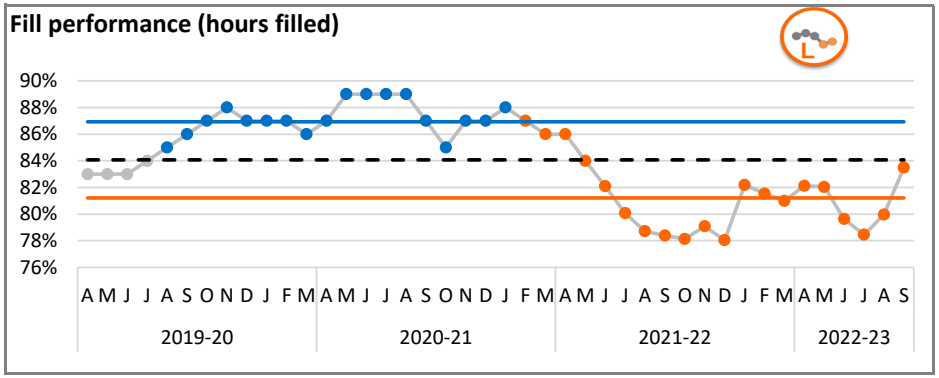
Work Together

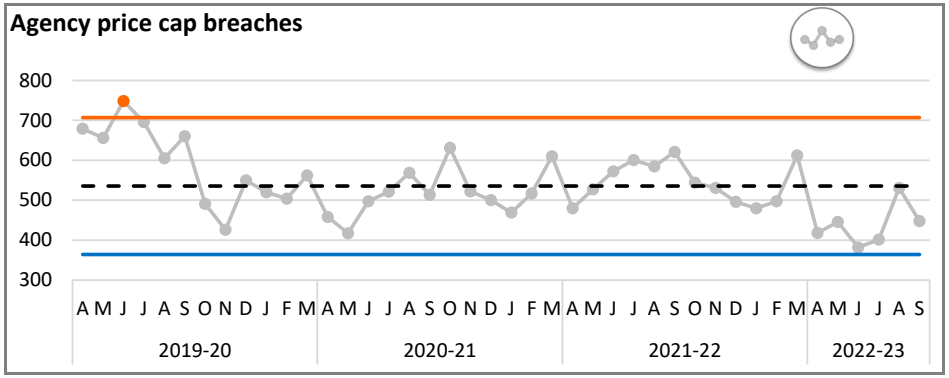
East and North Hertfordshire NHS Trust

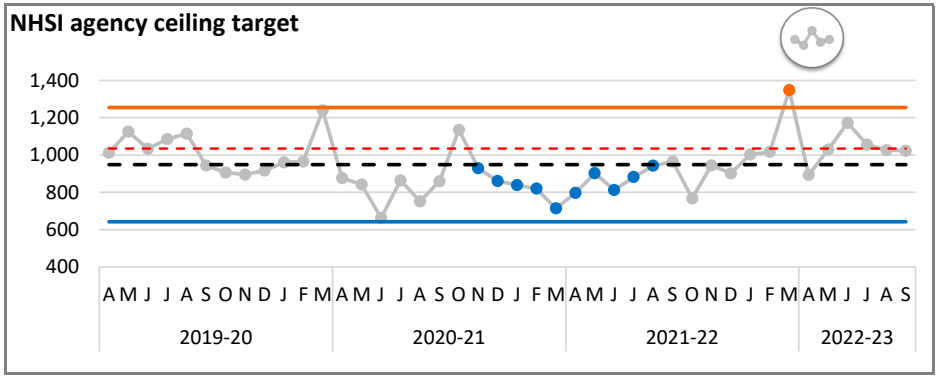










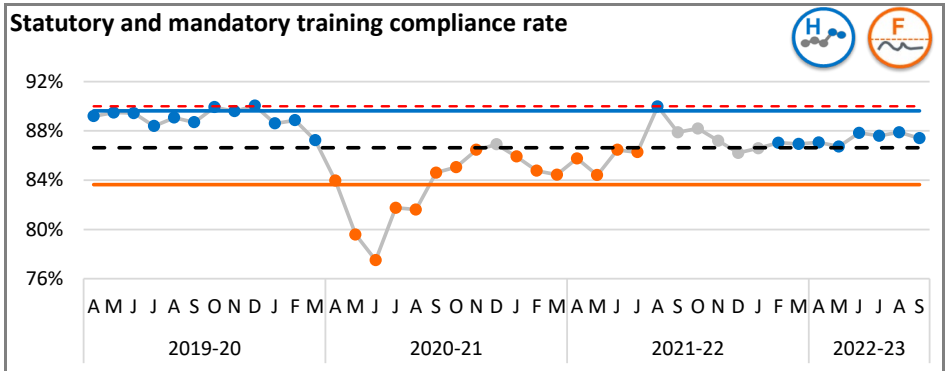


People

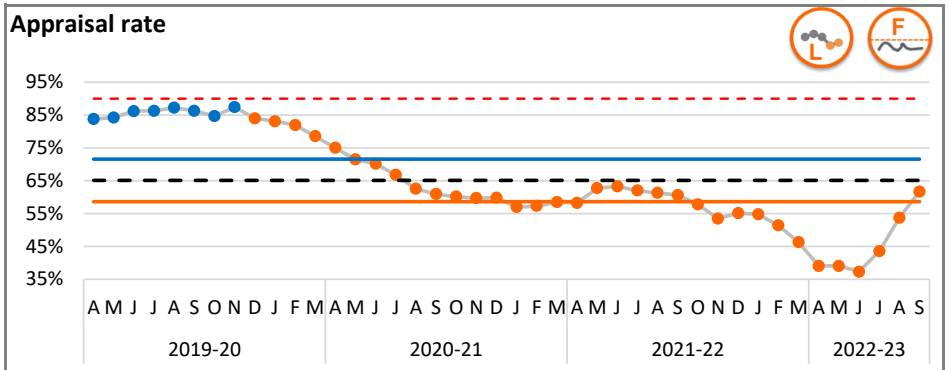
Grow Together

East and North Hertfordshire NHS Trust

Statutory and mandatory training compliance rate



Appraisal rate



Key Issues and Executive Response

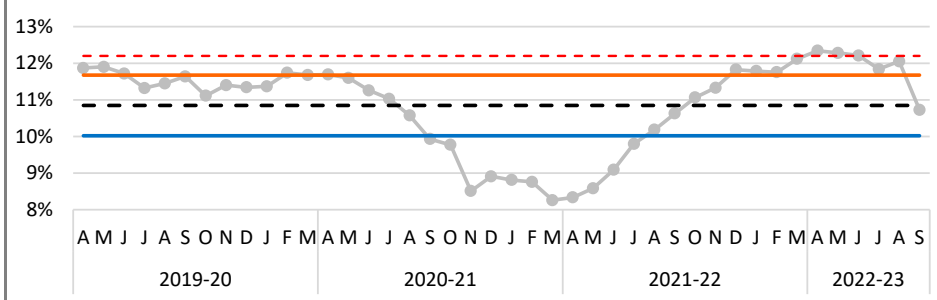
- We continue to see a steady increase in GROW together reviews since the last report (10% Increase) with the R&D division having made the most progress with completion of Grow together conversations
- Follow up of those yet to complete reviews continues, with a particular focus over the coming months on those areas with low compliance. With the Trust overall compliance rate at 57% a number of services are showing less than 30% compliance, these include areas such as Estates, Obstetrics, Community Paediatric services, Gynaecology, IT and Finance. Areas above 90% compliance and exemplars include: Contact Centre/Health Records, Critical Care, Pharmacy, Therapy Services and Elderly Medicine.
- Mandatory training has improved slightly this month. Actions to address DNAs, and targeted actions to address low compliance for medical staff has led to some improvements. However further action will be taken over the next months to discuss compliance rates at relevant divisional meetings including ARM. Targeted action is being taken with regards to MCA DOLs compliance rates, which has seen compliance rates increase by over 20% in the last 2 months and a safeguarding passport for both Adults and Children is being developed on the ENH Academy system.
- CPD funds for non-clinical staff to access training opportunities has been advertised in October, with expressions of interests being submitted. The Charitable bursary offer (Walter Cooper Bursary) for staff training and development will be advertised early in November.
- The Trust is currently undertaken a selection process for the Florence Nightingale Fellowship leadership programme and expects to be able to put circa 4 nursing leads forward for this prestigious bursary programme.

People

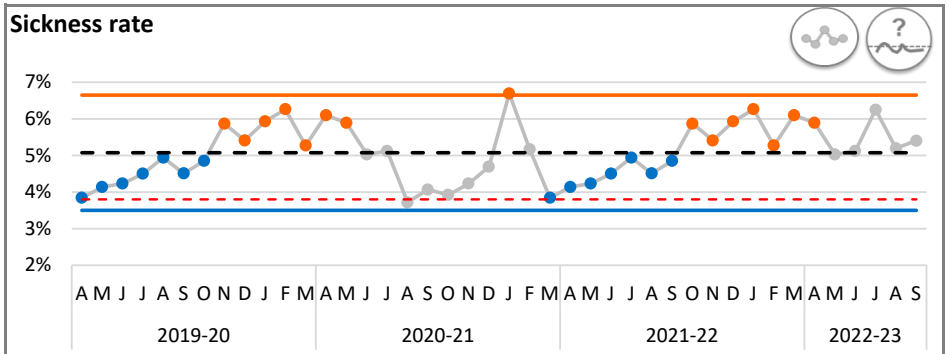
Thrive Together | Care Together

East and North Hertfordshire NHS Trust

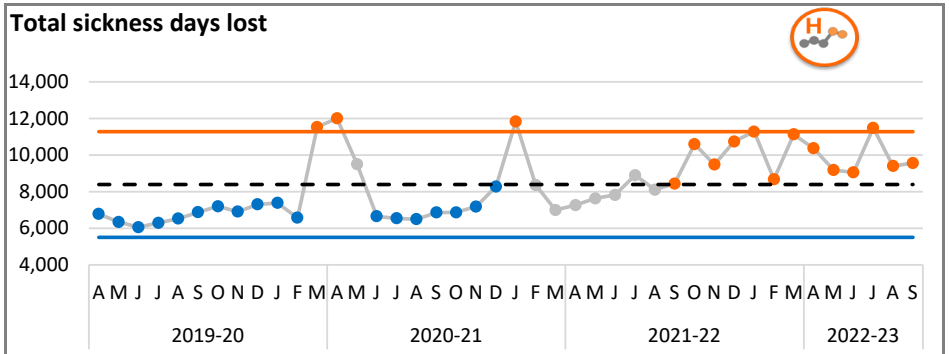
Turnover rate



Sickness rate



Total sickness days lost



Key Issues and Executive Response

Thrive Together

- National staff survey completion rates are above 20% having launched on 22nd September, areas with highest uptake have been rewarded and recognised with small tokens of appreciation, further promotion continues across our sites to increase completion rates
- Values Charter work continues across the Trust and the Board completed their charter which will be published and shared across ENHT in early November
- Employee relations improvement work is yielding traction on case work, with reduction in average time for disciplinary cases concluding being seen, however improvement work on reducing average time for grievances to conclude continues
- Cultural Intelligence work underway with further board development taking place in this quarter.

Care Together

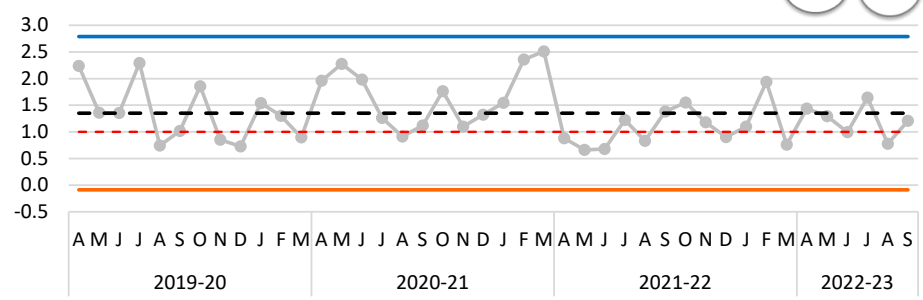
- Vaccination hub opened on 3rd October with uptake at 23%
- There are currently 50 long term and 39 short term sickness cases being supported through the employee relations service to ensure staff health and wellbeing and returning to work happens well
- Staff Community Shop is regularly used with weekly deliveries of stock, exploration of work with food stores for donations in train and plans in place to stock more seasonal goods for winter in the shop
- Winter wellbeing initiatives, e.g. hydration station, support for meals in work will commence into November in partnership with Catering
- Regional work is underway to review Here for You provision for longer term to support staff access to immediate support and targeted civility matters and health teams work is happening in areas with high levels of absence/case work and/or change.

People

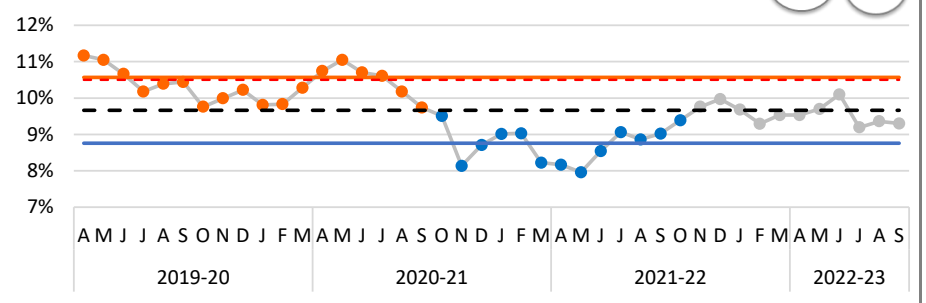
Thrive Together | Care Together

East and North Hertfordshire NHS Trust

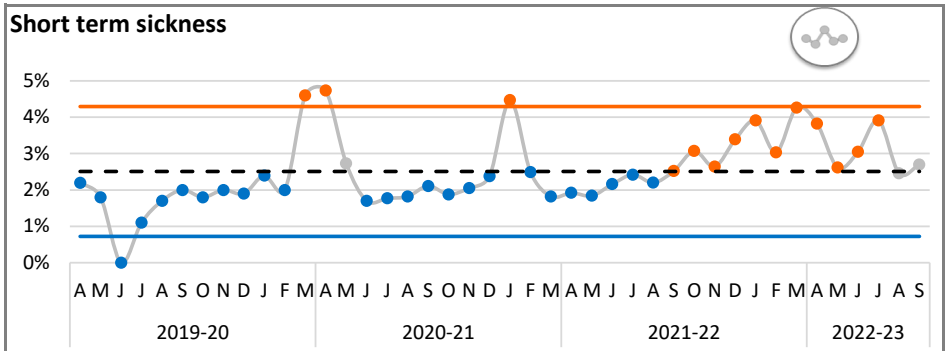
Net Ratio (Starters/Leavers)



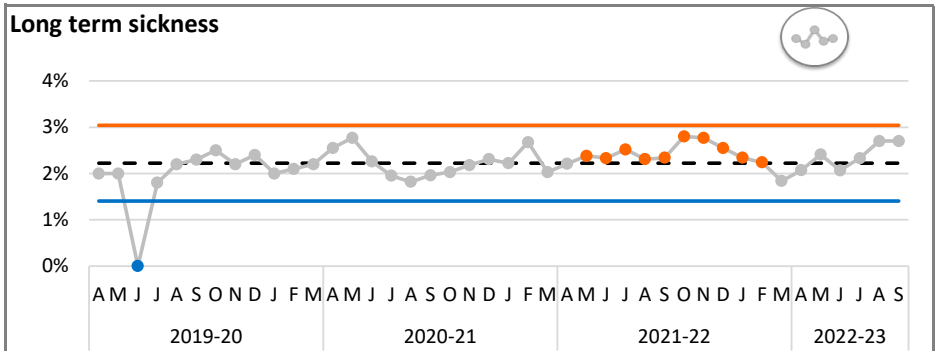
Qualified Nursing and Midwifery staff turnover



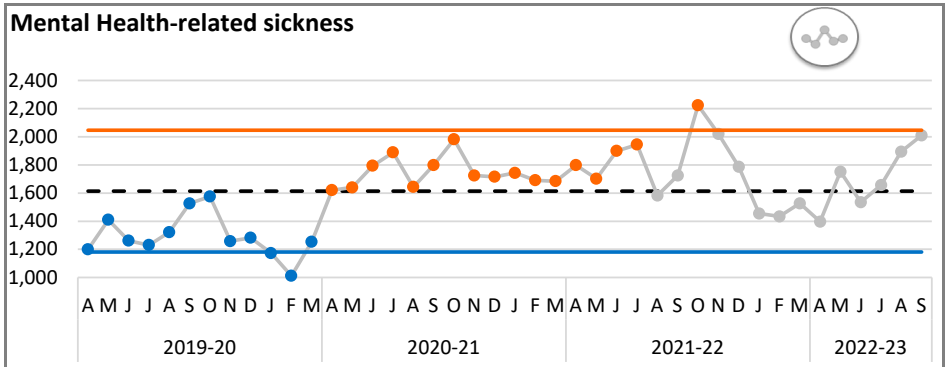
Short term sickness



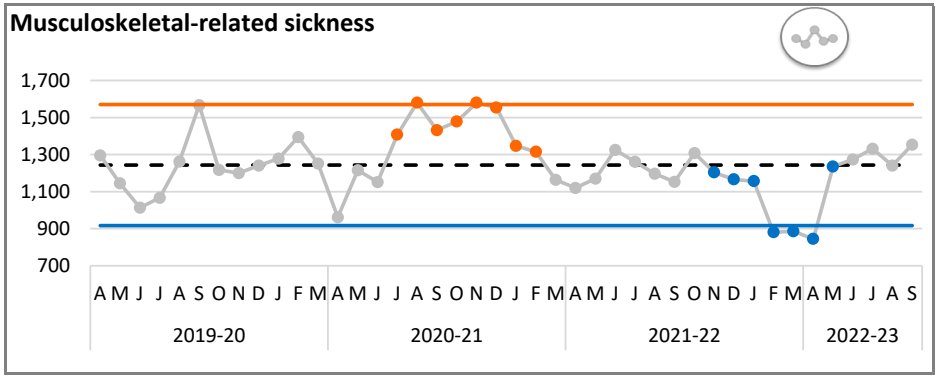
Long term sickness



Mental Health-related sickness



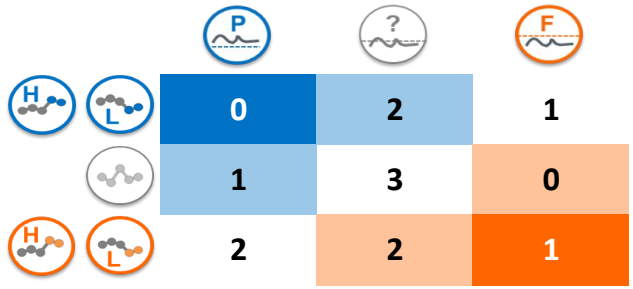
Musculoskeletal-related sickness



NHS
East and North Hertfordshire
NHS Trust

Sustainable Services

Month 06 | 2022-23



Sustainable Services

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Summary Financial Position	Surplus / deficit	Sep-22	-2.4	0.38		?	Common cause variation Metric will inconsistently pass & fail the target
	CIPS achieved	Sep-22	1,245	1,294			No data Apr-20 to Sep-21
	Cash balance	Sep-22	77.9	64.5	H	F	Twelve points above the upper process limit Metric will consistently fail the target
Key Financial Drivers	Income earned	Sep-22	45.3	51.1	H	?	Common cause variation Metric will inconsistently pass & fail the target
	Pay costs	Sep-22	29.5	31.8	H	?	Fourteen points above the mean Metric will inconsistently pass & fail the target
	Non-pay costs (including financing)	Sep-22	15.5	18.9	H	?	Nine points above the mean Metric will inconsistently pass & fail the target

Sustainable Services

Summary

East and North Hertfordshire NHS Trust

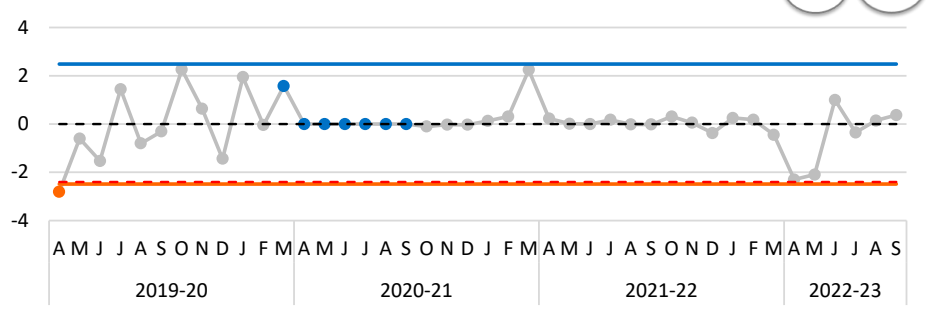
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Key Payroll Metrics	Substantive pay costs	Sep-22	24.9	27.9	H	P	Three points above the upper process limit Metric will consistently pass the target
	Average monthly substantive pay costs (000s)	Sep-22	0.9	4.9	H	F	Thirteen points above the mean Metric will consistently fail the target
	Agency costs	Sep-22	0.9	1.0			Common cause variation No target
	Unit cost of agency staff	Sep-22		9.6			Common cause variation No target
	Bank costs	Sep-22	3.7	2.9		P	Common cause variation Metric will consistently pass the target
	Overtime and WLI costs	Sep-22	0.5	0.4	H	P	Eleven points above the mean Metric will consistently pass the target
Other Financial Metrics	Elective Recovery Fund income earned	Sep-22	1.1	1.7		?	Common cause variation Metric will inconsistently pass & fail the target
	Drugs and consumable spend	Sep-22	2.8	3.5		?	Common cause variation Metric will inconsistently pass & fail the target
	Private patients income earned	Sep-22	0.4	0.4	H	?	Nine points above the mean Metric will inconsistently pass & fail the target

Sustainable Services

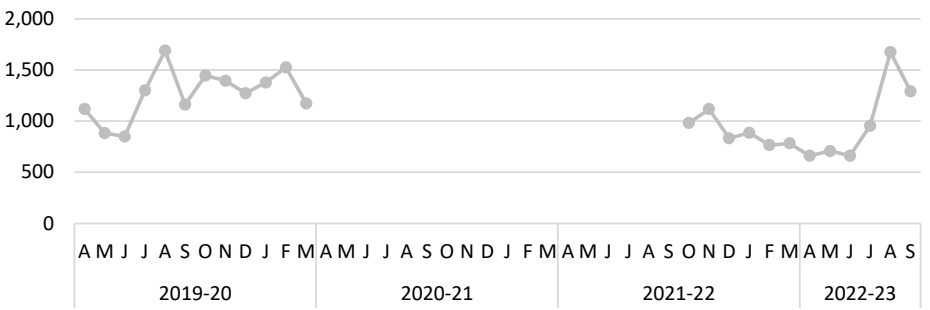
Summary Financial Position

East and North Hertfordshire NHS Trust

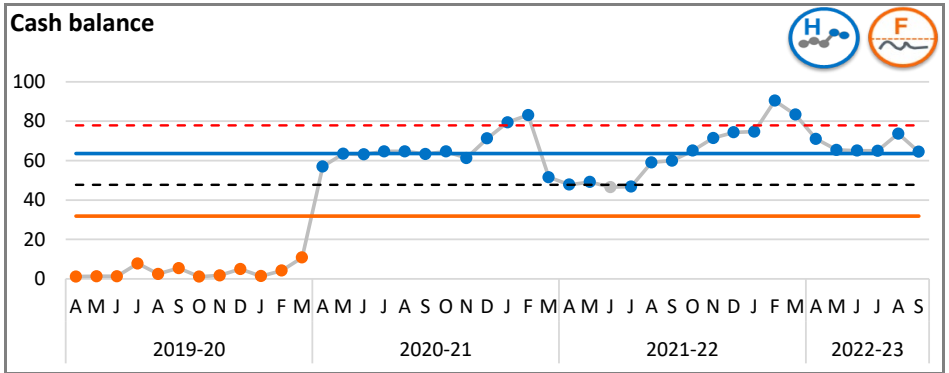
Surplus / deficit



CIPS achieved



Cash balance



Key Issues and Executive Response

- The Trust reports its M6 financial performance against the breakeven plan that it agreed and submitted in June 22.
- The Trust reports a balanced position in September, and a YTD deficit position of £3.2m. This remains broadly in line with the Trust's financial plan. However, the significant commitment of reserve funds has been required to achieve this.
- The Trust's elective activity plan assumes a gradual ramp up of capacity. Progress during the YTD has been modest compared with the 19/20 baseline, with a significant step changed anticipated in Q3. The YTD position assumes full receipt of planned ERF funds.
- Delivery against the Trust's CIP target remains a concern, with a YTD undershoot of £2.8m reported at M6. Divisional recovery plans are an urgent priority.
- Significant overspends against medical staffing budgets are reported at M6. These are concentrated in both Planned & Unplanned Divisions.

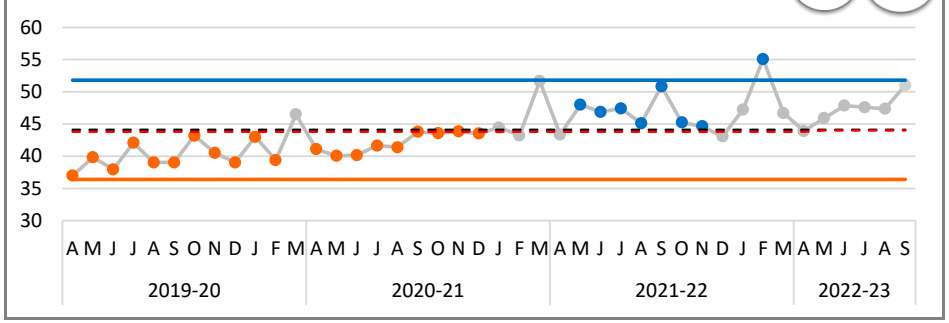
	Annual Budget £m	Budget YTD £m	Actual YTD £m	Variance YTD £m
Income	542.7	270.7	270.8	0.2
Pay	-352.8	-177.1	-176.7	0.4
Non Pay	-183.1	-93.2	-94.0	-0.8
EBITDA	**6.8**	**0.3**	**0.1**	**-0.2**
Financing Costs	-32.4	-16.4	-16.2	0.1
Retained Deficit exc. PSF	**-25.6**	**-16.0**	**-16.1**	**-0.1**
Top-Up Payments	10.0	5.0	5.1	0.1
Systems Funding	15.6	7.8	7.8	0.0
Surplus / Deficit (excl Fin Adj's)	**0.0**	**-3.3**	**-3.2**	**0.0**
Adj Financial Performance	-0.2	-0.1	-0.3	-0.2
Deficit (Incl Fin Adj's)	**-0.2**	**-3.3**	**-3.5**	**-0.2**

Sustainable Services

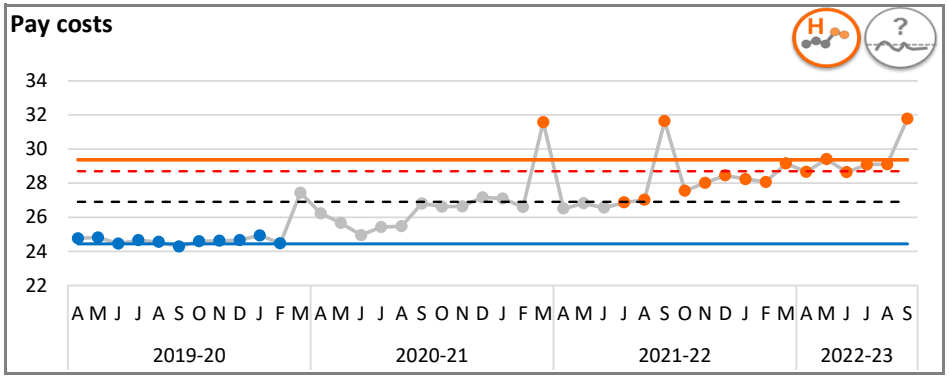
Key Financial Drivers

East and North Hertfordshire NHS Trust

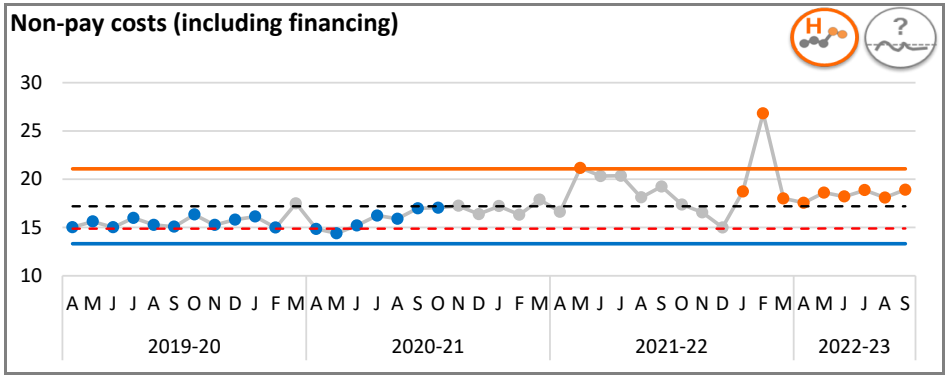
Income earned



Pay costs



Non-pay costs (including financing)



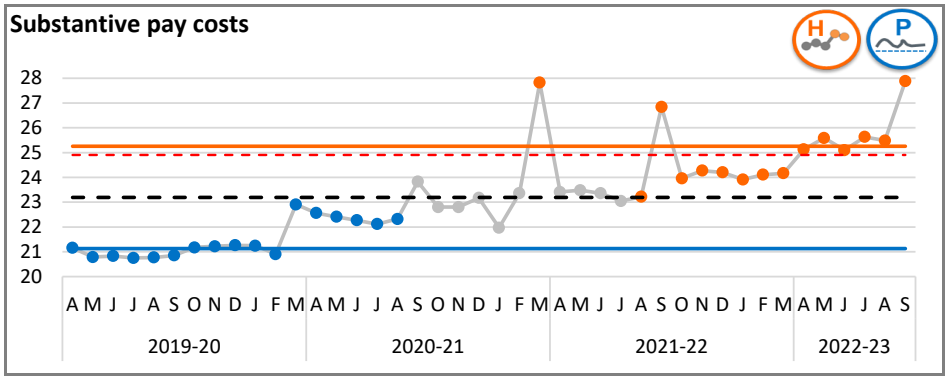
Key Issues and Executive Response

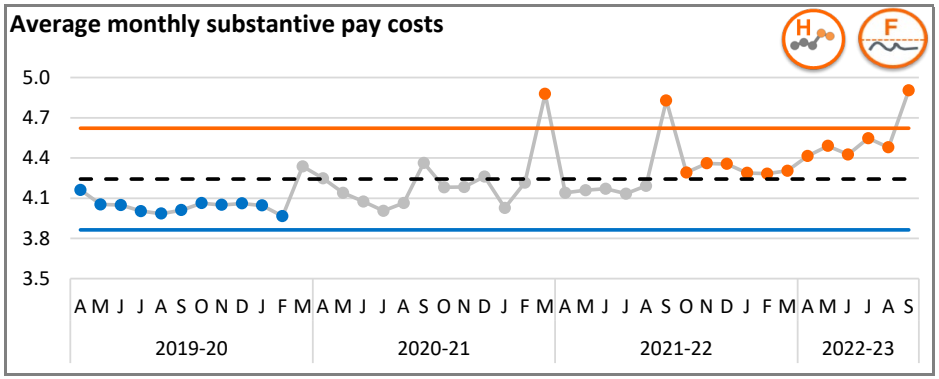
- Month 6 performance continues to present a significant challenge for the Trust. Whilst the YTD deficit position of £3.2m is in line with the financial plan, a number of key risk items remain within the reported position.
- A significant utilisation of non-recurrent reserves funding has been required in order to sustain plan achievement to date. This opportunity will not be available over the remainder of the financial year.
- Achievement against CIP targets (£2.8m slippage YTD) remains a major concern, particularly in light of the levels of non-recurrent savings.
- Overspending against medical staffing budgets - totals £1.5m for the YTD.
- Month 6 ERF performance and income was adversely impacted by the delay in procedure room mobilisation and the unplanned bank holiday.
- Inflation continues to be a high-risk area that is being captured and reported.
- A financial reset programme is being implemented in Q3, with 11 workstreams identified to support financial recovery.

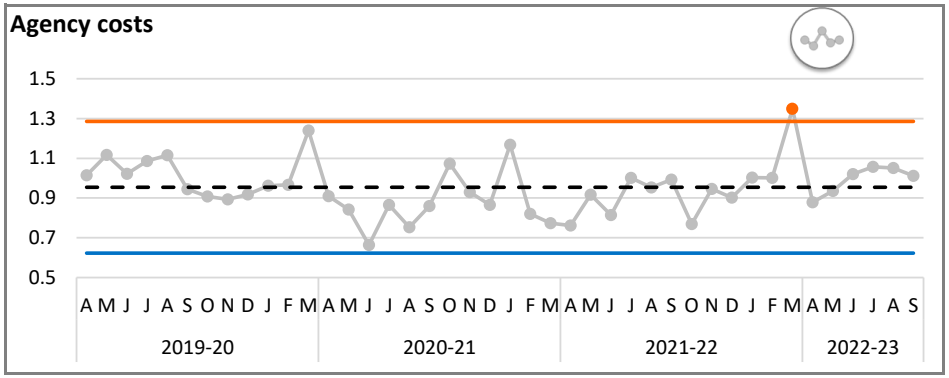
Sustainable Services

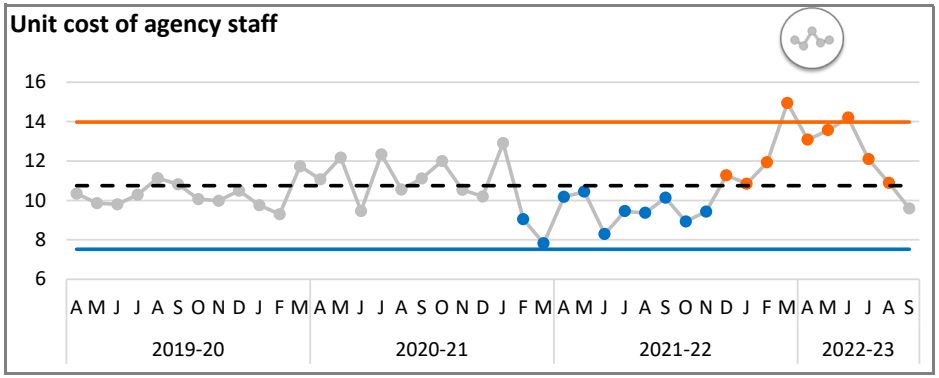
Key Payroll Metrics

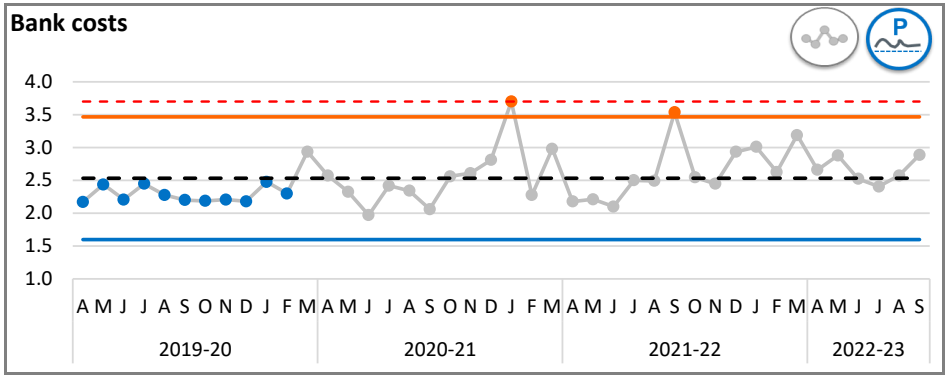
East and North Hertfordshire NHS Trust

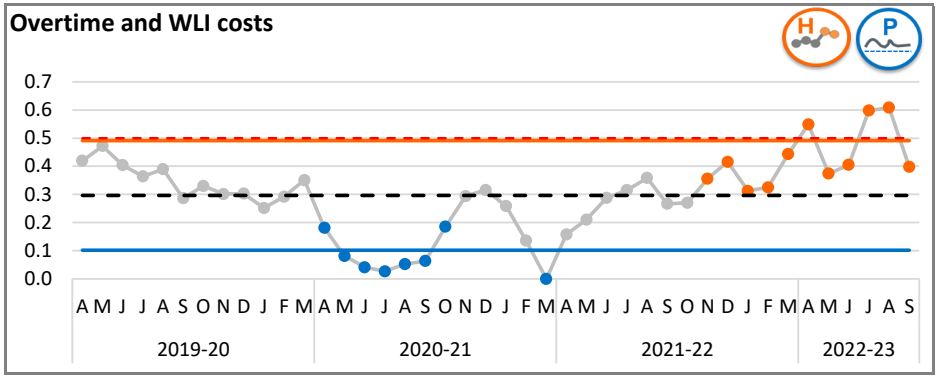








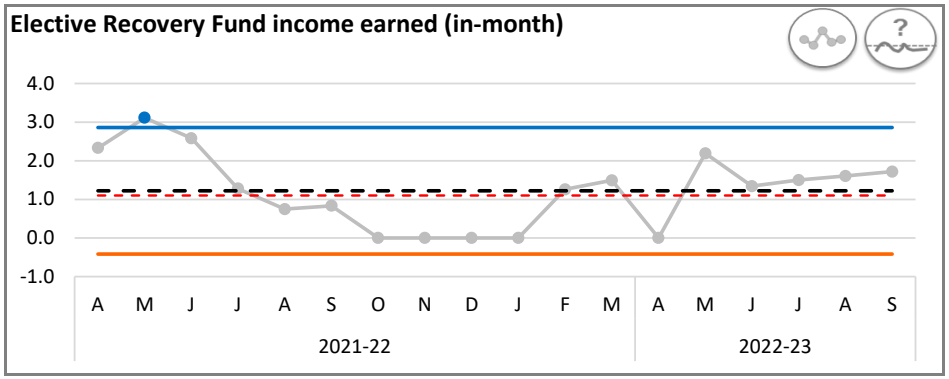


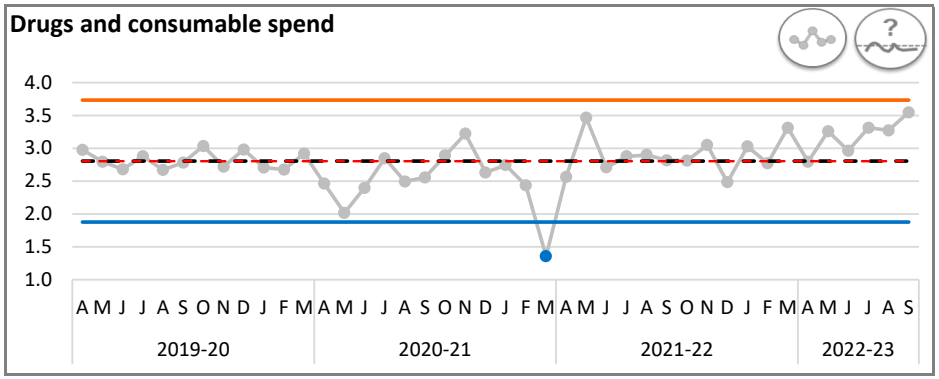


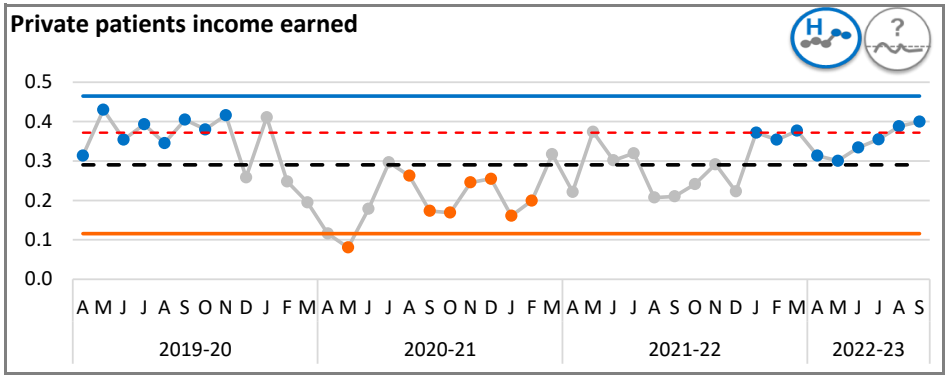
Sustainable Services

Other Financial Indicators

East and North Hertfordshire NHS Trust







East and North Hertfordshire NHS Trust

IPR | Supplementary Indicators

Month 06 | 2022-23

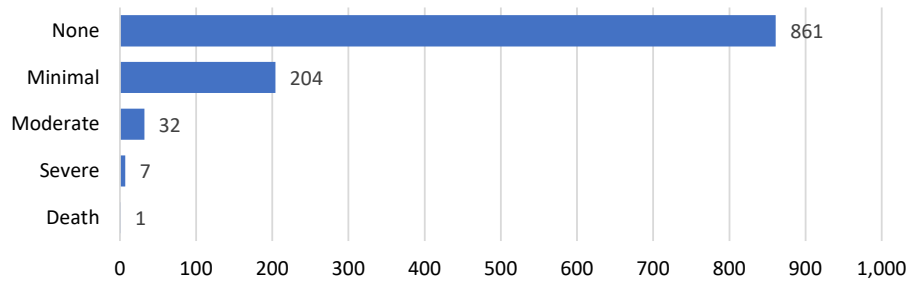
Data correct as at 21/10/2022

Safe Services

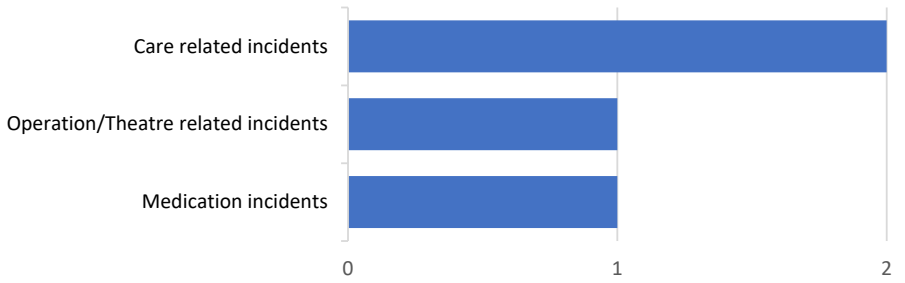
Supplementary Indicators

East and North Hertfordshire NHS Trust

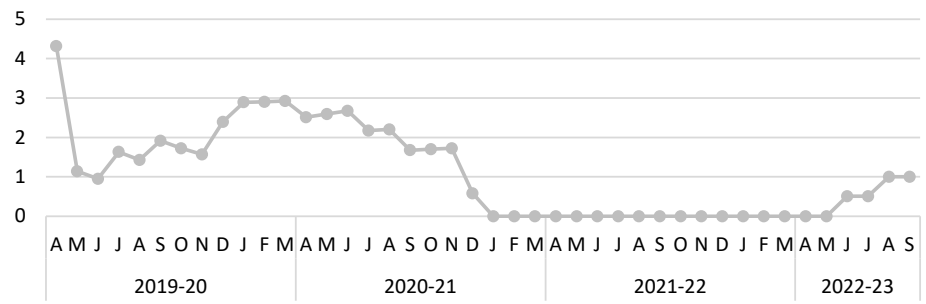
Number of incidents by level of harm - Sep-22



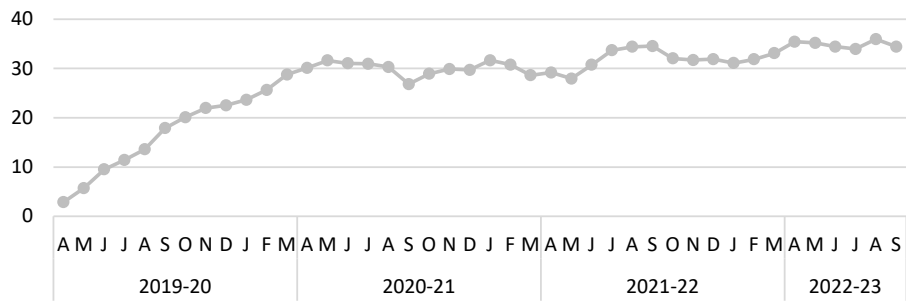
Serious Incidents Themes - Sep-22



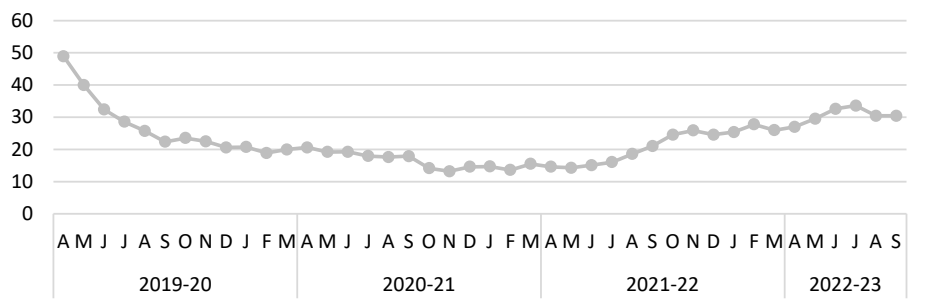
Hospital-acquired MRSA - rate per 100,000 bed days - rolling 12-months



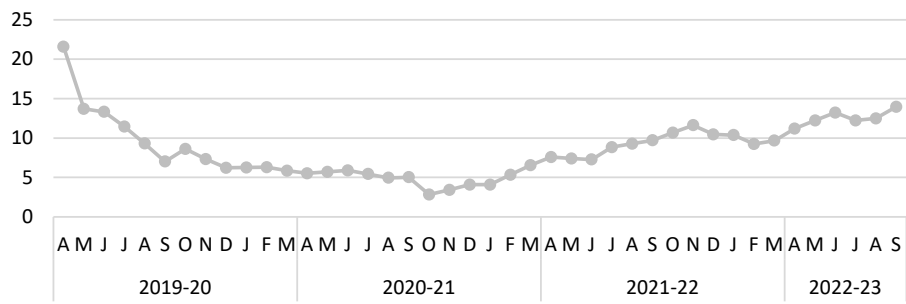
Hospital-acquired c.difficile - rate per 100,000 bed days - rolling 12-months



Hospital-acquired e.coli - rate per 100,000 bed days - rolling 12-months



Hospital-acquired MSSA - rate per 100,000 bed days - rolling 12-months



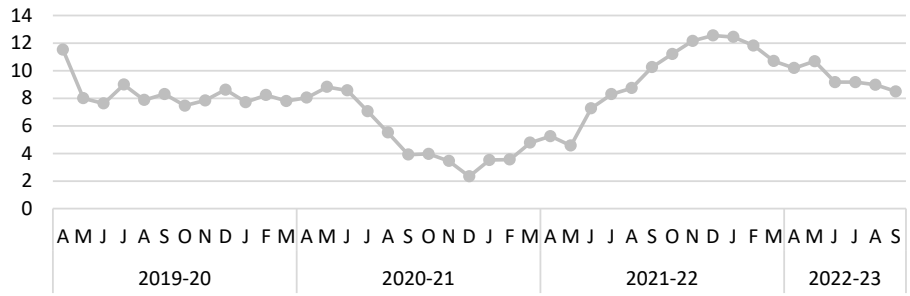
Month 06 | 2022-23

Safe Services

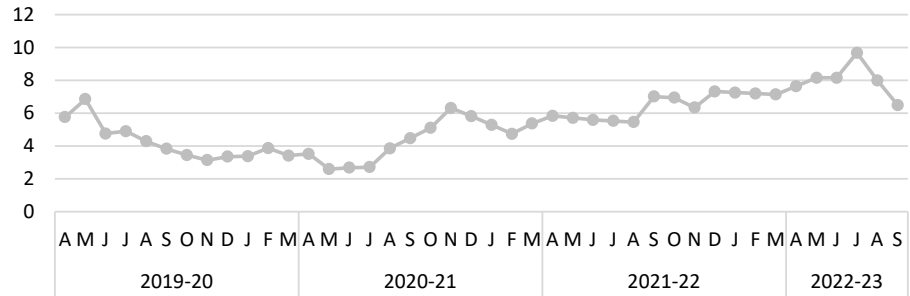
Supplementary Indicators

East and North Hertfordshire NHS Trust

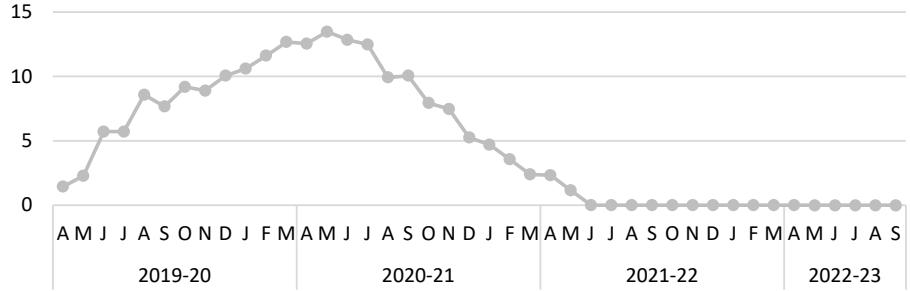
Rate of Klebsiella incidences per 100,000 bed days - rolling 12-months



Rate of Pseudomonas Aeruginosa incidences per 100,000 bed days - rolling 12-mont



Rate of CPO incidences per 100,000 bed days - rolling 12-months

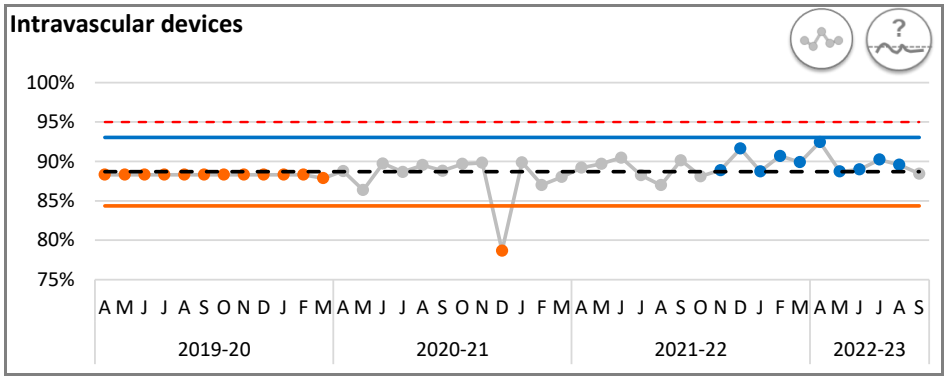


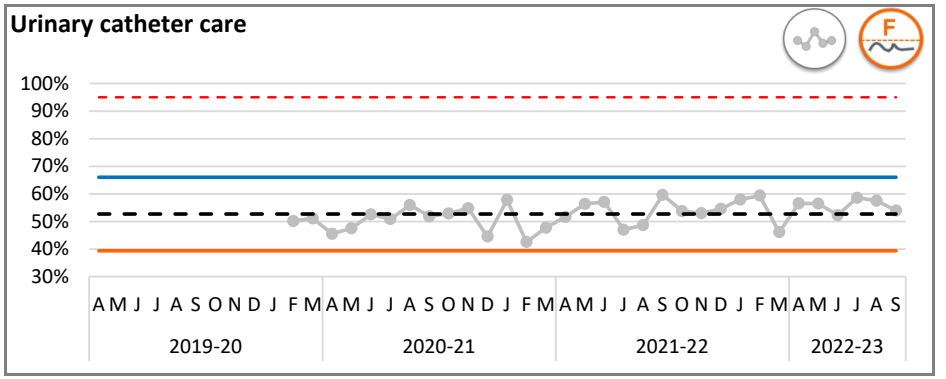
Month 06 | 2022-23

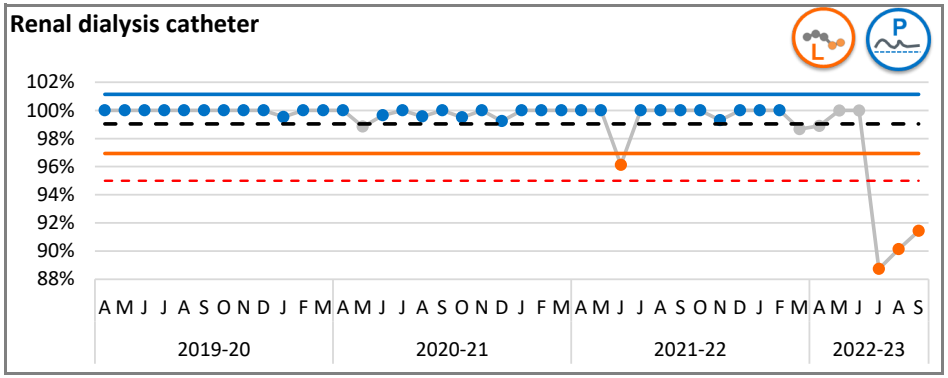
Safe Services

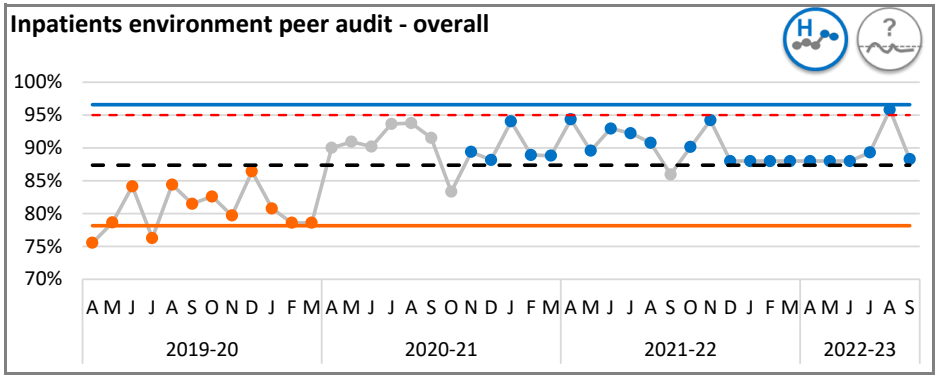
Supplementary Indicators

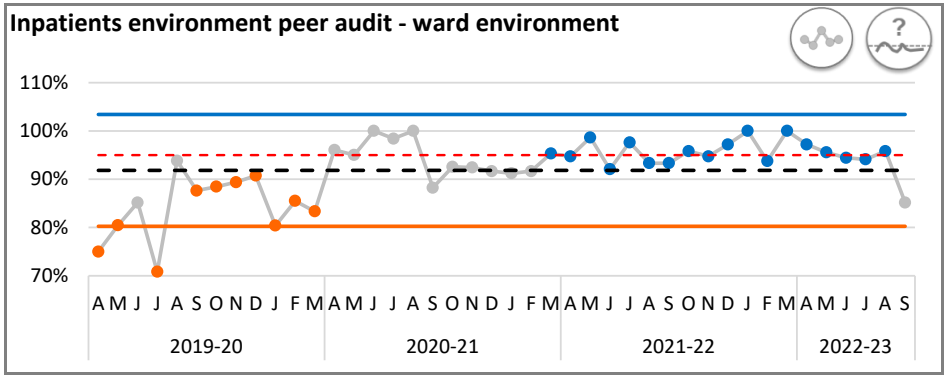
East and North Hertfordshire NHS Trust

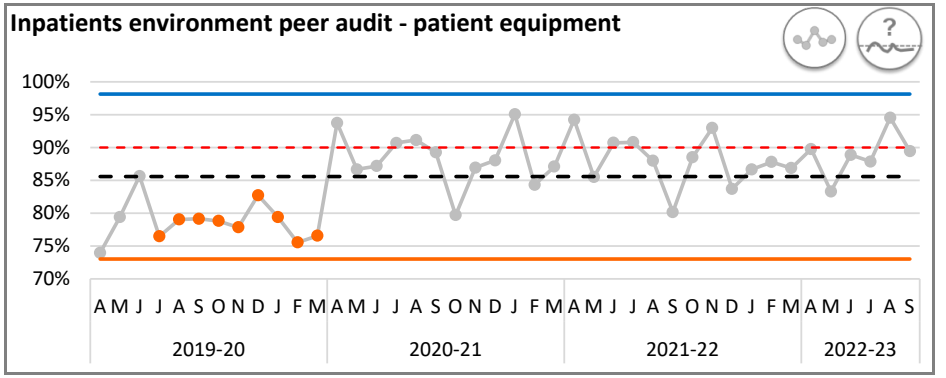












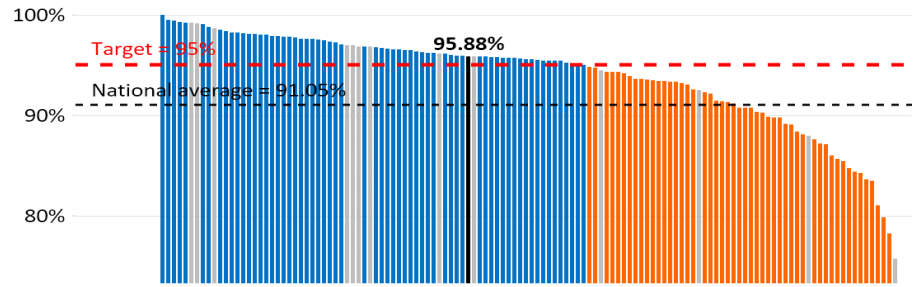
Month 06 | 2022-23

Caring Services

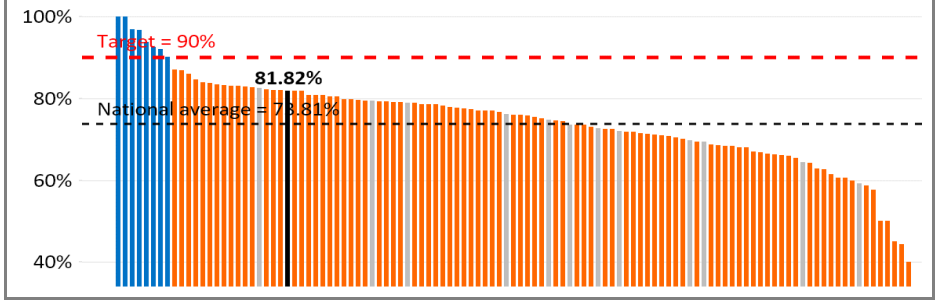
Supplementary Indicators

East and North Hertfordshire NHS Trust

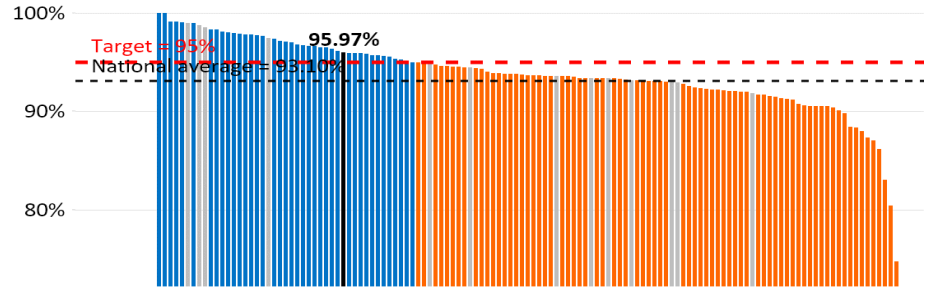
Inpatients FFT peer distribution - Aug-22



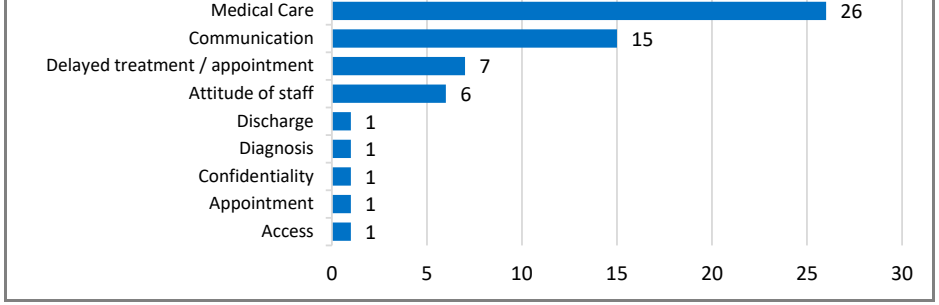
A&E FFT peer distribution - Aug-22



Outpatients FFT peer distribution - Aug-22



Complaints themes - Sep-22



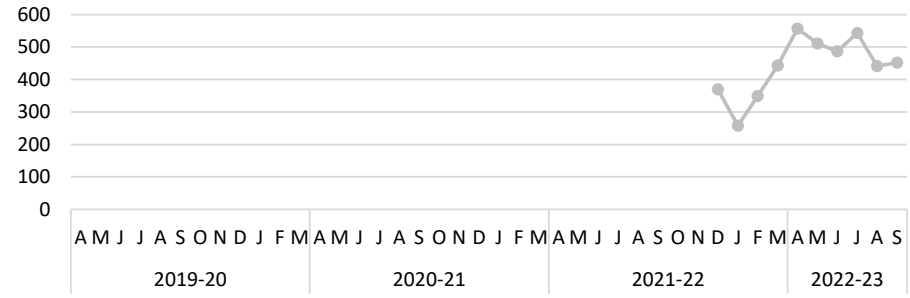
Month 06 | 2022-23

Responsive Services

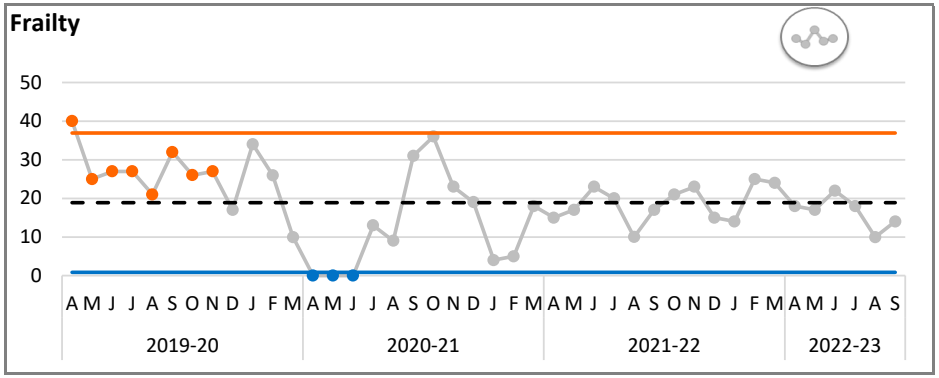
Emergency Department | Supplementary Indicators

East and North Hertfordshire NHS Trust

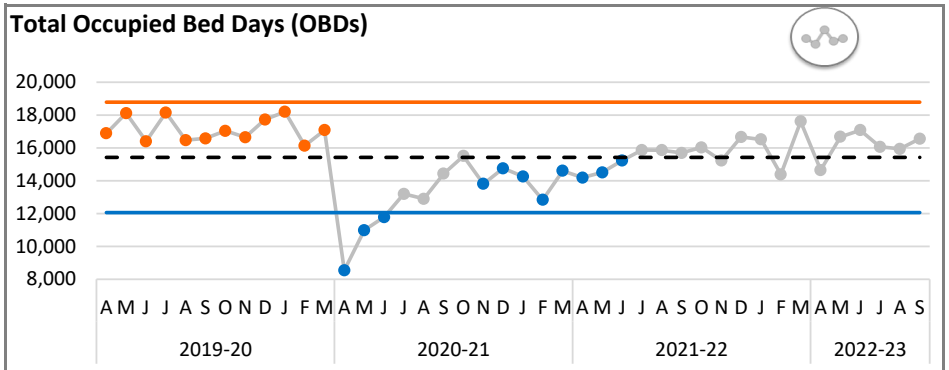
Average minutes from clinically ready to proceed to departure



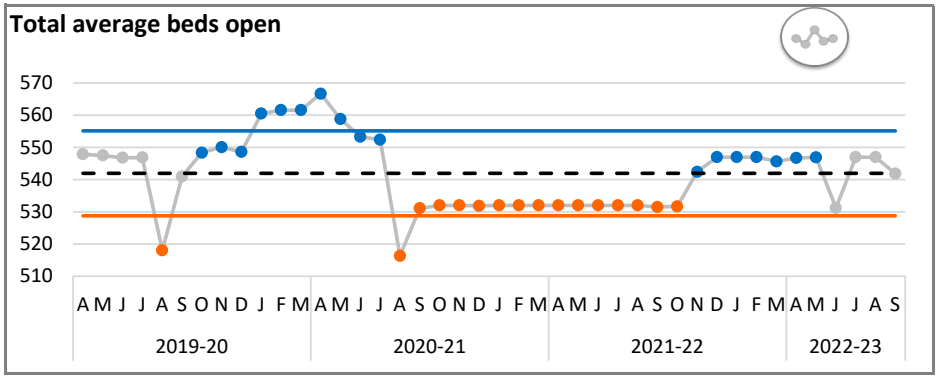
Frailty



Total Occupied Bed Days (OBDs)



Total average beds open



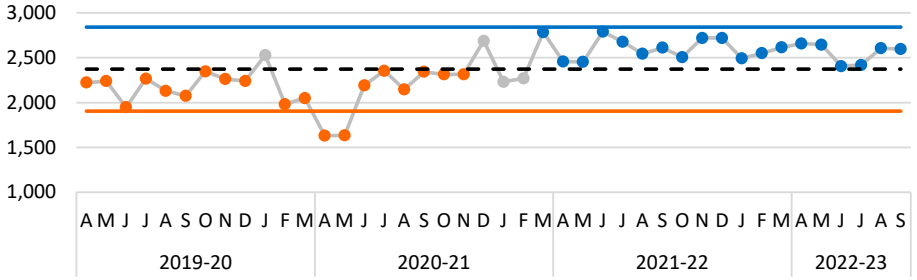
Month 06 | 2022-23

Responsive Services

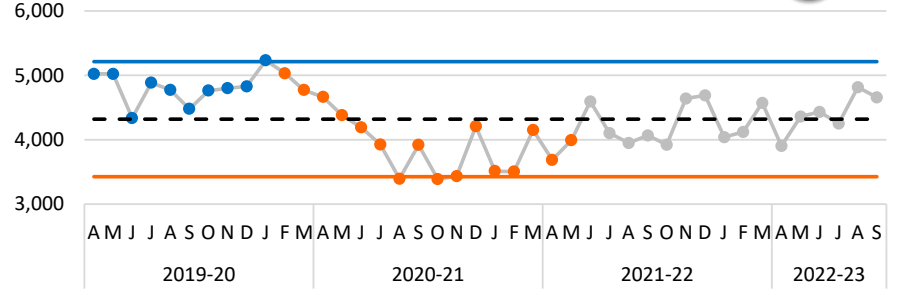
Cancer Waiting Times | Supplementary Indicators

East and North Hertfordshire NHS Trust

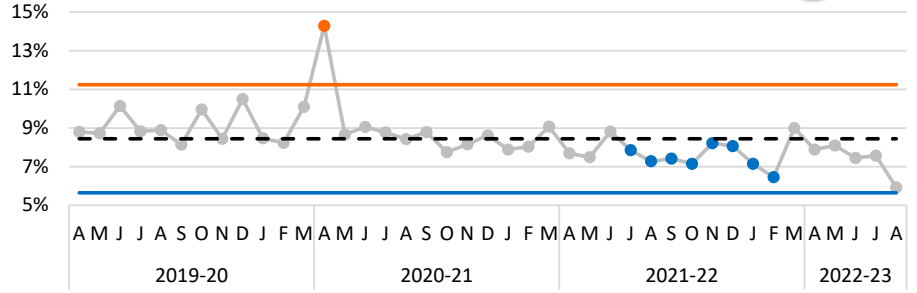
Chemotherapy activity



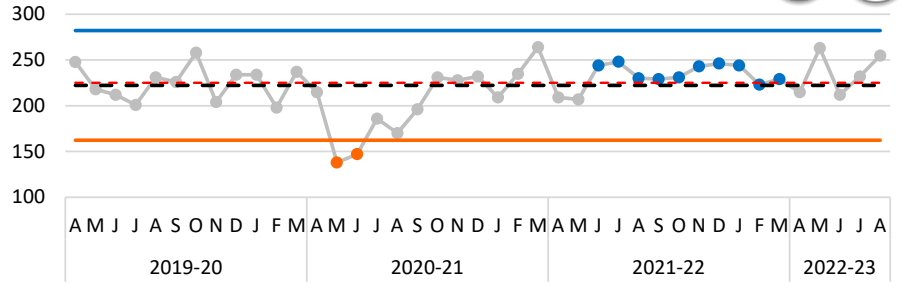
Radiotherapy activity



Conversion rate from suspected cancer referral



Total patients treated for cancer compared to 2019-20

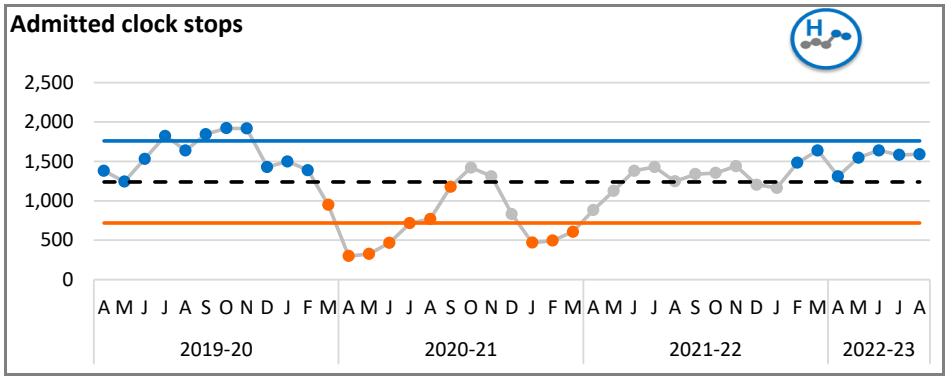


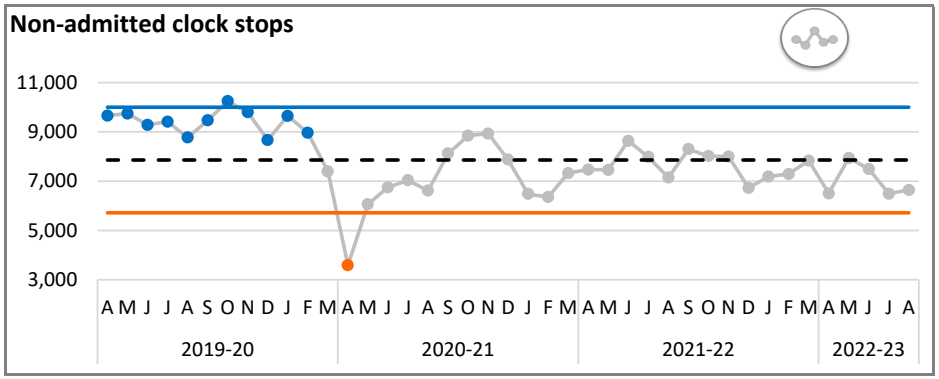
Month 06 | 2022-23

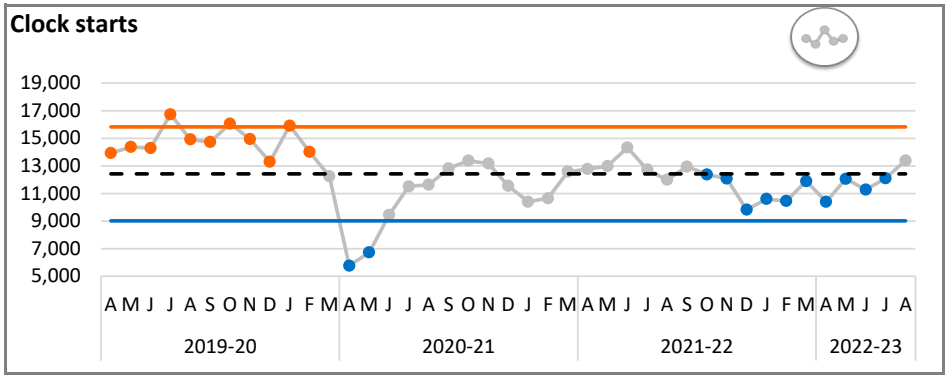
Responsive Services

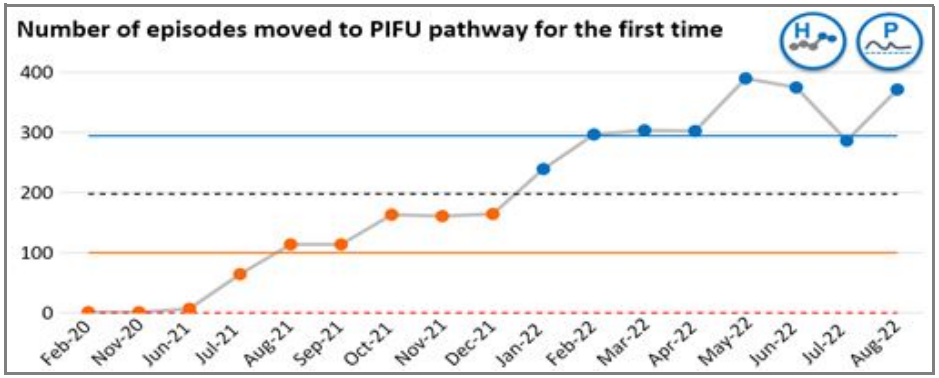
RTT 18 Weeks |Supplementary Indicators

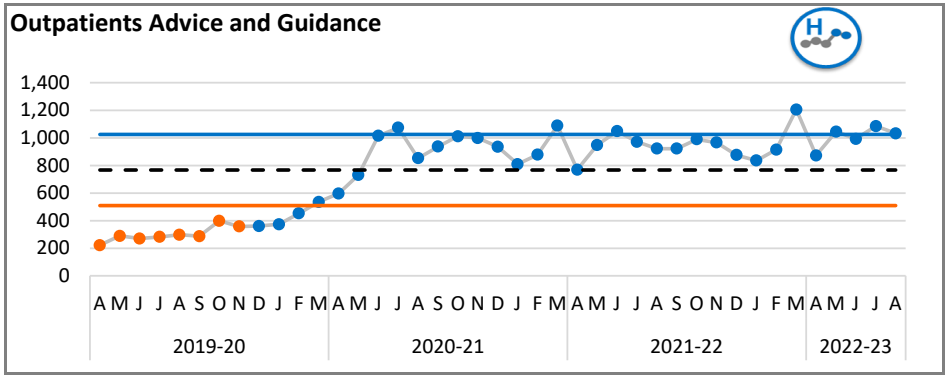
East and North Hertfordshire NHS Trust

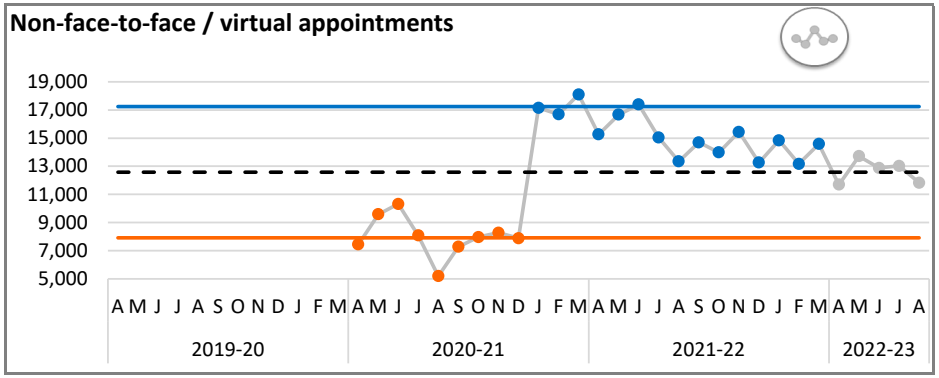










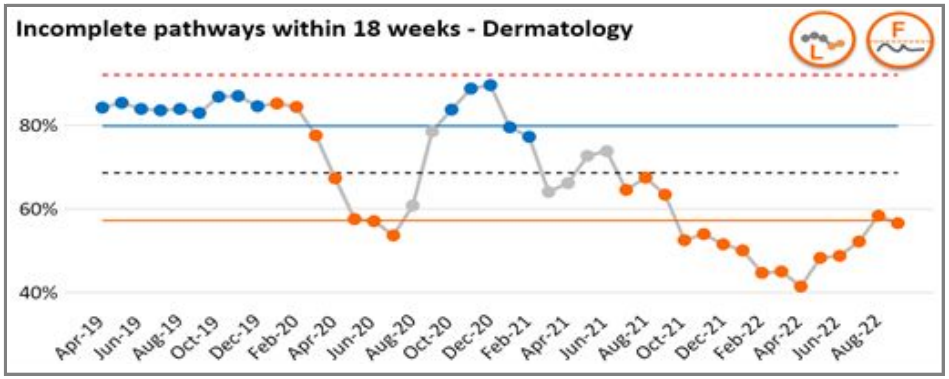


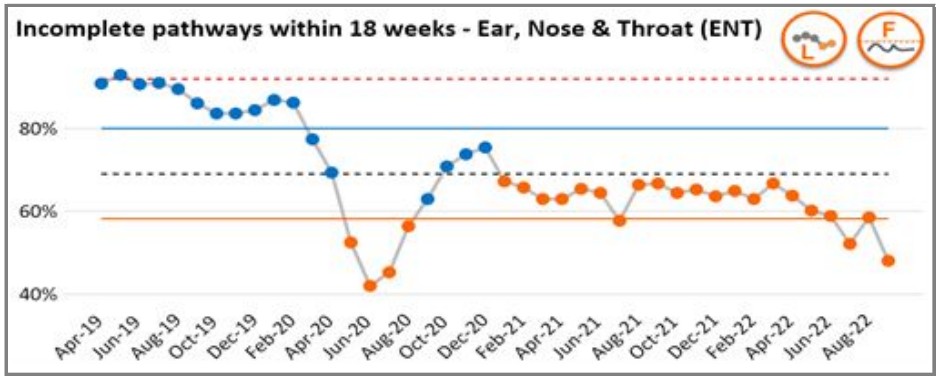
Month 06 | 2022-23

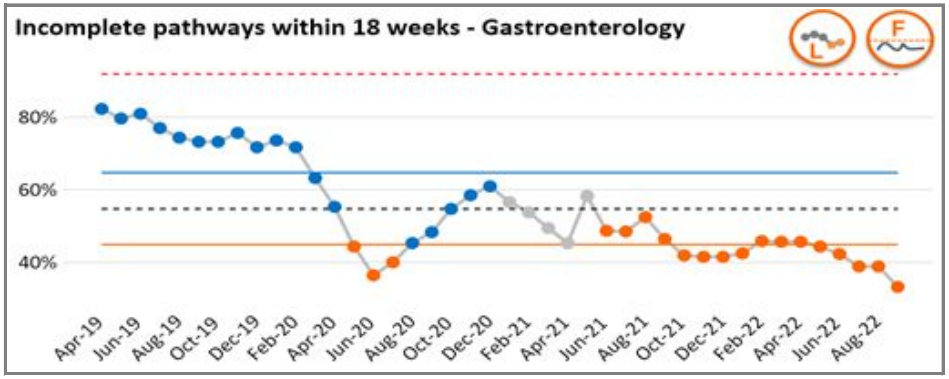
Responsive Services

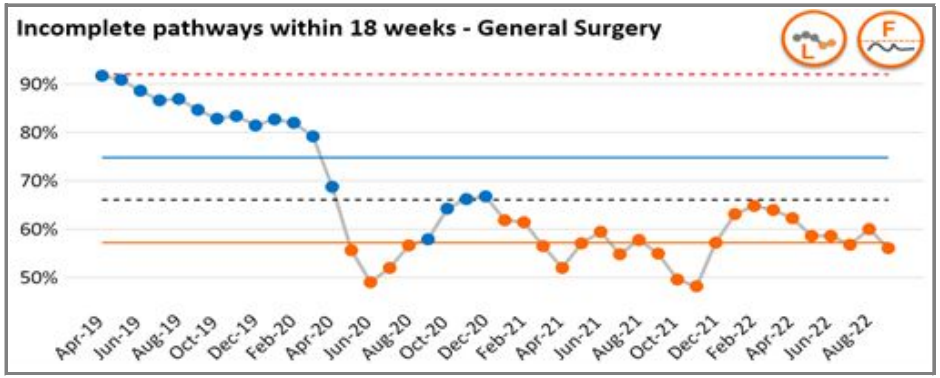
RTT 18 Weeks | Supplementary Indicators

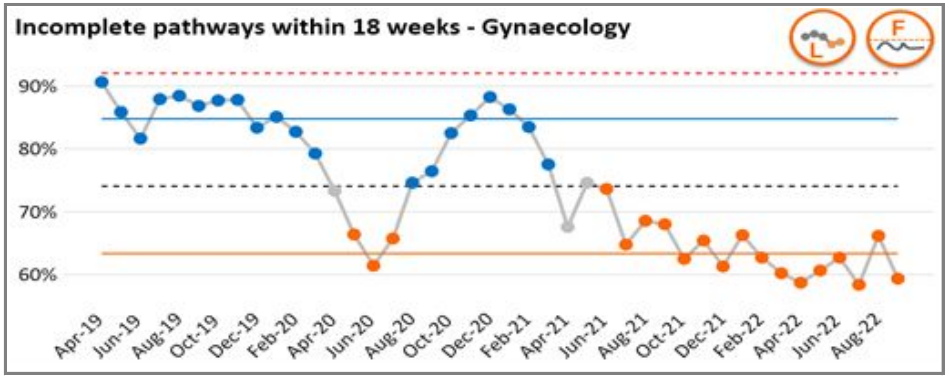
NHS
East and North Hertfordshire
NHS Trust

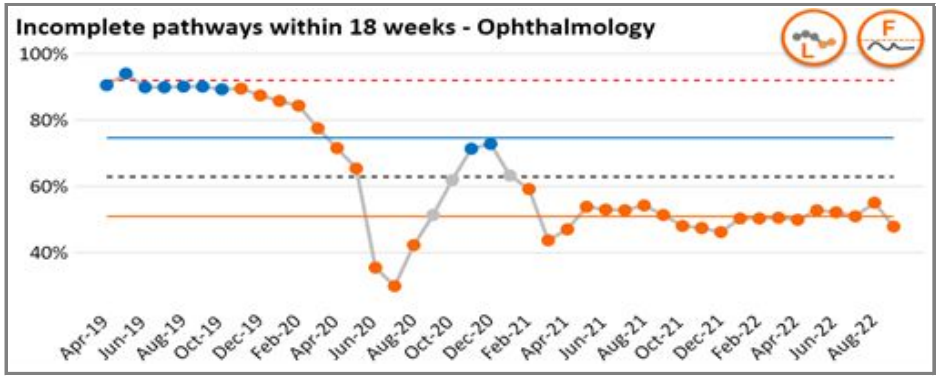










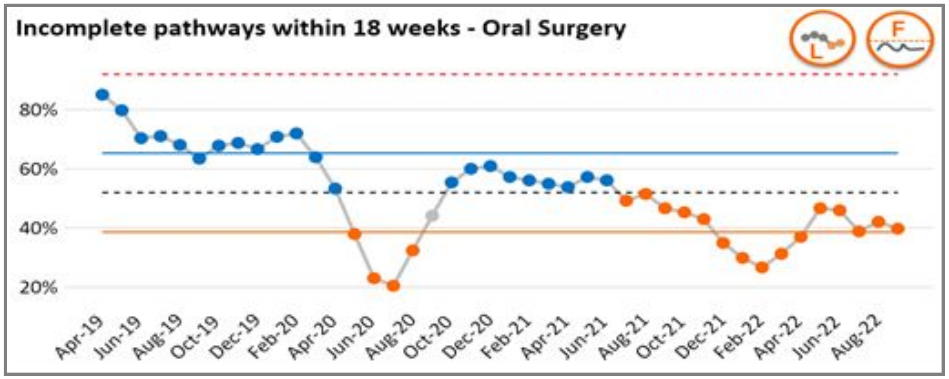


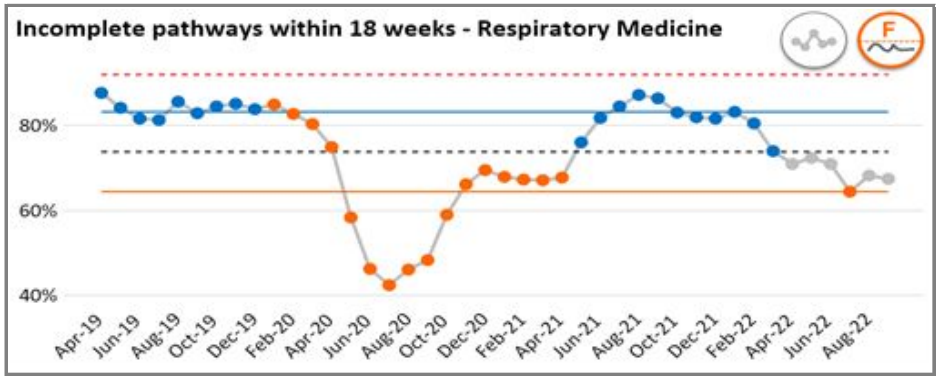
Month 06 | 2022-23

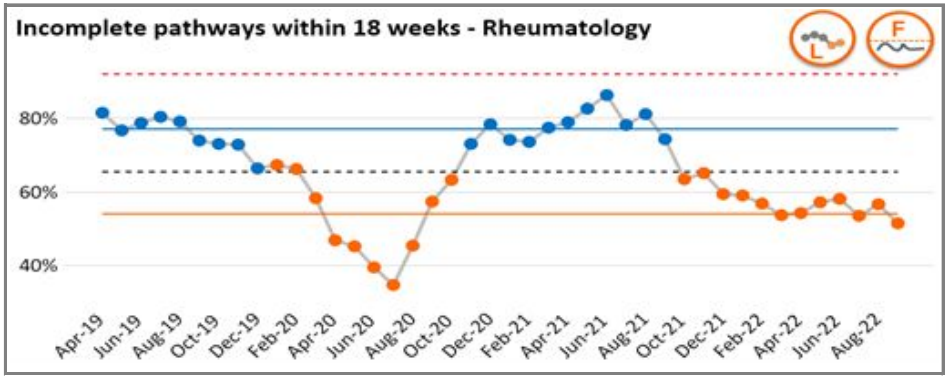
Responsive Services

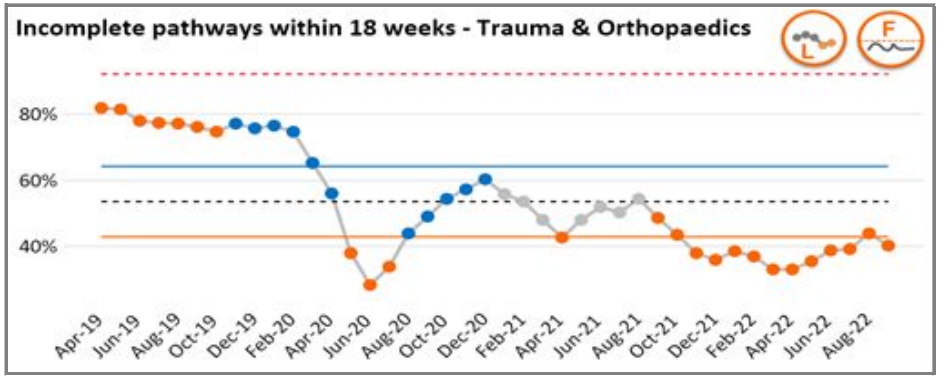
RTT 18 Weeks | Supplementary Indicators

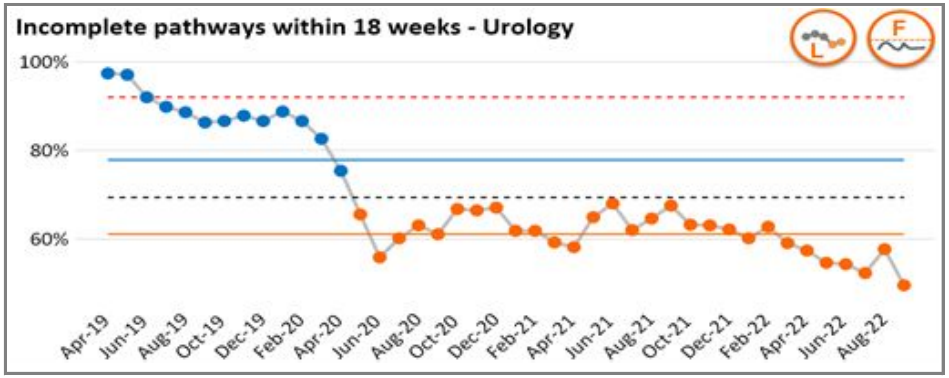
East and North Hertfordshire NHS Trust

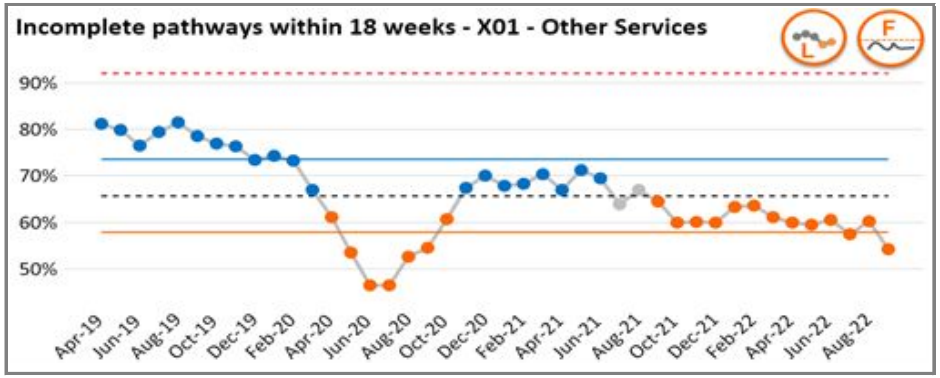












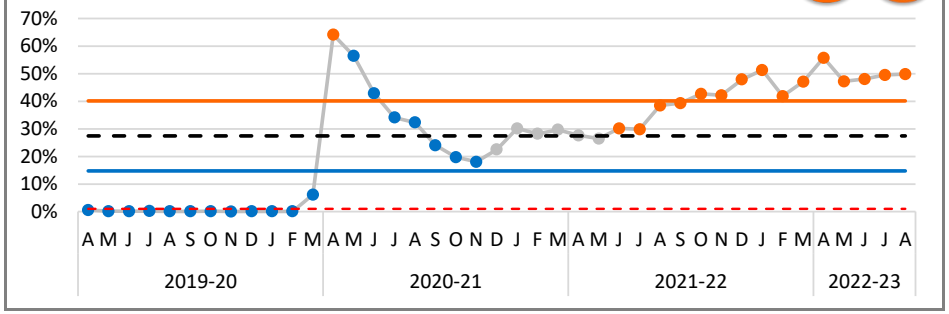
Month 06 | 2022-23

Responsive Services

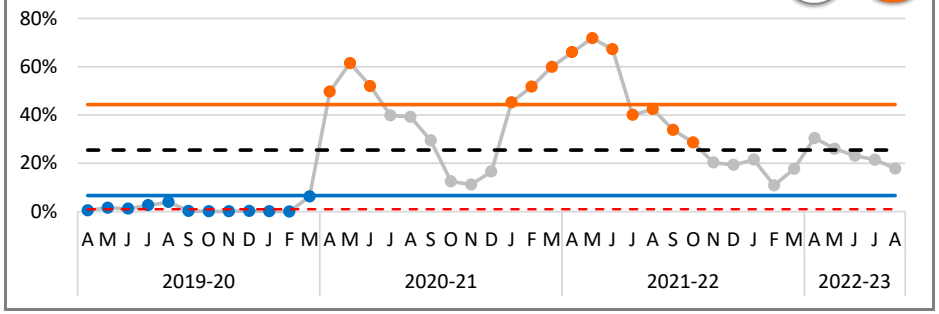
Diagnostics Waiting Times | Stroke Services | Supporting Indicators

East and North Hertfordshire NHS Trust

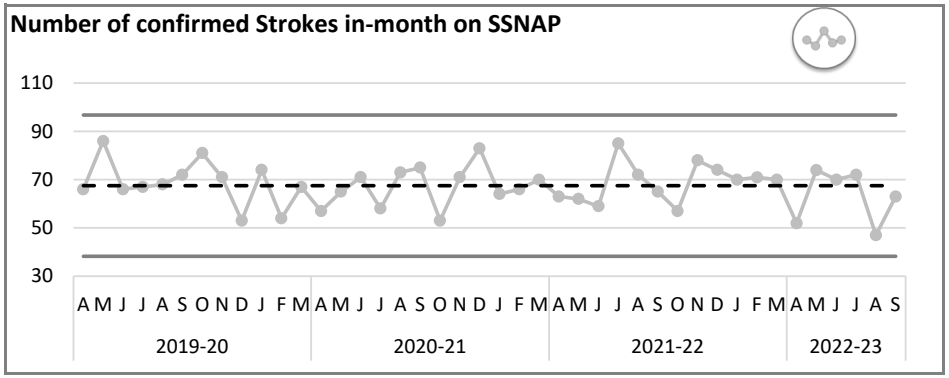
Patients waiting more than six weeks for a Radiology (all modalities)



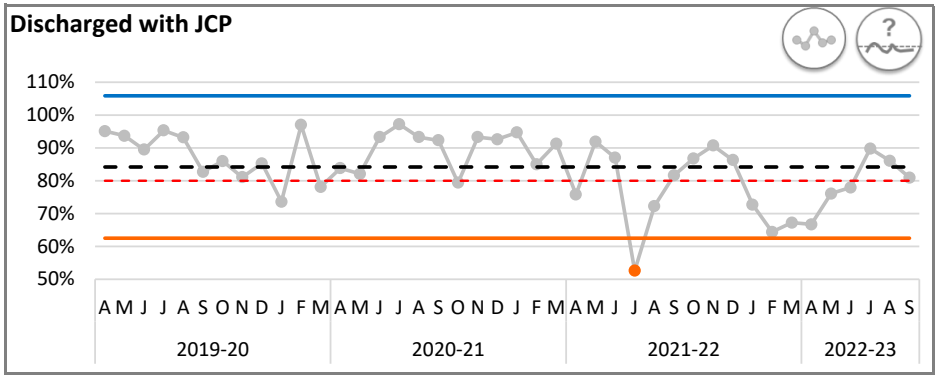
Patients waiting more than six weeks for Endoscopy (all modalities)



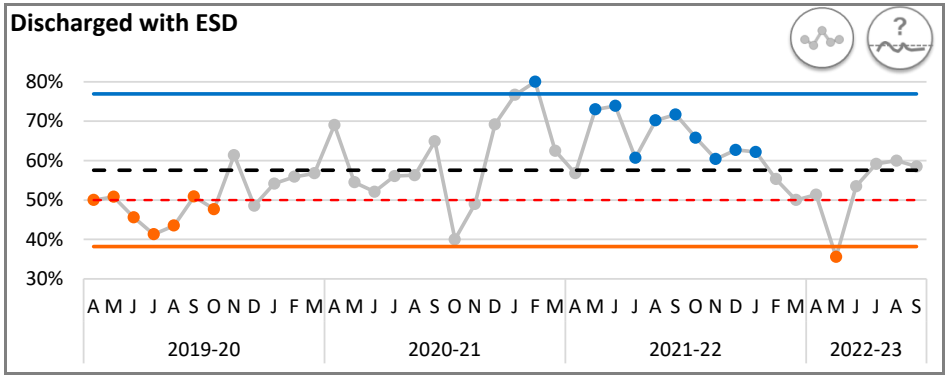
Number of confirmed Strokes in-month on SSNAP



Discharged with JCP



Discharged with ESD



Month 06 | 2022-23

People

Supplementary Indicators

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Pulse Survey	My leader	75%	79.8%	tbc			tbc			tbc			tbc		
	Harnessing individuality	60%	52.8%	tbc			tbc			tbc			tbc		
	Not experiencing discrimination	95%	70.8%	tbc			tbc			tbc			tbc		
	Well-being	70%	71.5%	tbc			tbc			tbc			tbc		
	Reasonable adjustments	50%	91.4%	tbc			tbc			tbc			tbc		
	Training and development opportunities	55%	55.1%	tbc			tbc			tbc			tbc		
	Talent management	55%	55.4%	tbc			tbc			tbc			tbc		
	Flexibility	55%	56.6%	tbc			tbc			tbc			tbc		
Staff FFT	Recommend as a place to work	60%	41.7%	tbc			tbc			tbc			tbc		
	Recommend as a place of care	70%	65.9%	tbc			tbc			tbc			tbc		
Staff Survey	Safety culture theme score	45.2%	44.7%							tbc					
	Perception of leadership culture	65.9%	65.8%							tbc					
	Engagement theme score	6.8	6.8							tbc					
	Bullying and harrassment score	19.6%	23.2%							tbc					

Month 06 | 2022-23

People

Supplementary Indicators

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Supporting Metrics	Relative likelihood of white applicant being shortlisted and appointed over BAME applicant	1	1.43	1.53			1.58			tbc			tbc		
	Relative likelihood of non-disabled applicant being shortlisted and appointed over disabled applicant	1	1.62	3.10			1.23			tbc			tbc		
	% of Clinical Workforce (AFC) on eRoster	> 90%	82%	82%	82%	82%	82%	82%	82%	82%	82%	83%	84%	84%	84%
	% of Medical & Dental on eRoster	> 60%			83.0%	84.0%	84.0%	84.0%	84.0%	85.0%	85.0%	83.0%	82.0%	84.0%	84.0%
	Model employer targets (% achieved)	100%	67%	83%			50%			tbc			tbc		
	Average length of suspension (days)	20	142.5	140.0	177.5	86.0	226.5	201.0	137.2	193.0	212.0	242.0	254.0	284.0	tbc
	Average length of Disciplinary (excluding suspensions - days)	60	71.6	51.0	54.9	43.5	72.5	112.4	86.3	81.7	142.0	159.0	109.3	99.8	66.0
	Average length of Grievance (including dignity at work - days)	60	23.3	37.0	46.9	45.9	57.7	64.8	94.2	77.3	109.0	96.0	87.6	87.5	95.0

Month 06 | 2022-23

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board		**Agenda Item**	11
Report title	ICS Stakeholder update		**Meeting Date**	07-09-22
Presenter	Martin Armstrong – Deputy CEO			
Author	Contributions from lead executives			
Responsible Director	Martin Armstrong – Deputy CEO		**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**	☐
	Discussion	☒	**Decision**	☐

Report Summary:

This document provides an update on ICS Stakeholder engagement.

Impact: where significant implication(s) need highlighting

Risk: *Please specify any links to the BAF or Risk Register*

BAF Risk 7 – Immature place and system collaborative processes and culture

Report previously considered by & date(s):

N/A

Recommendation	The Board is asked to discuss the ICS stakeholder update set out in the paper

To be trusted to provide consistently outstanding care and exemplary service

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Charter House
Parkway
Welwyn Garden City
Hertfordshire
AL8 6JL

27 September 2022

https://hertsandwestessex.icb.nhs.uk

Dear stakeholder,

September began with a visit to our area by Sir David Sloman, the chief operating officer of NHS England. Sir David met health and social care leaders from across Hertfordshire and west Essex and discussed plans for dealing with the pressures we will face this winter.

He heard about some innovative partnership work, as well as finding out about the challenges we face and the support we need. Sir David was able to see some of the community health improvement work led by Watford FC's Community Trust, which helps ease pressures by keeping people well, physically, and mentally. And when people do fall ill, the approach to developing virtual hospital services at West Hertfordshire Teaching Hospitals NHS Trust gives them first-class care from their own homes, freeing up beds for those who need them. All of this will help us to support our communities this winter. You can read more his visit here. We're very proud of what is being achieved across our ICS area and will continue to use these letters to share interesting projects with you.

It was also our pleasure to welcome Clare Panniker, Regional Director for the East of England to Hertfordshire and West Essex. Clare and Jane visited the Hertfordshire Community NHS Trust 'hub' at Robertson House in Stevenage and had the opportunity to meet with team members from several different services. Clare also met with the ICB executive to discuss a number of areas.

In the three months since the establishment of the Integrated Care Board at the start of July, we have made some significant process as an organisation across our key areas of focus - working with system partners to further strengthen our joint approach to tackling the ongoing unprecedented demand on Urgent and Emergency Care, to reduce the elective waiting lists, improve performance against our cancer targets, coordinate delivery of the autumn booster programme and improve access to Primary Care. Further detail on some of this work is included in this month's letter, with more to follow in the months ahead.

Two crucial enablers of improvement across those areas will be our workforce and ensuring we grasp the opportunities presented by digital transformation. We have developed system-wide strategies in both these areas - with both the Digital Transformation and People Strategies expected at the November meeting of the Integrated Care Board.

Dr Jane Halpin, Chief Executive

Rt. Hon. Paul Burstow, Chair

As we head into the autumn, our plans to ensure that our local NHS and social care services are prepared for the colder months of the year when they are at their busiest, are being finalised and funding agreed to implement them. We will provide more details on these initiatives in next month's letter.

This year, more so than ever, our local population will face additional challenges to their health and wellbeing. Our county and district council partners will be working together closely to support our communities, for example in west Essex, the NHS, local authority, and voluntary organisations have teamed up to try and tackle financial and health inequalities through the Harlow Community Hub.

Running on Friday mornings, the hub provides support to residents as part of a response to the challenges impacting the community since the pandemic hit. It was funded with a further grant by the NHS, Harlow Council and Essex County Council in April 2022 to support people affected by the cost of living crisis.

Local charity Rainbow Services run the hub in partnership with Mind in West Essex, Harlow Foodbank, Citizens Advice, and the Volunteer Centre Harlow. It offers a regular food bank, information on community and physical activities, access to volunteering and a school uniform service. Staff from the hub also support patients from Harlow North Primary Care Network, with Citizens Advice staff working in GP surgeries.

One of the ways in which people can protect their health this winter is by taking up the offer of a flu vaccine and a COVID booster jab if they are eligible. We expect to see higher numbers of flu cases this winter as many people's immunity to the virus has waned. This could mean that our health services are put under more pressure caring for people who develop complications as a result of flu, so we are keen that people at most risk come forward for their vaccination when they are invited. More details about the flu and COVID booster vaccination programme in Hertfordshire and west Essex can be found on our website: https://hertsandwestessexics.org.uk/covid-19

Update from the Integrated Care Partnership (ICP)

Work to develop our system's Integrated Care Strategy is progressing well. This significant project, which will guide our work for the next ten years, is being undertaken by lead officers from organisations across the ICS, under the auspices of the newly created Integrated Care Partnership. Extensive consultation on the strategy's aims will be starting shortly and we will update stakeholders on how they can be involved through future letters.

The new strategy will give us an opportunity to improve people's health and wellbeing, by encouraging collaboration, joint working, and integration across the Hertfordshire and West Essex ICS footprint, reaching out beyond the NHS and local authorities to other partners who are also able to influence wider issues that impact on health, such as housing, employment, education and community safety.

Dr Jane Halpin, Chief Executive

Rt. Hon. Paul Burstow, Chair

Once in place the strategy will be used to agree the steps that our ICP members will take together to deliver system-level, evidence-based priorities in the short, medium-and long-term, for which all partners will be accountable.

Members of the newly formed Integrated Care Partnership have committed to monthly development meetings, with time set aside to establish a shared level of understanding of the challenges faced across our footprint and the strengths and resources we have available to us.

Details of the membership of the Hertfordshire and West Essex Integrated Care Partnership are available on the website: https://hertsandwestessexics.org.uk/

Progress on key system priorities

Urgent and emergency care

Over the past few weeks, our NHS 111 service has been significantly affected by a national software issue which has put it under increased pressure. We are pleased that the problem has now been resolved and clinical systems restored enabling NHS 111 to begin to return to normal service levels.

NHS 111 is at the heart of our urgent and emergency care system and is there for people 24 hours a day throughout the year. By contacting NHS 111, patients are directed to the clinical advice they need, be that through a conversation with a clinician on the phone, help from a pharmacist or by booking them an appointment to see a health professional near them.

We want to make sure that we have the right urgent and emergency services for our population and make the best use of the staff and facilities we have. We are carrying out needs analysis work which will help us to build a comprehensive, meaningful picture of what urgent and emergency care services are required and where these should be to enable good access for people across Hertfordshire and West Essex. This will include looking at multiple sources of data to understand who needs urgent and emergency care and who could be better looked after in alternative settings.

The information gathered will be used to understand why people access services in the ways they do currently, including identifying opportunities for different services and alternative pathways. We will also focus on how we increase use of key preventative services. Stakeholders will be consulted throughout this piece of work to enhance our understanding of the findings. This work aims to bring together population health intelligence to produce an achievable urgent and emergency care strategy based on the actual needs of the population.

Population Health Management

Understanding the needs of the people living in our area is key to ensure we plan services effectively. Population health management (PHM) helps us to improve the health and wellbeing of people living in Hertfordshire and west Essex by using information about individual people and communities to understand local health and care needs, and how these vary for different populations. We can also use it to make sure the right services are in place to meet people's needs now and what these might be in the future. This includes promoting wellbeing and reducing health inequalities, often linked to wider determinants of health, such as housing and education.

We can also use PHM to identify individual people with health and care needs who might benefit from specific interventions. The support received might be medical but can also be social, such as support with housing and employment, which can impact physical and mental health.

A summary report of the health needs of the Hertfordshire and west Essex population is now available on the ICS website.

This high-level needs analysis is the first in a series of reports for the programme of work being delivered by our Population Health Management team. More detailed reports will follow in the coming weeks on health outcomes by primary care network and by the types of illness affecting those living in Hertfordshire and west Essex.

An example of an intervention which aims to reduce inequalities is the work led by Hertfordshire County Council and GATE Herts to improve mental health and wellbeing for Gypsy, Roma and Traveller Communities living across Hertfordshire.

The council is providing £10,000 funding for GATE Herts to run events including physical activity, celebrating culture and heritage, floristry sessions, storytelling and arts and crafts. GATE Herts is the only Gypsy, Roma and Traveller organisation in the county and has joined up with the council to look at ways in which we can bring people from these communities together to:

- improve mental health and wellbeing
- tackle stigma around mental health
- raise awareness of support services available
- reduce social isolation.

We know that the suicide rates for these communities are six times higher than the general population, seven times higher for men. By working with GATE Herts and community members, Hertfordshire's Public Health Service hopes to remove some of the barriers and inequalities the communities face in accessing mental health and suicide prevention services.

Transforming outpatient care

The NHS is giving patients greater control and convenience in their NHS hospital or clinic appointments – by offering telephone or video consultations, empowering people to book their own follow-up care, and working with GPs to avoid the need for an onward referral where possible.

This means less time travelling to hospital appointments and in waiting rooms, and better access to follow-up hospital care when needed. The planet also benefits from reducing the NHS's carbon footprint and contribution to congestion on the roads.

In Hertfordshire and west Essex, we are also giving GPs direct access to specialist consultant input which helps patients to make informed decisions about their care. It also ensures that patients only need to travel to hospital to see a consultant if it is necessary. In many specialties, patients choose when they would like a follow up with their hospital team, rather than a follow up appointment being scheduled for them. While this won't be suitable for all patients, for those for whom this is clinically appropriate, it gives patients direct access to guidance when they most need it and stops people having to go to hospital when their treatment is progressing as expected.

Improving cancer care

Diagnosing cancer early is key to treating it successfully and for people to live long and healthy lives in remission. Our ICS is focused on initiatives that will identify and treat people's cancer quickly. Our ambition, as set out in the NHS Long Term Plan is that 75% of patients will be diagnosed while their disease is at stage one or two. These are some examples of how our clinical teams are aiming to meet that challenge:

- Cytosponge is now being trialled in two of our hospitals as a less invasive alternative to an endoscopy. This procedure is more comfortable for patients and is used to find early oesophageal cancers as well as managing conditions like reflux

- Tele-dermatology services are supporting GPs to quickly access specialist opinions on potential skin cancers

- New Community Breast Pain Clinics are being developed to support patients with breast pain and who do not have a suspicion of cancer, so that they don't need to travel to a large hospital to receive their care

These and other early intervention initiatives offer patients a better experience within the right health care setting, a less invasive, less stressful diagnostic process and for those who may unfortunately receive a cancer diagnosis their cancer will have been found earlier and therefore the treatment they receive may be less complex and result in a better outcome.

We are still awaiting news from the government's New Hospitals Programme as to whether funding is available to progress our preferred option to relocate cancer services currently operating from outdated facilities at the Mount Vernon Cancer Centre to a proposed new centre based at Watford General Hospital.

While we wait for a decision, we are continuing to develop the details of that project. However, until capital funding is secured, the next key phase of work - a public consultation - cannot begin. In the meantime, a programme of work has been developed to sustain services on the current site, as a temporary measure. New equipment has been installed, such as a SPECT-CT - a type of scan which combines images to create 3D pictures and seven additional outpatient rooms have been added. A new relaxing garden has been created and rehabilitation gym is planned, with further upgrades to MRI and PET-CT scanners coming in the next year.

Our new health and care organisations – find out more

Remember that you can find out more about the Integrated Care Partnership, the Integrated Care Board, our Health and Care Partnerships or the new Hertfordshire Mental Health, Learning Disabilities and Autism Collaborative at our new website: https://hertsandwestessexics.org.uk/

The website is still developing and we will continue to make improvements and add more content. Please use the feedback function on the site if you have any suggestions or comments, so that these can be taken into account as the site develops.

You can follow the ICS on social media too – our Twitter handle is @HWE_ICS. The Twitter handle for the new Integrated Care Board is @HWEICB.

Yours faithfully,

Dr Jane Halpin
Chief Executive Officer

Hertfordshire and West Essex ICS

Hertfordshire and West Essex
Integrated Care Board

Rt Hon Paul Burstow
Independent Chair

Hertfordshire and West Essex ICS

Chair, Hertfordshire and West Essex
Integrated Care Board

Report

East and North Hertfordshire NHS Trust

Meeting	Trust Board			**Agenda Item**	12
Report title	Strategic Portfolio Update			**Meeting Date**	2 November 2022
Presenter	Kevin O'Hart, Director of Improvement				
Author	Kevin O'Hart, Director of Improvement				
Responsible Director	Kevin O'Hart, Director of Improvement			**Approval Date**	20 October 2022
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**		☐
	Discussion	☒	**Decision**		☐

Report Summary:

This report provides a summative update from the Executive Programme Board; this governance platform coordinates the development, oversight, and delivery of key internal and external strategic transformational priorities and objectives.
The portfolio is managed using a robust, standardised project and programme management model, supported by the transformation team.
This new model incorporates an executive SRO allocated to each programme who is accountable for delivery. Specific SRO allocations reflect a new, collective executive approach to strategic objective delivery.

Impact: where significant implication(s) need highlighting
Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

There are several areas within the portfolio requiring underlying changes in historical ways of working both internally and across the system; the necessary cultural changes in behaviour and mindset will require time to bring all stakeholders forward together, within a safe, continuous improvement environment.

Risk: *Please specify any links to the BAF or Risk Register*

Risk 11 Innovation
Risk 10 Technology, systems and processes

Report previously considered by & date(s):

Executive Programme Board 20 October 2022

Recommendation	The Board is asked to note the contents of the report.

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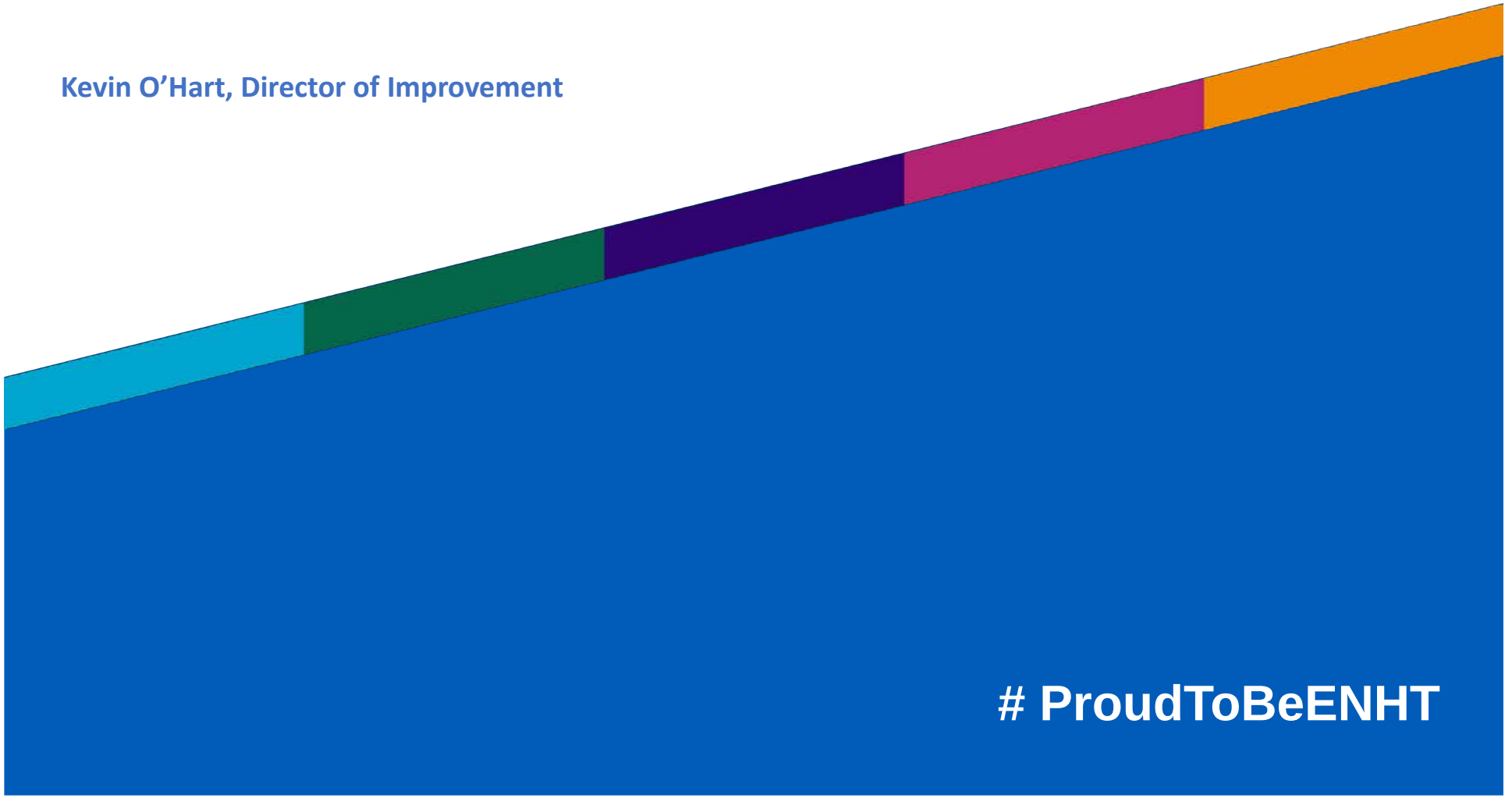
Strategic Transformation Portfolio Report

East and North Hertfordshire NHS Trust

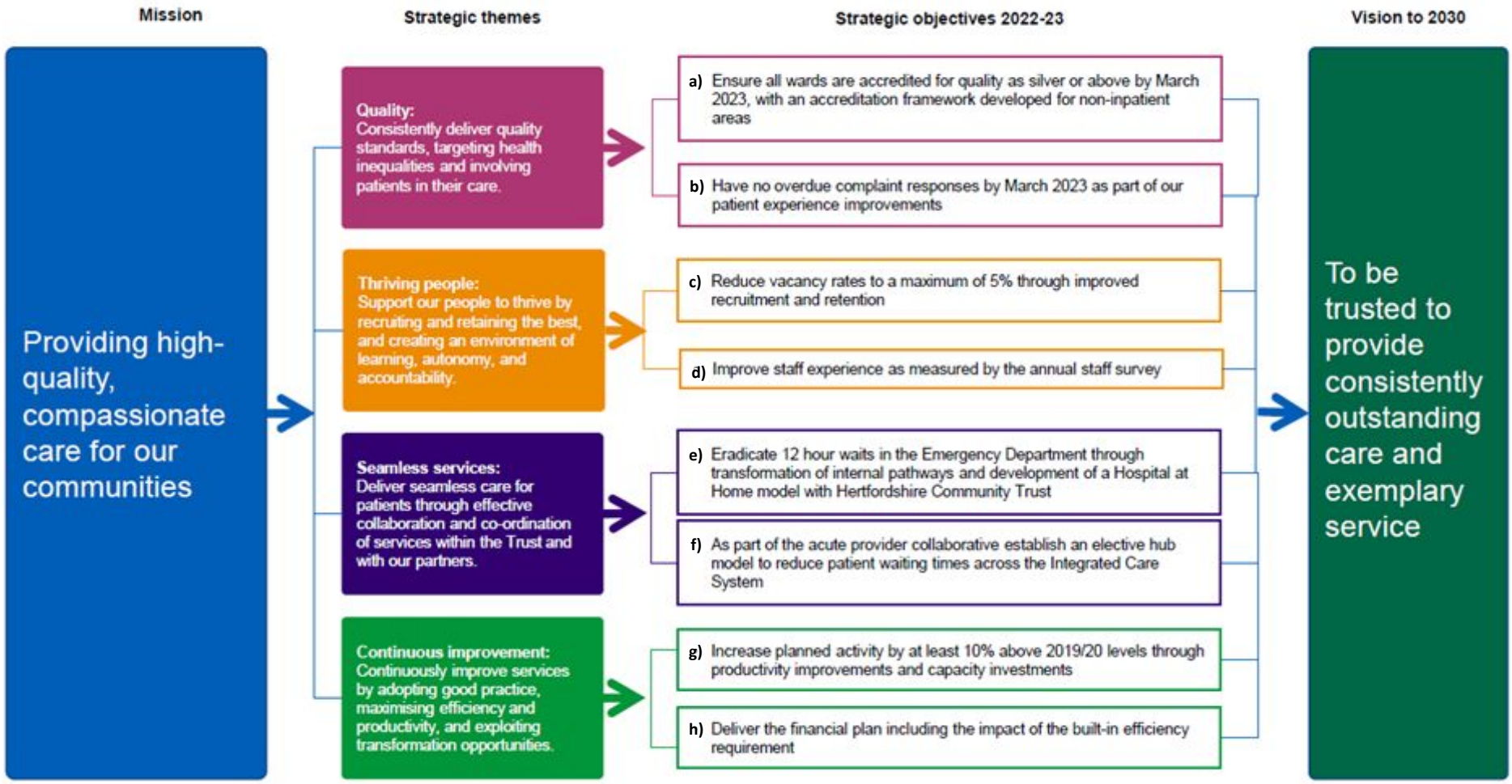
Trust Board
2 November 2022

Kevin O'Hart, Director of Improvement



Strategic Objectives 2022 - 23

East and North Hertfordshire NHS Trust



Executive Programme Board Updates

East and North Hertfordshire NHS Trust

Strategic Objective G - Community Diagnostic Centre	Milestones	KPIs
SRO – Kevin O'Hart, Director of Improvement		

Phase 1 of our national CDC Programme has delivered over 5,281 additional examinations across a range of modalities since April 2022, with a further 11,832 scheduled through to the end of March 2023. This activity is largely the result of extended opening hours evenings and weekends at QE11 for existing modalities including x-ray, ultrasound, CT and MRI. This has been achieved through a very successful overseas recruitment and retention programme , across specialities with significantly higher national vacancy levels.
Expanded capacity for DEXA scanning to assist increased osteoporosis diagnosis and management within our communities will commence from November. We have also launched a new direct access pathway for non-acute fatty liver disease with the first clinic appointments scheduled in December, by which time we also plan to launch our new one-stop ECHO service.
The feedback from patients regarding these new services both in terms of the care provided and the ability to book evenings and weekend, around busy work and family commitments has been exemplary. We have also demonstrated improvements in referral to test wait times where in the example of plain film x-ray, this has reduced to under ten days.
The funding decision from NHSE for phase 2 has confirmed approval for the development of new pathways in respiratory lung function and cardiology direct access holter. A formal MOU is still pending though we anticipate these services would mobilise in early 2023.
Phase 3 continues to be explored and if it were to progress would provide an additional MRI scanner unit at QE11, potentially in 2024/25.

Strategic Objective E - Discharge Improvement	Milestones	KPIs
SRO – Theresa Murphy, Chief Nurse		

Increased urgent and urgency care pressures necessitates the need to improve patient flow and efficient, safe discharge processes for patients. Significant work has now been completed to streamline the discharge section of NerveCentre, with the aim of increasing utilisation of the system, improving data collection and quality, and streamlining discharge processes. This work has provided the foundations for a new Board and Ward Rounds Standard Operating Procedure (SOP) , which has been approved after extensive consultation with nursing and medical colleagues. The aim of the SOP is to standardise the approach, documentation, and decision-making processes in board and ward rounds, which will support discharge decisions being made earlier in the day. The implementation process has begun, supported by Executive Team members allocated to wards to visit and provide support and oversight. There are a range of additional support options been made available via both via our internal transformation team and the NHS Emergency Care Improvement Support Team. Key metrics from the SOP are also now included in our internationally recognised, award-winning

Executive Programme Board Updates

East and North Hertfordshire NHS Trust

ward accreditation standards framework, to ensure ongoing assessment and assurance. Medical staffing implications of the SOP are been factored into job planning changes and any future consultation processes, which are overseen via our Medical Directors office.
In order to support improvements in our seven-day discharge processes we are also developing criteria-led discharge protocols; this is a process by which nurses and other health care professionals can discharge patients at any time, if the patient has met the criteria for discharge set by their consultant. This enables others to safely lead discharges within a clear competency framework, therefore increasing weekend discharges, and improving efficiency at other times of day. Two pilots are underway, one in scoping phase in gynaecology, and one in cardiology which has just ended. Early analysis of the cardiology results show a reduction in delays to discharges, and high levels of patient and staff satisfaction. Crucially, the pilot saw a significant improvement in the numbers of discharges before 12pm – an increase from 1.26% of patients discharged before 12pm, to 41% of patients (across 146 patients in scope). Learning from this pilot will be used to inform a wider roll-out in the months ahead.

Strategic Objective E - Hospital at Home	**Milestones**	**KPIs**
SRO – Michael Chilvers, Medical Director		

The HCT-led Hospital at Home service is a nationally recognised exemplar site and based on current activity , ENH will meet regional NHSE activity targets, with the largest proportion of referrals driven by community and primary care. Significant work has already been completed to support the centrally funded business case for 2023/24, before a framework for system reallocation is agreed ahead of 2024/25.
During October we launched a new pilot within trauma and orthopaedics which has involved nine patients discharged onto a new post-operative pathway to Hospital at Home . This has allowed patients to spend less time in a hospital bed, to go home or to their normal place of residence earlier , and with a range of support staff services offered either face-to-face or virtually , including remote morning to safely complete their care management. After the pilot is complete a comprehensive evaluation will be jointly undertaken with the ambition to expand these pathway's across other elective specialties. This would in turn release bed capacity so we can treat more patients from our waiting list in a more timely manner.
A joint HCT and EEAST handover at home pilot has recently tested the opportunity for patients to be reviewed from the ambulance stack system, to understand if there are opportunities to redirect people to Hospital at Home services instead of bringing people into ED. This involved an EEAST paramedic working in the community hub alongside HCT clinical triage team. Over the week of 5th – 12th October 68% (71) of patients intervened in in first week were redirected to community services. This included 25 patients referred to Hospital at Home and 20 patients managed via the emergency intervention vehicle.

Executive Programme Board Updates

East and North Hertfordshire NHS Trust

Strategic Objective G – Outpatients (PIFU & Follow-Up)	Milestones	KPIs
SRO – Mark Stanton, Chief Information Officer		
This programme continues to support the NHSE Planning Guidance target to move or discharge 5% of outpatient attendances to patient-initiated follow-up pathways (PIFU) by March 2023. PIFU pathways give patients and their carers the flexibility to self-manage and arrange their follow-up appointments as and when they need them, based on their symptoms and individual circumstances. We have now developed a range of PIFU pathways and models based on speciality specific requirements including PIFU (mutual protocol driven model between consultant and patient with automatic discharge after a predefined period if not initiated) , PIFU Plus (for patients with unpredictable LTCs episodes that may not correlate with planned OPD appointments), PIFU Inpatient (PIFU model following inpatient admission for higher risk patients) , and PCFU (A NHSE mandated PIFU pathway for cancer patients). We now have twelve specialties with live PIFU pathways and continue to explore wider opportunities with the remaining twelve teams. Progress is challenging and slow as this necessitates a completely new way of working for both patients and clinicians and this is reflected in national benchmarking data which highlights significant variation in performance both within different providers and between specialties. We are currently reporting 1% of patients have moved onto PIFU pathways with some specialties i.e. trauma and orthopaedics already exceeding the 5% target. Work is therefore ongoing with our Clinical Directors to understand how else we can increase PIFU activity in each individual area.		

Strategic Objective A – PALS & Complaints	Milestones	KPIs
SRO – Kevin O'Hart, Director of Improvement		
Our new PALS and Complaints Programme is focusing on improving our internal processes both within the corporate team and the Divisions to reduce response delays and improve the quality of our correspondence ensuring all concerns are fully addressed. We also aim to increase triangulation of themes and improvement actions to embed learning across the organisation and increase training and upskilling of our staff to empower everyone to resolve concerns at the earliest opportunity. The Trust leadership briefing on 4th October launched a renewed focus on PALS with the senior leadership team asked to make pledges for how they will support as individuals and with their local teams. This work has been expanded with initiatives that target recurrent PALS issues i.e. the volunteers service supporting lost property enquires, arrangements with the Contact Centre to fast track enquiries relating to appointments and patient flow coordinators liaising with discharge issues. Improvement work using small tests of change will now commence in two pilot specialities,		

Executive Programme Board Updates

East and North Hertfordshire NHS Trust

trauma and orthopaedics and obstetrics and gynaecology, where we currently see challenging response times to agree a series of actions and improvement trajectories.
Proposals are under development that aim to reduce the agreed policy timelines for each stage of our complaints process and revised escalation protocols with associated accountability actions linked to specific named roles to unlock delays, where local discussions have been unsuccessful. A wider communications programme is looking to refresh PALS leaflets , associated literature and ward posters to raise awareness and promote local resolution wherever possible.

Strategic Objective H – Surgical Pathways	Milestones	KPIs
SRO – Martin Armstrong, Director of Finance & Deputy Chief Executive		

A regional GIRFT review of theatres productivity has recently recognised continued strong performance across a range of metrics at ENHT. To share best practice across the region we have also started development of a system learning network with the first session held between ourselves and PAH on 20 October. Transformation teams met to share experiences and progress across a range of areas including Theatres, resulting in PAH seeking to work with us to establish a version of our 6-4-2 scheduling and booking model. Our aim is for this learning network to expand across the ICB, creating a safe space for learning and sharing of best practice across all portfolios.
The wider surgical pathway programme has overseen significant redevelopment of our pre-operative assessment service involving new clinic structures, a workforce review as well as a series of lean process mapping exercises to identify and remove waste. A complete overhaul of the Theatre scheduling timetable and associated job planning changes have also now been completed and initiated, in order to accommodate the new procedure rooms coming on line. In addition a new and improved clinical workforce model has been developed and signed off that transforms the education and training function within Theatres and strengthens individual theatre leadership teams. Funding converts historical temporary spending expenditure into a substantive workforce model, substantially increasing the number of band six roles without requiring new investment. The subsequent staff consultation process has now gone live and will run for 45 days.
Improvement work also continues in the roll-out of STAT, this is an automated artificial intelligence solution that aims to optimise booking lists through analysing and learning from consultants ongoing performance, thereby tailoring lists at an individual level.
Despite these enabling projects there has been limited success in increasing average cases per list, which in turn would provide an efficiency and productivity opportunity reflected through increased revenue. Subsequent work will now focus on bespoke actions at speciality level that can improve performance in this vital area. This will also be supported by a series of clinical audits into reasons for patient and hospital cancellations.

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	13
Report title	Charity Annual Accounts and Report			**Meeting Date**	2 November 2022
Presenter	Chief People Officer				
Author	Chief People Officer				
Responsible Director	Chief People Officer			**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**		☐
	Discussion	☐	**Decision**		☐

Report Summary:

To provide the Board with the audited accounts and the annual report which have been seen by the Charity Trustee Committee and approved by the Audit Committee.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

Risk: *Please specify any links to the BAF or Risk Register*

n/a

Report previously considered by & date(s):

n/a

Recommendation	The Board is asked to note the reports.

To be trusted to provide consistently outstanding care and exemplary service

East & North Hertfordshire Hospitals' Charity

NHS East and North Hertfordshire NHS Trust

Annual Report

2021/22

Contents

Foreword by the Chair of the Charity Trust Committee

Chair
01/04/21 – 31/12/21

On behalf of the Trustees, I am delighted to present the annual report and accounts for the East and North Hertfordshire Hospitals' Charity 2021-22. This has been another extraordinary year for everyone, and the charity has worked incredibly hard to support the four hospitals in the East and North Hertfordshire NHS Trust to help provide additional support to our patients, volunteers, and staff at a very difficult time.

By working closely with our clinical teams, we spent £1.538m on more than 120 projects and services. We were delighted to provide innovative pieces of equipment and creative projects which made a challenging environment a little easier for staff and patients. This has included refurbishment of 83 spaces for staff to enjoy, a woodland walk, a supportive men's health champion, comfort packs and boredom busters for patients.

Our fundraising income was £1.33m. COVID-19 continued to change the way we fundraised, so we developed a strategy to raise funds through online giving platforms. However, despite continuing restrictions, we managed to successfully deliver two face-to-face events last year with the generous support of our community - Herts Health Ride and a golf event. We also launched a public lottery in association with the Hospice Lottery which will provide regular income to our general funds.

Significant income for 2021-22 came from the legacies of grateful patients who received outstanding compassionate care within the Trust. They have kindly shown their gratitude and appreciation by leaving the charity a gift in their will. These benevolent individuals gave more than £534k to support our projects which will benefit patients and their families long into the future.

Our gift in kind income of £54k was much lower this year after the initial outpouring of support during the lockdowns of 2020. Gifts in kind are small acts of kindness that make a difference to staff and patients. This year staff were gifted tickets to football and rugby matches; children received Christmas and Easter gifts and patients received comfort items and sweet treats. Our volunteers were also surprised with lovely floral bouquets from Tesco!

In recognition of their exceptional effort during the pandemic, we wanted to support wellbeing and thank you initiatives for our hard-working staff. In July we hosted a week of events which included the NHS Big Tea, a BBQ, ice lollies, music and a Remembrance Day to remember all those who had sadly died of COVID-19 at the Trust. We also funded a memorial book for staff and supporters which captured in photographs the unwinding events of 2020-21. A week later, we were thrilled to welcome HRH The Princess Royal to the Lister to present our Butterfly Volunteers with their Queen's Award for Voluntary Service, the highest accolade a voluntary service can receive from Her Majesty The Queen. The charity-funded Butterfly Volunteer Service provides care and companionship to end of life patients at the Lister.

After a wonderful 8-year tenure, in December 2021 I stood down as chair of the charity management committee and we welcomed Dr David Buckle into the chair in January 2022.

Thank you

Chair
01/01/22 – 31/03/22

A big thank you to Mr Bob Niven for his fantastic work as chair of the hospitals' charity especially during the past two years which have been very demanding for us all.

I am delighted to be working with the hospitals' charity and our ambition for 2022-23 is to support East and North Hertfordshire NHS Trust through their recovery following COVID-19 and beyond. We will be raising funds to improve the wellbeing of patients, staff, volunteers, and visitors and will be recognising the importance of healthy spaces with our new initiatives and appeals: SafeSpace, The Sunshine Appeal and other green, sustainable initiatives. We look ahead with optimism and look forward to the opening up of community events and welcoming our donors onsite once again to see the special projects and services they help us fund.

On behalf of the trustees, I'd like to thank everyone associated with the charity – our staff, volunteers, supporters and partners, as we look ahead to working together to deliver above and beyond.

Thank you

Dr David Buckle

Chair of the Charity Trustee Committee
On behalf of the Corporate Trustee

About the charity

The Trustee presents its annual report and financial statement audited by the independent auditor for the year ended 31 March 2022, which has been prepared in accordance with the Charities Act 2011 and the Charities Statement of Recommended Practices (FRS 102).

East and North Hertfordshire Hospitals' Charity exists to enhance the experience for all patients within the East and North Hertfordshire NHS Trust (ENHT). The four hospitals we support are the Lister in Stevenage, the New QEII in Welwyn Garden City, Hertford County in Hertford and Mount Vernon Cancer Centre in Northwood, with more than 550,000 people cared for at our hospitals every year.

We raise funds to purchase the very best equipment; so that our staff can undertake cutting-edge research and to purchase those special extras - all to ensure our patients receive gold-standard treatment and care. Importantly, we only fundraise for projects that are outside of statutory funding responsibilities of the Trust. Everything we do goes above and beyond.

This year has been tough as our community based fundraising activities struggled to return to pre COVID-19 levels and footfall throughout the hospitals was reduced for most of the year. As always we are most grateful to our donors and the support we receive from patients saying thank you for the care they received, friends and family that wish to remember a loved one, staff fundraisers and trusts, foundations and corporates that believe in our vision.

Thank you.

Our year at a glance

APR

Thank you to Amaya, 5, who made 31 ‘bags of love’ to give to our patients. Each bag contained thoughtful gifts to help make staying in hospital that little bit easier.

11 local businesses donated thousands of Easter Eggs for us to give our to children in hospital over Easter.

MAY

In May we appointed Lauren as our What Matters To You Volunteer Co-ordinator. Lauren helped patients in hospital communicate with their loved ones.

We also opened our new parents lounge at Lister Hospital, after raising a huge £360k to build the new room. We created a lovely relaxing space for parents whose babies are in the neonatal unit.

Research N urse Carina Cruz also hula hooped non stop to for 4 hours to raise money for our research projects

JUN

We were proud to fund a TULA machine to help patients being treated for bladder cancer at the Lister Hospital. Ian who had the procedure said: ‘‘It was smashing, no problems at all, painless.’’

We also funded a license for a Rapid ARC, a form of radiation therapy, to improve treatment for patients at Mount Vernon Cancer Centre (MVCC).

And a big thank you to Northwood NATO spouses who raised over £10,000 for MVCC.

JUL

We were proud to be presented with The Queen’s Award for Voluntary Service by HRH The Princess Royal. The award is the highest award a voluntary group can receive in the UK.

We opened the new woodland walkway at MVCC to allow staff, patients and visitors to spend time in nature, whilst remaining close to the hospital.

70 cyclists took part in our Herts Health ride to raise money for all 4 hospitals.

We also ran a week long programme of thank you events for all our staff.

AUG

Thank you to Tesco for donating hundreds of bunches of flowers, which we handed out to all our volunteers.

We also purchased more sensory equipment to help create an environment where children and young people with complex needs can keep calm and relaxed.

SEP

Over 1,000 runners took part in Moor Park 10k and the junior fun runs, to raise a record-breaking £60,000 for the Lynda Jackson Macmillan Centre.

Our inaugral golf day raised £3,500 for the Sunshine Appeal and Jade and her keep pedalling team raised £2,255 for cancer services at Lister Hospital.

OCT

In partnership with local land agency, Walter Cooper, we launched a £10k bursary scheme for staff to apply for professional development opportunities that they otherwise thought were not possible.

7-year-old Jack raised £130 by holding a toy sale and we opened the charity-funded SPECT/CT scanner at MVCC. Dr Wong said: “The scanner will make a tremendous difference to people who come to the centre for treatments.’’

NOV

We purchased a multi-birth cot for the maternity unit at the Lister. This means new-born twins or more can sleep together in those important first days.

We also supported the Trust-wide launch of the Hug in a Mug initiative, filling mugs with treats and handing them to staff to pass on to colleagues that they wished to recognise.

Local comedian Richard Herring raised over £30,000 for our cancer services by running the Knebworth Half Marathon.

DEC

Our Christmas grotto opened and over 25 local companies dropped off Christmas gifts for our paediatric department.

The wonderful support our charity and play specialists have given 6 year old Elliot was featured in The Sun’s Joy to the Ward Christmas appeal and footballer, David James, and Feed Up Warm Up visited to drop off a bumper donation of children’s toys and treats for our staff.

We also opened our fern garden at MVCC so patients can have chemotherapy outside.

JAN

The ladies section at Chesfield Downs Golf club kindly raised £11k for our children’s ward and Butterfly Volunteer Service.

We celebrated reaching our target to raise £70k for our Helping Little Heartbeats appeal.

We funded another year of Cancer Hair Care services at the Lister Macmillan Cancer Centre to support people experiencing hair loss as a result of chemotherapy.

FEB

Hannah and Rosie in the Children’s Safeguarding team raised £1,650 after doing numerous fundraising events for us, including a 5k run.

We are announced as Charity of the Year for Todd in the Hole Festival.

As part of #timetotalk day we paid for muffins for all our staff to enjoy, as the Trust encouraged everyone to have conversations about mental health.

MAR

High Sheriff of Hertfordshire, Lionel C Wallace DL, visited our staff at Lister Hospital. He said: “When you think NHS, think community – our community deserves our support. Just amazing.”

Our performance

We said we would...	We did it!
Set up an appeal board for, and launch, our major capital appeal for outdoor spaces – The Sunshine Appeal	Led by Adrain Hawkins OBE we successfully set up an appeal board to lead our Sunshine Appeal. Over the year we built a full project proposal with our estates team and raised £140k (£51k currently pledged) towards the £440k target.
Continue outstanding donor stewardship and enhance the supporter journey with events, one-to-one donor meetings and thank you opportunities	Whilst still being limited by COVID-19 restrictions, we strived to meet as many of our donors as we could in person. We hosted 10 visits / tours of the hospital and ran a successful afternoon tea at Luton Hoo where staff and donors were thanked for their contribution over the past year.
Deliver mass participation events to increase our profile	We were proud to deliver three great events: Herts Health Ride saw over 70 cyclists taking park; Moor Park 10k and fun runs had over 1,000 runners and a golf day had 44 attendees.
Update our logo so that we are accessible and can be clearly identified as an NHS hospitals' charity	We unveiled our new logo in July 2021 and are confident it is modern, clear and accessible. We were proud to have designed it in-house with no additional costs and feedback has been positive.
Alongside the Trust, thank our colleagues for their efforts during the pandemic	We were proud to deliver an exceptional thank you week, with free BBQ and cake for all staff, at all sites. A programme of wellbeing events was delivered and over 300 guests attended our staff awards, which were entirely funded by corporate sponsorship.
Fund impactful projects that benefit our patients and help our staff go above and beyond	We continued to fund a wide range of projects to enhance patient expereince and help our staff feel valued, appreciated, and go above and beyond for our patients. Some of the incredible projects we are funded are detailed in the body of this report.

The year ahead

Our charity's strategic aims for 2022-23 are to:	
Trial new ways of fundraising	**Update our charity strategy for 2022 – 2025**
Complete our fundraising for the Sunshine Appeal	**Increase our brand's profile in the local community**
Rebuild our fundraising activity and mass participation event programme after the impact of COVID-19	**Review the effectiveness of our customer relationship management system**

Our fundraising year in numbers

In 2021/22 we raised £1,337,771

We spent £1.538m on charitable activity

We spent £348k on fundraising activity

*For more details on our charitable activity spending see our full annual report, available on our website www.enhhcharity.org.uk and published on the Charity Commission website.

How we spent our money in 2021/22

- Research projects £92k
- Volunteering projects £48k
- Art and refurbishment £56k
- Gifts in kind £54k
- Training and wellbeing £155k
- Support services and smaller items £567k
- Medical equipment, technology, capital and gifted assets £405k
- Governance costs £156k on charitable activity and £83k on cost of raising funds, other costs of raising funds £269k

The ways in which we help

NHS East and North Hertfordshire NHS Trust

Every year the charity works to strengthen the incredible work already carried out by the Trust.

1

ART AND REFURBISHMENT

Creating beautiful spaces inside and out

2

TRAINING AND WELLBEING

Initiatives to enable staff to go above and beyond

3

MEDICAL EQUIPMENT, TECHNOLOGY, CAPITAL AND GIFTED ASSETS

Supporting gold standard treatment and care

4

SUPPORT SERVICES AND SMALLER ITEMS

To enhance patient experience

5

RESEARCH PROJECTS

Pioneering research to help drive innovation

6

VOLUNTEERING PROJECTS

Providing extra support to patients and staff

This year the charity funded £1.3m of charitable activities for the benefit of patients at the East and North Hertfordshire NHS Trust, including Gift in Kind donations valued at £54k

Art and refurbishment: creating beautiful spaces inside and out

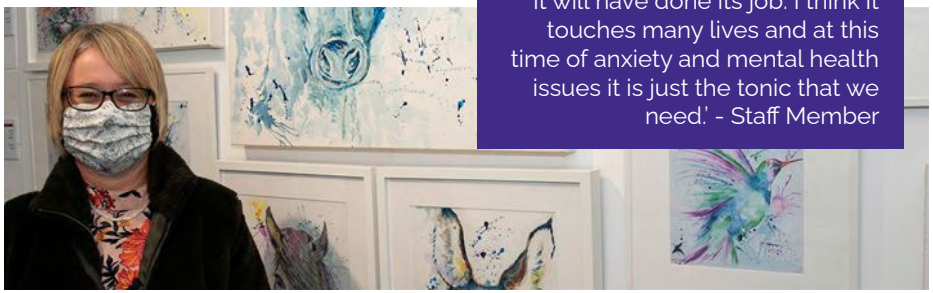
This year we were delighted to continue our work to improve spaces inside and outside our hospitals.

We have sold 110 pieces of art since launching and work with many artists from our local community.

Artlife @ The Lister

Our Artlife Gallery has gone from strength to strength, making art accessible to patients, visitors, and staff.

'I think the initiative is inspiring, it always gives me a lift when I walk along the corridor and 'drink in' the art work. If the exhibition allows just one member of staff, or patient, to stop and reflect, then it will have done its job. I think it touches many lives and at this time of anxiety and mental health issues it is just the tonic that we need.' - Staff Member



Woodland Walkway

We have invested significantly in Green Space for Health at Mount Vernon Cancer Centre. We were proud to build a new woodland walkway, wildflower meadow and fern garden and with the help of volunteers, we have planted trees and constructed a pond and moon canopy.

We also built a chemotherapy shelter, so our patients with cancer can receive short treatments outdoors, whilst remaining sheltered from sun and rain. Our staff now make circular walks part of their daily routine and our patients are able to spend more time outdoors, in comfort.

'I feel so troubled but when I sit there I feel calm and I feel better. My mind is buzzing and those thoughts just slip away when I'm here.'
- Patient being treated for cancer

Training and wellbeing: initiatives to enable staff to go above and beyond

This year we were able to support many initiatives, led by our colleagues, to enhance wellbeing. These include:

Supporting nursing and midwifery excellence by joining the Cavell Nurses Trust peer recognition scheme, so our nursing and midwifery staff can nominate their colleagues for an award. Over the year 24 awards have been awarded and celebrated with our Chief Nurse.

Paying for 18 **training and development** opportunities for staff, that are above and beyond the requirement of their role.

Launching the **Hug in a Mug** pay it forward scheme. We purchased 1,000 mugs which are filled with treats and gifts and passed between colleagues as a surprise to say “thank you”, “well done” or “you have made a difference”.

Celebrating our International Nurses by providing **welcome goody bags. 5,500 free muffins** were provided as part of ‘Time to Talk’ mental health day to give staff a small treat and encourage them to engage in conversations and if needed, to seek help.

A prize draw for all staff to win a **luxury Christmas hamper.**

Funding for our **women’s network and equality and diversity networks** to raise their profile and provide interesting seminars, events and initiatives for staff. These include paying for white ribbon accreditation which supports our Trust to reflect and challenge violence against women and young girls and non-binary people.

And finally, thanks to the generosity of our donors, we were able to put on a week of celebrations for all staff including providing burgers, ice creams and cakes for everyone and also a memorial photobook to thank our staff for their efforts over the pandemic.

‘Although it seems like a small gesture, it’s so nice to know we are appreciated and just makes our days that little bit brighter, thank you.’
- A member of staff

Medical equipment, technology, capital and gifted assets to enhance patient experience

The charity worked with our clinical colleagues to identify and purchase **equipment to support gold standard treatment and care,** including:

- Completing our project to purchase and install a new SPECT CT scanner which provides detailed imagery to aid diagnosis and treatment of our patients at Mount Vernon Cancer Centre
- Repurposing 'Chart Lodge' at Mount Vernon Cancer Centre, upgrading the building so it can be used for our outpatient clinic and provide a more comfortable experience for our patients.

Redirooms

The charity was honoured to purchase 4 Redirooms. These are pop-up infection control tents that can be used to isolate a bed on a ward, anywhere. This means infectious patients can be quickly and easily isolated without the need to move them into a side room. This helps protect other patients in a bay and means that patients get continuity of care and sometimes a faster discharge, by staying on their specialist ward.

'I am so incredibly happy as this has the potential to save lives over the winter, if used to its potential. I could see the joy on one of our colleagues faces today as we explained how it could be used within a bay in Paeds. The Trust, and the patients we will care for over this and coming winters, will owe you all a debt of gratitude. Thank you all so much.'
– A member of staff

Support services and smaller items

We also spent **£566,444** on smaller items of equipment and items **that improve the patient experience** throughout the Trust, including:

- Sponsorship of Admiral nurses to work on the dementia ward, supporting carers and families of patients
- Refurbishment of 83 spaces to create relaxing and comfortable areas in which our staff can take a well-earned break
- Provision of a kitchenette for the bereavement room in our maternity unit so parents can store and prepare their own refreshments
- Boredom buster magazines which are handed out to our patients to provide an activity whilst they are recovering from their illness
- A multiple pregnancy cot for twins and triplets to enable more than one baby to be next to their mother on the postnatal wards
- Two Airglove air warming systems to enable easier and more comfortable cannulisation
- Equipment to enhance and improve the experience of elderly patients and those with dementia, including communication aids, artwork for rooms, a sound system, drinking cups with handles and iPads
- Free wifi across the hospital sites
- A paediatric ECG machine to support our paediatric clinics make faster diagnoses
- A kangaroo cuddle chair so parents can be in a comfortable position to cuddle their babies, especially while their baby is in ITU on respiratory support with many wires and equipment attached
- Provision of a Cancer Hair Care service to help patients with hair loss at the Lister Macmillan Cancer Centre

Men's Health Champion

We were proud to secure funding to hire our first Men's Health Champion, Scott. He provides support to men who have had, or are about to have, radical surgery to remove their prostate due to prostate cancer, through one-to-one support, group workshops and awareness-raising events.

Research projects: pioneering research to help drive innovation

Each year the charity supports a wide variety of research programmes and staff can apply for funding to undertake projects that will help improve the experience of patients across all of our services.

This year, it included purchasing a specialist detector and finger probe to support a study into advanced kidney disease.

This research project aims to find if there is evidence of impaired removal of certain harmful substances from the blood, in individuals with kidney problems. If there is evidence of liver dysfunction this may help guide potential future therapies to improve prognosis for patients with kidney disease.

Volunteering projects: providing extra support to patients and staff

Last year we funded many different volunteer initiatives which were suggested by our clinical colleagues and designed to enhance patient experience at our hospitals. These include continuation of complementary therapy provision through our Lynda Jackson Macmillan Centre at Mount Vernon Cancer Centre, the Lister Butterfly service and our 'What Matters To You' service.

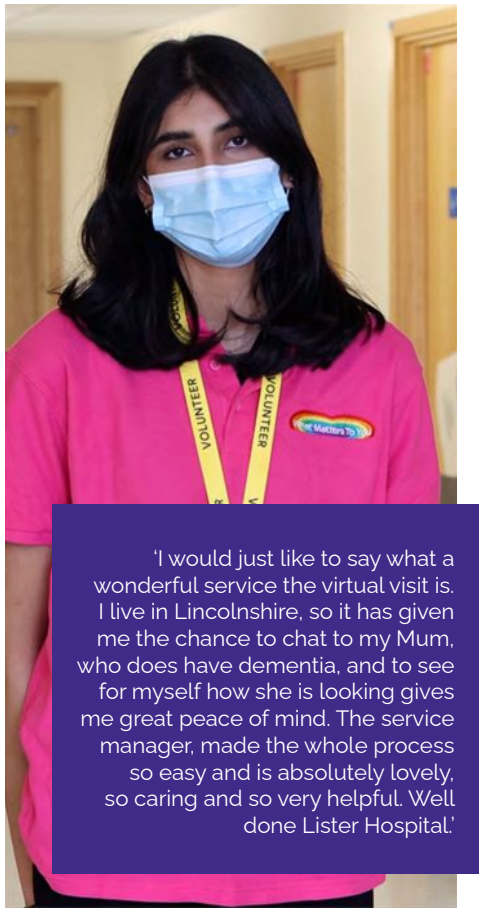
Butterfly Volunteer Service

Last year our Butterfly Volunteers were presented with the Queen's Award for Voluntary Service, by Her Royal Highness The Princess Royal.

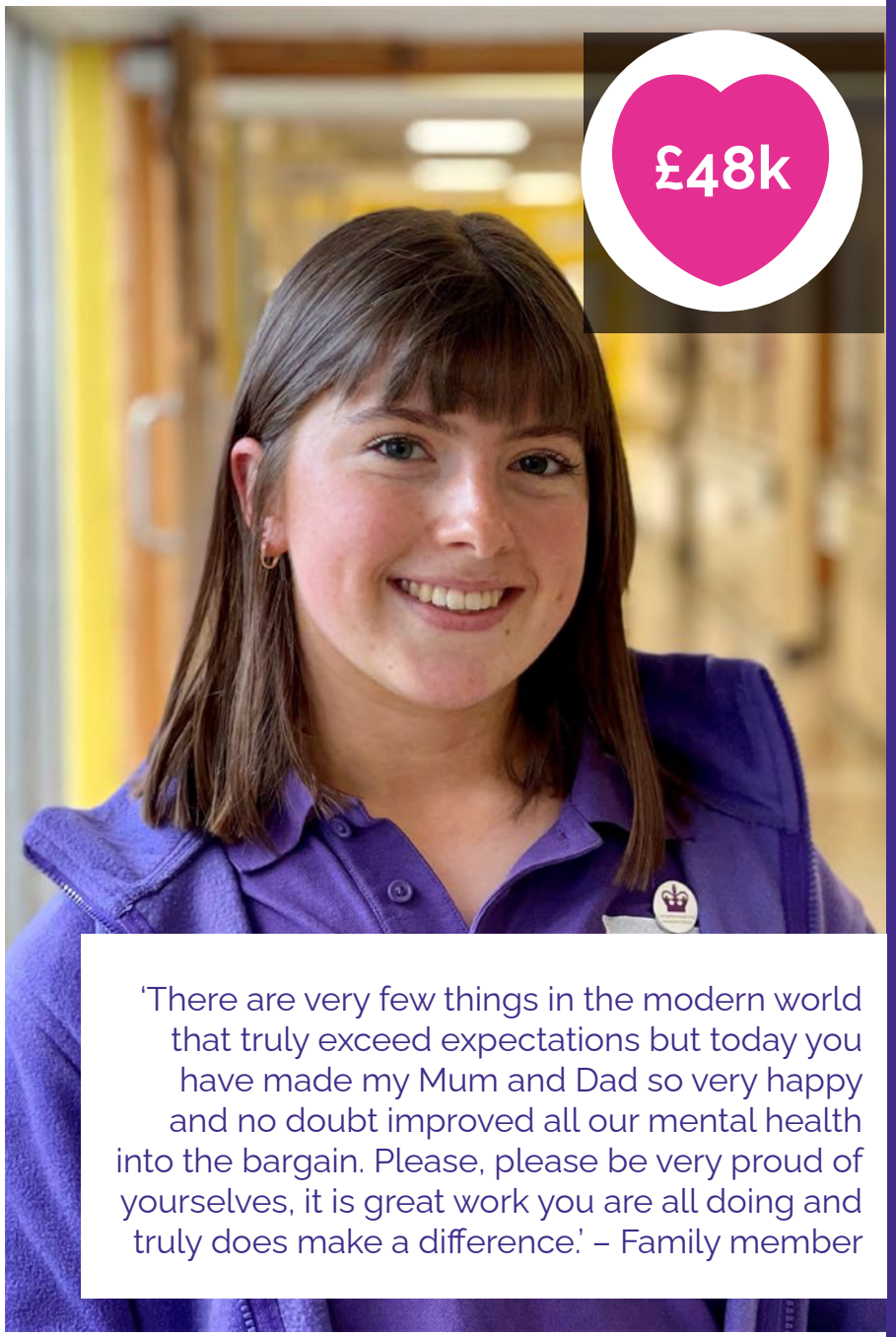
42 Butterfly Volunteers provided support and companionship to patients who were dying. They made 2,540 visits between April-March. 1,338 of those patients were alone at the time of the visit. The butterflies worked 9am-9pm, 7 days a week, 52 weeks of the year.

What Matters To You Service

We continued to deliver our 'What Matters To You' service. A team of volunteers supported patients who were unable to communicate directly with their family themselves and help them remain connected and informed during their stay in hospital. The team supported 1,500 virtual visits and delivered 1,800 'stay in touch' letters to patients.



'I would just like to say what a wonderful service the virtual visit is. I live in Lincolnshire, so it has given me the chance to chat to my Mum, who does have dementia, and to see for myself how she is looking gives me great peace of mind. The service manager, made the whole process so easy and is absolutely lovely, so caring and so very helpful. Well done Lister Hospital.'



'There are very few things in the modern world that truly exceed expectations but today you have made my Mum and Dad so very happy and no doubt improved all our mental health into the bargain. Please, please be very proud of yourselves, it is great work you are all doing and truly does make a difference.' – Family member

Structure, governance and management

The Charity has a Corporate Trustee, the East and North Hertfordshire NHS Trust. The NHS Trust Board of Directors, which comprises seven Non-Executive Directors (including Trust Chair) and five Directors, represent the NHS Trust in this matter. The NHS Trust Board, as Corporate Trustee, delegates responsibility to a Board Committee, the Charity Trustee Committee (CTC). This committee meets at least four times a year and the Chair of the Committee reports to the Trust Board, as Corporate Trustee, following each meeting.
The strategy of the East & North Hertfordshire NHS Trust Charitable Fund is to support East & North Hertfordshire NHS Trust by providing funds to benefit patients and support staff to feel valued. It does this by purchasing supplementary and complementary equipment or services that the Trust is unable to provide funding for via exchequer sources. The Charity carries out fundraising activities and relies upon the generosity of the local community, patients and their relatives and other donors who are familiar with, or who are sympathetic and generous in their support to their local NHS service.
The Charity Director is responsible for the day-to-day management of charitable funds, working with a Charity Management Committee to ensure the funds are spent in line with service priorities and donor wishes. The Trustee relies on the Charity Management Committee to ensure the effective use of charitable funds earmarked for clinical areas by applying their local or specialist knowledge.

Trustee responsibility in relation to the financial statements

The Charity Trustee is responsible for preparing a Trustees' Annual Report and financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice). The law applicable to charities in England and Wales requires the Charity Trustee to prepare financial statements for each year which give a true and fair view of the state of affairs of the Charity and of the incoming resources and application of resources of the Charity for that period. In preparing the financial statements, the Trustees are required to:

- select suitable accounting policies and then apply them consistently
- observe the methods and principals in the applicable Charities SORP
- make judgements and estimates that are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures that must be disclosed and explained in the financial statements:
- the financial statements are prepared on the going concern basis unless it is inappropriate to presume that the Charity will continue in business.

The Trustee is responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the Charity and to enable them to ensure that the financial statements comply with the Charities Act 2011, the applicable Charities (Accounts and Reports) Regulations, and of the provisions of the Trust Deed. They are also responsible for the safeguarding of the assets of the Charity and taking reasonable steps for the prevention and detection of fraud and other irregularities. The Trustee is responsible for the maintenance and integrity of the Charity and financial information included on the Charity's website in accordance with legislation in the United Kingdom governing the preparation and dissemination of financial statements.

Constitution, objects and power

The Trustee has been appointed under section 11 of the NHS and Community Care Act 1990. The East and North Hertfordshire NHS Trust Charitable Funds held on trust are registered with the Charity Commission, number 1053338. The objectives of the Charity are prescribed by section 93 of the National Health Service Act 1977 - in particular for any charitable purpose or purposes relating to the National Health Service wholly or mainly for the service provided by the East and North Hertfordshire NHS Trust. All new Trustees are given appropriate induction on their responsibilities as a Trustee, as laid down in guidance by the Charity Commission.

Risk management

The Charity Trustee Committee, on behalf of the Trustee, ensures that the Charity has met its obligations or risk management as set out in the Trust's Risk Management Strategy. It has a framework for risk identification and has reviewed the strategic business and operational risks that the Charity faces. The Trustee regularly reviews the risks and the Charity Team ensures actions are taken to mitigate the risks and monitor these. The Charity continued to review and strengthen its governance arrangements during 2021-2022.

Public benefit statement

The Trustees confirm that they have complied with the duty in section 4 of the Charities Act 2011 and have due regard for the Charity Commission's general guidance on public benefit. Our Charity's objective is to support any charitable purpose relating to East and North Hertfordshire NHS Trust, including research.
The Trustees ensure that this purpose is carried out for public benefit by working to the following aim. 'Our Charity's core function is to make a real positive impact on patient care within our Trust. We continue to help our hospitals innovate, improve and, most importantly, provide excellent care to our community above and beyond NHS funding. By supporting great science, excellent patient care and staff well-being within the East and North Hertfordshire NHS Trust, we are helping our local community to be healthier by providing the best care we can.

The Charity does not provide facilities directly to the public but provides facilities for the hospital and, in so doing, for the patients and staff of the hospitals.

Reserves and reserve policy

The Trustee recognises its obligation to ensure that funds received by the Charity should be spent effectively in accordance with the funds' objectives. The Charity's reserves comprise of those funds that are freely available for its general purposes. The reserves are held at a level that will ensure the charity can pay their committed expenditure. The Trustee considers it prudent that reserves should be sufficient to avoid the necessity of realising fixed assets held for the Charity's use.

Investment policy

The Investment Policy is to ensure the creation of sufficient income and capital growth to enable the Charity to carry out its purposes consistently year by year with due and proper consideration of future needs and maintenance of, if possible, an enhancement of the value of the invested funds while they are retained. With regard to investments, the Trustee excludes the tobacco sector, as defined by those companies that derive their income from such trading.
The Trustee also excludes companies that derive more than 10% of their revenues from the manufacture of alcoholic beverages, armaments, gambling, high interest rate lending or pornography.

Reference and administrative information

Corporate Trustee
East and North Hertfordshire NHS Trust

Principal office
Management Suite Lister Hospital Coreys Mill Lane
Stevenage SG1 4AB

Auditors
BDO LLP 16 The Havens Ransomes Europark Ipswich
Suffolk IP3 9SJ

Bankers
Lloyds Bank Plc Stevenage Branch 3 Town Square
Stevenage SG1 1BG

Investment advisors
Rathbone Brothers PLC 8 Finsbury Circus London EC2M 7AZ

Charity number
1053338

Corporate Trustee

The Charity is the legal responsibility of a sole Corporate Trustee – East and North Hertfordshire NHS Trust.
The Non-Executive and Executive Directors for the Trust for the year ending 31st March 2022 were as follows:

Ellen Schroder*	Chair
Nick Carver	Chief Executive (to December 2021)
Adam Sewell-Jones	Chief Executive (from January 2022)
Bob Niven*	Non-executive Director (to December 2021)
Val Moore*	Non-executive Director
Jonathan Silver	Non-executive Director
Peter Carter	Non-executive Director
David Buckle*	Associate Non-executive Director
Karen McConnell	Non-executive Director
Michael Chilvers	Medical Director
Martin Armstrong*	Director of Finance
Rachael Corser*	Director of Nursing
Sarah Brierley*	Director of Strategy (to August 2021)
Julie Smith	Chief Operating Officer
Thomas Pounds	Chief People Officer
Mark Stanton	Chief Information Officer
Biraj Parmar	Non-executive Director

The Board delegates responsibility for oversight of the Charitable Funds to the Charity Trustee Committee, the membership of which comprised of those members annotated with an*

Finance report

In the 2021/22 financial year the Charity received a total income of £1,338k - £981k of donations, grants and legacy income, £291k from other trading activities and investment income of £66k. The Charity is indebted to the generosity of patients, their families and carers, well-wishers and friends who have donated so generously to the work of the Charity.

The overall financial performance of the Charity recorded a net decrease in funds of £433k compared to the previous years increase as the Charity aims to meet its spending objectives. The valuation of the investment fund has been valued at £114k higher than at the start of the year. This increase is due to the continued recovery on investment following the impact of COVID-19 on market performance.

Events since the year end and future plans

The Trustee does not expect any significant changes in the objectives of the Charity in the forthcoming year and intends to continue to manage all charitable income and expenditure within best practice guidelines of the Charities Commission. The Trustee continues to be mindful of the impact that NHS priorities may have on current charitable fund priorities.

Statement of Trustee's responsibilities

The Trustee is responsible for preparing the Trustee's Annual Report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice). Charity law requires the Trustee to prepare financial statements for each financial year that give a true and fair view of the state of affairs of the Charity and of the incoming resources and application of resources, including the net income or expenditure, of the Charity for the year. In preparing those financial statements the Trustee is required to:

- select suitable accounting policies and then apply them consistently;
- observe the methods and principles in the Charities SORP;
- make judgments and accounting estimates that are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements;
- prepare the financial statements on a going concern basis unless it is inappropriate to presume that the Charity will continue in business.

The Trustee is also responsible for keeping accounting records that disclose with reasonable accuracy at any time the financial position of the Charity and enable them to ensure that the financial statements comply with the Charities Act 2011, and regulations made thereunder.

The Trustee is also responsible for safeguarding the assets of the Charity and therefore takes reasonable steps for the prevention and detection of fraud and other irregularities.

The Trustees declare that:

a) so far as each of the Trustees at the time of the report are aware, there is no relevant information of which the Auditors are unaware, and
b) they have taken all steps they ought to have taken to make themselves aware of any information and to establish that the Auditors are aware of this information

By Order of the Trustee:

(Signed) ……..…… Date:

Chief Executive – East and North Hertfordshire NHS Trust

(Signed) …… Date:

Trust Chairman – East and North Hertfordshire NHS Trust

Independent Auditor's report to the Corporate Trustee of East and North Hertfordshire NHS Trust Charitable Fund

Opinion

East and North Hertfordshire Hospital

Charitable Funds

Annual Accounts

For the year ending 31 March 2022

EAST AND NORTH HERTFORDSHIRE NHS TRUST CHARITABLE FUND

Statement of Financial Activities for the year ended 31 March 2022

	Note	2021/22 Unrestricted Funds £'000	2021/22 Restricted Funds £'000	2021/22 Total Funds £'000	2020/21 Unrestricted Funds £'000	2020/21 Restricted Funds £'000	2020/21 Total Funds £'000
Income and endowments	2.0						
Donations, legacies and Grants	2.1	831	151	982	1,436	366	1,802
Income from other trading activities	2.2	240	51	291	313	31	344
Income from investments	2.3	66	0	66	59	0	59
Income from charitable activities		1,137	202	1,339	1,808	397	2,205
Expenditure on charitable activities	3.0						
Expenditure on raising funds	3.1	(345)	(3)	(348)	(302)	(7)	(309)
Expenditure on charitable activities	3.2	(1,263)	(270)	(1,533)	(1,219)	(442)	(1,661)
Other expenditure	3.3	(5)	0	(5)	(7)	0	(7)
Total Expenditure on charitable activities		(1,613)	(273)	(1,886)	(1,528)	(449)	(1,977)
Net (losses)/gains on investments	6.1	81	33	114	485	195	680
Net income/(expenditure)		**(395)**	**(38)**	**(433)**	**765**	**143**	**908**
Net movement in funds		(395)	(38)	(433)	765	143	908
Reconciliation of Funds							
Total funds brought forward		2,822	1,107	3,929	2,057	964	3,021
Movement of funds in year		(395)	(38)	(433)	765	143	908
Total funds carried forward		**2,427**	**1,069**	**3,496**	**2,822**	**1,107**	**3,929**

The notes on pages 37 to 42 form part of these accounts.

Balance Sheet as at 31 March 2022

	Notes	2021/22 Unrestricted Funds £'000	2021/22 Restricted Funds £'000	2021/22 Total Funds £'000	2020/21 Unrestricted Funds £'000	2020/21 Restricted Funds £'000	2020/21 Total Funds £'000
Fixed Assets							
Investments	6.1	2,101	1,086	3,187	2,035	1,037	3,072
Total Fixed Assets		2,101	1,086	3,187	2,035	1,037	3,072
Current Assets							
Receivables	7.1	44	4	48	54	2	56
Cash at bank and in hand	7.2	561	77	638	736	85	821
Total Current Assets		605	81	686	790	87	877
Current Liabilities							
Payables: Amounts falling due within one year	8	(279)	(98)	(377)	(3)	(17)	(20)
Net Current Assets/(Liabilities)		326	(17)	309	787	70	857
Net Assets		2,427	1,069	3,496	2,822	1,107	3,929
Funds of the Charity							
Unrestricted funds	10	2,427	0	2,427	2,822	0	2,822
Restricted funds	11	0	1,069	1,069	0	1,107	1,107
Total Funds		**2,427**	**1,069**	**3,496**	**2,822**	**1,107**	**3,929**

The notes on pages 37 to 42 form part of these accounts.

Signed on behalf of the corporate trustee:

Signature: Chief Executive

Print Name

Date:

Signature: Chairman

Print Name

Date:

Statement of cash flows for the year ended 31 March 2022

	Notes	Total Funds 2021/22	Total Funds 2020/21
		£'000	£'000
Net cash used in operating activities	9	(249)	182
Cash flow from investing activities			
Interest and dividends received		66	59
Proceeds from sale of investments		0	0
Purchase of investments		0	0
Net cash inflow/(outflow)from investing activities		66	59
CHANGE IN CASH AND CASH EQUIVALENTS IN THE YEAR		(183)	241
Cash and cash equivalents beginning of period		821	580
CASH AND CASH EQUIVALENTS AT END OF PERIOD		638	821

Notes to the Accounts

Note 1 Accounting policies

(a) Basis of preparation and assessment of going concern

The accounts (financial statements) have been prepared under the historical cost convention with items recognised at cost or transaction value unless otherwise stated in the relevant notes to the accounts. The financial statements have been prepared in accordance with the Statement of Recommended Practice "Accounting and Reporting by Charities" preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS102) issued on 16 July 2014 and the Charities Act 2011.

The Charity constitutes a public benefit entity as defined by FRS102.

The Trustee considers that there are no material uncertainties about the Charity's ability to continue as a going concern.

(b) Funds structure

Restricted funds are funds which are to be used in accordance with specific restrictions imposed by the donor or trust deed. There are twelve restricted funds held by the Charity, and the names of the funds and purpose is stated in note 13.1 to the accounts.

Unrestricted income funds comprise those funds which the Trustees are free to use for any purpose in furtherance of the charitable objects. Unrestricted funds include designated funds where the Trustees, at their discretion, have created a fund for a specific purpose.

(c) Income recognition

All income is recognised once the Charity has entitlement to the income, it is probable that the income will be received and the amount of income receivable can be measured reliably.

Donations are recognised when the Charitable Trust has been notified in writing of both the amount and settlement date. In the event that a donation is subject to conditions that require a level of performance before the Charity is entitled to the funds, the income is deferred and not recognised until either those conditions are fully met, or the fulfilment of those conditions is wholly within the control of the Charity and it is probable that those conditions will be fulfilled in the reporting period.

Legacy gifts are recognised on a case by case basis following the granting of probate when the administrator/executor for the estate has communicated in writing both the amount and settlement date. In the event that the gift is in the form of an asset other than cash or a financial asset traded on a recognised stock exchange, recognition is subject to the value of the gift being reliably measurable with a degree of reasonable accuracy and the title to the asset having been transferred to the charity.

Interest on funds held on deposit is included when receivable and the amount can be measured reliably by the Charity; this is normally upon notification of the interest paid or payable by the bank. Dividends are recognised once the dividend has been declared and notification has been received of the dividend due. This is normally upon notification by our investment advisor of the dividend yield of the investment portfolio.

(d) Expenditure recognition

Liabilities are recognised as expenditure as soon as there is a legal or constructive obligation committing the Charity to that expenditure, it is probable that settlement will be required and the amount of the obligation can be measured reliably.

All expenditure is accounted for on an accruals basis. All expenses including support costs and governance costs are allocated or apportioned to the applicable expenditure headings. For more information on this attribution refer to note (f) below.

Grants payable are payments made to third parties in the furtherance of the charitable objects of the Charitable Trust. In the case of an unconditional grant offer this is accrued once the recipient has been notified of the grant award. The notification gives the recipient a reasonable expectation that they will receive the one-year or multi-year grant. Grant awards that are subject to the recipient fulfilling performance conditions are only accrued when the recipient has been notified of the grant and any remaining unfulfilled condition attaching to that grant is outside of the control of the Trust.

(e) Irrecoverable VAT

Irrecoverable VAT is charged against the expenditure heading for which it was incurred.

Notes to the Accounts (cont.)

(f) Allocation of support and governance costs

Support and governance costs have been allocated between expenditure on raising fund and charitable activities. Governance costs comprise all costs involving the public accountability of the Charity and its compliance with regulation and good practice. These costs include costs related to statutory audit and legal fees together with an apportionment of overhead and support costs.

Governance costs and support costs relating to charitable activities have been apportioned based on the number of individual grant awards made in recognition that the administrative costs of awarding, monitoring and assessing research grants, salary support grants and postgraduate scholarships are broadly equivalent. The allocation of support and governance costs are analysed in note 3.4.

(g) Costs of raising funds

The costs of generating funds consist of Fundraiser salaries, merchandise purchases, raffle prizes and lotto winnings as well as direct costs to events as shown in note 3.1. Also included is the allocated support and governance costs.

(h) Charitable activities

Costs of charitable activities include allocated governance costs, capital expenditure and an apportionment of support costs as shown in note 3.2.

(i) Fixed asset investments

Investments are a form of basic financial instrument and are initially recognised at their transaction value and subsequently measured at their fair value as at the balance sheet date using the closing quoted market price. The statement of financial activities includes the net gains and losses arising on revaluation and disposals throughout the year.

The main form of financial risk faced by the Charity is that of volatility in equity markets and investment markets due to wider economic conditions, the attitude of investors to investment risk, and changes in sentiment concerning equities and within particular sectors or sub sectors.

(j) Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and their opening carrying value or their purchase value if acquired subsequent to the first day of the financial year. Unrealised gains and losses are calculated as the difference between the fair value at the year end and their carrying value. Realised and unrealised investment gains and losses are combined in the Statement of Financial Activities.

EAST AND NORTH HERTFORDSHIRE NHS TRUST CHARITABLE FUND

		Unrestricted Funds	Restricted Funds	Total 2021/22	Unrestricted Funds	Restricted Funds	Total 2020/21
2	**Income and endowments**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
2.1	**Donations and legacies**						
	Donations	230	29	259	824	22	846
	Legacies	522	14	536	437	0	437
	Grants Received from Trusts and Foundations	79	108	187	175	344	519
		831	151	982	1,436	366	1,802
2.2	**Income from other trading activities**						
	Events	152	51	203	214	31	245
	Lottery and Raffles	35	0	35	34	0	34
	Merchandise Sales	3	0	3	0	0	-0
	Gift Aid	50	0	50	65	0	65
		240	51	291	313	31	344
2.3	**Income from investments**						
	Income from Equity Investments	66	0	66	58	0	58
	Interest on cash deposits	0	0	0	1	0	1
		66	0	66	59	0	59

		Unrestricted Funds	Restricted Funds	Total 2021/22	Unrestricted Funds	Restricted Funds	Total 2020/21
3	**Expenditure on charitable activities**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
3.1	**Expenditure on raising funds**						
	Fundraising Salaries	208	0	208	171	0	171
	Fundraising expenditure	31	3	34	32	7	39
	Just Giving charges	9	0	9	8	0	8
	Lottery	14	0	14	14	0	14
	Prizes & raffles	0	0	0	0	0	0
	Merchandise Purchases	0	0	0	0	0	0
	Support and Governance cost	83	0	83	77	0	77
		345	3	348	302	7	309
3.2	**Expenditure on charitable activities**						
	Patient Welfare, Equip, Ward Extras and Services	401	158	559	372	79	451
	Research Salary, Travel, Equipment & Training	29	63	92	90	0	90
	Staff Education, Training & Equipment	66	16	82	31	11	42
	Capital Equipment/Building Works/Refurbishments	531	32	563	85	342	427
	Wifi Project Expenditure	27	0	27	19	10	29
	Gift in Kind	54	0	54	436	0	436
	Support and Governance cost	156	0	156	186	0	186
		1,264	269	1,533	1,219	442	1,661
3.3	**Other expenditure**						
	Fundraising Software	5	0	5	7	0	7
		5	0	5	7	0	7

All staff costs were paid by East and North Herts NHS Trust and recharged to the Charity

3.4 **Allocation of support and governance cost**

Support and overhead costs are allocated between fundraising activities and charitable activities. Governance costs are those support costs which relate to the strategic and day to day management of a charity. The bases of allocation used is direct allocation - where a cost is wholly attributable to a particular activity

	Fundraising Activity £'000	Charitable Activity £'000	Total cost 2021/22 £'000	Fundraising Activity £'000	Charitable Activity £'000	Total cost 2020/21 £'000
Finance Management/Admin Costs	53	0	53	90	0	90
Management & Administration	56	0	56	51	0	51
Audit Fees	11	0	11	9	0	9
Membership	7	0	7	6	0	6
Travel Expenditure	0	0	0	0	0	0
Stationery & Printing	0	0	0	0	0	0
Overhead Costs	29	83	112	30	77	107
	156	83	239	186	77	263

4 Details of certain items of expenditure

4.1 **Trustee expenses**

There were no trustee expenses during the current or prior year.

4.2 **Fees for audit of the accounts**

	Total 2021/22 £'000	Total 2020/21 £'000
Auditor's fee for reporting on accounts.	11	11
	11	11

This fee is inclusive of VAT.

5 Paid Employees

The Charity did not employ staff during the current or prior year.

6 Fixed Assets

6.1 **Investment Assets**

	Total 2021/22 £'000	Total 2020/21 £'000
Carrying (market) value 1 April 2021	3,072	2,392
Cash at 1 April 2021	0	0
Add : Additions to investments at cost	0	0
Less : Disposals at opening value	0	0
Funds drawdown	0	0
(Loss) /gain on investments	114	680
Cash	0	0
Carrying (market) value at 31 March 2022	3,187	3,072

6.2 **Analysis of investments**

	Total 2021/22 Market value at year end £'000	Proportion %	Total 2020/21 Market value at year end £'000	Proportion %
UK Fixed Interest	242	7.60%	215	7.00%
Overseas Fixed Interest	0	0.00%	0	0.00%
UK Equities	1,201	37.70%	1,195	38.90%
Alternatives	500	15.70%	412	13.40%
Overseas Equities	1,170	36.70%	1,210	39.40%
Property	0	0.00%	0	0.00%
Cash	73	2.30%	40	1.30%
	3,187	100%	3,072	100%

Investment fixed assets are included at their mid-market price ex div at 31 March 2022.
Investments in equities and fixed asset securities are all traded on recognised stock exchanges.

All investments are managed in accordance with the Charity's investment policy.

7 Debtors, prepayments and cash

	Total 2021/22 £'000	Total 2020/21 £'000
7.1 **Debtors**		
Prepayments	2	7
Accrued income	46	49
Total debtors falling due within one year	48	56
7.2 **Cash in bank and Deposit Account**		
Deposit Account	638	820
Current Account	0	0
Petty cash	0	1
Total cash at bank and in hand	638	821

8 Creditors falling due within one year

	Total 2021/22 £'000	Total 2020/21 £'000
Accruals and other deferred income	377	20
Total creditors falling due within one year	377	20

9 Reconciliation of net movement in funds to net cash flow from operating activities

	Total 2021/22 £'000	Total 2020/21 £'000
Net movement in funds	(434)	908
Add back depreciation charge	0	0
Deduct interest income shown in investing activities	(66)	(59)
Deduct gains/add back losses on investments	(114)	(680)
Funds drawdown		
Decrease/(increase) in debtors	8	28
Increase /(decrease) in creditors	357	(15)
Net cash used in operating activities	(249)	182

10 Unrestricted Funds

10.1 **The following funds are unrestricted and have material balances**

FUND NAME	OBJECTIVES OF FUND
General Purposes	Patient & Staff Welfare, Medical Equipment, Research
Covid 19	Patient & Staff Welfare, Medical Equipment, Research
General Fund - Children	Patient & Staff Welfare, Medical Equipment, Research
UROLOGY	Patient & Staff Welfare, Medical Equipment, Research
Chart Lodge	Patient Welfare
Mount Vernon Cancer Centre	Patient & Staff Welfare, Medical Equipment, Research
Lynda Jackson Macmillan Cancer Support	Patient & Staff Welfare, Medical Equipment, Research
Cancer Research - MV	Patient & Staff Welfare and Medical Equipment
General Renal Fund	Patient Welfare - Research for Cancer Patients

	Fund balances at 31.3.21 £'000	Incoming resources £'000	Fund Transfer £'000	Outgoing resources £'000	Gains / (losses) £'000	Fund balances at 31.3.22 £'000
General Purposes	612	198	0	(285)	23	548
Covid 19	227	21	0	(115)	0	133
General Fund - Children	86	189	0	(7)	2	270
UROLOGY	56	19	0	(4)	2	73
Chart Lodge	121	0	0	(94)	1	28
Mount Vernon Cancer Centre	741	394	0	(391)	21	765
Lynda Jackson Macmillan Cancer Support	122	147	0	(109)	4	164
Cancer Research - MV	218	0	0	(17)	7	208
General Renal Fund	230	28	0	(4)	8	262
Other Funds	409	91	0	(475)	13	38
	2,822	1,087	0	(1,501)	81	2,489

11 Restricted Funds

11.1 **The following funds are restricted at 31 March 2022, and the objectives of these funds are stated below**

	FUND NAME	OBJECTIVES OF FUND
A	NHS Charities Together	Staff welfare and staff area improvement
B	Lister MacMillan Cancer Centre	Funds and Grants used for end of life care at Lister Hospital
C	John Bush Legacy	John Bush legacy
D	Patient Transport Lounge	Funds used for Patient Transport Lounge
E	Magic of Play	Funds used for the childrens wards
F	Butterfly Appeal	End of Life service
G	Forget-Me-Not Appeal	Funds used for Elderly Care Services at Lister Hospital
H	LAKPA	Grant received for advisor role within Renal
I	Scanner Appeal	For use for patients in desperate need
J	Hardship Funds	For use for patients in desperate need
K	Sunshine appeal	Staff and patient area improvement
L	Voluntary Services	Grant receveid to recruit volunteers
M	Mount Vernon Cancer Centre	Funds for the Scalp Coolers campaign

		Fund balances at 31.3.21 £'000	Incoming resources £'000	Fund Transfer £'000	Outgoing resources £'000	Gains / (losses) £'000	Fund balances at 31.3.22 £'000
A	NHS Charities Together	295	40	0	(216)	7	126
B	Lister MacMillan Cancer Centre	34	50	0	(5)	2	81
C	John Bush Legacy	535	0	0	(75)	16	476
D	Patient Transport Lounge	1	0	0	0	0	1
E	Magic of Play	2	11	0	(0)	0	13
F	Butterfly Appeal	119	56	0	(48)	4	131
G	Forget-Me-Not Appeal	107	0	0	(46)	2	63
H	LAKPA	4	0	0	0	0	4
I	Scanner Appeal	10	0	0	0	0	10
J	Hardship Funds	0	0	0	0	0	0
K	Sunshine appeal	0	83	0	(3)	1	81
L	Voluntary Services	0	16	0	0	1	17
M	Mount Vernon Cancer Centre	0	3	0	0	0	3
		1,107	259	0	(393)	33	1,006

11.2 **Total fund movement**

	Fund balances at 31.3.21 £'000	Incoming resources £'000	Outgoing resources £'000	Gains / (losses) £'000	Fund balances at 31.3.22 £'000
Fund totals	3,929	1,339	(1,886)	114	3,496

11.3 **Commitments and Contingencies**

The Charity has committed staff costs for the following areas:
Linda Jackson Macmillan Centre of £7k per month based at Mount Vernon Hospital.

There are active fundraising appeals to raise funds to continue these services.

12 Transactions with related parties

12.1 No remuneration or other benefits were paid to a trustee.

12.2 No loans were made payable or due to the Charity.

12.3 Other transaction with trustees or related parties:

Name of the trustee;	East & North Hertfordshire NHS Trust
Relationship to charity;	Corporate Trustee
Nature of transaction;	Contributions to NHS
Value:	2021/22 £1,446k (2020/21 £1,342k)
Included in the £1,446k is £375k in accruals	
Name of the trustee;	Mr David Buckles
Relationship to charity;	Trustee/Chair
Nature of transaction;	Donation
Value:	£7,000
Name of the trustee;	The Schroder Trust
Relationship to charity;	Trustee/Chair
Nature of transaction;	Donation
Value:	£5,000
Name of the trustee;	Mr Michael Chilvers
Relationship to charity;	Trustee/Chair
Nature of transaction;	Donation
Value:	£1,000

Support

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@enhhcharity enhhcharity.org.uk charity.enh-tr@nhs.net 01438 285182

Registered with FUNDRAISING REGULATOR

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	14
Report title	Summary Learning from Deaths Report			**Meeting Date**	2 November 2022
Presenter	Medical Director				
Author	Mortality Improvement Lead				
Responsible Director	Associate Medical Director for Reducing Unwarranted Variation			**Approval Date**	14 September 2022
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**		☐
	Discussion	☐	**Decision**		☐

Report Summary:

Reducing mortality remains one of the Trust's key objectives. This quarterly report summarises the results of mortality improvement work, including the regular monitoring of mortality rates, together with outputs from our learning from deaths work that are continual on-going processes throughout the Trust.

It also incorporates information and data mandated under the National Learning from Deaths Programme.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

1. **Trust Strategic Objectives:**

Quality: Consistently deliver quality standards, targeting health inequalities and involving patients in their care

Thriving people: Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability

Seamless services: Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners

Continuous improvement: Continuously improve services by adopting good practice, maximising efficiency and productivity and exploiting transformation opportunities.

2. **Compliance with Learning from Deaths NQB Guidance**
3. **Potential impact in all five CQC domains**

Risk: *Please specify any links to the BAF or Risk Register*

Please refer to page 5of the report

Report previously considered by & date(s):

Mortality Surveillance Committee – 14 September 2022

Recommendation	The Board is invited to note the contents of this Report.

To be trusted to provide consistently outstanding care and exemplary service

This report provides a summary of the information contained in the detailed Learning from Deaths report which has been considered both by the Mortality Surveillance Committee and the Quality and Safety Committee. This summary is provided to the public Board meeting in line with NQB Learning from Deaths national reporting requirements.

1. Key mortality metrics

Table 1 below provides headline information on the Trust's current mortality performance.

Table 1: Key mortality metrics

Metric	Headline detail
Crude mortality	Crude mortality is 1.19% for the 12-month period to July 2022 compared to 1.28% for the latest 3 years.
HSMR: (data period Jun21 – May22)	HSMR for the 12-month period is **91.45, 'First quartile'.**
SHMI: (data period Apr21 – Mar22)	Headline SHMI for the 12-month period is **89.82, 'as expected' band 2, a change from the previous report of 'better than expected' band 3.**
HSMR – Peer comparison	ENHT ranked 3rd (of 10) within the Model Hospital list* of peers.

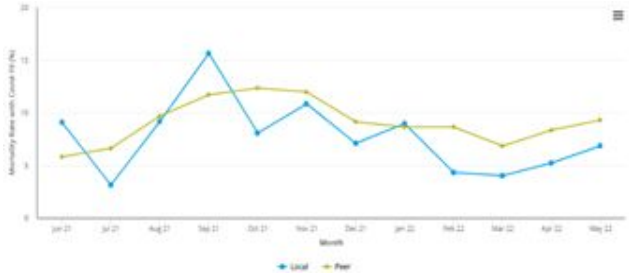
* We are comparing our performance against the peer group indicated for ENHT in the Model Hospital (updated in 2022), rather than the purely geographical regional group we used to use.

2. COVID-19

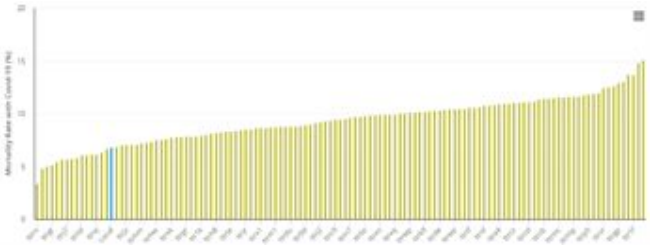
The following charts provided by CHKS show how the Trust's mortality rate for Covid compares with our national peers.

Fig 1: Covid-19 Peer Comparison: Jun21 to May22

Mortality Rate with Covid-19 (Peer: National)



Mortality Rate with Covid-19 National peer comparison



3. Mortality alerts

3.1 CUSUM alerts

The latest release from CHKS showed two HSMR CUSUM red alerts for the rolling year to May 2022. At May Mortality Surveillance Committee, it was agreed that coding of Coronary atherosclerosis diagnosis group should continue to be monitored by Cardiology/Head of Coding on a monthly basis, with an update to the Committee in 6 months. A coding review has been requested to check the non-Hodgkin's lymphoma deaths.

Table 2: HSMR CUSUM Alerts June 2021 to May 2022

	Relative Risk	Observed Deaths	Expected Deaths	"Excess" Deaths
38 - Non-Hodgkin`s lymphoma	140.34	7	5	2
101 - Coronary atherosclerosis and other heart disease	329.70	7	2	5

Source: CHKS (CUSUM alerts coloured)

The CHKS report also indicated six SHMI CUSUM red alerts for the period to February 2022, as detailed in the table below. These were for the diagnosis groups of ill-defined heart disease and skin disorders. These were discussed at September Mortality Surveillance Committee, where it was agreed that the Head of Coding will conduct coding reviews to assess what further action may be necessary.

Table 3: SHMI Outlier Alerts March 2021 to February 2022

	SHMI	Observed Deaths	Expected Deaths	"Excess" Deaths
16 - 20: Cancer; other respiratory and intrathoracic	190.26	3	2	1
53 - 95: Other nervous system disorders	191.02	7	4	3
58 - 101: Coronary atherosclerosis and other heart disease	278.46	10	4	6
61 - 104: Other and ill-defined heart disease	863.87	2	0	2
107 - 197: Skin and subcutaneous tissue infections	182.91	31	17	14
108 - 198, 199, 200: Skin disorders	232.51	26	11	15

3.2 External alerts

National Hip Fracture Database (NHFD) mortality alert (August 2019)
As previously reported, in June 2021 we received notification from the NHFD that in the forthcoming annual report we would be showing as a 3 standard deviation outlier. Figure 10 below shows the latest data from The National Hip Fracture Database for 30-day mortality has finally been updated. It now shows to April 2021.

For the period to December 2020, 30-day mortality stood at 12.0%, significantly above the national average. The latest data to April 2021 shows a significant improvement to 6.5%, compared to a national figure of 5%. As remedial work continues, delays to theatre access remain a key barrier to improvement. Following escalation to the Quality & Safety Committee, the Medical Director is now leading discussions between the service and Chief Operating Officer, to work on supporting initiatives.

4. Focus areas for improvement

Table 4: Focus Areas for Improvement

Diagnosis group	Summary update
Acute Myocardial Infarct	Following an initial six-month joint Cardiology-Coding initiative to review MI, it was agreed at May Mortality Surveillance Committee that the collaboration should continue with a further update in six months' time.
Sepsis	HSMR performance relative to national peer remains well placed. There has been some improvement regarding achievement of sepsis targets. A new clinical Sepsis Lead has been appointed.
Stroke	Latest SSNAP rating has been downgraded to D. The last 6 months has seen sustained improvement to both HSMR and SHMI. The most recently reported SSNAP risk adjusted mortality, considered a better mortality indicator, has improved – but is currently only available for the year 2019-20. Following the national set up of Integrated Stroke Delivery Networks (ISDNs), collaborative work via the East of England South network has led to the creation of a local area action plan aimed at the achievement of SSNAP A ratings for all trusts by March 2023.
Emergency Laparotomy	Focussed improvement work remains on-going. Positive news includes the ongoing engagement with the consultant palliative lead, enabling better consideration as to whether End of Life care would be in the best interest of the patient. Continuing delays to the re-establishment of the Surgical Assessment Unit/Surgical SDEC and the lack of a dedicated emergency theatre for general surgery continue to present challenges to improvement.

5. Learning from deaths data

5.1 Mandated mortality information

The Learning from Deaths framework states that trusts must collect and publish certain key data and information regarding deaths in their care via a quarterly public board paper. This mandated information is provided below for Q1 2022-23.

Table 5: Q1 2022-23: Learning from deaths data

	Jan-22	Feb-22	Mar-22
Total in-patient deaths	107	107	97
Mortality reviews completed	17	40	29
Total new ACONs raised	3	3	1
Concluded ACONs (2021-22 deaths): probably ≥50% due to problem in care	0	0	0
Learning disability deaths	3	2	3
Mental illness deaths	1	1	0
Stillbirths	2	3	0
Child deaths (including neonats/CED)	1	3	0
Maternity deaths	0	0	0
SIs declared regarding deceased patient	1	1	0
SIs approved regarding deceased patient	0	0	1
Complaints regarding deceased patient	0	0	2
Requests for a Report to the Coroner	9	8	13
Regulation 28 (Prevention of Future Deaths)	0	0	0

5.2 Learning from deaths dashboard and outcomes summary

The National Quality Board provided a suggested dashboard for the reporting of core mandated information. This is currently being used and is attached at Appendix 1.

It should be noted that for cases where Areas of Concern are raised, the current lapse in time between the death and completion of Stages 1, 2 and 3 of the review process means that the avoidability of death score is often not decided in the same review year. This should be borne in mind when viewing the data contained in the dashboard at Appendix 1, which only details the conclusion details for 2022-23 deaths which can appear to skew the data. Therefore, for the sake of transparency and robust governance this report details ACONs relating to all deaths which have been concluded during the quarter in question where the Mortality Surveillance Committee agreed an avoidability of death score of 3 or less (irrespective of the year in which the death occurred).

Table 6: 2022-23 concluded ACONs ratings

Apr-Jun 2022: Concluded ACONs discussed by Mortality Surveillance Committee		
Avoidability of Death Rating	**Definition**	**SI/RCA detail**
1	**Definitely avoidable**	**-**
2	**Strong evidence of avoidability**	**1 (SI)**
3	**Probably avoidable, more than 50-50**	**-**
4	Possibly avoidable, but not very likely, less than 50-50	2
5	Slight evidence of avoidablity	2
6	Definitely not avoidable	4
Quality of Care Rating	**Definition**	**SI/RCA detail**
A	Excellent	-
B	Good	-
C	Adequate	5
D	**Poor**	**3**
E	Very poor	1

Note: the above data relates to ACONs concluded during Q1 2022-23, irrespective of when the death occurred.

6. Learning and themes from concluded mortality reviews highlighted for concerns and learning opportunities (ACONs)

Cases raised as Areas of Concern (ACONs) as a consequence of mortality case record reviews, are central to the topics covered at clinical governance Rolling Half Days and other forums such as Mortality and Morbidity meetings. These meetings provided a forum for discussion, learning and the creation of appropriate Specialty-specific action plans and represent a key element of the Trust's learning from deaths framework.

Throughout the year emerging themes are collated and shared across the Trust via governance and performance sessions and specialist working groups. The information is also used to inform broad quality improvement initiatives.

7. Current risks

Table 7 below summarises key risks identified:

Table 7: Current risks

Risks	Red/amber rating
Fractured Neck of Femur mortality	
Medical Examiner Integration & Community expansion	
Mortality review reform: Using the new review tool for reporting	

3.0 Options/recommendations

The Board is invited to note the contents of this Report.

Appendix 1: ENHT Learning from deaths dashboard June 2022

East and North Hertfordshire NHS Trust: Learning from Deaths Dashboard: June 2022

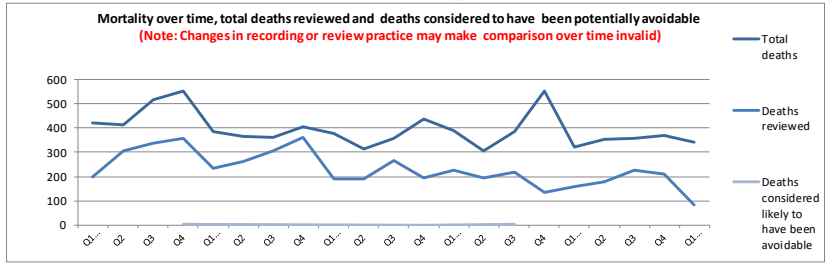
Description:
This dashboard is a tool to aid the systematic recording of deaths and learning from the care provided by East and North Hertfordshire NHS Trust and is based on the dashboard suggested by the National Quality Board in its Learning from Deaths Guidance published in March 2017. Its purpose is to record relevant incidents of mortality, deaths reviewed and lessons learnt to encourage future learning and the improvement of care.

Summary of total number of deaths and total number of cases reviewed under ENHT Structured Mortality Case Record Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
103	121	28	38	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
343	370	82	212	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
343	1405	82	772	0	0

Time Series: Start date 2017-18 Q1 End date 2022-23 Q1



Total Deaths Reviewed by RCP Methodology Score

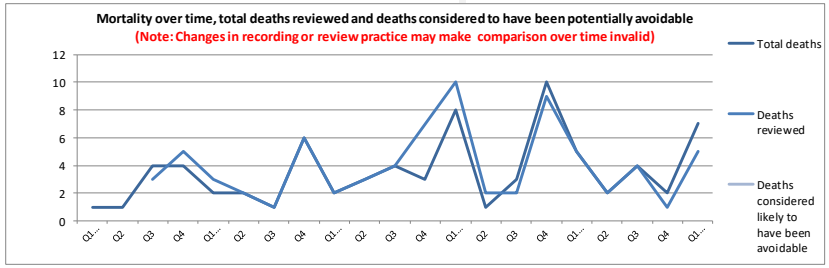
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	31	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD	83	100.0%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	83	100.0%

Summary of total number of learning disability deaths and total number reviewed under ENHT Structured Mortality Case Record Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
2	2	1	2	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
7	2	5	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
7	13	5	12	0	0

Time Series: Start date 2017-18 Q1 End date 2022-23 Q1



Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	15
Report title	A Framework of Quality Assurance for Responsible Officers and Revalidation			**Meeting Date**	2 November 2022
Presenter	Dr Michael Chilvers				
Author	Lesley Simpson and Dr Thomas Samuel				
Responsible Director	Dr Michael Chilvers			**Approval Date**	28 September 2022
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**		☐
	Discussion	☐	**Decision**		☐

Report Summary:

The purpose of this document is to:

- Assess effectiveness of medical annual appraisals to support the GMC revalidation requirements.
- Ensuring processes and policies are in place to support appraisers and medical appraises achieve the revalidation requirements.
- Provide details on actions agreed for 2022/2023 to support the above requirements.

Impact: where significant implication(s) need highlighting
Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

No significant impact

Risk: *Please specify any links to the BAF or Risk Register*

No significant risk

Report previously considered by & date(s):

Not applicable

Recommendation	No specialist recommendations.

To be trusted to provide consistently outstanding care and exemplary service

Classification: Official

Publication reference: PR1844

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2022

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team of East & North Hertfordshire NHS Trust can confirm that can confirm that

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

No change from last year:

Dr Thomas Samuel, Deputy Medical Director and Responsible Officer took over the RO responsibility within the Trust 2020 and has continued throughout 2022 into 2023 with his responsibility as current RO. Dr Samuel is also RO for Isabel Hospice and Garden House Hospice.

Comments:

Since the 20/21 AOA submission last September, there has been an on-going and steady increase in the performance for obtaining, timely qualitative data and completed appraisals for substantive employees using Premier IT and much work has continued for short term employees, as the Medical Advisory Guidance (MAG) GMC process is paper based with no software assistance, we have moved as many short-term employees as possible onto our Premier IT system and continue to do so. MS Teams has proved to be a very successful appraisal enabler since the start of the pandemic and continues to be the preferred method.

Completed actions from last year:

- The Lead Appraiser and Revalidation team have worked together now since November 2019 to support the ongoing improvement journey and to streamline the end-to-end appraisal process
- Regards visibility of the numbers and appraisal process for non-consultant grades on fixed term contracts using the MAG form, the year to date has seen a steady increase in completed appraisals, from the previous years for the short-term contract holders
- This year's Appraisal & Revalidation 'improvement journey' has seen a marked improvement in the reduction of the number of appraisals not completed within 3 months of appraisal due date.

Current Issues:

- Appraisal completion within due date: has greatly improved, reaching approximately 93% (completion outside of this is due to Maternity/long term sickness and leavers see breakdown in Section 2B below)
- The rising number of deferrals seen during Covid appears to have reduced however these deferrals should be seen as a positive and appropriate intervention and not as a negative action
- The increase in the number of trained appraisers continues to be a priority for the team and a 3-year tenure encouraged. High attrition rates/leavers continue to challenge the allocation of Appraisers to Appraisees.

- The contract review for Premier IT is due May 2023, we will consider merits of changing systems/provider, given recent advances in appraisal & revalidation IT Products and the Trust are considering a move to the L2P system which is now our Job Planning System.

Actions taken:

- During the past year the Appraisal and Revalidation team have tirelessly worked continually to improve all processes and procedures and to fine tune quality assurance methods by introducing a peer review undertaken by Medical Workforce Manager who joined the Trust in August 2021
- We have continued to support medical staff with lighter touch appraisals since advised during March 2020 (during Covid), altering our training and coaching as required
- We have aligned the monitoring and reminder schedule for both premier IT and MAG to improve compliance, we have also reworded our communications to our medical workforce using these reminders to encourage engagement during challenging times
- We have reviewed and relaunched premier IT reminders on the system and have aligned this process for the MAG manual process
- We have continued to deliver appraisal coaching sessions for overseas doctors who are new to the UK Medical appraisal process
- In conjunction with our Medical Recruitment team we have presented the GMC and NHS Appraisal & Revalidation requirements at Induction meetings, offering coaching to overseas doctors new to the process.

Actions for next year:

- Continue to support medical staff with light touch appraisals
- Consider a new Training Provider as recommended by the Academy of Royal College
- Evaluate and consider the QA findings from Lead Appraiser 1 to 1 QA sessions and identify methods to further improve quality
- Continue with the monitoring and reminder schedule for both premier IT and MAG, (aim to increase compliance rates by 2% to 95% by next year).
- Increase the availability of appraisal coaching sessions for overseas doctors who are new to appraisal process
- Review the current rate of short-midterm deferrals
- The contract review for Premier IT is now due May 2023, we will consider merits of changing systems, given recent advances in appraisal & revalidation IT Products we aim to streamline the appraisal process making data collection and 360% feedback more efficient and regularly provide quality assurance reports, through a fully integrated system
- Continue to run quarterly user groups, ensuring attendance of at least one of four groups per year, webinar training refreshers etc.
- The current policy is under review October 2022, this action was bought forward from last year
- To continue the audit performance process of current appraisers with on-going appropriate training/upskilling as scheduled (last delivered 15th June 2022) for a cohort of 8 new Appraisers (taking Appraiser total to 89) and we have plans in place to support those who are not demonstrating the competences required.

- To review of the number of appraisers to appraise quarterly with a focus on QA, we will ensure allocations of appraises do not exceed 6 per year (national guidance is 8 per year)
- All Appraisers are scheduled a 1 to 1 QA session with Lead Appraiser this commenced January 2022 will continue into 2023.

2. Designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes

Comments:

Following the team restructure in 20/21 the team has showed a steady increase in both compliance rates and quality. Performance has been further strengthened with the appointment and support of an experienced interim Band 7 appraisal and revalidation team lead, Lesley Simpson, Medical Workforce Manager, has provided this dedicated resource since August 2021. However a further restructure August 2022 results in the closure of this Band 7 post. The new team structure replaces this post with a dedicated team now comprising of one FTE Band 6 - Deputy Medical Workforce Manager, a 0.8 WTE Revalidation Officer, supported by one 0.6 Appraisal Administrator, reporting into the overall Trust's Medical Workforce Lead (Band 8). With the Lead Appraiser and Responsible Officer at the helm of the Appraisal & Revalidation service.

Actions for next year:

- Lead appraiser to attend Lead Appraiser regional and national forums /Academy of Royal College events and provide an update to all appraisers within the scheduled user groups
- Lead Appraiser and RO to both be appraised by externally sourced Appraisers
- Appraiser user groups should continue for all trained appraisers. Agreed to schedule these quarterly, next session planned September 2022 for one hour with input from RO and Lead Appraiser

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year:

None

Comments:

It is current practice that a monthly prescribed connection list is downloaded from GMC Connect portal which provides an accurate update of revalidation dates and numbers of appraisals required; this informs the monthly appraisal schedule, allowing the Revalidation team to plan 9 months to a year ahead.

New starter correspondence is emailed out to all employees on commencement at the trust, which includes instructions on how to connect to the trust designated body and the importance of doing this as soon as possible.

A monthly leaver report is reviewed, and employees are removed from designated body on GMC connect by the Medical Workforce Manager monthly. This ensures an accurate record of the prescribed connections is maintained.

Actions for next year:

To continue to carefully maintain the starter and leaver process to ensure accuracy of connections to the DB

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:

Rolled over to this year, delays to this review was due to resourcing pressures/COVID-19 backlogs

Comments:

Policy review is overdue however now underway, existing policy was last updated in 2017. This will reflect the necessary changes introduced by Appraisal 2020. Updated Appraisal is due to go to JLNC for their consideration and ratification in October 2022

Action for next year:

- A full review of current policy in line with Academy of Royal Colleges by Oct 2022

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year

External review, this has been rolled over to next year given the team focus this year has been to increase the number of completed appraisals and on quality improvements. However an informal review was undertaken by the new Medical Workforce Manager Lesley Simpson, during Q4 22/23 of which her findings inform this report as actions.

Comments:

External review is overdue however planned

Action for next year:

- Commission an external review from April 2023, when the appraisal process has ran a full cycle and compliance data is available. We will seek advice from

the Academy of Royal Colleges to determine who is best placed to conduct this review

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year:

- Audit of locum bank/agency appraisal has been actioned and all doctors are included in the short-term contract holder's process
- Review of GMC MAG process for fixed term employed doctors ensuring compliance

Comments:

We will continue to review short term employees who are employed as temporary bank/agency (which come at a cost) and agree with the RO/Lead appraiser how these are managed case by case.

Actions for next year:

- Continue to deliver appraisal coaching sessions for overseas doctors who are new to the UK Medical appraisal process by attending/presenting the induction slot of Recruitment Induction days and offering 1 to 1 coaching sessions with a senior Revalidation Team member
- Create an Appraisal Resource to offer initial guidance to support overseas Doctors better understand the process this will complement and shorten the Coaching sessions, allowing for a greater volume of coaching sessions to be delivered. Draft plans are in place to develop a video/e-handbook.
- We have identified that we do not hold an accurate list of all medical honorary contract holders/or those with other Trusts via SLA's and these are not always recorded on ESR. We need to better utilise job planning information and work with the resourcing team to ensure accurate records are maintained and reviewed and where appropriate to ensure all attached to us as a DB are supported with an appraisal and revalidation service. The introduction of L2P Job Planning System during 2022 and the investment and integration of this system with L2P's Appraisal and Revalidation elements (planned for May 2023) with further support the accuracy of data for Honorary contracts/SLA's

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

Action from last year:

No new actions

Comments:

The current checklist reviews the scope of practice which includes references to verify the doctor's fitness to practice for all their scope of practice. These are reviewed by the RO when appraisals are due for revalidation.

Actions for next year:

To continue as following process describes:

A monthly report request is sent re complaints and Incidents to obtain a report for doctors who have been directly involved in incidents and complaints

Monthly audit of appraiser output forms, identifying training needs with feedback to the individual appraiser and updates provided during scheduled user groups.

Commence the analysis of appraise feedback of the appraisal process for permanent doctors in Premier IT

Ensure staff have access to monthly reports on complaints and incidents, allowing them to discuss during scheduled appraisals and submit reflection. Discussions with Medical Directors office to use Datix cloud which may help facilitate this

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Comments:

Not Applicable

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:

This action has been rolled over to this year.

Comments:

Current policy is under review, the last Policy was approved and ratified by JLNC In 2017

Action for next year:

A review of the policy is underway and scheduled for completion during October 2022, ensuring the trust complies with national changes.

The policy will be reviewed by the board and ratified by the JLNC Oct 2022.

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:

- On-going review of numbers: Following a review of prescribed connections and number of trained appraiser for the trust, additional appraisers were recruited in June 2019, January 2020, September 2021 and again July 2022
- The reason was to limit allocations to a maximum of 6 appraises per appraiser, in line with the issued appraiser job description

Comments:

The number of appraisers against the prescribed connections for the trust are still too low this is caused by high attrition/leavers. The allocations require on-going review to ensure a fair distribution of Premier IT and MAG appraisal are undertaken.

Action for next year:

- Continue to review the ratio of appraises to appraiser
- Review number of allocations across appraisers (x6 per annum)
- Continue and schedule user groups and increase session to quarterly next User group Sept 30th 2021 with updates from RO and Lead Appraiser
- Quality assurance of appraisers and identify training and development activities

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year:

Actioned and Implemented

Comments:

We have developed and implemented a feedback process which is actioned through premier IT, whereby a feedback request is automatically generated and emailed to each Appraise following their Appraisal. This request for feedback on the Appraisal is automatically submitted and returned to the Appraiser (responses are then collated and reviewed by the Revalidation Officer). We are also developing a QA check list to use to review the quality of each appraisal undertaken. This audit exercise will be carried out by the Medical Workforce Manager, Lead Appraiser/RO to review appraisal quality undertaken for both Premier IT & MAG systems. This will be fed back individually, and common themes discussed at user group meetings.

We have now embedded the mentorship/buddying programme of new appraisers with high performing appraisers

Action for next year:

- Continue to audit appraises feedback on appraisals undertaken on Premier IT and align a similar process for the MAG process.Identify training and development activities to take to user groups
- Continue quarterly user groups with workshops where required
- Introduce monthly appraiser update communications following any local or national updates
- Fine tune the appraiser and revalidation folder on the knowledge centre. Upload user group material i.e. policy, guidance, presentations, meeting notes and any national guidance

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:

Developed and Implemented

Comments:

Following attendance at regional network meetings, the Lead Appraiser with the support of the Medical Workforce Manager have agreed a robust format/QA process to ensure appraisal are conducted to meet GMC guidance. A schedule has been developed and Appraisers are now regularly meeting with the Lead Appraiser to undergo a 1 to 1 QA session of their Appraisals to date

Action for next year:

We are currently further developing a quality assurance evaluation process by the end of 2022, which will include feedback and further training where required to all appraisers

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: East & North Hertfordshire NHS Trust	
Total number of doctors with a prescribed connection as at 31 March 2022 (380 on Premier IT System/140 MAG/5 Bank)	525
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022 (487 = 93% - 357 Premier IT/126 MAG/4 Bank)	487
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022 (38 of which 23 are on Premier IT/14 MAG/1 Bank)	38
Total number of agreed exceptions Why are 38 not completed? • 1 unauthorised missed • 9 doctors on career break, maternity leave or long term sickness • 16 doctors left the trust and did not complete the appraisal before they left • 3 appraisals are not complete but action is progressing (mainly March appraisals) • 9 appraisals are not complete, and no action has been taken at this stage (mainly March 2022 appraisals)	37 See detail of exceptions

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year:

Bought forward from last year

Comments:

Current Process is that all fitness to practice cases are discussed at the Decision Making Group (DMG) and where necessary NCAS are consulted. The DMG consists of:

1. Deputy Medical Director & Responsible Officer, Senior Medical Workforce Lead

Action for next year:

Bought forward - Review of the current Conduct, Performance and Ill-Health Procedures for Medical and Dental Staff to ensure the trust is maintaining compliance with the national procedures and RO regulations

Comments:

A procedure/policy review is required by January 2023

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year:

None to action

Completed actions from last year:

- Revalidations files are all reviewed by the appraisal and revalidation team and issues highlighted to Responsible Officer ahead of the submission date
- Positive recommendations are confirmed by email to a doctor and the GMC also send out this communication
- Doctors are contacted by the RO if a deferral or non-engagement recommendation is going to be made

Comments:

Changes made to revalidations in response to the coronavirus (COVID-19) pandemic resulted in 134 doctors who were due to revalidate between 17 March 2020 and 16 March 2021, had their revalidation submission dates moved back by one year

To accommodate flexibility in making recommendations, all these doctors were put under notice by the GMC. This means that responsible officers can submit recommendations to revalidate those doctors at any time up to their new submission date.

Following this decision and to manage the revalidation workflow in the following year, it was agreed to contact those doctors with original due dates from April to the end of September 2020 to give them the 2 options:

a, adhere to their new moved revalidation submission date in 2021, or

b, stay with the original 2020 revalidation submission date to be retained when documentary evidence is ready

The team also wrote to the remaining with submissions dates in October 2020 to March 2021 giving them the same options above.

Action for next year:

No further action required

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:

Nil

No changes since last report; no concerns.

Comments:

Medical workforce team continue to follow the SOP for ESR Gap Analysis and Audit SOP to ensure the information entered about employment checks on ESR for all new starters s accurate

Action for next year:

Quality and completeness of data entry will be checked on a monthly basis and analysed for gaps by the workforce governance team

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Carried forward from last year Comments: Established process and policies in place that support concerns raised. Action for next year: Ensure revised Conduct, Performance and Ill health Procedures for M&D staff policy is agreed and ratified by the LNC. Revised appraisal policies to be agreed and ratified by January 2023

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Carried forward from last year Comments: Established process and policies in place that support concerns raised. Action for next year: Ensure revised Conduct, Performance and Ill health Procedures for M&D staff policy is agreed and ratified by the LNC. Revised appraisal policies to be agreed and ratified by January 2023

1. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year:
Nil
Comments:
All the concerns are discussed in the DMG. A full analysis has not taken place over the past year due to on-going pressures due to COVID 19
Action for next year:
Full analysis to take place in the next financial year

2. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year:
Nil
Comment:
MPIT or transfer of Information (TOI) forms are used to obtain information on doctors working between hospitals. These forms require approval by the RO. This responsibility now sits within the Appraisal & Revalidation team and applied following appointment however further enquiry and discussion is required to determine whether this process should and could be part of pre-employment checks.
On receipt of an enquiry the revalidation and appraisal team request data from the appropriate departments, i.e. if there has been any complaints, incidents or claims relating to the doctor. Once received the form is completed and forwarded to the

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

RO to review and approval sought. This is currently in addition to the referencing (recruitment pre-employment checks)

Action for next year:

- Continue and review current process

3. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:

Currently Multi Organisational Working Reference (MOWR) is issued by the team from doctors practising privileges as recorded in the Scope of Practice identified on their last appraisal before revalidation.

Medical Workforce Lead and ERAS, sit on the Decision-Making Group, the most effective quorate of this group needs to be established

Comments:

To be carried forward 22/23

Action for next year:

- Review whether MOW references or a Medical Practice Information Transfer Form should be uploaded as supporting information evidence on yearly appraisals
- Discuss further with Lead Appraiser/RO to introduce from Jan 23
- Review Conduct, Performance and Ill-Health Procedures for Medical and Dental Staff has been in line with national procedures and route to be ratified by the LNC Jan 22
- Continue monthly Decision-Making Group meetings to discuss concerns raised are timely

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:

Nil

Comments:

- Medical Workforce team undertake appropriate pre-employments checks which include references for all permanent and fixed term contract holders. These records are maintained on TRAC
- The temporary staffing team administer checks for the bank trust locums and liaise with agencies for agency staff to ensure compliance
- Workforce governance monitor ESR records, undertaking a gap analysis of all new starters to ensure all appropriate records are completed and compliance is monitored.

Action for next year:

Continue with the above

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

General review of actions since last Board report

Some have been bought forward to next year

Actions still outstanding:

- Commission external review (support from the Royal Academy of Colleges)

Policy and Process Reviews:

- Medical Workforce Manager with Responsible Officer/Lead Appraiser to conduct a review of the policy and seek ratification by the JLNC by Oct 2022
- Draft Conduct, performance and Ill-Health Procedures for Medical and Dental Staff for ratification by the LNC by January 2023

- Evaluate the developed quality assurance process implemented during 2022 Review and evaluate by Jan 2023

New Actions, Current Issues:

- Further streamline processes following and in line with the policy review so that the administrative team can work efficiently and continue to make improvements
- Continue to improve the management and compliance rates for appraisals of short-term employees by mirroring those processes in place for substantive employees
- Continue to increase the lead time for recommendations by early review of appraisal and supporting information so that issues are highlighted in advance allowing the RO to discuss with the doctor ahead of making a recommendation and ensure no recommendations made after GMC deadline, currently working towards a 4-week lead time
- Ensure the draft Conduct, performance and Ill-Health Procedures for Medical and Dental Staff has been reviewed and been ratified by the LNC Jan 2023
- Review quarterly ratio of appraisers to appraise
- Develop and maintain an appraiser and revalidation folder on the knowledge centre Upload user group material i.e. policy, guidance, presentations, meeting notes and any national guidance (on-going)
- Ensure staff have access to monthly reports on complaints and incidents, allowing them to discuss during scheduled appraisals and submit reflection. Discussions with Medical Directors office to use Datix cloud which may help facilitate this.

Support Team Improvements**:**

- Training and support of the revalidation and appraisal team by the head of medical workforce and lead appraiser
- Keep resourcing and performance under review

Quality Assurance:

- Commission an external review once the policy has been ratified and embedded in 2023.
- Continue to undertake appraisal quality audits by reviewing the checklist process by undertaking spot-checks on appraisals for doctors, not under notice in that year
- Trust recognition and feedback for appraisers on their performance; ensure this is reviewed in their own appraisal
- Audit prescribed connections list accuracy to evaluate effectiveness of current processes
- Audit of locum (bank/agency) appraisal and revalidation process

Appraiser Resourcing:

- Continue to run user group forum quarterly next is due to be held 30th Sept 2022
- Continue with the mentorship/buddying programme of new appraisers with high performing appraisers
- Appraisal Lead continue to review ratio of appraiser to appraise quarterly and recruit and train in accordance (last trained 8 Appraisers June 15th, 2022). Next training is planned January 2023

Overall Conclusion:

The Appraisal & Revalidation team continue to make impressive progress on their improvement journey during 2021-2022. This is evidenced by the increased number of appraisals undertaken this last year **93%,** and the reduced number of agreed exceptions and quality improvements notably achieved through improved teamworking, engagement and communication with RO and Lead Appraiser and administration/systems process improvements, also the Lead Appraiser QA activity, including her support and feedback given to the medical workforce throughout the past year.

(see Page. 12)

Section 7 – Statement of Compliance:

The Board / executive management team – of the East & North Hertfordshire NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body:

Adam-Sewell Jones

Chief Executive

Date:

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Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	16
Report title	Assurance Report for Mount Vernon Ward 10 and 11			**Meeting Date**	2 November 2022
Presenter	Kevin Howell – Director of Estates and Facilities				
Author	Kevin Howell – Director of Estates and Facilities				
Responsible Director	Kevin Howell – Director of Estates and Facilities			**Approval Date**	19 October 2022
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**		☐
	Discussion	☐	**Decision**		☐

Report Summary:

This report is to identify to the Board issues raised following notification of potential asbestos issues for wards 10 and 11 at Mount Vernon Cancer Care Hospital. The aim of the report is to give assurance to the board that due diligence has been undertaken and that a decision has been made to remain in-situ in the ward areas despite the acknowledged existence of the asbestos roof. This decision was arrived at following receipt of supporting advice and mitigations from the professional appointed hospital managers (AP's)and independently appointed authorised engineers (AE's), for both East and North Hertfordshire NHS Trust (ENHT) and The Hillingdon Hospitals NHS Foundation Trust (Hillingdon Hospital). The board is asked to support this decision and acknowledge the enhancement of risk appetite on this matter when balanced against potential risks of either moving patients or having to look for alternative places to treat these patients. Support was sought from and gained at regional level on a professional basis and assurance have been given to NHSE that definitive monitoring and reporting will happen on a quarterly basis, any detrimental reports will be noted to the board through the Quality and Safety committee.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

There are no immediate impacts, financially, resourcing or legally on this decision as it is to remain in the existing environment. The risk of potential future contamination occurring through damage or accelerated deterioration is the enhanced risk appetite. If this comes to fruition there would be a joint liability between ENHT and Hillingdon Hospital which could have financial ramifications of physical moves or environmental works.

Risk: *Please specify any links to the BAF or Risk Register*

Mount Vernon Cancer Care infrastructure is on the risk register and this is reviewed as a part of this.

Report previously considered by & date(s):

N/A

Recommendation	The Board/Committee is asked to

	• Acknowledge the risks and the mitigations undertaken. • Support the ongoing reviews and monitoring systems as adequate. • Undertake to receive ongoing surveys, reviews and results on a biannual timetable unless more detrimental information comes to light. • Accept the professional internal and external advice on these matters. Support the continued usage of wards 10 and 11 for the ongoing treatment of inpatient cancer care and treatment within the radio isotopes room in the first instance for a maximum of five years pending review.

To be trusted to provide consistently outstanding care and exemplary service

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	17
Report title	Incidents and Inquests report			**Meeting Date**	2 November 202
Presenter	Theresa Murphy - Chief Nurse				
Author	Lucinda Berry, Legal and Governance Lead				
Responsible Director	Theresa Murphy, Chief Nurse			**Approval Date**	19 October 2022
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**		☐
	Discussion	☒	**Decision**		☐

Report Summary:

This report provides a quarterly update on incidents and Inquest activity across the Trust. It provides an overview of Q2 2022/23 activity and comparison across the previous 12 months where appropriate. It reviews reported incidents with a focus on patient safety incidents and Serious Incidents.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

N/A

Risk: *Please specify any links to the BAF or Risk Register*

BAF risk 008/21

Report previously considered by & date(s):

Patient Safety Forum 12 October 2022 and Quality and Safety Committee 26 October 2022

Recommendation	The Board is asked to note this quarterly update.

1

Quality and Safety Committee

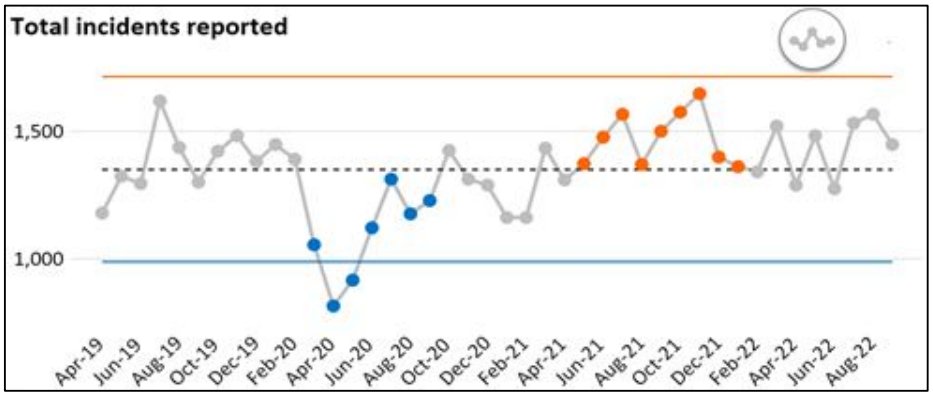
Incident and Inquests report October 2022

Executive Summary	Page No
Reported incidents – incident reporting ranges between 1200 – 1400 per month and across Q2 we have seen common cause variation. The number of open incidents forms on datix remains high; review and closure of these remains a priority for the Divisions, this continues to be impacted by operational and staffing pressures	2, 3
Patient Related incidents – There has been a 12% increase in patient related incidents reported in Q2 compared to Q1. 98% of those patient related incidents reported in Q2 resulted in either no harm or minimal harm, in line with previous months. We have seen an increase in Medication related incidents being reported although under 1% resulted in moderate harm or above.	3 - 7
Serious Incidents, including Never Events – One never event was declared in Q2 (July 2022). The case involves the wrong lesion being removed from a patient's tongue. The investigation has been completed and submitted to ICB and shared with the family. In Q2 there were 13 SI's declared and 22 SI's were completed and submitted to the ICB which was a significant improvement on previous quarters. Of the remaining open SI's, 19 are overdue.	7- 2
Learning – round table discussion forum has proved to be an effective learning forum but ongoing work is in progress refining the process including early agreement of Terms of Reference and sign off process. Two thematic learning reviews are in progress relating to mental health incidents in ED and Ophthalmology patients who were lost to follow up.	10
Inquests – During Q2 we have received 24 requests for statements for Inquests. We have not had any Prevention of Future Deaths reports issued.	12-14

1. All reported incidents

Prior to COVID-19, there was an average of **1230** incidents reported each month. Nationally, there was a reduction in incident reporting seen at the beginning of the pandemic between March 2020 – June 2020. This was reflected locally; our incident reporting at the beginning of the pandemic (March 2020) noted a statistically significant decrease to a monthly, with April 2020 showing the lowest number of incidents reported for a month at 789. As the pandemic progressed through the second wave there was only a marginal decline in incident reporting. As the graph below demonstrates, incident reporting levels have been gradually increasing since then and on average, they have sustained an increased reporting trend since May 2021, compared to pre-pandemic average of 1303 per month to a current average of **1472** incidents per month.

In April 2021 we saw a step change followed by a steadily improving trajectory of reporting. Since February 2022 we have seen common cause variation in the total number of incidents reported. It is recognised that the biggest driver to improvement in reporting is feedback; the ways in which we can improve our feedback are being explored. Teams are being encouraged to ensure incidents are a routine part of local discussions at quality huddles and team meetings.



Of the total incidents reported in since 1 April 2022, 78% are patient related incidents and 11% related to staff. Of the total incidents reported in Q3 of 2022/23, 77% related to patient safety and 11% related to staff. These proportions are in line with previous quarters and the general patterns seen.

On review of the Q3 2022/23 data, within staffing incidents the top 3 themes remain the same however there has been an increase in incidents reported relating to staffing:

- violence and aggression (144)
- staffing (108, in Q2 there were 74 reported)
- health and safety / security incidents (66)

1a) Approval Status of reported incidents

Each reported incident should be reviewed by the Incident Manager within three working days. It should be moved either to the category “awaiting final sign-off” if all remedial actions have been taken and the incident is ready for closure; or to the category “being reviewed” if further enquiries or information is required. The current approval status of all incidents is shown below.

Awaiting Review by Manager	919 records	750 Overdue
Being Reviewed by Manager	2225 records	2083 Overdue
Awaiting Final Sign-Off	789 records	637 Overdue

Whilst the previous report noted an improvement in the number of records awaiting review and being reviewed, regrettably that improvement has not continued through this quarter. It is acknowledged that the number of incidents awaiting review and final sign off remains high and it is recognised both within the Corporate Patient Safety team and the Divisions that the number of outstanding incident forms awaiting review and being reviewed is far higher than we would like it to be. Effective escalation of this issue is being explored with the wider Patient Safety team and Divisional Senior teams. To enable clearer oversight and monitoring of this, discussions are ongoing with the Information team having this data added to the monthly Quality & Safety report. It is hoped this will include breakdowns by Specialty and themes and it is hoped this will be available for the November IPR.

Despite the increase in numbers, the breakdown of the open incidents by divisional team remains in line with the previous report; 52% relate to the Medicine team, 9% relate to Women's and Children's Services and 17% relate to Surgery. Cancer Services and Clinical Support Services account for approximately 6% each.

Across all Divisions staffing and operational pressures, combined with the associated issues this generates, have impacted the timeliness and time available for review and closure of open incidents. Notwithstanding this, review of all the open incidents continues to be a priority for all the Divisions.

Within the Medicine team the new incident forms raised are reviewed daily by the Divisional Quality Team and appropriate feedback given to the reporter and clinical area where further action is required (for example any immediate patient safety / staff concern or if a rapid incident report is needed). In addition there are regular reviews by the Clinical Practice Team and the Matrons. It is recognised by the Governance team within Medicine that there are difficulties with outstanding incident forms being reviewed and closed and this is being highlighted through Divisional Board, Clinical Governance Leads and Specialty Exception meetings. In addition it is highlight daily at ward level. At present it is noted that there are more incident forms being raised daily than the team are able to close.

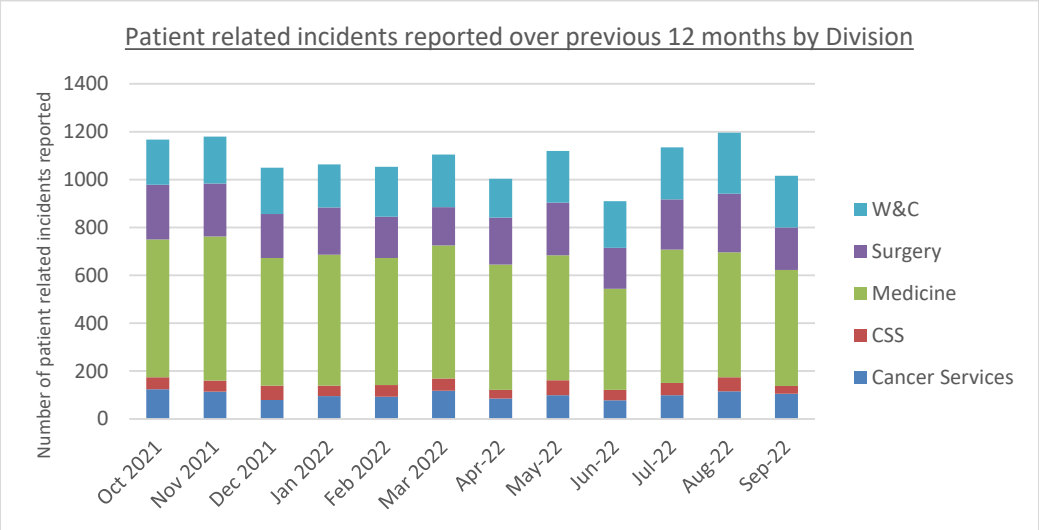
Within Women's Services ongoing meetings are in place with Matrons and Consultant Leads for areas to review outstanding/open datix. It is recognised that there has been an increase in the number of datix requiring closure and this has been impacted by leave. The Women's Services team expect the number of unactioned datix to be monitored and every effort made to keep the number of unactioned incident forms to a minimum.

Within Planned Care, overdue open incident forms are being highlighted and escalated at specialty performance review meetings, and Divisional Governance Committees. The team have identified the top 5 specialties to target; General Surgery, T&O, Ophthalmology, Operating Theatres and Urology. The Divisional Quality Managers are planning on attending rolling half day meetings to provide additional training.

2. Patient Related Incidents

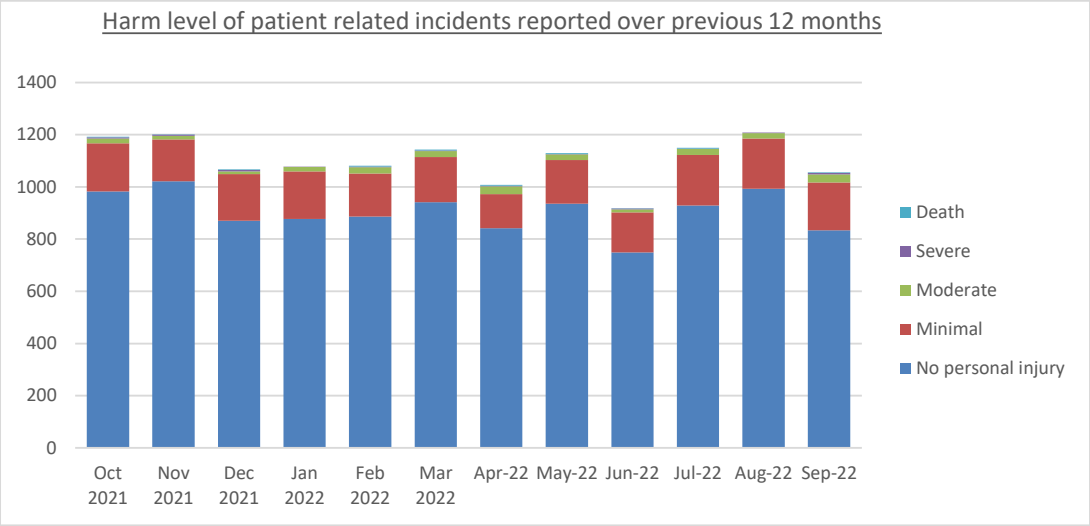
The graph below shows the number of patient related incidents reported by each Division

over the previous 12 months. It is recognised that this data reflects the old divisional structures however the current datix reporting system uses these. The medicine division (within Unplanned Care) have always had the highest number of incidents reported. It is of note that September has seen a reduction in incidents reported across all Divisions. This is felt to be likely due to ongoing operational pressures.



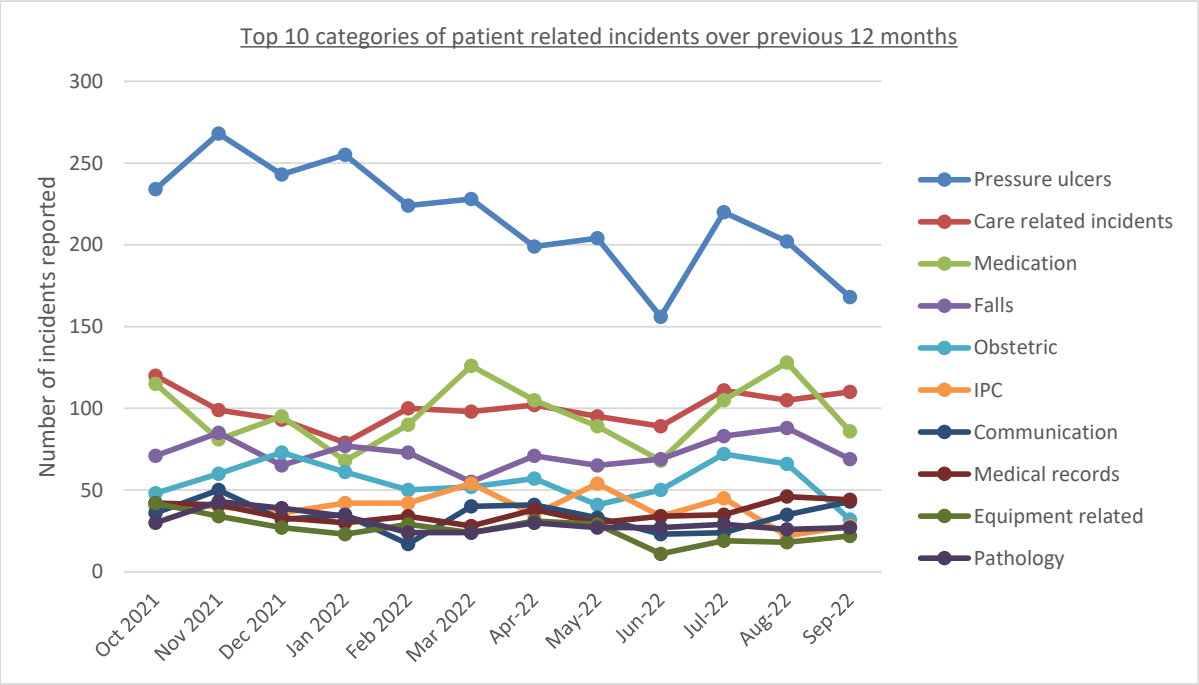
When incident forms are reported, an associated level of harm must be recorded. There is a weekly meeting with the Divisional Quality Managers and Corporate Patient Safety team, part of which includes reviewing every incident form reported over the previous week with a harm level of moderate or above. There is discussion about the incident, appropriate next steps and Duty of Candour where appropriate. This process is extremely valuable and helps ensure all such incidents are promptly acted upon, the harm level reviewed and considered for appropriate escalation. Following those discussions and further review by the Divisional teams, all incidents that have an agreed harm level of moderate or above are developed into a rapid incident report (RIR) that is then discussed at the Serious Incident Review Panel (SIRP), further information about SIRP is given below at section 2b).

Since the last report, **3414 patient related incidents** were reported onto datix (1 July 2022 – 30 September 2022) of note this is a 12% increase compared to Q1 when 3058 patient safety incidents were reported. Of those reported in Q2, 97% of those incidents reported resulted in no or minimum harm (this is in line with the usual proportions).



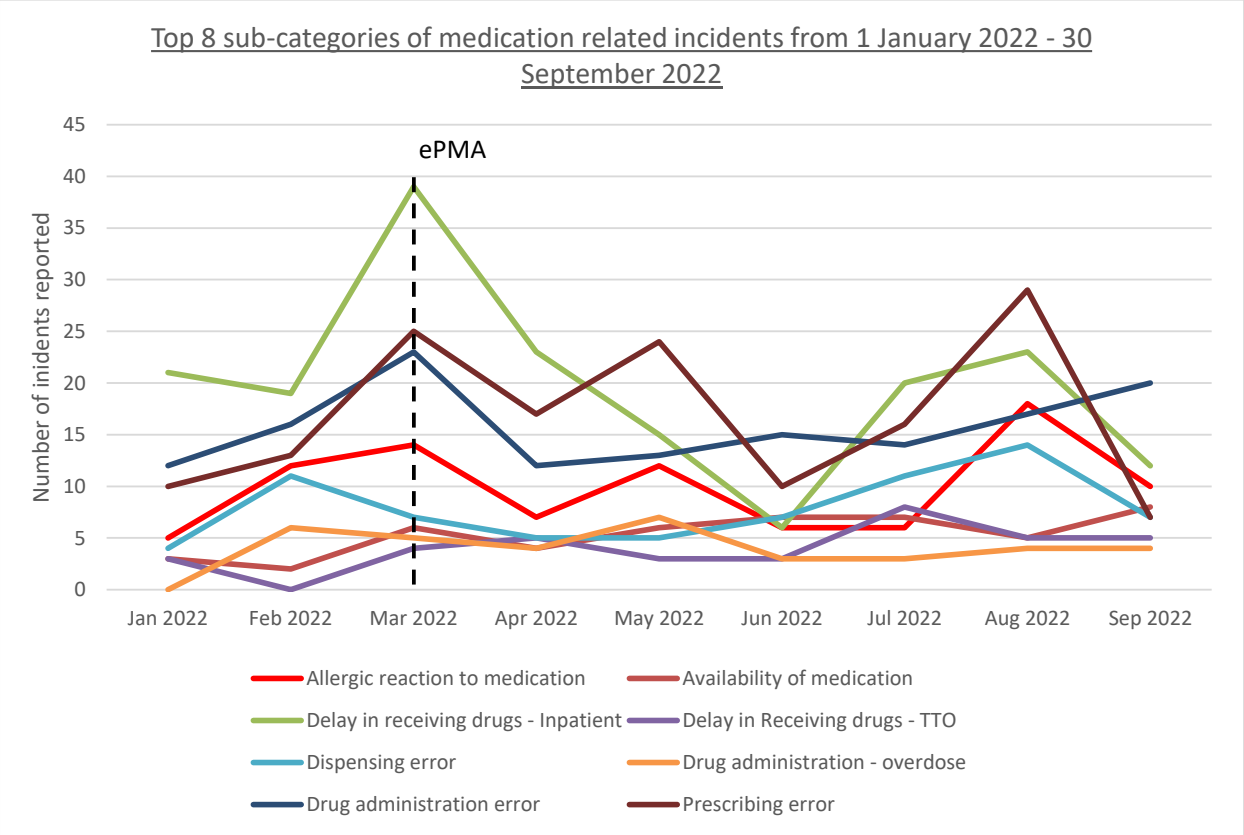
Whilst not evident from the graph above, analysis of the raw data shows there were 5 'severe harm' incidents reported in September. One of those cases has been discussed at SIRP already with the outcome of a Divisional roundtable meeting and 2 are scheduled for SIRP discussion imminently. Review of the other cases is ongoing to ensure that the level of harm noted is appropriate and presentation at SIRP is in progress. This will be monitored and if appropriate, an exception report will be provided to the Patient Safety Forum.

When reporting a patient related incident on datix, there are 46 possible categories for the reporter to use. The graph below demonstrates the top 10 categories of patient related incidents reported over the last 12 months. The data has been collected by the date the incident form was logged onto datix (rather than by date of incident). As detailed previously, pressure ulcer incidents are counted through a combined measurement of community and hospital cases.



The Trust saw an increase in falls during the pandemic as an adverse consequence of staffing challenges and co-horting patients with increased use of side rooms. However, it is pleasing to note that we remain below the national average for harm resulting from falls and the current falls rate continues to show common cause variation. It has been recognised that there has been an increase in falls reported resulting in no or low harm, particularly in the ED area.

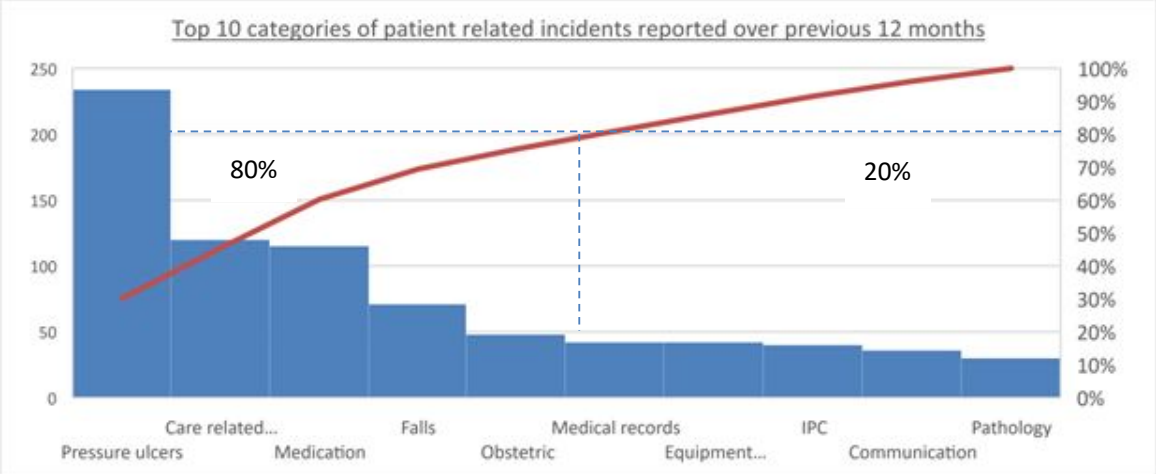
Historically, medication incidents and care-related incidents have fluctuated between being the second highest type of incident reported. As has been noted and discussed in previous reports, the electronic prescribing system (ePMA) roll-out lead to a spike in medication-related incidents being reported in March 2022. From 1 April 2022, the number of medication-related incidents was showing a downward trend and the March 2022 spike appeared to be a one-off however August 2022 has shown a similar spike. Of all the medication related incidents reported in Q1 and Q2 of 2022/23, under 1% resulted in moderate harm (2 incidents in Q1 and 3 in Q2, 2 of which relate to the same person and are being investigated as an SI). The rest of the incidents reported across both quarters resulted in no personal injury or minimal harm. Further detail as to the sub-category of medication related incidents is provided below.



The graph above shows the top 8 sub-categories of medication related incidents reported since 1 January 2022. The data has been provided from 1 January 2022 to demonstrate the position prior to going live with ePMA and during the ePMA implementation process. The increase is incidents involving an allergic reaction in August 2022 is noted and further review has identified that 55% of these occurred in two areas; the MacMillan Cancer Centre and the Chemotherapy suite at Mount Vernon. Whilst all of the incidents are noted as resulting in low or minimal harm, further review with the specific areas will be undertaken to identify themes and if any learning or further investigation is needed. This data will also be highlighted at the Trust's medication forum

where medication incidents, RCA's and SI's are routinely reviewed to identify any themes, trends and learning. In addition medication incidents are monitored by the Patient Safety Pharmacist in addition to the ongoing safer medicine strategy and harm free care improvement program.

The pareto chart below shows, 80% of patient safety incidents reported relate to Pressure ulcers, care related incidents, medication, falls and obstetrics incidents (those bars to the left of the horizontal dotted line).



A deep dive into 'care related incidents' has previously been provided for the Committee. The top 4 sub-categories of 'care related incidents' reported remains the same; delay in receiving treatment/care, failure of follow up arrangements, inadequate care, and inadequate observations undertaken. The last report noted an increase in February of incidents reported relating to 'failure to follow policy' (10 cases), that pattern has continued and it is the fifth highest sub-category of care-related incidents. It is of note that the number of these cases is small (on average 6 cases a month) and all the records have been reviewed they relate to a variety of departments across the Trust and all resulted in no/low harm.

2b) Serious Incident Review Panel (SIRP)

SIRP meetings take place twice a week and are chaired by either the Chief Nurse or Medical Director. They provide an open forum for clinicians and operational colleagues to present a summary of a patient safety incident, including details of Duty of Candour carried out and any immediate safety and learning actions taken. It is a very effective forum facilitating multi-disciplinary discussion and providing both support and challenge where appropriate. The table below details the cases discussed in Q3 with the relevant outcomes;

	Number of reports discussed	Outcome							
		SI declared	RCA	NFA	HSIB	Safeguarding /complaint	Thematic	Requires further info	Local learning only
July	30	9	4	4	0	0	0	3	10
August	39	3 Declared and 1 downgrade approved	2	4	1	1 complaint	1 (incl 6 incidents)	3	18
September	31	4	0	4	0	3 (2 complaints and 1	0	2	19

						safeguarding)			

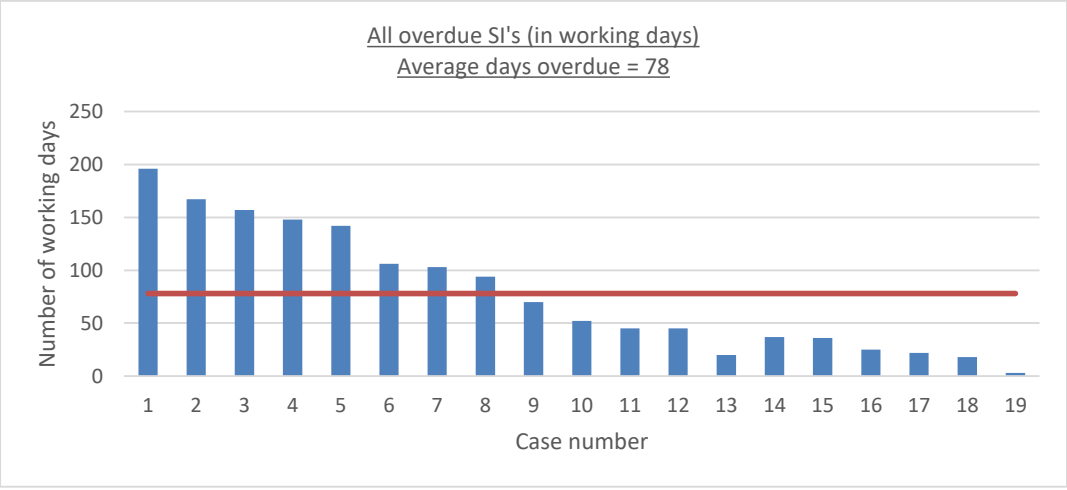
3. Serious Incidents

3a) SI position

Throughout the pandemic there was an increased number of overdue SI investigations due for completion. This remains a ongoing key priority to improve and reduce and there has been regular ongoing collaborative review by ENHT and the ICB to support this.

As at the point of writing, there are 31 open SI investigations of which 19 are overdue, 1 is with the Executive team for review and 14 are with the Divisional teams for review and approval. During Q2, 22 SI's were completed and submitted to the ICB. This is a marked improvement on Q1 when only 12 were completed and submitted (further detail on the closed SI's is provided later in the report). The quality of SI reports and the undertaking of investigations is being supported through new 'safety investigation science' training offered in partnership with Health Safety Investigation branch (HSIB), which started in January 2022. It was recognised that there needs to be an improvement across the wider teams in the timeliness of completing effective investigations and it is noteworthy that the Never Event investigation was completed and submitted to ICB on time and in addition, 3 of the SI's declared in Q2 are already with the Divisional team for review and approval.

The graph below shows the 19 overdue investigations which have an average of 78 days timeframe overdue. Whilst there is still improvements to be made, it is noteworthy that the position is better compared to the previous report which showed there were 28 overdue SI's with an average overdue timeframe of 96 days. These are being reviewed on a twice weekly basis with updates being shared. In addition an escalation report to the Divisional triumvate's is being trialed in order to ensure full support is provided to the divisional quality team and also to progress escalations of specific cases.

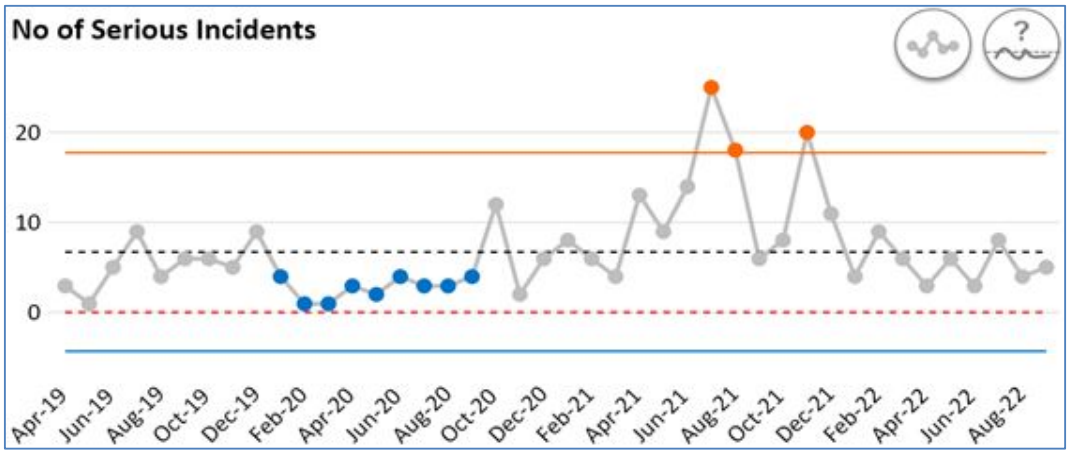


We have identified some processes where delays are occurring, and these are priority for improvement. Following the new national patient safety strategy objectives we have continued to develop alternative ways to the traditional root cause analysis investigation

methodology. This has provided the opportunity of clustering and thematic reviews for example at present we have an active investigation reviewing the care of mental health patients in ED; these are 3 individual cases which all resulted in no or low harm to the patients however we have recognised common themes and therefore are looking at the 3 together to identify the appropriate learning. The draft report has been completed working collaboratively with HPFT and is currently with the Divisional team for review and approval.

We have also embedded the use of round table meetings to discuss incidents which enable multi-disciplinary input to review what happened and why and also to discuss the most appropriate learning points and actions. The round table discussion format has been shown to be successful as a learning forum, attendance is mostly senior staff and it is an opportunity for staff involved in the incident and other frontline staff to be involved in the process. It also enables early cross-organisation discussions with colleagues from outside of the organisation (for example HPFT when reviewing cases involving mental health patients). This can help provide early feedback to both those directly involved and also those more senior staff from the wider teams. Now the process is embedded, the team are continuing to refine and streamline the process to continue to improve. Since the last report was provided, focus has been on early mutual agreement of the terms of reference and also a divisional lead who acts as an 'expert' point of reference for the SI manager. This has shown to improve the clarity of the scope of the investigations at the outset and help ensure that all key points of learning are captured. Moving forward, the focus remains on improving the timeliness of the reports, both from within the Corporate team preparing the first draft and also the Divisional review / approval stage.

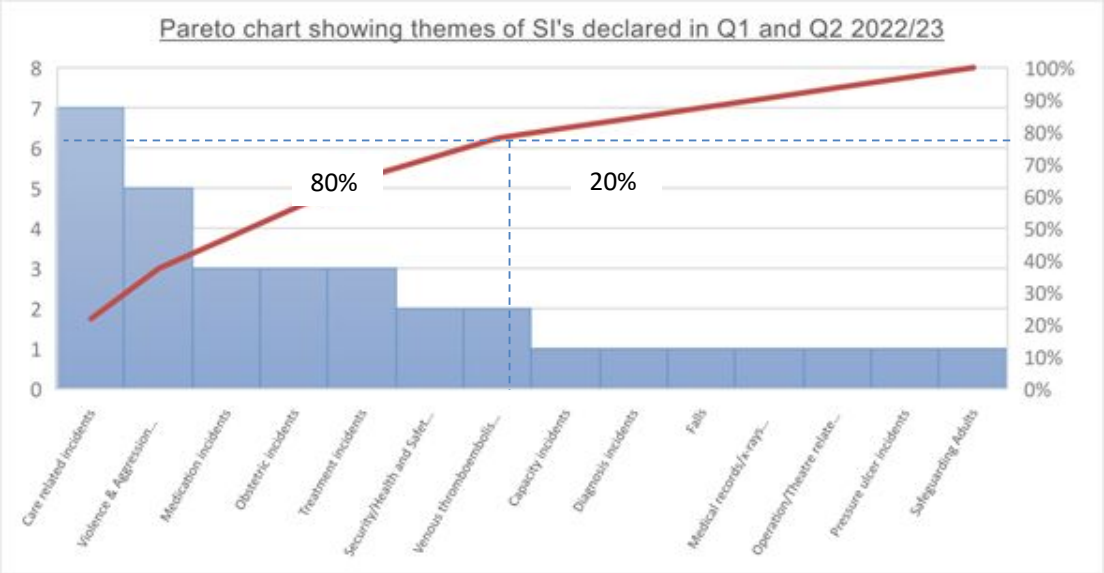
The chart below shows the average number of SI's declared each month and shows common cause variation across the previous 3 quarters.



Previous reports have provided detail of the themes of SI's from 2021/22 reviewing the financial year as a whole. It noted that infection prevention and control issues were the most common theme and this was reflective of the hospital onset hospital acquired COVID-19 cases and also commented on the increase in SI's that were seen relating to falls and provided detail of the focus on ongoing continuous improvement work through the Trust Harm Free Care Collaborative.

During Q2, 13 SI's were declared (this is a very slight increase from Q1 when 12 were declared). Of the 13 cases declared in Q2, 6 relate to Unplanned Care, 5 relate to Planned Care and 2 cover both divisions. Of the new SI's declared in Q2, it is pleasing to note that there are not any relating

to inpatient falls. Three cases relate to incidents involving patients with mental health needs and associated damage to property, staff and self-harm by the patient. These 2 SI's are in addition to the 2 previous SI's already under investigation involving patients with mental health needs. Two of the newly declared SI's related to Hospital Acquired Thrombosis (HAT), 2 relate to nursing care on the wards and 3 relate to delays in treatment (inpatient delays). There is also a newly declared thematic review ongoing looking at patients who may have been lost to follow up within Ophthalmology services. An associated Ophthalmology recovery and improvement group has already been set up alongside this investigation. It is of note that 3 of the SI's declared in Q2 are already drafted and with the Divisional team for review and approval.



The key themes are embedded within patient safety and patient experience improvement priority programs such as:

- The Deteriorating Patient Collaborative,
- Harm Free Care Collaborative
- Patient & Carer Experience (PACE) Improvement programs

3b) Learning from closed SI's

As noted above, in Q2, 21 SI's were completed and submitted to the ICB. This is a marked improvement on both Q4 2021/22 and Q1 2022/23 when 12 reports were submitted each quarter. These reports have also been shared with the patients involved and/or their families. Some examples and further detail on some of these cases and the learning/recommendations is provided below. More detail can be made available if this would be of use and interest to the Committee.

Delay in ECG monitor being attached and delay in recognition of the abnormal rhythm (ED)

The key findings of the investigation were that there was a missed opportunity in identifying SI elevation and delay in commencing PPCI protocol contributed to by ambulance ECG missing abnormalities and patient's presentation considered to be related to anxiety.

The recommendations were to continue to develop education for ED staff regarding ECG interpretation for all medical staff and the ED Practice Development team to review training on ECG interpretation for nursing staff, along with raise awareness of PPCI pathway and how it is initiated at all ED governance forums.

Incorrect transfer of 2 babies resulting in them spending a period of time with the wrong mothers

The investigation found that the relevant identification checks had not been undertaken on returning baby to mother and the documentation was unclear as to timings and recording of the incident. Immediate safety actions were taken including a safety alert issued regarding ID checks, development of laminated signage in cots with baby details, development of a sticker system to be put into medical records when babies are needing to be separated from their mothers with responsibility being given to a named midwife.

Retained haemostatic agent (Breast surgery – Never Event)

The investigation found that there was sub-optimal communication across the medical and theatre teams, staffing factors and sub-optimal completion of the WHO sign out check list. The recommendations and actions included review and consideration of allocating theatres within DSU for consistency for operating breast surgeon and share learning at theatres and breast RHD focusing on communication between teams and education around the use of Kerracel product.

3c) Never Event

There was one never event declared during Q2 of 2022/23. This was the first never event at ENHT in this financial year and related to the wrong lesion being excised from a patient's tongue. The investigation was completed and submitted to the ICB in a prompt manner and within the expected timeframe. The report has also been shared with the family. Of note, the family have requested financial compensation and this is under review with the Legal team. The investigation saw very good collaborative working between the Patient Safety Manager, the clinical team, Divisional Quality team within Planned care. The key findings were that the operating surgeon made a decision to remove the 'wrong' lesion as, in their opinion, this was a more worrying finding. This was not communicated to the theatre team either during or after the surgery, it was not documented on the operation note and the patient was not informed at the time. Recommendations and actions include a review of the theatres LocSSIP policy and to add to the theatres LocSSIP policy that photography can be considered where site marking is not possible, in addition to ensure a robust escalation process between recovery and theatre co-ordinators where concerns are raised.

	2019/20	2020/21	2021/22	2022/23
Wrong site surgery	1	2	4	1
Retained object	1	0	1	0
Oxygen tubing to air	1	1	0	0
Total	3	3	5	1

4. Duty of Candour

Through the SI framework processes we are aware of ongoing variation in application / compliance of duty of candour. This has been highlighted through the current quality assurance framework and at present we do not have assurance there is reliable application of candour in documentation. Through SIRP we have verbal assurance from clinical teams that candour has been applied, however on further case notes review documentation of an apology has been not

been consistently documented.

At last review on the datix system there were 142 outstanding moderate harm incidents that did not have the relevant Duty of Candour fields completed. The Divisional breakdown of this is;

- Medicine – 74
- Surgery – 42
- Womens & Childrens 7
- Clinical Support Services 6
- Operations 4
- Cancer Services 1

It is recognised that evidencing Duty of Candour remains an ongoing issue and this is being actively discussed within Divisional clinical governance meetings. Ongoing review of additional supportive measures are being explored in order to help clinicians, for example an aide memoire either in sticker format in the paper medical records or further training at a corporate rolling half day session. A digital solution has has been discussed at KOPS clinical oversight group with a new field being added into the inpatient notes for patient and family communication which includes Duty of Candour. Further detailed discussion of this is anticipated at the December Patient Safety Forum.

The corporate team continue to review and triangulate the data with the Divisional teams to ensure that datix is an accurate reflection of the position. A more detailed review will be taken to the next Patient Safety Forum. The matter will also be highlighted with the Divisional Quality teams. This risk is reflected on the risk register and being reviewed.

5. Inquests

Regulation 28 letters (Prevention of Future Deaths report)

During Q2 2022/2023, the Trust received no PFD reports.

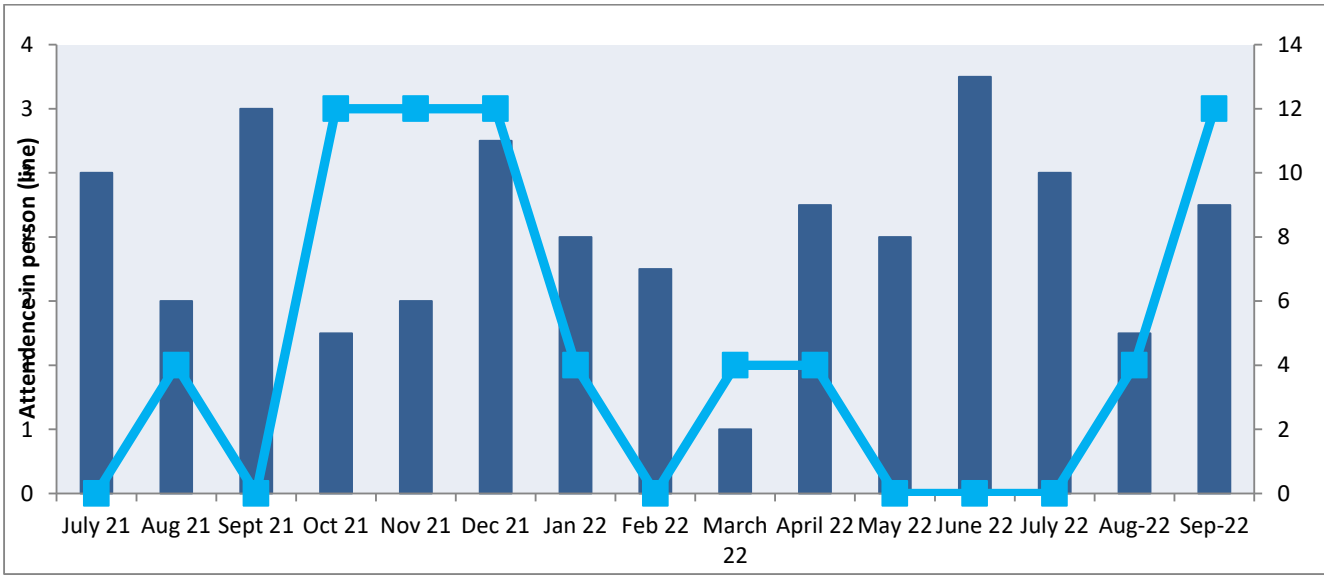
Inquest activity during Q2

From 1 July 2022 - 30 September 2022, the Trust received 24 requests for medical reports which is a slight decrease compared to 28 at the same time last year.

Of those 24 statements requested, 23 were from the Hertfordshire Coroner. 1 statement request came from the Suffolk Coroner's service and was a specific request for a statement to cover the events from a 2016 admission when the deceased presented to hospital following a fall.

It is of note that amongst these requests for reports, 2 relate to Covid-19 deaths (both likely to be community acquired Covid-19). Five of the requests relate to individuals who have died following a surgical procedure (2 general surgery procedures, 2 trauma and orthopaedic procedures and 1 vascular surgery procedure). From the Coroner's perspective, the pertinent question is whether the surgery has accelerated the death hence the Coroner's investigation. Review of the statements submitted thus far demonstrates that this is not the case across the investigations however this will be closely monitored and remain under review.

Of note, we have had 3 requests from the Coroner where the cause of death currently states *'pending further investigation'.* Although the postmortem results are awaiting further investigation, this does not halt the Coroner's Inquiry continuing in the interim.



Inquests Attended

As demonstrated on the above graph, the Trust has attended 4 Inquests in this quarter with evidence being provided in person by a witness.

Of the 4 cases, the Coroner came to the conclusion of accidental death due to fall (CC – INQ21.30). It is noteworthy that accidental death is a common conclusion that has increased in recent years. The conclusion in the other 3 inquests attended revealed a 'Narrative' conclusion (DW – INQ21.35, BK – INQ22.27 and BL – INQ22.02) Namely, the deceased died as a consequence of a necessary surgical procedure. On review of the papers, these conclusions were expected. A 'Narrative' conclusion is commonly seen across hospital related deaths, it is known as a 'long form' conclusion and allows the Coroner short, free text to detail what happened.

INQ22.02

With regards to this Inquest, questions were submitted by the family as part of their witness statements. These questions related to the training and experience of those who performed the surgeries (appendicectomy), the post-operative checks and appropriateness of the discharge processes followed. On review of the medical records and following discussion with the involved clinicians, care was found to be appropriate. The Committee can be encouraged that the concerns were formally responded to ahead of the Inquest and this formal letter was greatly received by both the Coroner and the family.

The Inquest concerning BL was heard on 6 September 2022. Three Consultant General Surgeons were requested to attend as witnesses as well as a Consultant Intensivist.

As above, the outcome was a narrative conclusion. Namely, death was as a consequence of a complication of a necessary surgical procedure (elective laparoscopic appendicectomy).

During the Inquest the Coroner amended the cause of death to be as follows:

1a) Multi-Organ Failure
1b) Abdominal Sepsis

1c) Bowel perforation following surgery on 7/12/21

2) Hypertension, Cardiomyopathy, Heart Failure and Chronic Kidney Disease.

15

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			Agenda Item	18
Report title	Finance Performance and Planning Committee			Meeting Date	2 November 2022
Presenter	Finance Performance and Planning Committee Chair				
Author	Assistant Trust Secretary				
Responsible Director	FPPC Chair			Approval Date	19 October 2022
Purpose (*tick one box only)* [See note 8]	To Note	☒	Approval		☐
	Discussion	☐	Decision		☐

Report Summary:
To present the report from the FPPC meeting on 26 July 2022.
Impact: where significant implication(s) need highlighting *Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal* *Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability* *CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources*
Risk: *Please specify any links to the BAF or Risk Register*
The discussions at the meetings reflect the BAF risks assigned to the FPPC.
Report previously considered by & date(s):
N/A

Recommendation	The Board/Committee is asked to note.

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FINANCE, PERFORMANCE AND PLANNING COMMITTEE MEETING
27 SEPTEMBER 2022

SUMMARY TO THE TRUST BOARD MEETING HELD ON 4 NOVEMBER 2022

The following Non-Executive Directors were present:
Karen McConnell (Chair), Ellen Schroder (Trust Chair) and Jonathan Silver

The following core attendees were present:
Adam Sewell-Jones, Martin Armstrong, Lucy Davies and Theresa Murphy

Stroke SSNAP Update

The Committee received and noted the update and were informed that the SSNAP rating remained at D, there was a lot of work underway and there had been improvement against the national average.

The Committee was informed that the door to needle pathway received a recommendation for improvement which would include Radiology support for patients to be taken straight to CT and inpatient MRI.

The Committee were disappointed with the lack of improvement in the score to date but heard that through October there would be a start on an improved trajectory, the data for SSNAP was three months in arrears and therefore improvement could be expected to be seen by February 2023. The Committee agreed that progress would be reviewed by the Quality and Safety Committee going forward.

It was noted that SSNAP was not the only measurement of Stroke and that mortality was also a good indicator. The Committee was informed that the Stroke mortality position was positive.

Medical Staffing Update

The Committee received and noted the Medical Staffing update and were informed that the current position was an overspend against budget. The risks and issues relating to the budget were discussed and next steps were agreed.

The Committee was informed that budget holders would need to be proactive in the reduction of high-cost agency and locums and consider, where appropriate, replacing high cost locums by recruiting into substantive posts.

Finance Report Month 5

The Committee received and noted the finance report for month five. The Trust reported a £3.9m deficit which was broadly in-line with the financial plan. The use of reserves to support this position was noted.

CIP delivery was £2.5m short of target and detailed discussions were underway with divisional teams to ensure that CIP targets were achieved.

There were potential opportunities within the Elective Recovery Fund (ERF); the second half of the financial year should see an improvement including with the opening of the procedure rooms.

Outturn Forecast

Pressure areas were highlighted as medical staffing, inflation, high-cost drug growth and pressures due to access targets. Non-recurrent reserves had been used and could no longer be relied upon.

Assumptions had been made on the underlying deficit including within the ERF and the forecast based upon capacity investment being within a window that provided an opportunity to over perform to the extent of £5.5m.

Covid costs remained an ongoing pressure along with reduced revenue streams including R&D and car parking.

The Committee was informed it was a challenging forecast and to address the issues 11 financial reset workstreams had been mobilised.

Costing Programme Update

Significant progress had been made and the majority of actions to address issues identified in 2019/20 had been completed. The 2021/22 national cost collection exercise had been submitted in August 2022.

Capital Programme Update

The Committee was informed that the reporting of an underspend was misleading as projects including the ward refurbishment had been delayed which had affected the position. Rather than a predicted underspend there had been significant pressure on the budget arising from equipment purchased in the previous year and the costs of the associated enabling work.

Retail and Car Parking

The Committee was informed that solutions for the non-clinical space at the front of the hospital were being explored as well as improved staff parking. It was noted that the Trust's Green Plan was a golden thread running through all possible solutions.

A needs assessment for car parking would be carried out which would include lease agreements, income streams, travel plans and modelling and the impact of agile working.

Elective Surge Hub

A range of options were being developed for the Lister site within the £22m cost envelope. The Committee heard that the project was a significant risk and discussions with the System to identify a solution continue.

Performance Report Month 5

The Committee received and noted the month five performance report.

The ED August responsive data demonstrated that the reset week had made a positive impact even though ambulance arrivals and mental health patients had increased through the month.

Opel 4 had been declared over a series of days and actions were being implemented to address the clinical model to improve streaming and handling of patients as they arrived in the ED.

Progress was being made in the application of NHSE guidance and removing patients from the PTL where they don't have cancer. The Committee heard that the 62-day wait list reduced from 16% to 13% in September. Work was underway on the 78-week trajectory with the intention of achieving the target by the end of March 2023.

Meetings and actions were in place to address the Tier 1 status. The cancer position had improved and performance had been better than expected.

Board Assurance Framework
The Committee received and noted the latest version of the Board Assurance Framework and the risks that had been assigned to the Committee.

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Karen McConnell
Finance, Performance and People Committee Chair
September 2022

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Trust Board – Part I			Agenda Item	18
Report title	Finance Performance and Planning Committee			Meeting Date	2 November 2022
Presenter	Finance Performance and Planning Committee Chair				
Author	Corporate Governance Officer				
Responsible Director	FPPC Chair			Approval Date	
Purpose (*tick one box only)* [See note 8]	To Note	☒	Approval		☐
	Discussion	☐	Decision		☐

Report Summary:

To apprise the Trust Board of the decisions made and significant items discussed at the Finance Performance and Planning Committee held on 25 October 2022.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

Risk: *Please specify any links to the BAF or Risk Register*

The discussions at the meetings reflect the BAF risks assigned to the FPPC.

Report previously considered by & date(s):

N/A

Recommendation	The Board is asked to note the report.

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FINANCE, PERFORMANCE AND PLANNING COMMITTEE MEETING
25 OCTOBER 2022

SUMMARY TO THE TRUST BOARD MEETING HELD ON 2 NOVEMBER 2022

The following Non-Executive Directors were present:
Karen McConnell (Chair), Ellen Schroder (Trust Chair) and Jonathan Silver (Non-Executive Director).

The following core attendees were present:
Adam Sewell-Jones, Crista Findell, Alison Gibson, Mel Gunstone, Mark Stanton and Michael Chilvers.

Network ll Imaging Update

The Committee received and noted a Network ll Imaging update. The Imaging Network was established following National recommendations and is a collaboration of five acute trusts in the Hertfordshire and West Essex ICS, Mid and South Essex ICS and Bedfordshire Hospitals. Collaborative workstreams have formed across the five Trusts with a clinical lead for each workstream. The Network has been successful in bidding for National capital funding covering both digital and modality upgrades. The workstreams and anticipated outcomes were highlighted together with the key milestone maps for leadership, workforce, equipment and digital.

It is anticipated there will be continued funding opportunities for the Trust through the Network for modality upgrades together with the potential opportunity to release some radiologist resource from some parts of the referral process and from some types of reporting. It will also deliver demand and capacity services to the Network.

NHSE expect the Network to be self-funding by April 2023, however the Network is unlikely to deliver cost savings within the next two years.

CDC Update

The Committee received and discussed the CDC update and were informed that Phase 1 of the CDC programme has delivered 6,050 additional examinations since April 2022 across several core diagnostic modalities. This has been achieved through extended opening hours at the QE11 site, supported through significant recruitment and retention exercises. As the Phase 1 modalities transition into business as usual from quarter four, Phase 2 pathways for new respiratory lung function clinics and cardiology direct access will mobilise once a Memorandum of Understanding has been received from NHSE.

Although there has been an improvement in carrying out tests on patients quickly, there continues to be a delay in sending out radiology reports. Ongoing training is taking place which together with an increase in capacity and rotation of staff should enable reports to be produced more quickly.

A new bid to NHSE in 2023/24 for ophthalmology and cytosponge is being reviewed.

Predictive Analytics

The Committee received and noted a report providing an update on the progress made with developing robust predictive analytics for both demand in the Emergency Department and Urgent Care Centre and for predicting readmissions. It set out the key focus of the work and the actions moving forward.

The model has assisted in operational planning and processes in emergency flow and has been used for 14 day predicted admission and discharge profiles which can be used to match this to the staffing profile required for predicted emergency demand. A clear focus on operationalising predictions and expanding their use so they become a key planning tool was welcomed.

Discharge Improvement

The Committee received and noted the update on the Trust's discharge improvement programme. This is a long term programme with several workstreams and improvements identified, including digitalisation of systems to ensure the correct data is captured. It focuses on key areas of clinical variation requiring behavioural change and increased compliance with policy and process based on recognised national standard. Good progress has been made across all workstreams and major risks and mitigations were noted.

Criteria led discharges will be piloted in some medical and surgical specialties and was an area identified as providing significant opportunities, particularly at weekends where historically, there have been less discharges.

Performance Report Month 6

The Committee received and noted the performance report; the main focus being on urgent and emergency care along with ambulance offloads. Ambulance handover times remain below the required standard and steps being taken to improve performance were discussed. Steps being taken to improve flow though the hospital were noted.

There has been a proposal to provide a temporary building outside the Emergency Department. The plan would be to use this for minors and GP support to reduce overcrowding in the department.

The FPPC were informed that paediatrics and the children's assessment unit have now moved into their new area.

Tier 1 for Cancer and RTT

The Committee were informed that although the Trust remains in Tier 1, the status is under review by NHSE to ensure the sustainability of progress being made. Current performance against the planned trajectories were noted and key risks particularly the lack of capacity in Community paediatrics were discussed.

Regarding cancer waiting times, a standard operating procedure is being developed on how to manage patients who 'could not attend' and 'did not attend'.

There has been an increase in breast and skin referrals which has been in line with national campaigns.

Hospital at Home

The Committee received and noted the current status relating to Hospital at Home. Work is being carried out to increase the utilisation of this service which is currently underutilised. One of the key benefits of hospital at home will be admission avoidance.

There has been considerable engagement work with Clinical Directors and specialities to explore further opportunities for early supportive discharge pathways. This is largely concentrated on a post operative model for Trauma and Orthopaedics.

Finance Report Month 6

The Committee received and noted a report summarising the Trust's financial performance. Year to date, there is a £3.2m deficit. Drivers for the deficit have been medical staffing overspends, CIP slippage and high cost drugs. The productivity challenge was also noted.

Outturn Forecast Refresh and Financial Reset Update

The Committee received and noted the revised outturn forecast for the Trust. The Committee were informed of the anticipated scale of the year end deficit, the key drivers behind the forecast position and how the forecast has changed since the last report. The report included a range of estimated outturn outcomes and the potential impact for the Trust. Significant reserves have been released along with technical adjustments, however these are non-recurrent. Bids have been put in for additional depreciation funding for revenue, however there is uncertainty whether this will be received. Inflation remains challenging. Elective delivery is of concern particularly whether this will be impacted by winter pressures.

The committee noted that shortcomings in financial achievements in 2022/23 will have an ongoing impact in 2023/24. These will add to the already challenging requirements in 2023/24 including the reduction in Covid funding, the Trusts share of the system convergence savings target and general national efficiency targets.
Financial reset meetings have been taking place with workstreams set up with clear briefs to mitigate the risks to the financial position in 2022/23 and to look at ways to help mitigate the financial challenges for 2023/24.The workstreams are being supplemented with support to budget holders including through training which will also be incorporated into the onboarding process.

Long Term Financial Model Refresh

The Committee received and noted the long term financial model refresh. The last major refresh was in 2019 to support the STP median term financial model with a small further update after the strategic refresh in 2020. ICS Directors of Finance have agreed the need for a system wide financial planning tool. This was welcomed by the Committee which also expressed a clear preference for the model to include workforce.

Board Assurance Framework

The Committee received and noted the latest version of the Board Assurance Framework and the risks that had been assigned to the Committee. The Committee challenged the reduction from 16 to 12 of the improving performance and flow through collaboration core. The Committee recognised that changes are planned, however there was a lack of evidence of improvement in performance and flow and with that in mind, it was agreed the score should remain at 16 until those controls are embedded.

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Karen McConnell
Finance, Performance and People Committee Chair
October 2022

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	19
Report title	Quality and Safety Committee Report to Trust Board			**Meeting Date**	2 November 2022
Presenter	Chair of Quality and Safety Committee				
Author	Assistant Trust Secretary				
Responsible Director	Chair of Quality and Safety Committee			**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**		☐
	Discussion	☐	**Decision**		☐

Report Summary:

To apprise the Trust Board of the decisions made and significant items discussed at the Quality and Safety Committee held on 28 September 2022.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

Risk: *Please specify any links to the BAF or Risk Register*

Report previously considered by & date(s):

Recommendation	The Board is asked to Note the report.

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QUALITY AND SAFETY COMMITTEE MEETING – 28 SEPTEMBER 2022

SUMMARY TO THE TRUST BOARD MEETING HELD WEDNESDAY 2 NOVEMBER 2022

The following Non-Executive Directors were present:

Peter Carter, Ellen Schroder, Val Moore, David Buckle

The following core attendees were present:

Michael Chilvers, Theresa Murphy

VTE Deep Dive

The Committee received and noted the VTE deep-dive and they were informed that VTE was part of the harm free care work that was underway including a process to move the assessments to NerveCentre was underway; inclusion of VTE in the Junior Doctor mandatory training sessions.

The Committee was informed there had been a reduction in the number of hospital-acquired cases of Thrombosis.

Board Assurance Framework

The Committee received and noted the latest edition of the Board Assurance Framework (BAF).

New and Emerging Risks

The Committee received and noted the New and Emerging Risk report and was informed that the Risk Management Group had met for the first time and the group would be gatekeeper of the high scoring risks and would report into the Audit and Risk Committee.

The Committee heard that the updated Corporate Risk Register and BAF would be complete by mid-January 2023 following support from the Good Governance institute.

Fire Response to Hertfordshire Fire & Rescue Service Recommendations

The Committee received and noted the fire response recommendations report and were informed that the Tower Block had been identified during the inspection as the compartmentation didn't fully support the evacuation procedure; an alternative evacuation plan had been recommended for provide safety for patients and staff.

The Committee heard that due to the co-operation of the Trust the Fire Service had suspended the Notice and would continue to undertake compartmentation surveys.

Quality and Safety Report Month 4

The committee received and noted the month four Quality and Safety report.

Key points discussed included:

- The HSMR and SHMI were reassuring. Discharge summaries remained an area of concern, but work was underway to complete them.
- There had been a cluster of MRSA infections in the Neonatal unit and the infection was a greater risk to babies. An external peer review had been commissioned and actions in place were to protect individual baby bedspace.

- Staffing challenges had been due to Covid symptoms and the management of skill mix in clinical areas.

Clinical Harm Reviews Update

The Committee received and noted the Clinical Harm Reviews update. They were informed that the online Lorenzo form for live reviews was active and Doctors would be prompted to complete the review.

Learning from Deaths Report

The Committee received and noted the Learning from Deaths report. The Committee was informed that although there had been a slight upward trend, HSMR and SHMI remained stable.

The Committee heard that the data analysis undertaken of the impact of the removal of MVCC would have a significant impact on the SHMI due to the coding of Chemotherapy patients. It was noted that there had been no changes to the care of patients.

Responsible Officer – Revalidation Annual Report

The Committee received and noted the Revaluation annual report. The Committee heard that consistent administrative support had positively impacted the process with a 93% completion rate.

Maternity Assurance Report

The Committee received and noted the Maternity assurance report and the supporting documentation.

The Committee was informed that:

- Maternity triage was an area of risk.
- 10-steps to safety submission was likely to be delayed due to the delayed results of maternity post-mortem results.
- Additional oxygen surveillance of pregnant women had been implemented in the community.
- The Ockenden final report would be discussed at the Hertfordshire Health Scrutiny meeting. The LMS for the Trust had the greatest number of amber actions but assurance could be provided.
- The Trust was compliant with 24/7 anaesthetic cover but there were gaps in the mid-level staffing plan and within neonatal.
- Training was flagging red but a lot of work had been done and the next report would highlight numbers in the mid-80's for completion.

Maternity Digital Strategy

The Committee received and approved the Maternity Digital Strategy. They heard it was aligned to both Trust and LMS strategies.

The Committee noted the following reports:

- Patient Safety Forum Escalation Repot
- Clinical Audit and Effectiveness Quarterly Report

Dr Peter Carter
Quality and Safety Committee Chair
September 2022

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board..			**Agenda Item**	19
Report title	Quality and Safety Committee Report to Trust Board			**Meeting Date**	2 November 2022
Presenter	Chair of Quality and Safety Committee				
Author	Assistant Trust Secretary				
Responsible Director	Chair of Quality and Safety Committee			**Approval Date**	28/10/2022
Purpose (*tick one box only)* [See note 8]	**To Note**	☒	**Approval**		☐
	Discussion	☐	**Decision**		☐

Report Summary:

To apprise the Trust Board of the decisions made and significant items discussed at the Quality and Safety Committee held on 26 October 2022.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

Risk: *Please specify any links to the BAF or Risk Register*

Report previously considered by & date(s):

Recommendation	The Board is asked to Note the report.

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QUALITY AND SAFETY COMMITTEE MEETING – 26 OCTOBER 2022
SUMMARY TO THE TRUST BOARD MEETING HELD WEDNESDAY 2 NOVEMBER 2022

The following Non-Executive Directors were present:

David Buckle, Ellen Schroder, Val Moore

The following core attendees were present:

Michael Chilvers, Theresa Murphy

Violence and Aggression Deep Dive

The Committee received and noted the Violence and Aggression deep-dive. It was noted the actual recorded numbers of incidents remained static but there was a view that the episodes had become more severe. The number of instances relating to mental health patients was also static over the last year. The Executive explained how they were taking this matter forward and quality and safety would continuously monitor,

Risk Management Update

The Committee received and noted the Risk Management Update. It was highlighted to the Committee that some of the risks in the paper were emerging risks and as such had not been through the risk governance process and would likely change. The Committee was informed that staff were being supported through the governance process for earlier approval of risks.

Board Assurance Framework

The Committee received and noted the latest edition of the Board Assurance Framework (BAF).

Quarterly Compliance Report

The Committee received and noted the Quarterly Compliance report and were informed that the key areas of focus were Maternity Services and the Emergency Department (ED). The Committee was informed that the CQC Inpatient survey had scored a similar score to the previous year and the action plan for improvement would be monitored through the Patient and Carer Experience Group.

Incidents and Inquests Quarterly Report

The Committee received and noted the Incidents and Inquests Quarterly Report. The Committee was informed that 97% of incidents caused no harm. In the reporting period one never event had occurred, and the learning had been embedded. The Committee was informed that of the 2 inquests, neither had areas for concern.

Paediatrics Incidents and Learning

The Committee received and noted the Paediatrics Incidents and Learning report. The Committee was informed that successful round-table discussions had taken place with Paediatricians and Anaesthetic teams which had been challenging and positive. There had been a thematic review looking at multiple areas including deteriorating patients, Sepsis awareness and adherence to policy and staff training. It was noted that the recording of Paediatric Sepsis screening was not reliable but no harm had occurred and a process was in place to improve performance.

Complaints, PALS and Patient Experience Report

The Committee received and noted the Complaints, PALS and Patient Experience report. The Committee was informed that the number of complaints relating to care and treatment in the ED continued to be high. The Committee heard that the Inpatient and Cancer national survey scores were lower than in previous year. A transformation project was underway within Complaints and PALS and progress would continue to be reported.

Quality and Safety Report Month 5

The committee received and noted the month five Quality and Safety report.

Key points discussed included:

- There was a month on month increase in VTE compliance and non-hospital-acquired pressure ulcers were being monitored at a weekly safeguarding meeting.
- Mortality remained stable. The 30-day mortality from the National Hip Fracture Database had highlighted the Trust at 12.3% against the national average in December 2020 however the update in June 2022 sees the Trust at 7.3% against the national average of 5.7% which highlighted a significant improvement.
- It was noted there had been challenges capturing feedback of Friends and Family tests and work was underway to ensure appropriate mechanisms for everyone to record information were in place.

Clinical Harm Reviews Update

The Committee received and noted the Clinical Harm Reviews update. They were informed that there had been no change since the last report. The Medical Director had been asked to return to the Committee the following month with an alternative plan to reduce the backlog.

CQC Maternity Inspection Update

The Committee received a verbal update following the CQC inspection of Maternity Services. The Committee was informed that the informal feedback had highlighted three positive areas including culture, teamwork, and leadership, they also highlighted areas of concern including documenting risk assessments.

Maternity Assurance Report

The Committee received and noted the Maternity assurance report and the supporting documentation.

The Committee was informed that:

- Maternity staffing was moving in the right direction and the recruitment of a number of newly qualified midwives who would all go through a full induction and preceptorship programme.
- The ability to deliver mandatory training remained a risk within the service however the team were confident the trajectory for compliance would be achieved.
- Weekly meetings had been set up which included the inclusion of external colleagues for the maternity transformation board.

The Committee noted the following reports:

- Clinical Audit and Effectiveness Quarterly Report
- Patient Safety Forum Escalation Repot
- Patient and Carer Experience Group Escalation Report

Dr David Buckle
Quality and Safety Committee Deputy Chair
October 2022

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Trust Board – Part I			**Agenda Item**	
Report title	Charity Trustee Committee Report to Board			**Meeting Date**	2 November 2022
Presenter	Chair of Charity Trustee Committee				
Author	Corporate Governance Officer				
Responsible Director	Chief People Officer			**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**		☐
	Discussion	☐	**Decision**		☐

Report Summary:

To appraise the Trust Board of the funding approvals made and the significant items discussed at the Charity Trustee Committee held on 12 September 2022..

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

N/A

Risk: *Please specify any links to the BAF or Risk Register*

N/A

Report previously considered by & date(s):

None

Recommendation	The Board is asked to Note the report.

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CHARITY TRUSTEE COMMITTEE MEETING HELD ON 12 SEPTEMBER 2022

SUMMARY REPORT TO BOARD

The following members were present: Dr David Buckle (CTC Chair), Mrs Ellen Schroder (Trust Chair), Ms Val Moore (Non-Executive Director), Thomas Pounds (Chief People Officer), Eloise Huddleston (Charity Director), Odunayo Basorun (Financial Controller), Mel Gunstone (Deputy Chief Nurse) Kelly Campbell (Deputy Financial Controller).

Key decisions made under delegated authority:

The Charity Trustee Committee (CTC) made the following decisions on behalf of the Trust under the authority delegated to it within its Terms of Reference:

Approval for expenditure over £5,000

The Committee discussed the following applications for expenditure over £5,000:

Proposal	Cost	Outcome
Safe Space: Refurbish four parent rooms in neonatal area, plus a consultation room.	£44,000	Consider a specific appeal being set up for funds to be raised externally.
Lister at 50 open day: Marquee purchased and will be used at future events. Funds required for celebrations.	£7,500	Celebrations put on hold due to occurring in the period of national mourning.
Patient announcement system in ED and Urgent Treatment Centre: Allows specific messages to be put onto television screens.	£8,480	Requires further consideration.
Audio and visual equipment for teaching rooms: The Charity to pay for the purchase of equipment. The Trust to be responsible for ongoing maintenance costs.	£25,300	Approved to be piloted in one area first.
AI auto contouring in radiotherapy treatment planning: To reduce time taken to process contouring of tumours from between 30 minutes to four hours down to 15 minutes. This would allow people to be redeployed to other areas and for more patients to be seen each year. Four manufacturers reviewed and the most appropriate one chosen.	£60,000	Approved.
Launch 12 month Green Scholar initiative: This would be a project to fund raise for. Approval required for 10 Green Scholars and 1 band 5 project support, delivering 10 individual projects for site sustainability and green practices at MVCC. The purpose would be to prevent inappropriate use of drug care to improve patient drug care.	£170,000	To be discussed further.
Support the updating and refurbishment of MVCC Post Graduate Centre: £40k requested from MVCC general funds and another charity would generate £100k to deliver the £140k required.	£40,000	Approval to support short to medium term work on the MVCC Post Graduate Centre at a more affordable option.
Repurposing an area in Outpatient waiting area for use for volunteer staff: Provide desks in reception areas.	£11,000	Approved.
Staff Survey Incentives: To provide money to incentivize staff to complete the staff survey to improve completion rates. A prize draw for a team to spend, equating to approximately £6-£10 per person.	£10,000	Approved, subject to being below £10,000.

Painting and Decorating: To improve reception areas at Lister Renal reception waiting area and St Albans dialysis unit.	£9,600	Approved.

Other Outcomes:

Major Projects Update – Sunshine Appeal

The Committee received and noted an update on the Sunshine Appeal. There has been a successful match funding campaign providing £300,000 which means the build can now progress. There had been a request for a change to the scope of the design to make it a more technical and medical space, which will have an impact on the price.

An additional 0.2WTE project management resource has been requested due to the complexities of the build.

The above requests will be considered further by the Committee.

Investment Portfolio Report

The Committee received and noted the report on the Charity's investment portfolio, presented by two representatives of Rathbones. The Committee were informed the main issues currently for investors has been inflation as a result of Covid and the energy crisis, along with anxiety about whether there will be a world recession.

The Committee was informed the Charity funds were holding 6% of cash and that Rathbones would release money when there were opportunities to do so.

External Audit Planning and timetable

The Charity Trustee Committee received and noted the external auditors report. The reports will be completed on 11 October 2022 ahead of the Trust Board meeting on 2 November 2022. The plan is to submit these to the Audit Commission before the end of December 2022.

Charity Finance Report Month 4

The Committee received and noted the month 4 report. It was noted that the Charity was on plan for income and that legacy was slightly above plan and fund raised income was slightly under plan. Expenditure has slightly underspent on capital items due to phasing, however the money will be spent by year end. The cost of raising funds to income ratio is in line with the plan. The net fund balance was £1.7m after deducted commitments. £145k of pledged income is expected in this financial year.

Charity Highlight Report

The Charity Highlight Report was noted by the Committee.

Annual Report and Accounts

The Committee received and noted the Annual Report and Accounts.

Dr David Buckle
Chair of the Charity Trustee Committee
September 2022

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	21
Report title	People Committee 20 September 2022 highlights report			**Meeting Date**	02.10.2022
Chair	Ellen Schroder				
Author	Stuart Dalton, Director of Corporate Governance				
Quorate	**Yes**	☒	**No**		☐

Agenda:

- Staff Survey – Unplanned Care
- Voice of our people – Disability Network staff story
- Values Next Steps
- Employee Relations Policy Update
- E-Roster / Workforce Deployment
- Workforce Disability Equality Standards – Data Submission
- Model Employer / Inclusive recruitment
- Freedom to Speak Up
- Board Assurance Framework

Alert:

- E-roster workforce deployment: whilst progress is being made, performance is 84% against the 90% target. The ambition was to achieve the 90% target no later than quarter 1 2023/24. Members requested an audit of the e-roster system, to provide independent assurance
- Workforce Disability Equality Standards (WDES): some staff were not willing to declare disabilities on ESR for reasons such as fear of discrimination. Whilst the WDES data submission was approved, the committee concluded the identified actions would not be enough by themselves to address the underlying issues and more committee time needed to be devoted to disability
- Model Employer / Inclusive recruitment: senior level diversity was not meeting the Model Employer targets and senior level diversity was not changing at the same pace as the overall workforce

Advise:

- Unplanned Care Staff Survey: a range of actions were happening to address the development themes identified: vacancy and sickness rates; staff seeking flexible working; staff working excessive hours and a desire for environment improvements
- The Committee supported combining BAF risks 5 (culture and leadership) and 6 (engagement and listening) into one risk given the overlaps between the two risks and the desire to minimise duplication

Assurance:

- The Values roll out was progressing well and was on track
- All employee relations policies would be refreshed by March 2023
- Statutory/mandatory training: there is a workplan to reduce reading time spent to complete the training and increase compliance

• Freedom to Speak Up (FTSU): the appointment of a full-time Freedom to Speak Up Guardian would enable regular assurance reports going forwards and the intention was to produce a FTSU strategy
Important items to come back to committee (items committee keeping an eye on):
• Gender pay gap; International recruitment induction; and Equality Delivery Standards to be on the agenda for the next People Committee meeting • Disability: For the annual cycle to be amended to provide more regular disability consideration • FTSU: To provide an update to the committee about what was being done about medical staffing engagement with FTSU and to develop reporting that compares FTSU themes with other Trusts
Items referred to the Board or a committee for a decision/action:
N/A

Recommendation	The Board is asked to **NOTE** the People Committee report

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Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	22
Report title	Audit and Risk Committee Board Report			**Meeting Date**	2 November 2022
Presenter	Chair of Audit and Risk Committee				
Author	Assistant Trust Secretary				
Responsible Director	Chair of Audit and Risk Committee			**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**		☐
	Discussion	☐	**Decision**		☐

Report Summary:

To present the report from the Audit and Risk Committee meeting held on 111 October 2022 to the Board.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

N/A

Risk: *Please specify any links to the BAF or Risk Register*

N/A

Report previously considered by & date(s):

N/A

Recommendation	The Board is asked to note the report.

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AUDIT AND RISK COMMITTEE MEETING – 11 OCTOBER 2022

SUMMARY TO THE TRUST BOARD MEETING HELD ON 2 NOVEMBER 2022

The following Non-Executive Directors were present:
Jonathan Silver (Chair), Karen McConnell, David Buckle

The following core attendees were present:
Martin Armstrong, Theresa Murphy, Kevin Howell

Internal Audit Reports:

Summary Internal Controls Assurance Report
The Audit and Risk Committee received and noted the Summary Internal Controls Assurance report.
The Committee was informed that the report for the Data Security and Protection Toolkit had been received and had achieved substantial assurance.

The Committee was informed that two audits had been finalised since the last Audit Committee meeting. Same Day Emergency Care and Infection Prevention and Control both received a reasonable assurance.

2022/23 Audit Strategy
The Audit and Risk Committee received and noted the 2022/23 Audit Strategy. The Committee was informed that the plan contained the old version of the BAF and once updated it would impact on the strategy.

Internal Audit Action Tracker
The Audit and Risk Committee received and noted the Internal Audit Action Tracker. The Committee was informed that the overdue actions list had reduced to 8. Overdue actions were being closely managed by the Deputy Director of Finance and the Internal Auditors.

Anti-Crime Update Report
The Audit and Risk Committee received and noted the Anti-Crime Update Report. The Committee was informed that the fraud risk assessment (FRA) had been completed. It was confirmed to the Committee that the FRA would feed into the anti-crime work plan for 2022/23.

External Audit Reports:

External Audit Progress Report
The Audit and Risk Committee received a verbal update for the external Auditors progress report.

The Committee was informed that the 2021/22 financial year had been closed and the certificate received.

The Committee was informed that the 2022 financial year end was the end of the formal contract with the external auditors, and they would put together a new fee proposal. The Committee heard that there were a lot of changes int eh external audit market including the introduction of international standard 315 which would enhance the requirement to understand the control environment which would add an additional element of work.

Other Reports:

Risk Next Steps and Corporate Risk Register
The Audit and Risk Committee received and noted the risk next steps and corporate risk register review report. The Committee was informed that the Risk Management Group (RMG) had met for the first time and the group would act as gatekeeper for risks being escalated to the corporate risk register. The Committee heard that the large number of risks on the corporate risk register hadn't highlighted the organisational priorities. To address this the ambition was for the RMG to present only approved risks and to support this, training would be delivered for staff.

The Committee was informed there was a culture of high scoring risks related to Capital bids to support funding applications and the RMG would provide assurance to the Audit and Risk Committee that Divisions were managing their risks.

Board Assurance Framework
The Audit and Risk Committee received and noted the BAF and were informed positive changes were being made.

External Audit Policy
The Audit and Risk Committee received and approved the External Audit policy.

Charity Annual Report and Accounts
The Audit and Risk Committee received and noted the Charity Annual Report and Accounts. The Committee was informed that the Charity accounts were in a positive position. The audit was almost complete, and the deadline was the end of January 2023, the final accounts would be seen by the Charity Trustee Committee in November.

HFMA Sustainability Audit
The Audit and Risk Committee received and noted the report. The Committee was informed that the evidence deadline had been 30th September 2022 and a final report would be due on 30th November 2022 with all actions completed by 30th January 2023. An extraordinary meeting of the Audit and Risk Committee would be scheduled in December 2022 to review the report.

Significant Losses and Special Payments
The Audit and Risk Committee received and noted the report. The Committee discussed the Pharmacy write-offs and agreed a detailed review would be seen at the next meeting.

Review of Register of Hospitality and Interests
The Audit and Risk Committee received and noted the report and approved the changes to the policy.

Premises Assurance Model
The Audit and Risk Committee received and noted the PAM update. The Committee was informed that the majority of the assessment ratings were either required moderate or minimal improvement and good.

The Committee heard that a comprehensive action plan would be produced and would act as the improvement plan. It would be monitored by the Estates and Facilities Board, Trust Health and Safety, fire and Security Group and would report up to the Audit and Risk Committee.

Cyber Security Report
The Audit and Risk Committee received and noted Cyber Security report. The Committee was informed that the highest risk areas for Digital across the Trust were increased instances of Phishing which were becoming more sophisticated desktop and server patching and the aged telephony. The Committee heard that with the management of Phishing and multi-factor authentication the expectation was for the Phishing risk to be a low status by December 2022. With the monthly patching schedule that risk was also expected to be low by December 2022. The telephony system would remain a high risk until funding had been identified to replace the system.

Data Quality and Clinical Coding Report
The Audit and Risk Committee received and noted the Data Quality and Clinical Coding Report. The Committee was informed that the CIPTS Theatre System was used extensively across the data quality and clinical coding teams as it contained a lot of patient information used by Consultants, a new system would be implement3d in the coming months.

The Audit and Risk Committee were informed that the clinician and clinical coder engagement programme was progressing and was improving the quality of documentation and the important of clinical data. The Committee heard that a review of the accuracy of outpatient coding was underway, through August and September the records had been refined to approximately 500 had been amended.

The Committee were informed that one of the Clinical Coding team had passed the NCCQ qualification and there were six more in training for the exam in March 2023.

Jonathan Silver
Audit and Risk Committee Chair
October 2022

Board Annual Cycle 2022-23

Notes regarding the annual cycle:

The Board Annual Cycle will continue to be reviewed in-year in line with best practice and any changes to national scheduling.

Items	April 2022	4 May 2022	June 2022	6 Jul 2022	Aug 2022	7 Sept 2022	Oct 2022	2 Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Standing Items												
Chief Executive's Report		X		X		X		X		X		X
Integrated Performance Report		X		X		X		X		X		X
Board Assurance Framework		X		X		X		X		X		X
Data Pack		X		X		X		X		X		X
Patient Testimony (Part 1 where possible)		X		X		X		X		X		X
Employee relations (Part 2)		X		X		X		X		X		X
Elective Recovery		X		X		X		X		X		X
Board Committee Summary Reports												
Audit Committee Report		X		X		X		X				X
Charity Trustee Committee Report		X		X				X		X		
Finance, Performance and Planning Committee Report		X		X		X		X		X		X
Quality and Safety Committee Report		X		X		X		X		X		X
Strategy Committee final meeting July 2022 before moving to Board Development		X		X								
EIC moving to People Committee		X		X		X		X		X		X
Strategy												
Planning guidance										X		
Trust Strategy refresh and annual objectives										X		
Strategic transformation update				X				X				X
Integrated Business Plan						X						

Board Annual Cycle 2022-23

Items	April 2022	4 May 2022	June 2022	6 Jul 2022	Aug 2022	7 Sept 2022	Oct 2022	2 Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Annual budget/financial plan		*(X) from 2023*										
Long-term strategic infrastructure						X						X
System Working & Provider Collaboration (ICS and HCP) Updates		X		X		X		X		X		X
Mount Vernon Cancer Centre Transfer Update				X		X		X		X		X
Other Items												
Audit Committee												
Annual Report and Accounts, Annual Governance Statement and External Auditor's Report – Approval Process		X										
Value for Money Report						X						
Audit Committee TOR and Annual Report								X				
Review of Trust Standing Orders and Standing Financial Instructions								X				
Charity Trustee Committee												
Charity Annual Accounts and Report								X				
Charity Trust TOR and Annual Committee Review												X
Finance, Performance and Planning Committee												
Finance Update (IPR)		X		X		X		X		X		X
FPPC TOR and Annual Report								X				
Quality and Safety Committee												
Complaints, PALS and Patient Experience Report		X				X				X		
Safeguarding and L.D. Annual Report (Adult and Children)				X								

Board Annual Cycle 2022-23

Items	April 2022	4 May 2022	June 2022	6 Jul 2022	Aug 2022	7 Sept 2022	Oct 2022	2 Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Staff Survey Results		X										X
Learning from Deaths		X		X				X		X		
Nursing Establishment Review				X						X		
Responsible Officer Annual Review								X				
Patient Safety and Incident Report (Part 2)		X		X				X				X
University Status Annual Report						X						
QSC TOR and Annual Review								X				
Strategy Committee – move to Board Development in September												
Digital Strategy Update				X								
People Committee & Culture												
People & workforce strategy annual progress report										X		
Trust Values refresh				X								
Freedom to Speak Up Annual Report								X				
Staff Survey Results		X										
Equality and Diversity Annual Report and WRES						X						
Gender Pay Gap Report		X										
People Committee TOR and Annual Report								X				
Shareholder / Formal Contracts												
ENH Pharma (Part 2) shareholder report to Board				X								