East and North Hertfordshire NHS Trust
Trust Board - Public Session

Lister Education Centre, Lister Hospital, Stevenage, SG1 4AB

1 May 2019 11:00 - 1 May 2019 12:30

AGENDA

#	Description	Owner	Time
1	Chair's Opening Remarks	Chair	11.00
2	Apologies for Absence: Jonathan Silver, Bob Niven, Michael Chilvers		
3	Declaration of Interests		
4	Questions from the Public Members of the public are reminded that Trust Board meetings are meetings held in public, not public meetings. However, the Board provides members of the public at the start of each meeting the opportunity to ask questions and/or make statements that relate to the work of the Trust. Members of the public are urged to give notice of their questions at least 48 hours before the beginning of the meeting in order that a full answer can be provided; if notice is not given, an answer will be provided whenever possible but the relevant information may not be available at the meeting. If such information is not so available, the Trust will provide a written answer to the question as soon as is practicable after the meeting. The Secretary can be contacted by email (joseph.maggs@nhs.net), by telephone (01438 285454) or by post to: Trust Secretary, Lister Hospital, Coreys Mill Lane, Stevenage, Herts, SG1 4AB. Each person will be allowed to address the meeting for no more than three minutes and will be allowed to ask only one question or make one statement. However, at the discretion of the Chair of the meeting, and if time permits, a second or subsequent question may be allowed. Generally, questions and/or statements from members of the public will not be allowed during the course of the meeting. Exceptionally, however, where an issue is of particular interest to the community, the Chairman may allow members of the public to ask questions or make comments immediately before the Board begins its deliberations on that issue, provided the Chairman's consent thereto is obtained before the meeting.		
5	Minutes of Previous Meeting For approval 5. Minutes of Trust Board meeting held on 6 March... 7	Chair	
6	Patient Testimony For discussion	Director of Nursing	
7	Chief Executive's Report For discussion 7. Chief Executive's Board Report May 2019.pdf 17	Chief Executive	
8	FORMULATING STRATEGY		

#	Description		Owner	Time
8.1	Nursing and Midwifery Strategy For approval 8.1 Trust Nursing, Midwifery and AHP Strategy.pdf	19	Director of Nursing	
8.2	Quality Strategy For information 8.2 Quality Strategy.pdf	31	Director of Nursing	
9	SHAPING CULTURE			
9.1	Talent Management Report For discussion 9.1 Talent Management and Development Report.p... 9.1 APPENDIX 1 Leadership Academy programme... 9.1 APPENDIX 2 ADDS Cohort 4 Flyer.pdf 9.1 APPENDIX 3 Exec Success Profile.pdf 9.1 APPENDIX 4 LMCD Pathway Leaflet 2019.pdf 9.1 APPENDIX 5 CUHP Senior Leadership Opportu...	57 63 65 67 69 73	Interim Chief People Officer	
10	ENSURING ACCOUNTABILITY			
10.1	Integrated Performance Report For discussion 10.1 Integrated Performance Report - Month 12.pdf	75	All Executive Directors	
10.2	Finance and Performance Committee Report to Board For discussion 10.2 (A) FPC Report to Board - 27.03.19.pdf 10.2 (B) FPC Report to Board - 26.04.19.pdf	123 127	Chair of FPC	
10.2.1	Revised FPC Terms of Reference For approval 10.2.1 Proposed Temporary Amendment to FPC Te...	133	Interim Chief People Officer	

#	Description	Owner	Time
10.3	Quality and Safety Committee Report to Board (April report to follow) For discussion 10.3 (A) QSC Report to Board - 26.03.19.pdf 139	Chair of QSC	
10.4	Audit Committee Report to Board For discussion 10.4 Audit Committee Report to Board - 01.04.19.p... 143	Chair of Audit Committee	
11	Board Assurance Framework and Risk Management Strategy For approval 11. (A) Board Assurance Framework Update.pdf 147 11. (A) Appendix 1 - BAF April 19 review.pdf 149 11. (A) Appendix 2 - Review of strategic risks.pdf 177 11. (B) Risk Management Strategy, Procedure and... 181 11. (B) Annex A - Risk appetite statements.pdf 221	Associate Director of Corporate Governance	
12	Annual Cycle For information 12. Board Annual Cycle 2019-20.pdf 251	Associate Director of Corporate Governance	
13	Matters Arising and Actions Log For information 13. Actions Log - Board Part 1.pdf 255	Chair	
14	Data Pack For information 14. Data Pack.pdf 257	All Directors	
15	Date of next meeting: 3 July, Lister Education Centre, Lister Hospital (11:00 am)		
16	BOARD TO RECONVENE AS CORPORATE TRUSTEES		

#	Description	Owner	Time
16.1	CTC Report to Board For discussion [P] 16.1 CTC Report to Board March 2019.pdf 283 [P] 16.1 Appendix 1 - Investment Policy.pdf 287 [P] 16.1 Appendix 2 - Budget Forecast 2019-20.pdf 295 [P] 16.1 Appendix 3 - Management of Charitable Funds... 299	Chair of CTC	

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday 6 March 2019 at 11.00am at Mount Vernon Cancer Centre

Present:	Mrs Ellen Schroder	Non-Executive Director (Chair)
	Dr David Buckle	Associate Non-Executive Director
	Dr Peter Carter	Non-Executive Director
	Ms Val Moore	Non-Executive Director
	Mrs Karen McConnell	Non-Executive Director
	Mr Bob Niven	Non-Executive Director
	Mr Jonathan Silver	Non-Executive Director
	Mr Nick Carver	Chief Executive Officer
	Mr Martin Armstrong	Director of Finance
	Dr Michael Chilvers	Medical Director
	Ms Rachael Corser	Director of Nursing
	Ms Julie Smith	Chief Operating Officer
In attendance from the Trust:	Ms Jude Archer	Associate Director of Corporate Governance / DPO
	Ms Sarah Brierley	Acting Director of Strategy
	Ms Debbie Frame	Executive Assistant (minute taker)
	Mr Joseph Maggs	Trust Secretary
	Ms Susan Young	Interim Chief People Officer
In attendance external to the Trust:	Charlotte Docherty	Member of the Public
	Deepa Nair	NHSI
	Elaine Ryan	Member of the Public
	Vanessa Wort	NHSI

19/019 CHAIR'S OPENING REMARKS

19/019.1 Mrs Schroder welcomed everyone to the meeting. Mrs Schroder also introduced Karen McConnell as a new Non-Executive Director member of the Board. Mrs McConnell would chair the Finance and Performance Committee.

19/020 DECLARATIONS OF INTEREST

19/020.1 There were no declarations of interest.

19/021 QUESTIONS FROM THE PUBLIC

19/021.1 Three questions had been submitted by Mr Justin Jewitt:

Question 1: Can you confirm your policy about communicating with patients attending the Trust in regard to the 62 day Cancer pathway? It would be most helpful and practical if you could publish the National target for activity on the 62 day Cancer pathway , what your patients should expect from your trust and , importantly, what action to take if the patient experiences anything different to the agreed timetable.

Question 2: Will the Trust place links, on its website, to agreed

videos on Cancer treatment and awareness that are already available through Macmillan's and Cancer Research UK?

Question 3: Will the Trust also convert all the leaflets from Macmillan's and CRUK into digital publications available 24x7 on its website (the formats are available FOC from the Cancer bodies)?

19/021.2 The Trust's response was provided by the Chief Operating Officer:

Question 1: There is a joint leaflet that has been produced by the Trust and the CCG but it is acknowledged that uptake has been variable. This leaflet will be relaunched following the appointment of new cancer tumour site leads.

The Trust's performance regarding the 62 day cancer standard is reported to the Trust Board (the meeting papers are available on the Trust's website). The reports that are presented to the Trust Board also provide context regarding the performance.

19/021.3 Question 2: These are already available but they are accessed via the Lynda Jackson Macmillan Centre webpages. It is recognised that these webpages could be made clearer. We are in the process of reviewing and redesigning the website and merging the separate LJMC website with the Trust's in order to make it more accessible.

19/021.4 Question 3: We would be happy to provide links to the leaflets that are available on the Macmillan and CRUK websites on the Trust's website. This would ensure that the latest versions are always available. This work will be completed by our communications team.

19/021.5 Mrs Schroder asked that the Trust's response is sent to Mr Jewitt.

19/022 APOLOGIES FOR ABSENCE

19/022.1 There were no apologies for absence.

19/023 MINUTES OF THE PREVIOUS MEETING

19/023.1 The Board reviewed and approved the draft minutes of the previous meeting held on 9 January 2019.

19/024 CHIEF EXECUTIVE'S REPORT

19/024.1 The Chief Executive then delivered his report, highlighting the following items and taking the remainder of the report as read:

- The Chief Executive welcomed Ms Karen McConnell as Non-Executive Director and Mrs Susan Young as Interim Chief People Officer.
- In response to a national news article that had been released earlier that day, the Chief Executive felt it important to note that, in relation to the planning of treatments involving radioisotopes, the Trust was currently following the national guidance which was to continue to plan the same volume of treatments. The Trust had not reduced its activity levels and was not elongating cancer waiting times as part of its planning for a possible 'no-deal' EU exit.

FORMULATING STRATEGY

19/025 **Strategy Development Programme Highlights Report and Programme Plan**

19/025.1 The Acting Director of Strategy delivered the Strategy Development Programme Highlights Report and Programme Plan. Communication planning was underway and the team were working to integrate the year 1 clinical strategy with the operating plan for 2019/20. Work was also progressing on the enabling strategies, in particular the research and development strategy and the quality strategy.

19/025.2 Ms Moore commented on links between the strategy and the NHS long term plan. The Acting Director of Strategy responded that the strategy is based on the information available at the time it was produced. The strategy had previously been reviewed against the NHS long term plan. Mrs Schroder confirmed the clinical strategy was the overarching strategy and supporting strategies would be developed in various areas. This would take in the region of 6-9 months.

SHAPING CULTURE

19/026 **Staff Survey 2018 Results**

19/026.1 The Interim Chief People Officer delivered a report regarding the Staff Survey 2018 Results. Last year the Trust's response rate had been one of the lowest response rates across the country. This year there was an increase to 42.8% which was close to the national average response rate.

19/026.2 The themes that the results had been grouped by were slightly different to previous years. This year it has been made simpler and the results were grouped into 10 themes. On 8 out of 10 themes the Trust scored below the average. In five of the themes, the Trust scored worse than it had in 2017, though within 0.2 difference. The Trust performed better in four of the theme areas and for the remaining theme there was no comparison available from 2017. The themes where there had been improvements were: safety culture, staff engagement, violence experienced and quality of care.

19/026.3 The Interim Chief People Officer explained that there was a strong incentive to improve the results and that research had demonstrated that staff experience correlates with patient experience.

19/026.4 Having received the results, the data would be analysed and action plans drawn up to address the issues highlighted. One of the learnings from last year was that the action plans that were developed had not all been monitored through to completion. It was important to learn from that for this year. One idea that was being explored was extending the staff leadership development programmes to a wider group of staff

19/026.5 The Chief Executive acknowledged this was a key priority for the Trust. He was disappointed the Trust had not made more progress. He suggested that there needed to be a greater focus on supporting band 6 and 7 staff who formed account for the majority of line managers within the NHS. Mrs Schroder agreed that better engagement with more junior managers would be beneficial.

19/026.6 Dr Carter acknowledged that whilst there had been progress in some areas the overall results were disappointing. When he joined the Trust at the time that the survey data was being collected he had found lots of staff were not engaged with the staff survey. He felt a more coordinated plan was needed to increase the response rate, which he felt would lead to a truer reflection of staff feeling. He suggested managers should be encouraged to take ownership for completion of the survey in their area. He commented that from his experiences visiting the wards he had found staff morale to be generally good, which was not reflected in the survey results.

19/026.7 Mr Niven commented on the importance of ensuring that action plans were followed through. He also suggested reviewing the areas where improvements had been made and common factors associated with the improvements.

19/026.8 Mrs Schroder commented that any actions that remained open and valid from last year should be retained in the new actions plan.

19/027 Quality Transformation Programme Update

19/027.1 The Director of Nursing presented the Quality Transformation Programme Update. Recent achievements included the ongoing development of the Quality and Safety dashboard and progress with the harm free care collaborative. The quality strategy was currently under development and would be presented to the next Quality and Safety Committee for approval.

ENSURING ACCOUNTABILITY

19/028 Integrated Performance Report

19/028.1 <u>Safe and Caring Services</u>
The Director of Nursing presented the update regarding the safe and caring services section of the IPR. The following updates were provided:

19/028.2 Never events – The Trust had not declared a Never Event in more than 120 days.

19/028.3 Pressure Ulcers - Due to national changes around how pressure ulcers are reported, it was expected that the numbers reflected in the next IPR would show an increase. Work had taken place to identify where the majority of pressure ulcers occurred so that targeted work could take place.

19/028.4 Sepsis – CQUIN criteria achievement for 2018-19 would require the adoption of the national NEWS 2.0 scoring systems to provide accurate identification of Sepsis. Unfortunately this had been delayed due to implementation issues with NerveCentre at other sites. There were also plans to increase capacity in the Sepsis team to help achieve some of the other aspects of the Sepsis targets.

19/028.5 Complaints – The complaints improvement programme work was starting to have a positive impact with the number of complaints responded to within the agreed timeframe improving from the previous month. The learning gained from the complaint process was also being used to improve service delivery.

19/028.6 Mrs Schroder commented that the drop in complaint numbers was significant. The Director of Nursing responded that the number of complaints received often followed a cyclical pattern, with a higher number of complaints corresponding with the winter pressures period.

19/028.7 Effective Services
The Medical Director presented the update regarding effective services. The updates provided included:

19/028.8 Mortality – Mortality rates had continued to improve over recent months and years. There would be a further discussion regarding mortality under the separate agenda item regarding the Learning from Deaths report.

19/028.9 Seven day services – The Medical Director explained the work that was taking place to work towards providing the same service at the weekend as was provided on weekdays. This work was also being supported by the Chief Operating Officer following her recent observations of the current provision of weekend services. The Trust would be recruiting an associate medical director who would play a key role in this work.

19/028.10 Responsive Services
The updates provided by the Chief Operating Officer relating to responsive services included:

19/028.11 ED performance for the month reported was 85.24% which was deterioration from the December position of 86.86%, though performance remained strong compared to local peers and the national position. The current performance was also an improvement on the performance at the same point in 2018. Recent work that had taken place included working with colleagues at the front door to avoid unnecessary admissions and more efficient use of the existing bed complement.

19/028.12 In terms of cancer performance, the Trust was complaint with 6 of the 8 standards. The Trust had benefitted from a cancer deep dive session led by NHSI with NHSE, CCG, cancer alliance and the cancer support unit. A comprehensive slide deck was presented which outlined the background to cancer performance at the Trust; Lorenzo impact; recovery action plans; and work with IST on demand and capacity. The response at the meeting had been positive. In terms of demand and capacity, the contracting of additional capacity had now been agreed.

19/028.13 RTT – The Trust was above the national position at 89.73% and remained on plan to report zero 52 week breaches at the end of March.

19/028.14 Diagnostics – Performance for January was 2.79%. Further work was needed to rectify the worsening backlog position.

19/028.15 Stroke – There had been an improvement of 2.4% compared to last year's position. The bed capacity had been a challenge in the winter period but it was expected that improvements in the stroke targets would start to be seen.

19/028.1 The Chief Operating Officer responded that the Trust was using

6 reset week (taking place this week) to focus on discharges and looking at medical outliers to improve the flow in the organisation.

19/028.17 Mr Niven asked about the work to improve weekend services. The Chief Operating Officer responded there would be a cost implication though some initiatives could lead to savings in other areas. In terms of paediatric emergency performance there was a significant improvement in performance. She would be attempting to articulate the benefit of these initiatives and reviewing other schemes that had not been taken forward previously. Mr Niven requested that the Board was kept informed of this work.

19/028.18 Dr Carter congratulated the team on the recent operational performance achievements. He noted the planned national changes to the 4 hour A&E target and commented that the target had much improved waiting times for many patients across the country since its introduction. If the target was to be relaxed, he urged caution and encouraged consideration to be given to any unintended consequences. The Committee briefly discussed the proposals and the impact of the 4 hour target. The Chief Operating Officer responded that performance against the target was important but quality and safety remained the primary concern.

19/028.19 Mrs Schroder commented on the attendances at A&E and the UCC which were up against the plan. She asked the extent to which the increase had been felt. The Chief Operating Officer responded that there had been some days with very high attendance levels which had a significant impact, though there were also quieter days closer to the level of the plan. The Director of Finance commented that most of the growth appeared to be from patients from south Cambridgeshire and Bedfordshire. He suggested this may be due to changes in demographics and housing developments over recent years.

19/028.20 <u>Well-led Services:</u>
The Chief People Officer presented the following updates from the well-led services section of the IPR:

19/028.21 The vacancy rate for the period was 7.3%. She reported that there may be pressure on the vacancy rate over the next couple of months as the start date for some international recruits had been delayed by a month. Improving recruitment from the domestic market and improving retention of existing staff were noted as areas of work that would help improve the vacancy rate further.

19/028.22 At the recent FPC meeting there had been a discussion about mandatory training rates which it had been felt could be improved. It was the plan to discuss this further at a future meeting

19/028.23 The final figure for staff vaccinated as part of the flu campaign (which finished on 28 February) was 65.6%. There would be a review of lessons learnt to seek to improve on the figure for next year.

19/028.24 The demand on temporary staffing increased during January. This continued to be monitored to assess which temporary staffing positions could be released once vacancies were filled.

19/028.25 Sickness rates had improved from last year. Following a request at a previous meeting, the workforce report (provided within the data pack) included data on the number of days lost due to sickness due

to mental health issues.

19/028.26 Sustainable Services:
The Director of Finance provided the following updates regarding the sustainable services section of the IPR:

19/028.27 January had been a more positive month in financial terms. There was an in-month surplus of £1M. The agreed revised control total target that the Trust was currently working to achieve was an underlying deficit of £23.1M at year end.

19/028.28 The overall pay position was showing £7.5m adverse to plan, with overspends against medical staff budgets accounting for £5.3m of the variance and £2.1m relating to overspend against nursing staff budgets.

19/028.29 SLA activity performance during January improved significantly following a poor December.

19/028.30 CIP delivery continued to fall short of the target, with CIP under performance now totalling £3.9M.

19/028.31 Mr Niven commented on the mixed success of the work taking place under the model hospital work streams. The Director of Finance responded that the nature of the schemes varied but many had led to improvements. The Trust would take any lessons learned into the planning for next year.

19/029 Learning from Deaths Report

19/029.1 The Medical Director presented the Learning from Deaths Report. Reducing mortality was one of the Trust's key objectives for 2017 to 2019. The data provided in the report showed that the Trust's crude mortality rate was 1.22% for the 12 month period to December 2018 compared to 1.47% over the last three years, HSMR for the 12 month period was 94.57 and was statistically 'better than expected' and SHMI for the 12 month period was 102.70 and 'as expected band 2'. Since the report had been produced, SHMI had improved even further and was now below 100 for the first time.

19/029.2 Despite the positive position overall, work continued to take place to look at the outliers. The Sepsis HSMR (a previous outlier) had reduced and was now in the 'better than expected' range. It was thought that further improvements were still possible in relation to this measure.

19/029.3 The Board were also informed that the introduction of the medical examiner post would be taking place over the next few months and regular updates would be provided.

19/029.4 The Board congratulated the team on the performance and the positive impact this had for patients. It was felt that this was a good news story that should be shared more widely.

19/030 Audit Committee report to Board

19/030.1 Mr Silver presented the Audit Committee report to Board. He provided an update on the latest internal audit reports considered by the Committee in January. Five of the audits were rated 'reasonable assurance' and two audits relating to the effective rostering of

locums and cash collection were rated 'partial assurance'.

19/030.2 Mr Silver commented that progress against actions arising from internal audits remained slow but there should be further progress by the time of the next Audit Committee meeting.

19/030.3 In relation to the counter fraud update received by the Committee, Mr Silver noted that there had been some discussion regarding staff working whilst absent due to sickness.

19/030.4 He also reported that the Audit Committee had requested some follow-up work regarding the quarterly junior doctor contract update in relation to the number of unfilled shifts. The Committee had also discussed the reporting route for the quarterly junior doctor contract update and this would be considered when annual cycles are reviewed.

19/031 Finance and Performance Committee Report to Board

19/031.1 The Committee considered the report regarding the January FPC meeting. Mr Silver referred to the CQUIN delivery report and noted that the toughest quarter was yet to come as the budget was back end loaded with the weighting in quarter 4 accounting for 41% of the CQUIN annual total. He also highlighted the detailed service line deep dive presentations for theatres and patient flow.

19/031.2 Mr Silver provided a verbal update regarding the February FPC meeting, noting that most of the key points had already been covered earlier in the meeting. He noted the deep dive presentations received from cardiology and cancer services. The cardiology presentation had required further work from the team to better understand the data. The cancer services deep dive had been more thorough and had highlighted a potential opportunity around private patient services.

19/032 Quality and Safety Committee Report to Board

19/032.1 Dr Cater presented the QSC report to Board. He referred to the fire safety updates considered by the Committee which had highlighted some concerns. He reported that there was now an interim fire officer in post who would help to lead on the actions identified.

19/032.2 Dr Cater referred to the presentations from the clinical areas, stating that these were generally of a high quality and are well received by the Committee.

19/032.3 Dr Cater also highlighted that the QSC meetings continue to have busy agendas and suggested that some items could be taken less frequently.

19/032.4 The Board also noted the University Partnership – Joint Management Committee Annual Report, which had been approved by the QSC in February. Mrs Schroder asked about progress with the Trust changing its name to reflect the partnership. The Associate Director of Corporate Governance would follow this up.

19/033 Gender Pay Gap Report

19/033.1 The Committee noted the Gender Pay Gap Report 2017/18 which had been considered and endorsed by the QSC at their previous

meeting. There was a national requirement for the data to be published by 31 March 2019. The report included an action plan of work to improve gender equality (many of the actions having been started in the previous year). The Quality and Safety Committee would continue to monitor progress against the action plan. Mrs Schroder commented that the report demonstrated an imbalance between a smaller number of higher paid men and a larger number of lower paid women. Mr Niven noted that pay is an indicator of equality in recruitment, development and promotion of staff and the Trust therefore needed to consider how to focus on these issues.

19/034 Board Assurance Framework

19/034.1 The Associate Director of Corporate Governance presented the latest Board Assurance Framework. The key risks continued to be discussed at the meetings of the Board committee.

19/034.2 It was noted that risk 12 ('there is a risk that the Trust is not able to secure the long-term future of the MVCC') had increased from a score of 12 last month to 16. This was associated with the availability of funding for capital equipment replacement and refurbishment programmes.

19/035 Annual Cycle

19/035.1 The Board noted the latest iteration of the 2018/19 annual cycle. The Board committees' annual cycles were currently being reviewed and these would feed into a refreshed Board annual cycle for 2019/20, which would be available for the next meeting.

19/036 Matters Arising and Actions Log

19/036.1 The Board noted the actions log.

19/037 Data Pack

19/037.1 The Board noted the data pack.

19/037.2 There being no further business the Chair closed the meeting at 12:28.

Ellen Schroder
Trust Chair

May 2019

East and North Hertfordshire NHS
NHS Trust

Chief Executive's Report

May 2019

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1. Corporate Update

I am delighted to announce that Duncan Forbes has been appointed as the Trust's new Chief People Officer. He has a wide range of experience as a Director of Human Resources and Organisational Development across the public and private sector, most recently at the Norfolk and Suffolk NHS Foundation Trust. Prior to this, Duncan was at HM Courts and Tribunal Service and Jaguar Land Rover. Duncan will join the Trust on 3 June 2019.

I would also like to announce the arrival of Mark Stanton, who has joined the Executive Team as our Chief Information Officer. Mark leads our IT department and is developing the digital programme that will take us to the next level of our digital development. Mark joins us from Dudley Group NHS Foundation Trust where he led a successful transition to a full electronic patient record. Prior to joining the NHS, Mark held a number of senior IT positions, including in the automotive and telecoms industries.

Stabilisation Project

I am pleased to advise that the Stabilisation programme managed by Channel 3 completed on 18th April 2019 and delivered the majority of the 90 identified actions relating to Lorenzo. There are a small number of deliverables relating to the Nervecentre product which will be completed in Q2 2019/2020 by Trust IT.

Therapy Services

On Monday, 1st April, we welcomed colleagues from Acute Therapy Services, which includes inpatient and outpatient physiotherapy and occupational therapy, who will be joining the Trust from Hertfordshire Community NHS Trust (HCT). I am delighted to welcome them to our team and we have already seen some of the fantastic work they have done to improve patient experience and quality of care

Flu Vaccinations

The staff flu vaccination campaign has now come to an end, and I would like to thank the 3,594 members of our team who had the vaccination this year. You have played a pivotal role in helping to prevent the spread of flu. Immunisation is one of the most effective ways we can reduce harm from flu and pressures on health and social care services during the winter. Altogether, over 65% of our frontline staff, and over 52% of non-clinical staff, were vaccinated against flu this year.

Hospital Charity Funds Lifesaving Liver Scanner

I am pleased to advise that the Trust's charity has funded a Fibroscan machine with support from local Rotary Groups and a grant from the Rotary Foundation. The scanner will be used by the Gastroenterology and Hepatology teams to detect early liver scarring and damage.

Liver damage has been traditionally measured with a biopsy and the Fibroscanner will help our patients by making this a quicker and more accurate.

2. Our Staff

Rheumatology Team in Nationwide Top 10 for Audit

Congratulations to the Rheumatology Team who have been recognised by the British Society got Rheumatology as being in in 7th place across the country for their use of the National Early Inflammatory Arthritis Audit.

Finalist in RCNi Awards

Our Carers Lead, Jodie Deards, has been shortlisted for the Commitment to Carers award in the prestigious RCNi Nurse Awards. Her nomination focused on her involvement in developing the Young Carers in Herts app.

Research Nurse Accepted for Prestigious Programme

I am delighted to share with you that Carina Cruz was successful in her application for the National Institute for Health Research 70@70 Senior Nurse Research Leader programme. She is one of 70 nurses around England, who will strengthen the research voice and drive improvements in future care for patients. Carina will be working with Director of Nursing, Rachael Corser, FNF chair professor Natalie Pattison and Anita Holme, lead research nurse on new initiatives to enhance innovation and help embed research.

Congratulations to Jeanette Dickson

Finally, Jeanette Dickson, our consultant clinical oncologist at the Mount Vernon Cancer Centre has been elected to the role of President of the Royal College of Radiologists (RCR). The RCR is responsible for training and standard setting nationally for clinical oncology and clinical radiology.

East and North Hertfordshire NHS Trust

Agenda Item: 8.1

TRUST BOARD - PUBLIC SESSION – 1 MAY 2019

TRUST NURSING, MIDWIFERY AND AHP STRATEGY

Purpose of report and executive summary:

To present the East and North Hertfordshire NHS Trust's Nursing, Midwifery and AHP strategy, 2019 -2024, designed to align with the priorities set out in Trust's clinical strategy. The Nursing, Midwifery and AHP strategy is ambitious, patient centred and the trust Values are at the core of all elements within the strategy.

During the development of this strategy staff across all the disciplines were consulted and asked to contribute via; workshops, surveys and feedback sessions. The pillars reflect the key priorities within the clinical strategy whilst also outlining ambitions for the future, aligning with the Chief Nursing Officer for England priorities and vision.

We have aimed to set both realistic and ambitious targets for our patients, workforce and partnership working. We will continue to review and update key priorities from the strategy:

- Developing and strengthening leadership
- Optimising pathways
- Valuing people
- Inspiring and innovating through research and quality improvement
- Ensuring quality and safety
- Partnership working

It is planned that this strategy will be launched during the week of International Nurses day.

Action required: For approval

Previously considered by: Quality and Safety Committee, 23 April 2019

Director:	**Presented by:**	**Author:**
Director of Nursing	Director of Nursing	Nursing senior leadership team

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
No

Any other risk issues (quality, safety, financial, HR, legal, equality):
Underpins the quality care delivered to our patients and the wellbeing of our nursing, midwifery and AHP staff.

Proud to deliver high-quality, compassionate care to our community

East and North Hertfordshire
NHS Trust

Nursing, Midwifery and Allied Health Professionals Strategy

2019 - 2024

Proud to deliver high-quality, compassionate care to our community

Contents

Introduction from Rachael Corser, Director of Nursing

It is with great pleasure and pride that I introduce our nursing, midwife and allied health professionals (AHP) strategy. During my first year at this trust I have spent time talking to all of you about what matters to you and what makes you proud to work here. This strategy sets out our vision for nurses, midwives and AHPs for the next five years. It is ambitious, it is patient-centred and the trust Values are at the core of the strategy.

I promise to work with you all to develop and strengthen leadership at all levels, with a personal commitment to support you all to be the best leaders you can be.

Building on our priorities set out within the clinical strategy, I will work with patients, service users, carers and colleagues internally and externally to optimise pathways and strengthen partnerships placing the East and North Hertfordshire NHS Trust on the map as a leader in influencing the development of innovative care pathways.

It is a priority for me that you all feel valued and in turn you value each other; placing your health and well-being at the centre of what we do.

We are in a unique position to innovate, lead research and inspire improvement through our well established relationships with external bodies; I am committed to working with you to progress this further. I am excited by the endless opportunities these foundations give us and the impact that your research, improvement and innovation will have on continuing to improve outcomes for our patients.

Delivering high-quality and safe care to our patients and continuing to improve their experience is fundamental, and developing and embedding our clinical excellence accreditation framework will enable us to reward and recognise excellence in care. I make a personal commitment to work with you to continue to develop this throughout the life of this strategy.

As we embark on new and exciting future nurse and midwife standards, holding ourselves to account for the implementation of this strategy is even more important. As we embrace the impact that digital innovation plays in our future, I am confident that we will see the year-on-year impact that digitalisation brings.

I make a personal promise and commitment to you all that I will do my best to place our patients, carers and staff at the centre of all I do. I promise to be your greatest advocate and ensure that the voice of nursing, midwifery and outreach care is at the forefront of what we do each day. In return, I ask that you bring this strategy to life and talk about it widely, be proud of what you do each day and continue to provide exceptional care to our patients; putting our patients first always. We have so much to be proud of and I look forward to working with you all to embed and deliver this strategy.

Developing and strengthening leadership

We will;

- Enhance well-being through supportive staff initiatives
- Identify and maximise individual potential – using values-based appraisal
- Support all staff to demonstrate leadership and teamwork
- Embed leadership and coaching programmes
- Ensure visibility of senior leaders

We will do this by;

- Working with health at work partners to reduce staff sickness level
- Improving staff satisfaction
- Developing clear career pathways and resources to encourage staff retention
- Developing structured talent identification processes
- Embedding an organisational culture that values both teamwork and leaders
- Improving access for all levels of staff to leadership and development opportunities
- Developing a structured ward leaders programme
- Introducing a multi-disciplinary preceptorship programme for all newly qualified staff
- Creating clear programmes for the development of preceptors and coaches
- Ensuring visible leadership – all staff will have access to all senior leaders
- Encouraging all senior clinical staff to work as part of Fundamental Friday - demonstrating excellence in care

Proud to deliver high-quality, compassionate care to our community

Optimising pathways

We will;

- Work across care crossing boundaries
- Influence, drive and deliver efficiencies in patient care pathways
- Work towards digital integration (with staff and patient access) and more telehealth solutions
- Use data and co-design to support development of patient services and pathways
- Ensure ease-of-use and pathway access

We will do this by;

- Multi-disciplinary engagement within all clinical areas, driving efficient and effective patient flow through clearly defined pathways
- Maximising golden discharges and discharge lounge usage
- Driving forward efficiencies that will enhance patient care and quality
- Multi-disciplinary involvement with the quality improvement hub to develop and embed evidenced based care pathways
- Developing Digital Exemplar wards which will showcase digital integration
- Driving IT training for all staff to support new ways of working
- Using best available data to support and develop our services and pathways
- Collaborating with our patients and users to co-design pathways that best meet their needs
- Creating solutions that are intuitive to navigate, ensuring that pathways are optimised so that patients are cared for at the right time and place

Valuing people

We will;

- Ensure professionalism and cross-boundary and trans-disciplinary working
- Promote good communication at all levels
- Encourage self-care and a caring environment for staff
- Foster an engaged flexible skilled multi-professional workforce that meets the needs of the Trust

We will do this by;

- Promoting excellence in our multi-disciplinary profession, showcasing exemplar models of good practice
- Fostering an environment where staff feel valued as a member of the team
- Improving staff satisfaction and reduce attribution by supporting and listening to staff
- Improving engagement and communication. Staff and patients will have access to senior leadership teams
- Champion personal resilience through personal development, supporting a culture of well-being
- Promoting psychological well-being and safety using staff engagement questionnaires that help promote staff satisfaction
- Formally recognising staff achievement and outstanding care
- Striving to be the first choice for multi-disciplinary staff employment, offering innovative staff solutions to help meet workforce demand
- Offering education and training
- Embracing a culture of lifelong learning in our professions

Inspiring and innovating through research and quality improvement

We will;

- Foster a culture where research and quality improvement (QI) is viewed as integral to practice underpins patient/ user care
- Strive to underpin all practice with best available evidence (developing evidence where not available)
- Develop research and QI skills
- Increase numbers of clinical academics and QI specialists

We will do this by;

- Promoting a culture of enquiry through research engagement
- Providing clear guidance and governance for continuous quality improvement and research initiatives
- Developing the most up-to-date evidence based practice
- Improving resource learning opportunities – research coaching, QI methodology and developing a community of practice for research to support sharing and learning
- Encouraging fellowship applications and supporting research into practice and practice into research
- Developing a collaborative approach to research bids to advance and improve the health of our population, and enhance experience for all

Ensuring quality and safety

We will;

- Support consistent delivery of compassionate, harm-free, outstanding care
- Manage and develop sustainable resources
- Transform our nursing, midwifery and AHP workforces to deliver outstanding care
- Ensure patient and carer experience is optimal

We will do this by;

- Striving to deliver excellence and compassion in care at all times, that reflects the professions and holds safety as paramount
- Using our Quality Dashboard and Nursing Quality Indicators to continuously improve our standards of care
- Developing solutions that are sustainable and realistic, but that remain aspirational for driving-up quality
- Constantly seeking to drive change in our workforce, through developing career pathways, in order to achieve outstanding care to our population
- Developing a ward accreditation scheme that will support wards to achieve outstanding care for patients and be recognised for it
- Using best practice models to drive forward care and enhance our learning from mistakes

Partnership working

We will;

- Work with patients and carers to co-produce services that best meet patients'/users needs
- Develop shared decision making councils
- Foster good communication across all partnerships, out into communities and across primary/secondary and tertiary care

We will do this by;

- Increasing partnership engagement, driving forward care by enhanced involvement in patient experience groups and local patient and public partners
- Driving innovation that is driven by front line staff - improvements will be aspirational, from local change to wider STP developments
- Sharing our strategic vision with our partners outside the trust and ensuring our vision aligns with broader local health priorities

Nursing, Midwifery and Allied Health Professionals Strategy

2019 - 2024

East and North Hertfordshire NHS Trust

Agenda Item: 8.2

TRUST BOARD - PUBLIC SESSION – 1 MAY 2019

Quality Strategy 2019/24

The following report presents the ENHT 'Quality Strategy 2019-2024'.

It describes

- Current situation of approach to Quality, aligning our Trust Values and cultural ambition.
- The background of Quality Transformation programme (QTP) phase of quality.
- The assessment of key drivers and quality priorities 'Quality Pillars'
- Recommendations to support the commitment to actively bring the strategy to life 'Listen, Learn & Act'
- Summary of suggested metrics for adoption during the delivery of the strategy.
- Explores where it will add value to Patients, Staff and The Trust Board and to the Trust Strategic Priorities.

It includes appendices

- Quality Stakeholders
- Quality Systems view/ Driver Diagram
- Annual Quality Plan 2019/20
- Roles & Responsibilities
- Reporting Structures
- References

Action required: For information

Previously considered by: Discussed in Quality & Safety Committee (March 2019).
Approved at the Trust Board Development Session on 3 April 2019.

Director:	**Presented by:**	**Author:**
Director of Nursing & Patient Experience	Director of Nursing & Patient Experience	Associate Director of Quality & Safety

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)

1. **BAF Risk 011/18** There is a risk that the Trust is not always able to consistently embed a safety culture and evidence of continuous quality improvement and patient experience
2. **BAF Risk 009/18** There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered impacting on the Trust's ability to deliver the required improvements and transformation
3. **BAF risk 007/18** There is a risk that the governance structures in the Trust do not facilitate visibility from board to ward and appropriate performance monitoring and management to achieve the Board's objectives

Any other risk issues (quality, safety, financial, HR, legal, equality):
Quality Governance, Quality Improvement and Patient Safety.

Proud to deliver high-quality, compassionate care to our community

East and North Hertfordshire NHS Trust

Quality Strategy 2019-2024

PROUD TO DELIVER HIGH QUALITY, COMPASSIONATE CARE TO OUR COMMUNITY

1.0 Executive statements

"I am proud to work with an NHS board where Quality and Safety is at the forefront of all that we do. I believe we are entering an exciting era where innovation will allow us to improve and deliver safer, more compassionate care for our community."

Ellen Schroder, Board Chair

"I feel proud to work in an organisation that strives towards achieving its full potential; I know we have many examples of excellence to celebrate."

Nick Carver, Trust CEO

"I am proud that our people are motivated to deliver excellent care. I believe that our quality strategy is the tool to allow us all the freedom to do this"

Dr Mike Chilvers, Medical Director

"I am really proud to champion this strategy because, quite simply, every single day I have the privilege of being able to make a difference to the nurses, midwives, carers and staff with whom I work. This strategy gives our staff a framework that places patient safety and patient experience at the core of all we do."

Rachael Corser, Director of Nursing & Patient Experience

2.0 Situation

A key strategic objective for the next 5 years at East and North Hertfordshire NHS Trust is for all our staff, clinical and non-clinical to……

'To feel proud to deliver high quality and compassionate care'

The vision of this strategy is to enable all our staff to work safely, by giving them the skills and authority to make changes that drive improvement for themselves and for their patients.

Our values support how we will all deliver high quality, compassionate care to our community:

- Patients first through patient co-design and innovation of quality improvements plans.
- Striving for continuous improvement and continually learning shall become integral in everything we do.
- Value everybody through robust governance and improvement frameworks that celebrate excellence.
- Be Open and Honest with candid, supportive skills that ensure fair balance of accountability and kindness.
- The strength of Teamwork is the core fundamental ingredient to any efforts of improving quality of what we do.

Our cultural ambition demonstrates our determination to improve the quality of care we all deliver.

Quality and compassion are at the centre of how we behave and act

Staff that are proud of the care they deliver

Feel our roles and purpose are clear

Feedback to staff and services in continuous processes

Visibility of Trust and leadership values through our choices, actions & behaviours

Staff feel empowered to deliver and improve performance in all areas

Shared responsibility of us all as we work to nurture talent

Confidence to challenge and speaking up in a safe and supportive climate

'I want to understand the real problems'
Ward Sister

'I want to measure the right things that show quality is improving'
Sepsis Nurse

'It is so frustrating when we focus on improving, and then it's not sustained'
Consultant

'Our organisation underperforms to its potential; I know we have more to celebrate'
CEO

'I have data and I want it to tell our story'
Nurse Specialist

'We have an untapped army who have the attitude and motivation to help drive the quality of care for our patients'
Student nurse Co-ordinator

'I have an idea to improve antibiotic compliance for sepsis, who can help me?'
FY2

3.0 Background

Over 2015-2019 East and North Hertfordshire NHS Trust has undertaken a co-ordinated and strategic approach to quality through the 'Improving Patients Outcomes' Strategy (2015-2018) and 'Patient and Carers Experience Strategy' (2015-2019). These have prioritised key work streams to deliver safe, personable, effective and reliable care through enabling the development of quality improvement capabilities and collaborative working. The future NHS England National Strategy of the 10-year view, published in January 2019, also supports and highlights the prioritisation needed to improve quality and outcomes for the decade ahead.

Our Trust CQC Inspection Report (2018) highlighted that the Trust is not yet consistently delivering high quality care across all services, or sustaining performance of key national standards. Furthermore, regulators and commissioners nationally have increased their scrutiny of patient safety issues, for example, the introduction and publication of 'never events' as a category of serious incident, and the new CQC inspection regime which specifically focuses on patient safety as a distinct domain.

Strong evidence describes how 'managing quality' well requires us to approach quality as a whole system: quality planning, quality assurance and quality improvement.

From September 2018, East and North Hertfordshire NHS Trust have transitioned from the Improving Patient Outcomes and Patient & Carers Experience Strategies towards a more holistic approach to align quality across our clinical and non-clinical services. This transformational design phase of our quality management has seen agreement and prioritisation of key pillars that will underpin the foundation of this 5 year strategy.

4.0 Assessment

What does quality mean?

Quality care crosses many domains of services provided in the NHS. The Institute of Medicine (IOM) describes quality care as:

"***Safe, Timely, Effective, Efficient and Personable***"

Delivering high quality, compassionate care ***involves the combined effort of all staff in all services*** e.g. Admin, facilities, domestic and housekeeping services, porters, managers, nursing, medical staff, volunteers, education and training staff, maintenance, directors and support workers. Together we shall strive to……


Understand where variation exists and use data to proactively drive improvement by reducing 'unwarranted variation '. Aiming to enable staff, to develop anlaytical capabilites, and access to real-time data from ward to board.


Foster a culture where staff can generate ideas, lead improvement efforts, feel valued and confident to influence the care they deliver. Provide supportive infrastructures to local teams with compassion and genuine openness. Continuously striving to understand the experiences, wisdom, ideas and creativity of others.

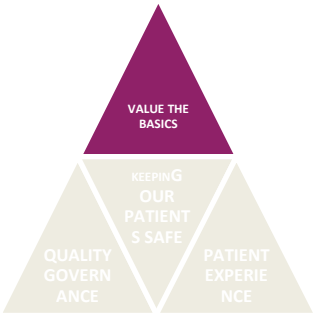

Enable our people with skills and knowledge to deliver high quality care strengthening their craftsmanship and expertise to execute their work well. Supporting staff with the practical application of quality improvement theory and imbedding these skills within routine roles.


Prioritise and understand what matters to staff, patients and carers who experience our organisation. Supporting staff to move focus with patients and carers from 'what is the matter' towards understanding 'what matters to you'?

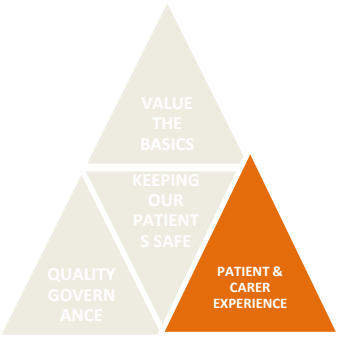
4.1 Key **quality pillars** have been identified to provide a structure in which to foucs our efforts of continuous imporvement.

I. Valuing the Basics
II. Patient & Carer Experiecne
III. Keeping our Patient Safe
IV. Quality Governaance

Each pillar shall have an annual quality plan to measure ourselves against (see appendix 1 for 2019/20 measurment plan).

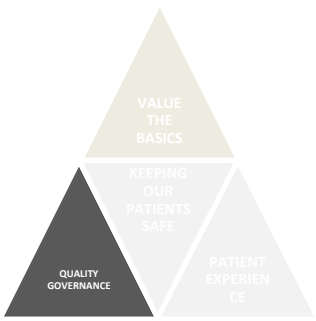


- Harm Free Care Collaborative- Falls, Tissue viability (pressure ulcers), Medication errors, Hospital acquired infections, Hospital acquired thrombosis, Urinary Tract Infections.
- Infection Prevention & Control
- Safeguarding Children and Adults
- Medical Devices and Use of Equipment



- Responsiveness to complaints
- Patient feedback locally
- Reliability to delivery our 'Carers Pathway'
- Promote volunteers as fully integrated team members within departmental teams
- End of Life care

- Reliable clinical harm reviews
- Improving staff experience, especially during safety incidents
- Reduce unwarranted variation - safer invasive procedures, Getting it Right First Time GIRFT
- Deteriorating Patients (SHMI)
- Sepsis
- Learning from deaths
- Maternity and our new-borns, and safer births



- Strengthen our systems to support Audit and Effectiveness
- Triangulate learning from patient feedback, claims, incidents
- Imbed robust Serious Incident Review Panels
- Improve how we disseminate learning from safety incidents
- Improve how we routinely learn from things that go well
- Ensure quality is given agenda space at meetings at all levels of the organisation, from ward to board
- Risk Management processes that support the identification, management and tracking of identified risk from ward to board.

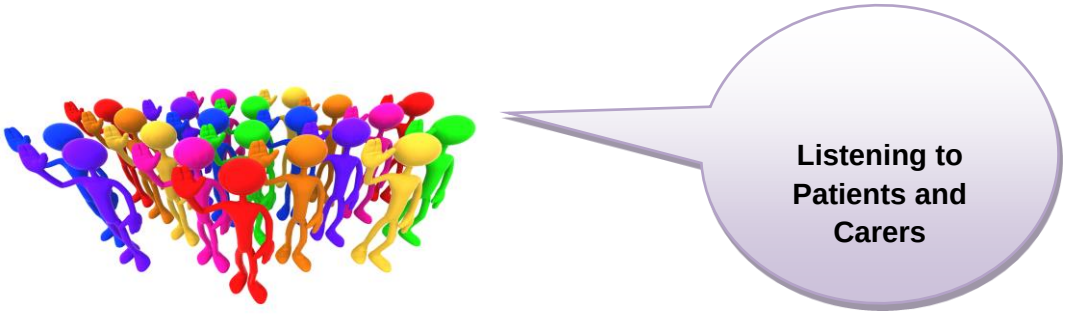
5.0 Recommendations

To enable all staff deliver high quality care we shall…….Listen, Learn and Act to enable all staff deliver quality care they are proud of.

Listen

The strategy shall engage key stakeholders across our services and community (see appendix 2). The first year of this 5 year strategy shall develop ways to provide supportive infrastructures in local teams that enable sharing of experiences, wisdom, ideas and creativity of others.

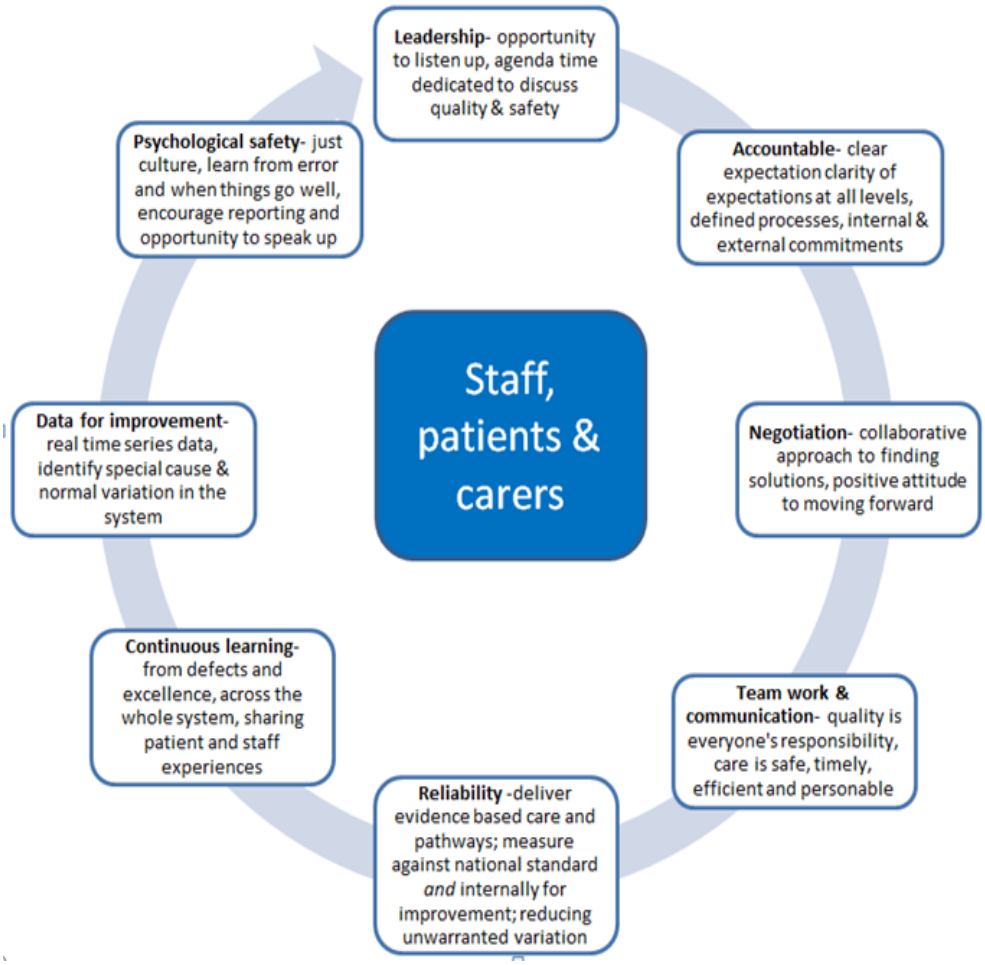
- Through a suite of options, we shall provide all staff (clinical and non-clinical) with easy access to staff support and information to ***influence*** quality within their roles.
- Ongoing re-design internal 'safety incident review' systems shall provide fast ***staff support***, providing immediate learning and intervention as needed.
- Provide opportunities e.g in 'quality clinics' that will ***empower*** all staff to discuss quality, scope new ideas and think how they could work differently.
- We shall design and imbed opportunities to listen and ***celebrate*** what staff *do well* on a day to day basis



- We believe our patients and carers should have opportunities to provide real time feedback during their care. We shall support all staff to prioritise local goals in alignment with real time patient carer feedback.
- We will strive to provide staff with tools and support to deliver meaningful 'partnership working' with family and carers. Moving conversations form asking 'what's the matter with you' to more meaningful '***what matters to you'***?

Learn

Our 'Quality Learning System' shall prioritise engagement with staff, patient and carers while also encompassing crucial learning required drive high quality compassionate care.



- We shall support clinical leaders deliver a 'Patient Safety Breakthrough Series Collaborative' and adoption of improvement science to capture learning cycles across multiple clinical priorities.
- We shall proactively seek new knowledge and insights from all non-clinical services where quality can be improved.
- We shall adopt a 'just' and 'restorative' approach to learning from errors, failures and lapses by asking …'Who has been harmed? What are their needs? How can we meet these needs'?
- We shall drive improvements to safety management systems that balance learning from errors equally with learning form what has gone well.

Act

- We shall define our model for improvement that helps builds capability and capacity for staff to drive quality care.
- Through deployment of a robust compliance framework, we shall enable staff from ward to board to understand their picture of a real-time ‘quality of care’ assessment.
- We shall publish an easy to use, and easy to access Quality & Safety Dashboard that provides real-time data from ward to board.
- Proactively build analytical capability to facilitate a strong organisational appreciation of ‘Quality Assurance’ and ‘Quality Improvement’ measures.
- Support all clinical and non-clinical staff practically apply quality improvement methods, we shall establish an ENHT Quality Hub that whith a dedicated ‘Quality Improvement Team’.
- We shall strengthen our ‘Clinical Audit and Effectiveness Programme’ to support clinical teams to comply with national mandatory standards, and demonstrate NICE compliance, in a framework that supports real-time identification of national compliance gaps and risks.

6.0 Summary

The inaugural year of this strategy shall build a sustainable framework to manage our systems to drive quality across all ENHT services and sites. (See appendix 3)

Every year our agreed quality plans and metrics shall be published; and through the five year strategy we shall demonstrate improvement year on year by:

- Increased number of trained staff in quality improvement theory
- Increased number of staff practically applying skills through quality improvement initiatives, across clinical and non-clinical quality goals
- Improved quality assurance and quality planning through improved compliance with clinical audit and effectiveness
- Improved compliance with our regulatory and contractual commitments
- Improved transfer of data from board to ward
- Improved culture of staff engagement and empowerment
- Improved patient experience and engagement

What does this strategy mean for our staff?

It support the national recognition of strong evidence highlighting how we must prioritise supporting our current and future NHS workforce, in the recognition that this support is fundamental to deliver high quality, safe care. Our aim is to provide a working environment where ENHT staff are happy and feel fulfilled in their work, where they look forward to going to work and are proud of the care they provide to their patients.

What does it mean for our patients?

It shall deploy opportunities to prioritise and focus on the delivery of compassionate care, by doing this we know it reduces errors, reduces stress and fosters excellence. It will support our staff to recognise and raise concerns with issues occurring in patient care and strengthen the adoption of behaviours that deliver a patient centred approach to the care they deliver.

What does it mean for our carers?

It shall strengthen carer resilience and provide support the carers in our community or voluntary sector organisations. Through deployment of this quality strategy framework we aim to raise awareness across our workface, and strengthen our processes, to strengthen carer co-design.

What does it mean for the board?

It shall correlate evidence between health system board prioritization of quality oversight; and higher performance on key quality indicators. High visibility of quality by a board has been shown to correlate with improved patient outcome and stronger leadership commitment to quality.

What does this mean for wider clinical strategic goals?

This strategy shall strive to develop easy to use, simple, staff friendly tools for staff to oversee and deliver high quality care. It will enable strong governance across care pathways across clinical and non-clinical pathways to promote quality improvement to be integral in everything we do.

Quality across our Strategic goals 2019/20	
People	• Support the practical application of Human Factor Sciences • Imbed Schwartz rounds opportunities for all staff • Develop skills and time in system to deliver After Action reviews • Celebrate excellence • Learn from day to day activities through quality MDT forums, pro-active listening up opportunities • Improve responsiveness to patient and carer complaints
Pathways	• Getting it right first time portfolio • National Safety Standards for Invasive Procedures • Safer more reliable discharges • Maternity and our new-borns- reducing stillbirths and neonatal deaths • Hospital Acquired Thrombosis
Sustainability	• Leadership for Improvement • Design and implement shared decision-making councils • Ward to Board deployment of QI skills • Ward Accreditation Framework • Assists with programmes of internal inspection/accreditation towards an overall 'Good' CQC Rating
Ease of use	• Launch ENHT Clinically Led Patient Safety Breakthrough Series Collaborative • Publish Quality & Safety dashboards • Easy access to staff support as directed by staff needs • Staff focused incidents management systems • Patient involvement in quality improvement initiatives

Appendices


Valuing the basics
Keeping our patients safe
Quality governance and risks
Patient experience

Appendix 1
2019/20 Annual Quality Measurement Plan

The governance expectations of these quality outcomes include the design and agreement of '**Specific Measurable Achievable Timely**' measurement plans.

Progress and trajectories shall be regularly reviewed through new Corporate, Divisional and Regulatory reporting structures (see appendix 5).

This measurement plan demonstrates how the quality pillars will influence our Clinical Strategy Goals.

Strategic Goal	Quality Pillar	Quality Outcome	Measure of Success 2019/20
Pathways	Keeping our patients safe	Getting it right first time portfolio	Reduced unwarranted variation across key GIRFT work streams throughout 2019/20 Demonstrated increased efficiency Demonstrated increased value proposition for services provided
		National Safety Standards for Invasive Procedures	Safer Surgery Collaborative working across theatres & other high prevalence clinical specialties for invasive procedures e.g. Cardiology, Radiology, Endoscopy, Maternity etc. Publication and sharing of Local Safety Standards for Invasive Procedures (LocSSIPs) within high prevalence specialties.
		Maternity and our new-borns	Support collaborate national work to reduce avoidable term babies admission to NICU
		Safe reliable discharges	Support clinical engagement with digitalisation strategy from stabilisation and implementation phases of patient information systems. Reduced trajectory of pending discharge summaries with improvement patient experience of discharge.

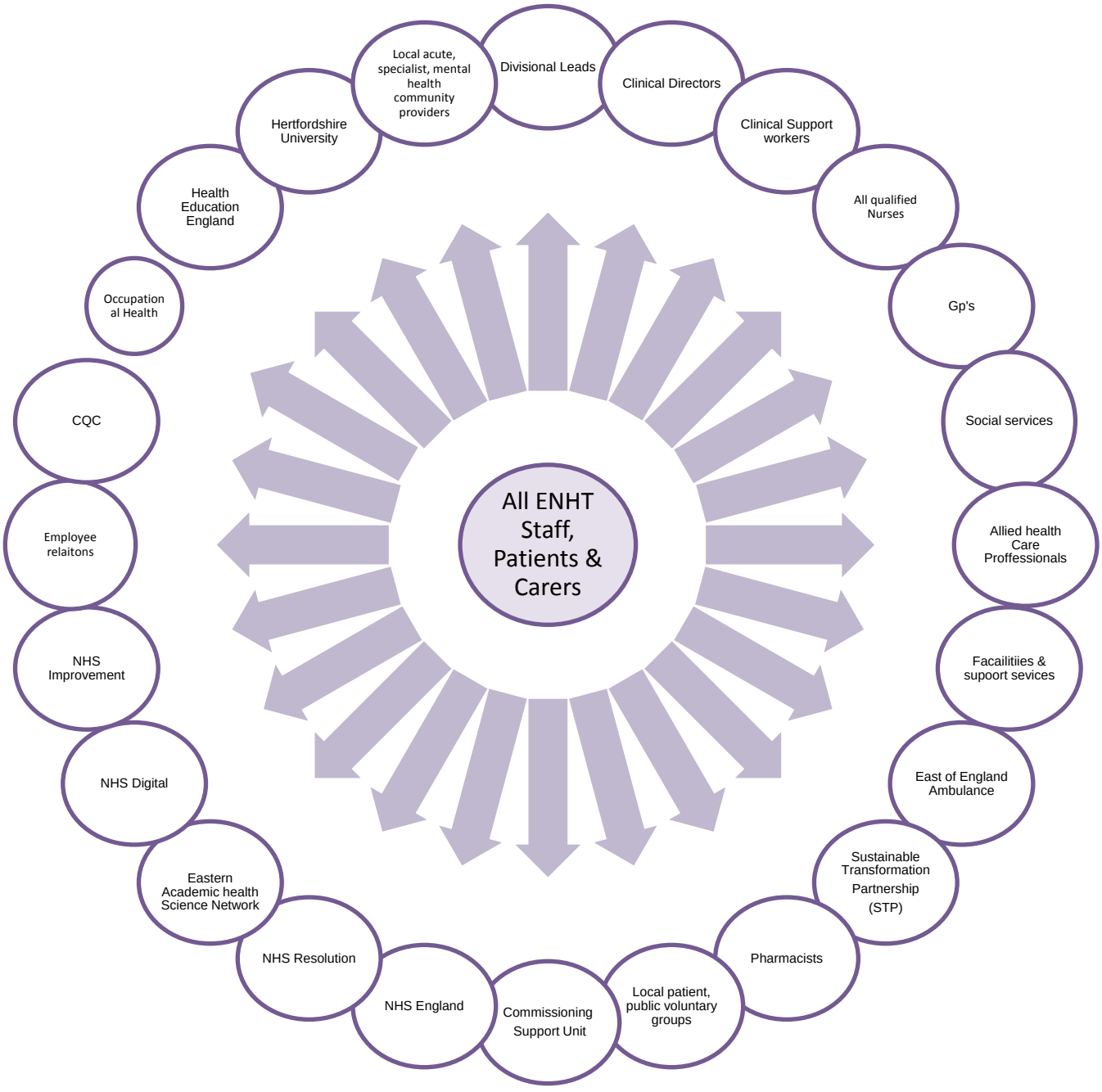
Strategic Goal	Quality Pillar	Quality Outcome	Measure of Success 2019/20
People	Keeping our patient safe	Support the practical application Human Factor Sciences	Work with current internal capabilities and scope external opportunities to share knowledge and expertise related to application of Human factors Sciences.
		Imbed Schwartz rounds trust wide	Seek expert psychology and clinical leadership support to design and imbed routine Schwartz Learning Forums. Deliver regular sessions monthly for staff.
		Develop skills to deliver After Action reviews	Design After action review curriculum and deploys training and support evenly across workforce.
		Celebrate excellence	Design ways to proactively recognise and promote good practise. Communicate and celebrate examples of excellence across all workforce forums.
	Patient Experience	Improve responsiveness to our patient voice through complaints	Work collaboratively with our patients and carers to provide quality responses to complaints. Redesign complaints response processes to improve timeless and efficiency of responses.

Strategic Goal	Quality Pillar	Quality Outcome	Measure of Success 2019/20
Sustainability	Quality Governance	Leadership for Improvement	Board leadership to support the deployment of quality improvement skills and measurement for improvement.
		Ward to Board deployment of QI skills	Empower clinical leaders to prioritise, design, test, learn from and scale quality improvement efforts. Enable a platform for face to face sharing and communicating with Board progress of QI initiatives.
		Ward Accreditation Framework	Design and test ENHT ward accreditation structures. Support the measurement and leadership of quality and enable scale and spread of trust wide ward peer review accreditation
		Shared decision-making councils	Design multi-disciplinary forums where structured approach to leading quality can occur. Agree council structure, chair and measures to enable easy adoption.
		Achieve over al 'Good' CQC Rating	Imbedded risk management processes. Proactive peer review of services and measurement for assurance. Design processes that pro-actively provide more visible, responsive support and interventions where services require improvement.
		Improved staff experience	Staff feel proud to deliver care at the Trust. Staff feel empowered to drive quality. Staff feel supported through incident processes. Staff feel listened too.
		Launch Quality Improvement Hub & Faculty	Invest in core Quality Improvement expertise to support the development towards quality improvement as integral way of working across ENHT. Design and deliver a Quality Improvement curriculum that supports and enables multiple areas of workforce to adopt and engage with improving quality of care.

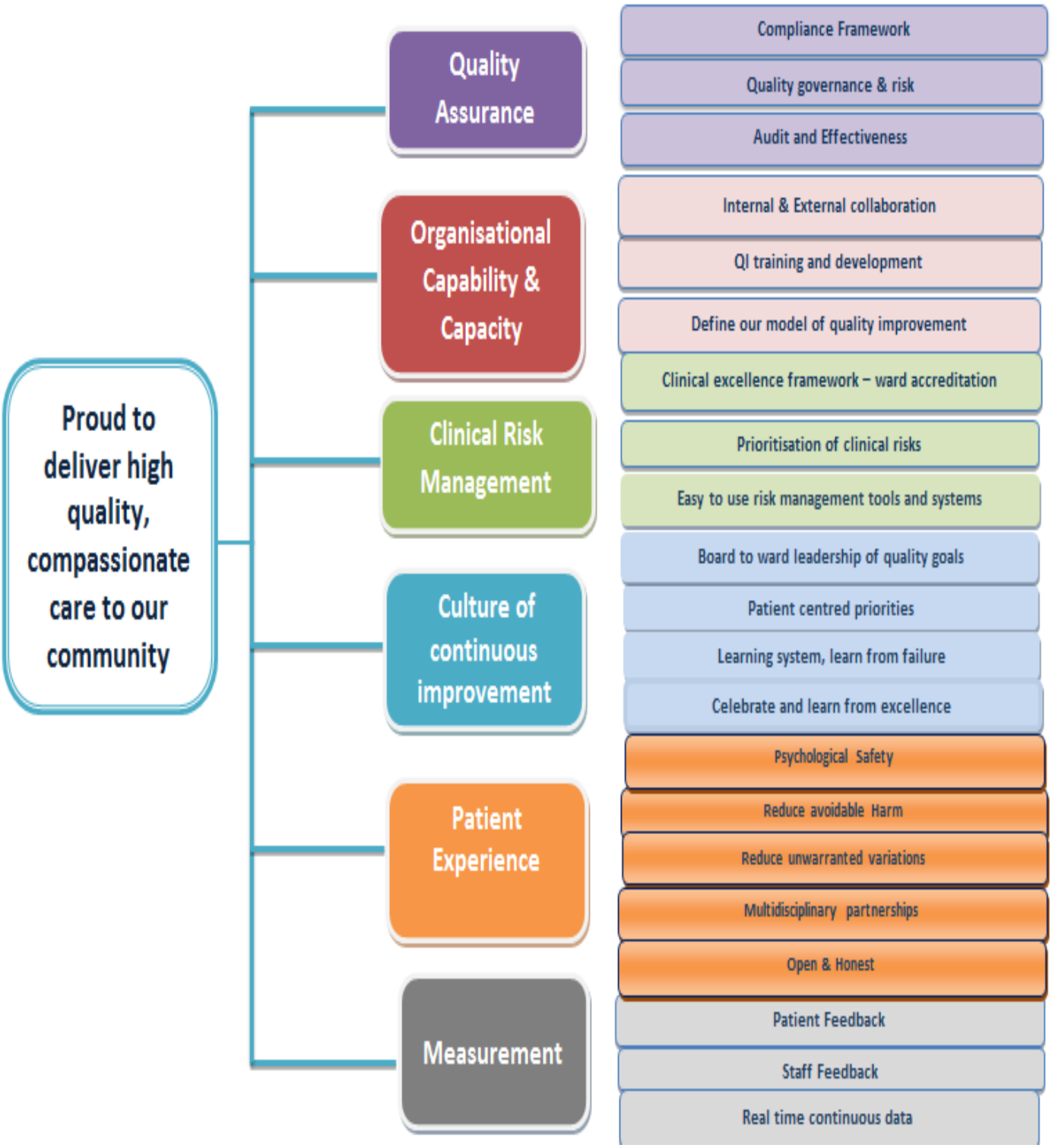
Strategic Goal	Quality Pillar	Quality Outcome	Measure of Success 2019/20
Ease of Use	Valuing the Basics	Launch ENHT Patient Safety Breakthrough Series Collaborative	Prioritise high risk, high prevalence safety concerns for adoption. Provide support from Quality Hub to design and deliver 18 month Breakthrough Series Collaborative across identified safety domains.
	Quality Governance	Publish Quality & Safety dashboards	Design robust measurement plans for all quality metrics on dashboard. Collaborative working with Systems Information, Quality & Safety and Clinical teams to ensure strong data analytical capabilities.
		Improve incident management systems	Deploy the agreed central Serious Incident Management teams Design meaningful feedback learning form incidents processes, across all workforce categories. Improve compliance systems for Duty of Candour requirements Design processes from ward to board that improve daily awareness of safety concerns.
	Patient Experience	Improve utilisation of feedback with Quality Improvements initiatives	Design learning system to incorporate meaningful listening forums within specialties. Support the enrolment of patients and carers to participate as team members with QI initiatives.

Appendix 2
ENHT Quality Stakeholders

We cherish excellence and professionalism wherever we find it - in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation. We recognise that all have a part to play in making ourselves, patients and our communities healthier'
NHS Constitution for England



Appendix 3:
Quality System Driver Diagram



Appendix 4:
Roles and Responsibilities

- **CEO** - As the accountable officer, the Chief Executive is responsible for Quality as part of wider governance arrangements within the organisation.
- **Director of Nursing** - is ultimately responsible for Quality & Patient Safety as part of a wider clinical governance responsibility, and works with the Medical Director to define the strategic direction of the organisation in relation to Quality & Safety.
- **Medical Director** – works closely with the Director of Nursing as part of clinical governance responsibility, however strategic decisions are taken in conjunction with the Director of Nursing.
- **Associate Director of Quality & Safety** – works closely with the Director of Nursing & Medical Director as part of a wider clinical governance responsibility to define the strategic direction of the organisation in relation to Quality & Safety.
- **Associate Director of Corporate Governance** works closely with the Director of Strategy, Director of Nursing & Medical Director as part of a wider corporate governance responsibility to define the strategic direction of the organisation in relation to corporate governance, compliance and risk.
- **Associate Medical Director Patient Safety** - The Associate Medical Director is accountable to the Medical Director and has specific responsibility to provide senior clinical leadership with respect to patient safety throughout the Trust; to promote a culture of patient safety and to take a lead role in developing and implementing the Trust Quality Strategy.
- **Associate Medical Director of Audit & Effectiveness** - The Associate Medical Director is accountable to the Medical Director and has specific responsibility to provide senior clinical leadership with respect to Clinical Audit & Effectiveness throughout the Trust; to promote a culture of quality assurance and improvement, and to take a lead role in developing and implementing the Trust Quality Strategy**.**
- **The Head of Patient Safety and Quality,** supported by the *Patient Safety Managers* and *Deputy Head of Quality Improvement*, are accountable to the Associate Director for Quality & Safety and are responsible for providing advice on, and facilitating, the effective management of patient safety. This responsibility includes establishing effective systems and processes to support the early identification of patient safety concerns and take a lead role in developing and implementing the Trust Quality Strategy.
- **The Head of Quality Improvement** will be an effective ambassador for the trust to support staff at all levels across the organisation. So-coordinating and supporting the delivery of quality improvements with staff at all levels in the organisation.
- **Quality Improvement Leads** shall work with the Head of QI to implement the quality improvement programme arising from clinical and non-clinical local initiatives; and contribute to building improvement capability and capacity across the organisation.
- **Divisional Quality & Safety Managers,** supported by Divisional Management team to deliver their Quality Governance agenda relating to the management and investigation of SIs, incident reporting, risk registers, complaints & claims, clinical audit plans and clinical effectiveness activity**.**
- **Clinical Audit & Effectiveness Manager,** supported by deputy and Clinical Audit Facilitators, is accountable to the Associate Director for Quality & Safety and has specific responsibility to provide strategic leadership of Clinical Audit & Effectiveness throughout the Trust, to promote a culture of quality assurance and improvement, and to take a lead role in developing and implementing the Trust Quality Strategy.
- **Senior Management / Divisional Directors** - with the support of the *Divisional Quality & Safety Manager* are responsible for ensuring that they engage fully with the Quality & Safety agenda, and are expected to take ownership of quality and patient safety issues related to the services they manage. They should actively address poor teamwork and poor practices of individuals, using approaches founded on learning, support and continual improvement, as well as effective appraisals, retraining and where appropriate revalidation.
- **All Trust staff** - Every person working for the trust has a duty to identify and help to improve the quality of care and reduce risks to the safety of patients, and to acquire the skills necessary to do so in relation to their own job and team.

Appendix 5
ENHT Organisational Quality & Safety Reporting Structure

East and North Hertfordshire NHS Trust

TRUST BOARD

QUALITY AND SAFETY COMMITTEE
Chair: Peter Carter
Non Executive Director

SUB COMMITTEE DIRECT REPORTS	PATIENT SAFETY COMMITTEE Chair: Director Of Nursing Rachael Corser	PATIENT & CARER EXPERIENCE COMMITTEE Chair: Director Of Nursing Rachael Corser	CLINICAL AUIDT & EFFECTIVENESS COMITTTEE Chair : Medical Director Michael Chilvers
Information Governance	Transfusion Board	Care Environment	Medical Devices
Trust Infection & prevention Control committee	Resuscitation Committee	Nutrition and Hydration	Radiation Protection
Divisional Board Q&S updates	Medication Forum	End of life Group	Mortality Surveillance
Safeguarding Board	Harm Free Care (Falls, VTE, CAUTI, PU)	Complaints & PALS	Clinical Governance (NICE, CA, Quality Assurance)
Estates & Environment	Deteriorating patient (Sepsis, Aki, Diabetes, Resuscitation)	Dementia Strategy group	Clinical Harm Reviews
Quality Improvement	Patient Safety Alerts	Patient Surveys	Medicines Management
Nursing, Midwifery and Allied Health Care Professionals Committee	Safer Surgery Improvement Collaborative	Organ Donation	Document Control – policies & procedures
Health and Safety Committee	Incidents & DOC & action plan Governance	Carers	Compliance framework & Well Led
BAF/Risk	Inquests & Claims	Care Environment	New Interventional procedures
Emergency Planning	Safety Culture		Discharge Summaries
Cancer Board	Safety Huddles		Risk management
Clinical Excellence Framework	Serious Incident Review Panel		

Divisional Chair, Divisional Director, Head of Nursing & Quality & Safety Manager

Divisional Boards	Divisional Clinical Governance Leads	Service level governance staff forums- and team leaders

(All staff) Daily Site safety Huddles & twice weekly Quality Huddles

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East and North Hertfordshire NHS Trust

Agenda Item: 9.1

TRUST BOARD - PUBLIC SESSION – 1 MAY 2019
TALENT MANAGEMENT AND DEVELOPMENT

Purpose of report and executive summary (250 words max):

The Trust's new Vision and Strategy has 'People' as one of its top priorities. It has a strong history of supporting its most talented staff with a range of development programmes.

This paper summarises the Trust's involvement in Talent Management and development at national, regional and local level. We are actively involved in a number of programmes and have an ambition to excel in this area by developing an even more structured approach in 2019/20. This will start with an internal diagnostic which will be used to develop a more comprehensive Talent Management Strategy. In the meantime this paper sets out progress to date.

Action required: For discussion

Previously considered by:
Executive Team
Finance and Performance Committee on 24 April 2019

Director:	**Presented by:**	**Author:**
Interim Chief People Officer	Interim Chief People Officer	Interim Chief People Officer

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☐
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☐
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☐

Does the issue relate to a risk recorded on the Board Assurance Framework? YES

1. There is a risk that the trust is unable to recruit and retain sufficient supply of staff with the right skills to meet the demand for services

2. There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered and motivated, impacting on the trust's ability to deliver the required improvements and transformation and to enable people to feel proud to work here.

Any other risk issues (quality, safety, financial, HR, legal, equality):

Proud to deliver high-quality, compassionate care to our community

TALENT MANAGEMENT AND DEVELOPMENT

1. Purpose of the Paper

The purpose of this paper is to update the Trust Board on the Trust's approach to Talent Management and Development, and to invite agreement to the additional strategic priorities for 2019/20 after which an implementation plan will be developed.

2. Background and Strategic Intent

The Trust has a strong history of supporting its most talented staff with a range of development programmes. The Chief Executive chairs the Regional Talent Board and plays an active part in replicating this good practice locally. The Trust and the region have a wide range of programmes for developing talent at all levels. The Trust's approach complements the regional approach, and covers the whole organisation. It starts from the fundamental belief that the organisation is full of talented and exceptional people whose talent the Trust wants to recognise and nurture. The approach is across all professions and levels in the organisation.

The Trust's new Vision and Strategy has 'People' as one of its top priorities. This is articulated as a vision in which "We create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce." The development of strong leaders at all levels should help us to achieve this.

A new lead for Talent Management has been recruited as part of the Workforce and OD team and will focus on a range of initiatives from supporting the national and regional talent management approaches and development programmes, through to support for operational managers and ward leaders and the development of internal talent pools.

In the meantime, this paper summarises the work to date and highlights the longer term strategic intent, which will include a plan to build Diversity and Inclusion in to our Talent Management approaches.

3. National Programmes

3.1 National Leadership Academy programmes

The Trust actively supports the national programmes which have been developed by the NHS Leadership Academy. A summary of these is at Appendix 1. The Mary Seacole programme, for example, is highlighted through the Trust's local Leadership, Management and Coaching Development Pathway (LMCPD), and one of our Divisional Chairs has been accepted recently on the Nye Bevan programme.

3.2 Graduate Management Training Scheme (GMTS)

The NHS GMTS is a national scheme with an annual intake of graduates with the aim of developing them for successful careers in healthcare. The scheme has been running since 1956 and a number of alumni have become Chief Executives. The majority of trainees have little or no NHS work experience when they start and they typically experience placements which give them both operational and strategic opportunities. This year the scheme is expanding considerably and expects to have 500 trainees in place by September 2019. Previously trainees were funded centrally, but in order to support the expansion, the model will now be co-funded with the costs being shared between the NHS Leadership Academy and host organisations. The cost to the Trust of hosting a trainee from September 2019 will be approximately £12,000 p.a. (for 2 years), per trainee. This year, partnership/collaborative bids were encouraged across STPs/ICSs

In March, NHS organisations were invited to bid to host trainees and this Trust decided to make the most of the opportunity and applies for five places, including a joint bid with Princess Alexandra Hospital NHS Trust for a further two. By 3 May the Trust is expected to complete a more detailed statement of bid particulars including details of the programme and placement manager, placement details and support available to trainees. Bids are reviewed by the Local Leadership Academy (LLA) and organisations interested in offering a trainee placement will be expected to demonstrate that they have the capacity and commitment to support trainees. Programme and Placement Managers will be required to attend mandatory training and local scheme activities

3.3 Health Education England (HEE) sponsored- Advanced Clinical Practice (ACP) and Physician Associate (PA) roles

The Trust is supporting a robust strategy to offer Advanced Nursing and the Physician Associate role to enable the development of talented people to progress their careers. These roles also provide improved continuity of care which is evidenced through patient compliments and feedback, and helping to maintain flow across the Hospital. Funding continues from HEE for the Advanced Clinical Practice (ACP) Master's Degree course. In the Trust 3 ACPs completed their course in 2018, 3 more will complete in 2019, with a further 3 undertaking the course in ED and 2 in Cancer. The qualified role supports a career pathway for experienced Clinicians which include nurses and paramedics. The ACP Masters pathway in the future will be funded by the Apprenticeship Levy.

The Trust will also progress the number of Physician Associate roles, with 20 students presently undertaking the M.Sc. credentialing at the Lister site. The PA role is attracting passionate and skilled science graduates and could be viewed as an important vehicle to attract talent into the NHS. PAs have impressed those who have worked with and supervised them. Improve learning and development opportunities for other staff. The research suggests that PAs can contribute to the development of other staff members – both by directly teaching and instructing but also by providing a service presence to free up medical trainees' time for educational activities. Funding for 2019-20 year is being proposed by the Regional HEE team, and will share PAs across primary and tertiary care platforms.

4 Regional Talent Programmes

4.1 Aspire Together Programme

'Aspire together' is part of the Regional Talent Board's (RTB) strategy for identifying future people for senior leadership appointments and the Midlands and East RTB is chaired by the Trust's CEO, Nick Carver. 'Aspire Together' helps to deliver compassionate, inclusive leadership, which is key to a high quality and sustainable health and care system. The objectives for the strategy include the development of a talent pool for future leadership roles, minimizing the reliance on external resourcing organisations. Through the development of robust data, improvements will be made to balance demand (immediate and predicted vacancies) and supply people who are available and ready to fill the post.

4.2 Accelerated Directors Development Scheme (ADDS)

ADDS is the regional development scheme for aspiring executives who have the motivation and potential to become a director in the next 9-36 months. The programme is targeted at all eligible senior leaders at band 8C (and equivalent) and above, and those working one below board level. In 2018 the Trust had one successful candidate on the programme, the current Divisional Director for Surgery, Women's and Children's services. The Medical Director was also a former participant.

This year's process to assess and select those who are interested in joining the programme was launched on 15 April, and for the first time self-nominations are invited as well as nominations from line managers. The aim of the self-nominations process is to improve the diversity profile of the participants. The flyer about the scheme, which will be for the fourth cohort, is attached at Appendix 2. The assessment and development process is being led by Korn Ferry and the

programme itself is designed by TPC Leadership. Each organisation can nominate up to three nominees who are considered against the Executive Director Success Profile, a high level overview of which is at Appendix 3.

The Executive Team will carry out a talent mapping exercise in early May with a view to identifying those nominees who will go forward to the regional assessment and development centre on 3 June. Successful participants then take part in 3 x 2 day residential events focused on group development, relationship building, personal leadership development needs, and systems leadership. Participants are encouraged to learn the director role through secondment and acting up opportunities and other experiential learning opportunities. Coaching and mentoring form part of the programme which runs from September 2019 to July 2020.

5 Local Talent Programmes

5.1 Leadership, Management and Coaching Development Pathway (LMCPD)

This in-house programme covers some core management skills for senior leaders and wider teams, including aspiring leader, leadership awareness, appraisal and feedback, as well as building and developing teams, and a new programme called 'Compassionate Service' which replaces previous customer service modules. The summary of the programmes currently available is at Appendix 4. The reach of these programmes is extensive, with over 700 people taking part in one of the programmes last year.

Part of this is the quarterly LEND programme based on the Trust's leadership behaviours: Listen, Empower, Nurture and Develop. The quarterly leadership LEND fora, based on these principles offer the following opportunities:

- An opportunity to meet and network with others
- An opportunity to hear from the CEO on the position and ambition of the organisation
- An educational opportunity as we share some leadership practice and techniques
- A revalidation opportunity as we produce attendance certificates for each event
- A time out opportunity to reflect from a different perspective on activity and work
- An opportunity to be supportive, connect with colleagues and have a little fun.

The current round of LEND events are an opportunity to discuss the Trust's new Vision and Strategy, as well as the staff survey results.

5.2 Development of Clinical Leaders

As part of the Trust's plan to re-structure the operational divisions, it is recognised that there is a need to develop its clinical leadership. To date, much of this type of development has been ad hoc, or through the ADDS programme, but there has not always been central oversight of some of the more ad hoc development programmes and it is not therefore clear whether the Trust and individuals have benefitted from those programmes in the most effective way.

We are currently therefore exploring the options available to us if we were to adopt a consistent and coherent to the development of our clinical leaders, for example by using a nationally recognised programme, such as those offered by the Kings Fund, and other local providers such as Cambridge University Health Partners (CUHP). The CUHP programme for 2019/20 is attached at Appendix 5. Nominations for the Learning to Lead Programme are now open, with a closing date of 29 April, but CUHP have indicated a willingness to work with the Trust to develop something more tailored to our own needs, aligned with the operational re-structure. The existing CUHP programme is aimed at consultant staff in their first 5 years of practice and senior non-medical leaders at Band 8A and above.

5.3 Apprenticeships

As well as developing senior leaders, the Trust also has a strong track record in developing talented people at other stages in their career, for example through apprenticeships. As can be seen from the annual education report for 2018/19 (presented to FPC on 24 April, alongside this

paper), the Trust has over 200 apprentices from Level 2 to Level 7 and makes good use of its £1.6m apprenticeship levy.

5.4 STP Approach to Talent Management

The Trust is also working with colleagues across the STP on the development of a Hertfordshire and West Essex Talent Academy, which will support the system to attract recruit and retain staff. A Leadership Academy is also planned to develop greater system leadership capacity and capability at all levels within the system. The STP plan includes the establishment of baselines from which the impact of talent management can be measured and to identify key performance indicators which can be used to measure progress and impact relating to talent management priorities and objectives. A range of methods will be used to regularly evaluate and gather feedback on talent management practices across the Trust to share best practice and highlight areas for improvement.

6 Talent Management Strategy

6.3 Talent Management Diagnostic

The Trust already has a sound approach to talent management and now wishes to move this to an even stronger position. A new Talent Management Lead has been recruited who will focus on a range of initiatives from supporting the national and regional talent management approaches and development programmes described in this paper, through to support for operational managers and ward leaders and the development of internal talent pools.

One of the early tasks for the Talent Management Lead will be to make an assessment of the Trust's position on Talent Management using a diagnostic tool which has been developed by the NHS Leadership Academy. This will be launched nationally later this year, and in the meantime, a small number of organisations per region will be trialling this. Whilst the Trust is not formally part of the 'early adopter' trial, we will use the principles behind this framework to self-assess where we are, with a view to the diagnostic then informing a longer term Talent Management Strategy which builds on our existing good practice.

The 'Talent Management Maturity Diagnostic Tool' is designed to diagnose areas of good practice in talent management and areas to improve at organisational level, and has been piloted in 12 organisations. An online diagnostic will be available later this year. Using the tool, Trusts will assess where they are in relation to the following:

- Enabling a culture of talent management
- Inclusively appreciating our people
- Identifying, managing and retaining talent
- Developing and mobilising talent
- Connecting to our local health and care system

An important enabler to the Talent management approach will be the redesign of a new appraisal system which in addition to a review of performance and future objectives, links to development plans, inputs into learning provision and be available digitally.

6.2 Building Diversity and Inclusion into Talent Management

This is an area in which the Trust is aiming to excel. The Midlands and East Regional Talent Board has developed a draft document suggesting ten high impact actions for inclusive talent management. These were developed with the input of diversity and inclusion advisors with the aim of supporting NHS organisations to increase the diversity of their workforce, particularly at senior level. Once finalised, these actions will be disseminated to all organisations in the region for implementation. The current draft lists the following actions, and it is proposed that ENHT develops a plan to implement these in advance of the formal launch:

- Be clear about, and then disseminate, a clear "business case" explaining why diversity and inclusion need to be central to successful talent management in your context.

- Ensure recruiters have a consistent idea of what ‘potential’ means in the search for candidates taking on senior roles in the NHS
- Explain the need for positive action
- Use data and careful listening to monitor and challenge progress
- Set targets
- Check you assumptions and data about ‘talent’ and ‘development’ for bias and act accordingly
- Understand the multiple and often subtle ways in which bias affects every stage of recruitment and development despite best intentions
- Give forthright and frequent feedback at every stage of recruitment and development reflecting on minimising bias
- Role model inclusive leader behaviours throughout development and recruitment and after appointment
- Get comfortable with being uncomfortable.

As part of this it is suggested that all members of the Board should take part in unconscious bias training.

Conclusion and Recommendations

The Committee is asked to note and endorse the current programme of work and to agree the additional, new priorities for 19/20 as follows:

- Completion of a Talent Management Diagnostic in advance of the national launch
- Development of a more structured approach to Talent Management through a new Talent Management Strategy
- Development of an implementation plan to build diversity and inclusion into talent management
- Clinical leadership development programme to be designed and to start in October 2019
- ADDS – the Executive to complete a talent mapping exercise to identify nominees for the regional assessment exercise by May 2019
- To scope the transformation of a new appraisal system to link with talent mapping, development plans and to be available digitally for completion by people by October 2019.

Subject to Board agreement of these priorities a plan will now be developed and presented to the FPC.

Susan Young
Interim Chief People Officer

Programmes 2019

NHS Leadership Academy

	EDWARD JENNER PROGRAMME	MARY SEACOLE PROGRAMME	ROSALIND FRANKLIN PROGRAMME	ELIZABETH GARRETT ANDERSON PROGRAMME	NYE BEVAN PROGRAMME	STEPPING UP PROGRAMME	READY NOW PROGRAMME	CHIEF EXECUTIVE DEVELOPMENT NETWORK
Who is it for?	Anyone who is interested in healthcare leadership	Those in their first leadership role	Mid level clinical or non-clinical leaders aspiring to lead large and complex programmes, departments,services or systems of care	Mid to senior clinical or non-clinical leaders aspiring to lead large and complex programmes, departments, services or systems of care	Those newly in or aspiring to be in an executive director role	Black, Asian or minority ethnic (BAME) colleagues working in bands 5 to 7	Black, Asian or minority ethnic (BAME) leaders working in bands 8a or above	Leaders at chief executive level in an NHS accountable role, focused on both service provision and system development
Duration	6 weeks (not time limited)	6 months	9 months	24 months	12 months	2 to 3 months	12 months	Ongoing
Time commitment	Recommended 5 hours of self-led work per week	5 hours per week self-led 3 out of office days split over 3 workshops	Minimum 4 to 5 hours per week 8 out of office days	Minimum 15 hours per week 22 out of office days including 4 residentials	Minimum 10 hours per week 17 out of office days including 4 residentials	4 to 5 out of office days split over 2 to 3 residentials depending on banding	12 out of office days split over 5 residentials	Flexible and driven by individual needs including: • quarterly 2 day development days • up to 4 additional sessions per annum
Learning methods	• Online • Work based application	• Online • Face-to-face workshops in regions • Work based application	• Online • Face-to-face workshops • Facilitated learning sets	• Online • Face-to-face residentials in Leeds • Self-managed learning sets • Work based application	• Online • Face-to-face residentials in Leeds • Self-managed learning sets • Work based application	• Face-to-face residentials in Leeds and London • Self-directed learning • Work based application	• Face-to-face residentials in Leeds • Self-directed learning • Work based application	• Face-to-face residentials in Leeds and London • Online virtual campus for learning and information • One-to-one sessions with a development coach
Awards	NHS Leadership Academy Award in Leadership Foundations	NHS Leadership Academy Award in Healthcare Leadership	NHS Leadership Academy Award in Senior Healthcare Leadership	NHS Leadership Academy Award in Senior Healthcare Leadership MSc in Healthcare Leadership	NHS Leadership Academy Award in Executive Healthcare Leadership	Certification of dedication and recognition	Certification of dedication and recognition	Not applicable
Cost	**Free**	**£995**	**£1,200**	**£6,000**	**£4,500**	**Fully funded**	**Fully funded**	**£5,000 per annum**
Bursary availability	Our bursary scheme supports talented individuals from under-represented groups across leadership levels who, without financial help, would miss out on the opportunity to access our excellent leadership development programmes. For information on eligibility, and whether a bursary is available for your chosen programme, please check the 'Key information' section on the specific programme page on our website.							

@NHSLeadershipAcademy @NHSLeadership NHS Leadership Academy

For more information, please visit
www.leadershipacademy.nhs.uk
or call 0113 322 5699

Health Education East of England
Hertfordshire, West Essex and BLMK

Accelerated Director Development Scheme (ADDS)

A unique development scheme for aspiring executive directors in Hertfordshire, West Essex, Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care System.

Developing people for health and healthcare

What's the scheme?

- A high-quality personalised leadership development scheme for aspirant directors from clinical, corporate and operational backgrounds in health and social care who aspire to become an Executive Director
- A Chief Executive sponsored scheme that will identify and develop high potential leaders for Hertfordshire, West Essex and BLMK ICS who can go on to fill key executive director roles within 9-36 months
- Co-designed, owned and delivered through a CEO/AO led talent forum through which members will sponsor and retain oversight of high potential participants

What's the development?

- An assessment and develop process in **June 2019** to identify strengths and areas for development
- A 12 month aspirant director development programme launching in **July 2019**
- A focus on system leadership with a mix of formal masterclasses and practical system wide work-based learning
- Working on 'real' system wide issues through Impact Groups with peers, projects and /or secondments
- Access to Executive Coaching
- Access to CEO-AO Mentoring

What's different about this scheme?

- Automatic shortlisting when ready for appropriate Executive Director roles linking development and job opportunity
- Ownership of the development scheme by the partner CEOs and AOs
- High visibility amongst CEOs and AOs across Hertfordshire, West Essex and BLMK ICS
- Opportunities to network and build relationships with other high potential individuals across the system

Eligibility and nomination

- Band 8c and above or equivalent; working one below board
- Self- nomination or nominated by line manager, sponsored by CEO/AO
- **Stage 1:** internal nomination process and sponsorship by CEO/AO
- **Stage 2:** undertake assessment/development process
- **Stage 3:** feedback and a personal development plan for all candidates
- **Stage 4:** if deemed 'ready' access to the scheme if deemed not yet ready internal support and development
- Nominations from clinicians are encouraged
- We are particularly keen to receive nominations from BME staff

Interested? **We encourage you to: read the nomination briefing pack, discuss ADDS with your line manager, CEO, AO, HRD or senior leader of your choice, complete and return your nomination form to your CEO/AO/HRD by 1st May. Your CEO/AO will inform you of the outcome of your nomination by 10th May 2019. Sponsored nominees will be invited to undertake the assessment and development process. For further information please contact the ADDS team via adds.enh-tr@nhs.net**

Aspire Together.

NHS Leadership Academy

Executive Director Success Profile

Competencies

The high performing Executive Directors of today are supported by the following competencies …

- Drives for better outcomes
- Takes people with them
- Speaks up
- Brings compassion and humility
- Brings a learning mindset

The high performing Executive Directors of tomorrow will be supported by the following competencies….

- Acts from a system's mindset
- Finds new solutions
- Develops people
- Creates a culture of inclusion

Experiences

- Driving change and delivering tangible results
- Engaging external stakeholders
- Engaging clinicians
- Cross-boundary working
- Managed budgets
- Managing poor performance
- Leading leaders and engaging the workforce
- Building a more inclusive and compassionate culture

Traits

The high performing Executive Directors of today are supported by the following traits …

- Decisive and action orientated
- Influence
- Flexible

The high performing Executive Directors of tomorrow will be supported by the following traits….

- Supportive and consultative
- Creative problem solvers
- Resilient

Drivers

- Demonstrates an understanding of what the role entails in terms of responsibility, risk and impact.
- Expresses a desire to learn, grow, do interesting work, and stretch oneself.
- Sense of purpose beyond self

Whilst this represents what good looks like for Executive Directors, it is not expected that anyone will have a strength on every aspect of the Success Profile. We understand that we need different styles and types of leadership.

ENHT Faculty of Leadership Development

Our people supporting the development of our current and future leaders


Rachael Corser


Phillip Smith


Jon Bramall


Julia Seez


Ellen Schroder


Steve Andrews


Michael Chilvers


Fariba Oak


Nick Carver


Jagdeep Kudhail


Jo Barks


Tom Pounds


Palmer Winstanley


Urvina Shah


David Brewer


Steven Povey


Jacqui Evans


Takura Chiketa


Alex Stocker


Eve Malcolm


Anne Black


Karen Heng


Georgina Fenwick-Morris


Keeley Cooper


David Leigh


Denise Edwards


Hayley Bradley

For queries and bookings, please contact:
odtraining.enh-tr@nhs.net

For information on the MCD Pathway please contact: julia.seez@nhs.net

CPD MEMBER The CPD Certification Service

NHS East and North Hertfordshire NHS Trust

Listen
Empower
Nurture
Develop

Leadership, Management and Coaching Development Pathway

2019 Edition

For aspiring, new and experienced leaders from all staff groups



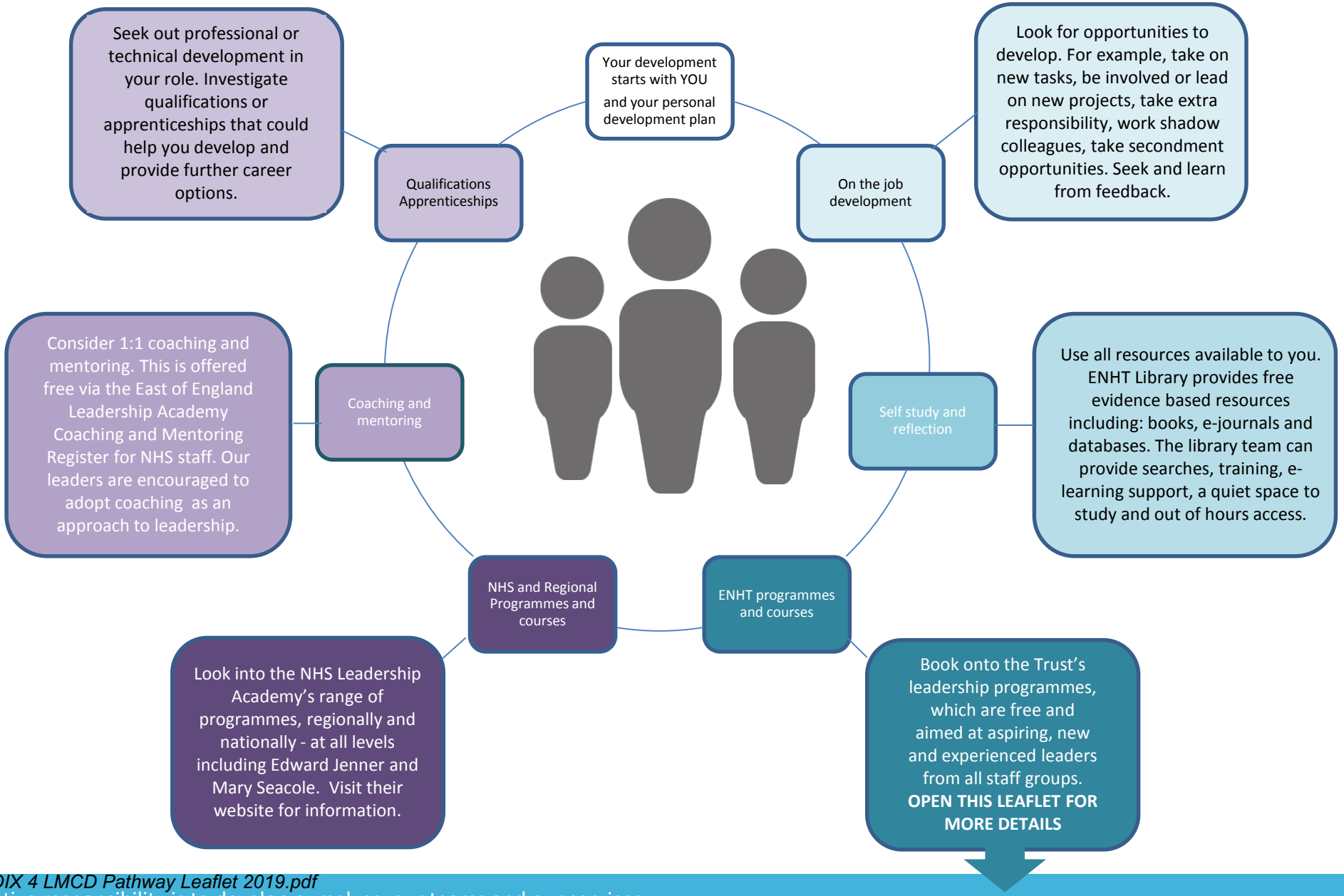






Photographs from the Trust's Celebration of Excellence Awards 2018

Developing YOU
Developing your TEAM
Developing TALENT in our organisation
To deliver high quality and compassionate care



ENHT Leadership, Management and Coaching Development PATHWAY (LMCDP) – developing effective and compassionate leaders

Are you currently in a non leadership role, aspiring to become a leader in the future?

Core programmes	Suggested level and role	Programme overview	Specific subjects covered	CPD
Aspiring Leaders	Staff who wish to explore furthering their career along management/supervision (suggested bands up to 5)	1 day introductory workshop that explores and examines the definition and purpose of leadership, its characteristics, skills & behaviour	Leadership behaviour, managing the workplace politics, analysis of levels/styles of leadership, change management, communication, leadership In the NHS and emotional intelligence	8 points

Are you currently in a supervisory role or looking to develop your first time leadership skills?

Core programmes	Suggested level and role	Programme overview	Specific subjects covered	CPD
Effective Supervisor Programme	Current team supervisors, or those at the entry point to a supervisory role (suggested bands 3-5)	3 day programme covering essential knowledge and skills required in order to effectively meet and fulfil the responsibilities and challenges of the role. Participants are required to attend on all 3 days.	Understanding and analysing stages of team development, communication style, principles of assertiveness, effective delegation, introduction to coaching, time management, emotional intelligence, principles of motivation, effective team briefs , presentation skills, understanding and managing change, diversity and inclusion, health and safety	24 points

Are you in a team leader role responsible for a team or department?

Core programmes	Suggested level and role	Programme overview	Specific subjects covered	CPD
Effective Manager Programme Module 1 - Core Skills	Leaders who manage and lead a team/department (managers, team leaders, experienced band 5 and essential for band 6/7, doctors and above)	2 day programme covering core management skills	The role of an NHS leader / manager; time management and delegation; emotional intelligence (MBTI) to develop your leadership skills; on the job coaching; developing effective teams; managing change; team communication and briefings	16 points
Effective Manager Programme Module 2 - Essential Knowledge		2 day programme covering essential workforce and finance knowledge	Effective and compassionate people management (ERAS and H@W); finance overview; importance of workforce informatics; effective rostering; workforce issues and team planning, diversity and inclusion	16 points
Effective Manager Programme Module 3 - Leadership in Practice		2 day programme providing an opportunity to question, learn from and engage with a range of senior leaders	Senior and executive leaders present their role, share experiences and their lessons learnt on leadership, including any models or advice with the opportunity for questions and answers	16 points
Effective Manager Programme Module 4 - Reflective Practice		1 day programme to build on reflective and learning tools/skills for both self and service development	Reflective models and skills, how perceptions shape ourselves, understanding others perspectives in order to develop services, learn from workplace episodes or events	8 points
Leadership Awareness – You and Your Leadership Approach		2 day programme that explores and raises awareness of the concept and challenges of leadership	Interactive and thought provoking, exploring personal ideas of leadership as well as practical techniques – create a career long interest in developing your leadership capacity	16 points
Coaching as an Approach to Leadership		2 day programme introducing the concepts and practice of coaching	To support the establishment of a coaching culture as a leadership approach. A practical & experiential programme using relevant models/concepts to support learning	16 points

Are you in an experienced team leader role responsible for a department or service or need specific leadership skills for your role?

Core PLUS programmes	Suggested level and role	Programme overview	Specific subjects covered	CPD
Essential Skills for Effective Projects	Experienced leaders who lead teams and service development (experienced organisational leaders and managers, experienced band 6 and essential for band 7/8/consultants and above)	2 day programme that will enable you to set clear expectations of the role leadership plays in guiding a project to success	The programme will develop project initiation skills, milestone setting, performance indicators, cost improvements, risk and factors to project success or failure	16 points
Quality and Service Improvement		2 day programme that will provide an understanding of the concept of quality and service improvement	Allow you to develop the practical skills and techniques that will help you and your team make either one off or continual service improvements	16 points
Building Agile and Effective Teams		2 day programme that will explore how you build and sustain an effective team	It will also examine the role of the leader in supporting dysfunctional as well as creating high performance teams	16 points
Accelerated Director Development Scheme (ADDS)	Aspirant directors who are 1 below Board level, CEO nominated (Band 8c and above, Divisional Directors/Chairs)	Assessment and Development Centre; 12 month programme to move up to Board level; CEO mentoring; executive coaching.	Preparing for a Board role, governance and accountability; compassionate leadership; focus on results; system leadership and building networks and relationships; diversity and inclusion; influencing and motivating; dealing with conflict	
Aspire Together	Those ready for an Executive Director role within 6 months; CEO and self-nomination routes	Under take the Aspire Together Gateway assessment process to assess readiness to be an Executive Director.	Development Feedback. Those identified as ready for an Executive Director gain access to the Midlands and East Aspirant Director Talent Pool and receive career coaching.	

ALL leaders should attend the following programmes, where applicable

Core ALL LEADERS programmes	Suggested level and role	Programme overview	Specific subjects covered	CPD
LEND Leadership forum sessions	All leaders (suggested band 5 and above)	2 hours, four times a year. Organisational update and leadership challenges and theory	Subject topic will vary each session – includes an update from the Chief Executive and a leadership development session	
Appraisal Skills for Managers	All leaders who manage the performance of others under Agenda for Change	Half day session	Essential skills of an appraiser, pay progression, appraisal documentation, assessment of PIVOT values, Trust 's vision & strategy, feedback skills, dealing with poor performance, formulation of objectives and personal development plan	4 points
Recruitment and Selection Skills	All leaders who are responsible for recruitment of staff	1 day programme	Gain knowledge in how to successfully recruit, understand the legal aspects, best practice and other considerations of all stages of the recruitment & selection process	8 points

NEW FOR 2019 - Additional programmes, workshops, masterclasses or bespoke training	
Compassionate service (all front line staff); Being in Better Contact; Developing Your Real Team ; Human Factors	More details to follow in 2019

All programme details can be found on the Leadership, Management and Coaching Development Pathway Knowledge Centre page or email odtraining.enh-tr@nhs.net for more information

Our programmes are delivered by the ENHT Faculty of Leadership Development and are free to all ENHT staff, places are also offered to the Sustainability and Transformation Partnership (STP)

Postgraduate Medical Centre
Postgraduate Education

CAMBRIDGE UNIVERSITY Health Partners
Knowledge-based healthcare

Senior Leadership Development Opportunities 2019-2020

	Learning to Lead	Leading for Excellence
Proposed target audience	Consultant staff and GPs in their first 5 years of practice and senior non-medical leaders (Band 8A and above)	Aspiring Clinical Directors, Directors of GP partnerships/Networks and non-medical leaders (Band 8B and above)
Programme overview	This programme will support participants to become effective healthcare leaders in a rapidly changing and challenging environment	This programme will enable senior clinical leaders to deliver high quality, safe and compassionate care whilst balancing a complex range of strategic, operational and clinical responsibilities
Faculty	Local and system leaders, The Judge Business School	National and local leaders, King's Fund, The Judge Business School
Venue	Doubletree by Hilton, Cambridge Belfry, Cambourne, Cambridgeshire	Madingley Hall, Cambridge
Days	9 days: 1 per month June 2019 to January 2020, and Celebration Event March 2020	9 days: 1 per month September 2019 to May 2020
Cost	£1900.00	£5000.00
Discount	CUHP members will receive discounted prices; any organisation supporting 5 or more delegates will receive discounted prices for each.	
Recruitment process	Interviews in April 2019	Nomination by employing Trust
Programme Lead	Dr Arun Gupta, Consultant in Anaesthesia and Neuro-Critical Care and Director of Postgraduate Education, Cambridge University Health Partners, Academic Health Science Centre	
Clinical Director	Dr Clive Lewis, Consultant Cardiologist, Deputy Medical Director, Director of Medical Education and Lead Appraiser, Royal Papworth Hospital	Dr Stephen Webb, Consultant in Anaesthesia and Intensive Care, Associate Medical Director and Lead Clinician for Clinical Governance, Royal Papworth Hospital
Programme Director	Chris Wilkinson	

For general expressions of interest please contact Emma Shone: es351@medschl.cam.ac.uk

For programme enquiries please contact Chris Wilkinson: chrisrwilkinson@sky.com

East and North Hertfordshire NHS Trust

Agenda Item: 10.1

TRUST BOARD - PUBLIC SESSION – 1 MAY 2019
Integrated Performance Report – Month 12

Purpose of report and executive summary (250 words max): The purpose of the report is to present the Integrated Performance Report Month 12 to the Trust Board. Key challenges and mitigations under each domain are identified within the report.		
Action required: For discussion		
Previously considered by: Executive Committee - 18 April, Quality and Safety Committee – 23 April, Finance and Performance Committee – 24 April.		
Director: All Directors	**Presented by:** All Directors	**Author:** All Directors / Head of Information and Business Intelligence

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

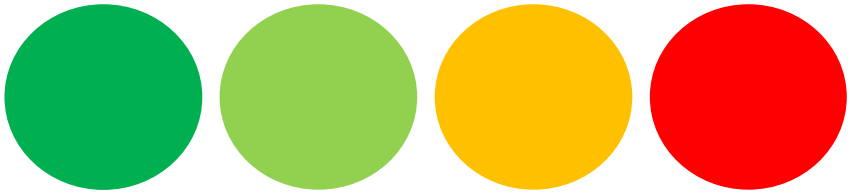
Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
Any other risk issues (quality, safety, financial, HR, legal, equality): Key challenges and mitigations under each domain are identified within the report.

Proud to deliver high-quality, compassionate care to our community

East and North Hertfordshire NHS Trust

Integrated Performance Report

Month 12 | 2018-19



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Performance Headlines

East and North Hertfordshire NHS Trust

Domain	Positive Performance	Challenges	Lead Director
Safe & Caring Services	**Quality learning event** 21st June 2019; all-day event - LEC, RHD slots, internal and external speakers Serious Incident Management RCA training for all staff is being designed and will be tested in April, go live May 2019. Duty of Candour drop in session currently being designed. Testing of new 'daily review of moderate harms underway' in medical division. **Improvement initiatives** Harm Free Care panel continue to measure baseline data and prioritise clinical areas for including Break Through Series. Time line pending QI team recruitment. **'Safer Surgery Collaborative'** Weekly meeting now occurring. Polices being reviewed. NatSSIP policy in Draft. Early stages of designing 'ENHT Human Factors College', plans underway for 'Surgical Team training' at start of lists. **Improving the Quality of Response to Complaints** Engagement with surgical division good. Divisional processes changing to improve timeliness of responses. **Improving IPC** Baseline data being collected for CAUTI improvement work. Ongoing handwashing & environmental audits continue.	**Dashboard data quality** Work in progress to get the data quality correct. Timely process and quality control/checking required. Current dashboard on version 3 with patient safety data. Measurement plans ready for testing next include Falls, Pressure Ulcers, Risk Register and Nursing Indicators. **Nerve Centre** Discussions underway to ascertain capability of organisational access to reliability of EObs activity. This will be crucial in the processes measurement of improving deteriorating patients; and achieving Falls CQUIN 2019/20. **Outstanding backlog incident management processes** Grouping of divisional RCA investigations underway. DOC data quality work continues. **Sepsis** Significant delays occurred to achieve NEWS 2.0 upgrade. Testing is underway to use new Nerve Centre app. Plan go live NEWS 2 23/4/29. Face to Face training occurring with CCOT. Plan to collate CQUIN data Q4 2018/19 in Q1 2019/20. **Recruitment to QI team** This is currently on QTP Risk register. Post have been matched but not yet approved for advert. Nursing CIpos have now been agreed. The pace and scale of QI work reflects the timeliness of recruitment.	 **Rachael Corser** **Director of Nursing**
Effective Services	**Mortality** Mortality rates have improved over the last 5 years as measured by both of the major methods: HSMR and SHMI **Hospital Standardised Mortality ratio (HSMR)** This measure is based on a basket of 56 patient groups with relatively predictable mortality and records death in hospital. Performance has been persistently in the 'as expected range'. There was a predictable, unsustained increase in HSMR following the introduction of the Lorenzo system in September 2017. This is a pattern commonly seen after the introduction of any PAS and is thought to be related to changes in depth of coding and, hence, predicted mortality. HSMR remained in the 'as expected' range during this period. The latest HSMR for the rolling 12 months to December 2018 is 93.0. 'Better than expected'. HSMR is generally available 3/12 in arrears. **Summary Hospital-level Mortality Indicator (SHMI)** This is a measure of mortality for all inpatients including up to 30-days post-discharge. Historically, ENHT's SHMI has been up to 10 points higher than the HSMR, which is thought to be related to the onsite hospice at Mount Vernon (a relatively unusual arrangement nationally). However, over the last 2 years the gap between SHMI and HSMR has reduced to the order of 7 points. Although a similar (to HSMR) increase in SHMI was seen post-Lorenzo launch, it too remained in the 'as expected' range. The latest SHMI for the rolling 12-months to September 2018 is 99.9. 'As expected'. SHMI is generally available 6/12 in arrears. **Crude mortality** This measure is available the day after the month end and has demonstrated a consistent decrease over the last 5 years. It is the factor with the most significant impact on HSMR. The improvements in mortality have been as a result of a combination of corporate level initiatives such as the Mortality review process and more directed areas of improvement such as the identification and early treatment of patients with sepsis, stroke, etc.	**Mortality** Mortality can be considered a proxy measurement of the overall care delivered to patients. Timely, high quality care, delivered by motivated, well-trained and caring staff results in better outcomes including reduced adverse events, complications and deaths. Although overall Trust mortality is within the 'as expected (SHMI) or better than expected' (HSMR) range, there are subgroups of patients where mortality is raised. A recent example of this would be in patients with sepsis, where high HSMR/SHMI resulted in a CQC alert in the Spring of 2018 as the Trust was a marked outlier for sepsis mortality. Continued, targeted work by the sepsis team as well as staff from ED and other areas of the Trust including Coding has resulted in a marked improvement back to an HSMR of 67.27 'better than expected'. There will always be groups of patients with higher mortality levels and the Mortality Surveillance Group monitors our data and after confirming whether the issue is real (via coding review) instigates a review of the patient pathway and a retrospective review of a sample of the affected patients to identify where changes to the pathway may be beneficial. We also work closely with Dr Foster to identify areas with a true rise in mortality where concentration of resources in reviewing coding and clinical pathways is likely to benefit future patients. **7 Day Services** The delivery of consistently high quality care to patients across the entire week has been a challenge for the Trust. There is currently a difference in mortality between weekend/weekday emergency admissions. Recent months have seen improvements in both with HSMR for weekday admission now 'better than expected' and for weekends 'as expected'. Consultant review within 14 hrs of emergency admission is lower at the weekend and an area where we need to improve our performance. A new post of Associate Medical Director for Reduction in Unwarranted Variation has been advertised with a portfolio to include consistent provision of services across the whole week. This new role is a result of the Trust's decision in 2018 to invest in an expanded Quality & Safety Team.	 **Michael Chilvers** **Medical Director**

Performance Headlines

East and North Hertfordshire NHS Trust

Domain	Positive Performance	Challenges	Lead Director
Responsive Services	**ED Performance** The Trust ED performance in March was at 81.00%, a slight improvement noted on the March 2018 position at 80%. Positively, the trust continues to report zero 12-hour trolley breaches. **Cancer Waiting Times** The trust delivered four compliant national cancer targets in February, to include; 2ww and 2ww breast, 31-day subsequent drug treatments and radiotherapy. In February 2019 the 31-day first definitive treatment was 95.1%; below the national target of 96%, which equates to 196 out of 206 pathways meeting the target, with ten breaches. Eight out of nine tumour sites met the target and excluding Urology the Trust would have achieved 100% against this standard. At the time of writing March is forecasting a return to five compliant standards. The Trust 62-day performance for February 2019 was 71.8 % pre-breach sharing and 75.4% post breach sharing, which is above the revised trajectory of 74.6%. **RTT** March's RTT performance was 90.56%. Demonstrating sustained improvement on the previous month's position. This is against the national position at around 87%. 52-week breaches – Month-end position was two 52-week breaches. Long waiters are being effectively managed with the only risk of patients becoming 52-week breaches due to 'tip-ins' or patient choice. This should be significantly reduced as a result of the launch of the new access plans through stabilisation. Going forward April is forecasting a zero month-end 52-week breach position. **Diagnostics** The March reported position for DM01 is 1.34% against the national mandated standard of 1%. This is a slight deterioration from the previous month position, but is due to an emerging cardiology issue that has come to light, whereby patients were being added to a pending access plan. This error has now been rectified. There are no concerns that this issue will re occur. The 2019-20 activity plan demonstrates a compliant position from the end of Q1. No concerns are being flagged regarding the trust ability to meet this target trajectory. **Stroke** Total stroke performance for February was 72.1%. This represents a 12.1% improvement on March 2018 position. The 4-hour target taking into account the exclusion of the inter-hospital transfer and inpatient stroke in March 2019 was 75.4% – compared to March 2018 of 62.9% – demonstrating an improvement of 12.5% compared to last year's performance. Work continues in expediting the stroke patient pathway, staff training and escalation of stroke bed capacity.	**ED performance** The trust ED 4-hour performance remains a challenge. Areas for priority are; maintaining capacity in assessment areas and minimising ambulance handover delays. The COO has met with the ambulance service and the CCG to review batching of ambulance arrivals. An audit will be undertaken to provide ambulance arrival and handover details to inform actions for improvement. A number of reset weeks have been agreed with system colleagues as regular occurring events for a system focus on flow, capacity and discharges. These will occur in end of June, end of September and early January. **Cancer Waiting Times** There are some positive aspects of cancer performance to report: • The 62-day performance at 75.4% is above the revised recovery trajectory. • In February 2019 the 28-day faster diagnosis performance was at 60%, this is the highest level of performance demonstrated to date. • The tumour site action plans will no longer be required to be discussed at the NHSE CRG meeting as the stakeholders are happy with the new process and the Trust internal governance arrangements. **Linac capacity** An emergency bid to replace LA1 has been submitted to STP for consideration for emergency capital funding with specialist commissioning and NHSI support. **Capacity and Flow** This remains a challenge for the organisation. There has been additional focus with the clinical, nursing and operational teams regarding the ownership of setting EDDs, ward processes and how the site office support and interact with the wards to identify, challenge and chase the discharges. There has been agreement to align the Ward Liaison Officers (WLO) more closely with the wards to create team working and renewed responsibility, but this remains a work in progress. At the time of writing the trust is approaching the 4 day Easter weekend and a significant amount of planning has taken place to ensure the trust is best placed to manage the prolonged period of out-of-hours period.	 **Julie Anne Smith Chief Operating Officer**

Performance Headlines

East and North Hertfordshire NHS Trust

Domain	Positive Performance	Challenges	Lead Director
Well-led Services	**Vacancy Rate** The vacancy rate continues to make improvements throughout the year and is now at 7.2% from a peak of 9% in August. Areas of significant improvement include Medical recruitment now and 3.7% and Clinical Support Workers at 12.2%. **Temporary Staffing** The agency ceiling target was achieved and ended the year under by £349k. The ratio of bank to agency staff is now 83% to 17% which is above the target of 78% bank and unfilled shifts were kept at a minimum. **Sickness** Sickness absence rates continue to be an outlier however month on month improvements have been made reducing the rate in month to 4.2% from a spike of 5.05% in December. More work is required to bring the Trust back to within the target range, this includes further support and influence managers to manage their sickness cases more robustly. **Turn-over** The Trust turn-over rate has dropped from a peak in August of 14.2% down to 13.29% and is lower than the turnover rates at the same point in 2018 (13.48%). Despite the people culture issues highlighted in the staff survey, the proactive work to support staff retention is indicating improvements are being made. A new strategy for further improvements is being developed for 19/20 but key areas of focus are flexible working, talent management and learning and development.	**Demand Management** Temporary staffing demand has been consistently high in quarter 4 and in increased again in March. The number of WTE utilised increased by 81 which was mainly an increase in bank staff. Analysis of the pay bill including controls on use of temporary staffing is being provided to the board in April. **Appraisals** Appraisal uptake rates have declined and are current at 82%. The Human Resources Business Partners have been working with divisional leadership teams to develop improvement plans and agree an improvement trajectory. QlikView reporting has been developed to demonstrate performance of all department and provides updates of staff outstanding appraisal. **Culture** The staff survey results were published on the 26th February. Scores for eight of the ten themes within the survey are worse than average and scores for five of the ten themes have deteriorated compared to last year. Divisional action plans have been developed supported by an over-arching action plan. Further consultation with staff is taking place to test and refine plans. The Trust cultural ambitions with be address with staff during the planned roadshow for the launch of the Trust-wide strategy.	**Susan Young** **Chief People Officer**

Performance Headlines

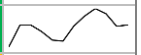
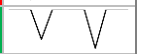
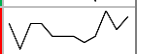
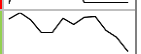
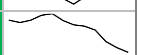
East and North Hertfordshire NHS Trust

Domain	Positive Performance	Challenges	Lead Director
Sustainable Services	The Trust has been able to deliver savings / efficiencies of £18.0m in 18/19. Whilst these savings have not been in the profile originally intended within its financial plan, this savings level is still at a rate significantly higher than historic norms. The Trust has been able to reduce the value of spend committed against agency staffing during 2018/19 to a level that is within the agency cap set by NHSI and also to a level below the corresponding value for 17/18. However, as set out in the challenges section the Trust has proved far less successful in managing all of the components that make up its paybill. Significant increases in planned and emergency activity levels have been experienced by the Trust during the course of 18/19 YTD. The Trust has been able to manage these increases, although this has been through a continuing reliance upon providing additional capacity via premium mechanism such as WLI's and Overtime, as opposed to improvements in theatre or outpatient efficiency. This means that any benefit that could have resulted to the Trust bottom line is extremely limited. In order to drive improved delivery and performance across a range of activity and financial settings the Trust has focused considerable time upon the development of improved Business Intelligence and Finance Reporting arrangements. This will provide a strong infrastructure to support ongoing efficiency and transformation progress in 19/20 and beyond.	The management of 18/19 pay budgets has proved extremely challenging. Whilst a significant element of the £10.7m YTD overspend is associated with marginal costs resulting from additional activity, material overspends have also resulted from under achievement against pay savings targets. In addition, whilst the Trust has increased its substantive headcount it has not been able to effect comparable reductions in temp staffing expenditure. On average the Trust is using over 100 WTE's more staff per month in 18/19 compared with the previous year. Achievement of pay savings in the YTD has been poor, with savings of only £2.0m delivered against total spend of £266m - or 0.8%. This does not represent a sustainable model of savings delivery moving into 19/20, especially given the outlying profile of Trust pay spend compared with national benchmarks. The Trust has experienced a very significant increase in Pathology costs during 18/19 against both budgets and prior year costs. This has been driven by a commercial service framework that is sub-optimal, combined with a failure to implement effective demand management arrangements internally. The urgent transition to arrangements that offer better VFM is essential. The delivery of planned surgical activity over recent months represents a significant challenge for the Trust. This has fallen materially below levels that had been agreed by the division. The challenge is underpinned by concern at the progress being made to improve the underlying levels of productivity and efficiency delivered within both Theatre and Outpatient environments. Performance was already poor compared with national comparators, and indeed has deteriorated further during 18/19 in respect of theatres. Urgent improvement in these settings is essential. The levels of Private Patient Income delivered by the Trust during 18/19 YTD is some £1.4m behind plan. The Trust has a significant challenge to review its PP revenue generation if it is to be successful in repatriating the NHS activity presently routed to private providers in Herts. CQUIN achievement across 18/19 has been extremely poor, with final year end delivery expected to report a shortfall in excess of £1.1m. The Trust will need to reconsider its approach to monitoring and targeting CQUIN delivery going forward if this risk is not to represent in 19/20.	 **Martin Armstrong** **Director of Finance**

Single Oversight Framework

East and North Hertfordshire NHS Trust

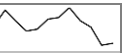
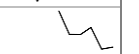
Quality of care

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
Caring	Written complaints - rate	Quarterly	Mar-19	Local	1.9	1.3	
Caring	Staff Friends and Family Test % recommended - care	Quarterly	Q2 2018-19	National	80.9%	74.8%	
Safe	Occurrence of any Never Event	Monthly (six-month rolling)	Mar-19	National	0	2	
Safe	Patient Safety Alerts not completed by deadline	Monthly	Mar-19	National	0	2	
Caring	Mixed-sex accommodation breaches	Monthly	Mar-19	National	0	0	
Caring	Inpatient scores from Friends and Family Test - % positive	Monthly	Mar-19	National (excl. IS)	95.0%	96.8%	
Caring	A&E scores from Friends and Family Test - % positive	Monthly	Mar-19	National (excl. IS)	90.0%	89.7%	
Caring	Maternity scores from Friends and Family Test - % positive - antenatal care	Monthly	Mar-19	National (excl. IS)	93.0%	100.0%	
Caring	Maternity scores from Friends and Family Test - % positive - birth	Monthly	Mar-19	National (excl. IS)	93.0%	100.0%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal ward	Monthly	Mar-19	National (excl. IS)	93.0%	83.1%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal community	Monthly	Mar-19	National (excl. IS)	93.0%	100.0%	
Safe	Emergency c-section rate	Monthly	Mar-19	Local	15%	17%	
Organisational health	CQC inpatient survey	Annual	2017	National	8.1	8.0	
Safe	Venous thromboembolism (VTE) risk assessment	Quarterly	Q3 2018-19	National	95%	94.7%	
Safe	Clostridium difficile (C. difficile) plan: C.difficile actual variance from plan (actual number v plan number)	Monthly	Mar-19	-	-	0	
Safe	Clostridium difficile – infection rate	Monthly (12-month rolling)	Mar-19	National	10.15	12.70	
Safe	Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Monthly (12-month rolling)	Mar-19	National	0.66	0.94	
Safe	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	Monthly (12-month rolling)	Mar-19	National	8.03	7.52	
Safe	Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI)	Monthly (12-month rolling)	Mar-19	National	18.44	16.46	
Effective	Hospital Standardised Mortality Ratio	Monthly (12-month rolling)	Dec-18	National	100	93.0	
Effective	Summary Hospital-level Mortality Indicator	Quarterly	Q2 2018-19	National	100	99.9	
Safe	Potential under-reporting of patient safety incidents	Monthly (six-month rolling)	Feb-19	National	48.6	45.7	

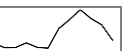
Finance

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
Financial sustainability	Capital service capacity	Monthly	Mar-19	National	1	4	
Financial sustainability	Liquidity (days)	Monthly	Mar-19	National	1	4	
Financial efficiency	Income and expenditure (I&E) margin	Monthly	Mar-19	National	1	4	
Financial controls	Distance from financial plan	Monthly	Mar-19	National	1	4	
Financial controls	Agency spend	Monthly	Mar-19	National	1	1	

Operational performance

A&E	A&E maximum waiting time of four hours from arrival to admission/transfer/discharge	Monthly	Mar-19	National	95%	81.0%	
RTT 18 weeks	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	Monthly	Mar-19	National	92%	90.6%	
Cancer Waiting Times	62-day wait for first treatment from urgent GP referral for suspected cancer	Monthly	Feb-19	National	85%	71.8%	
Cancer Waiting Times	62-day wait for first treatment from NHS cancer screening service referrals	Monthly	Feb-19	National	90%	79.2%	
Diagnostics Waiting Times	Maximum 6-week wait for diagnostic procedures	Monthly	Mar-19	National	1%	1.34%	
Dementia assessment and referral	The number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who:						
	a. have a diagnosis of dementia or delirium or to whom case finding is applied	Monthly	Feb-19	National	95%	-	
	b. who, if identified as potentially having dementia or delirium, are appropriately assessed	Monthly	Feb-19	National	95%	-	
	c. where the outcome was positive or inconclusive, are referred on to specialist services	Monthly	Feb-19	National	95%	-	

Organisational health

Organisational health	Staff sickness	Monthly	Mar-19	Local	3.4%	4.2%	
Organisational health	Staff turnover	Monthly	Mar-19	Local	12.0%	13.3%	
Organisational health	NHS Staff Survey Recommend as a place to work	Annual	2018	National	62.6%	53.9%	
Organisational health	Proportion of temporary staff	Monthly	Mar-19	Local	-	15.0%	

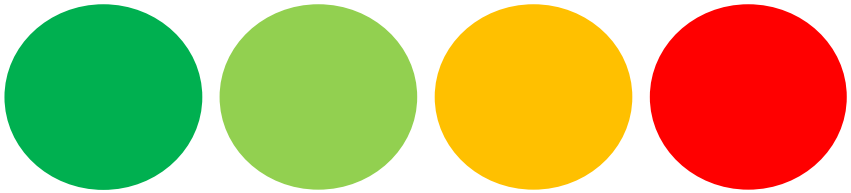
Quality Improvement Dashboard

Safe, Caring and Effective Services Headline Metrics

East and North Hertfordshire NHS Trust

Safe Services

Month 12 | 2018-19



Key Issues

Safety Thermometer
- Harm-free care (for all and new harms) were the better than the national average in March.

Patient Falls

YTD
- 678 inpatient falls recorded during the year resulted in no physical harm being sustained by the patients involved
- 134 incidents resulted in patients sustaining low harm injuries such as minor cuts and bruises
- 8 incidents resulted in patients sustaining moderate harm injuries
- 11 falls resulted in patients sustaining severe harm injuries

- 2017/18 resulted in 15 moderate or above harm from falls
- 2018/19 resulted in 20 moderate or above harm from falls

Serious Incidents & Never Events
- There have been 70 Serious Incidents reported YTD.
- As of 16/04/19 it has been 160 days since last Never Event.
- There were no Never Events reported in March.
- There were 4 SIs reported in March:
  - (Medicine) Deteriorating patient ED: ED GP referral with coffee ground vomiti, referred to medics with UGIB- the medics requested CT abdo to R/O obstruction, PTWR - AKI secondary to food poisoning, cardiac arrest in cubicle 10 in majors and moved to resus, moved to ITU, died despite maximum therapy in ITU.
  - (Medicine) Care of Elderly ward: Fall: Fall not seen by the staff but witnessed by the other patients. The staff saw the patient on the floor on his left side, sustained fractured NOF.
  - (Surgery) Gastro- Delayed Diagnosis Significant delay in Portal Vein Thrombosis diagnsosis from imaging, reslting in portal hype rtension including large Oesophageal and gastric varices.
  - (Medicine) CDU- fall- frail patient with dementia looked after in side-room, lights off. Fell from bed onto face. Imaging showed new pathological fractures post fall.

Infection Control
- Data check to follow, hand hygiene data outstanding
  - MRSA bacteraemia =
  - C difficile infections = (In April the allocation is changing according to NHSI requirements and could markedly affect the numbers reported)
  - E coli bacteraemia =
  - MSSA bacteraemia =

Hospital-acquired Pressure Ulcers
- Year to date we have reported hospital-acquired pressure ulcers.
- There were 19 reported in March
  - Category 4 = 0
  - Category 3= 0
  - Category 2 = 4
  - (Device-related Mucosal membrane (D)= 1
  - Device-related Unstageable= 1
  - Unstageable = 4
  - SDTI = 9

Sepsis
- Current backlog due to NEWS 2.0 implementation delay.
- Ongoing improvement planning has started in ED/AMU/SAU
- Agreed trajectories for improvement going forward are:
- Improve compliance with all aspects of sepsis 6 bundle from 20%-40% in pilot areas in 6months
- Improve to 80% within 12 months and scale and spread trust wide to 90% compliance with sepsis 6 bundle by 2024 (life of the quality strategy)

VTE
- Current data collection is under review. VTE clerk has now moved off site, and daily reviews now more difficult to achieve monthly.
- Current VTE risk assessment and RCA processes have been reviewed and show bottle necks on review processes. The governance of these processes are under review by Mike & Tim - and an action plan being formed

Executive Response

Safety Thermometer
- The Trust is in the highest (best performing) quartile for harm -free care in March.

Patient Falls
- Datix has been changed to reflect accurate categories needed to measure falls more accurately.
- Falls with harm 'rate' per 100 admissions now measured.
- New CQUIN criteria related to falls risk assessment under review.
- Falls continues as key priority in Harm Free Care Collaborative.

Serious Incidents and Never Events
- Ongoing improvements with management of incidents, action plans, DOC and daily surveillance of Moderate or above reported incidents.

Never Events / Safer Surgery
- Divisional plans underway to risk assess all areas against NE criteria in Q1 2019/20.
- ENHT Safety Standard Invasive Procedure Policy in draft (NatSSIP).
- Patient safety alert re. Safe cannula management post procedures discussed in theatre board, plans underway to audit complian ce against standard.
- Design and testing of surgical team board underway., good theatre engagement.
- Plans to video team work underway- and plan annual cycle of Human Factors team training.
- Planned launch ENHT NatSSIP May 2019 (RHD) with go live team HF training June on wards.
- Deteriorating Patient and Learning disabilities.
- Recognition, escalation and treatment of our Learning Disability patient population has been identified as primary driver for deteriorating patient collaborative.
- Cardiac arrest data poster published, thematic review of 2222 calls for the last year underway

Harm-free Care Collaborative
- Current baseline data being reviewed for urinary tract infection and medication errors
- Falls & UTI CQUIN shall be included in the collaborative
- Planning phase of 'Break through' series shall start when confirmation of QI posts known.

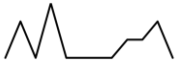
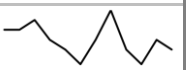
Infection Control
- Sharps waste disposal has been a concern since Jan.
- Concerns have been raised specifically about sharps (22 incidents since Jan) - sharps found in bags, bins.
- Safety alerts issued. Audit of all clinical areas, and emergency order of small sharps boxes placed and supplied.
- Ongoing bin audits and weekly discussion at quality huddles are included in sharps action plan (governance through IPC operat ional group).

Hospital-acquired Pressure Ulcers
- Data continues to be cleaned and validated by TVN team following clinical validation of damage.
- Device for catheters issue has been rectified – was a supply issue. No further penile damage to report.
- PU reduction collaborative relaunched in response to recent Category 4 PUs – this is cross divisional and focuses on react to re d and Tick-a-turn initiatives. Link nurse meeting to be held this month to take work further.
- PU reduction collaborative to produce an action plan addressing the themes highlighted through the SI reports for the recent category 4 Pressure ulcers.
- ENH will participate in the National NHSI PU prevalence audit April 29th to May 3rd.

Sepsis
- Sepsis CQUIN moving from data / measures for CQUIN to QI.
- Key priority areas will be identified for adoption of QI (ED, AMU, SAU).
- Adoption of QI with support of QI team and clinical experts (Sepsis team).

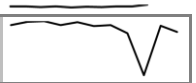
Safe Services

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Trend
Safety Thermometer	Harm-free care All harms	93.9	95.6	95.8	95.5	96.7	95.2	96.2	95.7	97.0	98.1	96.9	96.6	96.8	
	Harm-free care New harms	97.8	98.3	99.3	98.5	99.1	98.3	97.9	98.1	99.6	99.6	98.9	98.2	98.4	
Patient Falls	Number of patient falls	72	87	80	66	65	72	59	65	49	63	91	81	69	
	Rate of patient falls per 1,000 overnight stays	4.0	5.5	5.1	4.3	4.5	4.7	4.1	4.2	3.3	4.4	4.9	5.9	4.7	
	Number of patient falls resulting in serious harm	0	0	2	0	3	0	0	0	0	1	1	2	0	
Events and Incidents	Number of Never Events	0	2	0	0	1	1	0	1	1	0	0	0	0	
	Number of Serious Incidents	5	8	8	10	6	4	1	6	12	4	1	6	4	
Infection Control	Rate of MRSA incidences per 100,000 bed days	0.7	0.0	11.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
	Rate of c.difficile incidences per 100,000 bed days	10.2	28.8	5.6	0.0	17.2	28.7	5.9	23.1	6.0	11.5	15.3	11.3	0.0	
	Rate of e.coli incidences per 100,000 bed days	18.4	23.0	22.3	17.3	23.0	5.7	17.8	11.5	11.9	11.5	15.3	34.0	5.1	
	Rate of MSSA incidences per 100,000 bed days	8.0	11.5	16.7	0.0	5.7	11.5	11.9	0.0	11.9	11.5	5.1	0.0	5.1	
	Hand hygiene audit score	95%	96.5%	95.8%	94.2%	93.0%	85.4%	95.2%	94.3%	73.1%	82.2%	81.7%	76.3%	81.0%	

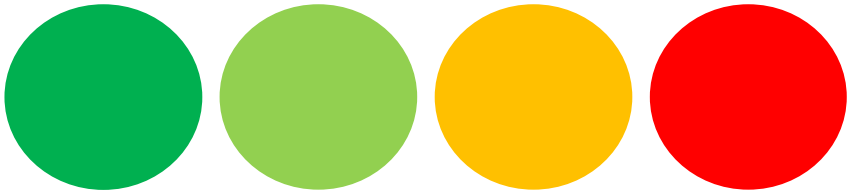
Safe Services

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Trend
Hospital-acquired Pressure Ulcers	Category 4	0	1	0	0	0	0	0	1	0	0	1	0	0	
	Category 3	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Category 2	2	3	2	3	2	0	3	4	3	1	3	3	4	
	Category 2(D) Device-related	-	-	-	-	-	-	-	-	1	0	2	0	1	
	Mucosal membrane (D) Device-related	-	-	-	-	-	-	-	-	-	1	5	1	1	
	Unstageable	1	1	3	1	3	1	1	0	0	0	2	1	4	
	SDTI	3	2	3	0	3	2	2	0	3	6	3	5	9	
VTE	VTE risk assessment	95%	96.6%	96.9%	96.9%	96.6%	96.8%	96.4%	96.6%	95.7%	91.4%	96.5%	95.9%	tbc	
Sepsis Screening and Management	Indicator 2a: Sepsis screening Emergency department	90%	90.7%	93.0%	100.0%	91.5%	90.0%	96.9%	95.5%	95.2%	98.6%	tbc	tbc	tbc	
	Indicator 2a: Sepsis screening Acute inpatient departments	90%	60.0%	80.0%	91.7%	73.3%	53.8%	83.3%	100.0%	77.3%	76.2%	tbc	tbc	tbc	
	Indicator 2b: Timely treatment of sepsis with IV antibiotics Emergency department	90%	67.9%	74.0%	68.0%	64.2%	60.8%	55.8%	60.6%	64.8%	67.9%	tbc	tbc	tbc	
	Indicator 2b: Timely treatment of sepsis with IV antibiotics Acute inpatient departments	90%	0.0%	60.0%	90.9%	61.5%	27.3%	57.1%	82.4%	70.0%	69.2%	tbc	tbc	tbc	

Caring Services

Month 12 | 2018-19



Key Issues

Friends and Family Test (FFT)

- The proportion of positive responses to the Inpatient, Antenatal, Birth, Community FFT and Outpatients FFT questions were better than the respective Trust targets in March.
- The proportion of positive responses to the A&E FFT question fell slightly **to 89.7%** in March, just below the Trust target of 90%.
- The proportion of positive responses to the Maternity Postnatal Ward FFT question fell to **83.1%** and was well below the Trust target (93%).
- The FFT response rate for A&E fell to 4.6% in March and continues to be well below the Trust target of 10%.
- The FFT response rate for Inpatients / Day Case was 41.3% in March, better than the Trust target of 40% and continues to be above the national average.
- The FFT response rate for Maternity (Birth question only) fell to 16.3% in March, well below the Trust target of 30%.

Complaints

- **Total number of complaints received YTD = 1036**
- There were **68** complaints received in March. Breakdown by division:
  - Surgery - 32 (50 closed)
  - Medicine - 19 (27 closed)
  - W&C - 6 (16 closed)
  - CSS - 6 (6 closed)
  - Cancer - 5 (8 closed)
  - Operations - 0 (2 closed)
- **100%** of complaints received were acknowledged within 3 working days.
- **64%** were responded to within the agreed timeframe, **which is a 9% increase** from last month. Average of 53% achieving timely responses.

Executive Response

Friends and Family Test (FFT)

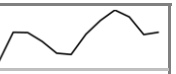
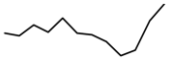
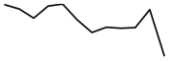
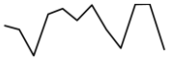
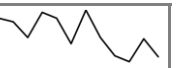
- The inpatient / day case percentage of patients who would recommend the Trust is higher than the national average and the response rate continues to exceed the latest national average response rate of 24.24%. The highest proportion of positive comments relate to staff.
- Negative comments related to the cleaning, particularly in toilets and bathrooms, temperature on the ward and noise at night from other patients.
- 7 patients out of 671 who responded to the A&E FFT survey were unlikely or extremely unlikely to recommend the service.
- The majority of feedback from patients is positive particularly in relation to staff. Negative feedback relates to waiting times and more staff needed.
- Outpatients compliment staff on their kind and caring attitude and for the care and treatment provided. There are concerns about waiting times in clinics and lack of information about reasons for the delays. Other concerns relate to administration around appointments, car parking and access to refreshments.
- On the postnatal ward 2 out of 165 women would not recommend the service. Women would like better provision of recliner chairs and facilities for partners and an improved ward environment.

Improvement efforts - Complaints

- 90-day improvement plan is ongoing. The target to be achieved was no more than 120 open complaints across all divisions. At the end of March, the total number of complaints open across the divisions was 108.
- Priority area identified - Surgical Division. Surgical divisional team engaged and a significant reduction in the number of complaints open has been achieved, with 49 open complaints at the end of March.

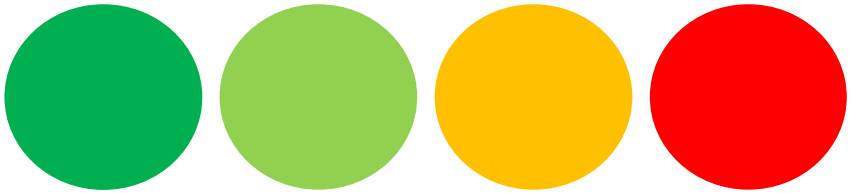
Caring Services

East and North Hertfordshire NHS Trust

Domain	FFT	Metric	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Trend
Friends and Family Test	Inpatients	Proportion of positive responses	95%	96.0%	96.8%	96.8%	96.6%	96.2%	96.2%	96.8%	97.2%	97.5%	97.3%	96.8%	96.8%	
		Total number of responses	1,778	1,881	2,170	1,979	2,146	2,004	1,905	2,322	1,874	1,391	2,094	1,791	1,889	
		Response rate	40%	42.3%	44.8%	42.0%	46.5%	44.5%	43.1%	47.9%	39.5%	32.1%	41.2%	41.1%	41.3%	
	A&E	Proportion of positive responses	90%	88.8%	89.4%	89.2%	91.9%	88.4%	88.9%	90.5%	89.9%	85.2%	90.2%	90.9%	89.7%	
		Total number of responses	1,241	527	545	490	332	450	649	560	417	297	610	806	671	
		Response rate	10%	4.3%	3.7%	3.6%	2.3%	3.5%	4.9%	3.9%	3.0%	2.2%	4.4%	6.1%	4.6%	
	Maternity	Antenatal care Proportion of positive responses	93%	100.0%	91.2%	100.0%	94.7%	95.8%	90.9%	100.0%	100.0%	96.8%	92.5%	100.0%	100.0%	
		Birth Proportion of positive responses	93%	96.6%	96.4%	97.6%	96.8%	98.4%	96.7%	96.5%	95.7%	94.1%	94.7%	98.1%	100.0%	
		Birth Total number of responses	137	179	192	166	186	184	150	141	139	135	132	157	71	
		Birth Response rate	30%	41.5%	39.4%	34.9%	40.8%	41.9%	34.1%	27.8%	30.3%	29.8%	30.2%	39.1%	16.3%	
		Postnatal ward Proportion of positive responses	93%	87.6%	86.8%	81.9%	89.7%	90.8%	88.6%	91.4%	86.9%	83.3%	91.6%	91.7%	83.1%	
		Postnatal community Proportion of positive responses	93%	100.0%	100.0%	100.0%	95.8%	100.0%	100.0%	100.0%	100.0%	94.6%	100.0%	100.0%	100.0%	
	Outpatients	Proportion of positive responses	95%	95.5%	96.6%	95.7%	94.7%	94.8%	94.9%	93.9%	93.6%	95.2%	94.1%	94.4%	95.5%	
		Total number of responses	-	1,561	1,755	1,431	1,175	1,911	1,896	1,733	1,982	1,683	2,037	2,281	5,320	
Complaints		Number of written complaints received	92	100	97	84	105	100	79	107	84	69	64	83	68	
		Rate of written complaints received	1.9	2.2	1.9	1.7	2.0	2.0	1.6	1.9	1.6	1.6	1.1	1.6	1.3	
		Proportion of complaints acknowledged within 3 working days	75%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%	100%	100%	
		Proportion of complaints responded to within agreed timeframe	80%	52%	91%	64%	67%	44%	52%	52%	47%	43%	53%	55%	64%	

Effective Services

Month 12 | 2018-19



Key Issues

Crude Mortality
- The in-month crude mortality rate improved to 11.6 deaths per 1,000 admissions.
- The rolling 12-months crude mortality rate improved to 11.2 deaths per 1,000 admissions in the 12 months to March, which remained better than the most recently available national rate of 13.4.

Hospital-Standardised Mortality Ratio (HSMR)
- The in-month HSMR increased to 95.6 in December, and remained better than the standard (100).
- The rolling 12-months HSMR improved to 93.0 in the 12 months to December.
- HSMR is available several months in arrears.

Summary Hospital-level Mortality Indicator (SHMI)
- The quarterly SHMI figure improved to 102.7 in Q1 2018-19 and then improved further to 99.9 in Q2 2018-19. This is the first time that SHMI has been below 100 since its inception in 2010.
- SHMI is available quarterly in arrears.

Re-admissions
- The total re-admission rate increased by 0.2% to 8.3% in September 2018. This corresponds to 832 re-admissions out of 9,988 spells.

Executive Response

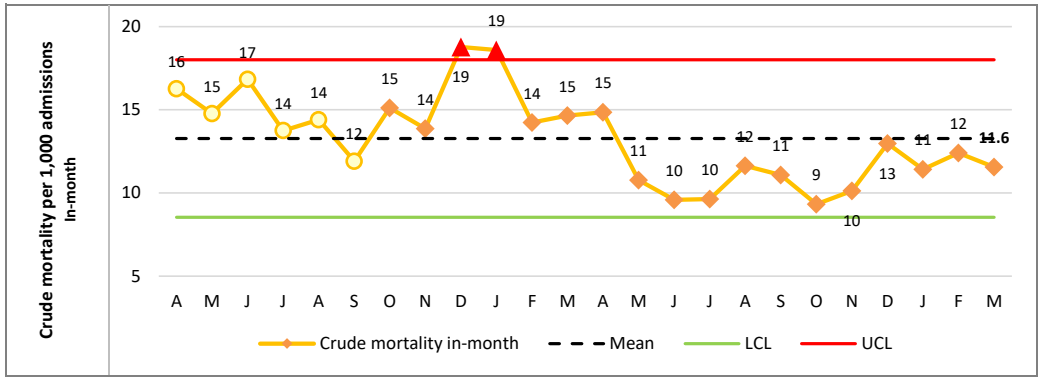
Mortality
- Mortality rates have improved over the last 5 years as measured by both of the major methods: HSMR and SHMI.

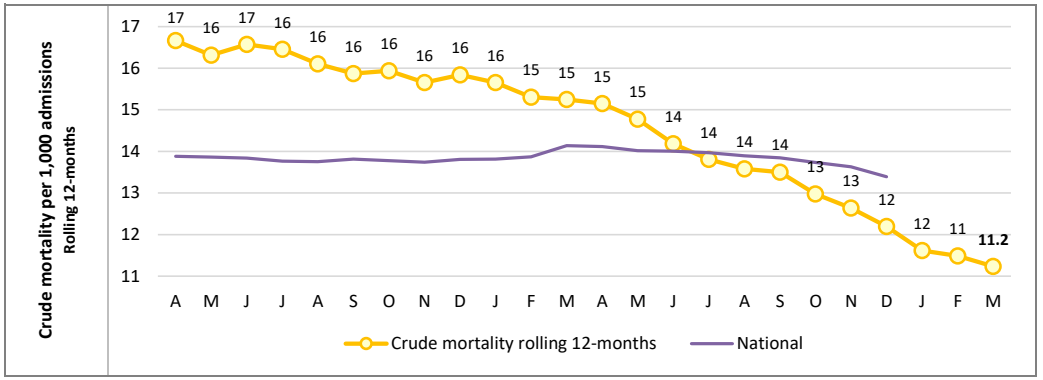
Hospital Standardised Mortality ratio (HSMR)
- This measure is based on a basket of 56 patient groups with relatively predictable mortality and records death in hospital. Performance has been persistently in the 'as expected range'. There was a predictable, unsustained increase in HSMR following the introduction of the Lorenzo system in September 2017. This is a pattern commonly seen after the introduction of any PAS and is thought to be related to changes in depth of coding and, hence, predicted mortality. HSMR remained in the 'as expected' range during this period. The latest HSMR for the rolling 12 months to December 2018 is 93.0. 'Better than expected'. HSMR is generally available 3/12 in arrears.

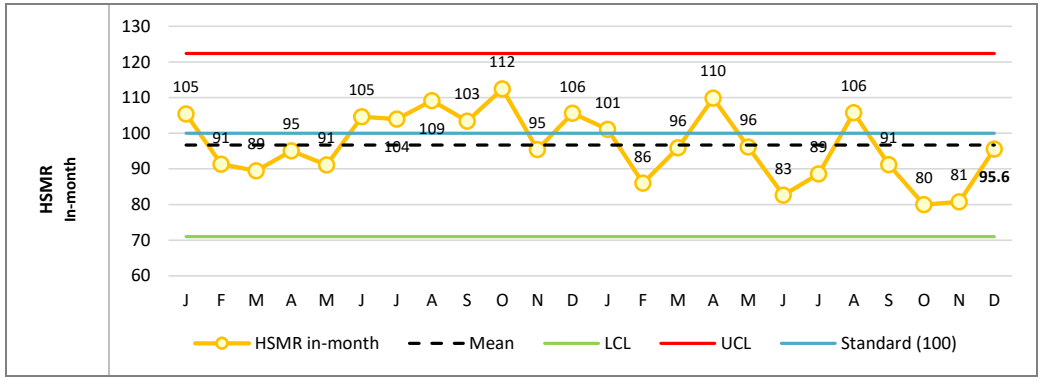
Summary Hospital-level Mortality Indicator (SHMI)
- This is a measure of mortality for all inpatients including up to 30-days post-discharge. Historically, ENHT's SHMI has been up to 10 points higher than the HSMR, which is thought to be related to the onsite hospice at Mount Vernon (a relatively unusual arrangement nationally). However, over the last 2 years the gap between SHMI and HSMR has reduced to the order of 7 points. Although a similar (to HSMR) increase in SHMI was seen post-Lorenzo launch, it too remained in the 'as expected' range. The latest SHMI for the rolling 12-months to September 2018 is 99.9. 'As expected'. SHMI is generally available 6/12 in arrears.

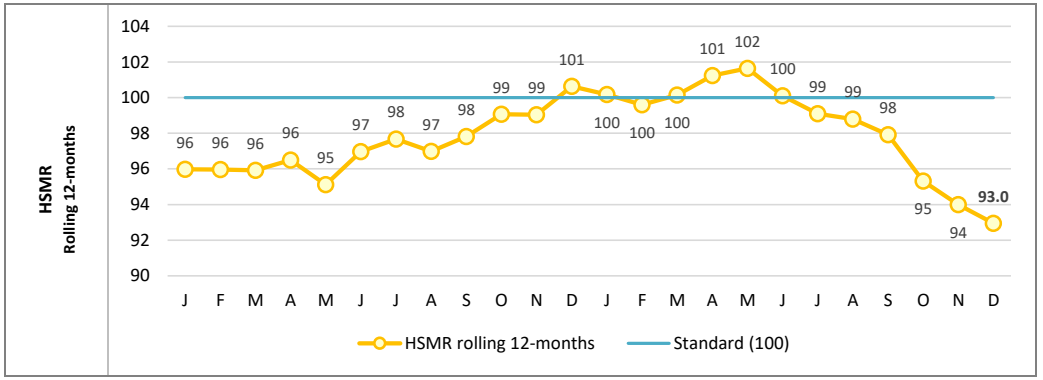
Crude mortality
- This measure is available the day after the month end and has demonstrated a consistent decrease over the last 5 years. It is the factor with the most significant impact on HSMR.
- The improvements in mortality have been as a result of a combination of corporate level initiatives such as the mortality review process and more directed areas of improvement such as the identification and early treatment of patients with sepsis, stroke, etc.

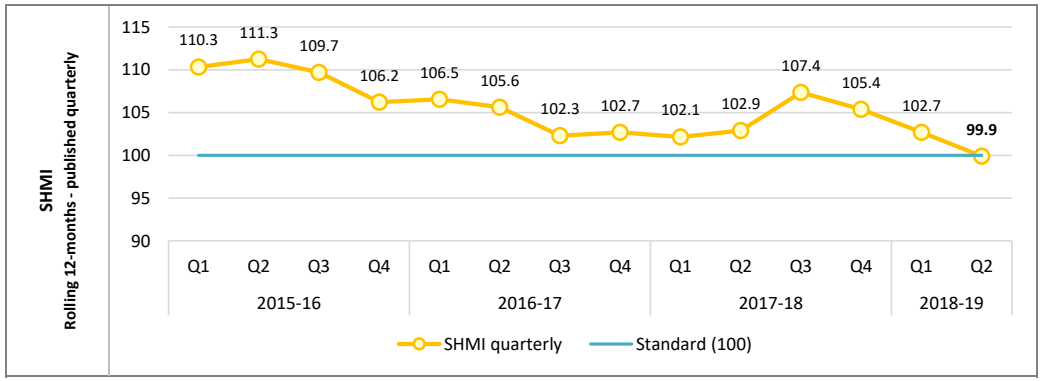
Re-admissions
- Historically the Trust reported higher than expected levels of re-admissions compared to the national average. However, the last three years have seen a consistent improving trend. The 12 months to February 2018 saw relative risk return to the 'as expected range'. The latest relative risk for the 12 months to September 2018 stands at 97.2 (Elective 91.2, Non-Elective 100.1) and sits within the 'lower than expected' range.


Crude mortality per 1,000 admissions
In-month
Crude mortality in-month
Mean
LCL
UCL


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

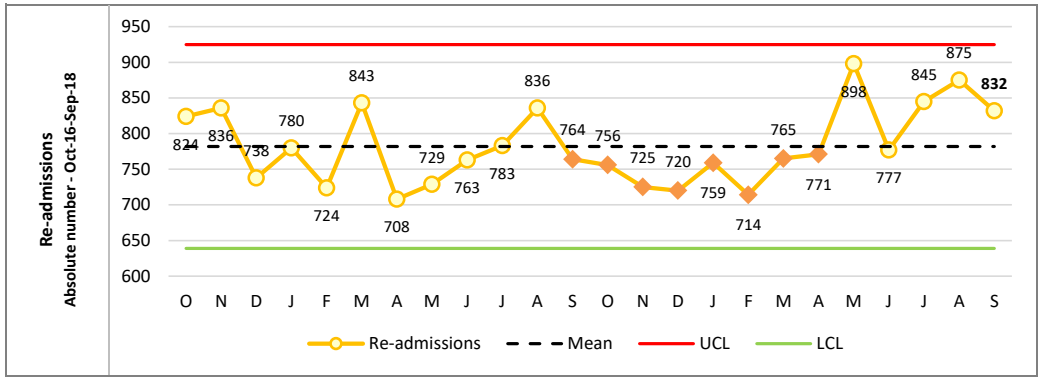

HSMR
In-month
HSMR in-month
Mean
LCL
UCL
Standard (100)

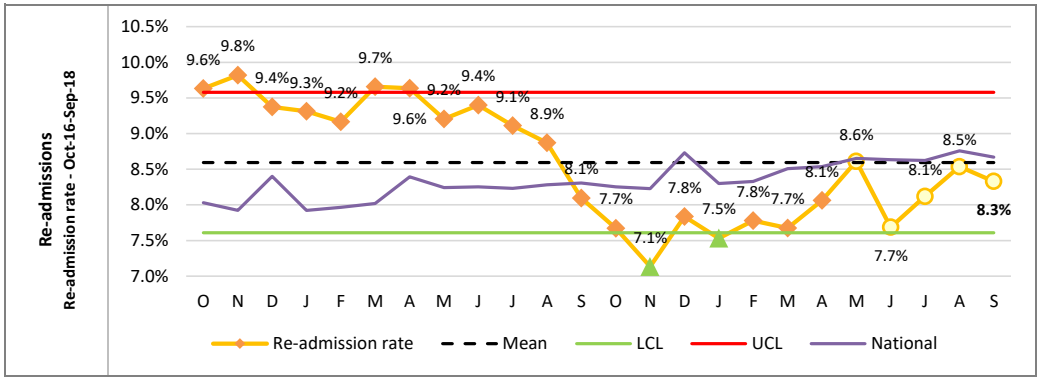

HSMR
Rolling 12-months
HSMR rolling 12-months
Standard (100)


SHMI
Rolling 12-months - published quarterly
2015-16
2016-17
2017-18
2018-19
SHMI quarterly
Standard (100)

Effective Services

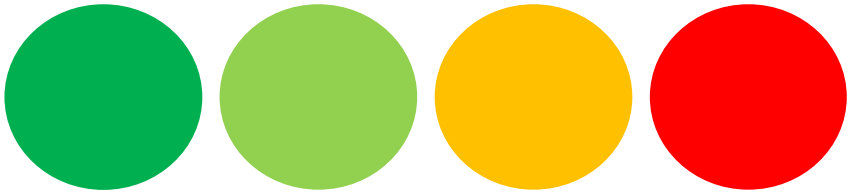
East and North Hertfordshire NHS Trust





Responsive Services

Month 12 | 2018-19



Key Issues

A&E
- Performance for the month of March 2019 was 81.00%.
- No 12-hour trolley waits were reported in March.

Cancer Waiting Times
- In February 2019 the Trust achieved 4 of the 8 national targets for cancer performance.
- The Trust 62-day performance for February 2019 was 71.8 % pre-breach sharing and 75.4% post breach sharing, which is above the revised trajectory of 74.6%
- The cancer recovery business case has been completed and is awaiting final internal Finance sign-off.
- Capacity challenges continue with specialist treatments such as RALP and Brachytherapy which is impacting on the Trust aggregate 62-day compliance.
- There is a further risk to the sustained compliance of the 31-day subsequent Radiotherapy & Chemotherapy performance due to:
  - Inadequate capital funds to replace LA1. Decision to be made on alternative patient flow by May 2019;
  - Current lack of clarity as to whether Baxter can deliver the Trust's full service specification for chemotherapy production after 28/2/20. Under specialist commissioning review.
- Commitment has been obtained from IMAS to support the Trust with ongoing work with:
  - External validation of the Trust 62-day recovery RAPs;
  - Work to deliver the 28-day faster diagnosis target.

RTT
- Incomplete performance for March was 90.56% with a reported backlog of 4,005. This is an improvement on the February position.
- There were two 52-week breaches reported in our March incomplete position against three reported in February.

Diagnostics
- DM01 performance for March is 1.34% against the national standard of 1% and the February position of 1.21%.

Stroke
- Improvement in Performance for March 72.1% compared to 69.0% February 2019 – March 2018 performance was 60% - so improvement of 12.1 % compared to last year's performance
- 4 hr target taking into the out the exclusion of the Inter hospital transfer and inpatient stroke - March 2019 75.4 % - compared to March 2018 of 62.9% - improvement of 12.5% compared to last year's performance.
- Training being arranged with ED doctors, to ensure that there is early escalation and referrals are being made to the Stroke team.
- Review of Stroke pathways for A&E and Inpatient – being reviewed and review meetings due to take place in March.
- Thrombolysis rate at 8.5%. Stroke Nurses commenced delivery of training to the Ambulance Crew, with the aim to help with early attendance to A&E within onset time.
- Ongoing significant improvement in 60-min to scan and 12-hrs to scan performance. Due to the implementing of the Stroke Nurses requesting scans at time of arrival in A&E – 46.5% performance for March 2019 this is mainly due to the capacity for the CT scan out of hours.
- Table above now showing the 16.7 % of thrombolysis received in less than 60 minutes as this is the gold standard, however up to 4.5hrs from onset time is NICE guidance approved. This has an impact on the arrival time to the Trust - as we are meeting the rate for 60mins Thrombolysis rate target of 11%
- Maintain performance of meeting of 40% target for ESD performance at 44.4% for March 2019.
- Charing Cross thrombectomy service now available 7-days per week until 23:00
- TIA performance within 24-hrs significantly – Data currently not available for March – details of actions to be undertaken with the RAP. Review of the national reporting requirements to ensure we are adhering and reporting as per national requirements.

Executive Response

A&E
- A slowly improving position against the Emergency Access target in March. although flow into the assessment areas remains challenged at times. Work streams continue to support change.
- Continued focus, with external support on Rostering, flow and ensuring staffing is appropriate to meet demand has begun.
- Internal work streams set up to ensure consistency in each work area, reviewing process, diagnostics, etc. to produce a SOP t o ensure a stable consistent approach.
- Work undertaken to improve communication with the SITE team in and OOH. SMoS training completed with additional sessions planned.
- Continued focus on Ambulance handover process and working with EEAS to reduce off -load delays.
- Renewed focus on 'Professional Standards' across the Trust, with a new process and relaunch of the standards.

Cancer performance (February)
- In February 2019, the Trust achieved 4 of the 8 national targets for cancer performance: 2ww including breast symptomatic, 3 1-day subsequent for drug treatments, and radiotherapy. Cancer performance is available one month in arrears.
- The Trust Two Week Wait (2WW) performance for February 2019 was 96.6% which equates to 1,154 out of 1,195 pathways meeting the 2WW standard, with 41 breaches of the standard being reported.
- In February 2019, the Trust-wide average days wait for a first appointment was at 10 days and the majority of patients were seen between 8 and 12 days.
- In February 2019 the 31 day 1st definitive treatment was 95.1%; below the national target of 96%, which equates to 196 out of 206 pathways meeting the target, with 10 breaches. 8 out of 9 tumour sites met the target and excluding Urology the Trust would have achieved 100% against this standard.
- In February 2019 the 28 faster diagnosis performance was 60% which equates to 668 out of 1114 pathways meeting the standard.
- Reported 62-day performance for February 2019 was 71.8% pre -breach/compliance sharing and 75.4 % post (80.6% excluding Urology), which is above the revised recovery trajectory of 74.6%. In February 2019, 3 out of 9 tumour sites met the standar d with 45% of avoidable breaches occurring in Urology.
- The tumour site action plans will no longer be required to be discussed at the NHSE CRG meeting as the stakeholders are happy with the new process and the Trust internal governance arrangements.

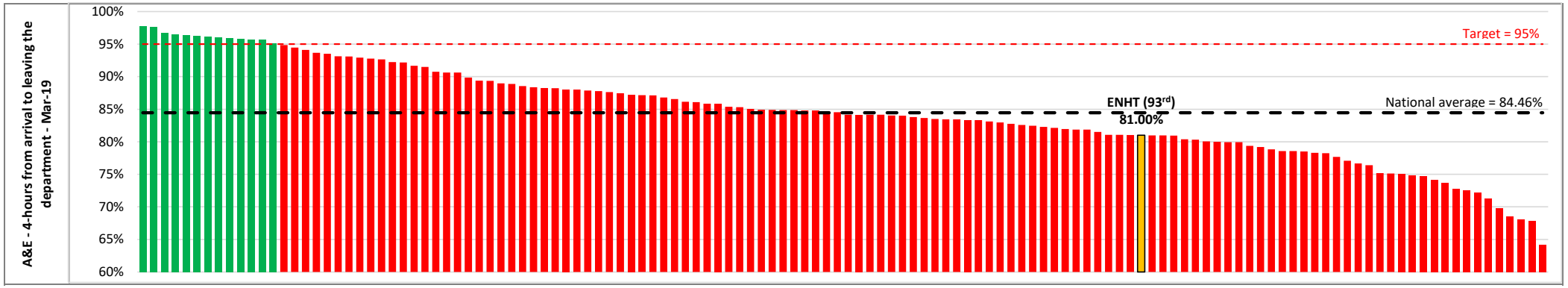
RTT
- Performance shows a small improvement over February. Our final 52 -week breach position was 2 against a plan of 0. Both patients were Oral surgery patients who chose treatment dates in April after clock corrections. Teams are now focussing on a small num ber of April breach risks and patients breaching in May.

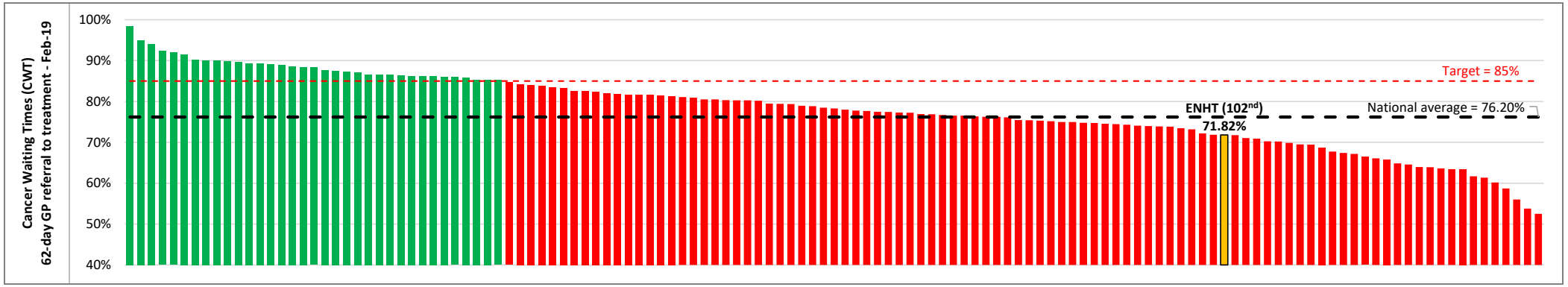
Diagnostics
- Diagnostics performance in March has worsened slightly, this is caused by a failure of tracking processes in Cardiology, this has now been resolved. Plans to outsource a limited number of Cardiology patients to Watford are in place up to the end of Q2. The c urrent Trust position is significantly better than predicted.

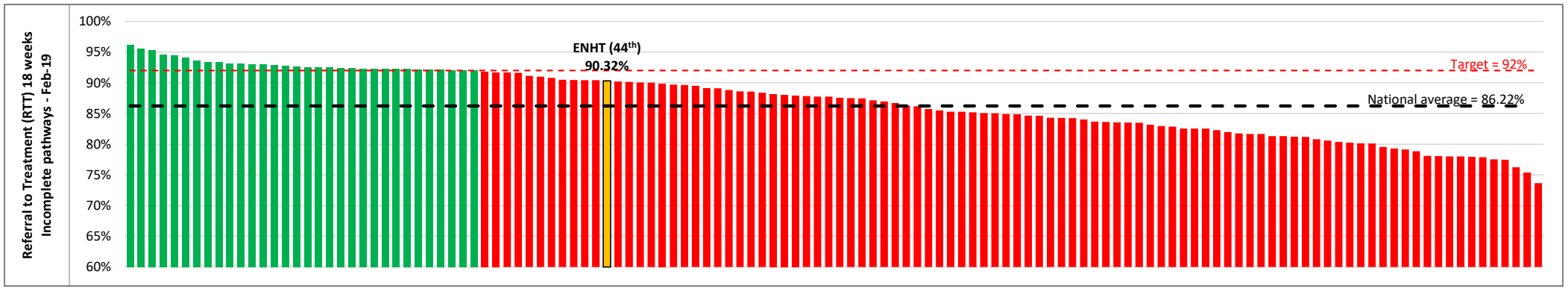
Responsive Services

Trust performance against all Trusts nationally

East and North Hertfordshire NHS Trust



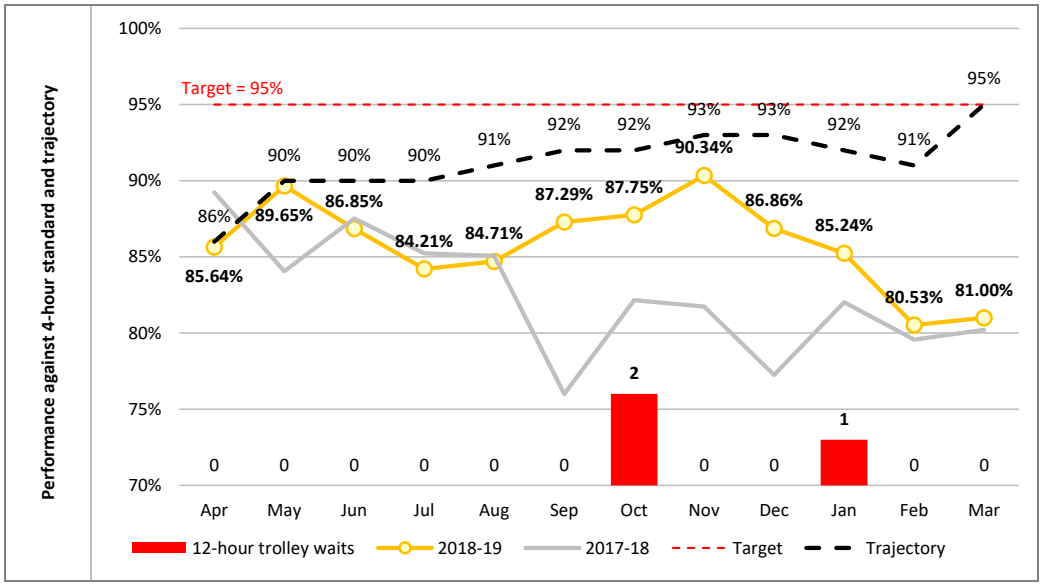




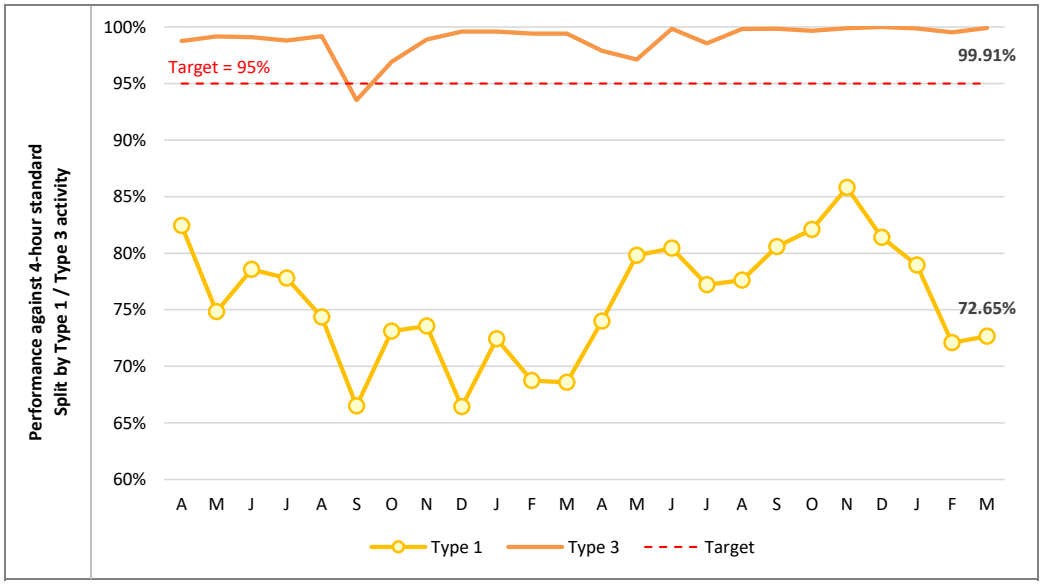
Responsive Services

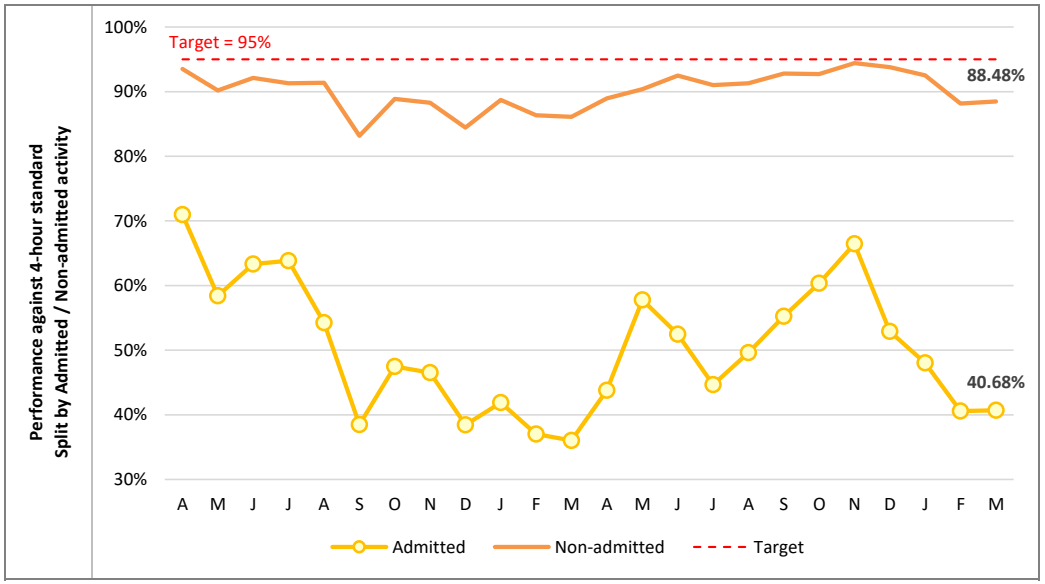
Emergency Department Performance

East and North Hertfordshire NHS Trust



Domain	Metric	Target	Feb-19	Mar-19	Change	Trend
Other Emergency Department measures	Ambulance handovers Proportion within 15 minutes	-	63%	62%	▼	
	Ambulance handover breaches 30-minutes	230	597	606	▲	
	Ambulance handover breaches 60-minutes	43	250	206	▼	
	Attendance to admission conversion rate	-	31.5%	32.2%	▲	
	Time to initial assessment 95th centile	15	60	75	▲	
	Time to treatment Median	60	83	86	▲	
	Left department before being seen for treatment	5%	1.8%	2.3%	▲	
	Unplanned re-attendance rate	5%	4.6%	4.4%	▼	





Responsive Services

Cancer Waiting Times

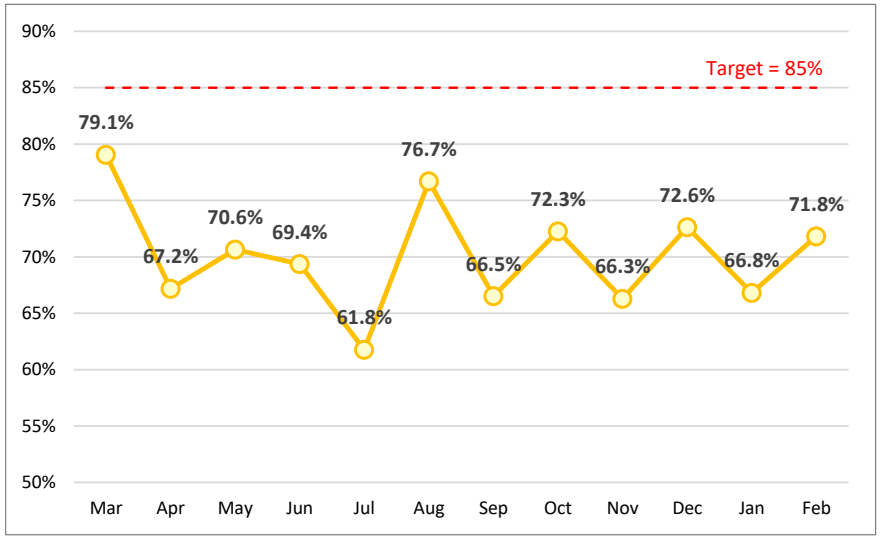
East and North Hertfordshire NHS Trust

12-months' performance - all standards

Standard	Target	2017-18		2018-19										
		Mar-18	YTD	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	YTD
Two week waits Suspected cancer	93%	97.4%	97.7%	89.3%	92.1%	91.8%	95.5%	95.1%	92.6%	97.1%	96.7%	97.2%	95.6%	96.6%	94.6%
Two week waits Breast symptomatic	93%	93.6%	94.0%	93.7%	91.8%	83.9%	97.3%	91.2%	88.8%	94.9%	94.4%	93.4%	94.5%	94.0%	92.4%
31-day First definitive treatment	96%	96.6%	93.0%	95.0%	92.4%	96.7%	90.8%	90.3%	95.3%	93.8%	91.8%	96.3%	96.0%	95.1%	93.8%
31-day subsequent treatment Anti-cancer drugs	98%	97.2%	95.8%	99.4%	99.3%	98.3%	99.3%	98.3%	100.0%	99.4%	97.99%	100.0%	98.7%	99.4%	99.1%
31-day subsequent treatment Radiotherapy	94%	92.4%	90.1%	91.7%	90.6%	91.1%	94.1%	95.0%	97.6%	97.9%	97.3%	97.2%	95.0%	98.0%	95.1%
31-day subsequent treatment Surgery	94%	91.3%	86.4%	88.5%	95.8%	60.0%	64.0%	100.0%	57.1%	74.2%	69.4%	84.2%	63.6%	76.5%	75.2%
62-day GP referral to treatment	85%	79.1%	73.8%	67.2%	70.6%	69.4%	61.8%	76.7%	66.5%	72.3%	66.3%	72.6%	66.8%	71.8%	69.2%
62-day Specialist screening service	90%	89.3%	72.0%	86.7%	75.0%	77.8%	60.7%	75.0%	87.5%	74.2%	86.2%	100.0%	72.7%	79.2%	78.2%

62-day GP referral to treatment Feb-19

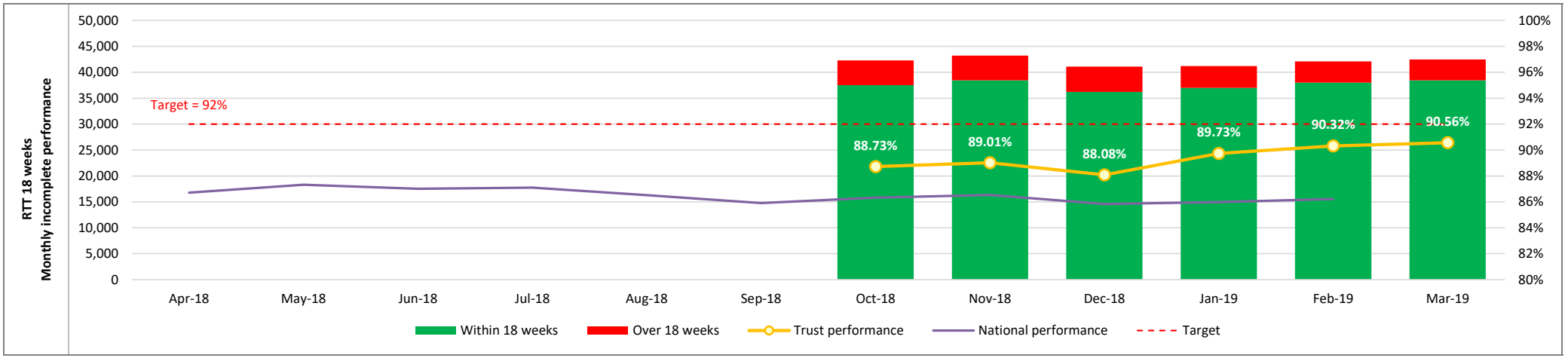
Tumour Site	Pre-breach sharing				Post-breach sharing			
	OK	Breach	Total	Perf.	OK	Breach	Total	Perf.
Breast	16.0	2.5	18.5	86.5%	16.5	2.0	18.5	89.2%
Gynaecology	2.5	2.5	5.0	50.0%	2.5	2.0	4.5	55.6%
Haematology	3.0	2.0	5.0	60.0%	3.0	2.0	5.0	60.0%
Head and Neck	1.5	1.5	3.0	50.0%	1.0	0.0	1.0	100.0%
Lower GI	5.5	3.0	8.5	64.7%	5.5	2.0	7.5	73.3%
Lung	3.0	1.0	4.0	75.0%	3.5	1.0	4.5	77.8%
Other	0.0	1.0	1.0	0.0%	0.0	1.0	1.0	0.0%
Sarcoma	1.0	1.0	2.0	50.0%	1.0	1.0	2.0	50.0%
Skin	20.0	2.0	22.0	90.9%	20.0	2.0	22.0	90.9%
Testicular	3.0	0.0	3.0	100.0%	3.0	0.0	3.0	100.0%
Upper GI	6.5	2.5	9.0	72.2%	6.5	2.0	8.5	76.5%
Urology	17.0	12.0	29.0	58.6%	17.0	11.0	28.0	60.7%
Total	**79.0**	**31.0**	**110.0**	**71.8%**	**79.5**	**26.0**	**105.5**	**75.4%**



Responsive Services

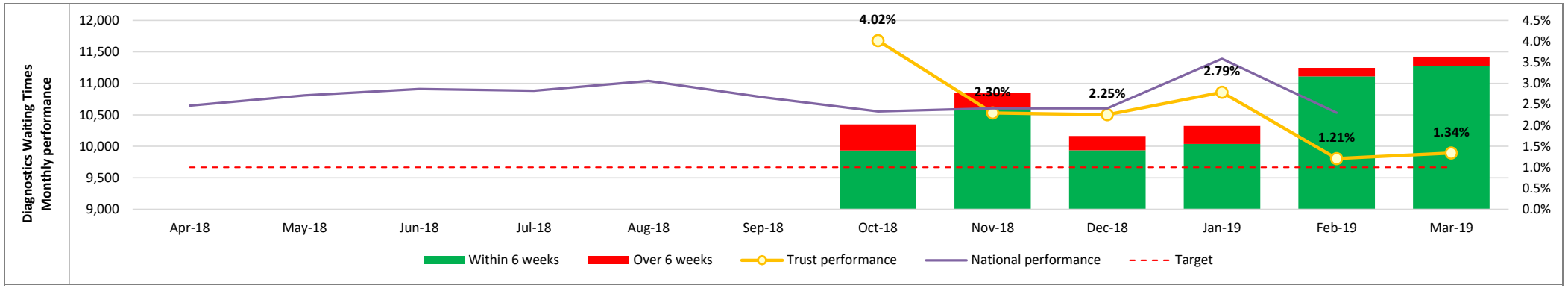
RTT 18 weeks

East and North Hertfordshire NHS Trust



RTT 18 weeks
In-month performance by Specialty - Mar-19

Specialty	Clock Stops - Admitted			Clock Stops - Non-admitted			Incomplete pathways						Clock Starts
	Total	Performance	Over 52 weeks	Total	Performance	Over 52 weeks	Within 18 weeks	Over 18 weeks	Total	Performance	Over 40 weeks	Over 52 weeks	
General Surgery	168	70.83%	1	588	91.16%	0	2,726	154	2,880	94.65%	3	0	1,106
Urology	147	91.16%	2	608	94.24%	0	1,683	53	1,736	96.95%	2	0	800
Trauma & Orthopaedics	165	47.27%	5	586	78.84%	3	2,660	538	3,198	83.18%	24	0	986
Ear, Nose & Throat (ENT)	146	73.29%	3	841	93.22%	1	2,295	151	2,446	93.83%	1	0	1,035
Ophthalmology	143	72.73%	0	584	91.27%	0	4,140	246	4,386	94.39%	1	0	1,435
Oral Surgery	38	23.68%	0	281	80.78%	0	1,795	161	1,956	91.77%	15	2	572
Plastic Surgery	83	83.13%	0	682	97.80%	0	2,085	66	2,151	96.93%	0	0	1,041
Cardiothoracic Surgery	0	-	0	9	100.00%	0	9	1	10	90.00%	0	0	5
General Medicine	3	100.00%	0	133	100.00%	0	1,521	5	1,526	99.67%	0	0	511
Gastroenterology	175	69.14%	2	343	72.30%	1	2,870	318	3,188	90.03%	8	0	739
Cardiology	88	97.73%	0	626	92.01%	1	2,441	134	2,575	94.80%	8	0	853
Dermatology	0	-	0	291	74.57%	0	1,152	225	1,377	83.66%	7	0	435
Thoracic Medicine	20	95.00%	0	330	83.33%	0	1,256	142	1,398	89.84%	6	0	480
Neurology	0	-	0	358	91.06%	0	1,181	57	1,238	95.40%	3	0	463
Rheumatology	2	100.00%	0	160	76.25%	0	888	158	1,046	84.89%	2	0	275
Geriatric Medicine	1	100.00%	0	71	88.73%	0	147	7	154	95.45%	1	0	87
Gynaecology	92	77.17%	0	482	86.31%	0	2,900	244	3,144	92.24%	19	0	1,015
Other	86	82.56%	1	3,005	83.66%	2	6,684	1,345	8,029	83.25%	84	0	3,504
Total	**1,357**	**73.25%**	**14**	**9,978**	**87.00%**	**8**	**38,433**	**4,005**	**42,438**	**90.56%**	**184**	**2**	**15,342**



Diagnostics Waiting Times
In-month performance by Specialty - Mar-19

Category	Modality	Within 6 weeks	Over 6 weeks	Total	Performance	13+ weeks
Imaging	Magnetic Resonance Imaging	1,971	2	1,973	0.10%	0
	Computed Tomography	1,575	1	1,576	0.06%	0
	Non-obstetric ultrasound	5,384	21	5,405	0.39%	0
	DEXA Scan	405	0	405	0.00%	0
Physiological Measurement	Audiology - audiology assessments	76	0	76	0.00%	0
	Cardiology - echocardiography	685	122	807	15.12%	10
	Neurophysiology - peripheral neurophysiology	101	1	102	0.98%	0
	Respiratory physiology - sleep studies	77	3	80	3.75%	0
	Urodynamics - pressures & flows	68	3	71	4.23%	1
Endoscopy	Colonoscopy	361	0	361	0.00%	0
	Flexi sigmoidoscopy	201	0	201	0.00%	0
	Cystoscopy	65	0	65	0.00%	0
	Gastroscopy	303	0	303	0.00%	0
Total		**11,272**	**153**	**11,425**	**1.34%**	**11**

Responsive Services

Stroke Services

East and North Hertfordshire NHS Trust

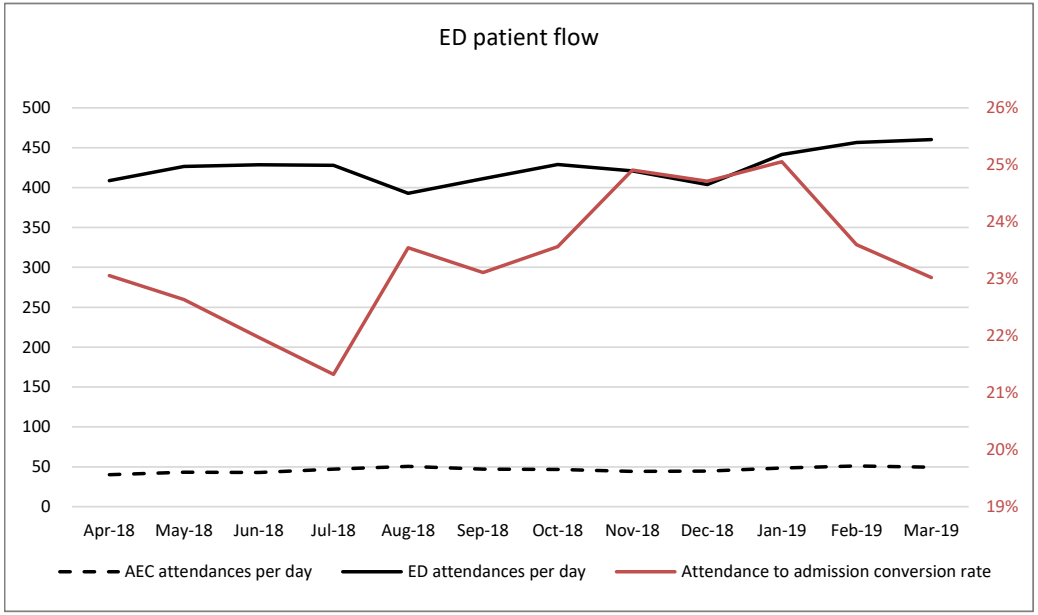
Domain	Metric	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Trend
Stroke	Trust SSNAP grade	A	A	A	A	A	A	A	A	A	A	tbc	tbc	tbc	
	Discharged with AF on anticoagulants	80%	100.0%	91.7%	92.9%	100.0%	87.5%	100.0%	88.9%	80.0%	100.0%	100.0%	100.0%	88.9%	
	4-hours direct to Stroke unit from ED	90%	63.2%	77.6%	80.6%	79.7%	65.2%	72.1%	75.9%	73.0%	75.4%	69.6%	69.0%	72.1%	
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	90%	69.5%	79.0%	81.7%	82.5%	69.8%	79.2%	75.9%	72.9%	76.1%	71.0%	72.7%	75.4%	
	Number of confirmed Strokes in-month on SSNAP	-	74	69	66	60	69	63	57	64	70	70	73	71	
	Proportion of patients spending 90% of time on the Stroke unit	80%	86.8%	86.6%	85.9%	93.3%	85.3%	93.5%	92.7%	88.9%	95.7%	95.7%	93.1%	88.4%	
	60-minutes to scan from time of arrival	50%	51.4%	56.5%	57.1%	56.7%	46.4%	61.9%	57.9%	54.0%	57.1%	50.0%	61.6%	45.6%	
	Scanned within 12-hours - all Strokes	100%	94.4%	95.7%	94.8%	100.0%	97.1%	98.4%	98.2%	93.7%	97.1%	100.0%	98.6%	98.6%	
	Total Thrombolysis rate for confirmed Strokes	11%	12.5%	7.2%	4.8%	16.7%	10.1%	9.5%	7.0%	14.3%	8.6%	10.0%	12.3%	8.5%	
	Thrombolysed within 60-minutes of arrival	-	77.8%	60.0%	66.7%	60.0%	42.9%	33.3%	25.0%	33.3%	n/a	42.9%	22.2%	16.7%	
	Discharged with JCP	80%	91.5%	98.0%	95.6%	100.0%	88.8%	97.8%	94.6%	97.6%	100.0%	100.0%	97.9%	100.0%	
	Discharged with ESD	40%	50.0%	46.9%	45.7%	59.2%	50.0%	54.3%	45.9%	64.4%	56.8%	48.1%	51.9%	44.4%	

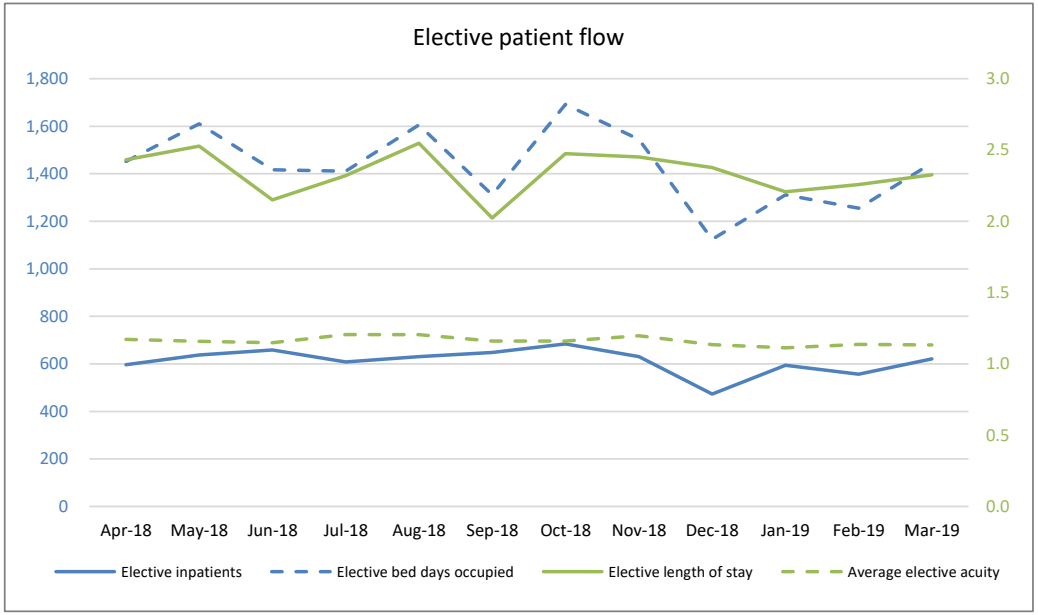
Responsive Services

East and North Hertfordshire NHS Trust

Patient Flow

Domain	Metric	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Trend
ED Flow Indicators	A&E & UCC attendances	12,261	13,227	12,854	13,268	12,178	12,333	13,297	12,627	12,517	13,690	12,788	14,266	
	Attendance to admission conversion rate	23.1%	22.6%	22.0%	21.3%	23.5%	23.1%	23.6%	24.9%	24.7%	25.1%	24%	23%	
	ED attendances per day	409	427	428	428	393	411	429	421	404	442	457	460	
	AEC attendances per day	40	43	43	47	51	47	47	44	45	49	51	49	
	4-hour target performance %	85.6%	89.7%	86.9%	84.2%	84.7%	87.3%	87.8%	90.3%	86.9%	85.2%	80.5%	81.0%	
	Time to initial assessment 95th centile	47	40	54	58	51	53	57	57	59	58	60	75	
	Ambulance handover breaches 30-minutes	422	203	248	511	457	406	491	247	373	516	597	606	

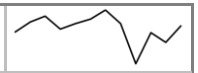
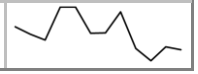
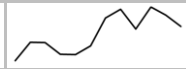
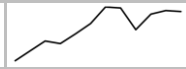




Responsive Services

Patient Flow

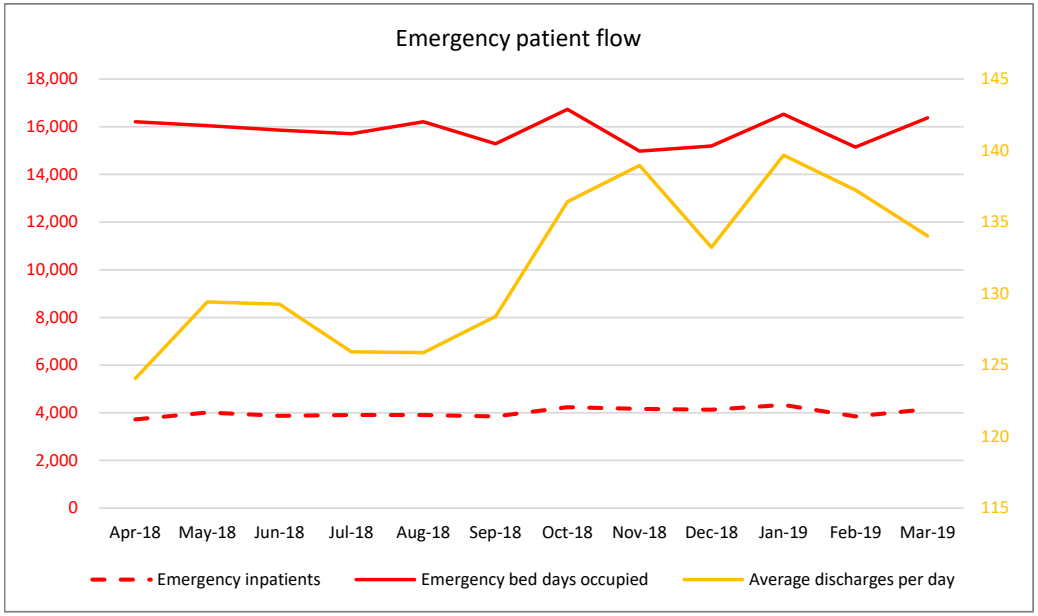
East and North Hertfordshire NHS Trust

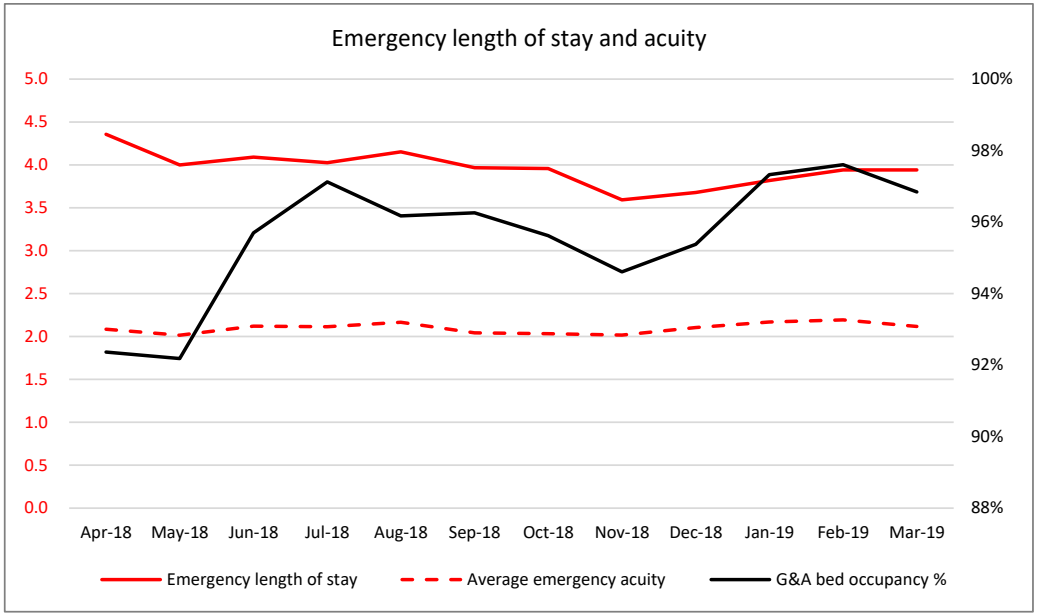
Domain	Metric	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Trend
Elective Inpatient Flow Indicators	Elective inpatients	597	637	659	608	630	648	684	630	473	594	556	621	
	Elective bed days occupied	1,452	1,610	1,417	1,411	1,605	1,311	1,692	1,544	1,124	1,311	1,255	1,445	
	Elective length of stay	2.4	2.5	2.2	2.3	2.5	2.0	2.5	2.5	2.4	2.2	2.3	2.3	
	Daycase rate %	83.2%	84.0%	82.8%	84.5%	83.1%	82.8%	84.0%	84.4%	86.0%	86.0%	84.8%	84.0%	
	Average elective acuity	1.2	1.2	1.1	1.2	1.2	1.2	1.2	1.2	1.1	1.1	1.1	1.1	
Emergency Flow Indicators	Emergency inpatients	3,722	4,012	3,878	3,904	3,902	3,852	4,229	4,169	4,130	4,330	3,843	4,155	
	Average discharges per day	124	129	129	126	126	128	136	139	133	140	137	134	
	Emergency bed days occupied	16,216	16,052	15,860	15,714	16,209	15,286	16,732	14,979	15,192	16,528	15,146	16,380	
	Emergency length of stay	4.4	4.0	4.1	4.0	4.2	4.0	4.0	3.6	3.7	3.8	3.9	3.9	
	Average emergency acuity	2.1	2.0	2.1	2.1	2.2	2.0	2.0	2.0	2.1	2.2	2.2	2.1	
	G&A bed occupancy %	92%	92%	96%	97%	96%	96%	96%	95%	95%	97%	98%	97%	
	Patients discharged via Discharge Lounge	63	88	112	106	130	156	198	195	141	180	189	186	
	Discharges before midday	15.9%	16.4%	16.4%	16.2%	15.4%	13.3%	14.7%	14.6%	14.6%	14.7%	14.4%	14.3%	
	Weekend discharges	15.8%	14.5%	16.8%	14.1%	14.6%	17.3%	13.8%	14.8%	17.2%	15.4%	15.7%	16.6%	
	Proportion of beds occupied by patients with length of stay over 14 days	24.0%	23.2%	22.9%	21.4%	20.5%	20.9%	21.1%	20.8%	18.7%	19.4%	19.1%	20.1%	
	Proportion of beds occupied by patients with length of stay over 21 days	13.6%	12.7%	13.5%	12.4%	11.7%	11.1%	12.2%	11.1%	9.8%	10.3%	9.5%	10.9%	

Responsive Services

East and North Hertfordshire NHS Trust

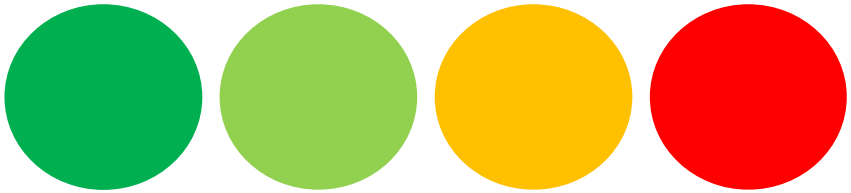
Patient Flow





Well-led Services

Month 12 | 2018-19



Key Issues

Staffing and Pay bill

- The vacancy and turnover rates both increased slightly in March, however both show an improvement from the start of the year.
- Agency spend remains on target however bank and permanent combined take pay bill above plan.
- The Trust is therefore overspent by £10.7m YTD in terms of the pay bill.

Sickness Absence

- Overall sickness rate reduced in March although remains above Trust target.
- Sickness absence is above plan at 4.2% in month and 4.3 year to date average.

Training & Development

- Appraisal compliance remained 82% in March, against a target of 90%.
- Mandatory training was under target by 1% in March.

Executive Response

The Trust continues to focus on nursing and medical recruitment to drive down the high cost temporary staffing spend. Although the vacancy rate for medical staff and non-qualified clinical staff went down the overall vacancy rate went up due to an increase in nursing vacancies. This was due to the ceasing of international recruitment in February in order to meet budgetary requirements. A business case for recruitment in 19/20 has been approved agreeing the continuation of international nurse recruitment at a lower level but with increased investment in domestic recruitment. The plans are set to achieve an increase in substantive workforce at a similar level to that achieved in 18/19 and achieve an over-all vacancy rate of 6%.

Securing suitable roles for the current third year student nurses who are due to qualify this summer is a priority and a comprehensive package is being developed to maximise registration opportunity. In addition, the recruitment open days continue to run on a monthly basis and a rotation scheme for band 5 nurses has been developed, which was formally approved in month 11. An internal transfer process was also approved in month 11 and is being launched to enable band 5 nurses to move within the Trust more easily rather than leave altogether.

There are a total of 43 WTE doctors in the pipeline, 10 who have already started, or are due to start, in month 12. A further 20 have confirmed start dates in 19/20. 4 further conditional offers have been made in month 12, in Clinical Oncology, Cardiology and Pathology.

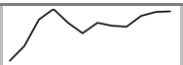
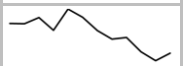
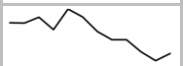
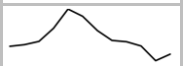
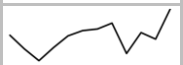
Sickness absence meetings are being held with divisions to address hotspots, ensure effective support and management and collate information on sickness absence related temporary staffing spend. Significant levels of intervention continue to be provided to managers whose team members require reasonable adjustments. Additional coaching and discussions are taking place to accurately articulate why adjustments may or may not be reasonable. All cases are monitored through the ERAS tracker system with a higher level of staff being supported and managed through to final stage review.

HR Business Partners are working with divisions to agree a recovery plan for improving appraisal rates. Reporting has been improved which demonstrates individuals outstanding.

Well-led Services

Workforce and Staff Development

East and North Hertfordshire NHS Trust

Domain	Metric	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Trend	Plan YTD	Actual YTD	Var YTD
Staffing	Approved Budget Establishment WTEs	5,877	5,892	5,919	5,930	5,916	5,905	5,915	5,912	5,912	5,923	5,927	5,927		5,927	5,927	0
	Permanent Staffing WTEs Utilised	5,038	5,028	5,011	5,016	5,011	5,002	5,052	5,084	5,084	5,077	5,114	5,123		5,670	5,123	-546
	Bank Staffing WTEs Utilised	406	452	429	467	521	463	508	473	435	485	495	566		217	566	349
	Agency Staffing WTEs Utilised	135	141	137	136	171	140	130	115	99	118	114	114		40	114	74
	Gap - Budget WTEs & Permanent WTEs	839	864	908	914	904	902	864	829	828	845	812	804		257	803	546
	Gap / Budget WTEs	14.3%	14.7%	15.3%	15.4%	15.3%	15.3%	14.6%	14.0%	14.0%	14.3%	13.7%	13.6%		6.0%	14.5%	8.5%
	Recruitable Vacant Posts	476	476	489	461	509	490	460	441	445	413	393	410		363	410	47
	Vacancy Rate	8.5%	8.5%	8.7%	8.2%	9.0%	8.7%	8.1%	7.8%	7.8%	7.3%	6.9%	7.2%		6.0%	7.2%	1.2%
	Turnover Rate	13.5%	13.5%	13.6%	13.8%	14.2%	14.1%	13.8%	13.6%	13.5%	13.5%	13.2%	13.3%		12.0%	13.6%	1.6%
Paybill Metrics	Total Trust Paybill - £m	22.7	23.0	22.4	22.8	23.4	22.8	23.2	23.2	22.9	23.5	23.2	23.6		266.1	276.8	10.7
	Total Permanent Staffing Costs - £m	19.5	19.8	19.6	19.7	20.1	19.5	20.0	19.8	20.0	20.3	20.0	20.1		250.7	238.5	-12.2
	Total Bank Costs - £m	2.2	2.1	1.9	2.1	2.2	2.3	2.3	2.3	2.0	2.2	2.2	2.5		11.8	26.2	14.4
	Total Agency Costs - £m	1.0	1.2	0.9	1.0	1.1	1.0	0.9	1.0	0.9	1.0	1.0	1.0		3.5	12.1	8.5
	Agency Costs as % of Paybill	4.4%	5.2%	4.0%	4.6%	4.7%	4.3%	3.8%	4.4%	3.8%	4.3%	4.4%	4.4%		1.3%	4.4%	3%

Well-led Services

Workforce and Staff Development

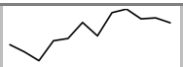
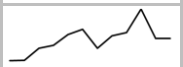
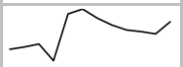
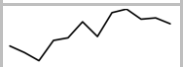
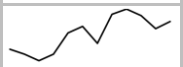
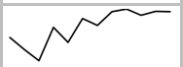
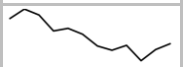
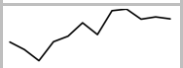
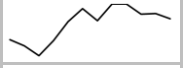
East and North Hertfordshire NHS Trust

Domain	Metric	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Trend	Plan YTD	Actual YTD	Var YTD
Training & Development	Staff Appraised	84%	86%	85%	86%	84%	83%	84%	86%	82%	83%	82%	82%		90%	84%	-6%
	Mandatory Training 100% Compliant	68%	69%	68%	64%	65%	65%	62%	62%	63%	61%	61%	62%		90%	64%	-26%
	Overall Training Compliant	88%	88%	87%	88%	88%	89%	88%	90%	90%	89%	89%	89%		90%	89%	-1%
Sickness	Sickness FTE Days Lost	6,313	6,323	6,105	6,561	6,299	6,089	7,293	7,477	8,189	7,832	6,845	6,835		79,292	82,160	2,869
	Short term sickness rates %	2.0%	1.9%	1.9%	2.1%	2.2%	1.8%	2.2%	2.5%	2.1%	2.4%	2.3%	2.1%		2.1%	2.1%	0.0%
	Long term sickness rates %	2.1%	2.1%	2.1%	2.0%	1.8%	2.1%	2.3%	2.2%	2.7%	2.4%	2.3%	2.0%		2.1%	2.2%	0.0%
	Sickness Rate	4.1%	4.0%	4.0%	4.1%	4.0%	4.0%	4.5%	4.8%	5.1%	4.8%	4.6%	4.2%		3.4%	4.3%	0.9%
	Staff on long term sick headcount	104	102	113	119	112	111	124	139	159	121	122	111		1,297	1,437	140
	Maternity % Headcount	2.1%	2.1%	2.1%	2.1%	2.2%	2.1%	2.2%	2.4%	2.4%	2.3%	2.3%	2.3%		1.8%	2.2%	0.4%
	Nursing (Q & U) sickness rate	5.2%	5.0%	5.4%	5.3%	5.3%	4.7%	5.0%	5.3%	5.8%	5.3%	5.3%	4.7%		5.3%	5.2%	-0.1%
	Nursing (Q & U) sickness days lost in month	3,324	3,325	3,477	3,494	3,471	2,989	3,376	3,461	3,900	3,559	3,226	3,190		41,298	40,790	-508

Well-led Services

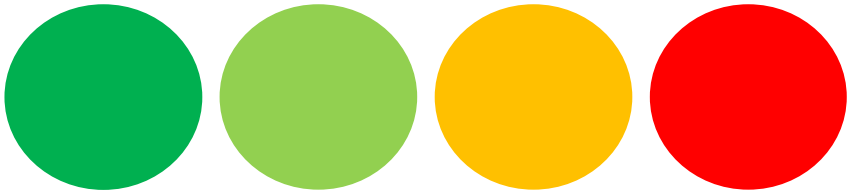
Workforce and Staff Development

East and North Hertfordshire NHS Trust

Domain	Metric	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Trend	Plan YTD	Actual YTD	Var YTD
Statutory and Mandatory Training	Conflict Resolution - 2 Years	90%	90%	89%	91%	91%	92%	91%	93%	93%	92%	93%	92%		90%	91%	1%
	Equality & Diversity	90%	90%	91%	91%	92%	92%	91%	91%	92%	93%	91%	91%		90%	91%	1%
	Equality, Diversity and Human Rights	67%	67%	68%	65%	73%	73%	72%	71%	70%	70%	69%	71%		90%	70%	-20%
	Fire Safety	84%	85%	85%	85%	85%	86%	84%	86%	86%	85%	85%	85%		90%	85%	-5%
	Health and Safety	90%	90%	89%	91%	91%	92%	91%	93%	93%	92%	93%	92%		90%	91%	1%
	IPC - Clinical 2 yr	90%	90%	89%	90%	91%	92%	90%	92%	93%	92%	91%	92%		90%	91%	1%
	IPC - Non-Clinical 2 yr	90%	88%	87%	91%	89%	92%	91%	93%	93%	92%	93%	93%		90%	91%	1%
	Information Governance	77%	79%	78%	74%	75%	74%	71%	70%	71%	68%	71%	72%		90%	73%	-17%
	Moving & Handling for People Handlers	92%	91%	90%	89%	91%	91%	91%	94%	94%	94%	93%	93%		90%	92%	2%
	Moving and Handling	91%	91%	90%	91%	92%	93%	92%	94%	94%	93%	93%	93%		90%	92%	2%
	Safeguarding Adults Level 1	89%	89%	88%	88%	89%	90%	89%	91%	91%	90%	90%	90%		90%	89%	-1%
	Safeguarding Adults Level 2	88%	88%	87%	86%	88%	89%	88%	90%	90%	90%	90%	89%		90%	89%	-1%
	Safeguarding Children Level 1	90%	90%	89%	90%	92%	93%	92%	94%	94%	93%	93%	92%		90%	92%	2%
	Safeguarding Children Level 2	90%	89%	89%	89%	92%	93%	92%	94%	93%	93%	92%	92%		90%	92%	2%
	Safeguarding Children Level 3	88%	86%	88%	85%	87%	89%	89%	88%	90%	88%	88%	87%		90%	88%	-2%

Sustainable Services

Month 12 | 2018-19



Key Issues

- The Trust's reported position at Month 12 is a deficit of £13.2m against a deficit plan of £0.3m, thus an adverse variance to plan of £12.9m at the year end. The position excluding the impact of the provider sustainability funding (PSF) is an adverse variance to plan of £8.0m.
- The Trust received £5.9m of PSF monies in M12 as a part of a national distribution of funds.
- Income shows a £9.1m favourable variance (excl. PSF and Pharma), of which £7.3m relates to over-performance on SLA income. The Trust has however incurred significant corresponding marginal and step change costs.
- The overall pay position is showing £10.7m adverse to plan. Overspends against Medical staff budgets accounts for £7.4m of this variance, and £2.8m relates to overspends against nursing staff budgets. The majority of this variance relates to shortfalls against workforce CIP schemes, and marginal costs associated with activity over performance.
- The 2018/19 financial plan had always anticipated that the second half of the year would see a significant increase in CIP delivery, and a rise in SLA income, to bring the Trust back to the agreed control total by the end of the financial year. The Trust was not able to deliver this stepped midyear change in financial performance.
- Trust financial performance was also impacted upon by a number of unplanned cost pressures, including significant increases in outsourced pathology costs, poor control of ED medical staffing costs, as well as unexpected consultant job planning arrears.
- The Trust submitted a reforecast outturn position to NHSI at Month 9. The final year end position is in alignment with this revised forecast.
- SLA activity performance improved in March, primarily driven by significant increases in levels of emergency and A&E activity, supplemented by improved planned delivery performance.
- CIP delivery continued to fall short of target. Cumulatively, CIP under achievement totalled £6.2m. The impact of shortfalls in pay efficiencies, particularly relating to outpatients and theatres, were offset to some extent by sizeable over performance on income/activity delivery.
- Shortfalls in Private Patient Income achievement and also shortfalls in the delivery of CQUIN targets have also had significant impacts upon the 18/19 position - combined impact - £2.4m.
- Consistent delivery of planned levels of surgical activity represents a significant ongoing concern. Achievement levels have generally been significantly below forecast levels in the second half of the year. Theatre productivity measures show a decline against 17/18 performance levels, which were themselves already extremely poor against national comparators. In addition, Theatre utilisation has been compromised in January, February and March by theatre infrastructure issues.

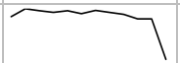
Executive Response

- As at Month 6 the Trust identified the likelihood of a material divergence from its Control Total without the agreement and implementation of a programme of significant remedial actions.
- These actions were outlined and agreed by the Trust Executive, Finance & Performance Committee and Trust Board at meetings during the course of September 2018. The mitigations were grouped under the generic heading of schemes designed to 'Improve Financial Delivery' (IFD).
- Within the scope of IFD - the Trust Executive met with all Divisional management teams on a weekly basis to review and track progress in the implementation and achievement of actions designed to improve the overall financial position. This was combined with a routine and detailed series of activities designed to improve discipline in respect of pay bill and non-pay management.
- In addition, the IFD programme has developed a series of 8 specific themes of project work designed to focus upon high impact areas where it is felt that significant progress can be made in reducing costs and controlling unplanned cost pressures. These eight project areas are led by specific Executive Directors, who are responsible for the achievement of these cost reductions - which were planned to total £4.0m between November and March. The project areas included - Private Patient maximisation, reducing ad-hoc payroll costs, delivering Procurement savings, reductions in A&C temporary staffing costs. As well as achieving reductions in Pharmacy and Pathology Costs. Finally, two project groups are focused upon achieving opportunities to reduce medical and nursing staffing costs through the improved rostering and planning.
- These IFD actions did provide mitigation benefit to the final outturn position, although on a more limited degree than had been originally anticipated.
- The Trust continues to maintain 'Model Hospital' project working groups, to drive progress across a number of other key clinical processes - i.e. Theatres, Outpatients, Consultant Job Planning as well as Inpatient Flow. The success and achievements of these groups has been extremely variable.
- The Trust also continues to schedule a weekly Information Assurance Group (IAG). Composed of key corporate and operational managers IAG meets to review and track SLA activity delivery and performance against both plan and forecast and agrees remedial action where required.
- The Trust PMO function remains embedded in terms of supporting divisional CIP projects, IFD meetings and activities as well as helping divisions to deliver improvements across key process themes.

Sustainable Services

Finance Plan Performance

East and North Hertfordshire NHS Trust

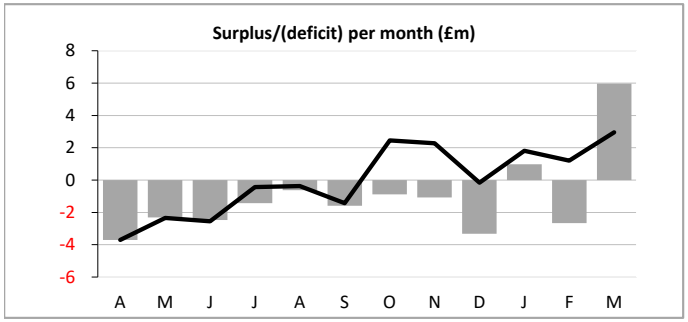
Domain	Metric	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Trend	Plan YTD	Actual YTD	Variance YTD
I&E Performance	SLA Income Earned	30.4	32.2	32.6	32.4	33.7	31.8	34.4	33.4	30.4	33.7	30.4	33.3		381.7	388.5	6.8
	Other Income Earned	3.3	5.5	4.3	4.8	5.4	4.8	5.0	5.3	5.1	5.4	4.8	-6.8		57.7	46.8	-10.9
	Pay Costs	22.7	23.0	22.4	22.8	23.4	22.8	23.2	23.2	22.9	23.5	23.2	23.6		266.1	276.8	10.7
	Non Pay Costs inc Financing	15.3	17.6	17.0	16.5	17.0	16.1	17.1	16.6	15.9	14.6	14.6	2.8		188.0	181.2	-6.8
	Underlying Surplus / (Deficit)	-4.4	-3.0	-2.5	-2.1	-1.3	-2.3	-0.9	-1.1	-3.3	1.0	-2.7	0.0		-14.6	-22.6	-8.0
	PSF Earned	0.7	0.7	0.1	0.7	0.7	0.7	0.0	0.0	0.0	0.0	0.0	5.9		14.4	9.5	-4.9
	Retained Surplus / Deficit	-3.7	-2.3	-2.5	-1.4	-0.6	-1.6	-0.9	-1.1	-3.3	1.0	-2.7	6.0		-0.3	-13.2	-12.9
Paybill Metrics	Substantive Pay Costs	19.2	19.5	19.3	19.3	19.8	19.3	19.6	19.4	19.7	19.9	19.7	19.8		250.2	234.4	-15.8
	Premium Pay Costs Overtime & WLI	0.3	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.3	0.4	0.4		0.5	4.1	3.6
	Premium Pay Costs Bank Costs	2.2	2.1	1.9	2.1	2.2	2.3	2.3	2.3	2.0	2.2	2.2	2.5		11.8	26.2	14.4
	Premium Pay Costs Agency Costs	1.0	1.2	0.9	1.0	1.1	1.0	0.9	1.0	0.9	1.0	1.0	1.0		3.5	12.1	8.5
	Premium Pay Costs As % of Paybill	15.6%	15.4%	14.1%	15.1%	15.6%	15.3%	15.3%	16.1%	14.1%	15.3%	15.3%	16.4%		5.9%	15.3%	9.4%

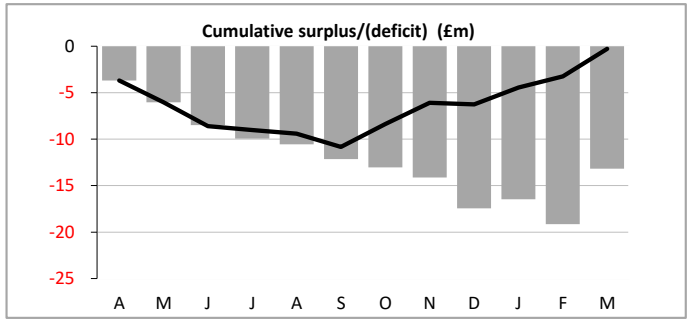
Sustainable Services

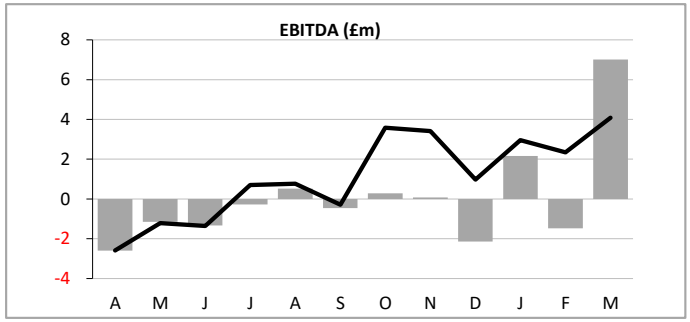
Finance Plan Performance

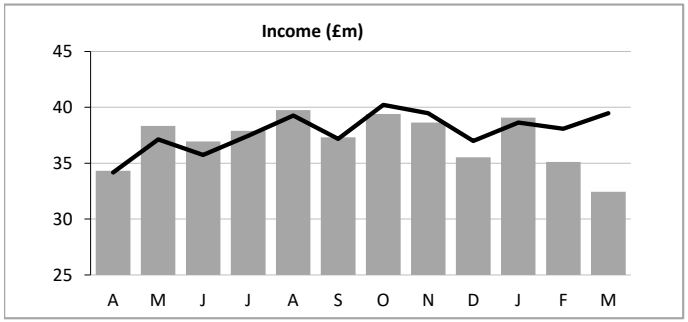
East and North Hertfordshire NHS Trust

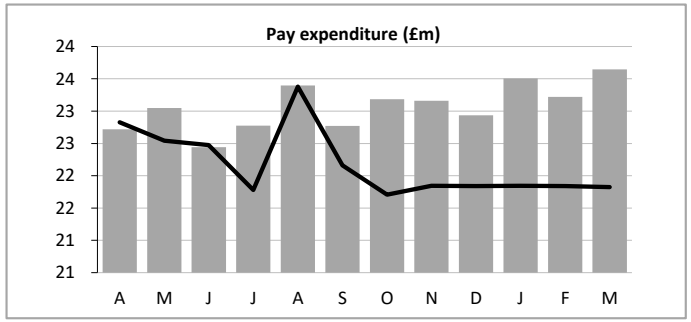
Domain	Metric	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Trend	Plan YTD	Actual YTD	Variance YTD
Single Oversight Framework	Capital Servicing Capacity	4	4	4	4	4	4	4	4	4	4	4	4		1	4	
	Liquid Ratio (Days)	3	3	4	4	4	4	4	4	4	4	4	4		1	4	
	I&E Margin	4	4	4	4	4	4	4	4	4	4	4	4		1	4	
	Distance from Plan	1	1	1	2	2	2	3	4	4	4	4	4		1	4	
	Agency Spend vs. Ceiling	1	2	1	1	2	1	1	1	1	1	1	1		1	1	
	Overall Finance Metric	3	3	3	3	3	3	3	3	3	3	3	3		1	3	

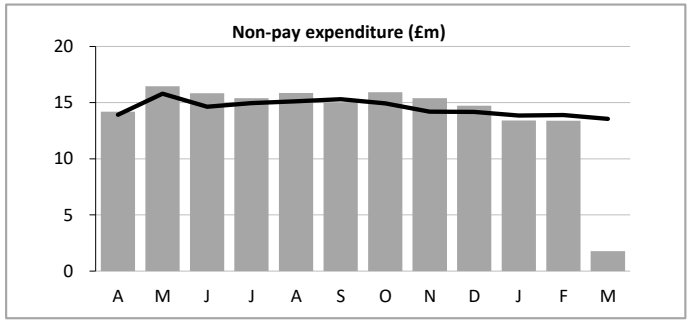












Sustainable Services

SLA Contracts - Income Performance

East and North Hertfordshire NHS Trust

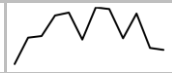
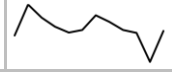
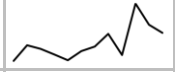
		In-Month			YTD		
		Planned Income	Actual Income	Income Variance	Planned Income	Actual Income	Income Variance
By Point of Delivery	A&E Attendances	1,780	1,909	129	20,871	23,173	2,302
	Daycases	2,618	2,456	-162	28,972	31,504	2,532
	Inpatient Elective	2,091	1,966	-126	23,112	22,373	-739
	Inpatient Non Elective	7,841	8,920	1,078	92,000	102,800	10,800
	Maternity	2,413	2,559	147	29,392	29,617	225
	Other	5,438	3,488	-1,950	57,085	47,623	-9,462
	Outpatient First	2,245	2,036	-209	24,880	24,171	-709
	Outpatient Follow Ups	2,136	1,977	-159	23,585	24,234	649
	Outpatient Procedures	1,124	1,134	10	12,430	12,763	333
	Other SLAs	55	55	0	655	655	0
	Block	835	835	-0	10,023	10,017	-6
	Drugs & Devices	3,251	3,200	-51	39,013	39,541	528
	Chemotherapy Delivery	512	528	15	6,145	6,773	628
	Renal Dialysis	1,044	1,084	39	12,534	12,750	216
	Total	33,385	32,145	-1,240	347,862	354,824	7,296

		In-Month			YTD		
		Planned Income	Actual Income	Income Variance	Planned Income	Actual Income	Income Variance
By Commissioner	East & North Herts CCG	19,178	18,949	-229	221,526	229,588	8,062
	Specialist Commissioning	7,350	7,057	-293	86,976	89,174	2,198
	Bedfordshire CCG	2,121	2,171	49	24,500	27,020	2,520
	Herts Valleys CCG	1,313	1,394	81	15,223	15,094	-130
	Cancer Drugs Fund	404	369	-35	4,847	4,699	-148
	Luton CCG	300	253	-47	3,455	3,381	-75
	PH - Screening	295	266	-29	3,405	4,316	911
	Other	2,424	1,687	-426	20,765	14,722	-2,651
By Division	Cancer Services	5,847	5,806	-41	69,059	71,564	2,505
	Medicine	9,791	10,364	573	113,603	120,794	7,192
	Women & Children	4,701	4,865	164	55,840	56,567	728
	Clinical Services	2,079	2,002	-76	24,727	24,269	-458
	Surgery	9,600	9,415	-185	108,140	111,504	3,364
	Other	1,367	-307	-1,674	9,329	3,294	-6,035

Sustainable Services

Activity and Productivity

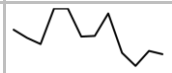
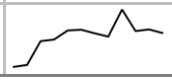
East and North Hertfordshire NHS Trust

Domain	Metric	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Trend	Plan YTD	Actual YTD	Var YTD
Patient Activity Levels	A&E & UCC	12,261	13,227	12,854	13,268	12,178	12,333	13,296	12,622	12,516	12,876	12,086	13,475		147,008	152,992	5,984
	Chemotherapy Atts	1,862	2,088	2,103	2,279	2,306	2,072	2,349	2,335	2,083	2,296	2,001	1,983		21,728	25,757	4,029
	Critical Care (Adult) - OBD's	475	489	665	554	636	491	839	569	566	729	464	577		6,688	7,054	366
	Critical Care (Paeds) - OBD's	519	530	511	531	602	505	589	404	486	398	379	442		6,857	5,896	-961
	Daycases	2,955	3,337	3,178	3,302	3,106	3,130	3,581	3,415	2,896	3,638	3,102	3,269		35,712	38,909	3,197
	Elective Inpatients	597	637	659	608	630	648	684	630	473	594	556	621		8,483	7,337	-1,146
	Emergency Inpatients	3,722	4,012	3,878	3,904	3,902	3,852	4,229	4,169	4,130	4,330	3,843	4,155		44,443	48,126	3,683
	Home Dialysis	142	150	146	172	164	163	182	175	186	195	163	178		1,318	2,017	698
	Hospital Dialysis	5,648	6,064	5,926	5,943	6,408	5,862	6,319	6,147	6,481	6,171	5,751	6,156		75,391	72,876	-2,515
	Maternity Births	436	500	473	454	442	447	478	464	447	441	381	445		5,468	5,408	-60
	Maternity Bookings	491	561	533	497	530	466	533	532	432	541	467	469		6,000	6,052	52
	Outpatient First	8,369	8,802	8,640	9,342	8,562	8,932	10,324	9,662	7,733	9,289	8,293	9,261		103,228	107,209	3,981
	Outpatient Follow Up	17,026	17,319	17,155	18,311	18,336	17,219	20,360	19,161	14,070	19,489	17,002	17,277		205,930	212,725	6,795
	Outpatient procedures	6,058	6,697	6,549	6,323	6,084	6,454	6,645	7,156	6,297	8,397	7,539	7,207		76,296	81,406	5,110
	Radiotherapy Fractions	4,074	4,633	4,802	4,833	4,921	4,566	5,125	5,273	4,381	5,286	4,773	5,048		58,395	57,715	-680

Sustainable Services

East and North Hertfordshire NHS Trust

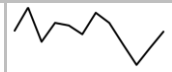
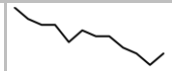
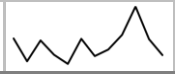
Activity and Productivity

Domain	Metric	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Trend	Plan YTD	Actual YTD	Var YTD
Throuhput	Elective Spells per Working Day	178	189	183	178	170	189	185	184	211	192	183	185		170	178	8
	Emergency Spells per Day	115	118	117	115	114	118	125	128	123	129	127	125		122	132	10
	ED Attendances per Day	409	427	428	428	393	411	429	421	404	415	432	435		403	419	16
	Outpatient Atts per Working Day	1,573	1,563	1,540	1,544	1,499	1,630	1,623	1,635	1,756	1,690	1,642	1,607		1,483	1,544	61
	Elective Bed Days Used	1,452	1,610	1,417	1,411	1,605	1,311	1,692	1,544	1,124	1,311	1,255	1,445		17,932	17,177	-755
	Emergency bed Days Used	16,216	16,052	15,860	15,714	16,209	15,286	16,732	14,979	15,192	16,528	15,146	16,380		197,218	190,294	-6,924
Efficiency	Admission Rate from A&E	23%	23%	22%	21%	24%	23%	24%	25%	25%	25%	24%	23%		23.3%	23.4%	0.1%
	Emergency - Length of Stay	4.4	4.0	4.1	4.0	4.2	4.0	4.0	3.6	3.7	3.8	3.9	3.9		4.4	4.0	-0.4
	Emergency - Casemix Value	2,086	2,015	2,119	2,114	2,166	2,043	2,033	2,018	2,103	2,170	2,194	2,119		2,017	2,098	82
	Elective - Length of Stay	2.4	2.5	2.2	2.3	2.5	2.0	2.5	2.5	2.4	2.2	2.3	2.3		2.2	2.3	0.1
	Elective - Casemix Value	1,171	1,158	1,148	1,205	1,205	1,160	1,161	1,197	1,134	1,113	1,137	1,132		1,172	1,160	-12
	Elective Surgical DC Rate %	83.2%	84.0%	82.8%	84.5%	83.1%	82.8%	84.0%	84.4%	86.0%	86.0%	84.8%	84.0%		85%	84.1%	-0.9%
	Outpatient DNA Rate % - 1st	15.2%	14.1%	12.4%	12.2%	12.1%	12.5%	12.0%	11.9%	12.8%	12.4%	12.5%	11.6%		13.8%	12.6%	-1.2%
	Outpatient DNA Rate % - FUP	11.0%	11.1%	9.0%	8.9%	8.5%	8.6%	7.5%	7.7%	8.2%	7.6%	7.1%	7.1%		11.5%	8.5%	-3.0%
	Outpatient Cancel Rate % - Patient	8.2%	8.3%	9.2%	9.2%	9.6%	9.6%	9.4%	9.3%	10.3%	9.5%	9.6%	9.5%		8.2%	9.3%	1.1%

Sustainable Services

Activity and Productivity

East and North Hertfordshire NHS Trust

Domain	Metric	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Trend	Plan YTD	Actual YTD	Var YTD
Efficiency	Outpatient Cancel Rate % - Hosp	6.2%	6.7%	6.6%	5.8%	5.9%	6.0%	6.6%	6.4%	6.7%	6.1%	6.3%	6.4%		6.4%	6.3%	-0.1%
	Outpatients - 1st to FUP Ratio	2.0	2.0	2.0	2.0	2.1	1.9	2.0	2.0	1.8	2.1	2.1	1.9		2.0	2.0	-0.0
	Theatres - Ave Cases Per Hour	2.7	2.9	2.8	2.7	2.8	2.9	2.8	2.6	2.9	2.7	2.7	2.8		2.9	2.8	-0.1
	Theatres - Utilisation of Sessions	80%	82%	78%	81%	80%	79%	82%	81%	78%	76%	78%	80%		85%	80%	-5%
	Theatres - Ave Late Start (mins)	33	31	30	30	27	29	28	28	26	25	23	25		27	28	1.2
	Theatres - Ave Early Finishes (mins)	40	35	40	37	35	40	36	38	41	47	40	37		39	39	-0.4

Sustainable Services

Cost Improvement Plan (CIP) Delivery

East and North Hertfordshire NHS Trust

Domain	Metric	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Trend	Annual Plan	Plan YTD	Actual YTD	Variance YTD
CIP Delivery by Workstream	Divisional Productivity Schemes	361	341	349	623	438	887	551	939	61	332	590	960		5,972	5,972	6,431	459
	Divisional Cat C income schemes	18	14	42	58	136	44	146	89	33	78	45	19		1,618	1,618	721	-897
	Divisional Non-pay schemes	138	134	170	343	256	254	565	317	511	69	335	315		4,666	4,666	3,408	-1,258
	Divisional Pay schemes	3	1	9	179	265	101	78	98	86	74	75	75		1,741	1,741	1,044	-697
	Model Hospital Outpatients	0	0	30	0	0	824	70	158	323	216	11	254		1,164	1,164	1,886	723
	Model Hospital Theatre efficiency	0	0	0	325	232	188	74	0	150	41	0	79		2,304	2,304	1,089	-1,215
	Pathology	0	26	10	306	38	35	39	42	55	61	71	71		1,298	1,298	753	-545
	Procurement	87	87	90	350	123	158	126	207	77	241	185	181		2,055	2,055	1,913	-143
	Under/(Over) identified	0	0	0	0	0	0	0	200	0	0	0	0		638	639	200	-439
	Workforce Cross cutting schemes	2	2	2	0	0	9	410	0	8	5	6	0		1,103	1,103	444	-659
	Workforce Temp staff reduction	0	0	0	0	416	2	-399	5	26	25	18	23		1,599	1,599	116	-1,483
	Total CIP Delivery	**609**	**605**	**702**	**2,184**	**1,904**	**2,502**	**1,660**	**2,055**	**1,330**	**1,141**	**1,336**	**1,976**		**24,158**	**24,158**	**18,004**	**-6,154**

Sustainable Services

Cost Improvement Plan (CIP) Delivery

East and North Hertfordshire NHS Trust

Domain	Metric	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Trend	Annual Plan	Plan YTD	Actual YTD	Variance YTD
CIP by Nature	Recurrent	606	602	691	1,749	1,676	2,375	1,514	1,971	1,059	1,212	1,250	1,879		21,022	21,022	16,584	-4,438
	Non-Recurrent	3	3	11	435	228	127	146	84	271	-70	86	97		3,136	3,136	1,420	-1,716
	Total CIP Delivery	**609**	**605**	**702**	**2,184**	**1,904**	**2,502**	**1,660**	**2,055**	**1,330**	**1,141**	**1,336**	**1,976**		**24,158**	**24,158**	**18,004**	**-6,154**
CIP Delivery by Division	Cancer	8	-3	16	159	286	233	173	345	127	121	87	145		2,437	2,437	1,696	-740
	Clinical Support	32	64	83	374	98	298	230	174	252	213	213	332		3,275	3,275	2,363	-912
	Corporate	206	207	210	215	657	235	237	264	322	110	289	241		3,967	3,967	3,192	-775
	Medicine	135	135	186	437	160	536	423	622	92	290	390	590		6,065	6,065	3,996	-2,069
	Surgery	70	70	100	567	440	904	284	482	425	275	225	491		5,978	5,978	4,332	-1,646
	Women's & Children's	158	132	107	432	263	296	313	168	112	133	133	178		2,436	2,436	2,425	-11
	Total CIP Delivery	**609**	**605**	**702**	**2,184**	**1,904**	**2,502**	**1,660**	**2,055**	**1,330**	**1,141**	**1,336**	**1,976**		**24,158**	**24,158**	**18,004**	**-6,154**
CIP Delivery by Type	Net Unidentified	0	0	0	0	0	0	-1	1	0	0	0	0		619	619	0	-619
	Non-Pay	224	246	267	991	401	422	696	541	420	532	559	518		7,763	7,763	5,817	-1,945
	Pay	6	4	45	513	930	-438	124	330	323	-35	115	131		8,458	8,458	2,048	-6,410
	Other	379	355	390	680	573	2,518	841	1,183	587	644	661	1,327		7,318	7,318	10,139	2,821
	Total CIP Delivery	**609**	**605**	**702**	**2,184**	**1,904**	**2,502**	**1,660**	**2,055**	**1,330**	**1,141**	**1,336**	**1,976**		**24,158**	**24,158**	**18,004**	**-6,154**

Sustainable Services

Productivity and Efficiency of Services - 2017-18 YTD vs. 2018-19 YTD

NHS East and North Hertfordshire NHS Trust

Activity Measures	2017-18 YTD	2018-19 YTD	Change
Emergency Department Attendances	148,894	152,992	4,098
Emergency Department Ave Daily Atts	408	419	11
Admission Rate from ED %	30.4%	23.4%	-7%
Non Elective Inpatient Spells	45,261	48,126	2,865
Ave Daily Non Elective Spells	124	132	8
Daycase Spells	35,357	38,909	3,552
Elective Inpatient Spells	8,086	7,337	-749
Ave Daily Planned Spells	119	127	8
Day Case Rate	81%	84%	3%
Adult & Paeds Critical Care Bed Days	13,503	12,950	-553
Outpatient First Attendances	101,748	107,209	5,461
Outpatient Follow Up Attendances	200,649	212,725	12,076
Outpatient First to Follow Up Ratio	2.0	2.0	0.0
Outpatient Procedures	72,175	81,406	9,231
Ave Daily Outpatient Attendances	1,026	1,100	73

Workforce Measures	2017-18 YTD	2018-19 YTD	Change
Average Monthly WTE's Utilised	5,543	5,658	115
Average YTD Pay Cost per WTE	47,456	48,924	3.1%
Staff Turnover	13.1%	13.6%	0.6%
Vacancy WTE's	663	803	140
Vacancy Rate	11.6%	14.5%	3.0%
Sickness Days Lost	79,292	82,160	2,869
Sickness Rate	4.3%	4.3%	0.1%
Agency Spend- £m's	12.4	12.1	-0.4
Temp Spend as % of Pay Costs	4.7%	4.4%	-0.4%
Ave Monthly Consultant WTE's Worked	307.0	312.2	5.2
Consultant : Junior Training Doctor Ratio	1 : 1.6	1 : 1.7	0.0
Ave Monthly Nursing & CSW WTE's Worked	2,401.1	2,417.3	16.3
Qual : Unqualified Staff Ratio	69 : 25	67 : 25	-0.1
Ave Monthly A&C and Senior Managers WTE's	1,206	1,240	33
A&C and Senior Managers % of Total WTE's	21.8%	21.9%	0.1%

Sustainable Services

Productivity and Efficiency of Services - 2017-18 YTD vs. 2018-19 YTD

NHS
East and North Hertfordshire
NHS Trust

Capacity Measures	2017-18 YTD	2018-19 YTD	Change
Non Elective LoS	4.4	4.0	-0.4
Elective LoS	2.2	2.3	0.1
Occupied Bed Days	215,150	207,471	-7,679
Adult Critical Care Bed Days	6,832	7,054	222
Paediatric Critical Care Bed Days	6,671	5,896	-775
Outpatient DNA Rate	10%	9%	-1.4%
Outpatient Utilisation Rate	28%	24%	-4.3%
Total Cancellations	105,243	123,512	18,269
Theatres - Ave Cases per Hour	2.9	2.8	-0.1
Theatres - Ave Session Utilisation	81%	80%	-1.6%
Theatres - Ave Late Start (mins)	27	28	1
Theatres - Ave Early Finishes (mins)	34.3	39.0	5
Radiology Examinations	396,134	404,161	8,027
Drug Expenditure (excl HCD & ENH Pharma) - £000s	8,491	10,749	2,258
High Cost Drug Expenditure - £000s	39,067	38,566	-501

Finance & Quality Measures	2017-18 YTD	2018-19 YTD	Change
Profitability - £000s	-27.3	-13.2	14.2
Monthly SLA Income £000s	30,852	32,378	1,526
Monthly Clinical Income per Consultant WTE	£100,502	£103,722	£3,220
High Cost Drug Spend per Consultant WTE	£127,262	£123,543	-£3,719
Average Income per Elective Spell	£1,157	£1,160	£3
Average Income per Non Elective Spell	£2,037	£2,098	£61
Average Income per ED attendance	£142	£152	£10
Average Income per Outpatient Attendance	£133	£133	£0
Ave NEL Coding Depth per Spell	2	2	-0
Procedures Not Carried Out	1,928	1,404	-524
Best Practice HRGs (% of all Spells)	9.8%	9.7%	-0.1%
Ambulatory Best Practice (% of Short Stays)	n/a	n/a	n/a
Non-elective re-admissions within 30 days Rolling 12-months to Sep-18	9,328	9,437	109
Non-elective re-admissions within 30 days % Rolling 12-months to Sep-18	9.26%	7.92%	-1.34%
SLA Contract Fines - £000's	370	210	-160

East and North Hertfordshire NHS Trust

Agenda Item: 10.2 (A)

TRUST BOARD - PUBLIC SESSION – 1 MAY 2019
FINANCE AND PERFORMANCE COMMITTEE – 27 MARCH 2019
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max):

To present to the Trust Board the summary report from the Finance and Performance Committee (FPC) meeting of 27 March 2019.

The report includes details of any decisions made by the FPC under delegated authority.

Action required: For discussion

Previously considered by:
N/A

Director:	**Presented by:**	**Author:**
Chair of FPC	Chair of FPC	Trust Secretary

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
The discussions at the meetings reflect the BAF risks assigned to the FPC.

Any other risk issues (quality, safety, financial, HR, legal, equality):

Proud to deliver high-quality, compassionate care to our community

FINANCE AND PERFORMANCE COMMITTEE – 27 MARCH 2019

EXECUTIVE SUMMARY REPORT TO TRUST BOARD – 1 MAY 2019

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

The following core attendees were present:
Nick Carver (Chief Executive Officer), Jude Archer (Associate Director of Corporate Governance), Martin Armstrong (Director of Finance), Mike Chilvers (Medical Director), Julie Smith (Chief Operating Officer) and Susan Young (Interim Chief People Officer).

DECISIONS MADE UNDER DELEGATED AUTHORITY:

FINAL BUDGET APPROVAL 2019/20

The Committee considered the final draft budget for 2019/20. The FPC had received delegated authority from the Trust Board to review and approve the budget. Following feedback from NHSI, the Trust had increased its planned CIP target level to £15m. The contracts with commissioners and NHS England had now been agreed. It was proposed that a block arrangement contract was in place for specialist commissioning rather than the payment by results (PBR) model. The plan included a £4m contingency and the paper included detail on some possible opportunities and risks. The Committee noted the limited capital available for 2019/20 and discussed possible funding options.

The Finance and Performance Committee approved the budget for 2019/20 on behalf of the Trust Board.

OTHER MATTERS CONSIDERED BY THE COMMITTEE:

BOARD ASSURANCE FRAMEWORK

The Committee considered the latest edition of the Board Assurance Framework. There would be a full review of the BAF over April to ensure that the risks remained relevant and aligned with the Trust's new five strategic priorities, clinical strategy and operating plan 2019/20. The key risks were covered through reports on the agenda for discussion.

INTEGRATED PERFORMANCE REPORT

The Committee received the latest Integrated Performance Report, covering month 11. The key points under each of the domains included:

Responsive Services –

- ED performance in February was at 80.53% which was a deterioration compared to recent months but an improvement on the performance at the same point in 2018. There would be continued focus on improving performance against this target.
- 5 of the 8 cancer performance standards were being achieved. The contracting of additional capacity had now been agreed.
- RTT – February performance was at 90.32%, demonstrating sustained improvement on the previous month's position and a position that was ahead of the national average.

Well-Led Services -

- The vacancy rate continued to make improvements and was now at 6.9% from a peak of 9% in August.

- The turnover rate had dropped to 13.17%, lower than the turnover rate at the same point in 2018.
- There was a continued focus on the development of actions in response to the staff survey results.

Sustainable Services -

- The Trust's reported position at Month 11 was a deficit of £19.1m against a deficit plan of £3.2m year to date. The year to date position excluding the impact of the provider sustainability funding was an adverse variance to plan of £8.4m.
- SLA activity was lower than targeted in February, primarily driven by significant reductions in Laminar Flow theatre capacity. There was a possibility that some legacy issues would also impact into March. This highlighted the importance of considerations relating to the support and maintenance of the theatre activity.

The Committee also received brief updates regarding the Safe, Caring and Effective domains which had been discussed at the Quality and Safety Committee meeting the previous day.

OUTTURN FORECAST

The Committee received the 2018/19 outturn forecast review. The revised control total deficit the Trust was aiming to deliver was £23.1m. It was considered that the control total deficit was likely to be achievable on the basis that March activity was in line with expectations. The anticipated CIP delivery was in the region of £17m. The Committee discussed the need to learn lessons from the current year in relation to CIPs, in order to be able to start delivering on CIPs earlier in the year and to ensure appropriate phasing of CIP delivery.

2019/20 CIP PLAN UPDATE

The Committee received an update regarding CIP planning for 2019/20. More work had gone into the early stages of planning so that the teams could start delivery sooner. The Committee noted that there must be a change in approach from last year in order to achieve the desired results. It remained the intention to phase the delivery of the CIPs but it was recognised that delivery planned for the end of the year must not be too ambitious given other challenges the Trust was likely to face at that time. It was noted that if the CIPs were delivered, the proposed contingency fund could be used for 'invest to save' schemes. It was noted the CIP target for the corporate team accounted for a significant proportion of the total this year. The FPC looked forward to seeing a more developed plan at their next meeting.

PAYBILL DEEP DIVE

The FPC received a report that had been requested at the previous meeting regarding the challenges the Trust had faced with regard to the paybill. The report had been developed jointly by the workforce and finance teams and provided an initial insight into the position. The report demonstrated that there had been year on year pay growth over recent years, as well as an overall increase in the volume of staff (WTE). Whilst the use of agency staff had reduced and the use of bank staff had increased, the proportion of permanent staff had remained fairly static. It was discussed that recruitment of a permanent member of staff should in theory lead to a drop in the number of temporary staff needed. A range of further work was suggested in order to better understand the position. The importance of understanding the assumptions and expectations used at the outset of the year was discussed. The Committee requested an update on the overall control framework and the actions taking place at a future meeting.

PLAN ON A PAGE
The FPC was asked to provide feedback on the draft 'Plan on a page 2019-20'. The overall format was endorsed but some updates to the content were suggested and agreed. The final version would be approved by the Board at the next Board Development meeting.

STRATEGY DEVELOPMENT PROGRAMME AND REPORT FROM STRATEGY PROGRAMME BOARD
The FPC received an update on progress with implementation of the Trust's Clinical Strategy 2019-24. Work was taking place to raise awareness of the new strategy and in relation to the development of the supporting strategies.

STRATEGIC PROJECTS REPORT
The Committee received an update regarding the Trust's key strategic projects. The Committee discussed some elements of the projects and noted the report.

EU EXIT REPORT
The FPC noted the latest EU exit report which reflected the latest position regarding the work that was underway across the Trust to identify and mitigate risks and ensure business continuity in the event of a 'No Deal' EU exit.

STABILISATION AND OPTIMISATION UPDATE
An update regarding the stabilisation and optimisation programmes was provided. Currently 32 of 90 stabilisation opportunities had been delivered. There would be a further update on delivery of the opportunities at the next Board Development meeting. The Committee discussed the provision of training, the Nervecentre system and its compatibility with Lorenzo and the current position in terms of the Trust's transition from stabilisation to optimisation.

Karen McConnell
Finance and Performance Committee Chair

March 2019

East and North Hertfordshire NHS Trust

Agenda Item: 10.2 (B)

TRUST BOARD - PUBLIC SESSION – 1 MAY 2019
FINANCE AND PERFORMANCE COMMITTEE – 24 APRIL 2019
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max):

To present to the Trust Board the summary report from the Finance and Performance Committee (FPC) meeting of 24 April 2019.

The report includes details of any decisions made by the FPC under delegated authority.

Action required: For discussion

Previously considered by:
N/A

Director:	**Presented by:**	**Author:**
Chair of FPC	Chair of FPC	Trust Secretary

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
The discussions at the meetings reflect the BAF risks assigned to the FPC.

Any other risk issues (quality, safety, financial, HR, legal, equality):

Proud to deliver high-quality, compassionate care to our community

FINANCE AND PERFORMANCE COMMITTEE – 24 APRIL 2019

EXECUTIVE SUMMARY REPORT TO TRUST BOARD – 1 MAY 2019

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

The following core attendees were present:
Jude Archer (Associate Director of Corporate Governance), Martin Armstrong (Director of Finance), Mike Chilvers (Medical Director), Julie Smith (Chief Operating Officer) and Susan Young (Interim Chief People Officer).

DECISIONS MADE UNDER DELEGATED AUTHORITY:

No decisions were made under delegated authority.

OTHER MATTERS CONSIDERED BY THE COMMITTEE:

BOARD ASSURANCE FRAMEWORK
The Committee received the latest Board Assurance Framework. The Committee were asked to endorse the proposed updates including the reduction of risk 1 (which was assigned to the FPC and related to capacity and demand) to a score of 16 for year end. The Committee also considered the revised strategic risks for 2019/20 following the Board Development discussion in April 2019. The risks were now being reviewed in line with the new BAF format approved by the Audit Committee, with the full review due to be presented to the Board Committees in May. The Committee suggested it would be useful to include a section on lessons learnt from 2018/19 in the next report. It was also suggested that reports in general could be more specific in relation to any relevant risks and potential impacts.

EXPANDED FPC TERMS OF REFERENCE FOR TRIAL PERIOD
Following the Board's agreement to extend the remit of the FPC to include all workforce matters for a trial period of three months, the Committee considered a proposed revised Terms of Reference for the duration of the trial period which reflected the expanded remit. The FPC broadly supported the proposed Terms of Reference.

DEEP DIVE METHODOLOGY
The FPC considered a paper which set out a proposed methodology and reporting cycle for a programme of deep dives to be provided by divisional teams in 2019/20. This was in order to ensure that the deep dives were productive and useful for both the FPC and the teams attending to present at the meetings. The Committee welcomed the review and supported the proposals.

INTEGRATED PERFORMANCE REPORT
The Committee received the latest Integrated Performance Report, covering month 12. The Committee received the following updates:

Safe and Caring and Effective Services:
A brief update was provided regarding the safe & caring and effective services domains, though it was noted that a detailed discussion had taken place at the QSC meeting the previous day.

Responsive Services:

- ED performance remained challenging with 81% achieved against the 4 hour target in March 2019. Work was continuing to take place to try and improve this

performance. The Committee discussed the A&E performance in terms of contributing factors and some of the next steps required.

- In terms of performance against the cancer targets, 4 of the 8 national targets for cancer performance had been achieved in February 2019. It was expected that a greater number of the standards would be met in the next edition of the IPR.
- RTT performance remained good, with the Trust performing above the national average.
- Diagnostics performance was at 1.34% against the national standard of 1%.

Well-led Services:

- It was noted that the vacancy rate was improving. The Committee briefly discussed the impact of international recruitment and noted that a business case relating to international recruitment of nurses had now been agreed by the executive team and would be presented to the next FPC meeting.
- There would be a discussion regarding the pay-bill later in the meeting.
- The agency ceiling target had been achieved for 2018/19
- Appraisal performance was below the target level and would be worked on with the divisional teams.
- The Committee also discussed mandatory training and agreed that a detailed breakdown of the components and metrics was needed for the next meeting.

Sustainable Services:

- The Trust had achieved against the revised control total target, ending the year with an underlying deficit of £22.6m. The Committee was informed of some of the key factors affecting M12 performance.
- It was noted that the External Audit of the Trust accounts was now commencing.

CIP PERFORMANCE ANALYSIS AND UPDATE

The Committee received a report on CIP performance. The report reflected on performance in 2018/19 and provided an update in terms of the 2019/20 CIP plan delivery. In terms of the 2019/20 plan, there had been good progress over recent weeks with £8.5m now in delivery. The Committee also discussed the phasing of the CIP plan which should be constructed so as to aim to reduce the risk of slippage from 2019/20 as much as possible. The Committee would continue to receive regular updates regarding the CIP plan and next steps.

MANAGEMENT OF BUDGET RISKS AND OPPORTUNITIES 2019-20

The Committee received an update on the risks and opportunities in relation to the 2019-20 budget. This report had been requested at the previous meeting so as to provide the FPC with a means of monitoring the risks. The Committee noted the report.

PAYBILL DEEP DIVE UPDATE

Following the discussions at the previous meeting, the Committee received two further update reports regarding work taking place to review issues behind the growth of the Trust's pay-bill. The Committee was informed that from the analysis it appeared that the growth in staffing numbers was in the context of a relatively stable position in terms of activity. The papers highlighted a number of areas for further work including a look into unit price increases, vacancy validation and approval processes and medical locum costs. The Committee also discussed the importance of realistic and achievable workforce planning, the effects of a focus on reducing agency costs and whether improvements could be made in terms of time to recruit. The Committee requested the development of an action plan and milestones to measure progress against the actions proposed.

EMPLOYEE RELATIONS STRATEGY
The Committee considered a draft employee relations strategy for approval. The strategy would help to address some of the concerns highlighted by the staff survey results, such as in relation to bullying and harassment. The strategy would also be a key means of improving sickness absence. It was considered that due to variations in the way that sickness was currently recorded across the Trust, work to improve sickness rates would be a complex task. It was considered that the possibility of extra investment to help with this work could be explored due to the potential benefits to quality, morale and finances that could be gained. The Committee also discussed the importance of providing good health and wellbeing support to staff. The FPC requested an action plan to monitor the implementation of the strategy.

TALENT MANAGEMENT REPORT
The paper outlined work taking place and opportunities available for Trust staff in relation to talent management. The Committee discussed the success of the Trust's LEND programmes and whether they could be utilised further. It was agreed that further details of objectives and outcomes that the FPC could measure progress against were needed.

EDI REPORT
The Committee considered an update regarding equality, diversity and inclusion. The EDI Strategy had been updated to reflect the NHS Long Term plan but it was recognised that the strategy did not yet align with Trust's new clinical strategy. The Committee requested that the strategy was developed further to include milestones and action plans.

GENDER PAY GAP UPDATE
The Committee noted the action plan that had been developed following the gender pay gap report (presented at the last Trust Board meeting). It was suggested that six-monthly updates were provided to the FPC regarding the action plan.

JUNIOR DOCTORS CONTRACT QUARTERLY UPDATE
The Committee received the latest junior doctors contract quarterly update. For the period of the report there were 77 Exception Reports submitted. Most of the reports were from Foundation Year Doctors in Medicine and Surgery. There were 6 patient safety reports in the period. The causes of the incidents that were deemed relevant in terms of patient safety were largely linked to absences on rotas that had not been covered. Relating to the impact of unfilled shifts, the Committee discussed the importance of new staffing roles to address national staffing shortages related to traditional roles.

NURSING AND MEDICAL EDUCATION REPORTS
<u>Nursing</u>
The Committee was informed that work was taking place to align all education services within the Trust. Currently the Director of Nursing was lead director for all statutory and mandatory training and there would be a more detailed look at this at the next meeting. Key updates provided included the latest position in terms of CPD funding allocations, an update regarding the new nursing associate role and work taking place to help develop ward leaders.

<u>Medical</u>
The Committee also received the medical education update. The need for more space for simulation and library services was highlighted. The FPC was informed that the Trust's allocation of core trainees had reduced. The report included an update on the latest GMC survey and annual trainee survey results. Regarding the GMC survey, it was reported that there had been an increase in red flags compared to the previous year and an action plan had been developed in response. The Committee also discussed the new physician's associate role.

FIVE YEAR STRATEGY DEVELOPMENT: PROGRAMME HIGHLIGHTS REPORT
The Committee received an update regarding the implementation of the Trust's new clinical strategy. The strategy was now in the communications phase and recent work included a programme of internal communications to inform staff of the new strategy. Key actions planned for the next reporting period included further work on the enabling strategies.

DIGITAL PROGRAMME UPDATE
The Committee received an update on the digital programme. The work relating to the stabilisation and optimisation of Lorenzo had now been brought in-house. The Committee discussed the optimisation possibilities identified previously and the need to ensure these were not lost, even if not taken forward at this time. The Committee also noted the ongoing importance of clinical engagement in relation to the digital programme. The FPC was informed of plans to develop a digital strategy in line with the Trust's clinical strategy.

Karen McConnell
Finance and Performance Committee Chair

April 2019

East and North Hertfordshire NHS Trust

Agenda Item: 10.2.1

TRUST BOARD - PUBLIC SESSION – 1 MAY 2019
Temporary Amendment to Committee Terms of Reference

Purpose of report and executive summary:
At the Board development meeting on 3 April, it was agreed that for a 3 month trial period, Workforce issues would be taken to the Finance and Performance Committee (FPC) to ensure that Workforce issues were given a higher prominence, and to give Board members the opportunity to have greater assurance regarding the workforce.

The purpose of this paper is to suggest some temporary amendments to the existing FPC terms of reference to enable the consideration of a wider range of issues over the next 3 months.

It is proposed that the July FPC meeting considers whether this has been a successful arrangement.

The proposed temporary amendments were endorsed by the FPC at their meeting on 24 April 2019.

Action required: For approval

Previously considered by:
Board Development Meeting on 3 April 2019 considered the proposal to establish a Workforce Committee.
Finance and Performance Committee meeting on 24 April 2019.

Director:	**Presented by:**	**Author:**
Interim Chief People Officer	Interim Chief People Officer	Interim Chief People Officer

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☐
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☐
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☐
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☐

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
1. There is a risk that the trust is unable to recruit and retain sufficient supply of staff with the right skills to meet the demand for services

2. There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered and motivated, impacting on the trust's ability to deliver the required improvements and transformation and to enable people to feel proud to work here.

Any other risk issues (quality, safety, financial, HR, legal, equality):

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EAST AND NORTH HERTFORDSHIRE NHS TRUST
FINANCE AND PERFORMANCE COMMITTEE 24 April 2019

TEMPORARY AMENDMENT TO FINANCE AND PERFORMANCE TERMS OF REFERENCE

Purpose of the paper

The purpose of this paper is to suggest some temporary amendments to the existing FPC Terms of Reference to enable the consideration of workforce issues over the next 3 months. The existing Terms of reference (ToR) are at Appendix 1, and the proposed amendments are listed below.

Decision requested

The committee is asked to approve the suggested amendments to the ToR.

Background

East and North Hertfordshire NHS Trust (ENHT) currently has 4 sub-committees of the Board covering:

- Finance and Performance
- Quality and Safety
- Audit, and
- Remuneration.

Workforce issues are currently split between the Finance and Performance Committee and the Quality and Safety Committee, which creates additional pressure for space on those already heavy agendas. Workforce issues tend to have less time on those agendas than the other main items and so do not have the same rigour and scrutiny applied as those other items. Many NHS Trusts and Foundation Trusts have found it useful to have a separate Workforce Committee or People and Organisational Development Committee.

At the Board development meeting on 3 April, a paper was presented proposing how ENHT might benefit from having a separate Workforce Committee. At that meeting it was agreed that, for a 3 month trial period, Workforce issues would be taken to the Finance and Performance Committee (FPC) to ensure that all Workforce issues were given a higher prominence, and to give Board members the opportunity to have greater assurance regarding the workforce.

Proposed Temporary Amendments

Additional Purpose (ToR 1):

To provide assurance to the board on the delivery of the People/Workforce strategy and ensure compliance with statutory targets and legislation relating to the employment of staff. The committee would also ensure that the trust's workforce has the capacity and capability to deliver the trust's strategic vision through effective management, leadership and development, workforce planning and organisational development.

Revised membership (ToR 3):

- Director of Nursing to become a core attendee
- Deputy Director of Workforce to become an additional attendee.

In addition, an omission from a previous version of the ToR was the addition of the PMO Director to the attendees, and it has been requested that this also be agreed in the revised version of the ToR.

Revised Quorum (ToR 4)

To include at least one Workforce representative (Chief People Officer or Deputy)

Additional Duties (ToR 6.4):

- Develop and oversee the delivery of the Trust's People/Workforce Strategy and ensure this is aligned with the trust's vision and strategy
- Scrutinise and oversee risks related to workforce (BAF risks and the highest of the other corporate/divisional risks)
- Identify annual objectives to inform an annual work plan.
- Review performance indicators relevant to workforce including sickness absence, bank/agency usage and expenditure, training, appraisal, staff turnover.
- Monitor action plans to deliver improved performance where performance below target
- Oversee delivery of specific CIP/efficiency programmes/ improvements relating to workforce
- Monitor and evaluate compliance with key legal and professional body requirements including revalidation arrangements
- Oversee and scrutinise trust processes and outputs for workforce planning, and approve submissions to NHSI and HEE
- Oversee the development and delivery of a workforce development plan based on annual training needs analysis conducted via the appraisal system to ensure education and training plans support the development of a competent and capable workforce
- Monitor the effectiveness of the trust's staff engagement strategy including review of staff survey results, monitoring implementation of the action plan and effectiveness of the arrangements to engage staff
- Ensure the development of standardised and improved HR systems and policies
- Provide assurance to the Trust board that HR initiative in support of strategic workforce development are making appropriate progress against agreed measures.
- Provide assurance that the Trust is compliant with relevant HR legislation and best practice.
- Oversee the Trust's involvement in STP workforce initiatives

Review and Evaluation of the trial

It is proposed that the July meeting considers whether this has been a successful arrangement. In doing so the Committee may wish to consider, for example, whether there has been:

- Progress on workforce issues as a result of the improved governance arrangements
- Sufficient time allocated to workforce issues, and
- Any adverse impact on other business of FPC.

Susan Young
Interim Chief People Officer

APPENDIX 1

EAST AND NORTH HERTFORDSHIRE NHS TRUST

FINANCE AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. Purpose

The purpose of the Finance and Performance Committee is to support the further development of the financial strategy of the Trust, to review the strategy as appropriate and monitor progress against it to ensure the achievement of financial targets and business objectives and the financial stability of the Trust.

This will include:

- overseeing the development and maintenance of the Trust's medium and long term financial strategy;
- reviewing and monitoring financial plans and their link to operational performance;
- overseeing financial risk management;
- scrutiny and approval of business cases and oversight of the capital programme;
- maintaining oversight of the finance function, key financial policies and other financial issues that may arise.

The Committee will also oversee aspects of the underpinning activity performance of the Trust, along with responsibility for the IM&T strategy transformation programme to improve data quality and hospital efficiency to ensure the Trust is prepared for forthcoming major financial challenges facing the NHS.

2. Status & Authority

The Committee is constituted as a formal Committee of the Trust Board and is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

3. Membership

Three Non-Executive Directors, one of whom will be nominated as Chair

Core Attendees:

Chief Executive
Director of Finance
Chief Operating Officer
Director of Strategy
Chief People Officer
Medical Director *(moved to core attendee)*
Company Secretary

Attendees:

Director of Nursing
Chief Information Officer/ Stabilisation Director
Deputy Director of Finance

All other Non-Executive Directors/Directors are welcome to attend.
Other staff will be invited to attend to present an item to the Committee or to support their personal development with the prior agreement of the Committee Chair.

If a conflict of interests is established, the above member/attendee concerned should declare this and withdraw from the meeting and play no part in the relevant discussion or decision.

4. Quorum

Two Non-Executive Directors and two core attendees one of whom should be either:

- Director of Finance or in their absence
- Chief Executive and a designated Finance representative

5. Frequency of meetings

The Committee will meet every month with the exception of August. The Chair of the Committee may convene additional meetings if required to consider business that requires urgent attention.

6. Duties

6.1 Financial Planning

Act as an Assurance Committee of the Trust's business and finance risks through the following activities

To determine or approve:

- The Trust's Marketing strategy and review and monitor progress against this;
- Individual investment decisions including a review of Outline and Full Business Cases between £500k and £1 million.

To recommend to the Board:

- The Trust's Integrated Business Plan, develop and approve a financial framework to support the delivery of the Trust's strategic objectives;
- The Medium Term Financial Strategy and the Long Term Financial Model and recommend its adoption to the Board;
- Approve proposals for the reinvestment of any surpluses generated by the Trust in undertaking its operational activities and recommend to the Board;
- Receive the annual plan and budgets for revenue and capital and recommend adoption by the Board;
- For investment decisions or schemes in excess of £1 million, the Committee will make a recommendation to the Trust Board, who will ultimately make a decision on the proposal;
- Recommend the Cost Improvement Programme to the Board and refer any potential concerns on quality to the Quality and Safety Committee for scrutiny.

To monitor and review:

- Enabling strategies and their impact on the Medium Term Financial Strategy and the Long Term Financial Model;
- The capital programme and work of the Capital Review Committee;
- The development of the annual Cost Improvement Programme and oversee development of the rolling programme that is to be incorporated into the Long Term Financial Model and monitor in year delivery;
- Value for money and efficiency issues as required to ensure problem areas are addressed and action taken as appropriate;
- The performance of Divisions and Services;
- Progress against the Sustainability and Transformation Partnerships;
- The development of financial forecasts and measures taken to promote financial sustainability.

6.2 Investments

To recommend to the Board:

- A Treasury Management Policy including delegated arrangements and recommend its adoption by the Board.

To monitor and review:

- Reports as appropriate from the Director of Finance on transactions undertaken on behalf of the Trust.

6.3 Performance

Regularly review the performance of the Trust against financial performance targets as described in the NHSI Single Oversight Framework. This review should include:

To determine or approve:

- In conjunction with the Audit Committee agree the timetable for the Annual Accounts and receive the External Auditors report and review and monitor the associated action plan.

To recommend to the Board:

- The application of contingency funding where appropriate;
- A review of the performance of the Trust against the NHS Improvement (NHSI) Oversight Framework and other national targets and local priority measures on the Trust's Integrated Performance Report.

To monitor and review:

- Financial performance in relation to both the capital and revenue budgets;
- Financial performance in relation to activity and Service Level Agreements;
- Financial performance in relation to sensitivity analysis and the risk environment;
- To commission and receive the results of in depth reviews of key financial issues affecting the Trust;
- To monitor the progress of the Trust's strategic projects;
- To monitor the benefits realisation of major projects.

6.4 Other duties

To recommend to the Board:

- The Information Management and Technology Strategy and monitor the implementation against the implementation plan.

To monitor and review:

- The people/workforce strategy and key indicators in relations to finance and performance;
- Procurement activities, progress against savings targets, tender waivers and key strategic tenders.

6.4 Financial Risk Reporting

The Committee will regularly receive financial risk register reports for review and consider with the appropriate escalation to the Trust Board and for incorporation within the Board Assurance Framework.

7. Reporting arrangements

The Committee will identify and report the key issues requiring Board consideration to the Trust Board after each meeting.

It will make recommendations to the Board, Executive Team and Executive Directors for these groups/individuals to take appropriate action.

8. Process for review of Committee's work including compliance with terms of reference

The Committee will monitor and review its compliance through the following:

- The Committee report to Trust Board;
- FPC annual evaluation and review of its terms of reference.

9. Support

The Company Secretary will ensure the Committee is supported administratively and advise the Committee on pertinent areas.

East and North Hertfordshire NHS Trust

Agenda Item: 10.3 (A)

TRUST BOARD - PUBLIC SESSION – 1 MAY 2019
QUALITY AND SAFETY COMMITTEE – 26 MARCH 2019
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max):		
To present to the Trust Board the summary report from the Quality and Safety Committee (QSC) meeting of 26 March 2019. The report includes details of any decisions made by the FPC under delegated authority.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of QSC	**Presented by:** Chair of QSC	**Author:** Corporate Governance Officer

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
The discussions at the meetings reflect the BAF risks assigned to the QSC.
Any other risk issues (quality, safety, financial, HR, legal, equality):

Proud to deliver high-quality, compassionate care to our community

QUALITY AND SAFETY COMMITTEE – MEETING HELD ON 26 MARCH 2019

SUMMARY REPORT TO TRUST BOARD – 1 MAY 2019

The following Non-Executive Directors were present:

Peter Carter (Chair), David Buckle (Associate Non-Executive Director), Val Moore and Ellen Schroder

The following core attendees were present:

Jude Archer, Nick Carver, Michael Chilvers, Rachael Corser, Tom Pounds and Julie Smith

The following points are specifically highlighted to the Trust Board:

Quality strategy

The Director of Nursing presented the draft Quality Strategy 2019-2024. Quality was one of the five priorities of the Trust's Clinical Strategy. The Quality Strategy would therefore be a key supporting strategy in delivering the Clinical Strategy. It was the intention to review and refresh the quality priorities on a yearly basis. The Committee supported the content of the strategy but suggested that the format and flow of the document could be improved. The Quality Strategy would be discussed again at the next Board Development meeting.

BAF Discussion and Corporate Risk Register Report, including Risk Management Strategy

The latest version of the Board Assurance Framework was presented for discussion. The Board Assurance Framework (BAF) provides a structure and process which enables the Board to focus on the principal risks which might compromise the achievement of the Trust's strategic objectives. The BAF would be reviewed over the next month to incorporate recommendations from the Internal Auditors and to review strategic risks and ensure alignment with the Trust's new five strategic priorities, clinical strategy and operating plan 2019/20 to identify any other potential strategic risks.

The Committee discussed the status of the risk register which provided an overview of key risk management developments in the Trust. The There was some discussion regarding the volume of risks and the performance of the various corporate and divisional teams. The Committee also requested further information regarding a risk relating to the water supply at MVCC.

Other outcomes:

Integrated Performance Report

The Committee reviewed the latest version of the IPR and were informed of the following key points:

Safe and Caring Domains –

- The Trust is in the highest (best performing) quartile for harm-free care in February.
- It had been several months since the Trust had last reported never event.
- An update was provided regarding sepsis compliance and NEWS2 implementation.

There remained a continued focus on improving complaints timeliness.

Effective Services -

- Mortality rate performance remained good and showed sustained improvements over the last 5 years. It was considered that this reflected improvements in quality that had taken place.

Responsive Services -

- In January 2019 the Trust achieved 5 of the 8 national targets for cancer performance. Extra capacity had now been agreed with the CCG. Delivery was targeted for September 2019.
- Increasing attendances at A & E had been a challenge, with performance in February 2019 of 80.53%. A variety of work was underway to help improve ED performance.
- Regarding RTT, incomplete performance for February was 90.32%.

Well led –

- The vacancy and turnover rates were above the Trust target in February, however both show an improvement on the previous month.
- The sickness rate reduced in February although remained above the Trust target. Work was taking place to support managers with long and short term absences.
- HR business partners were working with divisions to agree a plan for improving appraisals rates.

Draft Plan on a Page

The Head of Business Development presented the Draft Plan on a Page for discussion. The Plan on a Page was developed to focus attention on the key strategic objectives identified to support the Trust's identified strategic priorities of: Quality, People, Pathways, Ease of Use and Sustainability. The committee was asked to provide feedback on the document's alignment with the organisational priorities for 2019/20. The Committee supported the draft plan on a page.

Internal Audit Plan

The Associate Director of Corporate Governance presented the Internal Audit Plan for 2019/2020 for consideration by the Committee. The Audit Committee would review and approve the final work plan at their next meeting on 1 April. The QSC endorsed the draft plan for 2019-20.

Quality Transformation Programme Deep Dive – Hospital Acquired Thrombosis

The Committee received a Deep Dive in regard to Hospital Acquired Thrombosis (HAT). The paper informed the Committee of current governance processes and future plans regarding HAT. The Committee noted the update.

Staff Survey Update

An action plan to address the results of the staff survey conducted in 2018 was presented to the committee. In areas where the trust has had some focus over the past year, the results have improved compared with the previous position. However many of the results are not where the trust would want them to be, with 5 out of the 9 indicators which are comparable with last year having fallen. It was proposed that a bi-monthly update would be produced regarding progress with the actions being taken in relation to the staff survey. The Committee noted the draft plans and proposed governance arrangements.

Patient Safety Incident report

The Director of Nursing presented the patient safety incident report. The Committee noted the trends in the latest data. It was reported that the Trust was in the upper quartile regarding the proportion of patients with harm free care. The Committee also discussed GP liaison hotline queries. The Committee noted the report.

SI and Never Event Report

The Committee received an update regarding serious incident and never event data, including compliance. The Serious Incident Review Panels were now fully embedded. The

number of serious incidents declared compared with the same time period in 2017 has increased – most likely as a result of an improvement in identification processes. The Trust was now working towards improving timeliness of declaring SIs to the CCG. The Committee discussed duty of candour and some of the themes identified from the incidents.

Safer Staffing Report

The temporary staffing demand increased from January to February. This was due to the winter ward staffing demand and a higher level of non-worked time (annual leave, sickness, study leave and parenting leave) in addition to vacancies. Although bank filled hours increased and Agency filled hours remained static this did not fully meet the increase in demand. Rapid response bank pool shifts continued to be utilised to mitigate the risk of unfilled shifts. The Committee also briefly discussed staffing forecasts more generally. There would be further discussion on this at a future meeting.

Infection Prevention and Control Report

The Director of Nursing presented a report on infection prevention and control to inform the committee of infection prevention and control performance for the period ending 28 February 2019. The Committee noted there would be a focus on equipment cleanliness.

Clinical Harm Reviews Monthly Update

The Medical Director presented the latest Clinical Harm Review Monthly Update to inform the committee of developments relating to the Harm Review Process. Performance has improved due to a reduction in the surgery backlog.

The following reports were noted by the committee

QSC Subcommittee Escalation Reports

The Committee noted the escalation report from the Patient and Carer Experience Committee.

CQC and Compliance Update

The Committee noted the CQC and Compliance Update. The latest CQC Insight dashboard had been published since the report had been written. The Trust's position had improved move close to the median for all acute trusts.

Maternity Dashboard

The Committee noted the latest Maternity Dashboard.

HPFT Memorandum of Understanding

The Committee noted a Memorandum of Understanding between HPFT and Hertfordshire Partnership University NHS Foundation Trust (HPFT). The MoU dealt with issues where people with a mental health condition were detained under the Mental Health Act 1983 (as amended by the 2007 Act) (MHA) at ENHT or are transferred from HPFT to ENHT for treatment. It further covered details of how the two trusts can work together to ensure that patients detained under the MHA have their entitlements, obligations and safeguards as set out in the MHS observed.

Peter Carter
March 2019

East and North Hertfordshire NHS Trust

Agenda Item: 10.4

TRUST BOARD - PUBLIC SESSION – 1 MAY 2019
AUDIT COMMITTEE – 1 APRIL 2019
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max):

To present to the Trust Board the summary report from the Audit Committee meeting of 1 April 2019.

The report includes details of any decisions made by the Audit Committee under delegated authority.

Action required: For discussion

Previously considered by:
N/A

Director:	**Presented by:**	**Author:**
Chair of Audit Committee	Chair of Audit Committee	Trust Secretary

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
N/A

Any other risk issues (quality, safety, financial, HR, legal, equality):

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AUDIT COMMITTEE – MEETING HELD ON 1 APRIL 2019

SUMMARY REPORT TO BOARD – 1 MAY 2019

The following members were present: Jonathan Silver (Chair), Karen McConnell and Bob Niven

MATTERS REFERRED TO BOARD

Review of Risk Management Strategy and risk register report
The Committee received the latest risk register report which provided an update regarding the current risk register and an overview of key risk management developments in the Trust. The Committee noted the updates provided and briefly discussed the risk management performance of some of the divisional and corporate teams. Whilst some teams were already performing well, support was continuing to be provided to assist all areas to reach the desired level of performance.

The Committee also considered the draft Risk Management Strategy 2019-20. The updated strategy now included the risk escalation process that had been implemented during the year and also information regarding the Trust's risk appetite. The Committee endorsed the Risk Management Strategy 2019-20 for approval by the Trust Board.

OTHER

Internal Audit Progress Report
The Committee received the latest internal audit progress report. Since the last Audit Committee meeting, four final reports had been issued as follows:

- IT infrastructure
- Key Financial Controls – General Ledger
- Key Financial Controls – Creditors
- Key Financial Controls – Debtors

The IT infrastructure and Key Financial Controls – General Ledger audits received 'partial assurance' opinions, whilst the Key Financial Controls – Debtors audit received a 'reasonable assurance' opinion and the Key Financial Controls – Creditors audit received a 'substantial assurance' opinion.

The Committee discussed the actions being taken in relation to the two audits which received 'partial assurance' opinions. Regarding the IT infrastructure audit, it was recognised that a considerable amount of work was taking place in relation to IT infrastructure and cyber security more generally, but currently a number of key control issues existed which led to the 'partial assurance' opinion. The Committee received updates from the Associate Director of IT on the key issues identified by the audit. The possible use of external funding sources would be explored for issues where capital investment was needed. The Committee also discussed the testing of IT business continuity plans. An update on progress in this area would be provided for the next meeting.

Regarding the Key Financial Controls – General Ledger audit, the Committee were informed of the plans to improve key control design and compliance weaknesses. This was currently being explored with the ledger provider.

The Committee noted that four audits from the 2018-19 work pan remained in progress.

Internal Audit Tracking Report
The Committee received the latest version of the Internal Audit Tracking Report. Whilst some actions had been closed since the previous meeting, a number remained outstanding. The Committee were keen to see performance improve for the next meeting. The following actions were agreed to improve performance:

- There will be greater clarity around the director and action owners at the stage at which actions are agreed.
- Work will continue to take place with the Internal Auditors to look ahead to actions that are nearing their target date.
- There will be a review of actions around data quality to ensure that the action owners and lead directors are aware of the information required.
- The Committee will consider the possibility of inviting executive directors with outstanding actions to future meetings to be held accountable for the delay.
- Action target dates will be reviewed so that actions are due to be completed prior to the Audit Committee meetings.

Local Counter Fraud Specialist Progress Report and 2019/20 Plan
The Committee received the LCFS Progress Report, which detailed work that had taken place since the previous meeting. The Committee noted improvements in the risk profile relating to Declarations of Interest and Procurement. The Committee also noted feedback from the Internal Auditors related to the source of counter fraud referrals compared to other trusts and in relation to overseas visitors, which had been requested at a previous meeting. The Committee discussed that the highest category of referrals for the Trust was relating to staff working whilst sick. The Committee discussed the importance of taking all possible actions to deter staff from doing this.

The Audit Committee also received the draft LCFS work plan for 2019/20, which had been produced based on analysis of the Trust's emerging, internal and external fraud risks and the requirements of the NHS Counter Fraud Authority. The Committee approved the work plan.

Draft Head of Internal Audit Opinion
The Committee received the draft Head of Internal Audit Opinion for 2018/19. The draft opinion was currently expected to be the same as the previous year's opinion, as set out below:

'The organisation has an adequate and effective framework for the management, governance and internal control.

However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.'

Internal Audit Plan 2019-20
The Committee reviewed the proposed Internal Audit Plan 2019-20. The plan had been considered by the Executive Committee and Quality and Safety Committee and had also been discussed with the AC Chair previously. The Committee requested an additional audit regarding paybill control mechanisms to take place early in 2019/20. The Internal Auditors would work with the Trust to review how this could be accommodated. The Committee also requested to see the plan based on the number of working days involved in each audit (as opposed to just the fee). Subject to those changes, the Committee approved the Internal Audit Plan 2019-20.

Cyber Security Report
The Committee received the latest cyber security report. It was reported that good progress had been made with critical and high risks (with no current critical risks outstanding) but there had been a steady increase in medium and low risks over the last year. This increase was considered to be in part due to better monitoring of risks by the Trust and in part due to a continuously increasing volume of cyber threats nationally. The Committee noted the various key updates that were provided and the issues that were presented as being the most significant in terms of improving cyber security. The Committee requested feedback on outstanding high risk actions and noted the report.

Data Quality and Clinical Coding Report
The Committee considered the latest Data Quality and Clinical Coding Report. The report included an update regarding implementation of the Data Quality Improvement Strategy, validation of CCG claims and challenges and the discharge summary project. In terms of clinical coding, it was noted that the coding backlog and depth of coding had improved over the last couple of years. The Committee discussed the impact of Lorenzo stabilisation in terms of data quality and clinical coding. It was noted that there would be a further discussion on stabilisation and the move towards optimisation at the next Board Development meeting. It was agreed that there would be a deep dive in relation to discharge summaries for the next meeting.

Board Assurance Framework 2018/19 and revised framework for 2019/20
The Committee considered the latest edition of the BAF. The BAF continued to be presented to the QSC and FPC on a monthly basis and also to the Trust Board meetings that were held in public.

The Committee also considered the proposed revised framework for the BAF for 2019/20. This had been developed based on guidance from the Internal Auditors and NHS Providers and the types of framework used at other high performing trusts. It was the intention that the new framework would improve visibility and accountability relating to controls and action owners, and of the impact of the actions. The executive team would review the actions during April to ensure the risks remained relevant and appropriate. It was suggested that the actions should specify the desired outcomes so that those could be measured more easily. The Committee supported the proposed framework.

Policies for Audit Committee Approval:

- **Capital Asset Disposal Policy**
- **Treasury Management Policy**

The Committee reviewed the two policies referred to above. Subject to some minor changes, the Committee approved the policies.

Bad Debt Write Off for Audit Committee Approval
The Committee discussed a paper regarding two irrecoverable debts from overseas visitors. The paper sought approval from the AC for writing off the debts. Following consideration of the paper, the Committee supported the recommendations.

Jonathan Silver
Non-Executive Director

April 2019

East and North Hertfordshire NHS Trust

Agenda Item: 11 (A)

TRUST BOARD – PUBLIC SESSION – 1 MAY 2019
Board Assurance Framework Update

Purpose of report and executive summary (250 words max):
To present the latest version of the Board Assurance Framework for discussion (appendix 1) and the revised BAF strategic risks for 2019/20 (appendix 2) for consideration.

The Board are asked to

- Endorse the proposed updates – including the reduction of two risks to their target scores for the year end. Risk 1 (performance) to 16 and risk 11 (Quality) to 15.
- Consider any further recommendations and required assurances.
- Note no adverse changes in risk scores this month
- Note a total of 4 risks met their original targets for year end and a total of 12 if you consider the revised targets following a review at the end of Q3.
- Note risk 8 – Business Continuity will be de-escalated from the BAF to the Corporate Risk Register
- Consider the revised strategic risks for 2019/20 – following the Board Development discussion in April 2019
- Note that the risks are now being reviewed in line with the new BAF format approved in April 2019 by the Audit Committee with each Executive Director. The new format reflects the recommendations from Internal Auditors and best practice examples. It will enable the Board and its committees to have clearer visibility of the causes and effects of the risk and greater alignment of the controls, assurances and actions; thus supporting scrutiny and challenge and strengthening effective review and management of our risks. This will be in line with the strategic risks in line with the Operating Plan 2019/20 and Clinical Strategy 2019-2024. The full review will be presented to the Audit Committee and other Board Committees in May.

Action required: For discussion

Previously considered by:
Executive Committee, 18.04.19
Updates endorsed by QSC and FPC in April 2019.
The Board Assurance Framework is considered at each FPC,QSC & Public Board.

Director:	**Presented by:**	**Author:**
Director of Strategy	**Associate Director of Corporate Governance**	**Associate Director of Corporate Governance**

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☐

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
Yes – CQC compliance will link with all the BAF Risks

Any other risk issues (quality, safety, financial, HR, legal, equality):

Proud to deliver high-quality, compassionate care to our community

Board Assurance Framework: April 2019 year-end review for 2018/19.

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.

Level	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			

Trust risk scoring matrix and grading

Likelihood

Impact	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
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**

BOARD ASSURANCE FRAMEWORK OVERVIEW

Risk Ref	Risk Description	Lead Executive	Committee	Current Risk	Last Month	3 months ago	6 months ago	Target Score (reviewed January 2019)	Date added
Corporate objective 1: Delivering our promise on value and quailty									
001/18	There is a risk that within the context of the Healthcare Economy the Trust has insufficient capacity to sustain timely and effective patient flow through the system which impacts the delivery of the 62day cancer, RTT and the A&E 4-hour standards	Chief Operating Officer	**FPC**	**16**	**20**	**20**	**20**	**16 (was 12)**	01-03-18
002/18	There is a risk to the availability of appropriate staff to fill establishment for nursing and medical staff.	Director of Nursing /Medical Director/CPO	**QSC**	**12**	**12**	**16**	**16**	**12**	01-03-18
003/18	There is a risk that the Trust is unable to achieve financial performance in 18/19 as a result of not securing the required efficiency improvement within its cost improvement plan and its income.	Director of Finance	**FPC**	**25**	**25**	**16**	**20**	**25 (was 16)**	01-04-17
004/18	There is a risk that the Trust is unable to deliver target levels of patient activity and achieve reimbursement from commissioners for activity in 18/19	Director of Finance	**FPC**	**20**	**20**	**16**	**20**	**20 (was 12)**	01-04-17
005/18	There is a risk that the Trust's IT systems are not sufficiently embedded/stabilised to ensure the hospital is run in a safe and effective way	Director of Finance/ COO	**FPC**	**20**	**20**	**20**	**20**	**15** (was 10)	01-04-17
006/18	There is a risk that there is insufficient capital funding to address all high/medium estates backlog maintenance, including fire estates work, and funding for medical equipment	Director of Finance	**FPC**	**20**	**20**	**20**	**16**	**20 (was 16)**	01-03-18
007/18	There is a risk that the governance structures in the Trust do not facilitate visibility from board to ward and appropriate performance monitoring and management to achieve the Board's objectives	Chief Executive	**Board of Directors**	**12**	**12**	**12**	**12**	**12**	01-03-18
008/18	There is a risk that the Trust is not adequately prepared to deal with a major incident or emergency	Chief Operating Officer	**QSC**	**12**	**12**	**12**	**12**	**12 (was 9)**	01-03-18
013/18	There is a risk that the Trust is adversely affected by the United Kingdom's departure from the European Union, particularly in the event of no deal being secured.	Director of Strategy	**FPC**	**16**	**16**	**12**	**n/a**	**16**	19-09-18
014/18	There is a risk that the Trust's Estates and Facilities compliance arrangements including fire management are inadequate leading to harm or loss of life.	Director of Strategy	**QSC**	**20**	**20**	**N/A**	**N/A**	**10**	22/01/19
Corporate objective 2: New ways of caring									
009/18	There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered, impacting on the Trust's ability to deliver the required improvements and transformation	Chief People Officer	**FPC & QSC**	**16**	**16**	**16**	**16**	**16 (was 12)**	01-03-18
010/18	There is a risk that the Healthcare Economy does not work effectively to redesign new models of care, which impacts on the hospital's ability to manage demand for services	Director of Strategy	**FPC**	**12**	**12**	**12**	**12**	**12**	01-03-18
011/18	There is a risk that the Trust is not always able to consistently embed of a safety culture and evidence of continuous quality improvement and patient experience	Director of Nursing /Medical Director	**QSC**	**15**	**20**	**20**	**20**	**15 (was 10)**	01-03-18
Corporate objective 3: Develop the Mount Vernon Cancer Centre									
012/18	There is a risk that the Trust is not able to secure the long-term future of the MVCC	Director of Strategy	**FPC**	**16**	**16**	12	12	**16** (was 12)	01-03-18

Board Assurance Framework Heat Map – April 2019 year-end review

Frequency / Likelihood	Consequence / Impact: 1 None / Insignificant	2 Minor	3 Moderate	4 Major	
5 Certain	low 5	low 10	high 15	high 20 006/18 006/18 004/18 004/18 001/18	high 25 003/18 003/18
4 Likely	low 4	low 8	moderate 12 008/18 007/18 010/18 008/18 010/18	high 16 013/18 009/18 009/18 012/18 012/18 001/18 001/18	high 20 011/18 005/18 014/18
3 Possible	very low 3	low 6	moderate 9 007/18	moderate 12 002/18 00/18 002/18	high 15 011/18 005/18 011/18
2 Unlikely	very low 2	Low 4	Low 6	moderate 8	moderate 10 014/18
1 Rare	very low 1	very low 2	Very low 3	Low 4	high 5

008/18 Existing risk score

011/18 Target risk score

Movement from previous month

BAF risk	001/18	**There is a risk that within the context of the Healthcare Economy the Trust has insufficient capacity to sustain timely and effective patient flow through the system which impacts the delivery of the 62day cancer, RTT and the A&E 4-hour standards**

16

Strategic aim	**Delivering our promise on value and quality**
Latest review date	April 2019

Lead Executive	Chief Operating Officer
Board monitoring committee	FPC

Risk rating	**Impact**	**Likelihood**	**Total**
Initial (Feb 18)	4	5	20
Current (Mar19)	4	4	16
Target (Mar 19)	4	4	16

Change since last month

Related BAF & Corporate Risk Register entries

ID	**Score**	**Summary risk description**
002/18	16	Risk to patient care & safety due to lack of nursing &medical staffing

Key controls

- ED Patient flow improvement steering group/ Delivery Board
- Three times weekly work stream meetings including Red to Green
- Weekly ED Team/COO meeting
- Length of Stay consultant led reviews
- Daily system telephone conference
- Weekly access meeting chaired by COO
- Three tier cancer tracking meeting; Divisional PRMs
- Trust representation on A&E delivery Board/ Cancer Board/ STP
- Integrated Care Team engagement
- Additional management resource secured to support delivery of cancer timed pathway programme

Assurance on controls

- A&E Delivery Board (L1)
- System Resilience Group (L2)
- Reports to FPC and Board of Directors (L3)
- Floodlights scorecard (L1)
- NHSI PRM(L3)
- Cancer Board (L2)
- Daily and weekly ED sit-rep reporting
- Monthly breach validation audits
- Monthly Performance Deep Dives considered by FPC – e.g. ED in June 2018 and rolling programme
- NHSI – Deep dive – cancer recovery plan (L3)
- IPR Report to Feb and March 19 FPC meeting 6 and 5 out of the 8 cancer standards, RTT performance above national average
- Closure of escalation winter ward
- Internal Audit – Performance Framework report - reasonable assurance March 19)

Gaps in control	**Gaps in assurance**	**Actions to address gaps in controls and assurances**	**Due date**
Bed Occupancy and LOS reductions not being delivered consistently across specialities. Sufficient surgical capacity to deliver cancer treatments within required timeframes Demand and capacity modelling for all	• Accountability Framework arrangements • Impact of local Hospitals on Trust activity • Demand and capacity profiling by tumour site not available • Confirmation from HCC that the	• Implementation of the accountability framework • Implementation of ED patient flow improvement programme. • Information team working in partnership with cancer and access team to map demand and activity profiles across 2018/19 and provide data intelligence to inform recovery plans. • DMO1 reporting (diagnostic PTL) to be external reported from November.	In place In place Ongoing

tumour sites not complete. Funding received Funds received for winter planning by HCC not in the direct control of the trust Access to funding streams from the cancer alliance allocation	additional funding received in social care as part of the winter planning will deliver	• Develop and implement - Reducing LOS project . • COO liaison with HCC to again assurance on the projects following the additional allocation of social care funding for winter planning. • In support of Trust capacity D&C is ongoing to identify potential shortfall in capacity to meet demand. Any shortfall will be met through increased utilisation and productivity savings and business cases will be submitted through Trust investment process to highlight funding resource requirements. • Reset week scheduled March 2019 to support patient flow workstream and closure of additional capacity	In place and ongoing Ongoing Completed & escalation ward closed.

Risk score	**Feb 2018**	**March 2018**	**April 2018**	**May 2018**	**June 2018**	**July 2018**	**August 2018**
20	20	20	20	20	20	20	20
	September 2018	**October 2018**	**November 2018**	**December 2018**	**January 2019**	**February 2019**	**March 2019**
	20	20	20	20	20	20	16

BOARD ASSURANCE FRAMEWORK: April 2019 year-end review

BAF risk	002/18	There is a risk to the availability of appropriate staff to fill establishment for nursing and medical staff.

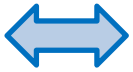
12

Strategic aim	Delivering our promise on value and quality
Latest review date	April 2019

Lead Executive	Chief Nurse/Medical Director/Chief People Officer
Board monitoring committee	QSC

Risk rating	Impact	Likelihood	Total
Initial (Feb 18)	4	4	16
Current (April 19)	4	3	12
Target (March 19)	4	3	12

Change since last month



Related BAF & Corporate Risk Register entries

ID	Score	Summary risk description
001/18	20	Insufficient capacity for timely patient flow
003/18	20	The Trust is unable to achieve financial performance
008/18	12	Governance arrangements do not facilitate delivery

Key controls

- Monthly nursing and midwifery workforce steering group
- Monthly nursing look ahead – heat map / agreed agency levels
- Site safety huddles to review real time staffing and capacity
- Quarterly establishment reviews – skill mix, acuity and dependency
- Safe care – 3 times daily staffing reviews
- University of Hertfordshire recruitment
- Rotation of band 5 nurses to aid retention
- NHSI Wave 2 retention programme
- Eroster
- Scheduled regular monthly updates of staffing data to NHSP, to ensure staffing lists as accurate as they can be.
- Retention Strategy
- Arrangements in place to support our employees who are EU nationals re Brexit-related settled status applications.

Assurance on controls

- Report to QSC on medical staffing (L2)
- Report to Board of Directors via QSC on safer staffing (L2)
- Workforce report to FPC (L2)
- Safer Staffing reports (L2)
- NHS Professionals continuously recruiting to nursing and midwifery band 2 and band 5 roles.
- Reviewing and trialling alternative shift patterns to attract staff; rapid response
- Development of joint recruitment and attraction strategy with STP.
- Launch of retention strategy focusing on band 5 nurses and band 2 CSWs.
- Local retention targets and plans

Gaps in control	Gaps in assurance
• 40,000 nurses short across the country • Camb/London recruitment/weighting • Capacity to balance quality, money and operational pressure. • Embedding Accountability Framework • Staff leavers higher than expected in some areas • Specific targeted recruitment required for some specialities / specialists	• Data consistency and quality • Improved retention rates • Recruitment in specialty / hard to recruit areas

Actions to address gaps in controls and assurances	Due date
• Hertfordshire wide recruitment and retention programme for temporary workers, e.g. Bank Network	*Ongoing*
• Daily review of patient safety concerns	
• Senior matron support out of hours to support clinical teams with maintaining patient safety and early escalation of patient safety concerns	
• Trust wide recruitment plans and targets	On going
• Two routes to becoming a CSW have been implemented: Care Certificate and Apprenticeships.	On going

• Deanery plans reduction in rotation of medical trainees to DGHs • Some International recruits put on hold until next financial year due to the financial position of the Trust		• The changes from Home Office re Tier 2 visa restrictions should benefit the organisation in respect of number of visas applied for that are approved. • Planned launch of Trust/DHSC pilot to trial flexible working • Opportunities for bank workers. • 3 key workstreams to achieve retention plan and targets – Improved Clinical Management and Team Development, Enhanced Employment Offer and Benefits, Improved Career Pathways – monthly board updates and progress reports with clear targets and deliverables including an employee engagement app, internal transfer policy, improved data on reasons for leaving • Regular recruitment open days are held for CSWs and nurses. • Rotation scheme for qualified nurses in operation to attract nurses who wish to experience a variety of settings. • Internal transfer register to be launched in January/February 2019 aimed at making it easier for nurses to move within the Trust and reduce numbers leaving the Trust. It is planned to extend this to other staff groups following the launch. • Resourcing Strategy to be launched in 2019/20 setting out the Trust's approach to recruitment and retention. • Business case for further international recruitment to be developed • Implement overseas recruitment plans for 2019/20	June start date June start date Ongoing January start date April 2019 April 2019 May 2019

Risk score	**Feb 2018**	**March 2018**	**April 2018**	**May 2018**	**June 2018**	**July 2018**	**August 2018**
16	16	16	16	16	16	16	16
	September 2018	**October 2018**	**November 2018**	**December 2018**	**January 2019**	**February 2019**	**March 2019**
	16	16	16	16	12	12	12

BAF risk	003/18	There is a risk that the Trust is unable to achieve financial performance in 18/19 as a result of not securing the required efficiency improvement within its cost improvement plan and its income.

25

Strategic aim	Delivering our promise on value and quality
Latest review date	April 2019

Lead Executive	Director of Finance
Board monitoring committee	FPC

Risk rating	Impact	Likelihood	Total
Initial (Feb 18)	4	5	20
Current (April 19)	5	5	25
Target (March 19)	4	5	25

Change since last month: ⇔

Related BAF & Corporate Risk Register entries		
ID	**Score**	**Summary risk description**
FIN9	20	CIP Plan Non Delivery
FIN1	20	Effective Management of Trust Cash Flow

Key controls

- Establishment of PMO function approved by the Board in Dec-16. At full establishment from Q2 17/18.
- Weekly workforce People Oversight Group review sessions in place
- Weekly divisional CIP development and monitoring sessions
- Industry standard CIP development methodology deployed in Q1 17/18
- Weekly cash flow management meetings in place with DoF
- Appropriate senior approval of all payment runs
- Cash Diagnostic Report undertaken by PWC with supporting action plan
- Cash reporting schedules to FPC and Trust Board each month
- Development of Qlikview Debtors and Creditors reports
- BI Steering Group established to co-ordinate development

Assurance on controls

- Weekly Financial Recovery Programme Board in place attended by all execs(L1)
- Monthly CIP / Financial Recovery updates provided to Finance Committee and NHSI (L1)
- CIP tracker in place to monitor delivery achievement (L1)
- Submission and approval of WC load required to agreed timetables (L1)
- Monthly cash reporting to FPC / Trust Board and NHSI(L2)
- Monthly Accountability Framework PRMs including finance (L1)
- Internal Audit – Financial Planning Process L3 +)
- Monthly Financial Assurance Meetings & PRM with NHSI (L1)
- Weekly Exec led Improving Financial Delivery (IFD) Meetings in Place
- Outturn Forecast presented to Sep FPC and monitored monthly

Gaps in control	Gaps in assurance
• Pace of CIP delivery achievement • Slippage in IFD mitigations • Significant shortfalls in elective activity deliver	• Some divisional CIP schemes remain unidentified

Actions to address gaps in controls and assurances	Due date
• Escalation / Progress reports to FPC and DEC	Ongoing
• Briefing reports to weekly PMB meetings re; CIP delivery	In place
• BI Steering Group established to co-ordinate development	October 18
• Weekly Improving Financial Delivery Meetings in place	Ongoing
• Operational plan and budget development for 2019/20	4 April 2019

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
20	20	20	16	16	16	16	16
	September 2018	**October 2018**	**November 2018**	**December 2018**	**January 2019**	**February 2019**	**March 2019**
	20	20	20	20	25	25	20

BOARD ASSURANCE FRAMEWORK: April 2019 year-end review

BAF risk	004/18	There is a risk that the Trust is unable to deliver target levels of patient activity and achieve reimbursement from commissioners for activity in 18/19

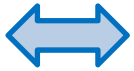
20

Strategic aim	Delivering our promise on value and quality
Latest review date	April 2019

Lead Executive	Director of Finance
Board monitoring committee	FPC

Risk rating	Impact	Likelihood	Total
Initial (Feb 18)	4	5	20
Current (Feb 19)	4	5	20
Target (March 19)	4	5	20

Change since last month



Related BAF & Corporate Risk Register entries		
ID	Score	Summary risk description
FIN2	20	Non Payment of SLA
FIN 3	20	Delivery of SLA Activity

Key controls

- Qlikview SLA income and activity application developed and in place
- Monthly SLA income reports to FPC / DEC and Divisions
- Weekly Information Assurance Group (IAG) in place to review deliver
- Monthly CQUIN meetings to review progress in place
- Contract monitoring meetings in place with all commissioners
- Key monitoring metrics reflected in new divisional PRM dashboards

Assurance on controls

- Independent reviews of coding and counting practice undertaken in 17/18 (L3)
- Actions plans to address findings in place and reviewed at IAG(L1)
- Regular Data quality and Clinical Coding updates to IAG and FPC (L2)
- Weekly OP drumbeat session re- introduced in January 2019

Gaps in control	Gaps in assurance
• Potential challenge from commissioners in respect of volume of planned work undertaken • Comprehensive bed model and associated demand & capacity modelling • Implementation of pathway change and the understanding of financial impacts • Requirement to support discharge summary remedial activity impacting upon DQ team capacity to respond to CCG challenges and queries	Lack of demand and capacity modelling

Actions to address gaps in controls and assurances	Due date
• weekly IAG meeting attended by appropriate Executives, Corporate and Divisional Officers to review weekly activity delivery and agree appropriate remedial action where required.	Ongoing
• The IAG also reviews the impact of recommended pathway change	Ongoing
• New CQUIN governance framework agreed for implementation	April 2018
• Business Impact Group set up to review the financial impact of Emergency Pathway redesign project	Ongoing
• D&C and bed modelling project launched	Aug 18

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
20	20	20	16	16	16	16	16
	September 2018	**October 2018**	**November 2018**	**December 2018**	**January 2019**	**February 2019**	**March 2019**
	20	16	16	20	20	20	20

BAF risk	005/18	**The Trust's IT systems are not sufficiently embedded/stabilised to ensure the hospital is run in a safe and effective way**

20

Strategic aim	**Delivering our promise on value and quality**
Latest review date	April 2019

Lead Executive	Director of Finance/ Chief Operating Officer
Board monitoring committee	FPC

Risk rating	**Impact**	**Likelihood**	**Total**
Initial (Feb 18)	5	4	20
Current (April 19)	5	4	20
Target (March 19)	5	3	**15**

Change since last month

⟺

Related BAF & Corporate Risk Register entries

ID	**Score**	**Summary risk description**
003/18	20	The Trust is unable to achieve financial performance
004/18	20	The Trust is unable to deliver target levels of patient activity
6114	20	Continuing failure to send Discharge Summaries electronically to the GP for every patient discharged

Key controls

- The Trust has developed a Lorenzo Stabilisation plan
- The Stabilisation plan is monitored and co-ordinated through a monthly Stabilisation Committee and bi weekly Steering Group
- Monthly progress reports are provided to the Trust Board and FPC
- The Trust has appointed a stabilisation director and project managers to co-ordinate activity
- Bi-monthly RTT oversight group
- Weekly Trust access meetings with CCG attendance

Assurance on controls

- The Trust was reviewed its Stabilisation plan with regulators (inc NHSI, NHSD)(L3)
- Regulators are included within the Stabilisation Committee membership (L2)
- Monitoring of key safety and quality indicators through PRM's (L2)
- Reports to Executive Committee, FPC and Board (L2)
- RTT oversight group reports into stabilisation board
- NHSI consultancy approval given in respect of C3 support spend
- Weekly Executive monitoring of implementation plans

Gaps in control	**Gaps in assurance**

Actions to address gaps in controls and assurances	**Due date**

• Tracker in respect of key stabilisation activities to allow performance management • Validated and reviewed PTL's • Consistency and compliance in application of new processes on the systems • Optimisation of Discharge Summary Processes	• Development of DQ dashboard to track stabilisation activity progress • Staff engagement in new systems and compliance with processes • Timeframe for Discharge Summary process optimisation	• Activity tracker to be monitored at future stabilisation committee meeting. • Super view PTL reports to be in place. • Validation support in place to support review of records. • Implementation of Lorenzo Stabilisation Plan. • Business Case to NHSI for consultancy / funding support. • DMO1 report (diagnostic PTL) due for release. • Weekly compliance report being developed that will provide full visibility of error rates and reasons and support targeted training. • Deployment of DXC resource to support Discharge. Summary process optimisation. • Stabilisation project formally launched with Trust engagement of key staff and support from Channel 3, and is currently in the fact finding initial project stage. Increased programme board to weekly	8th March In place Ongoing Ongoing June 2018 Sept 2018 Sept 2018 Ongoing

Risk score	**Feb 2018**	**March 2018**	**April 2018**	**May 2018**	**June 2018**	**July 2018**	**August 2018**
20	20	20	20	20	20	20	20
	September 2018	**October 2018**	**November 2018**	**December 2018**	**January 2019**	**February 2019**	**March 2019**
20	20	20	20	20	20	20	20

BOARD ASSURANCE FRAMEWORK: April 2019 year-end review

BAF risk	006/18	**There is a risk that there is insufficient capital funding to address all high/medium estates backlog maintenance, including fire estates work, and funding for medical equipment impacts on patient safety and service improvement**

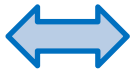
20

Strategic aim	**Delivering our promise on value and quality**
Latest review date	March 2019

Lead Executive	Director of Finance/Chief Operating Officer
Board monitoring committee	FPC

Risk rating	**Impact**	**Likelihood**	**Total**
Initial (Feb 18)	4	4	16
Current (April 19)	4	5	20
Target (March 19)	4	5	20

Change since last month



Related BAF & Corporate Risk Register entries		
ID	**Score**	**Summary risk description**
003/18	20	The Trust is unable to achieve financial performance

Key controls

- Six Facet survey undertaken in 17/18
- Capital review Group meets monthly
- Prioritising areas for limited capital spend through capital plan
- Fire policy and risk assessments in place
- Major incident plan
- Mandatory training
- Equipment Maintenance contracts
- Monitoring of risks and incidents

Assurance on controls

- Report on Fire Safety to Executive Committee (L2)
- Report on Fire and Backlog maintenance to RAQC(L2)
- Reports to Health and Safety Committee (L2)
- Capital plan report to FPC (L2)
- Annual Fire report (L3)
- PLACE reviews (L3)
- Reports to Quality and Safety Committee
- Deep dive review of the risks and mitigations (December 2018)
- new Monthly Fire Safety Committee established March (includes other sites)

Gaps in control	**Gaps in assurance**
• Not fully compliant with all Fire regulations and design • 1960s buildings difficult to maintain • No formalised equipment replacement plan or long term capital requirement linked through to LTFM • Estates and facilities monitoring structures and reporting	• Availability of capital

Actions to address gaps in controls and assurances	**Due date**
• Estates strategy to support the five-year trust strategy	Dec 2018
• Review, risk assess and prioritise equipment replacement for 2018/19	March 2018
• Review ongoing risks through RM processes / structures	Ongoing
• Develop capital equipment replacement plan	(TBC)
• Replacement plan integrated with CTC support intentions	May 2018
• Refurbishment and fire compliance work MVCC wards 10 and 11	July/August 2018 – completed
• Review of capital requirements for 2019/20	March 2019
• Review of non patient accommodation at MVCC (old building)	May 2019
• Communication plan to encourage staff to escalate issues	May/June 2019
• Estates and facilities monitoring structures and reporting	May/June 2019

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
16	16	16	20	20	20	20	20
	September 2018	**October 2018**	**November 2018**	**December 2018**	**January 2019**	**February 2019**	**March 2019**
	20	20	20	20	20	20	20

BOARD ASSURANCE FRAMEWORK: April 2019 year-end review

BAF risk	007/18	**There is a risk that the governance structures in the Trust do not facilitate visibility from board to ward and appropriate performance monitoring and management to achieve the Board's objectives**

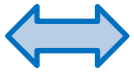
12

Strategic aim	**Delivering our promise on value and quality**
Latest review date	March 2019

Lead Executive	Chief Executive
Board monitoring committee	Board of Directors

Risk rating	Impact	Likelihood	Total
Initial (Feb 18)	3	4	12
Current (Mar 19)	3	4	12
Target (March 19)	3	4	12

Change since last month



Related BAF & Corporate Risk Register entries

ID	Score	Summary risk description
003/18	20	The Trust is unable to achieve financial performance

Key controls

- Monthly Board meeting/Board Development Session/ Board Committees
- Annual Internal Audit Programme/ LCFS service and annual plan
- Standing Financial Instructions and Standing Financial Orders
- Each NED linked to a Division (from January 2018)
- Commissioned external reviews – PwC Governance Review September 2017
- Review of external benchmarks including model hospital , CQC Insight and stethoscope – reports to FPC and RAQC (QSC)
- Board Assurance Framework and monthly review
- Performance Management Framework/Accountability Review meetings monthly
- New Trust Integrated Performance Document in development – from deployment at January Trust Board, FPC and QSC

Assurance on controls

- Visibility of Corporate risks and BAF as Board Committees and Board (L2)
- Internal Audits delivered against plan, outcomes report to Audit Committee
- Annual review of SFI/SFOs (L3)
- Annual review of board committee effectiveness and terms of reference (May-July) (L3)
- PwC Governance review and action plan closed (included well led assessment) (L3)
- Annual governance statement (L3)
- Counter fraud annual assessment and plan (L3)
- Annual self-assessment on licence conditions FT4 (L3)
- CQC Inspection report July 2018 –(overall requires improvement) and actions plan to address required improvements and recommendations (L3 -/+)
- Use of resources report July 2018 – requires improvement (L3 _/+)
- September 2018 Progress report on CQC actions and section 29a (L2 +) to CQC & Quality Improvement Board
- Annual review of RAQC to Board (L2 +)
- Internal Audit Report – Assurance and Risk Management (- reasonable assurance (L3)
- Board development session on Risk and Risk Appetite, Feb 2019

	• Internal Audit – Performance Framework report - reasonable assurance March 19)

Gaps in control	Gaps in assurance
• Limited visibility and challenge of corporate risks and BAF through Board committee • Development of an integrated performance report • Limitations of current performance monitoring and management forums and frameworks • Performance Management Framework/Accountability Framework • Implementation of Internal Audit Recommendations • NHSI Undertaking January 2019	• Embedded risk management - CRR and BAF • Embedding effective use of the Integrated performance report • Evidence of timely implementation of audit actions • Consistency in the effectiveness of the governance structure's at all levels • Capacity to ensure proactive approach to compliance and assurance • Review of 2019/20 risks on to the new BAF framework

Actions to address gaps in controls and assurances	Due date
• Implementation of revised Risk Management Strategy and BAF – annual review in February / March includes establishing risk appetite	March / April
• Follow up on actions from Internal Audits –process to review of outstanding actions agreed with IA including fortnightly updates to DEC and defining clearer line of accountability	Monthly
• Review of Divisional Board and PMF/PRM Terms of reference	Monthly
• Development of an integrated performance report	
• Annual review of effectiveness of Board Committee in line with governance review and new Committee Chairs	Q1 2018/19- annually
• Review of clinical governance structure by DoN & MD – recruitment in progress/ structures implemented in September	Implemented
• CQC improvement plans – reviewed monthly	On going
• Observational Audit of Board effectiveness under well led framework	August 2018 and monthly monitoring ongoing
• Recruitment into revised corporate & clinical governance structures (commenced)	
• Undertake review of well led developmental guidance	April 2019
• Work is in progress to map key quality metrics and information through the governance structures, to provide assurance of flow of information through relevant levels of our systems is achieved.	
• Early design of the organisational Quality dashboard is underway, to enable to interrogation of quality metrics and monitor performance from board to ward.	Jan 2019 March 2019
• Programme of self-assessments and internal mock inspection reviews against CQC standards commenced in January / development of dashboard	January and ongoing
• Discuss feedback from NHSI observations at Board and Board Committees and agree any changes to continue to strengthen Board Governance	April 2019
• Review BAF framework – approved by Audit Committee for 2019/20	April 2019

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
12	12	12	12	12	12	12	12
	September 2018	**October 2018**	**November 2018**	**December 2018**	**January 2019**	**February 2019**	**March 2019**
	12	12	12	12	12	12	12

BAF risk	008/18	**There is a risk that the Trust is not adequately prepared to deal with a major incident or emergency**

12

Strategic aim	**Delivering our promise on value and quality**
Latest review date	April 2019

Lead Executive	Chief Operating Officer (from end January 2019)
Board monitoring committee	QSC

Risk rating	**Impact**	**Likelihood**	**Total**
Initial (Feb 18)	3	4	12
Current (Apr 19)	3	4	12
Target (March 19)	3	4	12

Change since last month

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Related BAF & Corporate Risk Register entries

ID	**Score**	**Summary risk description**
005/18	15	The Trust's IT systems are not sufficiently embedded/stabilised

Key controls

- EPRR Plan in place to gain compliance with the Core Standards
- Business Impact Assessment process underway with Divisions
- CBRN plan and equipment in place
- Support in place by EPRR manager from Basildon NHS Trust
- Cyber security – firewall, testing, antivirus – internal and external testing on controls; work plan
- On call rotas on rotawatch

Assurance on controls

- EPRR Committee Chaired by AEO (Director of Strategy) (L2)
- Regular reports on progress against EPRR plan to RAQC(L2)
- Annual EPRR Core Standards Assurance process including external visit by NHSE(L3)
- Regular Attendance at LHRP(L2)
- Internal and external review of Cyber security (L3)
- Reports to audit committee, RAQC and Board (cyber) (L2)
- Organisational response to cyber incident (L1)
- Monthly update considered by RAQC
- Investment received for Cyber Security – NHSD risk rating reduced (L3)
- NHSE check and challenge session on EPRR core standards including Brexit Preparedness (L3)
- MI response to recent internal incidents

Gaps in control	**Gaps in assurance**
• Currently partially compliant with NHSE Core standards • Full training and awareness programme to be developed • Testing programme to be developed • Ability to implement all cyber security requirements • Current on call structure does not fully provide enough senior leadership on site	Availability in capital to invest in cyber security and delivery against agreed plan (some investment received)

Actions to address gaps in controls and assurances	**Due date**
• EPRR Officer in post	Completed
• Delivery of action plan in full	Ongoing monitoring
• Training for Gold, Silver and Bronze commanders (commenced)	May/June 2018
• All Business Continuity plans in place for Trust. Trust wide BCVP to be considered/approved by RAQC in September	Completed
• Major incident plan and Emergency planning policy statement to be considered/ approved by RAQC in September	Completed
• NHSE To consider the Trust's Core Standards submission	Completed
• Monitor and review of cyber security actions and explore	Oct 2018

		funding options • Consultation to review on call structure (commenced) • Review of IM&T business continuity policy and plan	Approved March 19

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
12	12	12	12	12	12	12	12
	September 2018	**October 2018**	**November 2018**	**December 2018**	**January 2019**	**February 2019**	**March 2019**
	12	12	12	12	12	12	12

BOARD ASSURANCE FRAMEWORK: April 2019 year-end review

AF risk	009/18	**There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered impacting on the Trust's ability to deliver the required improvements and transformation**

16

Strategic aim	**New ways of caring**
Latest review date	April 2019

Lead Executive	Chief People Officer
Board monitoring committee	FPC and QSC

Risk rating	Impact	Likelihood	Total
Initial (Feb 18)	4	4	16
Current (Apr 19)	4	4	16
Target (March 19)	4	3	12

Change since last month

⟺

Related BAF & Corporate Risk Register entries

ID	Score	Summary risk description
002/18	16	There is a risk to patient care and safety as a result of nursing and medical staffing capacity
003/18	20	The Trust is unable to achieve financial performance

Key controls

- LMCDP Leadership, Management and Coaching Development Pathway
- LEND Sessions
- Organisational Values (PIVOT) / Leadership Behaviours (LEND)
- Health and Well Being Strategy
- Dedicated Associate Director of Leadership and Change
- HR Policies including Raising Concerns Policy
- ERAS teams and Freedom to Speak Up Guardian
- People Strategy
- Update May 2018 – A series of indicators will be agreed by CPO Simons, senior workforce and OD team members and the Board on how we should measure and assess our culture.
- Staff Experience Workshops were launched in April 2018

Assurance on controls

- Workforce reports (includes culture) to QSC, FPC, Board (L2)
- LEND sessions quarterly (L1)
- LMCDP evaluation
- FFT (L1) – Improved position June 2018 – 49% rec place to work/ rec for care 74%
- Raising Concerns report to Audit Committee and Board (L2)
- Workshops – face to face and online (L1)
- Review of Insight and Model Hospital
- Board Development session July 2018 – (culture)
- NHS Annual Staff Survey and other local monthly survey reports

Gaps in control	Gaps in assurance
• Culture change approach • Talent management post/lead • Senior leadership training • Senior leadership programme	• Review outcomes of the actions being taken • Lack of resources to respond within necessary time period • Completion of staff survey action plans

Actions to address gaps in controls and assurances	Due date
• Review of LEND and leadership behaviours in a challenging environment	Ongoing
• Increased visibility of Senior Leadership Team (Divisional, Executive and Board)	Ongoing
• Develop and implement action plan following staff survey feedback	April 19
• Talent management job is agreed and a TM strategy will be developed	
• Talent management role advertised.	March 19
• Senior leadership programme developed for 2018 following ADDS.	

		• Undertake discovery phase of NHSi culture change programme. • Further Board Development session to include discussion on staff survey, underlying causes and actions. • NHSi discovery phase 1 presented to Board. After presentation to Board, next stage is on hold. • Board agreed to develop an ENHT specific response to culture change rather than the NHSi toolkit, and subsequently received a presentation of the proposed Trust response. • Senior leaders offered access to high level formal training through University of Hertfordshire and through ADDS. • Review of Communication strategy • Staff survey/engagement workshop	?June 2019 (TBC) Completed Oct 18 Underway Pathway agreed and recruitment underway May 2019 May 2019

Risk score	**Feb 2018**	**March 2018**	**April 2018**	**May 2018**	**June 2018**	**July 2018**	**August 2018**
16	16	16	16	16	16	16	16
	September 2018	**October 2018**	**November 2018**	**December 2018**	**January 2019**	**February 2019**	**March 2019**
	16	16	16	16	16	16	16

BAF risk	010/18	**There is a risk that the Healthcare Economy does not work effectively to redesign new models of care, which impacts on the hospital's ability to manage demand for services**

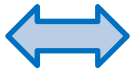
12

Strategic aim	**New ways of caring**
Latest review date	April 2019

Lead Executive	Director of Strategy
Board monitoring committee	FPC

Risk rating	**Impact**	**Likelihood**	**Total**
Initial (Feb 18)	3	4	12
Current (Apr 19)	3	4	12
Target (March 19)	3	4	12

Change since last month



Related BAF & Corporate Risk Register entries		
ID	**Score**	**Summary risk description**
001/18	20	The trust has insufficient capacity to sustain patient flow

Key controls

- Participation in STP work streams including Planned care, urgent and emergency care, frailty and cancer
- STP CEO bi-weekly meeting
- Early work in place to work with PAH on fragile and back office services
- Vascular Hub project with West Herts and PAH
- Cancer work stream of STP and representing STP Cancer Alliance
- Model Hospital redesign work
- Integrated discharge team
- External partner to support development of STP

Assurance on controls

- Reports to Board regarding progress on STP(L2)
- Regular oversight by NHSI and NHSE (L2)
- Monthly A&E delivery Board (L2)
- Transformation Board of the CCG(L2)
- Reports of Model Hospital work streams to Programme Board (L2)
- NHSE Deep-dive into cancer work stream (L3)

Gaps in control	**Gaps in assurance**
• Scope for accelerated development of STP and its governance arrangements • Need for external resource to develop STP to ICS	Oversight of the workstreams at local level

Actions to address gaps in controls and assurances	**Due date**
• Work programme of external partner to support development of STP	June 2018
• Development of STP wide strategy	Oct 2018
• New independent chair in place to drive progress. Ten year plan published sets out expectations for ICSs	Dec/ Jan 19
• Review of workstream representation and reporting into DEC	Feb 19

Risk score	**Feb 2018**	**March 2018**	**April 2018**	**May 2018**	**June 2018**	**July 2018**	**August 2018**
12	12	12	12	12	12	12	12
	September 2018	**October 2018**	**November 2018**	**December 2018**	**January 2019**	**February 2019**	**March 2019**
	12	12	12	12	12	12	12

BOARD ASSURANCE FRAMEWORK: April 2019 year-end review

BAF risk	011/18	There is a risk that the Trust is not always able to consistently embed a safety culture and evidence of continuous quality improvement and patient experience

15

Strategic aim	New ways of caring
Latest review date	April 2019

Lead Executive	Director of Nursing /Medical Director
Board monitoring committee	QSC

Risk rating	Impact	Likelihood	Total
Initial (Feb 18)	5	4	20
Current (Apr 19)	5	3	15
Target (March 19)	5	3	15

Change since last month

Related BAF & Corporate Risk Register entries		
ID	Score	Summary risk description
002/18	16	There is a risk to patient care and safety as a result of nursing and medical staffing capacity

Key controls

- Clinical governance strategy group
- Patient Safety Committee
- Quality Improvement Board
- Accountability Framework
- CQC Engagement meeting
- Increased Director presence in clinical areas
- SIs and Learning from death investigations
- Monthly patient safety newsletter
- Bi-weekly IPC improvement board
- Strengthened TIPCC membership and ToRs
- Quality and safety visits
- Safety huddles
- Policies and procedures
- New Quality Manager posts in each division
- Weekly review meetings of CQC improvement plans
- Clinical Harm Review Panel (Weekly)

Assurance on controls

- Reports to RAQC (L2)
- Quality review meetings with CCG (L2)
- Divisional Performance Meetings (L2)
- Clinical Governance Strategy Committee(L2)
- Monitoring of new to follow up ratios through OPD steering group and access meetings(L2)
- Peer Reviews (L3)
- Audit Programme (internal and external) (L3)
- Quality Transformation Programme – framework presented to RAQC, March 18 (L2) and presented to Board Feb 2019
- CQC Inspection report July 2018 –(overall requires improvement) and actions plan to address required improvements and recommendations (L3)
- NHSI Infection control review December 2018 - green (L3)
- Quality Dashboard / Compliance dashboard

Gaps in control	Gaps in assurance
• National guidance and GIRFT Gap analysis identifies areas for improvement • Consistency with procurement and engagement with clinicians • Patient safety team capacity	• Consistency in following care bundles • Implementation of action plans • Embedding of learning from

Actions to address gaps in controls and assurances	Due date
• Review and relaunch of care bundles related to prevention of death.	July 2018 June 2018
• Complete Gap analysis on GIRFT reports and develop and monitor action plans	July 2018
• Revised Clinical Governance structures – September	July 2018

• Gaps in compliance with IPC Hygiene Code leading to C-difficile outbreak in April 2018 and MRSA bacteraemia in May 2018 • Gap in compliance with CQC standards warning notice section 29A – Surgery Lister and UCC QEII - NHSI undertaking	SIs/Learning from Deaths • Data quality • Inconsistent audit and monitoring programme • Delivery against CQC improvement plan	implementation • Divisional Clinical Governance facilitators • Implementation of quality transformation programme/work streams • Weekly Quality Transformation Steering Group in place • Weekly CEO briefings on Quality Transformation Progress • Delivery and monitoring of IPC Improvement plan through b-weekly IPC improvement board • Delivery and monitoring of CQC improvement plans for Surgery Lister and UCC QEII • CQC improvement plans – reviewed monthly • Scope key organisational gaps for continuous improvement readiness, though trust wide Capability Self-Assessment Tool-auditing across 4 key organisational quality improvement domains – Leadership for Improvement, Previous improvement results, current Resources, Workforce and Human Resources; Data Infrastructure and Management and Improvement Knowledge and Competence. • Design and testing quality & safety dashboard measurement plans underway • Recruitment processes underway for Quality Matron and Deputy head of Quality Improvement • Planning inaugural Clinical Governance meetings – Trust wide review of audit & effectiveness processes and agree internal mandatory audit plans • Scoping underway to establish 2019/2020 Quality Accounts domains • Following Board quality Strategy session – further development of Quality Strategy underway for publication late March 2019 • Programme of self-assessments and mini internal inspection reviews • Review of Communication strategy • Staff survey/engagement workshop	March 2018 April 2018 Review October End of July 2018 August and Monthly monitoring April 2019 Aim start dates May 2019 8 March 2019 April 2019 April 2019 Commenced January 2019 May 2019 May 2019

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
20	20	20	20	20	20	20	20
	September 2018	**October 2018**	**November 2018**	**December 2018**	**January 2019**	**February 2019**	**March 2019**
	20	20	20	20	20	20	20

BAF risk	012/18	There is a risk that the Trust is not able to secure the long-term future of the MVCC

16

Strategic aim	Develop the Mount Vernon Cancer Centre
Latest review date	April 2019

Lead Executive	Director of Strategy
Board monitoring committee	FPC

Risk rating	Impact	Likelihood	Total
Initial (Feb 18)	3	4	12
Current (April 19)	4	4	16
Target (March 19)	4	4	16

Change since last month

⟺

Related BAF & Corporate Risk Register entries		
ID	**Score**	**Summary risk description**
003/18	20	The Trust is unable to achieve financial performance
		Refer to MVCC Risk Register

Key controls

- Monthly meetings with CEOs and Chairs of ENHT and Hillingdon NHS FT
- Clinical strategy for MVCC
- Development of a five-year strategy for the Trust
- Development of SLAs with MVCC
- Clinical and Academic Partnership in place with UCLH and MVCC, Board Established and has met to develop work plan
- Clinical strategy for MVCC

Assurance on controls

- Regular reports to FPC and the Board of Directors (L2)
- Regular reporting into the strategy Board (L2)
- Reporting to the Board of Directors on the progress of the UCLH/MVCC partnership (L2)

Gaps in control	Gaps in assurance
• Hillingdon has no long-term plan for the MVCC site • Availability of funding for capital equipment replacement and refurbishment programmes	Availability of capital funding Specialist commissioners long term planning Fitness for purpose of some of the accommodation in the old building

Actions to address gaps in controls and assurances	Due date
• SLA for Estates and Facilities at MVCC with Hillingdon	April 2018 (remains under review)
• MOU with Hillingdon for sale of the MV site	Oct 2018
• Development of a lease with Hillingdon for MVCC	Nov 2018
• Ongoing meetings of UCLH/MVCC Partnership Board	Ongoing
• Ongoing meetings MVCC strategy implementation group	Ongoing
• Executive meetings with MVCC Divisional leadership on the key risk areas and linking with stakeholders and partners	January 2019 / on going
• Specialist commissioners modelling activity for equipment replacement programme	March 2019

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
12	12	12	12	12	12	12	12
	September 2018	**October 2018**	**November 2018**	**December 2018**	**January 2019**	**February 2019**	**March 2019**

	12	12	12	12	12	16	16

BAF risk	013/18	**There is a risk that the Trust is adversely affected by the United Kingdom's departure from the European Union, particularly in the event of no deal being secured.**

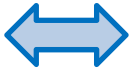
16

Strategic aim	Delivering our promises on value and quality
Latest review date	March 2019

Lead Executive	Director of Strategy
Board monitoring committee	FPC

Risk rating	**Impact**	**Likelihood**	**Total**
Initial (Feb 18)	3	4	12
Current (Mar 19)	4	4	16
Target (March 2019)	4	4	16

Change since last month



Related BAF & Corporate Risk Register entries

ID	**Score**	**Summary risk description**
003/18	20	The Trust is unable to achieve financial performance
002/18	16	There is a risk to the availability of appropriate staff to fill establishment for nursing and medical staff.

Key controls

- EPRR Committee, will lead on the business continuity arrangements, reviewing existing plans to ensure they respond to the possibility of a 'no-deal' Brexit.
- 23rd August SoS guidance and five technical notices published by UK Government
- Overseas recruitment mostly from outside Europe.
- Additional guidance has been issued to the NHS on Brexit on 21st December including action card for providers
- Weekly group in place in January to drive progress reporting to DEC/Executive Committee

Assurance on controls

- Regular reports to Executive Committee/DEC, FPC and the Board of Directors (L2)
- NHSE check and challenge session on EPRR core standards including Brexit Preparedness (L3)
- Paper to Board on 9th January 2019 and monthly

Gaps in control	**Gaps in assurance**
• Absence of clear deal in place between UK and EU post 29th march 2019	All Business continuity plans are in place

Actions to address gaps in controls and assurances	**Due date**
• Updating of the departmental BCPs – including review of specific plans relating to supplies, medicines, consumables and pathology reagents	October 2018 September 2018
• Workforce team have written to all staff to determine how many staff are from European countries outside the UK.	
• Review of technical notices/ advice as it is published by the Government / NHSI/NHS Providers	Ongoing
• Establish weekly Brexit task force meeting report to Exec / DEC	In place 18 January 2019
• In line with emergency planning - Establish Director on call arrangements for end March / early April	February 2019

Risk score	**Feb 2018**	**March 2018**	**April 2018**	**May 2018**	**June 2018**	**July 2018**	**August 2018**

	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	September 2018	**October 2018**	**November 2018**	**December 2018**	**January 2019**	**February 2019**	**March 2019**
	12	12	12	16	16	16	16

BOARD ASSURANCE FRAMEWORK: April 2019 year-end review

BAF risk	014/18	There is a risk that the Trust's Estates and Facilities compliance arrangements including fire management are inadequate leading to harm or loss of life.

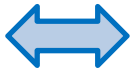
20

Strategic aim	Delivering our promise on value and quality
Latest review date	April 2019

Lead Executive	Director of Strategy
Board monitoring committee	QSC

Risk rating	**Impact**	**Likelihood**	**Total**
Initial (Jan 19)	5	4	20
Current (April 19)	5	4	20
Target (March 20)	5	2	10

Change since last month



Related BAF & Corporate Risk Register entries		
ID	**Score**	**Summary risk description**

Key controls
Fire Policy and Procedures Training – mandatory awareness training and fire wardens Ward based evaluation training for Sisters completed December 2018. Communication Plan **Fire Compliance meeting (fortnightly / now monthly).** Detailed Action Plan in place to address the recommendations of the 2 Fire AE reports, broken down into weekly tasks. Capital funding to make the necessary changes to the Estate to ensure compliance with guidance and fire compliance. **Estates & Facilities Compliance meeting (weekly).** Capital funding to make the necessary changes to the Estate to ensure compliance with guidance and fire compliance. Revenue funding to fund improvements. Detailed Action Plan in place to address the gaps in Estates & Facilities Compliance. Interim Fire Safety Officer in post from 11 Feb 2019

Assurance on controls
Authorised Engineers report 2018. (L3 –ve) Annual fire report to Quality & Safety Committee. Papers to Executive Committee / Quality & Safety Committee. Audits of high risk areas on Lister site Works completed on wards 10/11 MVCC 2018 Desktop Fire evacuation exercise carried out December 2018.(lister) Ward evacuation plans displayed in each ward and checked. January 2019 New Monthly Fire Safety Committee established March 2019 – includes representation from other sites – reports to H&SC and QSC.

Gaps in control	**Gaps in assurance**
Lack of capital funding to bring the Lister and other sites to compliance Lack of revenue funding for training Fire risk assessments due for Fire Safety Officer review Actions identified from Fire desktop review Revised fire procedures on each site	Fire risk assessments – all sites Monthly compliance report to Quality and Safety Committee Embedding revised governance structure

Actions to address gaps in controls and assurances	**Due date**
Detailed weekly Fire Compliance meeting to drive through progress against Action Plan.	Weekly
Revised fire policy agreed by Executive Committee in January 2019 – for roll out and communication plan	January 2019
Progress reports to H&S Committee and monthly to QSC	January 2019
Development of compliance report for QSC	
Recruitment of Fire Safety Officer – interim (in place) and permanent (in progress)	January / April 2019
Fire Risk assessments for review in Q4	April 2019
Monitoring of delivery capital investment programme	April 2019 / ongoing

		March 19 Barley decanted to 7a to support fire compliance works in Strathmore (4 wks) Programme of review of Fire risk assessments to be completed on all other trust sites Develop implementation plan for new training programme	May 2019 July 2019 June 2019

Risk score	September 2018	October 2018	November 2018	December 2018	January 2019	February 2019	March 2019
					20	20	20

Review of Board Assurance Risks for 2019/20 – April 2019

Risk Ref	Risk Description	Lead Executive	Committee	Current Risk	Proposal for 2019/20 BAF	Link to new strategic priorities / objectives
Corporate objective 1: Delivering our promise on value and quailty						
001/18	There is a risk that within the context of the Healthcare Economy the Trust has insufficient capacity to sustain timely and effective patient flow through the system which impacts the delivery of the 62day cancer, RTT and the A&E 4-hour standards	Chief Operating Officer	**FPC**	**16**	**Reword:** There is a risk that the trust is not able to provide timely and effective patient care through the delivery of compliant and sustained performance standards, specifically in relation to the 4 hour, RTT and cancer.	Pathways
002/18	There is a risk to the availability of appropriate staff to fill establishment for nursing and medical staff.	Director of Nursing /Medical Director/CPO	**QSC (/FPC)**	**12**	**Reword to consider the strategic impact / workforce planning** There is a risk that the trust is unable to recruit and retain sufficient supply of staff with the right skills to meet the demand for services	People
003/18	There is a risk that the Trust is unable to achieve financial performance in 18/19 as a result of not securing the required efficiency improvement within its cost improvement plan and its income.	Director of Finance	**FPC**	**25**	**Reword to be long term for sustainability / clinical strategy – agreed to combine these at Board development Session – (Agreeing revised wording with the Director of Finance)**	Sustainability
004/18	There is a risk that the Trust is unable to deliver target levels of patient activity and achieve reimbursement from commissioners for activity in 18/19	Director of Finance	**FPC**	**20**		Sustainability

005/18	There is a risk that the Trust's IT systems are not sufficiently embedded/stabilised to ensure the hospital is run in a safe and effective way	Director of Finance/ COO	**FPC**	**20**	**Retain**	Ease of Use
006/18	There is a risk that there is insufficient capital funding to address all high/medium estates backlog maintenance, including fire estates work, and funding for medical equipment	Director of Finance	**FPC**	**20**	**Retain**	Sustainability / Quality
007/18	There is a risk that the governance structures in the Trust do not facilitate visibility from board to ward and appropriate performance monitoring and management to achieve the Board's objectives	Chief Executive	**Board of Directors**	**12**	**Retain**	Sustainability / Quality
008/18	There is a risk that the Trust is not adequately prepared to deal with a major incident or emergency	Chief Operating Officer	**QSC**	**12**	**De-escalation from BAF and monitor through Corporate risk register – Approved at Board Development Session and Board Committees April 2019**	Quality
013/18	There is a risk that the Trust is adversely affected by the United Kingdom's departure from the European Union, particularly in the event of no deal being secured.	Director of Strategy	**FPC**	**16**	**Retain until conclusion reached**	Sustainability
014/18	There is a risk that the Trust's Estates and Facilities compliance arrangements including fire management are inadequate leading to harm or loss of life.	Director of Strategy	**QSC**	**20**	**Retain**	Sustainability / Quality
009/18	There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered, impacting on the Trust's ability to deliver the required improvements and transformation	Chief People Officer	**FPC & QSC**	**16**	**Retain and reword** There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered and motivated, impacting on the trust's ability to deliver the required improvements and transformation and to enable people to feel proud to work here.	People

Review of Board Assurance Risks for 2019/20 – April 2019

010/18	There is a risk that the Healthcare Economy does not work effectively to redesign new models of care, which impacts on the hospital's ability to manage demand for services	Director of Strategy	**FPC**	**12**	**Reword:** There is a risk that the STP does not work effectively to redesign new models of care, which impacts on the hospital's ability to manage demand for services	Pathways / Ease of Use
011/18	There is a risk that the Trust is not always able to consistently embed of a safety culture and evidence of continuous quality improvement and patient experience	Director of Nursing /Medical Director	**QSC / FPC**	**20**	**Retain**	Quality
012/18	There is a risk that the Trust is not able to secure the long-term future of the MVCC	Director of Strategy	**FPC**	**16**	**Retain**	Sustainability / Quality

East and North Hertfordshire NHS Trust

Agenda Item: 11 (B)

TRUST BOARD - PUBLIC SESSION – 1 MAY 2019

Risk Management Strategy, Procedure and Risk Appetite

Purpose of report and executive summary (250 words max):
The Board is requested to:

- Approve Risk Management Strategy (page 2) and Procedure (page 17), including the Trust's first risk management capability assessment, risk appetite statements and updates to reflect current developments and Internal Audit recommendations (January 2019).

- Approve the Risk Appetite Statements for the strategic priorities. (The policy was used at the Board workshop). See **Annex A to the Trust Risk Appetite Framework Policy.**

The 11 risk area appetite statements were approved at the Board Development workshop (06.02.2019). Individual Executive Directors were requested to review the 5 strategic priority risk appetite statements and comments were received on 3 of them (people, sustainability and ease of use).
The changes are reflected in Blue Text for ease of reference.

The implementation of the Risk Management Strategy and Procedure is supported by an implementation plan. This is monitored through the Audit Committee. The current emphasis with risk continues to be getting all clinical and non-clinical parts of the Trust to identify and review risks systematically and to have the training/facilitation to be able to do this. Risk clinics are being held in all the divisions and in Estates/Facilities. The Risk Manager is monitoring the risk clinics to ensure they are held regularly. The escalation of risks process within divisions is also being closely monitored and facilitated.

Action required: For approval

Previously considered by:
Quality and Safety Committee 26 March 2019 and Audit Committee, 1 April 2019 – endorsed and recommended to Board for approval.

Director:	**Presented by:**	**Author:**
Director of Strategy	Associate Director of Corporate Governance	Risk Manager

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
All BAF risks are affected by the strategy, procedure and risk appetite.

Any other risk issues (quality, safety, financial, HR, legal, equality):
Potential risk to patient safety, staff and organisation if risks are not dentified and reviewed appropriately or adequately controlled

Proud to deliver high-quality, compassionate care to our community

East and North Hertfordshire NHS Trust

Risk Management Strategy

2019-2020

Author: Sarah Cauchi, Risk Manager

Approved by: Audit Committee, 01.04.2019

Ratified by: Trust Board, date to be added

Version	Date	Comment
1	7 March 2018	Revised
2	13 June 2018	Updated to align risk scoring nomenclature with Datix and BAF, set escalation level to>14 instead of 12, set review standard to 3 months for risks <15, set KPIs, introduce formal escalation process and agree Risk Management Implementation Plan.
3	April 2019	Updated with summary of first Trust risk management capability assessment, risk appetite statements summary and the new Risk Appetite Framework Policy, monthly BAF review process and version control table added meeting IA recommendations (20.12.2018).
4	25 April 2019	Five strategic priority risk appetite statements have been added, following Executive Director review, to the eleven statements reviewed at the Board Workshop on 06.02.2019. Risk appetite statements are found at Annex A of the Risk Appetite Framework Policy.

Scope
The management of risk management applies to all Trust staff, contractors, volunteers, students, locums, agency and staff employed with honorary contracts.

Equality Impact Assessment
This document has been reviewed in line with the Trust's Equality Impact Assessment guidance and no detriment was identified. This policy applies to all regardless of protected characteristic - age, sex, disability, gender-re-assignment, race, religion/belief, sexual orientation, marriage/civil partnership and pregnancy and maternity.

Dissemination and Access
This document is intended for all Trust staff and can only be considered valid when viewed via the East & North Hertfordshire NHS Trust Knowledge Centre (Intranet). If this document is printed in hard copy, or saved at another location, you must check that it matches the version on the Knowledge Centre.

Associated Documentation
NHSI Single Oversight Framework
Performance Management Framework
Trust Risk Appetite Policy Framework and its annexes including Annex A Trust Risk Appetite Statement
Risk Management Procedure
Board Assurance Framework
All risk registers E.g. Corporate, Divisional and Speciality/department
Standing financial instructions, Scheme of delegation and authorisation from the Board of Directors, Standing Orders from the Board of Directors

Monitoring compliance with and the effectiveness of this document
Monitoring compliance with this strategy will be undertaken by the Trust's audit committee, and assurance will be sought through an annual review of the risk management system and the internal auditor's report on the effectiveness of the system of internal control.

Review
This document will be reviewed at least every 3 years.

Key Messages

- The Trust wants all staff to be alert to and identify and report risks, problems, areas of concern as well as opportunities and discuss these with their line manager and colleagues as well as report them on Datix. All risks are to be reported.

- The Trust wants all areas, with their staff, routinely to review their risk situation and act to ensure controls are effective.

- The Trust wants all staff in leadership roles to receive risk management training and coaching from the Risk Manager.

- The Trust wants all risks to be managed applying the Risk Appetite Framework Policy and its annexes, particularly Annex A Trust Risk Appetite Statement.

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1. STRATEGY STATEMENT

The Board of Directors is committed to the active management of risk, providing better care and a safer environment for patients, staff and other stakeholders.

The Trust is committed to having an open risk management culture that underpins and supports the work of the Trust and the improvement of patient care and safety and the safety of our staff, patients and visitors.

The Trust recognises that the provision of healthcare and the activities associated with the treatment and care of patients, employment of staff, maintenance of Trust sites and managing finances incur risks.

The Trust recognises the need to ensure there are proactive systems in place to effectively identify and manage its risks with the aim of protecting patients, staff and members of the public as well as its assets.

This strategy, its procedure and the Risk Appetite Framework Policy and its annexes, aim to describe:

- firstly a consistent and integrated approach to the management of all risk across all areas of the Trust

- secondly a commitment to the improvement of risk management through the organisation.

2. PURPOSE

This Risk Management Strategy aims to provide the framework and outline the processes needed to support the Trust in delivering its strategic and other objectives by identifying and managing risks.

The Risk Appetite Framework Policy describes the Trust process for the Board of Directors to determine its risk appetite across many risk areas. Also described, is the process for implementation in divisions, corporate directorates and committees to use the risk appetite in its routine decision making processes.

The Trust aims to ensure that the effective management of risk is an integral part of everyday management by having comprehensive risk management systems in place with clear responsibility and accountability arrangements throughout the Trust.

The approach to risk management includes clinical and non-clinical risk and aims to ensure that risk management is clearly and consistently integrated and not managed in silos. By achieving this we can:

- Keep our patients, staff and visitors safe and ensure high standards of patient care
- Protect the reputation and assets and finances of the Trust
- Anticipate changing internal and external circumstances and respond by adapting and remaining resilient
- Remain compliant (as a minimum) with health and safety regulations, insurance, accreditation and legal requirements.

We can do this by:

- Demonstrating the application of risk management principles in all activities of the Trust. This includes using the risk appetite descriptions to inform decision making at strategic, divisional and tactical levels.
- Clearly defining the roles, responsibilities and reporting lines within the Trust for risk management
- Making sure all staff understand the importance of effective risk management
- Maintaining a comprehensive risk register with regular review and proactive management.
- Ensuring effective controls are in place to mitigate the risk and rectify gaps in control

- Ensuring effective and documented procedures exist for the control of risk and provision of suitable information, training and supervision
- Ensuring the Trust has appropriate business continuity arrangements in place

3. RISK DEFINITION AND TYPES

Risk is defined as a barrier which, if realised, could stop an area from achieving its objectives or . negatively impact upon patient safety or its success. It includes hazards, threats and uncertainties as well as opportunities.

Risk management is defined as:

"*The systematic identification, evaluation and treatment of risk. A continuous process with the aim of reducing risk to organisations and individuals alike. 'The culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse effects*.'

(Australian/New Zealand Risk Management Standard 4360:2004).

Types of risk are outlined below. Where risks arise in relation to these, it is important that they are considered in relation to the Trust's stated and agreed risk appetite.

- **Risks to quality and outcomes (patient safety/clinical effectiveness/patient experience)**
  The Trust adopts a systematic approach to clinical risk assessment and management recognising that safety of patients is at the centre of all good health care. In order to deliver safe, effective, high-quality services, the Trust will encourage staff to work to minimise risk to patients as much as possible.

- **Risks to reputation and communication**
  The Trust adopts a careful approach to risks that affect the Trust's reputation and communications, whilst being fully committed to openness and transparency. Decisions with the potential to expose the Trust to additional scrutiny of its reputation will be considered carefully and progressed only with strong mitigations and careful management of any potential repercussions.

- **Financial risks**
  Risks which impact on the Trust's financial performance, these may include procurement risks, contractual risks and risks to the correct application of the Standing Orders and Standing Financial Instructions.

- **Organisational/major change programmes/projects and compliance/ regulation risks**
  The Trust endeavours to establish a positive risk culture within the organisation, where unsafe, non-compliant and unethical risks are not tolerated and where every member of staff feels empowered to identify and correct/escalate system weaknesses. The Trust aims to minimise risk to the delivery of services whilst maximising performance in line with value for money. All areas are required to have a proactive approach with staff involvement to identifying risks, to support the generation of a positive risk culture.

- **Opportunistic/commercial risks**
  Where new opportunities arise for the Trust in relation to providing new services or new projects, it is important that this is only considered in relation to the Trust's stated and agreed risk appetite.

- **Staffing risks**
  Examples of what these risks may include are staff safety, breaches of contractual, legal and equality obligations or any risks where the Trust could be perceived as not being consistent with a good, ethical employer. Risks relating to the competency of care giving, initiatives to broaden the Trust workforce and staffing innovations.

- **Equipment and supplies risks**
  Examples of these risks may include changing suppliers, service providers, equipment or supply problems/shortage, non-compliance with equipment or regulatory requirements, ageing equipment that is at risk of failure etc.

- **Estates/Facilities risks**
  Examples of these risks may include estates/premises risks including fire, non-compliance with buildings regulations and standards, occupational health risks, problems from lack of investment in infrastructure and maintenance, lack of compliance with alerts and external changes outside the Trust's control E.g. supply chains etc. causing patient and staff safety risks. Risks to service delivery may also occur.

- **Information Management and Technology (IM/IT) risks**
  Examples of these risks may include weak systems, processes and monitoring for IT systems, inadequate IT co-ordination or lack of aggregation and linking of IT problems. Also, procuring IT systems that cannot work together, weak information management and inappropriate patient communications being generated by the IT system. IT risks also may encompass weaknesses in systems used for clinical tests causing sub-optimal diagnostics, care, follow-up or serious IT system outages.

- **Corporate and Strategic risks**
  Risks affecting the delivery of the Trust strategic priorities (Quality, People, Pathways, Ease of Use and Sustainability).

4. TRUST RISK MANAGEMENT CAPABILITY

The Trust's first in-house risk management capability assessment has been undertaken by the Risk Manager and Assistant Director of Corporate Governance, and discussed at the Board risk management workshop in February 2019.

The assessment covered the Trust's:

- ability to carry risks (capacity)
- processes, systems, leadership and culture to manage risks (risk management maturity)
- propensity to take risk
- propensity to exercise control

The capability assessment has been used to define the risk appetite statements by the Board describing the circumstances in which risks can and cannot be taken by managers and staff at all levels in the Trust.

The Trust's risk management capability will be reviewed periodically, with subsequent amendment to the risk appetite statement, as required.

5. RISK APPETITE FRAMEWORK POLICY, STATEMENT SUMMARY AND TRUST RISK PROFILE

The Trust Risk Appetite Framework Policy (separate to this strategy, yet incorporated within it) describes the detailed processes for the Trust to determine, implement, monitor and review its risk appetite statement.

Template questions from the Trust Risk Appetite Framework Policy are to be used when drafting risk appetite statement content. Annex A of the Policy, the Trust Risk Appetite Statement (February 2019), provides detailed guidance from the board on the Trust risk appetite for different areas of risk and for Trust strategic priorities, as well as guidance upon escalation.

Key documents included with the Risk Appetite Framework Policy are:

- Annex A - Trust risk appetite statement (February 2019)
- Annex B - Summary of steps to create and maintain the Trust risk appetite
- Annex C - A comprehensive risk appetite guide for managers and clinical leaders
- Annex D - Questions for the boardroom, managers and clinical leaders – Risk appetite development, monitoring and review
- Annex E - Risk management capability assessment - February 2019 evaluation

The detail provided by these documents is essential for understanding and implementing the Trust risk appetite. Some key text is summarised below:

Trust commitment

The East and North Hertfordshire NHS Trust board have set the risk appetite for the organisation. The Trust will set, monitor and review its appetite for and attitude to risk in a risk appetite statement, as part of Trust Risk Management strategy and procedures, involving the views of internal and external stakeholders. Review will occur annually.

The risk appetite statement will define the board's appetite for different key risk areas identified, for the achievement of strategic objectives, compliance and ethical standards for the year in question.

Openness and **transparency,** particularly regarding reporting and escalating risks, will be promoted by the Trust risk appetite, as core values.

The Trust Risk Appetite Framework, Risk Appetite Statement and the commitment and actions that they require contribute to the Trust's commitments to achieve excellence regarding the Well Led standards of the CQC.

Risk appetite

Risks need to be considered in terms of both opportunities and threats. Risks can affect all the Trust's strategic objectives and its activities, finances, capability, performance and reputation. The amount of risk that is judged to be tolerable and justifiable is the "risk appetite". The risk appetite statement is the board decision framework on the appropriate exposure to risk it will accept in order to deliver its strategy over a given time frame.

Risk appetite describes, "The **amount of risk** that an organisation is willing to **seek or accept** in the pursuit of its long-term objectives" (IRM, 2011), the degree of risk that is judged to be tolerable and justifiable. Risk appetite can be seen as, 'the **amount of risk** that an organisation is prepared to **accept, tolerate, or be exposed to** at any point in time.' (HMT Orange Book definition 2005). The Trust risk appetite statement must not stifle innovation, growth and development.

Balanced risk profile - exposure and aggregated and interlinked level of risk

The Trust's risk appetite statement should address and **balance** several dimensions:

- The nature of the risks to be assumed.
- The amount of risk to be taken on.
- The desired balance of risk versus reward
- The aggregated and interlinked level of risk for the organisation and/or their area, to determine whether the overall risk exposure is acceptable or not.

The effect of a new potential risk on the overall risk exposure must be evaluated. The risk appetite statement should be applied, "to ensure overall alignment and to ensure the organisation has a balanced profile or portfolio of risk" (Institute of Internal Auditors, 2018).

The statements below describe the Trust board's risk appetite in relation to the primary risk groupings, risk appetites and levels as set by the Good Governance Institute (2012), ("A matrix to support better risk sensitivity decision taking") and other risk categories used by the Trust and reflected in its risk register and BAF.

Overall risk appetite statement summary

Reflecting a thorough evaluation of its development of risk management, covering risk capability, risk capacity and risk management maturity, the Trust has established its risk appetite for the areas and strategic priorities below.

Risk areas

The Trust has a LOW risk appetite, keeping the risk level MINIMAL**,** for risks in the following areas:

- Quality/outcomes
- Compliance/regulatory
- Financial/value for money

The Trust has a MODERATE risk appetite, with a CAUTIOUS risk level, for risks in the following areas:

- Reputation (inclining risk appetite *high*, risk level *open*)
- Staffing
- Equipment and Supplies
- Estates/Facilities
- IM/IT (inclining to risk appetite *low*, risk level *minimal*)

The Trust has a HIGH risk appetite, accepting an OPEN risk level, for risks in the following areas:

- Innovation
- Commercial
- Major change programmes and projects (inclining to *moderate,* risk level *cautious*)

Strategic priorities

The Trust has a LOW risk appetite, keeping the risk level MINIMAL**,** for risks in the following strategic priority area:

- **Quality -** "Deliver high quality care consistently across all of our services in terms of clinical quality, safety and compassion."

The Trust has a MODERATE risk appetite, keeping the risk level CAUTIOUS**,** for risks in the following strategic priority area:

- **People -** "Create an environment which retains staff**,** recruits the best and develops an engaged, flexible and skilled workforce able to meet the needs of our patients."

The Trust has a HIGH risk appetite, accepting an OPEN risk level (inclining to *moderate*, risk level *cautious*), for risks in the following strategic priority areas:

- **Ease of use** - "Redesign and invest in our systems and processes to ensure that they provide a consistently simple and quick experience for our patients, their referrers, and our staff, minimising frustration and maximising efficiency."

- **Pathways -** "Pursue actively the development of pathways across care boundaries, where this is in the best interests of patients and adds value."

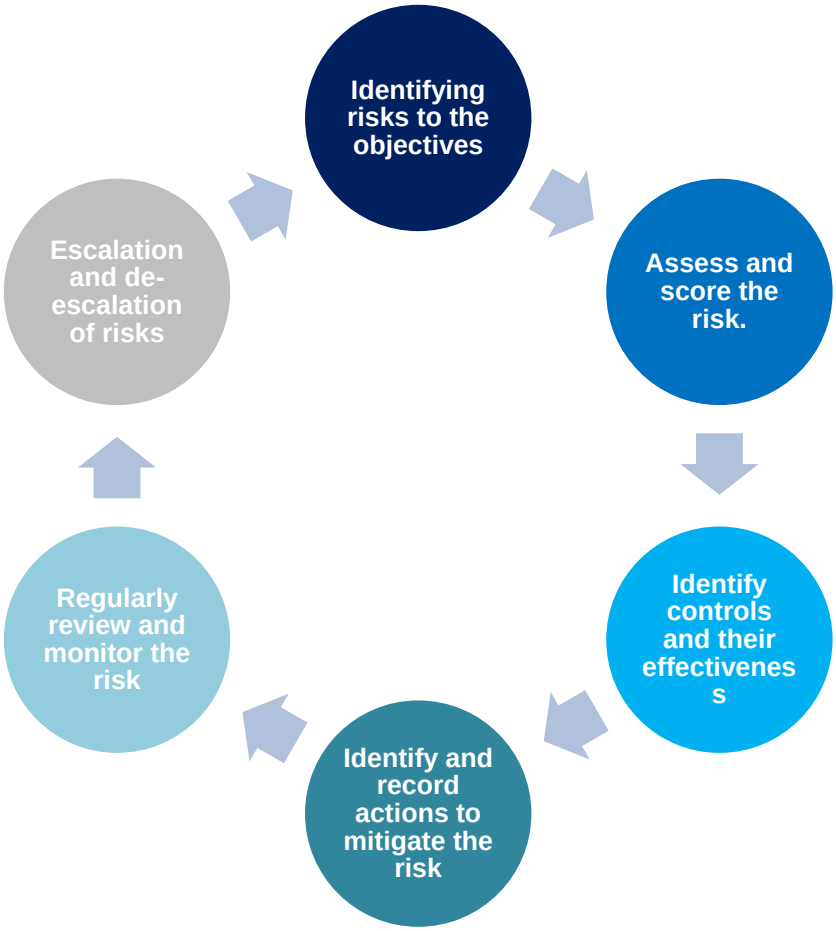
- **Sustainability** - “Develop a portfolio of services that are financially and clinically sustainable in the long-term.””

6. RISK MANAGEMENT PROCESS

A structured approach to the management of risk must be taken regardless of whether it is clinical or non-clinical in nature. Risks are identified, assessed and controlled and, where appropriate, escalated or de-escalated through the governance mechanisms of the Trust.

Risk management cycle

The Trust’s risk management cycle includes:



Staff, partners and others should be fully involved in each stage of identifying, assessing, controlling and reviewing risks.

7. RISK MANAGEMENT GOVERNANCE

There are different operational levels involved in the governance of risk in the Trust:

- Board of Directors
- Audit Committee

- Quality and Safety Committee, Finance and Performance Committee, Divisional Executive Committee and Divisional Operational Committee
- Divisional and directorate management teams
- Speciality teams

Risk management by the Board of Directors is underpinned by a number of systems of control through the following three mechanisms.

- **The board assurance framework (BAF)** sets out the strategic objectives of the Trust, identifies risks in relation to each strategic objective along with the controls in place and assurances available on their operation. The BAF is then used to drive the Board of Directors meeting agendas.

  Risks to the Trust's strategic priorities are identified by directors and through the Risk Manager's monthly risk report, which includes a thematic analysis of risks scoring 15 and above. Aggregated Risk themes from low risks are also included periodically and can inform the BAF, as required.

  The BAF risks are detailed individually in a BAF template and are reviewed monthly by the Executive Lead for each risk and the Executive/Divisional Executive Committee. In addition, monitoring the BAF is included in the terms of reference of the Audit Committee, Quality and Safety Committee and the Finance and Performance Committee enabling regular scrutiny, discussion, challenge of evidence and update of the risks. A bi-monthly narrative report is also provided to the Board of Directors.

  The BAF includes how assurances cover the controls identified and whether these are 1st, 2nd or 3rd line assurances. The Assistant Director of Corporate Governance ensures that risks are mapped to understand the level of assurances in place for each control and to identify areas where assurances are insufficient or not in place.

- **The annual governance statement** is signed by the Chief Executive as the Accountable Officer and sets out the organisational approach to internal control. This is produced at the end of the financial year and scrutinised as part of the annual accounts process.

  Additionally, the Audit Committee and other board sub-committees provide assurance of the robustness of risk processes and to support the board of directors.

- **Audit Committee** is the sub-committee of the Board of Directors which is responsible for maintaining oversight of the risk management processes across the Trust and implementation of the RM Strategy and Implementation plan.

- **Quality and Safety Committee (QSC)** Committees reporting to the QSC provide a more detailed specialist oversight of risk. These include the Clinical Effectiveness Committee, Patient Safety Committee and the Patient Experience Committee. As risks can often fall into several categories, the risk report to these committees includes a summary of all the committee risks to enable an integrated oversight of risk.

- **Finance and Performance Committee (FPC)** Committees reporting to the FPC provide a more detailed specialist oversight of risk. These include Capital Review Group, IM and IT Strategy Board. As risks can often fall into several categories, the risk report to these committees includes a summary of all the committee risks to enable an integrated oversight of risk.

- **Executive/ Divisional Executive Committee (Exec/DEC)** in operational detail, reviews risk plans, initiatives and papers, as required, prior to reporting to the Quality and Safety Committee or after the Board of Directors. Prior to the DEC, operational discussion on risk matters may also occur at the Divisional Operational Committee.

- **The corporate risk register (CRR)** is the corporate high-level operational risk register used as a tool for managing risks and monitoring actions and plans against them. New risks are added formally to the CRR only after Divisional Boards have approved the escalation of the risk. Datix risk includes an "Assessment for Escalation of Risk" section with boxes for Risk Leads, Divisional Boards and the Executive Committee to record their decisions concerning risk escalation and management. Used correctly, it demonstrates that an effective risk management approach is in operation within the Trust.

- **Corporate Services risk registers will cover risks from corporate areas such as nursing, strategy, finance, estates, workforce and IT** are maintained by an identified lead on behalf of the directorate, with support from the Risk Manager.

- **Divisional Risk Registers** are maintained by the Divisional Quality Managers on behalf of the division, with support from the Risk Manager.

- **Each division will have the following fundamental processes for managing risk** and meeting Trust risk management key performance indicators:

    - **A division level management forum** so the division can monitor that their risks are being appropriately managed. This includes that Risk Leads are regularly reviewing their risks and implementing effective control measures. Any required escalation to the Corporate Risk Register or de-escalation must be approved by the divisional board.

    - **All specialties will have a formal monthly minuted meeting** where their risks and controls are discussed and new risks identified.

    - **All areas will have identified Datix Risk Leads and Approving Managers** to manage risks operationally and approve risks according to the ASSURE risk quality tool.

    - All divisional leadership roles will be compliant with **risk management training standards.**

    - **Divisional Governance/Audit Leads and Divisional Quality Managers** have responsibilities regarding monitoring and facilitating the management of risk within their areas.

  The Risk Manager will facilitate risk clinics in divisions and non-clinical areas, where necessary, to support and guide divisions. The Process for Risk Clinics is used.

8. RISK MANAGEMENT ACTIVITIES

The Trust risk management activities are a part of its overall commitment to effective clinical governance and patient safety. The risk management approach is underpinned by additional Trust policies supported by on-going training including:

- Risk Management Procedure
- Trust Risk Appetite Framework Policy and its annexes particularly Annex A Trust risk appetite statement
- Management of Serious Incidents (SIs) procedure (CP 180)
- Adverse Incident Reporting and Investigation Policy (CSEC 049)
- Serious incidents investigation guidelines
- Management of Health and Safety at Work Policy (mhsw)
- Health and safety risk assessments
- Complaints and Concerns Policy (CSEC 008)
- Information Security policy and Records Management Policy (IG 002)
- Management of Alerts Procedure (CP 256)
- Business Continuity Plan
- Capability Policy
- All policies and procedures associated with healthcare acquired infections
- Violence and Aggression Policy (viol&agg)
- Safeguarding Adults from Abuse Policy (CSEC 021)
- Safeguarding Children Policy (CSEC 046)
- Management of financial risk and risks to the internal control environment through the application of the SFIs.

The Trust's systems of internal control are based on its on-going risk management programme that aims to:

- Identify principal risks to the achievement of goals set out in the annual plan
- Evaluate the nature and extent of risks
- Manage all risks effectively, efficiently and economically
- Enable the completion of the annual governance statement

9. DELIVERING THE STRATEGY

The strategic element of this risk management strategy and policy will be delivered by focusing on key themes of activity, linked to the Trust's strategic objectives.

Executive directors, senior management teams and departmental/ operational managers within the Trust will:

- Be clear about the Trust's quality priorities and strategic objectives
- Promote awareness and understanding of the benefits of proactive risk management, and promote a positive risk and patient safety culture
- Manage risks applying the Trust Risk Appetite Policy Framework and its annexes, particularly Annex A the Trust Risk Appetite Statement.
- Aim to meet the risk Key Performance Indicators (KPIs) by ensuring arrangements are in place in specialties and at divisional level for identifying, assessing, controlling, monitoring and reviewing risks and their controls. Key to making this happen is regular risk discussion involving staff at departmental/ward level.
- Distribute and disseminate, to their teams results of complaints, incidents, serious incidents, claims, near misses, audits and lessons learned

- Support compliance with appropriate legislation and standards including national risk management standards and CQC requirements

The Trust will:

- Ensure corporate ownership and accountability throughout the organisation of risk management and the need to mitigate risk along with the mechanisms for reporting and sharing learning across the organisation.

- Promote and support the ongoing development and Trust wide implementation of risk management strategies and policies according to best practice
- Apply and review the Trust risk appetite.
- Provide risk management training and facilitation programmes to support staff in implementing their risk management responsibilities and reporting of incidents.
- Ensure that all staff receive training in conducting health and safety risk assessments.
- Promote a strong risk management culture through involving all staff groups in both clinical and non-clinical areas. This is supported by the development of arrangements for routine management of risks in all areas.

10. RESPONSIBILITIES AND ACCOUNTABILITIES

RISK MANAGEMENT SPECIALISTS

The Trust has a range of risk management specialists who possess and maintain appropriate qualifications and experience sufficient to ensure that competent advice is available to staff. The specialists are responsible for creating, reviewing, facilitating and implementing policies, procedures, protocols and guidelines for the effective control of risk. Key risk management leads for the Trust are as follows:

- The **Assistant Director of Corporate Governance** is the corporate governance lead for the Trust and supports the Board of Directors in carrying out their responsibilities for risk management and takes the lead, on behalf of the board of directors, for maintaining the board assurance framework.

  The Assistant Director of Corporate Governance manages the Risk Manager. Strategic risk management approaches and systems are developed and support provided to the Board of Directors and Trust wide. The role ensures a clear relationship between Board Assurance Framework risks identified by the Board and the Trust risk register.

  The Assistant Director of Corporate Governance also manages the Compliance Manager who monitors Trust-wide regulatory standards including CQC, MHRA etc. New risks identified by the Compliance Manager are communicated to divisions for entry to the risk register and management action. This in turn is monitored.

- The **Risk Manager** is the Trust risk lead and is responsible for developing and facilitating implementation of the Trust Risk Management Strategy, Risk Management Procedure and Risk Appetite Framework Policy. This includes facilitation and drafting of the Board's Trust risk appetite statement supporting the Trust risk appetite process and drafting the Board's risk management capability assessment for Board approval, upon which the risk appetite is based.

The Risk Manager supports divisions and non-clinical areas with risk reports in an agreed format to facilitate ward to board governance and where necessary, escalation, of risks. The department also supports executive management of risk by managing the corporate risk register and reviewing the wider Trust risk register to provide assurance on the compliance with the risk management strategy and Risk Management Procedure.

The Risk Manager oversees the Corporate Risk Register and facilitates divisions' management of their risk registers. Divisions are facilitated by the Risk Manager to monitor their risk registers and the effectiveness of controls. The Risk Manager is responsible for delivering comprehensive Trust wide risk management training, facilitation and coaching programmes to enable all areas to develop their risk management processes as an integral part of routine organisational and departmental activity. The Risk Manager works closely with the Patient Safety Team on the management of alerts to facilitate monitored change occurs on the ground following alerts.

- The **Head of Quality and Patient Safety (HoQ&PS)** is the quality governance lead for the Trust and leads on the incident management policy which includes serious incidents. The HoQ&PS is accountable to the Medical Director / Director of Nursing through the Associate Director of Quality Improvement and is responsible for promoting and ensuring the implementation of Trust-wide systems and processes to enable the Trust to meet its requirements in relation to clinical governance. Alerts are managed by the HoQ&PS, with transfer of responsibility to risk management, through a handover process, as soon as resources are made available to risk management to undertake the work required to ensure implementation of the Alerts policy.

- The **Health and Safety Manager** is responsible for facilitating all areas of the Trust to proactively carry out health and safety risk assessments on their activities, processes, workplaces, equipment and people who are at particular risk. Where a risk has been identified as a result of a health and safety risk assessment, which is unable to be controlled to as low as reasonably practicable, the risk is entered onto the risk register.

- **Divisional Quality Managers** are responsible for ensuring all specialties are identifying, assessing, controlling and closing risks routinely, involving their staff, and accessing risk management training and support. They are responsible for supporting the on-going maintenance of the divisional risk register. They are responsible for facilitating and monitoring the implementation of alerts in their divisions.

- **Committee chairs**; For example: Patient Safety Committee, Clinical Effectiveness Committee and Patient Experience Committee. Chairs are responsible for enabling their committees to know the key risk themes from existing and emerging risks, identify any areas in the management of risks that require development or escalation to the Quality and Safety Committee or Executive Committee.

TRUST STAFF

All staff

- Staff should have an awareness and understanding of the risks that affect patients, visitors, and staff
- Line managers will involve their staff routinely in identifying risks and effective controls.

- Staff who are identified to implement actions to control risks, will do so with the support of their speciality.
- There will be proactive and regular communication on risk at all levels including ward/department/speciality. Communication should include staff, stakeholders and partners.
- All staff will have access to comprehensive risk guidance and advice
- Risk assessment and management – risks are assessed and acted upon to prevent, control, or reduce them to an acceptable level. Staff have the freedom and authority, within defined parameters, needed to take action to tackle risks, escalating them where necessary
- Measuring performance - exposure to risk is measured with the aim of reducing this over time. The culture of risk management is also measured and improved where applicable.

Datix Risk Lead
All risks will have an identified lead, known as the Datix Risk Lead, recorded on the Trust's Datix system. The Datix Risk Lead is responsible for ensuring the risk is managed and monitored to ensure controls and further actions are in place to mitigate the risk. It is the responsibility of the Datix Risk Lead to escalate risks scoring 15 and above, in line with the escalation process.

Action Owner
All risks have action owner(s), designated by the Risk Lead, to implement the action specified to mitigate the risk. The action owner should liaise closely with and update the Risk Lead on progress.

Approving Manager
All risks have Approving Managers who approve the management of the risk. The Trust ASSURE tool is used, following risk management training, by Approving Managers and others to check the risk is meeting appropriate standards with description, scoring, assurance etc. Any changes are made in liaison with the Datix Risk Lead. The Approving Manager is usually the Datix Risk Lead's senior manager or director. The Approving Manager and Datix Risk Lead work together over escalation of the risk to the Corporate Risk Register, if needed, using the Assessment for Escalation section on Datix.

Divisional Governance/Audit lead
All corporate areas, divisions, programme and project teams must have an identified Governance/Audit Lead.
The Governance/Audit lead will be responsible for:
- Consulting with teams to identify and assess risks and determine mitigating actions
- Ensuring risk registers undergo regular review and quality assurance
- Promoting the Risk Management Procedure and best practice within their division.
- Communicating changes to the Risk Management Strategy and Risk Management Procedure to staff within their area of the Trust
- They are responsible for facilitating and monitoring the implementation of alerts in their divisions, working closely with Divisional Quality Managers.

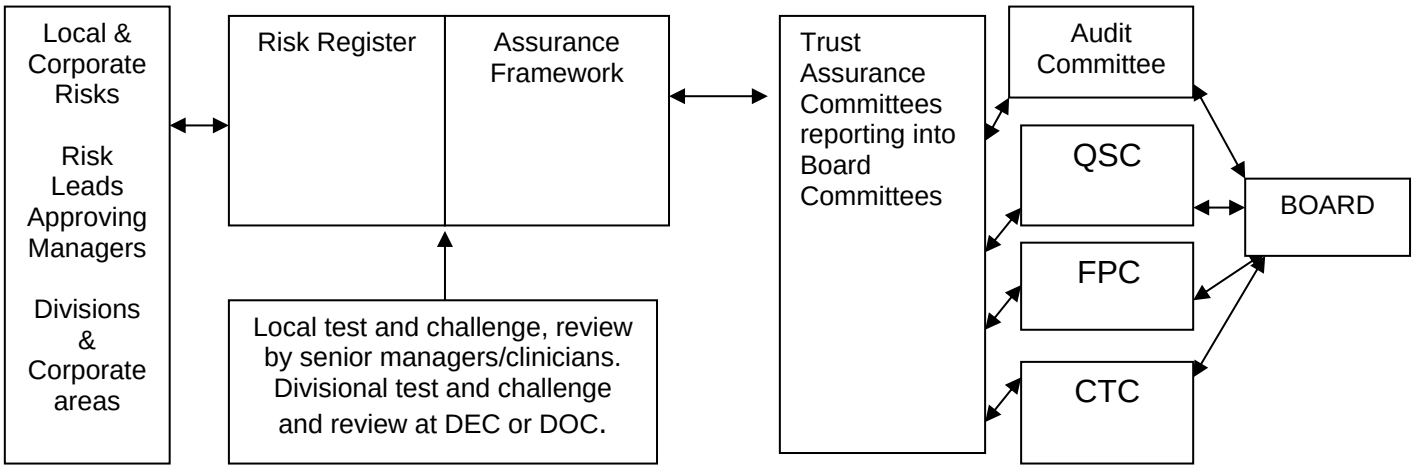
- Sharing information and knowledge on risks within their division, at key meetings such as clinical governance meetings, risk clinics etc.

11. ASSURANCE FRAMEWORK

Assurance structures
Assurance of achievement, weaknesses in delivery and key risks to the delivery of Trust objectives are reported through the assurance committees of the Board. The Audit Committee

maintains oversight of the risk management processes across the trust and implementation of the RM Strategy and Implementation plan. The quality assurance committees include the Patient Experience, Patient Safety and Clinical Effectiveness, Health and Safety Committees. The quality committees receive reports detailing the main causes of emerging risks along with the detail of the management of the risk. The Financial Performance Committee assurance committees include Strategy Board, IM&T Strategy Board and Capital Control Group. The Board assurance committees receive detailed reports to inform them of all significant risk exposures, material changes to risks and progress with risk management key performance indicators. The Trust assurance committees are responsible for providing assurance on the management of risk to the Board of Directors.

An overview of the assurance process is illustrated below.



12. TRAINING

A comprehensive training programme has been developed to support the successful implementation and embedding of the Risk Management Strategy, Risk Management Procedure and the Risk Appetite Framework. Training and facilitation is provided for all staff in leadership roles (Band 7 and above to CE level and including consultants). Training is provided to the Board of Directors at least every two years, to ensure that the requirements for understanding and discharging duties in relation to risk management at board level is reviewed and refreshed, thereby maintaining compliance with nationally agreed policy and practice.

Staff awareness and knowledge of risk management is facilitated through risk management information and guidance available on the Trust Knowledge Centre. Training will be included in Trust induction training.

The overall effectiveness of the delivery of risk management training for board members and senior managers is evaluated and monitored by the Risk Manager. Where such monitoring identifies deficiencies, recommendations will be agreed and an action plan developed and changes implemented accordingly.

13. RISK MANAGEMENT PROCEDURE

This Risk Management Strategy is underpinned by a comprehensive Risk Management Procedure which describes the process for effectively identifying, assessing, evaluating and monitoring all Trust risks whether they are clinical or health and safety related. This is available on the Trust's Knowledge Centre.

Risk Management Procedure

Version	Date	Comment
1	August 2007	Registration no Ex001 New policy following recommendation from NHS Litigation Authority
2	August 2009	Refresh – no significant changes
3	June 2012	Refresh – to update committees, monitoring arrangements
4	June 2015	Scheduled review. Registration no changed to CP 208
5	June 2016	Revised to strengthen arrangement for controls & oversight inc checklist to ensure actions & controls mitigate the risks
6	March 2018	Comprehensive revision to align with Risk Management Strategy
7	June 2018	Updated to align nomenclature with Datix, Risk Management Strategy & Board Assurance Framework
7.1	August 2018	Correction of table on page 7
8	March 2019	Escalation process added page 5 and 8, risk appetite referenced page 5, roles updated to reflect new risk function and alerts management changes and all Internal Audit recommendations (20.12.2018).

Equality Impact Assessment

This document has been reviewed in line with the Trust's Equality Impact Assessment guidance and no detriment was identified. This procedure applies to all regardless of protected characteristic – age, sex, disability, gender re-assignment, race, religion/belief, sexual orientation, marriage/civil partnership, pregnancy and maternity.

Dissemination and Access

This document can be considered valid only when viewed via the East and North Hertfordshire NHS Trust Knowledge Centre. If this document is printed in hard copy, or saved at another location, you must check that it matches the version on the Knowledge Centre.

Associated Documentation

Risk Management Strategy

Risk Appetite Framework

Performance Management Framework

Board Assurance Framework

All risk registers E.g. Corporate, Divisional and Speciality/department

Standing financial instructions, Scheme of delegation and authorisation from the Board of Directors, Standing Orders from the Board of Directors

Review

This document will be reviewed within three years of issue, or sooner in light of developments or new evidence.

East and North Hertfordshire NHS Trust

Risk Management Procedure

To be used alongside the Risk Management Strategy and the separate Risk Appetite Framework Policy and its annexes including Annex A Risk Appetite Statements

Table of Contents

1 PURPOSE

This procedure supports the implementation of the Risk Management Strategy at East and North Hertfordshire NHS Trust. It outlines how risks should be recorded and managed, including instructions on using Datixweb to support this process. It includes clarity around roles and responsibilities at all levels in the organisation and should be read in conjunction with the Risk Management Strategy.

The Trust Risk Appetite Framework Policy and its annexes, including Annex A Trust Risk Appetite Statement, are incorporated into the Trust Risk Management Strategy. Risk appetite is implemented and monitored using these documents rather than this procedure.

2 INTRODUCTION

The delivery of high quality healthcare requires the identification, management and minimisation of events or activities, which could result in unnecessary risks to patients, staff, visitors and members of the public. The management of risk is a key organisational responsibility of all staff employed by the Trust.

Datixweb, the Trust's risk management system, is used to support the recording, management, escalation and review of risks and production of risk registers across the Trust to ensure consistency of recording. Datix allows control measures to be recorded and actions to be scheduled, with a full audit trail of changes to the risk.. The system is able to report at different levels, look at trends across fields and record and manage actions. The Assessment for Escalation section enables information to be visible on what is needed at department/specialty and divisional levels to control risk and the response from divisional board and, if escalated further, from the Executive Committee. This process enables divisions to take action to de-escalate and mitigate risk, whenever possible.

This document provides information and guidance on the correct recording and use of Datixweb Risk Register at East and North Hertfordshire NHS Trust.

Should you need assistance with the Datix Risk Register contact the Risk Manager on 01438 284378.

3 DUTIES, ROLES AND RESPONSIBILITIES

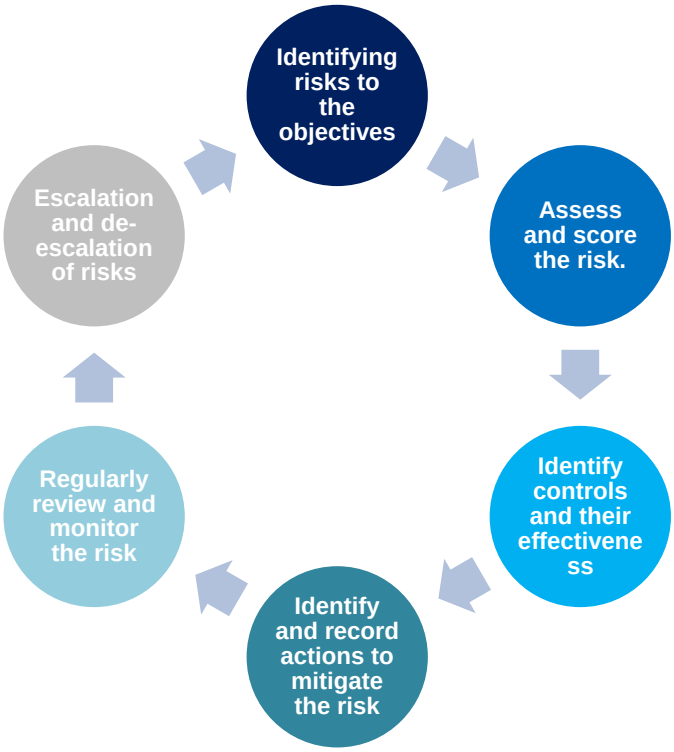
All staff
The management of risk is the business of everyone within the Trust. Every team/department/ward should have a clearly defined process for staff to follow to bring risks to the attention of the appropriate person. Staff should highlight risk issues with their line manager in the first instance. Staff are able to record risks directly on Datixweb via the intranet, however this should only be after discussion with their colleagues and manager.

Managers at all levels in the organisation
Managers are responsible for ensuring they have comprehensive risk registers in place, which are reviewed and actions implemented to mitigate risk, escalating risks if needed. Managers should have a routine meeting with staff where risks are discussed, reviewed and a proactive approach for identifying new risks with their staff.

4 THE RISK MANAGEMENT PROCESS

When a risk is identified it should be discussed first with colleagues and line managers, if possible, and then recorded using Datixweb.

There are six steps to the risk management process:



Throughout this cycle the Risk Lead has responsibility for reporting and escalating their risks, as required, using the Trust's risk Assessment for Escalation section on Datix.

5 RISK IDENTIFICATION AND RECORDING

Risk is defined as a barrier which, if realised, could impact upon patient safety and/or stop an area from achieving its objectives or impact negatively on its success. It includes hazards, threats and uncertainties as well as opportunities.

Risks can arise from any aspect of the Trust, for example:

- The external environment – political and/or commercial
- Clinical practice
- The environment
- Buildings and equipment
- Hazardous substances
- Staff, visitors, patients or contractors
- Procedures, systems or practices
- Financial activities
- Communication and information
- Legislation, including regulatory frameworks
- Business planning

When identifying a risk, staff should consider what could potentially threaten (or enhance) the achievement of the Trust's objectives. This will identify whether the risk is strategic, i.e. associated with a particular programme of work, or operational – affecting the day to day running of services. Each department is responsible for identifying risks. Some of these will be identified through risk assessments. All identified risks should be recorded on Datixweb.

A **Risk Register** is a log of risks that could threaten the achievement of the organisation's declared aims and objectives, or the delivery of services. It is important that it remains a dynamic document that provides a structured approach to risk management decision-making throughout the organisation.

5.1 Risk description

Once a risk has been identified then the risk will need to be appropriately described. It is essential to identify:

- What there is a risk of,
- Its cause and
- What the impact/consequence will be, if the risk is realised. The following guide should be used to describe all risks for inclusion on the Datix Risk Register;

There is a risk of …… caused by (or is due to) …… which, could lead to …… if not properly controlled or managed (Consequence/Impact).

It is helpful to quantify risk when describing the risk E.g. how frequently the risk occurs, how many patients/operating lists would be affected, or costs incurred/income lost Etc.

5.2 Risk controls and assurance

Controlling a risk involves a method by which systems and processes are put in place to either eliminate the risk from occurring at all or to mitigate (reduce) the likelihood of occurrence or its impact, should it occur.

Types of control measures that can reduce the risk's impact/consequence or likelihood of occurrence, help decide whether the risk should be transferred or retained include:

- systems and processes
- staff training
- contingency plans, policies, procedures, guidelines and protocols
- the design of equipment, buildings and materials and insurance.

Every risk must have at least one action identified to eliminate or mitigate the risk. Actions must be entered into the Actions section of Datix and Risk Leads must make it clear how the action relates to eliminating or mitigating the risk.

Assuring a risk means providing evidence which demonstrates that a risk has been effectively controlled. It is better to obtain an independent check that controls are working rather than rely on staff perceptions that something is in place.

6 RISK ANALYSIS AND SCORING

People have different perceptions of how they rate a risk. To make sure the Trust assesses risks in an objective and consistent way, a nationally agreed risk matrix is used and the Guide to Consequences of Risk with examples of degree of impact under different risk areas. Definitions and further help are detailed in Appendix 1.

	Consequence / Impact				
Frequency / Likelihood	**1 None / Insignificant**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Death, Catastrophe**
5 Certain	Yellow: low 5	Orange: moderate 10	Red: high 15	Red: high 20	Red: high 25
4 Likely	Yellow: low 4	Moderate: 8	Orange: moderate 12	Red: high 16	Red: high 20
3 Possible	Green very low 3	Yellow: low 6	Orange: moderate 9	Orange: moderate 12	Red: high 15
2 Unlikely	Green very low 2	Yellow: low 4	Yellow: low 6	Orange: moderate 8	Orange: moderate 10
1 Rare	Green very low 1	Green very low 2	Green very low 3	Yellow: low 4	Yellow: low 5

7 RISK ESCALATION

The structure for risk reporting, accountability and escalation /de-escalation for each level is described in Appendix 3.

7.1 Escalating divisional risks to the Corporate Risk Register (CRR)

The Divisional Board is the highest divisional level forum to discuss controls and action plans for divisional risks. It is also the forum where risks are approved for escalation to the Divisional Executive Committee for consideration for inclusion on the Corporate Risk Register, or for agreement that the risk will be continued to be managed at divisional level on the Divisional Risk Register.

All risks scoring 15 and above are escalated by the Risk Manager to the divisional board for consideration of their management. The divisional board confirms if the risk has to be escalated to the Executive Committee for additional support, because the division is not able adequately to manage or mitigate the risk. If the risk is escalated, and approved by the Divisional Executive Committee, then it is entered on the Corporate Risk Register.

The Risk Manager emails the Nursing & Medical Directors before the risks are reported to the Divisional Executive Committee, so they can contribute their input if they wish.

Many of these risks fall within common categories, such as old or inadequate equipment, old premises, staffing etc. In risk reports, these themes are identified across divisions and reported to the Quality and Safety Committee, Executive Committee etc.

Datix must be updated following Divisional Boards' decisions, so the Risk Manager knows whether to include the risk in draft reports to the Quality and Safety Committee, Divisional Executive Committee etc.

7.2 The Divisional Executive Committee

The Divisional Executive Committee meets formally on a monthly basis to review the Corporate Risk Register, and receive risk updates from clinical divisions and corporate areas. Candidate risks for the Corporate Risk Register are escalated by the Risk Manager at the Divisional Executive Committee who will make a decision regarding whether risks are suitable to be managed on the Corporate Risk Register or are still eligible to be managed at Divisional level.

7.3 The Corporate Risk Register

If it is decided that the risk is eligible for the Corporate Risk Register, this will be reported to the Quality and Safety Committee. Operationally, the Risk Lead identified at Divisional level will still have day to day responsibilities for managing the risk.

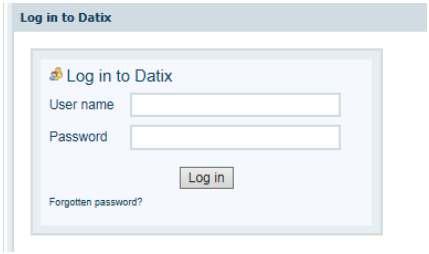
8 THE RISK MANAGEMENT PROCESS USING DATIXWEB

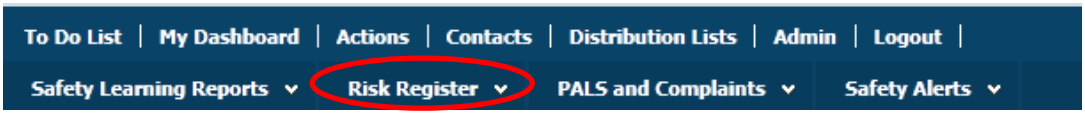
The Datixweb Risk Form 1 is the primary tool to record risks and can be accessed via the Knowledge Centre. It is a generic form for use to assess all kinds of risk and is the prime source of the information to review risks through Risk Registers at all levels of the organisation. The Datixweb form enables consistency in data collection. Risk registers are extracted and reported from Datix.

8.1 Logging on

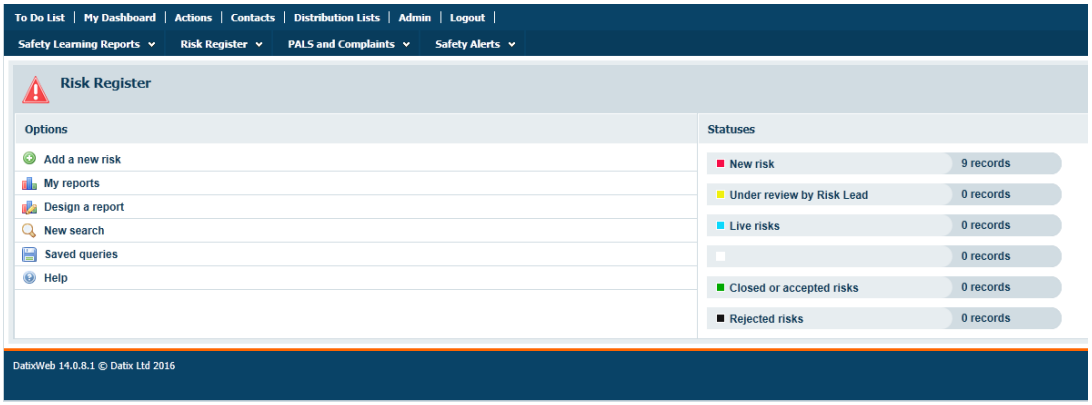
In order to enter a risk onto any of the risk registers you must first log on to the Datix system. Access the Datix system via the Knowledge Centre and log on:

http://nhs-harlow/Datix/Live/Index.php?action=login&form_id=4



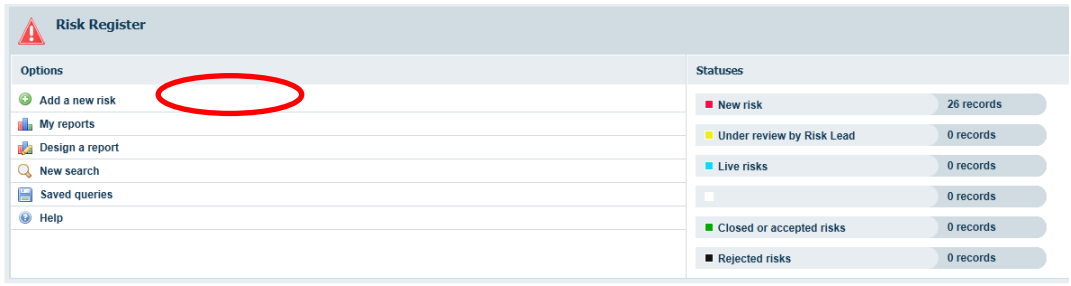


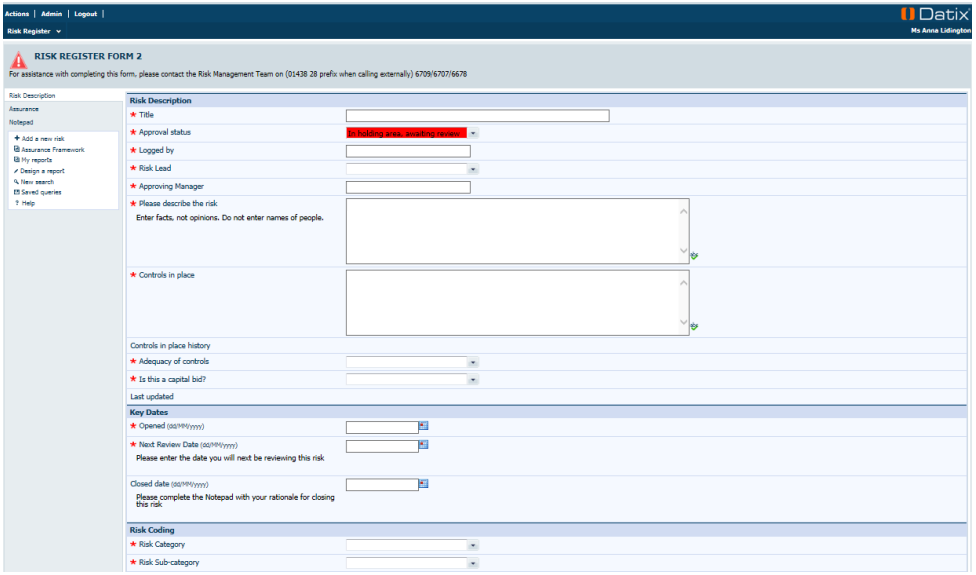
Once you have selected the Risk Register the 'home' screen will appear.



8.2 Adding a new risk: role of Risk Lead and Approving Manager including Risk Leads outside your division

To add a new risk select the "Add a new risk" option





The **Risk Lead** is the person who can operationally eliminate or mitigate the risk. Usually, the Risk Lead is within the division where the risk is. If the resolution of the risk lies outside the division E.g. if it is an Information Management/Information Technology (IM/IT) risk or an Estates risk, then the Risk Lead should be the IM/IT or Estates senior manager. The division and speciality where the risk is occurring are specified on Datix.

The **Approving Manager** is the senior person in the division who can take high level decisions about the risk and has the authority to approve/reject/change the risk score. The ASSURE tool is used, following training, to quality check the risk according to the Trust standard. All new risks must be checked by the Approving Manager and approved or rejected within 20 working days.

The **Risk Title** should help to identify the risk from a list of risks without giving you the full details of the risk.

The risk should then be **described.** This should always begin with "There is a risk that/risk of" to ensure the risk is clearly defined. In addition, it should include the underlying cause and the impact of the risk.

8.3 Existing controls

In the 'Existing Controls' field you should list the controls that are currently in place to mitigate the risk. These should not be things you are planning to do but those controls you have already put in place, e.g. bank staff covering a post, funds used to purchase new equipment, existing policies and strategies. It is important to separate what is in place i.e. existing controls from what is not yet in place i.e. planned actions in the Actions Section of Datix.

For the Adequacy of Controls select a value from the drop down list to indicate whether the control is:

Adequate – a risk is adequately controlled when all that can be done has been done to reduce the risk and the risk of the risk materialising or being realised is less likely.

Inadequate – a risk is inadequately controlled when the current controls introduced have not contributed to reducing the risk in any meaningful way and the risk is still a substantial one.

Uncontrolled – a risk is uncontrolled if the possibility of the risk being realised is present and highly likely.

If "inadequate" or "uncontrolled" is selected a further field must be completed with an explanation of why it is inadequate or uncontrolled.

Key dates - You must also enter the date the risk is added to the risk register, along with the next review date. The closed date must be completed when the risk is considered closed. This may be because the risk has now been fully controlled, E.g. new equipment has been purchased which means there is no longer a risk, or it may be that the risk has reached the target rating (see below) and is now considered to be as controlled as possible.

8.4 Risk rating

The risk register uses three risk matrices to record the risk rating. These are: ‘Initial’, ‘Current’ and ‘Target’.

Once the risk grading has been entered, stay in the record, as the next mandatory step is to identify at least one action to eliminate or mitigate the risk.

8.5 Assurance Framework

Once the Assurance Framework tab is opened for a new risk you will see the information that was entered the first time. Add and amend the controls and assurances as they progress, e.g. if you planned to put a process in place, you will have recorded this under ‘Gap in controls’. Once you have the process in place, you would move this action into the controls box. The same applies to assurances.

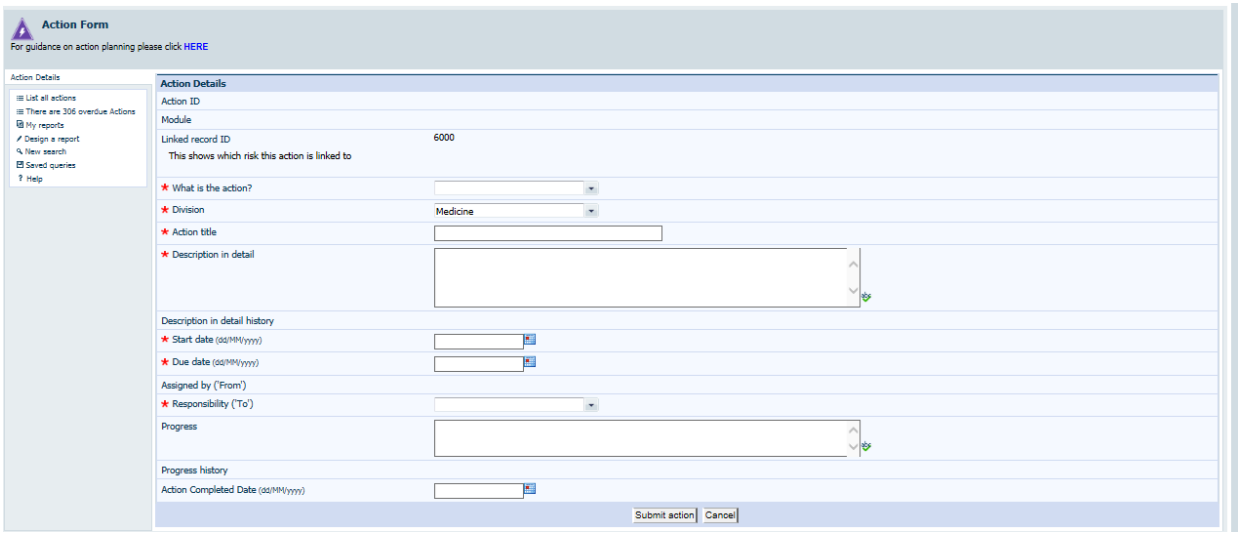
Ensure that the Review dates fields are updated in the Key Dates section of the Risk Details tab. This will help the Trust to monitor that all risks are being reviewed in line with the Risk Management Strategy and this procedure.

8.6 Actions

All risks must have at least one action. Record brief details of what further actions and controls will be put in place to manage/reduce/remove the risk. The Risk Lead must make it clear how the action relates to controlling the risk.

To create the new Action click the "Create a new action" link on the screen.

The 'Actions' section allows you to assign actions to specific individuals. These people should be a colleague or someone reporting to you with whom you have discussed the risk. Actions must be updated when the risk is reviewed.



You can submit as many actions as are required to control the risk.

8.7 Submit the risk

By clicking 'Save' at the bottom of the form you have completed the entry of a new risk. As you make changes to the information following reviews of the risk, keep the initial risk grading unchanged as this will serve as a record of what the risk was like when it was first entered.

The risk will then be stored in one of the areas, dependent on where this was coded to in the approval status. Action Owners receive an email notification when an action has been assigned to them. Risk Leads should ideally discuss the management of a risk with the Approving Manager and Action Owners, but if this is not possible, the Datix email system should be used to notify them the risk has been entered.

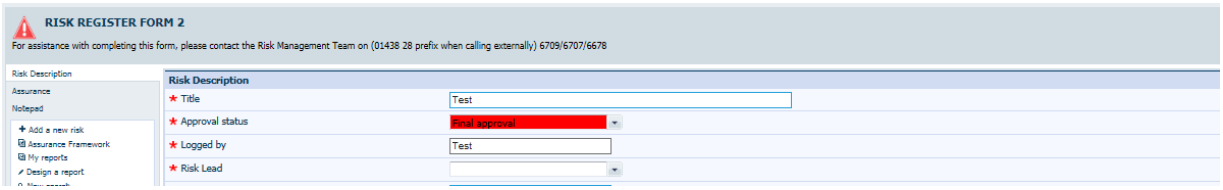
Once the risk has been saved it shows as a 'new risk'.

The Approving Manager is required to review the new risk and approve the content of the risk. Approval is given through changing the risk status from 'In holding area, awaiting review" to 'Final approval" or if more work is required or the record is not a risk the Approving Manager can reject the risk. All new risks must be checked **by the** Approving Manager **within 20 working days.**

8.8 Risk review and approval by Approving Manager

The Risk Lead has overall responsibility for ensuring that any outstanding work to a risk is conducted in a timely manner, including, if required, escalating the risk to the Divisional Board.

The Approving Manager should make any necessary amendments to the record and amend the status of the risk to reflect their decision, e.g. change the status to '**Final approval**' or 'Rejected Risk'



8.9 Trust standard for reviewing and updating risks

The Risk Lead is the person responsible for maintaining the record on the risk register and for managing or delegating actions, including on-going monitoring of the risk, ensuring controls and further actions are in place to mitigate the risk, and reporting on its overall status.

Use the tab Assurance framework in the left-hand drop-down menu for recording the progress in implementing controls and assurances.

Risk records are accessible to relevant managers at any time to enable regular review and updating, in conjunction with discussions at the relevant forum. This enables a continuous process of assessment of risks. The form incorporates a review date for risks to ensure that managers are reviewing and minimising risk.

As further actions are completed the current risk rating should be updated to reflect the current position and the additional controls added to the controls field. The action plan should also be amended. An audit trail is available to track a risk's history.

Datix risk records are essential pieces of evidence which may be required by the Trust in order to demonstrate to external regulators and commissioners that the Trust has robust systems in place for the management of risk and that these are operating effectively. The records may also need to be made available for the purpose of Internal Audit as part of the Trust's assurance framework.

In the 'Next review date' the date the risk should be reviewed should be recorded.

The Trust has set the following standard for reviewing risks:

- Below risk grade 15 - 3 monthly review
- 15 and above - monthly review

8.10 Escalating risks

The Risk Lead must complete the first two boxes of the Assessment for Escalation Section on Datix, giving more information about the impact of the risk and how it affects the department, patient safety, service delivery Etc and what is required to manage the risk. Guidance on escalating risks is on the Trust Knowledge Centre – "*Step by Step Guide to entering, escalating, updating a risk on Datix".*

Risks scoring 15 and above are escalated to the divisional board (clinical areas) or director (non-clinical areas) by the Risk Manager. The divisional board determines if the risk should be escalated further in the Trust or if it should be de-escalated, risk score reduced and managed within the division. The Risk Manager includes escalated risks in risk reports to the Divisional Executive Committee which decides if risks will be entered on the Corporate Risk Register and reported to the Quality and Safety Committee.

8.11 Closing the risk

A risk should be closed following a review by the Risk Lead and following full implementation of the risk actions which should bring the current risk score to the same level as the target risk score. Closed risks should be discussed at the divisional governance forum or divisional board. It is vital that the risk actions are embedded and effective or the risk could remain after closure.

To close the risk you should enter the date of closure to the “Date Closed” box and check the actions have all been implemented and the date of completion entered into each action.

Appendix 1 Guidance on Risk Grading and using the Guide to Consequences of Risk

The consequence score should be considered carefully. If it is chosen appropriately it will never change during the life of the risk. The actions that are put in place to minimise the risk should reduce the likelihood of it happening and therefore reduce the risk score.

5 x 5 Risk Scoring Matrix					
	Consequence / Impact				
Frequency / Likelihood	**1 None / Insignificant**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Death, Catastrophe**
5 Certain	Yellow: low 5	Orange: moderate 10	Red: high 15	Red: high 20	Red: high 25
4 Likely	Yellow: low 4	Orange: moderate 8	Orange: moderate 12	Red: high 16	Red: high 20
3 Possible	Green: very low 3	Yellow: low 6	Orange: moderate 9	Orange: moderate12	Red: high 15
2 Unlikely	Green very low 2	Yellow: low 4	Yellow: low 6	Orange: moderate 8	Orange: moderate 10
1 Rare	Green: very low 1	Green: very low 2	Green: very low 3	Yellow: low 4	Yellow: low 5

See Guide to consequence of risks chart below

Guide to consequence of risks

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/ minimal intervention or treatment No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for <3 days Increase in length of hospital stay by 1–7 days	Moderate injury requiring professional intervention Requiring time off work for 4–14 days Increase in length of hospital stay by 8–15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/ disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Additional examples	Incorrect medication dispensed but not taken Incident resulting in a bruise/graze Delay in routine transport for patient	Wrong drug or dosage administered, with no adverse effects Physical attack such as pushing, shoving or pinching, causing minor injury Self-harm resulting in minor injuries Grade 1 pressure ulcer Laceration, sprain, anxiety requiring occupational health counselling (no time off work required)	Wrong drug or dosage administered with potential adverse effects Physical attack causing moderate injury Self-harm requiring medical attention Grade 2/3 pressure ulcer Healthcare-acquired infection (HCAI) Incorrect or inadequate information /communication on transfer of care Vehicle carrying patient involved in a road traffic incident Slip/fall resulting in injury such as a sprain	Wrong drug or dosage administered with adverse effects Physical attack resulting in serious injury Grade 4 pressure ulcer Long-term HCAI Retained instruments/material after surgery requiring further intervention Haemolytic transfusion reaction Slip/fall resulting in injury such as dislocation/fracture / blow to the head Loss of a limb Post-traumatic stress disorder Failure to follow up and administer vaccine to baby born to a mother with hepatitis B	Unexpected death Suicide of a patient known to the service in the past 12 months Homicide committed by a mental health patient Large-scale cervical screening errors Removal of wrong body part leading to death or permanent incapacity Incident leading to paralysis Incident leading to long-term mental health problem Rape/serious sexual assault
Quality/ complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/ inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2)	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ review	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
		meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	complaint Local resolution (with potential to go to the Healthcare Commission) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	by the Healthcare Commission Low performance rating Critical report	ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than <£500,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £500,000-£1,000,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £1-5 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£5 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Appendix 2 The ASSURE tool

How to review a risk

Divisions, directorates, Approving Managers need to:

A **Accurate risk DESCRIPTION?**
Still relevant and structured with what could happen, cause and impact?
Quantified?

S **Systematic – ALL CONTROLS have been identified?**
All existing controls been identified in Datix "Current controls" section?
Actions section includes controls being put in place?

S **Satisfied controls are WORKING?**
Checks being made that controls are working?
Independent assurance, peer review etc better

U **UPDATE uncontrolled status and risk score**
-after controls in place

R **RISK appetite/tolerance**
Unsafe, unethical or non-compliant is unacceptable

RESPOND to staff who raised risk
Discuss at team meeting and send Datix email

REALISTIC actions?
Will planned actions bring current risk score to target risk score?

E **ESCALATE if risk score is =>15**
De-escalate when risk has reduced.
Close when current risk level = target score – or add new review date

EDUCATE – what learning is there from this risk?
Add to datix notepad and discuss with staff.

If you have any queries or require assistance – please contact Risk Management on 4378

Appendix 3: Chart A - Structure for risk reporting, accountability and escalation/de-escalation

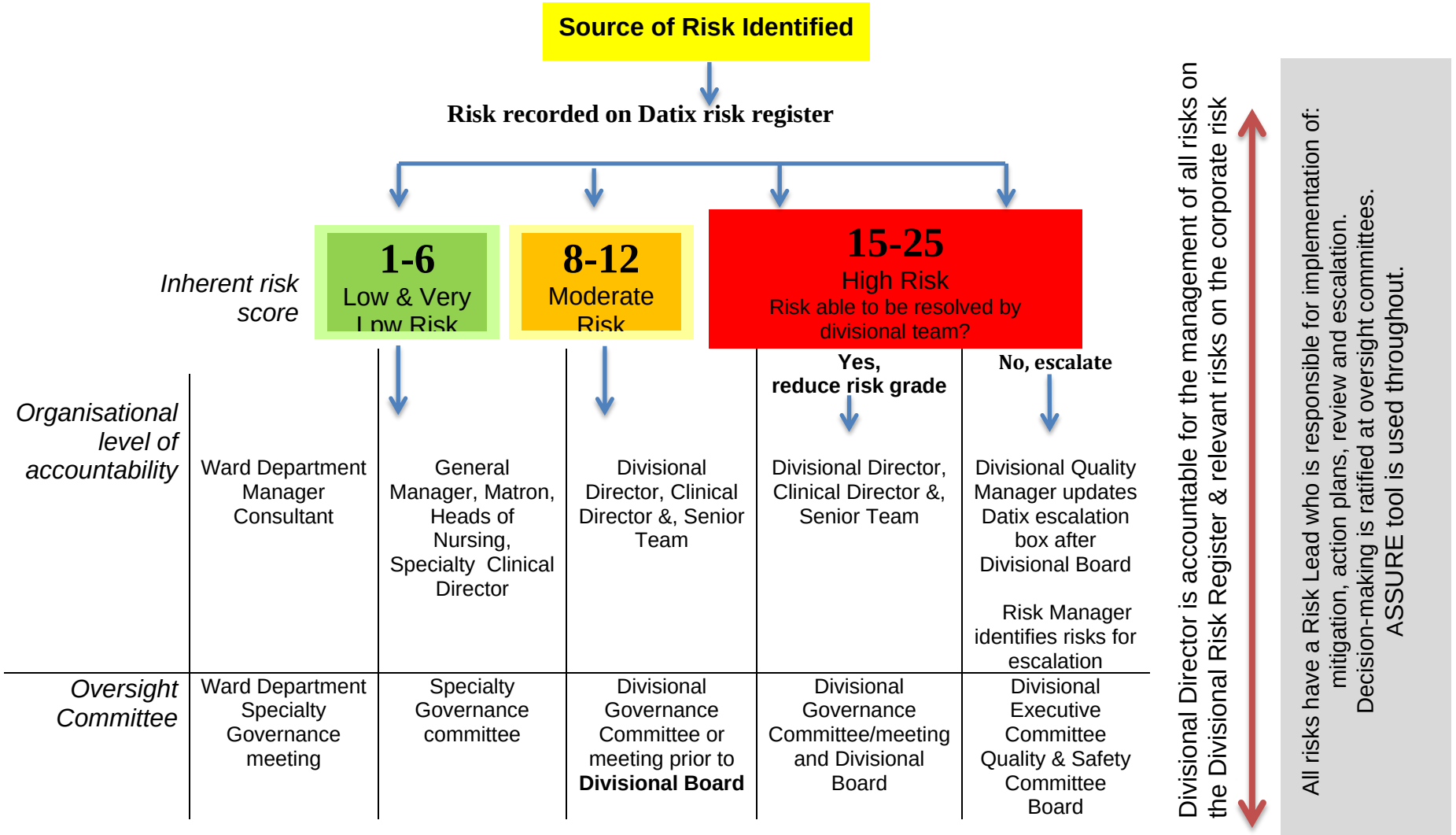
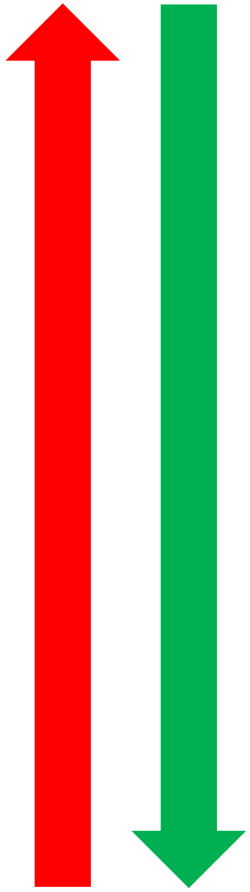


Chart B: Movement of risks

Escalation and De-escalation
What an effective system looks like

Escalation/ De-escalation



Board Assurance Framework
Risks to Trust's strategic priorities

Overall accountability:	**Trust Chair**
Accountable Officer:	**Associate Director of Corporate Governance**
Board Assurance:	**Audit Committee** **Quality and Safety & Finance and Performance Committees**

Corporate Risk Register

Overall accountability:	**Chief Executive**
Accountable Officer:	**Director of Strategy, Medical Director and Director of Nursing** **Associate Director of Corporate Governance** **Risk Manager**
Board Assurance:	**Divisional Executive Committee** **Performance Committees, Quality, Safety and Finance**

Divisional/Directorate Risk Registers

Overall accountability:	**Divisional Directors and Executive Directors of non-clinical directorates**
Accountable Officer:	**Risk level dependent – see Chart A**
Board Assurance:	**Divisional reporting to the Accountability Review Meetings / Executive Committee**

Annex A to Trust Risk Appetite Framework Policy

– TRUST RISK APPETITE STATEMENT (February and April 2019)

The Trust recognises that its long-term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, staff, the local community and strategic partners. The statements below describe the Trust board's risk appetite in relation to the primary risk groupings, risk appetites and levels as set by the Good Governance Institute (2012), ("*A matrix to support better risk sensitivity decision taking*") and other risk categories used by the Trust and reflected in its risk register and BAF.

This statement will guide the board of directors, clinical leaders and managers in their decision making and discussion and assessment of risk, in relation to the implementation of the Trust's strategic objectives, associated plans and other matters impacting on the well-being of patients and staff. This statement will be kept under regular review by the Trust board and relevant committees.

Further risk appetite statements will be made by the Trust board in relation to Trust strategic objectives and BAF themes.

For the Trust and each division, some standardised narratives/examples will be developed. These narratives/examples will aim explain the Trust risk appetite for different types of risk, and indicate how it should be interpreted in practice. Divisions also will review their Strategic Clinical Priorities' Objectives and Key Actions from the Trust Clinical Strategy, producing narratives/examples when necessary to provide guidance on how the Trust risk appetite should be interpreted in practice for these. Any divisional text must reflect the Trust risk appetite and be integrated with it, and be approved by the board.

When applying the risk appetite, the board, managers and clinical leaders must take into account the aggregated and interlinked level of risk for the organisation and/or their area, to determine whether the overall risk exposure is acceptable or not. In addition, the effect of a new potential risk on the overall risk exposure must be evaluated when applying the risk appetite to important decisions, situations and events.

A key aspect of the Trust's risk management maturity is having and following legal or regulatory requirements, regulations, national guidelines, professional Codes of Conduct, Trust policies, procedures, systems and processes, approved guidelines and similar approved documents. This Trust risk appetite statement requires compliance with these by all staff.

Risk area	
1	**Quality/outcomes** - risk appetite **low,** risk level **minimal**. (Including patient safety, care quality, staff safety, clinical risks, infection prevention and control (IPC), clinical and organisational innovation, patient experience, access, equality issues)
2	**Compliance/regulatory -** risk appetite **low,** risk level **minimal**. (Including legal requirements, regulatory/inspection requirements, professional standards, Codes of Conduct, ethical standards, system/process/policy compliance,

	service continuity)
3	**Innovation -** risk appetite **high,** risk level **open**
4	**Reputation** - risk appetite **moderate,** risk level **cautious** (inclining to risk appetite of **high**, risk level **open**) (including communications)
5	**Financial/value for money** - risk appetite **low,** risk level **minimal** (including insurability, contracts, SLAs, business continuity)
6	**Commercial** - risk appetite **high,** risk level **open**
7	**Major change programmes and projects** - risk appetite **high,** risk level **open** (inclining to risk appetite **moderate**, risk level **cautious**) (including effects of Brexit)
8	**Staffing** - risk appetite **moderate,** risk level **cautious**
9	**Equipment and Supplies** – risk appetite **moderate,** risk level **cautious** (including procurement and new product/services)
10	**Estates/Facilities** – risk appetite **moderate,** risk level **cautious** (Including Health and Safety, Fire, Occupational Health, Security)
11	**IT/IM** - Risk appetite **moderate,** risk level **cautious** (inclining to risk appetite **low**, risk level **minimal**)
Trust strategic priority	
1	**Quality -** "Deliver **high quality care** consistently across all of our services in terms of clinical quality, safety and compassion" - risk appetite **low,** risk level **minimal**.
2	**Ease of use** - "Redesign and invest in our **systems and processes** to ensure that they provide a consistently simple and quick **experience for our patients**, their referrers, and our staff, minimising frustration and maximising efficiency" - risk appetite **high,** risk level **open** (inclining to risk appetite **moderate**, risk level **cautious**)
3	**Pathways -** "Pursue actively the development of **pathways** across care boundaries, where this is in the best interests of patients and adds value" - risk appetite **high,** risk level **open** (inclining to risk appetite **moderate**, risk level **cautious**)
4	**People -** "Create an environment which retains **staff,** recruits the best and develops an engaged, flexible and skilled workforce able to meet the needs of our patients" - risk appetite **moderate,** risk level **cautious**
5	**Sustainability** - "Develop a **portfolio of services** that are financially and clinically **sustainable** in the long-term" - risk appetite **high,** risk level **open** (inclining to risk appetite **moderate**, risk level **cautious**)

SUMMARY - OVERALL TRUST RISK APPETITE

Reflecting a thorough evaluation of its development of risk management, covering risk capability, risk capacity and risk management maturity, the Trust has established its risk appetite for the areas and strategic priorities below.

Risk areas

The Trust has a **low** risk appetite, keeping the risk level **minimal,** for risks in the following areas:

- Quality/outcomes
- Compliance/regulatory
- Financial/value for money

The Trust has a **moderate** risk appetite, with a **cautious** risk level, for risks in the following areas:

- Reputation (inclining risk appetite **high**, risk level **open)**
- Staffing
- Equipment and Supplies
- Estates/Facilities
- IM/IT (inclining to risk appetite **low**, risk level **minimal**)

The Trust has a **high** risk appetite, accepting an **open** risk level, for risks in the following areas:

- Innovation
- Commercial
- Major change programmes and projects (inclining to **moderate**, risk level **cautious**)

Strategic priorities

The Trust has a **low** risk appetite, keeping the risk level **minimal,** for risks in the following strategic priority area:

- **Quality -** "Deliver **high quality care** consistently across all of our services in terms of clinical quality, safety and compassion."

The Trust has a **moderate** risk appetite, keeping the risk level **cautious,** for risks in the following strategic priority area:

- **People -** "Create an environment which retains **staff,** recruits the best and develops an engaged, flexible and skilled workforce able to meet the needs of our patients."

The Trust has a **high** risk appetite, accepting an **open** risk level (inclining to **moderate**, risk level **cautious**), for risks in the following strategic priority areas:

- **Ease of use** - “Redesign and invest in our **systems and processes** to ensure that they provide a consistently simple and quick **experience for our patients**, their referrers, and our staff, minimising frustration and maximising efficiency.”

- **Pathways -** “Pursue actively the development of **pathways** across care boundaries, where this is in the best interests of patients and adds value.”

- **Sustainability** - “Develop a **portfolio of services** that are financially and clinically **sustainable** in the long-term.”

RISK AREAS – RISK APPETITE (detailed description)

1. **QUALITY/OUTCOMES** - risk appetite **low,** risk level **minimal**.

(Including patient safety, care quality, staff safety, clinical risks, infection prevention and control (IPC), clinical and organisational innovation, patient experience, access, equality issues)

This text incorporates Trust Clinical Strategy 2019-2024 **Strategic Priority 1:**
Quality - *"Deliver **high quality care** consistently across all of our services in terms of clinical quality, safety and compassion."*

General statement

The Trust risk appetite is low and the board will take minimal risks related to patient and staff safety, patient experience or clinical outcomes, but without stifling organisational or clinical innovation. Its tolerance for risk taking will be limited to decisions where the potential for adverse consequent effects on patient and staff safety, experience or clinical outcomes are low and the potential for mitigating actions is strong, supported by robust governance systems and practice. The Trust seeks to avoid risks that adversely affect clinical outcomes, patient safety, patient experience, access to services and equality of access and opportunity. The Trust has no appetite for non-compliance with infection prevention and control standards and such risk should be avoided. The Trust has no appetite for non-compliance with regulatory requirements concerning systems, processes and departmental or individual action or inaction concerning serious risk identification, mitigation and organisational learning. Such risk should be avoided. This includes risks related to negative patient experience, complaints, claims, serious incidents and near misses. The Trust has a low risk appetite, with a minimal risk level, concerning serious risks in the areas of administration, communication systems, appointments, discharge summaries, waiting times and delays in procedures and outpatient appointments. Staff should mitigate such serious risks short-term, escalate urgently and promote improvements in systems and processes, with organisational learning.

Trust details/examples/narratives – as needed

Due to current financial pressures, target pressures and due to finite resources, all staff need to aim for efficient and cost-efficient managerial and clinical decision-making. Operationally, however, the Trust has a low, minimal risk appetite for decisions or innovations which introduce significant threats to individuals, or groups of patients or staff in terms of patient and staff safety, experience or clinical outcomes. Urgent mitigation action is required of staff at operational levels under these circumstances, as well as urgent escalation. The same is true for risks of serious breaches of medical or general ethics.

A higher propensity to take risk is more acceptable when there are clear clinical benefits possible. Even at the strategic level, however, little significant unmitigated risk-taking in these areas should be considered, with any innovations or initiatives requiring thorough risk/reward analysis and a cautious approach before being introduced. Innovations and initiatives of this kind require careful evaluation, and piloting before any more extensive rollout. If staff fear that application of this risk appetite statement generates risks of stifling a good opportunity for organisational or clinical innovation, however, this concern must be escalated.

The Trust risk appetite is higher for risks with low financial implications, or risks where low-cost innovations lead to improvements in care or efficiency.

When circumstances introduce fast clockspeed risks, "*where… unplanned or unexpected events…require a rapid response, or a response that is faster than internal processes are designed to manage…",* (IRM, 2011), all staff need to take decisions, at the pace that circumstances require, to mitigate risks of harm to individuals or groups of patients or staff. When circumstances appear to present opportunities for improvement, requiring unexpected urgent action, a more cautious attitude is needed, with much greater evaluation of risk versus reward, and a need to escalate.

The Trust has no appetite for non-compliance with fundamental infection prevention and control standards and such risks should be avoided. Fast clockspeed serious infection prevention and control risks, demanding a faster response due to risks to patient safety, require urgent action from all staff, as well as rapid escalation and application of Trust policies and procedures.

Risks can arise from inaction or missed opportunities concerning mitigation actions or ensuring Trust-wide organisational learning arising from negative patient experience, complaints, claims, serious incidents and near misses. All staff should act at once to prevent imminent risks of harm to others, and always escalate in such circumstances. Over time, trends and themes should be identified, mitigation undertaken and learning promoted. The Trust has no appetite for non-compliance with regulatory requirements concerning systems, processes and departmental or individual action or inaction concerning serious risk identification, mitigation and organisational learning. Such risk should be avoided.

The Trust has identified the strategic need to improve administration, communication systems, appointments, discharge summaries, waiting times and delays in procedures and outpatient appointments. The Trust has a low risk appetite concerning serious risks in these areas, which should be kept at a minimal risk level. When systems, processes, IT etc generate risks of harm to patients or significant poor service quality, staff should take personal responsibility to seek solutions that mitigate risks short-term, escalate urgently and promote improvements in systems and processes, with organisational learning.

2. **COMPLIANCE/REGULATORY -** risk appetite **low,** risk level **minimal**.

(Including legal requirements, regulatory/inspection requirements, professional standards, Codes of Conduct, ethical standards, system/process/policy compliance, service continuity)

General statement

The board has a low risk appetite, as a minimal level, related to compliance and regulatory issues, including health and safety. It will make every effort to meet regulator expectations and comply with laws, regulations and standards that regulators have set, unless there is strong evidence or argument to challenge them. The board is willing to take risk assessed opportunities where positive gains can be anticipated and are within the regulatory environment, ethical and professional standards. The Trust risk appetite to significant risks of damage to service continuity is low, and exposure to these risks should be at a minimal level.

Trust details/examples/narratives

At strategic, tactical and operational or project levels, the Trust has no risk appetite for decisions or actions
which are against law. These should be avoided by all staff, and all staff should escalate identified risks in these areas, reporting breaches of the law in line with their statutory and professional responsibilities. For risks involving threats to regulatory requirements, published professional standards and Codes of Conduct, Trust risk appetite is low, and risk level should be minimal. Even when staff mitigate such risks, escalation should be considered, to promote risk awareness and learning.

The Trust risk appetite to significant risks of damage to service continuity is low, and exposure to these risks should be at a minimal level. The board mitigates such risks through the Trust emergency planning and service continuity framework, plans, exercises and other preparations. At more tactical and operational levels, it is critical to escalate serious service continuity risks in advance of any adverse events occurring, and to mitigate them through control measures.

In terms of propensity to take risk, good opportunities for organisational or clinical innovation, which raise some less significant compliance and regulatory questions or concerns in these areas, should not be discounted automatically. This is even more the case when risks concern compliance with internal systems, processes or policies. Rather, if the balance of risk versus reward indicates that this would be worthwhile, such opportunities should be fully evaluated and escalated, usually to a strategic level, in case the risks they pose can be mitigated or eliminated. Very rarely, it may be acceptable for an internal system, process or policy to be reviewed, but the Trust has no appetite for risks caused by Trust systems, processes or policies being ignored or bypassed. The same is true for risks of serious breaches of medical or general ethics.

Guidance so far applies to slow clockspeed risks, "*Managed over a lengthy period of maturation…managed most effectively through traditional control mechanisms*." For fast clockspeed risks, similar risk appetites apply, with guidance to all staff to act at once to prevent, report, escalate and mitigate breaches of the law, and serious breaches of care standards.

3. **INNOVATION -** risk appetite **high,** risk level **open**

General statement

The board will actively seek opportunities for organisational innovation, strategic transformation and developing effective external relationships and alliances, depending on the nature of the innovation being proposed. It will seek innovation that supports quality, patient safety, patient experience and operational effectiveness, as well as innovations that represent best practice in the management of staff and their well-being. This means that it will support the adoption of innovative solutions that have been tried and tested elsewhere, which challenge current working practices and involve systems/technology developments as enablers of operational delivery. Other significant innovations will be limited to only essential developments and significant improvement opportunities, with decision-making held as at strategic level by senior management, but strong encouragement to staff at all levels to contribute and escalate ideas for innovation, and to innovate within guidelines for particular projects given by senior management.

Trust details/examples/narratives – as needed

Financial pressures require all staff to seek to identify and support innovations that promote efficiency and cost-efficiency. The Trust has a high risk appetite and open level for such innovations, but this is reduced, and can become low or minimal, if innovations present significant risks to care quality and standards, patient safety or good practice in the management of people. The impact of possible risks of organisational innovations upon day-to-day services will always be required as part of evaluation of any significant change proposal or programme, evaluating change capacity and resilience. The Trust will have a minimal or cautious appetite for risks of significant degradation of day-to-day services that could arise from significant organisational innovations. The same is true for risks of serious breaches of medical or general ethics arising from potential innovations. Escalation as required under these circumstances.

All significant innovations will require appropriate use of the full range of analytical tools to assess, control and manage risk and costs, E.g. a business case, user requirements analysis, risk assessment, equalities assessment, value for money assessment, piloting, testing, project management, parallel running, monitoring, review etc.

The Trust risk appetite is higher for risks with low financial implications, or risks where low-cost innovations lead to improvements in care or efficiency.

The Trust will have a moderate risk appetite, keeping risks at a cautious level, or a low risk appetite, keeping risks at a minimal level, for risks arising from innovations that, when aggregated and linked with other existing risks, lead the Trust exceed a prudent and manageable overall risk exposure level. All significant innovation risks, therefore, should be escalated, in order to ensure risk awareness of the board.

The board will take a long-term and ethical view to innovation risk, ensuring that short-term considerations do not outweigh the long-term financial soundness of the Trust, and its values as a good employer, its reputation, its ethical framework, access and continuity of services, or its ability to deliver safe, high quality services.

Temporary organisational innovations required to deal with risks caused by a genuine temporary crisis in service delivery may be necessary. The Trust has a high appetite and

open risk level concerning this type of fast clockspeed risk, provided risks and proposed solutions are escalated rapidly from operational levels to tactical or strategic levels, and provided they receive senior management approval very quickly.

4. **REPUTATION** - risk appetite **moderate,** risk level **cautious** (inclining to **open**) including communications

General statement

The board has a moderate risk appetite and a cautious approach, inclining to open, to risks that will affect the Trust's reputation and communications, whilst being fully committed to principles of openness and transparency. Decisions with the potential to expose the Trust to additional scrutiny of its reputation will be considered carefully and progressed only with strong mitigations and careful management of any potential repercussions. The Trust will incline towards having a high risk appetite, and an open risk level, when necessary, particularly regarding significant changes to services or organisational changes that are important or vital for the Trust to maintain or improve its services, care standards and long-term viability. This approach will be taken only after full evaluation and mitigation planning, and normally would be combined with appropriate stakeholder consultation. This risk appetite position, however, must not supersede statutory reporting obligations of staff, and must not prevent openness and transparency, even of bad news. The Trust has no risk appetite for any kind of cover-up or distortion of data or clinical outcomes, and this is to be avoided at all levels. All staff, however, have an obligation to prevent and mitigate risks of damage to the Trust's reputation, and this involves sharing and escalating concerns or bad news internally, giving the Trust an opportunity to investigate, and to mitigate reputation risks, always within the bounds of truthfulness.

Trust details/examples/narratives – as needed

Staff at all levels must aim to identify, mitigate and escalate reputational risks arising from decisions, for example about services. Decisions which would expose the Trust to serious public criticism, or which could harm its reputation within the local health economy, require a low risk appetite and minimal risk level. This does not mean that a sensible decision which might be unpopular should be discounted, but rather that such decisions should be evaluated for risk and reward, escalated and only taken when mitigation action, such as a communication strategy, has brought residual risk to acceptable levels. Decisions to accept risks of this kind must be at a strategic level, and usually involve more than one individual and consultation with the Chief Executive and/or Chairman. Since a decision affecting only a single patient or member of staff can be taken operationally, yet generate serious reputational risks for the whole Trust, all staff must aim to identify such risks and escalate before potentially contentious decisions are made. An example might be a decision to deny or discontinue treatment, when this could become a matter of public interest.

There are some occasions when the Trust risk appetite will incline towards being high, with an open risk level, for example concerning significant organisational changes or changes to services that are critically important for the Trust's care standards, improvements or long-term viability. This higher risk appetite would only be acceptable provided that consequences, risks and rewards receive full evaluation and mitigation planning. Appropriate stakeholder consultation normally would be part of this process. The Trust has found it necessary to take this approach previously. It anticipates needing to do so again in the future.

Reputational risks arising from bad news, service breakdown, failure to meet legal, professional or ethical standards, and similar causes, must be escalated rapidly, and dealt with at a senior strategic level.
Slow clockspeed serious reputational risks should be subject to risk versus reward evaluation, and normally include piloting different decision outcomes with representative stakeholders. Fast clockspeed, unexpected or unplanned reputational risks should be escalated as soon as possible. Operational staff should avoid communication or expressing a view, whilst providing reassurance that the issue will be escalated, and dealt with promptly and truthfully.

5. **FINANCIAL/VALUE FOR MONEY** - risk appetite **low,** risk level **minimal** (including insurability, contracts, SLAs, business continuity)

General statement

Trust risk capacity to carry significant financial risks is low, and its risk appetite must, therefore, be low also, keeping financial risks to a minimal level. This does not mean the Trust will not take decisions to spend money. The board will adopt a minimal risk approach to financial risks but it is prepared to invest in resources that deliver improvements in quality and patient safety.

Decisions to take financial risks, including overspending budgets, must be made within Trust financial guidelines. Significant financial and value for money risks must be escalated to strategic levels. Normally, the Trust appetite for significant financial risk arising from decisions of operational staff is low or none, ensuring that the Trust meets its financial obligations and remains viable.

Risks arising from value for money initiatives and innovations are inevitable, as the Trust seeks to maintain services in a period of funding constraints and increasing demand. However, financial or value for money decisions that may impact seriously on quality and patient safety will be subject to rigorous quality impact, compliance, ethical and equalities assessments, as well as careful evaluations of risk versus reward.

Trust details/examples/narratives – as needed

The Trust also has a more open approach to financial and value for money risks arising from decisions and innovations other than those related to quality, patient safety and improving the patient experience. The risk appetite reduces when the Trust has weaker or inadequate arrangements for ensuring business or service continuity through insurability, contracts or service level agreements (SLAs), or inadequate financial capability for replacement of older equipment, approaching the end of its useful life, that is critical to service provision. The board will take a long-term and ethical view to financial risk, ensuring that short-term considerations do not outweigh the long-term financial soundness of the Trust, its reputation, access and continuity of services or its ability to deliver safe, high quality services.

The Trust will have a low risk appetite, keeping risks at a minimal level, for risks arising from financial or value for money decisions that, when aggregated and linked with other existing risks, lead the Trust exceed a prudent and manageable overall risk exposure level. All significant financial or value for money risks, therefore, should be escalated, in order to ensure risk awareness of the board.

These requirements apply to slow clockspeed financial and value for money risks. Fast clockspeed risks require urgent escalation. In general, when faced with an urgent care decision requiring immediate action without senior guidance, staff at all levels need to balance financial risks against risks of harm to patients. In such cases, the Trust has no risk appetite for risks of serious breaches of patient safety or acceptable care standards.

6. **COMMERCIAL** - risk appetite **high,** risk level **open**

General statement

The board has a high risk appetite and an open approach to commercial risk, aligned with its approach to innovation. Following thorough evaluation of risk versus reward, it will support risk opportunities in business areas and markets where the potential to have significant commercial strength over its competitors is identified, and/or when it wishes to secure continuity to the benefits and outcomes for the Trust's patients and the wider community in which it operates.

On the other hand, the low risk appetite taken by the board to financial risks also applies to potential commercial activity, especially where uncertainty about financial rewards exists or where commercial failure or underperformance could cause financial damage to the Trust.

Authority for accepting commercial risk should be at the strategic level, with decisions being taken by very senior management, or the board. The board must always be made aware of significant commercial risks.

Trust details/examples/narratives – as needed

The Trust encourages identification by all levels of staff of identification of commercial opportunities and ideas for commercial innovation, and escalation of these suggestions. Authority to establish commercial initiatives normally will be strategic, with senior management evaluating the effect of risks versus reward and the effect of risks arising upon the aggregated and integrated Trust risk exposure profile.

Careful evaluation of risks arising from establishing any retailing operations on Trust premises will be required, including ensuring that risks of any arguable inconsistency between stock or food for sale and NHS values and purposes are identified and mitigated, or consciously accepted.

The board will take a long-term and ethical view to commercial risk, ensuring that short-term considerations do not outweigh the long-term financial soundness of the Trust, its reputation, its ethical framework, access and continuity of services or its ability to deliver safe, high quality services.

There are few circumstances in the NHS where fast clockspeed commercial risks may be generated, with the need for NHS commercial activity to be handled through established risk evaluation processes. If such risks do arise, they should be escalated rapidly and operational staff should avoid communication about them, whilst taking any necessary steps to ensure the safety of patients and the public.

7. **MAJOR CHANGE PROGRAMMES/PROJECTS – STAFFING RISK APPETITE STATEMENTS**

Major change programmes and projects - risk appetite **high**, risk level **open**
(inclining to risk appetite **moderate,** risk level **cautious)**
(including effects of Brexit)

General statement

Generally, the Trust has a high risk appetite, with an open risk level towards major change programmes and projects, yet inclining towards a moderate risk appetite and taking a cautious view to what is an acceptable risk level when appropriate. The Trust encourages staff at all levels to identify, suggest and escalate ideas for major change programmes and projects that will benefit the Trust's patients, the public, staff and other stakeholders, or improve efficiency and value for money. Authority to establish major change programmes and projects should be strategic. The Trust risk appetite is higher for risks with low financial implications, or risks where low-cost change programmes and projects lead to improvements in care or efficiency. Significant Trust changes resulting from Brexit should use the methodology and rigorous risk management of major change programmes and projects, applying the Trust risk appetite statement concerning these, as well as other risk areas, as needed. Significant Brexit related risks should be featured in the BAF.

Trust details/examples/narratives – as needed

It is essential for the Trust to be able actively to promote service improvements, efficiencies and organisational change through major change programmes and projects, generally with a high risk appetite and open risk level, yet inclining towards a more moderate risk appetite and cautious risk level when appropriate. The board will need to authorise major change programmes and the degree of risk that is acceptable for them. This must be based upon rigorous evaluation of consequences, risk and reward, along with the impact on the aggregated and interlinked overall risk exposure of the Trust.

The board will need to be aware of any divisional proposals for major change programmes or projects, and have the opportunity to assess their impact upon overall Trust risk exposure. Normally, the board will need to authorise major change programmes or projects, following a thorough evaluation of risk versus reward. Before authorisation can be given, the board will need to be satisfied that the change programme or project has the necessary resources, skills and project management infrastructure to be successful and to mitigate any identified risks. Another requirement will be satisfaction that the quality of risk management, and risk management reporting, within a change programme or project is sufficient.

Trust risk appetite is reduced, and can become low or minimal, if major change programmes and projects present significant risks to care quality and standards, patient safety or good practice in the management of people. The impact of possible risks upon day-to-day services will always be required as part of evaluation of any significant change proposal or programme, evaluating change capacity and resilience. The Trust will have a minimal or cautious appetite for risks of significant degradation of day-to-day services that could arise from major change programmes or projects. The same is true for risks of serious breaches

of medical or general ethics arising from them. Escalation is required under these circumstances.

All major change programmes and projects will require appropriate use of the full range of analytical tools to assess, control and manage risk and costs, E.g. a business case, user requirements analysis, risk assessment, equalities assessment, value for money assessment, piloting, testing, project management, parallel running, monitoring, review etc.

The Trust will have a low risk appetite, keeping risks at a minimal level, for risks arising from major change programmes and projects that, when aggregated and linked with other existing risks, lead the Trust exceed a prudent and manageable overall risk exposure level. All significant change programme and project risks, therefore, should be escalated, in order to ensure risk awareness of the board.

The board will take a long-term and ethical view to major change programme and project risk, ensuring that short-term considerations do not outweigh the long-term financial soundness of the Trust, and its values as a good employer, its reputation, its ethical framework, access and continuity of services, or its ability to deliver safe, high quality services.

Given the significant and wide-ranging effects of Brexit, possibly affecting most risk areas and strategic priorities, significant Trust changes resulting from Brexit should be planned and executed with the disciplines, techniques and monitoring of major change programmes and projects. This should include thorough risk versus reward assessment and rigorous risk management. It should include directorates and divisions leading on planned changes and coordinating with other parts of the Trust, applying the Trust risk appetite statement concerning major change programmes and projects, as well as other risk areas, as needed.

8. **STAFFING** - risk appetite **moderate,** risk level **cautious**

This text incorporates Trust Clinical Strategy 2019-2024 **Strategic Priority 4:**

- **People -** "Create an environment which retains **staff,** recruits the best and develops an engaged, flexible and skilled workforce able to meet the needs of our patients."

General statement

For staffing risks generally, the Trust risk appetite is moderate and the risk level is cautious, whilst encouraging innovation and positive organisation change. The Trust risk appetite is higher for staffing risks with low financial implications, or risks where low-cost changes lead to improvements in care or efficiency. The Trust risk appetite reduces to none for any risks to patient safety, or risks of serious breach of contractual, legal and equalities obligations. Such risks should be avoided. The Trust risk appetite is low for any staffing risks which make likely outcomes which could be perceived as inconsistent with being a good, ethical employer or significantly damage the Trust's strategic priority to "…*create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce able to meet the needs of our patients".* The Trust has a very low risk appetite for any risks concerning competency of care delivery staff, including for particular procedures or for temporary inappropriate redeployment from one specialty to another to cope with workforce shortages.

If patient safety risks are related to staff competency risks, the risk appetite reduces to none, and such risks should be avoided completely. The risk level for these kinds of risks should be minimal. The Trust has a low risk appetite for risks related to retention of key staff or staff groups with critical skills that are difficult to replace. Such risks should be escalated urgently and, when practicable, kept to a minimum and mitigated as far as possible.

The Trust has a high risk appetite and open risk level for any possible risks associated with initiatives to broaden the diversity of the Trust workforce, including regarding the active employment of older staff, particularly to meet specialty shortages and other workforce shortages, or to close skills gaps. The Trust has a high risk appetite and open risk level for risks associated with active recruitment of staff from abroad, always within the framework of appropriate Trust policies, legal and safeguarding requirements and employment best practice. Decisions to employ high numbers of staff from particular countries should be approved by the board, following thorough risk versus reward evaluation.

Trust details/examples/narratives – as needed

Financial pressures, targets, rising demand for services and the need continuously to improve productivity and the quality of services and skills, all require all staff to seek to identify staffing innovations, or to participate in staffing-related change programmes. To reduce costs and improve care quality, there is a need to redesign and transform services, to address workforce shortages and improve productivity. Risks associated with staffing innovation, organisational change and major staffing-related change programmes or projects can arise. The Trust has a high propensity to engage with these risks and to mitigate them, if the balance of risk versus reward indicates high probability of positive outcomes.

For staffing risks associated with change, the Trust risk appetite is moderate and the risk level is cautious. This is reduced, and can become low or minimal, if staffing innovations and change present significant risks to care quality and standards, patient safety, Trust finances or good practice in the management of people. The impact of possible risks of staffing innovations and change programmes upon day-to-day services will always be required as part of evaluation of any significant change proposal or programme, evaluating change capacity and resilience. The Trust will have a minimal or cautious appetite for risks of significant degradation of day-to-day services that could arise from significant staffing innovations. The same is true for risks of serious breaches of good employment practice, medical or general ethics arising from potential innovations. Escalation as required under these circumstances.

The board will take a long-term and ethical view to staffing innovation and change risk, ensuring that short-term considerations do not outweigh the long-term financial soundness of the Trust, and its values as a good employer, its reputation, its ethical framework, access and continuity of services, or its ability to deliver safe, high quality services.

The board will need to be aware of any divisional proposals for major staffing innovations or change programmes or projects, and have the opportunity to assess their impact upon overall Trust risk exposure.
The Trust will have a low risk appetite, keeping risks at a minimal level, for risks arising from major staffing innovations or change programmes and projects that, when aggregated and linked with other existing risks, lead the Trust exceed a prudent and manageable overall risk exposure level. All significant staffing innovation or change programme and project risks, therefore, should be escalated, in order to ensure risk awareness of the board.

Normally, the board will need to authorise major staffing innovations or change programmes or projects, following a thorough evaluation of risk versus reward. Before authorisation can be given, the board will need to be satisfied that the change programme or project has the necessary resources, skills and project management infrastructure to be successful and to mitigate any identified risks. Another requirement will be satisfaction that the quality of risk management, and risk management reporting, within a change programme or project is sufficient. All major change programmes and projects will require appropriate use of the full range of analytical tools to assess, control and manage risk and costs.

The risk level concerning competency of care delivery staff should be minimal, and the Trust risk appetite for risks of this kind is low. The risk appetite reduces to none if patient safety is placed at risk. Such risks should be avoided. Circumstances might include risks concerning particular procedures or temporary inappropriate redeployment of staff from one specialty to another to cope with workforce shortages.

The Trust has a low risk appetite for risks related to retention of key staff or staff groups with critical skills that are difficult to replace. Such risks should be escalated urgently and, when practicable, kept to a minimum and mitigated as far as possible. When retention is not possible, escalation, risk assessment of consequences and urgent mitigation actions are essential as early as possible. This should aim to avoid any risks of patient harm or significant degradation of service quality, and to reduce risks of harm to service continuity.

In order to meet specialty shortages and other workforce shortages, or to close skills gaps, the Trust has a high risk appetite and open risk level for risks associated with broadening the

diversity of the Trust workforce. This must always be done within the boundaries of Trust policies and safeguarding practice.

The Trust's high risk appetite for risks associated with active recruitment of staff from abroad, particularly to close specialty gaps and significant workforce gaps, requires that any associated risks be thoroughly assessed and mitigated, within the boundaries of Trust policies and safeguarding practice, and legal requirements. Decisions to employ high numbers of staff from particular countries should be approved by the board, following thorough risk versus reward evaluation.

At operational levels, low clockspeed risks should always be dealt with through appropriate Trust policies and risk management systems and processes, with escalation of any risks with implications beyond operational managers' remit.

Within Trust policies and budgetary limits, fast clockspeed staffing risks related to safe staffing capacity may be dealt with at operational levels at the pace necessary and through the methods necessary to prevent serious risks of harm to patient safety. This kind of situation should be rare, and should always be escalated immediately, seeking authority to continue. If, on very rare occasions, it is necessary to consider exceeding budgetary limits to mitigate serious risks to patient safety without being able to seek authority, then these risks should be mitigated.

Fast clockspeed risks of serious harm to staff welfare and well-being require a rapid response at operational levels, even without being able to seek authority, so that the right thing is done by the member of staff and the member of staff is not harmed. Urgent escalation is required.

Retention of staff has become increasingly challenging. Staff turnover is rising, although currently the Trust recruits more people than it loses. In September 18, vacant posts were at 9.7% for nursing and midwifery and 6.5% for medical staff. The Trust cannot cover 8% of vacant shifts.

9. **EQUIPMENT AND SUPPLIES** - risk appetite **moderate,** risk level **cautious** (including procurement and new product/services)

General statement

Overall, the Trust has a moderate risk appetite, with a cautious risk level, for equipment and supplies risks. This is the case for risks arising from changing suppliers or service providers. Risk appetite reduces to low, with a minimal risk level, for any significant equipment and supplies risks and supply problems concerning patient or staff safety, care quality, service continuity and financial stability. The Trust has no risk appetite for significant non-compliance risks related to equipment and supplies. The Trust appetite for risks associated with continuing to use older equipment is moderate, with a cautious risk level, in order to maintain services. For risks of this kind that are not being rigorously managed and mitigated, and for significant risks to patient or staff safety, risk appetite reduces to none. Such risks should be avoided. The same is true for serious risks related to insufficient implementation of Alerts, and the Trust Alerts Framework.

Trust details/examples/narratives – as needed

For major procurement of equipment and supplies, as well as following national and Trust procedures and standards, an assessment of risk versus reward will be required, applying the Trust risk appetite statement.

Financial constraints require staff at all levels to seek cost reductions. The Trust has a moderate risk appetite, with a cautious risk level, for risks arising from changing suppliers or service providers in order to reduce costs or improve care standards. This risk appetite assumes that a full assessment of risk versus reward will be done, comparing alternative suppliers or service providers and identifying risks associated with any proposed change. The Trust risk appetite reduces to low, with a minimal risk level for significant equipment and supplies risks to patient or staff safety, care quality and service continuity, as well as to long-term financial stability and maintenance of day to day services.

Whenever possible, potential risks of supply failure or shortage for current and future equipment and supplies need to assessed and, if possible, alternative sources of supply identified and arranged in advance. The Trust has a low appetite for risks related to supply problems or failures affecting patient safety and quality of care. These risks should be kept at a minimum level.

A key aspect of the Trust's risk appetite regarding equipment and supplies is having and following legal or regulatory requirements, regulations, national guidelines, professional Codes of Conduct, Trust policies, procedures, systems and processes, approved guidelines and similar approved documents. The same expectations apply regarding following manufacturers' requirements, standards and safety procedures when selecting, procuring, introducing, modifying, using and disposing of equipment and supplies. This Trust risk appetite statement requires compliance with these expectations by all staff, with no appetite for non-compliance risks of this kind, which should be avoided.

The need for replacement of much old clinical equipment essential for services, combined with financial pressure, creates business continuity and service degradation risks. In order to maintain essential services, the Trust appetite for risks of this kind is moderate, with a cautious risk level. Risk appetite reduces to none for risks of this kind that are not being

rigorously managed and mitigated, and for significant risks to patient safety. Risk management and maintenance must include making long-term provision for repair or replacement of equipment that is old or might fail, within required timescales to preserve services, as well as identifying and making arrangements for alternative providers for patients to be available in the event of serious service degradation or stoppage. Risks of this kind require escalation, as well as action at operational and tactical levels, so that the board are fully aware of risks, with board action being sought as necessary to prevent risks of any harm to patient safety.

The Trust risk appetite for serious risks or Never Events arising from insufficient implementation of particular Alerts, both in terms of gaps from the past and in the future, and insufficient implementation and use of the Trust framework for Alerts, is none. Such risks should be avoided and Alerts implemented fully. This should be done within required timescales, and with risk assessment of new Alerts and any risks arising from any implementation backlog previous alerts. Urgent escalation is required of Alerts related non-compliance risks.

The Trust propensity to take risk regarding equipment and supplies at senior tactical and strategic levels is higher than at operational levels, where exercising control is critical. Fast clockspeed risks require urgent escalation and urgent resolution at operational levels if there are serious risks of patient or staff safety, or care quality, being seriously compromised.

10. **ESTATES/FACILITIES**
(Including Health and Safety, Fire, Occupational Health, Security)

General statement

Overall, the Trust has a moderate risk appetite, with a cautious risk level, for Estates/Facilities risks. Risk appetite reduces to low, with a minimal risk level, for any significant risks to patient or staff safety, care quality, service continuity and financial stability. The Trust has a low appetite for Health and Safety or fire risks, or serious Occupational Health risks, which should be as minimal as is reasonably practicable. This risk appetite reduces to none where risks are caused by serious non-compliance. Such risks should be avoided. For risks caused by delaying some planned preventative maintenance, the Trust risk appetite is moderate, at a cautious risk level, as long as patient and staff safety, and care service quality, are not seriously affected, long-term costs are not significantly increased, and the level of aggregated risk is acceptable. The Trust has a moderate appetite, at a cautious risk level, for risks associated with outsourcing, as long as there is good, transparent and shared outsourcing provider risk management, the balance of outsourcing risk is positive, and the Trust avoids risk of being perceived as a poor employer. The Trust has no risk appetite for significant non-compliance Estates/Facilities risks, and for serious risks related to insufficient implementation of Alerts, and the Trust Alerts Framework.

Trust details/examples/narratives – as needed

Backlogs in planned preventative buildings maintenance are being addressed, but significant costs remain, particularly concerning fire. The Trust has a low appetite for Health and Safety or fire risks, or serious Occupational Health risks to individuals or groups, which should be as minimal as is reasonably practicable. This risk appetite reduces to none where risks are caused by serious non-compliance, including with fire standards and regulations, or where patient or staff safety is threatened. Such risks should be avoided.

The Trust has no risk appetite for serious non-compliance Estates/Facilities risks, relating to both external and internal standards and policies, and legal or technical requirements. Such risks should be avoided.
Due to cost constraints, the Trust generally has a moderate appetite, at a cautious risk level, for risks caused by delaying some planned preventative maintenance, when serious non-compliance risks do not arise, no risks are caused to patient or staff safety, care service quality is not seriously affected and delay does significantly increase costs long-term. Rigorous risk assessment and risk versus reward assessment, and regular monitoring and review of such risks must be done. The Trust has no appetite for a damaging level of aggregated risk arising from multiple delays to numerous major planned preventative maintenance requirements.

The Trust has a moderate appetite, at a cautious risk level, for risks associated with outsourcing, both current and new, as long as outsourcing lead to greater efficiency and cost efficiency, enhancing care quality and patient experience, without undermining long-term financial stability. Full risk versus reward assessment is essential, and the board will avoid too high a level of aggregated outsourcing risk and potential loss of control of risks in areas affecting patients. The Trust has a low appetite for outsourcing risks when the risk management of the outsourcing provider is not sufficiently transparent and shared, or a sufficiently high standard, or when the balance of risk shared between the outsourcing provider and the Trust is unclear, or negative. Outsourcing risks linked to possible

perceptions of the Trust as a poor employer have a low risk appetite, and should kept to a minimum level.

The Trust has a moderate appetite, at a cautious risk level, for risks associated with improving or transforming Estates/Facilities management services, to save costs and improve patient experience. For a moderate risk appetite to be maintained, day-to-day services and their quality need to be maintained, without risks to patient or staff safety, care quality or the reasonable expectations of staff of the Trust as a good employer.

The Trust risk appetite for serious risks or Never Events arising from insufficient implementation of particular Alerts, both in terms of gaps from the past and in the future, and insufficient implementation and use of the Trust framework for Alerts, is none. Such risks should be avoided and Alerts implemented fully. This should be done within required timescales, and with risk assessment of new Alerts and any of risks arising from any implementation backlog previous alerts. Urgent escalation is required of Alerts related non-compliance risks.

The Trust propensity to take risk regarding Estates/Facilities at senior tactical and strategic levels, especially regarding taking opportunities, is higher than at operational levels, where exercising control is critical. Fast clockspeed risks require urgent escalation and urgent resolution at operational levels, if there are imminent risks of serious compromise of patient or staff safety, or care quality.

11. **IT/IM** - Risk appetite **moderate,** risk level **cautious** (inclining to risk appetite **low**, risk level **minimal**)

General statement

Overall, at a more strategic level, the Trust risk appetite concerning IT/IM is moderate, and the risk level cautious, in order to enable significant existing problems to be remedied and to fulfil the potential of IT in service and productivity transformation. The Trust's risk appetite is moderate concerning improvements that allow IM&T to enable improvements in service quality, promote ease of use, new pathways and sustainability. The Trust risk appetite inclines to and becomes low, with risk kept to a minimal level, if there are weak systems, processes and monitoring for IT organisational processes and project management, or inadequate Trust IT coordination, or lack of aggregation and linking of relevant risks. The Trust risk appetite is low for: risks linked to hacking, data loss and breaches of legal and regulatory standards; risks caused by procurement of IT systems that cannot work together; weak information management and inappropriate patient communications being generated by computers; weaknesses in IT systems used for clinical tests and causing suboptimal diagnostics, care, or follow-up; serious weaknesses and outages of IT systems that are core parts of care processes. Such risks should be kept to a minimal level. The Trust has a low risk appetite concerning risks arising from IT/IM aspects of new care pathways. The Trust has a low risk appetite for risks associated with IT implementations, which should be kept to a minimal level and mitigated through sound, proven methodologies, tools, project management and monitoring. Risk appetite reduces at a more tactical level, and is low for IT change at an operational level, where there is a need for escalation of risks, and urgent resolution of problems. The Trust has a low risk appetite, with a minimal risk level, concerning risks arising from gathering and using information, views and data, including from sources outside the Trust and from research, which inappropriately neglects or excludes information, data and views from women and certain groups.

Trust details/examples/narratives – as needed

Existing risks related to IM&T are high, especially related to problems with Lorenzo and Nervecentre, and high variability in departmental IT systems, with a low Trust ability to carry any further significant IM&T risks. Despite this, at a strategic level, overall the Trust risk appetite is moderate, and the risk level cautious, in order to enable significant action to be taken to remedy problems and reduce risks, and because the potential for IT to transform or improve services, productivity, care quality and patient safety remains very great. The Trust's risk appetite is moderate concerning improvements that allow IM&T to enable improvements in service quality, promote ease of use, new pathways and sustainability. These should be pursued, with a cautious risk level. Examples include improvements to help the Trust achieve an integrated and digitised patient record and reduce its high reliance on paper-based services. Other examples include initiatives to increase the potential for IM&T to promote service improvements and integrate services, following a reduction in individual services' overly varied systems and processes. Lorenzo and Nerve Centre stabilisation is a high priority.

The Trust risk appetite becomes low, with risk kept to a minimal level, if any of the well-established processes and systems of IT procurement, implementation and project management are weak or under-resourced. Lack of a thorough and proven user requirements analysis and testing, for example, would generate unacceptable risks. Similarly, the Trust has a low risk appetite for risks associated with any lack of overall

coordination and control of Trust IM&T, with directorates and divisions undertaking procurement and making important decisions without adequate coordination and without aggregation and linking of relevant risks. Risk appetite reduces at a more tactical level, and is low for IT change at an operational level, where there is a need for escalation of risks, and urgent resolution of problems.

The Trust has no risk appetite for risks generated as a result of aggregated and linked risks arising from different existing and projected projects not being evaluated fully before approval is given for new IT projects or significant change.

The Trust risk appetite for risks linked to hacking, data loss and breaches of legal and regulatory standards is low, and these risks must be kept to a minimal level. The Trust has a low risk appetite for risks arising from procurement decisions where IT systems cannot communicate with each other, or work together, unless there is a very significant case for their use.

The Trust has a low risk appetite for risks arising from weaknesses in IT systems used for clinical tests, weak information management and inappropriate patient communications being generated by computers. The Trust risk appetite is low for risks of individuals or groups of patients receiving suboptimal diagnostics, care follow-up related to weaknesses in information management and IT systems. Such risks should be kept to a minimal level, and escalated rapidly, whilst applying the Trust risk appetite concerning reputation risks.

Development of the local and regional health economy requires close working in development of pathways with other healthcare providers and social care providers. The Trust has a moderate risk appetite, as a cautious risk level, for developing new ways of working supported by IT, in line with its strategic priorities.

The Trust has a low risk appetite for risks related to serious weaknesses and outages of Trust and departmental/divisional IT systems that are core parts of care processes. Risks to the running of these systems, their availability and their quality, should be minimal.

The Trust has a low risk appetite for preventable risks associated with IT implementations. Preventable risks should be kept to a minimal level. No IT project should be approved without demonstrating control of risks through well proven IT implementation project methodology, including human factors. User requirements analysis, testing, use of change management methodology, training, communications planning and other tools, along with rigorous programme and project management, are examples of elements that need to be present for the Trust to accept risks of IT implementations.

The Trust has a low risk appetite, with a minimal risk level, concerning risks arising from IT/IM aspects of new care pathways. Whenever possible, risks should be avoided of referrers and patients having to repeatedly provide the same data about themselves to different agencies, probably in different formats, within the new pathways being created by the trust across organisational and care boundaries. Processes of this kind should avoid creating frustration and risks of data discrepancies, or breaches of privacy requirements.

Nationally and internationally, women have often been excluded or neglected in datasets affecting healthcare and clinical decision-making, diagnosis and resource allocation. Similar problems can arise for other specific patient groups. The Trust has a low risk appetite, with a minimal risk level, concerning risks arising from gathering and using information, views and data, including from sources outside the Trust and from research, which inappropriately neglects or excludes information, data and views from women and certain groups.

Most IT risks are low clockspeed risks, needing to be processed through normal control mechanisms, but fast clockspeed risks, requiring urgent action and rapid response, can arise at strategic, tactical and operational levels. In such cases, operation level staff should escalate risks and seek urgent support. It would be unusual and usually not acceptable for local remedies to be used for significant IT problems, without approval after escalation. The Trust has used emergency planning control mechanisms to handle major hacking successfully and rapidly at a strategic level, and this kind of approach is the board's preferred response.

TRUST STRATEGIC PRIORITIES - RISK APPETITE

1. ***QUALITY*** *- "Deliver **high quality care** consistently across all of our services in terms of clinical quality, safety and compassion"*
   - risk appetite **low,** risk level **minimal**.

General statement

See text for the following risk area 1:

"Quality/outcomes - risk appetite **low,** risk level **minimal**."
(Including patient safety, care quality, staff safety, clinical risks, infection prevention and control (IPC), clinical and organisational innovation, patient experience, access, equality issues)

2. ***EASE OF USE*** *- "Redesign and invest in our **systems and processes** to ensure that they provide a consistently simple and quick experience for our patients, their referrers, and our staff, minimising frustration and maximising efficiency"*
   - risk appetite **high,** risk level **open** (inclining to risk appetite **moderate**, risk level **cautious**)

General statement

Generally, the Trust has a high risk appetite concerning the strategic priority, with an open risk level, inclining to a moderate risk appetite and cautious risk level, when appropriate. The Trust risk appetite becomes moderate and the risk level cautious if system and process innovations themselves, or implementing redesigned systems/processes practically, generates risks of short to medium-term uncertainties concerning ease of use. The Trust has a low risk appetite for significant risks to service quality or continuity, or to the positive views of referrers or staff arising from system and process redesign. The Trust has no risk appetite for risks of significant harm to patients or staff. In new pathway development, the Trust risk appetite is low, with a minimal risk level, for risks arising from obstacles to ease of use of Trust services by referrers and by individuals or groups of patients. The Trust risk appetite and risk level regarding this strategic priority reflects the text of risk areas described previously, that directly relate to improvements in ease of use, systems and processes.

Trust details/examples/narratives – as needed

Concerning this strategic priority, generally the Trust has a high risk appetite, with an open risk level, inclining to a moderate risk appetite and cautious risk level, when appropriate. The risk appetite is high for clearly effective improvements that tackle problems with ease of use of its services or its competitiveness in the local health economy, E.g. waiting times for outpatient consultations, ease of access and use of Trust services, delays in resolving GP concerns, insufficient engagement with Primary Care partners, lack of Learning Disability flags on Lorenzo.

The Trust risk appetite becomes moderate and the risk level cautious if system and process innovations themselves, or implementing redesigned systems/processes practically, generates risks of short to medium-term uncertainties concerning ease of use.

The Trust has a low risk appetite for significant risks to service quality or continuity, or to the positive views of referrers or staff arising from system and process redesign. Risks of this kind should be minimal.

The Trust has no risk appetite for risks of significant harm to patients or staff. These should be avoided.

Rigour is essential in planning, testing and monitoring of innovations to improve ease of use. All staff at operational and project levels are encouraged to contribute ideas and need to participate fully in activities that improve system and process design, but most innovations require tactical or strategic level risk management, approval and monitoring. Urgent escalation of risks related to ease of use is needed from operational and project levels, especially if individuals or groups of patients are disadvantaged, or at risk of suboptimal access or outcomes.

The Trust aims to develop new pathways across care sector and organisational boundaries. In new pathway development, Trust risk appetite is low, with a minimal risk level needed, for risks arising from obstacles to ease of use of Trust services by referrers and by individuals or groups of patients. Planning, testing and monitoring of new pathways must include ongoing assessment of such risks, keeping them minimal. Whenever possible, risks should be avoided of referrers and patients having to repeatedly provide the same data about themselves to different agencies, probably in different formats, within the new pathways. Processes of this kind should avoid creating frustration and risks of data discrepancies, or breaches of privacy requirements.

The Trust risk appetite and risk level regarding this strategic priority reflects the text of risk areas described previously, that directly relate to improvements in ease of use, systems and processes. Text concerning these risk areas is the most relevant: quality (1), innovation (3), commercial (6), major change programmes and projects (7) and IM/IT (11). Guidance given regarding these risk areas particularly should be followed concerning risks related to redesigning and investing in systems and processes that promote ease of use of Trust services.

3. ***PATHWAYS*** *- "Pursue actively the development of* ***pathways*** *across care boundaries, where this is in the best interests of patients and adds value"*
    - risk appetite **high,** risk level **open** (inclining to risk appetite **moderate**, risk level **cautious**)

General statement

Generally, the Trust has a high risk appetite for this strategic priority, with an open risk level, inclining to a moderate risk appetite and cautious risk level, when appropriate. Trust risk appetite reduces to low, with a minimal risk level, for risks arising from insufficient rigour in ensuring that some individuals and groups of patients do not experience suboptimal access to services, delays, bottlenecks or loops as a result of pathways crossing boundaries. The Trust has a low risk appetite for risks arising from quality, timeliness and management of data and information crossing boundaries, or for risks caused by technical or organisational barriers or delays to data and information crossing boundaries. The Trust has a low risk appetite for risks arising from Serious Incidents which occur in the Trust, but whose main underlying cause is found in a partnership agency. Trust risk appetite reduces to low if the full range of risk, change project management methodologies are not followed adequately in new pathway design, implementation and post implementation monitoring. Significant risks

of harm to patients or staff related to pathway changes bring the Trust risk appetite to none. The Trust risk appetite is high, with an open risk level, for pathway activities aimed at securing appropriate contracts. This reduces to moderate, cautious risk level, or even to low, for contracts and partnership activities that could create significant risks to quality of care, service continuity, patient or staff safety and long-term Trust financial viability. The Trust will have a low risk appetite for risks arising from new pathways across care boundaries that, when aggregated and linked with other existing risks, lead the Trust to exceed a prudent and manageable overall risk exposure level. The Trust has a low risk appetite for risks caused by insufficient joint planning, communications, IT system compatibility and data barriers, use of common language and terminology between the Trust and its potential partners, working across boundaries. The Trust has a low risk appetite for risks that arise from different organisations having insufficient understanding of each other's risk appetite, risk management and risk grading systems. The Trust risk appetite and risk level regarding this strategic priority reflects the text of risk areas described previously, that directly relate the development of pathways across care boundaries.

Trust details/examples/narratives – as needed

For this strategic priority, generally the Trust has a high risk appetite, with an open risk level, inclining to a moderate risk appetite and cautious risk level, when appropriate. This includes risks related to pursuing whole pathways of care to meet Sustainability & Transformation Partnership (STP) requirements, improve efficiency and meet identified opportunities. It includes risks concerning pathway work to prevent, reduce or delay significant clinical needs, in order to prevent people reaching crisis point in their care. It includes risks arising from interventions that focus upon reducing variation by adapting standardised pathways, developing place-based services within localities and shifting activity from reactive to proactive.

The Trust aims to innovate and integrate across traditional NHS boundaries (acute-community) and sector boundaries (health-social care-education), aiming to improve care quality and to make inpatient admission the exception rather than the norm. Trust risk appetite reduces to low, with a minimal risk level, or risks arising from insufficient rigour in ensuring that some individuals and groups of patients do not experience suboptimal access to services, delays, bottlenecks or loops as a result of pathways crossing boundaries. Similarly, the Trust has a low risk appetite for risks arising from quality, timeliness and management of data and information crossing boundaries, or for risks caused by technical or organisational barriers or delays to data and information crossing boundaries. The Trust has a low risk appetite for risks arising from trends of certain types of Serious Incident or breakdown in care, which occur in the Trust, but whose main underlying cause is found in a partnership agency. Such risks should be minimal.

As indicated in text concerning innovation, commercial and major change programme/project risk areas, Trust risk appetite reduces to low if the full range of risk, change project management methodologies are not followed adequately in new pathway design, implementation and post implementation monitoring. Such risks should be minimal. The Trust has no risk appetite for significant risks of harm to patients or staff related to pathway changes, which should be avoided.

The Trust risk appetite is high, with an open risk level, for pathway activities aimed at securing contracts and developing a track record and reputation for delivery, improving partnership working and increasing the relatively low current likelihood of being first choice

provider. The risk appetite reduces to moderate, with a cautious risk level, or even to low, for contracts and partnership activities that could create significant risks to quality of care, service continuity, patient or staff safety and long-term Trust financial viability. Rigour is essential in planning, testing and monitoring new pathways. All staff are encouraged to contribute ideas and need to participate fully in activities that improve pathway design, but new pathways require strategic level risk management, approval and monitoring. Urgent escalations of risks related to new pathways is needed from operational and project levels.

The Trust will have a low risk appetite, keeping risks at a minimal level, for risks arising from the development of pathways across care boundaries that, when aggregated and linked with other existing risks, lead the Trust to exceed a prudent and manageable overall risk exposure level. All significant cross boundary care pathway development risks, therefore, should be escalated, in order to ensure risk awareness of the board.

The Trust has a low risk appetite for risks caused by insufficient joint planning, communications, IT system compatibility and data barriers, use of common professional language and terminology between the Trust and its potential partners, working across boundaries. The Trust has a low risk appetite for risks that arise from different organisations having insufficient understanding of each other's risk appetite, risk management and risk grading systems. This could lead to miscommunication and over or underestimation of risks arising from a new pathway. These kinds of risks should be made minimal, and escalated urgently if identified.

Rigour is essential in planning, testing and monitoring of innovations to develop pathways. All staff at operational and project levels are encouraged to contribute ideas and need to participate fully in activities that improve pathway design, but most innovations require very senior tactical or strategic level risk management, approval and monitoring. Urgent escalation of risks related to pathway development and implementation is needed from operational and project levels, especially if individuals or groups of patients are disadvantaged, or at risk of suboptimal access or outcomes.

The Trust risk appetite and risk level regarding this strategic priority reflects the text of risk areas described previously, that directly relate the development of pathways across care boundaries. Text concerning these risk areas is the most relevant: quality (1), innovation (3), financial/value for money (5), commercial (6), major change programmes and projects (7) and IM/IT (11). Guidance given regarding these risk areas particularly should be followed concerning risks related to developing new pathways.

4. ***PEOPLE*** *- "Create an* ***environment*** *which retains staff, recruits the best and develops an engaged, flexible and skilled workforce able to meet the needs of our patients"*
    - risk appetite **moderate**, risk level **cautious**.

General statement

See text for the following risk area (8):

"Staffing - risk appetite **moderate,** risk level **cautious"**

Trust details/examples/narratives – as needed

5. ***SUSTAINABILITY*** *- "Develop a* ***portfolio of services*** *that are financially and clinically* ***sustainable*** *in the long-term*"
    - risk appetite **high,** risk level **open** (inclining to risk appetite **moderate**, risk level **cautious**)

General statement

The Trust has a high risk appetite for this strategic priority, with an open risk level, inclining to a moderate risk appetite and cautious risk level, when appropriate. This includes risks related to supporting STP targets, community alternatives to acute services, new pathway development, preventative strategies, new models of care, gaining access to capital funds, productivity improvement, service redesign and transformation, and achieving CIPs necessary for long-term financial sustainability. It includes risks related to dealing with services that are strategically essential to maintain, despite being unsustainable, and to investigating alternative provision for patients using other unsustainable services that may not be strategically essential. The Trust risk appetite is high concerning risks related to ensuring that diagnostics are ordered only once and only when clinically necessary. The Trust risk appetite becomes low, however, and the risk level minimal, for any changes, and development of its portfolio of services, that compromise service quality, service continuity or long-term financial sustainability. There is no Trust risk appetite for significant risks to patient or staff safety. The Trust will have a low risk appetite, keeping risks at a minimal level, for risks arising from the development of its portfolio of services that, when aggregated and linked with other existing risks, lead the Trust to exceed a prudent and manageable overall risk exposure level. The Trust risk appetite and risk level regarding this strategic priority reflects the text of risk areas described previously, that directly relate to the development of a portfolio of services that are financially and clinically sustainable in the long-term.

Trust details/examples/narratives – as needed

The Trust has a high risk appetite for this strategic priority, with an open risk level, inclining to a moderate risk appetite and cautious risk level, when appropriate. This includes risks related to activities and service portfolio development to support challenging STP targets, to reduce forecast demand for non-elective activity by 23% and forecast demand for planned care by 20% over the next 10 years. The Trust risk appetite is high regarding risks concerning work to support community alternatives to acute services and commissioners to deliver new pathways, support preventative strategies (particularly regarding the over 75 age

range, where a 19% growth is forecast over the next five years) and implement new models of care that avoid unnecessary attendances and admissions, and improve productivity, efficiency and effectiveness. Risk appetite is high concerning service redesign and transformation to address workforce shortages and improve productivity are needed, avoiding risks of the Trust not achieving the CIPs necessary for long-term financial sustainability. Access to capital funds is likely to be via STPs, and the Trust has a high risk appetite for risks arising from necessary productivity improvements.

The Trust has a high risk appetite, with an open risk level, to risks from work to improve the productivity and reduce the costs of some services that are strategically essential to maintain, despite being unsustainable through being clinically fragile or costing more than the Trust recovers through income. Equally, the Trust risk appetite is high regarding risks related to investigating alternative provision for patients using other unsustainable services that may not be strategically essential to maintain.

The Trust aims to ensure that diagnostics are ordered only once and only when clinically necessary. The Trust risk appetite is high concerning risks related to achieving this.

The Trust risk appetite becomes low, however, and the risk level minimal, for any changes, and development of its portfolio of services, that compromise service quality, service continuity or long-term financial sustainability. There is no Trust risk appetite for significant risks to patient or staff safety, which must be avoided. Guidance will be needed also from the section on the Reputation risk area (4).

Rigour is essential in planning, testing and monitoring new portfolios of services. All staff are encouraged to contribute ideas and need to participate fully in activities that improve the Trust's sustainability, but new service portfolios require strategic level risk management, approval and monitoring. Urgent escalations of risks related to development of the Trust's portfolio of services is needed from operational and project levels. All staff at operational and project levels are encouraged to contribute ideas and need to participate fully in activities that improve service portfolio design, but most innovations require very senior tactical or strategic level risk management, approval and monitoring. Urgent escalation of risks related to service portfolio development and implementation is needed from operational and project levels, especially if individuals or groups of patients are disadvantaged, or at risk of suboptimal access or outcomes.

The Trust has a low risk appetite, keeping risks at a minimal level, for risks arising from the development of its portfolio of services that, when aggregated and linked with other existing risks, lead the Trust to exceed a prudent and manageable overall risk exposure level. All significant service portfolio development risks, therefore, should be escalated, in order to ensure risk awareness of the board.

The Trust risk appetite and risk level regarding this strategic priority reflects the text of risk areas described previously, that directly relate to the development of a portfolio of services that are financially and clinically sustainable in the long-term. Text concerning these risk areas is the most relevant: quality (1), innovation (3), reputation (4), financial/value for money, (5), commercial (6), major change programmes and projects (7) and IM/IT (11). Guidance given regarding these risk areas particularly should be followed concerning risks related to developing a portfolio of sustainable services.

Board Annual Cycle 2019-20

A formal Trust Board meeting is held on alternate months with Board Development sessions held in the month in-between.

Items	*Apr 2019	May 2019	*Jun 2019	Jul 2019	Aug 2019	Sep 2019	*Oct 2018	Nov 2019	*Dec 2019	Jan 2020	*Feb 2020	Mar 2020
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 or Part 2 depending on the nature of the report)		x		x		x		x		x		x
Suspensions (Part 2)		x		x		x		x		x		x
Board Committee Summary Reports												
Audit Committee Report				x		x		x				x
Charity Trustee Committee Report		x		x				x		x		
Finance and Performance Committee Report		x		x		x		x		x		x
Quality and Safety Committee Report		x		x		x		x		x		x
Strategic												
Annual Operating Plan and objectives *(subject to change as dependent on national timeline)*												**x (TBC)**
Strategy Updates						**x Cancer and CSS**		**x Medicine and Surgery**		**x Women and Children's**		**TBC**
Sustainability and Transformation Plan (STP) (Part 2)		x		x		x		x		x		x

Board Annual Cycle 2019-20

Items	*Apr 2019	May 2019	*Jun 2019	Jul 2019	Aug 2019	Sep 2019	*Oct 2018	Nov 2019	*Dec 2019	Jan 2020	*Feb 2020	Mar 2020
Other Items												
Audit Committee												
Annual Report and Accounts, Annual Governance Statement and External Auditor's Report		**x** ***(Late May Audit Committee)***										
Annual Audit Letter				**x**								
Audit Committee TOR and Annual Report						**x**						
Raising Concerns at Work 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 and Performance Committee												
Finance Update (Part 2)		**x**		**x**		**x**		**x**		**x**		**x**
FPC TOR and Annual Report						**x**						
Digital Strategy Update (Part 2)		**x**		**x**		**x**		**x**		**x**		**x**
Market Strategy Review (TBC with Acting Director of Strategy)												**x**
Quality and Safety Committee												
Complains, PALS and Patient Experience Report						**x**						**x**
Safeguarding and L.D. Annual Report (Adult and Children)				**x**								
Detailed Analysis of Staff Survey Results												**x**

Board Annual Cycle 2019-20

Items	*Apr 2019	May 2019	*Jun 2019	Jul 2019	Aug 2019	Sep 2019	*Oct 2018	Nov 2019	*Dec 2019	Jan 2020	*Feb 2020	Mar 2020
Equality and Diversity Annual Report and WRES						x						
Gender Pay Gap Report												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						
Shareholder / Formal Contracts												
ENH Pharma (Part 2) [i]		x						x				

[i] To include the Annual Governance Review in November

*Please note Board Development sessions will be held on the 'even' months. This will support flexibility for the Board to be able to be convened for an extraordinary meeting if an urgent decision is required. However, forward agenda planning will aim to minimise this.

The Board Annual Cycle will continue to be reviewed in-year in line with best practice and any changes to national scheduling. The annual cycle will also be updated to reflect any changes that might be agreed in relation to the QSC and FPC annual cycles which are currently under consideration.

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

Agenda item: 13

EAST AND NORTH HERTFORDSHIRE NHS TRUST
TRUST BOARD ACTIONS LOG PART I TO 1 MAY 2019 MEETING

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
5 Sept 2018	18/168.5	Workforce – Student Nurses	To report to Board the impact of the number of Student Nursing joining the Trust following the government removal of the Student Nurse Bursary.	Nursing workforce strategy scheduled for discussion at March 2019. **March 2019:** Discussion due to take place at Quality and Safety Committee on 26 March and reported back to a future Board meeting. **April 2019:** Nursing and Midwifery Strategy due to be discussed at Board on 1 May.	Director of Nursing/ COO/Deputy COO	January 2019 *March 2019
9 Jan 2019	19/007.2	Trust Clinical Strategy	To review the Board agenda/annual cycle to ensure the Board is kept appraised of progress against the strategy.	**March 2019:** The Board and committee report schedules are currently under review. The new annual cycles will be in place by the time of the next Board meeting. **April 2019:** Updated annual cycle (including regular strategy update) provided on agenda for 1 May meeting.	Associate Director of Corporate Governance	April 2019

DATA PACK

Contents

1. Data and Exception Reports:

FFT

Friends and Family Test - March 2019

APPENDIX 2

Inpatients & Day Case	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely nor Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses	No. of Discharges	Total % response rate
5A	100.00	0.00	7	2	0	0	0	0	9	120	7.50
5B	97.44	0.00	32	6	1	0	0	0	39	65	60.00
7B	92.16	0.00	51	43	7	0	0	1	102	181	56.35
8A	100.00	0.00	37	25	0	0	0	0	62	90	68.89
8B	96.15	0.00	33	17	2	0	0	0	52	128	40.63
11B	96.67	0.00	41	17	1	0	0	1	60	114	52.63
Swift	97.65	0.00	71	12	0	0	0	2	85	192	44.27
ITU/HDU	100.00	0.00	3	0	0	0	0	0	3	10	30.00
Day Surgery Centre, Lister	96.60	1.46	151	48	3	1	2	1	206	413	49.88
Day Surgery Treatment Centre	98.89	0.56	154	24	1	1	0	0	180	470	38.30
Endoscopy, Lister	99.26	0.00	245	22	1	0	0	1	269	783	34.36
Endoscopy, QEII	98.55	0.00	61	7	1	0	0	0	69	356	19.38
SURGERY TOTAL	97.62	0.35	**886**	**223**	**17**	**2**	**2**	**6**	**1136**	**2922**	38.88
SSU	90.77	3.08	46	13	2	1	1	2	65	165	39.39
AMU - Blue	87.50	8.33	15	6	1	1	1	0	24	142	45.77
AMU - Green	92.68	2.44	34	4	2	0	1	0	41		
Pirton	94.00	2.00	36	11	2	1	0	0	50	68	73.53
Barley	100.00	0.00	12	2	0	0	0	0	14	43	32.56
6A	100.00	0.00	26	9	0	0	0	0	35	96	36.46
6B	92.86	3.57	20	6	0	1	0	1	28	55	50.91
11A	100.00	0.00	50	18	0	0	0	0	68	82	82.93
ACU	100.00	0.00	11	6	0	0	0	0	17	120	14.17
10B	92.59	0.00	16	9	1	0	0	1	27	107	25.23
Ashwell	100.00	0.00	13	6	0	0	0	0	19	46	41.30
9B	95.59	0.00	34	31	3	0	0	0	68	75	90.67
9A	100.00	0.00	33	1	0	0	0	0	34	64	53.13
Cardiac Suite	96.15	0.00	43	7	2	0	0	0	52	113	46.02
MEDICINE TOTAL	95.57	1.29	**389**	**129**	**13**	**4**	**3**	**4**	**542**	**1176**	46.09
10AN Gynae	94.44	1.39	50	18	3	1	0	0	72	96	75.00
Bluebell ward	90.91	0.00	20	10	3	0	0	0	33	222	14.86
Bluebell day case	100.00	0.00	2	3	0	0	0	0	5	8	62.50
Neonatal Unit	100.00	0.00	27	7	0	0	0	0	34	43	79.07
WOMEN'S/CHILDREN TOTAL	95.14	0.69	**99**	**38**	**6**	**1**	**0**	**0**	**144**	**369**	39.02
MVCC 10 & 11	97.01	1.49	56	9	1	0	1	0	67	108	62.04
CANCER TOTAL	97.01	1.49	**56**	**9**	**1**	**0**	**1**	**0**	67	**108**	62.04
TOTAL TRUST	96.82	0.69	**1430**	**399**	**37**	**7**	**6**	**10**	**1889**	**4575**	41.29

Continued over …..

Inpatients/Day by site	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses	No. of Discharges	Total % response rate
Lister	96.75	0.68	1313	383	35	7	5	10	1753	4111	42.64
QEII	98.55	0.00	61	7	1	0	0	0	69	356	19.38
Mount Vernon	97.01	1.49	56	9	1	0	1	0	67	108	62.04
TOTAL TRUST	96.82	0.69	**1430**	**399**	**37**	**7**	**6**	**10**	**1889**	**4575**	41.29

Accident & Emergency	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses	No. of Discharges	Total % response rate
Lister A&E/Assessment	86.65	1.03	259	163	50	3	2	10	487	11032	4.41
QEII UCC	97.83	1.09	150	30	2	1	1	0	184	3584	5.13
A&E TOTAL	89.72	1.04	**409**	**193**	**52**	**4**	**3**	**10**	**671**	**14616**	4.59

Maternity	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses	No. of Discharges	Total % response rate
Antenatal	100.00	0.00	8	3	0	0	0	0	11	460	2.39
Birth	100.00	0.00	47	24	0	0	0	0	71	436	16.28
Postnatal	83.10	2.82	35	24	7	1	1	3	71	436	16.28
Community Midwifery	100.00	0.00	10	2	0	0	0	0	12	553	2.17
MATERNITY TOTAL	92.73	1.21	**100**	**53**	**7**	**1**	**1**	**3**	**165**	**1885**	8.75

Outpatients	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses
Lister	96.07	0.98	458	226	18	2	5	3	712
QEII	96.04	1.61	503	152	11	4	7	5	682
Hertford County	96.11	0.56	103	70	5	1	0	1	180
Mount Vernon CC	94.25	0.00	72	10	3	0	0	2	87
Satellite Dialysis	98.68	0.00	66	9	1	0	0	0	76
OUTPATIENTS TOTAL	96.09	1.09	**1202**	**467**	**38**	**7**	**12**	**11**	**1737**

Trust Targets	% Would recommend	% response rate
Inpatients/Day Case	96%>	40%>
A&E	90%>	10%>
Maternity (combined)	93%>	30%>
Outpatients	95%>	N/A

2. Performance Data:

CQC Outcomes Summary

Our CQC Registration and recent Care Quality Commission Inspection

The Care Quality Commission inspected nine of the core services provided by East and North Hertfordshire NHS trust across Lister Hospital, the Queen Elizabeth II (QEII) Hospital and Mount Vernon Cancer Centre, between 20 and 22 March 2018. The returned on 2 April 2018 for an unannounced, follow-up inspection of the surgery core service at Lister Hospital. The well led inspection took place from 23 to 25 April 2018. The Use of Resources inspection, which is led by NHS Improvement took place on 11 April 2018.

At **Lister Hospital** CQC inspected:

- Urgent and emergency care
- Surgery
- Medicine
- Maternity
- Services for children and young people at Lister Hospital.

At the **QEII Hospital** CQC inspected:
- Urgent Care Centre

At the **Mount Vernon Cancer Centre** CQC inspected:
- Medicine
- Chemotherapy
- End of Life Care

At the October 2015 inspection, these core services were rated either as inadequate or requires improvement, apart from surgery, which was rated as good overall.

Summary of the Trust's Ratings

Our rating of the Trust stayed the same -**requires improvement**.
We were rated as **good** for caring and **requires improvement** for and safe, effective, responsive and well led.
We were rated as **requires improvement** for use of resources

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement → ← Jul 2018	Requires improvement → ← Jul 2018	Good → ← Jul 2018	Requires improvement → ← Jul 2018	Requires improvement → ← Jul 2018	Requires improvement → ← Jul 2018

	Safe	Effective	Caring	Responsive	Well-led	Overall
Lister Hospital	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Good ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018
Queen Elizabeth II Hospital	Inadequate ➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Good ➔➔ Jul 2018	Good ➔➔ Jul 2018	Inadequate ➔ Jul 2018	Inadequate ➔ Jul 2018
Mount Vernon Cancer Centre	Requires improvement ➔ Jul 2018	Good ➔➔ Jul 2018	Good ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018
Hertford County Hospital	Good Mar 2016	N/A	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Overall trust	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Good ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Good ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018
Community	Good Mar 2016	Good Mar 2016	Outstanding Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Overall trust	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Good ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018

The CQC have issued a number of requirement notices and set out a number of areas for improvement - “Must Do’s” and “Should Do’s”.

The requirement notices are:

- Regulation 12 HSCA 2008 (Regulated Activities), Regulations 2010 Cleanliness and infection control
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing
- Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

An action plan has been developed against all of these and was submitted to CQC on 24 August 2018. This will be monitored by the Quality Improvement Board, chaired by the Medical Director or Director of Nursing and reported to Board through the Quality and Safety Committee. A programme of internal and external inspections is in place to test and evidence progress and that the actions are embedded across the organisation.

Site Ratings

Lister Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good July 2018 ↑↑	Good July 2018 ↑	Good July 2018 ↑	Good July 2018 ↑	Good July 2018 ↑↑	Good July 2018 ↑↑
Medical care (including older people's care)	Requires Improvement July 2018 →←	Good July 2018 ↑	Good July 2018 →←	Good July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←
Surgery	Inadequate July 2018 ↓↓	Requires Improvement July 2018 ↓	Good July 2018 →←	Inadequate July 2018 ↓↓	Inadequate July 2018 ↓↓	Inadequate July 2018 ↓↓
Critical care	Good March 2016	Good March 2016	Good March 2016	Good March 2016	Requires Improvement March 2016	Good March 2016
Maternity	Requires Improvement July 2018 →←	Good July 2018 →←	Good July 2018 →←	Good July 2018 ↑	Good July 2018 →←	Good July 2018 ↑
Services for children and young people	Requires Improvement July 2018 →←	Good July 2018 ↑	Good July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←
End of life care	Good March 2016	Requires Improvement March 2016	Good March 2016	Good March 2016	Requires Improvement March 2016	Requires Improvement March 2016
Outpatients	Good March 2016	N/A	Good March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Good July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←

New QEII Hospital

Urgent and emergency services	Inadequate July 2018 ↓	Requires Improvement July 2018 →←	Good July 2018 →←	Good July 2018 →←	Inadequate July 2018 ↓	Inadequate July 2018 ↓
Outpatients and diagnostic imaging	Good March 2016	N/A	Good March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Inadequate July 2018 ↓	Requires Improvement July 2018 →←	Good July 2018 →←	Good July 2018 →←	Inadequate July 2018 ↓	Inadequate July 2018 ↓

Hertford County Hospital

Outpatients	Good March 2016	N/A	Good March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Good March 2016	N/A	Good March 2016	Good March 2016	Good March 2016	Good March 2016

Mount Vernon Cancer Centre

Medical care (including older people's care)	Requires Improvement July 2018 ↑	Good July 2018 ↑	Good July 2018 →←	Requires Improvement July 2018 ↑	Requires Improvement July 2018 →←	Requires Improvement July 2018 ↑
End of life care	Requires Improvement July 2018 ↑	Good July 2018 →←	Good July 2018 →←	Inadequate July 2018 ↓	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←
Outpatients	Good March 2016	Good March 2016	Good March 2016	Requires Improvement March 2016	Good March 2016	Good March 2016
Chemotherapy	Requires Improvement July 2018 ↓	Good July 2018 →←	Good July 2018 ↓	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←
Radiotherapy	Good March 2016	Good March 2016	Good March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Requires Improvement July 2018 ↑	Good July 2018 →←	Good July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←

Community Health Services for Children, Young People and Families

Community health services for children and young people	Good March 2016	Good March 2016	Outstanding March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Good March 2016	Good March 2016	Outstanding March 2016	Good March 2016	Good March 2016	Good March 2016

3. Quality and Safety Committee Reports:

Safer Staffing

East and North Hertfordshire NHS Trust

Agenda Item: 7.5

QUALITY AND SAFETY COMMITTEE – 23 APRIL 2019
Safer Staffing Report

Purpose of report
To update the Quality and Safety committee on safe staffing levels for the month of March and the impact this has had to;

- People productivity
- Financial Sustainability
- Investigations and actions on incidents and red flag events
- Patient Outcomes
- Patient, carer and staff feedback in relation to safe staffing levels

Executive Summary

- The Overall Fill Rate increased by 0.5% from 94.4% in February to 94.9% in March
- CHPPD remained static at 7.5
- Sickness Levels decreased slightly for Nursing Qualified and Unqualified staff
- Overall fill rate for temporary staffing increased by 0.3% from 67.7% in February to 69.4% in March. Demand hours increased by in excess of 7000 hours largely due annual leave at the top of the annual leave threshold (17% of staff on leave).
- Winter Pressures Ward 7A closed on the 7th March

Action required: For discussion

Previously considered by:
N/A

Director: Director of Nursing and Infection Control	**Presented by: Director of Nursing and Infection Control**	**Author: Safer Staffing matron, E-Roster Manager**

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)

Any other risk issues (quality, safety, financial, HR, legal, equality):

Proud to deliver high-quality, compassionate care to our community

1.0 Introduction

Whilst there is no single definition of 'safe staffing', NHS constitution, NHS England, CQC regulations, NICE guidelines, NQB expectations, and NHS Improvement resources all make reference to the need for NHS services to be provided with sufficient staff to provide patient care safely. NHS England cites the provision of an *"appropriate number and mix of clinical professionals"* as being vital to the delivery of quality care and in keeping patients safe from avoidable harm. (NHS England 2015)
East and North Hertfordshire NHS Trust is committed to ensuring that levels of nursing staff, which includes Registered Nurses, Midwives, Nursing Associates and Clinical Support Workers (CSWs), match the acuity and dependency needs of patients within clinical ward areas in the Trust. This includes ensuring there is an appropriate level and skill mix of nursing staff to provide safe and effective care using evidence based tools and professional judgement to support decisions. The National Quality Board (NQB 2016) recommend that on a monthly basis, actual staffing data is compared with expected staffing and reviewed alongside quality of care, patient safety, and patient and staff experience data. The trust is committed to ensuring that improvements are learned from and celebrated, and areas of emerging concern are identified and addressed promptly.

2.0 People Productivity

The following sections identify the processes in place to demonstrate that the Trust proactively manages nurse staffing to support patient safety.

2.1 Nursing Fill Rate

The Trust's safer staffing submission has been submitted to NHS Digital for March within the data submission deadline. Table 1 below shows the summary of overall fill % for this month and last month and % change. The full table of fill % can be seen in Appendix 1:

There are a number of other contributory factors which affect the fill rate for March. An exception report can be found in Appendix 2 showing those wards with a Registered Fill rate below 90% and any other points of note for the month.

Table 1

	Day		Night		Average 24 Hr		
Trust Average Fill Rates	**Registered**	**Care Staff**	**Registered**	**Care Staff**	**Registered**	**Care Staff**	**All Staff**
Trust Average (Current Month)	94.2%	88.5%	95.2%	106.7%	94.7%	95.3%	94.9%
Trust Average (Last Month)	93.8%	86.6%	95.2%	107.3%	94.4%	94.4%	94.4%
Change	↑ 0.4%	↑ 1.9%	↑ 0.0%	↓ -0.6%	↑ 0.3%	↑ 0.9%	↑ 0.5%

2.2 Care Hours per Patient day (CHPPD)

CHPPD is a measure of workforce deployment and is reportable to NHS Digital as part of the monthly returns for safe staffing.

CHPPD is the total number of hours worked on the roster by both Registered Nurses & Midwives and Nursing Support Staff divided by the total number of patients on the ward at 23:59 aggregated for the month (lower CHPPD equates to lower staffing numbers available to provide clinical care).

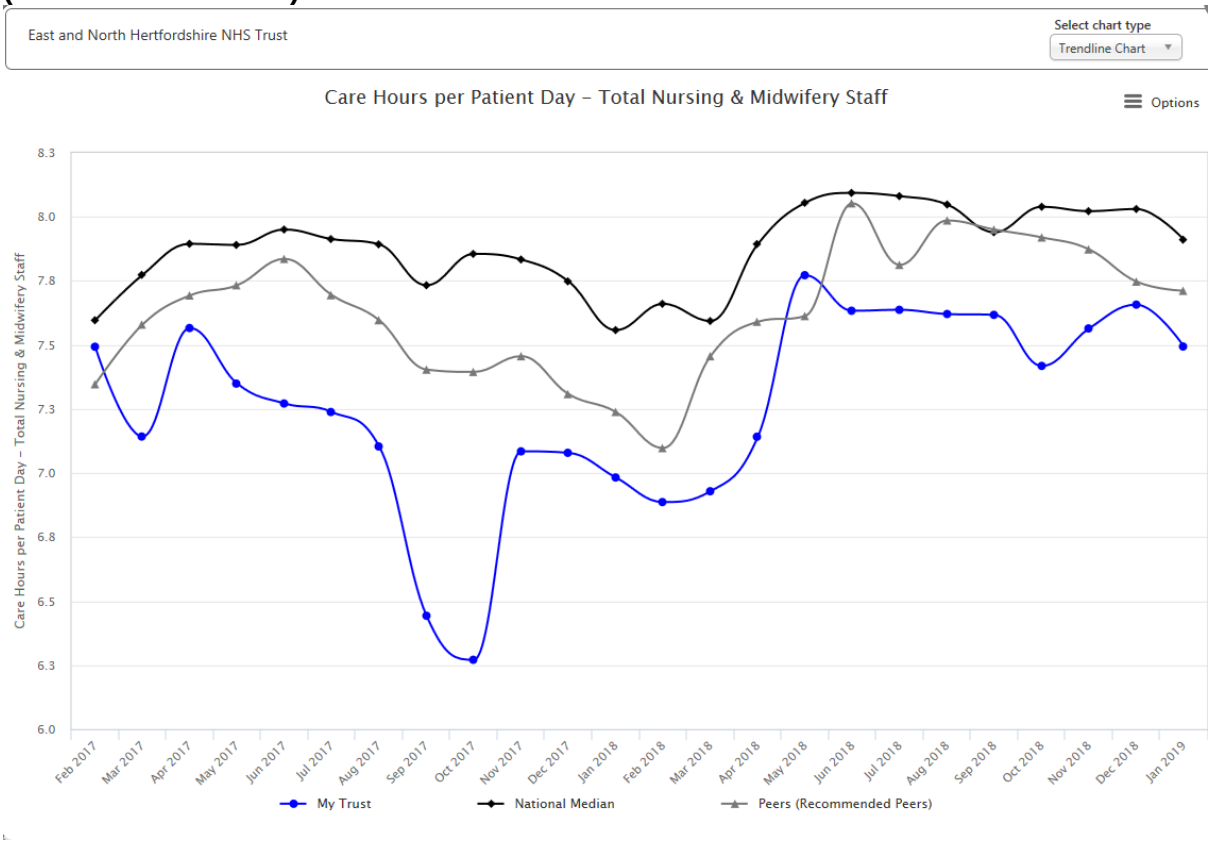
The Trust Average CHPPD for this month and last month can be seen in the table below. A full list of CHPPD by ward can be found in Appendix 3.

Table 2

	Average 24 Hr		
Trust Average CHPPD	**Registered**	**Care Staff**	**All Staff**
Trust Average (Current Month)	4.8	2.7	7.5
Trust Average (Last Month)	4.8	2.7	7.5
Change	0.0	0.0	0.0

The chart below shows the Trust average CHPDD alongside the National Median and our peer Trusts (as recommended by the Model Hospital dashboard). This data is reviewed at Trust and Ward level as shows that we are consistently delivering less care hours per patient day than the National Median and our Peers.

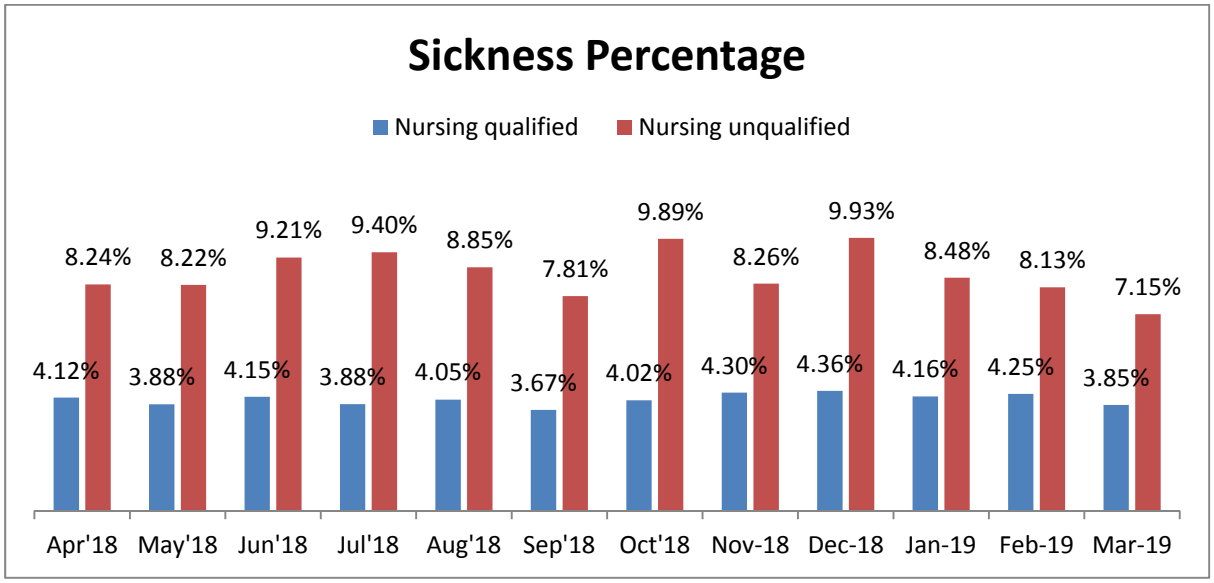
Chart 1 Care Hours per Patient Day (CHPPD): Data source Model Hospital Dashboard (latest available data).



3.3 Sickness

Chart 2 shows that sickness levels have decreased for both qualified and unqualified staff in March. There is ongoing work to address our above benchmark comparator sickness levels in our CSWs.

Chart 2 – Sickness Percentage by Staff Group



3.4 Enhanced Care

The Enhanced Nursing care team (ENCT) are a specialist substantive team who provide enhanced care, or 1-1 and are available 24 hours a day, seven days a week, ensuring that inpatients who are at risk to themselves or others are being effectively supported by specially trained staff to feel safe, secure and cared for at all times.
For the month of March 90 risk assessments were received by the team which is a decrease of 17 patients referred compared to February. Chart 3 shows that the patients referred to the team continue to remain high. The trust is seeing a higher acuity of patients and a higher number of patients requiring enhanced care support compared to 2016 as shown in chart. The team also support mental health patients who are referred by the RAID and CCAT teams that require 1-1 enhanced care. It should be noted that a number of patients requiring enhanced care specialling are also requiring support from our security teams. We are working with our colleagues in security to capture this data for future reports.
The team review all risk assessed patients on a daily basis and step the level of enhanced care up or down as required to provide a streamlined flexible service. The team continue to develop the service to ensure improved patient care and outcomes. Where demand exceeds capacity the shifts will be put out to temporary staffing to cover the requirement. Chart 4 shows the breakdown of care hours provided by the ENCT, NHS Professionals and Agency. The team has now become agency free and has not used any agency for enhanced care since December 2018. There continues to be robust check and challenge in place for all enhanced care a requirement, ensuring safe patient care is the main priority.

Chart 3

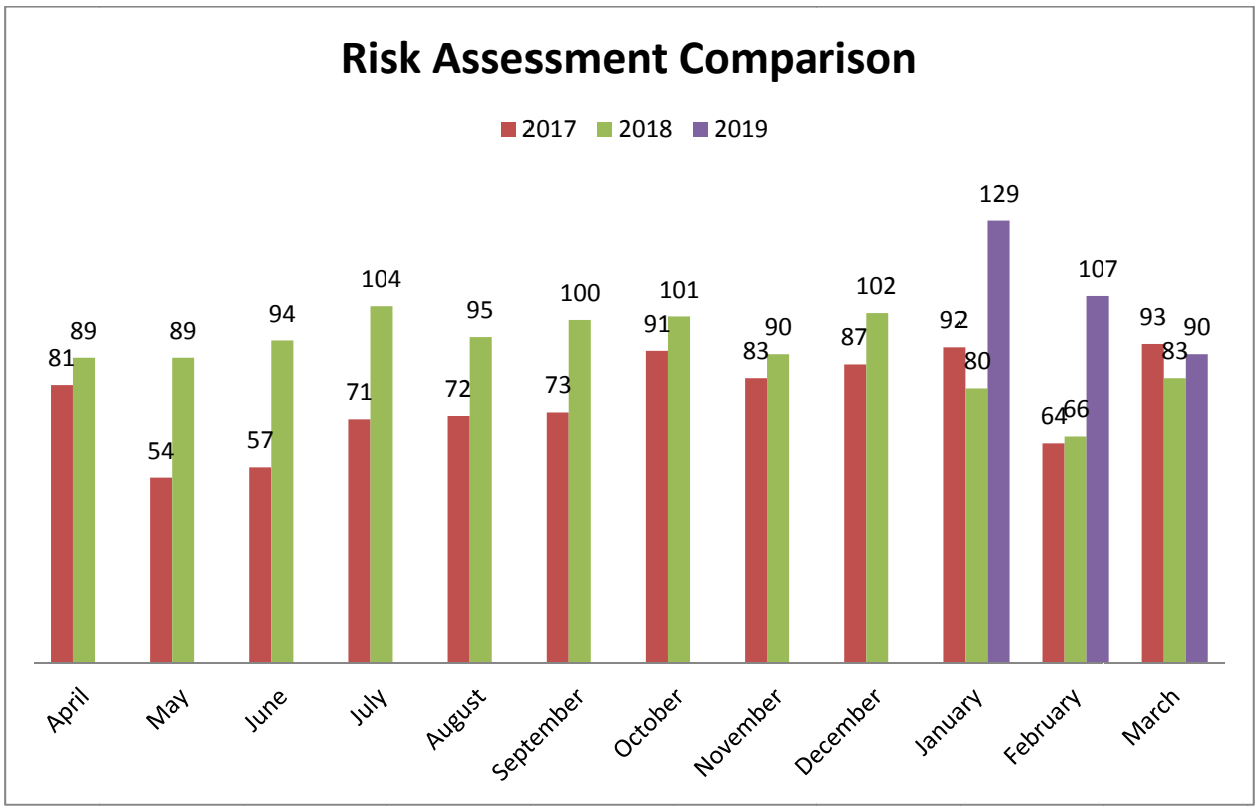
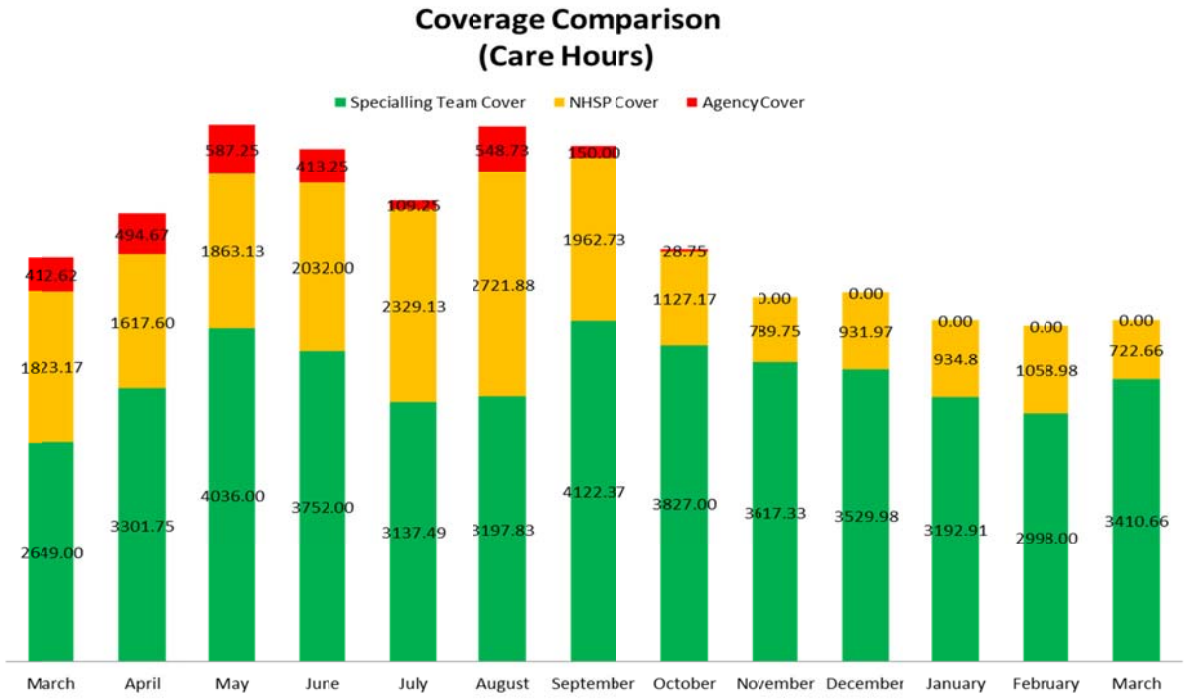


Chart 4



3.5 Recruitment and retention

March saw 9 WTE registered nurse new starters and 20.5 WTE leavers, giving a minus -11.4 for the month. This has resulted in a vacancy rate of 8.4%, an increase of 0.5% from February.
The vacancy rate for CSWs reduced in March by 0.1%, giving an overall vacancy rate of 12.2%. This equates to 79 WTE vacancies. In March there were 13.8 WTE starters and 11.1 leavers, giving a plus 2.7 WTE for the month.
The ongoing reduction in vacancy rate is largely because of the Trust broadening the pathways for new CSW's starting in the Trust.

4.0 Financial Sustainability

The Deputy Director of Nursing, all matrons, safer staffing team and heads of nursing meet monthly to prospectively review rosters to identify operational shortfalls and temporary staff requirements including agency usage/ requirements. Each ward is then RAG rated on a heat map and agency levels and restrictions agreed. Any additional ad hoc agency requirements outside of this meeting are authorised via the Director of Nursing or Deputy Director of Nursing.
Should a ward need to go above their planned agency usage a robust process is in place to be agreed by the director or deputy director of nursing.

To facilitate the reduction in agency costs, the trust have implemented a Rapid Response pool of nurses and CSWs. Bank staff get an enhanced pay rate in recognition of the workers commitment to be deployed at the time of reporting for work. The Rapid Response pool is used to mitigate daily staffing challenges such as sickness and short notice drop out to ensure wards are staffed safely. Agency spend in nursing and midwifery has reduced by 86% since March 2016**.**

4.1 Temporary Staffing Fill

Overall fill rate for temporary staffing increased by 0.3% from 67.7% in February to 69.4% in March. Demand hours increased by in excess of 7000 hours largely due annual leave at the top of the annual leave threshold (17% of staff on leave). The Trust's Winter Pressures Ward 7A closed on the 7th March, however we continued to open additional capacity areas on the Discharge Lounge and CDU B Bay to support operational pressures.
Bank fill rates increased by 1.65% and Agency fill rates decreased by 0.58%. The increase in demand resulted in 19,721 unfilled hours (23.8% of demand unfilled).

Table 3 Temporary Staffing Registered and Unregistered Hours Demand and Fill Rates

Last YTD Month & Year	Net Hours Requested *	NHSP Filled Hours	% NHSP Filled Hours	Agency Filled Hours	% Agency Filled Hours	Overall Fill Rate	Unfilled Hours	% Unfilled Hours
October 2018	74,919	47,137	62.9 %	10,961	14.6 %	77.5 %	16,822	22.5 %
November 2018	69,902	47,903	68.5 %	6,889	9.9 %	78.4 %	15,109	21.6 %
December 2018	68,088	44,686	65.6 %	6,090	8.9 %	74.6 %	17,312	25.4 %
January 2019	71,712	49,836	69.5 %	5,610	7.8 %	77.3 %	16,266	22.7 %
February 2019	75,662	51,225	67.7 %	5,602	7.4 %	75.1 %	18,836	24.9 %
March 2019	82,779	57,412	69.4 %	5,646	6.8 %	76.2 %	19,721	23.8 %

Chart 5 Nursing and Midwifery Temporary Staffing Demand and Fill Rates

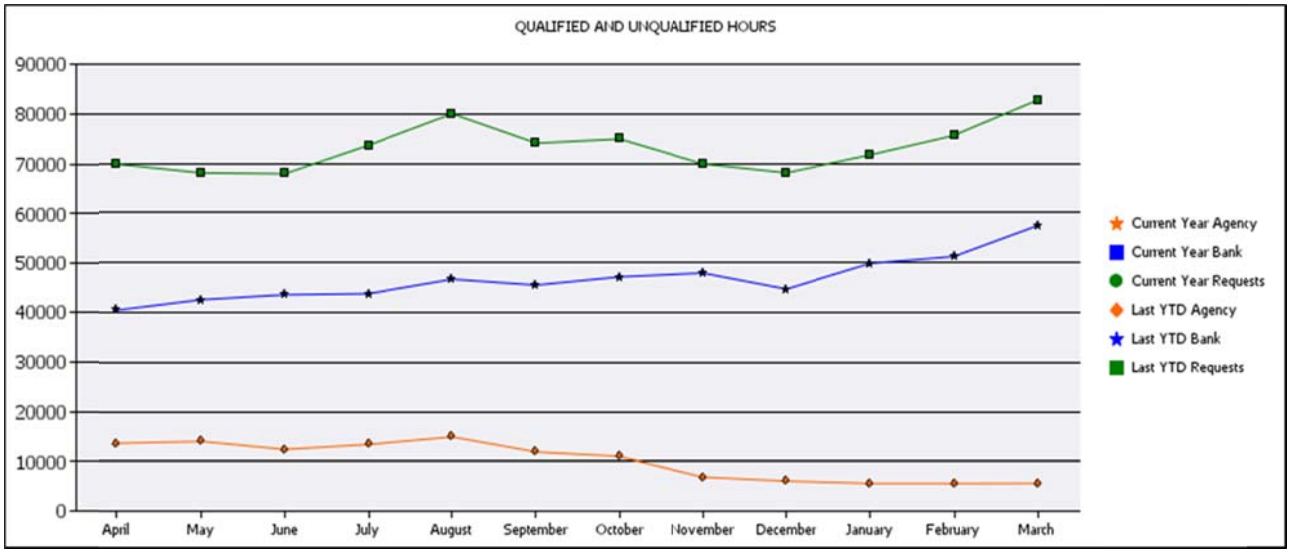


Table 4 Temporary Staffing Registered Hours Demand and Fill Rates

Last YTD Month & Year	Net Hours Requested *	NHSP Filled Hours	% NHSP Filled Hours	Agency Filled Hours	% Agency Filled Hours	Overall Fill Rate	Unfilled Hours	% Unfilled Hours
October 2018	46,510	28,209	60.7 %	8,608	18.5 %	79.2 %	9,692	20.8 %
November 2018	43,320	29,307	67.7 %	6,099	14.1 %	81.7 %	7,914	18.3 %
December 2018	41,716	25,679	61.6 %	6,001	14.4 %	75.9 %	10,035	24.1 %
January 2019	43,356	29,240	67.4 %	5,587	12.9 %	80.3 %	8,529	19.7 %
February 2019	47,080	31,169	66.2 %	5,596	11.9 %	78.1 %	10,315	21.9 %
March 2019	51,649	34,856	67.5 %	5,646	10.9 %	78.4 %	11,146	21.6 %

Table 5 Temporary Staffing Unregistered Hours Demand and Fill Rates

Last YTD Month & Year	Net Hours Requested *	NHSP Filled Hours	% NHSP Filled Hours	Agency Filled Hours	% Agency Filled Hours	Overall Fill Rate	Unfilled Hours	% Unfilled Hours
October 2018	28,410	18,928	66.6 %	2,352	8.3 %	74.9 %	7,130	25.1 %
November 2018	26,582	18,596	70.0 %	790	3.0 %	72.9 %	7,196	27.1 %
December 2018	26,372	19,007	72.1 %	88	0.3 %	72.4 %	7,277	27.6 %
January 2019	28,356	20,596	72.6 %	23	0.1 %	72.7 %	7,737	27.3 %
February 2019	28,583	20,056	70.2 %	5	0.0 %	70.2 %	8,521	29.8 %
March 2019	31,131	22,556	72.5 %	0	0.0 %	72.5 %	8,574	27.5 %

4.2 Roster KPIs

Table 6 shows the roster KPIs for the month of March as captured in the Nursing Quality Indicators Report. This shows that both the surgical and cancer wards were above threshold for Annual Leave. This had an impact on the unfilled shifts in March and put additional pressures on the wards. There is ongoing work with divisions to improve their roster KPIs and meetings have been arranged for roster improvement sessions with the director of nursing and the eRoster team.

Table 6 eRostering KPIs

SUMMARY		Trust	Medicine	Surgery	Women & Children	Cancer	Assessment Wards	Emergency Department	Dialysis
e-Roastering	% E-roster Deadline Met	36.51%	22.00%	41.25%	14.14%	33.00%	33.00%	66.00%	46.20%
	Net Hours %	0.48%	0.38%	0.34%	-0.40%	3.30%	0.00%	-0.45%	0.22%
	Net Hours Position	699.88	180.12	368.46	-168.87	174.18	0.43	83.68	61.88
	% of Actual Annual Leave	16.91%	15.17%	18.01%	16.54%	18.70%	16.10%	16.80%	17.06%

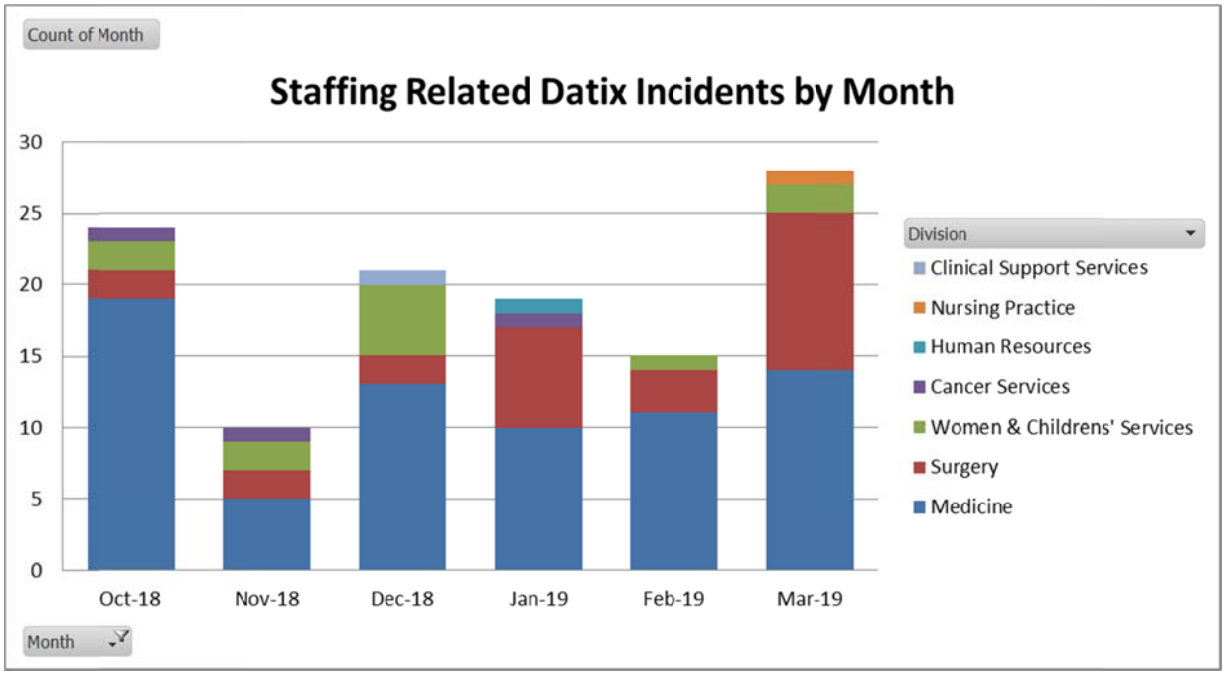
5.0 Investigations and actions on Incidents and red flag events

Shifts that fall below minimum staffing levels are escalated to the divisional staffing bleep holder who moves staff to balance risk across the division. Where the individual division is unable to mitigate independently this is escalated to the Divisional Heads of Nursing to balance risk across the organisation.

5.1 Datix Incidents

Chart 6 shows the number of staffing related Datix incidents logged in the last six month by speciality.
26 staffing related Datix were raised in March. All staffing related incidents are reviewed by the Safer Staffing Matron and DoN and actioned as appropriate. All Datix for March have been reviewed and actioned by the department managers.

Chart 6



5.2 Red Flag Events

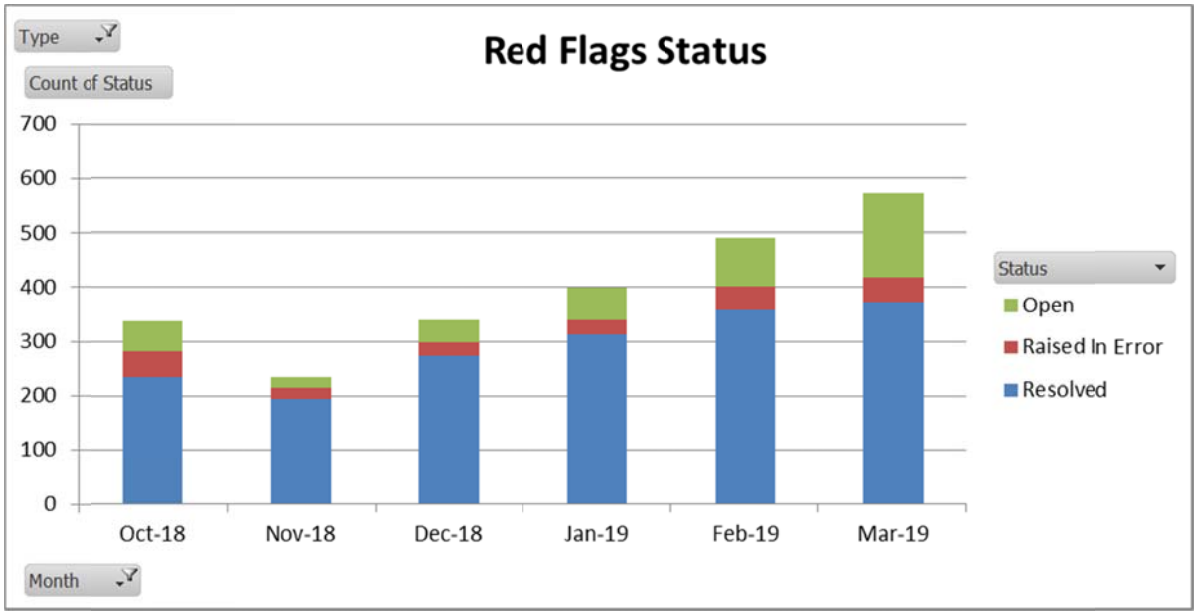
Red flags are NICE recommended nationally reportable events that require an immediate response from the Senior Nurse Team. "Red flag events" signal to the Senior Nurse Team an urgent need for review of the numbers of staff, skill mix and patient acuity and numbers. These events are considered as indicators of a ward requiring an intervention e.g. increasing staffing levels, facilitating patient discharge or closing to admissions for a temporary period following discussion and agreement with the operations centre and the executive on call.

Red flag notifications are completed in SafeCare and sent to a centralised staffing e-mail address. These notifications are then escalated at each of the three daily staffing meetings and closed once actions to mitigate are in place. The nurse in charge of the ward will try to resolve Red Flags with the help of the Divisional bleep holders who will act on escalated 'open' issues to help resolve them. Feedback from the wards has found the red flags are appropriate to the staffing challenges they need to escalate on a shift.

The Safer Staffing Team commenced work with the Maternity Services Team at the end of January and has set up Red Flag Events: signs that there may not be enough midwives available as per NICE guidance. The midwife in charge can now record red flag events and the action taken as a result using SafeCare. See **Appendix 4** for the Midwifery safe staffing update.

Chart 7 below shows the number of red flags raised each month over the last 6 months and their status excluding Maternity Red Flags. .

Chart 7



6.0 Patient outcomes

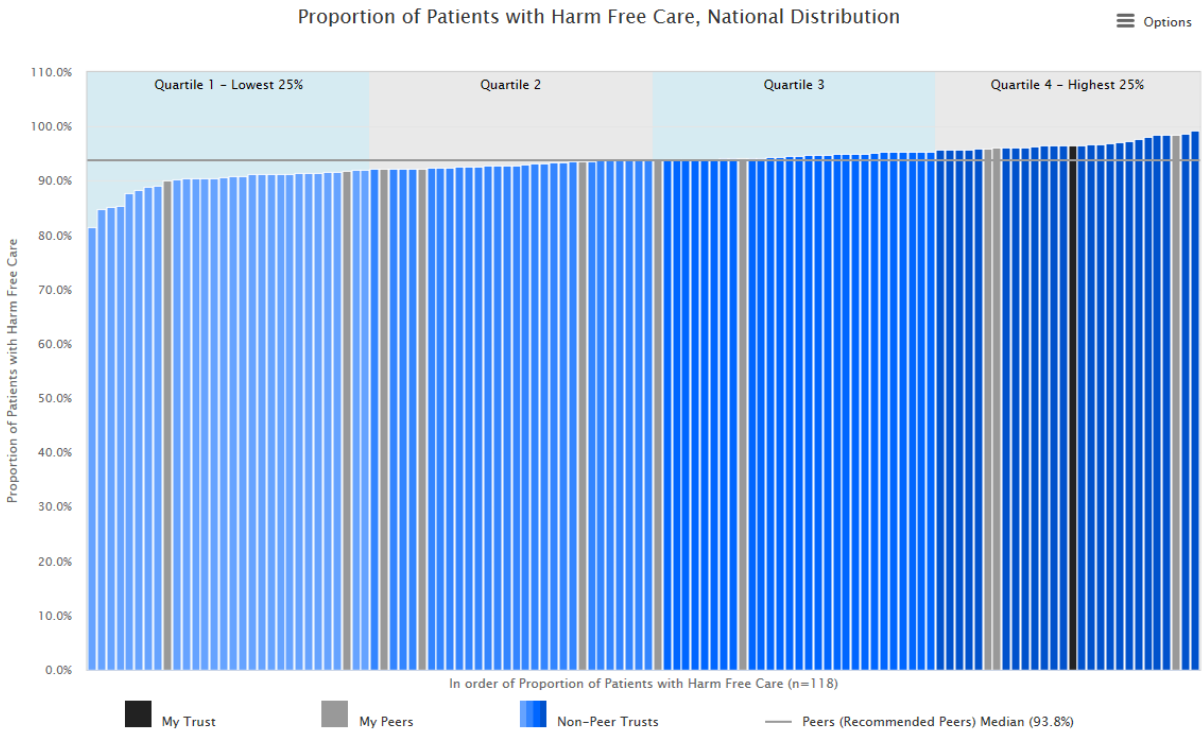
The Safer Staffing Team continues to monitor staffing at the three Daily Staffing meetings and weekly staffing look ahead meetings. Daily site safety meetings give a site overview of current issues and concerns relating to capacity, quality, patient care and safety concerns. This supports multi-professional informed decision making across the day. In addition to this there is a weekly look ahead meeting to ensure early mitigation / shift changes are agreed to pro-actively cover shortfalls.

6.1 Safety Thermometer

The NHS Safety Thermometer audit provides a 'temperature check' on levels of harm and enables the measurement of 'harm free care'. Harm free care is defined by the absence of pressure ulcers, harm from a fall, urine infection (in patients with a catheter) and new VTE. This report details the number of patients 'with harm' on the specified audit date – 13 March 2019. We acknowledge that the 'harm' may not have occurred on the ward that it is captured on and therefore encourage all wards/Divisions to discuss

the root cause analysis of all harms across Divisions. Chart 8 shows the benchmarking data from the NHSI model hospital dashboard. As a trust we are in the top quartile for harm free care.

Chart 8 Proportion of Patient with Harm Free Care (Feb 2019)



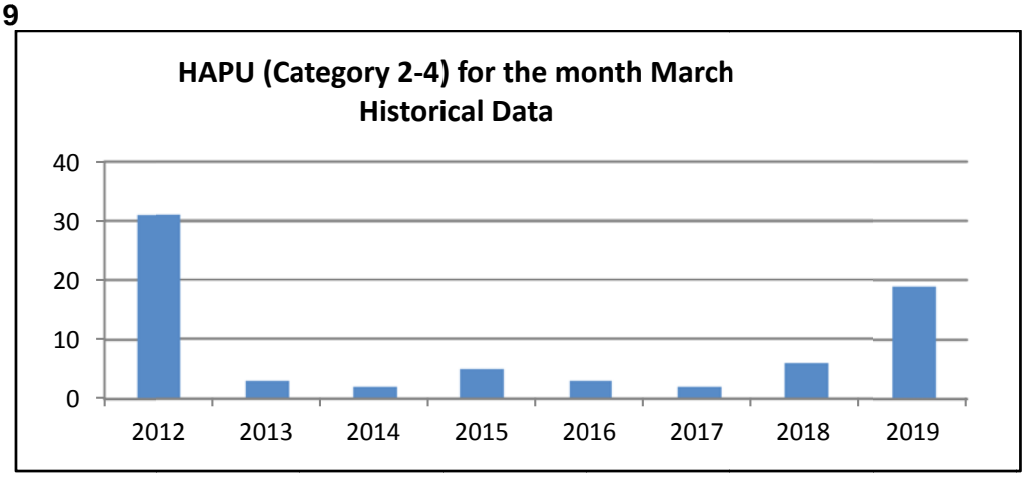
6.2 Falls

69 inpatient falls were recorded in the Trust during March which is a decrease of 5 incidents when compared to February. During 2018/19, 832 inpatient falls were recorded in the Trust which is 27 incidents lower than 2017/18. This equates to a 3.14% decrease in falls our target for 2018/19 was to achieve a 2.5% annual decrease. There is ongoing work to continue to improve our Falls, with the promotion of the Bay watch initiative.

6.3 Pressure Ulcers

For the month of March there were 19 new pressure ulcers (all categories). In compliance with the new NHSI Pressure ulcer (PU) recommendations suspected deep tissue injury (SDTI) numbers are now incorporated into main reporting figures.
March 2019 figure incorporates all categories of damage where 2012-2017 only counts category 2-4 and unstageable ulcers shown in Chart 9.

Chart 9



7.0 Patient, carer and staff feedback in relation to safe staffing levels

The trust asks the question within our Inpatient survey 'In your opinion, were there enough nurses on duty to care for you in hospital?' In March 2019 there were 1,030 inpatient surveys completed Table 7 shows the % responses to that question:

Table 7

Ward	Enough nurses
10AN	95
10B	75
11A	91
11B	99
5A	56
5B	71
6A	79
6B	68
7B	79
8A	63
8B	76
9A	82
9B	81
Acute Cardiac Unit (ACU)	85
AMU - Blue	73
AMU - Green	81
Ashwell	82
Barley	93
Bluebell	90
MVCC Ward 10/11	91
Pirton	95
SSU	57
Swift Ward	96
Total	**82**

7.1 Friends and Family

Table 8 shows the results for the friends and family test for the past 3 months. The percentage of patients that would recommend our trust for the month of March has decreased slightly from January.

Table 8

Summary of the last three months responses is shown below:

Month	% Would Recommend	% Would Not Recommend	No. of patients responding	% response rate [target 40%]
January 2019	97.28	0.33	2094	41.18
February 2019	96.76	0.39	1791	41.11
March 2019	96.82	0.69	1889	41.29

8.0 Recommendations

- Note the information on the nurse and midwifery staffing and the impact on quality and patient safety
- Note the content of the report and that mitigation is put in place where staffing levels are below planned.
- Note the content of the report is undertaken following national guidelines using research and evidence based tools and professional judgement to ensure staffing is linked to patient safety and quality outcomes.

References

Letter from Chief Nursing Officer (NHS England) to Chief Executives of Health Education England and NHS England, dated 3 June 2015

NQB (2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – Safe sustainable and productive staffing.

Appendix 1

	Day		Night	
Ward name	**Average fill rate + registered nurses/midwives (%)**	**Average fill rate + care staff (%)**	**Average fill rate + registered nurses/midwives (%)**	**Average fill rate + care staff (%)**
10B	95.5%	101.7%	95.3%	119.1%
11A	96.3%	102.5%	97.1%	115.0%
11B	90.6%	90.3%	100.7%	100.0%
5A	96.7%	84.0%	93.7%	102.4%
5B	92.9%	99.5%	96.6%	127.1%
6A	98.6%	94.9%	97.6%	130.5%
6B	93.6%	94.3%	98.6%	123.9%
10A Gynae	103.8%	72.9%	99.5%	100.0%
7B	98.0%	90.5%	95.4%	98.9%
7A	95.2%	103.9%	92.3%	121.4%
8A	95.4%	85.1%	96.3%	102.7%
8B	96.3%	82.6%	93.9%	104.4%
9A	101.5%	107.6%	94.1%	139.4%
9B	103.0%	88.6%	98.3%	114.5%
ACU	95.5%	86.3%	90.2%	105.5%
AMU-A	94.5%	88.2%	90.7%	101.4%
AMU-W	101.3%	101.8%	96.9%	115.8%
Ashwell	99.5%	94.2%	101.3%	125.0%
Barley	101.3%	92.9%	98.4%	124.8%
Bluebell	97.9%	80.2%	97.2%	78.1%
Critical Care 1	100.0%	100.0%	100.0%	100.0%
Dacre	93.5%	80.2%	98.0%	N/A
Gloucester	95.0%	66.5%	98.0%	89.9%
Mat CLU 1	97.0%	75.7%	93.1%	87.2%
Mat MLU	88.0%	80.8%	90.2%	89.1%
Pirton	83.2%	100.8%	96.3%	103.7%
SAU	93.8%	103.9%	96.7%	99.1%
SSU	100.7%	85.8%	99.9%	101.0%
Swift	87.4%	87.9%	100.2%	86.4%
Ward 11	60.6%	58.2%	71.3%	94.1%
Total	**94.2%**	**88.5%**	**95.2%**	**106.7%**

Appendix 2

Ward Staffing Exception Report

Wards with a Registered fill rate <90%, and wards where the planned staffing differs from actual.

Ward	Comment
7A	Ward 7A closed on the 7th March. Substantive staff were deployed back to their home ward or reassigned to an alternative ward with vacancies.
MLU	Low occupancy in month, staffing flexed across the Maternity Service to meet patient needs.
Pirton	Reduced occupancy in month, staff redeployed from Pirton to support safe staffing.
Swift	Reduced occupancy in month, staff redeployed from Pirton to support safe staffing.
Ward 11	Reduced occupancy in month, staffing flexed across the Cancer Services Division to support safe staffing.
Critical Care	Critical care noted an increase in the acuity in patients over the month of March. The increased acuity and vacancy levels resulted in the temporary reduction of beds to support safe staffing within the unit. Work is ongoing to source long line Agency Nurses with Critical Care skills.

Appendix 3

Ward name	Care Hours Per Patient Day (CHPPD)		
	Registered midwives/ nurses	Care Staff	Overall
10B	3.15	2.56	5.70
11A	3.93	2.00	5.93
11B	3.89	2.84	6.73
5A	3.11	2.25	5.36
5B	3.35	3.05	6.40
6A	3.21	2.72	5.92
6B	4.31	2.20	6.50
10A Gynae	5.67	2.41	8.08
7B	3.07	2.14	5.21
7A	4.65	4.08	8.73
8A	3.08	2.05	5.12
8B	3.16	1.78	4.94
9A	2.96	2.72	5.68
9B	3.05	2.20	5.24
ACU	4.42	2.28	6.70
AMU-A	5.55	3.43	8.97
AMU-W	4.16	3.58	7.75
Ashwell	3.89	3.25	7.14
Barley	3.65	2.94	6.59
Bluebell	8.26	3.37	11.63
Critical Care 1	16.29	1.94	18.23
Dacre	7.23	0.97	8.19
Gloucester	4.90	3.86	8.76
Mat CLU 1	30.90	5.96	36.86
Mat MLU	37.05	11.21	48.27
Pirton	4.65	2.70	7.34
SAU	7.56	3.83	11.38
SSU	3.55	2.93	6.48
Swift	4.19	2.57	6.76
Ward 11	5.75	3.48	9.23
Total	**4.8**	**2.7**	**7.5**

Appendix 4

Maternity Services Safer Staffing Report March 2019

Review of Midwifery Establishment NICE recommends that maternity units undertake a systematic process to calculate the midwifery-staffing establishment. Birthrate Plus has undertaken a workforce analysis and the results will be available next month.

Monthly Staffing Demand and Capacity

Funded Clinical Establishment supports an annual ratio of 1 midwife to 29 women (includes band 3 and 4 staff that support postnatal care). Ratios will vary month on month due to variations in birth numbers as the funded establishment supports all maternity activity both hospital and community care.

April to include Birthrate Plus Workforce Analysis Report results and an action plan

	January		February		March		April	
Midwives	175.26		175.26		175.26		175.26	
Band 3-4 Postnatal	10.52		10.52		10.52		10.52	
Total Funded Clinical	**185.78**		**185.78**		**185.78**			
Actual Worked	**185.74**		**183.29**		**189.18**			
	Births	**Ratios**	**Births**	**Ratios**	**Births**	**Ratios**	**Births**	**Ratios**
Predicted Births in month based on number of women EDD 4 months' time against funded* Clinical Establishment	478	30	412	29	428	27	440	29
12 Month Rolling Year to Date Against Funded Midwifery Establishment	5468	31	5396	31	5384	30		
Actual Births in Month against actual worked in month midwives	453	32	377	28	439	29		

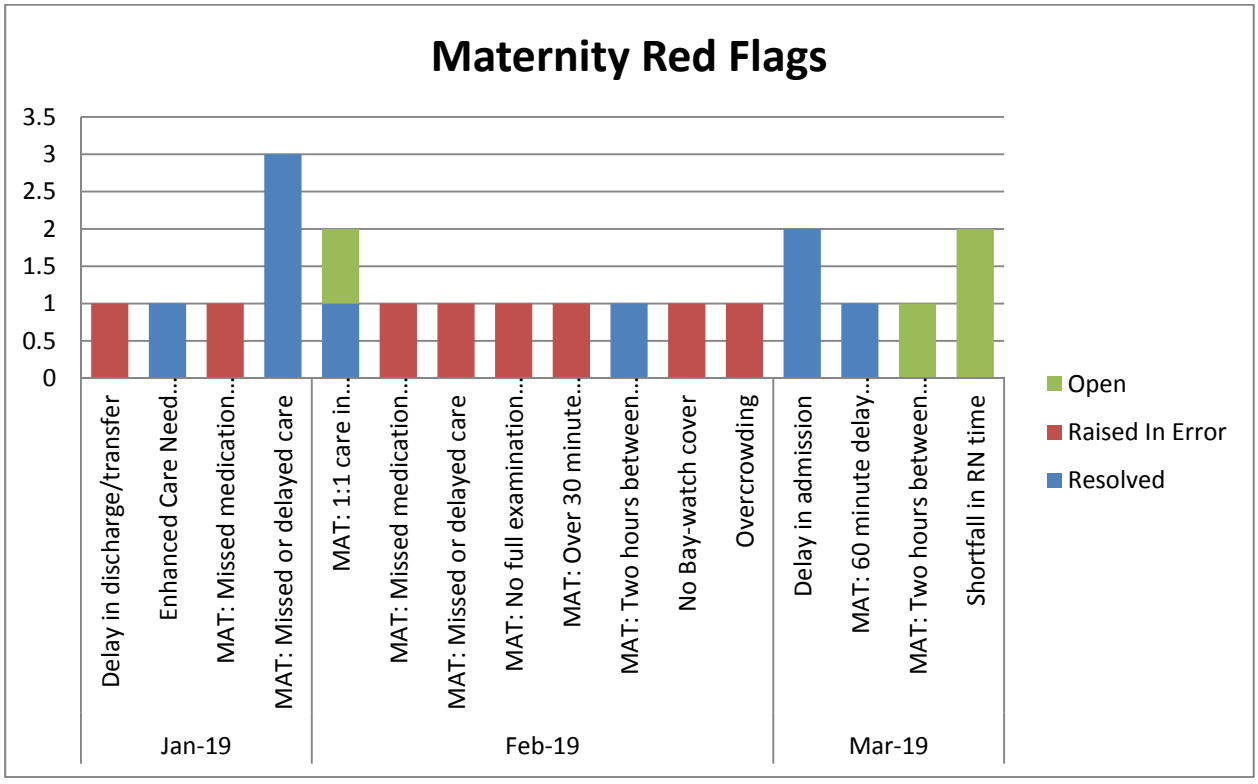
Midwifery red flag events

NICE Safe midwifery staffing for maternity settings 2015 defines Red Flag events as negative events that are immediate signs that something is wrong and action is needed now to stop the situation getting worse. Action includes escalation to the senior midwife in charge of the service and the response may include allocating additional staff to the ward or unit.

Red Flags are captured as part of the role of the manager of the day and the capture of red flags by the Senior Midwife on the shift on SafeCare from January 2019 will support this process. Further analysis of red flag events in Maternity will be available in future months once SafeCare training has been rolled out across the service.

The Red Flags as recommended by NICE are as follows

Missed medication during an admission
Delay of more than 30 minutes in providing pain relief
Delay of 30 minutes or more between presentation and triage
Delay of 60 minutes or more between delivery and commencing suturing
Full clinical examination not carried out when presenting in labour
Delay of two hours or more between admission for IOL and commencing the IOL process
Delayed recognition/ action of abnormal observations as per OEWS
1:1 care in established labour not provided to a woman



East and North Hertfordshire NHS Trust

Agenda Item: 16.1

TRUST BOARD - PUBLIC SESSION – 1 MAY 2019
CHARITY TRUSTEE COMMITTEE – 11 MARCH 2019
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present to the Trust Board the summary report from Charity Trustee Committee (CTC) meeting of 11 March 2019. The report includes details of any decisions made by the CTC under delegated authority.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of CTC	**Presented by:** NED member of CTC (in the absence of the CTC Chairman)	**Author:** Trust Secretary

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☐
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☐
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☐
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☐
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☐

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) N/A
Any other risk issues (quality, safety, financial, HR, legal, equality):

Proud to deliver high-quality, compassionate care to our community

CHARITY TRUSTEE COMMITTEE MEETING HELD 11 MARCH 2019

SUMMARY REPORT TO BOARD

The following members were present: Bob Niven (Committee Chairman), David Buckle (Associate Non-executive Director), Val Moore (Non-Executive Director) and Rachael Corser (Director of Nursing)

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:

Approvals for expenditure over £5,000
The Committee discussed a range of approvals for expenditure both under £5,000 and over £5,000. The Committee also discussed suggested fundraising projects. The following expenditures and fundraising projects were approved:

Expenditure over £5,000

- (Cancer division) Scalp Coolers x4 - £28,000 in total
- (W&C division) Magic Floor x2 - £15,335
- (Medicine division) Omni Projector - £5,070
- (Cancer division) New chairs for outpatients in MVCC – £3,000 (the Committee agreed that this was an exceptional case)
- (Medicine division) Benefit advisor role - £6,200
- (W&C division) Focused Course in Early Pregnancy Ultrasound training - £1,534 (note: this application was considered by CTC rather than the Charity Management Team due to the timing of the meetings)
- (W&C division) Focused Course in Early Pregnancy Ultrasound training Fay Clark, Matron for Gynaecology - £2,020 (note: this application was considered by CTC rather than the Charity Management Team due to the timing of the meetings)
- (Nursing) Nursing and Midwifery Excellence Framework – £40,000 (This was agreed in principle pending further details)
- (Medicine division) Rheumatology probe - £15,445
- (Cancer division) Schwartz rounds at Lister – £14,480
- (Cancer division) volunteering at MVCC - £101,290

Proposed Fundraising projects
The following proposals were agreed in principle subject to further scrutiny and business cases where relevant:

- (Cancer division) Scalp Coolers x5 - £35,000 in total
- (Surgery division) da Vinci SP – £500,000 (this is currently with NICE for approval)
- (W&C division) Foetal echo cardiogram – £65,000
- (W&C division) Birthing pool for CLU – £20,000
- (Cancer division) Expansion to volunteering service at MVCC – £270,000

The Committee also considered a proposal regarding Chart Lodge. The proposal was in relation to the transfer of funds from the Mount Vernon Post Graduate Medical Centre (a separate charity) to East and North Herts Hospitals Charity for 'the treatment of cancer patients at Mount Vernon, including, but not restricted to those patients treated at chart lodge'. On accepting these funds, the Trust and Charity would agree that any ongoing running costs of Chart Lodge would not be the

obligation of the Charity, and will continue to be the responsibility of East and North Herts NHS Trust. Overall this would be cost neutral. The CTC supported the proposal in principle and agreed that the next step would be to write to the Mount Vernon Post Graduate Medical Centre outlining the terms.

Other outcomes:

Investment Portfolio Update

The CTC received an update from the investment advisors (Rathbones) regarding the Charity's investment portfolio. Since 31 August 2018, the portfolio had underperformed its benchmark in relative terms, returning -3.4% versus the benchmark of -2.7%. Since the Trust had first moved its investments to Rathbones in 2016, the fund had slightly over performed the benchmark (returning 14.9% versus the benchmark return of 14.5%). The Committee discussed the balance of investments by market area, including the balance between Japanese and American stocks. The Committee also discussed the potential impact of the UK's EU Exit on the Charity's investments.

Divisional Fund Management Report – Women and Children's Services

The Woman & Children's divisional fund management report was presented by the general manager. Key points to note included:

- The Bancroft gardens had been installed and were scheduled to open in May.
- A charitable fund had been raised for charitable expenditure relating to the big build project for the construction of a neonatal unit. Fundraising would continue over the year.
- Funds would be used for the imminent purchase of magic floors for children's ED and Bramble ward.
- Charitable funding would be used to purchase training equipment relating to urogynaecology.

Investment Policy

The CTC received a draft investment policy which had been updated based on comments at the previous meeting. The purpose of the policy was to facilitate the effective management of the Charity funds, whether these are invested or held as liquid assets, to achieve the objectives of the Charity in the immediate and longer term future in conjunction with the identification and understanding of the risks. The policy detailed investment areas subject to restrictions on an ethical basis and the agreed ranges for each class of asset allocation. The policy was recommended to the Board as Corporate Trustees for approval. The policy is attached as Appendix 1.

Charity Strategy Progress Update

The Head of Charity provided an update on progress with the Charity strategy. The report detailed charity performance in terms of income, brand awareness, key achievements and progress against the strategy's KPIs. Analysis against performance from the past 6 years showed the Charity at Month 10 had achieved:

- The largest year on year uplift of fundraised income in 6 years
- The largest fundraised income in 6 years
- The lowest cost of fundraising staff salary as a percentage of funds raised (excluding legacies)

Other key achievements included an increase in collection tin income year on year and the launch of the new website, which was achieving good visitor numbers. The Committee discussed the staff lottery and plans to increase income received from that route and the process for engagement with those making donations through the website.

Charity Finance Report

The CTC considered the report which provided an update on the financial performance of the Charity to the end of February 2019. As at 28 February the Charity was reporting a £22k adverse variance to plan. Income was below the initial plan but in line with the

reforecast submitted in December to take account of delay in fully recruiting to the Charity team. Some capital plan items had been moved to 2019/20. The Committee discussed delays with raising purchase orders. It was agreed that further work with finance colleagues would need to take place to address these issues.

Budget Forecast 2019/20

The CTC received the budget forecast which outlined the Charity's income and expenditure plan for 2019/20. The Charity was continuing to deliver against the strategy objective to increase income to £3m by March 2021. Significant changes to how income is generated were made in 2018/19 alongside phase one a recruitment plan. Those changes would be consolidated in 2019/20. The proposed budget included staffing changes and costs had been planned to ensure that they continued to total less than 25% of planned income. The Committee endorsed the Budget 2019/20 for approval. The Budget is attached as Appendix 2.

Management of Charitable Funds Policy

The Committee considered a policy regarding the management of charitable funds. The purpose of the policy was to provide clear guidance on how Charitable Funds were to be manged within the Trust, especially procedures around income and expenditure. The policy would replace all existing policies and was supported by a detailed procedure document. The policy included the definition of charitable purpose, defined roles and responsibilities and delegated authorities and revised criteria for approving charitable spend. It was agreed that the policy would need to be revised to specify the value at which approval of funding would need to be taken by the Trust Board as Corporate Trustees (£500,000 and above). Subject to this amendment, the CTC recommended the policy for approval by the Trust Board. The policy is attached as Appendix 3.

New Website Demonstration

The CTC received a demonstration of the new Charity website. The website can be accessed via the following link: https://www.enhhcharity.org.uk/

Bob Niven
CTC Chair

May 2019

East and North Hertfordshire NHS Trust

Trust-wide Policy

For

Investment of Charitable Funds

A document recommended for use

In: The Trust's Associated Charity

By: **All Directors, managers and staff with involvement**

For: Investment of the Charity's resources

Key Words: Charity, Investment, Funds, Trust

Written by: Financial Controller

Supported by: {Name/s of supporter/s as necessary}
{Designation/s and Specialty/ies}

Approved by: **Charitable Trustees Committee**

…… Chairman

…… Date

Ratified by: Trust Board

…… Chairman

…… Date

Document issued: {Date of issue}

To be reviewed before: {Review by date}

To be reviewed by: {Designation of person to carry out review}

Document Registration No. CFund01 **Version No.** 2

Version	Date	Comment
1	2012	Although termed a 'Policy' this did not incorporate all the requirements
2	2019	Re-written in line with current investment strategy
etc		

Equality Impact Assessment
This document has been reviewed in line with the Trust's Equality Impact Assessment guidance and no detriment was identified. This policy applies to all regardless of protected characteristic - age, sex, disability, gender-re-assignment, race, religion/belief, sexual orientation, marriage/civil partnership and pregnancy and maternity.

Dissemination and Access
This document can only be considered valid when viewed via the East & North Hertfordshire NHS Trust Knowledge Centre. If this document is printed in hard copy, or saved at another location, you must check that it matches the version on the Knowledge Centre.

Associated Documentation
Standing Orders, Standing Financial Instructions and Scheme of Delegation

Review
This document will be reviewed within three years of issue, or sooner in light of new evidence.

Key Messages
- The resources of the Charity should be utilised in the best way to support the Charity's objectives
- The resources of the Charity need to be invested to achieve the best return for the Charity
- The Charity's resources should be protected to provide future benefits for the patients of East and North Herts NHS Trust
- Investment of the Charity's resources will be in line with the objectives above

1. INTRODUCTION

This Policy covers the investment strategy for the Trust's Charitable Funds.

The Trustees of the East and North Hertfordshire NHS Trust Charitable Fund (Charity number 1053338) (the Charity) are the Trust Board of the East and North Hertfordshire NHS Trust (the Trust). The Health Services Act 1977, section 93, gives NHS bodies the authority to hold charitable funds, which are derived from donations, legacies and investment returns. The Charity's objectives are to utilise the charitable funds for the benefit of the National Health Service, wholly or mainly for the services provided by the Trust, rather than accumulate funds with which to achieve investment returns.

As well as being governed by the statutory duties under the NHS Acts, as NHS trustees, the Trust must comply with the relevant Charities Acts and guidance.

Under the Trustee Act 2000, it is a legal requirement that, if the investment function is delegated to an Investment Manager, as in the case of the Charity, the Trustees must have a written investment policy which is kept formally under review.

2. SCOPE

This Policy applies to the investment of all funds of the Charity, which at 31st March 2018 totalled £3.4m. This covers the longer-term funds which are invested through an Investment Manager of £2.6m of the total above, plus the liquid cash resources of £0.8m.

The Policy covers the investment of all funds, whether or not they are intended for a restricted purpose.

3. PURPOSE

The purpose of this Policy is to facilitate the effective management of the funds, whether these are invested or held as liquid assets, to achieve the objectives of the Charity in the immediate and longer term in conjunction with the identification and understanding of the risks of the Charity.

The Trustees and Investment Managers have a duty to apply funds for the purposes outlined in the Charity's Governing documents and that the Charity Commissioners consider that a failure to give consideration to the spending of funds and to simply allow them to accumulate without good reason is a breach of trust.

4. DEFINITIONS

The Charity: the East and North Hertfordshire NHS Charitable Fund, registered charity number 1053338, a separate legal entity from East and North Hertfordshire NHS Trust.

Trustee: Charity Trustees are responsible for the general control and management of the administration of the Charity. The Charity has a corporate trustee - the Board of the Trust, which was appointed under the NHS and Community Care Act 1990.

Investment Manager: an individual or corporate body appointed by the Charity's Trustees to advise and make investment decisions on behalf of the Charity.

Charitable Trustees Committee: a sub-committee of the Board whose responsibility it is to oversee the management of Charitable Funds.

Common Investment Fund: an arrangement whereby the monies invested by a number of charities is pooled and invested in a range of investments in accordance with the published policy of the scheme. The size of each share is determined by the number of 'units' each contributor owns and investment returns (or losses) are allocated in the same proportion.

'Umbrella' Charity: a charity registered under a single name and number under which several funds are held and administered. These funds may have separate purposes and objectives and the balance will be managed by different fund holders. Income and expenditure is allocated to these fund balances individually, whereas investment returns will be allocated in proportion to the fund balances held.

Volatility of returns: there is a link between the rate of return that can be expected on an investment and the risk inherent in that type of investment. This is separate from the systemic or market rate of return, where a whole class of investments will be affected by an upturn or downturn in the market caused by macro-economic trends. The more risky an investment is seen to be, the higher the return that would be expected to be achieved. However, there is also the potential for large losses on this type of investment, where safer investments would have much lower rates of returns. This link between levels of risk and the rate of returns is known as the volatility of returns.

5. DUTIES

The Board – The Board as corporate Trustee of the Charity has the overall responsibility for setting the investment policy for the Charity through setting an overarching set of objectives that need to be taken into account when deciding on specific investment allocations. It is responsible for appointing the Investment Manager. The Board has delegated the responsibility for monitoring and making amendments to the portfolio of investments to meet the overarching objectives to the Charitable Trustees Committee.

Charitable Trustees Committee – the Committee has the responsibility to monitor performance of the portfolio of investments through the receipt and review of reports from the Investment Manager. The Investment Manager will attend CTC as required from their engagement and provide reports on performance to each quarterly CTC. They will give members the opportunity to raise questions about the performance of the investments and the appropriateness of moving investments into other areas. The Committee will update the Board with regard to significant changes or issues with performance of the investments.

Investment Manager – the Investment Managers appointed will be responsible or investing the available funds as far as possible to fulfil the investment objectives laid out below. They will provide quarterly reports to the CTC. They will take into account any concerns raised by the Committee in the allocation or performance of the funds. They will take into account the Trustees' stance on ethical investment.

Trust finance staff – The Trust, through its finance staff, carries out the financial administration of the Charity. It is their responsibility to ensure that the Charity keeps accurate records of the investments and properly accounts for investment returns and movements in the value of investments.

6. INVESTMENT STRATEGY

a) Investment Objectives

As stated above, it is not the Trustees' primary aim to accumulate funds and the investment strategy set out below is written with this in mind. Accordingly, a portion of the total funds will be held back as short term monies or working capital (assets which are capable of being released to generate cash quickly, or cash) with the rest constituting the investible portfolio (long-term monies), which is the subject of this policy paper, being invested.

The Trustees' objectives are:

- To maintain the value of the capital, excluding that for unusual capital projects that may require one-off reductions in investment capital, in real terms over the long term (5+ years). Capital losses over that term may be temporary but will be rarely on a permanent basis. (Medium risk profile).

- To realise capital gains i.e. returns on the investments achieved, only when there is a bona fide charitable purpose for them.

- To reinvest capital gains where no immediate charitable purpose exists.

- To receive dividends and interest from the investments as income to the charity and utilise it as such.

- To take normal charitable expenditure from ongoing donations and interest from investments that is surplus to administrative expenditure.

- To fund unusual major capital projects on a case-by-case basis from one-off reductions in investment capital.

- To hold, as liquid resources, a minimum of three months of anticipated charitable expenditure to prevent the unplanned requirement to liquidate investments. However, the Investment Managers have the discretion to increase the liquid element of the portfolio if market conditions should so dictate.

Subject to the recommendations of our independent adviser, the funds will be invested on a discretionary basis in the purchase of pooled funds, ordinarily Common Investment Funds (CIFs) or others where they are not available. Given that the Charity is an 'Umbrella' charity, the use of pooled funds is seen as an appropriate form of investment, rather than the specific investment of individual funds to achieve, for example, a return over a lifetime of a project.
The investment principles of the Trustees are to ensure:

a) A balance between income (interest or dividends) and capital growth whilst adopting an appropriate medium risk profile, accepting that this will impose a degree of volatility in performance.

b) The maintenance of the 'real' value of the capital within the portfolio after allowing for the effects of inflation but before any strategic change in historic expenditure levels.

c) That they are prepared to realise capital gains if achieved and if there is a bona fide charitable purpose for them.

d) An income between £65,000 and £80,000 p.a. from the portfolio, which is currently equivalent to a yield of approximately 2.5% - 3%.

e) That the administrative burden on the Trustees is kept to an acceptable minimum.

f) That they receive independent professional advice on the set up and monitoring of the performance of the investments.

b) Risk Profile and asset allocation

The Trustees are bound by the rules for Charities on investments and have adopted a strategy, which avoids speculation and high risk, while accepting *a reasonable degree of volatility of returns* . They will spread the investments over a number of different classes such as UK Equities, Overseas Equities, Bonds, Property and cash and have agreed to limit the exposure to non-traditional assets such as hedge funds and absolute return funds, subject to clear restrictions.

The Trustees will define a range for each asset class as set out in annex 1. The Investment Manager will provide regular information on the actual allocation within each class. Movements outside of the range will need to be explicitly approved by the Trustees.

c) Ethical Considerations

The Trustees have considered whether to impose any ethical restriction on the investment of the Charity's assets by their Investment Managers and are mindful that their primary duty is to seek the best returns within the limits of the overall investment policy.

The Trustees have decided to avoid direct investment in certain types of stocks and to this end they will specifically avoid direct investments in stocks adverse to health.

The Trustees do not wish to invest in companies connected with or generate more than 10% of its revenue from:

- Tobacco
- Alcohol
- Armament
- Gambling
- Pornography
- High interest lending

The Trustees accept that the investment in common investment funds (and similar products) may give the charity indirect exposure to such stocks. Any indirect exposure is monitored and will not exceed 10% of the total portfolio value.

d) Investment Powers

The appointed Investment Managers will be given discretionary powers and empowered to buy and sell securities on behalf of the Trustees, subject to the overall investment policy as set out in this document. All such transactions must be reported to the Trustees in the next quarterly review.

If the Charity is made aware of a legacy or donation that incorporates stocks and shares, these shall be liquidated as soon as practicable and the net proceeds passed to the investment fund managers for reinvestment.

7. PERFORMANCE AND COMPLIANCE MONITORING

Performance of the Investment Managers will be monitored by receiving quarterly reports at the Charitable Trustees Committee. These reports will contain information on performance against recognised indices and other appropriate benchmarked information.

If there is a potential exposure to non-ethical investments in excess of the parameters agreed, this will need to be reported immediately, otherwise compliance with this requirement needs to be reported annually.

Information regarding financial markets needs to be provided with each performance report, together with any recommendations on amendments that may be required to the investment parameters agreed with the Trustees. Compliance with the agreed parameters should be confirmed with each performance report.

8. REFERENCES

The main Charities Committee website provides further details on the responsibilities of Charities and Trustees for investment policies and can be found at https://www.gov.uk/guidance/how-to-invest-charity-money. Only elements of this guidance that is relevant to this Charity is included here.

Annex 1

Currently Approved Range of Asset Allocations

In line with the current professional advice to the Charitable Trustees Committee, the agreed ranges for each class of asset allocation are as follows:

Asset Type	Agreed %
Equities: UK and Global	40-80
Fixed Interest Bonds	0-30
Property and Alternative Investments	0-20
Cash	0-30

These approved ranges of asset allocation are approved by the Trustees and, as such, can only be amended by the Board. Within the ranges, the Charitable Trustees Committee can agree specific asset allocations on advice from the Investment Manager e.g. to increase the percentage of the portfolio held as cash at the maximum level in times of economic uncertainty.

Charity Income and Expenditure Plan 2019/2020

Introduction

This report outlines the charities income and expenditure plan for 2019/20. The Charity is continuing to deliver against the strategy to increase income to £3m by March 2021. Significant changes to how income is generated were made in 2018/2019 alongside phase one of a recruitment plan. 19/20 will see the charity consolidate those changes.

Historical Performance

In 2017/2018 £1,906k was raised and £218k was spent in order to raise this and run the charity. This resulted in the cost of raising funds being 11% of the total income raised. £737,857 was spent on charitable activities.

In 2018/2019 we are forecasting income of £1,167k and spend of £296k in order to raise this and run the charity. This resulted in the cost of raising funds being 25% of the total income raised. £1,593,239 is forecast for spend on charitable activities.

Income vs expenditure plan 2019/2020

2019/20 planned expenditure is higher than income. This is due to increased expenditure on charitable activities.

As of the end of January 2019 the Charities total fund balance is £3,832k. This amount does not include any income for February 2019 nor any legacy income of which we were made aware but have not received to date.

As in 18/19 It is recommended that these funds are partly utilised to deliver a larger impact in 2019/2020, hence the planned income being lower than planned expenditure/costs. This will in turn enable a higher income, as the charity is able to better promote its activities. It will also enable the charity to deliver on the expectation of our donors.

Plan summary for 2019/2020	19/20 Plan £
Income	2,200,000
Planned Cost of Fundraising (running costs)	-471,459
Governance and Running Costs on Charitable Activities	-141,214
Expenditure of Charitable Activities	-2,447,540
	-860,213
Total expenditure/costs	-3,060,213
% Planned Cost of Fundraising (running costs) of total expenditure/costs	15%
% Expenditure of Charitable Activities of total expenditure/costs	80%
% Governance and Running Costs on Charitable Activities of total expenditure/costs	5%
% Governance and Running Costs on Charitable Activities of income forecast outturn	6%
% Planned Cost of Fundraising (running costs) ratio to income	21%

2019/20 Income plan

In order to deliver £3,000k income by 2021 we aim to secure £2,200k in 2019/2020 and the below income plan reflects this. Legacy donations are included in the plan for 2019/2020 however the forecast has been completed with the expectation of significantly increasing our fundraising performance and return on investment,

Income Type	19/20 Plan £	18/19 Forecast Outturn £
Community	303,000	93,148
LJMC	229,150	152,554
Corporate giving/sponsorship	85,250	57,030
Dividend Income/bank interest	80,000	69,842
Individual giving	139,600	119,267
Gift Aid	100,000	22,563
In Memory	152,000	44,333
Legacies	555,000	169,841
Lottery	55,000	22,512
Major Donors	101,000	48,352
Merchandising	0	17,334
Tin Collection	50,000	22,040
Trusts and Foundations	350,000	327,979
Grand Total	£2,200,000	£1,166,795

2019/2020 Expenditure plan

Planned Cost of Fundraising

In order to significantly increase our income and fundraising performance, continued investment in the team is recommended, Costs have been planned with this in mind; ensuring they total less than 25% of planned income.

Planned cost of fundraising (running costs)	19/20 Plan £	18/19 Forecast Outturn £
Charity - Fundraising Salaries	-294,515	-173,670
Event Expenditure	-56,457	-25,704
Merchandise Expenditure	-32,798	-9,163
Fundraising Event Expenditure - Community	-12,540	-9,615
Collections - Just Giving Charges	-3,321	-5,860
Bank Charges	-916	-1,003
Training - Charity team	-2,200	-3,487
Travel and Subsistence - Charity team	-1,500	-1,512
Staff costs- Recruitment	-5,000	-2,995
Lottery Winnings	-14,400	-14,400
Finance Governance Costs	-4,432	-5,235
Trust Overhead Costs	-43,380	-43,336
Grand Total	-471,459	-295,980

Expenditure of Charitable Activities	19/20 Plan £	18/19 Forecast Outturn £
Patient Welfare A - Equipment Expense	-33,000	-37,373
Patient Welfare A - Fixtures and Fittings Expense	- 4,800	-12,476
Patient Welfare A - General/Misc Expenses	-7,400	-18,422
Patient Welfare A - Entertainment Expense	-6,550	8,405
Wifi Project Costs	-16,012	-13,349
LJMC Patient Welfare Patient Facing Staff Salaries	-207,984	-248,915
McMillan Education Hub Staff Salaries	-115,072	0
Patient Welfare A - Patient Services	-3,000	-1,465
LJMC - Research - Salary Expenses	-112,936	-125,286
Research - Travel Expenses	-720	-33
Staff Welfare A- Equipment Expense	-240	-1,803
Staff Welfare A - Fixtures and Fittings Expense	-1,200	0
Staff Welfare A - Education and Training	-50,000	-33,097
LJMC - Admin Salaries	-30,494	0
MV Salaries -Community Engagement Team salaries	-101,290	-91,440
Butterfly Project	-29,997	-28,145
Voluntary Services Database	-5,000	0
Volunteer Travel Expenses	-300	-499
Grand Total	-725,995	-620,706

Expenditure on Charitable Activities - Projects

It is planned that the charity will spend the following on capital in 2019/2020.

Expenditure of Charitable Activities	19/20 Plan £	18/19 Forecast Outturn £
Project costs	-1,721,545	-972,533
Grand Total	-1,721,545	-972,533

This includes a SPEC CT, the neonatal parent's room extension, the supportive care unit at MVCC and capital projects approved as projects to fundraise for on March 11th 2019. If funds are not raised the SPECT will not be purchased.

Governance and Running Costs

Governance and Running Costs on Charitable Activities	19/20 Plan £	18/19 Forecast Outturn £
Rent	0	-4,992
Salaries - ENHT Management Support	0	-7,061
Finance Management/Admin	-45,743	-45,157
Stationary	-360	-3,066
Audit Fees	-6,953	-6,953
Charity Team - Admin Support Salaries (Head of Charity)	-77,821	-75,182
Software	-5,833	-8,735
Institute of Fundraising	-3,605	0
Travel and Subsistence - ENHT Management Support	-900	-461
Legal Costs	0	-13,403
Grand Total	-141,214	-165,010

Recommendation

The East & North Hertfordshire Hospitals Charitable Trustees Committee is asked to approve the 2019/20 Plan.

Management of Charitable Funds Policy

Executive Summary

A new Management of Charitable funds policy is submitted for approval. The new policy replaces all existing policies and is supported by a detailed procedure document.

The policy now includes:

- Definition of charitable purpose
- Defined roles and responsibilities and delegated authorities
- The removal of any delegated authority of' fund holders' in line with new ways of working (trailed over 18/19).
- Revised criteria for approving charitable spend, as approved by CTC in December 2018.
- Sections on safeguarding, values and ethics
- The confirmation that the Charity follows the Trust SFI's and governance procedures for all charitable spend.

Request

CTC are asked to approve the policy and refer it to the Board for final approval.

Once printed off this is an uncontrolled document. Please check the intranet for the most up to date version.

March 2019

Management of Charitable Funds Policy

Author:	**Head of Charity**
Document Owner:	Head of Charity
Revision No:	Draft
Document ID Number	
Approved By:	
Implementation Date:	1st April 2019
Date of Next Review:	1st January 2021

Title	Location/Link
Charity Commission – NHS Charity Guidance	https://www.gov.uk/government/publications/nhs-charities-guidance
Trustee Act 2000	http://www.legislation.gov.uk/ukpga/2000/29/contents
SORP 2015 / FRS102	http://www.charitysorp.org/

Table of contents

1. Introduction

This policy governs the way in which the Trust's charitable funds are managed and utilised. The document is supported by detailed procedures.

The Health Services Act 1977 gives NHS bodies the authority to hold charitable funds. The Trust's charitable funds are derived from donations, legacies and investment returns. The charity's objectives are to utilise the charitable funds for the benefit of the National Health Service rather than to accumulate funds with which to achieve investment returns.

This document reflects charity law and guidance issued to NHS Bodies by the Charity Commissioners for England and Wales. The issue by the Charity Commissioners of the 'NHS Charitable Funds Guide' sets out in some detail the legal requirements and best practice to be followed by NHS Bodies. It can be accessed at https://www.gov.uk/government/publications/nhs-charities-guidance

Details of other sources of guidance and law are provided at the beginning of this document.

It is essential that authorising officers familiarise themselves with these procedures and comply with them at all times. If any member of staff is in any doubt about any matter relating to the receipt, ordering or payment of any item relating to Charitable Funds, then they should contact The Head of Charity or Financial Controller.

2. Purposes

The purpose of this policy is to provide clear guidance of how Charitable Funds are to be managed within East and North Herts NHS Trust, especially procedures around income and expenditure.

3. Scope

The Charity Commission

The Charity Commissioners for England & Wales is the organisation responsible for overseeing all charitable organisations. Under the Charities Act 1993, the Commission is required to:-

a) Keep a register of charities
b) Promote the effective use of charitable resources
c) Give charity trustees information or advice
d) Change trustees of a charity where necessary
e) Investigate and check abuse

The Commission does not have power to administer charities and will not normally interfere with the trustee's exercise of their discretion.

NHS Charities are within the jurisdiction of the Commission and are regulated by them.

All NHS Charities have to be registered with the Commission.

Charitable Purpose

Health Service bodies are not themselves charities, only the funds and property they hold on trust for exclusively charitable purposes constitute charities.

For a fund to be a charity it must have purposes which according to the law in England & Wales are exclusively charitable. Four main criteria are accepted:-

a) The relief of those in need, by reason of ill health or disability
b) The advancement of education
c) The advancement of religion
d) Other purposes beneficial to the community not falling in a), b) or c)

East and North Hertfordshire Hospitals' Charity is not set up for the relief of financial need.

Charities administered by Health bodies fall into category a) the relief of those in need, by reason of ill health or disability.

Summary of East and North Hertfordshire Hospitals Charity Charitable Purposes as defined by the Charity Commission

A purpose is not charitable unless it is for the public benefit. It must be of actual benefit, and must benefit the public as a whole or a sufficient section of the public. **A purpose is not charitable if it is wholly or mainly for the benefit of specific individuals.**

The Charity Commission allows expenditure on staff where it clearly enhances patient care.

Advancement of education - this is a charitable purpose where it enhances staffs knowledge above and beyond that which is required to carry out their duties. It includes funds for charitable medical research and the professional development of staff. If medical research is being financed by a charitable fund, the useful results of the research must be published so that the public will benefit.

Hospital staff welfare and amenity funds - these are charitable only because their immediate non-charitable purpose of providing benefits to the employees of the Trust, is perceived as being conducive to the furtherance of the charitable purposes of the Trust i.e. relieving people who are ill. The benefits must not go beyond what a good employer would consider reasonable to provide for its staff. The Charity Commission does not give specific guidance regarding what is reasonable.

Detailed guidance on expenditure types that meet charitable purposes as agreed by the Trustee of East and North Hertfordshire Hospitals Charity is in the body of this policy.

4. Definitions

Legal requirements covered within this Policy are outlined in the Charities Act 1993 and the Trustee Act 2000.

The Charity: the **East and North Hertfordshire Charitable Fund**, registered charity number 1053338, is a separate legal entity from East and North Herts NHS Trust.

Trustee: If an NHS body holds charitable funds as sole corporate trustee, the board members of that body are jointly responsible for the management of those charitable funds.

Members of both the Trust Board and Charitable Funds Committee are not individual trustees under charity law but act as agents on behalf of the corporate trustee.

Charity Trustee Committee – a sub-committee of the Board whose responsibility is to oversee the management of Charitable Funds. This sub-committee has delegated responsibility under the Trust's Standing Orders. The Charity Trustee Committee monitors the administration and performance of the Trust's charitable funds. The Committee is a standing sub-committee of the Trust Board, which meets at quarterly.

5. Roles and Responsibilities

This policy complies with Charity law and the Trust's Standing Orders and Standing Financial Instructions.

All members of staff who deal with charitable funds are responsible for following this policy and must ensure they adhere to it.

The Charity Trustee Committee acting as Trustees for the charity are responsible for the development, management and implementation of the policy, with the assistance of The Head of Charity and finance team.

Trusteeship and the Board

East and North Herts NHS Trust holds and administers charitable funds and does so as a corporate body (known as the *corporate trustee).*

The Trust is the sole corporate trustee of the Charity and the individual persons who, from time to time are responsible for the management of the corporate body, i.e. the Trust Board, are not themselves trustees of the charity. The duties, responsibilities and liabilities of trusteeship lie with the corporate body.

The corporate body must act through individuals to express its will, and therefore if the corporate body commits a breach of duty as trustee, it will have done so as result of a breach by the directors or other officers of their duties towards the corporate body.

The Trust has wide statutory powers to delegate administration of its trusts to officers, committees or sub committees. Where such powers are exercised the corporate body will remain as sole trustee and will be accountable for actions taken on its behalf. The Trust Board has delegated significant powers relating to Charitable Funds to the Charitable Trustee Committee.

Charitable Trustee Committee

The Charity Trustee Committee's key responsibilities are as follows:

- To provide strategic direction and oversight in growing the charity, ensuring a robust strategy for maximising charitable resources is in place, that establishes aims and objectives

- To champion the charity and its development, both externally and within the Trust

- To provide stewardship of charitable resources and ensure compliance with relevant legislation, guidance and Trust policies

- To set a clear framework for prioritising charitable expenditure, and establishing appropriate approval processes for agreeing new campaigns and spending existing charitable monies.

- To establish an annual plan with Charity Management Team to include budgets, fundraising targets and other agreed objectives

- To monitor performance against financial and other softer targets

- To manage the Head of Charity ensuring they demonstrate adherence to charitable objectives in spending charitable monies and provides added value to patients and staff.

- To manage the investment of funds through an agreed investment policy, and where necessary appointing Investment Fund Managers on its behalf in order to monitor performance.

- To supervise the staff in charge of the charity, and regularly reviewing their performance on behalf of the board.

- To ensure all four hospital sites are appropriately engaged with the charity.

- To ensure the appropriate safeguarding of charity staff, volunteers and donors.

- To approve on behalf of the Trustee the charity's annual Report and Accounts

- To review risk management issues and report to the Trust's Audit Committee

- To be accountable to the Trust Board as Trustee, and report on a regular basis regarding the Charity's strategic goals and performance

Investment Manager

The investment managers appointed will be responsible for investing the available funds as far as possible to fulfil the investment objectives. Further information is included within the Charitable Funds Investment Policy.

Charity Management Team

Charity Management team consists of Then Charity Executive lead, Head of Charity, Financial Controller or delegate and Trust Divisional Directors. CMT meet bimonthly.

Charity Trustee Committee relies on Charity Management Team to develop strategies and plans for CTC approval and to ensure that, once agreed, those strategies and plans are implemented effectively. The following matters fall within its remit:

- The production of regular management accounts
- The production regular management reports against objectives
- In conjunction with CTC, the production of an annual plan for the Charity.
- Approving Charity spend under £5,000
- The strategic direction of the Charity
- Maximising income to the Charity

- Ensuring that CTC has the full information necessary to fulfil its function
- Ensuring compliance with relevant legislation, guidance and Trust policies
- Ensuring effective and cost conscious management of the Charity

Head of Charity and staff

The Head of Charity is responsible for the day to day management of charitable funds, working with divisional directors and nominated fund advisors to ensure the Charity funds are raised ethically in line with best practise and funds are spent in line with service priorities and donor wishes.

Charitable funding requests are reviewed on an ongoing basis by the Head of Charity and requests for spend approved by Charity Trustee Committee (CTC) or Charity Management Team depending on the request.

The head of charity is responsible for the strategic management of the fundraising team and staff whose salaries are recharged to the Charity. Where clinical staff are employed staff will report into the appropriate clinical lead and the head of charity will provide administrative and financial management support.

Fund Advisors

Charity funds are held in designated funds. Where appropriate CMT will agree a fund advisor who will advise on the appropriateness of spend. Fund Advisors simply verifies expenditure and are NOT an Authorising Officer.

Charity Accountant and Financial Controller

The Charity Accountant simply verifies expenditure and is NOT an Authorising Officer.

The financial controller verifies expenditure and advises on financial management of charity funds, as part of CMT and CTC.

6. Approval process designated authority

In order to utilise charitable funds effectively and in line with the policy the following designated authority's apply:

Decisions on requests up to and including £25 are made within 24 hours by the Head of Charity and Financial Controller or Executive Director.

Decisions on requests up to and including £500 are made by Head of Charity plus Divisional Director or nominated substitute, Financial Controller or Executive Director.

Expenditure on activities to raise funds is approved by the Head of Charity to a total of £2,500 per item, in line with the approved annual budget.

Decisions on requests up to and including £5,000 are made by Charity Management Team (CMT). Where appropriate requests may be considered between meetings via correspondence where Executive Director, Divisional Director, Financial Controller and Head of Charity approval will form a consensus.

Requests above £5,000 are reviewed by CMT, with a recommendation for consideration and subsequently presented to CTC for consideration/approval. As the CTC meetings are quarterly, requests to spend funds over £5k are sometimes considered between meetings via correspondence where Charity Chair, Executive Director, Divisional Director, Financial Controller and Head of charity approval will form a consensus.

Spend above £500,000 must also be approved by Board as Corporate Trustee.

East and North Hertfordshire Expenditure Criteria as defined by CTC March 2019:

7. Expenditure of Charitable Funds

Charitable expenditure must be for the public benefit and cannot be for the benefit of a specific individual or group of individuals. It must have a direct or indirect link to actual benefit for the public or a wider group of individuals. Given that the principle purpose of the NHS is to deliver services to patients, then, in simple terms, the outcomes to be achieved using charitable funds should always be patient focused.

The Charity's funds are held as two main types:

- Unrestricted funds which may be used for expenditure that falls within the purpose of East and North Hertfordshire Hospitals' Charity.

- Restricted funds which also have to fall within the purpose of the Charitable Funds, but which may have further restrictions placed upon them e.g. for the benefit of certain areas or departments or for certain types of expenditure e.g. training.

The charitable objects of the East and North Herts Charitable Funds is defined as:

For any charitable purpose or purposes relating to the national health service wholly or mainly for the service provided by East and North Hertfordshire NHS Trust

Expenditure Criteria

In order to maximise the effectiveness of charitable funds the following criteria is applied:

Expenditure to run the charity and raise funds	should enable the charity to meet its charitable objects. Expenditure to run the charity and raise funds should have a clear and sound rationale which enables the charity to meet its charitable objects. Expenditure will normally enable charity to raise funds by way of increased promotional activity or investing in activities which produce a return on investment, in line with appropriate ethical considerations.

Expenditure on projects and equipment	**<u>Must be</u> above and beyond the obligation of the NHS and** ✓ *For the public benefit/patient benefit* ✓ *In line with the Trust's priorities* ✓ *Capable of being robustly defended in case of any query from a donor, the Charity Commission or the media.*
	<u>Must provide:</u> • Improvements in patient wellbeing, over the level that would normally be expected to be provided in an NHS hospital • Improvements in the patient's clinical care, above and beyond the obligation of the NHS through: ➢ *Research* ➢ *Education* ➢ *Introduction of new technologies* ➢ *New equipment* ➢ *Advances in diagnosis* ➢ *Advances in management*

When making funding decisions there must be due consideration of the following:

- Is the level of expenditure proportionate with the number of patients that are likely to benefit from it. The larger the expenditure the greater the number of patients that could be expected to be able to benefit.
- Are there any ongoing running or maintenance costs associated with the initial expenditure, These will need to be considered as part of the approval for expenditure. Is there an exit strategy for one off costs.
- Are there any issues with infection control or security, or any other health and safety issues. The Trust's normal policies will need to be complied with.
- Could the expenditure adversely affect other patients' experiences or the Trust's reputation. Equality and diversity guidelines should be taken into account. Also people's perceptions of artwork etc. may vary if this is purchased when rooms are being refurbished.

Expenditure on staff welfare	**Expenditure on staff must have a direct or indirect link with improving the level of care provided to patients**. The Charity Commission accepts that, so long as a direct benefit to staff translates demonstrably to relief of sickness of NHS patients, it is a legitimate use of the unrestricted charitable funds to provide such a benefit. This may include, in certain circumstances, as approved by CMT, expenditure to improve staff recruitment, retention and morale.
	Expenditure on staff must provide: ✓ Improved conditions of work and welfare for a whole group of staff and not for specific individuals, above and beyond employer obligations. ✓ Support for research ✓ Support for education ✓ Support for training

In deciding how to spend funds available for staff welfare purposes the Trustees need to consider:

- To what extent the intended charitable outcome from a particular payment can be measured and demonstrated.
- Have projects which provide patient benefit been prioritised
- How effective the particular payment used will be in delivering the ultimate outcome.
- How strong the connection may be between the particular payment used and the charitable outcome intended.

This approach does not rule out funding to individual member of staff where there is a clear link to the care of patients.

Examples of appropriate staff expenditure are available as Appendix 1

Approval Process

The Trustee must be able to demonstrate that, before applying charitable funds that there has been a clear, independent and open decision-making process. This is achieved through completing an application form for charitable spend and decision making in line with the above criteria at CMT and CTC.

All expenditure will comply with East and North Herts NHS Trust Standing Financial Orders and internal governance processes.

8. Fundraising

The Trust has established a fundraising team which is managed by the Head of Charity. The team is responsible for the co-ordination of fundraising activity and ensures Trust strategic objectives for charitable funds are met.

Fundraising is not a charitable purpose in itself; it has to be carried out in support of the purposes of the Trust's charitable objects. Where funds are registered as restricted, charity law states that donated income may not be used for fundraising activities, sponsorship should be obtained.

Under authority delegated by CTC, the Head of Charity is responsible for ensuring that:

• All fundraising is properly carried out;

• Associated expenditure is valid;

• All funds raised are properly accounted for;

• The costs of the fundraising do not exceed a reasonable proportion of the total funds raised.

All donations must be accepted the charity or the cash office only. Donations should not be accepted by any other members of staff or volunteers unless in a sealed donation envelope, which must be sent to the charity or cash office immediately. Donors should be directed to the website to make donations safely online.

Any staff, patients or members of the public wishing to raise money for charitable funds on behalf of the Trust must contact the fundraising team who will ensure appropriate approval is obtained. Appeal funds must not be established prior to gaining approval. Consideration will be given to the nature of the fundraising activity, the purpose for which funds are being raised and any revenue consequences resulting from the appeal.

Members of staff and other organisations may wish to fundraise independently of the NHS Trust charitable funds. If so, they must make it clear that they are doing so independently and not on behalf of the NHS Trust. Such activities shall not be promoted by the Trust.

When arranging fundraising events the reputation of the Trust and the Charity should be considered. Events that may be seen to be 'stunts' or lead to disrepute will not be supported by the Charity.

9. Criteria for accepting Charitable donations

Ethical Considerations when accepting charitable donations

It necessary to avoid establishing impossible, undesirable or administratively difficult objectives from any donation received. CTC, CMT or the Head of Charity's are able to decline a donation if it is felt the motivation or source was unethical or would bring disrepute to the Charity. In such instances the Head of Charity can enforce this immediately and will report this immediately to CTC.

When proactively securing partnerships and philanthropic donations the Charities ethical approach outlined in the investment policy will be followed and each gift will be discussed on a case by case basis at CTC.

9. Charity Values

East and North Hertfordshire Hospitals Charity prides its self on its values and as such alcohol by way of prize will not be permitted on any Trust site.

The NHS promotes healthy eating and use of unhealthy food in Charity promotion or fundraising activity will be moderated and a healthy option always available.

East and North Hertfordshire Hospitals Charity will fundraise in line with the values of East and North Hertfordshire NHS Trust.

10. Safeguarding

East and North Hertfordshire Hospitals' charity do not directly employ staff and defaults to the safeguarding policy of East and North Herts NHS Trust, in all areas of operation, including but not limited to where the Charity provides funding for staff post, provides services which utilise volunteers and has fundraising volunteers.

All volunteers will be referred through the Trust Volunteering team and all appropriate DSS checks and procedures will be used.

11. Consultation and Dissemination

This Policy has been formulated by taking into account the guidance issued by the Charity Commission. It was presented to the Charity Trustee Committee on12th March 2019 for their comments before they ratified it.

Once ratified by the Board, this Policy will be published on the Trust's intranet within the Charity and Finance Policies section.

12. Monitoring Compliance with Policy

The Charity Trustee Committee, Charity Management Team, The Director of Finance, The Trust Financial Controller and the Head of Charity have responsibility for the overall monitoring of the policy.

13. Related Policies

The following related policies & guidance are available on the Trust Intranet.

	Document
(a)	Standing Orders / Standing Financial Instructions
(b)	Limits of Delegation Policy
(c)	Code of Conduct
(d)	Standards of Business Conduct
(e)	Charitable Funds Investment Policy
(f)	Charity Commission website for guidance documents https://www.gov.uk/government/publications/nhs-charities-guidance
(g)	Charity Trustee Committee Committee Terms of Reference
(h)	Charities Statement of Recommended Practice 2005 and 2015www.charitycommission.gov.uk/Library/guidance/sorp05textcolour.pdf

	Document
	http://www.charitysorp.org/media/619101/frs102_complete.pdf
(i)	Body of charity law including Charities Act 1993, Trustee Investment Acts 1961 and 2000
(j)	Safeguarding policy

Appendix 1 Examples of Specific expenditure on staff

Training and education - The Charity will fund staff training and education where it can be shown that there is a direct or indirect benefit to the patients or staff of East and North Hertfordshire NHS Trust. This is covered in the policy and procedure for training.

Entertaining and Social events - The Charity will not fund events for the entertainment of sections of staff, such as Christmas dinners for a department, even if the funds of a specific area are sufficient to cover the cost. In addition to lacking parity across staff groups, staff entertainment is a taxable benefit unless specific criteria are met, which includes the requirement to be open to all Trust staff.

Routine expenditure on general benefits for staff, such as tea, coffee, milk or water will not be funded by the charity. Occasional events such as modest departmental team events that may have a strong motivational impact on staff and indirect benefit to patients can be supported at the discretion of CMT. Charitable funds will not be spent on alcohol.

Retirement and long service awards - We recognise the benefit of these awards. However in order to comply with the guidance and regulations from regulatory bodies, it is necessary that all funds should be spent in activities that directly benefit the patients of the Trust and translate demonstrably to relief of sickness of patients. In addition this is a taxable benefit, therefore the Charity is not able to support expenditure related to retirement and long service awards.

Gifts - Routine expenditure on gifts for staff will not be supported.For context the below list provides examples of Expenditure which would not be supported:

- Expenditure that is not charitable or which does not have the Committee's approval
- Expenditure on events which may have a poor effect on the Charities' or the Trusts' reputation such as "stunts";
- Attendance at a conference, the subject of which, however commendable, was not likely to benefit the health of the people of East and North Hertfordshire.
- Attendance at any event, accommodation or travel for a spouse or other person not providing a service to patients of East and North Herts NHS Trust. If an event has been arranged that other people can attend they must contribute the full cost of the event
- Staff training which is core, mandatory, part of a personal development plan or listed in an appraisal.
- Items essential to the structure of an ENH NHS Trust hospital site

- Purchase of a PC that is incompatible with ENH NHS Trust equipment; and / or is used solely for NHS work.
- A study day when the individual concerned is leaving the employment of ENHT
- Membership of professional organisations for the benefit of an individual. Where the membership has a clear group benefit in terms of access to publications or training at preferential rates, such that the cost is outweighed by the financial benefits of avoided costs, the fund manager will have the discretion to support the membership.
- Expenses incurred when normal purchasing guidelines have not been adhered to (e.g. express delivery charges, maintenance agreements on equipment) unless there are valid reasons.