Public Trust Board

Lister Education Centre, Lister Hospital, Stevenage

01/03/2023 10:30 - 12:30

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10. Strategic Transformation Update For discussion	Katherine Marwood - Programme Director	11:10-11:20	45

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For noting				

East and North Hertfordshire NHS Trust

Agenda item: 4

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday 11 January 2023 at 10.30am in the Lister Education Training Centre, Lister Hospital, Stevenage

Present:	Mrs Ellen Schroder	Trust Chair
	Mrs Karen McConnell	Deputy Trust Chair and Non-Executive Director
	Mr Jonathan Silver	Non-Executive Director
	Dr Peter Carter	Non-Executive Director
	Ms Val Moore	Non-Executive Director
	Dr David Buckle	Non-Executive Director
	Mr Adam Sewell-Jones	Chief Executive Officer
	Mr Martin Armstrong	Director of Finance & Deputy Chief Executive Officer
	Ms Lucy Davies	Chief Operating Officer
	Ms Theresa Murphy	Chief Nurse
	Mr Thomas Pounds	Chief People Officer
	Mr Kevin O'Hart	Director of Improvement
	Mr Kevin Howell	Director of Estates and Facilities
From the Trust:	Mr Stuart Dalton	Head of Corporate Governance
	Mrs Eilidh Murray	Assistant Director of Communications and Engagement
	Ms Sarah Simmons	Deputy Head of Communications and Engagement
	Ms Julia Smith	Assistant Trust Secretary (Minutes)
External Partners:	Ms Jane Halpin	Chief Executive - Herts and Wet Essex Integrated Care System (ICS)
	Mr Paul Burstow	Chair – Herts and West Essex Integrated Care System (ICS)
	Ms Samantha Harrison	CQC
	Ms Amica Patel	CQC
Members of the Public:	Ms Bev Summerhayes	East and North Hertfordshire NHS Trust

No	Item	Action
22/159	**CHAIR'S OPENING REMARKS**	
	The Chair opened the Public Board meeting and welcomed colleagues from the ICS and CQC. She informed the Board that Dr Buckle had been made a full Non-Executive Director for the following four years and Mrs McConnell had extended her term for an additional four years. Mrs Schroder explained that there would be a recruitment process for a new Associate Non-Executive Director and encouraged all Board members to talk to their	

networks. She said the role would be a paid and actively working position and the Board would benefit from someone with either HR or IT experience and with a diverse background.

22/160 APOLOGIES FOR ABSENCE

Apologies were received from:

Mark Stanton – Chief Information Officer

22/161 DECLARATIONS OF INTEREST

There were no new declarations of interest made.

22/162 MINUTES OF PREVIOUS MEETING

The minutes of the previous meeting held on 2 November 2022 were **APPROVED** as an accurate record of the meeting.

22/163 ACTION LOG

The Medical Director provided an update on action 22/057.5 which referred to a question from the public regarding the Trust becoming a no smoking site. The Medical Director informed the Board that the aim was to become a no smoking He said a plan was being developed that would take approximately 12 months to implement and would support staff with smoking cessation, implement safe areas to vape and ensure all patients and visitors were given notice of the intention of the Trust.

The Medical Director confirmed the no smoking would be across all Trust sites. He said a full proposal would be developed.

The Director of Estates and Facilities expressed safety concerns for staff when challenging people not to smoke. The Medical Director commented that staff smoking cessation was the main driver.

The Board **NOTED** the current Action Log.

22/164 QUESTIONS FROM THE PUBLIC

There were no questions from the public.

22/165 PATIENT STORY

The Chief Nurse presented the story of a 71-year-old female patient who suffered a fall at home and not wanting to disturb her more frail husband waited to call for help. She was a retired nurse and using her experience and pain, judged she had a fractured neck of femur.

Paramedics brought her to Lister where she waited for five to six hours, during this time she was administered pain relief and a fluid IV bag. Her husband received a cup of tea and sandwich, so they were happy because they were supported and cared for. Throughout her time in the ambulance the female patient continued

to be monitored and have her Observations taken.

The Chief Nurse had secured the patient space in the hospital when a AAA arrived which took priority and the patient had to remain in the ambulance.

Later in the day, a space was created in Orthopaedics and the patient was examined by two junior Orthopaedic doctors who admitted her to a ward where she had an x-ray and her bloods taken. A Health Care Support Worker (HCSW) took ownership of the patient and managed the care of the patient and her husband.

As the patient and her husband had arrived in an ambulance, he had no phone or walking stick and there was concern about how he would get home safely. The HCSW took him home at the end of her shift demonstrating a huge commitment to patient care.

The Chief Nurse went to see the patient who said she was very pleased with the care and treatment she had received from the ambulance crew and the Trust.

Mrs Schroder asked if the Chief Nurse had not been involved whether the patient would have been moved in the same way. The Chief Nurse explained to the Board that the Accountability Review Meeting had discussed front line staff being empowered to make the same level of decision and the ED Improvement Board were reviewing the processes. She said it was important for senior staff to role model good behaviours.

The Chief Executive commented that it was clear emergency care was not at the standard it should be however there had been no complaint from the patient discussed. He said he believed that the general public were on the whole accepting of the changes required and the Trust needed to continue to push for change and improvement. He said the Executive Directors couldn't be expected to be constantly on the front line, but the Chief Nurse had demonstrated how to flex the processes. He agreed staff needed to be empowered to make changes.

The Chief Operating Officer commented that process and role improvements had been reviewed and changes would be implemented.

The Chief People Officer highlighted that the patient experience illustrated the real challenge being faced by staff having to make agile and sometimes difficult decisions which could be challenging to manage.

22/166 CHIEF EXECUTIVE'S REPORT

The Chief Executive informed the Board that the recruitment process

for a new Medical Director had concluded with the role being offered to and accepted by Justin Daniels, he had a lot of experience and was a Paediatrician. He would start at the Trust on April 17. He said there had been a robust recruitment process and was pleased there had been a strong field of both internal and external candidates.

The Chief Executive explained to the Board that benefits would been seen from the two new procedure rooms in the Treatment Centre at Lister and the new one at the New QEII.

The Chief Executive highlighted that the operational pressures had been relentless, specifically over the festive period in December. He acknowledged the commitment from staff as metrics improved and the hospital felt more controlled. He explained that standards had been set on corridor care and risk-based decisions being made against the balance of risk.

The Chief Executive informed the Board that there was the expectation of the report from the Maternity Services review to arrive which would be discussed at the March Board meeting.

Mrs Schroder recognised that the level of care the Trust would like to provide would not be delivered until the pressures eased at the front and back door.

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

22/167 BOARD ASSURANCE FRAMEWORK

The Head of Corporate Governance informed the Board that system duties had been discussed and a system wide BAF would be considered. He said the finance risk had increased since the last Board meeting.

The Director of Finance explained to the Board that there were challenges delivering financial balance which was a system wide challenge.

Mrs Schroder explained that all risks were discussed in detail at Committee level. She said FPPC had the largest number of red risks. Mrs McConnell informed the Board that a meeting had been scheduled to discuss the FPPC risks pre and post mitigations where there had been no change to the score to understand what was required to improve those risks.

Mrs Schroder reminded the Board that the BAF risks had been refreshed and it would take time for the mitigations to embed and improve the scores.

The Board **RECEIVED** and **NOTED** the Board Assurance

Framework.

22/168 INTEGRATED PERFORMANCE REPORT

The Deputy Chief Executive and Director of Finance introduced the Month 8 Integrated Performance Report (IPR). He said the IPR reflected the six CQC domains.

The Deputy Chief Executive explained to the Board that the Trust was working hard to improve performance, and this was reflected in the volume of patient safety incidents of which 98% were low or no harm. He said December 2022 and January 2023 had been difficult and the Trust had taken exceptional action to manage the pressure because safety was always paramount.

The Chief Nurse explained that areas of escalation had avoided corridor care and the Trust were conscious of where patients were cared for.

The Chief Nurse informed the Board that there were escalations with the Hospital Ambulance Liaison Officer (HALO) and the East of England Ambulance Service (EEAST), and every designated escalation had a named nurse with staff supporting the areas. She said there had been an increase of staff out of hours to ensure all fundamentals of care were managed with strengthened supervision and senior nurses being included in the escalations. The Chief Nurse confirmed that all patients had a designated bed or ward space to go to.

The Medical Director commented that the escalations daily were clear. He said innovative staffing solutions were being tested and with the addition of two extra doctor shifts to speed up discharge to improve patient flow. He continued that there had been good work between the nursing, medical and operational teams.

Dr Buckle informed the Board that with the changes in the figures over time, he was assured, he highlighted that harm could be happening and asked if this area had been addressed. The Medical Director explained that it was a top priority on a daily basis, and risk was recognised and mitigated. He acknowledged the ED was an area of high risk and explained that there had to be balance as it couldn't utilise all the available resources.

Mrs Schroder commented that attendances were not substantially higher than pre-Covid, but the patients were more unwell and staying longer. The Chief Operating Officer agreed and commented that acuity varied and when clustering occurred it could create issues with the prioritisation of patients.

The Chief Operating Officer thanked ICS colleagues for the winter funding and explained to the Board that it had allowed the opening

of the ambulance handover unit with five trolley spaces which were staffed from a different contract. She said the Same Day Emergency Care (SDEC) unit had also opened with two bays of trolley and chair wait spaces.

The Chief Operating Officer explained to the Board that changes in practice such as reverse boarding would help with discharges and pull for safety was being used in escalation actions.

The Chief Operating Officer informed the Board that the Trust had implemented a zero tolerance of ambulance handovers of over three hours which had a very positive impact. She said following the Regional guidance of offload times of 30 minutes during strike action, the Trust had worked on achieving that target and there had been a sharp decline in the ambulance handover times over the past few weeks.

Mr Silver commented on the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) trends as they had increased over the last 18 months, he asked if there was an understanding for the increase. The Medical Director explained to the Board that the change was not statistically significant. He said crude mortality had returned to pre-Covid levels. He said the methodology remained the same for managing mortality; the areas where the Trust was an outlier would be reviewed and coding and pathways were checked for quality improvements.

Ms Halpin commented that in the context of the System and Region in relation to ambulance handover delays, the Trust was an outlier, however she recognised that work was being done to address the situation. She said that work needed to continue as there had been some improvement.

The Chief People Officer explained that over the previous 12 months, sickness levels were higher than had been anticipated. He said there had been a focus on recruitment for substantive staff and there had been an increase of 158 WTE with over 300 nurses recruited. He continued that conversion rates for students were high and the Trust was recognised as a good international employer.

The Chief People Officer commented that the Trust was agile for safer staffing and could redeploy as required. He said ensuring areas were staffed sufficiently for colleagues to take a rest was important and the rest spaces were being reviewed to ensure they contained the correct amenities.

The Director of Finance informed the Board that the financial position remained challenging, was off plan and a lot of work was underway on the financial reset with actions in place to deliver the best possible position. He recognised the primary financial provider was the System and commented that the Trust was working with

them closely.

Mrs Schroder commented that the elective procedure position had not been discussed but understood it had been reported the number of electives had been reduced due to the surgeons withdrawing. The Chief Operating Officer explained that elective performance had been good earlier in the financial year, but the BMA rate card issue was impacting the Trust and the updated position highlighted that 849 patients would not meet the 78-week standard. She said these patients were predominantly Community Paediatrics and solutions were being sought outside of the Trust which included the independent sector.

Mrs Schroder commented that with the reduction of 17 Theatres down to 10 that they were as fully occupied as possible.

Mrs McConnell asked whether the recruitment of Anaesthetists was progressing. The Medical Director explained that the process was underway and trainee practitioners were being recruited onto a training programme.

The Board **RECEIVED** and **NOTED** the Month 8 Integrated Performance Report

STRATEGY AND CULTURE REPORTS

22/140 SYSTEM PERFORMANCE REPORT AND STRATEGY

Ms Halpin explained that the biggest national challenge was the Urgent and Emergency Care Pathway although there was a good response across the Region. She said the community response was positive. Ms Halpin informed the Board that the performance against the operational plan for 2022/23 was good and elective performance at the Trust had been high which had been recognised with the de-escalation of the Tier 1 support.

Ms Halpin said the challenge was with the 52 and 78 week waits, she said she was confident the correct work was underway, but it would take time to achieve. She said the overall cancer waits were good and diagnostics were more challenging.

Ms Halpin commented that mutual aid outside of the emergency pressures was becoming more tangible and part of the daily thought process.

Ms Halpin recognised that mental health continued to be an intense challenge and demand and acuity had increased which was posing challenges across the System. She said primary care were also under pressure.

Mrs Schroder commented that primary care was difficult to measure and asked if there were additional measurements in place. Ms Halpin explained that a lot of the measures had ceased during

Covid. She said the model was moving to one of longer appointments which posed issues with visibility of data.

Dr Carter commented on the impact of mental health patients on the wards and in the ED. Ms Halpin explained that a large part of adult mental health was a failure to address their physical health needs; Dr Carter agreed and said it was a shared issue.

Ms Moore said she would be keen to be involved in supporting shared priorities and asked how they would be reported. Ms Halpin explained that the reporting was beginning to be developed, she said as the priorities had only been adopted in December the data preceded adoption. She continued that discussions were underway at a place-based partnership level and she was keen not to impose specific actions as all partners needed to agree what would move the System forward. She said there would be challenges in reporting, but it would be more important to have people involved in making a difference.

Mr Burstow introduced the strategy to the Board and explained it was a framework for all colleagues across the NHS, local government, and the community to see where they could contribute. He said it was an overarching move from a competitive model to one of collaboration to deliver healthcare. It included Population Health as well as Healthcare.

Mr Burstow explained that the planning guidance which had been received late in December would need to be translated alongside the strategic priorities into a joint plan for the next three years. He said as Chair of the Integrated Care Board (ICB) he would lead the work around autonomy regulation.

Mr Burstow informed the Board that the Workforce strategy had been approved

Mrs Schroder agreed with the strategy and commented that communication between the Boards could be improved. She said the Chief People Officer would follow-up to ensure the Trust fed into the Workforce strategy.

The Head of Corporate Governance asked how the Trust Board could support the ICB and its delivery. Ms Halpin explained that partnership working was how the System would enable place-based work which would be alongside the district and county councils. Mr Burstow said the Boards would make sure their strategies were circulated. He said there was a lot of operational dialogue and the mechanism for reporting needed to be agreed.

The Chief Executive commented that the Trust and ICB had different strategic priorities and different roles therefore the Trust contribution

may be small but would add value. He said for the Trust it would be about being the best Trust possible as part of the System as well as having a sense of the work the ICB would be doing rather than a sole focus on what the Trust would be delivering.

The Board **RECEIVED** and **NOTED** the System Performance Report and Strategy update.

22/141 PLANNING GUIDANCE

The Director of Finance explained to the Board that it was the time of the complex annual planning which was condensed into a small timeframe. He said better planning would lead to better results.

Mrs McConnell informed the Board that the FPPC had spent a lot of time discussing what the organisation was required to do. She highlighted the difficulty the challenge would likely be and the need to focus on how efficiencies would be achieved. She said there was awareness of the cultural changes required in the organisation and the need to expand that into the ICS.

Mrs Schroder commented that the Trust position was difficult, and it would be challenging to plan for the beginning of the financial year with a deficit.

The Chief Executive asked for the Board to recognise that the Trust was treating as many patients as possible under 18 months and would ensure focus remained on the areas of priority.

The Board **RECEIVED** and **NOTED** the 2023/24 Planning Guidance.

22/142 PEOPLE AND WORKFORCE STRATEGY ANNUAL PROGRESS REPORT

The Board **AGREED** to defer the People and Workforce Strategy update discussion to the March meeting.

22/143 MATERNITY BENCHMARKING UPDATE

The Chief Nurse highlighted that the Trust was above the national average for some of the MBRACE quality indicators with 2.5 stillbirths per thousand.

The Chief Nurse explained that the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme (MIS) applied to all acute Trusts delivering maternity services and the Trust had maintained compliance with all ten safety standards to reduce clinical risk.

She said the final evidence was being collated for the fourth year of the MIS and compliance had been independently judged and measured. She highlighted the element of the 'Saving Babies Lives' care bundle where the Trust had met the 90% training trajectory.

The Chief Nurse explained to the Board that for pre-term births the Trust was amongst the mid-range and every opportunity to drive improvement was taken.

The Chief Nurse highlighted there had been an independent review of the Ockenden immediate and essential actions.

The Chief Nurse drew the Boards attention to the weekly maternity improvement senate with colleagues from across the East of England and said there was a schedule of mock inspections over the coming six months. She informed the Board that the national maternity survey results had been released and the team would go through the learning.

The Board **RECEIVED** and **NOTED** the Maternity Benchmarking update.

22/144 STRATEGIC TRANSFORMATION UPDATE

The Board **AGREED** to defer the Strategic Transformation update discussion to the March meeting.

ASSURANCE AND GOVERNANCE REPORTS

22/149 REMUNERATION COMMITTEE TERMS OF REFERENCE

The Head of Corporate Governance informed the Board that the only change was to expand the responsibility of the Committee.

The Chief Executive highlighted that the VSM banding was outside of Agenda for Change to allow for flexibility.

The Board **RECEIVED**, **NOTED** and **APPROVED** the Remuneration Committee Terms of Reference.

22/150 LEARNING FROM DEATHS

The Medical Director informed the Board that the National Hip Fracture database update to July provided the Trust with an improved position of 6.7%. He said work was still underway to further improve the position in relation to access to Theatres.

The Medical Director explained to the Board that although there had been a spike in general mortality over a five-week period the Trust's position had not increased.

Mrs McConnell asked if Quality issues were included within the Theatre programme. The Medical Director confirmed that there was a robust process, he said where there was a trauma unfortunately elective procedures were cancelled.

The Board **RECEIVED** and **NOTED** the Learning from Deaths report.

East and North Hertfordshire NHS Trust

BOARD COMMITTEE REPORTS:

22/151 FINANCE, PERFORMANCE AND PLANNING COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary reports from the Finance, Performance and Planning Committee meetings held on:

29 November 2022

20 December 2022

22/152 QUALITY AND SAFETY COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary reports from the Quality and Safety Committee meetings held on:

30 November 2022.

21 December 2022

22/153 CHARITY TRUSTEE COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary report from the Charity Trustee Committee meeting held on 12 December 2022.

22/154 PEOPLE COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary report of the People Committee meeting held on 28 November 2022.

22/155 EXTRAORDINARY AUDIT COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary report from the Audit Committee meeting held on 7 December 2022.

22/156 ANNUAL CYCLE

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

22/157 ANY OTHER BUSINESS

No other business was raised.

22/158 DATE OF NEXT MEETING

The next meeting of the Trust Board will be on 1 March 2023.

Ellen Schroder
Trust Chair
January 2023

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

Agenda item: 5

EAST AND NORTH HERTFORDSHIRE NHS TRUST
TRUST BOARD ACTIONS LOG TO 1 MARCH 2023

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
4 May 2022	22/057.5	Question from the Public re smoking within Trust grounds	Review the smoking policy with a task and finish group to include Dr Alex Wilkinson, Occupational Health, expert opinions, staff and patient representatives, Mental Health team and the Ambulance Service	August 2022 update: Medical Director on leave for September Board but will provide an update to the Board in November. November 2022 update: this will be an ongoing project as all the groups work together.	Medical Director	Ongoing

East and North Hertfordshire NHS Trust

Chief Executive's Report

February 2023

Care Quality Commission (CQC) inspection of Maternity

Following its inspection of Maternity services at Lister Hospital in October 2022, the CQC published its report on 20th January. It rated the domains of Safe and Well-Led as inadequate (with the other domains of Responsive, Caring and Effective not reviewed and remaining rated as Good). This means that the rating for Maternity services has moved to Inadequate and a section 29a warning notice was issued with improvement deadlines through to April of this year.

The outcome of the inspection is disappointing to all involved and staff's primary concern is to the anxiety this could cause to those due to use our services. Most national quality indicators remain in line or better than peers, but staff have responded well to address the gaps identified.

Rapid improvements have been made and evidence has been submitted in line with the first two deadlines.

A full update is provided within the agenda and the Board will be kept fully briefed on progress against the required actions, as well as our broader Maternity Improvement Programme.

Industrial Action

The Trust has to date had limited exposure from ongoing industrial action due to its nurses and the local ambulances service staff not voting to take action. However, recent developments have now seen ambulance staff vote to take action, as well as junior doctors.

Details of planned action are not yet clear, but we will work in partnership with affected staff to balance their right to take action with maintaining essential clinical services.

Elective Recovery

This month we received some information from NHS England about how Trusts are managing the recovery period after Covid – specifically around elective procedures.

I'm pleased to tell you that for the first half of last year, we were the 7th best Trust in the country (out of 168 Trusts) for growth in elective activity, delivering 110% of the elective activity compared to the year before Covid.

Cytosponge

The cytosponge team have completed their 1,000th procedure last month.

The department has been involved with the NHS England cytosponge pilot since November 2020 and were one of the first three Trusts to take part.

Since then, the Trust has become the largest single site in the UK delivering this procedure, which is now available at the Lister Hospital and New QEII.

Cytosponge is a ‘sponge on a string’ test that collects oesophageal cells. These cells are identified and assessed to identify any cell changes to ensure that conditions, such as Barrett’s, do not progress to become oesophageal cancer.

Honours

Our former CEO, Nick Carver, was presented with his OBE by the Princess Royal this week for services to the NHS. I'd like to offer my congratulations to Nick following his many years of service in the NHS, including 19 as CEO here at the Trust.

Adam Sewell-Jones
Chief Executive

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	9
Report title	**Board Assurance Framework (BAF) Risks**			**Meeting Date**	1 March 2023
Presenter	Stuart Dalton, Head of Corporate Governance				
Author	Stuart Dalton, Head of Corporate Governance				
Responsible Director	Martin Armstrong, Deputy CEO			**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**		☐
	Discussion	☒	**Decision**		☐

Report Summary:

The BAF risks are enclosed for review (tracked changes show updates since the last Board review), including a Risks Summary, a Heat Map and the Trust's strategic priorities.

No risk scores have increased. Encouragingly, two risk scores are proposed for reduction following lead Committee consideration:

- Risk 4 *(Workforce shortages and skill mix – Thom Pounds)* from 12 to 9 to reflect a reduced likelihood. This is due to the concerns of significant staffing shortages arising from Brexit not materialising coupled with international recruitment outside of the European Union being positive and above other Trust averages. If the Board agrees with the reduced score, this will be the first 22/23 BAF risk mitigated down to a score of 9.
- Risk 9 *(Trust and system financial flows and efficiency – Martin Armstrong)* from 16 to 12 to reflect reduced likelihood of financial flow issues following the outturn Elective Recovery Fund (ERF) assumptions being aligned with Integrated Care System assumptions.

7 of the 11 BAF risks were originally red-rated. Through good mitigation work this is down to 4 red-rated risks (finances; culture; system-working; performance). Given the higher impact and/or likelihood of these 4 red-rate risks materialising, the latest position is set out below. It is particularly important the identified mitigation actions for these 4 risks are robust and will drive down the risk scores:

Risk 3 *(Financial constraints - to delivering quality standards – Martin Armstrong)*

- Risk 3 remains the highest scored risk on the BAF at 20.
- There has been strong performance on ERF meaning the risk of not delivering ERF activity levels is proposed to be removed as a Gap.
- To help understand reductions in Trust productivity, an extensive run rate and associated bridge analysis has been carried out.
- In the context of challenging Cost Improvement Programmes (CIP) targets proposed for 23/24 which will be crucial to achieving our financial plan, year-to-date slippage of CIP savings increased to £4.9m.

Risk 5 *(Culture, leadership and engagement - Thomas Pounds):*

- The well-led review identified culture as a key focus. No score change is proposed but there are some encouraging signs such as the staff survey response rate

increase, increased reporting on Datix, increasing engagement with the Freedom to Speak Up Guardian and the fast-tracking review work on policies. – A new gap has been identified relating to “Investment and support levels organisationally for Equality, Diversity & Inclusion programmes and resources restricts progress”. Risk 7 *(Immature place and system collaborative processes and culture – Martin Armstrong)* – The well-led review identified system-working as a key development area. The additional actions in the well-led review action plan, once approved, should help. Risk 8 *(Improving performance and flow through collaboration – Lucy Davies)* – There has been good progress including: 1) the operational restructure first phase is complete. The second phase is in early development; 2) the review of Accountability Review Meetings (ARMs) and performance structuring completed; 3) Diagnostic wait times demand and capacity analysis completed 4) “Clinical and administrative processes for progressing patients through their pathways” removed as a gap; 5) Additional mobile MRI capacity in place onsite; 6) The Integrated Performance Report (IPR) changed to reflect the new NHS England performance metrics.
Impact: where significant implication(s) need highlighting
Covered above
Risk: *Please specify any links to the BAF or Risk Register*
N/A - BAF
Report previously considered by & date(s):
Since the BAF was reviewed at January Board, all the BAF risks have been reviewed by their respective lead committees.

Recommendation	The Board is asked to **NOTE** the BAF

To be trusted to provide consistently outstanding care and exemplary service

East and North Hertfordshire NHS Trust

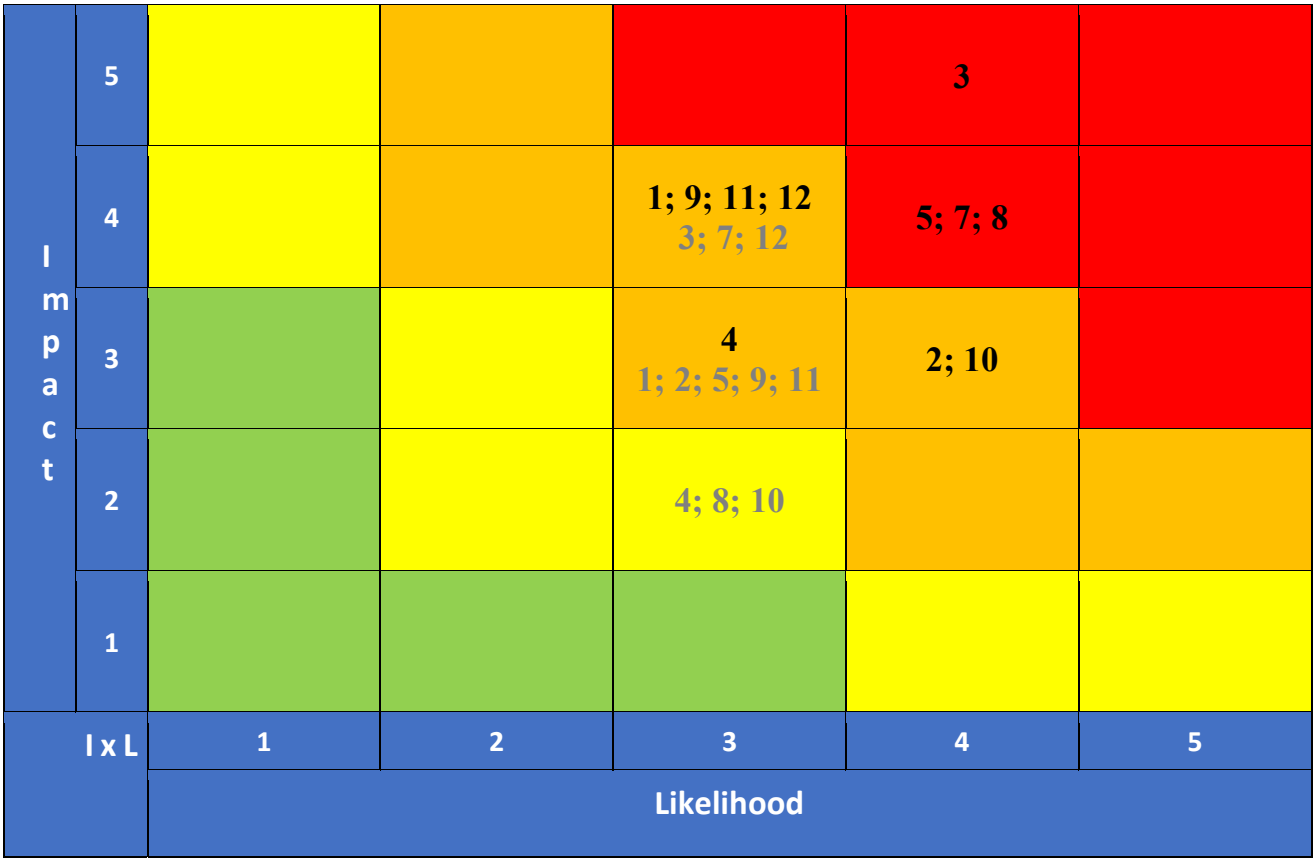
BOARD ASSURANCE FRAMEWORK REPORT

Section 1 - Summary

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

Section 2 Strategic Risk Heat Map

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



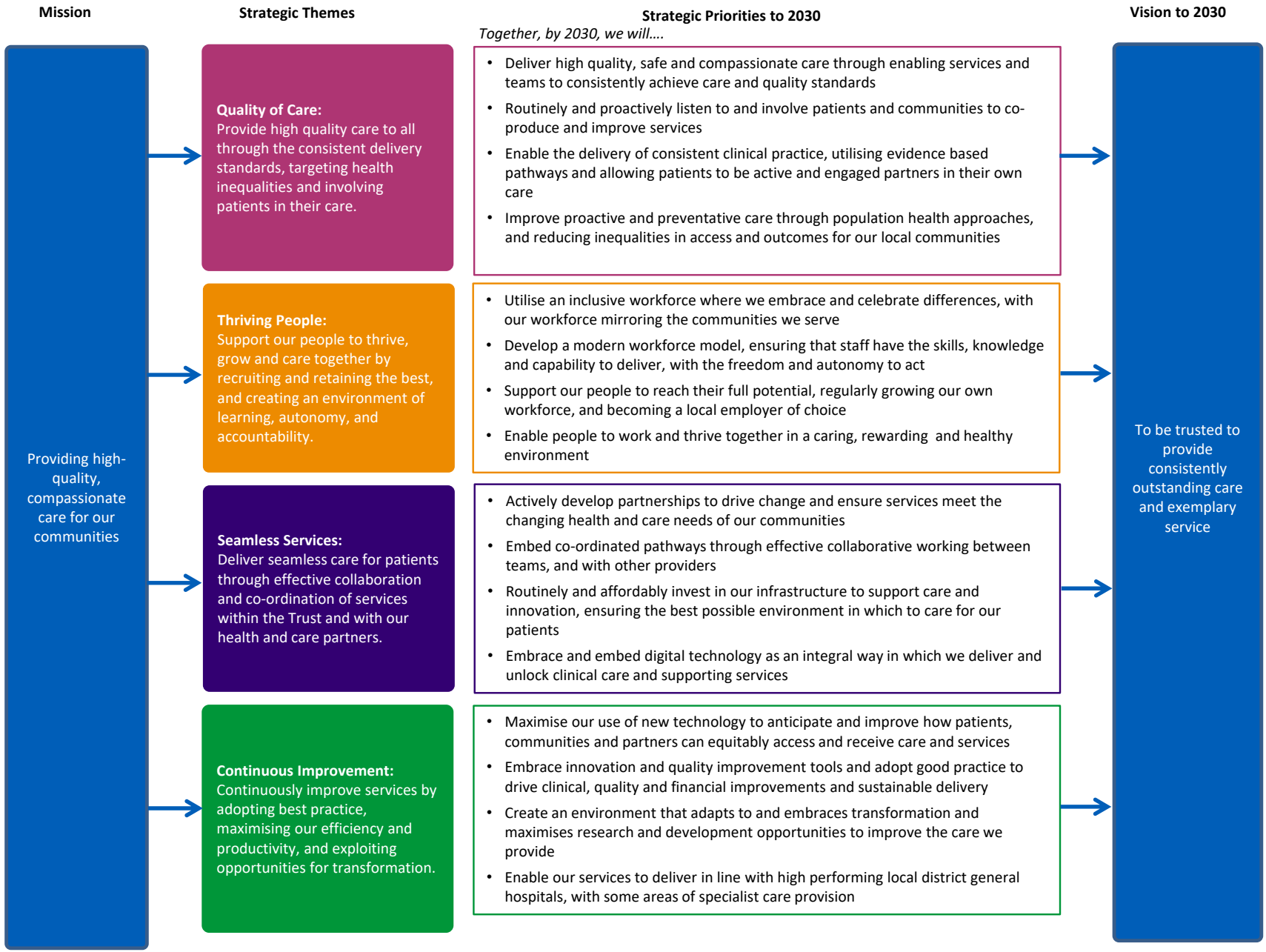
Risk Scoring Guide

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

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

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

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


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

Section 3 –Strategic Risks

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

	Impact	Likelihood	Score
Inherent	4	~~3~~4	~~12~~16
Current	4	3	12
Target	~~3~~4	~~3~~2	~~9~~8

Risk Trend

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

Controls	Assurances reported to Board and committees
Strategies and Plans • Clinical Strategy 2022-2030 • People Strategy • Annual Divisional workforce plans • Thematic review of complaints relating to staffing **Operational Systems and Resources** • Local recruitment and retention plans • Detailed establishment reviews across Nov/Dec 2022 • International recruitment plans • Training needs analysis reviews (capability building) • Fill rates and reviews • GROW appraisal and talent system weekly review via hot topics for nursing and midwifery/AHPs • Apprenticeship schemes • Change policy and toolkit • Pre and post reg training programs **Governance & Performance Management Structures** • Accountability and Review Meetings (ARM) • People Committee	**Internal Committee-level assurances** • Integrated performance report key indicators • Deep Dive recruitment briefs and reviews reports • Freedom to Speak up prevalence thematic analysis reports • Positive leadership rounds (January 2023) • Board members walk rounds to be piloted with positive leadership rounds (April 2023) • Deep dives for each division to establish staffing plans/budgeted WTE – ED, maternity and planned care. Check and challenge sessions for on rota staffing reviews due March 2023. **Third line (external) assurances** • Staff survey results • External benchmarking with Integrated Care Partnership, Integrated Care Board and other partners • Ad hoc feedback: Health Education England / Professional Bodies / Academic body (pre and post reg) partners feedback • Care Quality Commission engagements session feedback reports • Patient feedback (national) survey
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
No substantive care support worker development programme	Redesign of service delivery pathways and development of new roles including 'grow your own' skills/talent - *by end of Q4 2022/23*
• Recruitment and retention plans required for professional groups with identified high vacancy rates, e.g. pharmacy, administration	• Review of establishment in Electronic Staff record to confirm baseline staffing position - *by end of Q4 2022/23*

	• Specialty specific Recruitment and retention plans - *by end of Q4 2022/23* • CPO and CNO supporting deep dives in safer staffing *across October 2022 – CNO safer staffing paper due to go to TMG March 2023*
National and local cost of living and employment picture, which may make recruitment more challenging	To be confirmed *[The appropriate action to be discussed with the People team]*

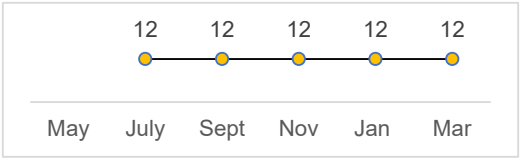
Current Performance - Highlights
The following points are highlighted from the Integrated Performance Report: • Transformation programmes delivering structure and people team changes are planned for delivery in 2022/23 • Vacancy rate overall has decreased slightly from 6.7% to 6.6% (414 vacancies). •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

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

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

	Impact	Likelihood	Score
Inherent	3	4	12
Current	3	4	12
Target	3	3	9

Risk Trend



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

Controls	Assurances reported to Board and committees
Partnership Arrangements • NHSE/I Recovery operational plan • Integrated Care Board agreements • Health watch. March 2023 maternity engagement focus • Provider collaborative • Elective HUB development / Community diagnostic HUB • Maternity Voices Partnership • Maternity Improvement Senate. Established and in place **Strategies and Plans** • Quality Strategy • National Patient Safety Strategy • National patient Experience Strategy **Systems and Resources** • QlikView Quality dashboards • Quality Oversight System 'EnHance'-. EnHance being implemented **Governance and Performance Management Structures** • Accountability review meetings • Patient and Carer Experience Committee - newly re-established carers forum Nov 2022 • Patient initiated Follow Up programme. Pilot follow up planned for SDEC. • Risk management group **Quality Management Processes** • Clinical harm reviews - cancer and non-cancer • Learning from incidents • Triangulation of incidents and complaints at divisional level. Triumvirates asked to present triangulation work. April 2023 QSC • PSIRF discovery phase to scope PSIRF plan • Model hospital information on service line and specialty standards	**Internal Committee-level assurances** • Elective recovery programme escalation reports • Cancer board escalation reports • Accountability Review Meetings escalation reports • Integrated performance reports to Board/ Committees • Executive Programme board escalation reports Sub Board Committees – assurance reports to board: • Patient and Carer Experience • Finance and Performance Committee • Audit and Risk Committee • Pace Committee **Third line (external) assurances** • NHS Annual specialty patient surveys (ED, cancer) reports • NHS Friends and Family survey results • Care Quality Commission assessment reports • HSIB reviews/reports • NHSE regulator review meeting escalation reports • Peer reviews of selected services • National patient survey

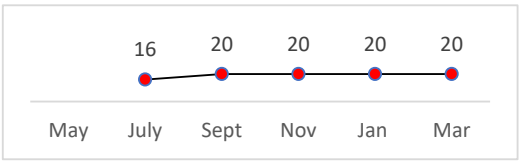
Sharing best practice Transformation programmes, specifically: • Discharge collaborative • Complaints transformation • Outpatient and theatre transformation • ICS transformation programme	
Gaps in Controls and Assurances	Actions and mitigations to address control / assurance gaps
Poor timelines in responding to concerns	Complaints transformation programme – *already in progress*
• Unwarranted variation across specialty booking Follow Up processes • Waiting list initiative payment model	• Establish safety improvement learning collaborative - *by end of Q3 2022/23 [OVERDUE]* • Transition to new a learning from incidents framework - *by end of Q4 2022/23* • Pro-active Communication plan with public and partners – *already in progress Director of Communications leading on this due Spring 2023.* • Moving beyond safe programme for clinical matrons 2022 by end of Q4 2022/23
Unwarranted variation on Clinical Harm Review – non-cancer backlogs	Business case for a digital solution - *in progress for >52weeks incidents by end of Q4 2022/23*
Clearer processes required for harm reviews relating to time waited for procedure	Implement and embed quality assurance framework - *by end of Q4 2022/23*
Delayed in patient information of non-cancer diagnosis	Improvement priorities focusing on clinical outcome letter processes, to be imbedded by end of *Q4 2022/23*
Referral To Treatment (RTT) TIER 1 rating due to long waiting times status	Implementation of intensive recovery plan *by end of Q4 2022/23*
Patient, public, stakeholder and partner engagement	Engagement strategy to be approved by the Board by Oct 23

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

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

	Impact	Likelihood	Score
Inherent	5	4	20
Current	5	4	20
Target	4	3	12

Risk Trend



Risk Lead	Chief Financial Officer	Assurance committee	FPPC

Controls	Assurances reported to Board and committees
Strategies and Plans • Approved 22/23 Revenue, Capital, CIP & Activity Plan **Operational Systems and Resources** • Financial Reporting Systems – Finance Qlikview Universe • Detailed monthly CIP performance reporting • Forecast Outturn Model and Monthly Reports • Detailed bridge analysis of deficit drivers **Governance & Performance Management Structures** • Monthly FPPC & Exec Committee Reporting • Monthly Divisional Finance Boards meetings • Monthly Capital Review Group • Financial Reset Steering Group – commences Nov-22 • Monthly cost-centre / budget holder meetings • Bi-weekly ICS Director of Finance meetings • Ratified SFI's and SO's, Counter Fraud Policy • Consolidated ICS Procurement Service & Governance • Outturn Variance Protocol to be implemented (~~Dec~~jan) • Triple Lock Investment Review protocol (Dec)	**First and second line (internal) assurances)** • Monthly Finance Report / Key Metrics to FPPC • Financial Reset Programme proposed to and supported by the Trust Board (07/09/22). Monitoring through Board, FPPC, TMG & Financial Reset Steering Group. **Third line (external) assurances** • Financial plan submitted to and approved by NHSE • Monthly financial reporting to NHSE & HWE System • External / Internal audit review of key financial systems and processes • National review of financial sustainability performance (complete in Q3) • Model Hospital / GIRFT / Use of Resources benchmarking
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Failure to deliver CIP savings at the level planned, placing financial pressure on the Trust and its system partners	• CIP Design and Delivery Framework approved at TMG (Oct) • CIP opportunities workshop (December) • Application of D&D and opportunities in 23/24 CIP programme work up in Feb and March. • Monthly financial reset meetings with divisions and Financial Reset Steering Group (In Place)
• ~~Gap in delivering ERF planned income and activity levels, creating the risk of revenue claw back~~	• ~~Financial Reset workstream to review and bolster ERF delivery arrangements (In Place)~~
• Risk of non-payment of ERF overperformance by ICB and NHSE	• ~~Dispute around terms of ERF payment escalated to SLG (Nov) with potential escalation to Region / National~~ Outturn ERF assumptions refreshed in M10 forecast and aligned with ICS assumptions.

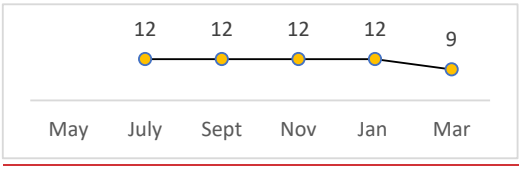
• Significant overspend against elements of the Trust's workforce establishment.	• Financial Reset – 'Medical Staffing' review to focus on this significant overspending area ~~(In Place)~~, follow up report to FPPC in February.
• Ratification of Medium-Term financial plan (MTFP) and assumptions – both Trust & ICS, triangulation with clinical strategy and improvement / transformation projects.	• Development and implementation of MTFP planning framework with ICS partner organisations. Ongoing work programme intended to complete Q4
• Significant reductions in Trust productivity in 22/23 vs pre-pandemic levels. Significant increases in staff volumes and costs not related to activity change.	• The Trust has undertaken extensive run rate and associated bridge analysis. This has framed areas for review and restatement for 23/24. This is formalized in a specific strand of budget setting activity. Delivery in February & March

Current Performance – Highlights
The following points are highlighted from the Integrated Performance Report: • Year to date deficit of £5.6m • Reliance upon non recurrent reserves to support plan achievement year to date • £4.9m YTD slippage against agreed CIP programme • Medical staffing budgets overspend of £2.3m YTD

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

Strategic Priority: **Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability**			Risk score ~~12~~9
Strategic Risk No.4: **Workforce shortages and skill mix**			
If global and local workforce shortages in certain staff groups persist or increase combined with not having the right skill mix	***Then*** the Trust may not have the required number of staff with the right skills in the right locations	***Resulting in*** a negative work experience for staff due to increased work burden	

	Impact	Likelihood	Score	Risk Trend
Inherent	~~3~~4	4	~~12~~16	
Current	3	~~4~~3	~~12~~9	
Target	~~3~~2	3	~~9~~6	



Risk Lead	Chief People Officer	Assurance committee	People Committee

Controls	Assurances reported to Board and committees
Strategies and Plans • Data accuracy between ESR and finance systems • Clinical Strategy 2022-2030 • People Strategy • Annual Divisional workforce plans and local Skill mix reviews • GROW and Succession plans • Tailored approach to nursing and medical and administration hotspots, with UK based campaigns supported by international recruitment plans **Learning and Development** • Apprenticeship schemes • Leader and Manager Development programmes **Recruitment and Retention** • Workforce Plans • NHSP and international recruitment • Various return to work schemes e.g. retire and return • Drive for 5% - recruitment and retention steering group • ICS retention pathfinders working groups **Staff Engagement & Wellbeing** • Thank you and engagement interventions • Staff Survey • Absence and referral rates • Take up of wellbeing services **Governance & Performance Management Structures** • Medical establishment oversight working group • Clinical oversight working group • Recruitment and retention group • Workforce reports – time to hire, pipeline reports • Executive Programme Board	**First and second line (internal) assurance** • IPR – to board and People Committee, including vacancy and turnover rates • WDES/WRES reports - to board and People Committee • Recruitment and Retention deep dives and reports – People Committee, ARM, Divisional Boards **Third Line (external) assurances** • Equality data for workforce (WRES/WDES) • Staff survey results
Gaps in Controls and Assurances	Actions and mitigations to address control / assurance gaps

• How we prioritise delivery • Capacity to deliver scale of changes alongside day to day service delivery e.g. scaling up agenda 'v' local changes to improve services, rely on same resources to deliver both.	• Prioritisation of programmes through board and agreed by executives in line with annual planning cycle • Improving workforce plans at divisional levels to inform prioritisation of plans to Board in line with the annual planning cycle (planning cycle Sept-March)
• Engagement and motivation to enable changes to be embedded e.g. where a change may mean we no longer deliver something ourselves and its delivered by others	• People change review report and updates which go regularly to divisional boards and sight being introduced to TMG on a regular basis (quarterly) • Support and development to managers leading change and supporting staff through change – scheduled regular development sessions throughout the year planned
• ~~Lack of agreed funding/joint budgets to enable scaling up to work~~ Competition for funding and resources across budgets to enable change at scale to happen	• Funding for large scale change to backfill release of experts to input early • Prioritisation agreed as above • Funding flows to support delivery requirements
• Capacity of key clinicians and senior leaders to work on the areas of change due to conflicting priorities	• Agreed protected time at outset of programme of change as an agreed priority – will require Programme Management Board and TMG sign-off
• Requirement for national and regional NHS workforce strategies as ENHT is dependent on these to ensure sustainable delivery of workforce changes	• Government commitment to produce NHS workforce strategy by Apr 24 • ICS workforce strategy produced January 23

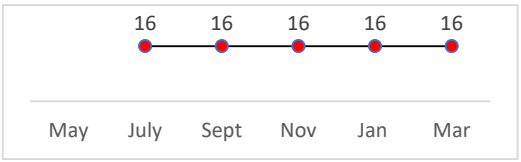
Current Performance - Highlights
The following key performance indicators are highlighted from Integrated Performance Report: • Plans to continue collaboration with the ICS for international nurse recruitment for 22/23 • Virtual training sessions and drop in events continue to take place in April and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

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

Strategic Priority: **Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability**			Risk score 16
Strategic Risk No.5: **Culture, leadership and engagement**			
If the culture and leadership is hierarchical and not empowering or compassionate and inclusive and, does not engage or listen to our staff and provide clear priorities and co-ordination	***Then*** staff experience relating to stress, bullying, harassment and discrimination will perpetuate and lead to ambiguity, information overload and staff fatigue.	***Resulting in*** staff disengagement, confused priorities, loss of purpose and low morale plus poorer staff morale and retention and ultimately poorer quality of services and patient outcomes and CQC ratings	

	Impact	Likelihood	Score
Inherent	4	4	16
Current	4	4	16
Target	3	3	9

Risk Trend



Risk Lead	Chief People Officer	Assurance committee	People Committee

Controls	Assurances reported to Board and committees
Strategies and Plans • People Strategy • ENHT Values • People policy reviews • Speak Up approaches • EDI Strategy • Leadership Development Plans **Learning and Development** • Core skill and knowledge programmes (management and Leadership) • Healthy Leadership, care support pyramid • Civility Matters • Mentoring and coaching programmes • Mandatory learning around inclusion, management and development of people • Speak up training **Recruitment and Retention** • Values assessment undertaken at application stage for senior roles and in shortlisting criteria • Pulse surveys • Feedback through local induction processes • Grievance and raising concerns policy and guidance **Staff Engagement & Wellbeing** • Core offer of support available linked to financial, physical, mental, spiritual and social wellbeing for all staff • Annual days to raise awareness of specific topics • Staff networks /Freedom To Speak Up/ Meet the Chief Executive • We have submitted our SEQOHS application for Health@Work services • Internal communications - all staff briefing, in brief and newsletter **Governance & Performance Management Structures**	**First and second line (internal) assurance** • Regular reports on progress against People Strategy • IPR **Third Line (external) assurances** • National staff survey results • WRES/WDES • Published equality data

• People Committee, staff side, Local Negotiating Committee • Divisional boards • Grow together reviews and talent forums • Staff networks	
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Capacity to undertake support and development in identified areas to improve leadership practice and engagement • ~~Lack of Organisational engagement in making things happen and embedding change~~ Challenges in the level of organisational engagement across ENHT to make things happen and embed sustainable change	• Prioritise approaches for service areas and deliver development work by end of Q4. Staff survey action plans support improvements happening locally and results are used to identify priority areas and specific support to low score areas
• Capacity to release staff and leaders to participate in development alongside day to day priorities	• Creative delivery and support to enable release and participation e.g. protected time; forward planned events and team talks • Dedicated agreement organisationally of time to develop e.g. to complete mandatory training
• Ability to resolve staff complaints quickly and easily	• People Policy reviews will be complete by March 2023 and a rolling programme for training managers in investigation, reports and hosting challenging conversations will follow during 2023/24 – on track
• Investment and support levels organisationally for EDI programmes and resources restricts progress	• EDI strategy produced by Apr 23 • EDS2 published Mar 23 with action plan to be delivered throughout the year • Gender pay gap actions embedded in organisation (between 2023-25) • Wider delivery of programmes such as cultural intelligence and civility matters across the whole organisation

Current Performance - Highlights

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

- Staff team talks have launched linked to staff survey results and actions collated in early June for monitoring progress later in the Autumn
- The increase in time to resolve disciplinaries is in part due to availability of investigation officers time and resource capacity in the system
- The time to resolve grievances continues to improve as a direct result of the ERAS team continuing to follow up and encourage early resolution

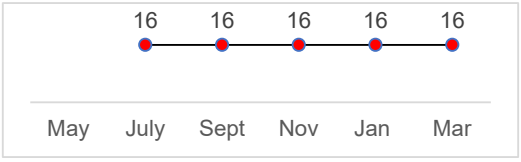
Associated Risks on the Board Risk Register

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

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

	Impact	Likelihood	Score
Inherent	4	4	16
Current	**4**	**4**	**16**
Target	4	3	12

Risk Trend



Risk Lead	Deputy Chief Executive	Assurance committee	FPPC

Controls	Assurances reported **to Board and committees**
Strategies and Plans • Clinical Strategy and Trust objectives • Joint strategic needs assessment • ICB and HCP strategies and priorities **Financial Controls** • Cross System pathway transformation commissioning priorities at PLACE/ICB/ICS **Governance & Performance Management Structures** • ICB Board • ICS Board • Place Board • Scrutiny committee • Health and wellbeing board **Relationships** • Strong networks around specific subject areas eg. UEC, Cancer etc	**First and second line (internal) assurances** • Escalation reports to: Quality and Safety Committee; People Committee: Clinical Audit & Effectiveness sub-committee • Integrated performance reports to Board/ Committees • Well led framework assessment and review reports • Elective recovery programme escalation reports • Feedback from ICB CEO attending Board bi-annually **Third line (external) assurances** • NHSE Board feedback forums

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

Current Performance - Highlights

The following key performance indicators are highlighted from the Integrated Performance Report:

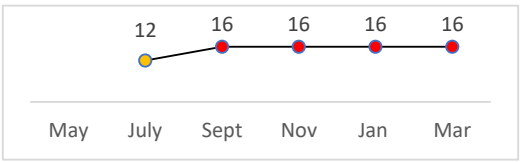
- the IPR does not include any measures that specifically highlight the effectiveness or not of collaborative arrangements

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

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

	Impact	Likelihood	Score
Inherent	4	4	16
Current	4	4	16
Target	4	2	8

Risk Trend



Risk Lead	Chief Operating Officer	Assurance committee	FPPC

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

	• ARM meetings – a revised format is currently being developed. – Completed
• Scope of validation of Patient Tracking Lists	• Increasing validation of Patient Tracking Lists – by Quarter 4 22/23
• Ambulance intelligent conveyancing lack of proactiveness	• System solution to intelligent conveyancing/ambulance intelligence will improve, but not fully address the challenge - ongoing
• Lack of social care and community capacity to support discharge • Utilisation of Hospital at Home not yet optimal – further work being undertaken to increase uptake.	• Extending scope of ~~hospitals~~hospital at home – not matching what we need (taking patients who are awaiting packages of care). This will partially address the challenge of timely discharge for medically optimised patients. ~~–~~ ongoing [timeline to be confirmed once known]
• Capacity to increase referrals to cancer pathways	• Review of ARM meetings to ensure effectiveness – by Quarter 4 –Completed
• Clinical and administrative processes for progressing patients through their pathways	~~• Increasing MRI insourcing capacity – Additional mobile capacity onsite by quarter 3, further capacity planned for quarter~~ • System being implemented to speed up the process of informing patients they do not have cancer – Quarter 4 22/23 - Completed
• Diagnostic wait times – Access Board, Cancer Board	• Demand and capacity analysis – Quarter 3 22/23 – Completed – presented to Jan 23 FPPC • Additional capacity in plan: CT, echo, ultrasound, DEXA, MRI and plain film – Quarter 4 22/23

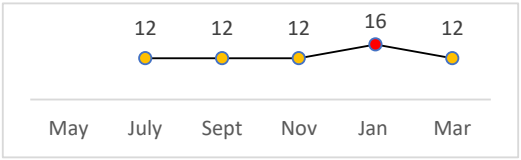
Current Performance - Highlights
The following key performance indicators are highlighted from the Integrated Performance Report: • % of 62 day PTL over 62 days • 62-day/ 31-day cancer performance • 78 weeks RTT • Ambulance handovers • ED 4 and 12 hour performance • Diagnostic waits • 2 week waits •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

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

Strategic Aim: **Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners**		**Risk score** ~~16~~12
Strategic Risk No.9: Trust and system **financial flows and efficiency**		
If finances do not move around the system in recognition of costs incurred in new models of care	***Then*** our and our partner financial positions will deteriorate	***Resulting*** in the inability to fund planned service delivery and regulatory scrutiny

	Impact	Likelihood	Score
Inherent	4	4	16
Current	4	~~4~~3	~~16~~12
Target	3	3	9

Risk Trend



Risk Lead	Chief Financial Officer	Assurance committee	FPPC

Controls	Assurances reported to Board and committees
Strategies and Plans • Signed SLA contracts with ICS commissioners for 22/23 – embedding finance and associated plans. • Clinical Strategy and associated prioritisation and development framework. Linked to place priorities **Financial Controls** • Monthly ERF & SLA activity reporting schedules **Governance & Performance Management Structures** • Establishment of SFA team to provide strategic finance transformation evaluation support • Bi-weekly ICS System Leaders meeting • Bi-weekly ICS DoFs and DDOFs meeting • Monthly E&N Herts Partnership Board & associated meetings • Elective Surgical Hub, Community Diagnostic Hub, Virtual Hospital and Heart Failure local and regional governance arrangements • PHM reporting mechanism to track changes in patient flows and associated costs and income • PHM steering and development group and link to place and system PHM development activity	**First and second line (internal) assurances** • System and Provider Collaboration reports to Trust Board advising on activity • Monthly project review sessions between Finance & Transformation Team. Transformation activity updates included in FPPC business cycle **Third line (external) assurances** • Consolidated ICS financial performance reports • Share further ICS performance reports as circulated by ICS.
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Risk of non-payment of ERF overperformance by ICB and NHSE	• ~~Dispute around terms of ERF payment escalated to SLG (Nov) with potential escalation to Region / National~~ Outturn ERF assumptions refreshed in M10 forecast and aligned with ICS assumptions.
• Establishment of transparent financial reporting environment across ICS partners	• ~~Q3~~Ongoing – ICS DoFs to work together to develop ICS financial framework for implementation
• Development of ICS financial risk management strategy	• ~~Q3~~Ongoing – ICS DoFs to work together to develop ICS financial framework for implementation
• Determination of place based financial responsibilities	• ~~Q3~~Ongoing – ICS DoFs to work together to develop ICS financial framework for implementation

• Development of long-term financial plan for ICS	• ~~Q3~~Q4 – ICS DoFs to work together to develop ICS financial framework for implementation
• Acute Provider Collaborative and associated business rules	• Approved by Trust ~~CEO's~~CEOs – Sep 22. ~~CEO's~~CEOs to review and approve collaborative governance arrangements (~~Dec~~Feb). Move to implementation phase
• Further Board dialogue to be facilitated to help develop further metrics that can support assurance	• To be addressed through future ~~Kings Fund and Board Development Sessions~~board development sessions

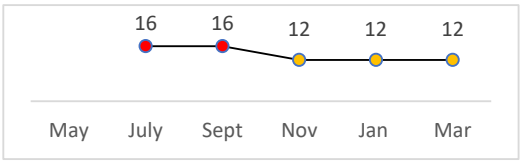
Current Performance - Highlights
The following key performance indicators are highlighted from the Integrated Performance Report: • Performance against ERF income and activity targets • Delivery of ~~CDH~~CDC activity levels

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

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

	Impact	Likelihood	Score
Inherent	4	4	16
Current	3	4	12
Target	2	3	6

Risk Trend



Risk Lead	Director of Transformation	Assurance committee	QSC

Controls	Assurances reported to Board and committees
Strategies and Plans • Board approved 22/23 Strategic Objectives • 10 Year Integrated Business Plan • Digital Roadmap • Front Line Digitisation **Systems and Resources** • QlikVIew dashboards/ deployment of SPC methodology **Governance & Performance Management Structures** • Executive Programme Board • Clinical Digital Design Authority • GIRFT Board • Programme and project delivery framework • ENH HCP Transformation Delivery Group • Provider collaborative Programme Board **Quality Management Processes** • Here to improve model **Training and Sharing Best Practice** • Trust-wide training and development programme • Learning events, safety huddles and debriefs	**First and second line (internal) assurances** • Monthly Divisional Board and Transformation meetings • Monthly programme reports • Digital programme boards • Key performance metric reporting to Board/Committees • Board and Committee transformation update reports • External /internal audit review of key programmes i.e., transformation portfolio, efficiency and productivity, strategic projects **Third line (external) assurances** • Annual and Pulse staff surveys • National benchmarking reports • NHS Model Hospital Portal • GIRFT programme
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
Control gaps • Single improvement methodology not established across the organisation	**Control treatments** • Procurement process to identify an improvement partner to roll-out a Quality Management System to commence December 22/23.
• Consistency with engagement across all staff groups to support improvement projects	• Roll-out strategic objectives aligned with Grow Together conversations and new Trust values and behaviors
• Ongoing number of trust projects require cultural change and formal organisational redesign approaches	• Formalisation of an organisational development change model and engagement programme to commence December 22/23 as part of Quality Management System preparation.

• Variation in business-as-usual systems and processes	• Adoption of lean thinking in pathway redesign model as part of the new Quality Management System.
• Improvement training compliance is variable across staff groups and levels of seniority	• Review of the current dosing model for improvement skills and training following confirmation of Improvement Partner in Q1 23/24.
• Benchmarking data comparisons not routinely understood to inform improvement priorities	• Development of a new annual benchmarking programme to monitor and evaluate performance and priorities to commence Q4 22/23.
Assurance gaps • Performance data indicates issues with sustaining changes and embedding culture of improvement and learning.	**Assurance treatments** • Review of current processes for aggregated Trust learning and gap analysis plan to be developed by end Q4 22/23.
• Programme milestones and KPIs reflect compliance issues with Trust project management principles	• New strategic project management governance framework established. External audit scheduled Q4 22/23.
• Engagement in the design and adoption of digital systems	• Review of mechanisms to ensure stakeholders have adequate time to engage in design and transformation. • Executive Programme Board to provide oversight and leadership regarding alignment resourcing and decisions
• Alignment of new transformation portfolio digital requirements with overarching Digital Roadmap	• Executive Programme Board to provide oversight and leadership regarding alignment resourcing and decisions

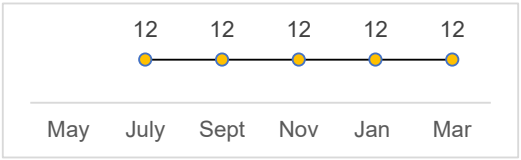
Current Performance - Highlights
•
• Improvement Partner ~~business case and tender specification agreed at Trust Management Group on 3rd November with~~ SQ procurement ~~process due to launch 1st December~~scoring session completed 20th January and five suppliers shortlisted for ITT stage.
• ~~Series of benchmarking data packs incorporating GIRFT and Model Hospital data used to inform progress across Outpatients and Surgical Pathways transformation programmes.~~
• Positive leadership walkrounds commenced 20th January.
• Internal audit ~~focusing on Hospital at Home to test new~~ regarding CDC Programme completed and programme governance arrangements ~~at Executive Programme Board now complete and draft report issued~~provided substantial assurance.
• A series of evaluations and learning events commenced to undertake an end of year review of the Trusts strategic portfolio with initial findings to be reported at February EPB.
• A series of lean-based, process mapping events are scheduled in February to review high-profile areas i.e. Workforce onboarding, DRP process, Endoscopy booking etc.

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

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

	Impact	Likelihood	Score
Inherent	5	4	20
Current	4	3	12
Target	3	3	9

Risk Trend



Risk Lead	Director of Transformation	Assurance committee	People

Controls	Assurances reported to Board and committees
Strategies and Plans • Quality / Patient Safety Strategy • EDI strategy **Systems and Resources** • QlikView Quality dashboards • Quality Oversight System 'EnHance' • Change Toolkit and Policy **Governance and Performance Management Structures** • Patient Safety Forum(s) • Collaborative(s) (harm free care/ deteriorating patient) • A just culture guide for evaluating patient safety incidents • Freedom to speak up guardian / network • Mortality review process • Clinical audit programme **Learning from Incidents** • Clinical and serious incident review panels • Schwartz rounds/ quality huddles/ Here for You sessions • After Action Review debriefs **Quality Management Processes** • CQC and compliance preparedness framework • Incident management KPIs • Patient safety specialist role (s) **Training and sharing best practice** • RCN Clinical Leadership Programme • QI Bite size, masterclass & coaching sessions • PDSA / quality improvement in action • Leadership rhythm / bite-size sessions • Human factors simulation training	**First and second line (internal) assurances** • Divisional quality meetings/ structures • Accountability Review Meetings • Key performance metric reporting to Board/Committees • External/ internal audit review programme i.e., BAF & Risk Management, MHPS • CQC peer/ ICB review assessments • Risk Management Group **Third line (external) assurances** • Annual and Pulse staff survey results • Care Quality Commission assessment process • ICB / Place Quality Surveillance Group • NHS patient survey results • NHS clinical incident reporting benchmarking
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
Control gaps • Single improvement methodology not established across the organisation	**Control treatments** Develop and roll-out a Quality Management System with Improvement Partnership support due to commence in Quarter 2 23/24.

• Freedom to Speak up Strategy not launched or imbedded	• Develop leadership and management framework to support freedom to speak up processes as part of BAU in Q4 22/23
• Variation in ward to Board quality governance structures and operational procedures	• Good Governance Institute review. • National Safety Incident Framework launch in Q1 23/24 in a phased approach.
Assurance gaps • Efficacy of current learning systems from incidents, complaints, audit and wider performance issues where there are reoccurrences of similar themes and outcomes.	**Assurance treatments** • Review of systems to capture and share learning • Develop and launch a refreshed vision for learning and improvement, closely linked to strategic objectives and Trust values to commence Q3 22/23.
• Level of staff absence, survey feedback themes and grievances reported by staff through FTSU Guardian.	• Review of ward/specialty MDT governance processes - develop MDT ward leadership model • Development of ICB / Place learning network

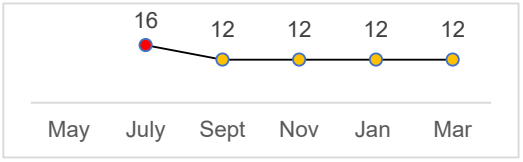
Current Performance - Highlights
~~• Improvement Partner business case and tender specification approved at Trust Management Group on 3rd November.~~ ~~• Selection questionnaire and short notice documentation submitted to procurement services with an opening date for the competitive process scheduled to start 1st December.~~ ~~• Risk Management Group established with remedial work to quality control the Corporate risk register underway.~~ ~~• Board development session from October used to develop risk appetite statements for inclusion in the new Risk Management Strategy document.~~ • Selection Questionnaire process for the Improvement Partner procurement completed 20th January with five suppliers shortlisted for final stage. • Action plan incorporating QI capability building as part of recommendations from the Good Governance Institute report completed. • Overview of new PSIF framework and internal roll-out plan submitted by Director of Quality and approved at TMG 5th January. • New complaints process underway with learning capture a standard requirement of the new triage documentation.

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

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

	Impact	Likelihood	Score
Inherent	4	4	16
Current	4	3	12
Target	4	2	8

Risk Trend



Risk Lead	Medical Director; (Chief Nurse)	Assurance committee	QSC

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

• Values and behaviour programmes • Freedom to speak up guardian / network • Medical Director quarterly update presentations & Q&A session - All consultant & SAS doctors invited • Medical Director's quarterly newsletter • MAC, LNC & JDF • Trainees in Leadership Support Group • Healthy teams Programme • Kindness and Civility Programme	
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
Control gaps Skills and knowledge within clinical workforce to learn how to drive change	• Combined efforts to drive skills and knowledge by people team, transformation team, quality improvement team and business information's analysts in progress • Engage with ~~and~~an improvement partner *end of Q3 2023/24 – likely to be in place earlier*
Capacity within clinical roles to apply change methodology	• Agreed job planning and rostered time demonstrated through Roster on PA allocation. To be reviewed as part of job planning criteria for 2023, full rollout by Q4 23-24 • Proposal to provide selection of trainees time to be involved in KOPs/QI and transformational projects
Unwarranted variation in quality assurance framework	Redesign quality assurance framework *by end of Q3 22/23* [OVERDUE]
Current national safety Incident framework	New safety incident response framework implements *by end of Q4 23-24*
No allocated Medical lead Quality Improvement	In short term lead identified is Associate Medical Director for Quality and Safety. Appointment of Deputy Medical Director for Quality Improvement scheduled for Q1, 2023-4
Operational pressures, especially throughout Q3 and Q4	Risk based approach to quality improvement and prioritising
Assurance gaps Improving evidence of imbedded sustainable changes following learning from incidents, complaints, audit, and wider performance issues	New national safety incident response framework (PSIRF) to be implement by Q4 23-24 will improve evidence

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

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

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	10
Report title	Strategic Transformation Update			**Meeting Date**	1 March 2023
Presenter	Katherine Marwood, Programme Director				
Author	Kevin O'Hart, Director of Improvement				
Responsible Director	Kevin O'Hart, Director of Improvement			**Approval Date**	23 February 2023
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**		☐
	Discussion	☒	**Decision**		☐

Report Summary:

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

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

There are several areas within the portfolio where success requires underlying changes in historical ways of working both internally and across the system. The necessary cultural changes in behaviours are currently limiting progress across a number of objectives. It will take time to bring all stakeholders forward together with a shared purpose, within a safe, continuous improvement environment. This journey will be supported and accelerated via the Improvement Partner proposal scheduled to commence in 2023/24.

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

Risk 11 Innovation
Risk 10 Technology, systems and processes

Report previously considered by & date(s):

Executive Programme Board 8 December 2022

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

To be trusted to provide consistently outstanding care and exemplary service

Strategic Transformation Portfolio Report

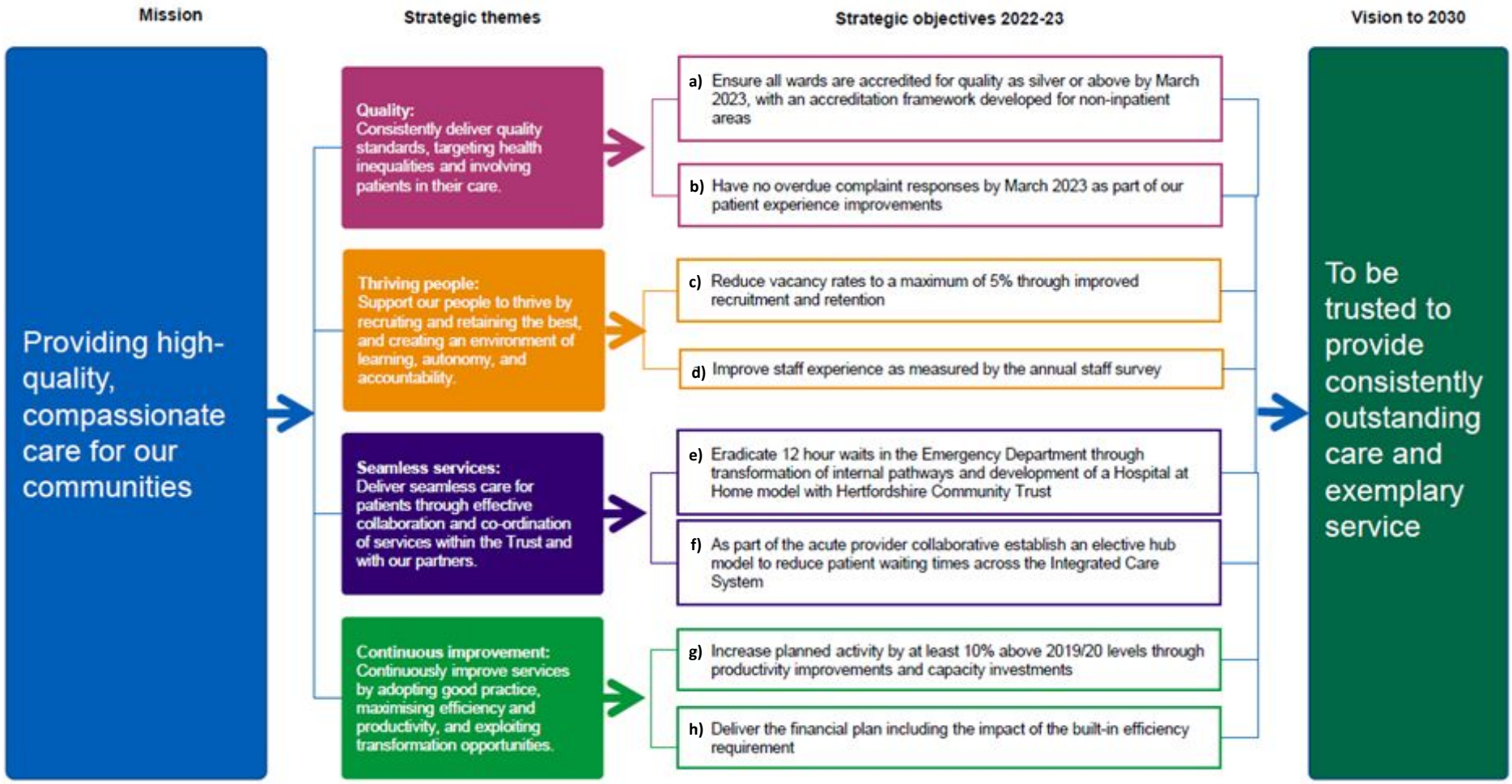
East and North Hertfordshire NHS Trust

Trust Board
1 March 2023

Kevin O'Hart, Director of Improvement

Strategic Objectives 2022 - 23

East and North Hertfordshire NHS Trust



Executive Programme Board Updates

East and North Hertfordshire NHS Trust

Strategic Theme Seamless Services - Care Closer to Home	Milestones	KPIs
SRO – Kevin O'Hart, Director of Improvement		

A task and finish group was established in August with the request from ENH Partnership Board to develop a Care Closer to Home ENH HCP Strategy. During a series of stakeholder sessions over the last few months we have subsequently built and agreed the main component parts for this joint document. This has included the development of a new service model blueprint which is people centred, targeted at locality level and promotes local, joint, multi-disciplinary services. The aim is to bring together services covering prevention, self-management, chronic management, exacerbations, acute management and reablement under a single point of access model that will target and support the most vulnerable 'high impact' people from our communities.
We are now in the process of mapping our initial Population Health Management (PHM) analysis with the cohort of people that are accessing services from all Providers most regularly so interventions can be targeted at those in most need, and therefore where greatest impact will be felt . It has been agreed the care of these patients will be at a local level as this reflects the most well-established, universally recognised boundaries that are contiguous with district and borough councils etc.
The strategy document was provisionally approved at December's Partnership Board, and the group is now developing a project plan to run a proof-of-concept pilot across one locality during Quarter 4. Learning from this process will then inform the wider scaling up and spread of the final model. There are no intended investment requirements for this work; this is about how we improve and redesign the deployment of our current resource to better meet people's needs.

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

The CDC programme continues to overperform against revised trajectory by 6%; an additional 8,920 examinations have been completed since 1st April. There are a further 8,193 tests to be completed by 31st March though these increases are now supported with a fully staffed, expanded rota establishment. The successful implementation of the first phase of the Community Diagnostic Centre programme has resulted in radiology being transferred to business as usual, with the associated documentation approved at the CDC Board in December. Timelines for handover of the other first phase specialties; cardiology and gastroenterology will be agreed in January 2023. The Fibroscan pathway is open to GP referrals. ECHO activity funded through the CDC programme has significantly reduced the backlog to 7 weeks. Further NHSE funding has been approved for the mobilisation of a respiratory diagnostic and Direct Access Holter

Executive Programme Board Updates

East and North Hertfordshire NHS Trust

pathway from April 2023, as part of Phase two of the programme. A bid is being developed for an additional MRI at the New QEII Hospital although it is likely NHSE capital funding will be deferred until 2024/2025.

Strategic Objective E - Discharge Improvement	Milestones	KPIs
SRO – Theresa Murphy, Chief Nurse		
Increased urgent and urgency care pressures necessitates the need to improve patient flow and efficient, safe discharge processes for patients. Significant digital changes have been made to increase the visibility of actions and tasks agreed during board and ward rounds, to support the achievement of the standards outlined in the Board and Ward Rounds SOP. As part of the implementation process, Ward Managers completed a self-assessment of their practice against the SOP and a further in-depth gap analysis was completed by Senior Divisional Nursing teams to identify areas for additional support and focus. Some areas may also require changes to consultant job plans in order to enable consistent early morning presence, and the Medical Director's Office have confirmed that job planning will be completed by April 2023 which will support this. To support the further roll out of Criteria-led Discharge, a nursing competency framework has been written and approved by the Clinical Skills Committee. This will enable the finalisation of the SOP and will support further roll out across specialties. ENT specialty commenced a criteria-led discharge pilot on 12/12/22 led by competent trained nurses, with clinical oversight from an ENT Consultant. This pilot will help inform the continuing development of the SOP and inform future pilots. The next pilot area will be with Gastroenterology. It is anticipated that criteria-led discharge will have a positive impact on both the time of day that discharges happen, and enable an increased level of weekend discharges. An additional piece of work is ongoing to review the use of the Discharge Lounge and the SOP which supports this. An engagement exercise is underway with nursing colleagues to identify any potential barriers to use, opportunities to increase the scope of activity, and opportunities to increase utilisation. Increased use of the Discharge Lounge earlier in the day will support improved flow into wards and contribute towards improving performance within urgent and emergency care flows.		

Strategic Objective E - Hospital at Home	Milestones	KPIs
SRO – Michael Chilvers, Medical Director		
The post-operative remote monitoring pilot within the Trauma and Orthopaedics specialty has now completed, with 12 patients		

Executive Programme Board Updates

East and North Hertfordshire NHS Trust

participating. Internal evaluation showed that for patients on the pilot the average length of stay was 2.2 days, compared to 3.6 days for the control group. A more detailed evaluation is underway with the support of the Academic Health Science Network and these findings will be used to inform additional improvement opportunities with surgical patients nationally. Media interest includes a Sky news report and a case study on the NHSE Transformation Perioperative Digital Playbook. The Planned Care Division and Transformation Team will be working together to expand this offer and scale up across additional surgical specialities in early 2023. Work is ongoing to identify other patient groups who currently reside within Acute beds at the Lister whose care could be provided by Hospital at Home, with pilots in planning phase (for example for patients with Acute Kidney Injury). The Handover at Home trial continues and led by HCT to pull suitably identified patients from the ambulance list into Hospital at Home. Current activity averages approximately 7 fewer patients per day being brought into Emergency Departments. Hospital at Home also presents an opportunity to support other patients with long term conditions which might exacerbate and require acute-level input, such as heart failure. As such Hospital at Home is being built into the target operating model for a proposed new place-based Integrated Heart Failure Service. Key features of the model include: secondary and primary care joint MDTs, a peripatetic specialist workforce, a Single Point of Access, a Service Lead to ensure cohesion across organisations, integration with Hospital at Home, and Community Diagnostics. A business case has been agreed in principle by Partnership Board, though at this stage the source of funding remains unconfirmed.

Strategic Theme Continuous Improvement - Improvement Partnership	Milestones	KPIs
SRO – Kevin O'Hart, Director of Improvement		

This programme will coordinate improvement work to co-design and roll-out a new ENHT Management System; this requires consistent patterns of collective activity through which the organisation systematically generates and modifies its operating routines in pursuit of improved effectiveness. This model will apply across all functions, all levels, and all pathways and services with the goal to foster a sustainable culture of continuous improvement capability across the organisation.
Adopting a lean methodology as our management system involves the whole organisation working together to enhance 'value' from the perspective of the patient, improving quality and safety of service delivery, and embedding a sustainable culture of continuous improvement. As an organisation we struggle with inefficient processes and unwarranted variation, lean offers a tailored solution to resolve these issues.
This programme requires an improvement partner with proven, subject matter expertise in the co-design and successful large scale deployment of a management system across NHS organisations. The procurement process commenced via a Selection Questionnaire process on 1 December; if approved the timeline would confirm the successful supplier by May 2023, with a commitment to mobilisation by early Quarter 3.This work will run over three years with a gradual incremental reduction in support as internal capability is established.

Executive Programme Board Updates

East and North Hertfordshire NHS Trust

Strategic Objective G – Outpatients (PIFU & Follow-Up)	Milestones	KPIs
SRO – Mark Stanton, Chief Information Officer		
This programme continues to support the NHSE Planning Guidance target to move or discharge 5% of outpatient attendances to patient-initiated follow-up pathways (PIFU) by March 2023. PIFU pathways give patients and their carers the flexibility to self-manage their follow up appointments but require a different new way of working for teams which has posed a challenge to implementation nationally across all providers. Due to Trust's slow progress with roll out, the PIFU Relaunch plan started in September with targeted engagement led by Clinical Directors to increase PIFU activity in each area. This has had a positive impact on Trust performance with improvement from 0.87% in Sept to 1.36% in Dec 22 (part month). There were 9 specialties live on PIFU in September and now there are 12 specialties with live PIFU pathways in December. Breast surgery and respiratory physiology are leading the way at over 10% of all patients on PIFU, neurology and trauma and orthopaedics exceeding the 5% target and work with remaining twelve specialties is ongoing. PIFU Inpatients is due to go live in February 2023 , and PCFU (A NHSE mandated PIFU pathway for cancer patients) due to go live in January 2023. Discussions are underway with NHS Intensive Care Support Team (IST) regarding launch of PIFU for DNAs process. Targeted communication plan has been developed to support with raising awareness and increased uptake through clinic walkabouts, posters in clinical areas, rolling half day presentations and daily news stories. Outpatient strategy workshop was held on 23rd November 2022 and has signalled the beginning of the development and design of the Trust Outpatient strategy and transformation plan. The aim of the workshop was to agree a plan for delivery of outpatients services to meet increasing demand in the most efficient way, in an appropriate setting through the most effective utilisation of systems and processes. The event has been attended by over 30 senior leaders across clinical and operational teams and seen great participation. Output of the day has seen key broad themes for improvement emerging around processes, patient communication, waiting list management and integrated pathways all of which will be scoped further fully with senior stakeholders, led by transformation and digital teams, over the coming months and will feed into Outpatient strategy and transformation plan.		

Strategic Objective A – PALS & Complaints	Milestones	KPIs
SRO – Kevin O'Hart, Director of Improvement		
Our new PALS and Complaints Programme is focusing on improving our internal processes both within the corporate team and the Divisions to reduce response delays and improve the quality of our correspondence ensuring all concerns are fully addressed. We also		

Executive Programme Board Updates

East and North Hertfordshire NHS Trust

aim to increase triangulation of themes and improvement actions to embed learning across the organisation and increase training and upskilling of our staff to empower everyone to resolve concerns at the earliest opportunity.
The programme continues to have excellent engagement and passion from the Complaints and PALS Teams, however progress and pace has been a challenge, therefore December was an agreed "reset" month whereby additional support was deployed to assist complaints department in drafting formal responses with an aim to accelerate reduction of backlog. 46 complaints have been sent out to corporate and unplanned care departments. The reset month has seen a very positive engagement across the Trust with at least 21 members of staff being involved. Improvement work using small tests of change has started in pilot specialities, trauma and orthopaedics and obstetrics and gynaecology, where we currently see challenging response times to agree a series of actions and improvement trajectories. New processes and complaints grading matrix has been developed to determine the route of investigation based on its complexity, reduced timelines for each stage of our complaints process and revised escalation protocols with associated accountability actions linked to specific named roles to unlock delays. Latest achievements also include a QlikView dashboard refresh to add visibility of the status of complaints and improved information breakdown. A comprehensive communications plan has also been developed including routine PALS presence on wards, complaints awareness training as part of core induction and "you said, we did" articles will be published on the Trust website.

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

A new Theatres ICB group will monitor theatre improvement, provide collective support, sharing best practice and levelling up performance across the system. Theatre leads are invited to a new monthly meeting; the inaugural session took place in December. GIRFT will join every other month with the intention to hold the ICB to account for GIRFT theatre metrics.
Clinical Networks are now in place for MSK, Ophthalmology, Urology, Gynaecology. These are clinically led bringing Trusts together as a system. Networks will be responsible for their theatre, outpatients' elements, provider collaboration development, High Volume Low Complexity (HVLC) work and compliance with GIRFT standards.
The system wide sharing of Theatre efficiency learning continues with colleagues from PAH joining ENHT 642 meetings in January. Senior Operations team members have visited Guys and St Thomas NHS Trust to learn from their experiences and were pleased to be able to share some of the success and best practice implemented at ENHT.
The staff consultation is complete, and the lead manager role has been recruited to commence mid- January. Individual meetings have resulted in the nursing leadership reviewing some additional options for the training and development model.

Executive Programme Board Updates

East and North Hertfordshire NHS Trust

Changes to how we pay non contracted work out of hours has resulted in a drop in uptake of additional sessions, and priority for theatre lists being given to those with the greatest clinical need. An interim timetable has been produced to commence in January to help mitigate this and enable each session available to be fully utilised. An audit of Suggested Theatre Allocation Times (STAT) booking tool performance will commence once the timetable is live and run for 8 weeks. The first phase of the new theatre system 'Bluespier' is live and working well. The next stage, introducing handheld devices to enable real time reporting will commence in the new year, this will provide more accurate insight into areas of opportunity for improvement.
Following on from the data review and reset of the Surgical Pathway programme, three specialities have been identified as having the greatest opportunity for improvement and resources redirected to support these. 1) Trauma and Orthopaedics, 2) Ophthalmology, and 3) Oral. There has been strong multidisciplinary engagement to identify key areas of improvement that can be tested via PDSA cycles to increase the average case per list and return performance to 19/20 levels.
A full review of the end-to-end process within the surgical pathway has been completed, and round table MDT sessions are booked in January to agree areas of opportunity that impact all specialities and actions / PDSA cycles to improve performance.

Strategic Objective E – Urgent & Emergency Care	Milestones	KPIs
SRO – Lucy Davies, Chief Operating Officer		

We continue to experience increasing and sustained non-elective pressure, leading to performance challenges with regards to ambulance handover delays, and length of stay in ED. Whilst the Trust is reactive to the demands, a shift to a more proactive approach needs to occur to ensure stability and safety within urgent and emergency care pathways. This new programme aims to improve UEC performance in four key areas: patient flow from ED into the wider hospital; increase the proportion of patients streamed to minors to improve how quickly they can be treated and discharged; reducing delays in ambulance handovers; and supporting paediatric ED to respond to significant and increasing pressures. In the short term the programme aims to make rapid improvements to support winter delivery, and ensure alternative UEC access points are well utilised to reduce pressure on services. In the longer term the programme will also progress towards the new mandate to have an Urgent Treatment Centre co-located with the ED on the Lister site. It will also review how we can make better use of the Trust's innovative predictive analytics tool to support improved delivery. Early actions have been taken to formalise and agree a new 'reverse boarding' protocol to enable ED to move patients into inpatient wards faster when a bed is becoming available, and the ambulance handover pathway has been process mapped with recommendations made. Next steps will include refreshing the 'full capacity protocol', making improvements to ambulance handover processes, and agreeing a 'Pull for Safety' model to ensure risk is appropriately spread throughout the organisation and improve patient experience and safety within ED.

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board		**Agenda Item**	11
Report title	People and Workforce Strategy Annual Progress Report		**Meeting Date**	1 March 2023
Presenter	Thomas Pounds – Chief People Officer			
Author	Thomas Pounds – Chief People Officer			
Responsible Director	Thomas Pounds – Chief People Officer		**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**	☐
	Discussion	☒	**Decision**	☐

Report Summary:

This report provides a summative update on the progress of the People Strategy.

The ICS's People Strategy, referred to at January's Board, has been uploaded onto Diligent's Resource Centre for easy reference.

Impact: where significant implication(s) need highlighting

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

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

Report previously considered by & date(s):

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

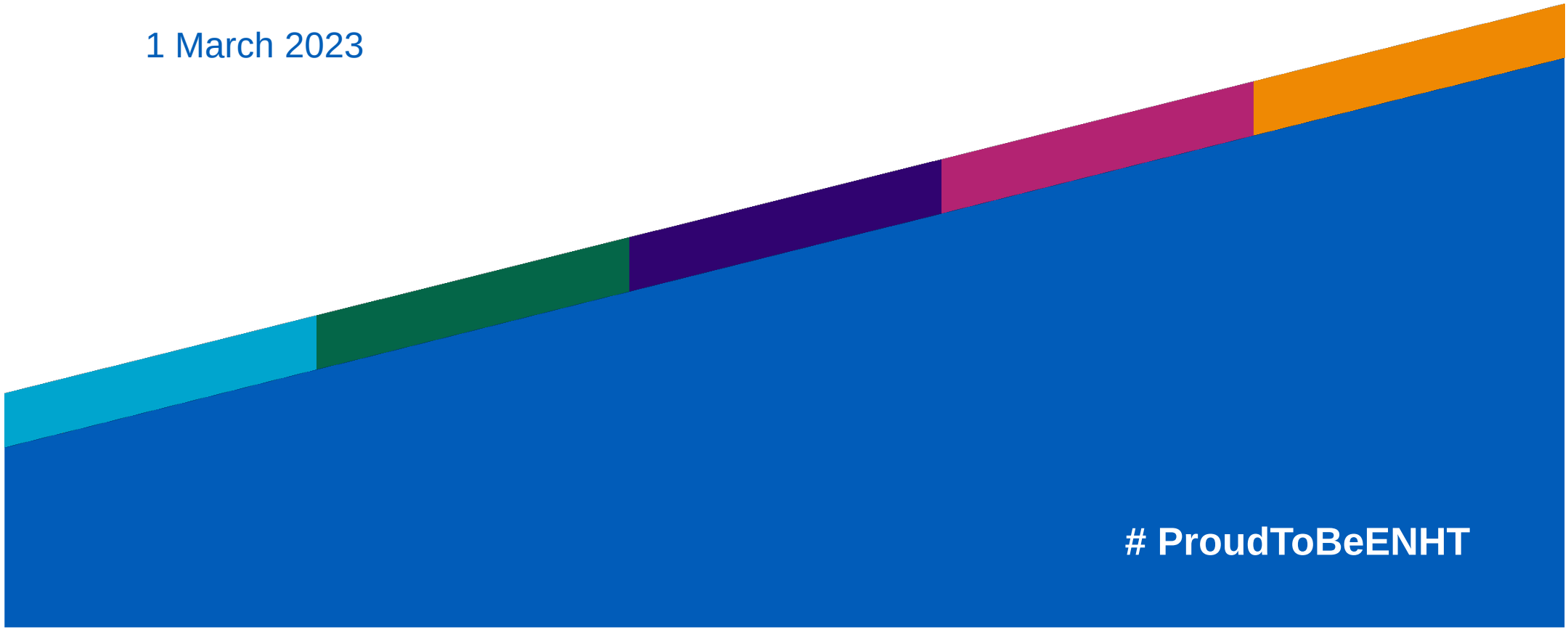
To be trusted to provide consistently outstanding care and exemplary service

People Strategy Update

Thomas Pounds, Chief People Officer

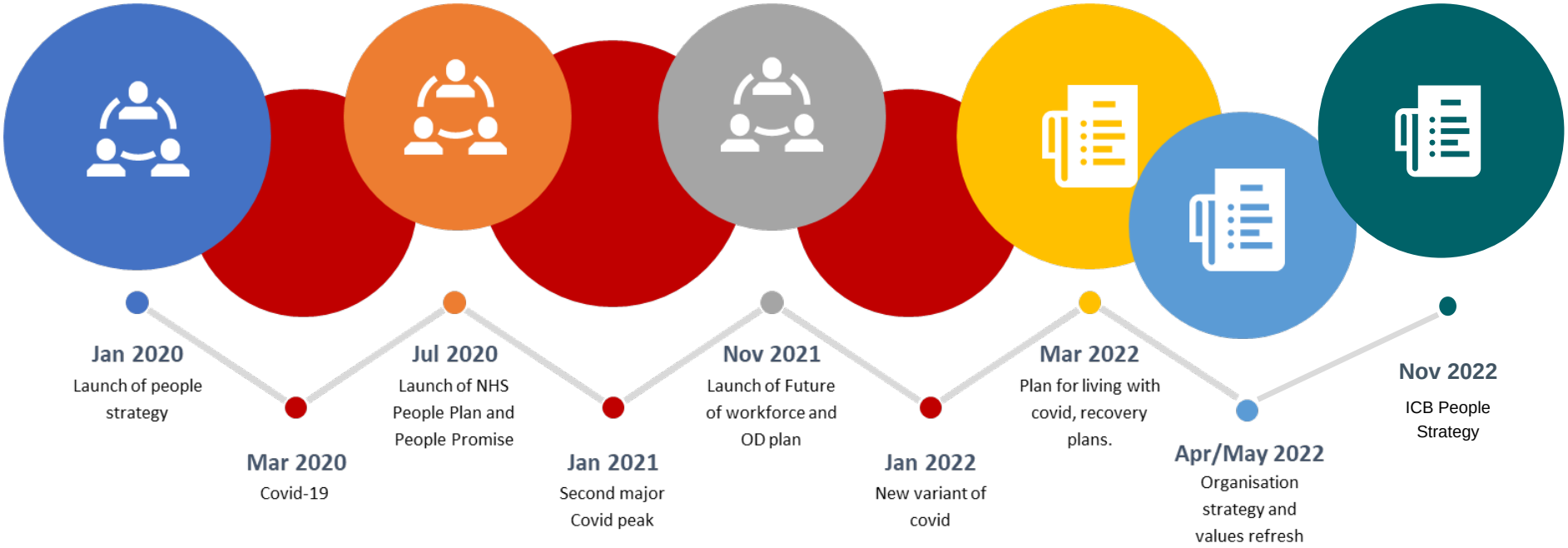
1 March 2023

East and North Hertfordshire NHS Trust



Background and context

NHS
East and North Hertfordshire
NHS Trust



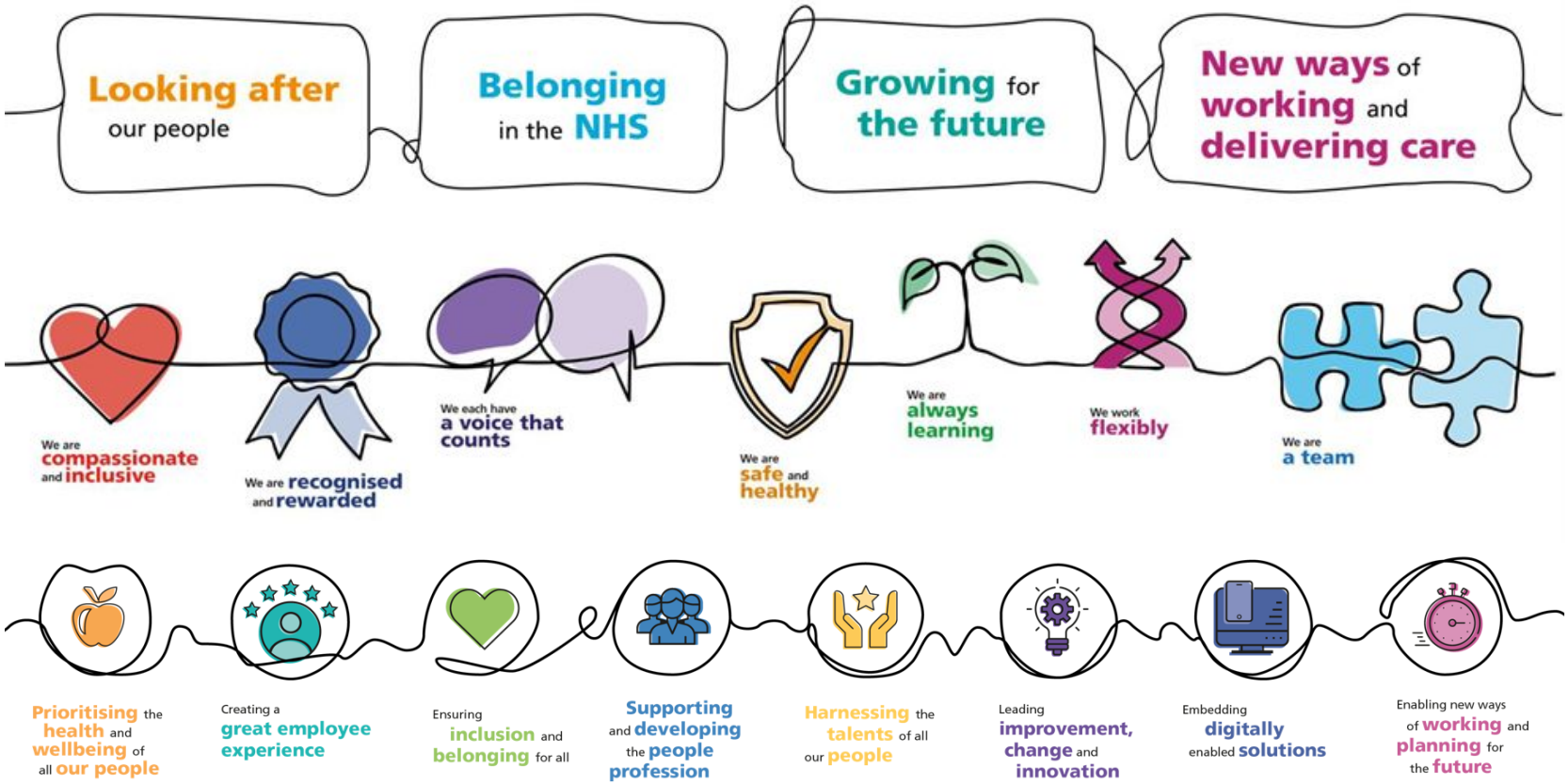
Background and context

East and North Hertfordshire NHS Trust

A PLACE WHERE EVERYONE CAN WORK, GROW, THRIVE AND CARE TOGETHER, FOR OUR PATIENTS

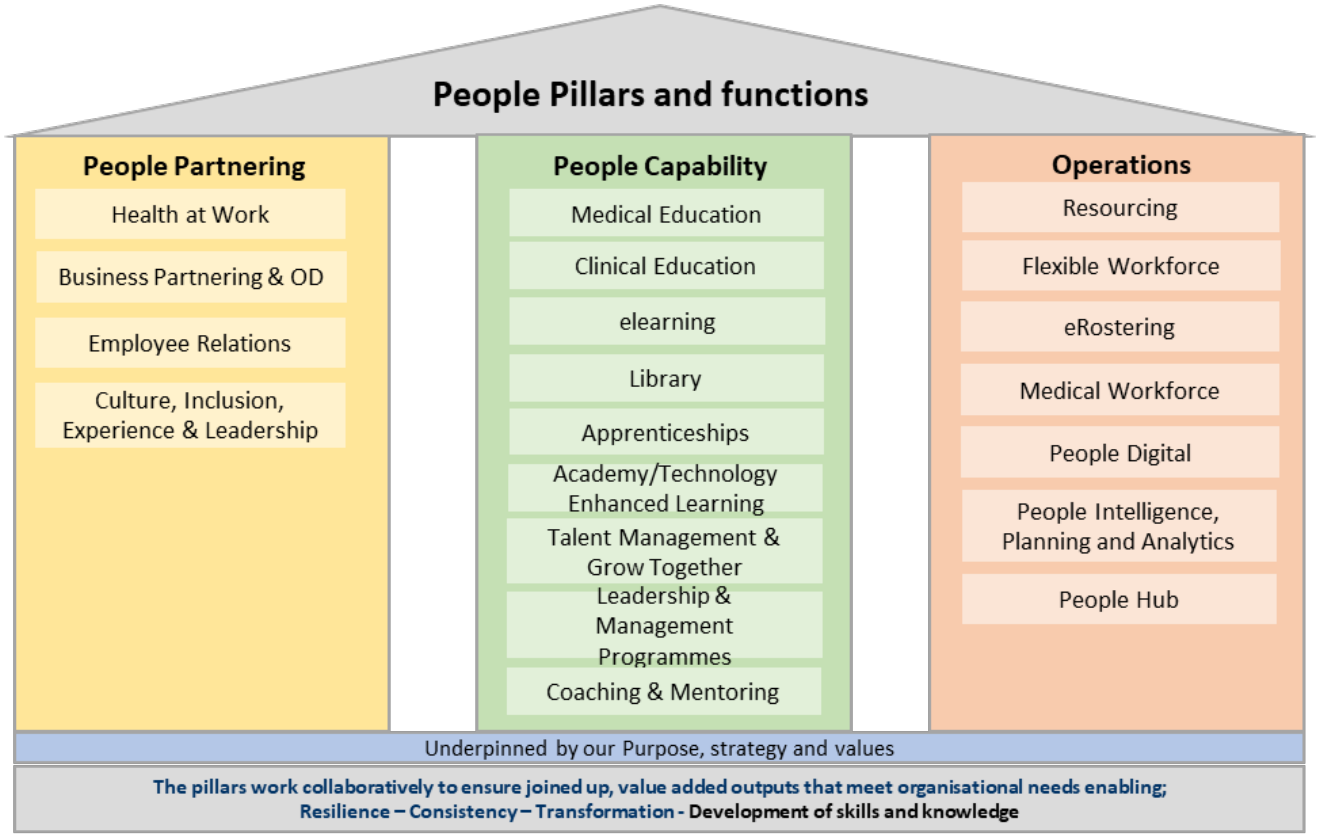
Background and context

East and North Hertfordshire NHS Trust



People Team Structure

East and North Hertfordshire NHS Trust



- Three pillars working vertically and horizontally to deliver the people strategy
- Recruitment to senior roles completed Jan 22
- Roles and structure finalised September 22
- Increased investment in people partnering to support culture change and workforce transformation
- Consolidation of people capability functions to ensure that there is multi disciplinary learning and education delivery, career pathways and a suite of learning tools
- Developing and improving customer experience and becoming more efficient through digital capabilities
- Ready for 'future of workforce and OD' progamme

Our Values

NHS
East and North Hertfordshire
NHS Trust

- Spring 2022 – 'Refresh Our Values Project' – engagement of around 500 individuals and teams across the organisation identifying behaviors that matter and the values that drive them
- Final draft shared on the leadership forum and final version produced in Summer 2022
- Teams began building of their own 'team charter' – this is a recognized technique in team building in which teams agree the behaviors that they will all hold themselves, and each other, accountable for
- Led by the OD and Business Partnering team all areas will have develop their team charter by the end of the financial year
- Board team charter was developed in November with final version to be shared

Work Together:
Developments and key achievements

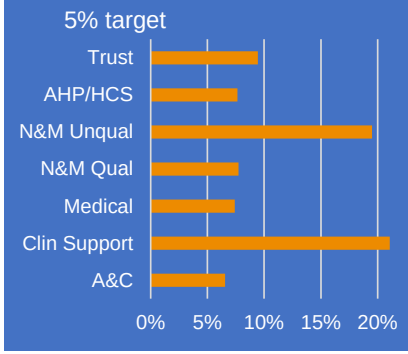
East and North Hertfordshire NHS Trust

Improved process and methodology for attraction and selection	The Resourcing team has significantly improved in international recruitment offer, recruiting more oversees workforce thant ever before. ENHT has provided the model for international recruitment across the ICS and has become the lead provider.
	Increase focus on inclusive recruitment practice with development on inclusion ambassador (IA) programme. There are now 26 IAs and the role has been developed to work at each stage of the recruitment process. The remit has been expanded to ensure inclusive recruitment for all protected characteristics and is now being rolled out across the ICS.
	Working with the ICS the Trust has expanded its reach and developed the brand with regular open days and events being held. Careers pages on the Trust website have been refreshed to increase attraction and experience at each interaction of the early onboarding stage continues to be strong.
Transformation of roles and organisation structure to deliver 21st century care	Detailed workforce plans have been developed by service line as part of the clinical strategy refresh. Following a review of how the service needs to transform over the next 5 to 10 years a review of the workforce requirement and transformation opportunities has been developed.
	New job planning software has been implemented and a programme for team job planning initiated. A new virtual assistant as a single entry point of 'HR admin' requirements
Develop infrastructure and leadership to support working flexibly	Since Oct 21, the Trust has participated in the 'flex for the future' timewise workshop to support trust wide engagement and develop a comprehensive plan. This has led to the development of principles and approach to agile working which is being trialed at Wiltron and Avenet House, a review of leave policy and a self rostering pilot.
	Rostering continues to be rolled out across clinical and non-clinical departments, including the implementation of a new rostering system for doctors which has improved functionality. Part of the implementation is to consider how erostering can be used to allocate and deploy more flexible and effectively.

Work together:
Performance against key measures

East and North Hertfordshire NHS Trust

Reducing vacancy factor

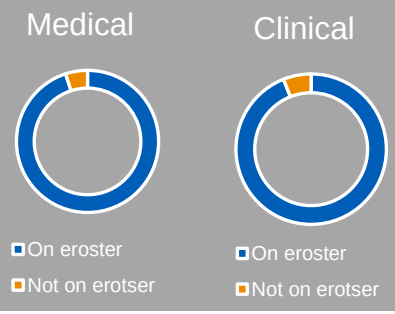


The overall vacancy rate is the same as it was at the start of the year at 9.4%. However, there has been an increase in staff in post of 82 WTE since the start of the year. Although not on the ambitious target of 5%, most staff groups are close with the exception of non-clinical support roles where significant improvement is required.

The latest staff survey shows the Trust as above average for flexible working. The has also been an upward trend in positive scores in the Pulse survey before it changed to the national mandated pulse questions. The scores are less favorable when it relates to the line managers support for flexible working.

Flexible working

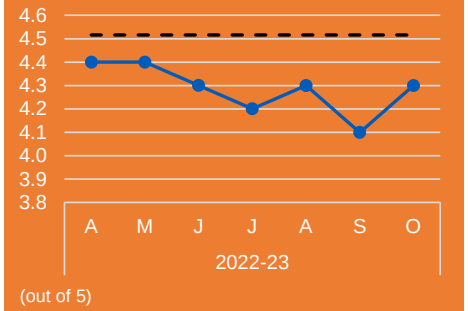
Utilising workforce deployment systems



The Trust has a target for 90% of all clinical staff to be utilising eroster. The utilisation levels have improved throughout the year and the Trust expects to hit the 90% target. The Trust recently procured new software for medical rostering which has improved functionality.

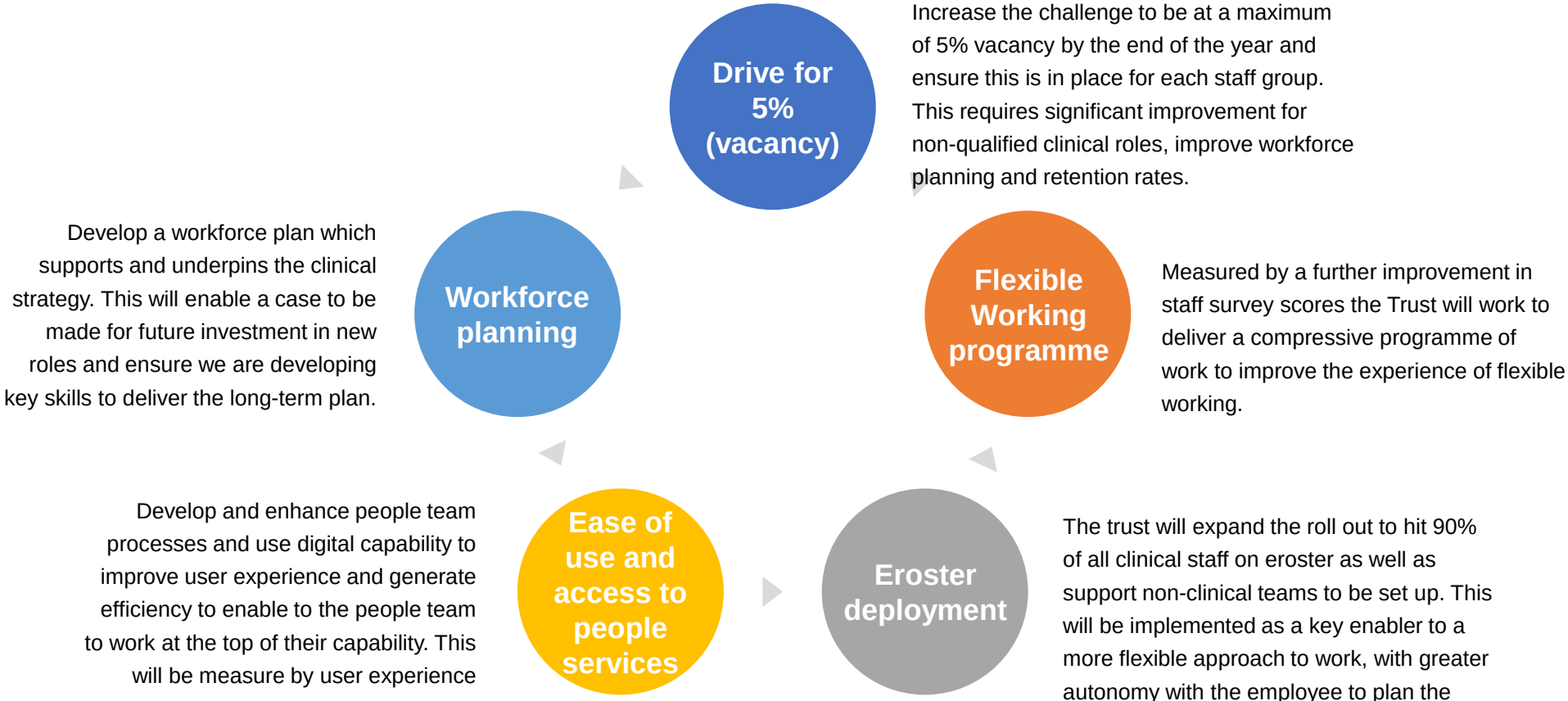
Customer experience of the recruitment team remains good but slightly off target. Time to hire has been on target 8 times in the last 12 month and has only marginally missed the target in the last two months.

Resourcing quality indicators



Work together: Priorities and next steps

East and North Hertfordshire NHS Trust



Grow together:
Developments and key achievements

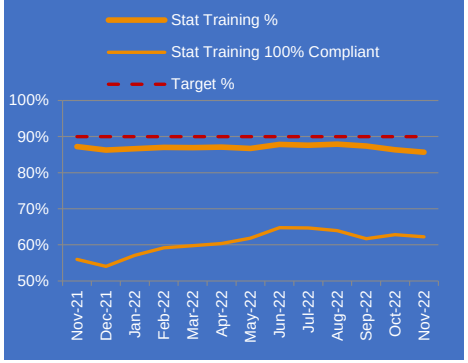
East and North Hertfordshire NHS Trust

Build foundations and fundamentals to support learning	The introduction of a learning management system and a technology enhanced learning (TEL) team has ensured access to learning and education through a virtual platform has vastly improved the experience for many people. It has meant that the Trust has accurate recording of all statutory and mandatory training, additional training which is essential to role can be accessed and the quality for learning material has a quality check approach.
Consolidation of learning, education and development function	People capability function has been established with new talent introduced to develop the services including an AD of People Capability to develop and implement the overall strategy. Through bringing the teams together there is a start to a multi-disciplinary approach to learning and the formation of the education board. Further service enhancements has ensured that we maximise the potential for funding and use of funds is more equitably and effectively allocated.
Develop Trust-wide approach to talent management	Implemented new grow together (appraisal) reviews and established this within ENH academy. The review focuses on what matters to the individual, a supportive career conversation and setting objectives. It also enables the capture of regular 1 to 1 conversations.
	Introduced the grow together cycle which sets out the flow from grow together review, into talent forum and the support and development planning. The first talent review forums were held and tested ready to be implemented across the organisation.
	The Trust has enabled access to a wider range of leadership and management development programmes to support nurturing and developing talent.
	Development of graduate managment trainee scheme and implemented a new portal and set up a process to offer compressive work experience
	Implementation of talent programmes focused on inclusion and increasing diversity from band 3 up to aspiring directors

Grow together:
Performance against key measures

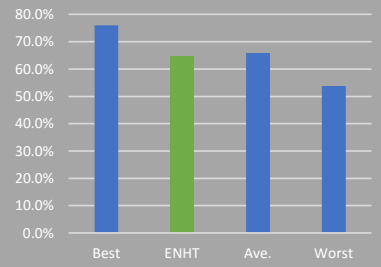
East and North Hertfordshire NHS Trust

Stat and man Training



The Trust implemented a new appraisl system and process at the start of the year which is where compliance rates fall away. However, as adoption for the new system increase compliance has improved each month since June

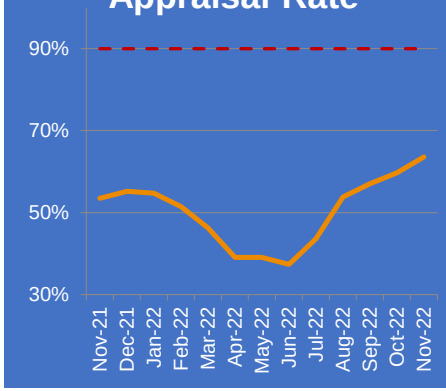
I have opportunity to improve my knowledge and skills



As a measure of the quality of appraisals the staff survey asks how it has helped people do their job. The score along with other quality questions shows the Trust is significantly above average. Where the Trust is below average is the consistency of receiving an appraisal which will be addressed as part of the grow together cycle.

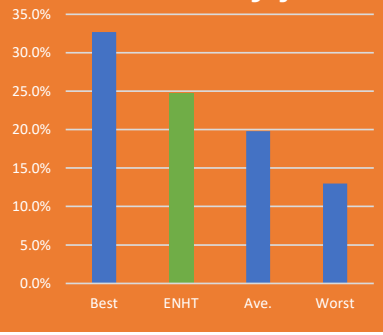
Since the full implementation of ENH Academy, compliance rates for statutory and mandatory training are consistently performing better, however at 86% we are still off target. It is also reassuring that more people are at 100% compliance with their training.

Appraisal Rate



Due to the change in the pulse survey and staff survey there is not consistent a measure to assess trend however the above demonstrates the trust current position compared to other Trusts concerning access to learning. The Trust is below average for this, and it is consistent with other questions related to learning and development.

(My appraisal) Helped me to do my job



Grow together: Priorities and next steps

NHS East and North Hertfordshire NHS Trust

Induction and onboarding

The trust will complete the redesign of the induction and set out a comprehensive framework for how to welcome and on-board staff from day one to the end of the first year in employment at the Trust.

Engagement of future workforce

The `trust will expand its reach to engage a wider workforce to support the local and domestic recruits, supporting to become an anchor institution. This will be demonstrated by increased work experience, volunteering and placements.

Embed talent approach

Achieve 90% appraisal rate by September through implementation of ‘grow together cycle’ and ensure everyone has a high-quality career conversation.

Development of career pathways

In line with the clinical strategy and workforce plan, ensure the development of education and development pathways to support transformation of workforce.

Develop technology enhanced learning

Enhance the range of learning materials based on training needs analysis to support specific roles to work at the top of their capability.

Thrive together:
Developments and key achievements

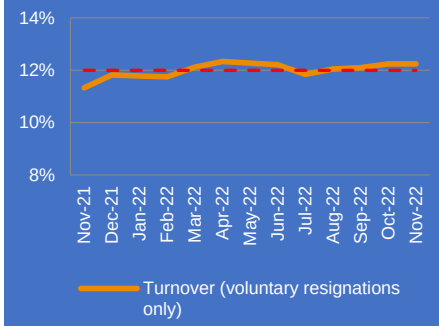
East and North Hertfordshire NHS Trust

Development of Leadership, management programmes	The Trust has developed its gateway process for identifying and allocating staff to both external and internal leadership programmes. Working closely alongside the 'Pathways to Excellence' staff have been supported on both the Florence Nightingale and RCN clinical leadership programmes amongst others. In addition, 291 delegates have attended the internal senior leadership development programme.
Development of a compassionate leadership behaviours	The delivery of the healthy leadership and teams model is structured around compassionate leadership skills. It provides a practical and structure approach with a strong focus on health and wellbeing and inclusion. Over the year 471 people have attended the bitesize sessions as well as 258 team/coaching interventions.
	Trust-wide engagement on trust values and development of team charters
	'Team-talk' session set up to explore themes and develop action plans against the staff survey information
Harnessing our individuality	The Trust has supported the networks to grow and thrive. The networks jointly went through a development programme to clarify purpose and objectives and are increasing able to influence on key strategic issues and policy development.
	Trust is engaging in cultural intelligence programme starting with extensive training for the executive and senior leadership team
	Key transformational work included the development of the inclusion ambassador role which has helped to improve the recruitment and selection policy and process and increase equity.
	The Trust has celebrated the diversity of its people in all its forms from staff Iftar, international nursing day, black history month, Hertfordshire pride, disability history month, international womens day to name just a few.

Thrive together:
Performance against key measures

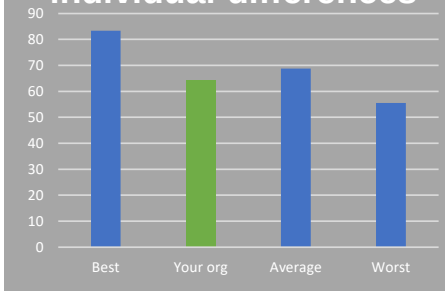
East and North Hertfordshire NHS Trust

Turnover rates



It is important that our most senior roles are representative of or our wider workforce and there was an under representation of staff from a BAME background. With increased focus, creating more equity and developing a more inclusive culture, the % of BAME staff at 8a and above has gone from 16.% to 21.2% against a target of 33%.

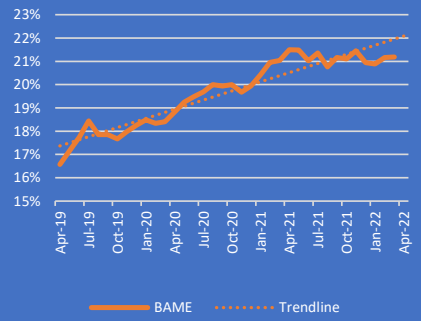
I think that my organisation respects individual differences



Bullying, harassment and abuse is an areas the trust has performed poorly in over the last 4 years. It is positive to see that the Trust improved slightly in the last year while the average trust has got worse, however being below average represents more progress is needed.

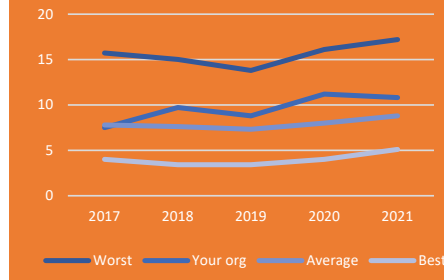
Levels of turnover have increased significantly from the previous year. However, when you break it down to where people have left for 'voluntary' reasons it has returned to pre-pandemic levels and is lower than the rates in 2018. The voluntary reason that has increase the most is work/life balance which alludes to the 'burn out' effect.

BAME Staff as % of Total Workforce for Band 8A+



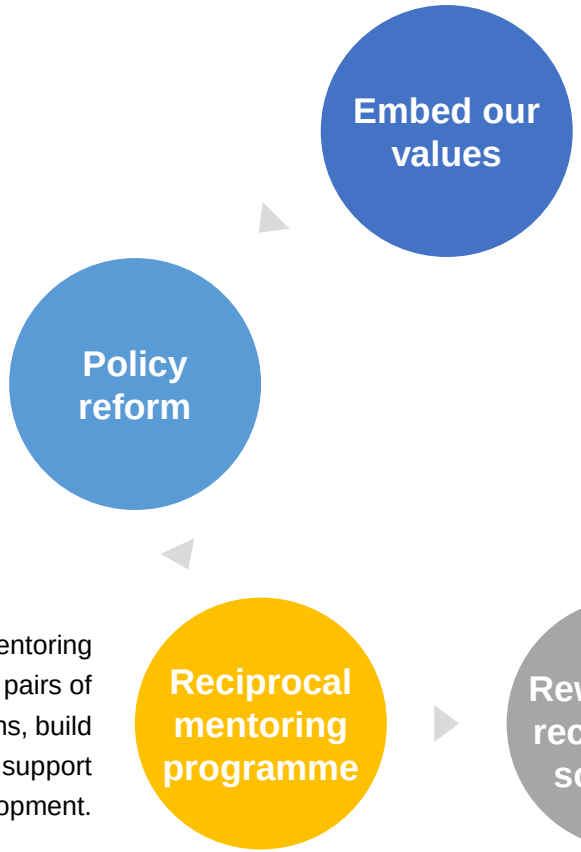
Key to the output of the healthy teams programme is a culture of civility and respect. This survey metric is a key measure for the progress of the work. As this is a new question, there is no trend analysis however the trust is some way off the benchmark average and is targeting to be in the upper third therefore more progress is required.

In the last 12 months have you personally experienced discrimination (colleagues)



Thrive together: Priorities and next steps

East and North Hertfordshire NHS Trust



The trust will complete the values refresh and ensure these are embedded within the organisation and inform how we behave, recruit and develop.

Healthy teams will evolve to connect each of the culture improvement programmes to maximise the impact and become embedded in the way we work. It will also develop a targeted approach using a range of cultural indicators.

We will continue to develop the way we celebrate our people, embracing our diversity, recognise achievements and show value for contribution at all levels.

Launch a reciprocal mentoring programme for a minimum for 20 pairs of people to develop connections, build cultural awareness and support development.

Re-design key policies to ensure they are people centered, support a just and learning culture and are ease to access and easy to use.

Care together:
Developments and key achievements

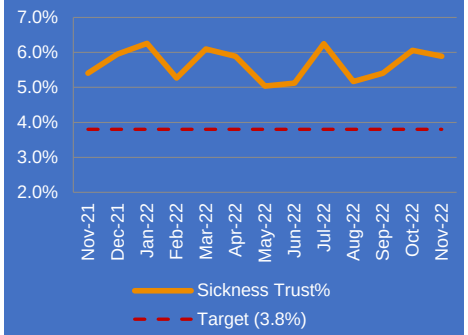
East and North Hertfordshire NHS Trust

Creation of ‘joy at work’ and recognition schemes	The trust has developed and implemented a range of recognition schemes over the last 12 months including the Daisy award, ‘hug in a mug’ scheme, thank you cards and length of service badges. In addition, it reintroduced the staff awards, provided an afternoon tea and ran a ‘thank you’ week including food and wellbeing events.
Improved physical and mental health and wellbeing in the organisation	Focus on the implementation of schemes to support financial wellbeing including the set up of a community shop, financial wellbeing support and information packs, enhanced financial support for community staff, toy and coat swap shops, reimbursement of blue light cards, concessions for parking and food.
	The Trust launched its flagship and award winning ‘Here for you’ service providing 24/7 expert support in dealing with the phycological impact of the environment. It has enabled a series of reflective space sessions where people can come together and share their experience and deal with the emotional impacts of work.
	The Health at work team have supported a significant increase in calls and referrals supporting staff. This has enabled referrals to support and therapy including physiotherapy, counselling, trauma support and long covid clinics.
Improved staff engagement	New structure embedded for freedom to speak up (FTSU) process including the appointment of a full time and dedicated Freedom To Speak Up Guardian, FTSU forum with a range of ambassadors across all staff groups
	Wide engagement with the development of the new Trust values
	A range of mediums for engaging with the workforce have been implemented including the leadership forum, all staff briefing, specialist topic briefings via glisser. The ask Adam email has been instated encourage ideas and feedback.
	Increased presence within wards and departments from senior leaders

Care together:
Performance against key measures

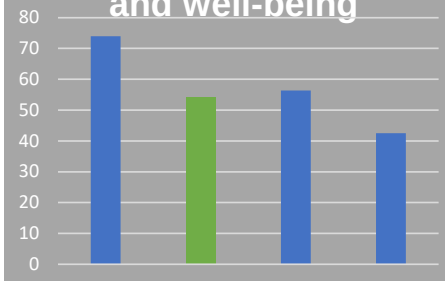
East and North Hertfordshire NHS Trust

% sickness absence



The measure of the impact of our wellbeing initiative has been the comparission of mental health related absence. For the first part of the year, it has larglu matched but in the last quarter there was a significant improvement, and it is currently ahead of the improvement trajectory.

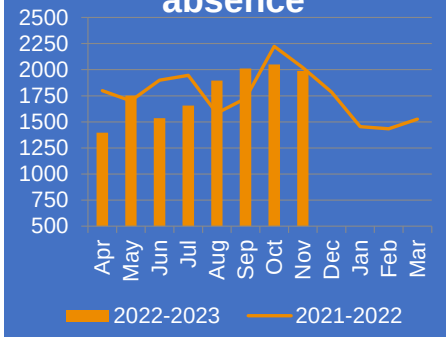
My organisation takes positive action on health and well-being



Investment into Freedom to speak up and work on creating phycological safety around raising concerns has been demonstrated through a more positive response to people reporting incidents of bullying, harassment and abuse.

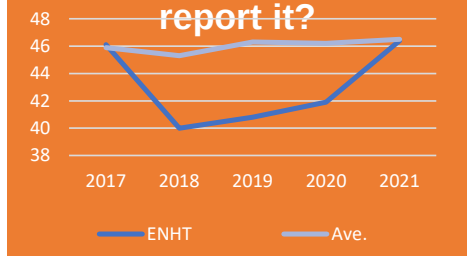
Sickness absence has been consistently high with various peeks over the last 12 months related to waves of Covid. In January 2023 we are likely to see higher than average sickness levels dues to a combination of covid, flu and other viruses that are in circulation.

Mental health related absence



The data in the staff survey demonstrates that the Trust is below average compared to other NHS organisation and is a significant way off the best. As much as the Trust can demonstrate a service of robust actions they are not being felt by a significant proportion of people across the organisation.

The last time you experienced harassment, bullyingor abuse at work, did you or a colleague report it?



Care together:
Priorities and next steps

East and North Hertfordshire NHS Trust

Support delivery of FTSU action plan

With the establishment of a full time Freedom to speak up guardian it must deliver against nationally set goals. The people team play a key part in this, and it must align to the range of facilities for raising concerns.

Establish routine Schwartz rounds

Schwartz rounds along with reflective spaces have been in place for the last 2 years. However, they need to become more routine and utilized more widely by the workforce.

Continue to embed hygiene factors

Focus on hygiene factors are key to the improvement of wellbeing for the most amount of people. The people team must work alongside estates and finance team for the delivery of programmes that improve staff experience.

Implement financial wellbeing initiatives

The current financial climate is putting increasing pressure on people lives and the organisation needs to demonstrates its recognition of this and support staff in any way it can.

Increase reach of Care Support Pyramid

The Care Support Pyramid is a model developed by ENHT which enables teams to plan and demonstrate what positive action they are taking to support health and wellbeing.

East and North Hertfordshire NHS Trust

Key priorities: Thriving people

1 Drive for 5% (vacancy)
Increase the challenge to be at a maximum of 5% vacancy by the end of the year and ensure this is in place for each staff group. This requires significant improvement for non-qualified clinical roles, improve workforce planning and retention rates.

2 Flexible Working programme
Measured by a further improvement in staff survey scores the Trust will work to deliver a compressive programme of work to improve the experience of flexible working.

3 Induction and onboarding
The trust will complete the redesign of the of the induction and set out a comprehensive framework for how to welcome and on-board staff from day one to the end of the first year in employment at the Trust. This includes management and leadership skills for people moving into new roles.

4 Ease of use and access to people services
Develop and enhance people team processes and use digital capability to improve user experience and generate efficiency to enable to the people team to work at the top of their capability. This will be measure by user experience scores.

5 Embed our values
Complete values refresh and ensure these are embedded within the organisation and inform how we behave, recruit and develop.

Governance and reporting structure

NHS
East and North Hertfordshire
NHS Trust

Summary and conclusions

East and North Hertfordshire NHS Trust

- Despite the changing background and environment in which we are operating, the people strategy set out at the start of 2020 is still fit for purpose and is a key enabler for the Trust in delivering its strategic priorities.
- The operating model for the people team needs to evolve rapidly and we need to continue to build internal capability, improve systems and operational delivery and invest in the resources to support the development of the workforce. It also must develop to be in the right shape for future development plans for the integrated care system and health and care partnership.
- The Trust has demonstrated its delivery against the objectives and plans previously set out but the data shows, particularly within the staff survey where there is more to do.
- The ENHT People strategy will work in support of the ICB strategy recently shared and more opportunities are to be explored where work can be delivered at scale and using the collective skills and expertise
- It is proposed that the progress of the priorities highlighted continue to be monitored by the People committee and through to the Trust board.
- The performance reports are currently under review but the People directorate will ensure these remain reflective of the people strategy objectives.

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	12
Report title	Gender Pay Gap Report (March 2021/2022)			**Meeting Date**	1 March 23
Presenter	Thomas Pounds, Chief People Officer				
Author	Celina Mfuko (ED&I Lead) & Laura Neligan (Head of PIPA)				
Responsible Director	Thomas Pounds – Chief People Officer			**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**		☒
	Discussion	☒	**Decision**		☐

Report Summary:

The Gender Pay Gap (GPG) reporting obligations are outlined in the Mandatory gender pay gap reporting introduced in the 2017 (The Equality Act 2010), aiming to narrow and, eventually eliminate the pay differential between men and women. This report captures the Trust gender pay gap analysis and findings covering the full period 2021/22 up to March 2022.

The paper is split into various sections

1. **Organisation background**
2. **Average Pay**
3. **Bonuses Pay**
4. **Benchmarking against similar Trust**
5. **Ethnicity Pay Gap**
6. **Summary of key findings and our action plan**

There has been positive movement in the data including a 4% improvement in the average gender pay gap since 2019 and 3% improvement in the mean average pay gap in the same timeframe. Benchmarking ourselves against other similar Trusts in the East of England Region provides a positive picture, as East & North Hertfordshire sits in the second position just after Cambridge University Hospital. There is still much work to do to reduce our gaps and the summary findings outlines how we can work towards further improvements.

Impact: where significant implication(s) need highlighting

There are potential legal financial, equity and staff engagement implications that arise where progress declines. Having effective policies, procedures and strategies for closing the gender pay gap seek to address factors and barriers common to most women and can additionally target other inequalities experienced by women belonging to specific groups, based on characteristics such as ethnicity, diverse abilities, caring responsibilities age as well profession groups.

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

There is a risk the trust is unable to recruit and retain sufficient supply of staff with the right skills to meet the demand for services. There is a risk that the culture and context of the organisation leave the workforce insufficiently empowered and motivated, impacting the Trust's ability to deliver improvements and transformation and enable people to feel proud to work here.

Report previously considered by & date(s):

[NA]

Recommendation	The Board/Committee is asked to note the contents of this paper discuss and **APPROVE** the gender pay gap report and action plans.

Gender Pay Gap Report (March 2021/2022)

EXECUTIVE SUMMARY

Gender pay gap (GPG) is the difference between average (mean and median*[1]) earnings of men and women, expressed relative to men's earnings. GPG should not be confused with unequal pay which is the unlawful practice of paying men and women differently for performing the same or similar work or work of equal value (Equality Act 2010). Figures produced by the Office of National Statistics (ONS) show the gender pay gap fell by almost a quarter for full-time employees between 2011 and 2021.

The gender pay gap reporting is a mandatory requirement for public sector organisations employing more than 250 staff.

This report analyses Trust data regarding any undervaluing of female work and pay for that work compared to male workers, as a measure it captures any pay inequalities resulting from differences in the kind of jobs performed by men and women and the gender composition of the organisation by seniority. East and North Hertfordshire NHS Trust Gender Pay Gap (snapshot date of March 2022) data will be submitted to the Government online reporting service no later than the statutory date of 30th March 2023.

The Trust is required to report the following:
Average (Ordinary pay) (section 2 of this report)

1. Mean[1] (average) gender pay gap using hourly pay rates
2. Median[2] gender pay gap using hourly pay rates
3. Percentage of men and women in the lower, lower middle, upper middle and upper quartile pay bands
4. Gender Pay Gap by staff groups (*this is local additional analysis*)
5. Gender pay gap for ordinary pay by Banding (*this is local additional analysis*)

Bonus pay (section 3 of this report)

6. Mean (average) gender pay gap using bonus pay
7. Median gender pay gap using bonus pay
8. Percentage of men and women receiving bonus pay

The definition of "Bonus" in Gender Pay Gap reporting is broadly defined under the Regulations as "any remuneration that is in the form of money, vouchers, securities, securities options, or interests in securities; and relates to profit-sharing, productivity, performance, incentive or commission".

ENHT Clinical Excellence Awards (CEA) which are counted as bonus', carry a one-off or fixed-term bonus. Any enhancements for unsocial hours for staff on 'Agenda for Change' or 'Medical and Dental'[3] contracts are paid a

1 Mean: is the average found by adding up all the values in a set of data and dividing it by the total number of values you added together.

2 Median: the middle number in the set of values. You find it by putting the numbers in order from the smallest to largest to find the middle number.

[3] https://www.nhsemployers.org/topics-networks/pay-pensions-and-reward/nhs-terms-and-conditions-service-agenda-change
https://www.nhsemployers.org/topics-networks/pay-pensions-and-reward/medical-and-dental-pay-and-contracts

month in arrears.

The Trust analyses the data and updates its action plan to respond to these findings. Details of how the calculations are made are available in Appendix 1.

1. ORGANISATIONAL BACKGROUND

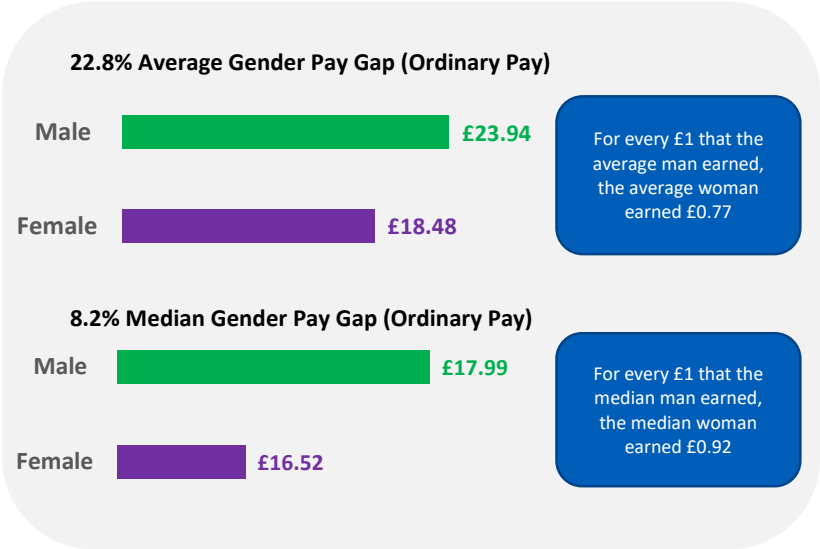
East and North Hertfordshire NHS Trust provides secondary and acute health care services for a population of around 600,000 in East and North Hertfordshire, parts of South Bedfordshire and tertiary cancer services for a population of approximately 2 million people across Hertfordshire, Bedfordshire, north-west London, and parts of Thames Valley.

We are committed to Inclusion, Equality and Diversity being at the heart of all we do to deliver for service users, their relatives and our 6,200 staff.

The composition of our workforce is presented in the table below; it is based on a staff list report from the Electronic Staff Record (ESR) as of 31st March 2022. It also represents the ratio of females to males in each staff group, and females and males in relation to all staff in each staff group.

Staff Group 2022	**Male** (as % of staff group)	**Female** (as % of staff group)	**Male** (as % of total Trust)	**Female** (as % of total Trust)
Additional Professional Scientific and Technical	21.6%	78.4%	0.7%	2.7%
Additional Clinical Services	16.6%	83.4%	2.5%	12.6%
Administrative and Clerical	16.3%	83.7%	3.7%	19.2%
Allied Health Professionals	20.3%	79.7%	1.0%	3.8%
Estates and Ancillary	63.5%	36.5%	3.6%	2.1%
Healthcare Scientists	36.6%	63.4%	1.1%	1.9%
Medical and Dental	54.7%	45.3%	7.7%	6.4%
Nursing and Midwifery Registered	12.0%	88.0%	3.7%	27.2%
TRUST TOTAL	**24.0%**	**76.0%**	**24.0%**	**76.0%**

2. AVERAGE (ORDINARY) PAY



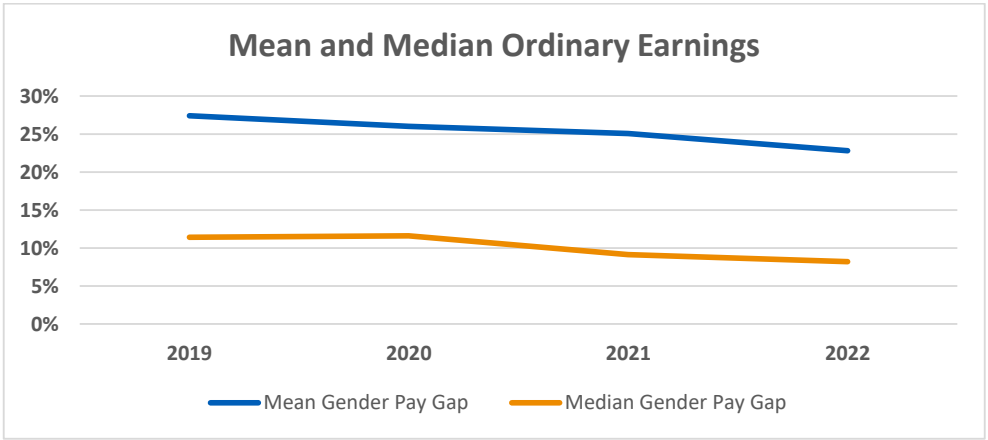
Average & Median Ordinary Earning

	2019	2020	2021	2022
Gender pay gap for Average Earnings	27.4%	26.0%	25.1%	22.8%
Gender pay gap for Median Earnings	11.4%	11.6%	9.1%	8.2%

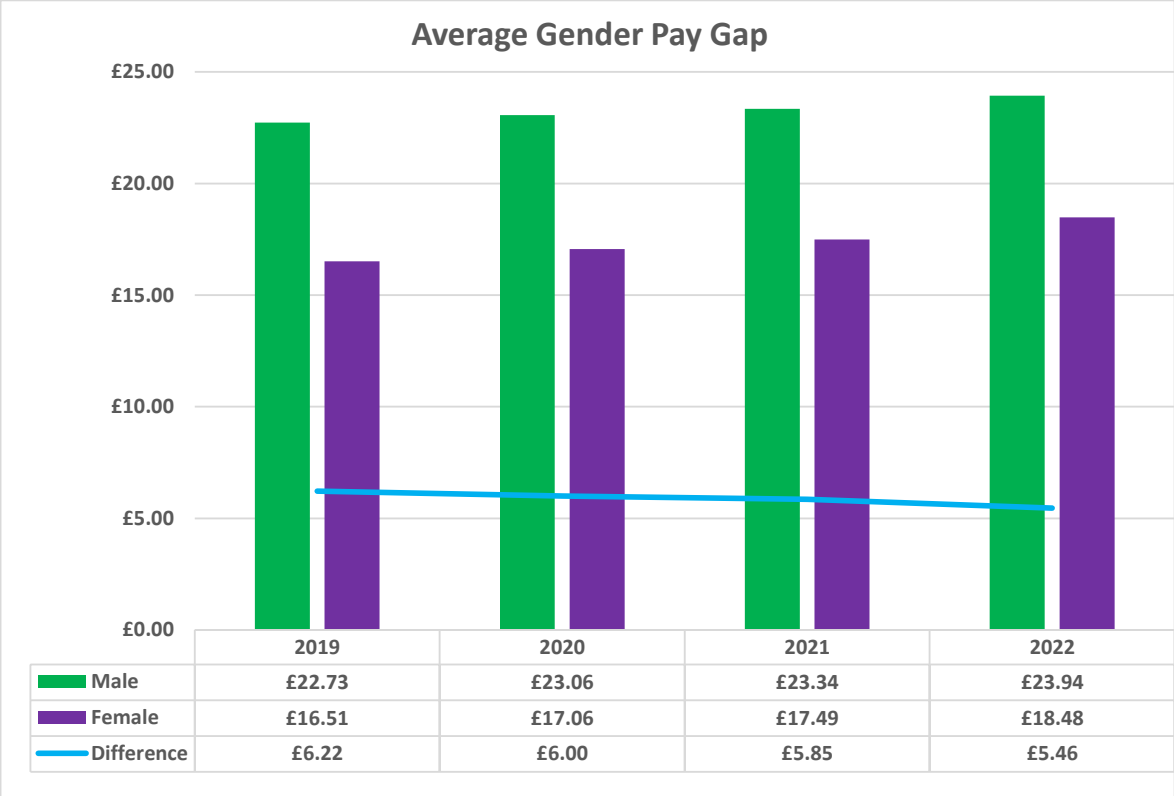
1. **Average gender pay gap** – The gender pay gap for average ordinary earnings for women in 2022 is **22.8%** less than for men; **this is over 2% better than the data for 2021 and a 4% improvement since 2019.**

2. **Median gender pay gap** – The gender pay gap for median ordinary earnings for women is **8.2%** less than for men; **this is a 1% improvement in comparison to 2021 and over a 3% improvement since 2019.**

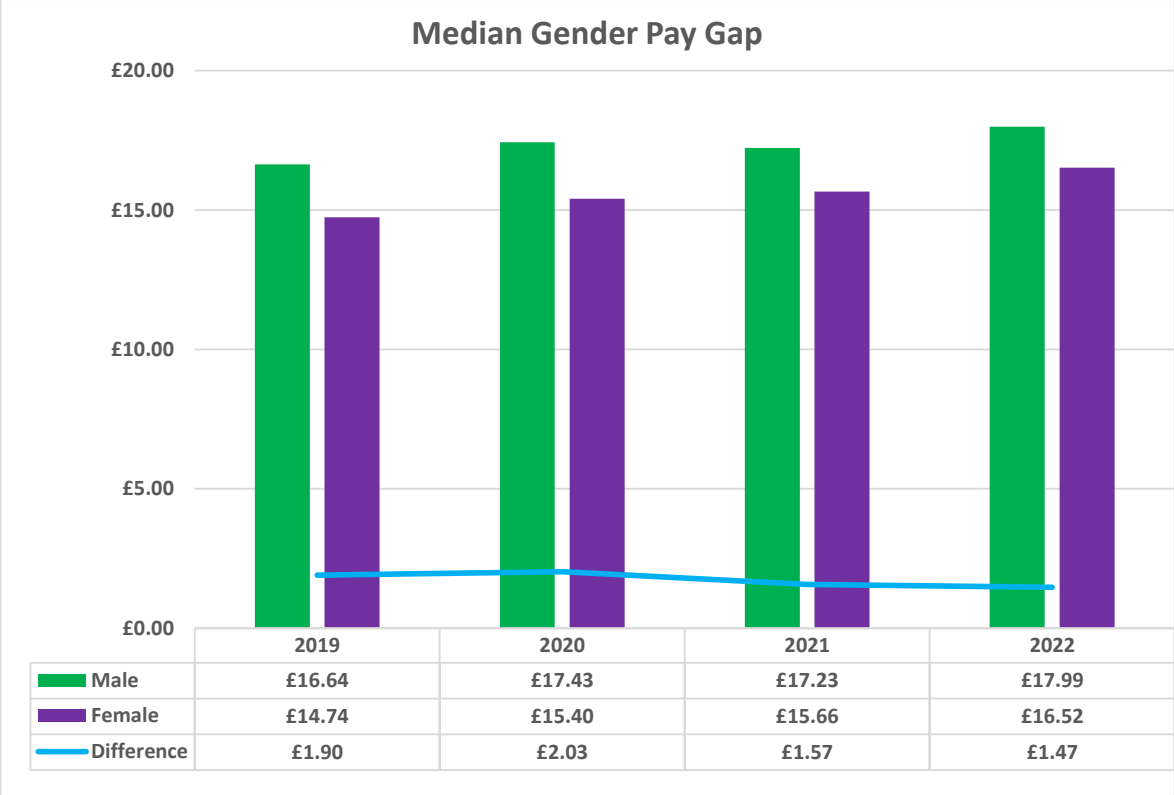
*With a gap of 22.8% average earnings and 8.2% median earning, the GPG focus group is exploring further targeted interventions to close the gap in addition to the existing Equity and Inclusion plans.



Cumulative Data



	2019	2020	2021	2022
Male	£22.73	£23.06	£23.34	£23.94
Female	£16.51	£17.06	£17.49	£18.48
Difference	£6.22	£6.00	£5.85	£5.46

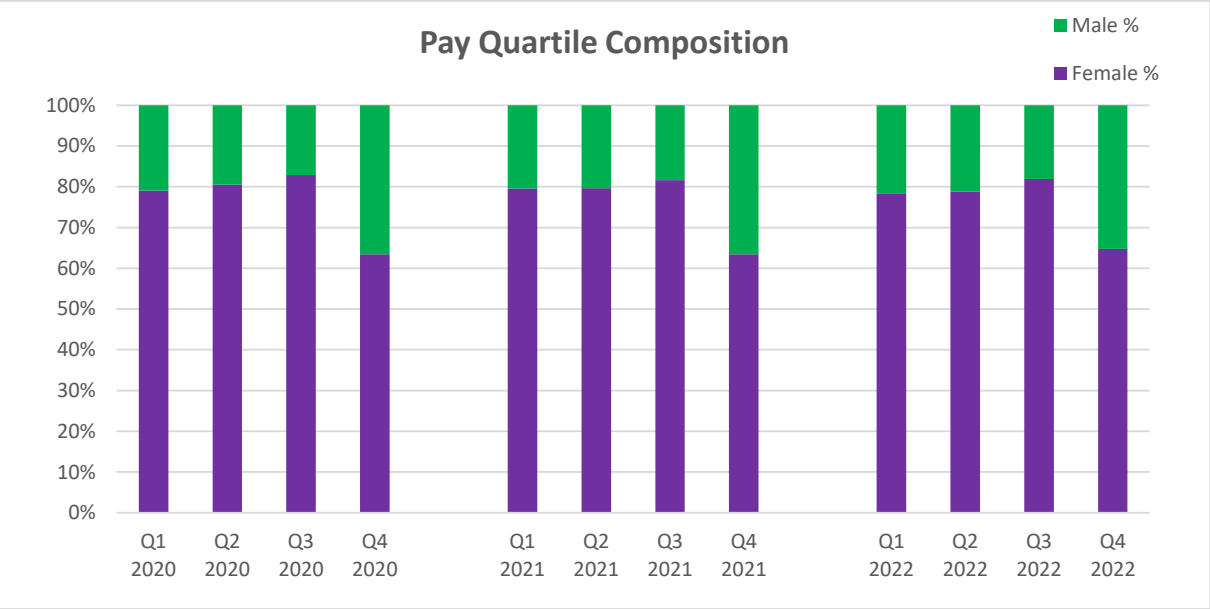


	2019	2020	2021	2022
Male	£16.64	£17.43	£17.23	£17.99
Female	£14.74	£15.40	£15.66	£16.52
Difference	£1.90	£2.03	£1.57	£1.47

Gender composition in each quartile pay band

To further understand pay gap in more details, it is useful to look at the proportion of workforce by gender in terms of seniority. This involves calculating the proportions of male and female employees and split between four 'quartiles' according to their level of pay. The tables below represent the proportion of male and female employees in each quartile pay band.

Q1 = Lower Quartile (lowest paid) Q2 = Lower Middle Quartile
Q3 = Upper Middle Quartile Q4 = Upper Quartile (Highest Paid)



The table (also shown in previous reports) highlights that representation at each quartile remains consistent and for Upper Quartile 4 (highest pay) it continues to show disparity on gender pay gap in favour of men. Based on Trust overall staff groups composition of 76% Female and 24% Male, as well as overall profile being 76% Female and 24% Male, Trust GPG data demonstrated that Men are highly represented in higher paid jobs, this snapshot of March 2022 shows that men make up of 35.2% of colleagues with the highest quartile of pay.

There has been stagnant improvement with reference to previous years, (higher percentage of men in upper quartile such as 36.5% for both 2020 and 2021) and the same for representation of women in Upper Middle quartile (81.6% for 2021 and 82% for 2022), this is a key area to direct our future interventions in where succession planning can create pipeline of talents and potentially enter the upper quartile (highest paid).

Marginal increase of women in the top quartile of 1% (April 2021 – March 2022) has taken place.

Gender Pay Gap by staff groups

To give greater detail around the mean difference, additional reports were taken from the Electronic Staff record (ESR). This highlights the gender pay differences by different staff groups, understanding this data can help to identify what is working well and where there are existing structures that may potentially reinforce inequality. A negative figure indicates a gender pay gap in favour of females, a positive figure indicates the pay gap that exists. Positive trends for some staff groups in comparison to year 2021 have been highlighted in green (**8.2%, 6.5% and 5.0%).** The

reverse is true for Allied Health Professionals and Nursing and Midwifery roles where the pay gap is reversed. The most significant gender pay gap, in favour of males continues to be in Administrative and Clerical roles, Additional Clinical Services and Medical & Dental staff groups.

Average Hourly Rates of Pay by Staff Group	Male	Female	Difference	2020 Pay Gap	2021 Pay Gap	2022 Pay Gap
Additional Professional Scientific and Technical	£21.77	£19.98	£1.79	10.4%	12.4%	8.2%
Additional Clinical Services	£12.06	£11.65	£0.41	3.4%	3.1%	3.4%
Administrative and Clerical	£19.41	£15.02	£4.40	27.7%	24.5%	22.6%
Allied Health Professionals	£19.96	£21.69	-£1.73	-5.6%	-7.4%	-8.6%
Estates and Ancillary	£12.47	£11.66	£0.81	6.2%	8.7%	6.5%
Healthcare Scientists	£23.10	£21.93	£1.17	8.3%	7.3%	5.0%
Medical and Dental	£39.00	£34.54	£4.46	11.1%	10.6%	11.4%
Nursing and Midwifery Registered	£18.22	£20.03	-£1.81	-7.4%	-9.3%	-9.9%
TRUST TOTAL	**£23.94**	**£18.48**	**£5.47**	**26.0%**	**25.1%**	**22.8%**

The coloured rating above is classified as follows compared to 2021:

- **Green** highlights a positive change for female workers
- **Red** shows a change in favour of male workers
- **Amber** shows slight positive change towards females, however the pay gap is still in favour of male workers
- **Blue** shows negative values which means female workers earn more than their male colleagues and the gap in favour of females is increasing
- The above excludes student midwives; the current cohort is all female

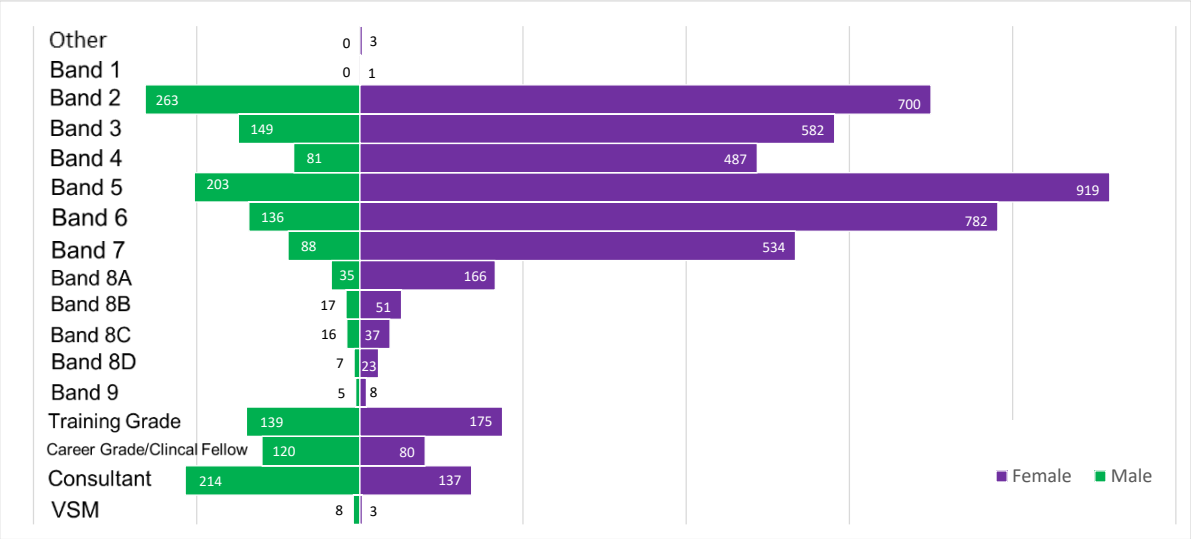
Data below suggests there is a positive gender pay gap for Agenda for Change employees' (in favour of females), whereas, medical and dental staff group's gender pay gap still shows in favour of males. This reflects the historical narrative of occupational segregation and widespread gender-biased roles of the healthcare workforce. More exploratory work to identify the existing barriers and to close the gap continues.

Mean average hourly rate	2021		2022	
	Non-Medical (AfC, Trust Pay, VSM & Tupe)	Medical and Dental	Non-Medical (AfC, Trust Pay, VSM & Tupe)	Medical and Dental
Male	£16.31	£38.09	£16.88	£39.00
Female	£16.07	£34.04	£17.01	£34.54
Difference	£0.24	£4.05	-£0.13	£4.46

Gender pay gap for ordinary pay by Banding

Gender Pay Gap by Band	Male	Female	Difference	2022 Pay Gap
VSM	£66.64	£66.20	£0.45	**0.7%**
Consultant	£51.67	£50.25	£1.42	**2.7%**
Career Grade/Clinical Fellow	£34.28	£32.00	£2.27	**6.6%**
Training Grade	£23.58	£23.39	£0.19	**0.8%**
Band 9	£52.52	£54.47	-£1.95	**-3.7%**

Band 8D	£46.06	£45.17	£0.89	**1.9%**
Band 8C	£38.15	£37.36	£0.79	**2.1%**
Band 8B	£31.10	£31.55	-£0.45	**-1.4%**
Band 8A	£26.90	£26.51	£0.39	**1.4%**
Band 7	£23.40	£23.60	-£0.20	**-0.8%**
Band 6	£19.72	£20.00	-£0.28	**-1.4%**
Band 5	£16.31	£16.50	-£0.19	**-1.2%**
Band 4	£12.63	£12.66	-£0.03	**-0.3%**
Band 3	£12.14	£11.61	£0.53	**4.3%**
Band 2	£11.13	£10.90	£0.23	**2.0%**
Band 1	-	£10.31	-	**-**
Other	-	£10.62	-	**-**
Grand Total	**£23.94**	**£18.48**	**£5.47**	**22.8%**

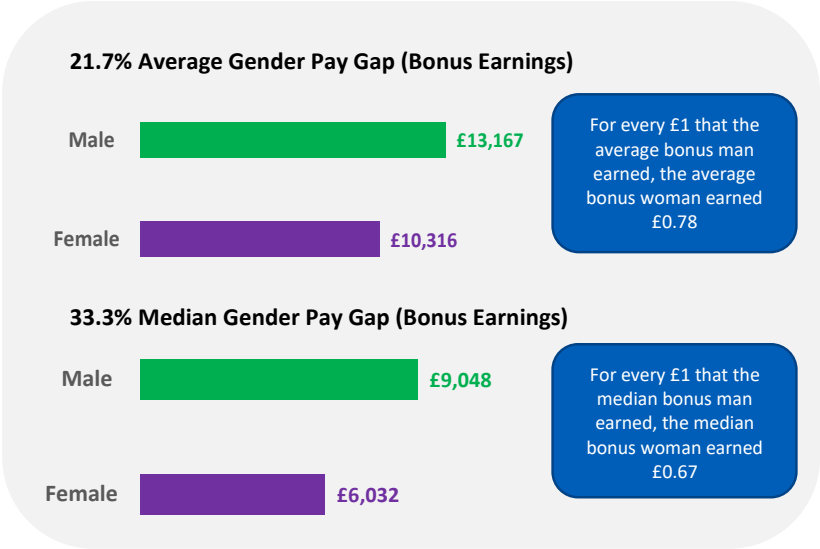


The data above should be viewed in relation to Trust workforce profile (composition of 76% Female & 24% male), the data shows female staff are under-represented across AfC bands 8b and above.

There is over representation of males in medical workforce although the number of females in training grades is in the majority and potentially could lead to a different outcome for the future.

3. BONUS PAY

The gender pay gap requires us to report on bonus payments received by men and women in our organisation. The main payment referred will be Clinical Excellence Awards (CEAs) which is awarded to eligible consultants. Due to the pandemic and as of March 2022 CEA award was split across all eligible permanent consultants in recognition of the COVID pandemic.



Gender	Average bonus 2020	Average bonus 2021	Average bonus 2022	Median bonus 2020	Median bonus 2021	Median bonus 2022
Male	£13,643	£13,257	£13,167	£9,048	£9,048	£9,048
Female	£11,488	£11,123	£10,316	£6,032	£6,032	£6,032
Difference	£2,155	£2,134	£2,851	£3,016	£3,016	£3,016
Pay Gap %	**15.8%**	**16.1%**	**21.6%**	**33.3%**	**33.3%**	**33.3%**

Average (mean) bonus pay gap – the gender pay gap data for mean average bonus earnings shows women's bonus payments are, on average, **21.6**% less than their male colleagues. **This is an increase of 5.5% on the previous years' data and an increase of 5.8% on the data from two years' ago.**

Median bonus pay gap – The gender pay gap for median average bonus earnings for women is **33.33%** less than for men, which is identical to the previous two years' data. The most likely reason for this is that most bonus' at the Trust are earnt by Consultants who receive Clinical Excellence Awards which are at set rates and for fixed periods of time. Additionally, we employ more male consultants than female, therefore the data will not vary much between one year and the next.

Gender composition of bonuses – The proportion of males receiving a bonus was **4.59**% compared to **0.81**% of female employees who were in receipt of a bonus payment. While the number of female recipients is almost comparable with last year the number of male recipients has reduced by 0.5%.

	2021			2022		
	Number of Bonus' paid	Total Employee Headcount	% of Staff Receiving a Bonus	No. Paid Bonus	Total Employee Headcount	% of Staff Receiving a Bonus
Male	75	1472	5.10%	68	1481	4.59%
Female	39	4744	0.82%	38	4688	0.81%

The table below represents the consultant body, with the gender composition and bonus payments distribution shown. The data for March 2022 shows CEA bonus was awarded to all staff who were eligible. The overall distribution of bonuses for Consultants remains broadly comparable to previous years.

Consultant Staffing	2020		2021		2022	
	Headcount	% receiving a bonus	Headcount	% receiving a bonus	Headcount	% receiving a bonus
Male	218	37.2%	220	33.6%	216	31.0%
Female	122	31.1%	135	28.1%	145	25.5%
TOTAL	**340**	**32.9%**	**355**	**31.5%**	**361**	**28.8%**

Understanding all data of staff groups, pay bands and bonus pay supports us identify exactly where gaps exist and what drives the gap. It may be worth exploring the GPG calculation in absence of CEA awards to see what this looks like. Furthermore, if the structure of existing CEA awards is the major driver of GPG, what discussions are required as an organisation and challenges to rethink how we award good performance and excellence within medical profession.

4. Gender Pay Gap: BENCHMARKING AGAINST SIMILAR TRUSTS

% Difference in hourly rate (Mean)	Employer Size	March 2017	March 2018	March 2019	March 2020	March 2021
Milton Keynes University Hospital	1000 to 4999	28.6%	28.1%	27.6%	20.0%	27.4%
East and North Hertfordshire	5000 to 19,999	29.0%	28.0%	27.4%	26.0%	25.1%
West Hertfordshire Hospitals	5000 to 19,999	14.9%	32.8%	27.9%	27.3%	27.2%
The Princess Alexandra Hospital	1000 to 4999	29.0%	29.0%	27.0%	6.3%	26.8%
Bedford General	merged Trust	29.0%	32.1%	31.7%	31.5%	-
Bedfordshire Hospitals	merged Trust (5000 to 19,999)	-	-	-	-	28.5%
Cambridge University Hospital	5000 to 19,999	22.3%	20.0%	20.2%	19.9%	20.6%
Mid and South Essex	merged Trust (5000 to 19,999)	-	-	-	30.0%	29.2%

% Difference in hourly rate (Median)	Employer Size	March 2017	March 2018	March 2019	March 2020	March 2021
Milton Keynes University Hospital	1000 to 4999	15.2%	14.1%	16.0%	28.9%	18.7%
East and North Hertfordshire	5000 to 19,999	13.2%	11.0%	11.4%	11.6%	9.1%
West Hertfordshire Hospitals	5000 to 19,999	8.0%	15.1%	14.9%	12.0%	11.7%
The Princess Alexandra Hospital	1000 to 4999	18.8%	23.0%	21.0%	3.9%	18.5%
Bedford General	merged Trust	11.8%	16.1%	17.3%	20.7%	-
Bedfordshire Hospitals	merged Trust (5000 to 19,999)	-	-	-	-	20.7%
Cambridge University Hospital	5000 to 19,999	3.4%	0.6%	3.2%	5.2%	7.7%
Mid and South Essex	merged Trust (5000 to 19,999)	-	-	-	17.6%	18.2%

Benchmarking ourselves against other similar Trusts in the East of England Region, does give positive picture as East & North Herts sits in the second position just after Cambridge University Hospital, the hourly rate (Mean) has dropped from 26.0% to 25.1% (this is now 22.8 data for March 2022). Similarly, the hourly rate (Median) was 11.6% in 2020 down to 9.1% in 2021 (this is now 8.2 data for March 2022).

Data above have been extracted from GPG website where Trusts have published their data although recent data covering for March 2021/2022 are not available yet, hence not possible for us to benchmark our recent figures.

5.SUMMARY OF KEY FINDINGS ON THIS REPORT

1. Overall the Trust representation data on ratio of males to females (% of staff group and % of total Trust) has not changed significantly.

2. The gender pay gap for average ordinary earnings for women in 2022 is 22.8% less than for men; this is over 2% better than the data for 2021 and a 4% improvement since 2019.

3. The gender pay gap for median ordinary earnings for women is 8.2% less than for men; this is a 1% improvement in comparison to 2021 and over a 3% improvement since 2019.

4. Trust GPG data demonstrates Men are still highly represented in higher paid jobs and data for March 2022 shows men make up of 35.2% of colleagues with the highest quartile of pay.

5. The most significant gender pay gap, in favour of males continues to be in Administrative and Clerical roles, Additional Clinical Services and Medical & Dental staff groups.

6. Data suggests there is a positive gender pay gap for Agenda for Change employees' (in favour of females), whereas medical and dental staff group's gender pay gap still shows a in favour of males.

7. The gender pay gap data for mean average bonus earnings shows women's bonus payments are, on average, 21.6% less than their male colleagues. This is an increase of 5.5% on the previous years' data and an increase of 5.8% on the data from two years' ago.

8. Benchmarking ourselves against other similar Trusts in the East of England Region provides a

positive picture, as East & North Herts sits in the second position just after Cambridge University Hospital.

6. ACTION PLAN

Below are some of the actions to implement and use quality improvement methodologies

Effective actions		Promising actions		Actions with mixed results	
GPG Task & Finish Group	Leads for this work stream Data integrity Deep dive on the data to understand issues and offer guidance on actions	**Other Policies**	Review the existing Menopause and any other relates policies	**Training**	Equity & Inclusion covering Public Sector Equality duty Linking with Cultural Intelligence work stream
Flexible Working Policy	Work with Staff Networks to review the existing policy Review existing data on applicants	**Intersectionality**	Ethnicity GPG to explore the impact of known inequalities and lack of representation at senior levels Explore data based on Disabilities	**Leadership & development**	Review the impact of internal & External offers in view of career progressions
Inclusive recruitment and selection	Link with existing Inclusive recruitment & Selection work stream	**Mentoring & Sponsorship**	Link with Reciprocal Mentoring for inclusion and other mentoring support available	**Offer Networking Programmes**	Career Networking such as Women in Leadership
Encourage salary negotiations	Review any existing salary range the Trust if offering	**Career progression**	Support available for career progression with an inclusion lens	**Set Internal targets**	Deep dive analysis which can support with Target setting – *discussed at the focus group*
Clinical Excellence Awards	Deep dive on the data and the process – *discussed at the focus group*	**Accountability** (People Committee)	Agreed actions for progress to be monitored and reported quarterly to the new Trust People Board.	**Raising Awareness**	Utilise range of Communication to raise an awareness

Appendix 1 Details on how calculations are completed.

For the calculation of **ordinary pay** the following has been taken into consideration:

- Basic pay
- Paid leave, including annual, sick, maternity, paternity, adoption or parental leave (except where an employee is paid less than usual or nothing because of being on leave)
- Area and other allowances (N.B. the Trust, due to its sites geographical location, awards outer, fringe and no High Cost Area Supplement, depending on employees' main base of work)
- Shift premium pay, defined as the difference between basic pay and any higher rate paid for work during different times of the day or night
- Pay for piecework

The calculation of an ordinary pay does not include any of the following:

- Remuneration referable to overtime.
- Remuneration referable to redundancy or termination of employment
- Remuneration in lieu of leave
- Remuneration provided otherwise than in money.

For the calculation of **bonus pay** the following has been taken into consideration:

- Any remuneration that is in the form of money, vouchers, securities, securities options, or interests in securities, and
- Relating to profit sharing, productivity, performance, incentive or commission.

The calculation of a bonus pay does not include any of the following:

- Ordinary pay
- Remuneration referable to overtime
- Remuneration referable to redundancy or termination of employment
- Remuneration in lieu of leave

The following staffs have been excluded from the Gender Pay Gap calculations as per the established national guidance:

- Those staff on no pay/reduced pay due to sickness absence
- Those staff on no pay/reduced pay due to maternity/paternity absence
- Staff on external secondment
- Bank/Agency staff

Board Report

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	13
Report title	CQC Update February 2023			**Meeting Date**	1 March 2023
Presenter	Douglas Salvesen - Clinical Director Amanda Rowley – Director of Midwifery Lesley Overy – Head of Midwifery				
Author	Amanda Rowley – Director of Midwifery				
Responsible Director	Theresa Murphy - Chief Nurse			**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**		☐
	Discussion	☒	**Decision**		☐

Executive Summary:

Executive Summary

Recognising the requirement for Maternity services to give assurance to board based on a number of core data sets in response to national reviews, the ambition of maternity transformation and long term plan, this will be presented in one assurance report.

For discussion this month:

- CQC Maternity CQC Update

Actions required by the Committee:

- Note the progress towards meeting the requirements within the section 29A notice

CQC Inspection

A compliance report has been submitted to the CQC to meet the second deadline within the section 29A of 13th February. Compliance with risk Assessment and standards of documentation remain substandard. Outputs are being captured on the Enhance platform with weekly reporting of improvements reported into the Maternity Improvement Committee.

CQC maternity service Survey

On the 11 January 2023, the CQC published their findings from their annual Maternity survey which considered the experiences of service users between 1st – 28th February 2022

ENHT maternity services have seen a decline in the survey ratings since 2019 and identified in the 8 worst performing trusts for the 2022 survey. A proactive approach to improvement has commenced to support real-time sustained improvement for women and their families:

MLU Closures

One divert of MLU reported for January. MLU Birth rate has increased in the last quarter from 4.7% in October to 11% in January 2023. Reduction in closures is supporting women's choice and releasing capacity on CLU and Gloucester ward.

Impact: where significant implication(s) need highlighting

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

Financial or resourcing

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

New Risks

7731 - The risk of noncompliance with GAAP 17368 National Perinatal Mortality Review Tool – Rating 4
7732 - The risk to women's experience due to the inability to provide Diamorphine for anaesthesia. Rating 10
7734 - The risk of women requiring hospital admission for threatened pre term labour due to national shortage of FFN – rating 4
7735 - The risk to women if there are insufficient Bakri Balloons for use in major obstetric haemorrhage – rating 20 – to close as stock arrived
7737 - The risk associated with not performing the full array of testing for women who have experienced a fetal loss – rating 8
7759 - The risk to service provision due to inadequate office space for obstetric doctors on CLU – rating 10
7760 0 - The risk to pregnant women if the department is unable to fully implement BSOTS – rating 10
7761 - The risk to infant breast feeding and maternal wellbeing due to the length of time from tongue tie referral to procedure – rating 8
7756 - Risk to patient care & outcome due to being partially compliant with NICE NG210 Pelvic floor dysfunction – rating 3

Report previously considered by & date(s):

January 23

Recommendation	The Quality and Safety Committee is asked to discuss and approve the content and next steps ahead of the February 2nd 2023 submission deadline via the board declaration template

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Email completed coversheet and related paper to: boardcommittees.enh-tr@nhs.net

East and North Hertfordshire NHS Trust

CQC update for Trust Board

February 2023

Amanda Rowley, Director of Midwifery

Background

- An announced inspection of Maternity Services at ENHT was undertaken by the CQC on 4th and 5th of October 2022 which focused on the Key lines of enquiry of safe and well-led.
- On 18th October 2022 the Trust received a Section 29a. warning notice stating:

“This warning notice serves to notify you that the Care Quality Commission has formed the view that the quality of health care provided by East and North Hertfordshire NHS Trust for the regulated activities above requires significant improvement”

- An Improvement Plan has been formulated in immediate response which the service are working through with clear timelines and trajectories for completion.
- The final CQC report was published on Friday 20th January and while the overall rating for the Trust remains “requires improvement “ the rating for maternity services has fallen from the previous rating of Good to Inadequate

East and North Hertfordshire NHS Trust

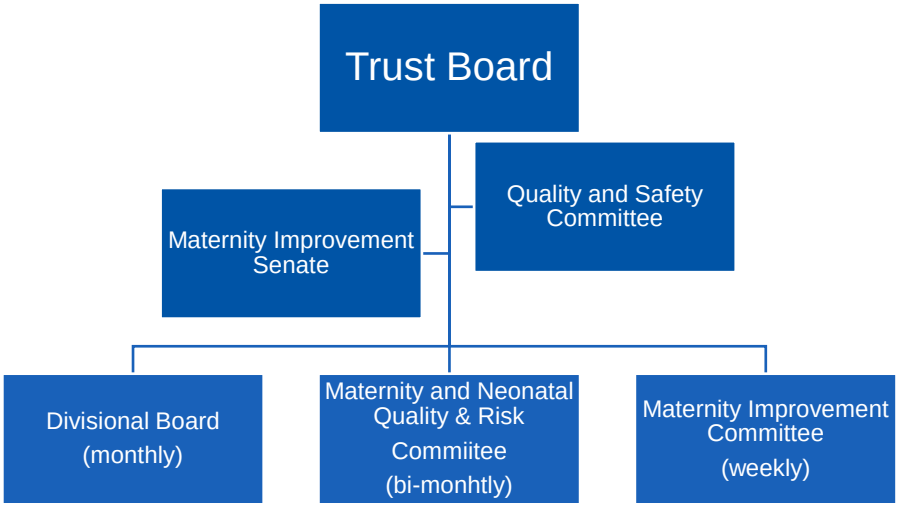
The Six Themes Identified

- Section 1. Maintenance, Equipment & Facilities
- Section 2. Infection Control
- Section 3. Risk Assessment, reporting & Mitigation
- Section 4. Training (Tracking & Monitoring Systems)
- Section 5. Training (Compliance)
- Section 6. Staffing

Governance and Escalation

East and North Hertfordshire NHS Trust

Our senior team and Trust Stakeholders have implemented a Maternity Improvement senate to ensure oversight at senior level and provide a direct line of communication to Trust Board.



4 |CQC maternity inspection update

Sustained Improvements since January submission

29A notice improvements to be implemented by 13/2/2023

Section 1 and 2:

Maintenance, Equipment & Facilities and Infection control

Improvements since 11th January submission

- Sustained improvements with daily checks and equipment cleaning > 90%.
- Increased compliance with Equipment servicing > 78%
- Introduction of a medical equipment co-ordinator role
- Works on Dacre and Gloucester bathrooms complete
- New recliner chairs, lockers, tables and cots have arrived for Gloucester ward
- Reduction in closures and increase in number of births on the MLU
- Improved processes and pathways for escalation to ensure timely follow up of estates and facilities repairs and improvements.
- Strengthened governance process and pathway for Infection prevention and control (IPC) with direct communication from ward to board.

CQC return – February update

29A notice improvements to be implemented by 13/2/2023

East and North Hertfordshire NHS Trust

Significant improvement were required as follows:

The Trust does not have effective systems to ensure staff consistently assess and manage the risks to service users including those who may be deteriorating in the maternity service. This is exposing women to the mothers and their babies to the risk of harm

Section 3: Risk Assessment, Mitigation and Reporting – 13th February 2023

Actions taken to address:

- Ligature risk assessments have been carried out in all inpatient areas.
- Anti-ligature call bells installed in bathrooms on Gloucester / Dacre.
- Replacement call-bell system has been ordered – Installation date confirmation awaited
- Daily review of call bell functionality.
- Manual desk top call bells procured for all area for any occasion when a call bell not functional and repair awaited.
- Implementation of BSOTS: Training underway. Current process being audited and reported weekly.
- Redesign of clinical area to include defined sluice area and designated assessment bays agreed – Installation schedule to be confirmed
- BSOTS Staffing model for Triage has been added to health roster with April go live date.
- Required equipment has been ordered with EDD of February 2023.
- Fetal monitoring audits in Triage demonstrate good levels of compliance.
- Waterbirth guideline has been reviewed and updated and now includes a Risk Assessment Matrix.
- Weekly audit schedule is in place to monitor compliance with Risk Assessments due to variability in compliance on point prevalence audit.

Work towards 17th April Submission deadline

East and North Hertfordshire NHS Trust

Section 4 and 5. Training - Tracking and Monitoring and Compliance

- Improving compliance with safeguarding level 3 training and compliance with safeguarding supervision
- Improving compliance with mandatory training and appraisals
- Focus on staff communication and engagement to support “closing the loop” of learning with weekly staff forums.
- Baby Abduction drill undertaken in February
- Reviewing systems and processes for tracking and monitoring of training compliance
- Appointment of a Matron for Training and Education and increased resource to the Practice Development Team

Section 6. Staffing

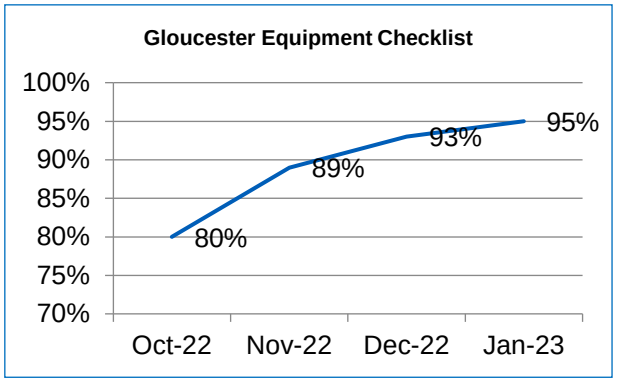
- 18 Newly Qualified Midwives commenced Oct 22-Jan 23.
- Current vacancy for midwives is an improved position of 9% in February 2023
- Strengthened pipeline position with 5 International Midwives and 4 band 5 Midwives receiving conditional offers.
- Increased staffing resources for Safety and Quality Team
- Dedicated recruitment and retention lead for maternity services
- Review of staffing models for Triage and Theatres
- Introduction of maternity specific activity and acuity tool to capture live data.
- New Director of Midwife in post November 2022,
- Open days and recruitment events planned for March, June and September

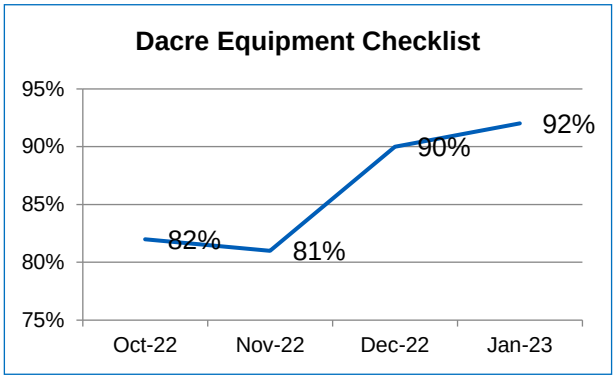
Evidence of Improvements

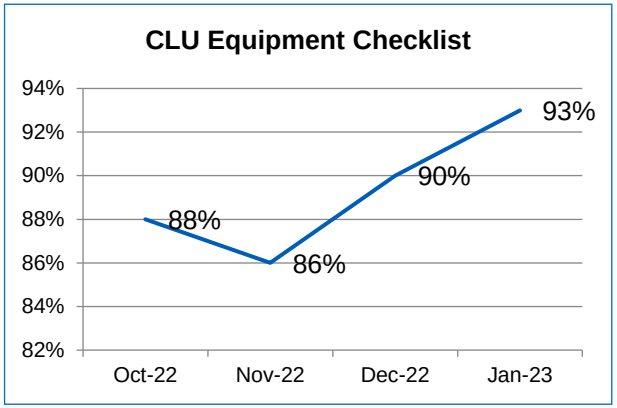
East and North Hertfordshire NHS Trust

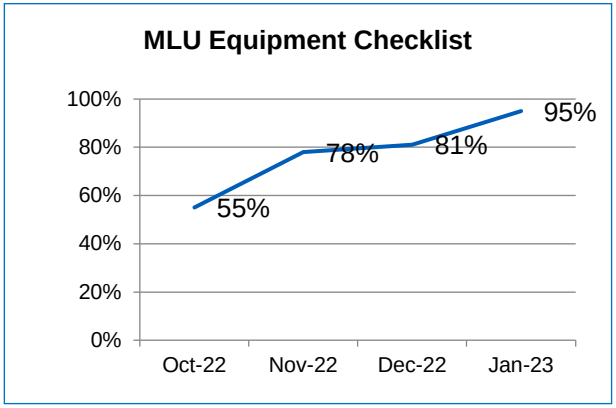
Daily Checks

- Daily “to the floor” hour of senior midwifery team and daily and weekly monitoring schedule (Manager of the day / Matrons) have seen compliance with daily safety and cleaning checks steadily increase.
- The last quarter has seen MLU births increase from 4.5% to 11% in January. This has supported increase compliance due to the reduction in closures of MLU (x1 closure in January).
- Areas of poorer compliance relate to fridge and freezer temperature monitoring. This has been exacerbated by house keeper vacancy which has now been addressed.
- Further work needed to ensure clear audit schedule and compliance monitoring of standards for mattress checking









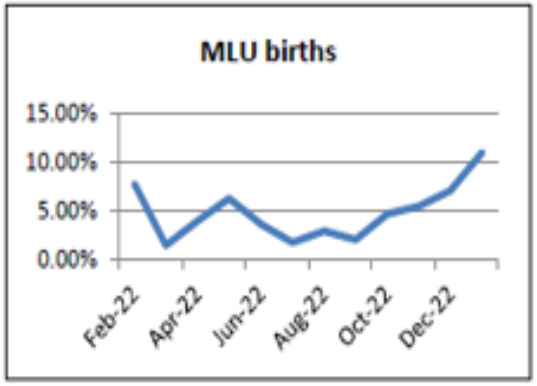
MLU Closures

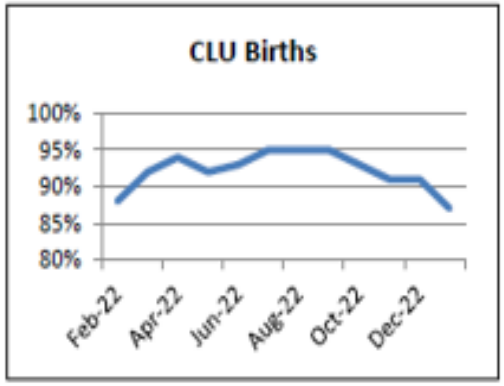
East and North Hertfordshire NHS Trust

MLU Closures

- One divert of MLU reported for January.
- MLU Birth rate has increased in the last quarter from 4.7% in October to 11% in January 2023.
- Reduction in closures is supporting women's choice and releasing capacity on CLU and Gloucester ward.
- Reduction in closures can be attributed to: Reduction in vacancy rate, Culture change to default position of MLU being open and change to process to include escalation to manager on call when MLU closure requested.

MLU births/ Midwife Led Births/ births on CLU: The number of births on MLU is increasing and therefore the number on CLU has been decreasing.





Reflections: Baby abduction drill – 7th February 2023

Reflection	
What worked well?	• Raised the alarm immediately • Aware that code Amber needed to be called • Care to women and communication excellent • Area of cot not touched or disturbed • Searching of the clinical area • Ensuring immediate safety of exits out of the ward • Scribing • Support from other ward areas (Dacre/mlu) • Debrief – Other members of staff helping to aid full debrief of all staff involved.
What have we learned from the situation?	• Where the baby abduction box lives • What a code Amber call includes • Systematic process of the policy • Importance of a leader and co-ordination • The usefulness of the 'role' cards within the red box • External members of staff (drs on clu) were not aware of what code amber meant • Correct numbers on the code Amber call
What do we need to improve?	• Greater awareness of the abduction drill for all staff • Understanding of what code Amber means • Clear Leadership within the emergency
Anything else?	• Security to know what code amber Is and how to 'lock down' the maternity unit • In the policy states 'amber call step down' this doesn't exist.
Actions to take forward	• Baby Abduction to be included in Midwifery mandatory day • Feedback to ward area at staff meeting • Additional Baby abduction box to place on Gloucester • Feedback to security re: training on maternity lockdown • Discuss with Penny Halford updating the code amber team activation list.

MESSAGE OF THE WEEK –
Shared Learning from Baby Abduction Drill.

Thank you to everyone who was involved in the baby abduction drill on Gloucester ward on Tuesday 7th February. The responsiveness of staff to this challenging and stressful situation was recognised in this important service drill.

Key message:
CODE AMBER is an emergency ALERT system for Child abduction or suspected abduction

Positive feedback

- Staff responded well and in a timely way to the emergency.
- The code amber was raised quickly
- Staff were allocated to monitor the doors to the ward area.
- Lockdown was initiated in line with policy.
- Family were well supported throughout the incident
- Great examples of team working before, during and after the drill.

Together-Safe | Kind | Excellent

Learning to share

- **Reminder: Dial 5555 and** 999 and state Code Amber in the event of a suspected abduction
- **Lockdown the clinical area**: It is important that visitors do not enter or leave the ward area until the incident has been stood down
- **Move family to private area** and allocate a staff member to stay with the family.
- **Secure the scene of incident** and do not touch the cot.
- Guidance will be updated to reflect learning for drill. Please see current guideline attached

CQC Maternity Service Survey results 2022

2022 Results for East and North Hertfordshire NHS Trust

East and North Hertfordshire NHS Trust

- On the 11 January 2023, the CQC published their findings from their annual Maternity survey which considered the experiences of service users between 1st – 28th February 2022.
- As part of the National Maternity Services Continuous Improvement Plan, women are asked to participate in a National Survey to share their feedback on the Maternity Service
- ENHT maternity services have seen a decline in the survey ratings since 2019 and identified as a poorer performing trust for the 2022 survey.

Where mothers' experience is best

- ✓ Mothers being able to see or speak to a midwife as much as they wanted during their care after birth.
- ✓ Mothers receiving help and advice from health professionals about their baby's health and progress in the six weeks after the birth.
- ✓ Mothers feeling that the midwife or midwifery team took their personal circumstances into account when giving advice during care after birth.
- ✓ The midwife or health visitor asking about mothers' mental health during their care after birth.
- ✓ Mothers being told who they could contact if they needed advice about any changes they might experience to their mental health after the birth.

Where mothers' experience could improve

- o Mothers being given appropriate information and advice on the risks associated with an induced labour, before being induced.
- o Partners or someone else involved in the mother's care being able to stay with them as much as the mother wanted during their stay in the hospital.
- o Partners or someone else close to the mother were involved in their care as much as they wanted to be during labour and birth.
- o Midwives providing mothers with relevant information, during their pregnancy, about feeding their baby.
- o Mothers being given information about their own physical recovery after the birth.

2022 Results for East and North Hertfordshire NHS Trust

East and North Hertfordshire NHS Trust

Where mothers' experience must improve

- Partners or someone else involved in the mother's care being able to stay with them as much as the mother wanted during their stay in the hospital and being involved in decisions about their care as much as they wanted.
- Delayed discharge.
- Given enough time to ask questions, discuss their pregnancy and access help when it was needed.
- Midwives providing mothers with relevant information during their pregnancy about feeding their baby, about their own physical recovery after the birth, about the risks associated with an induced labour, and about their choices with regard to of place of birth.

A proactive approach to improvement

- All daytime visiting restrictions lifted. Working with MVP to reintroduce the extension of visiting working towards 24/7 access.
- Sharing survey feedback with all staff including students.
- Continued focus on sustaining Midwifery recruitment and retention.
- Daily real time feedback and action progressing to QR code
- Focused stakeholder engagement events facilitated in collaboration with MNVP to gather feedback in real time and coproduce areas of improvement
- MNVP recruitment to promote inclusion and representation from all areas of our local community.

Meeting agenda

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board		**Agenda Item**	14
Report title	Risk Strategy and Policy		**Meeting Date**	1 March 23
Presenter	Theresa Murphy, Chief Nurse			
Author	Margaret Okojie, AD Quality Governance			
Responsible Director	Theresa Murphy, Chief Nurse		**Approval Date**	23/02/23
Purpose *(tick one box only)*	**To Note**	☐	**Approval**	☒
	Discussion	☐	**Decision**	☐

Report Summary:

This document is a new rewritten Risk Management Strategy and Policy that merges various documents previously known as:

- Risk management strategy
- Risk management procedure
- Risk appetite policy

This policy supports a wider recognition and drive of a structured improvement trajectory across the trust wide risk management functions. Key highlights include:

- Refreshed risk management reporting structure, through a newly designed Risk Management Group. Supported by oversight and traction and agreed risk management KPI's.
- New processes to support an improved quality of content within the documentation of risks and their management
- Clarity to escalation and ownership of identified risks
- Improved alignment with BAF and organisational risk appetite footprint
- Identify and manage risk management training needs across ENHT workforce

Impact: where significant implication(s) need highlighting

Adherence to this policy shall improve the management of clinical and non-clinical risk across key organisational functions. This shall support the reliability of delivering high quality care to our community.

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

As above

Report previously considered by & date(s):

Board Seminar – risk appetite (Oct 22)
Risk Management Group (3/2/23)
Audit and Risk Committee (17/01/23)
Trust management group (23/2/23)

Recommendation	The Board/Committee is asked to **APPROVE** the risk strategy

To be trusted to provide consistently outstanding care and exemplary service

DOC ID: CP 208

East and North Hertfordshire NHS Trust

Risk Management Strategy & Policy

About this document	
Document ID	CP 208 **Version:** 011
Full review due before	01 November 2026
Document type	Policy
Usage & applicability	For use Trust wide for use by all staff use at all sites

Summary

- This document provides the full framework the Trust follows regarding the governance of risks identified at the Trust
- This document also outlines the process that governs the registering of risks and defines responsibilities of various roles involved

What you need to know about this version

VERSION TYPE: **Full review of document – full consultation & endorsements**

- This version is a full rewrite and merges various documents previously known as:
  - Risk management strategy
  - Risk management procedure
  - Risk appetite policy

Document control info and governance record in "PART 4 - Document information"
Disclaimer: This document is uncontrolled when printed. See intranet for latest version.

Contents

Part 1 – Preliminary document information

Risk management governance structure

Further details found in section Risk Management Governance

1. Scope

This document provides the Trust's overarching framework, mandate and commitment by which risk is managed and is fully endorsed by the Trust Board. It focuses on risk management arrangements from an organisational rather than an individual perspective. The management of risk applies to all Trust staff, contractors, volunteers, students, locums, agency, and staff employed with honorary contracts

2. Purpose

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. This strategy sets out a pragmatic and effective multidisciplinary approach to risk management, which is underpinned by a clear accountability structure from Board to front line staff level.

It recognises the need for robust systems and processes to support continuous programmes of risk management enabling staff to integrate risk management into their daily activities and support better decision making through a good understanding of risks and their likely impact.

The Trust requires that all staff teams be enabled and, in a position, to 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 the Trust's risk management system. All identified risks are to be reported.

It is our aim that all identified risks are managed through applying the Trust risk appetite statement.

3. Definitions

A list of definitions has been provided underneath section 3.1 of this policy. An additional description can also be found as appendix 5.

4. Duties

The management of risks falls under the remit of the Chief Nurse who holds accountability for the implementation of this policy.

5. Associated Documents

The following documents are related Trust policies and procedural documents, which are advised reading to supplement this document and/or process. These items are different to the titles listed in Part 1 References, which contains external resources referenced in the development of this document.

Document title	Doc ID	Originator
Adverse Incident Reporting & Investigation Policy	CSEC 049	☒ENHT | ☐Affiliated network | ☐National/ regional

Management of Serious Incidents (SIs) procedure	CP 180	☒ENHT | ☐Affiliated network | ☐National/ regional
Health and Safety Policy	EST 031	☒ENHT | ☐Affiliated network | ☐National/ regional
Digital Clinical Risk Management System (Oct 22)	TBC	☐ENHT | ☐Affiliated network | ☐National/ regional
Management of Health and Safety at Work Policy	H&S mhsw	☒ENHT | ☐Affiliated network | ☐National/ regional
Health and safety risk assessments	H&S grapro	☒ENHT | ☐Affiliated network | ☐National/ regional
Complaints and Concerns Policy	CSEC 008	☒ENHT | ☐Affiliated network | ☐National/ regional
Information Security policy and Records Management Policy	IG 002	☒ENHT | ☐Affiliated network | ☐National/ regional
Management of Alerts Procedure	CP 256	☒ENHT | ☐Affiliated network | ☐National/ regional
Business Continuity Plan (within Major incident plan)	EPPR 002	☒ENHT | ☐Affiliated network | ☐National/ regional
Employee Performance Improvement (Capability Policy)	HR 31	☒ENHT | ☐Affiliated network | ☐National/ regional
All policies and procedures associated with healthcare acquired infections	CSEC 93	☒ENHT | ☐Affiliated network | ☐National/ regional
Violence and Aggression Policy	H&S viol&agg/HSS 002	☒ENHT | ☐Affiliated network | ☐National/ regional
Safeguarding Adults from Abuse Policy	CSEC 021	☒ENHT | ☐Affiliated network | ☐National/ regional
Safeguarding Children Policy	CSEC 046	☒ENHT | ☐Affiliated network | ☐National/ regional
Management of financial risk and risks to the internal control environment	TBC	☐ENHT | ☐Affiliated network | ☐National/ regional

6. Monitoring compliance

This document will be reviewed in **3 years** or earlier if any evidence or change in practice comes to light requiring an update to the document. Any further activity to monitor the use and compliance of this document is documented below. Monitoring arrangements are listed in Appendix 4

Further activity to monitor compliance	Lead (named role)	Schedule/frequency
Compliance with Risk Strategy	Audit & Risk	Annual

(annual review of risk management system and through the internal auditor's report on the effectiveness of the system's internal control)	Committee	

6.1. Equality Impact assessment

The Trust supports the practice of evidencing due regard to equality considerations. This means those involved have ensured the document and the function, outlined therein, 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.

This evidence is in the form of an equality impact assessment - a process which should be embedded within the early stages of planning or developments that relate to or impact on equality diversity and inclusion. This also applies to new proposals or changes on previous policy, procedure, strategy or processes that are coming up for review. More on this process for completing Equality Impact Assessments can be found on the Equality, Diversity & Inclusion section of the intranet.

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.

Part 2 – Risk Management framework

Statement

The Board of Directors of East and North Hertfordshire NHS Trust is committed to establishing and implementing an active, Risk Management Strategy, which minimises risk to its stakeholders through a comprehensive system of internal controls which would support its aims of providing better care and a safer environment for patients, staff and other stakeholders. As such, the system of internal control should

- Be embedded in the operation of the Trust and form part of its culture.
- Be capable of responding quickly to evolving risks; and
- Include procedures for reporting and escalating any significant control failings immediately to appropriate levels of management.
- Align to International Standard for Risk Management ISO 31000

The Risk Management Strategy therefore provides a framework, which encompasses strategic, financial, quality, reputational, compliance and health & safety risks.

1.1.1. 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.

1.1.2. The Trust recognises its responsibilities in 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. To this end, the Trust aims to ensure the safety of people who use our services, patients, carers, staff and the public and to deliver quality, patient centred services that achieve excellent results, promoting the best possible use of public resources, through an integrated approach to managing risks.

1.1.3. 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.

1.1.4. This strategy, policy and its procedure, aim to describe:

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

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

2. PURPOSE

This Risk Management Strategy provides the overarching framework, mandate and commitment by which risk is managed and is fully endorsed by the Trust Board. It focuses on risk management arrangements from an organisational rather than an individual perspective and outlines the processes needed to support the Trust in delivering its strategic and other objectives by identifying and managing risks.

2.1.1. The Risk Appetite Statement describes the Trust's 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.

2.1.2. 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. This strategy sets out a pragmatic and effective multidisciplinary approach to risk management, which is underpinned by a clear accountability structure from Board to front line staff level. It recognises the need for robust systems and processes to support continuous programmes of risk management enabling staff to integrate risk management into their daily activities and support better decision making through a good understanding of risks and their likely impact.

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

2.1.4. Keep our patients, staff and visitors safe and ensure high standards of patient care

2.1.5. Protect the reputation, assets and finances of the Trust

2.1.6. Anticipate changing internal and external circumstances and respond by adapting and remaining resilient

2.1.7. Remain compliant (as a minimum) with health and safety regulations, insurance, accreditation and legal requirements.

We can do this by:

2.1.8. 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.

2.1.9. Clearly defining the roles, responsibilities and reporting lines within the Trust for risk management

2.1.10. Making sure all staff understand the importance of effective risk management

2.1.11. Maintaining a comprehensive risk register with regular review and proactive management.

2.1.12. Ensuring effective controls are in place to mitigate the risk and rectify gaps in control

2.1.13. Ensuring effective and documented procedures exist for the control of risk and provision of suitable information, training and supervision

2.1.14. Ensuring the Trust has appropriate business continuity arrangements in place

3. RISK DEFINITION AND TYPES

For the purpose of this strategy and policy the following terms and definitions, which align to ISO31000 and Care Quality Commission (CQC) apply.

Descriptor	Definition
Risk	Risk is an uncertain event or set of events that, should it occur, will have effect on the achievement of objectives. 1. an effect is a deviation from the expected - it can be positive and/or negative and can address, create or result in opportunities and threats 2. objectives can have different aspects (such as financial, health & safety, quality, governance) and can apply at different levels (such as strategic, Trust-wide, project, process). 3. risk is often characterised by reference to potential events and consequences or a combination of these. 4. risk is often expressed in terms of a combination of the consequences of an event (including changes in circumstances) and the associated likelihood of occurrence.
Board Assurance Framework (BAF)	The Board level log of Strategic Risks. The BAF also includes any Operational Risks, which may affect the achievement of the Trust's strategic priorities escalated to the Board by the Executive.
Consequence	A measure of the impact that the predicted harm, loss or damage would have on the people, property or objectives affected.
Divisional Risks	Divisional risks are those risks that if realised could impact the trust the divisional, departmental or local level. Divisional risks are owned and managed by senior managers and are monitored by the divisional triumvirate management team.
Hazard	Anything that has the potential to cause injury, loss, damage or harm.
Issues Log	Issues are things that have happened that were not planned and require management action. A log of the Operational Issues requiring

Descriptor	Definition
	business as usual management and monitoring.
Lessons Log	A log of all the lessons captured during incident investigation, to reduce the likelihood of incidents re-occurring.
Likelihood	A measure of the probability that the predicted harm, loss or damage will occur
Operational Risks	Operational risks are risks that if realised could threaten the achievement of Trust wide business/service objectives requiring controls or mitigation outside/above business as usual management. Operational risks arise from the Trust's day-to-day activities – for example they may relate to non-completion of mandatory training, mismatch between capacity and demand in a particular service, or failure of an IT system or medical equipment. They are normally identified from the 'bottom-up' by managers or staff in the services themselves and are recorded on corporate, divisional or specialty risk registers. The great majority of the risks identified in the Trust are operational risks. Operational risks are monitored by the Executive team and identified relevant board committee.
Corporate Risk Register	**The Corporate Risk Register (CRR)** is a register of high-scoring operational risks which cannot be managed or controlled locally within the service or division and require the attention or assistance of Executive Directors. It is used as a tool for managing high risks and monitoring actions and plans against them. New risks are added formally to the CRR only after the Risk Management Group has approved the escalation of the risk. The decision to add risks to the CRR will be recorded on the Trust Risk Management system to demonstrate that an effective risk escalation process is in operation within the Trust
Issue	A problem, not so severe/serious enough for it to be considered a Risk and requires business as usual management.
Risk Appetite	The Trust's cultural, attitude/approach toward the management of risk, including setting the level of organisational risk that the Trust is willing to accept after mitigating actions have been applied. The purpose of risk appetite is to provide clear consistent guidance on the boundaries, levels of risk and opportunities to take in achieving the Trust's strategic objectives. In the absence of a defined risk appetite, there is an increased potential for the Trust to underperform against its objectives through

Descriptor	Definition
	lack of scope, clarity and management of expectations.
Risk Assessment	The process by which hazards are identified and the risk rated using tools implemented by the Trusts for use by all employees. Assessments can be either general or specific but will be undertaken by competent persons who have received the appropriate degree of information, instruction and training.
Risk Management	The systematic application of management policies, procedures and practices to identify, analyse, assess, treat and monitor risk.
Risk Matrix	The tool used to 'score' each risk and determine its place on the Risk Register.
Risk Mitigation	The systemic reduction in the extent of exposure to a risk and/or the likelihood of its occurrence.
Risk Register	A log captured electronically of all the risks that may threaten the success of the Trust in achieving its declared aims and Trust objectives.
Tolerable Risk	Risks that have been identified, assessed and evaluated and do not require any further mitigating actions.

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.

3.1.1. **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.

3.1.2. **Risks to reputation and communication.** The Trust adopts a careful approach to risks that affect the Trust's reputation, communications, and relationships with stakeholders both inside and outside the NHS, 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.

3.1.3. **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.

3.1.4. **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.

3.1.5. **Service development and 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.

3.1.6. **Workforce 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.

3.1.7. **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.

3.1.8. **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.

3.1.9. **Digital 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.

3.1.10. **Corporate and Strategic risks.** Risks affecting the delivery of the Trust strategic priorities (Quality, Thriving people, Seamless services, Continuous improvement).

3.2. Legislative, Regulatory and Guidance Framework for risk management

East and North Hertfordshire NHS Trust must ensure that its risk management arrangements meet the requirements of a number of legislative, regulatory and national bodies which are described below:

Legislation

The trust has statutory responsibilities for risk assessing and reducing risks under the Health and Safety at Work Act 1974; and the Management of Health and Safety at Work Regulations 1992 (amended 1999). In addition, the Trust has a number of responsibilities as outlined in the Health and Safety Policy.

Care Quality Commission (CQC)

The CQC utilises a risk-based approach to make decisions on compliance with the Fundamental Standards; as such it is essential the Trust make a connection between quality and risk. CQC Regulation 16 - Assessing and Monitoring the Quality of Service Provision requires that healthcare providers "have an up-to-date description of the systems and methods the continuous quality improvement system uses to identify, assess, manage, monitor and record risk".

NHS England and Improvement (NHSEI)

As a Trust it is essential that the Trust develops a strategy and culture which will enable compliance with the following frameworks/guidance:

- NHS Trust Code of Governance; and
- Compliance Framework, Section 3 Risk Assessment

NHS Resolution

The Trust is responsible for reporting all legal claims and litigation, as well as any incidents which have the potential for claims or litigation to NHS Resolution (formally The NHS Litigation Authority (NHSLA).

Best Practice

The Strategy is based on good practice from the National Patient Safety Agency (now subsumed into NHS Improvement) and the International Standard for Risk Management (Principles and Guidelines) ISO3100.

3.3. TRUST RISK MANAGEMENT CAPABILITY

The Trust's in-house risk management capability assessment has been undertaken in line with best practice and outcome discussed at the Board risk management workshop in October 2022. 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.

3.4. Risk appetite statement

The Trust Risk Appetite Statement - refreshed in October 2022- provides detailed guidance as set out by the board on the Trust's risk appetite for different areas of risk and aligned with the Trust's strategic priorities. The Trust risk appetite also provides guidance on escalation.

3.4.1. 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 its 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. The Trust risk appetite will be reviewed annually by the Board.

The risk appetite statement defines the board's appetite for different key risk areas identified with the aim of achieving the Trust's strategic objectives, compliance with regulatory and ethical standards for the year in question.

It is the Trust's ambition that its risk appetite promotes as core values openness and transparency, particularly regarding the reporting and escalation of risks.

The Trust's 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.

3.4.2. 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 should support the Board in making important decisions by providing a 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", and 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).

This Statement sets out the Board’s strategic approach to risk-taking by defining its boundaries and risk tolerance thresholds therefore supporting delivery of the Trust’s Risk Management Strategy and Policy

3.4.3. East and North Hertfordshire NHS Trust approach to risk

A degree of risk is inevitable in delivering and managing health services, particularly so in challenging times. For the safety of our patients, the wellbeing of our staff, and the stability of our finances, it is essential that foreseeable risks are identified and quantified, and that control measures are in place to mitigate them. Furthermore, the Trust board needs to be assured that these control measures are working in practice.

East and North Hertfordshire NHS Trust is ambitious to transform our services in order to meet the challenges of the present and the future. This ambition is outlined in our five-year strategy, which is based around four main themes: quality; thriving people; seamless services; and continuous improvement. Achieving these objectives will require investment, innovation, and in some cases, a departure from tried-and-tested ways of working.

We aim to be risk-aware rather than risk-averse. This means that we are prepared to take risks in pursuit of opportunities and recognise that we sometimes need to balance one risk against another. We will make informed, objective decisions about the level of risk that we are willing to accept. We will continuously monitor and manage our risks to ensure that they do not exceed this level of risk acceptance. We will do so in a consistent way across the organisation, guided by our risk management policy and our shared risk appetite.

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.

3.4.4. East and North Hertfordshire NHS Trust risk appetite

Risk appetite is defined as a decision about the level of risk that an organisation is prepared to accept, after balancing the potential opportunities and threats a situation presents. It takes into account the potential benefits of innovation and the threats that change inevitably brings. Our Trust board has defined its appetite for each of the five main types of risk facing NHS organisations: quality; financial; regulatory; workforce; and reputational risks.

3.4.5. Quality

We are cautious in our approach to risks affecting the quality of clinical services. This means that we prefer to avoid risk. However, in pursuit of better outcomes for patients, and to ensure that all who need our services can access them, we are prepared to take risks in the short-term, providing that those risks are well understood and controlled. We actively support research and innovation in pursuit of quality improvement.

3.4.6. Financial

In managing our resources, we are open to risk. This means that we are willing to accept some financial risks in order to provide safe, high quality and modern services. We mitigate these risks by adhering to the financial controls in our Standing Financial Instructions. We are committed to achieving value for money but recognise that the most economical option is not always the most efficient or effective.

3.4.7. Regulatory

In our dealings with regulatory agencies, we are open to risk. This means that we are prepared to face challenge from regulators, where we are confident that we can demonstrate to them that our actions and proposals are in the best interests of patients and are compliant with relevant laws, regulations and professional standards.

3.4.8. People

We take a risk-seeking approach. This means that we are willing to take risks which may have implications for staff, but which could improve the skills and capabilities of our workforce, as well as opening up new opportunities for colleagues. We recognise that organisational change and new working practices can be disruptive in the short-term but can benefit staff and patients alike in the longer term.

3.4.9. Reputational

We are willing to seek risk in terms of how we are perceived by patients, the public and partner organisations in the local health and care system. By this, we mean that we are prepared to take difficult decisions which may attract external scrutiny. To manage this risk, we will make a persuasive case for change and engage in open, meaningful dialogue with stakeholders both inside the NHS and outside.

3.5. 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.

3.5.1. Risk management cycle

The Trust's risk management cycle includes:

All Trust staff, partners, users of service and visitors should be fully involved in each stage of identifying, assessing, controlling and reviewing risks. There are different ways in which a risk can be managed. These are known as the 4Ts:

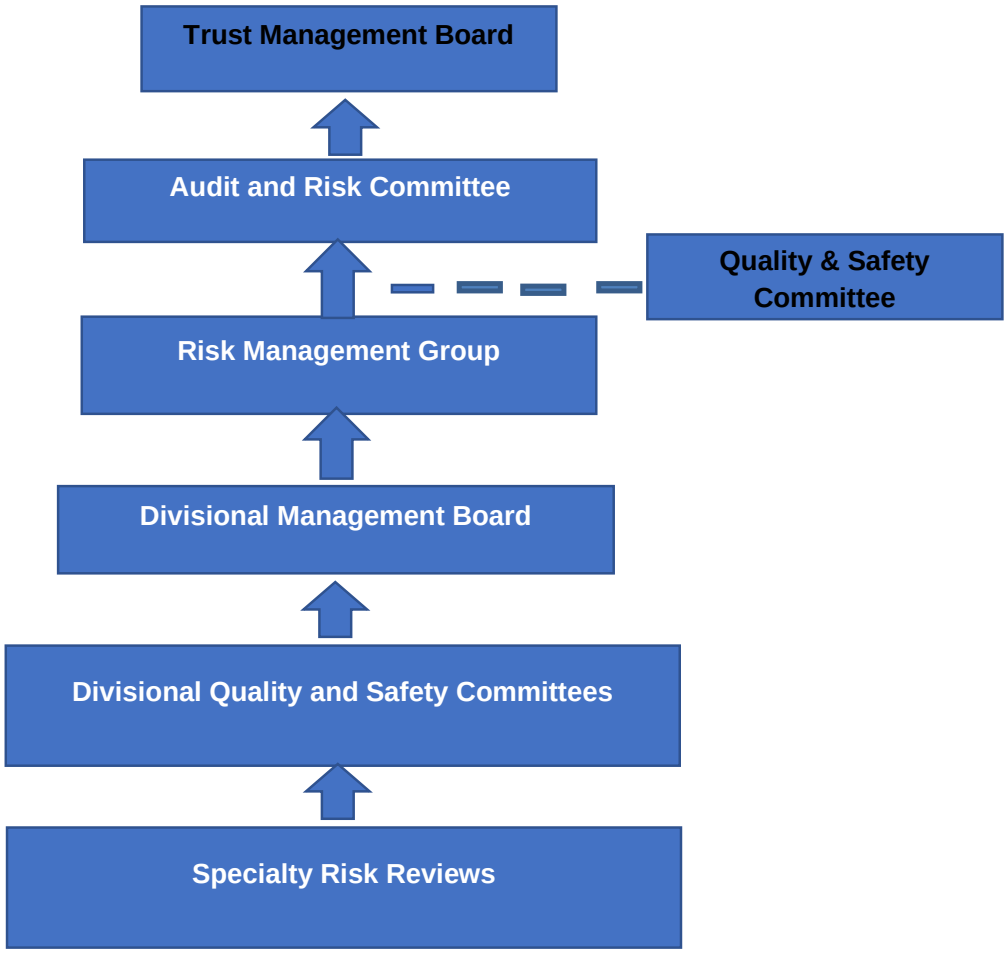
- Treat: take action to reduce the likelihood of the risk materialising, and / or to reduce the impact if it does. This is the approach which we take to most risks in the NHS and is shown in the diagram above.
- Terminate: eliminate the risk entirely by ceasing the activity which gives rise to the risk, for example by closing down a service which struggles to operate within its budget. As we are providing an essential public service in the NHS, this is usually not an option for us.
- Transfer: transfer the risk to someone else in exchange for a fee, for example by taking out an insurance policy, or outsourcing a service to a private sector provider. It is not usually possible to transfer the risk in its entirety - for example, an insurance policy normally has an excess payable by the policy holder.
- Tolerate: take an informed decision to accept the risk because the cost of reducing or eliminating the risk is disproportionate, and by taking action we may even create new risks for the organisation.

3.6. Risk Management Governance

There are different operational levels involved in the governance of risk in the Trust:

- Board of Directors/Trust Board
- Audit and Risk Committee
- Quality and Safety Committee, Finance and Performance Committee, People Committee, Executive Programme Board
- Risk Management Group (reporting to and providing assurance to the Audit and risk 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 mechanisms. The Committee and Group structures set out below are designed to ensure that risks are being effectively identified, assessed and mitigated

3.6.1. **The Trust Board** is responsible for establishing the strategy and for driving the Trust forward to achieve these. It is also responsible for ensuring that there are effective systems in place to identify and manage the strategic risks associated with the achievement of the Trust objectives through the Board Assurance Framework. The Trust Board is responsible for endorsing the organisation's system of internal control, including risk management. The Trust Board has reserved for itself the adoption of the Trust Risk Management Strategy and has collective responsibility for:

- Providing leadership on the management of risk;

- Ensuring risk management systems within the Trust are effective and fully operational across the whole organisation;
- Directing the reduction, elimination and exploitation of risk in order to increase resilience;
- Determining and communicating the risk appetite statement for the Trust;
- Ensuring the consistent approach to the application of the risk management strategy;
- Ensuring that the Trust has a programme in place for managing all types of risk at all levels;
- Reviewing and requesting assurances to demonstrate that risks have been identified, assessed and all reasonable steps have been taken to manage them effectively and appropriately;
- Receiving assurance that resources are available to support the risk management system and to manage risk within the agreed risk appetite;
- Protecting the reputation of the Trust and correctly scoring risks to the achievement of the Trust's strategic objectives via the Board Assurance Framework and regular review of such; and
- Ensuring all members of the Trust Board attend Board development and awareness training in relation to risk management

3.6.2. 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.

3.6.3. The BAF risks are detailed individually in a BAF template and should be reviewed monthly by the Executive Lead for each risk. In addition, monitoring the BAF is included in the terms of reference of the Audit and Risk Committee, Quality and Safety Committee, People 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.

3.6.4. The BAF includes how assurances cover the controls identified and whether these are 1st (departmental assurance), 2nd (organisational oversight) or 3rd (independent) line assurances. These line assurances are documented within the BAF standard operating procedure.

3.6.5. The Head of Corporate Governance ensures that BAF 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.

3.6.6. The Corporate Risk Register (CRR) is a register of high-scoring operational risks which cannot be managed or controlled locally within the service or division and require the attention or assistance of Executive Directors. It is used as a tool for managing high risks and monitoring actions and plans against them. New risks are added formally to the CRR only after the Risk Management Group has approved the escalation of the risk. The decision to add risks to the CRR will be recorded on the Trust Risk Management system to demonstrate that an effective risk escalation process is in operation within the Trust

3.6.7. 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 and Risk Committee and other board sub-committees provide assurance of the robustness of risk processes and to support the board of directors.

3.6.8. **Audit and Risk Committee** has delegated responsibility on behalf of the Board to seek satisfactory assurance that the Trust is meeting its statutory internal and external requirements to remain a safe and effective business through embedded and effective risk management systems and processes with appropriate support from internal/external audit. This includes maintaining oversight of the risk management processes across the Trust and implementation of the Risk Management Strategy and Implementation plan.

3.6.9. **Quality and Safety Committee (QSC)** has delegated responsibility on behalf of the Board to seek satisfactory assurance that there are adequate controls in place to ensure we provide high quality services and care to patients, people who use our services and is capable of meeting the CQC outcomes in relation to risk**.** Committees reporting to the QSC provide a more detailed specialist oversight of risk. These include the Clinical Effectiveness Committee, Patient Safety Committee, Health & Safety and the Patient Experience and Carer 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.

The Quality and Safety Committee receives reports detailing the main causes of emerging risks along with the detail of the management of the risk

3.6.10. **Finance and Performance Committee (FPC)** Committees reporting to the FPC provide a more detailed specialist oversight of risk. These include Capital Review/Control 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.

3.6.11. Divisional & Corporate Senior Management Team Meetings will:

3.6.11.1. Review divisional level or corporate services specific risks monthly, escalating risks as required.

3.6.11.2. Divisional Risk Registers will be maintained by the Divisional Quality Managers on behalf of the division, with support from the Quality Systems and Risk Manager where identified. This will include Risk Leads who

should ensure the regular review of risks and the implementation of effective control measures. This may be a separate meeting solely to discuss risk management, or it may be a meeting with a broader agenda but with a section of the agenda dedicated to risk management.

3.6.11.3. Ensure systems are in place to support delivery and compliance with legislation, mandatory NHS standards and relevant bodies.

3.6.11.4. Monitor the delivery of action plans to ensure gaps in controls are closed and to identify robust assurance mechanisms

3.6.11.5. Encourage and foster greater awareness of risk management throughout their divisions

3.6.11.6. Identifying emerging trends, themes and issues at an operational level across the trust and any resulting potential risks

3.6.11.7. It should be noted that all clinical specialties will have a formal monthly minuted meeting where their risks and controls are discussed and any new risks identified.

3.6.11.8. All areas will have identified risk leads and approving managers to manage risks operationally and approve risks according to the ASSURE risk quality tool.

3.6.11.9. All divisional (or corporate service) leadership roles will be compliant with risk management training standards.

3.6.11.10. Divisional Governance Leads and Divisional Quality Managers have responsibilities regarding monitoring and facilitating the management of risk within their areas.

3.6.11.11. The Quality Systems and Risk Manager will facilitate risk clinics in divisions and non-clinical areas, where necessary, to support and guide divisions.

3.6.12. **Risk Management Group (RMG)** is a management committee, chaired by the Deputy CEO and comprising other executives, senior managers, and divisional representatives. It acts as the gatekeeper to the Corporate Risk Register, monitors the implementation of risk management within divisions and corporate services including uptake of training programmes, and contributes to the development of the risk management strategy and associated policies. The Risk Management Group reports into and provides assurance to the Audit and Risk Committee.

3.6.13. Business Planning: risks, including those identified in the Board Assurance Framework and Trust Objective are considered during business planning cycles to ensure decisions regarding the Trust's Strategy and Annual Plan account for the current risk profile and appetite. A flowchart outlining how business planning aligns with risk management is provided in Appendix 1.

3.7. Risk management activities

3.7.1. 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

3.7.2. 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

Section 15 of this strategy document highlights the associated trust policies and standard operating procedures that supports its risk management activities.

3.8. Delivering the strategy

3.8.1. The strategic element of the Trust's risk management strategy and policy will be delivered by focusing on key themes of activity, linked to the Trust's strategic objectives.

3.8.2. Executive directors, senior management teams and departmental/ operational managers within the Trust will:

3.8.3. Communicate clearly the Trust's quality priorities and strategic objectives

3.8.4. Promote awareness and understanding of the benefits of proactive risk management, and promote a positive risk and patient safety culture

3.8.5. Manage all identified risks underlined by applying the Trust Risk Appetite statement

3.8.6. Work to achieve agreed 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.

3.8.7. Distribute and disseminate, to their teams results of complaints, incidents, serious incidents, claims, near misses, audits and lessons learned

3.8.8. Support compliance with appropriate legislation and standards including national risk management standards and CQC requirements

The Trust will

3.8.9. 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.

3.8.10. Promote and support the ongoing development and Trust wide implementation of risk management strategies and policies according to best practice

3.8.11. Apply and review the Trust risk appetite.

3.8.12. Provide risk management training and facilitation programmes to support staff in implementing their risk management responsibilities and reporting of incidents.

3.8.13. Ensure that all staff receive training in conducting health and safety risk assessments.

3.8.14. 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.

4. Assurance framework

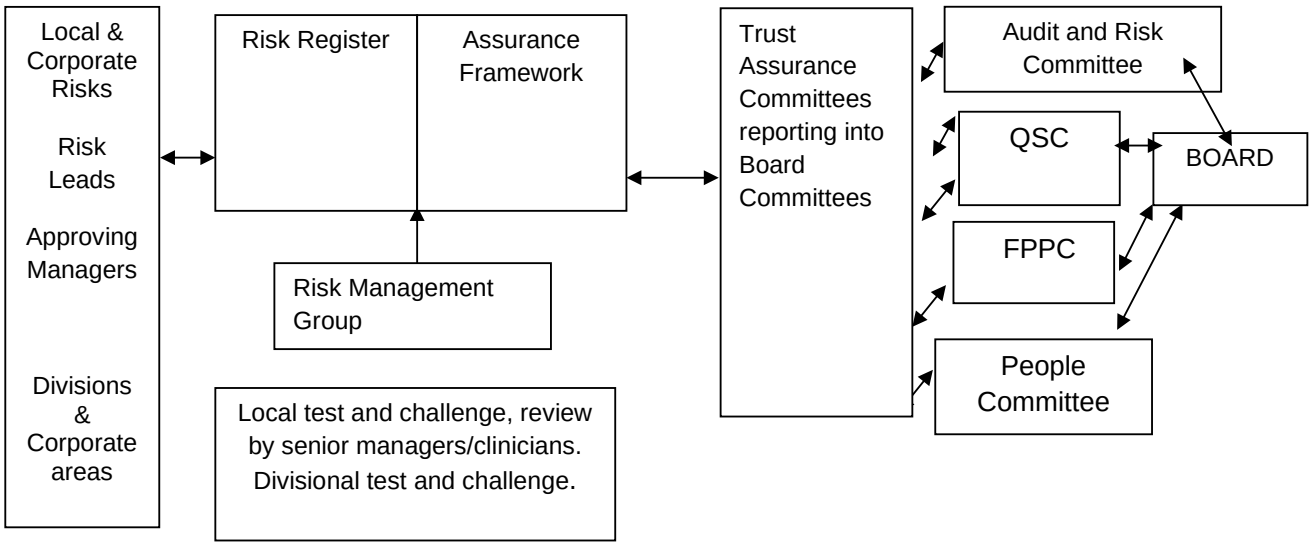
Assurance structures

Assurance of achievement, weaknesses in delivery and key risks to the delivery of Trust objectives are reported through the assurance committees of the Board.

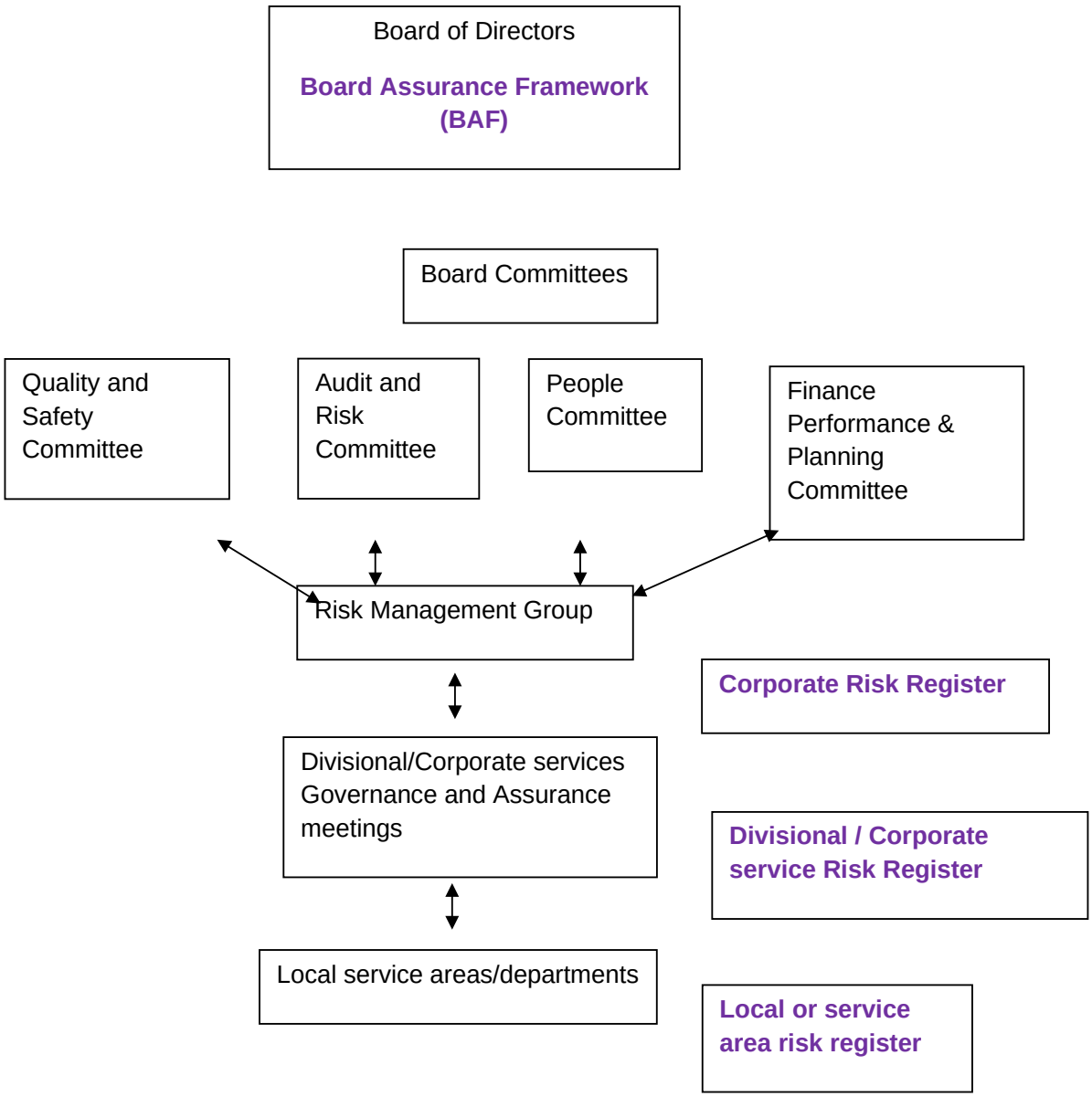
The Board assurance committees receive detailed reports to inform them of all significant risk exposures, material changes to risks and progress with risk management key performance indicators. The Trust assurance committees are responsible for providing assurance on the management of risk to the Board of Directors.

Detailed descriptions of the key functions of the Trust's assurance structures are highlighted in section 8 above.

An overview of the assurance process is illustrated below.



'Risk Escalation' flow chart:



5. TRAINING AND IMPLEMENTATION

5.1. The Trust is committed to equipping staff with the necessary skills required to undertake their roles competently and confidently. In turn, staff must take responsibility for developing these skills and participating in the lifelong learning process.

5.2. A comprehensive training programme has been developed to support the successful implementation and embedding of the Risk Management Strategy and Policy and the Risk Management Procedure. The programme is based on a training needs analysis which is developed, approved and reviewed by the Risk Management Group. Training and facilitation are provided for all staff in leadership roles (Band 7

and above to Executive 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.

5.3. A Training Needs Analysis (TNA) has been developed to identify the training requirements for the implementation of this strategy for all staff groups and Non-Executive Directors and is provided below.

Topic	Staff Groups	Frequency	Delivery
Risk Assessment & Management Training	Trust Board Executive Team Senior Managers Risk Owners	Every Three Years	In house face to face/teams' workshop
Electronic Risk Management	Senior Managers Risk Owners Administrative Staff	One Off and as required to facilitate system change	In house face to face/teams' workshop E-Learning

5.4. 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.

5.5. In addition to Statutory and Mandatory Training, the corporate quality governance risk team will deliver a programme of risk management training, including risk assessment. Compliance of training delivery will be included within performance indicators

RISK MANAGEMENT WORK PROGRAMME PROCEDURE

5.6. The risk management work programme will form part of the Integrated Governance work plan. The work programme is produced by the Associate Director of Quality which will outline the work to be delivered to ensure we continue to develop, implement and improve our risk management processes, systems and strategies.

5.7. Monitoring of compliance and delivery against the Risk Management Work Programme is undertaken by the Risk Management Group.

5.8. The Risk Management Strategy/Policy which describes the process for effectively identifying, assessing, evaluating and monitoring all Trust risks whether they are clinical or non-clinical related will be published on the Trust's intranet

6. RESPONSIBILITIES AND ACCOUNTABILITIES

The Trust's management of risk forms part of its overall approach to governance, with the following individual responsibilities

6.1. **Chief Executive Officer:** as Accountable Officer has overall responsibility for risk management and for ensuring the Trust has a Risk Management Strategy and

infrastructure in place to provide a comprehensive system of internal control and systemic and consistent management of risk. The Chief Executive will delegate specific roles and responsibilities as required, to ensure risk management is coordinated and implemented equitably to meet the Trusts objectives.

6.2. **Director of Finance** has the delegated board level responsibility for financial constraints and balances competing financial demands, facilities and estates and for the Trust's financial risk management activities. They will ensure that financial planning and financial risk management integrates with the clinical and organisational risks management activities. The Director of Finance seeks the Internal Auditor's Opinion on the effectiveness of Internal Control and Internal Financial Control.

6.3. **Chief Nurse**: has delegated board level responsibility for ensuring that all risk and assurance processes are devised, implemented and embedded, reporting to the Chief Executive Officer and Executive Team any significant issues arising from the implementation of this strategy including evidence of non-compliance or lack of effectiveness arising from the monitoring process so that remedial action can be taken. They also have delegated board level responsibility for quality, and patient experience in relation to risk management processes. They hold the responsibility for the Trust risk of non-compliance with CQC essential standards, and is the director with responsibility for safeguarding, decontamination and infection prevention and control.

6.4. **Medical Director**: has delegated board level responsibility for information governance in relation to risk management processes. The deputy Medical Director reports to the Medical Director and is the Trust's Caldicott Guardian with responsibility for information governance risk management

6.5. **Director of IT**: is the Senior Information Risk Owner (SIRO).

6.6. **Chief Operating Officer:** is responsible for the operational delivery of the Trusts services, and as such holds the executive level ownership for risks relating to the delivery of operational services.

6.7. **The Director of Quality** has the operational responsibility for ensuring the delivery and effectiveness of all risk management and assurance processes, and direct line management of the corporate quality and risk team. The Director of Quality is the lead for the development, review and renewal of the Trust Quality strategy. The Director of Quality will work to ensure that the Trust risk register accurately reflects the risk profile of the organisation that informs the Board and that it is used throughout the Trust to improve practice and quality of care. In addition, the Director of Quality also has the delegated responsibility for patient safety in relation to risk management processes.

6.8. **Director of People** has the board level responsibility for implementing effective workforce planning, staff welfare, recruitment and retention, organisational learning and development strategies. They are responsible for ensuring that risks relating to human resources and organisational development are identified, mitigated and managed.

6.9. **Director of Estates and Facilities** is responsible for the management of risks within their areas of operational responsibility. They are responsible for ensuring that risks are appropriately escalated according to the Trust Risk Management policy through to Executive and Trust Board where appropriate. They are responsible for ensuring that there are nominated individuals in their teams with explicit risk management responsibilities.

6.10. The **Head 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. The Head of Corporate governance leads, on behalf of the board of directors, in maintaining the board assurance framework (BAF), the development of the Risk Management Strategy and Procedure ensuring they are effectively coordinated, implemented and monitored across the Trust. The Head of Corporate Governance would work to ensure the effective integration between the Risk Management Strategy and Procedure and Board Assurance Framework. The Head of Corporate Governance has the responsibility for ensuring implementation of effective and suitable governance structures, developing, implementing, coordinating and maintaining the Trust Board Assurance Framework and ensuring the Board follows due process.

6.11. The **Associate Director of Quality Governance** has responsibilities for ensuring that strategic risk management approaches and systems are developed within the Trust. The Associate Director of Quality Governance acts as a source of additional support to the Board of Directors and Trust wide for the management of risks. The role ensures a clear relationship between the Corporate Risk Register and the Board Assurance Framework and act to develop and implement suitable and sufficient risk management training provision across the Trust, ensuring role specific training is provided. The Associate Director of Quality Governance will work in collaboration with the Director of Quality to effectively maintain the Trust's corporate risk register as an active document, monitoring any mitigation and action plans as well as monitoring risks and safety requirements from external agencies, including, but not limited to:

6.11.1. NHS England Improvement Patient Safety Division (Formally National Patient Safety Agency through the Central Alerts System)

6.11.2. Medicines and Healthcare Products Regulation Authority

6.11.3. Health and Safety Executive

6.11.4. NHS counter Fraud and Security Management Service (Formally NHS Protect)

6.11.5. NHS Resolution

6.11.6. National, Regional and Local Security/Intelligence briefings; and

6.11.7. Care Quality Commission

The Associate Director of Quality Governance manages the Compliance & Risk Lead.

6.12. The **Compliance and Risk Lead** actively monitors Trust-wide regulatory standards including CQC, MHRA etc and required resulting actions. New risks identified by the Compliance and Risk Lead are communicated to divisions for entry to the risk register and management action.

The Compliance and Risk Lead is responsible for developing and facilitating implementation of the Trust Risk Management Strategy and Policy, Risk Management Procedure and Risk Appetite statement. The role line manages the Quality Systems and Risk Manager.

6.13. **The Quality Systems and Risk Manager** holds responsibility for supporting the Trust's 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.

6.13.1 The Quality Systems and Risk Manager oversees the Corporate Risk Register and facilitates divisions' management of their risk registers. Divisions are facilitated by divisional quality governance managers to monitor their risk registers and the effectiveness of controls.

6.13.2 The Quality Systems and 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.

6.14. The **Patient Safety and Legal Governance Lead** leads on the incident management policy which includes serious incidents and the design and deployment of the new and emerging Patient Safety Incident Response Framework (PSIRF). The role is accountable to the Associate Director of Quality Governance

6.15. 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 because 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.

6.16. **Assistant Director of Communications and Engagement** has responsibility for managing the risks relating to the reputation of the organisation in relation to press and media coverage and stakeholder relationships and engagement. They are responsible for ensuring that risks relating to human resources and organisational development are identified, mitigated and managed.

6.17. **Divisional and Corporate Service Directors**: are accountable for the delivery of quality services in the areas within their remit and lead on the delivery of the Trust's Strategy with responsibility for ensuring that risks are appropriately identified and controlled. They will ensure the quality agenda is effectively

coordinated, resourced and implemented across the Trust in an integrated way; ensuring actions to improve the quality-of-service delivery are completed, measured and shared to identify lessons, areas for improvement and best practice.

6.17.1. Directors are accountable for ensuring that the potential effect on the quality-of-service delivery is risk assessed prior to approval of any new business proposal. They will ensure that the infrastructure to enable staff to deliver high quality care within their areas of responsibility continues to be in place.

6.17.2. Directors are responsible for risk management leadership and for ensuring sufficient resources have been allocated to undertake effective risk management.

6.17.3. Divisional and Corporate Directors are jointly responsible for:

6.17.4. Ensuring the Trust is compliant with risk management strategies, policies and processes

6.17.4.1. Ensuring service risks are managed;
6.17.4.2. Escalating risks, issues or requests to the Executive Directors; and
6.17.4.3. Managing, implementing and tracking mitigating actions, plans and lessons identified

6.18. **Senior Managers**: are responsible for ensuring systems are in place to implement and monitor programmes of quality improvement within their areas of responsibility in line with the Trust's priorities. Senior Managers are responsible for managing the strategic development and implementation of integrated risk and governance within their Divisional and service lines.
This includes ensuring:

6.18.1. Systems are in place to identify, assess and manage risks through implementation and review of Divisional Risks;

6.18.2. Effective systems are employed for reporting, recording and investigating of all adverse events, such as serious incidents, incidents, near misses, complaints, claims and outcomes of coroner inquests and legal proceedings

6.18.3. Senior Managers will identify risks within the care group and specialties, ensuring appropriate actions are taken, documented and completed to mitigate risks, complying with reporting and governance arrangements to ensure lessons identified and best practice are shared across the organisation. They will monitor their staff and service compliance against identified standards and safe systems of work whether set nationally or locally and will facilitate and act upon regular user feedback.

6.19. **Divisional and Corporate Service Directors** 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.

6.20. **Divisional Clinical Governance/leads:** All divisions and corporate services must have an identified Governance Lead. This person should be a manager with an appropriate level of seniority to fulfil this role. The Governance Lead will be responsible for:

6.20.1. Consulting with teams to identify and assess risks and determine mitigating actions

6.20.2. Ensuring risk registers undergo regular review and quality assurance

6.20.3. Promoting the Risk Management Procedure and best practice within their division or corporate service.

6.20.4. Communicating changes to the Risk Management Strategy and Risk Management Procedure to staff within their area of the Trust

6.20.5. Facilitating and monitoring the implementation of alerts in their divisions or corporate department.

6.20.6. Sharing information and knowledge on risks within their division, at key meetings such as clinical governance meetings, risk clinics etc.

6.21. **Risk Leads**: All risks will have an identified lead, known as the Risk Lead, recorded on the Trust's risk management system. The 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 Risk Lead to escalate risks scoring 15 and above, in line with the escalation process.

6.22. **Action Owner**: All risks are to have action owner(s), designated by the Risk Lead, to implement the action(s) specified to mitigate the risk. The action owner should liaise closely with and update the Risk Lead on progress.

6.23. **Approving Manager**: All risks must have approving managers who approve the risk prior to inclusion on the risk register. 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 Risk Lead. The Approving Manager is usually the Risk Lead's senior manager or director. The Approving Manager and Risk Lead work together over escalation of the risk to the Corporate Risk Register, if needed, via the monthly Risk Management Group.

6.24. **Committee chairs and chairs of management groups that oversee risk:** Chairs are responsible for enabling their committees/groups to know the key risk themes from existing and emerging risks, identifying any areas in the management of risks that require development or escalation to the Risk Management Group or Audit and Risk Committee.

6.25. **Council of Governors**: Trust Governors provide an additional level of assurance that strategic decisions taken by the Board are informed by the views and opinions of local people, people who use our services and staff.

6.26. **All Staff:** are accountable for the quality of the services they deliver and complying with, and participating in risk assessment processes as required. They will comply with identified standards and safe systems of work specific to their roles, whether identified in national, professional or Trust policy, procedures and guidelines. They will report quality issues, however caused, through identified channels to ensure prompt action can be taken using existing reporting systems within the Trust.

6.27. All Managers and staff have responsibility for managing risks within the services within which they work and for ensuring that they have attended the appropriate Risk Management Training commensurate to their role

MONITORING AND REVIEW

6.28. This strategy will be reviewed every three years from the date of ratification, or sooner should there be a change to business process, best practice, statutory duties or any other event which affects the arrangements outlined in this document.

6.29. Compliance with this strategy will be monitored annually by the Trust's Audit and Risk Committee and highlighted actions reported to relevant committees. 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.

6.30. Any non-compliance will be reported to the appropriate operational director for who would be expected to take appropriate action.

6.31. Monitoring arrangements are listed in Appendix 4

7. RISK MANAGEMENT PRINCIPLES

7.1. Healthcare provision and the activities associated with caring for patients and people who use our services, employing staff, providing premises and managing finances will always involve an inherent degree of risk. In broad terms, groups or areas that may be affected and/or have the potential to carry risks are:

- Patients, people who use our services, carers and visitors.
- Staff (including contractors and volunteers);
- Finances.
- The business of the Trust;
- Compliance with statutory duties; and
- The Trust's reputation

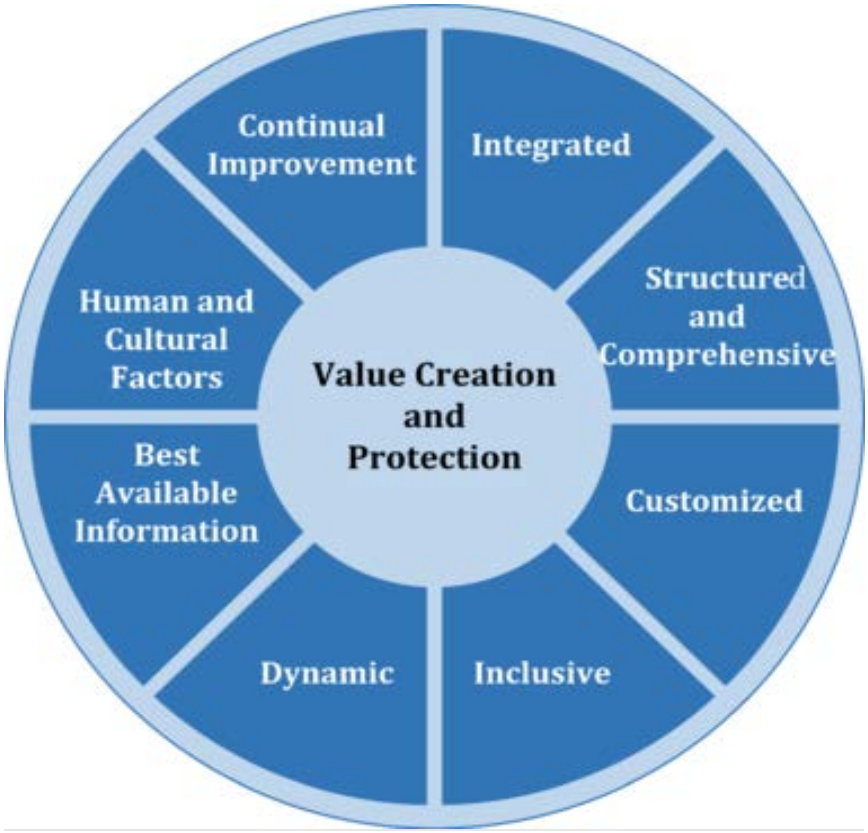
7.2. The possible key sources of risks to these groups are highlighted below:

- Actions/Acts or instances of omissions by hospital staff and contractors.
- Information systems and the reports they generate (information governance);
- Trust buildings, facilities and estates and associated environmental impact.
- Work force planning;
- Business Continuity i.e. the Trust's level of preparedness should an unexpected event occurs that disrupts and/or significantly impacts its ability to maintain critical functions and continued delivery of services. These events can include: Security breaches. Natural disasters. Power outages etc

- Internal change control
- Healthcare system pressure; and
- Changes to the commissioning environment

7.3. The purpose of risk management is the creation and protection of value. It aids the improvement of performance, encourages and supports innovation and the achievement of objectives. The principles outlined below provide guidance on the characteristics of effective and efficient risk management, communicating its value and explaining its intention and purpose.

7.4. The principles outlined form the foundation for the Trust's risk management strategy and should be considered when establishing the Trust's risk management framework and processes. These principles should enable the Trust to manage the effects of uncertainty on its objectives



7.5. Effective risk management requires the elements above and can be further explained as follows:

- **Integrated**: Risk management is an integral part of all organisational activities.
- **Structured and comprehensive**: A structured and comprehensive approach to risk management contributes to consistent and comparable results.
- **Customised**: The risk management framework and process are customized and proportionate to the Trust's external and internal context related to its objectives.

- **Inclusive**: Appropriate and timely involvement of stakeholders enables their knowledge, views and perceptions to be considered. This results in improved awareness and informed risk management.
- **Dynamic**: Risks can emerge, change or disappear as an organisation's external and internal context changes. Risk management anticipates, detects, acknowledges and responds to those changes and events in an appropriate and timely manner.
- **Best available information**: The inputs to risk management are based on historical and current information, as well as on future expectations. Risk management explicitly considers any limitations and uncertainties associated with such information and expectations. Information should be timely, clear and available to relevant stakeholders.
- **Human and cultural factors**: Human behaviour, factors and culture significantly influence all aspects of risk management at each level and stage.
- **Continual improvement**: Risk management is continually improved through learning and experience.

Framework

7.6. The purpose of the risk management framework is to assist the Trust in integrating risk management into significant activities and functions. The effectiveness of risk management will depend on its integration into the governance of the Trust, including decision-making. This requires support from stakeholders, particularly top management.

7.7. Framework development encompasses integrating, designing, implementing, evaluating and improving risk management across the organization. The below diagram illustrates the components of a framework:

7.8. The Trust has evaluated its existing risk management practices and processes, evaluated any gaps and addressed those gaps within its strategy framework. The components of the framework and the way in which they work together has been customised to the needs of the trust. The Trust Board has ensured that risk management is integrated into the Trust's activities to demonstrate leadership and commitment by:

7.8.1. Customising and implementing all components of the strategy framework;

7.8.2. Issuing a statement and policy that establishes a risk management approach, appetite, plan and course of action;

7.8.3. Ensuring that the necessary resources are allocated to managing risk;

7.8.4. Assigning authority, responsibility and accountability at appropriate levels within the Trust.

7.9. This will help the Trust to:

7.9.1. Align risk management with its objectives, strategy and culture;

7.9.2. Recognise and address all obligations, as well as its voluntary commitments;

7.9.3. Establish the amount and type of risk that may or may not be taken to guide the development of risk criteria, ensuring that they are communicated to the Trust and its stakeholders;

7.9.4. Communicate the value of risk management to the Trust and its stakeholders;

7.9.5. Promote systematic monitoring of risks;

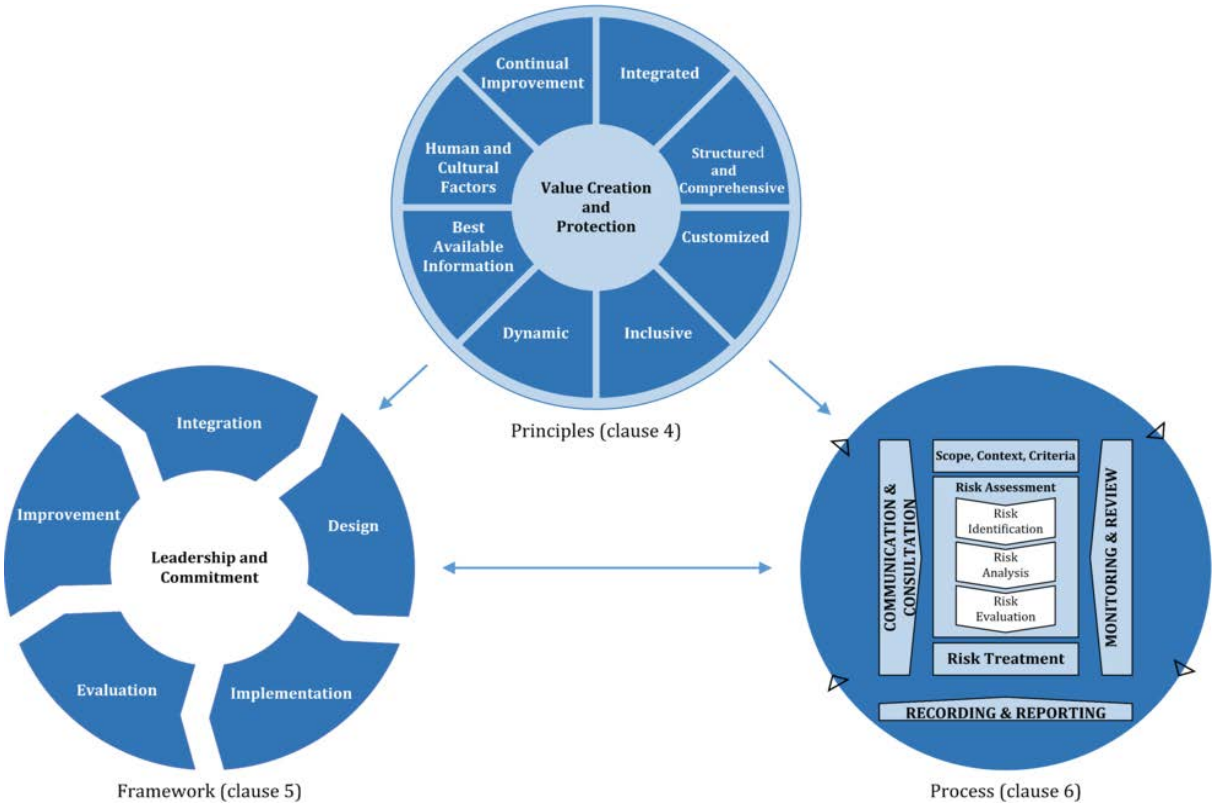
7.9.6. Ensure that the risk management framework remains appropriate to the context of the Trust.

8. Risk Management Process

8.1. The risk management process incorporates the systematic application of policies, procedures and practices to the activities of communicating and consulting, establishing the context and assessing, treating, monitoring, reviewing, recording and reporting risk.

8.2. The Trust supports the use of risk management process as outlined by ISO31000 in implementing its risk management strategy. Management and decision-making regarding risks are integral parts of the Trust's structure, operations and processes. It is the aim of the Trust that risk management is applied at strategic, divisional, care group, specialities, Trust identified improvement programmes or project levels. The dynamic and variable nature of human behaviour, human factors and inherent culture is considered throughout the risk management process ensuring that an iterative practice is achieved rather than a risk management process that is sequential.

8.3. Managing risk is based on the principles, framework and process outlined in below:



8.4. The Trust Risk Process Flow Chart is provided within Appendix 2.

RISK IDENTIFICATION

8.5. Risk may be identified through a variety of sources and several mechanisms and may be both proactive and reactive, including but not limited to:

8.5.1. Analysis of key performance indicators;

8.5.2. Capital and service development projects;

8.5.3. Change control processes;

8.5.4. Claims, incidents, serious incidents and complaints;

8.5.5. Clinical Risk Assessments;

8.5.6. Contingency/Disaster recovery planning and exercising;

8.5.7. Coroners reports;

8.5.8. Environmental and workplace risk assessments;

8.5.9. Equipment and system malfunction or failure;

8.5.10. Equipment purchase/modification;

8.5.11. Information Governance Toolkit;

8.5.12. Committees, groups or meetings;

8.5.13. Internal and external reviews, visits, inspections, audits and accreditation;

8.5.14. National recommendations;

8.5.15. New legislation and guidance;

8.5.16. Preventative maintenance issues;

8.5.17. Risk assessment of everyday operational activities, especially when there is a change in working practice or environment;

8.5.18. Safety alerts (e.g. Central Alerting System)

8.5.19. Staff and patient surveys; and

8.5.20. Raising Concerns Policy

8.6. Each risk identified should be clearly defined using simple, unambiguous and non-emotive language, using the 'If' and 'Then' concept.

RAISING NEW RISKS

8.7. Staff should raise any identified risks to their line manager through their established business processes. All new risks will be reviewed by a divisional senior manager to determine:

8.7.1. If the threat raised is a risk (requires mitigation and action outside of business as usual) or an issue (can be managed within business as usual). Where deemed an issue this will be moved to the divisional issues log;

8.7.2. Risk Title and Description accurately reflect the risk;

8.7.3. Risk Scoring accurately reflects the residual risk; and

8.7.4. Action and mitigations are appropriate and have been clearly outlined as part of the risk assesstment

8.8. RISK ANALYSIS AND EVALUATION

8.8.1. Risk analysis and evaluation involves developing a further understanding of the risk to enable an evaluation of how the risk should be treated. As such risk analysis involves the consideration of the causes and sources of the risk, their positive and negative consequences and the likelihood that those consequences may occur.

8.8.2. Ideally, risk analysis should be an objective process and wherever possible should draw on independent evidence and valid quantitative data. However, it is recognised that such evidence and data may not be available to the assessor(s), who will be required to make a subjective judgement. When facing uncertainty, the assessor(s) should take a precautionary approach.

8.8.3. To ensure consistency of risk quantification across the Trust a standardised set of descriptors and scoring matrices will be used for risk analysis.

RISK SCORING

8.9. The risk score will be based upon the consequence of a risk and the likelihood of it happening/being realised:

Consequence x Likelihood = Risk Score

8.10. The Trust uses four risk scores for/during the management of risks:

8.10.1. **Initial Risk Score**: This is the score given when the risk was first identified and is assessed with the current existing controls in place. This score will remain unchanged for the lifetime of the risk and is used as a benchmark against which the effect of risk mitigation can be measured.

8.10.2. **Previous Risk Score**: This is the score following the last review of the risk. This allows for comparison with the current risk score as it stands, showing change in direction from the last assessment.

8.10.3. **Current Risk Score**: This is the score following the application of controls. Effective controls should always reduce the initial risk score. The current (residual) risk score is taken at the time the risk was last reviewed in line with the set review dates. It is expected that the current risk score will reduce and move toward the Target Risk Score as action plans and mitigating actions are developed and implemented.

8.10.4. **Target Risk Score**: This is the score that is expected to be reached after the action plan and mitigating actions have been fully implemented to enable the risk to be reduced to a level which is tolerable.

8.11. **Scoring the Consequence:** Consequence must be scored using the Table of Consequences. Where there are multiple domains the highest consequence should be used.

8.12. **Scoring the Likelihood:** Likelihood must be scored using the Table of Likelihood, with existing controls in place.

8.13. **Risk Score:** Once the Consequence and Likelihood have been determined, the over-all risk score can be measured using the Risk Score Matrix.

8.14. **Risk Grade/Rating**: for grading risks, the scores obtained from the risk matrix are assigned grades as per the Grade descriptor. Risk grading makes evaluation of the risk easier with reference to the Trust wide risk profile; providing a systemic framework by which to identify the level at which risks will be managed, prioritising remedial action and availability of resources to address risks.

8.14.1. Risk rating also allows the Trust to set its risk appetite, with the 'Risk Treatment Table used to define the guidance on the documentation/registration of the risk, the urgency of action to mitigate the risk and clarifies ownership, reporting and oversight

	Consequence				
Likelihood	1. None/Insignificant	2. Minor (Green)	3. Moderate (Yellow)	4. Major (Orange)	5. Death/Catastrophic (Red)
5. Certain - Expected to occur at least **daily**	Yellow: low 5	Orange: moderate 10	Red: high 15	Red: high 20	Red: high 25
4. Likely - Expected to	Yellow: low 4	Moderate: 8	Orange: moderate	Red: high 16	Red: high 20

occur at least **weekly**			12		
3. Possible - Expected to occur at least **monthly**	Green very low 3	Yellow: low 6	Orange: moderate 9	Orange: moderate 12	Red: high 15
2. Unlikely - Expected to occur at least **quarterly**	Green very low 2	Yellow: low 4	Yellow: low 6	Orange: moderate 8	Orange: moderate 10
1. Rare - Expected to occur at least **annually**	Green very low 1	Green very low 2	Green very low 3	Yellow: low 4	Yellow: low 5

9. RISK ESCALATION

The structure for risk reporting, accountability and escalation /de-escalation for each level is described below:

Escalating divisional risks to the Corporate Risk Register (CRR)

9.1.1. The way that risks are entered onto the Corporate Risk Register (CRR) has changed (October 2022). The corporate risk register (CRR) is a register of high-scoring operational risks which cannot be managed or controlled locally within the service or division and require the attention or assistance of executive directors. It is used as a tool for managing high risks and monitoring actions and plans against them.

9.1.2. New risks will be added formally to the CRR only after the Risk Management Group has approved the escalation of the risk

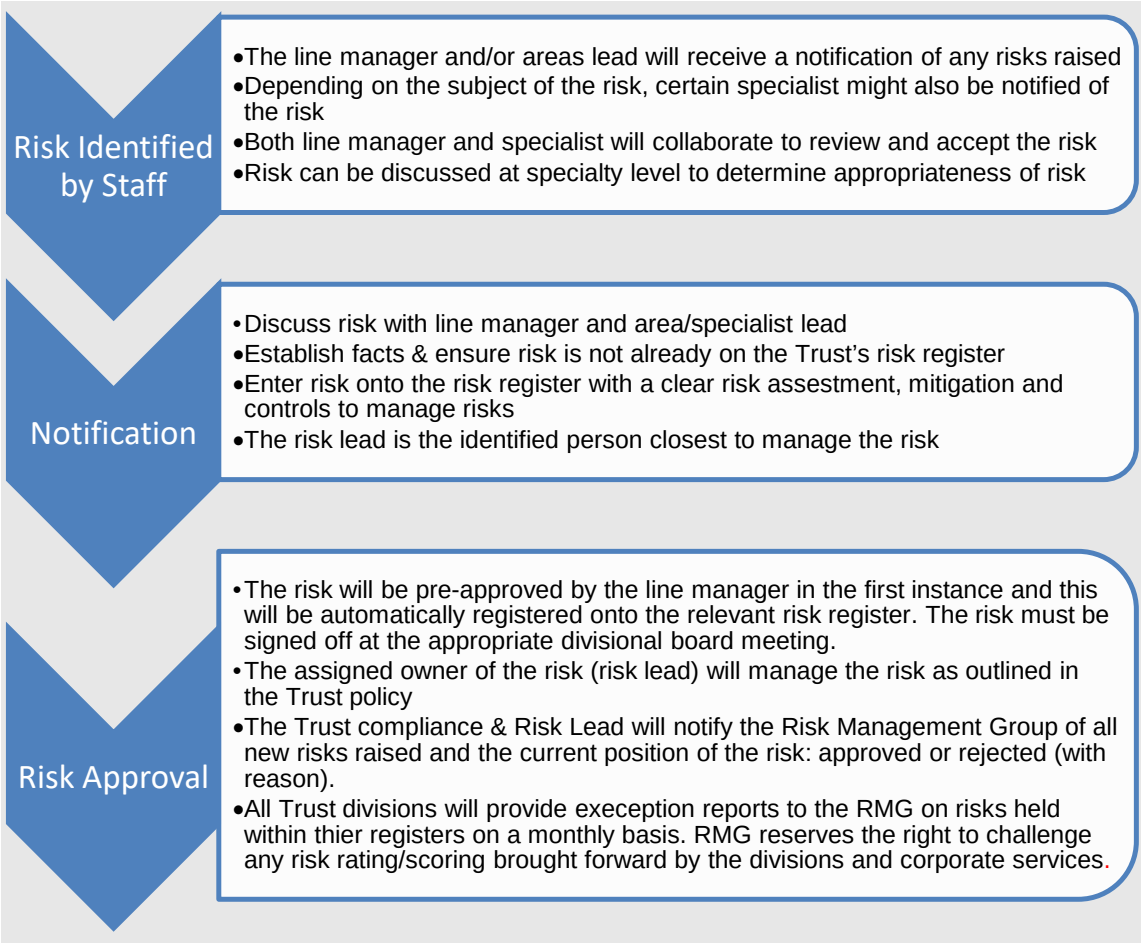
9.1.3. The Divisional Board is the highest divisional level forum to discuss controls and action plans for divisional risks. It is the forum where high scoring risks should be reviewed to see if they require escalation to the CRR via the Risk Management Group monthly meeting.

9.1.4. All risks added scoring 15 and above are reviewed by the Corporate risk team. The divisional board/executive director confirms if they approve the risk, its scoring and ensure that appropriate actions to mitigate the risk has been outlined within the risk assessment including any items to escalate for additional support.

9.1.5. 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, Audit and Risk Committee, the Finance Performance and Planning Committee and People Committee.

RISK APPROVAL PROCESS

9.2. Any member of staff can identify a risk and whilst approval does not need to be sought before adding a risk to the risk register it is best practice to discuss the risk with your line manager and/or other members of your service/team to ensure that you have all the relevant information.



RISK REVIEW AND MONITORING

9.3. The following minimum periods for review have been set for all risks and are aligned to the risk score.

Score	Level	Review Period
	Issue	Monthly Review
Tolerable	Tolerable	Six Monthly Review
(1 - 3)	Very low	Quarterly review
(4 - 6)	Low	Quarterly Review

Score	Level	Review Period
(8 - 12)	Moderate	Two Monthly Review
(15 - 25)	High/ Risk	Monthly Review

9.4. All risks must be reviewed and documented on the electronic risk management system in line with these timeframes; however more frequent review may be undertaken as necessary/required.

9.5. When undertaking the risk review the following questions should be considered.

Consideration	Description / Question	Impact / Outcome
Risk Description	Is the risk still the same or has it changed?	Risk updated to reflect the new nature of the risk or a new risk raised
Realisation of the risk	Has the risk occurred? To what extent?	Consider any new risks because of the risk occurring
Incidents, Complaints or Claims	Have there been related incidents, complaints or claims? or has the number of incidents, complaints or claims increased/ decreased?	May change the likelihood Score or Consequence
Control Effectiveness	Are the controls put in place effective in reducing the risk?	Change of consequence or likelihood score
Completed Actions & Effectiveness	Have mitigating actions been completed? If so how effective are they in reducing the risk?	Change to consequence or likelihood score
Consequence Score	Has the likelihood or consequence changed?	Change to consequence or likelihood score
Target Score	Is the target score still achievable or has it been reached?	Change to target score or closure of risk.

9.6. Risk monitoring will take place by the following groups.

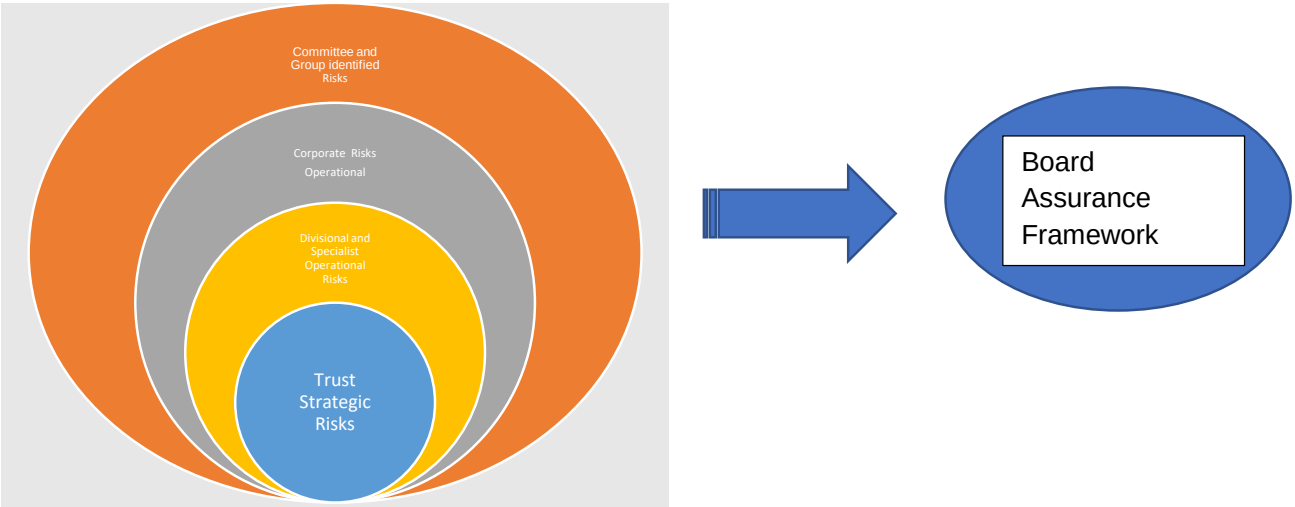
Register	Monitoring Group	Frequency
Board Assurance Framework	• Trust Board • Audit and Risk Committee	Monthly/ Quarterly
Trust Corporate Risk Register	• Risk Management Group • Audit and Risk Committee (quarterly review)	Monthly Quarterly
Divisional	• Divisional Management Team • Risk Management Group	Monthly
Care Group	• Divisional Management Team	Monthly

10. RISK DOCUMENTATION

10.1 All risks are entered onto the Trust Risk Register held on the electronic risk management system. As such the Trust has one centrally held risk register which is organised by risk level and source of risk

10.2 All risks must have appropriate risk assessment documentation with clear descriptions of risk title, description, mitigations, monitoring and actions.

10.3 All risks will be aligned with the Trust's Board Assurance Framework (BAF)



10.4 **Board Assurance Framework (BAF):** The Board Assurance Framework is the Board level register of risks which may affect the achievement of the Trust's strategic objectives. Risks on the BAF are owned and monitored by the Trust Board of Directors and managed through lead Committees. The Audit and Risk Committee monitor the BAF as part of its overarching risk management duty.

10.5 **Trust Corporate Risk Register:** The Corporate Risk Register (CRR) is a register of high-scoring operational risks which cannot be managed or controlled locally within the service or division and require the attention or assistance of Executive Directors. It is used as a tool for managing high risks and monitoring actions and plans against them. New risks are added formally to the CRR only after the Risk Management Group has approved the escalation of the risk.

10.6 **Divisional Risk Register:** Divisional operational risks impact on the achievement of the Trust wide business and service objectives. Divisional operational risks are owned by the Trust Senior Managers and monitored by Divisional and Corporate Services Senior Managers and relevant sub committees of the Board.

10.7 **Care Group/Corporate Services Risk Register:** These are risks that if realised could threaten the way in which the Trust operates at a divisional, departmental, or local/corporate service level, but are unlikely to directly impact the Trusts Strategic Objectives. Divisional risks are owned and managed by Managers and monitored by the divisional and corporate services senior management teams.

10.8 **Committee or Group Risk Registers:** To ensure sufficient assurance of the monitoring and management of risk across the Trust, Committee/Group Risk Registers will be formed from all risks relevant to the Terms of Reference for the Committee or Group. As such risks may be identified through the course of business of a committee and will be raised through the relevant executive and escalated to Executive Board as necessary/required.

10.9 In addition to the Risk Registers within the Trust the following also integrated within the Risk Management Process.

10.9.1 **Issues Log:** Issues logs are managed by divisions to document the operational issues, which require management through business-as-usual process. They are monitored and managed through the division, relevant committee and will be escalated to Executive team, as necessary. The Issues Log is held on the electronic risk management system.

10.9.2 **Health and Safety Risk Register:** Due to their specific nature, health and safety related risks must be recorded on the Trust Health and Safety Risk Assessment Form. Health and safety related risk assessments forms will be retained locally. Health and safety risks impacting the risk appetite will be included within the electronically held Trust risk register.

10.9.3 **Patient Clinical / Individual Risks:** Clinical Patient risks and those relating to individuals will be held locally using **the** appropriate clinical assessment form/documentation using the Patient Care Record in line with the Clinical Risk Assessment and Management Policy and Procedure. Systemic clinical risks will be added to the Trust risk register on electronic risk management system.

10.9.4 **Project / Programme Risks: Project** / Programme risks will be recorded using the projects own internal documentation, typically a risk log. Project and programme risks which impact outside of the project itself (with a current risk score of 15 or higher) will be added to the Trust Risk Register on the electronic risk management system

11. RISK OWNERSHIP, ESCALATION AND ASSURANCE

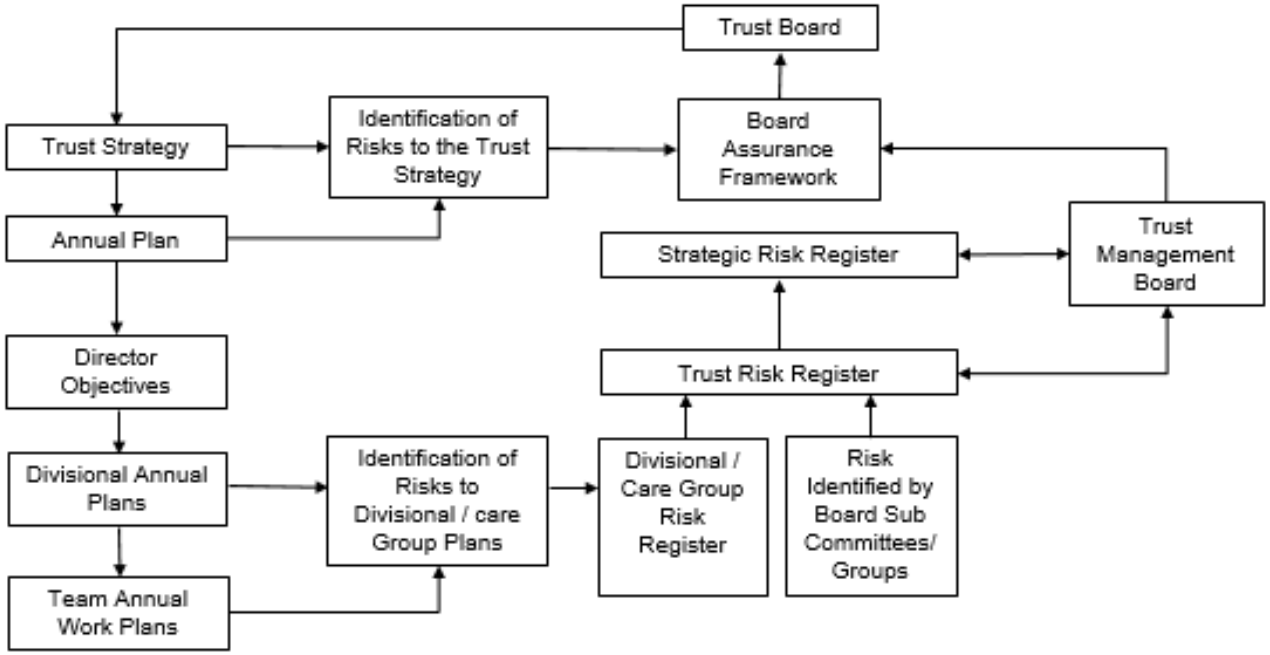
11.1. Risk owners are responsible for their risks, ensuring they are correctly scored, that suitable and effective controls are implemented, and action plans produced and monitored, with oversight and compliance monitored by the Trust's Risk Team.

11.2. The governance structure enables risks to be managed at the appropriate level within the Trust, ensuring a monitoring committee/group with responsibility for providing assurance that risks are effectively identified, assessed, monitored, and managed. Risks that have been robustly reviewed should either be escalated and deescalated as appropriate.

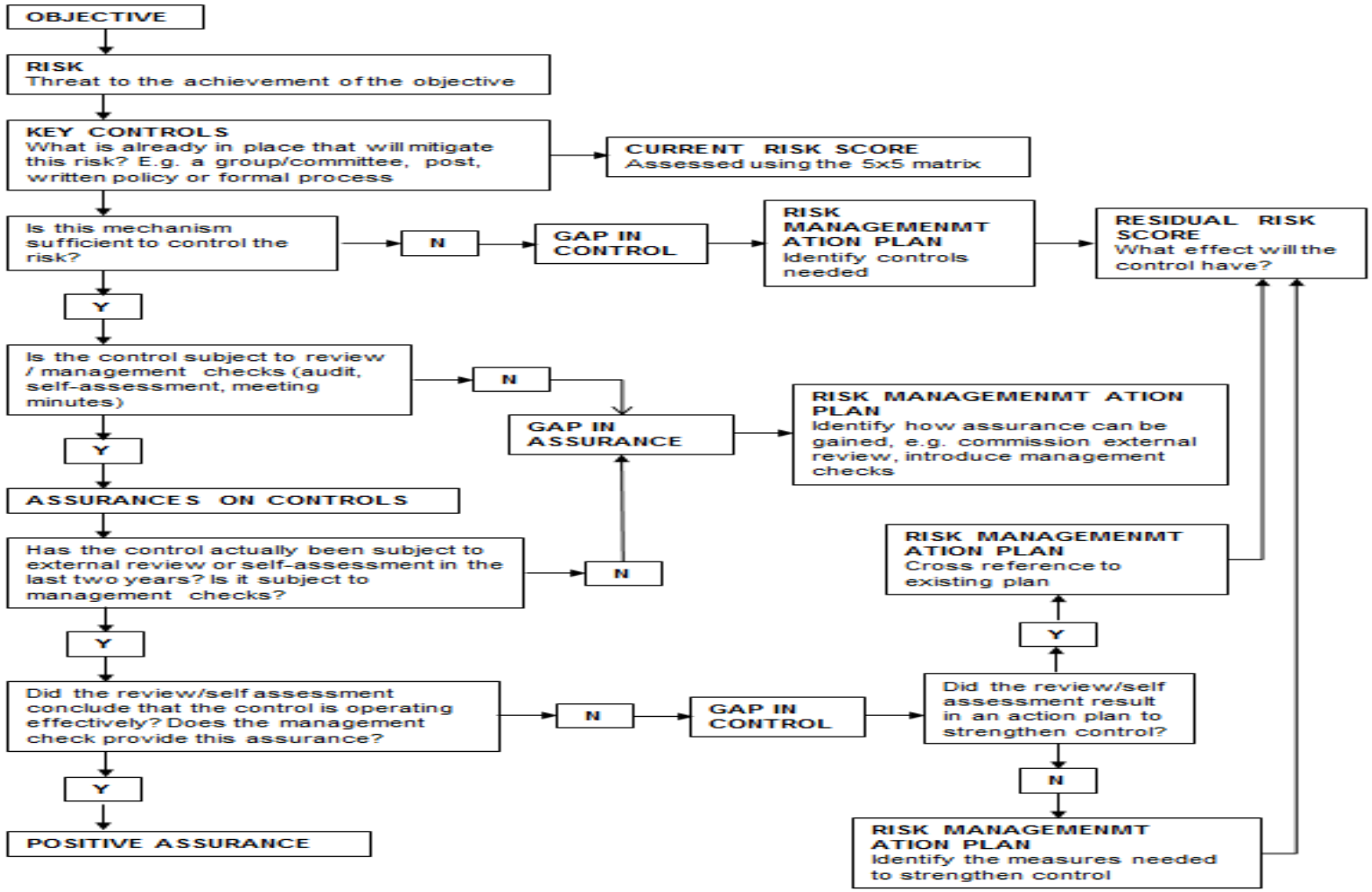
11.3. It is the responsibility of the monitoring committee/group to ensure that risks are escalated appropriately, including escalating themes where they are observed by a number of similar low-level risks.

Part 3 – Appendices

Appendix 1: BUSINESS PLANNING RISK MANAGEMENT FLOW CHART



APPENDIX 2: RISK PROCESS FLOWCHART



APPENDIX 3: TRAINING ARRANGEMENTS

Staff Member	Board level risk training	Risk video (full and summary versions)	Enhance System Training – Risk Module	Risk Management & Assessment Training	Intranet / leaflets (risk information only)	1-2-1 bespoke risk training
Executive Board Members / Executive Risk owners	Every three years via External Provider		As and when required		As and when required	As and when required
Governance teams		Full version once	On appointment, as and when required and system upgrades	Every two years or on appointment	As and when required	As and when required
Enhance Risk and Control Owners (Enhance Investigators)		Full version once	On appointment, as and when required and system upgrades	Every two years or on appointment	As and when required	As and when required
All staff		Summary version on appointment			As and when required	As and when required

APPENDIX 4: MONITORING ARRANGEMENTS

Element to be monitored	Executive Lead	Lead	How will compliance be monitored	Frequency	Who/what committee will receive results for information / action	Who will undertake the action planning for deficiencies and recommendations	How will changes be implemented and shared
Monthly Risk Scrutiny	Chief Executive	Director of Quality	Trust Management Board	Monthly	Risk Management Group	Head of Corporate Governance Director of Quality	Required changes to practice will be identified at the audit committee and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate/ lessons identified will be shared with all relevant stakeholders.
Divisional risk management structure	Chief Nurse	Divisional Directors	Internal Audit	Annual	Audit and Risk Committee	Associate Director for Quality Governance	
Board, Committee and Executive Management risk register review	Chief Nurse	Head of Corporate Governance	Internal Audit	Quarterly	Audit and Risk Committee	Head of Corporate Governance Director of Quality	
Process for management of risks locally, which reflects organisation wide risk management strategy	Chief Medical Officer	Director of Quality	Internal Audit	Annual	Audit and Risk Committee	Associate Director for Quality Governance	
Ensuring board members, executive and senior managers receive relevant risk	Chief Nurse	Director of	Internal Audit	Annual	Audit and Risk	Director of Quality	

Element to be monitored	Executive Lead	Lead	How will compliance be monitored	Frequency	Who/what committee will receive results for information / action	Who will undertake the action planning for deficiencies and recommendations	How will changes be implemented and shared
management training	Executive	Quality			Committee	Head of Corporate Governance	
Policy review	Chief Nurse	Director of Quality	Internal Audit	Annual	Audit and Risk Committee (Initial review) Trust Board (Final sign off)	Associate Director for Quality Governance	
A review of all risks with no movement	Chief Nurse	Director of Quality	Internal Audit	Every four months	Risk Management Group	Associate Director for Quality Governance	
A review of closed risks	Chief Nurse	Director of Quality	Internal Audit	Every six months	Risk Management Group	Associate Director for Quality Governance	

APPENDIX 5: RISK REGISTER FIELD DESCRIPTORS

Descriptor	Definition
Risk Identification	
Risk ID	Unique risk identification number
Risk added date	The date that the risk was identified
Risk origin	The source of the risk. For example, from another risk register: • Divisional risk register • Safeguarding risk register • Infection prevention and control risk register
Risk title	Succinct title for the risk
Risk description	Description of the risk
Risk Type	The risk type outlines the kind of risk; • Clinical (a risk affecting the care or safety of people who use our services) • Non-Clinical (a non-clinical risk which affects the business, staff, or assets of the organisation) • Trust wide (a risk which affects all aspects of the organisation e.g. both the care and safety of people who use our services and the business of the organisation
Risk Group	The risk group defines the theme of the risk; • Clinical Targets • Medical Devices • Emergency Preparedness (EPRR) • Estates and facilities, • External Stakeholders • Finance • Regulatory noncompliance • Health &Safety,

	• Security • Fire • Information Governance • Innovation (not listed but would be a good addittion) • Information Management and Technology Patient Safety Risks • Media (add reputation to identify those risk) • Training & Education • Human Resources Risks
Descriptor	**Definition**
CQC domain	The primary CQC Domain that would be affected should the risk be realised; • Caring • Effective • Responsive • Safe • Well-Led
Executive owner	The Executive Director with responsibility for ownership of the risk at Board level to ensure: • The risk is appropriately identified and managed • Review occurs within the required timeframes • controls and actions are suitable and effective • Target scores are achievable • Risk scores are accurate
Risk owner	The person responsible for the overall management of that risk and will ensure updates provided on controls and scores
Key existing controls	The list of what we are currently doing about the risk to control the risk effectively
Assurance on controls	The list of arrangement in place for obtaining assurance that the key controls in place are working effectively and having an impact

Adequacy of controls	Overview of the adequacy of the controls in place; • Adequate - Controls are in place and are adequately controlling the risk • Partial - (Some controls have been implemented and are adequate to control part of the risk; however further controls are required or are not adequate to control the risk • Inadequate - Controls in place are inadequate to control the risk • Uncontrolled - No controls are in place
Assurance strength	The strength of the assurance in place: • High • Medium • Low
Risk Analysis	
Initial risk score	The Risk Rating at the time it is identified (this should include with any existing controls in place at the time the risk is identified)
Likelihood	A measure of the probability that the predicted harm, loss or damage will occur
Consequence	A measure of the impact that the predicted harm, loss, or damage would have on the people, property or objectives affected.
Risk score	The Risk Rating is the Consequence x Likelihood
Direction of Risk Score	The direction of movement of the Residual Risk Rating since the last review/progress update; • ▲: Up - The Residual Risk Rating has increased • ▼: Down - The Residual Risk Rating has reduced • ▬: Same - The Residual Risk Rating has remained the same • N: New
Previous risk score	The risk score from the last time the risk was reviewed
Current risk score	The risk score at the moment
Risk treatment	How the risk will be managed; • Tolerate

	• Treat • Transfer • Terminate
Risk Evaluation, Treatment, Monitoring and Control	
Gaps in Control and or Assurance	What gaps in controls and assurance exist, which prevent the risk from be reduced to the Target Risk Score?
Mitigating actions to address gaps	What action needs to be taken to address the gaps in controls and assurance to ensure the risk can be reduced to the Target Risk Rating?
Action lead	The person with responsibility for delivering on the action
Action due date	When will the action required be completed by?
Action plan update	Free text update on the progress of the risk, outlining any blockages to delivering the actions required
Action RAG	An overview of the progress of the action; • Overdue - The completion date has passed and the action has not be implemented • At Risk - The action is at risk of not being implemented by the completion date • On Track - The action is on track to be completed by the completion date • Complete - The action has been completed
Target Risk Score	The Risk Score that once achieved will ensure the risk has been suitably and effectively controlled to reduce the risk to a tolerable level.
Relevant Committee/ Group	The committee, group, or meeting with responsibility for monitoring this risk or risk register
Last review date	The date the review/progress updated was completed
Next review date	The date the next review is required in-line with the required timeframes for review.

Part 4 – Document record

As per policy **CP 116 Trust policies and procedural documents**, this document is using the latest format of **Template for Trust-approved documents TMP 001 (Version 1)**.

Document info	Doc ID: CP 208, Version – 011 Risk Management Strategy & Policy
Document type	Select one option: ☐ Guideline, ☐ Pathway, ☒ Policy,☐ Procedure, ☐ Protocol, ☐ Standard Operating Procedure **Policy**
Document applicability across the organisation	SELECT ONE for each of the 3 items 1. **For use** ☒Trust wide; ☐ clinically cross specialty; ☐ in multiple areas (non-clinical) ☐ locally only 2. **For use by** (ROLES): ☒All roles, ☐clinical roles only, ☐non-clinical roles only 3. **For use at** (SITES): ☒All sites,☐ Lister Hospital, ☐New QEII, ☐Hertford County Hospital, ☐Renal Satellite sites, ☐Other: **For use Trust wide for use by all staff use at all sites**
Review cycle	☒ Every 3 years (standard) ☐Annual review ☐ Other: **01 November 2026**
Version type	SELECT ONE ☐New document – full consultation and endorsements ☒Full review of document - various amendments/ complete re-write ☐Full review of document - minor amendments ☐Full review of document - no changes to content, still fit for use ☐Interim update - document not fully reviewed, amendments only **Full review of document – full consultation & endorsements** Select the appropriate sign-off category ☒TYPE A (full review): All endorsers + approver required (Endorser 3 not required if both Endorser 1 & 2 are groups/ committees) ☐TYPE B (interim update): Endorser 3 + approver required ☐TYPE C (local use): Endorser 3 + approver required **TYPE A**
Keywords	Risk policy, risk strategy
Version author/owner	Margaret Okojie, Associate Director of Quality Governance ☐Cancer ☐Planned ☐Unplanned ☒Corporate/Directorate
Policies liaison	Margaret Okojie, Associate Director of Quality Governance ☒Cancer ☒Planned ☒Unplanned ☒Corporate/Directorate ☒ Women & Children

Document classifications	Please select all that apply to this document ☐ **Sensitive information**: This document contains sensitive information that should not be shared outside the organisation ☐ **Public website**: this document has been selected for publication on the Trust website, maintained by the Communications Dept. ☐ **Patient Consent**: This document contains content about patient consent ☒ **Forms** - This document contains forms in use at the Trust ☐ None of the above

Consultation

In the checklist below, the document author has considered the following **resource implications** and **impact to Trust-wide functions/services**, which also require **oversight** of local processes. Any of these listed stakeholders may also be an endorser of the final version of this document in the Record of agreement section.

If a new document, or newly amended content to this version contains processes that will have an impact on Trust functions and their users, the following actions are required.

Input from Trust function	Action required by author
1. Equality, Diversity & inclusion	Trust documents require an Equality Impact Assessment (EIA) as evidence that the protected characteristics under Equality Act 2010 have been considered, as per Part 1, section 6.1 in this document See Equality, Diversity & Inclusion section of the intranet for details and the form. This step could take **3 to 4 weeks**. It is advisable to start the process at the initial stages and share a draft for review. EIA approval (supplied via email):
2. Clinical Ethics Committee	This document may contain content that is contentious or raises moral debate. ☒No – proceed to next item ☐Yes – please see following actions **Step 1**: Seek advice from Clinical Ethics committee: ethics.enh-tr@nhs.net **Step 2**: Please provide the following info: Date of recommendations received: Were recommendations implemented and/or incorporated into document? ☒yes ☐no
3. Medicines Management (Pharmacy)	This document contains processes about the use of medicines at the Trust. ☒No – proceed to next item ☐Yes – please follow these steps **Step 1**: Contact local pharmacy lead to coordinate presentation to Therapeutics Policy Committee to request their **endorsement (formal agreement the document is fit for use at the Trust)**

Input from Trust function	Action required by author
	Step 2: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If TPC requires sign off on final file, the committee can be an endorser in the Record of agreement.
4. Nursing, Midwifery & AHP	This document contains processes that will have an impact on staff and care or that would affect work routines. ☒No – proceed to next item ☐Yes – please see following steps **Step 1:** For documents that are for Trust-wide use, **contact Nursing & Midwifery Excellence team** to discuss who would need to be involved in reviewing and agreeing the document is fit for use at the Trust. ☐Clinical skills group and/or ☐Nursing, Midwifery, AHP Quality Committee and/or ☐The appropriate training team eg Nursing/Maternity Training Team (For documents for local use, contact in the first instance). ☐Other: **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
5. Safeguarding	This document (either for local or Trust-wide use) contains processes or information that may have an impact on children or vulnerable adults using our services. ☒No – proceed to next item ☐Yes **Step 1**: Contact **Safeguarding** team for initial discussion.
6. People (Human resources)	This document (either for local or Trust-wide use) contains processes or information about the recruitment or management of staff or other processes applicable to staff. ☒No – proceed to next item ☐Yes **Step 1**: Contact Trust Partnership committee, staff side and/or staff network groups for initial discussions. **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If the stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
7. Finance	This document contains processes or information that affects the acquisition of resources (recurring or one-off) or payments of salaries or anything that has financial implications either Trust wide or locally within the Trust. ☒No – proceed to next item ☐Yes – please follow steps **Step 1**: Involve/request input from: ☐payroll, ☐local budget holders, ☐anti-fraud team

Input from Trust function	Action required by author
	Name of contact: **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If the stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
8. Estates & Facilities	This document contains processes or information about the use of Trust property or affects facilities and security on Trust premises ☒No – proceed to next item ☐Yes **Step 1**: Involve/request input from ☐Estates ☐Facilities **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If the stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
9. Digital (IT)	This document contains processes or information about the use of Trust computer hardware, software, or systems. This includes systems either managed by our local Digital team or an external supplier. ☒No – proceed to next item ☐Yes **Step 1**: Involve/request input from the appropriate team in Digital services **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If the stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.

Input from Trust function	Action required by author

10. Other areas or stakeholders

Please record evidence (ie date of meetings or email) of activity with any other departments, groups, stakeholders involved in the update/development of this document.

Team, department, stakeholder	Activity type	Date (meeting or email)
Risk Management Group	☐Content contribution ☐Agree fit for use ☐Other:	
Clinical Effectiveness Committee	☐Content contribution ☐Agree fit for use ☐Other:	
Audit and Risk Committee	☐Content contribution ☐Agree fit for use ☐Other:	
Quality and Safety Committee	☐Content contribution ☐Agree fit for use ☐Other:	

☒At least one of the above in the consultation list is a formal endorser in the Record of agreement.

☒I understand an endorser and/or approver may request evidence of consultation with any of the above – or any omitted -before their sign off is granted.

Implementation plan

The author of this document is also required circulate the current version and inform local staff and other key stakeholders (internal and, if applicable, external) of the existence of this document and any relevant updates.

Below is an outline of the standard activity following the approval of a document. The author may add actions in the implementation plan below. The pre-filled rows in grey are actions carried out by the formal Trust function for Trust-approved documents.

Action	Lead	Schedule of activity
Email final approved version to policies@enh-tr@nhs.net.	Version author	Upon approval
Document uploaded to the intranet so users can search for the document or browse via intranet folders.	Policies support	Upon completion of governance and standards checks
This version will be included in a summary of updated documents that is cascaded via internal	Documents Manager	Upon document

Action	Lead	Schedule of activity
communications channels, such as: • Monthly report on Intranet • Rolling half day • Shared at various meetings for divisions, committees, or groups		upload
Promote the updated document to ensure relevant areas are aware of the update/document and their role in ensuring compliance.	Version author	Team meetings
[insert or delete as required]		

Record of agreement

Full details of the **endorsement and approval process** can be found in policy **CP 116 - Trust policies and procedural documents**.

Document info	DOC ID: **CP 208**, Version: **011** Title: **Risk Management Strategy & Policy** Date of next full review **01 November 2026** Type **Policy** **|** Version type **Full review of document – full consultation & endorsements** Applicability **For use Trust wide for use by all staff use at all sites** Version author: **Margaret Okojie, Associate Director of Quality Governance** Sign-off type: **TYPE A** TYPE A (full review): All endorsers + approver required (Endorser 3 not required if both Endorser 1 & 2 are groups/committees) TYPE B (interim update): Endorser 3 + approver required TYPE C (local use): Endorser 3 + approver required
Endorser 1	**Risk Management Group** Formal agreement by endorser confirming this version is fit for use at the Trust was recorded at this group meeting held on **Day Month Year** under **item number/section** in the meeting minutes.
Endorser 2	**Clinical Effectiveness Committee** Record of formal agreement this version is fit for use at the Trust ☐supplied in email dated YYYY-MM-DD ☐in meeting minutes: [insert date and item number in meeting minutes stating agreement]
Endorser 3	☐ For full review **[Insert committee/group or Trust function stakeholder's name, role, dept]** ☐ For interim update: **[Insert name of head of service, stakeholder, or committee chairperson (endorser 1 for last full review)]** ☐ For local use only (for all version types) **[Insert name of head of service, department]** Record of formal agreement by **[insert endorser 3 as above]** that this version is fit for use at the Trust ☐supplied in email dated YYYY-MM-DD ☐in meeting minutes for [insert group]: [insert date and item number in meeting minutes stating agreement]
Approver	Upon considering the above endorsements, the approver **[Insert name of approver, role – as identified in formal sign-off process]** agrees this document is fit for use at the Trust. Confirmation of this agreement: ☐supplied in email dated YYYY-MM-DD ☐stated while in attendance at a meeting for **[insert meeting name, date and item record in meeting minutes stating agreement]**
Policy governance checks: ADMIN USE ONLY	

East and North Hertfordshire NHS Trust

Integrated Performance Report

Month 10 | 2022-23

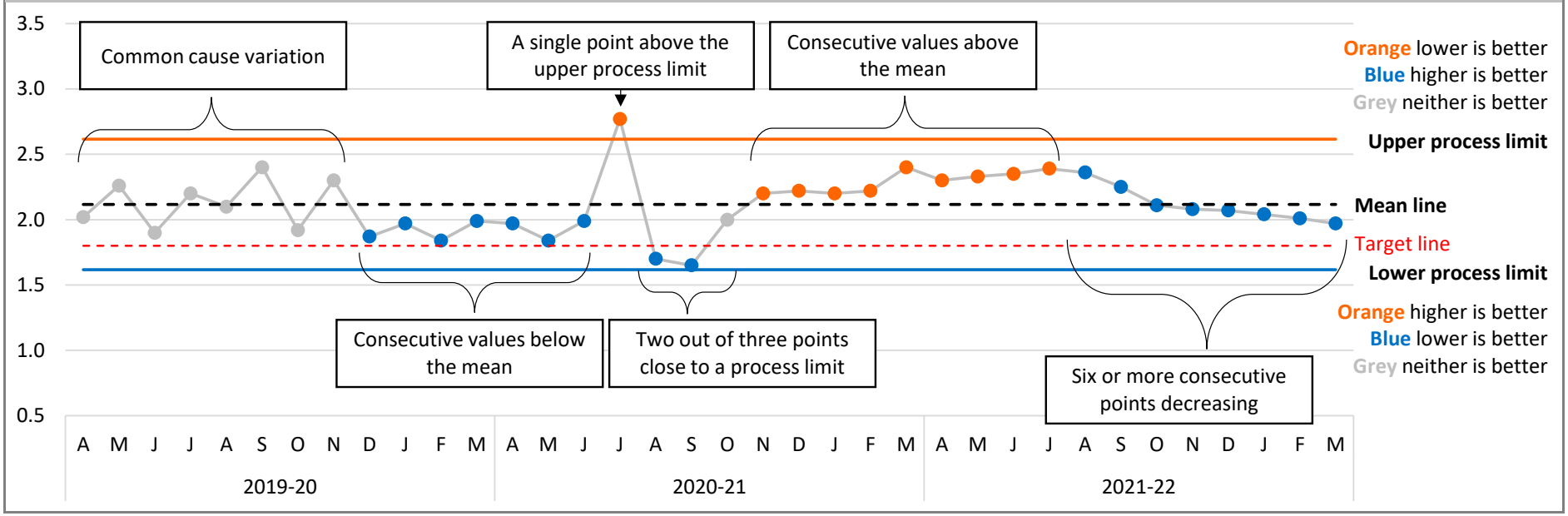
	P	?	F
H / L	0	5	5
	5	38	3
H / L	1	14	9

Data correct as at 23/02/2023

Integrated Performance Report

East and North Hertfordshire NHS Trust

How to interpret a Statistical Process Control (SPC) Chart



Variation

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

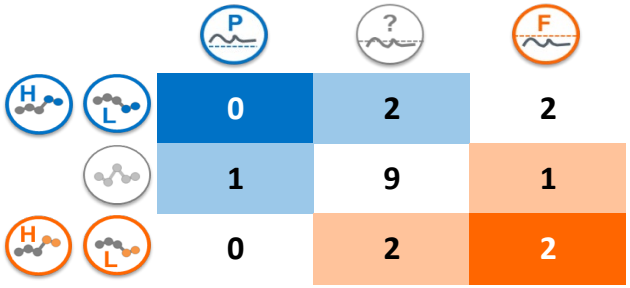
Assurance

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

NHS
East and North Hertfordshire
NHS Trust

Safe Services

Month 10 | 2022-23



Safe Services

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Safety Incidents	Total incidents reported in-month	Jan-23	n/a	1,025			Common cause variation No target
	Serious incidents in-month	Jan-23	0	7		?	Common cause variation Metric will inconsistently pass and fail the target
Infection Prevention and Control	Hospital-acquired MRSA Number of incidences in-month	Jan-23	0	0		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired c.difficile Number of incidences in-month	Jan-23	0	3		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired e.coli Number of incidences in-month	Jan-23	0	3		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired MSSA Number of incidences in-month	Jan-23	0	0		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired klebsiella Number of incidences in-month	Jan-23	0	2		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired pseudomonas aeruginosa Number of incidences in-month	Jan-23	0	1		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired CPOs Number of incidences in-month	Jan-23	0	0		?	Common cause variation Metric will inconsistently pass and fail the target
	Hand hygiene audit score	Jan-23	80%	90.6%		P	Common cause variation Metric will consistently pass the target
Safer Staffing	Overall fill rate	Jan-23	n/a	74.9%			Common cause variation No target
	Staff shortage incidents	Jan-23	n/a	56			Common cause variation No target

Month 10 | 2022-23

Safe Services

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cardiac Arrests	Number of cardiac arrest calls per 1,000 admissions	Jan-23	n/a	0.80			Common cause variation No target
	Number of deteriorting patient calls per 1,000 admissions	Jan-23	n/a	0.60			Common cause variation No target
Deteriorating Patients	Reliability of observations (4-hour)	Jan-23	n/a	68.2%	L		One point below the lower process limit No target
	Reliability of observations (1-hour)	Jan-23	50%	33.0%	L	F	Two points below the lower process limit Metric will consistently fail the target
Sepsis Screening and Management	Inpatients receiving IVABs within 1-hour of red flag	Jan-23	95%	100.0%	H	?	Seven points above the mean Metric will inconsistently pass and fail the target
	Inpatients Sepsis Six bundle compliance	Jan-23	95%	66.7%	H	F	Nine consecutive points above the mean Metric will consistently fail the target
	ED attendances receiving IVABs within 1-hour of red flag	Jan-23	95%	97.5%	H	?	Seven points above the mean Metric will inconsistently pass and fail the target
	ED attendance Sepsis Six bundle compliance	Jan-23	95%	73.8%	H	F	16 consecutive points above the mean Metric will consistently fail the target
VTE Risk Assessment	VTE risk assessment stage 1 completed	Jan-23	85%	68.4%	L	?	11 consecutive points below the mean Metric will inconsistently pass and fail the target
	VTE risk assessment for stage 2, 3 and / or 4	Jan-23	85%	42.1%	L	F	11 consecutive points below the mean Metric will consistently fail the target
	Correct low molecular weight heparin prescribed and documented administration	Jan-23	85%	94.6%		?	Common cause variation Metric will inconsistently pass and fail the target
	TED stockings correctly prescribed and documentation of fitted	Jan-23	85%	57.1%	L	?	11 consecutive points below the mean Metric will inconsistently pass and fail the target

Month 10 | 2022-23

Safe Services

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
HATs	Number of HAT RCAs in progress	Jan-23	n/a	62			Common cause variation No target
	Number of HAT RCAs completed	Jan-23	n/a	6			Common cause variation No target
	HATs confirmed potentially preventable	Jan-23	n/a	1			Common cause variation No target
PU	Pressure ulcers All category ≥2	Jan-23	0	26		F	Common cause variation Metric will consistently fail the target
Patient Falls	Rate of patient falls per 1,000 overnight stays	Jan-23	n/a	4.3			Common cause variation No target
	Proportion of patient falls resulting in serious harm	Jan-23	n/a	2.8%			Common cause variation No target
Other	National Patient Safety Alerts not completed by deadline	Jan-23	0	0			Metric unsuitable for SPC analysis
	Potential under-reporting of patient safety incidents	Dec-22	6.0%	4.7%			Metric unsuitable for SPC analysis

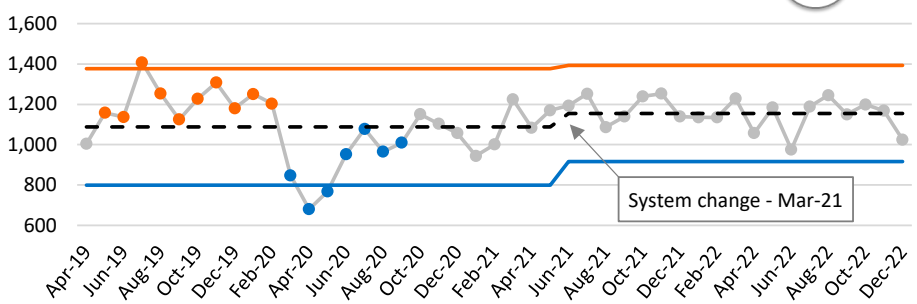
Month 10 | 2022-23

Safe Services

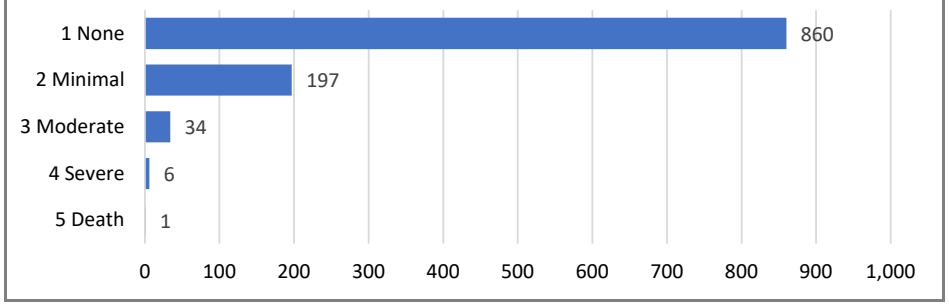
Patient Safety Incidents

East and North Hertfordshire NHS Trust

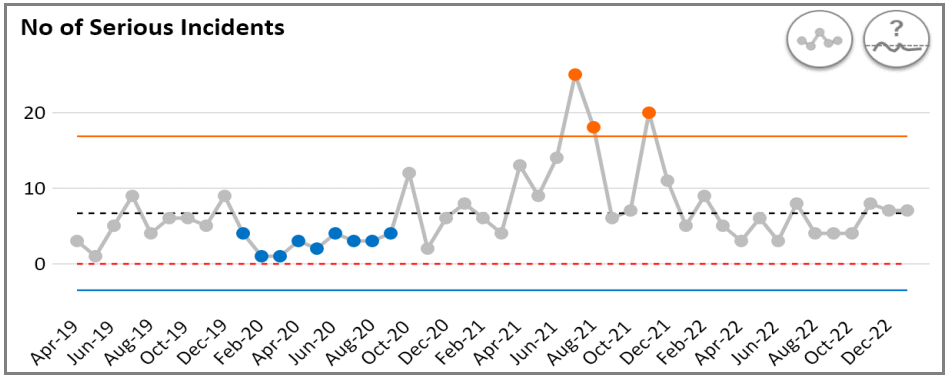
Total incidents reported



Number of incidents by level of harm - Jan-23



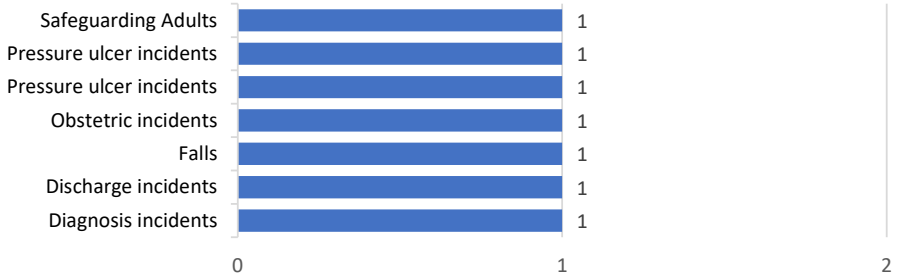
No of Serious Incidents



Key Issues and Executive Response

- Common cause variation in the number of incidents reported.
- Approximately 98% of incidents reported resulted in no or low harm, which is in-line with previous months.
- Common cause variation in the number of SIs declared.
- Ongoing work with Divisions re outstanding moderate harm incidents awaiting review at SIRP.
- One thematic review relating to Ophthalmology patients delayed to follow-up almost complete.
- The completed reports relating to the two Never Events declared in November are at final sign-off stage (one with Executive team and one with Divisional triumvirate).
- Ongoing focus on ensuring momentum maintained with progressing SI reports and associated learning promptly.
- Final preparations for transition of incident reporting from Datix onto ENHance in progress, number of incidents reported daily shall be monitored through the transition.

Serious Incidents Themes - Jan-23



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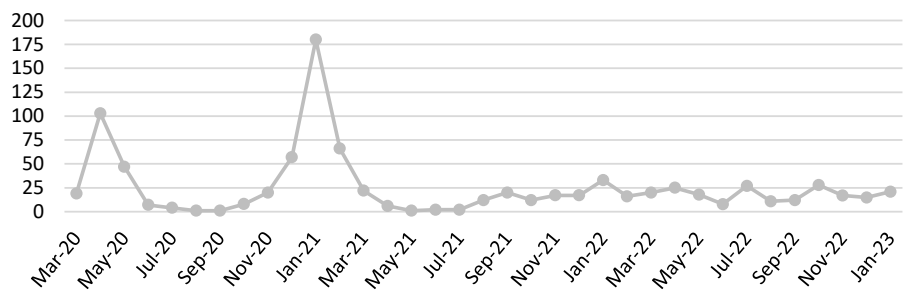
Safe Services

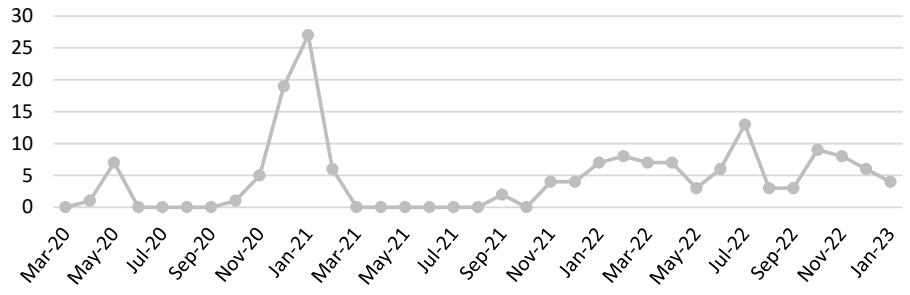
COVID-19

East and North Hertfordshire NHS Trust

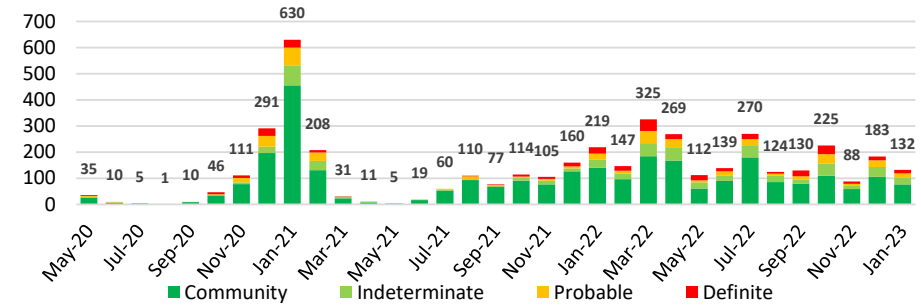
Number of deaths from COVID-19



Number of deaths from hospital-acquired COVID-19



COVID-19 cases by category



Key Issues and Executive Response

- A slight decrease in COVID cases were seen in January, the total number was 132. Of these cases 29 were contributed to probable or definite hospital-onset COVID.
- Sadly 21 patients died with a diagnosis of COVID in January, and 4 of these cases were related to hospital-onset COVID.
- Structured reviews are undertaken locally to capture learning where a hospital acquired infection has been identified. Where any potential harmful impacts are identified cases shall be represented to serious incident review panel.
- No clinical areas have required closure due to COVID of Influenzas infection management in January.
- Through COVID Specialist advisory group Trust policy has been agreed that any patients who have respiratory symptoms are swabbed for COVID19, but the asymptomatic swabbing regime changed. From January 23rd guidance supported changes to the requirements to swab asymptomatic patients for COVID19.
- This has coincided with the regional and local numbers decreasing and with the subsequent reduction for bed and bay closures.

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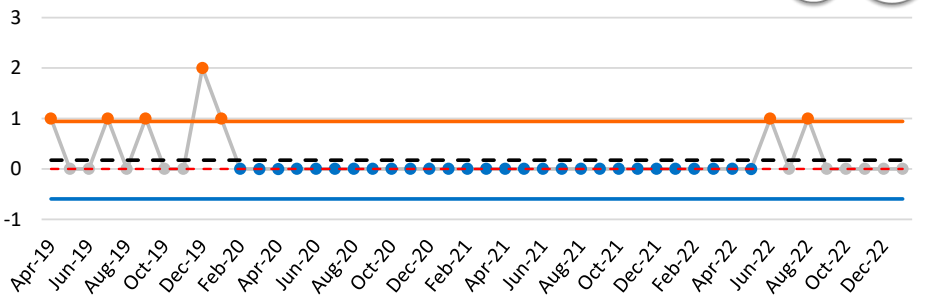
Safe Services

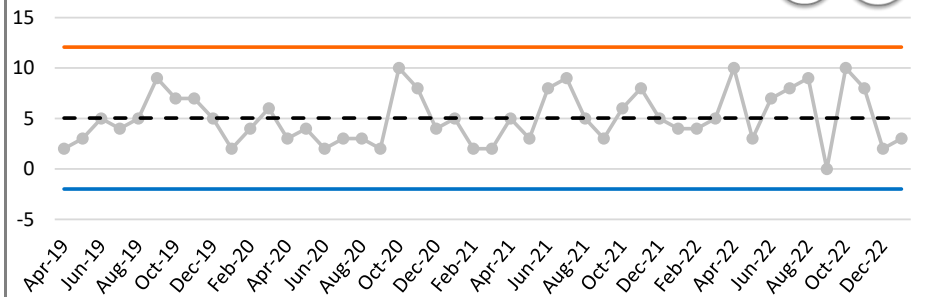
Infection Prevention and Control

East and North Hertfordshire NHS Trust

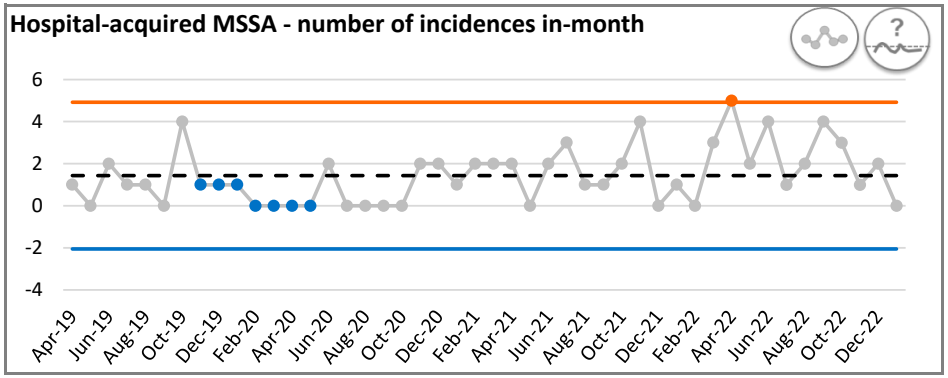
Hospital-acquired MRSA - number of incidences in-month



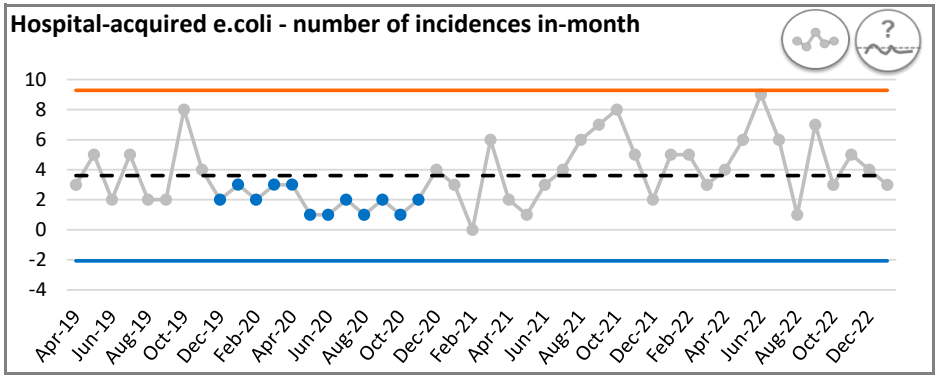
Hospital-acquired c.difficile - number of incidences in-month



Hospital-acquired MSSA - number of incidences in-month



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



- The C. difficile year to date (YTD) total is 59 against the threshold of 59. There are ten identified cases to be appealed, to be completed by March. There were two (2) Hospital Onset Healthcare Associated (HOHA), and one (1) Community Onset Healthcare Associated (COHA) in Jan '23. The IPC team are currently conducting a review of all 2022-2023 cases to date to identify common themes and areas for improvement in Trust's practices.
- The MRSA YTD total is one (1), which is above the threshold of zero (0). There are zero (0) cases in Jan '23.
- The MSSA YTD total is 24 (no threshold set). Zero (0) cases in Jan '23.

- The E.coli YTD total is 48, which is above the threshold of 46. There was one (1) COHA, and two (2) HOHA, a total of three HA E.coli. for Jan '23.
- The IPC team continues to carry out post infection reviews for these cases which should positively impact the improvement of HCAI BSIs.
- The IPC team continues to support the Trust with aspects on aseptic technique, safe vascular access, and safer sharps practice.

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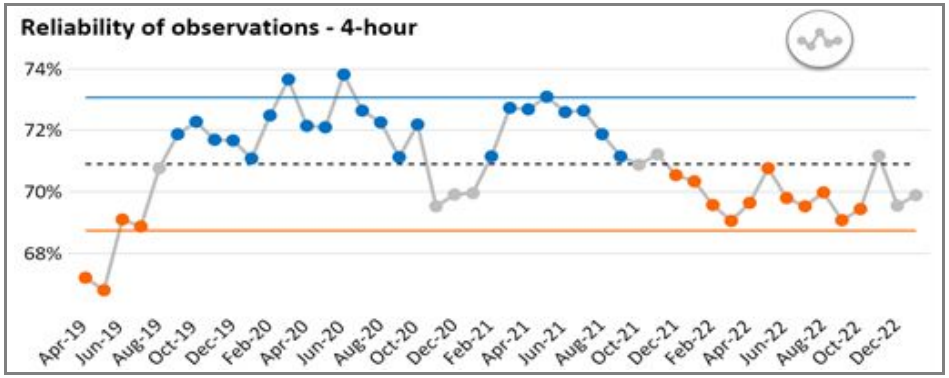
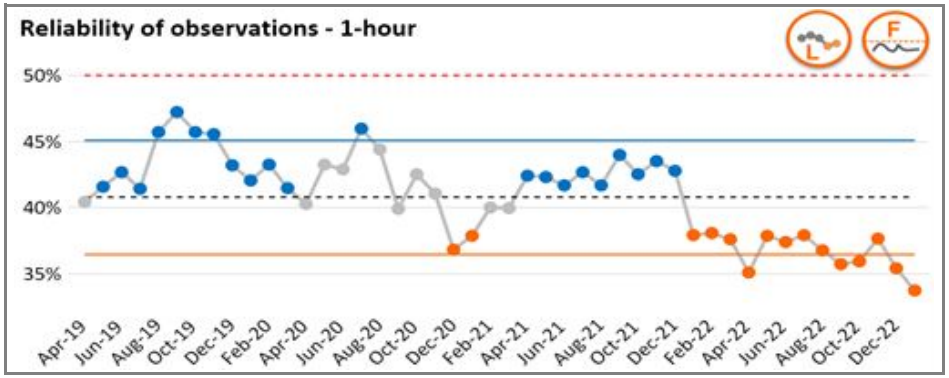
Safe Services

Deteriorating Patients

East and North Hertfordshire NHS Trust





Key Issues and Executive Response

- Slight decrease in reliability of hourly observations in January. Overall average of 4 hourly documentation remains 71% reliability. January experienced high Opel statuses, reduced staffing and high acuity.
- QI project commenced to look at task prioritisation/delegation which is hoped will support improved timeliness of observations on ward 7A. Learning from this will be rolled out across Divisions.
- 2 wards approached to be DP champion wards which will monitor and support reliability of observations, training, and equipment.
- Trust-wide drive on NEWS2 and Physiological Observation completion.

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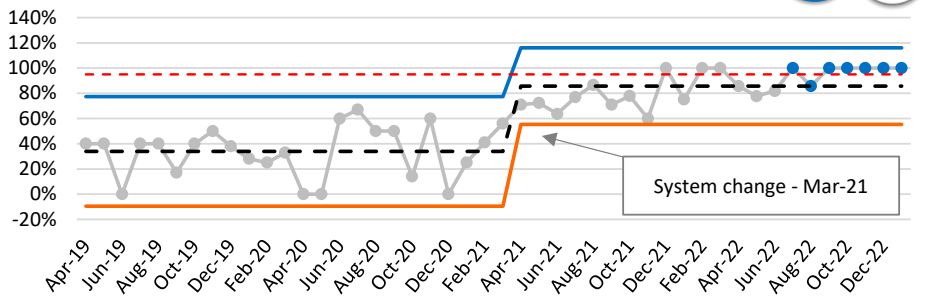
Safe Services

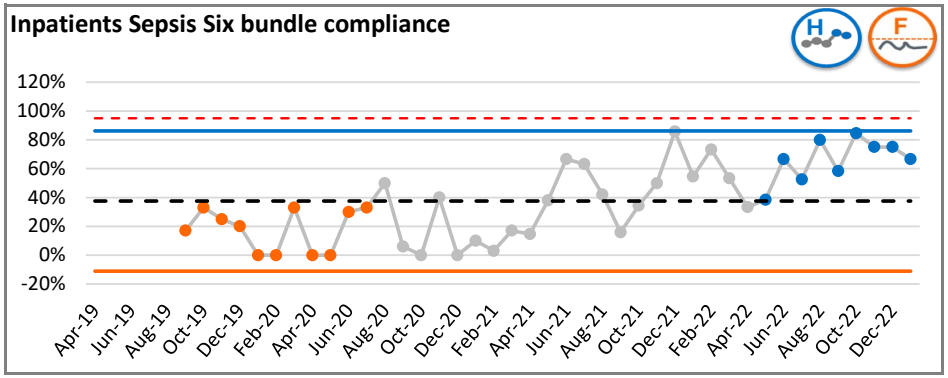
Sepsis Screening and Management | Inpatients

East and North Hertfordshire NHS Trust

Inpatients receiving IVABs within 1-hour of red flag



Inpatients Sepsis Six bundle compliance



Themes

Sepsis IP	2021-22		2022-23									
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Oxygen	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Blood cultures	79%	75%	55%	93%	82%	89%	92%	86%	82%	83%	86%	88%
IV antibiotics	100%	100%	86%	83%	82%	92%	86%	92%	100%	100%	100%	100%
IV fluids	67%	80%	50%	90%	86%	50%	100%	75%	86%	100%	100%	100%
Lactate	62%	55%	50%	86%	76%	67%	89%	70%	83%	88%	80%	63%
Urine measure	58%	50%	42%	60%	74%	73%	87%	76%	100%	88%	88%	75%

Key Issues and Executive Response

Themes

- Blood culture collection in the IP setting has continued to improve with 88% compliance in January.
- There has been a significant drop in compliance for urine output monitoring in January to 75% from 88% in December.
- IV fluid and IV antibiotic administration compliance has remains at 100% with an average time of 45 minutes and 30 minutes respectively.
- Lactate measurement has significantly decreased to 63% in January from 80% in December.
- Despite drops in compliance for both urine output and lactate measurements overall sepsis 6 compliance has remained improved to 79% for January from 75% for December.

Response

- The Sepsis Team continues to support IP areas by being clinically visible when Red Flag Sepsis triggers have been identified.
- Sepsis E-Learning is live on the ENH Academy, requiring all clinical staff in the trust (Nurses, CSWs, TNAs etc.) to complete. We are collating data regarding ward compliance to highlight areas who need additional support to completing this training.
- The Sepsis team are working to digitalise the sepsis proforma which will greatly benefit the IP setting allowing for clear documenting of the sepsis 6.
- The team has continuously been involved with CSW Induction to discuss Sepsis Red flags, identifying a deteriorating patient, and completing fluid balance charts.

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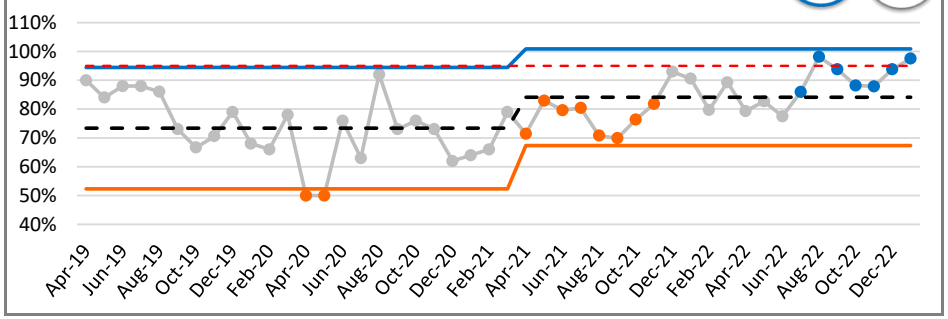
Safe Services

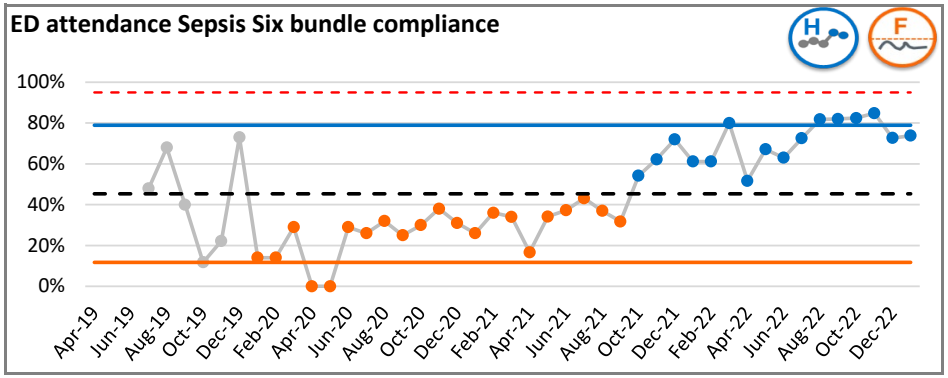
Sepsis Screening and Management | Emergency Department

East and North Hertfordshire NHS Trust

ED attendances receiving IVABs within 1-hour of red flag



ED attendance Sepsis Six bundle compliance



Themes

Sepsis ED	2021-22		2022-23									
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Oxygen	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Blood cultures	93%	90%	86%	89%	91%	87%	98%	93%	88%	94%	93%	90%
IV antibiotics	80%	89%	79%	83%	76%	86%	98%	92%	88%	88%	94%	98%
IV fluids	86%	90%	95%	86%	80%	93%	96%	96%	93%	90%	92%	97%
Lactate	87%	98%	87%	97%	95%	67%	98%	97%	100%	97%	100%	100%
Urine measure	76%	90%	69%	79%	77%	84%	81%	84%	88%	94%	78%	81%

Key Issues and Executive Response

Themes

- Slight decrease by 3% in compliance to blood culture collection.
- Administration of Oxygen within the one-hour target remains at 100%.
- IV antibiotic administration compliance has increased in January with 98% compliance and an average of 33 mins for administration.
- IV fluid compliance similarly to IV antibiotic compliance has increased within the one-hour target, going from 92% to 97%, with an average time of 33 mins to administration.
- Urine output measurement has slightly increased by 3%, brining compliance to 81% in January however remains an area for improvement.
- Overall Sepsis 6 compliance has increased to 80% in January from 73% in December.

Response

- ENH academy training for Sepsis remains live and we're continuing to monitor compliance with high staff turnover in the ED.
- The Sepsis team has been continuously supporting ED by being clinically visible when a Septic patient is identified, providing support and bedside education to newer/junior staff.
- The team assists the staff in completing the Sepsis 6 within an hour where possible.
- The team is continuing to trial the use of Digital Fluid Balance Chart in ED (particularly in Resus patients first).
- The Sepsis team is working to digitalise the sepsis proforma making it more accessible to staff.

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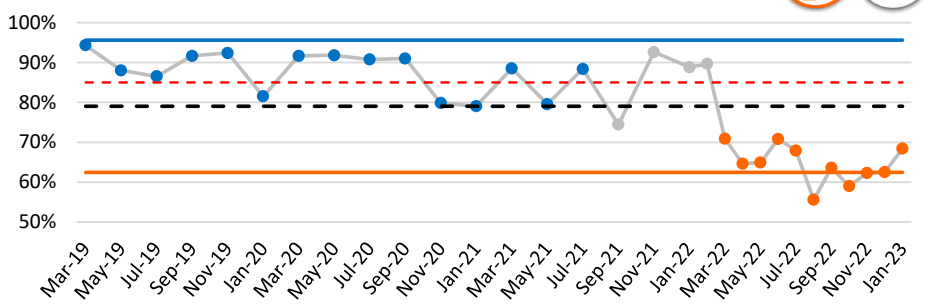
Safe Services

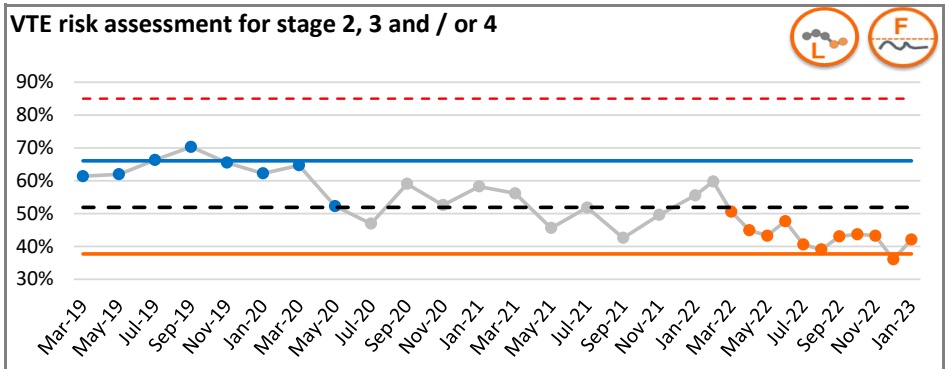
VTE Risk Assessment

East and North Hertfordshire NHS Trust

VTE risk assessment stage 1 completed



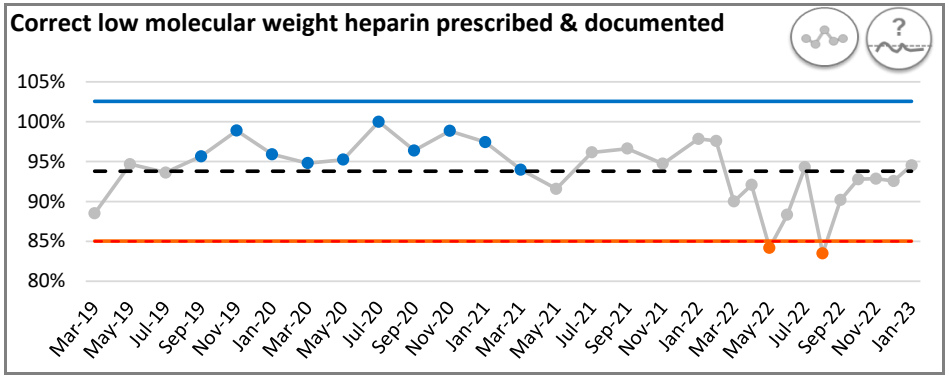
VTE risk assessment for stage 2, 3 and / or 4



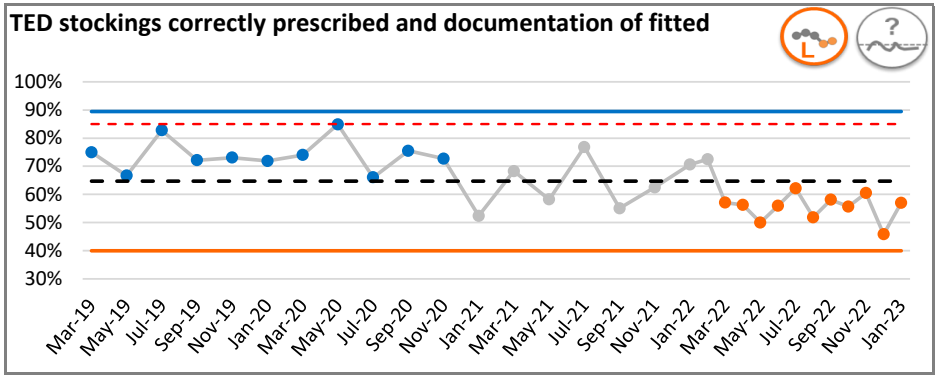
Key Issues and Executive Response

- From April 2022 data demonstrates full impact of ePMA roll out on VTE risk assessments and prescribing in Lorenzo.
- VTE risk assessment from Lorenzo into Nerve Centre rolled out 30th January 2023. Comms put in place and initial data to be monitored for compliance.
- Reporting in Nerve Centre to be rolled out alongside launch.
- VYE risk assessment now visible locally with 'patient safety at a glance' boards.
- Implemented semi-regular VTE update/HAT case presentation sessions with FY1/FY2 (on average 4 per year). To continue in 2023.
- Continue regular clinical engagement to share VTE data, improvement work and learning from HATs.
- Continue to improve patient engagement and review VTE patient information during admission and on discharge. Discharge 'blurb' in progress of approval to inform patients of increased risk and signs and symptoms of DVT/PE on discharge.

Correct low molecular weight heparin prescribed & documented



TED stockings correctly prescribed and documentation of fitted



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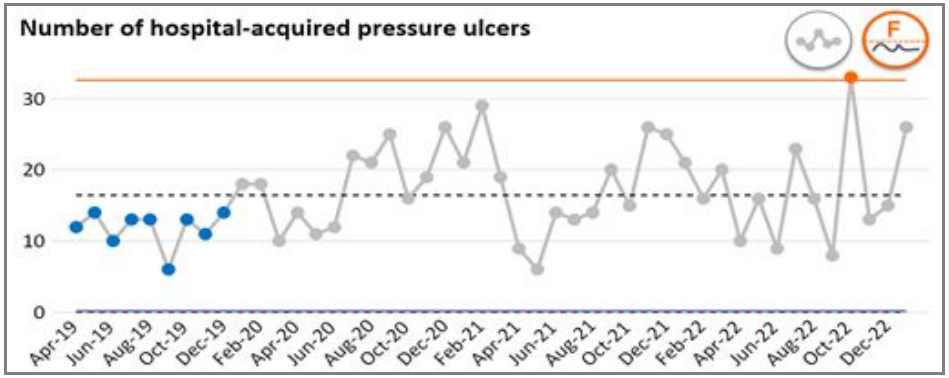
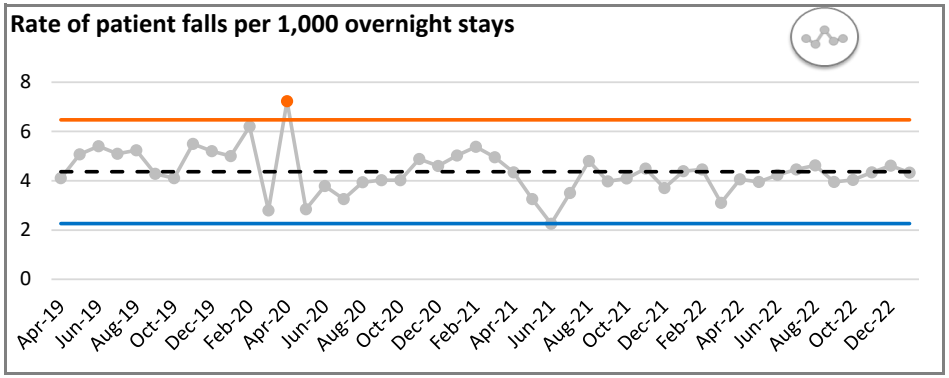
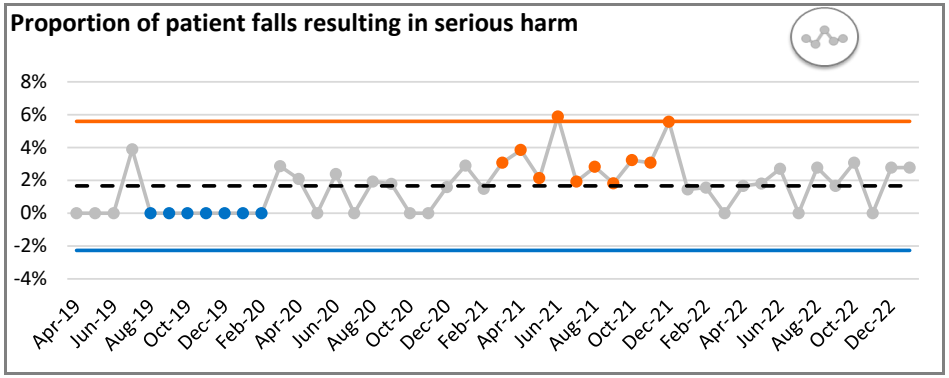
Safe Services

Pressure Ulcers | Patient Falls

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

Pressure ulcers

- Completion of digital waterlow assessment within 6 hours of admission is an improvement priority. This will be a CQUIN for 23/24.
- Lack of repositioning as main theme of learning reviews. Tissue Viability Nurse (TVN) to work on improving skin inspection and repositioning regimes following digitisation. TVN able to review assessment dashboard and focus training on areas showing red.
- TVN-related assessments and care plans now live in Nerve Centre and across all adult inpatient areas. This, alongside increased use of WABA app allows for TVN to have greater oversight of skin issues within ward areas.
- TVN auditing staff knowledge of pressure ulcer prevention, focusing on wards with highest number and then expanding to other areas. Work ongoing to address gaps in knowledge

Patient falls

- Inpatient falls data continues to show common cause variation.
- 2 Falls with moderate harms recorded for the month of January, both to be presented to SIRP.
- Falls policies and guidelines to be amended to reflect digitisation of documentation.
- Falls risk assessment and post fall assessment asked to be turned on in ED to monitor compliance, clinical practice team and falls lead will support in training.
- There were amendments in falls risk assessment and post fall assessment as reflected by the feedback of staff.

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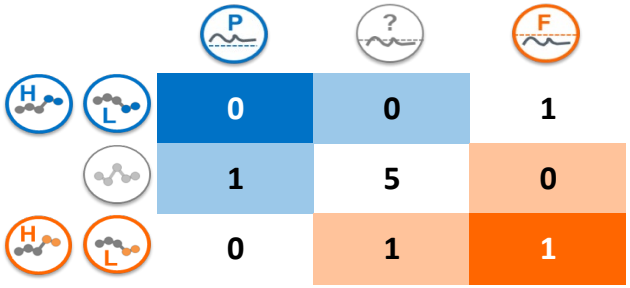
NHS
East and North Hertfordshire
NHS Trust

Caring Services

Month 10 | 2022-23



Caring Services

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Friends and Family Test	Inpatients positive feedback	Jan-23	95%	97.3%		?	Common cause variation Metric will inconsistently pass and fail the target
	A&E positive feedback	Jan-23	90%	98.5%		?	Common cause variation Metric will inconsistently pass and fail the target
	Maternity Antenatal positive feedback	Jan-23	93%	100.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Maternity Birth positive feedback	Jan-23	93%	100.0%	H	F	Two points above the upper process limit Metric will consistently fail the target
	Maternity Postnatal positive feedback	Jan-23	93%	96.3%		?	Common cause variation Metric will inconsistently pass and fail the target
	Maternity Community positive feedback	Jan-23	93%	0.0%	L	F	One point below the lower process limit Metric will consistently fail the target
	Outpatients FFT positive feedback	Jan-23	95.0%	97.0%		?	Common cause variation Metric will inconsistently pass and fail the target
PALS	Number of PALS referrals received in-month	Jan-23	n/a	204		-	Common cause variation No target
Complaints	Number of written complaints received in-month	Jan-23	n/a	53		-	Common cause variation No target
	Number of complaints closed in-month	Jan-23	n/a	56	L	-	Eight consecutive points below the mean No target
	Proportion of complaints acknowledged within 3 working days	Dec-22	75%	91.1%		P	Common cause variation Metric will consistently pass the target
	Proportion of complaints responded to within agreed timeframe	Dec-22	80%	56.3%	L	?	13 consecutive points below the mean Metric will inconsistently pass and fail the target

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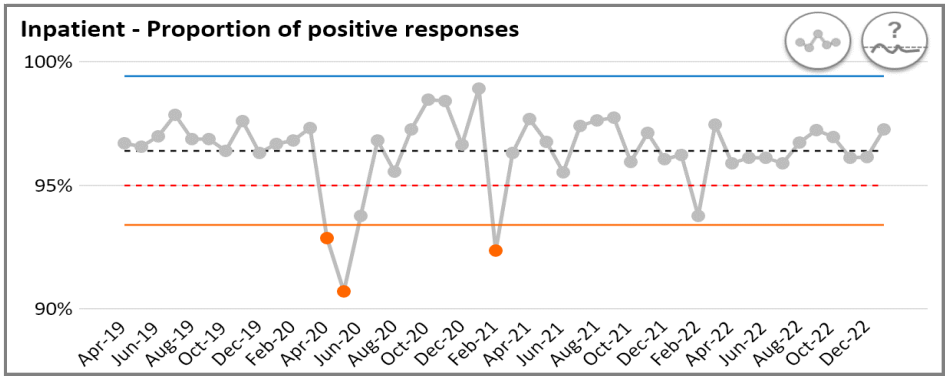
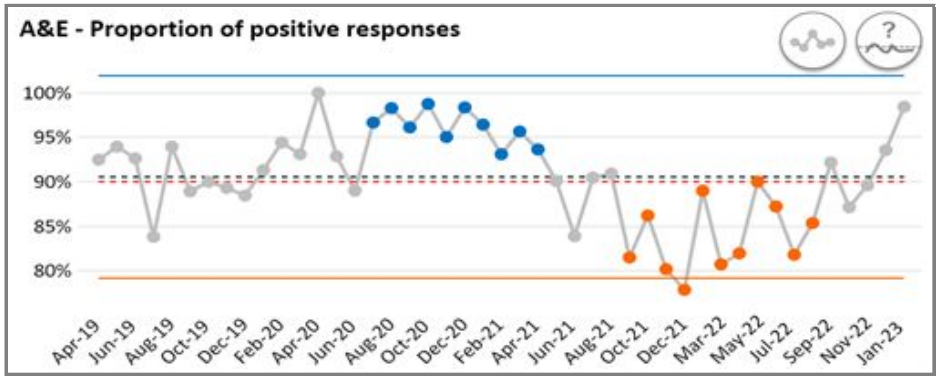
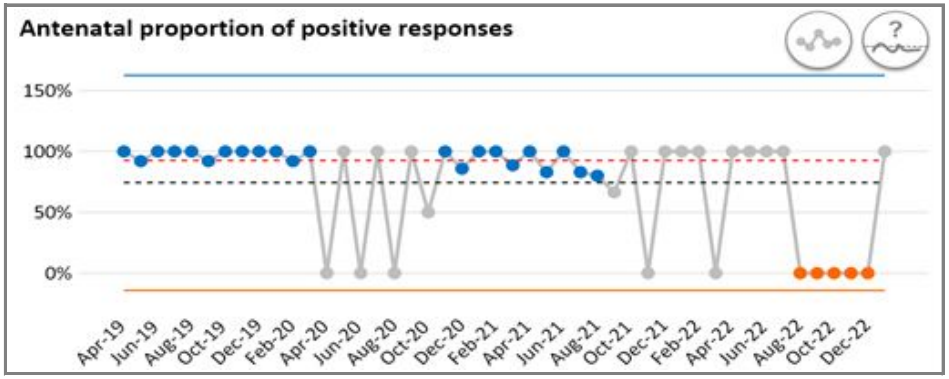
Caring Services

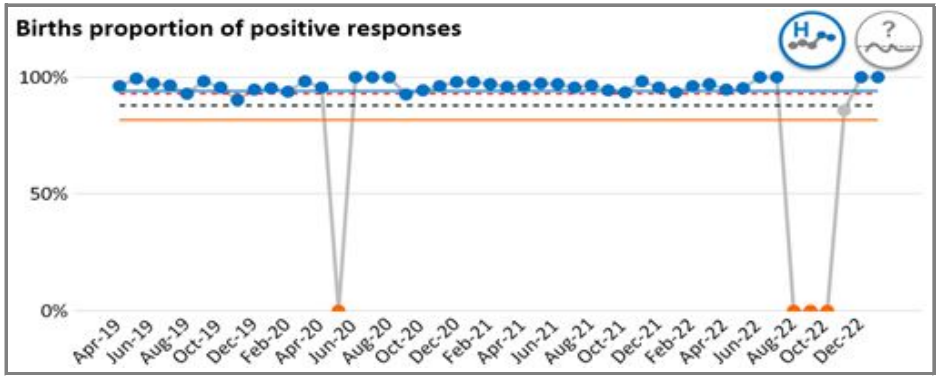
Friends and Family Test

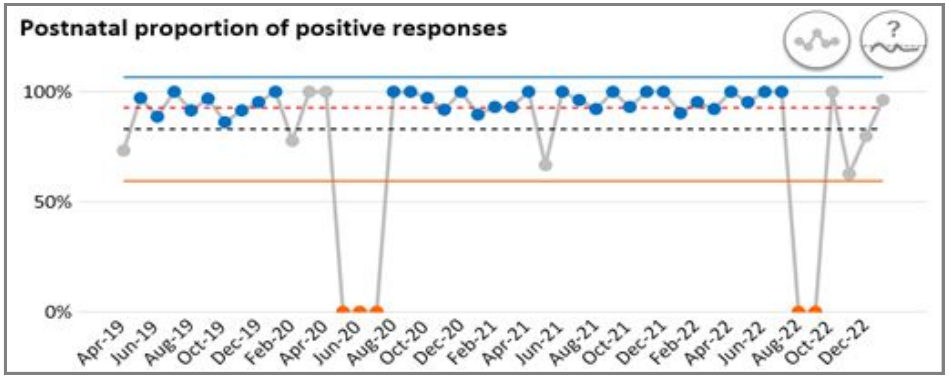
East and North Hertfordshire NHS Trust

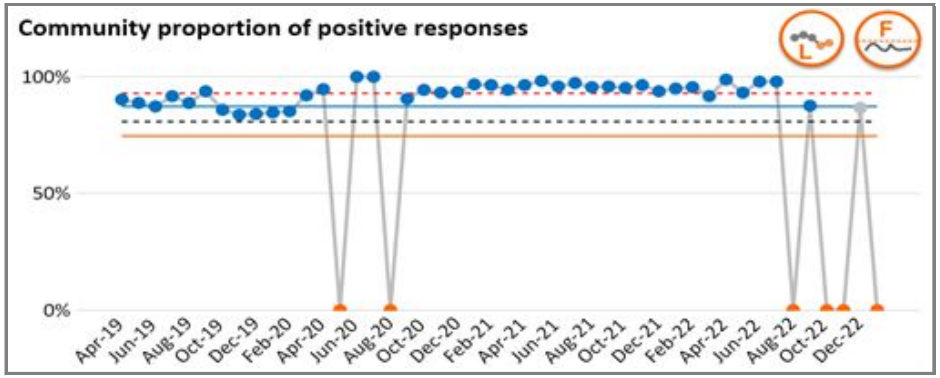












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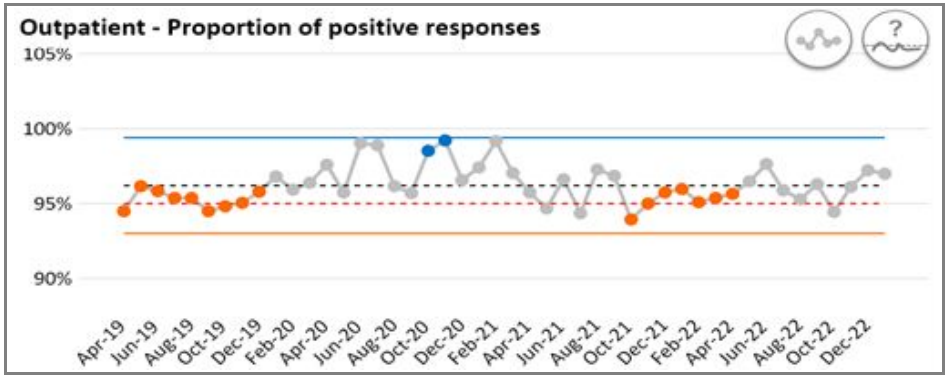
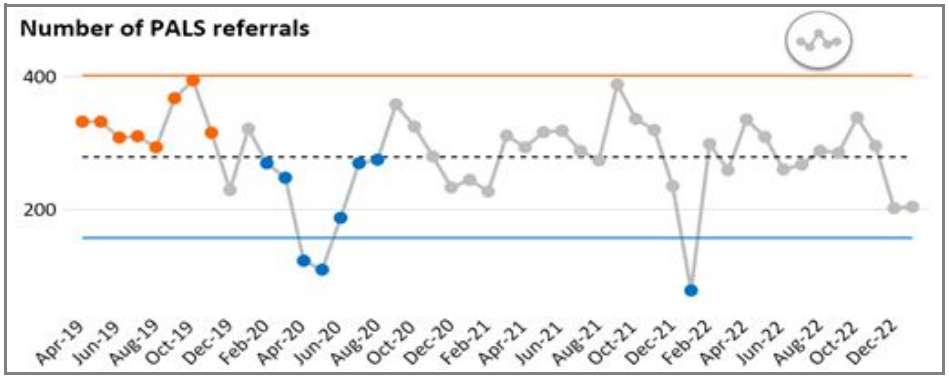
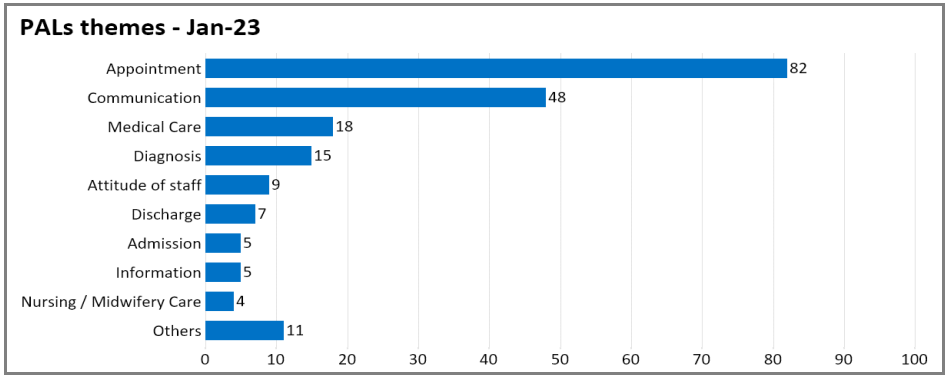
Caring Services

Friends and Family Test | Patient Advice and Liaison Service

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

Friends and Family Test

Excellence

- Postnatal and birth and antenatal continue to increase their feedback in a positive way.

Challenges

- Community midwifery results have decreased in the number of surveys again this month, further exploration needed as there is not a consistent amount of feedback received.

Actions

- Continue to work with ENHance to ensure that all functions and reporting systems are in place.

Patient Advice Liaison Service

Excellence

- Team morale remains high whilst tackling the backlog – 130 emails remain to be actioned.

Challenges

- PALS concerns are getting more complex and are taking longer to resolve.
- Reoccurring concerns over appointment times and cancellations.

Actions

- Continue to work on reducing the 4-week response timeframe.

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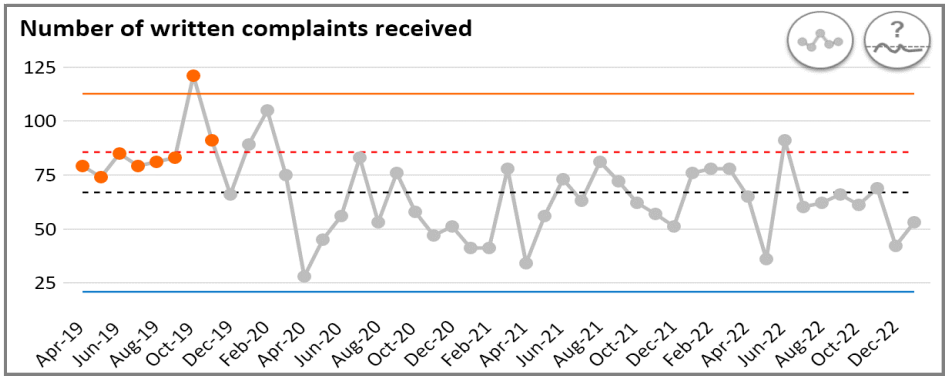
Caring Services

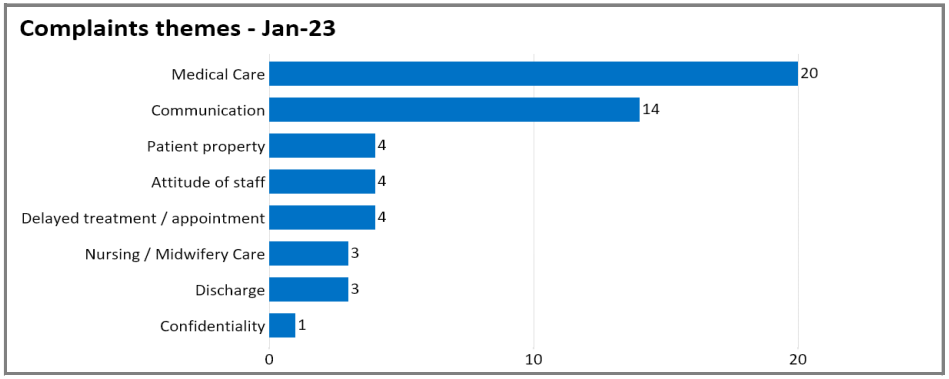
Complaints

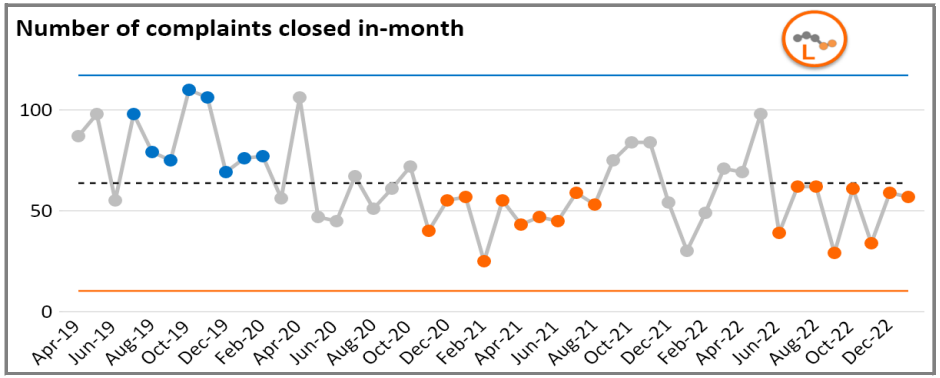
East and North Hertfordshire NHS Trust

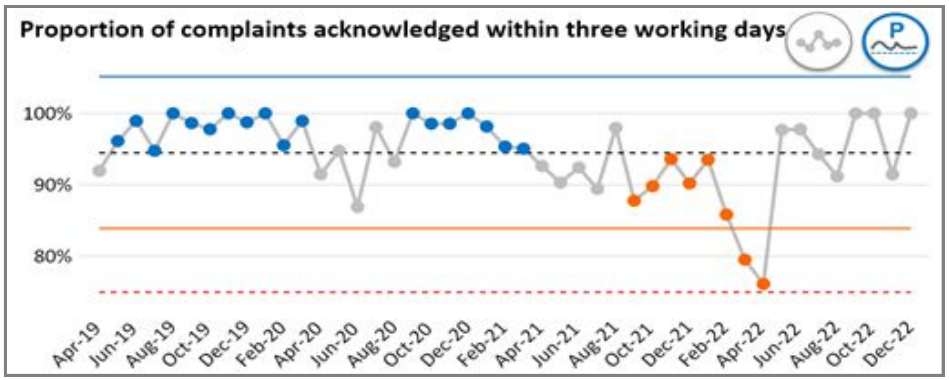


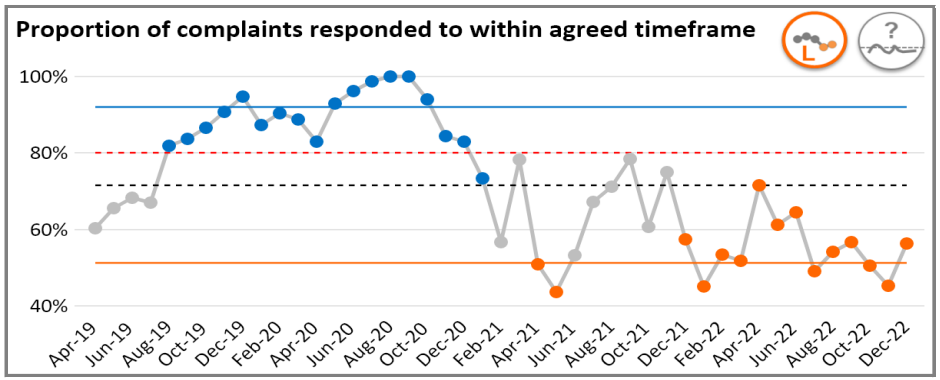
Please note that due to the ongoing migration from Datix to ENHance, complaints acknowledgement and response times for January were unavailable at the time of writing.

- Additional staff have been helping to draft complaints responses. Helping to additionally write 20 complaint responses.
- Drafting backlog clearance continues - 45 letters to draft until there is no drafting left within the team. Currently 199 complaints open.
- Continue work towards the Complaints and PALS transformation programme.









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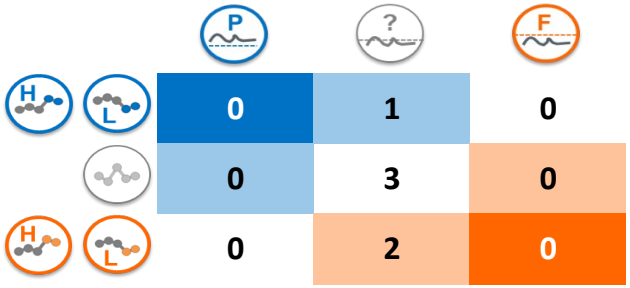
Effective Services

Month 10 | 2022-23



Effective Services

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Mortality	Crude mortality per 1,000 admissions In-month	Jan-23	12.8	15.1			Common cause variation Metric will inconsistently pass and fail the target
	Crude mortality per 1,000 admissions Rolling 12-months	Jan-23	12.8	11.6			Rolling 12-months - unsuitable for SPC
	HSMR In-month	Nov-22	100	94.4			Eight consecutive points above the mean Metric will inconsistently pass and fail the target
	HSMR Rolling 12-months	Nov-22	100	94.4			Rolling 12-months - unsuitable for SPC
	SHMI In-month	Aug-22	100	108.4			Common cause variation Metric will inconsistently pass and fail the target
	SHMI Rolling 12-months	Aug-22	100	92.1			Rolling 12-months - unsuitable for SPC
Re-admissions	Number of emergency re-admissions within 30 days of discharge	Oct-22	n/a	660			15 consecutive points below the mean No target
	Rate of emergency re-admissions within 30 days of discharge	Oct-22	9.0%	6.6%			17 consecutive points below the mean Metric will inconsistently pass and fail the target
Length of Stay	Average elective length of stay	Jan-23	2.8	2.4			Common cause variation Metric will inconsistently pass and fail the target
	Average non-elective length of stay	Jan-23	4.6	5.2			Two points above the upper process limit Metric will inconsistently pass and fail the target
Palliative Care	Proportion of patients with whom their preferred place of death was discussed	Jan-23	n/a	92.8%			Common cause variation No target
	Individualised care pathways	Jan-23	n/a	37			Common cause variation No target

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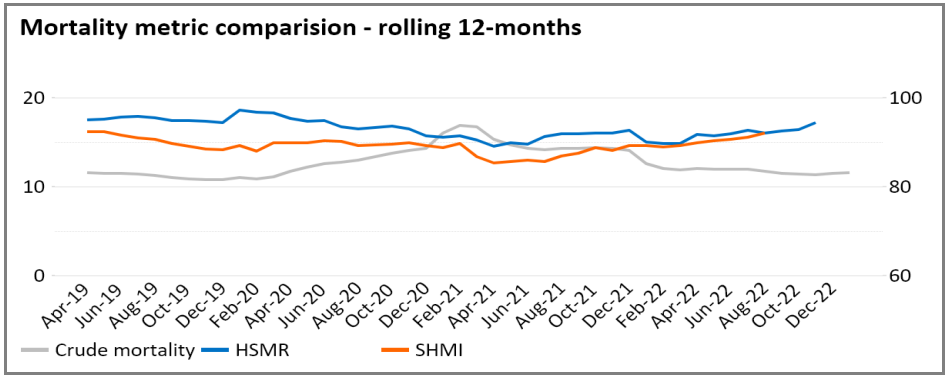
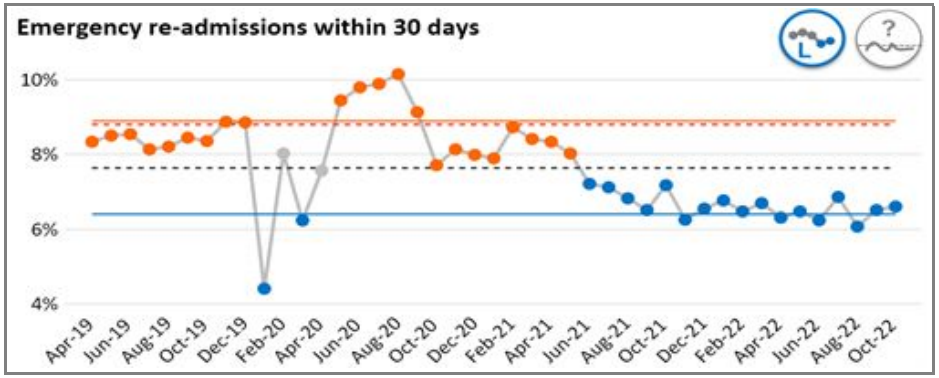
Effective Services

Mortality Summary | Emergency Re-admissions

East and North Hertfordshire NHS Trust





Key Issues and Executive Response

Mortality Metrics

- Following the rise in crude mortality seen during the pandemic, levels have now returned to pre-pandemic levels.
- We continue to be well placed vs national peers for both HSMR and SHMI.

Learning from Deaths

- Reforms continue regarding the Trust's learning from deaths framework, including the adoption of a SJR Plus Review format, developed by NHSE/I's 'Better Tomorrow' platform which commenced on 1 July 2022. Reforms will include the reduction in the number of reviews undertaken, with the focus being on gaining richer learning from the process.
- From 19 December the on-line SJR+ tool migrated from the NHSE ORIS platform to NHS Apps.
- The SJR Plus review format, adopted by the Trust in July, is very different to our existing review tool. Its adoption provides an opportunity to revisit our broader learning from deaths processes, to take into account recent and imminent changes in the fields of scrutiny, quality, and governance, including the introduction of the Medical Examiner function and the forthcoming introduction of the new PSIRF approach to patient safety.
- To provide additional clarity and focus, a Learning from Deaths Strategy has been developed which aligns with the Trust's overarching strategy and the Quality strategy. The strategy was approved by the Mortality Surveillance Committee in November 2022.

Re-admissions

- Recent months have seen re-admissions performance improve, with the Trust consistently tracking below the national average (15 consecutive months below the mean for the number of readmissions within 30 days and 17 consecutive months below the mean for the rate of readmissions within 30 days).
- The Trust's performance is well positioned in comparison to national and our Model Hospital peer group.

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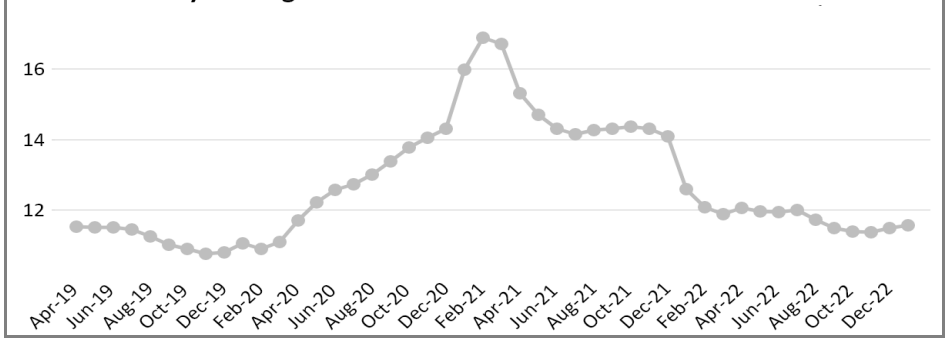
Effective Services

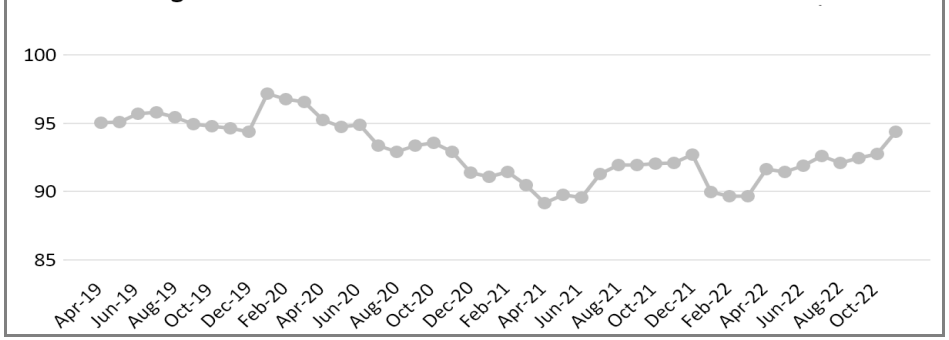
Mortality

East and North Hertfordshire NHS Trust

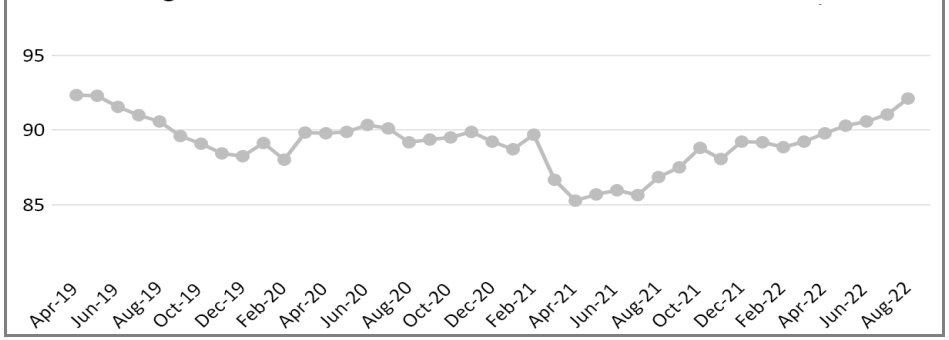
Crude mortality - rolling 12-months



HSMR - rolling 12-months



SHMI - rolling 12-months



Key Issues and Executive Response

- Crude mortality is the factor which usually has the most significant impact on HSMR. The exception has been during the COVID pandemic, when the usual correlation has been weakened by the partial exclusion of COVID-19 patients from the HSMR metric.
- The general improvements in mortality prior to the COVID-19 resulted from corporate level initiatives such as the learning from deaths process, focussed clinical improvement work. Of particular importance has been the continued drive to improve the quality of our coding.
- While the COVID-19 pandemic saw peaks in April 2020 and January 2021, most of the intervening and subsequent periods have seen us positioned below, or in line with, the national average. Recently rolling 12-month crude mortality has consistently tracked below the national mean.
- There has been an upward trend in in-month HSMR since December 2021. This contrasts with a downward trend in crude mortality for the same period, which is unusual as HSMR tends to follow the crude metric. The reason for this is not clear but is being monitored.
- Our rolling 12-month HSMR data to November 2022 shows the Trust has remained well positioned compared to our Model Hospital Peer group. It has slipped into the mid-range of trusts nationally, although both the points and positional change are small.
- The latest in-month position for August 2022 reported by CHKS shows common cause variation.
- Latest published rolling 12-month SHMI to August 2022 showed an increase from 91.31 to 92.6.
- This positions the Trust just outside the 'lower than expected' band, comfortably in the top quartile of trusts nationally. Despite the upward trend in SHMI, our position relative to peer has seen little change.

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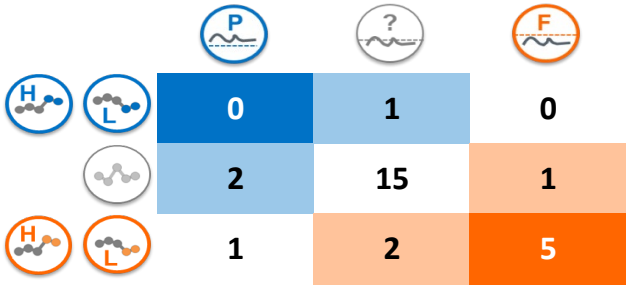
Responsive Services

Month 10 | 2022-23



Responsive Services

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Emergency Department	Patients waiting no more than four hours from arrival to admission, transfer or discharge	Jan-23	95%	64.6%	L	F	12 consecutive points below the lower process limit Metric will consistently fail the target
	Patients waiting more than 12 hours from arrival to admission, transfer or discharge	Jan-23	2%	10.4%	H	F	15 consecutive points above the upper process limit Metric will inconsistently pass and fail the target
	Percentage of ambulance handovers within 15-minutes	Jan-23	65%	11.6%	L	F	18 consecutive points below the lower process limit Metric will consistently fail the target
	Time to initial assessment - percentage within 15-minutes	Jan-23	80%	63.5%		F	Common cause variation Metric will consistently fail the target
	Average (mean) time in department - non-admitted patients	Jan-23	240	207.1	H	P	12 consecutive points above the upper process limit Metric will consistently pass the target
	Average (mean) time in department - admitted patients	Jan-23	tbc	612.9	H		5 consecutive points above the upper process limit No target
	Average minutes from clinically ready to proceed to departure	Jan-23	tbc	387			Insufficient data points for SPC analysis
	Critical time standards	Jan-23	tbc				Pending data
RTT & Diagnostics	Patients on incomplete pathways waiting no more than 18 weeks from referral	Jan-23	92%	50.9%	L	F	16 consecutive points below the lower process limit Metric will consistently fail the target
	Patients waiting more than six weeks for diagnostics	Jan-23	0%	48.4%	H	F	11 consecutive points above the upper process limit Metric will consistently fail the target

Month 10 | 2022-23

Responsive Services

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cancer Waiting Times	Two week waits for suspected cancer	Dec-22	93%	94.5%		?	Common cause variation Metric will inconsistently pass and fail the target
	Two week waits for breast symptoms	Dec-22	93%	92.4%		?	Common cause variation Metric will inconsistently pass and fail the target
	28-day faster diagnosis	Dec-22	75%	77.4%		?	Common cause variation Metric will inconsistently pass and fail the target
	31-days from diagnosis to first definitive treatment	Dec-22	96%	97.1%		?	Common cause variation Metric will inconsistently pass and fail the target
	31-days for subsequent treatment - anti-cancer drugs	Dec-22	98%	100.0%		P	Common cause variation Metric will consistently pass the target
	31-days for subsequent treatment - radiotherapy	Dec-22	94%	97.3%		P	Common cause variation Metric will consistently pass the target
	31-days for subsequent treatment - surgery	Dec-22	94%	94.6%		?	Common cause variation Metric will inconsistently pass and fail the target
	62-days from urgent GP referral to first definitive treatment	Dec-22	85%	91.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Patients waiting more than 104-days from urgent GP referral to first definitive treatment	Dec-22	0	3.0		?	Common cause variation Metric will inconsistently pass and fail the target
	62-days from referral from an NHS screening service to first definitive treatment	Dec-22	90%	70.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	62-days from consultant upgrade to first definitive treatment	Dec-22	n/a	71.1%			Common cause variation No target

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Responsive Services

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Stroke Services	Trust SSNAP grade	Q3 2022-23	A	D			
	% of patients discharged with a diagnosis of Atrial Fibrillation and commenced on anticoagulants	Jan-23	80%	71.0%			Common cause variation Metric will inconsistently hit and miss the target
	4-hours direct to Stroke unit from ED	Jan-23	63%	10.9%	L		Five points below the lower process limit Metric will inconsistently hit and miss the target
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	Jan-23	63%	11.3%	L		Five points below the lower process limit Metric will inconsistently hit and miss the target
	Number of confirmed Strokes in-month on SSNAP	Jan-23	n/a	66			Common cause variation No target
	If applicable at least 90% of patients' stay is spent on a stroke unit	Jan-23	80%	80.6%			Common cause variation Metric will inconsistently hit and miss the target
	Urgent brain imaging within 60 minutes of hospital arrival for suspected acute stroke	Jan-23	50%	50.0%			Common cause variation Metric will inconsistently hit and miss the target
	Scanned within 12-hours - all Strokes	Jan-23	100%	100.0%			Common cause variation Metric will inconsistently hit and miss the target
	% of all stroke patients who receive thrombolysis	Jan-23	11%	18.2%			Common cause variation Metric will inconsistently hit and miss the target
	% of patients eligible for thrombolysis to receive the intervention within 60 minutes of arrival at A&E (door to needle time)	Jan-23	70%	33.3%			Common cause variation Metric will inconsistently hit and miss the target
	Discharged with JCP	Jan-23	80%	92.1%			Common cause variation Metric will inconsistently hit and miss the target
	Discharged with ESD	Jan-23	40%	81.1%	H		One point above the upper process limit Metric will inconsistently hit and miss the target

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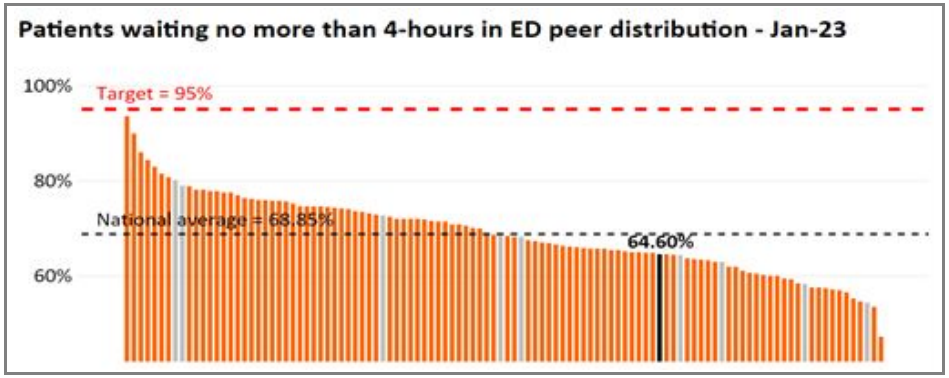
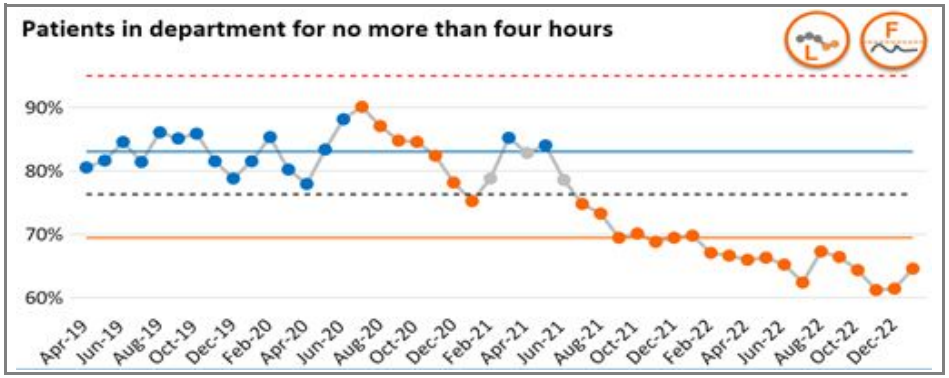
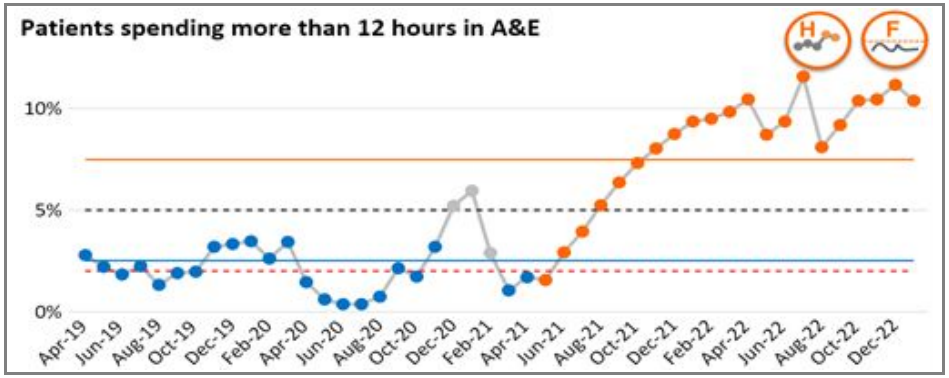
Responsive Services

Emergency Department

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

- **Marked improvements in ambulance handover during Jan as a result of Pull for Safety, focus and escalation; in addition to increased SDEC and ambulance handover unit capacity.**
- Zero tolerance to excess ambulance handover delays continued and was reduced from 2.5 hours to 1 hour on 13 January.
- Additional adult and paediatric beds opened following the full release of the increased adult assessment capacity and short stay ward, as well as the new paediatric ED which included increased CAU capacity.
- Further Medical SDEC capacity opened in January, including new speciality hot clinics, direct ambulance conveyance and direct access for medically GP expected patients.
- **Compliance with the 15 minute handover standard improved to the best since August 2021, coupled with the highest rate within 30 minutes since February 2022. The improvement is despite highest level of ambulance arrivals in last 7 months.**
- Monthly total attendances lowest since April 2021, largely due to reduction in paediatric attendances and increased direct access to medical SDEC. The reduction in activity is positively reflected in the time to initial assessment (triage) within 15 minutes exceeding 60% for the first time since March 2021.
- ED LOS exceeding 12 hours reduced for the first time in 5 months coupled with an improvement in compliance with the 4-hour standard.
- The admission conversion rate was at its highest since July 2022, reflecting increased acuity. Despite this the admitted ED LOS reduced for the first time in 4 months.
- Impact of increased SDEC flow is reflected in the reduced non-admitted LOS in ED and the improved compliance with the 4-hour standard.
- Bed days for patients Not Meeting the Criteria to Reside remains high with a noted increase compared to the last 2 months, with the second highest level experienced since April 2020.

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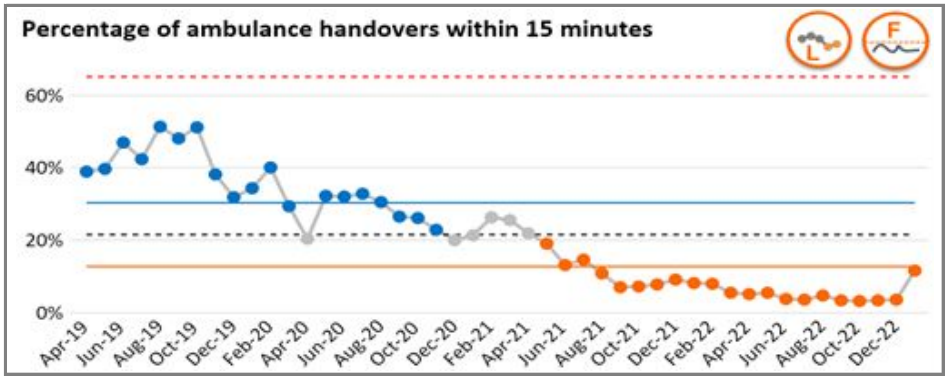
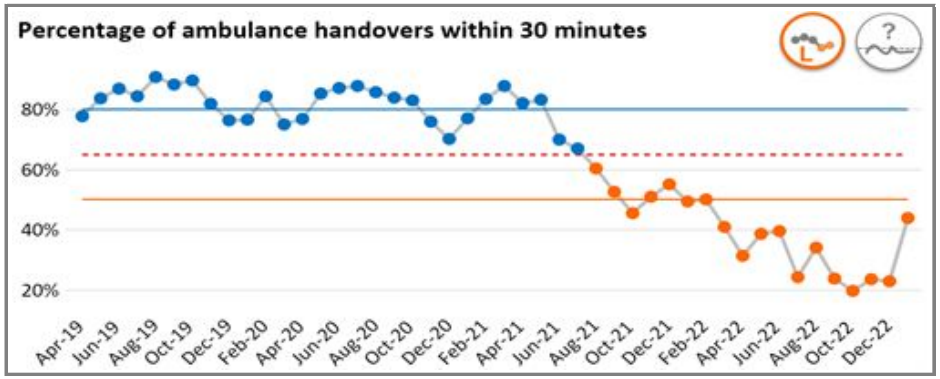
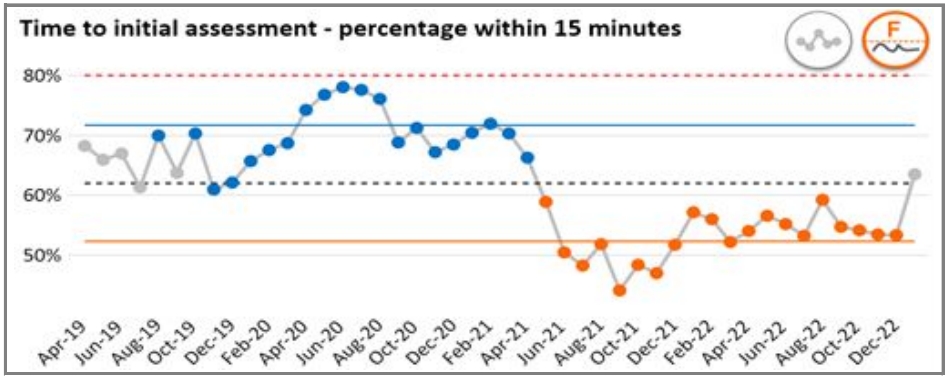
Responsive Services

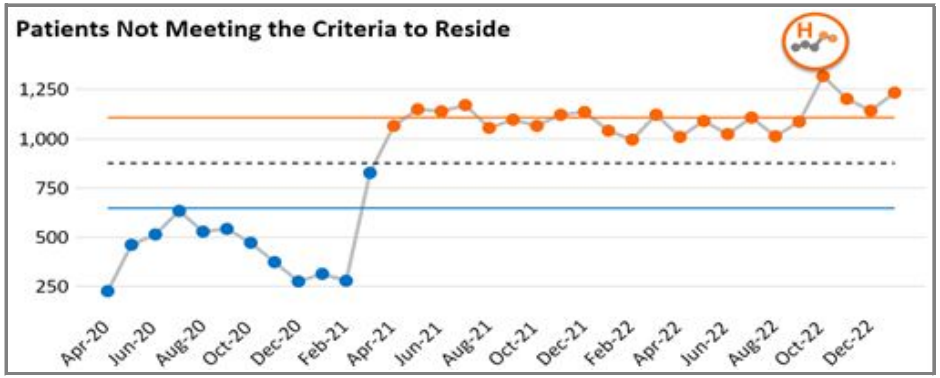
Emergency Department New Standards

East and North Hertfordshire NHS Trust









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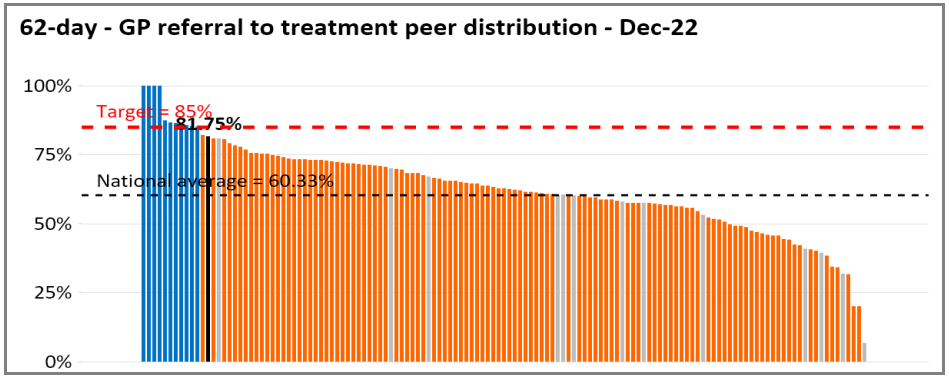
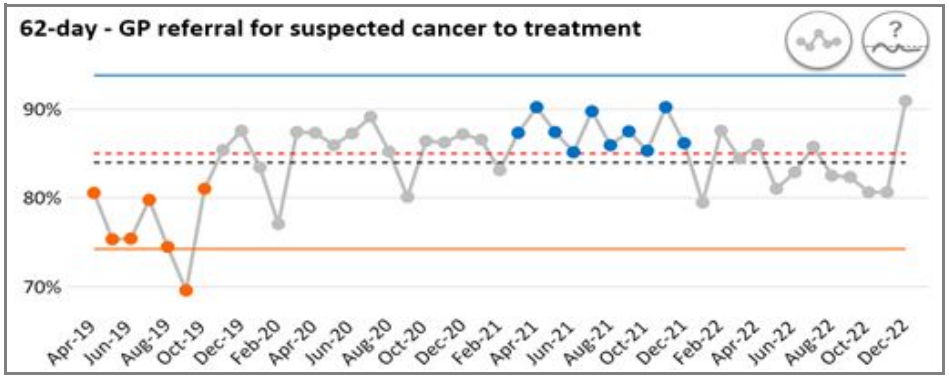
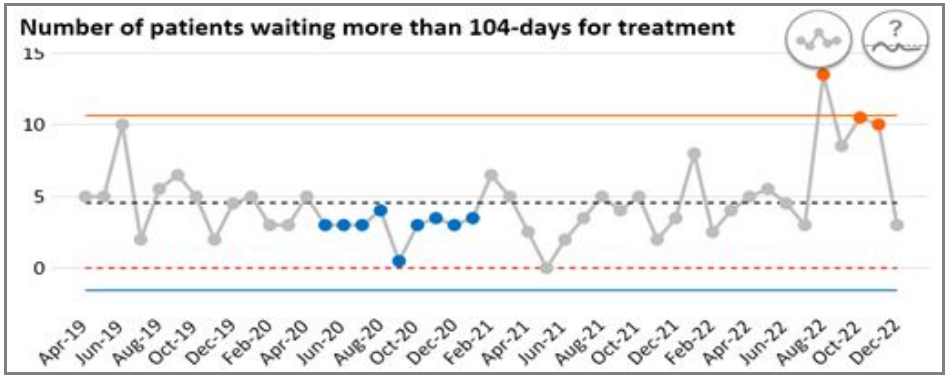
Responsive Services

Cancer Waiting Times

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

- The Trust moved from Tier 1 to Tier 2 in Oct 22 based on progress in reducing the 62-day pathway backlog.
- Tier 1 Action plan remains in place with Breast, Skin, Upper and Lower Gastrointestinal, MDT team, Histopathology and Radiology to improve MDT follow-up, reporting and more timely communication of diagnosis and next steps, particularly for patients who after diagnosis do not have cancer.
- However, staffing shortages remains an issue for the Anaesthetic department and Breast Radiology which will affect 62-day cancer performance and backlog for the coming months.
- Deep dives for tumour sites continue. Additional scrutiny and support leading to improved performance.
- Timed best practice pathways now in place for all Tumour sites to improve and sustain 62-day standard and deliver the Faster Diagnosis Standard performance.
- Achieved 6 of the 8 national targets in December: 2ww GP referral, 31-day first treatment, 31-day subsequent for Surgery, 31-day subsequent treatment for radiotherapy, 31-day second or subsequent treatment for chemotherapy and 62-day referral to treatment for all cancers.
- The Trust has not achieved the 2ww Breast symptoms, 62-day referral to treatment for Screening due to Radiology, patient delaying the diagnostic pathway and 1st appointment.
- Radiology and histopathology continue to prioritise cancer patients to avoid delays.
- The team will continue to analyse all breaches by Tumour Site to identify issues and resolve pathway delays.

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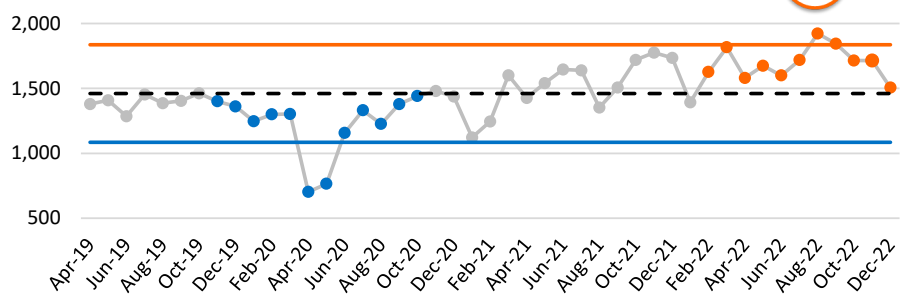
Responsive Services

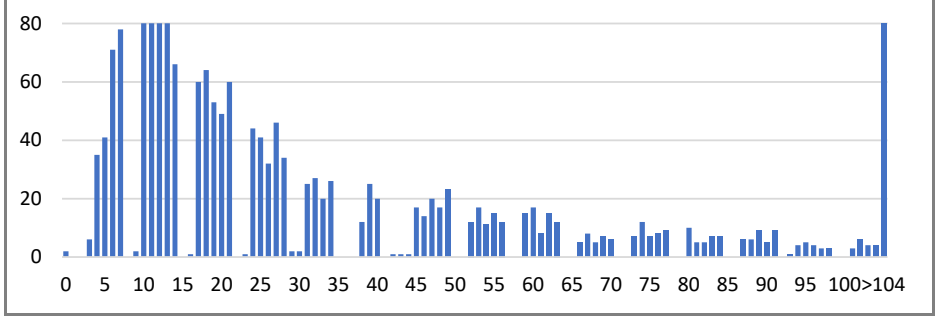
Cancer Waiting Times | Supporting Metrics

East and North Hertfordshire NHS Trust

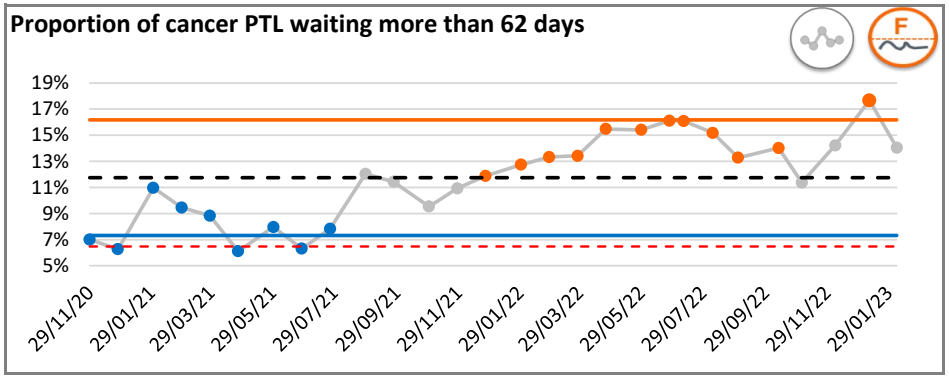
Suspected cancer referrals



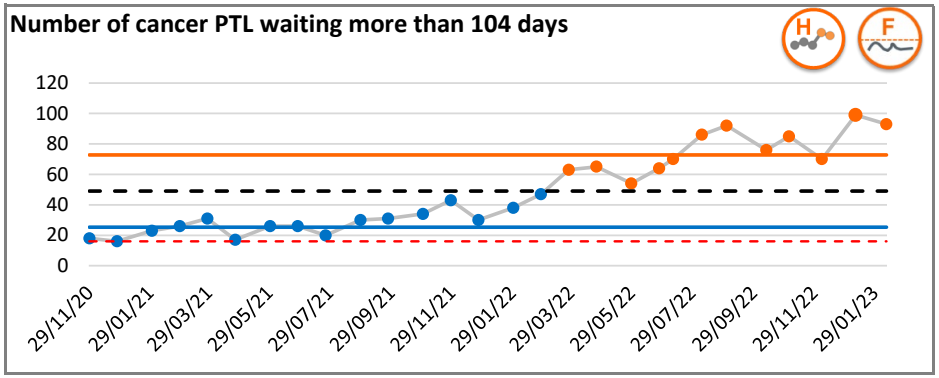
62-day PTL as at 06/02/2023



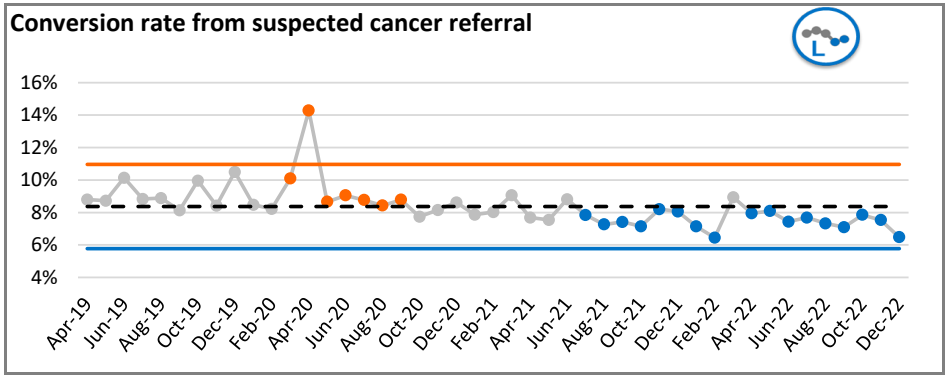
Proportion of cancer PTL waiting more than 62 days



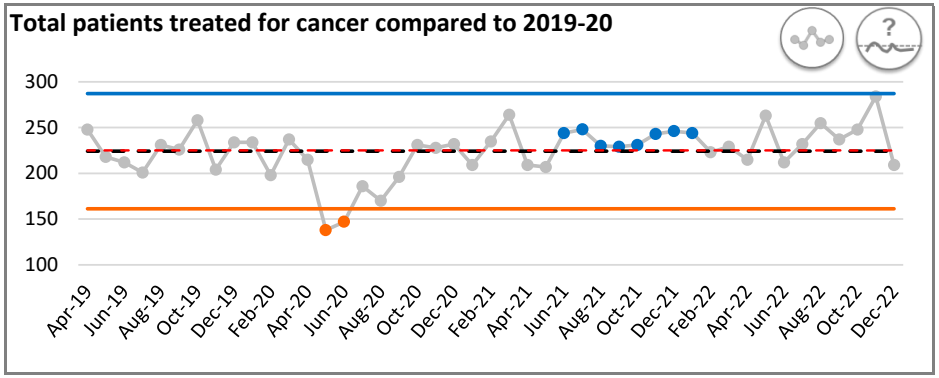
Number of cancer PTL waiting more than 104 days



Conversion rate from suspected cancer referral



Total patients treated for cancer compared to 2019-20



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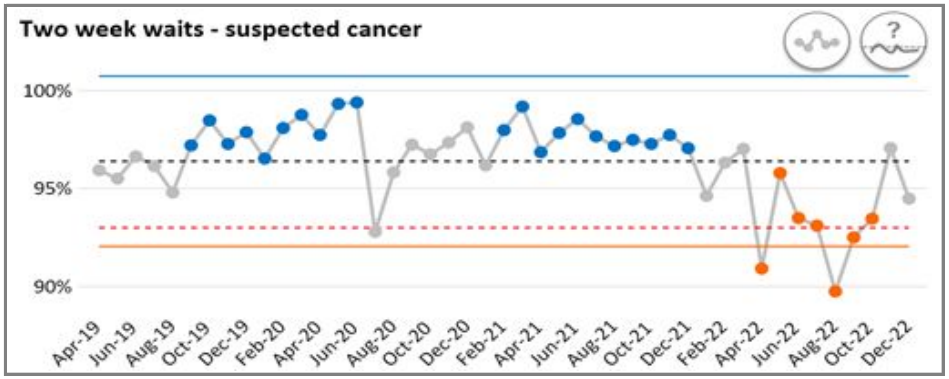
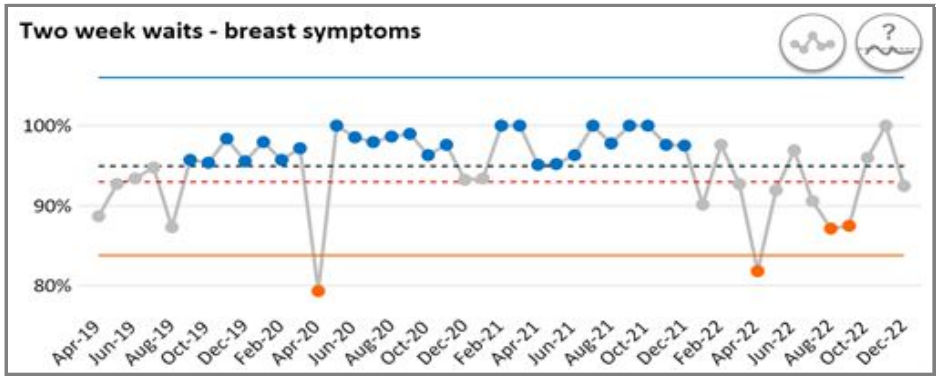
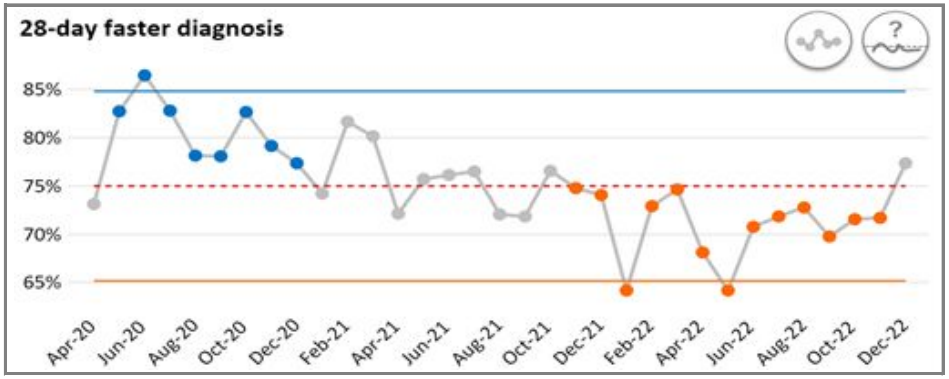
Responsive Services

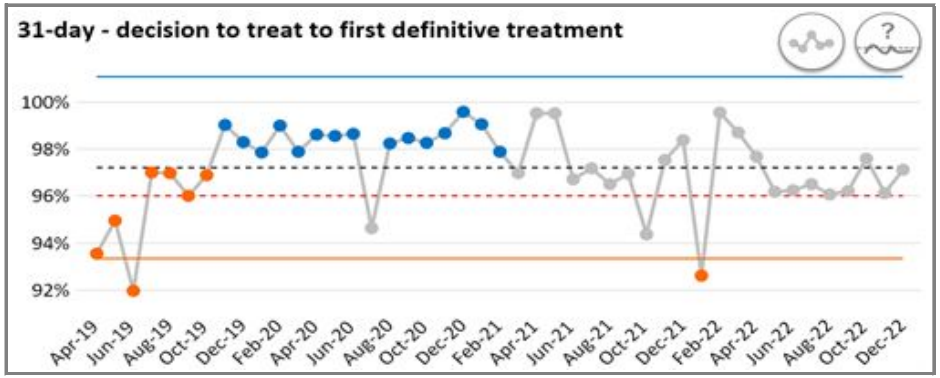
Cancer Waiting Times

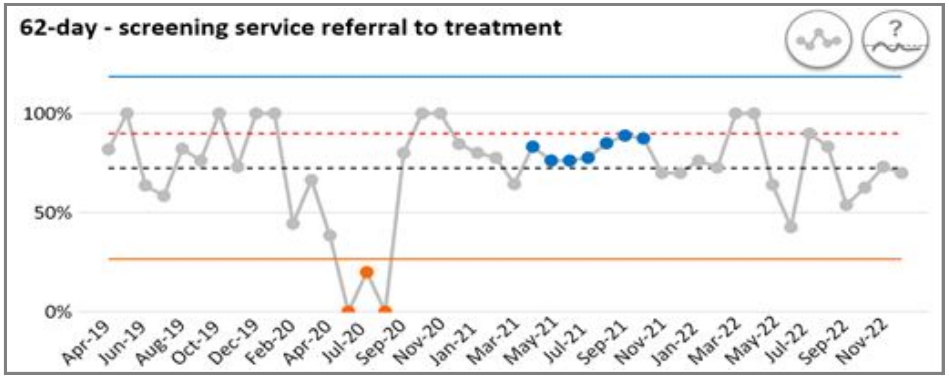
East and North Hertfordshire NHS Trust









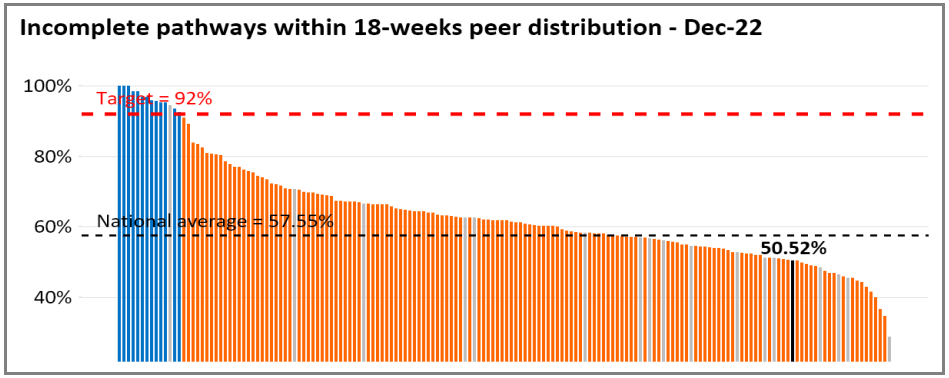


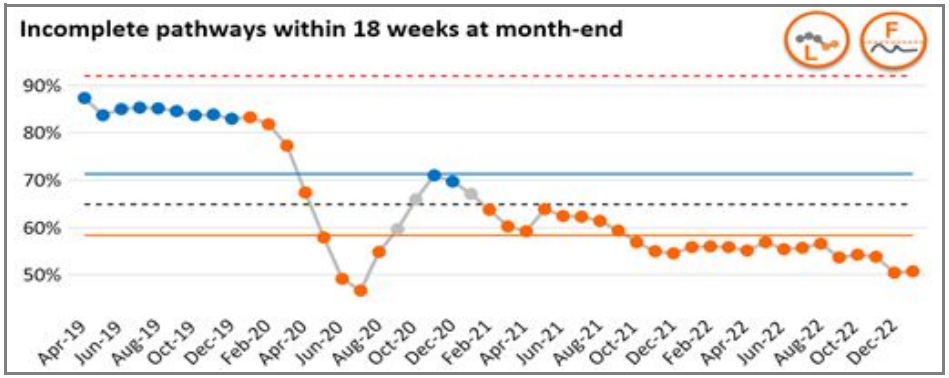
Month 10 | 2022-23

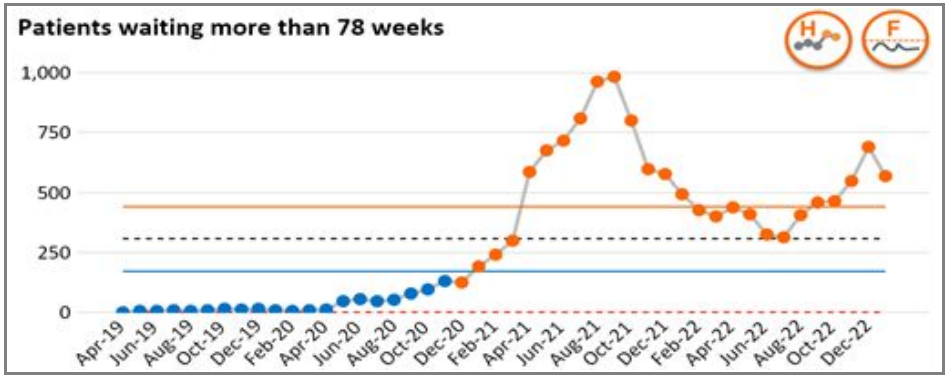
Responsive Services

RTT 18 Weeks

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

RTT Performance

- 78+ week waiters: The number of patients waiting 78+ weeks for an appointment is 0.91% of total RTT PTL.
- There were 1,202 patients on the incomplete Patient Tracking List (PTL) needing treatment by end March '23 to meet the 78-week target. 80% non-admitted; 20% admitted; a 34% reduction from last month.
- At end Jan, performance ahead of trajectory by 362 patients for the 78+ weeks patient cohort at the end of March, and 102 patients ahead of trajectory for 78+ in-month performance. Outsourcing and use of national mutual aid portal (DMAS) in place.
- Forecast patients waiting 78 weeks + at 31/3/23: 325 - a 40% improvement on original trajectory. 275 Community Paeds non admitted (national capacity challenges); 40-50 T&O admitted.
- 104+ week waiters: 1 patient was waiting 2 yrs + at the end of Jan – clinically complex procedure awaiting custom equipment; surgery carried out on 10/2/23.

Data Quality

- Patients waiting over 40 weeks are validated and all patients without an updated validation comment in the last 12 weeks are being reviewed.
- All patients waiting 78 weeks+ are actively managed.
- Validation continues to focus a proportion of time on the front end of the pathway to address potential DQ errors & reduce PTL size.

Activity

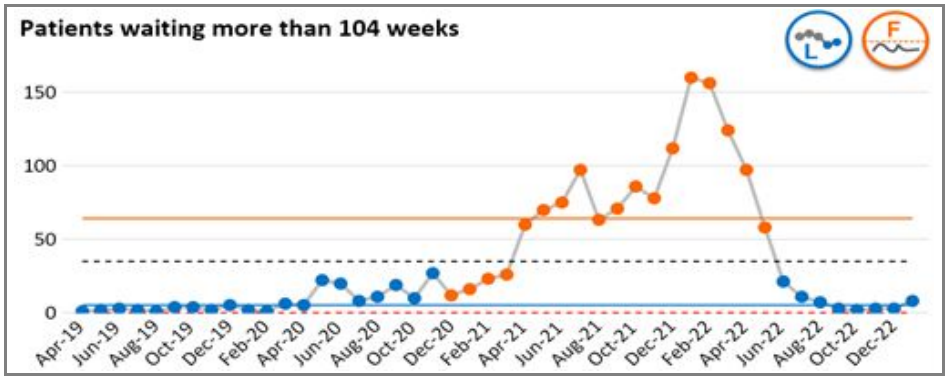
- Referrals received has remained above the mean since Sep-21.
- Outpatient and Day Case activity has increased in month.
- Inpatient activity has reduced in month.
- Patient Initiated Follow Up (PIFU) episodes have increased.
- Advice and Guidance remains stable on the Upper Control Limit.
- Theatre cases per list have remained on the Upper Control Limit.

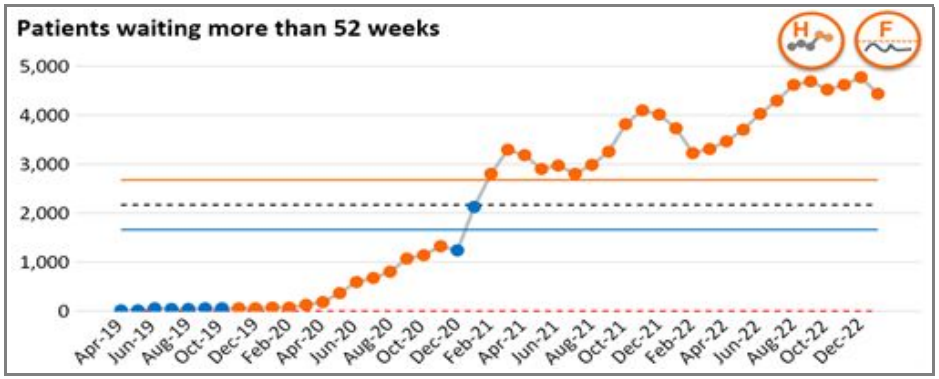
Month 10 | 2022-23

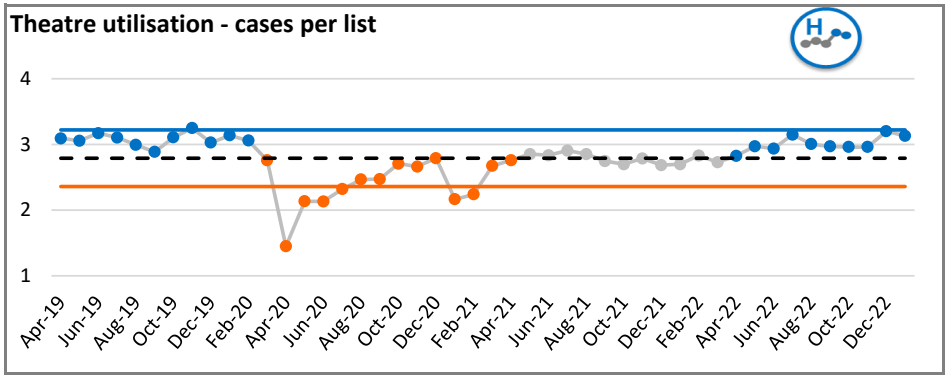
Responsive Services

RTT 18 Weeks Supporting Metrics

East and North Hertfordshire NHS Trust





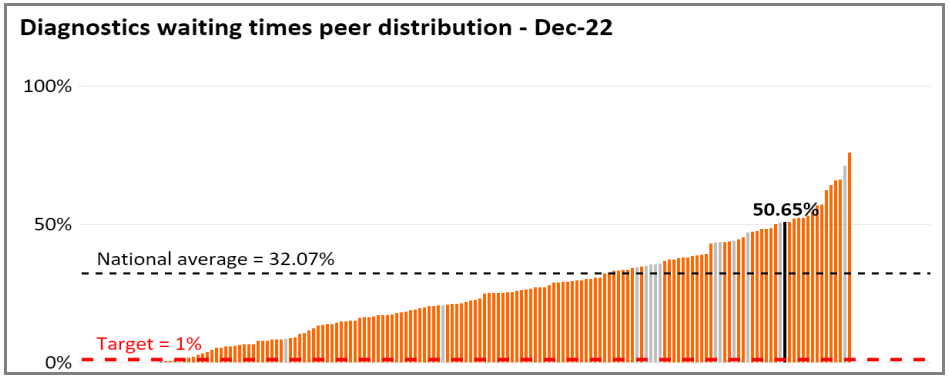


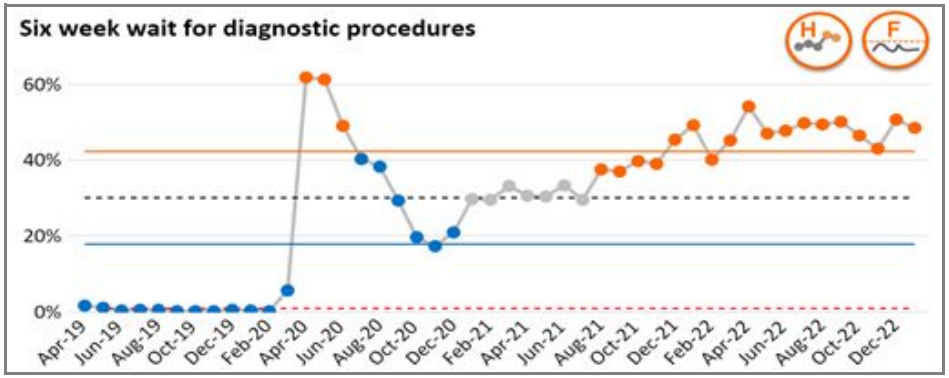
Month 10 | 2022-23

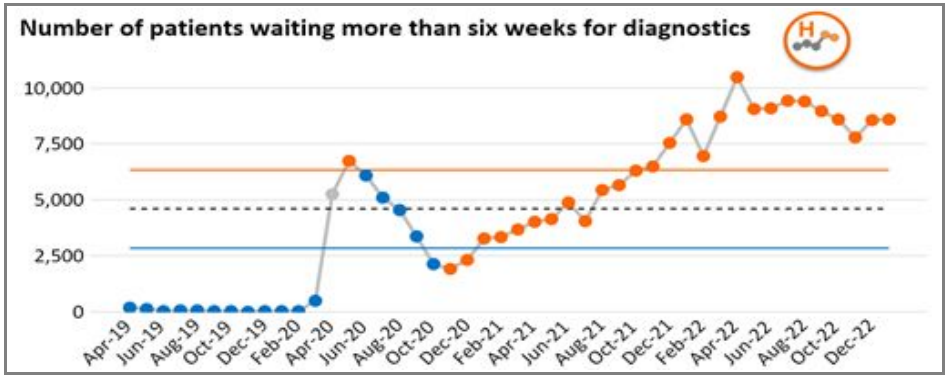
Responsive Services

Diagnostics Waiting Times

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

Improvements

- Community Diagnostic Centre (CDC) activity continues to meet trajectory or overdeliver for imaging with positive patient feedback.
- Reduction of longest Endoscopy waits. Additional GA lists secured.
- ECHO backlog now clear. Wait for new referral is approx. 5wks.

Challenges

- Slight deterioration in Imaging (DM01) position, mainly due to increased cancer activity - CT 13.5%, MRI 21.6% and NOUS 16.7%
- Cancellations due to CT and MRI breakdown at end of Jan
- 15% increase in demand in Jan for all imaging modalities vs Dec
- Continued sustained increase in cancer demand for CT, MRI & US, impacting ability to regain compliance with diagnostic waits within 6 weeks at a faster pace.
- Ongoing staffing challenges within Endoscopy team due to sickness & vacancies across admin & nursing. Unable to open 6th room
- Managing long waits for non-cancer following increases in 62 day pathway patients. Managing balance + risk.
- Risk to echo compliance due to challenges with recruitment to support 7 day working.

Actions

- Awarded funding by NHSE to cover 3-CT van days as part of Diagnostic March project
- Further MRI/CT radiographer training in CT/MRI
- Nursing recruitment ongoing in Endoscopy to utilise 6th room
- ECHO recruitment escalation and action plans in place. ECHO clinical review of referral criteria underway.

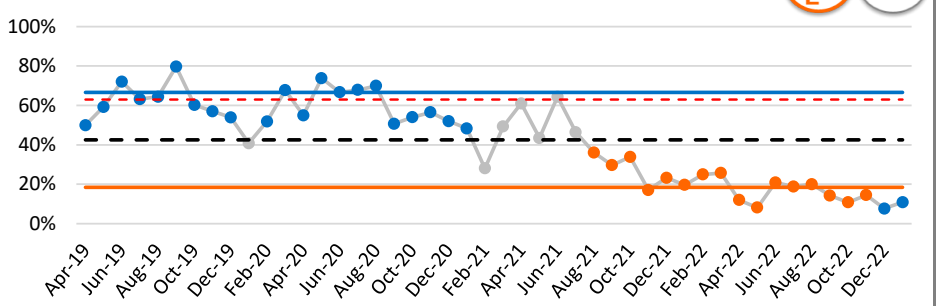
Month 10 | 2022-23

Responsive Services

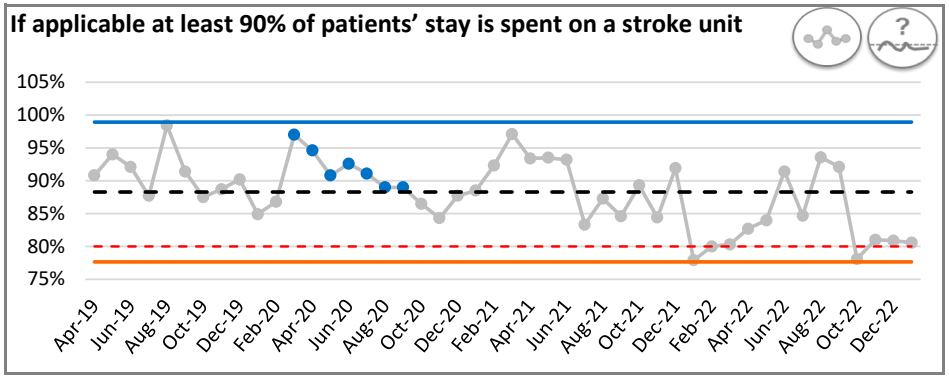
Stroke Services Supporting Metrics

East and North Hertfordshire NHS Trust

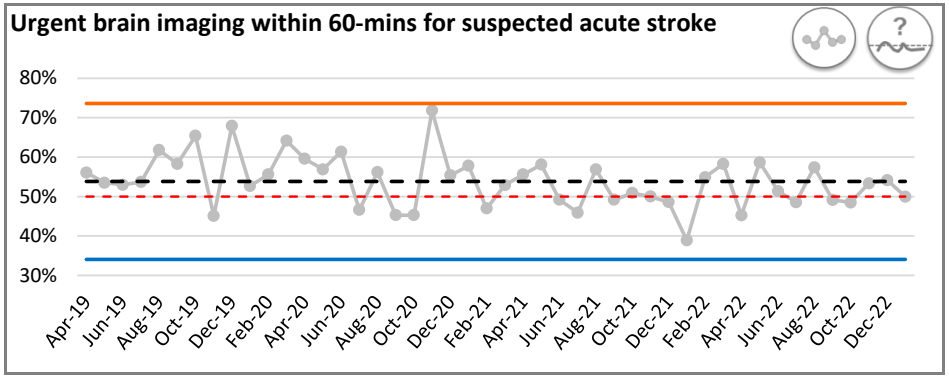
4-hours direct to Stroke unit from ED



If applicable at least 90% of patients' stay is spent on a stroke unit



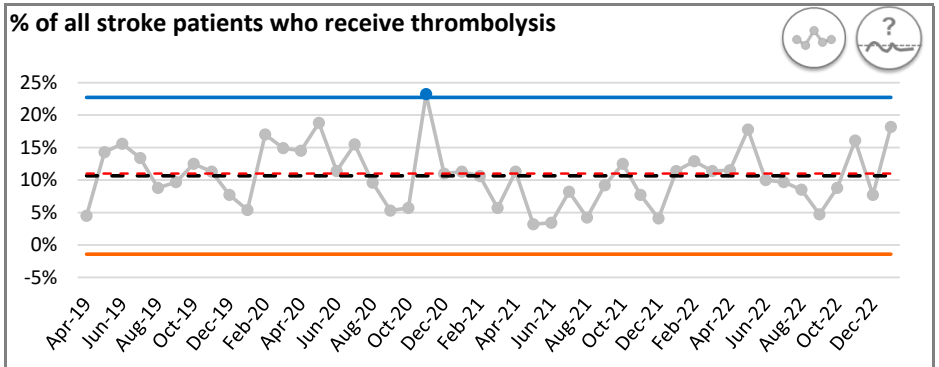
Urgent brain imaging within 60-mins for suspected acute stroke



Key Issues and Executive Response

- Admission directly from ED to the stroke unit remains an area where performance is not at the required standard, which is also recognised as a national issue.
- Trust implementation of LFD testing within ED, which reduces delay from ED to Stroke unit admission, when capacity is available.
- **Improvement on the Thrombolysis pathway in regard to the percentage of patients treated.**
- Concerns around the Radiology pathway for reporting and implementation of the National Optimal Stroke Imaging pathway. Gap analysis review scheduled in March at Stroke and Radiology meeting.
- **Physiotherapy and Occupational Therapy increased service provision to 6-day service in place and aims for 7 days from April 23.**
- **Other domains have stable systems and processes. Trust internal dashboard in development for tracking of performance at each domain - action plans in place to support improvement**.

% of all stroke patients who receive thrombolysis



Month 10 | 2022-23

East and North Hertfordshire NHS Trust

People

Month 10 | 2022-23

	P	?	F
H, L	0	0	1
	0	3	1
H, L	0	2	0

People

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Work	Vacancy rate	Jan-23	5%	9.8%	H	?	Five points above upper process limit Metric will inconsistently pass and fail the target
	Bank spend as a proportion of WTE	Jan-23	10%	9.6%		?	Common cause variation Metric will inconsistently pass and fail the target
	Agency spend as a proportion of WTE	Jan-23	4%	3.0%		?	Common cause variation Metric will inconsistently pass and fail the target
Grow	Statutory and mandatory training compliance rate	Jan-23	90%	85.9%		F	Common cause variation Metric will consistently fail the target
	Appraisal rate	Jan-23	90%	65.5%	H	F	Seven points rising trend Metric will consistently fail the target
Thrive	Turnover rate	Jan-23	12%	12.2%	H	?	14 points above the upper process limit Metric will incostistently pass and fail the target
Care	Sickness rate	Jan-23	3.8%	5.7%		?	Seven points above the mean Metric will inconsistently pass and fail the target

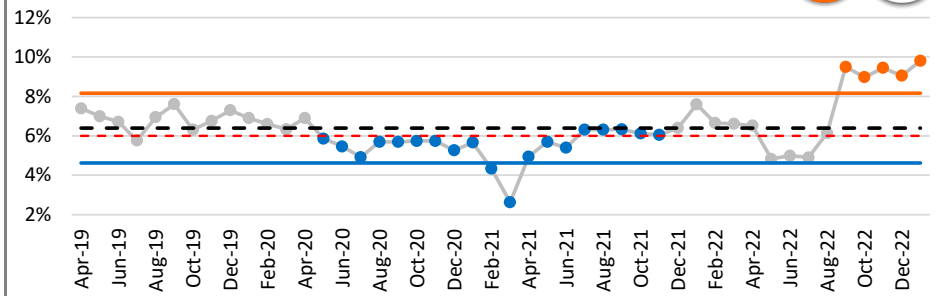
Month 10 | 2022-23

People

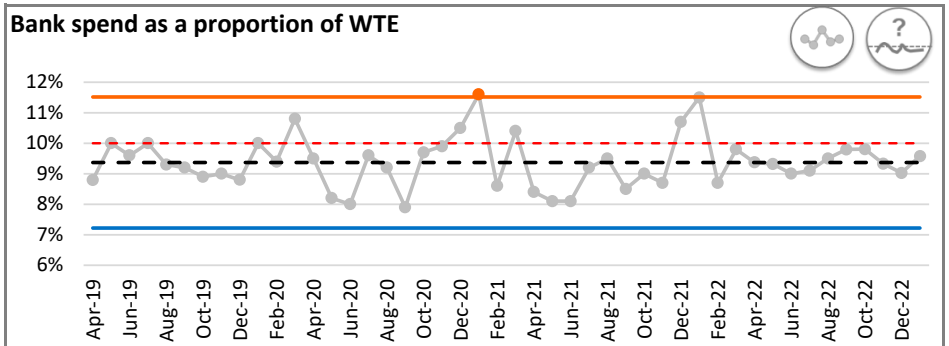
Work Together

East and North Hertfordshire NHS Trust

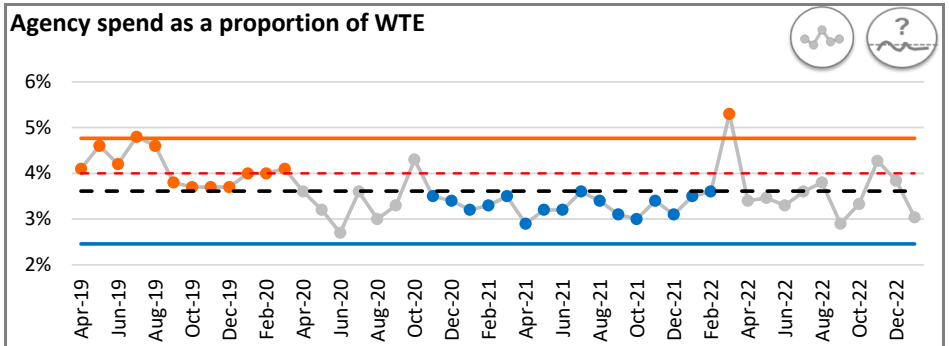
Vacancy rate



Bank spend as a proportion of WTE



Agency spend as a proportion of WTE



Key Issues and Executive Response

- The Trust continues to grow the workforce with an additional 186 whole time equivalent (WTE) compared to January 2022 and an increase of 27 WTE compared to the previous month. However an additional 81 WTE were added to the establishment from January which has meant that the vacancy rate has increased to 9.8%. The increase in establishment predominantly relates to winter funding monies aimed at supporting flow and improving quality of care.
- There are an additional 48 WTE nursing and midwifery employees in the Trust compared to the same point last year and an additional 36 WTE Doctors. This has been achieved due to a very successful overseas recruitment campaign as well as improvements in the uptake of students.
- The staff groups with the largest vacancy rate are unregistered nursing support staff and clinical support staff at 20% and 22% respectively. The Trust has increased its presence in the community. Throughout February and March the Trust is running a series of open days for people to learn more about the roles and setting up regular assessment centres to rapidly move people through the process. Partnerships with Indeed and the Job Centre are driving up activity. In addition a development programme is running with NHS professionals to train and develop staff on flexible contract arrangements.
- Enhancements are being made to the onboarding process to improve the experience of new starters by making it more streamlined, removing duplication and reducing the time to hire. The aim is to ensure all new employees have everything then need in place on day one in the organisation and ensure that they receive an exemplary welcome as part of the induction.
- Workforce plans for 23/24 are being reviewed and prepared for submission to the ICB with work in development to improve the medical establishment review processes.

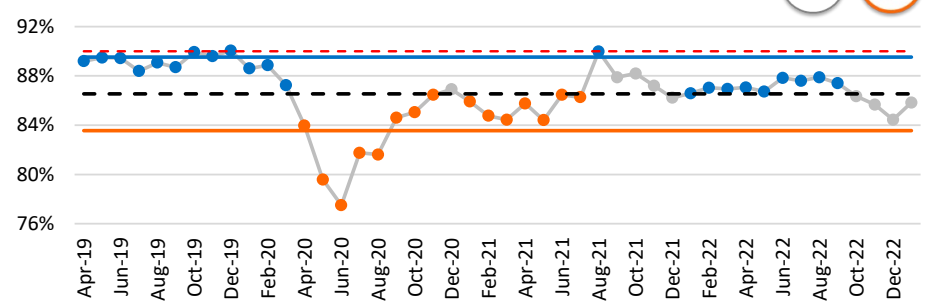
Month 10 | 2022-23

People

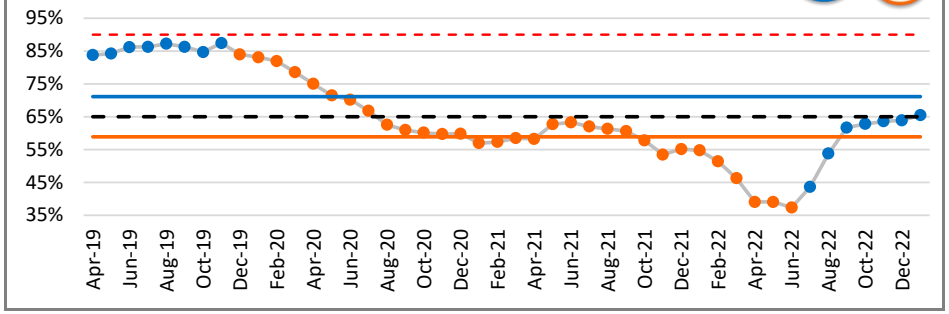
Grow Together

East and North Hertfordshire NHS Trust

Statutory and mandatory training compliance rate



Appraisal rate



Key Issues and Executive Response

- The Trust's appraisal window is due to open in April 2023 and work continues through promotion and training events to increase awareness and address queries. With the Trust's overall Grow Review compliance rate at 65%, we recognise that more work is required to secure improvements during this cycle. Ongoing reminders at Trust briefing and targeting low compliance departments continues. A communications plan and programme are in place.
- Mandatory training has shown an increase this month to 85.9%. Compliance rates are now being discussed in much more detail at relevant divisional meetings. The Trust's Statutory Mandatory Steering group continues to maintain oversight of all requests for additional role essential training courses, approvals are being held/delayed until statutory mandatory targets improve. People partners are working on key areas to support compliance improvements such as in maternity.
- Reviews of applications for Charity funded support for staff (Walter Cooper Bursary) to undertake professional development took place in January. The Trust received over 15 applications from staff for various developmental courses and has awarded a number of bursaries. Successful applicants are currently being contacted.
- The Trust celebrated apprenticeship week early in April with a number of apprentice events and presentations from education providers. The Trust has over 200 live apprenticeship programmes and this number continues to increase. The Trust apprentice's levy pot currently sits at around £2m, with apprenticeships being the first consideration for staff development.

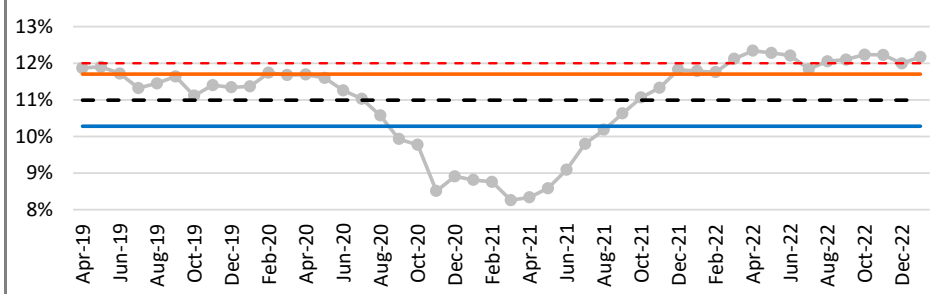
Month 10 | 2022-23

People

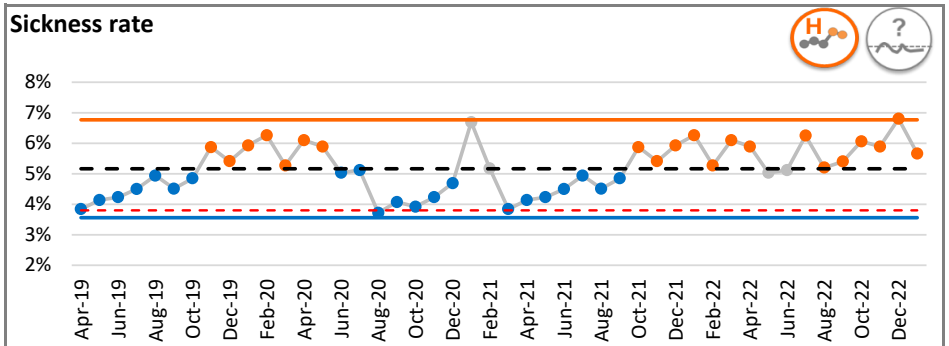
Thrive Together | Care Together

East and North Hertfordshire NHS Trust

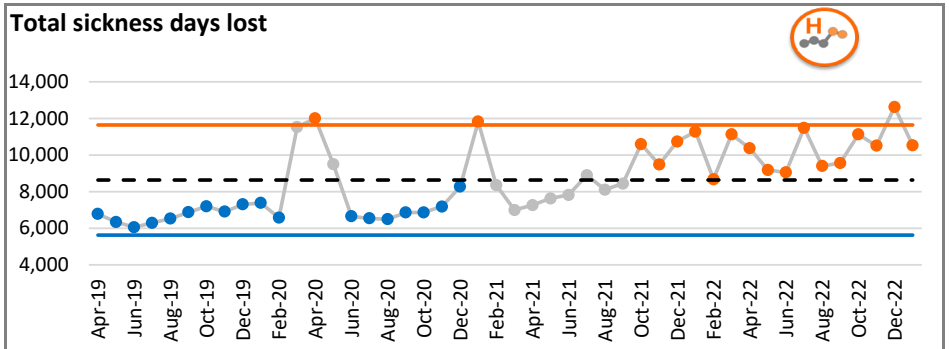
Turnover rate



Sickness rate



Total sickness days lost



Key Issues and Executive Response

Thrive Together

- Winter Wellbeing Make a Wish requests are significantly more this year with a more limited budget to meet all wishes, work continues to prioritise and meet demand and some demand may be supported via our charity, outcomes will provided from the end of March
- Plans for 2023/2024 Winter wellbeing are commencing in partnership with catering, estates, networks and staff side and a range of regular longer term options for consideration, funding and decision will come forward in 2023

Care Together

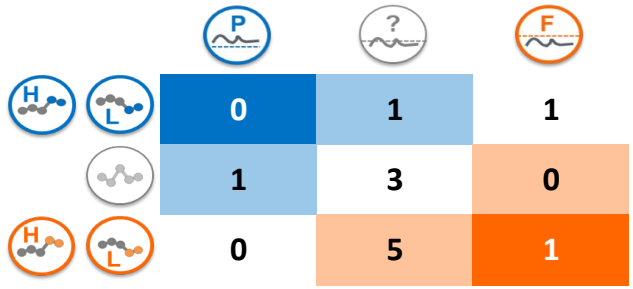
- Staff survey data and results still remains embargoed and will be released in early March 2023.
- Continue to see a reduction in time taken to complete formal disciplinary case work, focus will remain and commence on grievance with full review and update of these policies by March 2023.
- Plans for 2023/24 vaccination programme for ENHT and approaches shared with People Committee were approved
- Work will commence on musculoskeletal sickness with a review of sickness absence drop down menu reasons completed to ensure managers select correct reason rather than the first reason. Health at work will analyse areas with high MSK absence and provide education, manager and team support to improve the trend.

Month 10 | 2022-23

East and North Hertfordshire NHS Trust

Sustainable Services

Month 10 | 2022-23



Sustainable Services

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Summary Financial Position	Surplus / deficit	Jan-23	-2.4	0.08			Common cause variation Metric will inconsistently pass and fail the target
	CIPS achieved	Jan-23	1,245	1,066			Common cause variation No target
	Cash balance	Jan-23	77.9	61.7	H	F	18 consecutive points above the mean Metric will consistently fail the target
Key Financial Drivers	Income earned	Jan-23	45.3	50.1	H		Nine consecutive points above the mean Metric will inconsistently pass and fail the target
	Pay costs	Jan-23	29.5	30.1	H		17 consecutive points above the mean Metric will inconsistently pass and fail the target
	Non-pay costs (including financing)	Jan-23	15.5	19.9	H		13 consecutive points above the mean Metric will inconsistently pass and fail the target

Month 10 | 2022-23

Sustainable Services

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Key Payroll Metrics	Substantive pay costs	Jan-23	24.9	26.4	H	?	17 consecutive points above the mean Metric will inconsistently pass and fail the target
	Average monthly substantive pay costs (000s)	Jan-23	0.9	4.5	H	F	17 consecutive points above the mean Metric will consistently fail the target
	Agency costs	Jan-23		0.8			Common cause variation No target
	Unit cost of agency staff	Jan-23		9.5			Common cause variation No target
	Bank costs	Jan-23	3.7	2.9		P	Common cause variation Metric will consistently pass the target
	Overtime and WLI costs	Jan-23	0.5	0.3	H	?	12 consecutive points above the mean Metric will inconsistently pass and fail the target
Other Financial Metrics	Elective Recovery Fund income earned	Jan-23	1.1	2.4		?	Common cause variation Metric will inconsistently pass and fail the target
	Drugs and consumable spend	Jan-23	2.8	3.4	H	?	Nine consecutive points above the mean Metric will inconsistently pass and fail the target
	Private patients income earned	Jan-23	0.4	0.4		?	Common cause variation Metric will inconsistently pass and fail the target

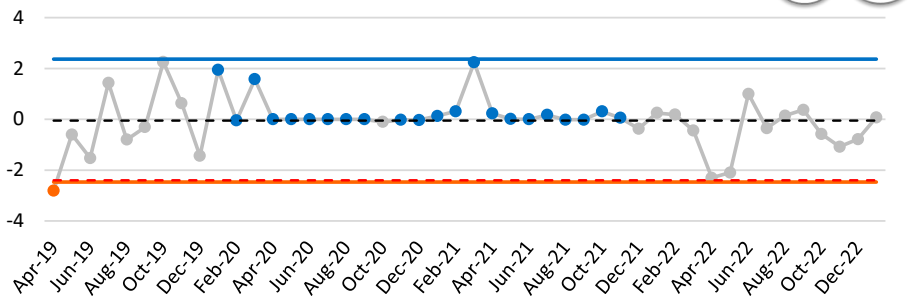
Month 10 | 2022-23

Sustainable Services

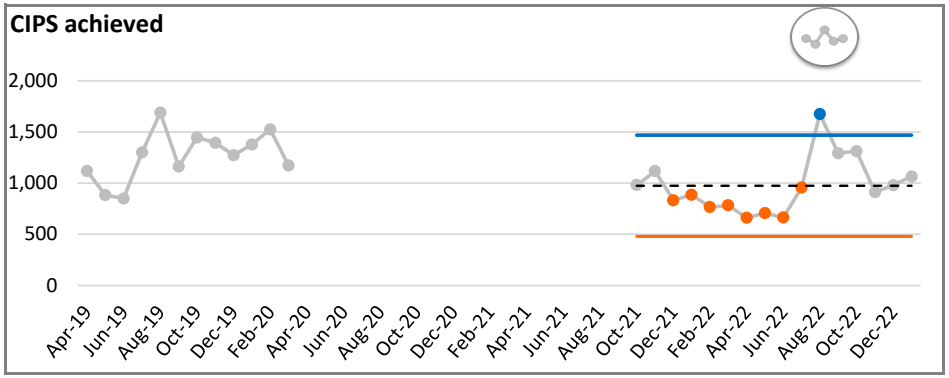
Summary Financial Position

East and North Hertfordshire NHS Trust

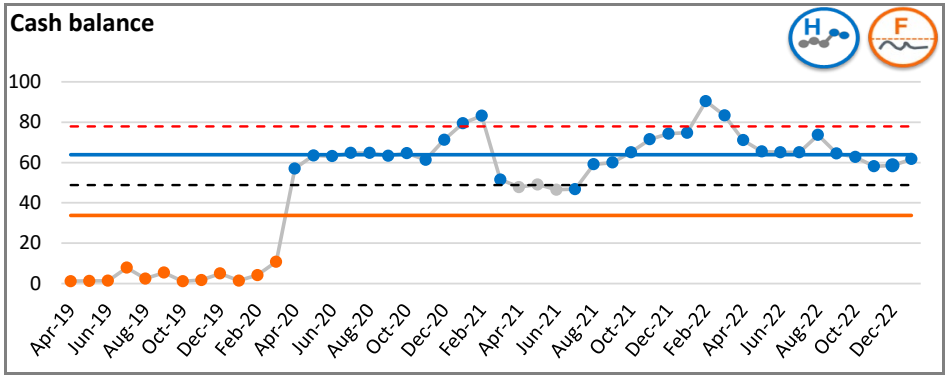
Surplus / deficit



CIPS achieved



Cash balance



Key Issues and Executive Response

- The Trust reports M10 financial performance against the breakeven plan that it agreed and submitted in June 22.
- The Trust reports a monthly surplus of £0.1m in January, and a YTD deficit of £5.6m. This represents an adverse variance of £4.5m against the YTD plan. It is important to note that there has been a significant commitment of non-recurrent reserves to achieve this position.
- The delivery of the Trust financial plan is at significant risk based on YTD performance. The Trust has initiated a range of financial reset activities in response, but nevertheless forecasts a year end deficit of £8.0m. This has been communicated to both HWE ICS and NHS England.
- The Trust's elective activity plan assumes a significant increase in delivery as the year progresses and additional activity comes online. The YTD position assumes full receipt of ERF funds achieved.
- Delivery against the Trust's CIP target remains a concern, with a YTD undershoot of £4.9m reported at M10.
- Significant overspends against medical staffing budgets are reported at M10. These are concentrated in both Planned & Unplanned Divisions.

	Annual Budget £m	Budget YTD £m	Actual YTD £m	Variance YTD £m
Income	543.1	452.2	456.8	**4.6**
Pay	-352.9	-294.0	-296.3	**-2.3**
Non Pay	-183.3	-153.3	-161.2	**-8.0**
EBITDA	**6.9**	**4.9**	**-0.8**	**-5.7**
Financing Costs	-32.4	-27.3	-26.9	**0.4**
Retained Deficit exc. PSF	**-25.5**	**-22.4**	**-27.7**	**-5.3**
Top-Up Payments	10.0	8.3	9.1	**0.8**
Systems Funding	15.5	13.0	13.0	**0.0**
Surplus / Deficit (excl Fin Adj's)	**0.0**	**-1.1**	**-5.6**	**-4.5**

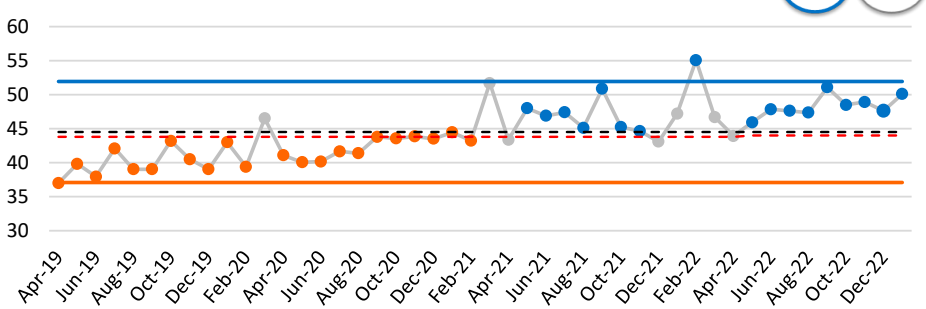
Month 10 | 2022-23

Sustainable Services

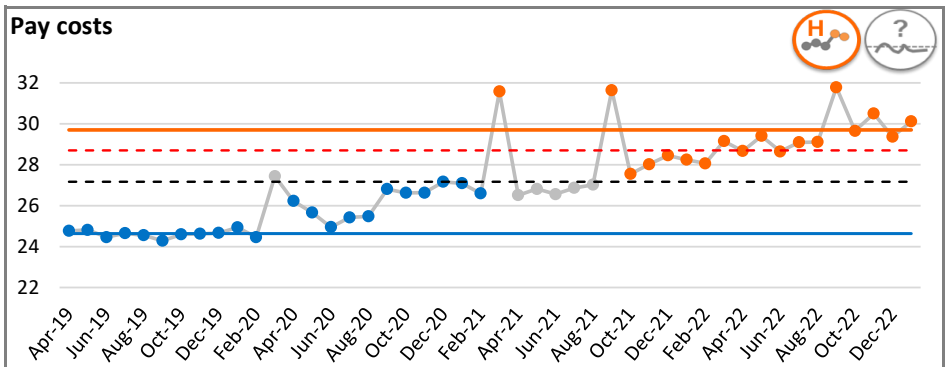
Key Financial Drivers

East and North Hertfordshire NHS Trust

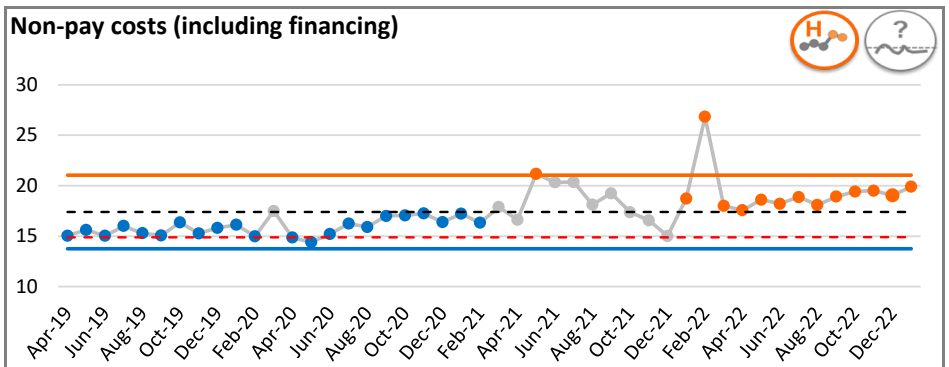
Income earned



Pay costs



Non-pay costs (including financing)



Key Issues and Executive Response

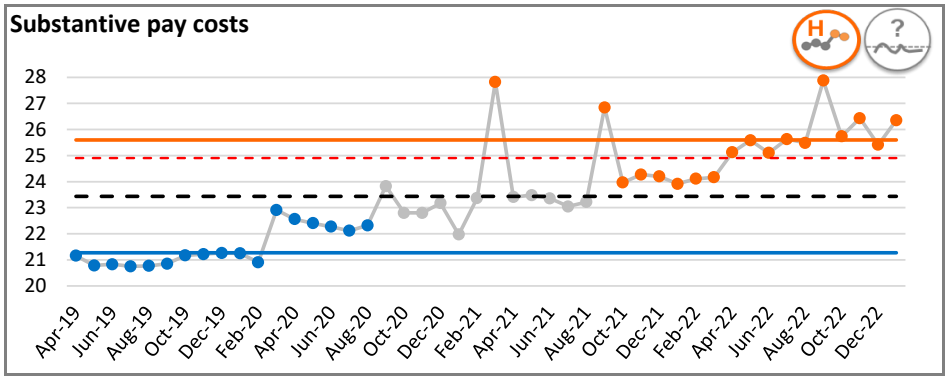
- YTD financial performance is off plan and represents a significant challenge for the Trust. A number of key risk items jeopardise the delivery of the financial plan.
- The Trust forecasts a year end deficit of £8.0m and has communicated this to both HWE ICS and NHS England and has taken required Outturn Variance Protocol actions in response.
- It is important to highlight that significant utilisation of non-recurrent reserves funding has been required in order to mitigate financial performance to date. This opportunity is not available over the remainder of the financial year, and the Trust will continue to focus upon actions to mitigate its underlying deficit run rate.
- Slippage against CIP targets (£4.9m YTD) represents a major concern at the M10 reporting point. Divisional capacity to support effective project and delivery arrangements remains a concern that requires redress.
- Levels of overspending against medical staffing budgets - totalling £2.3m across the YTD are significant. This is driven by a combination of issues including UEC pressures and a variety of sickness and unavailability issues resulting in higher costs.
- The delivery of additional volumes of elective activity are an important part of the Trust's plan for 22/23, both in terms of delivery waiting list improvements and also achieving financial efficiencies. Full receipt of earned ERF income is assumed in the YTD and forecast position.
- The Trust continues to monitor the impact of levels of inflation upon its financial plan. Particular pressures in respect of drugs and utility costs have already begun to emerge.
- Given a range of significant risk items that potentially compromise the delivery of the financial plan, the Trust has initiated a programme of 'Financial Reset'. This encompasses a number of work streams that target the improvement of the present run rate.
- The activities of the programme are over seen by an Executive Steering Group and supported by divisional reset meetings.

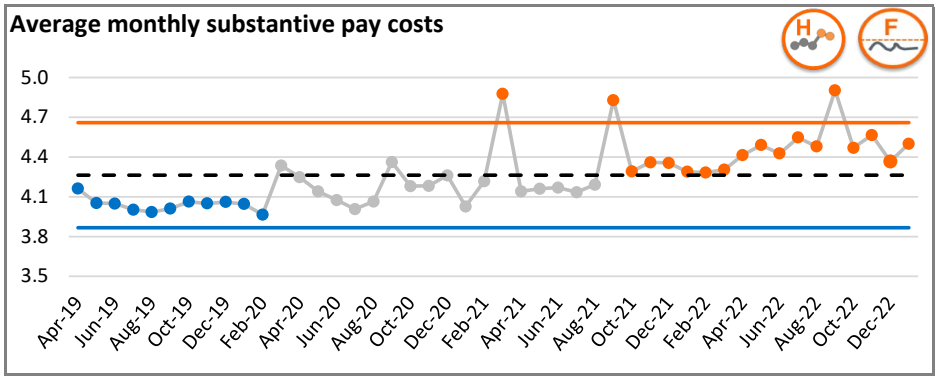
Month 10 | 2022-23

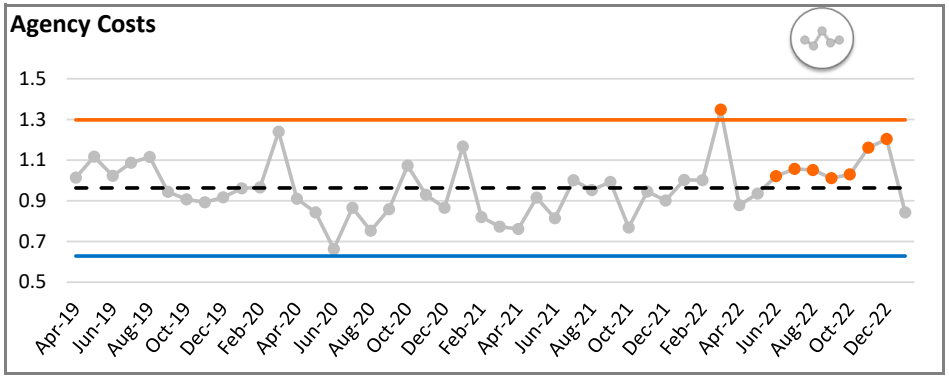
Sustainable Services

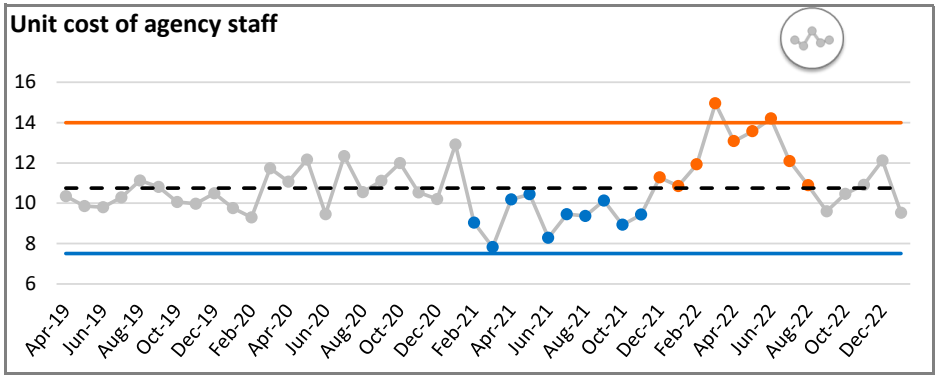
Other Financial Indicators

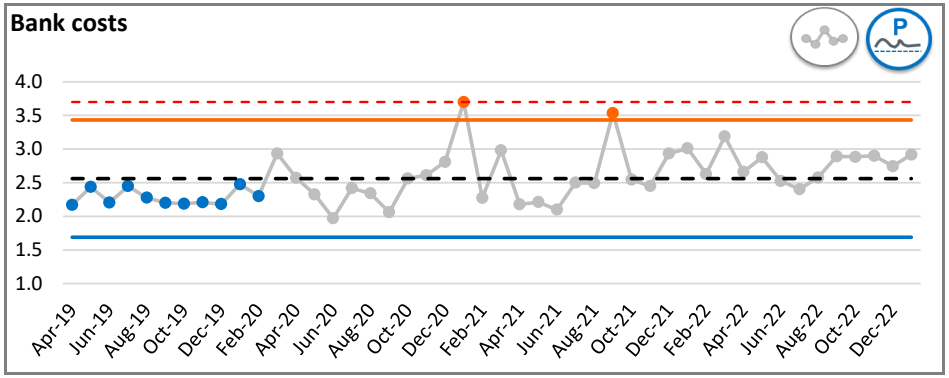
East and North Hertfordshire NHS Trust

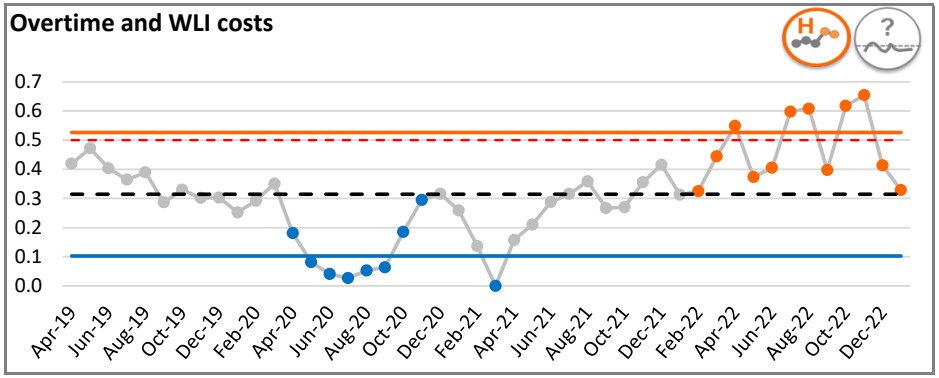












Month 10 | 2022-23

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	16
Report title	ICS Monthly Performance Report			**Meeting Date**	1 March 2023
Presenter	Martin Armstrong - Deputy CEO				
Author(s)	Herts and West Essex – Integrated Care System				
Responsible Director	Martin Armstrong – Chief Finance Officer			**Approval Date**	23-02-23
Purpose *(tick one box only)*	**To Note**	☐	**Approval**		☐
	Discussion	☒	**Decision**		☐

Report Summary:

The report attached is produced by Hertfordshire and West Essex integrated care system and sets out performance against a range of access dimensions across the system and the organisations that compose its membership.

Impact: where significant implication(s) need highlighting

The board is asked to note system performance issues and challenges, within the context of ENHT delivery.

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

NA

Report previously considered by & date(s):

NA

Recommendation	The Board is asked to note the report

To be trusted to provide consistently outstanding care and exemplary service

Hertfordshire and West Essex Integrated Care System Performance Report January 2023

Hertfordshire and West Essex Integrated Care System

Essex County Council

Hertfordshire

NHS

1

Executive Summary

URGENT CARE, Slides 6-12: Calls abandoned performance = better than national position but worse than regional and ED 4 hour performance = worse than regional and national position

- 111 performance improvements were seen in September with percentage of abandoned calls returning to meet standard; performance has since declined however although remains ahead of the national position, and will be further impacted by a significant increase in demand in December;
- Ambulance response times and ambulance handover performance continues to decline and remains an area of significant concern;
- ED 4 hour performance declined further in November and remains worse than both regional and national position. A deterioration was also seen in the % of patients spending more than 12 hours in department. ED attendances continue above historical averages;
- Data does not yet suggest plans are delivering overall improvement; trajectories for UEC priority metrics agreed with actions aiming to return performance to 21/22 levels, however did not meet in first month.

CANCER, Slides 20-21: 62 day first performance = better than regional and national position

- Continued high levels of 2 week wait referrals following significant spike in May;
- Although continuing below standard, October saw a marked improvement in 62 day first performance with the ICB ranking the 6th highest nationally. The number of patients waiting >62 days continues to decrease but remains behind recovery plan;
- ENHT have been de-escalated from Tier 1 to Tier 2 in line with performance improvements and WHTHT have been removed completely from the tiering system with consistent week on week improvements;
- Although not meeting standard, improved performance levels continue to be delivered against 28 day Faster Diagnosis Standard.

PLANNED CARE, Slide 17: 18 week performance = worse than regional and national position

- Continued delivery of 104 week recovery with zero capacity breaches;
- System focus on reducing the number of patients waiting over 78 weeks with activity currently ahead of revised plan trajectory; pressure remains predominantly in Trauma and Orthopaedics, Gastro and Community Paediatrics which are not forecast to meet 0 by March 23. ENHT have been de-escalated from Tier 1 to Tier 2 for 78 week recovery, with WHTHT remaining in Tier 1 due to data quality issues;
- The number of patients waiting over 52 weeks continues to increase and remains of concern.

DIAGNOSTICS, Slide 18: 6 week performance = better than regional position and worse than national position

- The number of patients waiting over 6 weeks for a diagnostic test continues at similar levels with performance improvement remaining fairly flat; some improvements were seen in October however;
- The system-wide diagnostic improvement plan was submitted in November to NHSE/I including recovery trajectories for all challenged modalities.

Community, Slides 13-17:

- Increased demand on adults & children's services resulting in waiting lists continuing at historically high levels & overall performance remaining below target. Longest wait of 63wks for adults & 76wks children;
- The percentage of children waiting less than 18 weeks has continued to significantly decline since April 22 with pressures in community paediatrics, therapies and audiology services.

MENTAL HEALTH, Slides 25-31:

- Demand continues to remain high in Adult, Older Adult and CAMHS services and is almost double pre-pandemic levels for non-inpatient urgent services (crisis services);
- Pressure for Mental Health Assessments and acute beds continues, with Out of Area Bed Days continuing to increase in October;
- Dementia diagnosis remains challenged in Hertfordshire however has seen an improvement in performance in the latest data;

PRIMARY CARE AND CONTINUING HEALTHCARE, Slides 32-33:

- Significant pressure from Respiratory illness and rapid increase in 'spot booking' from hotels set up by Home Office; total number of GP appointments remain higher than pre-pandemic levels and increased significantly in October with proportion of face to face appointments continuing to increase, reaching over 70% in October and November;
- The number of CHC assessments completed within 28 days remains a challenge in South West Herts however performance improved in October.

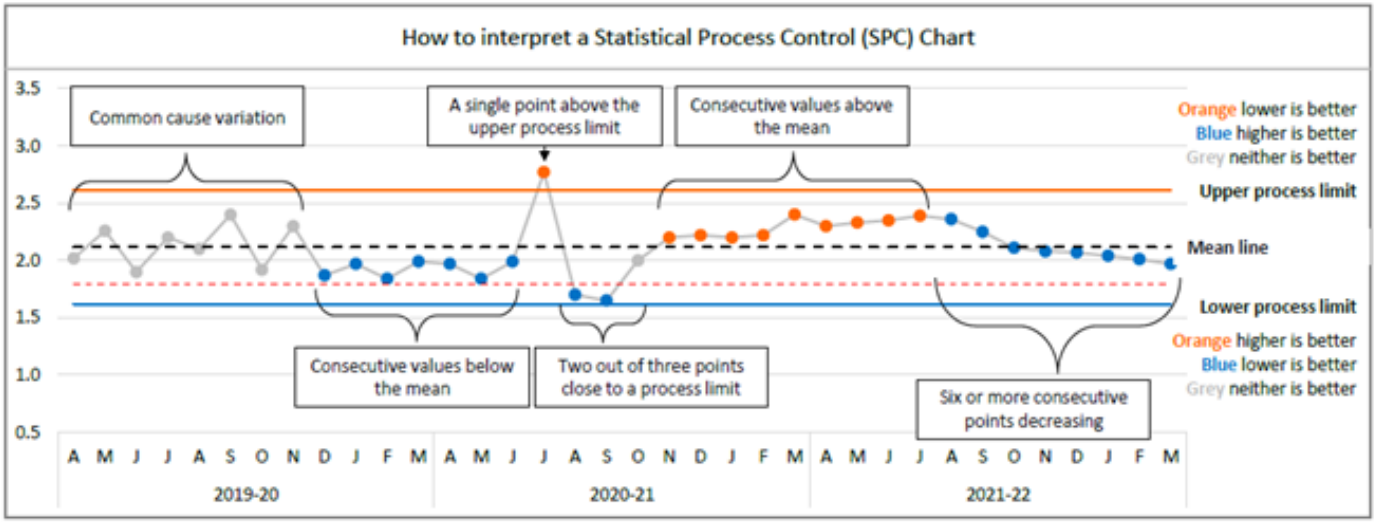
Executive Summary – Performance Overview

Metric	Latest month	Measure	Variation	Assurance	Mean	Lower process limit	Upper process limit
A&E - 4 Hour Standard	Nov 22	59.1%			67.9%	62.5%	73.3%
A&E - % spending more than 12 Hours in Dept	Oct 22	9.3%			6.4%	4.8%	8.1%
A&E - ED Average Attendance	Nov 22	41645			40296	34468	46124
Trolley Waits	Nov 22	192			170	-36	375
2 Hour Community Response	Oct 22	85.9%			83.9%	66.8%	101.0%
14 day LOS	Oct 22	13.7%			12.4%	10.3%	14.4%
Ambulance - Handover >60 Mins	Oct 22	1334			921	630	1213
EEAST: Cat 1 - Mean (<7min)	Oct 22	00:10:39			00:09:31	00:07:53	00:11:10
EEAST: Cat 2 - Mean (<18 Mins)	Oct 22	01:19:21			00:51:11	00:21:39	01:20:43
RTT - 18 Weeks	Oct 22	51.7%			58.5%	55.2%	61.9%
RTT - 52 Week Waits	Oct 22	9744			6759	5314	8204
RTT - PTL Size	Oct 22	145881			118434	111044	125824
RTT - 74 weeks	Oct 22	697			1039	689	1389
Diagnostics - 6 Week Wait	Oct 22	62.9%			65.3%	57.9%	72.6%
Diagnostics - PTL Size	Oct 22	24424			24625	20411	28839
Cancer - 2 Week Wait Standard	Oct 22	76.1%			79.5%	66.8%	92.2%
Cancer - 2 Week Wait Referrals	Oct 22	6171			5244	4174	6314
Cancer - 62 Day Standard	Oct 22	73.7%			74.6%	65.8%	83.4%
Cancer - 62 Day Total Waiting	Nov 22	547			610	387	834
Cancer - 104 Day Total Waiting	Nov 22	173			149	96	202
Cancer - 28 Day Faster Diagnosis Standard	Oct 22	68.0%			69.0%	58.6%	79.3%
Mental Health - Out of Area Placements	Oct 22	1322			850	496	1204
Mental Health - Dementia Diagnosis	Sep 22	61.6%			61.4%	60.8%	62.0%
Mental Health - IAPT Entering Treatment	Oct 22	2309			2387	1707	3068

A Dashboard including Place and Trust based performance is included within Appendix A of this report

3

Statistical Process Control (SPC)



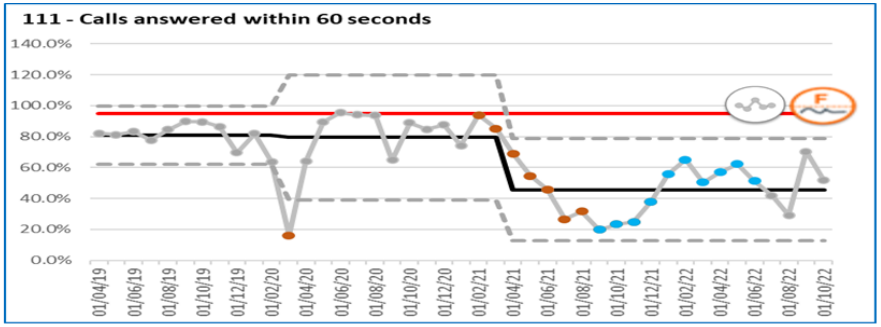
Variation	
H L	Special cause variation of concerning nature due to Higher or Lower values
H L	Special cause variation of improving nature due to Higher or Lower values
	Common cause variation No significant change

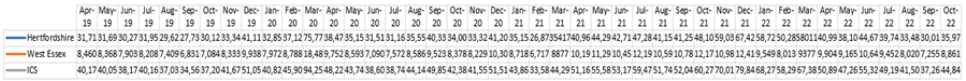
Assurance	
F	Consistent Failing of the target Upper / lower process limit is above / below target line
P	Consistent Passing of target Upper / lower process limit is above / below target line
?	Inconsistent passing and failing of the target

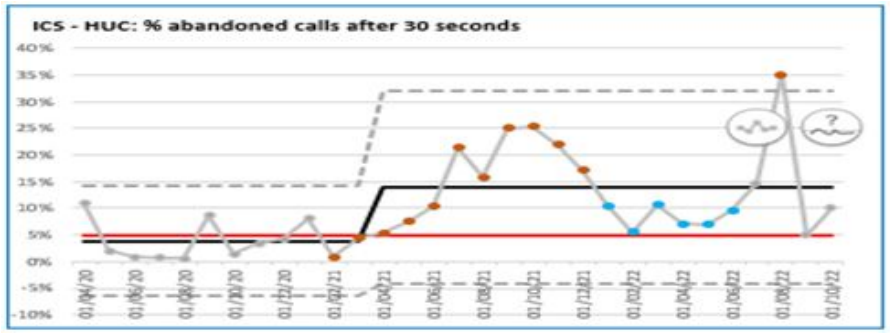
4

Performance by Work Programme

NHS 111

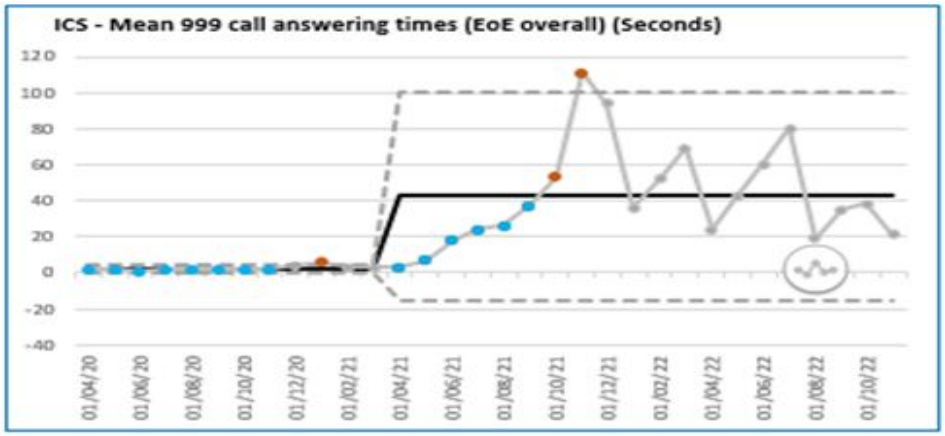


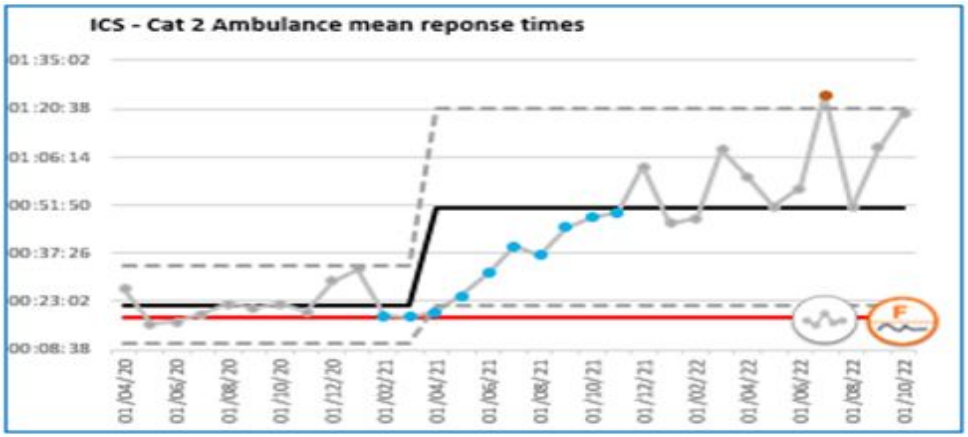


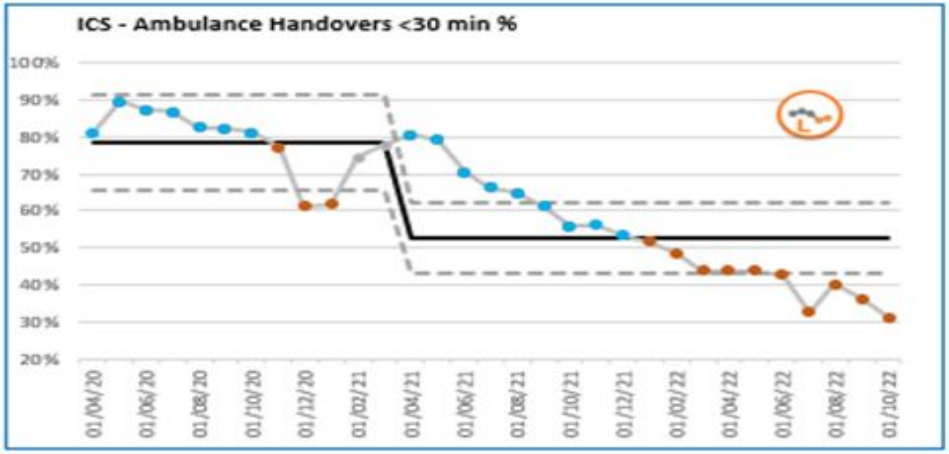


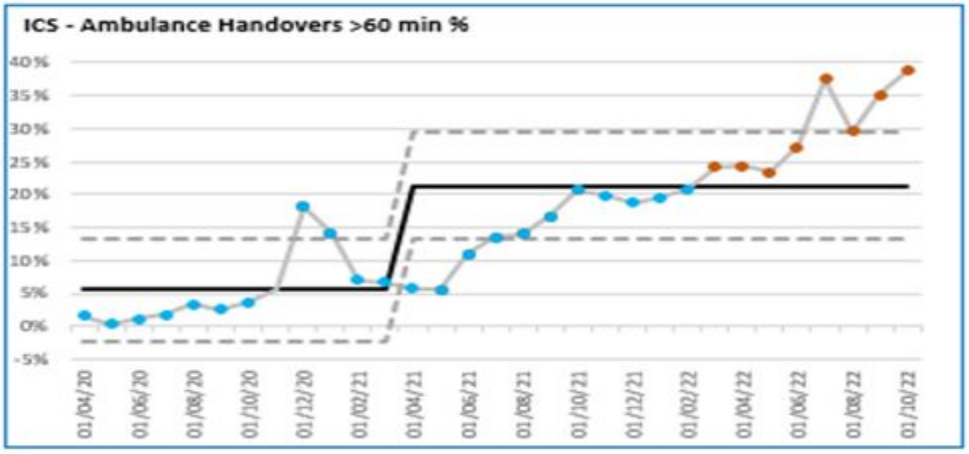
ICB Area	What the charts tell us	Issues	Actions	Mitigation
HUC	• Calls answered within 60 seconds saw improved performance levels from September, but December will see a sharp deterioration as a result of a significant increase in call volumes • After returning to meet standard in September, performance deteriorated to 10% in October for abandoned calls • Latest data for December shows abandonment rates as high as 40% due to exceptionally high call rates	• Critical Incident declared in December due to significant increase in call volumes • Strep A alert contributing towards high call volumes, longer queues and higher abandonment rates • Ongoing disruption from Adastra outage and the updated version created post August cyber attack • Post Event Messaging (PEM) remains an issue for all affected Providers	• Escalation calls established to manage response in respect of high call volumes in December • Two respiratory hubs established in Stevenage with work in progress to create further hubs • Most urgent PEMs already communicated to Practices. The remainder of PEMs created during Adastra outage now being discussed at national level • ADVANCED in communication with 111 Providers regarding new Adastra imperfections • HUC footprint Task & Finish Group in place to address challenges and actions across three ICBs (HWE, BLMK, C&P) • Weekly IUC Overview Reports from the Provider with monthly updates on workforce	• Rapid development of Respiratory Hubs to redirect from NHS 111 and ED • Exploring the opportunity to redeploy staff from the wider system for support • AiHVS initially redeployed to support longer queues • Range of staff support and welfare measures put in place by HUC

UEC - Ambulance Response and Handover









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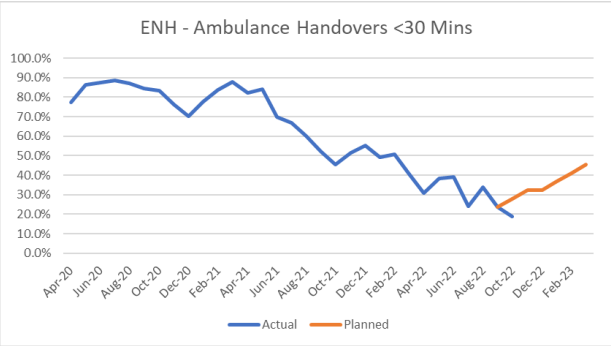
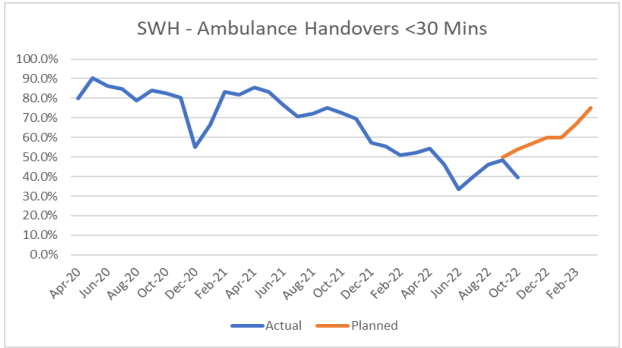
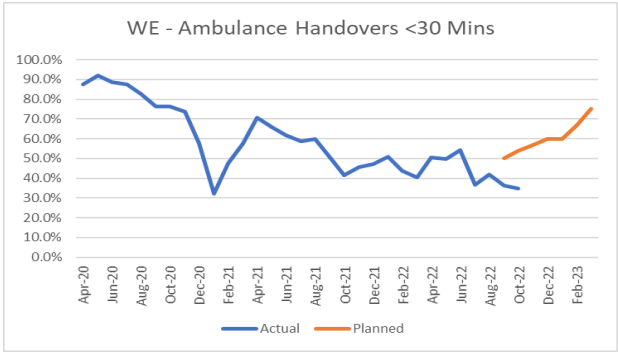
UEC - Ambulance Handover Improvement Trajectories

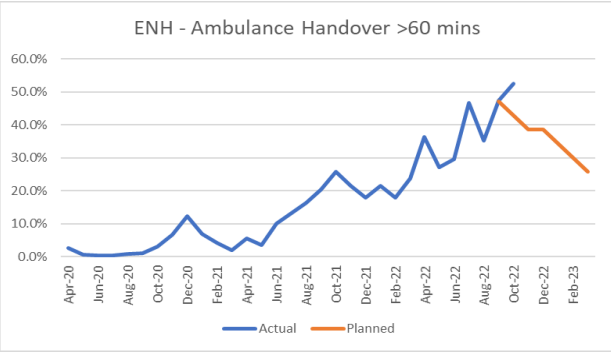
< 30 Minute Ambulance Handover Trajectories

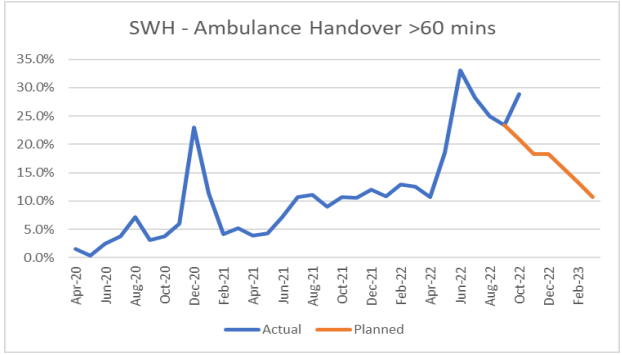


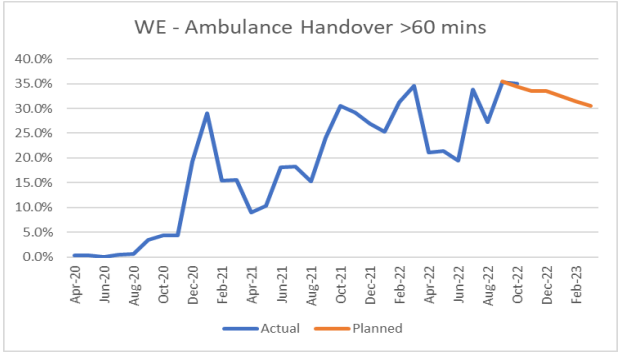




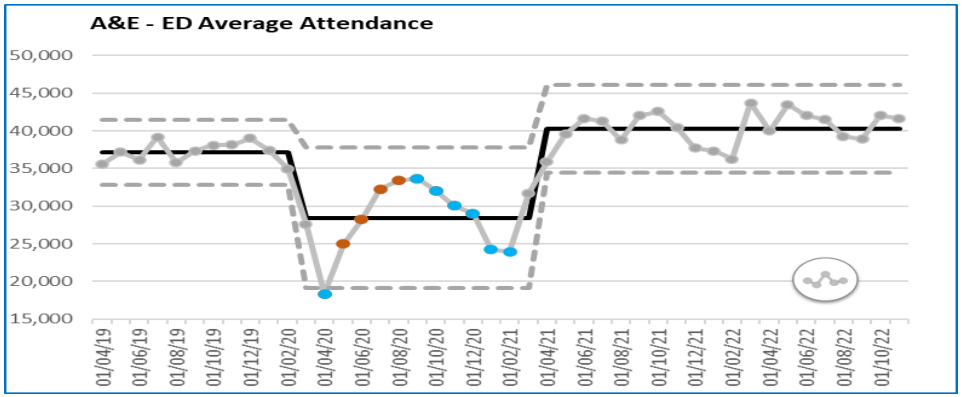
> 60 Minute Ambulance Handover Trajectories

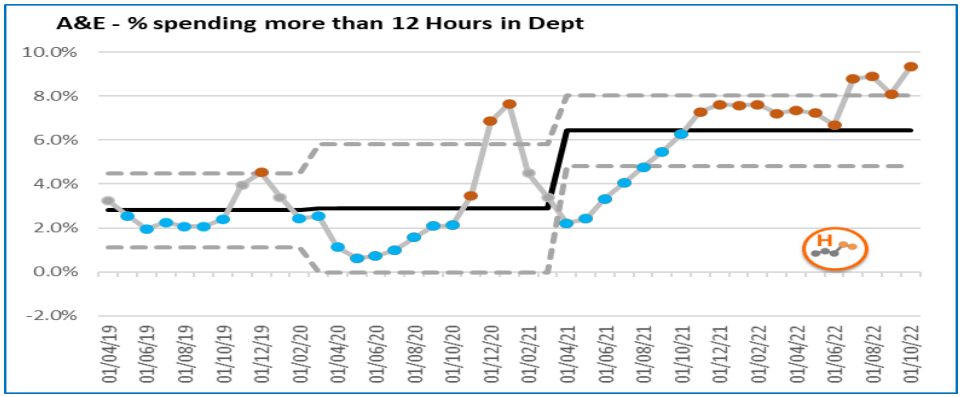


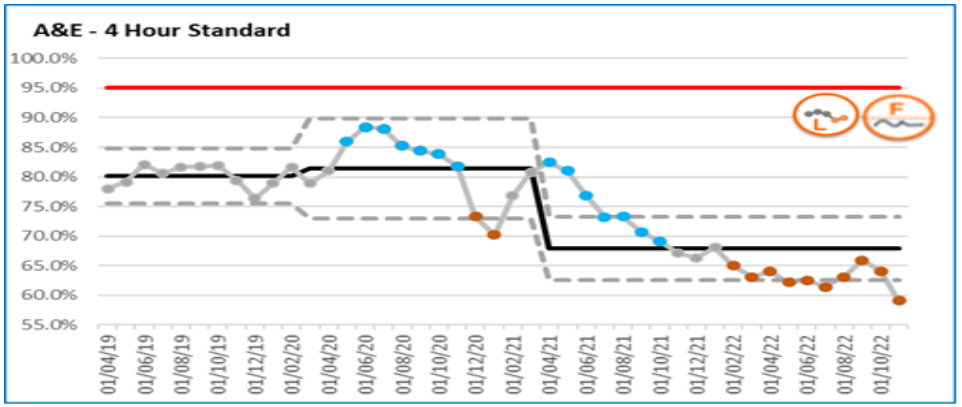


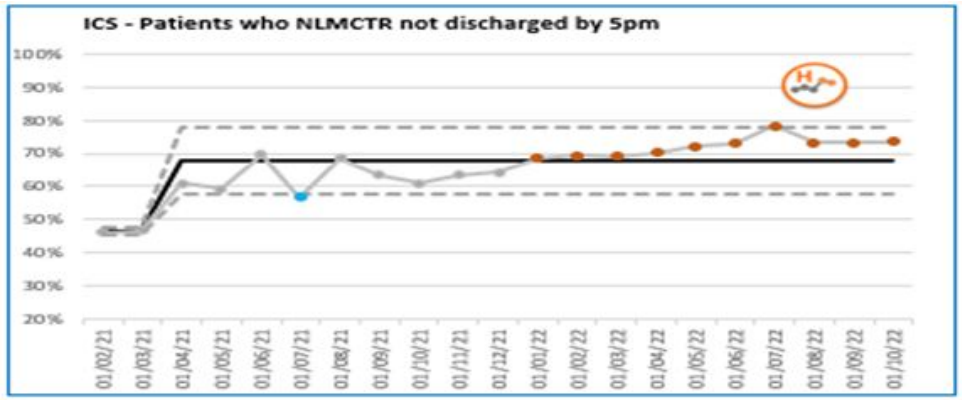


Urgent & Emergency Care (UEC)









Place	Patient Journey	Area	Indicator	Target	Previous Month	Current Month	Latest Month	Month Change
WE CCG	At Hospital	Hospital flow	Patients who NLMCTR not discharged by 5pm	-	70.7%	71.7%	October	
SWH CCG	At Hospital	Hospital flow	Patients who NLMCTR not discharged by 5pm	-	75.3%	75.6%	October	
ENH CCG	At Hospital	Hospital flow	Patients who NLMCTR not discharged by 5pm	-	72.7%	72.6%	October	

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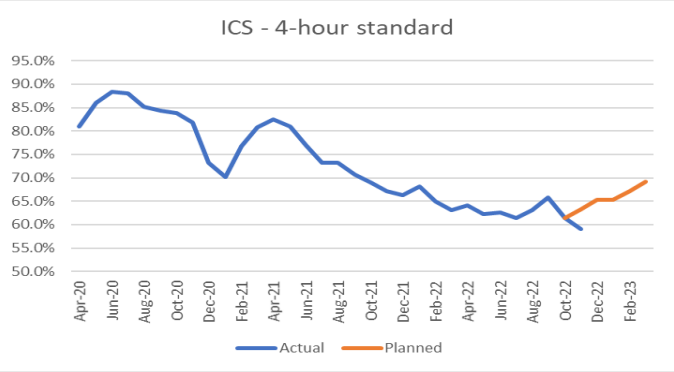
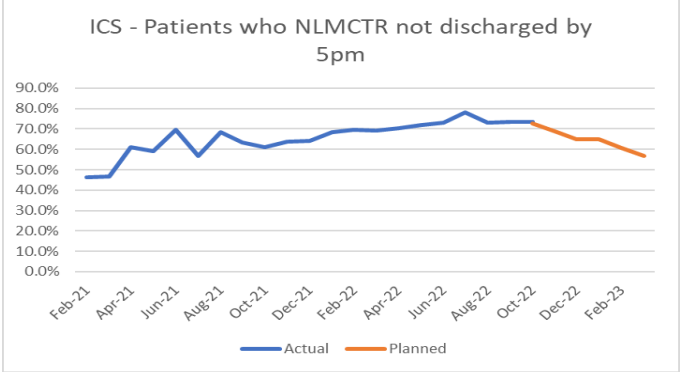
Urgent & Emergency Care (UEC) Improvement Trajectories

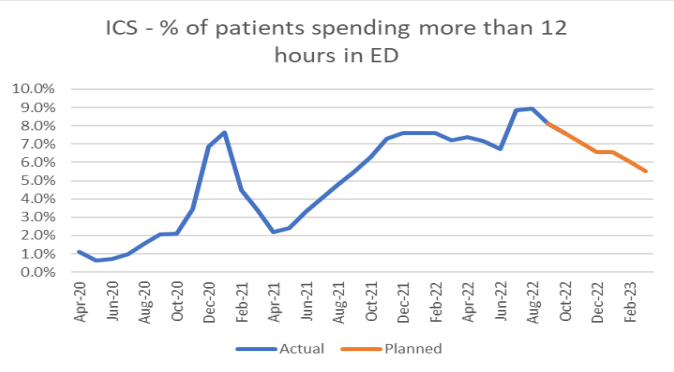
4 Hour Standard Improvement Trajectory



No Longer Meet Criteria to Reside (NLMCTR) Improvement Trajectory



12 Hours in ED Improvement Trajectory



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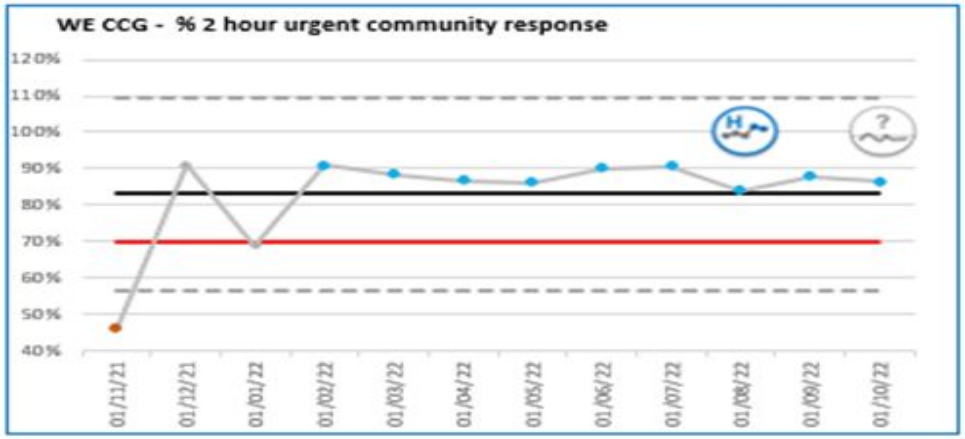
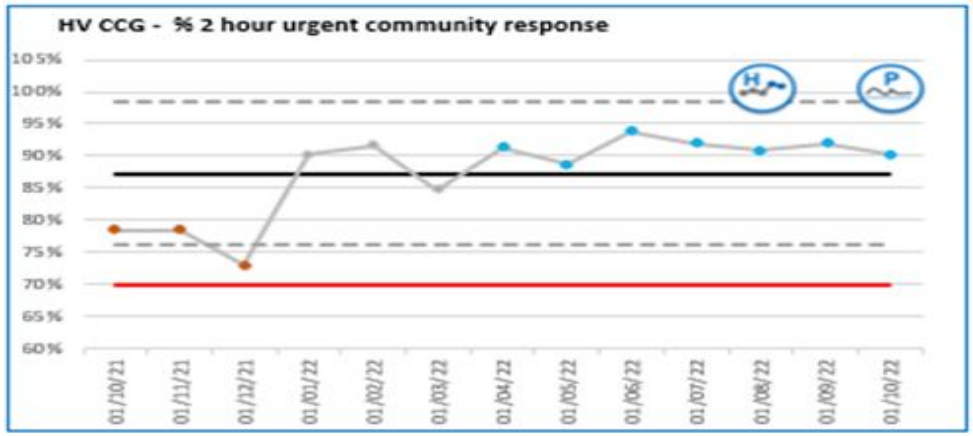
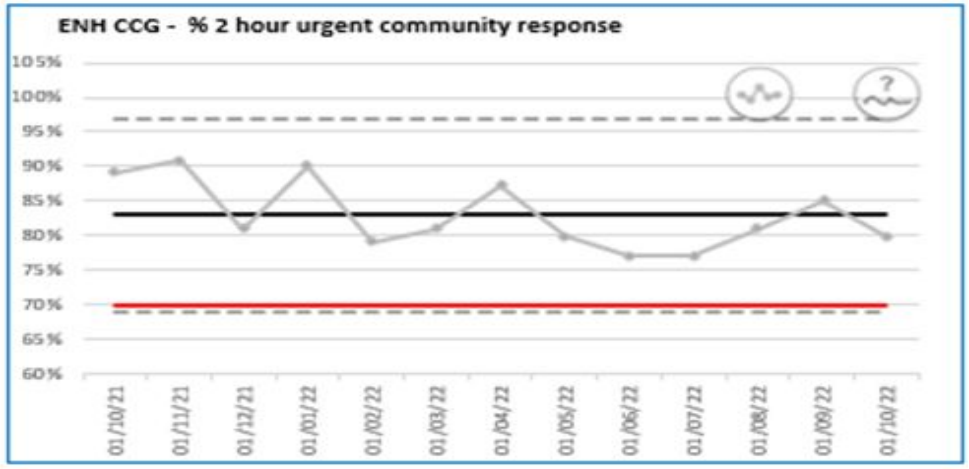
Urgent & Emergency Care (UEC)

ICB Area	What the charts tell us	Issues	Actions
ICB	• Category 2 ambulance response times deteriorated to October and remain of concern; • Performance against ambulance handover (withing 30 minutes and over 60 minutes) has also deteriorated and remains of significant concern; • ED attendances have remained consistently above historical averages over the last 12 moths coinciding with a continuing deterioration in performance against the 4hr standard; • 4-hour performance remains of concern and has declined across October and November; • The percentage of patients spending more than 12 hours in the ED department remains high, having further increased in October; • The percentage of patients who no longer meet the criteria to reside and who have not been discharged by 5pm have remained at significantly higher levels throughout 2022; • Above data points suggest EDs are experiencing exit block due to issues with discharge from wards. • Whilst only the first month, performance improvement trajectories for ambulance handover and 4hr standard performance are not being met. • Please see Appendix B, slide 35 for detail of performance by Place.	• Continued high demand for UEC services • Ambulance Handover delays • Increased Covid/Flu admissions and acuity of patients • Workforce availability and impact of Covid/Flu on the UEC workforce • MH assessment delays and bed shortages • Strep A impact from December onwards • Acute capital build in some areas impacting on the management of current and future demand until completion in December	**Alternatives to ED/reducing attendances:** • Implementation of the HARIS/Unscheduled Care Co-ordination (which includes call before convey and access to the Stack) to provide health care professionals working within our system access to appropriate clinical support to make the best use of services across the system and to reduce delays to improve performance. This program has commenced with support to EEAST Ambulance service (East of England Ambulance service); the HARIS proof of concept week was successful in reducing ambulance conveyance and demonstrated a related improvement in 30 & 60 minute handover times. Challenges continue with establishing a sustainable model and work continues with colleagues and region to develop. **System Strategy:** • Participation in the integrated Urgent and Emergency Care (iUEC programme) supported by the National Improvement team. The ICB is one of two systems that are participating in the pilot programme. The aim of the programme is to support development of a UEC strategy, support UEC recovery and reduce overcrowding in the EDs through diagnostics based on population health needs and service redesign. • Agreed Winter Action Plan and performance improvement trajectories set against Board Assurance Framework UEC priority metrics, aligned to Action Plan. New UEC Performance report to monitor delivery against trajectories with further supporting metrics covering the 8 Winter Domains. Adult Social Care Discharge fund agreed in December. • Strengthening of ICB and Place oversight and assurance arrangements linked to local escalation surge plans, and quality and performance frameworks. • Each acute provider has its own internal UEC improvement plan. • Please see Appendix B, slide 35 for detail of actions by Place.

UEC - Urgent 2 Hour Community Response





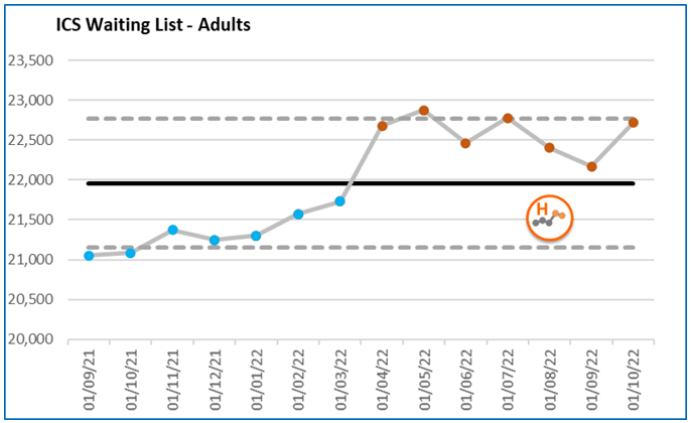


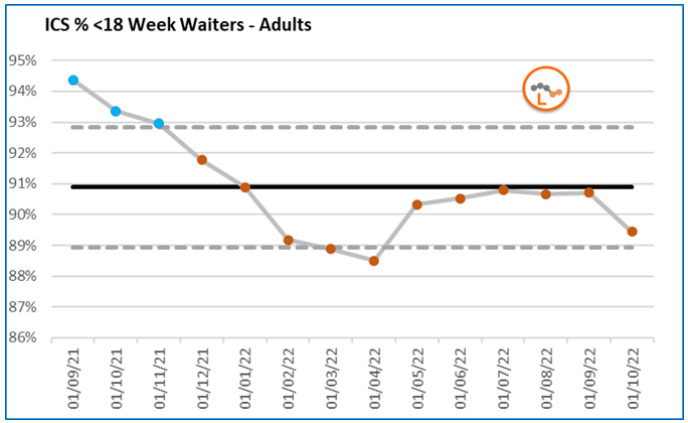
Activity	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
West Essex	289	353	468	465	428	337	451
East & North Herts	94	145	166	160	195	204	168
South & West Herts	147	142	157	162	165	124	163

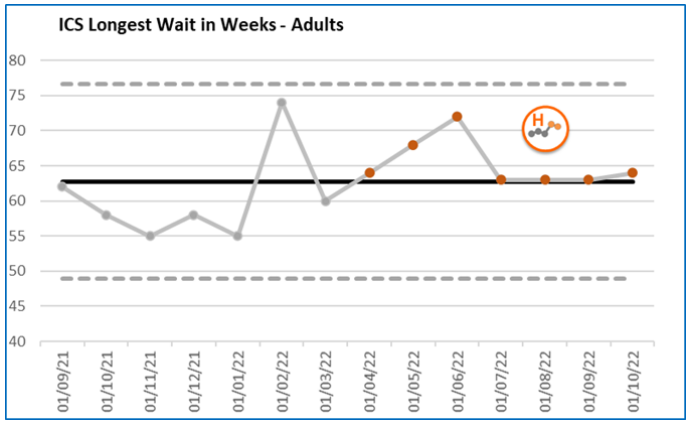
ICB Issues, escalation and next steps

- Improving or Common Cause Variation – no areas of concern
- Target being achieved in all three Places
- Provider BI leads have investigated the variances between West Essex and Hertfordshire activity and confirmed that the data is correct
- Service leads will undertake further work to understand the differences in activity levels by Place

Community Waiting Times (Adults)







		Patients Waiting			% waiting <18 weeks			Longest wait (weeks)			
Place	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ICS	Adults	22167	22719	↑	90.71%	89.44%	↓	63	64	↑	October

		Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	9976	10196	↑	86.63%	84.30%	↓	52	47	↓	October
ENH	AJM/Millbrook	358	353	↓	86.87%	79.60%	↓	63	64	↑	October
ENH	**All**	**10334**	**10549**	↑	**86.64%**	**84.14%**	↓	**63**	**64**	↑	**October**

		Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	CLCH	2493	2541	↑	90.13%	88.71%	↓	52	52	→	October
SWH	Connect	5871	5871	→	94.65%	94.65%	→	52	52	→	October
SWH	HCT	1045	972	↓	94.35%	96.09%	↑	41	43	↑	October
SWH	AJM/Millbrook	399	393	↓	84.96%	78.37%	↓	38	43	↑	October
SWH	**All**	**9808**	**9777**	↓	**93.08%**	**92.59%**	↓	**52**	**52**	→	**October**

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	EPUT	1894	2265	↑	100.00%	99.91%	↓	16	22	↑	October
WE	EPUT - Wheelchairs	131	128	↓	100.00%	99.22%	↓	17	21	↑	October
WE	**All**	**2025**	**2393**	↑	**100.00%**	**99.87%**	↓	**17**	**22**	↑	**October**

*** NOTE: Connect data has not been refreshed for October due to a data warehousing issue**

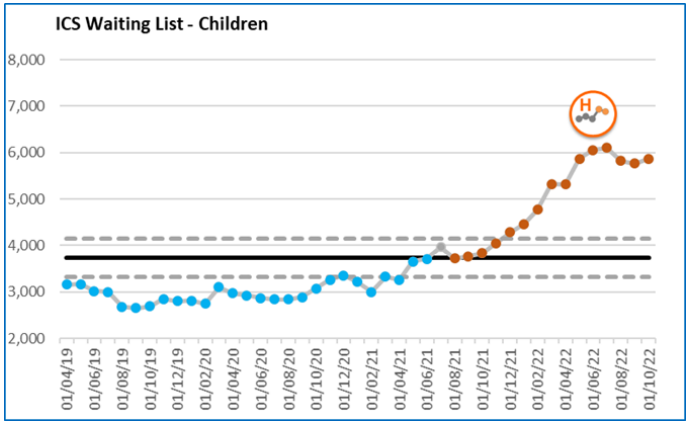
13

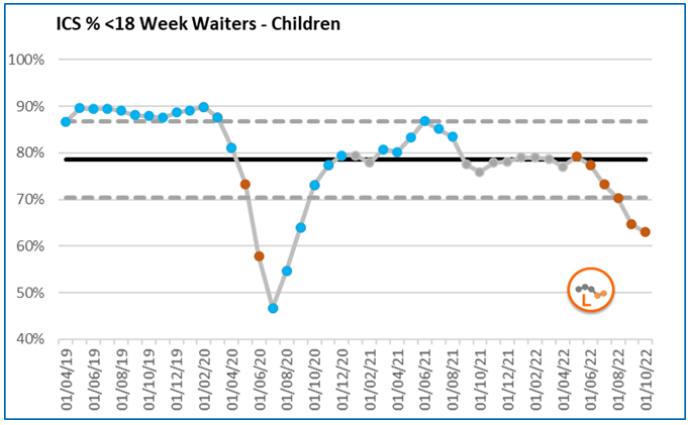
Community Waiting Times (Adults)

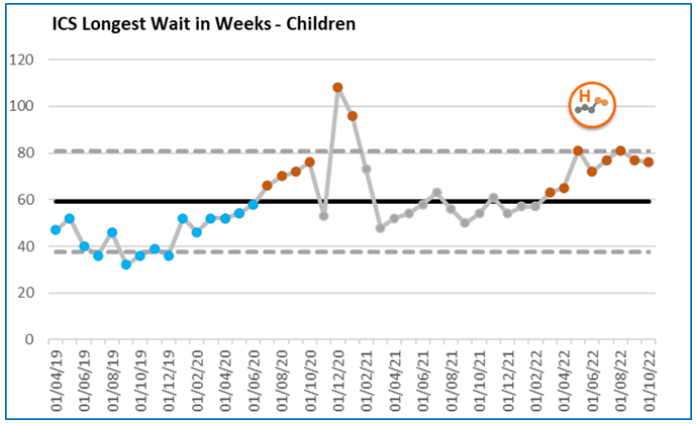
The NHS 18 week Referral to Treatment (RTT) standard only applies to consultant led services. For Adult community services this include Skin Health (ENH), Respiratory (S&W), and Podiatric Surgery (WE). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services are shown compared to an 18 week target for an overall view of waiting time performance. Full details of commissioned services in HWE is contained with Appendix D, slide 39.

ICB Area	What the charts tell us	Issues	Actions
ICB	• Overall, the total number of adults waiting on waiting lists remains statistically high. Across the system there were 552 more patients waiting in October than in September • Total patients waiting increased by 215 in ENH, and by 368 in WE • SWH waiting lists reduced by 31 overall. In particular, Community Neuro has made good progress to clear long waits. The longest waiter is currently at 52 weeks • The % of patients waiting less than 18 weeks shows a statistically significant trend of below average performance. October performance of 89.4% is the lowest since April 22 • There was a period of waiting time recovery in 2021, but this was followed by a sustained period of increased referrals • Consultant led 18 week RTT performance: ENH Skin Health – 91% SWH Respiratory – 74% WE Podiatric Surgery – 100%	Current referral rates are showing a pattern of statistical increase, demonstrating that there has been a sustained period of additional demand on adult community services. **East & North Hertfordshire (ENH)** • Waiting times for the Neuro Service in ENH remain below target, with referrals up YTD by 11% • Waiting times for the MSK Triage and Physio Service in ENH remain below target, with reduced activity compared to 2019/20 • Pain Management waiting lists and contacts have increased due to demand from Long Covid. Wait list performance is 39% lower than baseline **South & West Hertfordshire (SWH)** • Referrals have increased across multiple services • Staff sickness across some services has impacted wait times. However, this is now improving • Respiratory service currently holds the majority of long waiters. Demand cannot be met with current provision of consultant clinics **West Essex (WE)** • Whilst 18 week RTT was achieved, MSK services were breaching contracted standard in October due to workforce / recruitment issues	**East & North Hertfordshire (ENH)** • Neuro service has been reconfigured to increase capacity, with more virtual appointments and self-management • Increasing MSK Physio capacity though estates and recruitment. Also continuing to review pathways. MSK Triage piloting self booking for routine patients • Pain Management Service pilot screening tool agreed to assist with signposting on the Covid Rehab pathway. Anticipated to positively impact **South & West Hertfordshire (SWH)** • Continue to review respiratory long waits daily, prioritising those waiting the longest • Sourcing temporary Respiratory consultant capacity via bank and alternative Hospital Trusts • Continue to monitor long waits weekly **West Essex (WE)** • Vacancies in MSK services have been recruited to and performance has improved since October

Community Waiting Times (Children)







		Patients Waiting			% waiting <18 weeks			Longest wait (weeks)			
Place	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ICS	Children	5770	5868	↑	64.70%	63.04%	↓	77	76	↓	October

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	930	914	↓	75.48%	76.04%	↑	72	76	↑	October
ENH	AJM/Millbrook	84	91	↑	89.29%	78.02%	↓	43	48	↑	October
ENH	**All**	**1014**	**1005**	↓	**76.63%**	**76.22%**	↓	**72**	**76**	↑	**October**

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	HCT	4108	4158	↑	56.96%	54.28%	↓	77	75	↓	October
SWH	AJM/Millbrook	65	76	↑	78.46%	78.95%	↑	50	55	↑	October
SWH	**All**	**4173**	**4234**	↑	**57.30%**	**54.72%**	↓	**77**	**75**	↓	**October**

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	EPUT - Wheelchairs	33	34	↑	93.94%	97.06%	↑	27	25	↓	October
WE	HCRG/Virgin	550	595	↑	97.09%	97.98%	↑	26	46	↑	October
WE	**All**	**583**	**629**	↑	**96.91%**	**97.93%**	↑	**27**	**46**	↑	**October**

*** NOTE: Community Paediatrics data for ENH Place is not currently included in the above data. Development work underway with ENHT to include in future reporting**

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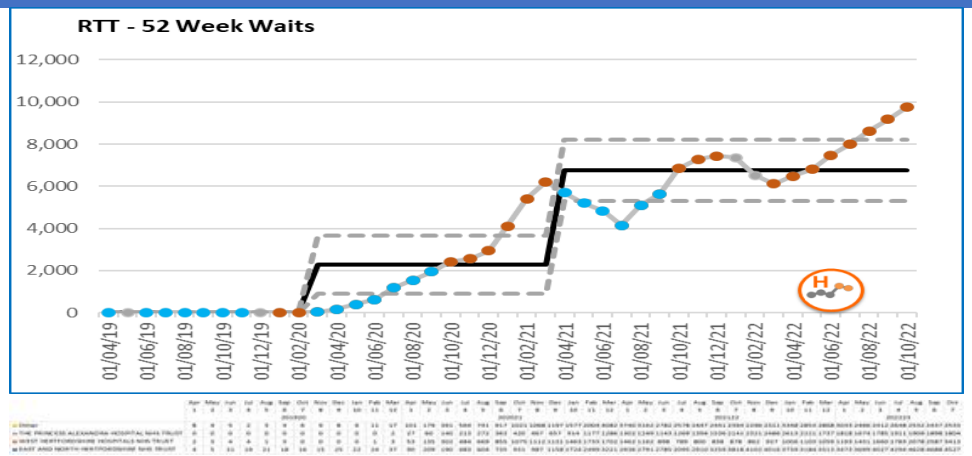
Community Waiting Times (Children)

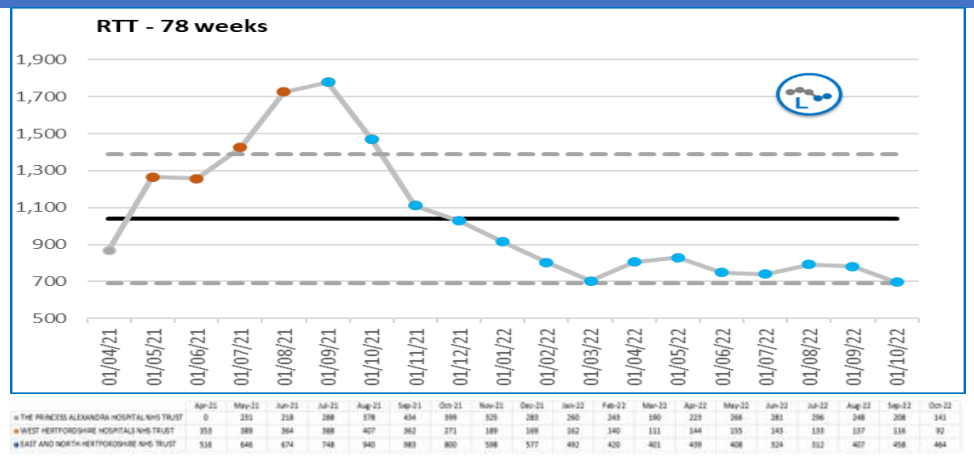
The NHS 18 week Referral to Treatment (RTT) standard only applies to consultant led services. For Children's community services this include Community Paediatrics (ICS wide) and Children's Audiology (SWH). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services are shown compared to an 18 week target for an overall view of waiting time performance. Full details of commissioned services in HWE is contained with Appendix D, slide 40.

ICB Area	What the charts tell us	Issues	Actions
ICB	• Overall, the total number of children waiting on waiting lists has increased. There are 98 more children waiting in October than in September across the system • The % of patients waiting less than 18 weeks is showing a statistically significant trend of decline since April 22. SWH performance is the most challenged, followed by ENH • There was a period of waiting time recovery in 2021, but this was followed by a sustained period of increased referrals • Current referral rates are showing a pattern of statistical increase demonstrating that there has been a sustained period of additional demand on children's community services • Consultant led 18 week RTT performance: SWH Community Paediatrics – 47% SWH Children's Audiology – 42% ENH Community Paediatrics – 73% WE Community Paediatrics – 93%	**Hertfordshire** • Waiting times across Hertfordshire for Children's Therapies (OT, Speech & Language and Physiotherapy) are below target • Waiting times in the SWH HCT Community Paediatrics service remains challenged. Referrals have increased by 27%, although service productivity has also improved - up by 28% • The Paediatric Audiology service in SWH remains challenged, with only 42% being seen within the target wait time **West Essex (WE)** • The most challenged service in WE is Community Paediatrics. Whilst still achieving the 92% standard, long waiters have increased, with one patient at 46 weeks in October. Indicative data for November shows improvement to c.97%	**Hertfordshire** • Children's Therapies – increasing capacity through recruitment, waiting list initiatives and outsourcing • Working closely with commissioners on wider improvements across Special Education Needs (SEN) / Education, Health & Care Plan (EHCP) processes • Community Paediatrics in SWH is receiving non-recurrent additional investment, increasing workforce capacity and introducing new specialist nursing posts. Risk remains on recruitment to these roles. Transformation Programme group established to take forward service redesign • Paediatric Audiology in SWH is focusing on higher priority appointments, especially follow up appointments. Signposting to interim advice whilst awaiting assessment. Analysis underway for workforce business case, as capacity is not currently sufficient to meet demand **West Essex (WE)** • WE Community Paeds Business Case approaching completion and will then progress through Place and ICB governance for review and decision

16

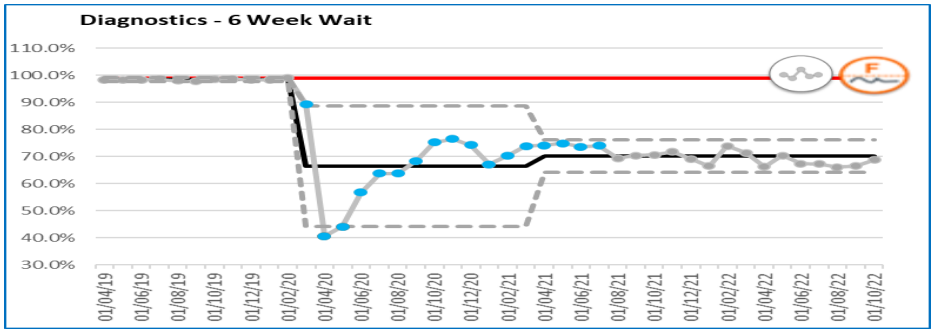
Planned Care – 52 & 78 Week Breaches

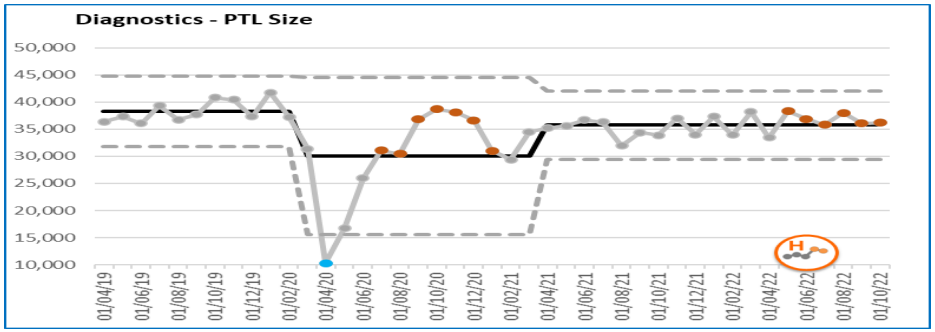




ICB Area	What the charts tell us	Issues	Actions	Mitigation
HWE	• No capacity breaches over 104 weeks • Continued overall improvement in number of patients waiting over 78 weeks however numbers have fluctuated across last 6 months • The number of patients waiting over 52 weeks continues to increase and remains a cause for concern	• Whilst there has been a reduction of longest waiting patients, not enough activity is being delivered to manage backlog effectively • 78 wks not projected to deliver '0' by March 23 • High referral volumes in early 21/22 now reaching their 52 week wait • UEC pressures impacting operating & bed capacity • Diagnostic waiting times • Staffing remains a challenge, particularly around anaesthetics • Lack of WLI additional capacity due to rate change • "Pop-ons" of long waiting patients identified through increased validation • Trauma and Orthopaedics, Gastroenterology and Community Paediatrics remain the main areas of pressure for long waiters	**Management of waiting lists:** • System focus on reducing number of patients waiting >78 weeks, with regional and national oversight; • ENHT has been de-escalated from Tier 1 to Tier 2 for 78 weeks with WHTHT remaining in Tier 1 due to data quality issues; • Demand, capacity & recovery plans in place with weekly specialty trajectories to monitor 78 weeks; • Weekly KLOEs in place with NHSEI to track 78 week position; • Fortnightly performance meetings with NHSEI support; • Validation and robust PTL management in place. **Increasing Capacity and Improving productivity:** • Pro-active identification of pressured specialties with mutual aid sought vial local, regional & national processes; • All providers signed up to Digital Mutual Aid System (DMAS) and have completed training; • Maximising use of ISP capacity and WLIs where possible • Community Paediatrics escalated to national level for mutual aid to support recovery; • Business case completed and going through ICB governance for a system high volume low complexity elective hub to add elective capacity from 24/25; • Mapping of elective programme in the UEC Winter Plan; • Theatre Utilisation Programmes in place; • Anaesthetist recruitment	• Actions delivering reductions in long waiting patients • National emphasis on prioritising patients in order of clinical need resulting in longer waits for routine patients • Clinical harm reviews and regular patient contact to manage patient safety and experience.

Planned Care – Diagnostics





ICB Area	What the charts tell us	Issues	Actions	Mitigation
HWEICB	• Some improvement seen this month, but 6 week wait recovery is fairly flat • Demand has increased between September and October and is a mix of Routine, Cancer and UEC • WHHT Imaging is performing well, with the exception of DEXA • PAH position is improved overall, particularly for CT. Endoscopy however is challenged • ENHT is performing well in Audiology and Cystoscopy, but Imaging is challenged • Physiological Measurement is challenged in all Places	• The biggest challenge remains workforce, particularly for DEXA, Audiology, NOUS and ECHO • Urgent/ Cancer referrals have increased and a review is being undertaken to understand if these are appropriate referrals. Initial work indicates they are • There is no additional revenue funding available for mobile units • ENHT have had issues in terms of estate and staffing for mobilising the CDC DEXA service • Staffing challenges have meant that the CDC NOUS service has not delivered the expected activity at the New QEII • Despite successful international recruitment of radiographers at ENHT and PAH, it takes time for onboarding and training to take place	• Over 8000 additional examinations have been undertaken at the New QEII CDC, with CT, MRI, X-ray and NOUS all performing above the revised trajectory • ENHT have an interim DEXA solution which will see activity increase in early 2023. Delay is due to staff training and sickness. WHHT are looking at insourcing and mobile options and will share resources with ENHT. Imaging Network also supporting looking at options to improve the DEXA position • PAH have recruited to a fixed term post and additional agency sonographers. NOUS position is looking better • iRefer CDS has been implemented at PAH and early signs are showing that it is having a positive impact • WHHT is working through internal governance processes to offer ENHT mutual aid for MRI • The system-wide diagnostic improvement plan was submitted in November to NHSE/I. This includes recovery trajectories for all challenged modalities. All modalities are expected to be DMO1 compliant by March 23 with exception of following challenged areas with longer recovery trajectories: Audiology, Non-Obstetric Ultra Sound, MRI (ENHT), ECHO (WHHT) and DEXA (WHTH and ENHT). • ENHT have commenced ECHO CDC services using an insourcing company; there was an issue with reporting but that has been resolved. This has seen an improvement in DM01 position. Activity is above revised trajectory. • There have been initial system-wide conversations regarding Audiology. Challenges are at PAH and WHTH. Initial actions are to review the ENHT service for learning, await analysis of the benchmarking data, and looking at mutual aid for PAH. WHHT has bid for 2 Audiology booths from underspend (1 x new and 1 x replacement) • The LOAs and MOUs for the CDCs have been received. Mobilisation can commence, but as PAH and WHHT will not be operational until late 23/24 this will not have an immediate impact. ENHT are due to submit a further business case for additional MRI at the CDC in 23/24	• CDC at ENHT is starting to see an impact on waiting times, but the service remains challenged due to staffing • WHHT are flexing their operational hours for each modality as and when required • PAH is using an MRI mobile unit on an ad-hoc basis to try and manage waiting times • System wide improvement plan finalised including trajectories for March 2023 ambitions

Planned Care – Theatre Utilisation

March 22

Theatres	ENH	PAH	W Herts
Utilisation - Capped	77%	62%	68%
Utilisation - Uncapped	80%	65%	77%
Average late starts (Minutes)	30	48	50
Average inter case downtime (minutes)	14	18	28
Average early finish (Minutes)	81	109	80
Average unplanned extensions (Minutes	30	61	96
Average cases per 4 hour session	2.6	1.8	2
BADS Day Case	79%	60%	71%

Source: Model Health System, NHSE & I

October 22

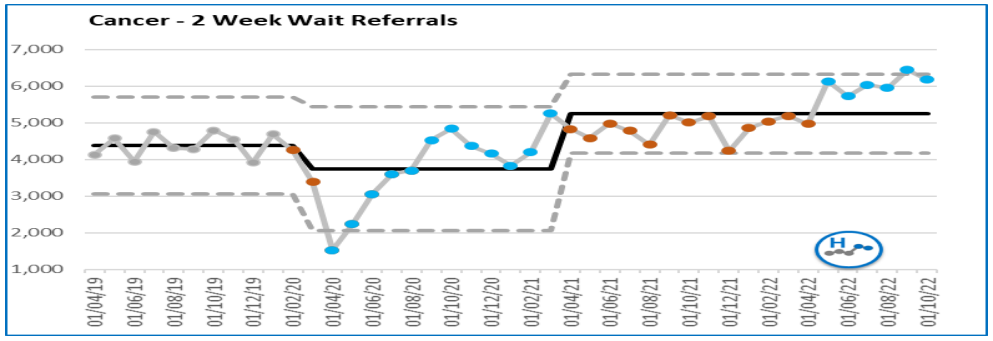
Theatres	ENH	PAH	W Herts
Utilisation - Capped	83%	69%	59%
Utilisation - Uncapped	85%	73%	62%
Average late starts (Minutes)	29	61	38
Average inter case downtime (minutes)	15	16	22
Average early finish (Minutes)	57	76	128
Average unplanned extensions (Minutes	32	51	125
Average cases per 4 hour session	2.5	1.8	1.7
BADS Day Case	83%	77%	67%

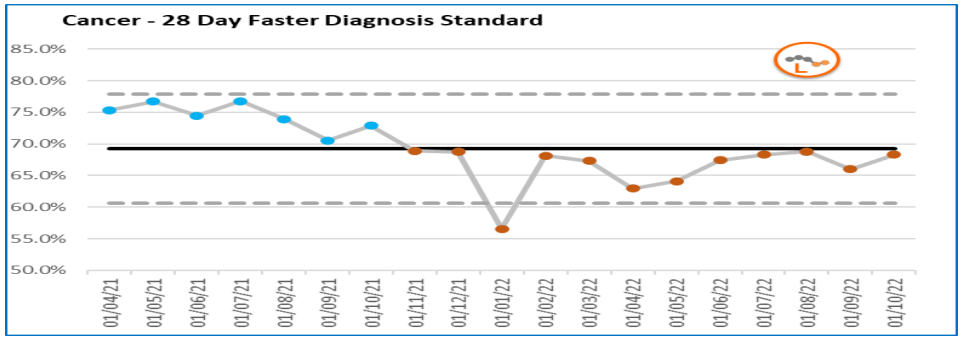
Source: Model Health System, NHSE (9/10/22)

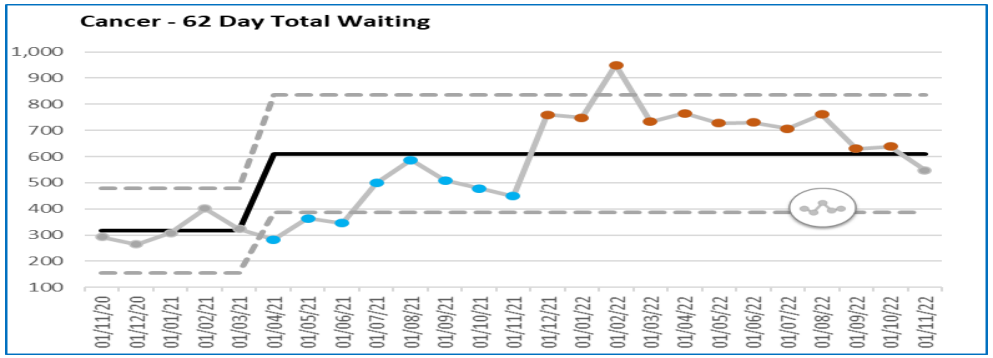
Worst quartile — Best Quartile

ICB Area	What the charts tell us	Issues	Actions
HWEICB	• Comparison of Model Hospital theatre utilisation data from March 22 to October 22, rag rated against quartile performance; • Both capped and uncapped utilisation has improved at ENHT and PAH but declined at WHTHT; • BADs Day Case Rates have improved at ENHT and PAH but declined at WHTHT.	• All Trusts need to further improve their theatre capped touch time utilisation to reach the 85% target • All Trusts need to further improve their BADs Day Case Rates to reach the 85% target • Self assessment of current status will identify specific issues and actions to form delivery plan	GIRFT High Value Low Complexity Targets (HVLC): 1. Theatres Capped Touch time Utilisation = 85% 2. Theatres Capped Touch time Utilisation for HVLC = 85% 3. BADS Day Case Rates = 85% • A system wide theatre efficiency and productivity group has been established which first met in December 2022; • The group will pull together the work programmes of each of the three providers which are already established; • The three focus points will be; delivery plan to improve compliance to the 85% target, a self assessment of the current status, and looking at right procedure, right place.

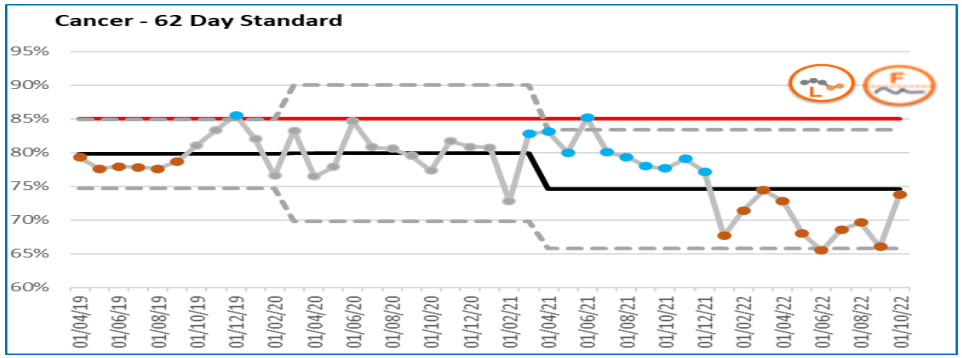
Cancer







	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	73	76	96	105	79	83	109	88	132	179	130	128	129	331	347	374	307	261	297	297	277	270	257	233
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	129	118	200	187	127	107	141	161	212	224	201	190	127	175	176	303	194	182	156	128	125	162	152	163
EAST AND NORTH HERTFORDSHIRE NHS TRUST	90	70	120	106	117	92	114	96	155	184	178	160	195	253	226	272	232	322	275	306	304	329	221	242



Cancer

ICB Area	What the charts tell us	Issues	Actions	Mitigation
West Essex / PAH	• 2 ww cancer referrals continue at significantly higher levels but saw a slight decrease in Oct • 28d FDS performance continues at improved levels in Oct, however delivery by March at risk • Following a dip in Sept 62 day performance remains below standard, but saw a significant improvement in Oct to 73.7% • Continued overall reduction in 62 day backlog; further work required to meet March 23 ambition of 427 – see slide 23	• Continued high referral levels • Cancer management, tracking and coding capacity • Urology, Lower GI, Skin & Gynaecology capacity – other tumour sites are achieving, or close to plan • Notable proportion of longest waiters are at tertiary centres	• Substantive Head of Cancer now in post • Pathway Transformation Manager has recently been appointed and will focus intensively on Urology in the first instance, then Lower GI • Rolling programme of Super PTL days is in place to target booking and validation on a service by service basis • Plans in place to maintain Christmas operating capacity • New Tele-Dermatology service is scheduled to launch in January	• System support and oversight in place with bi-weekly meetings • Weekly Key Lines of Enquiry (KLOE) process in place with Cancer Alliance • Cancer Harm Review process in place
South West Herts / WHTHT		• Overall there has been an improvement in cancer performance however delays in the 2 week wait pathway have affected performance against the 28 day faster diagnosis standard (63%) although this is better than last month's position (58%). • Increased level of referrals and workforce challenges are the main issues • Demand continues to outstrip capacity and remains a challenge to manage the new demand and backlog particularly in Breast and Skin for 2 week waits • Staffing challenges particularly in the Breast service • 62 day issues are due to slow diagnostic pathways and delays for outpatient capacity	• Trust moved out of Tiering system altogether (from Tier 1) with consistent improvement • Additional consultant posts (substantive + locum) for Upper GI, Breast, Radiology, Urology • Additional prostate template biopsy capacity created • Outsourcing (Gastro/Endoscopy, Breast, Prostate MRI capacity) • Nurse led clinics in Dermatology for imaging • Increasing straight to test (STT) pathways • Trust wide A&C recruitment events • Established a cancer long waits (90+ days) review meeting • Collaboration with PC to develop Breast pain clinic in community & continued roll out of dermoscopy • Breast 2ww referral form changes made to support demand • Substantive Lead for Cancer and Palliative care now in post • Continuation of the spotlight on cancer huddles and weekly cancer long waits reviews • Renewed focus on delays; clinical reviews and letter production • Dermatology advice & guidance service for lesions of diagnostic uncertainty launched	• Weekly Key Lines of Enquiry (KLOE) process in place with CA • All patients on PTL are tracked • Implemented clinical harm reviews for pts >28 days and diagnosed with cancer • Clinical review requested by MDT trackers and escalated to Divisional Directors • Current 62 day first performance is at 68% and an improvement from September • Good improvement in 62 day backlog, now with 9% of pathways over 63 days.
East & North Herts / ENHT		• Increased 2 ww referral levels and growth in PTL • Radiology continues to face major issues with capacity and staffing, likely to affect 62-day cancer performance and backlog for coming months • 31-day performance for Radiotherapy affected in September and October due to staffing issues; unable to recruit Band 6 staff • Histopathology challenges • Lack of WLI additional capacity due to rate change • Challenges with late referrals to ENHT as a tertiary centre impacting PTL waits >62 days	• Trust has been moved from Tier 1 to Tier 2 based on progress in reducing 62-day backlog • Histopathology and Radiology to improve MDT follow-up, reporting and more timely communication of diagnosis and next steps, particularly for patients who after diagnosis do not have cancer • Deep dives for tumour sites continue. Additional scrutiny and support leading to improved performance • Timed pathways now in place for all Tumour sites to improve and sustain 62-day standard • Work continues to improve and deliver the Faster Diagnosis Standard performance • Radiology and histopathology continue to prioritise cancer patients to avoid delays; offering WLI work to increase capacity • Team continue to analyse breaches by Tumour Site to identify issues and resolve pathway delays	• Weekly Key Lines of Enquiry (KLOE) process in place with Cancer Alliance • Fortnightly Tier 2 performance meetings and review of recovery • Robust weekly PTL management in place; clinical and operational review of patients waiting >62 and 104 days with clinical harm reviews in place

Performance v. 22/23 Operational Plans

Herts and West Essex Providers (please see Appendix C, slide 36 for performance by Place)

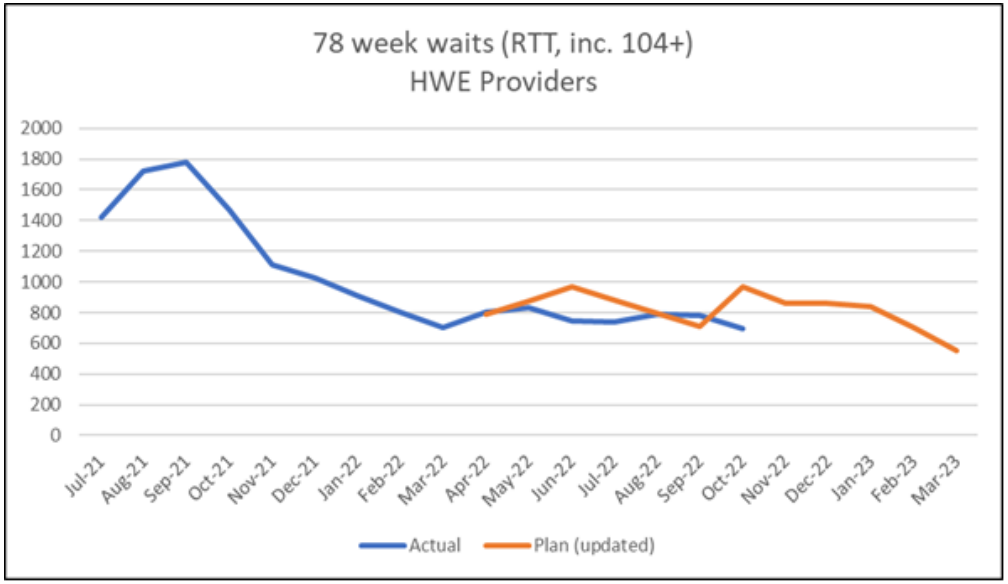
Baseline	22/23 Activity Plan	22/23 M1-7 Activity Plan	Area	Target
246,604	330,131	179,445	Activity	10% elective activity increase (19/20 levels RTT pathw ay)
	+34%			
N/A	0	2	Waitlist	104 w eek w aits eliminated by Jul 22 (w aitlist, end of Jun 22)
N/A	0	615		Eliminate 78 w eek w aits by Apr 23 (w aitlist, end of Mar 23)
6,109	6480	7174		52 w eek w aits trending dow n across 22/23
956,620	890,984	532,894	Outpatients	25% reduction in outpatient follow -ups by 2023
	-7%			
N/A	3.1%	1.5%		5% of outpatients moved or discharged to PIFU
8%	25%	25%		25% of consultations via video/telephone
N/A				16 specialist advice requests per 100 outpatient firsts
417,182	448,818	261,726	Diagnostics	20% increase in diagnostic capacity against 19/20 levels
	+8%			
289	267	418	Cancer	Reducing cancer 62+ day w aitlist to pre-pandemic levels
69%	69%	70%		Reduction in missed 28 day cancer decisions *(Measure is % decisions delivered in 28 days or less)*

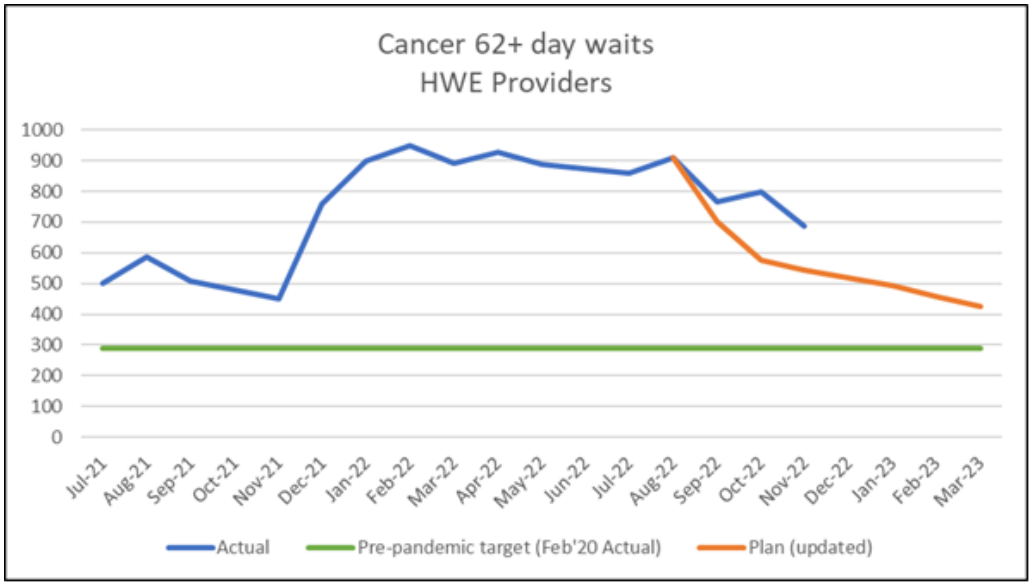
	M1-7 Actual							
	April	May	June	July	August	September	October	Total
Plan	16,815	19,497	22,586	30,620	29,143	30,317	30,467	**179,445**
Actual	16,815	20,581	19,866	18,336	18,833	20,939	21,207	**136,577**
Variance	0	1,084	-2,720	-12,284	-10,310	-9,378	-9,260	**-42,868**
Actual	124	77	35	15	9	5	4	**4**
Actual	806	829	748	741	792	782	697	**697**
Actual	6484	6804	7472	7988	8615	9173	9744	**9744**
Plan	72,089	76,682	73,718	82,239	74,852	75,573	77,741	**532,894**
Actual	70,256	79,357	72,553	71,481	72,114	72,555	72,864	**511,180**
Variance	-1,833	2,675	-1,165	-10,758	-2,738	-3,018	-4,877	**-21,714**
Actual	0.7%	0.9%	0.9%	0.7%	0.8%	0.8%	0.8%	**0.8%**
Actual	23%	22%	23%	23%	20%	21%	21%	**22%**
Actual	25	25	26	28	27	25	22	**26**
Plan	33,749	36,708	35,018	39,879	37,842	38,186	39,654	**261,036**
Actual	30,029	33,868	31,968	32,034	33,068	32,603	32,543	**216,792**
Variance	-3,720	-2,840	-3,050	-7,845	-4,774	-5,583	-7,111	**-44,244**
Actual	928	887	875	860	911	767	798	**767**
Actual	61%	62%	66%	68%	68%	65%	68%	**66%**

ICB Issues and escalations

- Activity significantly off planned levels for both elective and diagnostics (as seen nationally);
- Revised recovery trajectories agreed with NHSE/I and planning submissions updated;
- Good delivery against patients waiting over 104 weeks, with remaining patients a result of choice;
- Patients waiting over 78 weeks continues to reduce and whilst is not forecast to deliver zero by March 23, is currently ahead of revised trajectory – see next slide;
- 52 week waits are increasing and remain a significant area of concern;
- Overall, remain on track with Out Patient programmes of work;
- Cancer backlogs have reduced, however further work required to reduce to the revised March 23 ambition of 427 – see next slide.

Performance v. 22/23 Operational Plans

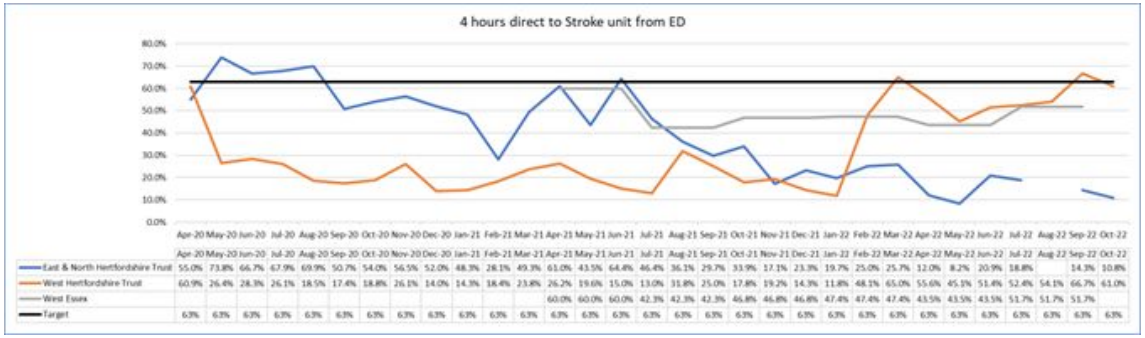


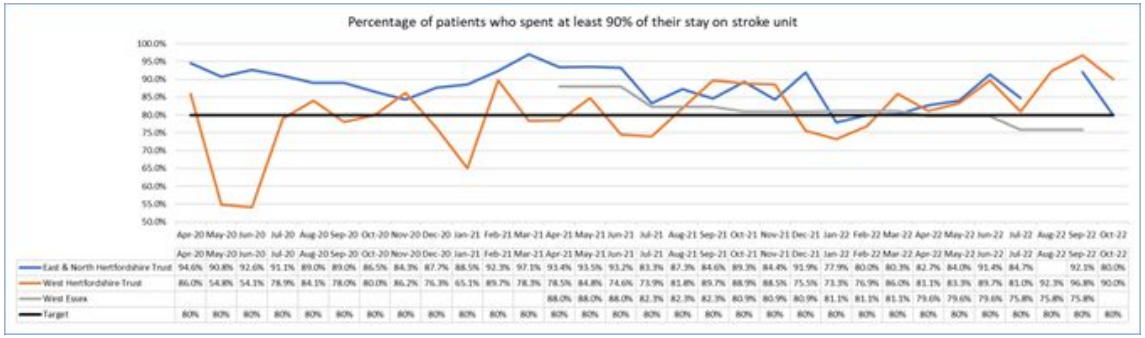


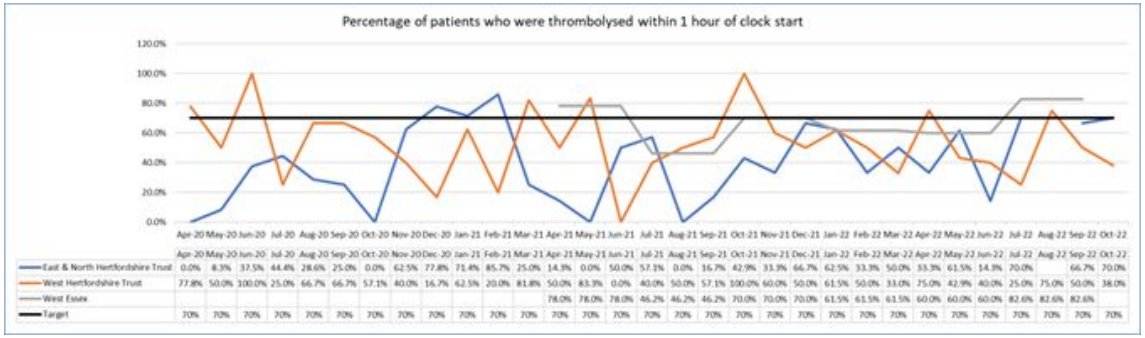
ICB Issues and escalations

- 78 week activity is currently ahead of revised plan, with the number of patients continuing to reduce overall;
- Cancer 62 day backlogs are reducing, however further work is required to reduce to the revised March 23 ambition of 427, with activity currently behind plan. Delivery of 62 day backlog trajectory in March 23 is at potential risk.

Stroke







ICB Issues, escalation and next steps

West Essex:

Barking, Havering and Redbridge Trust (BHRT) is the main provider of Stroke for West Essex patients. Reporting remains on a quarterly basis via the national SSNAP database.

- Q2 saw an 8% improvement in 4 hour admission performance, and thrombolysis performance improved by over 22%
- West Essex Stakeholder Programme Meeting scheduled for January. PAH / BHRT / EPUT
- T&F group established to review the pathway between PAH and Queens. Specific concerns re staffing to meet HASU standards, and increased DNAs from patient reluctance to travel
- Stroke Association contract extended to March 23. Business case to be presented to January Transformation Committee for approval to commence procurement
- ICB Squire and Catalyst funding bids successful

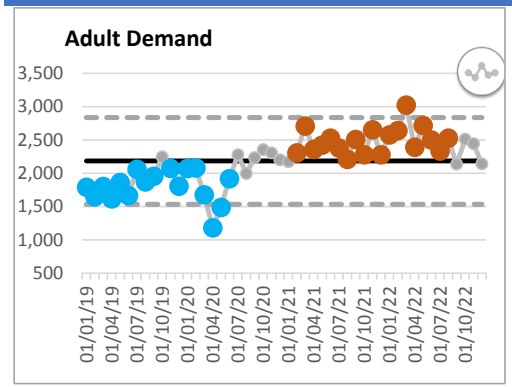
Herts (note: awaiting clarification of Aug 22 data):

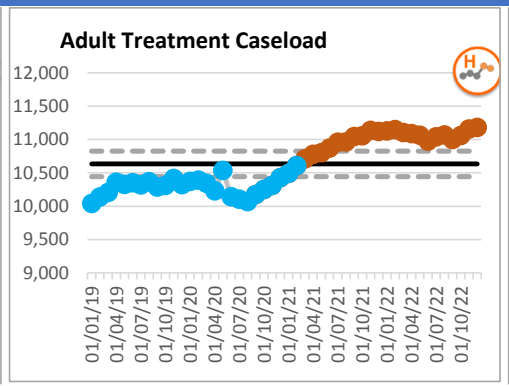
Performance continues to meet standard for the percentage of patients who spent at least 90% of their stay on a stroke unit, at 90% in WHTHT and 80% at ENHT in October. Performance further declined at WHTHT against the percentage of patients who were thrombolysed within 1 hour at 38% in October but returned to meet standard at ENHT at 70%. Performance remains below standard for 4 hours direct to stroke unit from ED at both Trusts, however WHTHT have seen an improvement in performance at 62.8% in October with ENHT performance further declining to 10.8% in October.

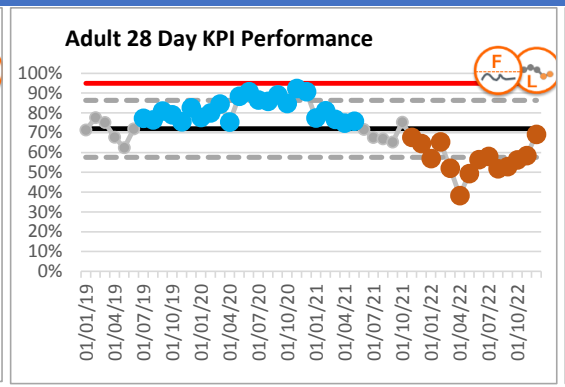
Next Steps

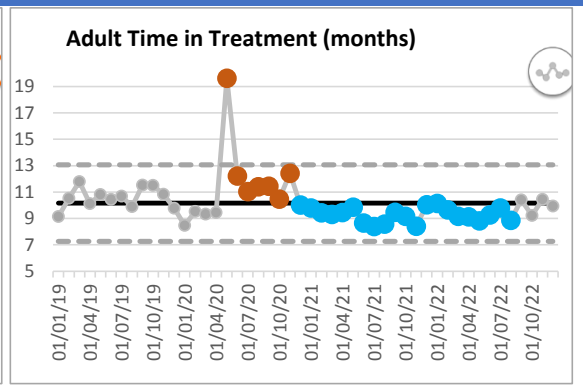
- WHTHT are undertaking a review of the noncompliant patient pathways to understand themes which need to be addressed. Maintaining ring fenced beds on the HASU and a ring-fenced side room for patients requiring thrombolysis whilst awaiting swab results. A review and validation of the reasons patients were not thrombolysed within the one hour window, was undertaken which showed clinical factors and complexity on presentation.
- WHTHT are working to their SSNAP improvement plan in response to their ISDN SSNAP review. This focuses on improving KPIs around access to MRI, reporting of CT Angio and workforce issues. Improvements have been made in access to MRI for people with suspected TIA.
- ENHT Stroke team are working with ED and external ICS working group on pathway review to support Stroke pathway from admission to discharge.
- ENHT have ringfenced Stroke bed capacity increasing it from 3 to 4 beds.

Mental Health – Adult Services



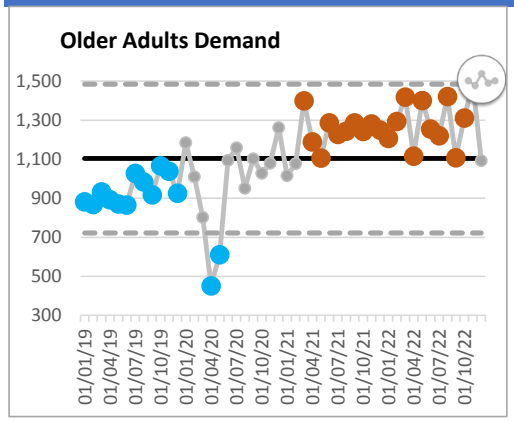


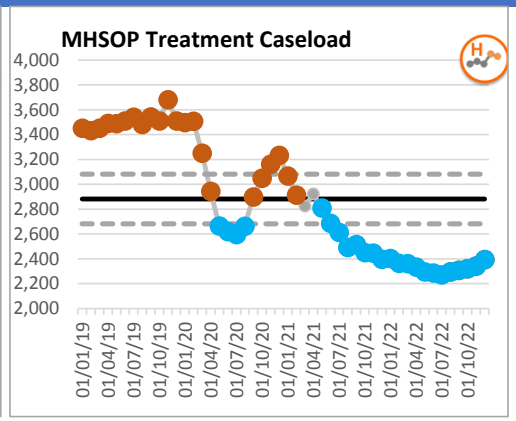


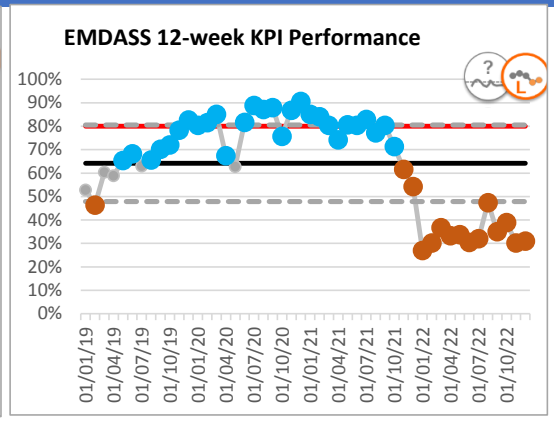


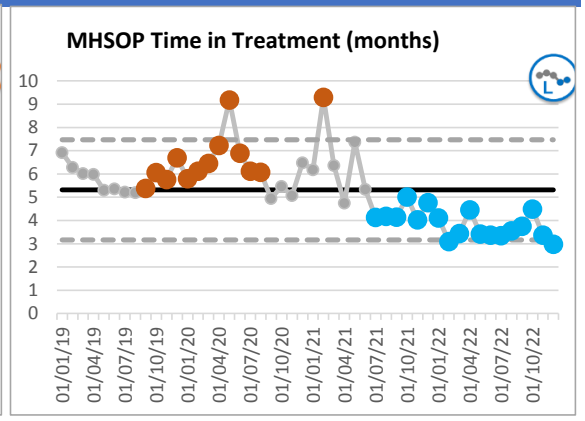
ICB Area	What the charts tell us	Issues	Actions	Mitigation
Adult Community Mental Health Services (HPFT and EPUT)	Referral demand has been on long term upward trajectory in the post pandemic period, however in Q3 referral demand has levelled off. There are 800 more service users in treatment now than there were at the start of the pandemic. The time it takes from referral to assessment has improved over the last quarter but we are still not meeting our 28 day assessment targets across the ICB.	Sustained high demand has resulted in a waiting list for HPFT's initial assessments, with high levels of vacancies in some teams, where recruitment is particularly challenging. In Dec 95% of service users were assessed within 48 days of referral, which is an improvement from Q2 (56 days). Sickness rates in December along with regular winter pressures have seen staff shortages compounded.	Agency staff recruited, who are currently undertaking additional assessments every week. Additional administrative support extended to community mental health teams to improve efficiency and responsiveness Commissioned external process efficiency consultant (LEAN) to optimise current processes Out of hours clinics to provide extra capacity from substantive staff and make access easier for service users	Flow continues across the adult community pathways with 95% of service users being seen within 48 days. Community Transformation continues to see more service users in primary care. Recovery for performance is expected in Q4 2022/23.

Mental Health – Older Adults Services



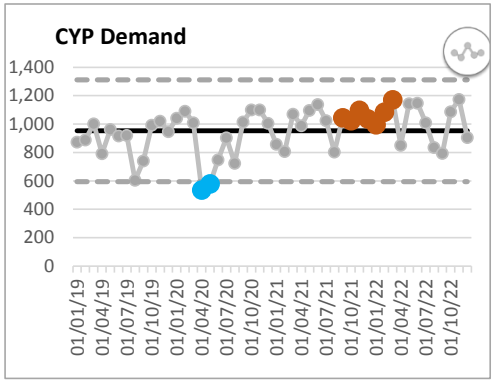


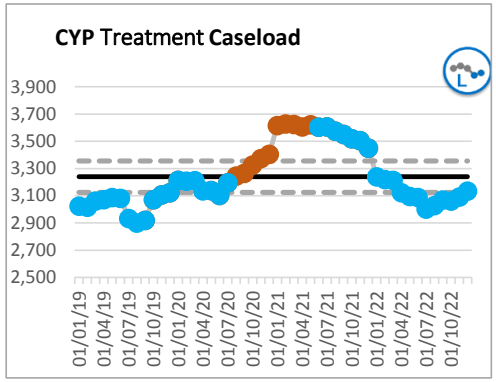


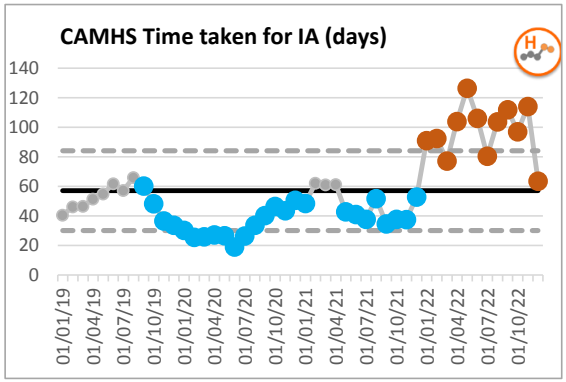


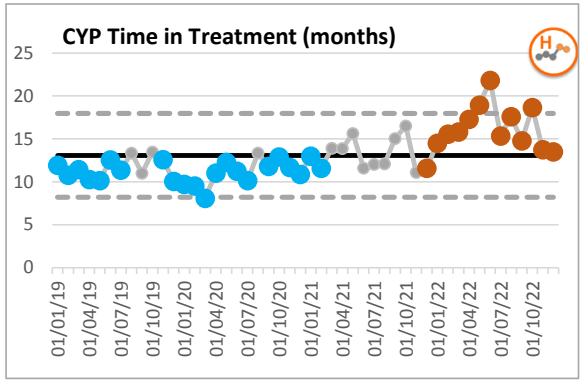
ICB Area	What the charts tell us	Issues	Actions	Mitigation
Older Adult Community Mental Health Services (HPFT and EPUT)	Increase in referral demand since Jan 2021 was initially due to suppressed demand during COVID and has continued to remain high. Increase in older population in Harlow + Uttlesford compared to national data. New partnership working arrangements with Alzheimer's UK has led to a reduction in overall caseloads in MHSOP in Herts. In Herts the EMDASS service was temporarily halted due to re-deployment of staff over the winter in 2021-2 which led to a backlog of diagnosis. Overall time spent on treatment pathways has stayed the same.	Not meeting access standards for referral to diagnosis for Dementia (EMDASS) Recruitment vacancies for Consultants, Registered Nurses, OT's in West Essex – impact Occupational Therapists Access to specialist brain imaging/scanning in West Essex	Recovery programme activity for EMDASS diagnosis service – expected to recover in Q4 West Essex International Recruitment programme; challenges around recruitment remain but not impacting on delivery of dementia diagnostic and treatment pathway Future expansion of community diagnostic capacity across ICB is being mobilised Targets being achieved in West Essex, with best practice to be shared across the system	Risk review and prioritisation for service users who have been waiting Additional clinics for evening and weekends to improve waiting times Primary care dementia diagnosis nurses improving activity with a focus in West on care home population. EMDASS recovery is planned for Q4 2022/23 but delivery at risk of slippage to Q1 23/24

Mental Health – CAMHS Services



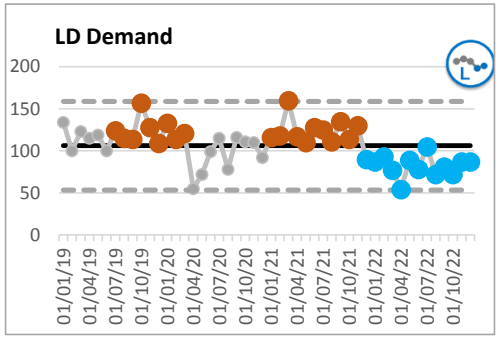


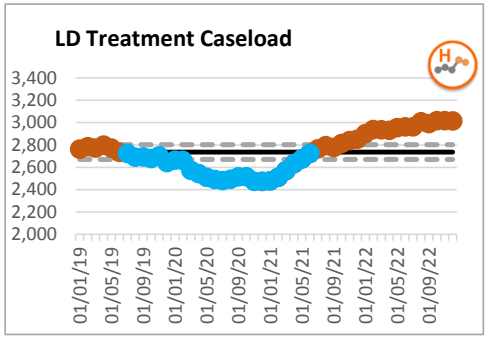


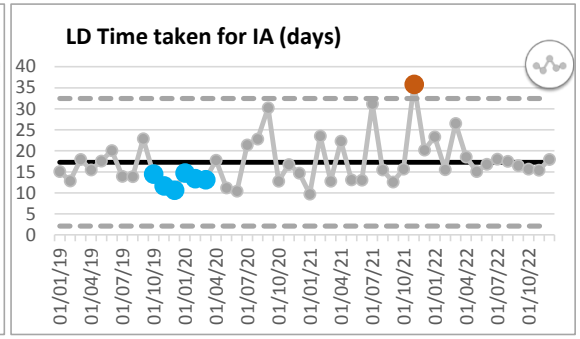


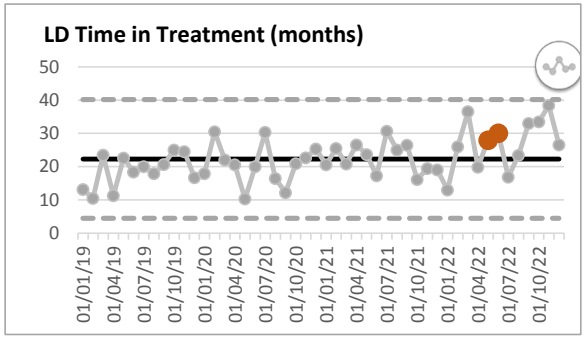
ICB Area	What the charts tell us	Issues	Actions	Mitigation
CAMHS (Herts and West Essex; HPFT and the Collaborative, HCT data to be added Q4)	Referrals into CAMHS have passed 1,000 per month over the last 12 months (20% up from pre-pandemic levels). This has translated to pressure on initial assessments but has not yet converted into increased caseloads in CAMHS. From Jan 2022 we have not met the performance KPI for initial assessments (Choice) Length of time from referral to discharge has grown by 5 months over the last year from a mean of 12 months to 17 months. This may be an indication of increased acuity.	Referral demand has led to an increase in the number of triage activity we need to provide in the single point of access. ADHD referrals are now beginning to flow through secondary mental health services into the newly commissioned primary care ADHD service. Some services have seen unexpected demand (e.g. Tier 3 Specialist CAMHS ED, Crisis, and Looked after children).	Recovery programmes for CAMHS ED, CAMHS Targeted and CAMHS crisis have completed in Q3 in line with projections. Recovery programme remains in place for CAMHS 28 days, due to complete in Q4 2023 Mobilisation and implementation of the new CAMHS ADHD service underway in Q3 and the first 100 cases transfer to primary care in Jan 2023. HCT's Data to be integrated in Q4 report	SPA Triage Tool improved to meet 5 day pass on to teams undergoing testing Job planning to continue in all quadrants to ensure qualitative approach Demand and capacity review commissioned to assess post-covid requirements in Q4. Recovery for referral to assessment times to 28 days expected in Q4 2022/23

Mental Health – Learning Disabilities Services



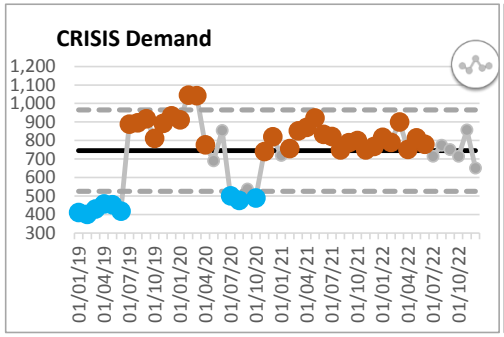


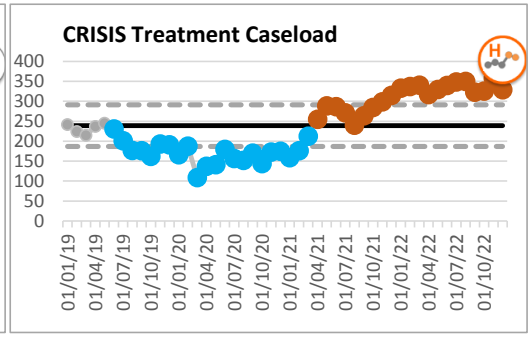


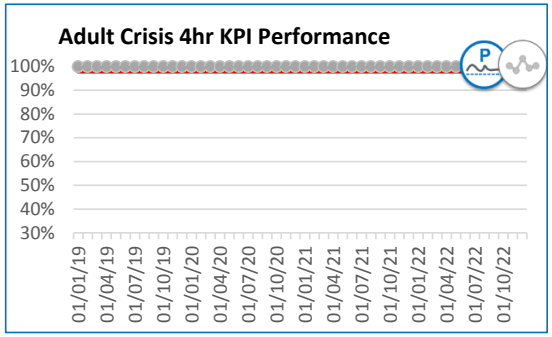


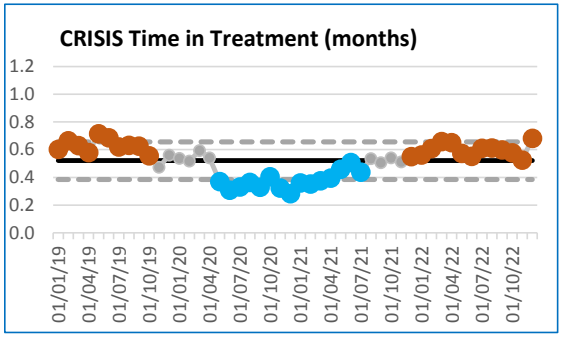
ICB Area	What the charts tell us	Issues	Actions	Mitigation
Learning Disabilities Service (Herts and West Essex)	Referrals and caseloads services dropped during Wave 1 and Wave 2 of the pandemic but have returned to pre-pandemic levels. Service Users are seen consistently within 28 days of referral and the average time it takes from referral to a completed assessment is 17 days	Successful re-integration of LD services in Essex enabling further opportunities for integrated learning and service delivery. Since the integration of Essex LD there appears to have been a growth in treatment caseloads. This is to do with data integration issues rather than a rising increase in actual cases.	Data cleansing programme in place to address post migration data cleansing issue in Q4. New service user and carer engagement and involvement programme aimed at improving care planning, service delivery and outcomes for LD service users across Herts and Essex.	Focus on reducing secondary waits and care co-ordination and risk management during wait periods. Working with commissioners ensure that GPs are aware and know how to refer directly into LD services

Mental Health – Non Inpatient Urgent Services



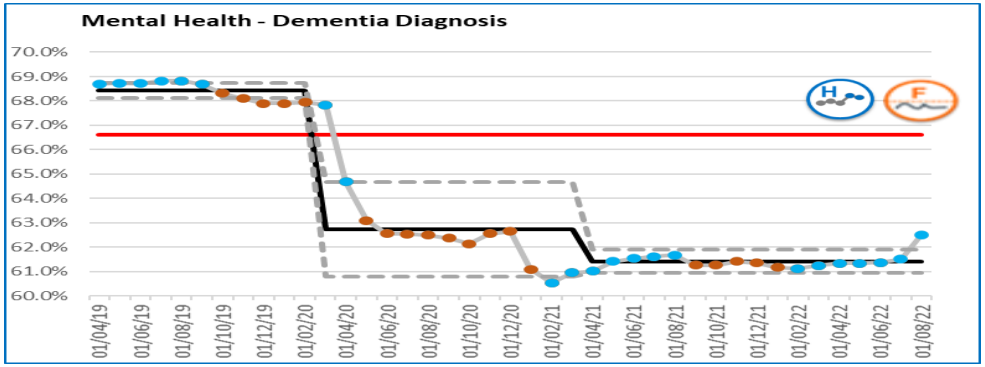


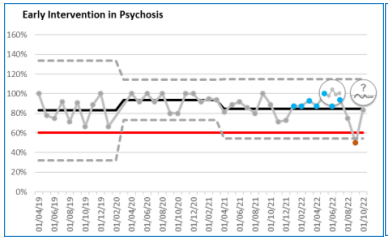




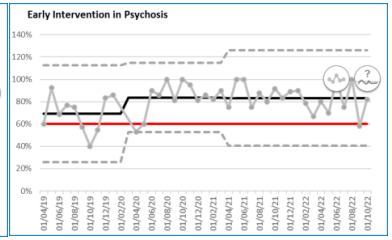
ICB Area	What the charts tell us	Issues	Actions	Mitigation
Crisis Services – Adults and Older Adults (HPFT Herts only, EPUT to be added Q4)	Crisis demand peaked in the 6 months following Wave 1 and Wave 2 of the pandemic. Demand levels did not grow in Q3 however the current crisis referral level is almost 100% higher than pre-pandemic. Caseloads are on high against historical baselines which reflects an increase in service user need and complexity. Service Users are seen consistently within 4 hours of referral and the average time under caseload management in the Crisis and Home Treatment Team is 1 month Note: In Essex, Crisis teams do not own team caseloads in favour of being an extension of the community team. Home First Team data to be added.	High demand and turnover on the Crisis and Home Treatment Team (CRHTT) led to pressure on the service.	Rolling recruitment and training for CRHTT has led to three new appointments in Q3. West Essex Home First Team data to be added for Q4	Agency support for Community Team releasing staff stepping up into CRHTT roles. Crisis teams expected to be fully recruited by end of Q4 2022.

Mental Health – Dementia Diagnosis and Early Intervention in Psychosis (EIP)

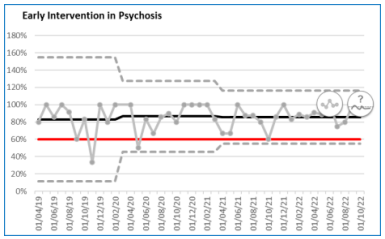




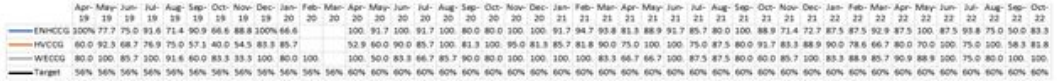
East and North Herts



South and West Herts

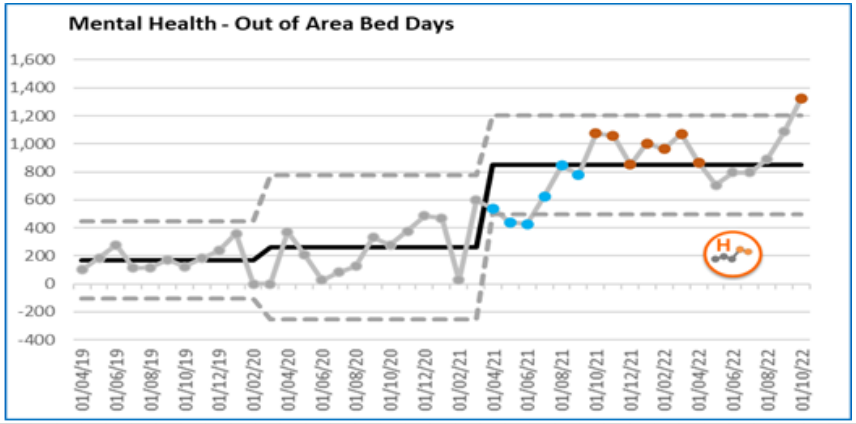


West Essex



ICB Area	What the charts tell us	Issues	Actions	Mitigation
West Essex / PAH	• Recorded Dementia Diagnosis September 2022 will be the last monthly publication in this series until early 2023. This is due to a change in the national data collection for these publications.	**Dementia Diagnosis Herts** • Recovery action plan agreed, actions commencing January 2023 • Data capture and coding • Staffing: Three of the four Dementia Specialist Nurses Recruited, who will be working at the Primary Care Services for older people	**Dementia Diagnosis Herts:** • Enhanced Commissioning Framework (ECF) for GPs to complete coding exercise to capture true diagnosis rate. Admin role in Primary Care Diagnosis Service to free Nurse Specialists . Practice Data reviewed monthly to target support. Focus on physical LTC - respiratory, MSK and older people **EIP:** • Work continuing to collate data at ICS level for SPC presentation in next report	**Herts:** • Continue with current actions to increase access to Dementia Diagnosis and IAPT services • Dementia Diagnosis actions will deliver recovery on trajectory by 2023/24 • Bring Recovery Action Plans into one forum to ensure central oversight • Support around identifying causes of low conversion rates at memory clinics and understanding/incorporating demographics such as age, deprivation, Etc. into the estimated prevalence figures that Herts are trying to meet
Herts	• ICS performance improved in August to 62.5% and the 66.6% standard continues to be met in West Essex. • The EIP national standard is being achieved in all three Places.			

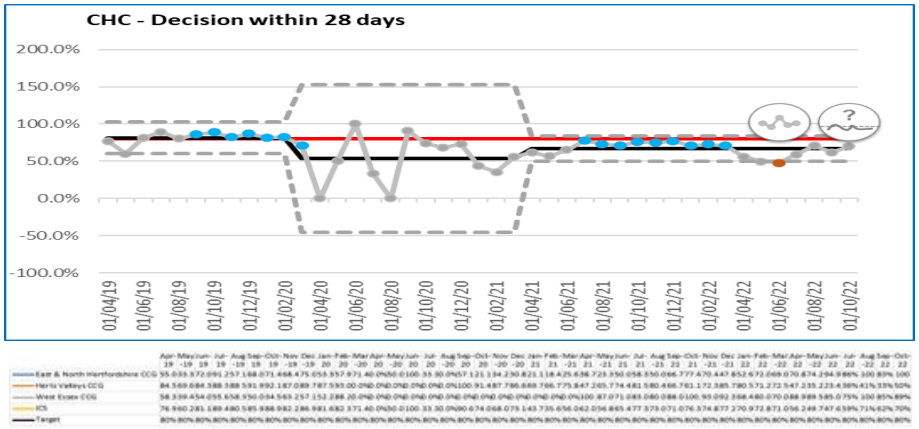
Mental Health – Out of Area Bed Days

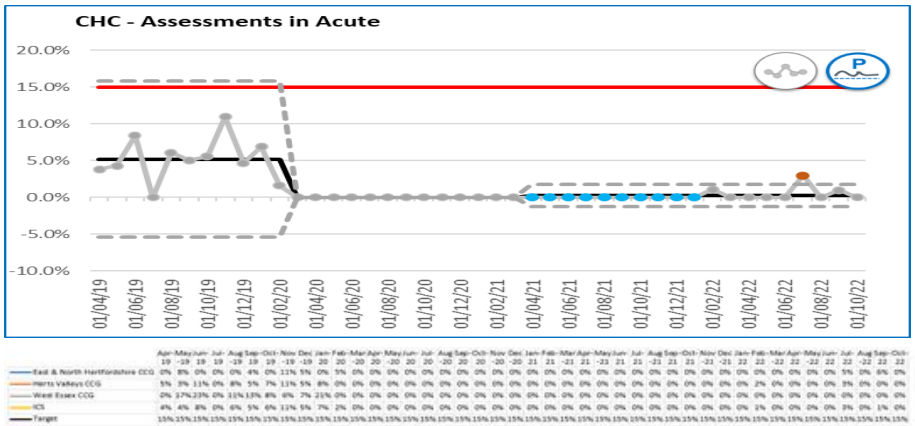


	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Hertfordshire	100	185	277	114	118	172	124	182	239	360			372	207	26	83	125	331	277	376	486	471	26	596	452	337	336	574	834	759	936	745	674	779	830	987	767	691	775	757	817	1034	1177
Hertfordshire Target	66	132	200	58	116	175	50	100	150	42			33	33	34	20	20	20	10	10	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
WECCG																									86	102	90	51	12	22	140	314	177	225	134	83	100	16	21	38	76	55	145

ICB Area	What the charts tell us	Issues	Actions	Mitigation
West Essex / PAH	• Out of Area Bed Days for West Essex increased considerably in October • A further rise is expected in Nov, however indicative data for Dec shows a significant improvement	• Pressure for Mental Health beds has increased substantially over the Covid, and has continued post-Covid, leading to a national shortage of beds, high occupancy rates and use of OOA beds	• SMART (Surge Management and Resilience Toolset) - providing real time ward data • Essex review of bed model and stock. Essex commissioners meeting to review outcomes in January • Multi Agency Discharge Event (MADE) scheduled for Jan	Out of Area Placement (OOAP) Elimination & Sustainability Impact System Group (Essex wide) in place to monitor the impact of the NHSE OOAP Action Plan.
Herts	• Continued increase in Out of Area Bed Days in October 22.	• Low number of beds per population • Pressure for MH beds increased substantially over Covid, and has continued post-Covid, leading to a national shortage of beds, high occupancy rates and use of OOA beds and this is likely to continue into Q4 2022/23 • Challenges in finding suitable placements for service users with complex needs • Ongoing refurbishment in Kingfisher Court resulting in closure of 2 beds	• Reduce admission through gatekeeping • Adopt purposeful Inpatient Admission Model • Daily OOAP reviews /dedicated clinical ownership for OOAPs • Reviewing what other areas are doing I.e. voluntary service input to pathways. Review community demand and capacity, to avoid admissions • Multi Agency Discharge Event (MADE) took place in November	Continue to engage with additional expertise as part of the national Getting It Right First Time programme to identify areas of improvement. • Bed management system New arrangements in place to monitor demand and capacity. In addition, new standard operating procedures in place to tighten standardise practice. • Integrated Discharge Team approach is being scoped out in Herts to improve coordination of discharges

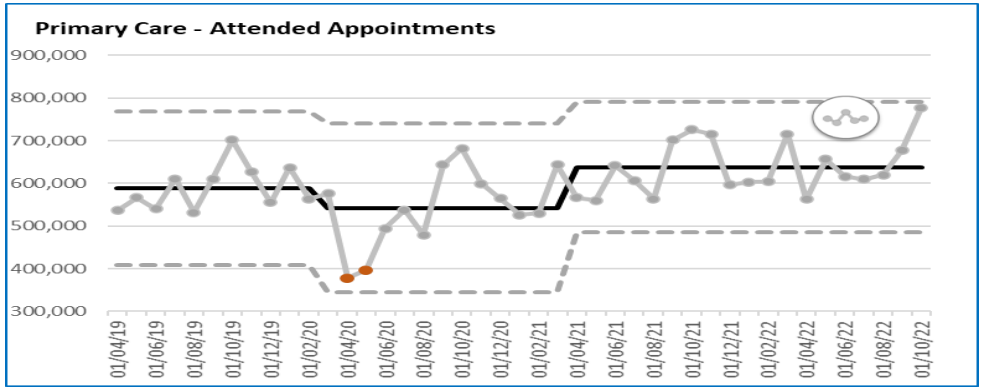
Continuing Health Care (CHC)

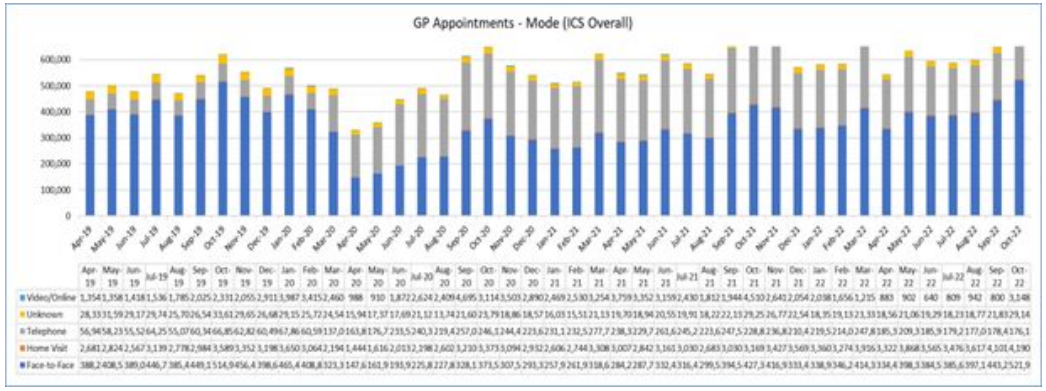




ICB Area	What the charts tell us	Issues	Actions	Mitigation
West Essex / PAH	• 100% of CHC referrals in West Essex resulted in a decision within 28 days, surpassing the standard of 80% • No patients received assessments in an acute setting	• 80% standard is unlikely to be reached in December due to a lower than expected volume being processed. Community Teams and staff vacancies continue. • Delayed allocations of Social Workers from out of area, particularly from London Boroughs. • Ongoing increasing backlog of CHC, FT and FNC reviews due to prioritising new assessments.	• The West Essex CHC Team continues to work alongside EPUT to provide additional resource and support. • The team is confident that Quarter 3 performance will be achieved. Recruitment for vacancies ongoing. 1 nurse recruited in the last round of interviews. • New reviews project about to commence to try and reduce increasing backlog.	• SWH action plan in place, supported by NHSEI • Performance standards continue to be monitored, issues escalated and risks mitigated • Agency cover requested for vacancies whilst recruitment continues • Setting trajectory and drive on clearing cases over 28 days
South West Herts / WHTHT	• Performance against decisions within 28 days remains below the expected 80%; however improvement continues, reaching 63% in November. • No patients received assessments in an acute setting	• Workforce issues, recruitment • Ongoing backlog of CHC & FNC reviews due to prioritising new DSTs • Referrals numbers continue to be high • Workforce issues including long term sickness absence in place-based senior leadership.	• Recruitment drive continues, interim cover in place to support the gaps • Prioritisation of fast track and 1:1 reviews. • Allocation and weekly tracking of 28 day assessments remains a priority • Case management in place for all cases over 6 weeks • Collaborative working with system partners; weekly meetings with LA • Face to face Nursing needs assessments are completed and evidenced. • Support/cover from senior leaders within the other two place areas	
East & North Herts / ENHT	• 100% of CHC referrals in East & North resulted in a decision within 28 days. • No patients received assessments in an acute setting	• Workforce issues such as sickness and annual leave • Ongoing delays receiving signed assessment paperwork from community, particularly Mental Health, may impact performance going forward	• The Team is confident that Quarter 3 performance will be achieved. • Weekly tracking of referrals over 28 days by caseload and CHC manager • Performance levels expected to be achieved in July	

Primary Care





ICB Area	What the charts tell us	Issues	Actions	Mitigation
ICB	• Total number of GP appointments decreased slightly in June and July, likely reflecting seasonality. Total appointments increased in August and again significantly in Sept and October • Proportion of face to face appointments continue to increase, reaching 67% of total attended appointments in August and over 70% in October and November	• General Practice continues to see increases in demand against a backdrop of working through the backlog, workforce pressures and negative media portrayal • Significant pressure from Respiratory illness • Rapid increase in 'spot booking' hotels set up without notice by Home Office to house asylum seekers with significant health need including scabies and diphtheria outbreaks	• Continue to implement actions funded through the Winter Access Fund, including advanced telephony and offsite storage of notes • An MDT group has been established to review the National GP Patient Survey (GPPS) data, and to develop an access framework and work programme • Working closely with BI team to develop an access dashboard for better monitoring of pressures • Primary Care Commissioning Committee (PCCC) has approved ICB funding to support additional capacity in general practice over winter. Funding level is the same as last year at £1.43 per weighted patient • There is national repurposing of Investment & Impact Fund monies to support additional capacity • Acute Respiratory Infection hubs set up to assist with system pressures and minimise flow back to General Practice from 111 and ED • Enhanced Commissioning Framework re-prioritised to assist with practice capacity	• Continue to support return of business as usual to General Practice through the relaunch of the ECF across the ICB, supported by investment • Continue to monitor access trends in the 3 places and to pick up individual practices with poor access through complaints and patient contacts • PCCC and Primary Care Board oversight of the GPPS results, and action plan developed through the Access MDT Group • Recruitment & Retention of Primary Care Workforce – a number of initiatives are offered to the Primary Care Workforce to support recruitment and retention which are supported by the HSE ICB Training Hub • Funding for spot booking hotels for health checks and MDT site visits agreed by PCCC until end March 23 • Daily review of OPEL reporting by practices and follow up by place Primary Care Teams with individual practices

Appendix A – Performance Dashboard

October 2022

Herts & West Essex ICS (Commissioner)

Area	Activity	Target	Latest published data	Data published	Trend *1	Variation	Assurance	National position (ICB vs National)	Regional position (ICB vs EoE Region)	ICB Ranking
111	Calls answered < 60 seconds	95%	51.8%	October 22	-35.63%			44.8% (Better)	50.8% (Better)	18th highest
	Calls abandoned after 30 seconds	5%	10.0%	October 22	50.34%			12.9% (Better)	9.7% (Worse)	15th highest
A&E	% Seen within 4 hours	95%	59.1%	November 22	-3.93%			68.9% (Worse)	65.7% (Worse)	6th lowest
	12 Hour Breaches	0	192	November 22	-76.04%			37,837	3,134	8th highest
Cancer	2ww All Cancer	93%	77.2%	October 22	7.62%			77.8% (Worse)	72.4% (Better)	26th (middle)
	2ww Breast Symptoms	93%	71.9%	October 22	10.85%			75.7% (Worse)	68.0% (Better)	18th lowest
	31 day First	96%	95.5%	October 22	1.36%			92.0% (Better)	91.7% (Better)	10th highest
	31 day Sub Surgery	94%	84.5%	October 22	2.72%			80.9% (Better)	81.7% (Better)	17th highest
	31 day Sub Drug	98%	100%	October 22	0.92%			98.8% (Better)	99.3% (Better)	14th highest
	31 day Sub Radiotherapy	94%	82.7%	October 22	-2.52%			90.8% (Worse)	87.9% (Worse)	7th lowest
	62 day First	85%	69.9%	October 22	10.49%			60.3% (Better)	62.1% (Better)	6th highest
	62 day Screening	90%	68.9%	October 22	18.71%			67.1% (Better)	72.2%(Worse)	22nd (middle)
	62 day Upgrade	85%	72.9%	October 22	5.27%			73.9% (Worse)	72.7% (Better)	22nd lowest
RTT	Incomplete Pathways <18 weeks	92%	55.5%	October 22	1.15%			60.1% (Worse)	56.7% (Worse)	8th lowest
	52 weeks	0	11,137	October 22	5.92%			383,724	56,394	8th lowest
Diagnostics	6 week wait	1%	31.2%	October 22	-7.36%			27.5% (Worse)	31.9% (Better)	19th lowest

Individual Trust

ICS Aggregate Provider	Trend	ENHT	Trend	PAH	Trend	WHTHT	Trend
51.8%	-35.63%	See individual CCG performance in the table below					
9.99%	50.34%						
59.08%	-3.93%	61.23%	-5.14%	54.41%	3.37%	60.15%	-7.32%
192	-76.04%	48	-214.58%	144	-29.86%	0	0.00%
76.13%	8.67%	93.47%	1.02%	67.90%	22.83%	67.84%	9.98%
72.35%	10.41%	95.95%	8.80%	88.00%	-1.21%	44.54%	43.87%
96.07%	1.23%	97.58%	1.41%	94.87%	3.70%	94.27%	-0.50%
97.18%	9.39%	95.56%	6.03%	100%	33.33%	100%	8.33%
100%	0.75%	100%	0.46%	100%	5.88%	100%	0.00%
85.79%	-1.72%	85.79%	-1.72%	N/A		N/A	
73.71%	10.44%	80.68%	-1.33%	65.31%	51.20%	68.66%	12.36%
65.38%	32.92%	62.50%	13.85%	84.62%	63.07%	56.52%	17.86%
66.67%	-1.69%	69.39%	18.54%	64.15%	-7.51%	66.67%	-9.46%
51.72%	1.25%	54.36%	1.11%	50.88%	-0.09%	49.45%	1.79%
9,744	5.86%	4,527	-3.56%	1,804	-5.21%	3,413	24.20%
37.14%	-6.41%	46.52%	-7.59%	27.36%	-4.54%	28.89%	-1.40%

Herts & West Essex ICS (Commissioner)

Area	Metric	Target	Latest published data	Data published	Trend *	Variation	Assurance	National position (ICB vs National)	Regional position (ICB vs EoE Region)	ICB Ranking
111	Calls answered < 60 seconds	95%	51.8%	October 22	-35.63%			44.8% (Better)	50.8% (Better)	18th highest
	Calls abandoned after 30 seconds	5%	10.0%	October 22	50.34%			12.9% (Better)	9.7% (Worse)	15th highest
Mental Health	Dementia Diagnosis rate *2	66.6%	61.6%	September 22	-1.43%			62.2% (Worse)	59.5% (Better)	n/a
	OOA placements *3	0	1,322	October 22	17.62%			54,865	11,250	n/a
CHC	% of eligibility decisions made within 28 days	80%	69.9%	October 22	11.61%			74.3% (Worse)	68.3% (Better)	11th lowest
	% of assessments carried out in acute	15%	0.0%	October 22	0.00%			n/a	n/a	n/a

Individual CCGs

ICS Aggregate Provider	Trend	East & North Herts	Trend	South & West Herts	Trend	West Essex	Trend
N/A		52.13%	-35.50%			50.61%	-36.15%
		9.73%	50.19%			11.06%	50.78%
		59.03%	-3.22%	60.89%	-0.53%	67.60%	-0.09%
		1177	12.15%			145	62.07%
		100%	16.67%	50%	33.33%	89.47%	5.00%
		0%	0.00%	0%	0.00%	0%	0.00%

LEGEND On/above target | Below target | Improvement on previous month's performance | Decrease on previous month's performance | No change on previous month's performance

Variation: Special Cause Concerning variation; Special Cause Improving variation; Common Cause

Assurance: Consistently hit target; Hit and miss target subject to random variation; Consistently fail target

*1 Against last month's performance

*2 **Temporary suspension of publication:** Recorded Dementia Diagnosis September 2022 will be the last monthly publication in this series until early 2023. This is due to a change in the data collection for these publications. When the publication resumes in 2023 all data will be back dated to April 2022 to provide a coherent time series.

*3 The October data for West Essex's Out of Area Placements is not currently available due to a query regarding data accuracy. The data shown in the table above is for Hertfordshire only.

*4 Compared to latest quarterly position.

Appendix B: Urgent & Emergency Care (UEC) by Place

ICB Area	What the charts tell us	Issues	Actions	Mitigation
West Essex / PAH	• High number of patients presenting at ED, but comparable to recent months • Number of patients experiencing handover delays >30 minutes continues to increase, and the planned recovery trajectory is not being achieved • 11.7% of patients spent >12 hours in ED, continuing a 12 month above average trend • The number of patients treated, admitted or discharged in under 4 hours improved slightly in November, but remains low at 54.4%	• Continued high attendances • Ambulance Handover Delays • ED staffing, vacancies & sickness • Covid patients within the Trust and contact beds closed impacting capacity and flow • MH assessments and bed shortages (national issue) • Estate footprint & size of dept	• Daily joint working with all system partners to create ED capacity aligned to local oversight arrangements • Daily calls and CCG support with discharges and Transport • Daily calls with EEAST to review pressures across local Trusts and enact "load levelling" • Nightingale Ward (18 beds) available as per escalation plans and staffing availability • Continue with established safety huddles and harm review arrangements • March 23 improvement ambitions for the 6 national UEC priority metrics have now been agreed across the ICS and will be overseen in West Essex at the Local Delivery Board (LDB) • IN / OUT patient flow programmes established • Recent appointments of an ED Nurse Consultant and a UEC Head of Nursing • Relocation of the discharge lounge to create additional ED capacity - delayed until February	Actions in place to ensure that patient safety is maintained; Jan UEC Board focusing on Safety
South West Herts / WHTHT	• Following an increase in September (14,100) attendances continued to rise further throughout Oct & Nov, reaching an average of 15,500 • 4 hour ED performance has declined since September (70%). October 64.7% with November dipping further to 60.3% • 12 hour total time in ED improved in Sept (5.5%) but saw a decline in October to 7.3% • Patients who NLMCTR not discharged by 5pm remains high but stable at around 75%	• High number of MH presentations, both in ED and on the wards. • MH bed shortages. Workforce issues across all providers . • WHTHT regularly having 60+ surge beds open • Staffing vacancies and sickness impacting all providers • Flu numbers beginning to increase	• A MADE has been arranged for week commencing 3rd January 2023. The two workstreams have been confirmed as NMCTR and prevention of admission • St Albans Integrated Urgent Care HUB (IUCH) phased launch from 31.10.22. Capacity for 70 pts per day, directly booked from GP & NHS 111. Minor Illness appointments full and increasing usage from GPs. • Reduced minor injury capacity as radiology process to WHTH is delayed & GP Connect not fully functional for GP bookings (workaround in place). HUC to progress urgently as part of mobilisation. Currently running with bank staff, substantive staff start in Jan '23. • VH - from October the soft launch of Community Onboarding for Heart Failure and COPD went live • StrepA Hubs being developed in Hemel Hospital, St Albans IUCH and Potters Bar Hospital (still TBC) to manage the increase in children's viral presentation and additional activity in CED	SRG/LDB work plans agreed in line with NHSE planning guidance and Board Assurance Framework.
East & North Herts / ENHT	• Handover performance continues to deteriorate however improvements seen towards end of Oct; • ED attendances remain at higher levels with further increases seen over Oct and Nov; • ED 4 hour performance continues to decline, dropping to 61.2% in November; • The % of patients spending more than 12 hours in the department also saw a decline over the last two months, at 10.2% in October; • % of patients not meeting criteria to reside & not discharged by 5pm remains high but did see an improvement in October.	• Continued high demand in number of attendances with average acuity also at its highest rate since February 2022 • Ambulance handover delays • ED staffing - vacancies and sickness/isolation • Covid and Flu patients within the Trust, contact beds closed impacting capacity and flow • MH assessments and bed shortages	• UEC Transformation action plan continues to be implemented • New SDEC area opened increasing capacity • New UTC style streaming model developed and came online in late November • A zero tolerance to handover delays above 3 hours introduced and demonstrated a notable reduction in handover delays towards end of October; actions are being taken to sustain this including joint working with EEAST to implement a new handover SOP with the aim to eliminate >60min offloads • Reverse boarding is becoming increasingly embedded as a business as usual practice • Focus on discharges and use of hospital @ home continues • Using SDEC as escalation space continues to be restricted • March 23 improvement ambitions for UEC priority agreed across the ICS and will be overseen in ENH through the SRG	Performance Improvement Trajectories agreed aligned to action plans.

Appendix C: Performance v. 22/23 Operational Plans by Place

East and North Herts Trust

Baseline	22/23 Activity Plan	22/23 M1-7 Activity Plan
104,880	138,641	77,505
	+32%	
N/A	0	0
N/A	0	377
3313	2914	3291
400,242	359,706	223,183
	-10%	
N/A	4.7%	1.7%
0%	26%	26%
N/A		
180,261	184,372	112,105
	+2%	
87	87	180
75%	74%	78%

Area	Target
Activity	10% elective activity increase (19/20 levels RTT pathw ay)
Waitlist	104 w eek w aits eliminated by Jul 22 (w aitlist, end of Jun 22)
	Eliminate 78 w eek w aits by Apr 23 (w aitlist, end of Mar 23)
	52 w eek w aits trending dow n across 22/23
Outpatients	25% reduction in outpatient follow -ups by 2023
	5% of outpatients moved or discharged to PIFU
	25% of consultations via video/telephone
	16 specialist advice requests per 100 outpatient firsts
Diagnostics	20% increase in diagnostic capacity against 19/20 levels
Cancer	Reducing cancer 62+ day w aitlist to pre-pandemic levels
	Reduction in missed 28 day cancer decisions

	M1-7 Actual							
	April	May	June	July	August	September	October	Total
Plan	7,816	8,554	11,535	12,112	12,688	12,688	12,112	**77,505**
Actual	7,816	9,494	9,139	8,072	8,241	9,353	9,015	**61,130**
Variance	0	940	-2,396	-4,040	-4,447	-3,335	-3,097	**-16,375**
Actual	96	56	21	9	7	2	2	**2**
Actual	439	408	324	312	407	458	464	**464**
Actual	3473	3699	4027	4294	4628	4688	4527	**4527**
Plan	33,377	33,990	31,737	34,856	28,372	28,950	31,901	**223,183**
Actual	30,904	34,899	31,661	31,545	32,011	32,832	32,734	**226,586**
Variance	-2,473	909	-76	-3,311	3,639	3,882	833	**3,403**
Actual	0.6%	0.7%	0.7%	0.6%	0.8%	0.8%	0.9%	**0.9%**
Actual	26%	26%	26%	27%	20%	21%	22%	**24%**
Actual	24	24	23	24	24	21	19	**23**
Plan	14,839	16,359	16,071	16,432	15,611	15,674	16,429	**111,415**
Actual	11,414	13,529	13,068	12,957	13,040	13,439	13,731	**91,178**
Variance	-3,425	-2,830	-3,003	-3,475	-2,571	-2,235	-2,698	**-20,237**
Actual	377	327	366	368	415	275	308	**308**
Actual	68%	64%	71%	72%	73%	70%	70%	**70%**

Appendix C: Performance v. 22/23 Operational Plans by Place

PAH

Baseline	22/23 Activity Plan	22/23 M1-7 Activity Plan	Area	Target
70,011	75,816	43,197	Activity	10% elective activity increase (19/20 levels RTT pathway)
	+8%			
N/A	0	0	Waitlist	104 week waits eliminated by Jul 22 (waitlist, end of Jun 22)
N/A	0	194		Eliminate 78 week waits by Apr 23 (waitlist, end of Mar 23)
1737	3,059	3,225		52 week waits trending down across 22/23
225,486	271,151	156,570	Outpatients	25% reduction in outpatient follow-ups by 2023
	+20%			
N/A	2.0%	1.5%		5% of outpatients moved or discharged to PIFU
4%	27%	27%		25% of consultations via video/telephone
N/A				16 specialist advice requests per 100 outpatient firsts
110,523	117,630	68,370	Diagnostics	20% increase in diagnostic capacity against 19/20 levels
	+6%			
121	75	75	Cancer	Reducing cancer 62+ day waitlist to pre-pandemic levels
61%	73%	75%		Reduction in missed 28 day cancer decisions

	M1-7 Actual							
	April	May	June	July	August	September	October	Total
Plan	5,317	5,941	6,678	6,643	5,902	6,232	6,484	**43,197**
Actual	5,317	6,088	5,911	5,646	5,644	5,953	6,076	**40,635**
Variance	0	147	-767	-997	-258	-279	-408	**-2,562**
Actual	14	12	10	3	0	0	0	**0**
Actual	223	266	281	296	248	208	141	**141**
Actual	1818	1674	1785	1911	1909	1898	1804	**1804**
Plan	19,736	22,231	23,018	23,120	22,398	22,968	23,099	**156,570**
Actual	19,754	22,354	19,593	18,917	18,371	17,497	18,088	**134,574**
Variance	18	123	-3,425	-4,203	-4,027	-5,471	-5,011	**-21,996**
Actual	0.9%	1.4%	1.5%	1.3%	1.4%	1.4%	1.4%	**1.4%**
Actual	27%	27%	28%	28%	27%	28%	28%	**28%**
Actual	5	5	6	6	7	6	5	**5**
Plan	9,258	9,852	9,852	9,852	9,852	9,852	9,852	**68,370**
Actual	9,258	9,793	9,073	9,604	10,193	9,242	9,491	**66,654**
Variance	0	-59	-779	-248	341	-610	-361	**-1,716**
Actual	252	220	178	177	199	204	219	**219**
Actual	64%	66%	74%	72%	73%	68%	68%	**70%**

Appendix C: Performance v. 22/23 Operational Plans by Place

West Herts Teaching Hospitals Trust

Baseline	22/23 Activity Plan	22/23 M1-7 Activity Plan
71,713	115,674	58,743
	+61%	
N/A	0	2
N/A	0	44
1059	507	658
330,892	260,127	153,141
	-21%	
N/A	2.1%	1.2%
8%	25%	22%
N/A		
126,398	146,816	81,251
	+16%	
81	105	163
72%	69%	74%

Area	Target
Activity	10% elective activity increase (19/20 levels RTT pathway)
Waitlist	104 week waits eliminated by Jul 22 (waitlist, end of Jun 22)
	Eliminate 78 week waits by Apr 23 (waitlist, end of Mar 23)
	52 week waits trending down across 22/23
Outpatients	25% reduction in outpatient follow-ups by 2023
	5% of outpatients moved or discharged to PIFU
	25% of consultations via video/telephone
	16 specialist advice requests per 100 outpatient firsts
Diagnostics	20% increase in diagnostic capacity against 19/20 levels
Cancer	Reducing cancer 62+ day waitlist to pre-pandemic levels
	Reduction in missed 28 day cancer decisions

	M1-7 Actual							
	April	May	June	July	August	September	October	Total
Plan	3,682	5,002	4,373	11,865	10,553	11,397	11,871	**58,743**
Actual	3,682	4,999	4,816	4,618	4,948	5,633	6,116	**34,812**
Variance	0	-3	443	-7,247	-5,605	-5,764	-5,755	**-23,931**
Actual	14	9	4	3	2	3	2	**2**
Actual	144	155	143	133	137	116	92	**92**
Actual	1193	1431	1660	1783	2078	2587	3413	**3413**
Plan	18,976	20,461	18,963	24,263	24,082	23,655	22,741	**153,141**
Actual	19,598	22,104	21,299	21,019	21,732	22,226	22,042	**150,020**
Variance	622	1,643	2,336	-3,244	-2,350	-1,429	-699	**-3,121**
Actual	0.7%	0.9%	1.0%	0.8%	0.8%	0.6%	0.4%	**0.4%**
Actual	15%	13%	14%	13%	13%	14%	14%	**14%**
Actual	47	46	46	50	48	45	39	**46**
Plan	9,652	10,497	9,095	13,595	12,379	12,660	13,373	**81,251**
Actual	9,357	10,546	9,827	9,473	9,835	9,922	9,321	**58,960**
Variance	-295	49	732	-4,122	-2,544	-2,738	-4,052	**-22,291**
Actual	299	340	331	315	297	288	271	**271**
Actual	51%	58%	56%	60%	60%	58%	58%	**58%**

Appendix D: HWE Adult Community Services

Elective & Specialist	E&NH	S&WH	West Essex
Cardiac Rehab	HCT/ENHT	CLCH	EPUT
Diabetes	HCT	HCT	EPUT
Continence services	HCT	CLCH	EPUT
Nutrition and Dietetic Service	HCT	HCT	EPUT
Speech and language therapy	HCT	CLCH	EPUT
Podiatry	HCT	CLCH	EPUT
Specialist palliative care	HCT	CLCH	EPUT
Heart failure service	-	CLCH	EPUT
Lymphoedema	HCT	CLCH	HCT
Tissue Viability	HCT	CLCH	EPUT
Leg Ulcer	HCT	CLCH (Herts one)	EPUT
Respiratory	HCT/ENHT	CLCH/WHHT	EPUT
MSK	HCT	Connect	EPUT
Chronic pain management	HCT	Connect	EPUT
Community Neuro/rehab	HCT	CLCH	PD/MS only
Pulmonary Rehab	HCT	CLCH	EPUT
Specialist Dentistry	HCT	HCT	-
Community Dermatology	HCT	-	GP Fed
Community ENT	-	Communitas	-
Community Gynaecology	-	The Gynaecology partnership	-
Long Covid	HCT	CLCH	EPUT
Diabetes eye screening	ENHT	HCT	Health intelligence Ltd
Sexual Health Services	CLCH	CLCH	Provide

Urgent & Emergency Services	E&NH	S&WH	West Essex
2 hour urgent response	HCT	CLCH	EPUT
Hospital at home/rapid response	HCT	CLCH	EPUT
Discharge to assess (at home)	HCT	CLCH	EPUT
Virtual ward/hospital	HCT	CLCH/WHHT	EPUT
Inpatient rehab beds	HCT	CLCH	EPUT
Inpatient stroke Neuro rehab beds	HCT	CLCH	EPUT
Respiratory services	HCT	CLCH	EPUT
Stroke (Early supported discharge)	HCT	CLCH	EPUT
Neuro ESD (NETT)	-	CLCH	-

Core community Services	E&NH	S&WH	West Essex
District Nursing	HCT	CLCH	EPUT
Community therapies (OT/PT)	HCT	CLCH	EPUT
Frailty clinics	HCT	CLCH	PAH
Enhanced health in care homes	HCT	CLCH	EPUT

Appendix D: HWE Children's Community Services

Children's Services within Hertfordshire and West Essex ICS is complex with a range of existing governance forums and a broad range of services provided primarily by NHS Trusts, but with a number of independent and 3rd sector organisations

Service	E&NH	S&WH	West Essex
ADHD	ENHT	HPFT	HCRG
Advocacy	KIDS	KIDS	Rethink / Open Door
Allergy	ENHT	WHHT	HCRG / PAH
ASD	ENHT	HCT	HCRG
Asthma Nurse specialist	n/a	HCT	To be established
Audiology	ENHT	HCT	PAH
Wellbeing Practitioners	HCT	HCT	HCRG
CHIS	HCT	HCT	Provide
Com. Nursing	ENHT	HCT	HCRG
Comm Paeds	ENHT	HCT	HCRG
Continence	n/a	HCT	HCRG
Continuing Care	ENHT	HCT	HCRG & Various Independent
CSAIS	EPUT (s/c HCT)	EPUT (s/c HCT)	EPUT
CYP Counselling	YCT, Youthtalk, Signpost, Rephael House & Safespace.	YCT, Youthtalk, Signpost, Rephael House & Safespace.	YCT
CYP Therapies	HCT	HCT	HCRG (SLT inclusive of dysphagia, PT inclusive of MSK)
Designated Medical Officer for SEND	ENHT	HCT	HCRG
Diabetes Nurse Specialist	ENHT	WHHT	PAH
Dietetics	HCT	HCT	HCRG / PAH
Eating Disorders	HPFT	HPFT	NELFT / BEAT
Epilepsy Nurse Specialist	ENHT	WHHT	PAH
Equipment	HCT	HCT	EPUT
Eye Care	ENHT	HCT/WHHT	PAH

Service	E&NH	S&WH	West Essex
Family Hubs/Children's Centres	Family Centre Services/Family Support Services/ HCT	Family Centre Services/Family Support Services/ HCT	HCRG
Health Visiting	HCT	HCT	HCRG
Hospice Care	Keech	Keech/Noah's Arc/ Rennie Grove	Haven House, EACH
Infant Mental Health	HCT	HCT	EPUT
LAC	HCT	HCT	HCRG
Lymphoedema	HCT	n/a	HCT
Mental Health Support Teams	HPFT/HCT	HPFT/HCT	West Essex Mind (mainstream) / HPFT (special schools)
Neuro-Rehab	Specialist commissioned	Specialist commissioned	Tadworth Children's Trust
Palliative Care Respite Service (EPIC)	Noah's Arc	Noah's Arc	Little Haven's
Palms	HCT	HCT	n/a
Parenting Support	HCC	HCC	Triple P (YCT from April)
Perinatal Mental Health	HPFT	HPFT	EPUT
School Nursing	HCT	HCT	HCRG
Sickle cell	HCT	HCT	PAH
Special care dentistry	HCT	HCT	PAH
Specialist CAMHS	ENHT	HPFT	NELFT
Specialist Healthcare Tasks	n/a	n/a	Provide
Specialist school nursing	ENHT	HCT	HCRG
Step 2 Service	JHCT	HCT	n/a
Therapeutic Health Based Coaching	n/a	n/a	NOW
Tier 4 CAMHS	HPFT	HPFT	EPUT
Transition coordinators	HCT	HCT	HCRG
Weight Management & other wellbeing services	Beezee Bodies	Henri/ Beezee Bodies	Provide

N.B. Virgin Care has now been transferred to HCRG Care Group

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	17
Report title	Finance Performance and Planning Committee 23 January 2023 highlights report			**Meeting Date**	1 March 2023
Chair	Karen McConnell – Committee Chair and Non Executive Director				
Author	Debbie Collins – Corporate Governance Officer				
Quorate	**Yes**	☒	**No**		☐

Agenda:

- Imaging Demand and Capacity
- Ambulance Handover Progress Update
- Finance Report Month 9
- Outturn and Financial Reset Update
- Performance Report Month 9
- 23/24 Business Planning Update
- Provider Collaboration Update
- Elective Surge Hub
- Outpatient Improvement Update
- Waste Tender
- Board Assurance Framework

Alert:

- Filling vacancies for specialist radiographers continues to be a challenge.
- The Trust continues to have an underlying deficit challenge.
- There continues to be a reduction in theatre activity. It was confirmed that cancer patients were being prioritised.
- Medical staffing overspend continues to be a challenge. The Committee challenged the increased establishment numbers compared to pre-pandemic levels and the level of temporary staff being used.
- It was reported there will be a £5m shortfall for the Elective Surge Hub due to open in 2024. It was not yet known who would be responsible for the shortfall.
- A waste tender evaluation was carried out. Sharpsmart were approved because they were the organisation who scored the highest. Choosing Sharpsmart rather than the incumbent organisation will involve an additional cost pressure of £89k. The Committee asked for clear evidence for the reasons for making this choice.

Advise:

- Imaging demand and capacity has remained static with the exception of an increase in cancer radiology and urology scans; along with an overall increase in cancer referrals.
- Waiting times have reduced as a result of the MRI vehicle on the Lister hospital site. Additional van days will be explored.
- There has been a focus on waste reduction across the organisation to assist with financial savings.
- The Committee were advised of the national objectives for 2023/24 and key priority operational areas.

- The Director of Finance met with colleagues from Princess Alexandra Hospital and West Hertfordshire Teaching Hospitals NHS Trust to jointly deliver a range of strategic priorities over the next five years.
- A system elective hub is scheduled to open in 2024 and is likely to be at St Albans Hospital and will provide additional system capacity. The hub will consist of three ringfenced theatres plus one procedure room. Activity will be high volume low complexity treatments.
- The Committee were provided with an update on the Patient Initiated Follow Up transformation programme (PIFU). The target is for 5% of patients to use this programme, however the Trust currently has 1.3%. However, there was a plan for short term wins and longer term improvements. The Committee agreed that a 5% target should be achievable.

Assurance:

- There has been improved compliance with ambulance handover times in line with national standards assisted by the opening of the ambulance handover unit in December 2022.
- Improvements with ambulance handover times will contribute to stroke patients being transferred to a stroke bed within four hours.
- Improved experience for patients in the emergency department, including patients with mental health concerns.
- The month nine position is reported against a break-even plan.
- Divisions continue to review their CIP performance.
- The Head of Corporate Governance met with the Director of Development at East and North Hertfordshire Health and Care Partnership to discuss system risks and mitigations.
- The Committee agreed for the four risks associated to FPPC to remain the same.

Important items to come back to committee (items committee keeping an eye on):

- None.

Items referred to the Board or a committee for a decision/action:

Recommendation	The Board is asked to NOTE the Finance Performance and Planning Committee report

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Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board meeting	**Agenda Item**	17
Report title	Finance Performance and Planning Committee 21 February 2023 highlight report	**Meeting Date**	1 March 2023
Chair	Karen McConnell – Committee Chair and Non-Executive Director		
Author	Debbie Collins – Corporate Governance Officer		
Quorate	**Yes** ☒	**No** ☐	

Agenda:

- RTT and Cancer Review
- Elective Intensive Support Team RTT and Cancer
- Agency and Medical Staffing
- Performance Report month 10
- Finance Report month 10
- Outturn and Financial Reset Update
- Annual Business Planning Update
- Costing Programme Update
- Community Diagnostic Centre
- Sustainability and Green Plan Update
- Linen and Laundry tender contract
- Board Assurance Framework

Alert:

- The Trust is required to have zero patients waiting over 78 weeks for treatment by 31 March 2023. Community paediatrics have the largest number of patients waiting over 78 weeks and it is unlikely that this will be zero by 31 March 2023 because it is booked to capacity until that date.
- Financial performance at Month 10 reports a surplus of £0.1m in month and a £5.6m deficit in the year to date. The financial reset work has not led to a significant improvement in the run rate. The Trust will be formally reporting a year end deficit, which has been agreed with the ICB from month 10.
- The Committee were disappointed with the level of CIP shortfall this year and asked for steps to be taken to ensure this position improved next year. This may require external resource/support.
- Business planning for 23/24 sets out the considerable risks for the Trust in achieving a break even plan. The two key challenges are the scale of and the need for a clear and coherent approach to the CIP programme together with the scale of the elective recovery enablement.

Advise:

- The Trust is required to have zero patients waiting over 78 weeks for treatment by 31 March 2023. In addition to Community Paediatrics, steps are being taken to address other challenged specialities. Two jumbo clinics are planned to clear non-admitted trauma and orthopaedic waiting lists by the end of February 2023. Plans are in place for increased admitted capacity together with transfer to the independent sector and WLI. Significant

improvements have been made with Gastroenterology. Risks to achieving the target are understood including for the potential Junior Doctors strike and mitigation is being developed or is in place.
- There has also been an introduction of a Digital Mutual Aid System (DMAS) to match patients with organisations that could treat their specific problem.
- The Elective Intensive Support team carried out a two day review of the Trust's approach to elective recovery, a reduction of patients waiting more than 78 weeks and 62 day Cancer recovery. They provided clear recommendations with an 18 point action plan and will support the Trust in delivering the plan. There will be cost implications in carrying out this plan.
- A review was carried out to identify the key drivers of the unsustainable increase in medical staffing costs since 2019/20 together with a range of responses being taken forward urgently by the key Directors.
- Risk 9 on the Board Assurance Framework which relates to the Trust and system financial flows and efficiency had reduced from 16 to 12.

Assurance:

- The Trust's cancer performance was amongst the highest in the country.
- The Trust has undertaken demand and capacity modelling for radiology, molecular tests, histopathology and endoscopy with an expected increase of 25% in referrals. Plans have been developed to continue improvement of the 62 day backlog and to deliver the faster diagnostic standard by March 2024.
- In the next year the ambition is to achieve faster cancer diagnosis with patients being provided with their diagnosis within 28 days, allowing more time to plan appropriate treatment.
- The Trust has a plan in place to reduce the number of patients waiting over 78 weeks in 2022/23 and an initial outline plan for 65 weeks in 2023/24. Demand and capacity modelling based upon 65 weeks delivery is in progress for 2023/24.
- Due to a sustained focus on ambulance handovers, the average handover times have reduced. This has been assisted by the opening of the Same Day Emergency Care unit. The ongoing risks and impact of flow through the hospital are recognised.
- Papers and discussion show a good understanding of the drivers of the anticipated year end deficit. This includes the range of outturn outcomes and the likely system position. Progress on the financial reset remains challenging.
- All audit recommendations from the costing assurance programme were completed or in progress. Key developments are being made to Patient Level Costing and Service Line Reporting to support the current financial framework.
- The Committee were provided with a Green Plan update and advised of positive steps already being taken, however some of those were not being evidenced. Eight work streams have been identified and senior leadership will be required for each of those work streams.

Important items to come back to committee (items committee keeping an eye on):

- The Committee will receive an updated report on medical staffing costs in six months time.

Items referred to the Board or a committee for a decision/action:

- A concern was raised about clinical harm reviews only been carried out once treatment was complete. This has been referred to the Quality and Safety Committee.
- It was agreed that the Green Plan and the key recommendations would be discussed at a Board awayday and that it may be integrated with a discussion on the Estates Strategy

Recommendation	The Board is asked to NOTE the Finance Performance and Planning Committee report

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Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board		**Agenda Item**	18
Report title	Quality and Safety Committee 25 January 2023 highlight report		**Meeting Date**	1 March 2023
Chair	Dr Peter Carter – Committee Chair and Non-Executive Director			
Author	Julia Smith – Assistant Trust Secretary			
Quorate	**Yes**	☒	**No**	☐

Agenda:

- Emergency Department Deep Dive
- Risk Management Update
- Incident Management and Emerging Safety Risks
- Board Assurance Framework
- Maternity
  - Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS)
- Integrated Care Board A&E Report
- Mortuary Deep Dove
- Quality and Safety Month 9 Report
- Q3 Patient Experience Report
- Responsible Officer Update (Mortality)

Alert:

- Risks in the Emergency Department were highlighted as overcrowding and waiting room care. The biggest concern from staff was not delivering the level of care they would like. Numbers of delay related harm had increased but the percentage of admission through the ED had slightly reduced.
- An increased number of patients not receiving follow-up was identified as an emerging risk.
- There continued to be high numbers of complaints relating to care and treatment in the Emergency Department

Advise:

- The Trust would be reporting a non-compliant status for the CNST MIS against two of the safety standards.
- The ICB Peer Review of medicines management in ED highlighted workforce, patient flow and staff skill mix. A weekly improvement committee were working on the actions to ensure an improved review in future.
- VTE risk assessment will move from Lorenzo to NerveCentre on 30 January, 95% compliance won't be achieved immediately but an improvement is expected.

Assurance:

- There were no red rated risks for the Committee and two risks had reduced.
- The ICB Peer Review of medicines management in ED made positive observations of care and compassion.
- In relation to the Mortuary, all 13 corrective and preventative actions had been completed and closed following the initial visit from the Human Tissue Authority (HTA) and the next visit was scheduled for 9th February.

• In 2022 completed medical appraisals achieved 93% compliance, the aim for 2023 is to achieve 95% compliance.	
Important items to come back to committee (items committee keeping an eye on):	
• Complaints • Emergency Department	
Items referred to the Board or a committee for a decision/action:	
N/A	
Recommendation	The Board is asked to **NOTE** the Quality and Safety Committee report

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Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	18
Report title	Quality and Safety Committee 22 February 2023 highlight report			**Meeting Date**	1 March 2023
Chair	Dr David Buckle – Acting Committee Chair and Non-Executive Director				
Author	Debbie Collins – Corporate Governance Officer				
Quorate	**Yes**	☒	**No**		☐

Agenda:

- Maternity National Patient Survey Deep Dive
- Integrated Risk, Compliance and Quality Assurance Report
- ICB Joint Quality Assurance Visit – children's ED
- Endoscopy Action Plan
- Board Assurance Framework
- Estates and Facilities Assurance Report
- Quality and Safety Month 10 Report
- Clinical Harm Review Update
- Maternity Assurance Report
- Quality and Safety Escalation Reports

Alert:

- The Trust has received a declining score in the Maternity National Patient Survey since 2019. A robust action plan will ensure improvements are made.
- The CQC have shared anonymous whistle blowing concerns in Endoscopy. An investigation was already underway, but the CQC interest precipitated a faster response. The main area of concern was potential patient delays partly due to an inadequate paper system.
- The Trust had received an audiology alert relating to babies. A meeting has been set up with the regional team to ascertain what the alert relates to and any concerns will be reported back to this Committee.

Advise:

- There have been significant delays of publishing policies within the agreed due dates, however there has been an improving trajectory following the establishment of a policy compliance group.
- A new electronic system in Endoscopy will remove the need for paper records and improve waiting times.
- Primary care recognise the increase in referrals into endoscopy services and have been reviewing a triage model to improve flow.
- A Premises Assurance Model (PAM) was submitted in September 2022, containing an extensive action plan to ensure policies and contracts are brought up to date.
- VTE is now on NerveCentre Live.
- Cardiology identified a raised mortality rate and this was being reviewed.
- The Committee noted a high sickness absence level in obstetrics and gynaecology, particularly with consultants.

- The numbers of babies being born in midwifery led units has increased which has released capacity to consultant led units and as a result, will improve flow.
- Most data on Datix has been transferred to ENHance and the remaining data will be transferred in quarter one of 2023/24.
-

Assurance:

- The Committee discussed a number of proactive actions and improvements made in maternity since the last report.
- Training and development remain a focus for the maternity department, particularly relating to compliance of safeguarding training.
- A process is in place to ensure conversations take place with women before leaving the maternity unit to discuss their experience.
- Individual teams around the Trust have been requesting internal inspections to ensure their business as processes are of a good standard.
- A peak in cardiac arrests had been investigated and no common themes were identified. Although the peak was only three per month, this had now reduced back down to baseline.
- The closure of the Children's Assessment Unit (CAU) had caused an increase in discharge summaries in CAU. Work was being carried out to clear the backlog and clinical harm reviews will take place where required.
- A new system called Envoy, will be implemented which will text patients on waiting lists asking them whether they still require an appointment and whether they believe they have suffered any harm by waiting longer for an appointment. When live, the system will start by contacting patients who have not yet had their first appointment and will then evolve into contacting patients who are awaiting a follow up appointment.

Important items to come back to committee (items committee keeping an eye on):

- An update to the Committee on the Envoy texting system in 3 month's time.

Items referred to the Board or a committee for a decision/action:

Recommendation	The Board is asked to **NOTE** the Quality and Safety Committee report

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Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board		**Agenda Item**	19
Report title	Audit & Risk Committee 17 January 2023 highlights report		**Meeting Date**	1 March 2023
Chair	Jonathan Silver - Audit & Risk Committee Chair and Non-Executive Director			
Author	Julia Smith – Assistant Trust Secretary			
Quorate	**Yes**	☒	**No**	☐

Agenda:

- Summary Internal Controls Assurance Report
- Internal Audit Action Tracker
- Anti-Crime Progress Report
- External Audit Progress Report
- Risk Management Update
- Risk Strategy
- Board Assurance Framework
- Code of Governance / Provider Licence
- Review of Accounting Policies
- Significant Losses / Special Payments
  - Pharmacy Write-Off Costs Review
- Tenders and Waivers Report
- Cyber Security Report
- Data Quality and Clinical Coding Report

Alert:

- Progress in the completion of outstanding internal audit actions had deteriorated and the Finance team would support their recovery.
- A code of governance and provider licence will commence on 1 April 2023 which will make significant changes to corporate governance within the Trust.
- The newly introduced IFRS16 – Leases would have significant impact on the 2022/23 accounts.
- A number of risks within the IT security area had increased, these could be reduced but would be reliant on the submitted revenue bids to improve security being successful in securing funds.

Advise:

- The Trust had been selected by the Counter Fraud Authority for a site visit to enable further analysis of evidence provided as part of the Risk Local Proactive Exercise.
- The external audit team had finalised the extension of the contract for the next two years; set-up meetings had agreed deliverables and dates.
- The Risk Strategy was approved to go to Trust Board.
- The number of waivers had almost doubled on the previous year with a lot of building works included.

Assurance:

• Three final reports had been issued since the previous meeting including Hospital at Home, IT Programme Management, Governance and Engagement and Workforce Establishment Control and Planning. All three of the audits delivered reasonable assurance. • A new matrix incorporating risk mitigations and oversight had identified some risks that had been scored highly, on interrogation it was determined they shouldn't be high rated risks. • The Board Assurance Framework had been rejuvenated and was making progress. • All patients lost property that could be returned had been returned and those that couldn't be identified would be disposed of and any monies received donated to the hospital charity. • The level of Pharmacy write-off costs had reduced, and the expectation was for this area to continue to reduce. • Clinical coders had adopted the use of Bluespier and the system was proving to be more useful than had been anticipated.	
Important items to come back to committee (items committee keeping an eye on):	
• Internal audit actions	
Items referred to the Board or a committee for a decision/action:	
N/A	
Recommendation	The Board is asked to **NOTE** the Extraordinary Audit Committee report

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Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board		**Agenda Item**	20
Report title	People Committee 14 February 2023 highlight report		**Meeting Date**	1 March 2023
Chair	Val Moore – Committee Chair and Non-Executive Director			
Author	Debbie Collins – Corporate Governance Officer			
Quorate	**Yes**	☒	**No**	☐

Agenda:

- Freedom to Speak Up
- Voice of our people – Women's Network
- Gender Pay Gap
- Health and Wellbeing
- Induction and Onboarding
- Statutory/Mandatory Training Update
- Grow Together
- Board Assurance Framework
- Matters Arising – EDS23

Alert:

- 3,500 staff are yet to complete their Speak Up training.
- Clinical Support Worker vacancies continue to be challenging because of competition from other organisations outside of the NHS.
- The statutory/mandatory training target is 90% and the Trust is currently at 80%.
- The Grow Together target is 90% and the Trust is currently at 63.9%.
- The Trust has received mental health funding from the ICS for the next six months. Should the funding not be provided beyond that time, this would create a risk.

Advise:

- The Gender Pay Gap Group would like more senior leadership representation.
- The Health and Wellbeing team have been focussing on menopause, muscular skeletal health and the vaccination programme.
- Passporting will be reviewed by the People team to ensure individuals moving from one NHS provider to another, can take their training compliance with them.

Assurance:

- There is now good structure in place to review Freedom to Speak Up conversations and identify themes and it was noted that more people are speaking up.
- The Trust's gender pay gap reduced in the past year, however there are still more men receiving Clinical Excellence Awards.
- The onboarding process has been improved to ensure new starters are ready to start work on day one.
- The Committee agreed to reduce the Workforce Shortage risk to 9.

Important items to come back to committee (items committee keeping an eye on):

None

Items referred to the Board or a committee for a decision/action:

None

Recommendation	The Board is asked to note the People Committee report

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Board Annual Cycle 2022-23

Notes regarding the annual cycle:

The Board Annual Cycle will continue to be reviewed in-year in line with best practice and any changes to national scheduling.

Items	April 2022	4 May 2022	June 2022	6 Jul 2022	Aug 2022	7 Sept 2022	Oct 2022	2 Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Standing Items												
Chief Executive's Report		X		X		X		X		X		X
Integrated Performance Report		X		X		X		X		X		X
Board Assurance Framework		X		X		X		X		X		X
Data Pack		X		X		X		X		X		X
Patient Testimony (Part 1 where possible)		X		X		X		X		X		X
Employee relations (Part 2)		X		X		X		X		X		X
Elective Recovery		X		X		X		X		X		X
Board Committee Summary Reports												
Audit Committee Report		X		X		X		X				X
Charity Trustee Committee Report		X		X				X		X		
Finance, Performance and Planning Committee Report		X		X		X		X		X		X
Quality and Safety Committee Report		X		X		X		X		X		X
Strategy Committee final meeting July 2022 before moving to Board Development		X		X								
EIC moving to People Committee		X		X		X		X		X		X
Strategy												
Planning guidance										X		
Trust Strategy refresh and annual objectives										X		
Strategic transformation update				X				X				X
Integrated Business Plan						X						

Board Annual Cycle 2022-23

Items	April 2022	4 May 2022	June 2022	6 Jul 2022	Aug 2022	7 Sept 2022	Oct 2022	2 Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Annual budget/financial plan		*(X) from 2023*										
Long-term strategic infrastructure						X						X
System Working & Provider Collaboration (ICS and HCP) Updates		X		X		X		X		X		X
Mount Vernon Cancer Centre Transfer Update				X		X		X		X		X
Other Items												
Audit Committee												
Annual Report and Accounts, Annual Governance Statement and External Auditor's Report – Approval Process		X										
Value for Money Report						X						
Audit Committee TOR and Annual Report								X				
Review of Trust Standing Orders and Standing Financial Instructions								X				
Charity Trustee Committee												
Charity Annual Accounts and Report								X				
Charity Trust TOR and Annual Committee Review												X
Finance, Performance and Planning Committee												
Finance Update (IPR)		X		X		X		X		X		X
FPPC TOR and Annual Report								X				
Quality and Safety Committee												
Complaints, PALS and Patient Experience Report		X				X				X		
Safeguarding and L.D. Annual Report (Adult and Children)				X								

Board Annual Cycle 2022-23

Items	April 2022	4 May 2022	June 2022	6 Jul 2022	Aug 2022	7 Sept 2022	Oct 2022	2 Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Staff Survey Results		X										X
Learning from Deaths		X		X				X		X		
Nursing Establishment Review				X						X		
Responsible Officer Annual Review								X				
Patient Safety and Incident Report (Part 2)		X		X				X				X
University Status Annual Report						X						
QSC TOR and Annual Review								X				
Strategy Committee – move to Board Development in September												
Digital Strategy Update				X								
People Committee & Culture												
People & workforce strategy annual progress report										X		
Trust Values refresh				X								
Freedom to Speak Up Annual Report								X				
Staff Survey Results		X										
Equality and Diversity Annual Report and WRES						X						
Gender Pay Gap Report		X										
People Committee TOR and Annual Report								X				
Shareholder / Formal Contracts												
ENH Pharma (Part 2) shareholder report to Board				X								