Agenda

East and North Hertfordshire NHS Trust

Meeting: Trust Public Board - Part I

Date: Wednesday 7 September 2022 – 10.30am – 12.30pm

Venue: Lister Education Centre, Lister Hospital, Stevenage

Standing Items				
Time	**Item Number**	**Item**	**Item owner**	**Purpose**
10.30	**1**	**Chair's Opening Remarks**	Trust Chair	For noting
	2	**Apologies for Absence**	Trust Chair	For noting
	3	**Declarations of Interests**	Trust Chair	For noting
	4	**Minutes of Previous Meeting**	Trust Chair	For approval
	5	**Actions Log**	Trust Chair	For noting
10.35	**6**	**Questions from the Public**	Head of Corporate Governance	For noting
10.40	**7**	**Staff Story - Civility Matters**	Chief People Officer	For discussion
10.50	**8**	**Chief Executive's Report**	Chief Executive	For discussion
11.00	**9**	**Board Assurance Framework**	Head of Corporate Governance	For discussion
11.10	**10**	**Integrated Performance Report**	All Directors	For discussion
Strategy Items				
11.35	**11**	**Integrated Care System (ICS) Briefing and System Working**	Deputy CEO	For discussion
11.40	**12**	**Reset Week Debrief**	Chief Operating Officer	For discussion
Assurance and Governance Items				
11.50	**13**	**Value for Money Report**	Director of Finance	For noting
11.55	**14**	**Infection Prevention and Control (IPC) Annual Report**	Chief Nurse	For noting

12.00	**15**	**Workforce Race Equality Standard (WRES)**	Chief People Officer	For approval
12.10	**16**	**Treasury Management Policy**	Director of Finance	For approval
12.15	**17**	**Audit Committee becoming Audit and Risk Committee**	Head of Corporate Governance	For approval
Committee Reports				
12.20	**18**	**Finance, Performance and People Committee Report to Board** 26th July 2022	Chair of FPPC	For noting
	19	**Quality and Safety Committee Report to Board** 27th July 2022	Chair of QSC	For noting
	20	**Strategy Committee Report to Board** 11th July 2022	Chair of Strategy Committee	For noting
	21	**People Committee Report to Board** 19th July 2022	Chair of People	For noting
	22	**Audit Committee Report to Board** 12th July 2022	Chair of Audit	For noting
Other Items				
	23	**Annual Cycle**	Trust Chair	For noting
	24	**Any Other Business**	Trust Chair	For noting
	25	**Date of Next Meeting**	Trust Chair	For noting
12.30	**26**	**Close**		

East and North Hertfordshire NHS Trust

Agenda item: 4

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday 6 July 2022 at 10.00am at Mount Vernon Cancer Care

Present:	Mrs Ellen Schroder	Trust Chair
	Mrs Karen McConnell	Deputy Trust Chair and 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
	Dr Michael Chilvers	Medical Director
	Mrs Rachael Corser	Chief Nurse
	Ms Lucy Davies	Chief Operating Officer
From the Trust:	Mr Thomas Pounds	Chief People Officer
	Mr Mark Stanton	Chief Information Officer
	Mr Kevin O'Hart	Director of Transformation
Also in attendance:	Mr Stuart Dalton	Head of Corporate Governance
	Ms Katie Goodyer	Nurse (Item 22/085)(via MS Teams)
	Ms Vicki Walker	Nurse (Item 22/085)(via MS Teams)
	Julia Smith	Assistant Trust Secretary (Minutes)
Members of the Public:	Ms Kelly Livermore	(Item 22/085)(via MS Teams)
	Ms Jagdeep Kudhail	
	Mr Philip Smith	
	Ms Rujuta Bance	
	Mrs E Hill	

No	Sub-No	Item	Action
22/079		**CHAIR'S OPENING REMARKS**	
	22/079.1	The Chair welcomed the Board	
22/080		**APOLOGIES FOR ABSENCE**	
	22/081.1	Apologies were received from:	
		Mr Jonathan Silver – Non-Executive Director	
		Mr Biraj Parmar – Non-Executive Director	
22/081		**DECLARATIONS OF INTEREST**	

22/081.1 There were no new declarations of interest made.

22/082 MINUTES OF PREVIOUS MEETING

22/082.1 The minutes of the previous meeting held on 4 May 2022 were **APPROVED** as an accurate record of the meeting.

22/083 ACTION LOG

22/083.1 The Board **NOTED** the current Action Log.

22/084 QUESTIONS FROM THE PUBLIC

22/084.1 Mrs Hill of Middlesex asked the Board: Why was the Haematology-Oncology service being withdrawn at Mount Vernon Cancer Care (MVCC)? She informed the Board that she had received this in writing, and it would affect 100 patients who attended the clinic at MVCC.

22/084.2 Mrs Schroder thanked Mrs Hill for her question and explained to her that questions from the Public were asked for in advance to ensure a full and detailed answer could be given. She said as there wasn't a MVCC representative at the Board they would be unable to provide her with an answer immediately.

22/084.3 The Medical Director explained to Mrs Hill that he would ask one of his colleagues from MVCC to respond to her question in writing and provide a full answer. **Medical Director**

22/084.4 The Head of Corporate Governance wrote down Mrs Hill's details.

22/084.5 The Board **NOTED** the question and **AGREED** the Medical Director would arrange for a full response in writing to be sent to Mrs Hill following the Board meeting.

22/085 PATIENT STORY

22/085.1 The Chief Nurse explained to the Board that the patient story would be the perspective from the partner of a patient in CCU. She introduced Katie Goodyer and Vicki Walker as two of the nurses who cared for the patient and supported the family. The Chief Nurse introduced Ms Kelly Livermore as the partner of the patient Stuart.

22/085.2 Ms Livermore explained to the Board that she tested positive for Covid on 11th December 2020 and the family went into isolation which had included home schooling their two young sons. She said her partner Stuart began to feel unwell on 15th December 2020, but he didn't have the classic Covid symptoms.

22/085.3 Ms Livermore explained to the Board that Stuart tested his oxygen levels with an Oximeter and his levels were low. She said she called 111 and explained Stuart's symptoms and an ambulance was dispatched and following the paramedic checks, they took Stuart to Lister Hospital where he was admitted for breathing difficulties and signs of Sepsis.

22/085.4 Ms Livermore explained to the Board that Stuart was moved from a ward to intensive care on 16th December 2020 and Nurse Collette called Ms Livermore and explained the details of Stuart's condition. Ms Livermore said Nurse Collette was kind and compassionate and was like the family's guardian angel, she said she waited for the daily update from the ICU nurses. Ms Livermore informed the Board that she learned as much as she could about Covid to be as informed as possible as she wasn't allowed into the hospital.

22/085.5 Ms Livermore explained to the Board that one of the hardest things was not being able to just ask a question, so she made notes in a book. Ms Livermore said it was the most difficult time in her life, but she continued to reassure her children that their Dad would be ok and home soon.

22/085.6 Ms Livermore informed the Board that Stuart's infection markers started to reduce. She said the ICU team made him believe he could get better. She said it was either day 6 or 7 in ICU that he face-timed their children, he was texting regularly and that enabled her to keep friends and family updated. Ms Livermore said Stuart deteriorated again, she said that Stuart hadn't wanted to be ventilated but that he needed to be to save his life.

22/085.7 Ms Livermore explained to the Board that she took him fresh clothes and cards from the children, she said the children couldn't see him. She said she was given his washing and told not to touch it for three days and then boil wash it. She said that was frightening to her.

22/085.8 Ms Livermore informed the Board that Stuart started to improve, she said she knew he was getting better because he was hungry! She said he wouldn't be home for Christmas so on Christmas eve she took a box of treats for Stuart and the nurses to say thank you for looking after him. She explained to the Board that Stuart was moved out from ICU and on the 27th December 2020, he was taken off oxygen and given a discharge date.

22/085.9 Ms Livermore explained to the Board that she took Stuart home to start his recovery and it was frightening waiting for him to get better. She said he was a young, fit, and healthy man and was shocked at how badly Covid had affected his overall health.

22/085.10 Ms Livermore thanked every member of staff; she said every single person played their part professionally and compassionately. She informed the Board that they were getting married and had baby number 3 on the way.

22/085.11 Mrs Schroder thanked Ms Livermore for sharing her story of Stuart's journey, she said it was very useful to the Board to understand the family's point of view of what happened. She said it demonstrated

that Covid strikes all ages with Stuart being young, fit, and strong.

22/085.12 The Chief Executive thanked Ms Livermore for sharing her story. He said it was testament to the type of person she was that on Christmas Eve with the worry and stress of Stuart's condition, she was thoughtful enough to think about the staff and he thanked her for that.

22/085.13 Dr Buckle commented that it highlighted the importance of good informative communication with relatives.

22/085.14 Dr Carter commented that doctors and nurses had seen more deaths in a few weeks than they would see in a year. He said over 60,000 NHS staff were being treated for PTSD. The Chief People Officer informed the Board that in terms of support, staff were not in need of it a year ago, but the need for that support was visible now. Mrs Schroder commented that managers needed to be aware of the signs and offer support. She said it was going to be a difficult environment over the coming months and years and there would be a lot of pressure on staff. It was confirmed that wellbeing would be monitored through the People Committee and escalated to Board by exception.

22/086 CHIEF EXECUTIVE'S REPORT

22/086.1 The Chief Executive informed the Board that the Chief Nurse had accepted a new role and would leave the Trust in September. He said Theresa Murphy had been recruited as the new Chief Nurse and would join the Trust so there was no handover gap. He said Theresa had been a Chief Nurse in the past and would bring a lot of experience. The Chief Executive congratulated the Chief Nurse.

22/086.2 The Chief Executive congratulated the former Chief Executive for his nomination in the Queen's birthday honours as well as the Chair of the Lister Area Kidney Patients Association.

22/086.3 The Chief Executive informed the Board that it was thank you week in the Trust and there would be multiple activities across the Trust sites. He said it was also an opportunity for celebrate the NHS's 74th birthday and present long service awards to staff.

22/086.4 The Chief Executive explained to the Board that the NHS was seeing an increase on Covid patients. He said the modelling for the region projected increased numbers potentially as high as the first wave. He said the first wave had more severe outcomes, but it would be the impact on staffing numbers which would add to operational pressures. The Chief Executive confirmed that mask wearing would continue in clinical buildings but not in non-clinical areas.

22/086.5 The Chief Executive explained that himself, the Medical Director and

the Head of Research and Development attended the Stevenage Science Campus, he said there would be investment in that area, they were keen to involve the local hospital and encourage others to support building research in the local community.

22/086.6 The Chief Executive informed the Board that the Chief Midwifery Officer had joined the private Board meeting to provide an overview of maternity services and a review of Ockenden. He said two Trust Senior Midwife Officers had been awarded for their achievements and were a credit to the Trusts' maternity services. Dr Carter commented on the Senior Midwife visit that the Trust had been the 65th Trust she had visited and had been complimentary about the service.

22/086.7 The Board **RECEIVED** and **NOTED** the Chief Executive Officer's report.

22/087 BOARD ASSURANCE FRAMEWORK

22/087.1 The Head of Corporate Governance informed the Board that the 2022/23 BAF would be presented to the Board Committees in July and said the specific risks would be considered in detail at Committee level.

22/087.2 The Board **RECEIVED** and **NOTED** the Board Assurance Framework.

22/088 INTEGRATED PERFORMANCE REPORT

22/088.1 The Deputy Chief Executive and Director of Finance introduced the Month 2 Integrated Performance Report and noted the new format. He said it was a large document that would continue to evolve and encouraged feedback from Board members.

22/088.2 **Safe, Caring and Effective**

The Chief Nurse highlighted the following from Safe and Caring:

- The dip in VTE performance had been predicted in part due to the ePMA roll-out. Work was underway to understand what was driving the reduction and to ensure appropriate actions were in place. The Harm Free Care team had been tasked to undertake a review.
- Sepsis was seeing improvement in areas, there had been issues with data collection but now staff were back on site, improvement was being seen. A lot of work would be required for patients waiting for urgent and emergency care.

22/088.3 The Medical Director highlighted the following from Effective:

- With the triangulation of mortality, re-admission, and length of stay as well as the move to the CHKS, there is a lot more detail

in the data.

- The triangulation of data would underpin the work and maximising the use of Hospital at Home.

22/088.4 **Responsive**

The Chief Operating Officer highlighted the following:

- The Emergency Department (ED) continued to feel the pressures of high attendances.
- Ambulances and acuity were not higher than pre-Covid. The pressures were from the physical areas either being shut for capital works or the impact of Covid on staff absences.
- Work was underway with System and internal colleagues to renovate urgent and emergency care. A workshop would be run to examine in a data-driven way the flow issues out of the ED and identify three actions that could help to resolve the issues.
- June ended with only one patient having waited more than 104 weeks for treatment and that patient had recently undergone surgery.
- Demand and capacity work for patients to wait no longer than 78 weeks had started.
- The level of demand for diagnostics was in-excess of capacity and it would be some time before the Trust started to reduce the backlog of patients to be seen. Additional InHealth mobile MRI units would be used, and mutual aid would be explored with West Herts NHS. These measures should facilitate a more stable position in around six months.
- The Trust continued to meet the 62-day cancer target, but it was not a comfortable position with the expectation of further deterioration. A detailed demand and capacity piece of work on cancer services would be required.
- Stroke beds had been ring-fenced on the unit to aid with improved performance on admission times for patients on the Stroke pathway. The SSNAP D rating was for the last quarter of 2021/22.

22/088.5 **Well-Led**

The Chief People Officer highlighted the following**:**

- Recruitment was positive with vacancy rates down from 6.5% to just below 5%. The percentage was down due to pump-priming the recruitment work to ensure numbers of staff were onboarded efficiently. There had been over 70 new starters but the

retention offer needed strengthening.

- Induction and on-boarding processes would be reviewed alongside the key stages of support to ensure Trust staff were the best they could be and flexible working to meet the needs of the staff and service would be important factors.
- A review of staff groups, rostering and temporary staffing would be undertaken to reintroduce staffing controls as at ambition to return to 95% usage across the organisation. Medirota had replaced Allocate which among other benefits provided more autonomy to the workforce to manage their time to increase flexibility.
- Grow Together conversations were underway across the organisation with the aim of completion by the end of August. The start had been delayed by the strategic priorities approval process. The conversations were proving to be valuable for a number of reasons including ensuring statutory and mandatory training was up to date, as well as returning to the highest possible standards.

22/088.6 **Sustainability**

The Deputy Chief Executive and Director of Finance highlighted:

- The 2022/23 plan had been finalised and approved and this would enable the Trust to receive additional funding from the Centre in month 3.
- It had been a difficult and challenging entry point to the new financial year with a £4.5m deficit in month 2 which would need to be managed.
- The ERF had enabled expansion to increase delivery and earn revenue to support costs. Additional capacity was expected at the end of the summer, June and July would be test points.
- CIP was £1.2m short of target, it had been set as an ambitious target and was at a concerning position at an early stage in the year. The teams were working to recover the position and there was good governance in place.
- Pressure against pay budgets, specifically medical staffing, sickness absence and non-availability was reported. The management of the Establishment was an important development and work the Divisions were carrying out with budget holders would ensure there were good control mechanisms in place.

22/088.7 Dr Buckle recognised it was the most difficult time within the NHS

and asked for assurance that patients waiting a long time within the ED were safe. The Chief Operating Officer explained to the Board that the ED staff used every opportunity to ensure patients were safe including consultations in ambulances to ensure those most unwell were prioritised for treatment. The Medical Director commented that the situation was far from ideal but reassured Dr Buckle that the seniority of staff undertaking tasks such as triage was to ensure patient safety. The Chief Nurse informed the Board that there were triggers around safety protocols and the risk was shared across the organisation. She said where there was a confirmed discharge on a ward, the ED patient would be moved to that area, there were hourly meetings to identify concerns around safety of patients and frequent round table conversations to manage issues as quickly as possible. The Chief Nurse explained that it only took one patient with complex needs to destabilise the department but there were processes and mitigations in place the manage safety in the ED.

22/088.8 Dr Buckle commented on the numbers of patients waiting for diagnostic tests and said there would be patients deteriorating whose diagnosis would be late. He asked if there were improvement plans in place. The Chief Operating Officer informed the Board that additional MRI capacity would be in place, but it would take in the region of six months before improvement would be seen. She assured the Board that Cancer pathways were diagnosed as a priority.

22/088.9 Ms Moore commented that there was good maternity data, and the ring fencing of Stroke beds was positive. She asked about the fundamentals of care such as pressure ulcers and whether there were improvements in the pipeline and tactics to join up at patient care level. The Chief Nurse recommended that a Harm Free Care deep dive be undertaken at the Quality and Safety Committee which could be reported back to Board to provide assurance. Chief Nurse

22/088.10 Mrs McConnell asked for assurance that increasing medical and nursing staff feeling the impact of PTSD were considered when the rostering was carried out to ensure they had the time for support. She said if medical staff were moving locations, was there a mechanism to identify the pressures they may be under. The Chief People Officer informed the Board that the minimum time for issuing rotas was 6 weeks and 8 weeks for Juniors which provided time for the reviewing of rotas and building flexibility into the system. Mrs McConnell asked how the Trust would identify medical staff from other locations coming into East and North Herts who required support, The Medical Director informed the Committee that the Junior Doctors would be managed through the Deanery and they would communicate with the Trust if there were known issues. The

Chief Nurse explained to the Board that within inpatients, the ward leaders had three days for supervisory time which would be expected to be backfilled for restorative supervision. She said there was a framework in place however more could be done.

22/088.11 Dr Carter commented that there was evidence that medical staff found it hard to discuss mental health issues and medicine had one of the highest suicide rates within the professional groups. He said lifestyle issues associated with shift work were also common and night shift nurses had a shorter life expectancy. He agreed everything that could be, was being done.

22/088.12 The Board **RECEIVED** and **NOTED** the Month 2 Integrated Performance Report

STRATEGY AND CULTURE REPORTS

22/893 STRATEGIC TRANSFORMATION UPDATE

22/089.1 The Director of Transformation informed the Board that a new Executive Programme Board had been established to provide overview of the delivery of transformation projects and seek assurance and identify programmes. He said there had been an introduction of Executive Senior Responsible Officers (SRO) which moved away from tradition Executive portfolios and used himself as an example as being the SRO for complaints.

22/089.2 The Director of Transformation explained to the Board that the portfolio approved at the May Board would evolve over the coming months. He said internal and external improvement projects were being reflected on including digital enablers, theatre timetables and supporting elective recovery.

22/089.3 The Director of Transformation informed the Board that there were a growing number of transformation projects which focused on system redesign and partner working. He said there had been a focus on new models of care and direct access models, hospital at home reaching out to community services and an element of work looking at readmissions, ED attendees and wrap around services with primary care.

22/089.4 The Director of Transformation explained to the Board that work was underway in areas where population health was being adopted and understanding how geographical locations could identify areas for improvement.

22/089.5 Mrs Schroder complimented the report and agreed the work should be monitored by Board. She said metrics within the report would be useful such as milestones, target dates and whether the projects were delivering value. Ms Moore noted that it would be good to see milestones and understand which committee monitored which piece

of work. The Transformation Director explained that the Executive Programme Board monitored all work.

22/089.6 The Board **RECEIVED** and **NOTED** the Strategic Transformation update.

22/090 SYSTEM WORKING AND PROVIDER COLLABORATION (ICS and HCP) UPDATE

22/090.1 The Deputy Chief Executive and Director of Finance informed the Board that on the 1st July 2022 the Integrated Care Boards (ICB) became legally established. He said that formality would shape future updates.

22/090.2 The Deputy Chief Executive and Director of Finance explained to the Board that the Pathology project had reached a crucial stage, the bid had been received and would be evaluated with a conclusion expected in August 2022. He said it would be reviewed at multiple Board Committees as it covered a range of disciplines.

22/090.3 The Deputy Chief Executive and Director of Finance informed the Board that work continued on the surge hub and although there had been a level of difficulty with system level decision making due to the other potential options identified, it had been agreed that the Lister Treatment Centre options be prioritised and finalised. He said some surge hubs already had confirmed funding with the building phase commenced. He continued that strategy development was important and needed to be prioritised.

22/090.4 Mrs Schroder asked what the barriers to decision making were. The Deputy Chief Executive and Director of Finance explained to the Board that it was important the system had a joint view and assessment of what was required for the service as well as a broad agreement to use the facility for elective recovery. Mrs Schroder commented that momentum was required and asked what could be done. The Deputy Chief Executive and Director of Finance explained to the Board that all levels within the hierarchy were all focused on expediting progress,

22/090.5 Mrs Schroder commented on winter planning and asked if there were the right forums in place with willingness to engage. The Chief Operative Officer explained to the Board that the mechanism for winter planning was in place. She said the Trust would be aligned to the national request to increase beds by 7.5%. Mrs Schroder asked for assurance that winter planning was being undertaken. The Chief Operating Officer explained to the Board that the Trust was waiting for the system planning detail, she said the Trust was engaged in the right groups and would be well positioned and sighted on winter plans.

22/090.6 Mrs Schroder commented that it would be important to understand what was happening across the ICS in terms of performance against financial targets. She said the Board had little visibility and asked that the information be included in future Board papers. The Deputy Chief Executive and Director of Finance explained to the Board that there was a range of quality and performance data that could be included in future papers. Mrs Schroder said that an overview would be valuable to the Non-Executive Directors.

22/090.9 The Board **RECEIVED** and **NOTED** the System Working and Provider Collaboration (ICS and HCP) update.

22/091 DIGITAL STRATEGY UPDATE

22/091.1 The Chief Information Officer informed the Board that the roadmaps for various systems had restarted and moved from transformation projects to business as usual. He said nursing assessments had been implemented, new equipment at ward level and work was increasing in the background. He continued that digital equipment used at ward and board rounds was a significant change in practice. He said Trust capital funding was being invested in preparation for the EPR. Specialities had been supported including theatre scheduling, ophthalmology, and support on wards as well as a significant amount of work with specialist groups.

22/091.2 Mrs Schroder commented that the whiteboards on wards needed to be removed in favour of digital screens. The Chief Information Officer informed the Board that there had been a delay with the digital screen but that would be resolved within a few weeks and the whiteboards could then be removed. He said there was a lot of old equipment on the wards, but they were moving to modern and fully functioning equipment which was providing them with the right tools.

22/091.3 The Chief Nurse informed the Board that the Chief Nursing Information Officer had made a significant difference to the organisation.

22/091.4 The Board **RECEIVED** and **NOTED** the Digital Strategy update.

ASSURANCE AND GOVERNANCE REPORTS

22/092 SAFEGUARDING AND LEARNING DISABILITY ANNUAL REPORT (ADULT and CHILDREN)

22/092.1 The Chief Nurse assured the Board that the annual report had been scrutinised in detail by the Quality and Safety Committee and the detail around the increase in demand and how the team continued to safeguard vulnerable people had been reviewed.

22/092.2 The Chief Nurse informed the Board that there was ongoing review of practices including the changes in health and care and the move

from Deprivation of Liberty (DOLs) to the Liberty Protection Safeguards.

22/092.3 The Chief Nurse informed the Board that the White Ribbon campaign continued and was driven by violence and aggression towards Trust staff. She said it would promote the practice and recognition and response to domestic abuse for staff and patients across all Trust sites.

22/092.4 Ms Moore explained to the Board she had tracked the safeguarding integration work and acknowledged the Trust had capacity issues. She said the priorities for the next year were correct. Ms Moore complimented the Safeguarding team on the work they had done and the integration of adult and children's safeguarding. Dr Carter supported Ms Moore in congratulating the team and on the importance of integrating adult and children's safeguarding.

22/092.5 The Board **RECEIVED**, **NOTED** the Safeguarding and Learning Disability Annual Report (Adult and Children).

22/093 LEARNING FROM DEATHS REPORT

22/093.1 The Medical Director informed the Board that there had been a sustained positive position for mortality.

22/093.2 The Medical Director informed the Board that the outlying areas would be recoded. He said various cardiology codes had escalated but with a combined process including the coder and clinician was making a significant difference.

22/093.3 The Medical Director informed the Board that under the Finance function a robust coding team had been developed but to support work with clinicians the coding team had moved to the Medical Directors office.

22/093.4 The Medical Director celebrated a member of the coding team for passing her coder exam and informed the Board that she had developed and progressed through the Trust.

22/093.5 The Medical Director informed the Board that there was a focus on the National Hip Fracture data as the data was old and highlighting mortality to be above the national average at 12%. The Medical Director informed the Board that an internal review was underway and assured them that more recently, 30-day mortality had reduced. He said the internal review would continue.

22/093.6 The Medical Director informed the Board that the output from the CCG audit of deaths in the community had been useful and would be considered by the Neck of Femur (NOF) team.

22/093.7 The Medical Director informed the Board that the HSPR data

remained above the national peer average.

22/093.8 The Medical Director informed the Board that there would be an audit of the NELA patients going to theatre to identify patients who would receive no benefit from surgery, and it was not in the patients' best interest.

22/093.9 Mrs McConnell asked for clarification on the mortality figures for skin disorders. The Medical Director informed the Board that there were certain codes being checked and confirmed with clinicians. He said this would be checked to ensure the coding was correct.

22/093.10 Dr Buckle commented that the mortality rates were excellent, and the Trust should be proud of them. He said one of his concerns was patient safety but was assured by the mortality rates.

22/093.9 The Board **RECEIVED** and **NOTED** the Learning from Deaths report.

22/094 NURSING ESTABLISHMENT REVIEW

22/094.1 The Chief Nurse asked the Board to approve the skill mix change in the respiratory ward. She said the review had been fully evaluated and challenged.

22/094.2 Mrs Schroder asked if it was a cost neutral change. The Chief Nurse confirmed it wasn't cost neutral.

22/094.3 The Board **RECEIVED** and **APPROVED** the Nursing Establishment review.

22/095 COMPLAINTS ANNUAL REPORT

22/095.1 The Chief Nurse explained to the Board that the annual report had been scrutinised by the Patient and Carer Experience group as well as the Quality and Safety Committee. She asked the Board to note the report and welcomed feedback in advance of the next year's report.

22/095.2 The Chief Executive commented on the return of the Therapy dogs and it was a positive experience for patients.

22/095.9 The Board **RECEIVED** and **NOTED** the Complaints Annual Report.

22/096 QUALITY ACCOUNT

22/096.1 The Chief Nurse informed the Board that the Quality Account was an excellent showcase of the work undertaken over the last year. She said it showcased national worthy outcomes for patients.

22/096.2 Mrs Schroder commented that a shortened version would have a great impact if distributed through GP practices for example.

22/096.3 The Chief Executive explained to the Board that the Quality Account was a piece of formal governance and caught between a showcase

of what had been delivered and what was mandated. He said early planning would showcase the work and the detail.

22/096.4 The Chief Nurse informed the Board that the Quality Account had been circulated for feedback externally to the CCG, Healthwatch and other System partners.

22/096.5 The Board **RECEIVED** and **NOTED** the Quality Account.

SUB-COMMITTEE REPORTS:

22/097 FINANCE, PERFORMANCE AND PLANNING COMMITTEE REPORT TO BOARD

22/97.1 The Board **RECEIVED** and **NOTED** the summary reports from the Finance, Performance and Planning Committee meetings held on 24 May 2022 and 28 June 2022.

22/098 QUALITY AND SAFETY COMMITTEE REPORT TO BOARD

22/098.1 The Board **RECEIVED** and **NOTED** the summary reports from the Quality and Safety Committee meetings held on 25 May 2022 and 29 June 2022.

22/099 CHARITY TRUSTEE COMMITTEE REPORT TO BOARD

22/099.1 The Board **RECEIVED** and **NOTED** the summary report from the Charity Trustee Committee meeting held on 7 June 2022.

22/100 PEOPLE COMMITTEE REPORT TO BOARD

22/100.1 The Board **RECEIVED** and **NOTED** the summary report of the People Committee meeting held on 17 May 2022.

22/101 AUDIT COMMITTEE REPORT TO BOARD

22/101.1 The Board **RECEIVED** and **NOTED** the summary report from the Audit Committee meeting held on 20 June 2022.

22/102 ANNUAL CYCLE

22/102.1 The Board **RECEIVED** and **NOTED** the latest version of the Annual Cycle.

22/103 ANY OTHER BUSINESS

22/103.1 No other business was raised.

22/104 DATE OF NEXT MEETING

22/104.1 The next meeting of the Trust Board will be on 7 September 2022.

Ellen Schroder
Trust Chair
July 2022

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

Agenda item: 5

EAST AND NORTH HERTFORDSHIRE NHS TRUST
TRUST BOARD ACTIONS LOG TO 7 SEPTEMBER 2021

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
4 May 2022	22/057.5	Question from the Public re smoking within Trust grounds	Review the smoking policy with a task and finish group to include Dr Alex Wilkinson, Occupational Health, expert opinions, staff and patient representatives, Mental Health team and the Ambulance Service	August 2022 update: Medical Director on leave for September Board but will provide an update to the Board in November	Medical Director	November 2022
4 May 2022	22/068.3	Ockenden Update	Undertake a gap analysis against the 15 core recommendations which would be benchmarked against with peer-to-peer challenge and review	Gap analysis, benchmarking and peer-review all completed	Chief Nurse	September 2022
6 July 2022	22/084.4	Question from the Public re service changes at Mount Vernon	Medical Director to organise a full response to the question posed to the Board by a member of the public	Complete. Response sent to member of the public, confirming the member of public's understanding of service changes was correct	Medical Director	Immediately
6 July 2022	22/088.9	IPR	Undertake a Harm Free Care deep dive at the Quality and Safety committee and report any escalations to Board		Chief Nurse	November 2022

Report Coversheet

East and North Hertfordshire NHS Trust

Chief Executive's Report

September 2022

Corporate Update

This meeting will be the final one for our chief nurse, Rachael Corser, who takes up her post as chief nursing officer at the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System later this month. We thank Rachael for all she has achieved during her time with the Trust and wish her well in her new role.

Theresa Murphy has now joined us as our new chief nurse and will be spending time handing over from Rachael this week. Theresa has significant experience at board level and has been the chief nursing officer in a range of organisations including Portsmouth University Hospital Trust and The Hillingdon Hospital Foundation Trust.

This month also sees the departure of Chinyama Okunuga, managing director for unplanned care, who has been appointed as chief operating officer at Whittington Health NHS Trust. We wish her every success in this new role.

Hospital Update

Services continue to be under significant pressure as we strive to treat our elective patients and reduce waiting times as well as managing the ongoing pressure of attendances through the Emergency Department.

Winter preparedness

NHS England has written to integrated care boards and trusts setting out objectives and metrics for this coming winter.

The eight objectives are:

1) Prepare for variants of COVID-19 and respiratory challenges, including an integrated COVID-19 and flu vaccination programme.
2) Increase capacity outside acute trusts, including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter.
3) Increase resilience in NHS 111 and 999 services, through increasing the number of call handlers to 4.8k in 111 and 2.5k in 999.
4) Target Category 2 response times and ambulance handover delays, including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged trusts.
5) Reduce crowding in A&E departments and target the longest waits in ED, through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services.

6) Reduce hospital occupancy, through increasing capacity by the equivalent of at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway.
7) Ensure timely discharge, across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the '100-day challenge'.
8) Provide better support for people at home, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.

Six metrics will be monitored as below:

1) 111 call abandonment.
2) Mean 999 call answering times.
3) Category 2 ambulance response times.
4) Average hours lost to ambulance handover delays per day.
5) Adult general and acute type 1 bed occupancy (adjusted for void beds).
6) Percentage of beds occupied by patients who no longer meet the criteria to reside.

Covid Update

At the time of writing, 40 inpatients had a diagnosis of Covid-19 with no positive patients in the Intensive Care Unit.

New guidance has been received from the government as follows:

Prevalence in the community has fallen and remains at a comparatively low level as we emerge from the current Omicron wave. This means that the likelihood that individuals entering high-risk settings such as the NHS are infectious has also reduced and the relative risk of onward transmission into these settings is lower. Therefore, routine asymptomatic testing in a number of settings will pause from 31 August.

This means most asymptomatic staff and patient testing will pause. Other infection prevention and controls measures remain under constant review by the Trust.

Mortuary

The Lister mortuary has been reopened following refurbishment. The six-month renovation means the mortuary team now have the ability to care for more of our deceased patients, as well as upgraded security equipment which includes card access, CCTV and intruder alarms.

The viewing rooms have also been decorated thanks to funding from our hospitals' charity and bespoke paintings donated by nurse and artist Dagmar Louw.

Professor Nikhil Vasdev

Nikhil has been appointed as a Professor of Robotic Surgery at the University of Hertfordshire's School of Life and Medical Sciences.

This further develops our strong relationship with the University.

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**	7 September 2022
Presenter	Stuart Dalton, Head of Corporate Governance			
Author	Stuart Dalton, Head of Corporate Governance			
Responsible Director	Each of the risks have been reviewed by the lead Director		**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**	☐
	Discussion	☒	**Decision**	☐

Report Summary:

The BAF risks (appendix 3) are attached for Board review. A summary of the 2022/23 BAF risks approved by the Board in July is presented (**appendix 1**), with the Heat Map (**appendix 2**) and the Trust's strategic priorities (**appendix 4**).

The following key risk points or changes are highlighted:

- Risk 3 (Financial constraints): Risk 3 is the highest scored risk on the BAF at 20 and therefore warrants particular attention from the Board
- Risk 8 (Improving performance and flow): The risk score has been increased from 12 to 16 to reflect performance challenges which are affecting our Trust (as well as Trusts nationally)
- Risk 12 (Clinical engagement with change): reduced risk score from 16 from 12 following the work to populate the controls demonstrated mitigations had reduced the risk

Impact: where significant implication(s) need highlighting

The trajectory section of the BAF will start to measure impact on risk scores from November Board.

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

An Executives' corporate risk brainstorming session is planned for 15 September to agree the top corporate risks. This will allow key corporate risks to be triangulated with BAF risks. Further details on enhancing corporate risk are included in the Audit & Risk Committee paper.

Report previously considered by & date(s):

The draft BAF risks were approved by Board on 6 July. This paper is the first completed/populated BAF. However, please note that due to the there not being committee meetings in August, the BAF has not been considered by committees, bar finance risks 3 and 9 which were considered by July FPPC. Therefore, further developmental work is anticipated following committees' consideration.

Recommendation	The Committee is asked to **NOTE** the BAF.

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 People Officer Chief Nurse Medical Director	People Quality & Safety	12	⟷
2.	**Population/stakeholder expectations**	Chief Nurse Medical Officer	Quality & Safety	12	⟷
3.	**Financial constraints**	Chief Financial Officer	Finance, Performance and Planning	20	↑
Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability					
4.	**Workforce shortages and skills mix**	Chief People Officer	People	12	⟷
5.	**Culture and leadership**	Chief People Officer	People	16	⟷
6.	**Engagement and listening**	Chief People Officer	People	16	⟷
Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners					
7.	**Immature place and system collaborative processes and culture**	Chief Nurse, Medical Director	Trust Board	16	⟷
8.	**Improving performance and flow**	Chief Operating Officer	Trust Board	16	↑
9.	**Financial flows and efficiency**	Chief Financial Officer	Finance, Performance and Planning	12	⟷
Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities					
10.	**Technology, systems and processes to support change**	Director of Transformation	Quality & Safety	16	⟷
11.	**Freedom to experiment**	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 italic [to be added once agreed as part of thefirst cycle of Committees in September/October]***

Impact						
	5				3	
	4			1; 8; 9; 11; 12	5; 6; 7; 8; 10	
	3				2; 4	
	2					
	1					
	I x L	1	2	3	4	5
		Likelihood				

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**

Section 3 –Strategic Risks

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

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

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

Controls	Assurances reported to Board and committees
Strategies and Plans • Clinical Strategy 2022-2030 • People Strategy • Annual Divisional workforce plans **Operational Systems and Resources** • Local recruitment and retention plans • International recruitment plans • Training needs analysis reviews (capability building) • Fill rates and reviews • GROW appraisal and talent system • Apprenticeship schemes • Change policy and toolkit • Pre and post reg training programs **Governance & Performance Management Structures** • Divisional Board Performance reports • Accountability and Review Meetings (ARM) • People Committee	**First and second line (internal) assurances** • Integrated performance report key indicators • Deep Dive recruitment briefs and reviews reports • Freedom to Speak up prevalence thematic analysis reports • Board members walk rounds **Third line (external) assurances** • Staff survey results • External benchmarking with ICP, ICB and partners • Ad-hock feedback: HEE / Professional Bodies / Academic body (pre and post reg) partners feedback • Care Quality Commission engagements session feedback reports
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• No substantive care support worker development programme • Unwarranted variation across recruitment and retention workforce specific plans e.g., pharmacy, admin staff • National cost of living and employment picture	• Redesign of service delivery and development of new roles to support pathways and grow your own skills/talent • Review of establishment in ESR for baseline • Specialty specific Recruitment and retention plans

Current Performance - Highlights

The following points are highlighted from the Integrated Performance Report:

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

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
	To be added following Executives' corporate risk brainstorming session on 15 September (this applies to all the BAF risks)	

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

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

Risk Lead	Chief Medical Officer/Chief Nurse	Assurance committee	QSC

Controls	Assurances reported to Board and committees
Partnership Arrangements • NHSE/I Recovery operational plan • ICB agreements • Health watch • Provider collaborative • Elective HUB development / Community diagnostic HUB **Strategies and Plans** Quality Strategy National Patient Safety Strategy National patient experience Strategy **Systems and Resources** • QlikView Quality dashboards • Quality Oversight System 'EnHance' **Governance and Performance Management Structures** • Accountability review meetings • Patient and Carer Experience Committee • Patient initiated Follow Up programme • Risk management group **Quality Management Processes** • Clinical harm reviews - cancer and non-cancer • Learning form incidents **Sharing best practice** Transformation work: • Discharge collaborative • Complaint's transformation • Outpatient and theatre transformation • ICS transformation programme	**First and second line (internal) assurances** • Divisional Board escalation reports • 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 **Third line (external) assurances** • NHS Annual specialty patient surveys (ED, cancer) reports • NHS Friends and family survey results • Care Quality Commission assessment reports • GP Liaison pathway prevalence and themes • NHSE regulator review meeting escalation reports • PLACE based Quality Group • ICS Quality Surveillance Group • ICB performance board reports • NHSE performance group reports • CCG (ICB) quality assurance visit feedback and action trackers • ICB Elective group escalation reports
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Poor timelines in responding to concerns	• Complaint's transformation programme in place

• Unwarranted variation across specialty booking Follow Up processes • Unwarranted variation on Clinical Harm Review - non cancer backlog • Less clear processes of harm review related to time waited for procedure included in Learning form deaths • Delayed in patient information of non-cancer diagnosis • RTT TIER 1 Status	• Safety improvement learning collaborative by Q3 • Transitioning to new a learning form incident framework by Q4 • Pro-active Communication plan with public and partners in progress • 'My planned care link'; linked to trust web page and patient info currently live • ICB case for approval Clinical harm review digital solution in progress for >52weeks incidents • Wider patient experience programme and codesign plans

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 of 68 complaints received each month on average
- On average 75% of complaint responses are responded to within agreed timeframe

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

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

Risk Lead	Chief Financial Officer	Assurance committee	FPPC

Controls	Assurances reported to Board and committees
Strategies and Plans • Approved 22/23 Revenue, Capital, CIP & Activity Plan **Operational Systems and Resources** • Financial Reporting Systems – Finance Qlikview Universe • Detailed monthly CIP performance reporting **Governance & Performance Management Structures** • Monthly FPPC & Exec Committee Reporting • Monthly Divisional Finance Boards meetings • Monthly Capital Review Group • Monthly cost centre / budget holder meetings • Bi-weekly ICS Director of Finance meetings • Ratified SFI's and SO's, Counter Fraud Policy • Consolidated ICS Procurement Service & Governance	**First and second line (internal) assurances)** • Weekly finance team planning meeting • Monthly Finance Report / Key Metrics **Third line (external) assurances** • Financial plan submitted to and approved by NHSE • Monthly financial reporting to NHSE • 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 • Gap in delivering ERF planned income and activity levels, creating the risk of revenue claw back • Significant overspend against elements of the Trust's workforce establishment. • Ratification of Medium-Term financial plan (MTFP) and assumptions – both Trust & ICS, triangulation with clinical strategy and improvement / transformation projects.	• (Q2) Development of outturn forecast to structure remedial and proactive financial activity in 22/23. • (Aug) Review of outlying specialties to identify opportunities for delivery improvement/cost reduction. • (Q2) Implementation of revised divisional financial management meeting structure • (Aug) implementation of additional CIP project managers within divisions. • Validation of MTFP

Current Performance - Highlights

The following points are highlighted from the Integrated Performance Report (data for June 2022):

- The Trust reports a deficit of £3.5m at Q1. This is in line with YTD plan, but significant financial risk items are embedded with the position that indicate significant challenges to plan delivery in the remain of the year.
- These risks include an undershoot of £2.1m against the agreed CIP savings plan, highlighting both gaps in a range of individual savings projects and also general gaps in the skills and capacity to deliver the programme. (see actions below)
- ERF income and activity is significantly below the value and volume of work targeted. The Trust presently assumes full receipt of these funds pending the planned escalation of additional elective activity.
- The Trust reports significant pay bill pressures in the YTD, particularly in relation to medical staffing budgets.

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

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

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

Risk Lead	Chief People Officer	Assurance committee	People Committee

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

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

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

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

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

Risk Lead	Chief People Officer	Assurance committee	People Committee

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

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

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

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

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

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

Risk Lead	Chief People Officer	Assurance committee	People Committee

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

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

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

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

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

Risk Lead	Chief Nurse / Medical Director	Assurance committee	QSC

Controls	Assurances reported **to Board and committees**
Strategies and Plans • Clinical Strategy and Trust objectives • Joint strategic needs assessment **Financial Controls** • Cross System pathway transformation commissioning priorities at PLACE/ICB/ICS **Governance & Performance Management Structures** • ICB Board • ICS Board • Place Board • Scrutiny committee • Health and wellbeing board **Relationships** • Strong networks *[specifics to be clarified]*	**First and second line (internal) assurances** • Escalation reports to: Quality and Safety Committee; People Committee: Clinical Audit & Effectiveness sub-committee • Integrated performance reports to Board/ Committees • Well led framework assessment and review reports • Elective recovery programme escalation reports **Third line (external) assurances** • NHSE Board feedback forums
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Defined governance frameworks	• ICB/ICS/Place leadership strategy group reports
• Missed opportunities to influence joint strategic needs assessment	•
• Developing role, responsibilities, and relationships	•
• Developing cross systems agreed values and behaviours	•

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

Associated Risks on the Board Risk Register

Risk no.	Description	Current score

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

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

Risk Lead	Chief Operating Officer	Assurance committee	FPPC

Controls	Assurances reported to Board and committees
Strategies and Plans • Recovery plans (Elective; Cancer; Stroke) • Cancer Strategy • System UEC strategy (incl ambulance and discharge flow) **Performance Information Controls** • IPR • Deep dives • Qlikview dashboards **Governance & Performance Management Structures** • Transformation programmes at the Programme Board • FPPC • ARMs – includes exception reports • Divisional Board meetings • Regular tumor group meetings and improvement workstreams • System-wide Cancer Board chaired by COO • Specialty exception meetings	**First and second line (internal) assurances** • Board (IPR; transformation) • FPPC (IPR & deep dives) • Board Seminar (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 • ARM meetings – revised format from September
• Scope of validation of Patient Tracking Lists	• Increasing validation of Patient Tracking Lists
• Ambulance intelligent conveyancing lack of proactiveness	• System solution to intelligent conveyancing/ambulance intelligence
• Lack of social care and community capacity to support discharge • Utilisation of Hospital at Home not yet optimal – further work being undertaken to increase uptake.	• Extending scope of hospitals at home – not matching what we need (taking patients who are awaiting packages of care)
• Capacity to increase referrals to cancer pathways	• ARM review (Laura Moore doing)
• Clinical and administrative processes for progressing patients through their pathways	• Increasing MRI insourcing capacity • System being implemented to speed up the process of informing patients they do not have cancer

• Diagnostic wait times – Access Board, Cancer Board	• TBC

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

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

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

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

Risk Lead	Chief Financial Officer	Assurance committee	FPPC

Controls	Assurances reported to Board and committees
Strategies and Plans • Signed SLA contracts with ICS commissioners for 22/23 – embedding finance and associated plans. • Clinical Strategy and associated prioritisiation and development framework. Linked to place priorities **Financial Controls** • Monthly ERF & SLA activity reporting schedules **Governance & Performance Management Structures** • Establishment of SFA team to provide strategic finance transformation evaluation support • Bi-weekly ICS System Leaders meeting • Bi-weekly ICS DoFs and DDOFs meeting • Monthly E&N Herts Partnership Board & associated meetings • Elective Surgical Hub, Community Diagnostic Hub, Virtual Hospital and Heart Failure local and regional governance arrangements • PHM reporting mechanism to track changes in patient flows and associated costs and income • PHM steering and development group and link to place and system PHM development activity	**First and second line (internal) assurances** • System and Provider Collaboration reports to Trust Board advising on activity • Monthly project review sessions between Finance & Transformation Team. **Third line (external) assurances** • Consolidated ICS financial performance reports • Share further ICS performance reports as they develop.
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Establishment of transparent financial reporting environment across ICS partners • Development of ICS financial risk management strategy • Determination of place based financial responsibilities • Development of long-term financial plan for ICS • Acute Provider Collaborative and associated business rules	• Q3 – ICS DoFs to work together to develop ICS financial framework for implementation • Distillation of ICS framework to a place level where appropriate. • Development and ratification of Acute Provider Collaborative during Q2 • Development of System / Place finance impact assessment report (Q2)

Current Performance - Highlights
The following key performance indicators are highlighted from the Integrated Performance Report (data from June 2022): • ERF income and activity is significantly below the value and volume of work targeted. The Trust presently assumes full receipt of these funds pending the planned escalation of additional elective activity.

- Virtual Hospital activity level remain significantly below levels targeted
- Community Diagnostic Hub activity is reported
- Outpatient referral levels have returned to volumes consistent with the pre pandemic period. Conversion rates between referrals and outpatient appointments have remained constant
- Further Board dialogue to be facilitated to help develop further metrics that can support assurance

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

Strategic Aim: **Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities**		Risk score 16
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	4	4	16
Target	2	3	6

Risk Trend

Future editions of this report will include a trend line showing the evolution of the risk score from month to month

Risk Lead	Director of Transformation	Assurance committee	QSC

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

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

Current Performance - Highlights
• Executive Programme Board now established with strategic objective portfolio reporting to Board commenced in July 2022. A schedule of deep dive reports to Committees to be approved end August, this will start with Discharge Improvement Programme reporting to FPPC in September. • Engagement exercise supported by Procurement Services with Improvement Partner draft tender specification to be complete by end August. This will be a competitive process with a capability assessment at outset. • Revised programme governance launched via EPB with organisational SOP to be complete early September, a new training offer has been launched to support divisional teams in improvement work.

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: **Freedom to experiment**	

If we do not foster a learning culture where experimentation and questions are encouraged and staff are supported to innovate and do the right thing when mistakes happen	***Then*** there is the risk staff will become disempowered, will not identify solutions, not challenge without fear, not learn from mistakes and managers will hide issues and the culture will be psychologically unsafe.	***Resulting in*** avoidable harm to patients, missed opportunities for improvement and potential regulatory intervention and a culture of uncivil behaviour and lack of trust amongst staff

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

Risk Lead	Director of Transformation	Assurance committee	People

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

• Variation in ward to Board quality governance structures and operational procedures **Assurance gaps** • Improving evidence of learning from incidents, complaints, audit and wider performance issues • Level of absence and grievances for staff	• Good Governance Institute review. • National Safety Incident Framework launch **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 • Review of ward/specialty MDT governance processes - develop MDT ward leadership model • Development of ICB / Place learning network

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

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

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

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

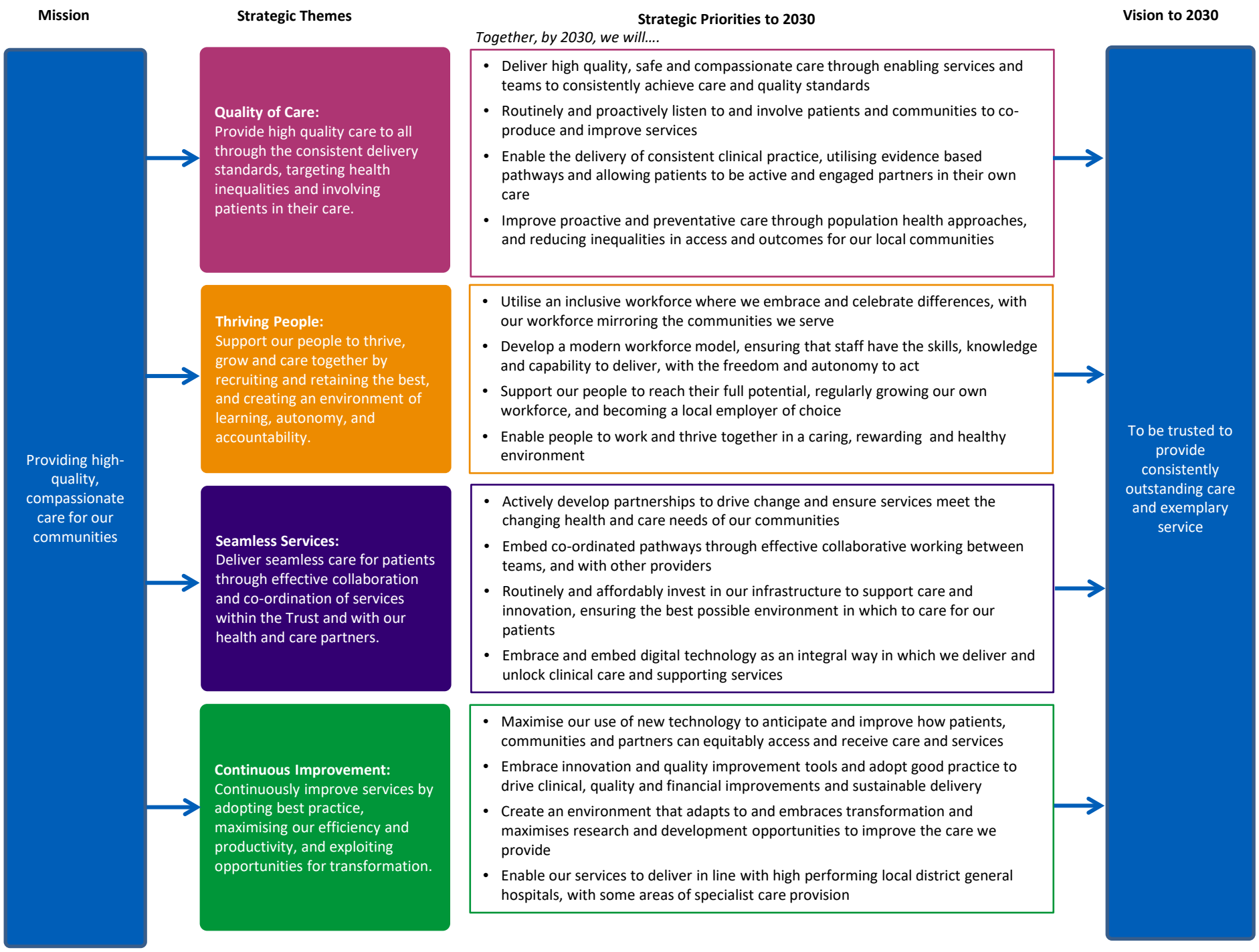
Risk Lead	Medical Director/Chief Nurse	Assurance committee	QSC

Controls	Assurances reported to Board and committees
Strategies and Plans • Clinical Strategy and objectives • Quality Strategy **Systems and Resources** • QlikView Quality dashboards • Life QI • Datix • Quality Oversight System 'EnHance' **Governance and Performance Management Structures** • Patient Safety Forum • Safety Incident Framework and Safety Improvement Collaborative(s) • Values and behavior programmes • Freedom to speak up guardian / network • Mortality review process • Clinical audit programme • Pathways to excellence programme • Digital clinical oversight group (keeping our patients safe programme) **Learning from Incidents** • Incident learning responses: serious incident reports, round tables, restorative culture framework, After Action Review (AARs) • Schwartz rounds • Quality huddles • Governance rolling half days **Quality Management Processes** • CQC and compliance preparedness framework • Safety Incident management framework • Quality Improvement service • Transformation service • Reward and recognition • Here for you service **Training and sharing best practice** • RCN Clinical Leadership Programme	**First and second line (internal) assurances** • Divisional transformational board escalation report • Education committee escalation report • Divisional Board escalation report • Accountability Review Meeting escalation report • External/ internal audit programme reports and action trackers • Peer assessment review report and action plan **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

• CD development Programme • Improvement and transformation capability sessions • Quality Improvement coaching • Leadership and human factors development programmes • Governance Rolling half days • Research programmes	
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 • Capacity within clinical roles to apply change methodology • Unwarranted variation in quality assurance framework • Current national safety Incident framework • No allocated Medical lead Quality Improvement • Operational pressures, especially throughout Q3 and Q4 • Sustainable financial situation **Assurance gaps** • Improving evidence of imbedded sustainable changes following learning from incidents, complaints, audit, and wider performance issues	• Combined efforts to drive skills and knowledge by people team, transformation team, quality improvement team and business information's analysts in progress • Agreed job planning and rostered time demonstrated through Roster on PA allocation • New safety incident framework implements by Q4 • Engage with and improvement partner Q4 • Redesign quality assurance framework by Q3

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 • Learning form deaths and mortality outcomes

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


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

NHS
East and North Hertfordshire
NHS Trust

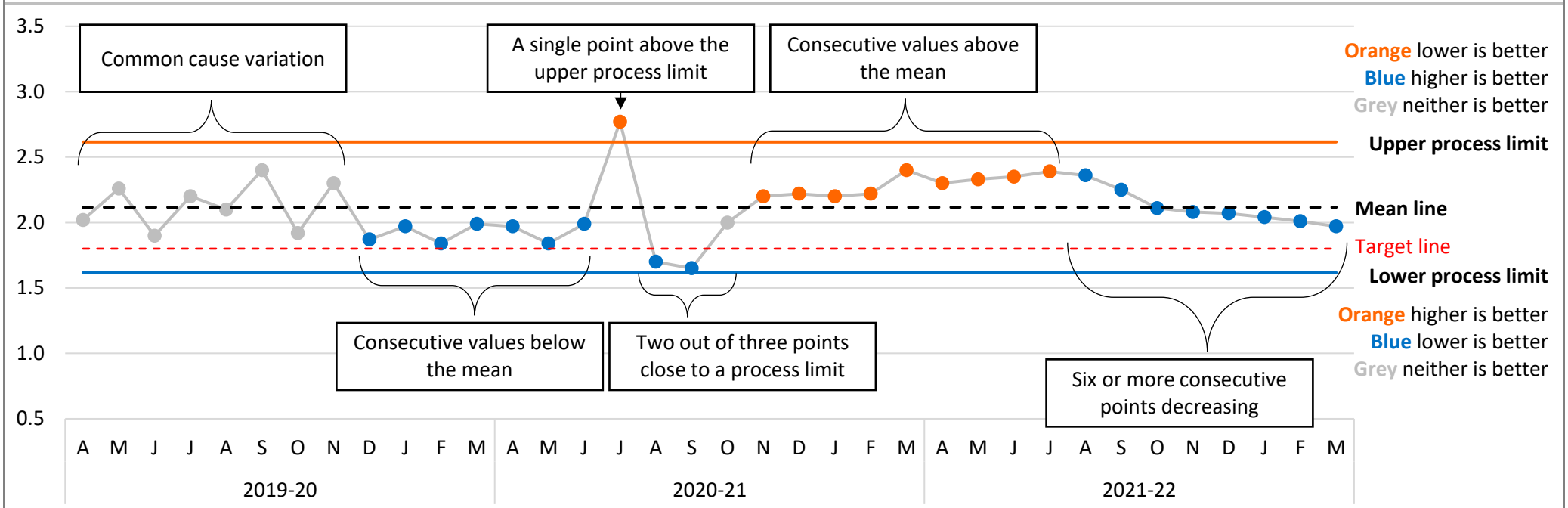
Integrated Performance Report

Month 04 | 2022-23

	P	?	F
H, L	0	4	4
	7	38	3
H, L	3	11	8

Data correct as at 24/08/2022

How to interpret a Statistical Process Control (SPC) Chart



Variation

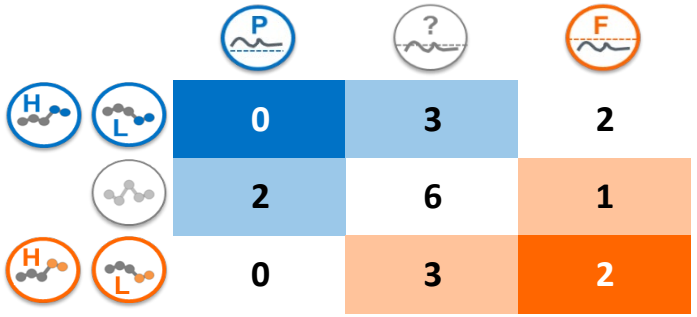
H L	Special cause variation of **concerning** nature due to **H**igher or **L**ower values
H L	Special cause variation of **improving** nature due to **H**igher or **L**ower values
	Common cause variation No significant change

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

Safe Services

Month 04 | 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	Jul-22	n/a	1,533			Common cause variation No target
	Serious incidents in-month	Jul-22	0	9		?	Common cause variation Metric will inconsistently pass and fail the target
Infection Prevention and Control	Hospital-acquired MRSA Number of incidences in-month	Jul-22	0	0		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired c.difficile Number of incidences in-month	Jul-22	0	0		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired e.coli Number of incidences in-month	Jul-22	0	6	H	?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired MSSA Number of incidences in-month	Jul-22	0	1		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired klebsiella Number of incidences in-month	Jul-22	0	3		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired pseudomonas aeruginosa Number of incidences in-month	Jul-22	0	4	H	?	One point above the upper process limit Metric will inconsistently pass and fail the target
	Hospital-acquired CPOs Number of incidences in-month	Jul-22	0	0	L	?	No hospital-acquired CPOs since Jun-20 Metric will inconsistently pass and fail the target
	Hand hygiene audit score	Jul-22	80%	91.6%		P	Common cause variation Metric will consistently pass the target
Safer Staffing	Overall fill rate	Jul-22	n/a	71.4%			Common cause variation No target
	Staff shortage incidents	Jul-22	n/a	71	H		One point above the upper process limit No target

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cardiac Arrests	Number of cardiac arrest calls per 1,000 admissions	Jul-22	n/a	0.60			Common cause variation No target
	Number of deteriorting patient calls per 1,000 admissions	Jul-22	n/a	0.99			Common cause variation No target
Deteriorating Patients	Reliability of observations (4-hour)	Jul-22	n/a	69.7%	L		Eight points below the mean No target
	Reliability of observations (1-hour)	Jul-22	50%	38.1%	L	F	Seven points below the mean Metric will consistently fail the target
Sepsis Screening and Management	Inpatients receiving IVABs within 1-hour of red flag	Jul-22	95%	100.0%	H	?	Seventeen points above the mean Metric will inconsistently pass and fail the target
	Inpatients Sepsis Six bundle compliance	Jul-22	95%	52.6%	H	F	Ten points above the mean Metric will consistently fail the target
	ED attendances receiving IVABs within 1-hour of red flag	Jul-22	95%	85.9%	H	?	Ten points above the mean Metric will inconsistently pass and fail the target
	ED attendance Sepsis Six bundle compliance	Jul-22	95%	72.5%	H	F	Ten points above the mean Metric will consistently fail the target
VTE Risk Assessment	VTE risk assessment stage 1 completed	Jul-22	85%	60.7%	L	?	One point below the lower process limit Metric will inconsistently pass and fail the target
	VTE risk assessment for stage 2, 3 and / or 4	Jul-22	85%	35.3%	L	F	One point below the lower process limit Metric will consistently fail the target
	Correct low molecular weight heparin prescribed and documented administration	Jul-22	85%	90.9%		P	Common cause variation Metric will consistently pass the target
	TED stockings correctly prescribed and documentation of fitted	Jul-22	85%	61.0%		?	Common cause variation Metric will inconsistently pass and fail the target

Safe Services

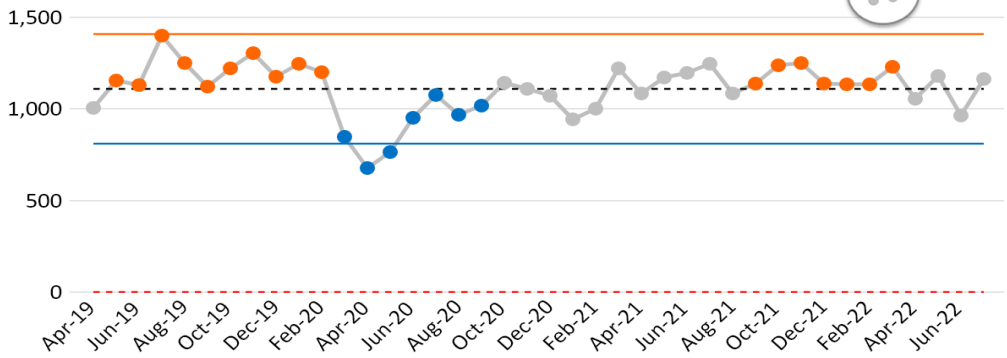
Summary

East and North Hertfordshire NHS Trust

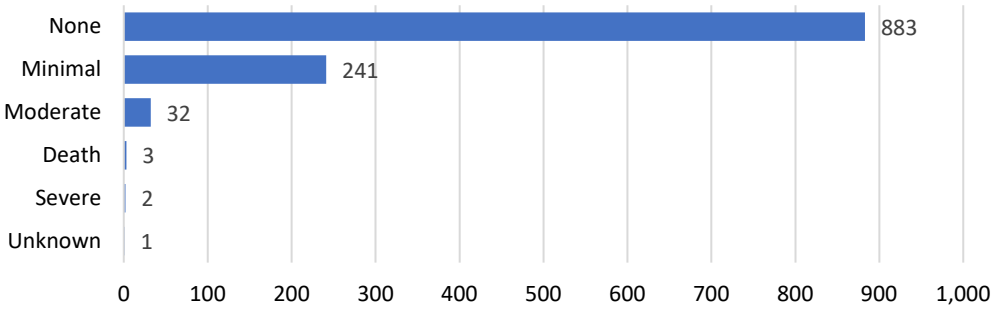
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
HATs	Number of HAT RCAs in progress	Jul-22	n/a	76			One point above the upper process limit No target
	Number of HAT RCAs completed	Jul-22	n/a	2			Common cause variation No target
	HATs confirmed potentially preventable	Jul-22	n/a	1			Common cause variation No target
PU	Pressure ulcers All category ≥2	Jul-22	0	23			Common cause variation Metric will consistently fail the target
Patient Falls	Rate of patient falls per 1,000 overnight stays	Jul-22	n/a	4.5			Common cause variation No target
	Proportion of patient falls resulting in serious harm	Jul-22	n/a	0.0%			Common cause variation No target
Other	National Patient Safety Alerts not completed by deadline	Aug-22	0	0			Metric unsuitable for SPC analysis
	Potential under-reporting of patient safety incidents	Jun-22	6.0%	4.9%			Metric unsuitable for SPC analysis

Patient Safety Incidents

Total incidents reported



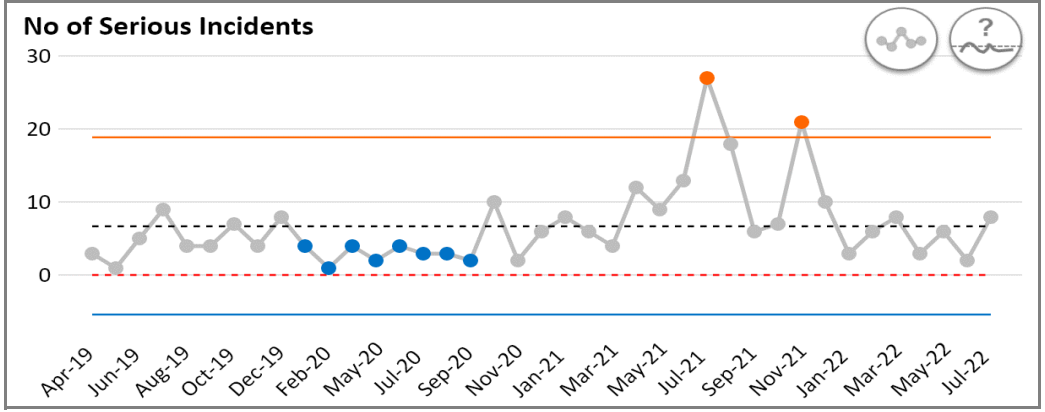
Number of incidents by level of harm - Jul-22



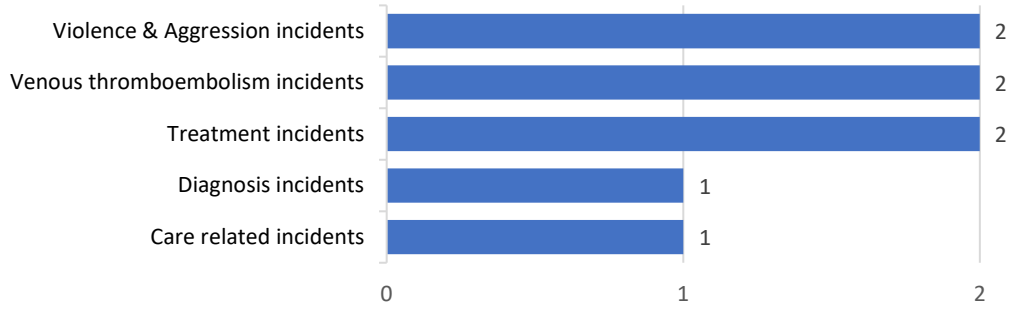
Key Issues and Executive Response

- Common cause variation seen in the number of incidents reported.
- Approximately 97% of incidents reported resulted in no or low harm (this is in-line with previous months).
- Common cause variation in the number of SIs declared each month.
- Improvement in overdue SIs noted with ongoing commitment from Divisions to support timely approvals.
- New executive sign off process introduced following trial which has had a positive impact and streamlined the process.
- Regular, close engagement with CCG to ensure alignment of data and provide updates as to progress with overdue SIs.
- Trial of reflection sessions for Patient Safety Managers.

No of Serious Incidents

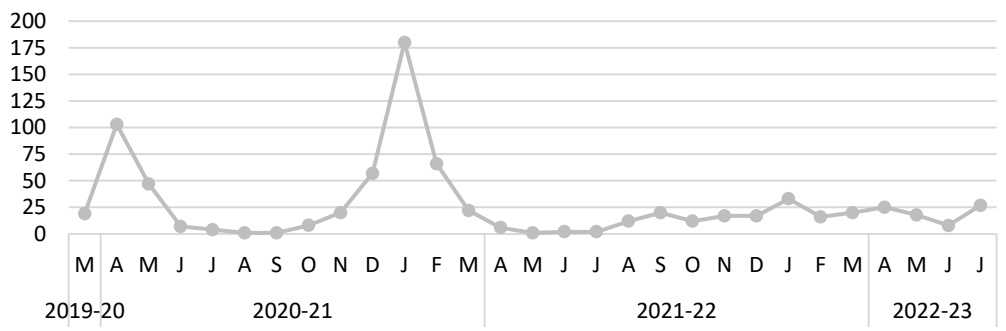


Serious Incidents Themes - Jul-22

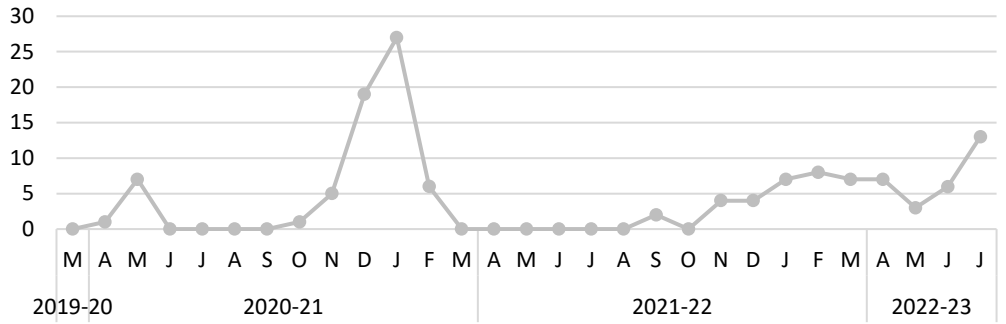


East and North Hertfordshire NHS Trust

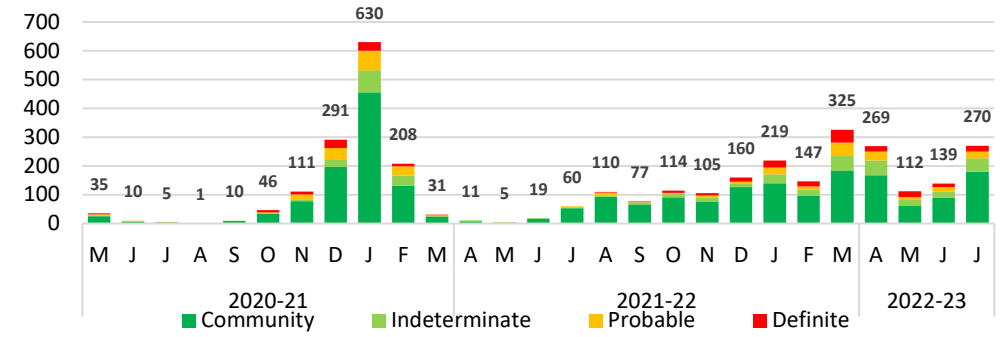
Number of deaths from COVID-19



Number of deaths from hospital-acquired COVID-19



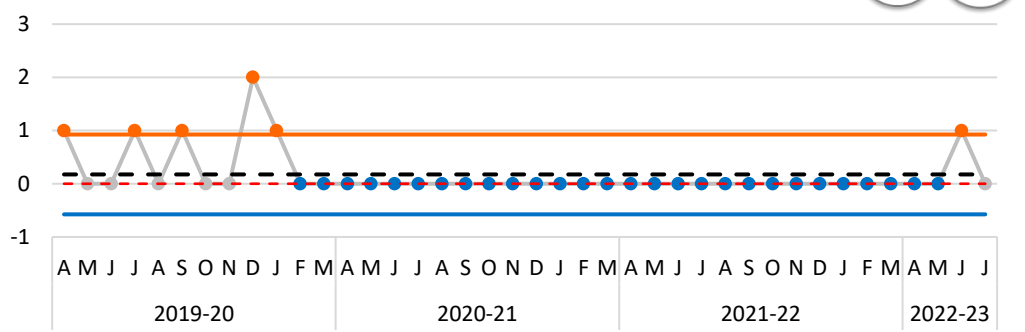
COVID-19 cases by category



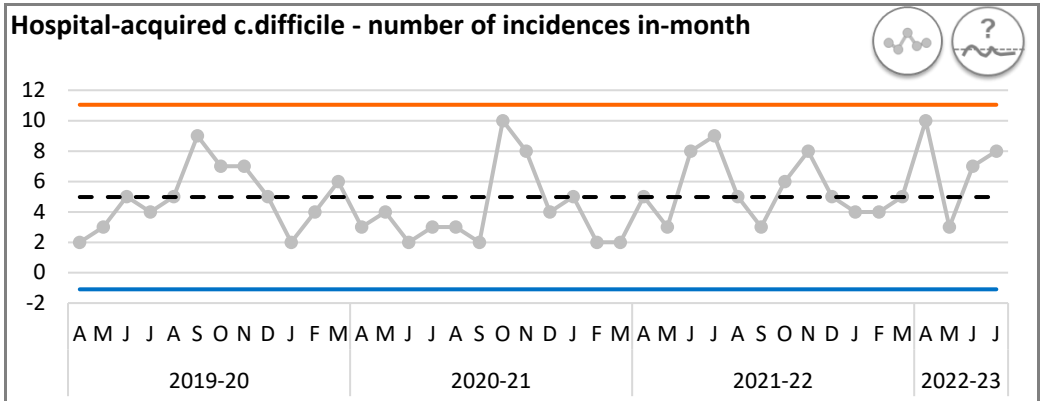
Key Issues and Executive Response

- A slight increase in COVID cases were seen in July, the total number was 270. Of these cases 44 were contributed to probable or definite hospital-onset COVID.
- Sadly 27 patients died with a diagnosis of COVID in July, and 13 of these cases were related to hospital-onset COVID.
- Structured reviews are undertaken locally to capture learning where a hospital acquired infection has been identified. Where any potential harmful impacts are identified cases shall be represented to serious incident review panel.
- One outbreak occurred in July and some clinical areas have seen increased prevalence of hospital-onset COVID.
- The trust continues to deliver a clinical specialist COVID advisory group where all new national and local guidance is reviewed, and plans agreed to implement accordingly.

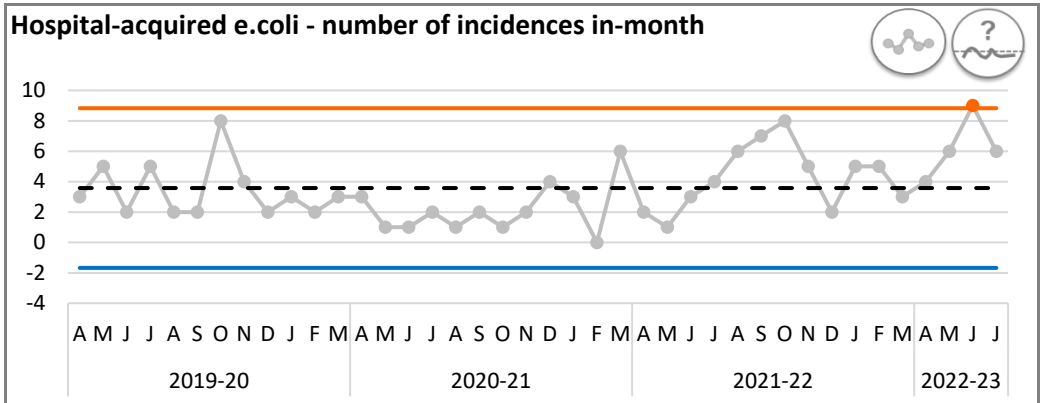
Hospital-acquired MRSA - number of incidences in-month



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



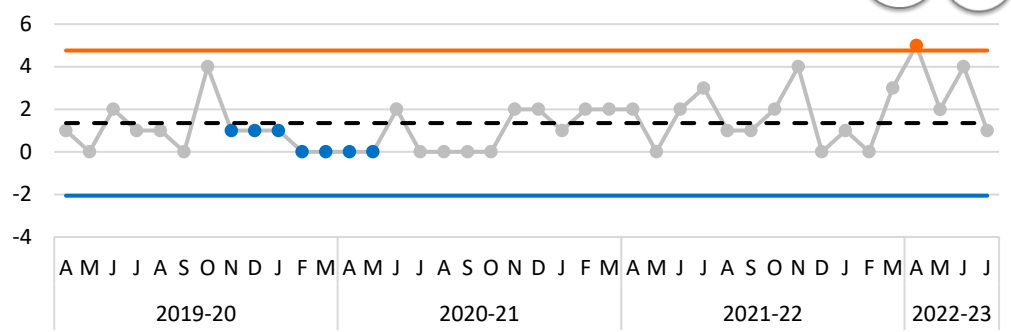
Hospital-acquired e.coli - number of incidences in-month



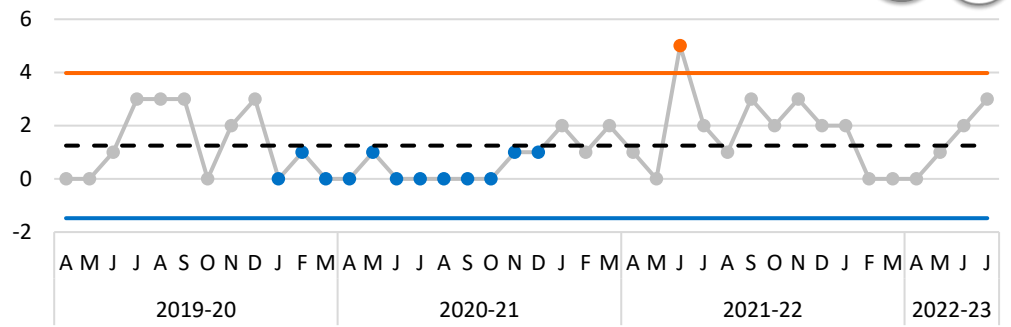
Key Issues and Executive Response

- The Trust reported 0 hospital-acquired infections (HCAI) MRSA blood stream infections (BSIs) in July 2022 against the annual target of 0.
- The Trust has reported 1 in 2022 - 2023 to date against the annual target of 0, which is above trajectory.
- The 1 MRSA HCAI that occurred in June, has been reviewed internally with the IPC team and the key IMT members and an external post infection review (PIR) meeting with the IMT and the external regulators has been scheduled for August.
- The Trust reported 8 HCAIs Clostridium Difficile Infection (CDI) for the month of July.
- The Trust has reported 28 in 2022 - 2023 to date against the annual target of 59, which is above trajectory.
- The IPC team are reviewing all HCAI cases for 2022 - 2023 and implementing an annual schedule to bring the relevant cases to the internal PIR panel.
- There has been an increased number of views for the loose stools bite size training video. The Clinical Practice Team (CPT) and ward managers are implementing boards across clinical areas containing QR codes for clinical staff.
- The Trust reported 6 HCAIs E.coli BSIs for the month of July.
- The Trust has reported a total 20 HCAIs in 2022 - 2023 to date against the annual target of 46, which is slightly above trajectory.
- IPC have completed all the PIR forms for 2021 - 2022 and are supporting the nursing and medical teams to identify any lessons and actions.

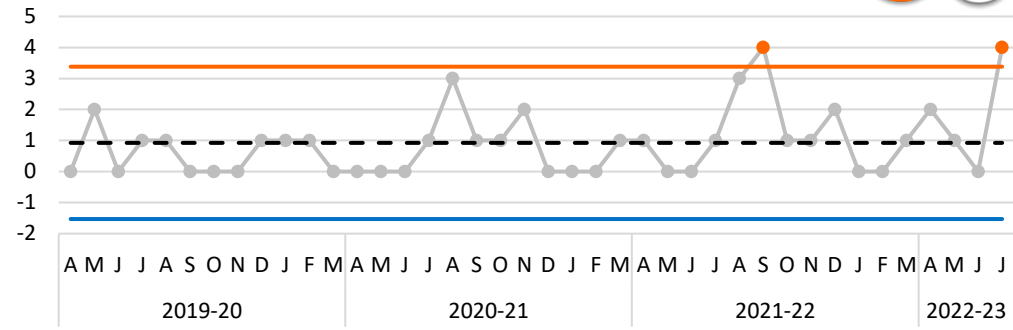
Hospital-acquired MSSA - number of incidences in-month



Hospital-acquired klebsiella - number of incidences in-month



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

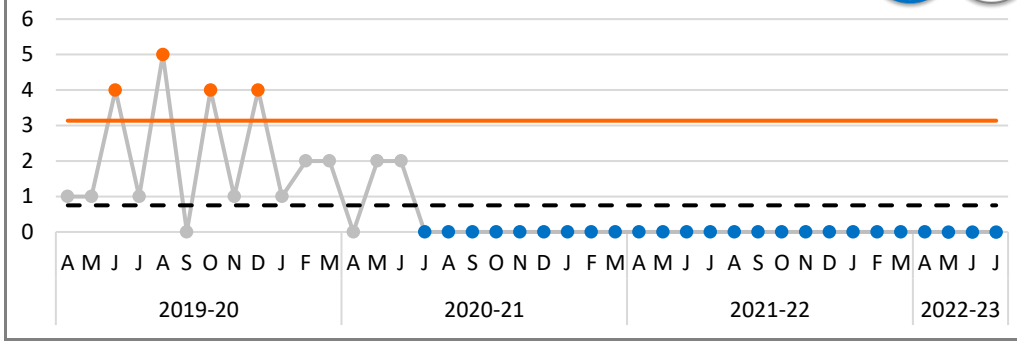


Key Issues and Executive Response

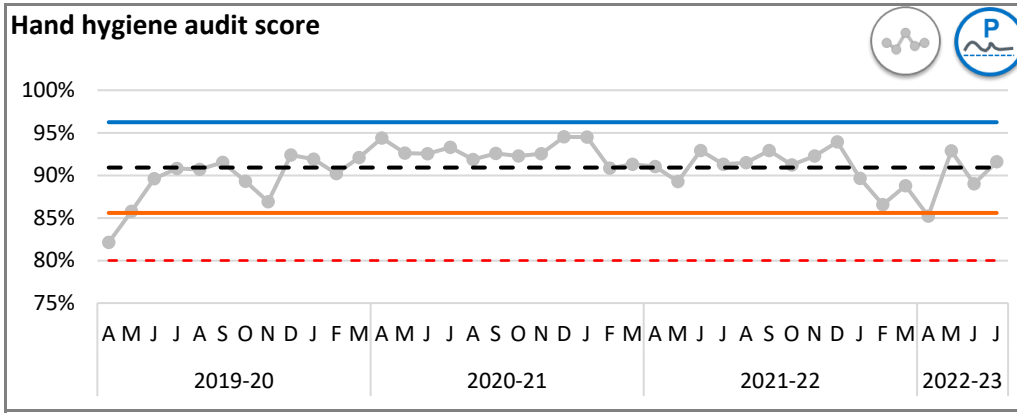
- The Trust reported 1 HCAIs MSSA BSIs for the month of July.
- The Trust has reported at total of 12 HCAIs in 2022 - 2023 to date, no target has been set for MSSA, therefore is non-applicable.
- There has been a significant decrease in MSSA BSIs HCAIs this month with only 1 HCAI being reported. This is due to the IPC team and CPT working together to review the practices and processes in place across the Trust and addressing issues.
- The Trust reported 3 HCAI Klebsiella BSIs for the month of July.
- The Trust has reported a total of 6 HCAI Klebsiella BSIs in 2022 - 2023 to date against the annual target of 22, which is below trajectory.
- The Trust reported 1 HCAI Pseudomonas aeruginosa BSIs for the month of July.
- The Trust reported a total of 4 HCAI Pseudomonas aeruginosa BSIs in 2022-2023 to date against the annual target of 11, which is slightly above trajectory.
- The IPC Deputy Director hosted an ICS Acute Trust Aseptic practice planning meeting in July, which discussed how the Trust can move forward with the safe practice of invasive vascular devices and the aseptic technique. A further 3 meetings will be scheduled, the first two taking place in September, one which will be attended by ENHT staff only and the other one will support collaborative work with PAH to discuss a schedule of the areas BBraun will audit and the business plan for the year. The 3rd meeting in October will discuss the BBraun audit results/feedback the business plan proposal.

East and North Hertfordshire NHS Trust

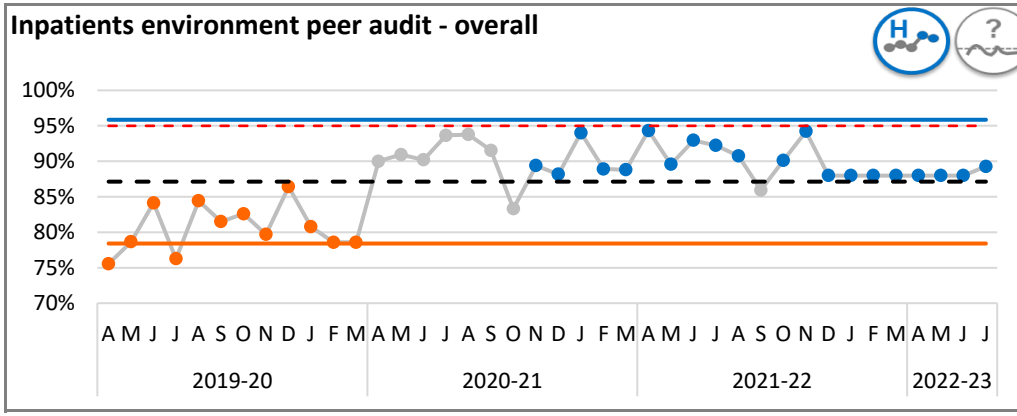
Hospital-acquired Carbapenemase Producing Organisms (CPOs)



Hand hygiene audit score



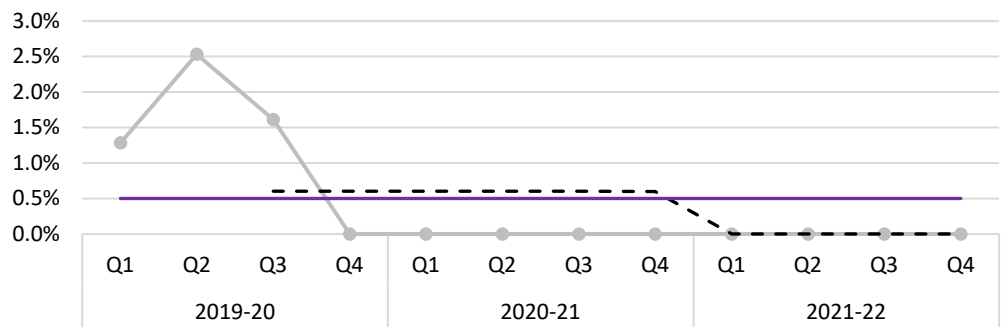
Inpatients environment peer audit - overall



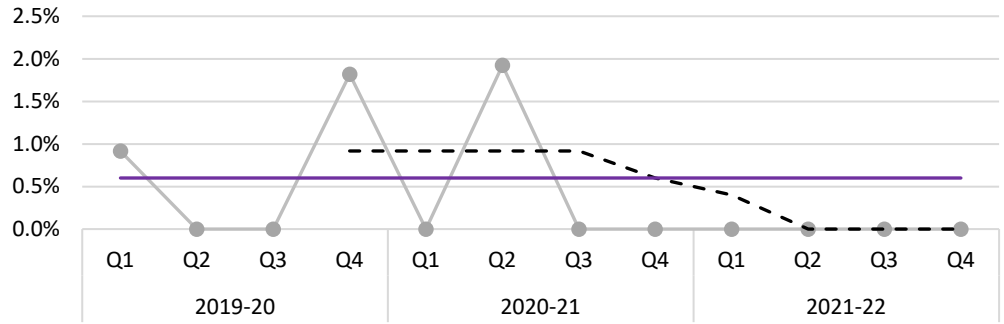
Key Issues and Executive Response

- The Trust has identified 0 HCAIs CPO infections in July.
- There has been an increase of CPO infections in recent months within the region.
- The Trust has seen a significant improvement throughout the Trust for Hand hygiene, IPC will continue to carry out hand hygiene competency training.

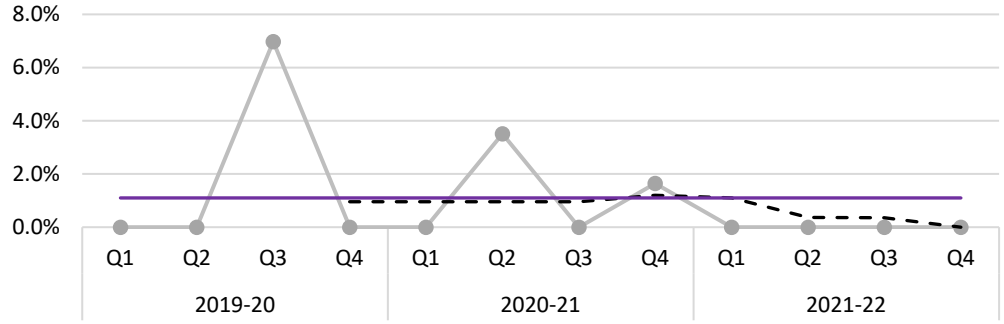
Surgical Site Infections - Total Knee Replacements



Surgical Site Infections - Total Hip Replacements



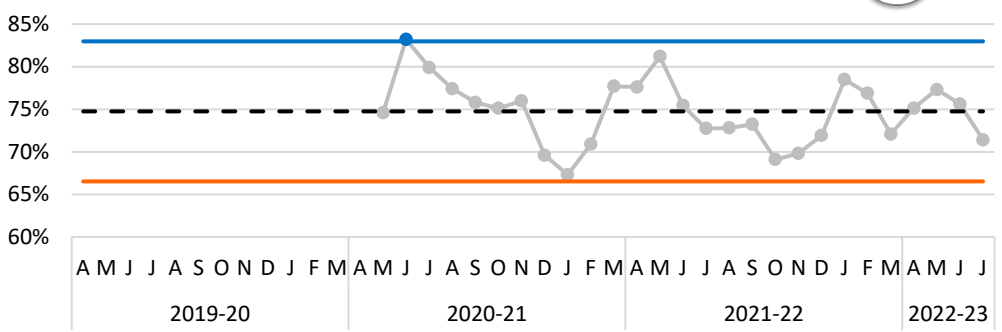
Surgical Site Infections - Fractured Neck of Femur



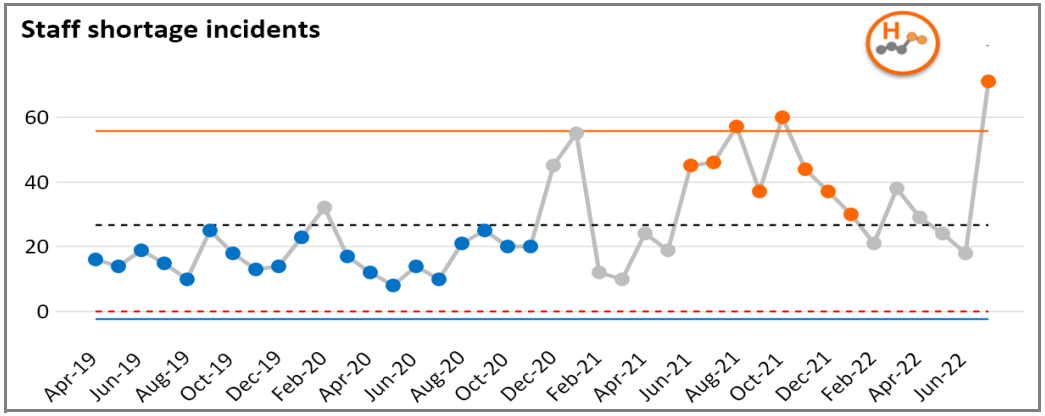
Key Issues and Executive Response

- SSI figures over the last 4 periods (April 2021 – March 2022) show an overall reduction in infection rates in all three categories monitored (Total Knee Replacement (TKR), Total Hip Replacement (THR) & Repair of Fractured Neck of Femur (NOF), compared to the 2014 - 2019 figures.
- The TKR infection rate remains at 0.0% in January - March 22 and the overall rate for the past 4 periods (April 2021 – March 2022) remains at 0.0%. This is below the national benchmark of 0.5%.
- There were 0 THR infections in January - March 22, which gives an infection rate of 0%. The THR rate over the last 4 quarters (April 2021 – March 2022) has remained at 0.0%, which is below the national benchmark of 0.6%.
- The NOF infection rate for January - March 22 remains at 0.0% and the rate for the last 4 quarters (April 2021 – March 2022) remains at 0.0%, which is below the national benchmark of 1.1%.
- A quality improvement project, led by the Planned Care Division, should begin when COVID-19 numbers allow the relevant stakeholders to be involved.
- Thus far, the most common causative organism is Staphylococcus aureus. The Planned Care Division has been asked to review the MSSA pre-operative screening process and eradication therapy for all patients to run in parallel with our MRSA detection.
- The pre-operative skin preparation agent of choice will be presented at the product selection group by the Pre-Operative Assessment team.
- A new position of Enhanced Recovery Nurse is being explored and they will play a vital role in enabling patients to contact a medical professional who is comfortable reviewing wounds, rather than having to attend their Primary Care Practitioner.

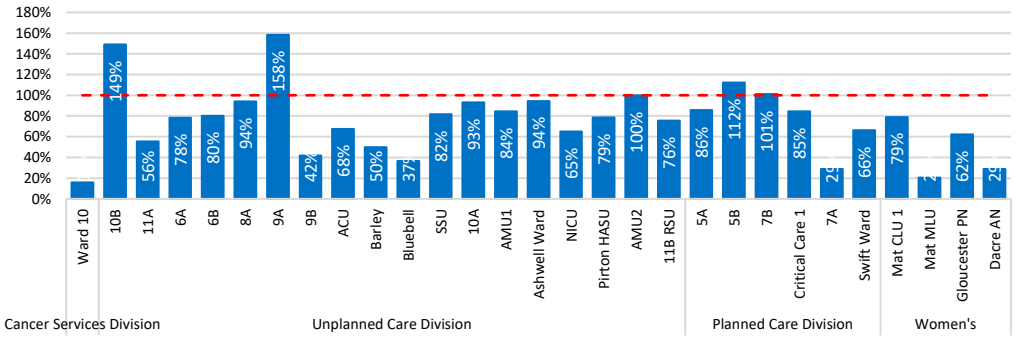
Safer Staffing - Overall fill rate



Staff shortage incidents



Safer Staffing - Supervisory Shift Report - July-22



Key Issues and Executive Response

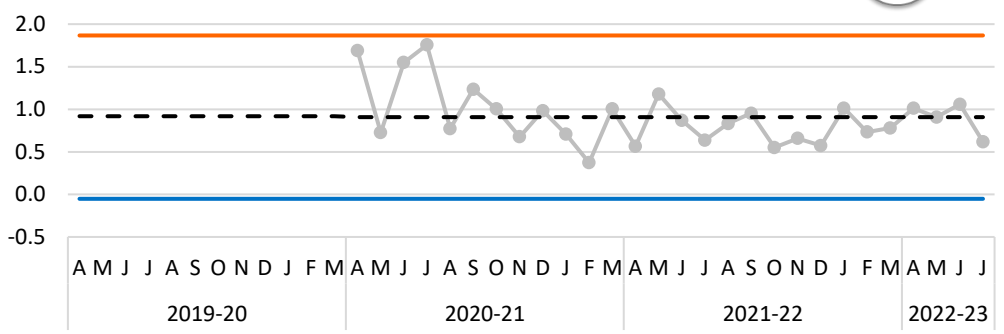
- Temporary staffing demand increased due to an increase in sickness rates. Staffing fill rates decreased as the fill rates could not match the increased demand. The Overall CHPPD decreased from 7.5 in June to 7.3 in July.
- The number of staffing shortage Datix has increased for the month of July. The top 3 departments raising Datix were Emergency department, Children's Emergency Department, and acute medicine. There are still challenges around Clinical support worker recruitment leaving shortfalls in most areas. NHSP CSW development programme has been commenced to support the CSW gaps and a HCSW focus group has been set up. Successful International recruitment continues.
- Week commencing 17th July, we instigated our surge staffing mitigation plan. Due to continued OPEL 4 status and unsafe staffing levels, Non-essential training was paused, and specialist nurse teams supported the clinical areas to support clinical staff and keep patients safe. All registered nurse shifts were sent to agencies to improve fill.
- Flexible Pool and Rapid Response pools are utilised to support short notice sickness and drop out. If unable to cover all the shortfalls shifts are released to agency on agreement by the head of nursing at the safer staffing meetings.
- Ward managers are rostered 75% supervisory time to provide adequate leadership and support for their department. As part of the safer staffing mitigation ward managers are utilised if supervisory and moved into the clinical numbers when shortfalls happen, or acuity increases. The supervisory shift report shows the amount of supervisory time each department delivered for the month; the supervisory time managers have taken for the month of July has fluctuated in areas where they have been supporting in a clinical shift.

Safe Services

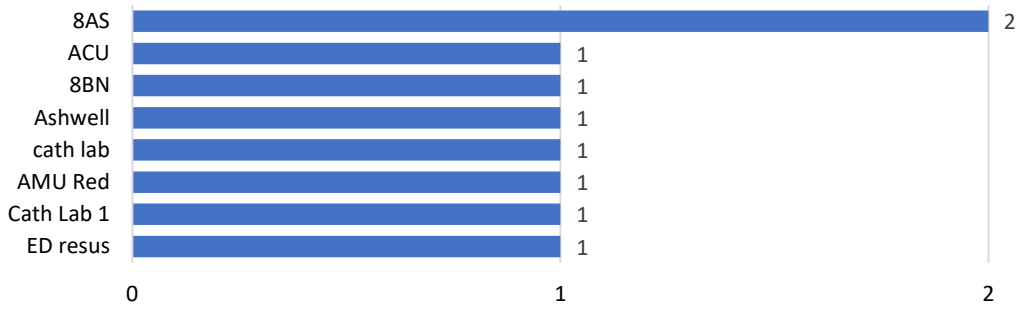
Cardiac Arrests

East and North Hertfordshire NHS Trust

Number of cardiac arrest calls per 1,000 admissions



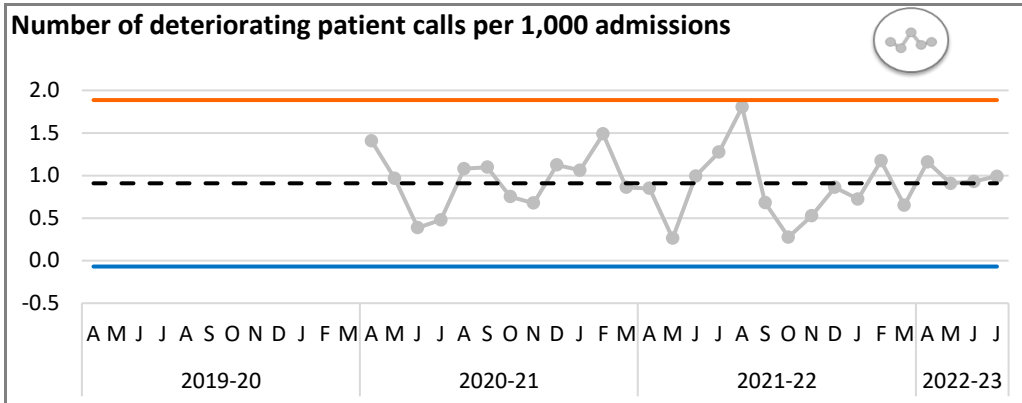
Number of cardiac arrest calls by location - Jul-22



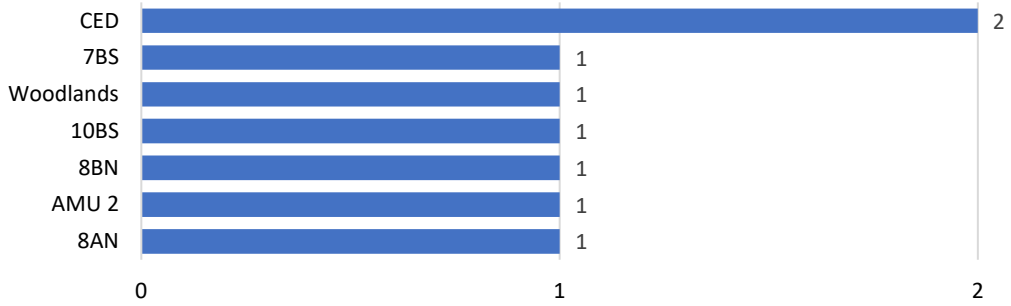
Key Issues and Executive Response

- The trusts cardiac arrest rate per 1000 admissions remains steady
- Human Factors project launched in July, examining the influencing factors that affect the recognition and management of the deteriorating patient and cardiac arrest.
- ReSPECT work continues across E&N Herts, this work is done in collaboration with palliative care teams, to support the quality of recognising and supporting end of life clinical presentations. Planned launch date ENHT 5th September.
- Plan to launch in situ simunlation training, to imbed real time simulation training across the Trust by january 2023. This aims to examine and support staff in the recognition and management of the deteriorating patient and examine the current systemic response to 2222 calls.

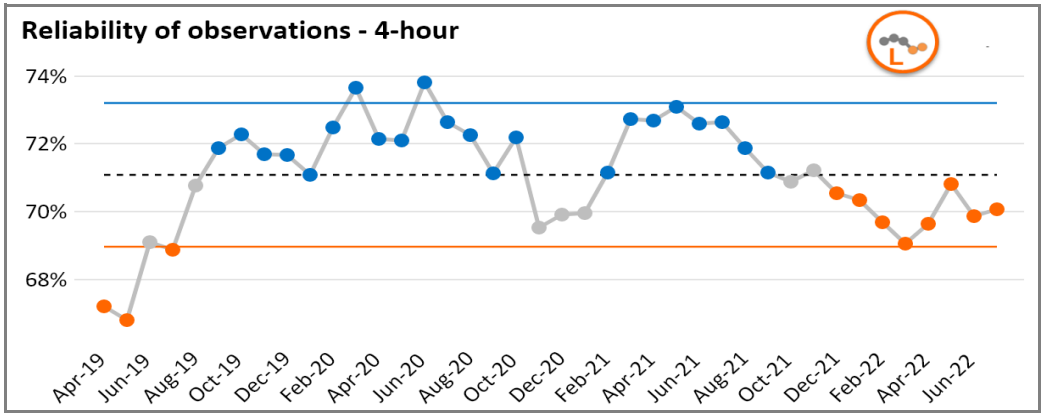
Number of deteriorating patient calls per 1,000 admissions

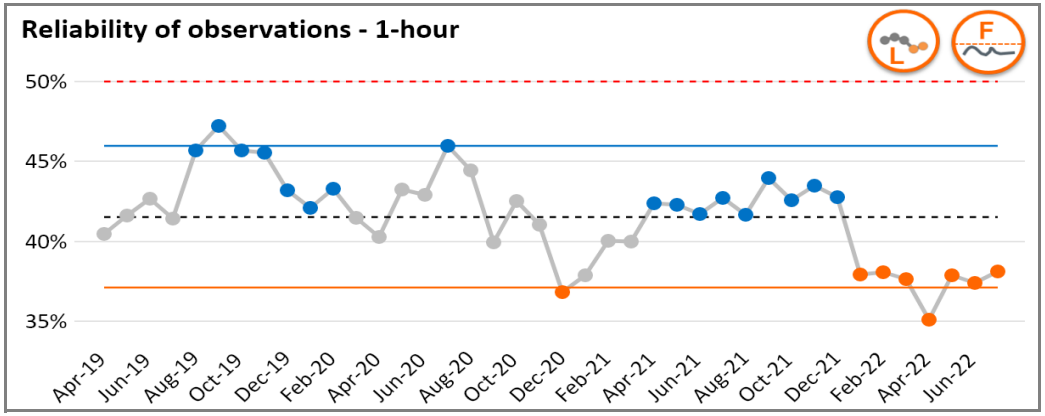


Number of deteriorating patient calls by location - Jul-22



Deteriorating Patients



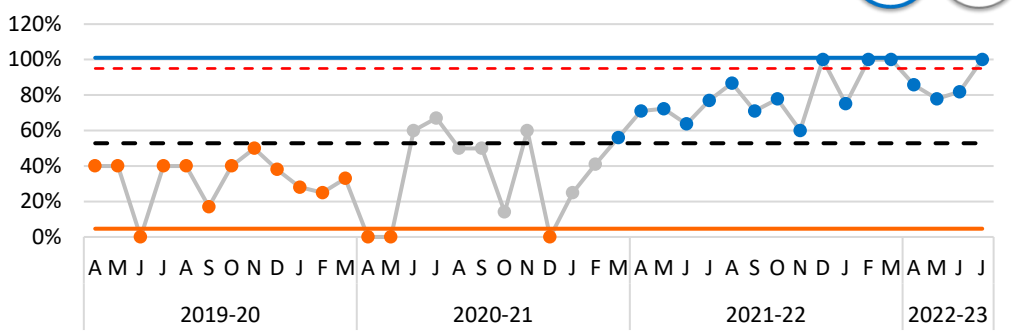


Key Issues and Executive Response

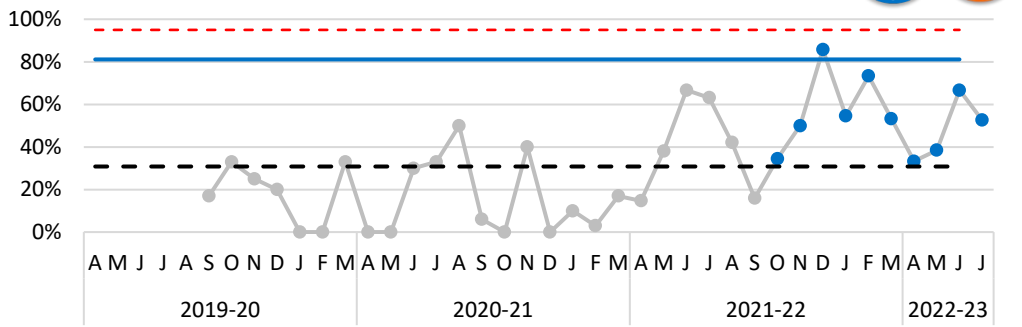
- Continued theme around short staffing versus increased acuity of patients/OPEL statuses causing pressure on discharges and flow on wards.
- Work ongoing with CCOT and QI to review and support improved equipment (observation machines, tympanics) on wards to undertake timely observations. Includes a review of repair /procurement and improving these processes. Working with ward managers to understand their shortfalls.
- Promotion of CCOT shadowing opportunities for nursing staff through Trust comms. It is hoped this will aid and support staff understanding of deterioration and response with focus on A to E approach and SBAR.

Sepsis Screening and Management | Inpatients

Inpatients receiving IVABs within 1-hour of red flag



Inpatients Sepsis Six bundle compliance



Themes

Sepsis IP	2021-22										2022-23	
	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Oxygen	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Blood cultures	53%	52%	54%	54%	85%	70%	79%	75%	55%	93%	82%	89%
IV antibiotics	87%	73%	72%	72%	100%	75%	100%	100%	86%	83%	82%	92%
IV fluids	86%	64%	60%	60%	100%	71%	67%	80%	50%	90%	86%	50%
Lactate	53%	46%	52%	52%	85%	70%	62%	55%	50%	86%	76%	67%
Urine measure	42%	16%	59%	59%	82%	67%	58%	50%	42%	60%	74%	73%

Key Issues and Executive Response

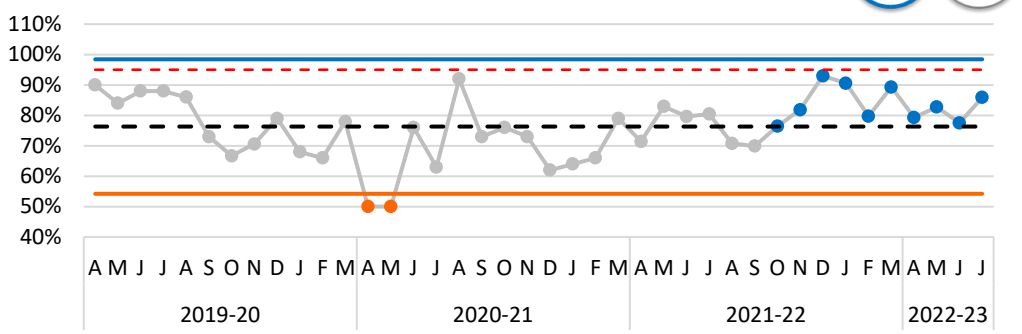
Themes

- Slight improvement with blood culture collection with an increase of 7% in compliance compared to June.
- Significant improvement by 10% with IV antibiotic administration within 6o minutes with a consequential average time of 16 minutes.
- Urine output measurement within 60 minutes from Red Flag Sepsis triggers has remained stable.
- IV antibiotics administration has remained within the target of less than 60 minutes from Red Flag Sepsis Triggers.
- Significant delay in IV fluid administration has been identified which resulted into a decline in the Sepsis 6 compliance in general.
- The Sepsis Team continues to have weekend shifts from 08:00 to 18:00 to support a 7-day cover and assist the ED and IP areas in the delivery of Sepsis 6.

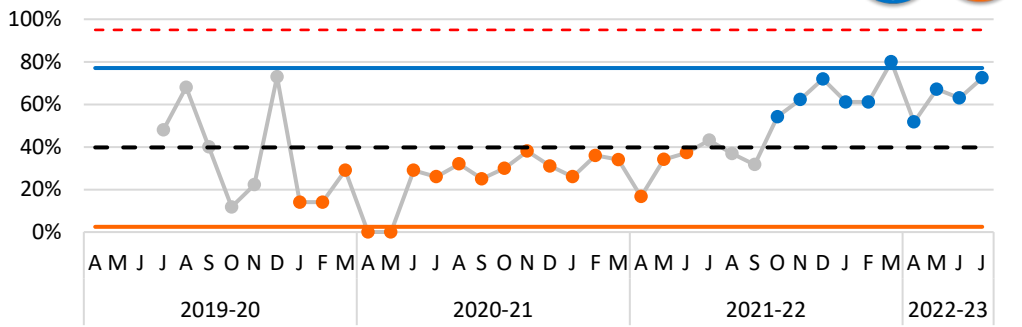
Response

- The Sepsis Team continues to run Sepsis teaching sessions via Teams to IP areas. Face to face teaching is currently on going with 7A.
- The Sepsis Team has completed the Sepsis E-Learning to be uploaded in the ENH Academy. Now on its final stage and waiting to be reviewed by panel for approval. A meeting with the Statutory Mandatory Training Committee will be held end of August 2022.
- Virtual Sepsis Teaching has been scheduled for 5A, 8A, 8B, and 10A.
- The team will start making a quick video regarding fluid balance and sent it to the Clinical Practice Team to be converted into a QR code for quick access.

ED attendances receiving IVABs within 1-hour of red flag



ED attendance Sepsis Six bundle compliance



Themes

Sepsis ED	2021-22										2022-23	
	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Oxygen	100%	100%	95%	94%	100%	95%	100%	100%	100%	100%	100%	100%
Blood cultures	74%	52%	88%	93%	95%	88%	93%	90%	86%	89%	91%	87%
IV antibiotics	71%	73%	76%	82%	93%	91%	80%	89%	79%	83%	76%	86%
IV fluids	77%	64%	85%	98%	98%	98%	86%	90%	95%	86%	80%	93%
Lactate	94%	46%	80%	76%	93%	100%	87%	98%	87%	97%	95%	67%
Urine measure	45%	45%	64%	71%	76%	61%	76%	90%	69%	79%	77%	84%

Key Issues and Executive Response

Themes

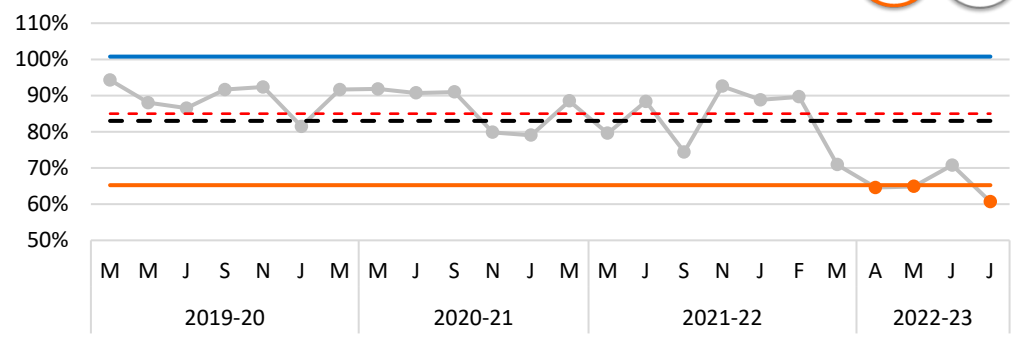
- Normal variation in compliance of blood culture collection.
- IV fluid and IV administration within 60 minutes from Red Flag Sepsis triggers has improved by 10% and 13% accordingly.
- Urine output measurement has also shown improvement.
- Sepsis 6 compliance as a whole has improved in ED.

Response

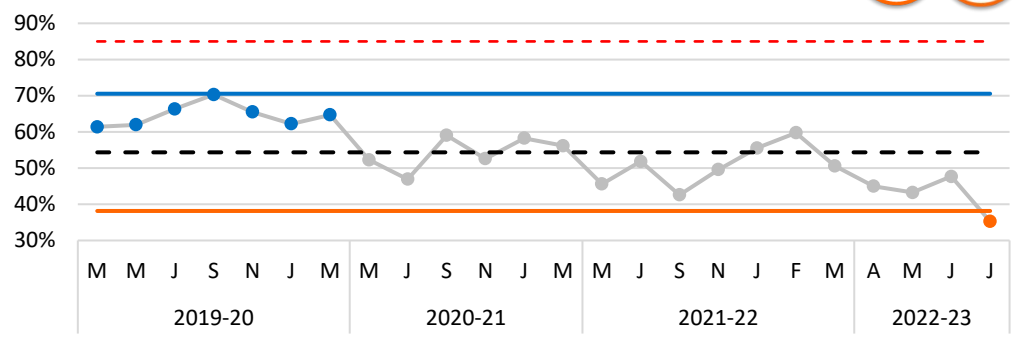
- The team is in communication with Practice Development Nurse (PDN) of ED and trainings are in place for newly qualified staff. The team is still waiting for confirmation from the ED Practice Development Team.
- The Sepsis Team has been continuously supporting ED by being clinically visible when a Septic patient is identified.
- The team assists the staff in completing the Sepsis 6 within an hour.

East and North Hertfordshire NHS Trust

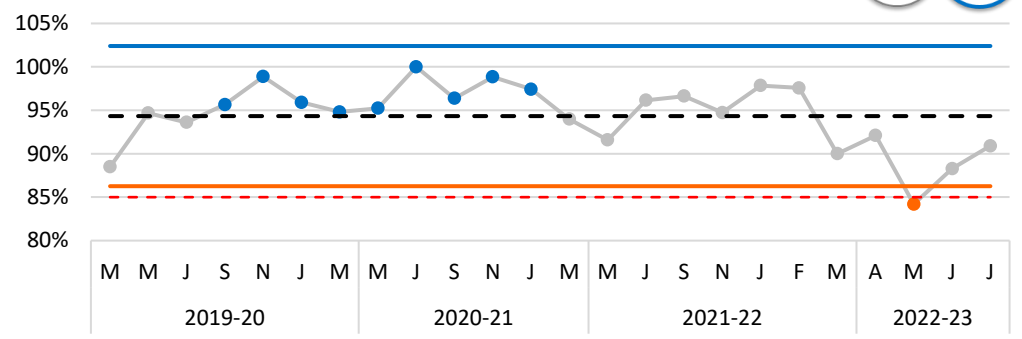
VTE risk assessment stage 1 completed



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



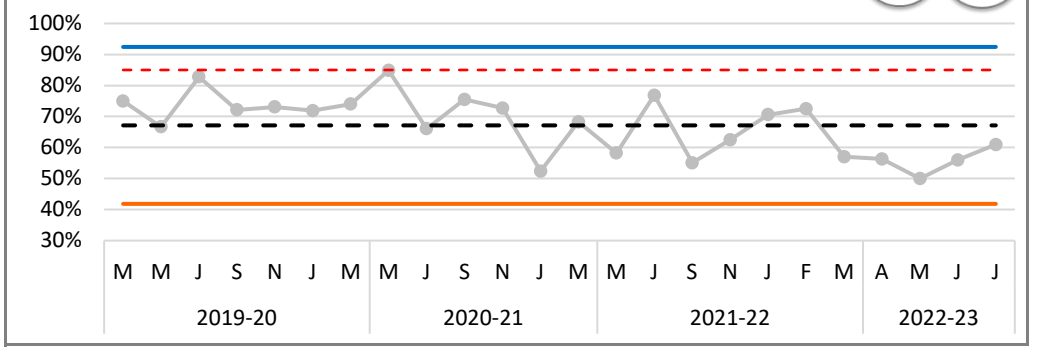
Correct low molecular weight heparin prescribed & documented



Key Issues and Executive Response

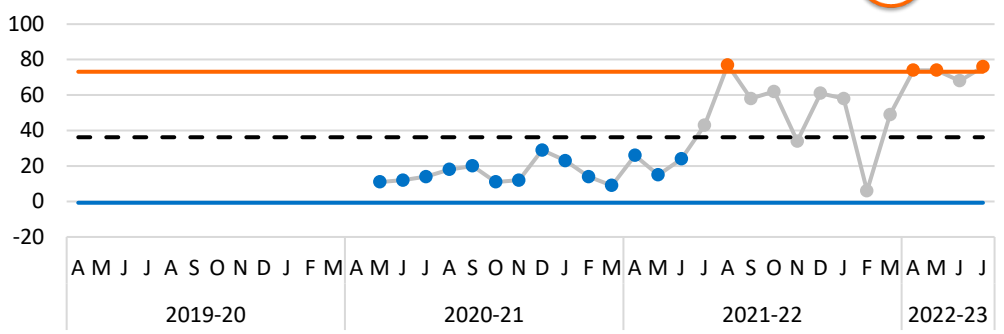
- ePMA rolled out across all adult in-patient medical and surgical wards during March 2022. From April 2022 data demonstrates full impact of the roll out on VTE risk assessments and prescribing.
- VTE digital options appraisal has been drafted.
- Establish if retrospective data capture from Lorenzo is possible for improved audit data.
- Progression towards the appointment of a VTE consultant - strengthen clinical leadership.
- Continue regular clinical engagement to share VTE data, improvement work and learning from HATs.
- Continue to monitor training figures for VTE and report the results at Thrombosis Action Group.
- Continue the on-going ward focused quality improvement work.
- Continue to improve patient engagement and review VTE patient information during admission and on discharge.

TED stockings correctly prescribed and documentation of fitted

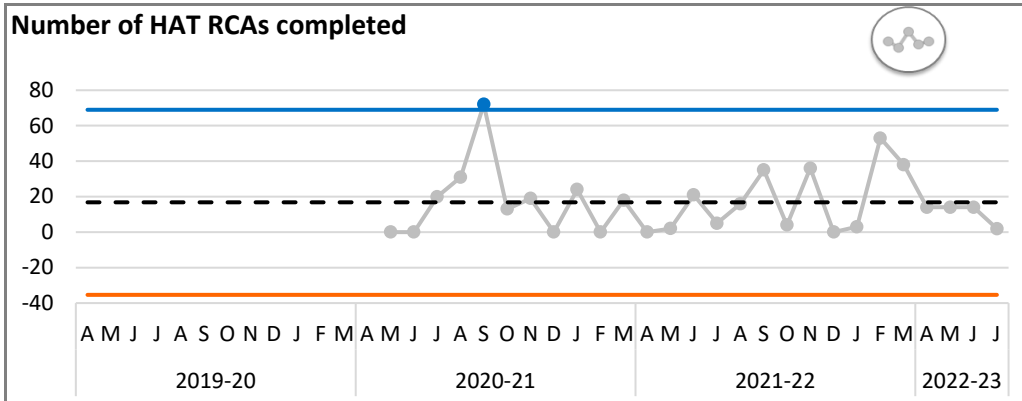


Hospital-Acquired Thrombosis (HAT)

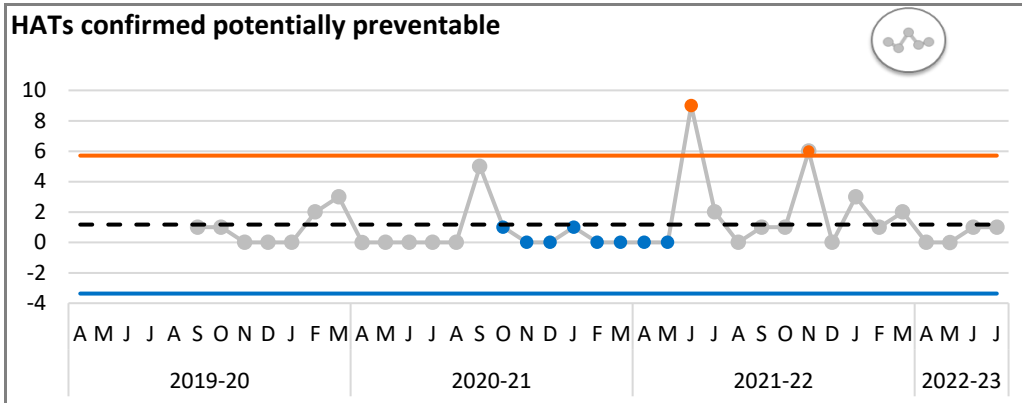
Number of HAT RCAs in progress



Number of HAT RCAs completed



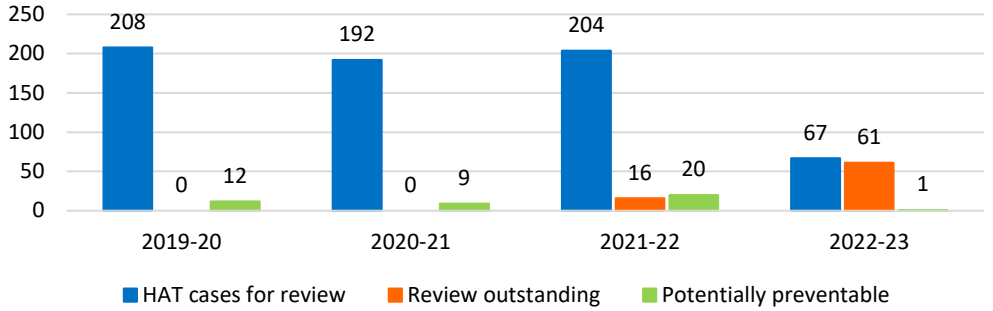
HATs confirmed potentially preventable



Key Issues and Executive Response

- Slight increase in number of HAT RCAs due to annual leave.
- Rapid review of HATs has allowed learning to be identified quicker and actions implemented in a timelier manner.
- HATs that are discussed at SIRP are shared at Thrombosis Action Group (TAG) to ensure the learning and associated actions have been completed.
- Continue regular clinical engagement to share VTE data, improvement work and learning from HATs.
- Continue progression towards a VTE/Thrombosis consultant - strengthen clinical leadership.

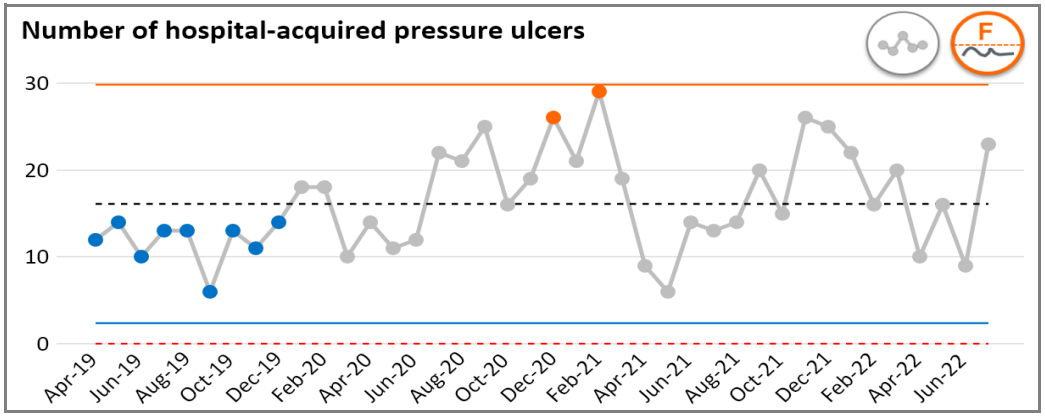
Annual HAT review prevalence

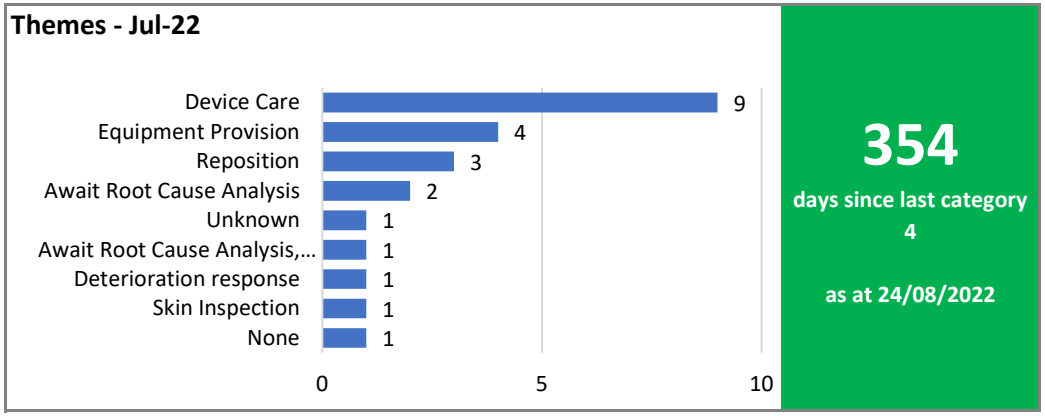


Safe Services

Pressure Ulcers

East and North Hertfordshire NHS Trust





354

days since last category 4

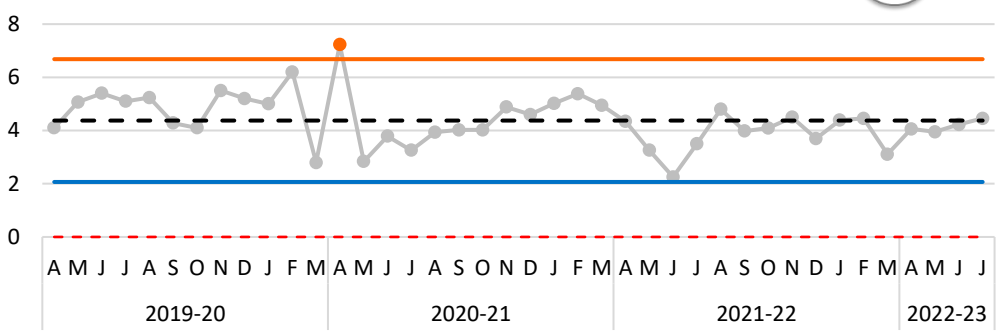
as at 24/08/2022

Key Issues and Executive Response

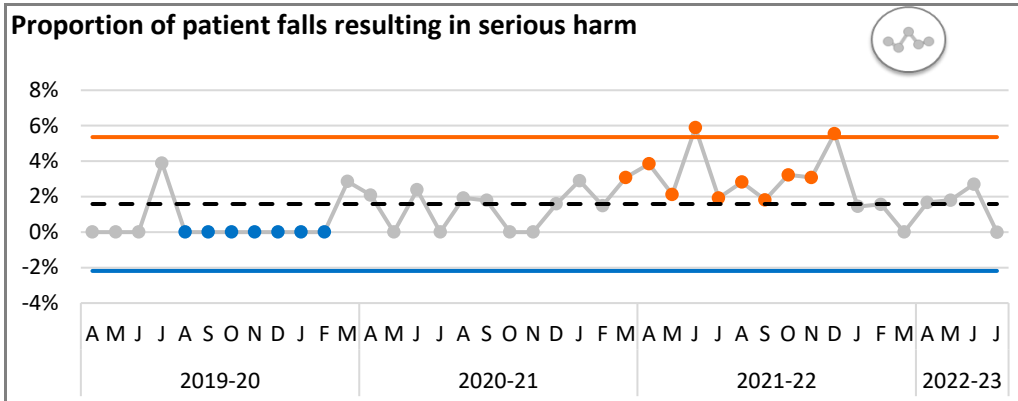
- Completion of digital waterlow assessment within 6 hours of admission is an improvement priority - improvement is starting to happen.
- Lack of repositioning as main theme of learning reviews. TVT to work on improving repositioning regimes following digitisation.
- TVN related assessments and care plans now live in NC and across all adult inpatient areas. this alongside increased use of WABA app allows for TVN to have greater oversight of skin issues within ward areas.
- TVN auditing staff knowledge check of PU prevention, focusing on wards with highest number and then expanding to other areas. - work ongoing to address gaps in knowledge.

Patient Falls

Rate of patient falls per 1,000 overnight stays



Proportion of patient falls resulting in serious harm

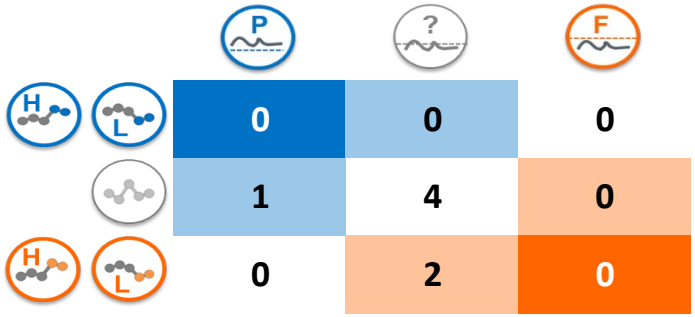


Key Issues and Executive Response

- Inpatient falls data remains to show common cause variation.
- All falls with serious harm in June were discussed and learnings identified will be share trust wide once populated.
- Falls Enhanced Care Plan is now live on Nerve Centre. This will replace the paper version of Risk of Falling-Patient Care Plan
- Post fall assessment is now live on nerve centre. This replaces the paper version of post fall proforma.
- The rest of falls prevention care plan will be launch on sprint 2 around September.

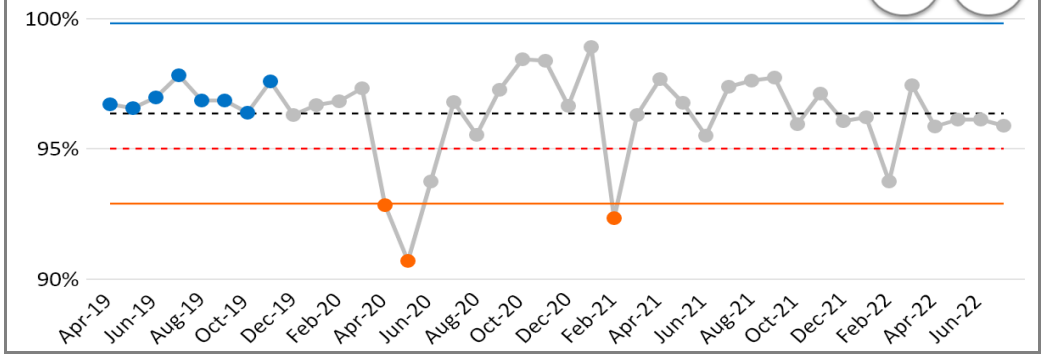
Caring Services

Month 04 | 2022-23

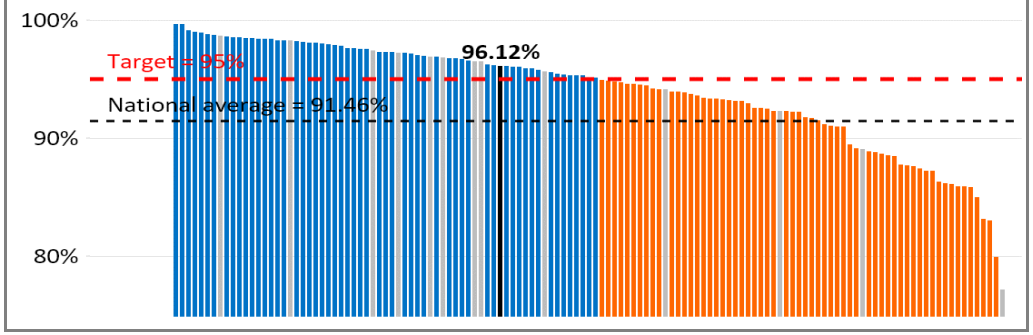


Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Friends and Family Test	Inpatients positive feedback	Jul-22	95%	95.9%			Common cause variation Metric will inconsistently pass and fail the target
	A&E positive feedback	Jul-22	90%	81.8%			Ten points below the lower process limit Metric will inconsistently pass and fail the target
	Maternity Antenatal positive feedback	Jul-22	93%	100.0%			Metric unsuitable for SPC analysis
	Maternity Birth positive feedback	Jul-22	93%	100.0%			Common cause variation Metric will inconsistently pass and fail the target
	Maternity Postnatal positive feedback	Jul-22	93%	98.2%			Common cause variation Metric will inconsistently pass and fail the target
	Maternity Community positive feedback	Jul-22	93%	100.0%			Metric unsuitable for SPC analysis
	Outpatients FFT positive feedback	Jul-22	95.0%	95.9%			Common cause variation Metric will inconsistently pass and fail the target
PALS	Number of PALS referrals received in-month	Jul-22		228			Common cause variation No target
Complaints	Number of written complaints received in-month	Jul-22		52			Common cause variation No target
	Number of complaints closed in-month	Jul-22		61			Common cause variation No target
	Proportion of complaints acknowledged within 3 working days	Jul-22	75%	93.2%			Common cause variation Metric will consistently pass the target
	Proportion of complaints responded to within agreed timeframe	Jul-22	80%	46.8%			Seven points below the mean Metric will inconsistently pass and fail the target

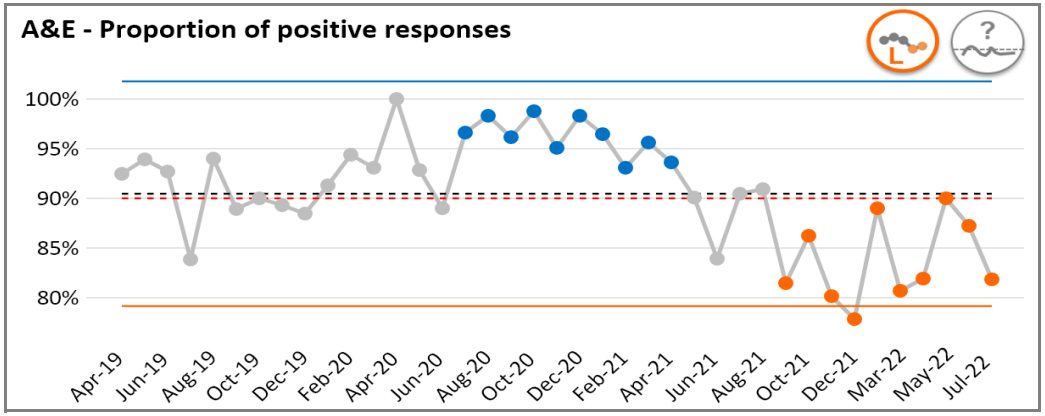
Inpatient - Proportion of positive responses



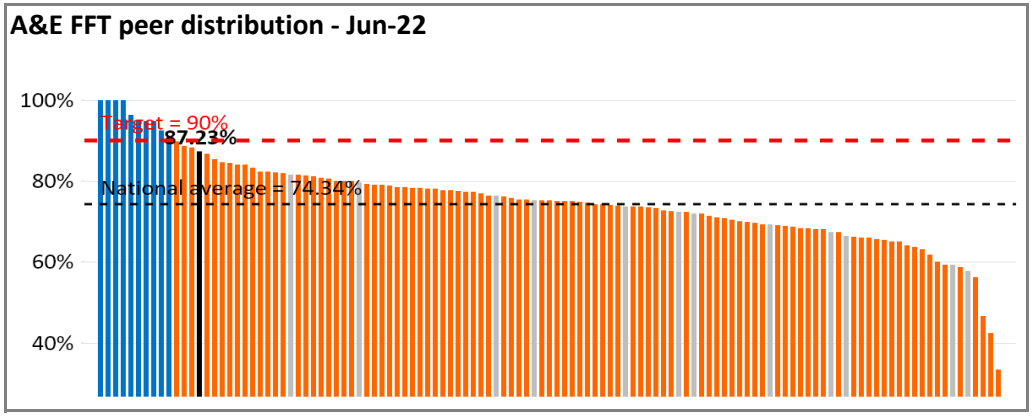
Inpatients FFT peer distribution - Jun-22



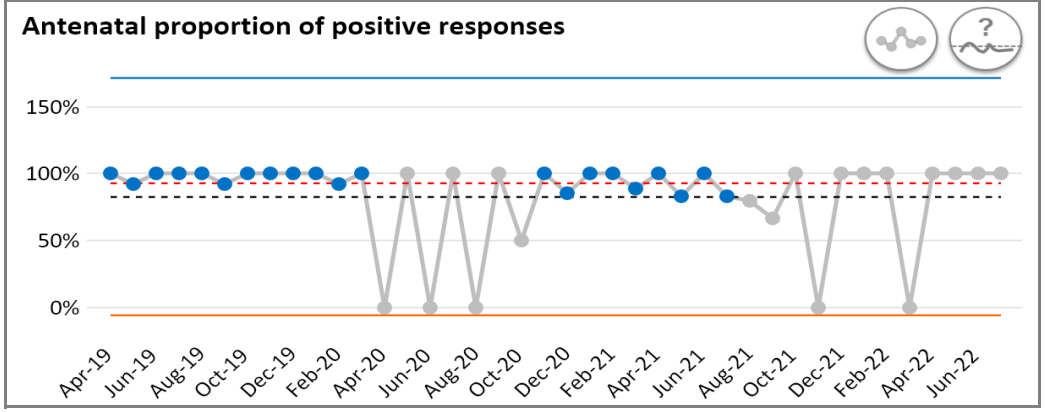
A&E - Proportion of positive responses



A&E FFT peer distribution - Jun-22



Antenatal proportion of positive responses



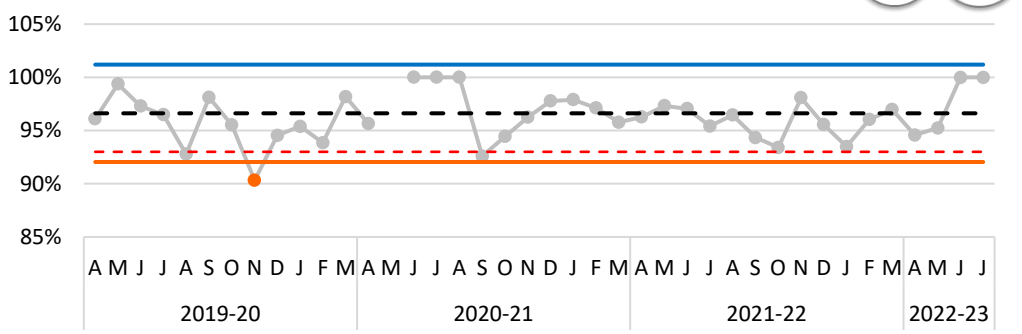
Maternity Antenatal FFT peer distribution - Jun-22

Peer comparison unavailable

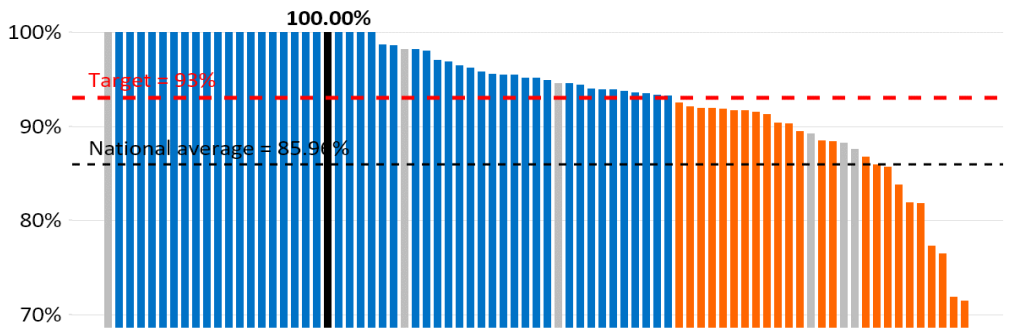
ENHT results supressed due to low response numbers

East and North Hertfordshire NHS Trust

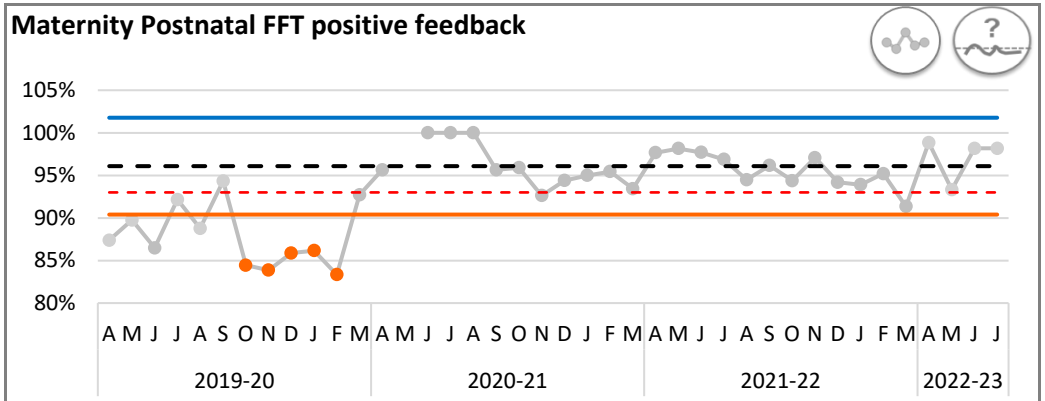
Maternity Birth FFT positive feedback



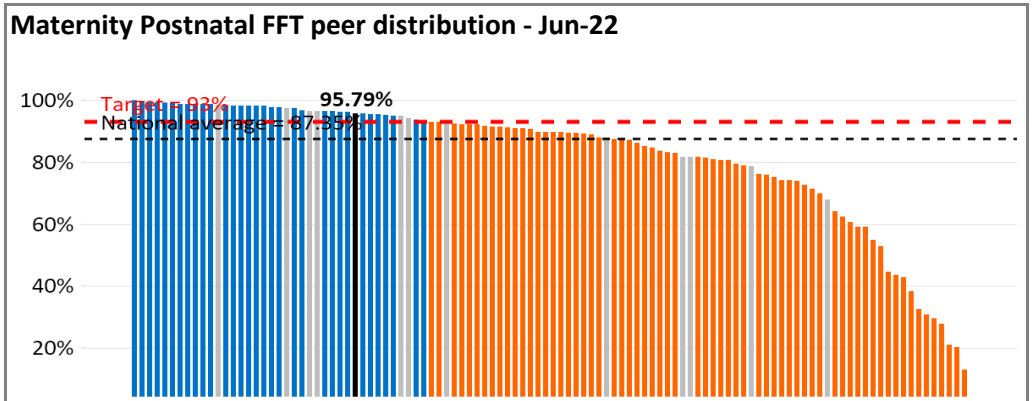
Maternity Birth FFT peer distribution - Jun-22



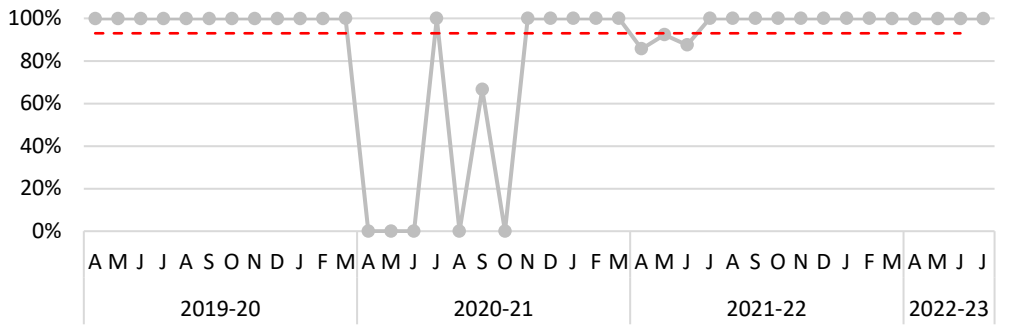
Maternity Postnatal FFT positive feedback



Maternity Postnatal FFT peer distribution - Jun-22

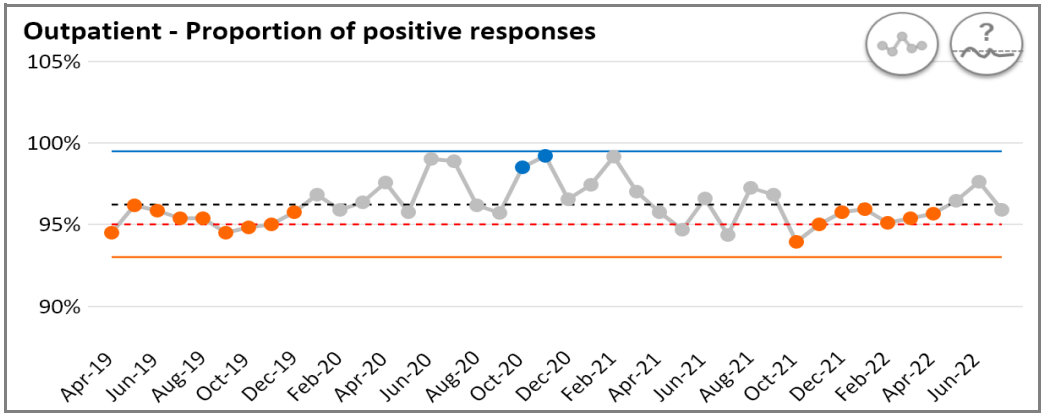


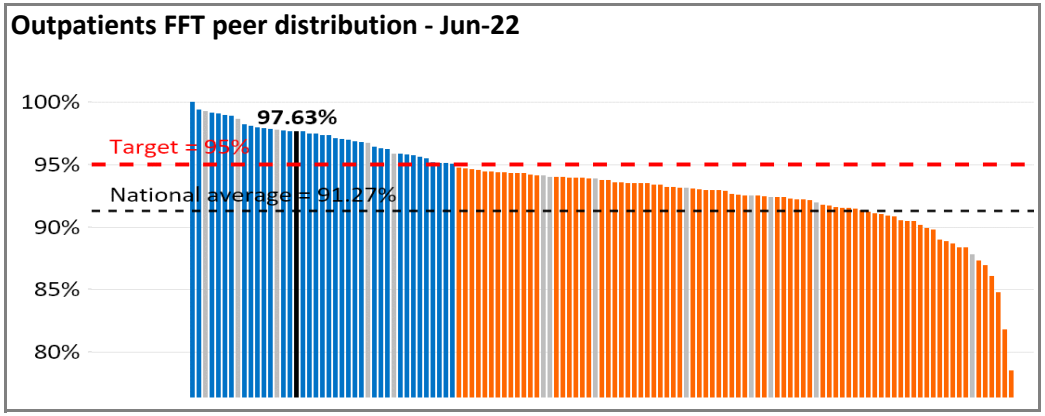
Maternity Community FFT positive feedback



Maternity Community FFT peer distribution - Jun-22

Peer comparison unavailable
ENHT results supressed due to low response numbers





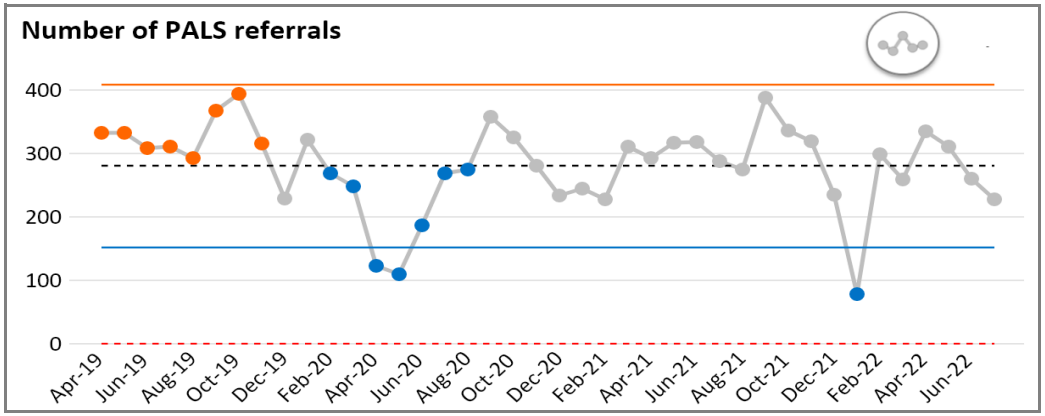
Key Issues and Executive Response

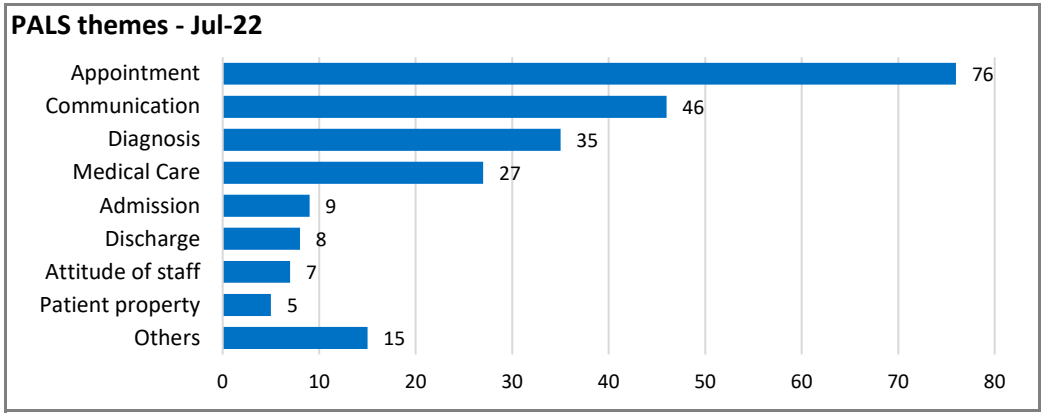
Challenges

- Due to new reporting system (ENHance) there have been problems with the QR codes used within areas, as such there has been a slight drop in survey completions.
- No app has been created yet so iPads can't be used to complete surveys.

Actions

- Continue to work with ENHance to ensure that all functions and reporting systems are in place.
- Promote learning of new system ENHance to staff so they are confident to use.





Key Issues and Executive Response

Excellence

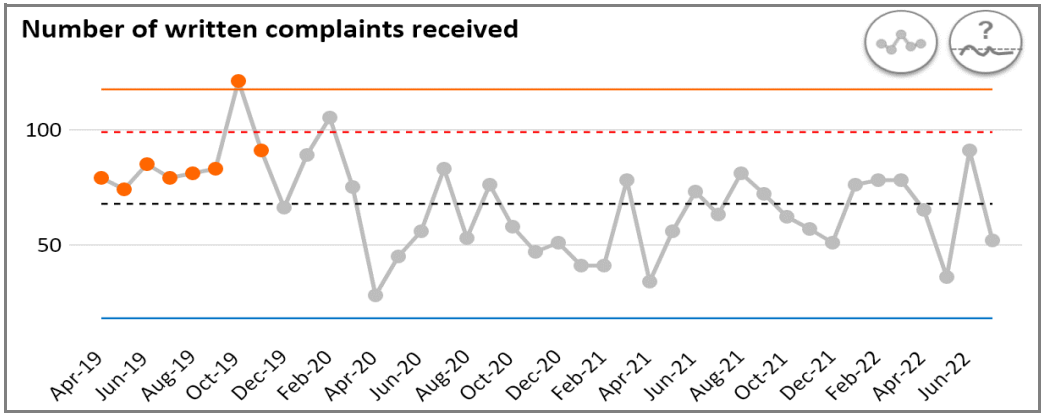
- Team continues to remain in high spirits.

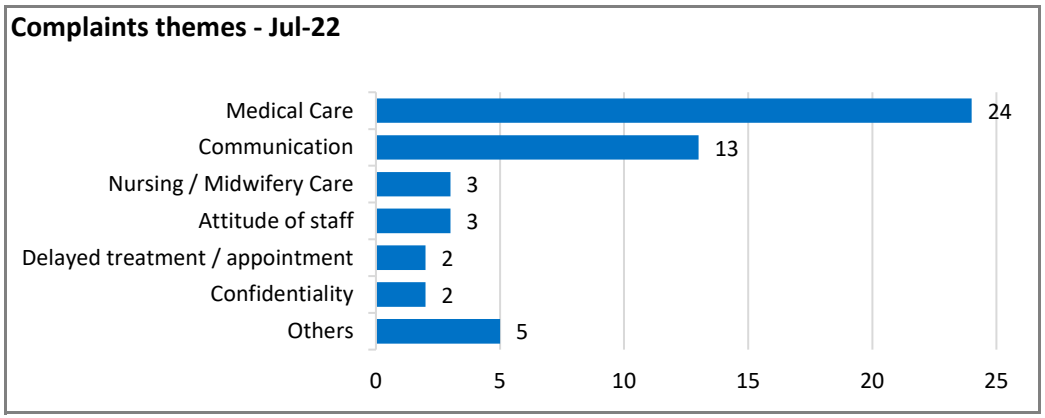
Challenges

- High volume of concerns around appointments, delays and waiting lists.
- Unable to manage the amount of traffic in generic inbox. 14 -21 working days has been set as a response time and has been included in the automatic email response.

Actions

- Response volunteers to aid with looking for lost property.
- Continue to work towards to Complaints & PALS transformation programme.





Key Issues and Executive Response

Excellence

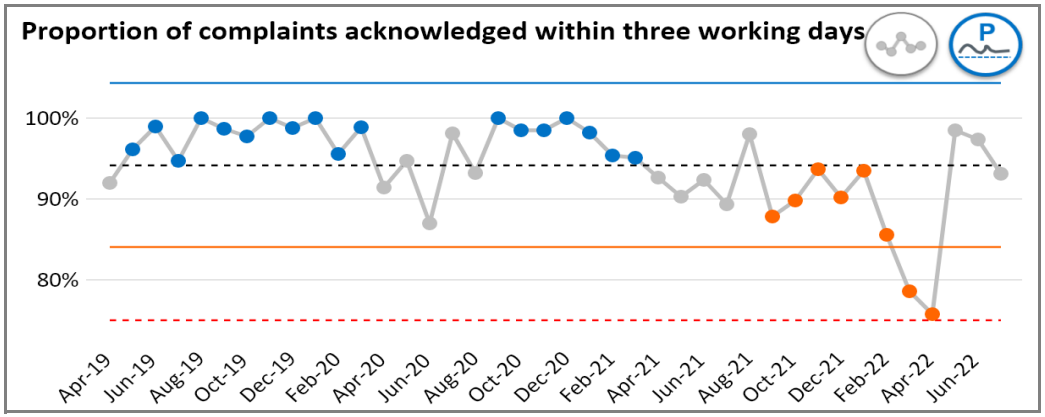
- Team continues to remain in high spirits.
- New complaint scoping process working really well to include complainants in finalising the concerns for investigation.

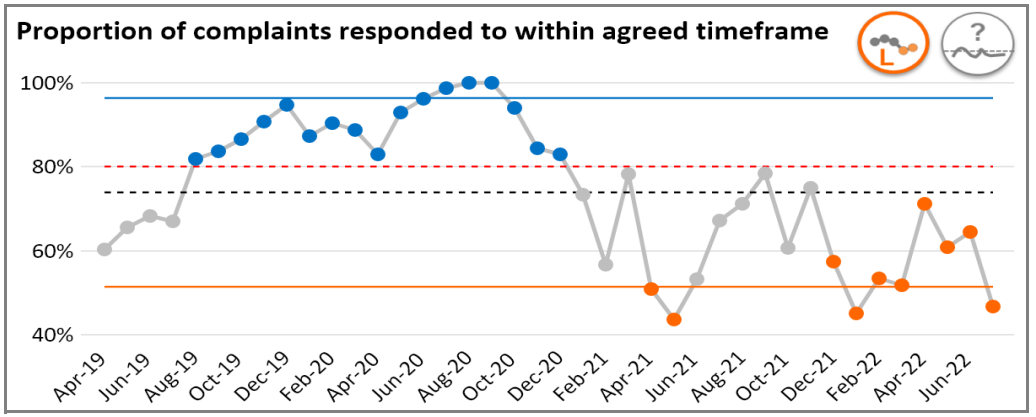
Challenges

- Due to AL and sickness the number of complaints closed in the month has reduced.
- Slight reduction on acknowledgment compliance but remains above 90%.
- Long delays in complaints being declared SI's, unhappy complainants when this occurs.

Actions

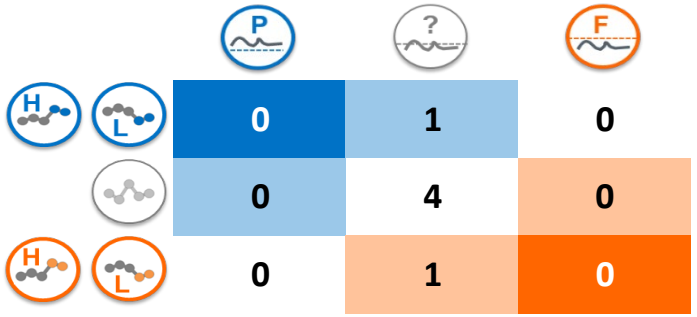
- Regular review of overdue cases and escalation to individual leads.
- Work with SI team to look for a solution to the large waiting times when a complaint is raised to be taken to SIRP.
- Continue to work towards to Complaints & PALS transformation programme.
- To continue to push acknowledgment towards 100%.





Effective Services

Month 04 | 2022-23



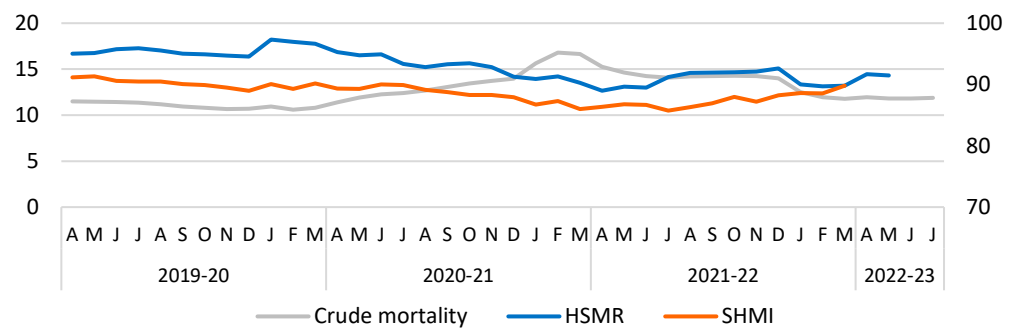
Effective Services

Summary

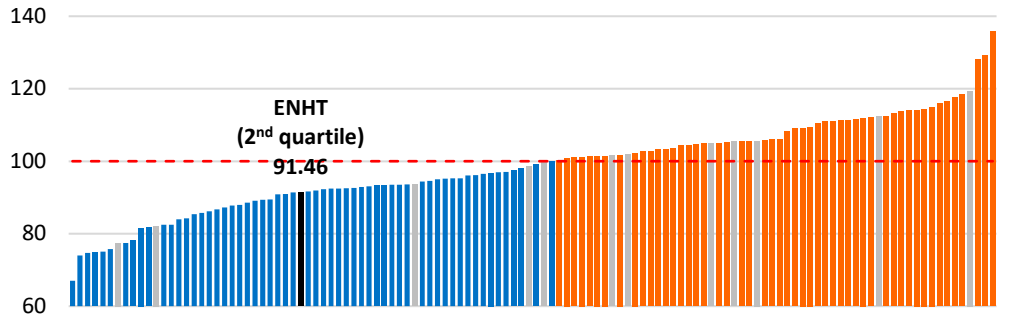
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Mortality	Crude mortality per 1,000 admissions In-month	Jul-22	12.8	9.7			Common cause variation Metric will inconsistently pass and fail the target
	Crude mortality per 1,000 admissions Rolling 12-months	Jul-22	12.8	11.9			Rolling 12-months - unsuitable for SPC
	HSMR In-month	May-22	100	97.3			Common cause variation Metric will inconsistently pass and fail the target
	HSMR Rolling 12-months	May-22	100	91.5			Rolling 12-months - unsuitable for SPC
	SHMI In-month	Mar-22	100	90.9			Common cause variation Metric will inconsistently pass and fail the target
	SHMI Rolling 12-months	Mar-22	100	89.8			Rolling 12-months - unsuitable for SPC
Re-admissions	Number of emergency re-admissions within 30 days of discharge	May-22	n/a	604			Nine consecutive points below the mean No target
	Rate of emergency re-admissions within 30 days of discharge	May-22	9.0%	6.2%			Two points below the lower process limit Metric will inconsistently pass and fail the target
Length of Stay	Average elective length of stay	Jul-22	2.8	2.2			Common cause variation Metric will inconsistently pass and fail the target
	Average non-elective length of stay	Jul-22	4.6	4.6			13 consecutive points above the mean Metric will inconsistently pass and fail the target
Palliative Care	Proportion of patients with whom their preferred place of death was discussed	Jul-22	n/a	84.5%			Common cause variation No target
	Individualised care pathways	Jul-22	n/a	24			Common cause variation No target

East and North Hertfordshire NHS Trust

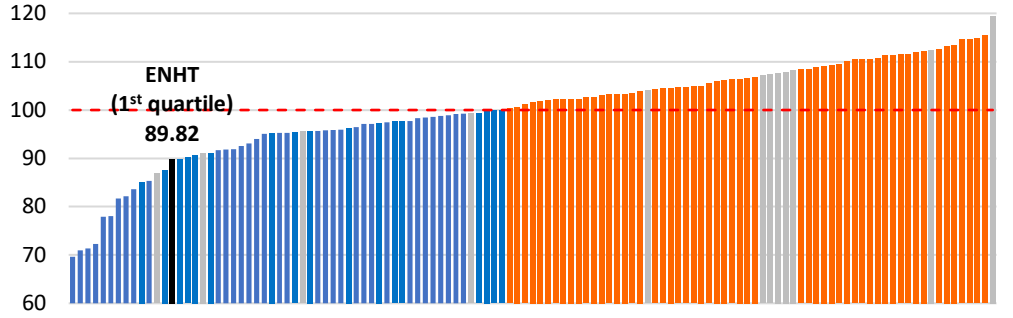
Mortality metric comparison - rolling 12-months



HSMR peer distribution - May-22



SHMI peer distribution - Mar-22



Key Issues and Executive Response

COVID-19

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

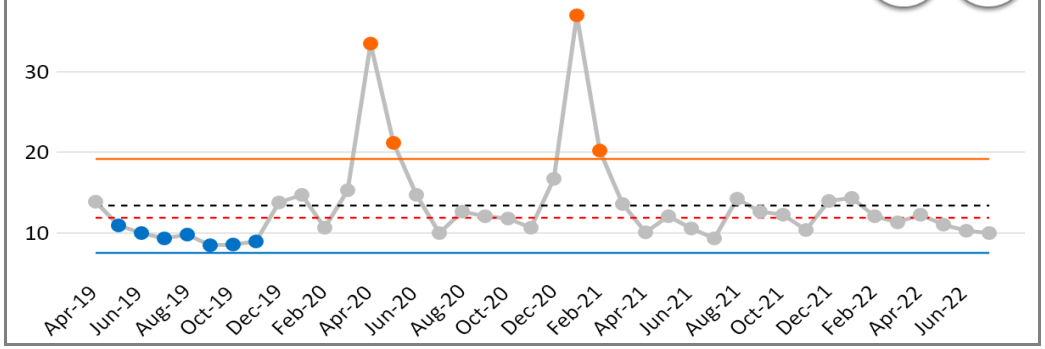
Learning from Deaths

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

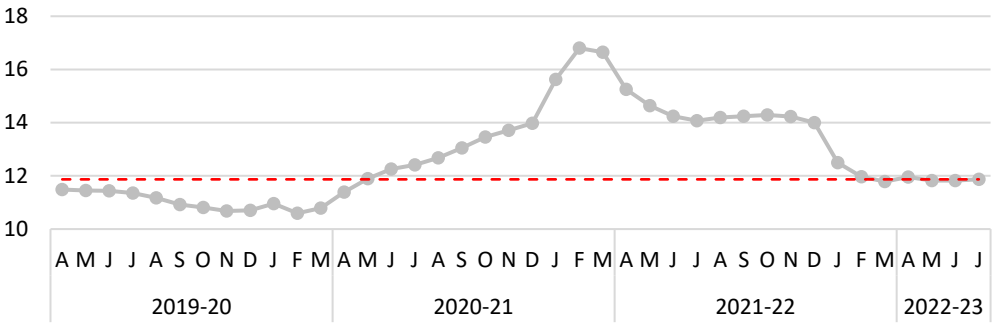
Mount Vernon

- While the secession of MVCC as part of the Trust, would affect both our HSMR and SHMI, it has been decided that it is currently premature to focus on the likely impact. The consequence of the split will continue to be monitored by the Mortality Surveillance Committee and highlighted should plans for the split mature.

Crude mortality per 1,000 discharges



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

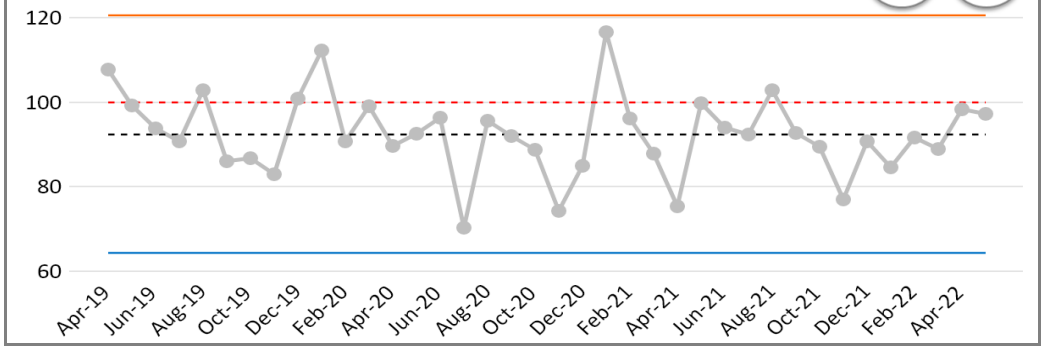


Key Issues and Executive Response

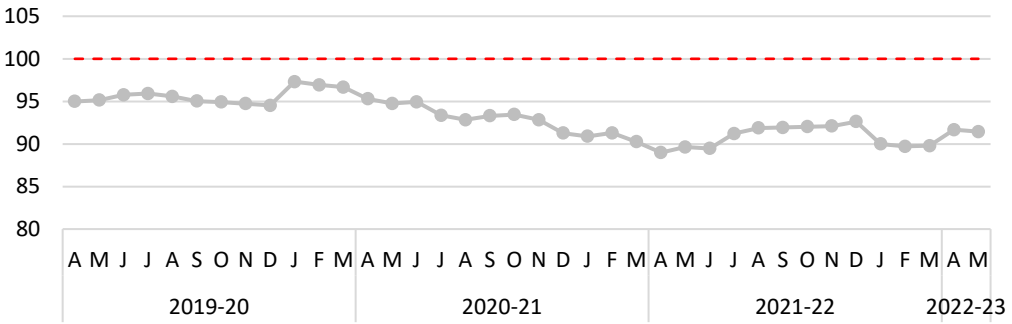
- Crude mortality is the factor with the most significant impact on HSMR. The exception was during the COVID pandemic, when the usual correlation was weakened by the partial exclusion of COVID-19 patients from the HSMR metric.
- The general improvements in mortality prior to the COVID-19 resulted from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

Hospital Standardised Mortality Ratio (HSMR)

HSMR - Hospital Standardised Mortality Ratio



HSMR - rolling 12-months



HSMR - mortality alerts Jun-21 to May-22

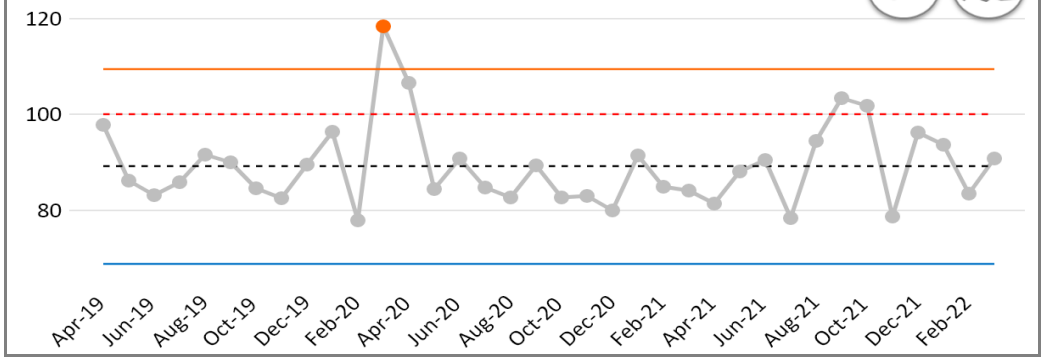
CCS Group	Deaths	Value	Alert	Description
101 - Coronary atherosclerosis and other heart disease	7	329.7	R	3-sigma breach in May-22

Key Issues and Executive Response

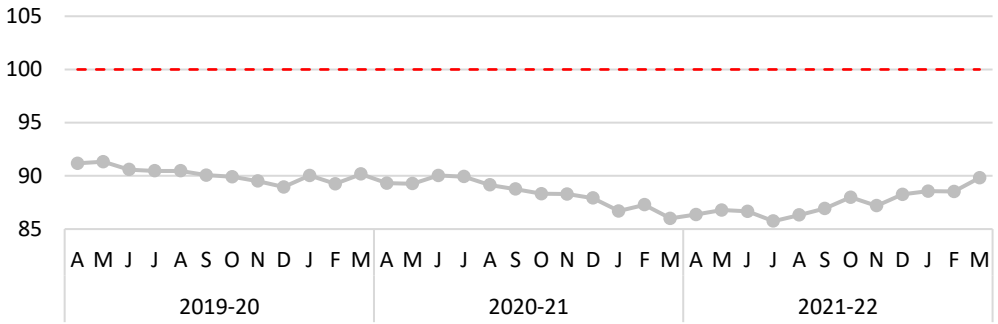
- There has been an upward trend in in-month HSMR since December 2021.
- However, the latest CHKS refresh providing rolling 12-month HSMR data to May 2022 shows a slight reduction from 91.7 to 91.5 with the metric remaining relatively stable and well positioned with regard to our national and Model Hospital Peer groups.
- Following the National Hip Fracture Database 3SD outlier alert for #NOF mortality (for the period Jan-Dec 2020) work has continued on the remedial action. The Service reports that a key remaining impediment to improvement is timely access to theatre. The Medical Director is leading continuing discussions regarding how to address this issue.
- Unfortunately, the National Hip Fracture Database has yet to update its risk adjusted mortality beyond December 2020, making the impact of our improvement work unclear.
- The Head of Coding has confirmed that the coding of the deaths underpinning the HSMR CUSUM alert for coronary atherosclerosis was correct. At May Mortality Surveillance Committee, it was agreed that coding of this diagnosis group would continue to be monitored by Cardiology/Head of Coding on a monthly basis, with an update to the Committee in 6 months.

Summary Hospital-level Mortality Index (SHMI)

SHMI - Summary Hospital-level Mortality Indicator



SHMI - rolling 12-months

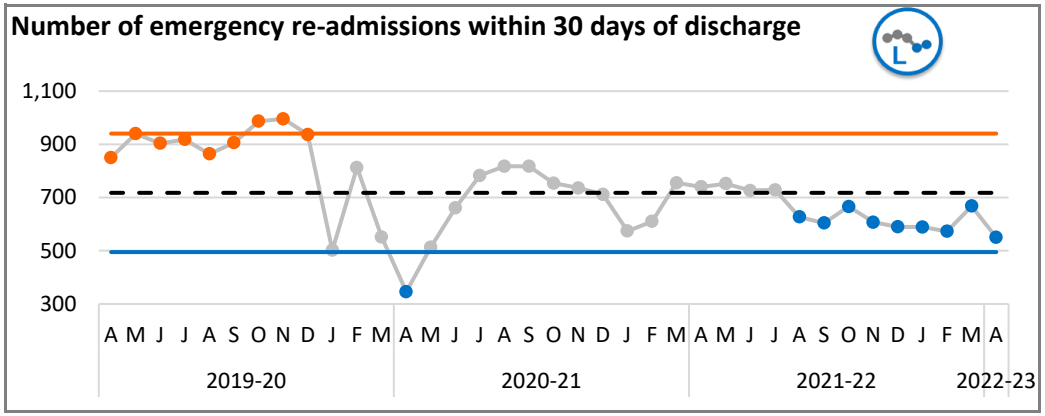


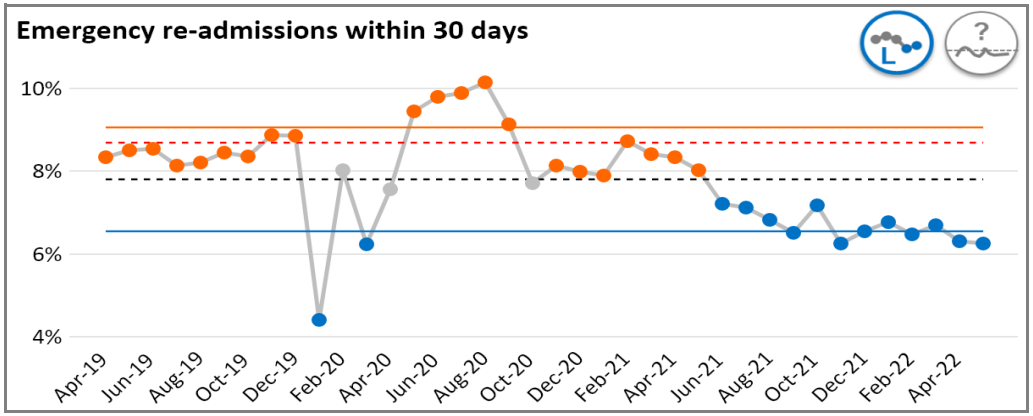
SHMI - mortality alerts Apr-21 to Mar-22

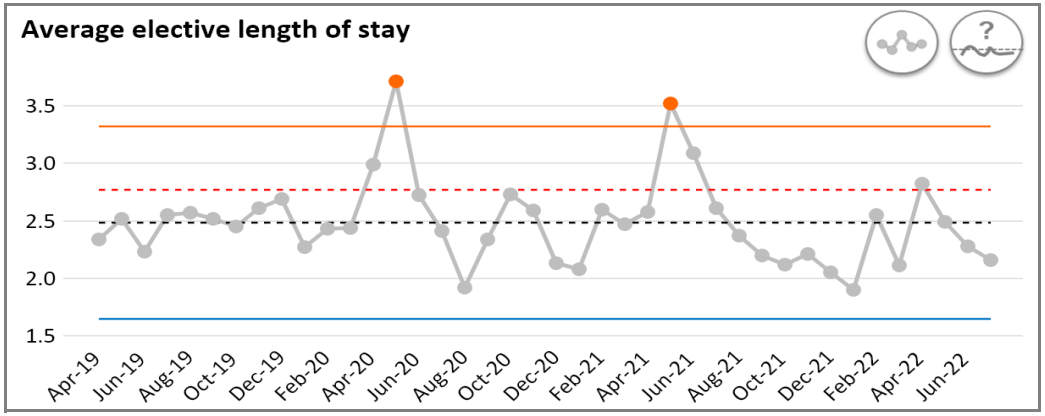
SHMI Group	Deaths	Value	Alert	Description
58 - 101: Coronary atherosclerosis and other heart disease	10	375.9	R	3-sigma breach in Mar-22

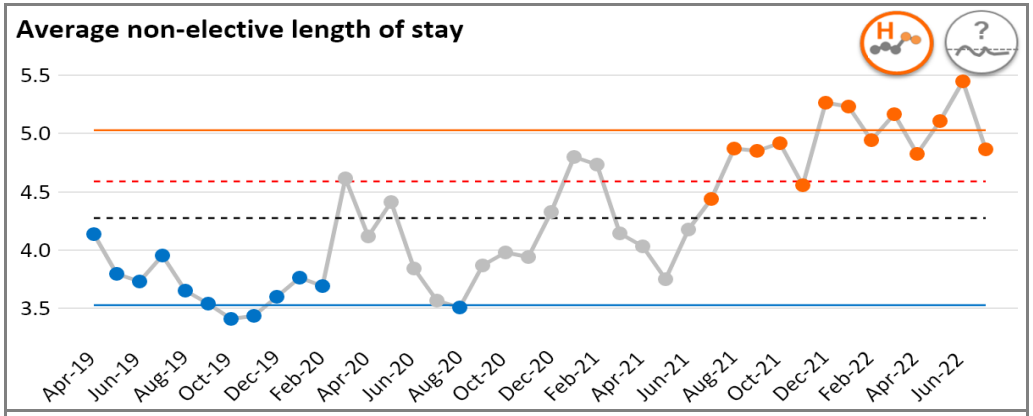
Key Issues and Executive Response

- The latest in-month position for March 2022 reported by CHKS shows common cause variation.
- Latest published rolling 12-month SHMI to March 2022, increased to 89.82.
- This means that the Trust has moved from the 'lower than expected' to 'as expected' in the latest publication.
- All SHMI alerts are discussed by the Mortality Surveillance Committee. Coding reviews of alerts for the latest period will be discussed at September Mortality Surveillance Committee.
- Alerts are considered in conjunction with other metrics and current performance information.
- Where further review is deemed appropriate, this starts with a Coding review. The detail of this is used to determine the need for further action, potentially involving a clinical review of the deaths underpinning the alert, or joint remedial work between coding and the clinical specialty.







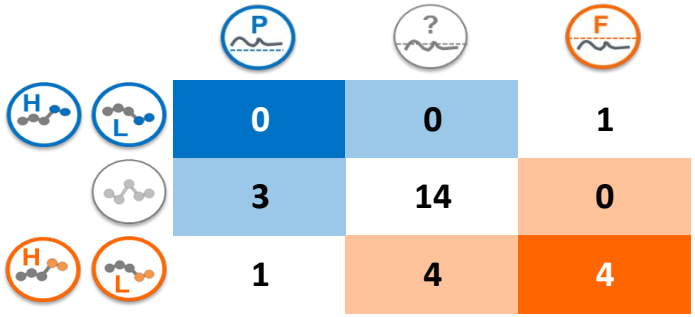


Key Issues and Executive Response

- Recent months have seen re-admissions performance improve, with the Trust consistently tracking below the national average.
- The Trust's performance is well positioned in comparison to our Model Hospital peer group.
- Recent months have seen a consistent upward trend in average non-elective length of stay (LoS).
- It should be noted that when average LoS is considered on CHKS, which provides a comparison with the national peer group, this upward trend is seen to be in line with the national picture.
- A review has commenced to look at the deaths of Medically optimised patients whose discharges were delayed and who subsequently died in hospital between January-June 2022.

Responsive Services

Month 04 | 2022-23



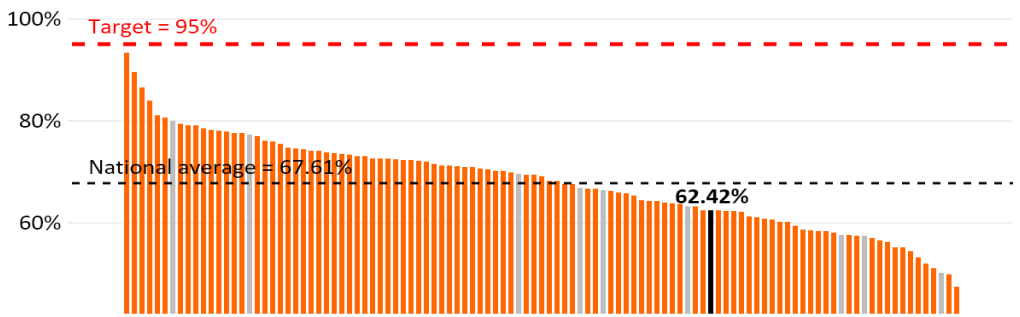
Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Emergency Department	Patients waiting no more than four hours from arrival to admission, transfer or discharge	Jul-22	95%	62.4%			11 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	Jul-22	2%	11.7%			10 consecutive points above the upper process limit Metric will inconsistently hit and miss the target
	Percentage of ambulance handovers within 15-minutes	Jul-22	65%	3.5%			14 consecutive points below the lower process limit Metric will consistently fail the target
	Time to initial assessment - percentage within 15-minutes	Jul-22	80%	53.1%			15 consecutive points below the mean Metric will consistently fail the target
	Average (mean) time in department - non-admitted patients	Jul-22	240	216.1			14 consecutive points above the mean Metric will consistently pass the target
	Average (mean) time in department - admitted patients	Jul-22	tbc	677.6			11 consecutive points above the upper process limit No target
	Average minutes from clinically ready to proceed to departure	Jul-22	tbc	547			Insufficient data points for SPC analysis
	Critical time standards	Jul-22	tbc				Pending data
RTT & Diagnostics	Patients on incomplete pathways waiting no more than 18 weeks from referral	Jul-22	92%	54.3%			18 consecutive points below the lower process limit Metric will consistently fail the target
	Patients waiting more than six weeks for diagnostics	Jul-22	0%	11			Two points below the mean Metric will consistently fail the target

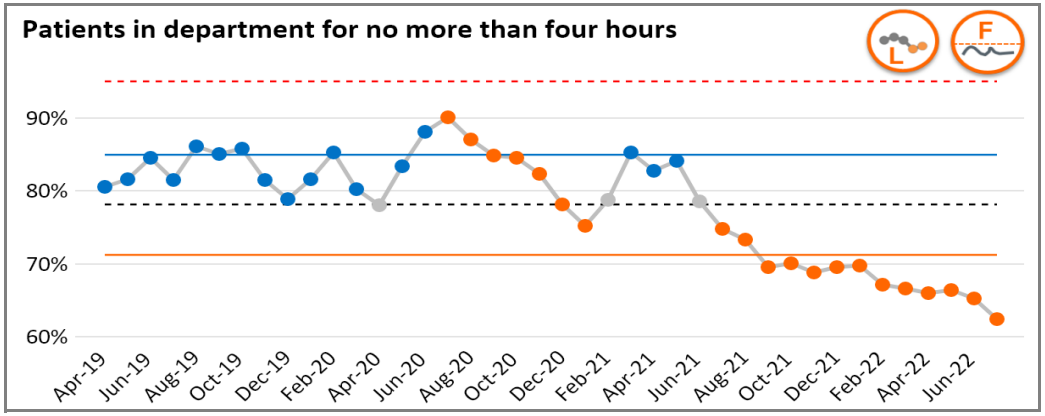
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cancer Waiting Times	Two week waits for suspected cancer	Jun-22	93%	93.50%		P	Common cause variation Metric will consistently pass the target
	Two week waits for breast symptoms	Jun-22	93%	97%		?	Common cause variation Metric will inconsistently hit and miss the target
	28-day faster diagnosis	Jun-22	75%	70.58%	L	?	Eight points below the mean Metric will inconsistently hit and miss the target
	31-days from diagnosis to first definitive treatment	Jun-22	96%	96.23%		?	Common cause variation Metric will inconsistently hit and miss the target
	31-days for subsequent treatment - anti-cancer drugs	Jun-22	98%	100.00%		P	Common cause variation Metric will consistently pass the target
	31-days for subsequent treatment - radiotherapy	Jun-22	94%	98.81%		P	Common cause variation Metric will consistently pass the target
	31-days for subsequent treatment - surgery	Jun-22	94%	82.50%		?	Common cause variation Metric will inconsistently hit and miss the target
	62-days from urgent GP referral to first definitive treatment	Jun-22	85%	82.35%		?	Common cause variation Metric will inconsistently hit and miss the target
	Patients waiting no more than 104-days from urgent GP referral to first definitive treatment	Jun-22	0	5.0		?	Common cause variation Metric will inconsistently hit and miss the target
	62-days from referral from an NHS screening service to first definitive treatment	Jun-22	90%	42.9%		?	Common cause variation Metric will inconsistently hit and miss the target
	62-days from consultant upgrade to first definitive treatment	Jun-22	n/a	70.5%			Common cause variation No target

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Stroke Services	Trust SSNAP grade	Q4 2021-22	A	D			
	% of patients discharged with a diagnosis of Atrial Fibrillation and commenced on anticoagulants	Jul-22	80%	100.0%			Common cause variation Metric will inconsistently hit and miss the target
	4-hours direct to Stroke unit from ED	Jul-22	63%	18.8%			13 consecutive points below the mean Metric will inconsistently hit and miss the target
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	Jul-22	63%	16.9%			5 consecutive points below the lower process limit Metric will inconsistently hit and miss the target
	Number of confirmed Strokes in-month on SSNAP	Jul-22	n/a	72			Common cause variation No target
	If applicable at least 90% of patients' stay is spent on a stroke unit	Jul-22	80%	84.7%			Common cause variation Metric will inconsistently hit and miss the target
	Urgent brain imaging within 60 minutes of hospital arrival for suspected acute stroke	Jul-22	50%	48.6%			Common cause variation Metric will inconsistently hit and miss the target
	Scanned within 12-hours - all Strokes	Jul-22	100%	94.6%			Common cause variation Metric will inconsistently hit and miss the target
	% of all stroke patients who receive thrombolysis	Jul-22	11%	9.7%			Common cause variation Metric will inconsistently hit and miss the target
	% of patients eligible for thrombolysis to receive the intervention within 60 minutes of arrival at A&E (door to needle time)	Jul-22	70%	28.6%			Common cause variation Metric will inconsistently hit and miss the target
	Discharged with JCP	Jul-22	80%	89.8%			Common cause variation Metric will inconsistently hit and miss the target
	Discharged with ESD	Jul-22	40%	59.2%			Common cause variation Metric will inconsistently hit and miss the target

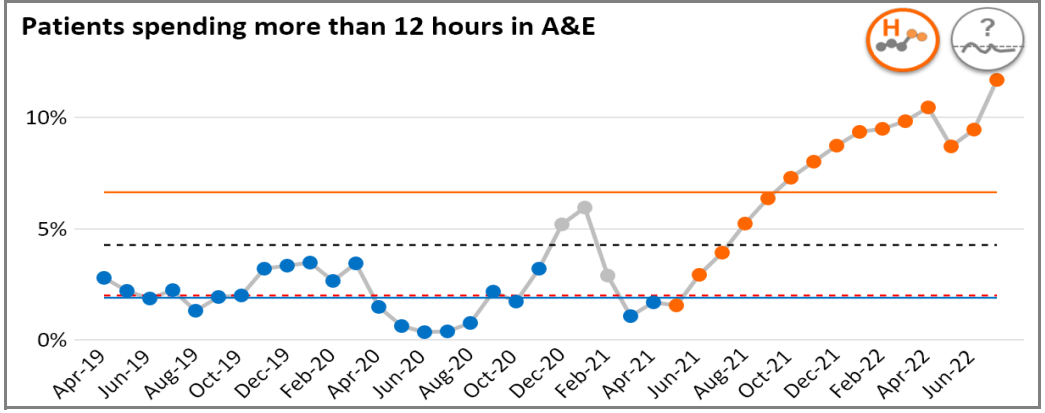
Patients waiting no more than 4-hours in ED peer distribution - Jul-22



Patients in department for no more than four hours



Patients spending more than 12 hours in A&E



Key Issues and Executive Response

- Arrivals by ambulance reduced for the 2nd consecutive month. However, walk-ins increased causing an overall rise in attendances.
- Time to initial assessment deteriorated for the 2nd consecutive month.
- Both admitted and non-admitted performance (time in ED) deteriorated.
- Admission conversion rates increased; however, zero-day admissions reduced. Patients discharged to hospital@home also reduced.
- Patients not meeting the criteria to reside (previously known as Medically Optimised) increased compared to previous month.
- Positively, discharges before midday increased for the 2nd consecutive month as well as a significant increase in weekend discharges, rising above 15% for the first time in 12 months.
- The rise in admission rates resulted in increased total length of stay for admitted patients, whereas reduced zero-day admissions is reflected in the increased non-admitted LOS i.e. patients who should have transferred to an assessment area / ward were alternatively treated and discharged from ED. This rise in LOS and increasing patients not meeting the criteria to reside contributed to increased ambulance handover delays.
- Surge ED cubicle capacity continued to be required i.e. 2 triage assessment rooms were often converted to cubicle spaces, causing continued inefficiencies at triage.

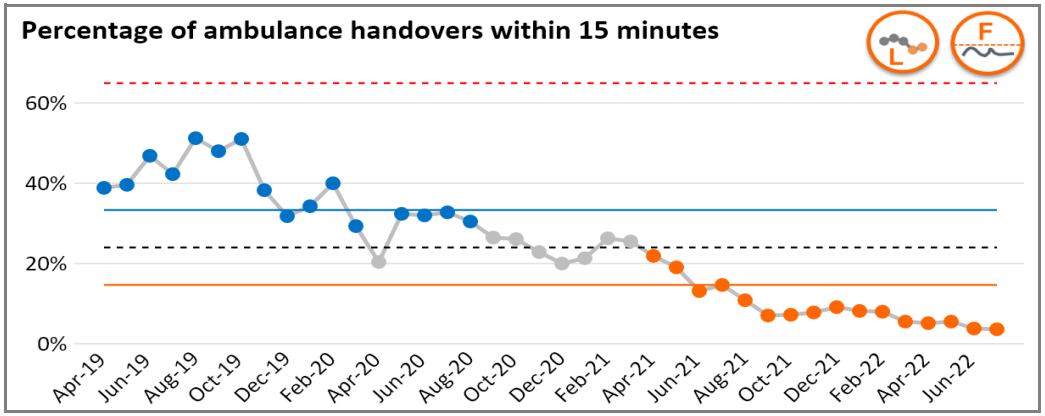
Actions

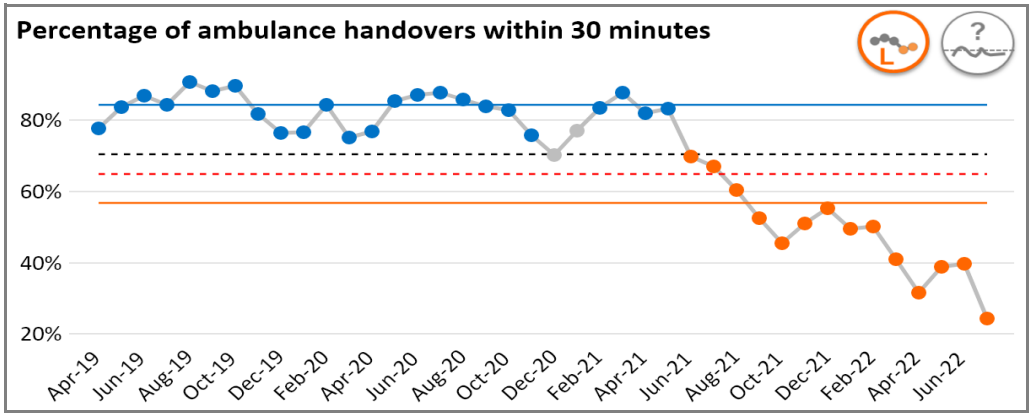
- A revenue case to support non-elective transformation and increased cubicle capacity has been presented to deputies. Outcome pending.
- The trust held a Reset Week in late July, with focus on flow and discharge. Flow from ED to assessment and ward and improving practices for the long term were key features.
- ECIST continue to support improvements around site management and patient flow.

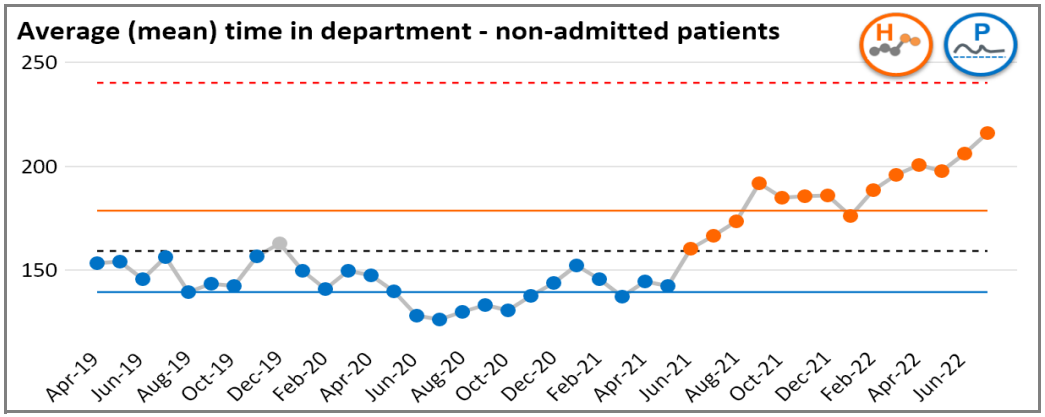
Responsive Services

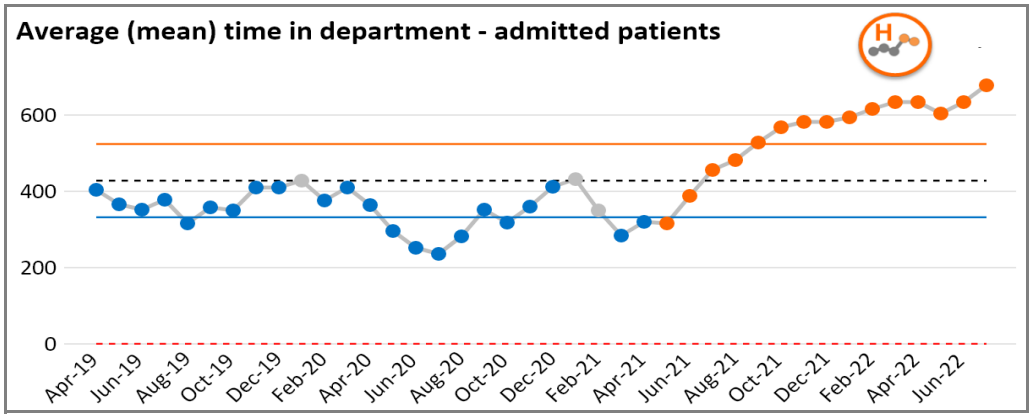
Emergency Department New Standards

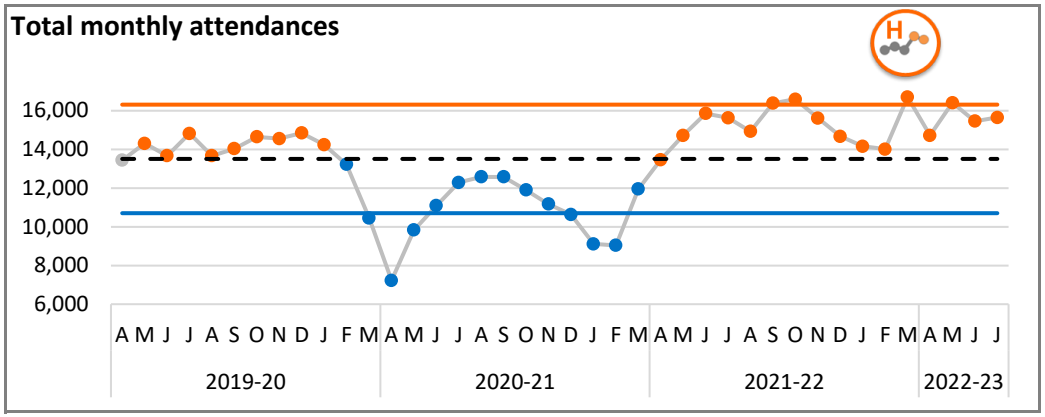
East and North Hertfordshire NHS Trust

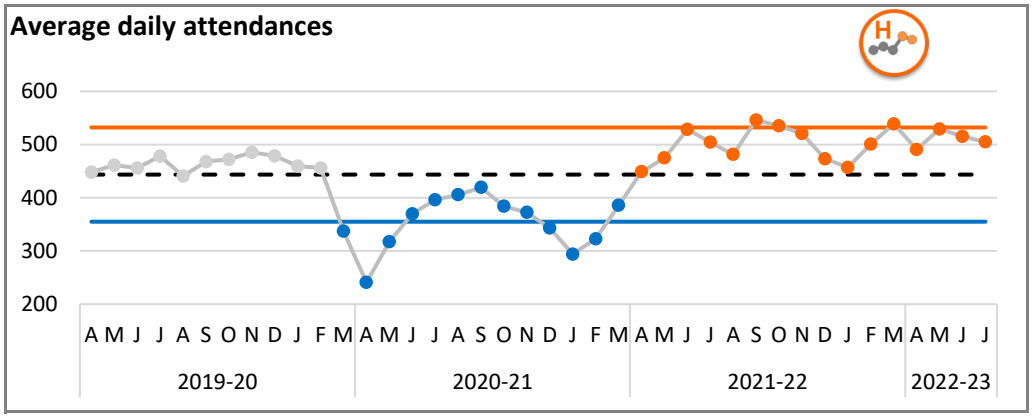


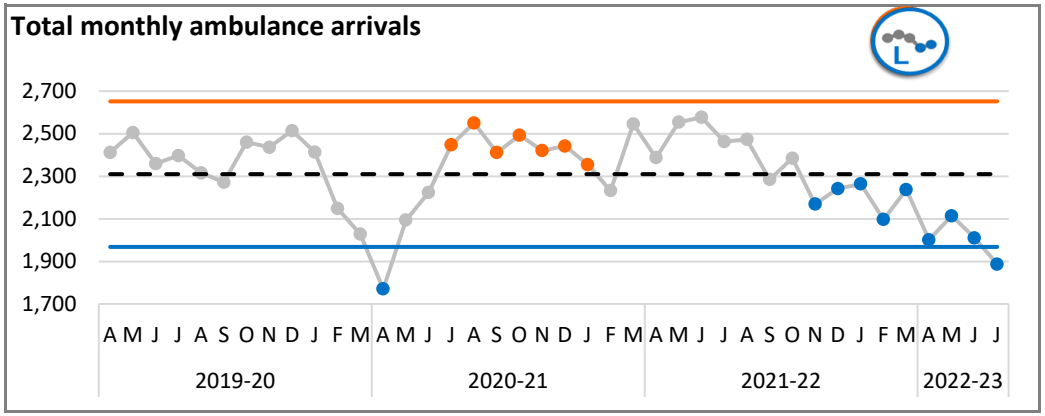


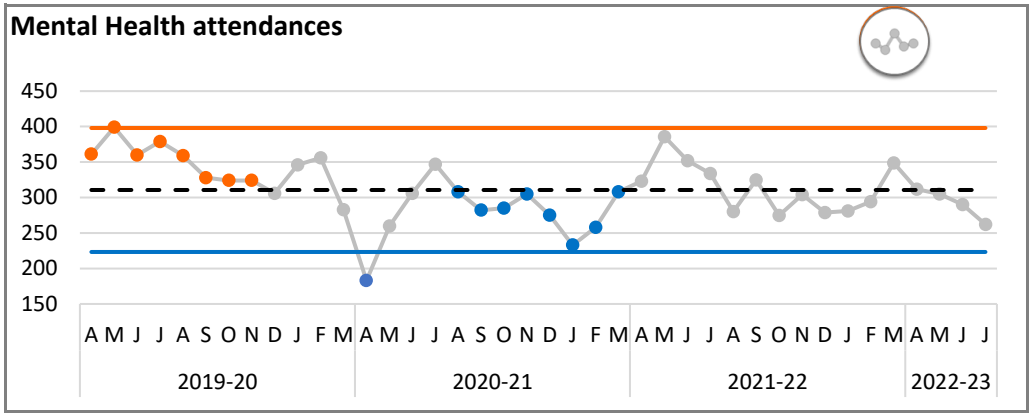


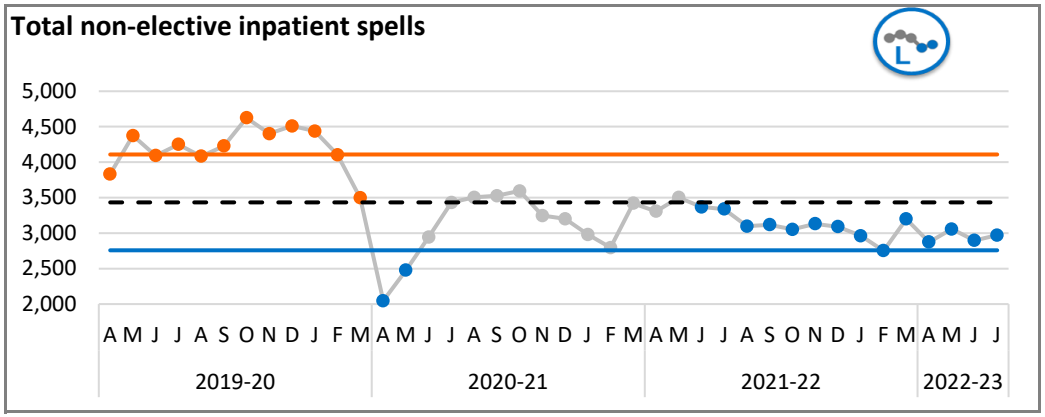


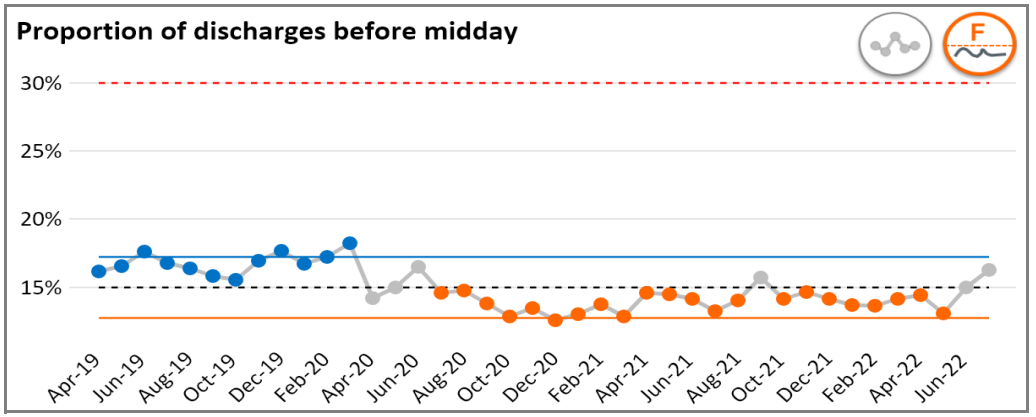




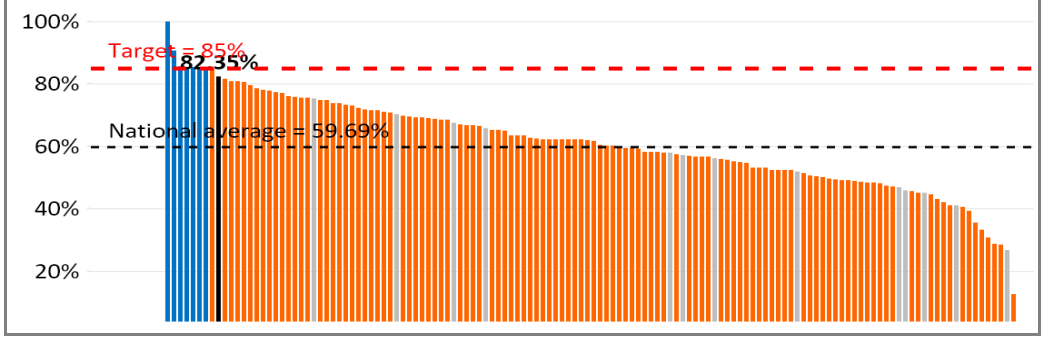

Total monthly ambulance arrivals
2,700
2,500
2,300
2,100
1,900
1,700
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J
2019-20
2020-21
2021-22
2022-23


Mental Health attendances
450
400
350
300
250
200
150
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J
2019-20
2020-21
2021-22
2022-23

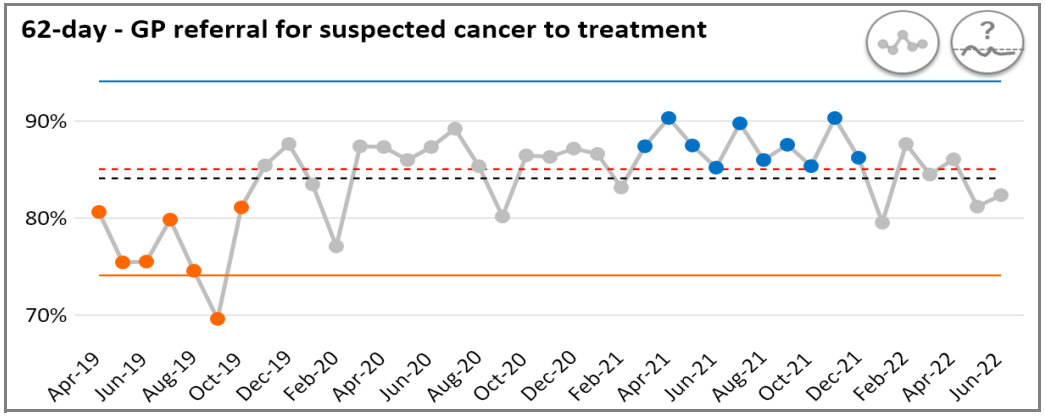

Total non-elective inpatient spells
5,000
4,500
4,000
3,500
3,000
2,500
2,000
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J
2019-20
2020-21
2021-22
2022-23


Proportion of discharges before midday
30%
25%
20%
15%
Apr-19
Jun-19
Aug-19
Oct-19
Dec-19
Feb-20
Apr-20
Jun-20
Aug-20
Oct-20
Dec-20
Feb-21
Apr-21
Jun-21
Aug-21
Oct-21
Dec-21
Feb-22
Apr-22
Jun-22

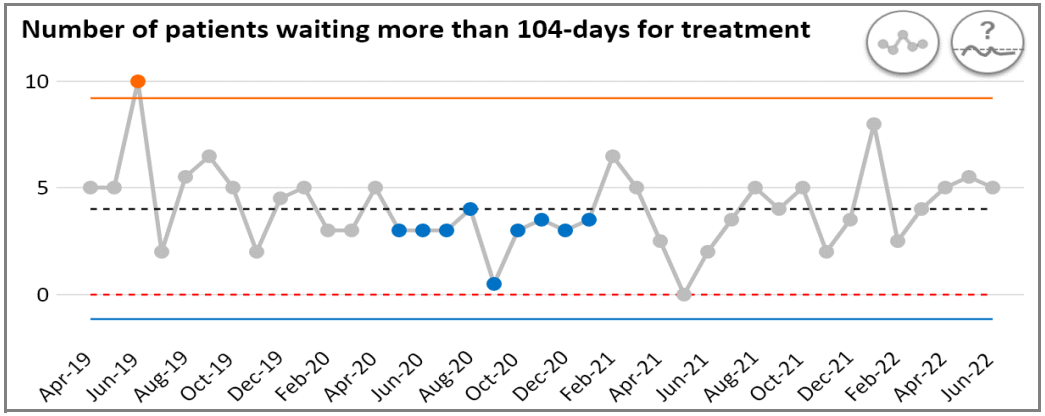
62-days GP referral to treatment peer distribution - Jun-22



62-day - GP referral for suspected cancer to treatment

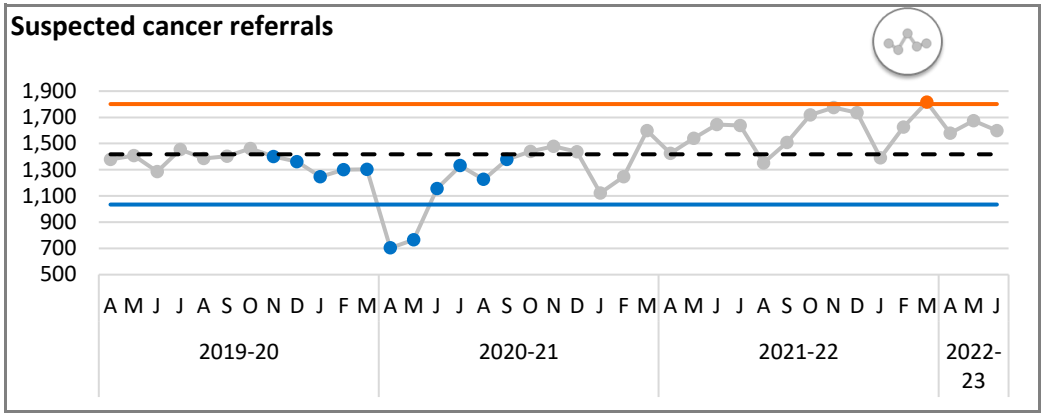


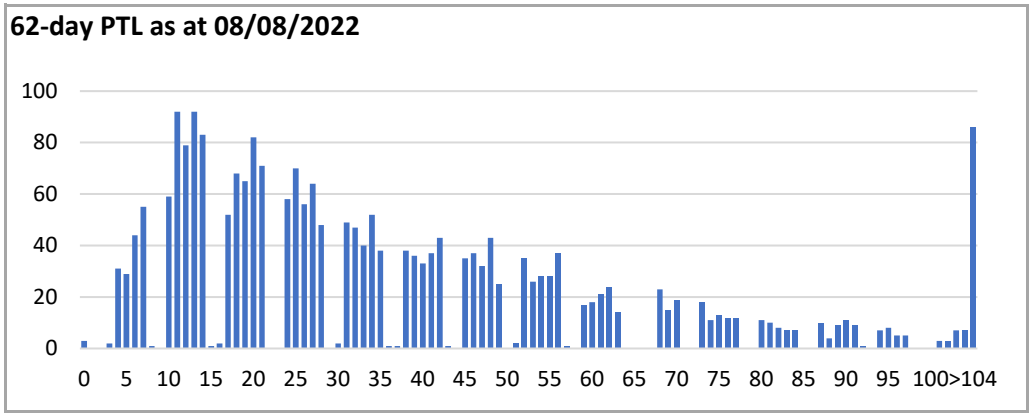
Number of patients waiting more than 104-days for treatment

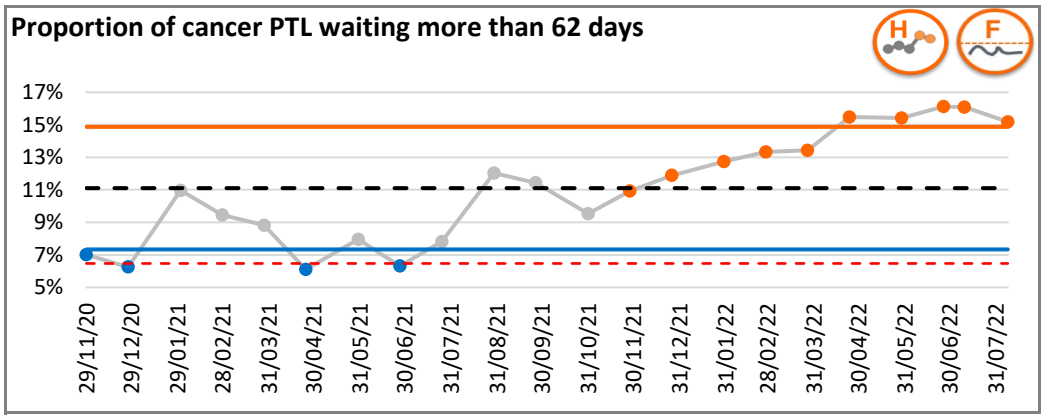


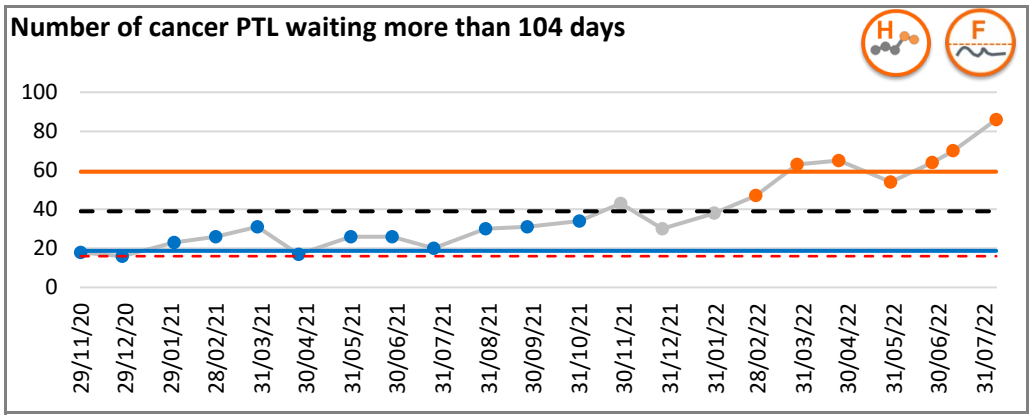
Key Issues and Executive Response

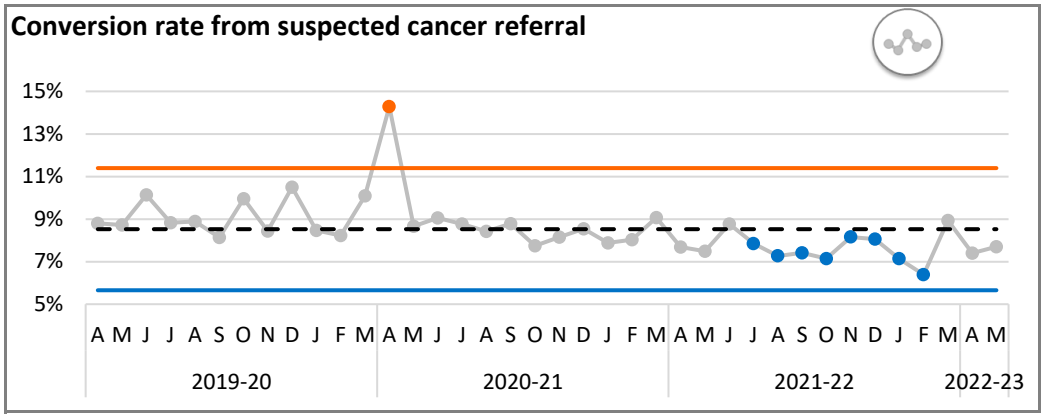
- Placed in Tier 1 nationally for elevated support due to rising number and proportion of patients waiting over 62 days on the cancer PTL. Percentage has risen from 6.5% (26 patients) to 16% (70 patients) in last 12 months.
- Tier 1 Action plan with Skin, UGI, LGI, MDT Tracking team, Histopathology and Radiology to improve MDT follow-up, reporting and more timely communication of diagnosis and next steps, particularly for patients who after diagnosis do not have cancer.
- Recovery action plan aims to reduce PTL backlog to 6% by March 23.
- However, Radiology and Histopathology continue to face major issues with capacity and staffing, likely to affect 62-day cancer performance for coming months.
- Deep dives for tumour sites continue. Additional scrutiny and support leading to improved performance.
- Timed pathways now in place for all Tumour sites to improve and sustain 62-day standard. Work continues to improve and deliver the Faster Diagnosis Standard performance.
- Achieved 5 of the 8 national targets in June: 2ww GP referral, 2ww for Breast symptoms, 31-day first treatment, 31-day second or subsequent treatment for chemotherapy, and radiotherapy.
- The Trust has not achieved the 31-day subsequent for Surgery, 62-day urgent referral to treatment for all cancers and 62 day for screening patients for June due to Radiology, Histopathology delays, capacity issues, Covid-19 and also patients delaying their diagnostic pathway.
- Radiology and histopathology continue to prioritise cancer patients from urgent and routine to avoid delays; offering WLI work to increase capacity.
- Monthly breach analysis to identify issues and resolve pathway delays.

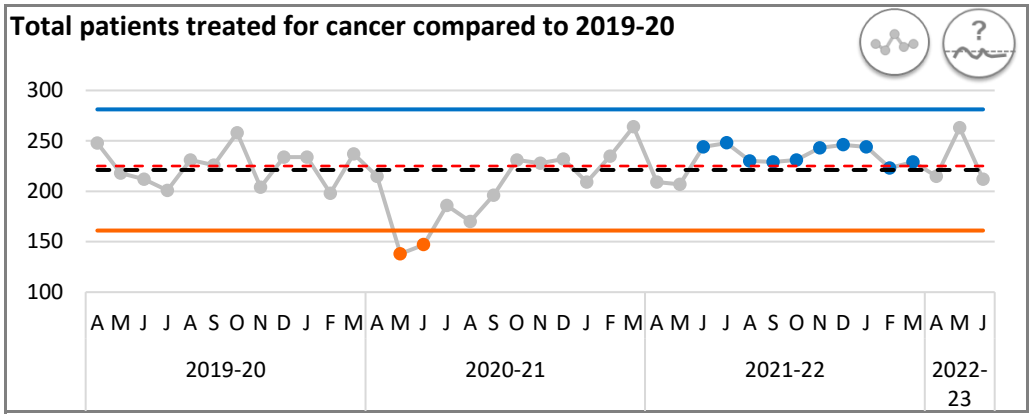

Suspected cancer referrals
1,900
1,700
1,500
1,300
1,100
900
700
500
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J
2019-20
2020-21
2021-22
2022-23


62-day PTL as at 08/08/2022
100
80
60
40
20
0
0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100>104


Proportion of cancer PTL waiting more than 62 days
H
F
17%
15%
13%
11%
9%
7%
5%
29/11/20 29/12/20 29/01/21 28/02/21 31/03/21 30/04/21 31/05/21 30/06/21 31/07/21 31/08/21 30/09/21 31/10/21 30/11/21 31/12/21 31/01/22 28/02/22 31/03/22 30/04/22 31/05/22 30/06/22 31/07/22


Number of cancer PTL waiting more than 104 days
H
F
100
80
60
40
20
0
29/11/20 29/12/20 29/01/21 28/02/21 31/03/21 30/04/21 31/05/21 30/06/21 31/07/21 31/08/21 30/09/21 31/10/21 30/11/21 31/12/21 31/01/22 28/02/22 31/03/22 30/04/22 31/05/22 30/06/22 31/07/22

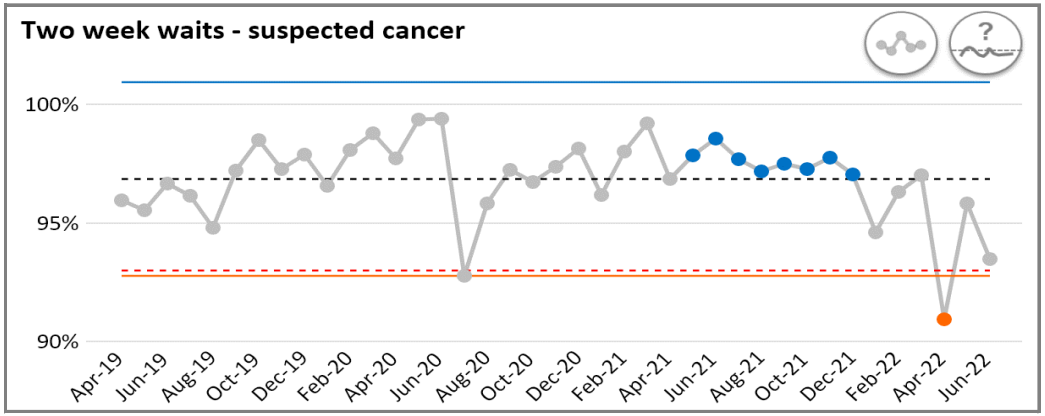

Conversion rate from suspected cancer referral
15%
13%
11%
9%
7%
5%
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M
2019-20
2020-21
2021-22
2022-23

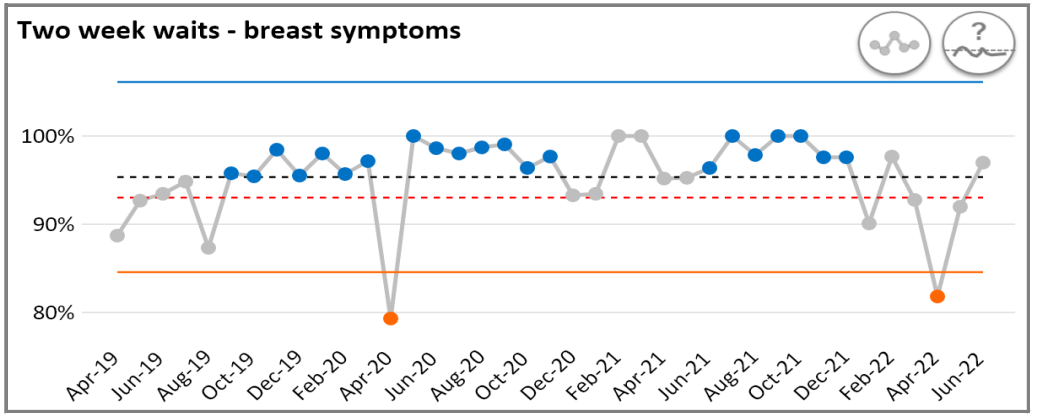

Total patients treated for cancer compared to 2019-20
?
300
250
200
150
100
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J
2019-20
2020-21
2021-22
2022-23

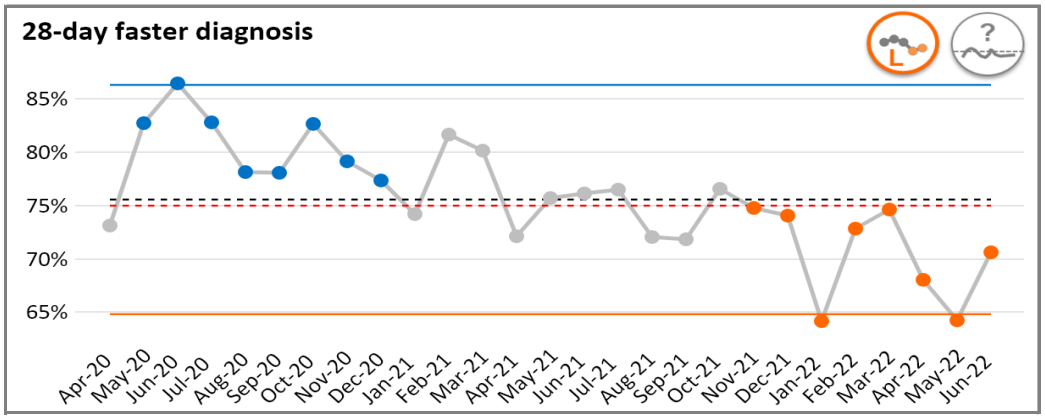
Responsive Services

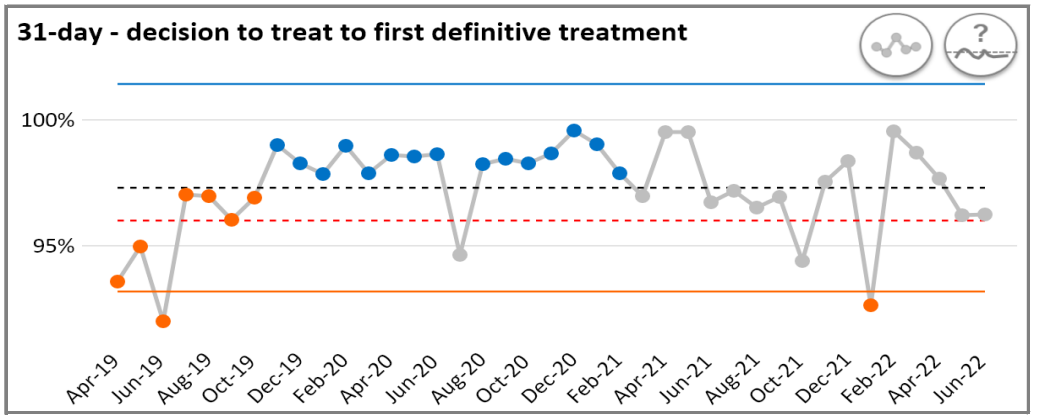
Cancer Waiting Times

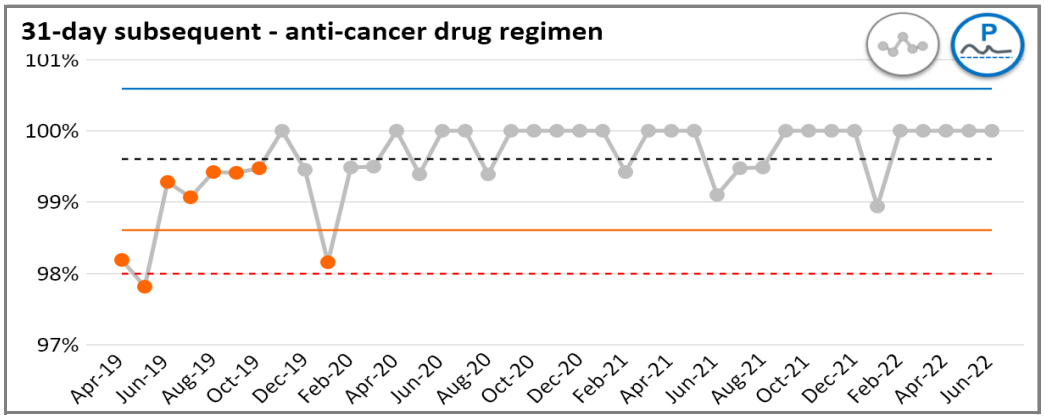
East and North Hertfordshire NHS Trust

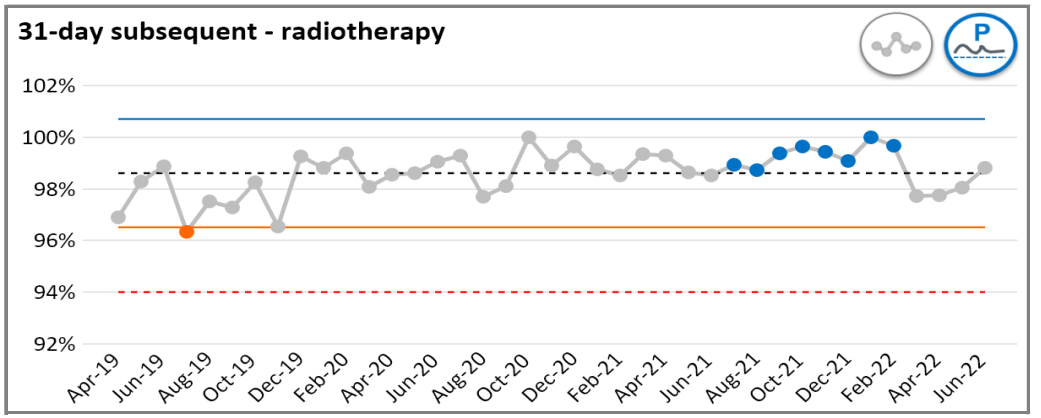


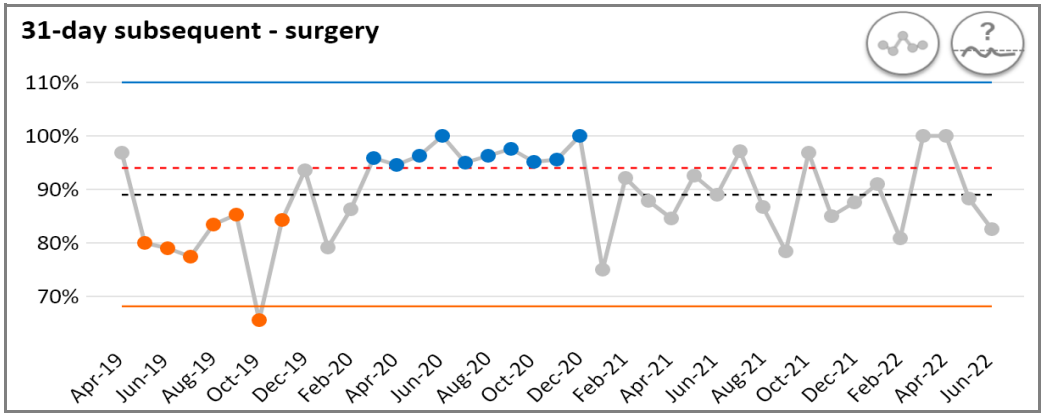


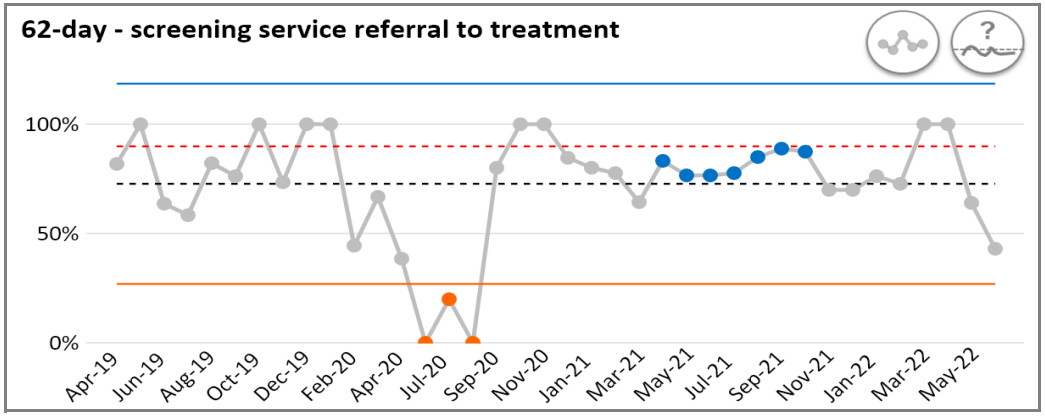


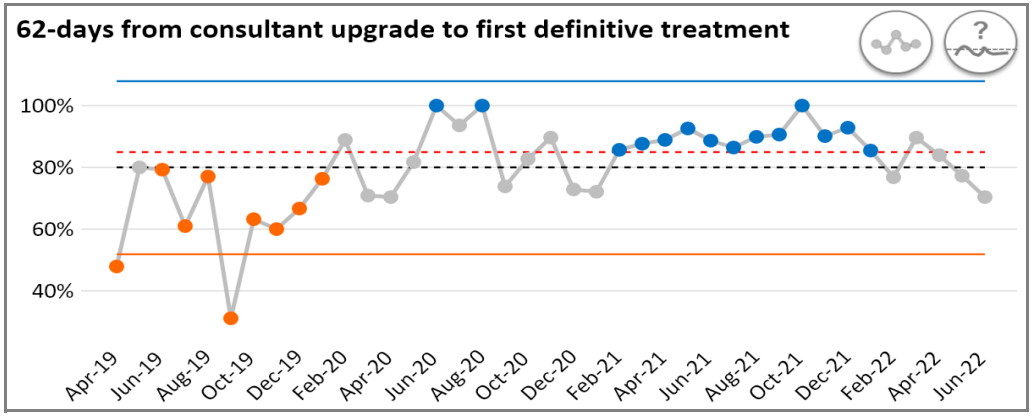


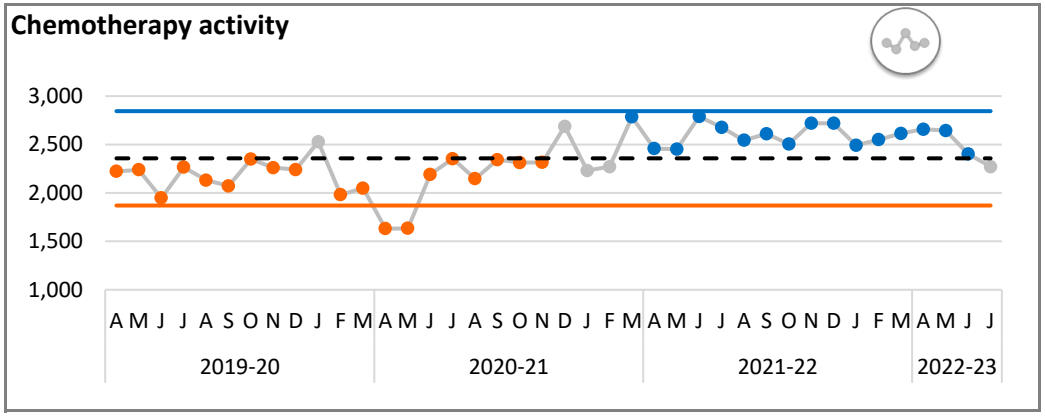


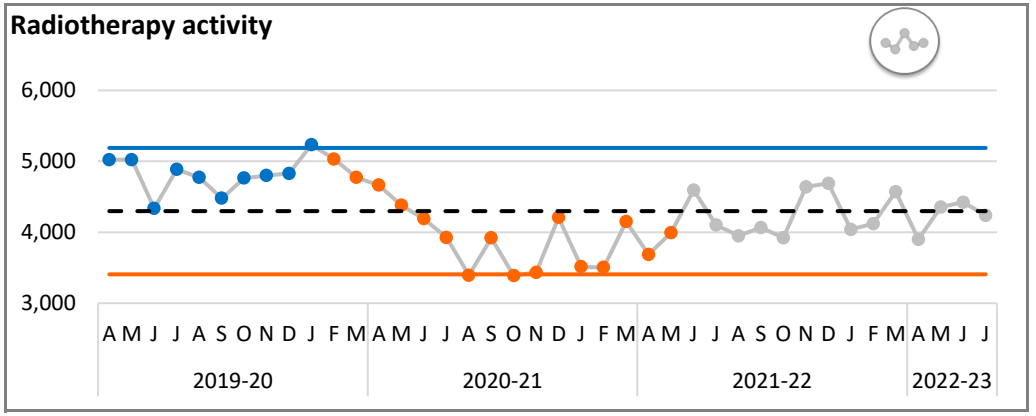



31-day subsequent - surgery
110%
100%
90%
80%
70%
Apr-19
Jun-19
Aug-19
Oct-19
Dec-19
Feb-20
Apr-20
Jun-20
Aug-20
Oct-20
Dec-20
Feb-21
Apr-21
Jun-21
Aug-21
Oct-21
Dec-21
Feb-22
Apr-22
Jun-22


62-day - screening service referral to treatment
100%
50%
0%
Apr-19
Jun-19
Aug-19
Oct-19
Dec-19
Feb-20
Apr-20
Jul-20
Sep-20
Nov-20
Jan-21
Mar-21
May-21
Jul-21
Sep-21
Nov-21
Jan-22
Mar-22
May-22

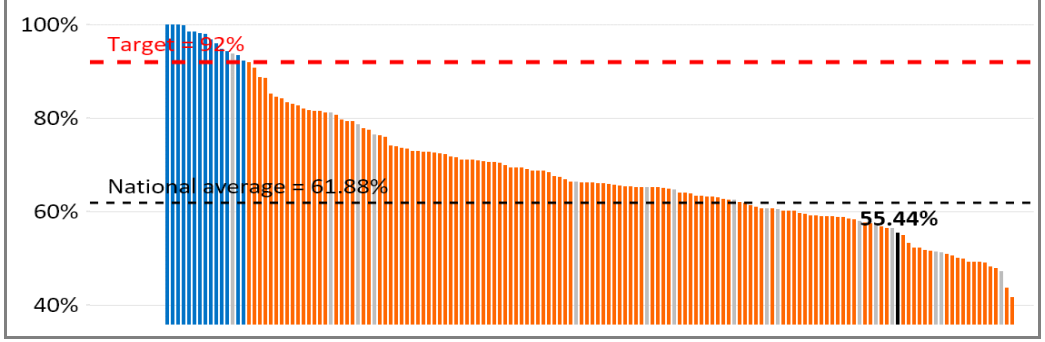

62-days from consultant upgrade to first definitive treatment
100%
80%
60%
40%
Apr-19
Jun-19
Aug-19
Oct-19
Dec-19
Feb-20
Apr-20
Jun-20
Aug-20
Oct-20
Dec-20
Feb-21
Apr-21
Jun-21
Aug-21
Oct-21
Dec-21
Feb-22
Apr-22
Jun-22


Chemotherapy activity
3,000
2,500
2,000
1,500
1,000
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J
2019-20
2020-21
2021-22
2022-23

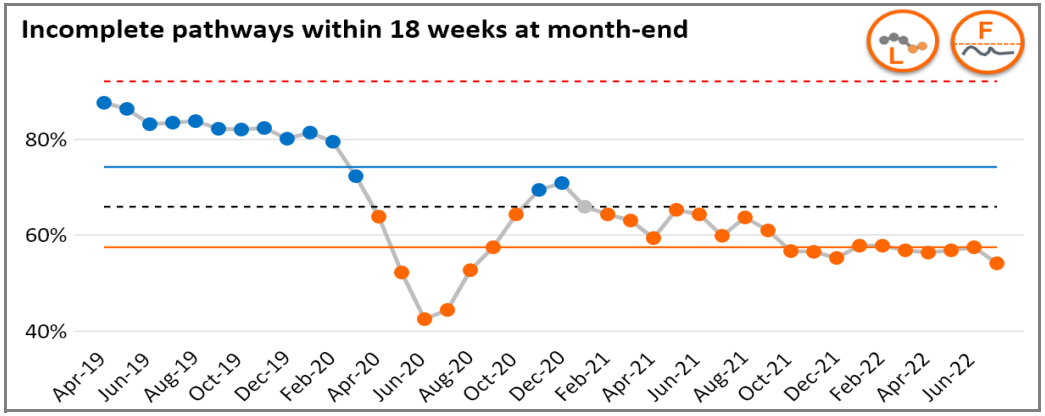

Radiotherapy activity
6,000
5,000
4,000
3,000
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J
2019-20
2020-21
2021-22
2022-23

East and North Hertfordshire NHS Trust

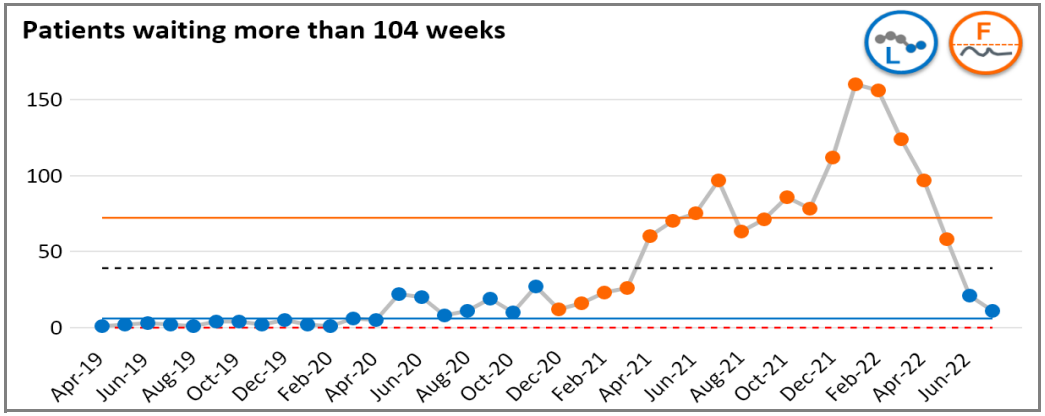
Incomplete pathways peer distribution - Jun-22



Incomplete pathways within 18 weeks at month-end



Patients waiting more than 104 weeks



Key Issues and Executive Response

RTT Performance

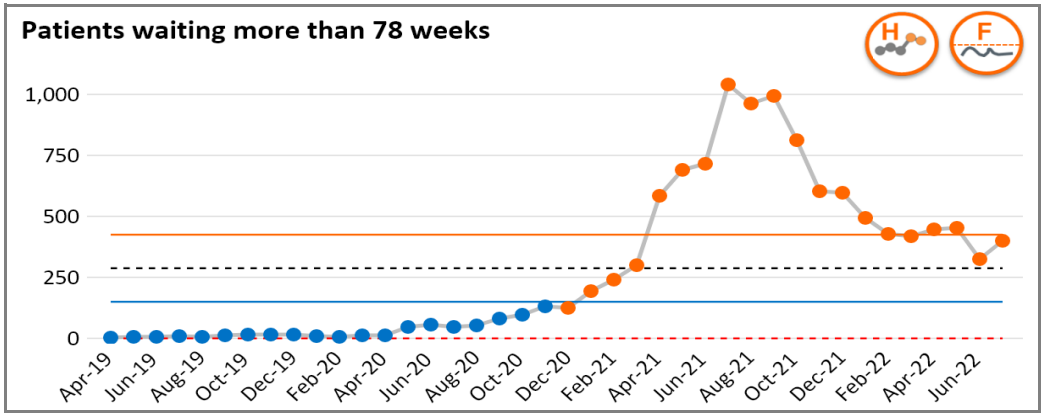
- Placed in Tier 1 nationally for elevated support due to challenges in clearance times to meet national target of 78-week maximum wait by end March 2023. Clearance times planned to improve.
- **78+ week waiters:** The no. of patients waiting 78 weeks for an appointment reduced in month from 333 to 312, 0.54% of total RTT PTL.
- There are currently 6,238 patients on the incomplete PTL who will need to be treated by the end of March 2023 to meet the 78-week target. 80% non-admitted; 20% admitted; a 17% reduction from last month (1,279 patients).
- Services are completing forecast trajectories to ensure capacity is available and performance can be monitored and managed.
- **104+ week waiters:** 9 patients were waiting more than 2 years at the end of July - 6 x patient choice, 2 x patients were unfit and 1 x complex patient. 5 of the patients will be treated in August; 3 chose to wait until September; 1 awaiting confirmation of equipment.

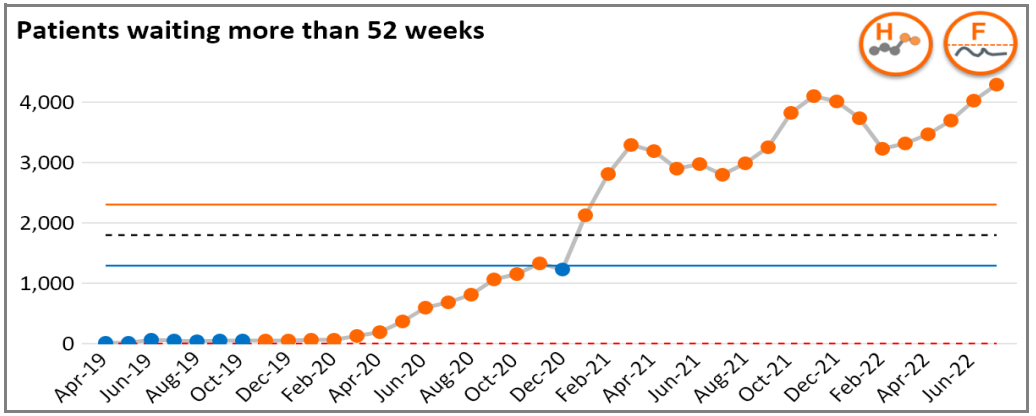
Data Quality

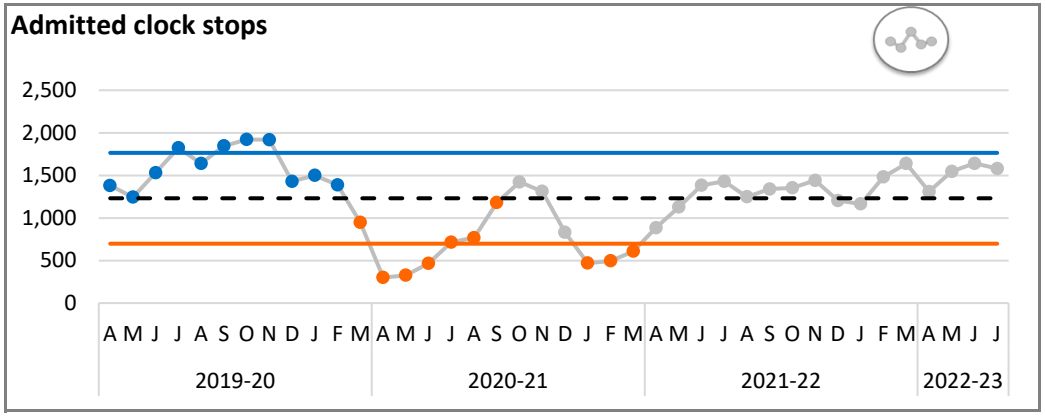
- A validation plan is in place to review all patients waiting on the incomplete PTL over 38 weeks.

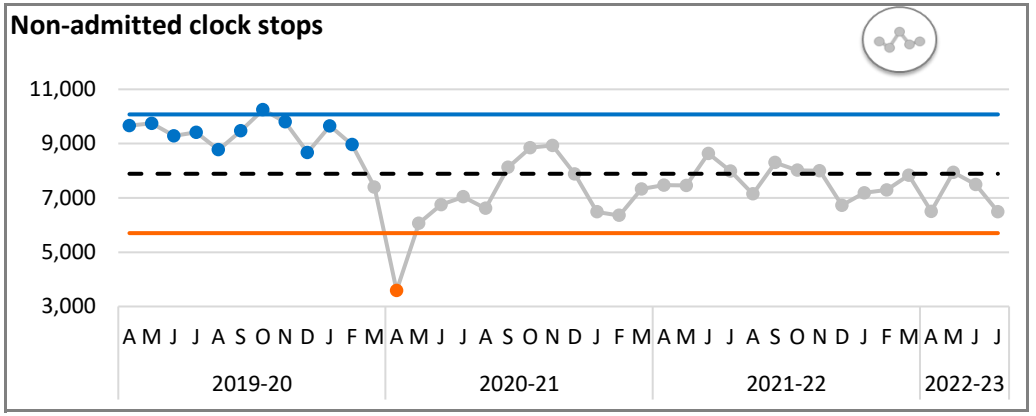
Activity

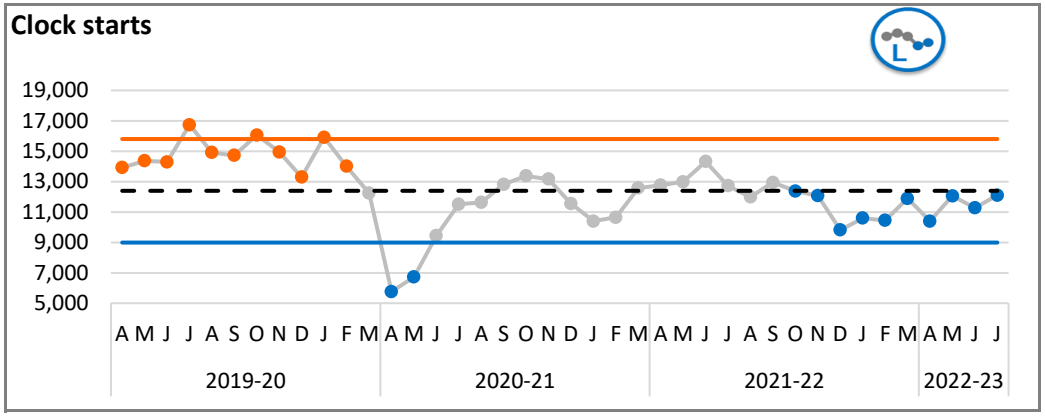
- Referrals have remained stable above the mean.
- Outpatient new appointments remain steady around the mean, with a continuing decrease in FUPs.
- **Day cases and IP activity have increased in month as per plan and remain above the mean.**
- **Theatre cases per list have continued to improve - now on the UCL.**
- PIFU episodes have decreased slightly in month but are on the UCL
- Advice and Guidance remains above the UCL.
- DNA rate has increased for the fifth month in a row, exceeding the UCL.

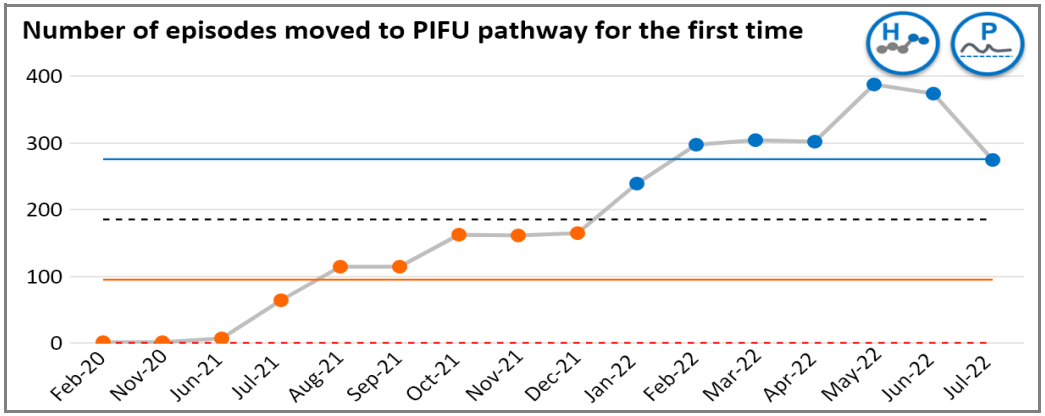

Patients waiting more than 78 weeks
H
F
1,000
750
500
250
0
Apr-19 Jun-19 Aug-19 Oct-19 Dec-19 Feb-20 Apr-20 Jun-20 Aug-20 Oct-20 Dec-20 Feb-21 Apr-21 Jun-21 Aug-21 Oct-21 Dec-21 Feb-22 Apr-22 Jun-22

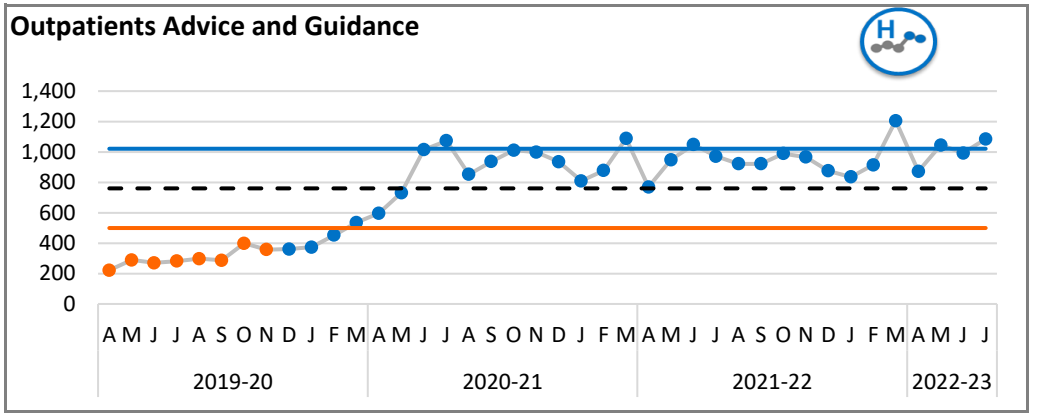

Patients waiting more than 52 weeks
H
F
4,000
3,000
2,000
1,000
0
Apr-19 Jun-19 Aug-19 Oct-19 Dec-19 Feb-20 Apr-20 Jun-20 Aug-20 Oct-20 Dec-20 Feb-21 Apr-21 Jun-21 Aug-21 Oct-21 Dec-21 Feb-22 Apr-22 Jun-22

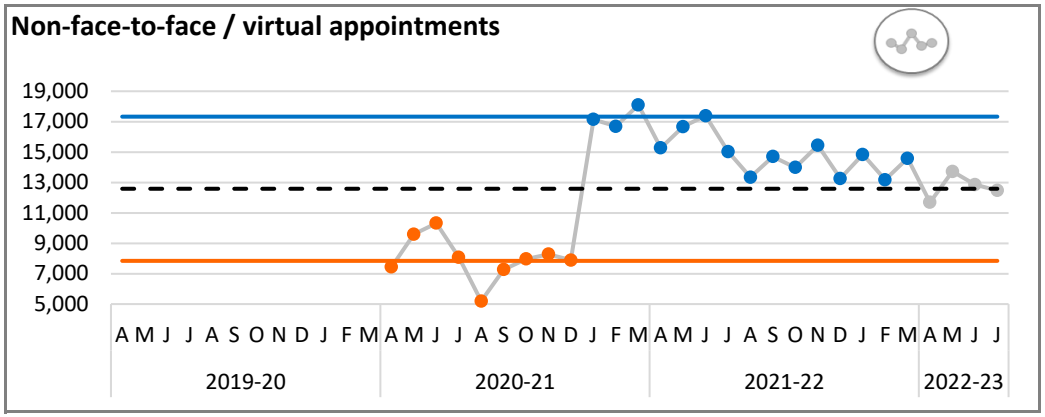

Admitted clock stops
2,500
2,000
1,500
1,000
500
0
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J
2019-20
2020-21
2021-22
2022-23

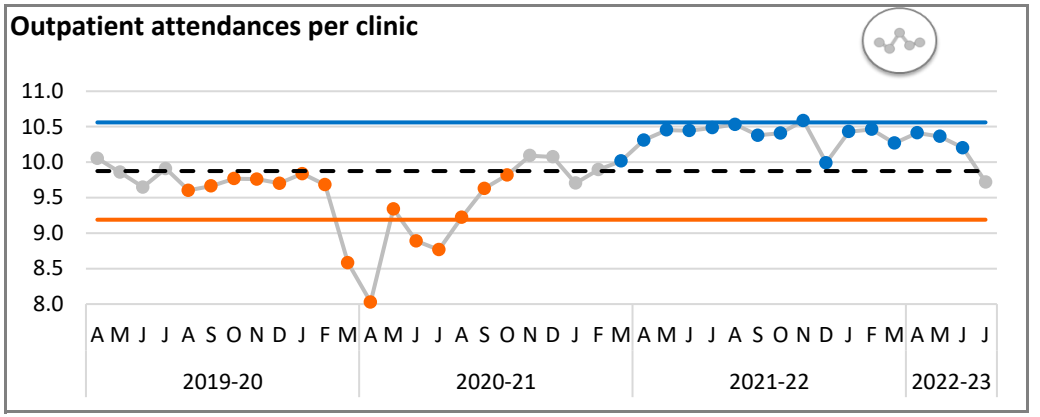

Non-admitted clock stops
11,000
9,000
7,000
5,000
3,000
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J
2019-20
2020-21
2021-22
2022-23

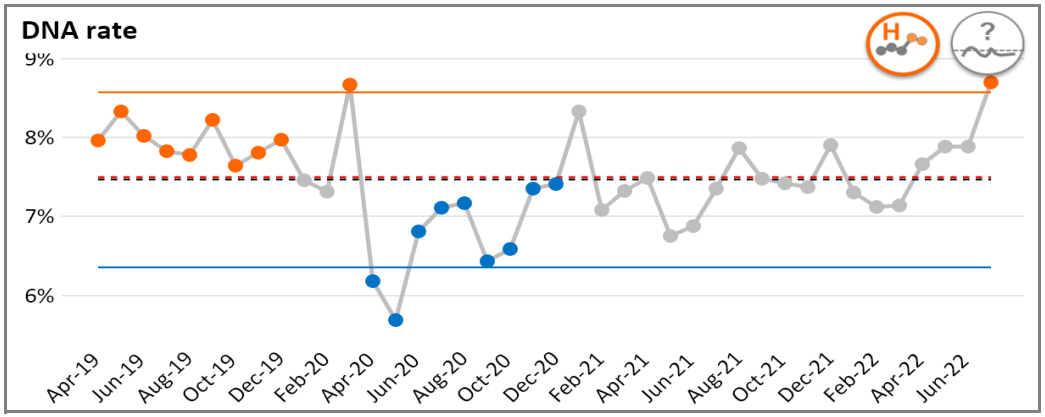

Clock starts
L
19,000
17,000
15,000
13,000
11,000
9,000
7,000
5,000
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J
2019-20
2020-21
2021-22
2022-23

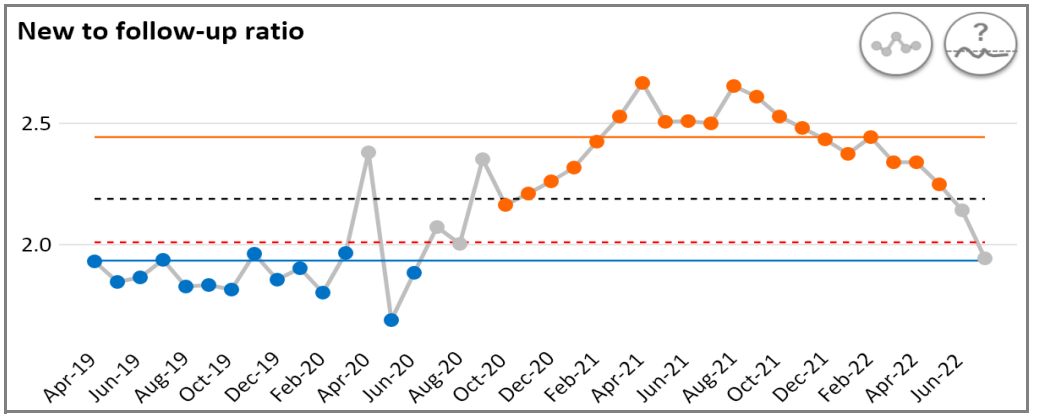

Number of episodes moved to PIFU pathway for the first time
H
P
400
300
200
100
0
Feb-20
Nov-20
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22

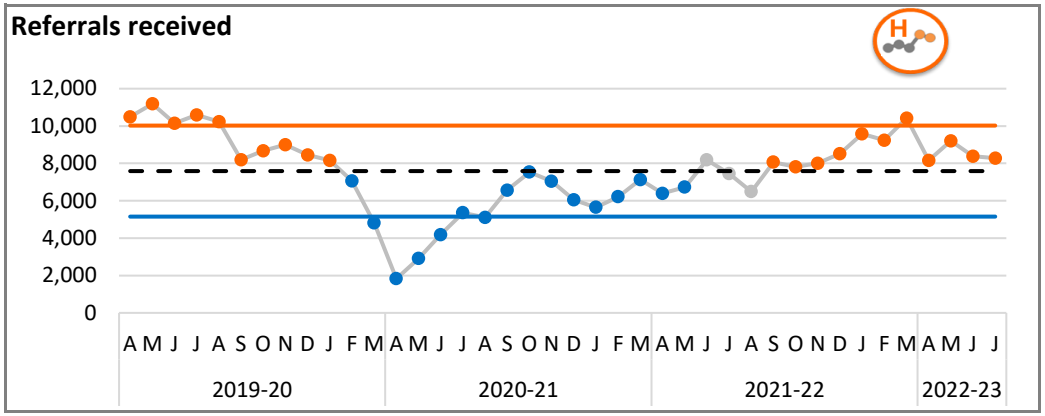

Outpatients Advice and Guidance
H
1,400
1,200
1,000
800
600
400
200
0
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J
2019-20
2020-21
2021-22
2022-23

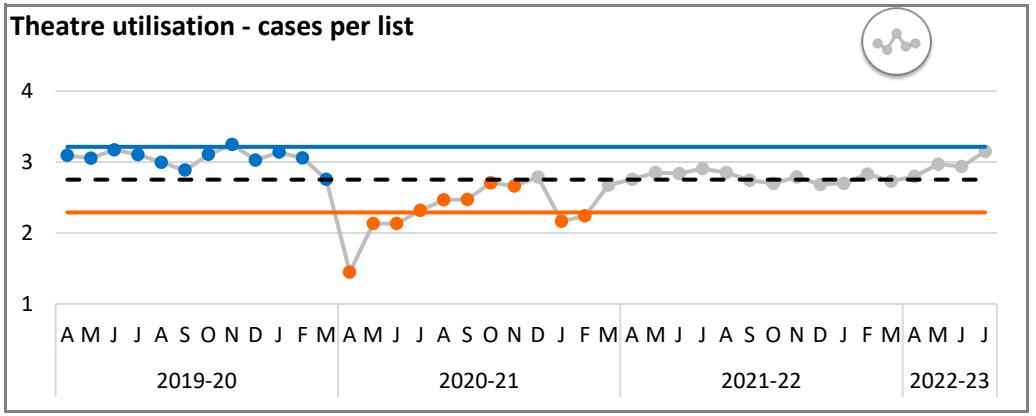

Non-face-to-face / virtual appointments
19,000
17,000
15,000
13,000
11,000
9,000
7,000
5,000
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J
2019-20
2020-21
2021-22
2022-23

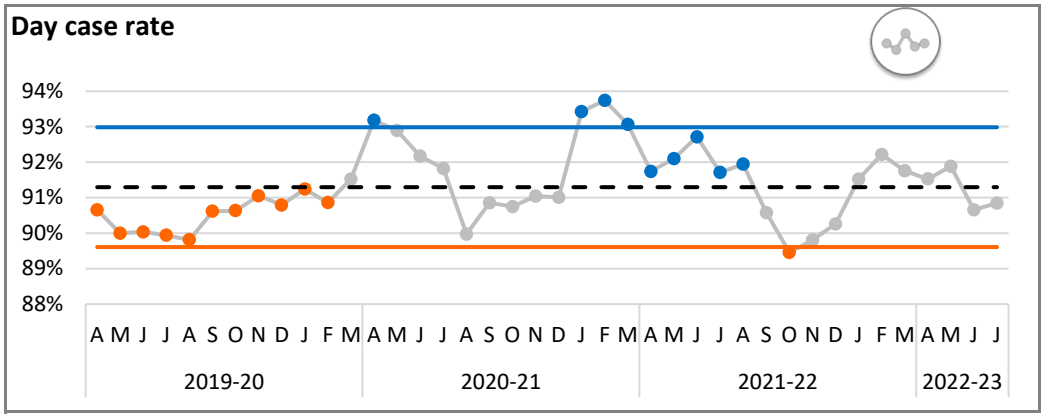

Outpatient attendances per clinic
11.0
10.5
10.0
9.5
9.0
8.5
8.0
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J
2019-20
2020-21
2021-22
2022-23


DNA rate
H
?
9%
8%
7%
6%
Apr-19
Jun-19
Aug-19
Oct-19
Dec-19
Feb-20
Apr-20
Jun-20
Aug-20
Oct-20
Dec-20
Feb-21
Apr-21
Jun-21
Aug-21
Oct-21
Dec-21
Feb-22
Apr-22
Jun-22


New to follow-up ratio
?
2.5
2.0
Apr-19
Jun-19
Aug-19
Oct-19
Dec-19
Feb-20
Apr-20
Jun-20
Aug-20
Oct-20
Dec-20
Feb-21
Apr-21
Jun-21
Aug-21
Oct-21
Dec-21
Feb-22
Apr-22
Jun-22

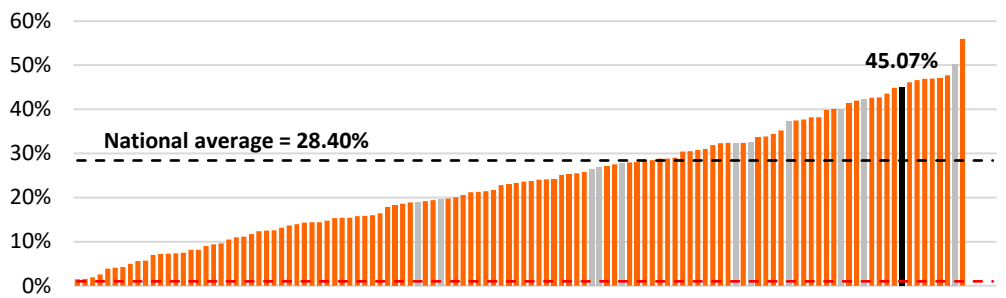

Referrals received
H
12,000
10,000
8,000
6,000
4,000
2,000
0
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J
2019-20
2020-21
2021-22
2022-23


Theatre utilisation - cases per list
4
3
2
1
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J
2019-20
2020-21
2021-22
2022-23

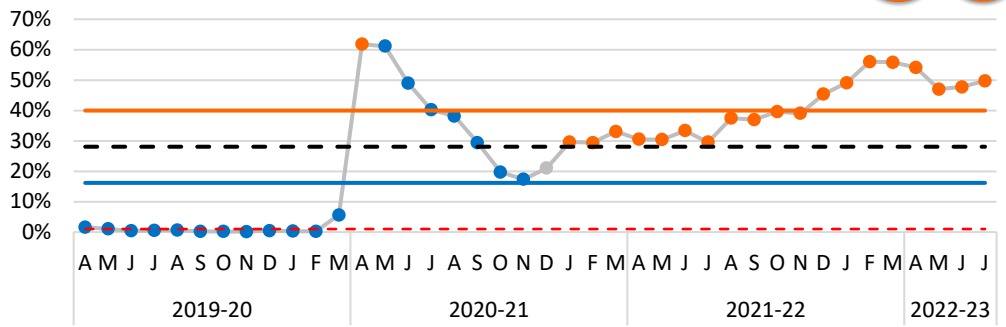

Day case rate
94%
93%
92%
91%
90%
89%
88%
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J
2019-20
2020-21
2021-22
2022-23

East and North Hertfordshire NHS Trust

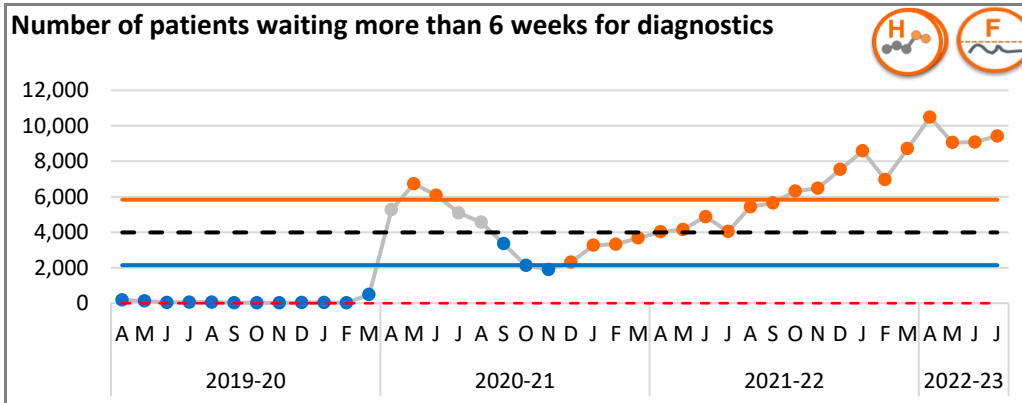
Diagnostics waiting times peer distribution - Jun-22



Proportion of patients waiting more than 6 weeks for diagnostics



Number of patients waiting more than 6 weeks for diagnostics



Key Issues and Executive Response

Improvements

- Additional MRI van in situ from 22nd Aug, running 5 days per week for 6m.
- Additional Gastroenterology Consultants starting Aug and Sept.
- Reduction in waiting time for CT- and US-guided injections, supporting RTT.
- Two reset weeks completed for Breast, reducing waiting list by 45% and then 18%. Further work ongoing.
- Community Diagnostic Hub: over-delivery for CT, MRI and Plain Film. Plans to increase US capacity from Oct.
- Echo funding approved for 7-day service - staff consultation pending.
- Echo insourcing capacity commenced 20th Aug with weekend lists to focus on backlog. Phased capacity with increase from Oct.

Challenges

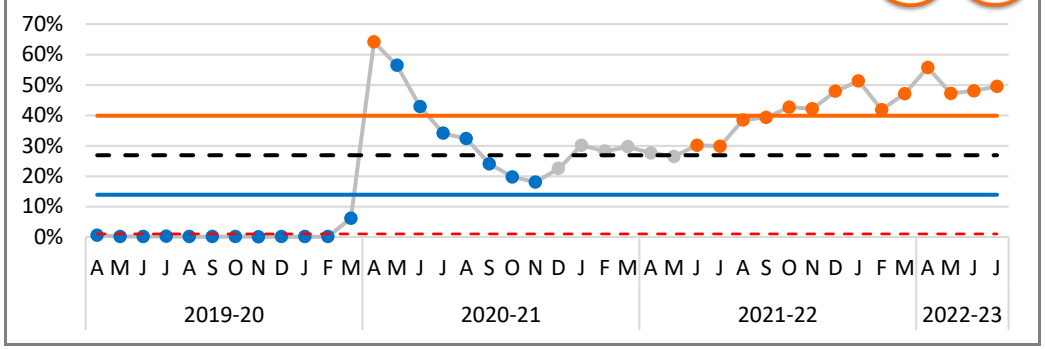
- Continued sustained increase in cancer demand for CT, MRI & US, impacting ability to regain compliance with diagnostic waits within 6 weeks (DM01).
- Continued increase in cancer demand in Gastroenterology.
- Workforce shortages (vacancy and sickness) => capacity shortfalls.
- Risk to echo compliance due to backlog

Actions

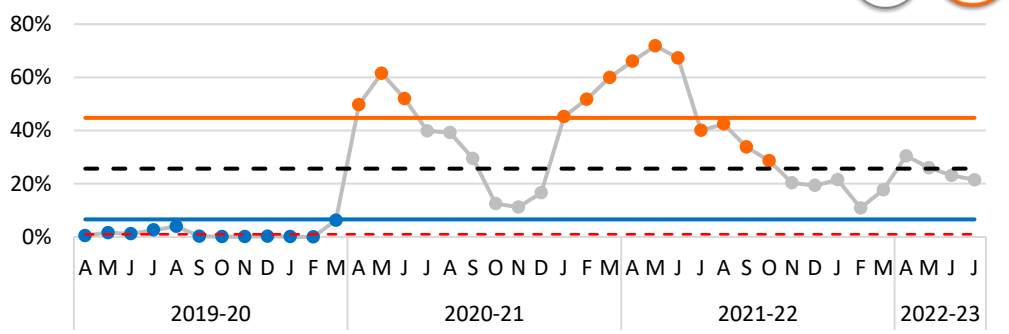
- Continued collaboration with ICS colleagues re mutual aid.
- Clinical review of requests and backlog.
- Gastroenterology Consultant vetting referrals.

Diagnostics Waiting Times Supporting Metrics

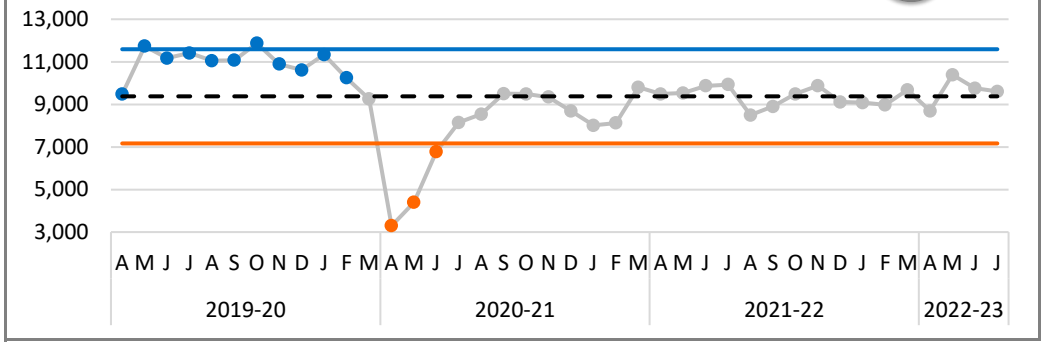
Patients waiting more than six weeks for a Radiology (all modalities)



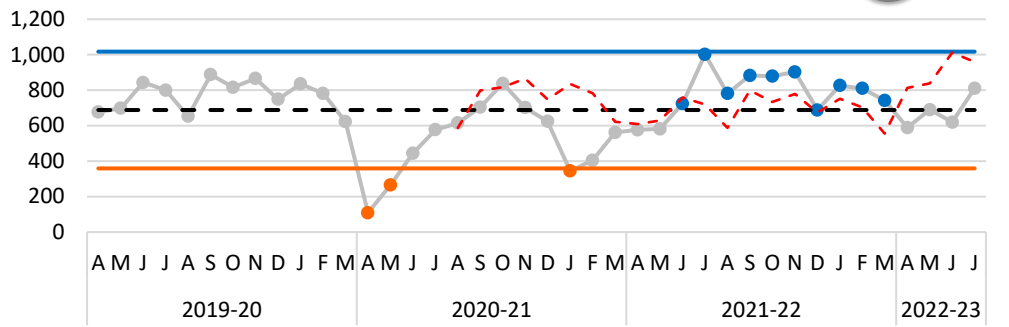
Patients waiting more than six weeks for Endoscopy (all modalities)



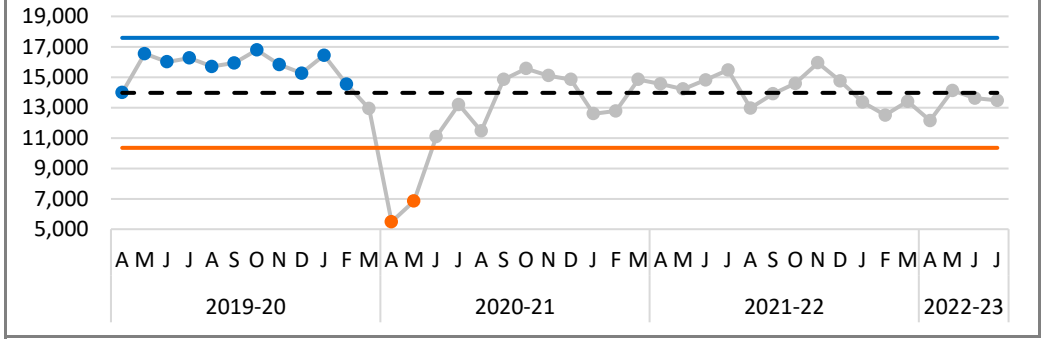
Radiology activity



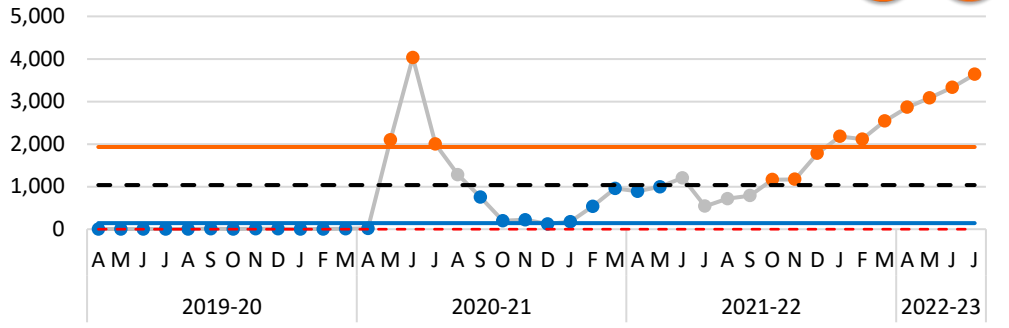
Endoscopy activity



Diagnostics activity - DM01 total tests / procedures

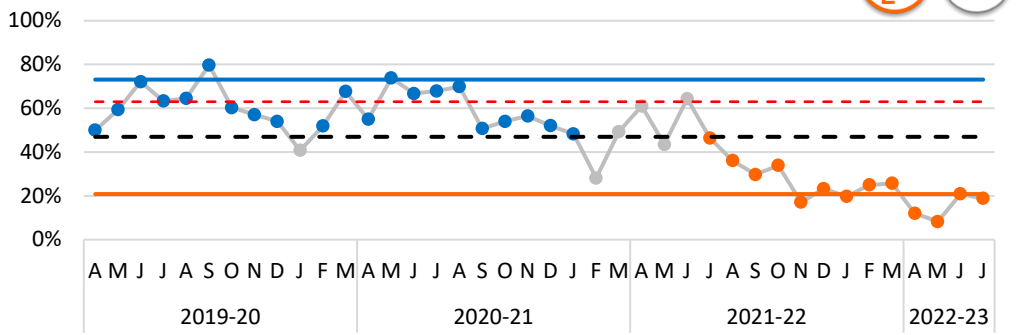


Patients waiting more than 13 weeks for diagnostics

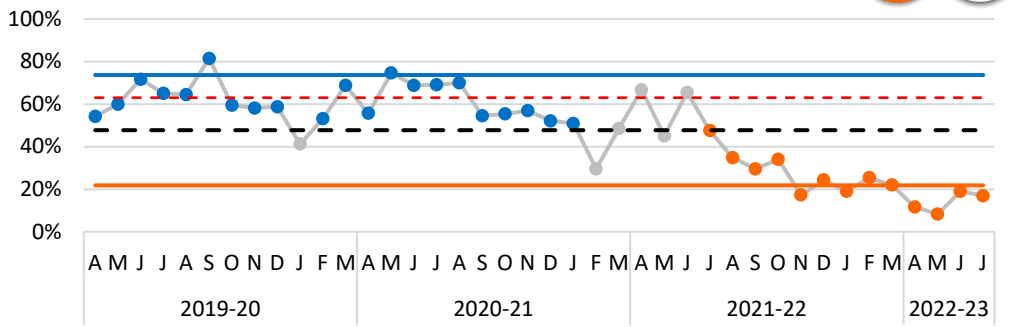


East and North Hertfordshire NHS Trust

4-hours direct to Stroke unit from ED



4-hours direct to Stroke unit from ED with exclusions

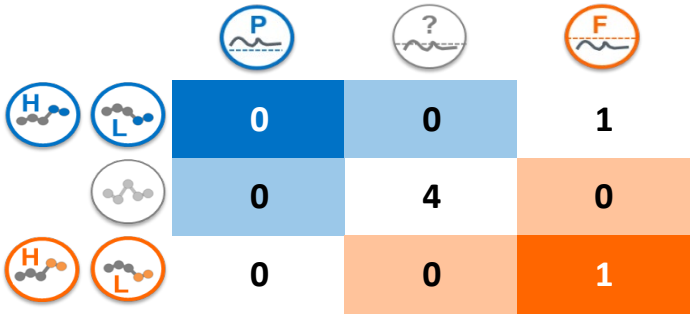


Key Issues and Executive Response

- SSNAP rating for Q1 2022-23 not yet released
- As per the SPC chart, the areas of ongoing concern are: Direct to Stroke unit within 4 hours, due to Covid swab delays and capacity issues; and Thrombolysis Door to Needle performance.
- **Direct to Stroke Unit within 4 hours.** Action taken: review and implement use of Lateral Flow Device for RAG green patients, from 08/08/22, to support moving patients within 4 hours.
- High number of breaches due to limited bed capacity and heavy trust wide prolonged operational pressures. **Ringfencing of Stroke bed capacity implemented from early June**. Daily monitoring of adherence.
- **Door to Needle performance for July**. Action: review of access to CT done and improvement plan underway. Escalation regarding Telemedicine delay: agenda item at regional meeting and data review. Real-time root cause analysis of breaches; review at monthly Stroke meetings and weekly teaching on learnings.
- Other domains have stable systems and processes, but ongoing monthly review for all domains supported with improvement plans.
- Training programme developed as part of NHS Academy 'Stroke Induction' for all medical teams within the trust and to form part of Mandatory training.
- Stroke service oversight to Operational teams within the Trust on the importance of achieving the SSNAP domains to improve patient outcomes and management of Stroke services.

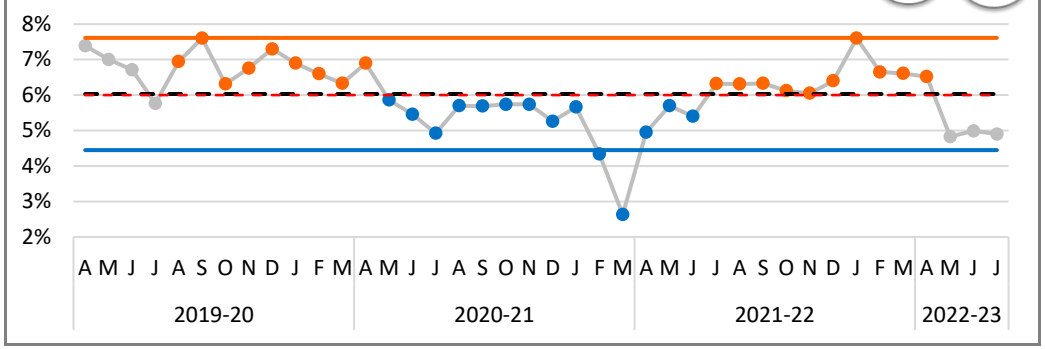
People

Month 04 | 2022-23

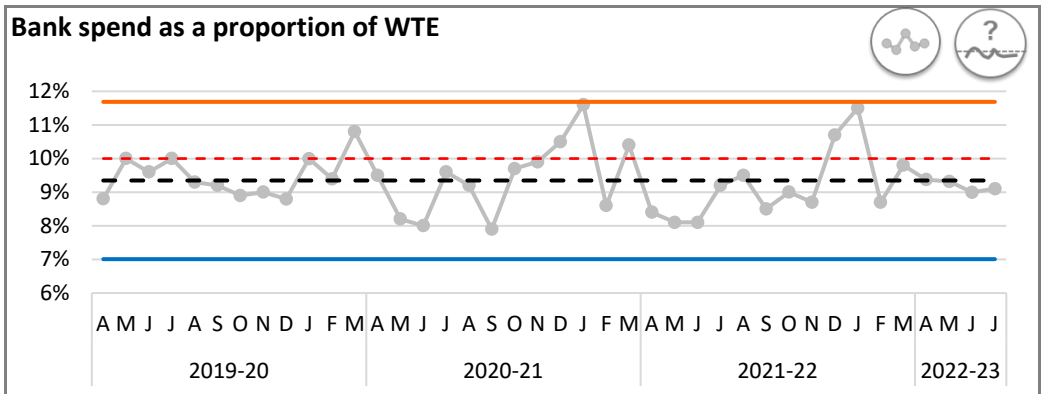


Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Work	Vacancy rate	Jul-22	6%	4.9%			Common cause variation Metric will inconsistently pass and fail the target
	Bank spend as a proportion of WTE	Jul-22	10%	9.1%			Common cause variation Metric will inconsistently pass and fail the target
	Agency spend as a proportion of WTE	Jul-22	4%	3.6%			Common cause variation Metric will inconsistently pass and fail the target
Grow	Statutory and mandatory training compliance rate	Jul-22	90%	87.6%			Seven points above the mean Metric will consistently fail the target
	Appraisal rate	Jul-22	90%	43.6%			Ten points below lower process limit Metric will consistently fail the target
Thrive	Turnover rate	Jul-22	12%	9.9%			Metric unsuitable for SPC analysis
Care	Sickness rate	Jul-22	3.8%	6.3%			Common cause variation Metric will inconsistently pass and fail the target

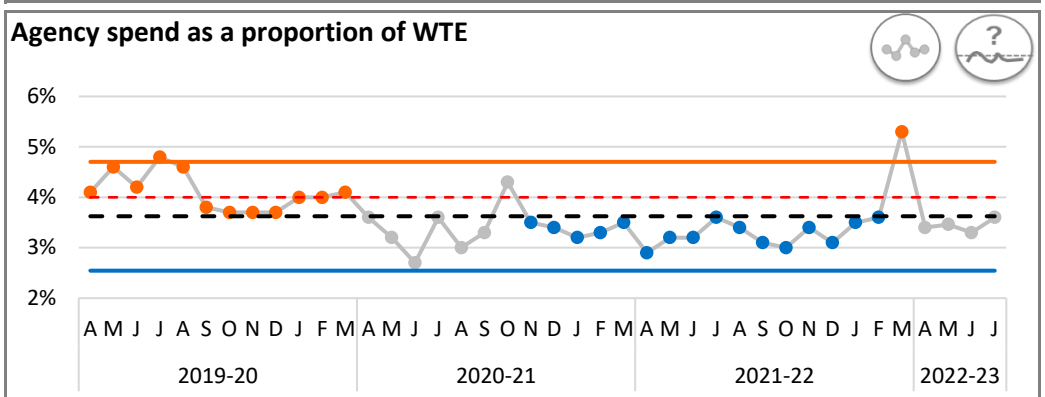
Vacancy rate



Bank spend as a proportion of WTE



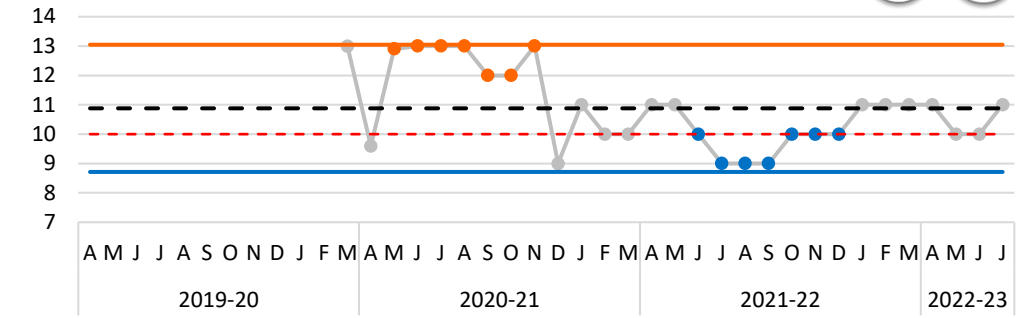
Agency spend as a proportion of WTE



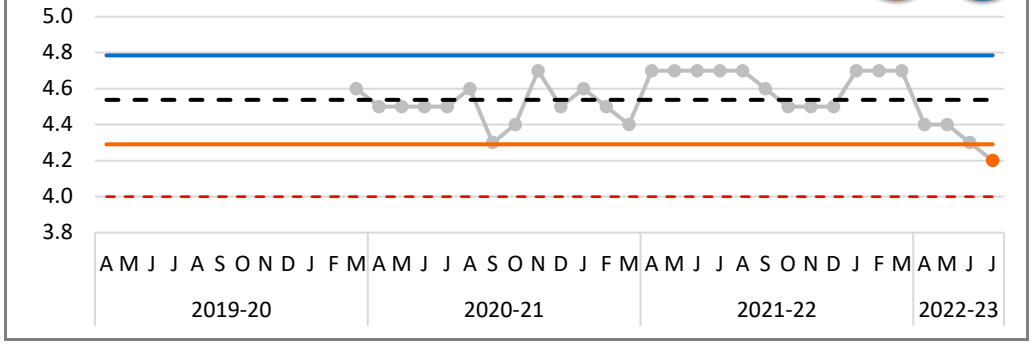
Key Issues and Executive Response

- The Care Support Worker Development programme has been re-introduced which gives a clinical entry pathway onto the bank and supports CSWD candidates with a comprehensive training programme, readying for future substantive Trust vacancies, 11 have now commenced and a further cohort is planned for the Autumn.
- International recruitment continues - 7 staff arrived in month, along with our first international midwife, 1 Radiographer, 1 Occupational Therapist and 1 Physiotherapist.
- Overall temporary staffing fill rate has deteriorated over the last two months. This is mainly due to an increase in demand for temporary staff due to additional activity and increase sickness absence. Much of the sickness is short notice making it harder to respond. Despite this overall bank hours have been increasing.
- Low sample numbers for recruitment experience data, on average candidates scored over 4 for their recruitment experience, 1 adverse experience which skews the overall number. The team continually monitor feedback for improving the experience of our new starters and will encourage a better response rate.
- Clinical area using electronic rostering increase by 2% and is now 6% off the national target.
- 160 new doctors onboarded for August Rotation with revised processes supporting a better recruitment experience into the Trust.
- September data will show new vacancy rate target as 5% and may lead to performance trend variation - we are currently running at 4.9% and therefore nearer to target than current data shows.

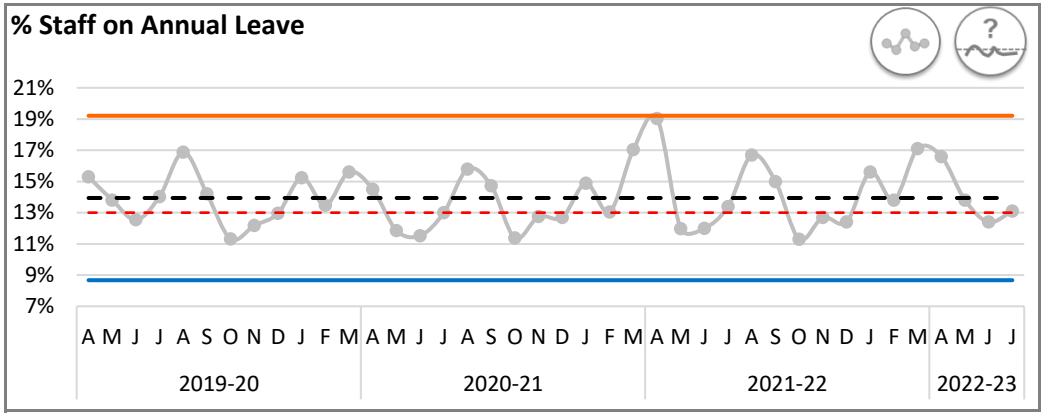
Time to hire (weeks)



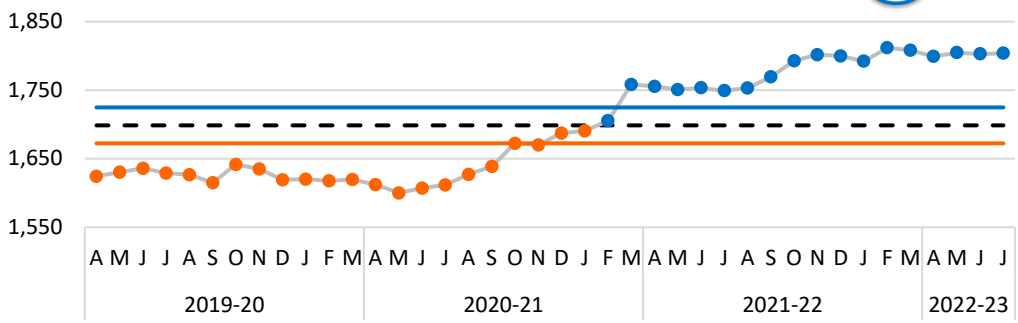
Recruitment experience



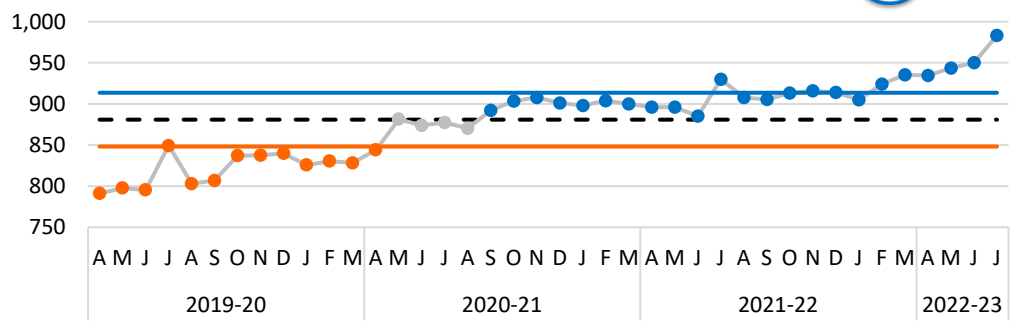
% Staff on Annual Leave



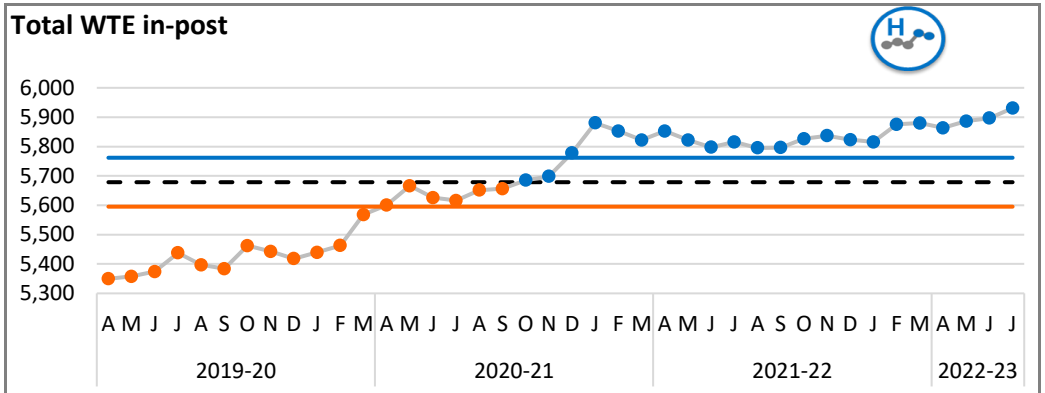
Nursing and Midwifery Qualified - WTE in-post



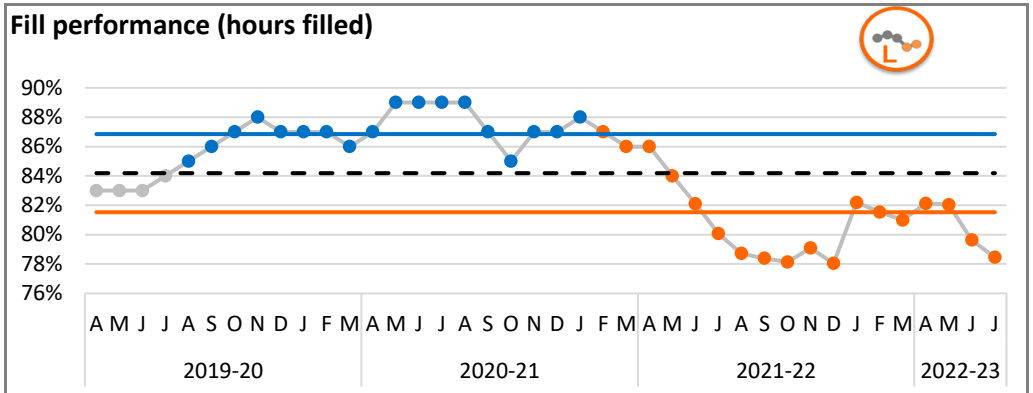
Medical - WTE in-post



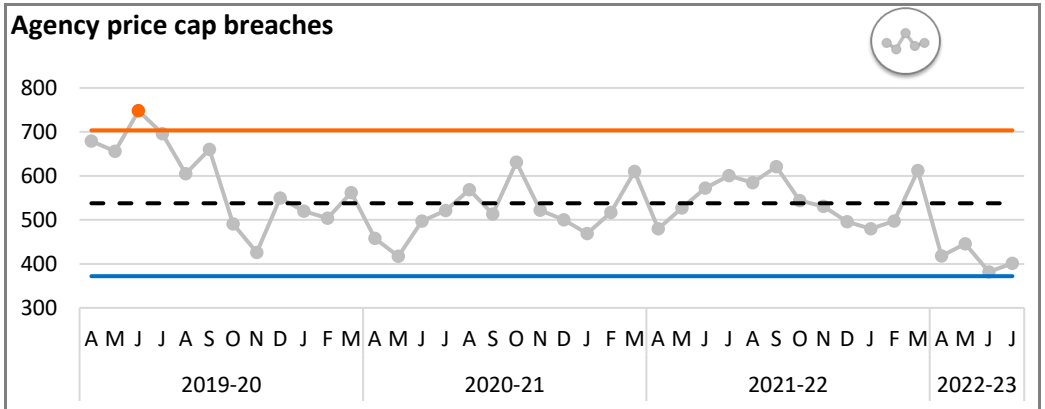
Total WTE in-post



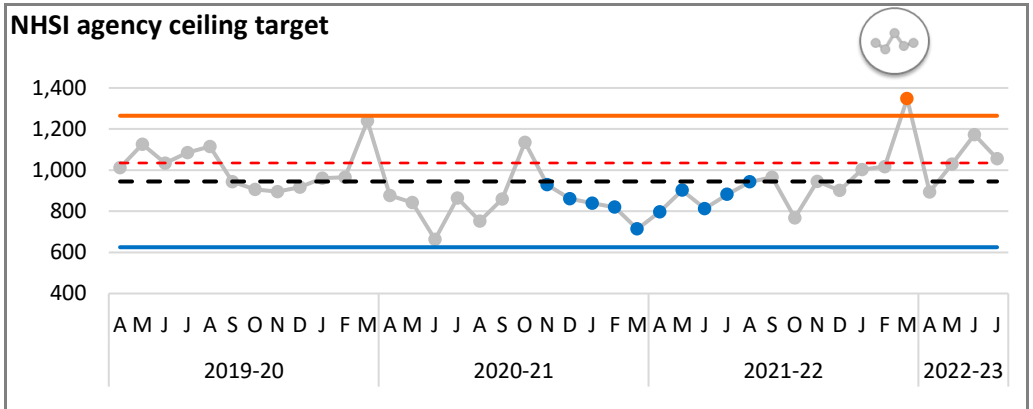
Fill performance (hours filled)



Agency price cap breaches

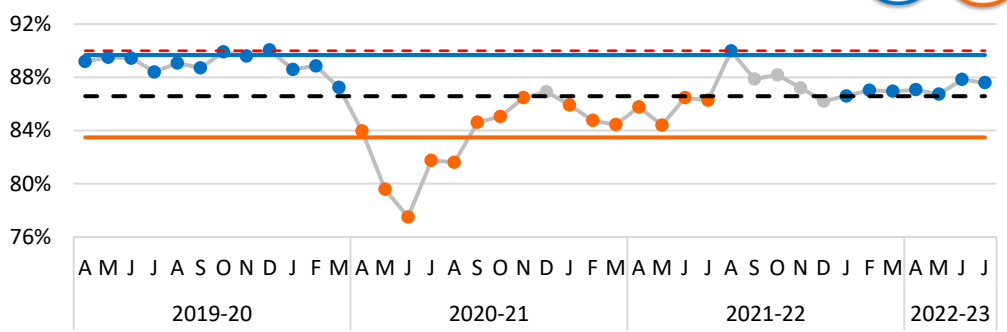


NHSI agency ceiling target

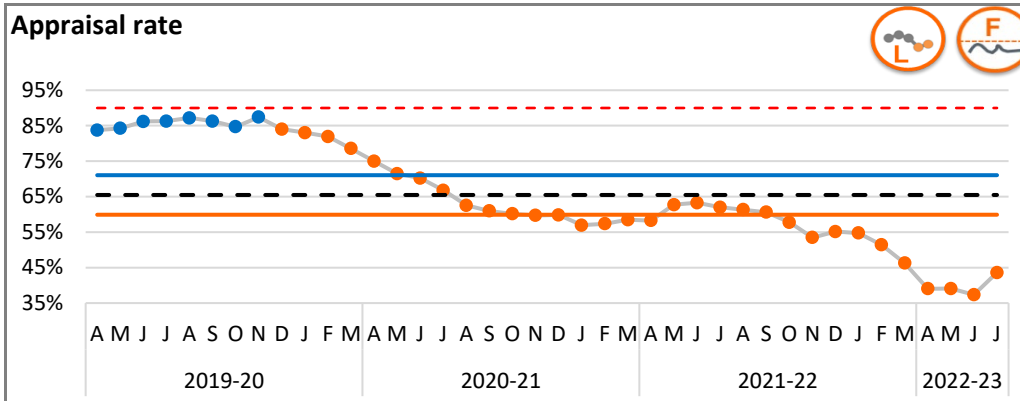


East and North Hertfordshire NHS Trust

Statutory and mandatory training compliance rate



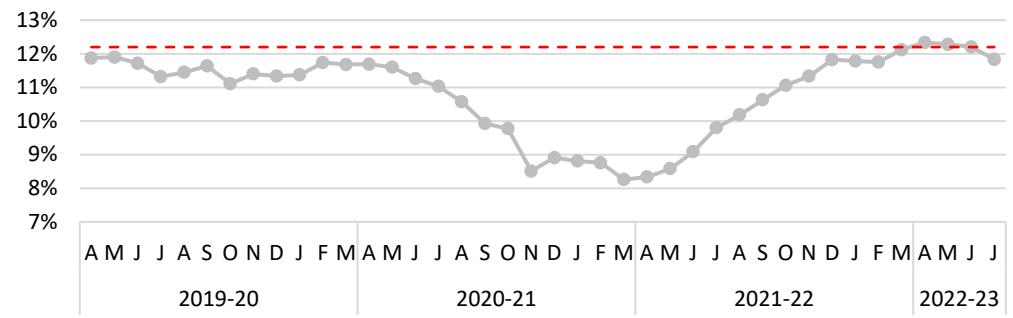
Appraisal rate



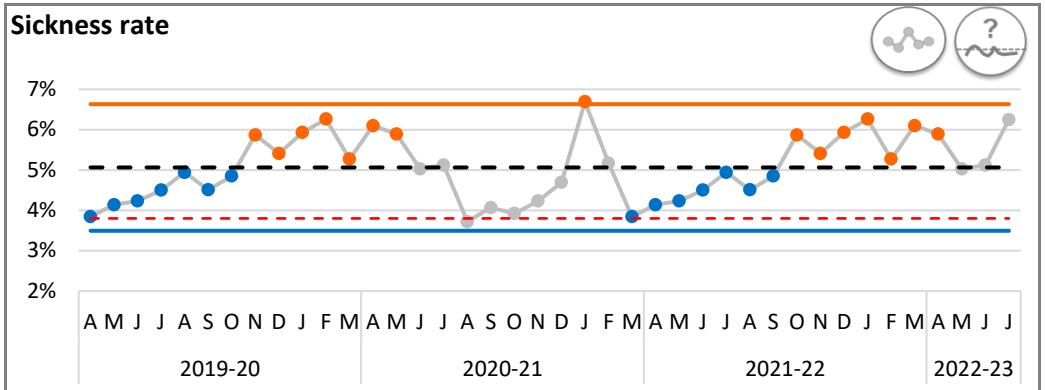
Key Issues and Executive Response

- Grow together reviews are progressing as part of the new April to August cycle. While the expected target has not been met for Month 4, we are showing a positive increase of over 6% when compared with month 3. This trend is expected to continue.
- Regular Grow Together reminders and compliance reports, are shared through Trust In -brief to improve compliance, which includes additional guidance for staff, as feedback indicates staff are still getting used to the system, hence lower than expected compliance rates.
- Mandatory training remains at 87%. Regular notifications are being sent via In-brief to prompt managers to ensure training is up to date. Actions to address DNAs, and targeted actions to address low compliance for medical staff are now in place.
- A number of mandatory training and essential training courses were stood down in July due to the Trust's OPEL status. It is anticipated that this will have an adverse effect on training figures. Cancelled sessions are however being re-booked.
- Learning opportunities continue to be promoted during the grow together cycle and the Trust's online CPD Portal for CPD requests and online course approvals has now launched.
- Additional Associate Educators (band 4) have been appointed on a 1-year short term basis in the clinical Education team, utilising NHSEI funding, to support the onboarding, education & retention programme of our Clinical Support workers (CSW). This additional resource will support our ongoing CSW retention programme, as this staff group has been highlighted as an outlier in terms of vacancy rates and attrition.

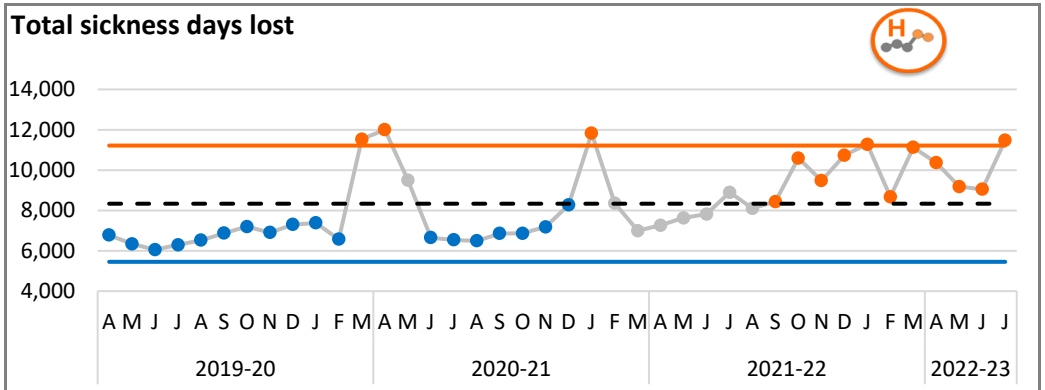
Turnover rate



Sickness rate



Total sickness days lost



Key Issues and Executive Response

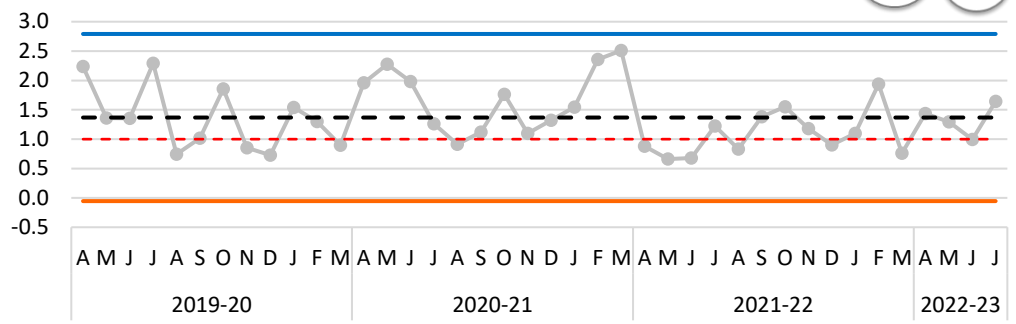
Thrive Together

- Lister at 50 plans are underway for various celebrations and activities to take place in September.
- People Pulse survey results show improvements in flexibility, wellbeing and reasonable adjustments, with more confidence shown in my leader.
- Staff Community shop opened on Friday August 5th and has had reasonable footfall, options for non-Lister locations are being explored and costed for consideration.
- Planning underway for Winter Wellbeing plans for staff across the Trust.
- The National Survey will launch in September and work underway to develop staff communications to raise awareness of benefits, support and other useful employee content to support connection and belonging in the Trust.

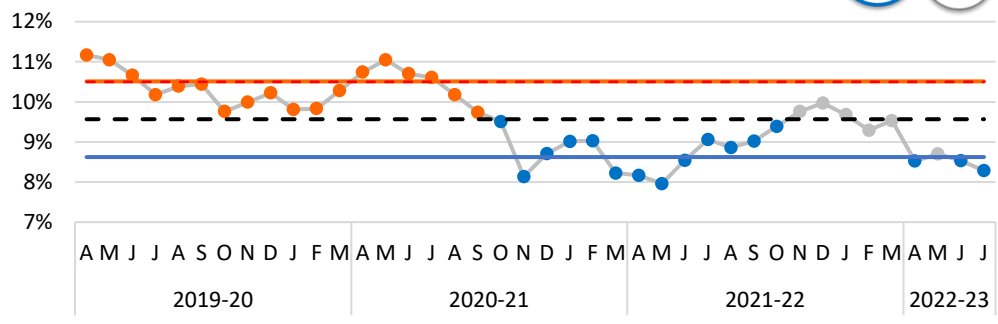
Care Together

- SEQOSH reaccreditation successfully secured with request to use our Occupational Health approaches and policies for examples of best practice.
- Short term sickness absence increased due to increased incidents of covid throughout July however long-term sickness remains within the expected threshold.
- Increases in grievances being raised continues, these are multi-dimensional and some serious, challenges with managers capacity to undertake quick investigations and delays due to sickness absence compound the challenge.
- A reset on all employee relation case work has commenced and communication will be sent to commissioning manager and investigating officer during September to confirm actions and timeframes, what roles and responsibilities are from ERAS and expected of managers working on the case.

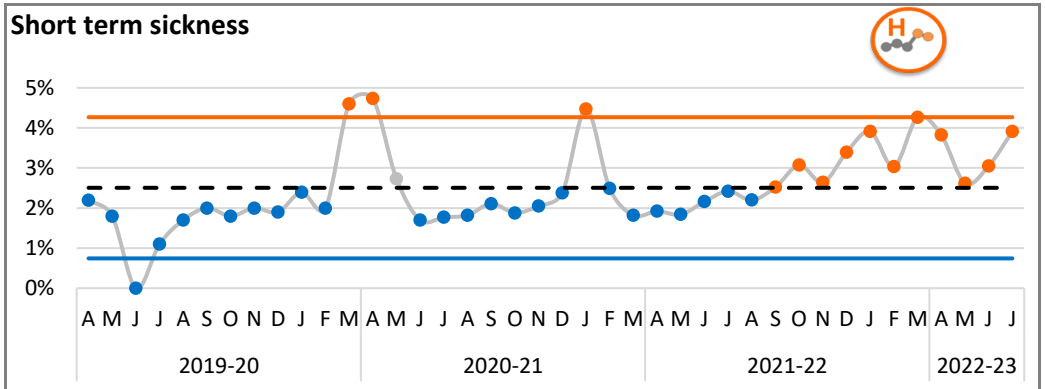
Net Ratio (Starters/Leavers)



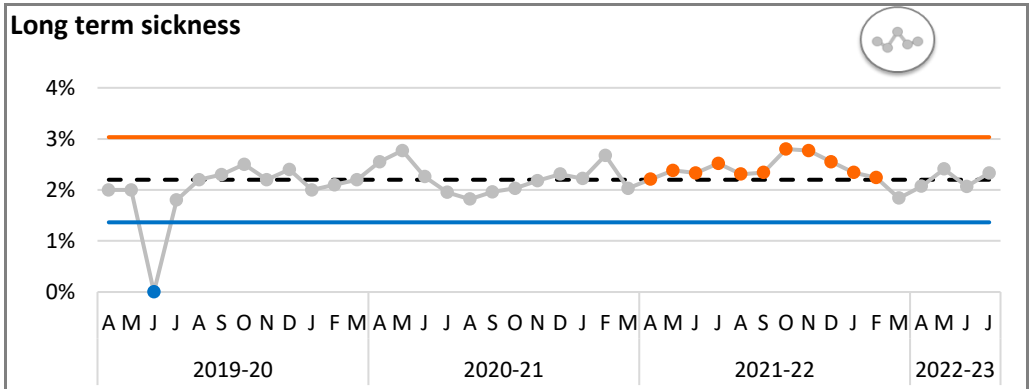
Qualified Nursing and Midwifery staff turnover



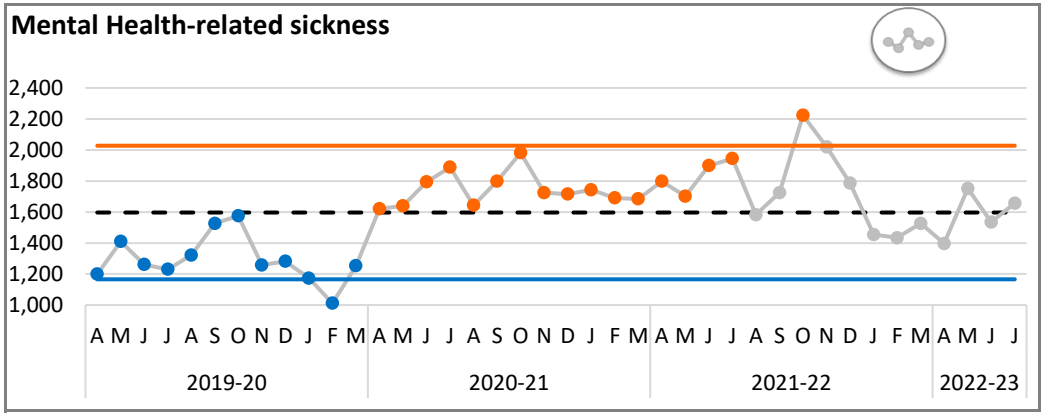
Short term sickness



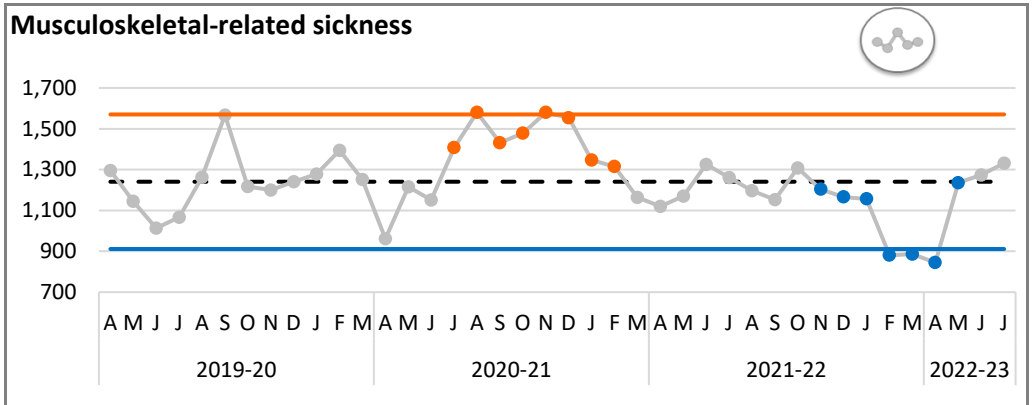
Long term sickness



Mental Health-related sickness

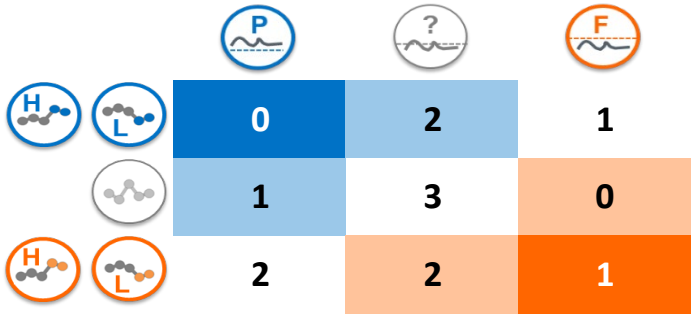


Musculoskeletal-related sickness



Sustainable Services

Month 04 | 2022-23



Sustainable Services

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Summary Financial Position	Surplus / deficit	Jul-22	-2.4	-0.4			Common cause variation Metric will inconsistently pass & fail the target
	CIPS achieved	Jul-22	1,245	956			No data Apr-20 to Sep-21
	Cash balance	Jul-22	77.9	65.0			Ten points above the upper process limit Metric will consistently fail the target
Key Financial Drivers	Income earned	Jul-22	45.3	47.6			Seven points above the mean Metric will inconsistently pass & fail the target
	Pay costs	Jul-22	29.5	29.1			Thirteen points above the mean Metric will inconsistently pass & fail the target
	Non-pay costs (including financing)	Jul-22	15.5	18.9			Seven points above the mean Metric will inconsistently pass & fail the target

Sustainable Services

Summary

East and North Hertfordshire NHS Trust

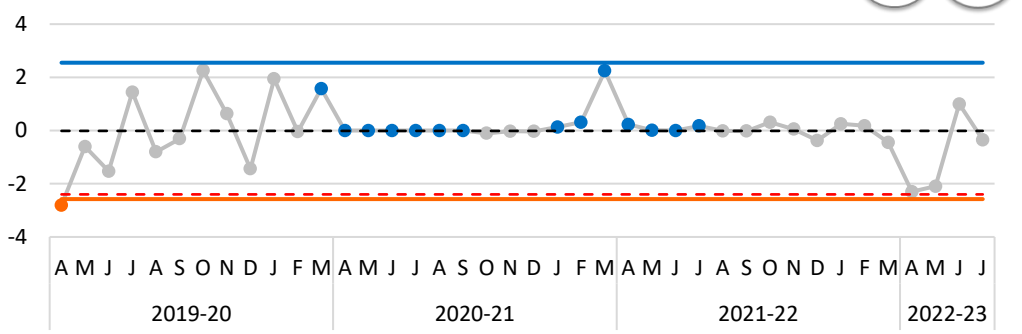
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Key Payroll Metrics	Substantive pay costs	Jul-22	24.9	25.6	H	P	Four points above the upper process limit Metric will consistently pass the target
	Average monthly substantive pay costs (000s)	Jul-22	0.9	4.5	H	F	Eleven points above the mean Metric will consistently fail the target
	Agency costs	Jul-22	0.9	1.1			Common cause variation No target
	Unit cost of agency staff	Jul-22		12.1			Eight Points above the mean No target
	Bank costs	Jul-22	3.7	2.4		P	Common cause variation Metric will consistently pass the target
	Overtime and WLI costs	Jul-22	0.5	0.6	H	P	Nine points above the mean Metric will consistently pass the target
Other Financial Metrics	Elective Recovery Fund income earned	Jul-22	1.1	1.5		?	Common cause variation Metric will inconsistently pass & fail the target
	Drugs and consumable spend	Jul-22	2.8	3.3		?	Common cause variation Metric will inconsistently pass & fail the target
	Private patients income earned	Jul-22	0.4	0.4	H	?	Seven points above th emean Metric will inconsistently pass & fail the target

Sustainable Services

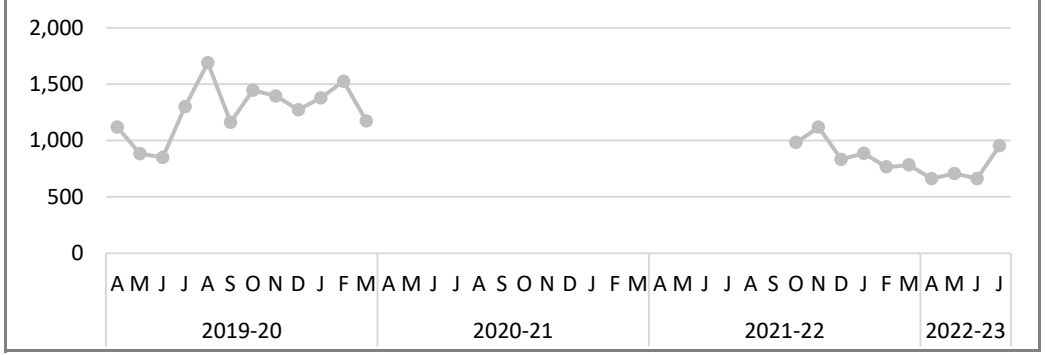
Summary Financial Position

East and North Hertfordshire NHS Trust

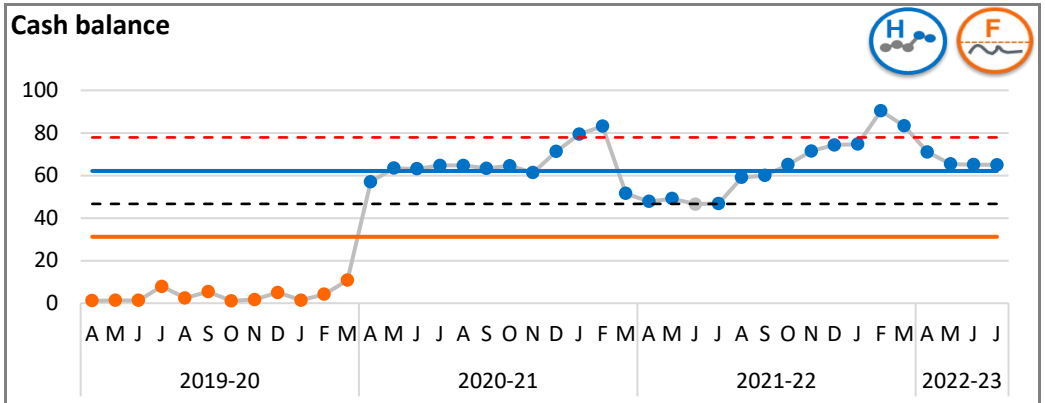
Surplus / deficit



CIPS achieved



Cash balance



Key Issues and Executive Response

- The Trust reports its M4 financial performance against the breakeven plan that it agreed and submitted in June 22.
- The Trust reports a £0.3m deficit in June, this increases the YTD deficit position to £3.7m. This remains broadly in line with the Trust's financial plan. However, significant commitment of reserve funds has been required to achieve this.
- The Trust's elective activity plan assumes a gradual ramp up of capacity. Progress during Q1 has been modest compared with the 19/20 baseline, with a significant step changed anticipated in Q2. The YTD position assumes full receipt of ERF funds.
- Delivery against the Trust's CIP target remains a concern, with a YTD undershoot of £2.6m reported at M4. Divisional recovery plans are an urgent priority.
- Significant overspends against medical staffing budgets are reported at M4. These are predominately concentrated in the Trust's urgent emergency care & Women & Children's pathways.

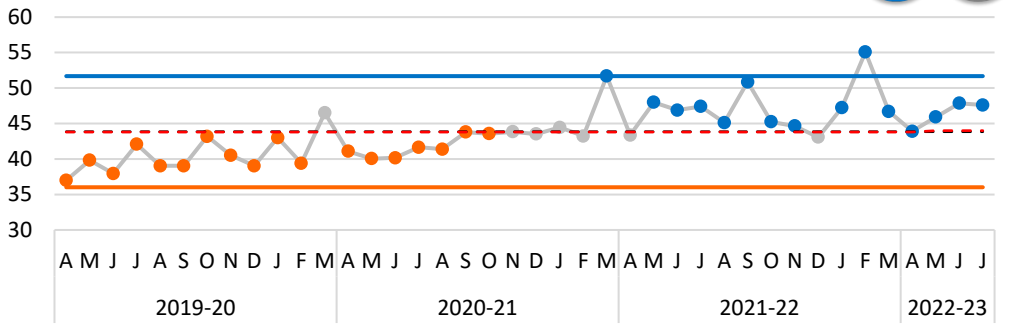
	Annual Budget £m	Budget YTD £m	Actual YTD £m	Variance YTD £m
Income	534.1	177.2	176.9	-0.3
Pay	-344.0	-115.5	-115.8	-0.3
Non Pay	-182.8	-62.9	-62.3	0.6
EBITDA	**7.2**	**-1.3**	**-1.2**	**0.0**
Financing Costs	-32.4	-10.9	-10.9	-0.0
Retained Deficit exc. PSF	**-25.2**	**-12.1**	**-12.1**	**-0.0**
Top-Up Payments	9.9	3.3	3.3	0.0
Systems Funding	15.3	5.1	5.1	0.0
Surplus / Deficit (excl Fin Adj's)	**0.0**	**-3.7**	**-3.7**	**-0.0**
Adj Financial Performance	-0.2	-0.1	-0.2	-0.1
Deficit (Incl Fin Adj's)	**-0.2**	**-3.8**	**-3.9**	**-0.1**

Sustainable Services

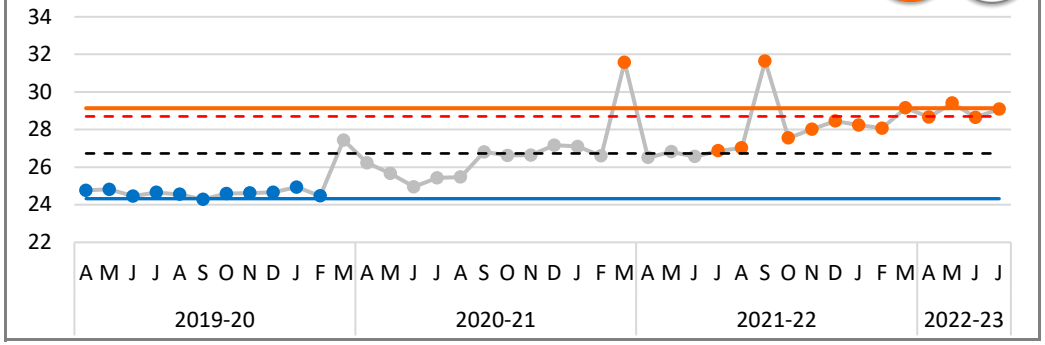
Key Financial Drivers

East and North Hertfordshire NHS Trust

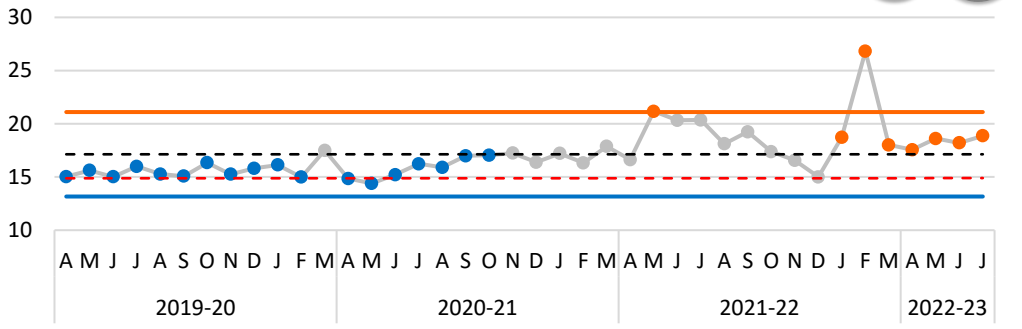
Income earned



Pay costs



Non-pay costs (including financing)



Key Issues and Executive Response

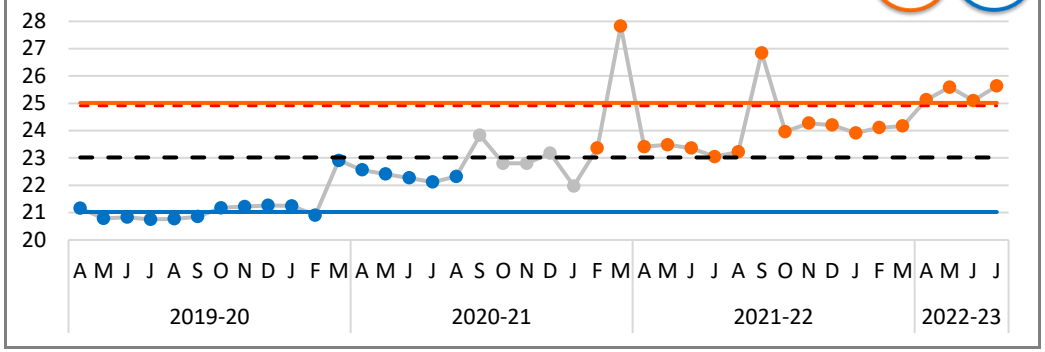
- Month 4 financial performance continues to represent a challenging start to the financial year for the Trust. Whilst the YTD deficit position of £3.7m is in line with the financial year, a number of key risk items remain within the reported position.
- It is important to highlight that significant utilisation of non-recurrent reserves funding has been required in order to sustain plan achievement to date. This opportunity will not be available over the remainder of the financial year, therefore plans to reset the Trust's underlying spend run rate are urgently required.
- Slippage against CIP targets (£0.6m in month, £2.6m YTD) represents a major concern at the M4 reporting point. Divisional capacity to support effective project and delivery arrangements remains a concern that requires redress. Additional project resource is presently being sourced.
- Levels of overspending against medical staffing budgets - totalling £1.3m 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.
- Whilst performance during Q1 was proved sluggish and progress subdued, July has provided stronger evidence of the impact of planned capacity growth. Whilst the volume of activity achieved remains below ERF plans, the value of the work has matched target. Full ERF income is assumed in the YTD position.
- The Trust has in place regular elective recovery performance meeting to monitor and support plan achievement. The enablement of procedure rooms in September represents a key phase of plan delivery.
- The Trust continues to monitor the impact of levels of inflation upon its financial plan. Particular pressures in respect of utility costs have already begun to emerge.
- A sequence of monthly divisional finance boards are in place chaired by the Director of Finance. However, in light of the deteriorating position forecast as a result of the Trust current underlying run rate it is likely that significant reset changes will be required.

Sustainable Services

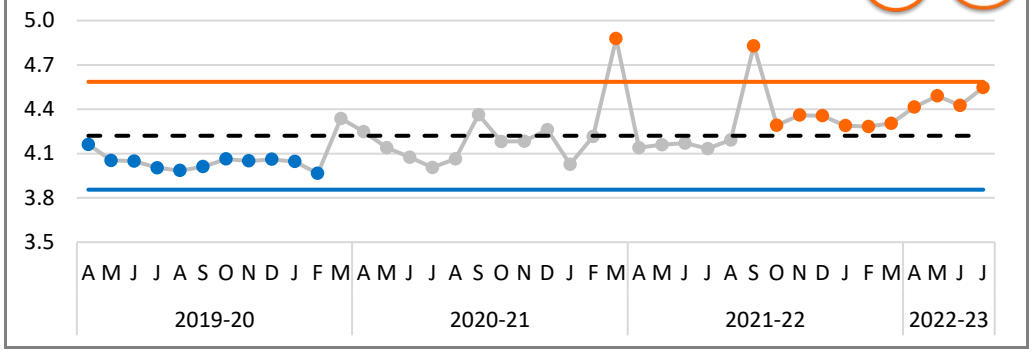
Key Payroll Metrics

East and North Hertfordshire NHS Trust

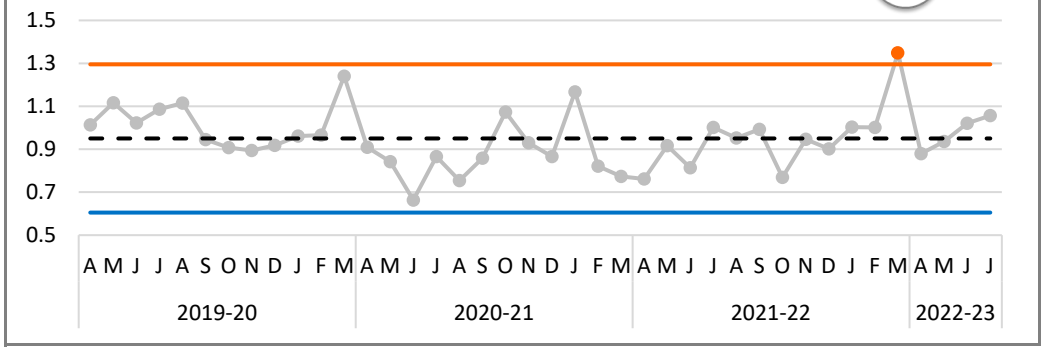
Substantive pay costs



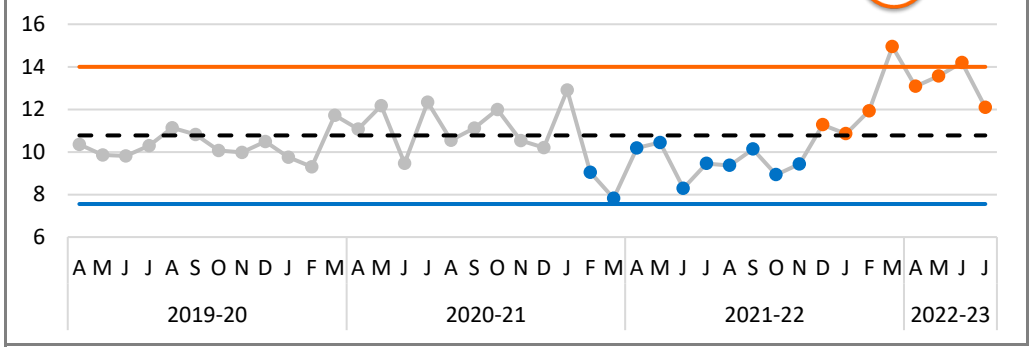
Average monthly substantive pay costs



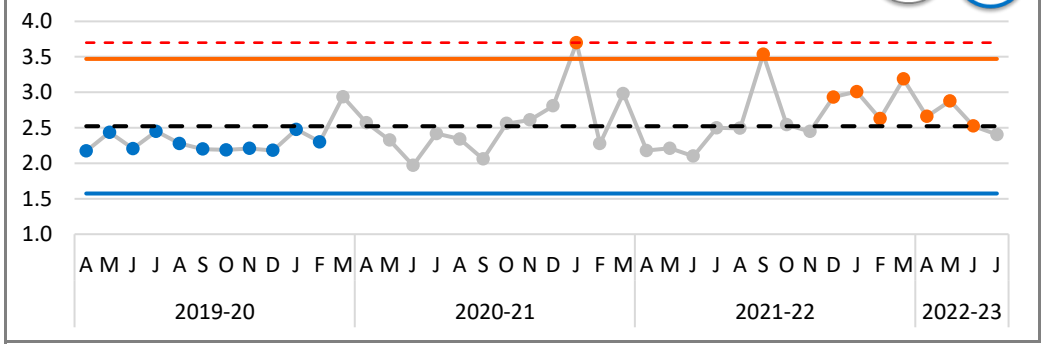
Agency Costs



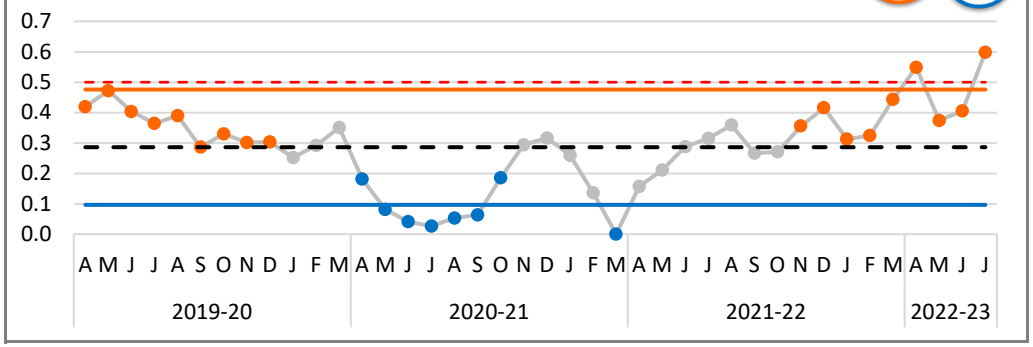
Unit cost of agency staff



Bank costs

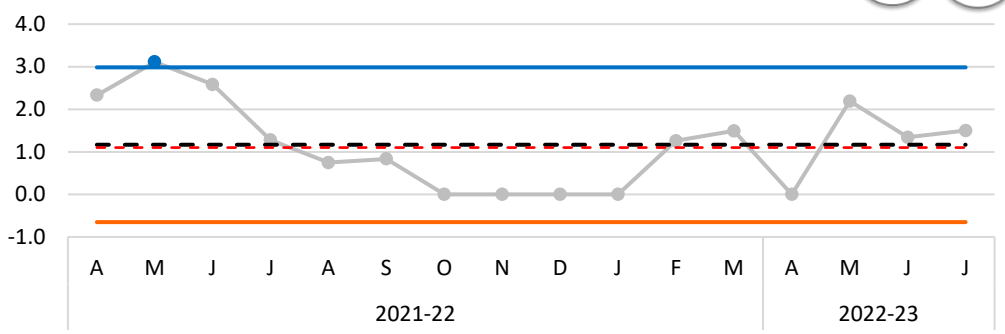


Overtime and WLI costs

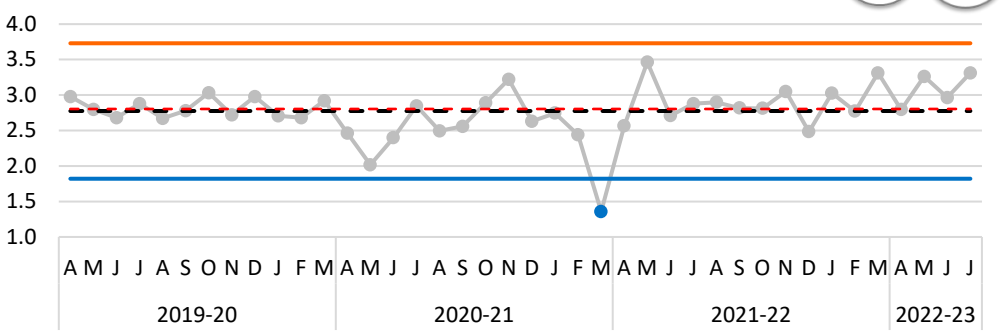


Other Financial Indicators

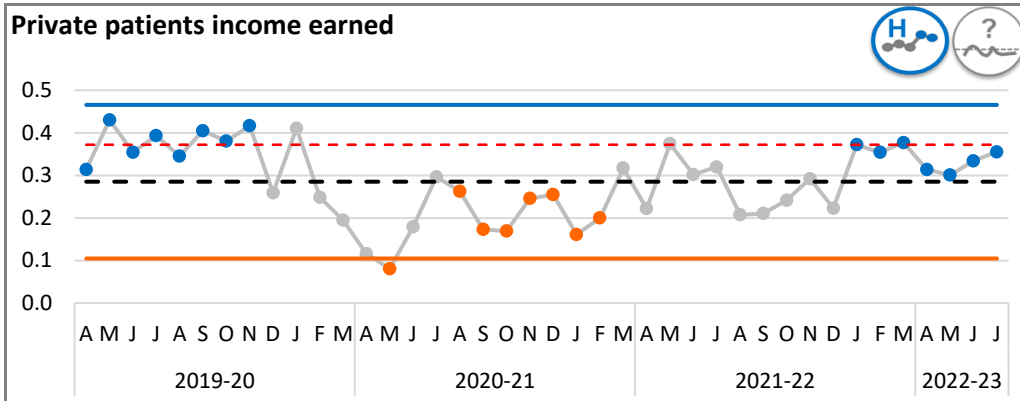
Elective Recovery Fund income earned (In month)



Drugs and consumable spend



Private patients income earned



Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Trust Board – Part I		**Agenda Item**	11
Report title	ICS Briefing and System Working		**Meeting Date**	07-09-22
Presenter	Martin Armstrong - Deputy CEO			
Author	Herts and West Essex – Integrated Care System			
Responsible Director	Martin Armstrong - Deputy CEO		**Approval Date**	11-08-22
Purpose	**To Note**	☐	**Approval**	☐
	Discussion	☒	**Decision**	☐

Report Summary:

The Herts and West Essex Integrated Care Board and System was formally established on the 1st July 2022.

The attached stakeholder briefing produced by the ICS provides on update on ICS structural developments, key system priorities and also areas of focus in respect of delivering improvements in health across the local population.

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

The board is asked to note the update and the alignment between system, place and Trust priorities and workstreams.

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 review and comment.

Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

Charter House
Parkway
Welwyn Garden City
Hertfordshire
AL8 6JL

4 August 2022

https://hertsandwestessex.icb.nhs.uk

Dear stakeholder,

Just over a month has passed since the establishment of the Hertfordshire and West Essex Integrated Care Board and our wider Integrated Care System.

During that time we've experienced the challenges of extreme temperatures combined with growing pressure on our urgent and emergency care services and the impact of rising Covid infections amongst staff and the general public.

A great deal of work is underway not only to ensure we meet these immediate challenges facing the NHS and social care services, but to seize the opportunities presented by system working to develop long-term solutions that deliver real improvements in the care people receive and the support they need to lead healthy and fulfilling lives.

In July we have had a real reminder of the importance of working across traditional boundaries to solve shared challenges. The recent heatwave has shown that climate change is not just an environmental emergency, but poses a major threat to our health with direct and immediate consequences for our patients and the NHS. Senior leaders from across the east of England gathered at the end of July to focus on sustainability and to talk about how to make each organisation's 'green NHS' plans a reality. By collaborating and working together, for example by expanding 'virtual hospitals' and supporting people at home, this is an example of how we can put patients first whilst making a contribution to solving a wider issue.

ICS development

Integrated Care Partnership's inaugural meeting

The first meeting of the Integrated Care Partnership also took place last week. The ICP will be a driving force in what is the biggest opportunity presented by the creation of an integrated care system - the opportunity to involve all organisations, and the residents of Hertfordshire and West Essex themselves, in developing an approach to population health which tackles variation and inequality, and ultimately achieves our vision of making Hertfordshire and West Essex the best place for health, wellbeing and care for everyone.

Dr Jane Halpin, Chief Executive

Rt. Hon. Paul Burstow, Chair

Some crucial work is already underway that will see us make strides towards making that vision a reality. Most importantly, between now and the end of the year we will be developing our ICP's strategy for the system, and after that the implementation plan to deliver it.

In both of those pieces of work we will be keen to ensure a genuine process of co-production with partners and the residents of Hertfordshire and West Essex.

We have an ambitious plan for the next 3 months including to:

- Establish our health and care professional senate to help to guide our approach to quality and other areas
- Revise the 'people plan' for our area, setting out a new vision for tackling the workforce issues that are at the heart of so many of the challenges facing the NHS and care services
- Further develop our skills and capacity to use Population Health Management approaches across the ICB
- Launch our full strategy for Primary Care across the system

At the same time as delivering these core workstreams, the Integrated Care Board has a crucial role to play alongside system partners as we continue to confront one of the most challenging operational environments the NHS has seen - with the continued need to respond to the pandemic, the increase in demand for primary care, mental health and other services, the backlog of elective care – where we are starting to see significant progress, plus the huge demand faced across urgent and emergency care and mental health sectors.

We are confident that by working as a system we are much better placed to meet those challenges than we have been in the past. Over the next few months we are keen to get out and about across our system to hear directly from staff who are delivering care in new ways. We'll continue to highlight examples of interesting and new projects through these letters to give you a flavour of the hard work that is taking place.

In this edition, we have a particular focus on some of the work that our medicines optimisation team carries out to support primary care colleagues in GP practices and in pharmacies, but also our patients in hospitals and in care homes. Their work plays a significant part in preventing residents of nursing and care homes needing to be admitted to hospital because of problems relating to their medicines and ensuring they can remain where they are most comfortable.

Progress on key system priorities

Since our last update to you, we have made progress in the following areas:

- Plans have been agreed for our second and third Community Diagnostic Centres (CDCs); to make more diagnostic testing available to local people and help reduce waiting times. Subject to being allocated funding, we are seeking to develop one at St Margaret's in Epping, one based across St Albans City Hospital and Hemel Hempstead Hospital, and to expand the existing CDC at the New QEII Hospital in Welwyn Garden City.

Our biggest challenge in making more testing capacity available is staffing and there is work is taking place across the east of England to try and address this.

- We are working closely with all NHS and independent hospitals across our area to reduce waiting times for patients needing non-urgent (elective) surgery. We are developing plans to enable more non-complex surgery to happen in a hub to serve our Hertfordshire and west Essex population, again in order to secure national funds to support this.

  We have significantly reduced the numbers of people who have been waiting the longest for their routine treatment. The small group of local patients who have now been waiting for treatment for two years have been treated or offered an alternative hospital for their care, if they would prefer.

- Our urgent and emergency care services remain extremely busy and our area's hospitals are continuing to see more patients in emergency departments than usual. All possible steps are being taken to ensure people who are medically fit to return home from hospital are discharged quickly and that we make full use of virtual wards so patients can receive care outside of an acute hospital where that's appropriate. We are also working with our hospitals and the ambulance service to reduce delays in ambulance handovers where we can.

  As always, we would welcome stakeholders' support in helping local people access the right service for them. Please share information about NHS 111 with your networks. NHS 111 is open 24 hours a day for urgent medical help and can book appointments at urgent care centres or with a GP or nurse. It can also be accessed online at www.111.nhs.uk

Delivering improvements in health and care

Pharmacy support in care homes

Our pharmacy teams have worked with care homes throughout the pandemic, helping to make sure medication is managed safely, is administered correctly and accurate records maintained. Residents of care homes often need to take multiple medicines and our pharmacists assist nursing staff to support individual people's needs and medicine regimes. The teams also work closely with colleagues in county councils to provide advice and training for care home staff and to reduce safeguarding risks linked to medicines.

The ICB's nursing and quality team is also working with Hertfordshire County Council to take a closer look at the data that is collected about admissions to hospital from care homes. This 'dashboard' will help us to find out if there are trends in why people are being taken to hospital and where to focus our support to care homes. For example, it may be that additional training is needed to help care homes identify residents earlier whose health may be worsening or to give staff the confidence and skills to manage some conditions safely in the care home.

Preventing people needing to be admitted to hospital unnecessarily is important both for individual patients who would prefer to be looked after in a familiar environment and also for the wider health and care system.

Better prescribing to reduce risk of harm to patients

The medicines optimisation team has also developed a support tool to help GPs work with patients to reduce their reliance on certain very strong opioid painkillers where high doses can be harmful if taken for a long time. Our data shows us that in some parts of Hertfordshire and west Essex, more of these types of painkillers are prescribed compared to the national average and making sure that patients have other alternatives and are supported to manage their condition is a priority.

In west Essex the team gives advice and support to patients, GPs and practice nurses on the optimal medication required to manage a patient's joint, bone and muscle pain. The majority of patients they support have complex needs and are helped over several months to eventually reduce their pain medication to a lower level.

Another way in which the pharmacy team is helping medicines to be used more effectively is through its award-winning antimicrobial app. This app is available free for any clinician across Hertfordshire and west Essex to download to their smartphone. It gives easy access to guidelines and is helping to make sure that antibiotics are only prescribed when they are needed. This is important because overuse of antibiotics will lead to them becoming less effective with some strains of bacteria becoming resistant to treatment.

Understanding patients' experiences of primary care

In July, the results of this year's national GP Patient Survey were published. The results are disappointing compared to previous years but reflect a trend across the country. This shows the pressure that GP practices are under with increased demand coupled with staffing pressures. Our ICB primary care team is analysing the results in detail in order to design a targeted programme of support for practices to improve patients' experiences of accessing care.

A programme of work continues across our area to improve the buildings that our GP practices operate from. Long awaited new premises at Herts and Essex for two Bishop's Stortford practices will be complete this autumn with business cases approved for new facilities for Schopwick Surgery in Elstree and Wallace House in Hertford plus extended premises for Garston Medical Centre. As new projects are agreed we will keep you updated through this bulletin.

Alongside the annual patient survey, there are other ways in which try to understand people's experiences of using their GP practice, which give us more immediate feedback.

Patient Participation Groups (PPGs) are groups of patients, carers and GP practice staff who meet to discuss practice issues and patient experience to help improve the service. They provide individual GP practices with valuable patient insight and perspective, plus are an additional way to share information with patients and influence the development of services.

The ICB is working with national charity the Patients Association to strengthen the PPGs we have in Hertfordshire and west Essex. This project will help PPGs increase the diversity of their membership and their community engagement, provide recruitment and training programmes, assistance to measure impact and support in gathering and analysing patient feedback.

The Patients Association has launched a survey to gather feedback on how PPGs in our area are currently operating; the results of which will influence the kind of support that is developed and implemented. If you are interested in this work you can access the survey here or contact heather.aylward@nhs.net for further information.

As an ICB board, we are committed to hearing and acting upon the voices of patients. Our board meetings in public will routinely feature 'patient stories' where someone with lived experience will share details about their care or that of a family member. Board members will hear different experiences of health and care services, both positive and negative which will help the ICB to learn and drive improvements where needed and share good examples of care across the system.

Supporting children's health

Shortness of breath is one of the main reasons that children are brought into A&E. The ICS **asthma transformation programme** was established in November 2021 and aims to ensure that children, their families and health care professionals are informed and empowered to manage asthma more effectively and confidently into adulthood. This means not just putting in place good services for when they are unwell, but linking in local councils to encourage healthy environments that support children and young people with asthma to remain well and to help children to access full education and activities unhindered by their condition.

In south and west Hertfordshire for example, an asthma and wheeze service with hospital and community clinicians is caring for children up to the age of 16 and delivering training to GPs and practice nurses. An 'asthma-friendly' schools programme is being planned with the help of schools and local councils.

As part of the integrated work taking place to speed up diagnosis and improve care for **children with ADHD or autism**, a new animation is being shared with local families to signpost to support and guidance for a child or young person with neurodiverse needs: View the video on YouTube.

Our new health and care organisations – find out more

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

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

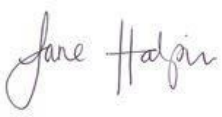
Dr Jane Halpin, Chief Executive

Rt. Hon. Paul Burstow, Chair

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

A short annual general meeting (AGM) for the year 2021/22, looking back at the final year of the CCGs is scheduled to take place on Friday 23 September. If you would like to attend, please email hweicbenh.communications@nhs.net to receive more information.

Yours faithfully,



Dr Jane Halpin
Chief Executive Officer

Hertfordshire and West Essex ICS

Hertfordshire and West Essex
Integrated Care Board

Rt Hon Paul Burstow
Independent Chair

Hertfordshire and West Essex ICS

Chair, Hertfordshire and West Essex
Integrated Care Board

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Trust Board – Part I			**Agenda Item**	12
Report title	Reset Week Debrief			**Meeting Date**	7 September 2022
Presenter	Lucy Davies, Chief Operating Officer				
Author	Katherine Marwood & Lucy Davies				
Responsible Director	Lucy Davies, Chief Operating Officer			**Approval Date**	26 August 2022
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**		☐
	Discussion	☒	**Decision**		☐

Report Summary:

Reset Week marked a change in approach at ENHT and delivered a number of improvements to flow with a positive impact on time to admission, time in ED and ambulance handover times.

The targets and improved processes remain in place.

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):

N/A

Recommendation	The Board is asked to Note the content and discuss this report.

To be trusted to provide consistently outstanding care and exemplary service

Reset Week and Beyond

ENHT

East and North Hertfordshire NHS Trust

Lucy Davies
Chief Operating Officer
ENHT
Lucy.davies11@nhs.net

 # ProudToBeENHT

Background

East and North Hertfordshire NHS Trust

- Due to significant pressures at the Lister Hospital and the Trust's ongoing OPEL 4 status, it was decided to have a "Reset Week" 29 July - 4 Aug
- Introduction of initiatives to improve patient flow through the hospital.
- Brief, debrief, reflect, and adapt daily throughout the week.
- Stood down all meetings, other than those essential to the running of the hospital.

- **Objectives:**
  1. Achieve 100 discharges per day, including at weekends.
  2. Achieve 3 discharges from each ward before 11am.
  3. Stop bedding SDEC and the Discharge Lounge, to ensure they are used as intended.

Internal activities – examples

East and North Hertfordshire NHS Trust

- Operational and senior nursing colleagues provided an increased presence on our wards.
- Use of lateral flow tests rather than PCRs for asymptomatic patients.
- Daily all users emails from COO updating on progress, asking for ideas
- Our “Support Squad” stood up to allocate corporate volunteers to support clinical teams.
- Stood up a Discharge Escalation Hub to support with unblocking barriers to discharge.

System support – examples

- Hertfordshire Partnership University NHS Foundation Trust (HPFT) mental health liaison team joined our staff in ED to help support caring for mental health patients.
- Hertfordshire Community Trust (HCT) relaxed the criteria for Hospital at Home, as well as providing more flexible community rehab provision.
- HCT provided a nurse from Hospital at Home to help identify suitable patients.
- Herts & West Essex ICS provided a GP to visit ED and give ideas and feedback. Existing daily call used for updates

Outcomes

East and North Hertfordshire NHS Trust

Day	Outcomes
Friday	1. Reduced wait to be seen in ED from 10.5 to 1.5 hours by 5pm 2. By 5pm, only two patients in ED waiting for an admission bed (compared to often 15 – 25) 3. Found inpatient beds for all patients temporarily bedded in SDEC
Saturday	1. Infection control and Site office teams worked together to reopen 16 beds overnight 2. By 4pm, only two patients in ED waiting for beds 3. SDEC remains un-bedded 4. Discharge lounge not bedded overnight
Sunday	1. 65 discharges achieved 2. By 4pm, only one patient in ED waiting for a bed 3. SDEC remains un-bedded 4. Support squad supported in Paediatric ED and maternity
Monday	1. Seven patients discharged before 11am, and a further three by 12pm 2. At 5pm, only two patients in ED waiting for a bed 3. The number of patients not meeting the criteria to reside has fallen each day, and now at its lowest for several weeks 4. SDEC and the discharge lounge remain un-bedded

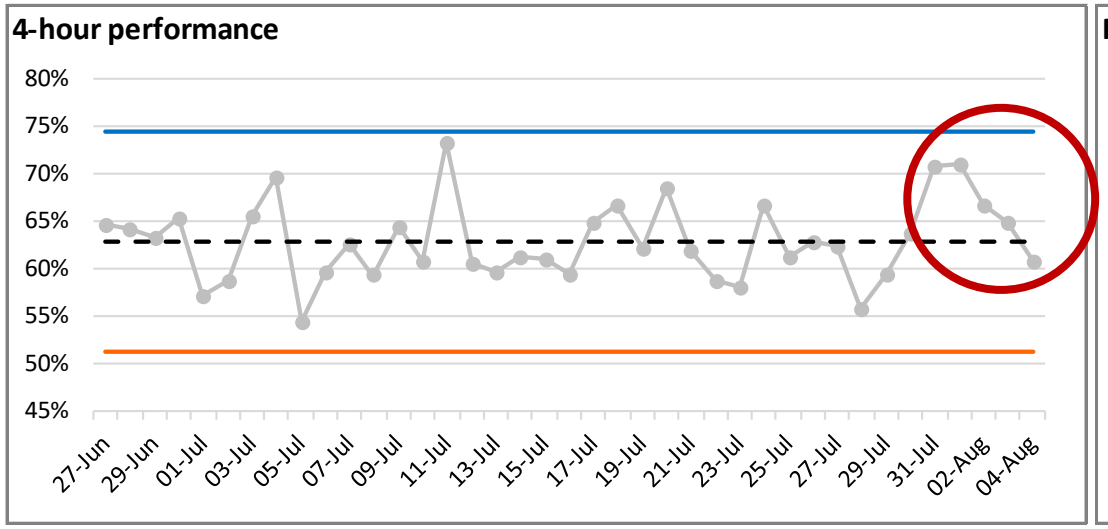
Outcomes

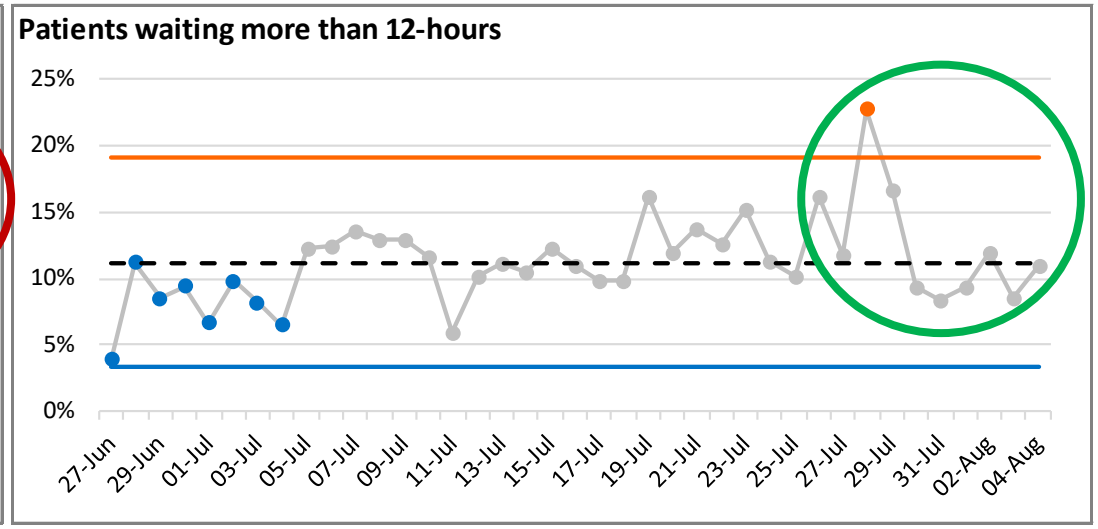
East and North Hertfordshire NHS Trust

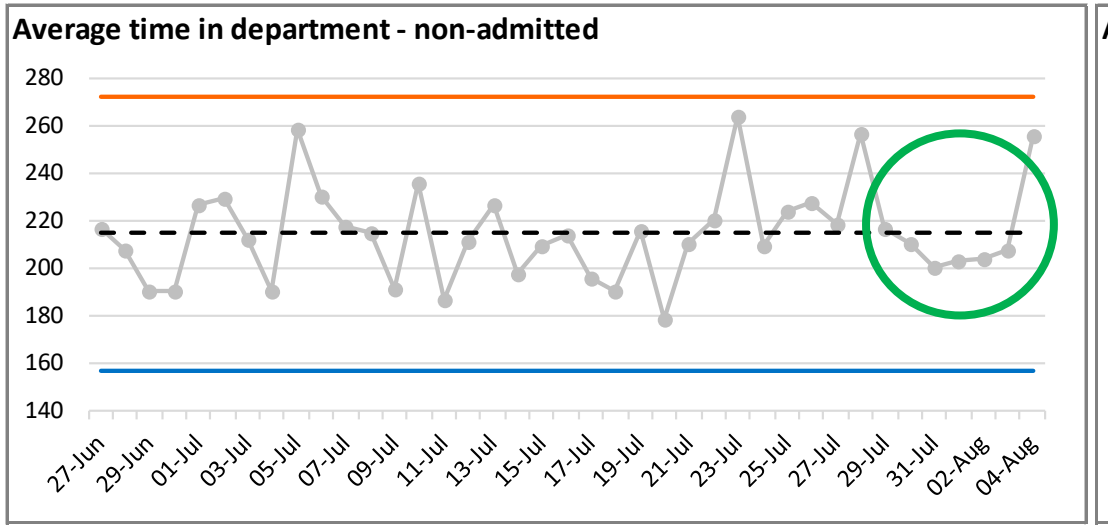
Day	Outcomes
Tuesday	1. At 4pm, only one patient in ED waiting for a bed 2. SDEC and the discharge lounge remain un-bedded 3. Achieved target of 100 discharges
Wednesday	1. Site office worked closely with Assessment to allocate 50% of patients who require admission to an inpatient ward 2. Support Squad volunteers collected data from wards to support the COVID spot check audit 3. Support Squad volunteers continue to support ED with completing an audit of patients coming in from GP surgeries to identify the best type of support 4. Achieved target of over 100 discharges
Thursday	1. Reduced bed occupancy level in the hospital from 90.5% to 85.3% 2. Significantly reduced the number of patients who no longer meet the criteria to reside 3. Ambulance handover times have reduced for 3 consecutive days 4. Achieved OPEL 2 status 5. Achieved target of over 100 discharges

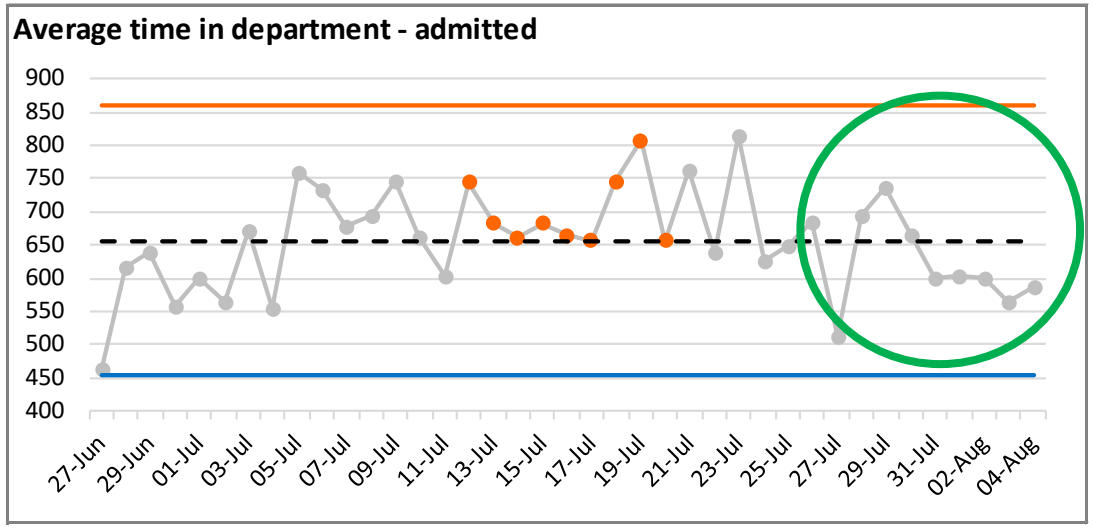
Data – key areas of change

East and North Hertfordshire NHS Trust



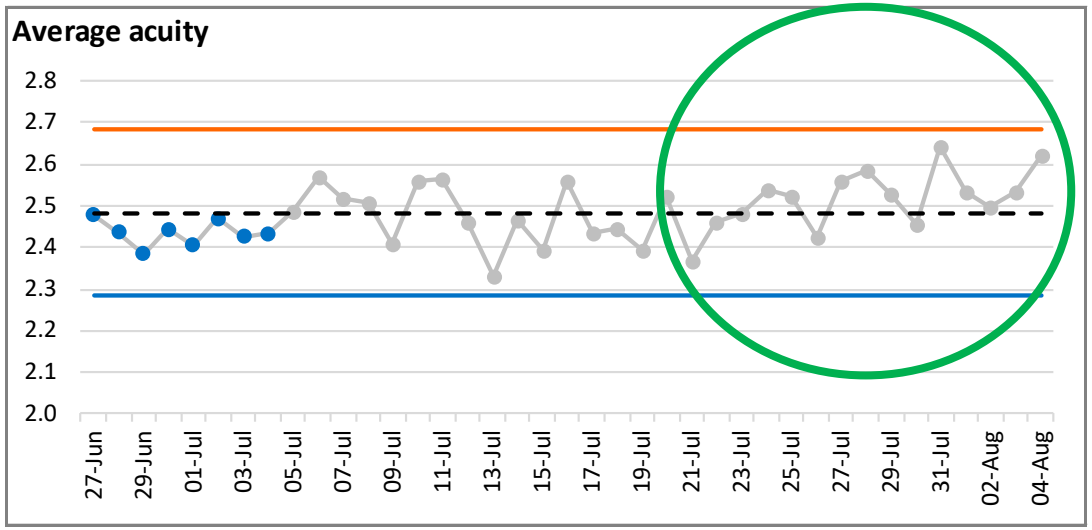


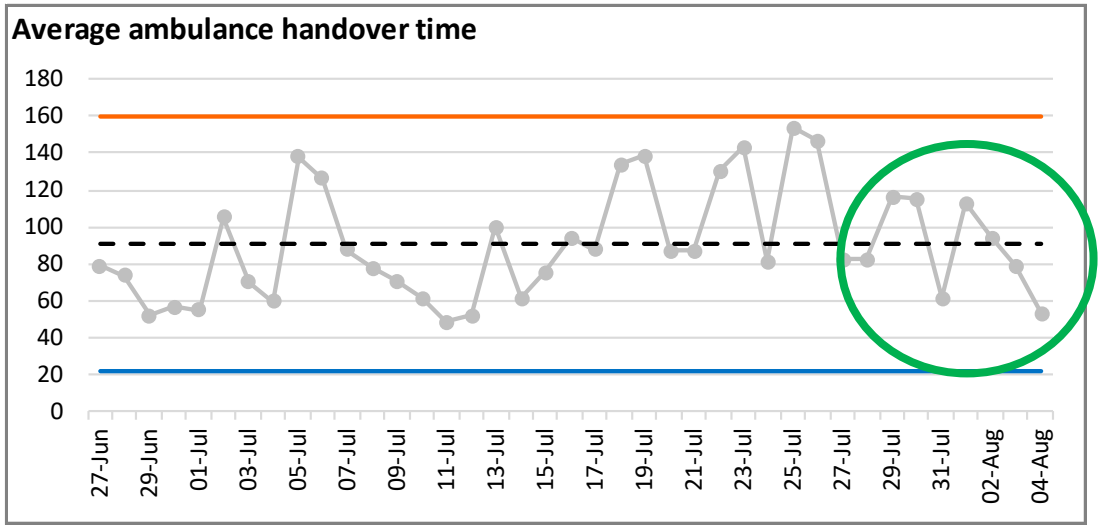


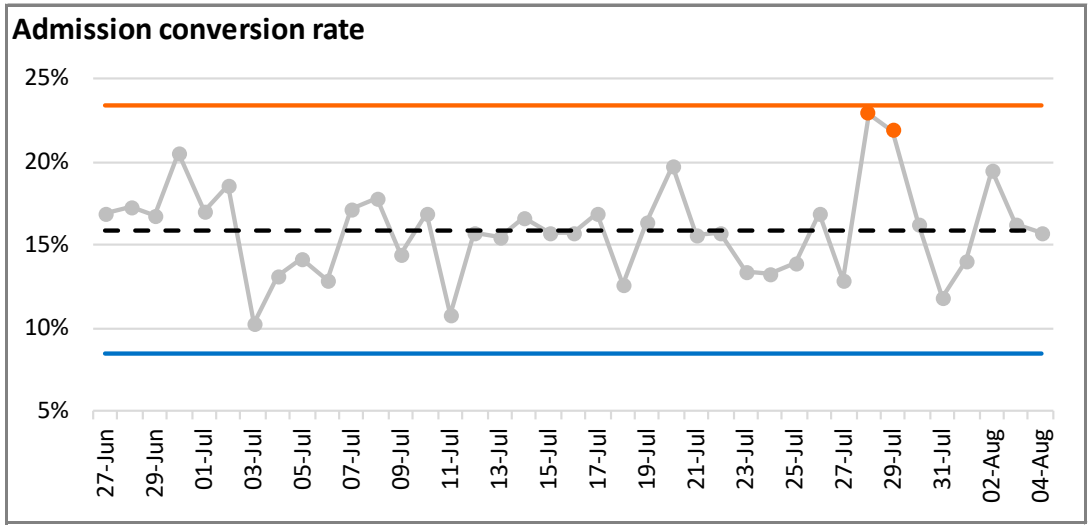


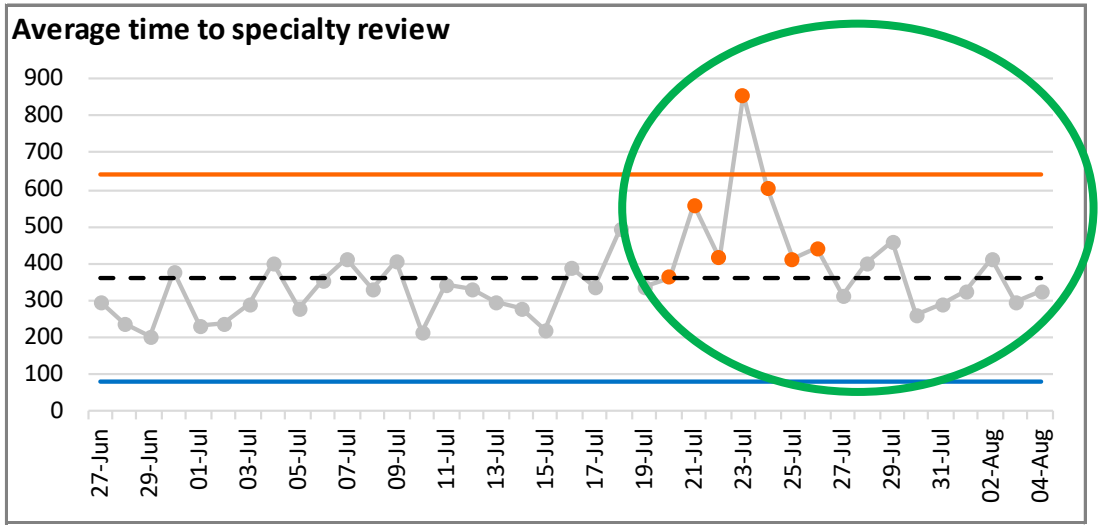
Data – key areas of change

East and North Hertfordshire NHS Trust



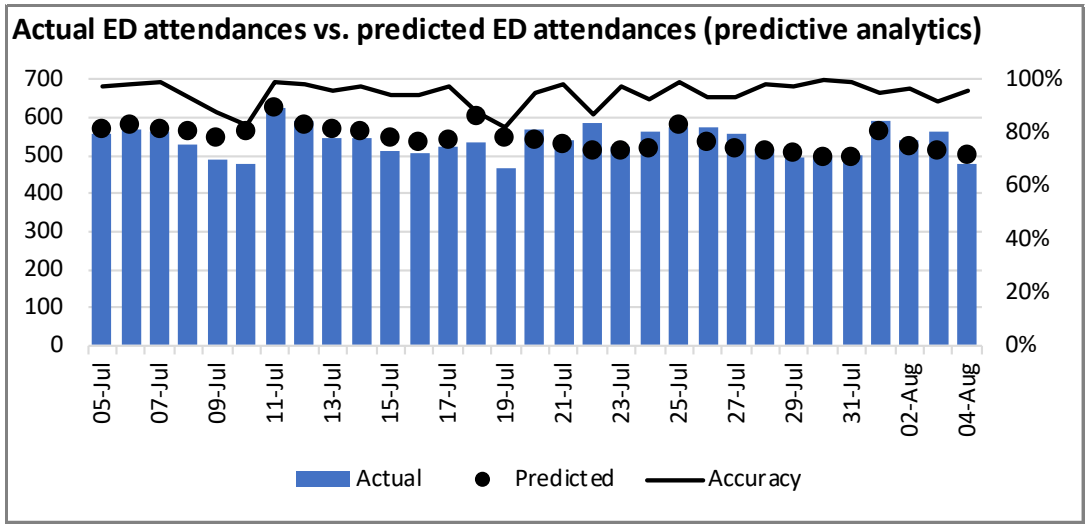


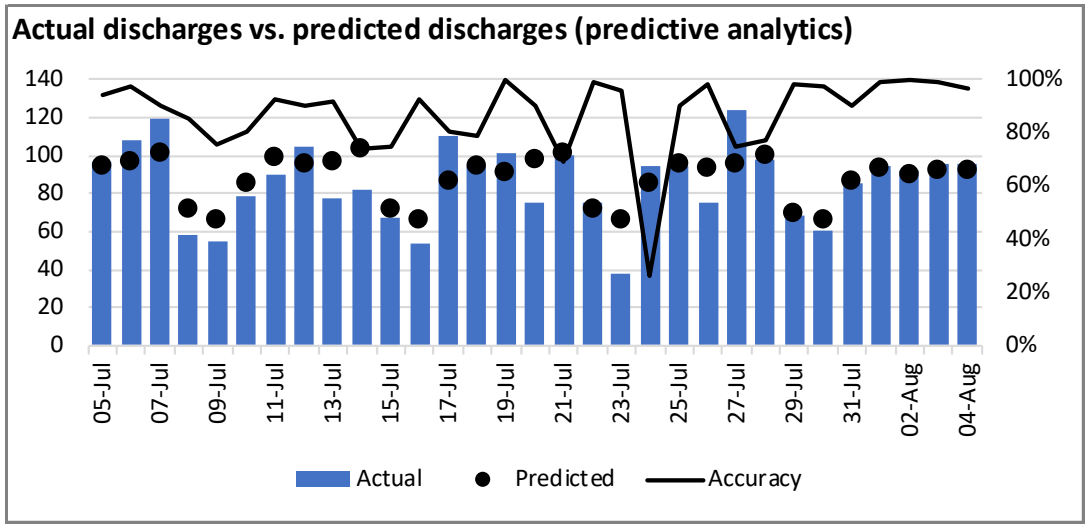


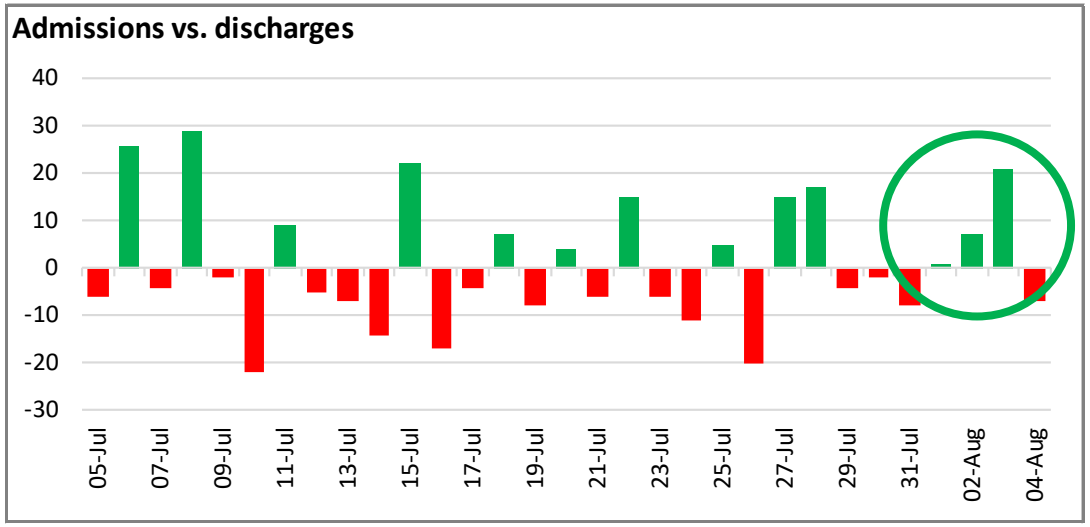


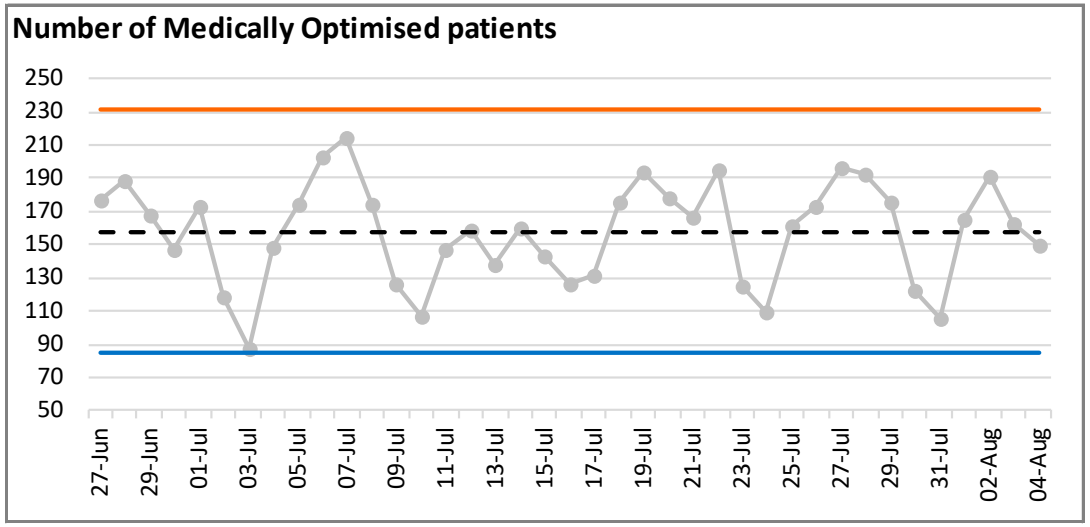
Data – key areas of change

East and North Hertfordshire NHS Trust









Reflecting on our objectives

East and North Hertfordshire NHS Trust

- **Progress against objectives:**
  - SDEC and Discharge Lounge both remained un-bedded throughout the week, and in the weeks since.
  - Tue – Thu: achieved just over 100 discharges per day.
  - Did not achieve 3 discharges before 11am from every ward, but an increasing number of definite discharges declared each morning.
  - Prizes given to Yellow Assessment, 5A North and 11A South for highest number of pre-11am discharges during the week.
- **Wider achievements:**
  - **Across Reset Week as a whole, discharges exceeded admissions by 8. In the three previous weeks, the comparative numbers were -2, -12 and -23.**
  - **Time to specialty review in ED improved significantly – by a third.**
  - **Positive shift downwards in the time spent by patients in ED – down by approx. one hour for admitted patients from Sun to Thurs.**
  - **Proportion of patients spending 12 hr + in ED down by a third, from 14% to 10%.**
  - **This is despite the acuity of patients presenting increasing during Reset Week.**

Cultural impact and learning

East and North Hertfordshire NHS Trust

- **Permission** to experiment, innovate, and do things differently
- **Knowing** we do have the power to change for the better
- **Opportunity** to challenge orthodoxies
- **Freedom** to challenge the status quo
- **Space** to focus time where it’s needed
- **Communication** as a key strength
- **Understanding** roles and responsibilities
- **Confidence** to ask for help and support
- **Using** our expertise in the right places

"My general view of Reset Week is that staff are being encouraged to think 'outside the box', which is leading to more critical thinking, inclusivity, engagement and the beginnings of innovation and some quality improvement. Very positive."

Continued impact – this is forever

East and North Hertfordshire NHS Trust

- We have **maintained** many of the positive processes implemented during Reset Week.
- The number of **patients staying in ED for over 12 hours** reduced by 33% during Reset Week
- **First week after Reset Week, 5 to 12 Aug**
  - We maintained OPEL 2 status and did not bed SDEC or the Discharge Lounge overnight.
  - The number of patients staying in ED for over 12 hours reduced by 14%.
- **Second week after Reset Week, 12 to 19 Aug**
  - Despite high demand in ED, and a temporary move to OPEL 3 status, we returned to OPEL 2.
  - We did not bed SDEC and it was used effectively with appropriate patients.
  - We did not bed the discharge lounge overnight.
  - The number of patients staying in ED for over 12 hours reduced by 0.33% this week
- **Third week after Reset Week (19 to 26 August)**
  - The focus was on unlocking planned care capacity and improving performance against the 4 and 12-hour ED standards.
- The **mental heath team** have maintained a presence in ED and this has had a positive impact.
- **Reverse boarding** is now a BAU activity to support patient flow where needed.

Faith’s smile says it all

East and North Hertfordshire NHS Trust

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Trust Board – Part I			**Agenda Item**	13
Report title	Value for Money Report			**Meeting Date**	7 September 2022
Presenter	Martin Armstrong Deputy CEO & Director of Finance				
Author	External Auditors				
Responsible Director	Martin Armstrong Deputy CEO & Director of Finance			**Approval Date**	25 August 2022
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**		☐
	Discussion	☐	**Decision**		☐

Report Summary:

To provide the Trust Board with the detail of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

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):

Audit Committee 12 July 2022

Recommendation	The Board is asked to note the report.

To be trusted to provide consistently outstanding care and exemplary service

VALUE FOR MONEY

Financial sustainability – planning and managing resources

Areas reviewed:

- How significant financial pressures relevant to short and medium-term plans identified and built into plans
- Plans to bridge funding gaps and to identify achievable savings
- Whether financial plans support the sustainable delivery of services in accordance with strategic and statutory priorities
- The consistency of financial plans with other plans such as workforce, capital, investment, and other operational planning which may include working with other local public bodies as part of a wider system
- Identification and management of risks to financial resilience e.g. unplanned changes in demand, including challenge of the assumptions underlying its plans.

Auditor's commentary on arrangements

How the body ensures that it identifies all the significant financial pressures that are relevant to its short and medium-term plans and builds these into them

During the first half (H1) of 2021/22, in the context of the COVID-19 pandemic, system envelopes were in place, comprising adjusted Clinical Commissioning Group (CCG) allocations, system top-up and COVID-19 fixed allocations with block payment arrangements in place for relationships between NHS commissioners (NHSE and CCGs) and NHS providers.

The funding arrangements for the second half (H2) remained broadly consistent, the general efficiency requirement for NHS providers increased from 0.28% to 0.82% and while there continued to be COVID-19 fixed allocations, these have reduced.

While elements of centralised funding continue, these tend to be based on the achievement of specific conditions, such as the Elective Recovery Funding which rewarded systems for meeting specific targets based on "pre-Covid "activity modelling. In addition, from 2022/23 the requirement for providers to formally identify and report against Cost Improvement Plans (CIP) has returned.

All of these in combination signal a change in tone and focus away from the financial insulation provided by the COVID-19 framework, to one of 'business as usual' albeit with a greater emphasis on system-level working. This gives added weight to the need for Trusts to ensure financial pressures are being actively identified and addressed.

The Trust prepares a 'Finance Report' on a monthly basis. This monitors performance against budget for the month prepared as well as for the year to date, with a review of the actual position against budget in respect of NHS contract income and activity levels, other income, pay costs and other costs. This also provides an overview of capital programme progress and balance sheet positions for the month and year to date. This report is presented to the Finance, Performance and People Committee (FPPC) at each of its meetings; the Committee discuss and challenge the contents. The discussion typically covers the risks and challenges faced to meet the budget requirements and observed unexpected performance/trends. While the finance reports do not routinely go to the Trust Board, the FPPC presents summaries of its activities to each Trust Board by way of executive summary reports, which includes the outcome of the review of the Finance Reports.

Alongside monitoring reports above, reports are regularly presented to the FPPC, Executive and Board on matters that are relevant to the Trust's financial planning. For instance, in September 2021 a report was taken to FPPC and subsequently to the Board by the Trust's Director of Finance in respect of the H2 planning guidance setting out the impact of the funding settlement for the final six months of the year and how this impacted the system and Trust. A similar report was presented in February 2022 on the financial planning arrangements for 2022/23.

VALUE FOR MONEY

Financial sustainability – planning and managing resources

Auditor's commentary on arrangements (continued)

Both of these reports demonstrate clearly how the Trust identifies the financial pressures it faces in the context of the wider health economy and how it seeks to address these. For example, the H2 planning guidance highlights the significantly lower amount of baseline funding, the need for a higher rate of efficiency savings (the results of which were reported at the subsequent FPPC) and the changes to specific funding sources; e.g. the increased thresholds for qualifying for Elective Recovery Fund (ERF) funding let to the Trust removing its expectation of future ERF receipts for the remainder of the year.

Similarly, the February 2022 financial planning report makes a direct link between system-level requirements (such as the need for system level financial balance), allocation changes, the status of commissioning and contracts for 2022/23 and the specific budget gaps engendered by changes from 2021/22 to 2022/23 (with the CIP target in effect being the balancing figure needed to achieve breakeven status).

Review of internal reporting and minutes of meetings at which financial reports are discussed has demonstrated active governance arrangements with quality reporting and genuine critical challenge.

We have also observed that financial risks are included within the Board Assurance Framework (BAF) along with controls and assurance to mitigate the risks, gaps in controls and assurance and actions to address gaps. Through review of Board minutes and attendance at Audit Committees, we have confirmed that these risks are regularly monitored, updated and challenged.

How the body plans to bridge its funding gaps and identifies achievable savings

In line with 2020/21, there were no formal requirements to report against Cost Improvement Plans (CIP) targets in 2021/22. The Trust was required to demonstrate efficiencies in line with 0.28% of turnover for the first half of 2021/22 and 0.82% for the second half.

For 2021/22, the Trust have reported £6.2m of efficiency savings against a target of £6.4m. Of the £6.2m achieved, £4.2m were recurrent and £2.0m non-recurrent. While this achievement fulfils the requirements of the financial framework as it currently stands, the target for 2022/23 (£17.8m) represents a significant increase on 2021/22.

The Trust's plan to break-even for the year is reliant on this target being met. The last year in which CIP was formally monitored and comparable in scale was 2019/20, being the year immediately prior to the onset of COVID-19 financial governance arrangements. During that year, the Trust achieved its target of £15.0m with a favourable variance of £0.2m. However, this was achieved following the introduction of unplanned schemes, rather than representing achievement of plans as originally established, and so the extent to which this can be taken as evidence of likely future performance, particularly noting this relates to a very different financial architecture and wider economic environment than is the case for 2022/23, is unclear.

VALUE FOR MONEY

Financial sustainability – planning and managing resources

Auditor's commentary on arrangements (continued)

In addition, whereas £15.0m represented circa 3.3% of the preceding year's operating expenditure (£453m), the comparative target for 2022/23 (by reference to this this year's operating expenditure), being £18.8m of £571m, while similar in relative terms (3.3%) remains an ambitious target and is higher in absolute terms by 25%.

Per discussions with the Deputy Director of Finance in June 2022, and as per the M1 CIP performance report presented to the FPPC (May 2022) while the full £18.8m has been identified, actual M1 achievement is at £0.661m against a M1 target of £1.245m. Within this there were some areas of individual overachievement (such as the cancer division), but the underachievement included the largest CIPs, being Planned Care and Unplanned Care.

To mitigate this the Trust have increased the frequency of the finance boards for both Planned and Unplanned Care (where larger underachievement have been noted) and are reviewing the corporate meeting structure.

We have not noted any significant weaknesses in the Trust's CIP arrangements, and it is not uncommon for initial underperformance against CIP to be 'caught up' as the year progresses (often through the identification of non-recurrent savings). Nevertheless, we note that as at M1 the Trust has delivered 53% of year-to-date plan and that as at 20 May 46% of the CIP remains red rated, with 25% amber rated. Per the Financial Plan for 2022/23, the Trust is reliant on achieving these savings to achieve its break-even duty.

Observation: The Trust should continue to explore opportunities for additional CIP to mitigate the risk of not achieving planned CIP. The Trust should have regard to wider system level developments and the extent to which system-level CIP or other provider collaborative level CIP can be engendered.

How the body plans finances to support the sustainable delivery of services in accordance with strategic and statutory priorities

Although nationally, restrictions relating to COVID-19 have been eased during the course of 2021/22, with no return to the strict national 'lockdowns' prevalent in 2020/21, the impact on the health service has continued to be significant, both in terms of volume and acuity of cases and the knock-on impact of staff absences due to sickness and self-isolation, as well as enhanced infection prevention control measures. In the case of the Trust, this had an impact throughout the year including the end of the year due to the impact of the 'Omicron' variant. Therefore, the sustainable delivery of other services has to be considered within this ongoing COVID-19 context.

Nevertheless throughout 2021/22 significant national and system-led initiatives to recover elective performance have been in place, most notably through the Elective Recovery Fund mechanism through which in the Trust's case resulted in an additional £13m of funding directly linked to recovering elective care, based on actual performance as measured against a pre-COVID benchmark.

In addition, the Trust, as part of its wider ICS role, has been exploring more structured way of expanding elective capacity such as through expansion or acquisition of hospital space (see Improving economy, efficiency and effectiveness). This seeks to address the backlog of high volume, low acuity cases which the Trust currently faces.

The Trust continues to embark on a significant capital programme, having utilised almost its entire Capital Resource Limit of £37m for the year (which in itself is an increase on the £28m utilised in the prior year). This has included the completion of the Emergency Department transformation at Lister Hospital.

VALUE FOR MONEY

Financial sustainability – planning and managing resources

Auditor's commentary on arrangements (continued)

From our review of the Board meeting minutes, we note that significant focus remains given to the impact of COVID-19 on the delivery of NHS services in the period of the pandemic, both in respect of the Trust's response to the direct impact of the pandemic and also the reinstatement of 'non-essential' services.

Sustainability is one of the Trust's five strategic priorities, from both a financial and clinical perspective, and there are clear objectives underpinning the path to achieving that strategic aim. The Trust has included on its BAF the risks identified against its ability to deliver against its strategic aims and objectives, one of which is the risk of financial delivery due to the radical change of the NHS Financial Framework associated with the current COVID pandemic. In 2020/21 Internal Audit issued substantial assurance in a report on Covid 19 financial governance in response to this risk.

Financial support for the provision of statutory and strategic priorities was in many respects more of a secondary consideration during 2021/22 than is usual, due to the revisions to the financial framework, but as noted throughout this report the Trust's arrangements to receive its entitlement of funding over the course of the year. We considered the impact of a COVID-19 environment on the Trust's service priorities and determined that the challenges were the same as those facing healthcare providers throughout the country. We note that these issues were taken regularly to Board and other committee meetings, with detailed action plans and monitoring observed to be in place.

How the body ensures that its financial plan is consistent with other plans such as workforce, capital, investment, and other operational planning which may include working with other local public bodies as part of a wider system

Internal audit reported (August 2021) against the Trust's Capital Programmes. The audit assessed whether the Capital Plan meets the requirements of the Trust's business plan and long term objectives, and are conducted in accordance with the procedures detailed in the Trust's Standing Financial Instructions, Standing Orders and Capital Plan. This audit provided reasonable assurance. The Capital Plan was approved by the FPPC on 31st March 2021 (prior to the commencement of the financial year) with progress reviewed monthly at the same Committee.

During the late stages of 2021/22, the Trust engaged with a number of suppliers to secure plant and machinery by way of 'vesting certificates'. This arrangement effectively means paying for capital assets in advance of receipt, in effect securing the Trust's right to receive the asset at a future point in time. As at 31 March 2022 equipment with a value of £2.4m (gross) had been procured in this way.

We observed that the matter of vesting had specifically been referred to as part of the Month 11 capital update presented to the 30 March 2022 FPPC, where the context for using these certificates, but also the risk associated with these, were highlighted, ensuring the FPPC were kept properly informed of the scale and nature of the issue.

Internal audit reported (February 2022) against the Mandatory Training & Appraisal which provided Reasonable Assurance. The review covered the arrangements in place for the management of mandatory training to staff within a sample of core specialities; validity of the Trust wide data compiled for mandatory training course attendances; and the systems and processes for identifying, booking and following-up non-attendance of courses. The second part of the audit covered staff appraisals. The review identified four important and five routine areas for improvement; effective training and appraisal underpins the Trust's ability to achieve its institutional objectives.

VALUE FOR MONEY

Financial sustainability – planning and managing resources

Auditor's commentary on arrangements (continued)

The FPPC's remit (during the year) included Finance, Performance and People, meaning detailed reporting is incorporated for all three of these areas. For example, the March 2022 FPPC received the Finance Report Month 11, Month 11 Capital Update, 2022/23 Financial Plan, Operating Plan & Workforce Plan, Workforce Report Month 11 and Performance Report Month 11. Though a broad remit (accommodated by 3.5 hour Committee length) this structure does support a direct link between financial planning and other plans.

We note that following a strategic refresh shortly after year end, the FPPC's remit and title will be changed to 'Finance, Performance and Planning Committee', with revised terms of reference being presented to the (existing) FPPC in April 2022 and adopted in in May 2022. The new structure, which includes a People Committee, is intended to give People matters more prominence by having its own Committee. Where strategic refreshes occur it is important that corresponding changes to terms in reference are in place to ensure that the new structure is supported by corresponding underlying updates to formal governance arrangements.

The monthly finance reports presented to FPPC (and summarised at a Board level) papers includes detail in respect of: income and expenditure (including divisional analysis), operational activity, workforce analysis, balance sheet, cash flow, capital and charity positions, all of which tie together within the report for discussion through income and expenditure and balance sheet statements for the period with sub analysis. If an issue within one area has consequences to another area, this will flow through the report ensuring consistency is maintained between them from a planning and governance perspective. The report is discussed and challenged both at FPPC and Board level and we have observed evidence of this discussion and challenge within the minutes of the meetings.

Similarly, Integrated Performance Reports that pass through the same governance channels include a Sustainable Services section which analyses Finance Plan, SLA income, Activity and Efficiency performance and draws out workforce metrics. These reports include commentary on issues arising throughout financial and operational performance, with Executive responses, which focus scrutiny of performance across service areas.

We note also that planning papers are presented consistently for review by the Board. For instance, review of Integrated Performance Reports and ad hoc papers on the ICS all pass through the same governance channels. In relation to system level financial planning, with interdependence for revenue and capital funding, papers appropriately include information for consideration on both the Trust and system position and implications for both. The Trust also participates in Director of Finance groups at system level which promotes consistency in the financial planning and priorities between the Trust and its ICS.

In addition to our minute review, we also know from our inquiry of key management personnel, brought forward audit knowledge and Audit Committee attendance, that the Trust's finance team works closely with operational divisions to ensure planning is joined up and consistent. An example includes how Divisional teams drive the design of the CIPs, and of equal relevance to this discussion, as noted previously, the focus of savings scheme is increasingly at wider system level and a shared PMO function (since rebranded the Transformation team) was developed with ICS partner, Hertfordshire Community NHS Trust, during 2020/21. CIPs are developed by operational managers but 'owned' by divisional triumvirate and signed off by local clinical leaders (to ensure clinical involvement in the CIP planning).

VALUE FOR MONEY

Financial sustainability – planning and managing resources

Auditor's commentary on arrangements (continued)

How the body identifies and manages risks to financial resilience, e.g. unplanned changes in demand, including challenge of the assumptions underlying its plans

The Trust has a risk management strategy in place which states risks are identified, assessed and controlled and, where appropriate, escalated or de escalated through the governance mechanisms of the Trust . The existing strategy has been in place since 2018. Management of financial risks and risks to the Trust's internal control environment are supported through the application of Standing Financial Instructions.

While the COVID-19 pandemic has placed considerable strain on the entire NHS, financially, provider organisations have been largely insulated from financial risk due to the temporary funding arrangements in place.

The end of this regime makes the Trust more susceptible to factors outside the Trust's control, and also confers a higher level of responsibility for addressing these factors.

One such factor is inflation; as at May 2022 Consumer Price inflation was 7.9%, which creates a potential significant cost pressure at a time where scrutiny on individual providers and systems is increasing and represents a risk to financial resilience. While the income budget does anticipate income inflation of £13.3m, this is outweighed by the expected pay inflation and other costs inflation of £11.2m and £3.4m respectively, and leaves the Trust susceptible to future changes in inflation. Per the M1 finance report for 2022/23 it was noted that "NHSE/I have confirmed that nationally further funding totalling of £1.6bn has been reprioritised from existing allocations to support service providers address the impact of higher than anticipated levels of inflation. This funding will be allocated to ICS bodies on a fair share's basis for further distribution. The Trust will work with HWE ICS partners to determine its share of this funding. Per discussions with the (then) Deputy Director of Finance, the Trust is expecting to receive an additional £5m as part of this.

The Trust is aware of the inflation risk, considering the "significant inflation risk given prevailing economic conditions" to be a risk factor which it will actively monitor. The Trust has reviewed its procurement contracts to check where there is a clause that stipulates the price can be increased by RPI / CPI. This has been designed to help identify the risk to the Trust posed by inflation. As part of this the Trust has identified £4.4m of such pressures of which £3.7m were identified as 'unfunded'.

As noted above, Trust management prepares a 'Finance Report' and 'Integrated Performance Report' for review of the Board and committees. These reports include analysis of under and overspend, revised forecasting to the year end and variances to date. From reviewing these reports in Board and Committee papers, we have confirmed that management also provides commentary on issues and why variances arise, with Executive responses, and consequently initiates identification and discussion of risks to the financial plan and consequential efficiency requirements.

Sitting below the BAF, Corporate Services risk registers cover risks from corporate areas, such as Finance, and are maintained by Risk Leads with support from the Risk Manager. Corporate areas have Governance/Audit Leads who are responsible for consulting with teams to identify and assess risks. There are mechanisms in place to involve all staff in risk identification. The Risk Leads and Divisional Boards/Corporate Directorates approve escalation of risks from Corporate Services/Divisional risk registers to a Corporate Risk Register.

VALUE FOR MONEY

Financial sustainability – planning and managing resources

Auditor's commentary on arrangements (continued)

Risks to the Trust's strategic priorities are identified by directors and through Risk Manager analysis reported quarterly and managed through the BAF. Risks to financial resilience will make it from the Corporate Risk Register on to the BAF if they are a risk to the Trust's strategic priorities and score at least 12 on the Trust's risk scoring matrix, for instance throughout 2021/22 a risk of financial delivery due to the radical change of the NHS Financial Framework associated with the current COVID pandemic was included on the BAF, as well as a risk around "longer term risk of the availability of capital resources to address all high/medium estates backlog maintenance, investment medical equipment and service development"

VALUE FOR MONEY

Governance - informed decisions and properly managing risks

Areas reviewed:

- Risks are assessed and monitored to gain assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud.
- The annual budget setting process is appropriate.
- Effective systems and processes are in place to ensure budgetary control, support statutory financial reporting requirements and ensure corrective action is taken where needed.
- The Trust makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency
- The Trust monitors and ensures appropriate standards, such as meeting legislative/regulatory requirements and standards in terms of officer or member behaviour.

Auditor's commentary on arrangements

How the body monitors and assesses risk and how the body gains assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud

Internal audit is part of the Trust's governance and risk assessment structure and is outsourced to a third-party provider, TIAA, and is particularly crucial to providing assurance over the Trust's operation of internal controls. The Audit Committee has received reports, progress updates and action logs from Internal Audit covering a wide range of areas, including those we would consider to be particularly relevant to the Trust.

A 2021/22 internal audit Assurance Review of Board Assurance Framework and Risk Management gave reasonable assurance. The report noted that the BAF would need to be updated in line with the upcoming changes to the Trust's organisational strategy, although for the BAF as it currently is evidence was provided of all risks on the BAF and Corporate Risk Register (CRR) being linked to Trust Objectives. The internal audit report also noted that per Board minutes for May, July and September 2021, confirmed the BAF was reviewed and discussed by Board at each meeting. Risk deep dives are taking place at the Audit Committee, in line with the agreed deep dive cycle.

Noting the need to implement two recommendations, the report provides assurance that the Trust has well designed and implemented processes and controls to assess and monitor risks. Note Internal Audit's programme is risk based. It is informed by a risk assessment which includes reviewing the Trust's risk registers, regulatory framework, external audit recommendations, previous internal audit work, the regulatory framework and corporate documentation, and is developed with input from senior managers and the Audit Committee.

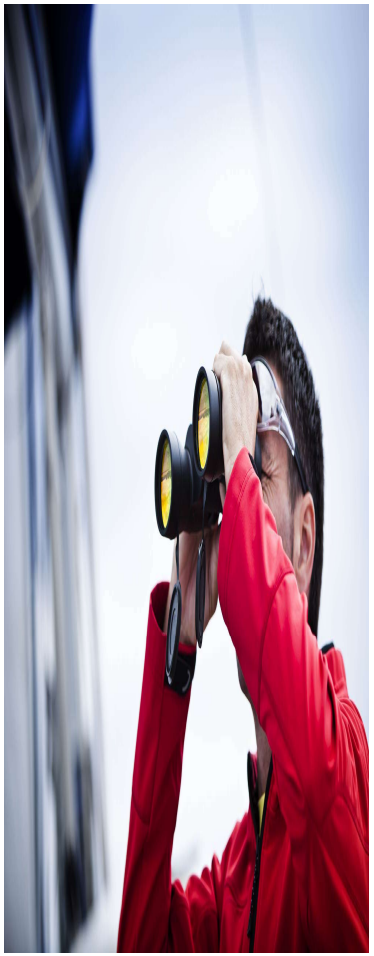
The Trust's Risk Manager supports corporate services and clinical divisions in identifying, evaluating and managing risk at corporate/divisional level.

Arrangements include monthly meetings to identify and discuss risks and related controls for inclusion on local/divisional risk registers; Corporate Directorate meetings/Divisional Boards for monitoring risk management and approving escalation/de escalation of risks to a corporate risk register; identification of Risk Leads and Approving Managers to manage and approve risks operationally; identification of divisional Governance/Audit Leads and Quality Managers with responsibilities for facilitating risk management a divisional level. Risks are escalated to a Corporate Risk Register and BAF based on assessed risk scores and relevance to the Trust's strategic priorities. Reports have been observed to be included within the papers for Board meetings.

Through our attendance at the Audit Committee and review of Board and other committee minutes, we have observed formal consideration of the principal risks to strategic objectives and active monitoring of those risks through the BAF. Strategic risks included in the document are assessed with reference to controls and assurance to mitigate the risks, gaps in controls and assurance and actions to address gaps. The BAF is also considered at other Board Committees including Finance, Performance and People Committee, Strategy Committee, Charity Trustee Committee and Quality and Safety Committee.

VALUE FOR MONEY

Governance - informed decisions and properly managing risks



Auditor's commentary on arrangements (continued)

The Trust has an anti fraud and bribery policy in place approved by Board. It has an accredited Local Counter Fraud Specialist (LCFS), provided by TIAA in addition to internal audit services, with a programme of proactive counter fraud and corruption work which is risk based. The LCFS reports to the Audit Committee. From attending the committees, and a review of counter fraud reporting and through direct discussion with the LCFS, we can confirm that no major issues were identified during 2021/22 that would significant VFM issues.

Internal audit recommendation progress is tracked on a quarterly basis at the Audit Committee. We identified the follow up of internal audit recommendations as a potential significant weakness, as it is an area where issues have been noted in the recent past and as part of previous VFM reviews. These include high volumes of recommendations outstanding, high or urgent recommendations overdue, and evidence of repeated shifting of agreed dates which, while generally circumstance-specific, nevertheless contribute to a drift in underlying control issues being addressed.

During the year the following internal audit reports received ratings of limited assurance.

- IT Disaster Recovery (July 2021)
- Premises Assurance Model Self Assessment (December 2021)

The fact that only two reports out of a total of sixteen that were finalised had limited assurance is indicative of a generally strong control environment, which is consistent with the Head of Internal Audit's annual report. In addition, there were no 'nil assurance' reports.

However, it is essential that findings relating to areas of known weakness are actively followed up.

We inquired with the Deputy Director of Finance and the Head of Corporate Governance as to whether, beyond the routine follow up internal audit recommendations, any further remedial work had been performed in these two areas where limited assurance was identified. While no formal 'deep-dives' have taken place, we note that the Head of Compliance & Sustainability - Estates & Facilities, provided a progress update to the Health & Safety, Fire and Security Meeting June 2022 (which reports to the Quality & Safety Committee) specifically on progress against internal audit recommendations. While there has been no such equivalent for Disaster Recovery, we note that the findings have been reflected in the corresponding BAF risk, and that a follow up audit is planned for 2023/24 (as per the rolling strategic internal audit plan presented in April 2022). Furthermore, as at 31/03/2022 the TIAA Recommendation Tracker does not contain any outstanding recommendations with respect to Disaster Recovery, demonstrating that the recommendations have been addressed.

VALUE FOR MONEY

Governance - informed decisions and properly managing risks

Auditor's commentary on arrangements (continued)

We note that the actions in the BAF generally do not contain due dates. This is consistent with the equivalent document seen last year and the mitigation remains the same, in that there is frequent scrutiny of the BAF and evidence of progress updates and therefore progress is discussed/challenged regardless of the presence of a due date. However, it is best practice for all actions to have due dates.

We also noted in some cases that the controls identified in the BAF related to future events which may or may not have subsequently occurred e.g. "New role of Head of Culture to commence in June 2021". In order for the Board to be assured that the information is current, references should be kept up to date.

How the body approaches and carries out its annual budget setting process

In response to the coronavirus pandemic, the NHS suspended much of its normal planning procedures. The commissioning model has also changed to a simpler allocation model rather than the previous contracted one. This set out the framework under which 2021/22 budgeting and performance was set and monitored.

As described in the Financial Sustainability section of this report, operational and financial planning for 2022/23 has necessarily taken a more 'business as usual' approach given the return of normal contractual arrangements, removal of COVID-19 support, and amidst a context of elective recovery needs.

The Trust submitted their 2022/23 Financial Planning Return (FPR) on 20 June 2022 in line with the revised national deadline. The plan analyses the Trust's projected income, expenditure, balance sheet position (including cash), capital schemes analysis/capital management plan, efficiency (CIP) by value/category/risk.

The March meeting of the FPPC received and approved the financial plan for the 2022/23 financial year. However, it was recognised that some aspects of the plan still required aspects of further clarification and detail that would only be available during April.

The April FPPC therefore received an update. Specific emphasis was made on the material and challenging nature of the savings requirement that is embedded within the 2022/23 (which we have commented on in the Financial Sustainability section or our report). This is considered a high-risk item by the Trust given remaining concerns in respect of divisional savings and governance capacity.

VALUE FOR MONEY

Governance - informed decisions and properly managing risks

Auditor's commentary on arrangements (continued)

With respect to in-year monitoring and performance, through review of the finance papers that go to the FPPC, we have not identified any significant under or overspends that were unexpected. Throughout the year a variance developed between budgeted income (higher than expected) and budgeted non-pay expenditure (also higher than expected). This did not adversely impact the overall net position which as at M11 was a surplus of £0.8m against a budget position of £0.0m; at that point in time income was £16.3m higher than forecast and non-pay expenditure £18.9m, but this was largely due to one-off costs that could not have been anticipated such as increased high-cost drugs (£4m), elective recovery provision (£7m) and the Nightingale unit (£3.1m) as well as MVCC remedial works (dilapidations provision of £7.5m). Most of these had corresponding funding.

Therefore, the final budgeted position was both close to that originally planned and variances related to things that are unlikely to be been foreseeable given that (with the exception of high-cost drugs, although these are reimbursed) the conditions for these things did not exist at the time the budget was originally set.

IA performed a Budget Setting and Financial Reporting 2021/22 Review. A "Reasonable Assurance" opinion was given with two Important action points identified, in relation to timeliness of budget sign-off and completion of Trust Finance and HFMA finance training.

How the body ensures effective processes and systems are in place to ensure budgetary control; to communicate relevant, accurate and timely management information (including non-financial information where appropriate); supports its statutory financial reporting requirements; and ensures corrective action is taken where needed, including in relation to significant partnerships

Budgetary control is principally monitored through monthly Finance reporting and Integrated Performance reports (inclusive of performance data for financial plans in addition to non financial performance). As commented earlier in this report, we have obtained evidence of effective scrutiny of these reports by the Board and its committees, FPPC in particular.

The Trust has a statutory financial reporting requirement to break even and budgeted to do so in 2021/22. This has been monitored regularly at FPPC, although no instances were noted of significant variance to the break-even plan. We observed in the prior year that where variances had occurred, check and challenge took place and resulting remedial actions were required and implemented, but the need for this did not recur in 2021/22.

Internal Audit also has a role in the Trust's arrangements relevant to this reporting criteria both directly and indirectly. In 2021/22 review of budgetary control took place which provided Reasonable Assurance. Key to supporting budgetary control arrangements is accurate underlying data and functioning core financial systems. A report into Core Financial Systems included Accounts Payable, Accounts Receivable, Treasury Management and General Ledger. IA performed a Core Financial Systems 2021/22 Review. A "Substantial Assurance" opinion was given with two routine action points identified.

VALUE FOR MONEY

Governance - informed decisions and properly managing risks

Auditor's commentary on arrangements (continued)

External audit work on the financial statements did not identify any significant control deficiencies; although some recommendations were made with respect to document retention for inter-NHS income and pharmacy invoices these did not ultimately undermine the Trust's governance arrangements or the quality of management information on which decisions were made. The sum of unadjusted misstatements was similarly immaterial, and these were not linked to significant control deficiencies.

Through review of minutes, performance reports and Internal Audit reporting it was evident systems for budgetary control, communication of management information and corrective action were in place.

How the body ensures it makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency. This includes arrangements for effective challenge from those charged with governance/audit committee

Primary oversight is the responsibility of the Trust's Board, with some delegated responsibilities to the Audit Committee. The Board is attended by all members of senior management when it meets (save apologies) and is presented with numerous papers covering a range of corporate and clinical matters of the Trust, with a good mixture of clinical and commercial expertise. We have reviewed papers and deemed them to cover key areas expected to inform effective decision making, for example operational and financial performance, summaries from the Board's committees, topical matters/risks relevant to the Trust's strategic priorities, governance and partnerships. A role of the Board is to ensure the Trust has appropriate arrangements for ensuring it exercises its functions effectively, efficiently and economically and complies with generally accepted principles of good governance as are relevant to it. Challenge and transparency are key to delivering robust governance and we have observed these behaviours during 2021/22 by the Board and its committees, including the Audit Committee which is responsible for maintaining an overview of the operation of internal control and governance.

We know from our review of Board and committee papers, minutes for these meetings and attendance at Audit Committee meetings, that the Board and its committees meet regularly and that key issues are addressed with effective challenge from members. We have also observed evidence of good arrangements in place regarding tracking and responding to the recommendations made by Internal Audit and that management has been held to account throughout the year regarding progress on recommended actions. The pace of implementing Internal Audit recommendations had been questioned by the Audit Committee, but there was an acceleration of implementing overdue actions during 2020/21, particularly those of high priority and recommended by the previous internal audit provider. This has continued into 2021/22. Management has confirmed that action is being taken against all recommendations remaining on the internal audit action tracker and as at 13th June 2022 there remains just 1 overdue urgent recommendation. Overall, there were 13 overdue recommendations at that point in time, which is an improvement on the comparable position at the end of 2020/21 (18 overdue) and 2019/20 (36).

VALUE FOR MONEY

Governance - informed decisions and properly managing risks

Auditor's commentary on arrangements (continued)

We made enquiries and obtained supporting documentation regarding why the high priority recommendation, related to processes for consistent completion of consultant job plans, remained on the tracker given implementation was past its due date (original due date was 30 April 2020, revised to 30 April 2021, 31 October 2021 and most recently 30 June 2022). We established that job planning policy updates had passed through a ratification process and a job plan decision making panel had been refreshed. The Trust had experienced issues with its job planning system, the supplier's upgrade did not improve the system as expected and testing is underway on a new provider system. We note that the need for further action was raised at the July 2021 Audit Committee with the Director of Finance and Medical Director putting together an options appraisal in regard to moving from the current software to new software.

On this basis there are adequate arrangements in place for following up on outstanding internal audit recommendations. In the case of a long-standing overdue recommendation around consultant job planning, we have identified the reasons for the delay and have noted that appropriate escalation has taken place to enable the Trust to implement the recommendation. The delay is due to the specifics of the recommendation, not due to underlying governance weaknesses.

The Trust was observed to have an established BAF to meet the requirements of the Annual Governance Statement, which provides reasonable assurance that there is an effective system of internal control in place to manage principal risks to the Trust's strategic priorities.

How the body monitors and ensures appropriate standards, such as meeting legislative/regulatory requirements and standards in terms of officer or member behaviour (such as gifts and hospitality or declarations/conflicts of interests), and for example where it procures or commissions services.

Responsibility for ensuring appropriate standards such as meeting legislative/regulatory requirements in terms of member behaviour sits primarily with the Audit Committee. Review of the effectiveness and compliance with key policies such as gifts and hospitality, declarations/conflicts of interest are confirmed to be covered by the Counter Fraud programme. This programme drew on the requirements of the NHS Standards in 2020/21 and incidentally the superseding Government Functional Standard's twelve components in 2021/22, in both of which policies and registers for gifts, hospitality and conflicts of interest are a component.

The Trust has an Anti-Fraud and Bribery Policy which was implemented in June 2020. The policy was ratified by the Audit Committee. Although the policy does not contain reference to the NHSCFA Strategy, work is undertaken in-line with the strategy. The policy is available via the Trust intranet, is referenced within fraud awareness sessions and communication was shared with the Trust to promote the policy to Trust staff. The Trust has a Managing Conflicts of Interest Policy in place (a joint gifts and hospitality policy).

VALUE FOR MONEY

Governance - informed decisions and properly managing risks

Auditor's commentary on arrangements (continued)

The 2021/22 Annual Governance Statement advises readers that the Trust has published on its website up to date registers of interests and gifts and hospitality for decision making staff, as required by 'Managing Conflicts of Interest in the NHS' guidance. We note that these registers are easy to locate and so are sufficiently prominent and were updated within the last 12 months, as required by the guidance.

Systems are in place to ensure conflicts of interest are identified, recorded and considered, include public declarations of interest at Board meetings, precluding conflicted individuals from related decision making. This has been confirmed through our review of the Board minutes.

Declarations are also obtained from senior management at financial year end for the purpose of preparing the related parties note for the annual accounts. We obtained and tested these declarations for completeness during the 2021/22 accounts audit.

The Trust has arrangements in place for officers and committees with responsibility for corporate risk management to receive reports on a regular basis and for the Board to take appropriate action to ensure that corporate risks are identified and effectively managed . From review of meeting minutes throughout the year, and attendance at meetings, it was noted that the Audit Committee and Board review items such as the BAF and risk register and that these include risks pertaining to compliance with regulatory and legislative standards.

Our own inquiries with management have not identified any compliance matters representative of VFM weaknesses.

Through review of the CQC reports, there is no evidence of significant breaches in the quality of service. The latest CQC inspection published in December 2019 gave the Trust an overall rating of requires improvement and we have viewed the Trust's arrangements for responding to these. The issues raised in this report did not represent significant breaches in provider license conditions or quality of service.

The Trust has a statutory financial reporting requirement to break even and budgeted to do so in 2021/22. Our review of FPPC reports for 2021/22 did not identify any instances where performance fell below the threshold and hence no remedial action was required.

VALUE FOR MONEY

Improving economy, efficiency and effectiveness - using information to improve services

Areas reviewed:

- Financial and performance information has been used to assess performance to identify areas for improvement.
- Services provided are evaluated to assess performance and identify areas for improvement.
- The Trust delivers its role within significant partnerships, engages with stakeholders it has identified, monitors performance against expectations, and ensures action is taken where necessary to improve
- Where the Trust commissions or procures services, this is done in accordance with relevant legislation, professional standards and internal policies, and assesses whether it is realising the expected benefits.

Auditor's commentary on arrangements

How financial and performance information has been used to assess performance to identify areas for improvement

Through review of Board papers, we have confirmed that the Board is provided with both financial and non financial performance information on a monthly basis, principally through the Integrated Performance Report and Finance Report. Board and committee members are able to challenge officers regarding departures from plans or expectations, as confirmed to meeting minutes. Within these reports, commentary is provided on the reasons for variances and executive responses, for the Board and relevant committees to identify and drive forward areas for improvement.

Through review of internal audit reporting during 2021/22 and the preceding year, we have confirmed a number of reviews focussed on financial and performance related information were completed.

The 2021/22 internal audit programme specifically included a review into Performance Information: Business Planning (Demand and Capacity Plans) which provided reasonable assurance.

The reports issued following internal audit reviews, with emphasis on any recommendations raised, are reviewed by the Audit Committee. By responding to the recommendations raised and implementing actions arising from these, the Trust is identifying areas for improvement. We have confirmed this process to be in place through our review of minutes and attendance at Audit Committee meetings.

Analysis of financial information provides direction to the Trust during the year on its trajectory against plan and statutory reporting requirements. This process allows the Trust to identify areas for improvement and to focus resource in these areas, although we noted in the Financial Sustainability section that no significant corrective actions needed to be taken in year.

How the body evaluates the services it provides to assess performance and identify areas for improvement

The Trust is required to report on the quality of its services against performance indicator targets throughout the year, culminating in an annual quality account report. The requirement for agreed upon procedures to be completed by an external auditor on the quality account was suspended during the coronavirus pandemic and has yet to return. However, the requirement remained for the Trust to publish a report in June 2022.

VALUE FOR MONEY

Improving economy, efficiency and effectiveness - using information to improve services

Auditor's commentary on arrangements (continued)

Quality indicators against which performance is measured for reporting are wide ranging and between them require numerous systems of processes and controls and IT applications to record and report accurate data. Performance against a wide range of indicators were monitored through the Board's Quality and Safety Committee (QSC) and reported to the Board through monthly Integrated Performance Reports.

Integrated Performance reporting provided graphical dashboards for clear illustration of performance trends and also provided commentary on key issues identified and executive responses to aid Board scrutiny. Monitoring the Integrated Performance report at public Board level demonstrates clear accountability for improvement and arrangements in place to secure these improvements. Through review of minutes, we observed the Board challenging performance, requesting further detail and suggesting follow up actions.

The Trust set four broad priorities for improvement linked to its five-year Quality Strategy and it has a programme of measures for progress across themes within its priorities for improvement. Performance against these measures and improvement priorities more broadly has been monitored by the QSC throughout 2021/22 and, given the broad scope of operational performance measures, through other non-Board sub committees such as the Patient Experience Committee, which report into the QSC.

The Internal Audit programme builds in review of systems and internal controls impacting quality account reporting, either directly e.g. Data Quality Friends & Family Test 2020/21, or indirectly e.g. Serious incidents and Clinical audit, (both 2020/21). These reports have been presented to the Audit Committee throughout the previous year, with no high priority recommendations but monitoring of implementation of recommendation through the internal audit action tracker. While there have been no similar reviews for 2021/22, we note that the Audit Committee does receive regular updates on Data Quality and Clinical Coding.

The Trust's last full CQC inspection was carried out in 2019 and returned an overall rating of 'requires improvement'. This was consistent with the previous rating, although the Trust had demonstrated improvement in a number of areas. In response to the CQC report, the Trust implemented a quality Improvement programme designed to address and monitor the improvements suggested as 'must' and 'should' by the CQC. Consequently, required actions have been were monitored through individual boards, committees and sub committees who are required to review progress.

For instance, the compliance team has linked with the divisional leads regularly to provide updates on the actions which are recorded on a central spreadsheet and reported through divisional governance structures to divisional boards. Joint concerns have been reported to a divisional oversight group, with executive and divisional leadership attendance, also providing CQC action plan updates.

VALUE FOR MONEY

Improving economy, efficiency and effectiveness - using information to improve services

Auditor's commentary on arrangements (continued)

The Quality and Safety Committee has received detailed CQC compliance updates, including overviews of improvement action progress (by June 2021 96% of actions had been implemented; by September 2021, all actions completed).

Internal Audit tested the Trust's Demand and Capacity Plans and reported findings to the Audit Committee during 2021/22 (reasonable assurance), in addition to a number of other quality areas including Harm Fee Care (substantial assurance) and Review of Discharge Processes – Discharge Summaries (reasonable assurance) subsequent to which recommendation implementation is monitored.

Clinical Audit also provide regular assurance reports to the Audit Committee.

Through performance reporting, actions plans, monitoring through governance channels, ongoing liaison with the CQC and internal audit reviews, the Trust has evidenced its commitment to improving services.

How the body ensures it delivers its role within significant partnerships and engages with stakeholders it has identified, in order to assess whether it is meeting its objectives

The Trust is a partner in the Hertfordshire and West Essex Integrated Care System (ICS), working collaboratively with trusts, commissioners and other public bodies across Hertfordshire and West Essex. Commissioners and providers within the ICS include East and North Hertfordshire CCG, Herts Valleys CCG, West Essex CCG, Princess Alexandra Hospital, West Hertfordshire Hospitals NHS Trust and several community and mental health trusts.

Management has expressed increasingly effective collaboration within the ICS, accelerated in some respects as a result of COVID-19. The financial framework for the second half of 2020/21 increased interdependence between partners for funding, e.g. system envelope allocations, capital funding prioritisation and Elective Recovery Fund incentives, budget plans and consequently savings requirements. We have reviewed evidence of the Trust participating in DoF /deputy DoF groups to negotiate allocations of 2020/21 system funding and devising an ICS financial plan for the first half of 2021/22.

This focus on system level collaboration has continued into 2021/22. The Board receives regular system collaboration updates. Highlights across the year include:

- exploring options for an Elective Surge Hub to support the reduction of elective waiting lists and the improvement of waiting times in line with NHS planning targets
- senior leaders' engagement events, with the most recent session focussing upon overcoming barriers to effective place-based working and consideration of the development of financial and business frameworks that could support the achievement of transformation priorities
- Provider Collaboration; being mechanisms through which providers will work together at scale to plan, deliver and transform services
- Expansion of 'Hospital at Home' to further rollout the capacity of virtual ward arrangements
- implementation of regular System Oversight & Assurance Group (SOAG) meetings
- partnership working projects (Stroke / Neuro and Community Paediatrics)

VALUE FOR MONEY

Improving economy, efficiency and effectiveness - using information to improve services

Auditor's commentary on arrangements (continued)

We note from the May 2022 Board minutes and discussions with senior management at the Trust that options are being considered both for expansion of the Lister Treatment Centre (at ENHT) or the potential option to purchase One Hatfield private hospital. There is past precedent for Trusts/systems acquiring private hospitals as a means of addressing waiting times / flow. The Trust should ensure that on inception of either option, that governance arrangements for the option are suitably integrated with those of the Trust/system as a whole.

An area where system-level co-operation has already substantively developed is in Procurement. We noted last year that a procurement transformation project was underway; the aim of this being to deliver significant savings to the ICS through consolidated procurement volumes between five Trusts within the partnership with common supplier needs. The governance structure for this programme sees Trust executive and procurement representatives participate in collaborative steering, governance and working groups.

A recent (February 2022) internal audit report into Procurement (to review effective controls in place over procurement, in particular with regard to the achievement of value for money) reported that

- Herts and West Essex Integrated Care System (HWE ICS) are currently updating procurement procedures and manuals
- HWE ICS are currently in process of aligning Standing Financial Instructions (SFI) of organisations in the ICS.

Procurement governance structure was highlighted in Terms of Reference (TOR) for Procurement Governance Board (PGB).

- The TOR for PGB states Finance and Performance Committee (FPC) of each member Trust will establish PGB, authorised to support and endorse activities within its TOR.
- Two actions (one important, one routine) have been identified in order to enable more effective future alignment of the Trust's procedural processes with those of the ICS.

How the body ensures it delivers its role within significant partnerships and engages with stakeholders it has identified, in order to assess whether it is meeting its objectives

Herts and West Essex Integrated Care System (HWE ICS) became responsible for the Trust's procurement services in August 2021.The ICS Procurement Service, hosted by West Hertfordshire Hospitals NHS Trust, brings together the procurement activities of five provider Trusts. The FPPC receives occasional updates on the Procurement Strategy, most recently in November 2021; the paper set out a proposal for how standardised reporting formats and performance monitoring should be conducted.

We have also seen the most recent (June 2022) Procurement Governance Board clinical and non-clinical procurement updates. These brief summaries provide a high-level snapshot of procurement activity relevant to that area.

As noted in the financial sustainability section, the Trust has reviewed its procurement contracts to check where there is a clause that stipulates the price can be increased by RPI / CPI. This has been designed to help identify the risk to the Trust posed by inflation.

VALUE FOR MONEY

Improving economy, efficiency and effectiveness - using information to improve services

Auditor's commentary on arrangements (continued)

There has been less focus on the procurement of services by commissioners / contract monitoring arrangements in 2021/22 due to the block contract arrangements in place. No issues have been identified in respect of these arrangements.

The capital resources available internally in the Capital Plan are determined with reference to the Trust's capital resource limit and capital planning reports taken to FPPC demonstrate this. While the original capital plan was set at £25.8m, this increased to £37.8m by the end of the year (of which £37.4m was achieved) with the increase driven entirely by new PDC funded projects (procedure rooms for elective recovery programme, theatre management system, theatre robot, community diagnostic centre and enabling digital infrastructure. Responsibilities for capital planning are split between the Trust and ICS, with the ICS ensuring capital spending remains within system capital budgets, setting prioritisation criteria for ICS wide capital allocations and agreeing schemes in be included in the capital plan with estates and finance directors.

The local counter-fraud specialist (LCFS) reviewed whether the organisation has proportionate processes in place for preventing, deterring and detecting fraud and corruption in procurement in 2019/20. They found evidence of policy review, relevant staff training and awareness of materials on procurement risk, evidence procurement processes were followed and evidence of action tracking and implementation leading to improvements in procurement processes. The LCFS also completed a proactive review into splitting orders to avoid tender rules in 2020/21, identifying two green rated recommendations that management responded to, and implementation has been monitored via the counter fraud action tracker. While no such pro-active work took place in 2021/22, Procurement Fraud remains an area of general focus as part of investigations work.

A report was taken to the January 2022 Audit Committee on the Trust's waiver volume and value during Q1-3. 38 waivers totalling £2.9m had been raised in Q1-3, of which 5 were considered avoidable. The report also provided detail on which suppliers received higher value tender waivers and which suppliers received more than one. This reporting demonstrated an openness to scrutiny of procurement practices. It is noted that the comparative values for waivers raised, value and volume considered avoidable were 64, £4.9m and 21 respectively, indicating an overall improvement in position.

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Trust Board – Part I		**Agenda Item**	14
Report title	Infection Prevention and Control Annual Report 2021-2022		**Meeting Date**	7 September 2022
Presenter	Lorraine Williams, Lead Infection Control Nurse			
Author	Lorraine Williams, Lead Infection Control Nurse			
Responsible Director	Rachael Corser, Chief Nurse		**Approval Date**	22.07.22
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**	☐
	Discussion	☐	**Decision**	☐

Report Summary:

The purpose of this report is to inform and provide assurance to the Trust Board, East and North Hertfordshire Clinical Commissioning Group, patients, public and staff. It provides an overview of the key work at East and North Hertfordshire NHS Trust with regard to infection prevention and control for the reporting period 1 April 2021 to 31 March 2022, and demonstrates the progress made against performance targets and compliance with the Health and Social Care Act 2008 (Reviewed 2010): *Code of Practice for the NHS on the prevention and control of infections and related guidance,* otherwise known as the *"Hygiene Code".*

Please note the appendices noted within the report are available on request.

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

This report will highlight the areas of Trust IPC practice that have positively impacted on patient, public, and staff safety. However, areas such as gram negative bacteraemia, antimicrobial stewardship, and estate issues must continue to improve.

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

Risks are identified within the TIPCC reports embedded within the report, and as such, have been overseen by the correct Trust governance processes and leadership.

Report previously considered by & date(s):

To be reviewed at TIPCC 25.07.22

Recommendation	The Board is asked to discuss the report.

Infection Prevention & Control Annual Report 2021 - 22

1. Executive Summary and Headlines

The purpose of this report is to inform and provide assurance to the Trust Board, East and North Hertfordshire Clinical Commissioning Group, patients, public and staff. It provides an overview of the key work at East and North Hertfordshire NHS Trust with regard to infection prevention and control for the reporting period 1 April 2021 to 31 March 2022, and demonstrates the progress made against performance targets and compliance with the Health and Social Care Act 2008 (Reviewed 2010): *Code of Practice for the NHS on the prevention and control of infections and related guidance,* otherwise known as the *"Hygiene Code".*

The Trust has experienced a year in which infection prevention and control (IPC) policies and practices have continued to be greatly influenced by the COVID19 global pandemic, which has impacted on all aspects of the health and social care system. However, through robust adherence to the key principles and requirements of the Hygiene Code, national and local guidelines and polices, and new and immerging guidance and science, the East and North Hertfordshire NHS Trust (ENHT) has provided increasingly safe IPC care through changing and adapting IPC practices wherever needed; despite an ever-changing environment. This has increasingly positively impacted the quality and safety of services for patients, and staff environments. This report will give the key highlights of the areas of the care environment related to IPC practice, followed by a more in depth review.

The Trust has declared compliance with the Hygiene Code and continues to be registered with the CQC, without conditions, across all sites.

The Trust continues to regard patient safety in relation to the prevention of Health Care Associated Infections (HCAI) as a key priority for the organisation.

	Headlines and key achievements
1	**<u>Covid-19 pandemic</u>** The Infection Prevention and Control team (IPCT) provided support to the Trust in all aspects of its infection prevention and control (IPC) statutory requirements and obligations. However, the financial year (FY) 2021-2022 that is; 1st April 2021 – 31st March 2022, continued to see a focus on the global SARS-CoV-2 pandemic alongside other pathogenic organisms, such as: Monkeypox, as well as other more familiar pathogenic organisms. IPCT supported the Trust in the implementation of the Public Health England (PHE), now the United Kingdom Health Security Agency (UKHSA), and The National Health Service England/Improvement (NHSE/I) guidance released throughout the year. This enabled the safe management of the Coronavirus infectious disease (COVID-19) suspected and positive patients, safety of visitors, members of the public, and the safe working of the staff at the Trust. In order to give assurance to the Board regarding IPC practices during the SARS-CoV-2 pandemic throughout the FY 2021-2022, Trusts have been required to utilise and complete a quarterly Board Assurance Framework (BAF). This document has been completed collaboratively by the East and North Hertfordshire NHS Trust (ENHT) with support from the IPC, Divisional, and Services leadership, and Trust Governance teams. These documents have continued to be central to directing, strengthening, and addressing Trust guidance and practice; providing the assurance required in the fast-paced and ever-changing environment of the pandemic.

For the completed BAFs FY 2021-2022 and NHS Gap Analysis please see the following appendices:

Appendix 1 – IPC board assurance framework – Spring/Summer
Appendix 2 – IPC board assurance framework – December 2021
Appendix 3 – Learning from NHS England and NHS Improvement – Quality improvement project gap analysis 2021

COVID-19 Guidance and Policy

NHSE/I and UKHSA guidance were reviewed temporaneously by the IPCT, Clinicians, and non-clinical experts. Trust proposals were presented to, and discussed at, the Specialist Advisory Group (SAG) chaired by the Director of IPC (DIPC), which met through the year. Recommendations were approved through the Gold management structure, which has remained beyond the FY 2021-2022.

Approved Trust guidance and policies were disseminated appropriately through relevant management structures, such as: The Silver and Bronze "Command and Control' groups (established in response to the incident management declared by the Department of Health and Social Care in 2020), and communicated via various platforms, formal and informal, including the Trust Gold Bulletin, the In Brief communications, Leadership Briefings, and All Staff Briefings.

April 2021 saw the implementation of the **'COVID-19: management of staff and exposed patients or residents in health and social care settings'** guidance, published in March 2021. Due to operational pressures across the Trust, the Infection Control Doctor (ICD), the Consultant Microbiologists, Deputy Director of IPC (Deputy DIPC), members of the IPCT, and Respiratory Consultant formulated the below Trust-wide guidance regarding testing and de-escalation of IPC practices for COVID-19 positive patients, as the majority of patients with COVID-19 infection were recognised as no longer infectious after 7 days. However, it was acknowledged that patients who were immunocompromised or patients with more severe disease, often shed the virus for longer, therefore, theses patient were excluded from the changes.

The UKHSA '**COVID-19 Guidance for maintaining services within health and care settings'** IPC recommendations below was published in June 2021 and reviewed by SAG and implemented across the Trust in its entirety. In response, the Deputy DIPC, IPC Deputy Lead Nurse, and the IPCT, along with the Nursing & Pathway to Excellence Project Manager, devised the Trust COVID-19 Care Plan below. The innovative COVID-19 Care Plan was completed for each patient to support their safe placement and the complex swabbing regimes. This supported an increase in patient and staff safety as prompt swabbing and identification of the infectious status was improved, decreasing cross-transmission. This innovation saw the IPCT awarded the prestigious BJN IPC Nurse Silver Award in 2022.

The IPCT reviewed the UKHSA '**Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022'** in December 2021, which enabled the identification of the main areas of focus for the Trust i.e., revisiting the placed based risk assessment, and reviewing and addressing the ventilation throughout the Trust, with a particular focus on clinical areas.

In March 2022, the Trust increased visiting in a carefully considered process, which was supported by the DIPC, ICD, Deputy DIPC, Deputy Chief Nursing Officer (DCNO), IPC Deputy Lead Nurse, SAG, Divisional leads, and Ward managers an others; in order to allow patients to see their friends and family on Mother's Day; despite operational and

infection challenges. This was based on a review of national and local Trust visiting guidance.

See the following appendices:

Appendix 4 – COVID-19 – Guidance for maintaining services within health and care settings
Appendix 5 – Testing and de-escalation of IPC practices for COVID-19 +ve patients
Appendix 6 – ENHT IPC Covid-19 care plan

COVID-19 Data

The Trust began to see COVID-19 positive patients and staff from the beginning of the pandemic and a definition was developed to categorise the acquisition of infection to allow for the identification of those that were nosocomial by UKHSA in May 2020. This definition was used throughout April 2021 – March 2022. (see Table 1 below)

Table 1: mandatory surveillance for nosocomial Covid-19 infection definition

From the 14th May 2020 NHSE/I introduced mandatory surveillance for nosocomial Covid-19 infection using the below four categories	
Community-Onset – First positive specimen date 2 days or less after admission	[<=2]
Hospital-Onset Indeterminate Healthcare-Associated - First positive specimen date 3-7 days after admission	[3-7]
Hospital-Onset Probable Healthcare-Associated - First positive specimen date 8-14 days after admission	[8-14]
Hospital-Onset Definite Healthcare-Associated - First positive specimen date 15 or more days after admission	[>=15]

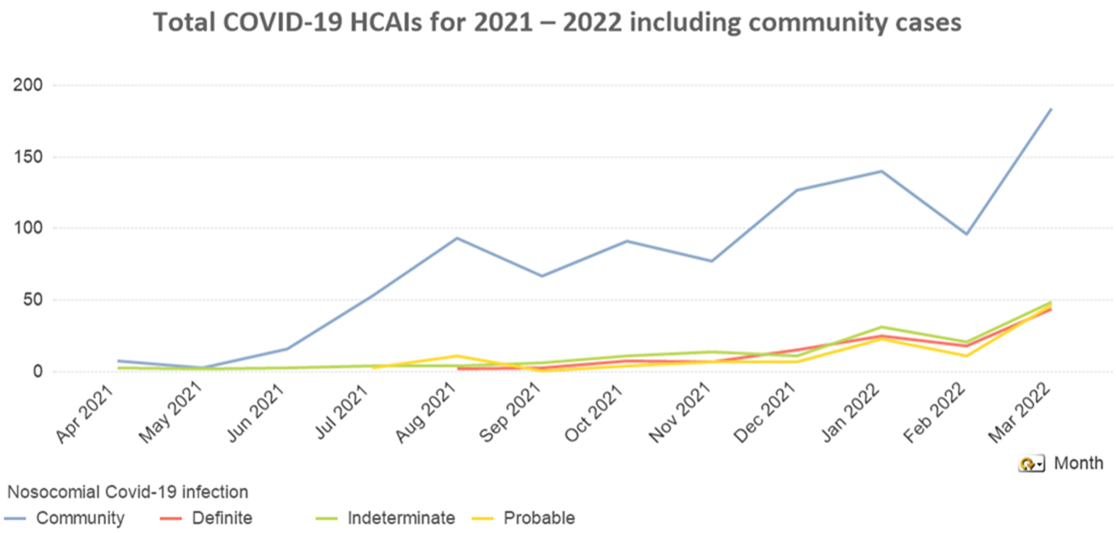
Table 2 shows the total numbers of identified COVID-19 positive patients in the Trust in all four UKHSA defined categories from May 14th, 2020 to the end of the Annual report period.

Table 2: Total numbers of COVID-19 positive patients in all four categories

		2020 - 2021	2021 - 2022
Community-Onset	[<=2]	964	955
HO Indeterminate	[3-7]	159	161
HO Probable	[8-14]	166	114
HO Definite	[>=15]	89	122
	TOTAL	1378	1352

Figure 1 displays the total numbers of identified COVID-19 positive patients in the Trust in all four UKHSA defined categories from May 14th, 2020 to the end of the Annual report period in graphic form.

Figure 1: Total COVID-19 HCAIs for 2021 – 2022 including community cases



The IPCT continued to review all positive COVID-19 patient cases defined as Probable and Definite Healthcare-Associated cases as defined by UKHSA, carrying out post-infection reviews (PIRs) to identify any lapses and/or learning and findings. The cases were discussed at Divisional and Trust IPC meetings to ensure that recommended actions were implemented. The DIPC requested and oversaw that nosocomial COVID-19 definite and probable cases, including those that were part of COVID-19 outbreaks and patients who sadly died with the disease, were presented to the Serious Incident Review Panel (SIRP) to ensure that any lessons learnt could be identified and practice could be improved where needed.

The COVID-19 Outbreak Policy and Standard Operating Procedures (SOP) continued to be utilised to govern the IPC processes and actions in support of the Trust. Multi-disciplinary outbreak meetings were held to support the areas in their management of the outbreaks, to review practices to highlight any gaps, and monitor actions required to provide assurance. Attendance from NHSE/I, UKHSA and CCG colleagues provided further guidance, advice and assurance, with the necessary daily 'IIMARCH' returns, requested by regulators, completed and submitted. The National requirement to provide daily 'IIMARCH' returns ceased in December 2020, and was replaced by an electronic online system database. However, to provide Trust assurance and give oversight of COVID-19 outbreaks the DIPC, ICD, Deputy DIPC and IPC Deputy Lead Nurse made the decision to continue the daily IIMARCH returns internally.

This collaborative approach continued to ensure that system-wide learning occurred throughout the region. This was further strengthened by the continued systems approach with peer reviews of outbreaks, adherence to national guidance, and place-based reviews by East and North Hertfordshire (ENH) NHS Trust, West Hertfordshire (WH) NHS Trust, West Essex (WE) NHS Trust, and the ENHWH&WE CCG, UKHSA, NHSE/I colleagues. This new and additional level of assurance has paved the way for the Integrated Care Systems (ICS) working due to come into force in July 2022.

The successful ENHT placed-based review took place in November 2021 (please see the regulator feedback below), which has been addressed through Trust IPC Committee (TIPCC) and other appropriate governance structures.

See appendix 7 – 2021-22 CCG NHSE visit

The Trust reported 23 COVID-19 outbreaks in 2021 – 2022, which ranged from 2 – 33 cases.

Table 3: outbreak summary 2021 – 2022

Ward	Outbreak declared	Total number of positive patients	Total number of positive staff	Last known positive patient result	Last known positive staff result	If no further positives earliest end date for outbreak (unless agreed patient moves occur) - this is the last day of outbreak.	Comments
Maternity	20/07/21	Probable: 2 **Total 2**	0	01/07/21	N/A	09/08/21	
9A North	23/08/21	Indeterminate: 1 Probable: 10 Definite: 1 **Total 12**	1	27/08/21	27/08/21	24/09/21	
Ashwell	10/09/21	Probable: 2 Definite: 3 **Total 5**	1	07/09/21	01/09/21	05/10/21	
7B South	21/10/21	Indeterminate: 1 Probable: 1 **Total 2**	0	18/10/21	N/A	15/11/21	
7A	12/10/21	Indeterminate: 3 Probable: 1 Definite: 1 **Total 5**	2	17/10/21	25/10/21	23/11/21	
6A South	01/11/21	Indeterminate: 2 Probable: 1 **Total 3**	0	30/10/21	N/A	27/11/21	
5A	01/11/21	Indeterminate: 1 Probable: 3 Definite: 4 **Total 8**	0	07/11/21	N/A	05/12/21	
6A North	10/11/21	Indeterminate: 2 Probable: 1 Definite: 3 **Total 6**	1	10/11/21	16/11/21	14/12/21	
8A North	24/11/21	Indeterminate: 1 Probable: 2 Definite: 2 **Total 5**	0	23/11/21	N/A	21/12/21	

9B South	29/11/21	Probable: 1 Definite: 5 **Total 6**	1	07/12/21	02/12/21	04/01/22	
7A South	20/12/21	Indeterminate: 2 Probable: 1 Definite: 3 **Total 6**	0	19/12/21	N/A	16/01/22	
Barley	04/01/22	Definite: 4 **Total 4**	1	03/01/22	02/01/22	31/01/22	
7B South	30/12/21	Indeterminate: 0 Probable: 3 Definite: 5 **Total 8**	5	05/02/22	10/01/22	05/03/22	
10A North	03/02/22	Indeterminate: 0 Probable: 3 Definite: 2 **Total 5**	2	28/01/22	03/02/22	03/03/22	
SSU	01/02/22	Indeterminate: 4 Probable: 5 Definite: 2 **Total 11**	7	01/02/22	03/02/22	03/03/22	
9B	24/01/22	Indeterminate: 2 Probable: 5 Definite: 4 **Total 11**	1	02/03/22	21/01/22	30/03/22	
St Albans	18/01/22	Indeterminate: 30 **Total 30**	4	21/02/22	21/02/22	21/03/22	
Ashwell	09/02/22	Indeterminate: 2 Probable: 3 Definite: 6 **Total 11**	11	28/02/22	18/02/22	28/03/22	

9A	27/01/22	Indeterminate: 3 Probable: 18 Definite: 12 **Total 33**	3	29/03/22	01/03/22	26/04/22	
5A	31/03/22	Indeterminate: 0 Probable: 4 Definite: 3 **Total 7**	3	22/03/22	01/04/22	29/04/22	
Barley	14/03/22	Indeterminate: 2 Probable: 9 Definite: 12 **Total 23**	3	01/05/22	24/03/22	29/05/22	
7A	10/03/22	Indeterminate: 5 Probable: 5 Definite: 5 **Total 15**	N/A	08/04/22	N/A	06/05/22	
8A North	31/03/22	Indeterminate: 1 Probable: 8 Definite: 1 **Total 10**	N/A	09/04/22	N/A	07/05/22	

Key

Outbreaks closed	
Outbreaks ongoing	
Outbreak to be reviewed	

Below are some of the factors identified as contributing to COVID-19 outbreaks:

Transmission also commonly occurred amongst people who had COVID-19 but were asymptomatic, this was evident in the second wave of the pandemic.

Our learning has identified that emphasising the importance of asymptomatic testing for both staff and patients help to prevent outbreaks and it was also identified the wards and departments where leaders are actively engaged in monitoring the recording of asymptomatic tests and providing friendly reminders, good reporting levels are maintained, this approach is encouraged in meetings and huddles.

In addition to not being able to wear face masks, patients with cognitive impairments were not always able to maintain social distancing, and staff found it challenging to maintain the hand, face and space guidance for these categories of patients.

The Trust followed national guidance around restricted visitors. Visitors were allowed in

certain circumstances and the appropriate policies put in place. However, these put an onus on ward nurses to ensure a particular set of procedures were followed with appropriate risk assessments needing to be undertaken by the ward and relevant checks made. Ward staff also had to manage the timing of these visits although an App was developed to allow these to be booked online.

Throughout the inpatient wards a sign-in sheet was encouraged to ensure anyone entering wards could be traced in the event of an outbreak.

Despite restrictions being in place on visiting to the wards, some patients continued to meet family, friends and other peer patients outside the ward areas and social distancing was not always adhered to. There were also some patients that refused to adhere to the guidance of social distancing despite positive encouragement from staff and notices being put up across the Trust.

The NHS track and trace app decreased the number of available staff on occasions because it 'pinged' staff from in-hospital contacts. In response to the track and trace app notifications, a flow chart was developed to safely keep staff at work where possible if they received a notification. There was a significant decrease in staffing numbers due to illness and self-isolation requirements.

When the measures in public settings started to be relaxed restrictions were reduced, which was different for healthcare settings compared to the general public, it was hard to identify the source of transmissions for staff, as there was an increase in socialising outside of work and patients were allowed visitors.

Possible staff cross-transmission was identified secondary to the inability to socially distance during break times in staff rooms. Following one of the actions from the outbreak IMT, it was advised to observe the placed-based risk assessment recommendations to reduce the risk of possible cross-transmission.

There were occasions when it appeared patients were not clearly informed of the need to isolate after the pre-admission PCR test which may have led to patients arriving on wards with COVID-19.

There were examples of delays in the communication of a positive result both between clinical staff and laboratory staff with ward staff.

It was identified during the investigation that several patients had experienced a delay in their discharge which impacted on their care and in some cases resulted in their status changing from negative to positive. Many of the delays were attributed to the social issues with identifying and securing care packages for patients returning home or to isolation units for those who were positive for Covid-19. One solution to this to speed up the discharge process was the introduction of a virtual ward which allowed for patients to be discharged with support by a virtual clinic GP service.

The Trust the cleaning is undertaken by a contracted company and in May 2021 the contract was taken over by a new provider. Due to the transition of contracts and sickness/self-isolation there was a reduction in staff, which impacted the response time to undertake enhanced cleaning of high-risk areas. Despite arrangements in place for regular and adequate cleaning, shared equipment was not always cleaned between uses.

The Trust acquired eight Redirooms from Gama Healthcare in February 2022, which provided alternative isolation facilities in particular circumstances, in the event that a patient who required urgent isolation where side room were not available. The Redirooms facility includes a canopy with an integral foot operated door, windows with

	optional privacy curtains, a High Efficiency Particulate Air 14 (HEPA) filter delivering 12 air exchanges per hour, with an inbuilt dispenser for gloves, aprons, wipes and alcohol hand rub in the entrance. In comparison, a normal ENHT ward side room has six air exchanges per hour. Deploying a Rediroom around a patient helps to mitigate the risk to co-patients turning positive as the Rediroom reduces particles in the air, which in turn minimises transmission. An outbreak leads to reduced bed capacity due to the necessary closure of beds and bays, however, by utilising the Rediroom, the Trust has minimised the number of unoccupied bed spaces. During February 2022 and March 2022 alone, the Rediroom was been deployed at least 32 times, totalling around 156 days usage. This roughly equates to a saving of over £40,000, assuming that cost of an empty bed is approximately £300 a day.
2	**Embedding IPC in the Trust structures and processes** Divisional IPC committees met throughout the year, although the meeting calendar was adjusted to accommodate Trust needs during the SARS-CoV-2 pandemic. A standardised internal reporting template was introduced for each Division to report to the Trust Infection Prevention & Control Committee (TIPCC), planned to take place on a bi-monthly basis. Please see the following appendices: Appendix 8 – TIPCC minutes – May 2021 Appendix 9 – TIPCC minutes – July 2021 Appendix 10 – TIPCC minutes – September 2021 Appendix 11 – TIPCC minutes – November 2021 Appendix 12 – TIPCC minutes – January 2022
3	**Improving Hand Hygiene** Hand Hygiene compliance remained a key focus throughout 2021 and 2022, transmission via contact is still recognised as the most common cause as a result, hand hygiene competency training was carried out by the IPCT. Hand hygiene audits are also carried out in each area, at least monthly, by staff in each area that have attended training and undergone a competency assessment, to ensure consistency. Hand hygiene compliance WHO Moments 1-5 saw decrease from 91% in April 2020 to 88% in March 2021. However, this is still above the Trust target of 80%.
4	**Antimicrobial Stewardship** In 2021-22 there were no CQUIN targets in relation to Antimicrobial Stewardship, solely due to the COVID-19 pandemic. However, this will be recommenced in 2022-23 with 2 out of 9 schemes focusing on AMS. In 2021-22 there were many challenges to AMS brought about by COVID-19. As the trust resumed normal practice following the peak of the pandemic the antimicrobial team have continued to focus on promoting AMS through education and training of the multidisciplinary clinical team. The annual Point Prevalence audit (PPA) was carried out in November 2021 to assess antimicrobial prescribing in the Trust (refer to section 4.3) and to review our standards of prescribing. Although the trust was unable to meet any of the standards during this audit cycle, an improvement in compliance was observed for standards 2 (100% of antimicrobial prescriptions have the indication documented on the drug chart), 3 (100% of antimicrobial prescriptions have the indication documented in the medical notes) and 5 (90% of antimicrobial prescriptions have a review or stop date documented in the medical notes) in comparison to the last audit cycle. In addition, standard 4 (90% of antimicrobial prescriptions have a review or stop date documented on the drug chart) remained comparable to the previous year. Analysis of Standard 1 (90% of antimicrobial

	prescribing follows the appropriate East and North Hertfordshire NHS Trust Antimicrobial guidelines) and 6 (90% of antimicrobial prescriptions had a documented review including review/stop date between 24-72 hours of initiation) revealed a decrease in compliance compared to 2020 PPA. As the trust resumes usual standards of practice post-pandemic further ward rounds and AMS education and training have resumed, which were previously held, with the aim to improving prescribing standards. The Trust continued monthly monitoring of compliance with review of antibiotics within 72 hrs for inpatients. The 90% compliance target was met between April – July, following which a fall in performance was observed between August – November. Education and training was targeted toward AMS, following this an improvement in compliance was observed between December 2021 - March 2022. During 2021 the Antimicrobial Stewardship pharmacy team structure was reviewed and amended to include a pharmacy technician to support AMS activities within the trust.	
5	**Improving surveillance of infections** The ICNet electronic surveillance system was implemented at the Trust in June 2019 and continues to be used as the main reporting system for microbiology results from the Cambridge University Hospital (CUH) pathology laboratory. This system enables a more timely and robust identification of infections from samples sent for testing, to facilitate a rapid response and reduce opportunities for cross-transmission. It also provides an improved reporting system to support mandatory surveillance, although this function has not yet been thoroughly explored or utilised in the surveillance processes in place during this financial year. ICNet has played an integral part in monitoring SARS-COV-2 cases from the beginning of the pandemic to date. As a result of the continued challenges presented by the unprecedented SARS-COV-2 global pandemic the plan to expand the use of ICNet for antimicrobial resistance monitoring and management and surgical site infection surveillance will take place during 2022 - 2023.	
6	**Control of seasonal winter outbreaks** There were no seasonal winter HCAI outbreak cases recorded. The extensive national and local IPC guidelines, policies, and mitigation measures implemented in 2021 – 2022 due to the SARS-COV-2 global pandemic (hand hygiene, PPE, and social distancing) helped. The national influenza vaccination programme contributed to the reduction of the number of seasonal winter outbreaks. There were three patients identified as positive for Influenza A or Influenza B during the period 01.09.21 to 31.03.22 (the winter period) and a total of 12 patients was identified as positive for Norovirus during the period from 01.06.21 - 31.03.22, with no outbreaks. This is remarkably lower compared with the same period in 2018-19 when there were 55 cases, and six outbreaks.	
7	**Lister Site**  **Reasonable Assurance** **Satellite**	**Water Safety** • A Responsible Person has not been appointed, this is a requirement of the HSE Approved Code of Practice, L8. • Policy in place with Water Safety Plan procedures currently being drafted. • An Authorising Engineer [Water] and an Authorised Person [Water] have been appointed. • A second Authorised Person [Water] has been assessed and

	Premises  **Limited Assurance**	recommended for appointment. • Competent Persons training has been completed in readiness for formal appointments. • Water Safety Group & operational sub-groups established. • Water safety risk assessments are up to date. • Control schemes documented at all Trust sites. • The programme of planned maintenance & monitoring at Lister Hospital is ongoing and up to date and demonstrates high levels of compliance with the control scheme. • The Trust has some very old water distribution infrastructure. A risk-based plan is required for future replacement & upgrades. • Work continues to engage with our colleagues & partners at each of the satellite premises to provide assurance that the relevant processes & procedures are in place for water safety. **Ventilation**
	Lister Site  **Limited Assurance** **Satellite Premises** To be confirmed	• There is a policy & limited procedure in place. These require updating. • An Authorising Engineer [Ventilation] and an Authorised Person [Ventilation] have been appointed. • Competent Persons training has been completed in readiness for formal appointments. • Ventilation Safety Group [VSG] meetings have been scheduled. • Critical ventilation systems are verified annually; inspection findings are reported to the VSG. • The Trust has some very old assets/AHU in poor condition. A risk-based plan is required for future replacement & upgrades. • The programme of planned maintenance of ventilation systems is ongoing and up to date. • Satellite premises have not been assessed separately from the Lister site at this time.
	Lister Site  **Limited Assurance** **Satellite Premises** To be confirmed	**Decontamination** • The position of “Decontamination Lead” for the Trust remains un-appointed, this is a requirement under the Department of Health HTM [Health Technical Memoranda] series guidance. • The Trust Decontamination Policy requires review. This should include a full review of roles & responsibilities. • An Authorising Engineer [Decontamination] has been appointed. • A Trust Decontamination Group [TDG] has been set up and the inaugural meeting was held 11 May 2021. A Terms of Reference has been drafted and submitted for consultation.

		• A Decontamination Estates Manager role has been employed to undertake the Authorised Person [Decontamination] duties, however this role has yet to be formally appointed by the AE[D]. • Initial AP[D] training has started and due for completion September 2022. • The AE[D] has completed an audit / gap analysis which identified opportunities for improvement. An action plan is to be developed to address these items. • The AE[D] has completed the JAG IHEEM audit for endoscope decontamination facilities, which identified the lack of a permit to work system. A permit-to-work system has been devised and an SOP drafted and submitted to the TDG for approval. • Satellite premises have not been assessed separately from the Lister site at this time.

8 **Surgical Site Infection (SSI)**

There have been zero SSIs over the last 4 periods April 2021 – March 2022 in all three categories monitored (Total Knee Replacement (TKR), Total Hip Replacement (THR) & Repair of Fractured Neck of Femur (NOF), compared to the 2014 - 2019 figures. This is remarkable, as the Trust has never achieved zero SSIs for a whole year running (4 periods) since the Trust started the surveillance reporting.

The table below shows performance for April 2020 – March 2021 alongside April 2021 – March 2022.

Table 4: Surgical site infection rates

Category of surgery	National benchmark	ENHT Jan 20 – Dec 20	ENHT April 21 – March 22
Total Knee Replacement (TKR)	**0.5%**	**0.6%**	**0.0%**
Total Hip Replacement (THR)	**0.6%**	**0.9%**	**0.0%**
Repair Neck of Femur Fracture (NoF)	**1.1%**	**1.0%**	**0.0%**

This has been achieved by the DIPC, Deputy DIPC and the Trauma and Orthopaedic Surgeon Consultant implementing a new process where the data is reviewed by the Orthopaedic surgical leads and the orthopaedic teams. This has strengthened the process of monitoring patients, surveillance and supporting to improve the outcome.

A new position of Enhanced Recovery Nurse is being explored and they will play a vital role in enabling patients to contact a medical professional who is comfortable reviewing wounds, rather than having to attend their Primary Care Practitioner.

9 **MRSA bacteraemia**

The Trust continues to report Zero cases of Trust allocated MRSA bacteraemia in FY

	2021-2022 for 25 consecutive months. Improvement groups, which were established prior to the COVID-19 pandemic to focus on local aseptic technique continued but were inhibited by the pandemic. Clinical Practice Facilitators and Educators across the Trust continued to lead improvements throughout April 2021 – March 2022. This has been further strengthened with involvement in national, multiagency improvement work on vascular access devices, with the Device Related Infection Prevention Practice (DRIPP) group.
10	***Clostridioides difficile*** The Trust has reported 65 healthcare associated cases (COHA/HOHA) in 2021 - 2022. This number is above the Trust ceiling target of 52 for 2021-22, however following the appeals process conducted with the CCG, 16 cases were appealed bringing down the Trust's overall total to 49. Despite the increase in incidence, the ribotyping process continues to demonstrate that there is no cross transmission thus far. UKHSA HCAI DCS team have agreed for the Trust to delete all cases which were successfully appealed In April 2021 – March 2022.
	Gram negative and positive bacteraemia In May 2021 UKHSA HCAI DCS apportionment categorisation changed to include Community onset healthcare associated cases for all reportable gram negative and positive bacteraemia, which will increase the total numbers attributed to the Trust
	IPC highlights The Trust IPCT held their first virtual IPC day in April 2021 via Microsoft Teams. There was an amazing breath of knowledge displayed through the experts who presented. Peter Carter (OBE and IPC Non-Executive Director) opened the proceedings and gave a vote of thanks to all staff, on behalf of the board for their outstanding work during the COVID-19 pandemic. Presentations were made by Dr Saba Qaiser (Infection Control Doctor), Lorraine Williams (Lead Infection Prevention and Control Nurse), Professor Jennie Wilson (President of the Infection Prevention Society and Senior University Lecturer), Mae Cometa (Deputy Lead Infection Prevention and Control Nurse) Steve Andrews (Associate Director for Leadership and Change), Rachael Corser (Chief Nurse and Director for Infection, Prevention and Control). An expert panel was joined by Dr Alex Wilkinson, Respiratory Consultant and Clinical Lead for Respiratory infection and TB with the Trust. The Trust IPC day event was a huge success, which saw over 220 attendees. The Trust IPC team also hosted the first (soon to be) Integrated Care System (ICS) Stronger Together IPC Link Practitioner and Champions day webinar event, which was delivered partnership with the Trusts neighbouring acute Trusts and CCG: West Hertfordshire Hospital, Princess Alexandra Hospital, and IPC NHS Herts Valleys, East & North Hertfordshire and West Essex Clinical Commissioning Group. An amazing 150 plus attendees joined the Stronger Together IPC webinar in November 2021, which gave the ICS an incredible opportunity to learn from experts such as: Dr Rowan Myron, Associate Professor of Healthcare Management at the University of West London, Dr Lynne Williams, Head of School Medical and Health Sciences, Julie Fraser from NHS England and NHS Improvement, Julie Fraser from NHS England and NHS Improvement, Chris Brooks Area Manager from Gama Healthcare, Dr Alex Wilkinson, ENHT Clinical Lead for Respiratory infection and TB, and Phil Lonsdale ENHT Decontamination and Water Safety Manager to help improve patient safety. The Deputy Director of IPC supported the Covid-19 vaccination as a condition of deployment (VCOD) in January by reaching out to Dr Donald Palmer an Associate Professor of Immunology, and an Honorary Senior Lecturer in Immunology at Imperial

	College London who delivered a well-received webinar in support of our unvaccinated staff. As Dr Donald Palmer is from a BME background he was able to address cultural issues raised in previous Trust webinar Q&As. The IPC team was recognised with a Silver award in the annual British Journal of Nursing awards (BJN) in March 2022 for producing a COVID-19 Care Plan to support the staff operationally and the safety of patients. The award, which is supported by the Infection Prevention Society, recognises the vital contribution nurses and teams make to infection prevention in healthcare through innovation, evidence-based practice, and vigilance in the workplace.
	<u>Key aims and challenges for 2022 – 2023</u> The past year's key aims, and challenges have been supported by the audit plan 2021 – 2022 please see appendix 13 – IPC audit programme 2021 – January - December **Trust IPC Annual Strategy 2022 -2023** See appendix 14 – IPC annual strategy 2022-23 This will be supported by the IPC annual audit programme 2022 -2023. See appendix 15 – IPC audit programme 2022-23 **ICS IPC five-year strategy** ICS IPC five-year strategy to follow once agreed.

2. Compliance with the Health and Social Care Act 2010

The Care Quality Commission (CQC) has used the Code of Practice as a key feature of registration. Failure to observe the Code may either result in an improvement notice being issued to the Trust by the CQC following an inspection, or in it being reported for significant failings and placed on "special measures". All NHS organisations must be able to demonstrate that they are complying with the Code. The Trust's Quality & Safety Committee and Board have continued to receive monthly reports on Infection Control performance and compliance during the reporting year.

3. Compliance with Criterion 1: a- Systems to manage and monitor the prevention and control of infection

Infection prevention and control (IPC) is the responsibility of everyone in the organisation. Key roles and arrangements are detailed below:

3.1 Infection Prevention and Control Structure

The Chief Executive Officer has overall responsibility for the control of infection within East and North Hertfordshire NHS Trust.

3.1.1 Non-Executive Director

Peter Carter the Non-Executive Director is an active member of the Trust Infection Prevention & Control Committee who supports and contributes to the work of the Committee and the Infection Prevention and Control agenda.

3.2 Senior IPC Management Team

The senior IPC management team meets regularly to discuss activity and issues. The senior team comprises the Director of Infection Prevention and Control (DIPC), the Infection Control Doctor (ICD), Deputy Director of Infection Prevention and Control (Deputy DIPC), and the Antimicrobial Pharmacist.

3.2.1 The Director of Infection Prevention and Control (DIPC)

The DIPC role is held by the Director of Nursing and is the Executive Lead for the IPC service, reporting directly to the Chief Executive. The role includes:

- Overseeing implementation of the IPC plan as Chair of the Trust Infection Prevention and Control Committee (TIPCC)
- Approving the Annual IPC report for public release.
- Authority to challenge inappropriate practice

3.2.2 The Infection Control Doctor (ICD)

The ICD is the Clinical Lead for the IPC service, reporting to the DIPC on IPC matters. The role includes:

- Advising and supporting the DIPC
- Overseeing local IPC policies and their implementation by ensuring that adequate laboratory support is in place
- A member of the Water Safety Group
- Supervising IPC education for doctors and delivering mandatory training lectures
- Providing expert clinical advice on infection management
- Producing, together with the IPC Lead Nurse, the annual IPC report
- Authority to challenge inappropriate practice including inappropriate antibiotic prescribing decisions.

3.2.3 Deputy Director of Infection Prevention and Control (Deputy DIPC)

The Deputy DIPC reports directly to the DIPC and works with the ICD. The role includes:

- Advising and supporting the DIPC and the ICD
- Chairing the TIPCC meetings in the absence of the DIPC
- Chairing the Water Safety Group
- Deputising for the DIPC in her absence
- Advising the Divisional IPC Committees which meet monthly and report to the TIPCC and Divisional Boards
- Supporting the Trust Decontamination service
- Responsible for identifying and supporting IPC training for all Trust staff
- Ensuring that all policies and guidelines related to infection prevention are valid and implemented across the service.

- Managing the infection control nurses' service level agreement with one external hospice
- Producing together with the DIPC and the ICD, the IPC Strategy, Annual Plan including the Audit Programme and the Annual IPC Report.
- Overall line management of the IPC Team

3.3 The Infection Prevention and Control Team

In 2021-22 the team consisted of:

April 2021 – September 2021	COVID - 19 Support
1.0 WTE IPC Deputy Director (Band 8C) 1.0 WTE IPC Deputy Lead Nurse (Band 8A) 2.0 WTE IPC Nurse (Band 6) 1.0 WTE IPC Data Coordinator/PA (Band 5) 1.0 WTE IPC Clinical Assistant (Band 4) 0.4 WTE IPC Clinical Assistant (Band 4) 0.5 WTE IPC Admin Assistant (Band4)	1.0 WTE IPC Clinical Assistant (Band 4) (From June 2020 to August 2021) 1.0 WTE IPC PPE Coordinator (Band 4) (From December to Present)
September 2021 – March 2022	
2.0 WTE IPC Deputy Director (Band 8C) 1.0 WTE IPC Deputy Lead Nurse (Band 8A) 2.0 WTE IPC Nurse (Band 6) 0.6 WTE IPC Nurse (Band 6) 1.0 WTE IPC Data Coordinator/PA (Band 5) 2.0 WTE IPC Clinical Assistant (Band 4) 0.4 WTE IPC Clinical Assistant (Band 4) 0.5 WTE IPC Admin Assistant (Band4)	

3.4 The Consultant Microbiologists

In addition to the Infection Control Doctor, the Trust employs two more consultant medical microbiologists (CMMs) who play an active role in IPC. There is cover 24 hours a day, 7 days a week provided by a CMM for clinical microbiology/Infection control.

3.5 The Antimicrobial Pharmacist

The Trust employs an Antimicrobial Pharmacist and 0.5 x Antimicrobial Technician who works closely with the ICD and other members of the IPC team. There is robust management of antimicrobial stewardship throughout the Trust. The Antimicrobial Pharmacist is secretary of the Trust Antimicrobial Forum (TAF), a sub-committee of the New Drugs and Formulary Committee.

The role of the Antimicrobial Pharmacy team also includes:

- Attending and contributing to the Trust Infection Prevention and Control Committee meetings and joint Infection Prevention and Control meetings (with the ICD/CMMs and IPC Team)
- Supporting antimicrobial stewardship initiatives by working closely with the ICD and the CMMs
- Joining and contributing to Antimicrobial Ward Rounds with the CMMs
- Carrying out audits in line with national guidance

- Providing multidisciplinary education and training regarding antimicrobial stewardship to clinical staff within the Trust
- Supporting the IPC with PIR processes for C.*difficile* and bacteraemias.
- Leading on antimicrobial related CQUINs and Cost Improvement Projects for the trust.
- Reviewing incidents occurring at the trust and leading on quality improvement projects to promote antimicrobial stewardship throughout the Trust.

3.6 The Trust Infection Prevention and Control Committee (TIPCC)

The committee is chaired by the DIPC and reports to the Trust Board via the Quality & Safety Committee. Membership of TIPCC includes the ICD, Medical and Nursing leads from all divisions, the local Consultant for Communicable Disease Control (or representative), the Infection Prevention and Control Nurse from the CCG, a Health at Work representative, the Clinical Governance officer, Head of Estates and Facilities, Decontamination representative, education representative, and the antimicrobial pharmacist.

4. Compliance with Criterion 1: b- Monitoring the prevention and control of infection

4.1 Mandatory Surveillance

Mandatory surveillance is carried out for MRSA, MSSA and Gram negative bacteraemia cases (*E.coli*, *Pseudomonas aeruginosa* and *Klebsiella*), cases of *Clostridioides difficile* infection and surgical site infection in elective total hip and knee replacement and fractured neck of femur surgery – see below for further details.

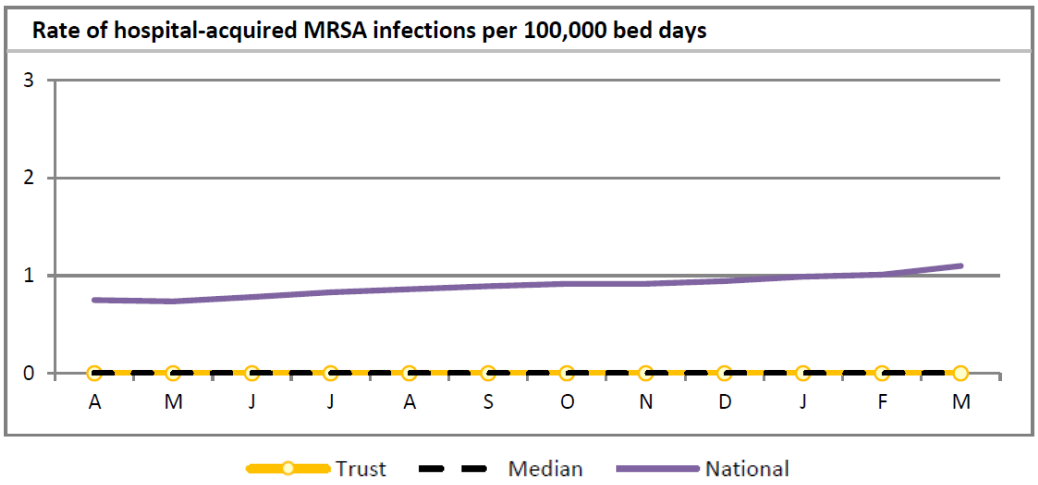
In May 2021 UKHSA Healthcare Associated Infections (HCAI) DCS apportionment categorisation changed to include Community onset healthcare associated cases for all reportable gram negative and positive bacteraemia's (*E.coli*, Pseudomonas aeruginosa and Klebsiella, MRSA, and MSSA), which contributed to the increase in HCAI cases across all gram negative and positive bacteraemia (please see below table).

Table 5: Gram negative and positive bacteraemia UKHAS HCAI DCS apportionment categorisation table

Apportionment category	Abbreviation	Definition
Hospital onset healthcare associated (counts towards Trust objectives)	HOHA	Specimen date is ≥3 days after the current admission date (where day of admission is day 1)
Community onset healthcare associated (counts towards Trust objectives)	COHA	Is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date)
Community onset community associated	COCA	For C. difficile: Is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 84 days prior to the specimen date (where day 1 is the specimen date) For bacteraemias: Is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 28 days prior to the specimen date (where day 1 is the specimen date)

4.1.1 MRSA blood stream infections (BSI)

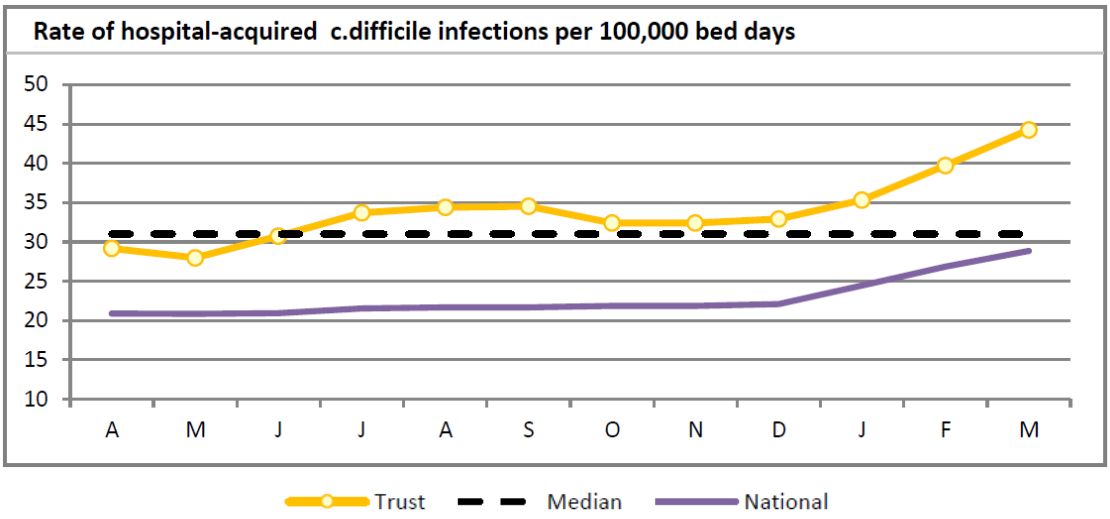
Isolates of MRSA (Meticillin Resistant *Staphylococcus Aureus*) from blood cultures have been reported since 2002; enhanced reporting using the Public Health England (PHE) MRSA Data Capture System began in 2006.



The Trust reported a total of zero MRSA bacteraemia's for April 2021- March 2022 for the second time running since 2015-2016, which is in line with the Trust ceiling target of zero. This sustained improvement is a result of collaborative efforts to identify areas of learning regarding Aseptic Non-Touch Technique (ANTT) practices and vascular access. Involvement in national improvement work has also positively impacted Trust bacteraemia's.

4.1.2 *Clostridioides difficile*-associated disease (CDAD)

Clostridioides difficile is a type of bacterium found in the gut that can cause diarrhoea in certain circumstances. It can cause a spectrum of symptoms from mild disease to severe colitis.



The Trust has reported 65 healthcare associated cases (COHA/HOHA) in 2021 - 2022. This number is above the Trust ceiling target of 52 for 2021-22, however following the appeals process conducted with the CCG, 16 cases were appealed bringing down the Trust's overall total to 49.

Following every case of Trust-associated C. difficile infection (CDI), a post infection review (PIR) is completed to identify any learning and actions to reduce the likelihood of further cases. The PIR is attended by relevant clinical teams, including involvement by the patient's Consultant or a representative from the treating team as well as the nursing team.

Learning was identified from the PIR process these included:

1. Delays in sending sampling:

- Inability to collect samples soaked in the pads
- Patient was on laxatives (need to wait 48 hours)
- Patient was thought to have overflow rather than CDI

2. Delays in isolation:

- Unavailability of side rooms (ward encouraged to datix these incidences)
- Trust policy is to isolate within 2 hours
- Isolate within 2 hours from identification of loose stools

3. Incomplete stool chart

4. Antimicrobial stewardship:

- Start of treatment has been delayed due to medicine not ward stock or drug not given until drug round
- CDI med not given but reason not documented
- PPIs and other antimicrobials not correctly reviewed

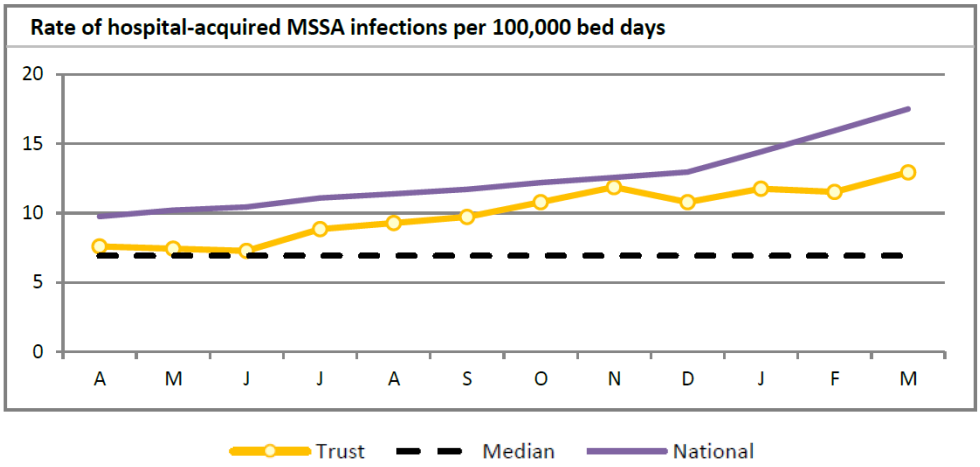
5. Communication challenges:

- Documentation not appropriately completed

Action plans have been developed by the ward teams including the treating clinicians in order to support the learning and ensure it is embedded. The learnings are being discussed in the monthly Divisional IP&C meetings to increase awareness. The Trust has recently embarked into employing electronic prescribing which is helpful in ensuring antimicrobials are prescribed and reviewed appropriately. Environmental clean of any case of CDI either antigen or toxin positive are being done using hydrogen peroxide vapor (HPV) fogging once side room is vacated and enhance clean is done daily. Commodes are being disinfected using actichlor solution all throughout the Trust. The IP&C team continues to do several audits to ensure we are keeping our environment safe to prevent cross-transmission or acquisition of any healthcare associated infections. Examples are: environment audit, isolation facilities, commode cleaning and hand hygiene & glove use. Moreover, the IPC team have continued with weekly CDI ward rounds despite the pandemic and the MDT rounds will restart soon to provide support for the wards where CDIs have occurred.

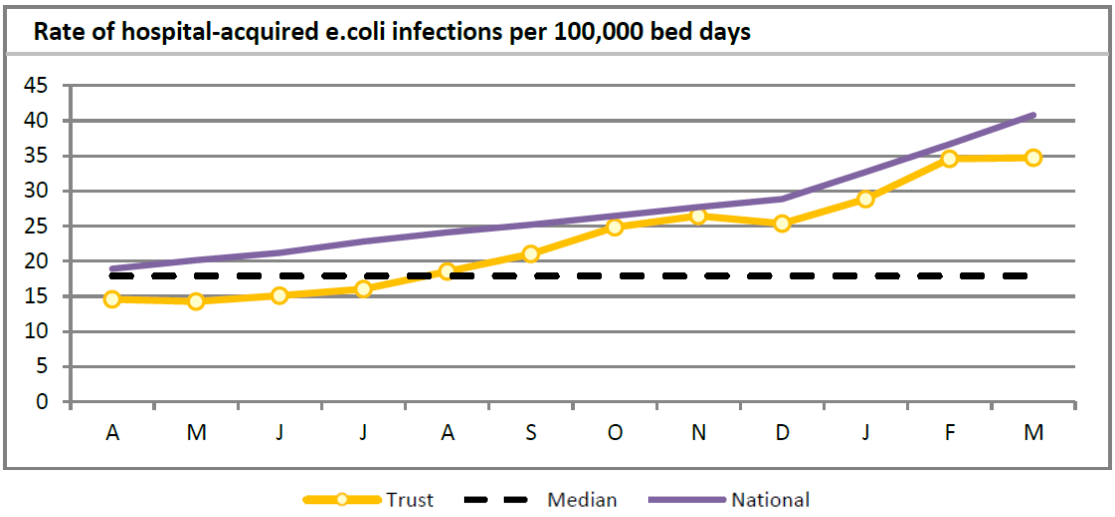
As a result of excellent engagement from the Trust Clinical teams the DIPC, Deputy DIPC and ICD agreed with Lynn Stewart the Associate Director of Infection Prevention & Control Hertfordshire and West Essex Integrated Care Board, that the PIR process would be chiefly an internal one.

4.1.3 Gram negative bacteraemia



The Trust reported a total of 18 MSSA HCAIs for April 2021- March 2022, no target has been set for MSSA, therefore is non-applicable.

This was achieved by created awareness through the Trust IPC day, Safer Sharps day, Hand Hygiene day, aseptic non-touch technique training, working with Unplanned Care and Planned care, and attending local divisional monthly IPC meetings.

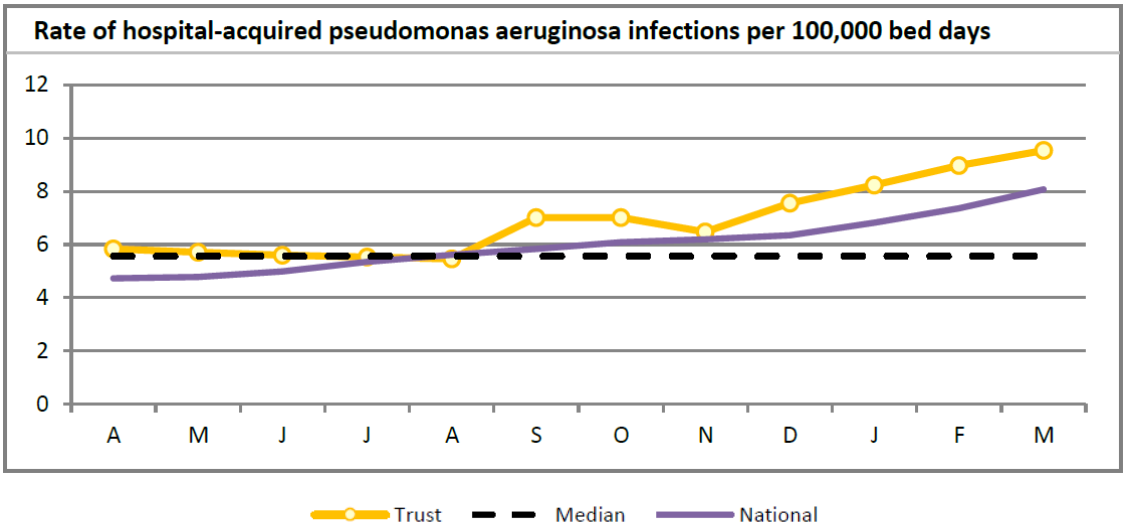


The Trust reported a total of 51 E.coli HCAIs for April 2021- March 2022, which is below the Trust ceiling target of 120 HCAIs April 2021- March 2022.

Due to the pressures of the pandemic in the last two years, it has been more challenging to get medical representation to attend the E.coli post infections reviews (PIRs).

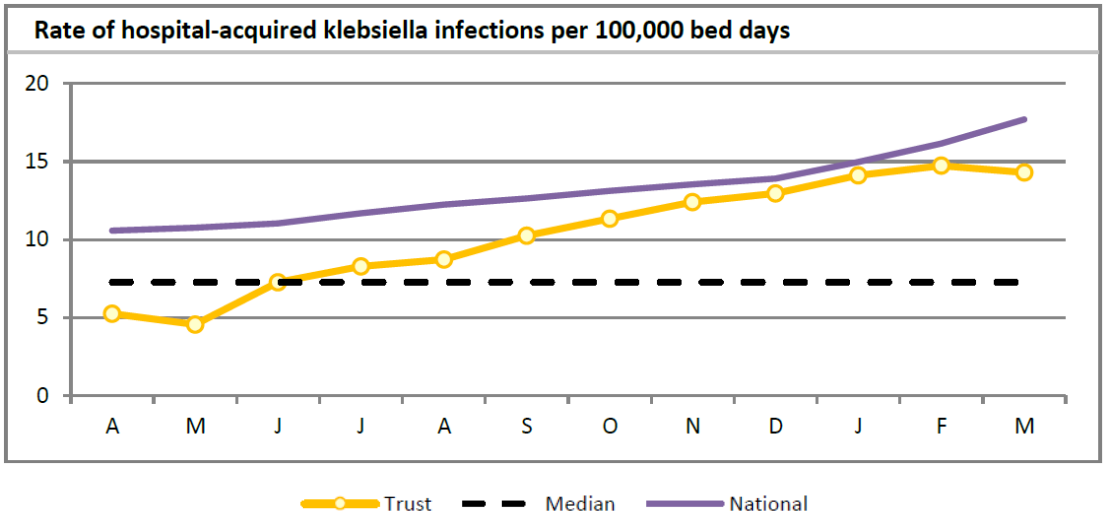
The PIRs will recommence and take place routinely throughout April 2022 – March 2023 with the clinical team including the treating clinician along with the Consultant microbiologist, antimicrobial pharmacist, and the IP&C Nurse representatives, Vascular nurse specialist as well as the Urology nurse practitioner to be part of the panel.

Due to the success in the reduction of hospital-acquired E.coli BSIs, the target for 2021-2022 of 120 hospital-acquired E.coli BSIs has been reduced this year 2022-2023 to 46.



The Trust reported a total of 14 Pseudomonas aeruginosa HCAIs for April 2021- March 2022, which is below the Trust ceiling target of 15 HCAIs April 2021- March 2022.

This was achieved by created awareness through the Trust IPC day, Safer Sharps day, Hand Hygiene day, aseptic non-touch technique training, working with Unplanned Care and Planned care, and attending local divisional monthly IPC meetings.



The Trust reported a total of 21 Klebsiella HCAIs for April 2021- March 2022, which is below the Trust ceiling target of 34 HCAIs April 2021- March 2022.

This was achieved by created awareness through the Trust IPC day, Safer Sharps day, Hand Hygiene day, aseptic non-touch technique training, working with Unplanned Care and Planned care, and attending local divisional monthly IPC meetings.

4.1.4 Trust HCAIs Thresholds

East and North Hertfordshire NHS Trust HCAIs summary 2021-2022/ HCAIs thresholds for 2022-2023

Organism	Threshold number	Actual number	2022 -2023 Threshold number
C.difficile	52	49	59
***MRSA**	0	0	0
E.coli	120	51	46
***MSSA**	N/A	18	N/A
Pseudomonas aeruginosa	15	14	11
Klebsiella	34	21	22

4.2 Incidents related to infections (including outbreaks)

No non COVID 19 outbreaks were identified in 2022 - 21

4.2.1 Carbapenemase producing organisms (CPO)

There were zero hospital-acquired carbapenemase producing organisms identified in April 2021 – March 2022

Carbapenems are a class of broad-spectrum intravenous antibiotics reserved for serious infections or when other therapeutic options have failed. One of the most concerning groups of Carbapenem Resistant *Enterobacteriaceae* (CRE) are those organisms which carry a carbapenemase enzyme that breaks down carbapenem antibiotics. This type of organism is called Carbapenemase Producing *Enterobacteriaceae* or Organism (CPE/CPO) and it has caused most outbreaks worldwide.

Patients who have tested positive for CPO are treated as positive on all subsequent visits and care episodes, requiring isolation in a side room and appropriate IPC precautions, as there is some uncertainty regarding the mechanisms and disease process. Several incidents of previously known CPO positive patients being readmitted to open bays were identified prior to the introduction of the ICNet electronic surveillance system in June 2019. The ICNet system has now been configured to enable prompt identification and isolation of readmitted patients previously identified as positive for CPO.

4.2.2 Norovirus/ Influenza Outbreaks

There were no seasonal winter HCAI outbreak cases recorded for a second year running since 2018-2019. The extensive national and local IPC guidelines, policies, and mitigation measures implemented in 2021 – 2022 due to the SARS-COV-2 global pandemic (hand hygiene, PPE, and social distancing) helped. The national influenza vaccination programme contributed to the reduction of the number of seasonal winter outbreaks.

There were three patients identified as positive for Influenza A or Influenza B during the period 01.09.21 to 31.03.22 (the winter period) and a total of 12 patients was identified as positive for Norovirus during the period from 01.06.21 - 31.03.22, with no outbreaks. This is remarkably lower compared with the same period in 2018-19 when there were 55 cases, and six outbreaks.

4.2.3 MRSA colonisation

No incidences of MRSA colonisation transmission were identified in 2021-22.

4.3 Antimicrobial stewardship

Point Prevalence Audit- carried out in November 2021

The antimicrobial point prevalence audit is usually carried out annually by the Trust to ensure compliance with PHE guidance which includes adherence to Trust guidelines for antimicrobial prescribing, documented indication in both notes and drug chart, and documentation in both notes and drug chart of 24-72 hour review/stop date.

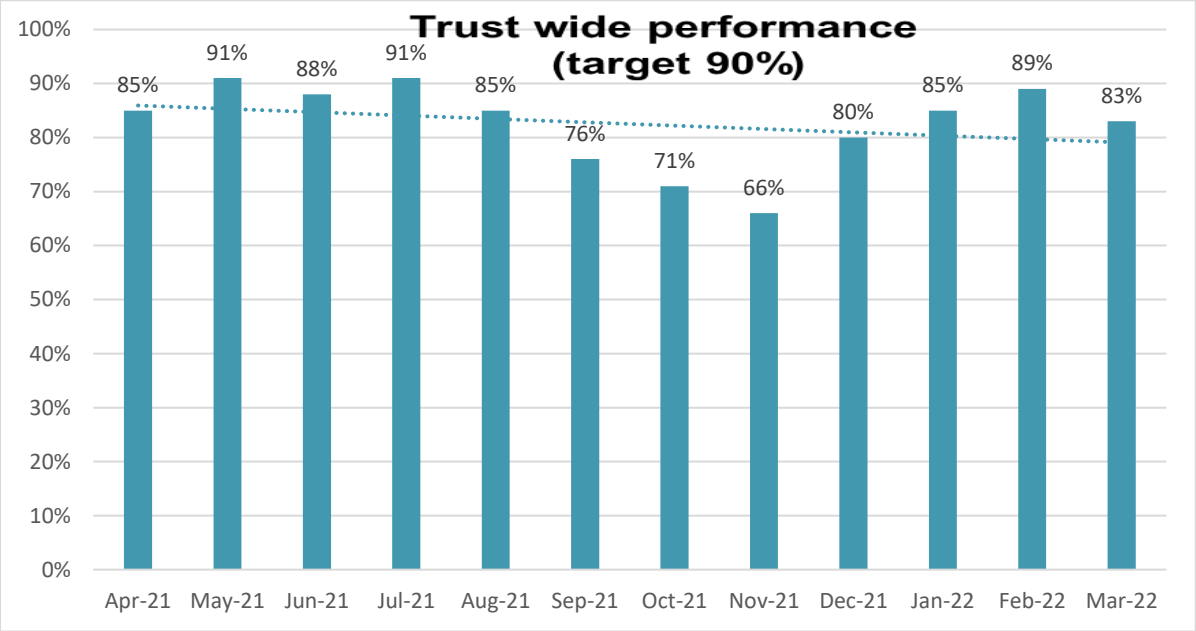
As part of both patient safety and optimisation of antimicrobials, the audit also recorded the documentation of allergy status and reactions on both the front page of the drug chart, and the antimicrobial prescription page. Additionally, the audit recorded data on the number of patients concurrently prescribed a proton pump inhibitor (PPI) with an antimicrobial agent as co-prescription has been identified as a risk factor for Clostridium *difficile.*

Table 1: Overview of standards' compliance rates and additional information gathered across the different divisions in the Trust. For the standards - "compliance with guidelines", "stop/review date on drug chart", "stop/review date on medical notes" an and "24-72 hours review" – the compliance was deemed not achieved <75% (Red), nearly achieved 75-89% (Amber), and achieved 90 -100% (Green). For the standards – "Indication on drug chart" and "Indication in medical notes" – compliance was considered not achieved if <90% (Red), nearly achieved 90-99% (Amber) and achieved if 100% (Green).

	Trust		Planned	Unplanned	Women	Children
	2021	2020				
Patients audited	540	432	172	324	21	23
Patients on antimicrobials	240	160	81	140	9	10
Number of antimicrobial prescriptions	306	207	102	179	9	16
Standard 1 (90%): Compliance with guidelines %	80.1% (245)	90.3%	88.2% (90)	73.7% (132)	88.9% (8)	93.8% (15)
Restricted antimicrobials prescribed %	17% (52)		14.7% (15)	18.4% (33)	0	25% (4)
Discussed with micro %	17.3% (53)	28.2%	11.8% (12)	22.9% (41)	0	0
Standard 2 (100%): Indication on drug chart %	85% (260)	84.4%	83.3% (85)	86% (154)	77.8% (7)	87.5% (14)
Standard 3 (100%): Indication in medical notes %	88.9% (272)	88.6%	91.2% (93)	87.7% (157)	66.7% (6)	100% (16)
Standard 4 (90%): Stop/review date on drug chart %	43.7% (134)	49.0%	43.1% (44)	47.5% (85)	55.6% (5)	0
Standard 5 (90%): Stop/review date in medical notes %	46.7% (143)	45.9%	48% (49)	45.8% (82)	44.4% (4)	50% (8)
Prescriptions more than 7 days %	15.4% (47)	14.8%	13.7% (14)	17.9% (32)	11.1% (1)	0
Standard 6 (90%): 24–72-hour review %	66% (126)	82.9%	67.8% (40) 43= excluded	65% (80) 58= excluded	80% (4) 4=excluded	50% (2) 12=excluded
IV route %	66% (202)	69.6%	73.5% (75)	58.7% (105)	66.6% (6)	100% (16)
Concurrently prescribed a PPI %	47.7% (146)	42.2%	41.2% (42)	58.1% (104)	0	0

Antibiotic review within 72 hours (inpatients) 2021-22

During 2021-22, monthly auditing continued of compliance with the requirement to review antibiotics within 72 hrs for all inpatients. The target was set at 90%, to maintain the improvements achieved in the previous year. Reviewing the duration of antibiotic usage helps to ensure they are used optimally – long enough to be effective; yet not too long to develop resistance and reduce collateral effects.
The graph below shows performance in 2021-22. The 90% target was met between April – July, following which a fall in performance was observed between August – November. Education and training was targeted toward AMS, following this an improvement in compliance was observed between December 2021 - March 2022. The team is focusing on further education and training and embedding EPMA into AMS.

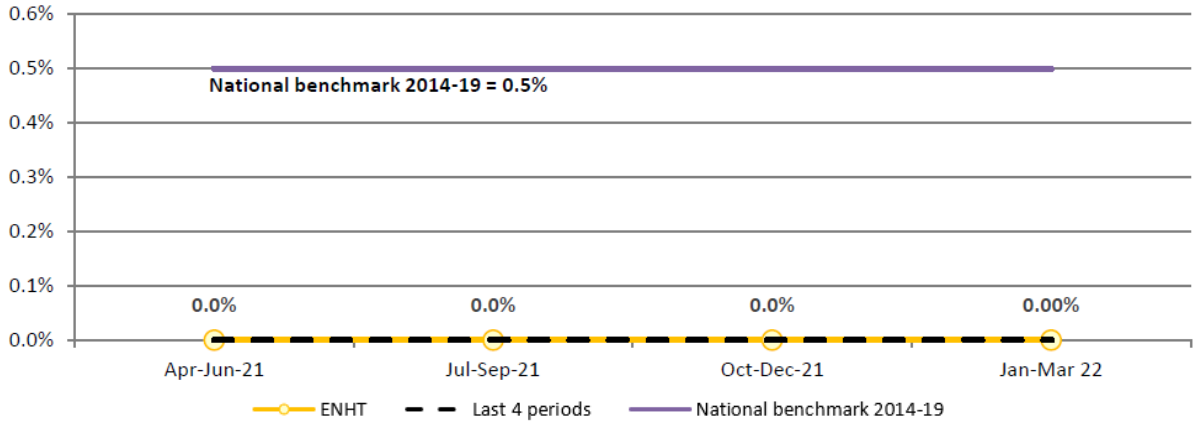


4.4 Surgical site infection

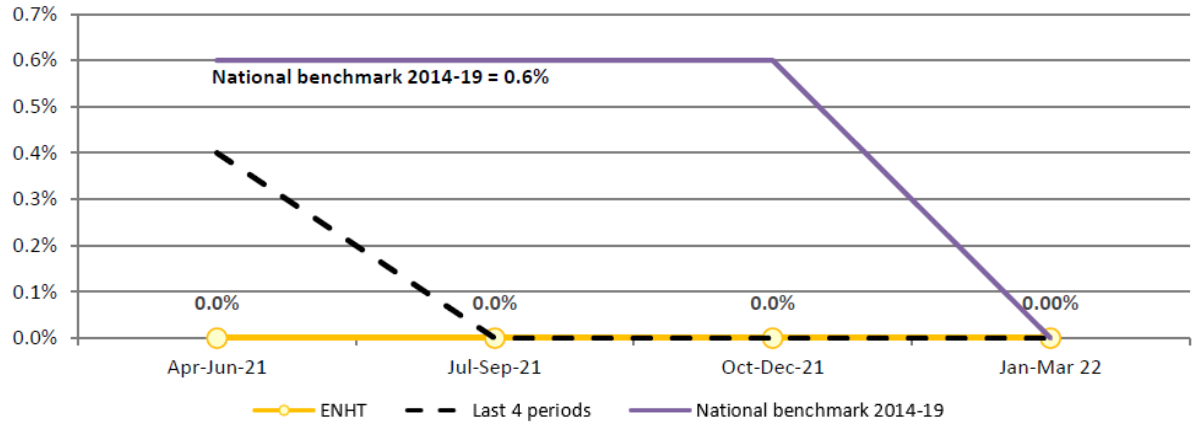
It is a mandatory requirement to conduct surveillance of orthopaedic surgical site infections using the Surgical Site Infection Surveillance Service of Public Health England. The minimum requirement is for a three month module of surveillance of *one* of the following Orthopaedic options:

- Total Hip Replacement (THR)
- Total Knee Replacement (TKR)
- Repair Neck of Femur Fracture (NOF)

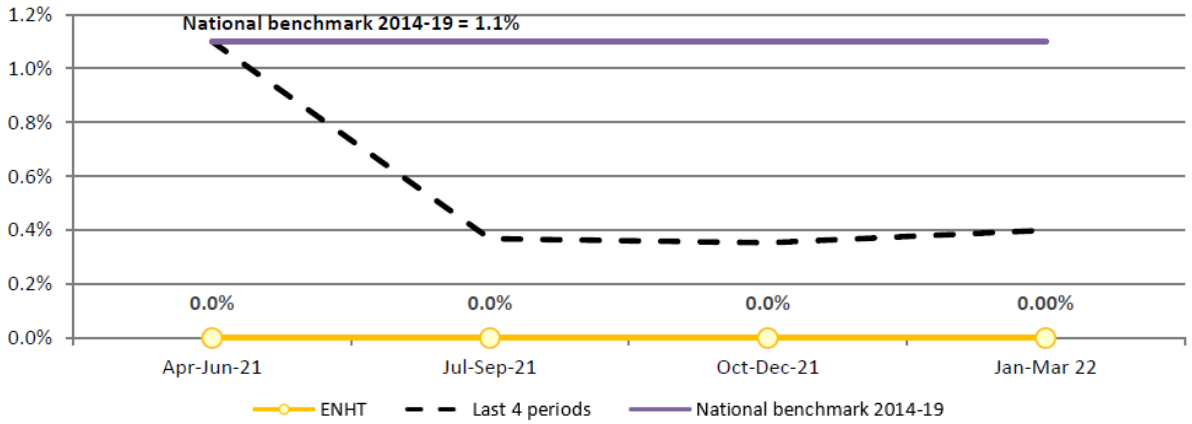
There have been zero SSIs over the last 4 periods April 2021 – March 2022 in all three categories monitored (Total Knee Replacement (TKR), Total Hip Replacement (THR) & Repair of Fractured Neck of Femur (NOF), compared to the 2014 - 2019 figures. This is remarkable, as the Trust has never achieved zero SSIs for a whole year running (4 periods) since the Trust started the surveillance reporting.



The above graph shows for TKR, the infection rate remains at 0.0% in January - March 22 and the overall rate for the past 4 periods (April 2021 – March 2022) remains at 0.0%. This is below the national benchmark of 0.5%.



The above graph shows for THR, the Trust's overall infection rate in January - March 22 remains at 0.0%. The THR rate over the last 4 quarters (April 2021 – March 2022) has remained at 0.0%, which is below the national benchmark of 0.6%.



The above graph shows for NOF, the Trust's overall infection rate for January - March 22 remains at 0.0% and the rate for the last 4 quarters (April 2021 – March 2022) remains at 0.0%, which is below the national benchmark of 1.1%.

5. Criterion 2: Clean and appropriate environment

5.1 Cleaning Services

East and North Hertfordshire NHS Trust has a responsibility to provide and maintain a clean and appropriate environment for healthcare. With a higher profile on improving cleanliness in hospitals this is now a key element of how each hospitals performance is judged and it is assessed in a number of ways which feature in the Care Quality Commission's (CQC) Essential Standards of Quality and Safety.

The majority of services are managed by external companies. Mitie provides services for Lister and Hertford County Hospital. The outcomes are still aligned to the National Specifications for Cleanliness in the NHS (2007) for part of 2021-22 period.
However, NHSEI has introduced the new National Standards for Healthcare Cleanliness (2021) (NSOC) in May 2021 with Trusts given 18 months to implement the new standards. From July 2021, Facilities lead the engagement with Mitie and nursing colleagues to discuss the functional risk ratings and the cleaning responsibilities framework of the new standards. Both have been agreed to enable progress towards implementation of the NSOC with a deadline completion of June 2022.

Cleaning services at the New QEII are provided by Accuro. Mount Vernon Cancer Centre services are provided in-house by the Hillingdon Hospitals NHS Foundation Trust. Services in the satellite renal dialysis units at Harlow and St Albans are managed through service level agreements with the respective Trusts that they are located in. Cleaning services for Chiltern Kidney Unit are managed by Mitie. Cleaning services for the Bedford Unit are managed by an external company.

The cleaning contracts including the satellite sites are managed and monitored by the Facilities Department at Lister Hospital.

5.1.2 Monitoring arrangements

The Domestic Contractor is required to carry out technical monitoring of cleaning standards.

The Trust continues to work to the National Specifications for Cleanliness in the NHS (2007) which must be met as a minimum, as detailed below:

Risk	Minimum Frequency (2007)	Minimum Score
Very High Risk	Over a period of a week all areas to have been audited at least once	98%
High Risk	Over a period of a month all areas to have been audited at least once	95%
Significant Risk	Over a period of quarter of a year all areas to have been audited at least once	85%
Low Risk	Over a period of a year all areas to have been audited at least once	75%

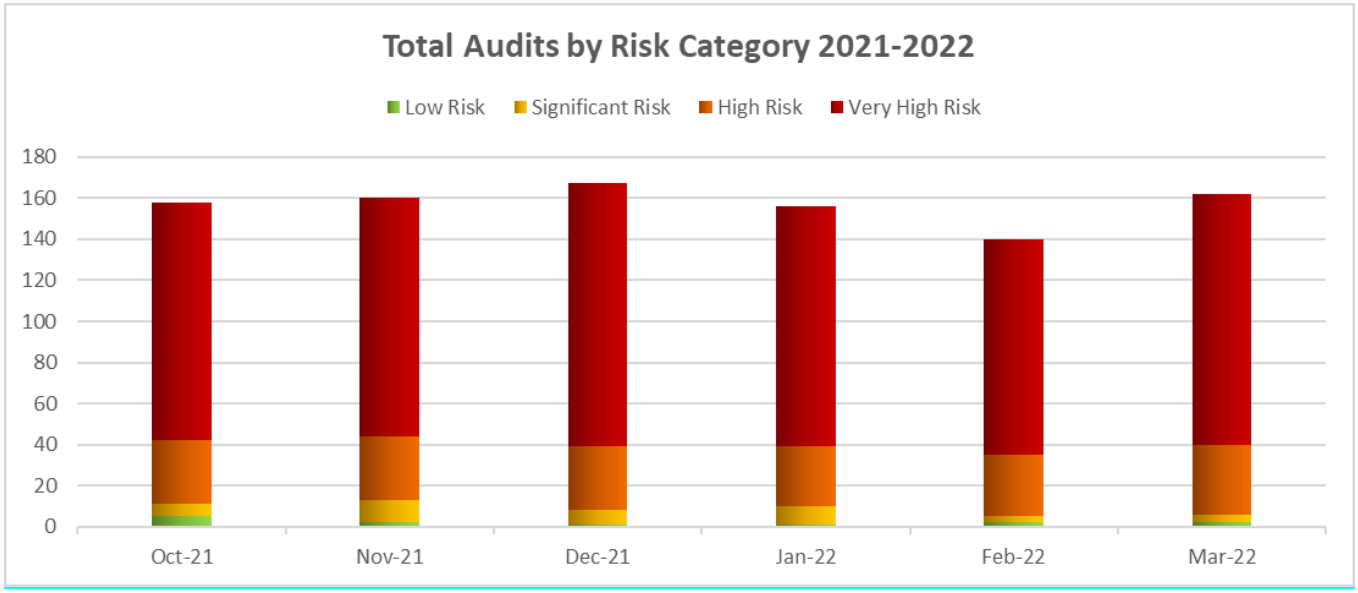
However, the Trust will be working with the frequencies set out in the National Standards for Healthcare Cleanliness (2021) which was introduced in May 2021, as detailed below including the introduction of two new functional risks, FR3 & FR5:

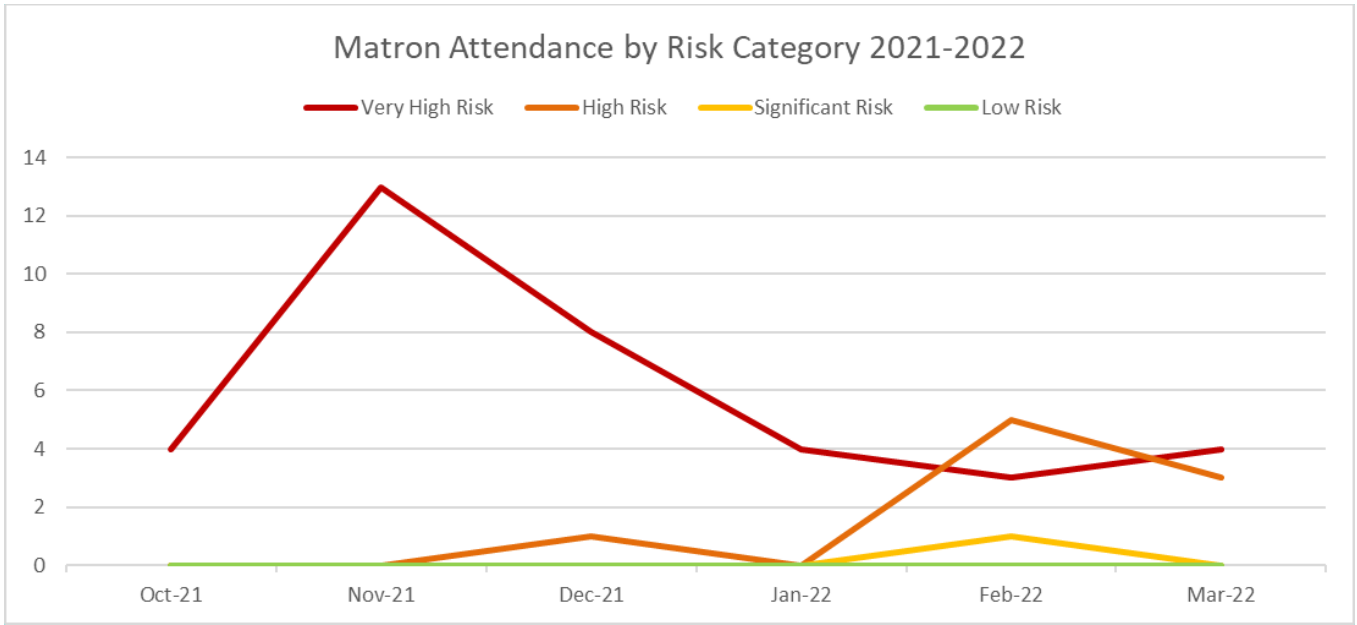
Risk	Minimum Frequency (2021)	Minimum Score
FR1	Over a period of a week all areas to have been audited at least once	98%

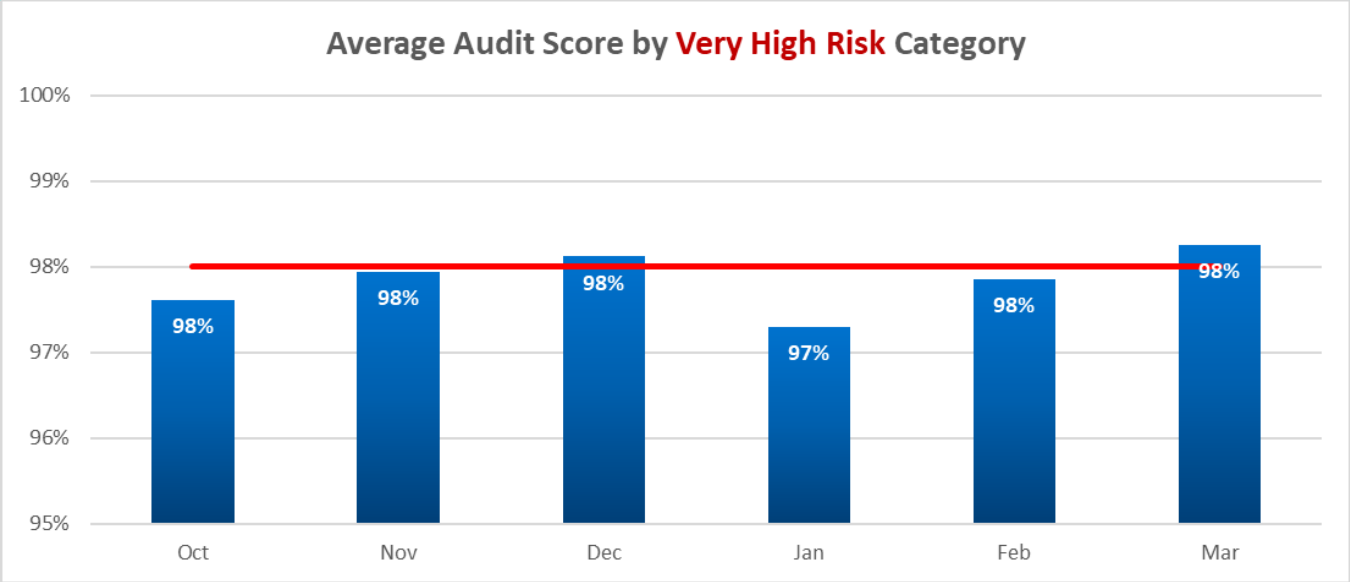
FR2	Over a period of a month all areas to have been audited at least once	95%
FR3 (New)	Over a period of a month all areas to have been audited at least once	90%
FR4	Over a period of every two months all areas to have been audited at least once	85%
FR5 (New)	Over a period of every two months all areas to have been audited at least once	80%
FR6	Over a period of quarter of a year all areas to have been audited at least once	75%

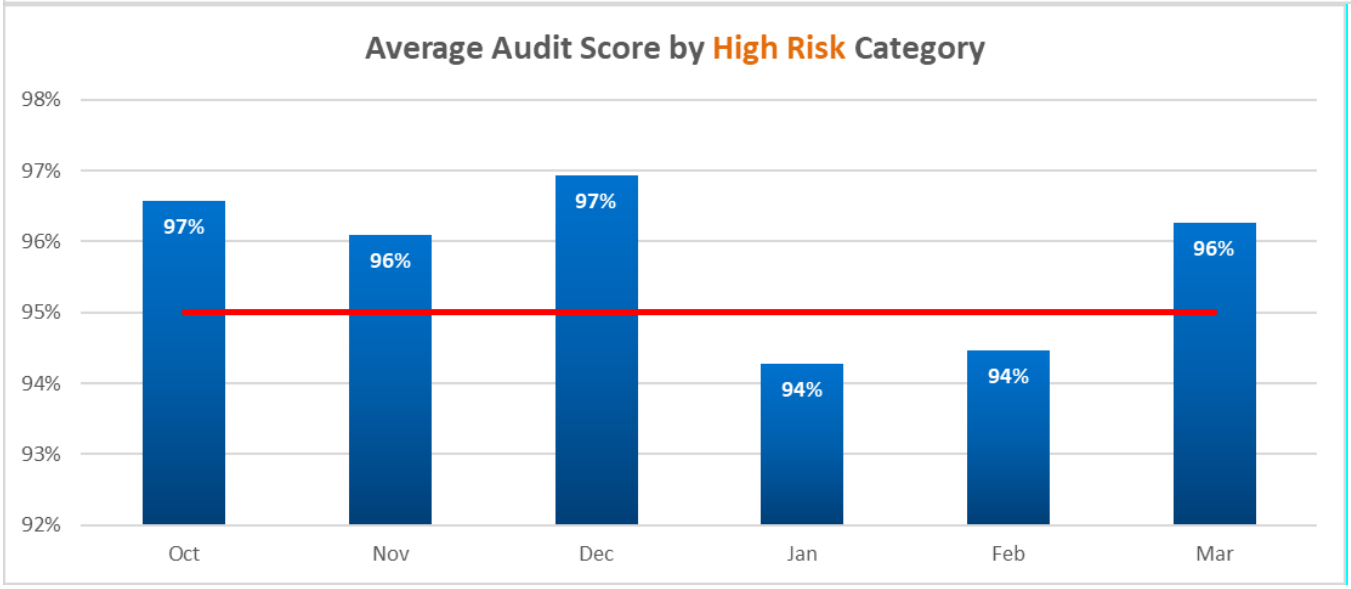
Regular audits of cleaning standards are carried out by Mitie and attendance at these by nursing staff is strongly encouraged for assurance. The target pass rates are 98% pass for Very High Risk areas and 95% for High Risk areas.

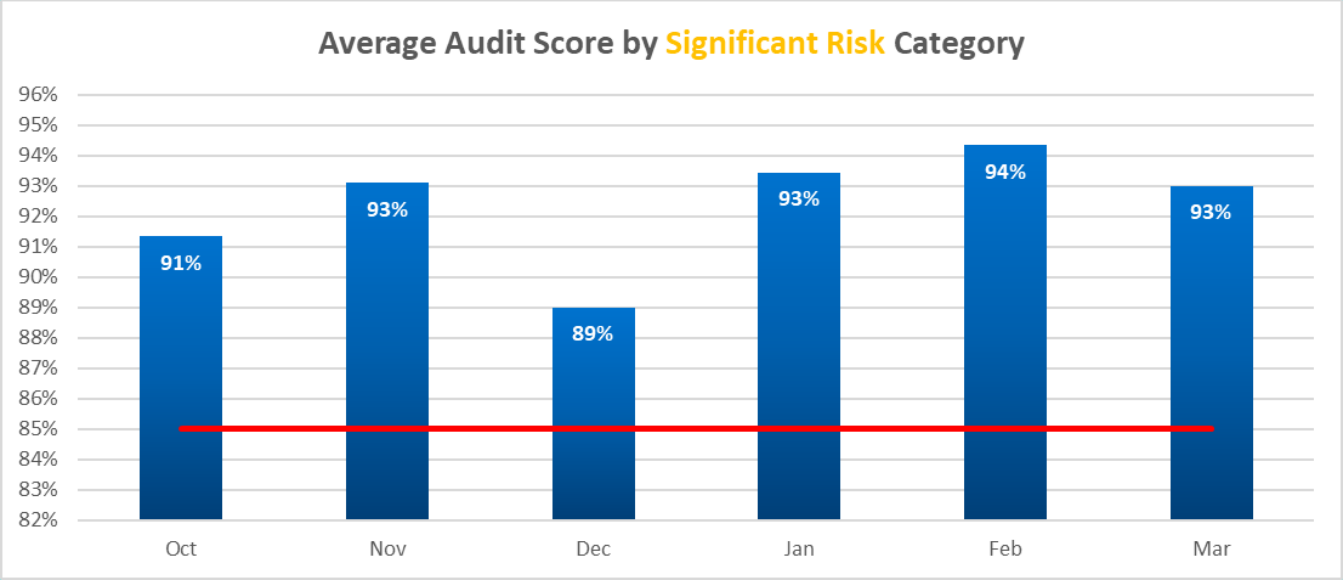
Due to the pandemic significant and low risk audits stopped between March 2020 and re-started in May 2020. All audits have since resumed for all areas.
The graphs below show performance in 2021-22

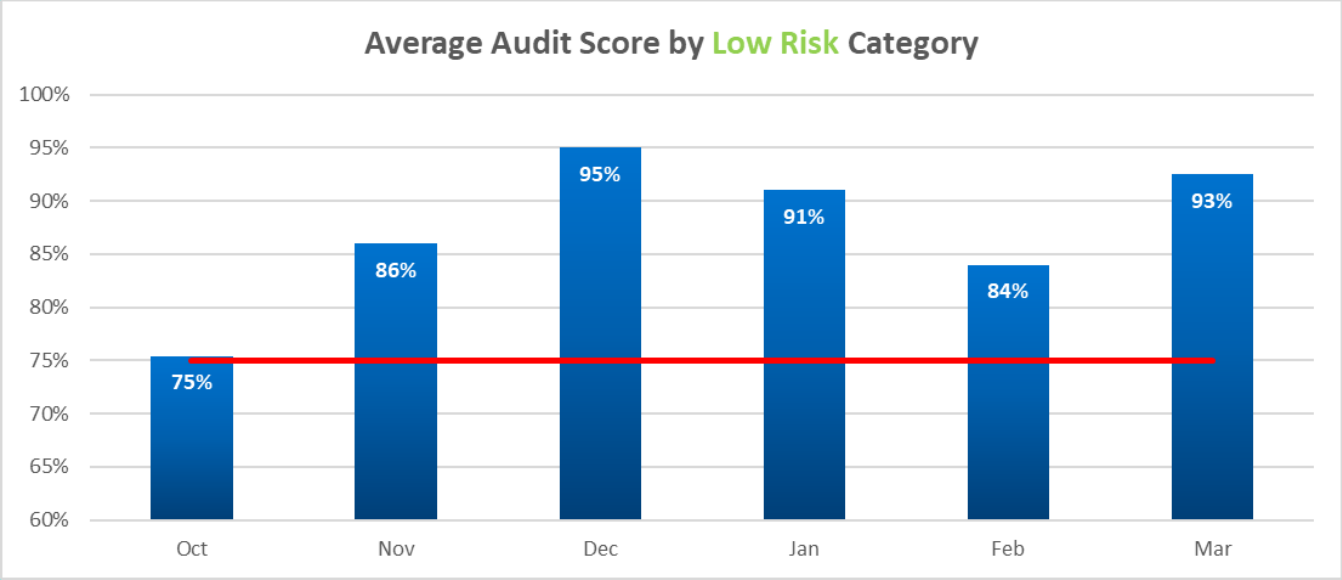





Average Audit Score by Very High Risk Category
100%
99%
98%
97%
96%
95%
98%
98%
98%
97%
98%
98%
Oct
Nov
Dec
Jan
Feb
Mar


Average Audit Score by High Risk Category
98%
97%
96%
95%
94%
93%
92%
97%
96%
97%
94%
94%
96%
Oct
Nov
Dec
Jan
Feb
Mar


Average Audit Score by Significant Risk Category
96%
95%
94%
93%
92%
91%
90%
89%
88%
87%
86%
85%
84%
83%
82%
91%
93%
89%
93%
94%
93%
Oct
Nov
Dec
Jan
Feb
Mar

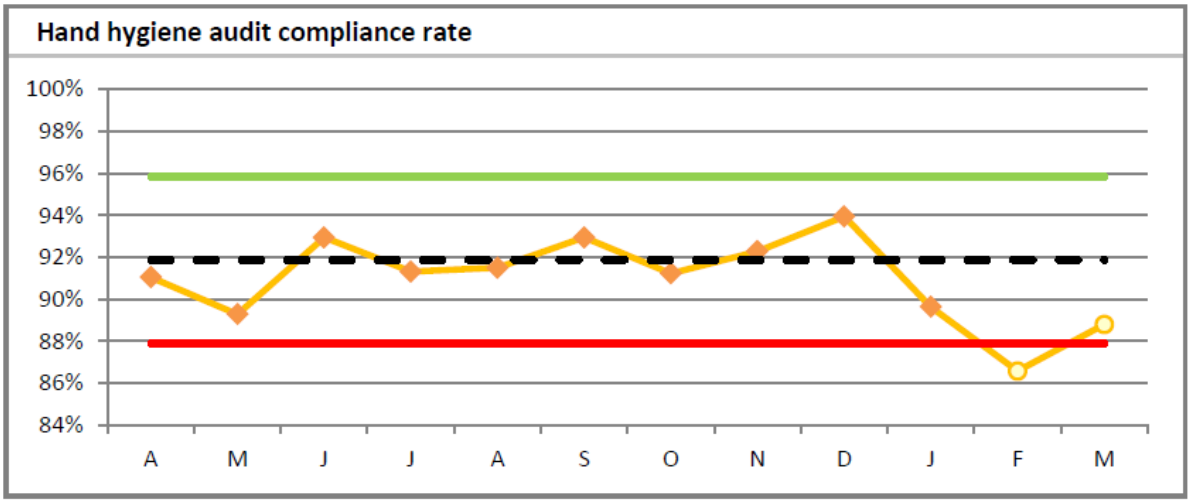


These audits are supplemented by weekly oversight Efficacy audits by a team comprising the Executive with overall responsibility for cleaning, senior nursing representatives, IPC, Estates, Facilities, and the Contractor.

In addition to the above monitoring arrangements, nursing staff undertake monthly cleaning/environmental peer audits in the clinical areas. Matrons also carry out assessments of their areas' environment including cleaning, at least monthly. The results are recorded electronically and reviewed by divisions.

Hand hygiene audits are also carried out in each area, at least monthly, by staff in each area that have attended training and undergone a competency assessment, to ensure consistency. Hand hygiene compliance WHO Moments 1-5 saw decrease from 91% in April 2020 to 88% in March 2021. However, this is still above the Trust target of 80%.

The graph below shows performance from 2021 - 2022.



5.2 Water Safety

The Trust's Water Safety Group (WSG) meets quarterly, reports to TIPCC and takes collective responsibility for the assessing risks, devising control & prevention measures, monitoring their implementation & reviewing their effectiveness. The terms of reference and core membership were reviewed in 2019 and re-issued along with an updated Water Safety Policy, which is due for review June 2023.

The water systems engineering & bacteriological risk assessments were reviewed in the early part of 2021 for the Lister Hospital and Trust-maintained satellite premises. The risk assessment review identified a range of risk minimisation actions which were prioritised according to risk. Work continues on completion of the these works. Furthermore, risk assessments have been updated to take account of building additions & modifications in 2021-22.

The primary control for prevention of water-borne pathogens at Lister Hospital is temperature and the secondary control is use of chlorine dioxide, an oxidising biocide. Specialist water hygiene services are provided for under a 3 year contract up to 2024 with an option to extend for two years until 2026. This contract has continued to deliver improvements in compliance with testing & inspection requirements. These improvements have revealed some challenges to maintaining target control limits in the hospital hot & cold water systems in specific areas. Remedial work targeted at improving controls have been included in the 2022-23 backlog maintenance programme. Overall positive counts have increased slightly from 25% to 28%. This was due to a shift in sampling strategy from post flush to pre flush sampling of showers which resulted in a 8% increase in positive counts from showers.

Action plans have been devised to address the temperature control issues and these are at various stages of completion. Examples of actions completed include engineering improvements to the hot water service to the Level 3 Macmillan & Renal areas, which have addressed the root cause of the hot water temperature issues in these areas and the installation of end-of-line automated flushing systems to increase the throughput of water in cold & drinking water systems.

Monitoring of chlorine dioxide dosing systems has highlighted that whilst some areas at the extremities of the water systems do not received the prescribed dosage, the dosing systems have been operating consistently within target parameters.

The Authorising Engineer [Water] has reported an assurance rating at Lister Hospital of "reasonable assurance".

In June 2020 it was reported that a patient at Mount Vernon Cancer Centre had tested positive for a Legionella infection. An incident control team (ICT) was formed, investigations and risk assessments were completed and as such, and with advice from external bodies PHE (now UKHSA) & NHSE/I the ICT agreed on the deployment of medical grade point-of-use water filters to protect vulnerable patients & staff. At the time of writing these filters remain in place and are strictly managed in accordance with manufacturer guidelines and the ENHT ICT remains active in pursuing a resolution to the water safety management concerns at MVCC and provides regular updates through the WSG.

Due to a potential increased incidence of Pseudomonas infections in peritoneal dialysis patients presenting with peritonitis in September 2021 at the home therapies unit at Lister hospital, which offers both home haemodialysis and peritoneal dialysis services, a multi-disciplinary approach was taken to investigate any causal links. Our external regulator colleagues were informed, and appropriate advice was taken. Please see report below for further details of the incident, the findings, and the actions. In conclusion, it was agreed that

this constituted an increase incidence and not a healthcare associated outbreak (Please see below for PD Peritonitis Review – Report).

See appendix 16.

Particular water safety challenges that continue to face the Trust in 2022 include:

1) Continued development of a robust system for providing assurance on water safety from our satellite sites managed by third parties including Hertford County, QEII, the renal satellite premises and Mount Vernon Cancer Centre. Each of these premises offers varied degrees of assurance with an overall assurance rating of “limited assurance” issued by the Authorising Engineer [Water].
2) Ensuring high levels of communication between planning and operational management to ensure that the safety of water systems is ensured at all times regardless of space utilisation factors.
3) Continued recognition and awareness of water safety as a day-to-day infection prevention & control matter for all staff, particularly in respect to the safe use of water in clinical environments and the identification & management of little-used water outlets.
4) Delivery of strategic engineering improvements to the aging infrastructure at Lister Hospital to optimise performance and minimise risk. The effectiveness of the improvements will be measured by monitoring compliance with target control limits (water temperature & residual chemical levels) and continued sampling and analysis.

5.3 Ventilation

The Trust’s Ventilation Safety Group meets quarterly, reports to TIPCC and takes collective responsibility for the assessing risks, devising control & prevention measures, monitoring their implementation & reviewing their effectiveness. The terms of reference and core membership were reviewed in 2021/22 and but require formal reissue with an updated Ventilation Policy, which is due for review. The Trust has appointed an Authorising Engineer for Ventilation. The annual audit was completed in February 2022.

The performance of critical ventilation systems is confirmed annually on a rolling programme of work. The programme for 2021 to 2022 was completed on schedule with all systems maintaining key performance criteria. Some of the ventilation plant is end-of-life and does not meet the minimum specification outlined in NHS England’s HTM03-01 (2021) guidance. Remedial work targeted at upgrading & replacing these systems has been included in the 2022-23 backlog maintenance programme.

During a review of the estates infrastructure at Mount Vernon Cancer Centre the critical ventilation systems were found to be in a poor state of maintenance . Remedial action is underway to repair this equipment and maintain it to the required standard.

Particular ventilation challenges that continue to face the Trust in 2022 include:

1) Continued development of a robust system for providing assurance on ventilation safety from our satellite sites managed by third parties including Hertford County, QEII, the renal satellite premises and Mount Vernon Cancer Centre.
2) Ensuring high levels of communication between planning and operational management to ensure that the clinical procedures requiring specialist ventilation are only provided from suitable facilities at all times, regardless of space utilisation factors.
3) Continued recognition and awareness of ventilation as a day-to-day infection prevention & control matter for all staff;
4) Delivery of engineering improvements to the aging infrastructure to optimise performance and minimise risk.

5.4 Decontamination

The management of Trust Decontamination has undergone a significant review over the past year - in response to concerns being raised about the function of the Trust Decontamination Group and associated governance arrangements.

Historically the Trust's default position had been to rely on the Estates Department to lead on all things 'Decontamination' for the entire hospital. More recently, following the appointment of an 'Authorised Person' (AP)*, direct responsibility had rested solely with this one individual.

(*C*urrently 'acting' AP, under the supervision of the AE)*

<u>New governance arrangements and reporting structure 2022_23</u>

Trust CEO has now appointed a Trust Decontamination Lead for Lister Hospital, to undertake the duties set out in the NHS Decontamination guidance HTM 01-01, and scope of HTM 00. These include the Decontamination Lead being organisationally responsible for the effective, and technically compliant, provision of decontamination services, chairing of the Trust Decontamination Group, and provide assurance to the Trust Board on all matters associated with decontamination.

The Trust has an appointed Authorised Engineer (AE) for decontamination and a recently appointed *Authorised Person. The most recent AE audit "Review of Decontamination Practice at the Lister Hospital" was conducted in February 2021. The trust decontamination compliance rating is currently at 'limited assurance'.

The Trust Decontamination Group (TDG) meets quarterly, reports to TIPCC. The terms of reference and core membership were reviewed and updated in March 2022. Following the revised governance arrangements, a gap-analysis of all relevant policies and standard operating procedures is underway. The Trust Decontamination Policy is undergoing review, this will be concluded / endorsed at TDG September 2022.

Outstanding recommendations highlighted in AE Audit February 2021, included in Trust Decontamination Action Plan 2022/23.

- Permit to work should be used for all maintenance and testing procedures on all decontamination equipment. Systems are in place, but not adhered to by clinical services
- Trust Decontamination and TSE Policy in place, but overdue for review, to reflect change in NICE IPG196 and IPG666.
- Periodic audit from IPC / Decontamination Lead for areas where local decontamination is undertaken
- Audit track & trace system - HSSD and ENT
- Refurbishment and replacement of obsolete RO Plant
- Replacement of end life-cycle / obsolete Endoscopy Washers

6. Criterion 3 & 4: Information on infections to service users and their visitors and information on infections to other providers

The Trust continues to use the switchboard and the Trust website as mechanisms for informing the public of infection outbreaks, eg during the winter period. A pre-recorded message is used. Posters and pop up banners are used in key locations on site to inform the public of increased incidence of Norovirus and Influenza. From December 2019, specific messages, posters and banners have been used in response to the Covid-19 pandemic.

Infection Prevention and Control (IPC) information leaflets are available on the Trust website for patients and members of the public to access. Printed copies are available for patients identified with infections at ward level.

There is an IPC section on the Trust website which provides information to patients on a number of IPC issues including the numbers of Clostridium *difficile* and MRSA BSI.

7. Criterion 5: Identification and prompt management of infection

The ICD and the Consultant Microbiologists provide advice on the prompt diagnosis and treatment of infections, including appropriate use of antibiotics. Close working relationships are also in place to facilitate the reporting of infections of public health significance to the local UKHSA Unit. In addition, the ICD works closely with UKHSA in the management of infection-related serious incidents in the hospital. The IPCT also liaise with their Public Health nursing colleagues in respect of infection control incidents.

The Trust's Management of Outbreaks policy is used to actively manage outbreaks, eg seasonal Norovirus and Influenza. Frequent meetings are conducted with multi-disciplinary team involvement to ensure cases are identified and controlled at an early stage to prevent onward transmission, thus reducing bed closures and operational impact. A new COVID-19 Outbreak Policy/SOP was developed, in line with national guidance, to ensure the robust management of COVID-19 infections and outbreaks in support of the Trust staff and patients.

8. Criterion 6: Involvement of all staff

The IPC Team works closely with all Trust staff to implement good practice and reduce HCAIs. IPC training is an integral part of Trust induction for all new staff (with presentations on both Infection Prevention and Antimicrobial Stewardship) and mandatory updates on key and emerging issues. The emerging infection: SARS-CoV-2 resulted in a programme of teaching, training, and ongoing support to introduce practices to ensure the safety of patients, staff, volunteers, and members of the public.

In addition to statutory & mandatory training, there is a rolling programme of training events for IPC Link Practitioners and other clinical staff, supported by Trust staff and external partners. In 2021-22, this included:

- Frequent briefings at the Quality Huddle meeting, ward and departmental meetings
- Bespoke training sessions for staff groups including G4S, catering staff, porters
- Ongoing hand hygiene training and hand hygiene audit training
- Training for Heads of Nursing, matrons, ward managers and Link Practitioners and Champions, PPE trainers to reflect themes identified from current incidents or seasonal infections.
- Collaboration with the Trust Communications Team to disseminate relevant information eg articles in the 'Daily News' and 'Gold' bulletins which is circulated Trust-wide
- IPC Link Practitioner and Champions day webinar

9. Criterion 7: Isolation facilities

The Trust has around 125 single-occupancy side rooms available across the Trust. Many of these side rooms do not have en-suite facilities which presents a challenge for meeting isolation requirements.

Demand for side rooms sometimes exceeds availability. Therefore, patients with infections are risk assessed to enable those with the highest priority requirement to be identified and isolated as required. This is reflected in the Trust Isolation Policy.

To aide best use of side rooms, the IPC Team give advice to the bed management team and attend the site meeting twice a day Monday – Friday, undertake daily reviews of side room occupancy and availability to inform best patient placement.

To support the greatly increased need for isolation, as a result of the global pandemic, estates assisted the departments and services to erect partitions, hoarding, and screens to increase the available side room capacity, to mitigate for the lack of ability to socially distance in all areas due to the age and layout of the ENHT estate, including satellite sites. This work has been supported

In order to support the Trust with the challenged isolation facility provision the Trust charity supported the Trust by purchasing an initial four Rediroom frames and 10 canopies. This was supported by the Trust acquiring a further four Rediroom frames with an additional 10 canopies. This provision has been shown to increase isolation facilities while decreasing patient movement and associated challenges.

11. Criterion 9: Policies

All policies required for compliance with the Health Code are in place. Most IPC policies are written by IPC Team members with support from other Trust staff with expertise in the relevant areas. Some policies are written by other teams in the Trust with the relevant experience with the support of the IPC Team. These policies are accessible to all staff on the Trust's intranet system.

With support from the Trust documents manager and the IPC team, to date all IPC owned policies have been reviewed and updated. Trust documents manager and the IPC team are currently devising a programme to enable all divisional IPC interest policies to be reviewed and updated in April 22 – March 23.

See appendix 17 – IPC policies 2022-23

12. Criterion 10: Health care workers: Infection Status, protection from infection and education in infection prevention & control

In 2021-22 The Health at Work service has worked in partnership with the IPC Team, to assess the potential infection risk for employees who know or suspect that they have contracted or have had a significant exposure to an infectious disease.
The primary focus during this year again has been protecting patients, staff, their families, and the wider community from covid-19. Collaboration on other significant issues such as sharps and splash incidents and immunisations has also taken place.

12.1 Sharps/splash incidents

During 2021-22, Sharps and splash injuries have been closely monitored. The Safer Sharps Steering Group meets regularly to review progress and identify further actions needed. This Group includes staff from multiple disciplines across the Trust.

The Health at Work service support managers to undertake investigations into sharps injuries, Health at Work provides immediate assessment, advice and support to employees who have been potentially exposed to blood borne viruses in an injury at work during office hours (Mon-Fri 08:00-16:30). They assess the risk of exposure to the recipient and obtain a blood sample from the recipient for serum save and hepatitis B immunity status (if not known). Health at Work advise on whether further treatment such as Post Exposure

Prophylaxis is required, if needed this is then provided by ED. Health at Work offer support to injured workers following injuries and arrange follow up blood tests where required.

Following an injury Health at Work try to explore with the employee what led to the injury occurring and if there was anything that could have prevented it. With the employees' consent, where it can be identified that changes in practice, such as correct use of devices, use of PPE and following correct disposal procedures can prevent future injuries, the Health at Work emails their manager summarising this advice and recommending that the manager discuss the issues with the employee as part of their investigation.

A monthly report is compiled of sharps injuries reported to Health at work and/or recorded on the Trust's incident reporting system (Datix). Details include the devices involved in sharps injury, staff groups injured and the likely cause of injuries.

In '21 - '22 there have been 162 injuries reported, 27 more than '20 - '21, this is an average of 15 a month. It must be noted that there have also been increases in the numbers of patients treated this year.

12.2 Immunisations and blood tests

Health at Work screens all new employees to identify specific required workplace immunisations and ensure compliance under the Health and Safety at Work Act (HSWA) 1974, to ensure protection for those at work and others who may be affected by their work activity, such as contractors, visitors and patients. The service continues to work to ensure that existing staff are compliant with immunisations appropriate to their role, in line with Department of Health guidelines.

Health at Work requests immunisation records from all new employees before they commence work, and an assessment of immunisation requirements is made in accordance with UK Health Security Agency guidelines. Health at Work electronically records immunisations in accordance with the General Data Protection Guidance. Health at Work advises all new employees who require further evidence of immunity to book an immunisation update appointment. Additional blood tests are required for staff undertaking Exposure Prone Procedures (EPP) before these duties are commenced.

Health at Work recalls staff who require vaccine boosters, reviews immunisation records of existing staff and provides advice to employees on immunisation updates needed, as required. If employees refuse vaccines or blood tests, fail to attend an appointment or to provide the required evidence of immunity, their manager is informed. Where necessary for patient and employee safety, advice may be given on adjustments to the employee's work.

12.3 Fit testing for FFP3 masks

The requirement for employers to fit-test all staff who are required to wear tight-fitting respirator masks, according to the Health & Safety Executive (HSE) (OC 282/28) remains for NHS organisations, in order to ensure the selected mask provides effective protection. The IPC team supported this requirement predominantly through the PPE coordinator working across Divisions.

UK manufactured FFP3 masks continued to show improved pass rates amongst staff groups compared to some of the previous masks.

The PPE coordinator continued to provide support to the Divisional fit-testers to maintain enough competent testers to meet the fit-testing needs.

In response to the Department of Health and Social Care **'FFP3 Resilience in the Acute setting'** guidance (please see below) there has been a recommendation from the Deputy DIPC through TIPCOG and TIPCC that the PPE Coordinator role remains, and an appropriate effective fit testing programme becomes embedded within the Trust that should be led by a collaborative team including Health and Safety, Health at Work, Human Resources, IPC, and Divisional colleagues. This should ensure all staff fit testing needs will be monitored, met, and recorded.

In addition, Powered Air Purifying Respirators (PAPR) are available for staff who require FFP3 standards of protection where fit testing cannot be completed, e.g., due to failure of all Trust approved makes and models of FFP3s or facial hair.

Through the FY 2021 - 2022 'Portacount' machines that work quantitatively, continued to be used in alongside with 'taste test' machines, which work qualitatively, to increase the capacity for fit-testing to meet the needs of the increased use of FF3 masks required in aerosol generating procedures (AGPs).

SOPs were developed by the IPC Team, SAG members, and other relevant stakeholders, and were supported by the PPE Coordinator, IPCT, and other staff members to ensure increased knowledge of the PPE required, the use of that PPE, and changing requirements in line with nationals and local guidance and this was substantially supported and monitored through the PPE Coordinator role.

13. Collaboration with external partners

Stronger together – A collaborative approach to IPC within Hertfordshire and West Essex
Infection Prevention and Control Teams have been thrown into the spotlight during the COVID-19 pandemic. During this time, expectations and demands on IPC have dramatically increased, and the need for robust assurance processes and transparent decision making within IPC has become paramount.

As Hertfordshire and West Essex has moved towards integrated care, we established a supportive network across the three local acute Trusts and CCG IPC Teams. This network was initially created to provide support and assistance to colleagues during times of extreme pressure and challenge within IPC, and to provide assurance to Boards and external regulators, but as we have moved into COVID-19 recovery phase this network has developed into a professional clinical and operational group undertaking assurance visits and peer reviews, as well as sharing learning, and developing standardised policies and reporting systems. It has helped develop an effective model for joined up working, reducing variation in IPC practices across organisations. To achieve this, it has been crucial to have a shared vision, and to foster Trust, mutual respect, and transparency between group members.

The network is now being extended to include other system partners and is providing a voice for IPC, helping to shape IPC as the ICS and Place-Based Partnerships are created by April 2022. The shared ambition is to create a truly collaborative approach across the local health and care system as whole, further exploring and developing opportunities for shared learning, professional development, and the prospect of secondment opportunities across the system in order to enhance local IPC resilience and productivity, and to improve patient outcomes and quality of local services.

14. Conclusion

Over the year 2021-22, key IPC developments in the Trust include:

- Successfully utilising the BAFs to support Trust IPC practices

- SAG was seen to be an affective governance mechanism to ensure the Trust remained in line with the updated national guidance
- COVID-19 data demonstrated that the Trust IPC practices successfully ensured that the number of hospital acquired infections remained significantly lower than the community acquired infections
- The Trust outbreak COVID-19 SOP continued to effectively support the management of outbreaks
- Trust's innovative stance allowed the procurement of new technology such as Redirooms that effectively supported Trust operations
- For multi factual reasons Antimicrobial Stewardship, though a challenge throughout 2021 – 2022, saw a marked improvement in the final quarter for the FY
- Apart from COVID-19 the Trust saw a remarkable achievement with no Influenza, Norovirus, or other pathogenic outbreaks
- The surgical site infection rate has significantly improved for THK, TKR, and NOF saw a remarkable improvement with zero SSIs identified for the last 4 periods (April 21 – March 22)
- There was an overall improvement with HCAIs identified throughout the FY however, CDIs and E.coli infections were the biggest challenges of the FY 2021-2022
- The FY 2021 – 2022 saw significant strides in ICS cross-acute Trust working with positive effects that will continue.

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Trust Board – Part I			**Agenda Item**	15
Report title	Workforce Race Equality Standard (WRES) for ENHT			**Meeting Date**	Sept 2022
Presenter	Chief People Officer				
Author	Equality and Diversity Manager				
Responsible Director	The Director who has vetted the paper as fit for purpose			**Approval Date**	August 18 2022
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**		☒
	Discussion	☒	**Decision**		☐

Report Summary:

The purpose of this report is to:

1. Highlight ENHT progress on equality and inclusion at local and system level.
2. Provide organisation Workforce Race Equality Standard (WRES) data, including a brief analysis which highlights areas for improvement.
3. Recommendations as to priority areas which align with NHS People Plan, ENHT Vision and People Team strategic priorities, to deliver and drive forward the equity and inclusion agenda.

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

Benefits of meeting and delivering recommendations in this report include improved retention and recruitment, lower turnover, less absence, a place where staff advocate for the Trust and somewhere individuals are able to reach their full potential.

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

Indirect impact on BAF Strategic risks:
1 Workforce requirements
4 Workforce shortages and skills mix
5 Culture and leadership
6 Engagement and listening

Report previously considered by & date(s):

2021

Recommendation	The Board/Committee is asked to 1. Approve and sign off WRES data 2. Review, discuss and approve the high priority areas for improvement

August 2022

East and North Hertfordshire NHS Trust

Workforce Race Equality Standard (WRES) Report 2022

1. Introduction and Scope

The Workforce Race Equality Standard (WRES)[1] aims to improve work experience and employment opportunities of Black, Asian and Minority Ethnic (referred as BAME in this report) staff in the NHS by taking positive actions to help address race inequalities in the workplace.

The trust has committed to making anti-racism a reality[2], which incorporates respect for dignity and human rights, as well as ensuring equitable opportunities free from discrimination for people with protected characteristics as defined by the Equality Act 2010.

East and North Hertfordshire NHS Trust is committed to being a leading organisation for promoting equality, diversity and inclusion in Hertfordshire. We aim to do this by creating a culture where everyone in the organisation is responsible for creating an environment which is supportive, fair and free from discrimination.

This report gives detailed information on our Black, Asian and Minority Ethnic (BAME) covering the period April 2021 to March 2022, it also presents our findings in relation to the national NHS Workforce Race Equality Standard (WRES). The information in this report is used understand trends and patterns of inequality and outlines our progression at local and system level and, areas that require our focus, including high priority improvement areas for 2022/2023, all designed and intended to drive positive change towards equity and inclusion and future WRES performance.

2. Context

Other reports of interests are the Trust staff survey results 2021 key findings.

Further reports of interest and relevance are set out here for reference:

- No More Tick Boxes,
- Sir Gordon Messenger - Leadership for a collaborative and inclusive future https://www.gov.uk/government/publications/health-and-social-care-review-leadership-for-a-collaborative-and-inclusive-future
- Race and Health Observatory report (here)
- NHS People Plan 2020-21 https://www.england.nhs.uk/ournhspeople/
- *Trust People Team Strategic Priorities (Thriving People)* and *ENHT Organisational Strategic Priorities (Vision to 2030)*

The NHS Workforce Race Equality Standard (WRES), which was introduced in 2015, is designed to improve the representation and experience of Black, Asian and Minority Ethnic (BAME) staff at all levels of the organisation. Nine indicators make up the WRES covering workforce data, the national NHS Staff Survey results and Trust Board composition as follows:

1. Percentage of staff in each of the NHS pay bands 1-9, plus those on Medical & Dental and Very Senior Managers contracts (including Executive Board members) compared with the percentage of staff in the overall workforce
2. Relative likelihood of staff being appointed from shortlisting across all posts
3. Relative likelihood of staff entering the formal disciplinary process
4. Relative likelihood of staff accessing non-mandatory training and CPD
5. Percentage staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months (from NHS Annual Staff Survey)

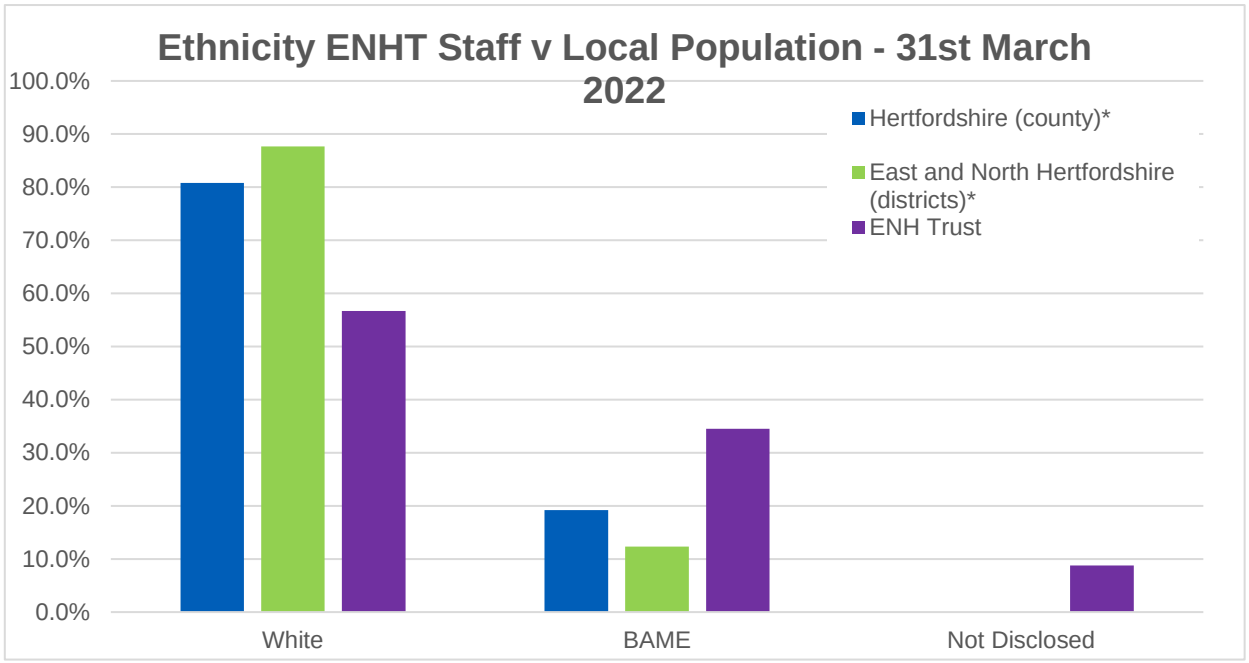
[1] https://www.england.nhs.uk/about/equality/equality-hub/workforce-equality-data-standards/equality-standard/
[2] Making anti-racism a reality, East of England Race Strategy 2021 (Appendix 1)

6. Percentage staff experiencing harassment, bullying or abuse from staff in the last 12 months (from NHS Annual Staff Survey)
7. Percentage staff believing that the organisation provides equal opportunities for career progression or promotion (from NHS Annual Staff Survey)
8. Percentage staff having personally experienced discrimination at work from manager, team leader, or other colleagues in the last 12 months (from NHS Annual Staff Survey)
9. Percentage difference between the organisations' Board voting membership and its overall workforce.

The table and graph below provide comparison of Trust employees against the local population. The Trust employs a greater proportion of staff who are from BME backgrounds than resident in the local population and therefore suggests we are representative of the population we serve.

Points to note, the population data is based on the 2011 census therefore is likely to change upon the release of the 2021 data; further work is underway in the Trust to reduce the number of 'not disclosed' ethnic origin data we hold for staff.

**Data from ONS Census 2011 (2021 data not available until October 2022)*



Medical Workforce Race Equality Standard (MWRES)
NHS England introduced the first Medical Workforce Race Equality Standard (MWRES) in September 2020 to specifically focus on medical staff whose make-up can differ widely from that of other NHS Staff group. The first national publication was made July 2021 providing baseline evidence for the medical workforce in the NHS and highlights areas for action specifically for this staff group.

As an early indicator for the 2022, East and North Hertfordshire NHS Trust has provided a breakdown of our medical workforce data (shown in the table below), this will form part of the national report which, is due to be published later in 2022. Work continues to improve our data and reduce the number of 'unknown ethnicity' records.

MWRES	2020			2021			2022		
	White	BAME	Unknown	White	BAME	Unknown	White	BAME	Unknown
Consultants	46%	48%	7%	43%	47%	10%	43%	47%	11%
Other Doctor Grades	20%	61%	18%	20%	60%	20%	14%	59%	27%
Junior Doctors	34%	49%	18%	29%	42%	28%	29%	45%	26%
TOTAL	**36%**	**51%**	**14%**	**32%**	**48%**	**20%**	**31%**	**49%**	**20%**

As part of achieving our ENHT mission and deliver our strategic objectives, ensuring our workforce is representative of our community and patient profile in relation to race is paramount. To make a real difference to our current WRES progress, a range of intentional, comprehensive and targeted interventions are required, together these build transformational, collaborative and inclusive behaviours to the organisation.

Interventions to debias local policy and procedures, co-create equitable, inclusive environments and recognise and appreciate differences through cultural change approaches, can lead to advancement in our journey to become a more inclusive organisation within the East of England region. There is strong evidence that a single intervention will not achieve equity and inclusion alone, and all interventions carry equal importance to form connectivity to support achieving positive and lasting changes.

In this report, we have included available 2022 data to provide as up to date and accurate picture of our performance as possible. We have made steady, positive progress in representation in our workforce over the past three years. We have more to do relating to diversity at senior and board level roles.

The data demonstrates the need to consistently improve our standing in the likelihood of BAME staff entering formal disciplinary processes compared to white staff and, in ensuring equity of access to development opportunities, we will continue to encourage more calling in and calling out of bullying and harassment and encouragingly, the figures indicate staff are beginning to speak up more.

3. Progress

The diagram below sets out some of our achievements during 2021/22 and further, the range of collaborative partnership work underway for our trust.

Collaborative Work with Partner organisations

- Inclusive recruitment and selection process
- Engage on Anti-Racism strategy by launching the See ME Fist campaign
- First steps towards - Leading inclusively with Cultural intelligence
- Plans to launch Reciprocal Mentoring for Inclusion in Sep 2022
- Engaging on Regional Maternity/Neonatal Equity & Inclusion Ambassador scheme
- ICS Inclusive Career Development Programme for BAME and Disabled members of staff – first cohort Sep 2022

Other upcoming collaborative schemes in 2022/23:

- Diversity in Health and Care Partners programme
- Restorative Just Culture – engagement with Mersey Care NHS FT
- Cultural Intelligence and Reciprocal Mentoring Programme for 22/23

4. Current Workforce Race Equality Standard (WRES)

a. ENHT data from 2019 to 2022 is shown in the table below and key priorities for ENHT are set out in 4e below.

Workforce Race Equality Standard (WRES) Indicators	East & North Herts (ENHT) WRES Data					WRESS Comparison to Regional & National Data	
	%Staff	ENHT 2019/2020	ENHT 2020/2021	ENHT 2021/2022	ENHT WRES Progress in comparison to last year	East of England WRES 2020/2021	National WRES 2020/2021
WRES 1 – Overall workforce % by Ethnicity	White	62.1%	59.6%	56.7%	Increase in Diverse Workforce	71.3%	73.1
	BAME	31.9%	32.6%	34.5%		23.9%	22.4%
	Unknown	6.0%	7.7%	8.8%	More work to be done	4.8%	4.6%
WRES 2 - Relative likelihood of White staff being appointed from shortlisting compared to BAME staff		1.57	1.32	1.39	More work to be done	1.73	1.61
WRES 3 - Relative likelihood of BAME staff entering the formal disciplinary process compared to White staff		1.44	2.25	1.39	Improvement	1.05	1.14
WRES 4 - Relative likelihood of White staff accessing non-mandatory training and CPD compared to BAME staff		1.35	1.22	1.37	More work to be done	1.03	1.14
WRES 5 - Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months		BAME 29.6% White 29.9%	BAME 30.6% White 25.9%	BAME 34.6% White 30.4%	More work to be done	BAME 29.8% White 26.9%	BAME 28.8% White 26.5%
WRES 6 - Percentage of BAME staff experiencing harassment, bullying or abuse from staff in last 12 months		BAME 31.2% White 28.4%	BAME 32.7% White 25.1%	BAME 31.1% White 26.5%	Improvement	BAME 28.6% White 25.8%	BAME 28.5% White 23.6%
WRES 7 – Percentage of BAME staff believing that trust provides equal opportunities for career progression or promotion		BAME 50.5% White 56.4%	BAME 46.5% White 53.9%	BAME 49.2% White 55.0%	More work to be done	BAME 45.4% White 56.5%	BAME 44.6% White 58.6%
WRES 8 - Percentage of BAME staff personally experienced discrimination at work from Manager/team leader/other colleagues		BAME 15.9% White 6.0%	BAME 19.6% White 7.2%	BAME 16.8% White 7.4%	Improvement	BAME 17.1% White 7.1%	BAME 17.3% White 6.7%
WRES 9 - Percentage of voting members of the Board representation by ethnicity	White	100.0%	100.0%	91.7%	Improvement	86.5%	82.4%
	BAME	0.0%	0.0%	8.3%		8.2%	12.6%
	Unknown	0.0%	0.0%	0.0%		5.3%	5.0%

b. WRES Data Key Findings

Appendix 4 contains the East of England WRES full data set and, this section summarises findings for our Trust within the data set.

The overall rate of minority ethnic staff has increased from (32.6% to 34.5% in 2022). We have more representation in our clinical workforce (36.37%) compared to our non-clinical and AfC non-clinical workforce, which has 16.8% representation and 48.0% in representation across all medical and dental roles. All data sets show better representation in lower band roles, with decreasing representation in more senior roles across all staffing groups.

c. WRES Indicators 1-4

White staff are 1.3 times or 6.5% more likely to be appointed from shortlisting, compared to minority ethnic staff, however this gap closed slightly since last year. The data shows more minority ethnic staff are applying for roles and being successful at shortlisting stage compared to three years ago, demonstrating our minority ethnic staff are keen to apply for roles, yet are not as successful in securing senior roles. We have commissioned specific development programmes for our BAME staff which commence in Autumn 2022 to actively support and improve in this area.

The Trust saw a spike in 20/21 on likelihood of minority ethnic staff experiencing formal disciplinary procedures, however, the 2022 data shows an improvement for current WRES data. This is attributable in part, due to a checklist introduced to determine whether any disciplinary case, regardless of ethnicity, has merit to progress to formal stages. Other work continues to better understand the processes and behaviours between managers and staff and, robust data collection on disciplinary procedures which do not fall into formal routes is being explored. The relative likelihood of White staff accessing non-mandatory training and CPD compared to BAME staff metric remains similar, with more opportunity for white staff compared to BAME staff.

d. WRES Indicators 5-8

We have seen a decrease in BAME staff (16.8%) who said they have experienced discrimination at work from a manager / team leader or other colleagues, this figure is still 9% more than the experience of white staff. The metrics of indicators five to eight are represented in the staff survey results, these have worsened in comparison to last year's staff survey. With reference to NHS People Promise, two themes scored lower than comparable organisations' average, the first '*we are compassionate and inclusive*' (Diversity & Equality) and second '*we each have a voice that counts'* (Raising Concerns). The rate of harassment, bullying and abuse (from patients and the public) has also increased for BAME staff, over 4% higher in comparison to white staff.

Work will continue to educate our staff and communities, that incivility towards our staff will be directly challenged and addressed through communication campaigns and building confidence for all our staff to positively challenge and call in uncivil behaviour. As we increase psychological safety in the workplace, it in turn increases staffs ability to positively advocate for others.

e. Model Employer

There is a promising emerging story against band 8a appointments (non-clinical roles) and we are meeting model employer targets for band 8a, 8b and 8d roles, providing work to increase representation at band 8c will strengthen the talent pipeline into future band 9 and VSM and this is where progress for 22/23 should be focussed. Further multi-dimensional analysis including a break down by staff group is review at the people committee.

Bands	BAME	White	Z Not Stated	Of which are Clinical	Of which are Non Clinical	Total Number	Proposed ENHT Target based on 34% of BAME staff	Model Employer 2022 Targets	Model Employer 2022 Target Met?
Band 8A	**52**	162	11	165	60	225	77	38	Yes
Band 8B	**19**	50	4	41	32	73	25	13	Yes
Band 8C	**10**	43	4	19	38	57	20	12	No
Band 8D	**7**	19	3	11	18	29	10	2	Yes
Band 9	**1**	12	0	3	10	13	5	2	No
VSM	**2**	18	0	1	19	20	7	3	No
Total	91	304	22	240	177	417	144	70	n/a

5. Equity and Inclusion Overall Priorities

Three key areas of priority are recommended by the National team based on our WRES data (*see high priority areas below*).

High priority areas for improvement within the Trust (to a maximum of three):
Indicator 9: Board representation (overall, voting members, and executive members)
Indicator 8: discrimination from a manager/team leader or other colleagues in last 12 months against BME staff
Indicator 6: harassment, bullying or abuse from staff in last 12 months against BME staff

Other key objectives (*pg. 9)* will continue to collectively address all disparities and inequalities faced by our Black, Asian, and Minority Ethnic colleagues, eliminate racism and all forms of discrimination, and bring a true sense of belonging in this organisation.

All work undertaken is underpinned by the People Strategy four pillars (Work, Grow, Thrive & Care together see diagram below) and the Trust ambition to create an environment which fosters equity and inclusion, supports progression and ensures the organisation is a place whereby everybody feels they belong; and likewise delivers inclusive services to the community we serve.

Working together through and with our staff diversity networks, will continue to ensure networks flourish and that we continue champion the principles of intersectionality whilst continuing delivery on the equity and inclusion agenda. As opportunities arise at Board level, we will increase diversity. Our freedom to speak up guardian work and people policy reviews are supporting and enabling staff to speak up about their experiences and to confidentially raise concerns to be addressed and resolved with and for them.

The diagram below shows in more detail the types of work planned and underway for ENHT for 2022/23.

6. Conclusion and Next Steps

ENHT's aim is to create momentum, whereby equity and inclusion is everyone's business as part of everyday work. We have identified in some cases, a lack of knowledge and, this has been taken into consideration in setting up our people objectives for this year 2022/2023.

We require more engagement from everyone and have received feedback from staff about intention to engage in various events, yet being unable to do so, sometimes due to operational pressures, and through inflexible arrangements within some areas also playing a part.

We have seen an improvement from our staff survey results and anecdotal data that more staff are now reporting on issues of racism and discrimination. We need to collectively ensure more awareness of the organisation's policies and processes for raising concerns at work, with reassurance about how concerns are handled, treated seriously and with transparency.

Equally, how we handle concerns pertaining to racism and discrimination to foster the healing process matters. There is strong evidence of its impact on mental and physical health and that when invalidated or handled inappropriately, this can lead to more mistrust, isolation, and feeling of loneliness, in turn impacting one's ability to deliver well at work.

We have in plan the launch of two new documents, ENHT ED&I policy underpinned by our ENHT Equity & Inclusion strategy. The two documents will foster a co-production approach with staff side and staff networks and all relevant stakeholders to ensure its effectiveness, inclusivity, and sustainability.

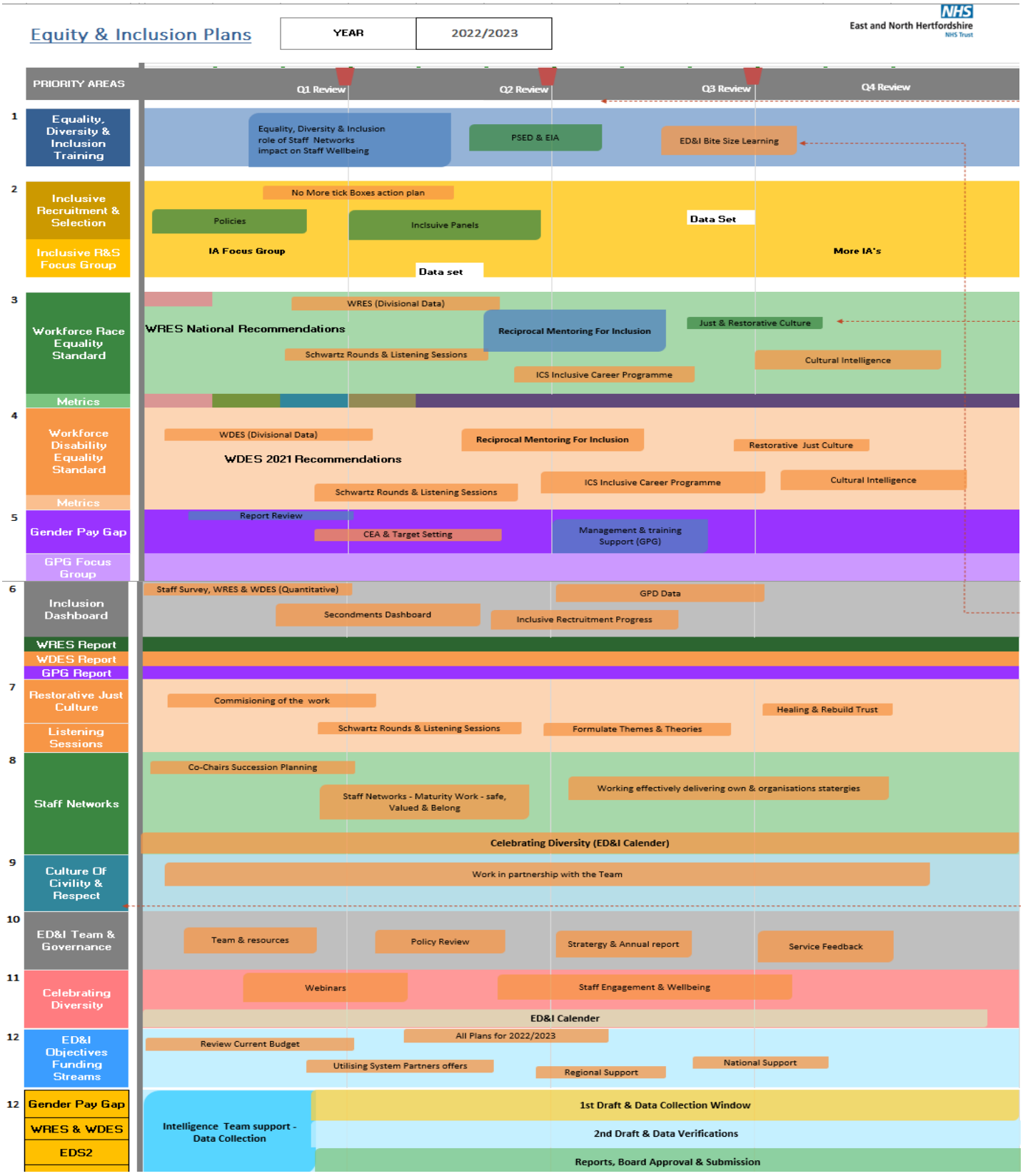
Working with People Intelligence, Planning and Analytics team we will further look at WRES data at divisional level, produce medical WRES as well as temporary workers (NHSP WRES) data, the latter will become a requirement for submission in 2023.

Equality, Diversity & Inclusion objectives so far, have been set in view of metrics from various data such Workforce Disability Equality Standard (WDES), Workforce Race Equality Standard (WRES), Gender Pay Gap (GPG), themes from NHS Staff survey, qualitative input from staff Networks and

People Pulse Survey. These tools provide assurance and help us monitor and see areas of improvement and overall experiences of staff and service users from the diverse groups.

The programme of work is mapped out (see below) and there is a considerable amount of work required to deliver our key priorities through various parallel action plans. We have the ambition to move further on equity and inclusion and as part of forward financial planning for 2023/24 will be seeking commitment to invest and divert funds as prioritised and agreed, to ensure success in ongoing delivery of the EDI agenda.

Appendix 1: Equality and Inclusion Plans



Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Trust Board – Part I			**Agenda Item**	16
Report title	Treasury Management Policy			**Meeting Date**	7 September 2022
Presenter	Crista Findell, Deputy Director of Finance				
Author	Odunayo Basorun, Financial Controller				
Responsible Director	Crista Findell, Deputy Director of Finance			**Approval Date**	8th July 2022
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**		☒
	Discussion	☐	**Decision**		☐

Report Summary:

This policy relates to treasury management which includes banking and cash arrangements and is intended to provide direction and help employees who may be involved with cash handling, banking arrangement, debtors and creditors and employee claims.

Impact: where significant implication(s) need highlighting

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

N/A.

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

There is a risk of cash mismanagement and fraud leading to loss if the policy is not adopted.

Report previously considered by & date(s):

N/A.

Recommendation	The Board is asked to approve the revised policy.

East and North Hertfordshire NHS Trust

Cash and Treasury Management

About this document	
Document ID	CP 272 **Version:** 002
Full review due before	31 July 2025
Document type	Policy
Usage & applicability	Trust wide

Summary

- To maintain good governance within East and North Hertfordshire NHS Trust ('The Trust'), there is need for a cash and treasury management policy to ensure the Trust's cash resources are managed in line with its regulatory financial requirement. The primary financial focus for a Trust is to deliver sustainable financial performance and as part of this the management of the Trust's cash is of critical importance to ensure the Trust services can run smoothly.

- This Policy therefore identifies the approach the Trust is expected to follow in the management of its cash and cash substitute resources and establishes the relationship between the Trust and the Department of Health and Social Care (DHSC), NHS England & Improvement (NHSE/I) HM Treasury (HMT) and the Government Banking Service (GBS), in relation to these matters.

- This policy is expected to complement but not replace the Trust's Standing Financial Instructions (SFIs).

What you need to know about this version

VERSION TYPE:

- Changed format.
- Update to processes and external organisations name

Contents

1. Scope

1.1 The Trusts cash balances are required to be invested with the Government Banking System (GBS). Investment in commercial banks, or stocks and shares, is not an available option for NHS Trusts.

1.2 Within the rules above the objectives of the Trusts cash management and treasury function are to support the operations of the Trust by:

1.2.1 providing accurate cash forecasts
1.2.2 always ensuring the availability of adequate levels of funding
1.2.3 identifying and managing the financial risks associated with holding insufficient, or excessive cash balances, and with insufficient or excessive projected cash balances
1.2.4 ensuring all cash transactions are adequately documented and authorised; And
1.2.5 managing and maintaining a strong set of relationships with banks, NHS England and Improvement (NHSE/I) and the Integrated Care Board (ICB) which meets current and future banking and funding needs.

1.3 This policy identifies the approach that the Trust is expected to follow in the management of its revenue and capital cash

1.4 It also identifies the procedures expected to be followed in the day-to-day management of the cash position and processing of accounts payable and accounts receivable transactions.

2. Purpose

2.1 NHS organisations are expected to operate in a climate of strong corporate governance and to ensure that public monies are used efficiently and effectively. In delivering this expectation the Trust needs to set out formally, its approach to managing its treasury function and minimising the risks that the Trust is exposed to in delivering its cash and treasury management duties.

2.2 The Trusts probity in conducting its treasury activities to ensure that it has sufficient cash resources available for at least twelve months is also essential for the Trust to be classified operationally as a ‘going concern’.

2.3 The Trust must comply with its statutory, regulatory and performance management obligations in managing its cash position, including meeting its External Financing Limit (EFL) target.

2.4 The Trust is required to maintain a bank account with their appointed bankers, through GBS. The Trust may also borrow from the Government and deposit surplus funds with HM Treasury.

2.5 The policy provides a clearly defined risk management framework for the Trust and those staff in the Trust responsible for treasury operations. Actions to manage this risk will vary over time and the policy will be reviewed regularly to reflect any changes in the Trust's operations and the on-going financial climate

3. Definitions

External Financing Limit (EFL) – is a cash limit on "net external financing" and is a statutory financial duty which the Trust is required to meet. Its purpose is to control the cash expenditure of the Trust as a whole to the level agreed by NHSE/I.

Government Banking Service (GBS) – GBS is part of HM Revenue and Customs and is the banking shared service provider to government and the wider public sector. It is responsible for holding the working balances of Government Departments and other public bodies in high level accounts at the Bank of England. These working balances are made available overnight to the National Loans Fund to reduce the government's borrowing costs.

Interim Financing Arrangements - There are a range of circumstances in which the Department of Health and Social Care provides funding as follows: -

- Normal course of Business: for capital investment and/or to support short-term working capital requirements where there is evidence of longer-term viability and ability to repay.
- Interim Support: The department may provide loans and in exceptional circumstances, Public Dividend Capital (PDC) to FTs or NHS Trusts which are in financial difficulty but only in such circumstances where it is necessary to support the continued delivery of services. This finance is normally a precursor to a longer-term Recovery Plan.
- Planned Term Support: Where a Recovery Plan is developed and agreed, longer term financial support is available. This support is expected to provide sufficient certainty and stability to aid recovery.

The type of support required will be decided between the Board, NHSE/I and Department of Health and Social Care in line with the prescribed criteria.

Capital Financing – Fund capital investment and specifically the purchase of assets (buildings and equipment) generally costing more than £5,000. Permanent discretionary capital PDC, while remaining available for some exceptional investment purposes is not available for the purposes set out above and may only be considered where there is an overriding central strategic imperative or there is a compelling value for money case from the perspective of the taxpayer.

4. Duties

4.1 In line with the Trust's Standing Financial Instructions and Scheme of delegation (copy available on the knowledge centre), responsibilities under the Treasury Management Policy are:

4.1.1 Board

a) approve all external funding arrangements including the Trust's Committed Working Capital Facility and any longer-term loans for investment in Trust operational services
b) approve the Trust's investment and borrowing policy
c) approve the relevant benchmarks for measuring performance
d) review and monitor investment and borrowing policy and performance against agreed benchmarks
e) monitor compliance with treasury policy and procedures
f) delegate responsibility for day-to-day treasury operations to the Trust's Director of Finance

4.1.2 Director of Finance

a) approve cash budgets and forecasts
b) approve cash management systems
c) ensure treasury activities are reported appropriately to the Trust Board
d) manage key banking relationships
e) delegate the responsibility for treasury management to the Deputy Director of Finance.

4.1.3 Deputy Director of Finance

a) ensure treasury activities are managed according to the Treasury Management Policy
b) ensure timely and accurate information is available to support the management of the treasury function
c) delegate the day-to-day responsibility for treasury management to the Financial Controller

4.1.4 Financial Controller

a) manage day to day banking relationships
b) Ensure accurate and timely recording in the Trust's accounting records of all treasury transactions
c) bank reconciliations are carried out monthly by the transaction team manager and reviewed by the Deputy Financial Controller – Technical and Reporting monthly with exceptional items being reported to the Director of Finance. A summary of items not reconciled, over 90 days old, to be included in the monthly Treasury Report
d) regular review of the Treasury Management Policy and recommending changes in the policy to the Deputy Director of Finance.

5. Associated Documents

The following documents are related Trust policies and procedural documents, which are advised reading to supplement this document and/or process.

Document title	Doc ID	Originator
Trust's Standing Financial Instructions (SFIs)	CG05	☒ENHT | ☐Affiliated network | ☐National/ regional
Managing Conflicts of Interest Policy	CG03	☒ENHT | ☐Affiliated network | ☐National/ regional
Anti-Fraud and Bribery Policy	CG04	☒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.

6.1. Equality Analysis

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.

6.2. Data Protection Impact Assessment (DPIA)

Trust functions involving the processing of personal data will require a DPIA Screening (DPIAS) to determine if additional protection measures are required. DPIAS can cover an entire system, team or broader set of processes. The Information Governance manager holds a list of DPIAS submitted by departments and other guidance of the process can be found in the Information Governance section of the intranet.

Part 2 – Treasury management

1. Bank Relationships and Cash Management

1.1 The development and maintenance of strong banking relationships is an important and key factor in enabling the Trust to manage its cash.

1.2 Key objectives in this area are to:

a) ensure the cost paid for banking services is competitive
b) to develop and maintain a strong relationship with a bank (or a number of banks)
c) monitor and ensure compliance with banking covenants
d) ensuring compliance with all banking mandates by checking that all banking transactions / documents are signed by authorised signatories of the Trust
e) ensuring the cash balance on other bank accounts outside the GBS account does not exceed the maximum allowed for NHS Trusts

1.3 The Director of Finance is responsible for managing all banking relationships and ensuring a consistency of approach across all banking services to achieve the optimum benefits for the Trust.

2. Cash & Treasury Management Control environment

2.1 The controls identified in this policy are designed to ensure that the Trust's cash and voucher management activities are undertaken in a controlled and properly reported manner. The overall control environment extends further than the specific management of cash and vouchers with cash equivalent to include the following:

- Clearly defined roles and responsibilities, that are understood by all, as described above;
- Regular monitoring and reporting of the progress of cash management;
- Systems to ensure effective cash flow, through vigorous management of receivable and payable transactions;
- Strict controls over authorisation limits in line with SFIs;
- Proper segregation of duties between the cashier's function, those who initiate expenditure and income transactions and those who reconcile cash and bank accounts; and
- Inclusion of treasury management activities within the scope of review by internal and external audit.

2.2 A rolling 12-month cash flow forecast will be used, and cash will be managed to ensure that:

- All financial obligations can be met on, or before, the day they fall due;
- Borrowing is a last resort and only taken when required. The Trust will not borrow in advance of need or borrow to invest;
- Borrowing costs are held to the minimum;

- Surplus cash achieves the best possible rate of return with the caveat that the Trust is obliged to lodge surplus cash with the HM Treasury; and
- The Board is kept fully aware of the Trust's on-going cash position and performance against its cash plan.

2.3 The Trust will maintain bank accounts with the GBS and (if required) with a commercial bank, approved by the Trust Board, in line with the SFIs.

2.4 The Trust's cash management procedures will be subject to periodic review by its internal and external auditor as part of their audit undertakings. Any weaknesses, or significant deviations from agreed policies and procedures will be reported to the Audit Committee and, where appropriate, to the Trust Board.

2.5 Cash must at all time be kept in a secured safe, under lock and key. Any alternative arrangement for safe keeping must be approved by the Director of Finance.

2.6 Detailed operational guidance, for the relevant financial operations, is shown in Appendix 1 to this policy.

2.7 Petty Cash Accounts

- The Trust has two petty cash account- holding locations – at Lister and Mount Vernon. If it is determined that a further petty cash float or cash office is necessary, then authorisation will be required from the Director of Finance and any new float would be subject to the levels set out in this policy.
- Petty cash account holders are also required to submit a monthly reconciliation of cash drawn and expenditure made to Cash Management Team.
- All cash top up request must be submitted to the Deputy Financial Controller for review and approval.
- The operational procedure for petty cash is shown in Appendix 1 to this policy.

2.8 Vouchers and other documents with cash equivalent values

- The Trust will maintain a record of all vouchers and any document with cash equivalent value. This record will contain voucher number, value and type of value
- All vouchers with cash equivalent will be stored in safe or other secured place approved by Deputy Financial Controller
- All issues and replenishment of voucher shall be recorded and approved by Deputy Financial Controller
- The division holding vouchers will provide reconciliation of purchases, issues and stock of vouchers to finance before approval of replenishment.

3. Policy effect

3.1 The annual operating cash forecast will be prepared in advance of the start of the financial year. This will be reviewed and updated on a daily basis in conjunction with monitoring of the Trusts bank accounts. The operating cash forecast will be reviewed on a weekly basis by the Financial Controller who will determine whether any cash shortfalls are anticipated.

3.2 Borrowing requirements will be determined by the Director of Finance or nominated deputy, normally the Deputy Director of Finance (Financial Management) or the Financial Controller.

3.3 Borrowing will always be a last resort, within the constraints of meeting payment obligations. Borrowing will be restricted to the minimum required to meet expected shortfalls. Under Department of Health rules, the primary source of additional capital is through loans or PDC made available through DH central programmes, however, in exceptional circumstances, where loans are deemed unaffordable, the NHSE/I may approach the DH to provide financing in the form of PDC. Trusts should not draw PDC in advance of need.

3.4 Cash cannot be borrowed with a view to investing.

3.5 The Trust will not borrow from any commercial organisation unless NHSE/I specifically allows this activity.

3.6 Bank accounts will not have overdraft balances. The Trust Board will not expect to require a guarantee or to use an overdraft facility.

3.7 In the event that surplus cash is forecast it will be held in the GBS bank account until required to maximise the return from interest. However, NHSE/I may deem that significant surpluses realised from capital transactions (sales and depreciation) should be re-invested or used to repay existing loan or Public Dividend Capital (PDC).

3.8 In accordance with current statutory requirements, any cleared balances in excess of £50,000 will be transferred on a daily basis from the Trusts commercial bank account to its GBS account.

3.9 All staff will support effective cash management in the Trust by ensuring that all invoices for payment receive prompt attention and are passed to the Payments Team. The Payments Team will comply, wherever possible, with the Better Payment Practice Code, i.e. payment within 30 days (or other terms) of receipt of an invoice or prompt resolution of a query.

3.10 Staff with a responsibility for providing goods or services to external parties will ensure that invoices are raised promptly. Staff will adhere to procedures prepared and

distributed by the Director of Finance when dealing with accounts receivable or payable.

3.11 The Transaction Team will ensure that sales invoices are raised on a timely manner and followed up regularly to ensure prompt payment. Where queries are raised by customers with regards to an invoice, the team should ensure they are actioned immediately to achieve prompt resolution.

3.12 The Board will receive a report each month detailing the Trusts cash position, performance against plan, forecast year end position and borrowing requirements to date. The Audit Committee and/or Finance, Performance and Planning Committee (FPPC) will seek further explanations or information as required.

3.13 In summary the Trust Board will receive the following on a monthly basis:

- Statement of Comprehensive Income;
- Statement of Financial Position;
- Statement of cash flows;

3.14 The Trusts FPPC will receive the following on a monthly basis:

- the information provided to the Trust Board as per above plus;
- Capital expenditure report
- Better Payment Practice Code Report;
- rolling 12 month cash flow.

3.15 Financing applications (for permanent, revenue and capital PDC or revenue or capital loan) will all be signed off by the Trust Board before these are submitted to NHSE/I.

4. Dissemination and Implementation

4.1 This document will be uploaded to the knowledge centre and to the Trust's website and will be communicated to relevant staff via email.

4.2 This document will be issued to all Finance staff involved in cash and Treasury Management.

Part 3 – Appendices

Appendix 1 – Operational Guide

Operational procedures applicable to Cash and Treasury Management

1.1 The overall objective of the procedures set out below is to ensure cash management activities are undertaken in a controlled manner as indicated in the above policy, thereby ensuring the Trust is not exposed to undue operational risks.

1.2 Segregation of duties is specified between those who manage the cash position, those who initiate payments, and those who account for transactions.

1.3 All transactions are recorded within the general ledger and are supported by an instruction, confirmation or approval.

1.4 All payment instructions and confirmations will require two authorised signatories in accordance with approved bank mandates.

1.5 Mandates will be reviewed regularly and sent to all counterparties.

1.6 Cheques that have not been cashed six months after date of issue will be written off.

1.7 Any cheques issued by the Trust that are subsequently lost will not be re-issued until they have been cancelled with the bank.

Bank mandates

2.1 The Trust Mandate is approved by the FPPC with regard to signatories and appropriate limits.

2.2 The FPPC can delegate to the Director of Finance to determine staff to be included in the bank mandate

2.3 Copies of bank mandate are sent to all counterparties together with specimen signatures of staff authorised to sign payments.

2.4 Copies of all bank mandates and authorised bank signatories shall be maintained by the Cash and Treasury Team and kept with the Deputy Financial Controller.

2.5 All payments must be signed by two signatories in accordance with the Trust's Scheme of Delegation.

2.2 The Trust will ensure that the DH authorised signatory list is maintained up to date and the DH are kept informed of changes to signatories as these occur.

Routine cash management procedures

3.1 The Cash and Treasury Team will:

1. Review the cash requirements on a daily basis, examining cash brought forward, daily transactions and the subsequent cash requirement or availability;

2. Review the required movement of funds between bank accounts on a daily basis;

3. Ensure that the Trust holds sufficient liquid funds to cover all known commitments, with a reasonable buffer held;

4. Review, where necessary, the draw-down of borrowed funds or payment of interest or capital to lenders;

5. Review the receivable and payable run information, to ensure the Trust maximises its cash position; and

6. Ensure all reconciliations and accounting requirements are in place.

Debtor management

4.1 For all goods and services provided by the Trust, subject to the requirements that, where possible, payment in advance should be collected for all on-site transactions

4.2 Invoices must be raised on a timely basis for goods and services provided by the Trust, including all private patient work.

4.3 An invoice to each of the Trust's main commissioners will be raised on the first day of each month (or where agreed 15th of the previous month) to allow the Trust's main commissioners to make a cash payment to the Trust based on a twelfth of the total contract value. Under the contract's guidelines and in line with the recommended time scale, an adjustment for under or over performance against the contracted value will be made on a monthly basis.

4.4 Invoices will be raised by the receivables function of the Finance Department, within three working days from the date sales orders are raised by the management accounts team.

4.5 When invoices are raised, credit control will be undertaken by the outsourced service provider (NHS SBS) and monitored by the Transaction Team. If invoices are not settled within the specified time periods, the debtor is immediately pursued by SBS.

4.6 An Aged Debt Report will be produced monthly and reviewed by the Financial Controller. The report will contain all relevant information e.g., organisation, age of debt, size of debt, type of debt etc.

Creditor management

5.1 Goods and services must be requisitioned using official ordering systems, as approved by the Trust except if specified in the Trust Standing Financial instructions.

5.2 The Trust Outsourced Procurement Service Provider has the responsibility for negotiating the best combination of trade discounts and settlement terms. NHS SBS will match and record invoices against orders. Invoices will be electronically scanned upon receipt, with e-mail notification to authorising officers who will then electronically authorise the invoice. It is the responsibility of those officers to authorise the invoices only if the goods and services received are satisfactory and to provide the payments team with a reason why an invoice should not be paid within given deadlines.

5.3 Additional controls are in place to ensure timeliness in the settlement of debts and to avoid late payment charges through monitoring of the promptness of authorisation.

5.4 Accounts Payable, overseen by the Deputy Financial Controller - Transactions, will ensure that settlement is within agreed terms or within thirty days, whichever is the shorter.

5.5 Creditors will usually be paid on a weekly basis to maximise the flexibility of terms and minimise the need for urgent payment runs. It is the Trust's aim to meet the payments laid down in the Public Sector Payment Policy.

5.6 Accounts Payable have a responsibility to provide information to the Deputy Financial Controller - Transactions on prospective weekly run values, ad-hoc high value invoices, late high value payments and any other exceptional items.

Monthly Cash flow

6.1 The schedule shows detailed cash flows for the next seven days and beyond at least one month of forecast transactions at a summary level, produced on a rolling basis and by key headings. It will show actual flows, for prior periods to the current date and forecast figures for future periods and will highlight the balance carried forward, along with the forecast transactions.

6.2 Cash flow projections will distinguish the key areas of expenditure i.e. pay, non-pay, PAYE, NI, TAX, Creditors etc.

6.3 The monthly movement report will be produced by the Deputy Financial Controller – Transaction and reviewed by the Financial Controller and Deputy Director of Finance on a monthly basis.

6.4 A brief written report will be prepared each month for the Board containing the following information:

1. Actual cash performance against the annual cash plan;
2. Analysis of cash/borrowings;
3. Receivable and payable positions.

6.5 The monthly Board reporting information and graphs will be supplied by the Financial Controller as per Trust timetables.

Annual Cash Flow forecasting

7.1 An annual cash flow projection will be produced at the start of each financial year to inform that year's plan. This will be signed off by the Trust Board.

7.2 By working day 10 of each month, a high-level outline (rolling) forecast for the next twelve months will also be produced. This information will be used to inform the Board of the Trust's long term cash flow position

Petty Cash Expenditure and Reimbursement

8.1 This procedure applies to the reimbursement of minor expenditure through petty cash reimbursement for employees of the Trust and reimbursement of travel claim for patients (where eligible).

Employee claim

8.2 Petty cash reimbursements are restricted to item(s) that are necessary for the performance of official duties and on occasions when it is;

1. unreasonable or impractical to purchase via the requisition route; or
2. poor value for money if invoiced (e.g. where there is a minimum order value for credit terms); or
3. a case of genuine emergency.

8.3 Petty cash floats are intended for reimbursement of minor values only and must NOT be used to avoid raising a requisition: because of failure to plan work accordingly; or to avoid the authorisation process.

8.4 This is to ensure that:

1. there are adequate internal controls and segregation of duties;
2. purchases are recorded against any existing contracts or orders;
3. budget holders authorise expenditure in advance and are aware of all commitments against their budget;

Patient claims

8.5 Patients who require reimbursement should ensure that the claim form is duly authorised by the division concerned

8.6 The cashier will review and ensure that patient is entitled to the reimbursement under NHS guidelines and that claim form is approved by the division before cash is disbursed

8.7 The cashier will review and ensure that patient claim form is fully completed and authorised in line with delegated authority of the Trust

8.8 All Patient claim forms will be securely kept or sent to finance when required

Claiming Reimbursement via Petty Cash

9.1 The petty cash float must be held securely by the Float Holder and reimbursements will only be made by the Float Holder or the nominated Float Holder Deputy(s).

9.2 Anyone requesting reimbursement via petty cash must have a Petty Cash Voucher from the Float Holder. The reason(s) for not raising a requisition and an alternative method of obtaining the goods or services will be discussed before a Petty Cash Voucher is issued.

1. Petty Cash will only be used to claim reimbursement of small incidental items of expenditure.

2. Any large or regular ordering of goods / services must be done through the normal procurement processes, in line with SFIs and SoD

3. The maximum amount that may be claimed in respect of any single claim of expenditure through the petty cash system is £25. Multiple claims cannot be made for the same expense and multiple claims cannot be submitted on the same day.

4. Petty Cash Expenditure Vouchers must be fully completed. It should be signed by both the float holder giving the cash and the employee receiving it.

5. Valid receipts are required for reimbursement. All expenditure must be supported by an original receipt which shows the supplier name, date, amount paid and a description of the item(s). Photocopies of receipts will not be accepted - in the event of a receipt being lost, an explanatory memo must be signed by the authorising officer.

6. If the Authorised Budget Holder is claiming the petty cash, they cannot approve the Petty Cash voucher themselves, this must be signed by their line manager. The approval cannot be delegated to a more junior staff member.

7. Advances of petty cash will only be made in exceptional circumstances. A written explanation must be provided to chief cashier stating the reasons for advances and approval must be sought from the Financial Controller before any cash is released.

8. The cashier should ensure that the correct financial code is quoted on the Petty Cash Voucher before authorising it.

Claiming Reimbursement via Petty Cash – Exclusions

1.1 The following items cannot be reimbursed via petty cash:

1. Staff advances
2. Other expenses claims such as staff travel, parking, petrol etc, should be submitted through payroll by filling the appropriate "Payroll Expense Claim Form" and must not be claim through petty cash.
3. Publications
4. Uniforms
5. Subscriptions

Replenishment of Petty Cash Float

11.1 The Petty Cash Float should hold at £6,500 for Lister and £2,000 for Mount Vernon. The Petty Cash Float should be checked, balanced and reconciled monthly by the Chief Cashier. Prior approval should be obtained from Transaction manager / Deputy Financial Controller for ordering any amount that will exceed the petty cash float.

11.2 Prior to replenishment of petty cash float chief cashier should;

1 Reconciled the petty cash records and check the following:

a. the correct opening float,
b. correct additions,
c. completeness and correctness of supporting vouchers

Any discrepancy must be immediately reported to the Financial Controller

2 The details of each claim are logged in petty cash Account Payment sheet, by number, date received, amount, cheque payee and remaining float value.

3 Once data is inputted into Oracle the original copy of Imprest Account Payment Sheet should be sent to Transaction Manager. The cash office should retain and file a copy of the submitted Imprest Account Payment Sheet with original individual vouchers/ claim forms submitted for each claim recorded on the sheet.

11.3 All petty cash float top up must be signed by Deputy Financial Controller before cash can be replenished

Replenishment of Petty Cash Float

12.1 Cash shall be collected by an authorised cash collection service company (currently G4S) on Tuesday and Fridays for Lister Hospital cash office, and Wednesdays and Fridays for Mount Vernon cash office.

12.2 Prior to arrival of G4S staff, the cashier will count and bag cash according to denomination. This shall be checked, and counter signed by another cashier. Counting, bagging, and checking must be completed by two people.

12.3 The cash bagged shall be recorded in the cash book with the bag reference number.

12.4 The cashier shall ensure that the cash collected is signed for and necessary signed forms are kept safely.

12.5 A copy of the cash book showing amount collected and signed form confirming collection shall be sent to finance

12.6 Finance shall reconcile on monthly basis, the amount collected by G4S to the amount deposited in the bank

12.7 Any discrepancy shall be notified to the Financial Controller immediately for investigation.

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 272 , Version – 002 Cash and Treasury Management
Document type	SELECT ONE ☐ Competency, ☐ Guideline, ☐ Pathway, ☒ Policy,☐ Procedure, ☐ Protocol, ☐ Standard Operating Procedure Selected- 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: Selected- Trust wide
Review cycle	☒ Every 3 years (standard) ☐Annual review ☐ Other: **31 July 2025**
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 Selected-37T37T Version sign-off category (ADMIN USE ONLY): ☐Type A (full review) ☐Type B (interim update) ☐Type C (local documents)
Keywords	
Version author	Odunayo Basorun, Financial Controller, Finance ☐Cancer ☐Planned ☐Unplanned ☒Corporate/Directorate
Policies lead for area	Name, role, dept/service/area ☐Cancer ☐Planned ☐Unplanned ☒Corporate/Directorate
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

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. This

Input from Trust function	Action required by author
1. **Equality, Diversity & inclusion**	Trust documents require an Equality Analysis screening as evidence that the protected characteristics under Equality Act 2010 have been considered, as per Part 1, section 6.1 in this document ☐As the document author, I understand I need to complete the Equality analysis screening to determine if a full assessment is required. See Equality, Diversity & Inclusion section of the intranet for details
2. **Data Protection**	Does this Trust document cover the use of a Trust function to process personal data? ☒No – proceed to next item ☐Yes. As per Part 1, section 6.2 in this document a Data Protection Impact Assessment Screening must be completed. Visit the Information Governance section of the intranet for instructions
3. 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 What was recommendation:
4. 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.
5. Nursing & Midwifery	This document contains processes that will have an impact on nursing and midwifery staff and care or that would affect 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 and Midwifery Executive Committee and/or ☐The appropriate training team e.g. 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.
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 -including staff side) should be included in 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

Input from Trust function	Action required by author
	☒Yes – please follow steps **Step 1**: Involve/request input from: ☐payroll, ☐local budget holders, ☐anti-fraud team 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. ☒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)
	☐Content contribution ☐Usability testing ☐Other:	
	☐Content contribution ☐Usability testing ☐Other:	
	☐Content contribution ☐Usability testing ☐Other:	
	☐Content contribution ☐Usability testing ☐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.

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Trust Board – Part I		**Agenda Item**	17
Report title	Audit Committee expanding to an Audit and Risk Committee		**Meeting Date**	7 September 2022
Presenter	Stuart Dalton, Trust Secretary			
Author	Stuart Dalton, Trust Secretary			
Responsible Director	Martin Armstrong, Deputy CEO		**Approval Date**	12 August 2022
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**	☒
	Discussion	☐	**Decision**	☐

Report Summary:

This paper seeks approval for Audit Committee to become an Audit and Risk Committee. Historically, Quality and Safety Committee has taken a lead role in oversight of corporate risk, where this more usually sits with Audit Committee.

To enact the changes requires amendments to the Standing Orders, Scheme of Delegation (**appendix 1 – relevant substantive change extracts**) and Terms of Reference for the Audit Committee (**appendix 2**) and the Quality and Safety Committee (**appendix 3**); which are presented for Board approval.

The Standing Orders and Scheme of Delegation have been changed to state "Audit and Risk Committee" instead of "Audit Committee" in numerous places These name changes are not included in appendix 1 to avoid lengthy Board papers that add no value. The whole document is included in the Resource Centre on Diligent (Resource Centre/Committee documents for Trust Board Part 1/ 7 September 2022 appendices papers). This is trialling using the new Diligent system to store supporting documents for Board/Committees to reduce the length of papers and focus on what is substantive. If the trial is successful, then the intention is to extend this shorter main papers with non-mandatory supporting papers approach to other Board and Committee papers.

Impact: where significant implication(s) need highlighting

The combined benefit/impact envisaged from these proposed improvements are:

- producing a clear top corporate risks register (operational risks as opposed to the risks to delivering the Trust's strategy – which are the BAF risks) that reflects the genuinely most critical operational risks to the Trust; and
- a clear framework to drive risk standards and provide meaningful assurance and the structures to promptly and effectively address priority actions identified. An Audit and Risk Committee is ideally placed to provide Trust-wide corporate risk management oversight. As part of the proposed enhancements to corporate risk management, a Risk Management Group is being established that will provide executive oversight of risk management and a new risk management module is being developed as part of the ENHance system that is replacing Datix.

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

N/A

Report previously considered by & date(s):

The BAF paper to Board on 6 July raised the option of an Audit and Risk Committee	
Recommendation	The Board is asked to approve: • Audit Committee becoming the Audit and Risk Committee • the amendments to the Standing Orders; Scheme of Delegation and Terms for the Audit and Risk Committee and Quality and Safety Committee to enact this change

APPENDIX 1

East and North Hertfordshire NHS Trust

TRUST-WIDE POLICY

for

STANDING ORDERS, RESERVATION AND DELEGATION of POWERS and STANDING FINANCIAL INSTRUCTIONS

A document recommended for use

In: Trust-wide

By: All staff

For: NHS Trusts are required by law to make Standing Orders (SOs), which regulate the way in which the proceedings and business of the Trust will be conducted.
High standards of corporate and personal conduct are essential in the NHS. These "extended" Standing Orders, incorporating the Standing Financial Instructions (SFIs), Schedule of Reservations of Powers (SRP) and Scheme of Delegated Authorities (SoDA) identify who in the Trust is authorised to do what.

Key Words: Policy, Standard Financial Instructions, Standing Financial Orders, Finance, Governance, Delegated Authorities

Written by: Trust Secretary
Financial Controller
Director of Procurement
Local Counter Fraud Specialist / Anti-Crime Specialist

Approved by:
Audit committee

Trust Ratification: Trust Board

Mrs Ellen Schroder (Trust Chair), 2022-05-04

Policy issued: 4 May 2022

To be reviewed before: **1 October 2023**

To be reviewed by: Trust Secretary / Financial Controller

Doc Registration No. CG05 **Version No.** 13

Version	Date	Comment
1	2010	
2	2012	

3	2013	Scheduled review: Updated to reflect the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation. Loss and compensation section updated. Delegated Limits reviewed.
4	October 2014	Scheduled review – Minor changes. Delegated limits reviewed.
5	October 2015	Scheduled review. Revised to reflect Capital Review Group Update to include revised process regarding centralisation of documents on the KC; improved escalation process and inclusion of a wider range of documents
6	October 2016	Scheduled review. Revised to ensure supports Board meeting moving to bi- monthly, include the Auditor Panel and strengthen procurement.
7	October 2017	Scheduled review. Updated in line with Organisational changes.
8	October 2018	Scheduled review. Updated in line with Organisational changes.
9	October 2019	Scheduled review. Updated in line with Organisational changes.
10	October 2020	Scheduled review. Updated in line with Organisational changes.
11	October 2021	Scheduled review. Updated in line with Organisational changes.
12	May 2022	To enable a committee restructure
13	Sept 2022	For Audit Committee to become an Audit and Risk Committee

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

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

Associated Documentation
Managing Conflicts of Interest Policy
Anti-Fraud and Bribery Policy
Trust Values & behaviours

Review
This document will be reviewed annually, or sooner in light of new legislation or new guidance issues by the department of Health.

Key messages
1. The consolidated document provides a single source of the key rules under which the Trust is managed and governed.
2. The regulations which determine the way that the Trust Board operates and the Trust is governed are spelt out in the Standing Orders.
3. Financial responsibilities and authorities are described in the SFIs and SoDA
4. All employees of the Trust need to be aware of their responsibilities and authorities described in this document. Failure to comply with this document is a disciplinary matter, which will be handled in accordance with the Trust's Disciplinary Policy. Where a breach constitutes a criminal offence, the matter may be subject to criminal investigation and will be handled in accordance with the Trust's Anti-Fraud and Bribery Policy and relevant legislation.

Page

CONTENTS

Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Trust Board.

4.6 Approval of Appointments to Committees

The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board as defined by the Secretary of State. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

4.7 Appointments for Statutory functions

Where the Board is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Board such appointment shall be made in accordance with the regulations and directions made by the Secretary of State.

4.8 Committees established by the Trust Board

The committees, sub-committees, and joint-committees established by the Board are:

4.8.1 Audit and Risk Committee

In line with the requirements of the NHS Audit Committee Handbook, NHS Codes of Conduct and Accountability, and more recently the Higgs report, an Audit Committee will be established and constituted to provide the Trust Board with an independent and objective review of the Trust's system of internal control including its financial systems, financial information, assurance arrangements including clinical governance, risk management and compliance with legislation. The Terms of Reference will be approved by the Trust Board and reviewed on a periodic basis. Assurances with regards to the ongoing management of risk are within the duties of the relevant sub-committee.

The Audit and Risk Committee will act as the lead oversight committee for Trust-wide corporate and strategic risk management. Other committees will support the Audit and Risk Committee through monitoring risks that fall within their remit.

The Higgs report recommends a minimum of three non-executive directors be appointed, unless the Board decides otherwise, of which one must have significant, recent and relevant financial experience.

4.8.2 Remuneration and Appointments Committee

In line with the requirements of the NHS Codes of Conduct and Accountability, and more recently the Higgs report, a Remuneration and Appointments Committee will be established and constituted.

The Higgs report recommends the committee be comprised exclusively of Non-Executive Directors, a minimum of three, who are independent of management.

The purpose of the Committee will be to make decisions on the remuneration and terms of service for the Chief Executive and other Executive Directors and those staff that are not covered by Agenda for Change or Medical and Dental Terms and

Conditions; to monitor and evaluate the performance of Executive Directors and to oversee contractual arrangements, including proper calculation and scrutiny of termination payments.

The Committee will also review and approve the Remunerations Framework for subsidiary companies of the Trust.

4.8.3 **Charitable Trustee Committee**

In line with its role as a corporate trustee for any funds held in trust, either as charitable or non charitable funds, the Trust Board will establish a Trust and Charitable Trust Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission.

The provisions of this Standing Order must be read in conjunction with Standing Order 2.8 and Standing Financial Instructions 29.

4.8.4 **Other Committees**

The Board may also establish such other committees as required to discharge the Trust's responsibilities. The Terms of Reference will be approved by the Trust Board and reviewed on a periodic basis.

These currently include:

i) Finance, Performance and Planning Committee - .
The purpose of the Finance, Performance and Planning Committee is to provide assurance to the Board that appropriate arrangements are in place to support the delivery of the financial and operational and workforce planning objectives which contribute to the delivery of the Trust Strategy. Through this work, the Committee will play a key role in ensuring the sustainability of the Trust.

The Committee's work will include:

- maintaining an overview of the development and maintenance of the Trust's medium and long term financial strategy;
- providing scrutiny of operational performance;
- monitoring workforce planning and establishment reviews;
- overseeing risk management for the duties of the Committee.
- To monitor and review the Trust's strategic plans for IT/Digital and the Green Plan.

ii) Quality and Safety Committee -
The purpose of the Quality and Safety Committee (QSC) will be to ensure that appropriate arrangements are in place for measuring and monitoring quality and safety including clinical governance, clinical effectiveness and outcomes, health inequalities, research governance, information governance, health & safety, patient and public safety, compliance with CQC regulation and some workforce issues relating to workforce capability and development, such as education and talent management, or where there is a clear and direct link to quality and safety issues. The Committee will be responsible for assuring the Board that these arrangements are robust and effective and support the delivery of the Trust's Clinical Strategy 2019-2024 and Quality Strategy.

~~Please note the Trust's Audit Committee will ensure the Board has a sound assessment of risk and that the Trust has adequate plans, processes and systems for managing risk and the Finance, Performance and People Committee will ensure the~~

~~monitoring of financial risk, unless there is potential impact or actual risk to quality identified; in these circumstances QSC will provide scrutiny.~~

iii) Auditor Panel - In line with the requirements of the Local Audit and Accountability Act 2014 the Trust has established an Auditor Panel to enable the Trust to meet its statutory duties by advising on the selection, appointment and removal of the External Auditors and on maintaining an independent relationship with them. The Terms of Reference are approved by the Trust Board and reviewed on a periodic basis. The committee is comprised of the Audit and Risk Committee Non-Executive Directors.

~~iii) Strategy Committee [this committee will cease from 1 September 2022]~~
~~The Strategy Committee is responsible for overseeing the delivery of the Trust's vision and strategic aims to 2024 and associated transformation of services. To provide Board level assurance of the leadership, commitment and alignment of corporate strategies, strategic projects and service and workforce transformation agreed under the scope of the committee.~~

iv) People Committee
The purpose of the People Committee is to provide assurance to the Board on all aspects of the development and delivery of the Trust's People strategy and plans to ensure and deliver a sustainable workforce that is engaged, motivated and well supported and oversee the development and delivery of the Trust's inclusion, equality and diversity strategy.

5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

5.1 Delegation of Functions to Committees, Officers or other bodies

5.1.1 Subject to such directions as may be given by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, sub-committee appointed by virtue of Standing Order 4, or by an officer of the Trust, or by another body as defined in Standing Order 5.1.2 below, in each case subject to such restrictions and conditions as the Trust thinks fit.

5.1.2 The National Health Service Act 2006 as amended by the Health and Social Care Act 2012 allows for regulations to provide for the functions of Trusts to be carried out by third parties. In accordance with The Trusts (Membership, Procedure and Administration Arrangements) Regulations 2000 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (amended) the functions of the Trust may also be carried out in the following ways:

(i) by another Trust;

(ii) jointly with any one or more of the following: NHS trusts, NHS England and Improvement (NHSE/I), Clinical Commissioning Group (CCGs), other health bodies or local authorities;

(iii) by arrangement with the appropriate Trust(s), local authority(ies), health body(ies) or CCG(s), by a joint committee or joint sub-committee of the Trust and one or more other health service bodies or local authority(ies);

(iv) in relation to arrangements made under S63(1) of the Health Services and Public Health Act 1968, jointly with one or more NHSI, NHS Trusts, CCG, health body or local authority.

5.1.3 Where a function is delegated by these Regulations to another Trust, health body or local authority then that body exercises the function in its own right; the receiving body has responsibility to ensure that the proper delegation of the function is in

SECTION C - SCHEME OF RESERVATION AND DELEGATION

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
	ALL COMMITTEES	1. Approving terms of reference for sub-committees reporting to that Committee (excluding delegating decision-making, which is reserved to the Board to approve any executive decision-making delegations to a sub-committee).
SFI 11.1.1	AUDIT COMMITTEE	The Committee will act in accordance with the Audit Committee Handbook, and: 1. Advise the Board on internal and external audit services; 2. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives; 3. The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit and Risk Committee, Chief Executive and Board. 4. Review the work and findings of the external auditors and consider the implications and management's responses to their work. 5. The Audit and Risk Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. 6 Monitor compliance with Standing Orders and Standing Financial Instructions; 7 Review schedules of losses and compensations and making recommendations to the Board. 8 Review the annual financial statements prior to submission to the Board. A full list of responsibilities can be viewed in the Terms of reference for this committee which are appended to this document
SFI 20.1.2	REMUNERATION AND APPOINTMENTS COMMITTEE (REMUNERATION COMMITTEE)	The Committee will approve the remuneration and terms of service for the Chief Executive and other Executive Directors and those staff that are not covered by Agenda for Change or Medical and Dental Terms and Conditions; to monitor and evaluate the performance of Executive Directors and to oversee contractual arrangements, including proper calculation and scrutiny of termination payments.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		The Committee will also review and approve the Remunerations Framework for subsidiary companies of the Trust. A full list of responsibilities can be viewed in the Terms of reference for this committee which are appended to this document
	QUALITY AND SAFETY COMMITTEE	The purpose of the Quality and Safety Committee (QSC) will be to ensure that appropriate arrangements are in place for measuring and monitoring quality and safety including clinical governance, clinical effectiveness and outcomes, research governance, health inequalities, information governance, health & safety, patient and public safety, compliance with CQC regulation and some workforce issues relating to workforce capability and development, such education and talent management, or where there is a clear and direct link to quality and safety issues.. The Committee will be responsible for assuring the Board that these arrangements are robust and effective and support the delivery of the Trust's Clinical Strategy 2019-2024 and Quality Strategy. ~~Please note the Trust's Audit and Risk Committee will ensure the Board has a sound assessment of risk and that the Trust has adequate plans, processes and systems for managing risk and the Finance, Performance and People Committee will ensure the monitoring of financial risk, unless there is potential impact or actual risk to quality identified; in these circumstances QSC will provide scrutiny.~~ A full list of responsibilities can be viewed in the Terms of reference for the committee which are appended to this document
	FINANCE, PERFORMANCE AND PLANNING COMMITTEE	The purpose of the Finance, Performance and People Committee is to provide assurance to the Board that appropriate arrangements are in place to support the delivery of the financial, operational and workforce planning objectives which contribute to the delivery of the Trust Strategy. Through this work, the Committee will play a key role in ensuring the sustainability of the Trust. The Committee's work will include:

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		• maintaining an overview of the development and maintenance of the Trust's medium and long term financial strategy; • providing scrutiny of operational performance; • monitoring workforce planning and establishment reviews • overseeing risk management for the duties of the Committee; • To monitor and review the Trust's strategic plans for IT/Digital and the Green Plan.
	CHARITY TRUSTEE COMMITTEE	The purpose of the Charity Trustee Committee is: • To ensure a robust strategy for delivery of the Charity aims and objectives • To champion the charity and its development, providing leadership both within the Trust and externally • To provide stewardship of charitable resources and ensure compliance with relevant legislation, guidance and Trust policies This is a delegated duty carried out on behalf of the East and North Hertfordshire NHS Trust, which is the sole *Corporate Trustee* of the charity, East & North Herts Hospitals (registered charity no 1053338). A full list of responsibilities can be viewed in the Terms of reference for the committee
	~~STRATEGY COMMITTEE~~ ~~[UNTIL 1 SEPTEMBER 2022]~~	~~The Strategy Committee is responsible for overseeing the delivery of the Trust's vision and strategic aims to 2024 and associated transformation of services. To provide Board level assurance of the leadership, commitment and alignment of corporate strategies, strategic projects and service and workforce transformation agreed under the scope of the committee.~~ ~~A full list of responsibilities can viewed in the Terms of Reference for the Committee.~~

APPENDIX 2

East and North Hertfordshire NHS Trust

AUDIT AND RISK COMMITTEE TERMS OF REFERENCE

Purpose

The purpose of the Audit and Risk Committee is to provide an independent and objective review of the Trust's system of internal control including its financial systems, financial information, assurance arrangements including clinical governance, ~~approach to~~ risk management and compliance with legislation.

Status and Authority

The Audit and Risk Committee is established as a formal committee of the Board. It is a non-executive committee and has no executive powers other than those specifically delegated in these terms of reference.

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is also authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Membership

Three Non-Executive Directors (excluding the Chair of the Trust Board), one of whom shall be appointed Chair by the Board. At least one member will have recent and relevant financial experience.

Quorum

Any two members of the Committee are required to be present.

Attendance

The Director of Finance, the ~~Associate Director~~Head of Corporate Governance, and appropriate internal and external audit representatives shall normally attend meetings. At least once a year the Committee will meet privately with the external and internal auditors.

The Chief Executive should be invited to attend, at least annually, to discuss with the Audit and Risk Committee the process for assurance that supports the Annual Governance Statement (AGS). He or she should also attend when the Committee considers the draft internal audit plan and the annual accounts. Other executive directors should be invited to attend, particularly when the Committee is discussing the areas of risk or operation that are their responsibility. Other senior managers may be required to attend as needed.

Frequency of Meetings

The Committee will consider the appropriate frequency and timing of meetings to allow it to discharge all its responsibilities, but it will not meet less than five times

during the year. The External Auditors or Head of Internal Audit may request a meeting if they consider that one is necessary.

Duties

The duties of the Committee can be categorised as follows:

Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy of:

- the strategic approach to risk management across the Trust, the policies and processes for preparing the Board Assurance Framework and Corporate Risk, including the quality of the evidence for assurance provided by Internal and External Audit, management and other sources
- to review and monitor the Board Assurance Framework and Corporate Risk Register and the effectiveness of the management of principal risks, including carrying out a robust assessment of the Trust's emerging and principal risks.
- assurances relating to the management of risk, including assurance that Divisional and corporate risk registers are maintained and updated appropriately and that the Trust can demonstrate effective controls and assurances are in place to mitigate risk.
- all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions to test the effectiveness of the framework, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets mandatory Public Sector Internal Audit Standards and provides appropriate

independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal
- review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework
- consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise audit resources
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- an annual review of the effectiveness of internal audit

External Audit

The Committee shall review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- consideration of the appointment and performance of the external auditors, as far as the rules governing the appointment permit, including the effectiveness of the external audit process and the external auditor's independence and objectivity
- discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy
- discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- review of all external audit reports, including the report to those charged with governance, agreement of the Auditor's Annual Report (including Value for Money Report) before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Other Assurance Functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (eg the Care Quality Commission, etc) and professional bodies with responsibility for the performance of staff or functions (eg Royal Colleges, accreditation bodies, etc).

The Committee will also undertake the following additional duties:

- To approve the Data Quality Strategy and monitor delivery against the indicators,
- Oversight of non-compliance of the Standing Orders or Standing Financial Instructions (receiving a report ~~on~~ should there be non-compliance).

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's

own scope of work. ~~In particular, this will include the Quality and Safety (QSC), the Finance, Performance and People Committee (FPPC), Strategy Committee (SC), Equality and Inclusion Committee (EIC) and the Charity Trustee Committee (CTC).~~

In reviewing the work of the Quality and Safety Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (eg clinical audit) as they may be appropriate to the overall arrangements.

Financial Reporting

The Audit Committee shall review the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance. The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Audit Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- the wording in the AGS and other disclosures relevant to the terms of reference of the Committee
- changes in, and compliance with, accounting policies, practices and estimation techniques
- unadjusted mis-statements in the financial statements
- significant judgements in preparation of the financial statements
- significant adjustments resulting from the audit
- letter of representation
- qualitative aspects of financial reporting.

Reporting Arrangements

Following each meeting, the Audit Committee will submit a report to the Board on how it has discharged its responsibilities. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

The Committee will report to the Board at least annually on its work in support of the AGS, specifically commenting on the fitness for purpose of the Board Assurance

Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements, the appropriateness of the evidence compiled to demonstrate fitness to register with the CQC and the robustness of the processes behind the Quality Account.

Process for Review

The Committee will complete an annual review of its terms of reference and conduct a self-assessment of its effectiveness on an annual basis, in line with the requirements of the Audit Committee Handbook.

Support

The Trust Secretary and Assistant Trust Secretary will ensure the Committee is supported administratively and advise the Committee on pertinent issues/areas.

APPENDIX 3

East and North Hertfordshire NHS Trust

QUALITY AND SAFETY COMMITTEE
TERMS OF REFERENCE

1. Purpose

The purpose of the Quality and Safety Committee (QSC) will be to ensure that appropriate arrangements are in place for measuring and monitoring quality and safety including clinical governance, clinical effectiveness and outcomes, health inequalities, research governance, information governance, health & safety, patient and public safety, compliance with CQC regulation and workforce issues relating to the 'Grow Together' pillar of the People Strategy, or where there is a clear and direct link to quality and safety issues. The Committee will be responsible for assuring the Board that these arrangements are robust and effective and support the delivery of the Trust's Clinical Strategy and Quality Strategy.

Please note the Trust's Audit Committee will ensure the Board has a sound assessment of risk and that the Trust has adequate plans, processes and systems for managing risk and the Finance, Performance and People Committee will ensure the monitoring of financial risk, unless there is potential impact or actual risk to quality identified; in these circumstances QSC will provide scrutiny.

2. Status and Authority

The Committee is constituted as a formal committee of the Trust Board.

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

The Committee challenges and provides assurance on all areas of risk within the remit of the Committee to the Audit Committee and the Trust Board. Please note: the Audit Committee provides an independent and objective review of the appropriateness and fitness for purpose of the Trust's systems of internal control and risk to the Trust Board.

3. Membership

Three Non-Executive Directors, one of whom will chair the committee.

Core Attendees

Chief Executive
Chief Nurse
Medical Director
Chief Operating Officer
Chief People Officer

Other attendees:

Chief Pharmacist
Patient Safety Leads
Head of Corporate Governance
Director of Midwifery
Director of Estates and Facilities
Director of Improvement

In addition to the above list of attendees the committee will co-opt attendance as required from the Chief Information Officer, Divisions, Infection Control, Health and Safety, Patient Safety, Clinical Governance, Information Team etc.

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

4. Quorum

The Committee will be quorate if two non-executive members are present, and two core attendees; one of which must be the Medical Director or Director of Nursing or their nominated representative.

5. Frequency of Meetings

The Committee will normally meet monthly with the exception of August (unless a meeting is required). The format of the meetings will be agreed with the Committee Chair and some meetings may include a focus on deep dive presentations if deemed appropriate and effective. The Chair of the Committee may convene additional meetings if required to consider business that requires urgent attention.

All attendees are expected to attend each meeting or to send a nominated deputy when they are unable to do so.

6. Duties

Managing Quality and Safety Risks

- To provide assurance to the Board that the services the Trust provides meet all national standards and are safe, effective, high quality and patient-focused
- To endorse and monitor the Trust's key governance strategies relating to quality and safety, such as the Quality Strategy.
- To review and monitor the Board Assurance Framework and the Corporate Risk Register risks assigned to the Committee, ensuring appropriate action is taken to mitigate risks where possible and advise the Board where acceptance of risk may need to be considered
- To monitor the standards and reviews from external bodies through receiving development plans, outcome reports and associated action plans, e.g. Care Quality Commission, NHS resolution, Health & Safety Executive (HSE), NHS Improvement (NHSI) and ensure action is taken for compliance.
- To improve and develop the effectiveness of the quality and safety assurance systems across the Trust by monitoring activity across the Trust through regular reports specified by the Committee in the Committee's Annual Cycle, and by exception
- To receive reports and monitor the progress in mitigating quality and safety risks arising from the Trust's major service developments
- To review the quality risk assessment of the CIP programme

- To work with the Audit Committee when appropriate, and specifically in agreeing the Annual Internal Audit plan and providing a review of effectiveness on the clinical audit.

Ensuring Compliance

- To monitor and advise the Board on progress against national and local quality and safety governance standards and compliance framework.
- To receive and review regular progress reports for achieving compliance against all aspects of the Quality of Services through the monitoring of the Fundamental Standards and CQC regulations.
- To monitor and advise the Board on compliance with the Hygiene Code and CQC Registration and Regulation
- To receive reports on the changes to Healthcare Regulation and assurance as to how the Trust will manage this process
- To review and approve the annual reports as stated in the annual cycle, with the exception of Health and Safety and Safeguarding which will be scrutinised prior to final approval by Trust Board
- To approve the annual declaration of the Data Security and Protection toolkit
- Working with the Audit Committee to approve the Quality Account

Improving Quality

- To endorse and monitor the implementation of the Trust's key quality strategies.
- To receive regular reports from the Trust and Divisions on Patient Safety and Clinical Quality and Outcomes ensuring appropriate action is taken
- To receive regular reports from the Trust and Divisions on Patient Experience Indicators ensuring appropriate action is taken
- To receive regular reports from the Trust and Divisions on Nurse/Patient Indicators and safer staffing ensuring appropriate action is taken.
- To review the biannual nursing establishment review prior to consideration and decision by the Trust Board.
- To support the implementation of quality improvement programmes.
- To be advised of the progress of any major quality initiatives in the Trust.
- Deliver better health outcomes for our whole community, and actions to reduce health inequalities.
- Improve access and experience for our patients.
- Improve data collection, use and reporting in relation to equalities and inclusion.
- Devise and monitor appropriate KPIs for equalities and inclusion to enable effective scrutiny of delivery against the equalities and inclusion priorities.
- To receive regular reports on the 'Grow Together' pillar of the People Strategy, including regarding learning and education, statutory and mandatory training, talent management, clinical staffing establishment requirements and the report of the Guardian of Safe Working Hours.
- To consider reports regarding any other workforce issues where there is a clear and direct link to quality and safety issues, such as regarding the work of the Freedom to Speak Up Guardian.
- To monitor the quality and safety performance metrics.
- To monitor the delivery of the annual plan and receive the annual report from the Joint Management Group in relation to the Trust's partnership with the University of Hertfordshire.

7. Reporting arrangements

The Committee will provide a report of each meeting to the Trust Board. It will make recommendations to the Board, Executive Team and Executive Directors for these groups/individuals to take appropriate action.

The Committee will provide reports to the Audit Committee as requested.

The core attendees and attendees will provide reports to the committee in relation to all areas of their portfolio and in line with the Annual Cycle and Action Log.

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

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

- The Committee report to Trust Board
- QSC annual evaluation and review of its terms of reference

9. Support

The Trust Secretariat will ensure the committee is supported administratively and advising the Committee on pertinent areas.

Approved at Board on 4 May 2022

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Trust Board – Part I		Agenda Item	18
Report title	Finance Performance and Planning Committee		Meeting Date	7 September 2022
Presenter	Finance Performance and Planning Committee Chair			
Author	Corporate Governance Officer			
Responsible Director	FPPC Chair		Approval Date	
Purpose (*tick one box only)* [See note 8]	To Note	☒	Approval	☐
	Discussion	☐	Decision	☐

Report Summary:

To present the report from the FPPC meeting on 26 July 2022.

Impact: where significant implication(s) need highlighting

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

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

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

Report previously considered by & date(s):

N/A

Recommendation	The Board/Committee is asked to note.

To be trusted to provide consistently outstanding care and exemplary service

FINANCE, PERFORMANCE AND PLANNING COMMITTEE MEETING
26 JULY 2022

SUMMARY TO THE TRUST BOARD MEETING HELD ON 7 SEPTEMBER 2022

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

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

Tier 1 Report

The Committee were advised that as part of the second phase of the elective recovery all providers have been assessed based on confidence of delivering against the targets for reducing the cancer 62 day backlog back to pre-pandemic levels by March 2023 and reducing the number of 78 week elective long waiters to zero by April 2023. The providers at the highest risk using this new means of assessment have been placed in Tier 1 and those less challenged but still indicating material risk are in Tier 2. The Trust has been placed in Tier 1 and will receive national support and oversight. Next steps were explained and discussed.

The Committee were advised of plans in place to increase elective activity, with a trajectory to be compliant by the end of March 2023.

Imaging Demand and Capacity Deep Dive

The Committee received a deep dive relating to imaging demand and capacity. The review covered MRI, CT and ultrasound within radiology. It focused on flow and matching demand to the capacity to deliver, including reducing the waiting list. The Committee were advised the Trust has remained within the turnaround time of 10-14 days for cancer against a standard of 14 days, with an aspiration to reduce this to 7 days to support the 28 day faster diagnosis. The ongoing risks and challenges including staffing were discussed.

The Committee were advised that MRI has been challenging due to changes in protocols and NICE guidance resulting in scans taking longer and downtime being longer because of the time taken to clean in between patients. An MRI vehicle has been secured to reside on the Lister hospital site for approximately seven months which should have a positive impact on reducing waiting times.

Performance Report Month 3

The Committee received and noted the responsive report for month three. The Committee noted that 29 beds had been closed on level 11 for a period of time due to flooding which had a negative impact on flow through the hospital and contributed to patients spending longer in the emergency department, impacting ambulance handovers.

Patients who do not meet criteria to reside remains over 1000 bed days per month and the team continue to explore solutions with Hertfordshire Community NHS Trust and Hertfordshire County Council.

Although the month had started with a high level of Covid admissions, this had reduced by the end of the month.

Finance Report Month 3

The Committee received and noted the month three Finance report. The Trust reported against the final break-even plan in June. The break-even plan includes the Trust's agreed share of the additional national funding of £1.6bn as well as a plan to release some financial support items as a non-recurrent measure to deliver break-even.

Specialties have been reviewed and it was noted that up to seven specialties have received additional investment which has not yet translated into additional work. Deep dives will take place with specialties to understand the situation.

The plan for the second half of the year will be reviewed to expand elective activity to achieve the Elective Recovery Fund target.

The Committee were advised that medical staffing was approximately £1.3m overspent at the end of the first quarter and will continue to be a feature in the coming months in the emergency department, emergency and acute medicine and womens and children. The Committee learned that the clinical oversight group meetings review agency controls and bank usage and that pay controls and measures have been put in place. The importance of good financial control was noted.

CIP Performance Report

The Committee received the CIP report and noted the progress to deliver the target for month three along with a deep dive into the Planned Care Division delivery. The shortfall against the target was £2m. The Committee noted the CIP requirement would increase as the year progresses and that the Trust has a large reliance on non-recurrent schemes this year.

The Committee learned that the Planned Care Division had the largest shortfall to date and had delivered £513k of its £1.6m target.

Next steps including the Finance team reviewing which vacancies could be removed or put on hold were discussed. CIP recovery workshops will take place in September for Planned and Unplanned Care and will be led by divisions with support from executives. Weekly financial oversight meetings take place across all services to ensure they know what they need to deliver

.

Vascular Surgery Business Case

The Committee received and noted the vascular surgery business case and were asked to approve a revised business case to reflect additional investment and a revised design solution.

The Committee approved the business case.

EPR Development – Options Appraisal

The Committee received and noted the EPR options appraisal. The Committee were advised that funds have been made available by NHS England (NHSE) to facilitate each NHS Trust to get to a Minimal Digital Foundation by March 2025. The Trust has been assessed by NHSE regional digital team as category two, which means the Trust has an EPR in place that requires extending or optimising.

The Committee considered the benefits and risks of the five EPR options.

Elective Surge Hub

The Committee were advised that the Trust has been engaging with the ICS to develop and seek regional approval for capital investment to create an elective surge hub for the Hertfordshire and West

Essex system in order to reduce waiting lists. A short form business case was submitted to region in February 2022 requesting funding for a central surge hub to be located at either Lister hospital or One Hatfield.

The Committee discussed the progress in determining the need, activity profile and potential capital build solutions at the Lister Treatment Centre that can be prioritised and formulated into a full business case.

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

_____

Karen McConnell
Finance, Performance and People Committee Chair
September 2022

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Trust Board – Part I			**Agenda Item**	19
Report title	Quality and Safety Committee Report to Trust Board			**Meeting Date**	7 September 2022
Presenter	Chair of Quality and Safety Committee				
Author	Corporate Governance Officer				
Responsible Director	Chair of Quality and Safety Committee			**Approval Date**	19 August 2022
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**		☐
	Discussion	☐	**Decision**		☐

Report Summary:

To apprise the Trust Board of the decisions made and significant items discussed at the Quality and Safety Committee held on 27 July 2022.

Impact: where significant implication(s) need highlighting

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

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

Report previously considered by & date(s):

[

Recommendation	The Board is asked to Note the report.

To be trusted to provide consistently outstanding care and exemplary service

QUALITY AND SAFETY COMMITTEE MEETING – 27 JULY 2022

SUMMARY TO THE TRUST BOARD MEETING HELD WEDNESDAY 7 SEPTEMBER 2022

The following Non-Executive Directors were present:

Peter Carter, Ellen Schroder, Val Moore, David Buckle

The following core attendees were present:

Michael Chilvers, Rachael Corser, Adam Sewell-Jones

Board Assurance Framework

The Committee received and noted the latest edition of the Board Assurance Framework (BAF). The Committee noted that a BAF will be presented in a new format in the future.

Compliance and Risk Update

The Committee received and noted a compliance and risk update and were advised of the new way in which the CQC will be carrying out inspections.

A deep dive will be carried out regarding corporate risks and reviewing those that have not been reviewed recently.

Emerging risks within the Emergency Department regarding overcrowding, health and safety, violence and aggression and administering medications for patients staying longer in the department were highlighted, including other emerging risks concerning supplier resilience and key clinical products. A review of all risks will take place.

Quality and Safety Report Month 3

The committee received and noted the month three Quality and Safety report.

Key points discussed included:

- There has been an ongoing improvement of sepsis management within the Emergency Department which is expected to continue to improve.
- A higher level of complaints relating to the Emergency Department had been received and was being reviewed.
- The number of medically optimized patients who continue to reside in hospital beds has been a challenge and a deep dive into the explanation for this will take place in the autumn.

Clinical Harm Reviews Update

The Committee received and noted the Clinical Harm Reviews update. Although clinical harm reviews had previously been identified as progressing at a slower than desired pace, these are now happening in real time. The real time reporting should prevent a backlog occurring. It was recognized by the Committee that the clinical harm reviews are time consuming for clinicians. It will be clarified whether this is a statutory obligation for the Trust.

Incidents and Inquests Quarterly Report

The Committee received and noted the Incidents and Inquests report. The common themes from the report were overdue serious incidents, overdue complaints and how the Trust supports divisions to reduce these numbers. There had been positive feedback on themes of learning.

The volume of inquests has increased by 76%. This may be because inquests were paused during the pandemic and there has been a focus on catching up.

The Committee heard that the number of serious incidents has increased. They were assured that all serious incidents are reviewed by a number of individuals, and that patients remain safe within the hospital.

The committee were advised there is now a better relationship with the coroner and it was identified that early discussions with relatives of deceased patients could avoid the coroner requesting an inquest.

Complaints, PALS and Patient Experience Report

The Committee heard there has been a focus on dealing with a backlog of complaints and learning from themes. Although there has been a challenge within the complaints team regarding capacity, the Committee were assured that the complaints and PALS teams have been working well together to understand issues and solutions.

The Committee discussed the potential benefit of there being a dedicated person on wards to speak to patients about their concerns, which could reduce the number of formal complaints.

Clinical Ethics Annual Report

The Committee were advised that additional ethical support had been provided during the pandemic period, should there be a need to limit access to ITU for example.

The Committee heard how the report demonstrated a wide range of specialties had been supported over the last few months. The Clinical Ethics Committee has a wide representation of approximately 30 people, however it was recognized that the committee would benefit from having more clinicians, nurses and therapists to ensure there are a wide range of views when making decisions.

Nursing and Midwifery Annual Report

The Committee received and noted the excellent and highly informative Nursing and Midwifery report.

The Committee were advised about ongoing work to ring fence the role of the midwife and the doctor to ensure they are not undertaking work they should not be doing when short staffed.

It was highlighted that the still birth rate in the first six months of 2022 was at the same level as the entire last two years. A deep dive was carried out to understand the reasons and the review highlighted there being no areas of concern.

Research and Development Annual Report

The Committee received and noted the Research and Development report. The Committee were advised that research had generated £20m income to the Trust in the last six years and had attracted a high calibre of people to join the organization.

The Research and Development team have been reviewing the possibility of collaboratively working with other organisations outside of the Trust.

Clinical Audit and Effectiveness Annual Report

The Committee received and noted the Clinical Audit and Effectiveness report. It was highlighted that the number of audits carried out has increased each year. Improvements have been made for all metrics since last year. All actions have been combined within specialties to make them more manageable. The clinical audit team have met with seven specialties and will continue to meet with others. The value of these targeted meetings was recognized by the Committee.

IPC Annual Report

The Committee received and noted the IPC report. The Committee were advised that the Trust is the only Trust regionally to have redirooms for aseptic techniques.

The Committee noted the following reports:

- Maternity Services Assurance Report
- Maternity Self-Assessment Tool Compliance
- Mortuary Update
- Clinical Effectiveness Committee Escalation
- Patient and Carer Experience Group Escalation

Dr Peter Carter
Quality and Safety Committee Chair
September 2022

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Trust Board – Part I			**Agenda Item**	20
Report title	Strategy Committee Board Report			**Meeting Date**	7 September 2022
Presenter	Strategy Committee Chair				
Author	Corporate Governance Officer				
Responsible Director	Strategy Committee Chair			**Approval Date**	18/07/2022
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**		☐
	Discussion	☐	**Decision**		☐

Report Summary:

To present to the Trust Board the summary report from the Strategy Committee meeting held on 11 July 2022.

Impact: where significant implication(s) need highlighting

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

N/A

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

The discussions at the meetings reflect the BAF risks assigned to the Strategy Committee.

Report previously considered by & date(s):

N/A

Recommendation	The Board/Committee is asked to Note the report

To be trusted to provide consistently outstanding care and exemplary service

STRATEGY COMMITTEE – 11 JULY 2022

EXECUTIVE SUMMARY REPORT TO TRUST BOARD

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

The following core attendees were present:
Martin Armstrong (Director of Finance and Deputy CEO), Michael Chilvers (Medical Director), Rachael Corser (Chief Nurse), Kevin O'Hart (Director of Improvement), Thomas Pounds (Chief People Officer).

MENTAL HEALTH STRATEGY

The Mental Health Strategy was presented to the Committee. The Strategy covers all age groups and supports collaborative working across the system. Funding secured through the ICS had enabled the recruitment of a mental health lead nurse and two care support workers to support the mental health patients' pathways and agenda.

The considerable challenges with capacity to look after mental health patients at the Trust were discussed. The Trust is working with Hertfordshire Partnership Foundation Trust to address this.

It was agreed the Strategy and proposed outcomes would be overseen by the Quality and Safety Committee.

STRATEGIC PLANNING FRAMEWORK (IBP)

The Committee received an overview of the proposed structure of the Integrated Business Plan. It was noted this would be a live document that would reflect the Trust's strategy and would be developed and maintained as part of the annual business cycle. It would be monitored by the Finance, Performance and Planning Committee (FPPC).

SYSTEM COLLABORATION

The Committee were updated on collaborative system and place based activity that the Trust is actively participating in.

The Committee discussed the opportunity of an elective surge hub.

VASCULAR SURGERY NETWORK

The Committee received an update on plans to build a hybrid theatre. Once a final business case has been approved this work can be progressed.

MVCC TRANSFER PROGRAMME

The Committee received a presentation on the current status of the MVCC transfer. The Committee noted that this had been discussed recently at Trust Board and noted plans in place to review options.

ICS PATHOLOGY PROCUREMENT

The Strategy Committee received a report to tender pathology services across the ICS. It was confirmed the project is currently at the bid evaluation and clarification stage. The project will be overseen by FPPC going forward

SUSTAINABILITY UPDATE – GREEN PLAN

The Committee received a sustainability and green plan update. The Trust has a sustainability group, which reports to the FPPC.

ANY OTHER BUSINESS

It was noted that this was the last Strategy Committee meeting and going forward, strategy and business planning will be discussed at Trust Board meetings and at the FPPC meetings as appropriate.

_____

Karen McConnell
Strategy Committee Chair

July 2022

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Trust Board – Part I			**Agenda Item**	21
Report title	People Committee Report to Board			**Meeting Date**	7 September 2022
Presenter	Chair of People Committee				
Author	Corporate Governance Officer				
Responsible Director	Chair of People Committee			**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**		☐
	Discussion	☐	**Decision**		☐

Report Summary:

To appraise the Trust Board of the decisions made and significant items discussed at the People Committee held on 19 July 2022.

Impact: where significant implication(s) need highlighting

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

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

Report previously considered by & date(s):

[

Recommendation	The Board is asked to Note the report.

To be trusted to provide consistently outstanding care and exemplary service

PEOPLE COMMITTEE MEETING – 19 JULY 2022

SUMMARY TO THE TRUST BOARD MEETING HELD WEDNESDAY 7 SEPTEMBER 2022

The following Non-Executive Directors were present:

Biraj Parmar, Jonathan Silver, Val Moore

The following core attendees were present:

Thomas Pounds, Rachael Corser, Amanda Harcus, Celina Mfuko, Eilidh Murray, Lucy Davies and Michael Chilvers

Matters Considered by the Committee:

Voice of our People – BAME Network

The Committee received a presentation highlighting the objectives of the BAME network and a review of activities and future plans. The quality of the events and webinars were praised.

Two new international nurses were invited to attend the meeting to share their experience of joining the Trust, to which the Committee will reflect on, and review changes in on-boarding procedures at a later date.

WRES Report and Update

The Committee received a WRES report which provided assurance for a variety of programmes of work to improve staff experience and employment opportunities.

The Committee Learned that the percentage of staff coming from an ethnic minority background has increased in the last four years from 31% to 34%, which is a greater percentage than the local population.

The People Committee noted the WRES team have set a ten year target for Model Employer.

Health and Wellbeing

The People Committee received a report highlighting approaches being taken to improve staff physical and mental wellbeing, focusing on the promotion of self-care and the availability of support and interventions to enable recovery.

The Committee were advised of interventions in place to reduce muscular skeletal sickness absence by ten percent.

The Trust now has 62 wellbeing champions along with Long Covid and menopause clinics.

Temporary Staffing

The Committee received a review of 2021/22 flexible workforce activities and performance and an overview of priorities for 2022/23.

The Committee were advised of a priority to improve local inductions for bank workers to ensure they settle in well.

Statutory and Mandatory Training

The People Committee were updated on the statutory and mandatory training compliance and learned that the Trust was 87% compliant against a target of 90%. It was noted that the new ENH Academy has transformed training and easier to use than the previous ESR system.

It was noted that some medics training courses have lengthy pre-reads and a review will be undertaken to ascertain whether courses and pre-reads could be shortened.

Grow Together Reviews

The Committee received the highlights of the current status of employee Grow Together reviews. The Trust was at 25% of target and there will be reminders sent to managers to ensure reviews are completed.

Safe Working Hours Report

The People Committee received and the safe working hours report and noted that there had been fewer exception reports and also noted there had been no safety reports or unsafe hours worked in the last quarter. It was noted that since the pandemic, many individuals have valued their work life balance more and this may have resulted in less people working additional hours, hence a reduction in exception reports.

Board Assurance Framework

The Committee were assured that the risk titles linked with the organisation's strategic priorities.

Thomas Pounds
Chief People Officer
On behalf of the People Committee Chair
September 2022

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Trust Board – Part I			**Agenda Item**	22
Report title	Audit Committee Board Report			**Meeting Date**	7 September 2022
Presenter	Chair of Audit Committee				
Author	Assistant Trust Secretary				
Responsible Director	Chair of Audit committee			**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**		☐
	Discussion	☐	**Decision**		☐

Report Summary:

To present the report from the Audit Committee meeting held on 12 July 2022 to the Board.

Impact: where significant implication(s) need highlighting

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

N/A

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

N/A

Report previously considered by & date(s):

N/A

Recommendation	The Board is asked to note the report.

To be trusted to provide consistently outstanding care and exemplary service

AUDIT COMMITTEE MEETING – 12 JULY 2022

SUMMARY TO THE TRUST BOARD MEETING HELD ON 7 SEPTEMBER 2022

The following Non-Executive Directors were present:
Jonathan Silver (Chair), Karen McConnell, David Buckle

Internal Audit Reports:

Summary Internal Controls Assurance Report
The Audit Committee received and noted the Summary Internal Controls Assurance report. The Committee was informed that the report for the Data Security and Protection Toolkit had been received and had achieved substantial assurance.

The Committee was informed that the Same Day Emergency Care audit report had been issued on 23rd May 2022 and had received no response to Management chasing.

The Committee heard that the slippage to the plan in Q1 had been scheduled into Q2.

Internal Audit Action Tracker
The Audit Committee received and noted the Internal Audit Action Tracker. The Committee was informed there were 14 urgent recommendations outstanding and new dates would be agreed. The Committee heard that completion dates for the Medical Devices and e-rostering actions would be identified as a matter of urgency as they were the oldest actions.

Anti-Crime Update Report
The Audit Committee received and noted the Anti-Crime Update Report. The Committee was informed that some areas remained outstanding due to personnel change. The Committee heard that TIAA would review outstanding issues to understand whether they had been completed and closed.

External Audit Reports:

Auditors Annual Report
The Audit Committee received and noted the Auditors Annual Report.

The Committee was informed that no weaknesses had been identified in the arrangements for Value for Money.

The Committee was informed that eight unadjusted differences had been identified in the audit which would increase the operating expenditure by £4.050m but this would have no material impact.

The Committee was informed that that no actual significant weaknesses had been identified in the risk assessment however there was a risk to the Trust breaking-even in 2022/23 if they failed to achieve the CIP target.

Final Audit Completion Report 2021/22
The Audit Committee received and noted the Final Audit Completion Report 2021/22.

The Committee was informed that there had been an issue relating to intangible assets. The interpretation of when t capitalise cloud-based software was not material and the main change was reflected in the report.

The Committee heard that the dividend from ENHPharma had been incorrectly accounted for and hadn't affected the group position.

Final Letter of Representation
The Audit Committee received and noted the Final Letter of Representation.

Other Reports:

Treasury Management Policy
The Audit Committee received and approved the Treasury Management policy. It was confirmed to the Committee that it had been refreshed to ensure it remained current and the processes had been reviewed.

The Committee discussed the use of petty cash and were assured the usage was reviewed regularly.

Capital Disposals Policy
The Audit Committee received and noted Capital Disposals Policy which was reviewed by the Committee every three years.

Jonathan Silver
Audit Committee Chair
July 2022

Board Annual Cycle 2022-23

Notes regarding the annual cycle:

The Board Annual Cycle will continue to be reviewed in-year in line with best practice and any changes to national scheduling.

Items	April 2022	4 May 2022	June 2022	6 Jul 2022	Aug 2022	7 Sept 2022	Oct 2022	2 Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Standing Items												
Chief Executive's Report		X		X		X		X		X		X
Integrated Performance Report		X		X		X		X		X		X
Board Assurance Framework		X		X		X		X		X		X
Data Pack		X		X		X		X		X		X
Patient Testimony (Part 1 where possible)		X		X		X		X		X		X
Employee relations (Part 2)		X		X		X		X		X		X
Elective Recovery		X		X		X		X		X		X
Board Committee Summary Reports												
Audit Committee Report		X		X		X		X				X
Charity Trustee Committee Report		X		X				X		X		
Finance, Performance and Planning Committee Report		X		X		X		X		X		X
Quality and Safety Committee Report		X		X		X		X		X		X
Strategy Committee final meeting July 2022 before moving to Board Development		X		X								
EIC moving to People Committee		X		X		X		X		X		X
Strategy												
Planning guidance										X		
Trust Strategy refresh and annual objectives										X		
Strategic transformation update				X				X				X
Integrated Business Plan						X						

Board Annual Cycle 2022-23

Items	April 2022	4 May 2022	June 2022	6 Jul 2022	Aug 2022	7 Sept 2022	Oct 2022	2 Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Annual budget/financial plan		*(X) from 2023*										
Long-term strategic infrastructure						X						X
System Working & Provider Collaboration (ICS and HCP) Updates		X		X		X		X		X		X
Mount Vernon Cancer Centre Transfer Update				X		X		X		X		X
Other Items												
Audit Committee												
Annual Report and Accounts, Annual Governance Statement and External Auditor's Report – Approval Process		X										
Value for Money Report						X						
Audit Committee TOR and Annual Report								X				
Review of Trust Standing Orders and Standing Financial Instructions								X				
Charity Trustee Committee												
Charity Annual Accounts and Report								X				
Charity Trust TOR and Annual Committee Review												X
Finance, Performance and Planning Committee												
Finance Update (IPR)		X		X		X		X		X		X
FPPC TOR and Annual Report								X				
Quality and Safety Committee												
Complaints, PALS and Patient Experience Report		X				X				X		
Safeguarding and L.D. Annual Report (Adult and Children)				X								

Board Annual Cycle 2022-23

Items	April 2022	4 May 2022	June 2022	6 Jul 2022	Aug 2022	7 Sept 2022	Oct 2022	2 Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Staff Survey Results		X										X
Learning from Deaths		X		X				X		X		
Nursing Establishment Review				X						X		
Responsible Officer Annual Review								X				
Patient Safety and Incident Report (Part 2)		X		X				X				X
University Status Annual Report						X						
QSC TOR and Annual Review								X				
Strategy Committee – move to Board Development in September												
Digital Strategy Update				X								
People Committee & Culture												
People & workforce strategy annual progress report										X		
Trust Values refresh				X								
Freedom to Speak Up Annual Report								X				
Staff Survey Results		X										
Equality and Diversity Annual Report and WRES						X						
Gender Pay Gap Report		X										
People Committee TOR and Annual Report								X				
Shareholder / Formal Contracts												
ENH Pharma (Part 2) shareholder report to Board				X								