East and North Hertfordshire NHS Trust
Trust Board - Public Meeting

Via MS Teams

3 March 2021 10:30 - 3 March 2021 12:30

AGENDA

#	Description	Owner	Time
1	Chair's Opening Remarks	Chair	10:30
2	Apologies for absence:		
3	Declaration of Interests	All	
4	Questions from the Public At the start of each meeting the Board provides members of the public the opportunity to ask questions and/or make statements that relate to the work of the Trust. Members of the public are urged to give notice of their questions at least 48 hours before the beginning of the meeting in order that a full answer can be provided; if notice is not given, an answer will be provided whenever possible but the relevant information may not be available at the meeting. If such information is not so available, the Trust will provide a written answer to the question as soon as is practicable after the meeting. The Trust Secretary can be contacted by email, joseph.maggs@nhs.net, by telephone (01438 285454) or by post to: Trust Secretary, Lister Hospital, Coreys Mill Lane, Stevenage, Herts, SG1 4AB. Each person will be allowed to ask only one question or make one statement. However, at the discretion of the Chair of the meeting, and if time permits, a second or subsequent question may be allowed. Generally, questions and/or statements from members of the public will not be allowed during the course of the meeting. Exceptionally, however, where an issue is of particular interest to the community, the Chairman may allow members of the public to ask questions or make comments immediately before the Board begins its deliberations on that issue, provided the Chairman's consent thereto is obtained before the meeting.		
5	Minutes of Previous Meeting For approval 5. Minutes of Public Trust Board Meeting - 0411202... 7	Chair	
6	Patient Story For discussion	Chief Nurse	10:35
7	Chief Executive's Report For discussion 7. Chief Executive Board Report - March 2021.pdf 15	Chief Executive	10:55

#	Description	Owner	Time
8	Integrated Performance Report For discussion 8. Chief Executive Board Report - IPR March 2021.... 17 8. Integrated Performance Report Month 10.pdf 19	Chief Executive	11:05
9	Recovery Update For discussion 9. Recovery Update.pdf 61	Managing Director - Planned Care	11:15
10	Recovery and Our People For discussion 10. People Recovery Report.pdf 71	Interim Chief People Officer	11:25
11	Health and Social Care Bill 2021 White Paper Briefing For discussion 11. Health and Social Care Bill White Paper Briefin... 79	Deputy CEO / Director of Strategy	11:35
12	Board Assurance Framework 2020-21 For discussion 12. BAF 2020-21.pdf 93	Associate Director of Governance	11:45
13	IPC Report For discussion 13. IPC Report.pdf 131	Chief Nurse	11:55
14	Maternity Assessment and Assurance Tool For information 14. Maternity Assessment and Assurance Tool Sub... 155	Chief Nurse	12:05
15	Gender Pay Gap Report For approval 15. Gender Pay Gap Report 2021.pdf 185	Interim Chief People Officer	12:15
16	Sub-Committee Reports		

#	Description	Owner	Time
16.1	**Finance, Performance and People Committee Report to Board** For information 16.1 a) FPPC Board Report 27 January 2021.pdf 193 16.1 b) FPPC Board Report 24 February 2021.pdf 197	Chair of FPPC	
16.2	**Strategy Committee Report to Board** For information 16.2 Strategy Committee Report 15 February 2021.... 201	Chair of Strategy Committee	
16.3	**Quality and Safety Committee Reports to Board** For information 16.3 a) QSC Board Report 26 January 2021.pdf 205 16.3 b) QSC Board Report 23 February 2021.pdf 209	Chair of QSC	
16.4	**Audit Committee Report to Board** For information 16.4 Audit Committee Board Report 19 January 20... 213	Chair of Audit Committee	
16.5	**Remuneration Committee Terms of Reference** For approval 16.5 Remuneration Committee Terms of Reference... 217	Chair of Remuneration Committee	
17	**Actions Log** For information 17. Public Trust Board Actions Log.pdf 223	Trust Secretary	12:25
18	**Annual Cycle** For information 18. Board Annual Cycle 2020-21.pdf 225	Trust Secretary	
19	**Data Pack** For information 19. Data Pack.pdf 229		

#	Description	Owner	Time
20	Date of next meeting 5 May 2021		

NOTE: THESE MINUTES WERE REVIEWED AND APPROVED BY THE BOARD AT THE PRIVATE MEETING IN JANUARY 2021

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday 4 November 2020 at 10.30am at the Lister Hospital, Stevenage & StarLeaf Video Conferencing

Present:	Mrs Ellen Schroder	Non-Executive Director (Trust Chair)
	Ms Karen McConnell	Non-Executive Director
	Ms Val Moore	Non-Executive Director (via conference call)
	Mr Bob Niven	Non-Executive Director (via conference call)
	Mr Jonathan Silver	Non-Executive Director (via conference call)
	Dr David Buckle	Associate Non-Executive Director (via conference-call)
	Mr Biraj Parmar	NeXT Director (via conference call)
	Mr Nick Carver	Chief Executive Officer
	Mr Martin Armstrong	Director of Finance and Deputy Chief Executive
	Ms Rachael Corser	Chief Nurse (via conference call)
	Mrs Julie Smith	Chief Operating Officer (via conference call)
	Dr Tim Walker	Deputy Medical Director (via conference call) (deputising for the Medical Director)
From the Trust:	Mrs Sarah Brierley	Director of Strategy (via conference call)
	Mr Tom Pounds	Interim Chief People Officer (via conference call)
	Mr Joseph Maggs	Trust Secretary (via conference call)
	Ms Jude Archer	Associate Director of Governance (via conference call)
	Ms Eilidh Murray	Head of Communications (via conference call)
	Ms Sharon Dudley	Nurse Team Manager For item 20/068 only (via conference call)
	Ms Julia Smith	Corporate Governance Officer (Minutes, via conference call)
Also in attendance:	Ms Georgina Fenwick-Morris	Observing the meeting (via conference call)

20/064 CHAIRS OPENING REMARKS

20/064.1 Mrs Schroder opened the Public Board meeting and welcomed all attendees. She congratulated Ms Moore on being reappointed as a Non-Executive Director for a further four years from September 2020.

20/065 APOLOGIES FOR ABSENCE

20/065.1 Apologies were received from Dr Peter Carter (Non-Executive Director) and Dr Michael Chilvers (Medical Director).

20/066 DECLARATIONS OF INTEREST

20/066.1 The Director of Strategy declared that she was now undertaking a

joint role as Director of Strategy for both East and North Herts NHS Trust and Hertfordshire Community NHS Trust.

20/066 QUESTIONS FROM THE PUBLIC

20/066.1 There were no questions from the Public.

20/067 MINUTES OF PREVIOUS MEETINGS

20/067.1 The minutes of the Board meeting held on 3 September 2020 were approved as an accurate record of the meeting.

20/068 PATIENT STORY

20/068.1 The Chief Nurse introduced Sharon Dudley (Nurse Team Manager), a clinical leader who as part of the Leadership Programme had been asked to undertake improvements in her area. The Chief Nurse explained that the Nurse Team Manager manages the virtual fracture clinic.

20/068.2 The Nurse Team Manager explained that she had implemented some effective changes within the virtual fracture clinic that were delivering benefit to patients. She explained about patient Mr R who was seen by the clinic following a fall. He was in a great deal of pain which was relieved quickly and easily and he was x-rayed without delay. The Nurse Team Manager saw the patient at his follow-up and asked him some questions regarding his experience.

20/068.3 The Nurse Team Manager explained to the Board that Mr R's feedback was excellent from the clear signage to the administration of pain relief to being asked what colour cast he would like. The patient had declined to have surgery and was complimentary that his wishes had been considered.

20/068.4 Mrs Schroder commended the Nurse Team Manager on her management of the virtual fracture clinic and the improvements she had implemented.

20/068.5 The Chief Nurse explained that the patient experience around pain management was a focus of the improvement programme and important improvements for the patient journey had been made.

20/069 CHIEF EXECUTIVE'S REPORT

20/069.1 The Chief Executive explained to the Board that he had written to all Trust staff following the announcement of a four week planned lockdown by the Government. He outlined the progress the Trust had made in recovering elective services. He informed the Board that the Non-Executive Director briefings would be reintroduced from 18 November 2020.

20/069.2 The Chief Executive explained that performance against the waiting lists had been good and they were at the same point as they were 12 months ago, albeit there had been a reduction in referrals. He said the long waiting patient numbers were also reducing but were still higher than pre-pandemic.

20/069.3 The Chief Executive commented that following the Board Development day which had focused on inclusion, the Interim Chief People Officer would provide an update on this work for the next meeting. Mrs Schroder commented that the session had been powerful and was a useful platform to develop an understanding of and work to address inequalities.

20/069.4 The Chief Executive highlighted the Integrated Performance Report and the accompanying summary which detailed a number of key achievements and challenges.

20/069.5 Mrs McConnell commented that there would be a Deep Dive to examine Stroke at the Finance, Performance and People Committee in December.

20/069.6 Mrs Schroder asked about visiting restrictions. The Chief Nurse explained that visitor restrictions had been retained although visiting would be supported in certain situations. She said work had been undertaken to support women through their birth journey. The Chief Nurse explained it was anticipated there would be changes through updated national guidance and said the Trust would follow the same process. She assured the Board that families can keep in touch digitally and work was underway to increase the capacity.

20/069.7 Mr Niven asked if there had been an effect on staff turnover due to COVID. The Chief Executive commented that the number of staff leaving the Trust had reduced over the period. The Interim Chief People Officer explained that following analysis across the region staff turnover had reduced. He said in terms of recruitment, COVID was having a negative impact in areas such as international recruitment however this was becoming more active and cohorts from the Philippines and India were currently in 14-day isolation and would start working when their quarantine ended. The Interim Chief People Officer commented that there was an increase in people interested in working for the NHS generally and the Trust would look to capitalise on this opportunity with the recruitment of a Deputy Director of Development.

20/070 INTEGRATED PERFORMANCE REPORT

20/070.1 The Board noted the content of the Month 6 Integrated Performance report.

20/071 PHASE 3 RECOVERY AND COVID UPDATE

20/071.1 The Chief Operating Officer presented an update regarding the phase 3 recovery plans and latest Covid position.

20/071.2 The Chief Operating Officer assured the Board that the Trust had oversight through the recovery steering groups to ensure capacity was maximised for as many patients as possible to be seen.

20/071.3 The Chief Operating Officer explained to the Board that delivery against target in September for Elective procedures and Outpatients were being over achieved and the forecast for October was predicted as being in a strong compliant position.

20/071.4 The Chief Operating Officer explained to the Board that some activities were competing for the same resources and this was being mitigated on a daily basis. She said there may be the need to step-down some activity to release Theatre staff to support patients but if the need arose it would be managed in a phased manner rather than a complete closure as had happened during the first phase of the pandemic.

20/071.5 The Chief Operating Officer explained to the Board that the Trust continued to reinforce the message to the public that the hospital was a safe environment and they can access the health care that they need.

20/071.6 The Chief Operating Officer informed the Board that the Executive Directors had undertaken a table-top emergency planning exercise to prepare for a second wave of COVID-19 patients. She explained that as a result of the session the daily 8.30am huddle had been reintroduced, the COVID surge dashboard was providing key information to assist with the management of activity and the patient placement strategy was reviewed daily. She said the Trust would support local ITU networks and what may be requested or required in terms of mutual aid as part of the regional plan.

20/071.7 The Chief Operating Officer explained to the Board that the Trust would be enhancing the incident management with the implementation of Silver Command feeding into Gold Command from Monday 9th November.

20/071.8 The Chief Operating Officer informed the Board that the flu vaccination for staff remained a priority and the latest figures were currently above the trajectory which was for over 50% of staff to be vaccinated by the end of October 2020.

20/071.9 Mrs McConnell asked about the benefits to the Trust in relation to the ED capital programme. The Chief Operating Officer explained to the Board that the £6m capital investment would benefit the ED by providing additional assessment space and radiology space, help patient flow and enable faster ambulance unloading.

20/071.10 Ms Moore asked about support available for staff as the exceptional pressures continued. The Chief Operating Officer explained that all the measures that were in place during the first wave of COVID were still in place. She said staff were being encouraged to use their holiday and take time to rest and to look out for each other. The Chief Operating Officer commented that work was underway to create additional space for downtime and all staff were reminded to socially distance.

20/071.11 Ms Moore asked if there were any issues with PPE availability and whether there were other issues that could affect either the Recovery or COVID preparation. The Chief Operating Officer explained to the Board that the PPE availability was in a positive position and the Trust had several months' supply with no rationing forecast. The Chief Operating Officer commented that point of care testing was very important and facilitated timely decisions for patients. She said there was a specialist advisory group for clinically led decisions on testing in conjunction with Microbiology which would feed decisions

through to Gold. She said the Executive remained sighted on the challenges and would continue to enact strategy and changes based on regional and national guidance.

20/071.12 Mrs Schroder asked about the testing of front line staff. The Chief Operating Officer explained that the strategy to test in places of highest risk remained in place. The Deputy Medical Director informed the Board that a limited pilot of regular staff testing was underway. The Deputy Medical Director commented that conversations would continue about the logistics of staff testing.

20/071.13 Mr Niven asked for an update on system support. The Chief Operating Officer commented that the Trust was just one part of the local healthcare system provision. She said Community and Primary care were both supporting patients. The Chief Operating Officer explained to the Board that all providers were working closely across the ICP on front door avoidance and the Same Day Emergency Care offer. She said work would be undertaken to understand what was driving attendance at the ED and how some patients could be managed differently and provide better support to patients.

20/071.14 Mrs Schroder asked whether some patients were reluctant or unable to attend appointments and if they were still having to isolate for 14 days prior to a procedure. The Chief Operating Officer explained to the Board that on the whole most patients appeared to be happy to attend when they were able to. She said isolation was still required for most surgical procedures and the Consultants were working with patients to understand concerns and issues.

20/071.15 Mrs Schroder commented that the Charitable spend authorised for improvement to staff rooms needed to move forward at a good pace. The Interim Chief People Officer explained to the Board that work was underway to progress the plans.

20/072 BOARD ASSURANCE FRAMEWORK

20/072.1 The Associate Director of Governance explained to the Board that since September the new Strategy Committee had been formed (though was yet to hold its first meeting). She said the ICP, MVCC and Digital risks would be moved to the Strategy Committee for oversight.

20/072.2 The Associate Director of Governance explained to the Board that the standardisation of the frequency of scoring had been implemented and as such three risks had been reduced using the methodology.

20/072.3 The Associate Director of Governance assured the Board that the Trust risk profile was in line with the national profile following the results of recent benchmarking that had been carried out.

20/072.4 The Associate Director of Governance informed the Board that the Finance, Performance and People Committee discussed the Capital risk and she would work with the Director of Finance regarding the articulation of this risk so that it captured both the short and longer term risks.

20/072.5 The Associate Director of Governance commented that the Pandemic risk had been reviewed by the Audit Committee where they had conducted a deep dive and were reassured the risk was being managed. She said due to the ongoing pandemic and winter issues the risk would remain at 20. The Chief Nurse commented that the ability to staff and maintain quality of care was a fine balance and supported the risk remaining at 20.

20/073 FINANCE, PERFORMANCE AND PEOPLE COMMITTEE REPORT TO BOARD

20/073.1 The Board received the reports of the Finance, Performance and People Committee meetings which were held on 30 September 2020 and 28 October 2020. Mrs McConnell commented that the meetings had mostly returned to business as usual in terms of the structure of the meeting. She said the changes to the way financial management was conducted across the Trust were positive and that the Committee would continue to seek assurance of the key indictors across the Trust.

20/073.2 Mrs McConnell commented on the flu update. The Acting Chief People Officer explained that the paper provided the Board with assurance that work is focused on delivering the flu vaccine to staff. The Interim Chief People Officer explained to the Board that a more direct approach of appointment setting for staff to attend to receive the flu vaccine had started.

20/073.3 Mrs McConnell asked if it was logistically possible for 45% of staff to receive the flu vaccine in a single month. The Interim Chief People Officer explained to the Board that there were no capacity issues with delivering the vaccine.

20/074 FINANCE, PERFORMANCE AND PEOPLE COMMITTEE ANNUAL REVIEW AND TERMS OF REFERENCE

20/074.1 The Board noted the annual evaluation and approved the revised Terms of Reference for the Finance, Performance and People Committee.

20/075 QUALITY AND SAFETY COMMITTEE REPORT TO BOARD

20/075.1 The Board received the summary reports of the Quality and Safety Committee meetings which took place on 30 September 2020 and 27 October 2020.

20/075.2 The Chief Nurse assured the Board that oversight of nosocomial infection would continue and a deep dive would be undertaken at the next Committee meeting in November.

20/076 QUALITY AND SAFETY COMMITTEE ANNUAL REVIEW AND TERMS OF REFERENCE

20/076.1 The Board noted the annual evaluation and approved the revised Terms of Reference for the Quality and Safety Committee.

20/077 LEARNING FROM DEATHS REPORT

20/077.1 The Board noted the latest Learning from Deaths Report which had been discussed at the Quality and Safety Committee.

20/077.3 Dr Buckle commented on the drop in Stroke performance. Mrs McConnell informed the Board that the Stroke Deep Dive would be carried out by the Finance, Performance and People Committee.

20/078 AUDIT COMMITTEE BOARD REPORT

20/078.1 The Board received a report from the Audit Committee held on 17 October 2020. Mr Silver explained to the Board that the Sustainability update was behind schedule in part due to COVID. He said the Committee had seen improvements in relation to the internal audit actions.

20/079 AUDIT COMMITTEE ANNUAL REVIEW AND TERMS OF REFERENCE

20/079.1 The Board noted the annual evaluation and approved the revised Terms of Reference for the Audit Committee.

20/080 STANDING ORDER & STANDING FINANCIAL INSTRUCTION

20/080.1 The Board approved the updated Standing Order and Standing Financial Instructions.

20/081 CHARITY TRUSTEE COMMITTEE BOARD REPORT

20/081.1 The Board received a report from the Charity Trustee Committee held on 14 September 2020.

20/081.2 Mrs Schroder asked about the NHS Charities Together funding that would be held by HCT. Mr Niven commented that the organisations would work closely together on the allocation of funding. The Director of Strategy explained to the Board that the funding was in the region of £200,000 and confirmed that the ICS would confirm the second tranche of funding. She said the ICS didn't have a structure for the allocation of funding and Mr Niven had written to them to ensure that an appropriate and transparent process was used to allocate the funds.

20/082 CHARITY ANNUAL REPORT AND ACCOUNTS

20/082.1 Mr Niven informed the Board that draft versions of the Charity Annual Report and Accounts had been considered by the Charity Trustee Committee and Audit Committee in September and October and the Board were asked to approve the final versions.

20/082.2 Mrs Schroder commented that the presentation of the Annual report was easy to use and read.

20/082.3 The Board approved the Charity Annual Report, Accounts and Letter of Representation and noted the findings of the External Auditors' completion report.

20/083 **ACTION LOGS**

20/083.1 The Board noted the content of the latest Public Trust Board Actions Log.

20/084 **ANNUAL CYCLE**

20/084.1 The Board noted the Annual Cycle 2020/2021.

20/085 **DATE OF NEXT MEETING**

20/085.1 The next meeting of the Trust Board will be on 13 January 2021.

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Ellen Schroder

Trust Chair

January 2021

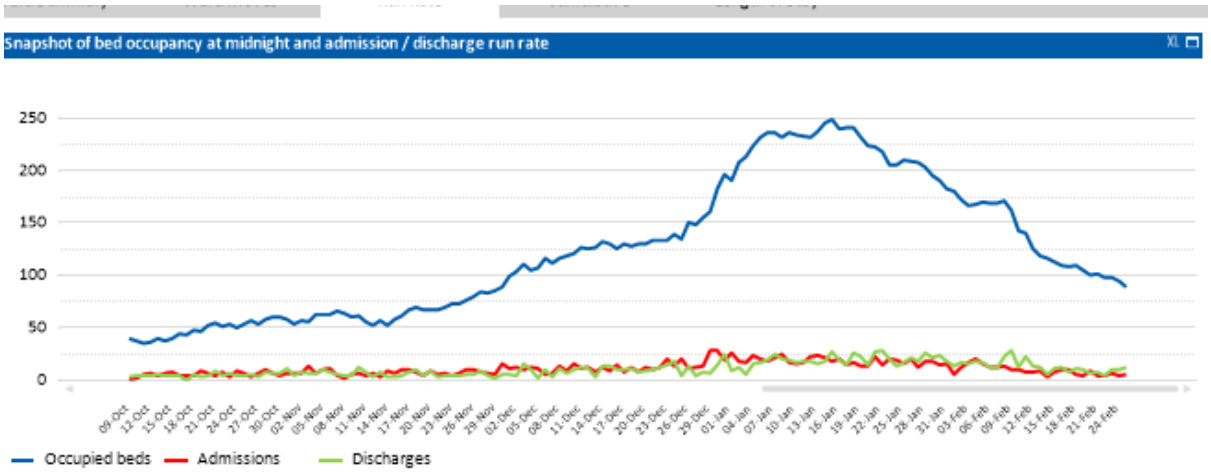
East and North Hertfordshire NHS Trust

Chief Executive's Report

March 2021

Covid 19 Pandemic

The period since the last meeting has been extremely busy with the Trust experiencing a peak of 249 Covid positive patients on 15 January. At the time of writing 82 Covid positive patients remain with the Trust.



At the peak, 31 Covid positive patients were being cared for in critical care on 20 January. At the time of writing 13 Covid positive patients remain within critical care.

Tragically 255, over 53% of all of the 477 total Covid deaths that have occurred within the Trust since the start of the pandemic have been in January and February (as at 25.02.21).

Staff absence which peaked at 595 (9.3%) on 14 January has now returned to 359 (6%).

Whilst performance against national standards in relation to the A&E 4 hour standard and RTT have been challenged, in common with the wider NHS, it is gratifying to note that the Trust's performance in relation to cancer waiting times is amongst the best nationally.

Whilst it is relatively easy to list a series of numbers that outline the Trust's activity since the last Board meeting, it is difficult to adequately convey the extent of the pressure faced by many Trust staff as they have sought to address the needs of the community.

I am deeply grateful to the public for their considerable and continuing support and encouragement and to our staff, for their immense commitment and resilience at such an incredibly pressurised time.

Vaccination

The Trust was pleased to be amongst the first sites administering the Covid vaccination (Pfizer) to members of the public in the first priority group and then health and social care staff.

To date approximately 80% of our staff have received a first dose of the vaccination and second doses started to be administered on 24 February.

It is a concern that members of BAME staff have taken up the offer of a vaccine at a lower rate than white staff. Whilst 85% of white staff and 80% of Asian/Asian British staff have received a first dose, only 57% of black staff have taken up the vaccination offer. We continue to work with our BAME staff to address the issue of vaccination hesitancy.

Service Restoration & Staff Recovery

The Chief Operating Officer will provide a detailed summary of our plans to restore services as the pressure of the pandemic lessens. We are very focussed upon the importance of addressing the needs of the local population as soon as possible. Whilst detailed national guidance is awaited at the time of writing we are gradually increasing services for patients with priority clinical needs.

The Acting Chief People Officer will outline how services will be restored whilst addressing the need to support our people and address their specific individual needs.

Working together to improve health and social care for all

On 11 February the NHS White Paper 'Working together to improve health and social care for all' was published. The White Paper has the triple aim of creating better health for the population, better quality care for all patients and financially sustainable service for tax payers. The Deputy Chief Executive will outline the white paper's proposals during the Board meeting, together with some of the potential implications.

Strategic Plan Developments

In the context of the publication of the White Paper and the profoundly changed context of the NHS post pandemic, the Trust is developing its strategic plan. Building upon the Trust's existing vision and strategic priorities we will be seeking to engage with both internal and external stakeholders. This work is referenced in the report of the Strategy Committee but will be reported upon in more detail at the next Board meeting.

Nick Carver
Chief Executive

East and North Hertfordshire NHS
NHS Trust

IPR Chief Executive's Summary

Safer Services

Nosocomial Infections

Of the Covid case reported in January, 98 (15%) were definite or probable hospital onset. A verbal update will be given on any current COVID19 outbreak management.

Others

There has been an increase in the numbers of reported cases of pressure ulcers and falls in January. A deep dive into the root cause is underway and will be reported through to the quality and safety committee at the end of March.

Caring Services

Friends and Family Test

All user groups have given increased levels of positive feedback although the number of respondents is substantially reduced.

Complaints

The number of complaints received is substantially reduced and the focus needs to be on reducing the number of open complaints.

Effective Services

Mortality

Crude mortality substantially increased in January with the latest wave of the pandemic.

The Trust's HSMR remains in the best performing quartile and for the first time the Trust's SHMI is better than expected.

Responsive Services

Performance against the A&E target (ENHT performance - 75.18%, national position 70.05%) and RTT (1,564 increase in backlog) has been challenged in January although in line with the national averages. In support of Urgent and Emergency Care a number of operational changes were put in place, to include:

- Closure of QEII urgent treatment service overnight to facilitate redeployment of staff to the Lister

- Creation of a Consultant and junior mega rota to support increased demand and patient care
- Redeployment of staff from non-clinical facing roles into patient supporting roles

The Trust's performance against the cancer standards continues to be amongst the best in the country.

Some improvement was noted regarding CT scanning times for stroke patients and thrombolysis rates, but further improvement is required and will the tracked by the FPPC through regular updates and oversight of the stroke recovery road map.

Well Led Services

The Trust continues to successfully grow its workforce, with increased recruitment and a declining turnover rate.

Although raised beyond target the Trust absence rate compares well with regional peers. ENHT is one of 2 Trusts in East of England to achieve targets for CSW recruitment.

A range of service have been put in place to support staff wellbeing.

Sustainable Services

In the context of a markedly changed environment and financial regime the Trust is on track to deliver its financial targets.

East and North Hertfordshire NHS Trust

Agenda Item: 8

TRUST BOARD – 3 MARCH 2021
Integrated Performance Report – Month 10

Purpose of report and executive summary (250 words max): The purpose of the report is to present the Integrated Performance Report Month 10 to the Trust Board. Key challenges and mitigations under each domain are identified within the report.		
Action required: For discussion		
Previously considered by: QSC and FPPC, 23 and 24 February 2021.		
Director: All Directors	**Presented by:** Chief Executive	**Author:** All Directors / Head of Information and Business Intelligence

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

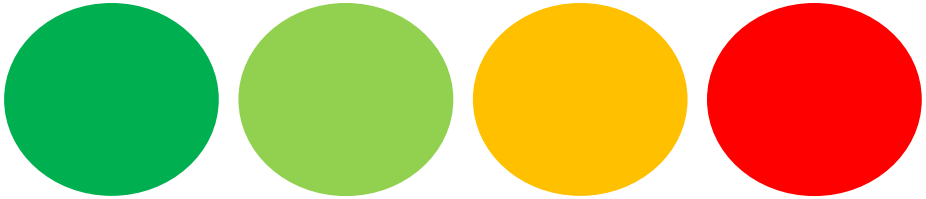
Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
Any other risk issues (quality, safety, financial, HR, legal, equality): Key challenges and mitigations under each domain are identified within the report.

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

East and North Hertfordshire NHS Trust

Integrated Performance Report

Month 10 | 2020-21



Data correct as at 19/02/2021

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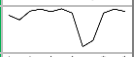
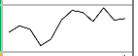
NHS Oversight Framework

East and North Hertfordshire NHS Trust

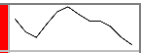
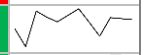
Quality of care

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
Overall	CQC rating	-	Dec-19	-	-	Requires improve-ment	
Caring	Written complaints - rate	Monthly	Jan-21	Local	1.9	0.6	
Caring	Staff Friends and Family Test % recommended - care	Quarterly	Q2 2019-20	National	81.3%	78.9%	
Safe	Occurrence of any Never Event	Monthly (six-month rolling)	Aug-20 - Jan-21	National	0	3	
Safe	Patient Safety Alerts not completed by deadline	Monthly	Jan-21	National	0	0	
Caring	Mixed-sex accommodation breaches	Monthly	Jan-21	National	0	no submission	
Caring	Inpatient scores from Friends and Family Test - % positive	Monthly	Jan-21	Local	95.0%	98.9%	
Caring	A&E scores from Friends and Family Test - % positive	Monthly	Jan-21	Local	90.0%	96.4%	
Caring	Maternity scores from Friends and Family Test - % positive - antenatal care	Monthly	Jan-21	Local	93.0%	100.0%	
Caring	Maternity scores from Friends and Family Test - % positive - birth	Monthly	Jan-21	Local	93.0%	97.9%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal ward	Monthly	Jan-21	Local	93.0%	95.0%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal community	Monthly	Jan-21	Local	93.0%	100.0%	
Safe	Emergency c-section rate	Monthly	Jan-21	Local	15%	15.1%	
Organisational health	CQC inpatient survey	Annual	2019	National	8.0	7.8	
Safe	Venous thromboembolism (VTE) risk assessment	Quarterly	Q3 2019-20	National	95%	88.1%	
Safe	Clostridium difficile (C. difficile) plan: C.difficile actual variance from plan (actual number v plan number)	Monthly (YTD)	Jan-21	NHSI	0	36	
Safe	Clostridium difficile – infection rate	Monthly (12-month rolling)	Feb 20 - Jan 21	National	20.62	25.26	
Safe	Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Monthly (12-month rolling)	Feb 20 - Jan 21	National	0.69	0.00	
Safe	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	Monthly (12-month rolling)	Feb 20 - Jan 21	National	8.81	7.69	
Safe	Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI)	Monthly (12-month rolling)	Feb 20 - Jan 21	National	17.04	12.08	
Effective	Hospital Standardised Mortality Ratio	Monthly (12-month rolling)	Nov-19 - Oct-20	National	100	84.1	
Effective	Summary Hospital-level Mortality Indicator	Monthly (12-month rolling)	Sep-19 - Aug-20	National	100	88.8	
Safe	Potential under-reporting of patient safety incidents	Monthly (six-month rolling)	Jul-20 - Jan-21	National	16.73%	14.85%	

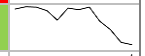
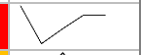
Finance

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
Financial sustainability	Capital service capacity	Monthly	Jan-21	National	1	n/a	
Financial sustainability	Liquidity (days)	Monthly	Jan-21	National	1	n/a	
Financial efficiency	Income and expenditure (I&E) margin	Monthly	Jan-21	National	1	n/a	
Financial controls	Distance from financial plan	Monthly	Jan-21	National	1	n/a	
Financial controls	Agency spend	Monthly	Jan-21	National	1	n/a	

Operational performance

A&E	A&E maximum waiting time of four hours from arrival to admission/transfer/discharge	Monthly	Jan-21	National	95%	75.18%	
RTT 18 weeks	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	Monthly	Jan-21	National	92%	67.20%	
Cancer Waiting Times	62-day wait for first treatment from urgent GP referral for suspected cancer	Monthly	Dec-20	National	85%	87.0%	
Cancer Waiting Times	62-day wait for first treatment from NHS cancer screening service referrals	Monthly	Dec-20	National	90%	84.6%	
Diagnostics Waiting Times	Maximum 6-week wait for diagnostic procedures	Monthly	Jan-21	National	1%	29.60%	
The number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who:							
Dementia assessment and referral	a. have a diagnosis of dementia or delirium or to whom case finding is applied	Monthly	-	National	95%	-	
	b. who, if identified as potentially having dementia or delirium, are appropriately assessed	Monthly	-	National	95%	-	
	c. where the outcome was positive or inconclusive, are referred on to specialist services	Monthly	-	National	95%	-	

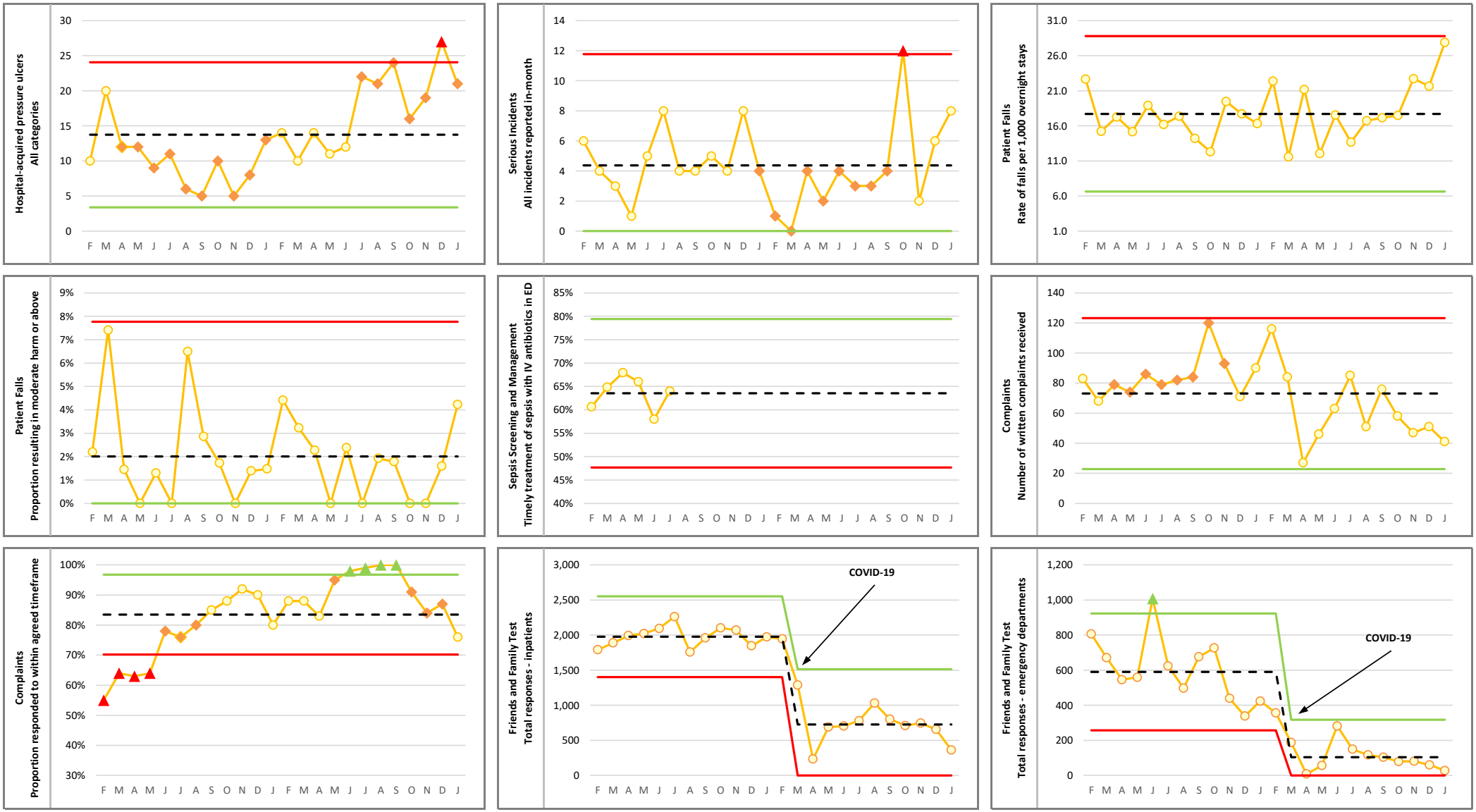
Leadership and workforce

Organisational health	Staff sickness	Monthly	Jan-21	Local	3.8%	6.69%	
Organisational health	Staff turnover	Monthly	Jan-21	Local	12.0%	11.9%	
Organisational health	Proportion of temporary staff	Monthly	Jan-21	Local	-	18.0%	
Organisational health	NHS Staff Survey Recommend as a place to work	Annual	2019	National	63.3%	58.1%	
Organisational health	NHS Staff Survey Support and compassion	Annual	2019	National	20.9%	22.5%	
Organisational health	NHS Staff Survey Teamwork	Annual	2019	National	65.5%	66.2%	
Organisational health	NHS Staff Survey Inclusion	Annual	2019	National	87.8%	86.7%	
Organisational health	BME leadership ambition (WRES) re executive appointments	Annual	2019	National	7.4%	0.0%	

Quality Improvement Dashboard

Safe, Caring and Effective Services Headline Metrics

East and North Hertfordshire NHS Trust



Safe Services

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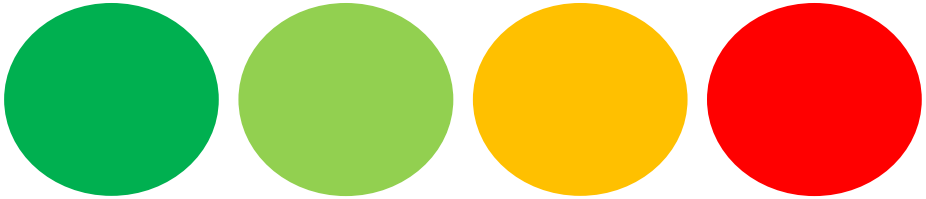


Key Issues

Patient Falls
- There were 70 Inpatient falls recorded in January.
- Number of falls in January resulting in serious harm = 3.

Serious Incidents & Never Events
- It has been 54 days since the last reported Never Event (as at 14th February 2021).
- There have been 0 Never Events in January.
- There were 8 serious incident themes reported in January:
  - Delay in delivery.
  - Failure to review pre-discharge.
  - Missed fracture.
  - HSIB case (attended with RFM, following delivery baby required cooling).
  - Retained wire following EBUS.
  - Unexpected death two days after chemotherapy.
  - Delay in diagnosis.

Infection Prevention & Control
- COVID-19 = 470 Community-Onset cases, 78 Hospital-Onset Indeterminate Healthcare-Associated cases, 68 Hospital-Onset Probable Healthcare-Associated cases & 30 Hospital-Onset Definite Healthcare-Associated cases in January
- MRSA bacteraemia = 0 cases in January.
- C difficile infections = 5 reportable cases in January.
- E.coli bacteraemia = 1 case in January.
- MSSA bacteraemia = 1 case in January.
- Klebsiella bacteraemia = 1 case in January.
- Pseudomonas aeruginosa bacteraemia = 0 cases in January.
- Hand hygiene compliance improved again from 93.55% in December, to 95.18% in January 2021 (target 80%).

Hospital-acquired Pressure Ulcers
- There were the following pressure ulcers reported for January.
  - Category 4 incl. (d) = 0
  - Category 3 incl. (d) = 0
  - Category 2 incl. (d) = 9
  - MM incl. (d) = 0
  - Unstageable incl. (d) = 2
  - SDTI incl. SDTI (d) = 10

Sepsis
- The sample of Inpatients for Q4 is currently at 10: Jan (10), currently below the Trust target (50).
- The sample of ED Patients for Q4 is currently at 15: Jan (20), currently below the Trust target (50).
- The sample showed an average time to antibiotic administration within in patient setting at 25% within 1 hour of Red Flag in January.
- The sample showed the average time in Emergency Attendances receiving antibiotics within 1 hour of Red Flag has improved to 6 4% in January, but remains below the Trust target (95%).
- 26% of patients received all Sepsis 6 interventions within 1 hour of Red Flag triggers in January.

VTE/HAT
- Potential harm from Hospital Associated Thrombosis continues to be presented to Serious Incident Review panel.
- HATs for review is at 16.92 (12 month rolling average to January).
- HATs reviews completed is at 17.67 (12 month rolling average to January).

Executive Response

Patient Falls
- System-wide themes from falls incidents remain a priority for continuous improvement within the Trust Patient Safety Programme – Harm Free Care. Improvement priorities include daily surveillance and accurate risk assessment of falls and high quality reliable mitigation of risk e.g. bay watch.
- The hepatology team are leading the adoption of safer medication management where it has been noted to contribute to high inc idence of falls, specifically improving time to administration of some specific medication regimes used within hepatology patients.

Executive Response

Serious Incident Review Panel
- 26 incidents were presented to serious incident review panel in January.
- 8 have been reported as serious incidents (1 of which being investigated by HSIB).
- 1 case requires more in-depth RCA learning reviews and 10 have triggered local learning reviews.
- Incident reporting remains in line with activity. The NLRS Benchmarking report indicates there is no evidence of under -reporting. We are still encouraging reporting and an increased reporting over time may indicate an improved reporting culture.

Infection Prevention & Control
- Nosocomial Infections: 647 cases recorded. 98 total revised recorded probable (HO.pHA) or definite (HO.dHA) nosocomial infec tions for January = 15% of total COVID cases recorded.
- In January the revised number recorded:
  - 68 Hospital-Onset Probable Healthcare-Associated cases.
  - 30 Hospital-Onset Definite Healthcare-Associated cases.
- Outbreaks:
  - 15 Outbreaks in total during the month of January.
  - 5 Outbreaks closed (MVCC 10+11, 8B South, Ashwell, 11A, H@W, and 9A).
  - 10 Outbreaks currently being actively monitored at the end of January 21.
  - Daily weekday outbreak Incident Management Team (IMT) meetings.
- New Guidance:
  - Novel coronavirus (COVID-19) standard operating procedure FM Service Guidance, gap analysis produced by Estates and Facilities.
  - Gap Analysis for updated guidance: COVID-19: Guidance for maintaining services within health and care settings Infection prevent ion and control recommendations.
- Other Indicators:
  - No Flu or Norovirus Healthcare-Associated cases reported.
  - Year-to-date C.difficile cases is 36, which is below trajectory.

Hospital-acquired Pressure Ulcers
- Total HAPU YTD is 187, with 21 recorded for the month of January.
- It has been 83 days since the trust last reported a grade 4 pressure ulcer. The last one was reported on 27/11/2020.
- Every hospital acquired Pressure Ulcer is investigated by a Tissue Viability Nurse. This is to enable identification of gaps in care so that learning can be identified and delivered.
- Quality improvement work this year will focus on Device Related PU and Moisture Associated Skin Damage.
- In compliance with the new NHSI PU recommendations the terms Unavoidable and Avoidable will no longer be used, however, where RCA shows no omissions in care and therefore no learning this will be captured and reported, so far this accounts for 17% of YTD pressure ulcers.
- Learning from previous serious incidents is taught during our restarted pressure ulcer prevention study day and pressure Ulce r prevention is taught to all new clinical staff on clinical induction in collaboration with Nurse Education.

Sepsis
- The Sepsis team has continued to respond to the COVID-19 pandemic emergency, the team has indeed been either fully redeployed or partially redeployed in to the wards and the task team.
- All team members will be reintegrated by the end of March.
- Even with only one nurse available working for both sepsis and task team, we continued to support the clinical teams with con tinuous quality improvement efforts to establish more compliance with antibiotics administration in within 1 hour. This reflects in the data that improved: the antibiotics administration compliance increased from 0% to 25% for inpatient and from 62% to 64% in ED.
- CCOT database now upgraded to improve Sepsis dashboard that CCOT/Sepsis can use. Will need additional funding to be used to f ull potential but will decrease nurse data inputting time and increase teaching and clinical time.
- The team are planning
  - a relaunch now that the pressure of the pandemic is decreasing.
  - restarting trainings and simulations as soon as possible
  - to introduce the role of sepsis link nurses to improve the compliance with the sepsis six and data collection.

VTE/HAT
- The national programme for measurement of VTE risk assessment remains suspended due to COVID -19 pandemic.
- Local quality improvement includes targeted focus groups with junior doctors to help improve compliance with VTE risk assessm ent.
- Due to the time lag between diagnosis of potential Hospital Acquired Thrombosis and the undertaking of phased RCA review it i s important to note that the number of HAT reviews completed monthly do not correspond to the cases added for review in that month and can relate to previous months. Therefore there will naturally be a 3 month delay in data clarification.
- All HAT incidents where any concern in care identified are presented to SIRP.

Safe Services

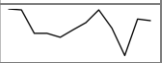
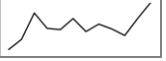
East and North Hertfordshire NHS Trust

Nosocomial Covid-19 infection	Total	Definite hospital onset (>=15 days post admission)	Probable hospital onset (8-14 days post admission)	Indeterminate onset (3-7 days post admission)	Community onset (<=2 days post admission	Total Definite & Probable hospital onset	Total Indeterminate & Community onset	
JANUARY (Weekly reporting commenced w/e 14/05/20)	298	30	68	78	470	210	962	

Domain	Metric	Target	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Trend
Events and Incidents	Number of Never Events	0	0	0	0	0	0	0	0	1	1	0	1	0	
	Number of Serious Incidents	5	1	0	4	2	4	3	3	4	12	2	6	8	
Hospital-acquired Pressure Ulcers	Category 4 - inc Category 4 (d)	0	0	0	0	0	0	0	0	0	0	1	0	0	
	Category 3 - inc Category 3 (d)	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Category 2 - inc Category 2 (d)	2	3	3	3	3	3	12	10	10	4	7	8	9	
	Mucosal membrane (d) Device-related	-	1	0	0	1	4	1	2	4	1	1	2	0	
	Unstageable inc Category Unstageable (d)	1	1	0	1	0	0	1	1	3	2	0	1	2	
	SDTI inc STDI (d)	3	9	7	10	7	5	8	8	7	9	10	16	10	
Sepsis Screening and Management	Inpatients with Sepsis - sample size	50	36		14			26			18			10	
	Inpatients receiving IVABs within 1 hour of Red Flag	90%	25%	33%	n/a	0%	60%	67%	50%	50%	14%	60%	0%	25%	
	Emergency attendances with Sepsis - sample size	50	169		21			114			156			15	
	Emergency attendances receiving IVABs within 1 hour of Red Flag	95%	66%	78%	n/a	50%	76%	63%	92%	73%	76%	73%	62%	64%	
	Sepsis six bundle compliance - ED	90%	14%	29%	n/a	0%	29%	26%	32%	25%	30%	38%	31%	26%	
Patient Falls	Number of patient falls	72	68	31	44	31	42	41	52	56	55	66	63	70	
	Rate of patient falls per 1,000 overnight stays	4.0	22.4	11.6	21.2	12.1	17.5	13.7	16.7	17.2	17.5	22.7	21.7	27.9	
	Number of patient falls resulting in serious harm	0	3	1	1	0	1	0	1	1	0	0	1	3	

Safe Services

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Trend
VTE	VTE risk assessment	95%	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	
	Cases for HAT review (12 month rolling average)	-	17.45	17.42	16.33	16.33	16.17	16.50	16.83	17.42	16.58	15.33	17.00	16.92	
	HAT reviews completed (12 month rolling average)	-	15.18	16.08	15.83	13.75	13.67	13.83	12.58	17.75	17.67	17.75	15.75	17.67	
	HATs confirmed potentially preventable	-	2	0	0	0	0	0	0	5	1	0	0	1	
Infection Control	Number of MRSA incidences	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Rate of MRSA incidences per 100,000 bed days	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
	Number of c.difficile incidences Healthcare-associated	4	4	6	3	4	2	3	3	2	10	0	4	5	
	Rate of c.difficile incidences per 100,000 bed days Healthcare-associated	19.0	24.6	34.6	26.2	33.8	17.5	20.4	20.4	14.1	56.8	0.0	22.7	27.9	
	Number of e.coli incidences	-	2	3	3	1	1	2	1	2	1	2	3	1	
	Rate of e.coli incidences per 100,000 bed days	18.5	12.3	17.3	26.2	8.4	8.7	13.6	6.8	14.1	5.7	11.7	17.0	5.6	
	Number of MSSA incidences	-	0	0	0	0	2	0	2	2	4	2	1	1	
	Rate of MSSA incidences per 100,000 bed days	8.0	0.0	0.0	0.0	0.0	17.5	0.0	13.6	14.1	22.7	11.7	5.7	5.6	
	Number of klebsiella incidences	-	1	0	0	1	0	0	0	0	2	1	0	1	
	Rate of klebsiella incidences per 100,000 bed days	7.6	6.2	0.0	0.0	8.4	0.0	0.0	0.0	0.0	11.4	5.9	0.0	5.6	
	Number of pseudomonas aerudinosa incidences	-	1	0	0	0	0	1	0	3	1	1	0	0	
	Rate of pseudomonas aerudinosa incidences per 100,000 bed days	3.7	6.2	0.0	0.0	0.0	0.0	6.8	0.0	21.1	5.7	5.9	0.0	0.0	
	Hand hygiene audit score	80%	90%	91.3%	94.1%	92.5%	92.4%	93.6%	92.2%	93.0%	92.4%	91.8%	93.6%	95.2%	

Caring Services

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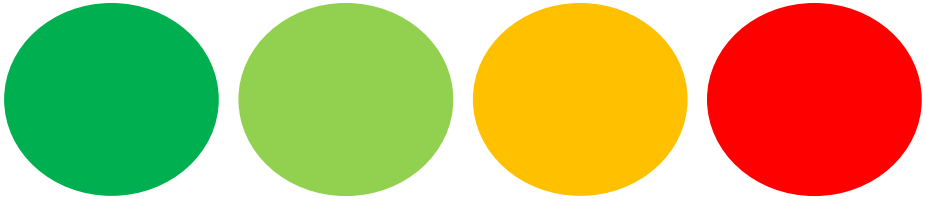


Key Issues

Friends and Family Test (FFT)

- The proportion of positive responses for Inpatients (98.90%), A&E (96.43%), Antenatal (100%) Births (97.90%), Postnatal Ward (95.0%) and Postnatal Community (100%) are all above their respective Trust targets. However A&E has reduced slightly from the previous month.
- The proportion of positive responses for Outpatients (91.22%) has decreased and has now fallen below the Trust target.
- Total responses for Inpatients (364) and A&E (28) have both decreased and are below their respective Trust targets.
- The total number of responses for Births (143) has increased again and is now above the Trust target.
- The total number of responses for Outpatients (195) has decreased by 71 in January compared to December (157).

Complaints

- Total number of complaints received in January = 41.
- The breakdown by division is as follows:
  - Planned Care = 13
  - Unplanned Care = 21
  - Cancer = 4
  - Operations = 3
- 96.36% of complaints received were acknowledged within 3 working days in January (53 of 55 due).
- 76% were responded to within the agreed timeframe in January (114 of 150 due).
- There were 81 open complaints at end of January 2021.

Executive Response

Friends and Family Test (FFT)

- December FFT data has been submitted to NHS Digital. In February we will start digital collection of FFT data and restart telephone FFT data collection as we have recruited our patient and carer experience support worker.
- The national Inpatient survey and the Children and Young People's survey for 2020 are due to be carried out for the trust by Picker. Posters informing patients how to opt out of these surveys have been displayed on the adult inpatient wards at both MVCC and Lister, and the children's Bluebell ward at Lister.
- Hospital visiting remains restricted apart from the existing permitted circumstances. In a response to this and the concerns raised about communication with our PALS team, the 'keeping in touch' service for families has been set up by the PACE, digital and workforce teams. Redeployed and shielding team members have supported the service which has been running since the beginning of February. Family members can request a virtual video visit a clinical update or both and when they make the booking they tell us what matters most to them about the call they are requesting. 184 calls were answered by the digital call centre. 26 virtual visits, 98 clinical updates and 28 where both were requested were completed. 100% were completed on the same day for virtual visits and 97.5% of clinical updates were made within one working day.
- The 'Stay in Touch' service, provided by the Voluntary Response Team, continues to deliver messages and photos or drawings to our patients. In January we delivered 179 letters and 215 photos bringing the totals to 1317 letters and 1493 photos since the service was set up.
- Our volunteer service offers a menu of options that patients and carers can request.

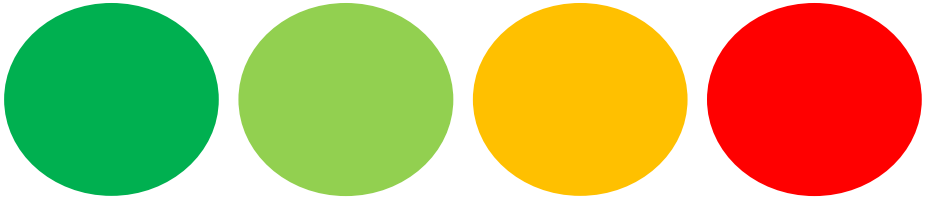
Complaints

- The number of new complaints received this month has dropped by 20% on the number received in December 2020.
- Financial year to date - (01 April 2020 - 31 January 2021) this Trust has received a total of 539 complaints compared to a total of 847 complaints received for the same period last year (01 April 2019 - 31 January 2020), a reduction of 308 complaints.
- The number of new complaints received reduced significantly at the beginning of the pandemic. NHS England recommended a pause in the complaints process to allow Trusts to respond to the pandemic. During that time the complaints team focused on reviewing processes and continued to respond to complaints and reduce the number open.
- During the second wave, NHS England has recommended extending the timeframe for responding to complaints due to the pressures on clinical staff.
- The complaints team continue to explore different ways of working to support complaint investigations in order to close open complaints.

Domain	FFT	Metric	Target	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Trend
Friends and Family Test	Inpatients	Proportion of positive responses	95%	96.8%	97.3%	92.7%	90.7%	93.8%	96.8%	95.5%	97.3%	98.5%	98.4%	96.7%	98.9%	
		Total number of responses	1,778	1,946	1,288	233	689	705	780	1,031	803	710	745	657	364	
	A&E	Proportion of positive responses	90%	94.4%	93.1%	100.0%	92.9%	89.0%	96.6%	98.3%	96.1%	98.7%	95.1%	98.3%	96.4%	
		Total number of responses	1,241	356	188	8	56	282	149	117	103	79	81	60	28	
	Maternity	Antenatal care Proportion of positive responses	93%	92.3%	100.0%	n/a	100.0%	n/a	100.0%	0.0%	100.0%	50.0%	100.0%	85.7%	100.0%	
		Birth Proportion of positive responses	93%	93.9%	98.2%	95.7%	n/a	100.0%	100.0%	100.0%	92.6%	94.4%	96.2%	97.8%	97.9%	
		Birth Total number of responses	137	114	110	23	0	2	1	8	27	126	133	135	143	
		Postnatal ward Proportion of positive responses	93%	83.3%	92.7%	95.7%	n/a	100.0%	100.0%	100.0%	95.7%	95.9%	92.6%	94.4%	95.0%	
		Postnatal community Proportion of positive responses	93%	100.0%	100.0%	n/a	n/a	n/a	100.0%	n/a	66.7%	0.0%	100.0%	100.0%	100.0%	
	Outpatients	Proportion of positive responses	95%	95.9%	96.4%	97.6%	95.8%	99.0%	98.9%	96.2%	95.7%	98.5%	99.2%	96.6%	91.2%	
		Total number of responses	-	2,273	1,276	83	271	204	369	392	419	471	389	233	195	
Complaints		Number of written complaints received	92	104	76	28	45	56	83	53	76	58	47	51	41	
		Rate of written complaints received	1.9	1.7	1.2	0.5	0.7	0.9	1.3	0.8	1.2	0.9	0.7	0.8	0.6	
		Proportion of complaints acknowledged within 3 working days	75%	100%	100%	100%	100%	82%	100%	100%	100%	100%	100%	100%	96%	
		Proportion of complaints responded to within agreed timeframe	80%	88%	88%	83%	95%	98%	99%	100%	100%	91%	84%	87%	76%	

Effective Services

Month 10 | 2020-21



Key Issues

Crude Mortality
- The in-month crude mortality rate increased from 16.6 deaths per 1,000 admissions in December to 35.4 in January.
- The rolling 12-months crude mortality rate continues to increase to 15.9 deaths per 1,000 admissions in the 12 months to January, and is slightly higher than the most recently available national rate of 15.3 deaths per 1,000 admissions (Dec -19 to Nov-20).

Hospital-Standardised Mortality Ratio
- The in-month HSMR has decreased from 80.3 in October to 69.9 in November.
- The rolling 12-months HSMR decreased from 84.3 in the 12 months to October, to 84.1 in the 12 months to November.
- The Trust remains in the best performing quartile of Trusts for HSMR.
- HSMR is usually available 2 months in arrears.

Summary Hospital-level Mortality Indicator (SHMI)
- The latest SHMI release for the 12 months to September has decreased to 88.75.
- For the first time ever, this places us in band 3; better than expected

Re-admissions
- The re-admission rate for 12 months to November has increased to 8.39% from 8.13% in the 12 months to October.

Learning from Deaths
- Where mortality reviews give rise to significant concern regarding the quality of care or the avoidability of the death, the case is subject to further scrutiny and discussion at the relevant Specialty clinical governance forum. The outcomes of these reviews are then considered by the Mortality Surveillance Committee.
- Following the 1st wave of COVID-19 mortality reviews restarted. Our reviewers worked hard to clear the backlog of reviews and the completion rate for deaths in scope rose to 65%. Clinical pressures of the 2nd wave together with an increase in deaths have resulted in this slipping to 52%.
- In addition to routine reviews 2 areas have been identified for further assurance and learning on the back of the COVID -19 pandemic: (1) Review of COVID-19 patients who died on a readmission within 28 days; (2) Deaths in the Community (COVID -19/nonCOVID-19) within 28 days of discharge. Detail of outcomes will be shared with the Board via the quarterly Learning from Deaths report.
- Work to integrate our mortality review process into the new Datix iCloud platform when this is implemented into the Trust is underway. Due to concerns raised by the Mortality Surveillance Committee, the mortality module will not go live on Datix iCloud until integration with Lorenzo takes place, the timeframe for which will depend on ITs forward plan capacity.

Executive Response

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

Crude Mortality
- This measure is available the day after the month end. It is the factor with the most significant impact on HSMR.

Executive Response (continued)

Crude Mortality (continued)
- The general improvements in mortality have been as a result of a combination of corporate level initiatives such as the mortality review process and more directed areas of improvement such as the identification and early treatment of patients with sepsis, stroke, etc. together with our continued drive to improve the quality of our coding.
- Our crude mortality has steadily improved over recent years. In the second half of 2019 our rolling 12 month crude mortality rate was consistently better than the national average. While our in-month rate increased significantly in April 2020 at the start of the peak COVID-19 period, this steadily decreased returning to levels similar to pre-COVID-19 period, until January 2021. While recent months have seen a steady increase in our rolling 12 month rate, it remains lower than the national rate.

Hospital Standardised Mortality ratio (HSMR)
- Our current HSMR of 84.1 (rolling 12 months to November2020) positions us in the best performing quartile of Trusts nationally. We remain focussed on driving further improvement.
- Following a number of outlier alerts within the Cardiology basket of diagnosis groups, a collaborative review has commenced between the Specialty and Coding teams to gain a better understanding and assurance regarding the underlying reasons for this.

Summary Hospital-level Mortality Indicator (SHMI)
- Following significant improvements in SHMI, there has now been a sustained period of stability. The latest figure of 88.75 (12 months to September 2020) sees the Trust positioned within the 'better than expected' band 3 for the first time since the indicator's inception in 2010. Our position relative to our national peers currently stands at 16th out of all acute non-specialist trusts (124).
- COVID-19 activity continues to be excluded from the SHMI by NHS Digital.
- The fact that SHMI includes deaths within 30 days of discharge, and the Trust has remained well placed in comparison to the national picture, provides some assurance that our response to COVID has not generally resulted in a disproportionate increase in deaths within 30 days of discharge. An in-month spike in March 2020 is being scrutinised in more detail.

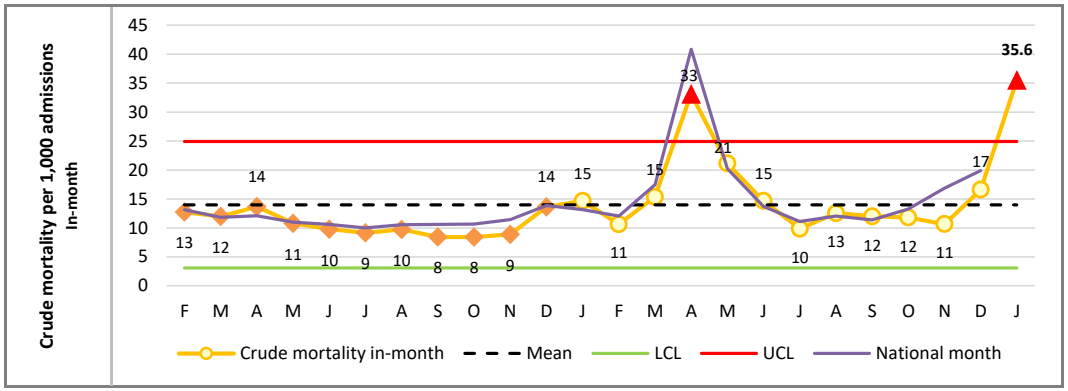
Re-admissions
- The Trust's re-admission rate has generally been consistent with the national performance. The period Mar-April 2020 saw a marked fall in numbers of readmissions, with numbers steadily increasing from May and July, stabilising in August/September. While April/May saw significant increases in our readmissions rate, this stabilised in June to August and fell in September and October, but rose slightly in November. This pattern was similar to the national picture. The significant changes in overall admissions and the change in case mix during this period make interpretation of this data challenging.

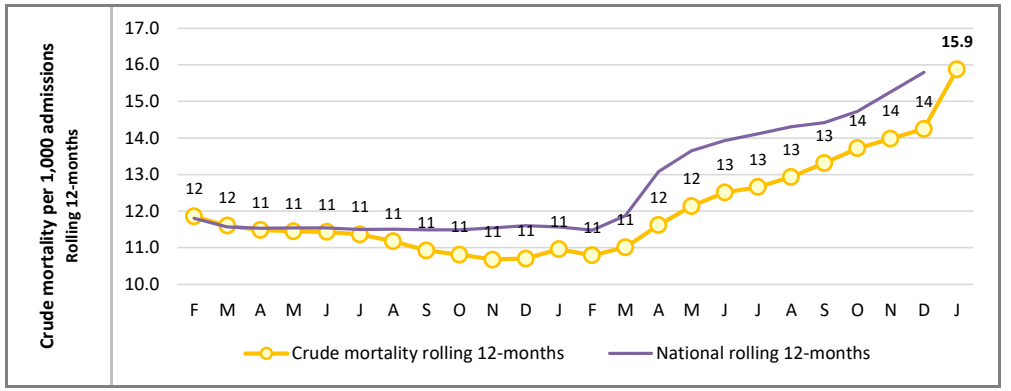
Learning from Deaths
- In addition to the outcomes of cases escalated to Specialties being considered by the Mortality Surveillance Committee, the quarterly Learning from Deaths report includes a summary of key themes emerging from these cases. This detail is shared with all Trust Specialties and with interested working groups such as Deteriorating Patient, End of Life and Seven Day Services Steering Group.
- While still firmly on the agenda, work with Business Informatics and the Head of Coding to gather appropriate data and set up reports to monitor, provide assurance regarding mortality data has slowed due to competing pressures. Discussions are now underway to create a dashboard on QlikView.

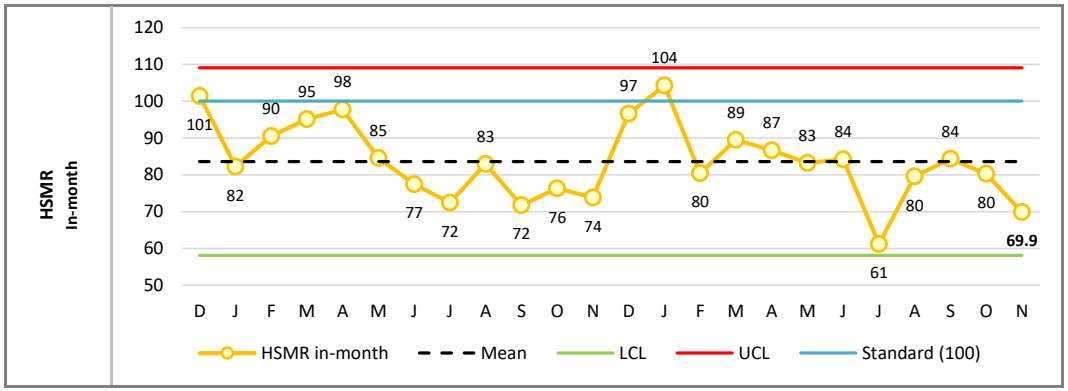
Specialist Palliative Care
- This data refers solely to patients under the care/review of the Palliative Care Team. Other data is available for deaths that are not known to the PCT. However, it resides in an access database and we are currently working through some data quality issues.

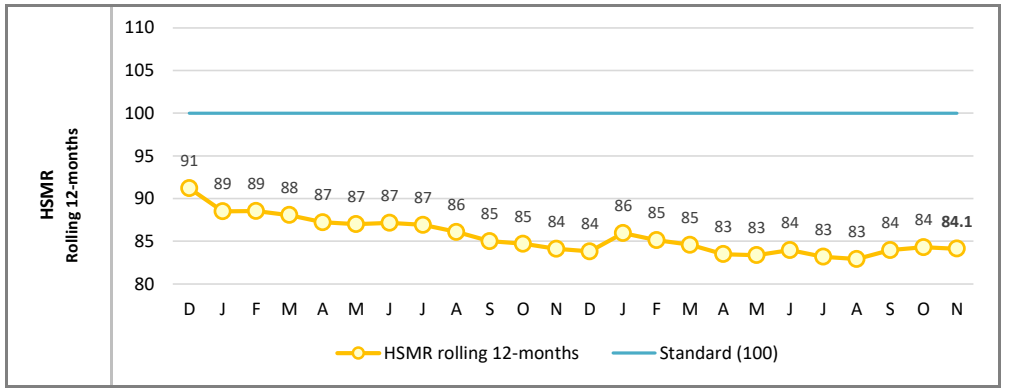
Effective Services

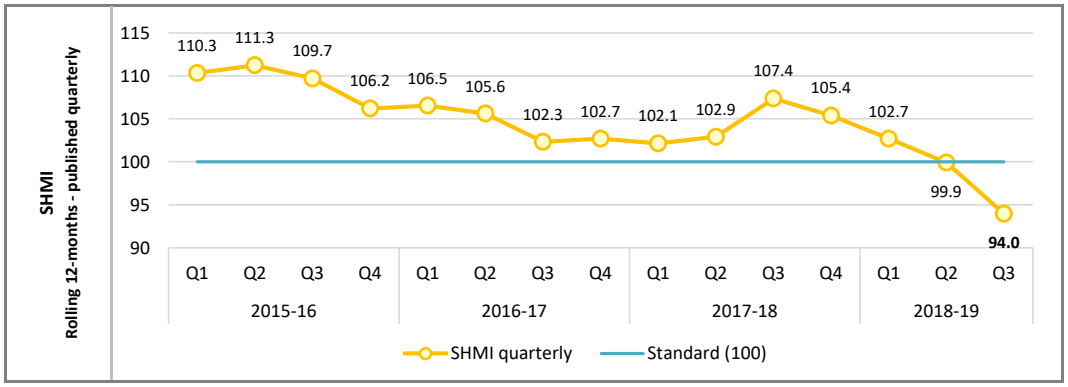
East and North Hertfordshire NHS Trust

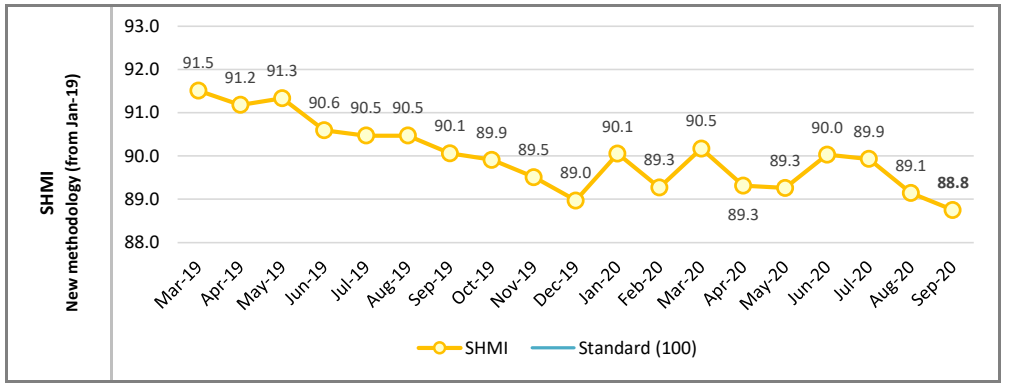






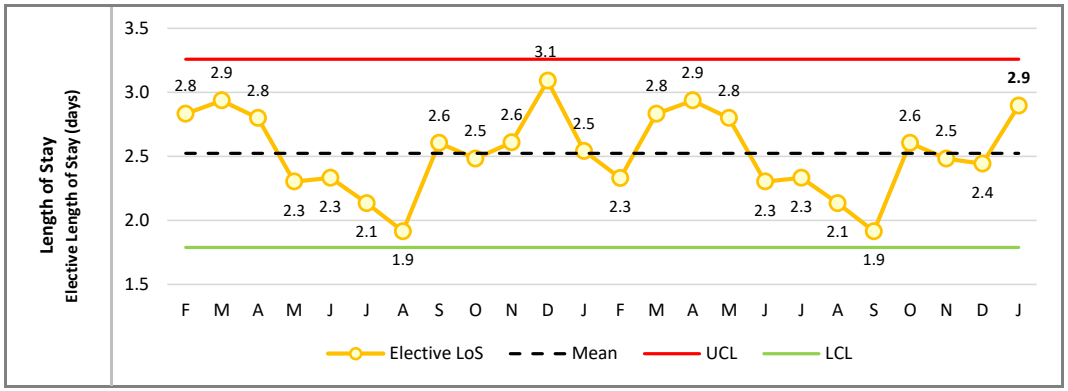


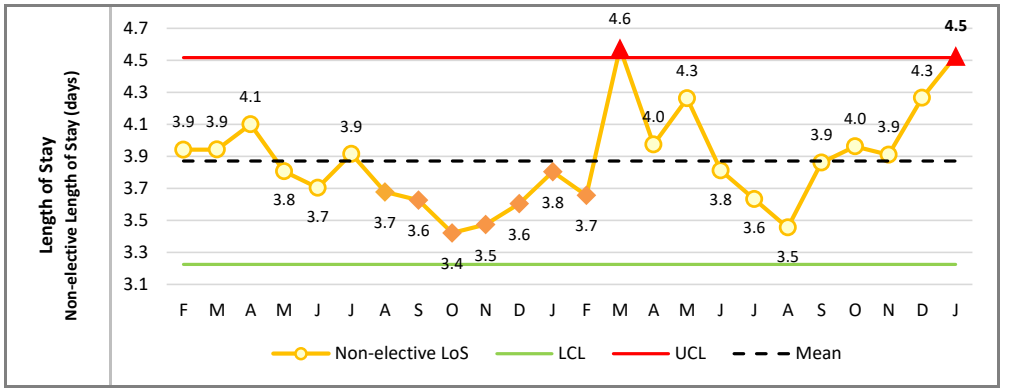


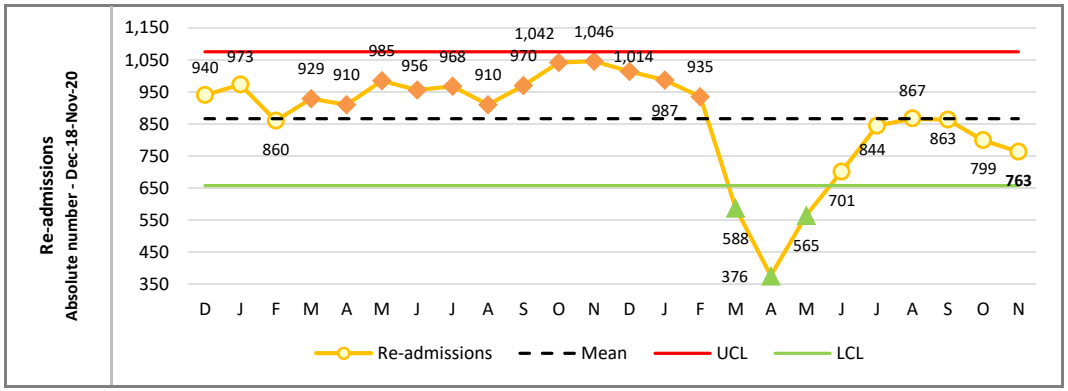


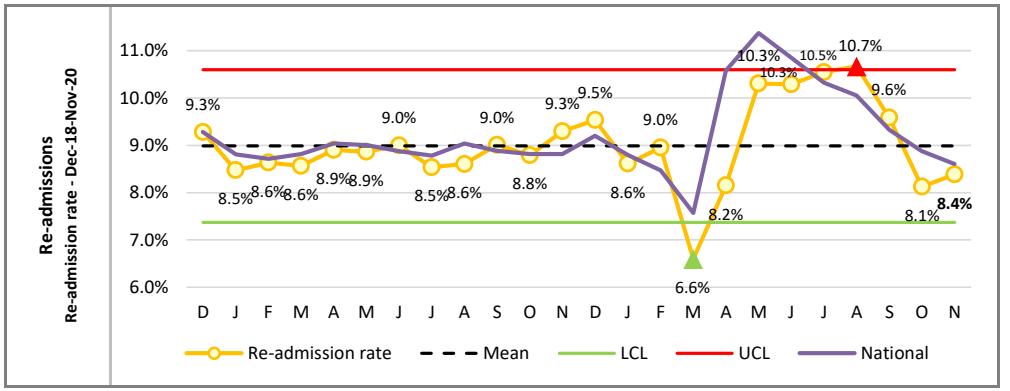
Effective Services

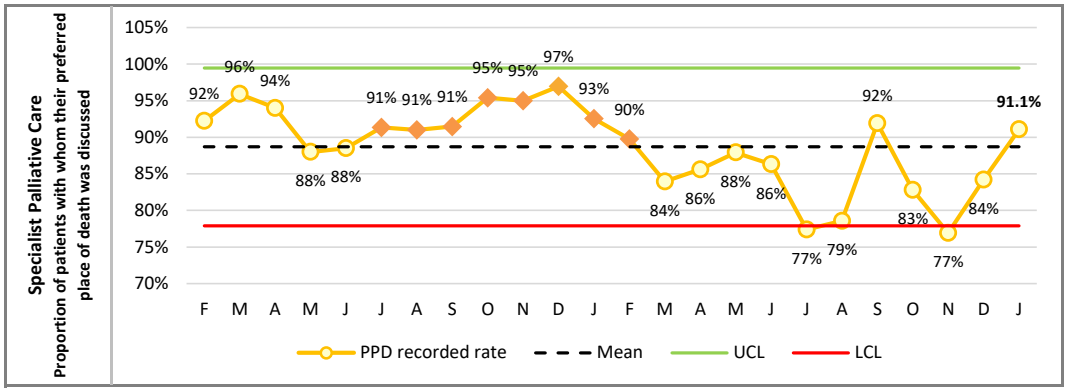
East and North Hertfordshire NHS Trust

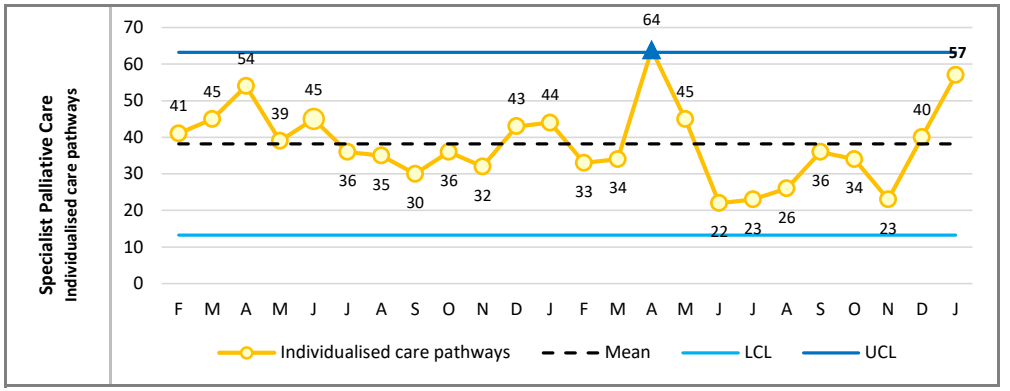






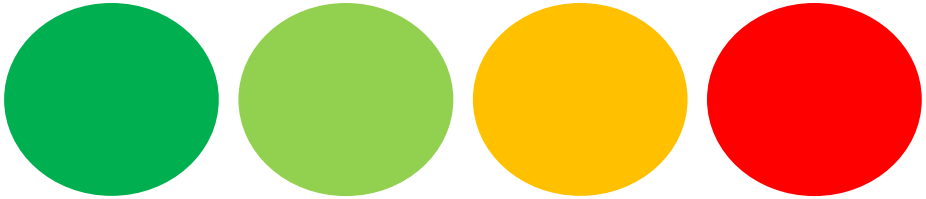






Responsive Services

Month 10 | 2020-21



Key Issues

A&E
- Performance for the month of January was 75.18%.
- There was one trolley wait reported in January.

Cancer Waiting Times
- The Trust achieved 7 out of the 8 national targets for cancer performance in December.
- The Trust 62-day performance for December was 86.96%.
- Good progress continues on the speciality cancer action plans, all plans being reviewed and updated weekly.
- Robust weekly cancer PTL management is in place.

RTT
- Incomplete performance for January was 67.20%. This is a reduction from the 69.73% reported in December.
- The December backlog was 14,367, an increase of 1,564 from 12,803 in December.
- There were 1,724 52-week breaches reported in the December incomplete position, an increase of 566 from the 1,158 reported in December.

Diagnostics
- DM01 performance for December was 29.60% against the national standard of 1% and the December position of 21.01%.
- Latest National performance for December was 29.17%.

Stroke
- Stroke performance for January is 48.3%.
- Thrombolysis performance is at 11.3% in January, matching the Trust target of 11%.
- Door-to-needle performance continued to improve in January to 71.4%, and is above the Trust target of 70%.
- CT 1hr to scanning is at 57.8% in January which is above the Trust target of 50%.

Executive Response

A&E
- Performance against the 4 hour standard continued to deteriorate in January compared to December. This reflects the Trusts c ontinued operational pressures in which we were in OPEL 3 for a majority of the month occasionally escalating into OPEL 4.
- Increasing staffing challenges due to increased absences as a result of COVID -19 was a continual theme with exceptional action t aken to respond including; commencing a junior doctor mega rota, closure of QEII overnight and redeployment of all registered nurses to inpatient areas. Despite the exceptional actions ability to open extended capacity remained challenging.
- Inpatient capacity was challenged further by closure of beds due to infection control measures associated to COVID -19.
- Non-admitted performance deteriorated significantly in January. This is a result increased numbers of stranded patients within ED, to later be discharged directly from ED.
- There was one reported 12hour trolley breach which was a result of the patient being unstable to transfer whilst removed from NIV.

Cancer Performance (December)
- In December, the Trust achieved 7 of the 8 national targets and 1 out of 3 -28 day FDS standards for Cancer performance: 2ww G P Referrals, 2ww Breast Symptoms, 31 - day First Treatment, 31-day Subsequent for Radiotherapy, Chemotherapy and Surgery, and 62 d ay urgent to treatment referrals for all Cancers, and 28 day FDS 2WW.
- The Trust has always previously delivered against the 2ww national standard which requires 93% of patients referred on a two -week pathway by their GP to have attended the 1st Outpatient appointment within 14 days. For December 2020 the Trust performance w as 98.1%.
- In December 2020, the Trust wide average days wait for first appointment is at 110 days and the majority of patients were see n between 8 and 12 days.
- The Trust has not consistently delivered against the Breast Symptomatic national standard which requires 93% of patients refe rred to have attended the 1st Outpatient appointment within 14 days. For December 2020, the Trust performance was 93.3%.

Executive Response (continued)

Cancer Performance (December - continued)
- The Trust has consistently delivered the 31-day second or subsequent treatment for Radiotherapy and Chemotherapy but not for the subsequent Surgery. For December 2020 the Trust Chemotherapy performance was 100%, the Trust Radiotherapy performance was 99.6% and the Trust subsequent Surgery performance was 100%.
- The Trust performance for 31-day to first definitive treatment was 99.6%. The standard requires 96% of patients to receive treat ment within 31 days of diagnosis.
- In December 2020, the Trust performance for the Faster Diagnosis is 79.10% for the 2ww patients, 70.7% for Breast Symptomatic and 51.50% for Screening patients.
- Reported 62-day performance for December 2020 was pre-sharing 82.7% and post-sharing 87.0%.
- Cancer performance is available one month in arrears.

RTT
- Performance declined in November and remains significantly below the required performance standard of 92%. The number of pati ents greater than 52 weeks has increased, but the overall PTL size.
- 3,000 plus admitted patients have been risk stratified against the Royal College guidelines. Patients are recorded as P1, P2, P3, P4, P5 and P6.
- Trust is prioritising P1 and 2 categorised patients only, as per Region/National Instruction to cease all P3, 4 work.
- The independent sector is being utilised to treat our waiting cancer patients only.
- 3 theatres remain operational on the Lister site, plus the private sector for December.
- Limited PTL management is in place –to allow for redeployment of staff to support the COVID 2 response.
- COVID 2 surge has resulted in the cancellation of elective activity.
- Recovery triggers in place.
- Recovery plan in development.

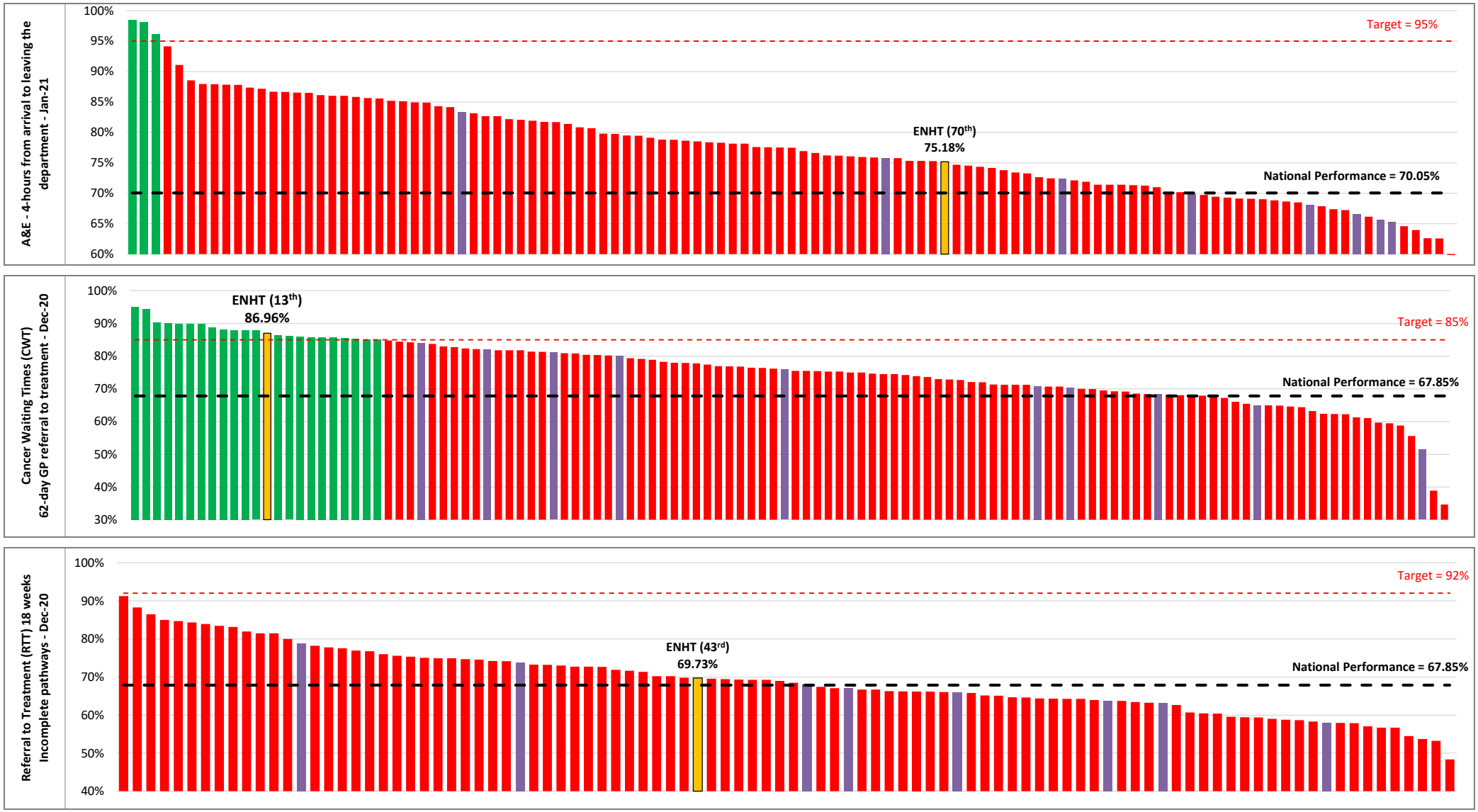
Diagnostics
- Performance declined in December, the numbers of patients waiting over 6 and 13 weeks increased. COVID 2 surge is impacting o n performance due to staffing and reducing the footfall into the organisation.
- Recovery triggers in place.
- Recovery plan in development.

Stroke
- January data had a decrease in number of Stroke (64) compared to previous month of 83 - this is just below the 20/21 average of 66.
- 4hr performance is under performing against the 63% target - due to low number of Stroke discharges in the month and a number of other factors, (breaches which relate to challenging diagnostic/complex case).
- There are a high number of patient pathways that are complex/challenging diagnosis, which has an impact on the delivery of 4h r performance.
- SNNAP rating performance reduction - main contributing factors are: OT/PT non-compliance of establishment in-line with National Specification, business case has been provided for approval to levels to be compliant and therefore provide the requirement of delivery of c are in accordance of the SNNAP requirement.
- Direct impact on MDT working due to OT/PT staffing levels.
- Door to Needle performance within 1hr 71.4% - Target of 70% has been achieved compared to previous months - this shows the impact of the actions from Task and Finish group for Thrombolysis pathway to review improvement plans for recovery of performance.
- Implemented in December - Pathway for CTA requesting now carried out by Stroke nurses and instant approval based on met criteria .
- Thrombolysed rate 11.3% January - ongoing Improvement from previous performance - there is still an ongoing risk. In light of th e changes to all services due to COVID-19 both ambulance and ED triage and scanning protocols added some delays. Internal analysis of each case i s to be carried out for future learning to be carried forward.
- CT performance for 1hr continues to meet the 50% target, ongoing risk due to the increase demand to CT services.
- Concerns ongoing with the requirements of Stroke beds needing to be used for Medical patients to support Trust position and t o ensure safety - this reduces the available capacity for Stroke bed and adherence to 4hr performance.
- All the other indicators for January performance met target s, with 4hrs performance not achieving and the 12hr scanning slig htly under the 100% target, which has been impacted by the COVID-19 cases and the IPC requirements of scanning at the end of list, which could and h as resulted in over 12hrs.
- Key element of the stroke pathway is the 1hr to scan which achieved the target in month.

Responsive Services

Trust performance against all Trusts nationally

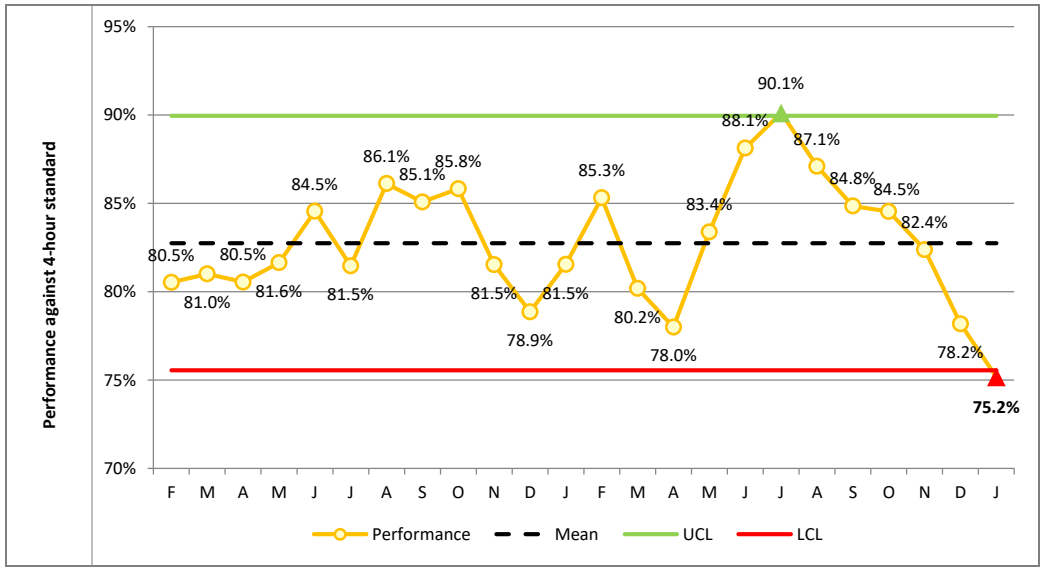
East and North Hertfordshire NHS Trust



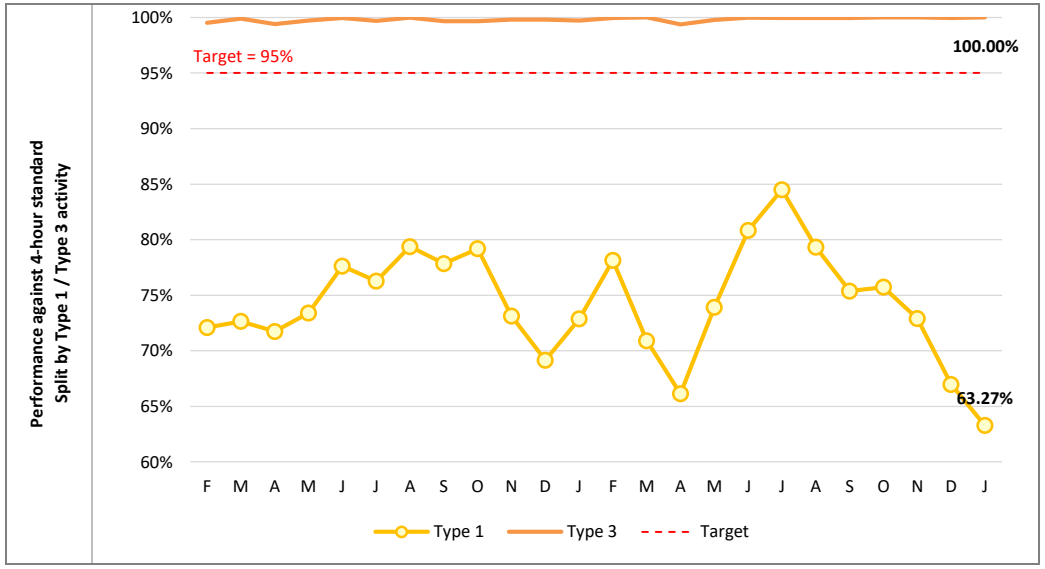
Responsive Services

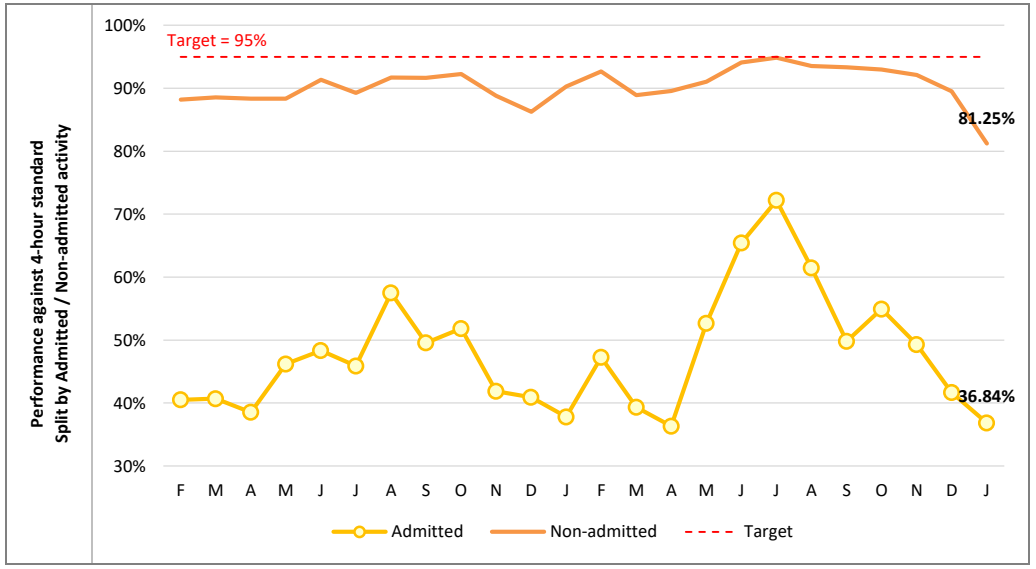
Emergency Department Performance

East and North Hertfordshire NHS Trust



Domain	Metric	Target	Dec-20	Jan-21	Change	Trend
Other Emergency Department measures	Ambulance handovers (Arrival to Handover) Proportion within 15 minutes	-	20%	tbc	▼	
	Ambulance handover breaches 30 minutes	334	634	tbc	▲	
	Ambulance handover breaches 60-minutes	73	265	tbc	▲	
	Attendance to admission conversion rate	-	37.8%	39.1%	▼	
	Time to initial assessment 95th centile	15	tbc	tbc	◀▶	
	Time to treatment Median	60	tbc	tbc	◀▶	
	Left department before being seen for treatment	5%	0.82%	0.64%	▲	
	Unplanned re-attendance rate	5%	6.13%	6.76%	▼	





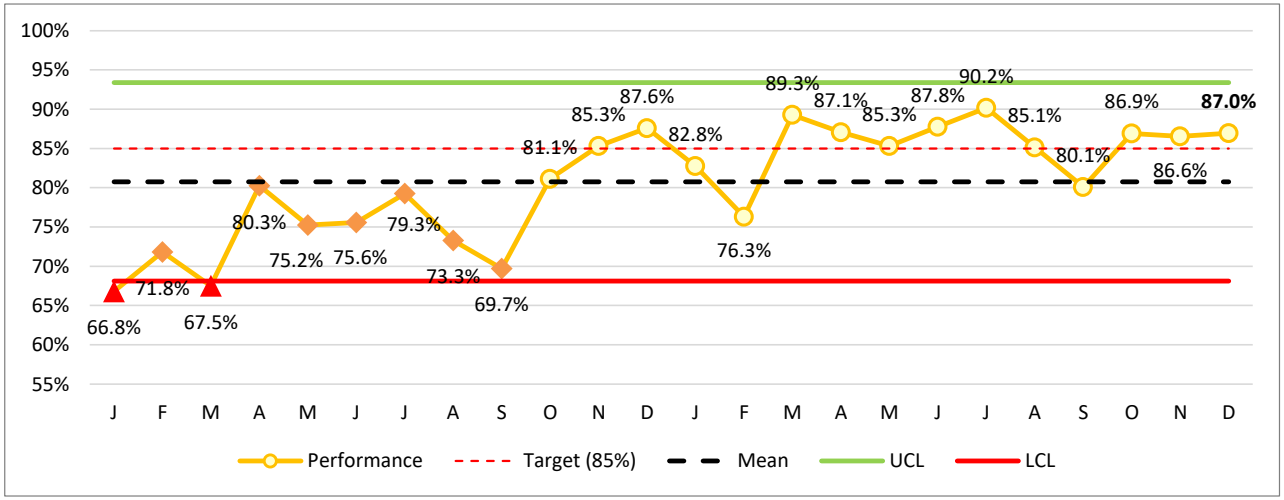
Responsive Services

Cancer Waiting Times

East and North Hertfordshire NHS Trust

12-months' performance - all standards	Standard	Target	2019-20				2020-21									
			Jan-20	Feb-20	Mar-20	YTD	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	YTD
	Two week waits Suspected cancer	93%	96.47%	98.08%	98.77%	96.95%	97.72%	99.35%	99.32%	92.80%	95.84%	97.25%	96.74%	97.36%	98.12%	97.01%
	Two week waits Breast symptomatic	93%	97.96%	95.70%	97.14%	94.10%	79.31%	100.00%	98.59%	97.98%	98.67%	99.00%	96.36%	97.64%	93.33%	96.80%
	31-day First definitive treatment	96%	97.82%	98.98%	97.89%	96.57%	98.60%	98.50%	98.63%	94.59%	98.22%	98.48%	98.28%	98.68%	99.57%	98.21%
	31-day subsequent treatment Anti-cancer drugs	98%	99.45%	98.16%	99.49%	99.50%	99.10%	100.00%	99.39%	100.00%	100.00%	99.39%	100.00%	100.00%	100.00%	99.87%
	31-day subsequent treatment Radiotherapy	94%	98.16%	99.49%	99.50%	99.10%	100.00%	99.39%	100.00%	100.00%	99.39%	100.00%	100.00%	98.90%	99.63%	98.86%
	31-day subsequent treatment Surgery	94%	79.07%	86.21%	95.83%	83.55%	94.44%	96.15%	100.00%	95.00%	96.15%	90.00%	95.12%	95.45%	100.00%	95.68%
	62-day GP referral to treatment	85%	82.76%	76.32%	89.27%	79.82%	87.08%	85.31%	87.78%	90.16%	85.15%	80.10%	86.92%	86.55%	86.96%	86.21%
	62-day Specialist screening service	90%	100.00%	44.44%	66.67%	76.67%	38.46%	0.00%	NIL	20.00%	0.00%	80.00%	100.00%	100.00%	84.62%	66.67%

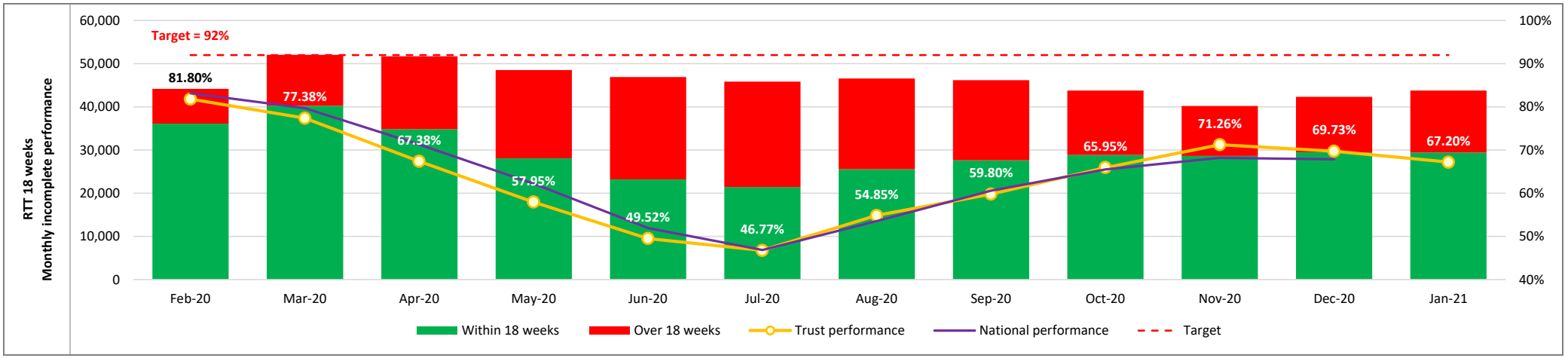
62-day GP referral to treatment Dec-20	Tumour Site	OK	Breach	Total	Perf.
	Breast	25.0	0.0	25.0	100.00%
	Gynaecology	6.0	2.5	8.5	70.59%
	Haematology	1.0	2.0	3.0	33.33%
	Head and Neck	2.0	2.0	4.0	50.00%
	Lower GI	12.5	6.0	18.5	67.57%
	Lung	6.5	1.0	7.5	86.67%
	Other	0.0	0.0	0.0	-
	Skin	14.5	1.5	16.0	90.63%
	Testicular	2.0	0.0	2.0	100.00%
	Upper GI	4.0	0.0	4.0	100.00%
	Urology	26.5	0.0	26.5	100.00%
	Total	**100.0**	**15.0**	**115.0**	86.96%



Responsive Services

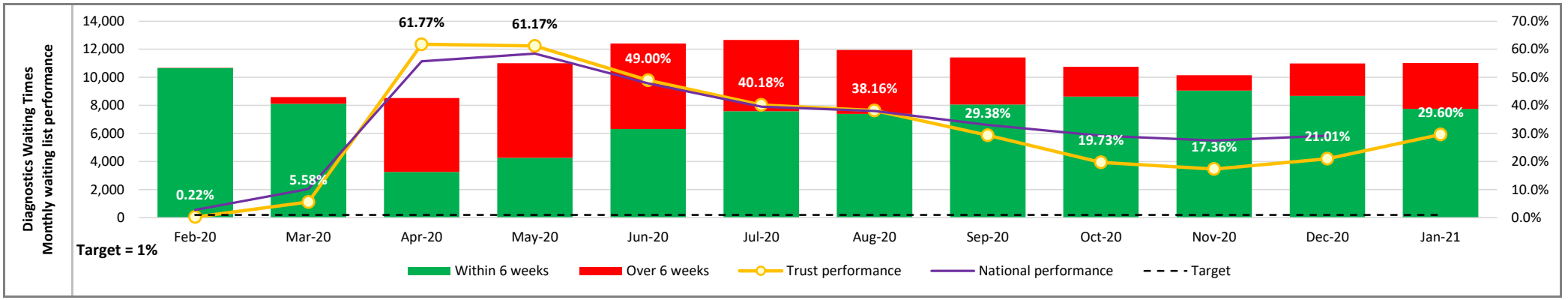
RTT 18 weeks

East and North Hertfordshire NHS Trust



RTT 18 weeks
In-month performance by Specialty - Jan-21

Specialty	Clock Stops - Admitted			Clock Stops - Non-admitted			Incomplete pathways						Clock Starts
	Total	Performance	Over 52 weeks	Total	Performance	Over 52 weeks	Within 18 weeks	Over 18 weeks	Total	Performance	Over 40 weeks	Over 52 weeks	
General Surgery	82	70.73%	0	194	78.35%	4	1,890	1,148	3,038	62.21%	356	130	632
Urology	55	83.64%	0	333	94.59%	2	1,303	776	2,079	62.67%	305	103	518
Trauma & Orthopaedics	12	16.67%	2	397	57.43%	29	2,163	1,651	3,814	56.71%	811	467	565
Ear, Nose & Throat (ENT)	23	73.91%	0	491	66.40%	0	2,229	1,027	3,256	68.46%	134	45	719
Ophthalmology	13	38.46%	2	400	81.00%	0	3,119	1,726	4,845	64.38%	465	113	840
Oral Surgery	12	25.00%	3	227	55.51%	4	1,267	906	2,173	58.31%	466	195	379
Plastic Surgery	32	84.38%	0	462	89.39%	1	1,069	591	1,660	64.40%	97	46	588
Cardiothoracic Surgery	0	-	0	11	81.82%	0	7	4	11	63.64%	1	0	5
General Medicine	1	100.00%	0	26	100.00%	0	507	117	624	81.25%	7	0	261
Gastroenterology	88	77.27%	2	235	63.83%	15	2,897	2,132	5,029	57.61%	876	224	697
Cardiology	13	92.31%	0	749	86.11%	1	1,563	394	1,957	79.87%	60	11	694
Dermatology	0	-	0	168	80.95%	0	909	219	1,128	80.59%	5	0	277
Thoracic Medicine	25	84.00%	0	202	68.81%	0	808	368	1,176	68.71%	92	9	280
Neurology	0	-	0	215	89.77%	0	359	21	380	94.47%	9	6	247
Rheumatology	0	-	0	91	72.53%	0	663	219	882	75.17%	58	6	166
Geriatric Medicine	0	-	0	24	45.83%	0	114	60	174	65.52%	10	0	18
Gynaecology	29	89.66%	0	255	89.02%	0	2,986	448	3,434	86.95%	110	62	1,016
Other	57	77.19%	5	1,897	81.23%	17	5,576	2,560	8,136	68.53%	888	307	2,493
Total	**442**	**74.66%**	**14**	**6,377**	**78.83%**	**73**	**29,429**	**14,367**	**43,796**	**67.20%**	**4,750**	**1,724**	**10,395**

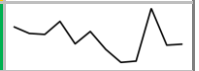
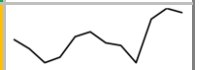
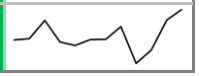


Diagnostics Waiting Times In-month performance by Modality - Jan-21	Category	Modality	Patients still waiting at month end					Number of tests / procedures carried out during the month			
			Within 6 weeks	Over 6 weeks	Total	Performance	13+ weeks	Waiting List	Planned	Unscheduled	Total
	Imaging	Magnetic Resonance Imaging	1,093	519	1,612	32.20%	8	1,709	110	0	**1,819**
		Computed Tomography	1,258	566	1,824	31.03%	49	2,696	316	1,128	**4,140**
		Non-obstetric ultrasound	3,713	1,242	4,955	25.07%	31	4,601	335	58	**4,994**
		DEXA Scan	321	428	749	57.14%	34	188	9	0	**197**
	Physiological Measurement	Audiology - audiology assessments	15	1	16	6.25%	1	35	0	0	**35**
		Cardiology - echocardiography	720	26	746	3.49%	8	821	0	0	**821**
		Neurophysiology - peripheral neurophysiology	76	11	87	12.64%	0	77	0	0	**77**
		Respiratory physiology - sleep studies	24	1	25	4.00%	1	87	0	0	**87**
		Urodynamics - pressures & flows	21	40	61	65.57%	14	7	0	0	**7**
	Endoscopy	Colonoscopy	218	230	448	51.34%	12	179	0	0	**179**
		Flexi sigmoidoscopy	78	69	147	46.94%	1	52	0	0	**52**
		Cystoscopy	36	14	50	28.00%	8	71	0	0	**71**
		Gastroscopy	186	116	302	38.41%	13	113	0	0	**113**
	Total		**7,759**	**3,263**	**11,022**	**29.60%**	**180**	**10,636**	**770**	**1,186**	**12,592**

Responsive Services

Stroke Performance

East and North Hertfordshire NHS Trust

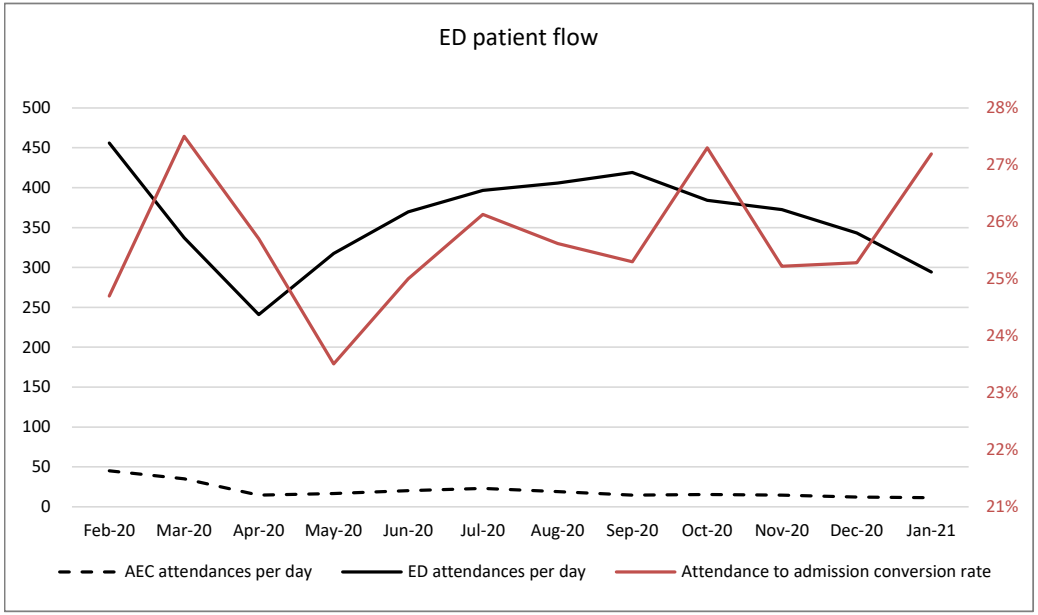
Domain	Metric	2019-20 Target	Feb-20	Mar-20	2020-21 Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Trend
Stroke	Trust SSNAP grade	A	C	C	A	B	B	B	C	C	C	tbc	tbc	tbc	tbc	
	% of patients discharged with a diagnosis of Atrial Fibrillation and commenced on anticoagulants	80%	83.3%	75.0%	80%	100.0%	100.0%	100.0%	88.9%	100.0%	100.0%	80.0%	87.5%	71.4%	100.0%	
	4-hours direct to Stroke unit from ED Actual	90%	51.9%	67.7%	63%	55.0%	73.8%	66.7%	67.9%	69.9%	50.7%	54.0%	56.5%	52.0%	48.3%	
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	90%	53.1%	68.8%	63%	55.6%	74.6%	68.8%	69.1%	69.9%	54.5%	55.3%	56.9%	52.1%	50.9%	
	Number of confirmed Strokes in-month on SSNAP	-	54	67	-	57	65	71	58	73	75	53	71	83	64	
	If applicable at least 90% of patients' stay is spent on a stroke unit	80%	86.8%	97.0%	80%	94.6%	90.8%	92.6%	91.1%	89.0%	89.0%	86.5%	84.3%	87.7%	88.5%	
	Urgent brain imaging within 60 minutes of hospital arrival for suspected acute stroke	50%	55.6%	64.2%	50%	59.6%	56.9%	61.4%	46.6%	56.2%	45.3%	45.3%	71.8%	55.4%	57.8%	
	Scanned within 12-hours - all Strokes	100%	94.4%	98.5%	100%	94.7%	98.5%	95.7%	100.0%	94.5%	96.0%	92.5%	100.0%	100.0%	98.3%	
	% of all stroke patients who receive thrombolysis	11%	17.0%	14.9%	11%	14.5%	18.8%	11.4%	15.5%	9.6%	5.3%	5.7%	23.2%	11.0%	11.3%	
	% of patients eligible for thrombolysis to receive the intervention within 60 minutes of arrival at A&E (door to needle time)	-	33.3%	20.0%	70%	0.0%	8.3%	37.5%	44.4%	28.6%	25.0%	0.0%	62.5%	77.8%	71.4%	
	Discharged with JCP	80%	97.0%	78.1%	80%	83.8%	82.1%	93.3%	97.2%	93.3%	92.3%	79.4%	93.3%	92.6%	94.7%	
	Discharged with ESD	40%	55.9%	56.8%	40%	69.0%	54.5%	52.1%	56.1%	56.3%	64.9%	40.0%	49.0%	69.2%	76.7%	

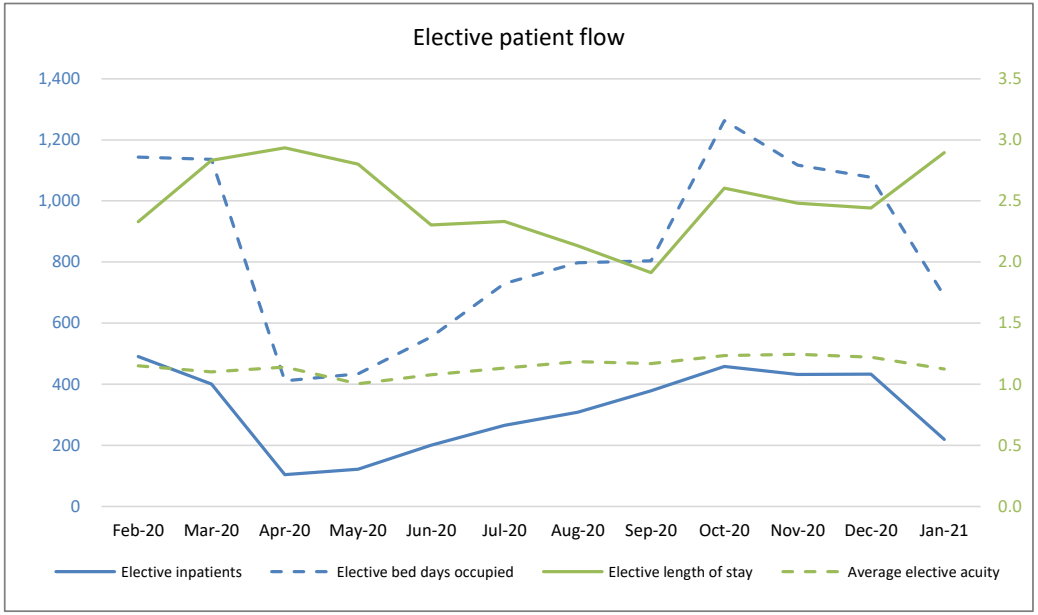
Responsive Services

East and North Hertfordshire NHS Trust

Patient Flow

Domain	Metric	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Trend
Emergency Department Flow Indicators	A&E & UCC attendances	13,228	10,457	7,228	9,838	11,091	12,289	12,578	12,580	11,904	11,173	10,639	9,119	
	Attendance to admission conversion rate	24.7%	27.5%	25.7%	23.5%	25.0%	26.1%	25.6%	25.3%	27.3%	25.2%	25.3%	27.2%	
	ED attendances per day	456	337	241	317	370	396	406	419	384	372	343	294	
	AEC attendances per day	45	35	15	17	20	23	19	14	15	15	12	11	
	4-hour target performance %	85.3%	80.2%	78.0%	83.4%	88.1%	90.1%	87.1%	84.8%	84.5%	82.4%	78.2%	75.2%	
	Time to initial assessment 95th centile	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	
	Ambulance handover breaches 30-minutes	274	394	316	235	76	242	285	317	350	507	634	tbc	

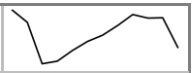
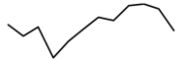
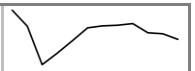
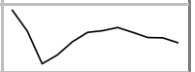
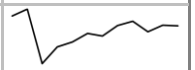
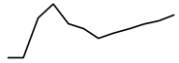
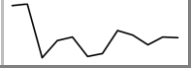




Responsive Services

Patient Flow

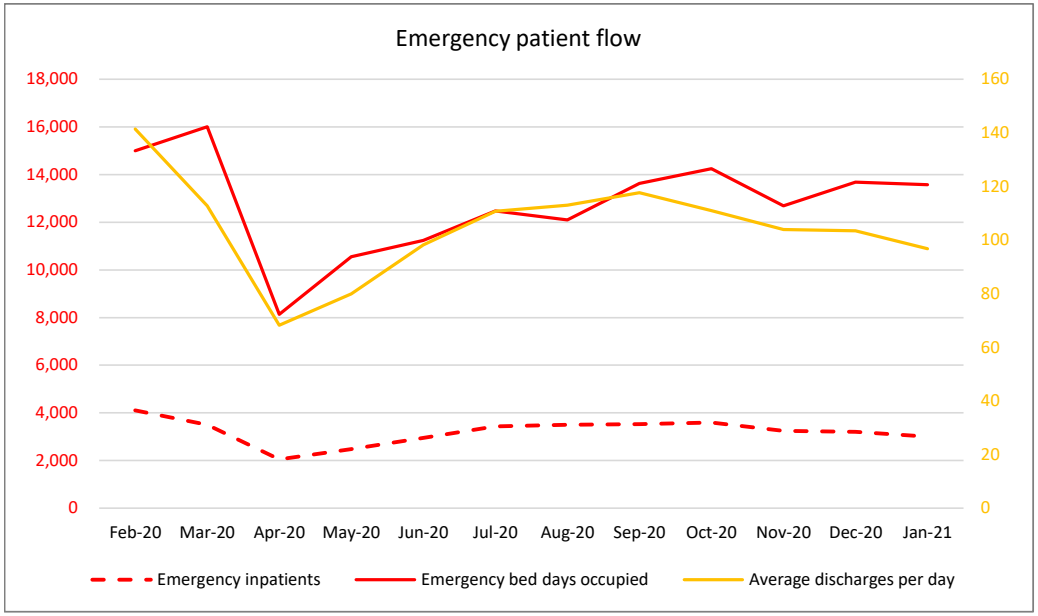
East and North Hertfordshire NHS Trust

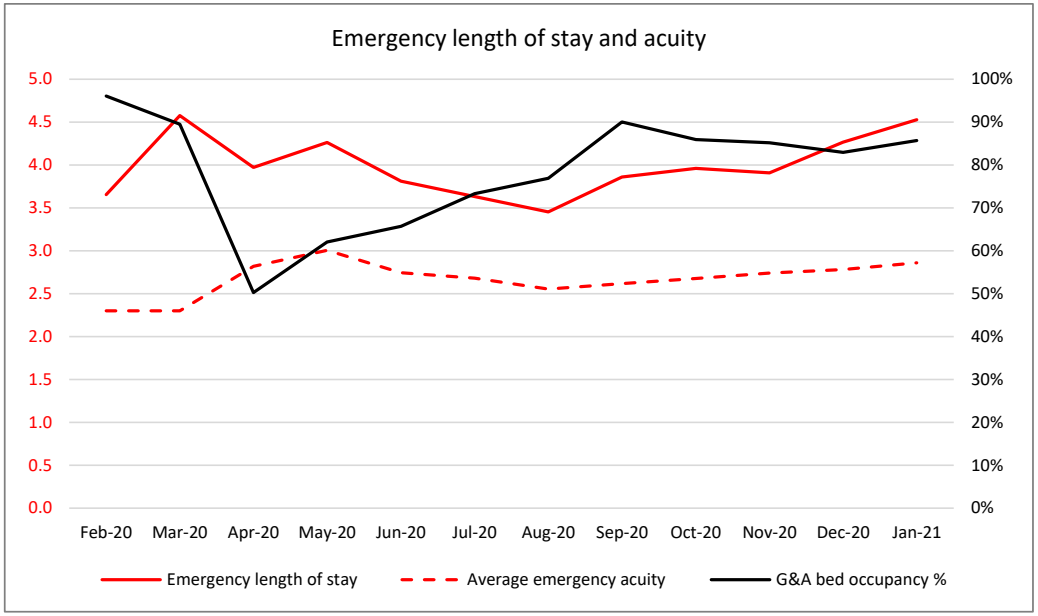
Domain	Metric	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Trend
Elective Inpatient Flow Indicators	Elective inpatients	491	401	104	122	200	265	308	378	458	432	433	219	
	Elective bed days occupied	1,144	1,136	411	434	555	730	798	804	1,263	1,117	1,077	689	
	Elective length of stay	2.3	2.8	2.9	2.8	2.3	2.3	2.1	1.9	2.6	2.5	2.4	2.9	
	Daycase rate %	87.4%	86.2%	85.9%	87.9%	86.6%	86.8%	85.3%	87.1%	87.7%	87.7%	87.0%	88.8%	
	Average elective acuity	1.15	1.10	1.14	1.00	1.08	1.13	1.18	1.17	1.24	1.24	1.22	1.12	
Emergency Flow Indicators	Emergency inpatients	4,103	3,497	2,047	2,477	2,947	3,433	3,503	3,529	3,595	3,246	3,206	2,999	
	Average discharges per day	141	113	68	80	98	111	113	118	111	104	103	97	
	Emergency bed days occupied	15,004	16,000	8,134	10,556	11,232	12,471	12,102	13,622	14,242	12,692	13,676	13,577	
	Emergency length of stay	3.7	4.6	4.0	4.3	3.8	3.6	3.5	3.9	4.0	3.9	4.3	4.5	
	Average emergency acuity	2.3	2.3	2.8	3.0	2.7	2.7	2.6	2.6	2.7	2.7	2.8	2.9	
	G&A bed occupancy %	96%	89%	50%	62%	66%	73%	77%	90%	86%	85%	83%	86%	
	Patients discharged via Discharge Lounge	393	311	310	467	488	564	509	518	554	504	465	234	
	Discharges before midday	14.2%	15.3%	11.7%	12.2%	13.7%	11.7%	11.7%	10.8%	9.6%	10.4%	10.2%	9.9%	
	Weekend discharges	16.2%	13.3%	14.2%	15.6%	12.9%	13.8%	15.8%	14.7%	16.8%	15.0%	13.9%	16.4%	
	Proportion of beds occupied by patients with length of stay over 14 days	22.8%	23.8%	13.6%	18.4%	17.7%	15.2%	15.9%	19.0%	18.4%	17.9%	19.3%	19.4%	
	Proportion of beds occupied by patients with length of stay over 21 days	13.7%	13.9%	6.8%	9.1%	9.6%	7.0%	7.4%	10.4%	9.8%	8.5%	9.5%	9.4%	

Responsive Services

East and North Hertfordshire NHS Trust

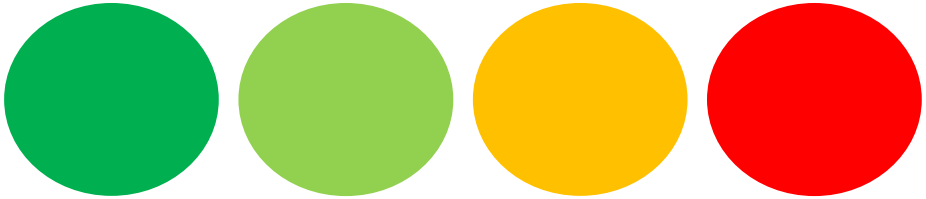
Patient Flow





Well-led Services

Month 10 | 2020-21



Key Issues

Work

- Overall vacancy rate increased by 0.4% to 5.7% for January, due to an overall increased recruitable establishment.
- 5698 WTE overall staff now in post - highest number of staff in post for 18 months.
- There are 70 more qualified nurses employed now than there were in January 2020.
- Agency spend decreased by 22k in M10 - the Trust is now £3.6m under 20/21 NHSI ceiling target.
- Overall demand for Temporary Staffing increased by over 18,000 hours against M9, over 109k bank hours were filled - the highest number in 21 months.

Grow

- Statutory and mandatory training compliance remains static at 85.9%.
- Appraisal rate 57%.
- To release staff time to respond to pandemic pressures some training and education paused.

Thrive

- Staff survey results have been received and remain under embargo
- Staff health and wellbeing during wave 2 / lockdown 3.

Care

- Covid vaccine hub went live 9.12.2020, over 18,000 vaccines given.
- Absence increased to 6.69% .
- Most absence attributed to Covid symptoms with a peak of 208 absent on 14.1.2021.

Executive Response

Work

- There are 297 applicants in the pipeline, 23 are registered nurses and 65 doctors plus 61 international nurses all due to start by the end of March 21
- Expecting overall increase of 195 WTE overall by March 2021, with the position as at end of January 2021 being an overall increase of 222 WTE, we are currently exceeding this forecast.
- We have significantly increased our overseas nurse recruitment capacity for the coming months, with an additional 86 nurses scheduled to arrive by early April.
- We aim to have a 0% vacancy rate for CSWs by 31.3.21. This equates to 100 vacancies, 60 interviews are being held w/c 25.1.21, with interviews being held weekly thereafter.
- We continue to work with the Shaw Trust to fill some of these vacancies with local people who are currently unemployed.

Executive Response

Grow

- Continued with a pause to education and training activity to allow clinical skills to be redeployed where needed for our pandemic response with a plan in place to recover educational and training from 1st March 2021.
- Learning management system project continues and is on track for launch in April 2021, co-production to develop capability across whole organisation.
- 27 third year student nurses are being offered appropriate remuneration to support the pandemic response . Learning opportunities and supervision to support those in practice. ENH are supporting remuneration of students in PVI sector across HWE STP.
- In order to get to the target of zero CSW vacancies by April 2021, training for the 143 new CSW's will be split into apprenticeship and in house care certificate training. Offering a variety of routes for new joiners. ENHT recognised as one of 2 Trusts in EoE on track to achieve targets for CSW recruitment.

Thrive

- Staff forums continue virtually to enable to staff to raise concerns about the workplace in a safe environment however attendance is low due to operational pressures
- Pyramid of health and wellbeing debrief sessions has been put in place from:
  - Schwartz rounds - the first held on 17.2.2021;
  - Reflective space - 11.2.2021 ED and renal with positive feedback;
  - Additional line manager and leadership support and coaching first 20 in the pilot for delivering change and support to their teams.
- Increased frequency of debriefing sessions will commence in March.

Care

- Paused vaccine delivery for 2 weeks pending delivery.
- A sickness absence task group has been established to data cleanse all absence data. Those with no or a past end date have reduced significantly.
- The task group are contacting managers and offering support in completing Health at Work referrals to support individuals return to work.
- Peak of 208 Covid-related absences on 14.1.2021 reduced to 66 on 17.2.2021.
- Increase in stress related absence so the health and wellbeing response is critical.
- Lateral flow testing to be rolled out to all staff in the coming months to monitor asymptomatic staff.

Well-led Services

Staff and Workforce Development

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Trend
Work	Vacancy Rate	6%	7.0%	6.6%	6.3%	6.9%	5.9%	5.5%	4.9%	5.7%	5.7%	5.7%	5.7%	5.3%	5.7%	
	Time to hire (weeks)	10	11.6	13.3	13.0	9.6	12.9	13.0	13.0	13.0	12.0	12.0	13.0	9.0	11.0	
	Recruitment experience	4	tbc	4.5	4.6	4.5	4.5	4.5	4.5	4.6	4.3	4.4	4.7	4.5	4.6	
	Relative likelihood of white applicant being shortlisted and appointed over BAME applicant	1	1.00			1.30			1.40			1.40			tbc	
	Relative likelihood of non-disabled applicant being shortlisted and appointed over disabled applicant	1	1.50			1.24			0.84			0.57			tbc	
	Agency Spend (% of WTE)	4%	4.0%	4.0%	4.1%	3.6%	3.2%	2.7%	3.6%	3.0%	3.3%	4.3%	3.5%	3.4%	3.2%	
	Bank Spend (% of WTE)	10%	11.5%	10.9%	12.7%	10.9%	8.2%	8.0%	9.6%	9.2%	7.9%	9.7%	9.9%	10.5%	11.6%	
	% of staff on eRoster	> 90%	49.0%	49.0%	49.0%	62.0%	62.0%	63.0%	63.0%	63.0%	64.0%	64.0%	65.0%	65.0%	64.0%	
	% of fully approved rosters in advance of 8 weeks	60%	39.0%	32.0%	26.6%	26.7%	33.6%	31.8%	21.3%	16.7%	25.0%	22.4%	22.1%	22.5%	22.7%	
	% of actual clinical unavalibility vs % of budgeted clinical unavailability (headroom) - Nursing & Midwifery ONLY	< 21%	27.0%	25.9%	29.8%	39.9%	36.2%	31.6%	27.3%	26.6%	26.3%	23.2%	26.6%	27.0%	32.5%	
	Pulse survey Flexibility	55%	52.0%			55.5%			59.5%			staff survey embargo			tbc	
Grow	Statutory & mandatory training compliance rate	90%	88.6%	88.9%	87.2%	84.0%	79.6%	77.5%	81.8%	81.6%	84.6%	85.1%	86.5%	86.9%	85.9%	
	Appraisal rate	90%	83.1%	82.0%	78.6%	75.0%	71.5%	70.2%	66.8%	62.5%	61.0%	60.2%	59.7%	59.8%	57.0%	
	Pulse survey Training and development opportunities	55%	55.0%			48.1%			53.0%			staff survey embargo			tbc	
	Pulse survey Talent management	55%	50.0%			53.1%			47.1%			staff survey embargo			tbc	
	Likelihood of training and development opportunities (BAME)	1	tbc			tbc			tbc			tbc			tbc	
	Likelihood of training and development opportunities (Disability)	1	tbc			tbc			tbc			tbc			tbc	
	LMCPD places filled	800 (cum)	120	93	55	57	0	0	0	0	tbc	tbc	tbc	tbc	tbc	

Well-led Services

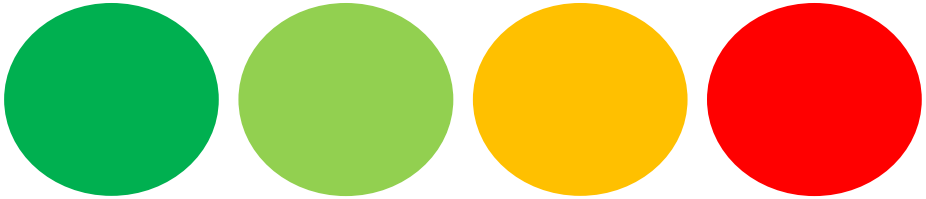
Staff and Workforce Development

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Trend
Thrive	Pulse survey My leader	75%	79.9%			77.9%			81.4%			staff survey embargo			tbc	
	Pulse survey Harnessing individuality	60%	51.7%			60.8%			59.8%			staff survey embargo			tbc	
	Pulse Survey Not experiencing discrimination	95%	62.2%			71.0%			72.2%			staff survey embargo			tbc	
	Turnover Rate	12.2%	12.8%	12.9%	12.9%	12.9%	12.8%	12.6%	12.9%	12.8%	12.9%	12.5%	12.3%	12.0%	11.9%	
	Model employer targets (% achieved)	100%	83%			83%			66%			83%			tbc	
	Average length of suspension (days)	20	8.5	32	63	62	70	0	0	0	0	29	60	22.5	33	
	Average length of Disciplinary (excluding suspensions) (days)	60	150	179	248	212	304	183	111	102.5	158	154	87	74.3	96	
	Average length of Grievance (including dignity at work) (days)	60	124	131	163	214	199	0	0	28	2	20	46	22	114	
Care	Pulse survey Well-being	70%	43.5%			67.0%			74.8%			staff survey embargo			tbc	
	Pulse survey Reasonable adjustments	50%	39.2%			67.5%			67.4%			staff survey embargo			tbc	
	Staff FFT Recommend as a place to work	60%	37.3%			47.7%			51.1%			staff survey embargo			tbc	
	Staff FFT Recommend as a place of care	70%	64.6%			69%			76.0%			staff survey embargo			tbc	
	Sickness Rate	3.8%	4.38%	4.15%	6.79%	7.28%	5.51%	3.96%	3.72%	3.72%	4.07%	3.92%	4.23%	4.69%	6.69%	
	Sickness FTE Days Lost	6,777	7,380	6,569	11,528	12,002	9,504	6,649	6,543	6,490	6,861	6,863	7,183	8,270	11,825	
	Mental health related absence (days lost)	1,650	1,173	1,011	1,253	1,620	1,640	1,794	1,889	1,643	1,799	1,981	1,725	1,716	1,743	
	MSK related absence (days lost)	1,285	1,278	1,394	1,252	961	1,216	1,152	1,407	1,580	1,431	1,478	1,580	1,554	1,347	

Sustainable Services

Month 10 | 2020-21

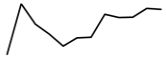


Key Issues	Executive Response
• In Qtr 3 the Trust developed and submitted a draft financial plan covering the remainder of the current financial year. The plan was also a composite part of an overall ICS system based plan that was submitted at the same point. The Trust's plan included an estimate of the resource requirements that are needed in order to achieve national P3 delivery priorities across the winter period. • In addition the plan included assumptions in respect of the receipt of both planned Top Up funding and also a share of ICS COVID-19 and Growth funds. These assumptions were agreed at a system level. The plan was presented and agreed at the October meeting of the FPPC and the November meeting of the Trust Board. The plan submitted was subsequently adjusted following Regional feedback and is now confirmed as targeting an outturn I&E deficit of £1.2m for 2020/21. This was approved at the December meeting of the FPPC. • The Trust's Month 9 financial performance is monitored against the approved plan. The January I&E position reports a marginal surplus of £133k, and a YTD deficit of £26k. The Month 10 position includes receipts of block income payments as confirmed by NHSE and supplemented by agreed planned Top up / System COVID-19 and growth disbursements totalling £4.4m in month. • A&E activity levels continued to reduce significantly in January reflecting growing public concern around increasing COVID-19 infection rates. M10 ED activity volumes were comparable to levels seen in May during the 1st wave of the pandemic, and were only 66% of the level experience in January last year. • Emergency inpatient activity levels also fell compared with December and total volumes of bed days occupied across the Trust bed base during January was some 22% lower than in the same period last year. However, coding depth and other analysis would suggest that the acuity of illness of patients is significantly higher than in the same period last year. The number of patients requiring critical care enhanced support rose sharply, increasing by over 50% on the preceding month and up 67% on the same period last year. • During the course of January the volumes of planned elective activity undertaken by the Trust have fallen significantly in response to the escalating impact of the COVID-19 2nd surge. The Trust budget plan includes provision for additional WLI and locum costs required to facilitate the step up in elective activity levels. The Trust has continued to monitor the financial impact of its delivery against targets as expressed through the mechanism of the Elective Incentive Scheme. This has operated from Month 6 onwards. To date the Trust has calculated a neutral impact from the application of the scheme in the year to date. The uptake in COVID-19 admission volumes in Q4 means that the application of the EIS framework is likely to be suspended for the remainder of the year. • The Trust capital programme has been supplemented in year by confirmation of a number of additional centrally funded schemes. Of particular significance are schemes to address Critical Infrastructure Challenges as well as cross year scheme to significantly enhance and develop the Trusts' Urgent and Emergency Care Infrastructure. The Trust has introduced expanded capital project monitoring arrangements to ensure the effective utilisation of these funds within the context of extremely challenging timeframes.	• The Trust has adapted its financial governance regime in response to the COVID-19 financial framework arrangements that have been introduced. Updates on financial control and governance changes have been consistently provided to the Trust Board. These arrangements will continue to be monitored via regular reports. • The Trust has also refined and developed its financial reporting arrangements to provide additional granularity in respect of the value and type of optional costs incurred by the Trust as it supports necessary COVID-19 capacity and its associated impacts. These are reflected in amended reports to Committees, the Trust Board and internal budget holders and management teams. • From the 1st November 2020 the Trust has implemented its revised Divisional structure. To support this significant transition the Director of Finance has defined a minimum specification of financial governance and control arrangements for each of the new divisions to operate within as they mobilise and come to full capability and capacity. These arrangements have been reviewed by the FPPC and will continue to be developed and iterated as appropriate. Specific Divisional Finance Boards are an important part of this new finance architecture and have taken place each month from November. • Finance and Corporate teams have worked during Q3 to agree and put in place a revised business partnering model to support new divisional teams. This will be further supplemented by a revised offering in respect of the implementation of a new Learning Management System during Q4. These developments are intended to both support the quality and effectiveness of financial decision making and facilitate the building and embedding of strong commercial skills within divisions. • Availability of accurate and timely business intelligence and modelling has been key in supporting the Trusts agile and flexible response to the current COVID-19 incident. It is important therefore that the Trust continues to expand the scope and sophistication of its BI universe at pace to support the need to supply relevant, timely and accurate data to clinicians and managers to enable more effective decision making and plan delivery. This will be an important competent in the Trust's recovery process. • In addition during Q3 the Trust has undertaken a detailed review of its planning processes to aid and supplement the building of effective and fit for purpose functional and organisational plans for the 2021/22 period. This is important within the context of likely significant changes in national and local payment mechanisms and also new and changing local governance and system management frameworks. These arrangements have been reviewed and discussed at the Executive Committee and FPPC.

Sustainable Services

Finance Plan Performance

East and North Hertfordshire NHS Trust

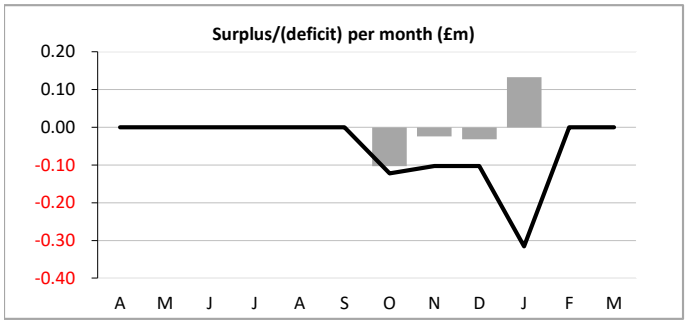
Domain	Metric	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-20	Trend	Plan YTD	Actual YTD	Variance YTD
I&E Performance	SLA Income Earned	33.4	36.6	36.2	36.2	36.2	36.2	35.9	36.2	36.4	36.5	36.5	37.1		359.7	363.3	3.6
	Other Income Earned	4.1	8.0	2.3	2.5	2.2	2.5	2.5	2.8	2.9	3.1	2.6	2.9		32.9	26.3	-6.6
	Pay Costs	24.5	27.4	26.2	25.7	24.9	25.4	25.5	26.8	26.6	26.6	27.2	27.1		260.1	262.1	2.0
	Non Pay Costs inc Financing	15.0	17.5	14.9	14.4	15.2	16.2	15.9	17.0	17.0	17.2	16.4	17.2		158.8	161.5	2.7
	Underlying Surplus / (Deficit)	-1.9	-0.3	-2.6	-1.4	-1.8	-3.0	-3.0	-4.8	-4.3	-4.3	-4.4	-4.3		-26.2	-33.9	-7.7
	Top up payments	-	-	2.6	1.4	1.8	3.0	3.0	4.8	4.2	4.2	4.4	4.4		25.6	33.9	8.3
	Retained Surplus / Deficit	-0.04	1.58	-0.00	0.00	-0.00	-0.00	-0.00	-0.00	-0.10	-0.02	-0.03	0.13		-0.64	-0.03	0.6
Paybill Metrics	Substantive Pay Costs	20.9	22.9	22.6	22.4	22.3	22.1	22.3	23.8	22.8	22.8	23.2	22.2		238.8	226.5	-12.2
	Premium Pay Costs Overtime & WLI	0.3	0.4	0.2	0.1	0.0	0.0	0.1	0.1	0.2	0.3	0.3	0.0		3.7	1.2	-2.5
	Premium Pay Costs Bank Costs	2.3	2.9	2.6	2.3	2.0	2.4	2.3	2.1	2.6	2.6	2.8	3.7		13.4	25.4	12.0
	Premium Pay Costs Agency Costs	1.0	1.2	0.9	0.8	0.7	0.9	0.8	0.9	1.1	0.9	0.9	1.2		4.2	8.9	4.7
	Premium Pay Costs As % of Paybill	14.5%	16.5%	14.0%	12.7%	10.7%	13.0%	12.4%	11.1%	14.3%	14.4%	14.7%	18.0%		8.2%	13.6%	5.4%

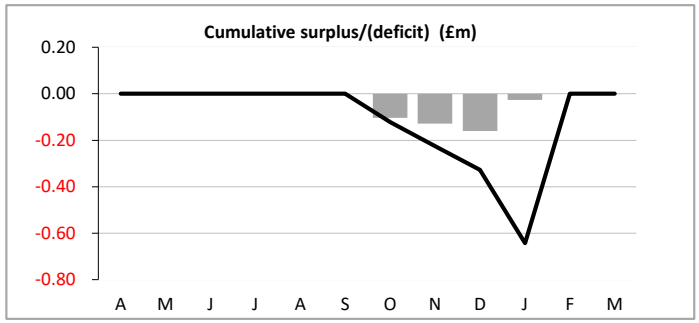
Sustainable Services

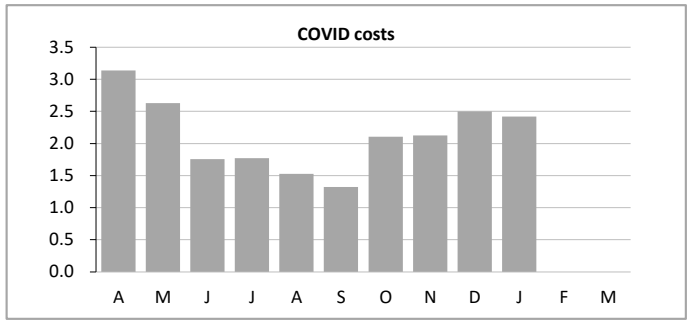
Finance Plan Performance

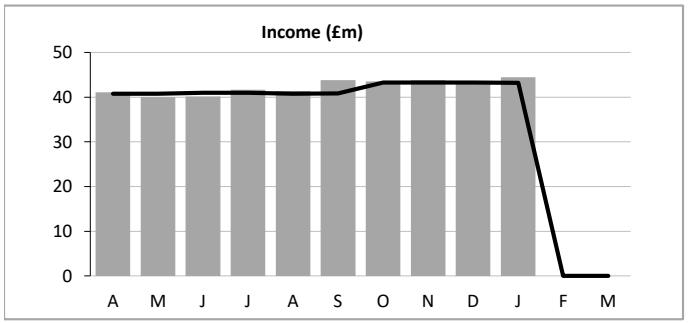
East and North Hertfordshire NHS Trust

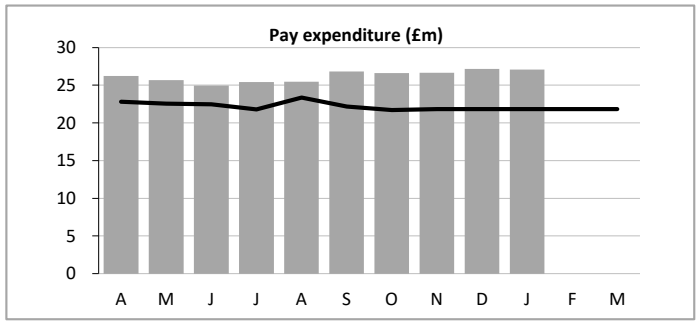
Domain	Metric	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-20	Trend	Plan YTD	Actual YTD	Variance YTD
Single Oversight Framework	Capital Servicing Capacity	4	4	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		1	n/a	
	Liquid Ratio (Days)	4	4	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		1	n/a	
	I&E Margin	3	2	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		1	n/a	
	Distance from Plan	1	1	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		1	n/a	
	Agency Spend vs. Ceiling	1	1	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		1	n/a	
	Overall Finance Metric	3	3	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		1	n/a	

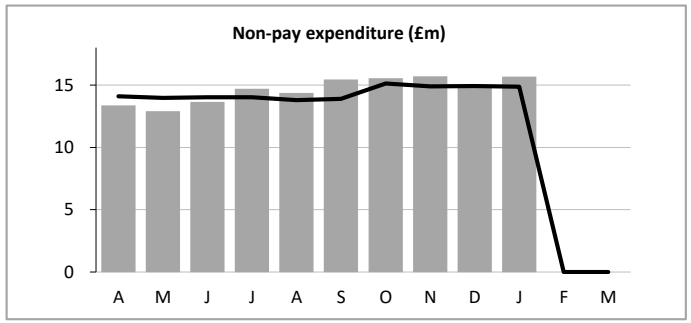












Sustainable Services

SLA Contracts - Income Performance

East and North Hertfordshire NHS Trust

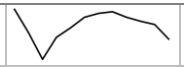
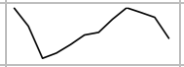
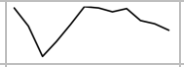
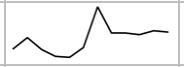
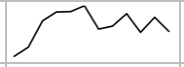
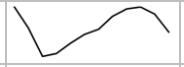
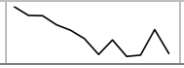
		In-Month			YTD		
		Planned Income	Actual Income	Income Variance	Planned Income	Actual Income	Income Variance
By Point of Delivery	A&E Attendances	2,329	1,656	-673	23,288	19,207	-4,080
	Daycases	3,091	1,484	-1,607	30,912	18,457	-12,455
	Inpatient Elective	1,918	919	-999	19,179	11,483	-7,696
	Inpatient Non Elective	9,712	8,171	-1,541	97,119	80,790	-16,329
	Maternity	2,546	2,608	62	25,461	24,717	-744
	Other	3,684	3,976	292	36,839	34,115	-2,724
	Outpatient First	2,106	1,780	-325	21,058	17,003	-4,055
	Outpatient Follow Ups	2,274	2,194	-80	22,741	20,986	-1,755
	Outpatient Procedures	1,156	751	-405	11,560	8,037	-3,523
	NHSE Block Impact	-499	5,442	5,941	-3,673	52,086	55,759
	Other SLAs	65	65	0	646	646	0
	Block	843	843	0	8,427	8,427	0
	Drugs & Devices	3,843	3,847	4	37,464	39,236	1,772
	Chemotherapy Delivery	607	584	-22	6,065	5,609	-456
	Radiotherapy	1,216	963	-253	12,157	10,463	-1,694
	Renal Dialysis	1,182	1,119	-63	11,820	11,574	-246
	Total	36	36	0	361	363	2

		In-Month			YTD		
		Planned Income	Actual Income	Income Variance	Planned Income	Actual Income	Income Variance
By Commissioner	East & North Herts CCG	21,634	21,634	0	216,345	216,346	1
	Specialist Commissioning	8,167	7,671	-496	81,672	80,618	-1,055
	Bedfordshire CCG	2,486	2,486	-0	24,861	24,862	1
	Herts Valleys CCG	1,404	1,404	-0	14,038	14,038	-0
	Cancer Drugs Fund	587	785	197	4,907	7,369	2,462
	Luton CCG	326	326	0	3,261	3,261	0
	PH - Screening	379	151	-228	3,788	1,495	-2,294
	Other	1,087	1,945	858	12,190	14,848	2,658
	Total	36,071	36,402	331	361,063	362,837	1,774
By Division	Cancer Services	6,811	6,773	-37	67,140	67,180	40
	Unplanned Care	17,156	15,040	-2,117	171,565	150,711	-20,853
	Planned Care	12,760	9,148	-3,613	127,603	92,867	-34,736
	Other	-656	5,442	6,098	-5,244	52,079	57,323
	Total	36,071	36,402	331	361,063	362,837	1,774

Sustainable Services

Activity and Productivity

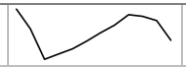
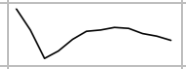
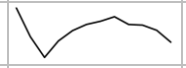
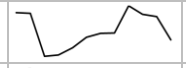
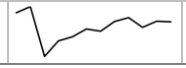
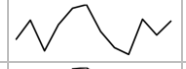
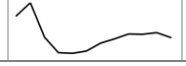
East and North Hertfordshire NHS Trust

Domain	Metric	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Trend	Plan YTD	Actual YTD	Var YTD
Patient Activity Levels	A&E & UCC	12,432	9,714	6,656	9,155	10,251	11,423	11,873	12,080	11,432	10,984	10,632	8,951		133,945	103,437	-30,508
	Chemotherapy Atts	2,177	2,049	1,631	1,634	2,192	2,354	2,147	2,343	2,313	2,315	2,645	2,213		22,694	21,787	-907
	Critical Care (Adult) - OBD's	460	619	700	728	488	512	737	467	631	649	780	1,180		6,168	6,872	704
	Critical Care (Paeds) - OBD's	265	416	448	509	434	546	494	358	580	584	339	268		5,549	4,560	-989
	Daycases	3,420	2,504	852	1,127	1,551	2,051	2,174	2,848	3,447	3,205	2,950	1,882		39,574	22,087	-17,487
	Elective Inpatients	491	401	140	155	241	313	374	420	485	450	441	238		5,617	3,257	-2,360
	Emergency Inpatients	4,103	3,497	2,483	2,975	3,554	4,149	4,097	3,974	4,074	3,684	3,571	3,353		42,821	35,914	-6,907
	Home Dialysis	148	160	147	140	139	150	193	165	165	163	167	166		1,653	1,596	-58
	Hospital Dialysis	6,288	6,549	7,310	7,569	7,576	7,755	7,078	7,160	7,522	6,977	7,420	7,012		64,433	73,379	8,946
	Maternity Births	414	420	393	443	445	443	433	418	436	408	368	443		4,421	4,230	-191
	Maternity Bookings	514	481	517	468	498	550	467	480	535	490	604	539		5,005	5,148	143
	Outpatient First	8,867	7,228	3,033	5,961	5,631	5,703	5,659	6,282	6,175	6,496	5,750	4,838		89,306	55,528	-33,778
	Outpatient Follow Up	16,347	14,389	6,549	6,463	9,311	11,385	11,948	14,965	15,126	14,801	13,529	12,689		172,831	116,766	-56,065
	Outpatient procedures	7,053	4,749	1,725	2,037	3,128	4,065	4,629	6,010	6,804	7,008	6,247	4,318		74,079	45,971	-28,108
	Radiotherapy Fractions	5,061	4,772	4,766	4,478	4,297	4,027	3,520	3,991	3,459	3,503	4,321	3,555		49,479	39,915	-9,564

Sustainable Services

Activity and Productivity

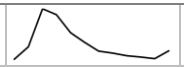
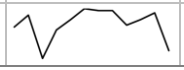
East and North Hertfordshire NHS Trust

Domain	Metric	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Trend	Plan YTD	Actual YTD	Var YTD
Throuhput	Elective Spells per Working Day	196	138	52	67	81	103	127	149	179	174	161	106		213	120	-94
	Emergency Spells per Day	143	109	65	76	94	107	109	113	112	103	99	93		140	117	-23
	ED Attendances per Day	444	313	222	295	342	368	383	403	369	366	343	289		438	338	-100
	Outpatient Atts per Working Day	1,613	1,256	595	761	821	920	1,112	1,239	1,278	1,348	1,216	1,092		1,586	1,030	-556
	Elective Bed Days Used	1,144	1,136	411	434	555	730	798	804	1,263	1,117	1,077	689		13,645	7,878	-5,767
	Emergency Bed Days Used	15,004	16,000	8,134	10,556	11,232	12,471	12,102	13,622	14,242	12,692	13,676	13,577		158,624	122,304	-36,320
Efficiency	Admission Rate from A&E	25%	27%	26%	24%	25%	26%	26%	25%	27%	25%	25%	27%		23.3%	25.6%	2.3%
	Emergency - Length of Stay	3.7	4.6	4.0	4.3	3.8	3.6	3.5	3.9	4.0	3.9	4.3	4.5		3.7	4.0	0.3
	Emergency - Casemix Value	2,264	2,382	2,819	3,005	2,744	2,683	2,556	2,620	2,678	2,740	2,781	2,859		2,297	2,748	452
	Elective - Length of Stay	2.3	2.8	2.9	2.8	2.3	2.3	2.1	1.9	2.6	2.5	2.4	2.9		2.5	2.5	-0.0
	Elective - Casemix Value	1,145	1,103	1,140	1,004	1,077	1,131	1,184	1,170	1,235	1,244	1,222	1,124		1,105	1,153	48
	Elective Surgical DC Rate %	87.4%	86.2%	85.9%	87.9%	86.6%	86.8%	85.3%	87.1%	87.7%	87.7%	87.0%	88.8%		85%	87%	2.1%
	Outpatient DNA Rate % - 1st	11.6%	13.0%	10.8%	12.7%	13.9%	14.1%	12.2%	11.0%	10.5%	13.1%	11.9%	12.9%		6.5%	12.2%	5.8%
	Outpatient DNA Rate % - FUP	6.4%	7.4%	5.5%	5.6%	13.9%	14.1%	12.2%	11.0%	10.5%	13.1%	11.9%	12.9%		7.5%	6.1%	-1.4%
	Outpatient Cancel Rate % - Patient	9.9%	12.3%	6.0%	3.2%	3.1%	3.5%	4.9%	5.7%	6.6%	6.6%	6.8%	6.0%		10.4%	5.3%	-5.1%

Sustainable Services

Activity and Productivity

East and North Hertfordshire NHS Trust

Domain	Metric	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Trend	Plan YTD	Actual YTD	Var YTD
Efficiency	Outpatient Cancel Rate % - Hosp	7.0%	12.7%	30.0%	27.2%	19.1%	14.7%	10.8%	9.8%	8.6%	8.0%	7.2%	10.9%		6.9%	13.5%	6.6%
	Outpatients - 1st to FUP Ratio	1.8	2.0	2.2	1.1	1.7	2.0	2.1	2.4	2.4	2.3	2.4	2.6		1.9	2.1	0.2
	Theatres - Ave Cases Per Hour	2.7	2.6	1.0	1.8	1.8	2.0	2.1	2.1	2.5	2.3	2.4	0.7		2.9	1.9	-1.0
	Theatres - Utilisation of Sessions	87%	81%	17%	34%	42%	47%	55%	61%	66%	72%	73%	21%		85%	49%	-36%
	Theatres - Ave Late Start (mins)	17	21	8	14	13	16	18	18	16	15	14	4		27	14	-13.1
	Theatres - Ave Early Finishes (mins)	32	41	10	30	38	46	44	44	34	38	43	15		39	34	-5.2

Sustainable Services

Productivity and Efficiency of Services - 2019-20 YTD vs. 2020-21 YTD

NHS East and North Hertfordshire NHS Trust

Activity Measures	2019-20 YTD	2020-21 YTD	Change
Emergency Department Attendances	134,293	103,437	-30,856
Emergency Department Ave Daily Atts	439	338	-101
Admission Rate from ED %	23.8%	25.6%	2%
Non Elective Inpatient Spells	42,835	30,982	-11,853
Ave Daily Non Elective Spells	140	101	-39
Daycase Spells	36,821	22,087	-14,734
Elective Inpatient Spells	5,434	3,257	-2,177
Ave Daily Planned Spells	138	83	-55
Day Case Rate	87%	87%	0%
Adult & Paeds Critical Care Bed Days	11,471	11,432	-39
Outpatient First Attendances	90,167	55,528	-34,639
Outpatient Follow Up Attendances	174,511	116,766	-57,745
Outpatient First to Follow Up Ratio	1.9	2.1	0.2
Outpatient Procedures	74,667	45,971	-28,696
Ave Daily Outpatient Attendances	1,109	713	-396

Workforce Measures	2019-20 YTD	2020-21 YTD	Change
Average Monthly WTE's Utilised	5,881	6,104	224
Average YTD Pay Cost per WTE	41,891	42,929	2.5%
Staff Turnover	12.8%	12.6%	-0.3%
Vacancy WTE's	854	785	-69
Vacancy Rate	13.8%	12.0%	-1.8%
Sickness Days Lost	68,008	82,191	14,183
Sickness Rate	4.3%	4.8%	0.5%
Agency Spend- £m's	10.0	8.9	-1.0
Temp Spend as % of Pay Costs	4.1%	3.4%	-0.6%
Ave Monthlty Consultant WTE's Worked	331.0	341.3	10.3
Consultant : Junior Training Doctor Ratio	1 : 1.7	1 : 1.7	0.0
Ave Monthly Nursing & CSW WTE's Worked	2,461.7	2,530.8	69.2
Qual ; Unqualified Staff Ratio	26 : 10	25 : 10	-0.0
Ave Monthly A&C and Senior Managers WTE's	1,303	1,338	36
A&C and Senior Managers % of Total WTE's	22.2%	21.9%	-0.2%

Sustainable Services

Productivity and Efficiency of Services - 2019-20 YTD vs. 2020-21 YTD

NHS East and North Hertfordshire NHS Trust

Capacity Measures	2019-20 YTD	2020-21 YTD	Change
Non Elective LoS	3.7	4.0	0.3
Elective LoS	2.5	2.5	-0.0
Occupied Bed Days	172,269	130,182	-42,087
Adult Critical Care Bed Days	6,221	6,872	651
Paediatric Critical Care Bed Days	5,250	4,560	-690
Outpatient DNA Rate	8%	7%	-0.6%
Outpatient Utilisation Rate	36%	28%	-8.2%
Total Cancellations	109,838	101,319	-8,519
Theatres - Ave Cases per Hour	2.7	1.9	-0.9
Theatres - Ave Session Utilisation	82%	49%	-33.5%
Theatres - Ave Late Start (mins)	21	14	-7
Theatres - Ave Early Finishes (mins)	39.0	34.2	-5
Radiology Examinations	348,846	272,889	-75,957
Drug Expenditure (excl HCD & ENH Pharma) - £000s	7,731	7,686	-46
High Cost Drug Expenditure - £000s	36,202	38,719	2,517

Finance & Quality Measures	2019-20 YTD	2020-21 YTD	Change
Profitability - £000s	-120	29	148.5
Monthly SLA Income £000s	34,855	36,333	1,478
Monthly Clinical Income per Consultant WTE	£105,299	£106,447	£1,148
High Cost Drug Spend per Consultant WTE	£109,368	£113,436	£4,068
Average Income per Elective Spell	£1,132	£1,153	£21
Average Income per Non Elective Spell	£2,301	£2,748	£447
Average Income per ED attendance	£174	£186	£12
Average Income per Outpatient Attendance	£131	£130	-£1
Ave NEL Coding Depth per Spell	5.7	7.3	1.6
Procedures Not Carried Out	1,807	1,145	-662
Best Practice HRGs (% of all Spells)	2.8%	4.2%	1.4%
Ambulatory Best Practice (% of Short Stays)	n/a	n/a	n/a
Non-elective re-admissions within 30 days Rolling 12-months to Oct-20	11,489	9,302	-2,187
Non-elective re-admissions within 30 days % Rolling 12-months to Oct-20	8.83%	9.08%	0.25%
SLA Contract Fines - £000's	278	0	-278

East and North Hertfordshire NHS Trust

Agenda Item: 9

TRUST BOARD - PUBLIC SESSION – 3 MARCH 2021
Recovery Update

Purpose of report and executive summary (250 words max): The purpose of the report is to present an update on the operational recovery in response to the effects of the Covid pandemic.		
Action required: For discussion		
Previously considered by: FPPC – 24.02.21		
Director: Chief Operating Officer	**Presented by:** Managing Director – Planned Care	**Author:** Managing Director – Planned Care

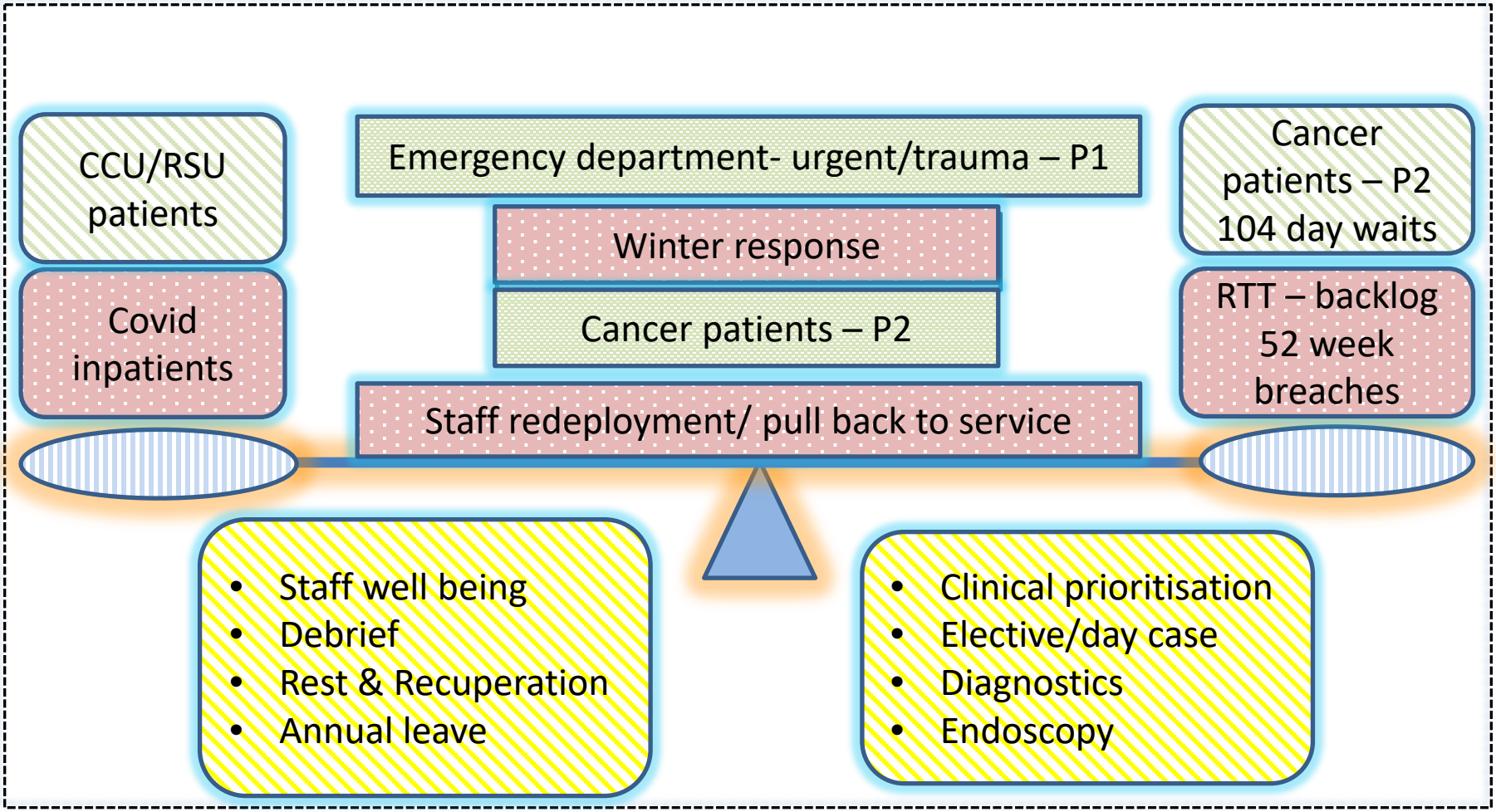
Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways: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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) **Operational performance**
Any other risk issues (quality, safety, financial, HR, legal, equality):

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

ENHT Board Meeting
3rd March 2021
COVID 2 Recovery

Balance - Covid response and recovery



Baseline triggers - to define start of substantive recovery
- opportunities for some speciality recovery in advance of these triggers

- Critical care capacity less than or equal to 22 patients (level 3 no greater than 14)
- Covid positive patients within hospital beds is less than 80
- Covid patient numbers support pulling back redeployed staff
- Total staff absence less than 245
- Limited impact from patient testing; patients ‘do not wish to attend’
- Patient confidence strengthened to come to hospital for care
- Vaccination hub BAU

Recovery principles – NHSE/I

East and North Hertfordshire NHS Trust

COVID-19 shone harsh light on some of the health and wider inequalities that persist in our society.
COVID-19 - disproportionate impact on many already facing disadvantage and discrimination.
Impact of the virus particularly detrimental on people living:

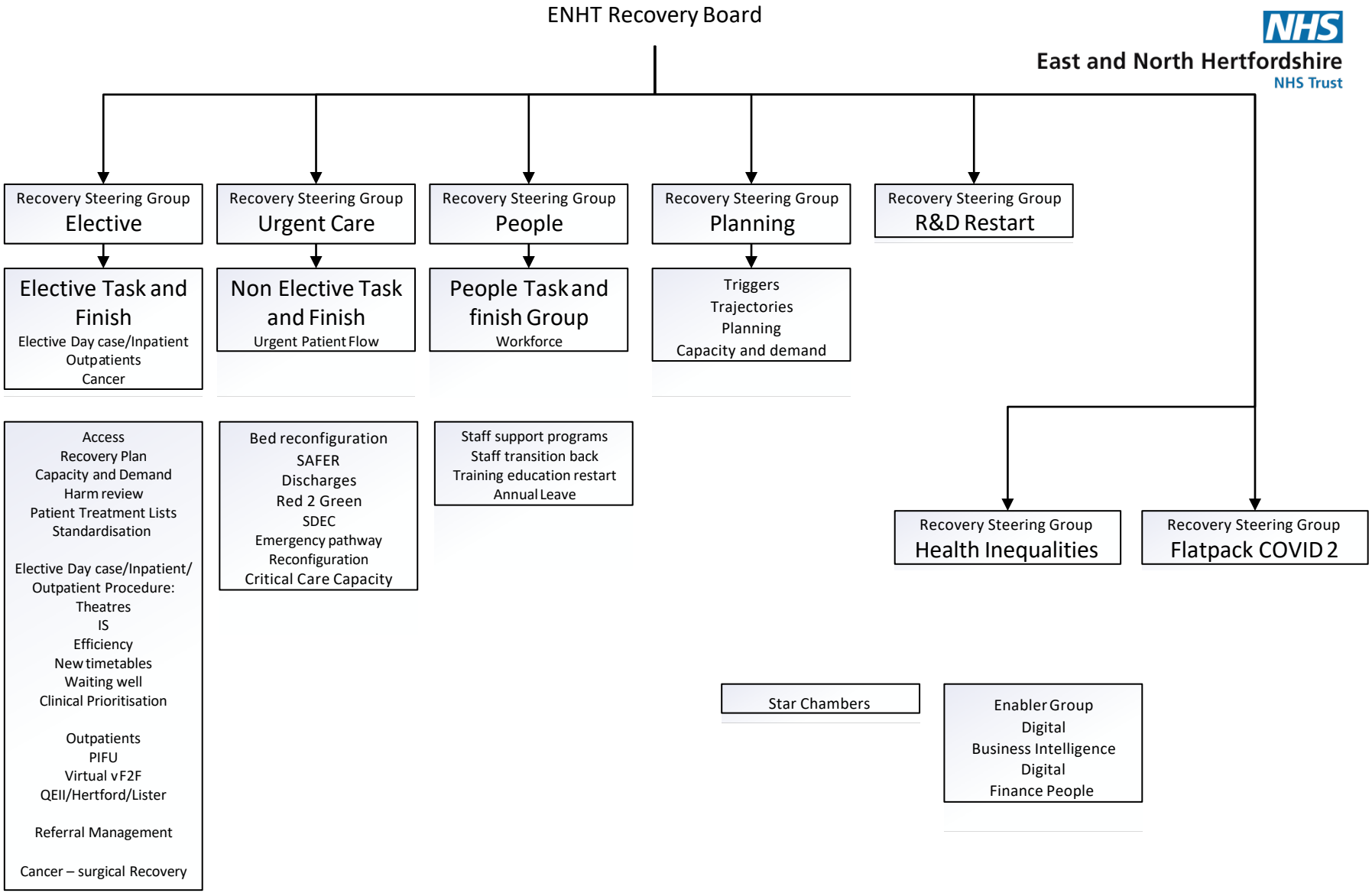
- in areas of high deprivation
- on people from Black, Asian and minority ethnic communities (BAME)
- on older people
- men
- those with a learning disability
- others with protected characteristics

Central part of responding to COVID-19 and restoring services must be to increase the scale and pace of NHS action to tackle health inequalities to protect those at greatest risk.
Eight urgent actions as principles for recovery:

- Protect the most vulnerable from COVID-19
- Restore NHS services inclusively
- Develop digitally enabled care pathways in ways which increase inclusion
- Accelerate preventative programmes which proactively engage those at risk of poor health outcomes
- Particularly support those who suffer mental ill-health
- Strengthen leadership and accountability
- Ensure datasets are complete and timely
- Collaborate locally in planning and delivering action

ENHT proposed recovery principles

- Digital first i.e. the use of video consultations
- Utilisation of physical capacity i.e. QEII; HCH; Independent sector
- 'Star chamber' to challenge plans, prioritisation and direction
- Changes on sustained basis, but not 'old world'
- Division and Speciality driven
- Activity solutions address health inequalities – as per the 8 recommendations from NHSE/I
- Workforce transformation solutions deployed
- System and integrated activity solutions explored
- Support patients to wait well
- Living with COVID i.e. reduction in change to cope with 'peaks troughs'



Quality | People | Pathways | Ease of use | Sustainability

Bed recovery – “flatpacked”

East and North Hertfordshire NHS Trust

Early March
Critical Care II in new ward block to move back to Critical Care L4 in the tower (baseline capacity 18)

Mid March
ACU to move from level 5 back to level 1 new ward block

Mid-late March
Surgical wards co-located on Level 5 and Level 7

Early spring – autumn
Bed demand plans in development, with aim of freeing up a floor in the tower – to facilitate tower ward refurbishment

Elective recovery

East and North Hertfordshire NHS Trust

Recovery governance in place:
Steering groups, task and finish groups, Recovery Board

Additional theatres open this week (22 February):

- 4 providing cancer/P2
- 3 emergency theatres
- Capacity in the independent sector
- Further theatres open as COVID patient number reduce/redeployment of staff
- 9 theatres (3 trauma and 5 cancer) from week commencing 1st March

- 4 endoscopy suites at Lister
- Diagnostics capacity increasing

Outpatient group focus:

- Clinic usage – space utilisation QEII, Hertford, Lister
- Use of non face to face appointments including video consultation
- Patient initiated follow up (PIFU)

Quality | People | Pathways | Ease of use | Sustainability

East and North Hertfordshire NHS Trust

Agenda Item: 10

TRUST BOARD - PUBLIC SESSION – 3 MARCH 2021

Recovery and our People

Purpose of report and executive summary (250 words max):		
Recovery of our people is an essential element of recovering our services after the most recent wave of Covid-19. As we enter the anniversary of the outbreak our people will be living through memories or the year gone and need support to process those as well as ensure their ability to move into the delivery of normal NHS activity to support our patients and community. This paper outlines the support that the Trust has provided to date and that planned over the next 6 to 9 months to continue supporting our people during this challenging time from a health and wellbeing perspective.		
Action required: For discussion		
Previously considered by: **N/A**		
Director: **Interim Chief People Officer**	**Presented by:** **Interim Chief People Officer**	**Author:** **Interim Deputy Chief People Officer**

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) **Risk 002 Workforce** **Risk 009 Culture**
Any other risk issues (quality, safety, financial, HR, legal, equality):

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

Recovery and Our People

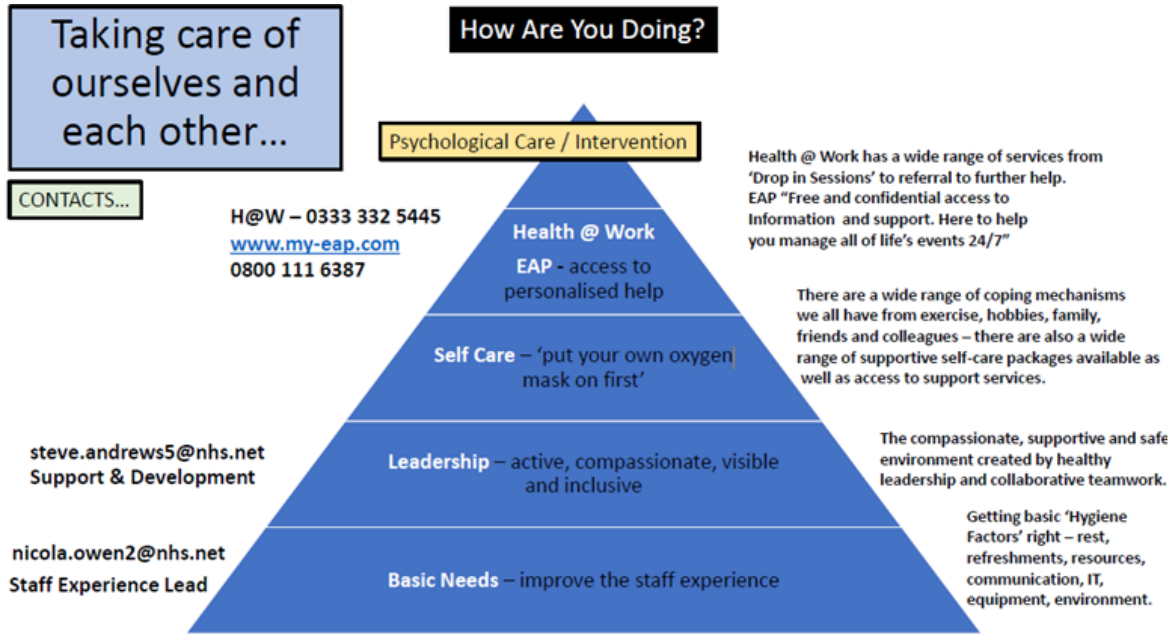
1.0 Introduction

The purpose of this paper is to advise the Trust Board on the support that is in place to address the health and wellbeing of our staff and that planned over the next 6 to 9 months to support the return to normal NHS activity.

The health and wellbeing of our staff as we reach and pass the anniversary of the outbreak and personal and professional events is essential to maintain their ability to stay well and to continue to provide excellent care to our patients.

2.0 Strategic Approach to Health and Wellbeing

The diagram below sets out our strategic approach to health and wellbeing, ranging from the localised development of consistent health and well-being interactions to the availability of enhanced services accessible to colleagues across the system. This paper concentrates on the interventions we have implemented and plans developed to ensure that staff, along with our patients are at the heart of service restoration and reset.



2.0 Occupational Support and Employee Assistance Programmes (EAP)

The Trust's Health at Work service remains accredited as a Safe, Effective, Quality, Occupational Health Service (SEQOHS) and we continue to provide excellent services to other organisations in the ICS with additional consideration being given to working collaboratively with two other organisations in the ICS.

Standard services including telephone advice line, manager's online referral, health assessments, immunisations and blood tests continued throughout both wave 1 and 2. Management referrals have continued throughout with an average of 107 per month over the last 12 months and muscular skeletal physio referrals on average of 9 per month. Throughout the pandemic the team have also provided support and guidance to both staff and managers on shielding, self-isolation, staff testing, risk assessments, and antibody testing.

The Health at Work team facilitates access to a range of support services. An enhanced EAP service providing a free independent support service for employees was launched in June 2020 with additional support available to staff. This year a trauma therapy service was made available for all staff as well as a 24/7 crisis line.

3.0 Risk Assessments

Risk assessments have been devised and continually reviewed throughout the pandemic for managers to assess their teams individual and role risk. These have enabled staff to be identified for working from home and redeployment. The majority of staff have had initial risk assessments with reviews being undertaken regularly. The risk assessment has recently been updated in line with current guidance and the latest reported figures for this version show a completion rate of 74% (4905) for all staff and 74% (1649) for staff of a Black, Asian or minority ethnic background.

The revised national risk assessment taking into account multiple risk factors has resulted in new shielding or clinical extremely vulnerable letters being sent out to additional staff in February 2021. As a trust we have agreed that these individuals should refrain from work until additional advice can be sought from their GP before returning to work.

A network has been established for colleagues who are shielding and has been led by one of our shielding staff members who felt they would like to have additional support but also offer support others in a similar position. The inaugural meeting took place in February with regular meetings booked going forward. Recommendations from this group are brought to the staff experience group for discussion and approval prior to implementation.

4.0 Vaccinations and Staff Testing

Over 80% of our staff have received or booked their first dose of the vaccine against Covid-19. Priority has been given to those in the most at risk categories and work areas. Additional webinars and communications are being circulated to support our Black, Asian and Minority Ethnic (BAME) colleagues, particularly those from a black background as there is a markedly lower uptake of just over 50% for this staff group.

Lateral flow testing has been available for clinical staff with over 2102 boxes provided to front line staff. Lateral flow is now open to all staff with the latest delivery at the end of February currently being distributed.

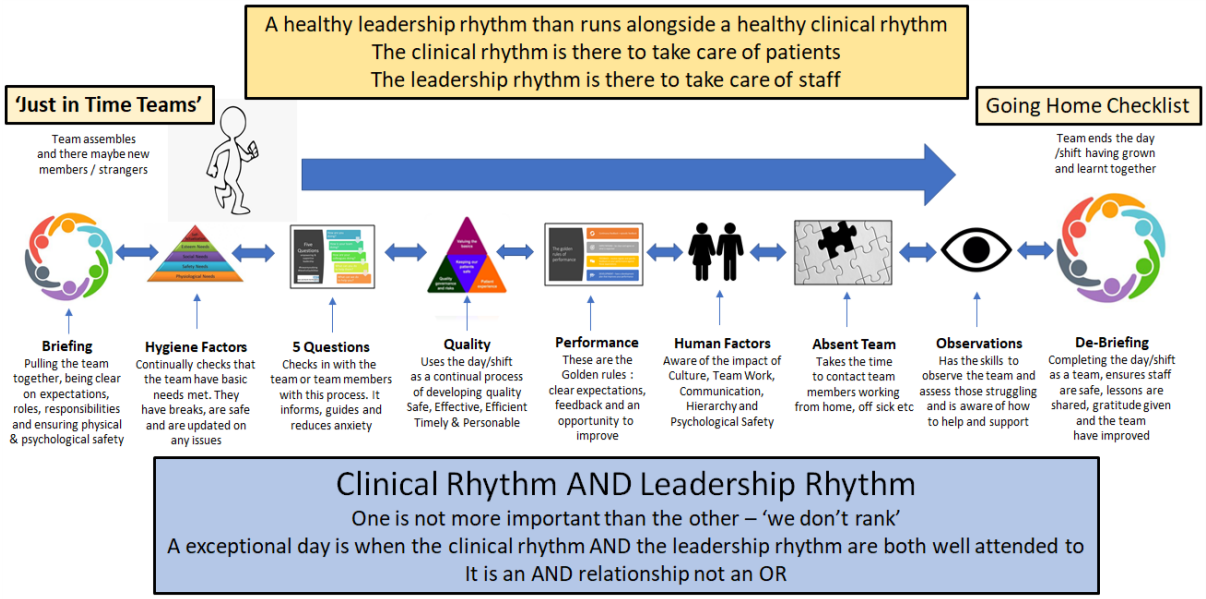
5.0 Here's How I'm Doing

There are a wide variety of support packages, self-care offers, resources and tools available that the Trust promotes to support the health and wellbeing of our people. However, with a large organisation it is not always to encourage access and uptake of these offers. In addition, it is natural that people may not always recognise that they need the help or the benefits to be gained. This is often more common for health care professionals with whom the focus is predominantly caring for others and not always taking the best care of themselves. To address this, a campaign has been devised known has 'Here's how I'm doing' where every day since the start of January an article has been produced of a member of staff sharing their story about what they do, how it impacts them and how they cope. This is shared along with a short case study of something on offer that is in place to support health and wellbeing. These stories have been shared widely to let people know that they are not alone in how they are feeling and there are options that can help and support.

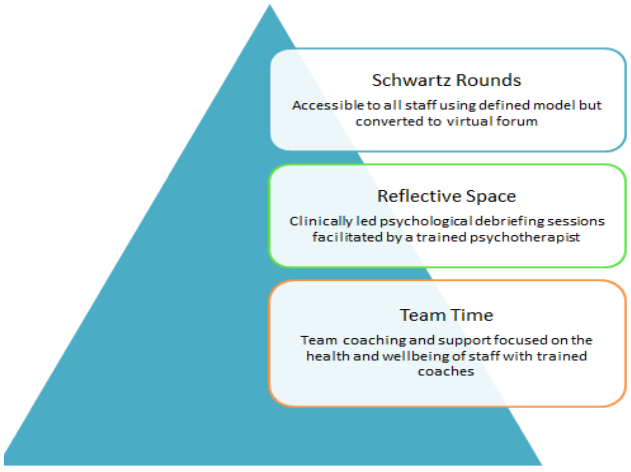
6.0 'How are you doing?' programme

During the first wave of the pandemic the Trust established a 'How are you doing?' team whose purpose was to focus on the staff's emotional response to the pandemic as well as their wellbeing. The team's work was based on the advice and evidence from the King's Fund and The British Psychological Society about helping people to deal with traumatic events.

The 'How are you doing?' programme has developed and now provides learning and development delivered in the flow of work, in order to create an approach to leadership which is compassionate and inclusive. A range of tools have been developed and methods deployed in the workplace that form part of the 'healthy leadership' model shown in the diagram below. This model, developed by the Trust, has been adopted across the Integrated Care System (ICS). In particular, the '5 questions', has been widely adopted and has become part of the common language. The principle is to normalise this approach so that the leadership culture is one that actively cares about each individual's health and wellbeing.



7.0 Psychological Support and debriefs



The diagram illustrates the structure for physiological support and debriefing available for our people at different levels of intervention. The sections below detail how these are used and what the plans are going forward.

7.1 Team Time

Team time provides facilitated sessions for team using the 'bite-sized' methods as part of the 'How are you doing?' programme. Facilitators are expert coaches that are integrated within team and departmental meetings to support with conversations based around the healthy leadership principles. An average of 9 Team Time sessions has been held each week since the start of February and will continue as part of the recovery support.

7.2 Reflective Space

Reflective spaces continue to support staff through psychological interventions with facilitators who are psychologists or psychotherapists able to support any discussion that may occur. Additional support is available through Health at Work representation should anyone require 1:1 support during the sessions. These sessions are weekly on a Thursday with teams based on need identified through the divisional structure.

7.3 Schwartz Rounds

Schwartz Rounds provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. The purpose of Schwartz Rounds is to understand the challenges and rewards that are intrinsic to providing care, not to solve problems or to focus on the clinical aspects of patient care. Rounds can help staff feel more supported in their jobs, allowing them the time and space to reflect on their roles. Evidence shows that staff who attend Schwartz Rounds feel less stressed and isolated, with increased insight and appreciation for each other's roles. They also help to reduce hierarchies between staff and to focus attention on relational aspects of care.

Feedback from the most recent Schwartz round with 16 attendees has been positive with further rounds planned on the third Wednesday of each month.

8.0 Developments and plans going forward

There are a number of interventions that can still be provided for our people to support their health and wellbeing now and for the future.

8.1 Annual leave

Firstly, we need to enable our teams to take their leave before we recover our services so that they can have time to reflect on what they have experienced and to recuperate so when we restart services we maintain the high standards of care our community expect. Plans are being developed within the divisions to see how this can be supported during the recovery period.

8.2 Improved rest and refuel spaces

To ensure that all staff have high quality rest and recuperation spaces, as part of the charitable donations from the 'here for each other' fund, 75 staff areas have been identified for refurbishment. Initial orders having been placed for replacement goods and additional orders will be placed by the end of February with work due for completion for the priority spaces by mid-March 2021. It is anticipated that all works will be complete by June 2021.

8.3 Recognise and reward

It's important to recognise and reward the contribution of all staff during the pandemic. The Trust will run an initiative each month providing simple gestures to recognise and thank staff. In February the Trust provided 'boost boxes' which were food packages handed out to all staff along with details of the support services each month. Variations of this theme will continue each month until July.

The Trust is also developing an offer to provide complimentary therapy services to staff such as massage, reflexology, osteopathy and chiropractic. This method has been piloted in two areas within the trust and feedback was extremely positive. It provides a way of thanking people individually while providing a service that grants rest and relaxation.

8.4 Time to listen

We need to create time to listen to the diverse experience of staff, acknowledge and recognise the different impact of COVID19 on different staff, in and outside work. As part of this the staff networks have been a key enabler for listening, gaining feedback and providing support. The BAME network has been pivotal in enabling discussion about the Covid-19 vaccine and why there hesitancy among certain communities. In addition, a shielding network has been set up and has raised important issues regarding support for staff who have not been able to attend work. Going forward, an open forum will be set up to engage with staff on an informal basis to engage staff in making improvements in staff experience.

The latest staff survey results have been released to Trusts and include feedback specific to the management of the pandemic and reflects the experience of people depending on how they were impacted during the pandemic for example if they were shielding, had been redeployed or were on a Covid-19 ward. The Trust will use the results to reflect on the experience and feed this into the learning for the organisations response to its recovery. Staff forums have been developed in each division to engage directly with to develop plans for improvement.

The Trust will ensure that all members of staff have a one to one with their line manager which focuses on their experience, what matters most to them and how to prepare themselves going forward. A series of tips, techniques and questions have been developed to help ensure there is a quality conversation focused on wellbeing.

8.5 The big thank you

As a trust we will say thank you to all our people in a week-long event in July 2021. This will include memorial event for those that have been lost to Covid and a celebration of all that has been achieved during this time.

9.0 Outcomes

During wave one we saw sickness absence rise to 7.28% during April 2020 however this was surpassed by absence in January 2021 which peaked at 8%. This is steadily decreasing however it is expected that absence will continue to wax and wane as anniversary events occur.

The Trust will also need to keep focus on retention levels as there is an expectation more staff will leave the NHS as the pandemic eases. Talking to our people to pick up on signals that they may be considering leaving and understand what is impacting their decision and

what we can do to help them to stay. If they do leave it will be important to keep them connected as enable them to take time out may encourage them to return after a break.

10.0 We are the NHS People Plan 20/21

As recommended in the NHS People Plan that each organisation should have a wellbeing guardian e.g. a non-executive director to look at the organisations activities from a health and wellbeing perspective and act as a critical friend. Mr Bob Niven has been nominated as the wellbeing guardian with a full briefing planned for March 2021.

11.0 Conclusion

The Trust Board is asked to note the work that has been undertaken to support the health and wellbeing of our staff.

To support our staff even further the ENHT People Team are leading on work both internally and at an ICS level on Health and Wellbeing to implement further supportive measures on a sustainable basis.

East and North Hertfordshire NHS Trust

Agenda Item: 11

TRUST BOARD - PUBLIC SESSION – 3 MARCH 2021
Health and Social Care Bill 2021 – White Paper Briefing

Purpose of report and executive summary (250 words max):		
The presentation outlines the key proposed changes within the NHS White Paper published on 11th February 2021. It describes the changes to the NHS environment that are being proposed; with the new structures that are the building blocks for integrated care systems. All health and care organisations will be required to take steps to respond to meet the legislative changes. The presentation sets out the current gaps in national guidance to enablers to facilitate the change. The impact and considerations for the Trust are summarised.		
Action required: For discussion		
Previously considered by: **Executive Committee, 18.02.21** **FPPC, 24.02.21**		
Director: **Deputy Chief Executive Officer and Director of Finance**	**Presented by:** **Deputy Chief Executive Officer and Director of Finance**	**Author:** **Head of Contracts**

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
Any other risk issues (quality, safety, financial, HR, legal, equality):

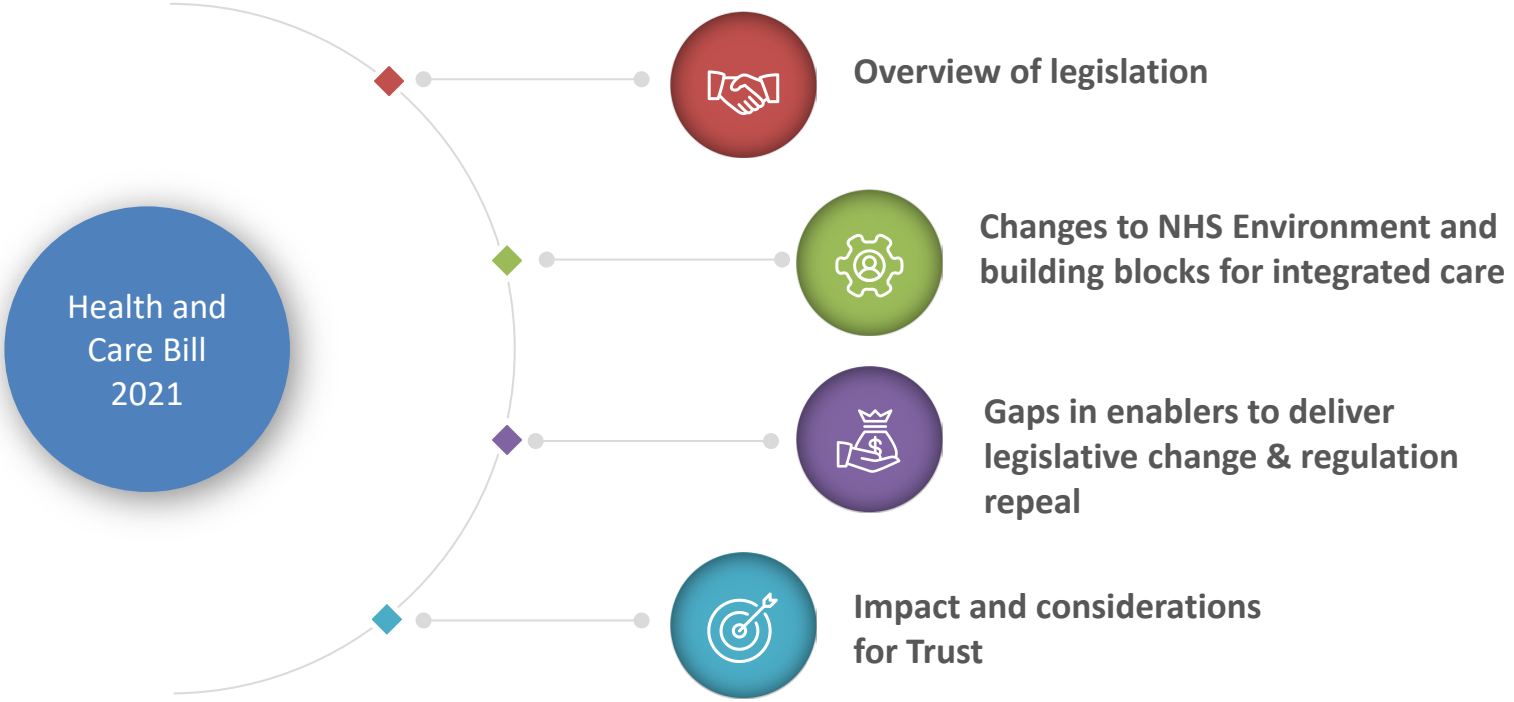
Proud to deliver high-quality, compassionate care to our community

Health & Social Care Bill 2021

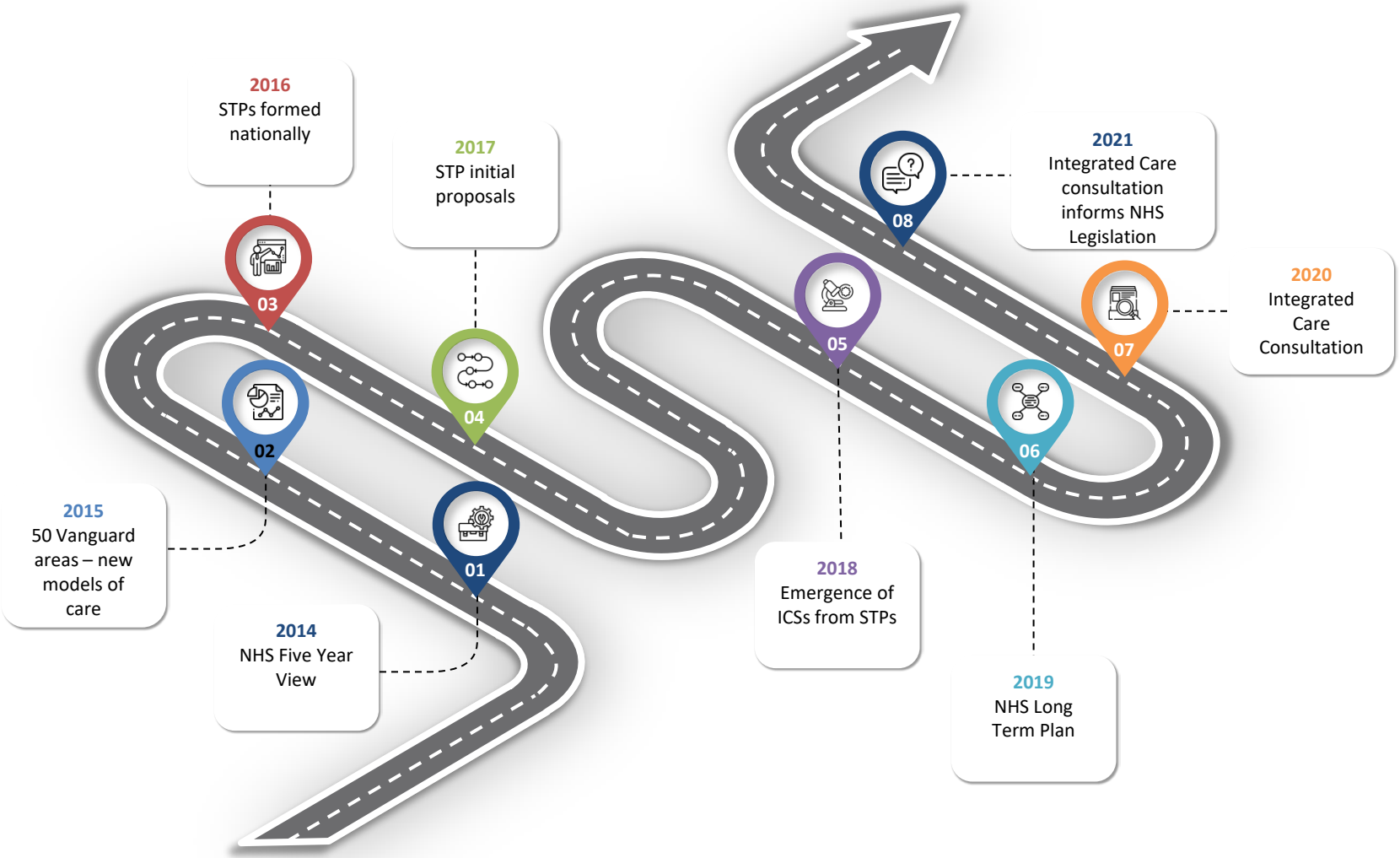
Legislative Proposals

February 2021

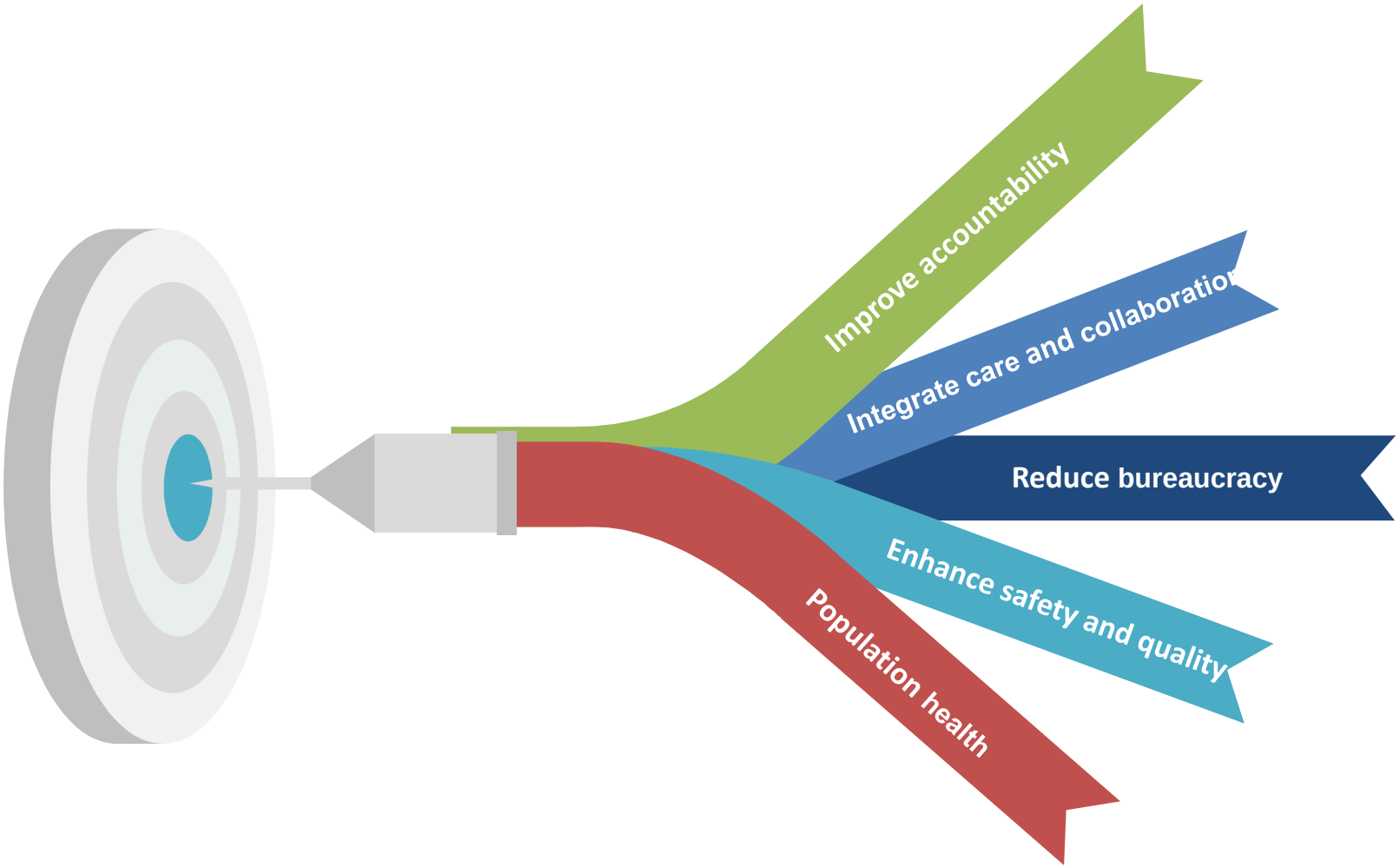
Contents


Health and Care Bill 2021
Overview of legislation
Changes to NHS Environment and building blocks for integrated care
Gaps in enablers to deliver legislative change & regulation repeal
Impact and considerations for Trust

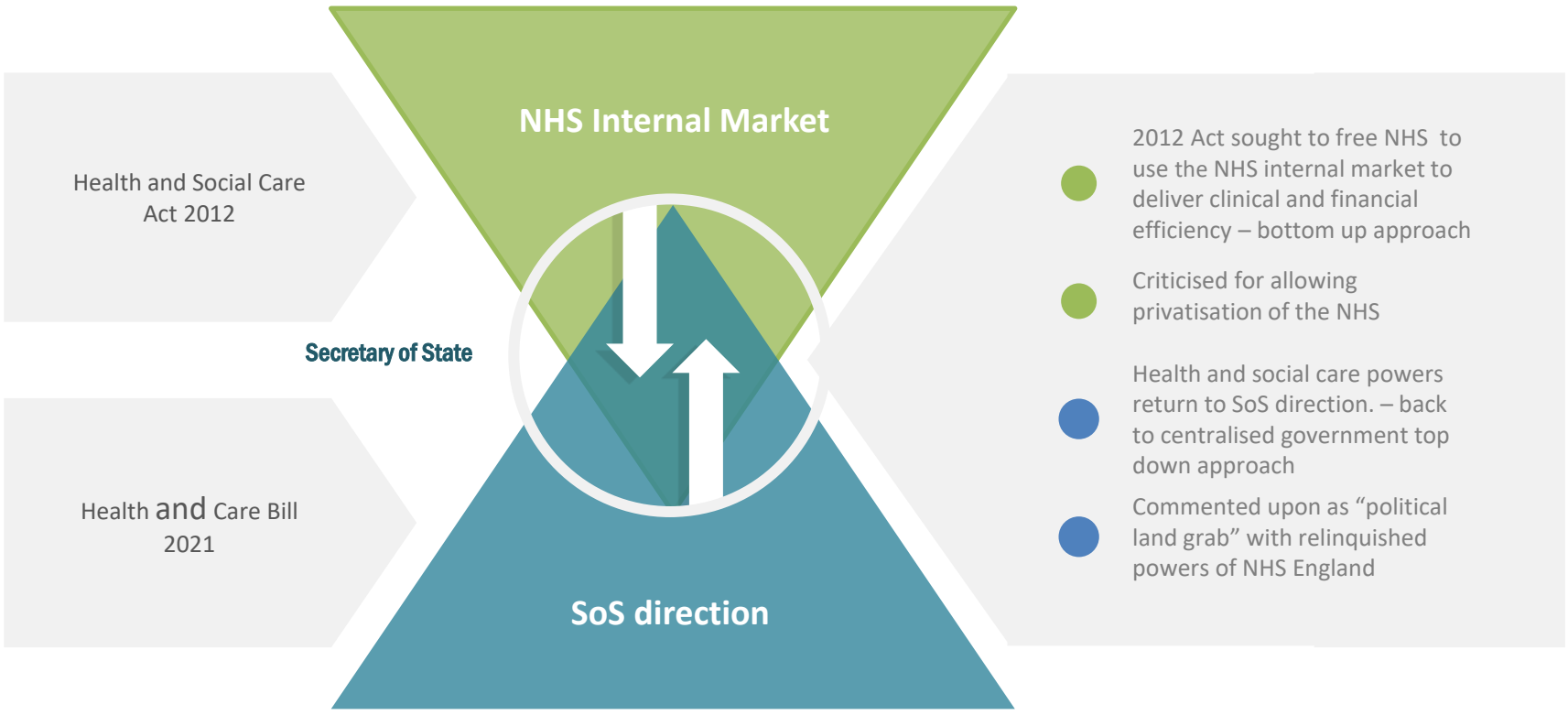
Timeline to Health & Care Bill 2021



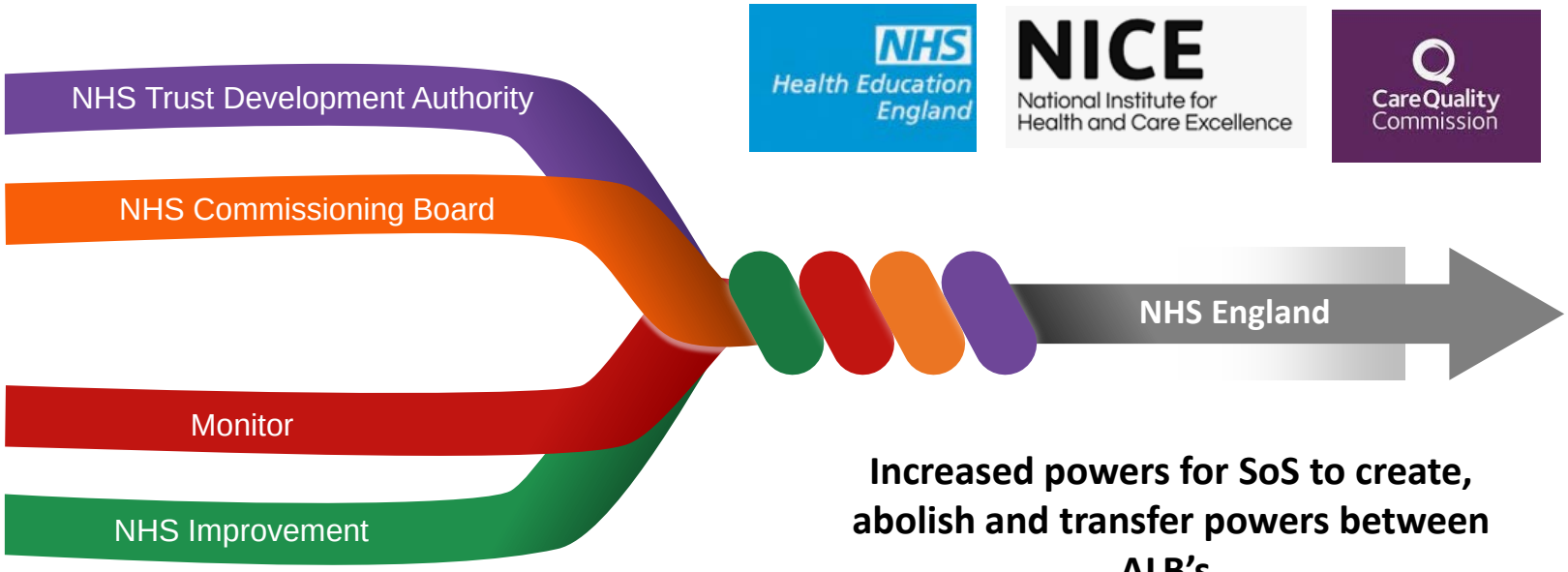
Legislation purpose and aims



Secretary of State powers of direction



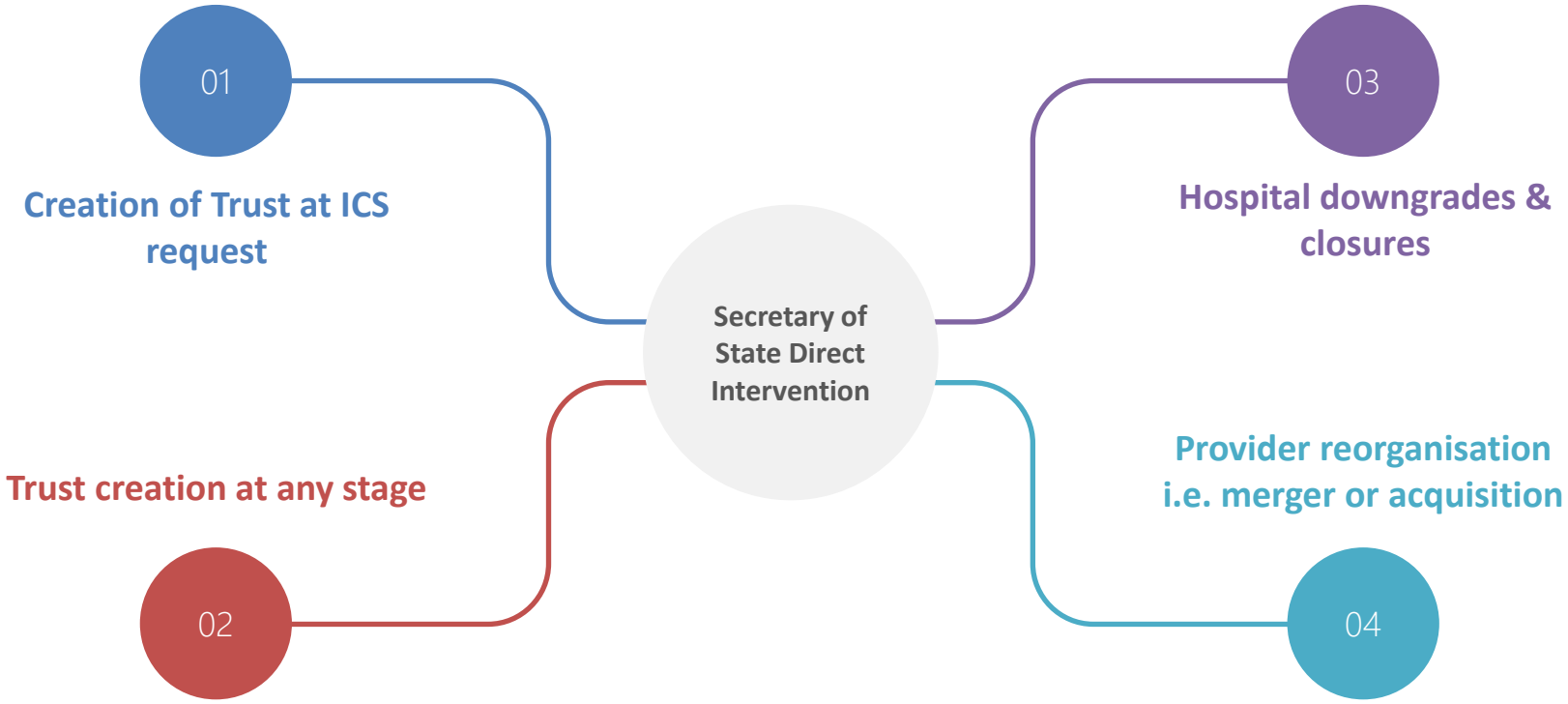
SoS powers over Arms Length



Increased powers for SoS to create, abolish and transfer powers between ALB's.

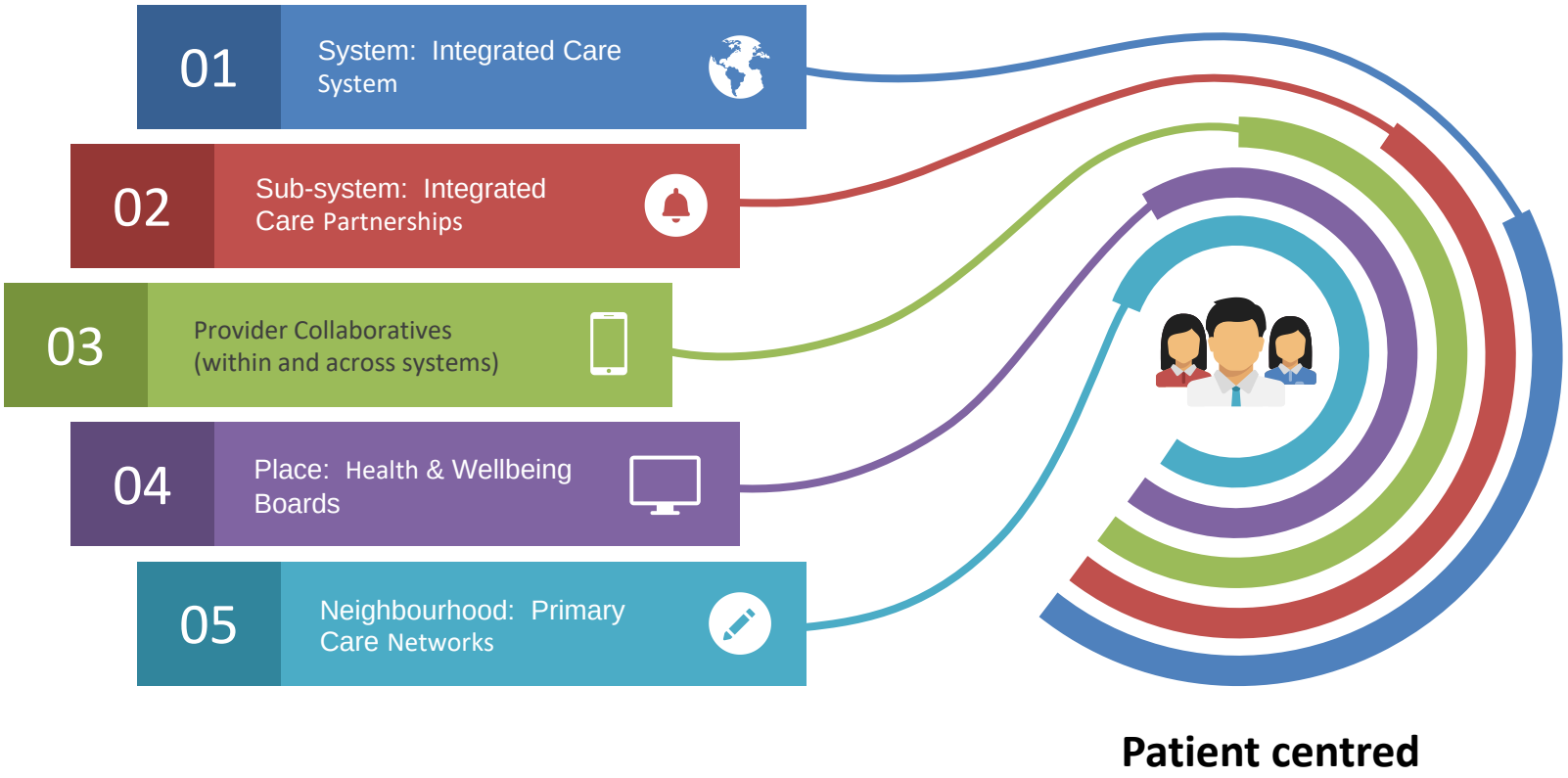
SoS powers over Trust's

Extended powers for SoS to directly intervene in Trusts creation and reconfiguration



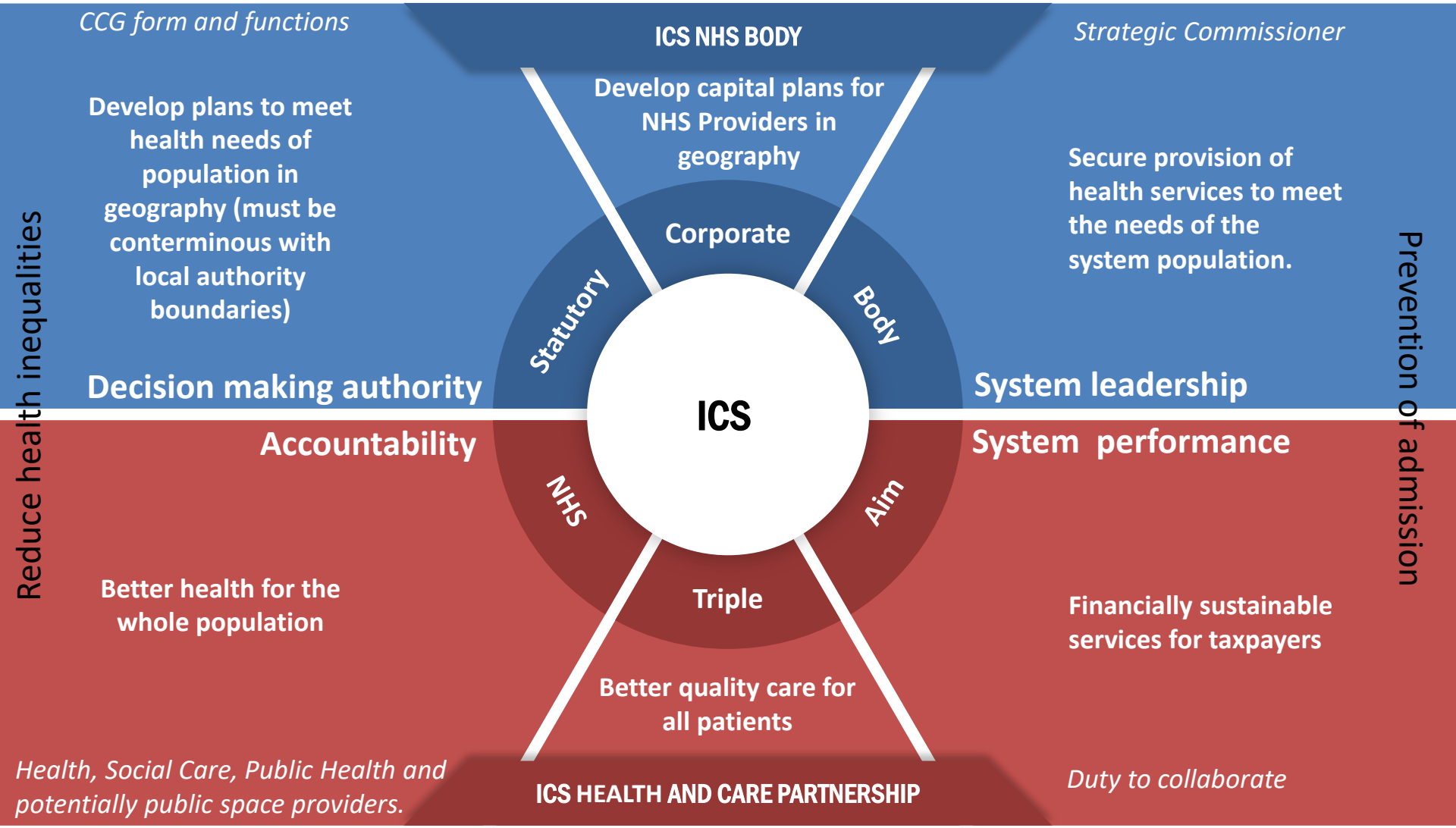
New NHS environment and building blocks for Integrated Care

Double integration: within the NHS to remove barriers for collaboration and working together an organised principle and between the NHS others i.e. local authorities to deliver improved outcomes to health and wellbeing for local people.



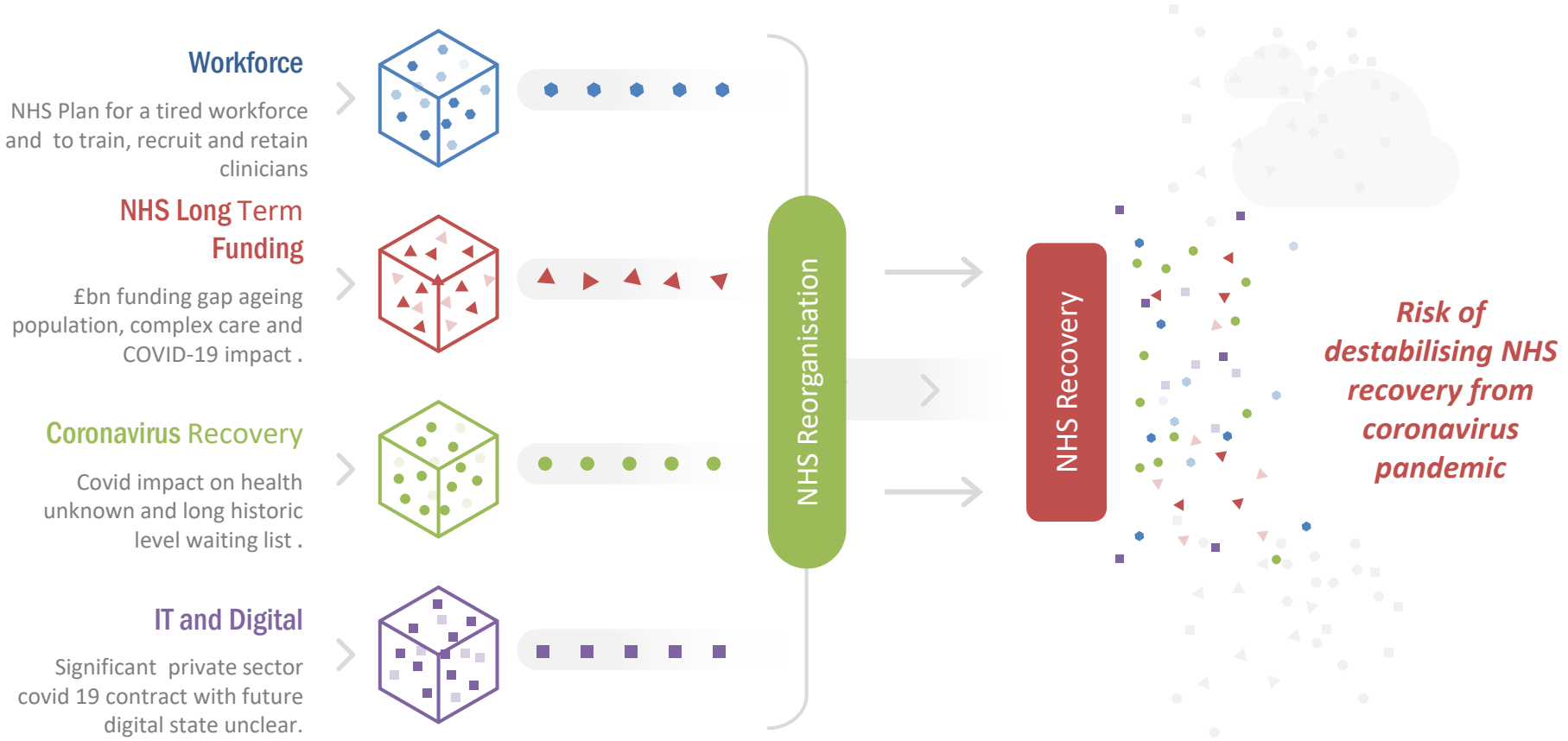
11. Health and Social Care Bill White Paper Briefing.pdf

Integrated Care Consultation outcome:
Option 2: Statutory ICS



11. Health and Social Care Bill White Paper Briefing.pdf

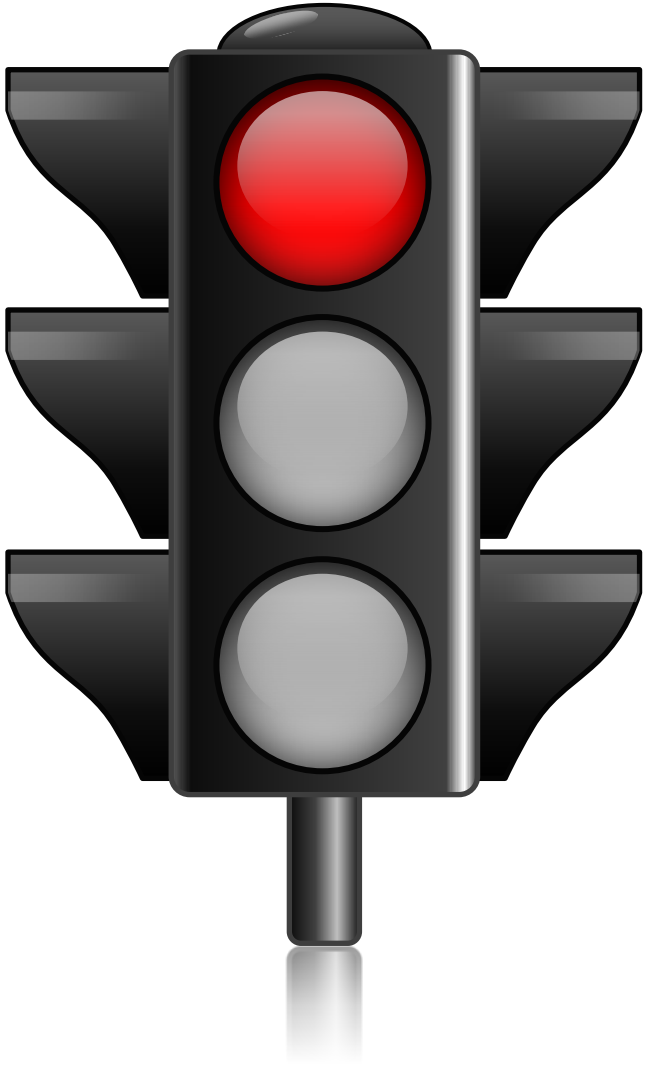
The Gaps in enablers to deliver legislative change



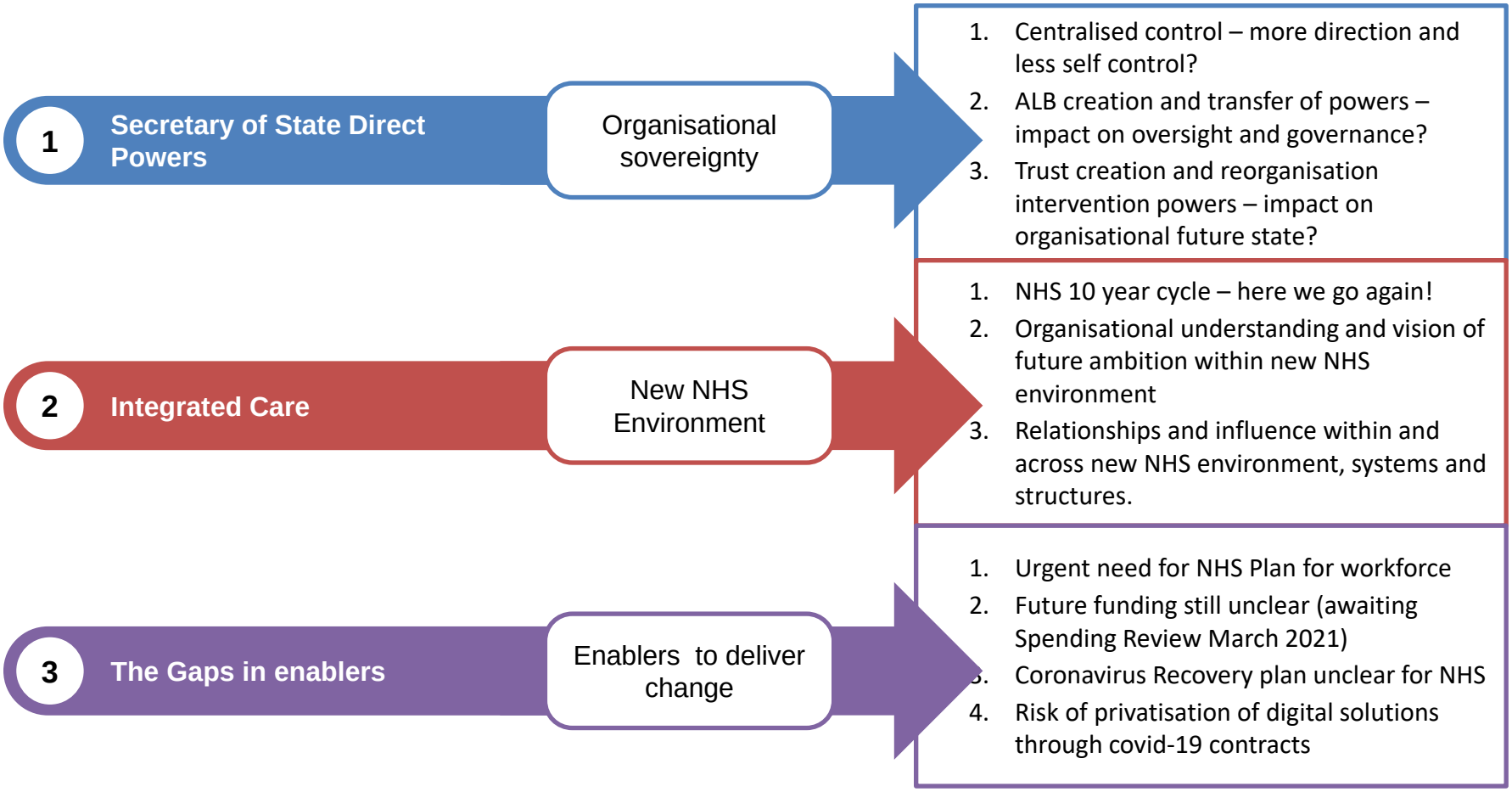
Procurement, Patient Choice and Competition Regulation 2013

Repeal of section 75

- Replaced with new Provider Selection Regime.
- **Procurement:** rules to be clarified for AQP and procurement to apply for tenders £615k+
- **Patient Choice:** NHS decision making bodies required to protect, promote and facilitate patient choice with respect to treatment and services.
- **Competition:** removed.



Impact for Trust



Considerations for Trust

#1
Sovereignty

#2
Environment

#3
Enablers

Sovereignty

What is the impact on the Trust's sovereignty as a result of the SoS powers and ICS future state; and what sovereignty is the Trust willing to relinquish to deliver the legislative aims and system ambitions?

Environment

What is Trusts' position within the new NHS environment and how do we develop the organisational understanding to implement the required changes?

Enablers

With lack of national clarity on key enablers; how does Trust identify and deliver the strategic requirements to achieve the legislative changes to meet it's statutory duties?

Agenda Item: 12

TRUST BOARD - 3 MARCH 2021
Board Assurance Framework Risks 2020-21

Purpose of report and executive summary (250 words max):
The BAF risks continue to be reviewed with each Director and Executive Team each month and at the Board and Board Committees and used to drive the agendas. This now includes the new Strategy Committee.

The Trust's strategic risks for the Board Assurance Framework 2020/21 on one page. **Appendix a.**

How the risks map across the Trust's strategic priorities and draft objectives for 2020/21v8 and providing assurance on the coverage. **Appendix b.**

The full current BAF, **appendix c**. The reviews in October 2020 included the implementation of the revised methodology on scoring the likelihood of the risk occurring, based on frequency that the risk / effects have occurred (see matrix below). This resulted in the reduction of the risk profile of three risks in October 2020.

Key points for the Board to note since the last meeting in January 2021:

- No changes to the risk scores and profile this month.
- The updates are shown in red for ease.
- The updates mainly reflect the impact of Covid Pandemic Surge 2 which continues to have a greater impact on the management of a number of the risks – Performance, Staffing, Quality and governance.
- Two risks remain at 20:
  Risk 10 Estates: The Director of Estates is in the process of reviewing all the Estates & Facilities risks with his senior team to inform the BAF. A series of workshops is now being scheduled during March to support this review. This is in conjunction with a review of the governance and assurance reporting within the Directorate.
  Risk 4 Capital: An update on the Capital programme was considered by the FPPC and remains under close monitoring to ensure the full allocation is used in 2020/21.

- The Strategy Committee recommends to the Board that risk 6 is expanded to incorporate the ICS and it was agreed that the implementation of the Strategic Planning Framework and Integrated Business Plan Structure, be reflected in Risk 7, Trust Governance.

- Internal Audit's annual review of the Board Assurance Framework focused on the assurance over the key controls in operation to mitigate the principal risks and whether the strength of those assurances align to the level of risk and concluded 'substantial assurance'. The main recommendation to further strengthen the BAF was to give separate references to the gaps in controls and assurance so that they can be easily mapped to the 'Action Plan to Address Gaps' section. This will be reflected in the annual review Risk Management Strategy and BAF for 2021/22. The intention is to present this to the Audit Committee at the next meeting in March 2021.

Action required: For discussion		
Previously considered by: Considered at each Board and Board Committee.		
Director: Chief Nurse	**Presented by: Associate Director of Governance**	**Author: Associate Director of Governance**

Trust priorities to which the issue relates:	**Tick applicable boxes**
Quality: To deliver high quality, compassionate services, consistently across all our sites	☒
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Ease of Use: To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term	X☐

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) Yes – CQC compliance will link with all the BAF Risks
Any other risk issues (quality, safety, financial, HR, legal, equality):

Board Assurance Framework: 2019/20 and transition to 2020 / 21

Risk Scoring Guide

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

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

Trust risk scoring matrix and grading

Likelihood / Impact	1 Rare (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

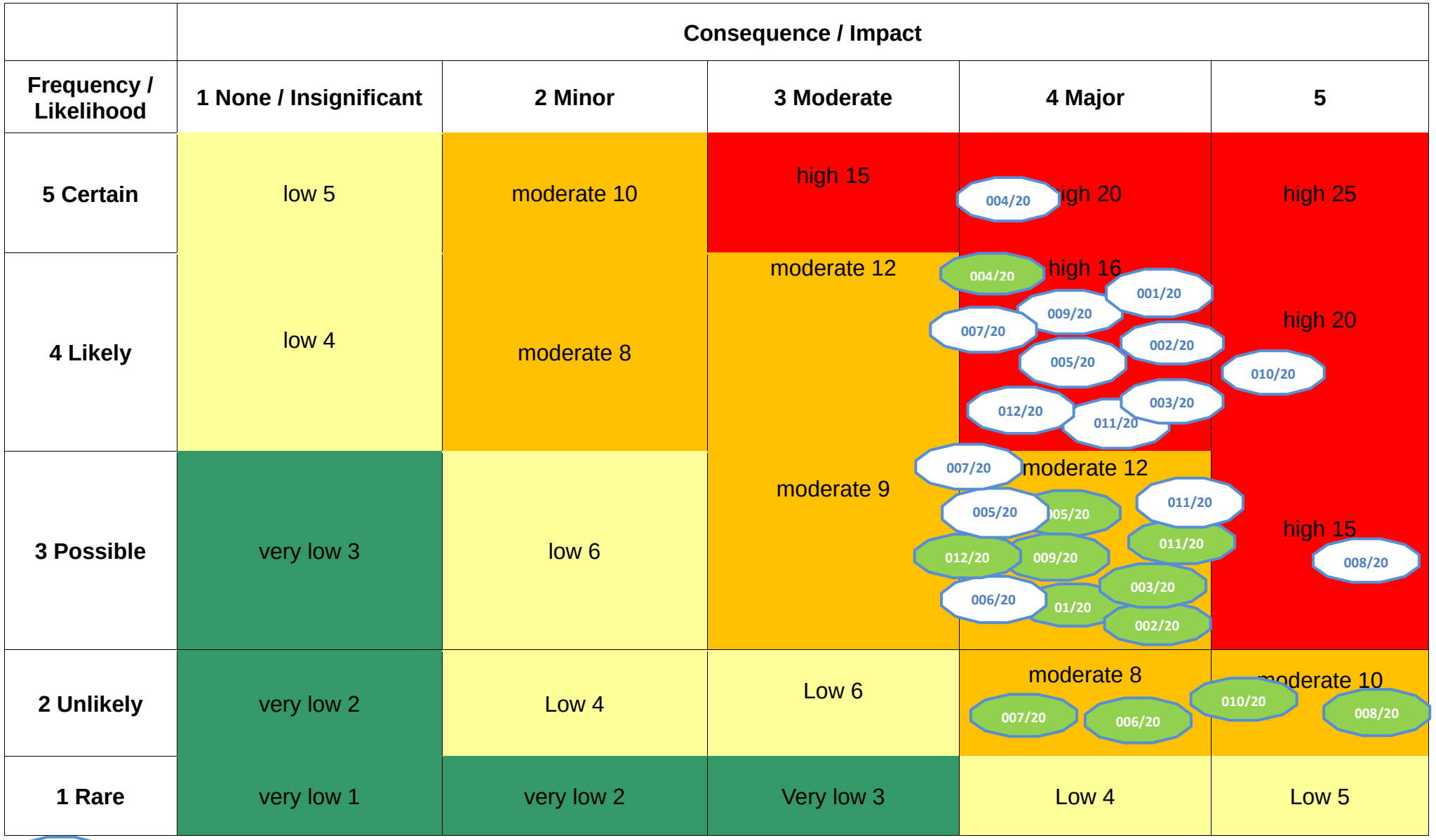
Risk Assessment	Grading
15 – 25	Extreme
8 – 12	High
4 – 6	Medium
1 – 3	Low

BOARD ASSURANCE FRAMEWORK OVERVIEW

Risk Ref	Risk Description 2020/21	Lead Executive	Committee	Current Risk Feb	Last Month Jan	3 months ago	6 months ago)	Target Score	Date added (Target dates for risk score/ changes)
001/20 *	Risk to operational delivery of the core standards and clinical strategy in the context of COVID recovery	Chief Operating Officer	FPPC	16	16	16	16	12	01.03.18 (June 21)
002/20 *	There is a risk that the workforce model does not fully support the delivery of sustainable services impacting on health care needs of the public	Chief Nurse /Medical Director/CPO	FPPC	16	16	16	16	12	01.03.18 (April 21)
003/20 *	Risk of financial delivery due to the radical change of the NHS Financial Framework	Director of Finance	FPPC	16	16	16	16	12	01.04.19 (TBC)
004/20	There is short term risk of spending the capital allocation for 2020/21 and a longer term risk of the availability of capital resources to address all high/medium estates backlog maintenance, investment medical equipment and service developments (Updated Dec 2020)	Director of Finance	FPPC	20	20	20	20	16	01.03.18 (TBC)
005/20	There is a risk that the digital programme is delayed or fails to deliver the benefits, impacting on the delivery of the Clinical Strategy	Chief Information Officer	Strategy	12	12	16	16	12	01.04.17 (At target)
006/20	There is a risk ICP / ICS partners are unable to work and act collaboratively to drive and support system and pathway integration and sustainability	Director of Strategy	Strategy	12	12	12	12	8	01.04.20 (Dec 20)
007/20 *	There is a risk that the Trust's governance structures do not enable system leadership and pathway changes across the new ISC/ICP systems whilst maintaining Board accountability and appropriate performance monitoring and management to achieve the Board's objectives	Chief Executive / Chief Nurse	Board	12	12	16	16	12	01.03.18 (21/22)
008/20 *	There is a risk that the Trust is not always able to consistently embed a safety and learning culture and evidence of continuous quality improvement and patient experience	Chief Nurse /Medical Director	QSC	15	15	15	15	10	01.03.18 (TBC)
009/20 *	There is a risk that our staff do not feel fully engaged and supported which prevents the organisation from maximising their effort to deliver quality and compassionate care to the community	Chief People Officer	FPPC & QSC	16	16	16	16	12	01.03.18 (March 21)
010/20 *	There is a risk of non-compliance with Estates and Facilities requirements due to the ageing estate and systems in place to support compliance arrangements	Director of Estates	QSC	20	20	20	20	10	22.01.19 (TBC)
011/20 was 012/20	There is a risk that the Trust is not able to transfer the MVCC to a new tertiary cancer provider, as recommended by the NHSE Specialist Commissioner Review of the MVCC	Director of Strategy	Strategy	12	12	16	16	12	01.04.20 (TBC)
012/20 *	Risk of pandemic outbreak impacting on the operational capacity to deliver services and quality of care	COO/Chief Nurse	QSC/Board	20	20	20	20	15	04.03.20 (April 21)

scope or articulation of the risk has changed for 2020/21 and is therefore not directory comparable to 2019/20.

Board Assurance Framework Heat Map –February 2021



008/20 Existing risk score

011/20 Target risk score

Movement from previous month

REVIEW OF STRATEGIC RISKS FOR 2020/21 – MAPPED TO TRUST STRATEGIC PRIORITIES AND DRAFT OBJECTIVES 20/21

Our Priorities

1. Quality:
R2 Workforce
R4 Capital
R5 Digital
R7 Governance
R8 Quality
R10 Estates
R11 MVCC
R12 Pandemic

2. People:
R2 Workforce
R8 Quality
R9 Culture
R12 Pandemic

3. Pathways:
R1 Op Delivery
R5 Digital
R6 ICP
R8 Quality
R12 Pandemic

4. Ease of Use:
R1 Op Delivery
R5 Digital
R6 ICP

5. Sustainability:
R1 Op Delivery
R3 Finance
R4 Capital
R6 ICP
R7 Governance
R10 Estates
R11 – MVCC
R12 Pandemic

Our Objectives 2020/21 v8 final draft

a) Enhance clinical leadership and service line delivery to further improve service quality, safety and transformation (R2 Workforce, R3 Finance , R5 Digital, R7 Governance, R8 Quality, R9 Culture, R11 MVCC, R12 Pandemic)

b) Improve patient outcomes, experience and efficiency by enhancing specialty-level inpatient care (R1 Op Delivery, R3 Finance, R4 Capital, R5 Digital, R8 Quality, R9 Culture, R10 Estates)

c) Support our people to feel valued and fully engaged to maximise their efforts to deliver quality and compassionate care (R2 Workforce, R7 Governance, R8 Quality, R9 Culture, R12 Pandemic)

d) Develop a future vision for the Trust's cancer services and support work with partners to transfer MVCC to a tertiary provider (R1 Op Delivery, R3 Finance, R5 Digital, R11 MVCC)

e) Safely recover operational performance affected by the COVID-19 pandemic (R1 Op Delivery, R3 Finance , R4 Capital ,R5 Digital, R10 Estates, R12 Pandemic)

f) Work with partners to meet the health and care needs of our community through and beyond the COVID-19 pandemic (R1 Op Delivery, R2 Workforce , R3 Finance , R5 Digital, R7 Governance, R8 Quality, R12 Pandemic)

g) Harness innovation, technology and opportunities for new models of care to right size and optimise our capacity to meet demand (R1 Op Delivery , R4 Capital, R8 Quality, R5 Digital , R8 Quality, R7 Governance, R9 Culture

h) Play a leading role in developing sustainable and integrated services through the ENH Integrated Care Partnership and ICS (R2 Workforce, R6 ICP, R7 Governance, R8 Quality, R9 Culture, R10 Estates, R12 Pandemic)

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2020-21

Trust Strategic Aim:	**Pathways: To develop pathways across care boundaries, where this delivers best patient care redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff** **Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term**					**Ease of Use: To**
Trust Strategic Objective:	**b) Improve patient outcomes, experience and efficiency by enhancing specialty-level inpatient care** **d) Develop a future vision for the Trust's cancer services and support work with partners to transfer MVCC to a tertiary provider e) Safely recover operational performance affected by the COVID-19 pandemic f) Work with partners to meet the health and care needs of our community through and beyond the COVID-19 pandemic g) Harness innovation, technology and opportunities for new models of care to right size and optimise our capacity to meet demand**		**Source of Risk:**	Strategic Objective IPR	**BAF REF No:**	001/20
Principal Risk Description: What could prevent the objective from being achieved? **Risk to operational delivery of the core standards and clinical strategy in the context of COVID recovery**			**Risk Open Date:**	01/07/2020	**Executive Lead/ Risk Owner**	**Chief Operating Officer**
			Risk Review Date:	Jan-21	**Lead Committee:**	**FPPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Increases / changes to capacity and demand . ii) leadership and capacity challenges iii) conflicting priorities iv) Inconsistency in application of pathways/ processes iv) Impact of COVID 19 measures - PPE, testing, social distancing, staff and patient risk assessments, availability of workforce. v) Impact of specialist commissioning review and resultant outcome for MVCC on staff retention and recruitment, impacting on effectiveness of the cancer team.	i) Limited ability to respond to changes in capacity and demand impacting on service delivery - changes to referal patterns following COVID. Patients presenting later to GP's ii) Adverse impact on sustaining delivery of core standards iii) impact on patient safety, experience and outcomes iv) increased regulatory scrutiny v) reputation - Public confidence	**Inherent Risk** (Without controls):	4	5	20	⇔
		Residual/ Current Risk:	4	4	16	
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
Risk Stratification of patients - Oversight by Clinical Advisory Group (Consultant Chair) Use of Private Sector (One Hatfield & Pinehill) Recovery programme - operation restart with governance structure and Recovery Steering Group with workstreams (reviewed & revised February 21) New Trust Delivery Framework (commenced September) Cancer Board Systemwide group chaired by Trust COO (SARG) COVID Specialist advisory group Task and Finish Group re Gastro surviellence and waiting list Weekly PTL Management - Cancer, RTT Recovery plans in place for diagnositics - Ultrasound and MRI Elective activity oversight task and finish group in place.	Flat packing of COVID Pandemic escalation plans / COVID Policies and procedures Sustained cancer performance - achieved the 8 cancer standards on June Recovery dashboard divisional and specialty based Monthly IPR and performance reports to FPPC and Board Deep dive reports to FPPC - ED performance and configuration; endoscopy review and Demand and capacity transformation model (Sept 20) Stroke deepdive to FPPC Dec 20 COVID - 19 Bed modelling report to Board 01/21	Sustained cancer performance - cancer data to FPPC in Feb 21 Stroke deepdive to FPPC Dec 20 and roadmap to sustained improved service to FPPC in Jan 21		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	

Complexity of operation restart in the context of COVID National changes to guidance and policy requiring local response at short notice. Phase 3 capacity modeling to deliver national targets within financial model 31 December 20: Trusts required to plan to pause P3 and P4 cases to support COVID surge	Define metrics to support monitoring of recovery Assurance on compliance with NICE changes and GIRFT Capacity to support increased demandpost COVID - Endoscopy and other specialities - delievery against plans Review of Harm review process / policy Effectivness of winter planning initiaitves / transformation with community Outcome of COVID tests to support optimum discharge	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
Operation Restart Programme with risk stratification recovery steering group	**COO**		In progress - weekly recovery streering group. Risk stratificaiton of patients on waiting list / surviellence and follow ups. Phase 3 activity submission. February 2021: operational recovery plan balancing covid response and recovery to FPPC in Feb 21, includes baseline triggers.	In progress
Ward reconfiguration Programme	COO/ Director of Estates/Chief Nurse	Q3/4	Capital funding bid - awaiting confirmation of outcome. To support elective programme and inpatinet risk reduction. Assessment area for medical and surgery combined	In progress
Implement Organisational restructure	COO		Consultation launched in August 2020. To go live in October. To go live 1 November 2020. Recuitment underway for vacant posts. DD for unplanned care due to commence in December 20. All key posts appointed into and structures now embedding	completed
Develop system recovery plan with ICP, PCN's, Community and Social Care services (e.g. further development of Ambulatory care to create ED capacity; discharge to assess)	COO		In progress - weekly recovery streering group. Risk stratificaiton of patients on waiting list / surviellence and follow ups. Phase 3 activity submission. Virtual covid ward developed and implemented in January 21.	
Review 7 day services.	Medical Director/COO		reducing the burden' paused the self assessment process during covid. However examples of development of 7 day services during covid.	
Review performance metrics	COO		Review of new national ED standards. Measures running in shadow form; paper to FPPC in Feb 21.	
Summary Narrative:				

October 20: Risk discussed and reviewed with COO including the risk likelihood score using the new standardised methodology. Risk remains at '16'. Rationale: Performance recovery plan in place in line with Simon Stevens Phase 3 national letter but this is with the competing challenge of COVID and winter pressures. Recent SI's delcared following delay in follow up and survielienceand delays to treatment following impact of COVID (nationally elective pathways were ceased although the Trust were able to use the private sector facilities for urgent procedures. Good example of the postitive work being undertaken was presented to FPPC in September and Harm review process reviewed and presented to QSC in September. Clear actions and risk stratification in place to improve/ recover the position. Deep dive of the harm reviews monitored through QSC (review October). Anticiate the risk will not reduce further prior to June 2021.
November 20: Phase 3 remains, (in the main), on track to deliver compliant targets for elective, day case, O/P and diagnostics. The continuation of this delivery remains in the balance as the organisation continues to manage the demands of winter, Covid response and recovery. There are a number of significant risks to the continuation of recovery; namely:
• Maintenance of operational safe levels of staff to support key services.
• Any potential increase in overall number of Covid patients in critical care and general beds. Expansion into surge critical care capacity will require some theatres and elective work to pause.
• Significant operational projects of lateral flow testing and Covid vaccination requiring senior oversight and deliver requiring other activities to be paused.

Mitigations are incident management structure in place to review the staffing and positive Covid patient position on a daily basis, through the Covid surge dashboard.
Steering groups and T&F groups have been established to oversee the planning and delivery of both the lateral flow tests and Covid vaccination programme.
December 2020: Implementation of SDEC and Think 111 First commenced in November / December 2020. ED capital reconfiguration programme.
January 2021: Trusts required to plan to pause P3 and P4 cases to support COVID surge. Elective activity oversight task and finish group in place.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2020-21

Strategic Aims: Sustainability, Quality, People	**We provide a portfolio of services that is financially and clinically sustainable in the long term . We deliver high quality, compassionate services consistently across all our sites. We create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce.**				
Strategic Objectives: a,c,f,h	**Enhance clinical leadership and service line delivery to further improve service quality, safety and transformation. Support our people to feel valued and fully engaged to maximise their efforts to deliver quality and compassionate care. Work with partners to meet the health and care needs of our community through and beyond the COVID-19 pandemic. Play a leading role in developing sustainable and integrated services through the ENH Integrated Care Partnership and ICS.**	**Source of Risk:**	strategic objectives	**BAF REF No:**	02
Principal Risk Description: What could prevent the objective from being achieved? **There is a risk that the workforce model does not fully support the delivery of sustainable services impacting on health care needs of the public.**		**Risk Open Date:**	Sep-20	**Executive Lead/ Risk Owner**	**Chief People Officer**
		Risk Review Date:	Feb-21	**Lead Committee:**	**FPPC and QSC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Failure to develop effective workforce plan/workforce model for each service that takes account of new/different ways of working. ii) Failure to maximise staffing options through the use of flexible working initiatives. iii)Failure to work collaboratively across the Integrated Care System. iv) Failure to develop staff to be able to work more flexibly in terms of role design.	i) Current staffing models may not be cost-effective. ii) There may be an adverse impact on service quality and safety. Iii) Recruitment costs may be higher than necessary. iv) Staff may not have the required skill set to support innovative role design and ways of working.	**Inherent Risk** (Without controls):	4	4	16	⇕
		Residual/ Current Risk:	4	4	16	
		Target Risk: **(Spring 2021)**	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
i) A process by which articulation of clinical strategy is linked to organisational redesign and workforce modelling. Ii)Workforce transformation approach to service development. iii)Demand and Capacity Modelling. iv) People Strategy action planning will seek to mitigate this risk. v) Redeployment Hub re-instated January 2021, supported by Task Team and training	i) Care Quality Commission service inspections ii) Staffing costs /staff turnover costs iii) Monthly safer staffing reports to QSC and Board Covid Pandemic Surge 2 - Staff deployment (safety and governance) to Board Jan 2021	Erostering Internal Audit - reasonable assurance		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:** Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
i) Inadequate links between service planning and workforce planning. Ii) Lack of horizon scanning to allow early recognition of potential skills gaps. iii) National shortages of clinical professionals and failure to engage clinicians in the workforce planning process. iv) COVID challenge to existing workforce model - ability to maximise using staff flexibly taking into account capability and covid risk assessments	i) the variation between current staffing arrangements and optimum workforce model is not yet quantified. Ii) ability readily monitor capability, specialist skills and risk assessments to maximise using staff flexibly	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete

i) Ongoing implementation of the People Strategy to support staff recruitment and retention, in particular through the development of a strategic forum to link future organisational design requirements with job design and provision of necessary educational support.	Chief People Officer		Staff deployment is being reviewed in light of the bed reconfiguration project, and the COVID second surge, this will also impact on recruitment activity. Working with Transformation Team on review and development of workforce models The Trust is using inclusion ambassadors in the recruitment process for posts at senior levels. A review of the scheme along with a number of other proposals to widen the scope and improve recruitment and selection practices is currently being undertaken.	In progress
ii) Enhance areas of staff supply:	Chief People Officer		Substantive - Increase in international recruitment pipeline (an addition 30 nurses have been identified in this financial year), expedite training for new international recruits (reduce from 12 weeks to 5 weeks), introduce temporary registration enabling new staff to work in registered capacity on the wards, new flexible working campaign advertised to build a pool of contracted flexible workers, increase flexibilities of care support worker recruitment and increase numbers of clinical support workers into the organisation using a variety of sources with an aim to achieve 0% vacancy rate.	In progress. There are now 70 additional nurses in post than there was in Jan 20, and currently exceeding the year end forecast for nursing by 30 WTE.
iii) Put in place redeployment process	Chief People Officer		Each area reviewed to identify full potential WTE that can be redeployed. This is either temporary redeployment to another team or to work as part of the 'task group'. The task group picks up a range of activities to release nursing staff to provide direct clinical care. Since 25th January week, 1,387 staff have been identified for redeployment, 1,149 of those have been placed (82%). Redeployment Hub is working with eroster/safecare/task teams to redeploy appropriately – majority of the staff identified are admin.	In progress
iv) Work with divisional leadership on demand and capacity modelling, and establish workforce architecture/modelling approach and capability.	Chief People Officer		Task group mobilised to review all activity impacting the demand for staff. Summary paper to be developed for FPPC and included within future planning principles. Revisited term of referance for Education Board to ensure cross divisional oversight of capability mapping. Workforce transformation steering group linking with clinical and medical workforce steering group.	In progress
v) Improve the offer to staff around flexible working.	Chief People Officer		Further to the Q1 Pulse Survey, work is underway to improve staff experience in areas whether survey responses identified particular issues, such as lack of support for flexible working.	In progress
Summary Narrative:				
October 2020: Review of the risk undertaken with CPO. Risk remains a 16. Taking into account the current complexities of COVID, winter and maintaining activity. It is anticipated that this will not reduce until Spring 2021. December 2020: risk to be reviewed to take into account current staffing pressures and new staffing risk on the corporate risk register for Unplanned care and increased number of red/ black shifts being experience in COVID surge 2.				

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2020-21

Strategic Aim:	**Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term**				
Strategic Objective:	**a) Enhance clinical leadership and service line delivery to further improve service quality, safety and transformation** **b) Improve patient outcomes, experience and efficiency by enhancing specialty-level inpatient care** **d) Develop a future vision for the Trust's cancer services and support work with partners to transfer MVCC to a tertiary provider** **e) Safely recover operational performance affected by the COVID-19 pandemic** **f) Work with partners to meet the health and care needs of our community through and beyond the COVID-19 pandemic**	**Source of Risk:**	- Operating Plan - Use of Resources - Financial Framework 2020/21	**BAF REF No:**	003/19
Principal Risk Description: What could prevent the objective from being achieved? Risk of financial delivery due to the radical change of the NHS Financial Framework associated with the current COVID pandemic		**Risk Open Date:**	01/04/2018	**Executive Lead/ Risk Owner**	**Director of Finance**
		Risk Review Date:	Feb-21	**Lead Committee:**	**FPPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
• Change in the national funding framework during COVID • Mid Year change in funding framework • Good financial management and governance not maintained • Allocation of resources via system mechanisms rather than based on activity volumes • Impact of revised operational targets (eg. P3 recovery / Winter & COVID Resilience) • Dilution of financial understanding and knowledge within divisional teams • New operational structures weakening traditional arrangements for strong financial control	• Significant increase in costs above funding levels • Financial balance not maintained • Failure to track expenditure causation • Unable to invest in service development • Challenge in tracking spend for regulatory and audit purposes • System funds allocated on differential basis • Spend committed recurrently in response to non recurrent circumstances • Breakdown of regular financial / business performance meetings • Weakening of traditional balance between - Finance / Performance & Quality	**Inherent Risk** (Without controls):	4	5	20	
		Residual/ Current Risk:	4	4	16	
		Target Risk: (Time frame TBC)	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Regular Monthly financial reporting arrangements in place • COVID expenditure tracking and approval processes in place • Recruitment approval mechanisms in place • Financial appraisal and pre-emptive agreement of winter pressure and P3 programmes • Attendance at regular national, regional and ICS DOF briefing and	• Monthly Finance Reports to FPC, Board and Divisions (L1) • Monthly cash reporting to FPC / Trust Board and NHSI(L2) • COVID governance and reporting briefing to FPPC • COVID financial planning updates to monthly FPPC and Exec Committee • Monthly Accountability Framework ARMs including Finance (L1) • Bi-Monthly Financial Assurance Meetings & PRM with NHSE (L1)	• Internal Audit Programme in place for 20/21 - re: key financial controls - substancial assurance • Delivery of 2019/20 financial plan and unqualified opinion on the Annual Report and Accounts. • NHSE and ICS review and approval of financial		• I&E delivery against financial plan • Cash balances maintained within prescribed limits • Capital spend to be

• Attendance at regular national, regional and ICS DOF briefing and engagement sessions • Suite of weekly internal Finance SMT meeting to track financial delivery and governance issues • Mth 1-6 and M7-12, internal budget frameworks in place • Strong framework of BI financial reporting tools deployed to track and monitor delivery • Weekly Demand & Capacity meetings to track P3 delivery achievement and associated PAM meetings to support accurate and comprehensive activity capture • MVCC Due Diligence meeting, plus Critical Infrastructure meeting • Implementation of Divisional Finance Boards to promote strong financial governance - Financial Planning 2021/22 & including ICS developments to FPPC in January 21.	• BI- Monthly Financial Assurance Meetings & PRIM with NHSE (L1) • Regular Data quality and Clinical Coding updates to PAM and AC (L2) • Weekly D&C activity tracking meetings • Forecast activity and winter planningbed model in place linked to M7-12 financial plan • Internal Audit review programme	• NHSE and ICS review and approval of financial plan - IA - COVID 19 Finanical Governance - Substancial assurance - Nursing bill analysis to FPPC January 21		• Capital spend to be maintained within approved levels • Temporary staffing spend to be maintained within agreed threshold

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:** Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
• Inconsistent delivery of routine budget management meetings across divisions • New divisional financial management arrangements still be to deployment • Variable capture and escalation of winter and in year cost pressures • Weak temporary staffing control environment in respect of medical and nursing staffing • Consistent communication and briefing of the COVID financial framework to divisional teams at a detailed level.	• Impact of COVID and revised future funding frameworks on Trust financial sustainability strategy • Embedding of core financial and business competencies within divisional teams • Clarity in respect of NHS contract and business arrangements for 21/22 • Impact of the Implementation of 'ENHT Way' as a means of delivering future financial savings - Assurance in respect of the delivery of the 20/21 winter bed plan within agreed parameters, with the associated risk of additional unplanned costs	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
Presentation of M7-12 financial framework to FPPC and Trust Board	Director of Finance	Oct	Completed - NHSE approval of plan pending for November	completed
Divisional Financial Management arrangements to be reviewed and implemented	Director of Finance / MD's (Planned & Unplanned)	Nov	Revised arrangements presented and approved at Nov DOG meeting. Implementation to proceed	In Progress
Development of Service Line Management arrangements	Director of Finance / MD's (Planned & Unplanned)	Q4	Action Plan update to December DOG meeting	In Progress
Review and Refresh of the Trust Financial Sustainability Strategy	Director of Finance	Q4	Progress Report to FPPC	In Progress
Continue to develop BI and support divisions / directorates using effectively	Director of Finance	Ongoing	Ongoing embedding and further development of dashboards and data sets development	In progress
Business Planning Guidance for 20/21 to be agreed and implemented	Director of Finance	Q3	Paper outlining arrangements to Nov Exec Committee and FPPC	In Progress

Summary Narrative:

October 2020: Review of the risk undertaken by Director of Finance. Risk remains a 16 timeframe for reaching target risk remains under review.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2020-21

Strategic Aim:	**Quality: To deliver high-quality, compassionate services, consistently across all our sites** **Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term**				
Strategic Objective:	e) Safely recover operational performance affected by the COVID-19 pandemic b) Improve patient outcomes, experience and efficiency by enhancing specialty-level inpatient care g) Harness innovation, technology and opportunities for new models of care to right size and optimise our capacity to meet demand	**Source of Risk:**	Business Plan, Clinical Strategy	**BAF REF No:**	004/20
Principal Risk Description: What could prevent the objective from being achieved? Updated December 2020 There is short term risk of spending the capital allocation for 2020/21 and a longer term risk of the availability of capital resources to address all high/medium estates backlog maintenance, investment medical equipment and service developments		**Risk Open Date:**	01.03.18	**Executive Lead/ Risk Owner**	**Director of Finance**
		Risk Review Date:	Feb-20	**Lead Committee:**	**FPPC**

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
• Lack of available capital resources to enable investment • Weakness in internal prioritisation processes • Weak in year delivery mechanisms to ensure commitment of resources • Weak assessment of the long term capital resources to meet strategic objectives • Requirement to repay capital loan debts • Volume of leased equipment not generating capital funding resources • COVID capital funding arrangements impact BAU capital requirements • Weak internal understanding of NHS capital funding arrangements • Poor internal business case development skills	• Aged equipments and assets - at our beyond lifespans • Increased associated risks to continuity and reliability of service delivery eg. Radiotherapy • Limited ability to invest in IMT, equipment and services developments • Limited innovation and associated limitations on ability to deliver efficiencies • Negative Impact on the potential to deliver the overarching Trust strategy • Annualised and sub optimal process of competitive short term bidding • Difficulty in expressing a coherent capital profile to external stakeholders eg. ICS / Region / DH	**Inherent Risk** (Without controls):	4	5	25	⟺
		Residual/ Current Risk:	4	5	20	
		Target Risk:	4	4	16	

Controls / Risk Treatment: (Preventive, Corrective, Directive or Detective)	Assurances on Control (+ve or -ve): Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	Positive Assurance (Internal or External) Evidence that controls are effective.	Positive Assurance Review Date	Key Performance Metrix aligned to IPR
• Six Facet survey undertaken in 17/18 • Capital Review Group meets monthly to review and manage programme spend • CRG Prioritising areas for limited capital spend through capital plan • Fire policy and risk assessments in place • Asset Register Maintained by the Finance Department	• Report on Fire Safety to Executive Committee (L2) • Monthly Capital Review Group (CRG meetings) feeding into FPC and Exec Committee (L1) • Report on Fire and Backlog maintenance to RAQC(L2) • Reports to Health and Safety Committee (L2) • Capital plan report to FPPC (L2)	• External Audit process reviews the appropriate accounting and treatment of capital assets. • DH / NHSE review and approval of strategic business case schemes requiring funding	• Annual Accounts Review Process - Q4 and Q1.	

• Asset Register Maintained by the Finance Department • Mandatory training • Equipment Maintenance contracts • Monitoring of risks and incidents • ICS capital monitoring processes across the system • Directors of Finance and E&F meet weekly with teams to track and facilitate capital spend • Equipment review process to support covid 19 pandemic requirements • Implementation of the new Capital and Cash Framework • Detailed Qlikview Capital Monitoring Application in place • Bi weekly MVCC Critical Infrastructure group with stakeholders	• Capital plan report to FPPC (L2) • Annual Fire report (L3) • PLACE reviews (L3) • Reports to Quality and Safety Committee • Deep dive review of the risks and mitigations (December 2018) • Steering Groups in place to oversee strategic programme delivery eg. Vascular, Renal, Ward Reconfiguration & ED • New Monthly Fire Safety Committee established March (includes other sites) - Capital programme report, FPPC Dec 20 and Jan 21.		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:** Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
• Not fully compliant with all Fire regulations and design • No effective arrangements presently in place to monitor and control space utilisation across the Trust • No formalised equipment replacement plan or long term capital requirement linked through to LTFM and Trust Strategy • Weaknesses in Estates and facilities monitoring structures and reporting • Absence of Overarching site Development Control Plan	• Availability of capital through either internal or national funding sources • Awaiting outcome of capital bids submitted through COVID / national Funding streams • Implementation of the new capital and Cash Framework • Transparent mechanisms to access Section 106 funding • Long Term Capital Investment Plan to regulate investment	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Estates strategy to support the trust clinical strategy	Director of Estates and Facilities	Q4	Development to be reported via FPPC and Strategy Committee	Not yet started
ii) Develop capital equipment replacement plan	Deputy Director of Finance	Ongoing	Ongoing	In progress
iii) Develop programme for Charity to support with fundraising	Deputy Director of Finance / Head of Charities	Ongoing	Ongoing	In progress
iv) Agree capital investment for 2020/21 and monitor delivery	Executive	May 2020 and ongoing	Capital programme approved through FPPC in May 2020. CRG will monitor delivery. Regular monthly reports to FPPC. Director of Finance and Director	In progress
v) Review other sources of funding / opportunities for investment	Director of Finance / Project leads	Ongoing	Review processes in place to track NHSE response to COVID bids	in progress
vI) Undertake detailed space utilisation survey, implement revised strategy and then monitor	Director of Estates and Facilities / Improvement Director	Q4	Transformation workstream enabled to review space utilisation within Outpatients	In progress

Summary Narrative:

October 2020: Review of the risk undertaken by Director of Finance. Risk remains a 20 timeframe for reaching target risk remains under review.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2020-2021

Strategic Aim:	**Trust Strategic Aims:** **Quality: To deliver high-quality,compassionate services,consistently across all our sites this delivers best patient care** **Pathways: To develop pathways across care boundaries, where experience for our patients, their referrers, and our staff** **Ease of Use: To redesign and invest in our systems and processes to provide a simple and reliable** **Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term** **Aims from the Digital strategy:** **1. RECORD Invest in our systems to record clinical information electronically that is stored in single, digitally- secure, integrated record which is paper-free at the point of care reducing repetition and improving safety, using fit for purpose equipment, networks, patient-facing technology and 'Internet of Things'** **2. SUPPORT Provide staff with easy to use, complete and up-to-date, high quality clinical information, and access to clinical decision- making tools and guidelines, enabling clinicians to consistently deliver best practice care** **3. SHARE Enable better co-ordination of pathways of care across a portfolio of services by sharing (with informed consent) clinical information with the patient and other care professionals involved in the patient's care, both within the Trust and the wider health and social economy**

Strategic Objective:	**Trust Objective: a) Enhance clinical leadership and service line delivery to further improve service quality, safety and transformation b) Improve patient outcomes, experience and efficiency by enhancing specialty-level inpatient care c) Support our people to feel valued and fully engaged to maximise their efforts to deliver quality and compassionate care d) Develop a future vision for the Trust's cancer services and support work with partners to transfer MVCC to a tertiary provider e) Safely recover operational performance affected by the COVID-19 pandemic g) Harness innovation, technology and opportunities for new models of care to right size and optimise our capacity to meet demand** **Digital Objective: The design and delivery of a Digital programme to support the Trust clinical strategy**	**Source of Risk:**	Digital Programme/ Strategy	**BAF REF No:**	005/20
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the digital programme is delayed or fails to deliver the benefits, impacting on the delivery of the Clinical Strategy		**Risk Open Date:**	Jun-20	**Executive Lead/ Risk Owner**	**Chief Information Officer (CIO)**
		Risk Review Date:	Feb-21	**Lead Committee:**	**Strategy Committee**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Staff Engagement / Adoption Lack of Clinical/Nursing/Operational engagement in system design - reduces likelihood of system adoption Lack of Clinical/Nursing/Operational adoption of digital healthcare creates innefective process which can introduce clinical risk **ii) Financial / Resource Availability** Failure to resource its delivery within timescales Trusts may not be in a position to finance the investment (including Lorenzo renewal 2022) **iii) Business Risk** IT resources may get diverted onto other competing Divsional projects **iv) Knowledge & Experience** Delivery team does not have the appropriate experience/knowledge to implement	i) Unable to deliver the Clinical strategy ii) Unable to deliver target levels of patient activity iii) Unable to meet contractual digital objectives (local, national, licience) iv) adverse impact on performance reporting	**Inherent Risk** (Without controls):	4	5	20	
		Residual/ Current Risk:	4	3	12	
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**		**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**

Staff Engagement Risk: Digital steering group(Consultant led design focus) and IT steering Group (Project Led delivery led) are in place for project Governance, prioritisation and to support clinical engagement **Business Risk:** CIO is member of the executive team and CIO/CCIO have an agenda item on at the Private board to ensure board members are apprised of progress and risks. **Financial / Resource Availability Risk:** Finance and PMO to be involved throughout the Business case process **Financial / Resource Availability Risk:** Business case identifies resourcing from the Divisions and makes provisions for back-fill where appropriate **Knowledge & Experience Risk:** Key roles (Programme Director, Procurement consultant, Architect etc.) are identified and recruited at and early stage an retained. New Performance Delivery Framework Clinically led workstreams feeding into the Digital Steering Group (model from EPMA) Digital roadmap to 2022, with 2020/21 priorities (July 2020)	• Reports to Executive Committee,Strategy Committee and Board (L2) • Weekly Executive monitoring(Where appropraite) aligned with clinical strategy - staff engagement acorss all sites, at all levels during COVID 19 adopting new many technologies for communication and service delivery Transformation DOG - Strategy for "Evolving our technology" , including road map to 2022 presented to Strategy Committee, Feb 2021.			
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**		
ii) Poor attendance from stakeholders at the Digital steering group ii) Availability of capital to deliver priorities iii) No long term digital plan beyond 2022 (Contractual end date for Lorenzo) iv) Key Digital roles not recruited to. v) Integration into Divisional planning for resource management delivery of tachical solutions to delivery the five priorities rather than the digital road map NHS I/ D/ X expection that we implement with little time and enable of - systems / timeface to enable local scruitinty	Publication of the roadmap and measures of progress Availabilty of funding to support delivery Recuitment strategy DSO and IGM capacity to support the DPIA processes	Green	Effective control is in place and Board satisfied that appropriate assurances are available	
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient	
		Red	Effective controls may not be in place and assurances are not available to the Board.	

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Publish Digital roadmap and engage with CAG to ensure each Project board has a clinical chair. Programmes only commence with appropaite stakeholder engaement	CIO	Jul-20	Approved by FPPC in July 2020. Strategy for "Evolving our technology" , including road map to 2022 presented to Strategy Committee, Feb 2021.	In progress
ii) Seek investment through ICS where available	CIO	Dec-20	on going . 250k awarded to Trust in february 21 to develop a detailed strategy and application for Digital Aspirant Programme	In progress, Complete
iii) Long term Lorenzo strategy/commercials to be finalised	CIO	Jan-21	Position paper to FPPC in July 2020	

iv)Complete IT workforce review and actively engage in the martket with HR support for recruting good candidates at pace.		Aug-20	Recruitment in progress - on track with recuirtment schedule - made offers by end of month. Key post holders taken up post / commencing.	Complete
v Implementation of a Business partner process (Post Silver)	CIO	Jul-20	recruitment process on track - end of year	In progress
vi) Relaunch of EMPA roll out		Aug 20	Training and rollout plan recommenced and on track. Paused due to Covid surge 2.	In progress
Summary Narrative:				
October 2020: Review of the risk undertaken with CIO. Risk reduce to 12. Current focus is delivery of tatical solutions to delivery the five priorities for year end rather than the approved digital road map and longer term clinical strategy; accepting initial risk to the delay to the digital road map and clinical strategy. Continues under review at FPPC and operationally via transformation and performance delivery oversight group. February 2021: Lead oversight committee now the Strategy Committee. The Committee endorsed the enh digital roadmap to 2022 and evolving technology platform.				

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2020-21

Trust Strategic Aim:	**Pathways: To develop pathways across care boundaries, where this delivers best patient care and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term**				**Ease of Use: To redesign**
Trust Strategic Objective:	**h) Play a leading role in developing sustainable and integrated services through the ENH Integrated Care Partnership and ICS**	**Source of Risk:**	National directives	**BAF REF No:**	Risk 006/20
Principal Risk Decription: What could prevent the objective from being achieved? ICP/ICS partners are unable to work and act collaboratively to drive and support system and pathway integration and sustainability		**Risk Open Date:**	01-Apr-20	**Executive Lead/ Risk Owner**	**Director of Strategy**
		Risk Review Date:	Feb-21	**Lead Committee:**	**Strategy**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Lack of effective collaborative system leadership ii) Executive, clinical and operational leadership and capacity iii) Ability of the ICP to effectively engage primary care iv) Lack of synergies between ICS and ICP strategic development and priorities iv) Lack of risk and benefit sharing across the ICP iv) Unweildy ICP governance arrangements	i) Failure to progress. Lack of strategic direction and modelling of collaborative leadership ii) Slow pace of ICP development and transformation of pathways. Perpetuautes inefficient pathways. iii) Primary care is not effectvely engaged in the development of the ICP impacting the scope and benefits of integration iv) Unwillingness or inability of organisations to adopt new pathways / services because of contractual, financial or other risks v) Impedes the paceand benefits of transformation	**Inherent Risk** (Without controls):	4	4	**16**	
		Residual/ Current Risk:	4	3	12	
		Target Risk:	4	2	8	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• ICP Partnership Board Building on the successful system working in response to the pandemic • ICS CEO bi-weekly meeting ICS Chairs' meeting • Vascular Hub project with West Herts and PAH • ENH improvement methodology • Integrated discharge team • OD support for ICP development • Joint QIPP/CIP approach for 20/21 Enabling workstreams with nominated lead Executive Director representative Development Director in post	Reports to Board and FPC Reports to ICS CEOs' Reports to Partnership Board Reports to ICP CPex and TDG ENH ICP Update report to Strategy Committee and Board - strategic objectives and implementation plan Pathology Procurement report, Dec 20 Vascular Services deep dive Dec 20			

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
• Partnership Board Scope for accelerated development of ICP and governance arrangements that support transformation at pace • Need to agree 20/21 priorities for transformation Need to commence pan-organisational improvement work Need to identify clinical leadership capacity to drive greater pan	Availability of population health data to inform priorities for transformation and improvement Partnership Board to commence Trust COO representaton at the ICP Transformation and development group to enable integrated pathway redesign. Assurance that ENHT voice fully represented by ICS in key discussions e.g. satellite	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient

system understanding of services and pathways and associated improvement work Need to influence and understand future ICP relationship with ICS Identification of dedicated capacity support ICP collaboration ICS Pathology Procurement delay of 6 months	radiotherapy. To be discussed at CEO level	Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Establish an effective ICP Partnership Board, governance and shared strategic direction	Director of Strategy	Ongoing	First meeting scheduled for 23 June 2020. Initial ICP governance being reviewed to support reset and build on pandemic response . Aug-20 : Partnership Board has reviewed and confirmed streamlined governance to support clinical leadership and delivery. Development of ICP strategic framework to be informed by population health data work underway. Nov-20: ICP PB continuing to be well attended and supporting the development of ICP-wide leader. Partnership Board has agreed ICP priorities for remainder 20/21. Population health data to be used to develop strtaegic framework and priorities when available. Dec-20: ICS commencing PHM development learning sets to commence in Q4 to facilitate PHM development in HWE and ENH.	In progress
ii) Agree and deliver system approach to building on collaboration and service transformation during pandemic response	Director of Strategy/ COO	Ongoing	Adaptation of pre pandemic ICP governance to support agile approach to collaboarative transformation to be considered by Partnership Board together with recomendations for reconfirming/ refining clear ICP strategic direction and priorities informed by population health data. Aug-20: ICP involvement in Phase 3 recovery planning - the trust is looking to ICP partnership to support delivery of recovery activity to help meet the needs of the community we serve. Nov-20: Winter and surge resilience planning being undertaken across the system with evidence of strong committment to partnership working. Positive early examples of joint working eg prevention of admission. Dec - 20: pandemic surge response is being supported by maturing system relationships and identifying opportunities eg enhance POA, virtual wards etc. Feb 21: Good cross organisational work with development of virtual covid ward to assist with reduced LOS in acute.	In progress
iii) Confirm and implement ENH improvement methodology across ICP	Director of Improvement	Ongoing	Aug-20: The Director of Improvement s leading the ongoing development of the ENH way internally - this is being adopted for capacity and demand work informing specilty recovery plans. He also expects to work with the newly appointed ICP Development Director to support the adoption of a consistent improvement approach across the ICP, supported by ICP collaboration. Nov-20: ENH Way launched 13/11/20 . Preventation of Admission project being jointly led and supported by ENHT and HCT.	In progress
iv) Identify clinical leadership capacity to support the development of collaborative, ICP integrated pathways	Medical Director/Director of Nursing	Ongoing	Under consideration in order to align with planned operational restructure. Aug - 20: The Executive Committee agreed that the restructure of the Medical Director's office would not include a deputy medical director for integration role currently due to affordability. Alternative ways of identifying and releasing clinical capacity to foster pan organisation clinical integration and pathway development are being explored. Nov-20: New Divisional structure commenced Nov-20. Clinical leadership appointments in progress.	In progress
v) Develop and agree contractual mechanisms/behaviours which support collaboration and system-wide integration whilst minimising adverse impacts on individual organisations	Director of Finance	Ongoing	Nov-20: Expected changes to secondary care funding in 21/22 under consideration. ICS DoFs group leading on this. Feb-21: Discussions ongoing regarding future model	
Summary Narrative:				

Aug -20: The Trust is increasingly seeking to engage ICP partners to develop a collaborative approach to meeting patients' needs. Whilst the ICP Partnership Board and supporting gvernance is at an early stage, the Trust is committed to supporting its clinical and operational staff to engage with this, enabled by a restructure of the Operations Directorate, led by the Chief Operating Officer, Medical Director and Director of Nursing .
October 20: Risk discussed and reviewed with Director of Strategy, including the risk likelihood score using the new standardised methodology. Risk remains at '12'. Rationale: The pace of ICP development and transformation of pathways is currently slow and impeded by the COO unable to attend

the ICP Transformation and Development Group - changing of the time to enable this is currently being consulted on; once resolved (approx December), it is anticpated that the risk can be reduced to the target risk of '8'. This also takes into account that the Development Director is now in post and Executive Directors have been nominated to support the enabling workstreams.
Nov-20: Positive evidence seen of continuing development of shared ICP awareness, agreement of short term priorities and the beginnings of jointly owned improvement work.
Jan-21 and Feb-21: surge in covid numbers is encouraging good collaborative working around prevention of admissions; vaccination planning also supporting joint working.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2020-21

Strategic Aim:	**Quality: To deliver high-quality, compassionate services, consistently across all our sites**				**Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term**
Strategic Objective:	**a) Enhance clinical leadership and service line delivery to further improve service quality, safety and transformation c) Support our people to feel valued and fully engaged to maximise their efforts to deliver quality and compassionate care f) Work with partners to meet the health and care needs of our community through and beyond the COVID-19 pandemic g) Harness innovation, technology and opportunities for new models of care to right size and optimise our capacity to meet demand h) Play a leading role in developing sustainable and integrated services through the ENH Integrated Care Partnership and ICS**	**Source of Risk:**	Strategic Objectives External reviews	**BAF REF No:**	**007/20**
Principal Risk Decription: What could prevent the objective from being achieved? **There is a risk that the Trust's governance structures do not enable system leadership and pathway changes across the new ISC/ICP systems whilst maintaining Board accountability and appropriate performance monitoring and management to achieve the Board's objectives**		**Risk Open Date:**	01.04.2020	**Executive Lead/ Risk Owner**	**Chief Executive**
		Risk Review Date:	Feb-21	**Lead Committee:**	**Board**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) In effective governance structures and systems - ward to board ii) Ineffective performance management iii) ineffective staff engagement iv) Impact of covid 19 pandemic outbreak	i) risk to delivery of performance, finance and quailty standards ii) risk of non compliance against regulations iii) risk to patient safety and experience and outcomes iv) reputational risk	**Inherent Risk** (Without controls):	4	5	**20**	⇕
		Residual/ Current Risk:	4	3	12	⇔
		Target Risk:	4	2	8	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Monthly Board meeting/Board Development Session/ Board Committees • Annual Internal Audit Programme/ LCFS service and annual plan • Standing Financial Instructions and Standing Financial Orders • Each NED linked to a Division (from January 2018) • Commissioned external reviews	• Commissioned external reviews – PwC Governance Review September 2017 NHSI review of Board and its committees 2019 • Visibility of Corporate risks and BAF as Board Committees and Board (L2) • Internal Audits delivered against plan, outcomes report to Audit Committee • Annual review of SFI/SFOs (L3)	Internal Audit report - risk management , performance framework, IG 2019 NHSI Infection control review - green - June 2019 Review of progress with QTP workstreams with NHSI/CCG - June 2019. Internal Audit - Surgical division governance - reasonable		

• Review of external benchmarks including model hospital , CQC Insight– reports to FPC and RAQC (QSC) • Board Assurance Framework and monthly review • Performance Management Framework/Accountability Review meetings monthly • Integrated Performance Report reviewed month at Trust Board, FPC and QSC - Quailty dashboard / compliance dashboard CQC steering group and action plan 2019/20 action plan to deliver the Trust strategy -Strategic programme board and trsut board monitoring - Safer sharps group - Daily Covid group, policies, pods in situ on Lister and QEII sites. Incident gold/silver command structure in place from mid March 2020 and reviewed weekly to ensure meets organisaitonal needs - Reviewed Board and Committee Governance structures approved in March 20 New weekly Quality Assurance meeting established in April - chaired by DoN/MD - supported by Compliance team and dashboard. (to support interim governance arrangement and quailty oversight durign pandemic) - transitioning back to BAU committees Sept - Nov Central record of contract / pathway reviews and agreed changes Record of national / regulatory changes and trusts response Delivery framework implemented in September 2020. Partnership Board and ICP Board and groups established and link to divisional structures	• Annual review of board committee effectiveness and terms of reference (May-July) (L3) • PwC Governance review and action plan closed (included well led assessment) (L3) • Annual governance statement (L3) • Counter fraud annual assessment and plan (L3) • Annual self-assessment on licence conditions FT4 (L3) • CQC Inspection report July 2018 –(overall requires improvement) and actions plan to address required improvements and recommendations (L3 -/+) • Use of resources report July 2018 – requires improvement (L3 _/+) • September 2018 Progress report on CQC actions and section 29a (L2 +) to CQC & Quality Improvement Board • Annual review of RAQC to Board (L2 +) • Internal Audit Report – Assurance and Risk Management (- reasonable assurance (L3) • Board development session on Risk and Risk Appetite, Feb 2019 • Internal Audit – Performance Framework report - reasonable assurance March 19) - Internal Audits 2019/20 scheduled for Data Quailty; Divisional Governance; HSE improvement notices on Sharps, Violence and aggression and moving and handling (-ve) Action plan in progress of delivery - Desktop reivew of Pandemic Flu plan scheduled for February 20 - Major incident structure and documentaion - log books, action logs, minutes RIDDOR reporting	assurance - July 2019. CQC Inspection report 2019 - Requires Improvement overall - UCC and surgery improved to requires mprovement. CYP achieved good. MVCC retained requires improvement. 6 monthly Quailty Account progress reported to QSC November and Board in January. Deep dive reviews on QI areas to QSC in December. Business continuity - compliant assessment validated 2019 Risk and Assurance Internal Audit - reasonable assurance May 20: Review of Major incident structures June 2020- Unqualified opinion on the Annual Report and Accounts June 2020- ICP BAF reviewed at QSC IPC BAF presented to QSC CQC review of IPC BAF July 2020 - assuranced on all ten KLOE CQC assurance on Medicines Management during COVID Postive feedback from ICO regarding an enquiry August 2020 Internal Audit - substancial assurance - HSE action plan HSE closure of COVID riddor. - Staff deployment safety and governance to Board January 21 Internal Audit - substancial assurance on Covid Financial Management; Core Financial Systems Internal Audit: BAF - substancial assurance	CQC IPC review July 2020	
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
Effectiveness of governance structures at ward to Divisional level • Fully embedding Performance Management Framework/Accountability Framework • Implementation of Internal Audit Recommendations • NHSI Undertaking January 2019 / CQC section 29a warning - surgery and QEII UCC - HSE Improvement notices received on V&A, MSD and sharps in October 2019 - Number of previous meetings - stepped down to support major incident (covid pandemic) - The Trusts existing clinical strategy is no longer appropriate to manage emerging risks and system changes	• Embedded risk management - CRR and BAF • Embedding effective use of the Integrated performance report • Evidence of timely implementation of audit actions • Consistency in the effectiveness of the governance structure's at all levels • Capacity to ensure proactive approach to compliance and assurance • Oversight of GIRFT programme and other exteranl reviews and follow up - follow up investigations on V&A and Sharps incidents - MH equipment - review and replacement programme - specialist training	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Monitor delivery of Risk Management implementaion plan 2020/21	Associate Director of Governance / Risk Manager	ongoing	Monthly reports to Board committees . Current capacity issues. Good divisional and directorate active engagement with the Risk Register. Risk clinics being established Sept/Oct to review 20+ risks and implement the scoring methodology for the likihood of the risk materialising. December 2020: IA review of BAF and Clinical Risk Registers in progress. Annual review of the RM strategy commenced. draft Internal Audit report for clinical risk management - reasonable assurance . BAF review is substancial assurance,	In progress
ii) Consider independant well led review in line with the national guiidance	Associate Director of Governance / Trust Secretary	Nov-20	Previous external review 2017 (best practice - 3 yearly). Examples of other trust reviews collated. Considering for Q2 2021/20 to test the effectivness of the new governance structures. Delayed due to Covid. CQC vitual well led assessment due in March 2021.; gap anaylsis underway.	In progress
iii) Review of governance structures in line with the Divisional Restructure	Associate Director of Governance / DCOOs	Nov-20	In progress. - Phased approach. Initial structures in place and these will be reviewed in 21/22.	In progress

iv) Review and implement the compliance framework	Associate Director of Governance	Oct-20	Rephasing the implemenation of the compliance framework - commence testing the audit tools for the fundimental standards in June. 50% review of table top fundimental standards completed to date. Review of compliance framework in line with CQCs new Transitional Regulatory Approach.	In progress
v) Review of governance with ICS/ ICP	Trust Secretary and Associate Director of governance		Partnership Board established. ICP structures in place, linking to Divisional structures	In progress
v) develop and implement action plan to address HSE findings and improvement notices	Associate Director of Governance	January 2020 - action plan to HSE July 2020	Action plan under development. Scheduled to present draft action plan to Executive Committee through to QSC in November/December. Trust partnership engaged. Action taken 23.10.19 to have a security officer in the ED 24/7 with immediate effect. Reviewing H&S structure to support a more proactive service across the Trust. Meeting with HSE January 2020 and updated action plan submitted, revised compliance timelines agreed. Monitoring delivery . End April - Evidence submission to HSE to consider compliance with the V&A and Sharps improvement notices - awaiting outcome. On track for compliance with M&H at end July. Testing of actions to ensure implemention is in progress and onoing. Awaiting outcome from HSE following submission of evidence. 100% compliant with sharps and V&A actions. 4 open actions for M&H to ensure actions embedded re training but not part of the core improvement notice. - Internal Audit review = substancial assurance	In progress
v) Review of strategic decision making during pandemic outbreak against the legal framework / advice - and ensure clear audit trail	Associate Director of Governance	end of May 2020 - revised to June	In progress. For discsussion at Audit Committee. Review of aspects of governance -in COVID surge 2 - governance structures/ redeployment / performance .	Completed
vi)Review of Performance framework and meeting structures to support delivery of the Trust Objectives	Executives	Jul-20	Financial Governance Proposal presented to FPPC in May 2020. Review of Performance framework and supporting meeting proposal to Executive Committee 4 June 2020. Revised delivery framework approved by executive - for Board approval in July. Followed by review of supportive meeting strucutres . Strategy Committee established in November 2020.	In progress
vi) Review Board members visibility and mechanisms of assurance outside of the meeting structure during the pandemic / restart	Trust Secretary and Associate Director of governance	Aug-20	Plans agreed with Chair and NEDs, including attendance at interviews, flex /rotation of attendance in person /virtual for Board and Committees - supporting social distancing and visits. Remains under review	in progress
vii) Implementation of the Strategic Planning Framework and Integrated Business Plan Structure	Deputy CEO/ Director of Strategy	Q2	Implementation of the Strategic Planning Framework and Integrated Business Plan Structure presented to Strategy Committee in February 2021; recommended to Board for approval.	In progress
Summary Narrative:				
October 2020: Risk reviewed and discussed with the Director of Nursing and reduced to 12- taking into account the assurances and frequency scoring matrix.				

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2020-21

Strategic Aim:	**Quality: To deliver high-quality,compassionate services,consistently across all our sites which retains staff, recruits the best and develops an engaged, flexible and skilled workforce boundaries, where this delivers best patient care** **People: To create an environment** **Pathways: To develop pathways across care**
Strategic Objective:	**a) Enhance clinical leadership and service line delivery to further improve service quality, safety and transformation** **b) Improve patient outcomes, experience and efficiency by enhancing specialty-level inpatient care** **c) Support our people to feel valued and fully engaged to maximise their efforts to deliver quality and compassionate care** **f) Work with partners to meet the health and care needs of our community through and beyond the COVID-19 pandemic g) Harness innovation, technology and opportunities for new models of care to right size and optimise our capacity to meet demand** **h) Play a leading role in developing sustainable and integrated services through the ENH Integrated Care Partnership and ICS**

Source of Risk:	Objectives Quailty Assurance data / CQC Inspection	**BAF REF No:**	**008/20**
Risk Open Date:	01/03/2018	**Executive Lead/ Risk Owner**	**Chief Nurse/ Medical Director**
Risk Review Date:	Feb-21	**Lead Committee:**	**QSC**

Principal Risk Decription: What could prevent the objective from being achieved?
There is a risk that the Trust is not always able to consistently embed a safety and learning culture and evidence of continuous quality improvement and patient experience

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Lack of consistant approach to quality improvement. 1. Preliminary plans to develop a culture of continuous quality imporvement skiills imbedded wihtin a stregethiend capablity & capacity infrastructue ii)Limited staff engagement 2. Capturing and pro-actively providing ontinous leanring opportunies require more structred strategy and deployment iii) Inconsistent ward to board governance structures and systems 3. Current governace structrues requires strengthening to reliably seel assurance of	1) Limited learning oppurtunites from current and future continuous quality activities 2) Poorer patient and staff expereince 3)Limited leadership development of all staff 4) impact on reputation iv) increased regulatory scrutiny	**Inherent Risk** (Without controls):	5	4	20	⇔
		Residual/ Current Risk:	5	3	15	
		Target Risk:	5	2	10	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Reports to QSC (L2) • Quality review meetings with CCG (L2) • Divisional Performance Meetings (L2) • Clinical effectiveness/ Patient Safety/Patient Experience Committee/ Health and Safety Committee reports (L2) • Nursing and Midwifery Executive Committee	• Clinical effectiveness committee / Patient Safety Committee/ Patient Experience Committee • Accountability Framework • CQC Engagement meeting • Increased Director presence in clinical areas • SIs and Learning from death investigations	• NHSI Infection control review June 2019 - Green • CQC Inspection report 2019 - Requires Improvement overall - UCC and surgery improved to requires improvement. • CYP achieved good. • MVCC retained requires improvement. • 6 monthly Quality Account progress reported to QSC November		

• Invasive procedure Clinical Group • Monitoring of new to follow up ratios through OPD steering group and access meetings(L2) • Peer Reviews (L3) • Audit Programme (internal and external) (L3) • Quality Strategy reports and Quality Improvement deep dives to QSC • CQC Inspection report July 2019 –(overall requires improvement) and actions plan to address required improvements and recommendations (L3) • NHSI Infection control review June 2019 - green (L3) • Quality Dashboard / Compliance dashboard • Internal Audit scheduled , Clinical audit and effectiveness procsses, Patietn safety incndent management. • RCN Clinical Leadership Programme • Pathways to Excellence Programme • Harm Free Care Collaborative • Deteriorating Patient Collaborative (Quality Improvement Break through Series Learning Collaborative) New Quality Assurance Meeting - weekly - chaired by DoN/MD supported by complaince team and dashboard. PPE clinical advisory group Covid risk assessments Covid Track & Testing Clnical Advisory Group Covid skills & training faculty Continuous Quality Patient Co-design forum Weekly Quality Huddle Recruitment of Quality Excelllence Matrons & Pathway to Excellence Programme Manager Quality Assurance Board and dashboard . Mental Health Strategy Group / Discharge Group - Jan 21 Ethics committee/ Panel and Policy reestablished	• Serious Incident Review Panel • Strengthened TIPCC membership and ToRs • Quality and safety visits • Medication safety quality peer reviews • Safety huddles • Quality Huddles (bi-weekly) • Policies and procedures • Quality Strategy updates • Divisional Quality Manager posts in each division • Weekly review meetings of CQC improvement plans • Clinical Harm Review Panel (Weekly) • Invasive Procedure Clinical group (safer Surgery Collaborative) • Recruitment and deployment of Quality Improvement team • Deteriorating Patient Quality Improvement Collaborative • Harm Free Care Collaborative • Thrombosis committee • Safer Sharps Committee • Appointment of Associate Medical Director for Quality Improvement & Safety • Recruitment of Improvement Director Patient experience feedback - new mechanisms and quartely review. Reduction in outstanding complaints and SI's Internal Audit Programme Joint meeting Quailty Oversight Meeting with NHSI, CCG and CQC bi monthly Action plans from Mental Health Strategy Group / Discharge Group	and Board in January. • Deep dive reviews on QI areas to QSC in December. • Quality Improving team KPis • Successful compleition of intial 2 waves of Pathway to Excellence achievements, and planning of wave 3 underway. • Sustain reduction cardiac arrest rates 7 day services - internal audit - reasonable assurance - Internal Audit - Clinical Audit (Substancial assurance) July 2020 - Internal Audit - SI's (reasonable assurance) July 2020 - CQC review of IPC BAF - compliant with all 10 KLOE - July 20 - CQC - positive medicines management review - covid 19 focused, Aug 20. - ICP BAF Update and assurance on 10 key actions to QSC Dec 20. - Maternity - assurance on Kirkup report to QSC Dec 20 - Learning from deaths - key metrics benchmark in as expected. - Staff deployment safety and governance to Board January 21		
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**		
• National guidance and GIRFT Gap analysis identifies areas for improvement • Consistency with procurement and engagement with clinicians • Patient safety team capacity • Gaps in compliance with IPC Hygiene Code leading to C-difficile outbreak in April 2018 and MRSA bacteraemia in May 2018 • Gap in compliance with CQC standards warning notice section 29A – Surgery Lister and UCC QEII Complex discharge pathway 3 Never events were reported in Q3 the SI reports are all being undertaken. Dec 20 PFD recieved from Coroner (Maternity SI) - Increased number of Mental Health Patients presenting	• Consistency in following care bundles • Implementation and tracking of action plans related to GAPS associted with National Audit & NICE guidance, GIRFT recommendaions, NatSSIP Audit compliance • Embedding of learniing from SIs/Learning from Deaths • Data quality • Delivery against CQC improvement plan - Delivery of harm review process following COVID impact on 52wk waits , follow up and survielience - Effectivness of Pathway for safe discharging of complex patients - complaints and referals - Assurance on Ockenden Report recommendations and PFD (Maternity) - Availability of staff to agreed levels due to increased sickness due to COVID 19	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Delivery of the Quality Strategy Priotrities	Chief Nurse / Medical Director	ongoing	Improving Patient Discharges Group with 4 delivery workstreams established. Deep dive topics scheduled for QSC. Monitoring fornightly on QA Dashboard. New 'keeping in touch' programme and other initiatives to support patient experience	In progress
ii) Delivery and monitoring of CQC improvement plans for Surgery Lister and UCC QEII and other core pathways and emergency support programme requirements	Associate Director of Governance / Chief Nurse	ongoing	Full review of action plan with each pathway in July and August 20 ; outcome will be presented to QSC. Positive meetings with CQC re IPC and Medicines Optimisation under the CQC's ESP. Preparing for Medicine, Surgery and well led reviews under the transitional regulatory model.	In progress

iii) review of structures and mechanisums to support embedding learning across the organisation	Associate Director of Governance / Chief Nurse		In progress - QSC structures reviewed and remain flexible to support the pandemic. Compliance framework plan under review for Q3/Q4. Developing process to ensure duty of candour for hospital acquired / probable / contact with covid and SIRP process in line with national guidance.	In progress
iv)• Complete Gap analysis on GIRFT reports and develop and monitor action plans	Medical Director	ongoing	GIRFT visits continue and accumulation of actions currently being undertaken. Non-Exectutive has been identified to chair GIRFT oversight committee.	Started
iv) Implement 7 day services plan	Medical Director	ongoing	Report to QSC June 2019. Steering group established. Information gathering started against each 7 day standard and current baseline of PA allocation. Action plan revised to support delivery	In progress
Implement the pathways to excellence programme	Chief Nurse		Programme recommenced in July 2020, paused in surge 2 and due to recomence in March 2021.	In progress
Review of Quailty safety and governance structures (including meeting structures) to support delivery of Quailty Governancne across the organisation	Associate Director of Governance / Chief Nurse		In progress - work scheduled with the new teams. Under current review with Planned and Unplanned care. Review of Patient Safety forum underway for relaunch in April 2021.	In progress
Review harm review and mortality review processes due to increased demand following COVID	Medical Director / Associate Director of Governance	Aug-20	Mortality reviews recommenced and priorisied. Harm review process is under review to ensure clear oversight and governance and inline with the Royal College of Surgeons prioritisation guidance.- work is in parallel to workstream on capacity / demand and review and risk stratification of patients - 52wks, survielience and follow ups.	Inprogress
Summary Narrative:				
October 2020: Risk review independantly with the Chief Nurse and Medical Director and taking into account the recent never event (last one approx 18 months ago), review of the harm process in view of the impact of COVID on RTT, follow up and survielience, the discharge themes from complaints. Actions and improvement plans are in place to support improvement and transformaiton - supported by the ENH Way and Transformation Teams and Quailty Improvement Teams working together. Re alignment of the Divisional and operational structures will support quality governance. Medical directors office now being established under a revised structure. CD JD reviewed along with Clinical Governance and Audit Lead JD. leadership development for the new consultants and improved communications through a quarterly medical director news letter. Linking with workforce team re a hospital at night team review and support developments. Medical workforce oversight group and job planning /temp recruitmnt /group being reinstated. January 2021: 3 Never events were reported in Q3 the SI reports are all being undertaken to establish route cause and lessons learnt. Second surge of COVID is impacting on the ability to undertaken proactive reviews and audits. Monitoring staffing risks of no harm on a weekly basis alongside the medium and severe harms with the divisions. Increased number of mental health patients presenting - established MH strategy group.				

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2020-21

Strategic Aims: Sustainability, Quality, People	**We provide a portfolio of services that is financially and clinically sustainable in the long term. We deliver high quality, compassionate services consistently across all our sites. We create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce.**
Strategic Objectives: a,b,c,f,g,h	**Enhance clincial leadership and service line delivery to further improve service quality, safety and transformation. Improve patient outcomes, experience and efficiency by enhancing speciality-level inpatient care. Support our people to feel valued and fully engaged to maximise their efforts to deliver quality and compassionate care. Work with partners to meet the health and care needs of our community through and beyond the COVID-19 pandemic. Harness innovation, technology and opportunities for new models of care to right size and optimise our capacity to meet demand.**

Source of Risk:	strategic objectives	**BAF REF No:**	009/20
Risk Open Date:	Sep-20	**Executive Lead/ Risk Owner**	**Chief People Officer**
Risk Review Date:	Feb-21	**Lead Committee:**	**QSC, FPPC**

Principal Risk Decription: What could prevent the objective from being achieved? **There is a risk that our staff do not feel fully engaged and supported which prevents the organisation from maximising their effort to deliver quality and compassionate care to the community.**

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Staff not sufficiently involved in changes that affect or impact them. ii) Organisational failure to invest in line manager skillset/capability. iii)Management style/actions may not enable staff engagement or empowerment. iv)Organisational failure to drive inclusivity, so some groups feel they cannot make their voice heard. v)Staff may not be able to access the support or training they need to develop in their role.	i) Quality and Safety Improvement Culture is not fully achieved ii) Opportunities for improving patient care are missed iii) Staff leave the Trust, resulting in higher recruitment costs, loss of skills, talent, organisational memory, and increased focus on induction rather than on staff development.	**Inherent Risk** (Without controls):	4	4	**16**	
		Residual/ Current Risk:	4	4	**16**	
		Target Risk: **(March 2021 and then review longerterm target risk)**	4	3	**12**	

Controls/ Risk Treatment: **(Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
i)Trust People Strategy designed to offer mitigations to this risk. Ii) All staff are expected to embody PIVOT values. Iii)Trust policies such as Dignity and Respect Policy and Raising Concerns Policy provide route for staff to voice concerns. iv) Freedom to Speak up Guardian can support staff to make their concerns known, so that the organisation can respond to those concerns. v)Staff Experience Group and Divisional Forums provide space for constructive dialogue with staff to impove staff engagement/experience. vi) Education Board provides means to drive forward new approaches to education and development for all staff.	i) Staff surveys, including quarterly Pulse survey ii) Monitoring of trends via reports to Trust Board and accountability through scrutiny at Trust Board. iii)Monitoring of level of challenge through application of staff policies, for example from under-represented groups.			

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
i)Failure to review and update some staffing policies ii)Need to develop education approach to supporting staff in under-represented groups iii) Need senior leadership development programmes to support the service improvement and transformation agenda.	Failure to achieve Integrated Performance Review targets is an indication of negative assurance where the targets are relevant to this risk.	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient

		Red	Effective controls may not be in place and assurances are not available to the Board.

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Embed compassionate leadership approach to organisational management.	Chief People Officer	ongoing	Culture, civility and behaviour paper considered at FFC in November 2020. Agreement given that behaviours and culture are lacking and must be improved. Task and Finish group met in december to consider possible toolkits or mechanisms to improve communication and behaviour between staff.	in progress
ii) Develop improved education and training offer for all staff groups.	Chief People Officer		Now managed through the Education Board, with a combined staff capability team supporting this agenda as part of the People Team. CPD offer for all registrants. There will be a review of all education offers. Leadership offer being clarfied and republished to ensure available to all staff Revisited terms of referance and new sub-commities to ensure strong oversight of offers	in progress
iii) Improve staff engagement through promotion of the EDI agenda, including support for staff networks.	Chief People Officer		The Trust is engaging with the EDI agenda through development and promotion of staff networks, which will feed into the Staff Experience Group. Black history and Speaking up month was in October. Time to Talk / Sharing story approach to develop understanding and allyship. Review of staff survey results in progress.	in progress
iv) Support and develop staff wellbeing services, in line with NHS People Plan and Trust People Strategy.	Chief People Officer		Support sessions are in place, the staff experience group hub is now available, health @work,wellbeing support sessions are also available. There is information on our intranet page outlining how these Wellbeing support services can be accessed. Wellbeing being promoted on a daily basis with ambassadors visiting key wards and locations in the Trust to offer support. Charity being apporached to support breakfast and break bags so that staff can grab food and refreshments even in short breaks when they may be unable to leave the ward fully. Scheduled EDI dates have been shared with the Trust.	in progress
v) Provide effective channel for staff communication through Staff Experience Group and Divisional Forums	Chief People Officer		The Staff Engagement Group meets regularly and will roll out a schedule of activities over the course of 2020. Your voice forums are being established across services. These have been postponed due to wave 2 however with be reestablished as soon as practicable.	in progress
vi) Roll out talent management approach and support career conversations across whole Trust.	Chief People Officer		The new approach to staff appraisals was launched in July 2020 and has been well received. Talent Boards and discussions becoming more available however on hold during wave 2, will be reestablished as soon as practicable.	in progress
Summary Narrative:				
January 2021: Risk reviewed with CPO. Risk remains at 16, it is anticipated that this will remain at this level for the foreseeable future. The last staff survey did not see a shift in reduction of B&H and it is unlikely to change in the most recent one which is due for publication in March 2021.. Due to the changing service needs in relation to Covid pandemic and winter pressures it is expected that this year work will need to focus on re-engaging staff and managers to support the development of cultural and behavioural standards that are acceptable to all even when under pressure.				

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2020-21

Strategic Aim:	**Quality: To deliver high-quality,compassionate services,consistently across all our sites** **Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term**				
Strategic Objective:	**b) Improve patient outcomes, experience and efficiency by enhancing specialty-level inpatient care** **e) Safely recover operational performance affected by the COVID-19 pandemic h)** **Play a leading role in developing sustainable and integrated services through the ENH Integrated Care Partnership and ICS**	**Source of Risk:**	Risk register /AE reports	**BAF REF No:**	010/20
Principal Risk Decription: What could prevent the objective from being achieved? **There is a risk of non-compliance with Estates and Facilities requirements due to the ageing estate and systems in place to support compliance arrangements**		**Risk Open Date:**	22/01/2019	**Executive Lead/ Risk Owner**	**Direcotr of Estates and Facilities**
		Risk Review Date:	Dec-20	**Lead Committee:**	**FPPC**

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Lack of robust data regarding current compliance ii)Lack of available resources to enable investment ii) Ineffective governance processes iii) Reactive not responsive estates maintainance iv) skill mix, expertise and capacity	i) lack of information to inform risk mitigation and decisions ii) Lack of assurance that routine maintainance is completed ii) risk of regulatory intervention iii) poor patient experience iv) potiental staff and patient safety risks	**Inherent Risk** (Without controls):	5	5	25	
		Residual/ Current Risk:	5	4	20	⟷
		Target Risk: **(Timeframe TBC)**	5	2	10	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
Fire Policy and Procedures Training – mandatory awareness training and fire wardens Ward based evaluation training for Sisters completed December 2018. Communication Plan Fire Compliance meeting (monthly). Detailed Action Plan in place to address the recommendations of the 2 Fire AE reports, broken down into weekly tasks. Capital funding to make the necessary changes to the Estate to ensure compliance with guidance and fire compliance. . Capital funding to make the necessary changes to the Estate to ensure compliance with guidance and fire compliance. Revenue funding to fund improvements. Detailed Action Plan in place to address the gaps in Estates & Facilities Compliance. Interim Fire Safety Officer in post from 11 Feb 2019 Reports to Health and Safety Committee Weekly environmental audits Water safety group and action plan Revised governance structure adopted within Estates & Facilities, along with a new Estates & Facilities Management Assurance Group (EFMAG), to receive reports and monitor progress. EFMAG report sto H&S Committee, within its revised governance arrangements. Revised governanec structure adopted within Estates & Facilities, along with a new Estates & Facilities Management Assurance Group (EFMAG), to receive reports and monitor progress. EFMAG report sto H&S Committee, within its revised governance arrangements.	Authorised Engineers report 2018. (L3 –ve) Annual fire report to Quality & Safety Committee. Papers to Executive Committee / Quality & Safety Committee. Audits of high risk areas on Lister site Works completed on wards 10/11 MVCC 2018 Desktop Fire evacuation exercise carried out December 2018.(lister) Ward evacuation plans displayed in each ward and checked. January 2019 New Monthly Fire Safety Committee established March 2019 – includes representation from other sites – reports to H&SC and QSC PLACE reviews Internal audit of estates and facilities compliance scheduled for Q3/4 E&F escalation reporting to both TIPCC and H&S Committees from EFMAG, adopting araes to celebrate and areas of concern. Trusts Water Safety Group is receiving trend analysis data on laboratory testt results, and the situation is stable, although continues to be significant. Final independent compliance audit report received October 19. Compartmentation works/firedamp works/alarm works are now underway from discretionary capital and additional backlog maintenance capital. There has been delays to the completion of numerous areas of work due to the Covid 19 pandemic and the need for the transformation of various areas to deal with the influx of patients. This is also affected the ability to train people due to social distancing. Capital works are now planned over the next two years with the highest risk items being dealt with at the earliest opportunity and training being brought back in line within the next six months.	AE Water Safety Report to Water Safety Group (Nov 19) confirmed positive progress in relation to water safety Compliance status report following review to date to FPPC in June 20 In a bid to formalise and standardise the reporting structure for the estates and facilities division new assurance documentation will be issued which reflects the same scoring mechanism and visual indicators across all of the statutory compliance issues. Within these assurance documents will be how we have supported through detailed and available evidence the validation of any assurance that goes towards board. All information packs and evidences are being drawn together in a bid to populate PAM and also for into our building management system, planet, to allow us to involve our operational maintenance teams and keep them informed of requirements.		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**		
Ineffective estates and facilities governacne structures Estate strategy due for renewal Lack of capital funding to bring the Lister and other sites to compliance Lack of revenue funding for training Fire risk assessments and actions due for Fire Safety Officer review Actions identified from Fire desktop review Confirmation all AO's now in post and visibilty of work programme Gaps in ongoing assurance on water safety identified Limited visibility on the compliance status for the Trusts satellites locations. Confirmation of level of compliance with Premisis Assurance Model (PAM) to inform gap analysis and work programme.	Full implementation of the Fire Strategy Effective Estates and facilities governance structures Limited assurance from other sites trust operates from Visiibility of AE reports and actions Limited assurance for Ventilation and decontamination - action plan in place £4.2 million has been made available to attempt to counteract high level backlog maintenance risk. This £4.2 million has approximately £800,000 set aside for fire mainly in the investment into the alarm systems and the potential issues with spandex panels on the main tower. These works are in addition to the funding that was approved in 2019 which allows for an additional £750,000 this year and 750,000 thousand next year into our infrastructure. Collection of the Premisis assurance model (PAM) documentation is underway – we will create an evidence library which should be complete in quarter four – we have appointed an external company to undertake the review of all areas and workshops will be held within the next three months. PAM will as a consequence of the review will produce a GAP analysis which will drive our response by identifying areas of priority investment for capital and revenue funds.	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Review and implement revised estates and facilities governance and reporting structure	Director of Estatesand Facilities	01/09/2019 revised date with Director April 2020	Paper presented to QSC in June 2019 outlining key workstreams. Implemention of the supporting committees commences with water safety, ventilation and electrical safety. E&F Governance structure and reporting arrangements were revised in August 2019, and to be reviewed 4th Qtr 2019/20. February - E&F structure and governance structure under review with new Director of Estates and Facilities. The outcome of a structural change to the division will be the presentation of a "state of the nation" report. As part of the state of the nation report there will be a declaration and methodology on how we deal with governance and who will have the responsibility and the obligation to provide evidence. Meeting to review and map E&F governance structure with Associate Director of Governance scheduled for end of February	

iii) Review of Estates Strategy	Director of Estates and Facilities	Mar-20	on hold until new estates and facilities director in post from January 2020. New Estates and Facilities Director commenced January 2020. Review of Estates Strategy Commenced The estate strategy requires a clinical strategy to be completed and ratified. All estate strategies should be led by the clinical strategy. In addition to this we are currently undertaking a transformation of our environments to reflect the changes which has happened during the pandemic. We need to await the completion of these transformations and agreements with our partners in the rest of the health economy that previous assumptions with regards to activity and services we provide still hold true. In the meantime and includes state strategy or statement of intent will be created for presentation to the board in the fourth quarter	
iv) review and implement mechanisms to ensure Estates, Facilities and Fire compliance assurance is received from partner organisations where trust operates from	Director of Estates and Facilities	Dec-19	Paper presented to QSC in June 2019 outlining key workstreams. Trust risk assessments have been shared with the relevant partners. Correspondence issued to all satellites CEO's requesting assurance on their water compliance and all areas of the HTM's and health & safety, for completeness. External review of compliance completed.	
iv) Substantive recuitment into leadership structure and other vacancies	Director of Estates and Facilities	Dec-20	Structure reviewed in July 2020 The proposed structure for the estates and facilities division has now been shared with the other executives following a review to attempt to maintain any structural changes within the current financial budgetary constraints. This in the main has been achieved the Deputy director of Estates and facilities (business and compliance manager) is undergoing final review of its grading. The revised structure will be included within the first state of the nation report which is due in quarter four is expected that all posts will be filled before the end of that quarter.	
v) Work with STP partners to ensure STP Estate Strategy reflects Trust priorities	Director of Estates and Facilities	Dec-20	ENH was represented at a meeting in September 2019, with the regional Estates & Facilities Directors. STP Estates Strategy completed and rated as Good by NHSI/E, Estates and Facilities continue to be representative and attend to all STP estate strategy meetings. Whilst the current Director of Estates knows the majority of the other officers in the region from prior works within Watford and Hillingdon he is attempting to make personal and professional partnerships with all concerned.	
iv)				
Summary Narrative:				
October 2020: risk reviewed by Director of Estates and team - no changes. Associate Director of Governance to have follow up discussion regarding the scoring and aims / timeframes for reduction. November 20: Director of Estates is in the process of reviewing all the Estates & Facilities risks with his senior team to inform the BAF and this will be completed by the end of December. This is in conjunction with a review of the assurance reporting. This review with the team has been delayed due to COVID pressures. Feb 2021: review of the risk commenced within the team and awaiting confirmation of workshop dates in March 21.				

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2020-21

Trust Strategic Aim:	**Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term Quality: To deliver high quality, compassionate services, consistently across all our sitesPathways: To develop pathways across care boundaries, where this delivers best patient care**				
Trust Strategic Objective:	**a) Enhance clinical leadership and service line delivery to further improve service quality, safety and transformation d) Develop a future vision for the Trust's cancer services and support work with partners to transfer MVCC to a tertiary provider**		**Source of Risk:**	Specialist Commissioning review	**BAF REF No:** 011/20 (was 12)
Risk Description: There is a risk that the Trust is not able to transfer the MVCC to a new tertiary cancer provider, as recommended by the NHSE Specialist Commissioner Review of the MVCC.			**Risk Open Date:**	Apr-20	**Executive Lead/ Risk Owner** **Director of Strategy**
			Risk Review Date:	Feb-21	**Lead Committee:** **Strategy**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Lack of continued commitment of the preferred provider to progress service transfer ii) Failure to make decision on long term service model following public consultation iii)inability of NHSE to reach agreement with providers , including investment required, and execute the transaction	i) Increase in uncertainty over future of MVCC and adverse impact on recruitment, retention, morale and research. ii) Potential detrimental impact on care pathways at Trust sites. Protracted strategic uncertainty impacting the abilty to deliver a sustainable service model for future services provided by MVCC iii) Protracted strategic uncertainty and increased financial pressures on the Trust iv) Potential impact on quality and safety	**Inherent Risk** (Without controls):	4	5	**20**	⟺
		Residual/ Current Risk:	4	3	12	
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
-Trust (and divisional) Clinical Strategy under development. (Cancer Strategy work will come together with MVCC Transfer activity through a new MVCC Transfer ENHT Steering Committee) - Strategic Programme Governance in place including MVCC Strategic Review Programme Board - UCLH Transition Team in place at MVCC - Weekly director level call with UCLH and NHSE. - Escalation reporting to Executive Committee and Board - ENHT MVCC Transfer Programme Director in place - ENHT MVCC Transfer Steering Committee in place from Dec 20 aligned with wider ENHT Governance - Terms of reference approved. - Internal MVCC Task & Finish Group established, focusing on Due Diligence and linking into NHSI/E fortnightly conference calls on topic - Clinical policies	• Regular reports to FPPC and the Board (L2) • Regular reporting into the Strategy Committee from December (MVCC Transfer Programme Mandate shared with Strategy Committee in 12/20.) • Clinical Advisory Group • Capacity and demand modelling • Monitoring of Quailty Indicators and audit of admissions policy • Director of Finance leading internal due diligence • Status reporting through ENHT Steering Committee (from January)	• Strategic review and recommendations from clinical advisory panel re MVCC, July 2019 • Positive Risk Review with Specialist Commissioners, December 2019 • Jan 20 NHSE approved the recommendation that UCLH is the preferred tertiary provider for MVCC (Jan 2020) subject to the outcome of due diligence. • NHSI/E Risk Review - significant assurance provided and decision to step down to BAU assurance monitoring. • Dec 2020 MVCC Review Programme Board - supported recommendation for full replacement and enhancement of current MVCC services on an acute site; shortlisted Watford (meets all essential criteria) and supported full options appraisal on the Watford site.		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
i) Agreement of funding of costs of due diligence and transition between organisations ii) Internal capacity to progress due diligence and engagement on long term service modelling iii) Preferred provider capacity to progress due diligence and service model development iii) Availability of capital funding for investment	Impact of COVID 19 on the timeline of transfer	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps				
Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Support NHSE to recommence and deliver MVCC Strategic Review Phase 2	Director of Strategy	June 2020 onwards	April 20 - because of delays caused by pandemic response, agreed provisional restart date of June 2020 and transfer target of April 21. Subject to confirmation with UCLH May 20 - Programme Board met 15/5/20 and approved outline timetable for next phase of review. Work with UCLH and MVCC clinicians to develop a new clinical model for MVCC to commence before the end of Q1, including input from patient experience. Aug 20 - Programme Board met 18 Aug. Agreed revised timeline proposed by NHSE and UCLH which would deliver Business Transfer Agreement in Sept 21 and transfer in Apr 22. UCLH Programme Director has commenced in post. Nov 20 - Programme Board met 21 October. Work is progressing to revised timelines with recommendations for future re-provision/clinical model and a shortlist of future sites due to December Programme Board. Dec 2020 MVCC Review Programme Board - supported recommendation for full replacement and enhancement of current MVCC services on an acute site; shortlisted Watford (meets all essential criteria) and supported full options appraisal on the Watford site. Feb 21 - Work is progressing on reprovision activity (decision making process for networked radiotherapy agreed; work underway with Watford to develop min/max schedule of accommodation for new Cancer Centre)	In progress
ii) Conclude negotiations regarding due diligence and transfer costs and deliver due diligence	Director of Finance	Jun-20	The MVCC Transfer Task & Finish group has resumed meeting and planning activity during May. The group has identified specific workstreams that can recommence activity to generate information and data to support the Due Diligence process with UCH and NHSE, that will culminate in the development of a joint Business Case that would underpin the transaction. The Trust has communicated the resumption of this actvity to UCH to ensure that joined up work between the the two organisations can recommence where practicable. Bi weekly Task and Finish groups chaired by the Director of Finance remain diarised going forward to co-ordinate this activity. Aug 20 - Trust due diligence continues. UCLH due diligence has commenced but due to organisational priorities, is running behind the ENHT data gathering. A Critical Infrastructure Group has been set up led by NHSE with key stakeholders in order to support shared understanding and agreement on responses to critical infrastructure issues prior to transfer. Nov 20 - Due diligence is progressing but with delays to internal milestones from a UCLH perspective due to other organisational priorities. The Critical Infrastructure Group is running bi-weekly as intended Jan 21 - Agreed to move CIG to monthly with informal fortnightly check-in given progress in key areas e.g. Linac funding. Increased risk of pandemic surge response reducing operational and clinical capcity to sustin DD timelines. UCLH	In progress

iv) Confirm planned equipment replacement programme including addressing need to replace LA1	COO/ Director of Strategy	Jun-20	LA1- 12 month extension for LA1 agreed with suppliers and commissioner wef September 2019. Business case to replace LA1 drafted and capacity and demand modelling shared with NHSE. 20/21 equipment requirements to be considered in Trust 20/21 capital planning process. May 20 - activity and capacity modelling refreshed to include potential COVID impact on demand and effects of hypofractination for breast cancer. Shared with NHSE. Trust in discussions with UCH regarding financial mechanisms to support funding linac purchase. Busines continuity plans being refreshed to support interim service. Aug 20 - mitigation plan for loss of LA1 in 20/21 agreed internally and with NHSE. External modelling indicates that this capacity is not required but that the next linac due for replacement (LA9) will need replacing to sustain capacity to meet demand. NHSE have commissioned external work to support resilience of LA9 this year and the Trust will undertake bunker enabling works in year in readiness for a new linac installation in 21/22. Funding for the new linac is to be identified in dsicussion with NHSE and UCLH. Nov 20 - Linac business case and covering letter shared with NSHE to enable exploration of funding options in the event of slippage in regional capital spend or access to emergency capital Dec 20 - Emergency capital funding for new Linac approved by NHSE . Director of Estates scheduling necessary works. Feb 21 - New Linac due for delivery at MVCC in late March	In progress
iv) Continue to support and monitor continuous quality and safety improvement and assurance at MVCC	Chief Nurse/Medical Director	Ongoing	Compliance and risk lead attend the MVCC risk clinic and clinical governance meetings. Audit results shared with the Trust and Specialist Commissioners. 47% of CQC 'must do' & 'should do' actions completed. Planned review of internal governance to ensure meet needs of Division, Trust and Commissioners. Scheduling CQC mock review for Q3. Nov 20 - Internal quality and safety assurance visit to MVCC completed in Q3, plans for external assurance visit in progress. Jan 21 - Dates for mock CQC inspection to be rescheduled in the context of pandemic surge.	In progress
Summary Narrative:				

Aug 20 - The transfer programme has recommenced . Phase 2 (future service model and location) is being led by UCLH with NHSE. The Trust is fully engaged and supporting this work. In anticipation of a reduction in the director of strategy's capacity following her appointment as joint director of strategy with Hertfordshire Community trust, the Trust is recruiting a fixed term senior programme director to support the director of strategy and internal leaders drive the Trust's transfer and future service redesign programme to provide additional capability. A watching brief is being kept on the potential impact of Covid-19/winter period on the plan. October 20: Risk discussed and reviewed with Director of Strategy, including the risk likelihood score using the new standardised methodology. Risk reduced to '12', the target risk. Rationale includes: Mitgations in place and staffing recruitment and retention being managed. Programme is progressing to the revised agreed timelines - transfer decision in September 2021 and completion in April 2022. This also takes into account that the Programme Manager is now in post.
Nov 20 - MVCC Transfer Strategic Programme work is progressing in line with the revised plan agreed in August. A watching brief is being kept on the potential impact of Covid-19/winter on progress against the plan.
Jan 21 - In light of the status of the pandemic (NHS incident level 5), Programme activity is under review with NHSE to assess what should continue and what may need to be delayed until pressures on the system ease.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2020/21

Strategic Aim:	**Quality: To deliver high quality, compassionate services, consistently across all our sites across care boundaries, where this delivers best patient care Pathways: To develop pathways People: To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term**
Strategic Objective:	**People: To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term**

Source of Risk:	External	**BAF REF No:**	012/20 (was 13 and orginally COVID focused_
Risk Open Date:	04-Mar-20	**Executive Lead/ Risk Owner**	**Chief Operating Officer/ Chief Nurse**
Risk Review Date:	Jan-21	**Lead Committee:**	**Board**

Principal Risk Decription: What could prevent the objective from being achieved? **Risk of pandemic outbreak impacting on the operational capacity to deliver services and quality of care**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Covid 19 outbreak/pandemic increases nationally and world wide - increasing testing, self isolation, school closures, sickness ii) Potential increased need of respiratory and critical care beds iii) Potential increase from containment to 'social distancing' iv) Enactment of the Civil Contingency Act v) Insufficent capacity for the increased demand - including ED and assessment and side room capacity	i) Risk of staff unable to attend work - due to self isolation or covid 19 positive. Potential up to 20% of staff off sick in peak of outbreak ii) Risk to patient safety as unable to provide safe staffing iii) There is a risk to the Trust's reputation if an outbreak was to occur/or criticism of our procedures. iii) Risk that some services are suspended for a period e.g. non urgent elective surgery, training iv) Risk of not meeting regulatory requirements	**Inherent Risk** (Without controls):	5	4	**20**	⇔
		Residual/ Current Risk: Anticipate reduction to 15 in Spring 2021	5	4	20	
		Target Risk:	5	2	10	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
Major incident policy and Business continuity plans in place. Major Incident Command structure - Gold , silver, bronze - GOLD and SILVER command structures reviewed/adapted to ensure continued support to organisation / major incident Communcation plan - internal and external Emergency Planning Group - Chaired by COO COVID Specialist advisory group with task and finish group strucutre reporting to it.	Business continuity - compliant assessment validated 2019 MVCC Business continuity tested 29 February - 01 March Montoring of Fit testing training / compliance Action plan - reviewed daily to respond to changing position Desk top review of pandemic flu plan completed Participating in regional STP covid table top exercise scheduled for	Business continuity - compliant assessment validated 2019 MVCC Business continuity tested 29 February - 01 March Legal guidance of trust responsibilites under civil contingency act - reported to Board April 2020. Critical care capacity maintained approx 50% 3 wks without any Hospital Acquired COVID		

(Revised October 2020) including Testing Clinical Advisory Group Supporting staff testing through available routes- Action plans/workstreams Review of Pathways and local BCP's Linked intoand represented at Local and National resilience fourms/ communications/ conference calls Oncall rotas at various levels Fit testers and training / PPE logistics and Clinincal Advisory group Reviewed Board and Committee Governance structures approved and inplace in March 20 New weekly Quality Assurance meeting established in April - chaired by DoN/MD - supported by Compliance team and dashboard. (to support interim governance arrangement and quailty oversight during pandemic) Central record of contract / pathway reviews and agreed changes Record of national / regulatory changes and trusts response Patient experience inititives - tell us more, post discharge calls, patient liaison role (on 9's), keep in touch - video calls and weblink to send photos/messages Staff skills and simulation training Critical care surge plan in place internal and regional Review and monitoring of O2 supply Increased mortuary capacity Monitoring, review and recording of all national guidance and directives recieved re pandemic Staff well being hub and deployment / reassignment processes- re-established January 21. Extensive works to supporting cohorting of covid patients ICP BAF June 2020 and refresh for Winter People and placed based risk assessments re COVID Social Distancing strategy Regional and Trust Local Indicators to suport decision making November: Steering Group and Task and Finish Group for Asymptomatic Lateral Flow	10.03.20 Doning and doff training Task and Finish Groups - minutes and plans Incident management log Daily Gold command covid 19 briefings Record of national / regulatory changes and trusts response Record of contract/ pathway changes Record of all national guidance and trust response Covid 19 dash board - capacity of CCU, covid and non covid beds and occupancy Review and monitoring of O2 supply - Pipework upgraded in critical areas ICP BAF June 2020 People and placed based risk assessments - awards of COVID Secure (Non clinical) and COVID Commended (Clinical) - audit programme in place Social distancing Incident Management Governance Structure revised January 2021; approved by GOLD . Reviewed and revised in February; approved by Execs and GOLD. Daily monitoring of O2 useage by Estates team, dashboard. Usage approx 50% during surge 2	IPC BAF presented to QSC CQC review of IPC BAF July 2020 - assuranced on all ten KLOE CQC assurance on Medicines Management during COVID COVID SAG - review of structure. mins and action log. October 2020 EPRR report to QSC, September 2020. Review of ED pathway to Exective Committee and FPPC October/November 2020: CQC Published FIRST re ED Prepareness - benchmarking -positive engagement meeting with CQC.		
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:** Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**		
1.Possibility of insufficient staff available on all shifts who have passed their FFP3 Fit testing 2.Possibility of staff coming back or being exposed to people who have come back from the affected regions and presenting for work without checking with Health at Work first. 3.Possibility of Trust visitors coming back or being exposed to people who have come back from the affected regions and presenting at the Trust. 4.There is a risk that patients are not screened on admission as per questions based on PHE guidance about recent travel. 5.There is a risk that Trust and agency/bank staff may be confused by various external sources of information about WN-CoV and IPC precautions to take 6. There is a risk people in the community with symptoms are directed to ED, when they should stay at home - due to unclear community guidance 7. Business continuity plans may need to include WN-CoV. 8. Updates to national advice daily as the position changes 9. Demand for assessment and beds exceeds sideroom and bed capacity Requested regent to enable patient and staff testing internally / capacity of CUH to support increased testing Impact of COVID surge 2 on capacity and staffing	BCP's for high risk areas / small specialitist services Continuity of supplies as position changes - awaiting further national guidance on PPE Ability to step up capacity esp in respiratory and critcal care pathways Senario planning of all pathways / cohorting On going resilience to sustain responsiveness to national guidance which is updated daily (esp in small teams / single posts) Recruiting into PPE lead Maintainance of safe staffing ratios due to the large number of staff off due to covid related sickness/self isolation Adequacy of Ventilation in clinical areas	Green	Effective control is in place and Board satisfied that appropriate assurances are available	
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient	
		Red	Effective controls may not be in place and assurances are not available to the Board.	

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) COVID Specialist Advisory Group oversight and leading policy, guidance and expertise - PPE, logistics, testing, social distancing, IPC issues	Chief Nurse/ Medical Director	on going	meets weekly to problem solve, provide guidiance and direction; gain assurance . Staff testing strategy under development. COVID Specialist advisory group , Chaired by Chief Nurse/ Medical Director with task and finish group structure reporting to it. (Revised October 2020) On going manangement of outbreaks and audit programme to support compliance .	In progress
ii) Testing Clinical Advisory Group leading policy, guidance and expertise regarding patients and staff testing	Medical Director	on going	Meets weekly to respond to changes to guidance and recommend changes to Covid SAG. Currently considering programme for testing staff - asymptomatic; response to LU4 local outbreak; trust patient testing. As above. Lateral flow testing commenced for front line staff in December.	In progress

iii) Develop trust approach and implementation plan for the Flu Campaign 2020/21	CPO	Q3	Campaign commenced. 31% as at 2nd wk October 2020. Comms in place and local peer vaccinators. Assurance Report due for FPPC in October and November Board.	In progress
iv) Continue Developing partnership working with Community and Care/Nursing homes to provide expertise to support care and treatment to prevent admission to hospital and improve outcomes	Chief Nurse	May / June 20	In place. Action closed. Trust remains represented on national learning group.	complete
v) Review lessions learnt to date from the COVID pandemic to inform trust wide major incident planning/ business continuity and pandemic prepardness	COO/ Chief Nurse	Oct-20	Initial Lessons learnt presented to Execs and Committees. Reflection and planning session held 23 September 2020 to inform planning, and triggers for MI response. Table top review held in September - Daily 'gold' meeting reinstated; supported by local dashboard (triggers inline with Opel status and leading indicators developed). Triggers re instating for flatpacked services under review. Annual review of all business continuity plans commenced in October 20 (this also supports EU Exit readiness). Plans in place for a 'lessons learnt' review in March 2021	In progress
vi) Prepare for National COVID Vaccination Programme in line with National Guidance	CPO / Emergency Planning	TBC once National Timeline confirmed	Task and finish group established including Chief Nurse, Operations, Estates, Medicines Management, HR. A steering group has been established to work through the operational and resourcing challenges of setting up the Covid vaccination programme, which needs to be operational for 1st December. Vaccination programme commenced 8th December in line with National Directive. January 2021: Commenced vaccinating staff (prioritising high risk staff and areas) . Week commencing 22 February commencing second vaccine doses in line with national guidance	In progress
vii) Implement the Asymptomatic Lateral Flow Staff Testing Programme	Medical Director	December in line with National Programme	Lateral flow tests kits are being distributed to all acutes week commencing 16/11, to provide testing for asymptomatic patient facing staff twice weekly. The test is a self-administered saliva test which does not need a lab to process, and takes 1 hour to produce a result. Then any positive lateral flow tests will be confirmed by PCR testing to determine which staff require isolation. A steering group has been pulled together which reports to testing CAG with Michael Chilvers as the SRO.	Completed and monitoring
viii) Review of models of working, skill mix including deployment of support functions to support safer staffing across clinical areas	Chief Nurse/ CPO / Medical Director	January and Q4	Safe surge plans and staffing plans developed for Critical care. Daily calls to ensure system wide support across the region. Implementation of task and finish group to support safe deployment of staff to support clinical areas under pressure. In place and monitored daily through 'gold' , redeployment hub and site meetings'	In progress
viiii) Review of ventilation in clinical areas and develop proposal for improvement	Director of Estates and Facilities/ Ventilation AE	Q4	Engaged with external company to review the adequacy of the ventilation in the clinical areas and developing a proposal for improvement. This is being monitored through Covid SAG and Health and Safety Committee.	In progress
Summary Narrative:				
October 2020: Risk reviewed with Emergency Planning Lead and COO. Reviewed assurances, controls, actions and level of risk. Review of risk - agreed likelihood of '4' likely x consequence '5'. Staffing is a critical factor currently - staff unable to work due to self isolation and unable to redeploy staff as during 'phase 3' operation recovery of services remains a competing priority whilst also managing winter pressures. Anticipate reduction to 15 in Spring 2021 . Proactive controls and mitigations remain in place to support readiness for a COVID second surge - our local Trust response and potential for mutual aid to our local Trusts. January 2021: Vaccination programe commenced on 8 December 20 in line withthe national directive and now expanded to vaccinate staff. Safe surge plans, including staffing for critical care in place. Greater number of staff off with COVID related symptoms due to LFT and new varient. Task and finish group established to support safe deployment of staff to support clinical areas under pressure. Monitoring of all staffing incidents weekly alongside all the moderate and severe harm incidents . 31 December 20: Trusts required to plan to pause P3 and P4 cases to support COVID surge.				

Agenda Item: 13

TRUST BOARD – 3 MARCH 2021

Infection Prevention & Control Report – January 2021

Purpose of report and executive summary (250 words max): To inform the Board of infection prevention and control performance for the period of 01-31 January 2021.		
Action required: For information		
Previously considered by: **QSC – 23.02.21**		
Director: **Director of Nursing & Infection Prevention & Control**	**Presented by:** **Director of Nursing & Infection Prevention & Control**	**Author:** **Lead Nurse Infection Prevention & Control**

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

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

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

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

Failure to act upon outcomes may increase risk to patients and staff and place the Trust at risk of breaching registration requirements set out in the Health & Social Care Act 2008.

Risk of not delivering on national targets for MRSA bacteraemia & Clostridium *difficile* and potential loss of income. For 2020-21, the ceiling for Hospital Onset MRSA bacteraemias remains at zero. The *Clostridium difficile* ceiling target for the Trust has been set at 52 cases for Hospital Onset Healthcare Associated and Community Onset Healthcare Associated cases.

Risk of not maintaining the reduction of surgical site infection (SSI) rates to the national benchmark in the three categories of orthopaedic procedures which are subject to surveillance. Actions being taken include a deep dive into all identified SSI cases to ensure all learning points are identified and addressed, auditing against national (NICE) guidance and taking measures preventing unnecessary theatre staff movement.

Infection Prevention and Control Board Report Objectives & Outcomes: December 2020

Executive Summary	**Key messages**	**Nosocomial Infections** - 647 COVID cases recorded - 98 total revised recorded probable (HO.pHA) or definite (HO.dHA) nosocomial infections for January - HO.pHA + HO.dHA = 15% of total COVID cases recorded - In January the revised number recorded: 68 Hospital-Onset Probable Healthcare-Associated cases 30 Hospital-Onset Definite Healthcare-Associated cases **Outbreaks** - 15 Outbreaks in total during the month of January - 5 Outbreaks closed (MVCC 10+11, 8B South, Ashwell, 11A, H@W, and 9A) - 10 Outbreaks currently being actively monitored at the end of January 21 - Daily weekday outbreak Incident Management Team (IMT) meetings **New Guidance (available on request)** - Novel coronavirus (COVID-19) standard operating procedure FM Service Guidance, gap analysis produced by Estates and Facilities. - Gap Analysis for updated guidance: COVID-19: Guidance for maintaining services within health and care settings Infection prevention and control recommendations. **Other indicators:** - No Flu or Norovirus Healthcare-Associated cases reported - Year to date C.difficile cases is 36, which is below trajectory	
IPC Covid Updates	**Covid-19 nosocomial infections and update**	From the 14th May 2020 NHSE/I introduced mandatory surveillance for nosocomial Covid-19 infection. Surveillance covers inpatients only and no targets have been set. The four categories are: - Community-Onset: First positive specimen date 2 days or less after admission - Hospital-Onset Indeterminate Healthcare-Associated: First positive specimen date 3-7 days after admission - Hospital-Onset Probable Healthcare-Associated: First positive specimen date 8-14 days after admission - Hospital-Onset Definite Healthcare-Associated: First positive specimen date 15 or more days after admission	

A review into the reported figures for Hospital-Onset Probable and Definite Healthcare-Associated Covid-19 during the month January revealed a discrepancy between the numbers submitted by the Trust for questions 21-22 of the Daily COVID SitRep figures and ICNET based numbers. A deep dive has taken place into the period 01.01.21 – 11.02.21, which has revealed some potential system errors. A summary report will made available for reference.

Main findings:

- A total of 57 cases over reported as Hospital-Onset Definite Healthcare-Associated
- A total of 6 cases under reported of Hospital-Onset Probable Healthcare-Associated
- **An overall of + 51 cases discrepancy**

In January, the revised Trust figures are:

470 Community-Onset cases
78 Hospital-Onset Indeterminate Healthcare-Associated cases
68 Hospital-Onset Probable Healthcare-Associated cases
30 Hospital-Onset Definite Healthcare-Associated cases

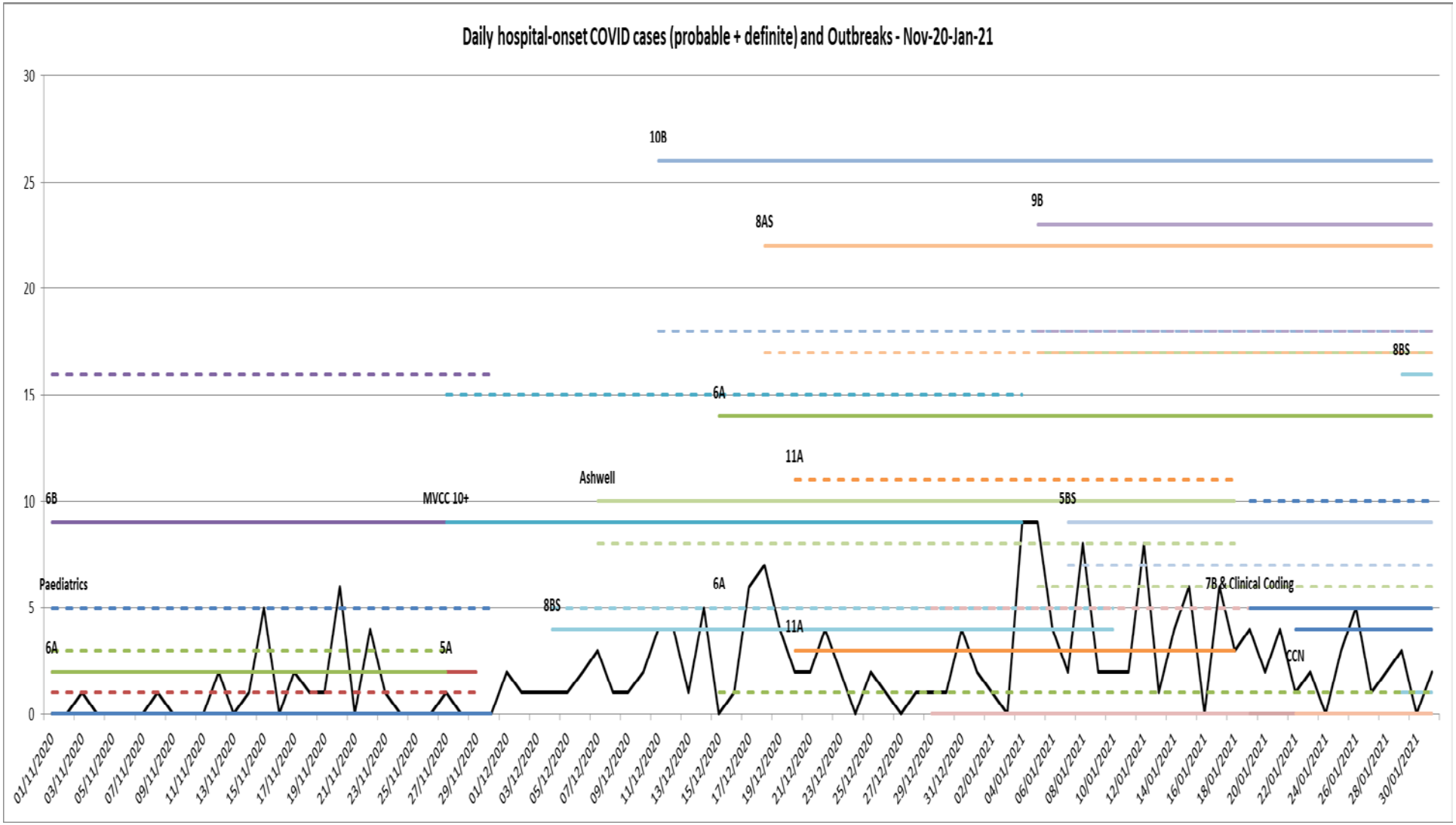
Hospital-Onset Probable and Definite Healthcare-Associated Covid-19 | Data SitRep for East and North Hertfordshire Trust December 2020 and January 2021 bed occupancy per 100,000 days

Jan-21		
Type	Total	Rate
Def	30	167.52
Prob	68	379.70
Total	98	547.22

Dec-20		
Type	Total	Rate
Def	28	159.02
Prob	39	221.49
Total	67	380.51

	COVID 19 Outbreaks	**COVID 19 Outbreaks** Outbreaks which ended in January after having no new positive cases associated to the outbreak for 28 days are: - MVCC Wards 10 &11 outbreak ended on the 04.01.21 there were a total of 9 positive patients and 15 positive staff member involved in the outbreak. - Ward 8B South outbreak ended on the 10.01.21 there were a total of 4 positive patients and 5 positive staff member involved in the outbreak. - Ashwell Ward outbreak ended on the 18.01.21 there were a total of 10 positive patients and 8 positive staff member involved in the outbreak. - Ward 11A outbreak ended on the 18.01.21 there were a total of 3 positive patients and 11 positive staff member involved in the outbreak. - H@W service outbreak ended on the 29.01.21 there were a total of 0 positive patients and 5 positive staff member involved in the outbreak. There will be reports produced summarising the outbreaks, actions identified, and lessons learnt for all completed outbreaks, presented at the next TIPCC. The Trust experienced ongoing or new outbreaks in January 9A, 9B, Clinical Coding, Children's Community Nursing Team, 10B, 8A South, 8B South, 7B, 6A, and 5B South. The main new areas of learning commonly identified continue to be: - Car sharing - Shared households - Single patient equipment - Increased auditing of the cleaning service by facilities - Shared staff equipment e.g. ward keys Frequent multi-disciplinary outbreak meetings are held to support the areas in their management of the outbreaks and monitor any gaps for assurance. These are attended by, NHSE/I, PHE and CCG colleagues when required, with daily SitRep returns completed.	

The following table sets out the Daily hospital-onset COVID cases (probable + definite) and Outbreaks from Nov-Dec-20



	IPC BAF and NHSE 10 Key Actions	The Trust Autumn/Winter BAF will be continually reviewed and updated throughout the winter period to ensure ongoing compliance. In line with national guidance, the BAF has been updated with additional lines of enquiry and the audit programme was adapted to reflect the changes. A comprehensive update will be given at the next TIPCC however; Planned and Unplanned Care have been supported to develop their own IPC BAF to ensure relevant actions are taken.		
	Water Safety	**Reasonable Assurance** 	1) Water Risk Assessments need to be updated. Plan is to complete these via an appointed sub-contractor beginning Jan 2021. 2) Water AE has confirmed that management of our water sub-contractors has improved greatly however issues remain with ability to improve satellite unit's services. 4) Once RA are completed we will be able to review and update all of the PPM required.	
	Ventilation	**Limited Assurance** 	1) A new ME Manager started work in Jan 2021. Also Water Manager completed Vent AP training in December. Both will need to be assessed by AE. Then our CP's needs to be trained & appointed. Policy & procedures are being updated by AE. 2) The Trust has some very old assets/AHU in poor condition. Capital project to provide theatre AHU in early 2021 via modular units 3) Ventilation systems management group needs to be reconvened and managed forward. AE annual re-audit due in Feb 2021.	
	Decontamination	**Reasonable Assurance** 	1) Water Risk Assessments need to be updated. Plan is to complete these via an appointed sub-contractor beginning Jan 2021. 2) Water AE has confirmed that management of our water sub-contractors has improved greatly however issues remain with ability to improve satellite unit's services. 4) Once RA are completed we will be able to review and update all of the PPM required.	
HCAI SURVEILLANCE	***C.difficile***	4 Hospital Onset Healthcare Associated (HOHA) case and 1 Community Onset Healthcare Associated (COHA) cases in January. Year to date position is 36 reported cases (HOHA / COHA) against the ceiling target of 52 cases for 2020-21. This is equivalent to 18.74 cases (data for Apr-Jul 2020) against the target of 25.3 cases per 100,000 bed days. Benchmarking data for January not available. The number of C.difficile cases year to date position is currently below the trajectory.		

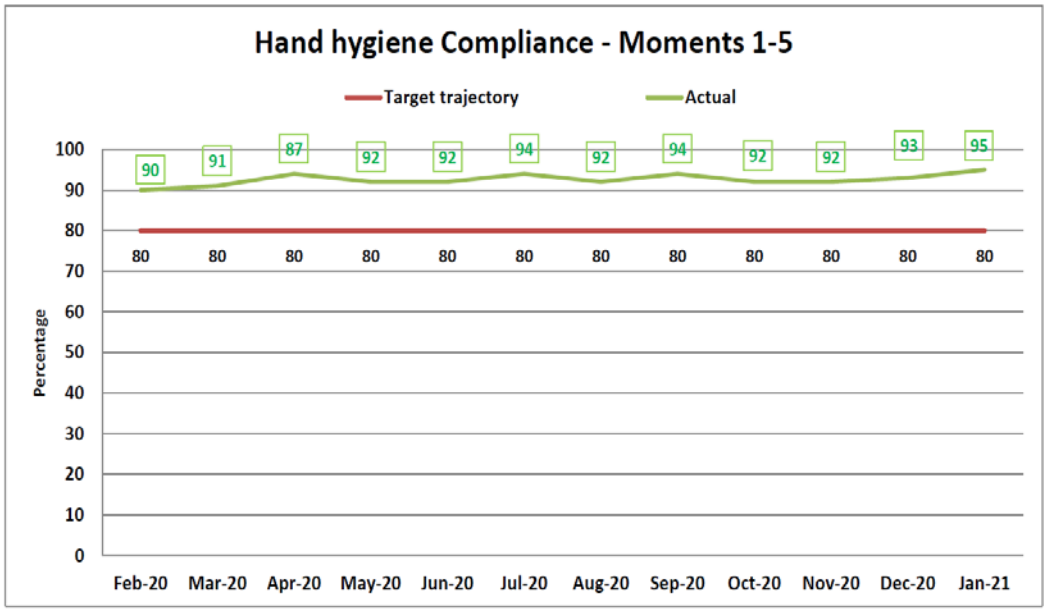
	MRSA bacteraemias	0 Hospital Onset and 0 Community Onset bacteraemia in January. Year to date position is 0 Hospital Onset cases and 6 Community Onset cases. Benchmarking data for not available.	
	MSSA bacteraemias	1 Hospital Onset MSSA bacteraemia in January. Year to date position is 14 Hospital Onset cases (no target set). RAG rating based on Trust rate of 3.12 cases per 100,000 bed days against EoE average of 5.11 cases (data for Apr-Jul 2020). Benchmarking data for January not available.	
	Gram negative bacteraemia: **National monitoring and reduction programme for E.*coli*, *Pseudomonas aeruginosa*, *Klebsiella species*.**	1 Hospital Onset E.*coli* bacteraemia in January. Year to date position is 17 Hospital Onset cases (no target set). RAG rating based on Trust rate of 10.93 cases per 100,000 bed days against EoE average of 14.54 cases (data for Apr-Jul 2020). Benchmarking data for January not available. The IP&C team continue internal reviews.	
		0 Hospital Onset *Pseudomonas aeruginosa* bacteraemia in January. Year to date position is 7 Hospital Onset case (no target set). RAG rating based on Trust rate of 1.56 cases per 100,000 bed days against EoE average of 3.20 cases (data for Apr-Jul 2020). Benchmarking data for January not available.	
		1 Hospital Onset *Klebsiella species* bacteraemia in January. Year to date position is 5 Hospital Onset cases (no target set). RAG rating based on Trust rate of 1.56 cases per 100,000 bed days against EoE average of 7.95 cases (data for Apr-Jul 2020). Benchmarking data for January not available.	
	Carbapenemase Producing Organisms (CPO)	0 new inpatient cases and 0 new outpatient cases identified in January. Year to date position is 3 inpatient cases and 1 outpatient case (no target set). RAG rating based on 2 probable cross transmissions in June. ICNet has been configured to provide alerts to the IP&C Team when known CPO-positive patients are readmitted to ensure prompt isolation.	
	Outbreaks / Periods of Increased Incidence	There were no reportable incidents or outbreaks during January other than what is stated above.	

	Surgical Site Infection	The infection rate for Total Knee Replacement for Apr–Jun 2020 was 0% as there were no operations during this quarter due to COVID. The overall rate for the last 4 quarters for which data has been provided is 1.5%. This remains above the national benchmark of 0.5% and the Trust remains an outlier. Data is being reviewed by the Orthopaedic surgical leads. Work is being carried out to strengthen the processes of monitoring patients, surveillance and supporting the orthopaedic teams to improve outcomes.	
		The infection rate for Total Hip Replacement in Apr–Jun 2020 was 0%, giving an overall rate of 0.4 % for the last 4 quarters for which data has been provided. This is below the national benchmark of 0.6%	
		The infection rate for Repair to Fractured Neck of Femur in Apr–Jun 2020 was 0%, giving an overall rate of 1.6% for the last 4 quarters. This is above the national benchmark of 1.1%.	
AUDITS	**High Impact Interventions (HII)**	HII audit scores in January recorded on IQVIA by ward nursing teams met the agreed standards except: - Intravascular Devices (Target: 95%, January: 89.88%) - Urinary Catheter Care (Target: 95%, January: 57.76%) - Inpatients Environment Peer audit – Overall (Target: 95%, January: 94.02%) - Inpatients Environment - Peer Audit - Ward Environment (Target: 95%, January: 91.67%) RAG rating based on scores meeting or exceeding the agreed standards in 4 out of 7 categories monitored. These HIIs have improved however, this will continue to be a focus with senior leadership teams until standards are raised throughout the organisation and the support is given where needed.	
ANTIMICROBIAL STEWARDSHIP	**Antimicrobial CQUINs**	The 2 antimicrobial CQUINs planned for 2020-21 have been cancelled due to the Covid-19 pandemic.	
	Antimicrobial review	Target to maintain 90% compliance for review of antibiotics within 72 hrs for all inpatients to 90%. Compliance to be monitored at least every 2 months by Pharmacy team. 2020-21: April 94%, May 95%, June 82%, July 100%, August 92%, September 94%, October 92%, November 82%, December 93%. January Antimicrobial review audit has been temporarily suspended to support COVDI 19 clinical work.	

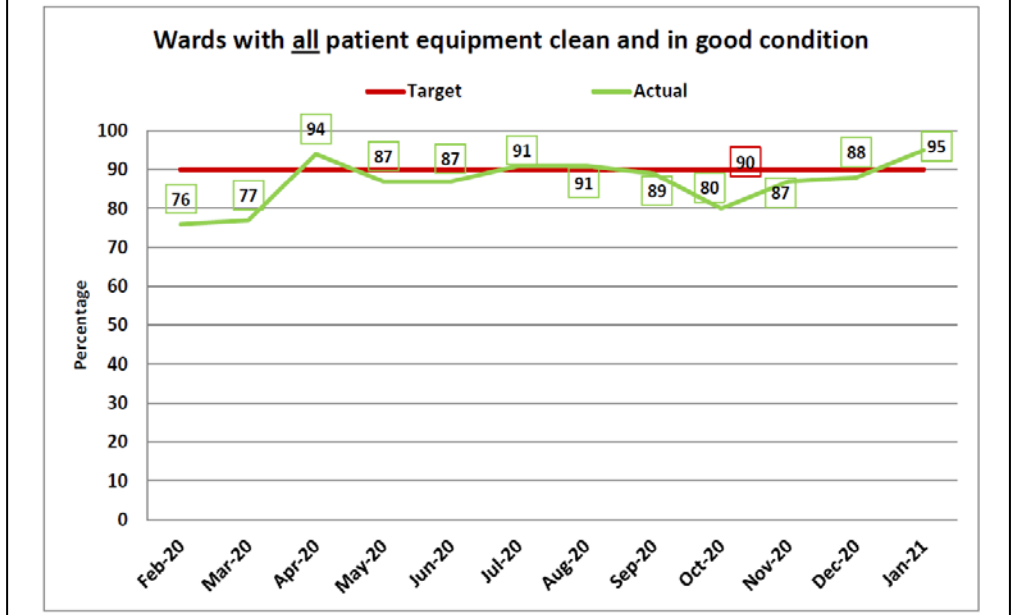
Note: RAG ratings are based on performance against set targets, previous year's performance or PHE benchmarking data, as specified.

IP&C Improvement Plan Trajectories

Hand hygiene



Inpatient Environment: Patient equipment cleanliness & condition



Audit scores are extracted from the IQVIA database of Trust-wide audits.

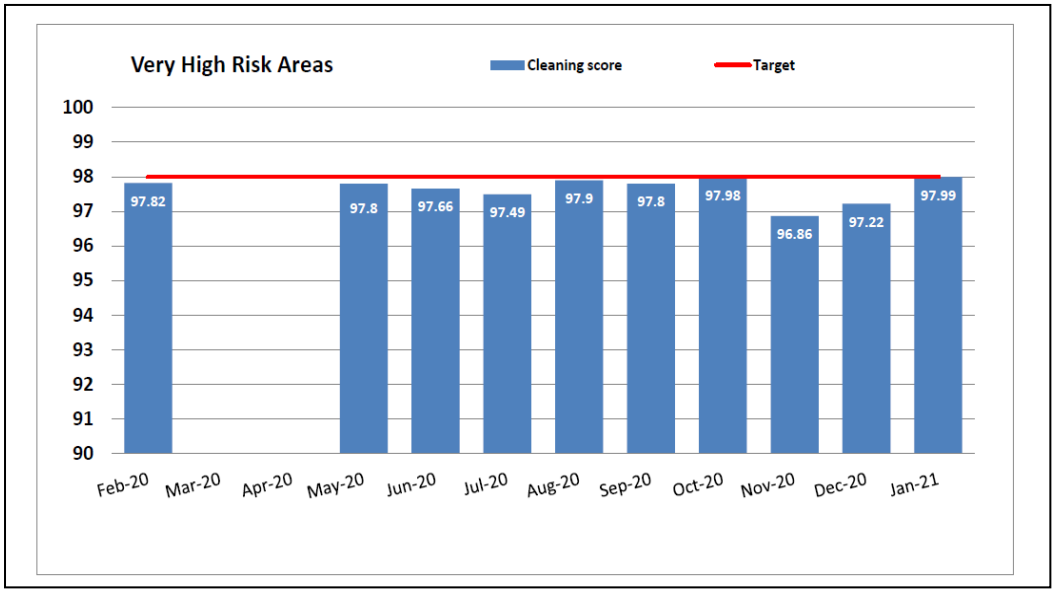
Hand Hygiene audits cover the World Health Organisation (WHO) Moments 1-5 see below:

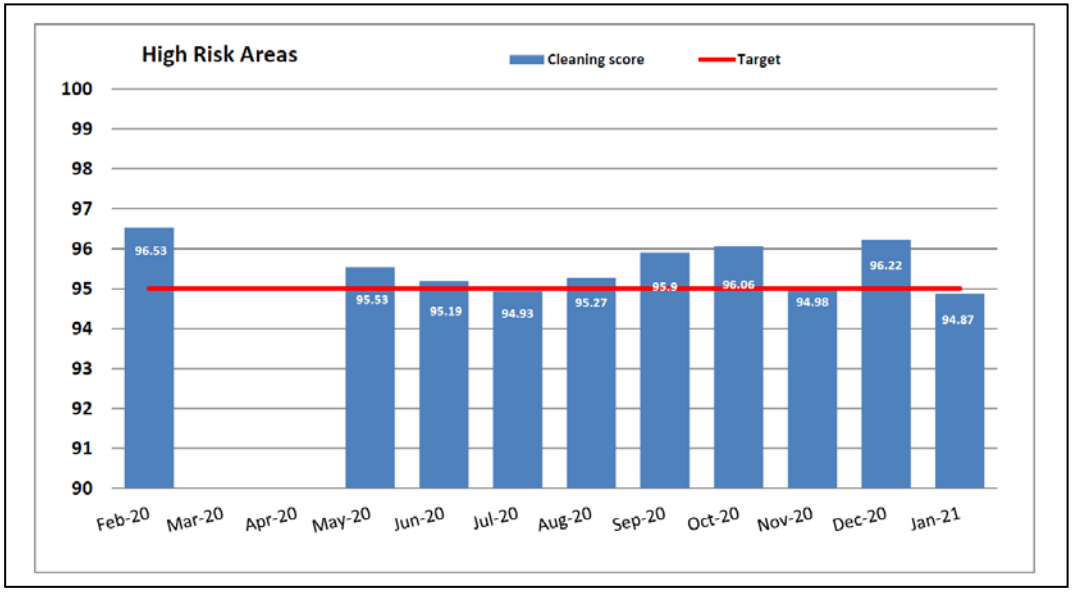
1. Before patient contact
2. Before clean/aseptic procedure
3. After exposure to body fluids
4. After patient contact
5. After contact with patient surroundings

From November 2019, cleanliness of commodes/other patient equipment and equipment condition is recorded as a single combined score which shows the percentage of wards with all commodes and other patient equipment clean, labelled as clean and in good condition.

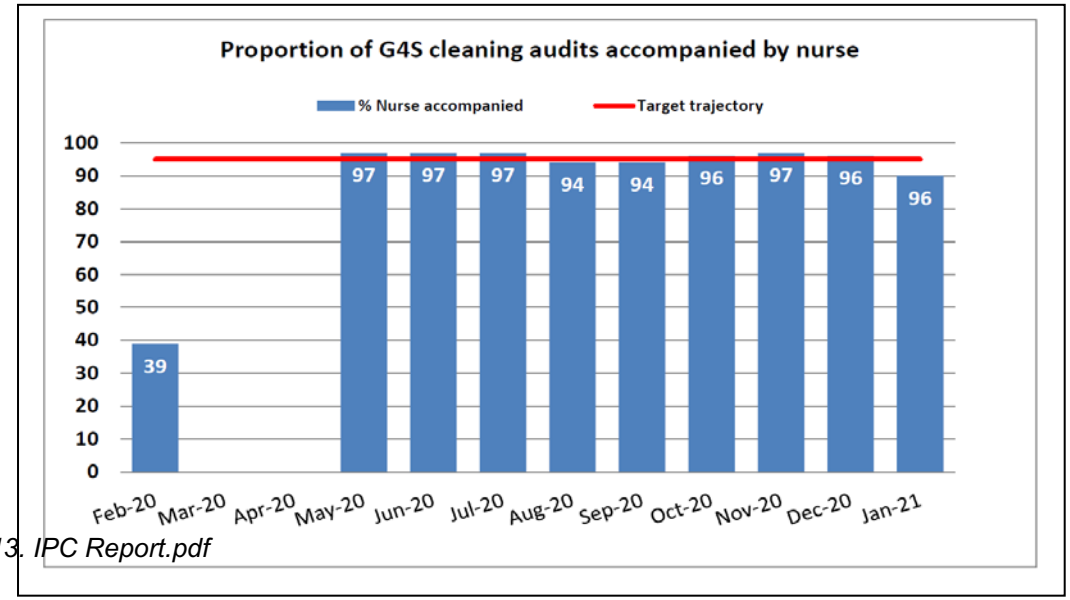
Cleaning audits: First time audit pass rates for very high risk and high risk areas

Note: Cleaning audits were suspended from March to the middle of May due to Covid-19 reconfiguration; compliance scores for March and April are not available.

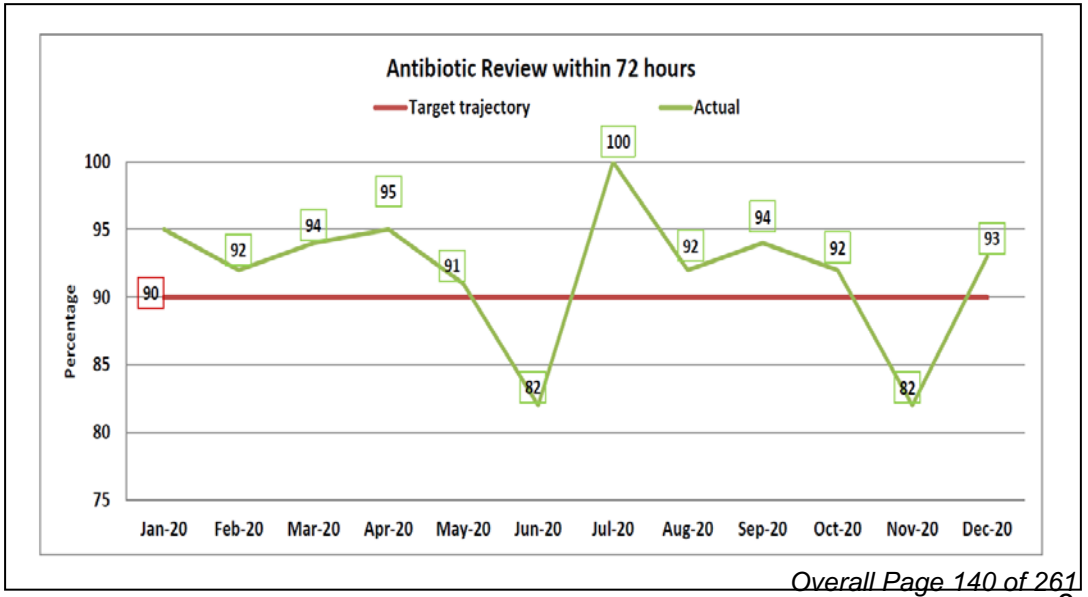




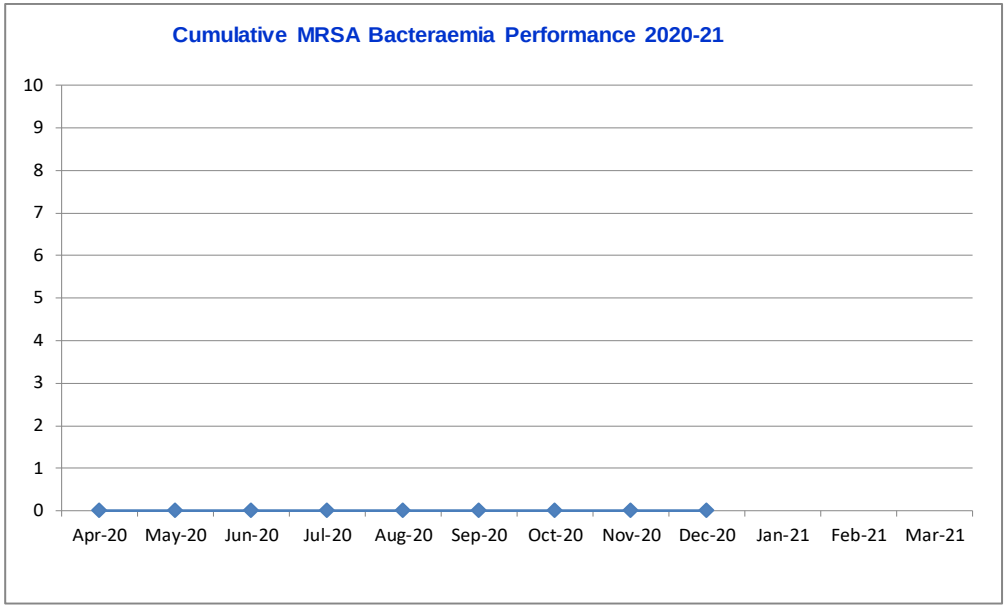
Cleaning audits: Attendance by nursing staff

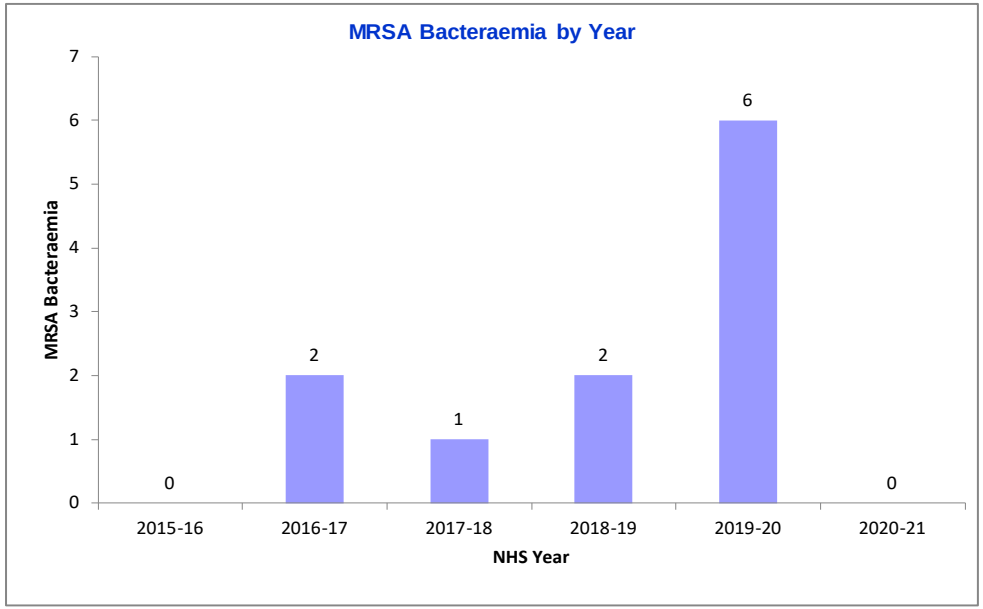


Antimicrobial stewardship



MRSA BACTERAEMIA – HOSPITAL ONSET





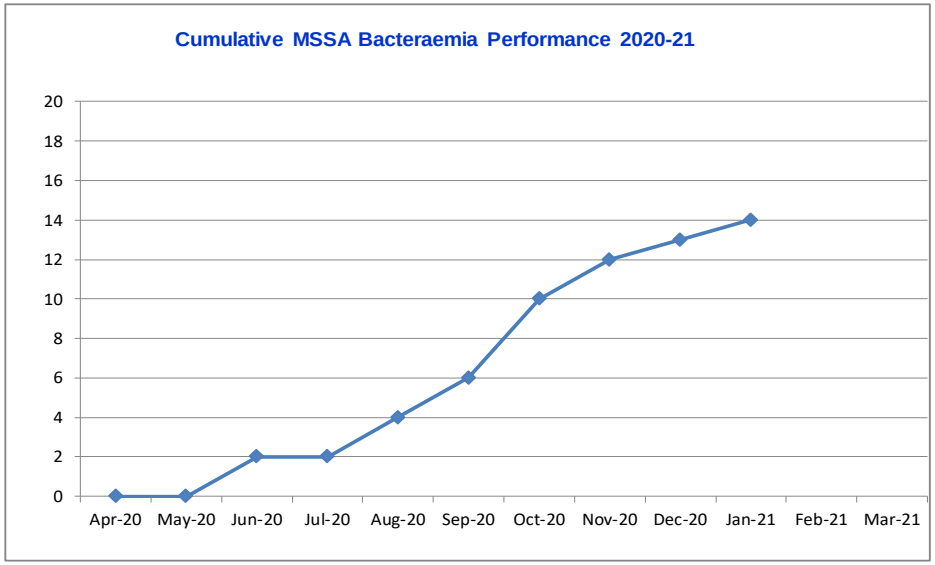
MRSA Bacteraemia by Division

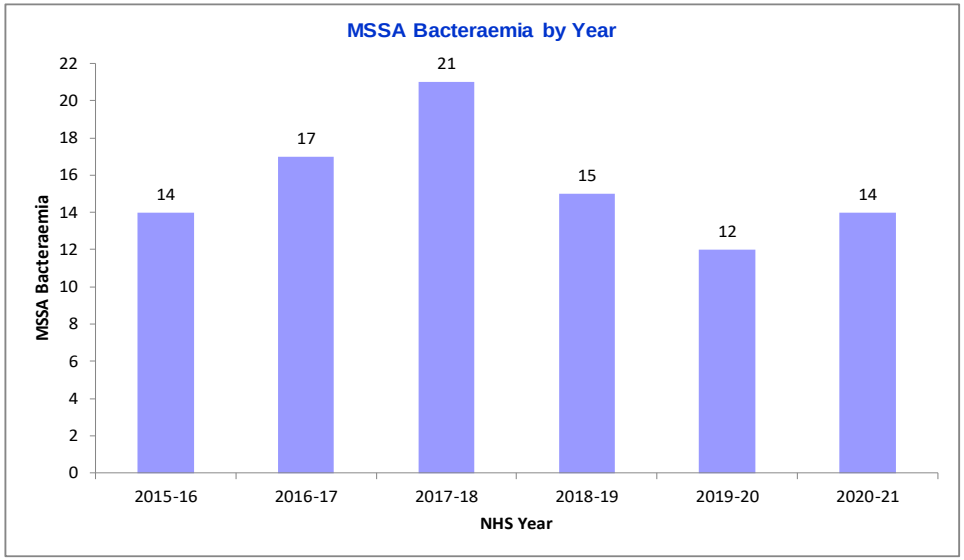
Division	2019-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	2020-21
Cancer	0	0	0	0	0	0	0	0	0	0				0
Medicine	5	0	0	0	0	0	0	0	0	0				0
Surgical	1	0	0	0	0	0	0	0	0	0				0
Women & Children	0	0	0	0	0	0	0	0	0	0				0
Grand Total	6	0	0	0	0	0	0	0	0	0				0

MRSA bacteraemias are classified as Hospital Onset if the sample is taken later than the day following admission. Cases are classified as Community Onset if the positive sample is taken on the day of admission or the following day.

Benchmarking data for Trust apportioned MRSA bacteraemias is not recorded by PHE since April 2018. The PIR process is now only required for Trusts / CCGs with the highest rates which includes ENHCCG.

MSSA BACTERAEMIA - HOSPITAL ONSET





Hospital Onset MSSA Bacteraemia by Division

Division	2019-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	2020-21
Cancer	0	0	0	0	0	0	0	0	0	0	0			0
Medicine	7	0	0	2	0	1	1	2	1	0	1			8
Surgical	4	0	0	0	0	1	1	1	1	1	0			5
Women & Children	1	0	0	0	0	0	0	1	0	0	0			1
MVCC	0	0	0	0	0	0	0	0	0	0	0			0
Grand Total	12	0	0	2	0	2	2	4	2	1	1			14

MSSA bacteraemias are classified as Hospital Onset if the sample is taken later than the day following admission. Cases are classified as Community Onset if the positive sample is taken on the day of admission or the following day.

MSSA – PHE Benchmarking Data

Public Health England

MSSA

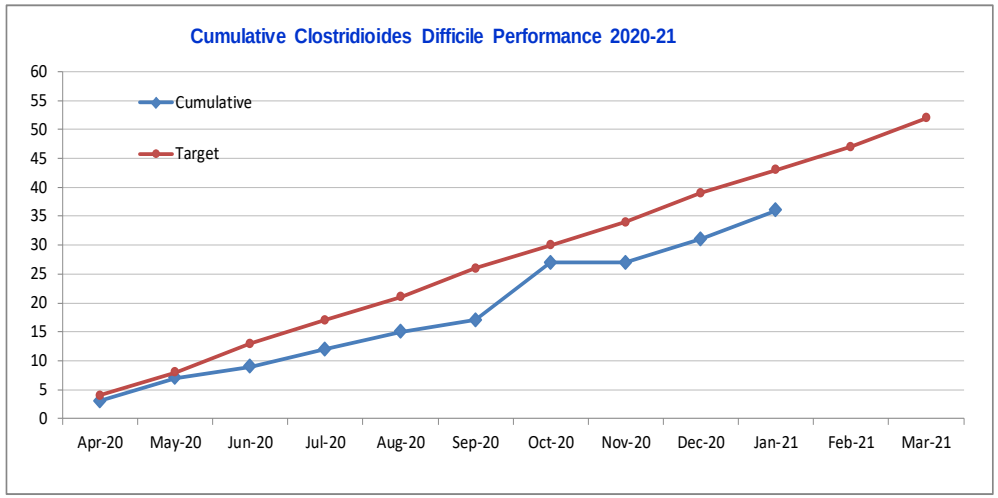
Count of all Hospital-Onset cases identified by acute trust per month

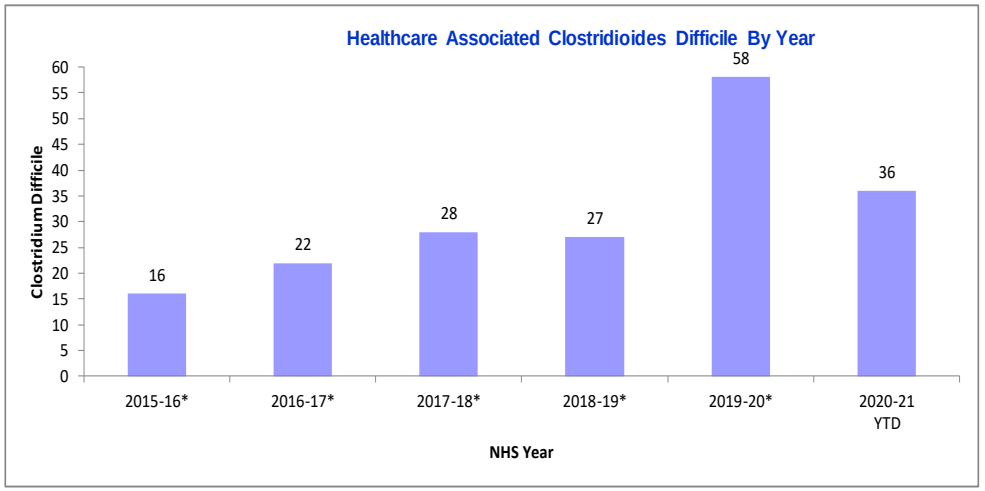
Trust Code	Acute Trust Name	Trajectory	2020									2021			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	3	1	2	3									9
RC1	Bedford Hospitals NHS Trust	N/A	0	0	0	0									0
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	0	2	0	1									3
RWH	East & North Hertfordshire NHS Trust	N/A	0	0	2	0									2
RDE	East Suffolk & North Essex NHS Foundation Trust	N/A	1	5	1	1									8
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	0	0	1	1									2
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	2	0	1	1									4
RQ8	Mid Essex Hospital Services NHS Trust	N/A	2	1	2	0									5
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	1	1	1	0									3
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	0	3	3	1									7
RGN	North West Anglia NHS Foundation Trust	N/A	2	2	1	0									5
RGM	Royal Papworth NHS Foundation Trust	N/A	1	0	0	0									1
RQW	Princess Alexandra Hospital NHS Trust	N/A	1	2	0	1									4
RAJ	Southend University Hospital NHS Foundation Trust	N/A	0	0	0	0									0
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	1	0	0	2									3
RWG	West Hertfordshire Hospitals NHS Trust	N/A	1	0	0	0									1
RGR	West Suffolk Hospitals NHS Trust	N/A	1	0	0	1									2
	East of England Total	**N/A**	**16**	**17**	**14**	**12**									**59**
	England Total	**N/A**	**167**	**210**	**239**	**253**									**869**

Hospital-Onset rate per 100,000 occupied bed days

Trust Code	Acute Trust Name	Trajectory	2020									2021			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	15.73	5.08	10.49	15.23									11.61
RC1	Bedford Hospitals NHS Trust	N/A	0.00	0.00	0.00	0.00									0.00
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	0.00	7.31	0.00	3.66									2.79
RWH	East & North Hertfordshire NHS Trust	N/A	0.00	0.00	12.70	0.00									3.12
RDE	East Suffolk & North Essex NHS Foundation Trust	N/A	3.08	14.92	3.08	2.98									6.07
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	0.00	0.00	8.63	8.35									4.24
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	11.08	0.00	5.54	5.36									5.45
RQ8	Mid Essex Hospital Services NHS Trust	N/A	13.75	6.65	13.75	0.00									8.45
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	7.24	7.00	7.24	0.00									5.34
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	0.00	11.22	11.59	3.74									6.65
RGN	North West Anglia NHS Foundation Trust	N/A	8.67	8.39	4.34	0.00									5.33
RGM	Royal Papworth NHS Foundation Trust	N/A	20.37	0.00	0.00	0.00									5.01
RQW	Princess Alexandra Hospital NHS Trust	N/A	8.68	16.79	0.00	8.40									8.53
RAJ	Southend University Hospital NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00									0.00
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	8.28	0.00	0.00	16.03									6.11
RWG	West Hertfordshire Hospitals NHS Trust	N/A	5.57	0.00	0.00	0.00									1.37
RGR	West Suffolk Hospitals NHS Trust	N/A	9.24	0.00	0.00	8.94									4.54
	East of England Total	**N/A**	**5.63**	**5.79**	**4.93**	**4.09**									**5.11**
	England Total	**N/A**	**5.76**	**7.01**	**8.24**	**8.44**									**25.51**

CLOSTRIDIOIDES DIFFICILE – HEALTHCARE ASSOCIATED





Healthcare Associated Clostridioides Difficile by Division

Division	2019-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	2020-21
Cancer	0	0	0	0	0	0	0	0	0	0	0			0
Medicine	36	2	3	1	2	2	2	8	0	2	3			25
Surgical	20	1	0	1	0	1	0	2	0	1	2			8
Women & Children	1	0	1	0	1	0	0	0	0	1	0			3
MVCC	1	0	0	0	0	0	0	0	0	0	0			0
Grand Total	58	3	4	2	3	3	2	10	0	4	5			36

C.difficile reporting requirements, allocation process and ceiling targets for 2020-21

For 2020-21, *C.difficile* toxin positive cases reported to the Healthcare Associated Infection Data Capture System (HDCS) are assigned as follows:

- **Hospital Onset Healthcare Associated (HOHA):** Detected in hospital 3 or more days after admission (previously 4 or more days after admission)
- **Community Onset Healthcare Associated (COHA):** Detected in the community (or within 2 days of admission) when patient has been an inpatient in the Trust in the previous 4 weeks
- **Community Onset Indeterminate Association (COIA):** Detected in the community (or within 2 days of admission) when patient has been an inpatient in the Trust in the previous 12 weeks but not the most recent 4 weeks
- **Community Onset Community Associated (COCA):** Detected in the community (or within 2 days of admission) when patient has not been an inpatient in the Trust in the previous 12 weeks.

The ceiling target remains at 52 cases for 2020-21.

C.difficile – PHE Benchmarking Data

Public Health England

Clostridioides difficile

Count of all Healthcare Associated cases identified by acute trust per month

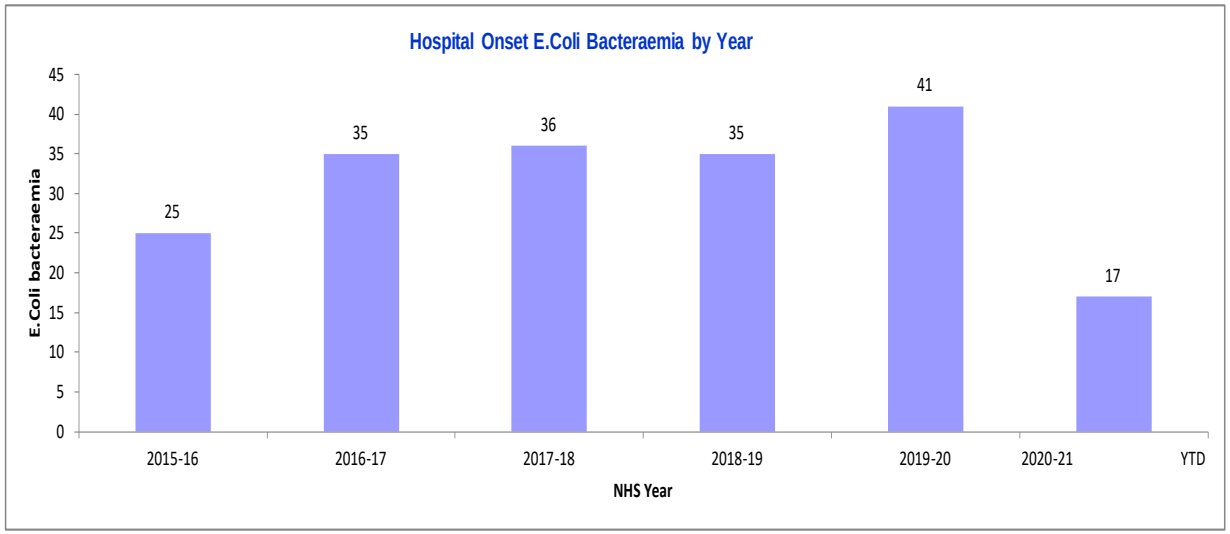
Trust Code	Acute Trust Name	Trajectory	2020									2021			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	51	1	2	3	6									12
RC1	Bedford Hospitals NHS Trust	14	0	1	1	0									2
RGT	Cambridge University Hospitals NHS Foundation Trust	95	4	3	5	5									17
RWH	East & North Hertfordshire NHS Trust	52	3	4	2	3									12
RDE	East Suffolk & North Essex NHS Foundation Trust	107	9	7	4	6									26
RGP	James Paget University Hospitals NHS Foundation Trust	24	2	1	0	2									5
RC9	Luton & Dunstable Hospital NHS Foundation Trust	19	4	4	3	6									17
RQ8	Mid Essex Hospital Services NHS Trust	83	2	2	2	2									8
RD8	Milton Keynes Hospital NHS Foundation Trust	22	1	0	1	3									5
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	35	4	8	9	10									31
RGN	North West Anglia NHS Foundation Trust	68	3	6	6	7									22
RGM	Royal Papworth NHS Foundation Trust	11	0	1	0	1									2
RQW	Princess Alexandra Hospital NHS Trust	27	1	2	1	4									8
RAJ	Southend University Hospital NHS Foundation Trust	51	8	4	8	5									25
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	44	2	3	5	6									16
RWG	West Hertfordshire Hospitals NHS Trust	34	3	2	0	6									11
RGR	West Suffolk Hospitals NHS Trust	20	2	1	3	5									11
	East of England Total	**757**	**49**	**51**	**53**	**77**									**230**
	England Total	**TBC**	**410**	**521**	**580**	**662**									**2173**

Healthcare-Associated rate per 100,000 occupied bed days

Trust Code	Acute Trust Name	Trajectory	2020									2021			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	21.40	5.24	10.15	15.73	30.45									15.48
RC1	Bedford Hospitals NHS Trust	10.00	0.00	8.36	8.64	0.00									4.25
RGT	Cambridge University Hospitals NHS Foundation Trust	28.60	15.11	10.97	18.89	18.28									15.79
RWH	East & North Hertfordshire NHS Trust	25.30	19.05	24.58	12.70	18.44									18.74
RDE	East Suffolk & North Essex NHS Foundation Trust	25.70	27.75	20.89	12.33	17.90									19.71
RGP	James Paget University Hospitals NHS Foundation Trust	18.60	17.25	8.35	0.00	16.70									10.61
RC9	Luton & Dunstable Hospital NHS Foundation Trust	8.70	22.16	21.44	16.62	32.16									23.16
RQ8	Mid Essex Hospital Services NHS Trust	42.00	13.75	13.30	13.75	13.30									13.52
RD8	Milton Keynes Hospital NHS Foundation Trust	13.30	7.24	0.00	7.24	21.01									8.90
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	11.30	15.46	29.92	34.78	37.40									29.46
RGN	North West Anglia NHS Foundation Trust	26.00	13.01	25.18	26.02	29.38									23.46
RGM	Royal Papworth NHS Foundation Trust	19.20	0.00	19.71	0.00	19.71									10.02
RQW	Princess Alexandra Hospital NHS Trust	17.60	8.68	16.79	8.68	33.59									17.07
RAJ	Southend University Hospital NHS Foundation Trust	29.10	55.02	26.62	55.02	33.28									42.28
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	29.70	16.56	24.04	41.40	48.08									32.58
RWG	West Hertfordshire Hospitals NHS Trust	15.10	16.72	10.79	0.00	32.36									15.08
RGR	West Suffolk Hospitals NHS Trust	15.80	18.48	8.94	27.71	44.70									24.99
	East of England Total	**TBC**	**17.25**	**17.37**	**18.66**	**26.23**									**19.91**
	England Total	**TBC**	**14.14**	**17.38**	**20.00**	**22.09**									**18.42**

E.COLI BACTERAEMIA – HOSPITAL ONSET

The Trust does not have specific targets at present. However, a number of strategies are being introduced in the Trust to minimise cases, including initiatives to reduce hospital acquired pneumonias (HAP) and catheter associated urinary tract infections (CAUTI). There is a whole health economy approach to reducing Gram Negative bacteraemias and the Trust is participating in this programme. A focus of this approach is to reduce Urinary Tract Infections (UTI), including participation in a CCG-led project to improve hydration. The IP&C Team will explore how ICNet can be used to support a process to identify and investigate catheter-associated UTIs which are related to E.coli bacteraemias.

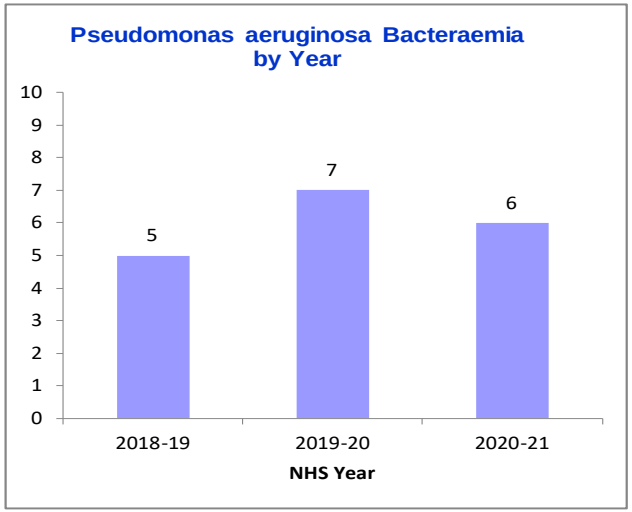


Hospital Onset E.Coli Bacteraemia by Division

Division	2019-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-19	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	2020-21
Cancer	0	0	0	0	0	0	0	0	0	0	0			0
Medicine	24	1	1	0	1	0	0	1	1	3	0			8
Surgical	12	1	0	1	0	0	0	0	1	0	1			4
Women & Children	4	1	0	0	1	1	2	0	0	0	0			5
MVCC	1	0	0	0	0	0	0	0	0	0	0			0
Grand Total	41	3	1	1	2	1	2	1	2	3	1			17

E.coli bacteraemias are classified as Hospital Onset if the sample is taken later than the day following admission. Cases are classified as Community Onset if the positive sample is taken on the day of admission or the following day.

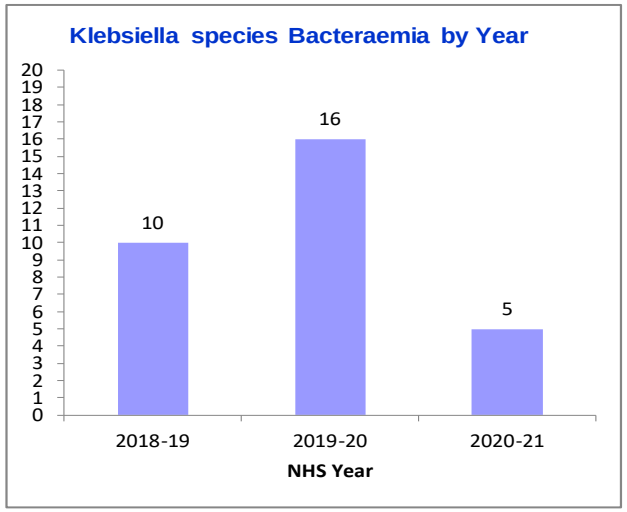
PSEUDOMONAS AERUGINOSA BACTERAEMIA – HOSPITAL ONSET



Hospital Onset Pseudomonas aeruginosa Bacteraemia by Division

Division	2019-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	2020-21
Cancer	0	0	0	0	0	0	0	0	1	0				1
Medicine	3	0	0	0	1	0	3	0	0	0				4
Surgical	4	0	0	0	0	0	0	1	0	0				1
Women & Children	0	0	0	0	0	0	0	0	0	0				0
MVCC	0	0	0	0	0	0	0	0	0	0				0
Grand Total	7	0	0	0	1	0	3	1	1	0				6

KLEBSIELLA SPECIES BACTERAEMIA – HOSPITAL ONSET



Hospital Onset Klebsiella species Bacteraemia by Division

Division	2019-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	2020-21
Cancer	**0**	0	0	0	0	0	0	0	0	0	0			**0**
Medicine	**7**	0	1	0	0	0	0	1	0	0	0			**2**
Surgical	**8**	0	0	0	0	0	0	1	1	0	1			**3**
Women & Children	**1**	0	0	0	0	0	0	0	0	0	0			**0**
MVCC	**0**	0	0	0	0	0	0	0	0	0	0			**0**
Grand Total	**16**	**0**	**1**	**0**	**0**	**0**	**0**	**2**	**1**	**0**	**1**			**5**

Pseudomonas aeruginosa and *Klebsiella species* bacteraemia are classified as Hospital Onset if the sample is taken later than the day following admission. Cases are classified as Community Onset if the positive sample is taken on the day of admission or the following day.

E.coli – PHE Benchmarking Data

Public Health England

Escherichia coli

Count of all Hospital-Onset cases identified by acute trust per month

Trust Code	Acute Trust Name	Trajectory	2020									2021			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	4	5	8	3									20
RC1	Bedford Hospitals NHS Trust	N/A	0	1	0	0									1
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	4	10	7	8									29
RWH	East & North Hertfordshire NHS Trust	N/A	3	1	1	2									7
RDE	East Suffolk & North Essex NHS Foundation Trust	N/A	3	0	8	6									17
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	1	4	3	3									11
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0	2	3	6									11
RQ8	Mid Essex Hospital Services NHS Trust	N/A	2	1	4	1									8
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	1	1	1	2									5
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	5	1	10	7									23
RGN	North West Anglia NHS Foundation Trust	N/A	4	5	2	7									18
RGM	Royal Papworth NHS Foundation Trust	N/A	1	1	0	1									3
RQW	Princess Alexandra Hospital NHS Trust	N/A	1	1	1	2									5
RAJ	Southend University Hospital NHS Foundation Trust	N/A	0	0	0	0									0
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0	1	0	2									3
RWG	West Hertfordshire Hospitals NHS Trust	N/A	0	3	1	2									6
RGR	West Suffolk Hospitals NHS Trust	N/A	0	0	0	1									1
	East of England Total	**N/A**	**29**	**37**	**49**	**53**									**168**
	England Total	**N/A**	**367**	**425**	**478**	**515**									**1785**

Hospital-Onset rate per 100,000 occupied bed days

Trust Code	Acute Trust Name	Trajectory	2020									2021			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	20.98	25.38	41.96	15.23									25.79
RC1	Bedford Hospitals NHS Trust	N/A	0.00	8.36	0.00	0.00									2.12
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	15.11	36.55	26.44	29.24									26.94
RWH	East & North Hertfordshire NHS Trust	N/A	19.05	6.15	6.35	12.29									10.93
RDE	East Suffolk & North Essex NHS Foundation Trust	N/A	9.25	0.00	24.67	17.90									12.89
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	8.63	33.40	25.88	25.05									23.34
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0.00	10.72	16.62	32.16									14.98
RQ8	Mid Essex Hospital Services NHS Trust	N/A	13.75	6.65	27.49	6.65									13.52
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	7.24	7.00	7.24	14.00									8.90
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	19.32	3.74	38.64	26.18									21.86
RGN	North West Anglia NHS Foundation Trust	N/A	17.35	20.98	8.67	29.38									19.20
RGM	Royal Papworth NHS Foundation Trust	N/A	20.37	19.71	0.00	19.71									15.03
RQW	Princess Alexandra Hospital NHS Trust	N/A	8.68	8.40	8.68	16.79									10.67
RAJ	Southend University Hospital NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00									0.00
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0.00	8.01	0.00	16.03									6.11
RWG	West Hertfordshire Hospitals NHS Trust	N/A	0.00	16.18	5.57	10.79									8.22
RGR	West Suffolk Hospitals NHS Trust	N/A	0.00	0.00	0.00	8.94									2.27
	East of England Total	**N/A**	**10.21**	**12.60**	**17.25**	**18.06**									**14.54**
	England Total	**N/A**	**12.65**	**14.18**	**16.48**	**17.18**									**15.13**

Pseudomonas aeruginosa – PHE Benchmarking Data

Public Health England

Pseudomonas aeruginosa

Count of all Hospital-Onset cases identified by acute trust per month

Trust Code	Acute Trust Name	Trajectory	2020									2021			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	0	1	1	1									3
RC1	Bedford Hospitals NHS Trust	N/A	0	0	0	0									0
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	2	4	2	4									12
RWH	East & North Hertfordshire NHS Trust	N/A	0	0	0	1									1
RDE	East Suffolk & North Essex NHS Foundation Trust	N/A	1	0	0	2									3
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	0	0	1	0									1
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0	0	1	0									1
RQ8	Mid Essex Hospital Services NHS Trust	N/A	0	2	0	0									2
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	0	0	1	1									2
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	1	0	3	1									5
RGN	North West Anglia NHS Foundation Trust	N/A	0	0	0	1									1
RGM	Royal Papworth NHS Foundation Trust	N/A	0	0	1	0									1
RQW	Princess Alexandra Hospital NHS Trust	N/A	0	1	0	0									1
RAJ	Southend University Hospital NHS Foundation Trust	N/A	0	0	0	0									0
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	1	0	0	3									4
RWG	West Hertfordshire Hospitals NHS Trust	N/A	0	0	0	0									0
RGR	West Suffolk Hospitals NHS Trust	N/A	0	0	0	0									0
	East of England Total	**N/A**	**5**	**8**	**10**	**14**									**37**
	England Total	**N/A**	**89**	**110**	**94**	**123**									**416**

Hospital-Onset rate per 100,000 occupied bed days

Trust Code	Acute Trust Name	Trajectory	2020									2021			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	0.00	5.08	5.24	5.08									3.87
RC1	Bedford Hospitals NHS Trust	N/A	0.00	0.00	0.00	0.00									0.00
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	7.55	14.62	7.55	14.62									11.15
RWH	East & North Hertfordshire NHS Trust	N/A	0.00	0.00	0.00	6.15									1.56
RDE	East Suffolk & North Essex NHS Foundation Trust	N/A	3.08	0.00	0.00	5.97									2.27
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	0.00	0.00	8.63	0.00									2.12
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0.00	0.00	5.54	0.00									1.36
RQ8	Mid Essex Hospital Services NHS Trust	N/A	0.00	13.30	0.00	0.00									3.38
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	0.00	0.00	7.24	7.00									3.56
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	3.86	0.00	11.59	3.74									4.75
RGN	North West Anglia NHS Foundation Trust	N/A	0.00	0.00	0.00	4.20									1.07
RGM	Royal Papworth NHS Foundation Trust	N/A	0.00	0.00	20.37	0.00									5.01
RQW	Princess Alexandra Hospital NHS Trust	N/A	0.00	8.40	0.00	0.00									2.13
RAJ	Southend University Hospital NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00									0.00
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	8.28	0.00	0.00	24.04									8.14
RWG	West Hertfordshire Hospitals NHS Trust	N/A	0.00	0.00	0.00	0.00									0.00
RGR	West Suffolk Hospitals NHS Trust	N/A	0.00	0.00	0.00	0.00									0.00
	East of England Total	**N/A**	**1.76**	**2.73**	**3.52**	**4.77**									**3.20**
	England Total	**N/A**	**3.07**	**3.67**	**3.24**	**4.10**									**3.53**

Klebsiella species – PHE Benchmarking Data

Public Health England

Klebsiella species

Count of all Hospital-Onset cases identified by acute trust per month

Trust Code	Acute Trust Name	Trajectory	2020									2021			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	1	4	3	2									10
RC1	Bedford Hospitals NHS Trust	N/A	0	0	0	1									1
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	10	2	4	6									22
RWH	East & North Hertfordshire NHS Trust	N/A	0	1	0	0									1
RDE	East Suffolk & North Essex NHS Foundation Trust	N/A	2	3	1	3									9
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	1	0	2	1									4
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	1	0	2	1									4
RQ8	Mid Essex Hospital Services NHS Trust	N/A	4	1	1	1									7
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	2	0	1	0									3
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	2	2	1	1									6
RGN	North West Anglia NHS Foundation Trust	N/A	3	2	2	0									7
RGM	Royal Papworth NHS Foundation Trust	N/A	4	0	2	0									6
RQW	Princess Alexandra Hospital NHS Trust	N/A	1	0	2	0									3
RAJ	Southend University Hospital NHS Foundation Trust	N/A	0	0	0	0									0
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	1	1	1	2									5
RWG	West Hertfordshire Hospitals NHS Trust	N/A	1	0	1	2									4
RGR	West Suffolk Hospitals NHS Trust	N/A	0	0	0	0									0
	East of England Total	**N/A**	**33**	**16**	**23**	**20**									**92**
	England Total	**N/A**	**301**	**236**	**213**	**253**									1003

Hospital-Onset rate per 100,000 occupied bed days

Trust Code	Acute Trust Name	Trajectory	2020									2021			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	5.24	20.30	15.73	10.15									12.90
RC1	Bedford Hospitals NHS Trust	N/A	0.00	0.00	0.00	8.36									2.12
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	37.77	7.31	15.11	21.93									20.43
RWH	East & North Hertfordshire NHS Trust	N/A	0.00	6.15	0.00	0.00									1.56
RDE	East Suffolk & North Essex NHS Foundation Trust	N/A	6.17	8.95	3.08	8.95									6.82
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	8.63	0.00	17.25	8.35									8.49
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	5.54	0.00	11.08	5.36									5.45
RQ8	Mid Essex Hospital Services NHS Trust	N/A	27.49	6.65	6.87	6.65									11.83
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	14.47	0.00	7.24	0.00									5.34
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	7.73	7.48	3.86	3.74									5.70
RGN	North West Anglia NHS Foundation Trust	N/A	13.01	8.39	8.67	0.00									7.46
RGM	Royal Papworth NHS Foundation Trust	N/A	81.47	0.00	40.74	0.00									30.05
RQW	Princess Alexandra Hospital NHS Trust	N/A	8.68	0.00	17.35	0.00									6.40
RAJ	Southend University Hospital NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00									0.00
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	8.28	8.01	8.28	16.03									10.18
RWG	West Hertfordshire Hospitals NHS Trust	N/A	5.57	0.00	5.57	10.79									5.48
RGR	West Suffolk Hospitals NHS Trust	N/A	0.00	0.00	0.00	0.00									0.00
	East of England Total	**N/A**	**11.62**	**5.45**	**8.10**	**6.81**									**7.96**
	England Total	**N/A**	**10.38**	**7.87**	**7.34**	**8.44**									**8.50**

Carbapenemase Producing Organisms

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.

The ICNet system was fully implemented in June 2019 and has been configured to enable prompt identification and isolation of readmitted patients previously identified as positive for CPO.

Two cases in Paediatrics in June 2020 have been investigated as probable cross-transmissions. Several meetings have been held to identify actions needed and to reinforce IP&C precautions. All other patients in the department have been tested and no further cases have been identified.

Carbapenemase-Producing Organisms - 2020-21

Division/Dept		2019-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	2020-21
INPATIENTS	Renal Ward - Lister	4	0	0	0	0	0	0	0	0	0	0			0
	Medicine	8	0	0	0	0	0	0	0	0	0	0			0
	Surgery	6	0	1	0	0	0	0	0	0	0	0			1
	W&C	1	0	0	2	0	0	0	0	0	0	0			2
	MVCC	0	0	0	0	0	0	0	0	0	0	0			0
RENAL DIALYSIS UNITS	Lister	0	0	0	0	0	0	0	0	0	0	0			0
	L&D	1	0	0	0	0	0	0	0	0	0	0			0
	Harlow	0	0	0	0	0	0	0	0	0	0	0			0
	St Albans	0	0	0	0	0	0	0	0	0	0	0			0
	Bedford	0	0	0	0	0	0	0	0	0	0	0			0
OUTPATIENTS	Lister	6	0	1	0	0	0	0	0	0	0	0			1
	QEII	0	0	0	0	0	0	0	0	0	0	0			0
	HCH	0	0	0	0	0	0	0	0	0	0	0			0
	MVCC	0	0	0	0	0	0	0	0	0	0	0			0
TOTAL (TRUST PATIENTS)		26	0	2	2	0	0	0	0	0	0	0			4

0

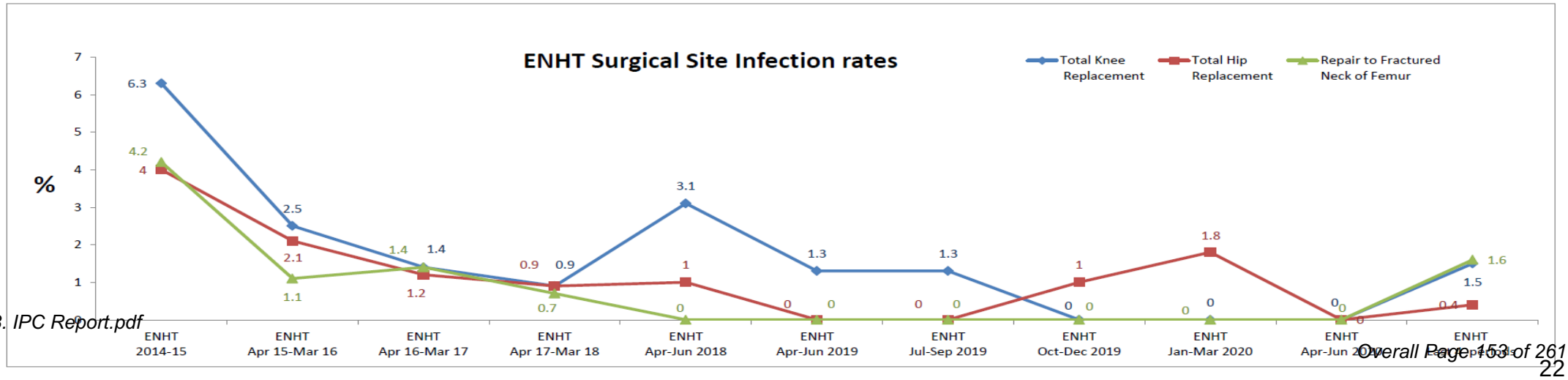
CPE Specimens		0	0	0	0	0	0	0	0	0	0	0			0

Surgical Site Infection Rates

SSI figures over the last 4 periods (April 2019-Jun 2020) show an overall reduction in infection rates in all three categories monitored (Total Knee Replacement, Total Hip Replacement & Repair of Fractured Neck of Femur), compared to the 2014-15 figures. There were no TKR in Apr-Jun 2020 due to COVID the TKR infection rate in Jan-Mar 2020 – Apr-Jun 2020 was 0% but the overall rate for the past 4 periods is 1.5%. This is above the national benchmark (0.5%) and the Trust remains an outlier. There was 0 THR infection in Apr-Jun 2020, which gives an infection rate of 0% due to the reduced number of operations carried out. The THR rate over the last 4 quarters was 0.4% which is below the national benchmark (0.6%). For the NOF, the rate for April-Jun 2020 was 0% and the rate for the last 4 quarters is 1.6%. This is above the national benchmark (1.1%)
SSI surveillance resumed from April 2019, having been suspended from July 2018 due to staffing issues. Most recent results for Jan-Mar 2020 are included below.

Surgical Site Infection rates	Apr 15-Mar 16 ENHT	Apr 16-Mar 17 ENHT	Apr 17-Mar 18 ENHT	Apr-Jun 18 ENHT	Apr-Jun 19 ENHT	July-Sep 19 ENHT	Oct-Dec 19 ENHT	Jan-Mar 20 ENHT	Apr-Jun 20 ENHT	* Last 4 periods ENHT	National Benchmarks 2014-2019
Total Knee Replacement	**2.5%**	**1.4%**	**0.9%**	**3.1%**	**1.3%**	**1.3%**	**0%**	**0%**	**0%**	**1.5%**	**0.5%**
TKR infections / ops	6 / 238	4 / 293	3 / 352	3 / 98	1 / 78	1 / 79	0 / 62	0 / 48	0 / 0	4 / 267	
Total Hip Replacement	**2.1%**	**1.2%**	**0.9%**	**1%**	**0%**	**0%**	**1%**	**1.8%**	**0.0%**	**0.4%**	**0.6%**
THR infections / ops	8 / 386	5 / 427	4 / 442	1 / 105	0 / 109	0 / 106	1 / 101	1 / 55	0 / 6	1 / 268	
Repair Fractured Neck of Femur	**1.1%**	**1.4%**	**0.7%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**2%**	**1.1%**
#NOF infections / ops	4 / 359	5 / 365	2 / 269	0 / 56	0 / 47	0 / 53	0 / 43	0 / 30	0 / 56	3 / 182	

*** The last 4 quarters for which data has been collected are considered most useful for identifying trends, due to the comparatively small no. of operations per quarter**
ENHT participation was suspended between July 2018 & March 2019 inclusive so there is no data for that period.



High Impact Intervention Audit Scores

High Impact Interventions	2019-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD 2020-21	Target	Amber
Hand Hygiene (MOMENTS 1-5)	89.45%	94.43%	92.50%	92.38%	93.55%	92.05%	93.53%	92.44%	91.77%	93.51%	95.18%			93.00%	80.00%	70.00%
Intravascular Devices	87.27%	88.79%	86.36%	89.73%	88.67%	89.54%	88.82%	89.67%	89.83%	78.68%	89.88%			88.61%	95.00%	80.00%
Urinary Catheter Care	53.45%	45.56%	47.50%	52.56%	50.84%	55.95%	51.83%	52.88%	54.78%	44.53%	57.76%			51.94%	95.00%	80.00%
Renal Dialysis Catheter	100.00%	100.00%	98.85%	99.65%	100.00%	99.57%	100.00%	99.51%	100.00%	99.24%	100.00%			99.66%	95.00%	80.00%
Inpatients Environment Peer Audit (Overall)	80.12%	90.00%	90.94%	90.20%	93.65%	93.77%	91.53%	83.33%	89.39%	88.18%	94.02%			90.41%	95.00%	80.00%
Inpatients Environment - Peer Audit - Ward Environment	83.64%	75.00%	96.08%	95.00%	100.00%	98.41%	100.00%	88.24%	92.59%	92.42%	91.67%			94.59%	95.00%	80.00%
Inpatients Environment Peer Audit (Patient Equipment Cleanliness & Condition)	75.59%	93.75%	86.67%	87.18%	90.68%	91.14%	89.25%	79.70%	86.96%	88.07%	95.08%			88.09%	90.00%	75.00%

Audit scores are extracted from the IQVIA database of Trust-wide audits.

Hand Hygiene audits cover the World Health Organisation (WHO) Moments 1-5 see below:

1. Before patient contact
2. Before clean/aseptic procedure
3. After exposure to body fluids
4. After patient contact
5. After contact with patient surroundings)

East and North Hertfordshire NHS Trust

Agenda Item: 14

TRUST BOARD – 3 MARCH 2021
Maternity Assessment and Assurance Tool

Purpose of report and executive summary (250 words max): To present to the Board the final version of the Maternity Assessment and Assurance Tool, as submitted by the Trust on 15 February. Prior to this final submission, the draft was discussed and approved at our extraordinary LMNS Partnership Board on the 12th February 2021 and at the Trust Quality and Safety Committee, a sub-committee of our Trust Board at the end of January 2021.		
Action required: For discussion		
Previously considered by: Discussed by QSC since publication of the Ockenden report.		
Director: Chief Nurse	**Presented by:** Chief Nurse	**Author:** Chief Nurse

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) Quality
Any other risk issues (quality, safety, financial, HR, legal, equality):

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

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NHS Trust

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15th February 2021

Wendy Matthews OBE
Regional Chief Midwife, Director of Nursing
East of England
NHS England & NHS Improvement

Sent via email only to: w.matthews3@nhs.net

Dear Wendy

Further to our initial response to the Immediate and Essential Actions (IEA) required following the publication of Donna Ockenden's (December, 2020) initial report, please find attached our completed Maternity assurance and assessment tool.

Thank you for your input and feedback following a review of our draft submission. We have updated our assurance and assessment tool in response to this. Prior to this final submission, the draft was discussed and approved at our extraordinary LMNS Partnership Board on the 12th February 2021 and at the Trust Quality and Safety Committee, a sub-committee of our Trust Board at the end of January 2021. The Trust Board will formally receive the final report on 3rd March 2021.

Please do not hesitate to contact me if you have any further questions or queries.

Yours sincerely

Rachael Corser
Chief Nurse

Enc. Appendix 1, Maternity assurance and assessment tool

Maternity services assessment and assurance tool

We have devised this tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their boards, Local Maternity System, and NHS England and NHS Improvement regional teams. Rather than a tick box exercise, the tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and any support requirements. We have cross-referenced the 7 IEAs in the report with the urgent clinical priorities and the ten Maternity incentive scheme safety actions where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the technical guidance.

We want providers to use the publication of the report as an opportunity to objectively review their evidence and outcome measures and consider whether they have *assurance* that the 10 safety actions and 7 IEAs are being met. As part of the assessment process, actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited. This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report. We would also like providers to undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report. We strongly recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2.

Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation. We expect boards to robustly assess and challenge the assurances provided and would ask providers to consider utilising their internal audit function to provide independent assurance that the process of assessment and evidence provided is sufficiently rigorous. If providers choose not to utilise internal audit to support this assessment, then they may wish to consider including maternity audit activity in their plans for 2020/21.

Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. This will ensure that the 7 IEAs will be implemented with the pace and rigour commensurate with the findings and ensure that mothers and their babies are safe.

Section 1

Immediate and Essential Action 1: Enhanced Safety

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.

- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.

- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Link to urgent clinical priorities:

(a) A plan to implement the Perinatal Clinical Quality Surveillance Model
(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1?	• LMNS governance lead in post to champion and promote quality and safety governance across the LMNS • LMNS Safety forum is in place to increase the partnership and share, monitor, improve and implement quality and safety issues across the LMNS. The summary from this forum is presented to LMNS programme board • Main responsibilities of the forum include: o review of nationally published reports, local measures, and feedback from women and families o review, monitor, and implement actions arising from the adverse incidents o review new guidance and benchmarking local data relating to quality and safety o review of updates from patient safety initiatives o develop a Safety Risk Strategy for the LMNS • The membership of the LMNS safety forum includes Consultant Obstetrician, Consultant Neonatologist and Safety/Risk midwife from all three Trusts in the LMNS to enhance collaborative working • Additional standing items on the LMNS Safety forum agenda include LMNS wide maternity and neonatal dashboard, LMNS wide joint safety highlight report, learning from risks, Safety and Quality initiatives. • LMNS wide Directors of Midwifery meeting is in place to review SIs and action plans • All new SIs are highlighted to the Trust Board in the integrated performance report. The board also receives a quarterly SI report which details themes and learning from all SIs. All SI reports are signed off by the Chief Nurse and the Medical Director. The sub-board committee (Quality and Safety Committee) receives monthly highlight reports. Non-Executive Director and Chief Nurse attend the Maternity & Neonatal Quality and Safety Committee where details around incidents and risks are shared and discussed. This structure is referenced in the Risk management strategy • Both the Trust level as well as LMNS level Maternity dashboard and Highlight report are in place which are thoroughly discussed at the LMNS safety forum • Maternity dashboard is shared at various forums e.g. with Trust Board via its subcommittee for Quality & Safety (QSC) on monthly basis, at Trust Women and Neonates Quality and Safety Committee (TWNQSC) on a bi-monthly basis, at Maternity and Neonatal Board on monthly basis, with all maternity staff on monthly basis and with LMNS programme board on quarterly basis • All maternal and neonatal deaths are discussed as part of the Perinatal Mortality Review Meeting (PMRT). External colleagues e.g. LMNS governance lead/ governance midwife from other Trust within the LMNS are in attendance. • Action plan in place for perinatal clinical quality surveillance model • High standard data is submitted to the Maternity Services Dataset monthly • All the qualifying cases are reported to HSIB and NHS Resolution's Early Notification Scheme

Describe how we are using this measurement and reporting to drive improvement?	• LMNS wide dashboard compares a range of local safety, quality, activity, and workforce indicators with other Trusts within the LMNS e.g. Number of Serious Incidents, Clinical risks/incidents for mothers, Clinical risks/incidents for babies, baby-friendly initiatives, saving babies lives, and workforce indicators.
	
	• These are also shared with all maternity staff via email, discussed, and scrutinised at TWNQSC and Trust QSC.
	
	• All perinatal deaths are reviewed at the PMRT meeting using National Perinatal Mortality Review Tool. The presence of an external midwife ensures independent scrutiny.
	
	• Scorecard based on monthly data submitted to Maternity Services Data Set (in comparison to other Maternity units) is discussed at Speciality meeting. Digital midwife, in collaboration with the IT team, ratifies all data before submission ensuring good quality data is submitted.
	
	• HSIB Reports, SIs, and learning from incidents are shared with all staff
	  ○ Monthly Governance Newsletter
	  ○ Safety Board
	  ○ SI and HSIB reports
	  ○ Action Plans
	  ○ Mandatory Study Days
	
	• QI methodology is utilised to drive improvement

How do we know that our improvement actions are effective and that we are learning at the system and trust level?	• A robust governance mechanism including a comparison of current data with historic data on monthly basis ensures continuous scrutiny. This is also scrutinised by comparing this data with other Trusts within the LMNS. This is further strengthened by the recent introduction of graphical presentation of the dashboard allowing better understanding and facilitating enhanced external scrutiny by independent stakeholders e.g. Non-Executive Director (NED) and members of Maternity and Neonatal Voices Partnership (MVP). • Any concerning aspects of the care are audited to seek additional assurance on a continuous improvement cycle

What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
Development of joint Neonatal dashboard	LMNS Governance Lead in collaboration with the regional lead by 28/02/2021	N/A	TWNQSC, LMNS safety forum
Engage with a new process developed by the Regional Network and develop a structured reporting mechanism identifying clinical changes are embedded with regional clinical oversight.	Clinical Governance Midwife by 28/02/2021	N/A	Guidelines group, LMNS safety forum, TWNQSC
Take part in the development of ICS quality surveillance group which will feed into the Regional quality surveillance group	Director of Midwifery from February 2021	N/A	LMNS safety forum, LMNS programme board
Quarterly board review of perinatal safety	Trust board – quarterly review from March 2021	N/A	Dashboard and exceptions report is shared with the board monthly

Immediate and essential action 2: Listening to Women and Families

Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role that reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at the Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions: **Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?** **Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?** **Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?**
Link to urgent clinical priorities: (a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. (b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

What do we have in place currently to meet all requirements of IEA 2?	• Discussions held and the Trust is committed to creating an independent senior advocate role that reports to both the Trust and the LMNS Board. The advocate will be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome. Awaiting further guidance from the Regional/National team. • A NED with oversight of maternity services is in place to support bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. They attend monthly feedback sessions with the staff alongside the Executive safety champion i.e. Chief Nurse. • The National Perinatal Mortality Review Tool (PMRT) is being used to review all perinatal deaths to the required standard. This is discussed at the monthly PMRT meeting and reported to the Trust Board via its committee for Quality and Safety on a quarterly basis. Parents are informed and involved in the process. • Service user's feedback is collected using various mechanisms. Patient experience feedback is shared with the maternity staff via the internal communication platforms. Friends and Family Feedback is collected monthly and reported to the monthly Speciality, bimonthly TWNSQC and Directorate Board meeting with actions to address areas for improvement. Analysis of and learning from complaints is presented at bimonthly TWNQSC, monthly Speciality, and Directorate Board. The divisional patient experience action plan is updated annually and reported through the trust patient experience committee. Women's stories and experiences are shared as part of midwifery mandatory study day. The Local Maternity and Neonatal Voices Partnership (MVP) is in place with a chair, vice-chair, and several regular members who support the operational aspects of the group. There is an MVP Facebook page and the newly appointed LMNS MVP lead supports communication and collaboration across the system to ensure the woman's voice is heard. The Facebook group is used to provide a communication platform and polls are run to gain specific feedback about aspects of the service to support continual improvement and co-production. We participate in MVP partnership board meetings every other month and monthly COVID specific MVP meetings to review service changes and items specific to the organisation of maternity care during the pandemic. The MVP produces the monthly infographic with stats and information requested by women and families. When on-site for meetings, the MVP colleagues undertake the walk the patch and gather on the spot feedback from women about the service which is immediately fed back during the meeting. The MVP have been invited to attend labour ward forums, guidelines group, and recruitment of midwives to support developments within the service. A BAME action plan to address inequalities in maternity services was developed in co-production with the MVP and an MVP member attends the progress meetings. There was a co-produced LMNS event to develop the operational guidance. There is an MVP lead for each of the LMNS work streams. • Local safety champions meet with board-level safety champions on monthly basis to discuss and escalate locally identified issues

How will we evidence that we are meeting the requirements?	• Maternity Safety Concerns Board and Maternity Safety Concerns Flow Chart are in place demonstrating the role of NED in collaborative working with maternity safety champions • Agenda and minutes of monthly PMRT meeting and the Trust Board's Quality and Safety Committee meeting support the use of the National Perinatal Mortality Review Tool to the required standard • Evidence of sharing patient experience feedback with maternity staff via the internal communication platforms • Minutes of the monthly Directorate Board meeting demonstrate the use of Friends and Family feedback with actions to address any areas for improvement • Midwifery mandatory study course material demonstrate the use of women's stories and experiences • Terms of reference for MVP, minutes of MVP meetings, development of BAME action plan, and the development of operational guidance demonstrate the effective working with MVP • Participation in East and North Hertfordshire "Whose Shoes workshop" and contributing in an "LMNS whose shoes workshop" demonstrates system-wide collaboration
How do we know that these roles are effective?	• Awaiting further guidance for the independent senior advocate role to recruit and develop effective governance around the role • NED participates in the TWNQSC meetings and monthly feedback sessions. They also provide support to the board level executive director for Maternity.

What further action do we need to take?	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**

To appoint an independent senior advocate role that reports to both the Trust and the LMNS boards	**Director of Midwifery**	Awaiting national model for a network of advocates.	Currently, the Patient safety team offers independent scrutiny for any adverse outcomes. Mediation service is also available if needed. F&F feedback, patient experience feedback, and analysis of and learning from complaints is in place.
To ensure that the appointed advocate is available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.	**Director of Midwifery**	Awaiting national model for a network of advocates.	Currently, the Patient safety team offers independent scrutiny for any adverse outcomes. Mediation service is also available if needed. F&F feedback, patient experience feedback, and analysis of and learning from complaints is in place.
NED to be included in the membership of MVP forum	**Head of Midwifery by 28/02/2021**	N.A	Participation of various maternity colleagues in MVP

Immediate and essential action 3: Staff Training and Working Together

Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

Link to Maternity Safety actions: **Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?** **Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?**
Link to urgent clinical priorities: (a) Implement consultant-led labour ward rounds twice daily (over 24 hours) and 7 days per week. (b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime, we are seeking assurance that an MDT training schedule is in place

What do we have in place currently to meet all requirements of IEA 3?	• Multidisciplinary training (MDT) program is in place but we are having slight disruptions due to COVID-related staffing pressures. Training compliance is reported at various forums e.g. TWNQSC, directorate Women's and Neonatal Board, and LMNS safety forum via maternity safety highlight report. CCG sights all the safety actions including safety action 8 – training, before being signed off by the Trust Board and submitted to the NHSR. • The MDT training includes monthly PROMPT virtual and face-to-face sessions, obstetric emergency training days for selected staff risk assessed in relation to areas of practice. Theatre and anaesthetic staff included with human factors principles underpinning skills and drills teaching and case reviews. CTG masterclasses and virtual whole day CTG study day with competency assessment for staff including case studies. Weekly MDT CTG case reviews run virtually supported by the CTG specialist Midwife and the Labour Ward Lead. HSIB, SI reports, and action plans are shared through the rolling half-day audit events. HSIB case reports and action plans are being shared with staff in folder format in clinical areas from January 2021. Skills and drills sessions are being organised and run on the spot in clinical areas from January 2021. Third-year student midwives are also facilitated to attend PROMPT. • MDT working is in place, Business case for recruitment of additional medical staff (consultants) as part of the annual budget planning meeting is in development to further support the MDT ward rounds. • Consultant-led ward rounds on the labour ward are held at 08:30 am, 1:00 pm, and 5:00 pm daily during the week i.e. Monday to Friday. On weekend, the Consultant-led ward round at 08:30 am and a board round with labour ward coordinator and senior registrar at 3:00 pm. The consultants covering the labour ward at the weekend are on site from 08.30 – 15.30 and on-call from home from 15.30. During the week there is a resident consultant cover Monday to Thursday inclusive. On Friday the consultant is on-site until 20.30 and subsequently on call from home. Further to the recent appointment from February 2021, there is a separate consultant cover for Obstetrics and Gynaecology. • Any external funding allocated for the training of maternity staff is ring-fenced and used for this purpose only e.g. LMNS funds for recruitments and training. CEO has signed off a statement of commitment, as part of the first submission of the response to Ockenden report, that all of year 3 (21/22) CNST incentive scheme refunds will be ring-fenced for use within maternity services. • Planned vs actual midwifery staffing levels are reported to the Trust Board on monthly basis as part of the Safer Staffing report. This is further strengthened by the development of the Continuity of Carer (COC) Implementation Plan. The plan clearly states the current midwifery establishment, the uplift required to deliver COC as per the NHS Long Term Plan, and the actions required to address the deficits in staffing levels. • The Trust has lowered its target for training compliance during the pandemic however the training compliance with in-house multi-professional maternity emergencies training still exceeds 90% for midwives. The training has been mapped around the core competency framework.

What are our monitoring mechanisms?	• The dedicated maternity training team regularly monitors the compliance of each maternity staff group. Staff members are sent reminders and booked onto the training. Attendance logs are used to update the training spreadsheet.		
Where will compliance with these requirements be reported?	Monthly compliance reports to Speciality and TWNQSC. Directorate Women's and Neonatal Board and LMNS safety forum via maternity safety highlight report. Planned vs actual midwifery staffing levels are reported to the Trust Board on monthly basis as part of the Safer Staffing report.		
What further action do we need to take?	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**
Externally validated evidence (through LMNS) for multidisciplinary training and working together, 3 times a year (currently part of safety highlight report)	Clinical Governance Midwife by 28/02/2021	N.A	Compliance figures are currently reported at various forums e.g. Speciality meeting, TWNQSC, Directorate board, etc.
Implement consultant-led labour ward rounds twice daily (over 24 hours) and 7 days per week.	Divisional Director by 30/09/21	Funding to recruit additional medical staff	Consultant-led ward rounds on labour ward are held twice daily Monday to Friday and once daily at the weekend
Review of job plans and on-call requirements to support this requirement to take place	Divisional Director by 30/06/2021	N.A	
Audit of MDT ward rounds and consultant attendance to cross-reference with safety incidents to identify any impact of reduced consultant presence.	Clinical Governance Midwife by 28/02/2021	N.A	MDT ward rounds in place
Review of rotas for evidence of skill mix	CLU Matrons by 28/02/2021	N.A	Daily Sitrep meeting, regular review of e-roster to ensure the skill mix.

Immediate and essential action 4: Managing Complex Pregnancy
There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre, there must be an agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

- Women with complex pregnancies must have a named consultant lead

- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed upon between the woman and the team

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

What do we have in place currently to meet all requirements of IEA 4?	• We are actively working with the regional team to develop Mat Med Network processes. SOP has been developed on maternal medicine pathways which will be ratified in March 2021. • All women with complex pregnancies are allocated a named consultant lead and regular audits of compliance are in place. Trust guidelines support the management of care pathways for women with complexities. Specialist services supported by midwives and the MDT are also in place to enable bespoke care packages including bereavement, mental health, fetal medicine, multiple pregnancy, diabetes, and a healthy lifestyle. • Updated referral pathways are in place for high risk Obstetric and complex care cases at booking. Where a complex pregnancy is identified, early specialist involvement is sought and management plans agreed upon between the woman and the team. Complex care pregnancy guidelines are included in the annual audit forward plan which will now include a named Consultant. Cases, where pathways have not been adhered to, will be monitored via Datix, and the risk management process • Compliance with Saving Babies Lives Care Bundle is monitored via a steering group. Data is collected at regular intervals to measure compliance against the process and outcomes measures. A comprehensive work plan is in place to warrant full compliance. • The East of England is establishing maternal medicine networks by April 2021 with a specific emphasis on complex pregnancies, BAME women, and morbidity adherent placentas. The trust is developing its local actions as part of an agreed Network approach. Protocols will be finalised between referrers and specialist centres to ensure seamless care, supported by the first nationally funded trainee in consultant level obstetric medicine. The Trust has developed and embedded pathway for referrals to some specialist tertiary centres concerning fetal medicine and screening pathways. Other tertiary referrals are made on a case-by-case basis.
What are our monitoring mechanisms?	Audit, Risk management meeting
Where is this reported?	Rolling half-day and action plan, Escalated to Speciality

What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Provide referral pathways into specialist centres and evidence of MDT for those Trusts without in-house specialist centres.	Clinical Director for Obstetrics by 28/02/2021	N.A	
Develop monitoring mechanism for complex pregnancies	Clinical Director for Obstetrics by 28/02/2021	N.A	

Immediate and essential action 5: Risk Assessment Throughout Pregnancy
Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional
- The risk assessment must include an ongoing review of the intended place of birth, based on the developing clinical picture.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of the intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.

What do we have in place currently to meet all requirements of IEA 5?	• National perinatal notes are in use which includes risk assessment categories • Additional stickers for risks such as aspirin and FGR are used • Thorough risk assessment is carried out at booking with referral pathways and Personal Care Plan commenced • Even though risk assessment is carried out at every AN contact, further work is required to improve record-keeping • Choice of place of birth is discussed at booking and throughout the journey by signposting women to access the mum and baby app • Personalised Care and Support Plan (PCSP) is offered through mum and baby app • Annual staff training is delivered on personalisation and choice • Personalised care plan reported nationally as part of MSDS submission and audited as part of the Audit plan
What are our monitoring mechanisms and where are they reported?	• Risk assessment for FGR/SGA reported at Saving Babies Lives Implementation Steering Group (SISG) • Personalised care reported as part of MSDS dataset • Annual audits reported at audit rolling half day • LMNS personalised care survey undertaken • Annual regional PCSP survey through LMNS

Where is this reported?	• Specialty meeting • LMNS operational board • Audit rolling half day • Regional transformation board/Clinical Network		
What further action do we need to take?	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
Staff education and awareness around completing risk assessments throughout the pathway at each contact and document (midwifery and obstetrics)	Antenatal care pathway lead in the clinic, Community matron, Community team leaders, Obstetric lead – Messaging by 28/02/2021	N.A	Full review at admission to the unit, Fetal monitoring risk assessment in place at the start of labour.
Identify obstetric lead for personalisation	Clinical Director Obstetrics by 28/02/2021	N.A	Consultant midwives working closely and reporting back to CD Obstetrics
Intended place of birth to be reviewed as part of the risk assessment at every antenatal contact and to be documented in the notes.	Antenatal care pathway lead in the clinic, Community matron, Community team leaders, Obstetric lead, Consultant midwives - Ongoing	N.A	Mum and baby app in place, place of birth reviewed at admission to the unit in labour.
Audit the evidence on the specified management plan updates in the records.	Consultant Midwives, Better Births Project Midwife – by 28/02/2021	N.A	

PCSP training package to be reviewed	Consultant Midwives, Better Births Project Midwife by 28/02/2021	N.A	

Immediate and essential action 6: Monitoring Fetal Wellbeing

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring fetal wellbeing –
- Consolidating existing knowledge of monitoring fetal wellbeing –
- Keeping abreast of developments in the field –
- Raising the profile of fetal wellbeing monitoring –
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

a) Implement the saving babies' lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies' lives care bundle 2 and national guidelines.

What do we have in place currently to meet all requirements of IEA 6?	• Named lead midwife and lead clinician in place and their JDs have been updated to include the criteria (all 9 elements included). Monthly training sessions, on job training, weekly meetings on Tuesdays and Wednesdays, and recently introduced physiological interpretation is in place • Weekly reviews, newsletters, FM faculty have regular meetings, Bespoke support, yearly study day, One to one discussions, case reviews • Attendance at network meetings (EoE and Nationwide), Working with LMNS (discussion with colleagues • Weekly meetings, Case reviews, Newsletters, Display board, Training • Fresh eyes, Fresh eyes stickers • Engagement with Clinical networks, Matneo SIP, collaboration with experts. Attendance at network meetings (EoE and Nationwide), Working with LMNS (discussion with colleagues. • Physiological CTG monitoring, weekly meetings for the C-section, and interesting cases review the cases where fetal monitoring comes out of concern. Training evidence via attendance logs for the last 12 months plus notification of how many sessions may/have been cancelled due to the pandemic and recovery plans. Attain meeting reviews. • The Trust has both a lead specialist midwife (funded until Jan 2021) and a lead obstetrician (the obstetric labour ward lead), to ensure best practice, learning, and support. In addition to MDT training which includes CTG masterclass, a day CTG virtual training is in place which includes case studies and a competency assessment. Weekly MDT CTG case reviews are also in place.

How will we evidence that our leads are undertaking the role in full?	• Up to date job descriptions • Attendance at meetings • Up to date training Package • Training compliance data • Guidelines in place • Attendance log at training • Discussion log, Newsletters • Minutes, Email discussion, Attendance at training, Fresh eyes, Fresh eyes stickers • Saving Babies Lives Implementation Steering Group meets every month. A comprehensive work plan is in place. SBLCB v2 is also discussed as part of the NHSR review meeting. Evidence of compliance with CNST incentive Plan SBLCBV2 via submissions and in-house action plans if not fully compliant		
What outcomes will we use to demonstrate that our processes are effective?	Training compliance, No. of incidents, Audits, HIE rates, stillbirths, themes from recommendations from HSIB		
What further action do we need to take?	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**

Immediate and essential action 7: Informed Consent All Trusts must ensure women have ready access to accurate information to enable their informed choice of the intended place of birth and mode of birth, including the maternal choice for cesarean delivery. All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum, and postnatal periods of care Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care Women's choices following a shared and informed decision-making process must be respected
Link to Maternity Safety actions: **Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?**
Link to urgent clinical priorities: a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

What do we have in place currently to meet all requirements of IEA 7?	• Mum and baby app has been launched which is in use now. The app is a comprehensive source of all the information mums need for their pregnancy, birth and beyond. This includes information about the maternity unit, pregnancy, personal care plans including personalised birth preference, labour and birth, and postnatal care. It offers an easy-to-navigate screen, multiple links and videos of a range of useful topics to include; emotional and physical wellbeing, mental health concerns, advice for partners, preparing for labour, stay in hospital, post-delivery care, baby care basics, mum and baby checks, recovering from different types of delivery and medical conditions and advice for when back at home. Personal preferences for each stage of the maternity journey can be documented, stored within the app for sharing with care providers, generating conversations that support collaborative and personalised care plans. The app also has a link to the maternity unit's website containing information about all the services and various leaflets links • Information on place and mode of birth is also discussed and documented in the in the perinatal institute antenatal notes (women held paper sheet), Page 28 of perinatal notes information on place of birth. In addition, there is a well-established birth options service • A guidelines group is in place which ensures that all the maternity guidelines are up to date and congruent with the national guidance. Member of MVP are also invited to this group. All women are provided with accurate and contemporaneous evidence-based information as per national guidance. Information is also available on the website (pathways and guidance). Together the Maternity website and Mum and Baby app cover all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care • Women leaflets (induction of labour, screening for you and your baby etc.) and proformas (maternal request c-section, vaginal breach birth, Vaginal birth after caesarean section etc.) in place • Consultant midwives in post • Perinatal Institute pregnancy notes are in use which allow recording of decision making. The notes have sections on preferences and management plan which are completed in collaboration with women at point of care. These allow women to participate and have informed choice of care. Personalised Management plan allows women specific treatments. Birth options clinics are in in place to offer choice of place of birth. At birth options clinics, individual risks are discussed and latest evidence shared with women to enable them to make informed choices on their care (service supports all choices eg. VBAC MLU, Mat request C/S, upright breech). The proformas in place are based on the latest evidence e.g. VBAC, upright breech. • Women's choices are always respected. Care is also supported outside the guidance to respect women's choice following informed discussion • Annual teaching on informed consent for Midwives and Doctors is in place. MVP feedback via the MVP Facebook page, emails and meetings. Personalisation training package includes involving women in the decision making around their care. Training on informed consent is also embedded with midwives and doctors. Developed working on formats in different languages and coproduction leads established at LMNS level. • Working group established to review and update the website to the best practice.

Where and how often do we report this?	• Patient experience report • Monthly F&F feedback • Pre COVID monthly MVP walking the patch and feedback • Key practice themes reported to specialty meeting • MVP feedback		
How do we know that our processes are effective?	• Survey of no. of birth options referral • evidence of complex birth plans, Patient experience reports		
What further action do we need to take?	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
Consider becoming early adopters for the "I decide" tool	Consultant midwife and Clinical Director Obstetrics – June 2021	Electronic records Training time and clinical support to embed	Consent forms in place for procedures
Review the virtual tour	Ward managers and senior team - March 2021		Pictures of areas available on the website
Increase the choice of place of birth information on the website	Consultant midwife		Mum and baby app in place
Raise awareness around the use of the mum and baby app by the users and staff	Consultant midwife		Consultant midwife working on videos (staff and women)
Review the leaflets	Consultant midwife		Current leaflets
Update the Trust Maternity website taking good practice from the Chelsea and Westminster website	Consultant midwife with Communications team March 2021		Mum and baby app, Current website

Section 2
MATERNITY WORKFORCE PLANNING
Link to Maternity safety standards: **Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard** **Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?**
We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020, and to confirm timescales for implementation.

What process have we undertaken?	• Birth rate plus (BR+) is in place for midwifery workforce planning. It was first undertaken in Quarter 3 of 2018-19 and presented to the Trust Board. A further staffing model was developed and put in place to support the roll-out of Continuity of Carer (CoC). This was to meet the National Trajectories and required uplift in staff to support 35% of women on a Continuity of Carer pathway by March 2021. Further uplift of 10 wte required to support >50% of women on CoC pathway by March 2022 has been supported by the Trust Board. • Board paper in December 2021 contains the action plan for full implementation. • Monthly staffing ratios generated for the Maternity dashboard • Monthly staffing paper as part of the Safer staffing report to the Trust board's Quality and Safety Committee • Consultant and Junior medical staff cover is in line with Safer Childbirth (RCOG) to ensure there are appropriate numbers of staff, with the appropriate competencies, available at all times. The unit provides 122 hours of Consultant presence on the labour ward. Rotas of trainees, Clinical Fellows, and SAS doctors are maintained to ensure 24 hour cover for the labour ward, triage, and wards. SHO rotas are designed in conjunction with medical Human resources**.** Sickness and gaps are covered by internal locums, either by current SHOs or by registrars covering shifts or duties during the day, or external locums (most of whom have worked here as an SHO / registrar before). CVs have been approved by HR or Consultant responsible for the rota • Clinical Director for Obstetrics undertakes an annual staffing review to establish whether prospective consultant obstetrician presence on Consultant Led Unit is in line with Safer Childbirth. Junior medical staff rotas are also managed accordingly and are WETD compliant. Any shortfalls identified are addressed via developing a business case. • As of February 2021, there is now a separate Consultant on call for gynaecology during the weekend to ensure safer staffing at Consultant level with a dedicated Obstetrician for maternity • ENHT uses the RCOG's standards for job descriptions and job plans which ensure that high standards of care are maintained by having the appropriate workforce, with the necessary competencies, in the right place at the right time.

How have we assured that our plans are robust and realistic?	• Use of nationally recognised staffing tool i.e. BR+ • Approval and implementation of staffing model to support CoC • Regular reporting and monitoring of CoC numbers at LMNS level • Regular reporting of staffing ratios and red flags to the Trust board's Quality and Safety Committee • Daily Sitrep meeting where staffing is discussed • Board assurance		
How will ensure oversight of progress against our plans going forwards?	• Approval of the action plan at the Trust board level • Regular reporting to: o TWNQSC o Directorate Maternity Board o Trust board's quality and safety committee		
What further action do we need to take?	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
To update the Trust workforce strategy in line with BR+ and as part of the Ockenden follow up actions.	Director of Midwifery, Chief Nurse by May 2021	Investment from the Trust Board	COC Implementation plan

MIDWIFERY LEADERSHIP

Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care

We have a Director of midwifery in place who is responsible and accountable to an executive director (Chief Nurse).
East and North Hertfordshire NHS Trust meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:

1. We have a Director of Midwifery and a Deputy Head of Midwifery in place
2. A lead midwife at a senior level in all parts of the NHS, both nationally and regionally. National and Regional Maternity Safety Champions in place. Locally LMNS forums in place, Director and Deputy Director of Midwifery attend weekly regional meetings with the Chief Midwifery officer and other ad hoc meetings as and when required. They also attend RCM forums, regional clinical meetings including safety forums, and National midwifery conferences and meetings
3. We have two consultant midwives in place who job share their role of leading, supporting, coaching, mentoring, inspiring, and empowering the midwifery colleagues
4. We have Specialist midwives who provide expert advice to colleagues and to women and their families. They act as a resource on issues relating to their area of specialism, championing improvements in the areas they work. E.g. Bereavement support midwife, Healthy lifestyles midwife, Clinical governance midwife, Fetal monitoring midwife, Multiple pregnancies midwife, etc.
5. Strengthening and supporting sustainable midwifery leadership in education and research – Consultant midwife works closely with the University of Hertfordshire and are committed to supporting them in strengthening and supporting sustainable midwifery leadership in education and research
6. We are committed to fund ongoing midwifery leadership development. We have a training budget that is managed by the Maternity training team via a waiting list. Colleagues are also encouraged to apply for NHS leadership academy courses. Internally, the Trust has a leadership development team and various leadership courses
7. We are committed to involve an RCM representative in the future recruitment of Director/Head of Midwifery and other senior midwifery leaders

NICE GUIDANCE RELATED TO MATERNITY

We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.

What process do we have in place currently?	• Gap analysis and action plan (GAAP) is completed for any published guideline including all relevant NICE guidelines • The completed GAAP is presented to the Women's Speciality and Directorate Board meetings • Progress against all GAAPs is monitored via Trust Women and Neonatal Quality and Safety Committee • Centrally, the Clinical Audit team keeps a record of all published NICE guidelines, and any outstanding actions are followed up regularly • Any changes or additions to guidelines identified by the GAAP's are managed through the guideline process with representation from both Midwifery and Obstetrics • Clinical Decisions Group led by Consultant Obstetrician and Senior Midwifery Team link into change needs highlighting update in guidance and discussion when considering the possibility of using non-evidence-based guidelines.		
Where and how often do we report this?	Specialty and Directorate Board meeting – monthly TWNQSC – bi-monthly		
What assurance do we have that all of our guidelines are clinically appropriate?	Guidelines group in place to ensure all suggested changes follow governance processes Monitoring arrangements for all guidelines Clinical Decisions Group meets monthly to discuss process changes that may feed into guidance		
What further action do we need to take?	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**

East and North Hertfordshire NHS Trust

Agenda Item: 15

TRUST BOARD - PUBLIC SESSION – 3 MARCH 2021

Gender Pay Gap Report February 2021

Purpose of report and executive summary (250 words max): This paper outlines the Gender Pay Gap analysis and findings based on data as at March 2020. The paper is split into two sections, the first on average pay and second on bonuses. The board is asked to consider and note the content and approve the publication of the same on the Trust and national websites.		
Action required: For approval		
Previously considered by: HR senior team FPPC – 24.02.21		
Director: Interim Chief People Officer	**Presented by:** Interim Deputy Chief People Officer	**Author:** Interim Deputy Chief People Officer & EDI Lead

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

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

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

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

Ineffective or inefficient staff management is likely to increase negative staff survey results, turnover, sickness absence and replacement costs.

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

TRUST BOARD

Gender Pay Gap Report 2021
(data as at 31 March 2020)

1. ORGANISATIONAL BACKGROUND

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

We are committed to Equality, Diversity and Inclusion (EDI) being at the heart of everything we do and deliver for service users and their relatives, as well as our 6,000 staff.

The composition of our workforce presented in the table below is based on the staff list report from the Electronic Staff Record (ESR) as of 31st March 2020. It represents the ratio of females to males in each staff group; and females and males in relation to all staff in each staff group.

Staff Group 2019	Males to females	Females to males	Males to all staff	Females to all staff
Add Prof Scientific and Technic	20.50%	79.50%	0.68%	2.65%
Additional Clinical Services	16.07%	83.93%	2.40%	12.55%
Administrative and Clerical	15.24%	84.76%	3.54%	19.67%
Allied Health Professionals	17.76%	82.24%	0.77%	3.55%
Estates and Ancillary	57.02%	42.98%	3.25%	2.45%
Healthcare Scientists	36.68%	63.32%	1.22%	2.10%
Medical and Dental	55.04%	44.96%	7.66%	6.26%
Nursing and Midwifery Registered	8.92%	91.08%	2.79%	28.31%
Overall	22.31%	77.69%	22.31%	77.69%

Staff Group 2020	Males to Females	Females to Males	Males to all staff	Females to all staff
Add Prof Scientific and Technic	20.21%	79.79%	0.63%	2.48%
Additional Clinical Services	16.56%	83.44%	2.52%	12.68%
Administrative and Clerical	15.74%	84.26%	3.74%	20.04%
Allied Health Professionals	16.89%	83.11%	0.81%	3.97%
Estates and Ancillary	57.38%	42.62%	3.32%	2.47%
Healthcare Scientists	40.31%	59.69%	1.27%	1.89%
Medical and Dental	55.34%	44.66%	7.78%	6.28%
Nursing and Midwifery Registered	9.48%	90.52%	2.86%	27.28%
Overall	22.92%	77.08%	22.92%	77.08%

2. CONTEXT AND REPORTING REQUIREMENTS

Gender pay gap reporting is a mandatory reporting requirement for public sector organisations employing in excess of 250 staff. The gender pay gap is the difference between average (mean and median) earnings of men and women, expressed relative to men's earnings. It should not be confused with unequal pay, which is the unlawful practice of paying men and women differently for performing the same or similar work or work of equal value.

The East and North Hertfordshire NHS Trust ("Trust") is therefore required to publish its gender pay gap data and any supportive narrative on its public facing website and submit its gender pay gap report/data to the government online reporting service.

The Trust is reporting the following information, as per these requirements in sections:

Average pay section 3

1. The difference between the mean hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees
2. The difference between the median hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees

Bonus pay section 4

3. The difference between the mean bonus pay paid to male relevant employees and that paid to female relevant employees
4. The difference between the median bonus pay paid to male relevant employees and that paid to female relevant employees
5. The proportions of male and female relevant employees who were paid bonus pay
6. The proportions of male and female full-pay relevant employees in the lower, lower middle, upper middle and upper quartile pay bands

The Trust will update our action plan to respond to these findings.

All information captured in this report is based on the calculations made relating to the pay period in which the snapshot day falls. Each snapshot is taken as at the 31 March of the previous year. (N.B. any enhancements for unsocial hours for staff on agenda for change and medical and dental contracts are paid a month in arrears). A detail of how the calculations are conducted is available at appendix 1.

3. AVERAGE PAY

Gender	Mean hourly rate 2018	Mean hourly rate 2019	Mean hourly rate 2020	Median hourly rate 2018	Median hourly rate 2019	Median hourly rate 2020
Male	£21.95	£21.56	£22.30	£16.23	£16.64	£17.54
Female	£15.91	£16.61	£17.19	£14.40	£14.57	£15.40
Difference	£6.04	£4.95	£5.11	£1.83	£2.07	£2.14
Pay Gap %	**27.53%**	**22.97%**	**23.00%**	**11.27%**	**12.44%**	**12.22%**

1. **Mean gender pay gap** – the data suggests that the gender pay gap for mean average ordinary earnings for women is **23%** less than for men which is very similar to 2019.

2. **Median gender pay gap** – the data suggests that the gender pay gap for median average ordinary earnings for women is **12.2%** less than for men, which is 0.2% improvement on 2019.

3. **Gender composition in each quartile pay band** – the tables below represent the proportion of male and female employees in each quartile pay band:

Quartile (2018)	Female	Male	Female %	Male %
1 (lowest pay)	1071	299	78.18	21.82
2	1116	252	81.58	18.42
3	1158	211	84.59	15.41
4 (highest pay)	866	502	63.30	36.70
Overall gender split	4211	1264	76.91%	23.09%

Quartile (2019)	Female	Male	Female %	Male %
1 (lowest pay)	1116	288	79.49%	20.51%
2	1126	277	80.26%	16.74%
3	1191	222	84.29%	15.71%
4 (highest pay)	900	512	63.74%	36.26%
Overall gender split	4333	1299	76.94%	23.06%

Quartile 2020	Female	Male	Female	Male
1 (lowest pay)	1158	308	78.99%	21.01%
2	1186	287	80.52%	19.48%
3	1221	253	82.84%	17.16%
4 (highest pay)	937	538	63.53%	36.47%
Overall gender split	4502	1386	76.46%	23.54%

The above tables highlight that although the representation at each quartile remains largely consistent, there is a disparity in tier 4 (highest pay) which is influenced mostly by the 'administrative and clerical' staff group, in corporate areas where there are more males in senior positions (senior managers who are non-clinical staff are categorised as 'administrative and clerical' staff).

4. Additional reporting

To give greater detail around the mean difference, additional reports were taken from the Electronic Staff record (ESR) – the following highlights the differences by staff group. Negative figures in Allied Health Professionals (AHP) and Nursing and Midwifery staff groups indicate a gender pay gap in favour of females. The most significant gender pay gap in favour of males are admin and clerical, healthcare scientists and, medical staff with a pay gap of **25.62%** (worse than 2019), **10.54**% (better than last year) and **12.93**% (better than last year) respectively.

Main Staff Group	Female Avg. Hourly Rate	Male Avg. Hourly rate	Difference	Pay gap 2018	Pay gap 2019	Pay gap 2020
Add Prof Scientific and Technic	£19.03	£20.46	£1.43	-0.13%	7.38%	6.99%
Additional Clinical Services	£11.16	£11.37	£0.22	3.41%	0.20%	1.90%
Administrative and Clerical	£14.02	£18.85	£4.83	20.90%	21.76%	25.62%
Allied Health Professionals	£20.64	£19.82	-£0.82	-5.00%	-5.33%	-4.16%
Estates and Ancillary	£11.27	£12.20	£0.93	7.58%	6.74%	7.62%
Healthcare Scientists	£19.39	£21.67	£2.28	15.21%	12.90%	10.54%

Medical and Dental	£33.62	£38.61	£4.99	15.40%	14.19%	12.93%
Nursing and Midwifery Registered	£18.55	£17.57	-£0.98	-9.35%	-7.91%	-5.55%

The RAG rating above is classified as follows compared to 2019:

- green highlights a positive change for female workers,
- amber shows a positive change towards female favour however remains significantly in favour of males
- red shows a change in favour / or significant level in favour of male workers.

The trust has also undertaken analysis of staff pay in order to identify potential gender pay gap separating Agenda for Change and Medical and Dental terms and conditions of pay. The data suggests that gender pay gap for Agenda for Change employees remains in favour of females, whilst the medical and dental staff group's gender pay gap remains in favour of males.

	2019 Mean average hourly rate Non Medical (AfC, Trust Pay, VSM & Tupe)	2019 Mean average hourly rate Medical and Dental staff	2020 Mean average hourly rate Non Medical (AfC, Trust Pay, VSM & Tupe)	2020 Mean average hourly rate Medical and Dental staff
Female	£15.72	£32.65	£16.19	£33.62
Male	£15.30	£38.05	£16.10	£38.61
Difference	£0.42	£5.40	£0.09	£4.99

4. BONUS PAY

Gender	Mean average bonus 2018	Mean average bonus 2019	Mean average bonus 2020	Median average bonus 2018	Median average bonus 2019	Median average bonus 2020
Male	£14,668.64	£9383.32	£9,607.81	£9,040.50	£9227.42	£9,048
Female	£10,732.85	£8880.49	£9,117.48	£6.027.04	£8524.57	£6,032.04
Difference	£3,975.79	£502.38	£490.33	£3,013.46	£702.85	£3,015.96
Pay Gap %	**26.83%**	**5.4%**	**5.10%**	**33.33%**	**7.6%**	**33.33%**

5. **Mean bonus pay gap** – the data suggests that the gender pay gap for mean average bonus earnings for women is **5.1**% less than for men, a continuing improvement of 0.3% compared to 2019.

6. **Median bonus pay gap** – the data suggests that the gender pay gap for median average bonus earnings for women is **33.33%** less than for men, which is significantly worse than last year and returns to the 2018 gap.

7. **Gender composition of bonuses** – the data shows that the proportion of males receiving a bonus was **5.63**%, whilst **0.8**% of female employees were in receipt of a bonus payment. While the number of female recipients is comparable with last year the number of male recipients has reduced by 0.8% compared to 2019.

As this represents a significant deterioration, further analysis will be completed to understand if this relates to actions the Trust has taken to influence the change or whether this was an exception. This is essential to understand so that the improvement can be sustained.

Gender	No. Paid Bonus	Total Employees	%	No. Paid bonus	Total Employee	%
Female	39	4657	0.83%	38	4778	0.8%
Male	86	1337	6.43%	80	1421	5.63%

Staff receiving a bonus will only apply to medical consultants due to the awards known as Clinical Excellence Awards, therefore when this is represented as a proportion of the entire Trust, which has a majority female workforce, it will show a far higher proportion in favour of males. However, of our total staff, only 340 employees (medical consultants) were eligible for bonus payments in 2020. The table below represents the consultant body with gender composition and bonus payments distribution. Out of 340 eligible staff, 118 were in receipt of clinical excellence award, which equated to **34.71**% in total distributed by **31.15**% of female compared to **36.7**% of male medical consultants were paid the award. While fewer people have received bonuses, the distribution of bonuses for consultants remains comparable to previous years.

Gender	2018 headcount consultants	2018 % of consultants with bonus	2019 headcount consultants	2019 % of consultants with bonus	2020 headcount consultants	2020 % of consultants with bonus
Female	104	33.65%	108	36.11%	122	31.15%
Male	210	39.05%	209	41.15%	218	36.7%
Grand Total	314	37.26%	317	39.43%	340	34.71%

5. KEY FINDINGS & RECOMMENDATIONS

Interventions are underway in the current year, for example, review of 'Trust pay' arrangements, and increased promotion of flexible working arrangements which are expected to make an impact in later years. National action is also being taken with regard to medical gender pay gaps following the publication of the report 'Mend the gap: The Independent Review into Gender Pay Gaps in Medicine in England' published in December 2020.

However, the key findings in this year's report indicate that there is more to do and the Trust will carry out a deep dive into the quartile and staff groups to establish interventions that may be suitable to help identify the issues and address the gap. Secondly a deep dive into the clinical excellence awards for medics which again shows a significant disparity between male and female recipients.

It is therefore suggested that the trust implement the following actions to progress this agenda in the first half of 2021/22.

1. Development of a focus group to
    - Complete a deep dive on the data
    - Establish any interventions that have been taken and made a difference.
    - Consider the checklists and actions recommended in the NHS Employers guidance
    - Make additional recommendations for action
    - Develop internal aspirational targets for improvement

2. Ensure the trust's recruitment and selection policy and process for internal and external candidates avoids potential bias against women.

3. Explore whether there are any genuine occupational requirements which may enable recruitment to post that are underrepresented by female employees.

4. Consider occupational stereotypes and create staff stories and share role models to reduce these.

5. To ensure that flexible arrangements apply equally to all posts irrespective of seniority which may assist female under representation at higher bandings.

6. Ensure that the Trusts talent conversations identify and remove barriers for all staff who would otherwise be dissuaded from exploring promotion.

7. Progress to be monitored and reported quarterly to the Finance, Performance and People Committee.

8. Early analyse of 2021 data to implement change in preparation for the March 2022 submission.

Appendix 1 Details on how calculations are completed.

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

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

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

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

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

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

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

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

NB – Bonus payments in the Trust are exclusively made up from Medical Consultants' merit awards (i.e. Clinical Excellence Awards)

East and North Hertfordshire NHS Trust

Agenda Item: 16.1 a

TRUST BOARD – 3 MARCH 2021

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE – 27 JANUARY 2021
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present to the Trust Board the summary report from the Finance, Performance and People Committee (FPPC) meeting held on 27 January 2021. The report includes details of any decisions made by the FPPC under delegated authority.		
Action required: For information		
Previously considered by: N/A		
Director: Chair of FPPC	**Presented by:** Chair of FPPC	**Author:** Assistant Trust Secretary

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

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

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

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE MEETING – 27 JANUARY 2021
SUMMARY TO THE TRUST BOARD MEETING HELD ON 3 MARCH 2021

The following Non-Executive Directors were present:
Karen McConnell (Chair), Ellen Schroder, Jonathan Silver, Bob Niven, Biraj Parmar

Performance Report
The FPPC considered the key points in relation to operational performance for month 9. ED had a performance of 78.81% against the 4hour target which although a reduction against month 8, was similar to December 2019. Two 12 hour trolley breaches were reported which were investigated and noted as isolated incidents. It was reported that cancer services remained compliant across all standards. RTT and Diagnostics had been part paused due to staff redeployment to support Covid wards and therefore the backlog had increased, although the mechanisms and planning for recovery were in place. An overview of the new ED standard commissioned through unplanned care will be brought to the Committee in February. Deep dives into core performance areas have been rescheduled as a result of the Covid pandemic and will recommence in March.

Stroke Service Roadmap
Despite the rescheduling of deep dives FPPC were pleased to receive the stroke services roadmap, setting out at a high level the steps to be taken to achieve sustainable improvements in performance. A further deep dive to assess progress is now planned for April. It was noted that stroke had a performance of 52% against a target of 63%. There has been an improvement of the door to needle times for the thrombolysis pathway with target of 70% surpassed during the month reaching 77.8%.

Redeployment and Sickness Absence
The Committee received an update on 'Redeployment and Sickness Absence' which provided a summary of the redeployment of staff to support areas with increased demand and staff shortages arising from Covid. The impact of current staff sickness levels and isolation and the current and planned support for the health and wellbeing of staff was reviewed.

Planning Update 2021/22
The FPPC received a presentation which noted the nationally stated operational priorities for the remainder of 2020/21, initial indicators as the basis for 2021/22 planning and the national proposals regarding Integrated Care Systems and the potential considerations for the Trust. The Committee agreed that the integrated care and system development risks and considerations will be referred to the Trust Board.

ICP Relationship Models
The Committee received a presentation on the possible ICP relationship models which set out a range of collaborative models that could be considered for the ENH ICP in order to inform the Trust's response to the ICP proposal. Following the discussion on this paper and the Planning Update noted above, the Committee agreed that the Executive team would prepare a paper looking at the wider strategic issues facing the Trust for the February Strategy Committee.

Budget Setting Update
The FPPC received an update regarding budget setting for 2021/22. It was confirmed that revenue funding will be distributed at system level, continuing the approach introduced this year. The systems revenue envelopes will be consistent with the LTP financial settlement. The build-up of the draft base budget for 2021/22 will be undertaken as a technical exercise by the finance department applying the agreed principles and assumptions to the current

2020/21 budget. The technical budget will require review and input by divisions and budget holders to ensure the agreed budget ground rules have been sensibly applied and that finance, activity and workforce plans are realistic. It was noted that the final budget would be brought to the March Committee.

Finance Report Month 9
The FPPC received the finance report for month 9. The plan for month 9 year to date was a £0.3m deficit, the actual financial performance for December was £0.2m favourable to that plan. It was also noted that elective activity remained constant in the month but performed well considering the increase in Covid patients in December. The elective Incentive Scheme was suspended in December as the Trust had more than 15% of beds occupied by Covid patients. ED and non-elective activity remained below last year's levels although adult critical care occupied bed days was above last year's levels. It was noted that the expectation was to broadly deliver the agreed plan and that the Trust is targeting a breakeven position by the end of the financial year. Annual leave accrual will be a national issue. The Trust has a month 9 provision but it is expected to increase significantly.

The Committee received a presentation on the Additional nursing Paybill Analysis. It was highlighted that actual bed occupancy was significantly less than normal levels whereas nursing levels had increased. Increases in nursing manpower requirements were driven by skill mix and other demands rather than patient volumes. The Committee agreed to return to this area and the management of nursing rotas in a future meeting. The Committee will also consider a Paybill analysis of medical staffing at a future meeting

Capital Programme Update
The FPPC received an update on the Capital Programme. It was noted that the spend was being closely monitored and that a list of prioritised items had been produced to ensure that capital monies were spent effectively.

Board Assurance Framework
The FPPC considered the latest BAF. Items within the BAF had been addressed during the meeting and there had been no changes to the risk ratings for month 9.

EU Exit Update
The Committee noted the report.

Karen McConnell
Finance, Performance and People Committee Chair
January 2021

East and North Hertfordshire NHS Trust

Agenda Item: 16.1 b

TRUST BOARD – 3 MARCH 2021

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE – 24 FEBRUARY 2021
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present to the Trust Board the summary report from the Finance, Performance and People Committee (FPPC) meeting held on 24 February 2021. The report includes details of any decisions made by the FPPC under delegated authority.		
Action required: For information		
Previously considered by: N/A		
Director: Chair of FPPC	**Presented by:** Chair of FPPC	**Author:** Assistant Trust Secretary

Trust priorities to which the issue relates:	**Tick applicable boxes**
Quality: To deliver high quality, compassionate services, consistently across all our sites.	☒
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Ease of Use: To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff.	☒
Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term.	☒

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

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

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE MEETING – 24 FEBRUARY 2021
SUMMARY TO THE TRUST BOARD MEETING HELD ON 3 MARCH 2021

The following Non-Executive Directors were present:
Karen McConnell (Chair), Ellen Schroder, Jonathan Silver, Bob Niven, Biraj Parmar

Performance Report
The FPPC considered the key points in relation to operational performance for month 10. ED had a performance of 75.18% against the 4hour target which although a reduction against month 9 was above the national average. Although the number of daily attendances reduced, the length of time to support increased. There was one reported 12 hour trolley breach. Cancer services maintained a good level of service achieving 7 out of the 8 national targets (the screening target was missed) for cancer performance in December.

RTT and Diagnostics had decreased performance in January with 1,724 52-week breaches which is an increase of 566 from the December performance. DM01 performance was 29.6% against a national standard of 1% and the December position of 21.01%. The Covid recovery plan and the resulting opening up of capacity will improve performance. The Committee plan to undertake a deep dive into this area.

The stroke service performance for January was 48.3% and the ongoing challenge has been recognised. The roadmap for the stroke service was presented to the Committee in January and a further deep dive will be presented in April.

The FPPC received the proposed new EUEC standards. The importance of digital adoption with particular regard for discharges was agreed.

People Strategy Progress Report
The Committee received the People Strategy Delivery report which provided an update of the progress made against the Strategy since it was approved in July 2020. There has been significant delivery against plans which was welcomed. However, not everything proposed for year one has been achieved due to competing demands in response to the pandemic, staff absence and turnover. It was anticipated that a detailed delivery and implementation plan will be provided in Q1 2021/22.

Resourcing Review
The FPPC received a report which provided a review of vacancy rates, resourcing activities and performance between October 2020 and January 2021 and provided a briefing on performance and the impact of Covid on activities under the Work Together pillar. It was noted that medical and dental have a minimal vacancy rate whereas clinical support workers had a higher vacancy rate due to high turnover. It was agreed that the e-rostering system, the learning management system, BAME outreach, and transformation of the workforce will be reviewed further at a future meeting.

Gender Pay Gap
The Committee received a report on the gender pay gap which provided analysis on progress since March 2020 and key findings. The current situation is broadly similar to last year with the areas of administration & clerical and medical staff being the two areas where average pay is higher for males. The Committee supported the recommendations in the report and it was agreed to look at benchmarking data. The report will be presented to the Trust Board in March.

Board Assurance Framework
The FPPC considered the latest BAF. There had been no changes to the risk ratings for month 10.
The internal audit's annual review of the BAF focused on the assurance over the key controls in operation to mitigate the principle risks and whether the strength of those assurances align to the level of risk and concluded substantial assurance. The report will go to the Audit Committee in March 2021.

EU Exit Update
The Committee received a verbal update for the EU Exit. It was noted that oversight of EU Exit was at the Gold meetings. It was also noted that EU staff had been reminded to apply for settled status.

Transformation and Integration Update
The Committee received a presentation which focused on system integration. A project group has been established, which is joint-chaired with ENHT and HCT, to review the step-up and step-down pathways from the hospital into the community. It is looking at optimising activity and then to design, test and validate new pathways that would increase the cohort of patients to benefit from this model of care. Due to the pace of Covid admissions the project was refocused to establish a virtual ward. The Committee welcomed the report and asked that cost effectiveness be reviewed alongside outcomes. It was agreed that it would be presented to a future FPPC.

Capital Programme Update
The FPPC received an update on the Capital Programme. The Trust has received confirmation of approval for the ward reconfiguration and other Covid capital requests submitted. The Committee was reassured that work was continuing to prioritise capital projects for 20/21 and to ensure our full allocation is spent by 31 March 2021.

Finance Report Month 10
The FPPC received the finance report for month 10. The plan for month 10 year to date was a £0.6m deficit with the actual financial performance for January being £0.6m favourable to that plan. There was a favourable variance of £0.4m due to a reduction in costs in delivery of elective activity which has only been partially offset by an increase in Covid related costs. It was noted that elective activity significantly reduced due to the pressure to treat an increasing number of Covid related patients and adult critical care activity was significantly higher than previous months.

Budget Setting 2021/22
The Committee received an update regarding budget setting. It was highlighted that the traditional baseline build-up was complex for 2021/22 as there is a requirement to accurately and separately identify any recurrent Covid impacts. The run-rate model is due to be submitted to NHSE/I in late February and will be used to understand the recurrent baseline for 2021/22. It was noted that any recurrent Covid costs will be tested in detail and need to be fully justified.

Health and Social Care White Paper Briefing
The Committee noted the report and deferred discussion to the Trust Board in March.

Karen McConnell
Finance, Performance and People Committee Chair
February 2021

East and North Hertfordshire NHS Trust

Agenda Item: 16.2

TRUST BOARD - PUBLIC SESSION – 3 MARCH 2021

STRATEGY COMMITTEE – 15 FEBRUARY 2021
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present to the Trust Board the summary report from the Strategy Committee meeting held on 15 February 2021. The report includes details of any decisions made by the Strategy Committee under delegated authority.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of Strategy Committee	**Presented by:** Chair of Strategy Committee	**Author:** Deputy Director of Strategy

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

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

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STRATEGY COMMITTEE – 15 FEBRUARY 2021

EXECUTIVE SUMMARY REPORT TO TRUST BOARD

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

The following core attendees were present:
Nick Carver (Chief Executive Officer), Sarah Brierley (Director of Strategy), Martin Armstrong (Director of Finance and Deputy CEO), Julieanne Smith (Chief Operating Officer), Michael Chilvers (Medical Director), Mark Stanton (Chief Information Officer), Kevin O'Hart (Director of Improvement), Kevin Howell (Director of Estates and Facilities), Mary Hartley (Deputy Director of Strategy)

MATTERS TO BE REFERRED TO THE BOARD
The Committee noted that the Board should further discuss engagement with the ICS on key Trust strategic matters.

MATTERS CONSIDERED BY THE COMMITTEE:

STRATEGIC PLANNING FRAMEWORK
The Committee received a proposal to develop an Integrated Strategic Business Plan. This work will be undertaken in the context of the existing vision and strategic priorities and develop a longer term (10 year) integrated strategic plan linking clinical service development plans with workforce, financial and capital planning. The Committee supported the proposal to engage external support to undertake detailed analysis for use by the Trust to develop its strategic plan. The Committee welcomed the clear and concise overview of the plan. It was agreed communication was key in engaging external stakeholders and presenting the proposal to clinicians and operational teams to ensure maximum engagement.

The Strategy Committee accepted the proposal and it was agreed that the Board should be kept closely involved in shaping the development of the strategic plan.

CLINICAL STRATEGY REFRESH – CANCER STRATEGY
The Strategy Committee received a presentation on the PESTLE and SWOT analysis for the development of the future post MVCC strategy for cancer services which had been developed with extensive internal and external engagement. It was noted that whilst this will be woven into the new Integrated Strategic Business Plan, a separate cancer strategy will still be required to support an integrated approach to cancer. Horizon scanning has been carried out to inform strategy development, including discussions with external stakeholders. Patient experience data had been included in the analysis. Factors with the greatest strategic impact include workforce, the increasing role of AI, robotics and the impact of COVID-19. The importance of recognising the key role the Lister hospital plays in cancer services, and the need to reinforce the position of a local cancer strategy for local cancer patients was noted.

The opportunity and ambition for satellite radiotherapy on site at Lister was also discussed and the Trust's approach to building the local case was noted in the context of expected NHSE criteria.

ENABLING STRATEGIES
The Committee received an update on the Digital Strategy and future developments, focused on moving to cloud storage. The Committee discussed the proposed move to a cloud-based storage system as encouraged by NHSX and NHS Digital. It was agreed this

was a practical identification of how we move forward. The Trust has applied for money to build a business case to be a Digital Aspirant. This would be used to aid adoption pieces which would increase current technological efficiency. The Committee discussed the role of neighbouring trusts and ICS perspectives on Digital Strategy. It was recognised that working with the same systems does not by itself lead to better integration.

An update on the development of the Sustainability Strategy was received.

VASCULAR HUB
The Committee heard an update on progress on the development of the Hertfordshire and West Essex Vascular Network. The position on anticipated revenue costs and income associated with creating a hub at Lister is now much clearer. Further work is being carried out to confirm cost mitigations including length of stay efficiencies and additional CIPS to close any residual gap. Work is now focussed on engagement with spokes (West Hertfordshire Hospitals NHS Trust and Princess Alexandra NHS Trust) to confirm the revenue impact on them and their proposed mitigations to enable the completion of an outline business case. There is ongoing engagement with the ICS to facilitate this first ICS pan-provider collaboration. It was noted that the business case will need to be approved by all three Trust Boards.

ICS PATHOLOGY PROCUREMENT UPDATE
The Strategy Committee noted an update on the ICS-wide procurement project. It was confirmed that there would be hot labs on each acute site, with a cold lab offsite. Discussions are now being held with potential bidders.

MVCC TRANSFER PROGRAMME UPDATE
The Committee received an update on the Mount Vernon Cancer Centre Transfer programme. NHSE is leading a 3-stage process to assess if there is a case for Satellite Radiotherapy as part of the future model for MVCC. It was noted that the estates element for Lister needed to be developed in preparation for the second phase, which will select the recommended location. Engagement with the ICS is ongoing.

RISK REPORT AND BOARD ASSURANCE FRAMEWORK 2020/21
It was agreed that the new strategy framework needed to be reflected in the governance risk and this would be updated for the next meeting.

Karen McConnell
Strategy Committee Chair

February 2021

East and North Hertfordshire NHS Trust

Agenda Item: 16.3 a)

TRUST BOARD - PUBLIC SESSION – 3 MARCH 2021

QUALITY & SAFETY COMMITTEE – MEETING HELD ON 26 JANUARY 2021

EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the QSC meeting of the 26 January 2021 to the Board.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of QSC	**Presented by:** Chair of QSC	**Author:** Trust Secretary / Corporate Governance Officer

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
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Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

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

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

QUALITY AND SAFETY COMMITTEE MEETING – 26 JANUARY 2021
SUMMARY TO THE TRUST BOARD MEETING HELD WEDNESDAY 3rd MARCH 2021

Note: Essential matters only were discussed due to extreme operational pressures in the hospital.

The following Non-Executive Directors were present:
Ellen Schroder, David Buckle, Peter Carter, Val Moore, Biraj Parmar

The following core attendees were present:
Nick Carver, Michael Chilvers, Rachael Corser, Julie Smith

Matters Considered by the Committee:

Quality Assurance Dashboard and Compliance Update

The Committee noted the content of the latest issue of the Quality Assurance Dashboard and Compliance Update. The Committee was informed of a Never Event relating to an incorrect biopsy site that was currently being investigated. There had been no harm to the patient. It was reported that the CCG have introduced clock stops for SI investigations where there would be challenges to generate all the learning due to current pressures caused by the Covid pandemic and the Trust had received approval to pause five.

It was also reported that the Trust had also responded to a CQC whistle blower enquiry. The CQC were satisfied with the Trust's response.

Infection Prevention and Control Report

The Committee noted the content of the IPC report. The Committee heard that the Trust currently benchmarked favorably amongst Acute providers for hospital acquired Nosocomial Covid infections.

Safer Staffing Report

The Committee was informed that detailed discussion regarding the actions being taken to mitigate staffing had taken place at the (Private) Board meeting on 13th January 2021. The Committee heard there had been a significant reduction in the fill rate and sickness absence had increased. The Committee was informed there had been a greater demand for Mental Health Nurses and work was underway with HPFT to manage this.

The Committee was informed that the short term redeployment of both operational and corporate colleagues was being coordinated to support clinical areas.

Ockenden Report

The Committee was presented with an overview of the seven actions highlighted in the report and details of the Trust's position against each action. The Committee heard that the Trust was in a positive position and was supported by a strong local maternity system. The Committee received assurance that the submission would be made by the deadline and further discussion would take place at the next Trust Board meeting.

Ethics Panel Escalation Update

The Committee was informed that the Ethics Panel was reviewing and reinstating the processes relating to ethical decision making regarding access to CCU that had been agreed at the outset of the Covid pandemic.

Reports for Noting:
The following reports were noted by the Committee:

- BAF
- IPR
- Junior Doctors Contract Quarterly Update
- Clinical Audit & Effectiveness Escalation Report

Ellen Schroder, Deputising as Committee Chair

January 2021

East and North Hertfordshire NHS Trust

Agenda Item: 16.3 b

TRUST BOARD - PUBLIC SESSION – 3 MARCH 2021

QUALITY & SAFETY COMMITTEE – MEETING HELD ON 23 FEBRUARY 2021

EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the QSC meeting of the 23 February 2021 to the Board.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of QSC	**Presented by:** Chair of QSC	**Author:** Trust Secretary / Corporate Governance Officer

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
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Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

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

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

QUALITY AND SAFETY COMMITTEE MEETING – 23 FEBRUARY 2021
SUMMARY TO THE TRUST BOARD MEETING HELD WEDNESDAY 3 MARCH 2021

Note: Essential matters only were discussed due to extreme operational pressures in the hospital.

The following Non-Executive Directors were present:
Ellen Schroder, David Buckle, Val Moore, Biraj Parmar

The following core attendees were present:
Nick Carver, Michael Chilvers, Rachael Corser

Matters Considered by the Committee:

Staff Survey Key Findings
The Committee discussed the initial findings of the 2020 staff survey. The results are currently embargoed and due to be published nationally on 11 March. Further discussion would take place at future meetings (including the 3 March 2021 Private Trust Board).

Compliance Update and Quality Assurance Dashboard
The Committee noted the content of the latest issue of the Compliance Update and Quality Assurance Dashboard. The Committee was informed that the QI, IPC and mortality teams were reviewing duty of candour processes relating to hospital acquired COVID infections. The Committee was informed that the number of complaints was lower than average for this time of year and work was underway with the Divisions to ensure ~~to ensure~~ responses were timely. The Committee heard that the CQC were due to undertake virtual assessments of surgery and medicine pathways in March and no issues were anticipated at this time.

Infection Prevention and Control Report
The Committee considered the latest version of the IPC report. The Committee was presented with the COVID19 hospital acquired data sets and informed that for much of the year to date the Trust had benchmarked favorably in terms of NCI rates, but more recently the data had indicated a deterioration in performance. In response, a deep dive was undertaken which identified that the Trust had over reported 51 cases of hospital acquired Covid. The causes of the over reporting were being reviewed and the process would be corrected going forward.

In relation to other IPC issues, it was agreed that the Committee would consider a deep dive regarding Surgical Site Infections at a future meeting.

Safer Staffing Report
The Committee noted the content of the updated safer staffing report. The Committee was informed of the extreme challenges the Trust had faced in terms of staffing in January 2021. It was reported that staff sickness and isolation had peaked around the middle of the month. The Committee was informed that CHPPD had decreased in January and that the Trust had introduced a RAG rating of Black to highlight the most challenged shifts. Black shifts formed the majority of the staffing census periods, with the greatest staffing risks on the night shifts. To safely manage wards and clinical areas task teams were set up and deployed to provide targeted support.

Pathways to Excellence
The Committee noted the timeline for the Pathways to Excellence standard and were informed that the Trust was one of 14 trusts nationally to be a part of the pilot programme working to achieve accreditation.

Discharges Update
The Committee heard of work being undertaken to improve the discharge process. The Committee was informed that discharges were a priority and system partners were keen to continue to work with and support the Trust in this area. It was agreed that this could be an area of focus for the ICP later this year.

Clinical Harm Reviews Update
The Committee noted the RTT and Cancer update paper and were informed that the number of patients waiting longer for elective surgery had been severely impacted by the recent wave of the pandemic, but there was a process in place to ensure all patients continued to be appropriately prioritised.

Continuity of Carer Action Plan
The Committee reviewed the Continuity of Carer action plan and noted that progress against the actions was going well despite concerns about hiring enough qualified midwives.

Maternity Dashboard and NHSR Progress Report
The Committee discussed the Maternity Dashboard, Maternity SI Report, Maternity Highlight Report and NHSR Progress Report. There was discussion regarding the length of time it had taken to conclude the investigation and learning from one of the more historic incidents. It was also noted that the Trust's response to the Ockenden report had been submitted and would be discussed further at the next Trust Board meeting.

Board Assurance Framework
The Committee noted the content of the latest version of the BAF.

Reports for noting:
The Committee noted the following reports:

- Reducing Unavoidable Variation Report
- Emergency Preparedness
- IPR

Ellen Schroder, Deputising as Committee Chair

February 2021

East and North Hertfordshire NHS Trust

Agenda Item: 16.4

TRUST BOARD - PUBLIC SESSION – 3 MARCH 2021

AUDIT COMMITTEE – MEETING HELD ON 19 JANUARY 2021

EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the Audit Committee meeting of the 19 January 2021 to the Board.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of AC	**Presented by:** Chair of AC	**Author:** Assistant Trust Secretary

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) N/A
Any other risk issues (quality, safety, financial, HR, legal, equality):

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AUDIT COMMITTEE MEETING – 19 JANUARY 2021
SUMMARY TO THE TRUST BOARD MEETING HELD ON 3 MARCH 2021

The following Non-Executive Directors were present:
Jonathan Silver (Chair), Karen McConnell, Bob Niven

Sustainability Update
The Director of Estates and Facilities reported to the Committee regarding the Trust's sustainability performance. It was noted that a new Sustainability Group has been formed and met in January for the first time with monthly meetings planned for the mid-term and changing to quarterly at a later date once the Trust was closer to being back on track. A Sustainability Manager was being recruited and should be in place by the end of March. The work stream action plan was also highlighted.

Internal Audit Reports:

Internal Audit Report and Internal Audit Action Tracker
The Internal Auditor noted that progress against the plan was reasonable with nine of the fourteen audits for the first three quarters of the financial year finalised and one at draft stage. Fieldwork for the remaining four was in progress and there had been delays by management in responding to the IT Disaster recovery report which had been escalated to the Chief Information Officer.

It was noted that the remaining reports were on track but that clinical pressures caused by the Covid pandemic could delay the process. The audits requiring clinical input had been moved to March and the corporate audits would take place in February.

The Committee received the latest internal audit action tracker. There were twenty nine open actions with twenty five of those outstanding. Of those, fifteen were legacy recommendations and ten had recently become outstanding. It was agreed that a timescale for improvement would be given.

Counter Fraud Progress Report
The Local Counter Fraud Specialist presented the report to the Committee. She highlighted the proactive and reactive activity carried out against the Counter Fraud work plan 2020/21 in line with the Standards for Providers as set out by the NHS Counter Fraud Authority.

External Audit Reports:

External Audit Plan
The External Auditor presented the Audit Planning Report which detailed the planned audit strategy. It was noted that planning materiality was set at the same rate as last year (1.75% of gross expenditure for the year). It was highlighted that there will be a further increase in fees to that noted due to the increased audit scope under the Code of Audit Practice which significantly increases the work of the auditors for reporting on an organisation's use of resources on which formal guidance is awaited.

The audit timeline was highlighted which although earlier than last year's submission, was approximately two weeks later than usual with a provisional deadline of 15th June. The timeline for a draft is currently under discussion.

The planned audit approach for the valuation of land and buildings was highlighted as the risk is heightened for 2020/21 as a full revaluation has been commissioned which may lead to more changes in assumptions used and inputs subject to audit assessment.

Other Reports:

Cyber Security Update
The Digital Operations Director and Deputy CIO presented a verbal cyber security report. The role of the Data Security Officer has been recruited and started that week. It was noted that for the last three months, cyber security work had been outsourced and all threats were reviewed and the Trust is advised whether action is required to be undertaken. It was added that a transition and handover period will be undertaken of a minimum of three months.

Tenders and Waivers Report
The Committee received an update of the Tenders and Waivers report which noted that the value and volume of the tender waivers had increased.

Significant Losses / Special Payments
The Deputy Director of Finance noted that the patient belongings claims were handled well and that pharmacy stock losses were inflated by short life chemo drugs which had not been used due to cancellations during the first wave of the pandemic.

Review of Accounting Policies
The Financial Controller presented the report which noted there were no changes in accounting standards to be reported that would impact 2020/21 as the introduction of the IFRS 16 (Leases) had been delayed in the public sector and will be adopted in April 2022. However, there will be a disclosure impact on 2020/21 accounts.

Board Assurance Framework
The Associate Director of Governance presented the Board Assurance Framework. The FPPC and Board had reviewed the construction of the capital risk to reflect the short and long term risk. The annual review of the BAF and risk register was underway with the Internal Auditor and the risk strategy was being reviewed and will be brought to the Audit Committee in March.

Jonathan Silver
Audit Committee Chair
January 2021

East and North Hertfordshire NHS Trust

Agenda Item: 16.5

TRUST BOARD PUBLIC MEETING – 3 MARCH 2021
Remuneration Committee Terms of Reference

Purpose of report and executive summary (250 words max): The Remuneration Committee's terms of reference have been reviewed and updated in line with the latest best practice. The changes are highlighted by 'track changes'. The Remuneration Committee has recommended the revised terms of reference for approval by the Trust Board		
Action required: For approval		
Previously considered by: **Remuneration Committee, 3 February 2021**		
Director: **Interim Chief People Officer**	**Presented by:** **Chair of Remuneration Committee**	**Author:** **Interim Chief People Officer / Trust Secretary**

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) **Governance**
Any other risk issues (quality, safety, financial, HR, legal, equality):

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REMUNERATION AND APPOINTMENTS COMMITTEE (EXECUTIVE)

TERMS OF REFERENCE

1. Purpose

To make recommendations to the Board 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.

2. Status and Authority

The Committee is constituted as a standing committee of the Trust Board and derives its powers from the Board of Directors (the Board) and has no executive powers, other than those specifically delegated in these terms of reference. The Committee is authorised:

a) To seek any information it requires from any employee of the trust in order to perform its duties;
b) To obtain, at the Trust's expense, outside legal or other professional advice on any matter within its terms of reference~~; to the total of £10,000 per annum;~~ and
c) To call any employee to be questioned at a meeting of the Committee as and when required.

3. Membership

The Committee shall be made up of the Chair~~man~~ of the Trust and all non executive directors.

Only members of the Committee have the right to attend Committee meetings.

Other individuals such as the Chief Executive, ~~Director of Workforce and Organisational Development~~Chief People Officer, Trust Secretary, the Chair or Managing Director of the subsidiary and external advisers may be invited to attend for all or part of any meeting, as appropriate.

The Board of Directors (the Trust Board) shall appoint the Committee chair~~man~~. The Committee chair~~man~~ shall be an independent Non-Executive Director who ideally is a member with relevant experience of remuneration matters.

In the absence of the Committee chair~~man~~ and / or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting who would qualify under these Terms of Reference to be appointed to that position by the Board. ~~.~~

4. Quorum

The quorum necessary for the transaction of business shall be 3 independent non executive directors. A duly convened meeting of the Committee at which a quorum is

present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

5. Frequency of Meetings

The Committee shall meet at least ~~once~~ twice a year and otherwise as required. ~~at such other times as the chairman of the Committee shall require.~~ Ordinarily the Committee will plan to meet four times throughout the year, however if remuneration decisions are required for new appointments or there are other urgent matters for the Committee to consider then additional meetings may be held. ~~these maybe held by a virtual committee.~~

In exceptional circumstances when an urgent decision is required and it is not possible to schedule an additional meeting of the Committee, with the agreement of the Chair, decisions may be made by virtual correspondence.

Notice of meetings
Meetings of the Committee shall be summoned by the secretary of the Committee at the request of the Committee Chair or any of its members. Meetings for the year should be scheduled at the start of the financial year.

Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, and any other person required to attend, no later than 5 working days before the date of the meeting. Supporting papers will be sent to Committee members and to to other attendees, as appropriate, at the same time.

Minutes of meetings
The secretary shall minute the proceeding and resolutions of all Committee meetings, including the names of those present and in attendance.

6. Duties

The Committee shall:

a) Determine and agree the framework or broad policy for remuneration and terms of service of the Trust's Executive Directors and other staff that are not covered by Agenda for Change or Medical and Dental Terms and Conditions;
b) In determining such policy, take into account all factors which it deems necessary. The objective of such policy shall be to ensure that Executive Directors of the Trust are provided with appropriate incentives to encourage enhanced performance and are, in a fair and responsible manner, rewarded for their individual contributions to the long term success of the trust;
c) Design remuneration policies and practices to support strategy and promote longterm sustainable success, with executive remuneration aligned to the Trust's purpose and values, clearly linked to the successful delivery of the Trust's strategy;
~~c)~~d) Review the ongoing appropriateness and relevance of the remuneration policy, taking into account its relationship and relativity with remuneration policies and terms and conditions in place for other staff groups;
~~d)~~e) Ensure that any contractual terms on termination, and any payments made, are fair to the individual and the Trust, aligned with the interest of the patients, that failure is not rewarded and that the duty to mitigate loss is fully recognised;
~~e)~~ Within the terms of the agreed policy and instructions issued by ~~the Secretary of State~~ NHS England/Improvement (NHSE/I), and in consultation with the

chair and/or chief executive, as appropriate, determine the total individual remuneration package of each Executive Director including but not limited to bonuses, incentives ~~payments~~ and other payments ~~awards~~ such as relocation expenses~~pension and cars~~;

f) ~~Consider the need for~~

~~f)~~g) Oversee succession planning within the Trust and review the succession planning and talent map annually;

~~g) Agree the policy for authorising claims for expenses from the Executive Directors;~~

h) ~~Be responsible for establishing~~ Receive assurance regarding the selection criteria, selecting, appointing and setting the terms of reference for any remuneration consultants who advise the Committee, ~~which should be at least every three years or when considering making large changes;~~ and to obtain reliable, up-to-date information about remuneration in other Trusts.

i) Receive assurance regarding the process for the appointment / removal of the Chief Executive and Executive Directors.

j) Authorise the use of an Appointment Panel, as required, for Executive appointments.

~~Review the remuneration framework for the staff on Trust Pay;~~

Regarding the subsidiary:

~~h)~~k) Agree the framework or broad policy for remuneration for Directors of the subsidiary

~~i)~~l) Approve Director appointments to the subsidiary Board ~~Director appointments~~;

~~j)~~m) Within the terms of the agreed policy, determine the total individual remuneration package of each subsidiary Director including but not limited to bonuses, incentive payments and other awards such as pension ~~and cars~~.

.

Other matters

The Committee shall:

a) Have access to sufficient resources in order to carry out its duties, including access to the trust secretariat for advice and assistance as required;

b) Be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;

c) Give due consideration to all relevant laws and regulations, NHSE/I guidance and the provisions of the Code of Governance;

d) Ensure that no director or senior manager shall be involved in any decisions as to their own remuneration outcome.

e) Work and liaise as necessary with other board committees, ensuring the interaction between committees and with the board is reviewed regularly.

a) ~~Oversee any investigation of activities which are within the terms of its reference;~~

7. Reporting arrangements

The Committee chair shall report formally to the Board, on a quarterly basis, on its proceedings ~~after each meeting~~ on all matters within its duties and responsibilities.

The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

An annual statement of the Trust's remuneration policy and practices which will form part of the Trust's Annual Report and register of attendance.

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

The committee shall:

a) Ensure that a periodic evaluation of the committee's own performance is carried out.

~~a)~~b) At least ~~once a year~~annually, review its terms of reference ~~own performance and terms of reference~~ to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.

9. Support

The ~~Associate Director of Corporate Governance~~Trust Secretary or their nominee shall act as secretary of the Committee.

Reviewed ~~March 2019~~ February 2021

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

Agenda item: 17

EAST AND NORTH HERTFORDSHIRE NHS TRUST
TRUST BOARD ACTIONS LOG TO 3 MARCH 2021

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date

No actions outstanding

Board Annual Cycle 2020-21

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.

**Note: Due to the operational pressures posed by the Covid pandemic, the January 2021 meeting was reduced to essential business only and held in private.*

Items	**3 Jun 2020**	**1 Jul 2020**	**Aug 2020**	**2 Sept 2020**	***Oct 2020**	**4 Nov 2020**	**Dec 2020**	**Jan 2021***	**Feb 2021**	**Mar 2021**
Standing Items										
Chief Executive's Report				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
Patient Testimony (Part 1 where possible)	X	X		X		X				X
Employee relations (Part 2)	X	X		X		X		X		X
COVID-19 Recovery	X	X		X		X				
Board Committee Summary Reports										
Audit Committee Report		X		X		X				X
Charity Trustee Committee Report		X				X		X		
Finance, Performance and People Committee Report		X		X		X		X		X
Quality and Safety Committee Report		X		X		X		X		X
Strategy										
Annual Operating Plan and objectives *(subject to change as dependent on national timeline)* - ***TBC***										

Board Annual Cycle 2020-21

Items	3 Jun 2020	1 Jul 2020	Aug 2020	2 Sept 2020	*Oct 2020	4 Nov 2020	Dec 2020	Jan 2021*	Feb 2021	Mar 2021
Strategy Quarterly Update		X				X				X ***See Strategy Cttee Summary Report***
System Working (ICS and ICP) Updates	X	X		X		X				X
Mount Vernon Cancer Centre Transfer Update		X				X				X
Other Items										
Audit Committee										
Annual Report and Accounts, Annual Governance Statement and External Auditor's Report	X ***(Extraordinary Board session TBC)***									
Annual Audit Letter				X						
Audit Committee TOR and Annual Report						X				
Raising Concerns at Work Report		X								
Review of Trust Standing Orders and Standing Financial Instructions						X				
Charity Trustee Committee										
Charity Annual Accounts and Report						X				
Charity Trust TOR and Annual Committee Review						X ***Deferred to January***		X		

Board Annual Cycle 2020-21

Items	3 Jun 2020	1 Jul 2020	Aug 2020	2 Sept 2020	*Oct 2020	4 Nov 2020	Dec 2020	Jan 2021*	Feb 2021	Mar 2021
Finance, Performance and People Committee										
Finance Update (Part 2)				X		X		X		X
FPPC TOR and Annual Report						X				
Digital Strategy Update (Part 2)		X				X ***Due to be considered by the Strategy Committee in December***				X
Equality and Diversity Annual Report and WRES				X						
Gender Pay Gap Report										X
Market Strategy Review - ***TBC***										
Quality and Safety Committee										
Complaints, PALS and Patient Experience Report				X						X ***Deferred to May***
Safeguarding and L.D. Annual Report (Adult and Children)		X								
Detailed Analysis of Staff Survey Results Note: Discussion at Public Board meeting deferred to May due to 2021 national publication date										X
Learning from Deaths		X				X		X		
Nursing Establishment Review		X ***Deferred***						X ***Deferred***		

Board Annual Cycle 2020-21

Items	3 Jun 2020	1 Jul 2020	Aug 2020	2 Sept 2020	*Oct 2020	4 Nov 2020	Dec 2020	Jan 2021*	Feb 2021	Mar 2021
Responsible Officer Annual Review				**X** ***Deferred due to national changes regarding revalidation***						
Patient Safety and Incident Report (Part 2)						**X**		**X**		
University Status Annual Report										**~~X~~** ***Timing of reporting changing from 2021***
QSC TOR and Annual Review						**X**				
Shareholder / Formal Contracts										
ENH Pharma (Part 2)		**X**								

DATA PACK

Contents

1. Data and Exception Reports:

FFT

2. Performance Data:

CQC Outcomes Summary

3. Learning from Deaths Report

1. Data and Exception Reports:

FFT

Friends and Family Test - January 2021

APPENDIX 2

Inpatients & Day Case	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses	No of Patients eligible to respond
5A	100.00	0.00	1	0	0	0	0	0	1	93
5B	NP	NP	0	0	0	0	0	0	0	48
6A	NP	NP	0	0	0	0	0	0	0	73
6B	100.00	0.00	0	8	0	0	0	0	8	47
7A	100.00	0.00	0	1	0	0	0	0	1	39
7B	97.56	2.44	28	12	0	1	0	0	41	112
8A	100.00	0.00	1	0	0	0	0	0	1	82
8B	100.00	0.00	16	1	0	0	0	0	17	100
9A	100.00	0.00	32	0	0	0	0	0	32	39
9B	NP	NP	0	0	0	0	0	0	0	47
10A	NP	NP	0	0	0	0	0	0	0	36
10B	NP	NP	0	0	0	0	0	0	0	64
11A	NP	NP	0	0	0	0	0	0	0	78
11B	NA	NA	0	0	0	0	0	0	0	0
ICU1	100.00	0.00	3	0	0	0	0	0	3	3
ICU2	NA	NA	0	0	0	0	0	0	0	0
AMU1	NP	NP	0	0	0	0	0	0	0	262
AMU2	NP	NP	0	0	0	0	0	0	0	45
Ashwell	100.00	0.00	3	7	0	0	0	0	10	36
Barley	92.59	0.00	20	5	2	0	0	0	27	29
Pirton	90.91	0.00	6	4	1	0	0	0	11	51
Swift	NP	NP	0	0	0	0	0	0	0	189
Day Surgery Centre, Lister	100.00	0.00	7	0	0	0	0	0	7	98
Day Surgery Treatment Centre	100.00	0.00	22	0	0	0	0	0	22	58
Endoscopy, Lister	100.00	0.00	104	1	0	0	0	0	105	493
Endoscopy, QEII	100.00	0.00	20	2	0	0	0	0	22	42
Cardiac Suite	100.00	0.00	7	2	0	0	0	0	9	65
MEDICINE/SURGERY TOTAL	98.74	0.32	**270**	**43**	**3**	**1**	**0**	**0**	**317**	**2229**
Bluebell ward	100.00	0.00	4	2	0	0	0	0	6	118
Bluebell day case	NA	NA	0	0	0	0	0	0	0	0
Neonatal Unit	100.00	0.00	20	7	0	0	0	0	27	83
WOMEN'S/CHILDREN TOTAL	100.00	0.00	**24**	**9**	**0**	**0**	**0**	**0**	**33**	**201**
MVCC 10 & 11	100.00	0.00	10	4	0	0	0	0	14	53
CANCER TOTAL	100.00	0.00	**10**	**4**	**0**	**0**	**0**	**0**	**14**	**53**
TOTAL TRUST	98.90	0.27	**304**	**56**	**3**	**1**	**0**	**0**	**364**	**2483**

Continued over …..

Inpatients/Day by site	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses	No. of Discharges
Lister	98.78	0.30	274	50	3	1	0	0	328	2388
QEII	100.00	0.00	20	2	0	0	0	0	22	42
Mount Vernon	100.00	0.00	10	4	0	0	0	0	14	53
TOTAL TRUST	98.90	0.27	**304**	**56**	**3**	**1**	**0**	**0**	**364**	**2483**

Accident & Emergency	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses	No. of Discharges
Lister A&E/Assessment	96.43	0.00	24	3	1	0	0	0	28	6936
QEII UCC	NP	NP	0	0	0	0	0	0	0	2382
A&E TOTAL	96.43	0.00	**24**	**3**	**1**	**0**	**0**	**0**	**28**	**9318**

Maternity	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses	No. eligible to respond
Antenatal	100.00	0.00	5	2	0	0	0	0	7	480
Birth	97.90	0.00	108	32	3	0	0	0	143	428
Postnatal	95.00	0.00	97	36	7	0	0	0	140	428
Community Midwifery	100.00	0.00	8	0	0	0	0	0	8	510
MATERNITY TOTAL	96.64	0.00	**218**	**70**	**10**	**0**	**0**	**0**	**298**	**1846**

Outpatients	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses
Lister	93.75	6.25	26	4	0	1	1	0	32
QEII	97.83	2.17	30	15	0	0	1	0	46
Hertford County	100.00	0.00	11	0	0	0	0	0	11
Mount Vernon CC	100.00	0.00	39	7	0	0	0	0	46
Satellite Dialysis	96.67	1.67	46	12	1	1	0	0	60
OUTPATIENTS TOTAL	97.44	2.05	**152**	**38**	**1**	**2**	**2**	**0**	**195**

Trust Targets	% Would recommend
Inpatients/Day Case	96%>
A&E	90%>
Maternity (combined)	93%>
Outpatients	95%>
NP = Not provided	

2. Performance Data:

CQC Outcomes Summary

Our CQC Registration and recent Care Quality Commission Inspection

The Care Quality Commission inspected eight of the core services provided by East and North Hertfordshire NHS Trust across Lister Hospital, the New Queen Elizabeth II (QEII) Hospital and Mount Vernon Cancer Centre, between 23 - 25 & 30 – 31 July 2019. The well led inspection took place from 10 – 11 September 2019. The Use of Resources inspection, which is led by NHS Improvement took place on 6 August 2019.

The inspectors focused on **Safety, Effectiveness, Responsiveness, Care and how well led services are** in eight core service lines:

At **Lister Hospital** CQC inspected:

- Surgery
- Critical Care
- Children's and young people
- End of life care
- Outpatient

At the **New QEII Hospital** CQC inspected:

- Urgent Care Centre
- Outpatients

At the **Mount Vernon Cancer Centre** CQC inspected:

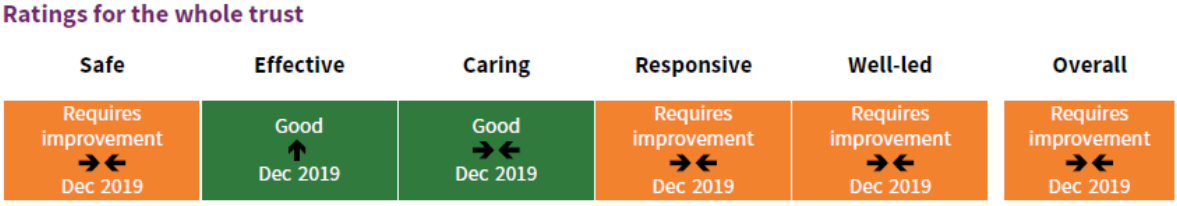
- Medicine (MVCC)
- Radiotherapy (MVCC)
- Outpatients

At the July 2019 inspection, these core services were rated either as requires improvement or good.

Summary of the Trust's Ratings

Our rating of the Trust stayed the same -**requires improvement**.
We were rated as **good** for caring and effective and **requires improvement** for and safe, responsive and well led.

We were rated as **requires improvement** for use of resources



	Safe	Effective	Caring	Responsive	Well-led	Overall
Lister Hospital	Requires improvement → ← Dec 2019	Good ↑ Dec 2019	Good → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019
Queen Elizabeth II Hospital	Requires improvement ↑ Dec 2019	Good ↑ Dec 2019	Good → ← Dec 2019	Requires improvement ↓ Dec 2019	Requires improvement ↑ Dec 2019	Requires improvement ↑ Dec 2019
Mount Vernon Cancer Centre	Requires improvement → ← Dec 2019	Good → ← Dec 2019	Good → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019
Hertford County Hospital	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Overall trust	Requires improvement → ← Dec 2019	Good ↑ Dec 2019	Good → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement → ← Dec 2019	Good ↑ Dec 2019	Good → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019
Community	Good Mar 2016	Good Mar 2016	Outstanding Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016

The CQC have issued a number of requirement notices and set out a number of areas for improvement - “Must Do’s” and “Should Do’s”.

The requirement notices are:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

An action plan has been developed against all of these and was submitted to CQC on 22 January 2020. This will be monitored by the Quality Improvement Board, chaired by the Medical Director or Director of Nursing and reported to Board through the Quality and Safety Committee. A programme of internal and external inspections is in place to test and evidence progress and that the actions are embedded across the organisation.

Site Ratings

East and North Hertfordshire NHS Trust

Lister Hospital

	Safe	Effective	Caring	Responsive	Well-Led		Overall
Urgent and emergency services	Good July 2018	Good July 2018	Good July 2018	Good July 2018	Good July 2018		Good July 2018
Medical care (including older people's care)	Requires Improvement July 2018	Requires Improvement July 2018	Requires Improvement July 2018	Requires Improvement July 2018	Requires Improvement July 2018		Requires Improvement July 2018
Surgery	Inadequate December 2019	Good December 2019	Good December 2019	Requires Improvement December 2019	Requires Improvement December 2019		Requires Improvement December 2019
Critical care	Good December 2019	Good December 2019	Good December 2019	Good December 2019	Good December 2019		Good December 2019
Maternity	Requires Improvement July 2018	Good July 2018	Good July 2018	Good July 2018	Good July 2018		Good July 2018
Services for children and young people	Requires Improvement December 2019	Good December 2019	Good December 2019	Good December 2019	Good December 2019		Good December 2019
End of life care	Good December 2019	Requires Improvement December 2019	Good December 2019	Requires Improvement December 2019	Requires Improvement December 2019		Requires Improvement December 2019
Outpatients	Good December 2019	Good December 2019	Good December 2019	Good December 2019	Good December 2019		Good December 2019
Overall	Requires Improvement December 2019	Good December 2019	Good December 2019	Good December 2019	Requires Improvement December 2019		Requires Improvement December 2019

New QEII

	Safe	Effective	Caring	Responsive	Well-Led		Overall
Urgent and emergency services	Requires Improvement December 2019	Good December 2019	Good December 2019	Good December 2019	Requires Improvement December 2019		Requires Improvement December 2019
Outpatients and diagnostic imaging	Requires Improvement December 2019	N/A	Good December 2019	Requires Improvement December 2019	Good December 2019		Requires Improvement July 2018
Overall	Requires Improvement December 2019	Good December 2019	Good December 2019	Requires Improvement December 2019	Requires Improvement December 2019		Requires Improvement December 2019

Hertford County Hospital

	Safe	Effective	Caring	Responsive	Well-Led		Overall
Outpatients	Good March 2016	Good March 2016	Good March 2016	Good March 2016	Good March 2016		Good March 2016
Overall	Good March 2016	Good March 2016	Good March 2016	Good March 2016	Good March 2016		Good March 2016

Mount Vernon Cancer Centre

	Safe	Effective	Caring	Responsive	Well-Led		Overall
Medical care (including older people's care)	Requires Improvement December 2019 → ←	Good December 2019 → ←	Good December 2019 → ←	Requires Improvement December 2019 → ←	Requires Improvement December 2019 → ←		Requires Improvement December 2019 → ←
End of life care	Requires Improvement July 2018	Good July 2018	Good July 2018	Inadequate July 2018	Requires Improvement July 2018		Requires Improvement July 2018
Outpatients	Good December 2019 → ←	N/A	Good December 2019 → ←	Requires Improvement December 2019 → ←	Requires Improvement December 2019 ↓		Requires Improvement December 2019 ↓
Chemotherapy	Requires Improvement July 2018	Good July 2018	Good July 2018	Requires Improvement July 2018	Requires Improvement July 2018		Requires Improvement July 2018
Radiotherapy	Good December 2019 → ←	Good December 2019 → ←	Good December 2019 → ←	Good December 2019 → ←	Good December 2019 → ←		Good December 2019 → ←
Overall	Requires Improvement December 2019 → ←	Good December 2019 → ←	Good December 2019 → ←	Requires Improvement December 2019 → ←	Requires Improvement December 2019 → ←		Requires Improvement December 2019 → ←

Community Health Services for Children, Young People and Families

	Safe	Effective	Caring	Responsive	Well-Led		Overall
Community health services for children and young people	Good March 2016	Good March 2016	Outstanding March 2016	Good March 2016	Good March 2016		Good March 2016
Overall	Good March 2016	Good March 2016	Outstanding March 2016	Good March 2016	Good March 2016		Good March 2016

2. Learning from Deaths Report

East and North Hertfordshire NHS Trust

Agenda Item: 3.1

TRUST BOARD - PUBLIC SESSION – 3 MARCH 2021

Learning from Deaths Report

Purpose of report and executive summary (250 words max):		
Reducing mortality is one of the Trust's key objectives. This quarterly report summarises the results of mortality improvement work, including the regular monitoring of mortality rates, together with outputs from our learning from deaths work that are continual on-going processes throughout the Trust. It also incorporates information and data mandated under the National Learning from Deaths Programme.		
Action required: For information		
Previously considered by: **Mortality Surveillance Committee 9 December 2020** **QSC 15 December 2020**		
Director: **Medical Director**	**Presented by:** **Medical Director**	**Author:** **Mortality Improvement Lead**

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) **No**
Any other risk issues (quality, safety, financial, HR, legal, equality): **Detailed on page 1 of report**

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

SECTION 1: LEARNING FROM DEATHS REPORT SUMMARY

1.1 Introduction

Reducing mortality remains one of the Trust's key objectives. This quarterly report summarises the results of mortality improvement work, including the regular monitoring of mortality rates, together with outputs from our learning from deaths work that are continual on-going processes throughout the Trust. It also incorporates information and data mandated under the National Learning from Deaths Programme.

The report has been approved by the Mortality Surveillance Committee.

The transition from Dr Foster to CHKS as a reporting source has now been completed. It should be noted that the CHKS figures cannot be compared with past data from Dr Foster, however the trends should be similar in both sets of data.

Further information on the key metrics, developments and current risks summarised on this page can be found in Sections 2 and 3, together with Appendix 1.

1.2 Key metrics

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

Metric	Result
Crude mortality	Crude mortality is 1.37% for the 12 month period to October 2020 compared to 1.25% for the latest 3 years.
HSMR: (data period Sep19 – Aug20)	HSMR for the 12 month period is **83.07, 'First quartile'.**
SHMI: (data period Jul19 – Jun20)	Headline SHMI for the 12 month period is **90.03 'as expected band 2'.**
HSMR – Peer comparison	ENHT is ranked 3rd (out of 9) within the Model Hospital list* of peers.

* We are comparing our performance against the peer group indicated for ENHT in the Model Hospital, rather than the purely geographical regional group we used to use. Further detail is provided in 2.2.3.

1.3 Headlines

- COVID-19
- HSMR has remained stable and is in the first quartile
- SHMI is stable in the 'as expected band' following a period of sustained reduction
- Medical Examiners: pilot commenced 1 October
- Mortality Review Tool development/Datix IQ: implementation work has commenced
- Regular on-going mortality monitoring via Mortality Surveillance Committee, Quality and Safety Committee and Board.

1.4 Current tasks

Table 2 below summaries key risks identified:

Risks	Report ref (Mitigation)
COVID-19	2.1
7 day service	2.6.1
Care bundles	2.6.2
Medical Examiner Introduction	2.6.3
Mortality Review – need for content/IT development	3.1
Mortality module incorporation onto Datix iCloud platform	3.1
Severe Mental Illness – Identification/flagging of patients	3.2.3

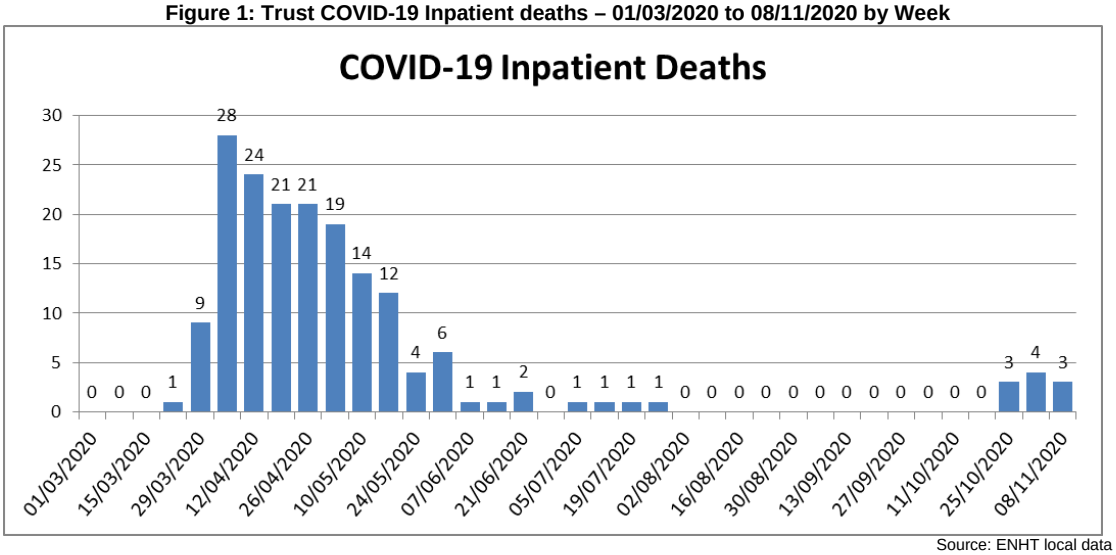
SECTION 2: MORTALITY PERFORMANCE

2.1 COVID-19

2.1.1 COVID-19 mortality data

The first COVID-19 death reported in the Trust occurred on 19 March 2020. Figure 1 shows subsequent deaths by week up to 08 November 2020. The dates shown are 'week-ending' dates. This chart shows our first local peak occurred week ending 5 April 2020. The first death in the second wave occurred on 21 October. From this date to 30 November a total of 24 patients have sadly died.

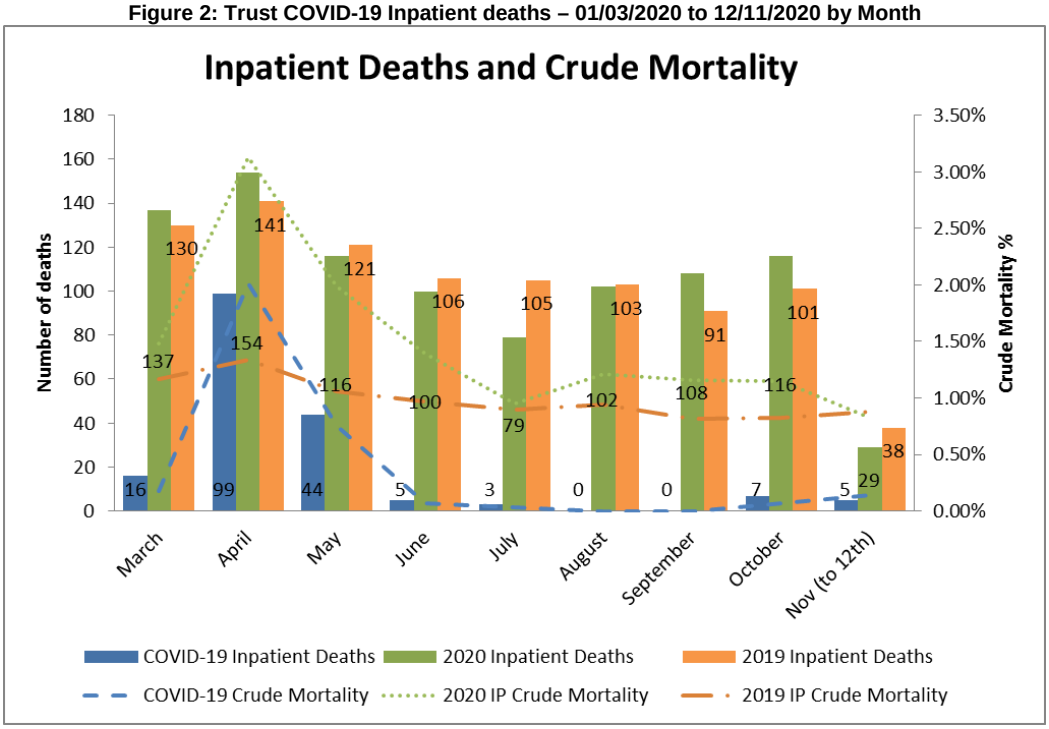
Figure 1: Trust COVID-19 Inpatient deaths – 01/03/2020 to 08/11/2020 by Week



Source: ENHT local data

Figure 2 below shows COVID-19 deaths relative to total Trust in-patient deaths, with a comparison to last year's data. It also indicates the associated crude mortality rates. After a break in deaths during August and September, a number of deaths have been recorded in October and November.

Figure 2: Trust COVID-19 Inpatient deaths – 01/03/2020 to 12/11/2020 by Month



Please note that the COVID-19 Crude Mortality has been calculated from the 2020 monthly discharges (and is not a proportion of the COVID-19 related discharges). This data has been taken from our ENHT data warehouse.

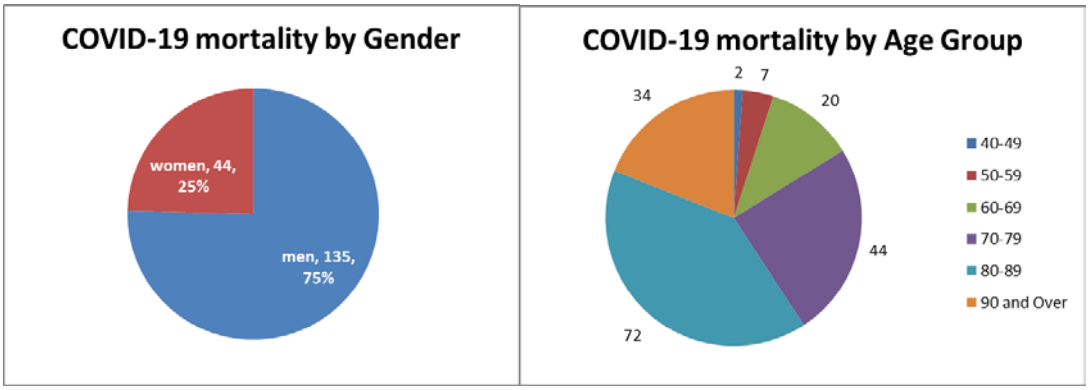
The multi-layered effects of the COVID-19 pandemic will make meaningful analysis and comparisons regarding mortality data challenging. To date our local data has shown the following trends.

There were 179 COVID-19 Inpatient deaths at the trust from 01 March 2020 to 12 November 2020 (latest data available at time of writing – 13 November 2020), this figure includes both patients who tested positive for COVID-19 and patients who had a clinical assessment of COVID-19.

Figures 3 and 4 show that our local findings regarding those patients worst impacted by the virus are broadly in line with nationally reported outcomes, namely; that significantly more men than women die from the disease and that the elderly are worst hit.

Fig 3: COVID-19 Inpatient deaths (01/03/20-12/11/20) by Gender

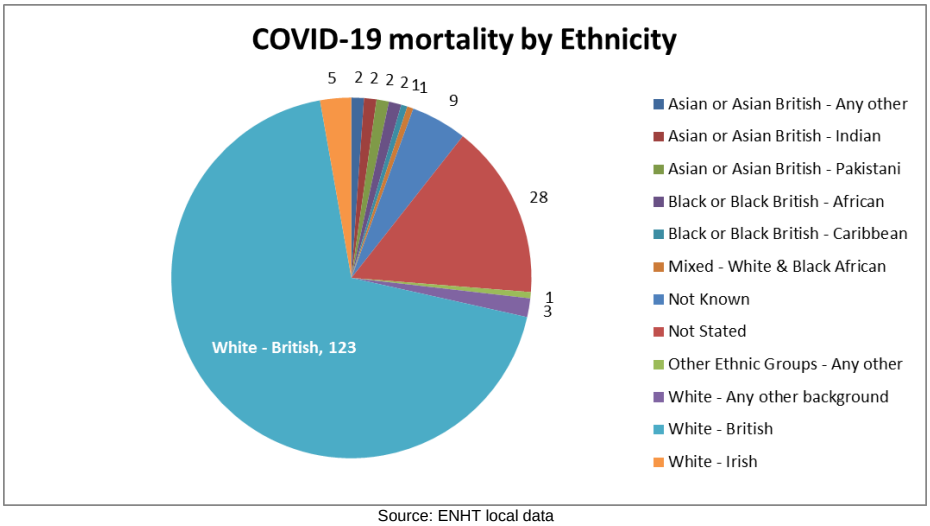
Fig 4: COVID-19 Inpatient deaths (01/03/20-12/11/20) by Age



Source: ENHT local data

Figure 5 does not demonstrate a bias towards the BAME population, but this may be a reflection of the demographics of the Hertfordshire region.

Figure 5: Trust COVID-19 Inpatient deaths – 01/03/2020 to 12/11/2020 by Ethnicity



Source: ENHT local data

2.1.2 COVID-19 and mortality review

During the initial response to COVID-19 all but priority mortality reviews were suspended to allow clinicians to focus on the requirements of the pandemic. As we entered our Restart Programme, our standard review process was resumed.

In additional to our BAU service, in order to better understand the impact of COVID-19, two specific cohorts of patients have been identified for further scrutiny:

i) COVID-19 patients who died on a readmission to hospital within 30 days of discharge,
ii) non-COVID patients who died in the community within 30 days of discharge.

For the first of these, the Lead Respiratory Mortality Reviewer was asked to undertake mortality reviews of 30 patients identified as having died of COVID on a readmission to hospital within 30 days. This review is now complete. Summary detail will be provided to the Mortality Surveillance Committee in December for discussion.

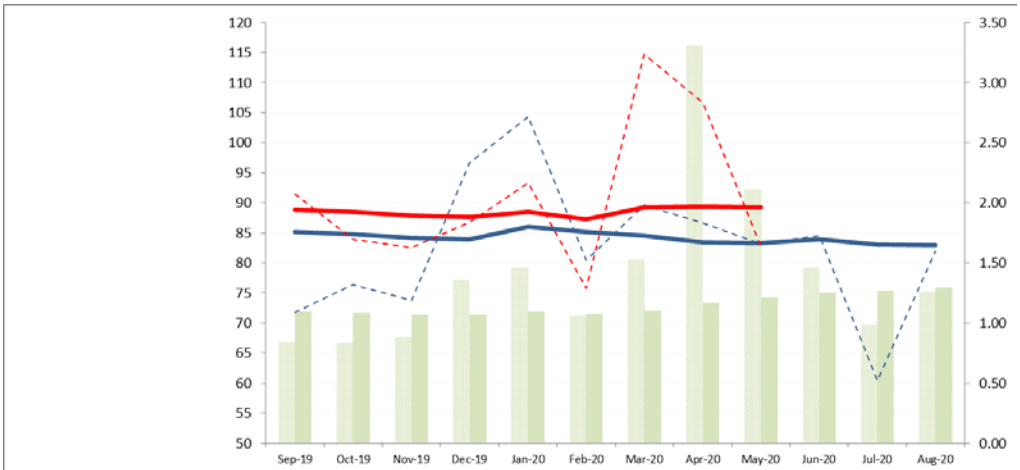
The second review is still in progress in collaboration with the Coding department.

Subject to winter pressures, it is intended that the outputs of these reviews will be available in time for a focussed look at COVID mortality one year on from the start of the pandemic, in the next report in March 2021.

2.2 Key metrics

2.2.1 Trust key metrics overview

Figure 6: Trust Key Mortality Metrics: Latest Position



	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20
Mortality Rate - Monthly	0.84	0.84	0.89	1.36	1.47	1.06	1.54	3.32	2.12	1.47	0.99	1.26
Mortality Rate - Rolling Month	1.09	1.08	1.07	1.07	1.10	1.08	1.10	1.16	1.21	1.25	1.27	1.29
HSMR - Monthly	71.7	76.3	73.7	96.7	104.3	80.4	89.5	86.6	83.1	84.5	60.4	81.9
HSMR - Rolling Month	85.1	84.8	84.2	83.9	86.0	85.1	84.5	83.4	83.3	83.9	83.1	83.0
SHMI - Monthly	91.5	84.0	82.5	86.7	93.3	75.8	114.7	106.7	82.8			
SHMI - Rolling Month	88.9	88.4	87.9	87.6	88.4	87.3	89.2	89.3	89.2			

The chart above shows the Trust's latest in-month and rolling 12 month trend for the three key mortality metrics: Crude mortality, HSMR and SHMI. This shows that the rolling 12 month position has remained relatively stable for HSMR and SHMI, however in-month HSMR decreased in July 2020 only to jump straight back up in August 2020.

Crude mortality: CHKS compares performance of crude mortality and reports that the average national crude in-patient mortality (for HES Acute trusts, all admissions excluding well babies) is 1.43%, and is 1.52% for the Model Hospital peer group for the twelve months to August 2020. This compares to 1.29% within ENHT for the same period. The Trust's locally recorded crude mortality rate, stands at 1.32% for the latest twelve months to October 2020.

HSMR: Our rolling 12 month HSMR for the last 6 months has remained broadly stable, with only small fluctuations seen. 83.07 was reported for the latest period (September 2019 to August 2020), compared to 83.53 for the previous release June 2019 to May 2020.

SHMI: While figure 6 above from CHKS data shows SHMI to February 2020 (89.2) NHS Digital has now refreshed to show the rolling 12 months to June 2020. It reports the Trust's SHMI currently standing at 90.03 for this period. This remains in the 'as expected' range (at the best performing end).

From the NHS Digital July 2020 publication (March 2019-February 2020) onwards, COVID-19 activity has been excluded from the SHMI. It was noted that the SHMI is not designed for this type of pandemic activity and the statistical modelling used to calculate the SHMI may not be as robust if such activity were included. Activity that is being coded as COVID-19, and therefore excluded, is monitored in a new contextual indicator 'Percentage of provider spells with COVID-19 coding'. For the July 2019-June 2020 SHMI calculation, 0.9% of the Trust's spells were excluded.

2.2.2 Trust In-month trend (crude/HSMR)

Figure 7 below provides the latest available in-month position, not only for crude and HSMR mortality rates, but also volume of deaths. The peak of the COVID-19 outbreak is shown by the spike in number of deaths in April 2020. The number of deaths in the summer months has fallen, however this has increased in the last three months. It should be noted that the Crude Mortality rate has not followed closely as there has been more inpatient activity in September and October.

The HSMR indicator partially excludes COVID-19 patients from the methodology as patients with a primary diagnosis of COVID-19 (in the first episode or second episode if the first contains a primary diagnosis of a sign or symptom) are placed in CCS group '259 - Residual codes; unclassified' and this is not one of the 56 CCS groups included in the HSMR model. With relatively few COVID-19 deaths in June to August this year, the HSMR line is following the Trust deaths trajectory for these months.

Figure 7: Trust Crude Mortality/HSMR latest in-month trend

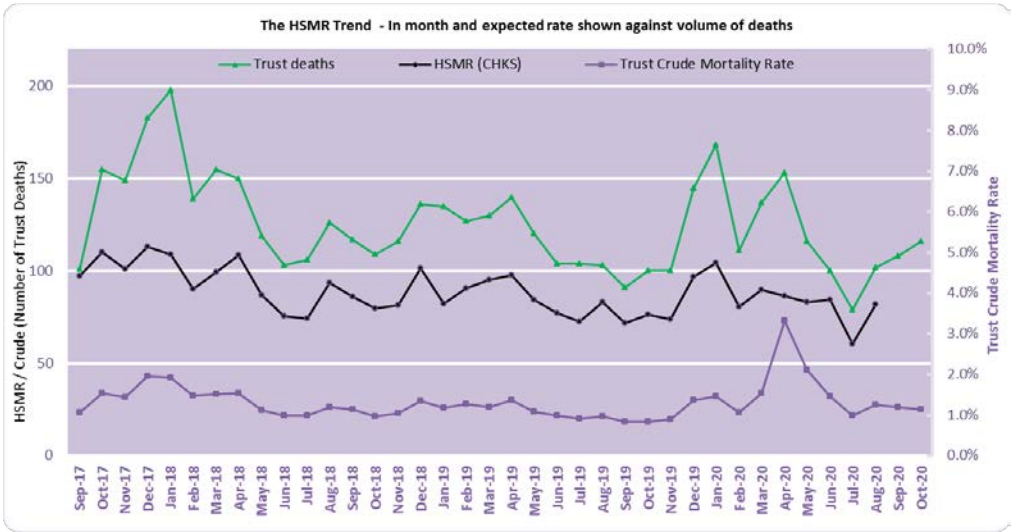
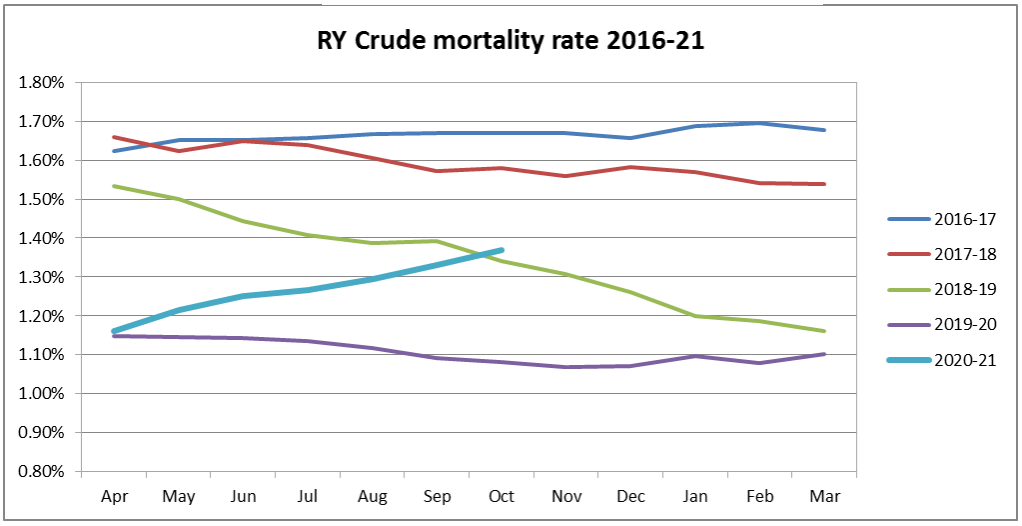


Figure 8 shows the trend in crude mortality rates over recent years. While this provides a good indication of the improving picture up to February 2020, it should be borne in mind that it has not been possible to use data solely from one source. This is due to the need for rolling year calculations to be based on changing data sources (pre-Lorenzo, our data warehouse [EDW] and most latterly CHKS).

Figure 8: 5 year crude mortality trends trend

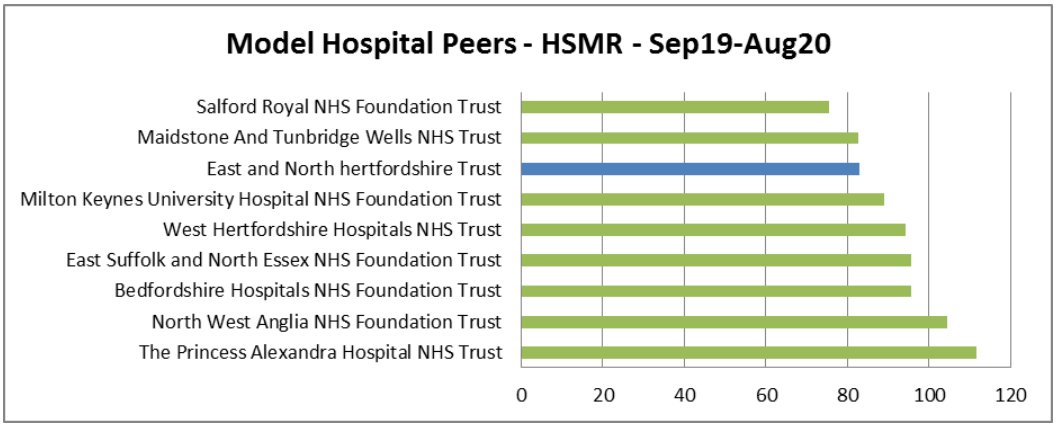


The recent increases in rolling year crude mortality rate reflects the number of deaths from the COVID-19 outbreak coupled with the reduced inpatient activity at the Trust during March-October 2020.

The observed number of deaths within the risk model for HSMR is the greatest factor determining the overall score for an organisation which means that crude mortality can be used as a useful predictor of coming HSMR performance. However, given the treatment of COVID-19 patients in the HSMR methodology (detailed above), there may be less of a correlation seen during the COVID period.

2.2.3 Trust HSMR peer comparison

Figure 9: Trust Model Hospital Peer comparison



For the purposes of performance assessment we have adopted the peer group indicated for ENHT in the Model Hospital framework, in place of the geographical East of England group of hospitals. It was felt that this should provide a better indication of performance. Figure 9 above shows how well placed we continue to be within this group.

2.2.4 Divisional HSMR performance

Table 3: Monthly Trust and Divisional HSMR September 2019 to August 2020

	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Trust
Cancer (Spec)	0.0	65.4	0.0	78.7	45.6	74.4	62.0	0.0	62.4	0.0	0.0	42.0	0.0	40.2
Clinical Support Services (Spec)	104.9	24.4	0.0	0.0	57.7	0.0	31.7	0.0	0.0	37.4	0.0	0.0	0.0	12.0
Medicine (Spec)	86.2	75.9	81.3	77.2	99.8	107.4	83.8	89.2	89.5	84.0	91.3	64.0	88.2	86.8
Surgery (Spec)	57.8	59.5	91.3	72.4	86.0	123.4	66.9	121.8	107.9	116.2	64.5	62.2	65.7	86.1
Women's & Children's (Spec)	0.0	0.0	0.0	0.0	93.1	0.0	0.0	0.0	0.0	0.0	100.7	0.0	0.0	18.1
Trust	**83.0**	**71.7**	**76.3**	**73.7**	**96.7**	**104.3**	**80.4**	**89.5**	**86.6**	**83.1**	**84.5**	**60.4**	**81.9**	**83.1**

Source: CHKS (scorecard alerts coloured; Specialty on Discharge)

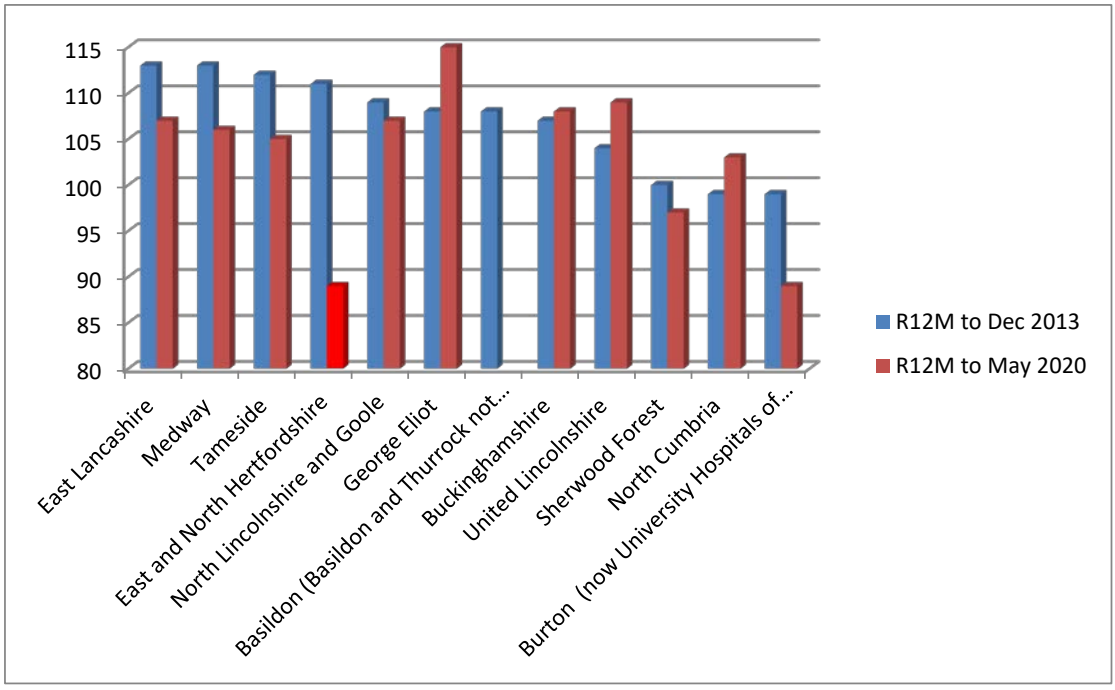
Table 3 shows Trust and Divisional monthly HSMR performance for the latest rolling 12 month period to August 2020. The CHKS red and amber alerts coding has been used to show HSMR above the 75th percentile Model Hospital peer group value, with red being statistically significant and amber not statistically significant.

2.2.5 SHMI seven year journey

Following the publication of Robert Francis's report into care at Mid Staffordshire NHS Foundation Trust in February 2013, Sir Bruce Keogh led a review of 14 Trusts that had high mortality rates. In July 2013 eleven of these trusts were put into special measures. At the time we narrowly missed that fate.

Seven years on, a comparison of the reduction in our SHMI, in comparison to those 11 trusts, serves as a positive reminder of the improvement we have achieved. Detail is provided below in figure 10:

Figure 10: SHMI comparison: Keogh Special Measures Trusts & ENHT: 2013 & 2020



2.3 Key quality measures

It is important to triangulate mortality data with other quality measures to give a balanced perspective on the quality of care provided by the Trust.

Table 4 below shows HSMR/SMR, together with average Length of Stay and Readmissions within 28 days. Length of Stay is an average of Bed days (excluding

well babies, regular attenders or renal dialysis patients) by Spells. Using CHKS, Readmissions are spells where the patient was readmitted as an emergency within 28 days of the discharge of previous admission, and this is shown as a percentage of total spells (excluding well babies, regular attenders or renal dialysis patients). The arrows show direction of change compared to the previous report (June 2019 to May 2020).

The amber and red alerts are relative to peers in our Model Hospital peer group.

Table 4: Key Quality Measures September 2019 – August 2020

	Trust Total		Elective		Non-Elective	
HSMR	83.1	↓	77.4	↓	83.1	↓
SMR	86.2	↓	76.1	↓	86.3	↔
Average Length of Stay	1.8	↔	0.2	↔	3.6	↔
Readmissions within 28 days (%)	8.9%	↑	4%	↑	**14.5%**	↑

Source: CHKS (scorecard alerts coloured)

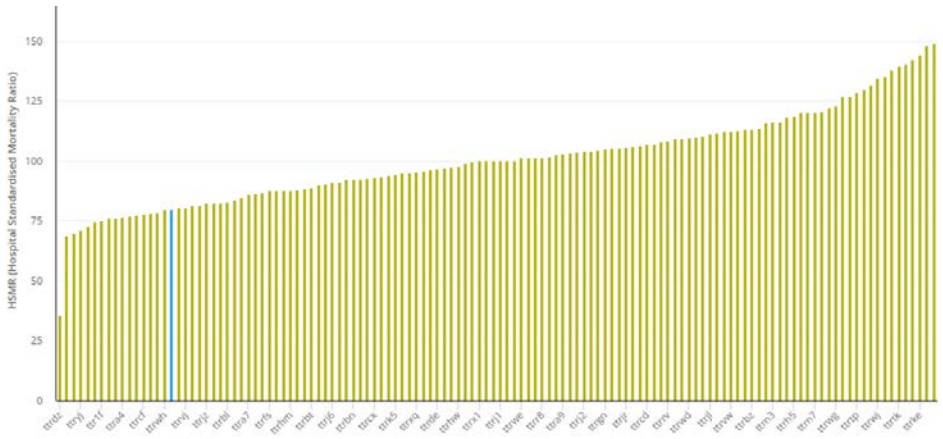
2.4 Mortality alerts

2.4.1 CQC CUSUM alerts

As previously reported, in March 2018 the Dr Foster Unit at Imperial College alerted the CQC to the Trust's CUSUM alerts for Septicaemia. In November 2018, following a request for further information, we provided a report to the CQC detailing the findings of our internal investigation. One focus of the investigation was an in-depth review of sepsis coding following the changes to national protocols. This resulted in significant changes being made to realign our coding with our new understanding of the requirements, with supporting training given to ensure a standardised approach moving forward. Since this time the CQC has continued to monitor the situation via its regular Engagement meetings with the Trust.

While the latest refresh of CHKS shown in figure 11 below, shows the Trust well placed compared to our national peers, significant fluctuations have been seen in our recent in-month data, with HSMR 99.4, 181.2 and 83.95 reported for Jun 20, Jul 20 and Aug 20 respectively. We continue to keep a close eye on sepsis mortality, with updates provided to the Mortality Surveillance Committee.

Figure 11: Septicaemia (except in labour) HSMR R12M to August 2020: national peer comparison



Headline door to needle time information has been provided below.

Table 5: Sepsis: ED/Inpatients key data: Q1 & Q2 2020-21

Metric	Target (per ¼)	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Inpatient							
Sample Size	50	NA	4	10	6	4	17
Antibiotics Within 1 Hour of Red Flag	90%	NA	0%	60%	67%	66%	50%
Average Time to Receiving Antibiotics	60 mins	NA	195 mins	41 mins	72 mins	69 mins	112 mins
Emergency							
Sample Size	50	NA	4	17	19	37	58
Receiving Antibiotics Within 1 Hour of Red Flag	90%	NA	50%	50%	63%	97%	73%
Average Time to Receiving Antibiotic	60 mins	NA	59 mins	40 mins	62 mins	46 mins	60 mins
Sepsis 6 Bundle Compliance	90%	NA	0%	35%	26%	32%	25%

The data reflects the challenging times seen throughout the COVID period, not least due to competing priorities, especially regarding staff allocation, as the below Sepsis staffing schedule for this period shows:

Table 6: Sepsis staffing: Nov-19 to Nov-20

Name	Position	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Anne Hunt	B7 WTE 1	END												
Alison Anderson	B7 WTE 0.8	START				SECONDMENT TO CCU/HD DURING COVID-19 PANDEMIC							SECONDMENT TO 8BS WINTER WARD	
Marianna Felli	B7 WTE 1													START DATE?
Alison Anderson	B6 WTE 0.8	END												
Anna Avards	B6 WTE 0.6						SECONDED TO RHEUMAYTOLOGY DURING COVID-19 PANDEMIC				MATERNITY LEAVE			
Eleanor Buyoc	B6 WTE 0.3	START				SECONDMENT TO ED YELLOW DURING COVID-19 PANDEMIC						END		
Jack Burt	B6 WTE 0.4			START		SECONDMENT TO AMU-2 SOUTH/RSU DURING COVID-19 PANDEMIC								
Caroline Meredith	Sepsis Consultant	END												
Yvonne Barlow	Sepsis Consultant				START									

Despite these capacity issues, initiatives aimed at improving the service continue, including:

- Teaching via Starleaf
- Working with ED developing blood culture policy
- Notice boards to show data findings for ED and inpatients
- Improving the sepsis module on NerveCentre
- Providing post-discharge guidance to patients with sepsis.

2.4.2 Other external alerts

National Hip Fracture Database (NHFD) mortality alert (August 2019)

Last point of concern was late 2018/early 2019 where the mortality rate climbed above the lower confidence interval.

Subsequently it came down throughout 2019 and was briefly below national average. It started to go up in early 2020 but increased significantly during the 1st COVID-19

lockdown period. It peaked at an adjusted rate of 11.5%. While it looks like the peak has been passed, and the rate is lowering, it will take several more months of data to show that convincingly.

The peak in the NOF "COVID" mortality was significantly higher than the NHFD mean. However, the NOF Lead believes there are clear and predictable reasons why this happened:

1. In March and April there was no routine testing of patients for COVID. It appears there was an outbreak amongst staff and patients during this time. There are publications already showing how badly NOF patients with COVID fare, and our experience demonstrates this.
3. During the first COVID wave, the normal NOF care was essentially dissembled. Half of the NOF ward was closed, two key consultants were redeployed and many of our patients were scattered across the hospital. The situation was reminiscent of the historical situation ten years ago before the Service was brought together. The Service is desperate to try to maintain its usual practice through a second wave.
4. There has been a clear drop in performance in terms of individual patient delays to theatre, mainly due to capacity. In the past we have been able to 'mop up' by breaking into elective theatre but that wasn't possible during the peak and is starting to become an issue again.

The unique situation faced this year makes it difficult to discuss factors / trends, beyond the points made above. There is positive news in the form of a replacement for the Service's longstanding middle grade and a new anaesthetic consultant to reinvigorate that side of practice. However, it is likely to take some time for potential benefits to be observed.

National Stroke Audit: Mortality Alert (January 2020)

- We were contacted by the Sentinel Stroke National Audit Programme (SSNAP) in January 2020 advising that while our position was not above the limit of 3 standard deviations from predicted mortality, and we were therefore not classified as a mortality outlier, we were 'quite close' to the threshold
- Although there was no formal requirement to act, a Chief Executive response was provided outlining the assurance work already undertaken and indicating that further work would follow to ensure no further opportunities for learning and improvement had been missed
- Collaborative work is underway between Stroke and Coding aimed at creating a regular monitoring system
- In the meantime, while not an outlier, Stroke mortality does remain high relative to the national average and this continues to be monitored.

Fig 12: Stroke HSMR R12M to Sep-20: National Comparison

National Emergency Laparotomy Audit (NELA)

November saw the publication of the National Emergency Laparotomy Audit – Sixth Patient Report covering procedures carried out between December 2018 and November 2019. Data submitted for this audit has shown significant improvement for the Trust in multiple areas, with our adjusted mortality rate reducing from 13.0 to 10.3 in comparison to the previous year.

At the same time the impact of COVID has meant that the actions that the NELA team wanted to have in place following the AHSN February 2020 peer review, are only now being realised:

- We have now established and extended the NELA team to include anaesthetic and radiology leads and data coordinator. In future it is hoped that a member of the medical/elderly care team will also be included. Efforts to achieve this are currently being hampered by a number of issues including a lack of funding to support the process, with consequent likely negative impact on length of stay and mortality for these patients
- An escalation policy has been established with the NELA data coordinator to make sure all records are completed in a timely manner and that emergency general surgical activity is monitored on a weekly basis to ensure all emergency procedures meeting NELA criteria, are appropriately recorded in the database
- NELA data presentation is being established as a regular/permanent item for both anaesthetic and surgical RHDs
- NELA data will be published within the Trust using a poster from the NELA website. Soon NELA data will be available on also be available on Qlikview to facilitate the monitoring of measurers and outcomes and provide monthly updates
- The current lack of reporting of other emergency surgical procedures meeting NELA criteria, and in some cases acceptance of high risk cases where Emergency Laparotomy should possibly have been considered futile, is thought to be contributing to the persisting reported elevated mortality rate. The NELA team is focussed on increasing awareness of the need to record all emergency surgical procedures meeting NELA criteria and to embed a multidisciplinary approach when considering Emergency Laparotomy for high risk patients. Both actions are defined in the Emergency Laparotomy pathway already in place
- The low percentage of emergency CT scan reported by consultant pre-operatively is thought to be incorrect. There is a discrepancy between reporting on ICE and PACS. The Radiologist Lead is reviewing all records entered since December 2019 to correct this before the closure of the year in Jan 2021
- Work is under way to highlight requests for CT scan within the Emergency Laparotomy pathway on ICE in order to prioritise the conduct and reporting of these within 1-2 hours
- The actual consultant anaesthetic presence is felt to be higher than what is currently being recorded due to incorrect entries in the database. The anaesthetic lead is currently reviewing these records. Additionally, it has been noted that when the consultant anaesthetist was not present, a senior anaesthetic doctor (SAS or post-CCT) was in fact present

- Every 3 months the NELA mortalities will be reviewed against the standard of care recommended by NELA within the mortality committee meeting with attendance from the local NELA leads.

As we continue to face the challenges presented by the COVID pandemic, every effort is being made to maintain the focus on important improvement work.

2.4.3 HSMR CUSUM alerts

From CHKS, HSMR CUSUM alerts have been shown for the following five CCS groups for the latest rolling year to August 2020 (Amber alert: 95% detection threshold; Red alert: 99.7% detection threshold), with Table 7 showing the CUSUM alerts sorted in descending order of "Excess Deaths".

Table 7: HSMR CUSUM Alerts September 2019 to August 2020

	Relative Risk	Observed Deaths	Expected Deaths	"Excess" Deaths
100 - Acute myocardial infarction	146.95	67	46.0	21.40
38 - Non-Hodgkin`s lymphoma	157.73	17	10.8	6.20
101 - Coronary atherosclerosis and other heart disease	190.34	8	4.2	3.80
151 - Other liver diseases	128.19	14	10.9	3.08
150 - Liver disease; alcohol-related	110.06	29	26.4	2.65

Source: CHKS (CUSUM alerts coloured)

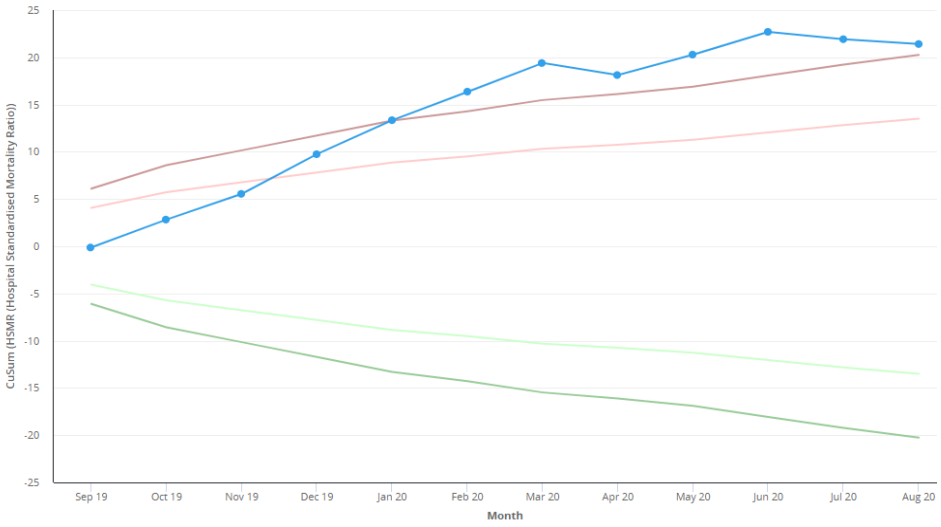
Figure 13 shows the Trust HSMR CUSUM for Coronary atherosclerosis and other heart disease has improved since the last report when it was reported that the second upper control limit (three standard deviations) had been breached.

Figure 13: Coronary atherosclerosis CUSUM chart September 2019 to August 2020

Previous work to understand the underlying causes of the coronary atherosclerosis alert showed a number of deaths which had been incorrectly coded, with appropriate amendments made. While the number of deaths involved is relatively small, the relative percentage of excess deaths remains high.

Figure 14 below shows the Trust HSMR CUSUM for Acute myocardial infarction with a red alert for the 12 month period to August 2020 as it has breached the second upper control limit (three standard deviations).

Figure 14: Acute myocardial infarction CUSUM chart September 2019 to August 2020



A coding review of non-Hodgkin's Lymphoma did not give rise to concerns. A request has been made for a similar review of the liver diagnoses, the outputs of which are awaited.

2.4.4 SHMI outlier alerts

Table 8 shows the SHMI outlier alerts by SHMI group according to CHKS (Amber alert: lower confidence limit above national average; Red alert: lower confidence limit in upper quartile).

Table 8: SHMI outlier alerts from June 2019 to May 2020

	SHMI	Observed Deaths	Expected Deaths	"Excess" Deaths
58 - 101: Coronary atherosclerosis and other heart disease	232.09	13	5.60	7
56 - 98,99: Hypertension	298.92	7	2.34	5

Source: CHKS (alerts coloured)

As various elements of the Cardiology diagnoses basket have continued to alert over the last year, further investigation of the underlying causes has been agreed with the Cardiology Clinical Director. Learning will be reported in due course.

2.5 Specific actions to address high mortality conditions

Mortality Alerts meetings, chaired by the Medical Director, are usually held monthly to review HSMR/SHMI CUSUM/outlier alerts, with agreed actions feeding into the Mortality Surveillance Committee. While Alerts meetings have been suspended during the COVID period, monitoring and reporting to the Mortality Surveillance Committee has continued.

The HSMR/SHMI trends of alerting groups are tracked. Investigation usually starts with coding reviews. Where concerns or uncertainty persist Specialty clinical reviews are requested. A watching brief is maintained until there is assurance regarding performance. When the number of deaths is very small, or the diagnosis group consists of a number of sub categories, the situation may be monitored before action is taken.

2.6 Associated trust initiatives

2.6.1 Seven day services

The Trust continues to work towards 7 day working and fully achieving the Keogh standards set out in the report NHS Services, Seven Days A Week. Originally ENHT was confirmed as being in the tranche of trusts tasked with achieving compliance against the four prioritised standards by the end of March 2018. Nationally it has now been indicated that all Trusts must be compliant with these standards by 2020. The four prioritised standards are:

- Standard 2: Time to Consultant Review
- Standard 5: Access to Diagnostics
- Standard 6: Access to Consultant-directed Interventions
- Standard 8: On-going Review.

To date the Trust has not achieved compliance with the four prioritised standards.

Following the development and submission of speciality level business cases, a clinical Seven Day Service Investment Review Panel was held on 3rd March to prioritise investment recommendations for the delivery of seven day services in 2020/21. The membership of the panel consisted of Divisional Chairs, Divisional Directors and colleagues from corporate departments such as finance and HR. The recommendations were due to be presented to the Executive Board for approval, however due to ongoing contract negotiations with Commissioners and the timing of the COVID-19 pandemic, this has not happened. Seven Day Service steering group meetings have been stepped down to operationalise the pandemic response. The plans developed by the divisions will contribute to the wider Trust-wide portfolio to deliver effective and sustainable services during the Trust recovery phase and beyond.

2.6.2 Care bundles

Our work to improve the use of available care bundles has been strongly supported by the CCG via the Mortality Review Group. Following the establishment of the Medical Director Office, discussion will take place to consider how best to provide Director level clinical support to drive this work forward.

In the meantime there are already quality improvements underway regarding key care bundles such as Sepsis, AKI and Pneumonia. Sepsis and AKI work has continued during the COVID period, albeit in a different shape.

2.6.3 Medical Examiner

As previously reported a team of Medical Examiners has now been recruited from within the Trust's existing consultant body and includes a Lead and Deputy, and multi-disciplinary representation. The Medical Examiner function is a process which sits outside the normal structure of the Trust and is responsible to the Medical director and the Regional Lead Medical Examiner structure. At present during the initial phase of introduction the process is non-statutory but will be a statutory requirement in next year.

The Lead Medical Examiner has continued to work towards the introduction of the service. However, the planned pilot start date of 1 March 2020, was postponed due to the COVID-19 pandemic. Despite this fact the Medical Examiners have liaised with

the Bereavement team throughout the crisis to give advice regarding death certification.

In July 2020 suitable office space to house the team was finally identified. A new target date for commencement of the Medical Examiner service of 1 October 2020 was set, allowing for appropriate preparation/settling in time. The Medical examiner function started on 1 October and is at present reviewing deaths in a small number of specialities. It is hoped to roll the process out to all deaths in the New Year.

As previously reported, the update from NHS Improvement in June 2019 highlighted the need for close collaboration between the Medical Examiner function and Learning from Deaths programme, with Medical Examiners being responsible for flagging cases warranting further review. This required interaction will be taken into account both at the outset of the Medical Examiner introduction and as plans progress for the migration of the Trust's mortality review process to the Datix iCloud platform.

2.6.4 Coding/data quality

The heads of both Coding and Data Quality continue to drive forward quality improvement initiatives. These are not only of direct significance regarding the provision of better quality information, but are also resulting in greater engagement by Clinicians as confidence in data provided to them increases. The seeds of this cultural shift continue to support future improvements.

COVID-19 classification has regular updates from the NHS Classifications department regarding latest WHO guidance. Clinical Coding takes account of all new guidance, incorporating it into relevant software to guide clinical coding staff in the correct assignation of ICD-10 codes. Clinical Coding also now manages the Independent sector activity recording on Lorenzo with two dedicated staff members. There is a good relationship between the Trust and Independent sector and where queries are escalated act immediately.

Clinical Coding continues to monitor and validate the Trust coded data.

SECTION 3: LEARNING FROM DEATHS

3.1 Mortality case record review process and methodology

Following the decision to adopt the Datix iCloud platform to support our Clinical Governance framework, initial background technical implementation work has been completed. The next phase of implementation is now underway with detailed discussions between Datix and the governance and quality leads regarding development needs of individual components of the system.

Of significant concern regarding the mortality module it the Trust's current intention not to link the Datix iCloud platform with Lorenzo. This represents a significant backwards step for mortality, as the existing mortality audit tool, despite its dated IT platform, has always linked with Lorenzo, and before that PAS, to autofill significant amounts of data.

Central to concerns is the potential derailment of hopes to incorporate the Medical Examiner process onto the system. Furthermore, the additional time to complete is not seen as an effective use of consultant resource and it is feared that the requirement for multiple entries of patient data across the system will increase the potential for error, duplication and undermine effectiveness.

This lack of systems' integration seems to go against the ethos of "Ease of Use", one of the Trust's five main strategic aims. In November, the Mortality Surveillance Committee moved to formally escalate its concerns regarding this issue. The outcome of this is awaited.

3.2 Mandated mortality information

The Learning from Deaths framework states that trusts must collect and publish certain key data and information regarding deaths in their care via a quarterly public board paper. This mandated information is provided below. In this report data has been provided for both quarter 3 and quarter 4.

3.2.1 Learning from deaths dashboard

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

It should be noted that for cases where Areas of Concern are raised, the current lapse in time between the death and completion of Stages 1, 2 and 3 of the review process, means that the avoidability of death score is often not decided in the same review year. This should be borne in mind when viewing the data contained in the dashboard at Appendix 1, which only details the conclusion details for 2020-21 deaths which can appear to skew the data. Therefore for the sake of transparency and robust governance during Q2 it should be noted that 1 ACON was concluded where the Mortality Surveillance Committee agreed an avoidability of death score of less than 3 (irrespective of the year the death occurred in).

Table 9: Q2 2020-21 Concluded ACONs: Avoidability Score ≤3

ID	Year of death	Serious Incident	Avoidability score	Avoidability definition
-	-	-	1	Definitely avoidable
ACON 507	2020-21	Yes	2	Strong evidence of avoidability
-	-	-	3	Probably avoidable: more than 50-50

This case has been investigated by the Patient Safety team as a Serious Incident. A remedial action plan has been put in place commensurate with the severity of the incident and detailed information provided in the Serious Incident report submitted to the Quality and Safety Committee.

In addition to agreeing on the avoidability of death, the Mortality Surveillance Committee now also makes an independent assessment of the quality of care received by the patient. This assessment is based on the following scale, taken from the PRISM mortality review model:

Table 10: Concluded ACONs: Quality of Care Rating Scale

Quality of Care Rating (PRISM model)	Definition
A	Excellent
B	Good
C	Adequate
D	Poor
E	Very poor

This report will detail concluded ACONs where the quality of care was assessed as D/E.

Table 11: Q2 2020-21 Concluded ACONs: Quality of Care Rating D/E

Quality of Care Rating	ID	Serious Incident
D	ACON 477 ACON 507	No Yes
E	ACON 500	No

From the above table it can be seen that of the 3 cases where care was considered to have been poor or very poor, 1 had been raised and investigated as Serious Incidents.

In the 2 cases that had not been considered as a Serious Incident, one concern related to the lack of response from the surgical team to repeated beeps and a failure to escalate this.

The other case related to a patient with a Learning Disability, which was not recognised until the penultimate admission. The main concern was not in relation to the patient's final admission but the multiple admissions in the months prior to death. The Committee felt that although the admissions were unavoidable, there was a lack of continuity of care with a number of admissions under a variety of specialties. The Committee felt it would be beneficial for a process to be developed when a patient has repeated admissions that would trigger the development of a treatment plan for that patient.

Table 12 below provides a year to date summary of concluded ACONs indicating both avoidability of death and quality of care ratings.

Table 12: Year to date concluded ACONs ratings

Apr-Nov 2020-21: 37 concluded ACONs discussed by Mortality Surveillance Committee		
Avoidability of Death Rating	**Definition**	**SI/RCA detail**
1	**Definitely avoidable**	**1 (SI)**
2	**Strong evidence of avoidability**	**7 (6 SIs, 1 RCA)**
3	**Probably avoidable, more than 50-50**	**1 (SI)**
4	**Possibly avoidable, but not very likely, less than 50-50**	**5 (2 SI, 1 RCA)**
5	**Slight evidence of avoidablity**	**12 (2 SI, 1 RCA)**
6	Definitely not avoidable	11

Quality of Care Rating	Definition	SI/RCA detail
A	**Excellent**	**0**
B	**Good**	**4**
C	**Adequate**	**9**
D	**Poor**	**19 (8 SIs, 2 RCAs)**
E	**Very poor**	**5 (4 Sis, 1 RCA)**

It is intended that the creation of a more useful dashboard will form part of the process developments alluded to in 3.1 above.

As the current dashboard does not cover all the data that the national guidance requires, the additionally mandated detail is provided below.

3.2.2 Learning disability deaths

Table 13: Q2 Learning Disability Deaths

	Jul-20	Aug-20	Sep-20
Learning disability deaths	0	0	1

In Q1 1 death occurred of a patient with a learning disability. This has been reported to the national LeDeR programme. It has also undergone a regular mortality review. The reviewer did not raise concerns and believed the death to have been unavoidable. A copy of the review has been provided to support the local external mortality review.

3.2.3 Severe mental illness deaths

The learning from deaths guidance stipulates that Trusts must have systems in place to flag patients with severe mental health needs so that if they die in an Acute Trust setting their care can be reviewed and reported on. No clear indication was given in the national guidance regarding what definition should be attached to the term 'severe mental illness'.

As previously reported, following discussions with our expert mental health colleagues at Hertfordshire Partnership University NHS Foundation Trust (HPFT), we decided to base our criteria for mortality review on the 'red flags' detailed in the national guidance for NHS mental health trusts, which was drawn up by the Royal College of Psychiatrists (RCPsych) in November 2018.

Internal approval has been given to include a supporting alert on Lorenzo. Further work will be required prior to the alert being activated, including creation of a supporting SOP to ensure there is clarity regarding identification of relevant patients and use of the alert. This was to be taken forward via the 'Treat as One' Task and Finish Group. Progress has been limited due to COVID.

Additionally, now that clarity has been gained as to which diagnoses should be considered for this cohort of patients, a regular report of deceased patients has been devised by the Business Information team but not finalised. This will not only include patients with Lorenzo flags, but will also use the relevant ICD10 codes recommended by HPFT.

Unfortunately, progress via the 'Treat as One' Task and Finish Group and Information report has stalled due to COVID-19 and will need to be resumed. One death of a patient with severe mental illness was identified in Q2.

Table 14: Q2 Severe Mental Illness Deaths

	Jul-20	Aug-20	Sep-20
Severe mental illness deaths	0	0	1

The one patient identified, died following a cardiac arrest. While neither the mortality review nor resuscitation review raised concerns, when it was discussed by the SI Panel, additional information was requested regarding VTE management as the post mortem had identified pulmonary embolism as the cause of death. The outcome is awaited.

3.2.4 Stillbirth, children and maternity deaths

Q2 statistics are provided below:

Table 15: Q2 Stillbirth, Children and Maternity Deaths

	Jul-20	Aug-20	Sep-20
Stillbirth	2	0	3
Children	1	0	0
Maternity	0	0	0

The child death was sadly that of a baby born at 20 weeks, who survived for several hours. Although born before the 22 week PMRT threshold, which would normally classify this as a miscarriage, the fact that the baby survived for a number of hours means that this is reported as a live birth with a discharge date of death and discharge method died.

3.2.5 Serious Incidents involving deaths

Table 16: Q2Serious Incidents Involving a Patient Death

Serious Incidents involving the death of a patient	Jul-20	Aug-20	Sep-20
Serious Incidents reported	0	0	1*
Serious Incidents: final report approved*	3	0	0

***** This SI regarding a new born baby, did not occur in Q2.It related to a previous death, where an RCA had been conducted, subsequent to which, an SI has been declared.

Key learning:

- Need to improve communication between clinical teams how to manage joint care more efficiently to ensure who has responsibility for which tasks
- The need to draft a SOP for the management of patients with an ileus following a RALP
- Sub-optimal practice around specialising and not adhering to policy regarding re-assessing a patient's risk of falls every 4 days
- Education and training required for doctors and nurses on deteriorating patients and TEP
- The blood transfusion policy to be reviewed to determine whether the wording surrounding urgent and non-urgent transfusion is clear enough – to amend as required.

** the reports approved do not necessarily relate to the incidents reported*

3.2.6 Learning from complaints

Table 17 below provides detail of the number of complaints received in Q2 that relate to a patient who has died while an inpatient.

Table 17: Q2 Complaints Involving a Patient Death

	Jul-20	Aug-20	Sep-20
Complaints received relating to an in-hospital death	3	1	2

Key themes:

July:

- Regarding the quality of care provided
- Mortality review and SI regarding diagnosis and treatment. Outcome a diagnosis could not have been arrived at any earlier and that earlier intervention would not have made a difference
- Complainant wanted to understand the care provided to her frail grandmother and to determine when end of life process started. As

	she held lasting Power of Attorney she questioned why she had not been consulted on all aspects of care. Advised that the clinicians will make decisions in the best interest of the patient.
August:	• Wife felt there was a lack of information shared with her when her husband was deteriorating. She raised a formal complaint but withdrew it as she was happy that the hospital contacted her. The PALS Team listened to her concerns and the ward responded. The patient had deteriorated quickly and due to COVID restrictions on visiting where in place at the time.
September:	• Complaint raised about the quality of care provided. This complaint is still under investigation • Concerns raised by family around discharge in March 2020. Reviewed by registrar each day, diabetes specialist nurse, heart failure nurse and Cardiology Specialist Registrar. Heart failure nurses communicated with family after discharge. Care package at home discussed. Readmitted in April 2020 and became unwell in the early hours of 12 April. At that stage no indication that she was nearing end of life. Still responsive and interacting with nurses. Family updated at 10.15am and asked to come in. Patient died at 10.30am before family arrived.

3.2.7 Learning from inquests

Table 18: Q2 Inquests into a Patient Death

	Jul-20	Aug-20	Sep-20
Requests for a Report to the Coroner	6	3	4
Regulation 28: Report to Prevent Future Deaths	0	0	0

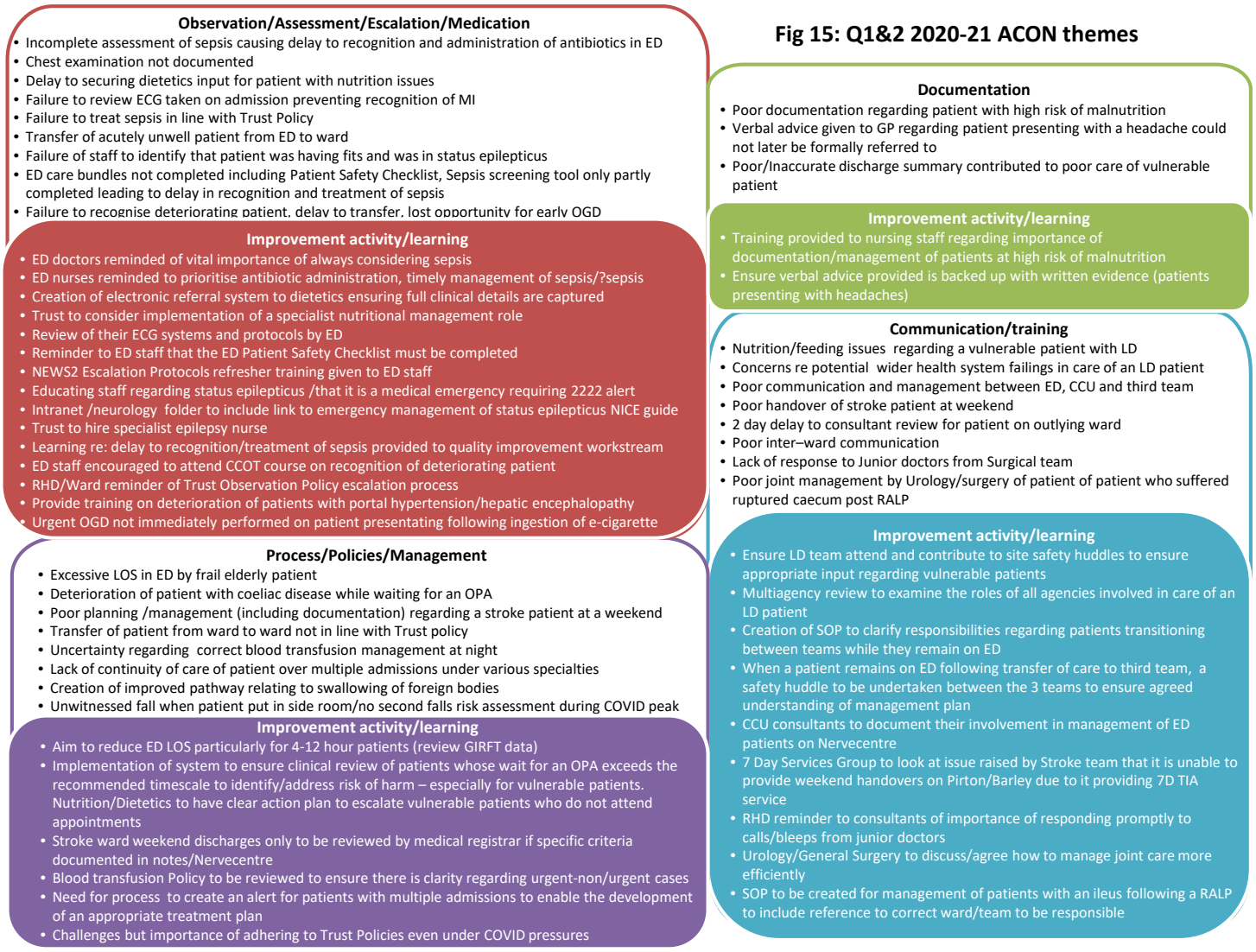
3.2.8 Learning from mortality reviews

Prior to COVID cases raised as Areas of Concern (ACONs) as a consequence of mortality case record reviews, were central to the topics covered at clinical governance Rolling Half Days. The RHD meetings provided a forum for discussion, learning and the creation of appropriate Specialty-specific action plans and represented a key element of the Trust's learning from deaths framework.

Changes necessitated by COVID-19 have meant that fewer ACONs have been concluded during these challenging times, partly due to competing commitments and partly due to changes to the conduct of Specialty meetings. We are working with divisional leads to encourage the completion of outstanding cases.

Throughout the year emerging themes are collated and shared across the Trust via RHDs and other interested specialist group. The information will also be used to inform broad quality improvement initiatives. Information sharing continues in the COVID era, even if the avenues for communication may at times need to be altered.

Figure 15 details key themes from ACONs concluded in Q1/2 2020-21:



4.0 Options/recommendations

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

Appendix 1: ENHT Learning from deaths dashboard September 2020

East and North Hertfordshire NHS Trust: Learning from Deaths Dashboard: September 2020

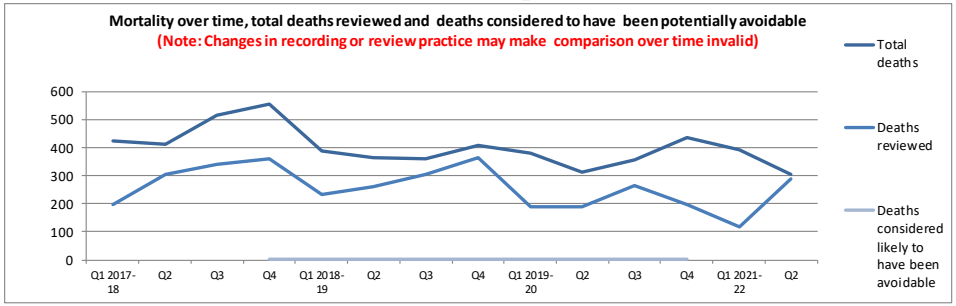
Description:
This dashboard is a tool to aid the systematic recording of deaths and learning from the care provided by East and North Hertfordshire NHS Trust and is based on the dashboard suggested by the National Quality Board in its Learning from Deaths Guidance published in March 2017. Its purpose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

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
695	1484	409	841	0	1

Time Series: Start date 2017-18 Q1 End date 2020-21 Q2



Total Deaths Reviewed by RCP Methodology Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-
This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD	0	-
This Year (YTD)	0	0.0%	This Year (YTD)	1	0.2%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	1	0.2%	This Year (YTD)	403	99.5%

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

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
9	12	12	9	0	0

Time Series: Start date 2017-18 Q1 End date 2020-21 Q2