East and North Hertfordshire NHS Trust
Trust Board - Public Session

MS Teams

5 May 2021 10:00 - 5 May 2021 12:00

AGENDA

#	Description	Owner	Time
1	Chair's Opening Remarks	Chair	10:00
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 - 0303202... 7	Chair	10:05
6	Patient Story For discussion	Chief Nurse	10:10
7	Chief Executive's Report For discussion 7. a) Chief Executive Board Report - April 2021.pdf 17 7. b) Chief Executive IPR Summary Report.pdf 19	Chief Executive	10:25

#	Description	Owner	Time
8	Integrated Performance Report For discussion 8. Integrated Performance Report.pdf 21	Chief Executive	
9	System Collaboration Update For discussion 9. Collaboration Update.pdf 63	CEO / Chair / Director of Strategy	10:45
10	Operating Priorities, Planning Response and People Recovery For discussion 10. a) Operating Priorities.pdf 67 10. b) People Recovery.pdf 89	Chief Operating Officer and Chief People Officer	10:55
11	Board Assurance Framework For discussion 12. a) Board Assurance Framework.pdf 99	Associate Director of Governance	11:30
12	Risk Management Strategy For approval 12. b) Risk Management Strategy Review 2021.pdf 139	Associate Director of Governance	
13	Learning from Deaths Report For discussion 13. LfD Report.pdf 159	Medical Director	11:40
14	IPC Report For discussion 14. IPC Report.pdf 185	Chief Nurse	11:45
15	Annual Report and Accounts - Proposal for approval process For decision 15. Annual Report and Accounts Approval Process.... 209	Director of Finance	11:50
16	Sub-Committee Reports		11:55

#	Description	Owner	Time
16.1	Finance, Performance and People Committee Report to Board For information 16.1 a) FPPC Board Report 31 March 2021.pdf 211 16.1 b) FPPC Board Report 28 April 2021.pdf 215	Chair of FPPC	
16.2	Strategy Committee Report to Board For information 16.2 Strategy Committee Report 20 April 2021.pdf 219	Chair of Strategy Committee	
16.3	Quality and Safety Committee Reports to Board For information 16.3 a) QSC Board Report 30 March.pdf 223 16.3 b) QSC Board Report 27 April.pdf 227	Chair of QSC	
16.4	Audit Committee Report to Board For information 16.4 AC Report to Board 24 March.pdf 231	Chair of Audit Committee	
16.5	Charity Trustee Committee Report to Board For information 16.5 CTC Board Report 8 March.pdf 235	Chair of CTC	
17	Actions Log For information 17. Public Trust Board Actions Log.pdf 239	Trust Secretary	
18	Annual Cycle For information 18. Board Annual Cycle 2021-22.pdf 241	Trust Secretary	
19	Data Pack For information 19. Data Pack.pdf 245		

#	Description	Owner	Time
20	Date of next meeting 7 July 2021		

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday 3 March 2021 at 10.30am at the Lister Hospital, Stevenage & via Microsoft Teams Video Conferencing

Present:	Mrs Ellen Schroder	Non-Executive Director (Trust Chair)
	Mrs Karen McConnell	Non-Executive Director
	Mr Jonathan Silver	Non-Executive Director (via conference call)
	Dr David Buckle	Non-Executive Director (Associate) (via conference-call)
	Ms Val Moore	Non-Executive Director (via conference call)
	Mr Bob Niven	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
	Dr Michael Chilvers	Medical Director (via conference call)
	Mrs Rachael Corser	Chief Nurse (via conference call)
From the Trust:	Mrs Sarah Brierley	Director of Strategy (via conference call)
	Mr Richard Hammond	Managing Director – Planned Care (deputising for the Chief Operating Officer) (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)
	Mr Mark Stanton	Chief Information Officer (via conference call)
Also in attendance:	Mr Hassan Iqbal	(Senior Anaesthetic Trainee ENHT) (via conference call)
	Ms Jenny Newsom	(via conference call)
	Mr Jeff Phillips	(Hertfordshire Community Trust)
	Mr Steve Palmer	(Healthwatch Herts) (via conference call)
	Mrs Bernadette Herbert	(Patient Story) (via conference call)

21/001 CHAIRS OPENING REMARKS

21/001.1 Mrs Schroder opened the Public Board meeting and welcomed all attendees. This was the first public meeting of the Trust Board held via MS Teams.

21/002 APOLOGIES FOR ABSENCE

21/002.1 Apologies were received from Dr Peter Carter (Non-Executive Director) and Mrs Julie Smith (Chief Operating Officer).

21/003 DECLARATIONS OF INTEREST

21/003.1 The Director of Strategy declared that she was undertaking a joint role as Director of Strategy for both East and North Hertfordshire NHS Trust and Hertfordshire Community NHS Trust.

21/004 QUESTIONS FROM THE PUBLIC

21/004.1 There were no questions from the Public.

21/005 MINUTES OF PREVIOUS MEETINGS

21/005.1 The Board noted the minutes of the 4 November 2020 meeting, which had already been reviewed and approved by the Board at its meeting in private session in January 2021.

21/006 PATIENT STORY

21/006.1 The Chief Nurse introduced Bernadette Herbert, who had recently received treatment at Lister hospital for Covid. Mrs Herbert had worked for the Trust's safeguarding team until she retired in 2019, though she had continued to work on a part time basis since then. She explained that she had developed Covid in January and provided details of the chain of events that led her to attending A&E due to her symptoms. She explained that it had not been a pleasant experience waiting outside the ED streaming pod on a cold winter's day but once inside the hospital she had felt very safe with the level of care she had received and had been reassured by the sight of familiar faces.

21/006.2 Mrs Herbert explained how she was transferred to the intensive care unit and placed on CPAP. She stayed on the intensive care unit for 11 days before being moved to ward 8a.

21/006.3 She explained that she had spoken with her family on video calls and and was grateful that the parish priest had been able to visit her. She said she felt that she had seen the best of the NHS during her time as an inpatient, witnessing staff displaying camaraderie, humour in the face of adversity and expert care.

21/006.4 Mrs Herbert reported that she had been impressed by the way the teams had been assembled to support intensive care, including the students working in ITU. She commented that she had not seen anyone out of their depth despite staff being redeployed to areas that were not their usual area of work.

21/006.5 She was ultimately discharged onto the virtual Covid ward, which meant she could return home and submitted observations three times a day. She had recently been discharged from the virtual ward and was pleased that it had meant she was able to return home sooner.

21/006.6 In terms of things that could be done differently or improved, she said the pod outside ED was not welcoming on a cold winter's day, the CPAP masks were painful and at times it was difficult to hear staff due to the PPE they were wearing. However, overall she said she couldn't fault the care provided and asked that her thanks be passed on to the staff.

21/006.7 Mrs Schroder thanked Mrs Herbert for joining the meeting to talk about her experiences. She thanked her for her feedback on the

issues that could be improved and her honest and heartfelt reflections. The Chief Executive echoed Mrs Schroder's comments.

21/007 CHIEF EXECUTIVE'S REPORT

21/007.1 The Chief Executive presented his report to the Board. He explained that the report covered a period in time which in his opinion was the most challenging the Trust had faced. He reported that over 50% of the deaths recorded by the Trust since the start of the Covid pandemic had taken place in January and February 2021. In this context, there had been a drop in the A&E and RTT performance standards and staff and resources had been reallocated to support critical care.

21/007.2 The Chief Executive highlighted that the Trust's continued provision of cancer services over the period was amongst the best in the country.

21/007.3 The Chief Executive reported that the Trust had been providing a vaccination service since December 2020. The service had been successfully deployed from a hub on the Lister site but there was some concern that staff from BAME backgrounds were vaccinated at a lower rate compared to other staff groups. The Trust's health at work service was working to address this issue.

21/007.4 It was reported that the Trust was beginning to consider the next steps in terms of the restoration of services, and further details would be provided later in the meeting.

21/007.5 The Chief Executive noted other key developments included the publication of the NHS White Paper and the initiation of a programme to refresh the Trust's strategy. Further updates would be brought to future meetings of the Board.

21/007.6 Finally, the Chief Executive noted that the Trust was currently advertising to fill the Chief People Officer vacancy.

21/007.7 Mrs Schroder asked what initiatives were being explored to increase uptake of the vaccine amongst BAME staff. The Interim Chief People Officer explained that managers were being asked to hold one to one dialogues with these staff to understand and alleviate their concerns. Mr Parmar advised he had attended some of the webinars held to support staff uptake and felt the work of the BAME network in this area was well aligned to the national initiatives.

21/008 INTEGRATED PERFORMANCE REPORT

21/008.1 The Chief Executive provided a summary of some of the key updates from the integrated performance report, including regarding nosocomial Covid infections, quality and safety metrics, mortality performance, operational performance and workforce issues including recruitment.

21/008.2 Mrs Schroder noted that there would be a report to the next Quality and Safety Committee assessing some of the impacts of the lower staffing ratios during the height of the pandemic.

21/008.3 She also highlighted that the Trust's SHMI rate compared very favourably nationally and had shown significant improvement over the last ten years. She congratulated those involved in this achievement.

21/008.4 Mrs Schroder also noted the impressive performance in terms of CSW recruitment.

21/009 RECOVERY UPDATE

21/009.1 The Managing Director for Planned Services presented the recovery update to the Board. He explained that issues such as PPE provision and staff testing availability were less significant compared to the first recovery period, but the impact on staff was potentially greater following a longer period of intense pressure.

21/009.2 The Managing Director explained that a series of baseline triggers had been identified to help define the point at which the Trust could start the substantive recovery process. This included measures such as critical care capacity and staff absence rates. In terms of principles for the recovery, a 'flat pack' approach to the Covid incident structure would be important, as would a focus on virtual access and ensuring equality of access. Patients would continue to be categorised based on priority, which would enable the Trust to manage clinical need.

21/009.3 Mrs Schroder asked about communication with patients on waiting lists. The Managing Director advised that the Trust had informed patients that priority two patients were continuing to be treated and clinicians were being asked to ensure honest conversations regarding the likely timescales were held with each of their patients. The Trust was also trialling a 'waiting well' package for the patients on the waiting list. The Director of Strategy suggested this initiative could be explored further with system partners especially with primary care.

21/009.4 Ms Moore was pleased to see the recognition of the issue of health inequalities in the recovery plans.

21/009.5 In terms of the availability of staffing as a trigger for the recovery, the Interim Chief People Officer advised that staff Covid sickness had been decreasing, however other sickness reasons had begun to increase. Additionally, a greater number of staff had recently been advised to shield.

21/009.6 The Chief Nurse advised that the QSC was well sighted on the issues of operational targets and the harm review process is robust.

21/009.7 The Board welcomed the update.

21/010 RECOVERY AND OUR PEOPLE

Note: The Director of Strategy left the meeting at this point.

21/010.1 The Interim Chief People Officer presented a paper which outlined the support that had been provided to date and future plans in terms of supporting the workforce from a health and well-being perspective

in response to the Covid pandemic.

21/010.2 The Interim Chief People Officer summarised the strategic approach to health and wellbeing that had been previously agreed by the Board, as detailed in the report. Continuing to support staff at this point in the pandemic was a high priority for the Trust. Furthermore, if adequate support was not provided, there was a risk that turnover could increase. The intended approach aligned with the Trust's People Strategy and would include:

- ensuring staff could take an appropriate amount of time to rest,
- providing psychological safe spaces,
- utilising charity funding to improve rest and recovery spaces,
- holding debriefing sessions with various teams supported by clinical psychologists,
- holding Schwartz rounds for staff,
- a programme of recognition and thanks to staff.

21/010.3 Mrs Schroder welcomed the paper. She said it was important to track which areas saw lower uptake of the initiatives available to them. Mr Niven agreed that figures regarding uptake would be useful, as well as more qualitative feedback from staff.

21/010.4 Mr Silver asked about staff testing uptake and compliance levels. The Interim Chief People Officer advised that both vaccinations and regular testing were fundamental to how the Trust would protect staff and their families. All staff now had access to the tests. The Medical Director advised that compliance with registering the results was being monitored as initially this had been somewhat inconsistent and there was now clear messaging on the importance of recording the result.

21/010.5 Mrs McConnell welcomed the paper. She asked if consideration had been given to supporting staff who had been redeployed outside their regular area of work. The Chief Nurse explained that it was the intention to explore some bespoke support for these staff.

21/010.6 The Interim Chief People Officer added that the staff survey would help to identify some of the experiences of staff who had been redeployed and currently the redeployment numbers were reducing.

21/010.7 The Board welcomed and noted the report.

21/011 HEALTH AND SOCIAL CARE BILL 2021 - WHITE PAPER BRIEFING

21/011.1 The Director of Finance presented to the Board a summary of some of the initial reflections from the recently published NHS White Paper. This included context and timelines relating to its publication as well as some of the key purposes and aims of the White Paper.

21/011.2 It was the intention that further reflections and analysis would flow into the work that was taking place in relation to the strategic framework and Board Development sessions.

21/011.3 Overall the paper highlighted some of the key issues the Trust would need to consider and work through both internally and with partners

over the coming months and years.

21/011.4 Ms Moore welcomed the paper. She believed a key aspect of integrated care should be reducing duplication among providers and changing settings of care where safe and efficient to do so. Additionally there could be financial drivers behind integration. She encouraged the view of the patient to be the starting point of integration.

21/011.5 Dr Buckle also welcomed the report. He noted that the White Paper began the process of shifting certain powers within the system. He asked what the potential risks were for the Trust. The Director of Finance highlighted that the duty to cooperate had been replaced by a duty to collaborate. He agreed that this would begin to alter the balance of power as the ICS became a statutory body, though local dynamics would continue to play a role.

21/011.6 Mr Niven asked about the potential of the changes leading to greater bureaucracy. This was still unknown at this stage but there was the possibility that it would increase, for example in the short term performance management may be undertaken at multiple levels.

21/011.7 Mrs McConnell agreed that the White Paper raised a number of key considerations for the Trust. She suggested this would form a significant part of the agenda of future meetings of the Strategy Committee.

21/012 BOARD ASSURANCE FRAMEWORK 2020-21

21/012.1 The Associate Director of Governance presented the Board Assurance Framework 2020-21. She requested the Board endorse the proposed updates in relation to risk 6 and highlighted that the development of the strategic framework refresh was now referenced within the document. She reported that two risks remained rated 20 and continued to be considered through the relevant Board subcommittee meetings.

21/012.2 The Associate Director of Governance also noted that the Internal Auditors had completed their annual review of the BAF and some suggested minor changes arising from their recommendations would be presented to the next Audit Committee for consideration.

21/012.3 The Board endorsed the proposed changes and noted the report.

21/013 IPC REPORT

21/013.1 The Chief Nurse presented the latest IPC report, which had been discussed in detail at the previous Quality and Safety Committee meeting. She explained that January had been a particularly challenging month in terms of the increased number of Covid positive patients the Trust was treating. There had been 98 recorded probable or definite nosocomial infections in January. The Trust had regularly benchmarked favourably against other trusts in this regard over the period. The report also provided an update on outbreak areas. These had reduced since January.

21/013.2 National guidance regarding discharging the duty of candour in

relation to nosocomial Covid had been published recently and a review of the guidance and current Trust processes would be a priority. Any learning would be reported to the Trust Infection Prevention and Control Committee and Quality and Safety Committee.

21/013.3 Incidences of other organisms remained low and it had been agreed that there would be a focus on SSIs at a future QSC meeting.

21/014 MATERNITY ASSESSMENT AND ASSURANCE TOOL

21/014.1 The Chief Nurse confirmed to the Trust Board that the Trust had submitted its response to the Ockenden report by the required deadline in February, as had been discussed and reported at previous QSC meetings. There were some partial gaps that had been mitigated against but the majority of the actions had been achieved. The main area of focus for the Trust arising from the actions was in relation to the workforce requirements

21/014.2 Ms Moore (who was the Board level champion for maternity safety) added that the maternity team were well placed to deliver on the findings of the report. She was impressed by their thoroughness and the assurance available from ward to Board. She commented that the maternity team was well connected with the local maternity system and noted that continuity of carer would be a key issue for the future.

21/014.3 Mrs Schroder welcomed the report and assurance provided. The Board noted the submission.

21/015 GENDER PAY GAP REPORT

21/015.1 The Interim Chief People Officer presented the Gender Pay Gap Report. The report had been considered at the last FPPC meeting and was required to be published by the Trust. The Interim Chief People Officer summarised that overall there was relatively little change compared to the previous year's report. The medical and dental staff group had a notable impact on the overall figures and with that group excluded the remuneration was much closer to parity.

21/015.2 The Interim Chief People Officer clarified that bonus payments applied only to medical staff and the Trust was working to ensure that the group responsible for awarding the bonus payments was representative of the workforce. Currently there were fewer female members of staff putting themselves forward for bonus payments.

21/015.3 The Interim Chief People Officer explained that the Trust policy in terms of VSM pay was under the remit of the Remuneration Committee and it was the intention to undertake further benchmarking data.

21/015.4 The Interim Chief People Officer advised that the women's network would be engaged to support the work plan and the Trust would look at how to make certain roles less gender specific.

21/015.5 Mr Niven asked how soon any changes to clinical excellence awards might take effect and asked for consideration to be given as to

whether any other changes could be made in the meantime.

21/015.6 The Board noted the report and approved it for submission.

SUBCOMMITTEE REPORTS:

21/016 FINANCE, PERFORMANCE AND PEOPLE COMMITTEE REPORT TO BOARD

21/016.1 The Board noted the summary reports from the 27 January and 24 February 2021 meetings of the Finance, Performance and People Committee. Ms Moore referred to the update regarding stroke performance and suggested it would be useful to have a further update from the FPPC after the next review.

21/017 STRATEGY COMMITTEE REPORT TO BOARD

21/017.1 The Board noted the summary report from the Strategy Committee meeting held on 15 February 2021.

21/018 QUALITY AND SAFETY COMMITTEE ANNUAL REVIEW AND TERMS OF REFERENCE

21/018.1 The Board noted the summary reports of the Quality and Safety Committee meetings. Mrs Schroder noted that these meetings had been reduced to core business only on account of the pressures the Trust faced at the time due to the Covid pandemic.

21/019 AUDIT COMMITTEE REPORT TO BOARD

21/019.1 The Board noted the summary report from the Audit Committee meeting held on 19 January 2021.

21/020 REMUNERATION COMMITTEE TERMS OF REFERENCE

21/020.1 The Board approved the revised Terms of Reference for the Remuneration Committee (which would become the Remuneration and Appointments Committee).

21/021 ACTION LOGS

21/021.1 The Board noted the content of the latest Public Trust Board Actions Log.

21/022 ANNUAL CYCLE

21/022.1 The Board noted the Annual Cycle 2020/2021.

21/023 DATA PACK

21/023.1 The Board noted the content of the Data Pack.

21/024 DATE OF NEXT MEETING

21/024.1 The next meeting of the Trust Board will be on 5 May 2021.

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Ellen Schroder
Trust Chair

May 2021

East and North Hertfordshire NHS
NHS Trust

Chief Executive's Report

April 2021

Covid Update

The Covid-19 pandemic NHS alert level is currently at Level 3 since its reduction on 25th March. The Trust has single figures (5) Covid-19 positive patients.

All staff have been offered access to undertake the twice-weekly Lateral Flow Testing (LFT), with staff within the Mount Vernon Cancer Services undertaking weekly PCR tests. Participating in the LFT programme has enabled the Trust to detect asymptomatic positive staff, mitigating further spread of Covid-19.

Surge capacity that has been established in response to the waves of Covid (i.e. Critical Care surge, Covid wards and re-deployment) has been 'flat-packed', with triggers identified for unpacking. Modelling is suggesting a Reasonable Worst Case Scenario (RWCS) of half the peak of the last wave between July and October.

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.

Service Restoration

Unplanned Care Division has established a recovery plan for both Elective and Non elective activity in line with the national recovery targets. Non elective activity is recovering at a quick pace, with increased attendances to Emergency Department and Urgent Treatment Centre. The Division has strengthened non elective patient pathways in SDEC and Ambulatory Care. The capital build continues at pace and will be completed in Quarter 3.

Priorities for the Planned Care Division are sustaining cancer performance and developing robust elective recovery plans to meet and exceed the recovery targets. The targets are 70% April, 75% May, 80% June, 85% July and then sustaining this level of delivery for the 1st half of the year.

AGM

Following the success of last year's AGM, we will follow the same virtual format for this year's event, to be held on 30 June. Whilst there is ambition for a face-to-face event, it is felt that a virtual event holds less risk.

There will be webinars each day in the week of 28 June, on topics voted for by staff, members, and the public, and the formal AGM at 4.30pm on 30 June.

Save the dates have gone out to stakeholders and members and planning is underway. Any feedback or suggestions should be shared with Eilidh Murray, Assistant Director – Communications and Engagement, by 14 May.

Inclusion Committee

As a Trust we have noted with sorrow the health and social inequalities that have been highlighted throughout the last 12 months and the Covid-19 pandemic. As our ongoing commitment to change the outcomes for our patients and staff we feel this is the time to introduce a committee as a sub board to focus on this. Titled the Equalities & Inclusion Committee it will provide oversight and assurance to the Board on plans for the following objectives:

1. Deliver better health outcomes for our whole community
2. Improve access and experience for our patients
3. Ensure a representative and supported workforce
4. Ensure inclusive leadership
5. Improve data collection, use and reporting
6. Devise and monitor appropriate KPIs for equalities and inclusion to demonstrate delivery against our priorities
7. Ensure compliance with legislative and governing body requirements.

Nick Carver
Chief Executive

East and North Hertfordshire NHS
NHS Trust

IPR Chief Executives Summary

Sustainable Services

- The Trust submitted its pre audit accounts at the end of April. They report a surplus of £2.5m for the financial year.
- It's is important that across a year of incredible change and tumult that the Trust has been able to continue to maintained its hard earned reputation for sensible financial husbandry.
- The scale of capital investment in our facilities across the year and the write off of historic debt obligations are also worthy of note/

Safer Services

- The Trust is maintaining a strong focus upon managing and reducing the number of both patient falls and all hospital acquired pressure ulcers.
- Quality Improvement initiatives to maintain and embed progress in these areas remain activity.
- Furthermore the focus and improvement of sepsis management remains a central and important focus.

Caring Services

Friends and Family Test

- The volume of patient responses to surveys continues to increase as the pandemic eases, although further work is required to improve all engagement.

Complaints

- The number of complaints remains substantially reduced and the focus needs to be on reducing the number of open complaints and ensuring that they are responded to within agreed timeframe

Effective Services

Mortality

- Crude mortality has begun to reduce following peak levels observed during the peaks observed during the second 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

- As the pandemic has slowly eased performance against the A&E target has improved (ENHT performance – 85.2%, national position 86.1%).

- In addition Trust performance against cancer waiting times has remained resilient, reflecting the Trusts actions to prioritise cancer related activity during the challenges of COVID wave 2

- Inevitably given the reduction of elective operating capacity during January and February the volume of patients waiting for planned treatment has grown during this period. At the end of March the number of patients waiting over 52 weeks had increased to 3,221.

- The Trust is working hard to rapidly restore the level of planned activity that is available to our patients, so that it's able to make quick and significant inroads into it's waiting list. This will remain a vital area of focus for the Trust as we move into the new financial year

- The Trust also recognises that further improvements are required in respect of performance against key stroke services measures. This will be 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. The total number of substantive staff employed by the Trust has grown by over 404 WTE's in the last 12 months.

- Turnover rates remain at a historic low level and this has assisted the Trust in growing its permanent workforce

- Sickness absence rates improved significantly during March as the pandemic eased. However, a significant range of services remain in place to support staff wellbeing as we adjust to and live with the consequence of the pandemic

- The Trust recognises that a significant challenge now presents in terms of helping staff to catch up with training and appraisal needs.

East and North Hertfordshire NHS Trust

Agenda Item: 8

TRUST BOARD – 5 MAY 2021
Integrated Performance Report – Month 12

Purpose of report and executive summary (250 words max): The purpose of the report is to present the Integrated Performance Report Month 12 to the Trust Board. Key challenges and mitigations under each domain are identified within the report.		
Action required: For discussion		
Previously considered by: QSC and FPPC, 27 and 28 April 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	☒

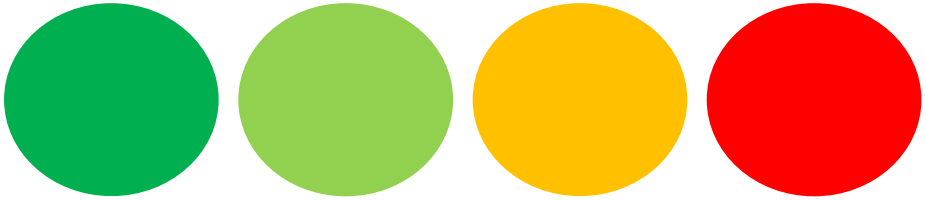
Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
Any other risk issues (quality, safety, financial, HR, legal, equality): Key challenges and mitigations under each domain are identified within the report.

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

East and North Hertfordshire NHS Trust

Integrated Performance Report

Month 12 | 2020-21



Data correct as at 28/04/2021

Contents

East and North Hertfordshire NHS Trust

NHS Oversight Framework

East and North Hertfordshire NHS Trust

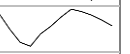
Quality of care

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
Overall	CQC rating	-	Dec-19	-	-	Requires improve-ment	
Caring	Written complaints - rate	Monthly	Mar-21	Local	1.9	1.1	
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)	Oct-20 - Mar-21	National	0	2	
Safe	Patient Safety Alerts not completed by deadline	Monthly	Mar-21	National	0	0	
Caring	Mixed-sex accommodation breaches	Monthly	Mar-21	National	0	no submission	
Caring	Inpatient scores from Friends and Family Test - % positive	Monthly	Mar-21	Local	95.0%	96.3%	
Caring	A&E scores from Friends and Family Test - % positive	Monthly	Mar-21	Local	90.0%	95.6%	
Caring	Maternity scores from Friends and Family Test - % positive - antenatal care	Monthly	Mar-21	Local	93.0%	88.9%	
Caring	Maternity scores from Friends and Family Test - % positive - birth	Monthly	Mar-21	Local	93.0%	95.8%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal ward	Monthly	Mar-21	Local	93.0%	93.4%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal community	Monthly	Mar-21	Local	93.0%	100.0%	
Safe	Emergency c-section rate	Monthly	Mar-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)	Mar-21	NHSI	52	40	
Safe	Clostridium difficile – infection rate	Monthly (12-month rolling)	Apr 20 - Mar 21	National	19.60	21.90	
Safe	Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Monthly (12-month rolling)	Apr 20 - Mar 21	National	0.78	0.00	
Safe	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	Monthly (12-month rolling)	Apr 20 - Mar 21	National	9.21	8.76	
Safe	Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI)	Monthly (12-month rolling)	Apr 20 - Mar 21	National	14.75	11.50	
Effective	Hospital Standardised Mortality Ratio	Monthly (12-month rolling)	Feb 20 - Jan 21	National	100	82.8	
Effective	Summary Hospital-level Mortality Indicator	Monthly (12-month rolling)	Dec 19 - Nov-20	National	100	88.8	
Safe	Potential under-reporting of patient safety incidents	Monthly (six-month rolling)	Sep 20 - Feb-21	National	17.39%	16.64%	

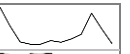
Finance

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

Operational performance

A&E	A&E maximum waiting time of four hours from arrival to admission/transfer/discharge	Monthly	Mar-21	National	95%	85.22%	
RTT 18 weeks	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	Monthly	Mar-21	National	92%	63.93%	
Cancer Waiting Times	62-day wait for first treatment from urgent GP referral for suspected cancer	Monthly	Feb-21	National	85%	83.4%	
Cancer Waiting Times	62-day wait for first treatment from NHS cancer screening service referrals	Monthly	Feb-21	National	90%	75.0%	
Diagnostics Waiting Times	Maximum 6-week wait for diagnostic procedures	Monthly	Mar-21	National	1%	33.07%	
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%	-	

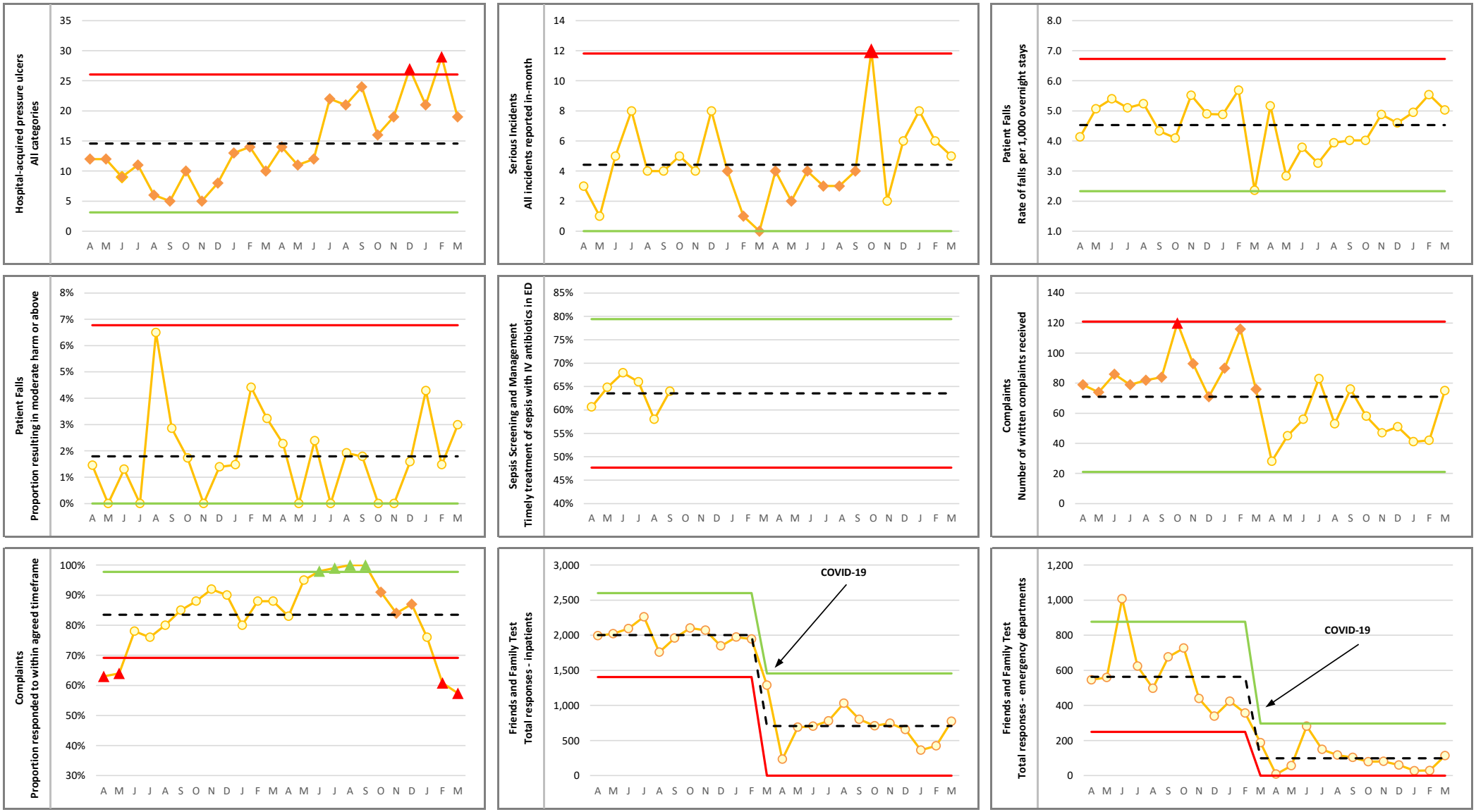
Leadership and workforce

Organisational health	Staff sickness	Monthly	Mar-21	Local	3.8%	3.84%	
Organisational health	Staff turnover	Monthly	Mar-21	Local	12.0%	11.2%	
Organisational health	Proportion of temporary staff	Monthly	Mar-21	Local	-	11.9%	
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

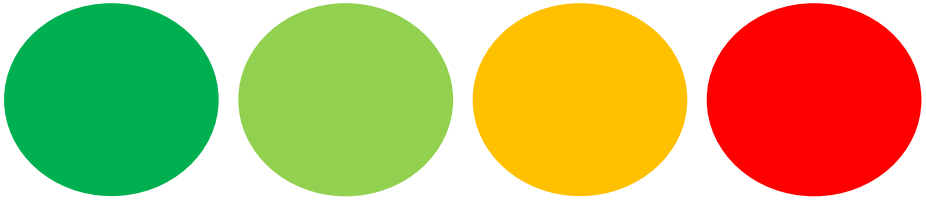
Safe, Caring and Effective Services Headline Metrics

East and North Hertfordshire NHS Trust



Safe Services

Month 12 | 2020-21



Key Issues

Patient Falls
- There were 67 Inpatient falls recorded in March.
- Number of Inpatient Falls in March resulting in serious harm = 2.

Serious Incidents & Never Events
- It has been 114 days since the last reported Never Event (as at 15th April 2021).
- There have been 0 Never Events in March.
- There were 5 serious incident themes reported in March:
  - Sub-optimal discharge
  - delay in PPCI pathway
  - unexplained cardiac arrest
  - delay in treatment
  - delay in recognising deteriorating patient (NB now formally downgraded)

Infection Prevention & Control
- COVID-19 = 0 Community-Onset cases, 0 Hospital-Onset Indeterminate Healthcare-Associated cases, 0 Hospital-Onset Probable Healthcare-Associated cases & 1 Hospital-Onset Definite Healthcare-Associated case in March.
- MRSA bacteraemia = 0 cases in March.
- C difficile infections = 2 reportable cases in March.
- E.coli bacteraemia = 4 cases in March.
- MSSA bacteraemia = 1 case in March.
- Klebsiella bacteraemia = 2 cases in March.
- Pseudomonas aeruginosa bacteraemia = 1 case in March.
- Hand hygiene compliance increased from 89.96% in February , to 90.83% in March 2021 (target 80%).

Hospital-acquired Pressure Ulcers
- There were the following pressure ulcers reported for February
  - Category 4 incl. (d) = 0
  - Category 3 incl. (d) = 0
  - Category 2 incl. (d) = 7
  - MM incl. (d) = 2
  - Unstageable incl. (d) = 3
  - SDTI incl. SDTI (d) = 7

Sepsis
- The sample of Inpatients for Q4 is currently at 61: Jan (10), Feb (28), Mar (23) which is above the Trust target (50).
- The sample of ED Patients for Q4 is at 80: Jan (15), Feb (22) and Mar (43), which is above the Trust target (50).
- The sample showed an average time to antibiotic administration within in patient setting at 56% within 1 hour of Red Flag in March.
- The sample showed the average time in Emergency Attendances receiving antibiotics within 1 hour of Red Flag has improved to 79% in March, but remains below the Trust target (95%).
- 34% of patients received all Sepsis 6 interventions within 1 hour of Red Flag triggers in March.

VTE/HAT
- Potential harm from Hospital Associated Thrombosis continues to be presented to Serious Incident Review panel.
- HATs for review remains at 16.25 (12 month rolling average to March).
- HATs reviews completed is at 16.42 (12 month rolling average to March).
- There were 0 Potential Preventable HATs in March.

Executive Response

Patient Falls
- Reducing harm from falls remains a priority for continuous improvement within the Trust Patient Safety Programme – Harm Free Care. Improvement priorities includes strict compliance with national guidelines in doing orthostatic blood pressure and visual assessment for inpatient over 65 y/o and baywatch compliance.
- Ongoing Quality improvement on areas with high incidence of falls focusing on enhancing staff skills in managing high risk falls patients, embedding good practices and adhering to trust's guidelines surrounding falls.

Executive Response

Serious Incident Review Panel
- 27 incidents were presented to serious incident review panel in March.
- 5 were reported as serious incidents (NB 1 of which has since been downgraded and no longer SI).
- 3 cases require more in-depth RCA learning reviews and 9 have triggered local learning reviews.
- There are 32 ongoing SI investigations and these are being closely monitored.
- Process to review hospital onset COVID-19 infections has commenced. Resources are being reviewed to ensure support to the process.

Infection Prevention & Control
- In February number of Nosocomial Infections recorded:
  - 0 Hospital-Onset Probable Healthcare-Associated cases.
  - 1 Hospital-Onset Definite Healthcare-Associated cases.
- Outbreaks:
  - Total of 4 ongoing outbreaks during the month of March.
  - Regular weekday outbreak Incident Management Team (IMT) meetings continued.
  - All outbreaks closed by 28th March 2021.
- New Guidance and Reports:
  - COVID-19 rapid guideline: managing COVID-19 NICE guideline [NG191].
  - Good infection prevention practice: using ultrasound gel.
  - Position Statement on current IPC guidance and use of PPE for new SARS-CoV-2 variants – December 2020.
- Other Indicators:
  - No Flu or Norovirus Healthcare-Associated cases reported.
  - Year-to-date C.difficile cases is 40, which is below the trajectory ceiling target of 52 cases.

Hospital-acquired Pressure Ulcers
- Total HAPU for 2020/21 is 235, with 19 recorded for the month of March.
- It has been 166 days since the trust last reported a grade 4 pressure ulcer. The last one was reported on 27/11/2020. our most common category of damage is the Suspected Deep Tissue Injury at 47% of all ulcerations.
- 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 as these ulcers account for 37% of all ulcers, with 60% of these occurring within our critical care department. additional improvement work will focus on 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 19% of ALL 2020/21 pressure ulcers. The most prevalent theme is inaccuracies and inconsistencies in documentation around skin inspection at 23%.
- Learning from previous serious incidents and RCA themes are used as the basis for teaching on our pressure ulcer prevention study day and pressure ulcer prevention is taught to all new clinical staff on clinical induction in collaboration with Nurse Education.

Sepsis
- For the first time quarterly sample size compliance was achieved for both Inpatient and ED.
- In March we saw further improvement in compliance with delivery of antibiotics within one hour: ED has gone from 66% to 79% while IP has gone from 41% to 56%. Even if this progress is promising we are still far away from our target of 95% compliance.
- In March overall compliance has improved for Inpatient setting from 10% to 17%.
- In March overall compliance has slightly decreased for ED setting from 36% to 34%.
- Data has been shared with ED matron. Noticed reduced compliance with sepsis tool use: programming action plan to improve compliance.
- Evaluating application of clinical coding to achieve more systematic data collection.
- Started QI project to improve compliance with sepsis six.
- Nomination of link nurses for every ward nearly achieved. Programming training to form link nurses and created tools to help them in their role.
- New training and teaching session are scheduled. Evaluating to implement additional eLearning to consolidate knowledge and awareness around sepsis.

VTE/HAT
- Improving the VTE risk assessment of patients remains a priority and recruitment of a trust VTE lead in is progress. Quality improvement includes targeted improved awareness within Junior Drs and consultant forums and ward round structures.
- The national programme for measurement of VTE risk assessment remains suspended due to COVID-19 pandemic.
- Due to the time lag between diagnosis of potential Hospital Acquired Thrombosis and the undertaking of phased RCA review it is 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 continue to be 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	
MARCH (Weekly reporting commenced w/e 14/05/20)	1	1	0	0	0	1	0	

Domain	Metric	Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Trend
Events and Incidents	Number of Never Events	0	0	0	0	0	0	1	1	0	1	0	0	0	
	Number of Serious Incidents	5	4	2	4	3	3	4	12	2	6	8	6	5	
Hospital-acquired Pressure Ulcers	Category 4 - inc Category 4 (d)	0	0	0	0	0	0	0	0	1	0	0	0	0	
	Category 3 - inc Category 3 (d)	0	0	0	0	0	0	0	0	0	0	0	1	0	
	Category 2 - inc Category 2 (d)	2	3	3	3	12	10	10	4	7	8	9	9	7	
	Mucosal membrane (d) Device-related	-	0	1	4	1	2	4	1	1	2	0	0	2	
	Unstageable inc Category Unstageable (d)	1	1	0	0	1	1	3	2	0	1	2	5	3	
	SDTI inc STDI (d)	3	10	7	5	8	8	7	9	10	16	10	14	7	
Sepsis Screening and Management	Inpatients with Sepsis - sample size	50	14			26			18			61			
	Inpatients receiving IVABs within 1 hour of Red Flag	95%	n/a	0%	60%	67%	50%	50%	14%	60%	0%	25%	41%	56%	
	Emergency attendances with Sepsis - sample size	50	21			114			156			80			
	Emergency attendances receiving IVABs within 1 hour of Red Flag	95%	n/a	50%	76%	63%	92%	73%	76%	73%	62%	64%	66%	79%	
	Sepsis six bundle compliance - ED	95%	n/a	0%	29%	26%	32%	25%	30%	38%	31%	26%	36%	34%	
Patient Falls	Number of patient falls	72	44	31	42	41	52	56	55	66	63	70	68	67	
	Rate of patient falls per 1,000 overnight stays	4.0	5.2	2.8	3.8	3.3	3.9	4.0	4.0	4.9	4.6	5.0	5.5	5.0	
	Number of patient falls resulting in serious harm	0	1	0	1	0	1	1	0	0	1	3	1	2	

Safe Services

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-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)	-	16.33	16.33	16.17	16.50	16.83	17.42	16.58	15.33	17.00	16.92	16.92	16.25	
	HAT reviews completed (12 month rolling average)	-	15.83	13.75	13.67	13.83	12.58	17.75	17.67	17.75	15.75	17.67	17.08	16.42	
	HATs confirmed potentially preventable	-	0	0	0	0	0	5	1	0	0	1	0	0	
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	3	4	2	3	3	2	10	0	4	5	2	2	
	Rate of c.difficile incidences per 100,000 bed days Healthcare-associated	19.0	26.2	33.8	17.5	20.4	20.4	14.1	56.8	0.0	22.7	27.9	12.4	11.2	
	Number of e.coli incidences	-	3	1	1	2	1	2	1	2	3	1	0	4	
	Rate of e.coli incidences per 100,000 bed days	18.5	26.2	8.4	8.7	13.6	6.8	14.1	5.7	11.7	17.0	5.6	0.0	22.3	
	Number of MSSA incidences	-	0	0	2	0	2	2	4	2	1	1	1	1	
	Rate of MSSA incidences per 100,000 bed days	8.0	0.0	0.0	17.5	0.0	13.6	14.1	22.7	11.7	5.7	5.6	6.2	5.6	
	Number of klebsiella incidences	-	0	0	0	0	0	0	2	1	0	1	1	2	
	Rate of klebsiella incidences per 100,000 bed days	7.6	0.0	0.0	0.0	0.0	0.0	0.0	11.4	5.9	0.0	5.6	6.2	11.2	
	Number of pseudomonas aerudinosa incidences	-	0	0	0	1	0	3	1	1	0	0	0	1	
	Rate of pseudomonas aerudinosa incidences per 100,000 bed days	3.7	0.0	0.0	0.0	6.8	0.0	21.1	5.7	5.9	0.0	0.0	0.0	5.6	
	Hand hygiene audit score	80%	94%	92.5%	92.4%	93.6%	92.2%	93.0%	92.4%	91.8%	93.6%	95.2%	90.0%	90.8%	

Caring Services

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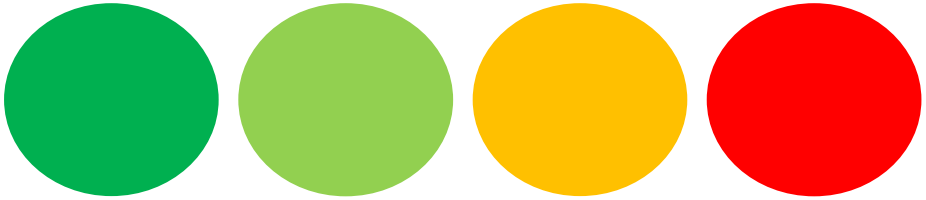


Key Issues

Friends and Family Test (FFT)

- The proportion of positive responses for Inpatients (96.25%), A&E (95.61%) , Outpatients (97.03%),Births (95.71%) , Postnatal Ward (93.43%) and Postnatal Community (100%) are all above their respective targets.
- Antenatal dropped to 88.89, below the Trust target of 93%.
- Total responses for Inpatients (774) and A&E (114) have both increased but remain below their respective Trust targets.
- The total number of responses for Births (142) has increased and remains above the Trust target.
- The total number of responses for Outpatients (337) has increased by 93 in March compared to February (244).

Complaints

- Total number of complaints received in March = 75.
- The breakdown by division is as follows:
  - Planned Care = 22
  - Unplanned Care = 44
  - Cancer = 3
  - Clinical Support Services = 6
- 94.74% of complaints received were acknowledged within 3 working days in March (72 of 76 due).
- 57.38% were responded to within the agreed timeframe in March (35 of 61 due).
- There were 110 open complaints at end of March 2021.

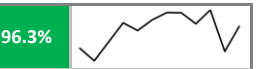
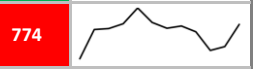
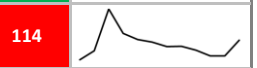
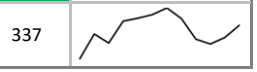
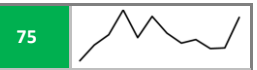
Executive Response

Friends and Family Test (FFT)

- The FFT positive response feedback for inpatients is above target again for March 2021.
- The Maternity Survey was carried out by Picker in March 2021.
- National guidance was issued to allow visiting for every patient, for one hour, by one person for the duration of their stay and to allow visits for all scans for pregnant women. The Trust is aiming to reopen visiting for adult inpatients and extend visiting to allow birth partners to accompany women to all planned antenatal clinics.
- The 'keeping in touch' service continues to offer virtual visits for people.
- The ‘Stay in Touch’ service, provided by the Voluntary Response Team, continues to deliver messages and photos or drawings to our patients. in April we have delivered 67 letters and 75 pictures. In the year April 2020 to March 2021 we have delivered 1553 letters and 1688 pictures.

Complaints

- There was a rise in the number of new complaints recorded in the month of March 2021 compared with previous months . This month 75 formal complaints were recorded compared to 42 in February 021 and 41 in January 2021.
- A total of 656 formal complaints were recorded in this financial year 2020/21 compared to 1058 formal complaints in the year 2019/20. This is a reduction of 38% , which is reflective of the pandemic. Following government guidelines many services were paused and only emergency treatment and services provided as the Trust prepared for the expected increase in emergency admisssions due to COVID-19.
- Current performance is not with the expectations of the service and steps to improve this include:
- Two new case handlers have been appointed to the vacancies in the team.
- The Complaints Manager is working with the team to review ways of working to increase performance including the timeliness and number of the responses closed each week.
- We will be reviewing our complaints service against the new good practice standards recently published by the PHSO.

Domain	FFT	Metric	Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Trend
Friends and Family Test	Inpatients	Proportion of positive responses	95%	92.7%	90.7%	93.8%	96.8%	95.5%	97.3%	98.5%	98.4%	96.7%	98.9%	92.2%	96.3%	
		Total number of responses	1,778	233	689	705	780	1,031	803	710	745	657	364	424	774	
	A&E	Proportion of positive responses	90%	100.0%	92.9%	89.0%	96.6%	98.3%	96.1%	98.7%	95.1%	98.3%	96.4%	93.1%	95.6%	
		Total number of responses	1,241	8	56	282	149	117	103	79	81	60	28	29	114	
	Maternity	Antenatal care Proportion of positive responses	93%	n/a	100.0%	n/a	100.0%	0.0%	100.0%	50.0%	100.0%	85.7%	100.0%	100.0%	88.9%	
		Birth Proportion of positive responses	93%	95.7%	n/a	100.0%	100.0%	100.0%	92.6%	94.4%	96.2%	97.8%	97.9%	97.1%	95.8%	
		Birth Total number of responses	137	23	0	2	1	8	27	126	133	135	143	139	142	
		Postnatal ward Proportion of positive responses	93%	95.7%	n/a	100.0%	100.0%	100.0%	95.7%	95.9%	92.6%	94.4%	95.0%	95.5%	93.4%	
		Postnatal community Proportion of positive responses	93%	n/a	n/a	n/a	100.0%	n/a	66.7%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Outpatients	Proportion of positive responses	95%	97.6%	95.8%	99.0%	98.9%	96.2%	95.7%	98.5%	99.2%	96.6%	91.2%	99.2%	97.0%	
		Total number of responses	-	83	271	204	369	392	419	471	389	233	195	244	337	
Complaints	Number of written complaints received		92	28	45	56	83	53	76	58	47	51	41	42	75	
	Rate of written complaints received		1.9	0.5	0.7	0.9	1.3	0.8	1.2	0.9	0.7	0.8	0.6	0.6	1.1	
	Proportion of complaints acknowledged within 3 working days		75%	100%	100%	82%	100%	100%	100%	100%	100%	100%	96%	86%	95%	
	Proportion of complaints responded to within agreed timeframe		80%	83%	95%	98%	99%	100%	100%	91%	84%	87%	76%	61%	57%	

Effective Services

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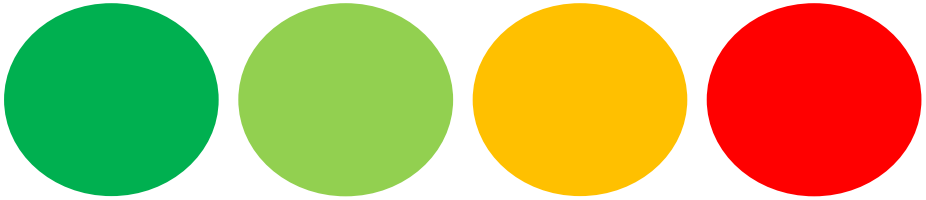


Key Issues

Crude Mortality
- The in-month crude mortality rate decreased from 20.2 deaths per 1,000 admissions in February to 13.1 in March.
- The rolling 12-months crude mortality rate has decreased slightly to 16.8 deaths per 1,000 admissions in the 12 months to March, but is lower than the most recently available national rate of 17.4 deaths per 1,000 admissions (Feb-20 to Jan-21).

Hospital-Standardised Mortality Ratio
- The in-month HSMR has increased from 81.7 in December to 113.7 in January.
- The rolling 12-months HSMR decreased again slightly from 82.5 in the 12 months to December, to 82.4 in the 12 months to January.
- The Trust remains within 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 November continued to decrease to 88.28.
- This has remained in the 'lower than expected, Band 3' category.

Re-admissions
- The re-admission rate for 12 months to January has increased slightly to 8.39% from 8.35% in the 12 months to December.

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.
- We have accepted that the number of mortality reviews completed for 2020-21 deaths will be lower due to the pandemic. The current completion rate stands at 52%. A final batch of 2020-21 deaths is being reviewed (in particular hospital onset COVID nosocomial deaths) prior to the focus moving onto 2021-22 deaths.
- 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 re-admission within 28 days; Shared with December Mortality Surveillance Committee, with agreement to review a 2nd wave batch of deaths. (2) Deaths in the Community (COVID-19/non COVID-19) within 28 days of discharge - initial findings have not indicated any inappropriate discharges.
- Work to integrate our mortality review process into the new Datix iCloud platform when this is implemented into the Trust continues.

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, when it peaked again. While recent months have seen a steady increase in our rolling 12 month rate, it has remained below the national rate for the corresponding month.

Hospital Standardised Mortality ratio (HSMR)
- Our current HSMR of 82.4 (rolling 12 months to January 2021) 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 88.28 (12 months to November 2020) sees the Trust positioned within the 'lower than expected' band 3 category. Our position relative to our national peers currently stands at 13th 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.

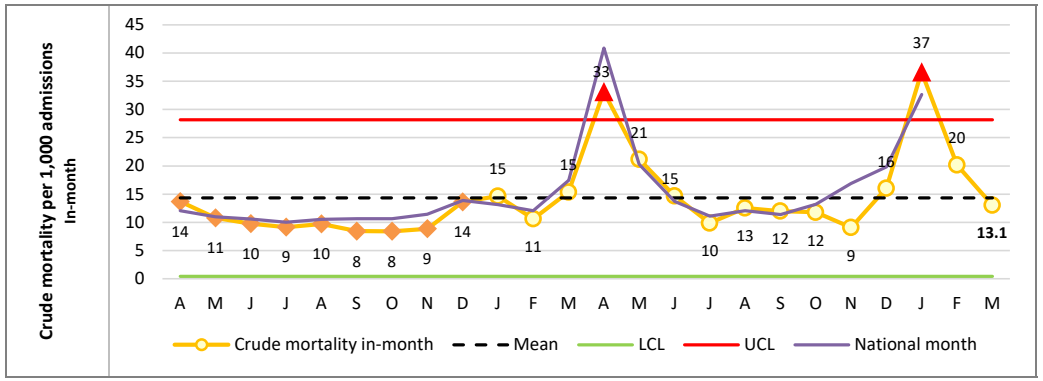
Re-admissions
- The Trust's re-admission rate has generally been consistent with the national performance. Significant dips in readmissions were seen in March and October 2020 while July and August saw the Trust's rate rise slightly above the national picture. The significant changes in overall admissions and the change in case mix during this period make interpretation of this data challenging but the Trust's position will continue to be monitored.

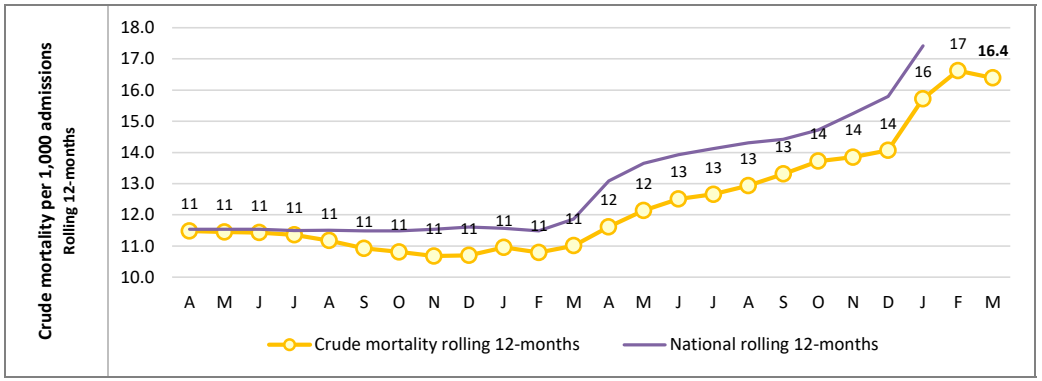
Learning from Deaths
- In addition to the outcomes of cases escalated to Specialties being considered by the Mortality Surveillance Committee, the quarterly Learning from Deaths report includes a summary of key themes emerging from these cases. This detail is shared with all Trust Specialties and with 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.

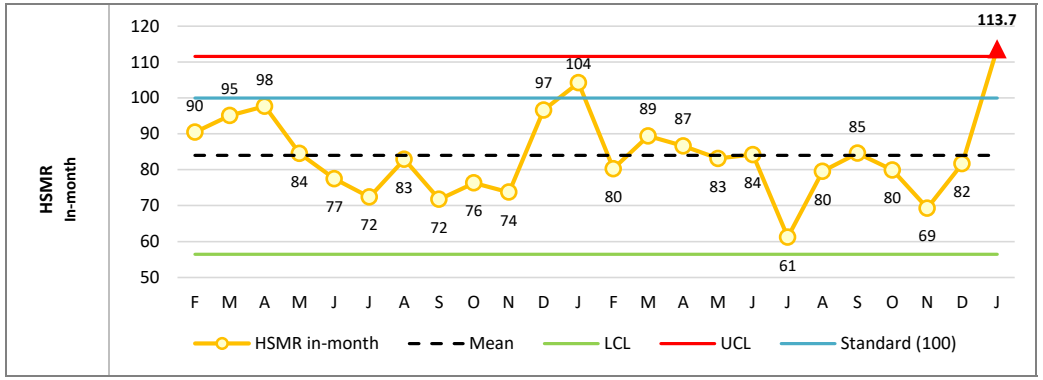
Specialist Palliative Care
- This data refers solely to patients under the care/review of the Palliative Care Team. Other data is available for deaths that are not known to the PCT. However, it resides in an access database and we are currently working through some data quality issues.

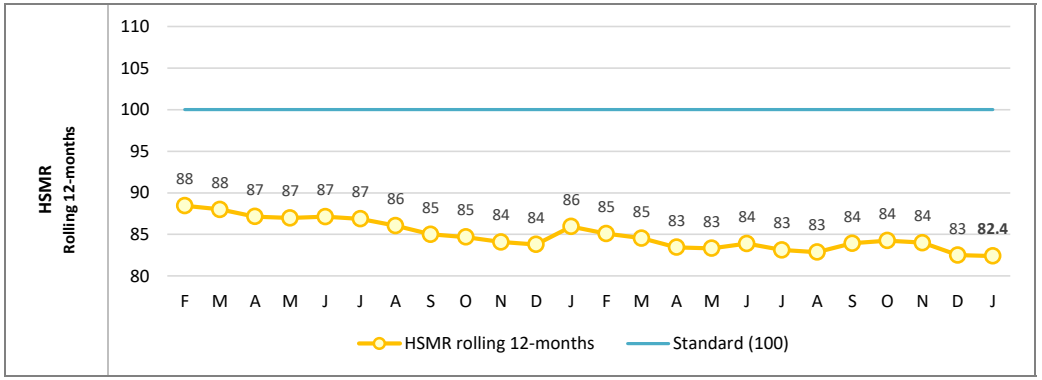
Effective Services

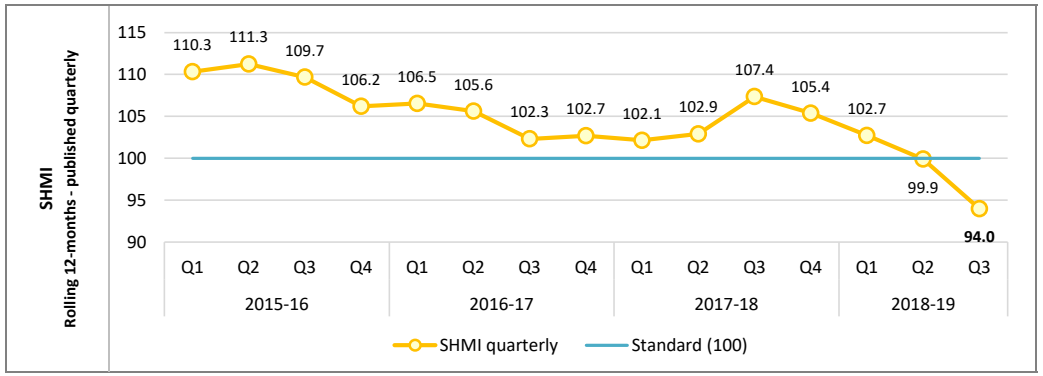
East and North Hertfordshire NHS Trust

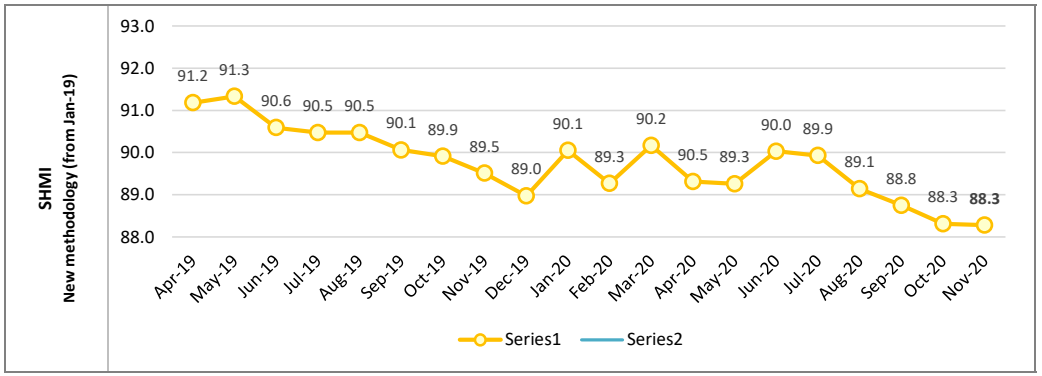




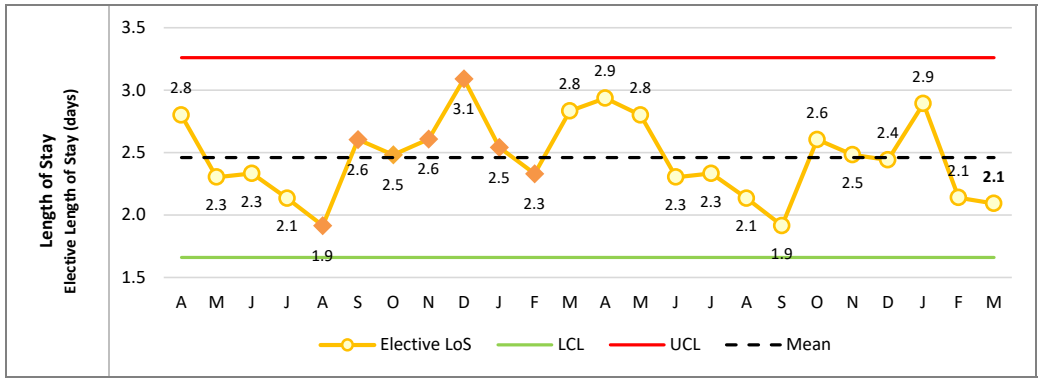


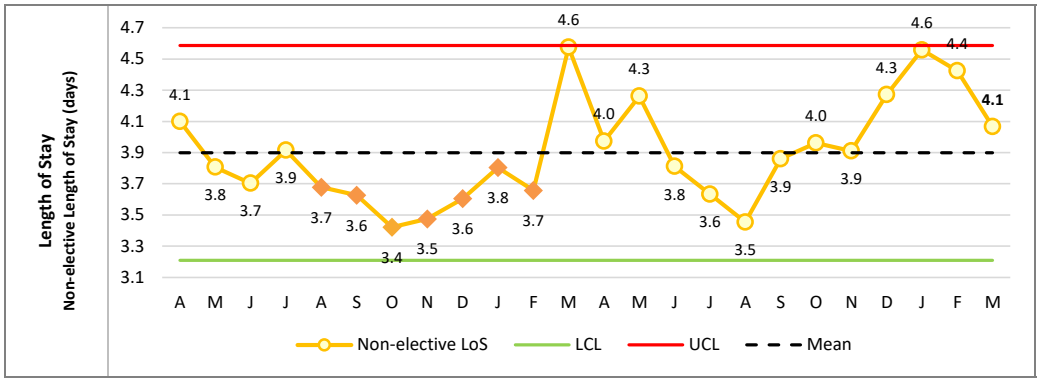


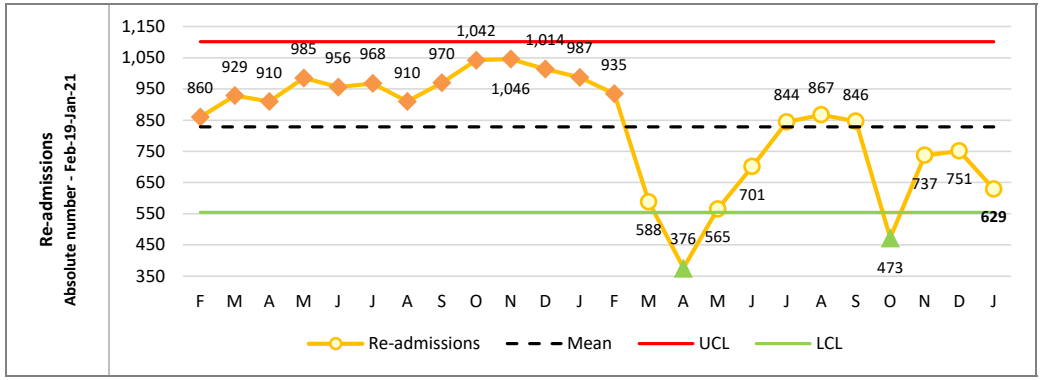


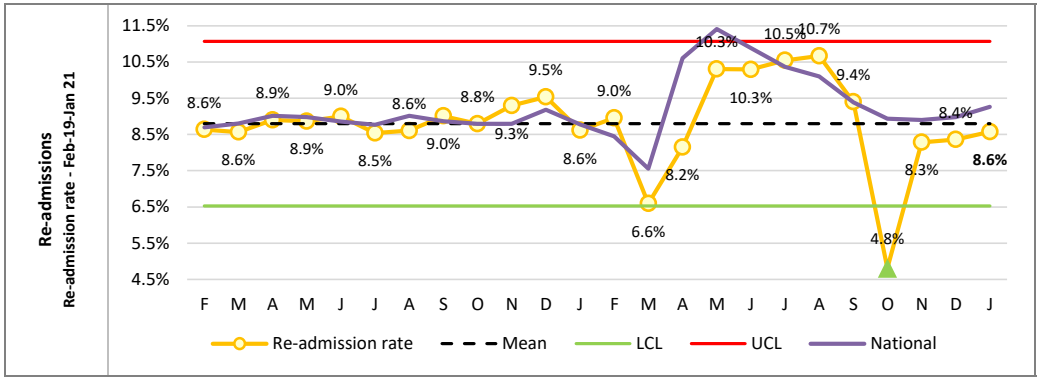


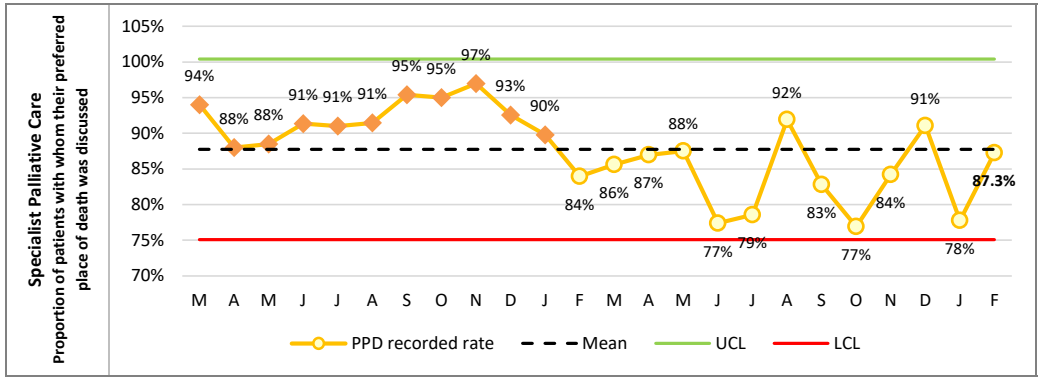
Effective Services

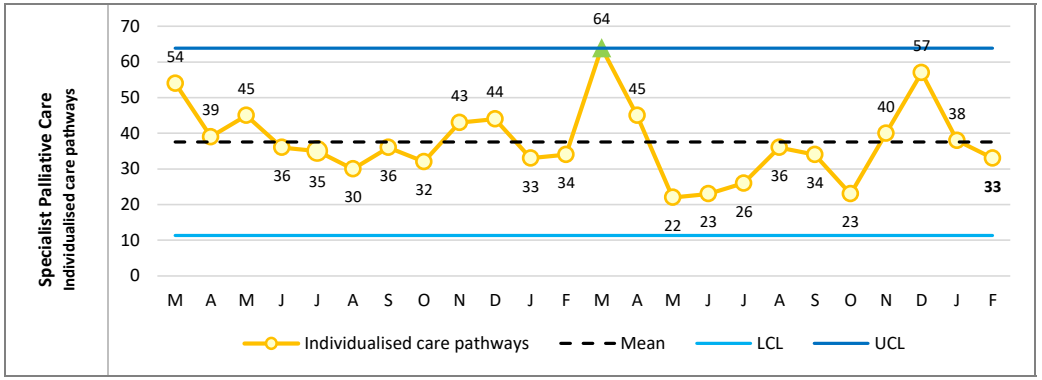






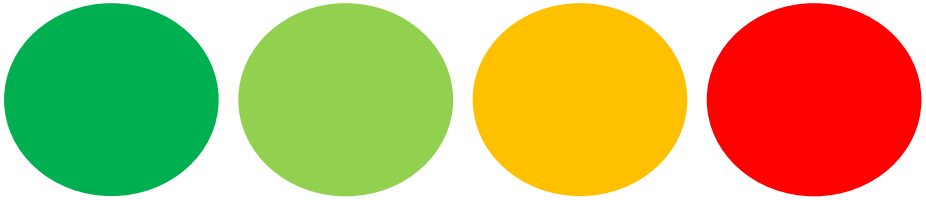






Responsive Services

Month 12 | 2020-21



Key Issues

A&E
- Performance for the month of March was 85.22%.
- There were zero waits reported in March.

Cancer Waiting Times
- The Trust achieved 5 out of the 8 national targets for cancer performance in February.
- The Trust 62-day performance for February was 83.41%.
- There were 6.5 pathways over 104 days for the 62 Day Standard, and 1 pathway over 104 days for 62 Day Screening.
- 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 March was 60.36%. This is a reduction from the 63.93% reported in February.
- The March backlog was 19,093 increase of 2,610 from 16,483 in February.
- There were 3,221 52-week breaches reported in the March incomplete position, an increase of 722 from the 2,499 reported in February.
- There were 21 patients waiting over 104 weeks: in February:- 104wks = 3; 105wks & 107 wks= 4 each; 110 wks = 2; 112 wks, 117 wks, & 121 wks = 1 each ; 122wks & 123 wks = 2 each; 125wks = 1

Diagnostics
- Due to the transition to a new system, we are currently unable to report Cardiology - echocardiography numbers this month. This is a temporary issue that we are aiming to have resolved for next month's DM01 submission.
- DM01 performance for March was 33.07% against the national standard of 1% and the February position of 29.42%.
- Latest National performance for February was 28.46%.

Stroke
- Stroke performance for March is 49.3%.
- Thrombolysis performance is at 5.7% in March, under the Trust target of 11%.
- Door-to-needle performance decreased in March to 25%, below the Trust target of 70%.

Executive Response

A&E
- Performance against 4 hour emergency standard demonstrated a significant improvement in March. Unlike recent months the improved performance was maintained consistently throughout the month. The most dramatic improvement was admitted performance. Despite an increase in Type 1 activity which demonstrated an increase to within 7% of recorded Type 1 activity in March 2018/19.
- The key contributory factors included; improved staffing levels across the trust providing increased flexibility to respond to daily demand, increased medical SDEC activity, revised bed modelling following the significant reduction of COVID inpatient cases. In addition extended operational leadership across ED/Assessment was introduced as a 3 month pilot, which early feedback suggests has had a positive impact.
- Steps to improve compliance further are currently underway including the introduction of a Trust wide 'Emergency ProfessionalStandards Operational Leadership Group'. The purpose of the Emergency Professional Standards Operational Leadership Group is to designand monitor delivery of a local recovery action plan to ensure sustained compliance with emergency professional standards in line with adefined trajectory of improvement.
- During March it is also noted that ambulance arrival to handover performance improved, with increased compliance with 15minute handover,. Furthermore, we also reduced handover delays above 30mins and 60mins.

Cancer Performance (February 21)
- In February 21, the Trust achieved 5 of the 8 national targets and 2 out of 3 -28-day FDS standards for Cancer performance: 2ww GP Referrals, 2ww Breast Symptoms, 31-day First Treatment, 31-day Subsequent for Radiotherapy and Chemotherapy, and also 28-day FDS 2WW and Breast symptoms.
- 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 February 2021 the Trust performance was 98.0%.
- In February 2021, the Trust wide average days wait for first appointment is at 9 days and the majority of patients were seenbetween 8 and 12 days.
- The Trust has consistently delivered against the Breast Symptomatic national standard which requires 93% of patients referredto have attended the 1st Outpatient appointment within 14 days. For February 2021, the Trust performance was 100.0%.

Executive Response (continued)

Cancer Performance (February - continued)
- The Trust has consistently delivered the 31-day second or subsequent treatment for Radiotherapy and Chemotherapy but not for the subsequent Surgery. For February 2021 the Trust Chemotherapy performance was 99.4%, the Trust Radiotherapy performance was 98.5% and the Trust subsequent Surgery performance was 92.1%.
- The Trust performance for 31-day to first definitive treatment was 97.8%. The standard requires 96% of patients to receive treatment within 31 days of diagnosis.
- In February 2021, the Trust performance for the Faster Diagnosis is 82.0% for the 2ww patients, 90.5% for Breast Symptomatic and 62.5% for Screening patients.
- Reported 62-day performance for February 2021 was pre-sharing 81.0% and post-sharing 83.4%.
- Cancer performance is available one month in arrears.

RTT
- Performance declined in March and continues to remain significantly below the required performance standard of 92%. The number of patients greater than 52 weeks and 104 weeks has increased, along with the overall PTL size.
- 5,565 admitted patients have been risk stratified against the Royal College guidelines. Patients are recorded as P1, P2, P3, P4, P5 and P6.
- 14 of the 17 theatres are operational on the Lister site, plus the private sector. As part of recovery we will opening to 17 from the 1st May.
- PTL management is now back in place and is reviewing and managing patients on our treatment lists. Validation remains in place.
- The Trust has submitted plans to deliver percentage recovery as set out nationally.
- The number of P3 patients clinically categorised remains consistent, so as part of recovery treatments are starting on the P3 and P4, concentrating on the long waiting patients.
- The Trust is planning to maintain the levels of face to face vs non face to face as delivered in the COVID-19 pandemic. The development of Patient Initiated Follow up in three key speciality for outpatients has started.

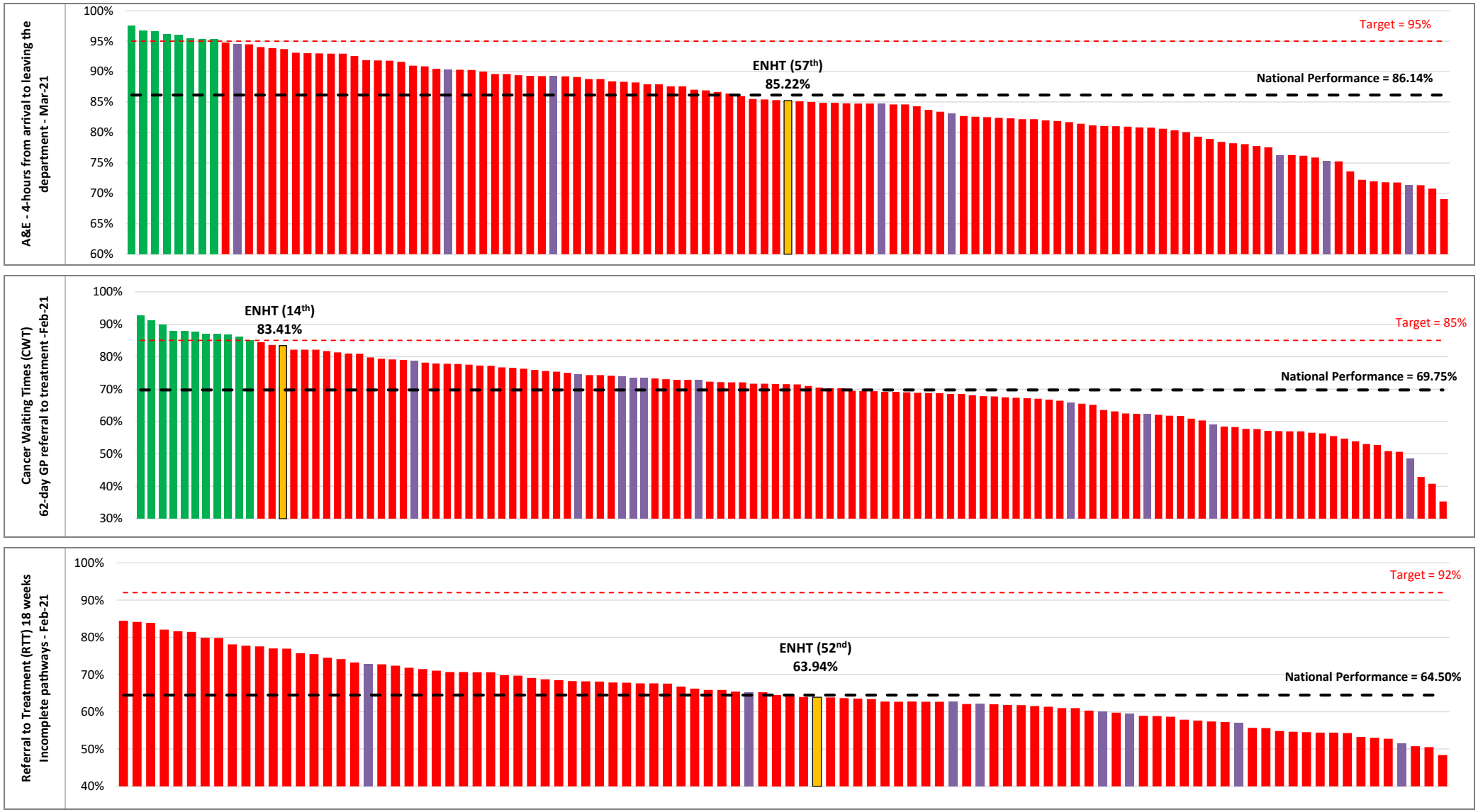
Diagnostics
- Performance declined in March, the numbers of patients waiting over 6 and 13 weeks has increased.
- Referrals/Demand remains as expected.
- Diagnostics relating to Cancer remained consistent, with prioritisation of these patients.
- Recovery has started towards 100% of 2019/20 activity levels.

Stroke
- 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.
- High number of delays to 4hrs. Out of hours are 53% of overall breaches.
- High impact of breaches in support of the IPC management, for turnaround times of results to safe placement of patients and reduce the risk of outbreaks - POC delays 7 - resulting in 19% of the overall breach reasons.
- Concerns are ongoing with the requirements of Stroke beds needing to be used for Medical patients to support Trust position and to ensure safety. This reduces the available capacity for Stroke bed and adherence to 4hr performance, impacting available bed capacity for the month of March, which resulted in 17% of the overall breach reasons.
- Challenging diagnosis and Complex patients - resulting in 33 of the overall breach reasons.
- SNNAP rating performance reduction. Main contributing factors are: OT/PT non-compliance of establishment in-line with National Specification. A,business case has been provided for approval to support levels to be compliant and therefore provide the necessary delivery of care in accordance with the SNNAP requirement.
- Door to Needle performance within 1hr is 25%. Impact is due to 4 patients of which 1 missed by 6mins and the other 3 clinical need and out of hours service.
- Thrombolysed rate is 5.7%. Impact is due to 4 patients of which 3 were clinical need - treatment required before thrombolysis could be safely adminsrated. There is still an ongoing risk. In light of the changes to all services due to COVID-19 both ambulance and ED triage and scanning protocols added some delays. Internal analysis of each case is to be carried out for future learning to be carried forward.
- CT performance for 1hr improvement in performance at 52.9%. Above target of 50%, but with ongoing risk due to the increase demand to CT services.

Responsive Services

Trust performance against all Trusts nationally

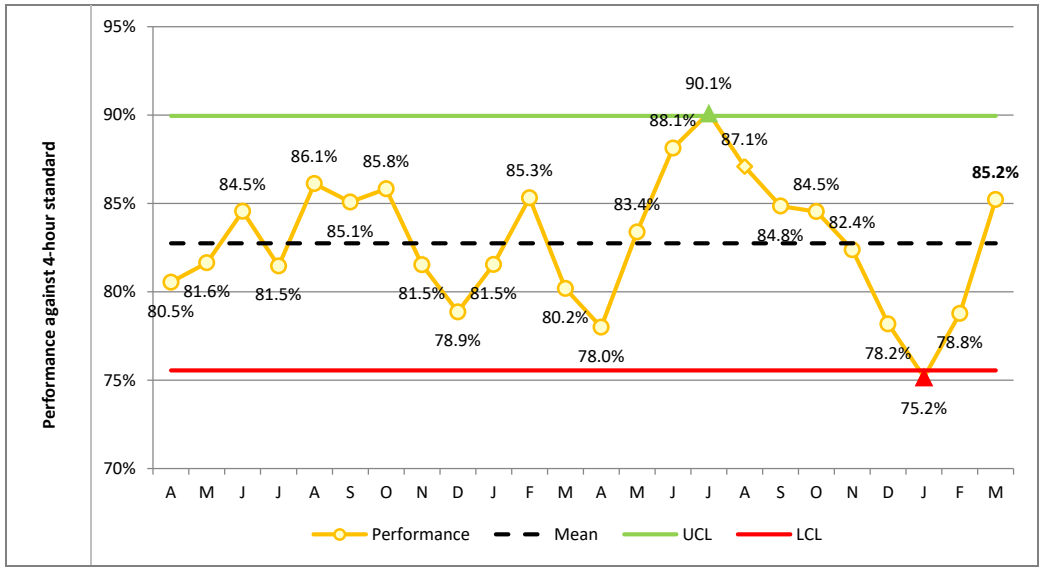
East and North Hertfordshire NHS Trust



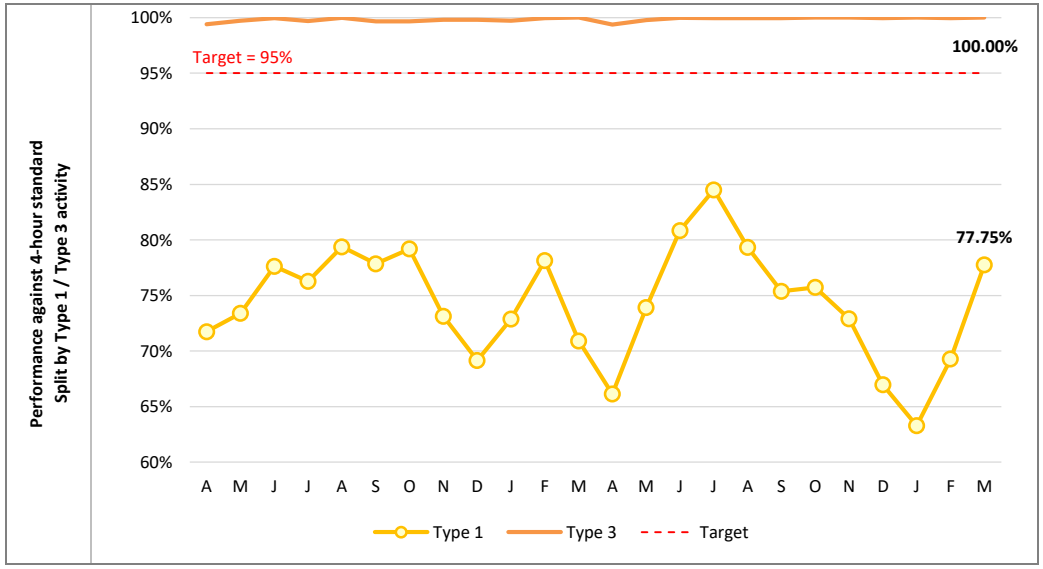
Responsive Services

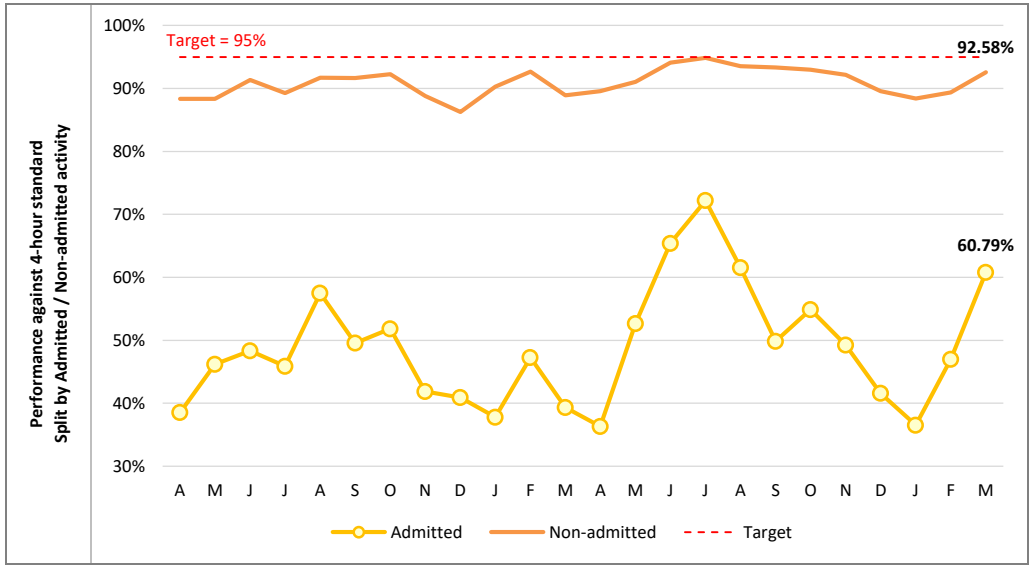
Emergency Department Performance

East and North Hertfordshire NHS Trust



Domain	Metric	Target	Feb-21	Mar-21	Change	Trend
Other Emergency Department measures	Ambulance handovers (Arrival to Handover) Proportion within 15 minutes	-	27%	26%	▼	
	Ambulance handover breaches 30 minutes	334	327	274	▼	
	Ambulance handover breaches 60-minutes	73	85	44	▼	
	Attendance to admission conversion rate	-	37.7%	36.6%	▼	
	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%	1.09%	▲	
	Unplanned re-attendance rate	5%	6.35%	5.51%	▼	





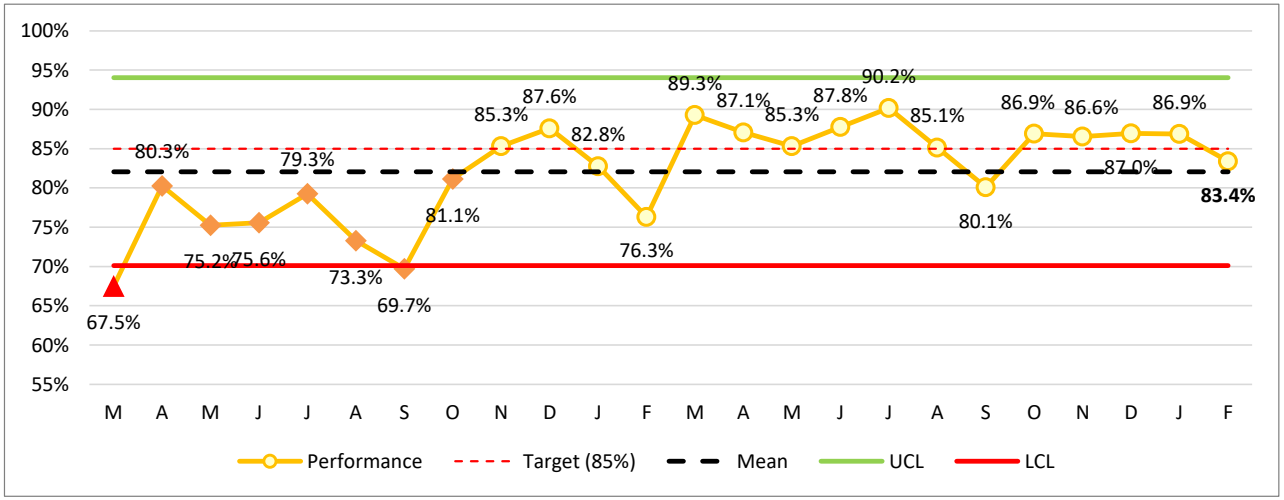
Responsive Services

Cancer Waiting Times

East and North Hertfordshire NHS Trust

12-months' performance - all standards	Standard	Target	2019-20		2020-21											
			Mar-20	YTD	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	YTD
	Two week waits Suspected cancer	93%	98.77%	96.95%	97.72%	99.35%	99.32%	92.80%	95.84%	97.25%	96.74%	97.36%	98.12%	96.17%	98.00%	97.03%
	Two week waits Breast symptomatic	93%	97.14%	94.10%	79.31%	100.00%	98.59%	97.98%	98.67%	99.00%	96.36%	97.64%	93.33%	93.40%	100.00%	96.71%
	31-day First definitive treatment	96%	97.89%	96.57%	98.60%	98.50%	98.63%	94.59%	98.22%	98.48%	98.28%	98.68%	99.57%	99.05%	97.84%	98.25%
	31-day subsequent treatment Anti-cancer drugs	98%	99.49%	99.50%	99.10%	100.00%	99.39%	100.00%	100.00%	99.39%	100.00%	100.00%	100.00%	100.00%	99.42%	99.84%
	31-day subsequent treatment Radiotherapy	94%	99.50%	99.10%	100.00%	99.39%	100.00%	100.00%	99.39%	100.00%	100.00%	98.90%	99.63%	98.76%	98.51%	98.82%
	31-day subsequent treatment Surgery	94%	95.83%	83.55%	94.44%	96.15%	100.00%	95.00%	96.15%	90.00%	95.12%	95.45%	100.00%	75.00%	92.11%	93.28%
	62-day GP referral to treatment	85%	89.27%	79.82%	87.08%	85.31%	87.78%	90.16%	85.15%	80.10%	86.92%	86.55%	86.96%	86.87%	83.41%	85.99%
	62-day Specialist screening service	90%	66.67%	76.67%	38.46%	0.00%	NIL	20.00%	0.00%	80.00%	100.00%	100.00%	84.62%	80.00%	75.00%	70.64%

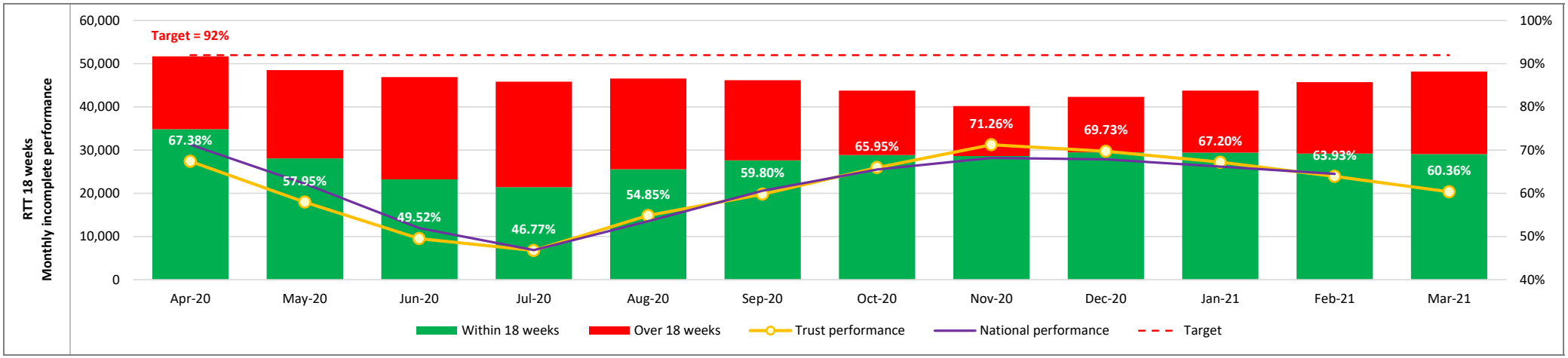
62-day GP referral to treatment Feb-21	Tumour Site	OK	Breach	Total	Perf.
	Breast	25.0	3.0	28.0	89.29%
	Gynaecology	6.0	1.0	7.0	85.71%
	Haematology	6.0	3.0	9.0	66.67%
	Head and Neck	7.0	0.0	7.0	100.00%
	Lower GI	6.0	7.0	13.0	46.15%
	Lung	2.0	1.0	3.0	66.67%
	Other	3.5	0.0	3.5	100.00%
	Skin	15.5	0.5	16.0	96.88%
	Testicular	3.0	0.0	3.0	100.00%
	Upper GI	5.5	1.5	7.0	78.57%
	Urology	16.0	2.0	18.0	88.89%
	Total	**95.5**	**19.0**	**114.5**	**83.41%**



Responsive Services

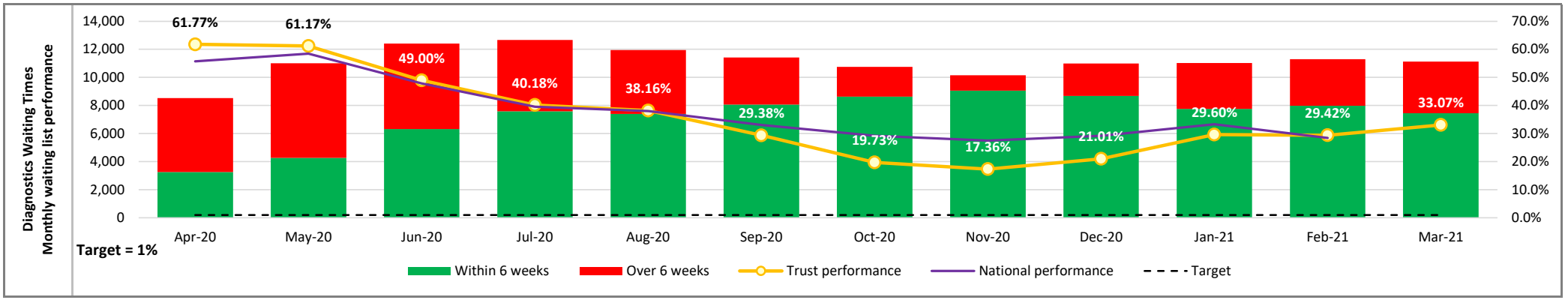
RTT 18 weeks

East and North Hertfordshire NHS Trust



RTT 18 weeks
In-month performance by Specialty - Mar-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	91	80.22%	0	209	81.82%	0	1,757	1,485	3,242	54.19%	411	232	629
Urology	105	82.86%	0	457	92.34%	0	1,222	915	2,137	57.18%	328	206	632
Trauma & Orthopaedics	10	30.00%	0	380	68.16%	0	1,893	2,284	4,177	45.32%	867	712	563
Ear, Nose & Throat (ENT)	41	85.37%	0	505	66.93%	0	2,004	1,321	3,325	60.27%	138	81	916
Ophthalmology	38	50.00%	0	379	90.77%	4	1,115	1,685	2,800	39.82%	452	331	495
Oral Surgery	2	0.00%	0	201	78.11%	0	1,290	1,129	2,419	53.33%	429	402	465
Plastic Surgery	49	83.67%	0	630	90.00%	0	1,109	495	1,604	69.14%	88	68	952
Cardiothoracic Surgery	0	-	0	4	75.00%	0	19	1	20	95.00%	1	0	14
General Medicine	0	-	0	23	100.00%	0	69	9	78	88.46%	0	0	70
Gastroenterology	87	85.06%	1	278	70.86%	3	2,367	2,674	5,041	46.95%	891	578	711
Cardiology	21	95.24%	0	634	87.22%	0	1,382	523	1,905	72.55%	29	19	690
Dermatology	0	-	0	267	65.17%	0	385	229	614	62.70%	2	0	211
Thoracic Medicine	20	80.00%	0	187	66.31%	0	704	409	1,113	63.25%	27	11	327
Neurology	0	-	0	223	95.52%	0	326	21	347	93.95%	3	3	178
Rheumatology	2	100.00%	0	247	53.85%	0	690	250	940	73.40%	21	16	290
Geriatric Medicine	0	-	0	28	46.43%	0	139	69	208	66.83%	7	2	67
Gynaecology	47	78.72%	0	319	84.64%	0	3,451	1,239	4,690	73.58%	105	79	1,079
Other	34	88.24%	0	2,129	81.35%	0	9,145	4,355	13,500	67.74%	827	481	4,282
Total	**547**	**79.89%**	**1**	**7,100**	**80.18%**	**7**	**29,067**	**19,093**	**48,160**	**60.36%**	**4,626**	**3,221**	**12,571**



Diagnostics Waiting Times
In-month performance by Modality - Mar-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	1,059	473	1,532	30.87%	8	1,960	210	89	**2,259**
	Computed Tomography	1,123	838	1,961	42.73%	327	3,568	682	1,299	**5,549**
	Non-obstetric ultrasound	4,266	1,047	5,313	19.71%	96	5,384	545	54	**5,983**
	DEXA Scan	357	509	866	58.78%	108	178	21	0	**199**
Physiological Measurement	Audiology - audiology assessments	25	2	27	7.41%	0	21	0	0	**21**
	Cardiology - echocardiography	0	0	0	-	-	0	0	0	**0**
	Neurophysiology - peripheral neurophysiology	59	0	59	0.00%	0	74	0	0	**74**
	Respiratory physiology - sleep studies	52	1	53	1.89%	1	80	0	0	**80**
	Urodynamics - pressures & flows	18	76	94	80.85%	38	15	0	0	**15**
Endoscopy	Colonoscopy	237	355	592	59.97%	218	270	0	0	**270**
	Flexi sigmoidoscopy	79	139	218	63.76%	65	61	0	0	**61**
	Cystoscopy	39	9	48	18.75%	4	115	0	0	**115**
	Gastroscopy	135	231	366	63.11%	95	227	0	0	**227**
Total		**7,449**	**3,680**	**11,129**	**33.07%**	**960**	**11,953**	**1,458**	**1,442**	**14,853**

Domain	Metric	2020-21 Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Trend
Stroke	Trust SSNAP grade	A	B	B	B	C	C	C	C	C	C	tbc	tbc	tbc	
	% of patients discharged with a diagnosis of Atrial Fibrillation and commenced on anticoagulants	80%	100.0%	100.0%	100.0%	88.9%	100.0%	100.0%	80.0%	87.5%	71.4%	100.0%	100.0%	85.7%	
	4-hours direct to Stroke unit from ED Actual	63%	55.0%	73.8%	66.7%	67.9%	69.9%	50.7%	54.0%	56.5%	52.0%	48.3%	28.1%	49.3%	
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	63%	55.6%	74.6%	68.8%	69.1%	69.9%	54.5%	55.3%	56.9%	52.1%	50.9%	29.5%	48.5%	
	Number of confirmed Strokes in-month on SSNAP	-	57	65	71	58	73	75	53	71	83	64	66	70	
	If applicable at least 90% of patients' stay is spent on a stroke unit	80%	94.6%	90.8%	92.6%	91.1%	89.0%	89.0%	86.5%	84.3%	87.7%	88.5%	92.3%	97.1%	
	Urgent brain imaging within 60 minutes of hospital arrival for suspected acute stroke	50%	59.6%	56.9%	61.4%	46.6%	56.2%	45.3%	45.3%	71.8%	55.4%	57.8%	47.0%	52.9%	
	Scanned within 12-hours - all Strokes	100%	94.7%	98.5%	95.7%	100.0%	94.5%	96.0%	92.5%	100.0%	100.0%	98.3%	97.0%	95.7%	
	% of all stroke patients who receive thrombolysis	11%	14.5%	18.8%	11.4%	15.5%	9.6%	5.3%	5.7%	23.2%	11.0%	11.3%	10.6%	5.7%	
	% of patients eligible for thrombolysis to receive the intervention within 60 minutes of arrival at A&E (door to needle time)	70%	0.0%	8.3%	37.5%	44.4%	28.6%	25.0%	0.0%	62.5%	77.8%	71.4%	85.7%	25.0%	
	Discharged with JCP	80%	83.8%	82.1%	93.3%	97.2%	93.3%	92.3%	79.4%	93.3%	92.6%	94.7%	85.0%	91.3%	
	Discharged with ESD	40%	69.0%	54.5%	52.1%	56.1%	56.3%	64.9%	40.0%	49.0%	69.2%	76.7%	80.0%	62.5%	

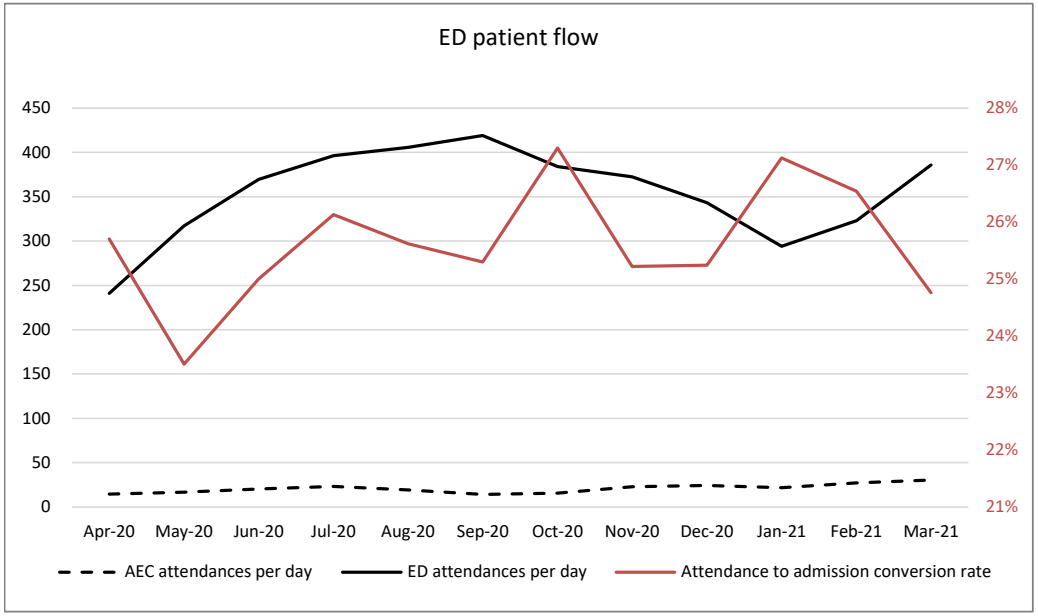
Breaches Mar 21	Breach reasons			Breach Reasons: 36
		• Challenging Diagnosis/Complex Patients = 12 • Late referral = 4	• Bed Capacity = 6 • Inpatient Stroke = 1 • COVID-19 Amber, Black, POC = 7 • Operational = 4	

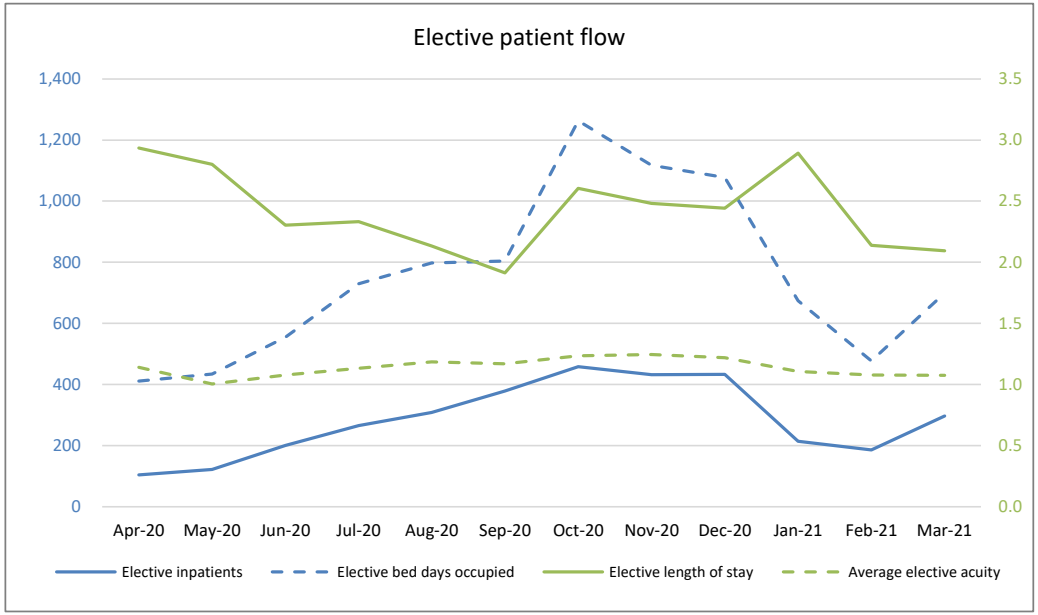
Responsive Services

East and North Hertfordshire NHS Trust

Patient Flow

Domain	Metric	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Trend
Emergency Department Flow Indicators	A&E & UCC attendances	7,228	9,838	11,091	12,289	12,578	12,580	11,904	11,173	10,639	9,119	9,044	11,955	
	Attendance to admission conversion rate	25.7%	23.5%	25.0%	26.1%	25.6%	25.3%	27.3%	25.2%	25.2%	27.1%	26.5%	24.8%	
	ED attendances per day	241	317	370	396	406	419	384	372	343	294	323	386	
	AEC attendances per day	15	17	20	23	19	14	15	23	24	22	27	31	
	4-hour target performance %	78.0%	83.4%	88.1%	90.1%	87.1%	84.8%	84.5%	82.4%	78.2%	75.2%	78.8%	85.2%	
	Time to initial assessment 95th centile	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	
	Ambulance handover breaches 30-minutes	316	235	76	242	285	317	350	507	634	467	327	274	

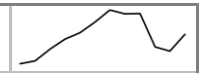
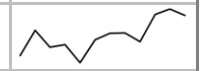
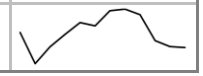
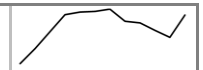
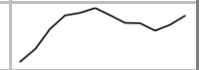
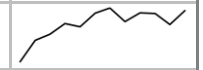
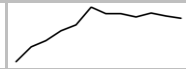
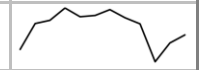




Responsive Services

East and North Hertfordshire NHS Trust

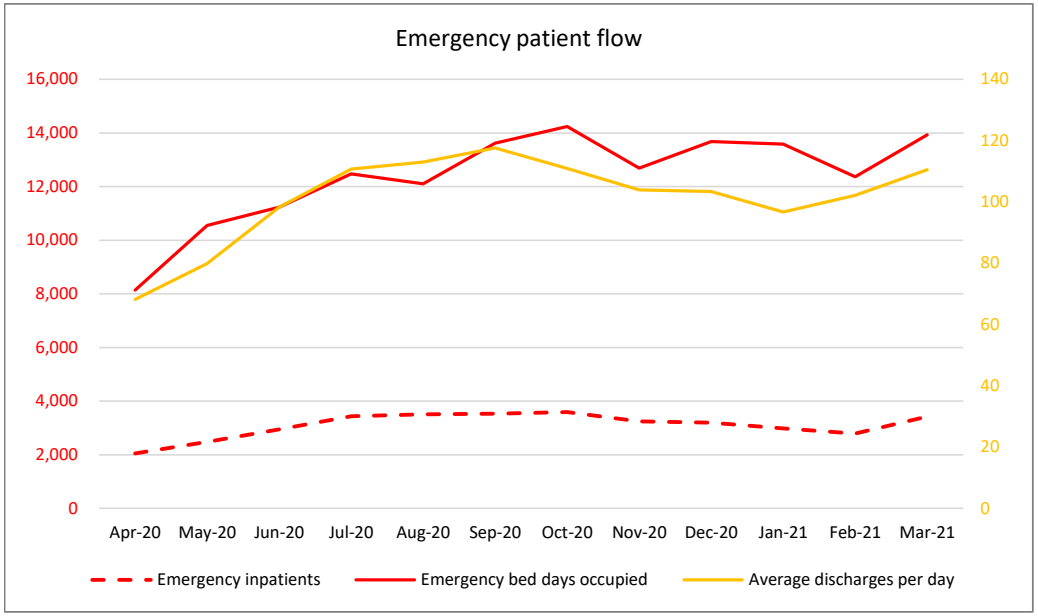
Patient Flow

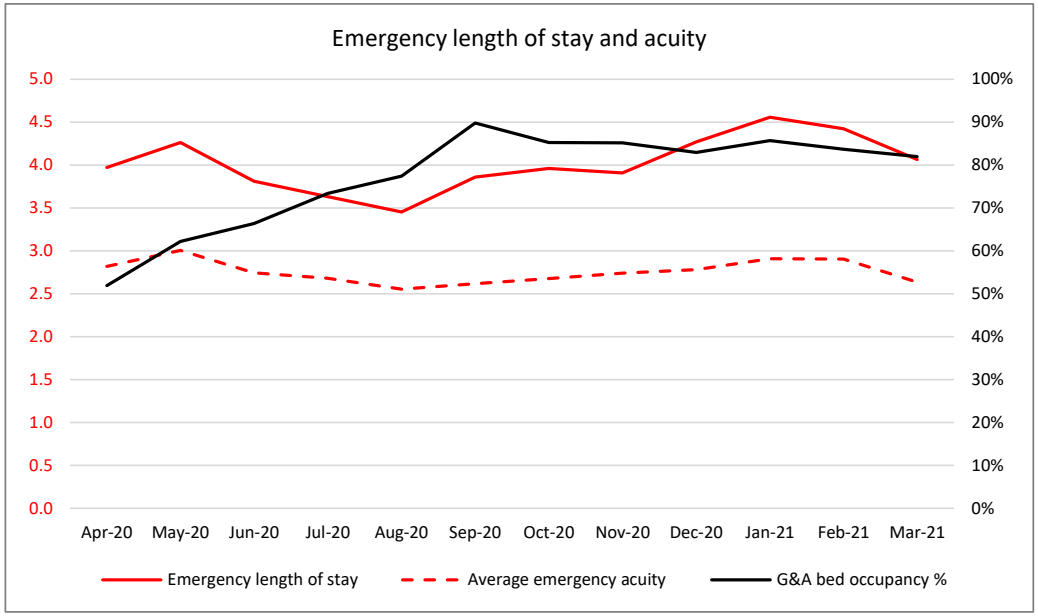
Domain	Metric	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Trend
Elective Inpatient Flow Indicators	Elective inpatients	104	122	200	265	308	378	458	432	433	214	186	297	
	Elective bed days occupied	411	434	555	730	798	804	1,263	1,117	1,077	674	477	699	
	Elective length of stay	2.9	2.8	2.3	2.3	2.1	1.9	2.6	2.5	2.4	2.9	2.1	2.1	
	Daycase rate %	85.9%	87.9%	86.6%	86.8%	85.3%	87.1%	87.7%	87.7%	87.0%	89.2%	89.6%	89.1%	
	Average elective acuity	1.14	1.00	1.08	1.13	1.18	1.17	1.24	1.24	1.22	1.11	1.08	1.07	
Emergency Flow Indicators	Emergency inpatients	2,047	2,477	2,947	3,433	3,503	3,529	3,595	3,246	3,202	2,981	2,794	3,425	
	Average discharges per day	68	80	98	111	113	118	111	104	103	97	102	110	
	Emergency bed days occupied	8,134	10,556	11,232	12,471	12,102	13,622	14,242	12,692	13,676	13,588	12,361	13,926	
	Emergency length of stay	4.0	4.3	3.8	3.6	3.5	3.9	4.0	3.9	4.3	4.6	4.4	4.1	
	Average emergency acuity	2.8	3.0	2.7	2.7	2.6	2.6	2.7	2.7	2.8	2.9	2.9	2.6	
	G&A bed occupancy %	52%	62%	66%	73%	77%	90%	85%	85%	83%	86%	84%	82%	
	Patients discharged via Discharge Lounge	310	467	488	564	509	518	554	504	465	234	348	398	
	Discharges before midday	11.7%	12.2%	13.7%	11.8%	11.7%	10.8%	9.6%	10.4%	10.2%	9.9%	11.3%	10.5%	
	Weekend discharges	14.2%	15.6%	12.9%	13.9%	15.8%	14.7%	16.8%	15.0%	13.9%	16.3%	13.0%	14.3%	
	Proportion of beds occupied by patients with length of stay over 14 days	13.6%	18.4%	17.7%	15.2%	15.9%	19.0%	18.4%	17.9%	19.3%	19.4%	20.4%	18.24%	
	Proportion of beds occupied by patients with length of stay over 21 days	6.8%	9.1%	9.6%	7.0%	7.4%	10.4%	9.8%	8.5%	9.5%	9.4%	10.8%	9.07%	

Responsive Services

East and North Hertfordshire NHS Trust

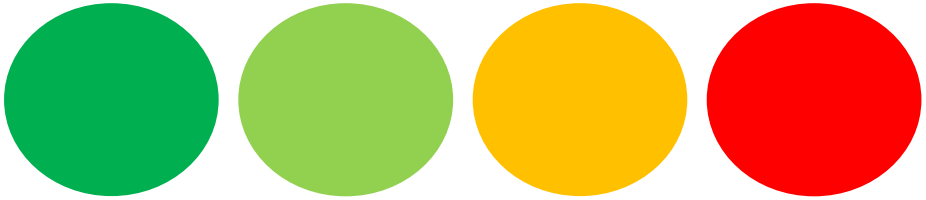
Patient Flow





Well-led Services

Month 12 | 2020-21



Key Issues

Work

- Vacancy position is at a historic low at 2.6% overall against a target of 6% – 157 vacancies, 37 of which are registered nurses/midwives.
- There are 404 additional people in post now than there were 12 months ago, with 146 of these being registered nurses/midwives.
- 88 CSWs started with the trust so far this year with a further 29 awaiting placements.
- NHSE/I agency spend ceiling was £1.8m ahead of target.
- Nursing & Midwifery staff unavailability remains high at 31.9% against a budget of 21%, this due high levels of sickness absence and annual leave being used at the end of the financial year.

Grow

- Statutory and mandatory training compliance declined slightly to 84.4%.
- Appraisal rate remains at 57%.
- Education and training time has restarted.

Thrive

- Staff turnover has significantly reduced from 11.8% to 11.2% and is 1% below target
- Staff survey results have been released. There has been an improvement in 5 of the 10 themes and a decline in 2.
- 3 themes are below average against comparators are Bullying &Harassment, Equality Diversity and Inclusion and Safety Culture.
- There has been a significant improvement in the score for health and wellbeing against last years staff survey score.
- Performance has dropped against the model employer targets set for BAME representation at senior levels. The target increases in the new calendar year and the Trust are meeting the expectations in 4 out of the 6 categories.

Care

- Sickness absence rate reduced to 3.84% compared to 5.17% in February.
- Although the sickness absence overall has reduced this is primarily due to a reduction in short term sickness related to covid and levels of MSK absence while absences related to mental health remain high.

Executive Response

Work

- Currently targeting 97 student nurses who qualify in Summer 2021 – with 27 applications received so far. Regular symposiums are held with students to encourage them to apply and to ask questions.
- Work on improving the quality of hires has begun with the implementation of a values based screening tool as well as psychometric assessments for senior/consultant role..
- Analysis and learning from the implementation of Inclusion Ambassadors as part of the recruitment and selection process is planned to be submitted to first Inclusion Board in May 2021.

Grow

- Education and training has restarted with Statutory and Mandatory training a priority. Divisional and Capability recovery plans have been discussed to deliver compliance, however it is recognised this will require a significant number of staff hours to achieve.
- The implementation of the new learning management system named ENH Academy continues and is on track for launch in April 2021.
- A refresh of all statutory, mandatory and essential training progressing to improve the quality of learning and experience for all users.
- CSW and OSCE nursing training continues at pace to hit trust and NHSEI targets.

Thrive

- The Executive team have approved the creation of an equalities and inclusion committee as a subcommittee to the Board. This committee will have the sole purpose of overseeing delivery of inclusivity for our people and patients. Approval will be sought at the May 2021 Board with the inaugural meeting due to be held later that month.
- A series of community engagement events have been held to review the outcomes in Equality Delivery Standards a full report of findings and grading will be shared with the Inclusion Board in May 2021.
- Focus on inclusion and specifically the achievement of the model employer targets has been made a key principle with the development of the integrated strategic business plan. Each service like will look at the workforce models, recruitment and development plans to ensure they are focused on the achievement of the targets.
- Staff forums continue virtually to enable staff to raise concerns about the workplace in a safe environment. Work is ongoing to increase attendance and representation.
- The staff shielding group continues to meet to provide peer support to those who have returned to work from shielding over the last 12 months.

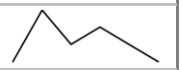
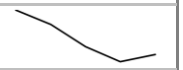
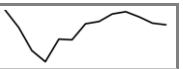
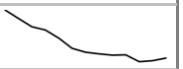
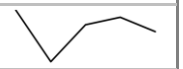
Care

- Pyramid of health and wellbeing debrief sessions continueshowever uptake needs to be improved. Work is being completed to increase marketing, engage senior leaders and implement improvements such as time changes and food being provided.
- Well-being 1 to 1's are continuing with all staff, improving the position from 85 to 89% in the last month.
- Guidance and tool kits have been developed to support staff who are shielding back to work in a safe and supportive way. Support is being provided to managers to ensure consistent and compassionate conversations take place.
- A task group is working with managers and offering support in completing Health at Work referrals to support individuals return to work.
- The Trust has now achieved 89% of staff receiving a COVID-19 vaccine. The vaccine centre on site will now be temporarily closed down however the Health and Work team will continue to promote and offer vaccines.

Well-led Services

Staff and Workforce Development

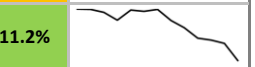
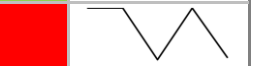
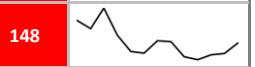
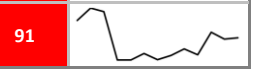
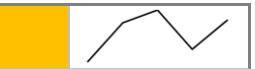
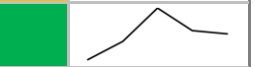
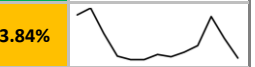
East and North Hertfordshire NHS Trust

Domain	Metric	Target	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Trend
Work	Vacancy Rate	6%	6.3%	6.9%	5.9%	5.5%	4.9%	5.7%	5.7%	5.7%	5.7%	5.3%	5.7%	4.3%	2.6%	
	Time to hire (weeks)	10	13.0	9.6	12.9	13.0	13.0	13.0	12.0	12.0	13.0	9.0	11.0	10.0	10.0	
	Recruitment experience	4	4.6	4.5	4.5	4.5	4.5	4.6	4.3	4.4	4.7	4.5	4.6	4.5	4.4	
	Relative likelihood of white applicant being shortlisted and appointed over BAME applicant	1	1.00	1.30			1.40			1.40			2.00			
	Relative likelihood of non-disabled applicant being shortlisted and appointed over disabled applicant	1	1.50	1.24			0.84			0.57			0.70			
	Agency Spend (% of WTE)	4%	4.1%	3.6%	3.2%	2.7%	3.6%	3.0%	3.3%	4.3%	3.5%	3.4%	3.2%	3.3%	3.5%	
	Bank Spend (% of WTE)	10%	12.7%	10.9%	8.2%	8.0%	9.6%	9.2%	7.9%	9.7%	9.9%	10.5%	11.6%	8.6%	10.4%	
	% of staff on eRoster	> 90%	49.0%	62.0%	62.0%	63.0%	63.0%	63.0%	64.0%	64.0%	65.0%	65.0%	64.0%	65.0%	66.0%	
	% of fully approved rosters in advance of 8 weeks	60%	26.6%	26.7%	33.6%	31.8%	21.3%	16.7%	25.0%	22.4%	22.1%	22.5%	22.7%	15.5%	22.8%	
	% of actual clinical unavalibility vs % of budgeted clinical unavailability (headroom) - Nursing & Midwifery ONLY	< 21%	29.8%	39.9%	36.2%	31.6%	27.3%	26.6%	26.3%	23.2%	26.6%	27.0%	32.5%	31.2%	31.9%	
	Pulse survey Flexibility	55%	52.0%	55.5%			59.5%			56.0%			60.0%			
Grow	Statutory & mandatory training compliance rate	90%	87.2%	84.0%	79.6%	77.5%	81.8%	81.6%	84.6%	85.1%	86.5%	86.9%	85.9%	84.8%	84.4%	
	Appraisal rate	90%	78.6%	75.0%	71.5%	70.2%	66.8%	62.5%	61.0%	60.2%	59.7%	59.8%	57.0%	57.3%	58.5%	
	Pulse survey Training and development opportunities	55%	55.0%	48.1%			53.0%			54.0%			52.1%			
	Pulse survey Talent management	55%	50.0%	53.1%			47.1%			55.0%			51.3%			
	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)	57	0	0	0	0	tbc	tbc							

Well-led Services

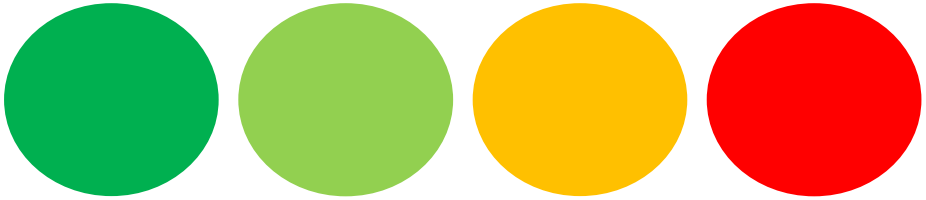
Staff and Workforce Development

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Trend
Thrive	Pulse survey My leader	75%	79.9%	77.9%			81.4%			87.0%			79.8%			
	Pulse survey Harnessing individuality	60%	51.7%	60.8%			59.8%			59.0%			57.7%			
	Pulse Survey Not experiencing discrimination	95%	62.2%	71.0%			72.2%			90.5%			68.4%			
	Turnover Rate	12.2%	12.9%	12.9%	12.8%	12.6%	12.9%	12.8%	12.9%	12.5%	12.3%	12.0%	11.9%	11.8%	11.2%	
	Model employer targets (% achieved)	100%	83%	83%			66%			83%			67%			
	Average length of suspension (days)	20	63	62	70	0	0	0	0	29	60	22.5	33	43	37	
	Average length of Disciplinary (excluding suspensions) (days)	60	248	212	304	183	111	102.5	158	154	87	74.3	96	102	148	
	Average length of Grievance (including dignity at work) (days)	60	163	214	199	0	0	28	2	20	46	22	114	86	91	
Care	Pulse survey Well-being	70%	43.5%	67.0%			74.8%			51.0%			68.6%			
	Pulse survey Reasonable adjustments	50%	39.2%	67.5%			67.4%			74.0%			60.4%			
	Staff FFT Recommend as a place to work	60%	37.3%	47.7%			51.1%			61.0%			47.8%			
	Staff FFT Recommend as a place of care	70%	64.6%	69%			76.0%			71.0%			70.3%			
	Sickness Rate	3.8%	6.79%	7.28%	5.51%	3.96%	3.72%	3.72%	4.07%	3.92%	4.23%	4.69%	6.69%	5.17%	3.84%	
	Sickness FTE Days Lost	6,777	11,528	12,002	9,504	6,649	6,543	6,490	6,861	6,863	7,183	8,270	11,825	8,357	7,005	
	Mental health related absence (days lost)	1,650	1,253	1,620	1,640	1,794	1,889	1,643	1,799	1,981	1,725	1,716	1,743	1,691	1,684	

Sustainable Services

Month 12 | 2020-21



Key Issues

- 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 final Month 12 financial performance is reported against the approved plan. The Year End I&E position reports a surplus of £2,526k. This full year 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 £42.6m across the year.
- The Trust anticipates submitting its draft accounts to the Department of Health by the 27th April 2021, and the external audit review of those accounts will commence in early May.
- The final year end position reflects the impact of an estimate of the costs of untaken staff annual leave as a result of the inpact of the pandemic. This accural totalled £4.2m and has been backed by central funding. The Trust has also recieved funding in March to address the loss of Category C income that iy has experienced across the year again as a result of COVID. This reimbursement was higher than expected levels.
- A&E activity levels increased significantly during March, although this only represents a return to 85% of normal pre pandemic levels. Similarly Emergency inpatient activity levels and occupied bed also increased compared with February but remain around 20% lower than pre COVID-19 norms. 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 fell sharply in March reflecting the significant reductions in COVID-19 + patients admitted.
- During the course of March the volumes of planned elective activity undertaken by the Trust increased as the impact of the pandemic eased. Although levels delivered well below normal levels
- NHSE has confirmed that the terms of the national Elective Incentive Scheme have been varied to ensure that providers are not penalised as a consequence of reductions in elective volumes that have resulted from the pandemic.
- 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 had introduced expanded capital project monitoring arrangements to ensure the effective utilisation of these funds within the context of extremely challenging timeframes. The final year end position of total capital spend of £32.5m is within approved limits.

Executive Response

- The Trust has across 20/21 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.
- The Trust has also during 20/21 refined and developed its financial reporting arrangements to provide additional granularity in respect of the value and type of variable 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 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 monthly Divsional 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 in April. 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 component 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

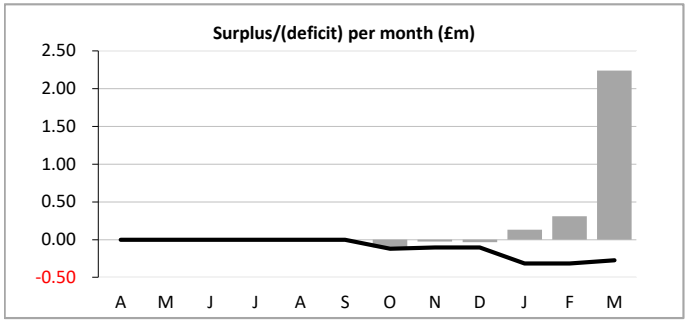
Domain	Metric	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Trend	Plan YTD	Actual YTD	Variance YTD
I&E Performance	SLA Income Earned	36.2	36.2	36.2	36.2	35.9	36.2	36.4	36.5	36.5	37.1	36.0	37.3		431.6	436.6	5.0
	Other Income Earned	2.3	2.5	2.2	2.5	2.5	2.8	2.9	3.1	2.6	2.9	2.9	10.0		39.2	39.2	0.0
	Pay Costs	26.2	25.7	24.9	25.4	25.5	26.8	26.6	26.6	27.2	27.1	26.6	31.6		314.5	320.2	5.7
	Non Pay Costs inc Financing	14.9	14.4	15.2	16.2	15.9	17.0	17.0	17.2	16.4	17.2	16.3	17.9		191.6	195.7	4.1
	Underlying Surplus / (Deficit)	-2.6	-1.4	-1.8	-3.0	-3.0	-4.8	-4.3	-4.3	-4.4	-4.3	-4.0	-2.1		-35.3	-40.1	-4.8
	Top up payments	2.6	1.4	1.8	3.0	3.0	4.8	4.2	4.2	4.4	4.4	4.3	4.4		34.1	42.6	8.6
	Retained Surplus / Deficit	-0.00	0.00	-0.00	-0.00	-0.00	-0.00	-0.10	-0.02	-0.03	0.13	0.31	2.24		-1.23	2.53	3.8
Paybill Metrics	Substantive Pay Costs	22.6	22.4	22.3	22.1	22.3	23.8	22.8	22.8	23.2	22.0	23.4	27.8		287.5	277.4	-10.1
	Premium Pay Costs Overtime & WLI	0.2	0.1	0.0	0.0	0.1	0.1	0.2	0.3	0.3	0.3	0.1	0.0		5.2	1.6	-3.6
	Premium Pay Costs Bank Costs	2.6	2.3	2.0	2.4	2.3	2.1	2.6	2.6	2.8	3.7	2.3	3.0		16.6	30.6	14.1
	Premium Pay Costs Agency Costs	0.9	0.8	0.7	0.9	0.8	0.9	1.1	0.9	0.9	1.2	0.8	0.8		5.2	10.5	5.4
	Premium Pay Costs As % of Paybill	14.0%	12.7%	10.7%	13.0%	12.4%	11.1%	14.3%	14.4%	14.7%	18.9%	12.2%	11.9%		8.6%	13.4%	4.8%

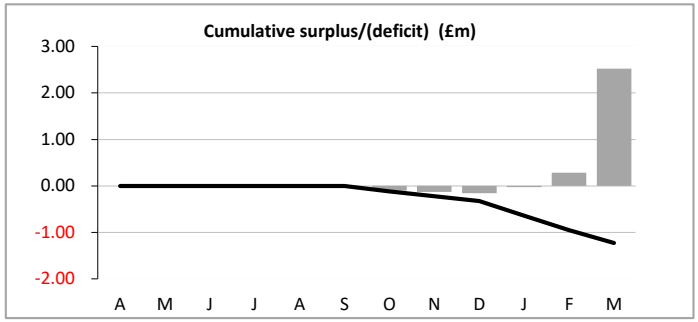
Sustainable Services

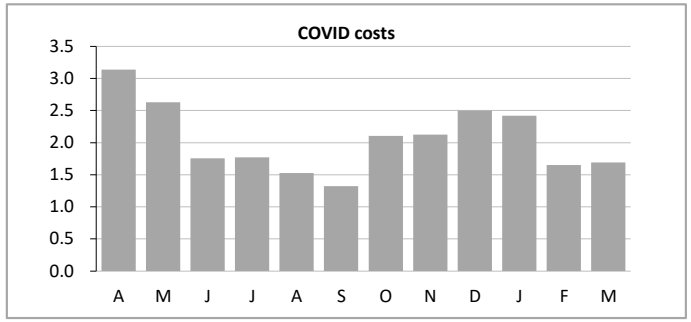
Finance Plan Performance

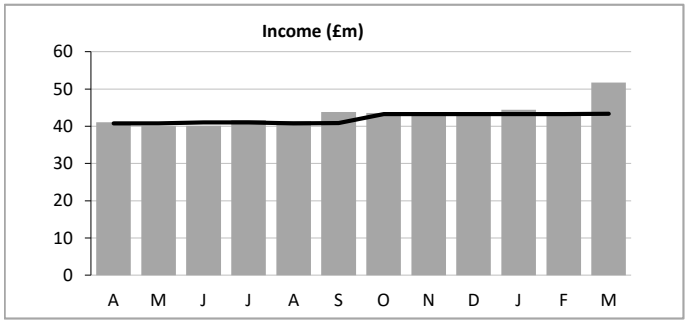
East and North Hertfordshire NHS Trust

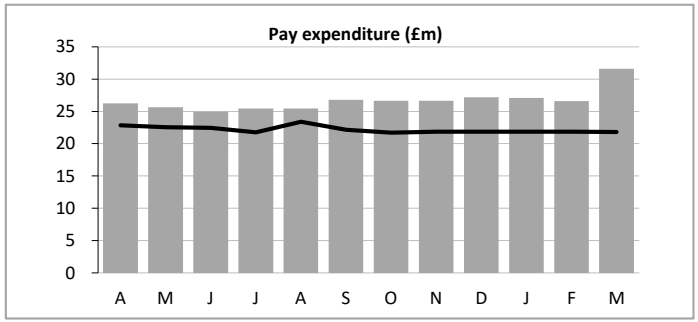
Domain	Metric	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Trend	Plan YTD	Actual YTD	Variance YTD
Single Oversight Framework	Capital Servicing Capacity	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		1	N/A	
	Liquid Ratio (Days)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		1	N/A	
	I&E Margin	N/A	N/A	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	N/A	N/A	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	N/A	N/A	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	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		1	N/A	

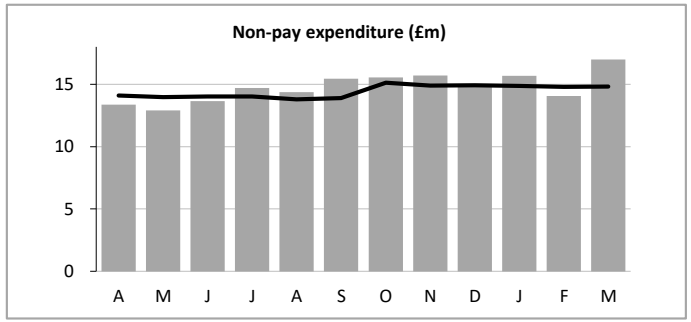












Sustainable Services

SLA Contracts - Income Performance

East and North Hertfordshire NHS Trust

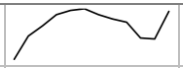
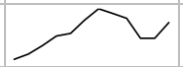
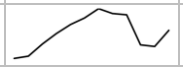
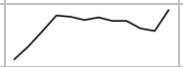
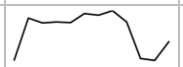
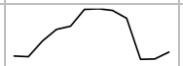
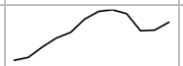
		In-Month			YTD		
		Planned Income	Actual Income	Income Variance	Planned Income	Actual Income	Income Variance
By Point of Delivery	A&E Attendances	2,329	2,247	-82	27,945	23,284	-4,662
	Daycases	3,091	2,121	-970	37,094	22,132	-14,962
	Inpatient Elective	1,918	1,178	-740	23,014	13,411	-9,603
	Inpatient Non Elective	9,712	8,691	-1,021	116,543	97,538	-19,005
	Maternity	2,546	2,677	131	30,553	29,660	-893
	Other	3,684	3,913	229	44,207	42,332	-1,876
	Outpatient First	2,106	1,707	-399	25,270	19,776	-5,494
	Outpatient Follow Ups	2,274	2,424	150	27,289	25,469	-1,821
	Outpatient Procedures	1,156	1,025	-131	13,872	10,096	-3,776
	NHSE Block Impact	-499	2,917	3,416	-4,671	59,750	64,421
	Other SLAs	65	65	0	775	775	0
	Block	843	843	0	10,113	10,113	0
	Drugs & Devices	3,843	5,070	1,227	45,150	48,472	3,323
	Chemotherapy Delivery	607	720	114	7,278	6,945	-334
	Radiotherapy	1,216	1,053	-163	14,589	12,503	-2,086
	Renal Dialysis	1,182	1,198	16	14,184	13,865	-320
	Total	36	38	2	433	436	3

		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	259,614	259,614	-0
	Specialist Commissioning	8,167	9,199	1,031	98,007	98,201	194
	Bedfordshire CCG	2,486	2,486	0	29,833	29,833	-0
	Herts Valleys CCG	1,404	1,404	-0	16,846	16,846	-0
	Cancer Drugs Fund	587	950	362	6,081	9,096	3,015
	Luton CCG	326	326	0	3,913	3,913	0
	PH - Screening	379	187	-192	4,546	1,818	-2,728
	Other	1,087	1,662	575	14,365	16,796	2,432
	Total	36,071	37,848	1,777	433,205	436,118	2,913
By Division	Cancer Services	6,811	8,139	1,329	80,761	82,266	1,505
	Unplanned Care	-656	2,917	3,573	205,878	180,975	-24,902
	Planned Care	12,760	10,740	-2,020	153,123	113,136	-39,987
	Other	17,156	16,052	-1,105	-6,556	59,741	66,297
	Total	36,071	37,848	1,777	433,205	436,118	2,913

Sustainable Services

Activity and Productivity

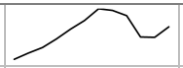
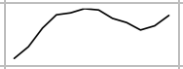
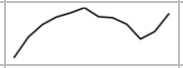
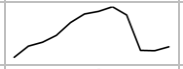
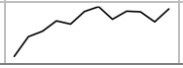
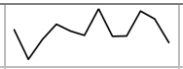
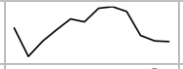
East and North Hertfordshire NHS Trust

Domain	Metric	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Trend	Plan YTD	Actual YTD	Var YTD
Patient Activity Levels	A&E & UCC	6,656	9,155	10,251	11,423	11,873	12,080	11,432	10,984	10,632	8,951	8,840	11,769		160,734	124,046	-36,688
	Chemotherapy Atts	1,631	1,634	2,192	2,354	2,147	2,343	2,313	2,315	2,689	2,232	2,268	2,759		27,233	26,877	-356
	Critical Care (Adult) - OBD's	700	728	488	512	737	467	631	649	870	1,170	1,117	731		7,402	8,800	1,398
	Critical Care (Paeds) - OBD's	448	509	434	546	494	358	580	584	339	268	372	492		6,659	5,424	-1,235
	Daycases	852	1,127	1,551	2,051	2,174	2,848	3,447	3,205	2,949	1,920	1,926	2,730		47,489	26,780	-20,709
	Elective Inpatients	140	155	241	313	374	420	485	450	441	233	223	334		6,740	3,809	-2,931
	Emergency Inpatients	2,483	2,975	3,554	4,149	4,097	3,974	4,074	3,933	3,936	3,652	3,556	4,371		51,385	44,754	-6,631
	Home Dialysis	147	140	139	150	193	165	165	163	155	148	139	176		1,984	1,880	-104
	Hospital Dialysis	7,310	7,569	7,576	7,755	7,078	7,160	7,522	6,977	7,521	7,215	6,673	7,557		77,319	87,913	10,594
	Maternity Births	393	443	445	443	433	418	436	408	368	437	350	448		5,305	5,022	-283
	Maternity Bookings	517	468	498	550	467	480	535	490	609	546	533	583		6,006	6,276	270
	Outpatient First	3,033	5,961	5,631	5,703	5,659	6,282	6,175	6,496	5,698	3,145	3,018	4,334		107,167	61,135	-46,032
	Outpatient Follow Up	6,549	6,463	9,311	11,385	11,948	14,965	15,126	14,801	13,378	5,977	6,012	7,277		207,397	123,192	-84,205
	Outpatient procedures	1,725	2,037	3,128	4,065	4,629	6,010	6,804	7,008	6,570	4,788	4,859	5,680		88,895	57,303	-31,592
	Radiotherapy Fractions	4,766	4,478	4,297	4,027	3,520	3,991	3,459	3,503	4,321	3,583	3,585	4,233		59,375	47,761	-11,614

Sustainable Services

Activity and Productivity

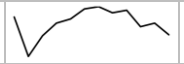
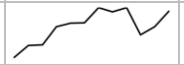
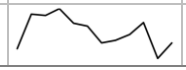
East and North Hertfordshire NHS Trust

Domain	Metric	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Trend	Plan YTD	Actual YTD	Var YTD
Throuhput	Elective Spells per Working Day	52	67	81	103	127	149	179	174	161	108	107	133		214	121	-93
	Emergency Spells per Day	65	76	94	107	109	113	112	103	99	92	96	106		140	122	-18
	ED Attendances per Day	222	295	342	368	383	403	369	366	343	289	316	380		439	339	-100
	Outpatient Atts per Working Day	595	761	821	920	1,112	1,239	1,278	1,348	1,221	696	694	752		1,595	955	-640
	Elective Bed Days Used	411	434	555	730	798	804	1,263	1,117	1,077	674	477	699		15,900	9,039	-6,861
	Emergency Bed Days Used	8,134	10,556	11,232	12,471	12,102	13,622	14,242	12,692	13,676	13,588	12,361	13,926		189,591	148,602	-40,989
Efficiency	Admission Rate from A&E	26%	24%	25%	26%	26%	25%	27%	25%	25%	27%	27%	25%		23.3%	25.6%	2.3%
	Emergency - Length of Stay	4.0	4.3	3.8	3.6	3.5	3.9	4.0	3.9	4.3	4.6	4.4	4.1		3.1	4.0	0.9
	Emergency - Casemix Value	2,819	3,005	2,744	2,683	2,556	2,620	2,678	2,740	2,783	2,909	2,907	2,635		2,297	2,757	460
	Elective - Length of Stay	2.9	2.8	2.3	2.3	2.1	1.9	2.6	2.5	2.4	2.9	2.1	2.1		2.1	2.4	0.3
	Elective - Casemix Value	1,140	1,004	1,077	1,131	1,184	1,170	1,235	1,244	1,219	1,105	1,078	1,075		1,105	1,139	34
	Elective Surgical DC Rate %	85.9%	87.9%	86.6%	86.8%	85.3%	87.1%	87.7%	87.7%	87.0%	89.2%	89.6%	89.1%		85%	87%	2.5%
	Outpatient DNA Rate % - 1st	6.7%	5.6%	6.5%	7.9%	6.7%	6.0%	6.7%	7.8%	6.5%	8.3%	7.1%	7.0%		6.5%	6.9%	0.5%
	Outpatient DNA Rate % - FUP	7.0%	6.1%	6.5%	7.9%	6.7%	6.0%	6.7%	7.8%	6.5%	8.3%	7.1%	7.0%		7.5%	6.9%	-0.6%
	Outpatient Cancel Rate % - Patient	7.8%	4.8%	4.0%	3.9%	5.6%	6.6%	7.8%	8.0%	8.6%	7.2%	5.1%	4.9%		10.4%	6.4%	-4.0%

Sustainable Services

Activity and Productivity

East and North Hertfordshire NHS Trust

Domain	Metric	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Trend	Plan YTD	Actual YTD	Var YTD
Efficiency	Outpatient Cancel Rate % - Hosp	41.7%	44.8%	33.1%	22.5%	13.1%	11.8%	8.8%	8.3%	7.4%	11.8%	11.4%	8.9%		6.9%	16.2%	9.3%
	Outpatients - 1st to FUP Ratio	2.2	1.1	1.7	2.0	2.1	2.4	2.4	2.3	2.3	1.9	2.0	1.7		1.9	2.0	0.1
	Theatres - Ave Cases Per Hour	1.2	1.5	1.5	1.9	2.0	2.0	2.3	2.2	2.3	1.7	1.9	2.2		2.9	1.9	-1.0
	Theatres - Utilisation of Sessions	67%	75%	74%	75%	75%	78%	82%	82%	82%	80%	85%	90%		85%	79%	-6%
	Theatres - Ave Late Start (mins)	29	31	22	24	24	22	19	17	16	17	17	15		27	21	-5.5
	Theatres - Ave Early Finishes (mins)	36	66	65	71	58	56	41	43	48	59	27	41		39	51	11.5

Sustainable Services

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

East and North Hertfordshire NHS Trust

Activity Measures	2019-20 YTD	2020-21 YTD	Change
Emergency Department Attendances	156,439	124,046	-32,393
Emergency Department Ave Daily Atts	429	340	-89
Admission Rate from ED %	24.2%	25.6%	1%
Non Elective Inpatient Spells	50,435	37,179	-13,256
Ave Daily Non Elective Spells	138	102	-36
Daycase Spells	42,745	26,780	-15,965
Elective Inpatient Spells	6,380	3,809	-2,571
Ave Daily Planned Spells	135	84	-51
Day Case Rate	87%	88%	1%
Adult & Paeds Critical Care Bed Days	13,231	14,224	993
Outpatient First Attendances	106,262	61,135	-45,127
Outpatient Follow Up Attendances	205,247	123,192	-82,055
Outpatient First to Follow Up Ratio	1.9	2.0	0.1
Outpatient Procedures	86,469	57,303	-29,166
Ave Daily Outpatient Attendances	1,090	662	-428

Workforce Measures	2019-20 YTD	2020-21 YTD	Change
Average Monthly WTE's Utilised	5,894	6,121	227
Average YTD Pay Cost per WTE	45,948	47,162	2.6%
Staff Turnover	12.8%	12.5%	-0.4%
Vacancy WTE's	822	731	-91
Vacancy Rate	13.3%	12.0%	-1.3%
Sickness Days Lost	73,939	90,548	16,609
Sickness Rate	4.3%	4.8%	0.5%
Agency Spend- £m's	10.9	9.8	-1.2
Temp Spend as % of Pay Costs	4.0%	3.4%	-0.7%
Ave Monthlty Consultant WTE's Worked	332.3	350.1	17.9
Consultant : Junior Training Doctor Ratio	1 : 1.7	1 : 1.7	0.0
Ave Monthly Nursing & CSW WTE's Worked	2,466.8	2,532.3	65.5
Qual ; Unqualified Staff Ratio	26 : 10	25 : 10	-0.0
Ave Monthly A&C and Senior Managers WTE's	1,304	1,341	37
A&C and Senior Managers % of Total WTE's	22.1%	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	3.8	4.0	0.2
Elective LoS	2.5	2.4	-0.1
Occupied Bed Days	16,537	157,641	141,104
Adult Critical Care Bed Days	7,300	8,800	1,500
Paediatric Critical Care Bed Days	5,931	5,424	-507
Outpatient DNA Rate	8%	6%	-1.5%
Outpatient Utilisation Rate	30%	27%	-3.0%
Total Cancellations	135,117	59,695	-75,422
Theatres - Ave Cases per Hour	2.7	1.9	-0.8
Theatres - Ave Session Utilisation	82%	79%	-3.7%
Theatres - Ave Late Start (mins)	20	21	1
Theatres - Ave Early Finishes (mins)	39.0	50.9	12
Radiology Examinations	409,610	333,460	-76,150
Drug Expenditure (excl HCD & ENH Pharma) - £000s	9,038	9,163	126
High Cost Drug Expenditure - £000s	43,844	47,916	4,072

Finance & Quality Measures	2019-20 YTD	2020-21 YTD	Change
Profitability - £000s	826	3,353	2,526.8
Monthly SLA Income £000s	34,881	36,385	1,504
Monthly Clinical Income per Consultant WTE	£104,624	£103,785	-£839
High Cost Drug Spend per Consultant WTE	£131,505	£136,675	£5,170
Average Income per Elective Spell	£1,131	£1,139	£8
Average Income per Non Elective Spell	£2,305	£2,757	£452
Average Income per ED attendance	£174	£188	£14
Average Income per Outpatient Attendance	£131	£127	-£4
Ave NEL Coding Depth per Spell	6.2	7.3	1.1
Procedures Not Carried Out	2,156	1,355	-801
Best Practice HRGs (% of all Spells)	2.9%	4.1%	1.2%
Ambulatory Best Practice (% of Short Stays)	n/a	n/a	n/a
Non-elective re-admissions within 30 days Rolling 12-months to Jan-21	11,577	8,298	-3,279
Non-elective re-admissions within 30 days % Rolling 12-months to Jan-21	8.86%	8.60%	-0.26%
SLA Contract Fines - £000's	575	0	-575

Agenda Item: 9

TRUST BOARD - PUBLIC SESSION – 5 MAY 2021

SYSTEM COLLABORATION UPDATE

Purpose of report and executive summary (250 words max):		
The purpose of this paper is to provide an update for the Board on the increasing role of collaboration as a means to support delivery of the Trust's strategic objectives and summarise the breadth of collaboration underway across the Trust to identify and realise benefits of collaboration for patients and our people. The Trust is increasingly engaging in building and developing relationships with a range of partners in order to continue to develop the effectiveness, quality and sustainability of services that the Trust and its partners provide. The increased national focus on collaboration as a key organising principle of the NHS and the ongoing development and strengthening of clinical (and triumvirate) leadership within the organisation is expected to inform the development of refreshed clinical service strategies by providing a platform encompassing Trust-wide and clinically-led identification of collaboration opportunities and needs. The Board is asked to: • note this report • note that this work will continue to be overseen by the Strategy Committee going forwards to receive assurance regarding the strategic alignment of collaboration.		
Action required: For discussion		
Previously considered by: N/A		
Director: **Director of Strategy**	**Presented by:** **Director of Strategy**	**Author:** **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	☒
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) 006/20
Any other risk issues (quality, safety, financial, HR, legal, equality): identified in the paper

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

TRUST BOARD – 5 MARCH 2021
COLLABORATION UPDATE

1. Purpose

The purpose of this paper is to provide an update for the Board on the increasing role of collaboration as a means to support delivery of the Trust's strategic objectives and the breadth of collaboration activities underway across the Trust to identify and realise the benefits of collaboration for patients and our people.

2. Background

This paper builds on an update provided to the Strategy Committee on 20 April 2020 and, whilst of relevance for all of the Trust's strategic objectives, is primarily aligned to work to deliver the organisation's strategic objectives relating to Pathways and Sustainability.

The recent White Paper, "Integration and Innovation: working together to improve health and social care for all" (DHSC, February 2021) further builds on the strategic direction of travel initially set out in the NHS Long Term Plan. The government intends to introduce a new duty to promote collaboration across the healthcare, public health and social care system. Whilst providers are expected to remain statutory organisations, this proposal will place a mandated duty to collaborate on NHS organisations (both ICSs and providers) and local authorities. Providers will be expected to belong to at least one provider collaborative in order to support delivery and resilience of some services across a wider geography.

The more recently published Operating Plan Guidance for 2021/22 (NHSI/E, March 2021) also sets out measures that will mean further development of integrated system working in the context of responding to the ongoing challenges presented by COVID-19, while also restoring services, meeting new care demands and tackling health inequalities. The guidance sets out six priorities for the year ahead, all of which are relevant to the potential role of collaboration:

1. Supporting the health and wellbeing of staff, and taking action on recruitment and retention

2. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19

3. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care, and manage the increasing demand on mental health services

4. Expanding primary care capacity to improve access, local health outcomes and address health inequalities

5. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED) improve timely admission to hospital for ED patients and reduce length of stay

6. Working collaboratively across systems to deliver on these priorities.

3. Update

Collaboration in this strategic context is a mechanism to address a need or realise an opportunity. This section aims to provide a summary, rather than exhaustive, overview of existing and developing collaboration. Individual directors will be able to add further detail to specific areas of collaboration with which they are involved.

The Trust has broad experience of working in partnership with a range of partners through clinical networks , for example critical care, and shared back office services, for example Payroll and Health@Work. The recent White Paper and Planning Guidance however marks a fundamental shift in approach and adoption of collaboration as mechanisms for service development and delivery. Providers will be expected to foster and utilise collaboration as a mechanism to address the Triple Aim (health outcomes, patient experience and system sustainability).

3.1 ICS level collaboration (Hertfordshire and West Essex)

In addition to developing its strategic commissioning role, the ICS has fostered the development of a pan-ICS approach to the recovery and restoration of elective activity and support for staff health and wellbeing in response to the pandemic; both areas where there is a clear benefit to collaborating to optimise recovery, restoration, reduction of unwarranted variation and equity of access. The Trust is also jointly procuring an ICS-wide pathology service across acute and primary care which is expected to facilitate greater pathology resilience, future innovation and, for West Hertfordshire Hospitals Trust and Princess Alexandra Harlow NHS Trust, enabling broader estate development.

3.2 ICP level collaboration (East and North Hertfordshire)

The primary focus of recent collaboration at ICP level has been on collaborative working to build on models adopted during pandemic surges, intended to reduce avoidable admissions to hospitals and/or facilitate earlier discharge in order to reduce acute length of stay and release inpatient capacity. This includes Discharge Home to Assess, Prevention of Admission and development of a virtual ward and remote monitoring to extend out of hospital care for patients.

There is strong strategic alignment in principle between ICP partners for this direction of travel to transform community, urgent and emergency care. Work is underway with both Hertfordshire Community Trust and East & North Hertfordshire CCG to assess and transition these models from pandemic response to sustainable and effective models of care. The effectiveness of this ICP level work and its impact on acute activity and length of stay will be a vital enabler of the Trust's ability during 2021/22 to invest in the Lister Hospital estate by undertaking ward upgrade work.

3.3 Provider collaboration

At provider level the Trust is engaged in a wide range of current and potential collaboration work both within and beyond the ICS. These include exploration of opportunities for joint work with a Primary Care Network, the development of a multi provider Radiology Network , exploration of collaboration to address potentially fragile services, working through the Local Maternity and Neonatal System to deliver the recommendations from the Ockenden Review (2020) and potential collaboration with tertiary partners as an enabler of the ongoing development of cancer services in East and North Hertfordshire as the Trust develops its future cancer strategy linked to the transfer of the Mount Vernon Cancer Centre to University College London Hospitals NHSFT. The Trust is also working specifically with Hertfordshire Community Trust to develop and test alternative models of collaboration for specific pathways of care as a means to advance pathway integration and working with Hertfordshire Partnership NHSFT through the Mental Health and Learning Disability Collaborative to improve the care of people with mental health and/or learning disability needs.

As the Board is aware, the Trust is also leading the first pan ICS major service collaboration; development of an ICS Vascular Network which is co-designed by providers to enhance patient outcomes, quality and service sustainability. Collaboration between acute clinicians has been developed through this process and this has shown the importance of investing capacity in building relationships and understanding different provider needs and cultures in order to co-design mutually agreeable proposals in the best interest of patients.

4. Conclusion

The Trust is increasingly engaging in building and developing relationships with a range of partners in order to continue to develop the effectiveness, quality and sustainability of services that the Trust and its partners provide. The increased national focus on collaboration as a key organising principle of the NHS and the ongoing development and strengthening of clinical (and triumvirate) leadership within the organisation is expected to inform the development of refreshed clinical service strategies by providing a platform encompassing Trust-wide and clinically-led identification of collaboration opportunities and needs.

5. Recommendation

The Board is asked to:

- note this report
- note that this work will continue to be overseen by the Strategy Committee going forwards to receive assurance regarding the strategic alignment of collaboration.

East and North Hertfordshire NHS Trust

Operating priorities & planning response 2021/22

Julie Anne Smith - Chief Operating Officer

Purpose of the presentation

East and North Hertfordshire NHS Trust

- To update the board regarding the ENHT operational priorities for 2021/22
- To share key areas of work within the plan
- To update the board on associated plans
- To reflect the trust priorities against the national planning guidelines and requirements
- To update the Board on action taken in response to national planning requirements, key submission dates for the response, and next steps

ENHT 2021/22 Operating priorities

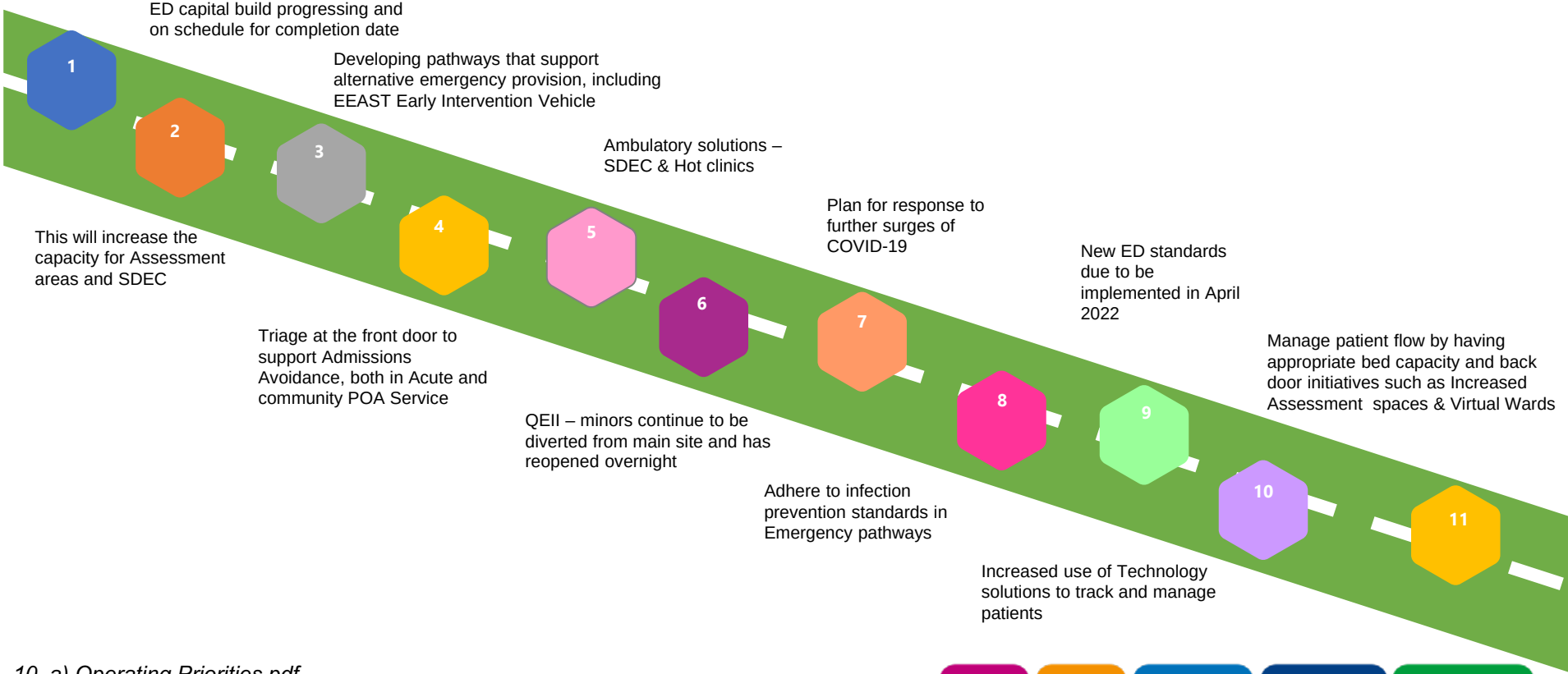
East and North Hertfordshire NHS Trust

A. Maintain provision of urgent & emergency services – ED capital build
B. Recover cancer & planned care services – meeting/exceeding targets
C. Respond to Covid demand – use of ‘flatpack’ method
D. Staff recovery; well-being; recruitment & retention
E. Bed plan aligned with demand
F. Capital refurbishment tower infrastructure & environment
G. Winter plan
H. Develop integrated pathway solutions across the system

Safe hospital environment for patients and staff

A. Maintain Urgent and Emergency Services

East and North Hertfordshire NHS Trust



B. Recover Cancer and Planned Care Services

East and North Hertfordshire NHS Trust

- Sustaining cancer performance - tumour site improvement meetings
- Performance reported with/without MVCC
- Develop the Lister cancer strategy and management in readiness for MVCC uncoupling
- Planned care recovery meet/exceed targets of 70,75,80,85% by July of 2019/20 activity value
- D&C planning
- Elective recovery to reduce the number of patients over 52 weeks and reduce the overall size of the Patients Treatment List (PTL)
- Clinical prioritisation of patients for admitted, non admitted and diagnostics to ensure priority is clinically driven and validation of patient data
- Reducing health inequalities with patients waiting well
- Gateways Elective recovery fund
    - PIFU – 3 specialities due to go live June 2021 – ENT, Neurology, Urology
    - High volume, low complexity recovery i.e. orthopaedics, acceleration of recovery
    - Advice and Guidance, promoting beyond the current performance, reducing the need for an outpatient appointment
    - Shared PTLs at ICS developing the opportunity for joint working, mutual aid and further development of elective activity hubs
    - Community Diagnostic hubs – diagnostics away from the Acute Trust and into the community promoting diagnostics 1st before referral to a secondary care service

C. Respond to Covid demand – ‘Flatpack’ Method

East and North Hertfordshire NHS Trust

- Triggers developed to determine when surge capacity is required – RAG rated on ‘QlikView’ dashboard, daily review of Regional and Trust figures
- Incident management remains in place horizon scanning
- Reasonable Worst-case Scenarios (RWCS), huge range, factor dependant, modelling planning for a subsequent wave half the peak of the last wave
- RWCS demand factored into bed plans

D: Supporting Staff Health and Well-being

East and North Hertfordshire NHS Trust

- People are at the heart of our plans
- Opportunity for staff to buy back carried over leave
- Health and well-being conversations with local manager and additional psychological support through debriefing pyramid in place for our people
- Equalities & Inclusion Board commencing in May 2021 to oversee improvement plans for WRES recruitment findings and accelerated model employer's targets
- IBP review to consider new ways of working developed through Covid for long term implementation, new roles and staff growth for 2022 – 2030
- e-Roster roll out due for clinical staff due for competition by end Dec 2021

E. Bed Plan and Modelling Assumptions

East and North Hertfordshire NHS Trust

- Bed baseline 558
- Non elective – slight delay from National target
  - A&E activity currently tracking at 96% of 2019/20 level
  - NEL activity currently tracking at 84% of 2019/20 level
  - Bed usage tracking at 102% of 2021/22 Plan
- Elective activity – April: 70%, May: 75%, June: 80%, July: 85%
- H1 in line with planning targets
- Bed surplus position in H1 needs to be closed and resources redirected to bed alternative initiatives
- Bed deficit (forecast starts November 21) – capacity delivered through bed alternative initiatives

Scenario 4A – used in ICS submission

East and North Hertfordshire NHS Trust

Scenario	Value
LOS Base Period Start	Oct-19
LOS Base Period Start	Dec-19
LOS Uplift	0%

Item	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Available Beds	575	541	556	556	556	556	556	556	556	556	556	556	556
Occupied Beds	451.9	458.2	469.6	485.7	486.7	485.2	482.7	503.3	517.4	530.5	535.7	538.4	523.8
Occupancy	78.6%	84.7%	84.5%	87.4%	87.5%	87.3%	86.8%	90.5%	93.1%	95.4%	96.3%	96.8%	94.2%
Beds for 92%	491	498	510	527	529	527	524	547	562	576	582	585	569
Bed Equivalent to Identify	-84	-43	-46	-29	-27	-29	-32	-9	6	20	26	29	13
Initiatives - Indicative Profile		5	10	15	20	25	30	35	40	45	50	55	60
Bed Equivalent to Identify	-84	-48	-56	-44	-47	-54	-62	-44	-34	-25	-24	-26	-47

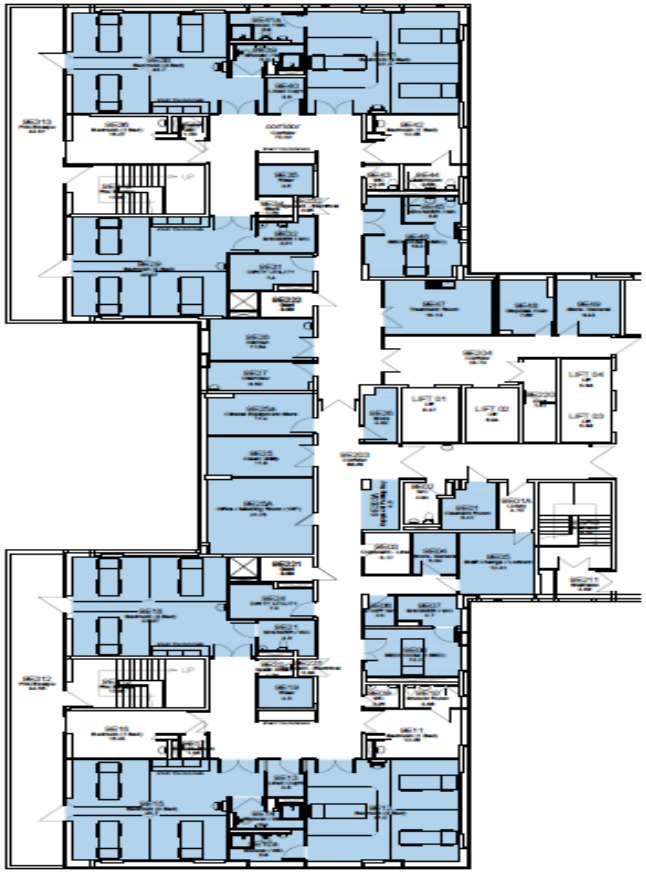
Split by Critical Care and General / Acute

Item	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Critical Care Available Beds	42	18	18	18	18	18	18	18	18	18	18	18	18
Critical Care Occupied Beds @ 2019/20	16.9	16.3	15.9	13.8	14.6	14.0	12.6	13.3	16.9	16.2	17.4	14.0	17.5
Available Beds	537	523	538	538	538	538	538	538	538	538	538	538	538
Occupied Beds	435.0	441.9	453.8	471.9	472.2	471.2	470.1	489.9	500.5	514.4	518.3	524.3	506.4
Occupancy	81.0%	84.5%	84.3%	87.7%	87.8%	87.6%	87.4%	91.1%	93.0%	95.6%	96.3%	97.5%	94.1%
Beds for 92%	472	480	493	512	513	512	511	532	544	559	563	569	550
Bed Equivalent to Identify	-65	-43	-45	-26	-25	-26	-27	-6	6	21	25	31	12

F: Ward Refurbishment Assumptions

East and North Hertfordshire NHS Trust

- Tower remains core IP activity area and is refurbished
- 24 bed wards
- £3 million to £3.5 million investment per year
- Critical infrastructure dealt with:
  - ventilation – new air handling units and ventilation ducts
  - drainage – new main soil states
  - possibly medical gases – localised control including pandemic continuity issues
- (Potential cost of critical infrastructure not yet finalised but in excess of £2 million for main infrastructure changes – will need to be phased due to financial constraints)
- Pandemic ward areas created on top three floors
- Ward 10a identified as first area refurbished
- Space utilisation programme progressed to identify relocation space for nonclinical areas and to increase utilisation of QEII and Hartford Lodge



TOWER A - NORTH & SOUTH

NHS
East and North Hertfordshire
NHS Trust

KEY PLAN
SCALE 1:500

Process

East and North Hertfordshire NHS Trust

Phase 1 – Year One

- Engineering design completed and agreed principles
- Identify potential nomads and agree with clinical teams
- Identify potential relocation area for nomads
- Undertake any remedial works for relocation of nomads (if any)
- Move nomadic teams
- Programme period – 4/ 5 months, commencing May 21 with planned completion September 21

Phase 2 – Year One (26 Weeks)

- Redeveloped one ward into new template
- Area created by decanting nomads from 10A or other areas into new locations / utilisation of spare capacity ward / implementation of bed reduction clinical proposals
- Programme. Six months (26 weeks) - commencing October 21 – completion March 2022
- Overall loss of beds from existing bed base, up to and including April 2022 – 0

G: Winter Plan

East and North Hertfordshire NHS Trust

- Winter initiatives continuously reviewed / commissioned for impact v cost
- Winter plan at ICP / ICS level
- Vaccination plan for Covid / flu will be critical
- Bed plan to maximise ability to isolate / cohort infectious patients particularly for critical care and respiratory
- Plans will be agile to accommodate emerging demand, for example anticipated increase in paediatrics in future COVID surges
- Tower Phase 1 will be complete delivering enhanced ventilation/air changes in support of management of infectious patients
- Winter bed plan to include IP sparing – Christmas & NY

H: Develop Integrated Pathway Solutions

East and North Hertfordshire NHS Trust

- Local ICP - community & social care; virtual pathways:
  - Cardiology
  - Respiratory
  - Pre op assessment
  - Falls / Frailty
  - Joint venture / Lead provider models – community paediatrics, Neuro & Stroke, Prevention of admission (PoA)
- ENH ICS – development of pathways across acute and community providers e.g. planned care recovery, joint PTLs, PIFU
- Provider collaborative – wider specialist networks, Vascular centralisation, opportunities - Papworth, CUH

Associated Plans

East and North Hertfordshire NHS Trust

- Financial plan - budget setting 2021/22
- Workforce, training & education plans – ENH Academy
- Quality strategy
- Strategic Planning refresh
- Digital roadmap
- Maternity – Implementation of Ockenden report & Continuity of Carer
- Mental health & learning disability strategy
- Transformation – ENHWay
- MVCC UCLH cancer strategic planning
- Violence against women & girls
- Vaccination programme
- Capital planning:
  - Emergency department; paediatric ED
  - Tower refurbishment
  - Medical equipment; E&F; digital

2021-22 Priorities; Operational Planning

East and North Hertfordshire NHS Trust

- NHS Planning Guidance for 21/22 published on 25 March
- Sets out NHS priorities for 2021/22
- ENHT has responded in line with the planning requirements as part of an ICS submission

Key themes:

Staff health and wellbeing

Address health inequalities

System working and collaboration

2021-22 Planning Priorities

East and North Hertfordshire NHS Trust

- Staff wellbeing – support, rest and recuperation
- Continuing to meet the needs of patients with Covid -19; vaccination programme
- Elective and cancer care – opportunities to transform delivery of services, restoration of services must address health inequalities
- Primary care, health outcomes and health inequalities – working with health, social care partners to improve outcomes in the following areas:
  - Cancer
  - Cardiovascular
  - Mental Health
  - Maternity services
  - Smoking cessation and weight management

2021-22 Planning Priorities

East and North Hertfordshire NHS Trust

- Emergency care, ED alternatives, timely admission and reduced LoS
  - NHS111
  - initial assessments
  - time spent in ED from arrival
  - transform community services
  - improve discharge
- Collaboration & system working – partnership working, health & social care
- Maternity and neonatal transformation and priorities – implement recommendations from Ockenden's report

Planning Submission Timeline

East and North Hertfordshire NHS Trust

- Working with ICP colleagues, CCG, HCT, HPFT, HCC to respond to the planning priorities
- Planning steering group established with work stream leads
- Plans at place level have been aggregated up to ICS level
- Draft submission: 6 May - submitted and await feedback
- Final submission: 3 June
- Final plan – ICS, Herts and W. Essex planning submission

Delivery to Plan – Assurance

East and North Hertfordshire NHS Trust

- D&C weekly meetings – elective recovery against targets
- Divisional Oversight Group – Q&S, finance, planning, transformation
- Accountability Review Meeting – Integrated performance, domain/KPI review and scrutiny
- Planned care recovery group – elective delivery Herts & W. Essex
- System Coordination & Oversight Group (SCOG, previously known as SARG), for system oversight
- EoE elective recovery group chaired by regional performance director
- ED check & challenge and Executive oversight board meetings

The Board is Requested …

East and North Hertfordshire NHS Trust

The Board is requested to note the operational priorities and the response to the planning requirements, to note that the draft submission has been submitted, the next steps regarding the final submission and the governance in place to provide oversight and assurance in monitoring delivery against the priorities and the plan.

East and North Hertfordshire NHS Trust

Agenda Item: 10. b

TRUST BOARD - PUBLIC SESSION – 5 MAY 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 pass the anniversary of the outbreak our people will be living through memories of 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 provides an update on the support that the Trust has provided to date and that are 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:		
Director: **Chief People Officer**	**Presented by:** **Chief People Officer**	**Author:** **Interim Deputy Chief People Officer / AD Leadership / Head of People at Work**

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

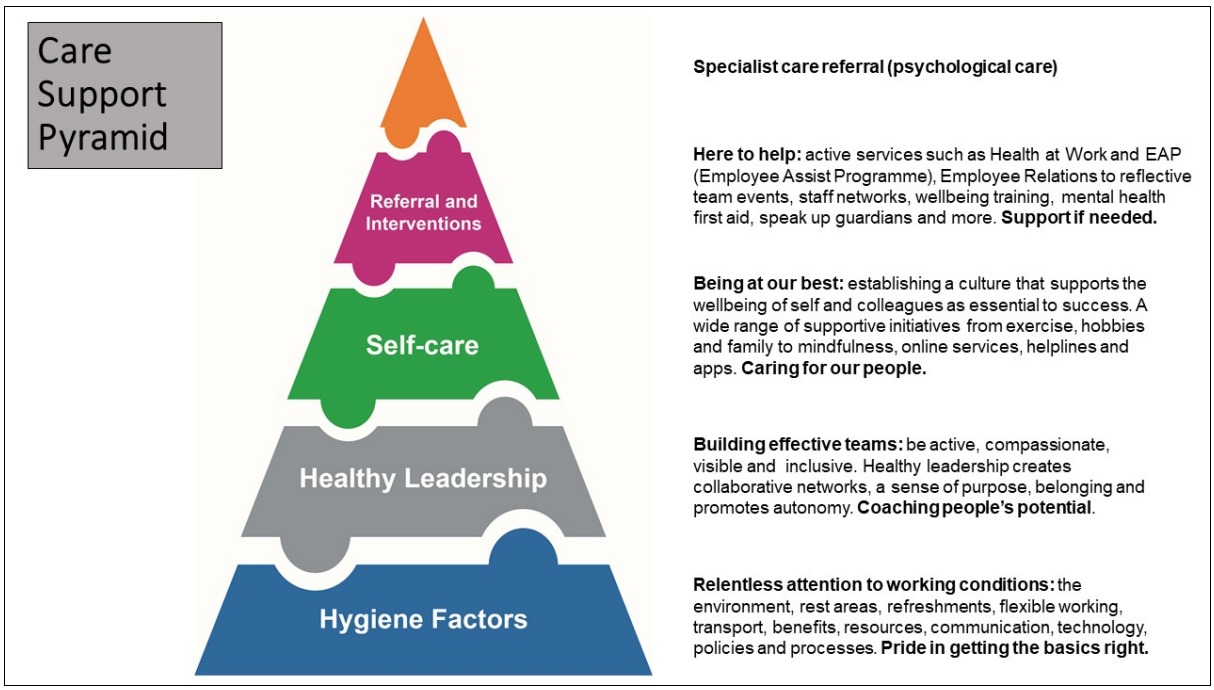
1.0 Introduction

The purpose of this paper is to update the Trust Board on the measures in place to support the recovery of our people, protect and promote their future wellbeing and enable the recovery of our patient services.

Over the past year there has been a heightened awareness of the value of healthy approaches to leadership and the importance of putting in place support and proactive wellbeing initiatives. The priorities now are to embed these approaches into usual routines and working patterns. Leadership success is through people and therefore their wellbeing is a leadership imperative.

2.0 Strategic Approach to Health and Wellbeing

The diagram below sets out our strategic approach to health and wellbeing, ranging from the practical and tangible daily needs through localised health and well-being interactions, to the availability of enhanced specialist services such as PTSD psychological support services accessible to colleagues across the system. This paper provides an update 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.



The dimensions of the 'Care Support Pyramid' are supported by evidence and practice from many sources including the British Psychological Society. While other structures exist this has created a manageable number of dimensions. Managers and teams are being asked to use the dimensions to group and highlight the responses from sources such as the Staff Survey but also other work to bring coherence and consistency.

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 81% (5485) for all staff and 84% (1864) for staff of a Black, Asian or minority ethnic background.

Staff members who have been shielding at home due to being defined as clinically extremely vulnerable have been able to return to the workplace since 1st April, a guidance document was developed to support shielding staff and their managers plan a safe and healthy transition. A series of webinars has also supported this process.

The shielding network, established by one of our shielding staff members in February has also helped to support vulnerable employees to transition safely back to the workplace. Regular meetings are continuing, and recommendations from this group are brought to the staff experience group for discussion and approval prior to implementation.

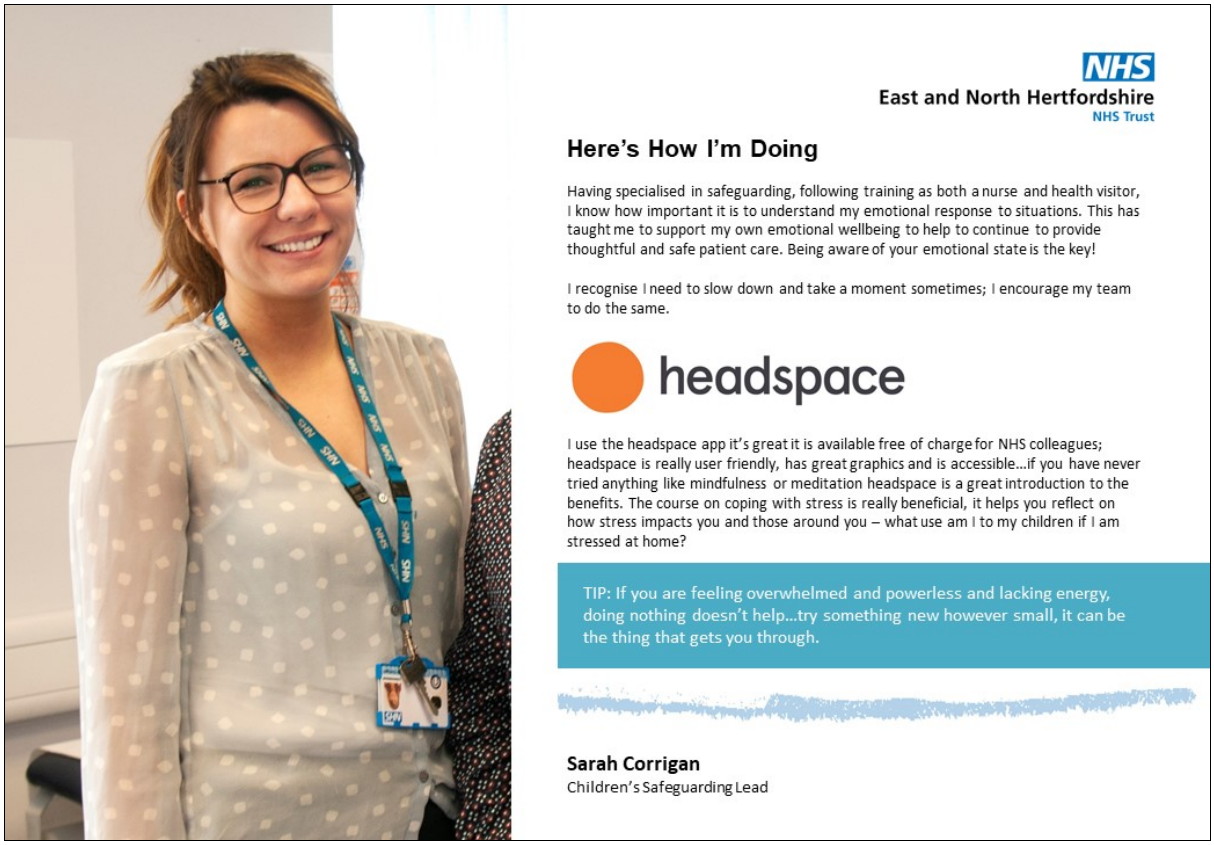
4.0 Vaccinations and Staff Testing

89% of staff have received the COVID-19 vaccine. The Lister vaccination centre closed on the 10th April, vaccines have continued to be provided by the Health at Work Service. All 2nd doses will be completed in the next two weeks. Unvaccinated staff continue to be encouraged and supported to receive the vaccine, both Moderna (advised for 18-30 year olds) and AstraZeneca (advised for over 30s) vaccines are available locally for staff members. The staff vaccine uptake continues to be markedly lower in our Black, African, Caribbean and Black British colleagues, additional communications and webinars have been circulated, but uptake remains at 64% for this group. The Lister vaccination centre will be ready to reopen for booster vaccines which may be required in the autumn.

Asymptomatic testing enables early identification of positive cases to reduce spread of infection, prevent a further surge of cases and helps to provide assurance of a safe caring and working environment. Lateral flow testing kits, each containing 25 tests are available for all employees, volunteers, students, contractors and temporary workers who regularly work in the Trust. Staff are advised to undertake and record twice weekly COVID-19 tests, so far 6724 test kits have been distributed.

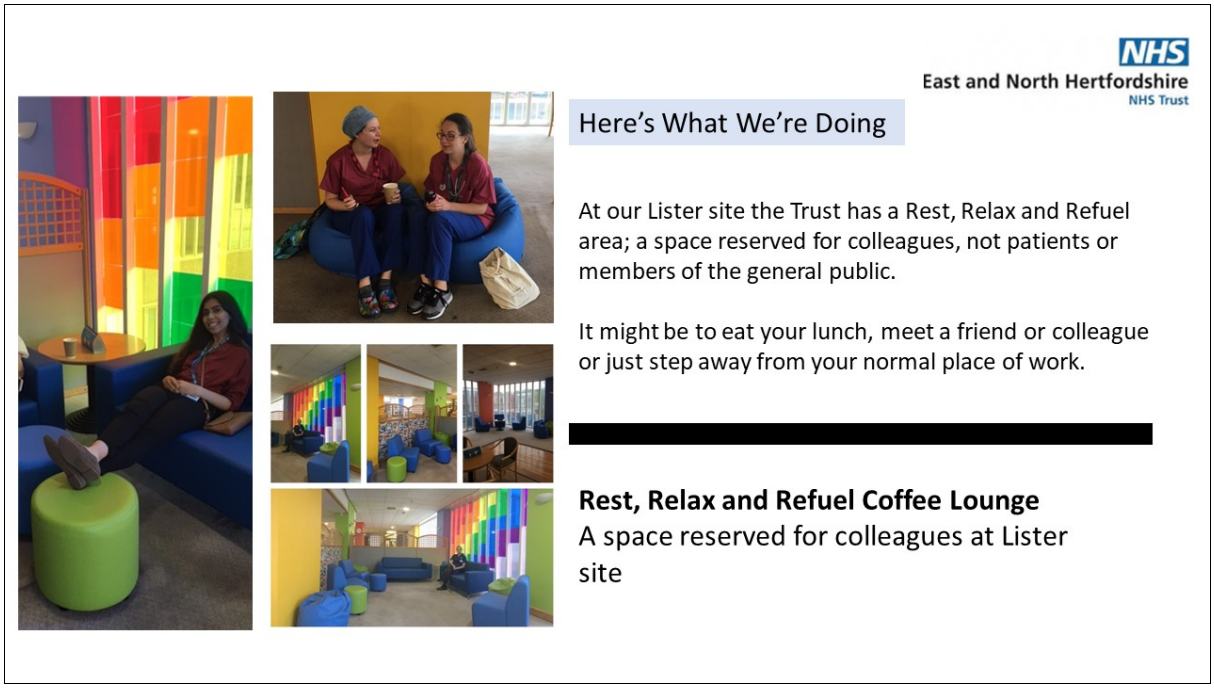
5.0 Here's How I'm Doing – The role modelling of self-care

There are a wide variety of support packages, self-care offers, resources and tools available that support the health and wellbeing of our people. However, colleagues are often reluctant to take them up as they prioritise the care for others, fear of appearing weak or genuine concern over career. In addition, it is natural that people may not always recognise that they need the help or the benefits to be gained. 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 to enhance their wellbeing and how they cope.



Here's What We're Doing - the tangible actions of the organisation

Partnering the individual role model activity of 'Here's How I'm Doing' has been the stories of the organisation's response in 'Here's What We're Doing' These are short case studies 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.

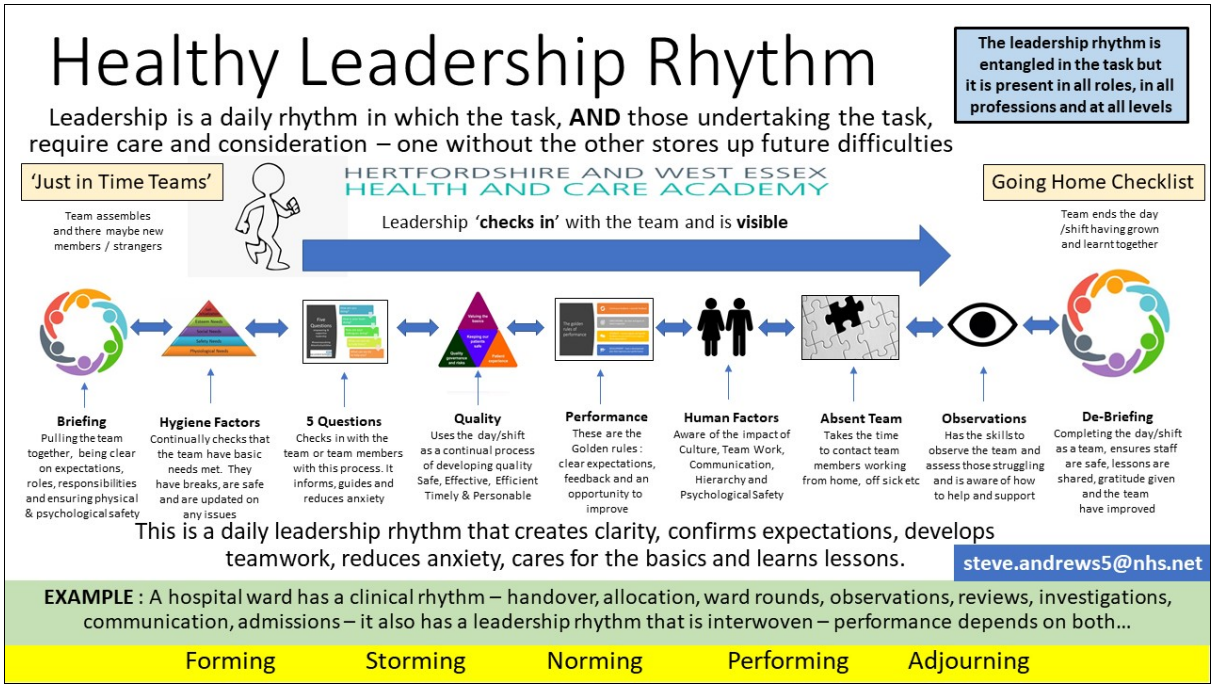


6.0 'How are you doing?' programme

During the first wave of the pandemic the Trust established a 'How are you doing?' team (HAYD) 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. A report of the first HAYD intervention was published in summer 2020 and the success of the work was recognised in awards and importantly has been picked up by several other organisations. The lessons learnt meant that the response to the second wave adapted and examples of new ideas are detailed above in 'Here's How I'm Doing' and 'Here's What We're Doing'. The interventions such as rapid 'team time' events, debriefs, 1:1 conversations and wellbeing awareness through leadership development were all reintroduced.

The 'How are you doing?' programme has developed further and now provides learning and development delivered in the flow of work, in order to create an approach to leadership which is uses leadership concepts that include wellbeing. A range of tools have been developed and methods deployed in the workplace that form part of the 'Healthy Leadership Rhythm' 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.

Leadership development has also emerged looking different. The changes are not simply due to the practical impact of the pandemic in terms of physical safety and technology but a refresh in thinking. Leadership without wellbeing is limited while leadership with a healthy, developed, cared for and engaged workforce has greater potential. The learning from the summer 'BiteSize' leadership events has now seen several new programmes launched for all levels of the organisation and they are referred to as leadership and wellbeing development.



Example – the start - teams

The 'Healthy Leadership Rhythm' considers teamworking as vital. On many clinical shifts the group that turn up at the start may contain strangers both to each other and the environment. The shift leader is required to take a group of strangers and turn them into a team in a matter of minutes. Context, accountability, dynamics and maturity may vary but an essential leadership ability is to create and sustain effective teams. Development and assessment should then focus on this ability at different levels and roles.

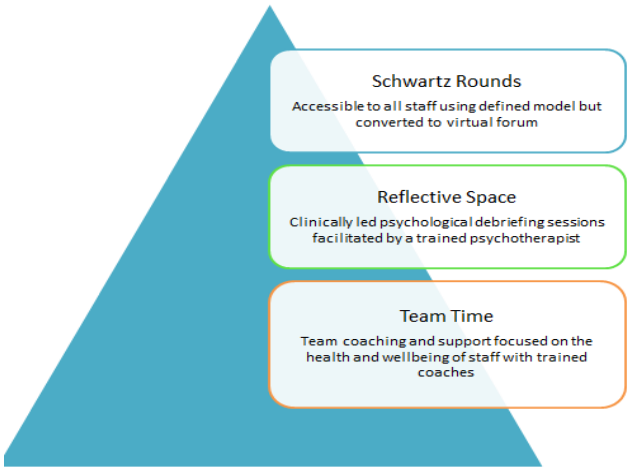
The HAYD approach and the development of 'Healthy Leadership Rhythm' have drawn on the best practice that existed pre pandemic as well as the emergent thinking over the last 12 months. The ideas of compassion, wellbeing, autonomy, belonging, inclusion and coaching are well established and when these ideas were engaged to support colleagues during the pandemic.

7.0 Psychological Support and debriefs

Over the last year levels of anxiety, depression and stress related issues have increased, there are also many people experiencing reduced energy levels, lowered motivation and engagement. To support our people a range of measures have been put in place to promote wellbeing and offer support.

Fatigue, feelings of stress and isolation make it more difficult to sustain compassionate patient care and healthy approaches to leadership. Reflection improves motivation and energy levels, prevents stress and anxiety by improving self-awareness, developing a better understanding of others, enhancing critical thinking skills and encouraging active engagement.

Our people do not all benefit from the same methods of reflection. To meet the health needs of all employees requires a range of reflection opportunities to be offered.



The diagram illustrates the structure for physiological support and debriefing available for our people at different levels of intervention. The initial uptake of these initiatives has been lower than expected, although positive feedback has been received from those who have accessed the support available.

The priorities for the next six months are to embed healthy approaches to leadership and enable initiatives to protect and promote wellbeing to be built into usual routines and working patterns.

The sections below detail how these are used and what the plans are going forward.

7.1 Team Time – supported time for teams to share, talk and support each other

Team time provides facilitated sessions for team using the 'bite-sized' methods as part of the 'How are you doing?' but also now acknowledged as being a role of local leadership. Facilitators are coaches and facilitators that support teams at bespoke events and also are integrated within team and departmental meetings to support with conversations based around the healthy leadership principles. During the peak of the second wave from December up to 9 Team Time sessions a week were being delivered with many more 1:1 wellbeing conversations. These will continue as part of the recovery with the emphasis being on local leadership supporting both Team Time and Wellbeing Conversations.

7.2 Reflective Space

Reflective Space sessions are held weekly at Lister and every two weeks at Mount Vernon Cancer Centre. Reflective Spaces are facilitated by a Clinical Psychologist from the Mental Health hub 'Here for You'. These sessions provide an opportunity for small groups of staff to meet face to face to share experiences.

60 people have attended a reflective space session, although the numbers are small many people have felt that it has made a big impact on them, one staff member reported *"I thought I was coping ok, I've not been ill, but I've just been so tired and couldn't stop thinking about everything I've been through. I didn't think I could do it all again if there's a third wave so was thinking of leaving, but, being able to talk and hear how others are dealing with it has made me realise I do want to keep doing the job that I love."*

7.3 Schwartz Rounds

Monthly Schwartz Rounds are being held, these provide a structured forum face to face and remotely 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.

At the 3 Schwartz rounds held since February 34 people have participated. To further increase uptake Schwartz rounds will be regularly and widely promoted, there will be an change in the timing from mornings to lunchtimes from May and attendees will be provided with a voucher for a drink and a snack.

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

While we are encouraging staff to take a break prior to the recovery of full elective services, in accordance with the national operational planning guidance we have developed guidance to enable our people to apply for the trust to buy back their carried over annual leave. This will be available for a short period to ensure that we can make payments and plan leave effectively across the year.

8.2 Target Vacancy Rate

At the start of the year the Trust had a target to reduce the vacancy rate below 6% across all staff groups. Recognising the importance of having a largely substantive workforce to manage the pressures on staffing that the pandemic has presented the Trust set out a plan rapidly increase it recruitment focusing on key clinical areas including nurses, care support workers and doctors. At the end of March the Trust achieved a historic low vacancy rate of 2.6% across all staff groups. This included a registered nurse vacancy rate of 2%, a care support worker vacancy rate of 3.8% and doctor vacancy rate of 1.7%.

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, 82 staff areas have been identified for refurbishment. Initial orders have now been approved by procurement and placed with providers. It is anticipated that all works will be complete by July 2021.

8.3 Recognise and reward

It's important to recognise and reward the contribution of all staff during the pandemic. The Trust has run initiatives of simple gestures to recognise and thank staff. Initiatives have included boost boxes and staff Iftar events. We have recently approved complimentary therapy services to be offered to up to 1600 staff throughout May and June such as

massage, reflexology, osteopathy and chiropractic. A week long thank you event is planned for July 2021.

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.

The staff networks continue to be a key enabler for listening, gaining feedback and providing support. As part of the Trusts response to equality and inclusivity we are introducing a sub board committee to focus and monitor this agenda. The network chairs will be invited to contribute to this committee with time to listen events part of the ongoing programme of delivery.

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 majority of staff have had one to one health and wellbeing discussions with their line manager which focuses on their experience, what matters most to them and how to prepare themselves going forward.

8.5 Grow Together

The launch of a new approach to Performance Review moves the idea of annual appraisal in a direction supporting recovery and workforce development. The shift sees a greater focus on the individual and their wellbeing through sections such as ‘What Matter’s To You’ and ‘About Me’. The shift in focus away from an episodic once a year moment to a continuous process of ‘checking in’ with colleagues is vital to maximising talent, supporting our people and increasing wellbeing.

8.6 ‘BiteSize’ Leadership and Wellbeing Modules

The launch of new leadership development programmes sees a recognition that wellbeing is a vital and successful part of daily leadership. Constructing an organisation, process and culture in which colleagues feel safe, where they feel they belong and where they can thrive is a key element of leadership. New modules are now delivered in ‘BiteSize’ sessions and new initiatives are being developed through 2021.

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 organisation's activities from a health and wellbeing perspective and act as a critical friend.

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.

Agenda Item: 12 a)

TRUST BOARD - 5 MAY 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.

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.

Since the previous Board meeting the key points to note are:

- Two risks remained at 20 at the end of 2020/21:
  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 have now been completed with the teams to review existing risks and identify additional risk that need to be captured. These will be reviewed and discussed with the Director of Estates and Facilities, Associate Director of Governance and Compliance Manager and recorded onto datix risk register. This is in conjunction with a review of the governance and assurance reporting within the Directorate and the new style compliance report considered at QSC in March 21. Assurance on the operational issues has strengthened over the past year and risk rating is currently being considered.
  Risk 4 Capital: An update on the Capital programme remained under close monitoring by Executives and FPPC to the end of March to ensure the full allocation was used in 2020/21. An update on the position and Capital Planning for 2021 discussed at FPPC in March 21. The risk rating is under current review although access to enough capital to support the delivery of the Trust's strategy will remain challenging.
- In February Risk 12: Pandemic risk reduced from 20 to 15. Evidence supports the effective ongoing management of the pandemic, including command structures, system working, IPC, risk prioritisation of all patients, delivery of cancer performance and flexible restore and recovery plans for our services and support to our staff.
- Across the last two months the Board Committee agendas are reflective of the strategic risks they are responsible for overseeing.

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 has been approved by the Audit Committee and reflected in the annual review Risk Management Strategy and the BAF template for 2021/22.

A review of the BAF and strategic risks across 2020/21 is being finalised to inform the annual governance statement and meetings have been held with each of the Directors to review and populate the BAF for 2021/22. This will be completed in May for test and challenge through the Executive Committee and Board Committees. The role of the new Inclusion Committee is being taken into account within this review. The Audit Committee with undertake a deep dive review of a different BAF risk at each meeting.

A formal review of the strategic risks will take place in the final stages of the development of the Trust's new Organisational Strategy.

Action required: For discussion		
Previously considered by: Considered at each Board and Board Committee. FPPC and QSC		
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	☒
People: To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways: To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use: To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

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

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

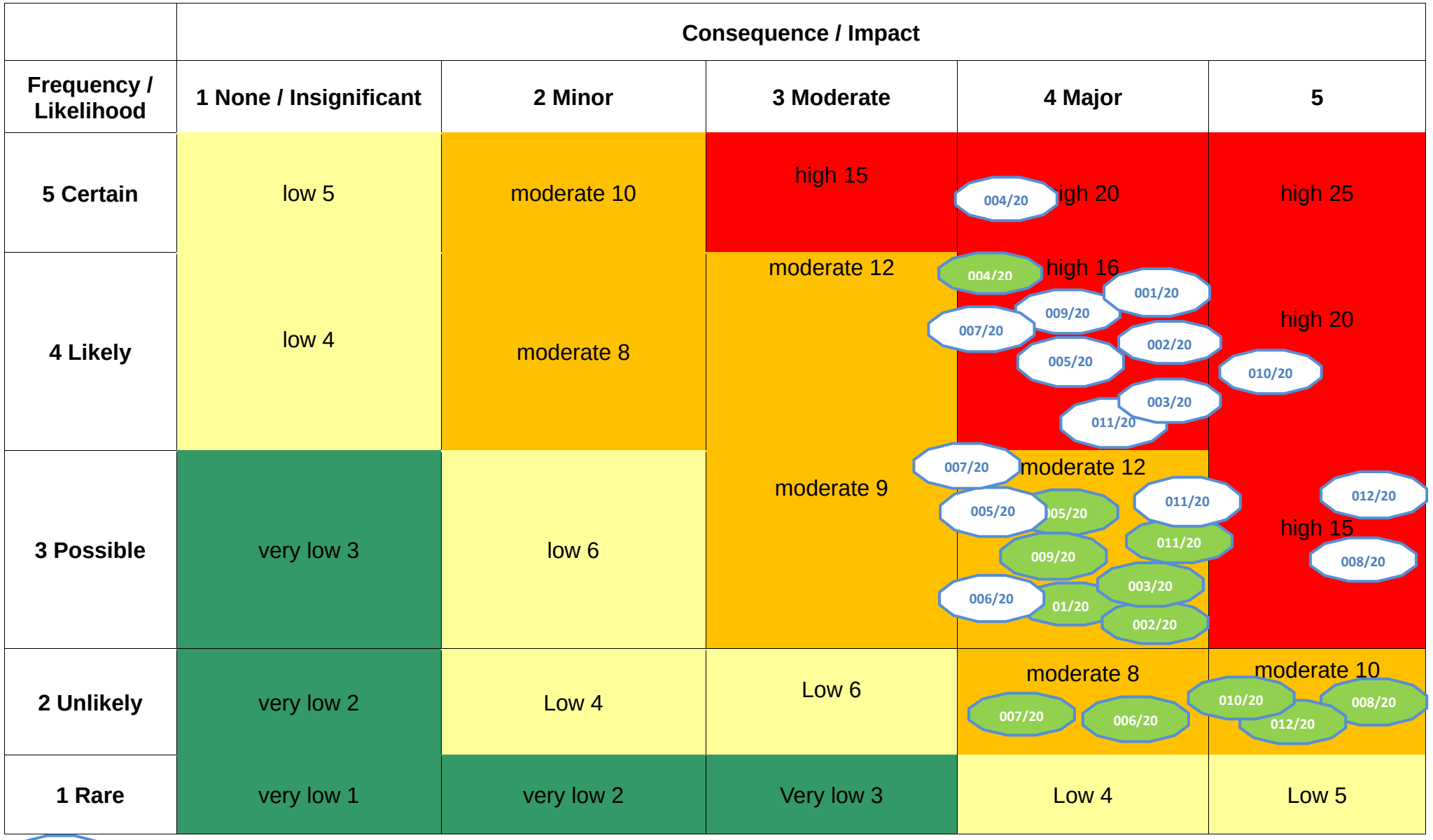
Risk Assessment	Grading
15 – 25	Extreme
8 – 12	High
4 – 6	Medium
1 – 3	Low

BOARD ASSURANCE FRAMEWORK OVERVIEW

Risk Ref	Risk Description 2020/21	Lead Executive	Committee	Current Risk April	Last Month March	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	**15**	15	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 –March 2021



REVIEW OF STRATEGIC RISKS FOR 2020/21 – MAPPED TO TRUST STRATEGIC PRIORITIES AND 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:	Mar-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. Theatre and Outpatient Transformation Programmes	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	Define metrics to support monitoring of recovery Assurance on compliance with NICE changes and GIRFT	Green	Effective control is in place and Board satisfied that appropriate assurances are available

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	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	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. See update in summary narrative	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. See update in summary narrative	
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.
March 2021: Target score 12 in Spring 2021.

Current levels of Covid+ patients in the trust continue to improve, in line with forecast trajectories. Currently 27 Covid + patients within the organisation with 2 remaining on CCU and 7 on RSU.
A recovery board is in place to oversee restoration, reset and resilience with outline targets of achieving activity levels of Q3 2019 in Q2 2021, with a ramp up of activity in Q1 of April – 60%, May – 70% and June 80%.
Recovery principles have been established based on the NHSE/I principles ensuring that actions to address health inequalities is a key priority as work starts.
In addition to overseeing the starting up of activity, there is transformation work ongoing to harness the accelerated changes around digital adoption and alternative methods of delivering care through innovation, which are part of the principles of recovery.
All patients have been prioritised for clinical urgency with the most clinically urgent patients, P1 and P2, urgent trauma and cancer patients being prioritised for treatment.
Staff who were redeployed in the pandemic, are being brought back into their regular job roles in support of opening up routine services.
This work underpins the opening up of core services and the ability of the organisation to deliver improvements and maintain core performance standards.
Cancer activity, both surgery and therapies were maintained throughout the pandemic, in support of patient care, demonstrating compliant levels of performance.
RTT and DM01 were more challenged with a pause required for all routine activity at the end of December 2021 which has resulted in a significant backlog of patients to be treated and a decline in the RTT performance.
The ED 4 hour standard has been negatively impacted by the requirement to provide Covid and Non-Covid EDs with the ability to deliver social distancing and isolation facilities for patients. However, it is anticipated that with the reduction of Covid + patients within the organisation and the improvements delivered through the ED capital programme that improvements will start to be delivered in relation to this standard. At the time of writing (mid-March), the monthly performance is 86%, demonstrating a significant improvement against the January/February position of sub 80%.
Stroke has a road map to delivery grade A SSNAP by the end of the calendar year 21/22, and the reduction in Covid+ patient numbers will support this improvement work.
There has been work undertaken by the modelling team to attempt to forecast elective and NEL demand and the bed profile of demand. Clearly, this is challenging work but, as always, the trust will plan for the remainder of the year with forecast activity levels and ensure (wherever possible), that resources and capacity are aligned to respond to that demand, and maintain flow across the trust.

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:	Mar-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 (a total of 86 will have been deployed between January 2021 and April 2021), 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.Paid student nurse placements offered and an addtional drive to convert these to substantive roles when they qualify.	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. 79 staff cleared through NHSP fast-track, blend of RN, CSW and admin staff - 82% of those staff have picked up a shift within 48 hours of adding to the system. Family Liaison Service staffed until end of February, BAU recommendation currently being worked through. Lessons Learnt / debrief session set up with key stakeholders for early March Redeployment process mobilised and in place from mid January until step down on 15th March, a total of 2,024 staff were identified for redeployment, over 88% of staff were placed temporarily. Redeployment Hub mobilised an MDT Task & Finish group which managed the hub, developed governance forms, reflected on lessons learnt and is currently developing action cards should the process need to be stood up at any point in the future.	completed
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:	Mar-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	• 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)	• 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.		• I&E delivery against financial plan • Cash balances maintained within prescribed limits

• 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 & PRM 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/
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. Financial Framework 2021/22 on agenda for FPPC discussion March 21. Operational Planning Guidance received w/c 22 March 21.	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:	Mar-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 • 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	• 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) • 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.	• 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.	

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. Capital Planning for 2021/22 paper to FPPC in March 21, based on new planning guidance.	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,compassionate services,consistently across all our sites this delivers best patient care experience for our patients, their referrers, and our staff long term** **Quality: To deliver high-** **Pathways: To develop pathways across care boundaries, where** **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** **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:	Mar-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:	Mar-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 effectviely 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 ICP Development Director in post, based at ENHT one day/week to support developing relationships Models of Collaboration work	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 identifyand release clinical leadership capacity to drive greater pan system understanding of servces and pathways and associated improvement work	Availability of population health data to inform priorities for transformation and improvement - ICS PHM learning set commenced March 21 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 radiotherapy. To be discussed at CEO level	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	

Need to influence and understand future ICP relationship with ICS Identification of dedicated capacity to support ICP collaboration ICS Pathology Procurement delay due to pandemic		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. **Mar 21 - PHM work continues.**	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. **Mar 21 - ongoing work on restoration and recovery; awaiting specifics from PHM to determine focus for next financial year, linked to operating plan development. Bilateral dsicussions commenced with HCT regarding future models of collaboration.**	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.25/03/2021 Collobaration continues with the agreement of three ICP contract pilots. ThE sucess of the covid virtual ward to be expanded across four new pathways. A ICP transformation group established by the ICP DD is slowing progressing the improvement model.	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. **Mar 21 - clinical teams now established.**	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. **Mar 21 - PHM work in progress, will help to define focus for next financial year across ICP. Financial allocations for new financial year under discussion with ICS; recovery work continues, building on benefits of collaborative working developed throughout COVID, with plans to expand virtual ward model.**				

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:	Mar-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 (L2)	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		

• Commissioned external reviews • 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 SFI/SFOS (L3) • Annual review of board committee effectiveness and terms of reference (May-July) (L3) • PwC Governance review and action plan closed (included well led assessment) (L3) • Annual governance statement (L3) • Counter fraud annual assessment and plan (L3) • Annual self-assessment on licence conditions FT4 (L3) • CQC Inspection report July 2018 –(overall requires improvement) and actions plan to address required improvements and recommendations (L3 -/+) • Use of resources report July 2018 – requires improvement (L3 _/+) • September 2018 Progress report on CQC actions and section 29a (L2 +) to CQC & Quality Improvement Board • Annual review of RAQC to Board (L2 +) • Internal Audit Report – Assurance and Risk Management (- reasonable assurance (L3) • Board development session on Risk and Risk Appetite, Feb 2019 • Internal Audit – Performance Framework report - reasonable assurance March 19) - 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	Internal Audit - Surgical division governance - reasonable 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 ; Clinical risk - reasonable assurance; Compliance framework - reasonable assurance. Positive CQC TRA reviews for Medicine and Surgery Core Pathways (with supporting gap analysis and evidence on KLOE)	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. IA Clinical risk review - reasonable assurance - aciton plan agreed.	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. IA on Complaince framework - reasonable assurance - developing plan / priorities for 2021/22	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	completed
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. Strategy Sessions commenced	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:	Mar-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		

• Nursing and Midwifery Executive Committee • 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	• SIs and Learning from death investigations • 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	• 6 monthly Quality Account progress reported to QSC November 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 Internal Audit: BAF - substancial assurance ; Clinical risk - reasonable assurance; Compliance framework - reasonable assurance. Positive CQC TRA reviews for Medicine and Surgery Core Pathways (with supporting gap analysis and evidence on KLOE) Quality Review paper to QSC March 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**		
• 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 . Review of delivery of quailty priories to QSC in March 21	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. Positive CQC TRA reviews for Medicine and Surgery Core Pathways (with supporting gap analysis and evidence on KLOE)	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. Programme recommencing in April.	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
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.**		**Risk Open Date:**	Sep-20	**Executive Lead/ Risk Owner**	**Chief People Officer**
		Risk Review Date:	Mar-21	**Lead Committee:**	**QSC, FPPC**

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. Programme of cultural leadership to be developed and implemented in 2021. Task and finish group being arranged for Srping 2021	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. LMS delivery to include new elearning to cover cultural competencies, communication style and leadership. laucnh of LMS April 2021 with modules coming online over the next 6 months.	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. Staff nteworks continue with improved attendance. Story sharing also being undertaken through HAYD team and staff experience hub. Inclusion Board being established in Spring 2021 to montior and improve engagement with EDI agenda	in progress
iv) Support and develop staff wellbeing services, in line with NHS People Plan and Trust People Strategy.	Chief People Officer		variety of psychological support available through Schawrtz rounds, reflective space, team time and hear for you individual support services. Boost boxes delivered to satff who are unable to leave the wards. Staff experience improved through rest and refuel area refresh, commencing deliveries have started in March 2021. MSK services offering phone triage and exercise plans to improve MSK issues. Very good feedback from recipients.mental Health First Aider train the trainers nearly accredited for role out to the Trust commencing in Spring 2021.	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. Although dates were postponed during covide response, dates being scheduled for the remainder of the year will be communicated shortly.	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:	Mar-21	**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. March 21: New E&F compliance report to QSC		

	and training being brought back in line within the next six months.			
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 . March 2021: New E&F Compliance report being presented to QSC.	

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. March 2021: Recruitment for permanent Deputy Director of Estates and Facilities commenced.	
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 (commenced).

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:	Mar-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. **Focus will expand from April 21 to include decoupling and transfer enabling planning** - 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 Quality 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. **Mar 2021 -** Work is progressing on reprovision activity. At February Programme Board, it was agreed that forecast activity and travel times to Watford were sufficient to warrant a networked radiotherapy site; Expressions of Interest in networked radiotherapy have been issued to Luton and Stevenage for response by mid-April; work underway with Watford to develop options for new Cancer Centre	In progress
ii) Conclude negotiations regarding due diligence and transfer costs and deliver due diligence	Director of Finance	Jun-20	*see earlier monthly updates for history.* 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 identifying high risks and seeking to mitigate. Mar 21 - CIG moved back to monthly due to delays in resolving some estates issues. UCLH milestones for completion of Due Diligence have slipped from end March to end May 21. UCLH have shared an initial set of draft Due Diligence reports	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. **Mar 21 - New Linac has been delivered at MVCC**	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. **Mar 21 - Due Diligence timelines have slipped by 2 months; the teams are working to mitigate any risks to the planned transfer date of April 2022. MVCC Medical Pathway have their virtual Assurance meeting with CQC in April – Weekly prep meetings in place. Planning to undertake our internal quality visit jointly with the ENH CCG early April**				

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** **staff, recruits the best and develops an engaged, flexible and skilled workforce** **clinically sustainable in the long term** **Pathways: To develop pathways** **People: To create an environment which retains** **Sustainability: To provide a portfolio of services that is financially and**
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:	Mar-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 (March 15) - Met**	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**
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 Montoring of Fit testing training / compliance 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		

COVID Specialist advisory group with task and finish group structure reporting to it. (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 support decision making	Participating in regional STP covid table top exercise scheduled for 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	3 wks without any Hospital Acquired COVID 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 . Remains in place weekly to consider and review the new/ changes to national guidance. e.g new visitors guidance in March 21.	on going
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.	on going

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/ April 2021. Commenced for SIlver.	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 . March 21 - vacinated over 80% of staff and follow ups 1:1's in place,	completed and ongoing
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'	Completed and now flatpacked
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. . 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.
March 2021: Target score 15 in Spring 2021 - recommend reduce to 15 - see details progress below

The trust remains in incident management structure but the level and frequency of meetings has reduced proportionate to the current level of the incident. There is a weekly Covid Specialist Activity Group as an expert advisor group providing recommendations to gold which is a weekly meeting chaired by the COO.

Current levels of Covid+ patients in the trust continue to improve, in line with forecast trajectories. Currently 27 Covid + patients within the organisation with 2 remaining on CCU and 7 on RSU.
Surge capacity around CCU, respiratory and support functions has been ‘flatpacked’ away to re-emerge as required.
An evaluation of our response to the pandemic and incident management has been undertaken and will feature as part of a discussion at the delivery oversight group for lessons learnt.
Our internal incident management structure is closely linked to the system management response and in turn regional and national response.
The EPRR function within the trust has been strengthened by the addition of an incident officer to support the emergency planning manager.
The vaccination programme has been a huge success with over 80% of trust staff vaccinated, with manager 1 to 1 conversations ongoing to ensure maximum vaccination take up is achieved, in support of our staff and patient safety and well-being.
Health at work remain closely linked to those patients that are shielding and additional guidance is expected this week for the return to work for shielding staff.
Clearly, the safe running of the hospital needs to continue alongside the ongoing pandemic challenges. In support of this the trust will continue to remain adaptable and flexible in our response to any changes in the pandemic and all methods of communication and horizon scanning are in place to ensure the trust is best placed to respond and keep our patients safe and support our staff.
There are comprehensive plans in place for staff recovery and recuperation, and this is in addition to ensuring that staff have regular access to annual leave and complimentary therapies.

East and North Hertfordshire NHS Trust

Agenda Item: 12. b)

TRUST BOARD - PUBLIC SESSION – 5 MAY 2021
RISK MANAGEMENT STRATEGY REVIEW

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

The Risk Management Strategy is a Board approved strategy and is reviewed annually to reflect any key changes. The current strategy has been reviewed to incorporate the recommendations outlined in the Internal Auditor review of the Assurance framework (substantial assurance).

The changes (noted in red) include:

- Updates to the Board Committees, including incorporating the Strategy Committee
- the latest Good Governance Institute guidance: 'Board guidance on risk appetite' (May 2020)
- adding the reference to the changing the Board Assurance Framework to include - Gaps in controls and assurance be given separate references so that they can be easily mapped to the 'Action Plan to Address Gaps' section

It should be noted that the detailed Risk Management Procedure is currently being updated. A review and summary against the risk implementation plan from 2020/21 and development of the plan for 2021/22 is scheduled to take place next month. This will be presented through Executive and Audit Committee in May 2021.

A full review of the Risk Management Strategy is planned for 2021/22 and will link in with the Trust's review of the organisation strategy.

The Board are asked to approve the proposed changes to the Strategy.

Action required: For approval

Previously considered by: Executive Committee March 2021
Audit Committee 24 March 2021

Director:	**Presented by:**	**Author:**
Chief Nurse	Associate Director of Governance	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	☒
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) 007/18 There is a risk that the governance structures in the Trust do not facilitate visibility from board to ward and appropriate performance monitoring and management to achieve the Board's objectives.

Any other risk issues (quality, safety, financial, HR, legal, equality):
Risk issues affected by this report cover all areas.

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

East and North Hertfordshire
NHS Trust

Risk Management Strategy

2018 -22

Reviewed March 2021

Version	Date	Comment
1	7 March 2018	Revised

2	13 June 2018	Updated to align risk scoring nomenclature with Datix and BAF, set escalation level to>14 instead of 12, set review standard to 3 months for risks <15, set KPIs, introduce formal escalation process and agree Risk Management Implementation Plan.
3	April 2019	Updated with summary of first Trust risk management capability assessment, risk appetite statements summary and the new Risk Appetite Framework Policy, monthly BAF review process and version control table added meeting IA recommendations (20.12.2018).
4	25 April 2019	Five strategic priority risk appetite statements have been added, following Executive Director review, to the eleven statements reviewed at the Board Workshop on 06.02.2019. Risk appetite statements are found at Annex A of the Risk Appetite Framework Policy.
5	29 March 2020	Through the March 2020 Audit Committee risk report, the Committee was asked to approve proposed Datix changes in principle (for confirmation by the Audit Committee meeting in June 2020) and the unchanged Risk Management Strategy and Procedure (Annex 1) with the addition of the “At a glance – Risk Appetite – Jan 2020”, document.
6	March 2021	Reviewed to reflected feedback from Internal Audit review of the Assurance Framework

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

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

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

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

Monitoring compliance with and the effectiveness of this document

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

Review
This document will be reviewed annually with an in depth review in four years .

Key Messages

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

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

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

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

1. STRATEGY STATEMENT

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

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

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

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

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

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

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

2. PURPOSE

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

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

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

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

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

We can do this by:

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

- Ensuring the Trust has appropriate business continuity arrangements in place

3. RISK DEFINITION AND TYPES

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

Risk management is defined as:

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

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

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

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

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

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

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

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

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

- **Equipment and supplies risks**

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

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

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

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

4. TRUST RISK MANAGEMENT CAPABILITY

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

The assessment covered the Trust's:

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

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

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

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

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

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

Key documents included with the Risk Appetite Framework Policy are:

- Annex A - Trust risk appetite statement (February 2019)

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

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

Trust commitment

The East and North Hertfordshire NHS Trust Board have set the risk appetite for the organisation. The Trust will set, monitor and review its appetite for and attitude to risk in a risk appetite statement, as part of Trust Risk Management strategy and procedures, involving the views of internal and external stakeholders. Review will occur in conjunction with a formal review of the strategy or earlier if indicated.

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

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

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

Risk appetite

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

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

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

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

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

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

The statements below describe the Trust board's risk appetite in relation to the primary risk groupings, risk appetites and levels as set by the Good Governance Institute (2020), (Applying Risk Appetite Matrix) and other risk categories used by the Trust and reflected in its risk register and BAF.

Overall risk appetite statement summary

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

Risk areas

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

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

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

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

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

- Innovation
- Commercial
- Major change programmes and projects (inclining to *moderate,* risk level *cautious*)

Strategic priorities

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

- **Quality -** "Deliver high quality care consistently across all of our services in terms of clinical quality, safety and compassion."

The Trust has a MODERATE risk appetite, keeping the risk level CAUTIOUS**,** for risks in the following strategic priority area:

- **People -** "Create an environment which retains staff**,** recruits the best and develops an engaged, flexible and skilled workforce able to meet the needs of our patients."

The Trust has a HIGH risk appetite, accepting an OPEN risk level (inclining to *moderate*, risk level *cautious*), for risks in the following strategic priority areas:

- **Ease of use** - "Redesign and invest in our systems and processes to ensure that they provide a consistently simple and quick experience for our patients, their referrers, and our staff, minimising frustration and maximising efficiency."

- **Pathways -** "Pursue actively the development of pathways across care boundaries, where this is in the best interests of patients and adds value."

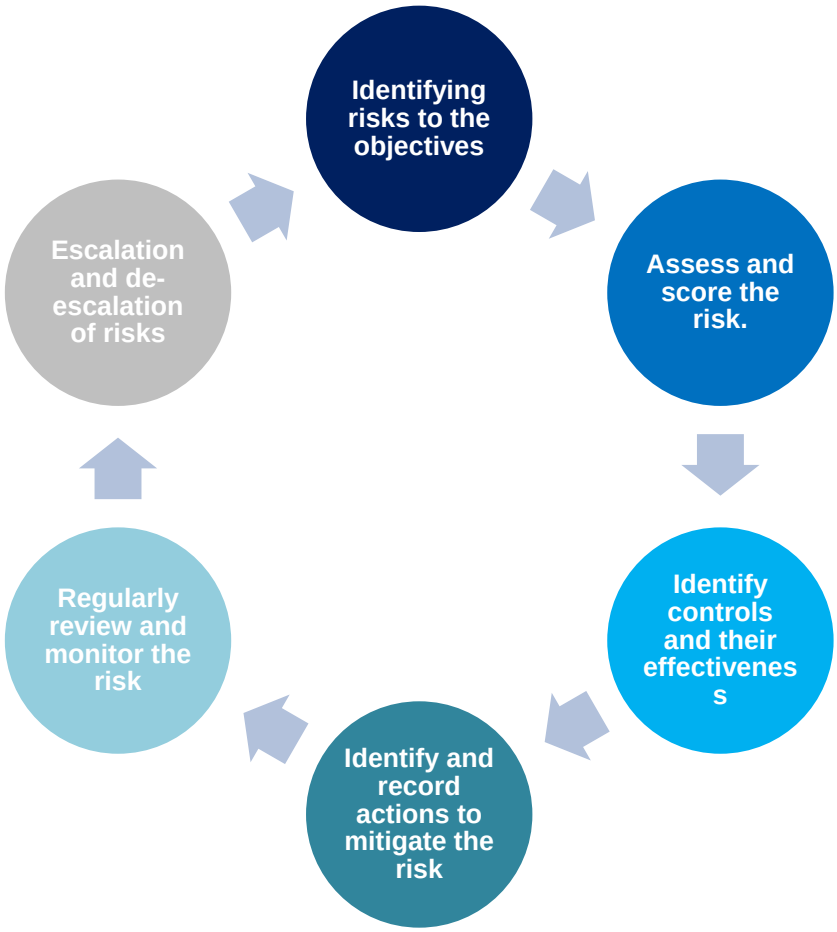
- **Sustainability** - "Develop a portfolio of services that are financially and clinically sustainable in the long-term.""

6. RISK MANAGEMENT PROCESS

A structured approach to the management of risk must be taken regardless of whether it is clinical or non-clinical in nature. Risks are identified, assessed and controlled and, where appropriate, escalated or de-escalated through the governance mechanisms of the Trust.

Risk management cycle

The Trust's risk management cycle includes:



Staff, partners and others should be fully involved in each stage of identifying, assessing, controlling and reviewing risks.

7. RISK MANAGEMENT GOVERNANCE

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

- Board of Directors
- Audit Committee
- Quality and Safety Committee, Finance, Performance and People Committee, Strategy Committee, Executive Committee and Divisional Oversight Groups
- Divisional Boards and directorate management teams
- Speciality teams

Risk management by the Board of Directors is underpinned by a number of systems of control through the following three mechanisms.

- **The board assurance framework (BAF)** sets out the strategic objectives of the Trust, identifies risks in relation to each strategic objective along with the controls in place and assurances available on their operation. The BAF is then used to drive the Board of Directors meeting agendas.

  Risks to the Trust's strategic priorities are identified by directors and through the Risk Manager's quarterly risk report, which includes a thematic analysis of risks scoring 15 and above. Aggregated Risk themes from low risks are also included periodically and can inform the BAF, as required.

  The BAF risks are detailed individually in a BAF template and are reviewed monthly by the Executive Lead for each risk and the Executive/Divisional Executive Committee. In addition, monitoring the BAF is included in the terms of reference of the Audit Committee, Quality and Safety Committee, Finance, Performance and People Committee and the Strategy Committee enabling regular scrutiny, discussion, challenge of evidence and update of the risks. A bi-monthly narrative report is also provided to the Board of Directors.

  The BAF includes how assurances cover the controls identified and whether these are 1st, 2nd or 3rd line assurances. The Assistant Director of Corporate Governance ensures that risks are mapped to understand the level of assurances in place for each control and to identify areas where assurances are insufficient or not in place.

  Gaps in controls and assurance be given separate references so that they can be easily mapped to the 'Action Plan to Address Gaps' section and provide greater oversight.

- **The annual governance statement** is signed by the Chief Executive as the Accountable Officer and sets out the organisational approach to internal control. This is produced at the end of the financial year and scrutinised as part of the annual accounts process.

  Additionally, the Audit Committee and other board sub-committees provide assurance of the robustness of risk processes and to support the Board of Directors.

- **Audit Committee** is the sub-committee of the Board of Directors which is responsible for maintaining oversight of the risk management processes across the Trust and implementation of the RM Strategy and Implementation plan.

- **Quality and Safety Committee (QSC)** Committees reporting to the QSC provide a more detailed specialist oversight of risk. These include the Clinical Effectiveness Committee, Patient Safety Committee and the Patient Experience Committee. As risks can often fall into several categories, the risk report to these committees includes a summary of all the committee risks to enable an integrated oversight of risk.

- **Finance, Performance and People Committee (FPPC)** Committees reporting to the FPPC provide a more detailed specialist oversight of risk. These include Capital Review Group, Finance Boards and various Performance groups. As risks can often fall into several categories, the risk report to these committees includes a summary of all the committee risks to enable an integrated oversight of risk.

- **Strategy Committee** Committees reporting to the Strategy Committee provide a more detailed specialist oversight of risk. These include Digital Strategy Board, Sustainability and various strategy groups. As risks can often fall into several categories, the risk report to these committees includes a summary of all the committee risks to enable an integrated oversight of risk.

- **Executive Committee (Exec)** in operational detail, reviews risk plans, initiatives and papers, as required, prior to reporting to the Quality and Safety Committee or after the Board of Directors. Prior to the DEC, operational discussion on risk matters may also occur at the Divisional Operational Committee.

- **The corporate risk register (CRR)** is the corporate high-level operational risk register used as a tool for managing risks and monitoring actions and plans against them. New risks are added formally to the CRR only after Divisional Boards/ Corporate Directorate Meetings have approved the escalation of the

risk. Datix risk includes an "Assessment for Escalation of Risk" section with boxes for Risk Leads, Divisional Boards and the Executive Committee to record their decisions concerning risk escalation and management. Used correctly, it demonstrates that an effective risk management approach is in operation within the Trust.

- **Corporate Services risk registers will cover risks from corporate areas such as nursing, strategy, finance, estates, governance, workforce and IT** are maintained by an identified lead on behalf of the directorate, with support from the Risk Manager.

- **Divisional Risk Registers** are maintained by the Divisional Quality Managers on behalf of the division, with support from the Risk Manager. These should be reviewed at Specialty Meetings, Directorate Board and Divisional Boards in accordance with the risk management procedure.

- **Each division will have the following fundamental processes for managing risk** and meeting Trust risk management key performance indicators:

    - **A division level management forum** so the division can monitor that their risks are being appropriately managed. This includes that Risk Leads are regularly reviewing their risks and implementing effective control measures. Any required escalation to the Corporate Risk Register or de-escalation must be approved by the divisional board.

    - **All specialties will have a formal monthly minuted meeting** where their risks and controls are discussed and new risks identified.

    - **All areas will have identified Datix Risk Leads and Approving Managers** to manage risks operationally and approve risks according to the ASSURE risk quality tool.

    - All divisional leadership roles will be compliant with **risk management training standards.**

    - **Divisional Governance/Audit Leads and Divisional Quality Managers** have responsibilities regarding monitoring and facilitating the management of risk within their areas.

The Risk Manager will facilitate risk clinics in divisions and non-clinical areas, where necessary, to support and guide divisions. The Process for Risk Clinics is used.

8. RISK MANAGEMENT ACTIVITIES

The Trust risk management activities are a part of its overall commitment to effective clinical governance and patient safety. The risk management approach is underpinned by additional Trust policies supported by on-going training including:

- Risk Management Procedure
- Trust Risk Appetite Framework Policy and its annexes particularly Annex A Trust risk appetite statement
- Management of Serious Incidents (SIs) procedure (CP 180)
- Adverse Incident Reporting and Investigation Policy (CSEC 049)
- Serious incidents investigation guidelines
- Management of Health and Safety at Work Policy (mhsw)
- Health and safety risk assessments
- Complaints and Concerns Policy (CSEC 008)
- Information Security policy and Records Management Policy (IG 002)
- Management of Alerts Procedure (CP 256)
- Business Continuity Plan
- Capability Policy
- All policies and procedures associated with healthcare acquired infections
- Violence and Aggression Policy (viol&agg)

- Safeguarding Adults from Abuse Policy (CSEC 021)
- Safeguarding Children Policy (CSEC 046)
- Management of financial risk and risks to the internal control environment through the application of the SFIs.
- Maternity Risk Management Strategy

The Trust's systems of internal control are based on its on-going risk management programme that aims to:

- Identify principal risks to the achievement of goals set out in the annual plan
- Evaluate the nature and extent of risks
- Manage all risks effectively, efficiently and economically
- Enable the completion of the annual governance statement

9. DELIVERING THE STRATEGY

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

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

- Be clear about the Trust's quality priorities and strategic objectives
- Promote awareness and understanding of the benefits of proactive risk management, and promote a positive risk and patient safety culture
- Manage risks applying the Trust Risk Appetite Policy Framework and its annexes, particularly Annex A the Trust Risk Appetite Statement.
- Aim to meet the risk Key Performance Indicators (KPIs) by ensuring arrangements are in place in specialties and at divisional level for identifying, assessing, controlling, monitoring and reviewing risks and their controls. Key to making this happen is regular risk discussion involving staff at departmental/ward level.
- Distribute and disseminate, to their teams results of complaints, incidents, serious incidents, claims, near misses, audits and lessons learned
- Support compliance with appropriate legislation and standards including national risk management standards and CQC requirements

The Trust will:

- Ensure corporate ownership and accountability throughout the organisation of risk management and the need to mitigate risk along with the mechanisms for reporting and sharing learning across the organisation.
- Promote and support the ongoing development and Trust wide implementation of risk management strategies and policies according to best practice
- Apply and review the Trust risk appetite.
- Provide risk management training and facilitation programmes to support staff in implementing their risk management responsibilities and reporting of incidents.
- Ensure that all staff receive training in conducting health and safety risk assessments.
- Promote a strong risk management culture through involving all staff groups in both clinical and non-clinical areas. This is supported by the development of arrangements for routine management of risks in all areas.

10. RESPONSIBILITIES AND ACCOUNTABILITIES

RISK MANAGEMENT SPECIALISTS

The Trust has a range of risk management specialists who possess and maintain appropriate qualifications and experience sufficient to ensure that competent advice is available to staff. The specialists are responsible for creating, reviewing, facilitating and implementing policies, procedures, protocols and guidelines for the effective control of risk. Key risk management leads for the Trust are as follows:

- The **Assistant Director of Corporate Governance** is the corporate governance lead for the Trust and supports the Board of Directors in carrying out their responsibilities for risk management and takes the lead, on behalf of the board of directors, for maintaining the board assurance framework.

  The Assistant Director of Corporate Governance manages the Risk Manager. Strategic risk management approaches and systems are developed and support provided to the Board of Directors and Trust wide. The role ensures a clear relationship between Board Assurance Framework risks identified by the Board and the Trust risk register.

  The Assistant Director of Corporate Governance also manages the Compliance Manager who monitors Trust-wide regulatory standards including CQC, MHRA etc. New risks identified by the Compliance Manager are communicated to divisions for entry to the risk register and management action. This in turn is monitored.

- The **Risk Manager** is the Trust risk lead and is responsible for developing and facilitating implementation of the Trust Risk Management Strategy, Risk Management Procedure and Risk Appetite Framework Policy. This includes facilitation and drafting of the Board's Trust risk appetite statement supporting the Trust risk appetite process and drafting the Board's risk management capability assessment for Board approval, upon which the risk appetite is based.

  The Risk Manager supports divisions and non-clinical areas with risk reports in an agreed format to facilitate ward to board governance and where necessary, escalation, of risks. The department also supports executive management of risk by managing the corporate risk register and reviewing the wider Trust risk register to provide assurance on the compliance with the risk management strategy and Risk Management Procedure.

  The Risk Manager oversees the Corporate Risk Register and facilitates divisions' management of their risk registers. Divisions are facilitated by the Risk Manager to monitor their risk registers and the effectiveness of controls. The Risk Manager is responsible for delivering comprehensive Trust wide risk management training, facilitation and coaching programmes to enable all areas to develop their risk management processes as an integral part of routine organisational and departmental activity. The Risk Manager works closely with the Patient Safety Team on the management of alerts to facilitate monitored change occurs on the ground following alerts.

- The **Health and Safety Manager** is responsible for facilitating all areas of the Trust to proactively carry out health and safety risk assessments on their activities, processes, workplaces, equipment and people who are at particular risk. Where a risk has been identified as a result of a health and safety risk assessment, which is unable to be controlled to as low as reasonably practicable, the risk is entered onto the risk register.

- **Divisional Quality Managers** are responsible for ensuring all specialties are identifying, assessing, controlling and closing risks routinely, involving their staff, and accessing risk management training and support. They are responsible for supporting the on-going maintenance of the divisional risk register. They are responsible for facilitating and monitoring the implementation of alerts in their divisions.

- **Committee chairs**; For example: Patient Safety Committee, Clinical Effectiveness Committee and Patient Experience Committee. Chairs are responsible for enabling their committees to know the key risk themes from existing and emerging risks, identify any areas in the management of risks that require development or escalation to the Quality and Safety Committee or Executive Committee.

TRUST STAFF

All staff

- Staff should have an awareness and understanding of the risks that affect patients, visitors, and staff
- Line managers will involve their staff routinely in identifying risks and effective controls.
- Staff who are identified to implement actions to control risks, will do so with the support of their speciality.
- There will be proactive and regular communication on risk at all levels including ward/department/speciality. Communication should include staff, stakeholders and partners.
- All staff will have access to comprehensive risk guidance and advice
- Risk assessment and management – risks are assessed and acted upon to prevent, control, or reduce them to an acceptable level. Staff have the freedom and authority, within defined parameters, needed to take action to tackle risks, escalating them where necessary
- Measuring performance - exposure to risk is measured with the aim of reducing this over time. The culture of risk management is also measured and improved where applicable.

Datix Risk Lead

All risks will have an identified lead, known as the Datix Risk Lead, recorded on the Trust's Datix system. The Datix Risk Lead is responsible for ensuring the risk is managed and monitored to ensure controls and further actions are in place to mitigate the risk. It is the responsibility of the Datix Risk Lead to escalate risks scoring 15 and above, in line with the escalation process.

Action Owner

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

Approving Manager

All risks have Approving Managers who approve the management of the risk. The Trust ASSURE tool is used, following risk management training, by Approving Managers and others to check the risk is meeting appropriate standards with description, scoring, assurance etc. Any changes are made in liaison with the Datix Risk Lead. The Approving Manager is usually the Datix Risk Lead's senior manager or director. The Approving Manager and Datix Risk Lead work together over escalation of the risk to the Corporate Risk Register, if needed, using the Assessment for Escalation section on Datix.

Divisional Governance/Audit lead

All corporate areas, divisions, programme and project teams must have an identified Governance/Audit Lead.

The Governance/Audit lead will be responsible for:

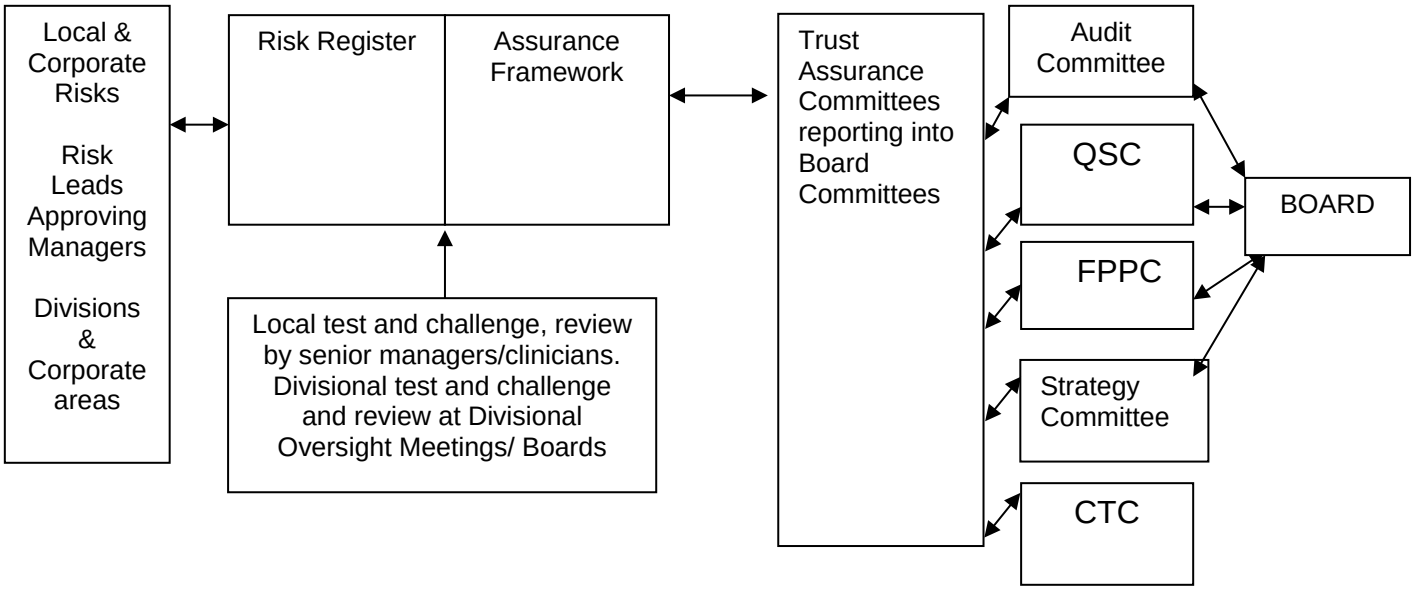
- Consulting with teams to identify and assess risks and determine mitigating actions
- Ensuring risk registers undergo regular review and quality assurance
- Promoting the Risk Management Procedure and best practice within their division.
- Communicating changes to the Risk Management Strategy and Risk Management Procedure to staff within their area of the Trust
- They are responsible for facilitating and monitoring the implementation of alerts in their divisions, working closely with Divisional Quality Managers.

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

11. ASSURANCE FRAMEWORK

Assurance structures
Assurance of achievement, weaknesses in delivery and key risks to the delivery of Trust objectives are reported through the assurance committees of the Board. The Audit Committee maintains oversight of the risk management processes across the trust and implementation of the RM Strategy and Implementation plan. The Committees of the Board receive detailed reports to inform them of all significant risk exposures, material changes to risks and progress with risk management key performance indicators. The Trust assurance committees are responsible for providing assurance on the management of risk to the Board of Directors.

An overview of the assurance process is illustrated below.



12. TRAINING

A comprehensive training programme has been developed to support the successful implementation and embedding of the Risk Management Strategy, Risk Management Procedure and the Risk Appetite Framework. Training and facilitation is provided for all staff in leadership roles (Band 7 and above to CE level and including consultants). Training is provided to the Board of Directors at least every two years, to ensure that the requirements for understanding and discharging duties in relation to risk management at board level is reviewed and refreshed, thereby maintaining compliance with nationally agreed policy and practice.

Staff awareness and knowledge of risk management is facilitated through risk management information and guidance available on the Trust Knowledge Centre. Training will be included in Trust induction training.

The overall effectiveness of the delivery of risk management training for board members and senior managers is evaluated and monitored by the Risk Manager. Where such monitoring identifies deficiencies, recommendations will be agreed and an action plan developed and changes implemented accordingly.

13. RISK MANAGEMENT PROCEDURE

This Risk Management Strategy is underpinned by a comprehensive Risk Management Procedure which describes the process for effectively identifying, assessing, evaluating and monitoring all Trust risks whether they are clinical or health and safety related. This is available on the Trust's Knowledge Centre.

Please note this strategy is due a full review during 2021/22.

NHS
East and North Hertfordshire
NHS Trust

AT A GLANCE – RISK APPETITE - JAN 2020

Some key points are identified for risk areas and strategic priorities. Strategic priorities - indicated with an *

LOW/MINIMAL	MODERATE/CAUTIOUS	HIGH/OPEN
Quality/outcomes* *"Deliver **high quality care** consistently across all of our services in terms of clinical quality, safety and compassion"* Patient safety, care quality, staff safety, clinical risks, infection prevention and control (IPC), clinical and organisational innovation, patient experience, access, equality issues -Tolerance for risk taking limited to decisions where *potential* for adverse effects on safety, experience or clinical outcomes is *low* and the potential for *mitigating actions is strong*, with *robust governance systems* and *practice.* - No appetite for non-compliance with IP&C standards or regulatory requirements E.g. concerning serious risk identification, mitigation and organisational learning. -Low appetite for serious risks re administration, communication systems, appointments, discharge summaries, waiting times and delays in procedures and outpatient appointments	**Reputation** - **inclining to high/open** Includes Communications -Decisions with the potential to expose the Trust to additional scrutiny of its reputation will be considered carefully and progressed only with strong mitigations and careful management of any potential repercussions. -Must not supersede statutory reporting obligations of staff, and must not prevent openness/transparency, even of bad news. -Risk appetite will incline to high/open E.g. for changes to services that are critically important for the Trust's care standards, improvements or long-term viability. The consequences, risks and rewards must receive full evaluation and mitigation planning.	**Ease of use*** - **inclining to moderate/cautious** *"Redesign and invest in our systems and processes to ensure that they provide a consistently simple and quick experience for our patients, their referrers, and our staff, minimising frustration and maximising efficiency" -*
Compliance/regulatory Legal requirements, regulatory/inspection requirements, professional standards, Codes of Conduct, ethical standards, system/process/policy compliance, service continuity -Nothing illegal - every effort to meet regulator expectations unless there is strong evidence or argument to challenge them -Staff to act at once to prevent, report, escalate and mitigate breaches of the law, and serious breaches of care standards	Staffing/people* "Create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce able to meet the needs of our patients" -Appetite is higher risks where low-cost changes lead to improvements in care or efficiency. Appetite reduces to nil for any risks to patient safety or breaches of contractual, legal and equalities obligations. -Appetite is low for risks about retention of key staff groups with critical skills that are difficult to replace	**Major change programmes and projects** - inclining to risk appetite **moderate/ cautious**) (including effects of Brexit) *-Trust encourages staff at all levels to identify, suggest and escalate ideas for projects that will benefit patients, public, staff or improve efficiency and VFM.* *-Authority to establish major programmes and projects is only at strategic level.* *-Appetite is higher for risks with low-cost projects that lead to improvements in care or efficiency* *-Appetite can be low/ minimal, if projects present significant risks to care quality and standards, patient safety or good people management..*

	-Use Trust policies for low clockspeed risks. - Fast clockspeed safe staffing risks may be dealt with at operational levels at necessary pace and through the necessary methods to prevent serious risks of harm to patient safety. This kind of situation should be rare, and should always be escalated immediately, seeking authority to continue.	
Financial/value for money Insurability, contracts, SLAs, business continuity -minimal risk approach to financial risks but Trust is prepared to invest in resources that deliver improvements in quality and patient safety -Significant financial and value for money risks must be escalated to strategic levels -In urgent care decisions requiring immediate action without senior guidance, staff at all levels need to balance financial risks against risks of harm to patients.	**Equipment and Supplies** (including procurement and new product/services) -Moderate appetite for changing suppliers or service providers, using older equipment. - Low appetite for significant risks and supply problems concerning patient/staff safety, care quality, service continuity and financial stability - Older equipment essential for services, combined with financial pressure, creates business continuity and service degradation risks. To maintain essential services, appetite is moderate. Appetite reduces to none if this kind of risk is not being rigorously managed and mitigated	**Pathways*- inclining to moderate/cautious** *"Pursue actively the development of pathways across care boundaries, where this is in the best interests of patients and adds value" -*
	Estates (Including Health and Safety, Fire, Occupational Health, Security) -Low appetite for significant risks to patient and staff safety, care quality, service continuity and financial stability. -No appetite for serious non-compliance	**Sustainability*** - inclining to **moderate/cautious**) *"Develop a portfolio of services that are financially and clinically sustainable in the long -term"*
	IT/IM - **inclining to low/minimal**	**Innovation** -Actively seek opportunities for organisational innovation, strategic transformation; developing external alliances that supports quality, patient safety/experience and operational effectiveness and innovations that represent best practice in staff management. -Appetite reduces if innovations present significant risks to care quality, patient safety and people management. -Business case, analytical tools, risk and equalities assessment etc.

		Commercial -Evaluation of risk v. reward required, Trust will support risk opportunities in business markets where potential to have significant commercial strength over its competitors is identified -Authority for accepting commercial risk is at only Trust strategic level -Long term, ethical view. Short-term considerations do not outweigh the long-term financial soundness of the Trust, its reputation, its ethical framework, access and continuity of services or its ability to deliver safe, high quality services.

East and North Hertfordshire NHS Trust

Agenda Item: 13

TRUST BOARD - PUBLIC SESSION – 5 MAY 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 10 March 2021** **Quality and Safety Committee – 30 March 2021**		
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 1.59% for the 12 month period to January 2021 compared to 1.27% for the latest 3 years.
HSMR: (data period Dec19 – Nov20)	HSMR for the 12 month period is **84.13, 'First quartile'.**
SHMI: (data period Oct19 – Sep20)	Headline SHMI for the 12 month period is **88.75 'lower than expected band 3'. One of only 15 Trusts of 124 in top band.**
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 update
- HSMR has remained stable and is in the first quartile
- SHMI is stable and for the first time is in the 'better than expected band'
- Medical Examiners: currently reviewing approximately 50% of deaths. Full implementation scheduled for 1 April 2021
- Mortality Review Tool/Datix iCloud: development work continues
- Regular on-going mortality monitoring via Mortality Surveillance Committee, Quality and Safety Committee and Board.

1.4 Current risks

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 Update

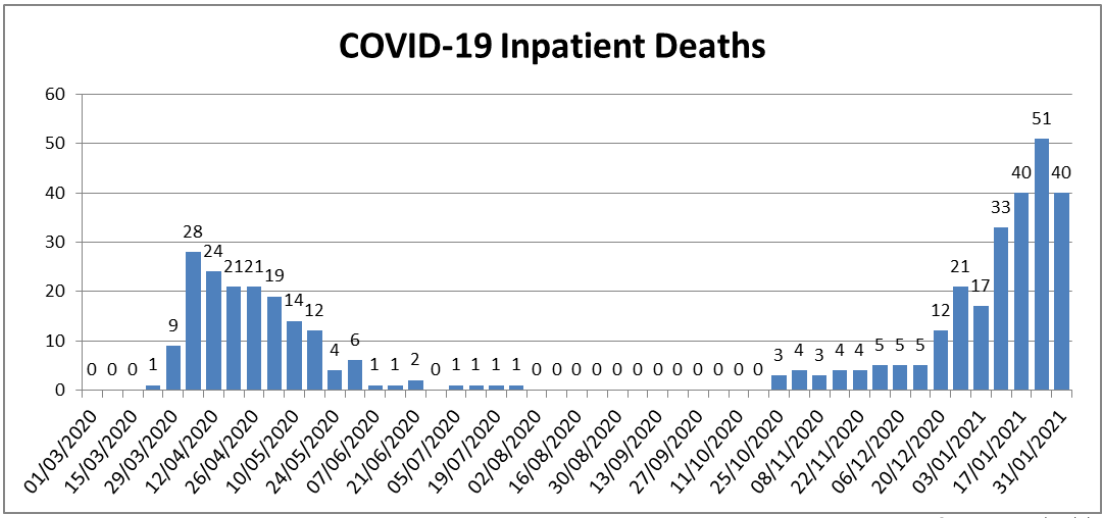
2.1.1 COVID-19 mortality data

2.1.1.1 COVID in-patient deaths

This quarterly report has been expanded to provide additional detail regarding COVID-19.

The first COVID-19 death reported in the Trust occurred on 19 March 2020. Figure 1 shows subsequent deaths by week up to 31 January 2021. The dates shown are 'week-ending' dates. This chart shows our first local peak occurred week ending 5 April 2020. There has been far more deaths in the second wave, with the second peak occurring in week ending 24 January 2021.

Figure 1: Trust COVID-19 Inpatient deaths – 01/03/2020 to 31/01/2021 by Week



Source: ENHT local data

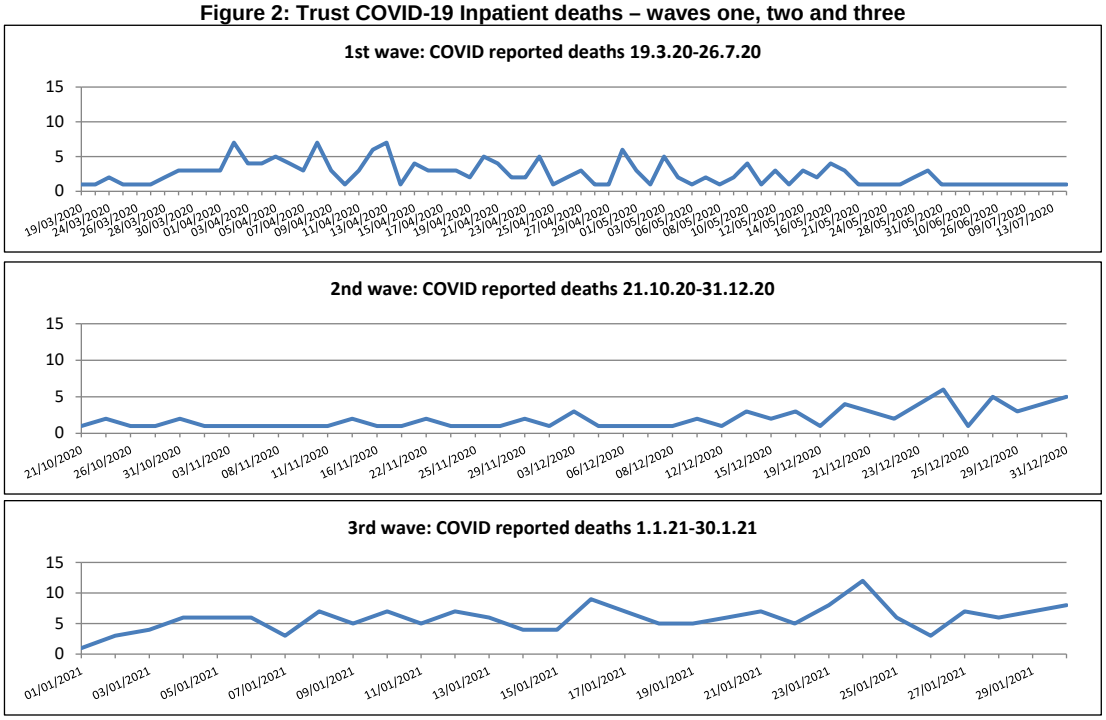
The multi-layered effects of the COVID-19 pandemic will make meaningful analysis and comparisons regarding mortality data challenging. To date our local data has shown the following trends.

There were 414 COVID-19 Inpatient deaths at the trust from 01 March 2020 to 31 January 2021, a significant increase when compared to 179 for 01 March 2020 to 12 November in the last report. This figure includes both patients who tested positive for COVID-19 and patients who had a clinical assessment of COVID-19.

2.1.1.2 COVID waves one, two and three

The 'third wave' from 1 January 2021 showed increased numbers of deaths.

Figure 2: Trust COVID-19 Inpatient deaths – waves one, two and three



2.1.1.3 COVID in-patient analysis

Figure 3 shows a change from the 25%/75% proportion of female/male deaths in the last report, to 34/%/66%. This suggests an increase in the proportion of female deaths in the recent months, highlighted by a 46%/54% split for January 2021.

Figure 4 shows that our local findings regarding those patients worst impacted by the virus are broadly in line with nationally reported outcomes, namely; the elderly are worst hit and there have been more deaths in the younger age groups with deaths in the 30-39 Age Group reported this time.

Fig 3: COVID-19 Inpatient deaths (01/03/20-31/01/21) by Gender

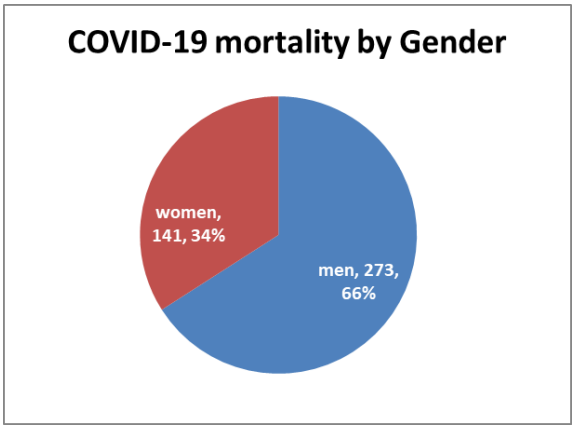
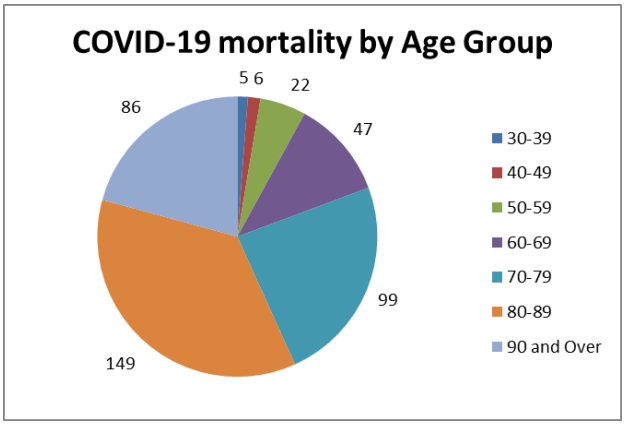


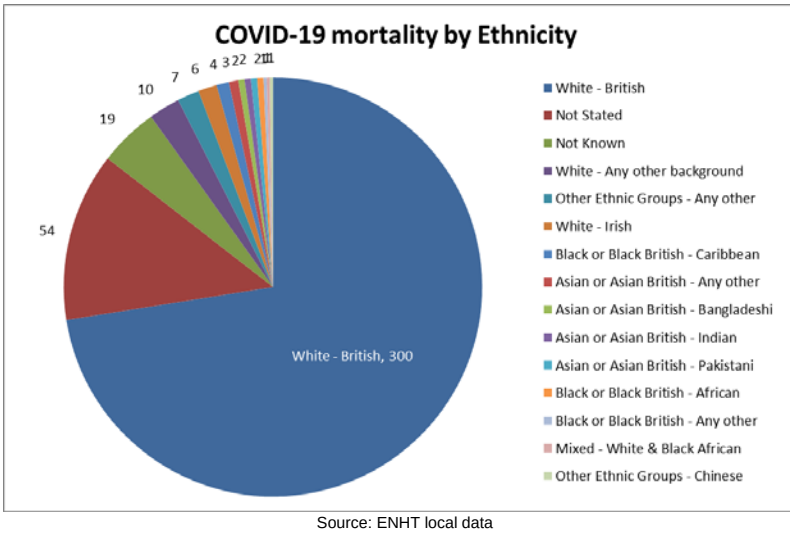
Fig 4: COVID-19 Inpatient deaths (01/03/20-31/01/21) by Age



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 31/01/2021 by Ethnicity

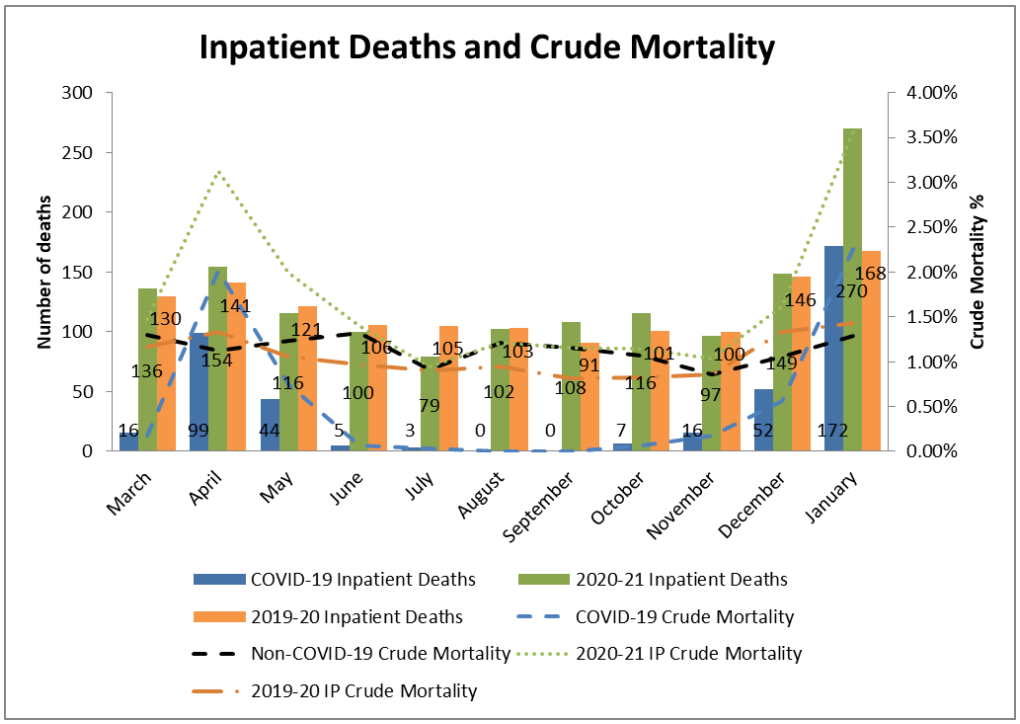


Source: ENHT local data

2.1.1.4 COVID in-patient deaths and crude mortality

Figure 6 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. The number of COVID-19 deaths in January 2021 was extremely high, and exceeded the total number of Inpatient deaths in the previous January prior to the start of the COVID-19 outbreak. Additionally, a line showing Non-COVID-19 Crude Mortality has now been added to the chart.

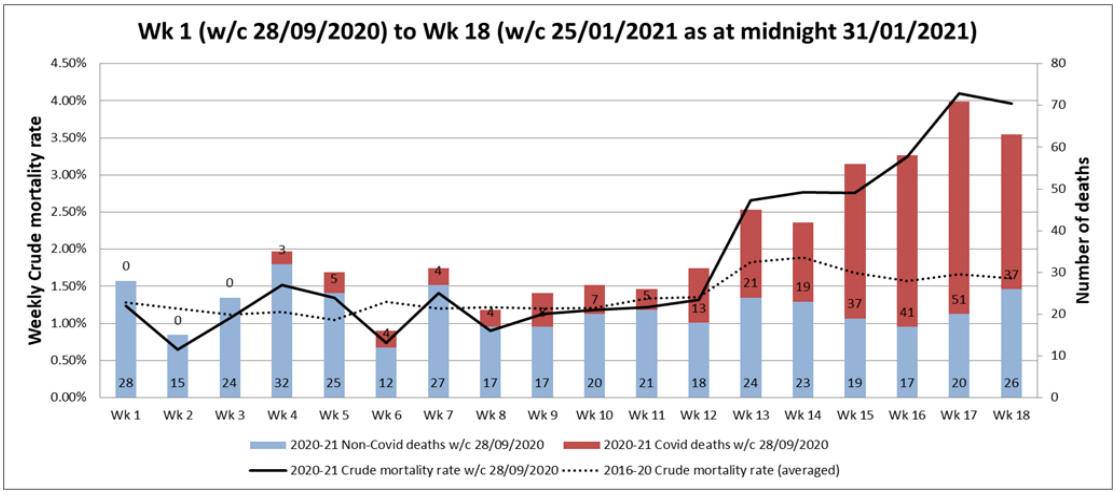
Figure 6: Trust COVID-19 Inpatient deaths – 01/03/2020 to 31/01/2021 by Month



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.

2.1.1.5 COVID in-patient Winter deaths 4 year average

Figure 7: Trust COVID-19 'Winter' Inpatient deaths 2020-21 vs 4 year average



Notes:

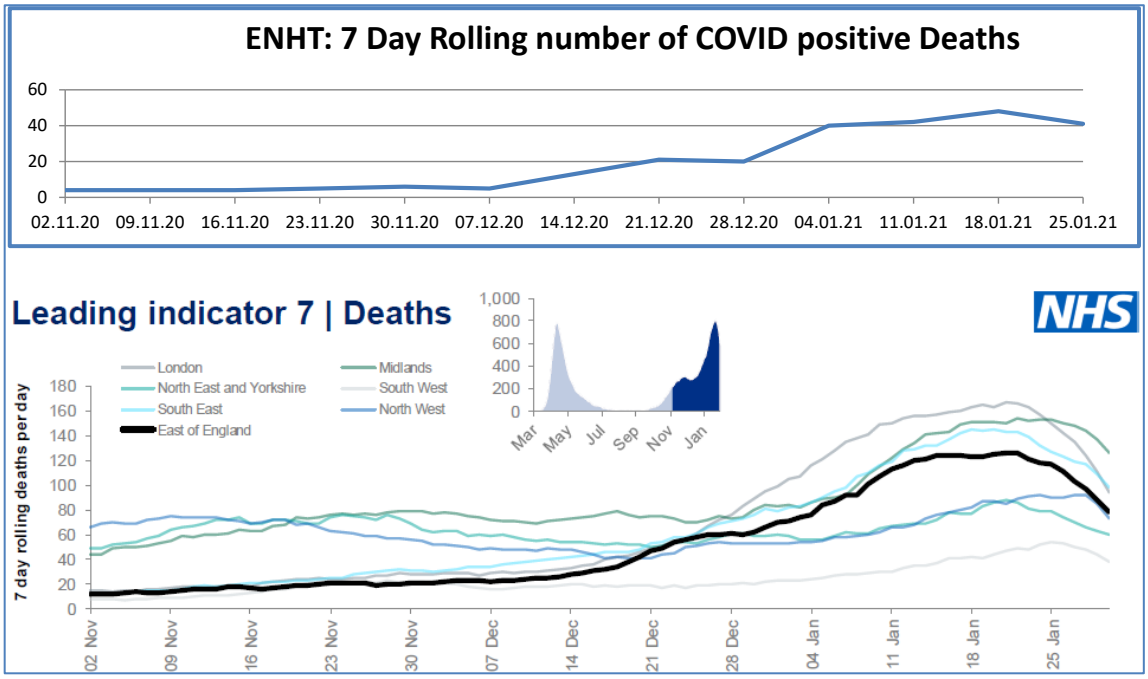
- *COVID deaths are COVID coded deaths and/or patient tested positive for COVID*
- *Jan 2021 total number of deaths taken as at midnight 31/1/21, not all Jan-21data will have been input*
- *Weeks are all 7 days of data*
- *Wk 1 is calendar year wk number 40 and includes 01 Oct for each of the 5 year.*

2.1.2 Potential indicators of performance

2.1.2.1 Latest regional peer comparison

Recent COVID data shows clear alignment with the regional/national picture.

Figure 8: COVID positive deaths: Recent regional peer comparison



2.1.2.2 CHKS COVID first wave report

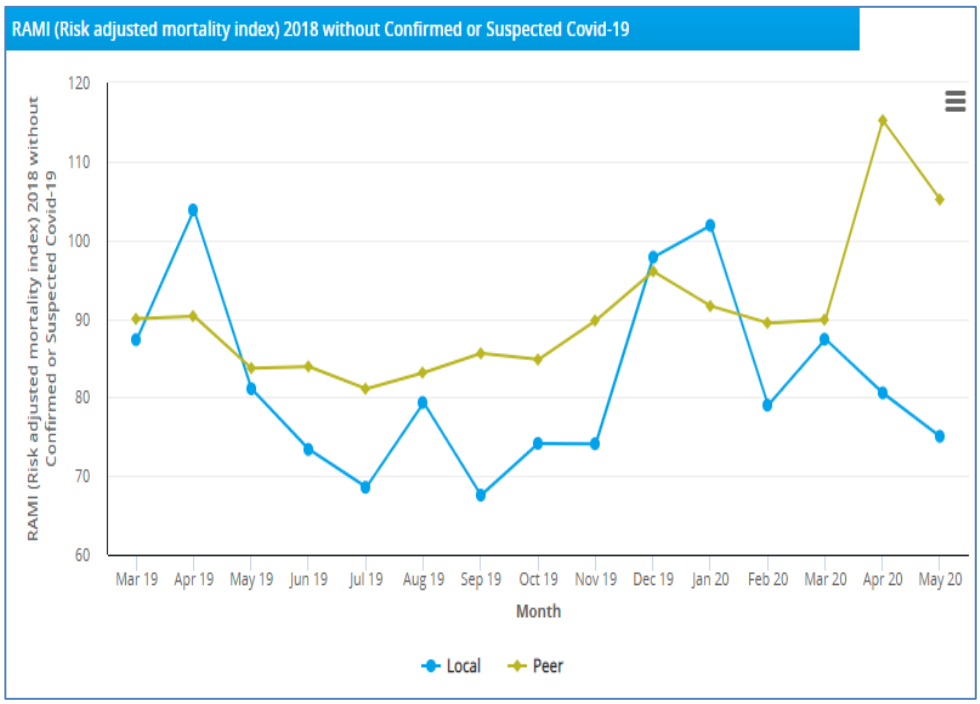
HSMR (largely excludes COVID):

- The Trust did not show a marked increase in contrast to higher rates in the national peer group
- CHKS intend to produce a second report - May/June 2021 which will provide detail regarding the Trust's performance in later stages of the pandemic.

Figure 9: CHKS First wave report: in-month HSMR vs National

CHKS RAMI indicator redesigned to exclude COVID

Figure 10: CHKS First wave report: in-month RAMI vs National

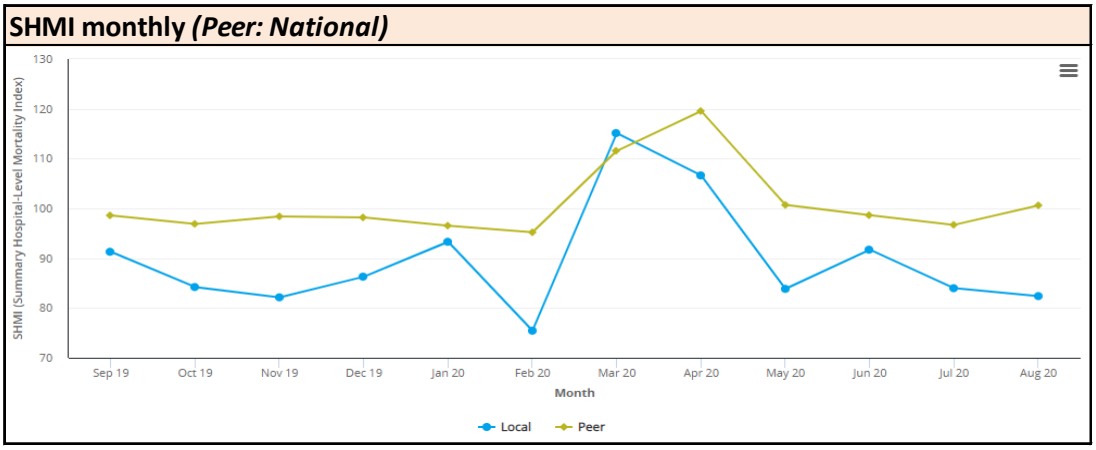


- When we exclude COVID our performance compares favourably with peers
- 'Reasonable assumption': Negative impact of pandemic on non-COVID patients less significant than for our peers.

2.1.2.3 COVID period in-month SHMI

SHMI excludes COVID deaths, but covers those occurring in the community within 30 days of discharge. This gives some indication of performance regarding non-COVID discharged patients.

Figure 11: First wave in-month SHMI vs National

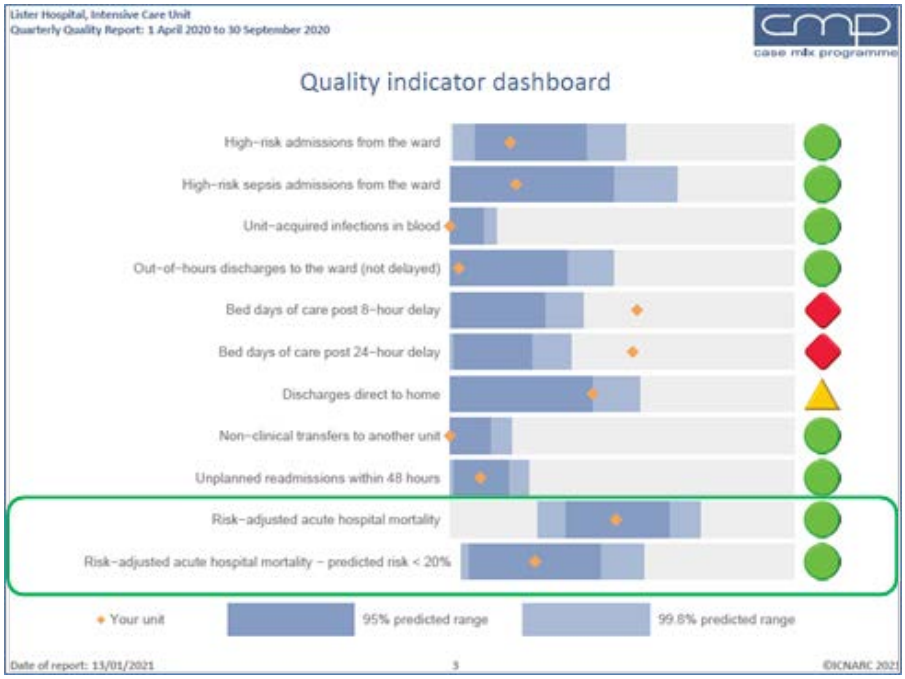


Scrutiny of deaths in the community within 30 days of discharge, underpinning the March 2020 spike, which represents the only point at which our in-month SHMI exceeded the national average, will be focussed on as part of the review detailed in 2.1.3) below.

2.1.2.4 ICNARC: Quality Report: 1 Apr20-30 Sep20

A recent ICNARC report indicates the Trust is well positioned regarding risk adjusted acute hospital mortality. This is another quality measure used to triangulate our performance during the pandemic.

Figure 12: ICNARC Quality report 1 Apr20 - 30 Sep20: Quality indicator dashboard



The two red flags reflect the ongoing wider Trust bed capacity challenge which results in patients remaining in ITU longer than is optimal from the perspective of the Critical Care Service.

2.1.2.5 Hospital acquired nosocomial infections

Work is currently underway to assess the impact of hospital acquired nosocomial infections with mortality reviews being prioritised for those patients who sadly went on to die from COVID.

2.1.3 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 January 2021 all but urgent requests were again suspended. From March reviews are recommencing. To date this year we have reviewed approximately 50% of the deaths in scope for the core Trust mortality review process. Over the next few months reviews will be focussed on any cohorts of patients where it is felt particularly important to gain assurance and learn from the extraordinary situation presented by the pandemic.

In additional to our BAU service, in order to better understand the impact of COVID-19, two specific cohorts of patients were 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. Summary detail was provided to the Mortality Surveillance Committee in December. The review showed that a number of patients may have caught COVID on their first admission and that a small number may have been discharged too soon. The review outcomes have been shared with those reviewing probable/definite nosocomial hospital acquired COVID infections. The Committee requested a similar review to be undertaken for a period covering the second COVID peak.

The second review is still in progress in collaboration with the Coding department. Early outputs from the review have not given rise to concerns as to whether patients were discharged too soon during the peak times in the pandemic. Further deaths will be reviewed to provide additional assurance/learning.

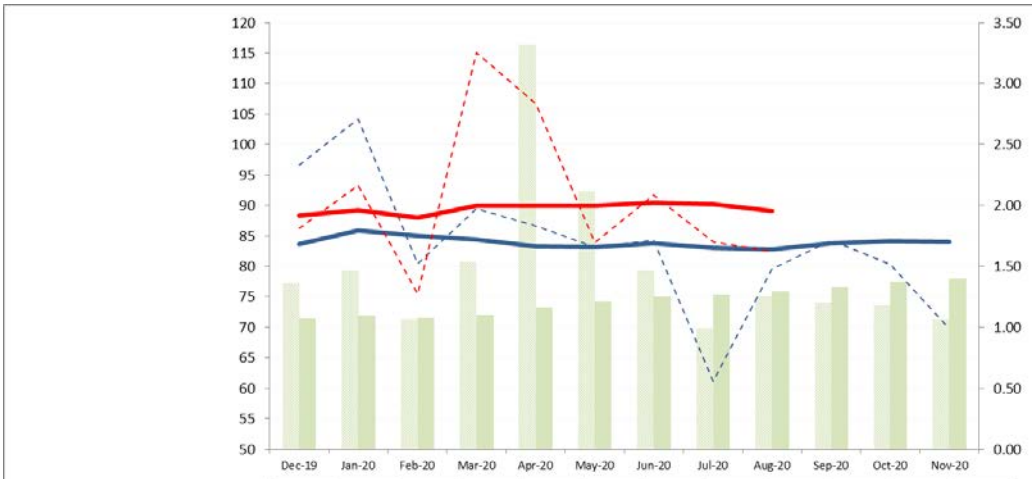
2.1.4 COVID Interim indications

- Latest death trend in line with region(s)
- Mortality indicators have remained stable & largely unaffected – providing some indication that non-COVID death rates have not significantly increased
- CHKS 1st wave report indicates positive performance compared to peers
- Significant increase in crude mortality Apr-20 and Jan-21
- Significant increase in deaths in 3rd wave
- Significant change to gender split in 3rd wave
- Gradual reduction in % of over 71yr old deaths, but they still account for large proportion of deaths
- 2020-21 winter spike significantly larger than recent years
- ICNARC Quality report 1 Apr-20 to 30 Sep-20 shows strong results for Critical Care risk-adjusted mortality rates.

2.2 Key mortality metrics

2.2.1 Trust key metrics overview

Figure 13: Trust Key Mortality Metrics: Latest Position



	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Mortality Rate - Monthly	1.36	1.47	1.06	1.54	3.32	2.12	1.47	0.99	1.25	1.20	1.18	1.07
Mortality Rate - Rolling Month	1.07	1.10	1.08	1.10	1.16	1.21	1.25	1.27	1.29	1.33	1.37	1.40
HSMR - Monthly	96.6	104.2	80.4	89.5	86.6	83.2	84.2	61.2	79.6	84.3	80.3	69.9
HSMR - Rolling Month	83.7	85.8	85.0	84.4	83.3	83.2	83.8	83.0	82.8	83.8	84.2	84.0
SHMI - Monthly	86.3	93.3	75.4	115.1	106.6	83.8	91.7	84.0	82.4			
SHMI - Rolling Month	88.4	89.2	88.0	89.9	90.0	89.9	90.5	90.2	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 as reported by CHKS. This shows that the rolling 12 month position has remained relatively stable for HSMR and SHMI.

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 1.53%, and is 1.59% for the Model Hospital peer group for the twelve months to August 2020. This compares to 1.40% within ENHT for the same period. The Trust's locally recorded crude mortality rate, stands at 1.59% for the latest twelve months to January 2021.

HSMR: Our rolling 12 month HSMR for the last 9 months has remained broadly stable, with only small fluctuations seen. 84.13 was reported for the latest period (December 2019 to November 2020), compared to 83.07 for the previous release September 2019 to August 2020.

SHMI: While figure 6 above from CHKS data shows SHMI to August 2020 (89.2) NHS Digital has now refreshed to show the rolling 12 months to September 2020. It reports the Trust's SHMI currently stands at 88.75 for this period. While only a marginal decrease, this has shifted the Trust into the 'lower than expected' band 3, for the first time since introduction of the metric in 2010.

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 October 2019-September 2020 SHMI calculation, 1.0% of the Trust's spells were excluded. NHS Digital also notes there has been a fall in the number of spells recorded by trusts between this publication and the previous SHMI publication, ranging from 0 per cent to 4 per cent. This is due to COVID-19 impacting on activity from March 2020 onwards and appears to be an accurate reflection of hospital activity rather than a case of missing data.

2.2.2 Trust In-month trend (crude/HSMR)

Figure 14 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 first wave 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. The very steep increase in the number of deaths in January 2021 is mirrored by a steep increase in the Crude Mortality, a reflection of the increased numbers of COVID-19 patients hospitalised in the second wave of the COVID-19 outbreak.

Figure 14: Trust Crude Mortality/HSMR latest in-month trend

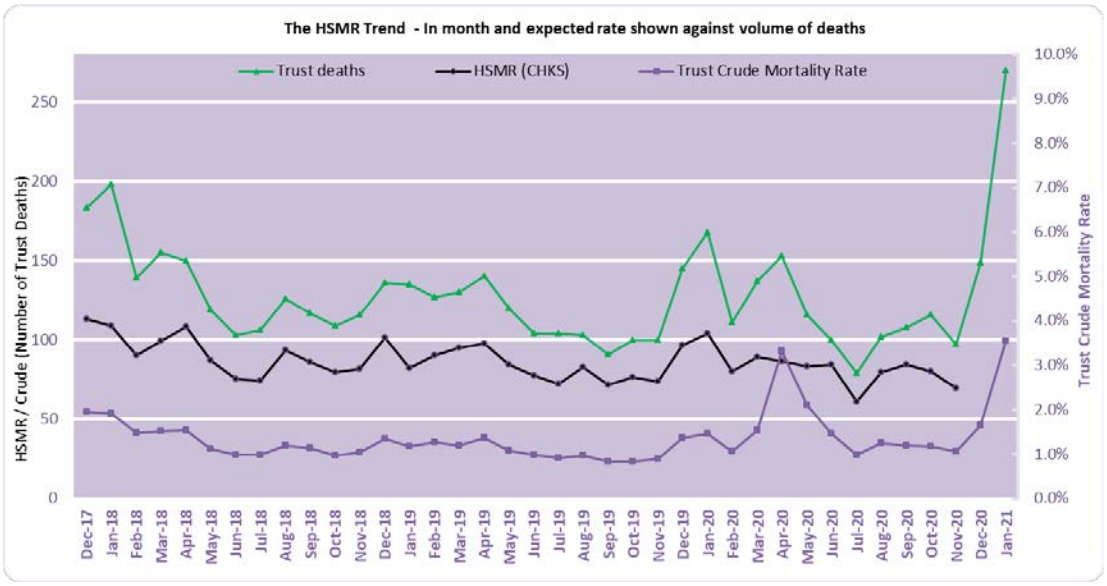
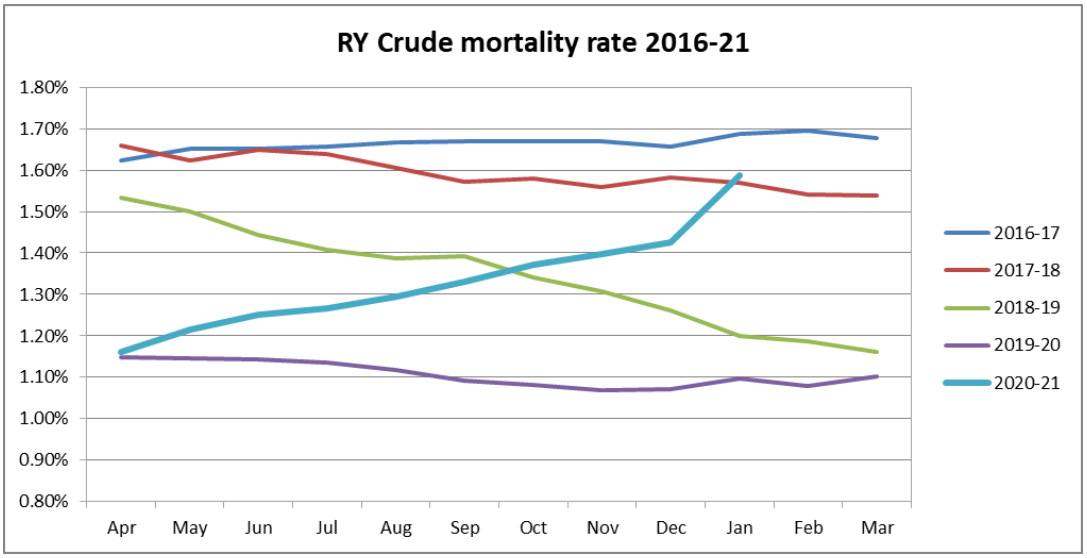


Figure 15 shows the trend in crude mortality rates over recent years. While this provides a good indication of the improving picture up to February 2020, it should be borne in mind that it has not been possible to use data solely from one source. This is due to the need for rolling year calculations to be based on changing data sources (pre-Lorenzo, our data warehouse [EDW] and most latterly CHKS).

Figure 15: 5 year crude mortality trends trend

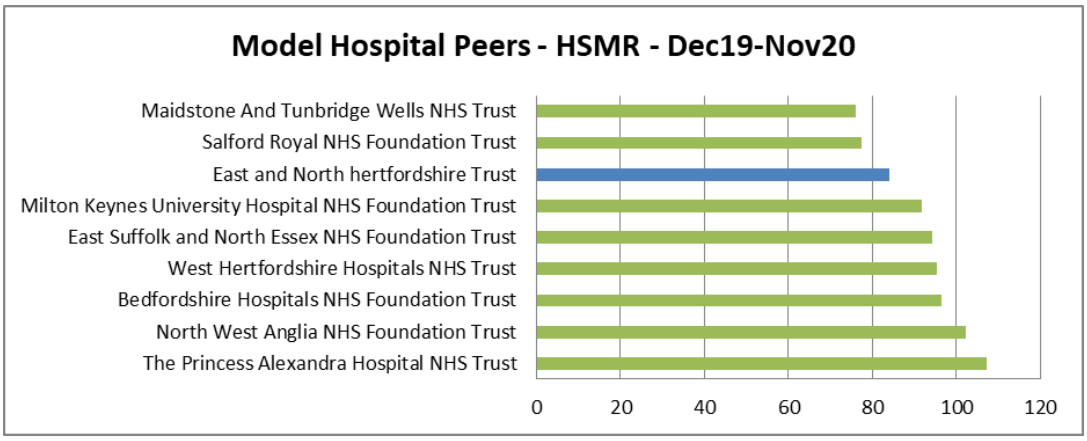


The recent increases in rolling year crude mortality rate reflects the number of deaths from the waves of the COVID-19 outbreak coupled with the reduced inpatient activity at the Trust during March 2020-January 2021.

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 16: 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 1: Monthly Trust and Divisional HSMR December 2019 to November 2020

	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	Trust
Cancer (Spec)	78.7	45.6	74.5	62.0	0.0	63.5	0.0	0.0	42.0	0.0	68.3	0.0	0.0	28.1
Clinical Support Services (Spec)	0.0	57.8	0.0	31.7	0.0	0.0	37.4	0.0	0.0	0.0	0.0	40.4	0.0	14.7
Medicine (Spec)	77.2	99.7	107.3	83.8	89.2	89.5	84.1	91.0	65.5	85.4	86.4	86.4	76.9	88.0
Surgery (Spec)	72.7	86.2	123.4	66.9	121.6	107.9	116.2	64.5	58.4	65.7	70.6	65.8	68.5	84.2
Women's & Children's (Spec)	0.0	93.0	0.0	0.0	0.0	0.0	0.0	100.7	0.0	0.0	271.7	0.0	0.0	44.4
Trust	**73.8**	**96.6**	**104.2**	**80.4**	**89.5**	**86.6**	**83.2**	**84.2**	**61.2**	**79.6**	**84.3**	**80.3**	**69.9**	**84.1**

Source: CHKS (scorecard alerts coloured; Specialty on Discharge)

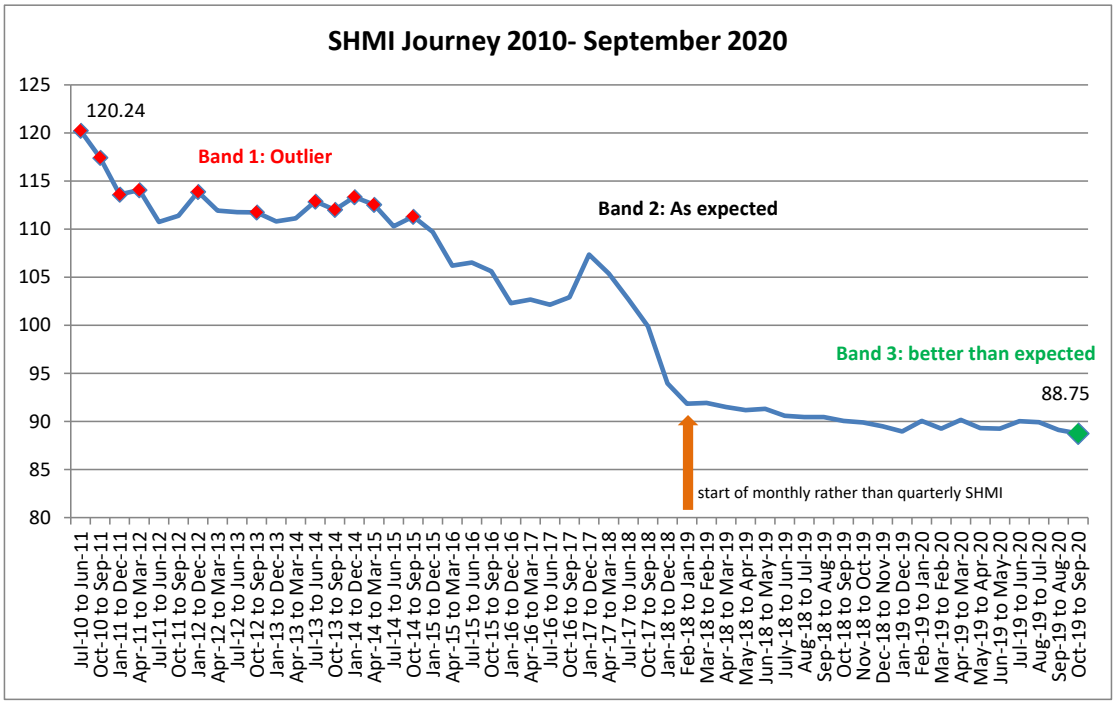
Table 1 shows Trust and Divisional monthly HSMR performance for the latest rolling 12 month period to August 2020. The CHKS red and amber alerts coding has been used to show HSMR above the 75th percentile Model Hospital peer group value, with red being statistically significant and amber not statistically significant.

The new Trust Divisional structure will be used in place of the above from the next report onwards.

2.2.5 SHMI seven year journey

The last report highlighted the improvement in our performance over the last 7 years in comparison to the other trusts subjected to Keogh review in 2013. Following the latest SHMI release which sees the Trust positioned within Band 3 for the first time Figure 17 below outlines the journey.

Figure 17: SHMI 2010 – September 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 2 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 (September 2019 to August 2020).

The red alert is relative to peers in our Model Hospital peer group.

Table 2: Key Quality Measures December 2019 –November 2020

	Trust Total		Elective		Non-Elective	
HSMR	84.1	↑	73.5	↓	84.2	↑
SMR	87.8	↑	75.5	↓	87.9	↑
Average Length of Stay	1.8	↔	0.2	↔	3.7	↑
Readmissions within 28 days (%)	8.9%	↔	4.0%	↔	**14.4%**	↓

Source: CHKS (scorecard alerts coloured)

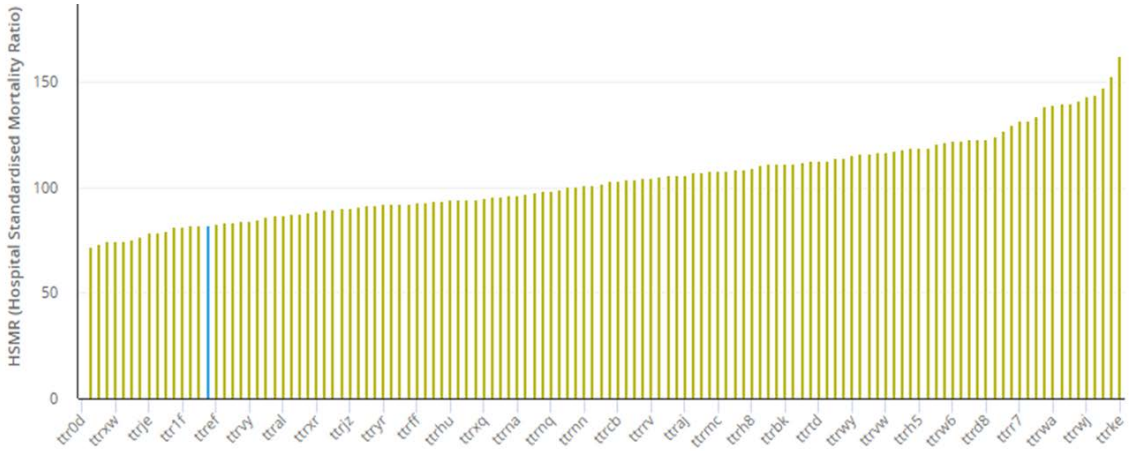
At February 2021 Mortality Surveillance Committee the issue of readmissions was discussed. It was agreed it would be beneficial to work more closely with Primary Care, perhaps by way of a regular report to PCNs. Initial work by the Head of Coding commenced to move this forward.

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 detailing the findings of our internal investigation. While the CQC continued to monitor the situation via its regular Engagement meetings with the Trust, it has now formally closed the alert. By way of sign-off, the latest refresh of CHKS shown in figure 18 below, shows the Trust is now well placed compared to our national peers.

Figure 18: Septicaemia (except in labour)
HSMR R12M to November 2020: national peer comparison



2.4.2 Other external alerts

National Hip Fracture Database (NHFD) mortality alert (August 2019)

The last point of concern was late 2018/early 2019 where the mortality rate climbed above the lower confidence interval.

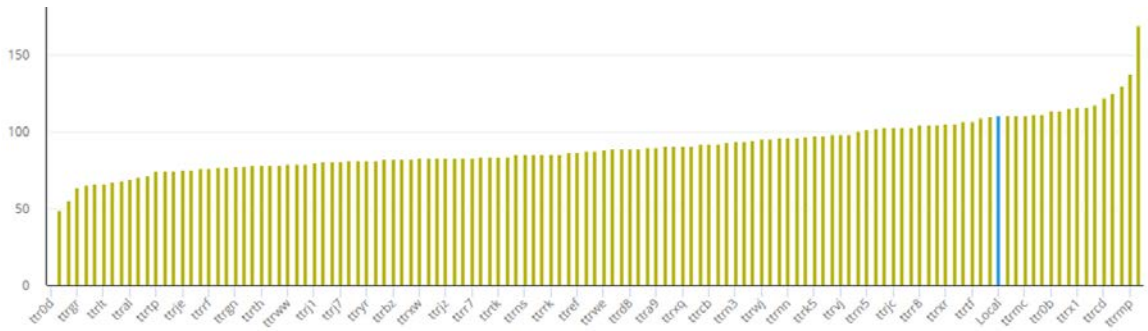
Subsequently it came down throughout 2019 and was briefly below national average. It started to go up in early 2020 but increased significantly during the 1st COVID-19 lockdown period, mainly due to the changes in care precipitated by the pandemic within the Trust. The peak in the NOF "COVID" mortality was significantly higher than the NHFD mean. The effect of this on our NHFD performance is not yet clear. The unique situation faced this year makes it difficult to discuss factors / trends, beyond the points made above at this point in time.

Of note is that in the Forward to the recently published National Hip Fracture Database Annual Report (January to December 2019), Lister's trauma unit was one of nine congratulated for demonstrating excellent quality of care for their patients, performing significantly above average against all six KPIs.

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 was instigated between Stroke and Coding aimed at creating a regular monitoring system, though limited progress has been made during the COVID pandemic
- In the meantime, while not an outlier, Stroke mortality does remain high relative to the national average and this continues to be monitored
- Our latest SSNAP rating was C, the reduction largely attributable to our current lack of therapy input with the associated impact on patient outcomes and mortality
- The NHS England lead recently warned that many stroke improvements have stalled or slipped, indicating that we are not alone in dealing with the challenges.

Fig 19: Stroke HSMR R12M to Nov-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 as detailed in the last report.

A key recent achievement to support ongoing improvement work has been the creation of a NELA area on Qlikview meaning that from now on real time data will be available.

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

The latest release from CHKS showed two HSMR CUSUM red alerts for the rolling year to November 2020 (Red alert: 99.7% detection threshold). Table 3 details HSMR for the alerting CCS groups, sorted in descending order by “Excess Deaths”.

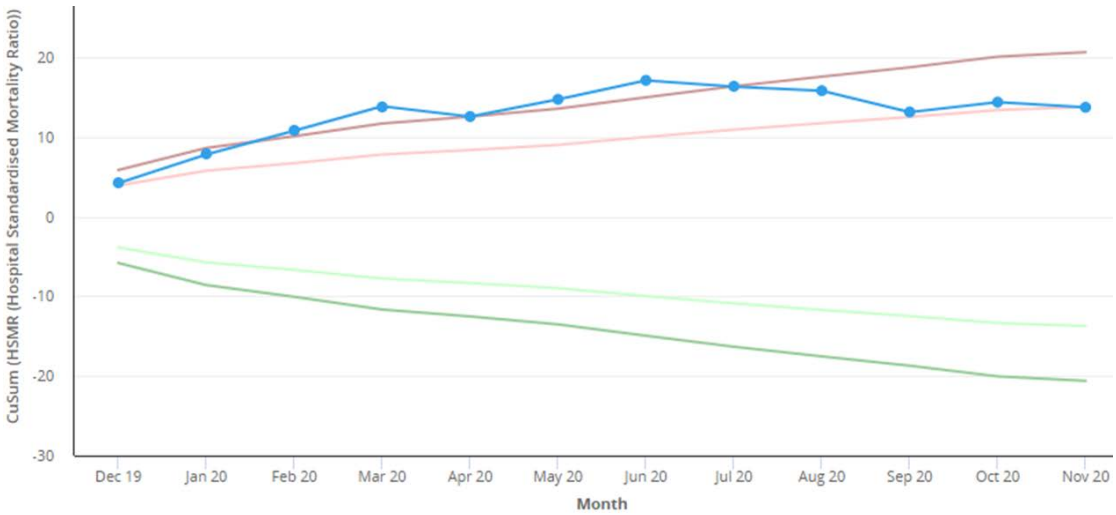
Table 3: HSMR CUSUM Alerts December 2019 to November 2020

	Relative Risk	Observed Deaths	Expected Deaths	“Excess” Deaths
100 - Acute myocardial infarction	128.98	61	47.3	13.7
133 - Other lower respiratory disease	212.73	16	7.5	8.5

Source: CHKS (CUSUM alerts coloured)

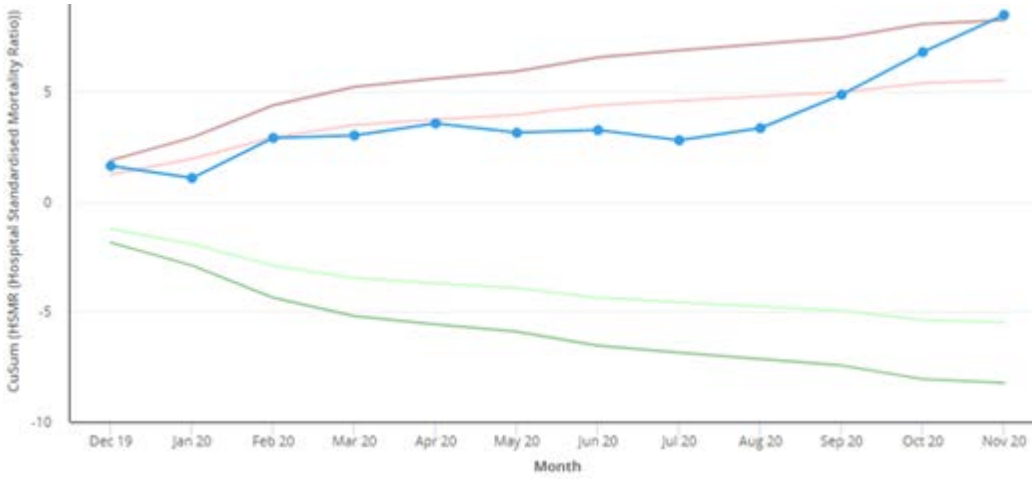
Figure 20 below shows the Trust HSMR CUSUM for Acute myocardial infarction with a red alert for the 12 month period to November 2020 as it has breached the upper control limit (three standard deviations). However, a reduction can be seen in the last 4 data points.

Figure 20: Acute myocardial infarction CUSUM chart December 2019 to November 2020



The figure below shows the Trust HSMR CUSUM for Other lower respiratory disease for the last 12 months to November 2020 and that it has breached the second upper control limit (three standard deviations) in November 2020.

Figure 21: Other lower respiratory disease CUSUM chart December 2019 to November 2020



A coding review of the 16 deaths underpinning the CUSUM alert for Other lower respiratory disease showed two instances where the coding needed to be amended. The review has been shared with the Respiratory Service Leads. The review did not give rise to further concerns.

2.4.4 SHMI outlier alerts

Table 4 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). There are no red alerts.

Table 4: SHMI outlier alerts from September 2019 to August 2020

	SHMI	Observed Deaths	Expected Deaths	"Excess" Deaths
57 - 100: Acute myocardial infarction	148.32	75	51	24

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 a coding review. 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. As we begin to emerge from the latest COVID peak, the plan for 2021-22, Q1 and Q2 is to focus on cardiology pathways including acute coronary syndrome (ACS), heart failure and primary percutaneous coronary intervention (PPCI).

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.

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 first wave of the COVID-19 pandemic. Despite this fact the Medical Examiners liaised with the Bereavement team throughout the first wave to give advice regarding death certification.

After suitable office space was finally identified in July 2020, the Medical Examiner service commenced on 1 October 2020. Following an initial small test pilot the service is now up and running well, covering CCU, Surgery, Cardiology and Care of Elderly, which account for approximately 50% of all deaths. No major issues or trends have been identified. Full implementation of the service is proposed from 1st April 2021.

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 has commenced from the outset of the service with priority mortality reviews requested where any concerns have been raised. Development work regarding the migration of the Trust's mortality review process to the Datix iCloud platform is also involving consideration of the potential for incorporation of the Medical Examiner process to further streamline our governance, quality and learning framework.

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. To this end, clinical coding has secured a one hour time slot on the next Grand round session on the 25th March 2021.

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. A GDPR Standard 1 Data Security Clinical Coding Audit is currently underway with the report and findings available in March 2021, which will also feed into the presentation at Grand round in March.

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, development work to support implementation is continuing. Following concerns raised by the Mortality Surveillance Committee, which were detailed in my last report, it has been agreed that the mortality module will not go live until the link between the Datix system and Lorenzo has been established, the timeframe for which will be dependent on our IT forward plan capacity.

While capacity for development in the COVID environment has been challenging, it has continued, if at a slower pace than originally planned. While initial configuration of the mortality module is nearing completion, this has involved significant change to the existing mortality review content and processes, which of necessity has gone ahead with limited clinical input. There will therefore need to be a significant element of clinical testing and review to ensure the final tool is fit for purpose and user friendly.

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 Q3 2020-21.

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 Q3 it should be noted that 2 ACONs were 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 5: Q3 2020-21 Concluded ACONs: Avoidability Score ≤3

ID	Year of death	Serious Incident	Avoidability score	Avoidability definition
-	-	-	1	Definitely avoidable
369 475	18/19 19/20	No (RCA) Yes	2	Strong evidence of avoidability
-	-	-	3	Probably avoidable: more than 50-50

These cases have been investigated by the Patient Safety team and a Root Cause Analysis or Serious Incident report completed. A remedial action plan has been put in place commensurate with the severity of the incident and detailed information provided in the Serious Incident and RCA 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 6: 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 7: Q3 2020-21 Concluded ACONs: Quality of Care Rating D/E

Quality of Care Rating	ID	Serious Incident
D	ACON 278	No
	ACON 359	No
	ACON 426	No
	ACON 466	Yes
	ACON 468	No
	ACON 489	No
	ACON 491	No
	ACON 502	No
	ACON 518	No
E	ACON 369	No (RCA)
	ACON 475	Yes

From the above table it can be seen that of the 11 cases where care was considered to have been poor or very poor, 2 had been raised and investigated as Serious Incidents and 1 Root Cause Analysis had been completed.

In the 8 cases that had not been considered as a Serious Incident, two cases related to the poor communication between two specialities, three cases related to a failure to follow Trust guidelines, one case involved multiple bed moves within the Trust, one case involved a poor communication between the Trust and another provider prior to patient transfer and one case involved very poor documentation.

Table 8 below provides a year to date summary of concluded ACONs indicating both avoidability of death and quality of care ratings.

Table 8: Year to date concluded ACONs ratings

Apr-Dec 2020-21: 54 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**	**9 (7 SIs, 2 RCA)**
3	**Probably avoidable, more than 50-50**	**1 (SI)**
4	Possibly avoidable, but not very likely, less than 50-50	8 (3 SI, 1 RCA)
5	Slight evidence of avoidablity	19 (2 SI, 1 RCA)
6	Definitely not avoidable	16

Quality of Care Rating	Definition	SI/RCA detail
A	Excellent	0
B	Good	5
C	Adequate	14
D	**Poor**	**28 (9 SIs, 2 RCAs)**
E	**Very poor**	**7 (5 Sis, 2 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 9: Q3 Learning Disability Deaths

	Oct-20	Nov-20	Dec-20
Learning disability deaths	0	2	1

In Q3 three deaths occurred of a patient with a learning disability. These have been reported to the national LeDeR programme. They have also undergone a regular mortality review. In two the reviewer did not raise concerns and believed the deaths to have been unavoidable. In the third an extra check is underway regarding a previous admission before a final conclusion is drawn. Copies of all our reviews are provided to support the local external LeDeR 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. Immediately prior to the January 2021 COVID peak a new Mental Health Strategy Working Group was set up, whose remit will incorporate the required alert development.

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 on both fronts has stalled due to the latest COVID-19 peak and will need to be resumed. Two deaths of a patient with potentially severe mental illness were identified in Q3.

Table 10: Q3 Severe Mental Illness Deaths

	Oct-20	Nov-20	Dec-20
Severe mental illness deaths	1	1	0

The death of the first of these patients was reviewed and no concerns raised. The second death, where there was lack of clarity as to whether the patient had a mental illness, is currently under review as an ACON.

3.2.4 Stillbirth, children and maternity deaths

Q3 statistics are provided below:

Table 11: Q3 Stillbirth, Children and Maternity Deaths

	Oct-20	Nov-20	Dec-20
Stillbirth	0	0	1
Children	0	1	0
Maternity	0	0	0

The child death was that of a 4 month old baby girl, who had encountered complications from birth, spending most of her short life between Lister and Addenbrookes prior to her death in November following a cardiac arrest at home six days after she had been discharged from Lister NICU. An initial review of her care and the events leading up to her death took place at the end of December, and have now been reopened, following concerns raised by the family.

3.2.5 Serious Incidents involving deaths

Table 12: Q3Serious Incidents Involving a Patient Death

Serious Incidents involving the death of a patient	Oct-20	Nov-20	Dec-20
Serious Incidents reported	3	1	1
Serious Incidents: final report approved*	0	2	1

Key learning:

- Removal of obsolete equipment should be dealt with promptly to avoid risk of falls
- Develop/review Standard Operating Procedure (SOP)/ pathway for reviewing internal urgent referral, including mitigating process in the absence of the named clinician
- Internal email referral had no failsafe system in place to monitor the referral. Clinician to consider copying the MDT Pathway Facilitators as a failsafe to monitor the referral
- To provide staff support/training at the beginning of a secondment cover
- To re-familiarise Medical Secretaries with urgent referral process
- Lack of investigation led to emergency surgery
- Outpatient CT colon scan was not booked. To review/embed process for mitigating future similar incident
- Suboptimal quality of discharge summary
- Lack of junior doctors' local induction, orientation required with each ward processes.

** the reports approved do not necessarily relate to the incidents reported*

3.2.6 Learning from complaints

Table 13 below provides detail of the number of complaints received in Q3 that relate to a patient who has died while an inpatient.

Table 13: Q3 Complaints Involving a in-patient Death

	Oct-20	Nov-20	Dec-20
Complaints received relating to an in-hospital death	1	2	3

Key themes:

- A common theme in these complaints is a lack of communication especially when the patient has started to deteriorate
- Concerns over not being able to contact the ward to speak to staff to find out how their loved one was progressing, not receiving regular updates until the patient is very close to end of life
- Families have felt excluded with the impact of the COVID pandemic meaning that there was either no visiting or restricted visiting until end of life is imminent
- These complaints reinforced the vital role of communication with families of patients who are/likely to deteriorate quickly and how critically important it is to identify patients nearing end of life and ensuring families are kept informed and included in decisions.

3.2.7 Learning from inquests

Table 14: Q3 Inquests into a Patient Death

	Oct-20	Nov-20	Dec-20
Requests for a Report to the Coroner	8	5	7
Regulation 28: Report to Prevent Future Deaths	0	0	1*

*A coroner's investigation was opened on 14 March 2019 and concluded on 11 November 2020. The conclusion at the Inquest was that EC died on 14 January 2019 at the Luton & Dunstable Hospital as a result of birth asphyxia during labour which was not properly managed constituting neglect contributing to the cause of death. The medical cause of death was perinatal asphyxia.

A Regulation 28 Report to Prevent Future Deaths was received on 15 December 2020. The matters of concern raised related to the Serious Incident conclusion being contradicted by the evidence heard at the Inquest, the evidence itself, the uncertainty that despite training implemented by the Trust, the same situation would not reoccur and that 100 maternity units in the country are following the wrong guidelines in relation to managing foetal heart rate monitoring in labour.

The Trust responded on 5 February 2021 with a full CTG action plan and written evidence of actions both taken and ongoing to assure the Coroner that we have learnt from this tragic incident and have put a number of measures in place to mitigate against a recurrence.

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 continue working with divisional leads to encourage the completion of outstanding cases.

Throughout the year emerging themes are collated and shared across the Trust via governance and performance sessions and specialist working groups. 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.

Key themes from ACONs concluded in Q3 and Q4 will be amalgamated and included in the June report.

4.0 Options/recommendations

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

Appendix 1: ENHT Learning from deaths dashboard December 2020

East and North Hertfordshire NHS Trust: Learning from Deaths Dashboard: December 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	387	0	268	0	2
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1082	1484	677	841	2	1

Time Series: Start date 2017-18 Q1 End date 2020-21 Q3

Total Deaths Reviewed by RCP Methodology Score

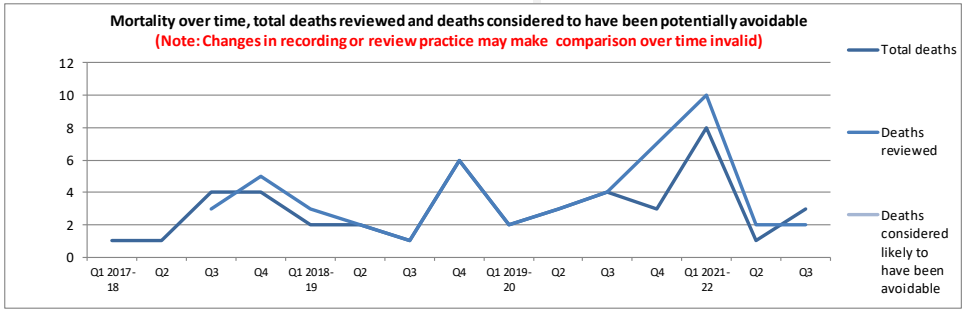
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	-	This Month	0	-	This Month	0	-	This Month	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)	3	0.4%	This Year (YTD)	0	0.0%	This Year (YTD)	3	0.4%	This Year (YTD)	8	1.2%	This Year (YTD)	665	97.9%

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	3	0	2	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
12	12	14	9	0	0

Time Series: Start date 2017-18 Q1 End date 2020-21 Q3



East and North Hertfordshire NHS Trust

Agenda Item: 14

TRUST BOARD – PUBLIC MEETING – 5 MAY 2021

Infection Prevention & Control Report – March 2021

Purpose of report and executive summary (250 words max): To inform the committee of infection prevention and control performance for the period of 01-31 March 2021.		
Action required: For information		
Previously considered by: **Quality and Safety Committee – 27 April 2021**		
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.

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

Infection Prevention and Control Board Report Objectives & Outcomes: March 2021

Executive Summary	**Key messages**	**COVID-19 Nosocomial Infections** The number of nosocomial infections recorded in March: ▪ Hospital-Onset Probable Healthcare-Associated cases - 0 ▪ Hospital-Onset Definite Healthcare-Associated cases - 1 **COVID-19 Outbreaks** ▪ Total of 4 ongoing outbreaks during the month of March ▪ Regular weekday outbreak Incident Management Team (IMT) meetings continued ▪ All outbreaks closed by 28th March 2021 **New Guidance** ▪ COVID-19 rapid guideline: managing COVID-19 NICE guideline [NG191] ▪ Good infection prevention practice: using ultrasound gel ▪ Position Statement on current IPC guidance and use of PPE for new SARS-CoV-2 variants – December 2020 **Other key infection indicators:** - No Influenza (Flu) or Norovirus Healthcare-Associated cases reported - Year-to-end C.difficile cases total is 40, which is below the ceiling of 52 cases for year 2020-2021.	

IPC Covid Updates

Covid-19 nosocomial infections and update

From the 14th May 2020 the 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

In March, the Trust reported:

March	Specimen Date / Days post admission	Total for 01/03/2021 - 31/03/2021	Total to date (from 14/05/20)
Community Onset	[<=2]	24	**978**
HO Indeterminate	[3-7]	7	**146**
HO Probable	[8-14]	0	**165**
HO Definite	[>=15]	1	**88**
	TOTAL	**32**	**1,377**

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

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

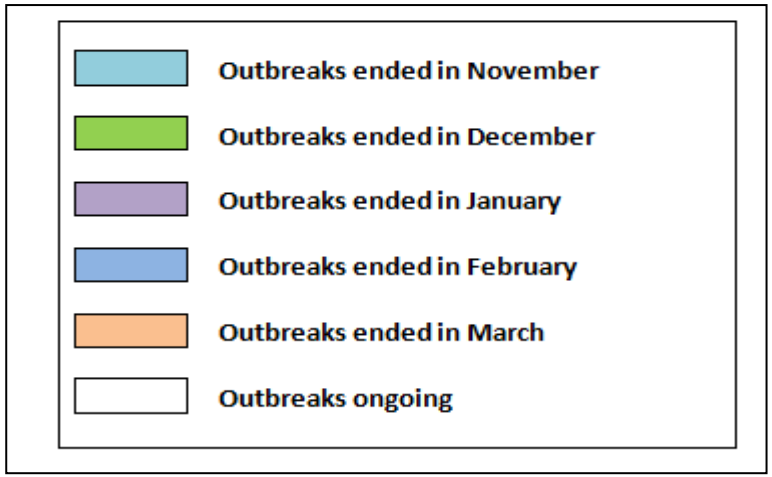
Jan-21		
Type	Total	Rate
Def	30	167.52
Prob	68	379.70
Total	98	547.22

Feb-21		
Type	Total	Rate
Def	9	55.64
Prob	32	197.83
Total	41	253.47

Mar-21		
Type	Total	Rate
Def	1	5.58
Prob	0	0.00
Total	1	5.58

COVID 19 Outbreaks

COVID 19 Outbreaks

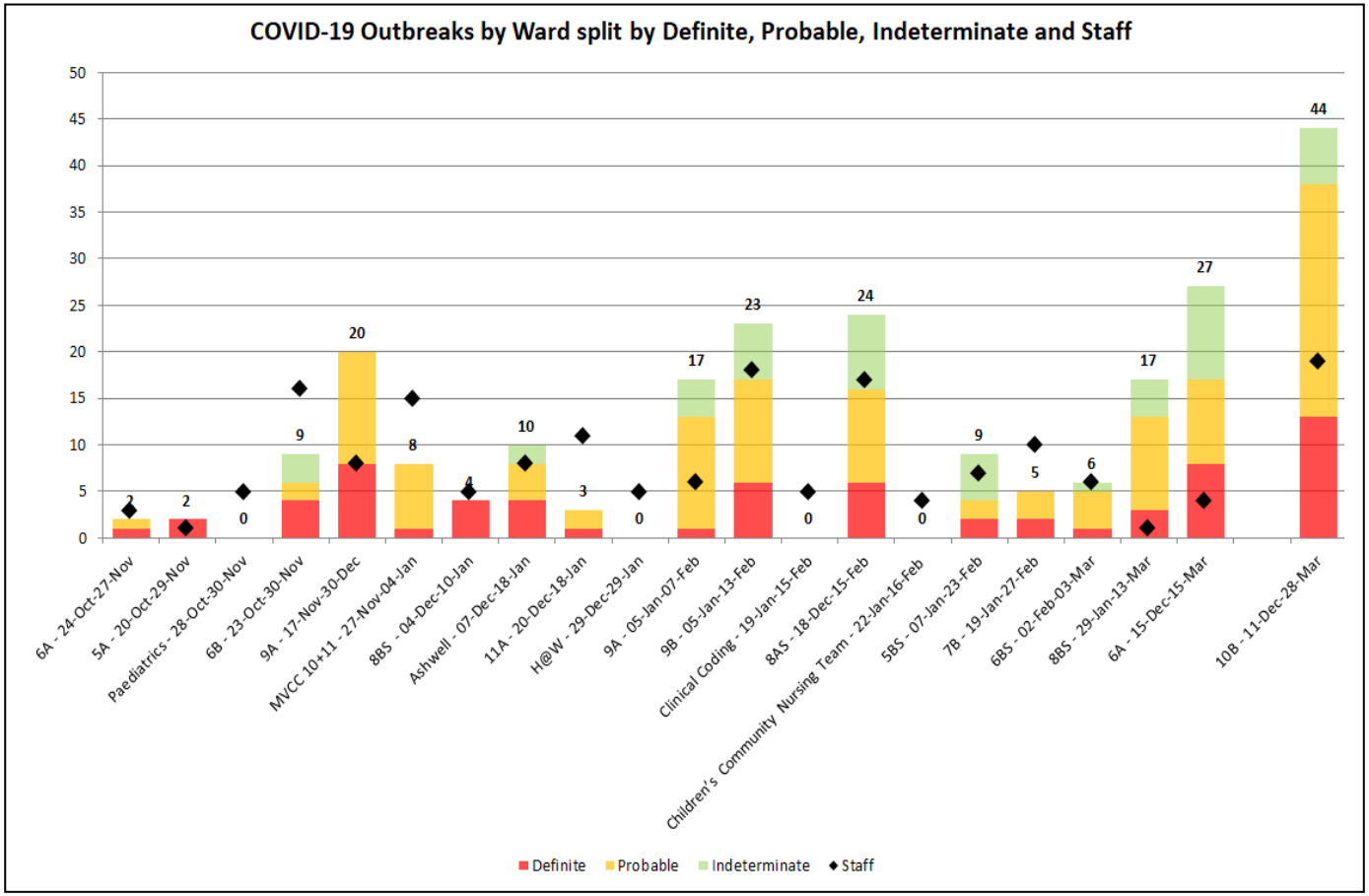


Ward	Outbreak declared	Total number of positive patients	Total number of positive staff	Last known positive patient result	Last known positive staff result	If no further positives earliest end date for outbreak (unless agreed patient moves occur) - this is the last day of outbreak.	Comments
Paediatrics	28.10.20	0	5			Ended on 30.11.20	
5A	20.10.20	Definite: 2 **Total 2**	1			Ended on 29.11.20	
6A	24.10.20	Probable: 1 Definite: 1 **Total 2**	3			Ended on 27.11.20	
6B	23.10.20	Indeterminate: 3 Probable: 2 Definite: 4 **Total 9**	16			Ended on 30.11.20	
9A	17.11.20	Probable: 12 Definite: 8 **Total 20**	8			Ended on 30.12.20	
MVCC 10+11	27/11/20	Probable: 7 Definite: 1 **Total 8**	15			Ended on 04.01.21	
8BS	04/12/20	Definite: 4 **Total 4**	5	13/12/20	12/12/20	Ended on 10.01.21	
Ashwell	07/12/20	Indeterminate: 2 Probable: 4 Definite: 4 **Total 10**	8	18/12/20	21/12/20	Ended on 18/01/21	
11A	20/12/20	Probable: 2 Definite: 1 **Total 3**	11	20/12/20	21/12/20	Ended on 18/01/21	
H@W	29/12/20	0	5	N/A	01/01/21	Ended on 29/01/21	
9A	05/01/21	Indeterminate: 4 Probable: 12	6	11/01/21	09/01/21	Ended on 07/02/21	

		Definite: 1 **Total 17**					
9B	05/01/21	Indeterminate: 6 Probable: 11 Definite: 6 **Total 23**	18	16/01/21	17/01/21	Ended on 13/02/21	
Clinical Codding	19/01/21	0	5	N/A	19/01/21	Ended on 15/02/21	
Children's Community Nursing Team	22/01/21	0	4	N/A	20/01/21	Ended on 16/02/21	
8AS	18/12/20	Indeterminate: 8 Probable: 10 Definite: 6 **Total 24**	17	15/01/21	19/01/21	Ended on 15/02/21	
5BS	07/01/21	Indeterminate: 5 Probable: 2 Definite: 2 **Total 9**	7	07/01/21	27/01/20	Ended on 23/02/21	
7B	19/01/21	Probable: 3 Definite: 2 **Total 5**	10	08/01/21	30/01/21	Ended on 27/02/21	
6BSouth	02/02/21	Indeterminate: 1 Probable: 4 Definite: 1 **Total 6**	0	04/02/21	N/A	Ended on 03/03/21	

8BSouth	29/01/21	Indeterminate: 4 Probable: 10 Definite: 3 **Total 17**	1	13/02/21	29/01/21	Ended on 13/03/21	
6A	15/12/20	Indeterminate: 10 Probable: 9 Definite: 8 **Total 27**	4	16/02/21	15/12/20	Ended on 15/03/21	
10B	11/12/20	Indeterminate: 6 Probable: 25 Definite: 13 **Total 44**	19	01/03/21	16/02/21	28/03/21	Staff swabbing LFT.

Table of outbreak summary: (condensed format)



	Water Safety	**Reasonable Assurance** 	1) Water safety plan, Group, and TOR all in place and functioning well. 2) Water Risk Assessment Specification confirmed and the contractor is due to start RA on site Jan 21. 3) AE has confirmed that Trust management of its water sub-contractors is improving. 4) Water quality issues exist in augmented care satellite units. A sub-group of water safety committee has been created to manage/review issues. 5) AP is looking to set up Zetasafe system to manage forward the PPM activity. Asset data needs to be uploaded once RA completed.	
	Ventilation	**Limited Assurance** 	1) A new Mechanical Manager started work Jan 21 and has picked up lead AP role. 2) Estates do not have any CPs appointed. Covered off by knowledgeable staff until new AP can assess/train and appoint them. 3) Some very old assets/AHU's in poor condition. Capital procurement/project of AHU that need replacing has been confirmed for 2020/21. 4) AE completed Annual audit in February and report issued with actions to take forward. 5) Ventilation Management group in place and chaired by HOE until AP can take forward.	
	Decontamination	**Limited Assurance** 	1) Deconcidal & Mark Walker have been appointed as the new AE from April 21 onward with a wider remit to review decon service across the whole site (Not Renal) 2) The Estates Services require an AP role within the services. A JD and Person spec is being defined for advert to add role to Estates Mgmt. team. 3) Decon. Policies & procedures do need to be reviewed and updated and a Decon. Group set up to take all issues forward. 4) The New AE conducted a site wide Decon Audit in February 2021 and a report has issued for review. 5) Our Water AE Tim Wafer has been contracted to perform AE duties for the Renal element of decontamination.	

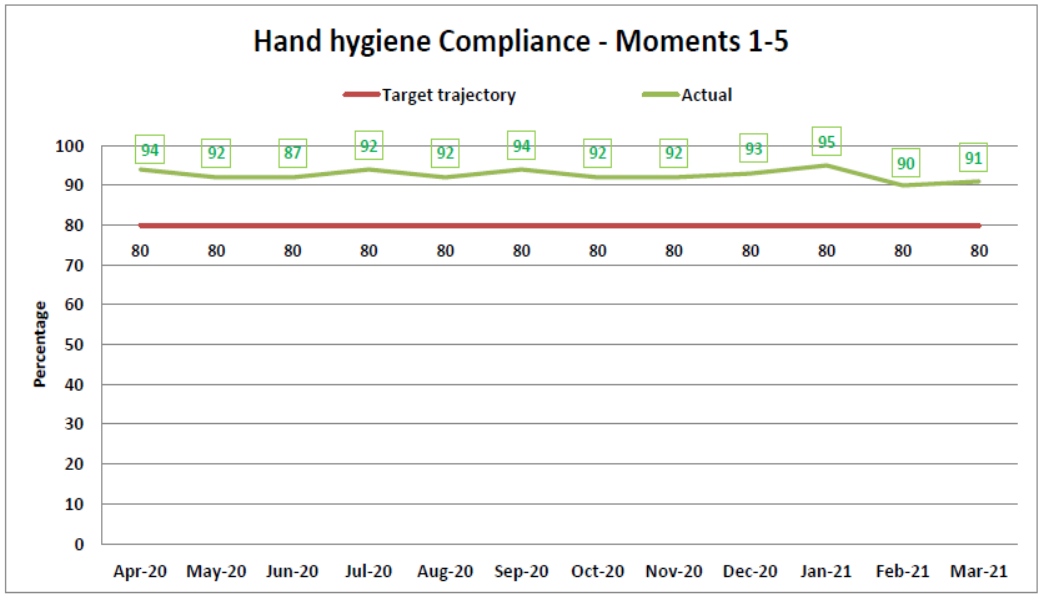
HCAI SURVEILLANCE	**C.difficile**	0 Hospital Onset Healthcare Associated (HOHA) case and 2 Community Onset Healthcare Associated (COHA) cases in March. Year to date position is 40 reported cases (HOHA / COHA) against the ceiling target of 52 cases for 2020-21. This is equivalent to 18.74 cases (data for Apr-Jul 2020) against the target of 25.3 cases per 100,000 bed days. Benchmarking data for March is not available. The number of C.difficile cases year to date position is below the trajectory for the year 2020 - 21	
	MRSA bacteraemias	0 Hospital Onset and 0 Community Onset bacteraemia in March. 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 March. Year to date position is 16 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 March not available.	
	Gram negative bacteraemia: **National monitoring and reduction programme for E.*coli*, *Pseudomonas aeruginosa*, *Klebsiella species*.**	4 Hospital Onset E.*coli* bacteraemia in March. Year to date position is 21 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 March not available. The IP&C team continue internal reviews.	
		1 Hospital Onset *Pseudomonas aeruginosa* bacteraemia in March. 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 March not available.	
		2 Hospital Onset *Klebsiella species* bacteraemia in March. Year to date position is 8 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 March not available.	

	Carbapenemase Producing Organisms (CPO)	0 new inpatient cases and 0 new outpatient cases identified in March. 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 March 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 March recorded on IQVIA by ward nursing teams met the agreed standards except: - Intravascular Devices (Target: 95%, March: 88.03%) - Urinary Catheter Care (Target: 95%, March: 47.73%) - Inpatients Environment Peer audit – Overall (Target: 95%, March: 88.81%) - Inpatients Environment - Peer Audit - Ward Environment (Target: 95%, March: 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 91%, February 92%, March 93%	

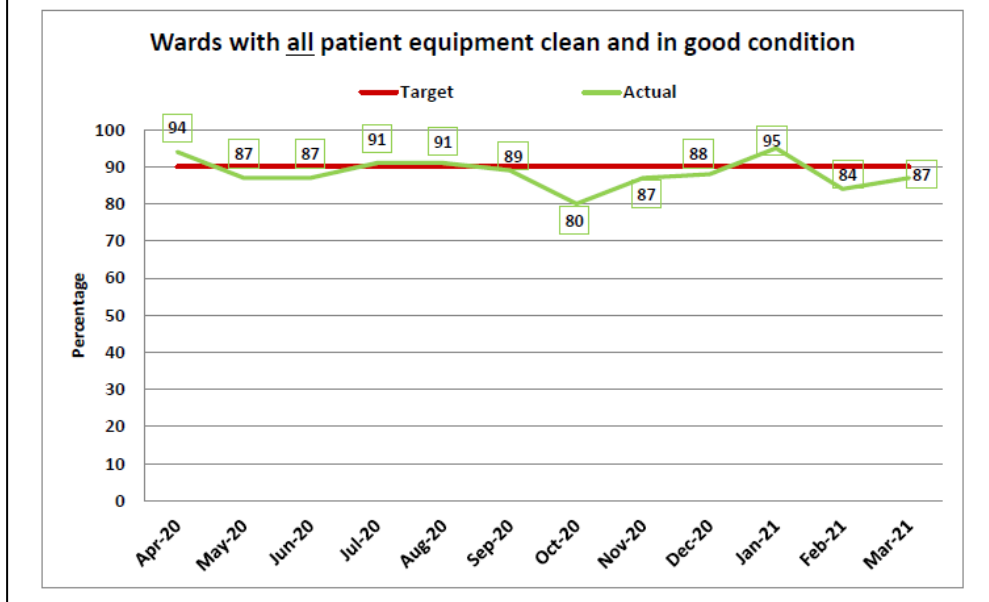
Note: RAG ratings are based on performance against set targets, previous year's performance or PHE benchmarking data, as specified.

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.

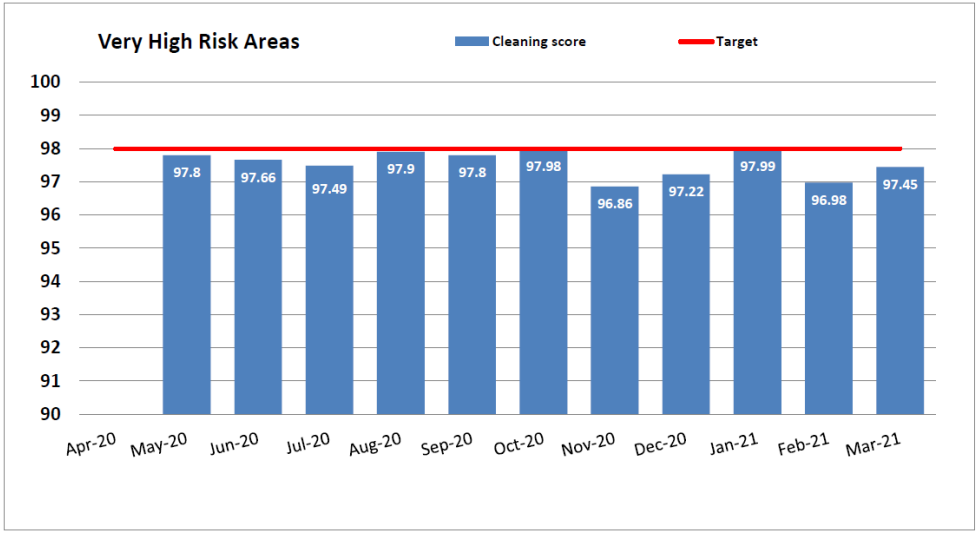
Hand Hygiene audits cover the World Health Organisation (WHO) Moments 1-5 see below:

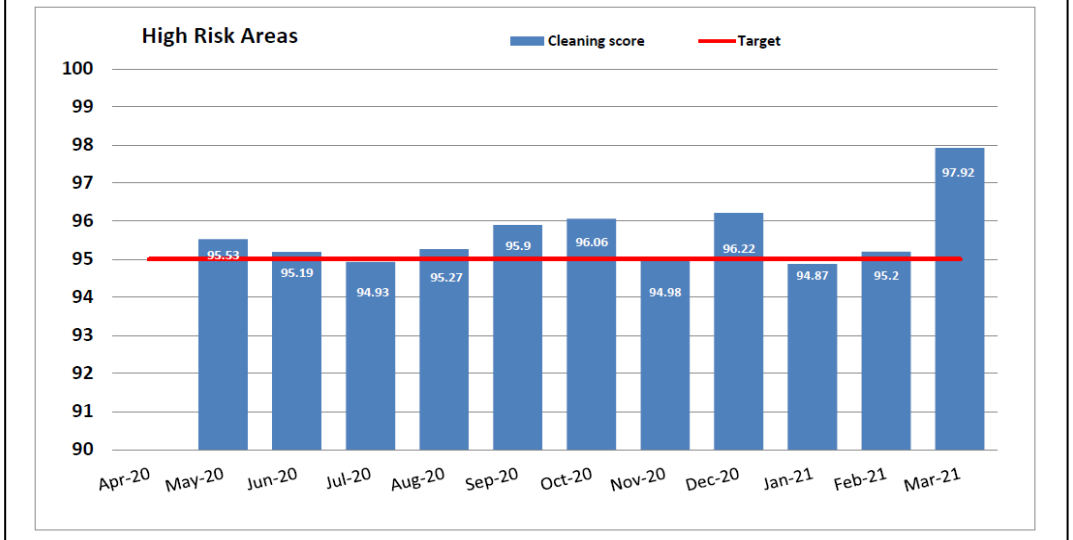
1. Before patient contact
2. Before clean/aseptic procedure
3. After exposure to body fluids
4. After patient contact
5. After contact with patient surroundings

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.

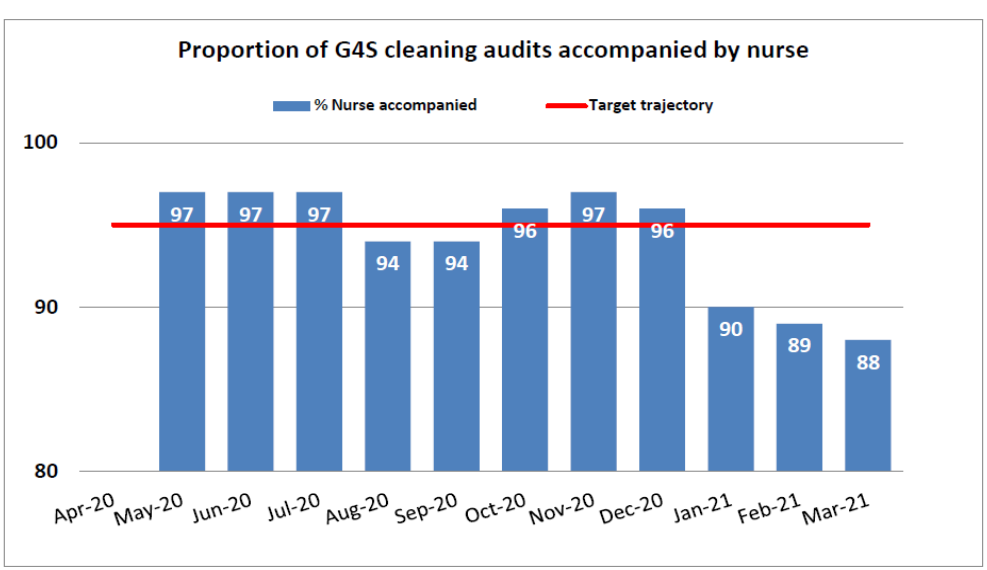
Cleaning audits: First time audit pass rates for very high risk and high risk areas

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.

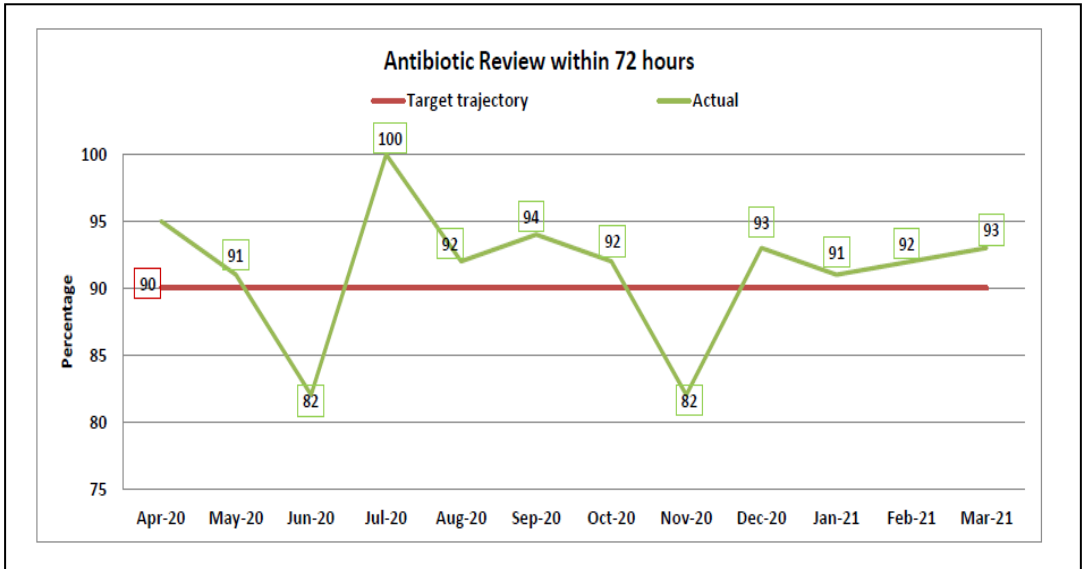




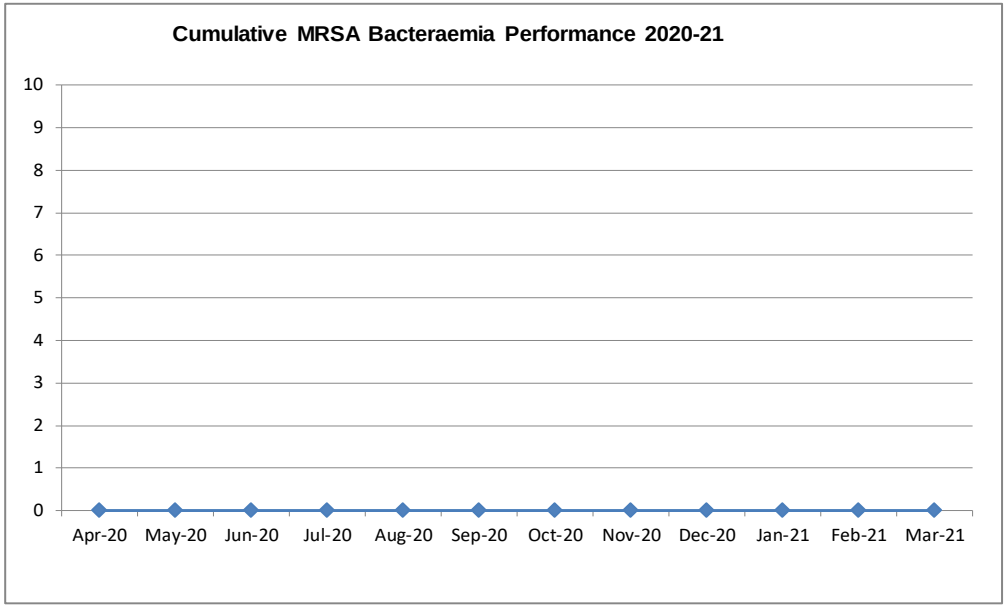
Cleaning audits: Attendance by nursing staff

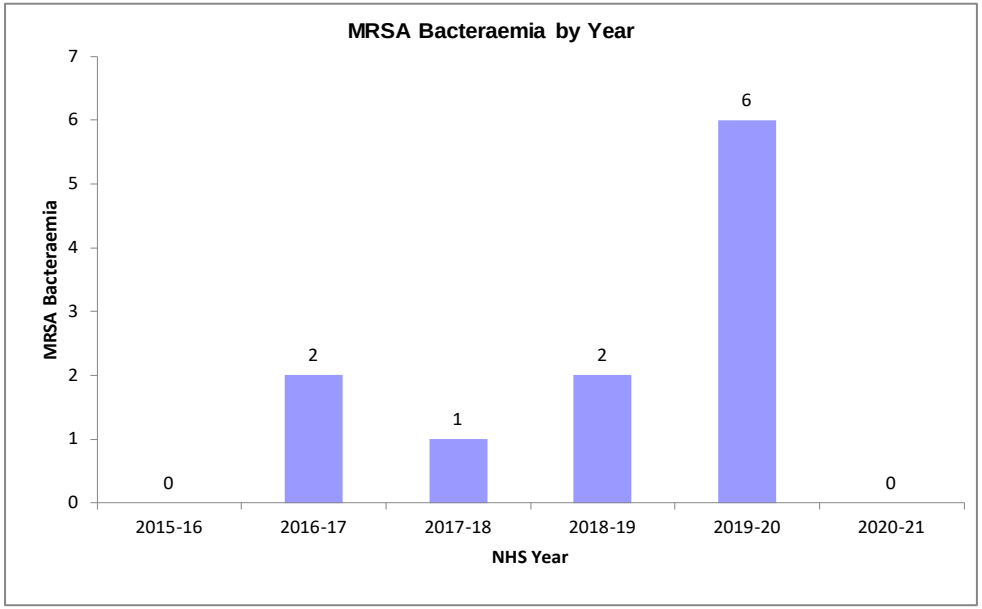


Antimicrobial stewardship



MRSA BACTERAEMIA – HOSPITAL ONSET





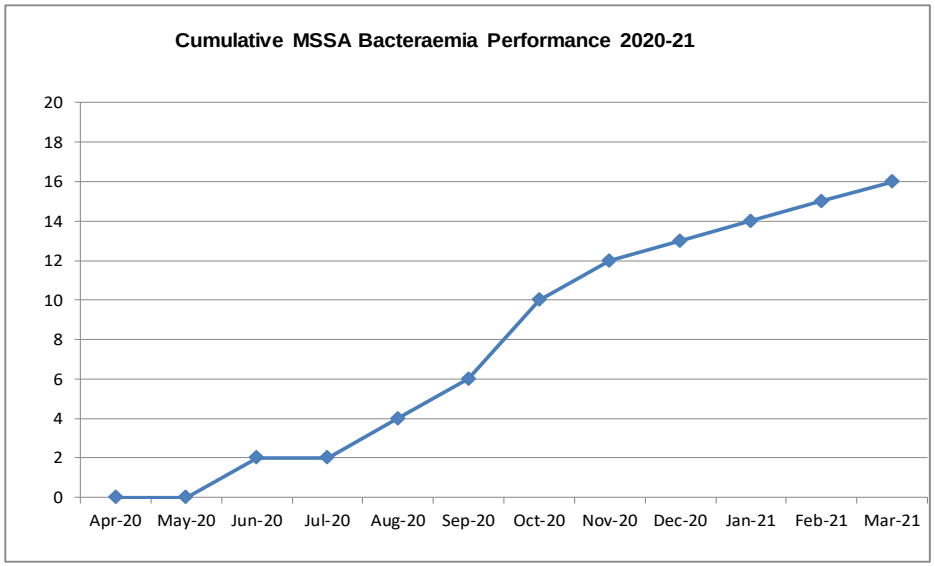
MRSA Bacteraemia by Division

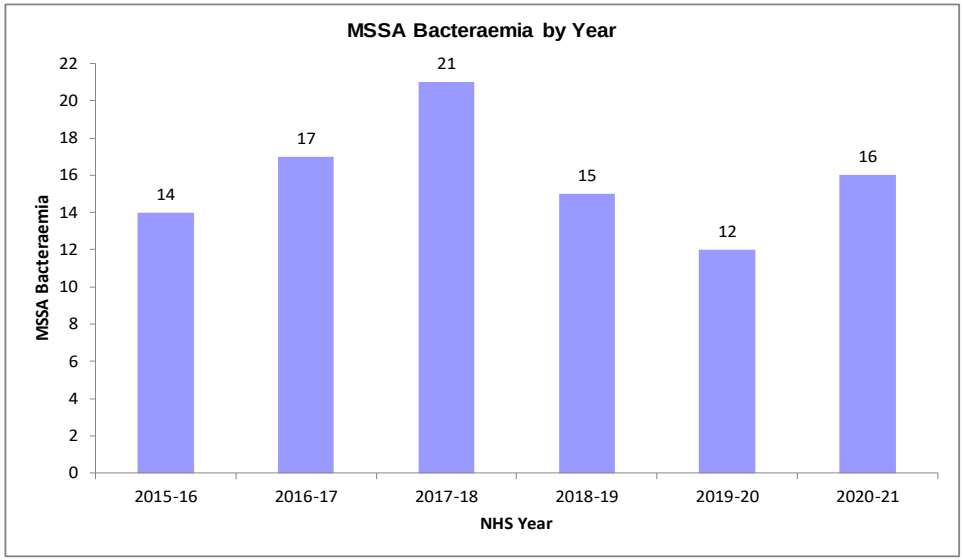
Division	2019-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	2020-21
Cancer	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Medicine	5	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Surgical	1	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Women & Children	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Grand Total	**6**	**0**	**0**	**0**	**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	0	0
Medicine	7	0	0	2	0	1	1	2	1	0	1	1	1	10
Surgical	4	0	0	0	0	1	1	1	1	1	0	0	0	5
Women & Children	1	0	0	0	0	0	0	1	0	0	0	0	0	1
MVCC	0	0	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	1	1	16

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

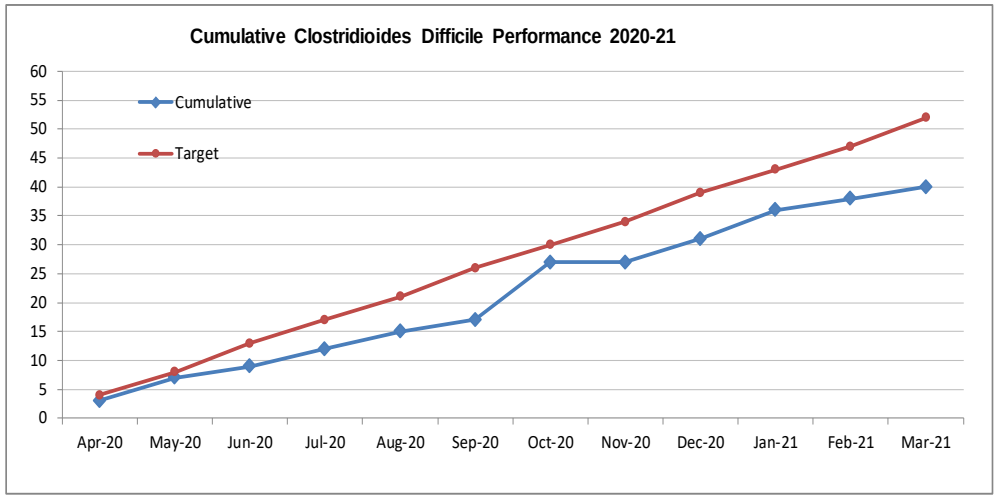
Count of all Hospital-Onset cases identified by acute trust per month

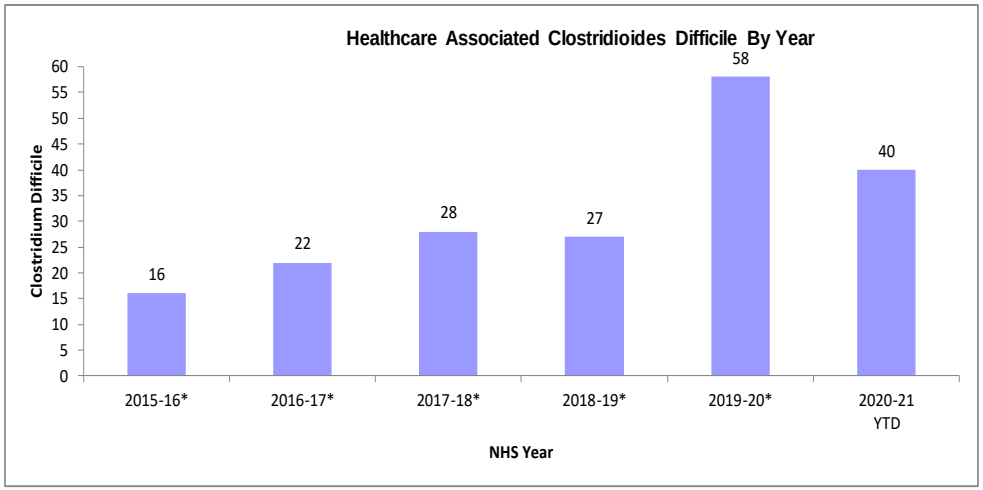
Trust Code	Acute Trust Name	Trajectory	2020 April	May	June	July	Aug	Sept	Oct	Nov	Dec	2021 Jan	Feb	Mar	Total
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	3	1	2	3									9
RC1	Bedford Hospitals NHS Trust	N/A	0	0	0	0									0
RGT	Cambridge University Hospitals NHS Foundation Trust	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 April	May	June	July	Aug	Sept	Oct	Nov	Dec	2021 Jan	Feb	Mar	Total
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	0	0
Medicine	36	2	3	1	2	2	2	8	0	2	3	2	1	28
Surgical	20	1	0	1	0	1	0	2	0	1	2	0	0	8
Women & Children	1	0	1	0	1	0	0	0	0	1	0	0	1	4
MVCC	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	58	3	4	2	3	3	2	10	0	4	5	2	2	40

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.

14. IPC Report.pdf

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

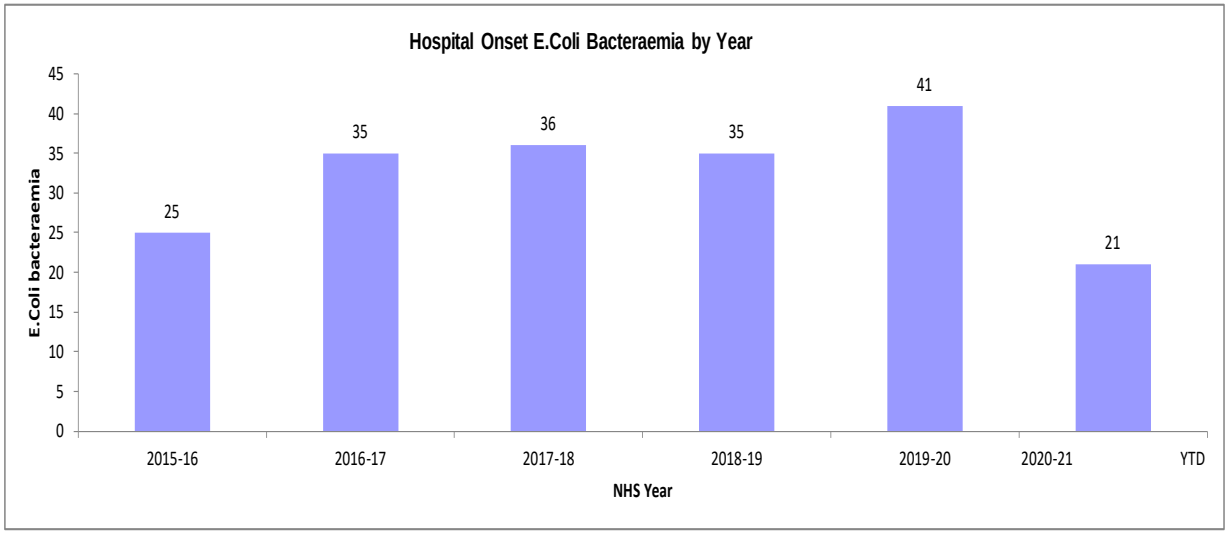
Trust Code	Acute Trust Name	Trajectory	2020									2021			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	51	1	2	3	6									12
RC1	Bedford Hospitals NHS Trust	14	0	1	1	0									2
RGT	Cambridge University Hospitals NHS 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.

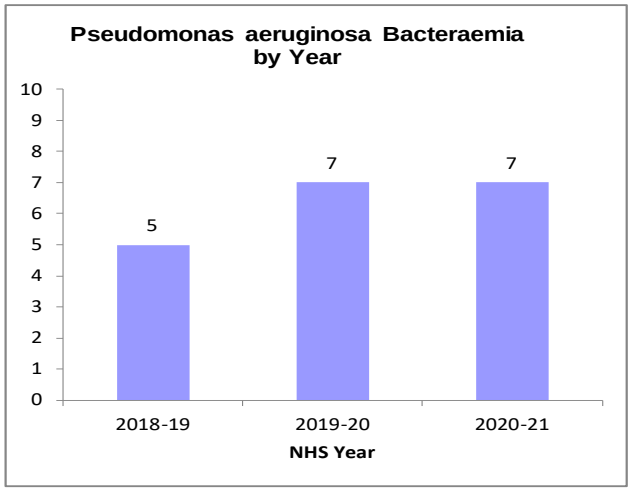


Hospital Onset E.Coli Bacteraemia by Division

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	0	0
Medicine	24	1	1	0	1	0	0	1	1	3	0	0	4	12
Surgical	12	1	0	1	0	0	0	0	1	0	1	0	0	4
Women & Children	4	1	0	0	1	1	2	0	0	0	0	0	0	5
MVCC	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	41	3	1	1	2	1	2	1	2	3	1	0	4	21

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	0	0	0	1
Medicine	3	0	0	0	1	0	3	0	0	0	0	0	0	4
Surgical	4	0	0	0	0	0	0	1	0	0	0	0	1	2
Women & Children	0	0	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	0	0
Grand Total	7	0	0	0	1	0	3	1	1	0	0	0	1	7

KLEBSIELLA SPECIES BACTERAEMIA – HOSPITAL ONSET

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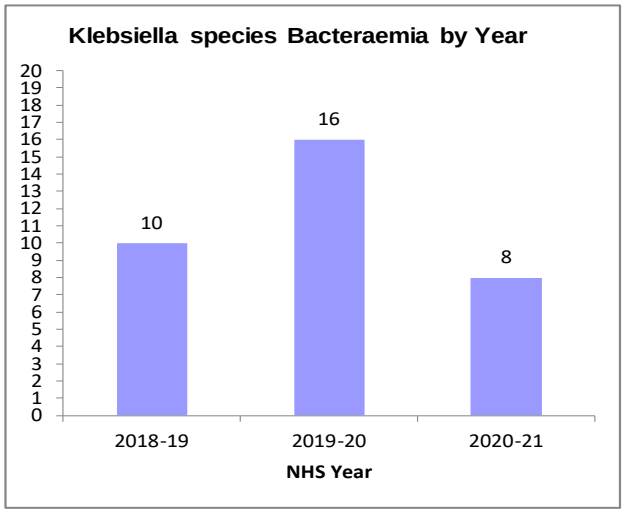


Hospital Onset Klebsiella species Bacteraemia by Division

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	1	1
Medicine	7	0	1	0	0	0	0	1	0	0	0	1	1	4
Surgical	8	0	0	0	0	0	0	1	1	0	1	0	0	3
Women & Children	1	0	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	0	0
Grand Total	16	0	1	0	0	0	0	2	1	0	1	1	2	8

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	0	0
	Medicine	8	0	0	0	0	0	0	0	0	0	0	0	0	0
	Surgery	6	0	1	0	0	0	0	0	0	0	0	0	0	1
	W&C	1	0	0	2	0	0	0	0	0	0	0	0	0	2
	MVCC	0	0	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	0	0
	L&D	1	0	0	0	0	0	0	0	0	0	0	0	0	0
	Harlow	0	0	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	0	0
	Bedford	0	0	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	0	0	1
	QEII	0	0	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	0	0
	MVCC	0	0	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	0	0	4

0

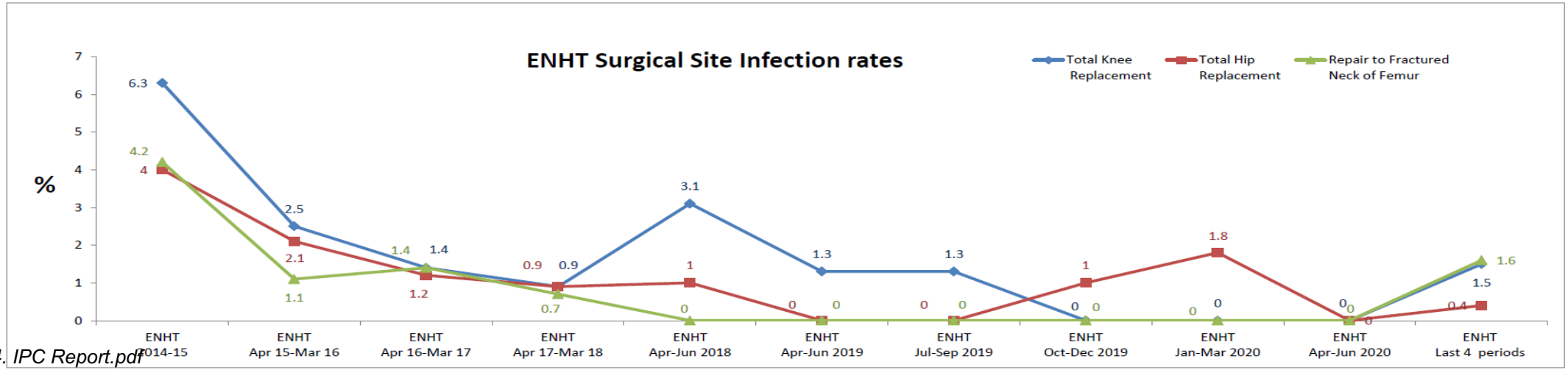
GP Patient Specimens	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

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%	89.96%	90.83%	92.58%	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%	87.00%	88.03%	88.46%	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%	42.50%	47.73%	51.12%	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%	100.00%	100.00%	99.70%	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%	88.93%	88.81%	90.11%	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%	91.23%	91.67%	93.98%	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%	84.35%	87.10%	87.64%	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: 15

TRUST BOARD - PUBLIC SESSION – 5 MAY 2021

ANNUAL REPORT AND ACCOUNTS 2020-21 – PROPOSAL FOR APPROVAL PROCESS

Purpose of report and executive summary: The report asks the Board to formally delegate authority for approval of the annual report and accounts to the Audit Committee.		
Action required: For decision		
Previously considered by: N/A		
Director: Director of Finance	**Presented by:** Director of Finance	**Author:** Trust Secretary

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

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

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

Request for delegation of authority for approval of Annual Report and Accounts 2020/21

Under the Trust's Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions, approval of the Annual Report and Accounts is a decision that is reserved to the Trust Board.

The next scheduled Trust Board meeting does not align with the timelines for production and submission of the Annual Report and Accounts. Therefore the Trust Board is asked to formally delegate approval of the audited Annual Report and Accounts 2020/21 to the Audit Committee.

All Trust Board members will have an opportunity to review and comment on the Annual Report and Accounts 2020/21 prior to final sign-off by the Audit Committee.

After submission, the Annual Report and Accounts will be made available on the Trust's website by no later than Monday 20 September 2021, as required.

This approach has been discussed with and supported by the members of the Audit Committee.

Recommendation:

For the Trust Board to formally delegate approval of the audited Annual Report and Accounts 2020/21 to the Audit Committee.

East and North Hertfordshire NHS Trust

Agenda Item: 16.1 a

TRUST BOARD – 5 MAY 2021

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE – 31 MARCH 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 31 March 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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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):

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FINANCE, PERFORMANCE AND PEOPLE COMMITTEE MEETING – 31 MARCH 2021
SUMMARY TO THE TRUST BOARD MEETING HELD ON 5 MAY 2021

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

Performance Report
The FPPC considered the key points in relation to operational performance for month 11. ED had a performance of 78% against the 4hour target with zero trolley waits reported in February. The RTT incomplete performance was 63% which was a reduction against January performance. The backlog was 16,483, an increase of 2,116 from January. The DM01 performance was 29% against a national performance of 33% in January. Cancer services remained compliant, achieving 6 out of 8 of the national targets. The Stroke performance was 28%, although the roadmap for improvements has been initiated.

Theatres
The Committee received the theatres transformation deep dive which described the journey through waves one and two of the Covid pandemic. During that period the new planned and unplanned care divisions had been formed. It was noted that patients had been clinically prioritised and surgery had been restricted. It was highlighted that collaboration within the system was good and the Trust worked with the independent sector to utilise space and to secure additional theatre capacity and nursing and anaesthetic staffing. The potential use of robotics was discussed and referred to the Strategy Committee. It was agreed that an update on Theatres would be provided later in the year.

Outpatient Transformation
The FPPC received the outpatient transformation presentation. It was noted that during the Covid pandemic second wave, staff were reallocated to other roles but as many outpatient services as possible had been continued. At the peak, 45% of patients were seen virtually. Space utilisation is currently being reviewed for efficiency and it was highlighted that reducing the patient treatment lists through virtual appointments was essential for recovery.

Capital Build and Operational Impact
The FPPC received the capital build and operational impact report. The capital investment in ED aims to improve patient experience, quality and safety and to help meet the new emergency standard which will be implemented in April 2022. It was noted that there may be some missed targets in the short term but that in the long term, performance would be improved. It was highlighted that the planning focused on growth within the next 5-10 years and the new build of the ED was not the solution to population growth but the way the patients are managed and the increase in the assessment area will have a significant impact.

Finance Report Month 11
The Committee received the finance report for month 11. The plan to date was a £1.0m deficit with the actual financial performance for February being £1.3m favourable to that plan. It was highlighted that a revised forecast had been submitted to NHSI of £2.6m deficit (£1.3m adverse variance to plan) which was entirely due to a provision for annual leave. Confirmation of whether it would be funded would be received in mid-April.

Capital Programme Update
The FPPC received the capital programme update. It was noted that it had been a busy month closing the capital position and Officers were confident that the target would be made.

National Planning Guidance
The Committee received the national planning guidance report. The thresholds and unlocking of funds is at system level and the plan is for the first six months of the financial year. It was noted that the planning guidance summarised priorities for health inequalities and set out the focus areas for workforce priorities.

Budget Planning Update
The FPPC received the budget planning update 2021/22 highlighting the six priorities for the year ahead and asking systems to develop fully triangulated plans across activity, workforce and finance for the next six months. The H1 funding settlement should form a strong baseline for the Trust to deliver NHS priorities although funding levels beyond that point are unknown. The planning timetable for the next few months will be brought to the Committee in April.

Capital Plan 2021/22
The Committee were updated regarding the capital plan for 2021/22. It was noted that 2020/21 had been an exceptional year with regards to the impact in terms of capital investment; the total capital expended by the Trust will be circa £30m. The Committee formally approved the capital plan for 2021/22 subject to recognition that capital planning is ongoing.

Improvement Plan Progress Report
The Committee received the improvement plan progress report. Behind each transformation programme a range of KPIs and targets had been agreed which will be monitored on QlikView. Work had been expanded into the ICP which will increase transparency in terms of underlying demand and capacity, utilisation of services and impact on admitted and same day pathways.

Workforce Planning
The FPPC received the workforce planning update. It was noted that workforce planning is influenced by a range of factors including bed reconfiguration and workforce timelines for planning actions. The next steps for 2021/22 in terms of resourcing, retention, workforce planning and access to additional talent pools were noted.

eRoster
The Committee received an update regarding the eRoster programme. It detailed the activities and performance between October 2020 and January 2021. eRostering had been rolled out to 65% of non-medical staff. The medical staff roll out was expected to be completed by May 2021.

Sickness Absence
The Committee received an update regarding sickness absence. The report showed a breakdown across staff groups and reasons for absence including findings highlighting the need for additional support for staff who have suffered from long covid and mental health conditions as a result of the pandemic. It was noted that overall sickness absence rates are 5.2% which is 1% higher than the rate at the same point as last year.

Board Assurance Framework and Risk Update
The FPPC considered the latest BAF. It was reported that there had been one change to the risk ratings for month 11. Risk 12 pandemic risk, had been reduced to 15 from a previous 20 rating with evidence supporting the effective ongoing management of the pandemic.

Karen McConnell
Finance, Performance and People Committee Chair
April 2021

East and North Hertfordshire NHS Trust

Agenda Item: 16.1 b

TRUST BOARD – 5 MAY 2021

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE – 28 APRIL 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 28 April 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:** 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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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 – 28 APRIL 2021

SUMMARY TO THE TRUST BOARD MEETING HELD ON 5 MAY 2021

The following Non-Executive Directors were present:
Karen McConnell (Chair), Ellen Schroder (Trust Chair), Bob Niven

Performance Report
FPPC considered the key points in relation to operational performance for month 12. ED had an improved performance of 85.22% which was maintained consistently throughout the month. ED numbers are increasing with an average of 386 people attending per day. This collates to an increase of 20% in adults and 46% increase in paediatric attendances. The RTT incomplete performance for March was 60.36%. This is a reduction from 63.93% reported in February. DMO1 performance for March was 33.07% against the national standard of 1% and the February position of 29.42%.

Cancer services achieved 5 out of 8 national targets for cancer performance in February. The Trust's 62 day performance for February was 83.4%. Stroke performance for March was 49.3% which is an increase of 28% from the previous month. A 6 month transformation of resource to support stroke has been agreed and there will be a deep dive for Stroke in June 2021.

Cancer Performance and Sustainability
The Committee received the Cancer Performance and Sustainability deep dive. There has been an increase in cancer referrals and baseline referrals have increased from 17% to 29% in the tumour sites. The 62 day cancer performance target was met and the Trust is seeing more advanced tumours, in line with national trends. Gynaecology, lower GI and lung areas are not performing as well as expected but this will improve. The committee discussed the sustainability of cancer performance once the Trust has separated from MVCC. The Cancer Strategy will be reviewed by the Strategy Committee.

SDEC Front Door Ambulatory Solutions
The Committee received the SDEC Front Door Ambulatory Solutions deep dive. The Planned Care division are putting more patients through the SDEC pathway which is currently at 20% with the expectation that it will be 30%-35%. Once the new ED build has been completed, 35% should be achieved and it will be effective in reducing the inpatient bed base, which will allow resources to be used elsewhere within the hospital. Risks and issues were discussed and a follow up later in the year was agreed.

Employee Relations
FPPC considered the key points in relation to employee relations for month 12. Formal management of sickness and absence was paused where appropriate due to the pandemic. While the majority of sickness reported was Covid related absence during the national Covid waves, other absence reduced in the same periods. Covid was not counted towards formal management triggers resulting in a reduction in formal absence management and formal disciplinary action was paused in the majority of cases. Issues are now being actively resolved in a less formal manner using a learning approach which has resulted in a more positive outcome. It was noted that the time to complete disciplinary and grievance cases has increased and a paper with an action plan will be brought to the next FPPC meeting for discussion. BAME colleagues have been more likely to be put forward for formal cases, although individually these cases were viewed as appropriate, the reason for the higher percentage will be reviewed by the Equality and Inclusion Committee.

Temporary Staffing
FPPC considered the key points in relation to temporary staffing for month 12 and a look ahead at 2021/2022 activities. Overall demand for temporary staffing has increased by 10% with a peak in January 2021, which was consistent with the second Covid wave. Nursing and midwifery accounted for 60% of the temporary staffing demand for 2020/2021, 36% of which was for qualified staff. The Trust finished 2020/2021 £1.8m under its NHSE/I agency ceiling target which was a significant achievement. NHSP supported redeployment throughout January and February 2021, processing over 180 fast-track applications onto the Bank. Reflections from lessons learnt debriefs identified a number of improvements that have been enacted around on-boarding of staff. The Committee noted that the decrease in vacancies across the trust should lead to a decrease in the volume of temporary staffing. The Committee will review temporary staffing usage in the future including medical staffing.

Finance Report Month 12
The Committee received the finance report for month 12. There was a £2.5m surplus at the end of 2020/2021 which is £3.7m favourable to plan. The year-end position is subject to external audit verification. The £2.5m surplus was mainly driven by additional income received in March 2021 to cover for non-patient care income loss due to the Pandemic, which exceeded forecast expectations. The Trust received central funding in March to cover the cost of unused Annual Leave which arose because of the pandemic. A scheme will be launched in May 2021 to offer to buy back unused annual leave from the previous year, up to 5 days.

Capital expenditure for month 12 was £15,626k against a plan of £13,557k. This included £2,178k donated equipment from DHSC. Total capital spend for the year was significantly higher than in previous years at over £32million (subject to audit). This included Covid-19 funded equipment and ward refurbishment, Estates, IT, medical equipment, DHSC donated equipment together with projects such as the ED major refurbishment.

The Trust ended the financial year with a cash balance of £52m which was an increase of £41m from the previous year. This is due to a significant decrease in receivables, an increase in creditors and surplus made by the Trust during the year.

MVCC Impact Assessment
The FPPC received the MVCC Impact Assessment. The initial impact assessment identified a number of critical actions to be completed in advance of the final impact assessment, currently planned to be presented to the ENHT Board in September 2021. This will include further analysis to understand the current key impacts in more detail, and the development of plans to mitigate impacts where possible. The planned date for transfer of services from ENHT to UCLH is April 2022.

Board Assurance Framework and Risk Update
The FPPC considered the latest BAF. The committee noted the focus on gaps and assurances which will be taken to the next executive committee and discussed at the next FPPC meeting. The BAF will also be taken to the Audit Committee and Inclusion Committee for their risks to be considered.

Final Budget Approval 2021/22
FPPC discussed and approved the H1-21/22 financial plan as presented. Risks and key issues were noted.

Karen McConnell
Finance, Performance and People Committee Chair
April 2021

East and North Hertfordshire NHS Trust

Agenda Item: 16.2

TRUST BOARD - PUBLIC SESSION – 5 MAY 2021

STRATEGY COMMITTEE – 20 APRIL 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 20 April 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:** 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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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 – 20 APRIL 2021

EXECUTIVE SUMMARY REPORT TO TRUST BOARD

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

The following core attendees were present:
Sarah Brierley (Director of Strategy), Martin Armstrong (Director of Finance and Deputy CEO), Michael Chilvers (Medical Director), Mark Stanton (Chief Information Officer), Kevin O'Hart (Director of Improvement), Kevin Howell (Director of Estates and Facilities), Thomas Pounds (Chief People Officer)

MATTERS TO BE REFERRED TO THE BOARD
No specific issues were referred to the Board.

MATTERS CONSIDERED BY THE COMMITTEE:

STRATEGIC PLANNING FRAMEWORK
The Committee received an update on the progress with the strategic planning framework refresh. The process had been developed further since the previous meeting of the Committee in February and a series of clinical and corporate workshops were now planned to take place during May. Preparation was underway to ensure that those attending the sessions were able to make best use of them.

The Committee discussed indicative programme timescales including planned reports to future meetings of the Strategy Committee. There was also some discussion regarding the implications of slippage against the programme timeline and in relation to the enabling strategies.

The Committee welcomed the update and noted the progress to date and future plans.

SYSTEM COLLABORATION
The Committee received an update on the latest work in relation to system collaboration within the ICP.

ENABLING STRATEGIES:
SUSTAINABILITY STRATEGY PROGRESS REPORT
The Committee received an update regarding the progress of the Trust sustainability group and a summary of the Trust's sustainability performance. The report also detailed the work stream plans for the group and specific actions identified by representatives and an outline of the new Green Plan. The Committee noted the report and keenness from staff in relation to engagement with this issue.

PEOPLE STRATEGY PROGRESS REPORT
The Strategy Committee received and noted an update on the strategic refresh from the perspective of the workforce work stream.

STRATEGIC ALIGNMENT OF TRANSFORMATION PLAN
The Committee received a report which provided detail of how the organisation's transformation portfolio aligned with the Trust's current strategic objectives, as well as highlighting the new transformation governance arrangements for the 2021/22 financial year. It was recognised that the transformation programme had a key role to play as a 'golden thread' through the Strategy Refresh rather than as a separate enabling group. The

Committee was satisfied with the assurance provided regarding the link between the transformation programme and the strategy refresh.

STRATEGIC PROJECTS:
VASCULAR SURGERY NETWORK UPDATE
The Committee received an update on the status of the vascular surgery project. The OBC development was close to completion and the intended timelines and approval process thereafter had been updated and were noted by the Committee. It was agreed that the Strategy Committee Chair would review the business case for strategic alignment given that the next Strategy Committee meeting was not due to take place until after the planned approval date.

MVCC TRANSFER PROGRAMME
The Strategy Committee noted the overview provided regarding the MVCC Transfer Programme. The overall RAG rating was amber.

ICS PATHOLOGY PROCUREMENT
The Committee noted the update regarding the ICS Pathology Procurement. The programme was on track but possible risks to delivery were noted.

ED TRANSFORMATION
The update relating to the ED transformation programme was noted. There were no specific risks requiring escalation. Assurance was provided that the work was aligned with the Trust's strategic direction. The Committee discussed the most appropriate forum for ongoing monitoring of delivery of the project.

BOARD ASSURANCE FRAMEWORK AND RISK REPORT
The Strategy Committee noted the latest version of the BAF and the risks that had been assigned to that Committee. Further discussion in relation to the digital risk was planned for the next meeting. The Risk Register Update was also noted.

Karen McConnell
Strategy Committee Chair

May 2021

East and North Hertfordshire NHS Trust

Agenda Item: 16.3 a)

TRUST BOARD - PUBLIC SESSION – 5 MAY 2021
QUALITY & SAFETY COMMITTEE – MEETING HELD ON 30 MARCH 2021
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the QSC meeting of the 30 March 2021 to the Board.		
Action required: For information		
Previously considered by: N/A		
Director: Chair of QSC	**Presented by:** Chair of QSC	**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 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 – 30 MARCH 2021
SUMMARY TO THE TRUST BOARD MEETING HELD WEDNESDAY 5 MAY 2021

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

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

Matters Considered by the Committee:

Quality Review
The Committee received the Quality Review report which provided a review of the delivery of high quality, compassionate services, consistently across all sites. The key findings of the review were that the second wave of the pandemic saw increased risk to quality of care in correlation with staffing pressures and ongoing high operational activity. The key areas and themes were care related incidents alongside three never events. The report concluded with next steps, both short term and the quality priorities for the next year. The longer term objectives will be focused on applying excellence and building safer systems.

Patient and Carer Experience Partnership Programme
The Committee heard an outline of the improvement programme for patient and carer experience and how it linked to the quality strategy. It was highlighted that the programme was key to enable the delivery of the quality strategy and that the success of the programme will involve the combined efforts of all staff across all services.

Statutory and Mandatory Training
The Committee received a presentation detailing the current compliance for mandatory and statutory training and appraisal plus the development of a new learning management system. It was noted that training had been paused in December and appraisals had steadily declined over the last 12 months due to the impact of the pandemic.

Learning from Deaths Report
The Committee received the learning from deaths report. It was noted that the transition from Dr Foster to CHKS as a reporting source had been completed therefore the figures were not compatible although the trends were similar. The Committee heard the HSMR had remained stable and is in the first quartile and that SHMI is also stable, in the 'lower than expected' band and at an historic low for the Trust.

Patients with Learning Disabilities during Covid
The Committee received a report regarding patients with learning disabilities during the Covid period. It was highlighted that the overall number of patients with learning disabilities admitted during 2020/21 decreased by 18.1% due to a decrease in elective activity and attendances were lower as the community had increased services to reduce patients entering hospitals. It was noted that treatment Escalation Plans (TEPs) would be an area of focus in the future.

Quality Assurance Dashboard and Compliance Update
The Committee noted the content of the latest issue of the Quality Assurance Dashboard and Compliance update. The delay of divisional approvals for serious incidents was highlighted and escalation processes and weekly updates have been instigated to improve the processes. The Committee heard the three virtual TRA assessments with the CQC had taken place and were positively received.

Infection, Prevention and Control Report
The Committee considered the latest version of the IPC report. The Committee heard that Covid infections remained the main focus and that all outbreaks had been closed. Recommendations from HSE regarding nosocomial infections and outbreaks would be incorporated into future learning. The Committee was informed that SSI rate was 1.5% which is above the national benchmark of 0.5%, therefore a deep dive will be undertaken into this area in future.

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

Reports for Noting
The Committee noted the following reports:

- Safer Staffing Report
- Estates and Facilities Assurance Report
- Internal Audit Plan 2021-22
- Maternity Dashboard and NHSR reports (Maternity Safety Highlight Report, Maternity Serious Incident Report and Continuity of Carer Action Plan)
- Integrated Performance Report
- CEC Escalation Report

Ellen Schroder, Deputising as Committee Chair

April 2021

East and North Hertfordshire NHS Trust

Agenda Item: 16.3 b)

TRUST BOARD - PUBLIC SESSION – 5 MAY 2021
QUALITY & SAFETY COMMITTEE – MEETING HELD ON 28 APRIL 2021
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the QSC meeting of the 28 April 2021 to the Board.		
Action required: For information		
Previously considered by: N/A		
Director: Chair of QSC	**Presented by:** Chair of QSC	**Author:** Trust Secretary

Trust priorities to which the issue relates:		**Tick applicable**
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	☒
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):

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QUALITY AND SAFETY COMMITTEE MEETING – 30 MARCH 2021

SUMMARY TO THE TRUST BOARD MEETING HELD WEDNESDAY 5 MAY 2021

The following Non-Executive Directors were present:

Ellen Schroder, Peter Carter, Val Moore, David Buckle

The following core attendees were present:

Michael Chilvers, Rachael Corser, Julie Smith, Tom Pounds

Matters Considered by the Committee:

DNACPR (Deep Dive)

The QSC received a presentation from the Resus Service Lead in relation to DNACPR, following the CQC's review of DNACPR practices. The presentation gave an outline of the key findings from the review and detailed how the Trust was responding to the recommendations and actions. It was concluded that whilst there had been good progress in relation to DNACPR practices in the Trust over recent years, there remained further work to be done in this area to embed changes.

The Committee thanked the Resus Service Lead for attending the meeting and requested further updates be provided to the Committee later in the year.

Guardian of Safe Working Hours Quarterly Update

The latest Guardian of Safe Working Hours Quarterly Update, covering the period January 21 – March 21, was received and noted by the Committee. There had been 21 Exception reports submitted in the period, with no patient safety reports or significant issues raised from Exception Reporting.

It was noted that a temporary emergency rota had been reinstated in January 2021 for Junior Doctors to provide cover of Medical wards and the surge in Medical work. This rota had been developed with Junior Dr representatives and there were no breaches of contractual hours.

People Capability Strategy

The Committee received an update on the People Capability Strategy and the indicative journey towards a 5 year people capability strategy for the organisation. The strategic objectives in relation to people capability were:

1. Standardised approach to capability building
2. Embed a culture of continuous learning
3. Collaborative approach with system partners on enterprise and work experience
4. Employing innovation to the delivery and learning development

The report also covered overarching principles, the outcome measures and the governance structure. The Committee was supportive of the approach being taken.

Quality Assurance Dashboard and Compliance Update

The Committee received the latest edition of the Quality Assurance Dashboard and Compliance Update. It was reported that a new risk had been added to the risk register in relation to an increase in the number of patients with serious mental health conditions and challenging behaviours attending the Trust, impacting on staff safety and our ability to deliver care to these patients and maintain a safe environment. The Committee discussed the actions being taken to address this issue.

It was also noted that the Lister Medicine, Surgery, Well Led and MVCC Medicine Transitional Regulatory Approach assessments with the CQC had now been completed and had been positively received.

Incidents and Inquests Report

The Incidents and Inquests Report provided detail of patient safety incidents by division, level of harm and category. It was reported that one Never Event had been declared since the last report (the patient did not come to harm). The report also provided an update on reviews relating to hospital onset Covid cases in line with NHSE/I guidance.

Infection, Prevention and Control Report

The Committee received the latest IPC report. It was noted that there had been 1 hospital onset definite case reported in March and all outbreak areas had now closed. It remained the intention to schedule a deep dive in relation to Surgical Site Infections for a future meeting.

Safer Staffing Report

The Committee noted the latest Safer Staffing Report. The data within the report indicated a positive position in terms of recruitment and retention in the month. It was also noted that the nursing establishment review was nearing completion and would be considered at a future meeting.

Patient Experience Report – Q4

The Committee received the report which detailed patient experience feedback, complaints and PALS activity in relation to Q4 (January – March 2021). The Committee discussed the planned changes regarding visiting arrangements due to take effect from next week and requested an update at the next meeting.

Maternity Reports:

- **Continuity of Carer Action Plan**

  The Committee noted the latest edition of the Continuity of Carer action plan. It was noted that national funding was expected to become available to support the maternity recommendations.

- **Maternity Incentive Scheme,**

  It was noted that the Trust was forecasting remaining compliant with the requirements of the maternity incentives scheme. It was reported that the Diamond Jubilee Maternity Unit is compliant with all the current requirements of information standard DCB1513 AMD 10/218 and currently no action plan is required.

- **Maternity Highlight Report**

  The Committee noted the content of the latest version of the Maternity Highlight Report.

- **Perinatal Mortality Report**

  The Committee noted the report which provided assurance that the maternity services are contemporaneously and continuously monitoring the Stillbirth and Neonatal death rates by means of the Perinatal Mortality Tool.

Clinical Harm Reviews

The Committee received a verbal update regarding the clinical harm review process. It was reported that the Trust was now in a position to begin to treat priority 3 and 4 patients. It was noted that cancer patient harm reviews had not paused during the pandemic as those patients had continue to be treated. It was agreed that there would be a regular report and recovery trajectory provided from the next meeting. The Committee also discussed the challenges in

terms of long waiters in specific specialties.

Board Assurance Framework

The Committee noted the latest edition of the Board Assurance Framework.

The Committee noted the following reports:

- **Integrated Performance Report**
- **Maternity Dashboard**
- **Patient Safety Specialists Memo**

Peter Carter
Quality and Safety Committee Chair
May 2021

East and North Hertfordshire NHS Trust

Agenda Item: 16.4

TRUST BOARD - PUBLIC SESSION – 5 MAY 2021

AUDIT COMMITTEE – MEETING HELD ON 24 MARCH 2021

EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the Audit Committee meeting of the 24 March 2021 to the Board.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of AC	**Presented by:** Chair of AC	**Author:** Trust Secretary

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

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

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AUDIT COMMITTEE MEETING – 24 MARCH 2021
SUMMARY TO THE TRUST BOARD MEETING HELD ON 5 MAY 2021

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

External Audit Reports:

External Audit Progress Report

The Audit Committee received an update regarding the External Auditors' work in relation to the Trust's Annual Report and Accounts 20/21. It was reported that due to staffing challenges the External Auditor was experiencing, it had been discussed and agreed with the Trust's finance team that it would be prudent to enact the option to extend the deadline for submission beyond the default date of 15 June to Tuesday 29 June 2021. It was confirmed that it remained the intention to aim to make the submission by the earlier date if possible.

The External Auditors were in the process of issuing their requests for information and would present the findings with risks and significant weaknesses at the next meeting. It was confirmed that no major issues had been identified to date.

The Audit Committee also discussed the Value for Money Report and anticipated timelines. It was anticipated that the report would be considered by the Trust Board in September.

Internal Audit Reports:

Internal Audit Progress Report

The Audit Committee received an update from the Internal Auditors. Three audits had been finalised since the previous report, as follows:

- Board Assurance Framework – Substantial Assurance
- Management of Clinical Risks – Reasonable Assurance
- To Take Out Medicines and Discharge Summaries – Limited Assurance

The Committee discussed the findings of the TTO and Discharge Summaries audit with the Managing Director for Planned Care, who provided assurance of the actions being taken in response to the findings. A key element of the work required was to foster a cultural change relating to the completion of discharge summaries. The Committee discussed next steps and future monitoring of progress against the actions.

Draft Annual Report and Head of Internal Audit Opinion

The Internal Auditors presented the draft annual report and Head of Internal Audit Opinion based on the work completed to date. At this stage, the internal auditors were anticipating issuing a 'reasonable assurance' opinion.

Internal Audit Action Tracker

It was reported that the number of outstanding actions had reduced to 18. Of most concern were 13 actions that had been outstanding for more than 1 year. The Committee discussed the outstanding actions with the Medical Director and Chief People Officer who provided assurance that their actions would be addressed by the revised target dates.

Annual Plan 2021/22
The Committee considered the draft Internal Audit Plan 2021/22. Feedback had been received from the Executive Committee which would also be incorporated. The Audit Committee supported the draft plan, acknowledging there would be some further discussion and final amendments.

Counter Fraud Progress Update and Plan 2021/22
The Anti-Crime Specialist presented an update on the work undertaken since the previous meeting of the Audit Committee. She highlighted that the Government Functional Standard were be required to be submitted before the next meeting of the Committee.

The Audit Committee also considered and approved the draft work plan for Counter Fraud for 2021/22.

Other Reports:

Data Quality and Clinical Coding Report
The Committee received an update regarding data quality and clinical coding services. It was reported that the team were returning to 'business as usual' duties following the Covid period whilst recognising certain service changes that would be retained. It was noted that clinical prioritisation of patients was a key focus for the data quality team.

Cyber Security Update
The Committee received an update on the Trust's cyber security arrangements and recent activities, including responses to cyber security threats and patching. An update regarding cyber security in relation to cloud services was requested for the next meeting.

Raising Concerns at Work Log
The Interim Chief People Officer presented the paper which provided the details of the Trust's current position and future plans with regard to Freedom to Speak Up arrangements. The report included detail of efforts work to raise awareness of the role and the main themes of concerns raised. Bullying and harassment accounted for almost three quarters of the concerns raised. The data indicated that medical staff were not currently utilising the service to the same extent as other staff groups. The Committee discussed future plans and the importance of ensuring medical staff were engaged in the process.

Board Assurance Framework
The Committee noted the latest edition of the Board Assurance Framework, which had been updated following feedback from a recent internal audit. The updated BAF for 2021/22 would be provided for the next meeting. A schedule of risk deep dives would be produced for the next meeting.

Review of Risk Management Strategy
The Committee considered the proposed changes to the Risk Management Strategy. The strategy had been updated to incorporate actions from the recent internal audit, but it was the intention to undertake a more substantial review and refresh next year, once the Trust's strategic refresh process had been completed. The Committee endorsed the strategy for consideration by the Trust Board.

Clinical Audit Assurances
The Committee received the Clinical Audit Assurance report. It was reported that the internal audit undertaken in 2020/21 had returned a 'substantial assurance' opinion. It was reported that a number of audits had been paused during the pandemic as per national guidance but had continued where possible (only 9% of audits had not been started in the year). The Clinical Effectiveness Committee had also been paused during the first wave of the

pandemic but had now restarted. There were no particular concerns to report but the importance of ensuring that the process resumed alongside the recovery of other activities was noted.

Jonathan Silver
Audit Committee Chair
May 2021

East and North Hertfordshire NHS Trust

Agenda Item: 16.5

TRUST BOARD – 5 MAY 2021
CHARITY TRUSTEE COMMITTEE – MEETING HELD 8 MARCH 2021
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present to the Trust Board **in its capacity as Corporate Trustee** the summary report from the Charity Trustee Committee (CTC) meeting held on 8 March 2021.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of CTC	**Presented by:** Chair of CTC	**Author:** Assistant Trust Secretary

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

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

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

CHARITY TRUSTEE COMMITTEE MEETING HELD 8 MARCH 2021

SUMMARY REPORT TO BOARD

The following members were present: Bob Niven (CTC Chair), Ellen Schroder (Trust Chair), Val Moore (Non-Executive Director) and Sarah Brierley (Director of Strategy)

Key decisions made under delegated authority:
The Charity Trustee Committee (CTC) made the following decisions on behalf of the Trust under the authority delegated to it within its Terms of Reference:

Approval for expenditure over £5,000
The Committee discussed the following applications for expenditure over £5,000:

Proposal	Cost	Outcome
To organise a series of thank you initiatives and events for staff to coincide with the 73rd anniversary of the NHS	£58,000 plus VAT	Approved in principal with a proviso to review whether certain elements could be provided by an external provider.
To professionally create, design, publish and print a memory book which documents the Covid-19 pandemic	£50,000	Approved
To fund a 10 hours p/w patient flow discharge coordinator	£10,000	Denied as it was felt that the coordination role was a core requirement
To fund 18 oxygen saturation machines	£12,380 plus VAT	Approved
To fund Beverly De Valois' scar work research for an additional 12 months	£11,775	Approved
To fund 2x Paxman Scalp Cooling systems	£38,533	Approved
To fund a high fidelity paediatric mannequin for resuscitation simulation training	£8,000	Approved with additional fundraising required

Other outcomes:

Divisional Training Budget
The Committee received the divisional training budget report which was in line with the new divisional restructure and the new training approval process. The Committee approved the report.

Charity Forecast / Income Plan 2021/22
The Committee received the forecast and income plan for the new financial year, with income estimated at £1.056 million. The Committee welcomed and approved the plan.

Management of Charitable Funds Policy Update
The Committee approved the amendments to the charitable funds policy.

Investment Portfolio Strategy and Update
The Committee were updated regarding the task and finish group actions. The investment fund policy had been updated and five investment funds had been shortlisted to bid for the tender. It had been agreed that the aim was to go out to tender by the end of April.

Next Major Charity Appeal
The Committee heard that the proposed new major appeal was 'The Sunshine Appeal'. It focuses on creating beautiful outdoor spaces to bring sunshine to the most critically ill and vulnerable patients and our incredible NHS staff. The Committee were informed that costs were currently being collated and the feasibility of the estate was being assessed.

The Committee noted the following reports:

- **Divisional Fund Management Report – Planned Care**
- **Here for Each Other Update**
- **Charity Finance Report**
- **Charity Activity Update**

Bob Niven
Chair of the Charity Trustee Committee
March 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 5 MAY 2021

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date

No actions outstanding

Draft Board Annual Cycle 2021-22

Notes regarding the annual cycle:

The Board Annual Cycle will continue to be reviewed in-year in line with best practice and any changes to national scheduling.

Items	April 2021	5 May 2021	June 2021	7 Jul 2021	Aug 2021	1 Sept 2021	Oct 2021	3 Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Standing Items												
Chief Executive's Report		X		X		X		X		X		X
Integrated Performance Report		X		X		X		X		X		X
Board Assurance Framework		X		X		X		X		X		X
Data Pack		X		X		X		X		X		X
Patient Testimony (Part 1 where possible)		X		X		X		X		X		X
Employee relations (Part 2)		X		X		X		X		X		X
Operational and People Recovery		X		X		X		X		X		X
Board Committee Summary Reports												
Audit Committee Report		X		X		X		X				X
Charity Trustee Committee Report		X		X				X		X		
Finance, Performance and People Committee Report		X		X		X		X		X		X
Quality and Safety Committee Report		X		X		X		X		X		X
Strategy Committee		X		X				X		X		
Inclusion Committee				X		X		X		X		X
Strategy												
Annual Operating Plan and objectives *(subject to change as dependent on national timeline)TBC*												

Draft Board Annual Cycle 2021-22

Items	April 2021	5 May 2021	June 2021	7 Jul 2021	Aug 2021	1 Sept 2021	Oct 2021	3 Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
System Working (ICS and ICP) Updates		X		X		X		X		X		X
Mount Vernon Cancer Centre Transfer Update		X		X		X		X		X		X
Other Items												
Audit Committee												
Annual Report and Accounts, Annual Governance Statement and External Auditor's Report – Approval Process		X										
Annual Audit Letter and Value for Money Report						X						
Audit Committee TOR and Annual Report						X						
Freedom to Speak Up						X						X
Review of Trust Standing Orders and Standing Financial Instructions								X				
Charity Trustee Committee												
Charity Annual Accounts and Report								X				
Charity Trust TOR and Annual Committee Review								X				
Finance, Performance and People Committee												
Finance Update (IPR)		X		X		X		X		X		X
FPPC TOR and Annual Report								X				

Draft Board Annual Cycle 2021-22

Items	April 2021	5 May 2021	June 2021	7 Jul 2021	Aug 2021	1 Sept 2021	Oct 2021	3 Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Equality and Diversity Annual Report and WRES *Note – Likely to move to Inclusion Committee*						X						
Gender Pay Gap Report *Note – Likely to move to Inclusion Committee*												X
Market Strategy Review - *TBC*												
Quality and Safety Committee												
Complaints, PALS and Patient Experience Report		X ***See April QSC***				X		X		X		
Safeguarding and L.D. Annual Report (Adult and Children)				X								
Staff Survey Results												X
Learning from Deaths		X		X				X		X		
Nursing Establishment Review				X						X		
Responsible Officer Annual Review						X						
Patient Safety and Incident Report (Part 2)		X				X		X				X
University Status Annual Report				X								
QSC TOR and Annual Review						X						
Strategy Committee												
Digital Strategy Update				X				X				X
Strategy Committee TOR and Annual Review						X						

Draft Board Annual Cycle 2021-22

Items	April 2021	5 May 2021	June 2021	7 Jul 2021	Aug 2021	1 Sept 2021	Oct 2021	3 Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Shareholder / Formal Contracts												
ENH Pharma (Part 2)				X								

DATA PACK

Contents

1. Data and Exception Reports:

FFT

2. Performance Data:

CQC Outcomes Summary

1. Data and Exception Reports:

FFT

Friends and Family Test - February 2021

APPENDIX 1

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	4	1	0	0	0	0	5	57
5B	66.67	0.00	2	0	1	0	0	0	3	49
6A	100.00	0.00	3	4	0	0	0	0	7	53
6B	50.00	50.00	1	1	0	2	0	0	4	41
7A	77.78	0.00	5	2	2	0	0	0	9	36
7B	86.67	1.67	36	16	7	0	1	0	60	117
8A	91.55	1.41	50	15	4	1	0	1	71	73
8B	95.45	4.55	9	12	0	0	1	0	22	109
9A	100.00	0.00	13	2	0	0	0	0	15	41
9B	94.12	2.94	25	7	1	0	1	0	34	50
10A	100.00	0.00	5	1	0	0	0	0	6	23
10B	66.67	33.33	2	0	0	0	1	0	3	50
11A	100.00	0.00	1	1	0	0	0	0	2	67
11B	NA	NA	0	0	0	0	0	0	0	0
ICU1	100.00	0.00	1	0	0	0	0	0	1	5
ICU2	NA	NA	0	0	0	0	0	0	0	0
SSU	NP	NP	0	0	0	0	0	0	0	27
AMU1	80.00	0.00	1	3	1	0	0	0	5	5
AMU2	92.86	0.00	9	4	1	0	0	0	14	51
Ashwell	95.45	0.00	10	11	1	0	0	0	22	27
Barley	84.62	0.00	20	2	2	0	0	2	26	35
Pirton	100.00	0.00	18	2	0	0	0	0	20	38
Swift	100.00	0.00	4	4	0	0	0	0	8	209
Day Surgery Centre, Lister	100.00	0.00	5	1	0	0	0	0	6	93
Day Surgery Treatment Centre	100.00	0.00	2	0	0	0	0	0	2	75
Endoscopy, Lister	96.97	0.00	32	0	1	0	0	0	33	397
Endoscopy, QEII	NA	NA	0	0	0	0	0	0	0	0
Cardiac Suite	100.00	0.00	13	1	0	0	0	0	14	285
MEDICINE/SURGERY TOTAL	92.09	1.79	**271**	**90**	**21**	**3**	**4**	**3**	**392**	**2013**
Bluebell ward	NP	NP	0	0	0	0	0	0	0	130
Bluebell day case	NA	NA	0	0	0	0	0	0	0	0
Neonatal Unit	96.30	0.00	20	6	1	0	0	0	27	65
WOMEN'S/CHILDREN TOTAL	96.30	0.00	**20**	**6**	**1**	**0**	**0**	**0**	**27**	**195**
MVCC 10 & 11	80.00	0.00	3	1	1	0	0	0	5	47
CANCER TOTAL	80.00	0.00	**3**	**1**	**1**	**0**	**0**	**0**	**5**	**47**
TOTAL TRUST	92.22	1.65	**294**	**97**	**23**	**3**	**4**	**3**	**424**	**2255**

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	92.36	1.67	291	96	22	3	4	3	419	2208
QEII	NA	NA	0	0	0	0	0	0	0	0
Mount Vernon	80.00	0.00	3	1	1	0	0	0	5	47
TOTAL TRUST	**92.22**	**1.65**	**294**	**97**	**23**	**3**	**4**	**3**	**424**	**2255**

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	93.10	6.90	24	3	0	0	2	0	29	6963
QEII UCC	NP	NP	0	0	0	0	0	0	0	2184
A&E TOTAL	**93.10**	**6.90**	**24**	**3**	**0**	**0**	**2**	**0**	**29**	**9147**

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	8	0	0	0	0	0	8	405
Birth	97.12	1.44	97	38	2	2	0	0	139	361
Postnatal	95.45	0.00	90	36	6	0	0	0	132	361
Community Midwifery	100.00	0.00	8		0	0	0	0	8	93
MATERNITY TOTAL	**96.52**	**0.70**	**203**	**74**	**8**	**2**	**0**	**0**	**287**	**1220**

Outpatients	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses
Lister	100.00	0.00	27	9	0	0	0	0	36
QEII	100.00	0.00	4	0	0	0	0	0	4
Hertford County	100.00	0.00	5	0	0	0	0	0	5
Mount Vernon CC	98.40	0.80	99	24	1	1	0	0	125
Satellite Dialysis	100.00	0.00	67	7	0	0	0	0	74
OUTPATIENTS TOTAL	**99.18**	**0.41**	**202**	**40**	**1**	**1**	**0**	**0**	**244**

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:

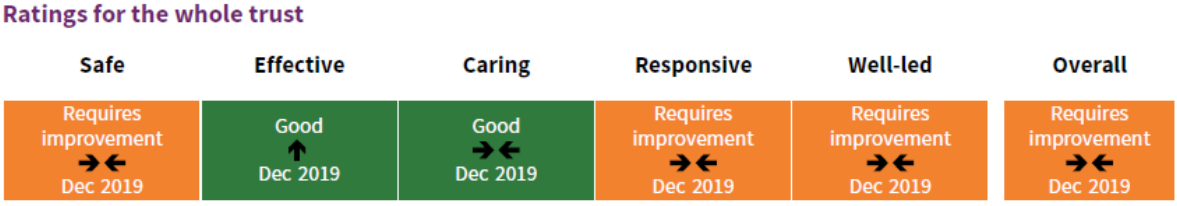
- Medicine (MVCC)
- Radiotherapy (MVCC)
- Outpatients

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