East and North Hertfordshire NHS Trust Board
1 July 2020, 9:00am
Held in the Trust Management Offices and via video conferencing

As the Trust was not able to hold a meeting in public during July, the Board considered a mix of public and private Board papers at the meeting on 1 July.

The reports which follow are reports that would ordinarily be considered at the public meetings of the Board:

East and North Hertfordshire NHS Trust

Agenda Item: 6

TRUST BOARD – 1 JULY 2020
Board Assurance Framework 2019 20 / 20-21

Purpose of report and executive summary (250 words max):
To present the latest version of the Board Assurance Framework 2019 20 and development of 20/2021(appendix 1) for consideration. Key areas of the risks to note at 20:

- Risk 4: There is a risk that there is insufficient capital resources to address all high/medium estates backlog maintenance, investment medical equipment and service developments. The FPPC in June 20 received a report regarding the COVID Financial Framework and related COVID capital requests that had been submitted to NHSI/E in line with the guidance and are awaiting funding decisions.

- Risk 11 There is a risk that the Trust's Estates and Facilities compliance arrangements including fire management are inadequate leading to harm or loss of life. The FPPC in June 20 received a compliance report on the current status which takes into account the third party reviews by the specialist Authorising Engineers. This will be a regular assurance report. Plans are in place to commence the development of a new Estates Strategy. The risk is under current review with the Director of Estates and Facilities.

- Risk of COVID-19 pandemic outbreak impacting on operational capacity to deliver safe services – current risk assessment remains at 20 (Risk 13) although this is currently under review. Mitigations are in place and considered within Operation Restart Programme.

As previously reported the review BAF risks to ensure they reflect the strategic risks for 2020/21was scheduled due in April 2020. This was to be informed by the new Operating Plan, strategic priorities and review of the clinical strategies however due to the national pandemic and the operation planning process for 2020/21 being suspended this was put on hold.
The review recommenced in June with each of the Directors and the outcome and revised BAF for 2020/21 will be presented to the Executive Committee and Audit Committee in July for final review and approval.

Please note: The attached current version of the BAF remains reflective of the 2019/20 BAF risks will not reflect the proposed changes until the review work is complete in July. A focus for 2020/21 will be on the assurances to assess the effective management of the risk and additional actions required to proactively manage the risk in line with the Board's Risk Appetite.
The annual Risk Management and Assurance review by the Internal Auditors has concluded 'reasonable assurance' and the Audit Committee approved remaining with the current BAF framework.

Action required: For discussion		
Previously considered by: The Board Assurance Framework is considered at each FPC,QSC & Board.		
Director: **Director of Nursing**	**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	x☐

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

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

Risk Scoring Guide

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

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

Trust risk scoring matrix and grading

Likelihood

Impact	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
Death / Catastrophe 5	5	10	15	20	25
Major 4	4	8	12	16	20
Moderate 3	3	6	9	12	15
Minor 2	2	4	6	8	10
None /Insignificant 1	1	2	3	4	5

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

BOARD ASSURANCE FRAMEWORK OVERVIEW

Risk Ref	Risk Description	Lead Executive	Committee	Current Risk (May)	Last Month (May)	3 months ago (March)	6 months ago (Jan)	Target Score	Date added (all reviewed in October 19)
001/19	There is a risk that within the context of the Healthcare Economy the Trust has insufficient capacity to sustain timely and effective patient flow through the system which impacts the delivery of the 62day cancer, RTT, the A&E 4-hour standard and Stroke performance (currently under review for 20/21)	Chief Operating Officer	**FPPC**	**16**	**16**	**16**	**16**	**12**	01-03-18
002/19	There is a risk that the trust is unable to recruit and retain sufficient supply of staff with the right skills to meet the demand for services (currently under review for 20/21)	Director of Nursing /Medical Director/CPO	**FPPC**	**16**	**16**	**16**	**16**	**12**	01-03-18
003/19	There is a risk that the Trust is unable to achieve financial sustainability to support the delivery of the Operational Plan and 5year clinical strategy (currently under review for 20/21)	Director of Finance	**FPPC**	**16**	**16**	**16**	**16**	**12**	01-04-19
004/19 (was 6)	There is a risk that there is insufficient capital resources to address all high/medium estates backlog maintenance, investment medical equipment and service developments	Director of Finance	**FPPC**	**20**	**20**	**20**	**20**	**16**	01-03-18
005/19	There is a risk that the digital programme is delayed or fails to deliver the benefits, impacting on the delivery of the Clinical Strategy (currently under review for 20/21)	Director of Finance/ COO	**FPPC**	**16**	**16**	**16**	**16**	**12**	01-04-17
006/20	ICP partners are unable to work and act collaboratively to drive and support system and pathway integration and sustainability (agreed for 20/21)	Director of Strategy	**FPPC**	**12**	12	N/A	N/A	N/A	01-04-20
007/19	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 (currently under review for 20/21)	Chief Executive	**Board**	**16**	**16**	**16**	**12**	**12**	01-03-18
008/19 (was 11)	There is a risk that the Trust is not always able to consistently embed of a safety culture and evidence of continuous quality improvement and patient experience (currently under review for 20/21)	Director of Nursing /Medical Director	**QSC**	**15**	**15**	**15**	**15**	**10**	01-03-18
009/19	There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered, impacting on the Trust's ability to deliver the required improvements and transformation(currently under review for 20/21)	Chief People Officer	**FPPC & QSC**	**16**	**16**	**16**	**16**	**12**	01-03-18
011/19(was 014/19	There is a risk that the Trust's Estates and Facilities compliance arrangements including fire management are inadequate leading to harm or loss of life. (currently under review for 20/21)	Director of Strategy	**QSC**	**20**	**20**	**20**	**20**	**10**	22/01/19
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. (replaces previous MVCC risk)** (currently under review for 20/21)	Director of Strategy	**FPPC**	16	16	N/A	N/A	N/A	01-04-20
013/20	New: Risk of Covid-19 pandemic outbreak impacting on the operational capacity to deliver services. **(currently under review for 20/21)**	COO/Director of Nursing	QSC/Board	**20**	20	20	N/A	N/A	04-03-20

Board Assurance Framework Heat Map – JUNE 2020

	Consequence / Impact				
Frequency / Likelihood	**1 None / Insignificant**	**2 Minor**	**3 Moderate**	**4 Major**	**5**
5 Certain	low 5	low 10	high 15	high 20 004/19	high 25
4 Likely	low 4	low 8	moderate 12 006/19	high 16 004/19 001/19 009/19 002/19 013/20 005/19 007/19 003/19 012/19	high 20 011/19
3 Possible	very low 3	low 6	moderate 9 006/19	moderate 12 005/19 003/19 009/19 008/19 012/19 002/19 01/19	high 15
2 Unlikely	very low 2	Low 4	Low 6	moderate 8 007/19	013/20 rate 10 011/19 008/19
1 Rare	very low 1	very low 2	Very low 3	Low 4	high 5

008/20 Existing risk score

011/20 Target risk score

Movement from previous month

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2019-20

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**				**Ease of Use: To**
Strategic Objective:	**Improve and sustain delivery of operational performance**	**Source of Risk:**	Strategic Objective IPR	**BAF REF No:**	001/19
Principal Risk Decription: What could prevent the objective from being achieved? **There is a risk that within the context of the Healthcare Economy the Trust has insufficient capacity to sustain timely and effective patient flow through the system which impacts the delivery of the 62day cancer, RTT, the A&E 4-hour standard and Stroke performance (Risk currently under review for 20/21)**		**Risk Open Date:**	01/03/2018	**Executive Lead/ Risk Owner**	**Chief Operating Officer**
		Risk Review Date:	Jun-20	**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 tax issue on Consultants willingness to undertake WLIs. v) Impact of specialist commissioning review and resultant outcome for MVCC on staff retension and recruitment, impacting on effectiveness of the cancer team. vi) Impact of pandemic - covid 19	i) Limited ability to respond to changes in capacity and demand impacting on service delivery ii) Adverse impact on sustaining delivery of core standards iii) impact on patient safety, experience and outcomes iv) increased regulatory scrutiny v) reputation	**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**
• ED Patient flow improvement steering group/ Delivery Board • Three times weekly work stream meetings including Red to Green • Weekly ED Team/COO meeting • Length of Stay consultant led reviews • Daily system telephone conference • Refresh of access board structure and governance led by the Deputy Coo with oversight by the COO • Monthly deep dive cancer meetings with CCG support, to challenge and review tumour site performance, quality and safety • Trust representation on A&E delivery Board/ Cancer Board/ STP • Integrated Care Team engagement • Additional management resource secured to support delivery of cancer timed pathway programme - CIMBIO reports and monitoring - speciality and consultant level monitoring of access plans when completed and failsafe TCI waiting list office reconciliation. Linked to training to improve compliance - Programme Boards - OPD Board, Theatre Board, Length of Stay review panel - ED breach review and vailidation and SoP - re launch of winter planning group July 2019 Comprehensive D&C work undertaken by speciality teams supported by in house D&C team and external IST team. Aim is to identify capacity gaps which will be addressed through a series of actions to include job plan review, efficiecy improvement e.g. reduction in DNA rate; increase utilisation in theatres and where required funding for substantive resources. Process to review and approve contract / pathways changes during covid 19 outbreak Covid and non covid pathways in place Operation Restart - Governance Structure and Plan	• A&E Delivery Board (L1) • System Resilience Group (L2) • Reports to FPC and Board of Directors (L3) • NHSI PRM(L3) • Cancer Board (L2) • Daily and weekly ED sit-rep reporting • Monthly breach validation audits • Internal Audit – Performance Framework report - reasonable assurance March 19) Internal audits scheduled for 2020/21 include the ED triage, SDEC and ambulance handover process and deep dives into several aspects of patient flow Regulator oversight - weekly detailed performance call - Audit Committee deep dive review - October 2019	Internal Audit – Performance Framework report - reasonable assurance March 19) Validated demand and capacity by tumor site modelling by NHSI - led to increase investment in urology. Internal Audit Radiology Utilisation - reasonable assurance Clinical Capacity and Utilisation Governance - partial assurance 2019 Audit Committee deep dive review October 2019 • The trust has been formally stepped down from IST cancer support due to the improvement in cancer performance. • IPR Report to Nov and Dec 2019 FPC/Board demonstrated 6 and 7 compliant cancer standards respectively, with 62 days above compliant levels of 85%+ performance.		Cancer performance ED Performance RTT performance

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**	
Bed Occupancy and LOS reductions not being delivered consistently across specialities. Sufficient surgical capacity to deliver cancer treatments within	• Accountability Framework arrangements • Impact of local Hospitals on Trust activity	Green	Effective control is in place and Board satisfied that appropriate assurances are available

Sufficient surgical capacity to deliver cancer treatments within required timeframes Demand and capacity modelling for all high impact tumour sites complete. Access to funding streams from the cancer alliance allocation - availabilty of capital to support developments Capacity to support the Stroke Care Pathway and KPI Reduced attendances at ED Pathways suspended / changed during pandemic (in line with natitonal guidance) Complexity of Operation Restart in the context of COVID	• Demand and capacity profiling for T&O, Pain , oral surgery to inform future business planning Review and response to Market analysis - Access to social care support at weekends - 7 day working linked to job planning	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) Implementation of patient flow work programme	Chief Operating Officer	on going	sameday emergency care programme in progress, reporting to the Patient Flow Board	In progress
ii) Implementation of agreed improvement plans for cancer, RTT and diagnostics - this is now linked to Operation Restart	Chief Operating Officer	on going	Cancer performance improving. 62 day pathway in track for delivery and sustained by October 2019. RTT- focus on delivery of reductin of 52 wk breaches. Trajectory agreed to be at 0 52 week breaches in July 2020. Funding requesting to deliver insourcing solution for endoscopy which would bring 0 position forward to April 2020.	In progress
iii) Review capacity and demand modelling outcomes and determine associated actions to support delivery of the clinical strategy	Chief Operating Officer	on going	All specilaities currently undergoing D&C modelling to determine the resourcing and efficiency gaps required to deliver the 18 week pathway. This work will be aligned with the contract discussions regarding the level of RTT activity agreed and commissioned with our commissioners. The desire is to deliver compliant RTT pathway treatments for our patients through substantive teams paid at plain time rather than adhoc and WLI sessions.	In progress
iv) Continue to review and strengthen operational and governance structures	Chief Operating Officer	on going	Perfect week delivered improved performance. 21 initiatives were commissioned post perfect week to support flow, to include U/S in the assessment areas; catheter nurse in ED; 7 day access to MRI. There are planned 3 times a year Perfect weeks in the diary, before Easter, before the summer holidays and prior to the next winter, to facilitate advance preparation and ensure the weeks' are as impactful as possible.	In progress
v) To agree and develop further integrated pathways of care with our commissioners	Chief Operating Officer	on going	Next transformation day is 6th March to further develop integrated pathways in support of patient care, access and improved use of capacity and flow.	In progress
Summary Narrative:				

20/21 system operating plan - bed occupancy plan to delver 92% occupancy. System bed solutions and bed alternative solutions have been drafted and agreed by providers and commissioners in support of delivering 92 % bed occupancy at the trust. These include increasing ambulatory pathway solutions within the trust; working with HCT colleagues on access to rehabilitation beds in the community and HCC colleagues on improving the use of discharge home to assess initiatives (DH2A).
April 20: Elective work suspended as per national guidance in March 2020 re covid pandemic outbreak, with the exception of urgent cancer pathways. Theatre lists supported by utilising the facilities of the provate sector. Pathways changes all in line with national/nice guidance, risk assessed and approved through Silver and Gold Command structure and with CCG. Recovery and new world programme in development.May: Operation restart commenced 1 June 2020. Risk under review

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2019/20

Strategic Aim:	**People:** **To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce**				
Strategic Objective:	**Develop, support, engage and transform our workforce to provide quality services**	**Source of Risk:**	Operational Plan, Clinical Strategy, IPR	**BAF REF No:**	002/19
Principal Risk Decription: What could prevent the objective from being achieved? **There is a risk that the trust is unable to recruit and retain sufficient supply of staff with the right skills to meet the demand for services** **(Risk under review for 2020/21)**		**Risk Open Date:**	1.3.18	**Executive Lead/ Risk Owner**	**Chief People Officer**
		Risk Review Date:	Jun-20	**Lead Committee:**	**FPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) National shortage of nurses and doctors ii) Limited strategic workforce planning iii) Availability of training iv)Staff availability impacted by covid-19 pandemic, for example some staff needing to isolate in response to covid-19 and resulting strain on other staff.	i) Impact on staff morale ii) Impact on quality and safety iii) adverse financial impact iv)covid-19 pandemic leading to non-availability of some staff, either because of self-isolation or because of traumatic stress response.	**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**
• Monthly nursing and midwifery workforce steering group • Monthly nursing look ahead – heat map / agreed agency levels • Site safety huddles to review real time staffing and capacity • Quarterly establishment reviews – skill mix, acuity and dependency • Safe care – 3 times daily staffing reviews • University of Hertfordshire recruitment • Rotation of band 5 nurses to aid retention • NHSI Wave 2 retention programme • Eroster • Scheduled regular monthly updates of staffing data to NHSP, to ensure staffing lists as accurate as they can be. • Arrangements in place to support our employees who are EU nationals re Brexit-related settled status applications. Strategic intent defined through work on new People Strategy 'How are You Doing' Initiative to support staff working in pandemic situation. Deployment Hub to match available staff resources with staffing need. Call Centre for Sickness Absence Reporting to provide next day absence reporting Introduction of new models of care, to ensure optimum utilisation of available staffing resources, including deployment of medical and nursing students into skills-appropriate roles . Support with accommodation (short and long term) for staff who need to live away from home to enable them to continue working during the pandemic.	• Report to QSC on medical staffing (L2) • Report to Board of Directors via QSC on safer staffing (L2) • Workforce report to FPC (L2) • Safer Staffing reports (L2) • NHS Professionals continuously recruiting to nursing and midwifery band 2 and band 5 roles. Fast track recruitment arrangement in place as response to covid-19 pandemic. • Reviewing and trialling alternative shift patterns to attract staff; rapid response • Development of joint recruitment and attraction strategy with STP. • Divisional increased headcount targets for 2019/20, which are reviewed regularly at Improving Financial Delivery meetings. - Internal audits scheduled for 2019/20 - consultant job planning, safer staffing,			

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**	
• 40,000 nurses short across the country • Camb/London recruitment/weighting • Capacity to balance quality, money and operational pressure. • Staff leavers higher than expected in some areas • Specific targeted recruitment required for some specialities / specialists	• Data consistency and quality • Improved retention rates • Recruitment in specialty / hard to recruit areas 5 yr Workforce strategy to support the new 5 yr clinical strategy Ability to staff the winter ward	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

• Deanery plans reduction in rotation of medical trainees to DGHs The daily scale of the staffing gap caused as result of covid-19 pandemic cannot be known in advance, particularly in respect of		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) Develop and implement workforce strategy to support the trust new 5 yr clinical strategy	Chief People Officer	September 19 (TBC)		In progress
ii) Implement overseas recruitment plans for 2019/20	Head of Recruitment	Jun-19	International and domestic nursing and medical recruitment was agreed in May 2019. An agreed target for international recruitment was confirmed along with an increased effort to recruit domestic nurses using a variety of tools and incentives to aid recruitment and retention. A paper proposing overseas nursing recruitment activity for 20/21 was tabled to Executives in January 2020 setting out recommended plans for overseas recruitment in 20/21. 87 new starters joined the Trust in March 2020 and the vacancy rate at the end of March 2020 was 6.3% against a target of 6%. Work is underway to recruit both domestic and international nurses, with 51 international nurses ready to be deployed, but delayed due to the COVID-19 pandemic. A further 61 UK based nurses are in the pipeline, 18 of whom are student nurses due to qualify in July 2020. We are actively keeping in touch with candidates and agencies to receive and give updates and are continuing to advertise vacancies and hold interviews, through a variety of methods.	In progress
iii) • People Strategy to be launched in 2019/20 setting out the Trust's approach to recruitment and retention.	Chief People Officer	Feb-20	Draft workforce redeployment policy to be produced by Head of HR as soon as possible.	In progress
iv) Review of Trusts Communication strategy to support recruitment and retention	Communication Team / Head of HR	Nov-19	The Head of Communications has developed a new Communication Strategy , which has been approved.	Complete
v) Review supporting interventions re mediicine division staff ing due to Winter Pressures and longer term recruitment strategy	Chief People Officer	Dec-19	Short term initiatives and incentives considered and approved through Executive Committee 12 Dec 19 for implementation. Some immediate additional efforts to increase nursing recruitment in Medicine have been undertaken with an increased number of overseas nurses being deployed between January and March 2020.	In progress

Summary Narrative:				

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2019-20

Strategic Aim:	**Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term**				
Strategic Objective:	**Meet our financial obligations** **Seek innovative STP-wide solutions to address clinically and financially unsustainable services**	**Source of Risk:**	- Operating Plan - Use of Resources	**BAF REF No:**	003/19
Principal Risk Decription: What could prevent the objective from being achieved? **There is a risk that the Trust is unable to achieve financial sustainability to support the delivery of the Operational Plan and 5 year Clinical Strategy. (Risk currently under review for 20/21)**		**Risk Open Date:**	01/04/2018	**Executive Lead/ Risk Owner**	**Director of Finance**
		Risk Review Date:	Jun-20	**Lead Committee:**	**FPPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Demand and capacity planning ii) Shortfall in CIP delivery iii) Good financial management is not embedded at all levels iv) Data quailty not optimised	i) Impact on cash flow ii) CIP programme not delivered iii) Financial plan not delivered iv) unable to invest in service development v) increased CCG test and challenge and regulatory scrutiny	**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 Metrics aligned to IPR**
• Qlikview SLA income and activity application developed and in place (weekly and monthly) • Monthly SLA income reports to FPC / DEC and Divisions • Divisional Performance & Activity meetings (PAM) in place to review deliver • Monthly CQUIN meetings to review progress in place • Contract monitoring meetings in place with all commissioners • Key monitoring metrics reflected in new divisional PRM dashboards • CIP Work programme and workstreams - Exec review weekly • Fully established PMO function in place supporting delivery • Finance and project training programmes in place for budet holders to access • Weekly Improving Finance Delivery IFD meetings in place • £3m Contingency fund building across YTD • Coding and Data Quality Strategy reviewed at Audit Committee Draft Budget plan 2020/21 , covid finaincial framework, covid reimbursement	• Independent reviews of coding and counting practice undertaken in 17/18 (L3) • Actions plans to address findings in place and reviewed at PAM (L1) • Regular Data quality and Clinical Coding updates to PAM and AC (L2) • Weekly OP drumbeat session re- introduced in January 2019 • CIP tracker in place to monitor delivery achievement (L1) • Monthly Finace Reports to FPC, Board and Divisions (L1) • Monthly cash reporting to FPC / Trust Board and NHSI(L2) • Monthly Accountability Framework ARMs including finance (L1) • Internal Audit – Financial Planning Process L3 +) • Monthly Financial Assurance Meetings & PRM with NHSI (L1) • FPC Deep Dives into remedial performance issues eg. Theatres	• Internal Audit - key financial control, CIP governance, performance framework 2018/19. • Summary of review of budget risks and controls into FPC May and June 2019 Performance Framework - reasonable assurance 2019 Month 10 delivery on track for delivery of financial trajectory/ control total. Delivery of 2019/20 financial plan and unqualified opinion on the Annual Report and Accounts.		• Delivery of Control Total Target (Trust Level) • I&E delivery against agreed 19/20 budget plans • Agency Staffing within NHSI notified ceiling • Cash balances within agreed EFL target
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**		

• Potential challenge from commissioners in respect of volume of planned work undertaken - major year-end settlements agreed. • Comprehensive bed model and associated demand & capacity modelling • Implementation of Same Day Admission pathway change and the understanding of financial impacts • Requirement to support discharge summary remedial activity impacting upon DQ team capacity to respond to CCG challenges and queries • Pace of CIP delivery achievement • Pace of Theatre and Outpatient transformation delivery • Slippage in IFD mitigations • Temporary staffing control environment in respect of medical and nursing staffing Review of financial goverancne for recovery and new world	• Limited demand and capacity modelling • delivery of CIP schemes • delivery of activity levels • Gaps in business skill sets across divisions eg. rostering, waiting list management, budgetary management	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 CIP programme and support in the development of remedial action plans where required, specifically in relation to Theatres and Temp staffing control (Medical and Nursing)	PMO Director	on going	CIP portfiolio value at 16.97M (113% of 2019/20 target. Additional improvement work continues. Significant scruitny of each scheme and monitoring of delivery.	In progress
ii) Monitor delivery of divisional operational plans through IFD meetings , PAM and Accounabilty review meetings	Director of Finance / CPO	on going	In place and IFD reviewed to support delivery and reproting to ARMs. New Delivery Framework for 20/21	In progress
iii) Implementaion of the outcomes of the capacity and demand modeling	Director of Finance / COO	on going	Delivery tracked through PAM Meetings	In progress
iv) Continue to develop BI and support divisions / directorates using effectively	Director of Finance	on going	Ongoing embedding and further development of dahsboards and data sets development	In progress
v) Prepare for use of resources assessment	Executive	Aug-19	outcome of assessment - - Requires improvement , December 2019	completed
Summary Narrative:				

Month 10 delivery on track for delivery of financial - risk score for review post Month 11

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2019-20

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:	**Design, develop, launch and embed the Quality Strategy Seek innovative STP-wide solutions to address clinically and financially unsustainable services Complete stabilisation and commence optimisation of Lorenzo and make our services easier to use**	**Source of Risk:**	Business Plan, Clinical Strategy	**BAF REF No:**	004/19
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that there is insufficient capital resources to address all high/medium estates backlog maintenance, investment for medical equipment and service development		**Risk Open Date:**	01.03.18	**Executive Lead/ Risk Owner**	**Director of Finance**
		Risk Review Date:	Jun-20	**Lead Committee:**	**FPPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Lack of available capital resources to enable investment ii) STP/ ICS role in influencing capital prioritisation iii) Requirement to repay capital loan debts iv) Volume of leased equipment not generating capital v) COVID capital funding arrangements impact BAU capital requirements	i) Poor patient experience ii) Patient Safety iii) limited ability to invest in IMT, equipment and services developments iv) limited innovation v) impact on delivery of clinical strategy	**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 • Prioritising areas for limited capital spend through capital plan • Fire policy and risk assessments in place • Major incident plan • Mandatory training • Equipment Maintenance contracts • Monitoring of risks and incidents • STP/ ICS reallocation/ monthly meeting Equipment review process to support covid 19 pandemic requirements	• Report on Fire Safety to Executive Committee (L2) • Monthly Capital Review Group (CRG meetings) feeding into FPC and Exec Committe (L1) • Report on Fire and Backlog maintenance to RAQC(L2) • Reports to Health and Safety Committee (L2) • Capital plan report to FPC (L2) • Annual Fire report (L3) • PLACE reviews (L3) • Reports to Quality and Safety Committee • Deep dive review of the risks and mitigations (December 2018) • new Monthly Fire Safety Committee established March (includes other sites)			• Capital Expenditure within agreed CRL

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 • 1960s buildings difficult to maintain • No formalised equipment replacement plan or long term capital requirement linked through to LTFM • Estates and facilities monitoring structures and reporting	• Availability of capital	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 five-year trust strategy	Director of Estates and Facilities	September (TBC)		Not yet started

ii) Develop capital equipment replacement plan	Deputy Direoctr of Finance	Sep-20		
iii) Develop programme for Charity to suppport with fundraising	Deputy Direoctr of Finance / Head of Charities	on going	ongoing	
iv) Agree capital investment for 2020/21 and monitor delivery	Executive	May 2020 and ongoing	Captial programme approved through FPCin May 2020. CRG will monitor delivery.	In progress
iv) Review other sources of fundung / opportunities for investment	Director of Finance / Project leads	on going	Bid to NHSI for review including additional funding for fire. Wave 5 bids in process of being developed.	in progress
Summary Narrative:				

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2019-20

Strategic Aim:	**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 services that is financially and clinically sustainable in the long term **Sustainability:** To provide a portfolio of				
Strategic Objective:	**Complete stabilisation and commence optimisation of Lorenzo and make our services easier to use**	**Source of Risk:**	Project	**BAF REF No:**	005/2019
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 under current review for 2020/21)		**Risk Open Date:**	Feb-18	**Executive Lead/ Risk Owner**	**Director of Finance / Chief Operating Officer**
		Risk Review Date:	Jun-20	**Lead Committee:**	**FPPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Poor staff engagement in new systems and processes ii) Not all staff received the required training and support iii) Not all existing trust systems interface between systems iv) Lack of funding natioanlly or locally to complete the programme	i) Unable to deliver financial performance 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	4	16	
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**iii)**	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
i) Digital programme 2019 iii) Internal monitoring of programme implementation through - FPC and Board , Staff training and communication - generic and targeted Clinical review group, operational and governance oversight group/clinical approval group reporting into Digital Programme Board	• Monitoring of key safety and quality indicators through PRM's (L2) • Reports to Executive Committee, FPC and Board (L2) • Weekly Executive monitoring of implementation plans . data quality internal audit scheduled for 2019/20 - CIMBIO reporting and monitoring linking to training and support plans . First clinical approval group (CAG) July 2019	Closed post stabilisation workstreams - access plans, ereferals, hardware - supported by external review group with NHSI/D Summary report on digital acheivements March to April 2020 to QSC/FPPC in April.		

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)Consistancy and compliance in the application of new processes on the systems ii) Availabilty of capital to deliver priorities - year 2 and beyond.		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) Complete rollout of the new discharge summary across all lorenzo wards	Michael Chilvers, MD / Anne Powell	End of May 2019	Wave 5 and 6 implementaiton plan for remaining areas 14.05.19-31.05.19. Completed and adherance to process being monitored. Project completed. Now being embedded into practice.	Completed.

ii) Develop Ditigal Strategy and associated Digital Programme	Mark Stanton, CIO	End of June 2019	In progress - report to FPC in June 2019. Rescheduled for September 2019 Discussed and endorsed by FPC. Programme for the next 3 years agreed by FPC with 20/21 Capital funding agreed	In progress, Complete
iii) Review and implementation of revised Digital Strategy Programme Governance	Mark Stanton, CIO	End of May 2019	Proposed governance structure to be presented to FPC in May 2019 . New structures implemented in July 2019	Completed.
iv) Implement the quick wins initiative programme	Mark Stanton, CIO	Ongoing	Commencing late May as a 6 wk programmeto deliver a number of outstanding pipeline requests. Developing as a tool for new IT governance and linking to larger digital programme deliveries. Report to FPC in June 19.	Completed.
Enabler greater CCIO engagement through more available CCIO PA's and clearer remit	Michael Chilvers /Mark Stanton	Apr-20		
iv) Continue vaildation of records to data to ensure adhererance to the new processes	Des Lane, Associate Director of Information /Richard Hammond Deputy COO	On going	On going and deteriorating patient digital workstream commenced. Discharge Summary Task and finish group chaired by Richard Hammand is now monitoring complaince and looking at medium to long term improvments. Daily reporting to Exec's in place	In progress
Summary Narrative:				

Risk carried forward from 2018/19. Stablisation to be completed by 31 May 2019. New digital strategy, associated digital programme and revised governance structure are in progress. Funding for EPMA confirmed from NHS Digital for implemetation by February 2020.April 20: Follow a successful launch on Barley ward in March -EPMA was paused during covid pandemic. Key workstreams deployed on enabling patient and staff communications ; infrastructure for new areas, romote working , romote clinics , virtual ward, bedside entertainment . Positive staff engagement in different ways of working.

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

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**				**Ease of Use: To redesign**
Strategic Objective:	**Play a collaborative, leading role in the development of the ENHT Integrated Care Partnership, optimising the Trust's expertise, skills and resources to drive the development of high quality, effective integrated services for patients. (Draft for 2020/21)**	**Source of Risk:**	National directives	**BAF REF No:**	Risk 006/20
Principal Risk Decription: What could prevent the objective from being achieved? **ICP 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:	Jun-20	**Lead Committee:**	**FPPC**

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 Partnerhip 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 appraoch for 20/21	Reports to Board and FPC Reports to ICS CEOs' Reports to Partnership Board			
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**		
• Partnership Board Scope for accelerated development of ICP and governance arrangements that support transformation at pace • Need to agree 20/21 priorities for transformation Need to commence pan-organisational improvement work Need to identify clinical leadership capacity to drive greater pan system understanding of servces and pathways and associated improvement work Need to influence and understand future ICP relationship with ICS Identification of dedicated capacity support ICP collaboration	Availability of population health data to inform priorities for transformation and improvement Partnership Board to commence	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) Establish an effective ICP Partnership Board, governance and shared strategic direction	Director of Strategy	Jun-20	First meeting scheduled for 23 June 2020. Initial ICP governance being reviewed to support reset and build on pandemic response	In progress
ii) Agreeand 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 fr st Partnership Board together with recomendations for reconfirming/ refining clear ICP strategic direction and priorities informed by population health data	In progress
iii) Confirm and implement ENH improvement methodology across ICP	Director of Improvement	Ongoing		
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	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		
Summary Narrative:				

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2019-20

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 sites**				
Strategic Objective:	**Improve and sustain delivery of operational performance** **Design, develop, launch and embed the Quality Strategy** **Meet our financial obligations**	**Source of Risk:**	Strategic Objectives External reviews	**BAF REF No:**	**007/19**
Principal Risk Description: What could prevent the objective from being achieved? **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 (risk currently under review for 2020/21)**		**Risk Open Date:**	01.03.2018	**Executive Lead/ Risk Owner**	**Chief Executive**
		Risk Review Date:	Jun-20	**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	4	16	
		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 • 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 -Stretegic 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) Central record of contract / pathway reviews and agreed changes Record of national / regulatory changes and trusts response June 2020 - Revised delivery framework for implementation	• Commissioned external reviews – PwC Governance Review September 2017 NHSI review of Board and its committees 2019 • Visibility of Corporate risks and BAF as Board Committees and Board (L2) • Internal Audits delivered against plan, outcomes report to Audit Committee • Annual review of SFI/SFOs (L3) • 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 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 assurnance - 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		

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 goverancne 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)	• 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 2019/20 including risk appetite	Associate Director of Corporate Governance / Risk Manager	ongoing	Monthly reports to Board committees	In progress
ii) Review of well led compliance and implement recommendations from NHSI Board and Committee observations to strenghten Board governance	Associate Director of Corporate Governance	Sep-19	Board development session in April commenced review of well -led. Follow up session scheduled for June 2019. Continue to review workforce matters, and reviewing DEC/Executive Committees	In progress
iii) Complete recruiment into revised corporate and quailty and safety structures and substantive Executive Director posts	Associate Director of Corporate Governance / Director of Nursing	Jul-19	One current vacancy in corporate goverance team; DPO now absorbed . Final QI posts in process of recruitment- completed . Compliance facilitator commenced.	completed
iv) Review and develop a 'business as usual' programme of compliance / quality and safety reviews	Associate Director of Corporate Governance / Director of Nursing	Oct-19	Review of self assessment frameworks and mock inspeciton paperwork in progress with current programme - draft compliance framework to QSC in November. Compliance revised for implementation in February 2020. Rephasing the implemenation of the compliance framework - commence testing the audit tools for the fundimental standards in June.	In progress
v) Review implementation of Trust clinical strategy and enabling strategies	Director of Strategy		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 security provision	In progress
vi) Review effectiveness of governance at a Divisional level	Associate Director of Corporate Governance	Jan-19	Internal Audit scheduled. ARM reflections. Internal audit of surgical division - reasonable assurance. In progress review during pandemic, recovery and operation restart	In progress
v) Implementation of project plan for CQC Inspection and Use of Resources Inspection	Associate Director of Corporate Governance / Director of Nursing	Aug-19	In progress with weekly reporting to Executive Committee. Inspections anticipated for July - Sept 19. CQC focus groups being promoted (3-5 July) . Inspections completed and awaiting draft reports and outcome . Action plan submitted to CQC in January 2020 - feedback stated comprehensive. engagement progamme agreed with CQC. Monitoring delivery . Actions paused during pandemic - Awaiting details of CQC's new emergency support framework and inspection programme.	In progress

v) develop and implement action plan to address HSE findings and improvement notices	Associate Director of Corporate 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 complaince with M&H at end July. Testing of actions to ensure implemention is in progress and onoing	In progress
v) Review of strategic decision making during pandemic outbreak against the legal framework / advice - and ensure clear audit trail	Associate Director of Corporate Governance	end of May 2020 - revised to June	For discsussion at July Audit Committee	in progress
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	In progress
vi) Review Board members visibility and mechanisms of assurance outside of the meeting structure during the pandemic	Trust Secretary and Associate Director of corporate governance			in progress
Summary Narrative:				
Deep dive of this risk was presented to Audit Committee in January 2020. Discussed with QSC and FPPC. Agreed to increase the risk rating to take into account the current HSE Improvement notices. Actions in place to deliver a compliant position by end of April 2020 for Violence and Agression and Sharps; end of July 2020 for Moving and Handling. Action plans in place for CQC must dos and should do's supported by test and challenge and implementaion of the complaince framework and monitoing of other 3rd party assessments. Reivew of Internal and External Auditor. Internal audit on Risk and Assurrance in progress.				

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2019-20

Strategic Aim:	**Quality: To deliver high quality, compassionate services, consistently across all our sites**				
Strategic Objective:	**Design, develop, launch and embed the Quality Strategy**	**Source of Risk:**	Strategic Objective CQC Inspection	**BAF REF No:**	008/19 (previously 011/18)
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 of a safety culture and evidence of continuous quality improvement and patient experience.** **(Risk for 2020/21 currently under review - Draft:The risk to embed cross cutting organisational learning. This includes learning from patient safety incidents and continuous improvement objectives).**		**Risk Open Date:**	01/03/2018	**Executive Lead/ Risk Owner**	**Director of Nursing /Medical Director**
		Risk Review Date:	May-20	**Lead Committee:**	**QSC**

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 capabolity & capcity infrastructue ii)Limited staff engagement 2. Capruring and pro-actively providing ontinous leanring opportunies require more sturctred strategy and deployment iii) Inconsistent ward to board governance structures and systems 3. Current governace structrues requires stregnthening to reliably seel assurance of	1) Limited learning oppurtunites from current and future continuous quality activities 2) Poorer patient and satff expereince 3)Limited leadership development of all staff 4) impact on reputation iv) increased regulatory scruitny	**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 • 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	• 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 • 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	• 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 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 Patwhay to Excellence achievements, and planning of wave 3 underway. • Sustain reduction cardiac arrest rates 7 day services - 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.	**Days**	
• National guidance and GIRFT Gap analysis identifies areas for improvement • Consistancy with procurement and engagement with clinicians	• Consistency in following care bundles • Implementation and tracking of action plans related to GAPS associted with	Green	Effective control is in place and Board satisfied that appropriate assurances are available

• 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	National Audit & NICE guidance, GIRFT recommendaions, NatSSIP Audit compliance • Embedding of learniing from SIs/Learning from Deaths • Data quality • Delivery against CQC improvement plan	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 Transformaiton Programme	Associate Director of Quailty Improvement	Complete May 2019	Quality transformation phase now complete. Objectives and quality priorities now imbedded with ENHT Quality Strategy	Complete- milestones and aciton now wihtin Quality Stratgey
ii) Delivery and monitoring of CQC improvement plans for Surgery Lister and UCC QEII and other core pathways	Associate Director of Corporate Governance / Director of Nursing	Ongoin	Internal monitoring and review continues each month. CQC action plan monitored through theatre improvement group and Theatre Board. Awaiting formal outcome and re-design of action plan from CQC inspection. Current factual accuray stage in progress of rpeort - new action plan to be finalised by Dec 2019.	In progress
iii) Launch and implementation of the quailty strategy with communication plan	Director of Nursing / Medical Director	ongoing	Launch event held in May 2019, supported with the Trust conversation session in June 2019. First learning trust wide event held 21 June . Invasive Procdure learning event held in October 2019. Reporting cycle to QSC reviewed with scheduled deep dives. Quality Improvement team now fully established. Regular tracking of QI and QS priorties undertaken through QSC. Offcial communication launch of QI planned for November, communication strategy in progress.Patient Co-design group now well established. Registered for National What Matters to you programme to inform Patient Experience Imporvements. Quality Imporvement training sesisons delivered to Quality Leaders. Organsiational collaborative apporach to deosgn ENH way to Improvement.	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
Summary Narrative:				

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2019/20

Strategic Aim:	**People: To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce**
Strategic Objective:	**Develop, support, engage and transform our workforce to provide quality services**

Source of Risk:	Strategic Objective Staff Survey	**BAF REF No:**	009/19
Risk Open Date:	01.03.18	**Executive Lead/ Risk Owner**	**Chief People Officer**
Risk Review Date:	Jun-20	**Lead Committee:**	**FPC & QSC**

Principal Risk Decription: What could prevent the objective from being achieved?

There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered and motivated, impacting on the trust's ability to deliver the required improvements and transformation and to enable people to feel proud to work here. (Risk under current review for 2020/21)

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Poor staff engagement ii) structures, systems and processes do not support raising concerns iii) staff do not feel empowered to effect change iv) stress of responding to Covid-19 pandemic	i) Failure to implement a learning culture ii) Opportunities for improvement missed iii) Quality and Safety Improvement culture is not achieved iv) limited engagement in service change vi) concerns are not raised vii) stressful situation may impact on behaviour of managers/staff	**Inherent Risk** (Without controls):	4	4	16	⟺
		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**
• LMCDP Leadership, Management and Coaching Development Pathway • LEND Sessions • Organisational Values (PIVOT) / Leadership Behaviours (LEND) • Health and Well Being Strategy • Dedicated Associate Director of Leadership and Change • HR Policies including Raising Concerns Policy • ERAS teams and Freedom to Speak Up Guardian • People Strategy • Staff Experience Workshops were launched in April 2018 - Equailty and diversity lead and forums - Dignity at work policy • Talent Management Lead in post • Interim Education Lead in post • Just and Learning Culture Steering Group •'How Are You Doing' team •'Psychological support interventions and debriefs Simulation training and staff upskilling •PPE	• Workforce reports (includes culture) to QSC, FPC, Board (L2) • LEND sessions quarterly (L1) • LMCDP evaluation • FFT (L1) – Improved position June 2018 – 49% rec place to work/ rec for care 74% • Raising Concerns report to Audit Committee and Board (L2) • Workshops – face to face and online (L1) • Review of Insight and Model Hospital • Board Development session July 2018 – (culture) • NHS Annual Staff Survey and other local monthly survey reports - FPC / Board - report on Talent Management June 2019 - Planned IA on Raising concerns in 2019/20 - Promotion of freedom to speak up guardian activites commenced • Just and Learning Culture Steering Group creating action plan			

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**	
• Culture change approach • • Senior leadership training • Senior leadership programme • Talent Management Strategy and Education Strategy under review/ development	• Review outcomes of the actions being taken • Lack of resources to respond within necessary time period • Completion of staff survey action plans • No Education Board currently in place	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 of leadership and education approach as part of education transformation	Chief People Officer	on going	Strategic work ongoing with a view to launch in June 2020.	Not yet started
ii) Increased visibility of Senior Leadership Team (Divisional, Executive and Board)	Chief People Officer	on going	Utilising technology to allow virtual meetings with senior leadership team to take place with colleagues across the Trust.	In progress
iii) Implement action plan following staff survey feedback	Chief People Officer	on going	All divisions have a local plan; these are monitored at Trust Board and at staff partnership meetings.	In progress
iv) Develop and implement talent management strategy	Chief People Officer	Aug-20	Talent management approach is happening across the organisation but is immature in delivery.	In progress
v)Review of Communication strategy	Head of Communications	Nov-19	Communication Strategy is in place and operational.	Complete
vi) Staff survey/engagement workshop and assocated actions	Chief People Officer	ongoing	Just and Learning Culture Steering Group meets regularly and will roll out schedule of activities over course of 2020.	In progress
Summary Narrative:				

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2019-20

Strategic Aim:	**Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long termQuality: To deliver high quality, compassionate services, consistently across all our sites**				
Strategic Objective:	**Design, develop, launch and embed the Quality Strategy Develop, support, engage and transform our workforce to provide quality services Meet our financial obligations**	**Source of Risk:**	Risk register	**BAF REF No:**	011/19 (previously 014/18)
Principal Risk Decription: What could prevent the objective from being achieved? **There is a risk that the Trust's Estates and Facilities compliance arrangements including fire management are inadequate leading to harm or loss of life. (Risk currently under review for 2020.21)**		**Risk Open Date:**	22/01/2019	**Executive Lead/ Risk Owner**	**Direcotr of Strategy/ Director of Estates and Facilities**
		Risk Review Date:	Jun-20	**Lead Committee:**	**QSC**

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:	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.	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		

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	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	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

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.		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.	In progress
ii) Continue to Implement fire strategy , new training plan and actions from external recommendations	Head of Safety and Securtiy / Fire Officer	monthly review	With the exeception of the renal satellites -All fire risk assessments now reviewed and actions are being taken to address /mitigate the risks and to inform future capital and maintainance works required - this will be risk assessment and prioritised. Some capital works approved for 2019/20. New Fire Officer in post since November. Annual AE report report in progress to inform work programme for 2020/21. Fire Safety Committee Continues to meet alternate months.	In progress
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	To commence
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.	In progress
iv) Substantive recuitment into leadership structure and other vacancies	Director of Estates and Facilities	Mar-20	Recuitment of new substantive Director of Estates and Facilities in progress. Recruitment and retention rates agreed by Executive committee in line with the region. Some successful recruitment - position being monitored. New Estates and Facilities Director commenced January 2020.	In progress
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,	Ongoing
Summary Narrative:				

July 2019: This risk is currently under review taking into account the new emerging non compliance issues, capactiy and skills within the team and awaiting to secure the permanent Director of Estates and Facilities.
Oct 2019: Whilst the status of compliance continues to be a significant concern, there is increasing visibility on the issues, based on external surveys, and the appointment of a panel of 'subject matter expert's, to help inform, support and challenge the Trust position. Similarly the mobilisation of the new governance structure and compliance monitoring within the E&F Division, including the adoption of a new compliance reporting format, has provided the foundations to move forward. Access to sufficient investment and the real estate strategy will be seminal to reducing the back log liabilities and and improving compliance, going forward. Reporting on compliance into the Health and Safety Committee will be strenghened. Nov
2019: Position strengthed by completion of external audit which is now being used to develop a risk based mitigation programme -monitor by EFMAG.
February 2020: E&F structure and governance structure under review with new Director of Estates and Facilities. Recruitment into substantive structure commencing. Annual reviews by AE are underway. Priorities for the E&F based on the external review.

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** **Quality: To deliver high quality, compassionate services, consistently across all our sites**
Strategic Objective:	**Improve and sustain delivery of operational performance** **Seek innovative STP-wide solutions to address clinically and financially unsustainable services**

Source of Risk:	Specialist Commissioning review	**BAF REF No:**	012/20
Risk Open Date:	Apr-20	**Executive Lead/ Risk Owner**	**Director of Strategy**
Risk Review Date:	Jun-20	**Lead Committee:**	**FPPC**

Risk : 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.

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) 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, retenetion, morale and research. ii) Potential impaxt of pathways of care 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 greater financial impact on the Trust iv) Potential impact on quality and safety	**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**
Trust (and divisional) Clinical Strategy Mount Vernon Cancer Centre Review Programme Board Transition Team Weekly director level call with UCLH and NHSE. Escalation reporitng to Executive Committee and Board . Internal MVCC Task & Finish Group established, linking into NHSI/E fortnightly confernance calls on topic. Clinical policies	• Regular reports to FPC and the Board (L2) • Regular reporting into the Strategic Development Committee Clinical Advisory Group Capacity and demand modelling Monitoring of Quailty Indicators and audit of admissions policy Director of Finance leading internal due diligence .	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 reccomendation that UCLH is the preferred tertiary provider for MVCC (Jan 2020) subject to the outcome of due diligence. NHSI/E Risk Review - singificant assurance provided and decision to step down to BAU assurance monitoring.		

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		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 UCH and MVCC clinicians to develop a new clinical model for MVCC to commence before the end of Q1, including input from patient experieince.	
ii) Conclude negotiations regarding due diligence and transfer costs and deliver due diligence	Director of Finance	Jun-20	The MVCC transfer Task & Finish group has resumed meeting and planning activity during May. The group has identified specific workstreams that can recommence activity to generate information and data to support the Due Diligence process with UCH and NHSE, that will cumulmunate in the developement of a joint Business Case that would underpin the transaction. The Trust has communicated the resumption of this actvity to UCH to ensure that joint up work between the the two organisations can recommence where practicable. Bi weekly Task and Finish groups chaired by the Director of Finance remain diarised going forward to co-ordinate this activity.	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 - acitivty and capacity modelling refreshed to include potential COVID impact on demand and effects of hypofractination for beast cancer. Shared with NHSE. Trust in dsicussions with UCH regarding financial mechasnism to support funding linac purchase. Busines continuity plans being refreshed to support interim service.	
iv) Coninue to support and monitor continuous quality and safety improvement and assurance at MVCC	Director of Nursing/Medical Director	Ongoing		
Summary Narrative:				

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

Strategic Aim:	**Quality: To deliver high quality, compassionate services, consistently across all our sites across care boundaries, where this delivers best patient care**				**Pathways: To develop pathways**
Strategic Objective:	**Improve and sustain delivery of operational performance**		**Source of Risk:**	External	**BAF REF No:** 013/20
Principal Risk Decription: What could prevent the objective from being achieved? **Risk of Covid-19 pandemic outbreak impacting on the operational capacity to deliver safe services (Risk currently under review for 20/21)**			**Risk Open Date:**	04-Mar-20	**Executive Lead/ Risk Owner:** Chief Operating Officer/ Director of Nursing
			Risk Review Date:	Jun-20	**Lead Committee:** Board

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:	5	4	20	
		Target Risk:	5	2	10	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
Major incident policy and Business continuity plans in place. 2.3.20: GOLD/ Incident Command Centre - lister established with additional support - GOLD and SILVER command structures reviewed/adapted to ensure continued support to organisation / major incidnet Daily Corona strategic command meeting Communcation plan - internal and external Supporting staff testing through available routes Action plans/workstreams Review of Pathways and local BCP's Linked into Local and National resilience fourms/ communications/ conference calls Second on call director in place / and smos (from 13.3.20) 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 / regulaory changes and trusts response Patient experience inititives - tell us more, post discharge calls, patient laison 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 Extensive works to supporting cohorting of covid patients ICP BAF June 2020 People and placed based risk assessments Social DIstancing strategy	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 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 / regulaory 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 ICP BAF June 2020 People and placed based risk assessments Social distancing	Business continuity - compliant assessment validated 2019 MVCC Business continuity tested 29 February - 01 March Legal guidance of trust responsibilites under civil contingency act - reprtred to Board April 2020. Critical care capacity maintained approx 50% 3 wks without any Hospital Aquired COVID IPC BAF presented to QSC		

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	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)	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) Corona virus action plan (responsive to daily national updates) and task and finish groups	**Chief Operating Officer/ Director of Nursing**	updated and reviewed daily	reviewed daily to respond to changing position , PPE, testing and social distancing groups now merged for a COVID Advisory Group	In progress
ii) Scenario planning - task and finish group to review bed capacity and ablilty to step up respiratory and critical care beds	**Emergency Planning lead**		task and finish group in place, revised bed configuration agreed for implementation commencing 13.02.20. Equipment to support increased demand identifed and procurement commenced.	In place and regualary reviewed
iii) Implemention of cohorting in Emergency Department - ?covid positive patients and non covid patients	Clinical Director ED / General Manager		Cohorting approved through Gold command for implementation . Further capacity developed through use of portacabin - Red (covid/?covid)) and yellow (non covid) patient pathways developed and implemented	In place from Evening 12.03.20
Review of strategic descion making against Legal guidance of trust responsibilites under civil continengence act to be completed.	Associate Director of Corporate Governance	Jun-20	In progress and to be reported to Audit Committee in July	to commence 12 May 20
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	Director of Nursing	May / June 20	In place	In progress
Summary Narrative:				

East and North Hertfordshire NHS Trust

Agenda Item: 7

TRUST BOARD – 1 JULY 2020

Integrated Performance Report – Month 2

Purpose of report and executive summary (250 words max): The purpose of the report is to present the Integrated Performance Report Month 2 to the Trust Board. Key challenges and mitigations under each domain are identified within the report.		
Action required: For discussion		
Previously considered by: FPPC and QSC (24.06.20)		
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	☒

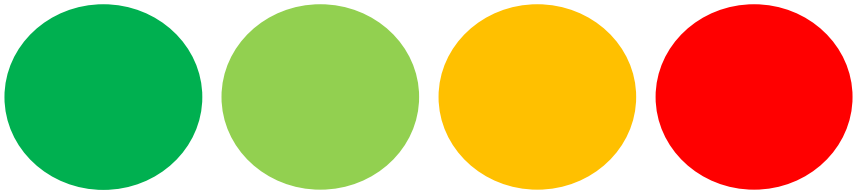
Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
Any other risk issues (quality, safety, financial, HR, legal, equality): Key challenges and mitigations under each domain are identified within the report.

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

East and North Hertfordshire NHS Trust

Integrated Performance Report

Month 02 | 2020-21



Data correct as at 19/06/2020

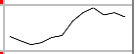
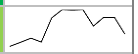
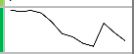
Contents

East and North Hertfordshire NHS Trust

NHS Oversight Framework

East and North Hertfordshire NHS Trust

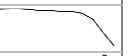
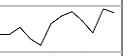
Quality of care

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
Overall	CQC rating	-	Dec-19	-	-	Requires improve-ment	
Caring	Written complaints - rate	Quarterly	May-20	Local	1.9	1.4	
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)	Dec-19 - May-20	National	0	0	
Safe	Patient Safety Alerts not completed by deadline	Monthly	Mar-20	National	0	0	
Caring	Mixed-sex accommodation breaches	Monthly	May-20	National	0	no submission	
Caring	Inpatient scores from Friends and Family Test - % positive	Monthly	May-20	National (excl. IS)	95.0%	90.7%	
Caring	A&E scores from Friends and Family Test - % positive	Monthly	May-20	National (excl. IS)	90.0%	92.9%	
Caring	Maternity scores from Friends and Family Test - % positive - antenatal care	Monthly	May-20	National (excl. IS)	93.0%	100.0%	
Caring	Maternity scores from Friends and Family Test - % positive - birth	Monthly	May-20	National (excl. IS)	93.0%	n/a	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal ward	Monthly	May-20	National (excl. IS)	93.0%	n/a	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal community	Monthly	May-20	National (excl. IS)	93.0%	n/a	
Safe	Emergency c-section rate	Monthly	May-20	Local	15%	11%	
Organisational health	CQC inpatient survey	Annual	2018	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)	May-20	NHSI	0	tbc	
Safe	Clostridium difficile – infection rate	Monthly (12-month rolling)	Jun-19-May-20	National	17.9	28.82	
Safe	Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Monthly (12-month rolling)	Jun-19-May-20	National	0.64	2.41	
Safe	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	Monthly (12-month rolling)	Jun-19-May-20	National	7.56	5.29	
Safe	Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI)	Monthly (12-month rolling)	Jun-19-May-20	National	17.98	17.81	
Effective	Hospital Standardised Mortality Ratio	Monthly (12-month rolling)	Apr-19 - Mar-20	National	100	84.4	
Effective	Summary Hospital-level Mortality Indicator	Monthly (12-month rolling)	Feb-19-Jan-20	National	100	89.0	
Safe	Potential under-reporting of patient safety incidents	Monthly (six-month rolling)	Sep-19 - Feb-20	National	56.6	44.4	

Finance

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
Financial sustainability	Capital service capacity	Monthly	May-20	National	1	n/a	
Financial sustainability	Liquidity (days)	Monthly	May-20	National	1	n/a	
Financial efficiency	Income and expenditure (I&E) margin	Monthly	May-20	National	1	n/a	
Financial controls	Distance from financial plan	Monthly	May-20	National	1	n/a	
Financial controls	Agency spend	Monthly	May-20	National	1	n/a	

Operational performance

A&E	A&E maximum waiting time of four hours from arrival to admission/transfer/discharge	Monthly	May-20	National	95%	78.0%	
RTT 18 weeks	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	Monthly	May-20	National	92%	57.95%	
Cancer Waiting Times	62-day wait for first treatment from urgent GP referral for suspected cancer	Monthly	Apr-20	National	85%	87.08%	
Cancer Waiting Times	62-day wait for first treatment from NHS cancer screening service referrals	Monthly	Apr-20	National	90%	38.46%	
Diagnostics Waiting Times	Maximum 6-week wait for diagnostic procedures	Monthly	May-20	National	1%	61.17%	
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%	-	

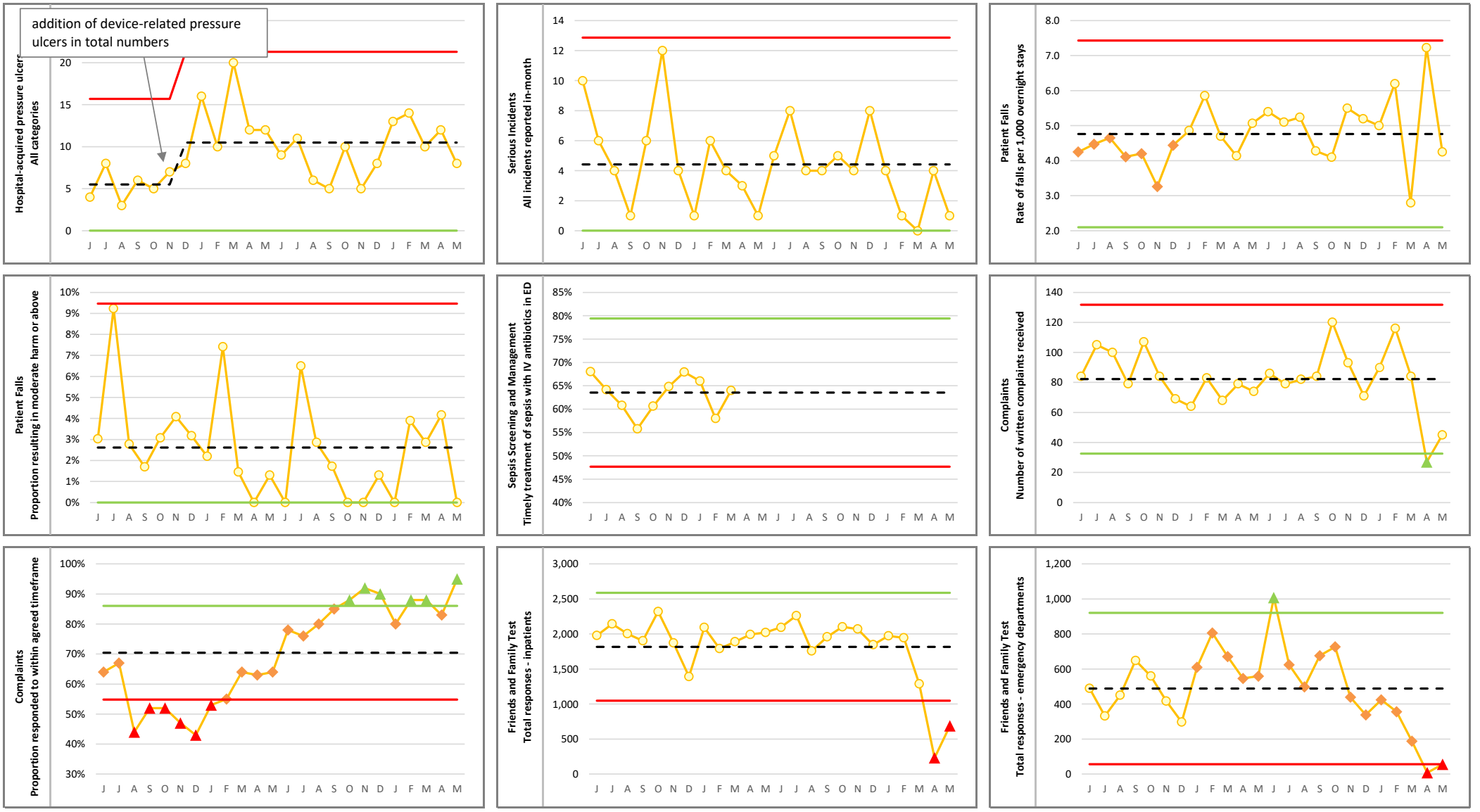
Leadership and workforce

Organisational health	Staff sickness	Monthly	May-20	Local	3.4%	5.51%	
Organisational health	Staff turnover	Monthly	May-20	Local	12.0%	12.8%	
Organisational health	Proportion of temporary staff	Monthly	May-20	Local	-	12.3%	
Organisational health	NHS Staff Survey Recommend as a place to work	Annual	2019	National	63.3%	58.1%	
Organisational health	NHS Staff Survey Support and compassion	Annual	2019	National	20.9%	22.5%	
Organisational health	NHS Staff Survey Teamwork	Annual	2019	National	65.5%	66.2%	
Organisational health	NHS Staff Survey Inclusion	Annual	2019	National	87.8%	86.7%	
Organisational health	BME leadership ambition (WRES) re executive appointments	Annual	2019	National	7.4%	0.0%	

Quality Improvement Dashboard

Safe, Caring and Effective Services Headline Metrics

East and North Hertfordshire NHS Trust



Safe Services

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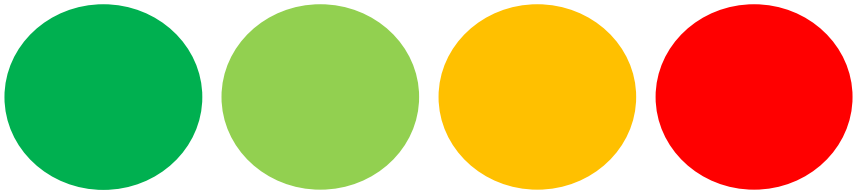


Key Issues

Patient Falls
- 35 inpatient falls were recorded in May.
- Number of falls in May resulting in serious harm = 1.

Serious Incidents & Never Events
- Zero Never Events were reported in May.
- There were 2 serious incidents reported in May:
  - 1 related in delay in treatment
  - 1 related to fall resulting in severe harm

Infection Prevention & Control
- COVID-19 (surveillance commenced on the 14th May 2020) 25 Community-Onset, 5 Hospital-Onset Indeterminate Healthcare-Associated, 3 Hospital-Onset Probable Healthcare-Associated and 3 Hospital-Onset Definite Healthcare-Associated cases.
- MRSA bacteraemia = 0Hospital Onset cases in May.
- C difficile infections = 4 reportable cases in May (1 hospital onset, 3 community onset health care associated).
- E.coli bacteraemia = 1 Hospital Onset cases in May.
- MSSA bacteraemia = 0 Hospital Onset cases in May.
- Klebsiella bacteraemia = 1 Hospital Onset case in May.
- Pseudomonas aeruginosa bacteraemia = 0 Hospital-onset cases in May.
- Hand hygiene compliance was 92.5% in May (Target 80%).

Hospital-acquired Pressure Ulcers
- There were the following reported for May:
  - Category 4 = 0
  - Category 3 = 0
  - Category 2 = 2
  - MM (D) = 1
  - Unstageable = 0
  - SDTI inc. SDTI (D) = 7

Sepsis
- A smaller sample of inpatient and ED sepsis cases were identified in May.
- This showed an average time to antibiotic administration within in patient setting was 59 mins within 1 hour of Red Flag.
- It showed the average time in Emergency Attendances receiving antibiotics to be 195 min within 1 hour of Red Flag.
- No patient successfully received all Sepsis 6 interventions within 1 hour of Red Flag triggers.
- Variation in achieving all Sepsis 6 bundle interventions shows key categories to be accurate fluid balance, timely antibiotics and timely blood culture samples.

VTE
- Potential harm from hospital acquired thrombosis is presented to Serious Incident Review panel. There were 4 HATs presented to SIRP in May 2020.
- Plans remain in progress to report HAT numbers through IPR processes.

Executive Response

Patient Falls
- We continue to monitor all falls, level of harm and themes across the Trust.
- Trust Clinical Lead has been identified and a start date is currently being agreed.

Executive Response (continued)

Serious Incident Review Panel
- It has been 235 days since the last reported Never Event (as at 16th June 2020).
- There were 27 cases presented in May 2020.
- 2 cases require RCA investigation; 2 have been reported as serious incidents others required local learning or no further action.

Infection Prevention & Control
- From the 14th May 2020 NHSE/I introduced mandatory surveillance for nosocomial Covid-19 infection. 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 and Hospital-Onset Definite Healthcare-Associated - First positive specimen date 15 or more days after admission. The IPC team are internally reviewing probable and definite Healthcare-Associated cases to identify any lapses and/or learning. The post infection reviews will be discussed in divisional and Trust IPC meetings to ensure that recommended actions are implemented. (no target has been set by NHSE/I)
- It has been over 130 days since our last reported Hospital Onset MRSA Bacteraemia. Please note assignment of MRSA bacteraemia may change. The Internal PIRs were performed and external PIRs including our external partners took place and a waiting for a final decision on assignment of MRSA bacteraemia.
- C.difficile internal PIRs were performed and external PIRs including our external partners took place. Of the 6 cases reviewed 2 will be revisited to determine the lapses and learning and 1 of the cases has no lapses and learning identified. For the 3 cases remaining the lapses and learning has been identified and actions are being agreed with the relevant teams.

Hospital-acquired Pressure Ulcers
- Current YTD pressure ulcers reported = 24.
- 50% of PU reported this month were on COVID-19 patients who were nursed in critical condition with Prone positioning putting increased pressure on areas of the body not usually exposed to pressure.
- There has also been a high number of Medical Device related PUs (50% of total) due to COVID-19 positive patients requiring invasive care to support them.
- 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. Any COVID-19 related PUs will be fully investigated and reviewed in line with current processes and learning shared..
- 2019 saw a rise in secondary ulcers, adding a new category of damage not previously reported following the new NHSI Recommendations.
- The Trust improvement aims for 2020/21 are a 20% reduction on our per 1000 bed days rate. Current rate is 0.57/1000 bed days.
- 21% of wards are one year or more pressure ulcer free.
- Targeted skin care training and support of pressure area care continues to be provided within COVID-19 on boarding upskilling for new staff to Acute areas.
- The Tissue viability team are now fully established and are working with the Quality Improvement team to restart our PU reduction campaign.

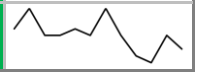
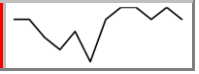
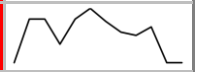
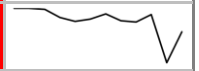
Sepsis
- During the month of May there continued to be limited data collection due to COVID-19 activity and the sepsis nurses being redeployed to support increased critical care capacity.
- As we move towards recovery the sepsis team, AKI and critical care outreach teams are working collaboratively to capture accurate data across ED and inpatient areas and identify areas for improvement focus.
- Digital solutions to aid the management of fluid balance are currently being reviewed.

VTE
- The data to identify VTE cases to undergo a HAT review is still being collected. Learning from VTE RCA's has been identified as priority for June 2020 virtual 'Rolling governance day'; this learning will be published across all specialities.

Safe Services

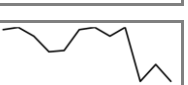
East and North Hertfordshire NHS Trust

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	
14-31-May	36	3	3	5	25	6	30	

Domain	Metric	Target	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Trend
Events and Incidents	Number of Never Events	0	0	1	0	1	1	0	0	0	0	0	0	0	
	Number of Serious Incidents	5	5	8	4	4	5	4	8	4	1	0	4	2	
Hospital-acquired Pressure Ulcers	Category 4 - inc Category 4 (d)	0	0	0	0	0	0	1	0	0	0	0	0	0	
	Category 3 - inc Category 3 (d)	0	0	0	0	0	0	1	0	0	0	0	0	0	
	Category 2 - inc Category 2 (d)	2	2	1	0	2	2	2	0	3	3	3	2	2	
	Mucosal membrane (d) Device-related	-	0	1	0	1	2	0	0	0	1	0	0	1	
	Unstageable inc Category Unstageable (d)	1	0	2	2	0	1	1	1	1	1	0	1	0	
	SDTI inc STDI (d)	3	7	7	4	2	5	0	7	9	9	7	9	7	
Sepsis Screening and Management	Inpatients with Sepsis - sample size	50	19	10	10	6	5	4	10	12	21	3	n/a	4	
	Inpatients receiving IVABs within 1 hour of Red Flag	90%	0%	40%	40%	17%	40%	50%	38%	28%	25%	33%	n/a	0%	
	Emergency attendances with Sepsis - sample size	50	17	33	22	15	12	18	19	59	69	41	n/a	4	
	Emergency attendances receiving IVABs within 1 hour of Red Flag	90%	88%	88%	86%	73%	67%	71%	79%	68%	66%	78%	n/a	50%	
	Sepsis six bundle compliance - ED	90%	tbc	48%	68%	40%	12%	22%	73%	14%	14%	29%	n/a	0%	

Safe Services

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Trend
VTE	VTE risk assessment	95%	90.2%	87.8%	87.2%	83.5%	88.8%	87.5%	87.9%	88.0%	tbc	tbc	tbc	tbc	
Infection Control	Number of MRSA incidences	0	0	1	0	1	0	0	2	1	0	0	0	0	
	Rate of MRSA incidences per 100,000 bed days	0.6	0.0	5.8	0.0	6.0	0.0	0.0	11.4	5.8	0.0	0.0	0.0	0.0	
	Number of c.difficile incidences Healthcare-associated	4	5	4	6	5	9	7	5	2	4	6	3	4	
	Rate of c.difficile incidences per 100,000 bed days Healthcare-associated	19.0	28.6	23.0	34.6	29.8	51.1	41.1	28.4	11.5	24.6	34.6	17.1	22.1	
	Number of e.coli incidences	-	2	5	2	2	8	4	2	3	2	3	3	1	
	Rate of e.coli incidences per 100,000 bed days	18.5	11.4	28.8	11.5	11.9	45.5	23.5	11.4	17.3	12.3	17.3	17.1	5.5	
	Number of MSSA incidences	-	2	1	1	0	4	1	1	1	0	0	0	0	
	Rate of MSSA incidences per 100,000 bed days	8.0	11.4	5.8	5.8	0.0	22.7	5.9	5.7	5.8	0.0	0.0	0.0	0.0	
	Number of klebsiella incidences	-	1	3	3	0	0	2	3	0	1	0	0	1	
	Rate of klebsiella incidences per 100,000 bed days	7.6	5.7	17.3	17.3	0.0	0.0	11.7	17.0	0.0	6.2	0.0	0.0	5.5	
	Number of pseudomonas aerudinosa incidences	-	0	1	1	0	0	0	1	1	1	0	0	0	
	Rate of pseudomonas aerudinosa incidences per 100,000 bed days	3.7	0.0	5.8	5.8	0.0	0.0	0.0	5.7	5.8	6.2	0.0	0.0	0.0	
	Hand hygiene audit score	80%	90%	90.8%	90.7%	91.4%	89.3%	86.9%	92.3%	92.2%	90.3%	91.3%	94.1%	92.5%	
Patient Falls	Number of patient falls	72	75	77	70	58	59	75	77	70	77	35	48	35	
	Rate of patient falls per 1,000 overnight stays	4.0	5.4	5.1	5.2	4.3	4.1	5.5	5.2	5.0	6.2	2.8	7.2	4.3	
	Number of patient falls resulting in serious harm	0	0	3	0	0	0	0	0	0	0	1	1	1	

Caring Services

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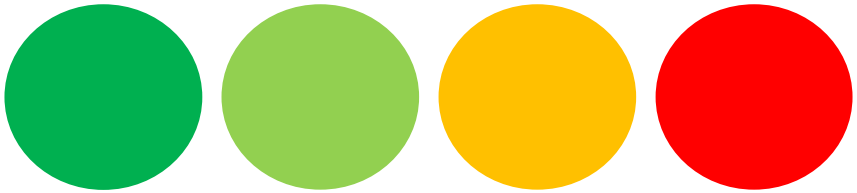


Key Issues

Friends and Family Test (FFT)

- The proportion of positive responses to A&E (92.9%), Antenatal (100%) and Outpatients (95.8%) are all above the monthly Trust targets in May.
- The proportion of positive responses to Inpatients has reduced to 90.7% and remains below the Trust target in May.
- Total Responses for Inpatients (689) and A&E (56), have both increased from April but remain below Trust targets. Total Responses for Outpatients (271) also increased from 83 in April to 271 in May.
- There were no responses for Births, Postnatal Ward & Postnatal Community in May.

Complaints

- Total number of complaints received since May 2020 = 46. The breakdown by division is as follows:
  - Surgery 11
  - Medicine 17
  - W&C 9
  - CSS 8
  - Cancer 0
  - Operations 1
- 100% of complaints received were acknowledged within 3 working days in May,
- 95% were again responded to within the agreed timeframe in May.
- There were 57 open complaints at end of May 2020.

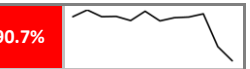
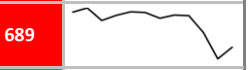
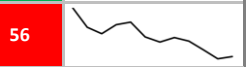
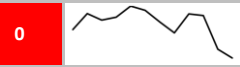
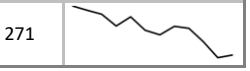
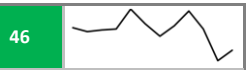
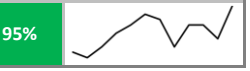
Executive Response

Friends and Family Test (FFT)

- The new wording of the FFT question was implemented from 1 April 2020; patients are now asked 'overall, how was your experience of our service?' Responses range from 'very good' to 'very poor'.
- At the beginning of April 2020 NHSE advised Trusts to stop using paper surveys/ tablets to collect patient feedback in case of infection risk. During April and May the www.tellusmore.org.uk link has been publicised which directs patients to the surveys on the Trust website. Post-discharge telephone calls have also been carried out to ask patients the FFT question.
- Because we are asking the new FFT question and using different collection methods/time the FFT results for April cannot be compared to those prior to March 2020.
- In line with NHS England guidance on managing Covid-19 we have introduced visiting restrictions to protect patients, staff and the public. Hospital visiting is only permitted in certain circumstances: if the patient is end of life; supporting someone with a mental health issue, a learning disability, autism, or dementia, where not being present would cause the patient to be distressed; they are a birthing partner accompanying a woman in labour; or they are a parent or appropriate adult visiting their child. We recognise the importance of protecting our patients and their visitor and have developed a risk assessment and patient information leaflet for visitors to ensure that that are fully briefed in advance of their visit.
- Whilst hospital visiting is restricted, family and friends are encouraged to stay in touch with their loved ones using technology and wards have been supported with electronic devices for this purpose. We have introduced a 'stay in touch' service where messages can be submitted via the Trust website, these are printed and delivered to patients daily. The Family Liaison Clinician (FLiC) role has been introduced on five wards; the FLiC supports the ward, patient and family members and ensures regular communication about what is happening, they have supported patient and family video calls and ensure that any questions from family members are answered. Feedback from relatives using this service has been extremely positive.

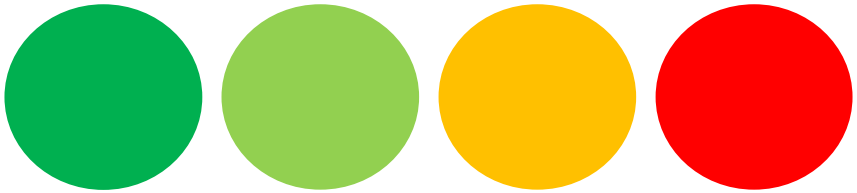
Caring Services

East and North Hertfordshire NHS Trust

Domain	FFT	Metric	Target	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Trend
Friends and Family Test	Inpatients	Proportion of positive responses	95%	96.9%	97.8%	96.9%	96.9%	96.3%	97.6%	96.3%	96.7%	96.8%	97.3%	92.7%	90.7%	
		Total number of responses	1,778	2,095	2,263	1,760	1,959	2,102	2,071	1,847	1,975	1,946	1,288	233	689	
	A&E	Proportion of positive responses	90%	92.7%	83.8%	94.0%	88.9%	90.0%	89.3%	88.5%	91.3%	94.4%	93.1%	100.0%	92.9%	
		Total number of responses	1,241	1,008	624	498	676	727	439	338	424	356	188	8	56	
	Maternity	Antenatal care Proportion of positive responses	93%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	100.0%	92.3%	100.0%	n/a	100.0%	
		Birth Proportion of positive responses	93%	97.3%	96.5%	92.9%	98.1%	95.6%	90.3%	94.6%	95.4%	93.9%	98.2%	95.7%	n/a	
		Birth Total number of responses	137	74	115	98	106	135	124	93	65	114	110	23	0	
		Postnatal ward Proportion of positive responses	93%	86.5%	92.2%	88.8%	94.3%	84.4%	83.9%	85.9%	86.2%	83.3%	92.7%	95.7%	n/a	
		Postnatal community Proportion of positive responses	93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	n/a	n/a	
	Outpatients	Proportion of positive responses	95%	95.8%	95.4%	95.4%	94.5%	94.8%	95.0%	95.8%	96.8%	95.9%	96.4%	97.6%	95.8%	
		Total number of responses	-	3,943	3,613	3,313	2,448	3,127	2,133	1,777	2,429	2,273	1,276	83	271	
Complaints	Number of written complaints received		92	86	79	82	84	120	93	71	90	116	84	27	46	
	Rate of written complaints received		1.9	1.7	1.5	1.8	1.7	2.2	1.8	1.6	1.8	2.5	2.1	1.0	1.4	
	Proportion of complaints acknowledged within 3 working days		75%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Proportion of complaints responded to within agreed timeframe		80%	78%	76%	80%	85%	88%	92%	90%	80%	88%	88%	83%	95%	

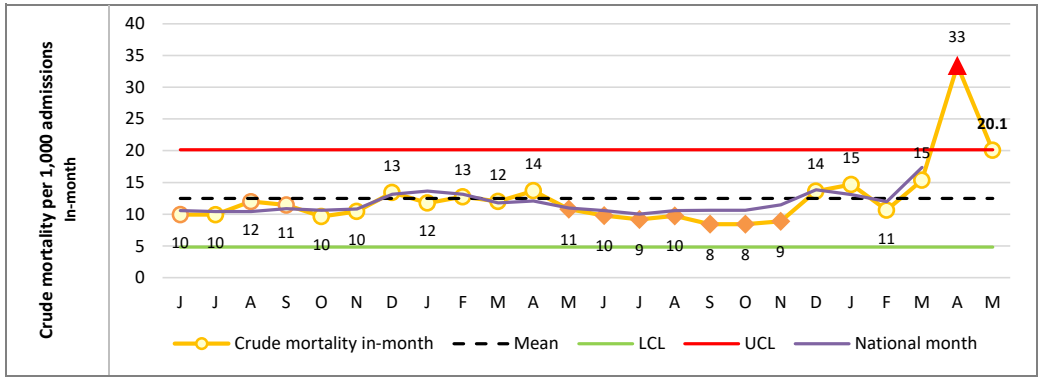
Effective Services

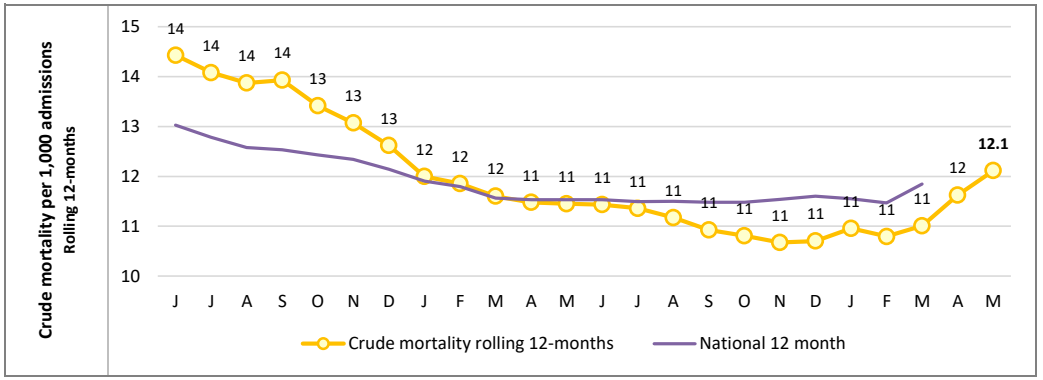
Month 02 | 2020-21

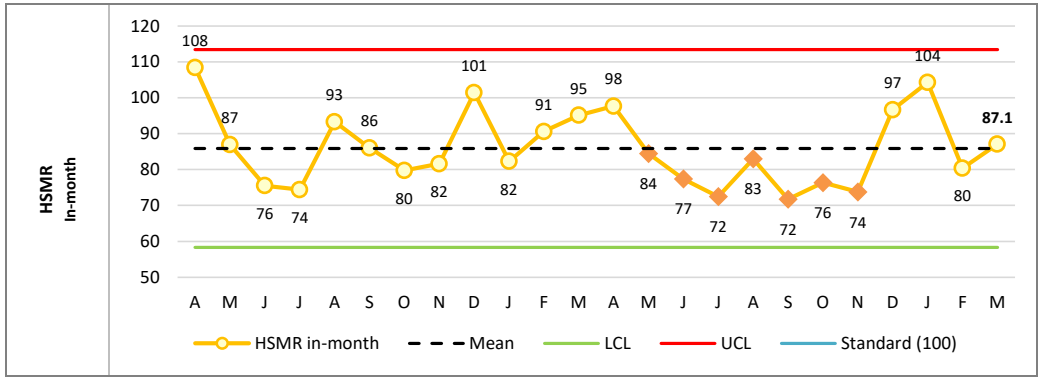


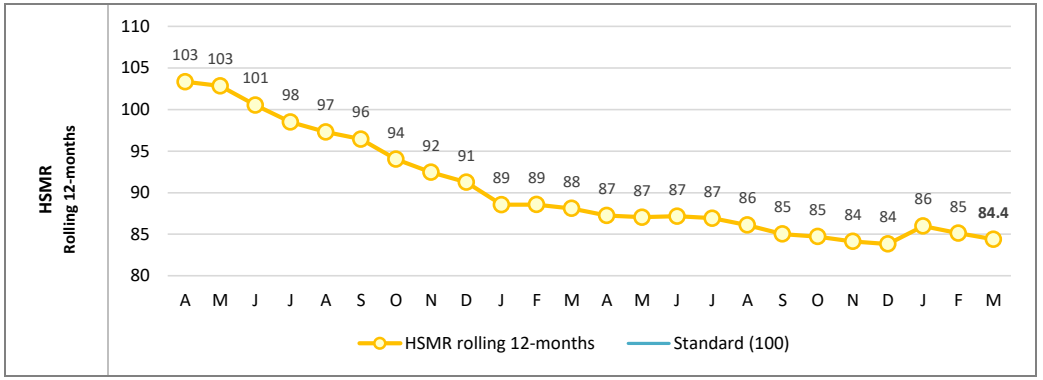
Effective Services

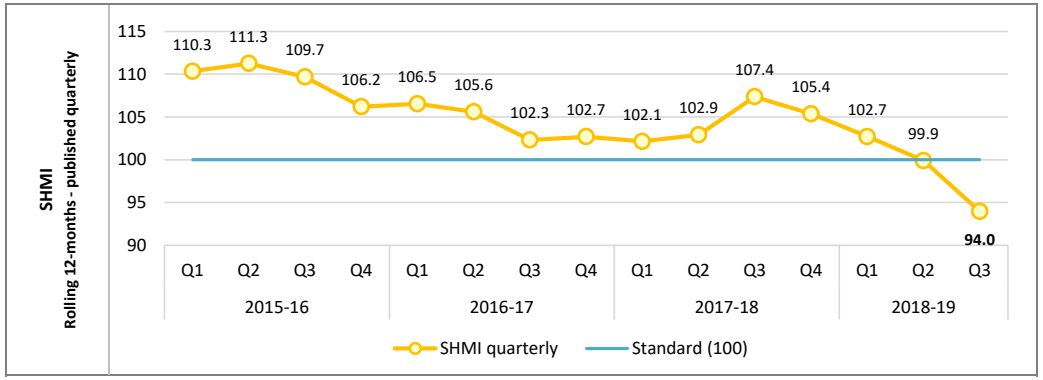
East and North Hertfordshire NHS Trust

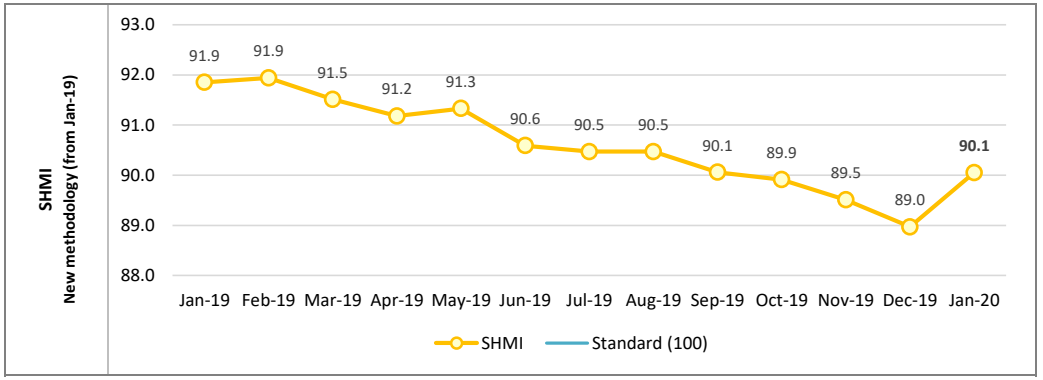






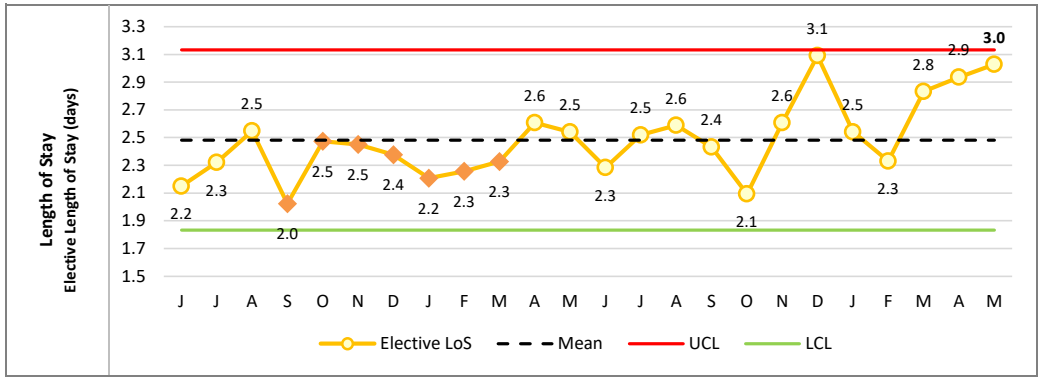


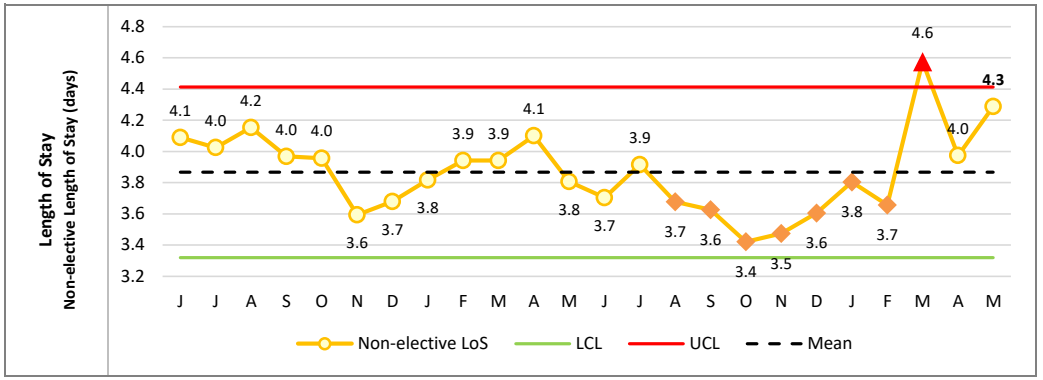


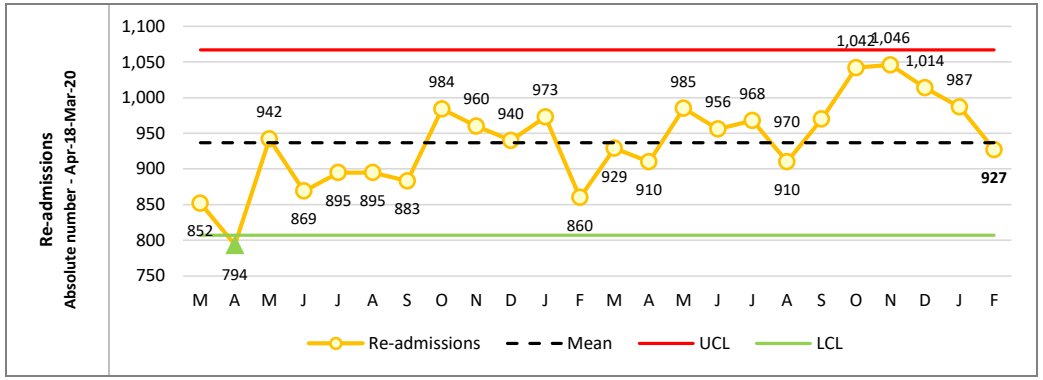


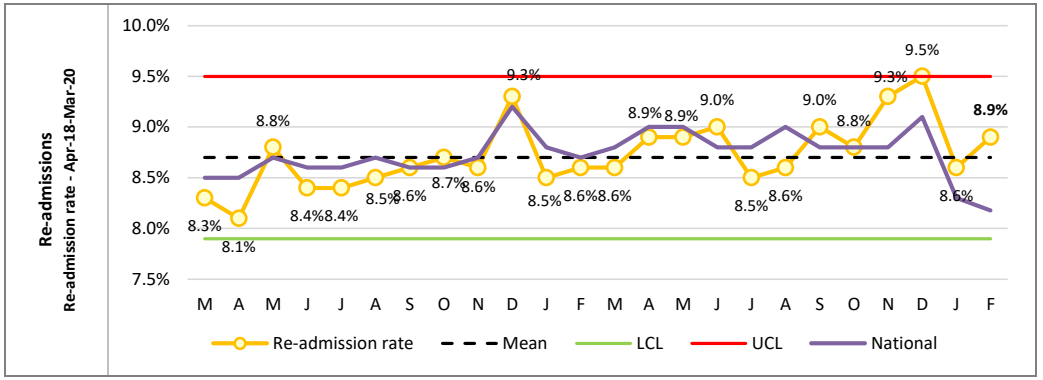
Effective Services

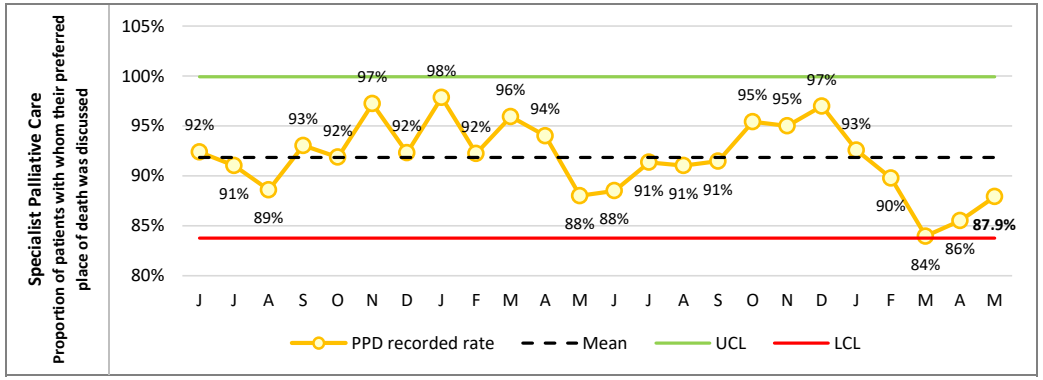
East and North Hertfordshire NHS Trust

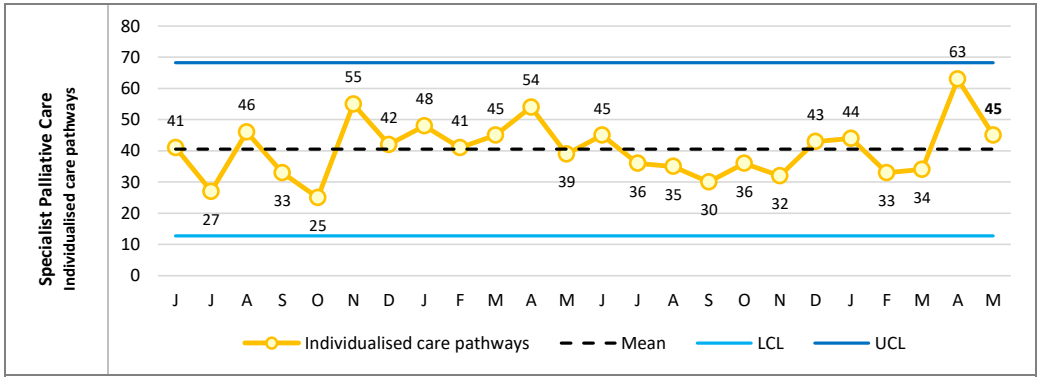












Key Issues

Please note that the data source for Crude Mortality, HSMR, SHMI and Re-admissions is now being taken from CHKS iCompare. Historic figures have been revised where available.

Crude Mortality
- The in-month crude mortality rate decreased to 20.1 deaths per 1,000 admissions in May.
- The rolling 12-months crude mortality rate increased slightly to 12.1 deaths per 1,000 admissions in the 12 months to May, and is slightly higher than the most recently available national rate of 11.8 deaths per 1,000 admissions (Apr-19 to Mar-20).

Hospital-Standardised Mortality Ratio (HSMR)
- The in-month HSMR increased to 87.1 in March, but remains better than the standard (100).
- The rolling 12-months HSMR decreased to 84.4 in the 12 months to March.
- The Trust remains in the second-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 January increased slightly to 90.5.

Re-admissions
- The re-admission rate increased slightly to 8.9% in February 2020.

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.
- At the start of the COVID-19 crisis, while time spent on preparation was key, and during the initial peak, routine mortality reviews were suspended to enable consultant reviewers to focus on frontline duties. The routine conduct of mortality reviews has now restarted and work is in progress to identify important areas for focussed analysis to provide appropriate assurance and learning during the COVID-19 pandemic.
- The monthly Mortality Surveillance Committee recommenced in June 2020 following a 3 month suspension due to COVID-19.

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 and has demonstrated a consistent decrease over the last 5 years. It is the factor with the most significant impact on HSMR.

Executive Response (continued)

Crude Mortality (continued)
- The improvements in mortality have been as a result of a combination of corporate level initiatives such as the mortality review process and more directed areas of improvement such as the identification and early treatment of patients with sepsis, stroke, etc. 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. However, our rate had increased over recent months, which was being monitored. April 2020, at the height of the COVID period, saw a marked increase, influenced more by the significant reduction in the number of inpatients than by an increase in deaths.

Hospital Standardised Mortality ratio (HSMR)
- While our current HSMR of 84.4 (latest CHKS data) makes us well-positioned in the second lowest quartile of Trusts, we remain focussed on driving further improvement. The start of the COVID-19 period in March saw an in-month increase in HSMR. Following the latest rise in crude mortality, we are waiting to see the impact of the multi-factorial changes brought about by COVID-19, on April in-month HSMR.

Summary Hospital-level Mortality Indicator (SHMI)
- Following significant improvements to SHMI, there has now been a sustained period of stability, within the lower end of the 'as expected' band 2. The latest figure of 90.5 sees the Trust as one of the best placed in the 'as expected' band. This places us 21st nationally out of acute non-specialist trusts (129).
- NHS Digital has indicated that initially COVID-19 activity will be excluded from the SHMI, starting from the Jul-20 publication (discharges for Mar19 – Feb20). It stated the SHMI model is not designed for pandemic activity which might reduce the robustness of the results if such activity were included. It also noted that the creation of temporary specialist hospitals (such as NHS Nightingale) would result in some trusts having more activity than others, making it inappropriate to band trusts as having a higher or lower than expected number of deaths when this would likely be as a result of COVID-19 activity.

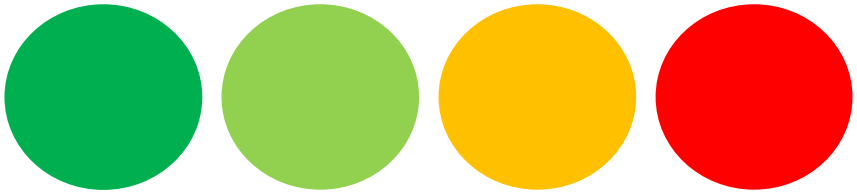
Re-admissions
- The Trust's re-admission rate has generally been consistent with the national performance. The most recent month (February 2020) saw a slight increase from 8.6% to 8.9%, which was still an improvement on the November/December levels which peaked at 9.5%.

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.
- Work remains ongoing with Business Informatics and the Head of Coding to gather appropriate data and set up reports to monitor, provide assurance and in time learning regarding COVID/non-COVID deaths.

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.

Responsive Services

Month 02 | 2020-21



Key Issues

A&E
- Performance for the month of May 2020 was 83.38%.
- There were no 12-hour trolley waits reported in May.

Cancer Waiting Times
- In April 2020 the Trust achieved 6 out of the 8 national targets for cancer performance.
- The Trust 62-day performance for April 2020 was 87.1%.
- Good progress continues on the speciality cancer action plans, all plans being reviewed and updated weekly.
- Commitment has been obtained from IMAS to support the Trust with ongoing work with:
- Histology Demand & Capacity model has been completed and awaiting final report from IST. Pathway analysis for Histology services has been completed awaiting IMAS reports;
- Continue to Work to deliver the 28-day faster diagnosis target, which is currently at 80% compliance;
- Development of metrics to demonstrate improvements in the performance whilst working to delivery of recovery trajectory.

RTT
- Incomplete performance for May was 57.95%, a continued deterioration from the 67.38% reported in April.
- The May backlog was 20,391, an increase of 3,519 from April.
- There were 209 52-week breaches reported in the May incomplete position, an increase of 119 from the 90 reported in April.

Diagnostics
- DM01 performance for May was 61.17% against the national standard of 1% and the April position of 61.77%..

Stroke
- Please note that Stroke performance for May was not available at the time of writing.
- Performance for April was 55.0%, a slight decrease compared to March performance of 67.7%.

Executive Response

A&E
- The Trust ED performance demonstrated significant and sustained improvement despite the ongoing challenges of COVID-19.
- Staffing has continued to be challenging but we have successfully been able to open further assessment space including 8 additional COVID-19 assessment beds and a new non COVID-19 5 bedded assessment area. In addition we have been able to reinstate CDU capacity in the COVID-19 ED.
- Ambulance handovers continue to be challenging but there has been a notable improvement and reduction in delays.
- The Trust has commenced work on a rapid improvement plan to address performance against 4 hour standard and ambulance handovers. Some actions have already been successfully completed such as CDU and assessment space. Actions over the next 1-2 months include; reviewing front door triage processes, SDEC and a redesign of operational triggers and associated actions to ensure effective and timely recovery/mitigation of risks associated to compliance with the key quality and safety indicators associated to A&E.

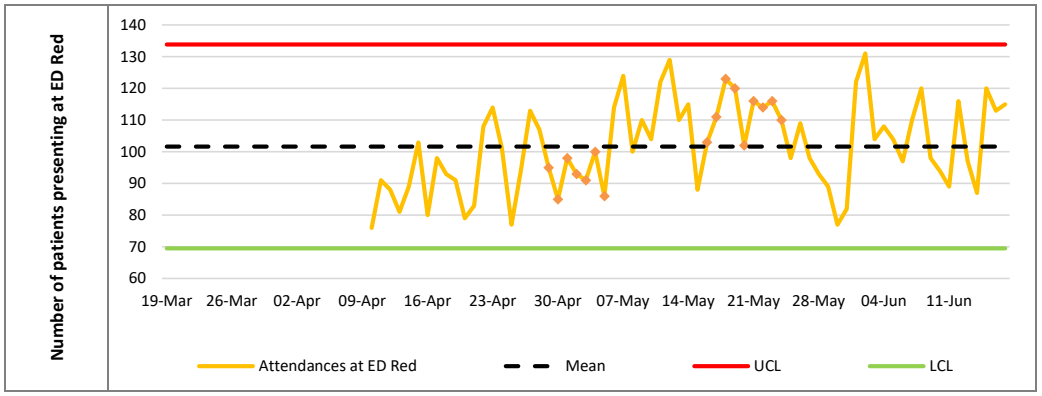
Executive Response (continued)

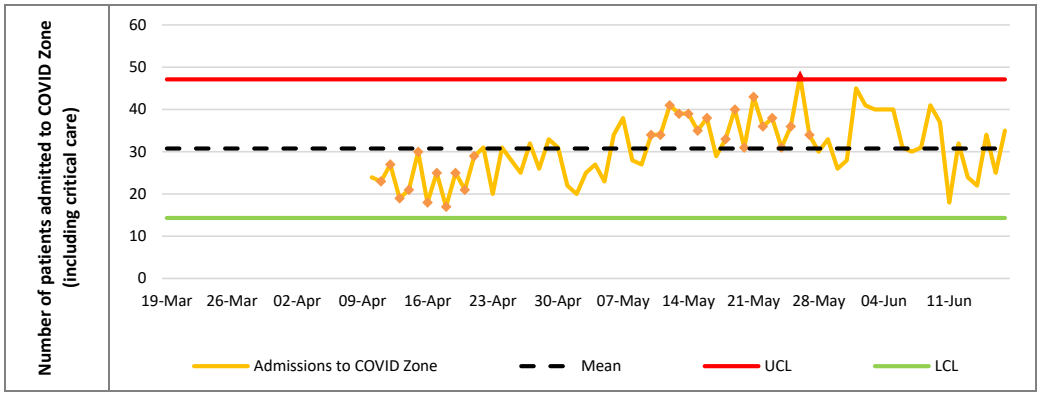
Cancer performance (April)
- In April 2020, the Trust achieved 6 of the 8 national targets for cancer performance: 2ww, 31-day subsequent for Radiotherapy, Chemotherapy, surgery, and 1st definitive treatment, and 62 day urgent referral to treatment of all cancers. Cancer performance is available one month in arrears.
- 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 April 2020 the Trust performance was 97.7%
- In April 2020, the Trust wide average days wait for first appointment is at 10 days and the majority of patients were seen between 8 and 12 days.
- The Trust has not consistently delivered against the Breast Symptomatic national standard which requires 93% of patients referred to have attended the 1st Outpatient appointment within 14 days. For April 2020, the Trust performance was 79.3% which was a result as the COVID-19 pandemic.
- The Trust has consistently delivered the 31-day second or subsequent treatment for Radiotherapy and Chemotherapy. For April 2020 the Trust Chemotherapy performance was 100%. For April 2020 the Trust Radiotherapy performance was 98.6% and the Trust subsequent Surgery performance was 94.4%.
- The Trust performance for 31-day to first definitive treatment was 98.6%. The standard requires 96% of patients to receive treatment within 31 days of diagnosis.
- In April 2020, the Trust performance for the Faster Diagnosis is 73.24% for the 2ww patients, 83.61% for Breast Symptomatic.
- Reported 62-day performance for April 2020 was 87.1%.

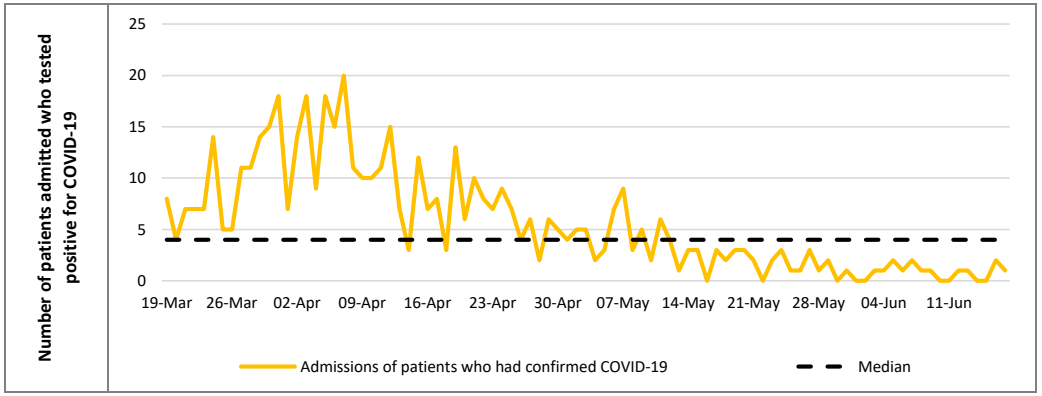
RTT
- Performance deteriorated further in May and remains significantly below our trajectory. Backlog pressures have increased due to the COVID-19 pandemic and the instruction to cease elective treatment from the 15th April 2020.
- Clinicians are reviewing their elective PTLs and risk-stratifying patients according to clinical need.
- The independent sector has been utilised to treat our clinically urgent and long waiting patients.
- The Trust is following a post-COVID -19 Elective recovery plan, which will see an improvement in performance.

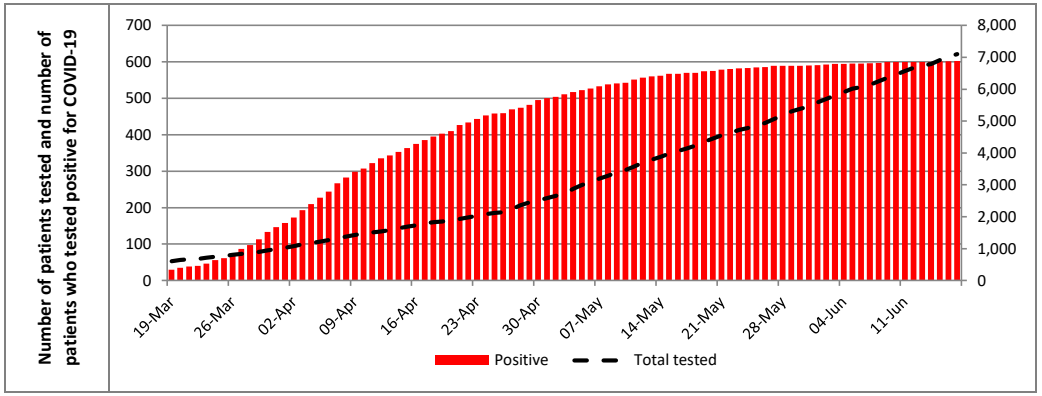
Diagnostics
- Diagnostic performance has not been delivered with the capacity being impacted by the COVID-19 pandemic, as a result of staff sickness, isolation and the number of aerosol generating procedures.
- The Trust is following a post-COVID-19 diagnostic recovery plan, which will see an improvement in performance.

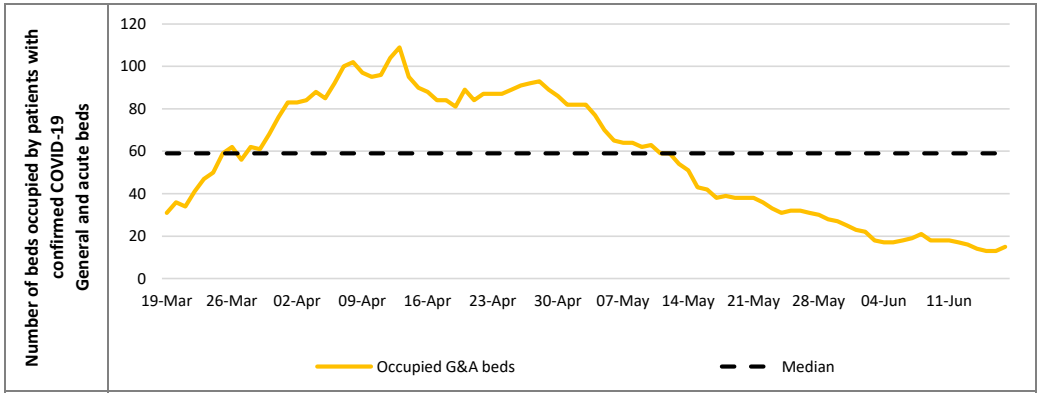
Stroke
- Please note that Stroke performance for May was not available at the time of writing.
- Direct impact mainly due to changes in standard operating procedures in ED and CT scanning relating to COVID-19 policies. These impacted on bed flow within the HASU and Acute Stroke unit. In some cases due to RAG rating status of patients some were outlied into clinically appropriate Ward areas, which was a direct breach for the 4hr target. This was offset by organising a cohorted area with stroke consultant and therapy input so only a small number of patients were recorded as not being admitted to a stroke unit.
- Thrombolysis rate was 14.5% in April.
- Thrombolysed within 60-minutes of arrival rate was 0% in April. Previously issues with performance were a direct result of the demand within the ED and impact on Ambulance service to support adherence to the 60min arrival target. This had been highlighted with EEAST and was being reviewed internally - regarding the achievement of the Target - whist managing high demand. 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.
- Changes in community provision resulted in altered ESD and community neuro team provision. Extra capacity rehab beds also created. 90% length of stay target has been maintained at 94.6% and discharge targets for JCP and ESD also both maintained at 83.8% and 69% respectively.

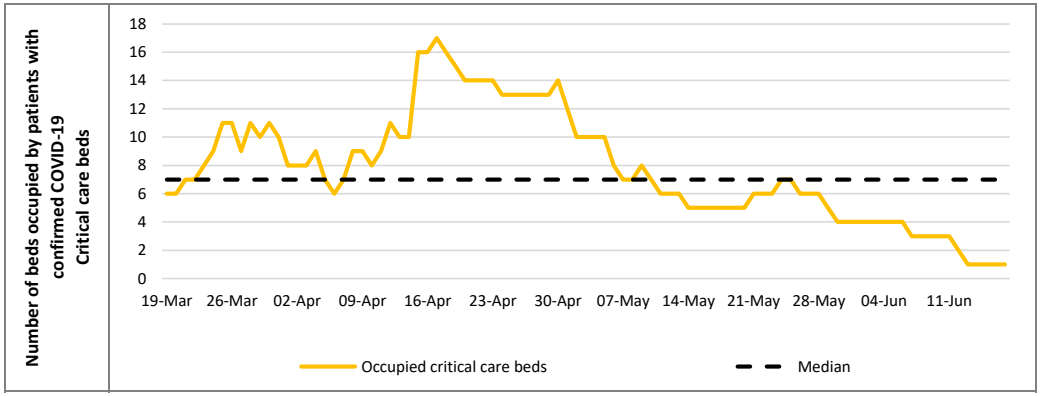

Number of patients presenting at ED Red
140
130
120
110
100
90
80
70
60
19-Mar 26-Mar 02-Apr 09-Apr 16-Apr 23-Apr 30-Apr 07-May 14-May 21-May 28-May 04-Jun 11-Jun
Attendances at ED Red
Mean
UCL
LCL


Number of patients admitted to COVID Zone (including critical care)
60
50
40
30
20
10
0
19-Mar 26-Mar 02-Apr 09-Apr 16-Apr 23-Apr 30-Apr 07-May 14-May 21-May 28-May 04-Jun 11-Jun
Admissions to COVID Zone
Mean
UCL
LCL

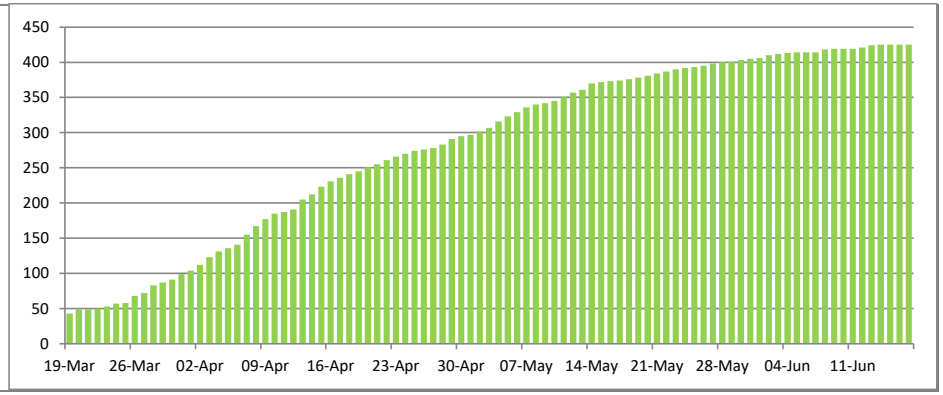

Number of patients admitted who tested positive for COVID-19
25
20
15
10
5
0
19-Mar 26-Mar 02-Apr 09-Apr 16-Apr 23-Apr 30-Apr 07-May 14-May 21-May 28-May 04-Jun 11-Jun
Admissions of patients who had confirmed COVID-19
Median


Number of patients tested and number of patients who tested positive for COVID-19
700
600
500
400
300
200
100
0
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
19-Mar 26-Mar 02-Apr 09-Apr 16-Apr 23-Apr 30-Apr 07-May 14-May 21-May 28-May 04-Jun 11-Jun
Positive
Total tested

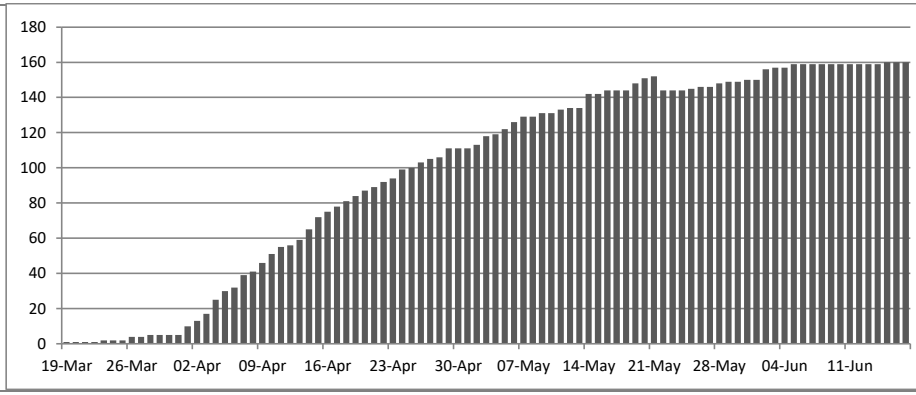

Number of beds occupied by patients with confirmed COVID-19 General and acute beds
120
100
80
60
40
20
0
19-Mar 26-Mar 02-Apr 09-Apr 16-Apr 23-Apr 30-Apr 07-May 14-May 21-May 28-May 04-Jun 11-Jun
Occupied G&A beds
Median


Number of beds occupied by patients with confirmed COVID-19 Critical care beds
18
16
14
12
10
8
6
4
2
0
19-Mar 26-Mar 02-Apr 09-Apr 16-Apr 23-Apr 30-Apr 07-May 14-May 21-May 28-May 04-Jun 11-Jun
Occupied critical care beds
Median

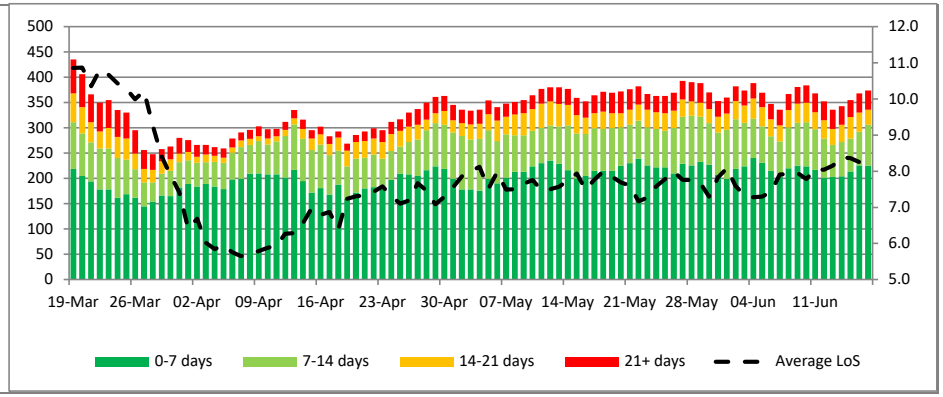
Cumulative discharges to their usual place of residence of patients who tested positive for COVID-19



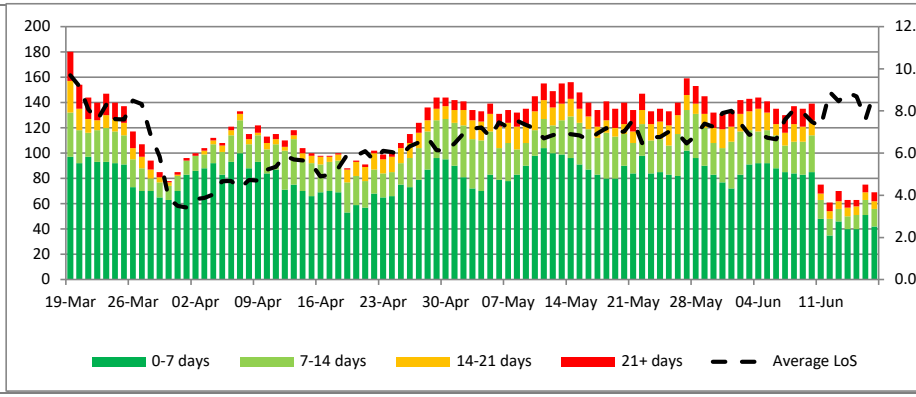
Cumulative inpatients who died who tested positive for COVID-19



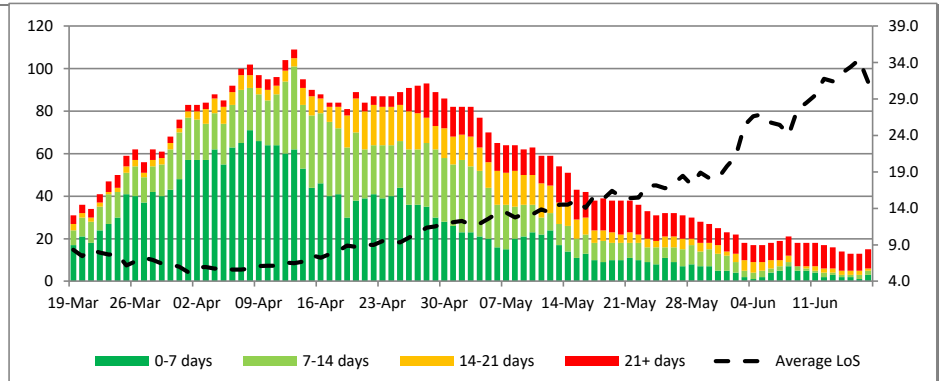
Number of beds occupied at midnight by LoS band and average LoS of beds occupied at midnight by date - Trust-wide



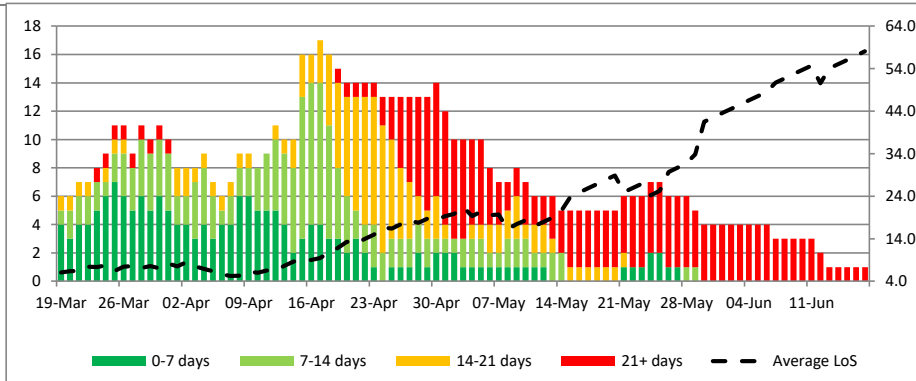
Number of beds occupied at midnight by LoS band and average LoS of beds occupied at midnight by date - COVID Zone



Number of beds occupied at midnight by LoS band and average LoS of beds occupied at midnight by date - COVID positive



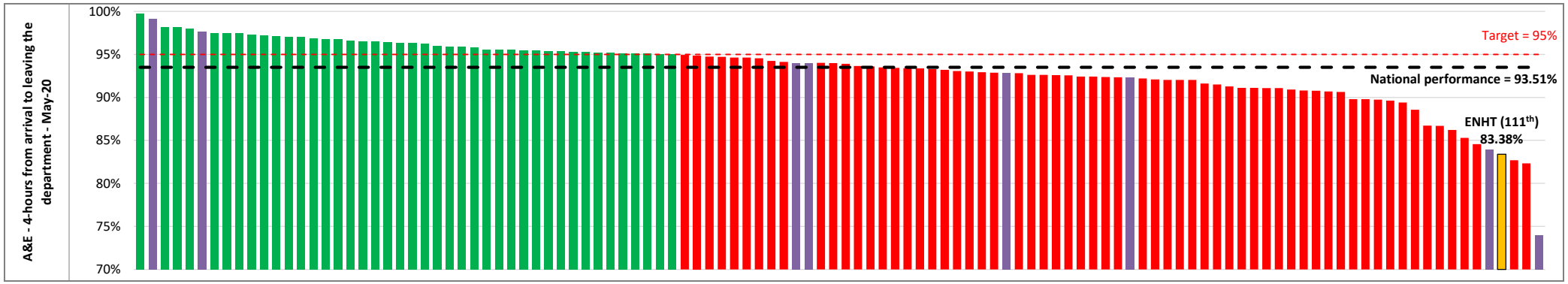
Number of beds occupied at midnight by LoS band and average LoS of beds occupied at midnight by date - COVID critical care

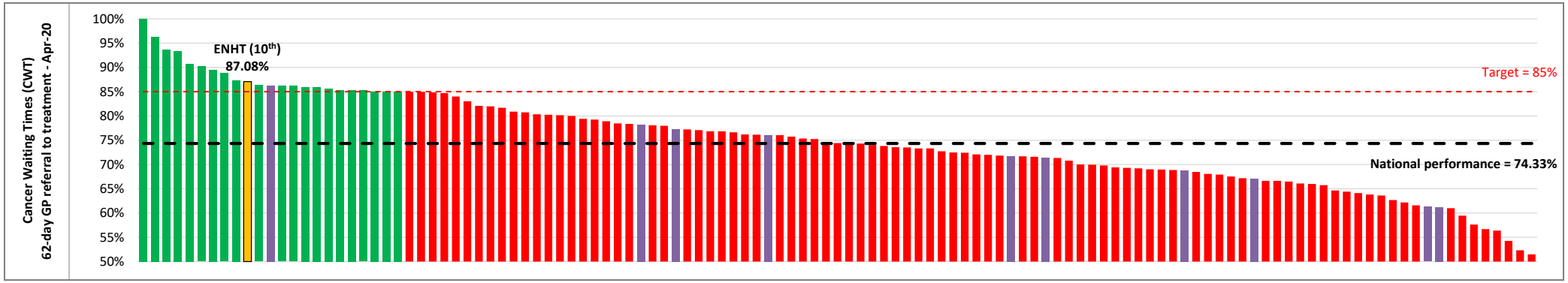


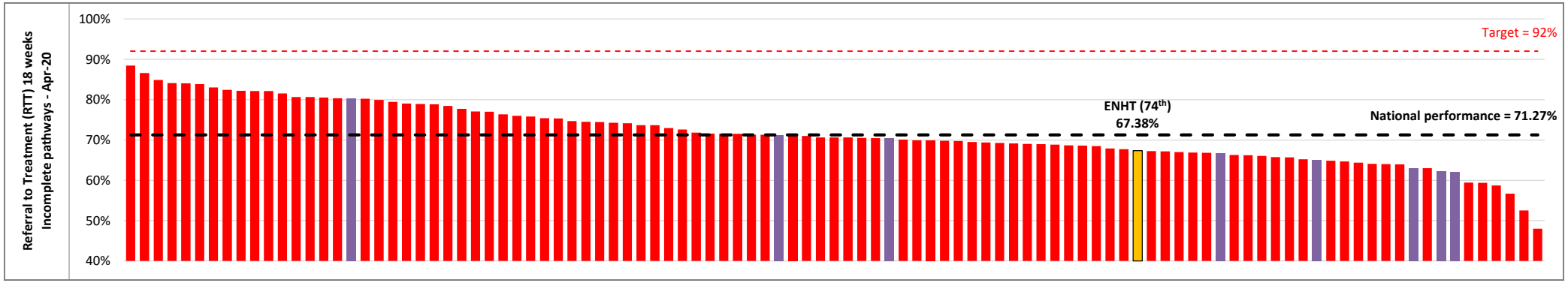
Responsive Services

Trust performance against all Trusts nationally

East and North Hertfordshire NHS Trust



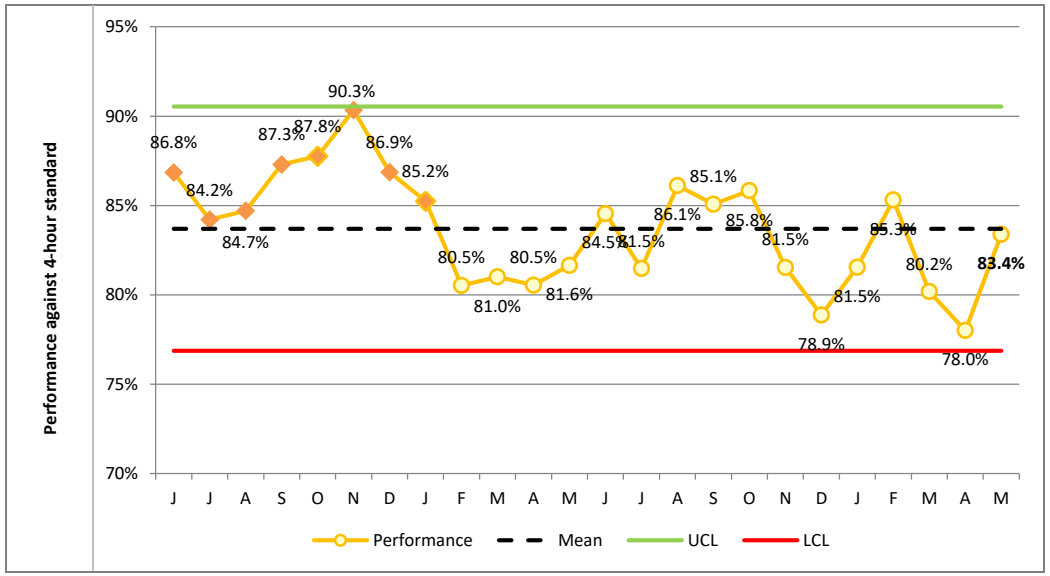




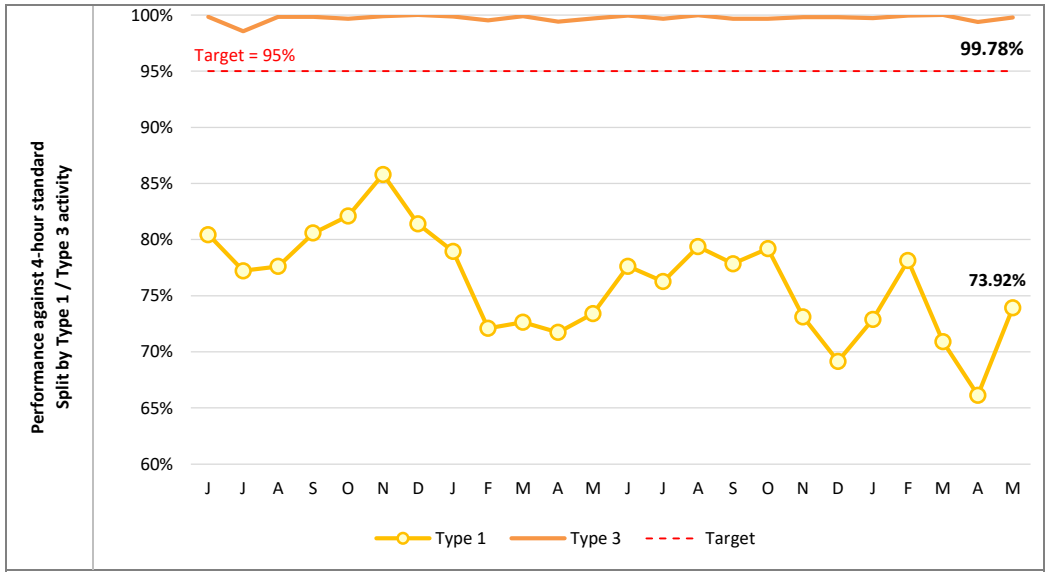
Responsive Services

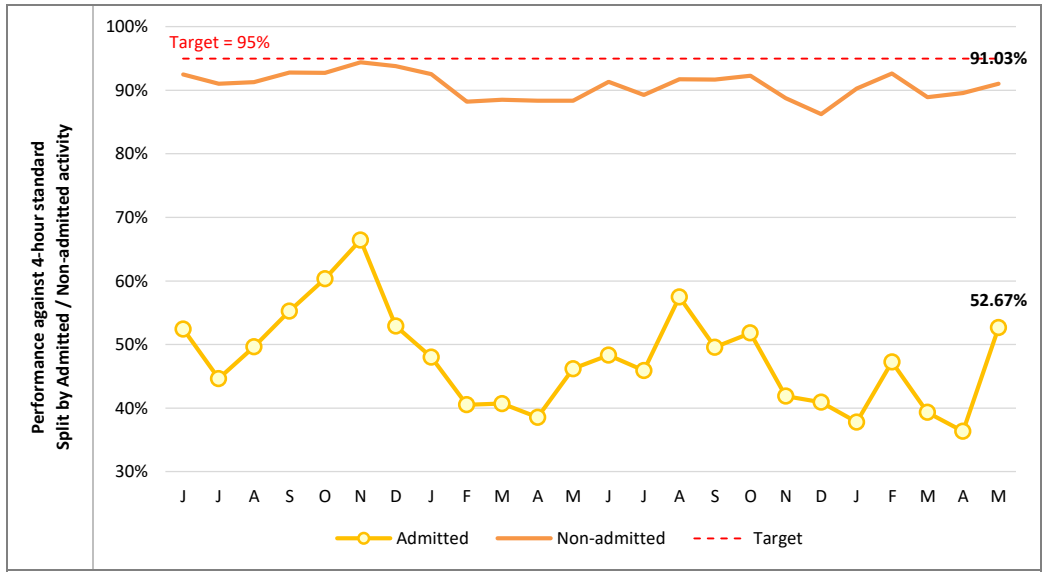
Emergency Department Performance

East and North Hertfordshire NHS Trust



Domain	Metric	Target	Apr-20	May-20	Change	Trend
Other Emergency Department measures	Ambulance handovers Proportion within 15 minutes	-	58%	64%	▲	
	Ambulance handover breaches 30 minutes	334	316	235	▼	
	Ambulance handover breaches 60-minutes	73	38	10	▼	
	Attendance to admission conversion rate	-	38.5%	34.8%	▼	
	Time to initial assessment 95th centile	15	40	38	▼	
	Time to treatment Median	60	49	57	▲	
	Left department before being seen for treatment	5%	0.6%	0.4%	▼	
	Unplanned re-attendance rate	5%	5.4%	6.0%	▲	





Responsive Services

Cancer Waiting Times

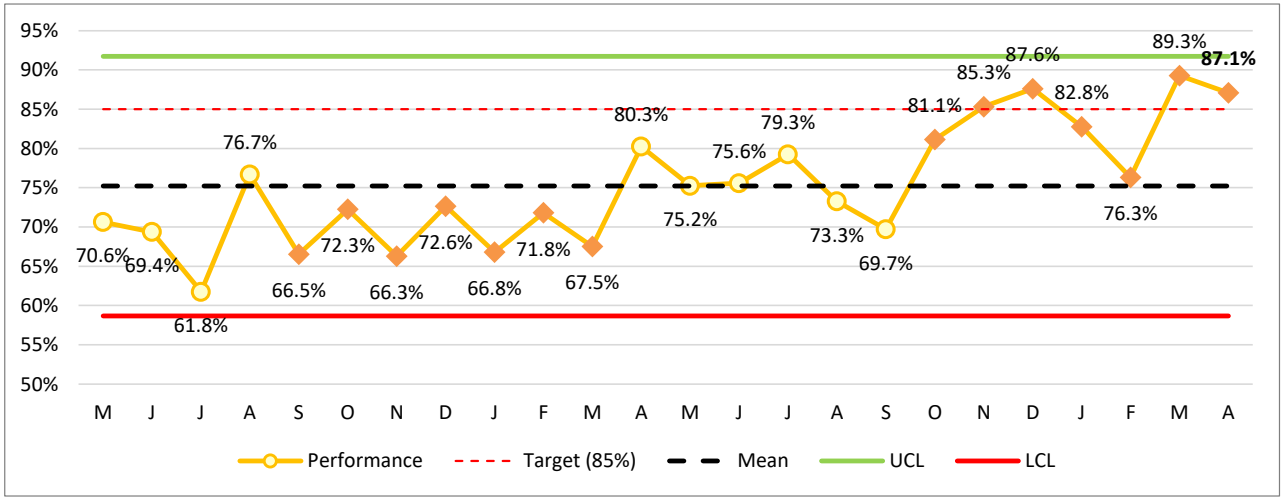
East and North Hertfordshire NHS Trust

12-months' performance - all standards

Standard	Target	2019-20												2020-21
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD	Apr-20
Two week waits Suspected cancer	93%	95.94%	95.59%	96.66%	96.15%	94.80%	97.22%	98.50%	97.43%	97.87%	96.47%	98.08%	98.77%	96.95%	97.72%
Two week waits Breast symptomatic	93%	88.68%	92.68%	93.39%	94.78%	87.30%	95.76%	95.37%	98.39%	95.52%	97.96%	95.70%	97.14%	94.10%	79.31%
31-day First definitive treatment	96%	93.52%	94.93%	91.90%	97.01%	96.97%	95.98%	96.88%	99.00%	98.29%	97.82%	98.98%	97.89%	96.57%	98.60%
31-day subsequent treatment Anti-cancer drugs	98%	98.19%	97.81%	99.29%	99.07%	99.42%	99.41%	99.48%	100.00%	99.45%	98.16%	99.49%	99.50%	99.10%	100.00%
31-day subsequent treatment Radiotherapy	94%	96.90%	98.27%	98.86%	96.32%	97.53%	97.27%	98.25%	96.54%	99.26%	98.81%	99.36%	98.06%	97.96%	98.56%
31-day subsequent treatment Surgery	94%	96.77%	80.00%	78.95%	77.42%	83.33%	85.19%	65.52%	84.21%	93.55%	79.07%	86.21%	95.83%	83.55%	94.44%
62-day GP referral to treatment	85%	80.25%	75.25%	75.58%	79.26%	73.28%	69.71%	81.14%	85.31%	87.60%	82.76%	76.32%	89.27%	79.82%	87.08%
62-day Specialist screening service	90%	81.82%	100.00%	63.64%	56.00%	82.35%	73.68%	100.00%	69.23%	100.00%	100.00%	44.44%	66.67%	76.67%	38.46%

62-day GP referral to treatment Apr-20

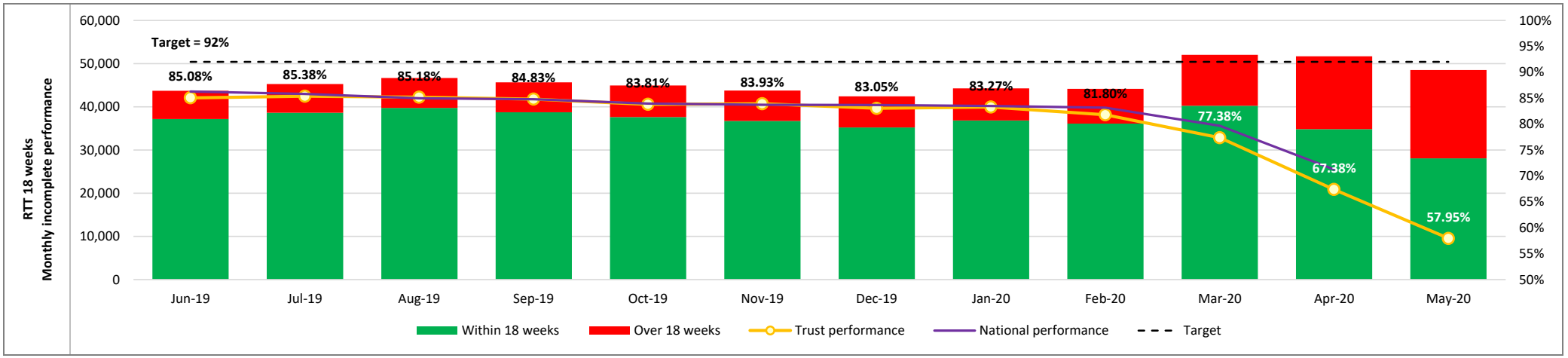
Tumour Site	OK	Breach	Total	Perf.
Breast	15.5	1.0	16.5	93.94%
Gynaecology	7.0	4.0	11.0	63.64%
Haematology	6.0	0.0	6.0	100.00%
Head and Neck	4.5	1.0	5.5	81.82%
Lower GI	6.0	4.0	10.0	60.00%
Lung	5.0	2.0	7.0	71.43%
Other	3.0	0.0	3.0	100.00%
Skin	17.0	1.0	18.0	94.44%
Testicular	0.0	0.0	0.0	-
Upper GI	3.5	0.0	3.5	100.00%
Urology	23.5	0.5	24.0	97.92%
Total	**91.0**	**13.5**	**104.5**	**87.08%**



Responsive Services

RTT 18 weeks

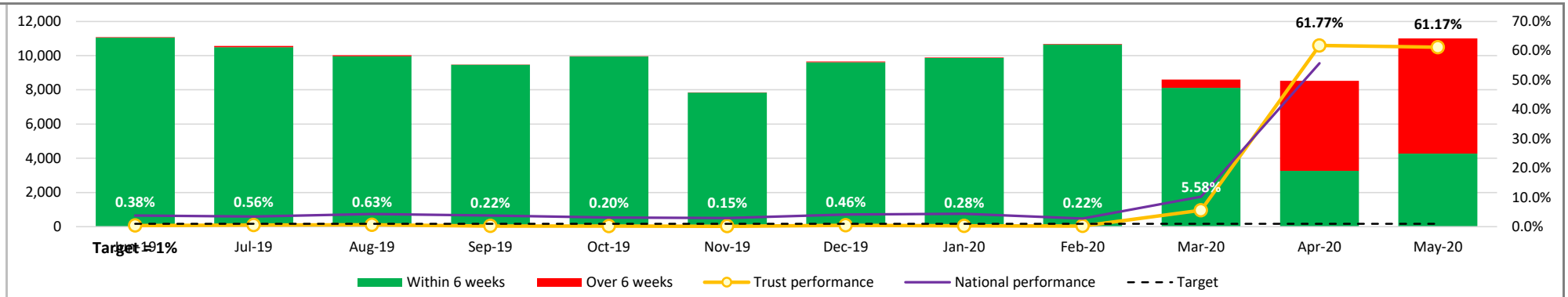
East and North Hertfordshire NHS Trust



RTT 18 weeks
In-month performance by Specialty - May-20

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	64	67.19%	0	151	74.83%	0	2,024	1,325	3,349	60.44%	83	8	385
Urology	50	70.00%	0	307	90.23%	0	1,359	612	1,971	68.95%	32	0	441
Trauma & Orthopaedics	4	0.00%	0	294	64.63%	2	1,833	2,418	4,251	43.12%	274	64	326
Ear, Nose & Throat (ENT)	10	60.00%	0	439	62.19%	0	2,079	1,355	3,434	60.54%	36	5	425
Ophthalmology	6	100.00%	0	530	38.87%	0	2,810	1,118	3,928	71.54%	17	3	259
Oral Surgery	8	25.00%	0	264	10.61%	0	1,049	1,318	2,367	44.32%	129	14	61
Plastic Surgery	50	90.00%	0	290	97.24%	0	593	345	938	63.22%	16	1	429
Cardiothoracic Surgery	1	0.00%	0	4	75.00%	0	14	4	18	77.78%	1	0	6
General Medicine	1	100.00%	0	9	100.00%	0	833	47	880	94.66%	0	0	225
Gastroenterology	70	62.86%	0	230	43.04%	0	2,390	2,399	4,789	49.91%	230	10	464
Cardiology	17	94.12%	0	428	62.85%	0	1,981	2,142	4,123	48.05%	37	2	417
Dermatology	0	-	0	201	78.11%	0	534	351	885	60.34%	9	0	168
Thoracic Medicine	3	66.67%	0	137	65.69%	0	1,097	613	1,710	64.15%	20	0	215
Neurology	0	-	0	565	88.14%	0	613	359	972	63.07%	7	2	152
Rheumatology	0	-	0	139	34.53%	0	662	673	1,335	49.59%	50	3	104
Geriatric Medicine	0	-	0	9	77.78%	0	106	52	158	67.09%	4	0	18
Gynaecology	14	78.57%	0	226	73.01%	0	2,487	1,063	3,550	70.06%	112	19	673
Other	25	80.00%	0	1,821	75.18%	1	5,638	4,197	9,835	57.33%	533	78	1,953
Total	**323**	**71.52%**	**0**	**6,044**	**67.55%**	**3**	**28,102**	**20,391**	**48,493**	**57.95%**	**1,590**	**209**	**6,721**

Diagnostics Waiting Times
Monthly waiting list performance



Diagnostics Waiting Times
In-month performance by Modality - May-20

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	479	582	1,061	54.85%	180	2,062	115	0	**2,177**
	Computed Tomography	847	718	1,565	45.88%	165	2,535	293	1,123	**3,951**
	Non-obstetric ultrasound	1,785	2,605	4,390	59.34%	869	4,442	183	48	**4,673**
	DEXA Scan	110	262	372	70.43%	46	214	20	0	**234**
Physiological Measurement	Audiology - audiology assessments	19	47	66	71.21%	14	16	0	0	**16**
	Cardiology - echocardiography	277	1,276	1,553	82.16%	515	919	0	0	**919**
	Neurophysiology - peripheral neurophysiology	61	84	145	57.93%	36	128	0	0	**128**
	Respiratory physiology - sleep studies	44	61	105	58.10%	0	125	0	0	**125**
	Urodynamics - pressures & flows	13	75	88	85.23%	46	45	0	0	**45**
Endoscopy	Colonoscopy	294	408	702	58.12%	94	276	0	0	**276**
	Flexi sigmoidoscopy	101	165	266	62.03%	42	96	0	0	**96**
	Cystoscopy	57	17	74	22.97%	3	95	0	0	**95**
	Gastroscopy	188	434	622	69.77%	85	204	0	0	**204**
Total		**4,275**	**6,734**	**11,009**	**61.17%**	**2,095**	**11,157**	**611**	**1,171**	**12,939**

Responsive Services

Stroke Services

East and North Hertfordshire NHS Trust

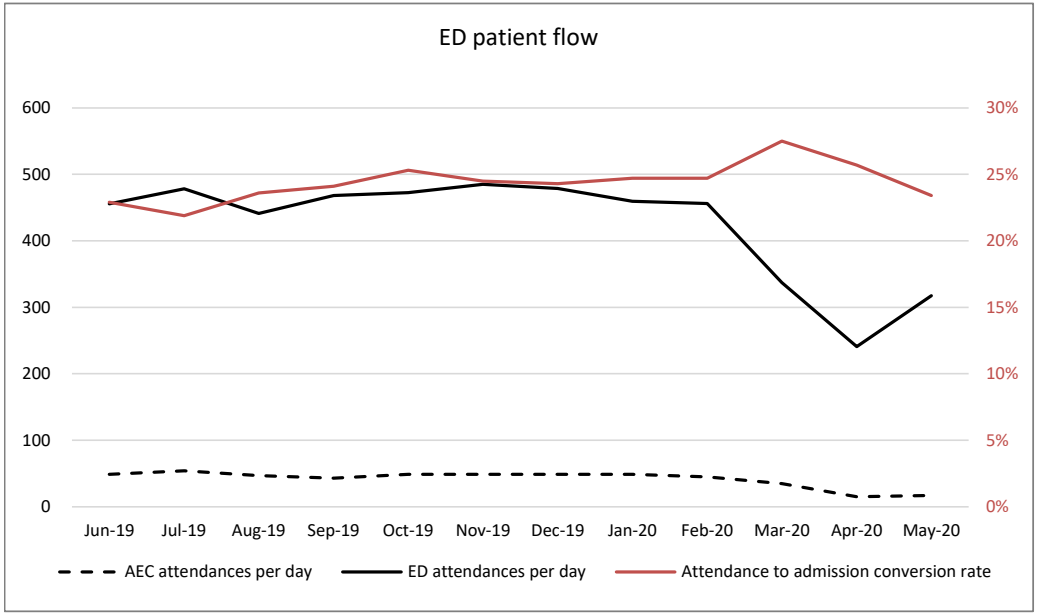
Domain	Metric	Target	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	Trend
Stroke	Trust SSNAP grade	A	A	A	B	B	B	B	B	B	tbc	tbc	tbc	tbc	
	Discharged with AF on anticoagulants	80%	100.0%	100.0%	77.8%	100.0%	100.0%	100.0%	88.9%	85.7%	75.0%	83.3%	75.0%	100.0%	
	4-hours direct to Stroke unit from ED	90%	59.3%	72.1%	63.3%	64.5%	79.7%	60.3%	57.1%	54.0%	40.8%	51.9%	67.7%	55.0%	
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	90%	60.0%	71.7%	65.1%	64.5%	81.5%	59.5%	58.2%	58.7%	41.2%	53.1%	68.8%	55.6%	
	Number of confirmed Strokes in-month on SSNAP	-	86	66	67	68	72	81	71	53	74	54	67	57	
	Proportion of patients spending 90% of time on the Stroke unit	80%	94.0%	92.1%	87.7%	98.4%	91.4%	87.5%	88.7%	90.2%	84.9%	86.8%	97.0%	94.6%	
	60-minutes to scan from time of arrival	50%	53.5%	53.0%	53.7%	61.8%	58.3%	65.4%	45.1%	67.9%	52.7%	55.6%	64.2%	59.6%	
	Scanned within 12-hours - all Strokes	100%	98.8%	92.4%	97.0%	100.0%	95.8%	97.5%	95.8%	94.4%	94.6%	94.4%	98.5%	94.7%	
	Total Thrombolysis rate for confirmed Strokes	11%	14.3%	15.6%	13.4%	8.8%	9.7%	12.5%	11.3%	7.7%	5.4%	17.0%	14.9%	14.5%	
	Thrombolysed within 60-minutes of arrival	-	50.0%	70.0%	66.7%	50.0%	28.6%	70.0%	50.0%	25.0%	25.0%	33.3%	20.0%	0.0%	
	Discharged with JCP	80%	93.7%	89.5%	95.3%	93.2%	82.7%	86.0%	81.1%	85.3%	73.6%	97.0%	78.1%	83.8%	
	Discharged with ESD	40%	50.8%	45.6%	41.3%	43.5%	50.9%	47.7%	61.4%	48.6%	54.2%	55.9%	56.8%	69.0%	

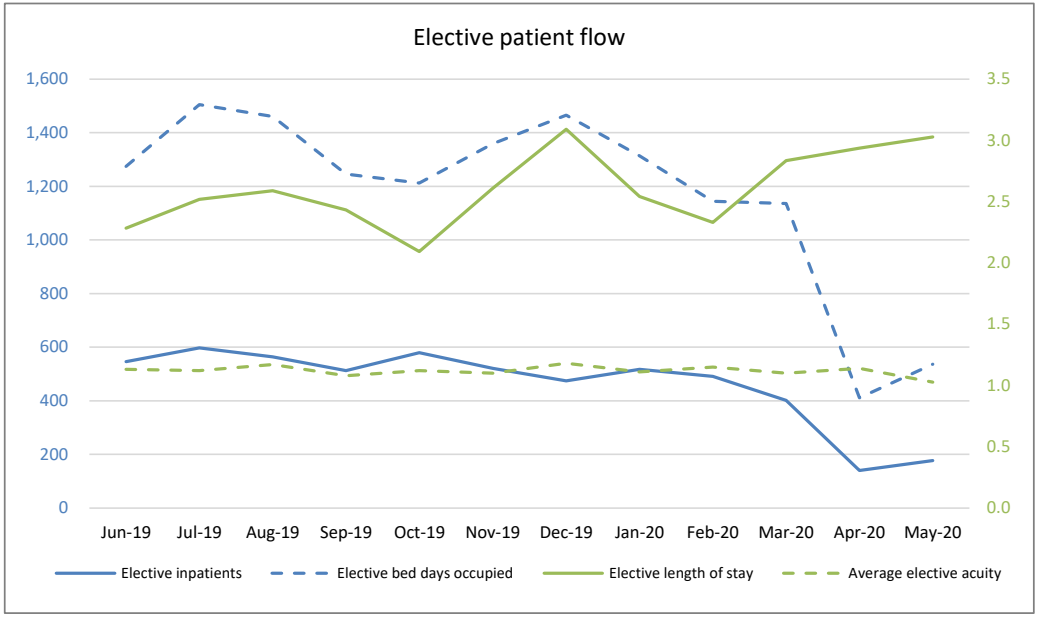
Responsive Services

East and North Hertfordshire NHS Trust

Patient Flow

Domain	Metric	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Trend
Emergency Department Flow Indicators	A&E & UCC attendances	13,675	14,821	13,676	14,041	14,649	14,556	14,848	14,243	13,228	10,457	7,228	9,838	
	Attendance to admission conversion rate	22.9%	21.9%	23.6%	24.1%	25.3%	24.5%	24.3%	24.7%	24.7%	27.5%	25.7%	23.4%	
	ED attendances per day	456	478	441	468	473	485	479	459	456	337	241	317	
	AEC attendances per day	49	54	47	43	49	49	49	49	45	35	15	17	
	4-hour target performance %	84.6%	81.5%	86.1%	85.1%	85.8%	81.5%	78.9%	81.5%	85.3%	80.2%	78.0%	83.4%	
	Time to initial assessment 95th centile	62	74	58	66	51	61	62	64	59	59	40	38	
	Ambulance handover breaches 30-minutes	262	336	180	227	215	360	453	458	274	394	316	235	

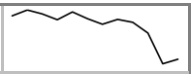
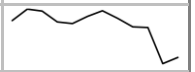
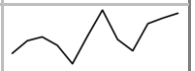
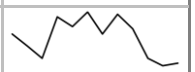
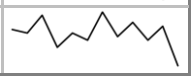
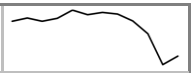
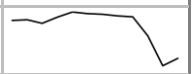
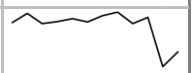
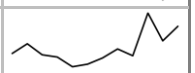
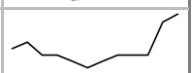
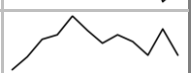
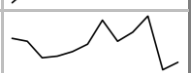
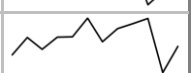
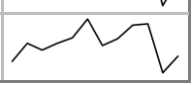




Responsive Services

Patient Flow

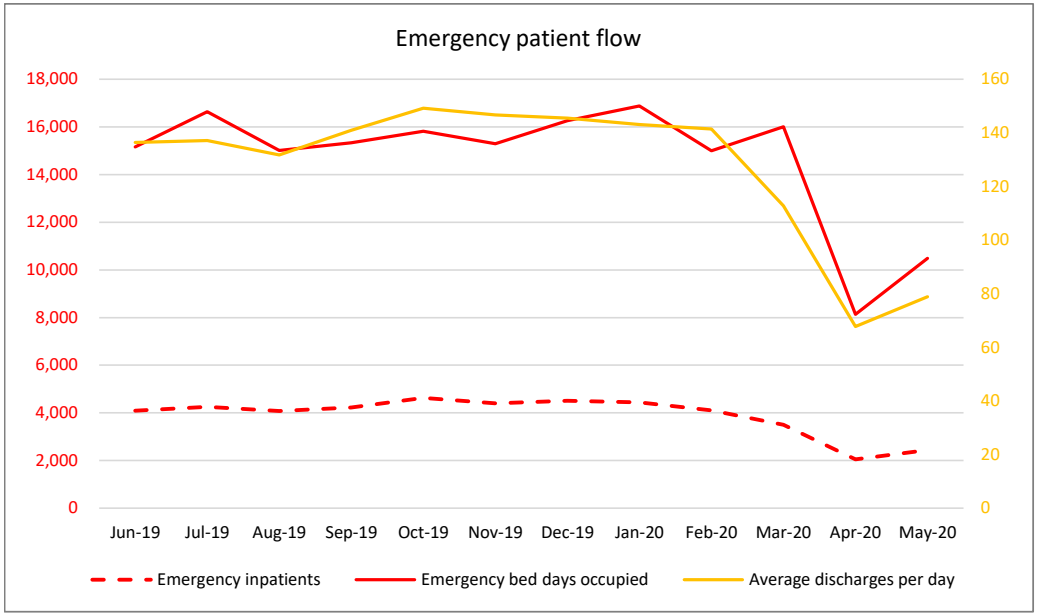
East and North Hertfordshire NHS Trust

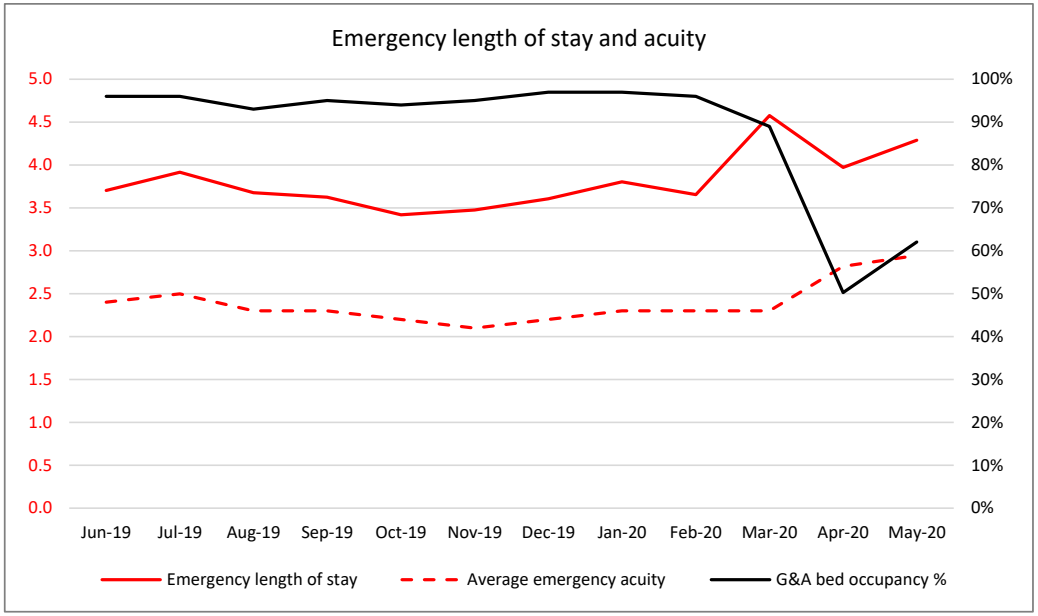
Domain	Metric	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Trend
Elective Inpatient Flow Indicators	Elective inpatients	546	597	564	512	579	521	474	517	491	401	140	177	
	Elective bed days occupied	1,274	1,504	1,460	1,245	1,212	1,359	1,465	1,314	1,144	1,136	411	536	
	Elective length of stay	2.3	2.5	2.6	2.4	2.1	2.6	3.1	2.5	2.3	2.8	2.9	3.0	
	Daycase rate %	87.2%	86.7%	86.2%	87.9%	87.5%	88.1%	87.2%	88.0%	87.4%	86.2%	85.9%	86.0%	
	Average elective acuity	1.13	1.12	1.17	1.08	1.12	1.10	1.18	1.11	1.15	1.10	1.14	1.03	
Emergency Flow Indicators	Emergency inpatients	4,092	4,251	4,083	4,228	4,624	4,401	4,510	4,438	4,103	3,497	2,047	2,444	
	Average discharges per day	136	137	132	141	149	147	145	143	141	113	68	79	
	Emergency bed days occupied	15,153	16,643	15,015	15,333	15,821	15,290	16,258	16,883	15,004	16,000	8,134	10,481	
	Emergency length of stay	3.7	3.9	3.7	3.6	3.4	3.5	3.6	3.8	3.7	4.6	4.0	4.3	
	Average emergency acuity	2.4	2.5	2.3	2.3	2.2	2.1	2.2	2.3	2.3	2.3	2.8	2.9	
	G&A bed occupancy %	96%	96%	93%	95%	94%	95%	97%	97%	96%	89%	50%	62%	
	Patients discharged via Discharge Lounge	224	302	406	432	546	457	383	433	393	311	467	310	
	Discharges before midday	13.8%	13.6%	12.5%	12.6%	12.9%	13.4%	15.0%	13.6%	14.2%	15.3%	11.7%	12.2%	
	Weekend discharges	17.0%	14.1%	15.7%	15.7%	14.2%	16.3%	16.4%	15.2%	16.2%	13.3%	14.2%	15.8%	
	Proportion of beds occupied by patients with length of stay over 14 days	16.8%	20.0%	17.8%	20.1%	20.1%	23.7%	19.2%	21.7%	22.6%	23.6%	13.4%	18.4%	
	Proportion of beds occupied by patients with length of stay over 21 days	8.2%	10.9%	9.9%	10.9%	11.7%	14.5%	10.5%	11.6%	13.5%	13.7%	6.6%	9.0%	

Responsive Services

East and North Hertfordshire NHS Trust

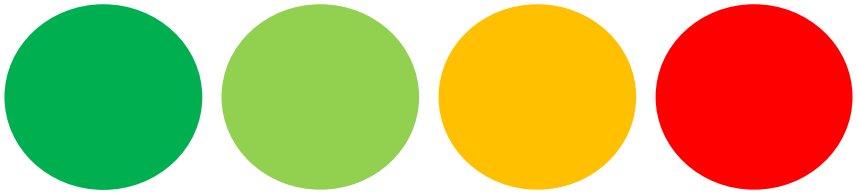
Patient Flow





People

Month 02 | 2020-21



Key Issues

Training & Development
- Appraisal compliance decreased from 75% to 71.5%, against a target of 90%.
- Overall statutory and mandatory training compliance decreased from 84% to 79.6% against a target of 90%.

Staff Turnover
- Overall reduced in month 2 by 0.3% and is 0.3% lower than the same month in the previous year.
- An area of concern is qualifies nursing and midwifery which has increased over the last four months from 11.4% to 12.6%. However, turnover is at a lower rate than the same month the previous year.

Sickness Absence
- Overall sickness absence rate decreased by 1.8% to 5.5% but is still significantly higher than the previous year which was 3.8%.

Staffing and Pay bill
- Overall staff utilised including bank and agency increased by 68 WTE.
- Agency expenditure reduced by £94K and was £252k under the agency ceiling.
- The Trust retains its NHSI agency ceiling target at £12.42m for 20/21.

Executive Response

The continued decision by the Trust to pause all training due to the COVID-19 pandemic (with a small number of exceptions), including statutory and mandatory training and appraisal has resulted in a further decline in the statutory and mandatory training compliance and appraisal compliance. All new starters are completing their statutory and mandatory training requirements through the e learning for health e-learning packages.
A recovery plan has been developed which will involves reinstating the completion of appraisals and moving all statutory and mandatory training to e-learning (where possible) and where training needs to be face to face ensuring that social distancing requirements are being met and where possible alternative IT solutions available are being used. A proposal to secure funding for a new learning management system has been submitted to the staff experience group.
A people capability plan is being developed which incorporates a review of all learning, education and training facilities, bringing all Learning, Education and Development teams together, digitalisation, a new governance structure and getting the basic fundamentals in place to ensure that all staff are able to deliver high quality, safe care to patients. A new Trust Education Board will launch in June to oversee the

Executive Response (continued)

New appraisal paperwork has been developed and has been shared with stakeholders for feedback with a view to launching over the summer with supporting training. Talent boards, looking at the talent of our staff have also commenced.

The Staff Experience Group has reconvened and continues to develop plans to make East and North Herts the best place to work and embed the People Strategy. Focus has been on the 'care together' pillar of the people strategy and the opportunity presented by the charity money that has been donated for staff. It is looking at improving rest and recovery spaces and development for leaders as part of the fundamentals of staff wellbeing. Plans are also being developed for Trust-wide recognition schemes.

The Trust has appointed a new senior manager in the People team who is leading the organisation agenda on Equality, Diversity and Inclusion and Freedom To Speak Up. Focus has been on building the influence of the staff networks. Use of video conference has helped to boost attendance at network meetings. In May the Trust held 2 staff Iftars to celebrate Ramadan.

Staff risk assessments remain a priority and processes are in place to risk-assess all staff whilst prioritising all staff considered vulnerable. Regular Glisser sessions have been held as an extension to the BAME network to enable discussion and information sharing in relation to the impact of Covid-19 on BAME colleagues. A support line specifically for BAME colleagues has been set up in partnership with Hertfordshire Partnership FT.

Vacancy rate for all staff groups decreased by 1.0% - from 6.9% to 5.9% - in month 2 against an overall target for 20/21 of 6%. The overall Trust position for qualified nursing in month 2 saw 12 WTE new starters and 20 WTE leavers, this has resulted in a vacancy rate of 7.4% and equates to 128.7 vacancies. The qualified UK nurse/midwifery pipeline currently indicates a total of 90.5 WTE future new starters. In addition to the UK nursing pipeline, there are an additional 62 international nurses in the pipeline. Further international recruitment will take place once Operation Restart and subsequent bed configuration plans are confirmed. The overall Trust position for medical recruitment for month 3 is a vacancy rate of 1.56%, this equates to 13.96 WTE vacancies. There are 56 doctors in the recruitment pipeline, 23 with confirmed start dates. In addition, we have recruited 83.37 WTE already this financial year with only 18.40 leavers, giving us an increase in establishment of 64.97 WTE, 47 WTE of the new starters were interim Foundation Year 1 doctors who all started in the month of May to help combat COVID-19.

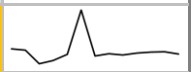
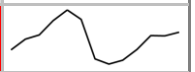
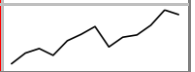
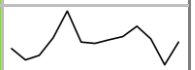
All responses to the COVID-19 call to work for the NHS are being managed through the NHS Professionals Fast Track service. Overall temporary staffing demand decreased by 8% against the previous month, all staff-groups experienced a decrease. Agency filled shift activity decreased by 11% consistent with agency expenditure reducing by £94k against the previous month; the Trust was under the agency ceiling by £252k. The NHSI agency ceiling target remains the same for 20/21 at £12.42m.. Overall agency utilisation for all staff-groups is down by 31% year on year. Bank fill target increased for 20/21 to 85%, M2 achieved 89% which is our highest bank fill performance in 13 months.

People

Workforce and Staff Development

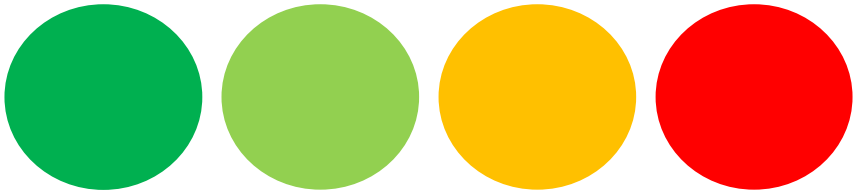
East and North Hertfordshire NHS Trust

Domain	Metric	Target	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Trend
Work	Vacancy Rate	6%	7.0%	6.7%	5.8%	6.9%	7.6%	6.3%	6.8%	7.3%	7.0%	6.6%	6.3%	6.9%	5.9%	
	Time to hire (weeks)	10	12.3	10.8	12.3	11.3	13.6	13.7	10.5	10.3	11.6	13.3	13.0	9.6	12.9	
	Recruitment experience	4										4.5	4.6	4.5	4.5	
	Relative likelihood of being shortlisted and appointed (BAME)	1						1.3			1.0					
	Relative likelihood of being shortlisted and appointed (Disability)	1						1.0			1.5					
	Agency Spend (% of WTE)	4%	4.6%	4.2%	4.8%	4.6%	3.8%	3.7%	3.7%	3.7%	4.0%	4.0%	4.1%	3.6%	3.2%	
	Bank Spend (% of WTE)	10%	11.7%	11.1%	11.7%	10.8%	10.5%	8.9%	10.4%	10.1%	11.5%	10.9%	12.7%	10.9%	8.2%	
	% of staff on eRoster	> 90%									49.0%	49.0%	49.0%	62.0%	62.0%	
	% of fully approved rosters in advance of 8 weeks	60%	21.7%	16.8%	29.0%	30.0%	25.0%	30.0%	29.0%	33.0%	39.0%	32.0%	26.6%	26.7%	33.6%	
	% of actual clinical unavalibility vs % of budgeted clinical unavailability (headroom) - Nursing & Midwifery ONLY	< 21%	26.3%	25.7%	24.0%	28.9%	26.7%	24.1%	25.0%	25.5%	27.0%	25.9%	29.8%	39.9%	36.2%	
	Pulse survey Flexibility	55%						53%			52%					
Grow	Statutory & mandatory training compliance rate	90%	89.5%	89.4%	88.4%	89.1%	88.7%	89.9%	89.6%	90.0%	88.6%	88.9%	87.2%	84.0%	79.6%	
	Appraisal rate	90%	84.3%	86.2%	86.3%	87.2%	86.3%	84.7%	87.4%	84.0%	83.1%	82.0%	78.6%	75.0%	71.5%	
	Pulse survey Training and development opportunities	55%						73.0%			55.0%					
	Pulse survey Talent management	55%						60.8%			50.0%					
	Likelihood of training and development opportunities (BAME)	1														
	Likelihood of training and development opportunities (Disability)	1														
	LMCPD places filled	800 (cum)	84	47	104	12	79	149	120	93	55	57	0	0	0	

Domain	Metric	Target	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Trend
Thrive	Pulse survey My leader	75%						70.3%			79.9%					
	Pulse survey Harnessing individuality	60%						51.7%			51.7%					
	Pulse Survey Not experiencing discrimination	95%						91.2%			62.2%					
	Turnover Rate	12.2%	13.1%	13.0%	12.3%	12.5%	12.8%	15.1%	12.7%	12.8%	12.8%	12.9%	12.9%	12.9%	12.8%	
	Model employer targets (% achieved)	100%									100.0%					
	Average length of suspension (days)	20	32	55	64	95	119	98	12	0	8.5	32	63	62	70	
	Average length of Disciplinary (excluding suspensions) (days)	60	61	168	133	152	105	122	115	77	150	179	248	212	304	
	Average length of Grievance (including dignity at work) (days)	60	36	71	86	64	112	133	159	92	124	131	163	214	199	
Care	Pulse survey Well-being	70%						66.5%			43.5%					
	Pulse survey Reasonable adjustments	50%									39.2%					
	Staff FFT Recommend as a place to work	60%	44.1%		52.6%			58.0%			37.3%					
	Staff FFT Recommend as a place of care	70%	67.8%		79.0%			66.0%			64.6%					
	Sickness Rate	3.8%	3.82%	3.75%	3.74%	3.90%	4.25%	4.25%	4.23%	4.35%	4.38%	4.15%	6.79%	7.28%	5.51%	
	Sickness FTE Days Lost	6,777	6,346	6,054	6,299	6,522	6,871	7,199	6,903	7,304	7,380	6,569	11,528	12,002	9,504	
	Mental health related absence (days lost)	1,650	1,409	1,262	1,230	1,322	1,527	1,575	1,258	1,282	1,173	1,011	1,253	1,620	1,640	
	MSK related absence (days lost)	1,285	1,144	1,014	1,066	1,262	1,567	1,217	1,200	1,241	1,278	1,394	1,252	961	1,216	

Sustainable Services

Month 02 | 2020-21



Key Issues

- The Trust reports a Month 2 I&E position of breakeven. This is in line with the expectations of the exceptional COVID-19 financial framework that has been implemented across the NHS in England between 1st April and 31st July 2020.
- In the context of this financial framework the Trust has received SLA income funding from commissioners in line with the block payment values calculated by NHSE. In addition the Trust has received a fixed 'Top Up' payment of £2.8m YTD direct from the Department of Health to address the difference between its received SLA income and its underlying cost base. This Top Up value will continue to be receipted by the Trust on a monthly basis during the interim financial framework stage.
- Furthermore, the Trust has claimed an additional COVID specific Top Up relating to the YTD reporting period. This claim equalises the impact of COVID -19 expenditures net of the underlying financial position to ensure that the Trust is able to report a breakeven position as directed by NHSE. The value of this COVID -19 Top Up in April was £1.2m, no further COVID-19 Top Up was claimed for May.
- As previously reported to the Finance Committee and Trust Board a series of data capture and reporting systems have been implemented to ensure that the Trust is accurately and transparently able to report the addition COVID-19 costs that it has occurred in the year to date that cover the specific financial impacts associated with the current incident. These have been detailed in a specific report to the FPC and are also presented within national monitoring returns.
- In the YTD the Trust calculates that it has incurred specific COVID-19 costs of £5.8m. Of this quantum some £3.9m pertains to additional costs to both support its revised clinical model and also to address higher levels of staff sickness and unavailability. The remainder pertains to extra non-pay costs incurred such as PPE. In addition the Trust also estimates that in the YTD the value of Category C 'Other Income' receipts was some £1.5m less than a normal 'business as usual ' run rate. The reductions being particularly pronounced in respect of Private Patient and R&D income receipts.
- The volume and value of SLA patient care activity that was undertaken by the Trust in May was considerably below normal run rate levels. Comparing Month 2 activity delivery with February (the last full pre -COVID-19 month), total A&E attendances were 26% less, Outpatients attendances were 49% less, total bed days occupied by patients 32% less and Day cases & inpatient elective activity was 68% less. Had activity and income been priced and reported on a PbR basis rather than through a block, receipts would have been some £25.1m less than actually received.
- Whilst activity levels in May remained considerably below normal levels across most Points of Delivery in the Trust, the impact upon the organisations cost base has been. Excluding the impact of COVID -19 specific costs, business as usual expenditure levels have decreased by only 6.4%.
- Normal contracting and business relationships with commissioners are currently suspended until at least 31st October 2020. In addition as per the current COVID-19 financial framework internal CIP and efficiency programmes are also suspended.

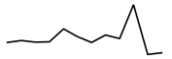
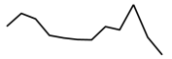
Executive Response

- The Trust has adapted its financial governance regime in response to the current exceptional financial framework arrangements that have been introduced. A summary of financial control and governance changes that have been made were presented to the Finance and Performance Committee at its April meeting. It is expected that these arrangements will continue to be monitored via regular reports to both this Committee and also to the Audit Committee going forward across the duration of the incident.
- The Trust has also refined and developed its financial reporting arrangements to provide additional granularity in respect of the value and type of optional costs incurred by the Trust as it supports necessary COVID-19 capacity and its associated impacts. These are reflected in amended reports to Committees, the Trust Board and internal budget holders and management teams.
- As the Trust moves into a formal recovery phase that will seek to restore planned and emergency services, it will need to consider these arrangements in respect of their inter-relationship with its cost base. It is likely that in many areas the scope and scale of services provided across the remainder of 20/21 and potentially beyond is likely to remain significantly below pre COVID-19 levels. The Trust will therefore need to give specific attention to how it varies the size of its back office, middle office and front line services to match this reduced requirement. This needs to be supported by an improvement understanding of cost classification and behaviour.
- 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 as defined in 'Operation Restart'.

Sustainable Services

Finance Plan Performance

East and North Hertfordshire NHS Trust

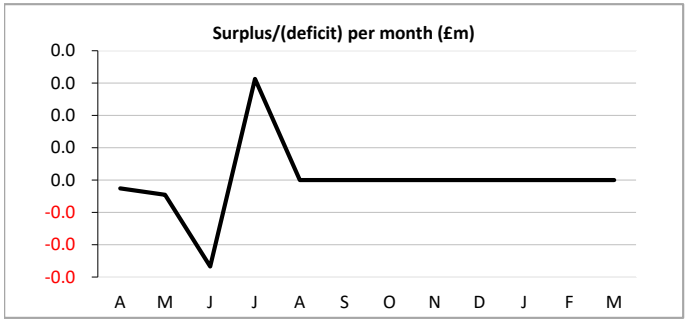
Domain	Metric	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Trend	Plan YTD	Actual YTD	Variance YTD
I&E Performance	SLA Income Earned	33.5	37.2	34.3	34.3	36.4	34.6	33.8	36.6	33.4	36.6	36.2	36.2		72.0	72.4	0.4
	Other Income Earned	3.6	3.8	3.7	3.7	5.2	4.3	3.6	4.5	4.1	8.0	2.3	2.5		9.5	4.7	-4.8
	Pay Costs	24.5	24.7	24.5	24.3	24.6	24.6	24.7	24.9	24.5	27.4	26.2	25.7		50.5	51.9	1.4
	Non Pay Costs inc Financing	15.0	16.0	15.3	15.1	16.3	15.3	15.8	16.1	15.0	17.5	14.9	14.4		31.0	29.3	-1.8
	Underlying Surplus / (Deficit)	-2.3	0.4	-1.9	-1.4	0.6	-1.0	-3.1	0.0	-1.9	-0.3	-2.6	-1.4		-0.0	-4.1	-4.1
	Top up payments	-	-	-	-	-	-	-	-	-	-	2.6	1.4		0.0	4.1	4.1
	Retained Surplus / Deficit	-1.5	1.4	-0.802	-0.3	2.3	0.6	-1.4	1.9	-0.0	1.6	-0.0	0.0		-0.0	-0.0	0.0
Paybill Metrics	Substantive Pay Costs	20.8	20.8	20.8	20.9	21.2	21.2	21.3	21.2	20.9	22.9	22.6	22.4		47.4	45.0	-2.4
	Premium Pay Costs Overtime & WLI	0.4	0.4	0.4	0.3	0.3	0.3	0.3	0.3	0.3	0.4	0.2	0.1		0.0	0.3	0.3
	Premium Pay Costs Bank Costs	2.2	2.4	2.3	2.2	2.2	2.2	2.2	2.5	2.3	2.9	2.6	2.3		2.3	4.9	2.6
	Premium Pay Costs Agency Costs	1.0	1.1	1.1	0.9	0.9	0.9	0.9	1.0	1.0	1.2	0.9	0.8		0.8	1.8	0.9
	Premium Pay Costs As % of Paybill	14.8%	15.8%	15.4%	14.1%	13.9%	13.8%	13.8%	14.8%	14.5%	16.5%	14.0%	12.7%		6.1%	13.3%	7.2%

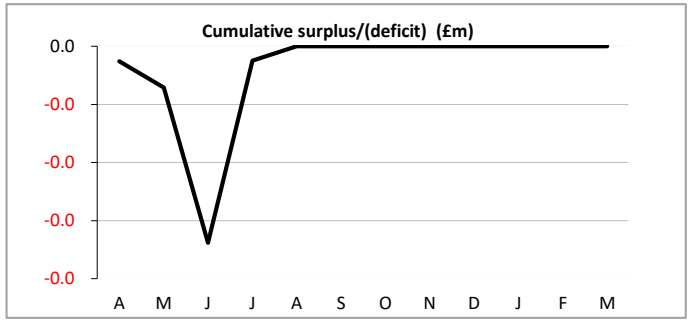
Sustainable Services

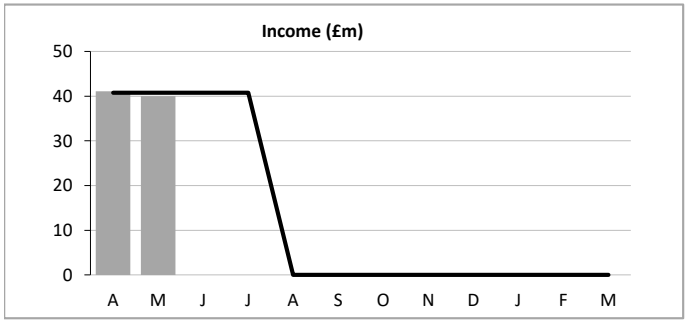
Finance Plan Performance

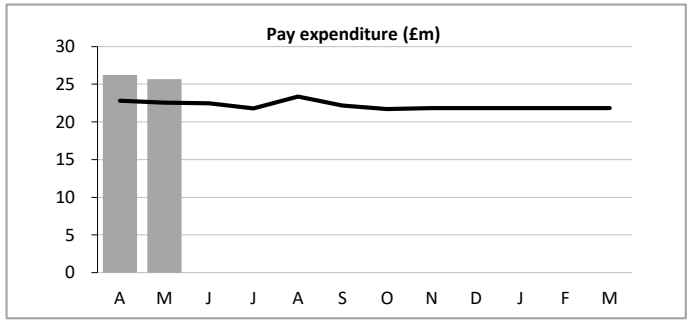
East and North Hertfordshire NHS Trust

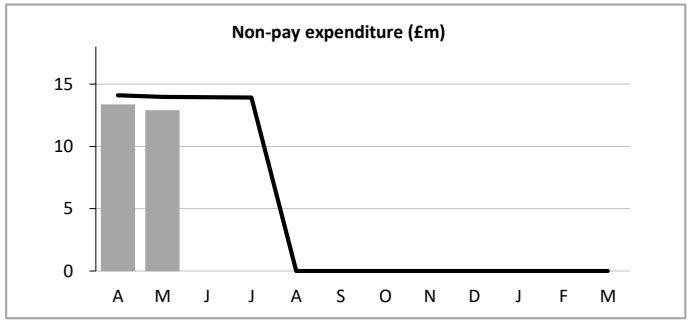
Domain	Metric	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Trend	Plan YTD	Actual YTD	Variance YTD
Single Oversight Framework	Capital Servicing Capacity	4	3	4	4	4	4	4	4	4	4	n/a	n/a		1	n/a	
	Liquid Ratio (Days)	4	4	4	4	4	4	4	4	4	4	n/a	n/a		1	n/a	
	I&E Margin	4	4	4	4	3	3	3	3	3	2	n/a	n/a		1	n/a	
	Distance from Plan	1	1	1	1	1	1	1	1	1	1	n/a	n/a		1	n/a	
	Agency Spend vs. Ceiling	1	1	1	1	1	1	1	1	1	1	n/a	n/a		1	n/a	
	Overall Finance Metric	3	3	3	3	3	3	3	3	3	3	n/a	n/a		1	n/a	











Sustainable Services

SLA Contracts - Income Performance

East and North Hertfordshire NHS Trust

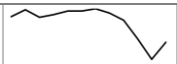
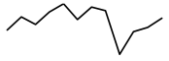
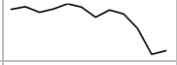
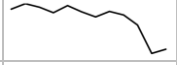
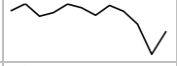
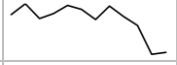
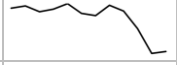
		In-Month			YTD		
		Planned Income	Actual Income	Income Variance	Planned Income	Actual Income	Income Variance
By Point of Delivery	A&E Attendances	2,329	1,779	-550	4,658	3,077	-1,581
	Daycases	3,091	821	-2,270	6,182	1,510	-4,672
	Inpatient Elective	1,918	517	-1,401	3,836	965	-2,871
	Inpatient Non Elective	9,712	7,374	-2,338	19,424	13,277	-6,147
	Maternity	2,546	2,363	-183	5,092	4,729	-363
	Other	3,736	2,847	-889	7,472	5,501	-1,970
	Outpatient First	2,095	1,416	-678	4,189	2,229	-1,960
	Outpatient Follow Ups	2,184	1,259	-925	4,368	2,479	-1,889
	Outpatient Procedures	1,156	285	-871	2,312	550	-1,762
	NHSE Block Impact	-179	10,974	14,662	-357	24,766	14,662
	Other SLAs	65	65	0	129	129	0
	Block	843	843	0	1,685	1,685	0
	Drugs & Devices	3,682	3,051	-632	7,364	6,076	-1,288
	Chemotherapy Delivery	607	387	-219	1,213	795	-418
	Radiotherapy	1,216	1,041	-174	2,431	2,269	-163
	Renal Dialysis	1,182	1,163	-19	2,364	2,299	-65
	Total	36,182	36,185	3	72,363	72,337	-26

		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	43,269	43,269	0
	Specialist Commissioning	8,167	8,167	0	16,334	16,334	0
	Bedfordshire CCG	2,486	2,486	-0	4,972	4,972	-0
	Herts Valleys CCG	1,404	1,404	-0	2,808	2,808	0
	Cancer Drugs Fund	426	426	0	853	853	0
	Luton CCG	326	326	-0	652	652	-0
	PH - Screening	379	570	191	758	1,139	381
	Other	1,359	1,171	-187	2,718	2,309	-408
By Division	Cancer Services	6,587	5,241	-1,346	13,174	10,418	-2,756
	Medicine	12,075	8,985	-3,091	24,150	16,370	-7,781
	Women & Children	5,044	4,086	-959	10,089	8,041	-2,048
	Clinical Services	2,158	1,274	-884	4,316	2,660	-1,656
	Surgery	10,530	4,964	-5,566	21,059	8,789	-12,271
	NHSE Block Impact	-179	10,974	11,152	-357	24,766	25,123
	Other	-34	662	696	-69	1,294	1,362

Sustainable Services

Activity and Productivity

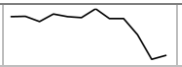
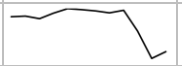
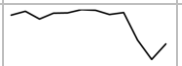
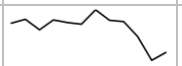
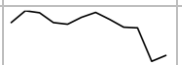
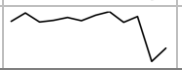
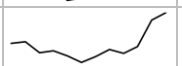
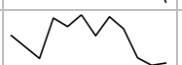
East and North Hertfordshire NHS Trust

Domain	Metric	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Trend	Plan YTD	Actual YTD	Var YTD
Patient Activity Levels	A&E & UCC	12,942	13,968	12,845	13,230	13,745	13,769	14,126	13,467	12,432	9,714	6,656	9,155		26,789	15,811	-10,978
	Chemotherapy Atts	1,948	2,266	2,131	2,073	2,348	2,261	2,241	2,528	2,177	2,049	1,631	1,486		4,539	3,117	-1,422
	Critical Care (Adult) - OBD's	580	671	534	580	584	668	633	707	460	619	700	818		1,234	1,518	284
	Critical Care (Paeds) - OBD's	427	516	465	549	605	498	583	558	265	416	446	507		1,110	953	-157
	Daycases	3,708	3,879	3,512	3,722	4,070	3,841	3,215	3,662	3,420	2,504	851	1,085		7,915	1,936	-5,979
	Elective Inpatients	546	597	564	512	579	521	474	526	491	401	140	177		1,123	317	-806
	Emergency Inpatients	4,092	4,251	4,083	4,228	4,624	4,401	4,510	4,465	4,103	3,497	2,047	2,444		8,564	4,491	-4,073
	Home Dialysis	161	158	163	147	144	150	164	160	148	160	147	140		331	287	-43
	Hospital Dialysis	5,813	6,281	6,306	5,963	6,313	6,264	6,627	6,444	6,288	6,549	6,172	6,323		12,887	12,495	-392
	Maternity Births	427	453	449	438	467	440	436	414	414	420	393	442		884	835	-49
	Maternity Bookings	501	507	444	474	518	507	475	530	514	481	518	455		1,001	973	-28
	Outpatient First	8,944	9,845	8,244	8,675	9,788	9,312	8,354	9,598	8,867	7,228	3,341	6,256		17,861	9,597	-8,264
	Outpatient Follow Up	16,734	19,196	15,893	17,009	18,795	17,931	15,640	18,627	16,347	14,389	7,983	8,439		34,566	16,422	-18,144
	Outpatient procedures	7,429	7,719	6,935	7,306	8,029	6,750	6,449	7,799	7,053	4,749	1,500	1,766		14,816	3,266	-11,550
	Radiotherapy Fractions	4,338	4,884	4,775	4,480	4,764	4,800	4,828	5,232	5,061	4,772	4,663	4,272		9,896	8,935	-961

Sustainable Services

Activity and Productivity

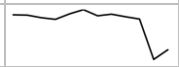
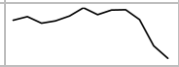
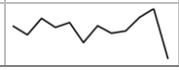
East and North Hertfordshire NHS Trust

Domain	Metric	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Trend	Plan YTD	Actual YTD	Var YTD
Throuhput	Elective Spells per Working Day	203	203	185	212	202	198	231	195	196	138	52	66		220	55	-165
	Emergency Spells per Day	132	133	129	138	145	143	142	139	143	109	65	75		140	74	-67
	ED Attendances per Day	431	451	414	441	443	459	456	434	444	313	222	295		439	259	-180
	Outpatient Atts per Working Day	1,577	1,671	1,412	1,650	1,592	1,545	1,903	1,642	1,613	1,256	675	866		1,640	714	-926
	Elective Bed Days Used	1,247	1,504	1,460	1,245	1,212	1,359	1,465	1,314	1,144	1,136	411	536		2,819	947	-1,872
	Emergency Bed Days Used	15,153	16,643	15,015	15,333	15,821	15,290	16,258	16,883	15,004	16,000	8,134	10,481		32,199	18,615	-13,584
Efficiency	Admission Rate from A&E	23%	22%	24%	24%	25%	24%	24%	25%	25%	27%	26%	23%		23.3%	24.6%	1.3%
	Emergency - Length of Stay	3.7	3.9	3.7	3.6	3.4	3.5	3.6	3.8	3.7	4.6	4.0	4.3		3.9	4.1	0.2
	Emergency - Casemix Value	2,434	2,459	2,277	2,308	2,222	2,116	2,213	2,331	2,264	2,382	2,820	2,948		2,297	2,884	587
	Elective - Length of Stay	2.3	2.5	2.6	2.4	2.1	2.6	3.1	2.5	2.3	2.8	2.9	3.0		2.6	3.0	0.4
	Elective - Casemix Value	1,128	1,120	1,169	1,084	1,121	1,104	1,180	1,110	1,145	1,103	1,139	1,028		1,105	1,084	-21
	Elective Surgical DC Rate %	87.2%	86.7%	86.2%	87.9%	87.5%	88.1%	87.2%	88.0%	87.4%	86.2%	85.9%	86.0%		85%	86%	0.9%
	Outpatient DNA Rate % - 1st	11.7%	11.6%	11.8%	11.4%	11.0%	11.6%	12.1%	11.7%	11.6%	13.0%	10.8%	12.5%		11.9%	11.9%	0.0%
	Outpatient DNA Rate % - FUP	7.9%	7.3%	7.3%	7.5%	7.3%	7.1%	6.8%	6.1%	6.4%	7.4%	5.8%	5.3%		7.5%	5.4%	-2.1%
	Outpatient Cancel Rate % - Patient	10.6%	10.3%	10.6%	10.3%	10.1%	9.6%	10.9%	9.8%	9.9%	12.3%	5.7%	3.1%		10.4%	4.1%	-6.3%

Sustainable Services

Activity and Productivity

East and North Hertfordshire NHS Trust

Domain	Metric	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Trend	Plan YTD	Actual YTD	Var YTD
Efficiency	Outpatient Cancel Rate % - Hosp	6.2%	6.2%	6.1%	6.4%	6.3%	6.6%	6.7%	6.6%	7.0%	12.7%	28.2%	25.1%		6.9%	25.3%	18.4%
	Outpatients - 1st to FUP Ratio	1.9	1.9	1.9	2.0	1.9	1.9	1.9	1.9	1.8	2.0	2.4	1.3		1.9	1.7	-0.2
	Theatres - Ave Cases Per Hour	2.8	2.8	2.7	2.6	2.8	3.0	2.7	2.8	2.7	2.6	1.2	1.5		2.9	1.4	-1.5
	Theatres - Utilisation of Sessions	81%	83%	79%	80%	83%	88%	84%	87%	87%	81%	66%	58%		85%	62%	-23%
	Theatres - Ave Late Start (mins)	25	26	25	18	16	17	17	18	17	21	29	12		27	21	-5.8
	Theatres - Ave Early Finishes (mins)	36	30	41	35	38	25	36	31	32	41	47	15		39	31	-8.5

Sustainable Services

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

NHS East and North Hertfordshire NHS Trust

Activity Measures	2019-20 YTD	2020-21 YTD	Change
Emergency Department Attendances	26,201	15,811	-10,390
Emergency Department Ave Daily Atts	430	259	-170
Admission Rate from ED %	23.2%	24.6%	1%
Non Elective Inpatient Spells	8,208	4,491	-3,717
Ave Daily Non Elective Spells	135	74	-61
Daycase Spells	7,093	1,936	-5,157
Elective Inpatient Spells	1,094	317	-777
Ave Daily Planned Spells	134	37	-97
Day Case Rate	87%	86%	-1%
Adult & Paeds Critical Care Bed Days	2,313	2,471	158
Outpatient First Attendances	17,484	9,597	-7,887
Outpatient Follow Up Attendances	34,587	16,422	-18,165
Outpatient First to Follow Up Ratio	2.0	1.7	-0.3
Outpatient Procedures	16,169	3,266	-12,903
Ave Daily Outpatient Attendances	1,119	480	-639

Workforce Measures	2019-20 YTD	2020-21 YTD	Change
Average Monthly WTE's Utilised	5,817	5,964	147
Average YTD Pay Cost per WTE	8,523	8,700	2.1%
Staff Turnover	13.0%	12.9%	-0.1%
Vacancy WTE's	829	744	-85
Vacancy Rate	13.6%	12.6%	-1.0%
Sickness Days Lost	13,186	21,506	8,321
Sickness Rate	4.2%	6.4%	2.2%
Agency Spend- £m's	2.1	1.8	-0.4
Temp Spend as % of Pay Costs	4.3%	3.4%	-0.9%
Ave Monthly Consultant WTE's Worked	324.0	339.0	15.0
Consultant : Junior Training Doctor Ratio	1 : 1.7	1 : 1.7	0.0
Ave Monthly Nursing & CSW WTE's Worked	2,463.7	2,450.5	-13.2
Qual : Unqualified Staff Ratio	26 : 10	25 : 10	-0.0
Ave Monthly A&C and Senior Managers WTE's	1,279	1,323	44
A&C and Senior Managers % of Total WTE's	22.0%	22.2%	0.2%

Sustainable Services

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

East and North Hertfordshire NHS Trust

Capacity Measures	2019-20 YTD	2020-21 YTD	Change
Non Elective LoS	3.9	4.1	0.2
Elective LoS	2.6	3.0	0.4
Occupied Bed Days	35,018	19,562	-15,456
Adult Critical Care Bed Days	1,264	1,518	254
Paediatric Critical Care Bed Days	1,049	953	-96
Outpatient DNA Rate	8%	6%	-2.3%
Outpatient Utilisation Rate	14%	29%	14.5%
Total Cancellations	21,932	28,312	6,380
Theatres - Ave Cases per Hour	2.7	1.4	-1.3
Theatres - Ave Session Utilisation	79%	62%	-17.2%
Theatres - Ave Late Start (mins)	23	21	-2
Theatres - Ave Early Finishes (mins)	38.7	30.9	-8
Radiology Examinations	69,458	40,355	-29,103
Drug Expenditure (excl HCD & ENH Pharma) - £000s	1,641	1,260	-382
High Cost Drug Expenditure - £000s	6,748	6,022	-726

Finance & Quality Measures	2019-20 YTD	2020-21 YTD	Change
Profitability - £000s	-2,820	-54	2,766.3
Monthly SLA Income £000s	33,997	36,183	2,186
Monthly Clinical Income per Consultant WTE	£104,931	£106,733	£1,801
High Cost Drug Spend per Consultant WTE	£20,827	£17,762	-£3,065
Average Income per Elective Spell	£1,152	£1,084	-£68
Average Income per Non Elective Spell	£2,327	£2,884	£557
Average Income per ED attendance	£174	£195	£21
Average Income per Outpatient Attendance	£131	£112	-£18
Ave NEL Coding Depth per Spell	n/a	n/a	n/a
Procedures Not Carried Out	382	119	-263
Best Practice HRGs (% of all Spells)	0.9%	4.4%	3.5%
Ambulatory Best Practice (% of Short Stays)	n/a	n/a	n/a
Non-elective re-admissions within 30 days Rolling 12-months to Feb-20	10,847	11,644	797
Non-elective re-admissions within 30 days % Rolling 12-months to Feb-20	8.58%	8.88%	0.30%
SLA Contract Fines - £000's	10	0	-10

Division	Not started	In progress	Passed	Total	%
CANCER	54	5	70	129	54%
CAPITAL	3	0	2	5	40%
CSS	28	3	65	96	68%
DATA QUALITY/CODING	0	1	7	8	88%
FACILITIES	3	2	1	6	17%
FINANCE	6	2	212	220	96%
FINANCE - INFORMATION	2	0	12	14	86%
FINANCE - IT	0	2	3	5	60%
MEDICINE	163	23	133	319	42%
NURSING PRACTICE	9	1	3	13	23%
PMO	4	0	66	70	94%
STRATEGY	3	0	0	3	0%
SURGICAL	124	9	99	232	43%
TRUST MGT	6	0	2	8	25%
W&C	44	6	109	159	69%
WORKFORCE	12	0	4	16	25%
FINANCE - INCOME	3	0	5	8	63%
Grand Total	**464**	**54**	**793**	**1,311**	60%

East and North Hertfordshire NHS Trust

Agenda Item: 8 a)

TRUST BOARD – 1 JULY 2020

QUALITY AND SAFETY COMMITTEE – 24 JUNE 2020

EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present to the Trust Board the summary report regarding the Quality and Safety Committee meeting held on 24 June 2020.		
Action required: For discussion		
Previously considered by: **N/A**		
Director: Chair of QSC	**Presented by:** Chair of QSC	**Author:** Board Committee Secretary / 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):

QUALITY AND SAFETY COMMITTEE MEETING – 24 JUNE 2020
SUMMARY TO THE TRUST BOARD MEETING HELD ON WEDNESDAY 1 JULY 2020

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

The following core attendees were present:
Rachael Corser, Michael Chilvers, Nick Carver, Sarah Brierley, Duncan Forbes, Jude Archer, Julie Smith

Matters considered by the Committee:

Maternity CNST Reports: BAPM Standards Action Plan
The QSC received details of the Trust's BAPM Standards action plan, which would support the Trust's work towards achieving the Clinical Negligence Scheme for Trusts (CNST) 10 steps to safety.

The Chief Nurse explained that over the last two years the Trust has been compliant with all ten safety standards within the CNST programme. She summarised that there were no concerns to escalate at this stage with actions in place to address any gaps which are monitored through the Neonatal Committee.

Quality Assurance Dashboard
The Quality Assurance Meeting dashboard provided a range of key performance metrics including relating to Serious Incidents, risks, patient experience, safeguarding and HSE and CQC compliance. The dashboard had been developed over the period of the COVID pandemic and would continue to be strengthened and expanded (such as to include learning and training). The Committee discussed the impact of the fall in complaints and SIs over since the start of the pandemic and using the increased capacity wisely. The Committee noted the detail in the dashboard.

Safer Staffing Report
The Interim Deputy Chief Nurse presented the key points of the report to the Committee. It was reported that whilst national staffing submissions had been temporarily suspended during the initial COVID response, the Trust had continued to manage staff utilisation in an efficient way to ensure any shortfalls have been mitigated. It was also reported that there was ongoing work to support future bed modelling and future bed reconfiguration, with a full nursing establishment review planned for September. She reported that the number of staff shielding and self-isolating had reduced in May. There was some discussion regarding recruitment and retention of nursing staff and support being provided for student nurses.

IPC Report
The Committee noted the content of the IPC report. The Chief Nurse gave assurance to the Committee that the IPC team have continued to focus on all Infection, Prevention and Control priorities.

The Chief Nurse raised two areas where performance needed to improve: the number of Surgical Site Infections and High Impact Intervention audits. She noted that to address these issues the approach is being refreshed, there will be input and management from the clinical leads, ensuring good practice in terms of cleaning and the fundamentals of IPC will also be key. She said there is no room for complacency in relation to Infection, Prevention and Control.

IPC BAF
The Lead IPC Nurse presented eight areas of non-compliance against the IPC board assurance framework of 63 lines of enquiry which has been developed by NHSE/I. She gave an overview of the mitigations and actions that are in place to address the gaps.

The Chief Nurse commented that governance has also been strengthened which includes the re-instatement of the specialist advisory group.

The Committee thanked the Lead IPC Nurse for all her hard work over the last few months.

Learning from Deaths
The Medical Director presented the report to the Committee and highlighted the Crude mortality in the 12 month period to April was 1.16% compared to 1.27% for the last 3 years. The SHMI and HSMR data did not yet cover the period of the COVID pandemic. The report included some initial analysis of the COVID deaths reported in the Trust. These had peaked in April but had been reducing since. The report also included details of SHMI and HSMR outlier alerts and the actions the Trust was taking in response. There was some discussion regarding the trends in relation to LD deaths nationally and locally.

Risk Report
The Associate Director of Governance presented the risk report and highlighted a community paediatrics risk which had been reviewed by Division and increased. The risk had been escalated to the relevant team to support with the mitigation. She reported that the highest rated risks were continuing to be reassessed and reduced as appropriate.

Emergency Preparedness
The Chief Operating Officer presented the report to the Committee and informed the members that the Trust remains compliant against the EPRR core standards. She also reported that the Trust's incident management response was able to be deployed rapidly and effectively if it was deemed necessary to support with the Trust's response to COVID or another incident. There was some discussion regarding increasing the capacity of the EPPR team to support robustness of the service.

People Capability Strategy
The Committee agreed to defer this report to the July meeting.

Annual Reports
The Committee took the following reports as read:

- Health and Safety Annual Report
- Nursing, Midwifery & AHP Progress Report
- Quality Account (it was noted that the Trust Board would be asked to approve the Quality Account at the meeting on 1 July)

REPORTS FOR NOTING

Maternity Dashboard
The Committee noted the content of the Maternity Dashboard.

IPR
The Committee noted the report which would be discussed at the 1st July Trust Board meeting.

Clinical Harms Review
The Medical Director provided an update on work that would be taking place to work through harm reviews. He advised he would be looking to implement a streamlined process to support the divisions with this work.

East and North Hertfordshire NHS Trust

Agenda Item: 8 b)

TRUST BOARD – 1 JULY 2020

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE – 24 JUNE 2020
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present to the Trust Board the summary report from the Finance, Performance and People Committee (FPPC) meeting held on 24 June 2020. The report includes details of any decisions made by the FPPC under delegated authority.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of FPPC	**Presented by:** Chair of FPPC	**Author:** Trust Secretary/ Board Committee Secretary

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

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

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE – 24 JUNE 2020

EXECUTIVE SUMMARY REPORT TO TRUST BOARD

The following Non-executive Directors were present:
Karen McConnell (FPPC Chair), Ellen Schroder (Trust Chair), Jonathan Silver (Non-Executive Director), Bob Niven (Non-executive Director), Val Moore (Non-Executive Director) and David Buckle (Associate Non- Executive Director).

The following core attendees were present:
Nick Carver (Chief Executive), Martin Armstrong (Director of Finance), Julie Smith (Chief Operating Officer), Duncan Forbes (Chief People Officer), Sarah Brierley (Director of Strategy), Michael Chilvers (Medical Director) and Rachael Corser (Chief Nurse).

MATTERS CONSIDERED BY THE COMMITTEE:

STROKE DEEP DIVE
The Committee was presented with a deep dive on stroke performance. The presentation detailed the current performance issues, reasons for the decline in SNNAP performance (a decline from A to B) and key actions that were being taken to improve performance. It was noted that the national target for 4 hours direct to stroke unit had been reduced to 63% from 90%. A recovery trajectory was in place to reach a point where the target was met consistently. The Committee discussed the key actions in place to achieve the desired progress, the planned timescales and potential barriers/risks to delivery. The team considered the ongoing provision of IT support a key element of a sustainable recovery. Staffing issues were also discussed and the steps being taken which when complete should lead to improvements in the SNNAP scoring. The FPPC welcomed the presentation and requested an update at a future meeting.

PERFORMANCE REPORT - MONTH 2
The FPPC received an update on the operational performance for Month 2. The Chief Operating Officer reported that ED performance had improved despite the ongoing challenges of COVID-19. The Trust continued to be a positive outlier in terms of compliance with cancer standards. There was some discussion regarding the extent of activity various services were experiencing compared to pre-COVID levels. Constraints on activity levels included the need for social distancing and patient choice.

It was discussed that whilst ED performance had improved, relative performance to other trusts was not significantly different. The priority the Trust had placed on the COVID streaming pathways was considered to be a possible factor for this and the effectiveness of this approach in terms of outcomes for patients is being assessed. It was also reported that work was taking place to ensure the Trust model was effective going into winter.

STRATEGIC APPROACH TO HEALTH AND WELL BEING
The FPPC received a report which provided details of the development of the strategic approach to Health and Wellbeing across the ICS which the Trust was leading on. It was considered that there were a number of benefits to this approach. The FPPC sought clarification regarding some of the details, including the financial arrangements. The FPPC supported the report and direction of travel.

PEOPLE TEAM RISK UPDATE
The FPPC was presented with a quarterly update on the Trust's workforce and people related risks. The report presented identified risks and current controls that were in place and action plans for mitigation. It was recognised that the risks were in transition and

consequently there were some omissions, including in relation to equality and diversity related risks. The FPPC noted the report.

MVCC TRANSFER UPDATE
The FPPC received a report on the Mount Vernon Cancer Centre. The purpose of this paper was to update the FPPC on the progress of the strategic review led by Specialised Commissioners into the future model for the Mount Vernon Cancer Centre (MVCC) and identification of a preferred new provider. It was proposed by the Director of Strategy that an ICP cancer strategy was developed, rather than a Trust specific strategy. The Committee was informed of some of the risks relating to the process. The FPPC noted the update.

ESTATES AND FACILITIES COMPLIANCE REPORT
The FPPC received a report on estates and facilities compliance. The report summarised the Trust's compliance with the key requirements through a RAG rating system. It was noted that evidence was still being collated in relation to some of the requirements. The Committee welcomed the progress to date and the clarity provided by the report.

RISK REPORT
The Committee received the key headlines from the Risk Report. It was reported that 15 new risks have been reported in June 2020 across divisions out of which 5 had been rated as 15 or above. The report also highlighted that a new work based risk assessment template in relation to working safely during COVID had been developed and deployed. The FPPC noted the report.

MONTH 2 FINANCE REPORT
The FPPC was presented with the Trust's financial position for Month 2. The Director of Finance highlighted that the Trust reported a break-even finance position at Month 2, in line with the national COVID financial arrangements for the NHS for the period 1 April to 31 July 2020. The report provided details of the run rate and activity levels. Activity levels had increased slightly since Month 1 but remained significantly short of pre-COVID levels. The report included details of the COVID related costs incurred in month (largely pay related), though these had been partially offset by a reduction in Business as usual expenditure. The FPPC discussed the funding arrangements and noted the report.

COVID FINANCIAL FRAMEWORK UPDATE
The FPPC received an update on the COVID financial framework. The Deputy Director of Finance reported that there had been little change in terms of national guidance since the previous report in May. He noted that the Trust was awaiting NHSE/I feedback on some COVID capital funding decisions. The FPPC noted the report.

Karen McConnell
Finance, Performance and People Committee Chair

June 2020

AUDIT COMMITTEE MEETING
SUMMARY TO THE TRUST BOARD MEETING HELD ON 1 JULY 2020

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

ANNUAL REPORT AND ACCOUNTS FOR 2019/20:

Internal Audit Annual Report & Head of Internal Audit Opinion

There had been no changes to the internal audit report for 2019/20 since it had been reviewed and accepted by the Committee at the meeting on 26 March.

The Internal Audit Opinion remains as "The organisation has an adequate and effective framework for risk management, governance and internal control".

The Audit Committee noted the Opinion.

Annual Governance Statement

The final draft of the Annual Governance Statement presented to the Committee was subject to approval by the External Auditors. The additional subsections of the statement included the Health and Safety Executive improvement notices and the work undertaken to date to ensure compliance; Emergency Planning and the progression made in the last year and the COVID-19 pandemic.

The Associate Director of Governance informed the Committee that national guidance had been followed in the drafting the statement

The Audit Committee endorsed the Annual Governance Statement for submission to Board for approval, subject to any formal feedback from the External Auditors.

Draft Annual Report

The Committee were informed that the Draft Annual Report had been reviewed by the Non-Executives during a meeting prior to the Committee meeting. Their feedback had been incorporated into the report and there were no other significant changes to note. Feedback had also been received from the Executives and was incorporated in an updated version.

The Audit Committee endorsed the Annual Report for submission to the Board for approval.

Final Accounts

The Committee were informed that the Non-Executive Directors had met prior to the Committee meeting to go through the final accounts in detail and no significant changes had been made since the meeting.

In response to a question regarding Trust debtors, the Director of Finance informed the Committee that the Finance team will focus on reducing Trust debt and will develop a debt profile report which will be reported at FPPC. He said this will ensure there is improved accountability and management of performance.

The Audit Committee endorsed the 2019/2020 Final Accounts for submission to the Board for approval.

External Audit ISA Report
The External Auditor presented the report to the Committee and highlighted the outstanding matters.

The External Auditor reported the valuation of land and buildings was still outstanding. He said when the original valuations were done, they were all within a reasonable range. COVID has had an unclear impact on market values and all external audit companies are waiting for an evaluation report commissioned by NHSI/E. Until this report has been received the Auditors would be unable to complete their work.

The Committee discussed some of the deficiencies identified by the Auditors and management responses. No significant deficiencies had been identified.

The External Auditor explained that a final letter of representation will be provided once all work is complete and he has already discussed an arrangement for the letter to be signed electronically.

The Committee discussed the likely impact of the land and buildings valuations and the implications should the evaluation report not be received in time for the accounts to be submitted within the deadline.

The Committee noted the report subject and outstanding matters.

Letter of Representation
The Committee discussed the Letter of Representation as part of the External Audit Report and recommended it to the Board for approval.

INTERNAL AUDIT REPORTS:

Internal Audit Plan
The Internal Auditor presented an update report and plan and provided an update regarding the online tracker. The system has been uploaded with all previous outstanding recommendations and once administrator access has been granted, the Trust will be able to make updates and begin to use the system.

The Internal Auditor explained to the Committee that the new plan has been developed in conjunction with the Director of Finance as well as the previous Internal Auditors. A COVID-19 key risk has been included which details the potential impact on financial governance.

The Committee discussed the contents of the plan. The Committee discussed the importance of ensuring cyber security is adequately covered through the work plan.

The Committee also discussed how to manage the issue regarding unsigned employment contracts as identified by the External Auditors. The Director of Finance suggested an internal audit of the recruitment systems. The Internal Auditor explained there is a planned Payroll audit and it could form part of the scope of that audit.

The Committee approved the plan for the current year subject to minor amendments as discussed.

Local Counter Fraud Work Plan
The Local Counter Fraud Manager introduced the plan and explained it had previously been approved by email correspondence. She said she was working with the Associate Director of Governance and Trust Secretary on the Conflicts of Interest Policy and is working on a proactive COVID related risk review which will be issued to the Trust in the coming week.

The Committee approved the plan.

Local Anti-Fraud and Bribery Policy
The Trust Secretary explained the policy is usually reviewed every two years and the trigger for the current review was the new Internal Auditors and LCFS. The policy sets out advice to employees in dealing with fraud, bribery and corruption or suspected fraud, bribery or corruption. This policy details the arrangements made in the organisation for such concerns to be raised by employees or members of the public and had been updated to include the contact details for the Local Counter Fraud Manager.

The Committee approved the policy.

OTHER REPORTS:

Quality Account
The Associate Director of Governance explained to the Committee that the Quality Account had been drafted but national guidance was that it did not need to be submitted until December 2020. She said the changes to the regulation for this year meant the Quality Account was no longer subject to External Audit opinion. She said it had been submitted to some Stakeholders for comment and the CCG have returned some points for clarification. The intention is for the Quality Account to be submitted to the Quality and Safety Committee in June for recommendation for approval by the Board at the July meeting. The aim is for a summary to be ready in time for the AGM in July.

East and North Hertfordshire NHS Trust

Agenda Item: 8 d)

TRUST BOARD – 1 JULY 2020

CHARITY TRUSTEE COMMITTEE – 8 JUNE 2020

EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present to the Trust Board the summary report from the Charity Trustee Committee (CTC) meeting of 8 June 2020. The report includes details of any decisions made by the CTC under delegated authority.		
Action required: For discussion		
Previously considered by: **N/A**		
Director: Director of Strategy	**Presented by:** Chair of CTC	**Author:** Board Committee Secretary / 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):

CHARITY TRUSTEE COMMITTEE MEETING HELD 8 JUNE 2020

SUMMARY REPORT TO BOARD

The following members were present: Bob Niven (CTC Chair), Val Moore (Non-Executive Director), David Buckle (Non–Executive Director), Ellen Schroder (Trust Chair) 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
The Artlife Project	£9983.50	Approved and the possibility of using some of the COVID related donations would be explored.
GE Vivid S70 Cardiovascular Ultrasound machine (including probes and software)	£43,000	Approved in principle, subject to further detail on the sustainability of the service proposed. The CTC also requested that fundraising for this project was explored as an alternative to allocation from existing funds, with a view to reviewing progress in September.
Contactless donation point/artwork installation in Lister's main concourse	£6,000 inc VAT	Approved.
12 months funding for Scar Work for breast cancer treatment.	£10,000	Approved £5k subject to assurance and clarification of spending position on funds previously allocated in respect of Scar Work.
SPEC CT funding	£310,000	Charitable funding allocation approved.
Bereavement Payment for staff and family	£2000	Not approved – though the CTC acknowledged there could be situations where one-off payments could be considered and deemed acceptable

Other outcomes:

Divisional Fund Management
The CTC was presented with a report on Divisional fund management within the Women and Children's division. The report summarised the current position regarding the charitable funds held within the Women's and Children's Division and noted the progress made between the Division and the Charity over the last year. The Committee welcomed the report and made recommendations around fundraising for Women's Services.

Investment Portfolio Update
The Committee was presented with an update on the investment portfolio. It was reported that COVID had adversely impacted investment and the stock market but that equities have been made more robust and defensive and had performed at around the benchmark level. The CTC recommended that Rathbones should provide a report on measurement against inflation over time for future meetings. The Committee also suggested consideration was given to the Charity's long term investment aims in order to inform its investment and expenditure strategy. The CTC noted the report.

Staff Well Being – COVID Update
The Committee considered an update on staff well-being from the Chief People Officer including the use of donations in kind to refurbish the Level 3 Coffee Lounge at Lister as a Rest, Refuel and Relax area. The Charity has asked the Trust to develop proposals for use of the funds donated under the #hereforeachother appeal and wishes to demonstrate effective and timely use of these to donors and for staff to feel a benefit. The staff experience group had been engaged to contribute to the development of proposals for charitable funding. The CTC recommended that this should be a long lasting support. Further updates would be provided outside of the meeting or at the September CTC meeting, depending on progress.

Charity Strategy Update and COVID Implications
In response to the pandemic and the actual and expected impact on charitable activities and fundraising, the Committee was provided with a revised income forecast and income protection and growth strategy for 20/21. The Committee discussed the changed profile of the Charity and successes and challenges over the period of the COVID pandemic. The original income plan for the year had been revised in light of the impact of COVID-19 and was presented for approval (attached as Appendix 1). It was also reported that the charity's planned development of a new long-term strategy beyond the MVCC transfer had been impacted by demands of responding to COVID and its intended approach was also under review. It was noted that the estimated transfer date for MVCC had also been pushed back as a result of the pandemic to September 2021 at the earliest. The Charity was keen to maximise relationship with new donors and its raised profile during the pandemic to drive growth in income. A key strand of this will be the development of a new major appeal to launch in the second half of the year. The Charity will explore ideas with the Trust and bring a shortlist of proposals to the next CTC in September. The intention was to complete work on a new strategy ready for the end of the financial year. The CTC recommended that the annual cycle be amended to reflect this and approved the plan for 20/21 as presented. Meanwhile it was noted that the forecast was for a major shift in fundraising income to the Lister site relative to MVCC.

Charity Activities Update
The Committee was presented with an update on the Charity's recent activities. The report included details of notable donations. A highlight was the increased internal and external engagement the Charity had experienced over the period, with a surge in income from third party fundraising and donations over the last few months from

both the local community and corporate organisations (some £300,000 at the time of the meeting). The CTC supported the update and commended the Interim Head of Charity and her team for the work achieved in a short period.

Charity Finance Report
The Committee were presented with the closing position of the Charity Finance for 2019/20 and year to date performance to the end of April 2020. The Committee noted the figures regarding the cost of raising funds ratio to income and the breakdown of the Charity's expenditure. It was also noted that there had been a shift in the proportion of income received by site, with the Lister site receiving significantly more charitable donations than Mount Vernon Cancer Centre over the period. The CTC noted the report.

Annual Review of Risk Register
The Committee were presented with updates on the Charity's most significant risks as recorded on the risk register. The CTC discussed the possibility of including a risk related to failing to reduce the cost of fundraising ratio.

Bob Niven
Chairman of the Charity Trustee Committee

June 2020