East and North Hertfordshire NHS Trust
Trust Board - Public Session

Boardroom / StarLeaf

2 September 2020 10:00 - 2 September 2020 12:30

AGENDA

#	Description	Owner	Time
1	Chair's Opening Remarks	Chair	10:00
2	Apologies for absence: JSi, DF		
3	Declaration of Interests	All	
4	Questions from the Public At the start of each meeting the Board provides members of the public the opportunity to ask questions and/or make statements that relate to the work of the Trust. Members of the public are urged to give notice of their questions at least 48 hours before the beginning of the meeting in order that a full answer can be provided; if notice is not given, an answer will be provided whenever possible but the relevant information may not be available at the meeting. If such information is not so available, the Trust will provide a written answer to the question as soon as is practicable after the meeting. The Trust Secretary can be contacted by email, joseph.maggs@nhs.net, by telephone (01438 285454) or by post to: Trust Secretary, Lister Hospital, Coreys Mill Lane, Stevenage, Herts, SG1 4AB. Each person will be allowed to ask only one question or make one statement. However, at the discretion of the Chair of the meeting, and if time permits, a second or subsequent question may be allowed. Generally, questions and/or statements from members of the public will not be allowed during the course of the meeting. Exceptionally, however, where an issue is of particular interest to the community, the Chairman may allow members of the public to ask questions or make comments immediately before the Board begins its deliberations on that issue, provided the Chairman's consent thereto is obtained before the meeting.		
5	Minutes of Previous Meeting For approval	Chair	
6	Patient Story For discussion	Chief Nurse	10:05
7	Chief Executive's Report For discussion 7. Chief Executive Report.pdf 7 7. Appendix 1 - IPR - CEO Summary - August.pdf 9	Chief Executive	10:20

#	Description	Owner	Time
8	Integrated Performance Report For discussion 8. IPR - Month 4.pdf 13	Chief Executive	10:30
9	Recovery Phase 3 Update For discussion 9. Recovery Phase 3 Update.pdf 55	Chief Operating Officer	10:50
10	Board Assurance Framework 2020-21 For approval 10. BAF 2020-21.pdf 63	Associate Director of Governance	11:05
11	Finance, Performance and People Committee Report to Board For discussion 11. 29 July FPPC Report to Board.pdf 93	Chair of FPPC	11:25
11.1	WDES and WRES Reports For approval 11.1 a) Workforce Equality Standards - Overview.p... 97 11.1 b) Workforce Race Equality Standard Report a... 99 11.1 c) Workforce Disability Equality Standard Rep... 111	Chief People Officer	
12	Quality and Safety Committee Report to Board For discussion 12. 28 July QSC Report to Board.pdf 119	Chair of QSC	11:35
12.1	Safeguarding Annual Report For approval 12.1 Safeguarding Children and Adults Annual Rep... 123	Chief Nurse	
12.2	Complaints, PALS and Patient Experience Quarterly and Annual Reports For approval 12.2 Patient Experience Quarterly and Annual Rep... 163	Chief Nurse	

#	Description	Owner	Time
12.3	Health and Safety Annual Report For approval 12.3 Annual Report of the Health and Safety Comm... 207	Director of Estates and Facilities	
13	Audit Committee Report to Board For discussion 13. 20 July Audit Committee Report to Board.pdf 229	Chair of Audit Committee	11:45
13.1	Annual Audit Letter For noting 13.1 Annual Audit Letter.pdf 233	Director of Finance	
14	CTC Report to Board For discussion 14. 5 August CTC Report to Board.pdf 251	Chair of CTC	11:50
15	Staff Wellbeing Support For discussion 15. Staff Wellbeing Support.pdf 255	Chief People Officer	11:55
16	Strategy Committee - Terms of Reference For approval 16. Strategy Committee - Terms of Reference.pdf 267	Director of Strategy	12:10
17	Actions Log For information 17. Public Trust Board Actions Log.pdf 271	Trust Secretary	12:20
18	Annual Cycle For information 18. Board Annual Cycle 2020-21.pdf 273	Trust Secretary	
19	Data Pack For information 19. Data Pack.pdf 277		

#	Description	Owner	Time
20	Date of next meeting 4 November 2020		

Chief Executive's Report

Although the Board has continued to meet on a frequent and regular basis since the start of the Covid 19 pandemic, this is the first Public Board meeting since March.

The initial intensity of Covid 19 related activity required the Trust to extensively and rapidly rearrange services, to care for approximately 6,000 patients who potentially had Covid 19. This has now been replaced with a different, but in many respects greater challenge.

The Trust is now restarting services in accordance with the requirements set out by Sir Simon Stevens, but doing so in the context of the need to maintain enhanced infection control procedures in accordance with national guidance.

Essentially the Trust is seeking to do 3 things namely:-

1. To accelerate the return to near normal levels of non Covid health services making full use of the capacity available in the "window of opportunity" between now and winter.

2. To prepare for wider demand pressures, alongside maintaining continuing vigilance in the light of further probable Covid spikes local and possibly nationally.

3. To do the above in a way that takes account of lessons learned during the first Covid peak; locking in beneficial changes; and explicitly tackling fundamental challenges including: support for our staff, and action on inequalities and prevention.

During the Board meeting, Directors will receive a progress report from Julie Smith, the Chief Operating Officer, demonstrating the progress being made on the requirements for the "Phase 3" outlined in the Simon Stevens letter. This will clarify the further steps to understand the operational actions required, and the financial implications of the achievements of the mandated targets.

At the commencement of the pandemic the Trust Board outlined 2 strategic priorities:

1. To provide the best possible care for local people.

2. To ensure that the support provided for our employees was amongst the best available in the NHS.

The Trust's people strategy was published just before the pandemic and based upon 4 core principles, namely that we should work, grow, thrive and care together.

Many of the themes present in the Trust's people strategy are echoed in the recently published NHS People Strategy and it will be important that we focus upon the delivery of our people strategy if we are to successfully respond to the substantial challenges that we, in common with the rest of the NHS, now face.

In the Board meeting we will be considering how we are supporting the well-being of our people.

In this first Public Board meeting of the pandemic, I want to place on record my thanks to our people for the way in which they have responded to the most substantial challenge of this generation and to assure the public of our collective commitment to continue to mobilise to address their health needs.

Attached as Appendix 1 to this paper is my draft Chief Executive Summary of the principal issues outlined in the Trust's IPR.

East and North Hertfordshire NHS Trust

IPR – Chief Executives Summary

SAFE

- 6 new inpatients were admitted with Covid-19 in July. 1 of them is believed to be probably healthcare associated, i.e. first positive specimen was 8-14 days after admission.

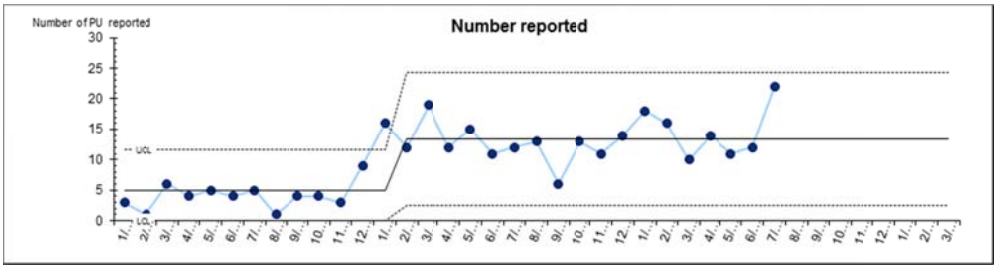
- Since this case, on the 24th of July, there have been no further healthcare associated cases.

- 26% of patients received all sepsis 6 interventions within 1 hour of red flag triggers in July.

- Our AIM is to achieve 95% of all sepsis 6 interventions in ED by March 2021, and 95% all sepsis 6 interventions in acute in-patient clinical areas by March 2021 and improvement plans (sepsis team now returning from Covid secondment in acute clinical areas, to sepsis posts) are being agreed. Deep dive/assurance will be provided at QSC end of Sept.

- There have been 12 grade 2 tissue damage incidents reported in July. This in an increase but remains within trust normal variation count (average 13/month)- SPC chart below

- 21% of wards are one year or more pressure ulcer free.



- Heel ulcers have reduced by 22%, however, we continue to see an increase in Medical Device Related Pressure Ulcers (MDRPU).

- Medical Device Related Pressure Ulcers have increased (from 8 to 24) when compared to the same period last year.

- This increase has instigated a QI project within critical care in collaboration with Tissue viability due to 65% of trust wide data of this harm reported this year occurring within the critical unit. The increase is mostly due to an increase in the use of devices to manage critically unwell Covid 19 patients and the intrinsic mechanisms associated with the virus.

- Legionella - A number of enhanced water safety precautions have been implemented at MVCC following identification of a case of Legionella in a patient with a recent admission. Our authorised engineer states that we have achieved reasonable assurance. Monthly reviews are undertaken with our water safety group which comprises of infection control, estates, nursing and medical representation and validated by an external independent assessor appointed as our authorised engineer, again in line with statutory protocol.

CARING

- Hospital visiting continues to be permitted only in certain circumstances.

- Whilst hospital visiting is restricted, enabling family and friends to stay in touch with their loved ones remain a priority.

- The 'Stay in Touch' online service enables friends and relatives to send messages to inpatients via the Trust website. Since the service was set up at the end of April, nearly 600 messages have been delivered to patients to date.

- Our volunteer's service have also re-designed their roles to offer a new 'rapid response' service to support ward areas. This means on daily basis wards can call for support from volunteers to facilitate the co-ordination of more reliable liaison with families and carers.

- There is no national benchmarking data available for the FFT at the moment; Trusts were told to cease the monthly submission of FFT data to NHS Digital in March 2020 – data submission should be resuming from 1 December 2020.

EFFECTIVE

- Although the crude mortality rate remains higher than pre-Covid levels, there has been a substantial reduction from June to July.

- Although comparison of mortality rates is challenging the latest HSMR for May is encouraging.

- There has been an increase in readmissions consistent with the national picture.

- Mortality reviews have now resumed and 2 new review areas have been initiated.

  - Covid-19 patients who died on readmission within 28/7.

- Death in the community (Covid or Non Covid) within 28/7 of discharge.

RESPONSIVE

- Cancer performance is exceptionally encouraging. We are one of few Trusts in East of England to achieve the 62/7 standard.

- RTT – There are 483 52/52 breaches

- A risk stratification approach has been undertaken by each of the specialities, led by the clinical leads to ensure the immediate available capacity is utilised to prioritise the most clinically urgent patients. This has been validated via the system planned care recovery work stream and adopted by the national team. This ensures a consistent approach across the system to include the harm review process.

- The phase 3 recovery planning submissions underpin the work undertaken to increase activity to 80% of last year's activity in September and 90% in October.

- A formal demand and capacity approach is being undertaken to establish speciality baseline capacity, and then the resultant capacity gap is addressed through a set of initiatives which focus on productivity, demand management and workforce solutions.

- Through the recovery work it is anticipated that diagnostics (MRI, CT and U/S) will meet the recovery targets of 90% and 100% within quarter 3.

- A&E – There was an improvement in performance to just over 90% in July. Subsequent deterioration in August.

- We are reviewing the current configuration of the Red and Yellow EDs to establish if this is the optimum arrangement to support emergency patient flow through both the Covid negative and Covid query pathways.

WELL LED

- Turnover has increased in month, but overall we have reduced turnover by 1.1% over the past year.

- Appraisals Complete – 67% vs 90% target

- Revised appraisal paperwork has been launched and virtual training to support the delivery of appraisals has also commenced.

- Statutory and Mandatory Training Complete - The MaST transformation programme and recovery plan are on track and compliance has increased to 81.8%. Changes to staff who need to complete moving and handling training may impact compliance rates next month. Staff are now able to complete the majority of their mandatory and statutory training via e-learning which will automatically update on ESR. A full communication plan and support for staff with e-learning is being rolled out.

- Staff well-being – there has been an increase in days lost for mental health across the region.

SUSTAINABILITY

- We continue to operate under block reimbursements arrangements supplemented by both planned and reactive COVID top up reimbursements. As at M4 we required a total COVID top of c.3m in order to break even. This represents a run rate that will be continued into August and September.

- High level details of the financial framework moving into the autumn period and beyond, suggest that this will continue to be based on block payments and planned COVID top ups, although reactive levels of COVID funding will be allocated to systems rather than organisations. The value of blocks, top ups and system allocations remain to be determined. In addition from September under P3 guidance systems will be challenged to deliver enhanced levels of activity, with system under and over performance adjusted for against these targets. The system rules than underpin these arrangements remain to be determined, although on balance this represents a significant risk for the Trust.

- Whilst activity levels across the year to date are significantly below 'normal' levels costs have remained consistent with last year. Whilst an element of this contradiction is a consequence of the inevitable impact of agreed pay inflation, it also reflects the assessment that approximately 70% of Trust costs are likely to be fixed in nature in the short term irrespective of activity levels delivered.

- Variable temp staffing costs have continued at broadly pre COVID rates despite reduced activity and occupancy.

- The finance team are now working with divisions to establish appropriate check and challenge arrangements.

East and North Hertfordshire NHS Trust

Agenda Item: 8

TRUST BOARD - PUBLIC SESSION – 2 SEPTEMBER 2020

Integrated Performance Report – Month 4

Purpose of report and executive summary (250 words max): The purpose of the report is to present the Integrated Performance Report Month 4 to the Trust Board. Key challenges and mitigations under each domain are identified within the report.		
Action required: For discussion		
Previously considered by: Executive Committee – 26.08.20		
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	☒

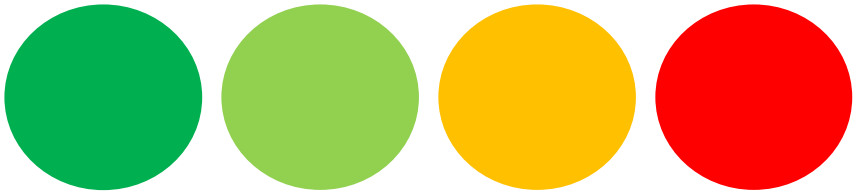
Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
Any other risk issues (quality, safety, financial, HR, legal, equality): Key challenges and mitigations under each domain are identified within the report.

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

East and North Hertfordshire NHS Trust

Integrated Performance Report

Month 04 | 2020-21



Data correct as at 21/08/2020

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	Jul-20	Local	1.9	2.1	
Caring	Staff Friends and Family Test % recommended - care	Quarterly	Q2 2019-20	National	81.3%	78.9%	
Safe	Occurrence of any Never Event	Monthly (six-month rolling)	Feb-20 - Jul-20	National	0	0	
Safe	Patient Safety Alerts not completed by deadline	Monthly	Aug-20	National	0	0	
Caring	Mixed-sex accommodation breaches	Monthly	Jul-20	National	0	no submission	
Caring	Inpatient scores from Friends and Family Test - % positive	Monthly	Jul-20	National (excl. IS)	95.0%	96.8%	
Caring	A&E scores from Friends and Family Test - % positive	Monthly	Jul-20	National (excl. IS)	90.0%	96.6%	
Caring	Maternity scores from Friends and Family Test - % positive - antenatal care	Monthly	Jul-20	National (excl. IS)	93.0%	100.0%	
Caring	Maternity scores from Friends and Family Test - % positive - birth	Monthly	Jul-20	National (excl. IS)	93.0%	100.0%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal ward	Monthly	Jul-20	National (excl. IS)	93.0%	100.0%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal community	Monthly	Jul-20	National (excl. IS)	93.0%	100.0%	
Safe	Emergency c-section rate	Monthly	Jul-20	Local	16%	15%	
Organisational health	CQC inpatient survey	Annual	2019	National	8.0	7.8	
Safe	Venous thromboembolism (VTE) risk assessment	Quarterly	Q3 2019-20	National	95%	88.1%	
Safe	Clostridium difficile (C. difficile) plan: C.difficile actual variance from plan (actual number v plan number)	Monthly (YTD)	Jul-20	NHSI	0	tbc	
Safe	Clostridium difficile – infection rate	Monthly (12-month rolling)	Aug-19-Jul-20	National	17.64	23.80	
Safe	Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Monthly (12-month rolling)	Aug-19-Jul-20	National	0.61	2.41	
Safe	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	Monthly (12-month rolling)	Aug-19-Jul-20	National	6.96	5.29	
Safe	Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI)	Monthly (12-month rolling)	Aug-19-Jul-20	National	16.25	17.32	
Effective	Hospital Standardised Mortality Ratio	Monthly (12-month rolling)	Jun-19 - May-20	National	100	83.5	
Effective	Summary Hospital-level Mortality Indicator	Monthly (12-month rolling)	Apr-19-Mar-20	National	100	90.2	
Safe	Potential under-reporting of patient safety incidents	Monthly (six-month rolling)	Jul-19-Jun-20	National	55.3	47.5	

Finance

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

Operational performance

A&E	A&E maximum waiting time of four hours from arrival to admission/transfer/discharge	Monthly	Jul-20	National	95%	90.1%	
RTT 18 weeks	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	Monthly	Jul-20	National	92%	46.77%	
Cancer Waiting Times	62-day wait for first treatment from urgent GP referral for suspected cancer	Monthly	Jun-20	National	85%	85.31%	
Cancer Waiting Times	62-day wait for first treatment from NHS cancer screening service referrals	Monthly	Jun-20	National	90%	NIL	
Diagnostics Waiting Times	Maximum 6-week wait for diagnostic procedures	Monthly	Jul-20	National	1%	40.18%	
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%	-	

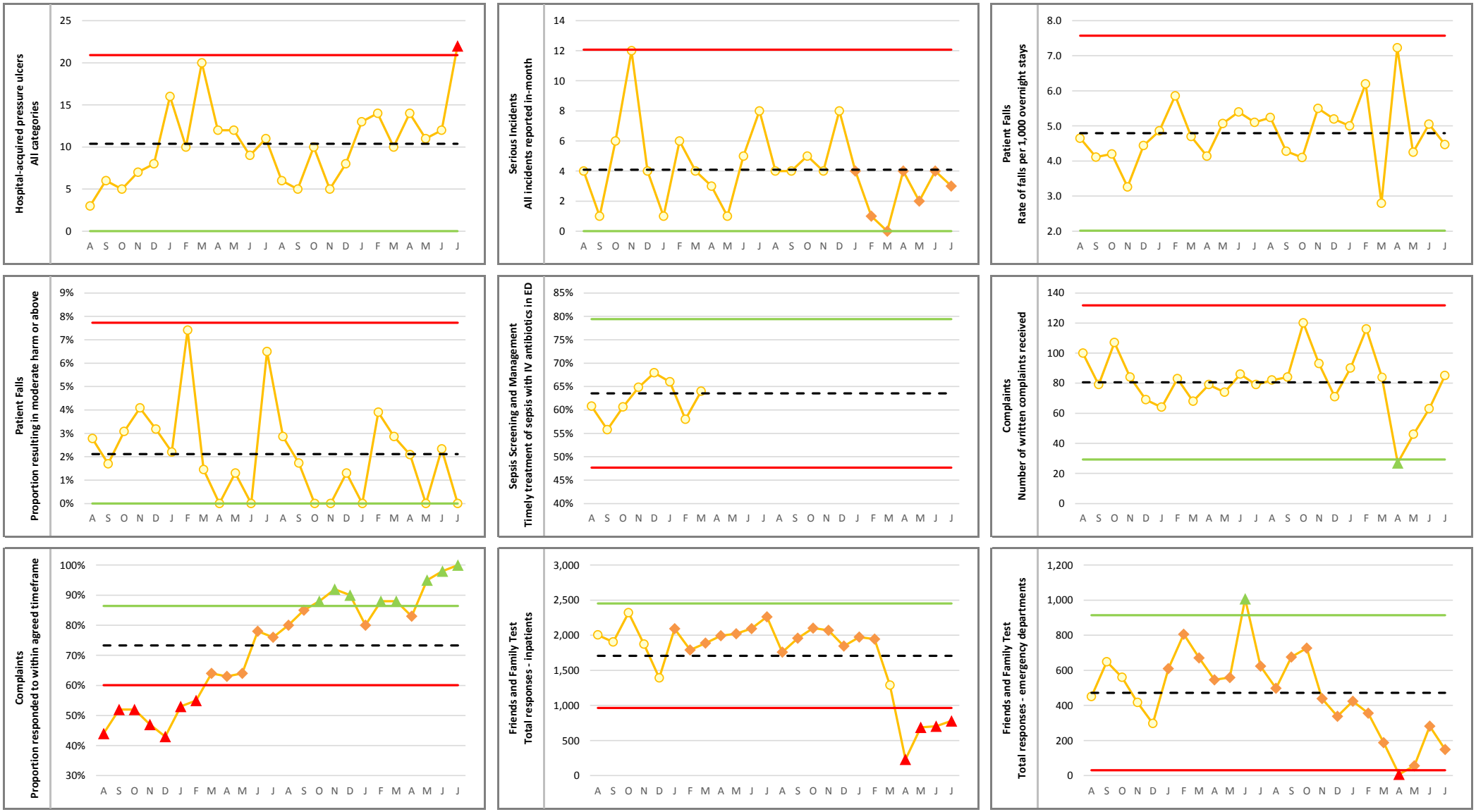
Leadership and workforce

Organisational health	Staff sickness	Monthly	Jul-20	Local	3.4%	3.72%	
Organisational health	Staff turnover	Monthly	Jul-20	Local	12.0%	12.9%	
Organisational health	Proportion of temporary staff	Monthly	Jul-20	Local	-	12.9%	
Organisational health	NHS Staff Survey Recommend as a place to work	Annual	2019	National	63.3%	58.1%	
Organisational health	NHS Staff Survey Support and compassion	Annual	2019	National	20.9%	22.5%	
Organisational health	NHS Staff Survey Teamwork	Annual	2019	National	65.5%	66.2%	
Organisational health	NHS Staff Survey Inclusion	Annual	2019	National	87.8%	86.7%	
Organisational health	BME leadership ambition (WRES) re executive appointments	Annual	2019	National	7.4%	0.0%	

Quality Improvement Dashboard

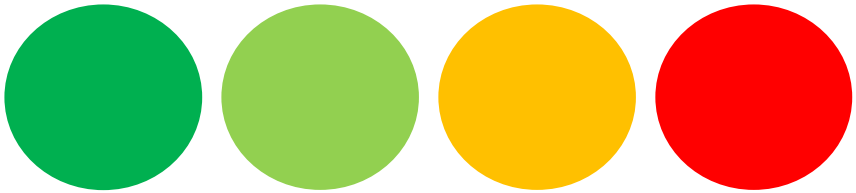
Safe, Caring and Effective Services Headline Metrics

East and North Hertfordshire NHS Trust



Safe Services

Month 04 | 2020-21



Key Issues

Patient Falls
- 46 inpatient falls were recorded in July.
- Number of falls in July resulting in serious harm = 0.

Serious Incidents & Never Events
- It has been 299 days since the last reported Never Event (as at 19th Aug 2020).
- There were 4 serious incidents reported in July.
  - 2 Maternity - 1 delayed escalation of blood results and 1 failure to recognise labour.
  - 1 Thematic review of failed otr sub-optimal discharges.
  - 1 Delay in treatment of fracture.
  - Others requiring local learning, complaint response or no further action.

Infection Prevention & Control
- COVID-19: 6 new inpatient cases in July (1 Probable Healthcare Associated, 5 Community Onset). Since 14/05/20, 9 Definite & Probable Healthcare Associated cases & 46 Indeterminate & Community Onset cases.
- MRSA bacteraemia = 0 Hospital Onset cases in July.
- C difficile infections = 3 reportable cases in July (1 Hospital Onset & 2 Community Onset.)
- E.coli bacteraemia = 2 Hospital Onset cases in July.
- MSSA bacteraemia = 0 Hospital Onset cases in July.
- Klebsiella bacteraemia = 0 Hospital Onset cases in July.
- Pseudomonas aeruginosa bacteraemia = 1 Hospital-onset case in July.
- Hand hygiene compliance was 93.55% in July (Target 80%).
- 1 case of Legionella identified in a MVCC patient which is being investigated to identify the possible source.

Hospital-acquired Pressure Ulcers
- There were the following reported for July:
  - Category 4 incl. (d) = 0
  - Category 3 incl. (d) = 0
  - Category 2 incl. (d) = 12
  - MM incl. (d) = 1
  - Unstageable incl. (d) = 1
  - SDTI incl. SDTI (d) = 8

Sepsis
- The sample of Inpatients was 6 in July.
- ED (19) Sepsis cases has increased in July.
- The sample showed the average time in Emergency Attendances receiving antibiotics within 1 hour of Red Flag has deteriorated (63%).
- The sample showed an average time to antibiotic administration within in patient setting was 67% within 1 hour of Red Flag in July.
- 26% of patients received all Sepsis 6 interventions within 1 hour of Red Flag triggers in July.

VTE
- Potential harm from Hospital Associated Thrombosis is presented to Serious Incident Review panel.
- There were zero HATs RCA reports presented to SIRP in July 2020.

Executive Response

Patient Falls
- We continue to monitor all falls, level of harm and themes across the Trust.
- A new Trust Clinical Lead has now started. Priorities include improving the reliability of falls risk assessments and an MDT Quality Improvement team has started within ward 8a, where safer medication review has been identified as a key improvement driver.

Serious Incident Review Panel
- 29 cases were presented to the SIRP in July 2020.
- 5 cases require RCA investigation; 4 have been reported as serious incidents.

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;
  - Hospital-Onset Definite Healthcare-Associated - First positive specimen date 15 or more days after admission.
- The IPC team continue to carry out internal reviews of Probable and Definite Healthcare-Associated cases to identify any lapses and/or learning. The post infection reviews are discussed in Divisional and Trust IPC meetings to ensure that recommended actions are implemented (no target has been set by NHSE/I). The last Definite Healthcare Associated case was on 19/05/20 and the last Probable Healthcare Associated case was on 24/07/20. The review of this case identified that the patient was not swabbed for COVID-19 on admission nor after 7 days and this has been fed back to the relevant teams.
- There has been no hospital-onset MRSA bacteraemia year-to-date. There have been 3 Community Onset cases year to date and the Trust has participated in joint post infection reviews.
- The IPC team have introduced internal reviews for all Hospital Onset gram negative bacteraemia and a formal post infection review process for Hospital Onset E.coli bacteraemia is currently being finalised.
- C.difficile internal PIRs have taken place for the 9 cases up to end June. There were no lapses contributing to the acquisition of the infection, but some learning was identified relating to antimicrobial stewardship and documentation and this has been fed back to the clinical teams. PIR meetings are pending for the 3 cases in July.
- Following the identification of a positive Legionella urinary antigen result on 27/07/20 for a patient with a recent admission to MVCC, an Incident Control Team was established, comprising representatives from ENHT, MVCC, Hillingdon Hospital, North West London HPT and East of England HPT. Additional water samples from various sites have been tested and further tests are being carried out as part of the proactive response to ensure patient safety.
- At least 116 members of staff attended virtual Water Safety training sessions delivered by the Trust's external Authorising Engineer for Water.

Hospital-acquired Pressure Ulcers
- Learning from July has seen tissue damage secondary to prone patient positioning related damage. TVN and Critical Care are working together to learn and improve risk assessments for future care delivery.

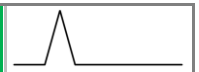
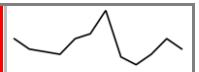
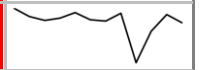
Sepsis
- Themes to improve within Sepsis management include fluid balance management. This continues to be a priority for improvement efforts within CCOT & Sepsis team. The team are currently reviewing operational procedures to align opportunities. New team structures are currently being reviewed.
- A new named Clinical Lead for Sepsis has now been identified.

VTE
- The data to identify VTE cases to undergo a HAT review is still being collected. Learning from VTE RCAs has successfully been shared across specialties in virtual 'Rolling Governance Days".

Safe Services

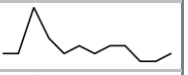
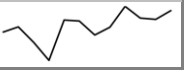
NHS
East and North Hertfordshire
NHS Trust

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	
01-31 Jul	6	0	1	0	5	9	46	

Domain	Metric	Target	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Trend
Events and Incidents	Number of Never Events	0	0	1	1	0	0	0	0	0	0	0	0	0	
	Number of Serious Incidents	5	4	4	5	4	8	4	1	0	4	2	4	3	
Hospital-acquired Pressure Ulcers	Category 4 - inc Category 4 (d)	0	0	0	0	1	0	0	0	0	0	0	0	0	
	Category 3 - inc Category 3 (d)	0	0	0	0	1	0	0	0	0	0	0	0	0	
	Category 2 - inc Category 2 (d)	2	0	2	2	2	0	3	3	3	3	3	3	12	
	Mucosal membrane (d) Device-related	-	0	1	2	0	0	0	1	0	0	1	4	1	
	Unstageable inc Category Unstageable (d)	1	2	0	1	1	1	1	1	0	1	0	0	1	
	SDTI inc STDI (d)	3	4	2	5	0	7	9	9	7	10	7	5	8	
Sepsis Screening and Management	Inpatients with Sepsis - sample size	50	10	6	5	4	10	12	21	3	n/a	4	10	6	
	Inpatients receiving IVABs within 1 hour of Red Flag	90%	40%	17%	40%	50%	38%	28%	25%	33%	n/a	0%	60%	67%	
	Emergency attendances with Sepsis - sample size	50	22	15	12	18	19	59	69	41	n/a	4	17	19	
	Emergency attendances receiving IVABs within 1 hour of Red Flag	90%	86%	73%	67%	71%	79%	68%	66%	78%	n/a	50%	76%	63%	
	Sepsis six bundle compliance - ED	90%	68%	40%	12%	22%	73%	14%	14%	29%	n/a	0%	29%	26%	

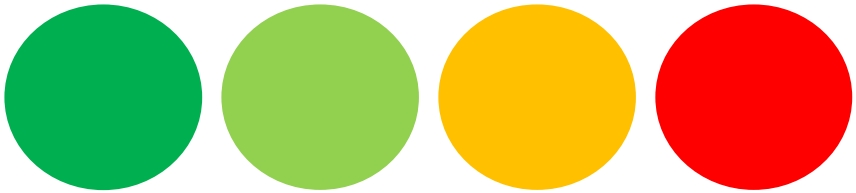
Safe Services

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Trend
VTE	VTE risk assessment	95%	87.2%	83.5%	88.8%	87.5%	87.9%	88.0%	tbc	tbc	tbc	tbc	tbc	tbc	
Infection Control	Number of MRSA incidences	0	0	1	0	0	2	1	0	0	0	0	0	0	
	Rate of MRSA incidences per 100,000 bed days	0.6	0.0	6.0	0.0	0.0	11.4	5.8	0.0	0.0	0.0	0.0	0.0	0.0	
	Number of c.difficile incidences Healthcare-associated	4	5	5	9	7	5	2	4	6	3	4	2	3	
	Rate of c.difficile incidences per 100,000 bed days Healthcare-associated	19.0	28.8	29.8	51.1	41.1	28.4	11.5	24.6	34.6	17.1	22.1	11.4	17.3	
	Number of e.coli incidences	-	2	2	8	4	2	3	2	3	3	1	1	2	
	Rate of e.coli incidences per 100,000 bed days	18.5	11.5	11.9	45.5	23.5	11.4	17.3	12.3	17.3	17.1	5.5	5.7	11.5	
	Number of MSSA incidences	-	1	0	4	1	1	1	0	0	0	0	2	0	
	Rate of MSSA incidences per 100,000 bed days	8.0	5.8	0.0	22.7	5.9	5.7	5.8	0.0	0.0	0.0	0.0	11.4	0.0	
	Number of klebsiella incidences	-	3	3	0	0	3	0	1	0	0	1	0	0	
	Rate of klebsiella incidences per 100,000 bed days	7.6	17.3	17.9	0.0	0.0	17.0	0.0	6.2	0.0	0.0	5.5	0.0	0.0	
	Number of pseudomonas aerudinosa incidences	-	1	0	0	0	1	1	1	0	0	0	0	1	
	Rate of pseudomonas aerudinosa incidences per 100,000 bed days	3.7	5.8	0.0	0.0	0.0	5.7	5.8	6.2	0.0	0.0	0.0	0.0	5.8	
	Hand hygiene audit score	80%	91%	91.4%	89.3%	86.9%	92.3%	92.2%	90.3%	91.3%	94.1%	92.5%	92.4%	93.6%	
Patient Falls	Number of patient falls	72	70	58	59	75	77	70	77	35	48	35	43	46	
	Rate of patient falls per 1,000 overnight stays	4.0	5.2	4.3	4.1	5.5	5.2	5.0	6.2	2.8	7.2	4.3	5.1	4.5	
	Number of patient falls resulting in serious harm	0	0	0	0	0	0	0	0	1	1	1	1	0	

Caring Services

Month 04 | 2020-21



Key Issues

Friends and Family Test (FFT)

- The proportion of positive responses in July for IP (96.8%) was up from June (93.8%), A&E (96.6%) was up from June (89.0%) and OP (98.9%) was down from June (99.0%). All are above their Trust targets in July.
- The proportion of positive responses for Antenatal, Births, and Postnatal Wards and Community were all at 100% in July.
- Total Responses for Inpatients (780) and OP (369) have both increased from June but remain well below their Trust targets.
- Total Responses for A&E (149) and Births (1) have both decreased from June.

Complaints

- Total number of complaints received in July 2020 = 85. The breakdown by division is as follows:
  - Surgery 20
  - Medicine 30
  - W&C 21
  - CSS 7
  - Cancer 2
  - Operations 5
- 100% of complaints received were acknowledged within 3 working days in July.
- 99% were responded to within the agreed timeframe in July.
- There were 88 open complaints at end of July 2020.

Executive Response

Friends and Family Test (FFT)

- Through July, post discharge phone calls have continued to provide feedback alongside the completion of paper and electronic surveys. In July we saw a slight increase in the receipt of completed paper surveys but this is still significantly below the receipts pre-pandemic and continues to be encouraged.
- As we are now asking the new FFT question 'overall, how was your experience of our service?' and using different collection methods/time, the FFT results since April should not be compared to those prior to March 2020.
- Hospital visiting is still restricted and 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. Restrictions on visiting continue to be kept under constant review by the patient experience group.
- 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. The 'Stay in Touch' service enables friends and relatives to send messages to inpatients via the Trust website. Since the service was set up at the end of April, nearly 600 messages have been delivered to patients to date.
- Through COVID-19 management communication with family and carers has also been supported in some wards through a Family Liaison Clinical service (Flic). The service aligns with MDT ward care and proactively communicates with family and carers daily to maintain communication with loved one. There are currently new quality improvement initiatives in place on wards 10b and 6a to scale and spread learning from FLIC services.

Quality Improvement: Discharges

- Triangulation of complaints, patient feedback and patient safety data has highlighted the requirement to prioritise a review and improvement of our whole systems and processes surrounding the discharge of our patients. This is a Trust wide, multi-professional and collaborative approach.

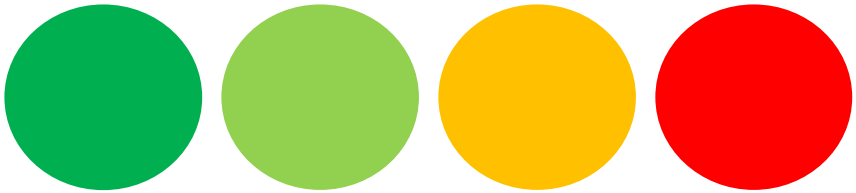
Caring Services

NHS
East and North Hertfordshire
NHS Trust

Domain	FFT	Metric	Target	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Trend
Friends and Family Test	Inpatients	Proportion of positive responses	95%	96.9%	96.9%	96.3%	97.6%	96.3%	96.7%	96.8%	97.3%	92.7%	90.7%	93.8%	96.8%	
		Total number of responses	1,778	1,760	1,959	2,102	2,071	1,847	1,975	1,946	1,288	233	689	705	780	
	A&E	Proportion of positive responses	90%	94.0%	88.9%	90.0%	89.3%	88.5%	91.3%	94.4%	93.1%	100.0%	92.9%	89.0%	96.6%	
		Total number of responses	1,241	498	676	727	439	338	424	356	188	8	56	282	149	
	Maternity	Antenatal care Proportion of positive responses	93%	100.0%	92.3%	100.0%	100.0%	100.0%	100.0%	92.3%	100.0%	n/a	100.0%	n/a	100.0%	
		Birth Proportion of positive responses	93%	92.9%	98.1%	95.6%	90.3%	94.6%	95.4%	93.9%	98.2%	95.7%	n/a	100.0%	100.0%	
		Birth Total number of responses	137	98	106	135	124	93	65	114	110	23	0	2	1	
		Postnatal ward Proportion of positive responses	93%	88.8%	94.3%	84.4%	83.9%	85.9%	86.2%	83.3%	92.7%	95.7%	n/a	100.0%	100.0%	
		Postnatal community Proportion of positive responses	93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	n/a	n/a	n/a	100.0%	
	Outpatients	Proportion of positive responses	95%	95.4%	94.5%	94.8%	95.0%	95.8%	96.8%	95.9%	96.4%	97.6%	95.8%	99.0%	98.9%	
		Total number of responses	-	3,313	2,448	3,127	2,133	1,777	2,429	2,273	1,276	83	271	204	369	
Complaints		Number of written complaints received	92	82	84	120	93	71	90	116	84	27	46	63	85	
		Rate of written complaints received	1.9	1.8	1.7	2.2	1.8	1.6	1.8	2.5	2.1	1.0	1.4	1.6	2.1	
		Proportion of complaints acknowledged within 3 working days	75%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	82%	100%	
		Proportion of complaints responded to within agreed timeframe	80%	80%	85%	88%	92%	90%	80%	88%	88%	83%	95%	98%	99%	

Effective Services

Month 04 | 2020-21



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 from 14.1 deaths per 1,000 admissions in June to 9.6 in July.
- The rolling 12-months crude mortality rate increased slightly again to 12.6 deaths per 1,000 admissions in the 12 months to July, but is lower than the most recently available national rate of 15.7 deaths per 1,000 admissions (Jun-19 to May-20).

Hospital-Standardised Mortality Ratio

- The in-month HSMR is at 84.0 in May, and remains better than the standard (100).
- The rolling 12-months HSMR is at 83.5 in the 12 months to May.
- 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 March has increased to 90.2.

Re-admissions

- The re-admission rate for 12 months to May has increased to 10.2% from the April position of 8.1%.

Learning from Deaths

- Where mortality reviews give rise to significant concern regarding the quality of care or the avoidability of the death, the case is subject to further scrutiny and discussion at the relevant Specialty clinical governance forum. The outcomes of these reviews are then considered by the Mortality Surveillance Committee.
- Following the core COVID-19 period the conduct of mortality reviews has now restarted. In addition to routine reviews 2 areas have been identified for further assurance and learning on the back of the COVID -19 pandemic: (1) Review of COVID-19 patients who died on a readmission within 28 days; (2) Deaths in the Community (COVID-19/nonCOVID-19) within 28 days of discharge.
- 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-19 period, saw a marked increase, influenced more by the significant reduction in the number of inpatients than by an increase in deaths. May , June, July 2020 saw significant decreases back to pre-COVID-19 level.

Hospital Standardised Mortality ratio (HSMR)

- Our current HSMR of 83.5 (rolling 12 months to May 2020) positions us 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. However, this has been followed by 2 months of reduction in April and May. Rolling 12 month HSMR has reduced every month since January 2020.
- **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 90.2 (March 2020) sees the Trust as one of the best placed in the 'as expected' band. This places us 19th 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 period Mar-May 2020 has seen a marked fall in numbers of readmissions, although these result in a significant increase in readmissions as a percentage of admissions. The significaNT changes in overall admissionsa and the change in case mix during this period make interpretation of this data a challenge.

Learning from Deaths

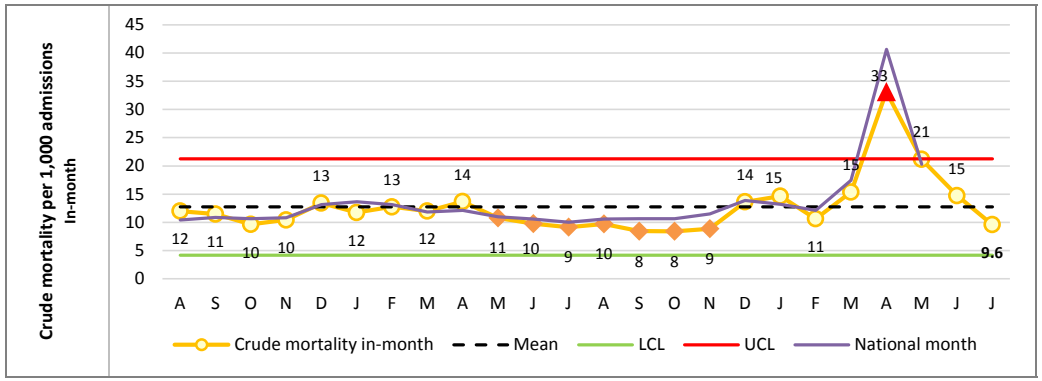
- In addition to the outcomes of cases escalated to Specialties being considered by the Mortality Surveillance Committee, the quarterly Learning from Deaths report includes a summary of key themes emerging from these cases. This detail is shared with all Trust Specialties and with interested working 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-19/non-COVID -19 deaths.

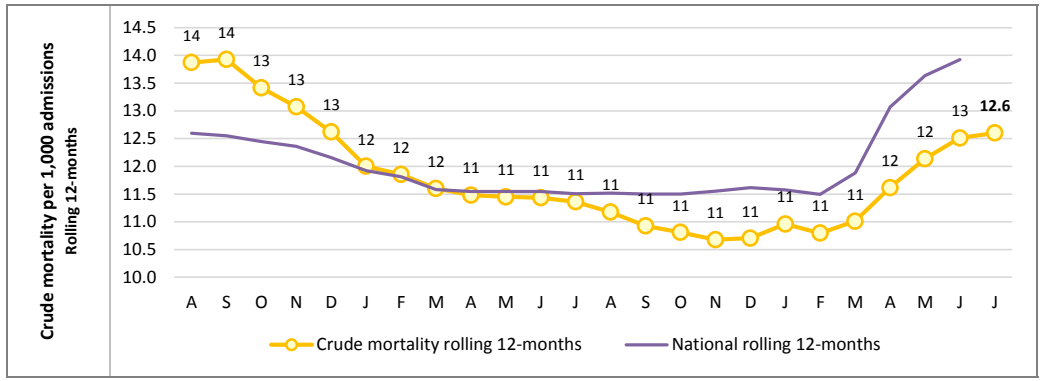
Specialist Palliative Care

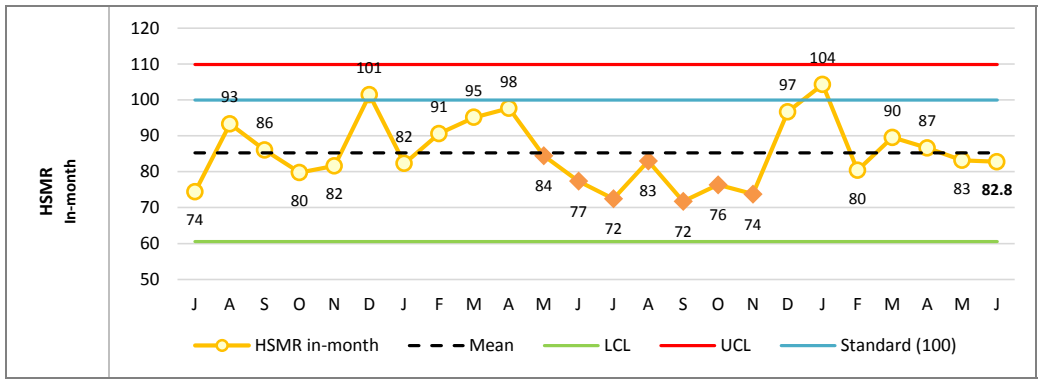
- This data refers solely to patients under the care/review of the Palliative Care Team. Other data is available for deaths that are not known to the PCT. However, it resides in an access database and we are currently working through some data quality issues.

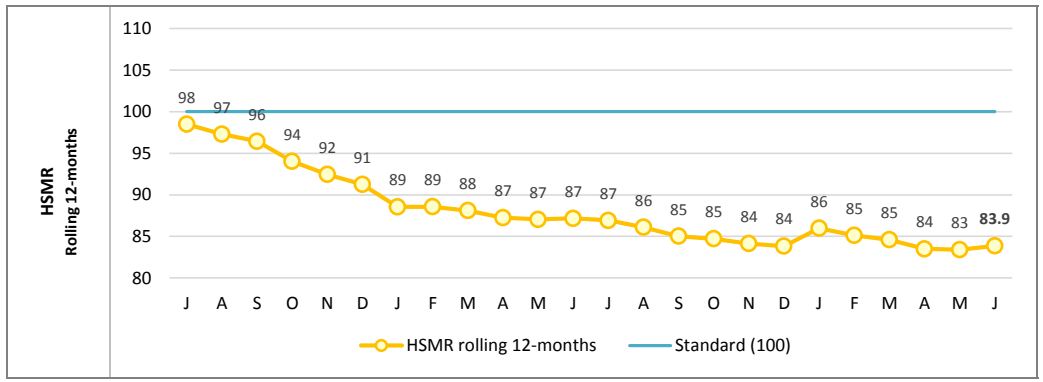
Effective Services

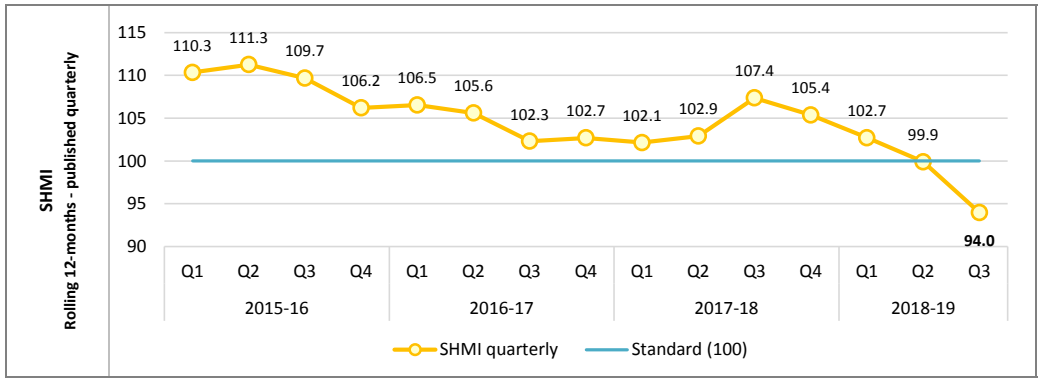
East and North Hertfordshire NHS Trust

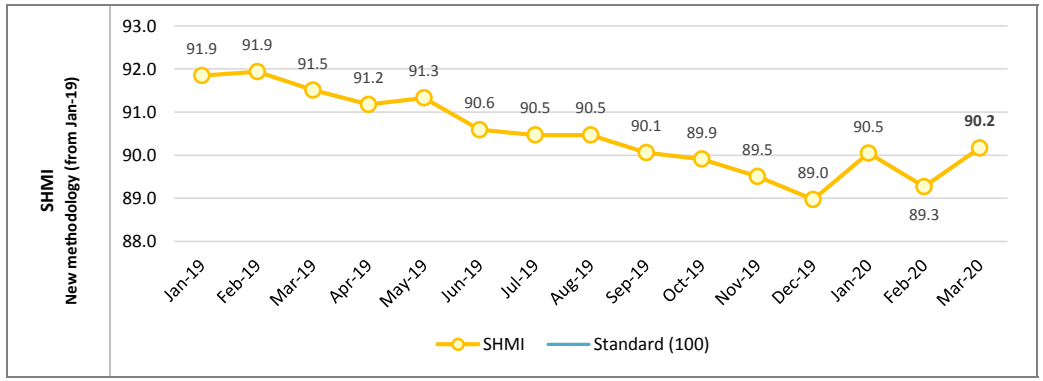






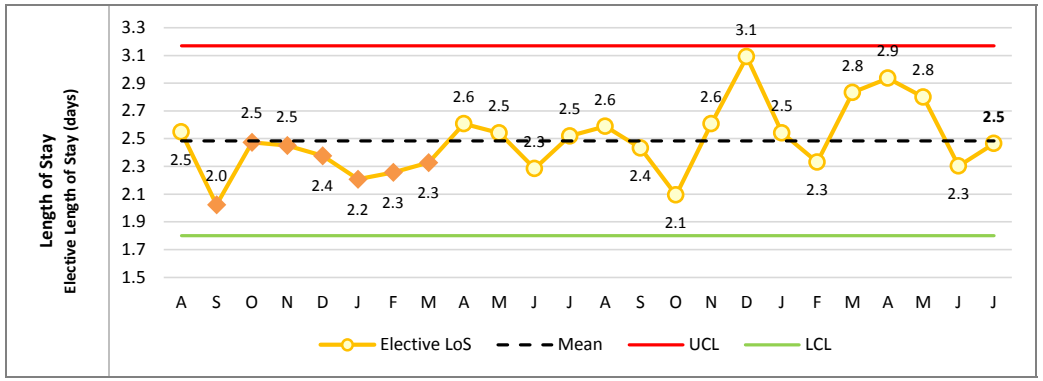


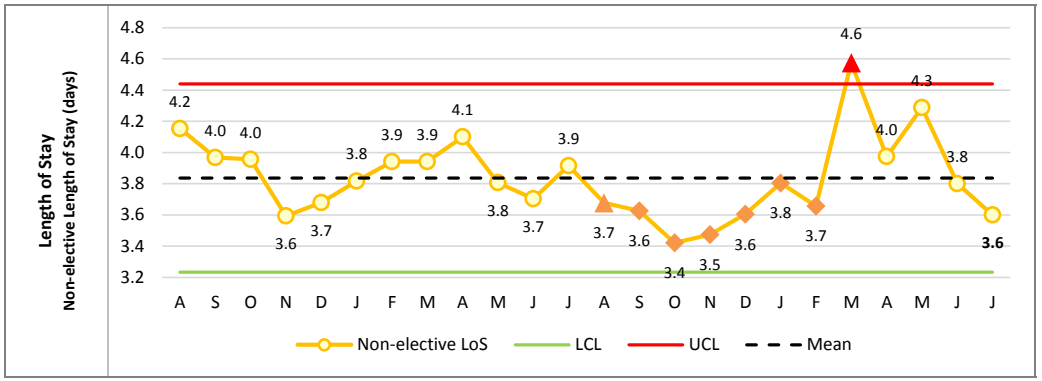


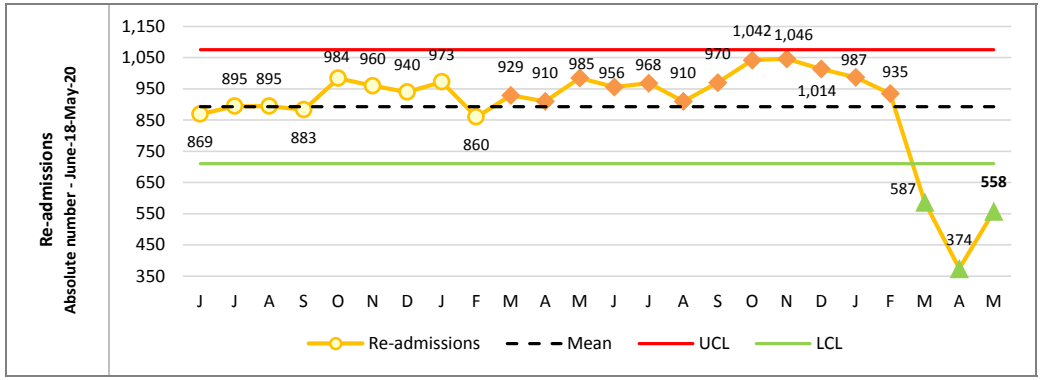


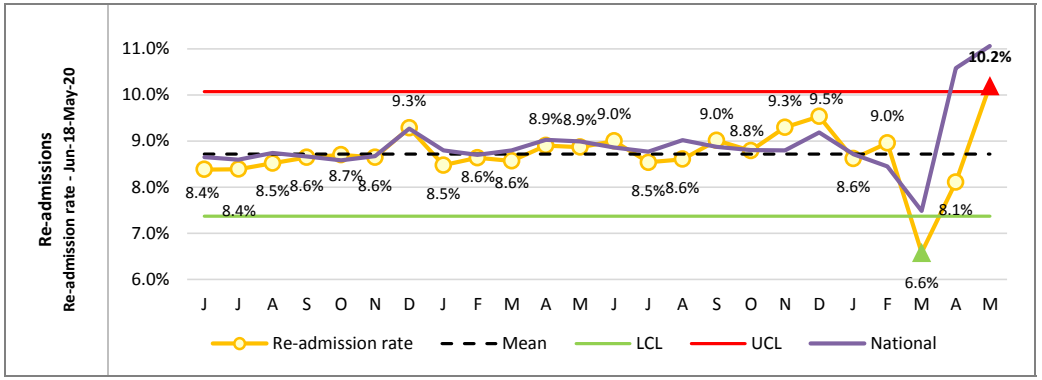
Effective Services

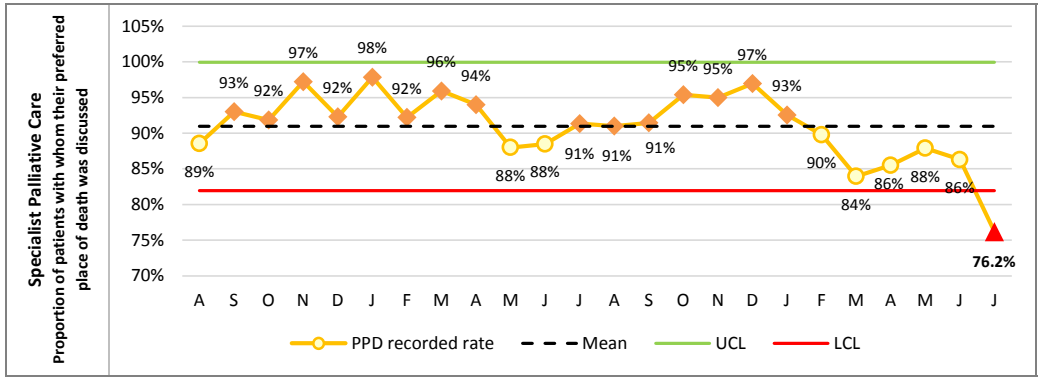
East and North Hertfordshire NHS Trust

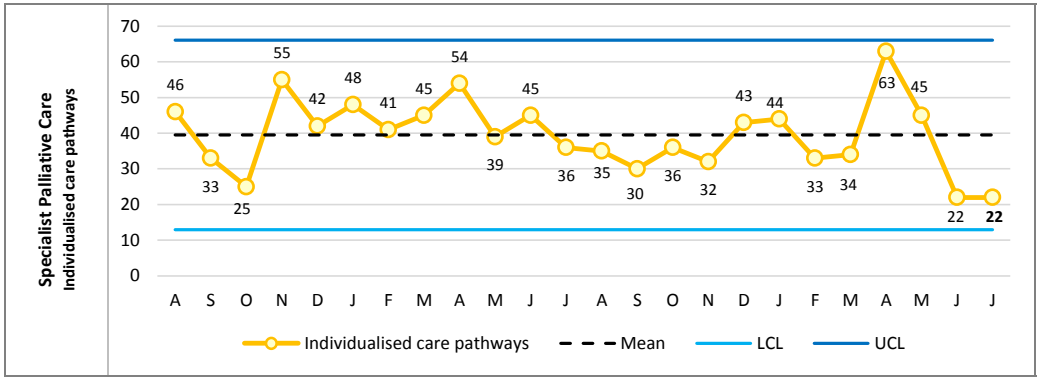






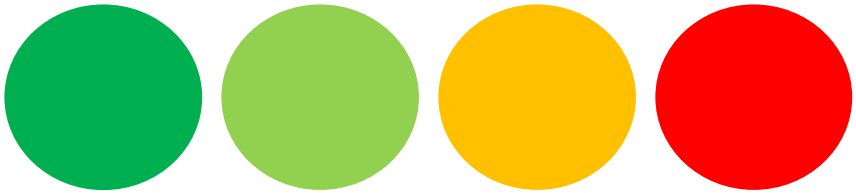






Responsive Services

Month 04 | 2020-21



Key Issues

A&E
- Performance for the month of July 2020 was 90.11%.
- There were no 12-hour trolley waits reported in July.

Cancer Waiting Times
- The Trust achieved 8 out of the 8 national targets for cancer performance in June.
- The Trust 62-day performance for June was 87.8%.
- Good progress continues on the speciality cancer action plans, all plans being reviewed and updated weekly.
- Robust weekly cancer PTL management is in place.

RTT
- Incomplete performance for July was 46.77% a continued deterioration from the 49.52% performance reported in June.
- The July backlog was 24,403, an increase of 739 from June.
- There were 483 52-week breaches reported in the July incomplete position, an increase of 293 from the 190 reported in June.
- Robust weekly RTT PTL management is in place.

Diagnostics
- DM01 performance for July was 40.18% against the national standard of 1% and the June position of 49%.
- Recovery of Ultrasound and MRI DM01 expected in October.

Stroke
- Stroke performance for July was 67.9%.
- Thrombolysis performance remains above the target of 11%, 15.8% in July.
- Door-to-needle performance has significantly increased in July to 44.4%, although remains well below the target of 70%. Task an d Finish group in place for review of Thrombolysis pathway based on the outcome of the Audits and data review from SNNAP.
- One of the current reasons for the decline in performance is the impacted the ED spilt in response to COVID and timing to CT scanning.
- CT 1hr to scanning has taken a declined and hasn't met the 50% target - which therefore has a delay within the Stroke pathway.

Executive Response

A&E
- Performance improved in July to 90.11% despite an increase of attendances of >1200 in the month.
- Admitted performance demonstrated a dramatic improvement from 65.43% in June to 72.20% in July.
- Success as a whole is reflective of the rapid improvement action plan which commenced in late May.
- The main contributory factor for the dramatic improvement in July was increased assessment capacity with the opening of incre ased Yellow Assessment area. In addition the Trust implemented improved escalation processes including a trust wide WhatsApp grou p operating 24/7 enabling early identification of triggers that may impact upon performance to enable early mitigation and resp onse e.g. highlighting arrivals over the last hour and the impact this may have to speciality referrals, diagnostics and flow into assessment.
- Further projects to sustain improvement include continued work surrounding bed configurations and introduction of Frailty Assessment and SDEC pathways.
- Ambulance handovers improved from an average of >24mins in June to <20mins in July. This was achieved through a 'straight to yellow' pilot, which commenced in early July. This pilot continues throughout August with a view to formally review in early September and embed as business as usual by October 2020.

Executive Response (continued)

Cancer performance (June)
- In June, the Trust achieved 8 of the 8 national targets for cancer performance: 2ww, 2ww Breast Symptoms, 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 June 2020 the Trust performance was 99.3%.
- In June 2020, the Trust wide average days wait for first appointment is at 8 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 June 2020, the Trust performance was 98.6%.
- The Trust has consistently delivered the 31-day second or subsequent treatment for Radiotherapy and Chemotherapy but not for the subsequent surgery. For June 2020 the Trust Chemotherapy performance was 100%, the Trust Radiotherapy performance was 99.0% and the Trust subsequent Surgery performance was 100%.
- 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 June 2020, the Trust performance for the Faster Diagnosis is 85.9% for the 2ww patients, 88.7% for Breast Symptomatic and 0.0% for screening patients due to Covid-19.
- Reported 62-day performance for June 2020 was pre-sharing 86.7% and post sharing 87.8%.

RTT
- Performance deteriorated further in June and remains significantly below our trajectory. Backlog pressures have increased due to the COVID-19 pandemic.
- Clinicians have reviewed their elective PTLs and risk-stratified patients according to clinical need.
- The independent sector has been utilised to treat our clinically urgent and long waiting patients.
- There are now 18 theatres operational on the Lister site, plus the private sector.
- Recovery trajectory has been developed for Theatres which is in line with the NHSI/E activity expectations.
- Use of PPE, patient testing/shielding and staffing still remains limiting factors to recovery.

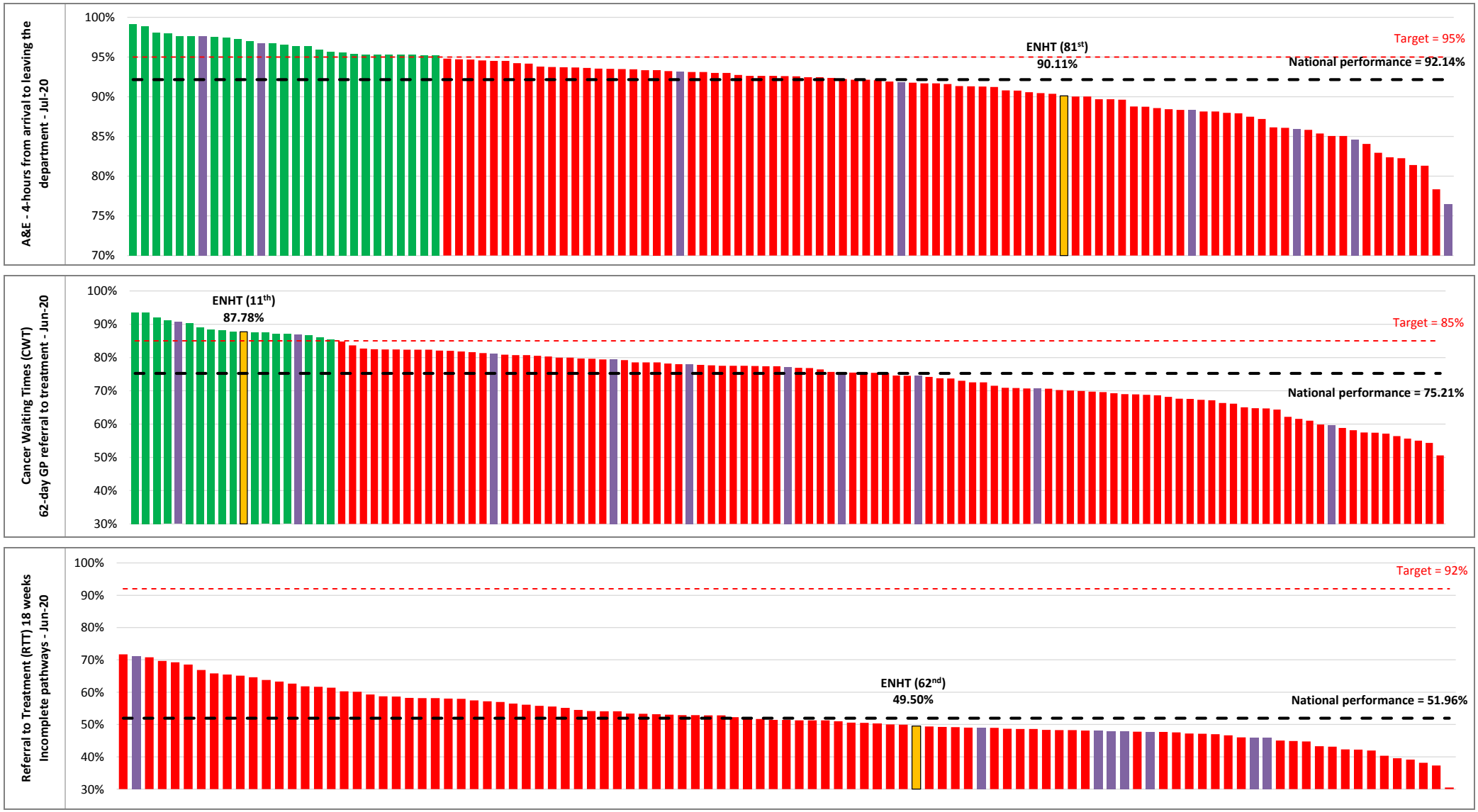
Diagnostics
- Diagnostic performance has not been delivered with the capacity being impacted by the COVID-19 pandemic, as a result of staff sickness, isolation and the number of aerosol generating procedures. This has now generated a backlog
- The Trust is following a post-COVID-19 diagnostic recovery plan.
- Changes in IPC regulation and the access to more testing have allowed an improvement in list utilisation.

Stroke
- Direct impact mainly due to changes in standard operating procedures in ED and CT scanning relating to COVID-19 policies. These impacted on delays to patients' pathways and therefore impact on performance indicators within the Stroke performance.
- Impact on of ED activity numbers and the spilt across the Red/Yellow Ed - impact on capacity of clerking patients following a DTA within the 4hrs.
- Ongoing review of data and pathways to support business case for SPR out-of-hours service to support ED.
- SNNAP rating performance reduction - main contributing factors are - OT/PT non-compliance of establishment in-line with National Specification - business case has been provided for approval to levels to be compliant and therefore provide the requirement of delivery of care in accordance of the SNNAP requirement.
- Direct impact on MDT working due to OT/PT staffing levels.
- Door to Needle performance - Task and Finish group to review and improvement plans for recovery of performance.
- Thrombolysed within 60-minutes of arrival rate was 44.4% in June. 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.

Responsive Services

Trust performance against all Trusts nationally

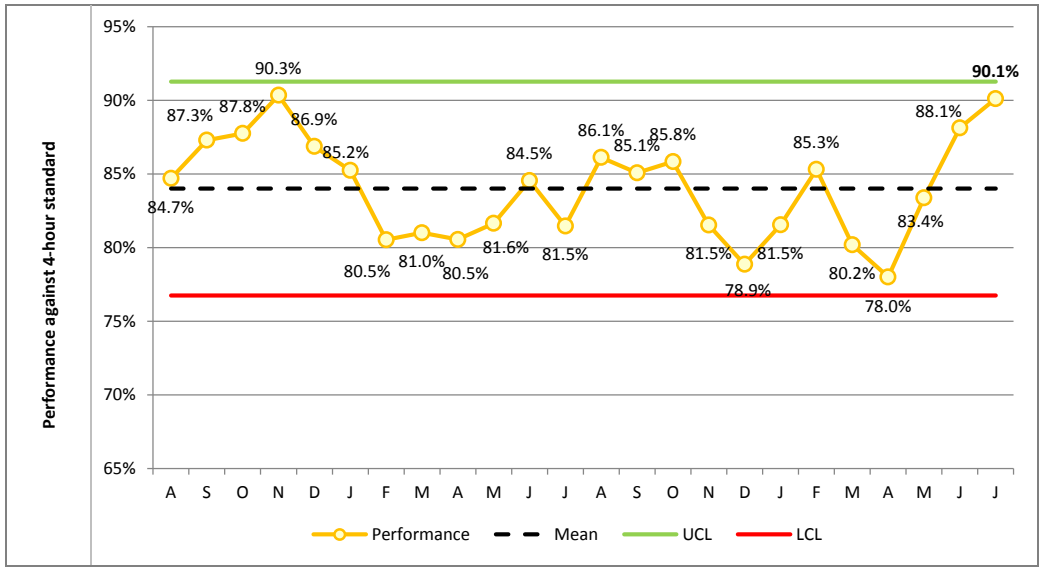
East and North Hertfordshire NHS Trust



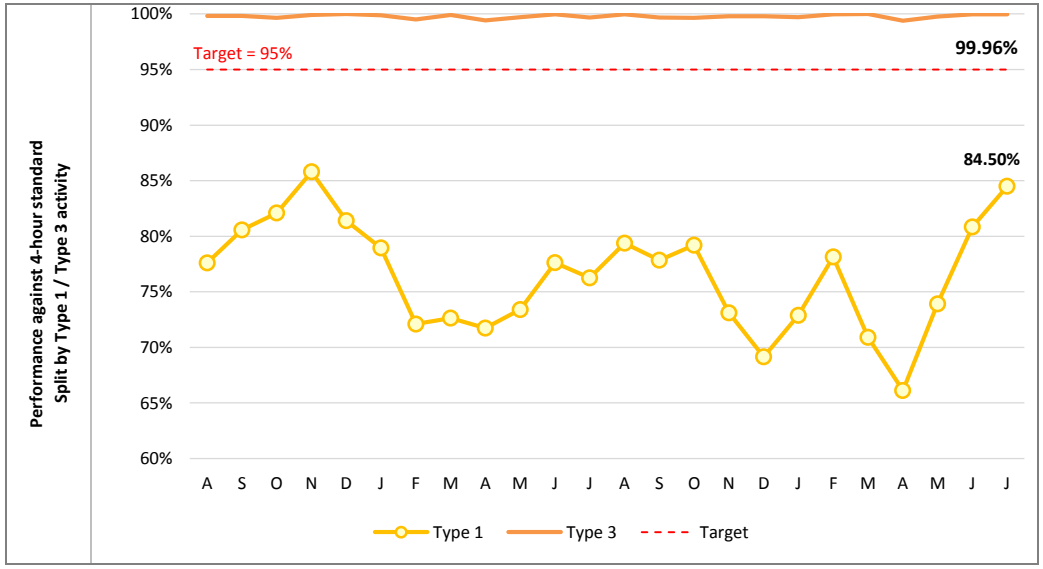
Responsive Services

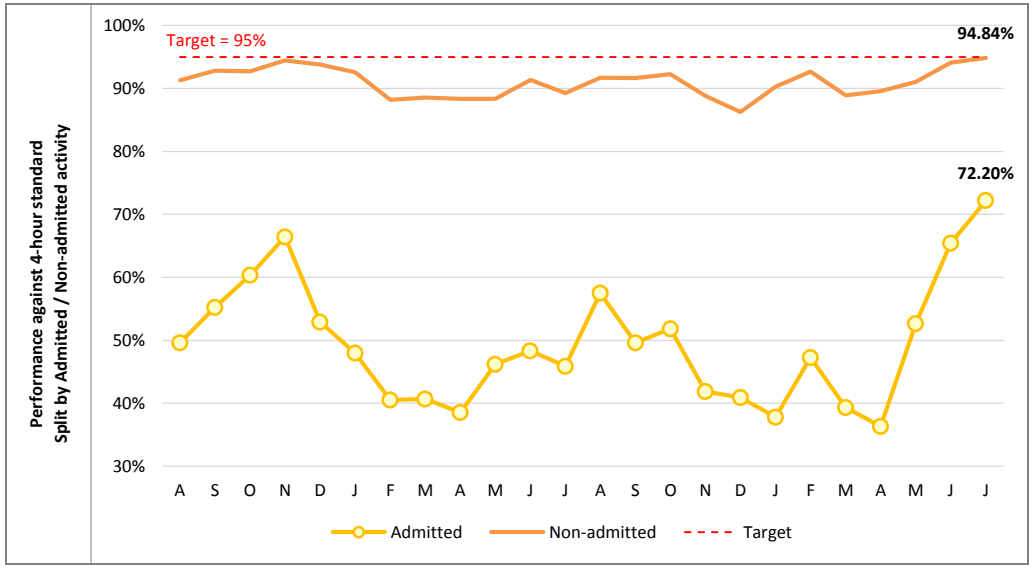
Emergency Department Performance

East and North Hertfordshire NHS Trust



Domain	Metric	Target	Jun-20	Jul-20	Change	Trend
Other Emergency Department measures	Ambulance handovers Proportion within 15 minutes	-	65%	tbc	▲	
	Ambulance handover breaches 30 minutes	334	76	tbc	▼	
	Ambulance handover breaches 60-minutes	73	2	tbc	▼	
	Attendance to admission conversion rate	-	38.2%	39.1%	▲	
	Time to initial assessment 95th centile	15	34	35	▲	
	Time to treatment Median	60	54	63	▲	
	Left department before being seen for treatment	5%	0.87%	0.91%	▲	
	Unplanned re-attendance rate	5%	6.76%	6.13%	▼	





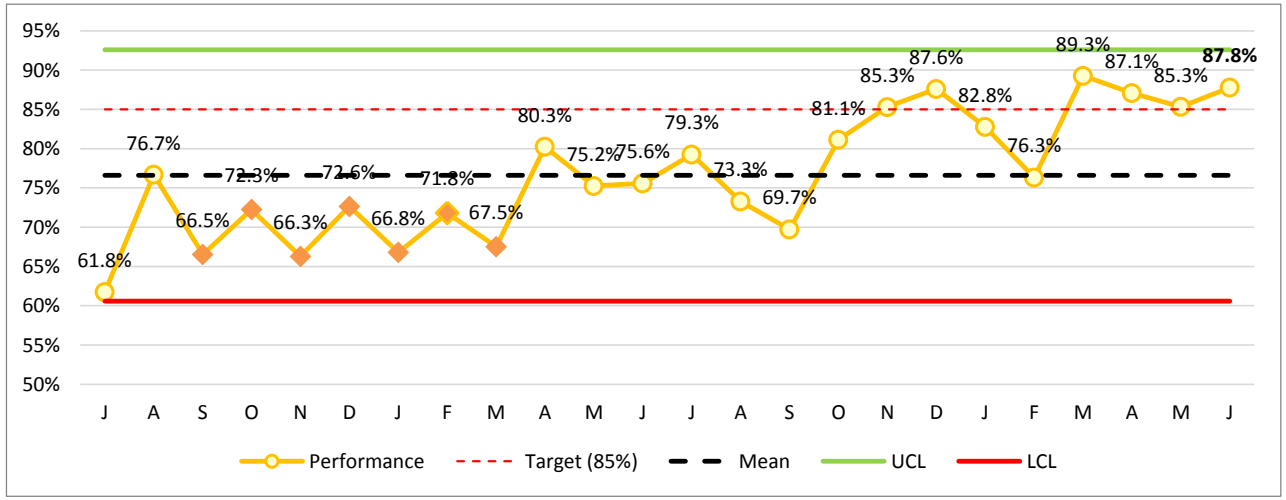
Responsive Services

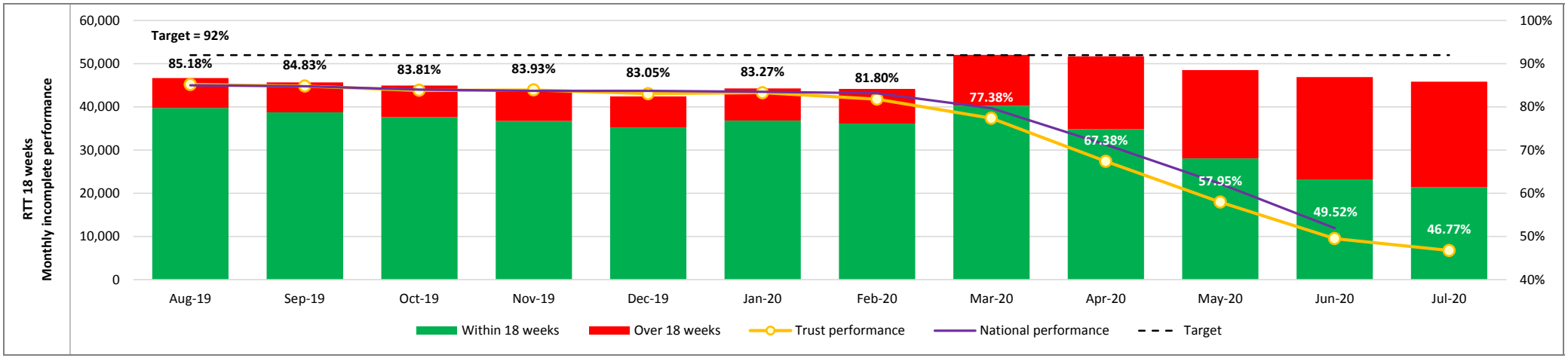
Cancer Waiting Times

East and North Hertfordshire NHS Trust

12-months' performance - all standards	Standard	Target	2019-20										2020-21			
			Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD	Apr-20	May-20	Jun-20	YTD
	Two week waits Suspected cancer	93%	96.15%	94.80%	97.22%	98.50%	97.43%	97.87%	96.47%	98.08%	98.77%	96.95%	97.72%	99.35%	99.32%	98.90%
	Two week waits Breast symptomatic	93%	94.78%	87.30%	95.76%	95.37%	98.39%	95.52%	97.96%	95.70%	97.14%	94.10%	79.31%	100.00%	98.59%	95.27%
	31-day First definitive treatment	96%	97.01%	96.97%	95.98%	96.88%	99.00%	98.29%	97.82%	98.98%	97.89%	96.57%	98.60%	98.50%	98.63%	98.58%
	31-day subsequent treatment Anti-cancer drugs	98%	99.07%	99.42%	99.41%	99.48%	100.00%	99.45%	98.16%	99.49%	99.50%	99.10%	100.00%	99.39%	100.00%	99.81%
	31-day subsequent treatment Radiotherapy	94%	96.32%	97.53%	97.27%	98.25%	96.54%	99.26%	98.81%	99.36%	98.06%	97.96%	98.56%	98.59%	99.04%	98.74%
	31-day subsequent treatment Surgery	94%	77.42%	83.33%	85.19%	65.52%	84.21%	93.55%	79.07%	86.21%	95.83%	83.55%	94.44%	96.15%	100.00%	97.09%
	62-day GP referral to treatment	85%	79.26%	73.28%	69.71%	81.14%	85.31%	87.60%	82.76%	76.32%	89.27%	79.82%	87.08%	85.31%	87.78%	86.75%
	62-day Specialist screening service	90%	56.00%	82.35%	73.68%	100.00%	69.23%	100.00%	100.00%	44.44%	66.67%	76.67%	38.46%	0.00%	NIL	31.25%

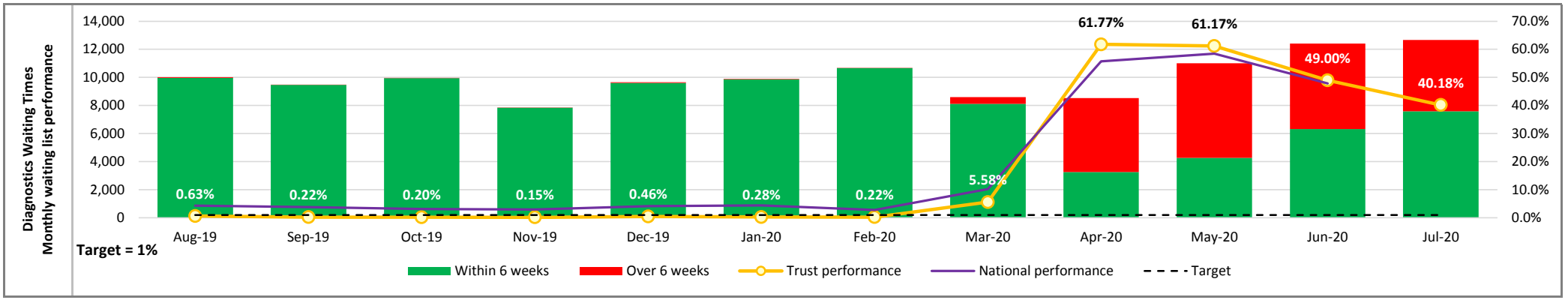
62-day GP referral to treatment Jun-20	Tumour Site	OK	Breach	Total	Perf.
	Breast	25.5	1.0	26.5	96.23%
	Gynaecology	3.0	1.0	4.0	75.00%
	Haematology	4.0	2.0	6.0	66.67%
	Head and Neck	5.0	2.0	7.0	71.43%
	Lower GI	3.5	1.0	4.5	77.78%
	Lung	5.0	1.0	6.0	83.33%
	Other	0.0	0.0	0.0	-
	Skin	20.5	2.0	22.5	91.11%
	Testicular	0.0	0.0	0.0	-
	Upper GI	3.0	0.0	3.0	100.00%
	Urology	9.5	1.0	10.5	90.48%
	Total	**79.0**	**11.0**	**90.0**	**87.78%**





RTT 18 weeks
In-month performance by Specialty - Jul-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	131	38.93%	1	189	74.07%	1	1,707	1,502	3,209	53.19%	138	25	754
Urology	76	60.53%	0	274	81.39%	0	1,375	874	2,249	61.14%	57	4	639
Trauma & Orthopaedics	24	12.50%	0	544	62.32%	13	1,282	2,375	3,657	35.06%	421	169	804
Ear, Nose & Throat (ENT)	73	36.99%	2	560	51.79%	0	1,405	1,541	2,946	47.69%	69	12	769
Ophthalmology	44	18.18%	1	342	51.75%	0	1,235	2,705	3,940	31.35%	113	5	673
Oral Surgery	27	18.52%	1	262	30.15%	1	444	1,631	2,075	21.40%	226	49	306
Plastic Surgery	63	49.21%	1	378	95.50%	0	829	400	1,229	67.45%	47	6	786
Cardiothoracic Surgery	2	100.00%	0	6	100.00%	0	12	6	18	66.67%	1	0	6
General Medicine	0	-	0	38	100.00%	0	983	162	1,145	85.85%	0	0	369
Gastroenterology	103	61.17%	0	339	33.63%	0	1,889	2,676	4,565	41.38%	209	24	807
Cardiology	43	65.12%	0	537	33.89%	0	1,417	2,080	3,497	40.52%	48	9	688
Dermatology	0	-	0	236	87.29%	0	497	384	881	56.41%	7	0	320
Thoracic Medicine	19	84.21%	0	181	60.22%	0	831	1,008	1,839	45.19%	35	0	398
Neurology	0	-	0	259	76.06%	0	271	476	747	36.28%	17	8	250
Rheumatology	1	0.00%	0	134	29.85%	0	437	714	1,151	37.97%	13	0	171
Geriatric Medicine	0	-	0	13	30.77%	0	85	75	160	53.13%	0	0	39
Gynaecology	33	63.64%	0	452	56.42%	0	2,146	1,035	3,181	67.46%	137	27	949
Other	47	53.19%	6	2,219	71.47%	10	4,597	4,759	9,356	49.13%	559	145	2,788
Total	**686**	**47.52%**	**12**	**6,963**	**62.42%**	**25**	**21,442**	**24,403**	**45,845**	**46.77%**	**2,097**	**483**	**11,516**



Diagnostics Waiting Times
In-month performance by Modality - Jul-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	942	296	1,238	23.91%	92	2,062	115	0	**2,177**
	Computed Tomography	1,108	588	1,696	34.67%	73	2,535	293	1,123	**3,951**
	Non-obstetric ultrasound	3,814	1,917	5,731	33.45%	234	4,442	183	48	**4,673**
	DEXA Scan	231	349	580	60.17%	271	214	20	0	**234**
Physiological Measurement	Audiology - audiology assessments	41	19	60	31.67%	3	16	0	0	**16**
	Cardiology - echocardiography	476	1,160	1,636	70.90%	871	919	0	0	**919**
	Neurophysiology - peripheral neurophysiology	87	105	192	54.69%	16	128	0	0	**128**
	Respiratory physiology - sleep studies	54	14	68	20.59%	6	125	0	0	**125**
	Urodynamics - pressures & flows	12	104	116	89.66%	81	45	0	0	**45**
Endoscopy	Colonoscopy	362	198	560	35.36%	125	276	0	0	**276**
	Flexi sigmoidoscopy	147	95	242	39.26%	53	96	0	0	**96**
	Cystoscopy	59	25	84	29.76%	12	95	0	0	**95**
	Gastroscopy	245	221	466	47.42%	161	204	0	0	**204**
Total		**7,578**	**5,091**	**12,669**	**40.18%**	**1,998**	**11,157**	**611**	**1,171**	**12,939**

Responsive Services

Stroke Performance

East and North Hertfordshire NHS Trust

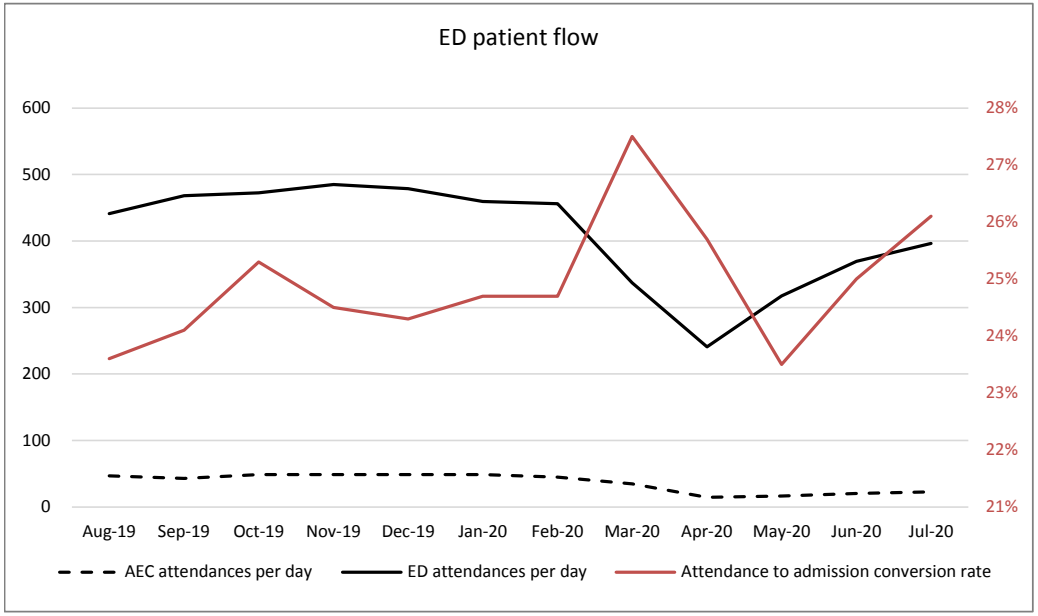
Domain	Metric	2019-20 Target	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	2020-21 Target	Apr-20	May-20	Jun-20	Jul-20	Trend
Stroke	Trust SSNAP grade	A	B	B	B	B	tbc	tbc	tbc	A	tbc	tbc	tbc	tbc	
	% of patients discharged with a diagnosis of Atrial Fibrillation and commenced on anticoagulants	80%	100.0%	100.0%	88.9%	85.7%	75.0%	83.3%	75.0%	80%	100.0%	100.0%	100.0%	88.9%	
	4-hours direct to Stroke unit from ED Trajectory	-	n/a	n/a	n/a	n/a	n/a	n/a	n/a	-	52.1%	72.1%	tbc	tbc	
	4-hours direct to Stroke unit from ED Actual	90%	79.7%	60.3%	57.1%	54.0%	40.8%	51.9%	67.7%	63%	55.0%	73.8%	66.7%	67.9%	
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	90%	81.5%	59.5%	58.2%	58.7%	41.2%	53.1%	68.8%	63%	55.6%	74.6%	68.8%	69.1%	
	Number of confirmed Strokes in-month on SSNAP	-	72	81	71	53	74	54	67	-	57	65	71	58	
	If applicable at least 90% of patients' stay is spent on a stroke unit	80%	91.4%	87.5%	88.7%	90.2%	84.9%	86.8%	97.0%	80%	94.6%	90.8%	92.6%	91.1%	
	Urgent brain imaging within 60 minutes of hospital arrival for suspected acute stroke	50%	58.3%	65.4%	45.1%	67.9%	52.7%	55.6%	64.2%	50%	59.6%	56.9%	61.4%	46.6%	
	Scanned within 12-hours - all Strokes	100%	95.8%	97.5%	95.8%	94.4%	94.6%	94.4%	98.5%	100%	94.7%	98.5%	95.7%	100.0%	
	% of all stroke patients who receive thrombolysis	11%	9.7%	12.5%	11.3%	7.7%	5.4%	17.0%	14.9%	11%	14.5%	18.8%	11.4%	15.5%	
	% of patients eligible for thrombolysis to receive the intervention within 60 minutes of arrival at A&E (door to needle time)	-	28.6%	70.0%	50.0%	25.0%	25.0%	33.3%	20.0%	70%	0.0%	8.3%	37.5%	44.4%	
	Discharged with JCP	80%	82.7%	86.0%	81.1%	85.3%	73.6%	97.0%	78.1%	80%	83.8%	82.1%	93.3%	97.2%	
	Discharged with ESD	40%	50.9%	47.7%	61.4%	48.6%	54.2%	55.9%	56.8%	40%	69.0%	54.5%	52.1%	56.1%	

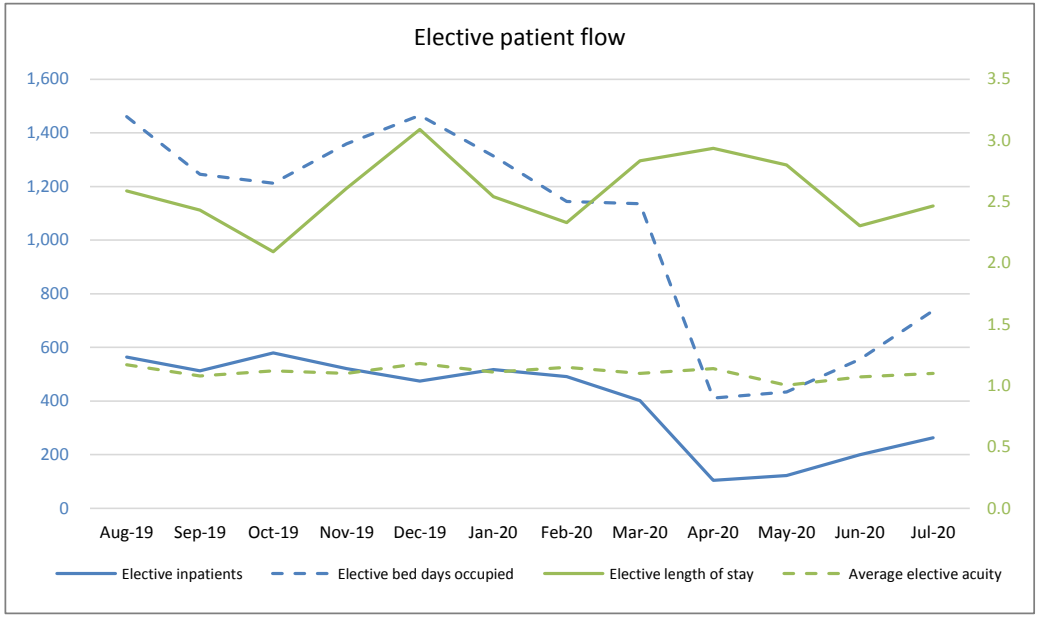
Responsive Services

East and North Hertfordshire NHS Trust

Patient Flow

Domain	Metric	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Trend
Emergency Department Flow Indicators	A&E & UCC attendances	13,676	14,041	14,649	14,556	14,848	14,243	13,228	10,457	7,228	9,838	11,091	12,289	
	Attendance to admission conversion rate	23.6%	24.1%	25.3%	24.5%	24.3%	24.7%	24.7%	27.5%	25.7%	23.5%	25.0%	26.1%	
	ED attendances per day	441	468	473	485	479	459	456	337	241	317	370	396	
	AEC attendances per day	47	43	49	49	49	49	45	35	15	17	20	23	
	4-hour target performance %	86.1%	85.1%	85.8%	81.5%	78.9%	81.5%	85.3%	80.2%	78.0%	83.4%	88.1%	90.1%	
	Time to initial assessment 95th centile	58	66	51	61	62	64	59	59	40	38	34	35	
	Ambulance handover breaches 30-minutes	180	227	215	360	453	458	274	394	316	235	76	tbc	

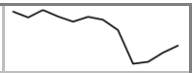
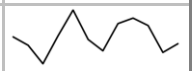
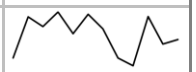
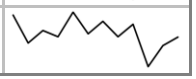
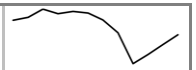
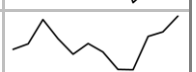




Responsive Services

Patient Flow

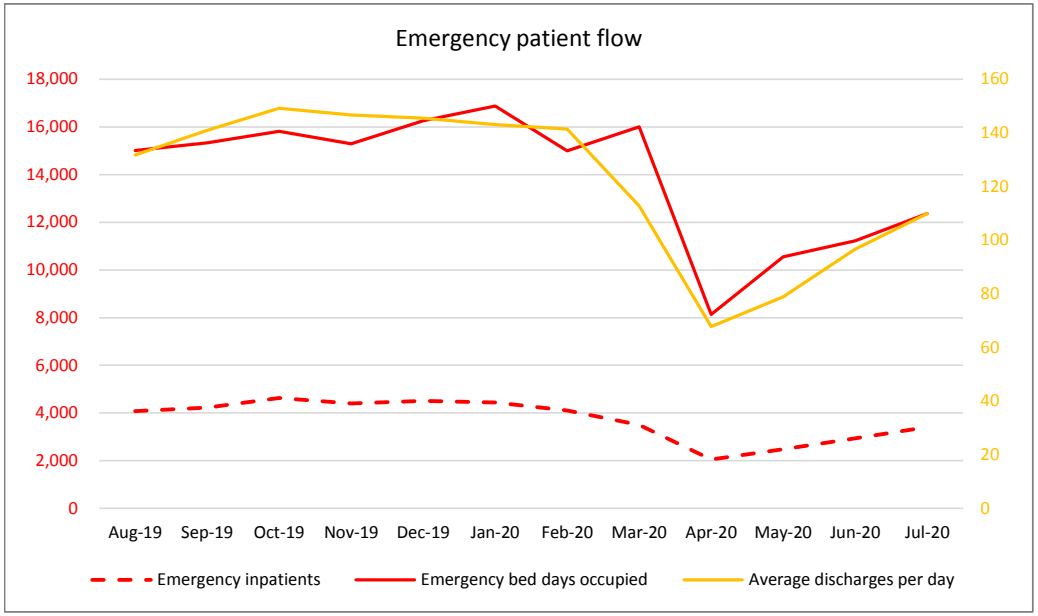
East and North Hertfordshire NHS Trust

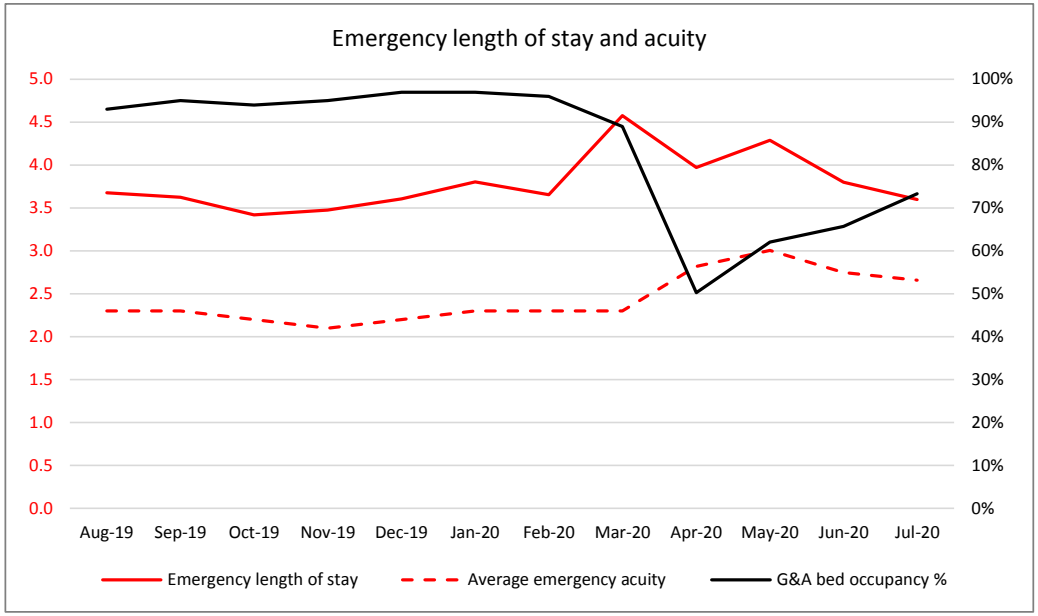
Domain	Metric	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Trend
Elective Inpatient Flow Indicators	Elective inpatients	564	512	579	521	474	517	491	401	104	122	200	263	
	Elective bed days occupied	1,460	1,245	1,212	1,359	1,465	1,314	1,144	1,136	411	434	555	737	
	Elective length of stay	2.6	2.4	2.1	2.6	3.1	2.5	2.3	2.8	2.9	2.8	2.3	2.5	
	Daycase rate %	86.2%	87.9%	87.5%	88.1%	87.2%	88.0%	87.4%	86.2%	85.9%	87.9%	86.8%	87.0%	
	Average elective acuity	1.17	1.08	1.12	1.10	1.18	1.11	1.15	1.10	1.14	1.00	1.07	1.10	
Emergency Flow Indicators	Emergency inpatients	4,083	4,228	4,624	4,401	4,510	4,438	4,103	3,497	2,047	2,477	2,943	3,406	
	Average discharges per day	132	141	149	147	145	143	141	113	68	79	97	110	
	Emergency bed days occupied	15,015	15,333	15,821	15,290	16,258	16,883	15,004	16,000	8,134	10,556	11,228	12,362	
	Emergency length of stay	3.7	3.6	3.4	3.5	3.6	3.8	3.7	4.6	4.0	4.3	3.8	3.6	
	Average emergency acuity	2.3	2.3	2.2	2.1	2.2	2.3	2.3	2.3	2.8	3.0	2.7	2.7	
	G&A bed occupancy %	93%	95%	94%	95%	97%	97%	96%	89%	50%	62%	66%	73%	
	Patients discharged via Discharge Lounge	406	432	546	457	383	433	393	311	310	467	489	564	
	Discharges before midday	12.5%	12.6%	12.9%	13.4%	15.0%	13.6%	14.2%	15.3%	11.7%	12.2%	13.8%	11.9%	
	Weekend discharges	15.7%	15.7%	14.2%	16.3%	16.4%	15.2%	16.2%	13.3%	14.2%	15.7%	12.9%	13.9%	
	Proportion of beds occupied by patients with length of stay over 14 days	20.0%	20.3%	20.3%	23.9%	19.4%	21.8%	22.8%	23.8%	13.6%	18.4%	17.7%	15.2%	
	Proportion of beds occupied by patients with length of stay over 21 days	10.9%	11.0%	11.9%	14.6%	10.7%	11.7%	13.7%	13.9%	6.8%	9.1%	9.6%	7.0%	

Responsive Services

East and North Hertfordshire NHS Trust

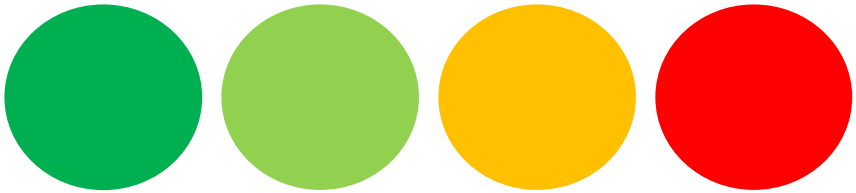
Patient Flow





Well Led Services

Month 04 | 2020-21



Key Issues

Staff Wellbeing
- Days lost due to mental health has increased on last month by 149.24 to 1888.97 days.
- Turnover remains steady and slightly increased to 12.87% (.32%) compared to last month.

Pulse Survey
- 55.5% staff reported they had a level of flexibility to balance their life .
- 67% staff reported that their manager cared about them as a person.
- Staff from all divisions reported over 50% of reasonable adjustments are being accepted.

Training & Development
- Appraisal compliance decreased from 70.2% to 66.8% against a target of 90%.
- Overall statutory and mandatory training compliance increased from 77.5% to 81.8% against a target of 90%.

Staffing and Pay bill
- Overall staff utilised including bank and agency increased by 60 WTE.
- Agency expenditure increased by 202k and was £170k under the agency ceiling.
- 205k of agency spend was against COVID-19 cost centre, with 151k attributed to Medics.
- Trust retains its NHSi agency ceiling target at £12.42m and £893k under YTD target.

Executive Response

- Staff absence due to mental health has increased this month. Intelligence from HRBPs indictaes this is due to the level of change and uncertainty occurring within the Trust. Staff are being supported through organisational change programmes through referrals to Health @ Work and are able to access our Employee Assistance scheme.

- The pulse survey conducted in Q1 highlighted that 55.5% of respondents stated they feel the Trust is flexible in allowing work life balance and that their manager cares about them. The People Business Partners are working with the Divisions to identify key hots spots and themes and have reported plans for development and support at the Staff Experience Group (SEG). Progress reviews are monitored at the Divisional SMTs and quarterly SEGs.

- We are on track with our transition of making changes to training requirements and refresher periods to align to the CSTF. This has seen an increase in statutory and mandatory training compliance but as further changes are made this may lead to a drop in compliance next month. Staff are now able to complete the majority of their mandatory and statutory training via e-learning and once completed this will automatically update on ESR.

Executive Response (continued)

- 43 student nurses and 22 student midwives who have qualified this summer will be starting permanent employment with the Trust between now and November 2020. A student celebration event was held on the 17th August to say well done to all the students who have qualified over the summer. During August we had an intake of 136 junior doctors. A revised and virtual induction programme took place with really positive feedback.
-
- Work has been undertaken to progress an opportunity to commence a MBA apprenticeship programme with Ashridge offering a programme to a small number of senior leaders identified for development as part of the recent talent boards. This programme will support and align with the development of the triumvirate leadership model following the operations restructure.

- The vacancy rate for the Trust at the end of M4 was 5.01%, this equates to 298 WTE posts. The current vacancy rate is the lowest in 12 months. Several pieces of work are underway which may affect the vacancy rate in the future, including the bed reconfiguration and the Task and Finish Group on data aligning, which will create a single source of data truth. Work needs to commence to review workforce skills to redistribute staff and create clinical pathways for the development of exisiting staff to accommodate organisational and service needs. 57 international nurses are in the pipeline pending deployment. 13 of the 57 are already in the UK with NMC registration and are starting in July/August.

- Overall temporary staffing demand increased by 5% against the previous month, all staff-groups experienced an increase, notably AHP (41%). Agency utilisation for all staff-groups is down by 29% year on year. Bank fill target increased for 20/21 to 85%, M4 achieved 89% which was our highest bank fill performance in 13 months. Work with Divisions continues to understand bank and agency demand.

- The People Hub continues to develop, with the Resourcing workstream due to go live for 1st line support. ERAS and Temporary Staffing scoping is underway for a September go-live. Helpdesk software is being scoped in conjunction with IMT with 2 products on the final shortlist.

- Aggressive eRostering rollout plans continue for Medical & Non Medical with a target to achieve full rollout by March 21 and December 20 respectively. The allocate contract is due to expire in May 21, a tender scoping exercise is underway with Herts Procurement support – award expected November 2020.

Well Led Services

Staff and Workforce Development

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Trend
Work	Vacancy Rate	6%	5.8%	6.9%	7.6%	6.3%	6.8%	7.3%	7.0%	6.6%	6.3%	6.9%	5.9%	5.5%	4.9%	
	Time to hire (weeks)	10	12.3	11.3	13.6	13.7	10.5	10.3	11.6	13.3	13.0	9.6	12.9	13.0	13.0	
	Recruitment experience	4								4.5	4.6	4.5	4.5	4.5	4.5	
	Relative likelihood of white applicant being shortlisted and appointed over BAME applicant	1				1.34			1.00			1.30				
	Relative likelihood of non-disabled applicant being shortlisted and appointed over disabled applicant	1				1.01			1.50			1.24				
	Agency Spend (% of WTE)	4%	4.8%	4.6%	3.8%	3.7%	3.7%	3.7%	4.0%	4.0%	4.1%	3.6%	3.2%	2.7%	3.6%	
	Bank Spend (% of WTE)	10%	11.7%	10.8%	10.5%	8.9%	10.4%	10.1%	11.5%	10.9%	12.7%	10.9%	8.2%	8.0%	9.6%	
	% of staff on eRoster	> 90%							49.0%	49.0%	49.0%	62.0%	62.0%	63.0%	63.0%	
	% of fully approved rosters in advance of 8 weeks	60%	29.0%	30.0%	25.0%	30.0%	29.0%	33.0%	39.0%	32.0%	26.6%	26.7%	33.6%	31.8%	21.3%	
	% of actual clinical unavalibility vs % of budgeted clinical unavailability (headroom) - Nursing & Midwifery ONLY	< 21%	24.0%	28.9%	26.7%	24.1%	25.0%	25.5%	27.0%	25.9%	29.8%	39.9%	36.2%	31.6%	27.3%	
	Pulse survey Flexibility	55%				53.0%			52.0%			55.5%				
Grow	Statutory & mandatory training compliance rate	90%	88.4%	89.1%	88.7%	89.9%	89.6%	90.0%	88.6%	88.9%	87.2%	84.0%	79.6%	77.5%	81.8%	
	Appraisal rate	90%	86.3%	87.2%	86.3%	84.7%	87.4%	84.0%	83.1%	82.0%	78.6%	75.0%	71.5%	70.2%	66.8%	
	Pulse survey Training and development opportunities	55%				73.0%			55.0%			48.1%				
	Pulse survey Talent management	55%				60.8%			50.0%			53.1%				
	Likelihood of training and development opportunities (BAME)	1														
	Likelihood of training and development opportunities (Disability)	1														
	LMCPD places filled	800 (cum)	104	12	79	149	120	93	55	57	0	0	0	0		

Well Led Services

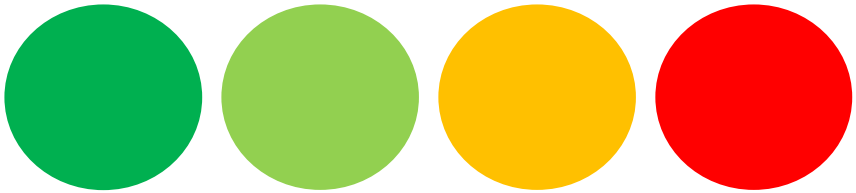
Staff and Workforce Development

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Trend
Thrive	Pulse survey My leader	75%				70.3%			79.9%			77.9%				
	Pulse survey Harnessing individuality	60%				51.7%			51.7%			60.8%				
	Pulse Survey Not experiencing discrimination	95%				91.2%			62.2%			71.0%				
	Turnover Rate	12.2%	12.3%	12.5%	12.8%	12.3%	12.7%	12.8%	12.8%	12.9%	12.9%	12.9%	12.8%	12.6%	12.9%	
	Model employer targets (% achieved)	100%							83%			83%				
	Average length of suspension (days)	20	64	95	119	98	12	0	8.5	32	63	62	70	0	0	
	Average length of Disciplinary (excluding suspensions) (days)	60	133	152	105	122	115	77	150	179	248	212	304	183	111	
	Average length of Grievance (including dignity at work) (days)	60	86	64	112	133	159	92	124	131	163	214	199	0	0	
Care	Pulse survey Well-being	70%				66.5%			43.5%			67.0%				
	Pulse survey Reasonable adjustments	50%							39.2%			67.5%				
	Staff FFT Recommend as a place to work	60%	52.6%			58.0%			37.3%			47.7%				
	Staff FFT Recommend as a place of care	70%	79.0%			66.0%			64.6%			68.6%				
	Sickness Rate	3.8%	3.74%	3.90%	4.25%	4.25%	4.23%	4.35%	4.38%	4.15%	6.79%	7.28%	5.51%	3.96%	3.72%	
	Sickness FTE Days Lost	6,777	6,299	6,522	6,871	7,199	6,903	7,304	7,380	6,569	11,528	12,002	9,504	6,649	6,543	
	Mental health related absence (days lost)	1,650	1,230	1,322	1,527	1,575	1,258	1,282	1,173	1,011	1,253	1,620	1,640	1,794	1,889	
	MSK related absence (days lost)	1,285	1,066	1,262	1,567	1,217	1,200	1,241	1,278	1,394	1,252	961	1,216	1,152	1,407	

Sustainable Services

Month 04 | 2020-21



Key Issues

- The Trust reports a Month 4 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. The Trust has received confirmation that this emergency framework will be extended in duration until the 30th September 2020. Further formal guidance is still awaited in respect of arrangements that will apply over the remainder of the 20/21 financial year.
- In the context of this current 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 £5.8m 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-19 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 YTD is £3.1m, the COVID Top-Up specifically claimed for June was £1.5m.
- 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 FPPC and are also presented within national monitoring returns.
- In the YTD the Trust calculates that it has incurred specific COVID-19 costs of £9.3m. Of this quantum some £5.4m pertains to additional pay 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 £3.0m 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 July was considerably below normal run rate levels. Comparing Month 4 activity delivery with February (the last full pre-COVID-19 month), total A&E attendances were 8% less, Outpatients attendances were 36% less, total bed days occupied by patients 19% less and Day cases & inpatient elective activity was 41% less. Had activity and income been priced and reported on a PbR basis rather than through a block, receipts would have been some £35.7m less than actually received.
- Whilst activity levels in June remained considerably below normal levels across most Points of Delivery in the Trust, the impact upon the organisations cost base has been more marginal. Excluding the impact of COVID-19 specific costs, business as usual expenditure levels have decreased by only 0.2%.
- 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 provides across the remainder of 20/21 and potentially beyond is likely to remain significantly below pre COVID-19 levels.
- However, in contrast in a number of other service areas it is likely that the Trust will need to incur a significant range of expanded premium costs in order to deliver service restoration to the scale desired by national planning guidance.
- Furthermore, 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 varied activity delivery environment. 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.

Sustainable Services

Finance Plan Performance

East and North Hertfordshire NHS Trust

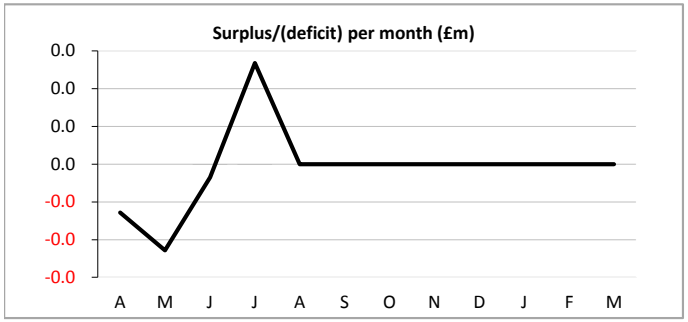
Domain	Metric	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Trend	Plan YTD	Actual YTD	Variance YTD
I&E Performance	SLA Income Earned	34.3	34.3	36.4	34.6	33.8	36.6	33.4	36.6	36.2	36.2	36.2	36.2		144.0	144.7	0.7
	Other Income Earned	3.7	3.7	5.2	4.3	3.6	4.5	4.1	8.0	2.3	2.5	2.2	2.5		19.6	9.4	-10.2
	Pay Costs	24.5	24.3	24.6	24.6	24.7	24.9	24.5	27.4	26.2	25.7	24.9	25.4		101.5	102.3	0.7
	Non Pay Costs inc Financing	15.3	15.1	16.3	15.3	15.8	16.1	15.0	17.5	14.9	14.4	15.2	16.2		62.0	60.7	-1.3
	Underlying Surplus / (Deficit)	-1.9	-1.4	0.6	-1.0	-3.1	0.0	-1.9	-0.3	-2.6	-1.4	-1.8	-3.0		-0.0	-8.9	-8.9
	Top up payments	-	-	-	-	-	-	-	-	2.6	1.4	1.8	3.0		0.0	8.9	8.9
	Retained Surplus / Deficit	-0.8	-0.311	2.3	0.6	-1.4	1.9	-0.0	1.6	-0.0	0.0	-0.0	-0.0		-0.0	-0.0	0.0
Paybill Metrics	Substantive Pay Costs	20.8	20.9	21.2	21.2	21.3	21.2	20.9	22.9	22.6	22.4	22.3	22.1		95.1	89.4	-5.7
	Premium Pay Costs Overtime & WLI	0.4	0.3	0.3	0.3	0.3	0.3	0.3	0.4	0.2	0.1	0.0	0.0		0.3	0.3	0.0
	Premium Pay Costs Bank Costs	2.3	2.2	2.2	2.2	2.2	2.5	2.3	2.9	2.6	2.3	2.0	2.4		4.5	9.3	4.8
	Premium Pay Costs Agency Costs	1.1	0.9	0.9	0.9	0.9	1.0	1.0	1.2	0.9	0.8	0.7	0.9		1.6	3.3	1.7
	Premium Pay Costs As % of Paybill	15.4%	14.1%	13.9%	13.8%	13.8%	14.8%	14.5%	16.5%	14.0%	12.7%	10.7%	13.0%		6.4%	12.6%	6.2%

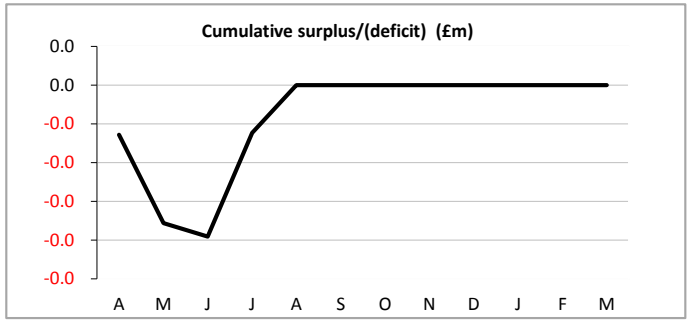
Sustainable Services

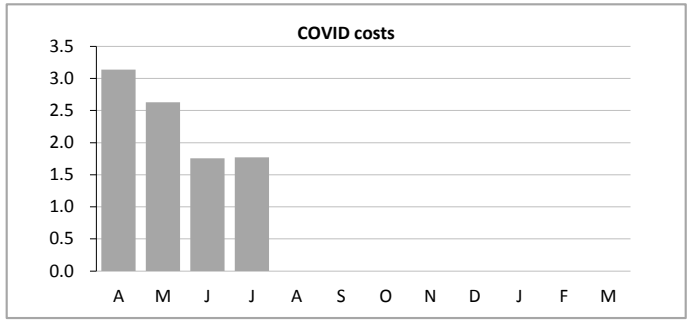
Finance Plan Performance

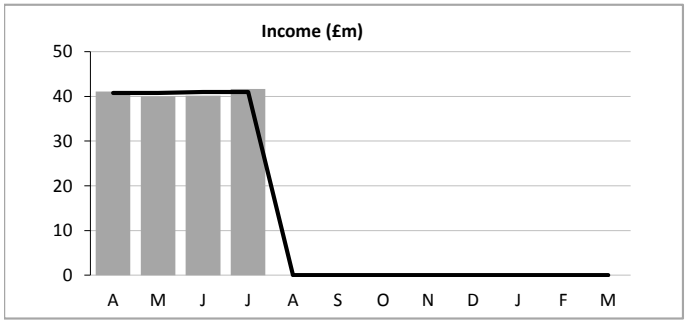
East and North Hertfordshire NHS Trust

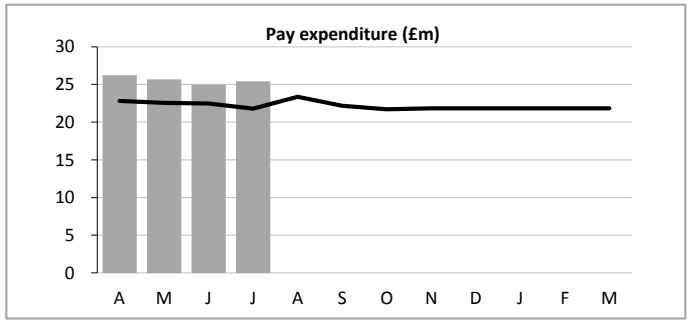
Domain	Metric	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Trend	Plan YTD	Actual YTD	Variance YTD
Single Oversight Framework	Capital Servicing Capacity	4	4	4	4	4	4	4	4	n/a	n/a	n/a	n/a		1	n/a	
	Liquid Ratio (Days)	4	4	4	4	4	4	4	4	n/a	n/a	n/a	n/a		1	n/a	
	I&E Margin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

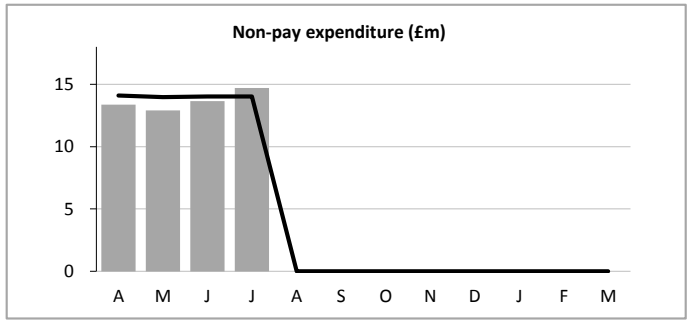












Sustainable Services

SLA Contracts - Income Performance

East and North Hertfordshire NHS Trust

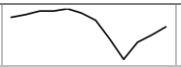
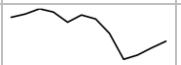
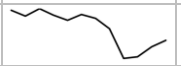
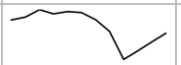
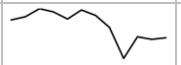
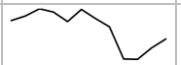
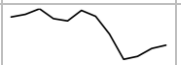
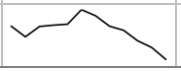
		In-Month			YTD		
		Planned Income	Actual Income	Income Variance	Planned Income	Actual Income	Income Variance
By Point of Delivery	A&E Attendances	2,329	2,153	-176	9,315	7,108	-2,207
	Daycases	3,091	1,546	-1,545	12,365	4,310	-8,054
	Inpatient Elective	1,918	989	-929	7,671	2,645	-5,026
	Inpatient Non Elective	9,712	9,271	-441	38,848	31,047	-7,801
	Maternity	2,546	2,509	-37	10,184	9,779	-405
	Other	3,684	3,307	-377	14,736	11,893	-2,843
	Outpatient First	2,106	1,742	-364	8,423	5,999	-2,424
	Outpatient Follow Ups	2,274	2,013	-261	9,096	6,763	-2,334
	Outpatient Procedures	1,156	532	-624	4,624	1,577	-3,047
	NHSE Block Impact	-280	4,179	14,662	-1,118	34,599	14,662
	Other SLAs	65	65	0	258	258	0
	Block	843	843	0	3,371	3,371	0
	Drugs & Devices	3,682	4,059	377	14,728	14,030	-698
	Chemotherapy Delivery	607	559	-48	2,426	1,924	-502
	Radiotherapy	1,216	1,099	-117	4,863	4,473	-390
	Renal Dialysis	1,182	1,214	32	4,728	4,693	-35
	Total	36,130	36,080	-50	144,519	144,469	-50

		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	86,538	86,538	-0
	Specialist Commissioning	8,167	8,409	241	32,669	34,072	1,403
	Bedfordshire CCG	2,486	2,486	0	9,944	9,944	0
	Herts Valleys CCG	1,404	1,404	0	5,615	5,615	0
	Cancer Drugs Fund	426	638	212	1,705	2,334	629
	Luton CCG	326	326	0	1,304	1,304	0
	PH - Screening	379	-0	-379	1,515	-0	-1,515
	Other	1,307	1,182	-125	5,227	4,660	-567
By Division	Cancer Services	6,624	6,933	309	26,497	24,291	-2,206
	Medicine	12,116	10,751	-1,364	48,462	38,145	-10,318
	Women & Children	5,051	4,569	-482	20,204	17,202	-3,002
	Clinical Services	2,160	1,959	-201	8,641	6,254	-2,387
	Surgery	10,544	7,041	-3,504	42,177	21,372	-20,806
	NHSE Block Impact	-280	4,179	4,458	-1,118	34,599	35,717
	Other	-86	648	735	-346	2,606	2,952

Sustainable Services

Activity and Productivity

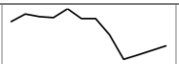
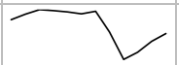
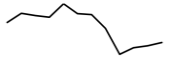
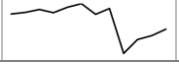
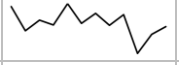
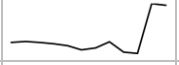
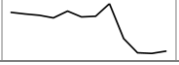
East and North Hertfordshire NHS Trust

Domain	Metric	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Trend	Plan YTD	Actual YTD	Var YTD
Patient Activity Levels	A&E & UCC	12,845	13,230	13,745	13,769	14,126	13,467	12,432	9,714	6,656	9,155	10,251	11,424		53,578	37,486	-16,092
	Chemotherapy Atts	2,131	2,073	2,348	2,261	2,241	2,528	2,177	2,049	1,631	1,634	2,167	2,025		9,078	7,457	-1,621
	Critical Care (Adult) - OBD's	534	580	584	668	633	707	460	619	700	728	488	512		2,467	2,428	-39
	Critical Care (Paeds) - OBD's	465	549	605	498	583	558	265	416	448	509	434	546		2,220	1,937	-283
	Daycases	3,512	3,722	4,070	3,841	3,215	3,662	3,420	2,504	852	1,127	1,582	1,994		15,830	5,555	-10,275
	Elective Inpatients	564	512	579	521	474	526	491	401	140	155	241	299		2,247	835	-1,412
	Emergency Inpatients	4,083	4,228	4,624	4,401	4,510	4,465	4,103	3,497	2,047	2,477	2,943	3,406		17,128	10,873	-6,255
	Home Dialysis	163	147	144	150	164	160	148	160	147	140	139	150		661	576	-86
	Hospital Dialysis	6,306	5,963	6,313	6,264	6,627	6,444	6,288	6,549	6,172	6,323	6,547	6,737		25,773	25,779	6
	Maternity Births	449	438	467	440	436	414	414	420	393	443	445	428		1,768	1,709	-59
	Maternity Bookings	444	474	518	507	475	530	514	481	517	468	498	546		2,002	2,029	27
	Outpatient First	8,244	8,675	9,788	9,312	8,354	9,598	8,867	7,228	3,033	5,961	5,611	5,816		35,722	20,421	-15,301
	Outpatient Follow Up	15,893	17,009	18,795	17,931	15,640	18,627	16,347	14,389	6,549	6,463	9,267	11,432		69,132	33,711	-35,421
	Outpatient procedures	6,935	7,306	8,029	6,750	6,449	7,799	7,053	4,749	1,504	1,891	2,876	3,316		29,632	9,587	-20,045
	Radiotherapy Fractions	4,775	4,480	4,764	4,800	4,828	5,232	5,061	4,772	4,663	4,379	4,190	3,865		19,792	17,097	-2,695

Sustainable Services

Activity and Productivity

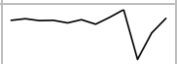
East and North Hertfordshire NHS Trust

Domain	Metric	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Trend	Plan YTD	Actual YTD	Var YTD
Throuhput	Elective Spells per Working Day	185	212	202	198	231	195	196	138	52	67	83	100		215	76	-139
	Emergency Spells per Day	129	138	145	143	142	139	143	109	65	76	94	106		140	89	-51
	ED Attendances per Day	414	441	443	459	456	434	444	313	222	295	342	369		439	307	-132
	Outpatient Atts per Working Day	1,412	1,650	1,592	1,545	1,903	1,642	1,613	1,256	583	753	807	894		1,601	759	-842
	Elective Bed Days Used	1,460	1,245	1,212	1,359	1,465	1,314	1,144	1,136	411	434	555	737		5,575	2,137	-3,438
	Emergency Bed Days Used	15,015	15,333	15,821	15,290	16,258	16,883	15,004	16,000	8,134	10,556	11,228	12,362		64,002	42,280	-21,722
Efficiency	Admission Rate from A&E	24%	24%	25%	24%	24%	25%	25%	27%	26%	24%	25%	26%		23.3%	25.1%	1.8%
	Emergency - Length of Stay	3.7	3.6	3.4	3.5	3.6	3.8	3.7	4.6	4.0	4.3	3.8	3.6		3.9	3.9	0.1
	Emergency - Casemix Value	2,277	2,308	2,222	2,116	2,213	2,331	2,264	2,382	2,819	3,005	2,747	2,661		2,297	2,808	511
	Elective - Length of Stay	2.6	2.4	2.1	2.6	3.1	2.5	2.3	2.8	2.9	2.8	2.3	2.5		2.5	2.6	0.1
	Elective - Casemix Value	1,169	1,084	1,121	1,104	1,180	1,110	1,145	1,103	1,140	1,004	1,071	1,099		1,105	1,078	-26
	Elective Surgical DC Rate %	86.2%	87.9%	87.5%	88.1%	87.2%	88.0%	87.4%	86.2%	85.9%	87.9%	86.8%	87.0%		85%	87%	1.9%
	Outpatient DNA Rate % - 1st	11.8%	11.4%	11.0%	11.6%	12.1%	11.7%	11.6%	13.0%	10.8%	12.6%	13.7%	13.4%		6.5%	12.8%	6.3%
	Outpatient DNA Rate % - FUP	7.3%	7.5%	7.3%	7.1%	6.8%	6.1%	6.4%	7.4%	5.7%	5.5%	13.7%	13.4%		7.5%	5.5%	-2.0%
	Outpatient Cancel Rate % - Patient	10.6%	10.3%	10.1%	9.6%	10.9%	9.8%	9.9%	12.3%	5.7%	3.0%	2.9%	3.3%		10.4%	3.7%	-6.7%

Sustainable Services

Activity and Productivity

East and North Hertfordshire NHS Trust

Domain	Metric	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Trend	Plan YTD	Actual YTD	Var YTD
Efficiency	Outpatient Cancel Rate % - Hosp	6.1%	6.4%	6.3%	6.6%	6.7%	6.6%	7.0%	12.7%	28.2%	25.6%	17.8%	14.0%		6.9%	18.7%	11.8%
	Outpatients - 1st to FUP Ratio	1.9	2.0	1.9	1.9	1.9	1.9	1.8	2.0	2.2	1.1	1.7	2.0		1.9	1.7	-0.3
	Theatres - Ave Cases Per Hour	2.7	2.6	2.8	3.0	2.7	2.8	2.7	2.6	1.2	1.5	1.5	1.9		2.9	1.5	-1.4
	Theatres - Utilisation of Sessions	79%	80%	83%	88%	84%	87%	87%	81%	67%	75%	74%	74%		85%	73%	-12%
	Theatres - Ave Late Start (mins)	25	18	16	17	17	18	17	21	29	31	22	24		27	27	-0.2
	Theatres - Ave Early Finishes (mins)	41	35	38	25	36	31	32	41	36	66	65	71		39	60	20.2

Sustainable Services

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

NHS East and North Hertfordshire NHS Trust

Activity Measures	2019-20 YTD	2020-21 YTD	Change
Emergency Department Attendances	53,111	37,486	-15,625
Emergency Department Ave Daily Atts	435	307	-128
Admission Rate from ED %	22.8%	25.1%	2%
Non Elective Inpatient Spells	16,551	10,873	-5,678
Ave Daily Non Elective Spells	136	89	-47
Daycase Spells	14,680	5,555	-9,125
Elective Inpatient Spells	2,237	835	-1,402
Ave Daily Planned Spells	139	52	-86
Day Case Rate	87%	87%	0%
Adult & Paeds Critical Care Bed Days	4,507	4,365	-142
Outpatient First Attendances	36,273	20,421	-15,852
Outpatient Follow Up Attendances	70,517	33,711	-36,806
Outpatient First to Follow Up Ratio	1.9	1.7	-0.3
Outpatient Procedures	31,317	9,587	-21,730
Ave Daily Outpatient Attendances	1,132	522	-610

Workforce Measures	2019-20 YTD	2020-21 YTD	Change
Average Monthly WTE's Utilised	5,844	6,030	186
Average YTD Pay Cost per WTE	16,887	16,958	0.4%
Staff Turnover	12.8%	12.8%	-0.1%
Vacancy WTE's	824	694	-130
Vacancy Rate	13.5%	12.0%	-1.5%
Sickness Days Lost	25,420	34,698	9,278
Sickness Rate	4.1%	5.1%	1.0%
Agency Spend- £m's	4.2	3.3	-1.0
Temp Spend as % of Pay Costs	4.3%	3.2%	-1.1%
Ave Monthly Consultant WTE's Worked	324.7	343.7	19.0
Consultant : Junior Training Doctor Ratio	1 : 1.7	1 : 1.7	0.0
Ave Monthly Nursing & CSW WTE's Worked	2,464.1	2,477.1	13.0
Qual : Unqualified Staff Ratio	26 : 10	24 : 10	-0.1
Ave Monthly A&C and Senior Managers WTE's	1,294	1,335	41
A&C and Senior Managers % of Total WTE's	22.1%	22.2%	0.0%

Sustainable Services

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

NHS East and North Hertfordshire NHS Trust

Capacity Measures	2019-20 YTD	2020-21 YTD	Change
Non Elective LoS	3.9	3.9	0.1
Elective LoS	2.5	2.6	0.1
Occupied Bed Days	69,577	44,417	-25,160
Adult Critical Care Bed Days	2,515	2,428	-87
Paediatric Critical Care Bed Days	1,992	1,937	-55
Outpatient DNA Rate	8%	6%	-1.7%
Outpatient Utilisation Rate	17%	29%	11.8%
Total Cancellations	44,727	49,138	4,411
Theatres - Ave Cases per Hour	2.7	1.5	-1.2
Theatres - Ave Session Utilisation	80%	73%	-7.7%
Theatres - Ave Late Start (mins)	25	27	1
Theatres - Ave Early Finishes (mins)	35.5	59.6	24
Radiology Examinations	139,994	94,754	-45,240
Drug Expenditure (excl HCD & ENH Pharma) - £000s	3,057	2,715	-342
High Cost Drug Expenditure - £000s	13,798	13,884	85

Finance & Quality Measures	2019-20 YTD	2020-21 YTD	Change
Profitability - £000s	-2,283	-118	2,766.3
Monthly SLA Income £000s	34,667	36,177	2,186
Monthly Clinical Income per Consultant WTE	£106,759	£105,248	£1,801
High Cost Drug Spend per Consultant WTE	£42,492	£40,391	-£3,065
Average Income per Elective Spell	£1,138	£1,078	-£68
Average Income per Non Elective Spell	£2,387	£2,808	£557
Average Income per ED attendance	£174	£190	£21
Average Income per Outpatient Attendance	£130	£127	-£18
Ave NEL Coding Depth per Spell	n/a	n/a	n/a
Procedures Not Carried Out	828	316	-263
Best Practice HRGs (% of all Spells)	1.7%	4.5%	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 Mar-20	10,924	11,310	386
Non-elective re-admissions within 30 days % Rolling 12-months to Mar-20	8.60%	8.45%	-0.15%
SLA Contract Fines - £000's	10	0	-10

Division	Not started	In progress	Passed	Total	%
CANCER	53	5	71	129	55%
CAPITAL	3	0	2	5	40%
CSS	26	3	65	94	69%
DATA QUALITY/CODING	0	1	7	8	88%
FACILITIES	3	2	1	6	17%
FINANCE	15	4	222	241	92%
FINANCE - INFORMATION	2	0	12	14	86%
FINANCE - IT	0	2	3	5	60%
MEDICINE	153	24	137	314	44%
NURSING PRACTICE	9	1	3	13	23%
PMO	4	0	66	70	94%
STRATEGY	3	0	0	3	0%
SURGICAL	123	8	101	232	44%
TRUST MGT	6	0	2	8	25%
W&C	43	6	109	158	69%
WORKFORCE	12	0	4	16	25%
FINANCE - INCOME	3	0	5	8	63%
#N/A	5	0	0	5	0%
Grand Total	**463**	**56**	**810**	**1,329**	61%

East and North Hertfordshire NHS Trust

Agenda Item: 9

TRUST BOARD - PUBLIC SESSION – 2 SEPTEMBER 2020

Recovery Phase 3 Update

Purpose of report and executive summary (250 words max): The purpose of the report is to present an update on the phase 3 recovery.		
Action required: For discussion		
Previously considered by: Executive Committee – 26.08.20		
Director: Chief Operating Officer	**Presented by:** Chief Operating Officer	**Author:** Deputy Chief Operating Officer

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

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

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

East and North Hertfordshire NHS Trust

East and North Hertfordshire NHS Trust
COVID - Phase 3 Recovery Plan

Quality | People | Pathways | Ease of use | Sustainability

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

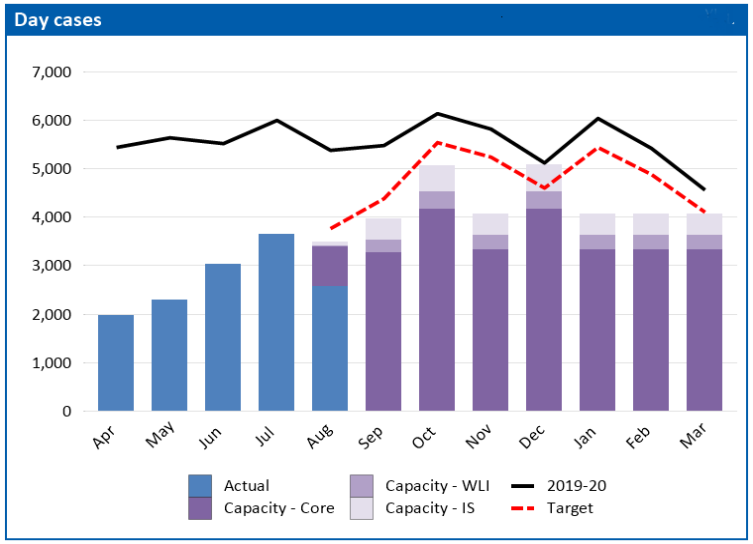
National Expectations for Phase 3 Recovery

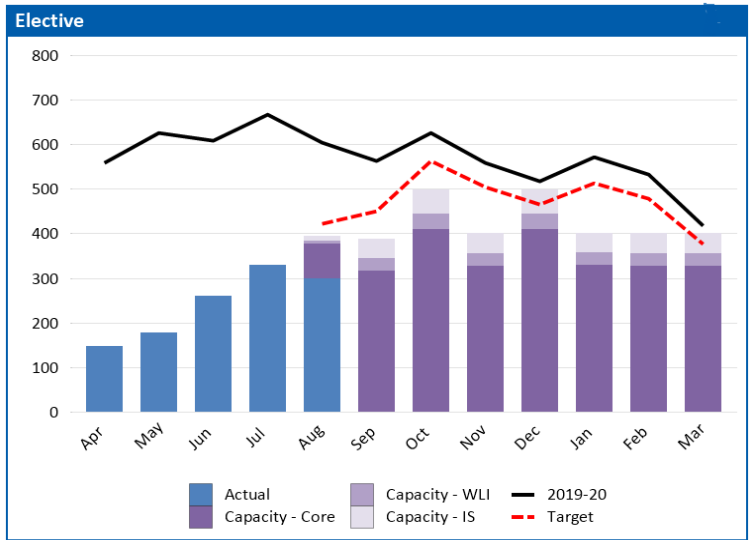
East and North Hertfordshire NHS Trust

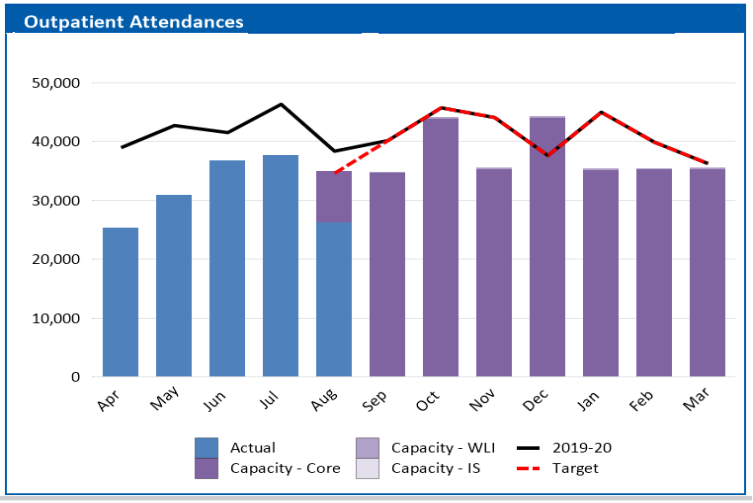
- On 31 July 2020 NHS England confirmed the national expectations regarding the third phase of the NHS response to the COVID-19 pandemic.
- The expectation is for organisations to return to near-normal levels of activity between now and winter including;
  - In September, delivering at least 80% of last year's activity for both overnight electives and for outpatient/day-case procedures, rising to 90% in October (while aiming for 70% in August);
  - This means that systems need to very swiftly return to at least 90% of their last year's levels of MRI/CT and endoscopy procedures, with the goal to reach 100% by October; and
  - 100% of last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the balance of the year (and aiming for 90% in August).
- The letter alluded to a change in the financial framework which had been in existence for the initial response to COVID-19 and suggested a framework whereby there are 'system' funding envelopes issued to support delivery of the above targets.
- The Hertfordshire and West Essex Integrated Care System (HWE ICS) are required to submit a draft system activity and workforce plan, including supportive narrative, on 1 September with a final submission due 21 September.

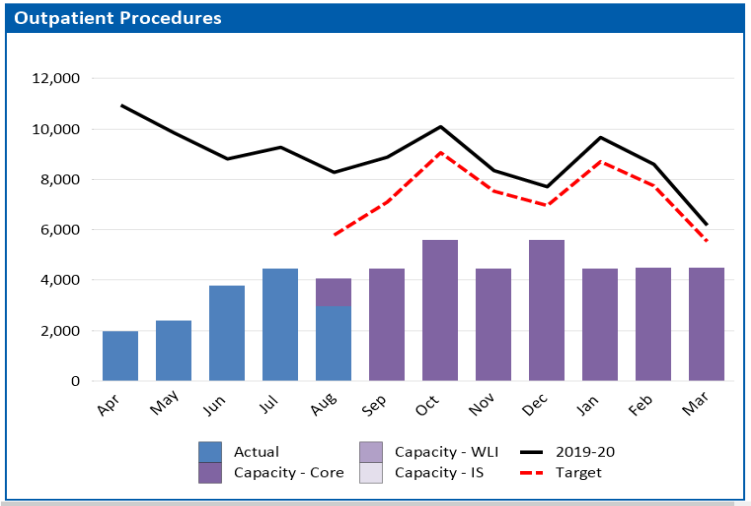
Current Position Against Phase 3 Targets

East and North Hertfordshire NHS Trust









Quality | People | Pathways | Ease of use | Sustainability

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

ENHT Approach

East and North Hertfordshire NHS Trust

- In order to ensure that there is a clear operational plan to deliver the Phase 3 recovery targets, ENHT has taken the approach of using detailed demand and capacity modelling to understand:
  - The level of activity that needs to be undertaken by month and specialty level to achieve the Phase 3 targets;
  - The available core internal capacity to undertake the required activity levels;
  - The bridging interventions and additional capacity to meet the gap between the core capacity and the Phase 3 targets.
- For 1 September 2020 submission:
  - ENHT has focussed its efforts on producing an accurate activity plan based on existing available core capacity, without any additional bridging interventions or premium capacity included;
  - At present, there is a significant gap between what can be delivered within existing capacity and the national expectations;
  - Submission provides the baseline to identify the actions required to close the gap at specialty level compared to the Phase 3 targets.
- For 21 September 2020 submission:
  - Will provide a finalised plan based on the analysis of internal available capacity, with bridging actions identified to meet the Phase 3 targets, which will include premium activity rates, use of the independent sector and other actions.
- ENHT will require additional funding in order to be fully compliant with the Phase 3 targets. The unfunded actions to bridge the gap to the targets will be identified in the 21 September 2020 submission.

Assessed Position Against Phase 3 Targets
1 September 2020 Submission

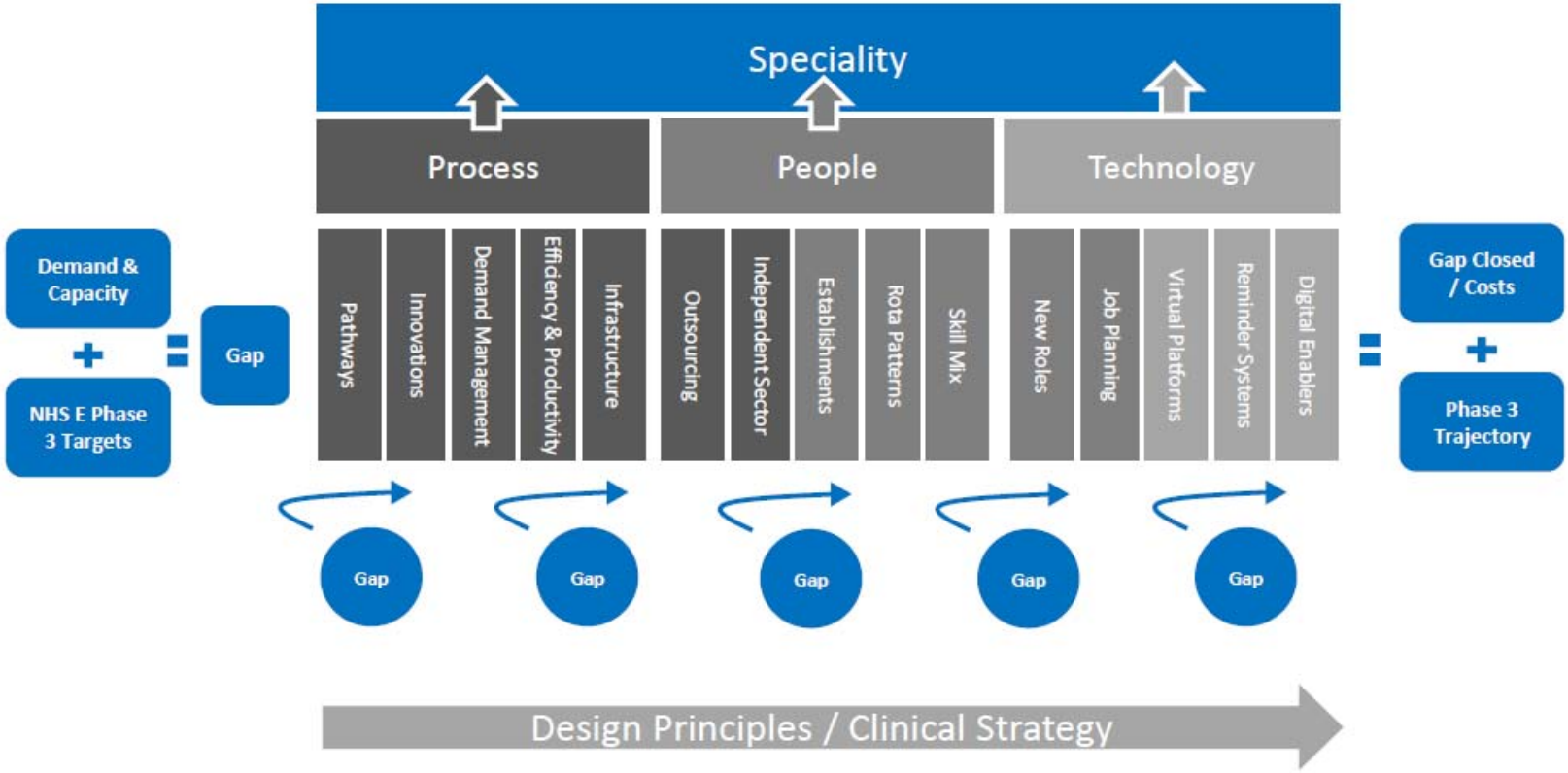
East and North Hertfordshire NHS Trust

		Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Day Case	Assessment of Capacity	77%	77%	84%	104%	93%	96%	105%
	Target	80%	90%	90%	90%	90%	90%	90%
Elective	Assessment of Capacity	59%	59%	68%	81%	77%	76%	80%
	Target	80%	90%	90%	90%	90%	90%	90%
Outpatients (all)	Assessment of Capacity	76%	80%	83%	85%	85%	85%	82%
	Target	100%	100%	100%	100%	100%	100%	100%
MRI	Assessment of Capacity	90%	100%	100%	100%	100%	100%	100%
	Target	90%	100%	100%	100%	100%	100%	100%
CT	Assessment of Capacity	60%	70%	70%	70%	70%	70%	70%
	Target	90%	100%	100%	100%	100%	100%	100%

Note:
Outpatient Assessment of Capacity includes both attendances and procedures, with procedures currently showing a significant gap compared to the required target

ENHT's Approach to Bridge the Gap

East and North Hertfordshire NHS Trust



Quality | People | Pathways | Ease of use | Sustainability

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

Key Risks

East and North Hertfordshire NHS Trust

COVID

Where relevant and possible to do so, ENHT is ensuring that pathways can take an individual's Covid risk into account. However, it is not possible to predict what COVID related demand is likely to be over the coming months, especially in the event of a second surge.

Financial

To achieve the Phase 3 targets, there will be a need for substantial levels of premium rate activity to bridge the gap from available capacity, which is currently unfunded. It is also unclear how the system funding envelope will work should any part of the system fail to achieve the targets.

Testing

The availability and quick reporting of testing prior to a procedure is key as it supports a reduction in downtime between procedures and maintains safety and quality through enabling non-COVID pathways to be put in place.

PPE

For some activities / procedures there is an increased down time between procedures to maintain safe infection prevention and control measures. This places limitations on what can be delivered within existing capacity.

Patient Confidence

It is imperative that the public are confident to attend hospital for their appointment / procedure. However, there remains some unwillingness to attend for fear of contracting COVID. Public reassurance is therefore key to delivering the required activity levels.

Shielding

There is a risk and high potential of staff and patients shielding in future outbreaks of COVID. Increase in numbers of shielding people will result in reduced capacity and/or patients not attending for their appointment.

Agenda Item:10

TRUST BOARD – 2 September 2020
Board Assurance Framework Risks 2020-21

Purpose of report and executive summary (250 words max):
The review of the BAF risks ensuring they reflect the strategic risks for 2020/21 was delayed this year from April 2020. The review is informed by the National Operating Plan, Trust 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 work was put on hold. The review recommenced in June with each of the Directors. The strategic risks have now been reviewed , updated and the changes have been endorsed by the Executive Committee and Committees of the Board (QSC, FPPC and Audit Committee).

The following pages outline:

- the changes to the articulation of the Trust's strategic risks for the Board Assurance Framework 2020/21. These were endorsed by the Executive Committee and approved by the Audit Committee in July 2020. Appendix a.
- how the risks map across the Trust's strategic priorities and draft objectives for 2020/21v8 and providing assurance on the coverage. Appendix b
- the BAF, appendix c. Please note there is ongoing work with the workforce senior team regarding the workforce and culture risks. The full detail of these two risks will be presented in full to the FPPC and QSC in September 2020.

Key points to note for the BAF:

- There are changes to the articulation of 8 risks
- The Board approved the changes to risk 6 (ICP) and risk 11 (MVCC) earlier in 2020 and risk 5 (Digital) in September 2019; no further changes are proposed for these risk descriptions.
- The Executive Committee considered Risk 12 (COVID Pandemic) and agreed that although the critical/strategic risk elements are captured in the other BAF risks under Operational Delivery, Finance, Quality, Workforce and Governance it should remain a risk on the BAF due to the continuing potential significant impact. The wording has altered to reflect the wider risk of any pandemic not just the COVID 19 pandemic.
- All the risks have been updated for July/August 2020 and the assurances remain under review.
- The risks will continue to be reviewed with each Director and Executive Team each month and at the Board and Board Committees and used to drive the agendas. The Audit Committee will continue to have a deep dive review of a risk at each meeting. This is identified from referral by Board or by the Audit Committee Chair.

The Board are asked to approve the changes to the articulation of the 12 strategic risks and consider if any further assurances are required.

Action required: For approval		
Previously considered by: Executive Committee July 2020, Audit Committee and Board Committees		
Director: Chief Nurse	**Presented by: Associate Director of Governance**	**Author: Associate Director of Governance**

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

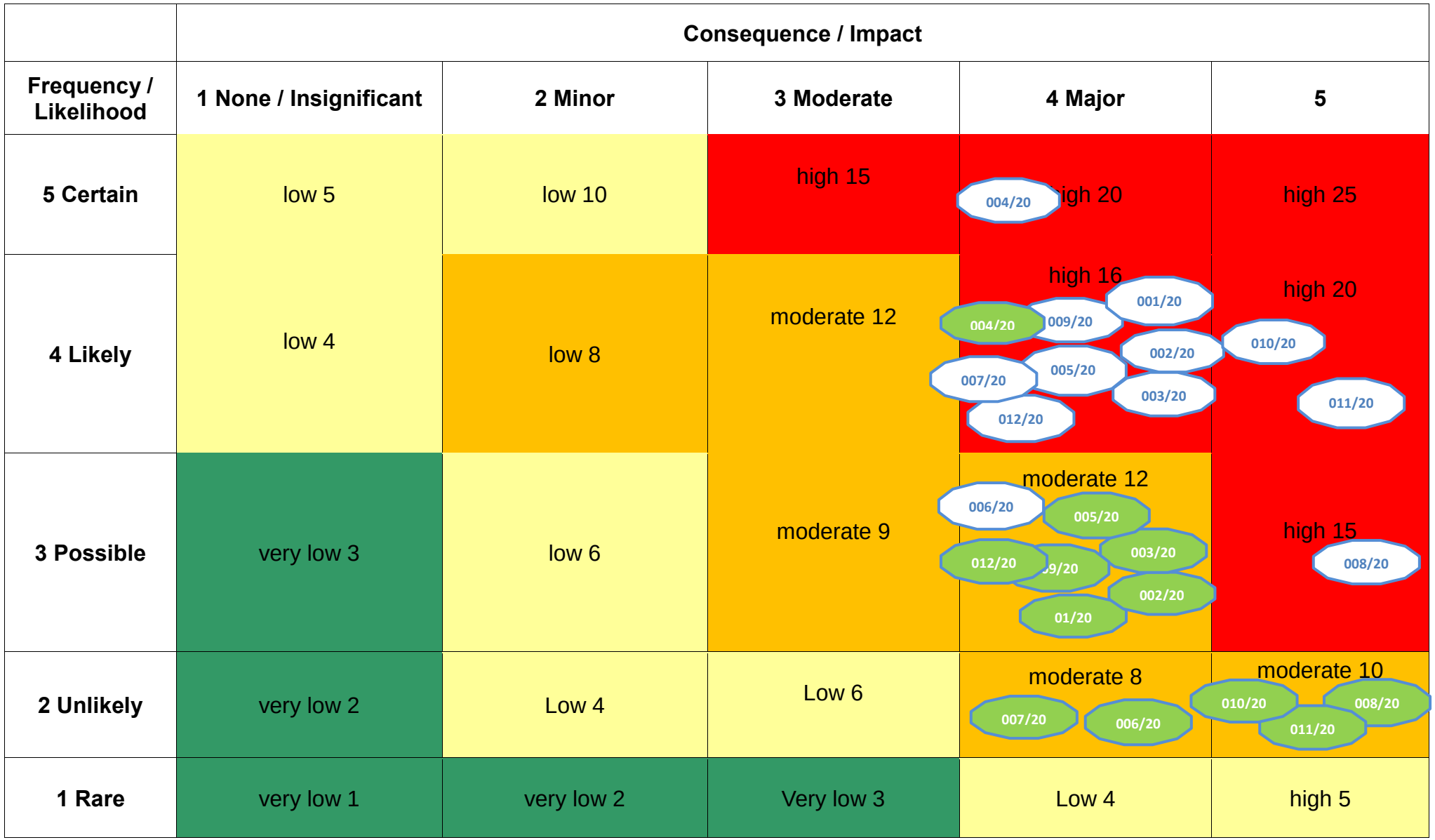
Risk Assessment	Grading
15 – 25	**Extreme**
8 – 12	**High**
4 – 6	**Medium**
1 – 3	**Low**

BOARD ASSURANCE FRAMEWORK OVERVIEW

Risk Ref	Risk Description 2020/21	Lead Executive	Committee	Current Risk July	Last Month June	3 months ago (Feb)	6 months ago (Dec)	Target Score	Date added/ reviewed
001/20	Risk to operational delivery of the core standards and clinical strategy in the context of COVID recovery	Chief Operating Officer	**FPPC**	**16**	**16**	N/A	N/A	**12**	*01-07-20
002/20	There is a risk that the workforce model does not fully support the delivery of sustainable services impacting on health care needs of the public	Chief Nurse /Medical Director/CPO	**FPPC**	**16**	**16**	N/A	N/A	**12**	*01-07-20
003/20	Risk of financial delivery due to the radical change of the NHS Financial Framework	Director of Finance	**FPPC**	**16**	**16**	N/A	N/A	**12**	*01-07-20
004/20	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
005/20	There is a risk that the digital programme is delayed or fails to deliver the benefits, impacting on the delivery of the Clinical Strategy	Chief Information Officer	**FPPC**	**16**	**16**	**16**	**16**	**12**	1- 09- 19
006/20	There is a risk ICP partners are unable to work and act collaboratively to drive and support system and pathway integration and sustainability	Director of Strategy	**FPPC**	**12**	12	N/A	N/A	8	01-04-20
007/20	There is a risk that the Trust's governance structures do not enable system leadership and pathway changes across the new ISC/ICP systems whilst maintaining Board accountability and appropriate performance monitoring and management to achieve the Board's objectives	Chief Executive / Chief Nurse	**Board**	**16**	**16**	N/A	N/A	**12**	*01-07-20
008/20	There is a risk that the Trust is not always able to consistently embed a safety and learning culture and evidence of continuous quality improvement and patient experience	Chief Nurse /Medical Director	**QSC**	**15**	**15**	**15**	**15**	**10**	*01-03-18 Minor change
009/20	There is a risk that our staff do not feel fully engaged and supported which prevents the organisation from maximising their effort to deliver quality and compassionate care to the community	Chief People Officer	**FPPC & QSC**	**16**	**16**	N/A	N/A	**12**	*01-07-20
010/20	There is a risk of non-compliance with Estates and Facilities requirements due to the ageing estate and systems in place to support compliance arrangements	Director of Estates	**QSC**	**20**	**20**	**20**	**20**	**10**	*01-07-20
011/20 was 012/20	There is a risk that the Trust is not able to transfer the MVCC to a new tertiary cancer provider, as recommended by the NHSE Specialist Commissioner Review of the MVCC	Director of Strategy	**FPPC**	16	16	N/A	N/A	12	01-04-20
012/20 Was 013/20	Risk of pandemic outbreak impacting on the operational capacity to deliver services and quality of care	COO/Chief Nurse	QSC/Board	**20**	20	20	N/A	15	*01-07-20

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

Board Assurance Framework Heat Map –July 2020



008/20 Existing risk score

011/20 Target risk score

Movement from previous month

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

Our Priorities

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

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

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

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

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

Our Objectives 2020/21 v8 final draft

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

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

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

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

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

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

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

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

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

Trust Strategic Aim:	**Pathways: To develop pathways across care boundaries, where this delivers best patient care** **redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff** **Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term**				**Ease of Use: To**
Trust Strategic Objective:	**b) Improve patient outcomes, experience and efficiency by enhancing specialty-level inpatient care** **d) Develop a future vision for the Trust's cancer services and support work with partners to transfer MVCC to a tertiary e) Safely recover operational performance affected by the COVID-19 pandemic provider f) Work with partners to meet the health and care needs of our community through and beyond the COVID-19 pandemic g)** **Harness innovation, technology and opportunities for new models of care to right size and optimise our capacity to meet demand**	**Source of Risk:**	Strategic Objective IPR	**BAF REF No:**	001/20
Principal Risk Description: What could prevent the objective from being achieved? **Risk to operational delivery of the core standards and clinical strategy in the context of COVID recovery**		**Risk Open Date:**	01/07/2020	**Executive Lead/ Risk Owner**	**Chief Operating Officer**
		Risk Review Date:	Aug-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 COVID 19 measures - PPE, testing, social distancing, staff and patient risk assessments, availability of workforce. v) Impact of specialist commissioning review and resultant outcome for MVCC on staff retention and recruitment, impacting on effectiveness of the cancer team.	i) Limited ability to respond to changes in capacity and demand impacting on service delivery - changes to referal patterns following COVID. Patients presenting later to GP's ii) Adverse impact on sustaining delivery of core standards iii) impact on patient safety, experience and outcomes iv) increased regulatory scrutiny v) reputation - Public confidence	**Inherent Risk** (Without controls):	4	5	20	
		Residual/ Current Risk:	4	4	16	
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
Risk Stratification of patients - Oversight by Clinical Advisory Group (Consultant Chair) Use of Private Sector (One Hatfield & Pinehill) Recovery programme - operation restart with governance structure and Recovery Steering Group with workstreams New Trust Delivery Framework (commencing September) Cancer Board Systemwide group chaired by Trust COO (SARG) COVID Specialist advisory group Task and Finish Group re Gastro surviellence and waiting list Weekly PTL Management - Cancer, RTT Recovery plans in place for diagnositics - Ultrasound and MRI	Flat packing of COVID Pandemic escalation plans / COVID Policies and procedures Sustained cancer performance - achieved the 8 cancer standards on June	Sustained cancer 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**		
Complexity of operation restart in the context of COVID National changes to gudiance and policy requiring local response at short notice.	Define metrics to support monitoring of recovery Assurance on compliance with NICE changes and GIRFT Capacity to support increased demandpost COVID - Endoscopy and other specialities - delievery against plans Review of Harm review process / policy	Green	Effective control is in place and Board satisfied that appropriate assurances are available	
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient	

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

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
Operation Restart Programme with risk stratification recovery steering group	**COO**		In progress - weekly recovery streering group. Risk stratificaiton of patients on waiting list / surviellence and follow ups.	In progress
Ward reconfiguration Programme	COO/ Director of Estates/Chief Nurse		Capital funding bid - awaiting confirmation of outcome	
Implement Organisational restructure	COO		Consultation launched in August 2020	In progress
Develop system recovery plan with ICP, PCN's, Community and Social Care services (e.g. further development of Ambulatory care to create ED	COO			
Review 7 day working	Medical Director/COO			
Review performance metrics	COO			
Summary Narrative:				

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

Strategic Aim:	**Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term**				
Strategic Objective:	**a) Enhance clinical leadership and service line delivery to further improve service quality, safety and transformation** **b) Improve patient outcomes, experience and efficiency by enhancing specialty-level inpatient care** **d) Develop a future vision for the Trust's cancer services and support work with partners to transfer MVCC to a tertiary provider** **e) Safely recover operational performance affected by the COVID-19 pandemic** **f) Work with partners to meet the health and care needs of our community through and beyond the COVID-19 pandemic**	**Source of Risk:**	- Operating Plan - Use of Resources - Financial Framework 2020/21	**BAF REF No:**	003/19
Principal Risk Decription: What could prevent the objective from being achieved? **Risk of financial delivery due to the radical change of the NHS Financial Framework**		**Risk Open Date:**	01/04/2018	**Executive Lead/ Risk Owner**	**Director of Finance**
		Risk Review Date:	Aug-20	**Lead Committee:**	**FPPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Demand and capacity planning - post covid ii) Shortfall in CIP delivery iii) Good financial management is not sustained 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 Metrix 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 delivery (New Delivery Framework approved July 2020) • 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 / transformation • Finance and project training programmes in place for budget holders to access • Coding and Data Quality Strategy reviewed at Audit Committee Draft Budget plan 2020/21 , covid financial framework, covid reimbursement Block agreement set with Region New Capital and Cash scheme	• 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) •	• Internal Audit - key financial control, CIP governance, performance framework 2019/20. Delivery of 2019/20 financial plan and unqualified opinion on the Annual Report and Accounts.		

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**	
• Comprehensive bed model and associated demand & capacity modelling - post COVID	• Limited demand and capacity modelling due to COVID • delivery of CIP schemes	Green	Effective control is in place and Board satisfied that appropriate assurances are available

• Implementation of new pathway models and technologies Temporary staffing control environment in respect of medical and nursing staffing Review of financial governanca for recovery and new world - unknow Financial Framework for 2020/21 Impact of MVCC decoupling / transfer	• delivery of activity levels due to COVID complexicity - • Gaps in business skill sets across divisions eg. rostering, waiting list management, budgetary management Interim Financial Framework in place - Q1 and Q2 2020/21	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
Impact of COVID 19 on capacity and efficiency - COVID recovery and winter plan	Director of Finance		Proposal to engage external support to FPPC in July 2020.	In progress
Review of future Finanical framework for core capacity 2020/21	Director of Finance		Proposal to engage external support to FPPC in July 2020.	In progress
Implementation of Service Line Reporting	Director of Finance			In progress
Implementation of the new Delivery Framework	Director of Finance	Sep-20		In progress
Continue to develop BI and support divisions / directorates using effectively	Director of Finance	on going	Ongoing embedding and further development of dashboards and data sets development	In progress
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**				**Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term**
Strategic Objective:	**e) Safely recover operational performance affected by the COVID-19 pandemic b) Improve patient outcomes, experience and efficiency by enhancing specialty-level inpatient care g) Harness innovation, technology and opportunities for new models of care to right size and optimise our capacity to meet demand**	**Source of Risk:**	Business Plan, Clinical Strategy	**BAF REF No:**	004/20
Principal Risk 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 medical equipment and service developments**		**Risk Open Date:**	01.03.18	**Executive Lead/ Risk Owner**	**Director of Finance**
		Risk Review Date:	Aug-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 - Implememtation of the new Capital and Cash Framework	• 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)			

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 . Awaiting outcome of capital bids submitted through COVID / national Funding streams - Implememtation of the new Capital and Cash Framework - capital allocation is now through STP/ICS	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps				
Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete

i) Estates strategy to support the trust clinical strategy	Director of Estates and Facilities	(TBC)		Not yet started
ii) Develop capital equipment replacement plan	Deputy Director of Finance			
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 2020-2021

Strategic Aim:	**Trust Strategic Aims:** **Quality: To deliver high-quality,compassionate services,consistently across all our sites this delivers best patient care** **Pathways: To develop pathways across care boundaries, where experience for our patients, their referrers, and our staff** **Ease of Use: To redesign and invest in our systems and processes to provide a simple and reliable** **Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term** **Aims from the Digital strategy:** **1. RECORD Invest in our systems to record clinical information electronically that is stored in single, digitally- secure, integrated record which is paper-free at the point of care reducing repetition and improving safety, using fit for purpose equipment, networks, patient-facing technology and 'Internet of Things'** **2. SUPPORT Provide staff with easy to use, complete and up-to-date, high quality clinical information, and access to clinical decision- making tools and guidelines, enabling clinicians to consistently deliver best practice care** **3. SHARE Enable better co-ordination of pathways of care across a portfolio of services by sharing (with informed consent) clinical information with the patient and other care professionals involved in the patient's care, both within the Trust and the wider health and social economy**				
Strategic Objective:	**Trust Objective: a) Enhance clinical leadership and service line delivery to further improve service quality, safety and transformation b) Improve patient outcomes, experience and efficiency by enhancing specialty-level inpatient care c) Support our people to feel valued and fully engaged to maximise their efforts to deliver quality and compassionate care d) Develop a future vision for the Trust's cancer services and support work with partners to transfer MVCC to a tertiary provider e) Safely recover operational performance affected by the COVID-19 pandemic g) Harness innovation, technology and opportunities for new models of care to right size and optimise our capacity to meet demand** **Digital Objective: The design and delivery of a Digital programme to support the Trust clinical strategy**	**Source of Risk:**	Digital Programme/ Strategy	**BAF REF No:**	005/20
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the digital programme is delayed or fails to deliver the benefits, impacting on the delivery of the Clinical Strategy		**Risk Open Date:**	Jun-20	**Executive Lead/ Risk Owner**	**Chief Information Officer (CIO)**
		Risk Review Date:	Aug-20	**Lead Committee:**	**FPPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Staff Engagement / Adoption Lack of Clinical/Nursing/Operational engagement in system design - reduces likelihood of system adoption Lack of Clinical/Nursing/Operational adoption of digital healthcare creates innefective process which can introduce clinical risk **ii) Financial / Resource Availability** Failure to resource its delivery within timescales Trusts may not be in a position to finance the investment (including Lorenzo renewal 2022) **iii) Business Risk** IT resources may get diverted onto other competing Divsional projects **iv) Knowledge & Experience** Delivery team does not have the appropriate experience/knowledge to implement	i) Unable to deliver the Clinical strategy ii) Unable to deliver target levels of patient activity iii) Unable to meet contractual digital objectives (local, national, licience) iv) adverse impact on performance reporting	**Inherent Risk** (Without controls):	4	5	20	
		Residual/ Current Risk:	4	4	16	
		Target Risk:	4	3	12	

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

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

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Publish Digital roadmap and engage with CAG to ensure each Project board has a clinical chair. Programmes only commence with appropaite stakeholder engaement	CIO	Jul-20	Approved by FPPC in July 2020	In progress
ii) Seek investment through ICS where available	CIO	Dec-20		In progress, Complete
iii) Long term Lorenzo strategy/commercials to be finalised	CIO	Jan-21	Position paper to FPPC in July 2020	
iv)Complete IT workforce review and actively engage in the martket with HR support for recruting good candidates at pace.		Aug-20		Completed.

v Implementation of a Business partner process (Post Silver)	CIO	Jul-20		In progress
vi) Relaunch of EMPA roll out		Aug 20	Training and rollout plan recommenced	In progress
Summary Narrative:				

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

Trust Strategic Aim:	**Pathways: To develop pathways across care boundaries, where this delivers best patient care and invest in our systems and processes to provide a simple and reliable experience for our patients, theirreferrers, and our staff Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term**				**Ease of Use: To redesign**
Trust Strategic Objective:	**h) Play a leading role in developing sustainable and integrated services through the ENH Integrated Care Partnership and ICS**	**Source of Risk:**	National directives	**BAF REF No:**	Risk 006/20
Principal Risk Decription: What could prevent the objective from being achieved? ICP 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:	Jul-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 approach 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	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	

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		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 . Aug-20 : Partnership Board has reviewed and confirmed streamlined governance to support clinical leadership and delivery. Development of ICP strategic framework to be informed by population health data work underway.	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. Aug-20: ICP involvement in Phase 3 recovery planning - the trust is looking to ICP partnership to support delivery of recovery activity to help meet the needs of the community we serve.	In progress
iii) Confirm and implement ENH improvement methodology across ICP	Director of Improvement	Ongoing	Aug-20: The Director of Improvement s leading the ongoing development of the ENH way internally - this is being adopted for capacity and demand work informing specilty recovery plans. He also expects to work with the newly appointed ICP Development Director to support the adoption of a consistent improvement approach across the ICP, supported by ICP collaboration.	
iv) Identify clinical leadership capacity to support the development of collaborative, ICP integrated pathways	Medical Director/Director of Nursing	Ongoing	Under consideration in order to align with planned operational restructure. Aug -20: The Executive Committee agreed that the restructure of the Medical Director's office would not include a deputy medical director for integration role currently due to affordability. Alternative ways of identifying and releasing clinical capacity to foster pan organisation clinical integration and pathway development are being explored.	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:				

Aug -20: The Trust is increasingly seeking to engage ICP partners to develop a collaborative approach to meeting patients' needs. Whilst the ICP Partnership Board and supporting gvernance is at an early stage, the Trust is committed to supporting its clinical and operational staff to engage with this, enabled by a restructure of the Operations Directorate, led by the Chief Operating Officer, Medical Director and Director of Nursing .

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

Strategic Aim:	**Quality: To deliver high-quality, compassionate services, consistently across all our sites**				**Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term**
Strategic Objective:	**a) Enhance clinical leadership and service line delivery to further improve service quality, safety and transformation c) Support our people to feel valued and fully engaged to maximise their efforts to deliver quality and compassionate care f) Work with partners to meet the health and care needs of our community through and beyond the COVID-19 pandemic g) Harness innovation, technology and opportunities for new models of care to right size and optimise our capacity to meet demand h) Play a leading role in developing sustainable and integrated services through the ENH Integrated Care Partnership and ICS**		**Source of Risk:**	Strategic Objectives External reviews	**BAF REF No:** **007/20**
Principal Risk Decription: What could prevent the objective from being achieved? **There is a risk that the Trust's governance structures do not enable system leadership and pathway changes across the new ISC/ICP systems whilst maintaining Board accountability and appropriate performance monitoring and management to achieve the Board's objectives**			**Risk Open Date:**	01.04.2020	**Executive Lead/ Risk Owner** **Chief Executive**
			Risk Review Date:	Jul-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	• Commissioned external reviews – PwC Governance Review September 2017 NHSI review of Board and its committees 2019 • Visibility of Corporate risks and BAF as Board Committees and Board (L2) • Internal Audits delivered against plan, outcomes report to Audit Committee • Annual review of SFI/SFOs (L2)	Internal Audit report - risk management , performance framework, IG 2019 NHSI Infection control review - green - June 2019 Review of progress with QTP workstreams with NHSI/CCG - June 2019. Internal Audit - Surgical division governance - reasonable		

- Commissioned external reviews • Review of external benchmarks including model hospital , CQC Insight– reports to FPC and RAQC (QSC) • Board Assurance Framework and monthly review • Performance Management Framework/Accountability Review meetings monthly • Integrated Performance Report reviewed month at Trust Board, FPC and QSC - Quailty dashboard / compliance dashboard CQC steering group and action plan 2019/20 action plan to deliver the Trust strategy -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 in September 20.	- Annual review of SFI/SFOs (L3) • Annual review of board committee effectiveness and terms of reference (May-July) (L3) • PwC Governance review and action plan closed (included well led assessment) (L3) • Annual governance statement (L3) • Counter fraud annual assessment and plan (L3) • Annual self-assessment on licence conditions FT4 (L3) • CQC Inspection report July 2018 –(overall requires improvement) and actions plan to address required improvements and recommendations (L3 -/+) • Use of resources report July 2018 – requires improvement (L3 _/+) • September 2018 Progress report on CQC actions and section 29a (L2 +) to CQC & Quality Improvement Board • Annual review of RAQC to Board (L2 +) • Internal Audit Report – Assurance and Risk Management (- reasonable assurance (L3) • Board development session on Risk and Risk Appetite, Feb 2019 • Internal Audit – Performance Framework report - reasonable assurance March 19) - Internal Audits 2019/20 scheduled for Data Quailty; Divisional Governance; HSE improvement notices on Sharps, Violence and aggression and moving and handling (-ve) Action plan in progress of delivery - Desktop reivew of Pandemic Flu plan scheduled for February 20 - Major incident structure and documentaion - log books, action logs, minutes RIDDOR reporting	Internal Audit - Surgical division governance - reasonable assurance - July 2019. CQC Inspection report 2019 - Requires Improvement overall - UCC and surgery improved to requires mprovement. CYP achieved good. MVCC retained requires improvement. 6 monthly Quailty Account progress reported to QSC November and Board in January. Deep dive reviews on QI areas to QSC in December. Business continuity - compliant assessment validated 2019 Risk and Assurance Internal Audit - reasonable assurance May 20: Review of Major incident structures June 2020- Unqualified opinion on the Annual Report and Accounts June 2020- ICP BAF reviewed at QSC IPC BAF presented to QSC CQC review of IPC BAF July 2020 - assuranced on all ten KLOE CQC assurance on Medicines Management during COVID Postive feedback from ICO regarding an enquiry August 2020	CQC IPC review July 2020	

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
Effectiveness of 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 2020/21	Associate Director of Governance / Risk Manager	ongoing	Monthly reports to Board committees . Current capacity issues. Good divisional and directorate active engagement with the Risk Register. Risk clinics being established Sept/Oct to review 20+ risks and implement the scoring methodology for the likihood of the risk materialising	In progress
ii) Consider independant well led review in line with the national guiidance	Associate Director of Governance / Trust Secretary	Nov-20	Previous external review 2017 (best practice - 3 yearly).	
iii) Review of governance structures in line with the Divisional Restructure	Associate Director of Governance / DCOOs	Nov-20		
iv) Review and implement the compliance framework	Associate Director of Governance	Oct-20	Rephasing the implemenation of the compliance framework - commence testing the audit tools for the fundimental standards in June.	In progress
v) Review of governance with ICS/ ICP	Trust Secretary and Associate Director of governance			

v) develop and implement action plan to address HSE findings and improvement notices	Associate Director of Governance	January 2020 - action plan to HSE July 2020	Action plan under development. Scheduled to present draft action plan to Executive Committee through to QSC in November/December. Trust partnership engaged. Action taken 23.10.19 to have a security officer in the ED 24/7 with immediate effect. Reviewing H&S structure to support a more proactive service across the Trust. Meeting with HSE January 2020 and updated action plan submitted, revised compliance timelines agreed. Monitoring delivery . End April - Evidence submission to HSE to consider compliance with the V&A and Sharps improvement notices - awaiting outcome. On track for compliance with M&H at end July. Testing of actions to ensure implemention is in progress and onoing. Awaiting outcome from HSE following submission of evidence. 100% compliant with sharps and V&A actions. 4 open actions for M&H to ensure actions embedded re training but not part of the core improvement notice.	In progress
v) Review of strategic decision making during pandemic outbreak against the legal framework / advice - and ensure clear audit trail	Associate Director of Governance	end of May 2020 - revised to June	In progress. For discsussion at Audit Committee	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 / restart	Trust Secretary and Associate Director of governance	Aug-20	Plans agreed with Chair and NEDs, including attendance at interviews, flex /rotation of attendance in person /virtual for Board and Committees - supporting social distancing and visits.	in progress
Summary Narrative:				
Awaiting outcome from the				

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

Strategic Aim:	**Quality: To deliver high-quality,compassionate services,consistently across all our sites which retains staff, recruits the best and develops an engaged, flexible and skilled workforce boundaries, where this delivers best patient care**				**People: To create an environment Pathways: To develop pathways across care**
Strategic Objective:	**a) Enhance clinical leadership and service line delivery to further improve service quality, safety and transformation b) Improve patient outcomes, experience and efficiency by enhancing specialty-level inpatient care c) Support our people to feel valued and fully engaged to maximise their efforts to deliver quality and compassionate care f) Work with partners to meet the health and care needs of our community through and beyond the COVID-19 pandemic g) Harness innovation, technology and opportunities for new models of care to right size and optimise our capacity to meet demand h) Play a leading role in developing sustainable and integrated services through the ENH Integrated Care Partnership and ICS**	**Source of Risk:**	Objectives Quailty Assurance data / CQC Inspection	**BAF REF No:**	**008/20**
Principal Risk Decription: What could prevent the objective from being achieved? **There is a risk that the Trust is not always able to consistently embed a safety and learning culture and evidence of continuous quality improvement and patient experience**		**Risk Open Date:**	01/03/2018	**Executive Lead/ Risk Owner**	**Chief Nurse/ Medical Director**
		Risk Review Date:	Jul-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 capablity & capacity infrastructue ii)Limited staff engagement 2. Capturing and pro-actively providing ontinous leanring opportunies require more structred strategy and deployment iii) Inconsistent ward to board governance structures and systems 3. Current governace structrues requires strengthening to reliably seel assurance of leanring	1) Limited learning oppurtunites from current and future continuous quality activities 2) Poorer patient and staff expereince 3)Limited leadership development of all staff 4) impact on reputation iv) increased regulatory 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	• Clinical effectiveness committee / Patient Safety Committee/ Patient Experience Committee • Accountability Framework • CQC Engagement meeting • Increased Director presence in clinical areas • SIs and Learning from death investigations	• NHSI Infection control review June 2019 - Green • CQC Inspection report 2019 - Requires Improvement overall - UCC and surgery improved to requires improvement. • CYP achieved good. • MVCC retained requires improvement. • 6 monthly Quality Account progress reported to QSC November		

• Nursing and Midwifery Executive Committee • Invasive procedure Clinical Group • Monitoring of new to follow up ratios through OPD steering group and access meetings(L2) • Peer Reviews (L3) • Audit Programme (internal and external) (L3) • Quality Strategy reports and Quality Improvement deep dives to QSC • CQC Inspection report July 2019 –(overall requires improvement) and actions plan to address required improvements and recommendations (L3) • NHSI Infection control review June 2019 - green (L3) • Quality Dashboard / Compliance dashboard • Internal Audit scheduled , Clinical audit and effectiveness procsses, Patietn safety incndent management. • RCN Clinical Leadership Programme • Pathways to Excellence Programme • Harm Free Care Collaborative • Deteriorating Patient Collaborative (Quality Improvement Break through Series Learning Collaborative) New Quality Assurance Meeting - weekly - chaired by DoN/MD supported by complaince team and dashboard. PPE clinical advisory group Covid risk assessments Covid Track & Testing Clnical Advisory Group Covid skills & training faculty Continuous Quality Patient Co-design forum Weekly Quality Huddle Recruitment of Quality Excelllence Matrons & Pathway to Excellence Programme Manager Quality Assurance Board and dashboard	• SIs and Learning from death investigations • Serious Incident Review Panel • Strengthened TIPCC membership and ToRs • Quality and safety visits • Medication safety quality peer reviews • Safety huddles • Quality Huddles (bi-weekly) • Policies and procedures • Quality Strategy updates • Divisional Quality Manager posts in each division • Weekly review meetings of CQC improvement plans • Clinical Harm Review Panel (Weekly) • Invasive Procedure Clinical group (safer Surgery Collaborative) • Recruitment and deployment of Quality Improvement team • Deteriorating Patient Quality Improvement Collaborative • Harm Free Care Collaborative • Thrombosis committee • Safer Sharps Committee • Appointment of Associate Medical Director for Quality Improvement & Safety • Recruitment of Improvement Director Patient experience feedback - new mechanisms and quartely review. Reduction in outstanding complaints and SI's Internal Audit Programme Joint meeting Quailty Oversight Meeting with NHSI, CCG and CQC bi monthly	• 6 monthly Quality Account progress reported to QSC November and Board in January. • Deep dive reviews on QI areas to QSC in December. • Quality Improving team KPis • Successful compleition of intial 2 waves of Pathway to Excellence achievements, and planning of wave 3 underway. • Sustain reduction cardiac arrest rates 7 day services - internal audit - reasonable assurance - Internal Audit - Clinical Audit (Substancial assurance) July 2020 - Internal Audit - SI's (reasonable assurance) July 2020 - CQC review of IPC BAF - compliant with all 10 KLOE - July 20 - CQC - postive medicines managemetn review - covid 19 focused, Aug 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**		
• National guidance and GIRFT Gap analysis identifies areas for improvement • Consistency with procurement and engagement with clinicians • Patient safety team capacity • Gaps in compliance with IPC Hygiene Code leading to C-difficile outbreak in April 2018 and MRSA bacteraemia in May 2018 • Gap in compliance with CQC standards warning notice section 29A – Surgery Lister and UCC QEII Complex discharge pathway	• Consistency in following care bundles • Implementation and tracking of action plans related to GAPS associted with National Audit & NICE guidance, GIRFT recommendaions, NatSSIP Audit compliance • Embedding of learniing from SIs/Learning from Deaths • Data quality • Delivery against CQC improvement plan - Delivery of harm review process following COVID impact on 52wk waits , follow up and survielience Effectivness of Pathway for safe discharging of complex patients - complaints and referals	Green	Effective control is in place and Board satisfied that appropriate assurances are available	
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient	
		Red	Effective controls may not be in place and assurances are not available to the Board.	

Action Plan to Address Gaps

Action:	Lead:	Due date	Progress Update	Status: Not yet Started/In Progress/ Complete
i) Delivery of the Quality Strategy Priotrities	Chief Nurse / Medical Director	ongoing	Improving Patient Discharges Group with 4 delivery workstreams established.	In progress
ii) Delivery and monitoring of CQC improvement plans for Surgery Lister and UCC QEII and other core pathways and emergency support programme requirements	Associate Director of Governance / Chief Nurse	ongoing	Full review of action plan with each pathway in July and August 20 ; outcome will be presented to QSC. Postive meetings with CQC re IPC and Medicines Optimisation under the CQC's ESP.	In progress
iii) review of structures and mechanisums to support embedding learning across the organisation	Associate Director of Governance / Chief Nurse		In progress	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	In progress
Implement the pathways to excellence programme	Chief Nurse		Programme recommenced in July 2020	In progress
Review of Quailty safety and governance structures (including meeting structures) to support delivery of Quailty Governancne across the organisation	Associate Director of Governance / Chief Nurse		In progress	In progress

Review harm review and mortality review processes due to increased demand following COVID	Medical Director / Associate Director of Governance	Aug-20	Mortality reviews recommenced and priorisied. Harm review process is under review to ensure clear oversight and governance and inline with the Royal College of Surgeons prioritisation guidance.- work is in parallel to workstream on capacity / demand and review and risk stratification of patients - 52wks, survielience and follow ups.	Inprogress
Summary Narrative:				

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

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

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

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

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

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Review and implement revised estates and facilities governance and reporting structure	Director of Estatesand Facilities	01/09/2019 revised date with Director April 2020	Paper presented to QSC in June 2019 outlining key workstreams. Implemention of the supporting committees commences with water safety, ventilation and electrical safety. E&F Governance structure and reporting arrangements were revised in August 2019, and to be reviewed 4th Qtr 2019/20. February - E&F structure and governance structure under review with new Director of Estates and Facilities. The outcome of a structural change to the division will be the presentation of a "state of the nation" report. As part of the state of the nation report there will be a declaration and methodology on how we deal with governance and who will have the responsibility and the obligation to provide evidence.	
iii) Review of Estates Strategy	Director of Estates and Facilities	Mar-20	on hold until new estates and facilities director in post from January 2020. New Estates and Facilities Director commenced January 2020. Review of Estates Strategy Commenced The estate strategy requires a clinical strategy to be completed and ratified. All estate strategies should be led by the clinical strategy. In addition to this we are currently undertaking a transformation of our environments to reflect the changes which has happened during the pandemic. We need to await the completion of these transformations and agreements with our partners in the rest of the health economy that previous assumptions with regards to activity and services we provide still hold true. In the meantime and includes state strategy or statement of intent will be created for presentation to the board in the fourth quarter	

iv) review and implement mechanisms to ensure Estates, Facilities and Fire compliance assurance is received from partner organisations where trust operates from	Director of Estates and Facilities	Dec-19	Paper presented to QSC in June 2019 outlining key workstreams. Trust risk assessments have been shared with the relevant partners. Correspondence issued to all satellites CEO's requesting assurance on their water compliance and all areas of the HTM's and health & safety, for completeness. External review of compliance completed.	
iv) Substantive recuitment into leadership structure and other vacancies	Director of Estates and Facilities	Dec-20	Structure reviewed in July 2020 The proposed structure for the estates and facilities division has now been shared with the other executives following a review to attempt to maintain any structural changes within the current financial budgetary constraints. This in the main has been achieved the Deputy director of Estates and facilities (business and compliance manager) is undergoing final review of its grading. The revised structure will be included within the first state of the nation report which is due in quarter four is expected that all posts will be filled before the end of that quarter.	
v) Work with STP partners to ensure STP Estate Strategy reflects Trust priorities	Director of Estates and Facilities	Dec-20	ENH was represented at a meeting in September 2019, with the regional Estates & Facilities Directors. STP Estates Strategy completed and rated as Good by NHSI/E, Estates and Facilities continue to be representative and attend to all STP estate strategy meetings. Whilst the current Director of Estates knows the majority of the other officers in the region from prior works within Watford and Hillingdon he is attempting to make personal and professional partnerships with all concerned.	
iv)				
Summary Narrative:				

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

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

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 Strategy Committee (from October) 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	Impact of COVID 19 on the timeline of transfer	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	Lead:	Due date	Progress Update	Status: Not yet Started/In Progress/ Complete
i) Support NHSE to recommence and deliver MVCC Strategic Review Phase 2	Director of Strategy	June 2020 onwards	April 20 - because of delays caused by pandemic response , agreed provisional restart date of June 2020 and transfer target of April 21. Subject to confirmation with UCLH. May 20 - Programme Board met 15/5/20 and approved outline timetable for next phase of review. Work with UCH and MVCC clinicians to develop a new clinical model for MVCC to commence before the end of Q1, including input from patient experieince. Aug 20 - Programme Board met 18 Aug. Agreed revised timeline proposed by NHSE and UCLH whivch would deliver Business Transfer Agreement in Sept 21 and transfer in Apr 22. UCLH Programme Director has commenced in post.	
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. Aug 20 - Trust due diligence continues. UCLH due diligence has commences but due to organisational priorities, is running behind the ENHT data gathering. A critical infrastructure group has been set up led by NHSE with key stakeholders in order to support shared understanding and agreement on responses to critical infrastructure issues prior to transfer.	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. Aug 20 - mitigation plan for loss of LA1 in 20/21 agreed internally and with NHSE. External modelling indicates that this capacity is not required but that the next linac due for replacement (LA9) will need replacing to sustain capacity to meet demand. NHSE have commissioned external work to support resilience of LA9 this year and the Trust will undertake bunker enabling works in year in readiness for a new linac installation in 21/22. Funding for the new linac is to be identified in dsicussion with NHSE and UCLH.	
iv) Continue to support and monitor continuous quality and safety improvement and assurance at MVCC	Chief Nurse/Medical Director	Ongoing		
Summary Narrative:				

Aug 20 - The transfer programme has recommenced . Phase 2 (future service model and location) is being led by UCLH with NHSE. The Trust is fully engaged and supporting this work. In anticipation of a reduction in the director of strategy's capacity following her appointment as joint director of strategy with Hertfordshire Community trust, the Trust is recruiting a fixed term senior programme director to support the director of strategy and internal leaders drive the Trust's transfer and future service redesign programme to provide additional capability.

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 care boundaries, where this delivers best patient care the best and develops an engaged, flexible and skilled workforce the long term** **Pathways: To develop pathways across** **People: To create an environment which retains staff, recruits** **Sustainability: To provide a portfolio of services that is financially and clinically sustainable in**				
Strategic Objective:	**People: To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce** **Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term**	**Source of Risk:**	External	**BAF REF No:**	012/20 (was 13 and orginally COVID focused_
Principal Risk Decription: What could prevent the objective from being achieved? **Risk of pandemic outbreak impacting on the operational capacity to deliver services and quality of care**		**Risk Open Date:**	04-Mar-20	**Executive Lead/ Risk Owner**	**Chief Operating Officer/ Chief Nurse**
		Risk Review Date:	Aug-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. Major Incident Command structure - Gold , silver, bronze - GOLD and SILVER command structures reviewed/adapted to ensure continued support to organisation / major incident Communcation plan - internal and external Emergency Planning Group	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	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 Acquired COVID		

Emergency Planning Group Brexit Business continuty group (on pause currently) Testing Clinical Advisory Group COVID clinical advisory group 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 Oncall rotas at various levels Fit testers and training / PPE logistics and Clinincal Advisory group Reviewed Board and Committee Governance structures approved and inplace in March 20 New weekly Quality Assurance meeting established in April - chaired by DoN/MD - supported by Compliance team and dashboard. (to support interim governance arrangement and quailty oversight during pandemic) Central record of contract / pathway reviews and agreed changes Record of national / 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	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 - awards of COVID Secure (Non clinical) and COVID Commended (Clinical) Social distancing	3 wks without any Hospital Acquired COVID IPC BAF presented to QSC CQC review of IPC BAF July 2020 - assuranced on all ten KLOE CQC assurance on Medicines Management during COVID		
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) COVID Specialist Advisory Group oversight and leading policy, guidance and expertise - PPE, logistics, testing, social distancing, IPC issues	Chief Nurse/ Medical Director		meets weekly to problem solve, provide guidiance and direction; gain assurance . Staff testing strategy under development	In progress
ii) Testing Clinical Advisory Group leading policy, guidance and expertise regarding patients and staff testing	Medical Director		meets weekly to respond to changes to guidance and recommend changes to Covid SAG. Currtently considering programme for testing staff - asymptomatic; response to LU4 local outbreak; trust patient testing	
iii) Develop trust approach and implementation plan for the Flu Campaign 2020/21	CPO			

iv) Continue Developing partnership working with Community and Care/Nursing homes to provide expertise to support care and treatment to prevent admission to hospital and improve outcomes	Chief Nurse	May / June 20	In place	In progress
v) Review lessions learnt to date from the COVID pandemic to inform trust wide major incident planning/ business continuity and pandemic prepardness	COO/ Chief Nurse			
Summary Narrative:				

East and North Hertfordshire NHS Trust

Agenda Item: 11

TRUST BOARD - PUBLIC SESSION – 2 SEPTEMBER 2020

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE – 29 JULY 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 29 July 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

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):

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

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE – 29 JULY 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:
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:

FIRE PRECAUTION WORKS – PROGRESS REPORT
The FPPC received an update regarding the Trust's progress with fire precaution works, as requested by the Board at the meeting on 1 July. Some delays from the original plan were expected, largely due to the impact of the COVID pandemic. It was noted that additional capital was now available which would support planned outstanding fire and estates requirements. The FPPC noted current risks relating to fire and requested further detail at a future meeting. The FPPC encouraged the Director of Estates and Facilities and his team to ensure as few delays to the plan as possible.

WDES AND WRES REPORTS
The FPPC received the Trust's submissions for the Workforce Race Equality Standards and Workforce Disability Equality Standards. Key issues were highlighted within the covering reports and action plans would be developed with the support of the staff network groups. It was also noted that a Board Development session regarding equality and diversity was scheduled for September.
The WDES and WRES are attached as Appendix 1 for approval by the Trust Board.

RESOURCING REPORT
The FPPC considered a report regarding the Trust's resourcing activities and performance. It was reported that the Trust's vacancy rate was the lowest it had been in 5 years, with a similar number of staff being recruited but retention rates improving. This was in part due to the changed job market caused by the COVID pandemic. The Committee noted that plans to reconfigure the wards would result in changes to the establishment. These plans were currently being worked through.

WORKFORCE PLANNING
The Committee received a presentation regarding workforce planning and the need for a different approach in terms of the deployment of staff so as to reduce the need for additional high cost recruitment. The presentation outlined that approximately 20-30% of staff were currently not in post due to being on sickness leave, as a result of delays in recruitment etc., and that minimising these issues could significantly improve the number of staff deployed in the Trust at any given time without increasing recruitment rates. The FPPC supported the work to strengthen this approach and requested further detail at future meetings.

INDEPENDENT CONTRACTORS AND HIGH VALUE AGENCY WORKERS QUARTERLY REPORT
The FPPC noted the latest quarterly report which provided an overview of the independent contractors and high value agency workers currently employed by the Trust.

MONTH 3 FINANCE REPORT
It was reported that the Trust remained at a breakeven position at Month 3 in line with the national framework. The Committee considered the underlying activity rates, noting that these had increased over recent months but were still below pre-COVID levels.

COVID FINANCIAL FRAMEWORK
The Committee noted the latest report providing an update on the national COVID financial framework. The framework was not significantly changed since the previous update.

SERVICE LINE REPORTING
The FPPC considered a presentation regarding changes to the approach to Service Line Reporting (SLR). The FPPC considered the role of SLR in enabling change in terms of clinical leadership and ownership and in supporting the Trust's new delivery framework. The FPPC welcomed the report and were supportive of the approach.

CIPS – REFLECTIONS FROM 19/20 AND LESSONS FOR 20/21
The Committee considered a report in relation to learning from the 2019/20 CIP scheme. Following the changes that had taken place in the first half of the year, it was recognised that there were inefficiencies in systems as a result of COVID that would need to be understood more thoroughly. It was also noted that the future approach would probably need to be more cost based rather than income generating. The FPPC welcomed the report and requested to be kept informed of progress over the year.

FUTURE FINANCIAL FRAMEWORK
The FPPC received a short paper outlining current thinking and considerations in relation to the likely development of the future national finance framework. A key element was likely to be closer working with system partners in relation to finance. Further detail would be provided at future meetings once available.

POST COVID CAPACITY AND EFFICIENCY
The FPPC received an update on work that was taking place to assess and analyse the impact of COVID on capacity and efficiency. A third party was being engaged to provide an objective view of the Trust's findings and assumptions.

NEW CAPITAL AND CASH FRAMEWORK
The FPPC received an update on changes to the capital and cash framework. The report set out the temporary COVID funding arrangements. It detailed changes relating to loan to Public Dividend Capital (PDC) conversion, the new capital regime, and public dividend changes. The Committee noted the report.

RISK REPORT AND BOARD ASSURANCE FRAMEWORK 2020/21
The FPPC considered the latest risk report and BAF. The BAF risks for 20/21 had been discussed with the Executive Committee and updated. The Audit Committee had also endorsed the changes to the BAF and had approved an alternative approach to risk scoring in relation to the risk register. The Committee noted the current highest rated risks and supported the proposed changes.

DIGITALISATION STRATEGY UPDATES
The FPPC received updates from the Chief Information Officer in relation to the digital strategy. The presentation included details of the current systems and a roadmap for the next two years. The importance of ensuring clinical engagement with the decision making and as part of any deployment process was highlighted. The Committee also noted the achievements in 2019/20 including infrastructure upgrades and the Trust's digital response to the COVID pandemic. The FPPC welcomed the update on the digital strategy and supported the direction of travel.

PERFORMANCE REPORT
The FPPC considered the key points in relation to operational performance for Month 3. ED performance had improved. However, the impact of the split ED system in response to COVID was thought to be causing inefficiencies relative to other trusts and NHSI were now engaging with the Trust to understand the performance issues. Cancer performance remained relatively strong and work was taking place to assess and address demand for endoscopy services. Stroke performance had deteriorated slightly but remained a significant focus for the operational team. The Recovery Steering Group remained in place and continued to play a key role in working through the Trust's recovery following the changes to services that were made earlier in the year in response to the COVID pandemic. The FPPC noted the update.

Karen McConnell
Finance, Performance and People Committee Chair

August 2020

East and North Hertfordshire NHS Trust

Agenda Item: 11.1 a)

TRUST BOARD - PUBLIC SESSION – 2 SEPTEMBER 2020

Workforce Equality Standards - Key Dates and Timeline

Purpose of report and executive summary (250 words max): **To provide the Board with an overview of the workforce equality standards with key dates for the board to note between July and October.**		
Action required: For information		
Previously considered by: FPPC – 29.07.20		
Director: **Chief People Officer**	**Presented by:** **Deputy Director of Workforce and OD**	**Author:** **Deputy Director of Workforce and OD**

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

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

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

Workforce Equality Standards - Key Dates and Timeline

What are the Workforce Equality Standards?

- Workforce Disability Equality Standards cover race (WRES) and disability (WDES)
- Data-based standard that aims to help improve the experiences staff in the NHS by driving equality and inclusion standards
- The ten evidence-based metrics enable NHS organisations to compare the workplace and career experiences of Disabled and non-disabled staff.
- The WDES and WRES is mandated by the NHS Standard Contract.
- NHS trusts are required to publish an annual report containing their 2020 metrics data and action plan.

July

- WRES and WDES data collection completed and submitted to board
- Build up of data pack based on Race equality standards

August

- Work with staff network for development of:
  - Organisational education and development plan
  - High impact actions providing a practical plan for delivering improvements on equality standards
- 31st August deadline for submission of data return

September

- Creation of board development program for race equality standards:
  - Development – listening, lived experience in organisation
  - Observations and reflections using from information and data
  - Outline of practical plan showing high impact actions
  - Continuous engagement and learning cycle
  - Delivery of board development session

October

- Sign-off of action plans
- Deadline to publish data and action plans 31st October
- Develop information pack for public presentation for EDS2 review

East and North Hertfordshire NHS Trust

Agenda item: 11.1 b)

TRUST BOARD - PUBLIC SESSION – 2 SEPTEMBER 2020

Workforce Race Equality Standard (WRES) Report and Action Plan August 2020

Purpose of report and executive summary (250 words max): This report shows that although the workforce has a higher proportion of BAME staff than the local population this is not evenly distributed across staff groups or grades. Other metrics analysed show that BAME staff are proportionally less likely than White staff to be shortlisted for posts, take up training or be recruited to the Board. It also shows that they are more likely to be subject to formal disciplinary processes. An action plan including undertaking further analysis is required to ensure these findings are accurate and addressed for future employees is included in the paper for approval. The data and action plan have been uploaded to the national website on 31.8.20.		
Action required: For approval		
Previously considered by: **FPPC – 29 July 2020**		
Director: Chief People Officer	**Presented by:** Deputy Director of Workforce & OD	**Author:** Head of HRBP and EDI Manager

Trust priorities to which the issue relates:		
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): Effective management and inclusive leadership of staff will ensure retention of workforce enabling effective transformation and improvement.

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

NHS Workforce Race Equality Standard (WRES)

Report and Action Plan 2019-2020

1. Introduction

The purpose of this report it to present our Workforce Race Equality Standard (WRES) data and analysis to the Board for approval and submission.

It provides assurance to NHS England and our commissioners and to the Trust's Black and Minority Ethnic (BAME) staff, as well as the wider workforce, on the effective implementation of the NHS Workforce Race Equality Standard.

It further highlights high level analysis of the WRES data and actions that address issues, gaps and general improvements aligned to NHS Workforce Equality Standards and broader models of good practice. Timeframes for completion of the data spreadsheets and supporting narrative are determined nationally.

WRES – Key Dates for 2020	
WRES Data Collection Period	6th July to 31st August 2020
WRES Spreadsheet (returned via SDCS) and WRES Online Reporting Form deadline	31st August 2020
Publication of Board Approved Trust WRES Action Plans	31st October 2020

2. Background

The introduction of the Equality Act 2010 merged and re-enforced previously separate legislation for equality, diversity and inclusion. In response, NHS England, with its partners, has prioritised its commitment to tackling discrimination and creating an NHS where the talents of all staff are valued and developed. Respect, equality and diversity are central to changing culture and are at the heart of the workforce implementation plan (NHS Long Term Plan).

Since 2015 all NHS organisations have been required as part of the NHS Standard Contract to demonstrate how they are addressing gaps in race equality across a range of staffing areas through the Workforce Race Equality Standard (WRES).

This followed from the publication of "The Snowy White Peaks", a research report by Roger Kline of Middlesex University that looked into barriers and discrimination affecting BAME job applicants and employees across the NHS.

The WRES standard applies nationally agreed action to ensure NHS employees from black and minority ethnic (BAME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

NHS organisations are expected to collect and analyse data and report annually by producing a WRES action plan that will deliver progress against the nine WRES metrics.

3. Local population demographics by ethnic group

	Asian/Asian British %	Black/African/ Caribbean/Black British %	Mixed/ multiple ethnic groups %	Other ethnic group %	White %
East Hertfordshire	1.9	0.7	1.6	0.3	95.5
North Hertfordshire	5.4	2.0	2.7	0.5	89.5
Stevenage	5.8	3.4	2.7	0.5	87.7
Watford	17.9	5.8	3.4	0.9	71.9
Welwyn Hatfield	7.9	4.5	2.5	1.0	84.1
Hertfordshire	6.5	2.8	2.5	0.6	87.6

(Source: https://www.hertfordshire.gov.uk/microsites/herts-insight/topics/population.aspx)

Hertfordshire's minority ethnic population is growing with 12.4% of the county's population belonging to an ethnic group other than White British. Watford has the highest minority ethnic population, followed by Welwyn Hatfield, Hertfordshire and Stevenage simultaneously. East Herts has the smallest minority ethnic populations.

4. WRES Metrics & Findings

The full WRES data sheet is available at appendix 1 for information. The following sections highlight the findings for each of the metrics in turn.

Metric 1. Percentage of staff in each of the Agenda for Change AfC (including executive Board members) Bands 1-9 or Medical and Dental Subgroups and Very Senior Management (VSM) compared with the percentage of staff in the overall workforce

In 2019 our BAME workforce was 31% of our overall workforce; this has increased slightly to 32% of our workforce in 2020.

	31 MAR 2019				31 MAR 2020				
Non- Clinical	White	BAME	Unknown	BAME %	White	BAME	Unknown	BAME %	% Diff.
Under Band 1	0	0	0	0	0	0	0	0	0
Band 1	84	52	3	37%	16	7	1	29%	-8%
Band 2	276	38	13	12%	356	92	19	20%	8%
Band 3	360	61	11	14%	364	66	11	15%	1%
Band 4	328	57	8	15%	371	60	13	14%	1%
Band 5	89	24	5	20%	100	31	5	23%	3%
Band 6	83	21	1	20%	77	15	2	16%	4%
Band 7	53	11	6	16%	57	15	6	19%	3%
Band 8A	46	9	0	16%	48	9	0	16%	0%
Band 8B	21	6	2	21%	21	5	2	18%	3%
Band 8C	16	4	1	19%	20	6	0	23%	4%
Band 8D	13	3	2	17%	18	3	1	14%	3%
Band 9	4	1	1	17%	6	1	1	13%	4%
VSM	23	0	1	0%	21	0	0	0%	0%

The table above shows the distribution of staff in non-clinical posts. This shows that there has been a marked improvement in appointing BAME staff to all levels of non-clinical posts with increased percentage of BAME staff in most posts at Band 4, 5 and 7. Whilst you can see there has been an improvement in overall representation, it is notable that the improvement is in the lower bands and from 8A and above there has only been 1 improvement at band 8C whilst for bands 8B, 8D and 9 the situation has worsen. For bands 8A the trust position is similar to year 2019 and we do not have any representation of BAME at VSM despite having 21 staff in post.

	31 MAR 2019				31 MAR 2020				
Clinical	White	BAME	Unknown	BAME %	White	BAME	Unknown	BAME %	% Diff.
Band 1	1	0	0	0%	1	0	0	0	0%
Band 2	375	153	30	27%	368	150	26	28%	1%
Band 3	189	91	12	31%	192	87	13	30%	1%
Band 4	73	33	0	31%	88	33	4	26%	5%
Band 5	415	472	112	47%	378	508	88	52%	5%
Band 6	510	257	27	32%	510	270	38	33%	1%
Band 7	362	114	19	23%	373	133	18	25%	2%
Band 8A	95	19	4	16%	106	27	5	20%	5%
Band 8B	23	7	1	23%	27	9	0	25%	5%
Band 8C	10	8	2	40%	11	6	3	30%	10%
Band 8D	4	0	0	0%	4	1	0	20%	20%
Band 9	2	0	0	0%	2	0	0	0%	0%
VSM	1	0	0	0%	1	0	0	0%	0%

The table above shows the distribution of staff in clinical posts. A significant proportion of staff within Bands 2 – 5 are from a BAME background with the most in Band 5 at 52% of the clinical band 5 workforce. However, this significantly reduces from Band 8A onwards. While this is much higher than the local demographics for all bands and is indicative of the international recruitment required to ensure sufficient nursing staff within the UK, work needs to continue to improve the accessibility of higher banded posts for our BAME workforce. BAME representation in clinical roles is higher than the overall workforce percentage up to Band 6 however is lower thereafter with the exception of Band 8c.

	31 MAR 2019				31 MAR 2020				
Medical	White	BAME	Unknown	BAME %	White	BAME	Unknown	BAME %	% Diff.
Consultants	146	151	20	48%	155	162	23	48%	0%
Non-Consultants	39	94	21	61%	37	111	33	61%	0%
Trainee Grade	138	156	69	43%	118	170	62	49%	6%

For medical grades there is near parity between White and BAME staffs with 48% of staff within the medical workforce of a BAME background. There has been no change in comparison to 48% of last year data. There is a marked increase (6%) of BAME staff in the Trainee Grade posts. BAME representation in our medical workforce remains higher than the percentage of the overall workforce.

Metric 2. Relative likelihood of staff being appointed from shortlisting across all posts.

	Nationally			ENHT	
	2017	2018	2019	2019	2020
Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BAME	1.60	1.45	1.46	1.28	1.57

The table above shows that White applicants in the Trust are 1.57 more likely to be appointed from shortlisting than BAME applicants. This is an increase of 23% from our last year data and is worse in comparison to last year national average (1.46). The work is underway to improve this situation, for example the introduction of Inclusion ambassadors (IA) to be involved in early stages of recruitment for all senior positions at Band 8A and above. The new appraisal system (career conversation) will aim to identify BAME staff who have talents and skills that they can be supported though their career development. More work needs to be done to ensure that at every decision making table, BAME staff are being presented and with a voice that has a vote in decision making process.

Metric 3. Relative Likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

	Nationally			ENHT	
	2017	2018	2019	2019	2020
Relative likelihood of BAME staff entering the formal disciplinary process compared to white staff	1.37	1.24	1.22	1.64	1.44

The likelihood of BAME staff entering form disciplinary processes is still higher than the national average of 1.24 at 1.64 and 1.44 respectively.

Actions to date to mitigate the use of formal processes where unnecessary will included the introduction of a Inclusion ambassadors (IA) who will utilise pre-disciplinary checklist to assesses the remedial actions taken prior to formal action being instigated as well as the overall culture of that particular area. Discussions are also underway on how to best address behaviour issues and have meaningful conversations on issues such as bullying, harassment and discrimination. The new People Strategy is focusing on a person centred, restorative rather than punitive approach which will assist in further reducing the numbers of formal disciplinarians for all staff. We are encouraging the board to understand that this is a very serious issue and the behaviour and culture that we have not made enough progress with addressing has led to this disparity

Metric 4. Relative likelihood of White staff accessing non-mandatory training and CPD.

	Nationally			ENHT	
	2017	2018	2019	2019	2020

Relative likelihood of white staff accessing non-mandatory training and CPD compared to BAME staff	1.22	1.15	1.15	1.41	1.35

BAME and White staffs are all able to access non-mandatory training and CPD on an equal and fair basis. All courses are available for all staff irrespective of their background, identity or ability. Our Trust figures are improving, although the likelihood of White staff accessing training is still higher (1.41 & 1.35 respectively) compared to the national average of 1.15.

Our Trust is updating appraisal paperwork and replace with Grow together, a new appraisal system based on the design delivered by the national leadership academy as part of the Talent toolkit. This pro-active push will hopefully profile opportunities and nurture more interest from BAME staff to take up internal as well as external training and development opportunities in conjunction with the BAME network to meet staff needs.

This will include line managers being made aware of what they should do to support these national NHS priorities. For example, targeted courses from the Leadership Academy such as “Stepping Up” and various talent management programmes focused on identifying and attracting sign up from BAME staff.

Metric 5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.

Harassment, bullying or abuse from patients, relatives or the public shows a remarkable decrease for BAME staff (30%) and a slight increase for White staff (30%) compared to previous years data (29% White staff and 35% BAME staff).

Metric 6. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

Harassment, bullying or abuse from staff shows a slight decrease for BAME staff (31%) similarly decrease for White staff (28%) compared to previous years data (30% White staff and 32% BAME staff).

Metric 7. Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion.

Data from 2019 survey shows that 77% of BAME staff report they are satisfied with opportunities, a decrease from 80% on year 2018. White staff report higher levels of confidence at 85% - year 2019, an increase from 82% reported year 2018. Work with teams and our established five staff networks are ongoing with the hope of addressing concerns.

Metric 8. Percentage of staff personally experienced discrimination at work from a manager, team leader or other colleague in the last 12 months.

There is an increase in the percentage of BAME staff experiencing discrimination at work from their manager, team leader or other colleagues from 2017 to 2019 (12%, 15% & 16% respectively). For White staff, last year showed a decrease of 1%, (2017 to 2019, 6%, 7% & 6% respectively).

In relation to Metrics 5 to 8 the Trust has developed a new People Strategy which prioritises the development of an inclusive workforce where everyone can bring their whole-self to work. Staff networks, established last year, continue to enable staff to have a voice and enable discussion around these findings. Their voice is essential for the organisation to understand and prioritise any interventions that can support all staff at work. The strategy also includes the development of a just and learning culture which ensures that all staff are offered restorative interventions rather than punitive sanctions following errors where appropriate. The just culture framework being developed will include working groups and ambassadors to address myths about firm management and bullying harassment and enable managers to have adult to adult conversations with staff about performance. Furthermore, staff awareness of Freedom to Speak Up guardian (FTU) and use this platform to raise their concerns. This development aims to address bullying and harassment and improve equality of opportunity.

Metric 9. Percentage difference between the organisation's Board voting membership and its overall workforce.

The ethnic composition of the Trust Board has remained the same for the past three years with no visible minority or BAME representation. There were 14 Board members in 2018, similarly to 14 Board members in 2019, all being White. This compares with a workforce profile where 62% of staff are White and 32% being BAME, 6% being unknown. Every effort will therefore be made to actively encourage a diverse pool of applicants for future vacancies. Support will be sought from the BAME network to identify ways in which to appeal and reach the wider BAME community for prospective applicants.

5. Key priorities and actions

The identified actions to address the issues highlighted in this report are outlined on **Appendix 2:**

6. Recommendations

The Trust Board is asked to note and approve the contents of this report and WRES action plan for submission.

Appendix 1 WRES data collection (excel spreadsheet)

WRES2 v5.0.xlsm

Appendix 2

ACTIONS TO ADDRESS ISSUES FROM WRES DATA

NHS Trust

AIM	Desired Outcomes	Priorities (1-3 months)	Priorities (3, 6 – up to 12 months)
BAME NETWORK WITH A VOICE	• staff have access to appropriate support and feel safe to express their lived experience of race and racism • Staff feel empowered to contribute in raising concerns and making suggestions for change	• Work with senior team managers to Allocate protected time for designated individual to attend and contribute in BAME network meetings. • The Power of Staff stories • Review membership and improve BAME representation at key decision making groups	• Celebrating diversity - Network events with key note speakers • Well attended and fully functional network with appropriate representation from all staff group
ORGANISATIONAL EDUCATION PROGRAMME	• Programme aiming to educate our senior Leaders – start with the Board • Ensure all mid managers have completed revised Equality, Diversity & Inclusion ambassadors training and other relevant training (unconscious bias, micro-aggressions)	• Seek external advice and draw on other organisations to inform inclusion strategy and how to tackle racism • Reference group	• Reverse mentoring • Introduction of WRES data expertise – WRES Expert programme
CULTURE CHANGE	• Role of IA on recruitment as well as their involvement as culture champions • Organisation becoming culturally intelligent	• Cultural intelligence expert to coach senior team. • All Leaders - awareness and understanding of anti-racism and cultural intelligence	• Confidently raise and address issues of race equality and inclusion initiatives • Analyse data on current grievances and disciplinaries
STAFF DEVELOPMENT AND CAREER PROGRESSION	• Ensure fair advertising and recruitment process for staff - Strengthen the role of IA within interview processes • Meaningful Career conversation during appraisals	• WRES data broken down to profession group • Access to Training and developmental opportunities in particular for nursing and admin & clerical groups	• Career developmental and training path for BAME staff co-designed with BAME Network & EDI Lead

SubmissionTemplate
Workforce Race Equality Standards 2018/19 template

	Answer Required
	Auto Populated
	N/A

INDICATOR	DATA ITEM		MEASURE	31st MARCH 2018						31st MARCH 2019						Notes
				WHITE		BME		ETHNICITY UNKNOWN/NULL		WHITE		BME		ETHNICITY UNKNOWN/NULL		
		1a) Non Clinical workforce		ESR figures	Verified figures	ESR figures	Verified figures	ESR figures	Verified figures	ESR figures	Verified figures	ESR figures	Verified figures	ESR figures	Verified figures	
1	Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce	1	Under Band 1	Headcount	0	0	0	1	0	0	0	1	0	0	0	1	
		2	Band 1	Headcount	86	86	56	56	3	3	84	84	52	52	3	3	
		3	Band 2	Headcount	264	264	34	34	12	12	276	276	38	38	13	13	
		4	Band 3	Headcount	313	316	64	64	12	12	360	360	61	61	11	11	
		5	Band 4	Headcount	339	339	54	54	8	9	328	328	57	57	8	8	
		6	Band 5	Headcount	100	100	17	17	5	5	89	89	24	24	5	5	
		7	Band 6	Headcount	83	83	16	16	4	4	83	83	21	21	1	1	
		8	Band 7	Headcount	49	49	9	9	4	4	53	53	11	11	6	6	
		9	Band 8A	Headcount	39	39	11	11	0	0	46	46	9	9	0	0	
		10	Band 8B	Headcount	21	21	5	5	3	3	21	21	6	6	2	2	
		11	Band 8C	Headcount	10	10	3	3	0	0	16	16	4	4	1	1	
		12	Band 8D	Headcount	15	15	0	0	0	0	13	13	3	3	2	2	
		13	Band 9	Headcount	7	7	1	1	1	1	4	4	1	1	1	1	
		14	VSM	Headcount	21	21	0	0	2	2	23	23	0	0	1	1	
			1b) Clinical workforce of which Non Medical														
		15	Under Band 1	Headcount	0	0	0	0	0	0	0	1	0	0	0	0	
		16	Band 1	Headcount	1	1	0	0	0	0	1	1	0	0	0	0	
		17	Band 2	Headcount	408	408	123	123	24	24	375	375	153	153	30	30	
		18	Band 3	Headcount	198	198	108	108	13	13	189	189	91	91	12	12	
		19	Band 4	Headcount	79	79	27	27	0	0	73	73	33	33	0	0	
		20	Band 5	Headcount	471	471	409	409	112	112	415	415	472	472	112	112	
		21	Band 6	Headcount	502	502	258	258	23	23	510	510	257	257	27	27	
		22	Band 7	Headcount	368	368	103	103	17	17	362	362	114	114	19	19	
		23	Band 8A	Headcount	99	99	18	18	4	4	95	95	19	19	4	4	
		24	Band 8B	Headcount	24	24	6	6	1	1	23	23	7	7	1	1	
		25	Band 8C	Headcount	13	13	9	9	2	2	10	10	8	8	2	2	
		26	Band 8D	Headcount	4	4	0	0	0	0	4	4	0	0	0	0	
		27	Band 9	Headcount	1	1	0	0	0	0	2	2	0	0	0	0	
		28	VSM	Headcount	2	2	0	0	0	0	1	0	0	0	0	0	
			Of which Medical & Dental														
		29	Consultants	Headcount	150	150	149	149	20	20	146	146	151	151	20	20	
		30	*of which Senior medical manager*	Headcount		0		0		0		0		0		0	
		31	Non-consultant career grade	Headcount	27	47	35	84	6	14	23	39	36	94	5	21	
		32	Trainee grades	Headcount	152	152	130	130	57	57	138	138	156	156	69	69	
		33	Other	Headcount	20	0	49	0	8	0	16	0	58	0	16	0	
2	Relative likelihood of staff being appointed from shortlisting across all posts	34	Number of shortlisted applicants	Headcount		2465		1570		410		2762		1515		260	
		35	Number appointed from shortlisting	Headcount		862		537		261		598		257		146	
		36	Relative likelihood of appointment from shortlisting	Auto calculated		0.3496957404		0.3420382166		0.6365853659		0.2165097755		0.1696369637		0.5615384615	
		37	Relative likelihood of White staff being appointed from shortlisting compared to BME staff	Auto calculated		1.02						1.28					
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Note: This indicator	38	Number of staff in workforce	Auto calculated		3869		1695		342		3780		1842		372	
		39	Number of staff entering the formal disciplinary process	Headcount		32		10		8		34		19		4	
		40	Likelihood of staff entering the formal disciplinary process	Auto calculated		0.0082708710		0.0058997050		0.0233918129		0.0089947090		0.0103148751		0.0107526882	
		41	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff	Auto calculated				0.71						1.15			

SubmissionTemplate
Workforce Race Equality Standards 2018/19 template

Answer Required
Auto Populated
N/A

	INDICATOR	DATA ITEM		MEASURE	31st MARCH 2018						31st MARCH 2019						Notes
					WHITE		BME		ETHNICITY UNKNOWN/NULL		WHITE		BME		ETHNICITY UNKNOWN/NULL		
4	**Relative likelihood of staff accessing non-mandatory training and CPD**	42	Number of staff in workforce	Auto calculated		3869		1695		342		3780		1842		372	
		43	Number of staff accessing non-mandatory training and CPD:	Headcount		794		316		21		1041		359		20	
		44	Likelihood of staff accessing non-mandatory training and CPD	Auto calculated		0.2052209873		0.1864306785		0.0614035088		0.2753968254		0.1948968512		0.0537634409	
		45	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff	Auto calculated		1.10						1.41					
5	**Percentage of staff experiencing harassment, bullying or abuse from**	46	% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Percentage		29.00%		35.00%				29.00%		35.00%			
6	**Percentage of staff experiencing harassment, bullying or abuse from staff in**	47	% of staff experiencing harassment, bullying or abuse from staff in last 12 months	Percentage		21.00%		25.00%				21.00%		25.00%			
7	**Percentage believing that trust provides equal opportunities for career progression in the last 12 months**	48	% staff believing that trust provides equal opportunities for career progression or promotion	Percentage		82.00%		80.00%				82.00%		80.00%			
8	**have you personally experienced discrimination at work from any of the**	49	% staff personally experienced discrimination at work from Manager/team leader or other colleague	Percentage		7.00%		15.00%				7.00%		15.00%			
9	**Percentage difference between the organisations' Board voting membership and its overall workforce** **Note: Only voting members of the Board should be included when considering this indicator**	50	Total Board members	Headcount		12		0		0		14		0		0	
		51	*of which: Voting Board members*	Headcount		9		0		0		11		0		0	
		52	*: Non Voting Board members*	Auto calculated		3		0		0		3		0		0	
		53	Total Board members	Auto calculated		12		0		0		14		0		0	
		54	*of which: Exec Board members*	Headcount		6		0		0		7		0		0	
		55	*: Non Executive Board members*	Auto calculated		6		0		0		7		0		0	
		56	Number of staff in overall workforce	Auto calculated		3869		1695		342		3780		1842		372	
		57	Total Board members - % by Ethnicity	Auto calculated		100.0%		0.0%		0.0%		100.0%		0.0%		0.0%	
		58	Voting Board Member - % by Ethnicity	Auto calculated		100.0%		0.0%		0.0%		100.0%		0.0%		0.0%	
		59	Non Voting Board Member - % by Ethnicity	Auto calculated		100.0%		0.0%		0.0%		100.0%		0.0%		0.0%	
		60	Executive Board Member - % by Ethnicity	Auto calculated		100.0%		0.0%		0.0%		100.0%		0.0%		0.0%	
		61	Non Executive Board Member - % by Ethnicity	Auto calculated		100.0%		0.0%		0.0%		100.0%		0.0%		0.0%	
		62	Overall workforce - % by Ethnicity	Auto calculated		65.5%		28.7%		5.8%		63.1%		30.7%		6.2%	
		63	Difference (Total Board -Overall workforce)	Auto calculated		34.5%		-28.7%		-5.8%		36.9%		-30.7%		-6.2%	

East and North Hertfordshire NHS Trust

Agenda item: 11.1 c)

TRUST BOARD - PUBLIC SESSION – 2 SEPTEMBER 2020

Equality and Diversity Update July 2020

Purpose of report and executive summary (250 words max): This paper provides an update on the Workforce Disability Equality Standard that is due for publication on October 2020. It seeks approval to publish the required data set for the WDES metrics and the associated narrative report.		
Action required: For approval		
Previously considered by: FPPC – 29 July 2020		
Director: Chief People Officer	**Presented by:** Deputy Director of Workforce and OD	**Author:** Deputy Director of Workforce and OD

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

Does the issue relate to a risk recorded on the Board Assurance Framework? YES 1. There is a risk that the trust is unable to recruit and retain sufficient supply of staff with the right skills to meet the demand for services 2. There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered and motivated, impacting on the trust's ability to deliver the required improvements and transformation and to enable people to feel proud to work here
Any other risk issues (quality, safety, financial, HR, legal, equality): **I**neffective or inefficient staff management is likely to increase negative staff survey results, turnover, sickness absence and replacement costs.

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

NHS Workforce Disability Equality Standard (WDES)

1. Introduction

NHS England, with its partners, has prioritised its commitment to tackling discrimination and creating an NHS where the talents of all staff are valued and developed. Respect, equality and diversity are central to changing culture and are at the heart of the workforce implementation plan (NHS Long Term Plan).

The NHS Workforce Equality Standards are designed to address under-representation in the area of Disability (WDES) with development underway for a further standard focussed on Sexual Orientation. The standards use nationally designed spreadsheets supported by technical guidance bulletins and regional briefing events to ensure national comparisons can be made. Timeframes for completion of the data spreadsheets and supporting narrative are determined nationally.

WDES – Key Dates for 2020	
WDES Data Collection Period	6th July to 31st August 2020
WDES Spreadsheet (returned via SDCS) and WDES Online Reporting Form deadline	31st August 2020
Publication of Board Approved Trust WDES Action Plans	31st October 2020

This report provides the Board with the initial WDES data set and narrative due for publication on 31st October 2020.

The Board is asked to approve:

- The submission of the metrics and narrative report for the WDES

2. Background

The Workforce Disability Equality Standard (WDES) came into force on 1st April 2019. It is mandated through the NHS Standard Contract. The WDES evolved from the design of the WRES with some adaptive changes. There are ten metrics that enable NHS organisations to compare the experiences of Disabled and non-Disabled staff, which they will then use to implement action plans.

3. Workforce Disability Equality Standard Metrics

The Trust is required to submit the data set using the national format. The full 10 WDES metrics report are included - appendix 1 in excel format.

The highlights of the report are:

1. Percentage of disabled staff in each band shows a significant proportion of staff do not report whether they consider themselves to have a disability or not.

		% Disabled	% Non-disabled	% Unknown
Non-Clinical	Bands 1 - 4	4%	66%	30%
	Bands 5 - 7	3%	69%	28%
	Bands 8a – 8b	0%	75%	25%
	Bands 8c – 9 & VSM	0%	83%	17%
Clinical	Bands 1 - 4	3%	66%	31%
	Bands 5 - 7	2%	69%	29%
	Bands 8a – 8b	0%	60%	40%
	Bands 8c – 9 & VSM	0%	39%	61%
Medical	Consultants	0%	42%	58%
	Non-Consultants Career Grade	1.66%	49.72%	48.62%
	Trainee Grades	0.29%	45.14%	54.57%

2. Relative likelihood of a non-disabled applicant being appointed from shortlisting is 2.41; an increase from 1.60 reported year 2019. Therefore, disabled applicants less likely to be appointed than non-disabled applicants.

3. Likelihood of entering capability process is 0.00. As a Trust we have not managed any disabled staff under formal capability and therefore those with a disability are less likely to enter a formal process than those without. It is also worth noting that out of 64 capability cases reported, 49 did not state ability/disability status.

4. From the staff survey - In the last 12 months, percentage of staff experiencing bullying, harassment or abuse from:

	NHS Staff Survey 2018			NHS Staff Survey 2019		
	% disabled	% Non-disabled	Dif.	% disabled	% Non-disabled	Dif.
Patients/service users, their relatives or other members of the public	35.0%	30.0%	5%	36.5%	28.3%	8.2%
Managers	25.0%	16.0%	9%	23.7%	14.7%	9%
Other colleagues	27.0%	21.0%	6%	28.1%	20.1%	8%
At work, they or a colleague reported it	41.0%	41.0%	0%	38.1%	41.1	3%

5. From the staff survey 2019 - Percentage of disabled staff (75%) compared to non-disabled (84%) staff who believe the Trust provides equal opportunities.

6. From the staff survey 2019 – percentage of disabled staff (34%) compared to non-disabled staff (26%) who have felt pressure to attend work despite not feeling well enough to do so.

7. From the staff survey 2019 – percentage of disabled staff (33%) compared to non-disabled staff (50%) report they are satisfied with the way the organisation values their work.

8. From the staff survey 2019 – percentage of disabled staff (73%) who have reported that the Trust has made adequate adjustments for them to do their work.

9.
    a. Overall engagement scores of disabled staff (6.4) compared to non-disabled staff (7).
    b. Has the Trust taken action to facilitated disabled voices in the organisation?

        Yes – via the Disabled Staff Network and Disability Confident framework.

10. Board representation

	% Disabled	% Non-disabled	% Unknown
Total Board Members - % Disability	**0%**	**50%**	**50%**
Voting Board Member - % Disability	**0%**	**0%**	**100%**
Non-Voting Board Member - % Disability	**0%**	**78%**	**22%**
Executive Board Member - % Disability	**0%**	**0%**	**100%**
Non-Executive Board Member - % Disability	**0%**	**78%**	**22%**
Overall workforce - % Disability	**2%**	**64%**	**33%**
Difference (Total Board - Overall workforce	**-2%**	**-14%**	**17%**
Difference (Voting membership - Overall workforce	**-2%**	**-64%**	**67%**
Difference (Executive membership - Overall workforce	**-2%**	**-64%**	**67%**

4. Workforce Disability Equality Standard narrative

Attached at Appendix 1 is the draft narrative report recommended for publication on August 2020.

Key findings:

- Low number of staff declaration in view of their disability status
- Higher number of disabled staff from experiencing bullying & harassment
- Disabled staff not being shortlisted for interviews
- Access to work issues

Appendix 2 sets out the goals and the high level actions that need to be carried out to address these.

5. Recommendations

The Board is asked to:

- Note the contents of this report
- Approve the publication of the data set for WDES

The Team will come back with further detailed plan which has been agreed with the disability staff network for impact actions to take forward

Appendix 1

WDES - V6.xlsx

Appendix 2 – Action Plan

NS TO ADDRESS ISSUES FROM WDES DATA

Goals	Specific Actions	Timeline
• To investigate and actively seek to address the low numbers of staff with disability status recorded on ESR.	• Campaign for raising awareness to be conducted by EDI Team with support from Occupational Health	• Within 1 – 3 Months
• To address negative experience in the workplace by disabled members of staff compared to others as shown by staff survey results.	• Implementing Workforce Disability Equality Standard (WDES) requirements and actively conducting interview with disabled members of staff to address their concerns	• 3-6 Months
• To address Concerns raised by disabled members of staff during network meetings with regards to access issues	• Work with Estates Team to Improve Access to work	• 6-12 Months
• To address the disparities of disabled members of staff from being shortlisted for interviews	• Ensure fair advertising and recruitment process for staff - Strengthen the role of IA within interview processes for disabled applicants	• ASAP using existing inclusion ambassadors

WDES Data Collection 2020

Trust **EAST AND NORTH HERTFORDSHIRE NHS TRUST** **RWH**

Please select Trust from drop down bar. If your Trust is not listed due to a recent merger or otherwise, please contact data collections. Contact details on the Cover tab.

					Snapshot of data as at 31st MARCH 2020							
					Disabled staff		Non-disabled staff		Disability Unknown or Null		Overall	
METRIC	INDICATOR	DATA ITEM		MEASURE	# DISABLED	% DISABLED	# NON-DISABLED	% NON-DISABLED	# UNKNOWN/NULL	% UNKNOWN/NULL	TOTAL	Notes
1	Percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.		**1a) Non Clinical Staff**									
		1	Under Band 1	Headcount	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	
		2	Bands 1	Headcount	1	4.2%	15	62.5%	8	33.3%	24	
		3	Bands 2	Headcount	18	3.9%	290	62.1%	159	34.0%	467	
		4	Bands 3	Headcount	14	3.2%	294	66.7%	133	30.2%	441	
		5	Bands 4	Headcount	18	4.1%	310	69.8%	116	26.1%	444	
		6	Bands 5	Headcount	4	2.9%	94	69.1%	38	27.9%	136	
		7	Bands 6	Headcount	3	3.2%	66	70.2%	25	26.6%	94	
		8	Bands 7	Headcount	2	2.6%	53	67.9%	23	29.5%	78	
		9	Bands 8a	Headcount	0	0.0%	47	82.5%	10	17.5%	57	
		10	Bands 8b	Headcount	0	0.0%	17	60.7%	11	39.3%	28	
		11	Bands 8c	Headcount	0	0.0%	23	88.5%	3	11.5%	26	
		12	Bands 8d	Headcount	0	0.0%	20	90.9%	2	9.1%	22	
		13	Bands 9	Headcount	0	0.0%	6	75.0%	2	25.0%	8	
		14	VSM	Headcount	0	0.0%	15	71.4%	6	28.6%	21	
		15	Other	Headcount	0	0.0%	2	100.0%	0	0.0%	2	
		16	Cluster 1 (Under Band 1, Bands 1-4)	Total	51	3.7%	909	66.1%	416	30.2%	1376	
		17	Cluster 2 (Band 5 - 7)	Total	9	2.9%	213	69.2%	86	27.9%	308	
		18	Cluster 3 (Bands 8a - 8b)	Total	0	0.0%	64	75.3%	21	24.7%	85	
		19	Cluster 4 (Bands 8c - 9 & VSM)	Total	0	0.0%	64	83.1%	13	16.9%	77	
			1b) Clinical Staff									
		20	Under Band 1	Headcount	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	
		21	Bands 1	Headcount	0	0.00%	0	0.00%	1	100.00%	1	
		22	Bands 2	Headcount	15	2.76%	360	66.18%	169	31.07%	544	
		23	Bands 3	Headcount	11	3.77%	205	70.21%	76	26.03%	292	
		24	Bands 4	Headcount	5	4.00%	72	57.60%	48	38.40%	125	
		25	Bands 5	Headcount	9	0.92%	696	71.46%	269	27.62%	974	
		26	Bands 6	Headcount	29	3.55%	548	66.99%	241	29.46%	818	
		27	Bands 7	Headcount	14	2.67%	351	66.98%	159	30.34%	524	
		28	Bands 8a	Headcount	0	0.00%	85	61.59%	53	38.41%	138	
		29	Bands 8b	Headcount	0	0.00%	19	52.78%	17	47.22%	36	
		30	Bands 8c	Headcount	0	0.00%	8	40.00%	12	60.00%	20	
		31	Bands 8d	Headcount	0	0.00%	2	40.00%	3	60.00%	5	
		32	Bands 9	Headcount	0	0.00%	1	50.00%	1	50.00%	2	
		33	VSM	Headcount	0	0.00%	0	0.00%	1	100.00%	1	
		34	Medical & Dental Staff, Consultants	Headcount	0	0.00%	142	41.76%	198	58.24%	340	
		35	Medical & Dental Staff, Non-Consultants career grade	Headcount	3	1.66%	90	49.72%	88	48.62%	181	
		36	Medical & Dental Staff, Medical and dental trainee grades	Headcount	1	0.29%	158	45.14%	191	54.57%	350	
		37	Other	Headcount	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	
		38	Cluster 1 (Under Band 1, Bands 1-4)	Total	31	3.22%	637	66.22%	294	30.56%	962	
		39	Cluster 2 (Band 5 - 7)	Total	52	2.25%	1595	68.87%	669	28.89%	2316	
		40	Cluster 3 (Bands 8a - 8b)	Total	0	0.00%	104	59.77%	70	40.23%	174	
		41	Cluster 4 (Bands 8c - 9 & VSM)	Total	0	0.00%	11	39.29%	17	60.71%	28	
		42	Cluster 5 (Medical & Dental Staff, Consultants)	Total	0	0.00%	142	41.76%	198	58.24%	340	
		43	Cluster 6 (Medical & Dental Staff, Non-Consultants career grade)	Total	3	1.66%	90	49.72%	88	48.62%	181	
		44	Cluster 7 (Medical & Dental Staff, Medical and dental trainee grades)	Total	1	0.29%	158	45.14%	191	54.57%	350	
2	**Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts.** Note: i) This refers to both external and internal posts. ii) If your organisation implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme. This information will be collected on the WDES Online Survey to ensure comparability between organisations.	45	Number of shortlisted applicants	Headcount	171		2036		73			
		46	Number appointed from shortlisting	Headcount	22		632		12			
		47	Likelihood of shortlisting/appointed	Auto-Calculated	0.13		0.31		0.16			
		48	Relative likelihood of non-disabled staff being appointed from shortlisting compared to Disabled staff	Auto-Calculated	2.41							A figure below 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to be appointed from shortlisting.
3	**Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.** Note: i) This Metric will be based on data from a two-year rolling average of the current year and the previous year (2018/19 and 2019/20). ii) This Metric was voluntary in year one and is now mandatory.	49	Number of staff in workforce	Auto-Calculated	147		3989		2063			
		50	Number of staff entering the formal capability process	Headcount	0		15		49			
		51	Likelihood of staff entering the formal capability process	Auto-Calculated	0.00		0.00		0.02			
		52	Relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff	Auto-Calculated	0.00							A figure above 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to enter the formal capability process.
4-9a	**Metrics 4, 5, 6, 7, 8 and 9a are collected as part of the NHS Staff Survey. As the results of these are published on the NHS Staff Survey website, you are not required to enter data for these metrics as part of completing your submission but they are still part of the WDES. Please visit the following link to view your data for your Action Plans: http://www.nhsstaffsurveyresults.com/**											
9b	**b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (yes) or (no)** Note: For your Trust's response to b) If yes, please provide at least one practical example of current action being taken in the relevant section of your WDES annual report. If no, please include what action is planned to address this gap in your WDES annual report. Examples can be found in the 2019 Annual Report.	53	Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (yes) or (no)	(yes) or (no)	Yes							
10	**Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:** • By Voting membership of the Board • By Executive membership of the Board This is a snapshot as of at 31st March 2020.	54	Total Board members	Headcount	0		7		7		14	
		55	*of which: Voting Board members*	Headcount	0		0		5		5	
		56	*: Non Voting Board members*	Auto-Calculated	0		7		2		9	
		57	Total Board members	Auto-Calculated	0		7		7		14	
		58	*of which: Exec Board members*	Headcount	0		0		5		5	
		59	*: Non Executive Board members*	Auto-Calculated	0		7		2		9	
		60	Number of staff in overall workforce	Auto-Calculated	147		3989		2063		6199	
		61	Total Board members - % by Disability	Auto-Calculated		0%		50%		50%		
		62	Voting Board Member - % by Disability	Auto-Calculated		0%		0%		100%		
		63	Non Voting Board Member - % by Disability	Auto-Calculated		0.00%		78%		22%		
		64	Executive Board Member - % by Disability	Auto-Calculated		0%		0%		100%		
		65	Non Executive Board Member - % by Disability	Auto-Calculated		0%		78%		22%		
		66	Overall workforce - % by Disability	Auto-Calculated		2%		64%		33%		
		67	Difference (Total Board - Overall workforce)	Auto-Calculated		-2%		-14%		17%		
		68	Difference (Voting membership - Overall Workforce)	Auto-Calculated		-2%		-64%		67%		
		69	Difference (Executive membership - Overall Workforce)	Auto-Calculated		-2%		-64%		67%		

East and North Hertfordshire NHS Trust

Agenda Item: 12

TRUST BOARD PART 1 – 2 SEPTEMBER 2020

QUALITY AND SAFETY COMMITTEE – MEETING HELD ON 28 JULY 2020

EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the QSC meeting of the 28 July 2020 to the Board.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of QSC	**Presented by:** Chair of QSC	**Author:** Trust Secretary / Corporate Governance Officer

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

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

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

QUALITY AND SAFETY COMMITTEE MEETING – 28 JULY 2020
SUMMARY TO THE TRUST BOARD MEETING HELD ON 2 SEPTEMBER 2020

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

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

STANDING ITEMS:

Quality Assurance Dashboard

The Quality Assurance Meeting dashboard provided a range of key performance metrics including Serious Incidents, risks, patient experience, safeguarding and HSE and CQC compliance.

The Committee were informed that the Trust was investigating incidents in relation to the discharge process. They were told an external supplier had been engaged to undertake the investigation to ensure the learning was generated promptly.

QUALITY, SAFETY AND PATIENT EXPERIENCE REPORTS

IPC Report

The Committee noted the content of the IPC report.

The Committee were informed that there had been zero hospital acquired cases of COVID and one probable case for July that the IPC team were investigating to ensure all learning would be used moving forward. Cases of C.diff and MRSA were below the trajectory.

There was some discussion regarding Surgical Site Infections and it was suggested that a deep dive be provided at a future meeting.

Safer Staffing Report

The Committee were presented with the key points of the report. They were informed that the number of qualified nurses had increased with 17.3 WTE new starters as well as a reduction in leavers. The sickness rate decreased in June for qualified and unqualified nursing staff. A pipeline of new starters remained in place.

Clinical Harm Reviews

It was explained to the Committee that the previously postponed cancer clinical harm reviews had recommenced. They were informed that the clinical harm process for the RTT breaches is now being developed and the 52 week breaches had increased. Risk stratification was underway to determine the priority order for the reviews.

Clinical Audit and Effectiveness

It was reported to the Committee that 68% of completed audit actions were on schedule, which included all actions from audits from the last five years. The Committee were informed that following an historic decision not to follow-up certain types of NICE guidance, work is now underway to bring this work up to date as the team is again at full strength.

CNST Reports

Perinatal Mortality Review

The Committee received and discussed the Perinatal Mortality Review Tool report covering Q1. It was explained to the Committee that the purpose of the paper was to deliver assurance to the Committee regarding the perinatal mortality review process and formed part of the requirement to declare compliance with safety standards.

Maternity Self-Assessment Tool

It was explained to the Committee that the self-assessment tool was published by NHSI/E prior to the COVID pandemic. The Committee were informed that the maternity team had scored themselves red or amber in each area and by the end of the year the Trust will be compliant and peer challenge will be invited.

Risk Report

The Committee were presented with the risk report and it was highlighted there were two risks reporting at 25, one of which had been reviewed and mitigated already and the other would also be reviewed as part of the standard process. The Committee were informed that the Audit Committee had approved a new risk scoring approach which would help to standardise practices.

Board Assurance Framework

The Committee were informed that the Audit Committee had approved the risks for 2020/21 at their July meeting. They were told that 8 risks had changed and the Board had already approved risks 6 (ICP), 11 (MVCC) and 5 (Digital) and no changes were proposed for those risk descriptions. The Executive had also discussed a COVID-19 risk and agreed that although it is captured in other strategic risks, it should also remain on the register in some form.

WORKFORCE/STAFFING REPORTS

Mandatory and Statutory Training and Appraisals

It was explained to the Committee that the appraisal and training process had been reviewed and statutory and mandatory training was being reinstated. The Committee were informed that electronic learning platforms were being reviewed to minimise the requirement for classroom training. They also heard that training compliance was currently under the Trust target due to the pause during the pandemic and a recovery trajectory would be produced.

People Capability Strategy

The Committee were presented the strategy and it was highlighted that the ambition was to set high level objectives for the learning process. The Committee were informed that the education teams from different areas of the organisation were coming together and therefore the structure would be less fragmented and more efficient. The Committee were also informed that the Executive were working through the development of a workforce recruitment strategy which was being shaped by the bed capacity model.

Junior Doctors Contract

It was highlighted to the Committee that there had been a reduction in exception reports. Of the five reported, there were no patient safety reports or unsafe working hours reported. It was acknowledged by the Committee that the Junior Doctors had risen to the challenge during the height of the COVID-19 pandemic, they focused on service provision to provide clinical care and worked more frequent shifts than would ordinarily be the case. The Committee expressed their thanks for their efforts.

ANNUAL REPORTS

Safeguarding Children and Adults Annual Report
The Committee noted the success of the integration of children's, maternity and adult safeguarding teams. The Committee were informed that a single safeguarding team had increased capacity and that the change also supported improved family engagement. Additional capacity had been secured for the next six months. It was also noted that the Admiral Nurse was due to leave the Trust and it was hoped the post could be retained. The Annual Report is attached as item 12.1.

Research and Development Annual Report
The Committee received a report regarding the R&D division covering the period April 2019 – March 2020. It was reported that the division had delivered a good progress in most areas and the report also set out priorities for 2020/21. The Committee were informed that the most significant issue for the team at present was the transfer of MVCC.

Patient Experience Quarterly Report and Annual Report
The Committee heard that the approach to patient experience is a key focus for the Trust. It was reported that recent survey scores were disappointing and would be a focus for improvement. The Committee noted the Annual Report (attached as item 12.2).

REPORTS FOR NOTING

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

IPR
The Committee noted the report.

_____

Peter Carter

QSC Chair

September 2020

East and North Hertfordshire NHS Trust

Agenda Item: 12.1

TRUST BOARD - PUBLIC SESSION – 2 SEPTEMBER 2020

Safeguarding Children and Adults Annual report

Purpose of report and executive summary (250 words max): **To provide the Safeguarding Children and Adults Annual report 2019/20.** **The Trust Board are asked to approve the report.**		
Action required: For approval		
Previously considered by: **QSC – 28.07.20**		
Director: **Chief Nurse**	**Presented by:** **Chief Nurse**	**Author:** **Adult Safeguarding Lead Nurse** **Children Safeguarding Lead Nurse**

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

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

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

Annual Report

Safeguarding Children and Adults

2019/2020

Safeguarding Children Team
Maternity Safeguarding
Safeguarding Adults Team

June 2020

Executive summary

The Safeguarding Annual Report 2019/2020 outlines the work undertaken by the Trust during the past year. Safeguarding is the term used for protecting children and adults from abuse or neglect.

Safeguarding is a whole systems approach and the Trust is a partner agency of the Hertfordshire Children's Safeguarding Partnership (HCSP) and the Hertfordshire Safeguarding Adult Board (HSAB). The Trust is represented on the boards by the Director of Nursing. Within the Trust each Division has a representative on the Safeguarding Committee which meets every 2 months.

Summary of Key highlights of 2019/2020 include:-

- **Establishment of one safeguarding team for the organisation.** This required a merge and restructure of the safeguarding teams already based within the organisation – utilising the experience and expertise already available within the teams. A new safeguarding structure was designed reflecting the needs of the organisation and the scale and complexity of the services it provides.
  The Director of Nursing is the Executive Lead for Safeguarding. Each Division has a leadership team who are responsible for ensuring the systems and frameworks for safeguarding are proactively supported and embedded into practice in their service areas. The team continues to sit both within Women's and Children's division (safeguarding children) and Corporate services (safeguarding adults).
  The New structure was implemented in January 2020.
- **Safeguarding activity.** The past year has again seen a significant increase in the activity of the team. Referrals to children's social care have increased by 38%, Information sharing by 20% on previous year, individuals identifying themselves as carers by 183% - 69 included young carers not previously known to young carers teams. Adult safeguarding referrals increased by a further 34%. Increase in DOLS applications following increased educational opportunities for staff, targeted 1:1 work and visibility of the safeguarding team to areas where needed.
  All demonstrating an increased awareness of the risks and concerns and appropriate response – including the early help agenda.
- **Audit program.** Completion of an extensive audit program identifying areas of good practice, improvements made and embedded in practice, and further areas for development and improvement – including staff awareness of safeguarding for 16 and 17 yr olds and risks around exploitation,
- **Paediatric liaison.** Electronic system for sharing unscheduled attendances to Hertfordshire Community NHS Trust – in addition to the full paediatric liaison service.
- Funding secured for an adult epilepsy nurse – yet to recruit to post
- Paediatric liaison nominated for a RCNI award for young carers
- Introduction of purple wrist band to acknowledge vulnerabilities in relation to LD
- 4 clinical areas now have **Purple Star accreditation** and 2 more are in progress
- **LeDeR** – the number of reviewers increased within the organisation
- **Level 3 training compliance** achieved for Women's and Children's Division
- **New referral process** to local authority for children's successfully introduced to organisation, leading to improvement in the quality of referrals
- **Think family improvements** – increase seen in referrals which is indicative of a continued increase of awareness and response. The joining of the safeguarding teams has led to improvements in communication and knowledge around the think family agenda

- **Was not brought policy** launched following audit
- In response to **COVID** – enabling safeguarding processes to remain core to any pathway and process changes
- **FGM-IS** went live within maternity and unscheduled care settings
- **Maternity Database** has changed in 2020 to meet the new requirement for information to be presented in SBAR (Situation, Background, Assessment, Recommendations) format, to enable front line staff to access more concise, up-to-date recommendations for safeguarding children when women present to the maternity unit.
- **Introduction of hospital youth worker.** The Hospital youth work project (HYW) went live in the Trust on the 14th February 2020 - a service to enhance youth worker support to children and young people between the ages of 11-21 yrs to address the wider causes of poor mental health in children and young people, including domestic abuse, Child Sexual Exploitation and County Lines.

Next steps and priorities for the year ahead

- COVID recovery- implementing the new practice and responding to safeguarding surge
- Further improvements on understanding how effective we are – electronic safeguarding dashboard and review further details around some of the data collected and what this means for our patient outcomes, and the development of a workforce that holds safeguarding central to what they
- Development of a safeguarding handbook
- Continue and step up preparations for the implementation of Liberty Protection Safeguards (LPS) which will replace DOLS in 2020.
- Develop and implement a Modern Day slavery Strategy driven by the safeguarding committee.
- Maintain audit activity to test out the effectiveness of safeguarding arrangements
- Ensure process in place for Trust sharing of information to the multi-agency risk assessment conferences for domestic abuse.
- Developing a transitional safeguarding process for children and young people within services moving across to adult services within ENHT.
- Continue to review the training provided to ensure is as flexible and reflects service need, and ensure compliance is maintained.
- Develop and implement a Neglect strategy - to include self –neglect.
- Implement the recommendations from the national learning disabilities audit.
- Review the supervision strategy in relation to community maternity teams
- Pathway development for maternity out of area discharges
- CP-IS for maternity services

Acknowledgements:

We would like to thank all the contributors to this year's Safeguarding annual report:

Looked After Children, Medical Advisor for Adoption and Fostering
The Carers Lead
The Admiral Nurse
The Enhanced Nursing Care Team
Hospital Youth Worker

1.0 Introduction

This is the Annual Report for Child and Adult Safeguarding for East and North Hertfordshire NHS Trust for 2019/2020. The report outlines the work undertaken by the Trust since April 2019 to support the frameworks for Safeguarding.

Safeguarding children and young people and protecting them from harm is everyone's responsibility and remains a fundamental element of care. Safeguarding children promotes the welfare of children and prevents them from harm. Children and young people are defined as those under the age of 18 years, however, if the young person has 'special needs' the age incorporates up to the young person's 19th birthday.

Adult Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about working with adults who have care and support needs, who may be in vulnerable circumstances and at risk of abuse or neglect and unable to protect themselves. Multi-agency teams work together and with the individual, to prevent and stop the risks and experience of abuse or neglect.

Making Safeguarding personal means that an adult's wellbeing is promoted and that there is regard for the adult's views, wishes, feelings and beliefs in deciding on any action to be taken, wherever possible.

The Care Act 2014 definition of an adult at risk is: a Person aged 18 years and over, who has needs for care and support (whether or not the local authority is meeting any of those needs) and is experiencing, or is at risk of, abuse or neglect, and as a result of their care or support needs is unable to protect him or herself against abuse or neglect, or the risk of it.

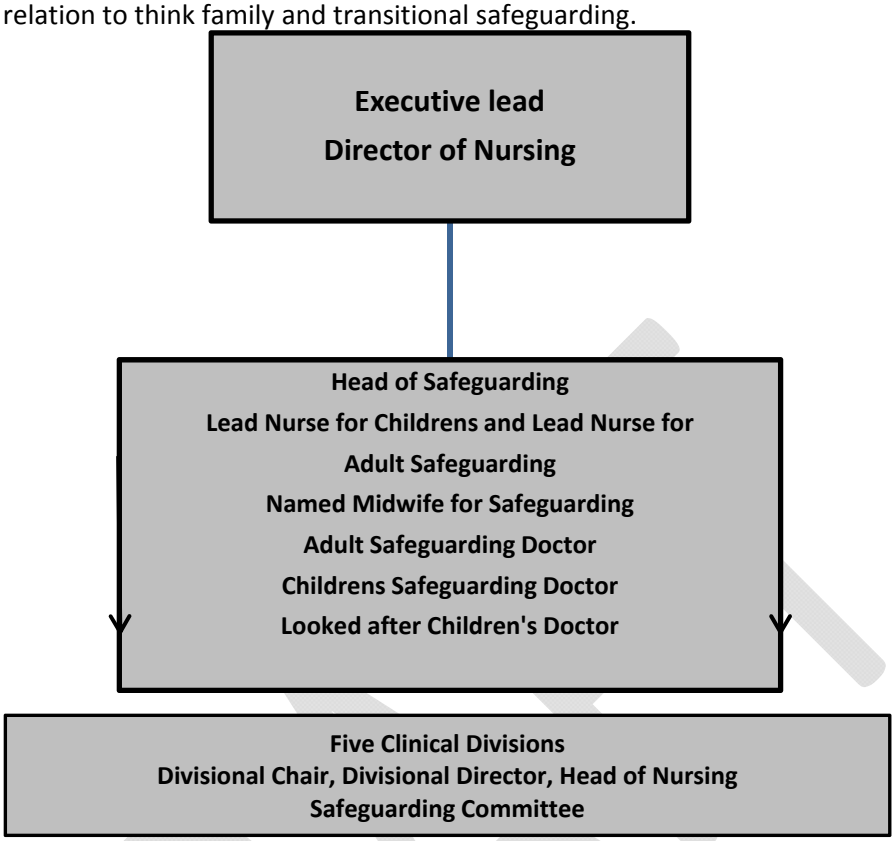
Safeguarding in NHS organisations is a statutory and regulatory requirement. The Trust is accountable and regularly reports to the CCG, Hertfordshire Safeguarding Children's Partnership and Hertfordshire Safeguarding Adults Board, and CQC inspections.

The statutory requirements that relate to the safeguarding are:-

- Childrens Act 1989 and 2004
- Safeguarding Vulnerable Groups Act 2006
- The Care Act 2014

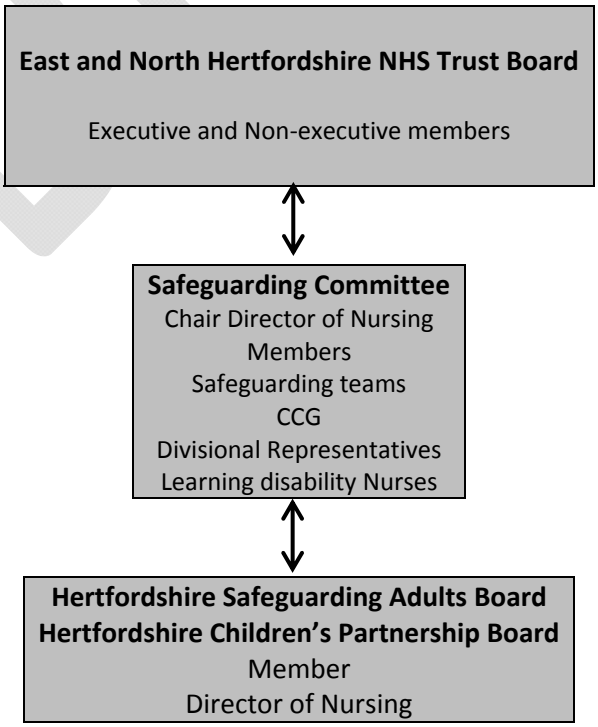
2.0 Safeguarding structure

Over the last 12 months we have brought together the adults and children's safeguarding teams into one integrated team – providing broader expertise across the safeguarding agenda – and in particular in relation to think family and transitional safeguarding.



Rachael Corser, Director of Nursing and Patient Experience is the Executive Lead for Safeguarding. The Director of Nursing is the member of the Hertfordshire Children's Safeguarding Partnership and the Hertfordshire Safeguarding Adults Board.

2.1 Safeguarding committee structure



2.2 Safeguarding team

The safeguarding team has seen several changes in the team structure and positions. We have recruited a Head of Safeguarding to set the future priorities of the safeguarding team. We have in place lead safeguarding nurses who lead on their area of speciality within the team (children's, maternity and adult safeguarding) (Table 1). The Named Midwife post became a job-share in October 2019 due to retirement. A third safeguarding midwife has now been employed for 15hrs per week, building resilience into the team.

Table 1

Safeguarding Team					
Head of Safeguarding – Cheryl Lewis					
Maternity		**Children**		**Adults**	
Named/ specialist Midwife	Teresa Drakes & Emma Bell	**Lead for Children's Safeguarding**	Sarah Corrigan	**Lead for Adult Safeguarding**	Enda Gallagher
Safeguarding Midwife	Suzy Stracey	**Named Doctor**	Dr Vinod Tyagi	**Named Doctor**	Vacant
		Lead Safeguarding Trainer/Safeguarding Children's Nurse	Kim Rundel	**Adult Safeguarding Nurse**	Bernadette Herbert
		Safeguarding Children's Nurse/Lead Paediatric Liaison	Tina O'Sullivan		
		Looked After Children Doctor	Paula Moore		
		Paediatric Liaison	Vacant		

Within the Clinical and Non-Clinical Divisions the Divisional Director, Divisional Chairs, Heads of Nursing or Senior Managers are responsible for the implementation of and compliance with Trust policies and procedures and maintaining standards of practice and quality of care provision with clinical and non-clinical teams. Nominated leads from within the divisions are responsible for reporting to the joint committee the safeguarding activity within their division. They continue to be supported by the safeguarding leads and head of safeguarding with their role.

The Safeguarding teams work closely and collaboratively with the Independent Domestic Violence Advisors (Refuge), Social Services, Local Authority Safeguarding teams, CCG safeguarding teams and other Health safeguarding teams in Hertfordshire, police, HSCP, and HSAB Health liaison teams

2.3 Safeguarding Specialists

The work of the safeguarding team can be divided into 5 areas within the Trust:-

- Acute paediatrics including emergency care, inpatient care, and day services – including paediatric day surgery, outpatients and Chronic Fatigue service
- Community paediatrics including child development centre, continuing care, special schools nursing, community children's nursing – including Diabetes, Epilepsy, ADHD and special needs health visitors
- Community Child Protection (CP) on-call rota – medical and nursing rota for CP medicals

- Adult services – where concerns are identified regarding an adult's attendance and the impact of that presentation on a dependent child – Think Family. The majority of this activity takes place within the Trusts unscheduled care settings, but is applicable to all adult areas of the Trust.
- Maternity Services including inpatient services and community midwives

The Safeguarding team monitor performance through the use of a comprehensive dashboard updated monthly, the information is used to review the work plan, and is shared with the relevant boards and committees for monitoring purposes.

The role of the Head of safeguarding along with the safeguarding maternity, children's and adults specialists within the safeguarding team for the Trust is to:-

- Lead on the strategy for safeguarding, ensuring the framework for safeguarding is in place to comply with statutory and regulatory requirements
- To review, update and implement Trust policies and guidelines to ensure they adhere to statutory requirements and up to recommendations and HSCP/HSAB guidance.
- To provide advice and guidance to staff about safeguarding matters
- Risk assessment and supervision
- Multi-agency information sharing meetings – including fortnightly maternity, psychosocial, strategy discussions, and discharge planning
- To review all safeguarding referrals and cases where safeguarding concerns identified to ensure appropriate safeguarding response from the clinicians and if further liaison and or escalation is required – in addition adult safeguarding refer any concerns raised to appropriate county safeguarding team or agency.
- Participate in Safeguarding Adults Reviews and investigations and support the local authority when making decisions relating to section 42's which do not relate to care in the Trust this supportive role is linked to our HSAB membership.
- To insure robust investigations of incidents of abuse or neglect raised against the Trust are undertaken and gaining assurance from clinical areas that identified learning has been incorporated into Trust/local clinical practice.
- To advise staff on safeguarding protection plans or actions for Trust patients
- To develop and review safeguarding training packages in line with the Intercollegiate documents and provide statutory/mandatory training for staff
- To review and advise on serious incidents relating to safeguarding cases
- To work together with Trust staff and teams to provide high quality, safe services for patients, in particular those at risk of abuse and/or neglect
- To participate as required in multiagency rapid reviews, domestic homicide reviews, partnership case reviews, safeguarding adult reviews, and section 42 enquiries
- Provide information and clinical advice to Social Work teams, Hertfordshire constabulary and safeguarding leads on safeguarding cases.
- Investigate incidents of abuse or neglect raised against the Trust
- Represent the Trust and participate in sub-groups and activities of the Hertfordshire Safeguarding Children's Partnership and Hertfordshire Adults Safeguarding Board
- Lead on PREVENT safeguarding
- Provide paediatric liaison service for the Trust

- To work alongside commissioned adult safeguarding support staff such as the Trusts IDVA service and the Health liaisons team whose members are honorary employees Trust employee.
- Oversee the Trust compliance in relation to MCA and DoLS
- Ensure there are processes in place to routinely flag a service users LD status on electronic patient records.

2.4 Trust policies and procedures which support the framework for Safeguarding are:

- Safeguarding Children from Abuse
- Safeguarding children and young people in Urgent Care Settings
- Safeguarding Children Supervision and Peer Review policy
- Safeguarding Adults from Abuse and Neglect and Prevent policy
- Hertfordshire procedures for Safeguarding Children from Abuse
- Hertfordshire procedures for Safeguarding Adults from Abuse
- Female Genital Mutilation policy
- Mental Capacity Act policy
- Deprivation of Liberty Safeguards policy
- Care of Adults with Learning Disability policy
- National LD mortality review Standard Operating Procedure
- Domestic Abuse policy
- Chaperoning policy
- Was Not Brought Policy
- Employee and workforce policies and procedures
- Disclosure and Barring checks and disclosure of information, Trust policy
- Raising Concerns at Work policy – 'Whistleblowing'
- Statutory and Mandatory training policy
- Equality, Diversity and Human Rights Strategy
- Safer Staffing
- Serious Incidents policy and clinical incident reporting
- Complaints policy
- Dementia policy
- Delirium policy
- Trust Carers policy

Policies and procedures are regularly updated to reflect any changes in practice, learning from case reviews and national guidance and recommendations. Any updates or new policies continue to be approved by the joint safeguarding committee.

During the reporting year, the following Trust policies and Standard operating procedures (SOP) have been updated and or introduced:-

- Safeguarding Children from Abuse - updated
- Safeguarding children and young people in Urgent Care Settings - updated
- Was not brought Policy – new policy
- MCA and DOLS policy - updated
- Purple Wrist Bands – new SOP

In addition, the safeguarding team have been involved in the update of the following Hertfordshire wide Policies and Procedures (HSCP/HSAB)

- Pre-birth Protocol

- Rapid Response Protocol for Child Death

Pathways updated and developed:

- Paediatric transfer from QE2 to Lister – including non-accidental injury - updated
- Management of the acutely unwell adult presenting with dependents – New pathway

During the COVID – 19 outbreak the safeguarding leads assisted in the development of policies and rapidly revised clinical pathways to insure that they remained compatible with the Trusts statutory safeguarding requirements.

3.0 Governance and Assurance

3.1 Trust Safeguarding Committee

The Safeguarding Committee is chaired by the Director of Nursing. Representation is provided from the clinical divisions across the Trust – whom provide divisional reports to the committee, the Trust Safeguarding team, the CCG Designated Nurses for Child and Adult Safeguarding, and the Learning Disability Liaison Nurse.

The Safeguarding Committee continue to meet bi-monthly and reports to the Trust Board via the Director of Nursing.

The committee is responsible for sign off of all new/updates to safeguarding policies, safeguarding action plans, and oversight of the safeguarding Dashboard.

Updates are provided from the HSCP and HSAB, and any new national and local safeguarding reports are discussed and actioned as necessary.

The Learning Disability Working Group is a sub-group of the safeguarding committee and continues to meet bi-monthly.

3.2 CQC inspection September 2019

ENHT underwent a CQC inspection in September 2019. The results showed overall the Trust requires improvement – actions in relation to safeguarding were around level 3 training compliance for anaesthetists. An action plan is in place which is monitored at the joint safeguarding committee.

3.3 Arrangements to Safeguard Children under Section 11 of the Children Act 2004

A Section 11 audit visit was carried out in April 2019 by East and North Hertfordshire CCG to the Trust to ensure compliance with our responsibilities under the Children's Act to safeguard children. Positive feedback at the time of the visit was received with clear actions identified to further improve the service. The audit established that the Trust was able to demonstrate that it was meeting the statutory requirements. A detailed action plan was developed and monitored through the divisional board and joint safeguarding committee, this is track for completion.

3.4 Adult safeguarding assurance visit

The local CCG conducted their annual quality assurance in October 2019 they identified areas of good practice and also made a number of recommendations.

Good Practice by the commissioners.

It was acknowledged that the Trust worked closely during the year with a Learning disability provider and a mental health provider to coproduce enhanced systems and processes which better support vulnerable persons accessing our services.

The commissioners acknowledged the positive benefit of the development of a virtual ward for patients with learning disabilities which ensures that patient reviews from key specialities such as the critical care outreach team (CCOT) and sepsis teams can be better prioritised based on clinical need.
The commissioners noted the routine work of the Trust Safeguarding Committee members in supporting clinical staff in making decisions which are underpinned through safeguarding legislation.
The commissioners highlighted that the Trust had good processes in place to ensure that the mental capacity act is implemented in clinical practice and there is good oversight on the location and clinical progress of individuals under a DoLs in the organisation.

A detailed action plan was developed to implement the recommendations, and is monitored at joint safeguarding committee.

3.5 External reporting

A CCG dashboard for safeguarding children is completed for each quarter to provide assurance on key performance indicators such as supervision and training compliance, as well as various other outcome measures in relation to figures of child protection medicals and referrals to agencies tasked with safeguarding of children. The metrics are agreed as part of the contract for the safeguarding service.

4.0 Safeguarding Activity

4.1 Child Protection Medicals

Child protection (CP) medicals are undertaken as per the guidance of Royal College of Paediatrics and Child Health. All child protection medicals are done by a consultant or a senior trainee under consultant supervision. Child protection medical proforma is in line with the revised RCPCH guidance.

Child protection medicals are done by both acute and community paediatrics team. Children referred by social care team to community paediatrics team are seen in the Bramble child protection unit.

Before any child protection medical examination takes place consent is taken. We explain in details about the process and also the right to withdraw consent at any stage of child protection medicals. We have a separate consent form for medical photography and a subsection for use of medical images for peer review and teaching and both subsections are explained to the consent holder.

There were 168 CP medicals completed in 19/20 compared to 189 in 18/19. Physical abuse remains the most prevalent reason for Child Protection medical referrals. This includes sibling medicals. (Table 2)

Table 2

April 2019 – Mar 2020	Physical	Neglect	Sexual	Emotional	Mixed - Physical, Neglect, Emotional	Review	Total
Acute	30	0	0	0	0	0	**30**
Community	124	6	0	0	8	0	138
TOTAL	**154**	**6**	**0**	**0**	**8**	**0**	**168**
2018/19	136	8	9	0	NA	0	189(including sibling medicals)

This year we have introduced a skeletal survey consent form (in line with Royal College of Radiology guidelines) in which the doctor requesting the skeletal survey takes an informed written consent for the skeletal survey from carer who has parental rights and the radiographer also confirms it at the time of procedure. The consent form was also shared with the safeguarding team at the West Herts trust.

We now have introduced a meeting with West Herts safeguarding team and the meeting was held in 2019. We shared examples and experiences about skeletal survey and also discussed our skeletal survey audit. Another meeting was scheduled in March 2020 but has been postponed, however will be reinstated shortly possibly on virtual platform.

The number of child protection medicals for neglect continues to be low, despite neglect being the highest category of child protection plan being in place in Hertfordshire. This has been raised by the head of safeguarding to HSCP and designated nurse and doctor. Neglect was the subject of a quality conversation that was held following a referral to the rapid review panel for children attending the Trust with worrying signs of neglect. The quality conversation identified the benefits of a cp medical for children with signs of neglect.

Furthermore, during the reporting year, the independent scrutineer for Hertfordshire undertook a review into cp medicals across all sites of the county – results of this are pending, and any actions and learning to come from this will be actioned and overseen at both the joint safeguarding committee and the safeguarding partnership.

4.2 Referrals to Children's Social Care

Recognising and referring vulnerable children and families is a key role and responsibility of all staff working for ENHT.

Referrals are made to Children's Services when a professional considers a child or unborn baby to be at risk of significant harm – these include children attending with possible non-accidental injury, and concerns involving neglect. Referrals are also made when adults present for care and issues identified around domestic abuse, mental health, and drug and alcohol issues (Think family agenda).

In 2019, Hertfordshire children's social care introduced a new web based system for making safeguarding referrals. The Trust went live with this new process in August. This new way of reporting concerns, gives greater opportunity for oversight from the safeguarding team of the referrals made, however there may still be referrals made by individuals that may not be shared with the safeguarding team if not using the generic account.

The number of referrals made to children's social care from the Trust fluctuates depending on need. Referrals and process, is discussed in all levels of training, supervision, and weekly psychosocial meetings.

The numbers of referrals made are reported on the Trust safeguarding Dashboard, and the CCG dashboard.

There is an annual quality audit which reviews the referrals made by the organisation. The latest audit following the implementation of the new referral process demonstrated a considerable improvement in the quality of referrals made to children's social care.

Table 3 outlines the numbers of referrals made during reporting period compared with the previous reporting 2 year periods. The table demonstrates a continuous year on year increase on numbers of referrals made - this reporting year saw a 38% increase on referrals made to children's social care.

When looking at the breakdown of the figures further – the number of referrals made in relation to maternity safeguarding have decreased by 8%, whilst the referrals made in relation to children's safeguarding have increased by 45% on the previous years.

All maternity cases identified with concerns are risk assessed against the pre-birth protocol, those that are at immediate risk and or meet threshold for referral, are referred at time concern is identified. If threshold has not been met, the case is discussed at the maternity information sharing meeting to see what further input maybe required. The maternity information sharing meeting continues to have representation from children's social care – who are involved in the decision making of the level of response the concerns required.

The majority of the increase in referrals for children are in relation to the think family agenda, along with increased safety netting around 16 to 18 year olds attending the organisation, continued awareness raising of the paediatric liaison criteria, and multi-agency attendance to the weekly psychosocial meeting. All referrals made by the CAMHS Crisis Acute Treatment Team (C-CATT), for patients attending ENHT are equally recorded in this data as the patient is receiving care from ENHT as well. Quarter 4 reporting included the month of March, attendance to the Trust reduced in both paediatric and adult presentations due to the impact of COVID. This directly correlated with a reduction in concerning presentations relating to safeguarding to the Trust and a drop off in the number of referrals made to local authorities.

Table 3

Year	Q1	Q2	Q3	Q4	Total
2019-20	**156**	**253**	**271**	**214**	**894**
Maternity	43	30	32	24	129
Paediatrics	113	223	239	190	765
2018-19	**107**	**123**	**153**	**175**	**558**
Maternity	44	30	33	33	140
Paediatrics	63	93	120	142	418
2017-18	**129**	**109**	**111**	**142**	**491**
Maternity	82	50	49	81	262
Paediatrics	47	59	62	61	229
2016-17	**129**	**109**	**111**	**142**	**491**
Maternity	82	50	49	81	262
Paediatrics	47	59	62	61	229

4.3 Maternity Risk Assessment

Risk assessment is undertaken through assessing Information Sharing Forms (ISFs) completed by Midwives and other professionals. The most frequent theme continues to be maternal mental health.
A newly streamlined process is now in by perinatal mental health midwife alongside the specialist perinatal mental health team. ISFs are now dual purpose for mental health referral and will be further developed this year to gain consent specifically for referrals to other organizations, particularly women experiencing domestic abuse.

The number of births in the period 1st April 2019 to 31st March 2020 was 5262 and the number of ISFs was 1351 (an increase of 179 from 2019). The ISFs continue to be classified into two streams: returned to midwifery for monitoring or discussed at multiagency meetings. Information coming to maternity meetings additional sources e.g. police, social care, Marie Stopes International, GP surgeries, maternity units). The numbers of ISF's discussed at the Maternity information sharing meetings were 554 (decrease of 80 in the last year) this may reflect closer joint working with perinatal mental health team and lack of multi-agency focus for single issues of late booking or non-attendance for maternity care where cases are held by midwifery until safeguarding issues are clear.

Current cases are tracked at this meeting and information shared regarding outcomes of assessments, child in needs plans, child protection plans and thresholds for legal planning.
In the period 1st April 2019 to 31st March 2020 there were 41 Initial Case Conferences (significant decrease of 13 from 2019, reflecting more cases being held as Child In Need (CIN). FGM cases were stable at 12 cases.

Table 4 illustrates the number of cases the midwifery team held which were CIN or CP. There has been a clear change in this reporting year, in the number of unborn babies on CP plans (decreasing), with an increase with on CIN plans. This reflects the picture Hertfordshire wide where the number of children on CP plans is reducing yearly, with more CIN plans in place.

Table 4

Year	CIN	CP
2018/2019	34	53
2019/2020	49	41

4.4 Requests for Information – S17, 47 and Multi-agency safeguarding hub (MASH)

Where requested to do so by local authority children's social care, practitioners have a duty to co-operate under section 27 of the Children Act 1989 by assisting the local authority in carrying out its children's social care functions – including information sharing.

Information sharing requests from children's services for Section 17, Section 47 and MASH inquiries has decreased by 9%. (Table 5) However this workload still places an additional pressure on resources due to the time to complete the information gathering and collating. This decrease in requests does not correlate with the increase seen in referrals, however the requests for information is following the contact made with children's social care, the outcome of the contact and if this progresses to an assessment. A recommendation from this finding is to monitor the outcome of referrals made to children's social care.

Table 5

Year	Q1	Q2	Q3	Q4	Total
2019-20	**305**	**400**	**400**	**423**	**1528**
2018-19	**459**	**508**	**713**	**296**	**1680**
2017-18	**651**	**707**	**522**	**463**	**2343**

4.5 Paediatric Liaison

The paediatric liaison service has again seen significant changes over the past year on how the service is delivered and on activity levels.

The Trust was requested by Hertfordshire Community NHS Trust (HCT) to review the way in which information is shared between the two Trusts. This was following the decommissioning of the paediatric liaison service at a neighbouring district general hospital covered by HCT. A proposal was presented to ENHT of an electronic sharing of basic information regarding an attendance to the organisation. The CCG supported this new proposal. However, we disagreed that the new proposal would not share enough detail regarding associated safeguarding concerns, and also did not support early intervention and prevention – reducing the number of cases that require additional escalation to services.. In recognition of this request, we implemented the new IT system to run alongside the existing paediatric liaison service. All attendances are shared via the electronic system with additional screens for risk in place. In addition, the information sharing criteria remains in place for those children attending the organisation with additional concerns that benefit from having their information shared with their health visitor, school nurse and any other identified

professional involved in their care and wellbeing as relevant. This information continues to be shared via the paediatric liaison service, and contains detailed information on the attendance, findings and outcomes, and any further additional support that maybe required. Risk analysis is then more meaningful based on a full picture of the presentation - taking action to support a child, young person or their family early in the life of a need, or as soon as it emerges, with the aim of meeting a need early, preventing escalation of need and presentations requiring more specialist interventions.

Additional changes which have been implemented during report period;

- Discharge Summaries for 16 and 17 year olds attending the organisation are now screened alongside the ISF criterion and flagged to the Liaison Nurse for review, ensuring that a clear safety netting process is in place for all children who attend.
- All Discharge Summaries that have gone through the safety netting process and highlighted to have met the criterion for liaison, continue to be reviewed by the Liaison Nurses, written on psychosocial database and actioned. Many of which highlight young people attending adult ED with mental health difficulties, assault, and signs of exploitation. We now receive updates and outcomes of the child's care on all of these Discharge Summaries. Cases are escalated as required to appropriate agency for ongoing intervention and support.
- Regular CCAT, young carers, Care Grow Live (CGL), Families first and IDVA's attendance at psychosocial has been achieved - which facilitates multiagency discussion surrounding the needs of children and their families and enhances wider staff knowledge of community support services and early help agenda.
- Further work has been taken to ensure attendance of community nursing services and UCC at psychosocial meetings to again strengthen the workforce knowledge surrounding psychosocial issues for children & young people.
- The paediatric liaison service have quarterly meetings with health visiting and school nursing services to enable and facilitates effective communication between agencies, provide assurance that service is working well together and address any issues which have arisen – ensuring a timely and appropriate response

Table 6 below highlights the activity for paediatric liaison in relation to the number of attendances liaised to Health visiting and school nursing teams. Since 2017, the changes implemented in the paediatric liaison service has seen a significant increase in information sharing forms received and intervention offered (a further 20% increase on previous reporting year). These figures continue to demonstrate how both the aide memoir and staffs increased awareness of vulnerability and risk factors, is resulting in additional review and oversight, identification of support services to meet earlier need, and improved sharing information with other agencies that hold further information to interpret the admission in context of the child's holistic care.

This increase in work has not come with additional resources and has placed additional burden on the safeguarding and paediatric liaison team. Despite IT solutions being implemented to support the paediatric liaison service, the screening of all attendances continues to be in place, and year on year the numbers screened are increasing (a further 10% increase on previous reporting year). This screening and safety netting process has been recognised by the CCG as a 'need to continue' to practice.

Table 6

Year	Q1	Q2	Q3	Q4	Total
2019-2020					
LIAISED CHILD ATTENDEES	10472	9922	11559	9482	**41435**
NUMBER OF PSYCHO-SOCIAL REFERRALS	913	855	1108	866	**3742**
2018-19					
LIAISED CHILD ATTENDEES	10579	9177	10830	9906	**40492**
NUMBER OF PSYCHO-SOCIAL REFERRALS	648	710	781	855	**2994**
2017-18					
LIAISED CHILD ATTENDEES	5441*	8242	10368	9906	**33957**
NUMBER OF PSYCHO-SOCIAL REFERRALS	426	499	424	506	**1855**

**Service only provided for East Hertfordshire (North Hertfordshire provided by HCT – this service was decommissioned and commissioned for the North to be provided by ENHT from Q2 onwards).*

4.6 Looked-After Children Health Assessments

LAC children are seen on a regular basis for Health Assessments. These take place within 28 days of the child coming into care (Initial Health Assessments - IHAs), then every 6 months (under 5's) or annually (5+) (Review Health Assessments - RHAs). Paediatricians carry out all LAC IHAs for under 10's and RHA's for all children where Adoption is in their care plan. HA's are requested by the child's social worker and arranged through the LAC team.

Timescales in 2019-20 were that IHAs should be completed and returned to the LAC team within 10 working days of the request. In 2019-20 the agreement was that RHA's were completed and returned within 5 weeks.

We also agreed with the LAC team and commissioners that children in special schools would have their LAC Health reviews in school at the same time as their annual health review even if this was out of timescales as it is in the child's best interest.

The LAC team now routinely give us the names of any children who "breach". This enables these breaches to be investigated and where appropriate, covered through exemption reporting. Exemption reports are completed for breaches for which we aren't responsible (eg last minute was not brought, carers refusing to bring the child etc)

It was agreed with Commissioners that the target was 90% for both IHAs and RHAs. The figures are reported to the joint safeguarding committee bimonthly, where they are recorded on the dashboard. The figures are also supplied to the Health of Looked After Children Leadership group which meets quarterly.

The Courts are continuing to favour placements within the extended family and Adoption is considered very much a last resort. This has led to a reduction in the number of children becoming Looked After and also a reduction in the number of Adoptive Placements.

Another Government Directive has led to the setting up of "Adopt East" which has brought 6 agencies within the region to work together more closely. The process is moving forward slowly but at the moment Hertfordshire continues to work as a single Agency. The proposed merger with Luton was abandoned in December at a very late stage at the request of Luton.

4.7 Numbers

In 2019/20 we carried out 129 LAC medicals, 73 IHAs and 56 RHAs. This was a significant reduction to last year and was partly due to appropriately trained nurses doing more of the RHAs. The Trust

has continued to review available capacity for LAC's. We have reduced the number of dedicated clinics for LACs but we do have the flexibility to increase capacity if required

Table 7

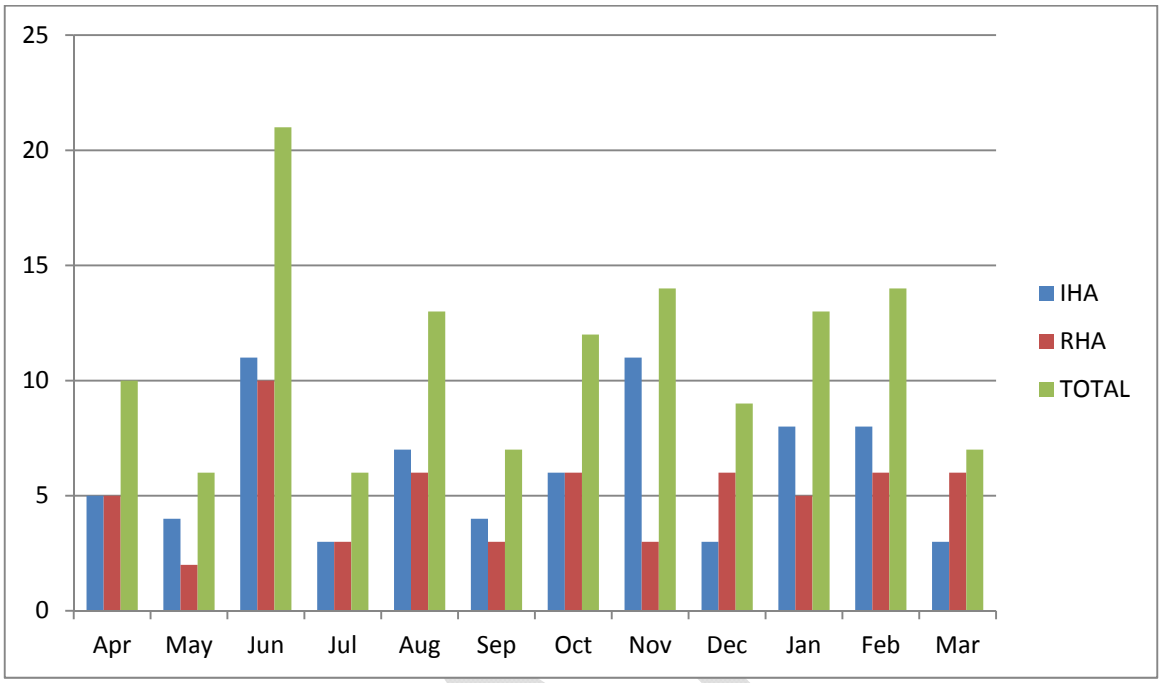
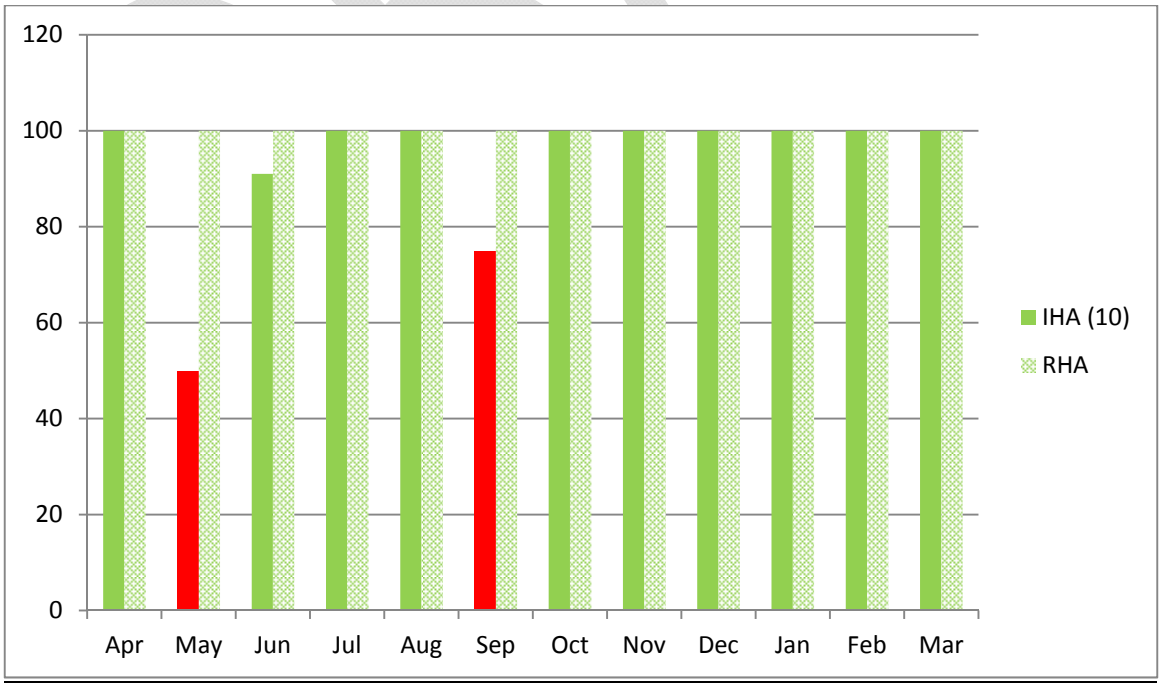


Table 7 shows considerable variation in the demand for health assessments across the year with a huge peak in June followed by a low in July. (These highs and lows are not predictable. This wide variation in the workload presents a considerable challenge in offering timely appointments whilst at the same time utilising vacant appointment slots.)

4.8 LAC HEALTH REVIEWS 2019/20 - timescales



The tables shows the percentages of HA's meeting timescales. The columns are RAG rated (red = <80% amber = 80-90%, green = >90%). The first column for each month represents IHAs returned within 10 days, and the 2rd RHAs returned within 5 weeks.

Because numbers, for HA's are often below 10, 1 HA breaching timescales can put the monthly average below 90%. Our overall averages for the year were:

IHA's 94.5% (69 out of 73 meeting timescales)
RHA's 100% (56 out of 56 meeting timescales)

There were a lot more exemption reports (21) this year whereby breaches were not deemed to be East & North Herts fault. A number of these occurred in March where COVID restrictions significantly impacted on carer's ability to attend.

Thus over the year we are meeting timescales as agreed with commissioners and accepting the numbers have been smaller, our performance has improved compared with 2018/19.

March was beginning to be impacted by the challenges of COVID19 and we had started to do telephone consultations with foster carers. This has presented a number of problems and I, along with a number of medical colleagues across the region, feel that there is a safeguarding risk in not seeing the children. We have already had one instance where the information given by the foster carer was not entirely accurate. We are planning to resume face-to-face consultations for IHAs from the beginning of June but I appreciate some foster carers will need persuading to attend hospital.

It is very likely that in the aftermath of COVID, CORAM/BAAF will carry out a review of the whole adoption and fostering process and their recommendations may fundamentally change the way we work. Practice continues until any update is received.

4.9 Child Deaths

Since the 1st April 2008, it has been mandatory for Local Safeguarding Children's Boards (LSCB) Child Death Overview Panels (CDOP) to review all deaths of children (birth up to their 18th birthday), to identify if there are any preventable factors that contributed to their death.

The lead for child death within ENHT sits with the head of nursing for paediatrics and is supported by the clinical director for paediatrics. The paediatric liaison nurse, along with a senior nurse within the paediatric emergency department continues to be the link professional's for CDOP. These link professionals represent the Trust at CDOP meetings and share agency summary reports.

During the reporting period, ENHT reported 8 deaths of children, 7 of which were unexpected and 1 of which was expected.

All child deaths continue to be reported on Trust datix and reviewed by the Serious Incident Review Panel who support the decision making process if further investigation is required. In all cases 72 hour reports are completed and taken to panel for further decision making on any further review required. 1 case went on to have a rapid review undertaken – with no further review required following the multi-agency meeting.

4.10 Safeguarding Adult Concerns

From April 2019 to March 2020 the Trust recorded 502 Safeguarding Adults at Risk concerns; these include all concerns reported by Trust staff as well as those raised about care in the Trust.

53 were about care in the Trust, 6 concerns were substantiated against the Trust and a further 2 are awaiting an outcome of S42 enquiries.

The categories of alleged abuse or concerns for safeguarding adults included: neglect and acts of omission, self-harm, self-neglect, financial, physical, sexual and psychological abuse, domestic abuse and modern slavery. Domestic abuse accounted for 21% of cases referred for safeguarding, however in some cases on further investigation the situation that has arisen is due to the care needs of one or other of the parties involved, e.g. where an elderly couple are struggling to look after each other, or family members are struggling with care, and the available supportive services are not involved with the family. In these cases care needs review and provision of support services can help to resolve the problems. 58% of adult safeguarding concerns raised in the Trust related to suspected acts of neglect or omissions which occurred in a community setting such as a care home or at a domestic address.

Concerns about the Trust which were substantiated included:

- Failure to manage medications appropriately during admission notably transdermal analgesics
- Discharge omissions in relation to the restart of care packages or key information missing from district nurse referrals
- Omitted essential medications upon discharge
- Failure to apply for a DoLs in a patient whose care constituted a deprivation of Liberty.

Actions taken within the Trust have included:

- Site Safety huddles enhanced to ensure that there is a whole systems approach to the needs of vulnerable patients, e.g. with LD are known about by the senior site team and actions are taken to escalate concerns or solutions to treatment requirements or procedures. Also attended by the LD nurses
- LD working group continues to implement and monitor improvements in LD care throughout the Trust.
- Purple Wrist bands introduced to raise awareness of individuals patients learning disability needs.
- Safe management of transdermal patches protocol introduced.
- Increased MCA and DoLs education delivered to specialing team improvements evidenced against with a 21% increase seen in DoLS applications completed by the Trust in 2019/20 when compared to the previous year.

4.11 Prevent – referrals to Channel Panel

During 2019/20 no referrals met the threshold for referral to the local authority channel panel.

4.12 Independent Domestic Violence Advisor

Independent domestic violence advisors continue to provide a hospital based service to ENHT, seeing high risk victims of domestic abuse. During reporting period, 180 referrals were made to the IDVA service, up …… on previous reporting year, demonstrating an increase in recognition of domestic abuse and responding to people's needs.

IDVA's have continued to provide bespoke, bite size training to staffing groups and are visible throughout the Lister hospital site.

4.13 Domestic Homicide Reviews (DHRs)

DHRs are a statutory requirement under the Domestic Violence, Crime and Victims Act 2004. DHR means 'a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

a) a person to whom he/she was related or with whom he/she was, or had been, in an intimate personal relationship, or a member of the same household as him/herself
b) held with a view to identifying lessons to be learnt from the death' (Home Office 2016).

The Trust has provided information for one domestic homicide case during 2019/20, the case is ongoing DHR and no specific actions have been identified for the Trust.

The adult safeguarding nurses is a member of the HSAB domestic homicide review sub-group.

4.14 Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS)

The Mental Capacity Act is an important part of everyday practice in the NHS and it is the responsibility of all Trust staff to have regard for the requirements of the act.

All staff receives training on MCA and DoLS in their statutory and mandatory training, which is provided at induction and in two yearly updates. At the end March 2020, 88% of staff were compliant with statutory/mandatory training requirements.

In addition MCA and DoLS training is included in the study days held for Preceptorship Nurses and Preparation to practice clinical support workers led by the nurse education team.

4.15 Deprivation of Liberty Safeguards (DoLS)

DoLS provide legal protection for those people aged 18 years and over who lack the mental capacity to consent to the arrangements for their care or treatment in a hospital, or care home, and in whom, within the meaning of Article 5 of the European Convention of Human Rights (ECHR), are deprived of their liberty, in their best interests, to protect them from harm.

The Supreme Court established the 'acid test' in March 2014 and stated that a deprivation of liberty should be considered where:

- The person is under continuous supervision and control **and**
- is not free to leave **and**
- lacks the mental capacity to consent to remain in hospital or a care home

The person does not have to be saying or showing that they want to leave for a deprivation of liberty to be considered.
During 2018/19, 296 Urgent DoLS applications were made by the Trust this increased to **375** in 2019/20

5.0 Rapid Reviews (RR's) Safeguarding Adults Reviews (SAR), Partnership Case reviews (PCR)

In accordance with national guidance, rapid reviews, and domestic homicide reviews (RR/DHR) are requested by the HSCP when a child dies or is seriously injured in circumstances where there are concerns and the case requires a whole system review, to support the process of identifying how we improve our safeguarding system. All children who are seriously injured or die as a result of injuries are reported as a serious incident to the HSCP and CCG regardless without any failing being attributed to the Trust.

Following a Rapid Review, a decision is made to determine if a child safeguarding practice review is required. Table 8 outlines the number of reviews ENHT were involved with for the reporting period.

Table 8

	RR (children)	SAR (adult)	DHR
Children's (including maternity)	**3**	**N/A**	**0**
Adults	**N/A**	**1**	**1**

All rapid reviews ENHT were involved with, 2 of the cases had no outcomes of no further review being required, with 1 case a decision for a MAPPA SCR to be completed in the county of Kent.

ENHT made 1 referral to the rapid review panel, which was not accepted for a rapid review, but a quality conversation took place with the key agencies involved to unpick the learning. There were no actions identified for ENHT, but learning identified the value of cp medicals for neglect.

In addition, 1 chronology was submitted from the speciality of safeguarding children's – with no further input required.

Serious Case Review for Child J, who was born at Prince Alexandra Hospital in Harlow, has been published. The learning event was held in December 2018 and recommendations have been made. A meeting has been held with Princess Alexandra Hospital in order to implement this recommendation. Action relates to Princess Alexandra and process for sharing information with community midwife.

All recommendations from reviews are embedded into training and actions reviewed at the Trust joint safeguarding committee.

The SAR's that the Trust was involved with during the year highlighted the importance of multiagency working in relation to the care of individuals with a learning disability who are within the last 12 months of life. The learning from the incident will be developed by Hertfordshire safeguarding adult board sub group known as the improving healthcare outcomes group a member of the Trusts safeguarding adult team is a member of this group.

The DHR investigation which the Trust is involved with has not yet reached a conclusion however no learning had been identified to date for the organisation.

5.1 Safeguarding Quality Assurance and Audit Activity

During the reporting period, a comprehensive audit programme was undertaken and action plans developed to address the recommendations. Table 9 gives a brief overview of the audits undertaken during reporting period, and the learning from these.

Table 9

Safeguarding Audit or Quality Assurance Activity undertaken by Topic/Title	Methodology i.e. Employee Survey, dip sample, case file audit, Customer Survey etc.	Outcome (Summary of key findings / learning)	Has the learning and actions been implemented?
Staff's Awareness of Safeguarding For 16 and 17 year olds attended ENHT	Case File Audit	The audit demonstrates some areas of good practice in consideration of safeguarding issues, for this age group, however the documentation used needs to be updated in relation to risk assessment tools available for staff and some basic questions around demographics to be mandatory in order to help identify risk further. It also	Learning has been shared; some actions remain outstanding due to priorities around COVID-19. Actions back on track for completion.

Safeguarding Audit or Quality Assurance Activity undertaken by Topic/Title	Methodology i.e. Employee Survey, dip sample, case file audit, Customer Survey etc.	Outcome (Summary of key findings / learning)	Has the learning and actions been implemented?
		demonstrated gaps in the safety netting process for this age group. More importantly a need to continue to raise awareness of the vulnerabilities of 16 and 17 year olds attending must continue.	
Paediatric liaison audit	Dip sample of psychosocial database	The audit demonstrated a clear increase in the number of referrals to paediatric liaison and liaison activity over the last 2 years. This reflects a clear increase in front line recognition of children's psychosocial needs and the need for information sharing for early help and safeguarding purposes. The audit also reflected that the liaison service is effectively providing risk assessment surrounding wider contextual safeguarding concerns for children & young people, identification of young carers and private fostering arrangements. It was noted that the safety netting process held within the paediatric liaison service has an effective safety netting process and is instrumental in ensuring that all children's attendances are further screened for additional safeguarding concerns and are acted upon in a timely manner. Further learning from this audit, reflects the need for frontline staff to be more aware of community/early help support services for children & their families and making referrals at the time of the attendance.	All actions completed – Awaiting sharing at RHD – cancelled due to COVID
Referrals to children's social care	Audit of referral forms	The audit demonstrated a significant improvement on the previous year's audit in relation to the quality of information included on the referrals made to children's social care. Some areas of improvement required around consent, and the think family agenda	Action plan to be drawn up to address gaps Consideration for future audits to include outcome from children's social care
Skeletal survey	Retrospective audit of case files		
Think Family	Dip sample of adult presentations with features of domestic abuse, drugs and alcohol and acute mental health presentations.	The re-audit for think family has reflected a marked improvement in the routine enquiry of whether a patient has dependents	Yes - continue promoting the think family agenda throughout the organisation.
Neglect Audit	Multi-Agency case audit – led by HSCP	To examine multi-agency response to prevention and early intervention. Do families receive	Awaiting results from HSCP

Safeguarding Audit or Quality Assurance Activity undertaken by Topic/Title	Methodology i.e. Employee Survey, dip sample, case file audit, Customer Survey etc.	Outcome (Summary of key findings / learning)	Has the learning and actions been implemented?
		an appropriate level of help and support as soon as issues and concerns are first identified? Are relevant and suitable assessment tools utilised where Neglect is suspected?	
Supervision Audit	Staff survey – led by HSCP	The survey has been valuable in validating the benefits staff finds with safeguarding supervision, evidencing areas of good practice. Only one area of improvement around sharing of supervision records with the supervisee needs an action to address.	Action to be put in place for this
National learning disability benchmarking audit against. December 19 – February 20.	Service user audit feedback requested from 150 patients with an LD who attended the Trust in 2019. 50 Staff surveys included. Activity audits to benchmark outcomes for patients with LD compared to patients without and LD.	The Trust is awaiting the full results of the audit to benchmark against organisations nationally. It has been identified that People with LD would benefit from receiving easy read appointment letters. There is no changing places toilet facility at the Lister site. There is a need for one to be installed. There is confusion amongst some members of staff surrounding the definition of learning disabilities and differentiating from the diagnosis of a learning difficulty.	Request made for ELearning package on Learning disabilities to be mandated to all Trust staff. Members of the estates team have been co-opted into the Trusts Learning disability working group with a target of having a changing places toilet facility on the lister site by March 2021. A key objective of the working group is that Easy read appointment letters will be the standard appointment letter for individuals with and LD by August 2020.
Learning disability patient experience audit. (09/01/2020)	This audit was assisted by the CCG in conjunction with the Trusts patient experience and safeguarding team and independent experts by experience.	On the 9th January 2020 all patients with a learning disability onsite were visited by a member of the audit team. The patient or their carers where spoken to give feedback on their experience.	All patients or there carers interviewed on the day reported a positive experience. Decision was made to incorporated this type of audit into a quarterly process however this plan has been impeded by -19
MCA and DoLs audit (February 2020)	Quality check completed on all DoLs authorisation requests. Activity check conducted on patient specialing in the Trust.	Not all patients with loss of mental capacity who were under the control of the enhanced care team had a DoLs in place.	Education given to members of the enhanced care team, awareness of MCA and DoLS highlighted at frequent site safety meetings to raise awareness. DoLs applications in March and April rose by 44% in comparison to January and February 2020.

6.0 Training, Supervision, Peer review

To protect children and adults from harm, all healthcare staff must have the competences to recognise maltreatment and to take effective action as appropriate to their role. ENHT is committed to ensuring that all staff receives the correct level of training to safeguard children and adults from harm and abuse. The Trust also actively promotes a "Think Family" approach.

The Trust has a Safeguarding Children's Training Strategy and Training Needs Analysis in place which is based on the Intercollegiate Document, Safeguarding Children and Young People: Roles and Competencies for Health Care Staff. Fourth Edition (2019). The strategy outlines the levels of training staff require to be compliant and frequency of training.

Safeguarding training is provided for all Trust staff through the statutory/mandatory training programme and new staff induction programme. All staff receive mandatory updates every two years, Adult Safeguarding level 1 & 2, MCA, DoLS and Prevent awareness.

Compliance with training attendance is recorded on the Electronic Staff Record and monitored through monthly reports to line managers, the Statutory-Mandatory Training Committee and the Safeguarding Committee.

6.1 Training Compliance

During the reporting period, the Trust worked towards achieving 90% compliance (set by CQC and CCG) for all levels of safeguarding training, and has maintained an overall compliance rate above 90% for all levels for children safeguarding combined for the year. Level 3 safeguarding children's continues to remain below 90%, (Jan/Feb 2020 reached 90%). The safeguarding team continuously raise this at board level, divisional level and manager level.

Compliance is currently significantly lower due to suspension of training in light of the Covid pandemic. The safeguarding team have been actively encouraging staff to engage with other forms of training such as e-learning/workbooks in order to maintain compliance for all levels of safeguarding.

During paediatric supervision sessions, slightly condensed level 3 sessions have been provided to help maintain compliance and these have been offered to other staff groups within supervision sessions when timings allow. The final end of year position is outlined in table 10

Table 10

Safeguarding Children's Training: year to date (end of March 2020)	
Level	**Overall Trust compliance (target 90%)**
1 & 2	**91%**
3	**88%**
Directorate – level 3 compliance	
Women & Children's	**90%**
Medicine	**83%**
Safeguarding Adults Training: year to date (End of March 2020)	
Level	**Overall Trust compliance**
1 (all staff)	**89%**
2 (Clinical staff)	**88%**
MCA and DoLS (Clinical staff)	**88%**
Prevent awareness (all staff)	**92%**

Prevent Level 3 (Clinical staff and on call senior managers)	**86%**

Training content is reviewed throughout the year to incorporate any changes in legislation and guidance. In addition training is updated to reflect findings from national and local Serious Case Reviews and audit findings. Different modes of training are available: this includes face to face classroom sessions, e learning and workbooks. A training passport is in the process of being trialled within the Neonatal Unit to encourage staff to take advantage of other training sessions especially those offered by outside agencies to help maintain their level 3 compliance and increase knowledge of current themes.

The Level 3A learning package in the form of a workbook specifically for staff working with 16 up to 18 year olds, (CQC directive), initially rolled out throughout the surgical division, has now been rolled out across the Trust and has been incorporated within induction and vital training sessions. The expectation is that it will take approximately another year for all staff to be fully compliant with level 3A.

The Adult Safeguarding nurse has continued to oversee the delivery of training to Trust staff on Level one and Level two safeguarding along with the attainment of statutory training requirements for prevent level 3 and the implementation of the HMSP adult victim pathway for human trafficking and modern slavery.

6.2 Additional Training

Staff are encouraged to attend external training events provided by Hertfordshire Safeguarding Children's Partnership this contributes to training compliance for the staff member.
Additional specialised sessions have continued to be provided for staff within ENHT Sessions provided during the reporting period have included:-

- Modern Slavery
- County Lines
- Domestic Abuse
- Domestic Homicide Review case study
- CYP gangs Unit
- Empathy Project
- Families Feeling Safe
- Sexual health
- Harmful Sexual Behaviours
- FII
- Perinatal mental health
- FGM awareness

There have been six safeguarding champions meetings over the recorded period during which there have been additional training sessions/updates including:

- ACE's
- DA updates
- Bruising policy
- CP processes
- Brook Traffic Light Tool
- SARC

6.3 Supervision

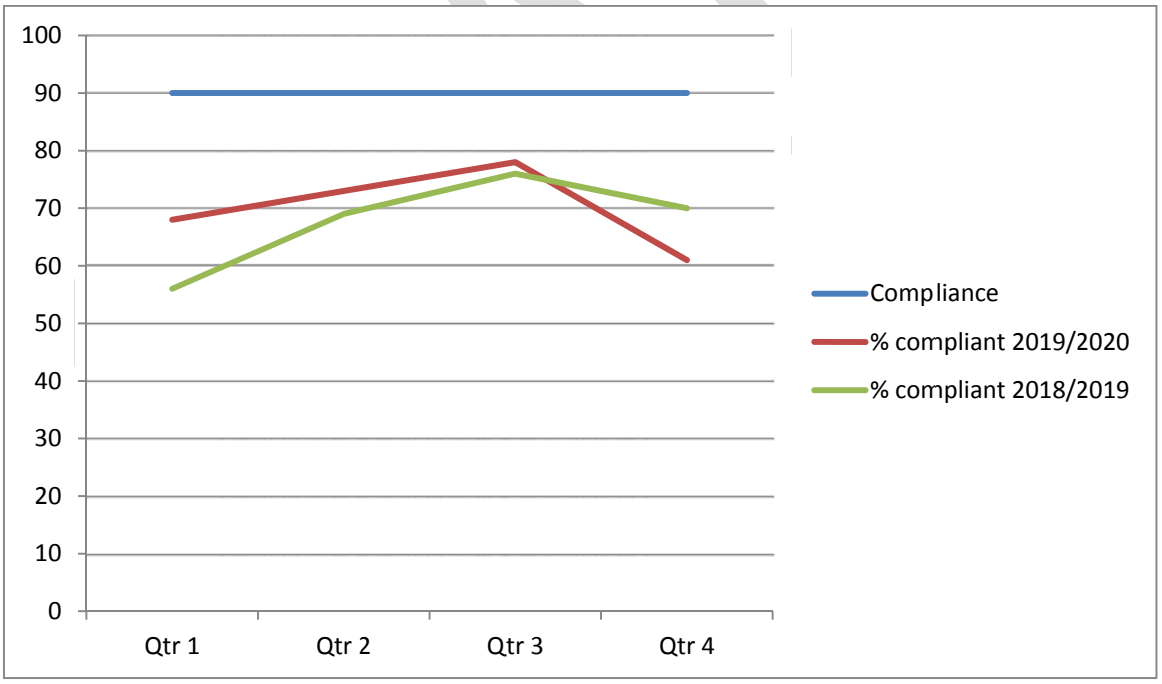
The safeguarding team continue to provide formal and informal safeguarding supervision to all frontline clinical staff working in paediatrics and to midwives. The Trust target for compliance as set by the Clinical Commissioning Group (CCG) is at 90% for Band 6 and 7 staff and caseload holders working within community setting.

In addition, informal supervision is available for all trust staff on a needs basis.

Supervision is provided to the safeguarding team by the CCG, and by the named nurse and midwifes within the Trust. In addition, peer support has been set up for the safeguarding nurses with West Herts NHS Trust safeguarding nurses.

Working Together 2018 acknowledges the importance of staff safeguarding supervision to enable staff to reflect on practice, learn from case discussions and obtain support for the emotional aspects associated with their work. It is known that attendance at supervision increases staff knowledge, skills, and supports emotional consequences of face to face contact with child protection cases. It also aids staff to assume responsibility for their own practice in a safe and supportive manner.

The following chart demonstrates compliance with supervision for the reporting period. It is worth noting that these figures do not always reflect the ad-hoc supervision provided to staff – which is the safety net for when concerns present and support and advice is required by the safeguarding team.



This last year saw a gradual improvement in compliance with safeguarding supervision on the previous reporting year – except for the last reporting quarter. This could mainly be attributed to the impact of COVID – regular supervision meetings were postponed due to redeployment of staff to the 'frontline' and team times where supervision is provided were cancelled. Ad Hoc supervision continued for cases, and the safeguarding children's team had oversight of all cases referred and where safeguarding concerns were identified and shared with the safeguarding team. An improvement is expected to be seen for the year ahead with the regular supervision programme having recommenced.

In addition to safeguarding supervision, clinical supervision is provided to staff who are caseload holders - combined with safeguarding supervision, this results in staff receiving supervision every 6-8 weeks (clinical supervision figures are not included within the safeguarding supervision report).

Supervision is carried out every four months for community midwives who carry a caseload. The rates remain consistently 94% and above. Ad-hoc face-to-face supervision and advice is provided to midwives in all inpatient areas of the maternity unit, during daily workday visits by the Named Midwife and Safeguarding Midwife. Both are contactable by mobile phone for advice and support. Additional supervision models are now being employed, allowing for flexibility to meet the differing needs of different practitioners. Ad-hoc supervision is recorded in a communication record held by the maternity safeguarding team.

To increase safeguarding awareness and provide regular updates the safeguarding team attend the community midwives monthly meetings with a place on the agenda. Newsletters are sent to the maternity unit. The Named Midwife meets with the Head of Midwifery on a monthly basis to discuss and update safeguarding information and issues.

Continuity of Carer pilots have launched during this period. The maternity safeguarding team have been providing orientation and additional supervision of these teams whose midwives have complete flexibility and who may work more closely with their women. At the end of the period these continuity teams were being disbanded due to COVID-19.

6.4 Peer Review

Peer review is a form of reflective practice and helps to decrease professional isolation and sharing of best practice.

The goal of peer review is provide a uniform practice by a proactive culture of shared learning, supervision, education and training and improvement of service and multiagency processes. It is a core competency for all clinical staff working with children to undertake regularly documented reviews of practice, including peer review. It is a component of the Clinical Governance Framework and is expected by the GMC and professional bodies. Peer review for junior and senior medical staff is led by Named Doctor for child protection on a fortnightly basis. All the child protection medicals are discussed including reports. Photographs are shown first to the team with a brief outline of the history. The lead consultant retains accountability, with this applying to any subsequent document changes. Discussions are around evidence bases of the case findings and recommendations are discussed. Table 11 demonstrates attendance to peer review during the reporting period.

Peer review is used as a training format using case discussions and is well attended by acute and community paediatricians and their medical teams. The attendance is monitored. Peer review attendance is recorded on electronic staff record (ESR) at level three and is monitored.

Peer review survey was done this year showing a positive experience and positive contributor to shared learning. Supervision is also offered and is delivered as a combination of individual and group sessions as well as ad-hoc supervision on the need of case basis.

Table 11

2019/20	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Acute and neonatal Consultants	*	9	5	4	6	6	9	4	6	*	11	**	60
Community Consultants	15	25	14	10	11	21	8*	12	14*	**	16	14	160
Total	15	34	19	14	17	27	17	16	20		27	14	220

*attendance sheet could not be located, **No peer review

7.0 Care of Adults with a Learning Disability

The Acute Liaison Learning Disability Nurses (Hertfordshire Health and Community Services) are involved with supporting patients with Learning Disabilities (LD) and their carers when using hospital services. They will assist Trust staff in making reasonable adjustments for patients, advising staff about what reasonable adjustments might be required, using appropriate communication tools for people with LD, enabling appropriate discharge packages of care, end of life care and will provide training for staff around the needs of patients with a learning disability.

The Trust uses an LD alert on the electronic patient records – alerts are available to use on Nerve Centre and Lorenzo. As of March 2020 there were 2776 individuals listed on our electronic records who had an LD alert flag on their records the majority of these individuals are Hertfordshire residents.

Learning disability alert	2019/20
ED attendances	417
Inpatient admissions	166
Day case admissions	105
Outpatient appointments	218

The alerts on the Nerve centre produce a daily report which is emailed to the LD nurses and matrons so that they are aware of the patients who are in hospital. At the daily site safety huddle on the acute site (Lister Hospital) all the patients with LD are discussed to ensure that if there are any concerns about care or any delays which need to be resolved these can be acted on by the right people in a timely manner. The LD nurses participate in these meetings.

7.1 Learning disability working group and improvement action plan

During 2019/20 there has been focused work on improving care for patients with learning disability. There were no SI's declared during the year relating to the care of individuals with a learning disability.

The Trust participated in the National learning disability audit in January 2020 to benchmark Trust performance against NHSI/E standards for the care of individuals with a learning disability. Areas were deficits are noted will incorporated into the Trusts LD working group's action plan. The bespoke Trust performance report is due to be received by the Trust from the NHSI/E audit team in July 2020.

The Learning Disability Working Group was set up and is meeting bi-monthly; it is chaired by the Director of Nursing. The membership includes the commissioners, representatives from the clinical divisions, the LD nurses, safeguarding teams, family carers, sepsis nurse, equality and diversity lead,

7.2 Improving Health Outcomes

The Trust has continued to participate in the Hertfordshire 'Improving Health Outcomes' group, the multi-agency group leading on the implementation of strategies to improve health outcomes for people with LD as part of the work of the LeDeR mortality review steering group. .

The Lead Adult Safeguarding Nurse and the Trust Lead Sepsis Nurse are members of the multi-agency Hertfordshire health outcomes group which meets quarterly.

7.3 National Mortality Review for people with Learning Disability (LeDeR programme)

From April 2017 Hertfordshire began to notify the deaths of people with LD, aged 4 years and over to the National Mortality Review programme. The aim of the programme is to review the deaths of people with LD to identify the learning for policy makers and services, so that improvements can be made for the health outcomes of people with LD, improve mortality rates and reduce the risks of premature death.

The Trust participates in the Hertfordshire LeDeR steering group and the Health Outcomes group. The Lead Adult Safeguarding Nurse and Lead Sepsis nurse also participate as reviewers for the LeDeR programme in Hertfordshire.

Deaths of patients with LD within the Trust are notified to LeDeR and will also be reviewed internally by the mortality review process.

During 2019/20 there were 13 deaths of patients with LD in the Trust

- Median age 64
- Men 6– median age 69 years (range 53-90)
- Women 7 – median age 69 years (range 17-78 years)
- Pneumonia and sepsis where the most common causes of death which is in keeping with national findings.

8.0 Interdisciplinary, Partnership and Multi-Agency working

8.1 Partnership Working - Hertfordshire Safeguarding Children Partnership/ Hertfordshire Safeguarding Adults Board

The Trust has continued to demonstrate a high level of commitment to partnership working through active participation in key partnership and board meetings. The Director of Nursing continues to represent the Trust on the HSCP/HSAB board; the safeguarding team are active members of many sub-groups attached to HSCP/HSAB.

Work has continued this year on the pre-birth protocol, and a focus on gangs and knife crime, learning and strategy. Children missing from education have also been an area of work ENHT has actively raised and engaged with within the partnership.

The Named Midwife has worked alongside Named Nurse for safeguarding children in Primary Care to embed the sharing of information which may impact on the pregnancy and UBB between GP and maternity units. The Named Midwives have also contributed to a working party to look across agencies at provision for parents who are care leavers - a vulnerability pathway is to be developed to meet the needs of this and all vulnerable groups.

8.2 Dementia care

The Admiral Nurse, has been in post since January 2018. Year 1 evaluation was published in January 2019 and has been shared with other Trust's considering converting their dementia CNS into Admiral Nurse. The evaluation report was a poster presentation at 2019 UK Dementia Congress.

The Admiral Nurse provides specialist dementia support for families and patients, working alongside them and giving 1 to 1 support when things get challenging or difficult. The support can be psychological support or providing expert advice and information to help families understand and cope with their thoughts feelings and behaviour, and to adapt to the changing situation when caring for and living with someone with dementia. Covering also the practical side of caring for someone who has dementia or advanced dementia.

During year two these are some of the activities undertaken by the admiral nurse:

- worked with 228 family carers
- delivered 874 activities to support best practice in dementia care
- trained 397 professionals to Tier 1 dementia knowledge
- trained 19 professionals to Tier 2 knowledge
- held University of Hertfordshire Student Nurse's forums on dementia care
- supported over 85 Trust Dementia Champions
- held once a month carers support group in partnership with Hertfordshire Partnership Foundation NHS Trust

The admiral nurse works across the main inpatient site alongside ward staff and clinical teams. Patients are identified from the Dementia alert on Nerve Centre, the electronic patient record by Hannah or she receives referrals from professionals in the Trust or community services. The primary reason for referral is to provide information about available services but also she will receive referrals for patients experiencing high levels of distress or changes in the person's presentation or condition.

The admiral nurse will also provide advice and guidance to health and social care professionals, for example:

- promoting person centred care
- supporting with mental capacity assessments and deprivation of liberty safeguards
- maintaining records of hydration and nutrition
- monitoring for constipation or bowel habits
- managing pain
- managing changing behaviours, including confusion and agitation and using distraction methods or activities that help to calm or reassure the person
- promoting the use of dementia specific pain rating tools
- promoting best practice, kind and compassionate care for patients with dementia
- developing the role of dementia care champions

The admiral nurse has also:

- developed and implemented the Dementia and Delirium care pathways, these have received recognition from CQC

- The Year of the Nurse and Midwife celebrations at the Trust dedicated February to Dementia and held an dementia awareness activity at the Quality Huddle
- Finalist for Trust 'Proud to make a difference staff awards'- patient experience category
- Tier 1 Dementia Awareness training is now part of the Trust-wide Vital Training programme.
- supported the work for the National Dementia audit
- worked with the palliative care nurses to ensure the needs of patients with dementia were being met and to set up the appropriate support in the community
- produced a bi-monthly newsletter and bi-monthly champions meeting
- provided training for new student nurses working in the Trust
- led the dementia strategy meetings with clinical teams
- promoted the care of people with dementia through publicity and information events – such as for Dementia Awareness week, the Trust annual general meeting and engagement with local Schools.

8.4 COVID-19

During the pandemic the Admiral Nurse has been supporting wards with Mental Capacity Assessments, Best Interest decisions and Deprivation of Liberty applications.

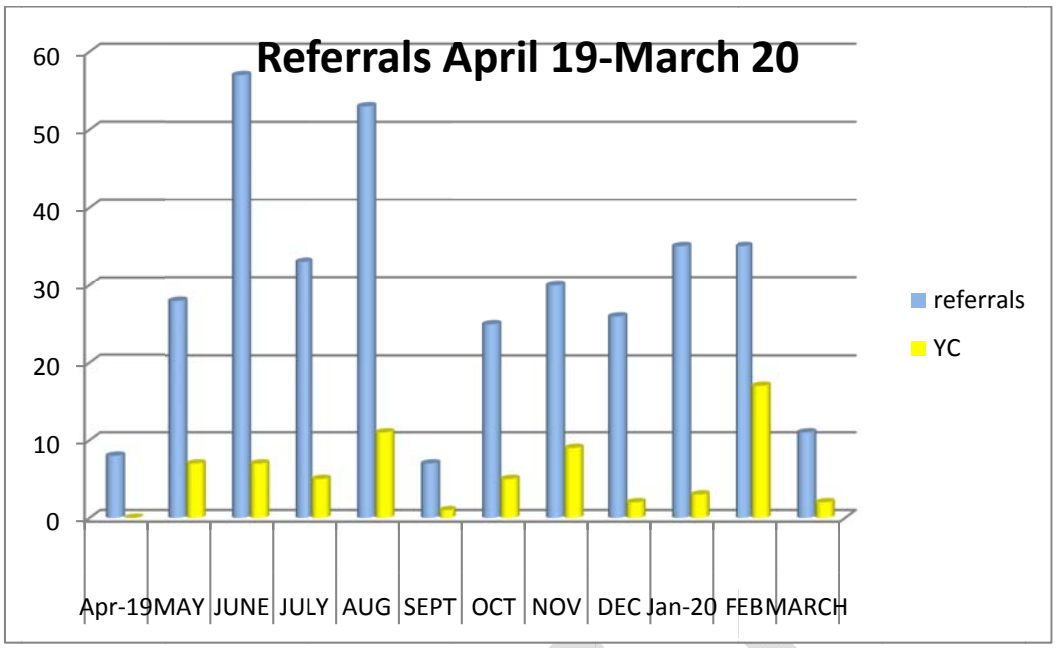
The Admiral Nurse has supported families during this period and organised FaceTime, been point of contact for families, support given during end of life care and signposted to community support.

8.5 Carers Report April 2019-March 2020

An unpaid carer is someone who cares (unpaid) for family or friends who have a disability, illness or who need support in later life. There is no age limit to caring (Carers UK)

April 2019- March 2020 saw the largest number of carer contacts, supports, and referrals to outside organisations since the post was established. A total of 348 individuals who experienced care within ENHT, were also identified as an unpaid carer, and signposted to support within the community. This was an increase of 183% from 2018-2019 totals.

Carer support extended to the paediatrics services. Through close working with safeguarding children's team and children's services, we identified and supported 69 young carers**,** who were previously not know to the community young carer teams. It has been identified that the young carers being identified in the acute setting have higher needs than those from community identification. We acknowledge that a hospital admission for a family with young carers can be a crisis admission, which accounts for their higher needs compared with their community peers. The young carer work is now part of a QI project (currently on hold due to covid) which will complete in the next 6 months.



The Trust continues to support carers being able to stay overnight with the person they care for. We have 12 guest beds at Lister site and through charity funding was able to provide 5 guest beds for MVCC. At the Lister site, we provide snack bags for carers who are spending long hours supporting the person they care for. Catering supplied 1010 carer snack bags within the adult in-patient wards. The snack bag programme was extended to NICU to support mothers breasting feeding their babies.

8.6 Monthly Carer awareness stands

Joint working with community carer support organisations, Carers in Hertfordshire (CiH) and Cross Roads Care (CRC), a monthly carer stand has become embedded within the Trust at the charity corner. This was an opportunity to meet and support carers coming into the Trust, register for carers support and to be given information and advice for their caring roles.

8.7 Outpatient carer support

Unpaid carers were added to the priority group, that when attending out-patient appointments, if they showed the CiH carer passport they could be fast tracked through clinic to enable them to return to their cared for in a timely manner. We also used the opportunity for carers to register themselves with staff on a temporary passport which was referred to CiH. Approximately 15 carers were identified this way prior to lock down of clinics.

8.8 Young Carers App research

A study to co-produce, and explore the impact of, an app-based support intervention on young carers started September 2018 with planned end date September 2020. We have recruited 22 young people for the research and completed first stage interviews and group work. We are at app refinement stage when we halted the research during the covid period. We received a charitable donation of £4000.00 for the app development.

8.9 Training and development

Training was co-developed and delivered with carers. This training was delivered to student nurses, pediatric nurses, consultants and medics, paediatric community teams and NICU staff. 235 staff received carer awareness training.

8.10 What Matters Most (WMM)

In conjunction with NHSI, the Trust piloted 'What Matters Most ' toolkit to learn what matters most to our staff who have caring responsibilities. As a result of this work 5 themes emerged

- The need for improved organisational recognition of staff who are carers.
- The need to establish a 'Peer Staff Carers Champion'.
- Training for managers about staff who are carers.
- Establish working group of staff who are carers to review quality and relevance of Carers Policy.
- Establish a forum or network for staff who are carers.

A carers network has now been set up with executive sponsorship – and will progress with the themes identified.

8.11 Young Carers Take Over Day 27th August 2019

ENHCCG received funding from NHS to support 'take over days' for CiH young carer (YC) executive group. The YC's did a take-over day in each of the Hertfordshire NHS organisations. On the 27th August, we hosted 8 young carers at Lister hospital. The aim was for the YC's to learn what services ENHT provide and how we can become more YC friendly. The YC's visited out-patients department, Children's ward and children's emergency department and the adult emergency department. They had a talk from Dr Tim Fishlock, Head of Technology Transfer, Health Enterprise East Ltd about app development and intellectual property. We also incorporated a feedback session of the young carers app as part of the YC app research.

We asked what mattered most to the young carers when they come into the hospital. The two important things were:

- As part of an admission for a young person, in the assessment, ask if they are a young carer
- To have an area on a ward that they could rest and 'chill' when visiting

We have fed this back to the children's and paediatric teams and they now include this in their conversations. AMU Green, have turned an area on their ward to a peaceful waiting space for carers. The YC team received funding from NHS to produce a video celebrating this health-focused project and filming at Lister hospital followed. The release was delayed due to covid but will coincide with the launch of Carers Week June 8th 2020.

8.12 Purple Wrist bands

Working alongside Health Liaison Team, and safeguarding adult's team, we introduced purple wrist bands for patients with a learning disability (LD) to increase awareness for staff at ENHT. Patients with LD can now decide if they wish to wear a purple wristband within the inpatient settings of East and North Hertfordshire Trust (ENHT). This will enable Health Care Professionals to know instantly they have a Learning Disability (LD) and ensure reasonable Adjustments are made for that person if required.

This was initially co-produced and trialled alongside the ENHT LD working group which gave the approval for Trust wide roll-out. The roll-out of the purple bands has been hindered with covid but is being relaunched.

8.13 Mount Vernon Cancer Centre

Working with the Estate's department at Hillingdon NHS Trust (MVCC site) we introduced a Palliative care car-parking pass for the families of patients on the end of life plan on Wards 10 & 11. Ward staff complete a permit form and the family give this to the car park office. They can purchase a palliative butterfly pass, £5.00 for 7 day car park pass. This initiative has been also rolled out across the whole Hillingdon NHS Trust.
This was launched 19th August.

8.14 Enhanced Nursing Care team

The Enhanced Nursing care team (ENCT) are a specialist substantive team who provide enhanced care, or 1-1 and are available 24 hours a day, seven days a week, ensuring that inpatients who are at risk to themselves or others are being effectively supported by specially trained staff to feel safe, secure and cared for at all times.
The enhanced nursing care team lead by Matron Emily Watts and Team Leader, Rizaldy Tibio continues to provide an enhanced level of care and support to patients who need either 1 to 1 support or enhanced supervision during their hospital admission. This can be with patients who are confused and agitated, at high risk of harm from falls, have dementia or delirium or are at risk of self-harm or wandering away from a ward. All patients referred to the team are reviewed daily to the level of requirement and input required ensuring the mental capacity act has been adhered to. The team now provide care for children and adults.

The team has won numerous awards and recognition for the innovative way the team supports our most vulnerable patients. The ENCT continue to receive positive feedback about the care provided both from the patient's family/relatives and other professionals in the Trust. In terms of improving the quality of care for patients there is now more consistency in providing care and support to some of the most vulnerable patients in the Trust. There is less reliance on ad hoc staffing to provide support for patients, including eliminating the use of unregistered agency staff; this provides an improved level of service at less cost.

Staff have received additional training for care of people with dementia, learning disability and mental health illness therefore the level of enhanced support is more appropriate to the needs of the patient. The team can provide care 24 hours a day, seven days a week and can be flexible and responsive to the care needs of the patient wherever the patient is situated.

8.15 Butterfly volunteers

The butterfly volunteers continue to provide support for patients, their families and friends when patients are coming to the end of their life in hospital. They can provide a supportive environment for family or friends or sit with the dying patient when they do not have family or friends who can stay with them.

8.16 Hospital Youth Worker

The Hospital youth work project (HYW) went live on the 14th February 2020 after an intensive induction with YC Hertfordshire and the NHS. The aim of the project is to strive to address the wider causes of poor mental health in children and young people, including domestic abuse, Child Sexual Exploitation (CSE) and County Lines. The project aims to support those who are experiencing mental health problems within the Trust and other Trust community settings and act as an access hub for signposting.
The project has been gaining momentum and to date has engaged with 68 young people. The referrals have come from the safeguarding team, CCATT, wards and also specialist areas of the Trust such as Diabetes and Epilepsy. The project is currently running across the Lister Hospital and the QEII.

Some of the young people seen are struggling with many issues and therefore the interventions can be as many as 3 per young person. Currently the project captures data for CSE, Gangs, Substance Misuse, CA, Child Looked after, Missing Education, Home Education, teenage pregnancy and wellbeing.

Intervention	Count
Well Being	58
Other	18
CSE	4
Gangs	9
Pregnancy	5
Substance Misuse	6
CA	0
CLA	4
Missing Ed	7
Home Ed	0

The HYW has made strong links with CCATT, Herts Police/St Giles Trust, young carers, Domestic abuse services and Substance misuse services allowing for a multiagency holistic approach for the young person

Currently there are 15 young people actively engaging with the project. 48 cases have now been closed as they have been signposted to local services or did not need continuing support.

Some common themes that have been seen currently are:

- The general age range of referrals is 13-17
- High number in 15-17 year old males with punch injuries, displaying anger or perpetrating domestic abuse
- During covid numbers for CSE and Child Exploitation increased.
- Overall engagement increased since lockdown was implemented.

8.17 Care Grow Live (CGL)

Change Grow Live, operating under the local Hertfordshire name of Spectrum, are the contracted provider to deliver drug and alcohol treatment and support services across Hertfordshire. This includes dedicated hospital liaison teams in both Lister Hospital and Watford General Hospital.

The Lister Hospital substance misuse liaison team consists of a Substance Misuse Specialist Nurse and a Brief Interventions Recovery Worker. Spectrum CGL's nurse provides advice to staff regarding alcohol detoxification and opiate substitute prescribing, as well as patient review and harm minimisation advice and guidance. Spectrum CGL's Brief Interventions Worker delivers brief interventions comprising of advice, awareness, health promotion, signposting and referral to patients who present to the emergency department and related wards and also provides a pathway into Spectrum CGL offering seamless support for those being discharged from hospital. The service also provides ongoing liaison between the hospital and Spectrum CGL whilst being treated in hospital. The team has delivered approximately 550 interventions to patients at Lister Hospital over the past year.

Spectrum's Brief Intervention Worker attends the weekly child protection psychosocial meeting and works with the safeguarding team in the hospital to ensure appropriate sharing of information between the hospital and Spectrum drug and alcohol service.

8.18 Perinatal mental health midwife

The new role of Perinatal Mental Health Midwife post commenced in June 2019, this role was to develop the service for perinatal mental health in line with the 'Better Births' initiative. The work is nearing its end of its first year – an impact statement is to be produced.

9.0 Risk register

The safeguarding risk register is reviewed bimonthly at the joint safeguarding committee. Table 12 outlines the current risks on the register and any actions that are outstanding to reduce the risk.

Table 12

Risk	Title	Current score	Outstanding Actions
5412	Risk of missed safeguarding children concerns - Adults whom present with risk factors and the Think family agenda	12	• ED staff to record if adults who attend have any children or dependants and identify if there are any safeguarding concerns • Update of risk assessment tool on Nerve Centre • Think family - staff to be aware of the think family agenda, routine enquiry, and application of the safeguarding children's policy.
4381	Children at risk if compliance with safeguarding children's training less than 90%	12	• To achieve above 90% compliance with level 3 safeguarding training within the medicine division • To achieve above 90% compliance with level 3

Risk	Title	Current score	Outstanding Actions
			safeguarding training within Women's and Children's division
6492	FGM-IS – not routinely checked when child attends the ED department	10	• Staff routinely check FGM-IS in a timely fashion in order to aid risk assessment. Senior sister within department to identify process.
5187	Risk that the Supervising Authority for Deprivation of Liberty Safeguards (DoLS) cannot authorise standard applications in time	9	• Supervising Authority are automatically extending 7 day urgent applications to 14 days. • Matrons for clinical areas are tasked with monitoring DoLS applications and notifying the Adult Safeguarding lead when urgent is due to expire and whether Supervising Authority have undertaken Best Interests and Mental Health assessment. • Adult Safeguarding lead nurse and CQC compliance officer maintain database and request regular updates on progress from Matrons and DoLS team • Clinical staff need to use the least restrictive options in providing care and treatment to patients if clinically appropriate and patient safety can be maintained
6553	Introduction of an additional wristband in purple for patients with LD (To highlight that individuals with LD require additional support and reasonable adjustments.	8	• Training of all patient fronting staff has occurred - at present this one off training. The LD team are on Trust induction training to capture all new staff. • The purple bands have been trialled on 4 wards by the LD Action Group, obtaining feedback from a range of organisations and carers. • A SOP has been developed with staff and will be attached to the LD Policy and is available on the KC.
6591	Adult safeguarding referrals (HCS changing to a direct electronic reporting	10	• HCS to send the Trust a 48 hourly report of safeguarding concerns raised by staff in the

Risk	Title	Current score	Outstanding Actions
	mechanism for health care staff reporting concerns, which could lead to a reduction in Trust oversight)		Trust. • Nursing staff will have to save a PDF copy of each referral they make and send the copy to the Trusts safeguarding adult's team. • Roll out of the change has been suspended until autumn 2020, education will be provided to all clinical areas in advance.

Table 13 outlines the risks that have reached their target score and become as accepted risks, but remain on the risk register. Controls are reviewed periodically to ensure the risk score does not change.

Table 13

Opened	Speciality	Risk title	Initial Score	Current Score	Target Score	Date Accepted
24/07/2019	Safeguarding children	Children's social care referrals – Hertfordshire	6	6	6	11/03/2020

A risk in relation to CP-IS and outpatients was closed during the reporting year. This risk was identified following an audit regarding children not brought to outpatient appointments. However, following exploration of visibility of this being implemented, current IT systems used in outpatient care settings not compatible with CP-IS. As this is not a national requirement to have implemented, the risk was closed, with the mitigation that when a child is referred, safeguarding information is expected to be included in any such referral. Equally, any concerns raised to the safeguarding teams via information sharing processes, CP-IS can be checked for further information on a case by case basis.

Agenda Item: 12.2

TRUST BOARD - PUBLIC SESSION – 2 SEPTEMBER 2020

Comments, Compliments, Concerns, Complaints Update and Annual Report

Purpose of report and executive summary:

Purpose: To inform the Board of the Trust's position with regard to the Q1 (April-June 2020) patient experience feedback, complaints and PALS activity and to present the Patient Experience Annual Report for approval.

Executive Summary:

The majority of feedback received via the Trust's patient experience surveys, including the friends and family test question, is positive. The highest number of positive comments relate to staff and care/treatment and the highest number of negative comments relate to the environment and communication.

The Patient Advice Liaison Service (PALS) received several contacts in relation to management of appointments during the COVID-19 Pandemic. PALS have supported relatives who were not allowed to visit patients during the Pandemic by contacting the wards during busy periods and relaying messages.

The number of formal complaints raised by patients and relatives reduced by 46% during the period April – June 2020. Patients and relatives raised concerns in relation to infection control and the environment when they attended the hospital for emergency treatment during the COVID-19 Pandemic.

Action required: For information / approval

Previously considered by:
QSC – 28.07.20

Director:	**Presented by:**	**Author:**
Chief Nurse	Chief Nurse	Project Manager – Nursing and Patient Experience/ Complaints Manager

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
No

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

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

East and North Hertfordshire NHS Trust

DIRECTOR OF NURSING AND PATIENT EXPERIENCE REPORT – JULY 2020

COMMENTS, COMPLIMENTS, CONCERNS, COMPLAINTS

Introduction

We aim to provide our patients and their carers with the best possible experience whilst they are using our services. This combined patient experience, complaints and PALS report provides an update on patient feedback and initiatives in place to improve patient experience.

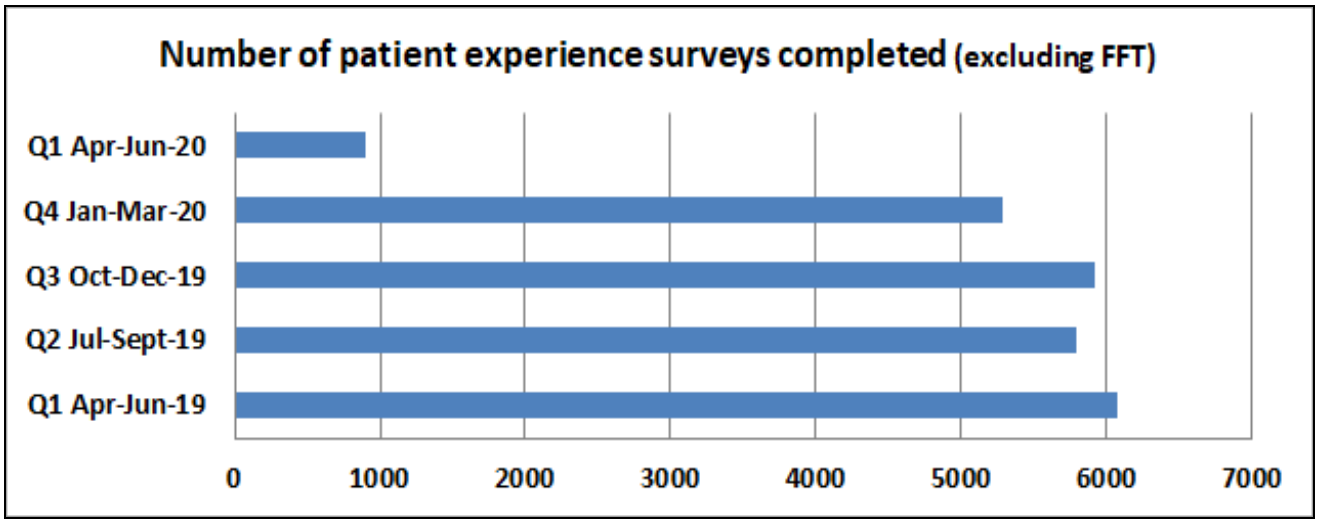
We continue to welcome all patient feedback, and hearing about patients' experiences during the Coronavirus pandemic will be as important as at any other time. However, we have not been able to proactively encourage feedback in the usual ways due to more pressing operational demands on our staff. This has had an impact on the quantity of patient feedback received, particularly our local surveys including the friends and family test question.

Rachael Corser
Chief Nurse

Patient Experience Headlines	Page No	RAG
National Cancer Survey 2019 The Trust scored 'within the expected range' for 16 questions and 'below the expected range' for 36 questions. Comparing ENHT results for 2018 and 2019, there was 1 question 'significantly higher', the remaining 51 questions showed no significant change.	**18 - 20**	
Patient Experience Annual Report 2019-20 This year's annual report is different in light of resources required to deal with Covid-19. It includes details of patient experience initiatives to support Covid-19 and mandatory data relating to patient experience feedback and complaints. **Appendix 1 –** Patient Experience Annual Report 2019-20	**20**	
Patient Advice and Liaison Service (PALS) In Q1 2020-21, 416 PALS concerns were received, compared to 830 in Q4 2019-20.	**21-24**	
Formal Complaints In Q1 2020-21, 136 formal complaints were received, compared to 294 in Q4 2019-20.	**24 - 28**	
Acknowledgement rate and telephone contact The NHS Complaints Regulations (2009) stipulate that formal complaints must be acknowledged within three working days. In Q1 2020-21, 82% of all formal complaints received across the Trust were acknowledged in writing or via telephone within three working days with 100% compliance within four working days. The Complaints Manager has actively addressed this to ensure 100% compliance is achieved next month.		
Timeframe for response The Trust KPI is for 80% of complaints to be responded to within the agreed timeframe. Year to date 92% of complaints have been responded to within the agreed timeframe agreed with the complainant.		
PHSO In Q1 2020-21 the Parliamentary Health Service Ombudsman did not make made any requests for papers due to pausing their service during the Covid-19 Pandemic.	**28**	

Patient Experience Surveys

Number of patient experience surveys completed on IQVIA (previously called Meridian) **patient survey system – (excluding FFT):**



There has been a significant decrease in the total number of patient experience surveys completed – 894 in Q1 2020-21, compared to 5,288 in Q4 2019-20. This is because of the need for staff to concentrate resources on managing the Covid-19 pandemic.

Word clouds generated from Inpatient and Day Case comments received between April-June 2020

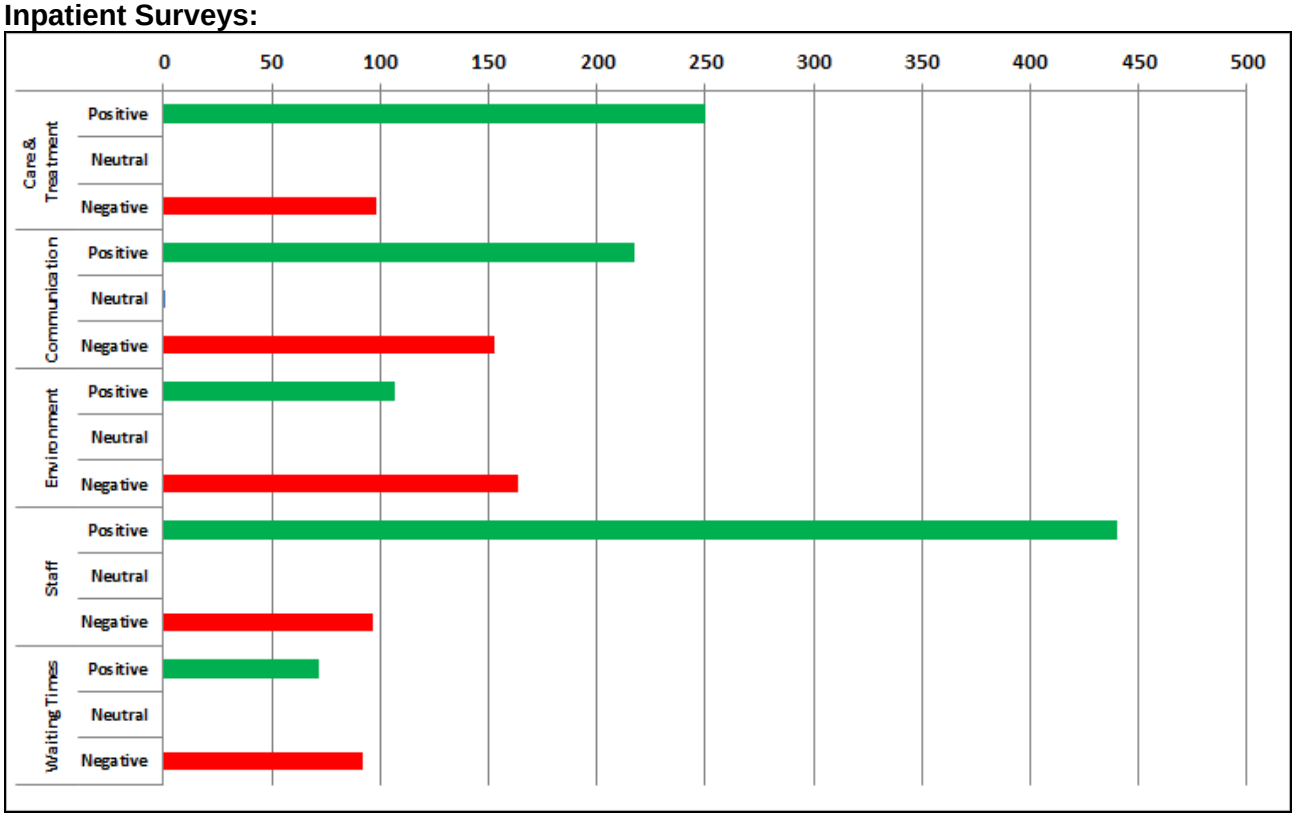
What was good about your stay/visit?

What would have made your experience better?

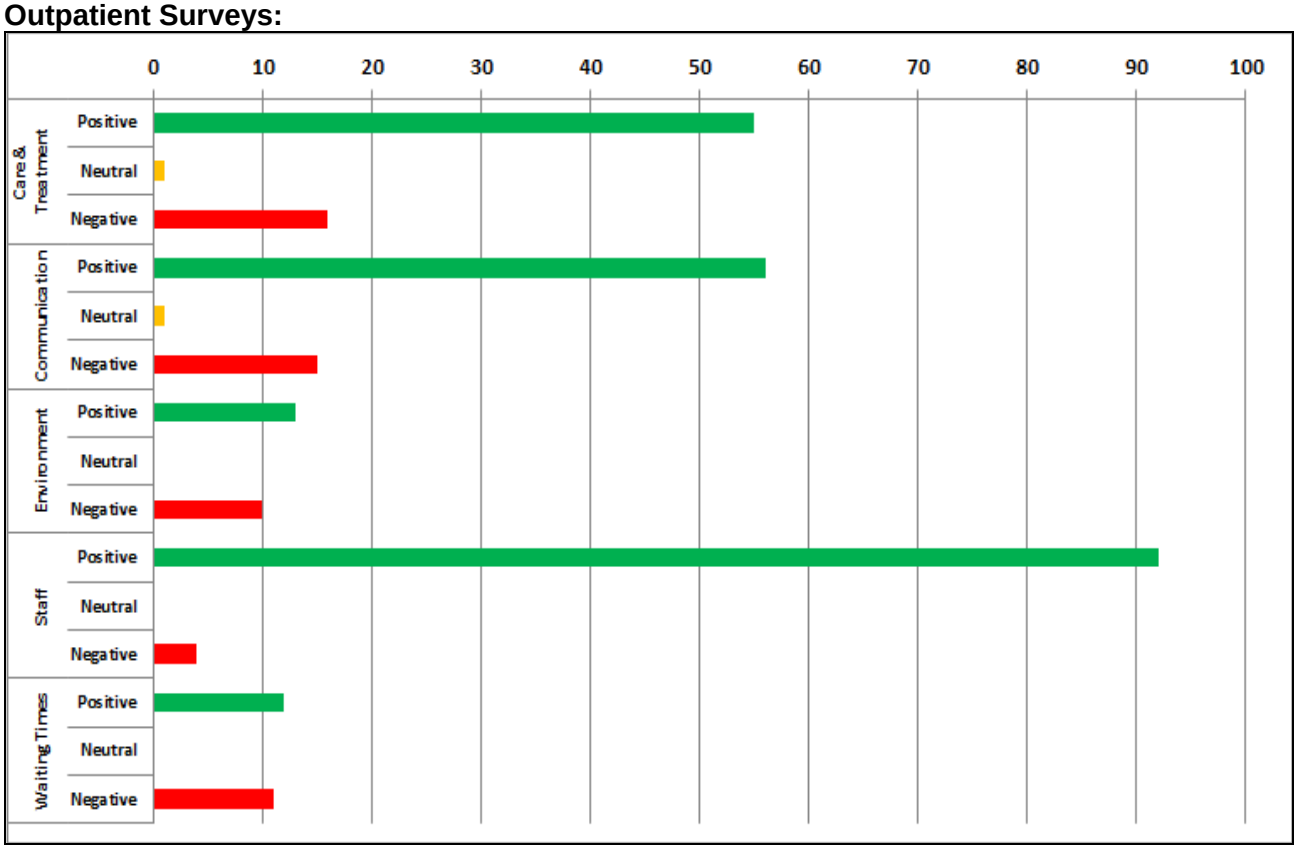
The IQVIA (previously called Meridian) patient experience survey system automatically allocates a positive, neutral or negative rating to patient comments, theming them against the following five categories: Care and treatment, Communication, Environment, Staff, Waiting. This system has been set up using a 'word bank' against each of these categories.

The graphs below summarise the number of positive, negative and neutral comments against each category for Q1 for the Inpatient surveys and Outpatient surveys:

Inpatient Surveys:

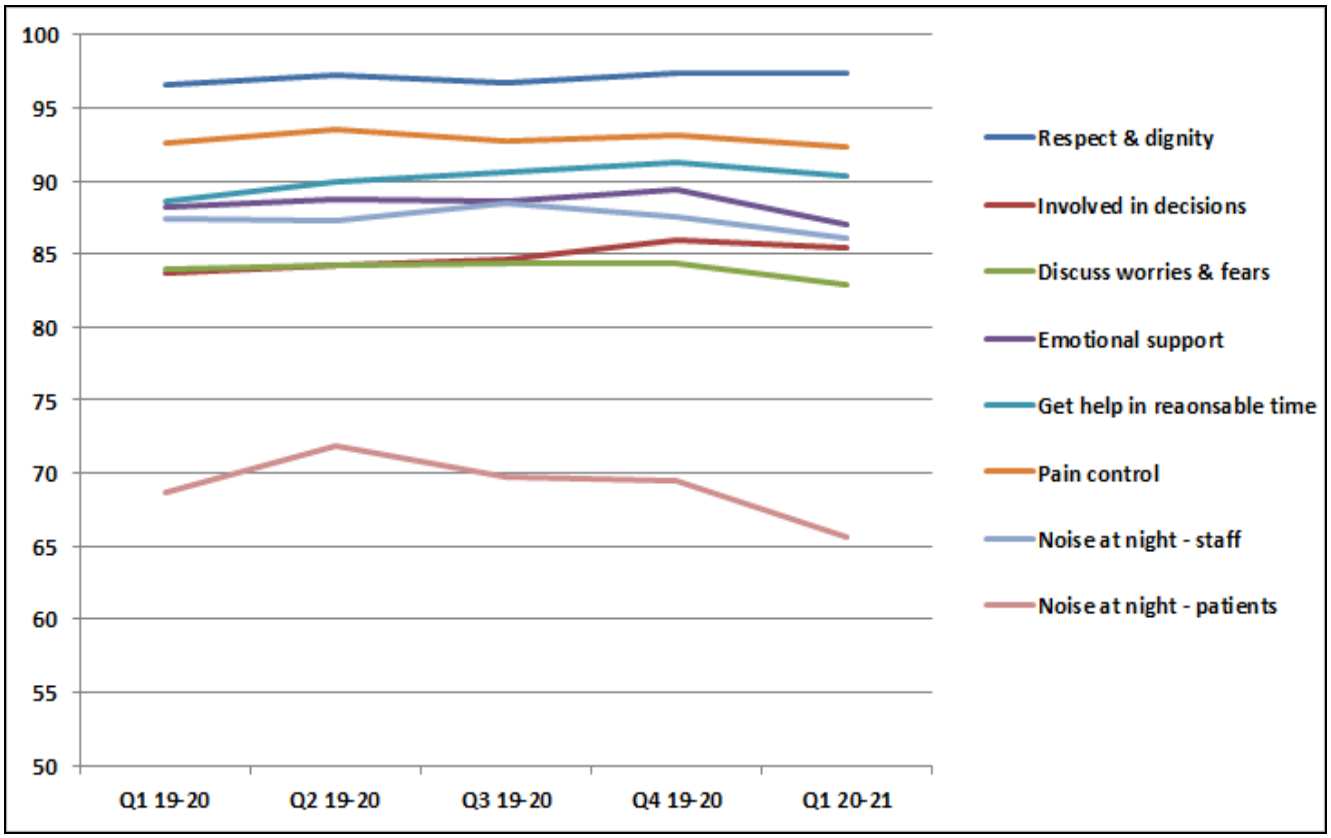


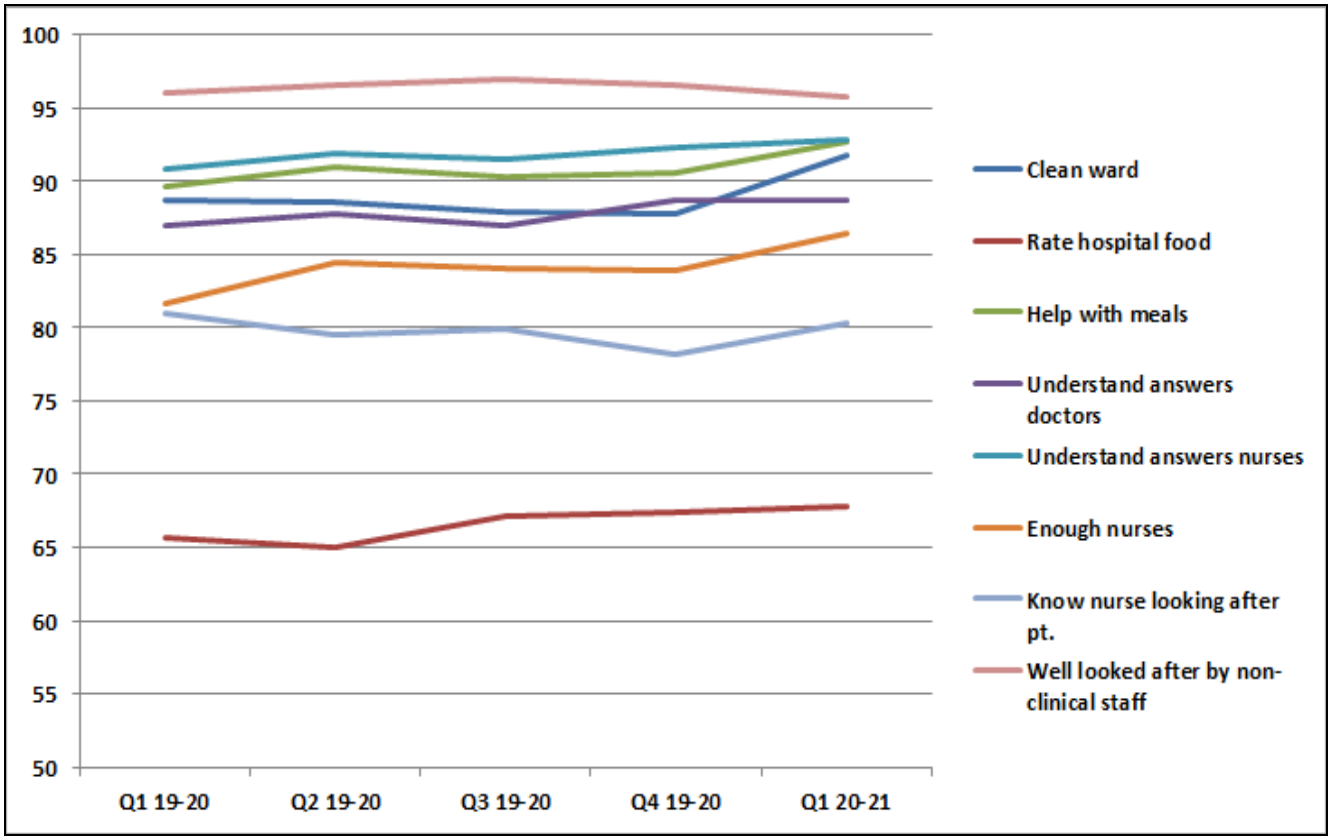
Outpatient Surveys:



Inpatient Survey

Comparison of responses to questions in the Inpatient survey: Q1 2019-20 to Q1 2020-21





Responses received to the Inpatient survey show that the key areas of concern for patients remain 'rating of hospital food' and 'noise at night from other patients.

The Friends and Family Test

NHS England/Improvement contacted trusts on 30 March 2020 advising that the FFT reporting requirement to NHSE/I stopped with immediate effect to enable staff resources to be diverted towards more immediate priorities during the COVID-19 pandemic. They also advised that trusts temporarily stop using feedback cards, i-pads and tablets to collect patient feedback as these may pose an increased risk of infection to staff and patients.

A process was developed to carry out post-discharge telephone calls with patients who had been discharged from hospital to ask for their feedback. The telephone calls have been carried out by staff within the Patient Experience and PALS Team. Many patients have welcomed the opportunity to talk to a member of staff about their experience and it has enabled us to share with patients some of the changes and improvements that have been made in response to specific queries.

The NHS England revised guidance for the Friends and Family Test came into effect from 1 April 2020. There is a new mandatory question that asks, in the context of each service, **'Overall, how was your experience of our service?'** There are six new response options ranging from 'very good' to 'very poor'. There are also changes to the timing requirements for obtaining feedback for maternity, A&E and inpatients to bring them into line with other NHS services where patients can give feedback at any time they want to.

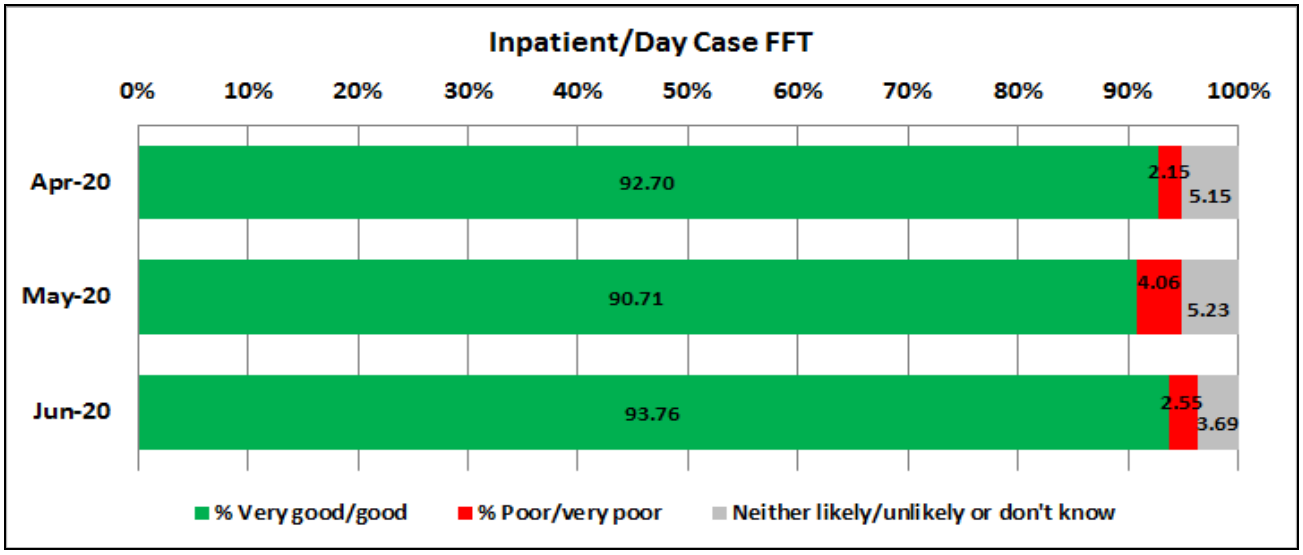
In light of the change to the wording of the FFT question and the different methods used to collect feedback, the percentage of patients who report that their experience was 'very good/good' or 'poor/very poor' should not be compared to previous FFT results.

Access to the Trust's surveys continues to be promoted to patients via the Trust website and the quick link: www.tellusmore.org.uk – posters with this link and a QR link are widely displayed throughout the Trust.

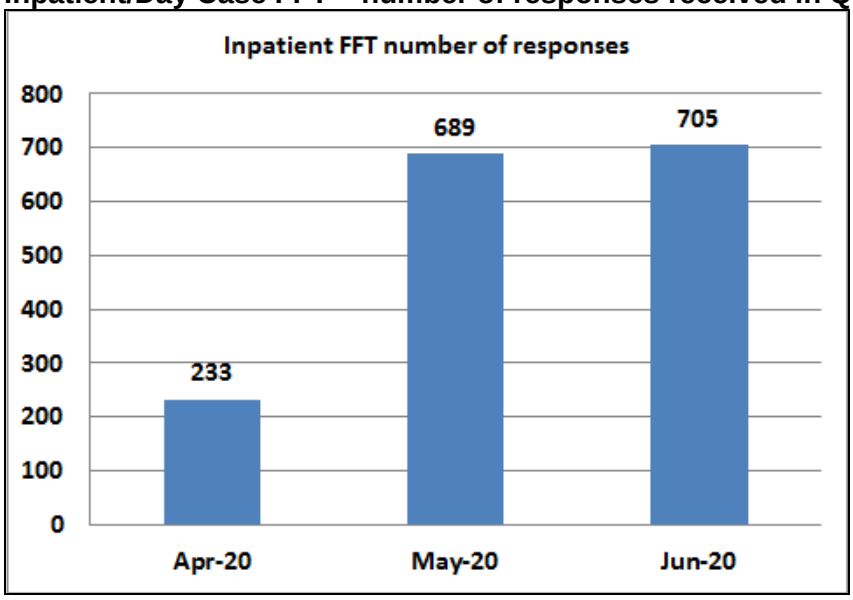
Number of patients responding to Friends and Family Test in Q1 2020-21:

	Inpatients/ Day Case	A&E	Outpatients	Maternity				TOTAL
				Antenatal	Birth	Postnatal	Community	
Apr-20	233	8	166	0	23	23	0	453
May-20	689	56	283	1	0	0	0	1029
Jun-20	705	282	204	1	2	1	0	1195
Q1 TOTAL	**1627**	**346**	**653**	**2**	**25**	**24**	**0**	**2677**

Inpatients & Day Case FFT



Inpatient/Day Case FFT – number of responses received in Q1



The staff were fabulous. The Patient Liaison team phoned me after every morning's MDT meeting, regarding my Mum, for an update. The staff were comforting, I am incredibly grateful for the staff keeping in touch with us. The system worked really well with Macmillan staff updating us and staff there liaising. They also asked if there were any messages to be passed onto Mum as we couldn't speak to her. Mum is now better and she has recently celebrated her 94th birthday which we are so grateful for.

Ward 9B Apr '20

Lovely friends in bay. Staff are absolutely lovely. Amy & Rachel are absolute diamonds, very helpful. I have been assisted with everything I have needed. Housekeepers always supply me with tea and biscuits when I want. Absolute gems. No animosity which was lovely. Although my condition is terrible, the staff have always made it more bearable.

Barley Apr '20

Took a long time to be discharged. Waiting for letter and Pharmacy. Not organised as well as expected. Had to have 3rd Covid test before discharge and had to walk to the area - would be better to have the test on the ward as I was exhausted.

Ward 7B Jun '20

The food could have been better. I was in for COVID but it was difficult for staff to come in because of gowning up and everything. The first two days I had a choice of food but the last six days I had what I was given. But that was in the early days when they were just starting all the ward moves and it was a bit suck it and see. It was already improving as I was leaving, I'm not complaining!

Ward 7A Apr '20

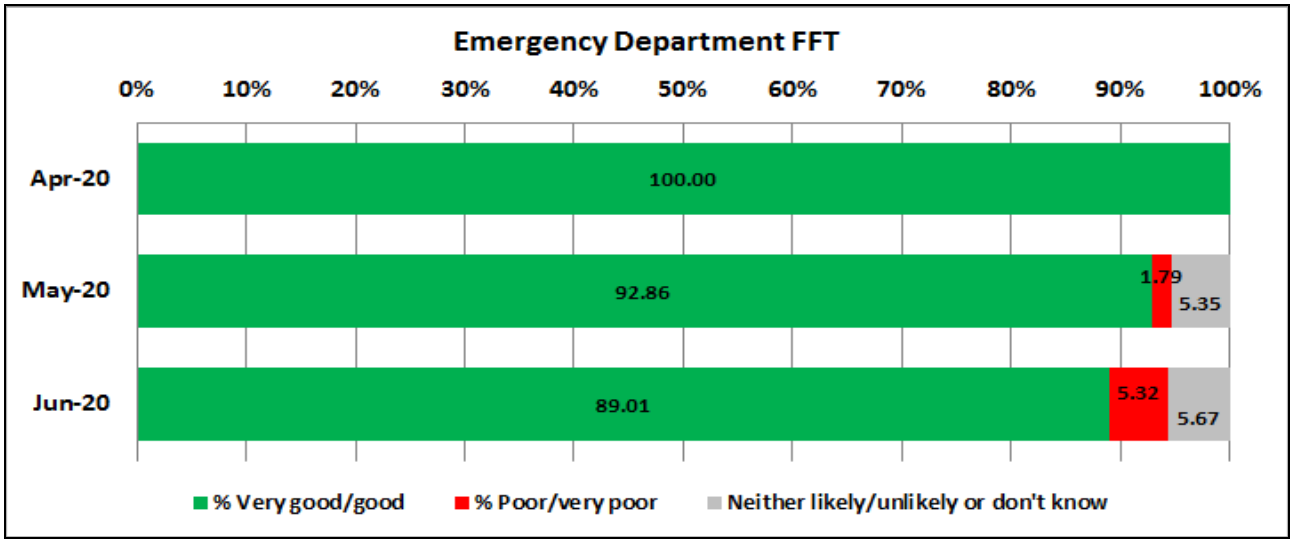
The care I received was 10/10 across all areas, I couldn't ask for anything more. I felt comfortable from the very first day.

Ward 6A Jun '20

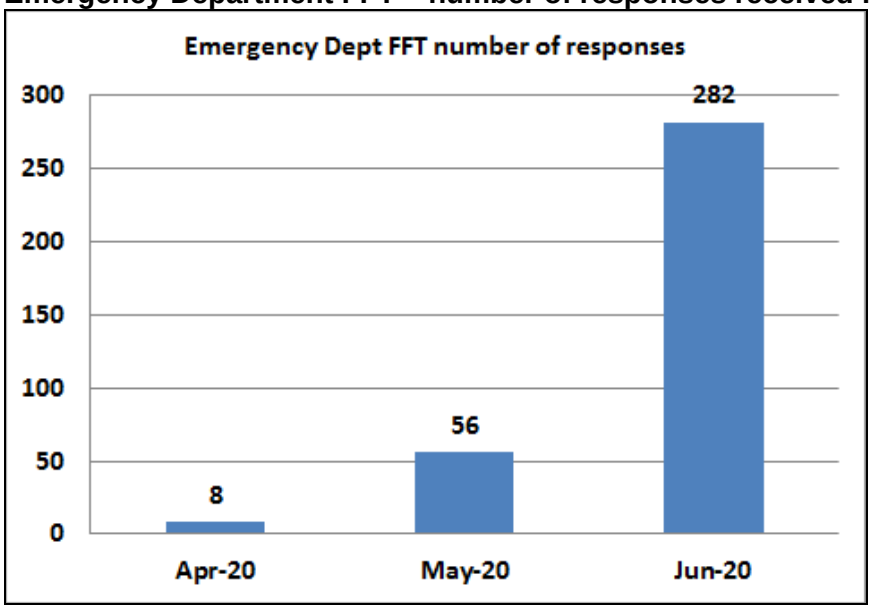
The nurses and doctors made sure I was informed at all stages and made me feel comfortable when having questions. Everything has been excellent.

Bluebell ward Jun '20

Emergency Department / Urgent Care Centre FFT



Emergency Department FFT – number of responses received in Q1



Nicely controlled with all of the Coronavirus problems, waiting room was kept empty.

UCC QEII Apr '20

Everyone was friendly. Clean and quick, felt fine coming in because of the situation. Felt at ease.

ED Lister Jun '20

The doctor was not helpful. The GP referred us to A&E and the doctor rolled her eyes and said typical. I also don't feel she examined my baby properly. The wait was long, so an indication of the waiting time and being kept updated would be better.

Children's Assessment Unit May '20

Excellent. How they dealt with the pandemic was very good. Everyone had PPE. Social distancing was maintained. They made us very relaxed and comfortable. The staff directed the conversation towards my daughter which made her calm. The play specialist gave my daughter a gift! Compared to another hospital, Lister is 100% better.

Children's Assessment Unit Jun '20

Under the current circumstances I thought the staff dealt with me perfectly. I got treated very quickly and all staff that dealt with me were perfect and caring. I couldn't have asked for any better treatment.

ED Lister Jun '20

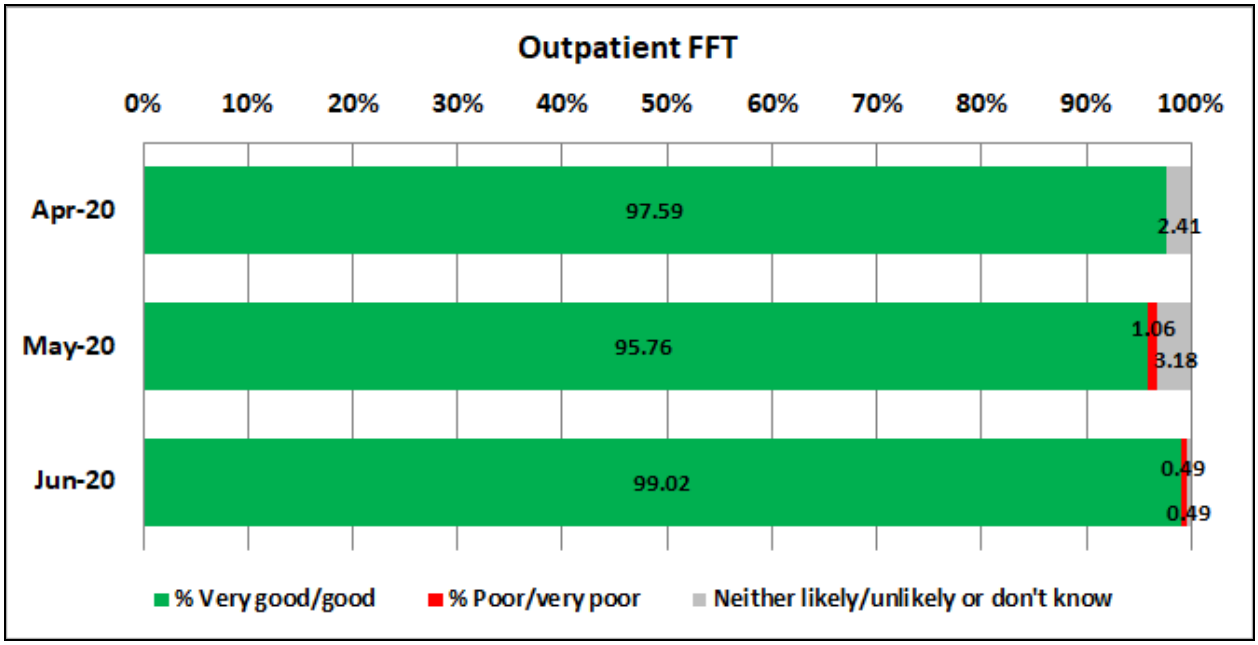
Didn't wait too long – social distancing in place. Department very clean, couldn't have asked for any better treatment.

UCC QEII Jun '20

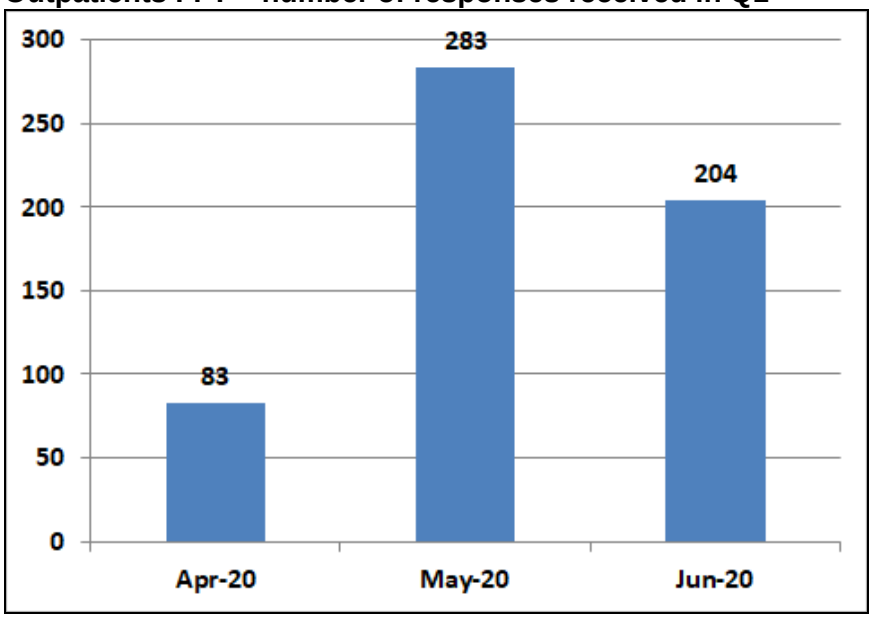
Poor communication in delays - in department t 11 hours. Not offered any refreshments.

ED Lister Jun '20

Outpatient FFT



Outpatients FFT – number of responses received in Q1



I had a telephone consultation on 30th April for my haematology appointment and I found it very easy, especially at present. I think for follow-up appointments with no special issues the hospital should think about continuing to do this in the future and save time and money.

Haematology Lister Apr '20

It would have been better if they had phoned me that they have another surgery to do because I arrived at 6.30am and was sent home again until 12.30pm for my surgery because they had an emergency.

Pre-op Assessment, Treatment Centre Jun '20

Examples of comments from Outpatient FFT responses:

I could not have had better care, especially in the difficult times the NHS are facing. Well done to all who have put their own safety on line to bring us continuous excellent care.
Dialysis Satellite Unit, Harlow May '20

Seen straight away, did not have to wait around. Got checked on. Having someone that knows what they are doing makes you feel at ease. Nurses are great.
Macmillan Cancer Centre, Lister Jun '20

If the chairs were comfortable because I had a knee replacement and the chairs were too low for me.
Medical Day Unit, Lister May '20

It was very good and well organised. Social distance and staff were nice.
Medical Day Unit, Lister Jun'20

The girls are always really good. I've been coming for about 10yrs now for an infusion and it's like talking to friends. This time we were in different rooms and they were very careful with all this going on.
Rheumatology, Lister Apr '20

Communication good. Directions to the unit was good. Staff excellent. Perfect.
RITA 6B, Lister May '20

The speed and efficiency of each visit was excellent. The nurse Sharon was absolutely excellent with my son. She was informative and helpful, but more importantly, compassionate, considerate and a pleasure to see each week. She is a real credit to the NHS.
Dermatology HCH Apr '20

I was seen promptly on arrival. Good explanation of the screening procedure. I was impressed with the general handling of the precautions regarding COVID-19.
Retinal Screening, Treatment Centre Jun '20

Appointments cancelled and not being told until I got to the centre. Waiting times could be better because the wrong time was on the system, admin in general is not good. Get some more nursing staff.
Macmillan Cancer Centre, Lister Jun '20

Everything was well organised. It was done on time, we didn't have to wait at all. We felt very safe due to Covid-19 precautions. My Mum was very happy and comfortable.
Medical Day Unit, Lister May '20

Transport to be improved to reduce me waiting around for a long period of time.
Dialysis Satellite Unit, St. Albans Apr '20

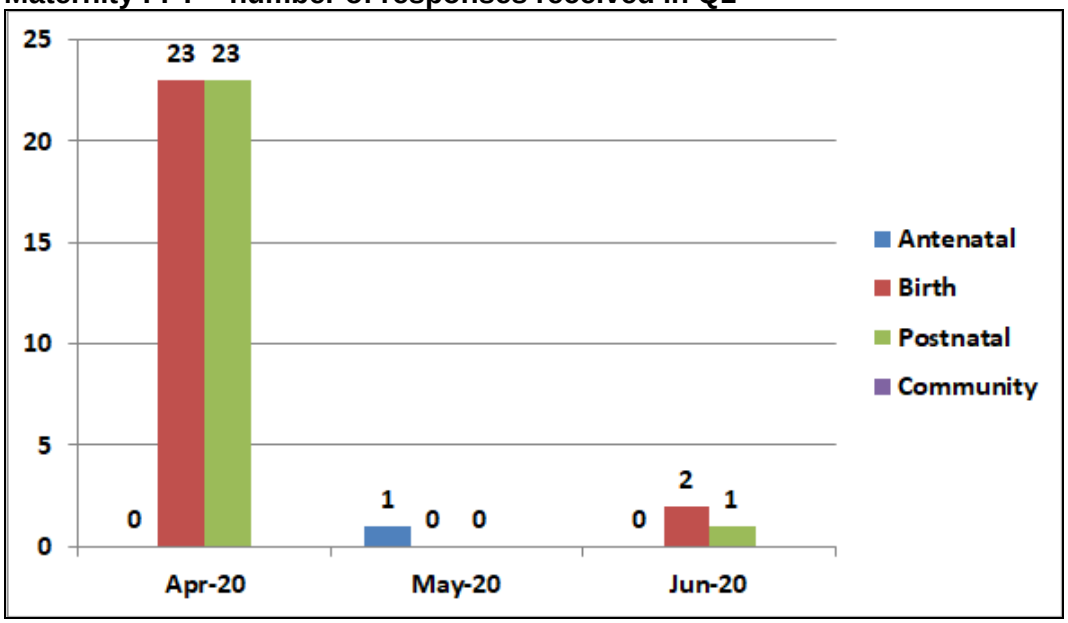
I have been attending the Chemo Suite for 6 years. I cannot praise the staff highly enough throughout this whole period. They have managed to make what could have been a stressful scary time, a very calm bearable experience.
MVCC Chemo Suite Apr '20

Treatment has never stopped despite lockdown. Treated quickly. Always staff to talk to if any problems. Staff outstanding.
Macmillan Cancer Centre, Lister May '20

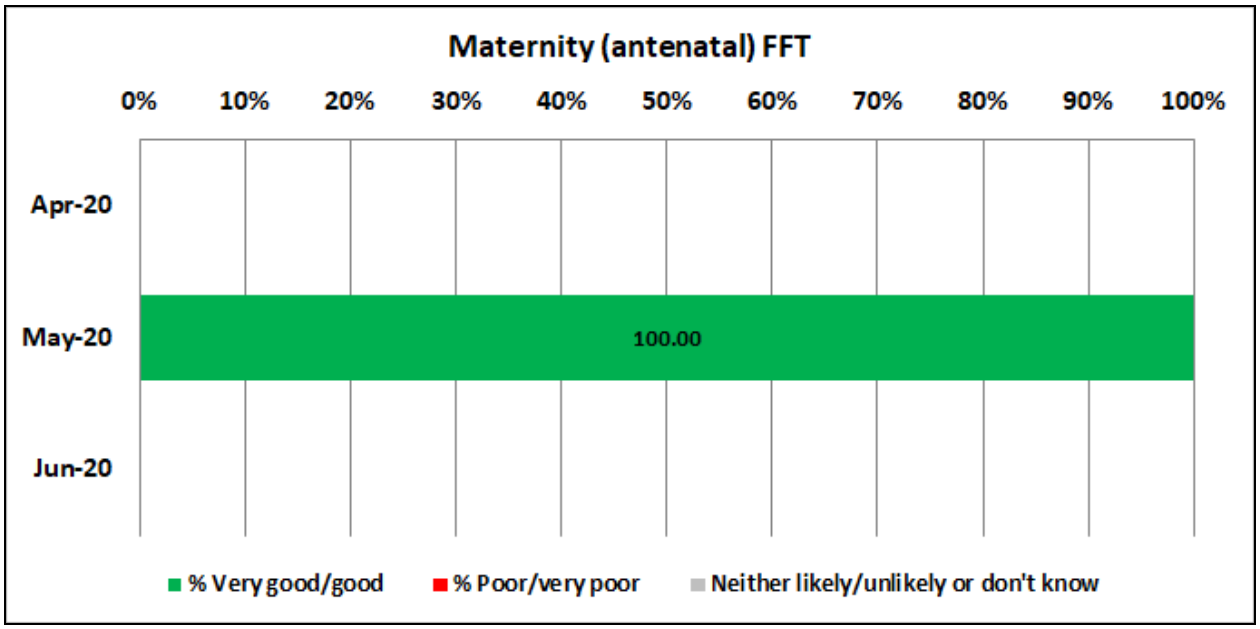
Staff very supportive and attentive, communication was good too. It was better than expected.
Eye Clinic, Treatment Centre Jun '20

Maternity : Antenatal, Birth, Postnatal and Community Midwifery FFT

Maternity FFT – number of responses received in Q1



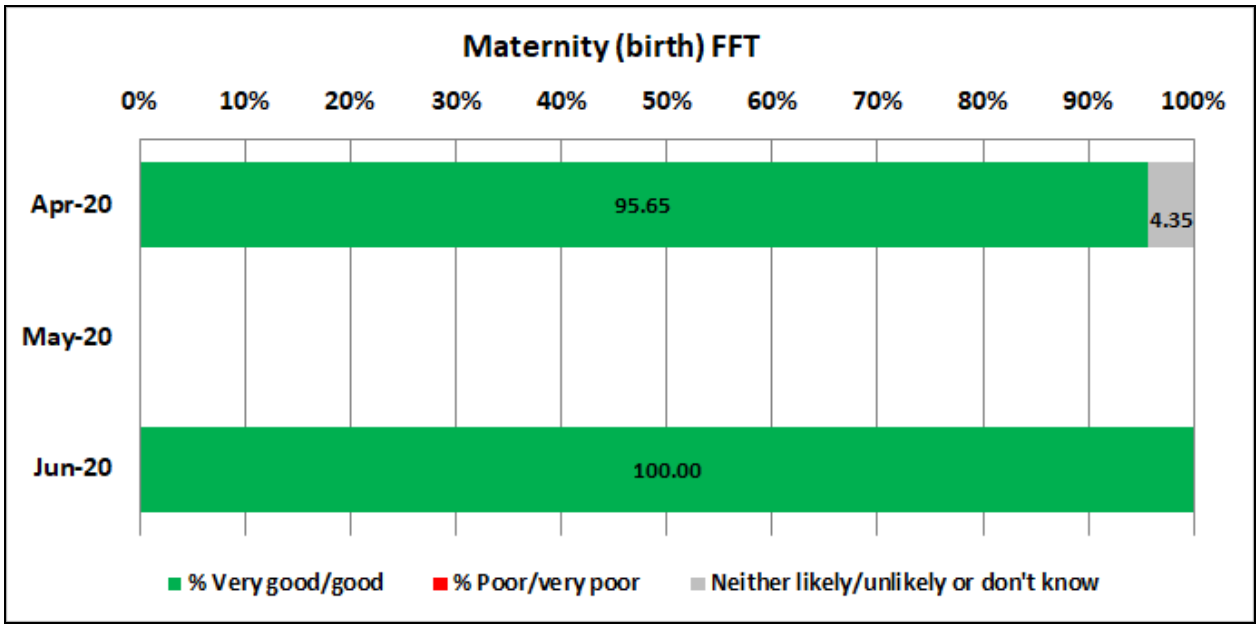
Antenatal FFT



I have very bad morning sickness at the moment and coming for my first appointment alone without my partner's support having not slept being sick all night sent me over the edge - I was crying a lot - but every member of staff who helped me was absolutely fantastic - I saw one young midwife first who was so kind, then I saw a phlebotomist who was so professional and brilliant at calming me down, finally I was sent to the early pregnancy area for some advice on the sickness - both the women I saw here were so supportive. Can't thank you all enough.

Lister May '20

Birth FFT



I loved the care from the consultants downstairs - brilliant assistance. All doctors, consultants, registrar, midwives were awesome! I have also bumped into Ria in the corridor who asked how do I feel, which makes you feel cared for.
Consultant Led Unit Apr '20

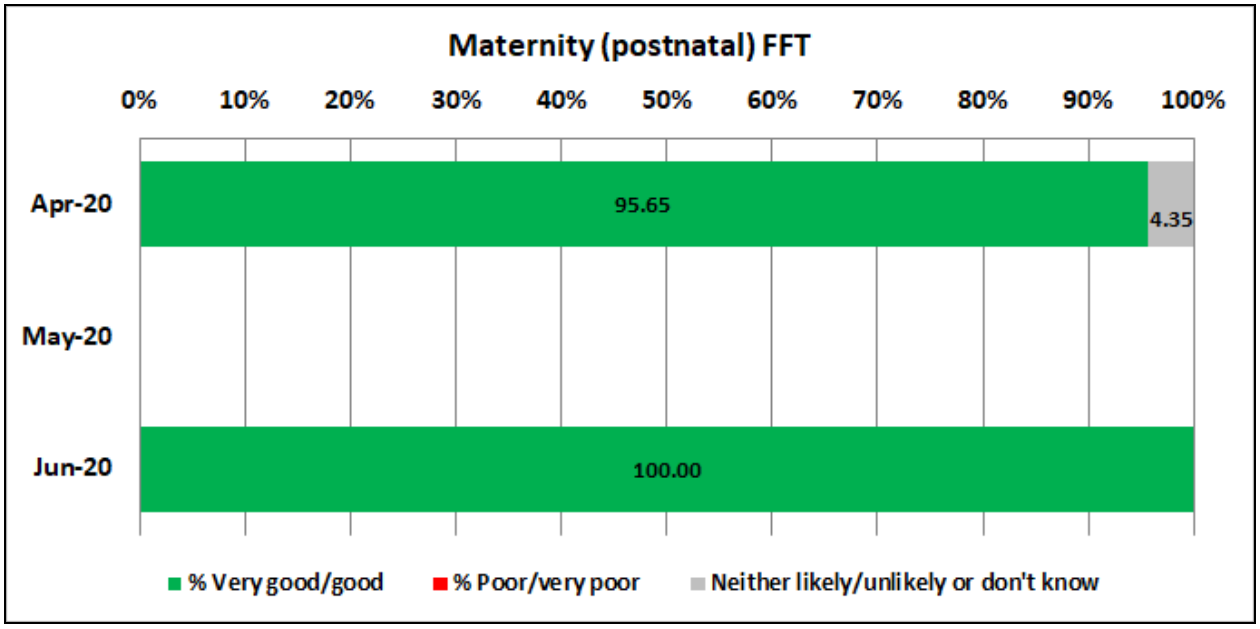
Probably natural birth instead of induction but that cannot be influenced. Perhaps use of gas and air in Dacre ward would be something good to introduce.
Consultant Led Unit Apr '20

From the moment we entered the unit, our Midwife Jess took control of the situation and made us feel very comfortable. Throughout the birth she explained each step and the options very clearly with an incredible bedside manner. This kept us informed and enabled us to make decisions easily, which was very important to us as first time parents. Without Jess's encouragement throughout the labour, I would have struggled to give birth to our son as easily as I did. For that we are forever grateful. Throughout it felt like Jess went above and beyond the call of duty which leaves us with positive, long lasting memories of the birth of our first child. We felt that the support exceeded our expectations from Jess and all midwives that looked after us at the MLU as we felt truly cared for and so did our baby :-)
Midwife Led Unit Jun '20

The midwives were so attentive to me and my partner. When the birth started to become more complicated than planned they reassured and supported us the whole way through.
Consultant Led Unit Apr '20

Every member of staff was amazing from start to finish at every step of the way. Great experience.
Consultant Led Unit Jun '20

Postnatal FFT



In regards to the COVID-19 pandemic, the team responded amazingly. It was difficult for mothers to be alone with no visitors and also difficult for partners not being able to see their partners and babies. I think the team were thoughtful and supportive whilst also following the new procedure put in place for everyone's safety.

Gloucester ward Apr '20

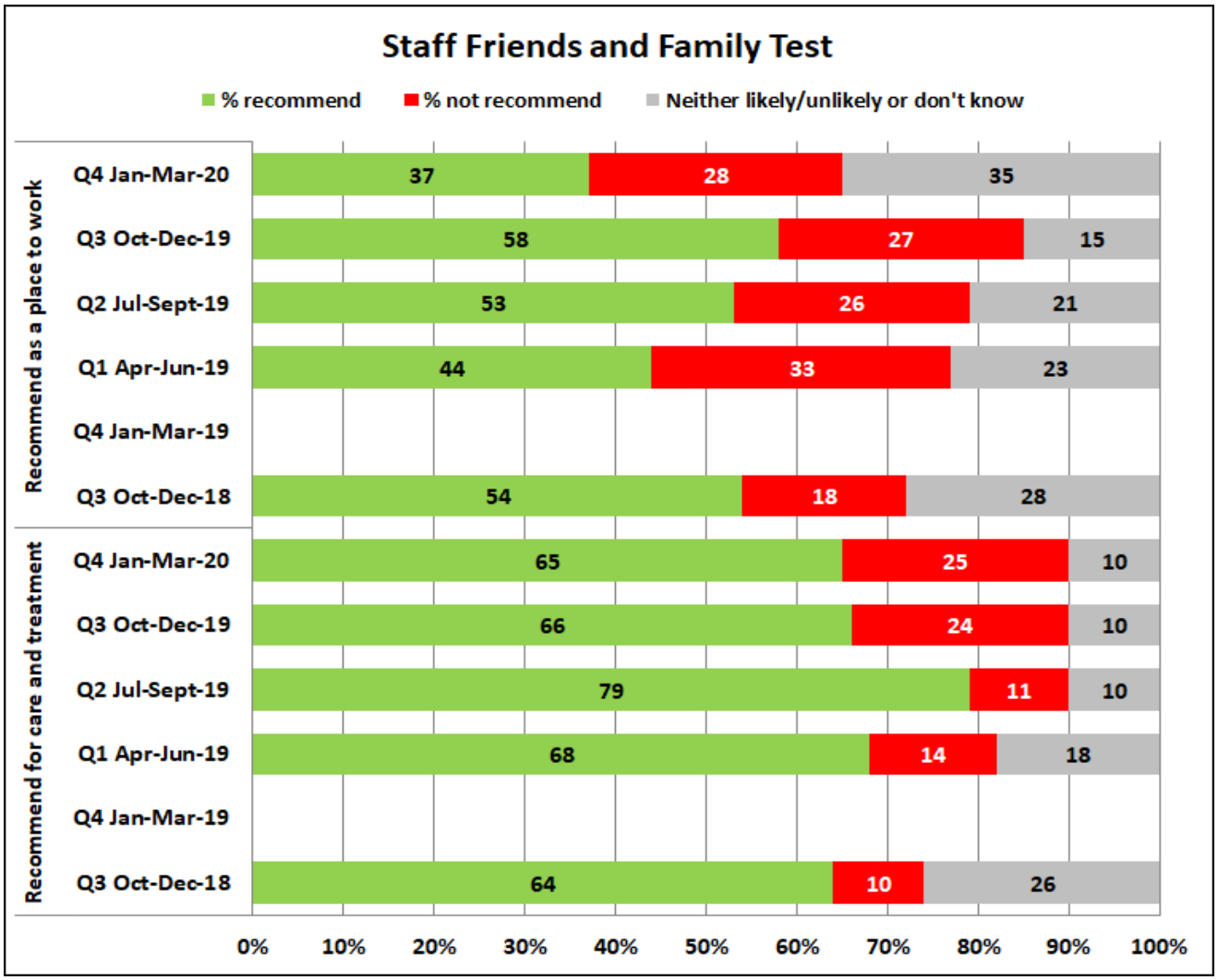
Staff amazing. Always on hand to help and offer support.

Gloucester ward Jun '20

Community Midwifery FFT

No responses received in Q1.

Staff Friends and Family Test



Number of staff responding:

Q3 2018-19	2,389 (43%)
Q4 2018-19	0 (0%)
Q1 2019-20	177/5,803 (3.27%)
Q2 2019-20	76/5,926 (1.28%)
Q3 2019-20	2,544 (43%)
Q4 2019-20	209 responses

In Quarters 1, 2 and 4 staff FFT responses are taken from the local Trust staff survey.

In Quarter 3 staff FFT responses are taken from the national staff survey.

Q4 2018-19 Staff FFT survey data not submitted from the Trust.

NHS Choices and Social Media Feedback (Quarter 1 April - June 2020)

NHS Choices **Facebook** **Twitter**

My daughter who is 2 years old had surgery twice by the same doctor, bearing in mind she is a strong willed young lady, he was lovely couldn't ask for someone better. The ENT department were more than amazing and helped me with everything, made sure I was ok as well as my little one. To be honest if it wasn't for this doctor I don't think I would have coped, can't thank them enough - AMAZING human beings.

Ear, Nose & Throat, Lister - May 2020

As a current NHS worker during these horrible Covid times, I arrived slightly late to get my bloods done on a Friday evening. The brilliant staff in pathology were super kind and stayed a little later for me to get my bloods done. I use this service regularly and they are always so polite, kind, friendly, helpful and compassionate! Thank you ladies for a great experience, you're a credit to our NHS!

Haematology, QEII - June 2020

I am diagnosed with terminal cancer and awaiting a transplant. I arrived for a blood test at 7.40 am, aware that it is a busy time but assuming it would be cleaner not having had patients there overnight. The department opens at 8, and there was a queue. I handed my papers and asked if I could wait in my car until 8 as I was shielding and was very afraid to be out. The receptionist agreed. At 8 I went back and explained I had been waiting outside. By now all the people who had been waiting before me had been replaced by another queue. I waited, and when two people who had come in after me were called I asked if I would have to wait much longer as by now I'd been a total of 40 minutes and was shielding, the reply was a terse "A lot of people are shielding, it won't be long". I explained again that I'd given her my form at 7.40 and had asked if it would be ok to wait outside and she replied that she hadn't seen me. I appreciate people are busy, and it wasn't a huge wait, but I got home and broke down because I was so afraid. The receptionist wasn't practicing social distancing, standing right next to people in the corridor collecting forms, she didn't wear a mask or gloves and spoke very abruptly to an elderly gentleman who was taking a while to stand up to move along in the queue. I don't know what has happened to the concern for mental health but I am left feeling incredibly vulnerable. I do not usually go to QE2 but I'd gone to Hertford the previous day and it was closed, and I couldn't get a home visit in time and so I had no choice. A little thought and a kind word would have made a lot of difference.

Phlebotomy, QEII - June 2020

I had to go to A&E which I was terrified of in the Coronavirus climate, however the hospital is extremely well organised to take account of the current context. I felt safe and I was given exhaustive tests and examinations to resolve my medical emergency. I was seen by 3 separate doctors and they couldn't have done more to address my current health problems. All the staff, doctors, nurses, porters were caring and compassionate. I am so impressed by the level of care provided by the Lister Hospital and I'd like to thank them all very much.

General Surgery, Lister - April 2020

I had to attend the hospital this morning for an urgent appointment for my baby daughter. I was disappointed at how lax the whole hospital has become with regards to Coronavirus awareness and prevention. There was no provision for Hand Sanitiser, Face Masks or Disposable gloves at the main entrance to the hospital I simply strolled in - fortunately I had made my own arrangements for all the items above. Equally there seemed to be little regard for social distancing within the hospital by patients, guests or staff alike who had a lax and inconsistent attitude in their approach to wearing (or not) PPE within the hospital, social distancing and gathering in groups. No floor signage, no one way / one direction layouts, and no one advising or enforcing the regulations. The poor organisation and discipline of the Lister has also been my previous experience and is in stark contrast to Welwyn Garden City urgent care, and Cambridge Addenbrooke's. Which unfortunately means we only attend the Lister in cases of emergency or last resort.

Lister Hospital - May 2020

National CQC Adult Inpatient Survey 2019 (published July 2020)

The CQC Adult Inpatient survey survey asked the views of adults who had stayed overnight as an inpatient in July 2019. 488 patients responded to the ENHT survey, a response rate of 41.4% (compared to 42.4% in the 2018 survey).

Inpatients were asked what they thought about different aspects of the care and treatment they received. The survey is divided into 11 sections and a score out of ten allocated for each question and section. Each trust is assigned a category showing whether their score is 'better', 'about the same' or 'worse' than most other trusts for each section and question.

Comparison to other Trusts 2011-2019:

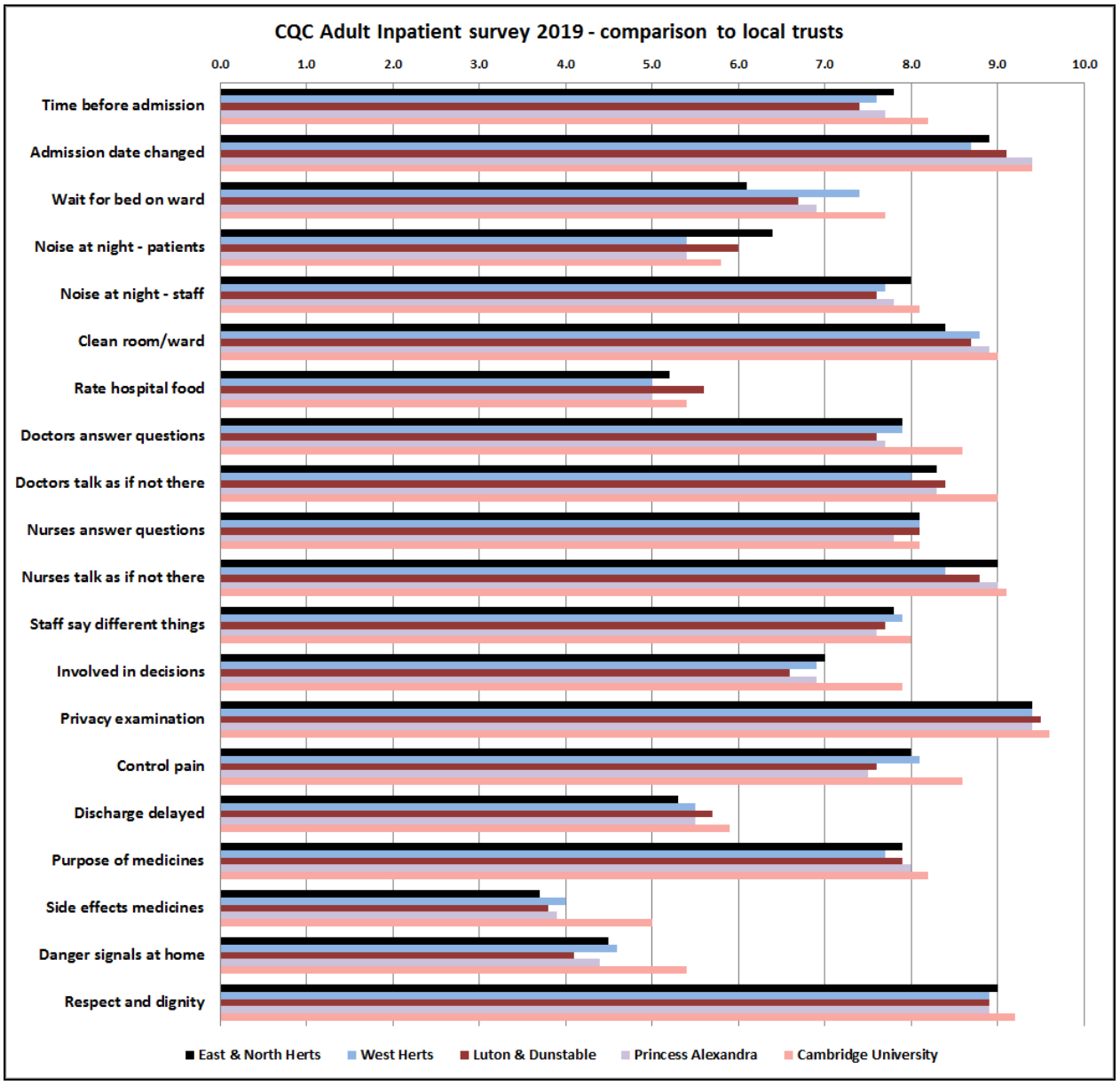
Section		2011	2012	2013	2014	2015	2016	2017	2018	2019
1	Emergency department	Worse	Same	Same	Same	Same	Same	Same	Same	Same
2	Waiting list or planned admissions	Same	Same	Same	Same	Same	Same	Same	Same	Same
3	Waiting to get a bed on a ward	Same	Same	Same	Same	Same	Same	Same	Same	Same
4	The hospital and ward	Worse	Worse	Same	Worse	Same	Same	Same	Same	Same
5	Doctors	Worse	Same	Same	Same	Same	Same	Same	Same	Same
6	Nurses	Same	Same	Same	Same	Same	Worse	Same	Same	Same
7	Care and treatment	Same	Same	Same	Same	Same	Same	Same	Same	Same
8	Operations and procedures	Same	Same	Worse	Same	Worse	Same	Same	Same	Worse
9	Leaving hospital	Same	Same	Same	Same	Same	Same	Same	Worse	Same
10	Overall views of care and services	Same	Same	Same	Same	Same	Same	Same	Same	Same
11	Overall experience				Same	Same	Same	Same	Same	Same

Compared to other Trusts:

The Trust scored 'about the same' as other Trusts for 56 questions in the 2019 inpatient survey and 'worse than other trusts' for the following 7 questions:-

- Operations and procedures: Beforehand, were you told how you could expect to feel after you had the operation or procedure?
- Operations and procedures: After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?
- Leaving hospital: Discharge delayed due to wait for medicines/to see doctor/for ambulance
- Leaving hospital: How long was the delay?
- Leaving hospital: Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?
- Leaving hospital: Did a member of staff tell you about medication side effects to watch for when you went home?
- Feedback on care and research participation: Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?

The NHS Outcomes Framework indicator 4b: 'patient experience of hospital care' is measured by scoring the results of a selection of questions from the national Inpatient survey. The table below compares ENHT responses to these questions with local Trusts:



Question:
Q6: How do you feel about the length of time you were on the waiting list before your admission to hospital?
Q7: Was your admission date changed by the hospital?
Q9: From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?
Q14: Were you ever bothered by noise at night from other patients?
Q15: Were you ever bothered by noise at night from hospital staff?
Q16: In your opinion, how clean was the hospital room or ward that you were in?
Q19: How would you rate the hospital food?
Q23: When you had important questions to ask a doctor, did you get answers that you could understand?
Q25: Did doctors talk in front of you as if you weren't there?
Q26: When you had important questions to ask a nurse, did you get answers that you could understand?
Q28: Did nurses talk in front of you as if you weren't there?
Q33: Did a member of staff say one thing and another say something different?
Q34: Were you involved as much as you wanted to be in decisions about your care and treatment?
Q40: Were you given enough privacy when being examined or treated?
Q42: Do you think the hospital staff did everything they could to help control your pain?
Q51:Discharge delayed due to wait for medicines/to see doctor/for ambulance
Q57: Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?
Q58: Did a member of staff tell you about medication side effects to watch for when you went home?
Q60: Did a member of staff tell you about any danger signals to watch for after you went home?
Q67: Overall, did you feel you were treated with respect and dignity while you were in the hospital?

Comparison of ENHT 2018 and 2019 survey results

There are 61 questions that can be directly compared to the 2018 survey.

The Trust scored 'significantly higher' for the following question:

- During this hospital stay, did anyone discuss with you whether you would like to take part in a research study?

The Trust scored 'significantly lower' for the following question:

- From the time that you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?

There was 'no significant difference' for the remaining 59 questions.

National Cancer Survey 2019 (published June 2020)

The CQC standard for reporting performance based on 'expected ranges' has been used in this report. This means that Trusts are only flagged as outliers if their scores deviate from the range of scores that would be expected for Trusts of the same size.

The survey was sent to adult patients (aged 16 and over) with a primary diagnosis of cancer discharged from an NHS Trust after an inpatient episode or day case attendance for cancer related treatment in the months of April-June 2019. In ENHT 1,070 patients responded to the survey – a response rate of 58% (61% nationally).

ENHT results	2019	2018	2017	2016	2015
No. of question score **above** expected range	0	0	0	1	0
No. of question score **within** expected range	16	9	30	42	35
No. of question score **below** expected range	36	42	22	9	15

Questions scoring below expected range:

No.	Question	2019 ENHT	2019 National	2018 ENHT
2	Patient thought they were seen as soon as necessary.	80	84	81
7	Test results explained in completely understandable way.	76	80	74
10	Patient told they could bring a family member of friend when first told they had cancer	70	77	70
11	Patient felt they were told sensitively that they had cancer	82	86	80
12	Patient completely understood the explanation of what was wrong	70	73	70
13	Patient given easy to understand written information about the type of cancer they had.	69	74	69
14	Patient felt that treatment options were completely explained.	78	83	80
15	Patient felt possible side effects were definitely explained in an understandable way	68	73	68
16	Patient definitely given practical advice and support in dealing with side effects of treatment	64	67	62

No.	Question	2019 ENHT	2019 National	2018 ENHT
17	Patient definitely told about side effects that could affect them in future	49	57	49
18	Patient definitely involved as much as they wanted in decisions about care and treatment	78	81	73
20	Patient found it very or quite easy to contact their CNS.	80	85	82
21	Patient got understandable answers to important questions all or most of the time	84	87	85
22	Hospital staff gave information about support or self-help groups for people with cancer.	83	88	84
23	Hospital staff discussed or gave information about the impact cancer could have on day to day activities	81	84	79
30	Hospital staff didn't talk in front of patient as if patient wasn't here.	77	84	79
32	Patient's family or someone close definitely felt able to talk to a doctor.	67	72	67
36	Patient always given enough privacy when discussing condition or treatment	81	85	80
37	Patient definitely found hospital staff to discuss worries or fears during their inpatient visit.	43	52	48
40	Patient given clear written information about what should / should not do after leaving hospital	82	86	81
41	Hospital staff told patient who to contact if worried about condition or treatment after leaving hospital.	90	94	90
43	Patient definitely found hospital staff to discuss worries or fears during their outpatient or day case visit.	61	71	62
44	Cancer doctor had the right documents at patient's last outpatient appointment.	94	96	93
46	Beforehand patient completely had all information needed about radiotherapy treatment.	79	86	79
47	Patient completely given understandable information about whether radiotherapy was working	50	60	50
49	Beforehand patient completely had all information needed about chemotherapy treatment.	77	84	80
50	Patient given enough information about whether chemotherapy was working in a completely understandable way.	60	68	61
51	Hospital staff definitely gave family or someone close all the information needed to help with care at home.	53	60	49
52	Patient definitely given enough support from health or social services during treatment.	44	52	43
53	Patient definitely given enough support from health or social services after treatment.	35	45	36
55	General practice staff definitely did everything they could to support patient during treatment.	53	58	51
56	Different people treating and caring for patient always work well together to give best possible care.	66	73	54
57	Patient given a care plan.	28	38	24
58	Overall the administration of the care was good or very good.	82	89	80
59	Patient felt length of time for attending clinics and appointments for cancer was about right.	46	69	45
61	Patient's average rating of care scored from very poor to very good.	8.5	8.8	8.47

Compared to the 2018 national cancer survey

There was one question significantly higher than in the 2018 survey, the remaining 51 questions showed no significant change.

Significantly higher

No.	Question
60	Someone discussed with patient whether they would like to take part in cancer research.

Asked to rate their care on a scale of zero (very poor) to 10 (very good) patients gave an average rating of 8.5 (8.47 in 2018). This is below the expected range for the Trust (8.7-8.9) and below the national average of 8.8.

Change overall (since 2015 national cancer survey)

Change overall indicates a significant change overall (2015 – 2019):

Significantly higher

No.	Question
1	Saw GP once or twice before being told they needed to go to hospital.
60	Someone discussed with patient whether they would like to take part in cancer research.

Significantly lower

No.	Question
55	General practice staff definitely did everything they could to support patient during treatment.
58	Overall the administration of care was good or very good.
59	Patient felt length of time for attending clinics and appointments for cancer was about right.

An additional analysis of the national cancer survey responses by tumour group and hospital site (Lister and MVCC) has been requested.

Patient Experience Annual Report 2019-20 – Appendix 1

This year's annual report is different in light of resources required to deal with Covid-19. It includes details of patient experience initiatives to support Covid-19 and mandatory data relating to patient experience feedback and complaints.

Patient Advice and Liaison Service (PALS) Concerns

PALS received 416 concerns in Q1 2020-21 compared to 830 in Q4 2019-20. The table below details the number of PALS concerns by division in Q4:

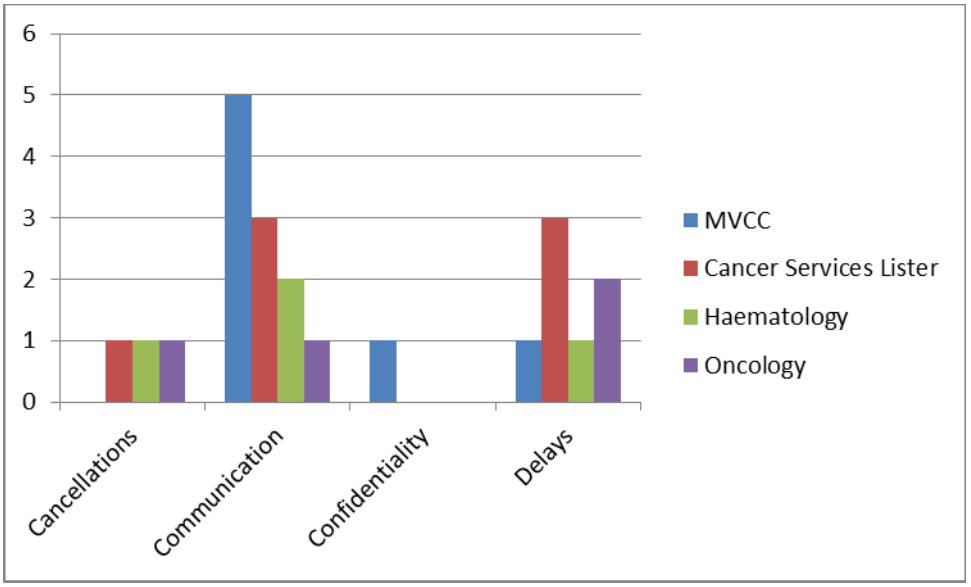
	April 2020	May 2020	June 2020	Total
Cancer Services	11	5	6	22
Clinical Support Services	10	5	23	38
Medicine Division	41	45	45	131
Surgery Division	41	38	84	163
Women & Childrens' Services	17	14	26	57
Operations Division	2	1	2	5
Totals:	**122**	**108**	**186**	**416**

The graphs below detail the number of PALS concerns received per division by specialty and subject for Q1:

Cancer Services

Cancer Services received 22 concerns in Q1 compared to 36 in Q4.

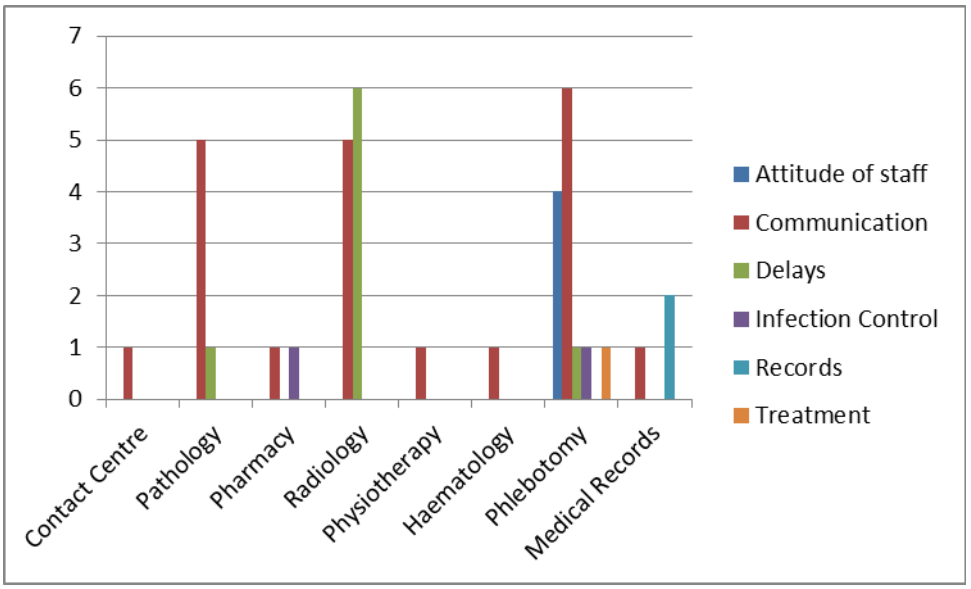
Concerns by specialty and subject – Q1



Clinical Support Services

Clinical Support services received 38 concerns in Q1 compared to 51 concerns in Q4.

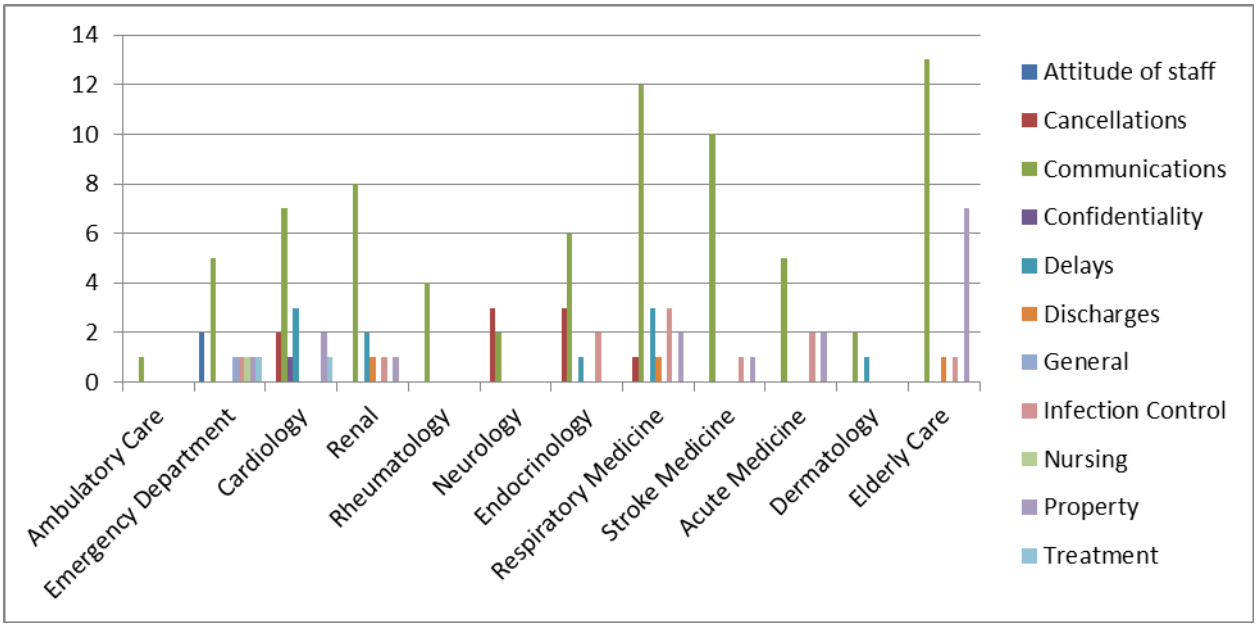
Concerns by specialty and subject – Q1



Medicine Division

Medicine Division received 131 concerns in Q1 compared to 219 concerns in Q4.

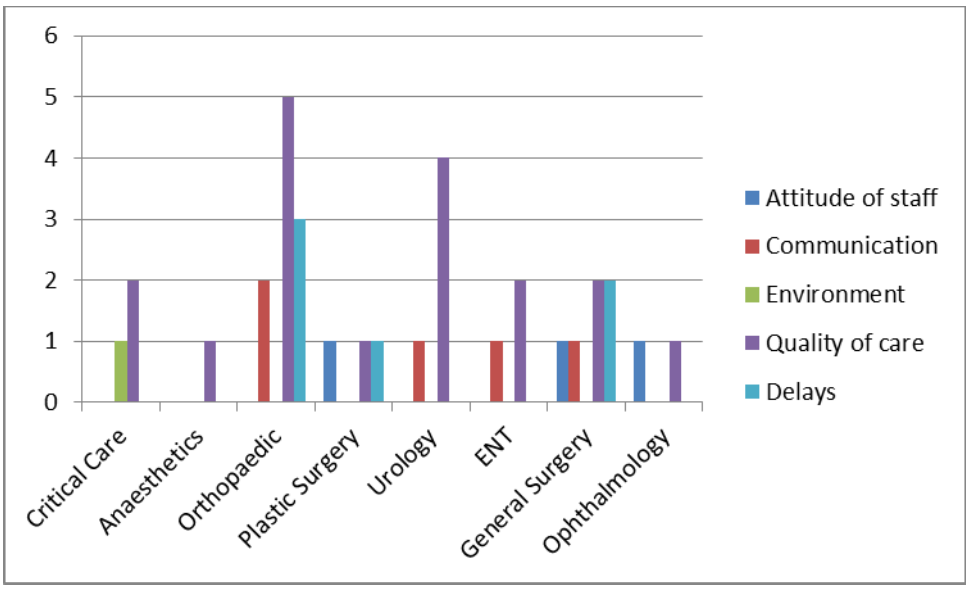
Concerns by specialty and subject – Q1



Surgery Division

In Q1 Surgery Division received 33 complaints compared to 117 in Q4. The graph below details the number of complaints by speciality and subject.

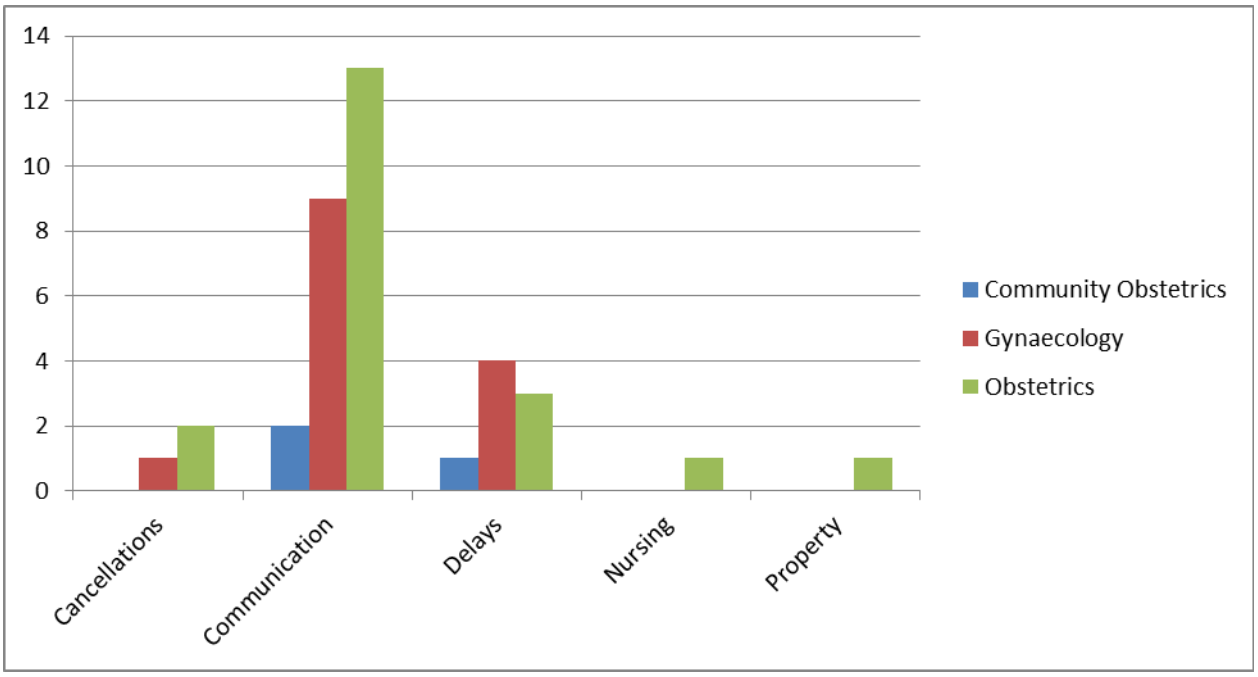
Concerns by specialty and subject – Q1



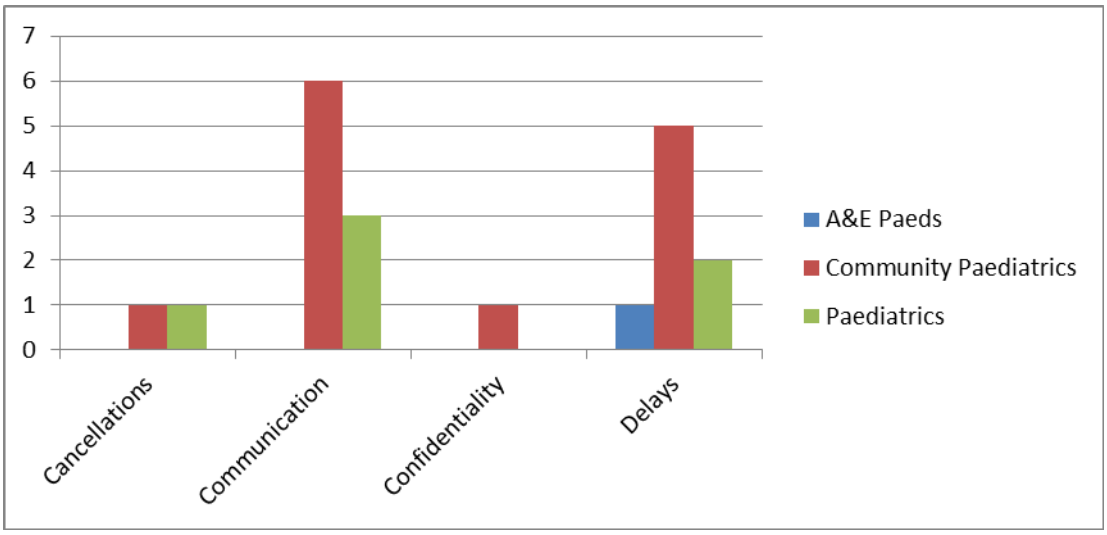
Women's and Children's Services

Women and Childrens' Services received 57 concerns in Q1 compared to 103 concerns in Q4.

Concerns by specialty and subject – Q1



Children's Services concerns by specialty and subject – Q1



Formal Complaints

The Trust received 136 formal complaints in Q1. Further detail with regard to the speciality and subject of complaints for all divisions is provided later in the report. The table below shows the number of complaints by division in Q1:

	April 2020	May 2020	June 2020	Total
Cancer Services	1	0	2	3
Clinical Support Services	5	8	7	20
Medicine Division	11	16	30	57
Surgery Division	6	11	16	33
Women & Childrens' Services	4	9	8	21
Op's	1	1	0	2
Totals:	**28**	**45**	**63**	**136**

Timeframe for acknowledgement of formal complaints

The complaints team acknowledged 82% of all complainants within three working days, either in writing, email or via telephone with 100% compliance being achieved within four days. This matter is being addressed by the Complaints Manager, to ensure 100% compliance moving forward.

Timeframe for response

The Trust KPI is for 80% of formal complaints to be responded to within an agreed timeframe. The table below details the percentage of complaints responded to per division within the agreed timeframe.

	April 2020	May 2020	June 2020	YTD
Cancer Services	100%	100%	100%	100%
Clinical Support Services	100%	100%	100%	100%
Medicine Division	83%	90%	100%	91%
Surgery Division	79%	100%	96%	92%
Women & Childrens' Services	83%	86%	100%	90%

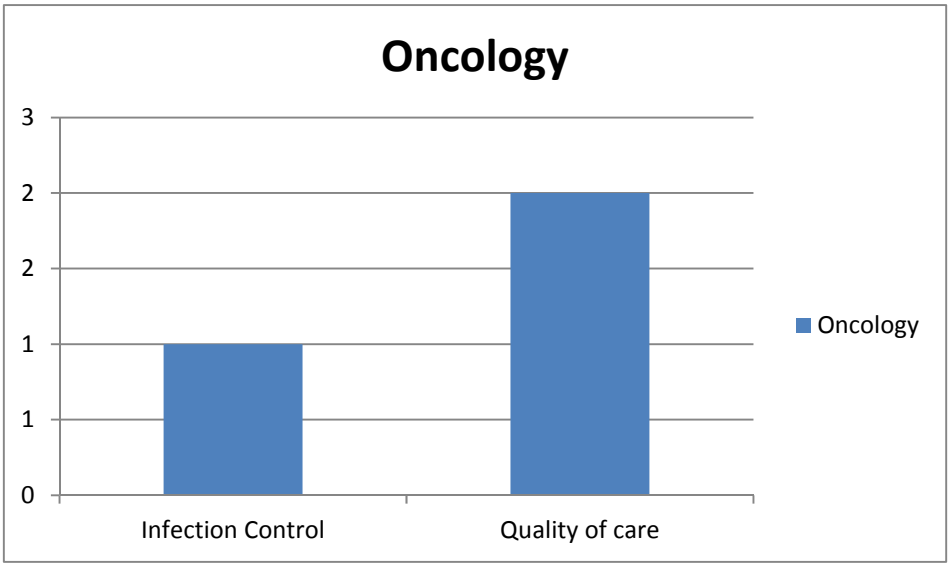
Patients and carers are encouraged to raise questions or concerns about their hospital experiences. The outcome of complaint investigations are shared with the relevant ward, department and divisions so that staff understand what they are doing well and where they need to make improvements.

The following graphs detail the number of complaints per division by specialty and subject for Q1.

Cancer Services

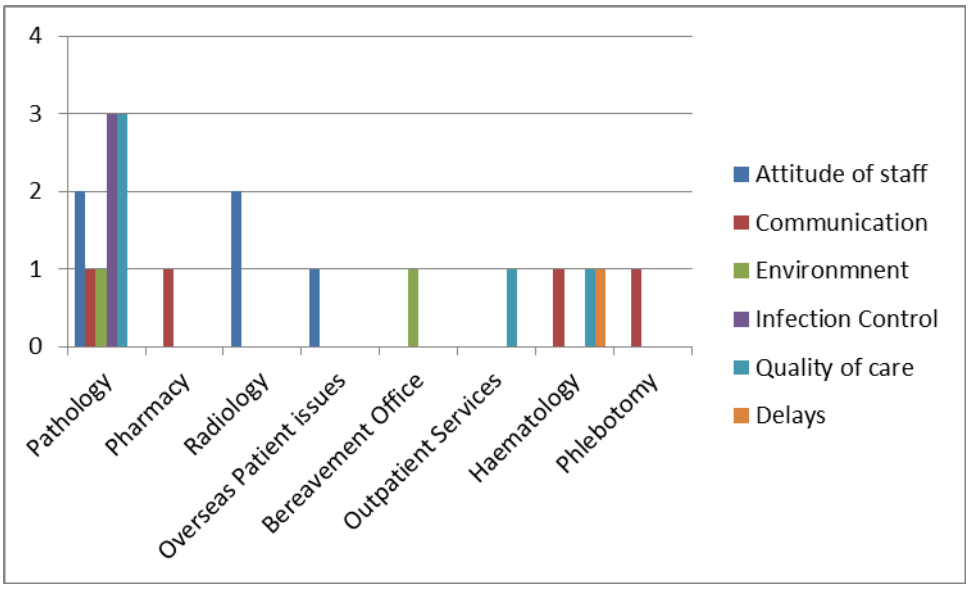
In Q1 Cancer Services received 3 complaints compared to 8 in Q4. The graph below details the number of complaints by speciality and subject.

Cancer Services complaints by specialty and subject – Q1



Clinical Support Services complaints by speciality and subject – Q1

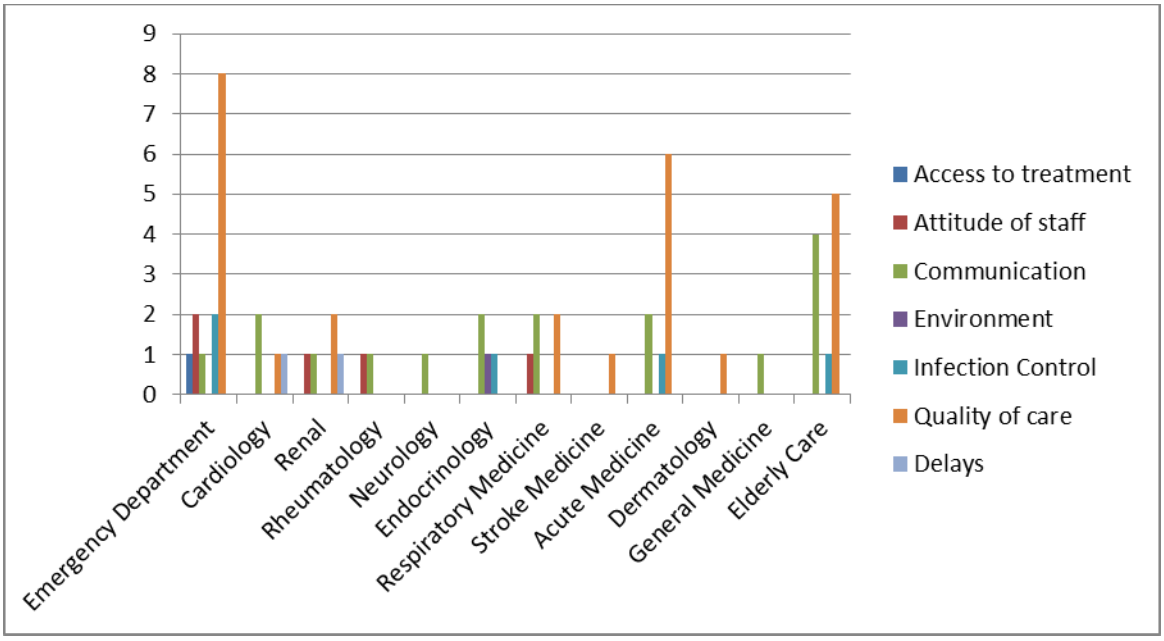
In Q1 Clinical Support Services received 20 complaints compared to 18 in Q4. The graph below details the number of complaints by speciality and subject.



Medicine Division

In Q1 Medicine Division received 57 complaints compared to 90 in Q4. The graph below details the number of complaints by speciality and subject.

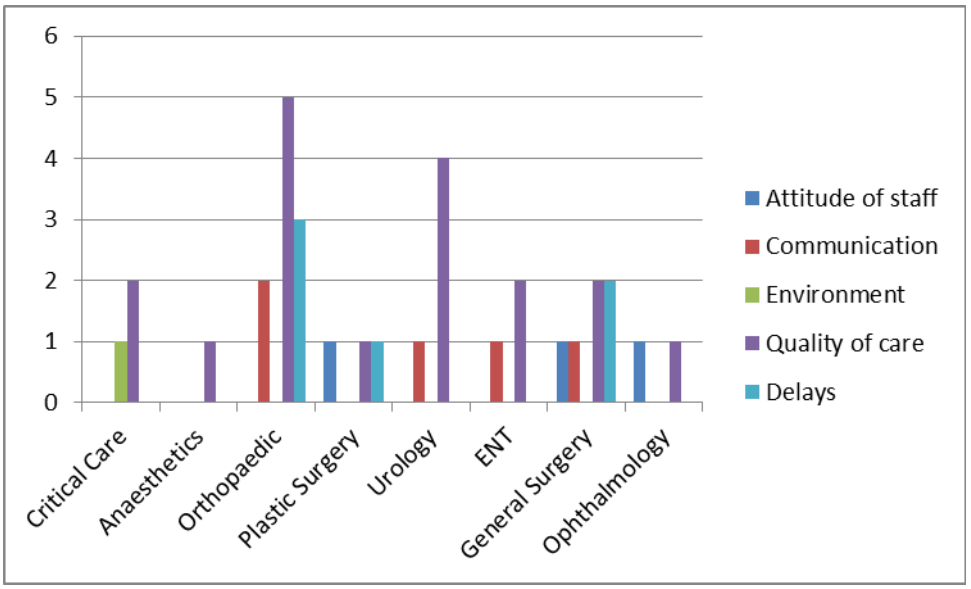
Medicine complaints by specialty and subject – Q1



Surgery Division

In Q1 Surgery Division received 33 complaints compared to 117 in Q4. The graph below details the number of complaints by speciality and subject.

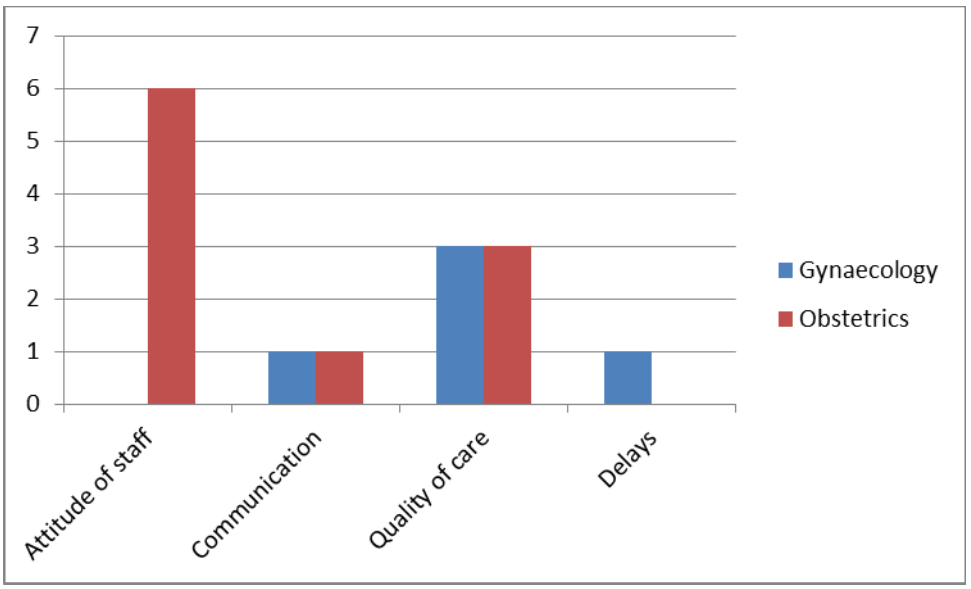
Surgery division complaints by specialty and subject – Q1



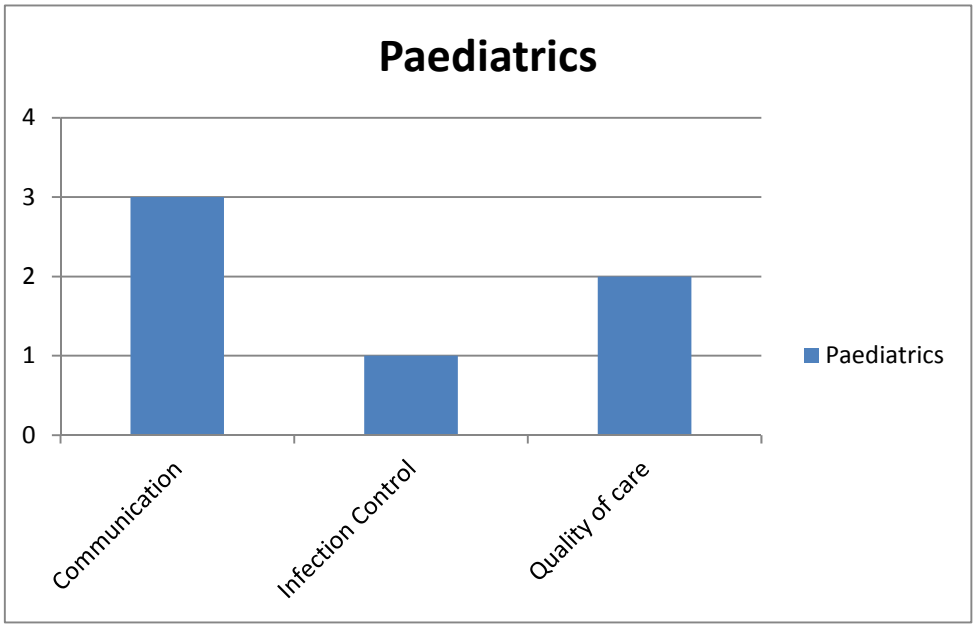
Women and Childrens' Services

In Q1 Medicine Division received 21 complaints compared to 50 in Q4. The graph below details the number of complaints by speciality and subject.

Women's Services complaints by specialty and subject – Q1



Children's Services complaints by speciality and subject – Q1



Parliamentary & Health Service Ombudsman (PHSO)

In Q1 2020-21 the Parliamentary Health Service Ombudsman did not make made any requests for papers due to pausing their service during the Covid-19 pandemic.

East and North Hertfordshire NHS Trust

Patient Experience Annual Report 2019-20

including Complaints and Patient Advice and Liaison Service (PALS)

#hello my name is…

Rachael

We aim to provide our patients and their carers with the best possible experience whilst they are using our services. We encourage patients and carers to provide feedback and raise questions or concerns about their hospital experiences in a variety of ways including talking to staff in the wards/departments, completing one of our patient surveys, including the Friends and Family Test question (how likely are you to recommend our ward/department to friends and family if they needed similar care or treatment?), completing one of the national patient experience surveys, sharing their patient story, posting comments on social media/NHS Choices, contacting PALS or making a formal complaint.

All feedback is shared with the relevant ward or department to enable teams to share positive feedback and consider suggestions for improvements made by patients and carers. Each ward/department has a 'learning from your experience' poster which is updated monthly to share the actions that have been taken as a result of patient and carer feedback. Each Division has a patient and carer experience action plan which is discussed and monitored by the Trust's Patient and Carer Experience Committee.

The Trust takes part in the national patient experience surveys co-ordinated by the Care Quality Commission and Department of Health. This feedback is valuable as it enables the Trust to compare performance with other trusts throughout the country. In 2019-20, the Trust received feedback from the following national surveys: Inpatients 2019, Cancer 2018 and Maternity 2019. The timeframe for publication of national survey data is approximately 10-12 months after the survey month. For example, the Inpatient survey 2019 was sent to patients who were in hospital in July 2019, the survey results were published by the Care Quality Commission in July 2020. A summary of results from these national surveys is included in the 'Facts and Figures' section of this report. This section also shows the full breakdown of patient experience survey responses during 2019-20 and a breakdown of complaints and PALS enquiries. This wealth of feedback has helped the Trust prioritise areas for improvement which are incorporated within the Divisional patient and carer experience action plans.

This year's patient and carer experience annual report is different to previous years in light of the resources required to deal with Covid-19. This has been a particularly challenging time for staff and trusts have been encouraged to look at different ways of working, prioritising patient care. Details of actions to improve patient and carer experience in the trust are published in the trusts Quality Account as well as on social media and the trusts website. We encourage you to view these sources of information to keep up to date with actions to improve patient and carer experience.

Changes to improve patient and carer experience during Covid-19:

Family Liaison Clinicians

The Family Liaison Clinician (FLiC) role was established to support patients and their families to remain connected and to be kept well informed of their progress whilst there were restrictions on hospital visiting during Covid-19. The service is predominantly aimed at those patients unable to communicate directly with their family themselves using a mobile device. The Family Liaison Clinicians have supported nursing and medical staff with communications with patient's next of kin and other members of the multi-disciplinary team.

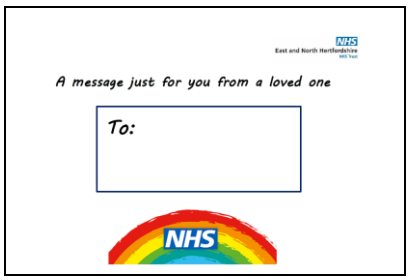
The FLiC join the nursing and medical handover meetings each day and contact the patients next of kin to provide an update on the patient's condition and feedback any message from the family to the patient. They support patients to stay in contact with their family and friends either by phone or video link. The FLiC find out what matters most to patients and their families and use this information to improve the patient experience, this has included providing favourite cakes and goodies, reading material etc. The team share a message and knitted heart with the patient and family members to help them feel connected.

Family Liaison Clinician supporting a patient video call

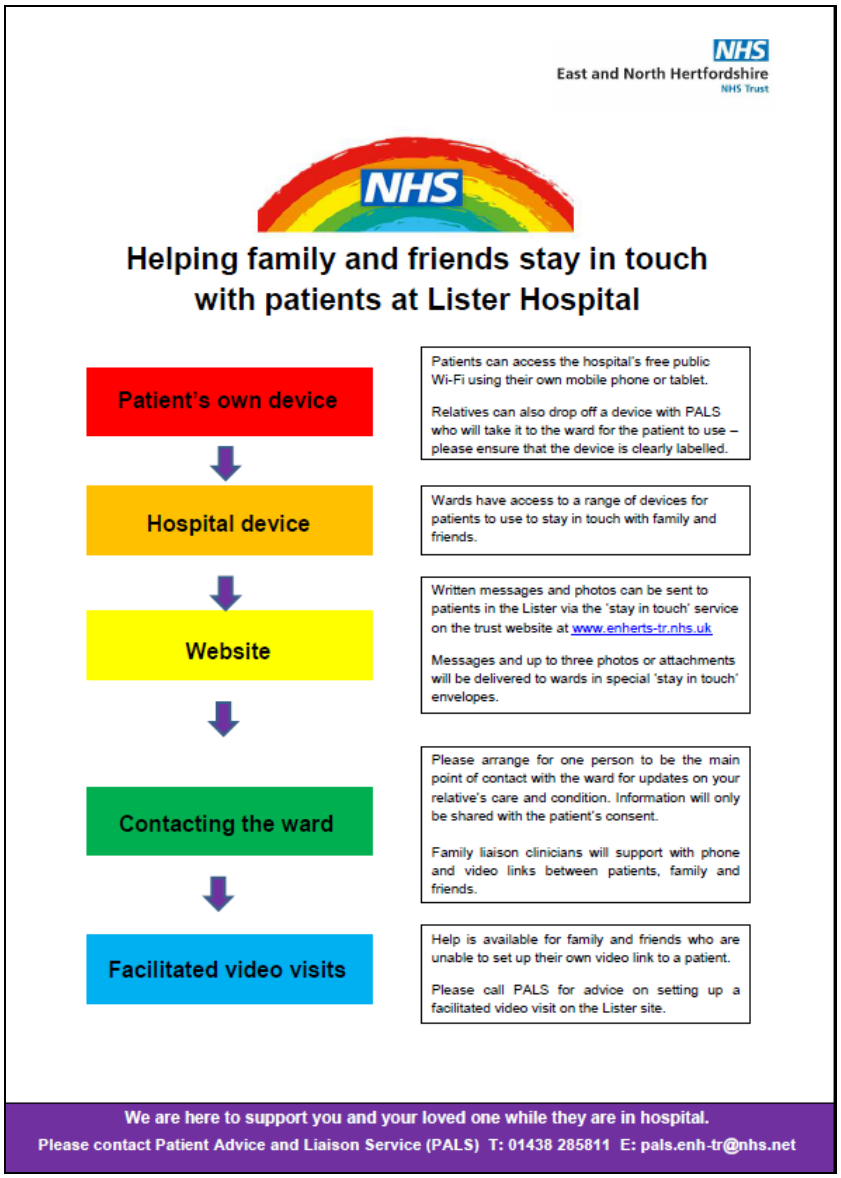
Supporting family and friends to Stay in Touch with patients

In line with government guidance during Covid-19, hospital visiting had to be restricted. In response to this we established a 'stay in touch' service where family and friends can complete a simple form on the trust website with a message and up to three photographs or pictures for a patient in Lister Hospital or Mount Vernon Cancer Centre. Messages are printed and delivered to patients in special 'stay in touch' envelopes.

Patient receiving 'stay in touch' message



A poster outlining the variety of ways that family and friends can stay in touch with their loved ones was developed and shared with the public on the Trust website, via social media and displayed in over 45 local shops and businesses:



Stay in Touch poster for the public

In line with Government guidance, we continued to support hospital visiting in the following exceptional circumstances:

- The patient is close to the end of their life.
- Birthing partner accompanying a woman in labour.
- A parent or appropriate adult visiting their child.
- Supporting someone with a mental health issue, a learning disability, autism, or dementia, where not being present would cause the patient to be distressed.

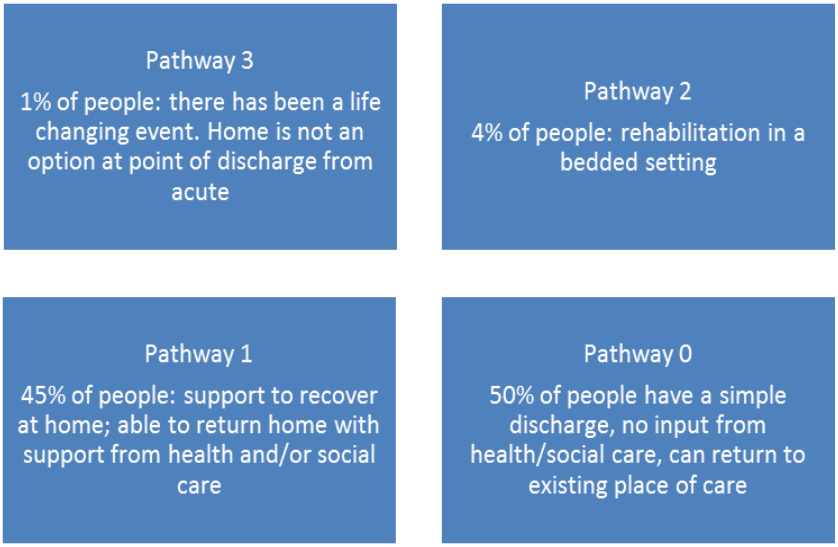
A risk assessment tool was developed to ensure that family and friends had no Covid-19 symptoms and were fully aware of the potential risks of coming into hospital especially if they had specific health conditions.

We developed a patient information leaflet guiding family and friends about what to expect if they came into hospital to visit their loved one, the infection prevention precautions that they must adhere to, such as wearing personal protective equipment, performing hand hygiene and the need to observe social distancing.

Discharge to Assess

In response the COVID-19 pandemic, the Trust had to be responsive to the new discharge requirements as laid out by the government. This meant that we needed to follow a 'discharge to assess' (D2A) model so that our patients did not stay in a hospital bed any longer than was necessary by ensuring the assessment and organisation of on-going care took place in the community.

The Patient Flow Team (PFT), Integrated Discharge Team (IDT), Therapy and Pharmacy services have transformed the way in which they worked to support wards with effective discharge planning and the transfer of patients through the discharge lounge within 1 hour of being deemed medically optimised (MO) and discharged from the hospital within 3 hours. The PFT are responsible for leading on all 'Pathway 0' discharges whilst the IDT and therapy teams are responsible for 'Pathway 1-3' patients as they play a lead role in assessing and providing care for these patients. All D2A pathways are successful due to the joint working between the Clinical Commissioning Group (CCG), NHS, social care, community and voluntary sectors.



Staff ensure that:

- All patients are set an estimated discharge date (EDD) and a criteria-led discharge plan is in place.
- All medically optimised patients are discharged from the ward or transferred to the discharge lounge within 1 hour of review.
- All patients are discharged from the acute hospital within 3 hours of being deemed MO.
- All patients requiring health or social support are swabbed 72 hours in advance of their EDD.
- All care home patients are referred to the IDT prior to discharge to ensure infection prevention assurances are in place prior to leaving hospital.
- Patients are recorded as MO on the Nervecentre system and the correct care pathway documented.
- Medications to take home and the patients discharge summary are completed 24 hours prior to the patients discharge.
- Every discharged patient receives a call back 24 hours after discharge from either the PFT or IDT. All data is captured and reported to NHS England/Improvement.

The final section of this report includes the 'facts and figures' relating to the collection of patient feedback in 2019-20. It includes details of our national patient survey results, local patient surveys including the friends and family test question, PALS concerns, formal complaints and complaints referred to the Parliamentary and Health Service Ombudsman.

Rachael Corser
Chief Nurse

Facts and Figures 2019-20

National Patient Experience Surveys

National Adult Inpatient Survey 2019

The annual survey of Adult Inpatients is undertaken in all NHS acute hospitals and results are published by the Care Quality Commission (CQC).

Survey month	Report received	Response rate	
		No.	%
July 2015	June 2016	509	42
July 2016	May 2017	459	38
July 2017	June 2018	431	35
July 2018	June 2019	514	42
July 2019	July 2020	488	41

Inpatients were asked what they thought about different aspects of the care and treatment they received. The survey is divided into 11 sections and a score out of 10 allocated for each question and section. Each trust is assigned a category showing whether their score is 'better', 'about the same' or 'worse' than most other trusts.

Section		2012	2013	2014	2015	2016	2017	2018	2019
1	Emergency department	Same	Same	Same	Same	Same	Same	Same	Same
2	Waiting list and planned admissions	Same	Same	Same	Same	Same	Same	Same	Same
3	Waiting to get a bed on a ward	Same	Same	Same	Same	Same	Same	Same	Same
4	The hospital and ward	Worse	Same	Worse	Same	Same	Same	Same	Same
5	Doctors	Same	Same	Same	Same	Same	Same	Same	Same
6	Nurses	Same	Same	Same	Same	Worse	Same	Same	Same
7	Care and treatment	Same	Same	Same	Same	Same	Same	Same	Same
8	Operations and procedures	Same	Worse	Same	Worse	Same	Same	Same	Worse
9	Leaving hospital	Same	Same	Same	Same	Same	Same	Worse	Same
10	Overall views and experiences	Same	Same	Same	Same	Same	Same	Same	Same
11	Overall experience			Same	Same	Same	Same	Same	Same

The Trust scored 'about the same' as other trusts for 56 questions in the 2019 Adult Inpatient survey and 'worse than other trusts' for the following 7 questions:-

- Operations and procedures: Beforehand, were you told how you could expect to feel after you had the operation or procedure?
- Operations and procedures: After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?
- Leaving hospital: Discharge delayed due to wait for medicines/to see doctor/for ambulance
- Leaving hospital: How long was the delay?
- Leaving hospital: Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?
- Leaving hospital: Did a member of staff tell you about medication side effects to watch for when you went home?
- Feedback on care and research participation: Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?

The Divisional patient experience action plans will be reviewed to incorporate actions in response to this feedback.

National Cancer Patient Experience Survey 2018

The CQC standard for reporting performance based on 'expected ranges' has been used in this report. This means that Trusts are only flagged as outliers if their scores deviate from the range of scores that would be expected for Trusts of the same size.

The survey was sent to adult patients (aged 16 and over) with a primary diagnosis of cancer discharged from an NHS Trust after an inpatient episode or day case attendance for cancer related treatment in the months of April-June 2018. In ENHT 1,122 patients responded to the survey – a response rate of 63% (64% nationally).

ENHT results	**2018**	**2017**	**2016**	**2015**
No. of question score **above** expected range	0	0	1	0
No. of question score **within** expected range	9	30	42	35
No. of question score **below** expected range	42	22	9	15

Questions scoring below expected range:

No.	**Question**	**2018 ENHT**	**2018 National**	**2017 ENHT**
2	Patient thought they were seen as soon as necessary.	81	84	81
6	The length of time waiting for the test to be done was about right.	85	88	85
7	Given complete explanation of test results in understandable way	74	79	76
8	Patient told they could bring a family member of friend when first told they had cancer	70	78	73
9	Patient felt they were told sensitively that they had cancer	80	85	82
10	Patient completely understood the explanation of what was wrong	70	74	70
11	Patient given easy to understand written information about the type of cancer they had.	69	74	69
12	Patient felt that treatment options were completely explained.	80	83	79
13	Possible side effects explained in an understandable way	68	73	70
14	Patient given practical advice and support in dealing with side effects of treatment	62	67	64
15	Patient definitely told about side effects that could affect them in future	49	56	51
16	Patient definitely involved in decisions about care and treatment	73	79	76
17	Patient given the name of the CNS who would support them through their treatment	88	91	88
18	Patient found it easy to contact their CNS.	82	85	82
19	Get understandable answers to important questions all or most of the time	85	88	87
21	Hospital staff gave information about impact cancer could have on day to day activities	79	83	79
26	Staff explained how operation had gone in understandable way	75	79	79
29	Patient had confidence and trust in all doctors treating them	82	85	85
30	Patient's family or someone close definitely had opportunity to talk to doctor.	67	74	67
31	Patient had confidence and trust in all ward nurses.	65	75	69
32	Always / nearly always enough nurses on duty	58	67	64

No.	Question	2018 ENHT	2018 National	2017 ENHT
34	Always given enough privacy when discussing condition or treatment	80	86	85
35	Patient was able to discuss worries or fears with staff during visit	48	53	50
36	Hospital staff definitely did everything to help control pain	79	84	82
37	Always treated with respect and dignity by staff	83	89	90
38	Given clear written information about what should / should no do post discharge	81	87	84
39	Staff told patient who to contact if worried post discharge	90	94	92
41	Patient was able to discuss worries or fears with staff during visit.	62	71	63
42	Doctor had the right notes and other documentation with them.	93	96	93
44	Beforehand patient had all information needed about radiotherapy treatment.	79	86	79
45	Patient given understandable information about whether radiotherapy was working	50	60	49
47	Beforehand patient had all information needed about chemotherapy treatment.	80	84	79
48	Patient given understandable information about whether chemotherapy was working.	61	68	61
49	Hospital staff gave family or someone close all the information needed to help with care at home.	49	60	51
50	Patient definitely given enough support from health or social services during treatment.	43	53	43
51	Patient definitely given enough support from health or social services after treatment.	36	45	32
53	Practice staff definitely did everything they could to support patient	51	59	59
54	Hospital and community staff always worked well together	54	61	58
55	Patient given a care plan.	24	35	29
56	Overall the administration of the care was very good/good	80	88	87
57	Length of time for attending clinics and appointments was right.	45	69	56
59	Patient's average rating of care scored from very poor to very good	8.47	8.80	8.6

Compared to the 2017 national cancer survey

Compared to the 2017 survey, there were two questions significantly lower, the remaining 49 questions showed no significant change.

Significantly lower

No.	Question
53	Practice staff definitely did everything they could to support patient.
57	Length of time for attending clinics and appointments was right.

Asked to rate their care on a scale of zero (very poor) to 10 (very good) patients gave an average rating of 8.5 (8.6 in 2017). This is below the expected range for the Trust (8.7-8.9) and below the national average of 8.8.

National Maternity Survey 2019

Women were eligible for the survey if they had a live birth during February 2019, were aged 16 years or older and gave birth under the care of an NHS trust. 126 acute NHS trusts participated in the survey. 150 women responded to the ENHT survey, a response rate of 41% (37% nationally).

ENHT results **better** than most trusts for 2 questions:

- During your pregnancy, did you have a telephone number for a member of the midwifery team that you could contact?
- If you contacted a midwife or health visiting team were you given the help you needed?

ENHT results **worse** than most trusts for 2 questions:

- Did you get enough information from either a midwife or doctor to help you decide where to have your baby?
- During your pregnancy did midwives provide relevant information about feeding your baby?

ENHT results were the **same** as other trusts for the remaining 44 questions.

Compared to the 2018 maternity survey:

ENHT results were **significantly higher** for 1 question:

- Thinking about your stay in hospital, how clean was the hospital room or ward you were in?

ENHT results show **no significant difference** between the 2018 and 2019 survey results for 28 questions. There were a number of changes made to the maternity survey in 2019 which means that historical comparisons cannot be provided for all questions.

Local Patient Surveys

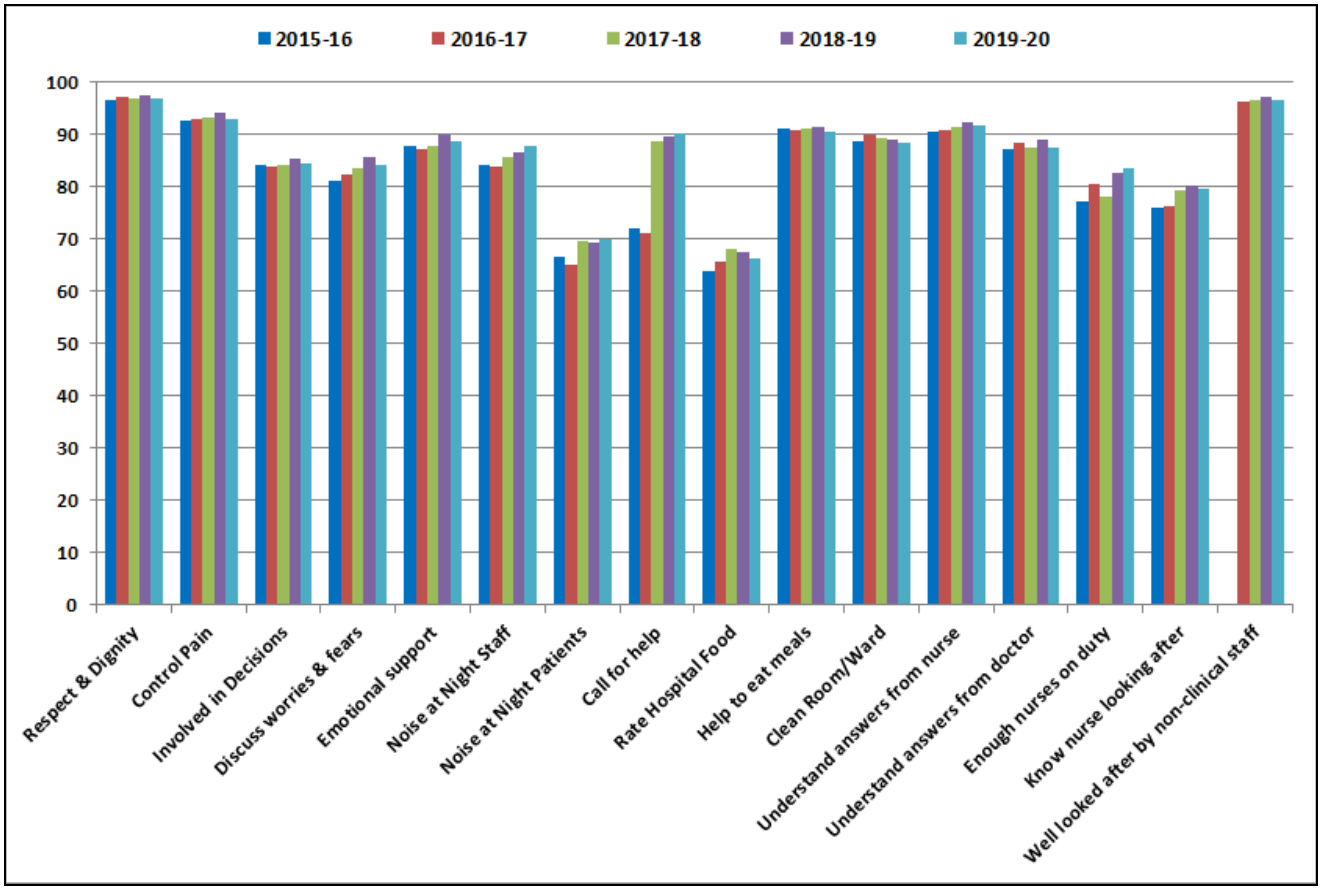
The Trust continually monitors feedback from patients and uses this feedback to make changes and improvements to the services it provides. An electronic patient survey system is in place called 'IQVIA' which enables patients to provide feedback by completing a survey on a simple electronic device (i-Pad) whilst they are in the hospital, or on a paper survey if preferred. During 2019-20, 23,086 patients completed one of our surveys (excluding the single question Friends and Family Test survey), a decrease from 24,628 surveys completed in 2018-19.

IQVIA Local Patient Experience Surveys	**No. completed 2015-16**	**No. completed 2016-17**	**No. completed 2017-18**	**No. completed 2018-19**	**No. completed 2019-20**
Inpatient	9,685	11,954	12,239	12,311	11,587
Maternity	2,946	3,031	2,625	1,820	1,341
Day Case	2,374	3,679	2,091	760	706
Outpatients	1,993	2,123	5,447	5,969	5,814
Renal Dialysis Unit	1,016	1,278	1,101	1,453	1,352
Discharge	903	739	583	677	731
Emergency Department/ UCC	349	372	321	279	157
Assessment	174	528	832	652	697
Neonatal Unit	150	121	139	154	182
Critical Care	15	51	107	200	245
Community Respiratory		45	221	275	214
Experience of End of Life Care			16	52	50
Bramble Safeguarding			3	1	0
Renal Tele-clinic			41	25	10
TOTAL	**19,605**	**23,921**	**25,766**	**24,628**	**23,086**

Each month around 1,000 patients complete our inpatient survey whilst on the ward. This enables the Trust to monitor feedback month by month and address any areas of concern. The questions asked within the inpatient survey are:

Respect and dignity	Did you feel you were treated with respect and dignity while you were in the hospital?
Control pain	Do you think the hospital staff did everything they could to help control your pain?
Involved in decisions	Were you involved as much as you wanted to be in decisions about your care and treatment?
Discuss worries & fears	Did you find someone on the hospital staff to talk to about your worries and fears?
Emotional support	Do you feel you got enough emotional support from hospital staff during your stay?
Noise at night - staff	Were you ever bothered by noise at night from hospital staff?
Noise at night - patients	Were you ever bothered by noise at night from other patients?
Call button response / Response to call for help	How many minutes after you used the call button did it usually take before you got the help you needed? Question changed in August 2017 to: If you needed attention, were you able to get a member of staff to help you within a reasonable time?
Rate hospital food	How would you rate the hospital food?
Help to eat meals	Did you get enough help from staff to eat your meals?
Clean room/ward	In your opinion, how clean was the hospital room or ward that you were in?
Understand answers from nurse	When you had important questions to ask a nurse, did you get answers that you could understand?
Understand answers from doctor	When you had important questions to ask a doctor, did you get answers that you could understand?
Enough nurses on duty	In your opinion, were there enough nurses on duty to care for you in hospital?
Know nurse looking after	Do you know which nurse is in charge of looking after you? (this would be a different person after each shift change)
Well looked after by non-clinical staff	Did you feel well looked after by the non-clinical hospital staff (e.g. cleaners, porters, catering staff)?

The following chart shows a comparison of the inpatient survey results between 2015-16 to 2019-20:



Friends and Family Test

The Friends and Family Test question is asked of inpatients/day case, maternity, accident and emergency and outpatients. Patients are asked '**how likely are you to recommend the ward/department/service to friends and family if they needed similar care or treatment'**. The question must be asked at or within 48 hours of the patients' discharge from hospital.

The Trust's FFT results for all elements are reported as the 'percentage of patients who would/would not recommend' the service.

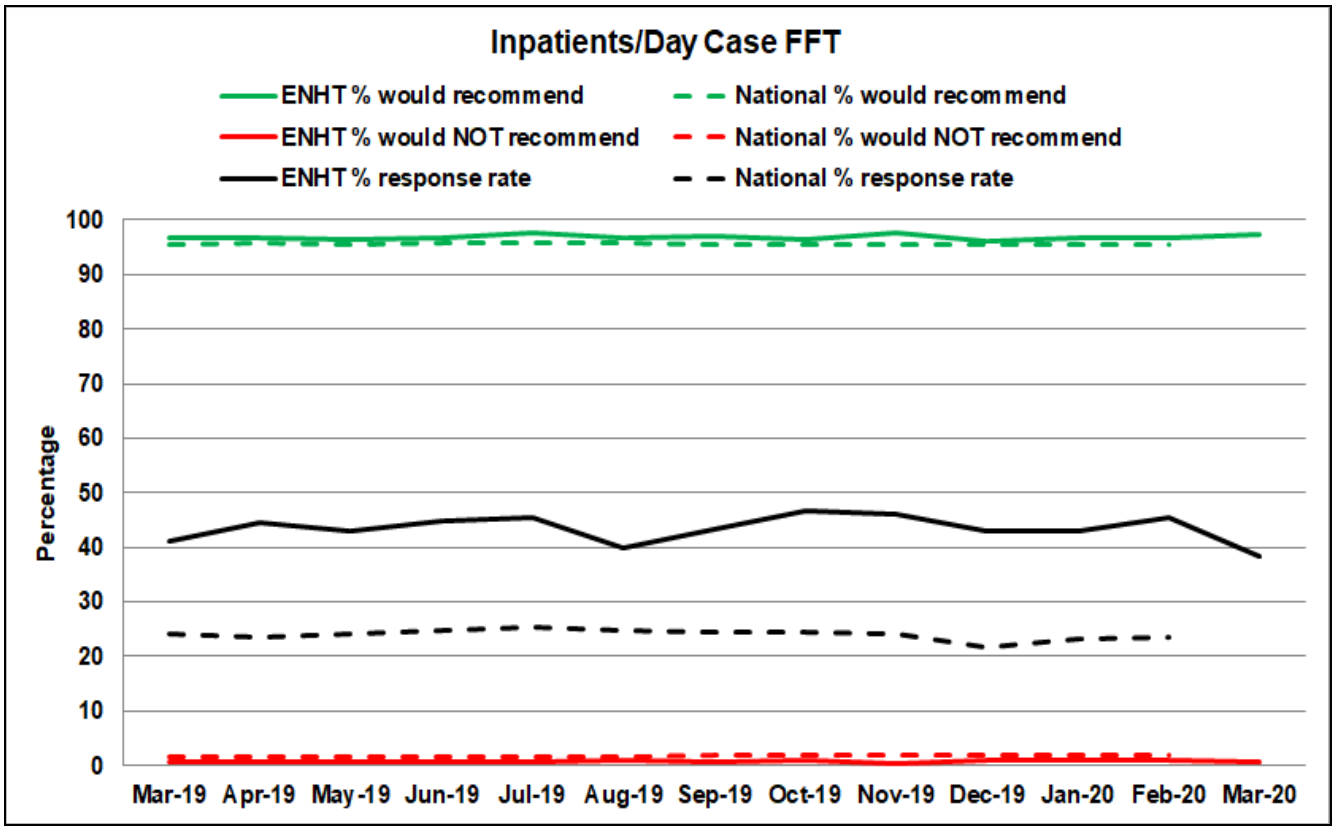
An easy read version of the FFT survey is offered to people (with appropriate support if needed) who have dementia, learning disability, are profoundly deaf, deafblind, blind/vision loss, have little or no English or low levels of literacy. Guidance is available for staff offering the FFT survey to patients with dementia or a learning disability. The FFT survey is also available on the Trust's intranet and website as a short video clip translated into British Sign Language and translated into different languages.

Summary of Trust FFT results and response rates (2019-20):

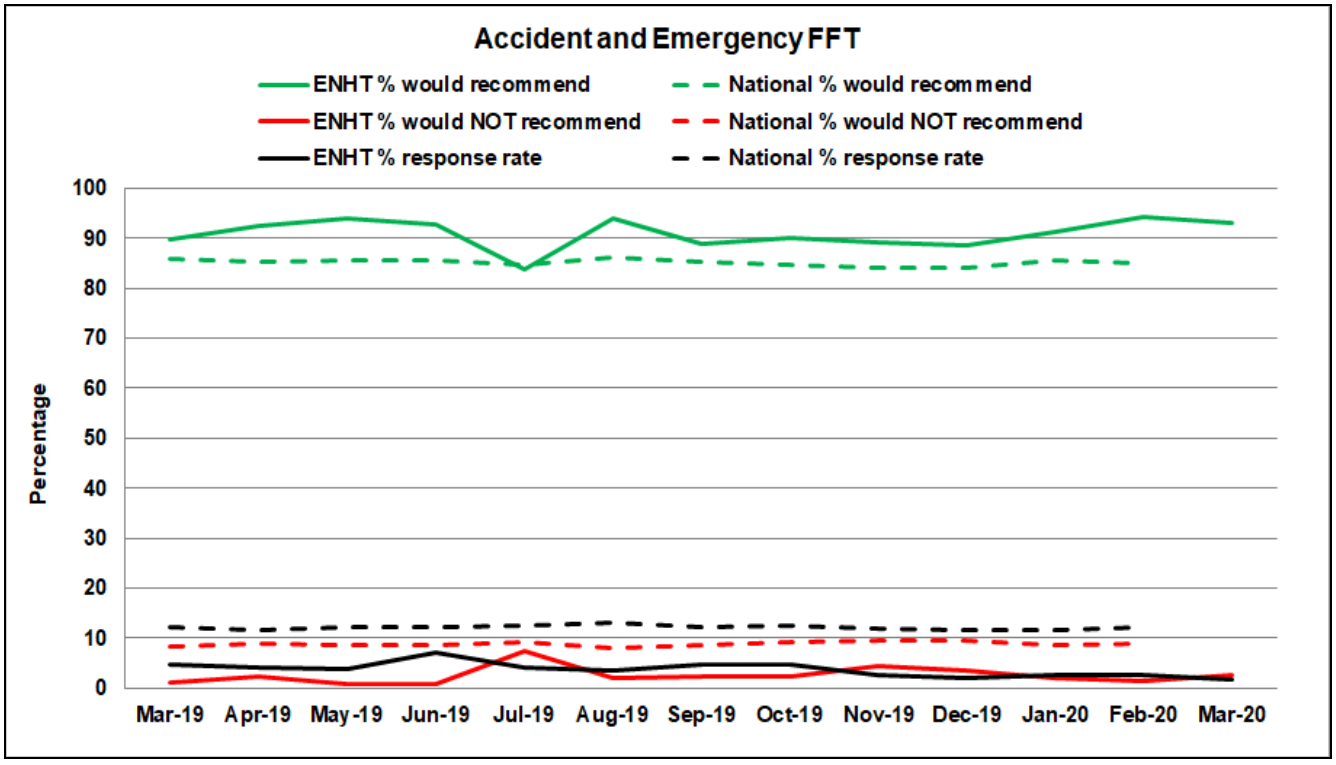
In 2019-20 65,035 patients responded to the Friends and Family Test question (compared to 55,136 in 2018-19).

For each element of the Friends and Family Test question, the Trust monitors the percentage of patients who would recommend, the percentage of patients who would not recommend and the response rate. The charts below show this information with a comparison to the national average where available.

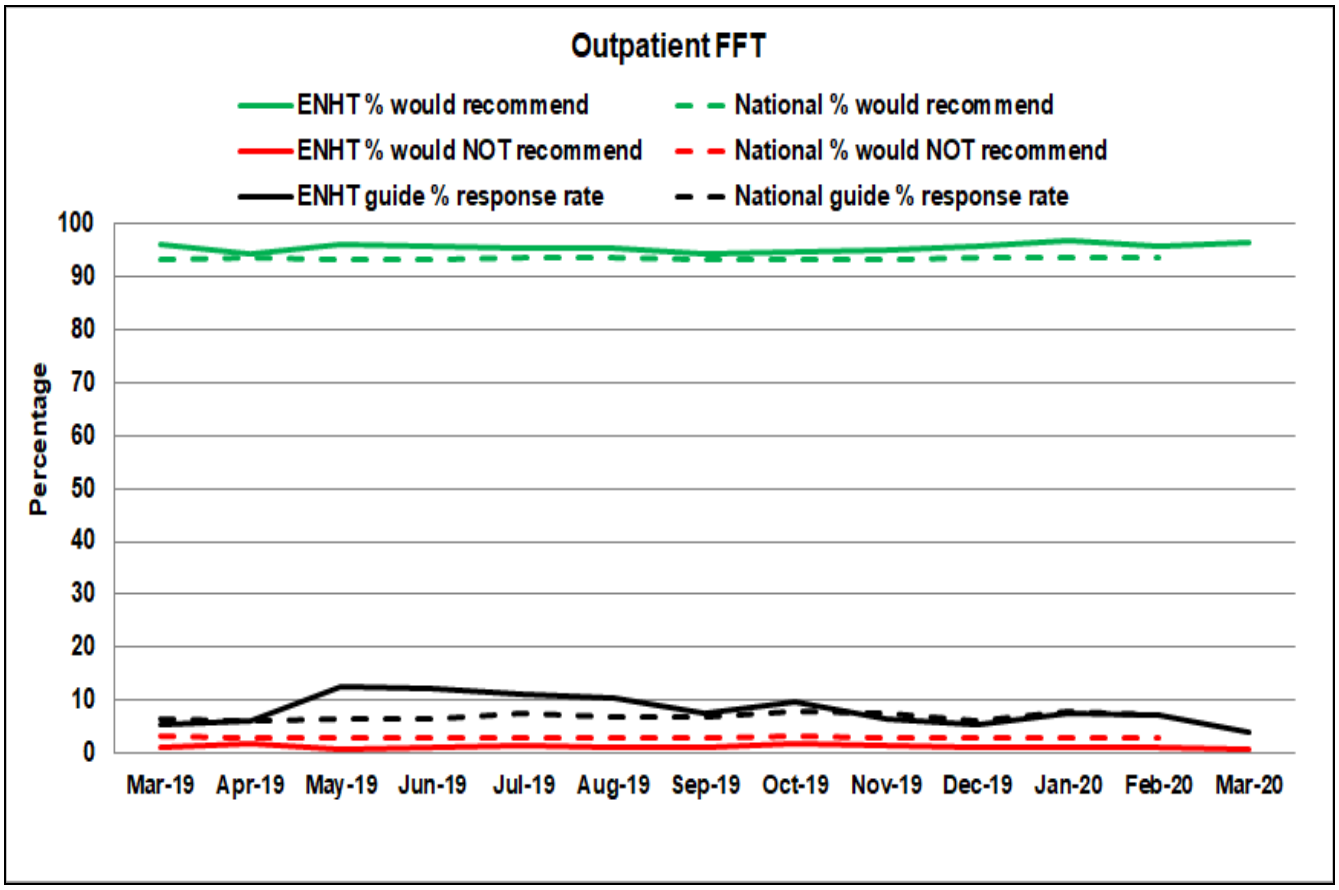
Inpatients and Day Case



Accident and Emergency



Outpatients

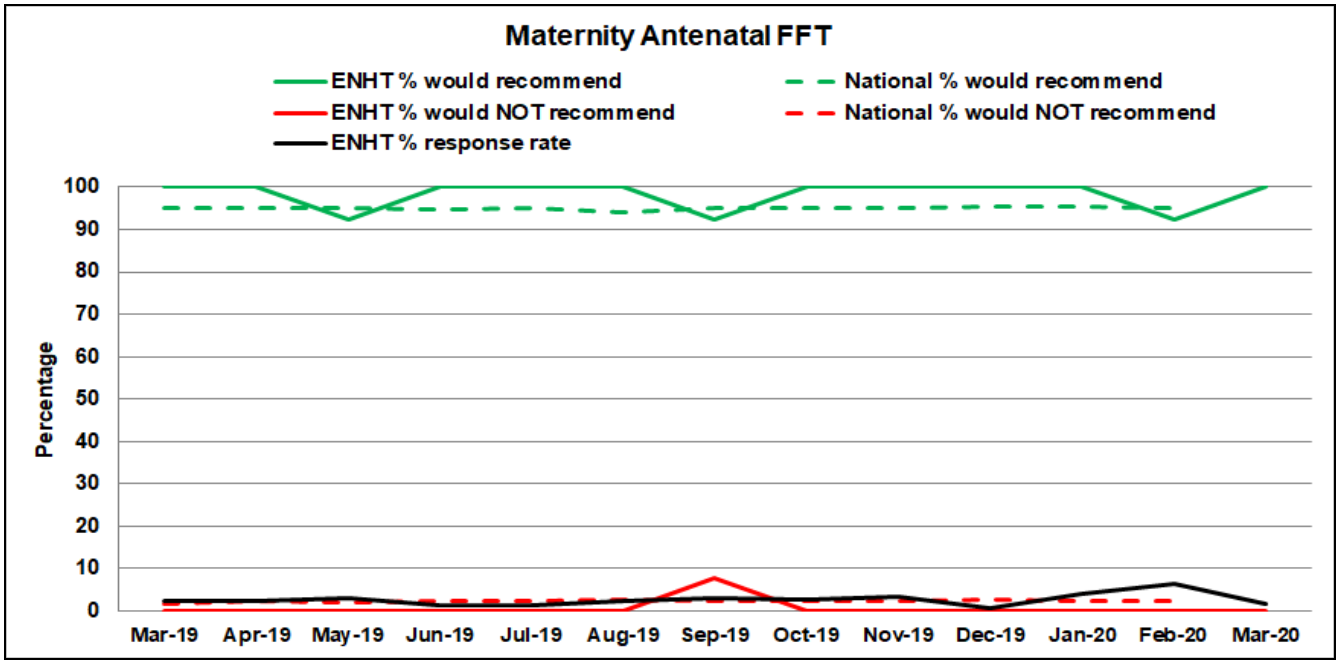


Maternity

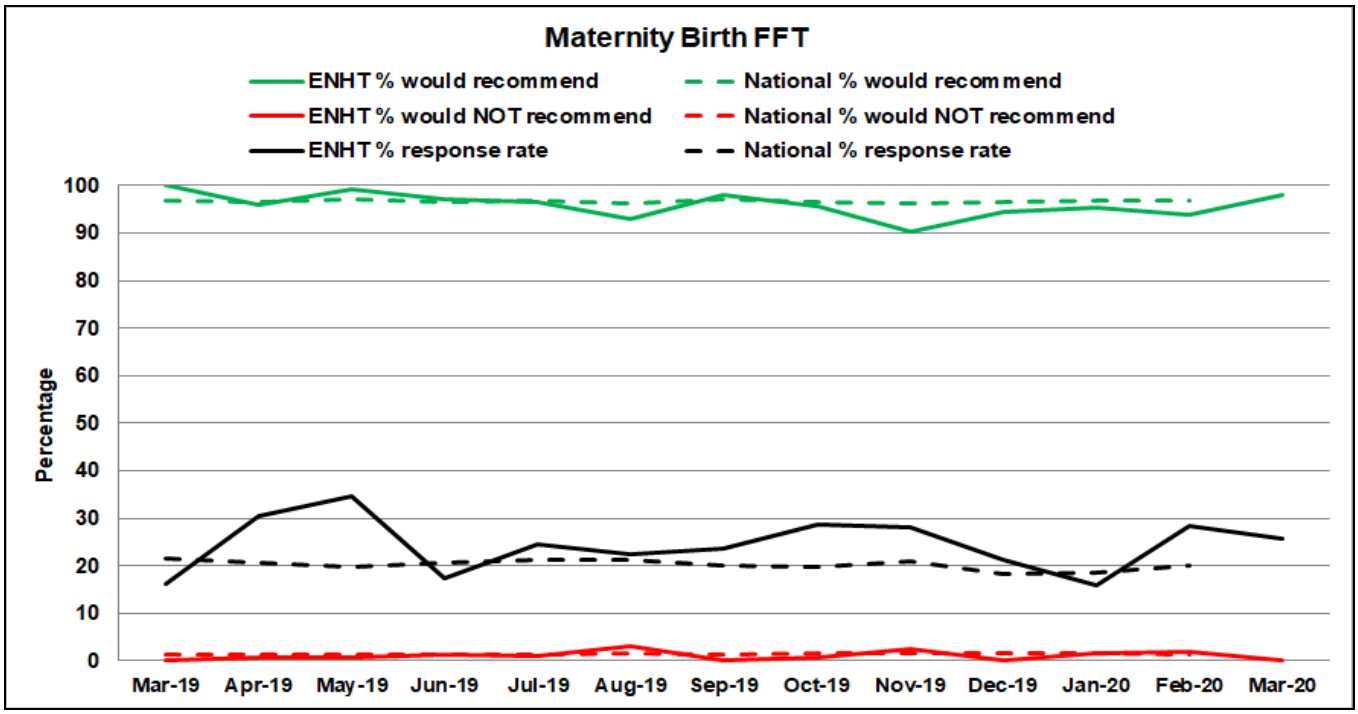
Each woman is asked the FFT question at four stages:

- Antenatal service (at or around 36 week antenatal appointment)
- Birth unit/homebirth
- Postnatal ward
- Postnatal community service (at discharge from care of community midwifery team)

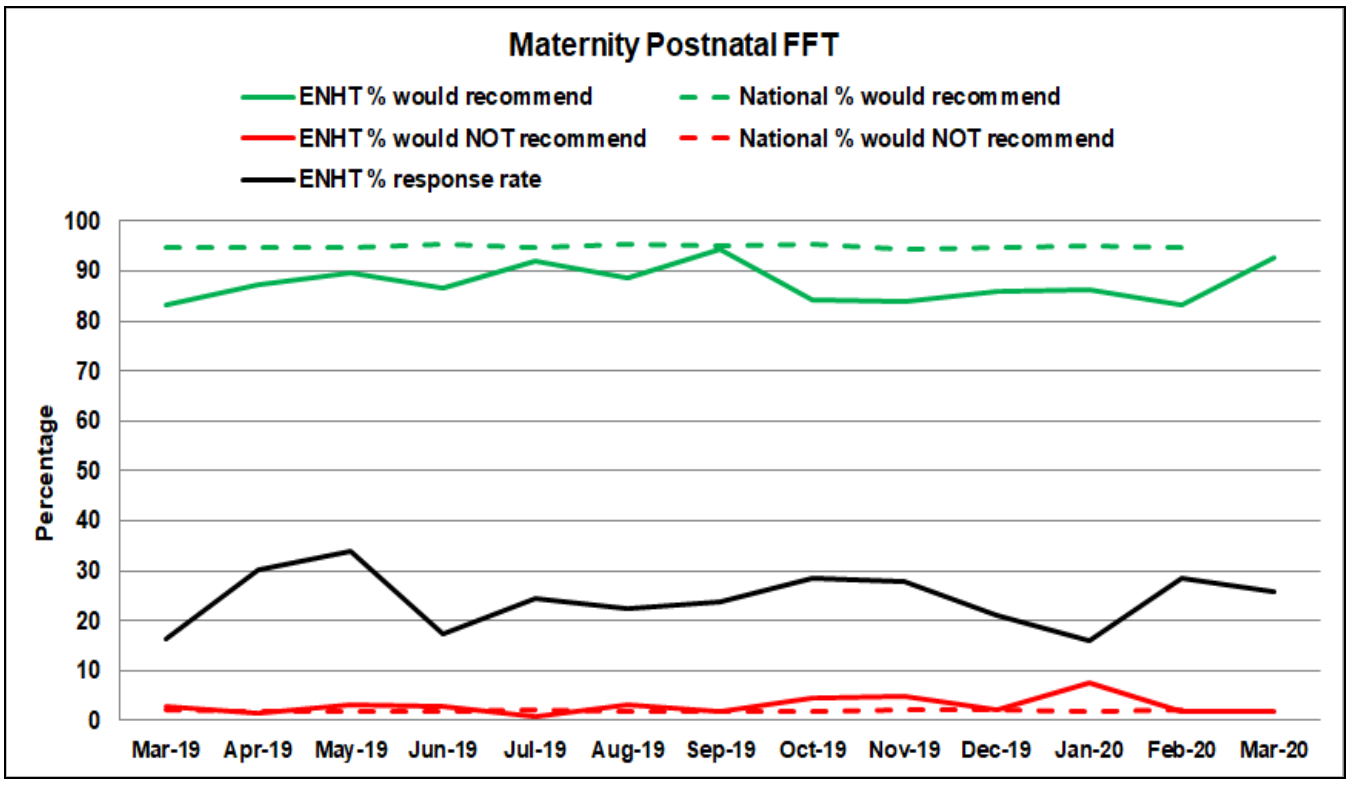
Antenatal



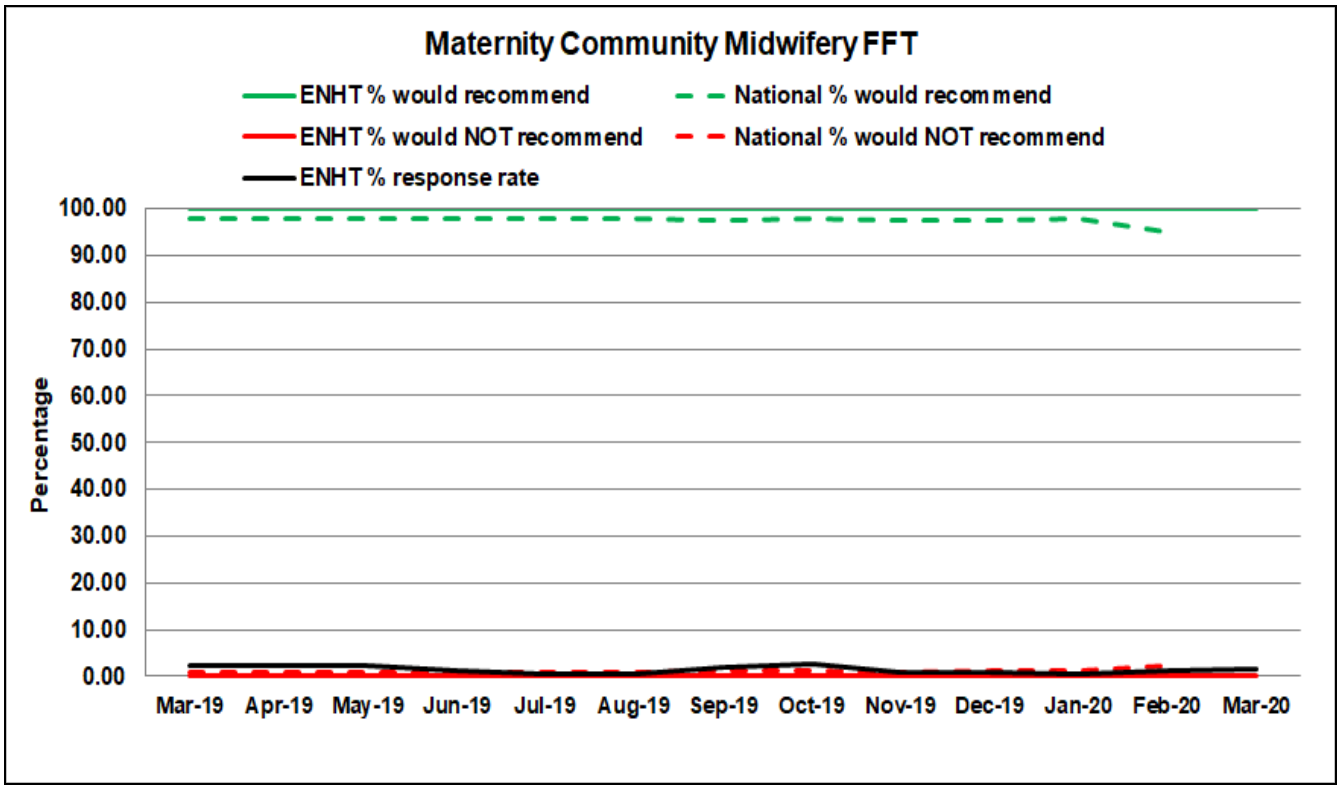
Birth



Postnatal



Community Midwifery



Complaints and Concerns

This report provides a summary of formal complaints received in 2019-20 in accordance with the NHS Complaints Regulations (2009).

The Trust is committed to improving the experience of our patients and complaints and concerns provide valuable information to ensure that learning is identified and changes made to ensure that our patients, carers and relatives have a positive experience.

Users of the services are encouraged to discuss their concerns with staff at the point a problem is identified. However, it may be the case that the patient, carer or relative feels unable to do this, or staff may have tried to resolve the issue but have not achieved this. The Patient Advice and Liaison Service (PALS) provide 'on the spot advice and support' with the aim of timely resolution. In the event that this has not been achieved, PALS will give advice on the formal complaints process.

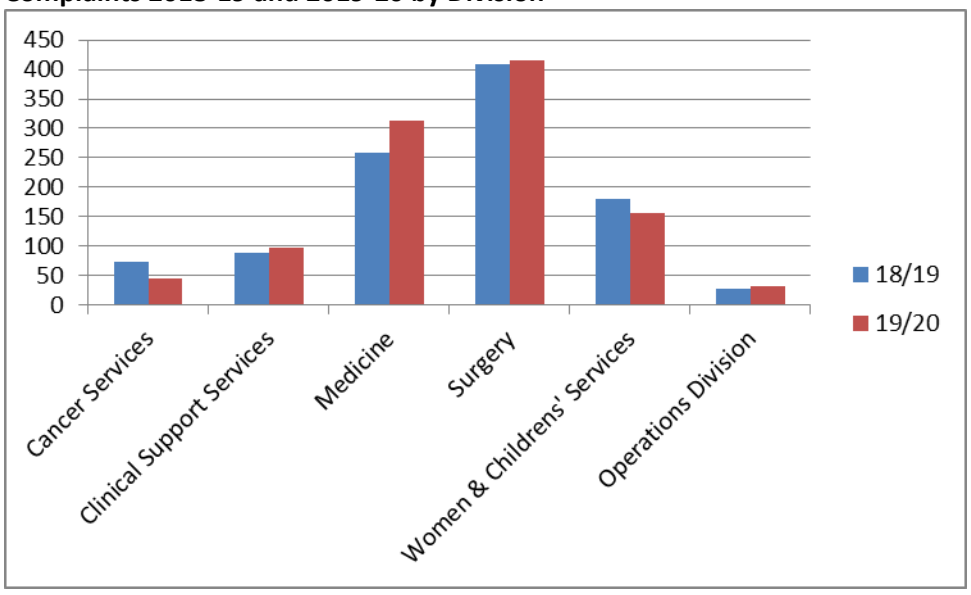
Prior to commencing a formal investigation our complaints team, where possible, telephone patients to try to resolve their complaint informally, particularly if the complaint relates to treatment that the patient is receiving at the time the complaint has been raised.

The Trust recognises the value that learning from complaints and concerns brings. It is vital to make the process simple and easily accessible, and leaflets and posters are displayed throughout the hospital to help facilitate patient and carer feedback.

The following charts provide an indication of the Trust's position during 2018-19 and 2019-20 for complaints and concerns.

In 2019-20 a total of 1,058 complaints were received, this is a slight increase on the number received in 2018-19 (1,036).

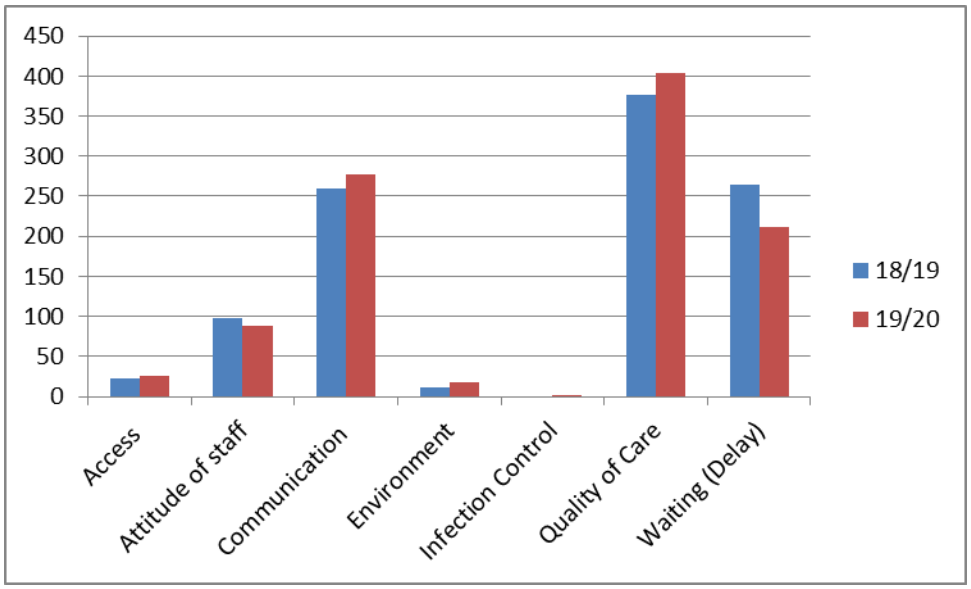
Complaints 2018-19 and 2019-20 by Division



Subject of formal complaints

Complaints data assists with measuring the success of learning. The patient experience strategy set out to reduce complaints relating to treatment/appointments, cancellations of surgery or clinic appointments along with complaints about the quality of treatment provided.

The following table details the primary subject of complaints received over the last two financial years.



Contact with complainants

There is a mandatory requirement to acknowledge all formal complaints within three working days of receipt. In 2019-20, 100% of all complaints received were acknowledged within this timeframe.

Learning from complaints and concerns

Analysis of the themes from complaints and concerns is used to identify areas of the Trust that need additional resources or support to improve patient experience. In, addition the information gathered is compared with other patient experience feedback. Examples of measures taken to improve patient experience following complaints are included in this report.

Parliamentary and Health Service Ombudsman

In 2018-19, 3 investigations were investigated by the PHSO.

In 2019-20, 14 papers were requested. A Cancer Services case was investigated surrounding the communication regarding a cancer patient and an action plan was prepared. This case was partially upheld and closed. The PHSO advised that after a review of a case in relation to quality of care they would not be investigating and had closed the case. The PHSO have paused their service during the COVID-19 Pandemic. We will await their decision on the rest of the cases once they resume their service.

Specialty	Subject	Outcome
Cancer	Communication	Partially upheld
Medicine	Quality of care	PHSO advised would not be investigating

East and North Hertfordshire NHS Trust

Agenda Item: 12.3

TRUST BOARD – PUBLIC SESSION – 2 SEPTEMBER 2020
Annual Report of the Health & Safety Committee

Executive summary: The purpose of the report is to present the Annual Report of the Health & Safety Committee for the reporting period April 2019 to March 2020. *Note: Some confidential information has been removed from this version of the report – the full report was considered by the Quality and Safety Committee on 24 June 2020.*		
Action required: For approval		
Previously considered by: **Health, Safety, Fire & Security Group – 3 June 2020** **QSC – 24 June 2020**		
Director: **Director of Estates & Facilities**	**Presented by:** **Director of Estates & Facilities**	**Author:** **Safety & Security Manager**

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

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

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

Health and Safety Annual Report – 2019 to 2020

1. Aim of Report

To inform the Health, Safety, Fire and Security Group, Trust Board and sub groups of the Trust Board on activities undertaken relating to health, safety and security management and compliance during the period of 1st April 2019 to 31st March 2020.

2. Performance over the reporting period

2019-20 targets aimed to achieve a reduction of incidents compared to last year. The following were achieved:

- Slips, trips, and falls by patients: (from fixings, fittings or maintenance of the estate)
- Sharps injuries to staff:
- Public liability claims by patients and visitors:
- Slips, trips, and falls by staff:
- Employer liability claims by staff:

However, increases were reported in the following incidents:

- Referrals for work related stress: increase of 23%
- Physical assaults of staff: increase of 37.5%
- Musculoskeletal Injuries: increase of 14%
- Slips, trips, and falls by visitors: increase of 25%
- Slips, trips, and falls by staff: increase of 14%

Fire Incidents: There were no significant fires reported during this reporting period

3. Actions and Learning:

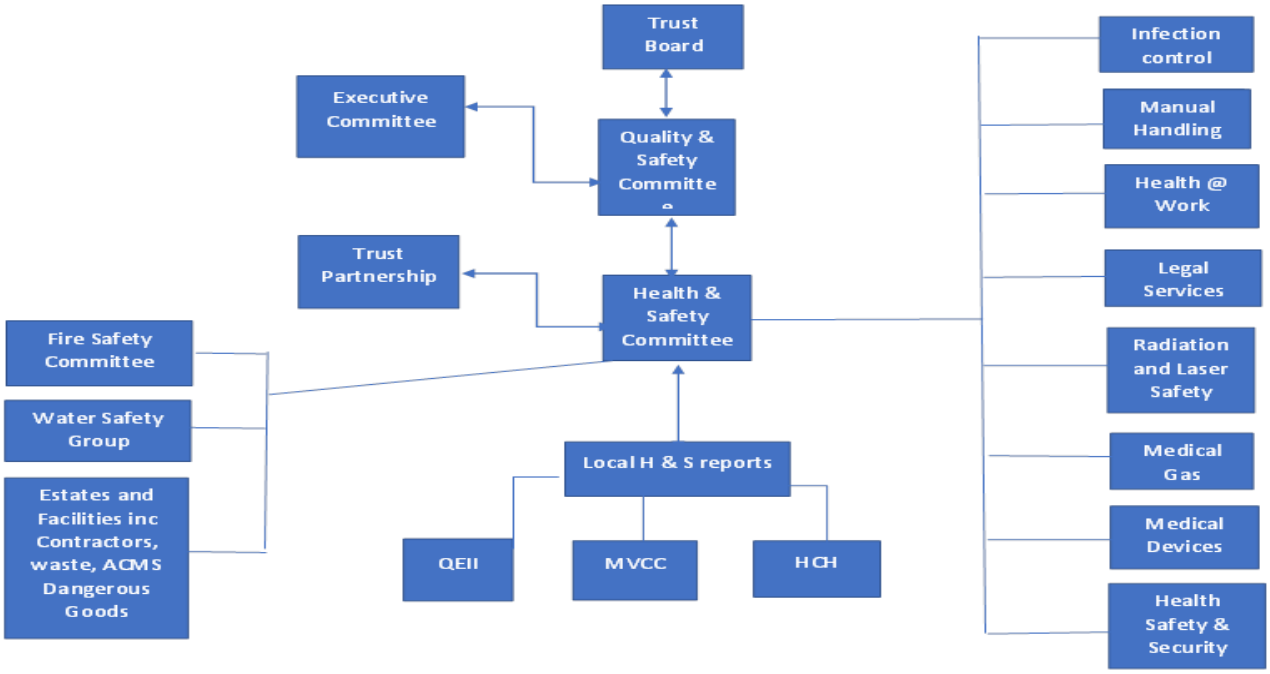
- Investigation of all incidents to ensure that lessons are learnt, and appropriate control measures put in place to prevent a reoccurrence.
- Liaison with the Health@work teams to reduce the number of sharps injuries
- Analysis of sharp and splash injuries to identify trends by device type, procedure, and staff group

4. Strategic Context

This report details Trust-wide health and safety performance throughout 2019- 2020 in order to comply with the Health and Safety at Work Act 1974 and associated statutory regulations, with particular reference to Health and Safety, Fire Safety, Moving and Handling and Health@Work

The Safety and Security team reported to the Associate Director of Corporate Governance during this reporting period. The Health@Work team are accountable to the Director of Workforce and Organisational Development and liaise with the Safety and Security team regarding the management of health risks that affect Trust employees and contractors. The Trusts Security Management is managed by the same team. Since May 2017, the department also has responsibility for fire safety management.

Table 1 Committee Reporting Structure (2019 – 2020)



5. Committees/groups

- The Health and Safety Committee met bi- monthly and was chaired by the Associate Director of Corporate Governance. Both reported to the Quality and Safety Committee and Trust Board.
- A Fire Safety Committee was established in March 2018. The Committee met monthly and included representation from estates, partner organisations, safety team, and representatives from other Trust sites. Meetings changed to bi- monthly on alternate months with the Health & Safety Committee.
- Health and Safety is a regular agenda item at the Trust partnership which meets monthly.
- The Safety and Security Manager attends the Patient Safety Committee and Emergency Response and Resilience Committee.
- Health and safety performance data is reviewed at Divisional Performance Review meetings

6. Monitoring compliance and effectiveness

A monthly set of performance indicators are used to measure health and safety performance; these include a number of Health@work outcomes including skin surveillance and new referrals for work related stress. These metrics were discussed at the Health & Safety Committee, Quality and Safety Committee and Trust Partnership.

Key health and safety metrics are included in the Trust Floodlight Scorecard and reported monthly to the Quality and Safety Committee and Trust Board.

7. RIDDOR Analysis

In the 2019 -2020 reporting period there were 25 RIDDOR reportable incidents; this is an increase of 2 compared to the number reported in 2018- 2019. 24 were injuries to staff and 1 to a visitor.

Of the 24 staff RIDDOR reportable incidents 7 were manual handling injuries, 10 slips, trips or falls and 3 assaults. 4 were associated with exposure to harmful substances, 15 were injuries to workers which resulted in their incapacitation for more than seven days.

Table 2 RIDDOR reportable incidents 2019-2020 by incident type

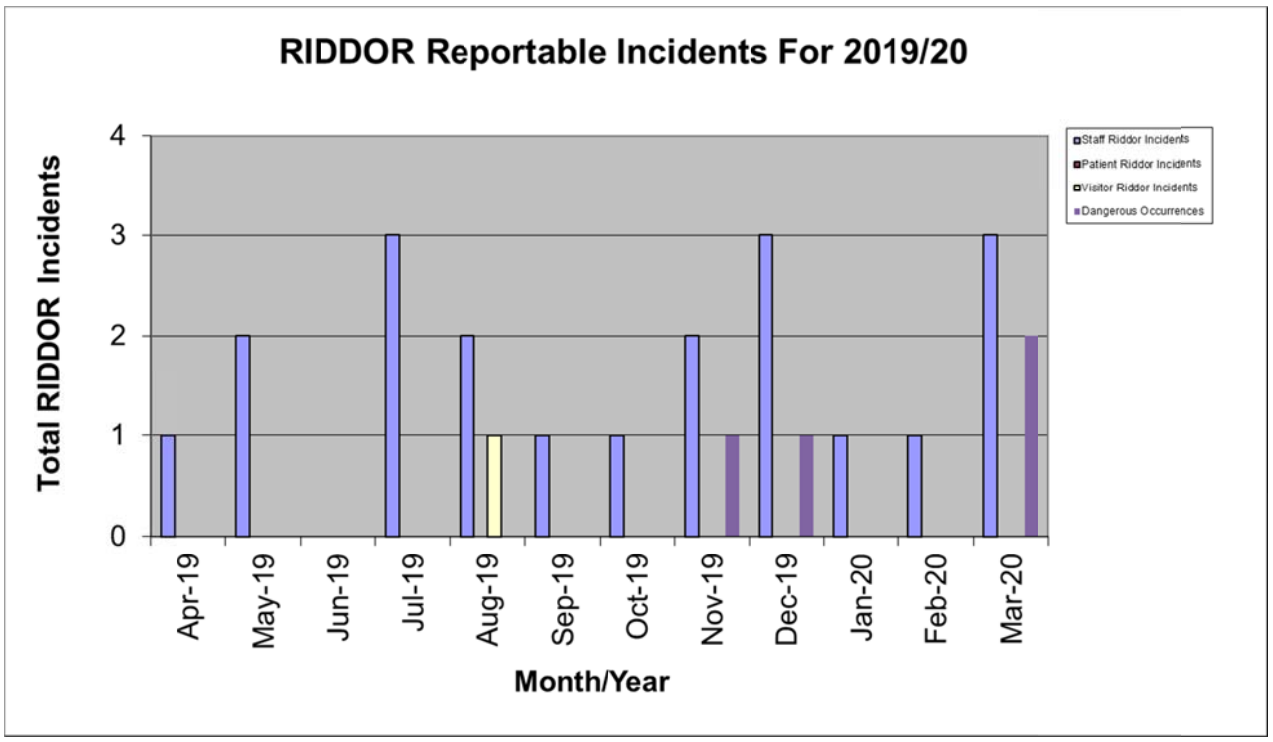
Summary of Incidents (by date of incident)

F2508 Incidents April 2019 - March 2020

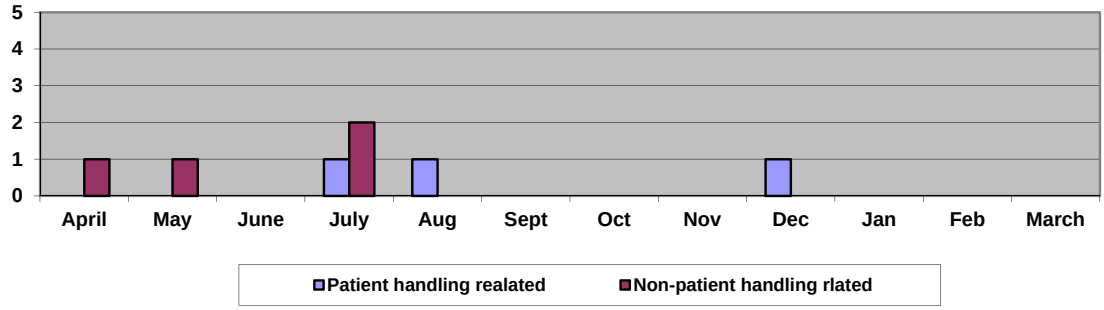
Cause of Injury	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Moving & Handling	1	1		3	1				1			
Exposure to a Harmful Substance								1	1			2
Slip/Trip/Fall		1			1		1	2	1	1	1	2
Fall from Height												
Assault						1			1			1
Hit Something fixed or stationary												
Contact with Moving Machinery												
Another Kind of Accident					1							
Unknown												
Stress												

Outcome of Incidents	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Specific Injury		1			1		1	1				1
>7 Day Injury	1	1		3	2	1		1	3	1	1	1
Dangerous Occurrence								1	1			2

Graph 1 RIDDOR reportable incidents by month



Graph 2 Manual Handling related reportable Injuries by month incident occurred & sub-category



A total of **7** RIDDOR reportable injuries to staff related to moving & handling incidents.
3 patient handling related & 4 non-patient handling related.

(For comparison with the previous year with **9** RIDDOR reportable injuries to staff related to moving & handling incidents; 4 patient handling related & 5 non-patient handling related.)

- There has been a slight decrease in RIDDOR reportable injuries to staff from patient handling related incidents with 3 reported this year in comparison to 4 last year. The previous four-year average has been 7.2 per year.

- There has been slight decrease in RIDDOR reportable injuries to staff involved in object / inanimate load handling incidents with 4 reported this year in comparison to 3 last year, this is however less the previous four year average of just under 6 per year.

  All staff involved continue to be checked for compliance with statutory / mandatory training and followed up as necessary.

8. Incident Analysis

- Physical assaults are the highest cause of injuries to staff; however, the majority have been associated with confused patients and the level of harm caused has been minor.

- Sharps and splash injuries are the second highest cause of injuries.

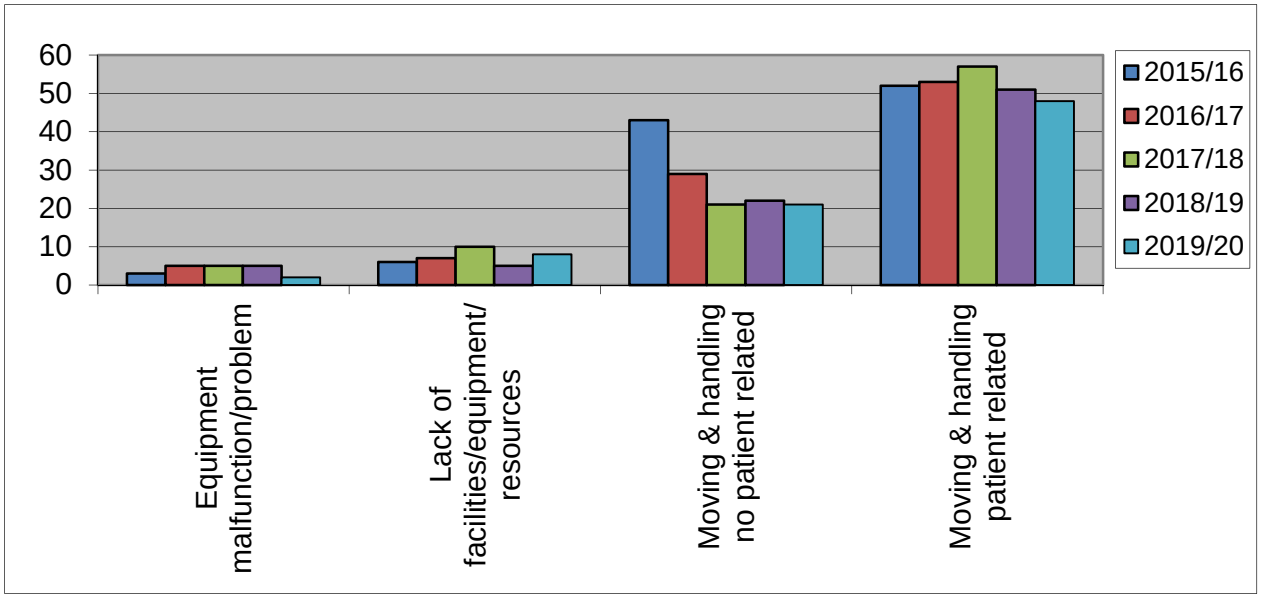
- Slips trips and falls are also a main cause of injury to both staff and visitors

- Incident rates and trends from DATIX have been reviewed bi-monthly, and findings submitted to the Health and Safety Committee

Manual Handling related Incidents

- Incident rates and trends from DATIX have been reviewed bi-monthly, and findings submitted to the Health & Safety Committee.

Graph 3: Incidents by category for the financial year 2019-20 & previous 4 year comparison 2015/16 – 2018/19



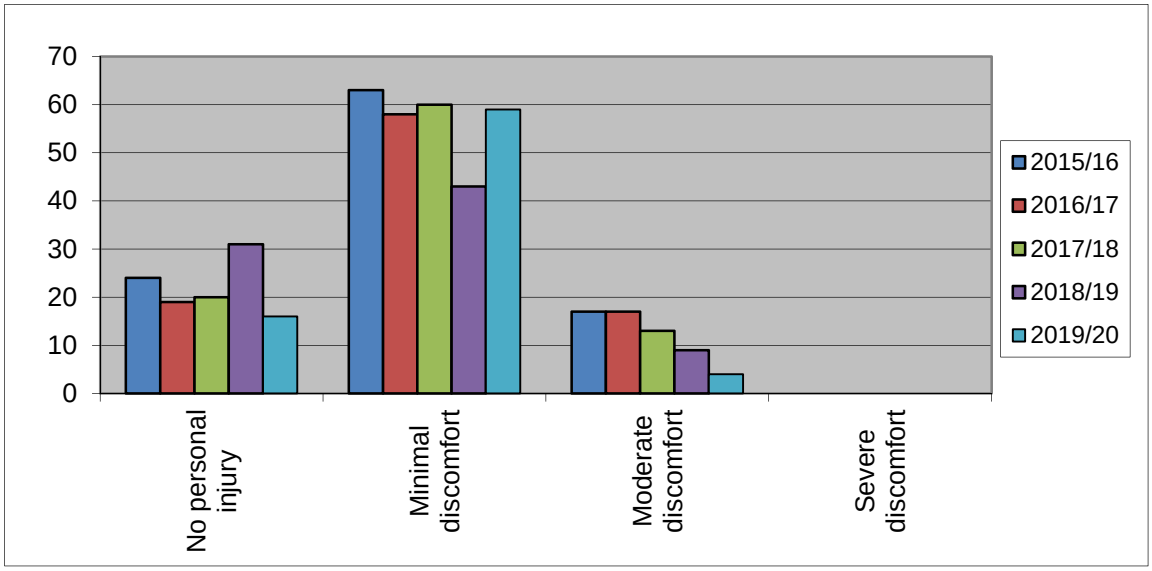
In Summary

Total incidents for this financial year = **79**

48 PH related + 21 Non-PH related + 8 lack of equipment / resources + 2 equipment malfunction / failure)

The year showed a total of **79** incidents reported with the same number of non-patient related / object handling incidents and a slight decrease the number of patient handling related incidents in comparison to last year.

Graph 4: Manual handling incidents by severity for this financial year 2019-20 & previous 4-year comparison 2015/16 – 2018/19

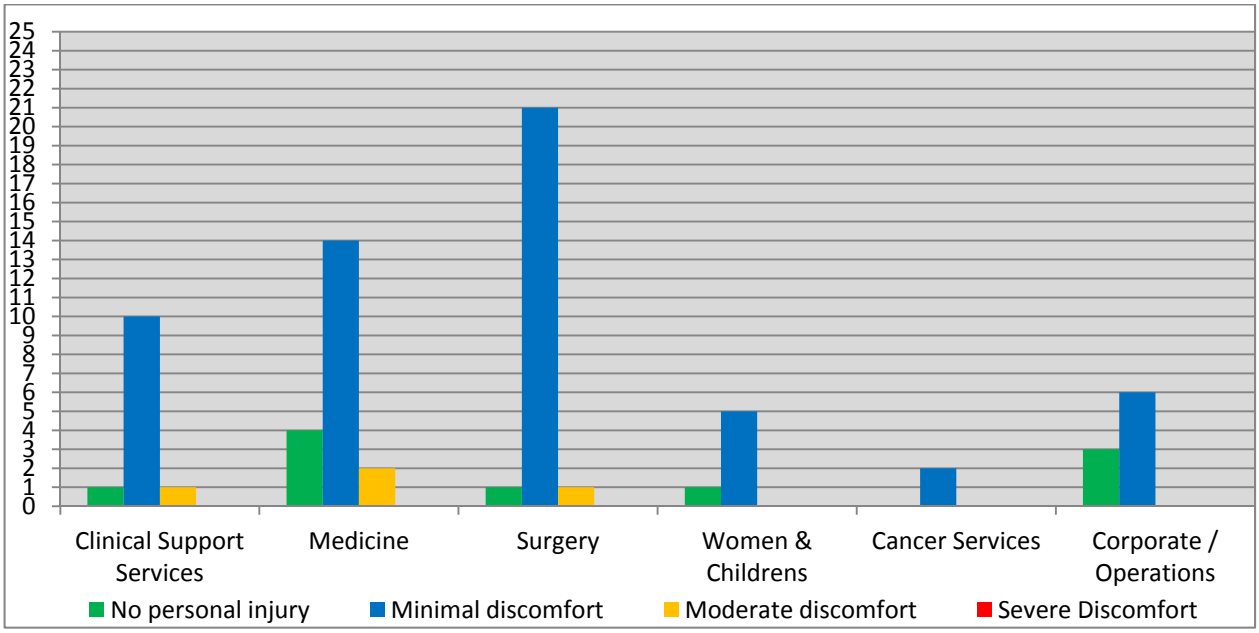


In Summary

The year showed a decreased number in the both the no personal injury and moderate discomfort categories (total of 4 moderate), with no reported incidents in the severe discomfort category. For the fifth straight year no incidents have been reported with a category of severe discomfort at the time of reporting.

There were 2 less RIDDOR reportable injuries than last year.

Graph 5: Manual handling incidents by division & severity for this financial year 2019-20



9. Training

Health and Safety Training

The Health and Safety team delivers health and safety awareness training at Induction and Vital mandatory training days. Safety, security, and conflict resolution training continue to be delivered as part of the VITAL training for all staff; this ensures that staff receive refresher training every two years. Training metrics indicate that 92% of staff are compliant with their Health and Safety and conflict resolution competencies

Table 3: Staff Health & Safety Training

Course	Number of courses run	Number Attended	Cancelled courses
Competent person	14	124	1 (covid)
COSHH	9	21	3 (1covid)
Managers	9	20	4 (2 covid)
Display Screen Equipment	10	56	2
Fire Warden Training	38	278	5 (1 covid)

Medical Gas Training (HTM02 compliance)

The medical gas training is now delivered by staff reading a handout and completing eight questions which are submitted to the Health & Safety Department for checking and if a pass is achieved the member of staff's competency is updated. There is still an expectation that staff receive local training within their individual departments.

Manual Handling Training

Mandatory Moving and Handling Training Courses continue to be provided on both the Trust Induction programmes and the VITAL statutory & mandatory training programmes. Manual handling underpinning knowledge training being provided for both clinical & non-clinical staff, with practical patient handling training given to clinical staff on the use of the Trust's Standard (Operating) Procedures for patient handling and lessons learnt from reported adverse incidents.

In addition to these courses the team provides update and introductory training for Departmental Manual Handling Risk Assessors & Handling Co-ordinators (link workers); introductory training for other staff groups as required such as student nurses.

Table 4:Training Compliance for Moving & Handling training:

2019-20 averages from ESR figures

Staff Group	Course	Competency / frequency	Compliant	Non - Compliant
All Trust staff:	Manual Handling -underpinning knowledge	Moving & Handling / 2 years	**Average for the year = 92.68%**	**Average for the year = 7.32%**
All Clinical staff:	Patient Handling - Induction or update	Moving & Handling for People Handlers / 2 years	**Average for the year = 90.02%**	**Average for the year = 9.98%**

Training Summary

Compliance rates for manual handling training have remained stable relative to last year showing a compliance rate of 93 - 94% for most months. A slight downturn in March is due to the suspension of planned statutory / mandatory training.

Compliance rates for practical patient handling training have shown a slight (1.5%) decline in compliance rate although above 93% for most months. This again is due to the suspension of planned statutory / mandatory training.

Compliance with HSE improvement Notice

Following the HSE inspection in late September, and subsequent improvement notice for moving & handling equipment ENEP01/02/10/2019, a comprehensive action plan has been devised and worked through.

The Trust has owned a significant number of ageing patient hoists and stand aid hoists. A planned program of replacement has been commenced. To date 22 new hoists have been purchased by the Trust between September and February at a cost of circa £67,000. A continued audit / review

of equipment necessary for the lifting and / or moving of patients will further ascertain additional equipment necessary to ensure compliance.

In response to other material breaches further actions have included:

- A full review of all patient handling training – this has been implemented with a planned start date in 2020 with practical training to be included for additional staff groups and include competence on equipment use.
- funding for an additional Band 6 Moving & Handling Advisor to enhance the team has been provided review of patient handling needs assessment documentation has taken place

10. Health and Safety Executive Inspection

The Health and Safety Executive conducted an inspection in September 2019 as part of a national inspection schedule in relation to compliance with the management of violence and aggression and manual handling. As a result of pre inspection data sent to the inspectors, the management of sharps was added to the inspection schedule of the 4 inspectors who attended site for 5 days.
As a result of the inspection, the Trust received 3 notices of contravention, one in relation to the management of violence and aggression, one for manual handling and one for the management of sharps. An action plan has been developed to address all of the issues identified and work is on-going to complete the actions and discharge each of the notices. The progress is monitored by the Health & Safety Committee.

11. Policies

All health, safety and security policies are available for staff to access via the Health & Safety pages of the Knowledge Centre. Master copies have been retained on each of the Trust sites to ensure access can be maintained in the event of any Information Technology or electrical interruptions.

12. Health & Safety Red File Audit

During 2019-2020 the audit process was based on the completion of a short, simple audit with four questions emailed to departmental/ ward managers monthly using the Median survey tool. Managers open the link to the Trusts Health & Safety audit tool page and submit the answers to the questions asked. There is one action per question. The website provides an up to date dashboard so that at any time the safety team can view who has started the audit, who has completed it and who has not done anything at all.
Audit questions are based on the Trusts Health & Safety Strategy and additional questions focus on emerging issues and incidents as they arise. The intention is to provide a quick and simple check of compliance that staff find easy to complete and also incorporates some questions in relation to Fire Safety.

13 Legal Services

East & North Hertfordshire NHS Trust is a member of the NHS Resolution Risk Pooling Scheme for Trusts (RPST), which, subject to the membership rules, indemnifies the Trust for non-clinical claims. These claims fall into two categories. **Employer Liability (EL)** claims are those made by Trust employees who have injured themselves during the course of their employment. **Public Liability (PL)** claims are those made by visitors whilst on Trust premises and have to be considered in view of the Trust's responsibility to provide a safe place for the public. In addition, the Trust has indemnity under the **Property Expenses Scheme (PES)** for damage to its buildings and other related expenses such as business interruption.

Table 5: Excess levels for all categories of these claims as detailed below:

Scheme	Excess level
Employers Liability (EL)	£10,000
Public Liability (PL)	£3,000
Property Expenses (PES)	£20,000

Table 6: Trust contributions

Scheme	2016/17	2017/18	2018/19	2019/20	2020/21
EL & PL	£213,048	£189,683	£188,730	£158,142	£191,870
PES	£16,906	£15,829	£47,349	£24,737	£31,680

Graph 6: The number of new non-clinical claims received by type over the last five financial years. It is pleasing to note the decrease in new claims received this year by members of the public. Further detail of the new employer and public liability claims received in 2019/20 was provided at the Quality and Safety Committee meeting.

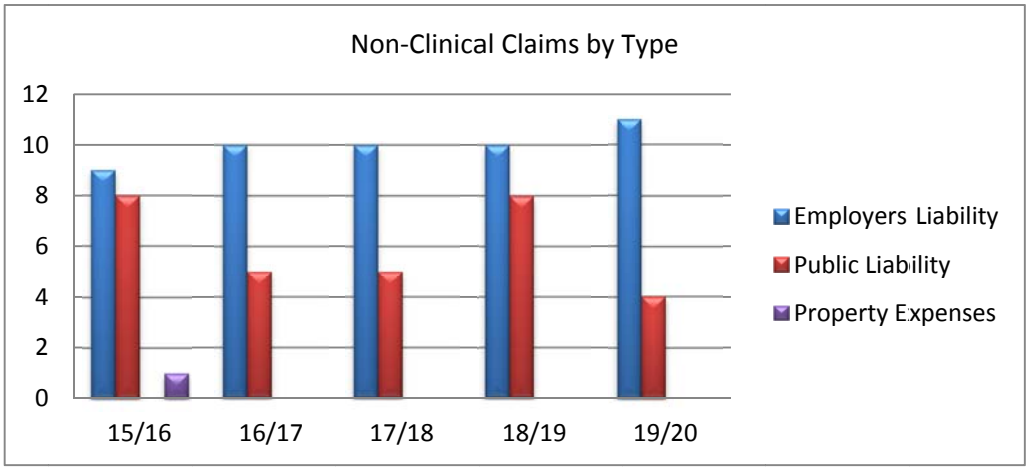


Table 7: New claims received by incident type over the last 3 financial years: The case in the category 'other' relates to an accidental burn injury. Slips, trips and falls have consistently been the highest incident type.

	17/18	18/19	19/20	Total
Slip/Trip/Fall (Indoors)	2	2	3	7
Slip/Trip/Fall (Outdoors)	1	4	1	6
Struck by building fabric/equipment	2	1	3	6
Moving and Handling (Patient / equipment)	2	1	0	3
Needle stick Injury	0	1	1	2
Verbal/Physical Assault by Patient	1	0	1	2
Other	0	0	1	1
Faulty Equipment	1	0	0	1
Exposure to dust/asbestos/chemicals	0	0	1	1

Comparative data and Monitoring

Regrettably due to issues with NHS Resolution's extranet, there is no benchmarking data available at present. This will be monitored, and an exception report provided to the Committee when the data becomes available.
All new claims are reported to the bi-monthly Health and Safety Committee along with any themes and trends. In addition, any learning/notable points identified from investigations is shared both with the Divisions directly and at the Committee.

Closed Claims

In 2019/20 a total of 18 employer and public liability claims were closed. Of these, 4 were settled (22%) and the rest were repudiated / withdrawn. Further detail on the 2019/20 closed cases, along with reasons for settlement / successful defence, was provided at the Quality and Safety Committee meeting. This low settlement figure is an improvement on previous years; in 2018/19 we settled 50% of closed cases and in 2017/18 we settled 37%.

Table 8 Comparative breakdown of the financial details

	2017/18 (financial year)	2018/19 (financial year)	2019/20 (financial year)
Damages	£26,047	£42,653	£28,700
Claimant's Solicitors costs	£21,909	£18,203	£70,442
Defence Solicitors costs	£4,167	£298	£40,461
Total payments	£52,123	£61,154	£139,603

Summary

Although the investigations carried out into new claims made seek to identify any learning or risk reduction measures, it should be noted that where the date of the incident predates the claim by a significant time, working methods and environmental factors might well have changed in the interim. The successful defence of claims is reliant upon good documentation – incident forms, witness statements, risk assessments, maintenance records etc. The centralisation of training records on ESR has been helpful.

15. Estates and Facilities

Fire Safety

Please refer to the Annual Fire Safety Committee report for more detailed information.

Management of Contractors

The electronic logging system remains in use for contractors attending site to be checked and signed in, thereby authoring access and works programmed through the site. This controls he access given to contractors ensuring that they have submitted and had approval on works RAMS for each visit. The Control of Contractors Policy is to be rewritten to add further controls on the contractors visiting and undertaking works on Trust sites

Water Safety

The Water Safety Policy is complete and has been approved by the Trust's WSG. This has now been escalated for ratification for completion
A "Part 1" water safety plan has been drafted dated October 2019 and is available to view on the Estates V: Drive
The 2018 water risk assessments are to be superseded by newly commissioned reports in 2020. Due to Covid-19 lockdown it is not clear when these will be able to take place as access to all areas of the hospital is required. A tender specification has been prepared but the work has not yet gone to tender.

Flushing infrequently used outlets

The issues at Lister hospital with local ownership on the flushing of these outlets has improved with the reporting of these events having increased, there are still some locations where forms are being returned spasmodically by a combination of ward staff, G4S & housekeeping staff. It can be seen from the reduction in water sample positives found for Legionella and Pseudomonas that staff awareness and the increased flushing of water outlets is having a direct effect. These improvements can be, in part, directly attributed to the IP&C team involvement when carrying out their ward audits; however there is still room for improvement in the continuing identification of outlets which become infrequently used which will help maintain the improvement found in our water quality. The WSG reiterates that it is the responsibility of the 'user' of the water system to flush any infrequently used outlets within their area of responsibility and that Estates only pick up the outlets in areas not occupied or that become temporarily unoccupied for any reason.

Waste

The collapse of the Trust's clinical waste contractor in December 2018 led to the utilisation of a national recovery/contingency contract. The issues that surrounded lack of service to the Trust from the contingency contractor led to the appointment of a new, local clinical waste contractor, Novus with effect from 1st April 2019.
Receipt of additional 770 litre bins in July enabled moving toward a full bin exchange service. As with any new contract, there were some service issues, however, these have since been resolved with Novus taking delivery of a double deck lorry, which has reduced the number of daily collections needed to service Lister site, ensuring a complete site clearance on a daily basis.
NHS England-Improvement set up a working group in early 2020, with the aim to define and implement national standards regarding NHS waste disposal and with a view to re-writing HTM07-01 in order to provide better guidance and structure within NHS Trusts. East and North Herts NHS Trust is represented on this group. This project is currently on hold as a result of the Covid-19 emergency.
A number of issues relating to incorrect disposal of sharps waste resulted in a Trust-wide approach to investigate why there were so many issues and what measures needed to be in place to ensure that staff have the ability and the correct equipment needed to dispose of sharps correctly.
The Covid-19 emergency has seen the continuation of the increase in clinical waste produced by the Trust, particularly at Lister and QEII sites. Whilst there is a significant overall increase in the total quantity of clinical waste disposed of, the mix of waste types has changed. The quantity of waste requiring high temperature incineration remains, relatively static and the quantity of offensive (tiger) waste has reduced. The significant increase is in the orange (infectious/AT) waste stream. This would be expected during such a crisis as a result of additional PPE disposal and increase in the number of infectious patients treated at any one time. This trend is expected to continue during the 2020/2021 financial year.

Asbestos monitoring and management

Details from any new asbestos survey reports, removals/encapsulations as from March 2020 is to enter in to temporary excel spreadsheet until new survey is carried out by new appointed survey company (AEC). The temporary excel spreadsheet register shall migrate to planet database system once the Planet is commissioned and full training is given to Estate staff on Health &Safety module.
No incidents have been reported in relation to accidental disturbance of Asbestos Containing Materials (ACM) throughout the course of the year at the Lister Hospital site.
Asbestos removal on 6BN in the clean utility AIB board removed at high level.

16. Health@ work Service

Table 9: Skin Surveillance

Skin Health surveillance	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total
Skin health questionnaires	**97**	**57**	**78**	**108**	**91**	**100**	**60**	**54**	**43**	**54**	**64**	**27**	**833**
Initial face to face assessments	1	0	1	3	5	2	0	4	3	1	0	0	**20**
Review assessments face to face	3	2	2	2	5	3	1	4	3	2	7	4	**38**
Telephone assessments	2	1	1	0	1	1	2	4	1	1	3	4	**21**
New management referral for contact dermatitis	0	0	0	0	0	0	0	0	0	0	0	0	**0**
New self-referral for contact dermatitis	0	0	0	0	0	0	0	0	0	0	0	0	**0**
New diagnosed cases of contact dermatitis	0	0	0	0	0	0	0	0	0	0	0	0	**0**
New diagnosed cases of latex allergy	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Number of referrals to dermatology	0	0	0	0	0	0	0	0	0	0	0	0	**0**

Table 10: Referrals for Stress at Work

New management referrals - work related stress	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total
Total	**5**	**6**	**4**	**5**	**5**	**6**	**11**	**7**	**6**	0	**9**	**4**	**76**

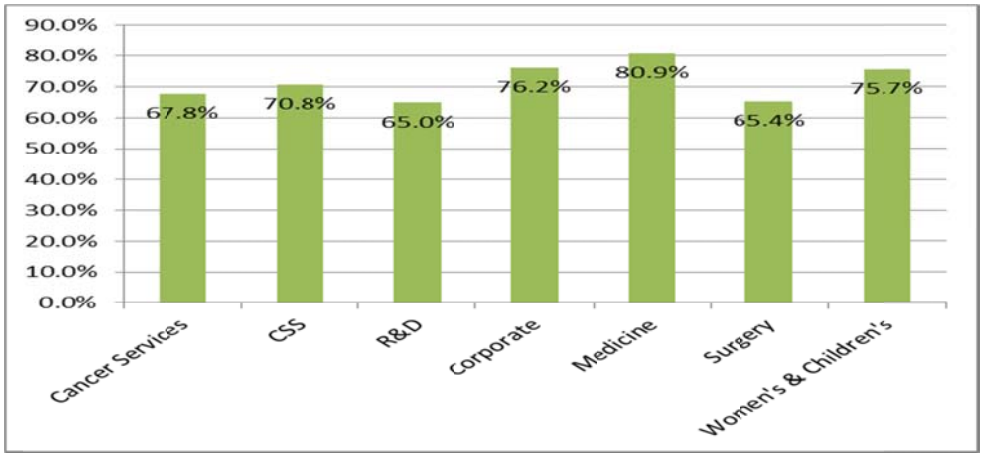
Table 11 Support referrals

Wellbeing	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total
Fast track physiotherapy referrals	3	10	11	3	9	6	9	17	8	10	9	0	**77**
Employee Assistance Programme: Calls	21	30	27	20	29	33	25	34	44	49	16	43	**371**
Employee Assistance Programme: Web hits	60	37	39	26	9	46	34	5	19	5	22	16	**318**
Referral for online CBT	4	2	0	1	0	0	1	0	0	0	0	0	**8**

Staff flu vaccine uptake

Staff were offered flu vaccines between October 2019 and February 2020, vaccination of health care workers protects them and reduces the risk of them spreading flu to their patients, colleagues, and family members. Our ambition was to vaccinate all staff with direct patient contact. 3114 frontline staff received the vaccine; this represents 73.1%, which is 7.5 percentage points higher than last year. 505 (11.8%) frontline staff chose to decline the vaccine. In addition, vaccines were received by 559 non-frontline staff and 476 other temporary workers, students, and volunteers. The most successful division was Medicine where 80.9% of frontline staff were vaccinated.

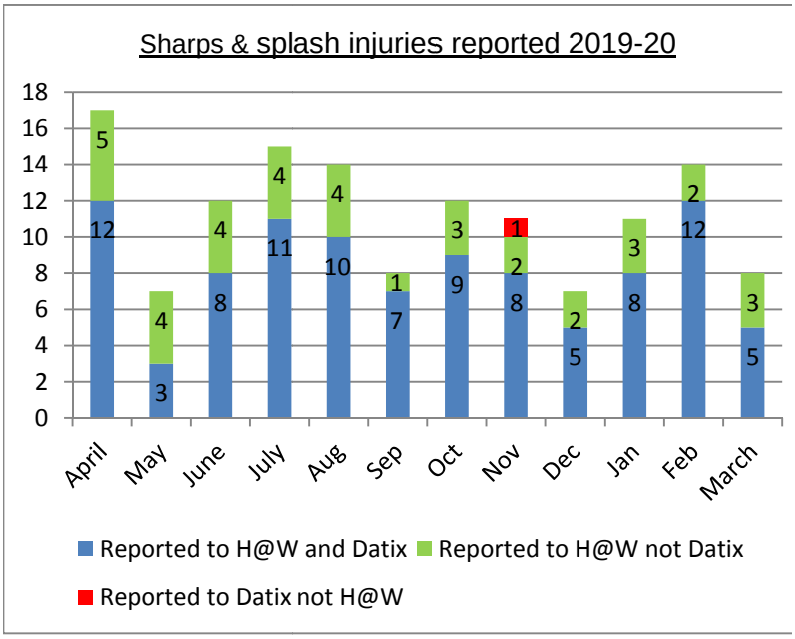
Graph 7: Divisional Flu vaccination results



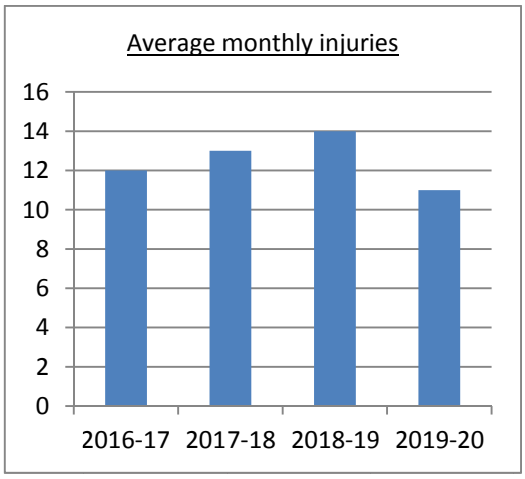
Sharps and splash injuries

Graph 8: Sharps and Splash injuries

In total there have been 136 injuries reported, an average of 11 a month which demonstrates an improvement in injury prevention.



Graph 9: Comparison of monthly average for the last 4 years



Graph 10: Comparison of sharps and splash injuries over the last 2 years

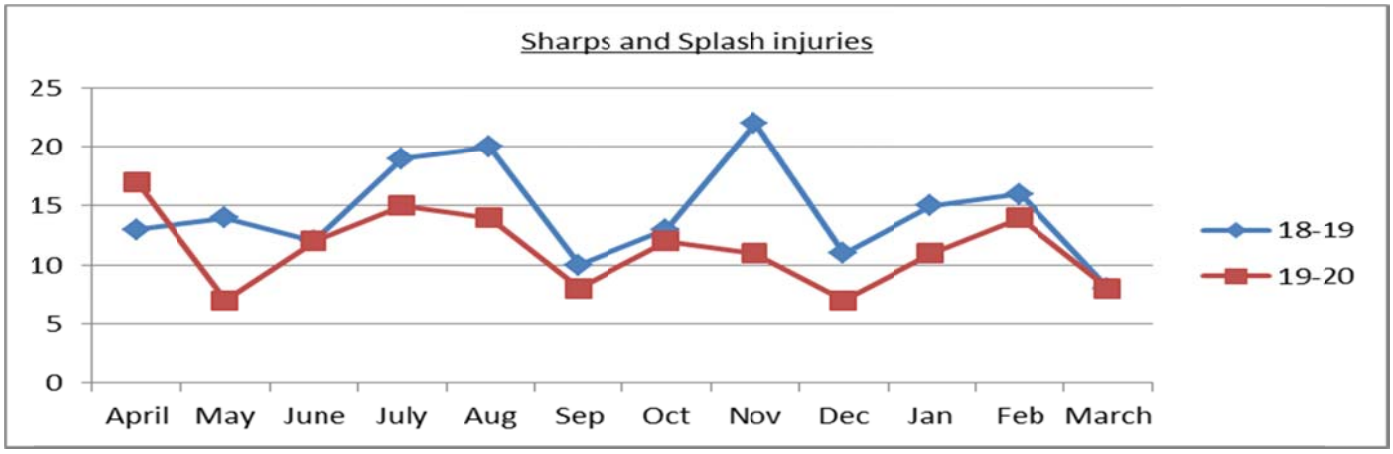
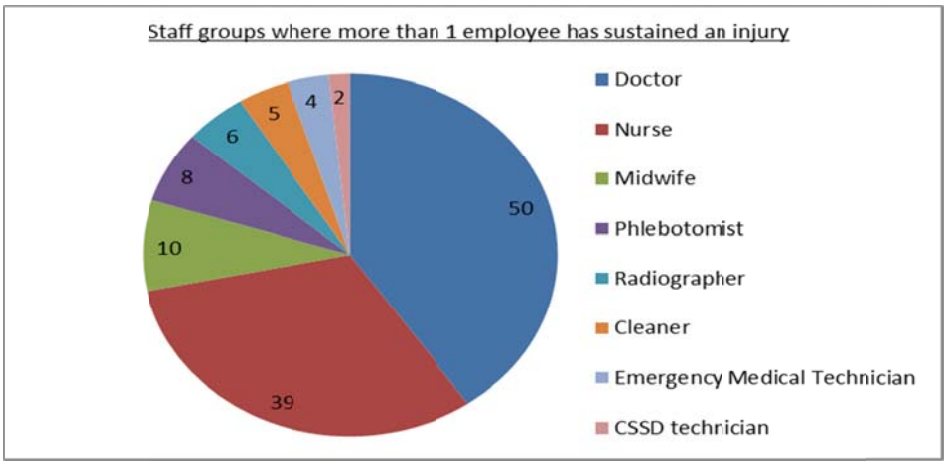


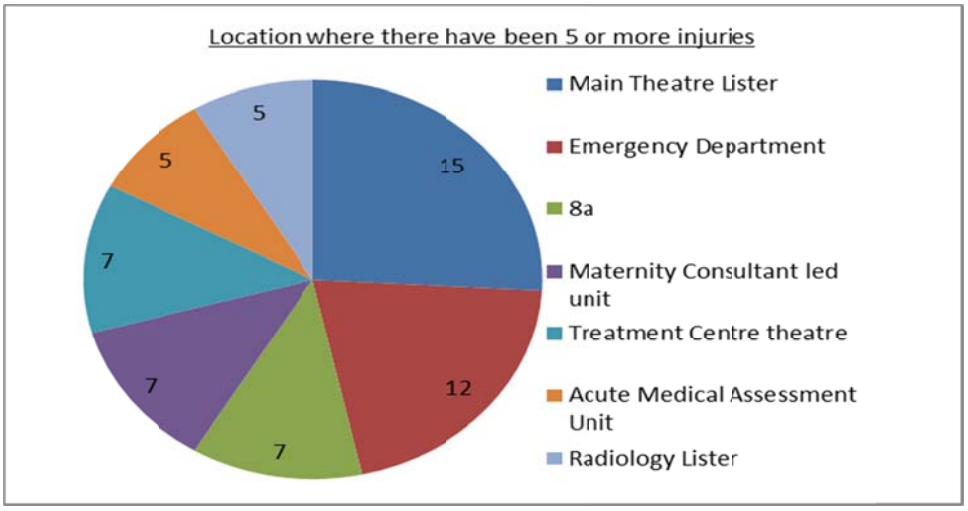
Table 12: Injury data obtained by other Trusts identifies the rate of injury per 1,000 employees is lower at ENHT than most of our neighbours. However, no preventable injury is acceptable and further improvements are required.

	West Herts	**ENHT**	Addenbrookes	Luton & Dunstable	Milton Keynes	Bedford	Princess Alexandra
Employees	5000	**5991**	10,842	4,523	3,800	2,700	3,617
Average monthly sharps & splash injuries	7	**11**	21.4	10.25	10.5	8	Not provided
Average monthly injuries per 1000 employees	1.4	**1.83**	1.97	2.26	2.76	2.96	

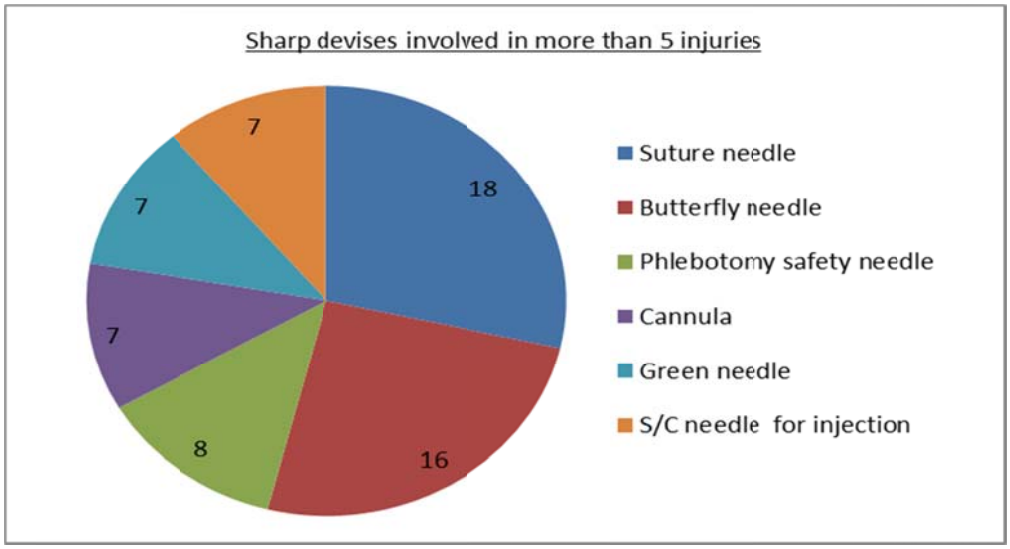
Graph 11: Summary of injuries reported 2019-20



Most injuries were sustained by doctors and nurses. Injuries occurred in 50 different locations, but most commonly in the following:



There were 23 splash injuries and 40 different sharp objects involved in injuries, the most common of which are:



Many of the injuries were preventable, the top 3 avoidable causes were:

Incorrectly closing 'safety needle'	14
Not wearing a visor	15
Not immediately disposing of sharps at point of use into a sharps bin	25

Covid-19

As the NHS faces one of the most challenging times in its history the Trust is ensuring that staff health and wellbeing given high priority. An enhanced level of mental and physical support has been provided to vast numbers of staff who are affected by Covid-19. The Health at Work team has expanded its support and advisory helpdesk and is providing health advice to safely maximise the number of healthcare workers available to care for patients. A call handling system has been operational since the 16th March since this time 3084 calls have been answered regarding Covid-19.

Support and guidance is offered to managers and staff where staff may be more vulnerable to COVID-19, such as those with underlying health conditions around reasonable adjustments and redeployment. Advice can be offered on return to work after testing, isolation or illness, safe deployment of volunteers and temporary staff and mental health support. Information around frequently asked questions is undated frequently and available on the knowledge centre.

Staff testing for Covid-19
Clinical staff who have symptoms of COVID-19 (or have a household member who has symptoms of COVID-19) are being referred for testing.

Enhanced support
The coffee lounge is being transformed to provide rest relax refuel and reflect areas, free refreshments are kindly provided through donations.

The ‘How are you doing?’ team are offering individual and team support, advice and facilitated debriefing. A ‘How are you doing’ hub has been established in the Lister community hub to provide a central location for sourcing information and help. A range of online self-help resources, a series of tools to support yourself and your team and opportunities for support such as mindfulness sessions, the employee counselling and support service and the national NHS staff helpline have been publicised. Drop-in sessions have been offered at Lister, QEII, Mount Vernon, Hertford County and Wiltron House for staff to seek confidential support and where appropriate onward referral for counselling, CBT or other support services.

HowAreYouDoingTeam

As a team we are growing and would love you to join and support our work and commit to our HowAreYouDoing Charter, to take care of ourselves and others. We will continue to share news, stories, tools and interventions and will connect to other organisations so we can learn and share as we go. More services will be added as we grow and learn.

Help spaces - To relax, refresh and find support

HowAreYouDoing Hub

This is at the Lister (Community hub) - contains plenty of supportive information that is updated, usually staffed by one of the team, has an appreciation wall for the positive stories and good wishes we receive and a feedback area. Please visit and see how we can help.

HowAreYouDoing Rest, Relax and Refresh Area

This is at the Lister (staff coffee lounge) - will be kitted out with comfortable furniture, music, refreshments and support. Please visit and take a few minutes to rest.

HowAreYouDoing Staff Support Area

This area - yet to be confirmed - will provide space to drop in, talk to one of the team, make appointments for 1:1 support, pick up information, attend bitesize training, hold group debriefs.

Pay it Forward

We offer to provide acts of kindness to you and simply ask you to do the same to others.

Interventions - Accessible to you and your team

1:1 Support

We offer individual support and can tailor this to your needs be it coaching, mentoring or psychological support or someone to hear your concerns.

Structure Debriefs (lessons learned and psychological support)

We offer to facilitate debriefs for your team and work with you and your team to provide support. We can also train you and your team members to run your own team briefs.

Group Support

We offer to work with your team if they need support and guidance; this can be for any subject matter and we can tailor to suit your needs.

Bite Size Learning

We offer a range of structured learning sessions to use with your teams, to support you to lead in difficult times, have challenging conversations and more - your suggestions are welcomed.

Link Support

We offer to link you to the support either you or your team need. For some areas you will be linked with one of our team members, if you would like a link for your area please get in touch.

Mindfulness and Exercise

We offer to provide you with a wide range of support tools, links and leaflets to help reduce anxiety and stress levels, please visit our hub for information and advice.

We are here to help you, for support for you and your team please:

Visit: HowAreYouDoing hub, level 3 @ Lister
Email: howareyoudoing.enh-tr@nhs.net
Phone: 07551311667 for training support
KC: Home Page / Coronavirus / HowAreYouDoing

17. Infection Prevention & Control

The Infection Prevention and Control Team provide updates to the Health and Safety Committee and produce their own annual report for The Infection Prevention and Control Committee. Please refer to the Infection Prevention and Control annual report for further information.

18. Security Management

The results of the National Staff Survey show that the percentage of staff experiencing violence from patients, carers and visitors is 14.7% compared to the National Average for acute trusts of 15.1%. Further work is required to ensure that all incidents are documented and that we have accurate records of the level of violence and aggression experienced by staff across the Trust.

Table 13 Comparison of incidents from this year and previous year

2019 – 2020 incidents by category	
Aggressive behaviour (non-physical assault)	48
Inappropriate behaviour	18
Verbal abuse	196
Assault (physical contact made)	162
Totals:	424

2018 - 2019 incidents by category	
Aggressive behaviour (non physical assault)	39
Inappropriate behaviour	11
Verbal abuse	93
Assault (physical contact made)	120
Totals:	263

The figures show an increase in the number of incidents of violence and aggression reported by staff compared to those reported in the previous year which follows the trend reported across the NHS. Of the assaults, 3 were RIDDOR reportable with the injured staff off work for 7 days or longer. Fortunately, the level of physical harm caused in all incidents was low and the majority associated with mental health service users, confused patients, and those under the influence of drugs or alcohol.

Improvements completed in 2019/2020

An additional security officer was introduced into Emergency Department, to address challenging behaviour and provide reassurance to staff and visitors

A Breakaway training programme to reduce the number of incidents of violence and aggression was introduced. Staff from the Emergency Department and the enhanced care team attended the training. A 12-month training programme has been arranged prioritising the training of staff in high risk areas as part of the HSE Action plan, however this was temporarily suspended as a result of the Coronavirus pandemic.

A Violence and Aggression workshop was held in February providing an opportunity for staff and partners to discuss the management of violence and aggression within the Trust. As a result of the feedback, the Violence and Aggression policy has been revised and improved liaison with Herts Constabulary aims to increase the use of both Police and Trust sanctions for patients and visitors who abuse staff.

The Trust continues to benefit from a good collaborative partnership with Hertfordshire Constabulary. The regular attendance of a dedicated Police Community Support Officer on the Lister site has been well received by staff, patients, and visitors

The use of body worn cameras by the security officers has helped to improve the prosecution of offenders

Monitoring compliance & effectiveness

Daily checks of the Datix incident reporting system are completed to identify security incidents and ensure that appropriate actions have been taken. Incidents of physical assault are reported within the monthly health & safety metrics reported to the Health and Safety Committee.

Incidents of note:

Police Reports

Police have confirmed that crimes recorded for the Lister site continue to decline when compared with historical data. Police crime figures associated with the site also include the incidents associated with the assault of police officers and public order offences associated with patients in police custody.

The continued reduction of incidents can be attributed to an improved security service and the systems and processes in place. The installation of the patient property safes has reduced incidents of theft of patient property. The use of CCTV continues to be an effective deterrent. and has secured successful prosecutions over recent months.

Carlisle Support Services provide the security on behalf of the Trust supporting, Lister, QEII and alarm responses for HCH and GWP.

19. Conclusion

2019-2020 has been a challenging year. The Trust aims to make further sustainable improvements in 2020--2021. Raising the profile of Health, Safety, Fire and Security .Improving the safety culture will mitigate the risks associated with the management of safety and security; ensure statutory compliance and the health, safety, security and welfare of our staff, patients and visitors.

20. Recommendation

The Trust Board are asked to note the contents of this report and note the performance of the Health and Safety Department and Specialist Advisors in delivering its Statutory Health, Safety, Fire and Security responsibilities.

East and North Hertfordshire NHS Trust

Agenda Item: 13

TRUST BOARD - PUBLIC SESSION – 2 SEPTEMBER 2020

AUDIT COMMITTEE – MEETING HELD ON 20 JULY 2020
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present the summary report from the Audit Committee meeting of 20 July 2020 to the Trust Board. The report includes details of decisions made by the Audit Committee under delegated authority.		
Action required: For discussion		
Previously considered by: **N/A**		
Director: Chair of Audit Committee	**Presented by:** Chair of Audit Committee	**Author:** Trust Secretary / Corporate Governance Officer

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
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):

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

AUDIT COMMITTEE MEETING – 20 JULY 2020
SUMMARY TO THE TRUST BOARD MEETING HELD ON 2 SEPTEMBER 2020

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

Sustainability Update
The Director of Estates & Facilities reported to the Committee regarding the Trust's sustainability performance. Achieving the targets would be a challenge and require an increased focus from a variety of teams across the Trust. He said that a recovery plan and timetable would be developed for the next Audit Committee meeting in October.

Cyber Security Update
The Data Security Officer presented the cyber security report which covered a period of seven months. He highlighted the changes to the ways of working through the height of COVID-19, work that had taken place to upgrade over 2000 workstations to Windows 10 and the achievement of the Cyber Essentials Certification.

The Data Security Officer reported there had been two relevant high security alerts from NHS Digital which were quickly resolved and there were no high or critical actions outstanding.

Data Quality & Clinical Coding Report
The Head of Data Quality informed the Committee that it had been a challenging few months for the team but the focus was now on recovery and transforming and improving the quality of data. The Head of Clinical Coding explained to the Committee that during the height of the COVID-19 pandemic, the clinical coding team supported other areas of the Trust including wards and the data quality team. The team were also asked to support the collation of data for external Sitreps. The Committee thanked the team for their hard work over the period.

INTERNAL AUDIT REPORTS

Internal Audit Report and Internal Audit Action Tracker
The Internal Auditors informed the Committee that there had been some delays to the original plan, in part due to the impact of the COVID pandemic. The Q1 actions were underway and would be completed by the end of July. The Committee was informed that both Q1 and Q2 reports would be presented at the next Audit Committee meeting.

There was discussion about the outstanding actions which had reduced from 60 to 33. The Director of Finance commented that over the last three months progress was slower than might have ordinarily been the case on account of the focus on the COVID pandemic; however he recognised the importance of the actions and said he was expecting the deployment of TIAA's portal to be beneficial in enabling the Executive Directors to easily comment on and close the actions.

Counter Fraud Progress Report
The Local Counter Fraud Specialist presented the report to the Committee. She highlighted the completion of the COVID risk review and generation of an associated action plan. She also provided a summary of the fraud alerts explaining four referrals had been received and investigations commenced.

EXTERNAL AUDIT REPORTS:

External Audit AAL Report
The Committee received the Annual Audit Letter for 2019/20. The External Auditor informed the Committee there had been an update to the fees as there had been a variation agreed relating to PPE valuations. It was confirmed that the content letter was consistent with the Audit Completion Report.

The Committee approved the additional PPE related fees and recommended the Annual Audit Letter to the Board for noting. Overall, the audit fees were lower than planned to reflect the removal of the requirement for external assurance on the Quality Account.

OTHER REPORTS

Proposed Board Assurance Framework 2020/21 and Risk Update
The Audit Committee were asked to review the proposed changes to the Board Assurance Framework risks for 2020/21. The risks had been discussed at the Executive Committee previously. The Associate Director of Governance informed the Committee that the COVID risk (12) had been reviewed by the Executive and although COVID is captured in multiple other risks, they believed that the risk of a pandemic should remain as a separate risk. The Committee approved the proposed changes to the Board Assurance Framework 2020/21.

The Committee also received an update on the Corporate Risk Register and supported a proposal to update the scoring matrix for risks to create a more consistent approach across the Trust.

Significant Losses/Special Payments Report
The Committee received the 6 monthly update on significant losses and special payments. The Deputy Financial Controller informed the Committee that Pharmacy stock losses increased in the second half of the financial year. A significant factor relating to the increase of stock losses was cancelled patient appointments due to COVID-19.

The Committee discussed the overseas patient debt and the Financial Controller explained to the Committee that there were improved processes in place to determine the correct course of action.

Debtors Analysis
The Committee considered the analysis of Trust debtors that had been requested at the previous Audit Committee meeting. The Deputy Financial Controller informed the Committee that although the outstanding debt had increased, overall debt is reducing significantly. It was highlighted that a significant proportion of the debt belonged to other NHS bodies. It was agreed that a further update would be considered at the next Audit Committee meeting in October.

Clinical Audit Assurances
The Audit Committee received the Clinical Audit Assurances report. The Committee was informed that a self-assessment of the processes and systems that are in place to demonstrate compliance had identified some areas of weakness for which actions have been put in place and would be monitored through the Clinical Effectiveness Committee.

During Q1 a total of 404 audits were carried out across the Divisions. There had been good engagement despite a national pause of most clinical audits due to COVID. It was reported that work was underway to identify the gaps with previous NICE guidance.

Raising Concerns Report
The Associate Director of Governance informed the Committee that 30 raising concerns cases were raised over the last year. She said there were no specific themes and all cases were investigated. She explained to the Committee that from May 2020 Celina Mfuko had taken on the role of Freedom to Speak Up Guardian and is looking at promotional literature to provide staff with more information.

The Associate Director of Governance informed the Committee that the How Are You Doing Team is still in place and is supporting staff along with the HR team. She said there is also a new Employee Assistance package for staff to use.

Managing Conflicts of Interest Policy Review
The Trust Secretary explained to the Committee that the policy had been reviewed and updated in conjunction with the Counter Fraud Specialist and there were no significant strategic changes proposed in relation to the policy. The Committee discussed the threshold for the declaration of shareholdings and the Trust Secretary agreed to review this aspect of the policy and recirculate to the Audit Committee members.

The Committee approved the policy subject to the amendment referred to above.

Corporate Credit Card Policy
The Committee approved the policy relating to the use of the corporate credit card.

East and North Hertfordshire NHS Trust

Agenda Item: 13.1

TRUST BOARD - PUBLIC SESSION – 2 SEPTEMBER 2020

External Auditor's Annual Audit Letter

Purpose of report and executive summary (250 words max): The purpose of the report is present the External Auditor's Annual Audit Letter for the year ended 31 March 2020 for noting by the Trust Board.		
Action required: For information		
Previously considered by: **Audit Committee – 20 July 2020**		
Director: **Director of Finance**	**Presented by:** **AC Chair**	**Author:** **External Auditors**

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

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

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

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Annual Audit Letter: Year ended 31 March 2020

IDEAS | PEOPLE | TRUST

BDO

WELCOME
Introduction

Purpose of the Annual Audit Letter

This Annual Audit Letter summarises the key issues arising from the work that we have carried out in respect of the year ended 31 March 2020. It is addressed to the Trust but is also intended to communicate the key findings we have identified to key external stakeholders and members of the public.

Responsibilities of auditors and the Trust

It is the responsibility of the Trust to ensure that proper arrangements are in place for the conduct of its business and that public money is safeguarded and properly accounted for.

Our responsibility is to plan and carry out an audit that meets the requirements of the National Audit Office's (NAO's) Code of Audit Practice (the Code). Under the Code, we are required to review and report on:

- The Trust's financial statements.
- The auditable parts of the Remuneration and Staff Report.
- Whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are also required to review and report on the Annual Report, Governance Statement and the Trust Accounts Consolidation schedules.

We recognise the value of your co-operation and support and would like to take this opportunity to express our appreciation for the assistance and co-operation provided during the audit.

[scan BDO signature on final version]

BDO LLP

14 July 2020

Rachel Brittain
Engagement Lead

t: 020 7893 2362
m: 07971 716487
e: rachel.brittain@bdo.co.uk

Ross Beard
Audit Manager

t: 01473 320785
m: 07966 282745
e: ross.beard@bdo.co.uk

Azola Dudula
Audit senior

t: 01473 320777
m: 07492 535239
e: azola.dudula@bdo.co.uk

David Eagles
Relationship Partner

t: 07473 320728
m: 07967 203431
e: david.eagles@bdo.co.uk

AUDIT CONCLUSIONS

Executive summary

Financial statements

- We reported our detailed findings to the Audit Committee on 16 June 2020.
- We issued an unmodified true and fair opinion on the financial statements on 25 June 2020.
- Going concern disclosures were sufficient.
- We referred a matter to the Secretary of State on 27 May 2020, under Section 30 of the Local Audit and Accountability Act 2014, when we had reason to believe that the Trust was planning to not meet its cumulative break even duty in its medium term planning, as this indicated that the Trust had begun a course of action that was unlawful.

Use of resources

- We issued an unqualified conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources on 25 June 2020. In doing so we lifted a qualified 'except for' conclusion issued in recent years in respect of the Trust's arrangements for sustainable resource deployment.

Other financial reporting matters

- After adjusting for issues identified by the audit, the final Remuneration and Staff Report was properly prepared.
- The Governance Statement complied with relevant guidance and was not inconsistent or misleading with other information we are aware of.
- The Annual Report, which includes the Performance Report and the Accountability Report, was consistent with the financial statements and knowledge acquired in the course of the audit.
- The Trust Accounts Consolidation schedules used in the preparation of the NHS England group consolidation was consistent with the financial statements.

THE NUMBERS
Executive summary

Final materiality

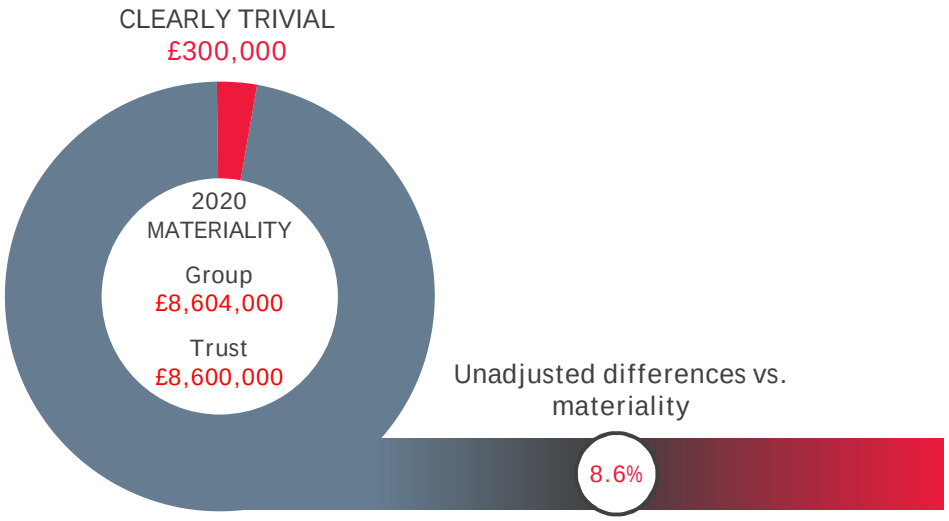
Group final materiality was determined based on gross expenditure.

Material misstatements

Our work to date did not identify any material misstatements.

Unadjusted audit differences

We identified projected audit adjustments that, if posted, would decrease the surplus for the year by £738,479.



FINANCIAL STATEMENTS

We set out below the risks that had the greatest effect on our audit strategy, the allocation of resources in the audit, and the direction of the efforts of the audit team.

Risk description	How the risk was addressed by our audit	Results
Management override of controls Auditing standards presume that management is in a unique position to perpetrate fraud by overriding controls	We carried out the following planned audit procedures: • Reviewed and verified journal entries made in the year, agreeing the journals to supporting documentation. We determined key risk characteristics to filter the population of journals. We used our IT team to assist with the journal extraction; • Reviewed estimates and judgements applied by management in the financial statements to assess their appropriateness and the existence of any systematic bias; and • Reviewed unadjusted audit differences for indications of bias or deliberate misstatement.	We used BDO's analytics software to review journals posted throughout the year and during the financial reporting close process for characteristics considered to be unusual. The review identified 30 journals that were potentially duplicated and 3 journals posted during the close period with descriptions flagged as a risk. These journals were tested to source documentation with no issues noted. We reviewed management judgements and decisions in making significant accounting estimates in the current year's financial statements and completed a retrospective review of estimates in the prior year's financial statements. This review covered the valuation of land and buildings, depreciation, income and expenditure accruals and PFI accounting. No instances of management bias were identified. Our audit work did not identify any issues to report.

FINANCIAL STATEMENTS

Risk description	How the risk was addressed by our audit	Results
Revenue recognition Under auditing standards there is a presumption that income recognition presents a fraud risk.	We carried out the following planned audit procedures: • Updated our understanding of the Trust's internal control environment for the significant income streams, including how this operates to prevent loss of income; • Reviewed the outturn contract income against service level agreements for key NHS commissioners and reconciled outturn activity with management estimate of forecast final outturn contract income; • Reviewed the process for resolving discrepancies between the Trust and NHS commissioners through the agreement of balances process and the rationale behind management's estimate of amounts receivable where there were contract disputes; and • Checked that income was recognised in the correct accounting period by substantively testing an increased sample of non-NHS income throughout the year, plus invoices raised and cash receipts around year end.	Our review of controls in place to prevent misreporting of income did not identify any deficiencies in control. However, our substantive work identified a continuance of control deficiency identified in the prior year in respect of accruing revenue in the correct period. We were able to corroborate outturn revenue transactions to commissioning contracts for all commissioners with which the Trust recorded material revenue, and a sample of others. Where mismatches remained between revenue reported by the Trust and respective expenditure reported by other NHS bodies, subsequent agreement was obtained or the Trust's position was been substantiated such that total agreed balances not agreed were non-material. Sample testing over the accuracy, existence and completeness of non-NHS income transactions identified two transactions misstated in the financial statements. The audit differences identified were extrapolated to determine a projected misstatement value across the population not sampled. The projected misstatement was £738,479. No adjustment was made in respect of this. Testing that post year end transactions are reported in the correct period identified no issues.

FINANCIAL STATEMENTS

Risk description	How the risk was addressed by our audit	Results
Expenditure cut-off In public sector bodies there is a risk of fraud related to expenditure.	We carried out the following planned audit procedures: • Checked that expenditure is recognised in the correct accounting period by substantively testing an increased sample of NHS and non-NHS expenditure around year-end.	We reviewed samples of invoices recorded in the accounts payable ledger and cash payments from the Trust's bank accounts during the period from 1 March 2020. This exercise provided assurance that transactions around the year-end were recorded in the correct accounting period. Our audit work did not identify any issues to report.

FINANCIAL STATEMENTS

Risk description	How the risk was addressed by our audit	Results
Valuation of land and buildings The valuation of land and buildings is a significant risk as it involves a high degree of estimation uncertainty.	We carried out the following planned audit procedures: • Reviewed the instructions provided to the valuer and the valuer's skills and expertise in order to determine if we can rely on the management expert; • Confirmed that the basis of valuation for assets valued in year is appropriate based on their usage; • Reviewed the appropriateness of assumptions used in the valuation of land and buildings, including those related to the use of a Modern Equivalent Asset (MEA) methodology, and movements against relevant indices; • Formed our own expectations regarding the movement in property values and compared this to the valuations reflected in the Trust's financial statements. We followed up valuation movements outside of an expectation range; and • Reviewed accuracy and completeness of information provided to the valuer, such as floor areas.	Instructions provided to the professional valuer were adequate and the valuer is sufficiently qualified to provide the valuation. Information used by the valuer having been provided by the Trust was substantiated on a sample basis. We confirmed on a sample basis that valuation movements were accurately recorded in the Trust's asset register and accounted for in line with the reporting framework. The bases of asset valuations were in line with applicable valuation and accounting frameworks and we considered assumptions used by the valuer to be appropriate based on information available. The valuer included a material uncertainty paragraph in their report, in relation to which we considered the Trust's disclosure and concluded this was appropriately disclosed in the financial statements. Our audit report will drew attention to this material uncertainty by way of an emphasis of matter paragraph.

FINANCIAL STATEMENTS

Risk description	How the risk was addressed by our audit	Results
Going concern Whilst the Trust is forecasting breakeven for the year, this is after over £20m in provider funding, so there remains a notable underlying deficit and there is a risk of inadequate disclosures relating to going concern.	We carried out the following planned audit procedures: • Reviewed the going concern disclosures in the financial statements to ensure they comply with the requirements of the Group Accounting Manual; • Reviewed long term plan and cash flow forecast for the period to 30 June 2021, factoring in changes to the financial framework in response to coronavirus and related guidance letter issued by NHSI. • Issued an updated section 30 report given the cumulative deficit and plan which does not return the Trust to a breakeven position.	The Trust removed the material uncertainty included in the going concern disclosure in previous years. We agreed with this assessment. In 2019/20 the Trust reported a surplus of £2.3m and it is forecasting to breakeven in subsequent years to 2023/24. Funding arrangements for 2020/21 are uncertain whilst block funding and truing-up mechanisms are in place during the coronavirus pandemic. NHS Improvement issued a letter to providers advising they can "continue to expect NHS funding to flow at similar levels to that previously provided where services are reasonably still expected to be commissioned. While mechanisms for contracting and payment are not definitively in place, it is clear that NHS services will continue to be funded, and government funding is in place for this". The Trust prepared a cash flow forecast giving consideration to NHSI guidance and the assessment did not indicate a risk of cash shortfalls, nor a requirement for bridging loans to meet operational needs or other obligations. Plans are in place for repayment of all borrowing, including those to be converted to PDC 2020/21 and others. Anticipated cessation of tertiary cancer service provision at Mount Vernon will reduce direct income and expenditure for the Trust in materially equal measures. The impact on the Trust's subsidiary ENH Pharma remains uncertain but this did not present a risk to the Trust's going concern status. Our audit work did not identify any issues.

FINANCIAL STATEMENTS

Risk description	How the risk was addressed by our audit	Results
Related party transactions There is a risk of inadequate disclosures relating to related parties.	We carried out the following planned audit procedures: • Updated our understanding of the related party transactions identification procedures in place and reviewed relevant information concerning any such identified transactions • Discussed with management and reviewed Board member and senior management declarations and obtained representations to ensure there were no potential related party transactions not disclosed.	Identification of related parties outside the Department of Health and Social Care group and other public sector bodies, relies largely on declarations of interest from key management personnel. All required declarations were received for consideration in the construction of the financial statements, however we identified active directorships on Companies House that had not been disclosed in respective declarations. As such, whilst this control is designed as expected, it did not operate effectively and a deficiency was reported in the Audit Completion Report. Our searches for related party transactions did not identify any additional parties that required disclosure. Our consideration of necessary disclosure of group components, ministers, senior officials and non-executives assessed as related party relationships under IAS 24 by the Department of Health Social Care did not identify any omitted parties that required disclosure.

MATERIALITY, ERRORS AND CONTROL DEFICIENCIES

Our application of materiality

We apply the concept of materiality both in planning and performing our audit and in evaluating the effect of misstatements.

We consider materiality to be the magnitude by which misstatements, including omissions, could influence the economic decisions of reasonably knowledgeable users that are taken on the basis of the financial statements.

Importantly, misstatements below these levels will not necessarily be evaluated as immaterial as we also take account of the nature of identified misstatements, and the particular circumstances of their occurrence, when evaluating their effect on the financial statements as a whole.

The materiality for the group financial statements as a whole was set at £8.604 million. This was determined with reference to a benchmark of gross expenditure (of which it represents 1.75 per cent) which we consider to be one of the principal considerations for the Trust in assessing its financial performance.

We agreed with the Audit Committee that we would report all individual audit differences in excess of £300,000.

Audit differences

We identified two audit differences not corrected in the final financial statements, which both overstated revenue. We extrapolated these to project that revenue is overstated by £0.738 million, i.e. correcting for these misstatements would have resulted in the Trust reporting a £0.738 million lower surplus for the year. These misstatements did not, therefore, have a material impact on our opinion on the financial statements.

Internal controls

We reported no new significant deficiencies in respect of the Trust's controls. Management has agreed to implement recommendations in respect of non-significant deficiencies.

OTHER FINANCIAL REPORTING MATTERS

Referral to the Secretary of State

We referred a matter to the Secretary of State on 27 May 2020, under Section 30 of the Local Audit and Accountability Act 2014, when we had reason to believe that the Trust was planning to not meet its cumulative break even duty in its medium term planning, as this indicated that the Trust had begun a course of action that was unlawful.

Remuneration and Staff Report

We identified factual and disclosure misstatements in the auditable parts of the Remuneration and Staff Report, which were corrected in the final report.

Annual Governance Statement

The Governance Statement was found to comply with NHS England's guidance and was not inconsistent or misleading with other information we were aware of from our audit of the financial statements, the evidence provided in the Trust's review of effectiveness and our knowledge of the Trust.

Other information in the Annual Report

The Annual Report, which includes the Performance Report and the Accountability Report, was consistent with the financial statements and knowledge acquired in the course of the audit.

Trust Accounts Consolidation schedules

We are required to provide an opinion to the Trust to confirm that the financial information included in the Trust Accounts Consolidation schedules (and used in the preparation of the NHS England Group consolidation) is consistent with the audited financial statements.

We reported that the consolidation schedule was consistent with the financial statements.

USE OF RESOURCES

Audit conclusion

We issued an unqualified use of resources conclusion in respect of both the sustainable finances risk and partnership working risk.

This means that we consider that we consider that previously reported significant weaknesses in arrangements for planning finances effectively, to support the sustainable delivery of strategic priorities and maintain statutory functions, had been addressed sufficiently such that the previously qualified 'except for' conclusion could be lifted.

We set out below the risks that had the greatest effect on our audit strategy.

Risk description	How the risk was addressed by our audit	Results
Sustainable finances Whilst the Trust is forecasting breakeven for the year, this is after over £20m in provider funding, so there remains a notable underlying deficit. Significant savings need to be delivered to maintain balanced budgets.	We carried out the following planned audit procedures: • Reviewed the financial outturn, Cost Improvement Plan (CIP) performance, cash flow management and projections, and LTFM assumptions.	In the prior year we reported a qualified 'except for' conclusion in respect of this risk. We lifted this qualification for 2019/20 due to improved financial performance and the planning that helped to secure this, a healthy outlook for the mid to long term and a clear repayment plan for remaining borrowing from 2020/21. The Trust set a budget for 2019/20 to meet its control total of breakeven (including performance based funding allocations built into the financial framework). It reported a surplus of £2.32m, or £0.83m on a control total basis. A key factor in the Trust achieving this outcome was attaining its Cost Improvement Programme target of £15m, surpassing the target by £0.2m. In April 2020 government policy was announced regarding the issue of public dividend capital (PDC) to enable providers to repay interim borrowing in 2020/21. This will remove £146.8m of the loan principal reported in 2019/20 and leave the Trust with a considerably reduced £43.2m of normal course of business (NCB) capital borrowing. The Trust's Long Term Plan budgets for repayment of remaining NCB capital loans in line with agreed repayment schedules. The Trust's current trajectory to 2023/24 is to continue to breakeven despite reducing funding allocations, in line with the wider NHS effort to return to sustainable financial balance. Whilst there are challenges ahead for the Trust to achieve its Long Term Plan and necessary savings when the funding regime reverts from current Covid-19 measures, in 2019/20 arrangements were in place to secure sustainable deployment of resources.

USE OF RESOURCES

Risk description	How the risk was addressed by our audit	Results
Partnership working The Trust and partners are moving towards an Integrated Care System (ICS) from 1 April 2020. There is a risk that arrangements put in place are not adequate to support objectives and address financial issues, including risk sharing.	We carried out the following planned audit procedures: • Reviewed documentation relating to STP developments, including ICS structure and arrangements • Reviewed Trust BAF relating to STP/ICS issues • Discussed arrangements with officers.	The move towards an ICS had the potential to result in significant changes to governance arrangements with system partners. Arrangements in 2019/20 operated substantially in line with existing STP arrangements, which reduced the risk arising from change. This is not in itself indicative of risk given the move to ICS is an evolution rather than sudden, and the footprint and key partners of the ICS are not different to the STP. ICS status was granted in May 2020 and with changes in leadership from June 2020, substantive changes to how the system operates in partnership are more likely in 2020/21. The Trust was effective in monitoring risks related to STP/ICS operations through its Board Assurance Framework, identifying controls that mitigate the risk of the system not achieving its strategic objectives and areas requiring improvement. The financing regime for providers began to incorporate more system-linked assessment for funding in-year, particularly with regard to the framework for capital allocations and performance based Financial Recovery Fund allocations for 2020/21 planning. Whilst the COVID-19 financial framework disrupted this linked funding for at least the first half of 2020/21 and likely significantly longer, there is evidence that the ICS governance arrangements are in place for considering and responding to the evolving system-based funding at partnership level. Our audit work did not identify any issues.

REPORTS ISSUED AND FEES

Fees summary

		2019/20 Actual £	2019/20 Planned £	2018/19 Actual £
Audit fee				
Audit fees	Trust	TBC	£55,870	£52,400
	ENH Pharma	TBC	£7,200	£7,200
	Charitable Fund	TBC	£5,400	£5,805
Non-audit assurance services				
Fees for audit related services – Quality Account		£597	£4,880	£4,880
Total fees		£69,067	£73,350	£70,285

Our fee for non-audit assurance services is adjusted to reflect the removed requirement for external assurance on the Quality Account for NHS Trusts in 2019/20, as part of measures announced by NHSI in response to the coronavirus outbreak. Costs incurred by BDO in respect of this engagement before the regime change are charged on a time and materials basis.

Reports issued

We issued the following reports in relation to the 2019/20 audit:

Report	Date
Audit Plan	12 January 2020
Audit Completion Report	16 June May 2020
Annual Audit Letter	20 July 2020

FOR MORE INFORMATION:

Rachel Brittain

t: 020 7893 2362
m: 07971 716487
e: rachel.brittain@bdo.co.uk

East and North Hertfordshire NHS Trust

Agenda Item: 14

TRUST BOARD - PUBLIC SESSION – 2 SEPTEMBER 2020
CHARITY TRUSTEE COMMITTEE – EXTRAORDINARY MEETING HELD 5 AUGUST 2020
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present to the Trust Board the summary report from the Extraordinary Charity Trustee Committee (CTC) meeting held on 5 August 2020.		
Action required: For information		
Previously considered by: N/A		
Director: Chair of CTC	**Presented by:** Chair of CTC	**Author:** Trust Secretary

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

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

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

EXTRAODINARY CHARITY TRUSTEE COMMITTEE MEETING
HELD 5 AUGUST 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), Karen McConnell (Non-Executive Director) and Sarah Brierley (Director of Strategy)

Approvals in Excess of £5,000 - #HereForEachOther proposals

The CTC held an extraordinary meeting to consider initial proposals for allocating the first tranche of funding made available through the Charity's #HereForEachOther campaign. The donations had been received in recognition and thanks for the hard work of the Trust's staff during the COVID pandemic.

The report considered by the CTC also outlined the approach to developing the proposals. The plans had been discussed and developed with the staff experience group and the initial ideas had been informed through direct engagement with staff during the COVID pandemic.

The specific proposals, aligned with the People Strategy, were:

- *Thrive together* – Focus on EDI networks
  Funding for the EDI networks events, promote initiative and resources and to allow network chairs availability. (£20k cost for the year).
- *Care together* – Enhancements to working areas to support staff health
  Funding the refurbishment of staff areas including providing furniture and ambience items, decorating / wall art, flooring / carpet and labour. (Approx. 50 areas at a total cost of approx. £200k).
- *Care Together* – Reward and recognition
  Random acts of kindness schemes, recognition of ENHT long service with pin badges and funding of celebration / recognition and wellbeing events for staff. (£15k cost).
- *Care together* – Rest, relax and refuel areas
  Rest, relax and refuel garden for staff with memorial tree and benches and other outdoor seating at other sites. (£45k cost).
- *Grow together* – Refresh physical learning spaces
  Funding the refurbishment of staff training and education areas, including providing furniture and decorating / labour. (£5k cost).

The CTC discussed the proposals. The CTC were mostly supportive of the proposals but requested further detail was provided at the next meeting. The CTC also discussed the importance of utilising the donations as effectively and efficiently as possible and requested that a working group was established to oversee the deployment of these funds and report back to the CTC.

The CTC supported each of the proposals outlined above in principle, subject to:

- Trust Board consideration of the Trust's general approach in relation to staff support (Charity funded and otherwise) (due to be discussed at the Board meeting on 2 September),
- providing greater detail and assurance on implementation of the proposals at the next meeting of the CTC on 14 September, in particular regarding the Reward and Recognition proposal, and,
- establishing a working group to oversee the work and report back to CTC on the proposals, in particular regarding the refurbishment of staff areas.

NHS Charities Together Funding Briefing

The CTC also received a brief update in relation to the next stages of funding from the national NHS Charities Together funding.

Bob Niven
Chairman of the Charity Trustee Committee

August 2020

East and North Hertfordshire NHS Trust

Agenda Item: 15

TRUST BOARD - PUBLIC SESSION – 2nd September 2020

Staff Wellbeing Support

Purpose of report and executive summary (250 words max): Covid-19 has created an unprecedented situation for the NHS. Our response to it must continue to be sympathetic, supporting our staff to sustainably deliver safe, high quality and compassionate care whilst also being flexible in our approach to work, skills and leadership, as people's needs and anxieties shift over time, recognising that individual reactions to this type of pressure are also likely to be personal and unique. This paper outlines the support that the Trust has been providing to our staff during this challenging time from a health and wellbeing perspective, the impact that this has had on staff, and our plans to lead on and develop further the health and wellbeing offering to our staff and staff across the ICS. The Trust Board are asked to consider a nomination, from the Non-Executive Directors, for this Wellbeing Guardian role.		
Action required: For decision		
Previously considered by:		
Director: **Chief People Officer**	**Presented by:** **Deputy Director of Workforce and OD**	**Author:** **Interim Deputy Director of People Capability**

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

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

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

1.0 Introduction

The purpose of this paper is to advise the Trust Board on the support that is in place to address the health and wellbeing of our staff. The health and wellbeing of our staff has become even more important in recent months as a result of Covid-19 which has had an impact on staff both personally and professionally. This paper outlines the staff wellbeing support that the Trust has in place, the additional support that was introduced during Covid-19 and further plans to develop the health and wellbeing offering to staff in the future.

2.0 Background and Context

Covid-19 has created an unprecedented situation for the NHS, for Trusts working across the Integrated Care System and for our staff. Daily our clinical and non-clinical colleagues are facing new situations and incredible pressures to save lives, deal with significant illness, face new situations, make good decisions on the basis of little information, and compassionately lead people through trauma and stress and manage anxieties.

The management of this new and challenging situation is likely to go on for some time and, whilst not as acute as first predicted, the potential stress and trauma generated by working under pressure for so long will generate challenges for our leadership of people in the immediate and long term. Our response to it must continue to be sympathetic, supporting our staff to sustainably deliver safe, high quality and compassionate care whilst also being flexible in our approach to work, skills and leadership, as people's needs and anxieties shift over time, recognising that individual reactions to this type of pressure are also likely to be personal and unique.

The national 'we are the NHS: People Plan' launched in July 2020 sets out clear intent with practical application for 'looking after our people'. It outlines the responsibility of each organisation to ensure that their people have the practical and emotional support they need to do their jobs. As a Trust there are a number of measures that we already have in place to support our staff from a health and wellbeing perspective but we recognise that there is also more that we need to do and work is being undertaken at an integrated care system level to develop and implement further packages of care to support staff.

3.0 Strategic Approach to Health and Wellbeing

Our ENHT People Strategy states that we want 'a place where everyone can work, grow, thrive and care together, for our patients'. Two pillars of the people strategy, care together – I feel safe, healthy and cared for as a human being; and thrive together – compassionate leadership helps me get the job done, have a focus on staff wellbeing and support. The diagram below sets out our strategic approach to health and wellbeing, ranging from the localised development of consistent health and well-being interactions to the availability of enhanced services accessible to colleagues across the system. This strategic approach which forms the foundation of our work here at ENHT directly resulted in the adoption of a system wide provision of staff support.

4.0 Staff Health and Wellbeing Support in Place

The following health and wellbeing support is currently in place for our staff.

4.1 Occupational Health

The Trust's Health at Work service is accredited as a Safe, Effective, Quality, Occupational Health Service (SEQOHS) and we are providing excellent services to other organisations and NHS Trusts within the Integrated Care System including CCG shared services, Hertfordshire Partnership Trust and Hertfordshire Community Trust. As a result we are currently in discussion with Princess Alexandra and Central London Community Healthcare NHS Trust about the potential to provide occupational health services to them in the future. The core services provided by the Health at Work team includes the following:

- Telephone advice line for self-referral and for providing information and support for managers.
- Managers online referral system to request written occupational health advice.
- Consultation appointments face to face, by telephone or video.
- New employee online health assessments.
- Occupational immunisations and blood tests for new employees with a recall system for boosters.
- Sharps and splash injury advice, follow up screening and support
- Musculoskeletal post injury advice service
- Skin health surveillance
- Night workers assessments
- Referral to physiotherapy
- Confidential electronic storage of occupational health records

Throughout the pandemic the team have also provided support and guidance to both staff and managers on shielding, self-isolation, staff testing, risk assessments, and antibody testing.

This service exceeds in all aspects those provided by the private sector to the system NHS Trusts.

4.1.1 Risk Assessments

The health at work team developed a staff risk assessment during the pandemic as to whether staff could remain at work in their current role, needed to be redeployed into an alternative role, or needed to work from home. All managers have been asked to complete a risk assessment with their team members with a particular focus on high risk staff with underlying health conditions, or from a BAME background. If staff are unable to return to their roles following a risk assessment temporary adjustments to the employee's role, duties, working hours, department or division have been implemented to enable a return to a covid-19 secure working environment. If a suitable position in a covid-19 secure area cannot be identified the employee remains at home on paid special leave or arrangements can be made for the employee to work from home. If staff are able to be redeployed into a covid-19 secure area, this is managed though the ERAS team who have access to a list of redeployment opportunities. Risk assessment compliance is discussed at weekly SMTs, ARM and Divisional Board meetings and is reported weekly to the Deputy Director of Workforce. 60% of staff have had a risk assessment which equates to 3752 staff. 98% of BAME staff (1911 staff) have been risk assessed. Further work is ongoing to ensure that all staff within the Trust have a risk assessment.

Managers are required to review individual risk assessments for vulnerable staff weekly to enable the deployment of staff back to clinical areas where the risk assessments indicates that this is safe to do. A risk assessment template is provided to support managers in undertaking risk assessments of vulnerable staff. Where managers require advice they are encouraged to contact the Health at Work advice line. The importance of completing ongoing risk assessments and guidance in how to do effective risk assessments and support the safe return of staff has been focused upon in Glissers. The Health at Work Team also continue to provide ongoing support to staff who are shielding.

4.1.2 Staff Testing

The ability to test symptomatic staff or a symptomatic member of their household was also set up during the pandemic. The member of staff, or their manager, is able to contact the health at work team who can arrange an appointment at one of our local testing centres. This has meant that when staff or a household member test negative, we have been able to bring that member of staff back to work quickly. Where staff have tested positive we have ensured that they have continued to isolate to reduce the risk of passing on the infection to anyone else which has resulted in lower infection rates.

Processes are currently being put in place to implement asymptomatic staff testing across the Trust. This is currently being undertaken at Mount Vernon and the Lister Macmillan Cancer Centre with plans to expand this testing even further.

Antibody Testing has also been made available to all staff at the Trust with 5150 staff (86%) taking up the opportunity to have the test with 13% of staff testing positive. Whilst there is no guarantee that an individual cannot contract Covid-19 again or the length of immunity many staff have found the process psychologically beneficial to know whether they have had Covid-19 or not.

4.2 Employee Assistance Programme

During the pandemic an ICS wide tender was completed for an Employee Assistance Programme (EAP). This vastly improved service was launched in June. The EAP service provides a free independent support service for employees offering confidential support, information and advice on personal, work, family and relationship and general daily life matters. The website offers access to free information and webinars. Employees are able to seek free short term counselling and other therapies using a stepped care approach to mental health which is underpinned by NICE guidelines. The service is available 24 hours a day, 365 days of the year and can be accessed online or over the telephone.

4.3 How are you doing team?

During the pandemic the Trust established a 'How are you doing?' team who's purpose was to focus on the staff's emotional response to the pandemic as well as their wellbeing. The team's work was based on the advice and evidence from the King's Fund and The British Psychological Society about helping people to deal with traumatic events. A group of staff made up of the representatives from the Organisational Development Team, the People Team, Quality and Safety Team and Psychology visited wards on a daily basis, providing one to one and group support and asked five questions which would help staff based on the evidence outlined above:

- How are you doing?
- How are your team doing?
- How are your colleagues doing?
- What can you do to help them?
- What can we do to help you?

These questions enabled important conversations to take place and a 'You said… We did' response, for example, developing short training sessions and tools to support staff, and instilled a compassionate leadership approach. This approach encouraged staff that they needed to look after their own health and wellbeing as well as that of their teams and colleagues. Further documentation on briefing and debriefing, communicating during a crisis, healthy leadership, psychological support, coaching and therapy support and supporting colleagues was also made available for staff.

This work has now been incorporated into business as usual. There is a real focus on providing health and wellbeing support across the ICS of which the ENHT People Team have been a main lead and contributor. The work of the 'How are you doing' Team has been shared across the ICS and even nationally with the five question approach being adopted by the Hertfordshire and West Essex ICS as well as other Trust's nationally.

A wellbeing hub was also set up which gave information to staff and signposted colleagues to useful resources which was staff for at least 7.5 hours each day. The team also ran debriefing sessions for teams that had encountered distressing events. A psychologist was also on hand to offer support to the ITU team several times a week. Wobble rooms were also made available in ITU and Maternity that provided a safe space to staff to go. A 'Rest, Relax and Revive' area was also established in the main coffee lounge at the Lister with the support of generous donations from the community. The team also worked with the charity to distribute generous donations from the community fairly across the Trust. Data was sampled for three weeks, which show the following:

- 459 interventions

- 328 conversation took place
- 95 'We said ….we did' conversations took place.

Qualitative feedback received from staff included the following:

"Thank you for your support. The sessions have been invaluable"

"It's really helped knowing that other people have these thoughts and feelings too"

"I love the 5 questions.. I now always have them in my head when I start a conversation"

4.4 Schwartz Rounds

To increase the post trauma support, the Trust held its first Schwartz Round at Mount Vernon in July with virtual participants over starleaf. The session focussed on the effects of the pandemic on staff and was well attended, with very positive reviews. Schwartz Rounds provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. The purpose of Schwartz Rounds is to understand the challenges and rewards that are intrinsic to providing care, not to solve problems or to focus on the clinical aspects of patient care. Rounds can help staff feel more supported in their jobs, allowing them the time and space to reflect on their roles. Evidence shows that staff who attend Schwartz Rounds feel less stressed and isolated, with increased insight and appreciation for each other's roles. They also help to reduce hierarchies between staff and to focus attention on relational aspects of care. There is a roll out plan to train further Schwartz Round facilitators to enable these rounds to happen monthly. The next Schwartz Round is planned to take place within ED. Again there is a plan to develop this approach further across the ICS.

4.5 Psychological Trauma Therapy

Currently in response to the potential additional risk of exposure to trauma during the Covid-19 pandemic HPFT, our local mental health trust, provides a free helpline for psychological trauma therapy and accelerated access to confidential telephone support and up to three therapy sessions. This is only currently available to employees who are registered with a GP in Hertfordshire. All other staff are referred to the national helpline.

Again we are working with Essex Partnership University Trust (EPUT) and Hertfordshire Partnership University NHS Foundation Trust (HPFT) to develop plans to offer an ongoing psychological trauma therapy service across the ICS. Further details can be found in section 7.2 below.

4.6 Occupational Physiotherapy

Occupational Physiotherapy services are also provided by a national external organisation, which provides access to musculoskeletal health promotion materials in addition to referrals for physiotherapy, telephone assessment, and treatment with telephone or face to face physiotherapy sessions, as required, from a national network of providers. This service is also offered by the Trust to the rest of the system and those organisations that we provide an Occupational Health service to.

4.7 Access to Fit Testing and training on use of PPE

Support was also give to staff with regards to their physical and psychological safety by ensuring that all appropriate staff were fit tested to wear a mask. Over 2800 staff were fit tested during the pandemic with a 75% pass rate. Staff who failed the fit test were advised that they would need to wear a hood and training was provided on how to use this. Training sessions on how to put on and take off Personal Protective Equipment (PPE) was also undertaken with staff. As a result our staff were kept safe at all times and as a result we saw lower staff infection rates in comparison to other Trusts. In the last staff pulse survey 70% of staff advised that they had access to sufficient personal protective equipment such as masks, gloves, gowns and sanitiser required for their role to keep them safe.

4.8 Confidential Telephone Support Service to BAME Staff

A confidential telephone support service for BAME staff has been set up by senior BAME staff that has enabled colleagues across Hertfordshire and west Essex to support each other. This was implemented by the system but hosted by HPFT during the pandemic. All calls are confidential and staff can call the service seven days a week to talk to a trained advisor about a concern they may have, to discuss something they may not wish to discuss directly with their manager or to debrief following a situation or scenario.

4.9 Maintaining Health and Wellbeing

Opportunities, services and initiatives to make it easier for staff to adopt healthier lifestyle choices and seek self-care advice continue to be promoted. Staff health and wellbeing initiatives are planned and delivered by the Health at Work Service working in partnership with other groups such as, staff networks, organisation development, employee relations, staff side, health and safety and infection prevention and control. Organisations across the integrated care system are currently sharing ideas and approaches.

Bite sized training sessions are being rolled out across the trust focused on how we model care for ourselves, support each other and create healthy teams. More bespoke training will be developed to increase the knowledge and understanding of how to support with staff mental health such as mental health first aid and Schwartz round training. A business case is currently being developed by the ICS, which adopts many of the initiatives that have already been implemented by the People and Organisational Development Teams with key members of the Trust taking the lead on developing and implementing these approaches across the ICS.

4.10 Additional Support

Staff have also been given access to a number of national health and wellbeing apps as a way of providing additional support during these challenging times. In addition a number of staff networks have been developed across the Trust including a Women's network, BAME network, Disability Network, Carers network which also gives staff another forum in which to gain advice and support from their colleagues and raise any concerns that they may have. The recently formed staff experience group also has representation from across the Trust and enable staff to put forward ideas and give feedback on support that is required. Staff health and wellbeing was also included in the staff induction programme.

5.0 Health and Wellbeing and Staff Support in the Divisions

Divisions have also provided their own additional staff support from a health and wellbeing perspective. Some examples of the support are as follows:

- Ran SMT session with the Head of Health at Work to discuss how to equip managers to deal with staff who are suffering from stress and mental health issues. Very interactive session where managers were given advice and information and encouraged to work more closely with Health at Work.

- Focus on return to work meetings and ensuring line managers are asking the right questions to ensure staff are well enough to be back at work and support/adjustments are in place where needed.

- Noticeboards and team meetings have been used to highlight avenues for employee support.

- Focus on bullying and harassment ensuring all staff are aware of how to report incidences and that anything reported is dealt with sensitively and appropriately.

- New Compassionate Service training sessions were trialled initially with Phlebotomy and Contact Centre, with the aim to empower and enable all staff to make a difference in every interaction with patients, relatives and colleagues and to feel proud of the service provided. Approximately 600 staff attended these sessions.

- Focus on time spent/relationships with line managers – the aim is to ensure staff have a better relationship with their managers which better allows staff to feel confident in raising issues including any related to their health and wellbeing.

- Recognition of teams that have gone above and beyond and recognition of work during Covid-19

- 'What matters to you' conversations

- Divisional memory jar to share positive experiences and energise staff

- Post incident support to provide a listening ear and safe space to talk. Involving staff with learning from incidents

- Briefings at the start and end of each shift for staff to be able to check in with how they are feeling

- Human Factors Training

- Support for new starters

- Selfcare boxes for staff and appreciation tea

- BAME Staff Newsletter

6.0 Outcomes

During the pandemic we saw sickness absence rise to 7.28% during April 2020. This has steadily decreased month on month and as at July 2020 the sickness absence rate was 3.72% which is equivalent to sickness absence rates at the same time last year.

Key to improving sickness absence rates, especially following the peak of the pandemic, is the support for staff health and wellbeing and the work of the Health at Work Team. The fundamental elements for enhancing this is through improving hygiene factors that impact on an individual's working day and providing compassionate and inclusive leadership.

The most recent people pulse survey showed the following outcomes:

- 67% of staff said their manager cared about them as a person
- 67.5% of staff who had a physical or mental health condition or disability that required a reasonable adjustment felt that reasonable adjustments had been made
- 61% of staff felt supported and included whilst working from home
- 67% of staff had access to health and wellbeing information needed at this time

All of this information shows that the additional health and wellbeing support provided by the Trust to all staff has had a positive impact in staff feeling that the Trust has looked after their health and wellbeing during these challenging times. This has also had a positive impact on sickness absence rates reducing quickly to expected levels.

7.0 Next Steps/Further Developments

The management of this new and challenging situation is likely to go on for some time and, while not as acute as first predicted, the stress and trauma generated by working under pressure for so long will generate challenges for our leadership of people in the immediate and long term. Our response to it must continue to be sympathetic to this situation, supporting our staff to sustainably continue to deliver safe, high quality and compassionate care whilst also being flexible as people's needs and anxieties shift over time, recognising that individual reactions to this type of pressure are also likely to be personal and unique.

As a result a strategic approach to health and wellbeing has been developed by the HR Directors across the Integrated Care System. Members of the People Team at ENHT have been instrumental in leading and developing this strategic approach both within the Trust and across the system. The development of the ICS health and wellbeing business case has been led by the ENHT Health at Work Team. The benefits of working as a system are clear. Bringing together resources and developing a single strategic approach enables a scaling up of support services and introducing specialist support and interventions. This can be achieved while developing a consistent approach to improve the health and wellbeing of Hertfordshire and West Essex health and social care staff. Additional areas of focus for the Trust will be as follows:

7.1 Compassionate Leadership and Management

Evidence shows that compassionate leadership and management enhance employee health and wellbeing, improves employees experience at work, and supports the delivery of quality compassionate care to our community. Enabling compassionate leadership and

management requires the development of a set of clear expectations and a package of resources to support people to achieve these including development opportunities.

The Trust is working across the Integrated Care System (ICS) to develop a consistent approach which has been led by the Deputy Director of Workforce and OD and the Associate Director of Leadership which will then be used to leverage the benefit for the Trust from shared resources to deliver learning locally. The approach would be based on a set of agreed learning principles and developed content delivered based on 3 levels of learning.

Level 1 – Foundation: The expectation is that all leaders would complete this. It would be developed as bite-size and electronic learning which can be planned and delivered internally.

Level 2 – Intermediate: This is to develop specialist skill and knowledge for a select number of people working in each area within organisations (approx. 1 to every 30 colleagues) being a health and safety competent person and being mental health first aid trained. The Health and Safety Executive (HSE) now recognises the need for employers to offer mental health first aid training in addition to physical first aid to ensure a safe working environment. In light of the current pandemic it is really important that we support our staff with regards to their mental wellbeing.

Level 3 – Advanced: Learning would be aimed at fewer specialists who would facilitate Schwartz rounds.

7.2 Psychological Trauma Therapy

A specialist service is required to provide early and sustained support, assessment and treatment for psychological trauma. Healthcare workers are repeatedly exposed to potentially traumatic situations such as dealing with death and dying, while also working in situations with other psychological hazards such as long working hours, sleep disruption, excessive workload and exposure to infectious diseases. These hazards pose a significant additional risk of mental health problems such as Post-Traumatic Stress Disorder (PTSD).

People with PTSD may present with a range of symptoms affecting day to day life. Organisations have moral and legal duties to consider the psychological needs of their workforce following exposure to potentially traumatic events in the workplace. Additionally, it makes economic sense to avoid loss of valuable people to the effects of psychological trauma. In addition to the personal benefits to the employee and their family providing Trauma Therapy will reduce costs due to temporary staff during sickness absence, recruiting and training staff to replace those who leave work.

Work is underway to put a SLA in place with both mental health providers in the ICS. This work is also being led by the ENHT Health at Work team.

7.3 System Wide Benefits

Plans are also in place to promote benefits that support health and wellbeing and improve staff experience.

A business case is currently in development across the ICS to address the additional support requirements from a staff health and wellbeing perspective.

8.0 Flu Vaccination Programme 20/21

This year's flu vaccination programme will be even more important than in previous years and planning is already underway to provide a vaccine to all staff, in particular frontline workers, from September onwards. Flu planning sessions have taken place throughout the summer with the aim of vaccinating 80% of our frontline staff. A business case has been signed off by the Executive Team. A lessons learnt session has taken place following last year's flu campaign and this feedback is being taken into consideration. We have also made contact with other Trusts who achieved the target to establish if there is anything else that we can learn in advance of this year's campaign. There is engagement from both the Medical Director and Chief Nurse with regards to ensuring that we encourage as many staff as possible to have the vaccine to keep themselves, their patients and their families safe.

9.0 We are the NHS People Plan 20/21

The 'We are the NHS' People Plan that was published in July 2020 has staff health and wellbeing as an area of focus. Employers are being asked to take all the necessary steps and redouble their efforts to keep people safe, or risk them leaving. The majority of the areas of focus are things that we are already undertaking as a Trust. For example from September 2020 all members of staff should have a health and wellbeing conversation which should be reviewed at least annually. Managers undertaking risk assessments with their staff is enabling that conversation to take place. In addition from October 2020 employers should ensure that all new staff have a health and wellbeing induction. This was incorporated into our revised induction at the start of the pandemic.

9.1 Health and Wellbeing Guardian

It has been recommended in the NHS People Plan that each organisation should have a wellbeing guardian e.g. a non-executive director to look at the organisations activities from a health and wellbeing perspective and act as a critical friend. Due to the importance of the health and wellbeing of our staff the Trust Board are asked to consider a nomination, from the Non-Executive Director team, for this Wellbeing Guardian role. A role profile is currently in draft.

10.0 Conclusion

The Trust Board is asked to note the work that has been undertaken, particularly in response to the Covid-19 pandemic, to support the health and wellbeing of our staff. This is evidenced in the reduced sickness absence rates and the fact that our staff feel that we have supported them to look after their health and wellbeing at this challenging time. To support our staff even further the ENHT People Team are leading on work both internally and at an ICS level on Health and Wellbeing to implement further supportive measures on a sustainable basis. The Board are also asked to nominate a Non-Executive Director to be the Wellbeing Guardian for the Trust.

East and North Hertfordshire NHS Trust

Agenda Item: 16

TRUST BOARD - PUBLIC SESSION – 2nd September 2020

Strategy Committee - Draft Terms of Reference

Purpose of report and executive summary (250 words max): To review and approve the Terms of Reference for the new Strategy Committee, a formal committee of the Trust Board which is responsible for overseeing the delivery of the Trust's vision and strategic aims to 2024 and associated transformation of services and workforce. The draft Terms of Reference have been developed with input from executive directors, the Trust Board Chair and the Chair of the Finance, Performance and People Committee. The first meeting of the Strategy Committee is scheduled for Wednesday 21st October 2020.		
Action required: For approval		
Previously considered by: This is the first time the report has been submitted to any Board for approval.		
Director: **Director of Strategy**	**Presented by:** **Director of Strategy**	**Author:** **Director of Strategy**

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) Risk 001/20 - Risk to operational delivery of the core standards and clinical strategy in the context of COVID recovery. Risk 005/20 - There is a risk that the digital programme is delayed or fails to deliver the benefits, impacting on the delivery of the Clinical Strategy.
Any other risk issues (quality, safety, financial, HR, legal, equality): N/A

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

East and North Hertfordshire NHS Trust

STRATEGY COMMITTEE

TERMS OF REFERENCE (DRAFT)

1. Purpose

To be responsible for overseeing the delivery of the Trust's vision and strategic aims to 2024 and associated transformation of services. To provide Board level assurance of the leadership, commitment and alignment of corporate strategies, strategic projects and service and workforce transformation agreed under the scope of the committee.

2. Status & Authority

The Committee is constituted as a formal Committee of the Trust Board and is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

3. Membership

Three Non-Executive Directors, one of whom will be nominated as Chair.

Core Attendees:

Chief Executive
Chief Information Officer
Director of Improvement
Director of Estates and Facilities
Director of Strategy
Deputy Director of Strategy
Chief People Officer
Director of Nursing
Medical Director

Other staff will be invited to attend to present an item to the Committee or to support their personal development with the prior agreement of the Committee Chair.

If a conflict of interests is established, the above member/attendee concerned should declare this and withdraw from the meeting and play no part in the relevant discussion or decision.

4. Quorum

Two Non-Executive Directors and two core attendees one of whom should be either:

- Chief Executive
- Director of Strategy

5. Frequency of meetings

The Committee will meet bi-monthly with a review in March 2021.

6. Duties

- To keep under review the Trust's strategic objectives, mission and vision statements and monitor their delivery
- To review and monitor the development and delivery of the Trust's clinical strategy to 2024
- To maintain oversight of the development, alignment and delivery of enabling and corporate strategies (People, Finance, Digital, Estates and Quality)
- To maintain strategic oversight of system integration in relation to Trust services, functions and strategies obtain assurance regarding the Trust's strategic responses to this
- To obtain assurance regarding the design and delivery of transformation in support of strategic objectives
- To consider outputs from population health data and strategic analyses and implications for the Trust's clinical strategy and service provision
- To consider outputs from population health data and strategic analyses and implications for the Trust's clinical strategy and service provision
- Provide advice to the Finance, People & Performance Committee regarding the strategic alignment of investment cases over £5m in capital value
- Monitor the Trust's alignment with national and regional strategic direction and ICS and Integrated Care ICP strategic priorities and programmes - ensuring strategic responses are robust
- To develop and recommend annual objectives for approval by the Board
- To ensure that the Trust's strategic vision and progress are effectively communicated internally and externally
- Maintain oversight of the risks and mitigations associated with these programmes of work, review the associated Board Assurance Framework risks and provide assurance to the Board on the management of these risks
- Maintain oversight of the Sustainability Strategy

7. Risk Reporting

The Committee will regularly receive risk register reports for the areas relevant to its duties for review and consider with the appropriate escalation to the Trust Board and for incorporation within the Board Assurance Framework.

8. Reporting arrangements

The Committee will be accountable to the Trust Board for fulfilling its duties and will report to the Board following each meeting.

It will make recommendations to the Board, Executive Team and Executive Directors for these groups/individuals to take appropriate action.

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

The Committee will monitor and review its compliance through the following:

- The Committee report to Trust Board

10. Support

The Director of Strategy will ensure the Committee is supported administratively and advise the Committee on pertinent areas.

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

Agenda item: 17

EAST AND NORTH HERTFORDSHIRE NHS TRUST
PUBLIC TRUST BOARD ACTIONS LOG TO 2 SEPTEMBER 2020

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date

No actions outstanding

Board Annual Cycle 2020-21

Notes regarding the annual cycle:

Monthly Trust Board meetings have been held since the start of the COVID-19 pandemic with a focus on core business.

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

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

Board Annual Cycle 2020-21

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

Board Annual Cycle 2020-21

Items	3 Jun 2020	1 Jul 2020	Aug 2020	2 Sept 2020	*Oct 2020	4 Nov 2020	*Dec 2020	Jan 2021	*Feb 2021	Mar 2021
Gender Pay Gap Report										X
Market Strategy Review (TBC)										X
Quality and Safety Committee										
Complaints, PALS and Patient Experience Report				X						X
Safeguarding and L.D. Annual Report (Adult and Children)		X								
Detailed Analysis of Staff Survey Results										X
Learning from Deaths		X				X		X		
Nursing Establishment Review		X ***Deferred***						X		
Responsible Officer Annual Review				X ***Deferred due to national changes regarding revalidation***						
Patient Safety and Incident Report (Part 2)						X		X		
University Status Annual Report										X
QSC TOR and Annual Review						X				
Shareholder / Formal Contracts										
ENH Pharma (Part 2)		X								

DATA PACK

Contents

1. Data and Exception Reports:

FFT

Friends and Family Test - July 2020

APPENDIX 2

Inpatients & Day Case	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses	No of Patients eligible to respond
5A	95.83	0.00	17	6	1	0	0	0	24	70
5B	83.33	16.67	4	6	0	0	2	0	12	67
6A	94.12	0.00	26	6	2	0	0	0	34	99
6B	86.36	4.55	10	9	2	1	0	0	22	55
7A	100.00	0.00	1	0	0	0	0	0	1	1
7B	97.78	0.00	56	32	2	0	0	0	90	158
8A	98.08	1.92	44	7	0	1	0	0	52	97
8B	98.90	1.10	67	23	0	0	1	0	91	170
9A	100.00	0.00	13	2	0	0	0	0	15	62
9B	100.00	0.00	33	20	0	0	0	0	53	65
10A	96.88	0.00	23	8	1	0	0	0	32	36
10B	96.30	3.70	20	6	0	1	0	0	27	73
11A	100.00	0.00	2	0	0	0	0	0	2	75
11B	NA	NA	0	0	0	0	0	0	0	0
ICU1	50.00	50.00	1	0	0	1	0	0	2	4
ICU2	100.00	0.00	1	0	0	0	0	0	1	2
AMU1	NP	NP	0	0	0	0	0	0	0	656
AMU2	NP	NP	0	0	0	0	0	0	0	41
Ashwell	94.12	0.00	10	6	1	0	0	0	17	66
Barley	NP	NP	0	0	0	0	0	0	0	48
Pirton	100.00	0.00	35	11	0	0	0	0	46	46
Swift	75.00	12.50	6	0	1	0	1	0	8	200
Day Surgery Centre, Lister	100.00	0.00	9	3	0	0	0	0	12	144
Day Surgery Treatment Centre	99.10	0.00	102	8	1	0	0	0	111	145
Endoscopy, Lister	100.00	0.00	14	3	0	0	0	0	17	375
Endoscopy, QEII	100.00	0.00	2	3	0	0	0	0	5	62
Cardiac Suite	100.00	0.00	39	2	0	0	0	0	41	54
MEDICINE/SURGERY TOTAL	97.34	1.12	**535**	**161**	**11**	**4**	**4**	**0**	**715**	**2871**
Bluebell ward	90.00	1.67	40	14	4	1	0	1	60	146
Bluebell day case	100.00	0.00	3	0	0	0	0	0	3	12
Neonatal Unit	NP	NP	0	0	0	0	0	0	0	65
WOMEN'S/CHILDREN TOTAL	90.48	1.59	**43**	**14**	**4**	**1**	**0**	**1**	**63**	**223**
MVCC 10 & 11	100.00	0.00	2	0	0	0	0	0	2	47
CANCER TOTAL	100.00	0.00	**2**	**0**	**0**	**0**	**0**	**0**	**2**	**47**
TOTAL TRUST	96.79	1.15	**580**	**175**	**15**	**5**	**4**	**1**	**780**	**3141**

Continued over …..

Inpatients/Day by site	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses	No. of Discharges
Lister	96.77	1.16	576	172	15	5	4	1	773	3032
QEII	100.00	0.00	2	3	0	0	0	0	5	62
Mount Vernon	100.00	0.00	2	0	0	0	0	0	2	47
TOTAL TRUST	96.79	1.15	**580**	**175**	**15**	**5**	**4**	**1**	**780**	**3141**

Accident & Emergency	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses	No. of Discharges
Lister A&E/Assessment	96.83	3.17	98	24	0	0	4	0	126	8244
QEII UCC	95.65	0.00	16	6	1	0	0	0	23	3581
A&E TOTAL	96.64	2.68	**114**	**30**	**1**	**0**	**4**	**0**	**149**	**11825**

Maternity	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses	No. eligible to respond
Antenatal	100.00	0.00	1	0	0	0	0	0	1	459
Birth	100.00	0.00	0	1	0	0	0	0	1	419
Postnatal	100.00	0.00	0	1	0	0	0	0	1	419
Community Midwifery	100.00	0.00	1	0	0	0	0	0	1	474
MATERNITY TOTAL	100.00	0.00	**2**	**2**	**0**	**0**	**0**	**0**	**4**	**1771**

Outpatients	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses
Lister	98.63	0.46	185	31	2	1	0	0	219
QEII	100.00	0.00	2	0	0	0	0	0	2
Hertford County	100.00	0.00	13	3	0	0	0	0	16
Mount Vernon CC	96.00	4.00	22	2	0	1	0	0	25
Satellite Dialysis	100.00	0.00	100	7	0	0	0	0	107
OUTPATIENTS TOTAL	98.92	0.54	**322**	**43**	**2**	**2**	**0**	**0**	**369**

Trust Targets	% Would recommend
Inpatients/Day Case	96%>
A&E	90%>
Maternity (combined)	93%>
Outpatients	95%>

NP = Not provided

2. Performance Data:

CQC Outcomes Summary

Our CQC Registration and recent Care Quality Commission Inspection

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

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

At **Lister Hospital** CQC inspected:

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

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

- Urgent Care Centre
- Outpatients

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

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

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

Summary of the Trust's Ratings

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

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

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

Ratings for a combined trust

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

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

The requirement notices are:

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

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

Site Ratings

East and North Hertfordshire NHS Trust

Lister Hospital

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

New QEII

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

Hertford County Hospital

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

Mount Vernon Cancer Centre

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

Community Health Services for Children, Young People and Families

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