East and North Hertfordshire NHS Trust
Public Trust Board

REMOTE MEETING via TEAMS

2 March 2022 10:30 - 2 March 2022 12:30

AGENDA

#	Description	Owner	Time
1	STANDING ITEMS		
2	Chair's Opening Remarks	Chair	10:30
3	Apologies for absence		
4	Declaration of Interests	All	
5	Minutes of Previous Meeting For approval 5. Public Board Minutes 12 Jan 2022 inc KMC input... 5	Chair	
6	Actions Log For information 6. Public Trust Board Actions Log.pdf 17	Trust Secretary	

#	Description	Owner	Time
7	**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, stuart.dalton3@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.		
8	**Patient Story** For discussion	Chief Nurse	10.35
9	**Chief Executive's Report** For discussion 9. CEO Report.pdf 18	Chief Executive	10:55
10	**Board Assurance Framework** For discussion 10. BAF March 22 Board.pdf 20	Associate Director of Governance	11:05
11	**Integrated Performance Report** For discussion 11. IPR - M10 2021-22.pdf 51	All Exec Directors	11:10
12	**STRATEGY SECTION**		
13	**System collaboration update** For discussion 13. System Collaboration update.pdf 94	Deputy CEO	11.35

#	Description	Owner	Time
14	Digital Strategy update For approval 14. Digital Strategy update.pdf 100	Chief Information Officer	11.40
15	ASSURANCE AND GOVERNANCE SECTION		
16	Ockenden one year on progress update For discussion 16. Ockenden - one year on progress update.pdf 110	Chief Nurse	11.50
17	Elective recovery For discussion 17. Elective Recovery.pdf 117	COO	12.05
18	Sub-Committee Reports		12:15
18.1	Finance, Performance and People Committee Report to Board For noting 18.1 FPPC Board Report 012622 v2 approved by th... 146	Chair of FPPC	
18.2	Quality and Safety Committee Report to Board For noting 18.2 QSC Board Report 012522 approved by the C... 150 18.2 QSC Board Report 022222 approved by Chair.... 154	Chair of QSC	
18.3	Strategy Committee Report to BoardTo follow For noting	Chair of SC	
18.4	Audit Committee Report to Board For noting 18.4 Audit Committee Board Report 18 January 20... 158	Chair of Audit	
19	Annual Cycle For noting 19. Board Annual Cycle 2021-22.pdf 161	Trust Secretary	

#	Description	Owner	Time
20	Data Pack For noting [P] 20. Data Pack 2 Mar 22 Board combined.pdf 165		
21	AOB		12.25
22	Date of next meeting 6 April 2022 - Board Development 4 May 2022 - Trust Board		

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday 12 January 2022 at 10.30am at the Lister Hospital, Stevenage & via Microsoft Teams Video Conferencing

Present:	Mrs Karen McConnell	Non-Executive Director (Meeting Chair)
	Dr Peter Carter	Non-Executive Director
	Ms Val Moore	Non-Executive Director (via MS Teams)
	Mr Jonathan Silver	Non-Executive Director (via MS Teams)
	Dr David Buckle	Non-Executive Director (Associate) (via MS Teams)
	Mr Biraj Parmar	Non-Executive Director (via MS Teams)
	Mr Adam Sewell Jones	Chief Executive Officer
	Mr Martin Armstrong	Director of Finance & Deputy Chief Executive Officer
	Dr Michael Chilvers	Medical Director (via MS Teams)
	Mrs Rachael Corser	Chief Nurse (via MS Teams)
	Mrs Julie Smith	Chief Operating Officer (via MS Teams)
From the Trust:	Mr Thomas Pounds	Chief People Officer (via MS Teams)
	Ms Jude Archer	Associate Director of Governance (via MS Teams)
	Mr Mark Stanton	Chief Information Officer (via MS Teams)
	Mr Kevin Howell	Director of Estates & Facilities (via MS Teams)
	Mr Kevin O'Hart	Director of Improvement (Via MS Teams)
	Mr Stuart Dalton	Trust Secretary (via MS Teams)
Also in attendance:	Ms Deborah Price	Local Journalist (via MS Teams)
	Ms Eilidh Murray	Head of Communications (ENHT) (via MS Teams)
	Ms Julia Smith	Minute Taker (ENHT) (via MS Teams)

No	Sub-No	Item	Action
22/001		**CHAIR'S OPENING REMARKS**	
	22/001.1	The Chair informed the meeting that the meeting room attendees were in a Covid secure environment with good ventilation, social distancing and mask wearing.	
	22/001.2	The Chair welcomed Adam Sewell-Jones to his first Board meeting as Chief Executive. The Chair also noted that this meeting was the first for Biraj Parmar as a full Non-Executive Director.	
22/002		**APOLOGIES FOR ABSENCE**	
	22/002.1	Apologies were received from Mrs Schroder, Trust Chair.	
22/003		**DECLARATIONS OF INTEREST**	
	22/003.1	There were no declarations of interest.	
22/004		**MINUTES OF PREVIOUS MEETING**	
	22/004.1	The minutes of the previous meeting held on 3 November 2021 were	

approved as an accurate record of the meeting.

22/005 **ACTION LOG**

22/005.1 There were no outstanding actions on the Action Log.

22/006 **QUESTIONS FROM THE PUBLIC**

22/006.1 There were no questions submitted from the Public.

22/007 **CHIEF EXECUTIVE'S REPORT**

22/007.2 The Chief Executive gave the Board an update on the Covid position:

- The position of Omicron was fast moving. However, case numbers were currently plateauing both in general and in the ICU. The high dependency beds were not seeing the level of severity compared to previous waves of the pandemic.
- Operationally the hospital remained challenging, but staffing absence levels compared favourably against other NHS organisations. ENHT were not seeing the levels reported nationally and had been able to maintain services.
- The Lister site had been selected as the East of England surge hub should Covid cases increase as per the national modelling and a Nightingale hospital was being erected on the Lister Plaza. The Trust was playing an important role to ensure additional bed capacity across all regions of the country should a covid super-surge result in inpatients levels beyond the numbers hospitals could safely accommodate. However, whilst the Trust was preparing for the worst case scenario, it was hoped that Covid hospitalisation numbers did not reach the levels that would trigger the need to use the facility. The Board understood that the Nightingale may not be needed but agreed that it was far better that the Trust prepared with extra beds that were not needed rather than having patients that could not be cared for properly.
- The Board was presented with a video of the progress of the Nightingale build by the Director of Estates and Facilities. He highlighted that contractual issues were being worked through and that it was expected the equipment would be onsite and the final commissioning would be complete by 31st January 2022. The timetable although challenging was on schedule and Project Management had been provided by NHS England / Improvement (NHSE/I). The intention for use of the setting was for low acuity patients to ensure patient safety was paramount.

22/007.3 The Chief Executive informed the Board that the local CCG with support from the Trust had taken the decision to close the new QEII

overnight due to low levels of activity; he reported that the transition had been successful.

22/007.4 The Chief Executive explained to the Board that the Trust had been awarded an additional £6.88m in funding. He said three new procedure rooms across the Lister and QEII sites were being constructed. He continued that the purchase of a third surgical robot for certain complex procedures, a new digital scheduling system for Theatres and a specialist digital system for Ophthalmology would all improve patient experience and efficiency.

22/007.5 Mrs McConnell asked if the building of the Nightingale hospital was impacting the speed of the building of the new procedure rooms. The Director of Estates and Facilities explained to the Board that there were two separate contractors who were working together and both projects remained on schedule.

22/007.6 The Board **NOTED** the CEO's report.

22/008 BOARD ASSURANCE FRAMEWORK

22/008.1 The Board received and considered the latest edition of the BAF.

22/008.2 The Associate Director of Governance informed the Board that the Board sub-committees had reviewed all their risks in December and had not made any changes to the risk ratings. She said that following robust conversations around risks, the increased activity, the pressure on the specialities, operational activity and maintaining quality, all risks would continue to be a focus of the Board sub-committees.

22/008.3 The Associate Director of Governance informed the Board that the operational risk was rated at 20 and all others remained at a rating of 16 or below. She said all risks had mitigations and actions in place to ensure they were actively managed.

22/008.4 Mrs McConnell confirmed with the Board that risks had been discussed in detail at the Board sub-committees.

22/008.5 The Board **NOTED** the BAF.

22/009 INTEGRATED PERFORMANCE REPORT

22/009.1 The Director of Finance introduced the Month 8 Integrated Performance Report and noted that the areas of focus would be People, Responsive and Infection Prevention and Control.

22/009.2 **<u>People</u>**

The Chief People Officer highlighted the following:

- The main area of focus had been on planning, increasing capacity and effective deployment during increased pressures and staff unavailability due to Covid.
- The winter staffing hub had been deployed as well as a series of initiatives including deployment of the rapid response team,

flexible start and end times for shifts to maximise the use of temporary resourcing and centralised absence reporting to make best use of the workforce.

- Vacancy rates were in a good position over the last quarter.
- Support for staff continued to be a focus with the refurbishment of rest areas, different ways for staff to receive refreshments, recognition schemes, staff check-in sessions, wellbeing 121's and psychological support where appropriate.
- Senior leaders continued to emphasise the importance of the Covid and flu vaccinations, 96% of staff were confirmed as having received the first Covid vaccine dose and there remained a continued effort to support as many staff as possible in being fully vaccinated.

22/009.3 Dr Carter commented on the low response rate to the staff survey and was disappointed as it did not reflect his experience when he visited areas of the hospital and talked to staff, he felt the engagement should be higher than 39%. The Chief People Officer informed the Board that the final response rate was 42%, which was in line with national response rates for Acute Trusts, but agreed with the goal of a higher response rate. He said the Trust needed to demonstrate to staff how it had responded to their feedback which may encourage more people to complete future surveys.

22/009.4 Ms Moore complimented the good work being done and the volume of good news. She asked why appraisal compliance was low for November and commented that when appraisal conversations were positive and worthwhile it developed loyalty. The Chief People Officer explained the appraisal rate would not improve in the current covid climate but in April, as new organisational objectives were cascaded it was expected the number of appraisals to increase.

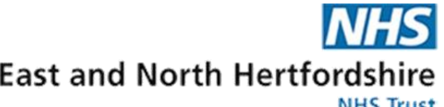
22/009.5 Mr Parmar asked if there was a connection between the staff who were content being more likely to complete the staff survey and if any analysis could be done on numbers of staff accessing well-being support and those completing the survey. The Chief People Officer assured the Board that there was a range of mechanisms for staff to access support and the percentage of staff accessing these could be identified. The Chief Nurse agreed that there was a direct correlation between good wellbeing and use of staff surveys.

22/009.6 **Responsive Services**

The Chief Operating Officer highlighted the following:

22/009.7

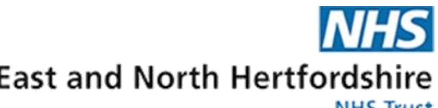
- Cancer Waiting Times
  The 62 day cancer standard target of 85% was surpassed in October with 86.1%. The Chief Operating Officer informed the Board that there was only a small number of Acute Trusts maintaining and improving this standard and ENHT was one.



She continued that November performance had further surpassed the target at 89.2% due to fast intervention.

- Diagnostics
  There had been a small improvement in diagnostics in-month through the use of existing initiatives including the community diagnostic hub and the QEII increasing diagnostic hours.
- The East of England were developing an Imaging Network of which the Chief Operating Officer would be the Senior Responsible Officer and the group would focus on areas including Imaging workforce and ensuring that all Imaging facilities and equipment were fully utilised.
- RTT
  Significant work was still underway to prioritise cancer patients to ensure the sickest patients were seen as well as the more urgent and those who had waited 104 weeks, 78 and 52 weeks. The RTT validation process was to ensure high quality patient information to enable accurate prioritisation.
- National funding had been received for additional treatment rooms, cancer diagnostics and a new surgical robot which would increase procedures, reduce recovery time and maintain the Trust as a leader in the field.
- Ambulance Waits
  There had been no deterioration in the Ambulance handover times although, in common with other Acute Trusts during covid, the expected standard was not met.
- A new area in the ED had opened for Ambulance handovers where ED staff would work with Paramedics to reduce the waiting times and to ensure patients were supported by the right staff. Improvements were expected in late December and January.
- The System approach to support the discharge process which would also support the front-door.
- Stroke
  There had been a reduction in achieving the 4 hour metric and Stroke remained a significant focus area for the Trust. The SSNAP metrics scanned times for 60 minutes and 12 hours were good but there were concerns around the urgent pathway. Several of the Non-Executive Directors were supporting the Stroke leadership team alongside the Stroke Network.

22/009.8 The Medical Director informed the Board that significant improvement had been made on Stroke mortality since 2017/18 when the Trust had been identified as close to being an outlier, he said that the although HSMR data remained high it had improved and aligned the Trust to peers whereas the SHMI data presented



ENHT as improved against peers. He said the Board could take assurance from the trajectory the data demonstrated.

22/009.9 The Chief Nurse informed the Board that the patient experience team had received a minimal amount of negative feedback from Stroke patients and increasing numbers of patients would recommend the Trust's Stroke services. She said the Stroke wards were accredited Silver which was a multi-professional platform as well as a digital exemplar for care of Stroke patients.

22/009.10 Dr Buckle commented he had visited the Stroke service and thanked the Chief Nurse and Medical Director for their continued support. He said he was assured the service was safe and that this would need to be maintained through the aspiration to achieve a SSNAP A rating.

22/009.11 Mrs McConnell commented that during the visit she had discussed detailed action plans and seen the commitment of the teams to implement changes in challenging circumstances. She was optimistic that the next planned deep dive would highlight the actions being implemented were making a positive difference.

22/009.12 **Quality, Safe and Caring**

The Chief Nurse explained to the Board that Infection, Prevention and Control (IPC) had been discussed at length at the Quality and Safety Committee in December, she highlighted:

22/009.13 There were only six empty beds due to IPC issues and all of these were in bays, there were no whole ward closures. The Chief Nurse commented on the hard work of the IPC team through the pandemic and she was proud of their continued response.

22/009.14 The Chief Nurse gave the Board assurance by explaining a full IPC BAF review would highlight any gaps and that actions to address any gaps would be covered.

22/009.15 The Chief Nurse explained to the Board that there had been zero outbreaks from other organisms further demonstrating the hard work of all teams.

22/009.16 The Chief Nurse informed the Board that visiting had been restricted due to the triggers being reached. She said the keeping in touch service would support families to maintain contact and the specialist advisory group would continue to review until the local incidences of Covid reduced.

22/009.17 The Board **NOTED** the Integrated Performance Report

22/010 2022-2023 PLANNING GUIDANCE

22/010.1 The Director of Finance presented the 2022/23 Planning Guidance to the Board and commented that it did not contain anything unexpected in the key priorities.

22/010.2	The Director of Finance drew the Board's attention to the Elective Recovery Programme slide and explained that the scale of the ambition for the elective recovery for systems to deliver 10% more elective activity than pre-pandemic would increase to 30% in three years. The Director of Finance informed the Board that ENHT was already carrying out a lot more activity than other Trusts of a similar size.
22/010.3	The Director of Finance highlighted to the Board the significant agenda for urgent and emergency care priorities that would increase and improve patient flow. He continued that the Virtual Ward would help to achieve this and by working with partners on mobilisation there had already been some success.
22/010.4	The Director of Finance informed the Board that there continued to be an emphasis on and investment in digital capability and this would continue into 2022/23.
22/010.5	The Director of Finance updated the Board that the commencement of the Integrated Care System as a statutory body had been deferred by three months to 1 July 2022 and that national and local plans would be adjusted.
22/010.6	The Director of Finance explained to the Board that the key features would be explored in a deep dive at a later date but in summary there would be a transition to a situation closer to business as usual and away from block payments. A reduced amount of support funding would be available as we transition from exceptional circumstances.
22/010.7	The Director of Finance highlighted that the timelines around the main priorities would be challenging. He said there would be some significant challenges such as mobilisation of virtual wards and eliminating 104 week waits. The Director of Finance commented that the challenges would extend to future years.
22/010.8	Mrs McConnell sought assurance that plans to address the challenges would continue to be examined through the Board and Board sub-committees. The Director of Finance explained to the Board that there was further work to do in briefing and planning and turning aspirations into meaningful plans to support both patients and staff.
22/010.9	Ms Moore commented that big organisational changes can be subject to delays which may cause issues as staff plan to retire or change jobs. The Chief Executive agreed with Ms Moore and added that change unsettles people and therefore the recruitment plan needed to continue to move ahead.
22/010.10	Dr Carter noted that there was no visible vehicle within the guidance to address the need for the ICS and local community to work together on issues such as admission avoidance.

	22/010.11	The Chief Executive explained that the National Guidance commenced with a series of caveats based on Covid which ultimately may change the final guidance. He added that the extra clinics and Saturday clinics would be a step change on a permanent basis. He continued that the Trust would need to be mindful of what the capacity changes would be and be agile in terms of new ways of working and opportunities.
	22/010.12	Board members congratulated the Finance team on the quality of the presentation.
	22/010.13	The Board **NOTED** the 2022/23 Planning Guidance
22/011		**SYSTEM COLLABORATION REPORT**
	22/011.1	The Director of Finance introduced the report and summarised the areas of collaboration.
	22/011.2	The Director of Finance highlighted the System Governance – Design and Reform section of the report. He explained during quarter 3 the Trust participated in task and finish groups to inform the shape of the future system. The groups covered governance arrangements and the target operating model.
	22/011.3	The Director of Finance informed the Board that there was significant interest at a system level in the Virtual Ward operating model and this would be a focus area.
	22/011.4	The Director of Finance explained that the Enhanced Services Steering Group had concentrated on areas including prevention of admission and discharge to home.
	22/011.5	The Director of Finance commented on the work with Hertfordshire Community Trust (HCT) over the last year and the work to develop models of service, leadership. Stroke, Neuro and community Paediatrics would be key focus areas.
	22/011.6	Ms Moore commented that it was a positive approach to new arrangements and looking at how effectively they were working across the areas and the way they feel for patients. She said the paper discussed the Lister site and asked if other sites were included. The Director of Improvement explained that a great deal of exploratory work and relationship building had been done with the Trust, HCT and the Council and a result there was a clear shared vision of moving services and improving pathways. He said there would be more clarity on how this could be moved forward around the virtual hospital and other areas.
	22/011.7	The Board **NOTED** the System Collaboration report.
22/012		**COMMUNITY DIAGNOSTICS CENTRE**
	22/012.1	The Director of Improvement informed the Board that the business case had been considered in detail at the November Finance, Performance and People committee (FPPC). He said it was being

presented to the Board for approval of the Community Diagnostic Hub five year plan utilising NHS funding. He continued that the plan also detailed the additional revenue expenditure required post NHS England funding to maintain the Hub.

22/012.2 The Director of Improvement informed the Board the Trust had been successful in securing national funding for diagnostic provision. He said the Phase 1 implementation would concentrate on services and Phase 2 would be around transformation and the wider expansion based on population health needs and improving outcomes and quality of life.

22/012.3 The Director of Improvement Highlighted to the Board that it was a Healthcare Partnership programme which included patient representation.

22/012.4 The Board received, **NOTED** and **APPROVED** the Community Diagnostic Hub business case.

22/013 LEARNING FROM DEATHS

22/013.1 The Medical Director informed the Board that the figures for Crude Mortality remained reassuring. He explained that for Hospital Standardised Mortality Ratio (HSMR) for the 12 month period the Trust was in the first quartile and for Summary Hospital-level Mortality Indicator (SHMI), ENHT was one of only 14 Trusts of 123 in the highest performing band.

22/013.2 For waves one and two of Covid the Trust were in the expected range for mortality for those patients confirmed to have Covid. The Trust was in a more positive position than others within the Trusts peer group.

22.013.3 There had been one HSMR alert for the other lower respiratory disease category and there were no SHMI outliers. A Pathway review would follow an investigation and would be managed through the mortality surveillance group.

22/013.4 The latest data from the National Hip Fracture Database (NHFD) highlighted a peak in December 2020 of 12%, however, the rate had since reduced to 10.8%. This was still above the national average and a deep dive into Hip Fracture patients would be undertaken to further understand the issues and apply the learning.

22/013.5 Areas highlighted for improvement included Acute Myocardial Infarction, Sepsis, Stroke and Emergency Laparotomy. Emergency Laparotomy was now in single figures but would remain a focus.

22/013.6 The Medical Director highlighted the learning and themes from concluded mortality reviews and assured the Board that actions were reviewed and completed.

22/013/7 The Chief Nurse commented that the mortality rate for LD patients was encouraging. She informed the Board that there had been a deep dive at the Equality and Inclusion committee and asked the

Board to note that there had been zero avoidable deaths in that specific community of patients.

22/013.8 The Board congratulated the teams on the positive position and the positive assurance the paper demonstrated.

22/013.9 The Board **NOTED** the Learning from Death report.

22/014 NURSING ESTABLISHMENT REVIEW

22/014.1 The Chief Nurse explained to the Board that the paper was presented to the Board for approval and highlighted that it had been discussed at length at the Quality and Safety committee and the FPPC.

22/014.2 The Chief Nurse informed the Board that there had been a good methodology undertaking the annual review and the results had been triangulated with clinical teams.

22/014.3 The Chief Nurse informed the Board that there was a recommendation for an uplift to reflect the inpatient requirement and temporary investment through winter.

22/014.4 Ms Moore informed the Board that the paper had been discussed and approved through the Board sub-committees for this year. She said study time for the ward areas needed to be ring-fenced other than in an emergency situation and there was an underlying intention to better cope with study leave.

22/014.5 The Board **NOTED** and **APPROVED** the recommendations in the Nursing Establishment review.

22/015 GREEN PLAN

22/015.1 The Director of Estates and Facilities presented the Green Plan to the Board and highlighted that it had been seen by the Board at an early stage in its development.

22/015.2 The Director of Estates and Facilities informed the Board that the plan had been managed through the Sustainability Group, as well as the Strategy committee. The Herts and West Essex ICS had commended the plan.

22/015.3 The Director of Estates and Facilities commented that there was further work to do to build partnerships outside of the Trust. He said creating sustainability through the use of estates and the development of procurement standards would be important. He informed the Board that with an Energy Manager, investing in the building fabric and commissioning a site-wide plan, net carbon zero could be achieved by 2040.

22/015.4 Mrs McConnell commented that a communication plan had been developed to support the Green Plan and that timing the launch of the plan would be important as staff were currently distracted by managing Covid. Mrs Moore agreed the importance of an effective

communication plan.

22/015.5 The Board **NOTED** and **APPROVED** the Green Plan.

22/016 REDUCING THE GOVERNANCE BURDEN DURING COVID

22/016.1 The Trust Secretary presented the paper and explained to the Board the intention was to reduce the burden during Covid to release time for key members of staff to focus on the operational pressures in the hospital.

22/016.2 Dr Buckle commented it was an appropriate move but the senior leadership team would need to accept there would be consequences of reducing the burden.

22/016.3 The Chief Executive commented that the leadership team would be available and would be undertaking routine work. He said it needed to be part of the efficiency gain and therefore not mandated but available if capacity allowed.

22/016.4 The Board **NOTED** and **APPROVED** the recommendations in the reducing the governance burden during Covid.

SUB-COMMITTEE REPORTS:

22/017 FINANCE, PERFORMANCE AND PEOPLE COMMITTEE REPORT TO BOARD

22/017.1 The Board received and noted the summary reports from the Finance, Performance and People Committee meetings held on 24 November 2021 and 15 December 2021.

22/018 QUALITY AND SAFETY COMMITTEE REPORT TO BOARD

22/018.1 The Board received and noted the summary reports from the Quality and Safety Committee meetings held on 23 November 2021 and 14 December 2021.

22/019 COMPLAINTS, PALs and PATIENT EXPERIENCE ANNUAL REPORT

22/019.1 The Board received and noted the Complaints, PALs and Patient Experience Annual report.

22/020 EQUALITY & INCLUSION COMMITTEE REPORT TO BOARD

22/020.1 The Board received and noted the summary report of the Equality & Inclusion Committee meeting held on 7 December 2021.

22/021 STRATEGY COMMITTEE REPORT TO BOARD

22/021.1 The Board received and noted the summary report of the Strategy Committee meeting held on 17 November 2021.

22/022 CHARITY TRUSTEE COMMITTEE REPORT TO BOARD

22/022.1 The Board received and noted the summary report of the Charity Trustee Committee meeting held on 13 December 2021.

22/023		**ANNUAL CHARITY REPORT and ACCOUNTS**
	22/023.1	The Board received, noted and approved the Annual Charity Report and Accounts.
22/024		**ACTIONS LOG**
	22/024.1	The Board received the latest version of the Actions Log.
22/025		**ANNUAL CYCLE**
	22/025.1	The Board received the latest version of the Annual Cycle.
22/026		**DATA PACK**
	22/026.1	The Board received the Data Pack.
22/027		**DATE OF NEXT MEETING**
	22/027.1	The next meeting of the Trust Board will be on 2 March 2022.

Karen McConnell
Deputy Trust Chair
January 2022

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

Agenda item: 6

EAST AND NORTH HERTFORDSHIRE NHS TRUST
TRUST BOARD ACTIONS LOG TO 2 MARCH 2022

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date

Chief Executive's Report

March 2022

I have continued to spend time in various departments across the Trust as part of my induction to the organisation. This has included observing front line clinical teams in areas such as robotic surgery in the Lister Treatment Centre, radiotherapy at the Mount Vernon Cancer Centre and Renal Dialysis in Harlow.

I have been struck by both the complexity of the work being undertaken as well as the skill and patient focus of the staff in those teams.

The hospitals remain extremely busy as we seek the balance the desire to treat as many patients as possible with reduced waits for treatment and the ongoing challenges of managing services in a safe way as the Covid pandemic continues.

Covid Update

The number of Covid positive patients in the Trust continues to run in the 50-60s with 59 positive patients (at the point of writing 21 February). The numbers in Critical Care are thankfully much lower with only 1 positive Covid patient and 0 positive Covid patients in Respiratory Support Unit (RSU). Staff sickness absence levels for the month was 6.3% of which 3.9% was short term absence largely relating to Covid. On average the Trust had 138 people absent per day due to Covid sickness or isolation which was amongst the lowest in the region.

The impact of the removal of national Covid restrictions will be reviewed and any changes recommended will then be communicated across the trust. The use of the redirooms (rapid temporary inpatient isolation tents) has been very positive allowing patients to be isolated on the ward and reducing the need to close beds in the adjacent bays.

Covid Treatment

In terms of treatment of Covid, staff at Lister Hospital have given potentially life-saving treatments to more than 300 people who are most at risk of becoming seriously ill from Covid.

The antibody and antiviral treatments are being offered to high-risk patients who have tested positive and treatment commenced in September 2021 to suitable inpatients at the hospital, and since December this has been expanded to those in the community. In some cases, this means taking an antiviral medicine at home, while for other patients they are asked to come into hospital for an infusion of monoclonal antibodies – which have been proven to lessen the chances of them being admitted to hospital due to Covid.

To date, staff have assessed more than 800 referrals and treated more than 300 eligible patients.

Nightingale Hospital

Fortunately, the Nightingale unit was not required to support surge bed capacity as the impact of Covid patients and staff isolating has reduced. A number of potential alternative uses were explored including an inpatient facility to support care of the elderly patients, medically optimised patients or patients coming to the end of their post elective recovery.

These alternative options to the potential Covid surge were explored by our clinical teams who did not feel that the unit was suitable for these alternative options due to a number of clinical risks. This final position was fed back to the national team, who were grateful that alternative uses had been explored but supported our decision. The unit remains on site pending deconstruction sometime in March/April. This is in line with all other Nightingale units apart from the Preston unit which has been utilised to support cancer patients.

Quality Award

Finally, congratulations to the gastroenterology team who have been awarded JAG accreditation for endoscopy services – demonstrating that they meet best-practice quality standards.

Gastroenterology endoscopy and colonoscopy services are essential to both diagnose and treat conditions involving areas such as the oesophagus, stomach, intestines, and rectum – including some cancers. These services are carried out at the Lister Hospital and New QEII Hospital and have continued throughout the pandemic.

JAG (the Joint Advisory Group on Gastrointestinal Endoscopy) accreditation measures the service on 4 areas – clinical quality, patient experience, workforce, and training.

Adam Sewell-Jones
Chief Executive

Agenda Item:10

TRUST BOARD PUBLIC SESSION, MARCH 2022
Board Assurance Framework Risks 2021/22

Purpose of report and executive summary (250 words max):
The BAF risks continue to be reviewed with each Director and Executive Team each month and at the Board and Board Committees and used to drive the agendas. The Trust's strategic risks for the Board Assurance Framework 2021/22 on one page. **Appendix a.** These with the exception of removing the reference to the short term risk of spending the capital allocation for 2020/21 (Risk 4) the scope of the risks remained unchanged for 2021/22. A formal review of the strategic risks will take place in the final stages of the development of the Trust's new Organisational Strategy. An early review of this in September has not indicated significant changes. The Trust's strategic priorities have been mapped to the Trust objectives for 2021/22 providing assurance on the coverage. **Appendix b.**

The BAF 2021/22 has been completed with each of the lead directors, **appendix c,** using the revised template approved by the Audit Committee. This supports greater visibility of the actions linked to the gaps in controls and assurance. Any updates to the text, controls and assurances from the previous month are highlighted in red text for ease.

Over the last months the Board and its Committees have continued to focus the agendas and discussions on the strategic risks, particularly with regards to the sustained increase in activity and pressures in specific specialities, e.g., ED, Assessment, Maternity, Paeds, Mental Health, and Critical Care. This was further compounded by the system pressures, the pandemic and recovery programme. The impact is beginning to reduce on a number of the BAF risks including Performance, Quality, People and governance. Short, medium and longer term actions remain in place to support the mitigation and active management of the risks. There are not any recommended changes to the ratings this month and key areas are covered on the Committee agenda and cycles.

The Board Committees have approved the risks they are the lead Committee and note for the Board:

- Risk 1 – Operational Performance: Recovery plans for elective performance are in line with the national requirement. FPPC considered deep dives on stroke and discharge improvement. A review of the risk score is in progress to consider when this can be appropriately reduced.
- Risk 4 – Capital: Recognising the significant investment of 2021/22, the overall risk assessment considered and agreed remains a 16 rating due to the level of risks that remain on the corporate risk register related to equipment and the estate.
- Risk 8 – Quality: Sustained improvements in key quality indicators noted including incident report, sepsis and positive quality CQC virtual assessments and internal/CCG quality assurance visits. Due to the profile of the issues impacting on risk changing over the last few months the risk score remains unchanged.
- Internal Audit annual review of the BAF and Corporate Risk Register concluded 'reasonable assurance.' The recommendations are already part of the work plan and include Board training session on risk for 2022/23; reduce risks overdue review; and align the 2022/23 BAF to the new Organisational strategy.

Action required: For discussion

Previously considered by: Considered at each Board and Board Committee. FPPC and QSC

Director: Chief Nurse	Presented by: Associate Director of Governance	Author: Associate Director of Governance

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

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

Any other risk issues (quality, safety, financial, HR, legal, equality): As documented under each risk

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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 <3 days off work, if staff	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	**Moderate**	Moderate injury requiring professional intervention RIDDOR reportable incident	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
4	**Major**	Major injury leading to long term incapacity requiring significant increased length of stay	Intermittent failures in a critical service Significant underperformance of a range of key targets	National media coverage and increased level of political / public scrutiny. Total loss of public confidence	Loss of between £501,000 and £5m
5	**Extreme**	Incident leading to death Serious incident involving a large number of patients	Permanent closure / loss of a service	Long term or repeated adverse national publicity	Loss of >£5m

Trust risk scoring matrix and grading

Likelihood / Impact	1 Rare (Annual)	2 Unlikely (Quarterly)	3 Possible (Monthly)	4 Likely (Weekly)	5 Certain (Daily)
Death / Catastrophe 5	5	10	15	20	25
Major 4	4	8	12	16	20
Moderate 3	3	6	9	12	15
Minor 2	2	4	6	8	10
None /Insignificant 1	1	2	3	4	5

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

BOARD ASSURANCE FRAMEWORK OVERVIEW

Risk Ref	Risk Description 2021/22	Lead Executive	Committee	Current Risk Feb	Last Month Jan	3 months ago	6 months ago	Target Score	Date added (Target dates for risk score/ changes)
001/21	Risk to operational delivery of the core standards and clinical strategy in the context of COVID recovery	Chief Operating Officer	**FPPC**	**20**	**20**	16	16	**12**	01.03.18 (June 21)
002/21	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 & Inclusion**	**16**	**16**	16	16	**12**	01.03.18 (April 21)
003/21	Risk of financial delivery due to the radical change of the NHS Financial Framework	Director of Finance	**FPPC**	**12**	**12**	16	16	**12**	01.04.19 (TBC)
004/21	There is a long term risk of the availability of capital resources to address all high/medium estates backlog maintenance, investment medical equipment and service developments (Updated May 2021)	Director of Finance	**FPPC**	**16**	**16**	**16**	**20**	**15**	01.03.18 (TBC)
005/21	There is a risk that the digital programme is delayed or fails to deliver the benefits, impacting on the delivery of the Clinical Strategy	Chief Information Officer	**Strategy**	**12**	**12**	**12**	**12**	**12**	01.04.17 (At target)
006/21	There is a risk ICP / ICS partners are unable to work and act collaboratively to drive and support system and pathway integration and sustainability	Director of Finance	**Strategy**	**12**	12	12	12	8	01.04.20 (April 22)
007/2	There is a risk that the Trust's governance structures do not enable system leadership and pathway changes across the new ISC/ICP systems whilst maintaining Board accountability and appropriate performance monitoring and management to achieve the Board's objectives	Chief Executive / Chief Nurse	**Board**	**12**	**12**	16	16	**12**	01.03.18 (21/22)
008/21	There is a risk that the Trust is not always able to consistently embed a safety and learning culture and evidence of continuous quality improvement and patient experience	Chief Nurse /Medical Director	**QSC**	**15**	**15**	**15**	**15**	**10**	01.03.18 (TBC)
009/2	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	**QSC & Inclusion**	**16**	**16**	16	16	**12**	01.03.18 (March 21)
010/2	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**	**15**	**15**	**15**	**20**	**10**	22.01.19 (TBC)
011/21	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 Finance	**Strategy**	16	16	16	12	12	01.04.20 (TBC)
012/21	Risk of pandemic outbreak impacting on the operational capacity to deliver services and quality of care	COO/Chief Nurse	QSC/Board	**10**	10	15	20	10 (Met June 21)	04.03.20 (April 21)

**Changes to the risk scores discussed at the October Board Committees and approved by Board in November.*

Board Assurance Framework Heat Map – February 2021

	Consequence / Impact				
Frequency / Likelihood	**1 None / Insignificant**	**2 Minor**	**3 Moderate**	**4 Major**	**5**
5 Certain	low 5	moderate 10	high 15	high 20 Existing: 001/21	high 25
4 Likely	low 4	moderate 8	moderate 12	high 16 Existing: 004/21, 009/21, 002/21, 005/21, 007/21, 011/21 Target: 004/21	high 20
3 Possible	very low 3	low 6	moderate 9	moderate 12 Existing: 007/21, 005/21, 003/21, 006/21 Target: 05/21, 011/21, 009/21, 003/21, 01/21, 002/21	high 15 Existing: 010/21, 008/21
2 Unlikely	very low 2	Low 4	Low 6	moderate 8 Target: 007/21, 006/21	moderate 10 Existing: 012/21 Target: 010/21, 012/21, 008/21
1 Rare	very low 1	very low 2	Very low 3	Low 4	Low 5

008/21 – Existing risk score

011/21 – Target risk score

Movement from previous month

REVIEW OF CURRENT STRATEGIC RISKS– MAPPED TO TRUST STRATEGIC PRIORITIES AND DRAFT OBJECTIVES 2021/2022

Our Vision

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

Our Priorities

1. Quality:	2. People:	3. Pathways:	4. Ease of Use:	5. Sustainability:
R2 Workforce R4 Capital R5 Digital R7 Governance R8 Quality R10 Estates R11 MVCC R12 Pandemic	R2 Workforce R8 Quality R9 Culture R12 Pandemic	R1 Op Delivery R5 Digital R6 ICP R8 Quality R11 Pathways R12 Pandemic	R1 Op Delivery R5 Digital R6 ICP	R1 Op Delivery R3 Finance R4 Capital R6 ICP R7 Governance R10 Estates R11 – MVCC R12 Pandemic

Our Objectives 2021/22 ***Board approved***

a)Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030 (R1 Op Delivery, R2 Workforce, R3 Finance , R4 Capital ,R5 Digital, R6 ICS/ICP, R8 Quality, R10 Estates,)

b)Safely restore capacity, and operational and clinical performance affected by the COVID-19 pandemic, working across the system to maximise patient benefits pandemic (R1 Op Delivery, R3 Finance , R4 Capital ,R5 Digital, R10 Estates, R12 Pandemic)

c) Embed and develop the new divisional structure and leadership model to further improve service quality (R1 Op delivery, R7 Governance, R8 Quality, R9 Culture)

d) Create a health and well-being offer that is amongst the best in the health service (R2 Workforce, R9 Culture)

e) Progress and develop our equality performance to build an inclusive culture in the workplace (R2 Workforce, R7 Governance, R9 Culture)

f) Using a population health management approach to plan and focus improvements, reduce health inequalities, and improve patient outcomes, experience and efficiency (R3 Finance, R5 Digital, R6 ICS/ICP, R8 Quality)

g) Working with system partners, progress development and delivery of integrated and collaborative services, making them easier to use for patients (R1 Op Delivery, R2 Workforce , R3 Finance , R5 Digital, R7 Governance, R8 Quality, R12 Pandemic)

h) Harness innovation, technology and digital opportunities to support new models of care (R1 Op Delivery , R4 Capital, R5 Digital , R8 Quality, R7 Governance, R9 Culture)

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

Our values

We put our PATIENTS first; we strive for excellence and continuous IMPROVEMENT; we VALUE everybody; we are OPEN and honest; we work as a TEAM

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: 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

Strategic Objective: a)Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030 b)Safely restore capacity, and operational and clinical performance affected by the COVID-19 pandemic, working across the system to maximise patient benefits pandemic c) Embed and develop the new divisional structure and leadership model to further improve service quality g) Working with system partners, progress development and delivery of integrated and collaborative services, making them easier to use for patients h) Harness innovation, technology and digital opportunities to support new models of care i) Develop a future, local vision for the Trust's cancer services, and support work with partners to safely transfer MVCC to a tertiary provider	**Source of Risk:** Strategic Objective IPR National Directives	**BAF REF No:**	001/21
Principal Risk Decription: 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: Feb-22	**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. vi) Increased risk to delivery of the ERF targets. More challenging delivery targets from 1st July (95% activity against a 19/20 baseline) – if the system does not meet these targets ERF monies will not be paid. vii) The Emergency Care Data Set (ECDS) for urgent and emergency care is being revised and Trusts will be expected to report against three new metrics from 1 November 2021 ('time to initial assessment', '12 hours in the department' and 'clinical ready to proceed') - viii) Impact of winter could impact on overall capacity within the hospital Targets set out in the NHSE/I guidance 'delivery plan for tackling the Covid-19 backlog of elective care'	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 vi) Financial Impact if the Trust does not meet the ERF targets - ERF monies will not be paid. vii) Reputational risk if performance standards are not achieved viii) Risk of winter demand/ illenses on overall capacity within the hospital	**Inherent Risk** (Without controls):	4	5	**20**	↔
		Residual/ Current Risk:	4	5	20	
		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 is ongoing, overseen by the Clinical Advisory Group. The group is chaired by a consultant. The Trust continues to have oversight of performance through three Delivery & Oversight Groups which meet monthly and focus on (1) Quality and Safety, (2) Performance and Transformation and (3) Finance and Workforce. In addition, a range of groups meet regularly to focus on specific aspects of performance and recovery. These groups take a targeted approached to review performance, identify risks and determine corrective action. These groups include a system-wide Cancer Board chaired by Trust's Chief Operating Officer, a weekly Gastroenterology group and the weekly Executive Committee. A weekly access meeting takes place. Recovery plans are in place for all specialities and progress is reviewed on a weekly basis. A series of deep dives - on monthly basis winter initiatives have been agreed to enable the Trust to respond to the pressures of the winter period; there is a risk that the additional staff required may not be available.	We have a set of 'flat pack' Covid escalation plans ready for use if required and we have developed Covid policies and procedures. We have developed a recovery dashboard which is divisional and specialty based. FPPC receives and reviews our IPR, performance reports and deep dives at its meetings. It also reviews ED performance and configuration, progress in relation to the endoscopy review and demand and capacity modelling. In addition we have divisional delivery operational groups, divisional Board meetings and a fortnightly clinical transformation group. Performance Deep Dives - Stroke, July 2021, Sept 21, Feb 22 Performance relating to ambulance handovers monitored through usual governance processes including the IPR. Theatre and Outpatients deep dives to FPPC, December 21. Major Trauma and Discharge Improvement Deep Dive Feb 22	Recovery of our performance continues to be good and we are exceeding our plans. Performance against RTT and diagnostics is improving. -RTT and DMO1 deep dive to FPPC June 21. The number of patients waiting over 18 weeks is decreasing.		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:** Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**		Amber
C1 Complexity of operation recovery in the context of COVID C2 National changes to guidance and policy requiring local response at short notice C3 Phase 3 capacity modeling to deliver national targets within financial model	A1 Define metrics to support monitoring of recovery A2 Capacity to support increased demand post COVID - endoscopy and other specialities - delivery against plans A3 Effectiveness of winter planning initiatives/ transformation with community A4 Optimisation and effective discharge	Green	Effective control is in place and Board satisfied that appropriate assurances are available	
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient	
		Red	Effective controls may not be in place and assurances are not available to the Board.	

Action Plan to Address Gaps (Action plan under review with Lead Direcotr and Managing Directors's)					
Action:	**Cross reference to gaps in controls and assurances (C1, C2...../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Deliver Operation Recovery Programme inline with national guidance and with risk stratification	C1, C2, C3	COO, MD's (Planned and Unplanned Care)		Monitored weekly and monthly. Access Manager now in post.	
ii) Continue to engage with our ICS and ICPs. Develop system recovery plan with ICP, PCN's, Community and Social Care services (e.g. further development of Ambulatory care to create ED capacity; discharge to assess)	C1, C2, C3, A1, A3, A2	COO, MD's (Planned and Unplanned Care)		Workstreams in place. Winter planning paper to FPPC in October 21 . Winter initiaitves approved - task and finish groups to monitor implementation	
iii) Delivery of the ED reconfiguation programme and SDEC	A1, A3	Unplannned Care Managing Director		ED capital plan and action plan report to FPPC , Sept 21.	in progress
iv) Delivery of discharge improvement programme	A4	COO		Discharge improvement update on October agenda for FPPC	in progress
v) Delivery of bed reconfiguration programme	A2., A3	COO/ Director of Estates			
iv) Review delivery performance metrics in line with standards	A1,	COO		Review of new national ED standards. Measures running in shadow form; paper to FPPC in Feb 21. Exploring the use of predictive analyitics (FPPC in June 2021)	
iv) Delivery of elimination of ambulance handover waits	A1,	COO		Action in place including earlier escalation to surge plans	
Summary Narrative:					

July 2021: New guidance has been issued requiring performance to be at 95% against 19/20 activity levels. This will be challenging to achieve, particularly with increasing Covid numbers and a predicted 4th Covid wave. If the system as a whole does not achieve the targets ERF monies will not be paid. Sept 21: Although challenging the Trust has so far performed well against these new standards. As we approach winter, competing pressures and an increase in Covid numbers and a potential decrease in available workforce could make this position harder to sustain'.
October 2021: Risk level reviewed at QSC and FPPC and recommended increasing the risk from 16 to 20; recognising the impact of the current operational performance/ challenges and continued challenges of activity, winter pressures, competing priorities, impact of staff sickness. FPPC recieved a deep dive and assurance on the Discharge Improvement Programme and Winter Planning - including internal and system wide actions/initiatives to support mitigation of the risk. Noting next months deep dive will focus on RTT recovery.
November 2021: The Board considered the requirement to eliminate ambulance handovers and approved the proposed actions. Monitoring will take place through the usual governance processes including the IPR.
December 2021: Impact of the level 4 incident on performance and operational delivery is under close review.Response developed in line with the national guidance.
February 2022: We are closely monitoring the performance of all specialities. We are developing plans to recover elective performance and deliver the targets set out in the February 2022 'delivery plan for tackling the Covid-19 backlog of elective care'. NHSE/I published a 'delivery plan for tackling the Covid-19 backlog of elective care'. The guidance sets out plans for the NHS to return to pre-pandemic performance as soon as possible. The intention is that around 30% more elective activity is delivered in 2024/25 than before the pandemic. Risk rating under review to consider if it can be reduced.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: Sustainability, Quality, PeopleWe provide a portfolio of services that is financially and clinically sustainable in the long term . We deliver high quality, compassionate services consistently across all our sites. We create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce.

Strategic Objective: **a)Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030** **d) Create a health and well-being offer that is amongst the best in the health service** **e) Progress and develop our equality performance to build an inclusive culture in the workplace g) Working with system partners, progress development and delivery of integrated and collaborative services, making them easier to use for patients**	**Source of Risk:**	strategic objectives	**BAF REF No:**	002/21	
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the workforce model does not fully support the delivery of sustainable services impacting on health care needs of the public.	**Risk Open Date:**	Sep-20	**Executive Lead/ Risk Owner**	**Chief People Officer**	
	Risk Review Date:	Jan-22	**Lead Committee:**	**FPPC and QSC**	

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Failure to develop effective workforce plan/workforce model for each service that takes account of new/different ways of working. ii) Failure to maximise staffing options through the use of flexible working initiatives. iii)Failure to work collaboratively across the Integrated Care System. iv)Failure to develop staff to be able to work more flexibly in terms of role design. v) Impact of the pandemic and self isolation guidance on the availability of staff	i) Current staffing models may not be cost-effective. ii) There may be an adverse impact on service quality and safety. Iii) Recruitment costs may be higher than necessary. iv) Staff may not have the required skill set to support innovative role design and ways of working.	**Inherent Risk** (Without controls):	4	5	**20**	⟷
		Residual/ Current Risk:	4	4	16	
		Target Risk: (TBC)	4	3	12	

Controls/ Risk Treatment: **(Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
i) A process by which articulation of clinical strategy is linked to organisational redesign and workforce modelling. ii)Workforce transformation approach to service development. iii)Demand and Capacity Modelling. iv) People Strategy action planning v) Finance and People Divisional Board / Divisional Oversight Group. Established Workforce triggers and redeployment processes	i) Care Quality Commission service inspections / TRA's ii) Staffing costs /staff turnover costs iii) Monthly safer staffing reports to QSC Nursing establishment review, Dec 21 Workforce Assurance Framework for winter, Dec 21(N&M)	Erostering Internal Audit - 'reasonable' assurance 2020.		yes

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:** Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
C1. Inadequate links between service planning and workforce planning. C2. Lack of horizon scanning to allow early recognition of potential skills gaps. C3. National shortages of clinical professionals and failure to engage clinicians in the workforce planning process. C4. COVID/ Post covid challenge to existing workforce model - ability to maximise using staff flexibly	A1 the variation between current staffing arrangements and optimum workforce model is not yet quantified. A2 ability readily monitor capability, specialist skills and risk assessments to maximise using staff flexibly	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient

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

Action Plan to Address Gaps

Action: (Actions under review with CPO)	Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)	Lead:	Due date	Progress Update	Status: Not yet Started/In Progress/ Complete
i) Ongoing implementation of the People Strategy to support staff recruitment and retention, in particular through the development of a strategic forum to link future organisational design requirements with job design and provision of necessary educational support.	C1, A1	Chief People Officer		Staff experience Group in place to consider exit interview data / undertaking workforce planning with services via the integrated business planning process will identify new ways of working and roles to support development / education board considers other development and training mechanisms to support R&R. Jan 22: The Staff engagement group has not met in Dec/Jan due to Covid pressures and staff absences and work will reconvene in February	In progress
ii) Enhance areas of staff supply	C2	Chief People Officer		Continue to work with NHS Professionals on bank recruitment to support staffing shortfalls, plans have been agreed for 21-22 with clear targets in place throughout all staff-groups. / International recruitment continues to identify and recuit additional staff as needed	In Progress
iii) Work with divisional leadership on demand and capacity modelling, and establish workforce architecture/modelling approach and capability	C1, C2, A1	Chief People Officer		Workforce Planning gap identified in current establishment, has been addressed in the revised people team structure. Some work has been undertaken with the planning team around demand and capacity modelling but in it's infancy.	In progress
iv) Improve the offer to staff around flexible working.	C4, A2	Chief People Officer		flexible working review being undertake in conjunction with establishment review to assess winter and summer plans and options appraisals. Jan 22: Research working group completed and scope report due end January, pilot of flexible working to be identified and run with view to scale up later in 2022 in other areas	In progress
v) delivery of a Education and a capability strategy for the organisation	C1, C2, C3, C4	Chief People Officer		The People Stategy launched in 2019, bringing education, training and Leadership under capability. A number of senior personnel changes and covid has led to a slow and steady implementation of this plan. In June 2021 the Capability strategy was launched, this has been presented to QSC. To deliver against the strategy structural changes remain to be implemented, which are planned for Q4. Currently the service is reliant on a high number of seconded staff to meet demands and there are a small number of staff absent due to long term sickness causing a significant impact on service delivery, particularly in Medical Education. These are hard to fill with bank and senior leaders are having to directly support services. A deep dive into the LDA and education finances is required to ensure in future that activity and payment are met, ensuring quality and value for money Jan 22:New AD commenced in post Jan and this work is now underway	In Progress
Summary Narrative:					

December 2021: Impact of the pandemic and self isolation guidance on the availability of staff. Staff Risk assessments in place in line with national guidance. Workforce triggers and redeployment processes reviewed and ready to stand up when required.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term

Strategic Objective: a)Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030 b)Safely restore capacity, and operational and clinical performance affected by the COVID-19 pandemic, working across the system to maximise patient benefits pandemic f) Using a population health management approach to plan and focus improvements, reduce health inequalities, and improve patient outcomes, experience and efficiency g) Working with system partners, progress development and delivery of integrated and collaborative services, making them easier to use for patients i) Develop a future, local vision for the Trust's cancer services, and support work with partners to safely transfer MVCC to a tertiary provider	Source of Risk:	Operating Plan- Use of Resources - Financial Framework 2021/22	BAF REF No:	003/21
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 associated with the current COVID pandemic	**Risk Open Date:**	01/04/2018	**Executive Lead/ Risk Owner**	**Director of Finance**
	Risk Review Date:	Feb-22	**Lead Committee:**	**FPPC**

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

Controls/ Risk Treatment: **(Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Regular Monthly financial reporting arrangements in place• COVID expenditure tracking and approval processes in place• Recruitment approval mechanisms in place• Financial appraisal and pre-emptive agreement of winter pressure and P3 programmes • Attendance at regular national, regional and ICS DOF briefing and engagement sessions • Suite of weekly internal Finance SMT meeting to track financial delivery and governance issues • Mth 1-6 and M7-12, internal budget frameworks in place • Strong framework of BI financial reporting tools deployed to track and monitor delivery • Weekly Demand & Capacity meetings to track P3 delivery achievement and associated PAM meetings to support accurate and comprehensive activity capture • MVCC Due Diligence meeting, plus Critical Infrastructure meeting • Implementation of Divisional Finance Boards to promote strong financial governance - Financial Planning 2021/22 & including ICS developments to FPPC in January 21.	Monthly Finance Reports to FPC, Board and Divisions (L1) • Monthly cash reporting to FPC / Trust Board and NHSI(L2) • COVID governance and reporting briefing to FPPC • COVID financial planning updates to monthly FPPC and Exec Committee• Monthly Accountability Framework ARMs including Finance (L1) • Bi- Monthly Financial Assurance Meetings & PRM with NHSE (L1) • Regular Data quality and Clinical Coding updates to PAM and AC (L2) • Weekly D&C activity tracking meetings • Forecast activity and winter planningbed model in place linked to M7-12 financial plan • Internal Audit review programme - Costing Assurance Audit and action plan to FPPC in June 2021			I&E delivery against financial plan Cash balances maintained within prescribed limits • Capital spend to be maintained within approved levels • Temporary staffing spend to be maintained within agreed threshold

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**	(Amber)
C1 nconsistent delivery of routine budget management meetings across divisions C2 Impact from the system funding distribution under the new finance framework C3 Variable capture and escalation of winter and in year cost pressures C4. Weak temporary staffing control environment in respect of medical and nursing staffing C5 Ongoing COVID ineffiencies	A1. Impact future funding frameworks on Trust financial sustainability strategy A2. Embedding of core financial and business competencies within divisional teams A3 Clarity in respect of NHS contract and business arrangements for 21/22 A4 Impact of the Implementation of 'ENHT Way' as a means of delivering future financial savings A5 Assurance in respect of the delivery of the 21/22 summer and winter bed plans within agreed parameters, with the associated risk of additional unplanned costs	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps (Actions under review by Lead Director)

Action:	Cross reference to gaps in controls and assurances (C1, C2...../ A1, A2 etc)	Lead:	Due date	Progress Update	Status: Not yet Started/In Progress/ Complete
i) Launch and development of Finance Academy for all Budget holders	C1, A2	Director of Finance		Launched in May 2021	In progress
ii) Development of Finance Sustainablity Strategy in line with the NHS Financial Framework and monitoring delivery	C2, C5, A1, A3,	Director of Finance		H2 planning guidance and budgets , FPPC Sept / October 21	
iii) Continue to develop BI and support divisions / directorates using effectively	C1, C4	Director of Finance			
iv) Engagement with Divisions/ Directrates on delivery on financial savings from month 6	C5, A4, A5	Director of Finance / Direcotr of Improvement / MD's (Planned ad Unplanned)		H2 CIP Delivery plan to Sept / October 21 FPPC	
Summary Narrative:					

October 2021: Risk level reviewed at FPPC and recommended reducing from 16 to 12, taking in to account the current and forecast position including the reports on the H2 Planning Guidance and budget and H2 CIP delivery. December / January/ February: No changes

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

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)Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030 b)Safely restore capacity, and operational and clinical performance affected by the COVID-19 pandemic, working across the system to maximise patient benefits pandemic h) Harness innovation, technology and digital opportunities to support new models of care	**Source of Risk:** Business Plan, Clinical Stra	**BAF REF No:**	004/21
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk of the availability of capital resources to address all high/medium estates backlog maintenance, investment medical equipment and service developments.	**Risk Open Date:** 01.03.18	**Executive Lead/ Risk Owner**	**Director of Finance**
	Risk Review Date: Feb-22	**Lead Committee:**	**FPPC**

Causes	Effects:
Lack of available capital resources to enable investment • Weakness in internal prioritisation processes • Weak in year delivery mechanisms to ensure commitment of resources • Weak assessment of the long term capital resources to meet strategic objectives • Requirement to repay capital loan debts • Volume of leased equipment not generating capital funding resources • COVID capital funding arrangements impact BAU capital requirements • Weak internal understanding of NHS capital funding arrangements • Poor internal business case development skills	• Aged equipments and assets - at our beyond lifespans • Increased associated risks to continuity and reliability of service delivery eg. Radiotherapy • Limited ability to invest in IMT, equipment and services developments • Limited innovation and associated limitations on ability to deliver efficiencies • Negative Impact on the potential to deliver the overarching Trust strategy • Annualised and sub optimal process of competitive short term bidding • Difficulty in expressing a coherent capital profile to external stakeholders eg. ICS / Region / DH

Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
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**
• Six Facet survey undertaken in 17/18• Capital Review Group meets monthly to review and manage programme spend • CRG Prioritising areas for limited capital spend through capital plan • Fire policy and risk assessments in place • Asset Register Maintained by the Finance Department • Mandatory training• Equipment Maintenance contracts • Monitoring of risks and incidents • ICS capital monitoring processes across the system • Directors of Finance and E&F meet weekly with teams to track and facilitate capital spend • Equipment review process to support covid 19 pandemic requirements • Implementation of the new Capital and Cash Framework • Detailed Qlikview Capital Monitoring Application in place • Bi weekly MVCC Critical Infrastructure group with stakeholders	• Annual AE report on Fire Safety to H&S Committee (L2) - Monthly Fire Safety Committee • Monthly Capital Review Group (CRG meetings) feeding into FPC and Exec Committee (L1) • Report on Fire and Backlog maintenance to RAQC(L2) • Reports to Health and Safety Committee (L2) • Capital plan report to FPPC (L2) • Annual Fire report (L3) • PLACE reviews (L3) • Reports to Quality and Safety Committee • Steering Groups in place to oversee strategic programme delivery eg. Vascular, Renal, Ward Reconfiguration & ED • Capital programme report, FPPC May 21. - Risk Register reports to CRG	• External Audit process reviews the appropriate accounting and treatment of capital assets. • DH / NHSE review and approval of strategic business case schemes requiring funding		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**	
C1. Not fully compliant with all Fire regulations and design C2. No effective arrangements presently in place to monitor and control space utilisation across the Trust C3. No formalised equipment replacement plan or long term capital requirement linked through to LTFM and Trust Strategy C4. Weaknesses in Estates and facilities monitoring structures and reporting C5. Absence of Overarching site Development Control Plan	A1. Availability of capital through either internal or national funding sources A2. Implementation of the new capital and Cash Framework A3.Transparent mechanisms to access Section 106 funding A4. Long Term Capital Investment Plan to regulate investment	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	Cross reference to gaps in controls and assurances (C1, C2...../ A1, A2 etc)	Lead:	Due date	Progress Update	Status: Not yet Started/In Progress/ Complete
i) Estates strategy to support the trust clinical strategy	C1, C5, A4	Director of Estates and Facilities	TBC	Development to be reported Strategy Committee	Not yet started
ii) Develop capital equipment replacement plan	C3, A4	Deputy Director of Finance	Ongoing	Capital Planning for 2021/22 paper to FPPC in March 21, based on new planning guidance.	In progress
iii) Develop programme for Charity to support with fundraising	A1	Deputy Director of Finance / Head of Charities	Ongoing		In progress
iv) Agree capital investment for 2021/22 and monitor delivery	C4, A2	Executive	May-22	Report to May FPPC. For 6 monthly review. Report on ED capital plan to FPPC in Sep 21. Up date on ED project and Captial spend against plan to FPPC in November 2021	In progress
v) Review other sources of funding / opportunities for investment	A1, A3	Director of Finance / Project leads	Ongoing		In progress
vI) Undertake detailed space utilisation survey, implement revised strategy and then monitor	C2	Director of Estates and Facilities / Improvement Director	TBC		In progress
Summary Narrative:					

June 2021 ,following review, including structures and monitoring in place, further actions and oversight of the risks, and the FPP Committee discussions in May 21, the rating has reduced to 16. October 2021: FPPC discussed the risk rating and confirmed it remains a 16; taking into account the longer term position of access to capital . December / January: No changes February: Overall risk assessment considered and agreed remains a 16 due to the level of risks that remain on the corporate risk register related to equipment and estate.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: Trust Strategic Aims: Quality: To deliver high-quality,compassionate services,consistently across all our sites 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

Strategic Objective: Trust Objective: a)Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030 b)Safely restore capacity, and operational and clinical performance affected by the COVID-19 pandemic, working across the system to maximise patient benefits pandemic f) Using a population health management approach to plan and focus improvements, reduce health inequalities, and improve patient outcomes, experience and efficiency g) Working with system partners, progress development and delivery of integrated and collaborative services, making them easier to use for patients h) Harness innovation, technology and digital opportunities to support new models of care i) Develop a future, local vision for the Trust's cancer services, and support work with partners to safely transfer MVCC to a tertiary provider 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:	005/21
Risk Open Date:	Jun-20	Executive Lead/ Risk Owner	Chief Information Officer (CIO)
Risk Review Date:	Feb-21	Lead Committee:	Strategy Committee

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

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 AvailabilityFailure to resource its delivery within timescalesTrusts may not be in a position to finance the investment (including Lorenzo renewal 2022) iii) Business RiskIT resources may get diverted onto other competing Divsional projects iv) Knowledge & ExperienceDelivery team does	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, licence) iv) adverse impact on performance reporting	**Inherent Risk** (Without controls):	4	5	**20**	
		Residual/ Current Risk:	4	3	12	
		Target Risk:	4	3	12	

Controls/ Risk Treatment: **(Preventive, Corrective, Directive or Detective)**	**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**
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 engagementBusiness 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 processFinancial / Resource Availability Risk:Business case identifies resourcing from the Divisions and makes provisions for back-fill where appropriateKnowledge & Experience Risk:Key roles (Programme Director, Procurement consultant, Architect etc.) are identified and recruited at and early stage an retained.New Performance Delivery Framework Clinically led workstreams feeding into the Digital Steering Group (model from EPMA) Digital roadmap to 2022, with 2020/21 priorities (July 2020)	• Reports to Executive Committee,Strategy Committee and Board (L2)• Weekly Executive monitoring(Where appropraite) aligned with clinical strategy- staff engagement acorss all sites, at all levels during COVID 19 adopting new many technologies for communication and service delivery Transformation DOG - Strategy for "Evolving our technology" , including including road map to 2022 presented to Strategy Committee, Feb 2021.	Disaster recovery - IA - Limited (action plan in place) Cyber Maturity - IA - green except - network security and secure configuration		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**	
C1. Poor attendance from stakeholders at the Digital steering group C2. Availability of capital to deliver priorities C3. No long term digital plan beyond 2022 (Contractual end date for Lorenzo) C4 Integration into Divisional planning for resource management delivery of tachical solutions to delivery the five priorities rather than the digital road map NHS I/ D/ X expection that we implement with little time and enable of - systems / timeface to enable local scruitinty	A1. Delivery of the roadmap and measures of progress A2. DSO and IGM capacity to support the DPIA processes for increase pathway changes (action to be confirmed with CIO) A3 Clinical engagement and leadership to support developing and embedding the changes	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:	Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)	Lead:	Due date	Progress Update	Status: Not yet Started/In Progress/ Complete
i)Engagement and delivery of the digital roadmap against plan	C1, A1	CIO		Sept 21 update - Delivery in progress. Roadmap has been updated on all workstreams and was presented to the Trust in July 2021. October : KOPS (Keeping our patients safe) launched in October 2021. November 2021: Update on digital strategy presented to Strategy Comm.	In progress
ii) Seek investment through ICS where available	C2	CIO		Sept 21 update - Creation of a business Case to support Digital Aspirant/Unified Technology Digital funding is underway. ICS and regional stakeholders engaged. Other funding oppertunities being actively pursued as they become available.	In progress
iii) Long term Lorenzo strategy/commercials to be finalised	C3	CIO		Sept 21 update- Lorenzo strategy under consideration within the scope of above business case.	In progress
iv) Implementation of a Business partner process (Post Silver)	C4	CIO		Sept 21 update - No update but in progress	In progress
v) Relaunch of EMPA roll out	A1	Deputy Medical Director, Chief Pharmacist and CIO		Sept 21 update - Rollout planning has now commenced. EPMA full rollout delayed.	In progress
vi) recruitment into Chief Nurse Information Officer Role	A3	Chief Nurse	Jan-22	Recruitment commenced August 21 interviews scheduled for end September. October 21: Appointed and due to commence in January 2021.	In progress
Summary Narrative:					

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: 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

Strategic Objective: **a)Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030 f)** **Using a population health management approach to plan and focus improvements, reduce health inequalities, and improve patient outcomes, experience and efficiency**	**Source of Risk:** National directives	**BAF REF No:**	Risk 006/21
Principal Risk Description: What could prevent the objective from being achieved? ICP/ICS partners are unable to work and act collaboratively to drive and support system and pathway integration and sustainability	**Risk Open Date:** 01-Apr-20	**Executive Lead/ Risk Owner**	**Director of Finance (From August 21)**
	Risk Review Date: Feb-22	**Lead Committee:**	**Strategy**

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Lack of effective collaborative system leadership ii) Executive, clinical and operational leadership and capacity iii) Ability of the ICP to effectively engage primary care iv) Lack of synergies between organisational, ICS and ICP strategic development and priorities v) Lack of risk and benefit sharing across the ICP vi) Complex 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 pace and benefits of transformation	**Inherent Risk** (Without controls):	4	4	**16**	
		Residual/ Current Risk:	4	3	12	⟺
		Target Risk:	4	2	8	

Controls/ Risk Treatment: (Preventive, Corrective, Directive or Detective)	Assurances on Control (+ve or -ve): Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	Positive Assurance (Internal or External) Evidence that controls are effective.	Positive Assurance Review Date	Key Performance Metrix aligned to IPR
• ICP Partnership Board Building on the successful system working in response to the pandemic • ICS CEO bi-weekly meeting ICS Chairs' meeting • Joint projects such as Vascular Hub project with West Herts and PAH; ICS pathology procurement; Imaging Networks • ENH improvement methodology - 'here to improve' • Integrated discharge team • OD support for ICP development • ICP Development Director based at ENHT one day/week to support developing relationships - ENH ICP Directors' Group	Reports to Board and FPC Reports to ICS CEOs' Reports to Partnership Board Reports to ICP CPex and TDG Collaboration Report to Strategy Committee and Board Pathology Procurement report, Vascular Services report and monitoring via Stategy Committee and Board Population health data presented to FPPC in May 21			

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	Gaps in Assurance: Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	Reasonable Assurance Rating: G, A, R	
C1. Partnership Board Scope for accelerated development of ICP and governance arrangements that support collaborative transformation at pace C2 Need to identify and release clinical leadership capacity to drive greater pan system understanding of population health and priorities for ICP improvement work C3. Need to influence and understand future Trust and ICP representation with ICS from Apr 22 - Identification of dedicated capacity to support provider collaboration C4 Maximising the implementation of an improvement model to build capability and capacity	A1. Availability of population health data to inform shared priorities for transformation and improvement A2. ICS PHM learning set commenced March 21 Trust COO representaton at the ICP Transformation and development group to enable integrated pathway redesign. A3. Assurance that ENHT voice fully represented by ICS in key discussions e.g. satellite radiotherapy. To be discussed at CEO level	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps (action plan under reivew with Lead Director)

Action:	Cross reference to gaps in controls and assurances (C1, C2...../ A1, A2 etc)	Lead:	Due date	Progress Update	Status: Not yet Started/In Progress/ Complete
i) Continue to review and evolve the ICP and ISC governance structures in line with national guidance	C1, A3	Chief Executive (with Associate Director of Governance & Trust Secretary)		MoU recommended for approval by statutory Boards. New ICS design guidance published June 2021 - ICP governance under development by Impact Group.	in progress

ii) Agree and deliver approach ICP priorities through collaboration - developing risk and benefit sharing	C3, A2	COO/ Director of Finance		ICP developing refreshed strategy and developing plans for April 22 in conjunction with ICS development and transformation. Bi-lateral work undertaken with HCT on potential models of collaboration. Agreed joint transformation project to develop enhanced services in the community to support reduction of acute LoS and alternatives to admission at Lister.	in progress
iii) To consider with the ICS/ICP a joint improvement model to collaborate on to facilitate cross organisational working and building capability and capacity. E.g 'here to improve'	C4	Director of Improvement		The ICP Virtual Transformation Model has now been established and sucessfully working since January 2021. Agreement was reached this month for all Providers toa dopt the same PM3 project software solution. Discussions regarding our CI model are ongoing as there is not yet a shared vision.	
iv) continue to identify clinical leadership capacity to support the development of collaborative, ICP integrated pathways	C2, C4	Medical Director/Director of Nursing			
v) To share the ENHT population health data with the wider ICS and ICP to facilitate discussion and agreement of priorities	C3, A2, A1	Director of Finance		Population health data under development. ICP commenced a health inequalities sub-group to enhance and advice CPEx on health inequalities.	in progress
vi) To review the Trust representation at the revised ICS workstreams for 2021/22	A3	Director of Improvement with COO/ Director of Finance		On hold pending ICS confirmation of 21/22 transformation programmes. Director of Strategy attends ICS Design & Delivery Group to maintain connection with ICS programmes pending confirmation.	Not yet started
Summary Narrative:					

Feb 22 - Bid submitted to ICS re development of elective hub at Lister Hospital, incorporating capacity for PAH and WHHT. ICS presenting elective hub conccept to Region with exact location to be decided. Ongoing work with system partners to support patient flow into and out of hospital.
Jan 22 - work ongoing re future governance structure of ENH HCP; strategy refresh in final stages; population health steering group helping to provide focus on future service development. CDH work progressing.
Sep 21 - DDoS contributing to development of ICP Strategy; ongoing work on Strategy Refresh, including areas identified for PHM projects; transformation team part of shared project resource on key collaborative ICP projects
Aug 21 - confirmation received of funding for year 1 of CDH; business case for year 2 approved in principle by Execs; work on IBP continues
July 21 - ICP bid submitted for Community Diagnostic Hub at QEII, with pilot in community; helping to build joint working with system partners
June 21 - MoU recommended for approval by statutory Boards. ICP developing refreshed strategy and developing plans for April 22 in conjunction with ICS development and transformation. Work underway to test alternatve models of collaboration. Agreed joint transformation project to develop enhanced services in the community to support reduction of acute LoS and alternatives to admission.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

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: **c) Embed and develop the new divisional structure and leadership model to further improve service quality e) Progress and develop our equality performance to build an inclusive culture in the workplace g) Working with system partners, progress development and delivery of integrated and**	**Source of Risk:**	Strategic Objectives External reviews	**BAF REF No:** 007/21
Principal Risk Decription: What could prevent the objective from being achieved? 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	**Risk Open Date:**	01.04.2020	**Executive Lead/ Risk Owner:** **Chief Executive**
	Risk Review Date:	Feb-22	**Lead Committee:** **Board**

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

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Monthly Board meeting/Board Development Session/ Board Committees • Annual Internal Audit Programme/ LCFS service and annual plan • Standing Financial Instructions and Standing Financial Orders • Each NED linked to a Division • Commissioned external reviewsReview 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 - Board committees with Annual Cycles included scheduled deep dives. - Incident gold/silver command structure in place from mid March 2020 and reviewed/ flexed to ensure meets organisaitonal needs Delivery oversight framework in place. Partnership Board and ICP Board and groups established and link to divisional structures Board development programme	• Commissioned external reviews – PwC Governance Review September 2017 NHSI review of Board and its committees 2019 • Visibility of Corporate risks and BAF as Board Committees and Board (L2)• Internal Audits delivered against plan, outcomes report to Audit Committee • Annual review of SFI/SFOs (L3) Annual review of board committee effectiveness and terms of reference (May-July) (L3) • PwC Governance review and action plan closed (included well led assessment) (L3) • Annual governance statement (L3) • Counter fraud annual assessment and plan (L3) • Annual self-assessment on licence conditions FT4 (L3) • CQC Inspection report July 2018 –(overall requires improvement) and actions plan to address required improvements and recommendations (L3 - /+) • Internal Audit Reports - Major incident structure and documentaion - log books, action logs, minutes RIDDOR reporting - Jan 22: Reducing the burden review to Board and Executive	Internal Audits 2020/21 reasonable or substancial assurance on Serious incidents, clinical audit, risk management, BAF, compliance framework, health and safety, DSPT, Financial audits CQC - Positive TRA's - Medicine, Surgery, MVCC Medicine, IPC , ED and medicinces management and well led in 2020/21 NHSI/E - positive vists to ED and Assessment and ICP visit (September / October) Internal Audit - BAF and riskreview - reasonable assurance		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**	
C1. Effectiveness of governance structures at ward to Divisional level C2 Implementation of Internal Audit Recommendations C3 HSE Improvement notices received on V&A, MSD and sharps in October 2019 (awaiting formal closure with HSE) C4 The Trusts existing clinical strategy is no longer appropriate to manage emerging risks and system changes C5 Changes to Board members/ organisational leadership	A1 Embedded risk management and risk appetite - CRR and BAF A2 Embedding effective use of the Integrated performance report / BAF in discussions A3 Evidence of timely implementation of audit actions A4 Consistency in the effectiveness of the governance structure's at all levels A5 Capacity to ensure proactive approach to compliance and assurance A6 Ensuring compliance with other external reviews and follow up	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:	Cross reference to gaps in controls and assurances (C1, C2...../ A1, A2 etc)	Lead:	Due date	Progress Update	Status: Not yet Started/In Progress/ Complete
i) Implementation against plan of the revised Compliance and Risk Framework	C2, C3, A1, A3, A6 , A5	Associate Director of Governance	on going	Compliance and Risk framework combined and priorities drafted. Discussed divisional oversight group in May 21. Sept: Progress report to QSC and reivew of priorites scheduled for October 2021 inline with the new regulation regimes . Internal Audit - reasonable assurance.	In progress
ii) Review of the Board and Divisional Governance structure to ensure effective and reduce duplication (including links to ICS/ICP)	C1, A2, A4	Associate Director of Governance	Q2, ongoing	Board and Board committee review in progress. Review of the new divisional structure against the orginal objectives is in progress for completion at the end of Dec/ jan . Review of governance strucutres as an ICS/ICP commenced.	In progress
iii) Recruitment of new CEO	C5	CPO/Chair	Dec-21	completed - commenced in January 2022. Induction scheduled	completed
iv) Implementation of the Strategic Planning Framework and Integrated Business Plan Structure	C4	Deputy CEO/ Director of Strategy		Implementation of the Strategic Planning Framework and Integrated Business Plan Structure presented to Strategy Committee in February 2021; recommended to Board for approval. Strategy Sessions commenced. Monitored by IBP steering group and Strategy Committee. September 21: Progress reviewed by Strategy Committee and discussion on system collaboration refered for full Board	In progress
v) review of external regulatory actions - CQC and HSE to support closure at next review.	C1, C3, A6	Associate Director of Governance		CQC inspectiion action plan - scheduled for closure in June 2021; testing compliance. Testing HSE actions; training elements recommenced. . Sept 21: CQC action plans reviewed and closed with divsional boards. On going review of the fundimental standards in place and programme of testing. On going testing in place	In progress
vi) Scope / consider independant well led review in line with the national guiidance	C1	Associate Director of Governance / Deputy CEO		To review with new CEO, and Head of Corporate Services in January - scoping being considered	
Summary Narrative:					

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: 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

Strategic Objective: a)Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030 c) Embed and develop the new divisional structure and leadership model to further improve service quality f) Using a population health management approach to plan and focus improvements, reduce health inequalities, and improve patient outcomes, experience and efficiency g) Working with system partners, progress development and delivery of integrated and collaborative services, making them easier to use for patients h) Harness innovation, technology and digital opportunities to support new models of care	**Source of Risk:** Objectives Quailty Assurance data / CQC Inspection	**BAF REF No:**	008/21
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: Jan-22	**Lead Committee:**	**QSC**

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Lack of consistent approach to quality improvement. ii) Need to embed culture of improvement and learning iii) Inconsistent ward to board governance structures and systems iv) Workforce skill mix, capability and capacity v) increase in activity on some specialities (ED, Assessment, Maternity, Paeds, CCU, Mental Health) post covid vi) Increase in complaints and SIs related to post covid activity and delays in pathways. vii) Fatigued workforce	1) Limited learning opportunites from current and future continuous quality activities 2) Poorer patient and staff experience 3)Limited leadership development of all staff 4) impact on reputation 5 increased regulatory scrutiny	**Inherent Risk** (Without controls):	5	4	**20**	⟷
		Residual/ Current Risk:	5	3	15	
		Target Risk:	5	2	10	

Controls/ Risk Treatment: (Preventive, Corrective, Directive or Detective)	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
Quality and Safety Governace Structure - reporting into Patient Safety Forum, Patient and Carer Experience, Clinical Audit and Effectiveness, ICP, Safeguarding, Health and Safety Reports to QSC as per annual cycle including deep dives. Pathways to excellence framework and programme 'Here to improve' programme Training and development programmes including Leadership pathway and QI Harm free care and deteriorating patient collaborative Patient and Carer Experience Programme Patient safety specialists / leads Mental Health Srategy Group Complex discharge Improvement group Quailty and Safety Dash boards Oversight of 'hot spots' with clear leads and committee structure, May 21 (QSC and Q&C DOG) Learning events - IPC, safety huddles Clincal Harm Review process and panel Divisional quailty structures GIRFT Board Health Inequalities Committee	ToR, Minutes and papers for the Quailty and Safety Committee Structures Report and deep dives to QSC Internal Audit Programme CQC TRAs and gap analysis Quailty and Safety visits and audit programme Action plans from Mental Health Strategy Group / Discharge Group Maternity surge plan and fortnightly Maternity focus with commissioners, regulators and region LMS - mins and actions (meeting de-escalated)	Positive CQC TRA reviews for Medicine (lister and MVCC) and Surgery Core Pathways (with supporting gap analysis and evidence on KLOE) and well led. EoI, OPD Internal Audits 2020/21 reasonable or substancial assurance on Serious incidents, clinical audit, risk management, BAF, compliance framework, health and safety, DSPT, Routine Deep dive review at Audit Committee October 2021. Ockenden response October 2021. Pathways to excellence - ward accreditations Quailty Assurance visits (CCG and Trust) NHSI IPC visit 22.10.21 Stroke, Sepsis and VTE deep dive Feb 22		

Gaps in Controls	**Gaps in Assurance:** Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**	
•C1 National guidance and GIRFT Gap analysis identifies areas for improvement C2 Consistency with engagement with clinicians C3 Patient safety team and complaints team capacity (impact of COVID) C4 Complex discharge pathway (core action and oversight listed in Risk 1) C5 3 Never events were reported in 20/21 C6 Increased number of Mental Health Patients presenting at the Trust - Adults and CYP	A1 Consistency in following care bundles A2 Implementation and tracking of action plans related to GAPS associted with National Audit & NICE guidance, GIRFT recommendaions, NatSSIP Audit compliance A3 Embedding of learniing from SIs/Learning from Deaths/ never events A4 Delivery against CQC improvement plan A5 Delivery of harm review process following COVID impact on 52wk waits , follow	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

C7 VTE compliance C8: Environmental Agency review C9: HTA Notice of Direction February 22	up and survieliance A6 Effectivness of Pathway for safe discharging of complex patients - complaints and referals A7 Assurance on Ockenden Report recommendations and PFD (Maternity) A8 Implementation of End of Life Strategy A9 Ward to Board visibility of key Q& S metrics A10 Consistancy of meeting the food hygiene standards and routine assurance A11: Evidence of delivery against HTA standards	Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Cross reference to gaps in controls and assurances (C1, C2...../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) i) Delivery of the Quality Strategy Priotrities	C1-7, A1-9	Chief Nurse / Medical Director	ongoing	2021/22 priorities under review . Chief Nurse and Medical Director strategy session scheduled. Priorities under review including strenghtening the divisional governance structures - sessions scheduled for February / March	In progress
ii) Delivery and monitoring of CQC improvement plans and preparedness for future inspections	A4, C2,	Associate Director of Governance		Quailty visit programme recommenced. Compliance and risk framework reviewed. Monthly review of fundimental standards recommenced. Review of divisional action place in progress and governance, compliance, cqc communcation plan in place with supporting materials . January _ QAV visits focusing on safety and wellbeing	in progress
iii) Implemention of patient safety strategy priorities	A2, A3, A5, A7	Patient Safety Specialists		Quailty and safety digital update to QSC Sept 21. Annual cycle of deep dives to the committee reviewed.	in progress
iv) Implementaiton of End of Life strategy and priorities	A8	Medical Director			In progress
v) Develop and implement Mental Health Stategy for Acute Care and work in collboration with the system to support patients required to stay longer in acute care whilst awaitng speciaist beds	C6	Chief Nurse		Mental health strategy in development. System working to develop local solutions to support acute patinets awaiting inpatient beds.	In progress
vi) Implementaion of pathways to excellence	A3, A5	Chief Nurse		Programme recommenced.	In progress
vii) Review harm review, hospital onset COVID reviews and mortality review processes due to increased demand following COVID	C3, C2	Medical Director and Chief Nurse		Progress under currently review to support the increased volum due to Covid.	In progress
iv) Review complaints process and oversight in line with PHSO guidance and increases following COVID	C3	Chief Nurse		Responding to complaints remains a focus. Interium addiitional resources in place to support recovery plan. Recruitment of new Head of Patient Experience in progress; interviews Sept.	In progress
vii) Complete Gap analysis on GIRFT reports and develop and monitor action plans	C1	Medical Director		Report to QC sept 21	in progress
viii) Review the quailty and safety metrix ward to board with BI	A9	Associate Chief Nurse		work in progress and compliance team also reviewing compliance and assurance data sets . Exploring different systems to support greater visibilty of ward to board reporting	In progress
ix) Implementation of Datix Icloud	A9	Associate Director of Governance	Q2/Q3	Project plan and workstreams in place. Awaiting IT to complete the required technical solution due in July 2021. Will then progress to commence inplementaion across Q2/Q3 . Sept 21: Technical solution completed at end August to enable Datix to complete confirguations. User testing to commence in Oct. Review of programm timetime commenced and to be agreed in October. October 2021: claims module went live in October. Anticipate programme to deliver the rest of the modules in Q4.	In progress
x) Implementation of new cleaning contract and active monitoring of the standards	C7, A10	Director of Estates		Supporting implementation of the new cleaning contract and cleaning standards. Contract monitoing, training, early escalation in plan. Further challenged by the increased levels of activity. October 21: Internal IPC / environmental supportive audits in place.	In progress
xi) Delivery of HTA compliance against standards	C8, A11	COO		Action plan in place, supported by project manager, steering group and workstreams. Full refurbishment of the Mortuary scheduled to commence 7 March 2022	In progress

Summary Narrative:					
October 21: Routine deep dive review at Audit Committee October 2021, Discussion on the impact of the backlog of activity , current activity pressures and changes to pathways in the context of quailty and safety. Assurance given on the actions being taken. Also discussed Medical Director and Chief Nurse holding joint strategic session for their senior teams. This will include review of quality and safety priorities, maximising working together and supporting the divisions effectively and streamlining meeting structure where possible.					

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: Sustainability, Quality, People **We provide a portfolio of services that is financially and clinically sustainable in the long term. We deliver high quality, compassionate services consistently across all our sites. We create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce**

Strategic Objective: **c) Embed and develop the new divisional structure and leadership model to further improve service quality** **d) Create a health and well-being offer that is amongst the best in the health service** **e) Progress and develop our equality performance to build an inclusive culture in the workplace**	**Source of Risk:**	strategic objectives/ Staff Survey	**BAF REF No:**	009/21
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that our staff do not feel fully engaged and supported which prevents the organisation from maximising their effort to deliver quality and compassionate care to the community.	**Risk Open Date:**	Sep-20	**Executive Lead/ Risk Owner**	**Chief People Officer**
	Risk Review Date:	Dec-21	**Lead Committee:**	**QSC, FPPC, Inclusion**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Staff not sufficiently involved in changes that affect or impact them. ii) Organisational failure to invest in line manager skillset/capability. iii)Management style/actions may not enable staff engagement or empowerment. iv)Organisational failure to drive inclusivity, so some groups feel they cannot make their voice heard. v)Staff may not be able to access the support or training they need to develop in their role.	i) Quality and Safety Improvement Culture is not fully achieved ii) Opportunities for improving patient care are missed iii) Staff leave the Trust, resulting in higher recruitment costs, loss of skills, talent, organisational memory, and increased focus on induction rather than on staff development.	**Inherent Risk** (Without controls):	4	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**
i)Trust People Strategy designed to offer mitigations to this risk. ii) All staff are expected to embody PIVOT values. iii)Trust policies such as Dignity and Respect Policy and Raising Concerns Policy provide route for staff to voice concerns. iv) Freedom to Speak up Guardian can support staff to make their concerns known, so that the organisation can respond to those concerns. v)Staff Experience Group and Divisional Forums provide space for constructive dialogue with staff to impove staff engagement/experience. vi) Education Board provides means to drive forward new approaches to education and development for all staff. New role of Head of Culture to commence in June 2021 Equality and Inclusion Committee from May 21	i) Staff surveys, including quarterly Pulse survey ii) Monitoring of trends via reports to Trust Board and accountability through scrutiny at Trust Board. iii)Monitoring of level of challenge through application of staff policies, for example from under-represented groups.			

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**		Amber
C1. failure to review and update some staffing policies C2. Need to develop education approach to supporting staff in under-represented groups C3. Need senior leadership development programmes to support the service improvement and transformation agenda. C4. Maximising the support networks abilty to influence service and culture change C5. Maximining staff access to wellbeing offers	A1. Failure to achieve Integrated Performance Review targets is an indication of negative assurance where the targets are relevant to this risk. A2. Capacity of F2SUG and static reporting	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:	**Cross reference to gaps in controls and assurances (C1, C2...../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Embed compassionate leadership approach to organisational management.	C1,	**Chief People Officer**	Jul-21	leadership rhythms and compassionate leadership conversations being rolled out across the orgnaisation. 150 targetted to attend ICS sessions 145 confirmed. Additional programmes being identified as part of culture strategy for FPPC consideration in July 2021	in progress
ii) Develop improved education and training offer for all staff groups.	C2	Chief People Officer	Oct-21	Capability strategy developed to support all staff groups across the organisation. Now developing further the delivery of the roadmap	in progress

iii) Improve staff engagement through promotion of the EDI agenda, including support for staff networks.	C4	Chief People Officer	Aug-21	Head of culture in post from 4.6.2021 identifying new ways of working to relaunch culture strategy / staff network chairs backpay agreed via Exec in June 2021 / EIC to include feedback from staff networks / reciprocal mentoring planned for September 2021 / listening events planned in August to hear what is working and what improvements could be made. Head of People Culture in post from 1.6.2021 working on a culture plan aligned to the Trust People Strategy. Allocation of time agreed by the Board for Staff Network Chairs, job purpose and descriptions being finalised for existing chairs. A Staff Network Chair's Away Day was held on 12.7.2021 where the group worked on objectives and outcomes over the next 12 months.	in progress
Support and develop staff wellbeing services, in line with NHS People Plan and Trust People Strategy.	C5	Chief People Officer	Oct-21	wellbeing pyramid in place for all staff / regular communication of how to access and feedback given on effectiveness / review of interventions to be iundertaken in Autumn 2021	in progress
Provide effective channel for staff communication through Staff Experience Group and Divisional Forums	A1	Chief People Officer	Sep-21	Staff voice and staff experience group ongoing with regular reports to SEG and FPPC. Next report in September 2021	in progress
Roll out talent management approach and support career conversations across whole Trust.	A1, C2, C3	Chief People Officer	Oct-21	Grow together launch on ENH academy taken place in May 2021, managers and staff to discuss long term plans plus CPD. Review in Autumn 2021	in progress
Review of Freedom to Speak Up approach and implement development plan	A2	Chief People Officer/ Chief Nurse	Oct-21	FTSU guardian identified and project plan being developed. Detailed plan to be delivered to FPPC Autumn 2021. Business case approved by Executive committee to support new structure October 21: Fulltime FTSUG appointed and should commence in the new year. Our Trust has been chosen to take part in a pilot project on Inclusive Freedom to Speak up; workshops in place for October/November.	in progress
Summary Narrative:					

July 21: All interventions in place are highlighting particular areas of concern across the organisation, and interventions are being streamlined around these areas to maximise impact. A multi-disciplinary task and finish group is being set up including senior staff from the departments affected to implement the work.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: 1. Quality: 5. Sustainability:

Strategic Objective	Source of Risk:		BAF REF No:	
Strategic Objective: **a)Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030 b)Safely restore capacity, and operational and clinical performance affected by the COVID-19 pandemic, working across the system to maximise patient benefits pandemic**	**Source of Risk:**	Strategic Objectives/ AE reports	**BAF REF No:**	010/21
Principal Risk Decription: What could prevent the objective from being achieved?	**Risk Open Date:**	21.01.19	**Executive Lead/ Risk Owner**	**Director of Estates and Facilities**
	Risk Review Date:	Feb-22	**Lead Committee:**	**QSC**

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Lack of robust data regarding current compliance ii)Lack of available resources to enable investment ii) Ineffective governance processes iii) Reactive not responsive estates maintainance iv) skill mix, expertise and capacity	i) lack of information to inform risk mitigation and decisions ii) Lack of assurance that routine maintainance is completed ii) risk of regulatory intervention iii) poor patient experience iv) potiental staff and patient safety risks	**Inherent Risk** (Without controls):	5	5	**25**	⟷
		Residual/ Current Risk:	5	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**
Revised leadership and governance structure within Estates & Facilities, Premises assurance framework/data base Specialist Authorised engineers in place as per statutory requirements, annual reports to H&S Health and Safety Group reports into QSC. Meets 6 weekly. Health and Safety Strategy 2020 Fire Policy and Procedures Capital funding prioritiesed Other statutiry groups and supportive workstreams Audit programme including - Weekly environmental audits Water safety group and action plan Ventilation group Links to corporate meeting includign COVID speciatist advisory group.	Assurance reports under statutory requriements - June QSC 21. E&F risk register reviewed and updated. - Risk clinics / workshops held in 2021 Authorised engineer reports Fire safety annual report Internal Audit - PAM (limited assurance) - report to QSC and Audit committees			

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**		(Amber)
C1. Ineffective estates and facilities governance structures C2. Estate strategy due for renewal C3. Lack of capital funding to bring the Lister and other sites to compliance C4. Implementation of actions from the AE reports C5 Limited visibility on the compliance status for the Trusts satellites locations. C6 Confirmation of level of compliance with Premisis Assurance Model (PAM) to inform gap analysis and work programme. C7. Optimal Space utilisation and decision making process for changes	A1. Limited assurance from other sites trust operates from A2. Actions to adress limited assuranceassessment for H&S, Medical Gases, Ventilation and decontamination A.3 PAM GAP analysis and action plan to inform decision making	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:	Cross reference to gaps in controls and assurances (C1, C2...../ A1, A2 etc)	Lead:	Due date	Progress Update	Status: Not yet Started/In Progress/ Complete
i) Substantive recuitment into leadership structure and other vacancies	C1, A1	Director of Estates and Facilities	Aug-21	Recruitment of E&F Compliance and Deputy Director of E&F underway	COMPLETED

ii) Development of Estates Strategy in line with the Organisational strategy	C3, C2	Director of Estates and Facilities	TBC	Progress report to Strategy Committee in September 21. Estates Strategy completed December 2021	COMPLETED
iii) Space Utilisation review and implement governance of decision making	C7	Director of Estates and Facilities	Dec-21	Systems for the management of space being investigated and compared. Investment required to implement Space Utilisation Group (SUG) is now established with standard agenda, terms of reference (clear process), and risk-log. Group meets once a month, is chaired by Director of Estates & Facilities, membership /attendance is good.	COMPLETED
iv) Ensure actions plans and monitoring in place to raise the areas of 'limited assurance' to 'reasonable assurance' - for H&S, Medical Gases, Ventilation and decontamination . Including HSE notices.	C3, C2	Director of Estates and Facilities		Head of Compliance now in post, developing / implementing guideline for governance, control requirements and responsibiliies for all critical systems and functions. Feeding into the Premises Assurance Model (PAM). Estates Compliance monthly meeting in process of being established. Estates Compliance Meeting established, meetings are now scheduled 2nd Wednesday of each month, standard agenda, terms of reference, with the Head of Compliance as Chair. Agenda includes update on all critical functions, including monitoring of actions plans against AE Audits. A Compliance Report is updated on a monthly basis and tabled at the Estates & Facilities Board Meeting. Monitoring of action plans in place, monitoring via monthly Estates Compliance Group and quarterly critical area safety groups. Majority of compliance areas due for annual audit, when assurance levels will be assessed and revised by Authorised Engineer's. Poor trust engagement flagged with Ventilation / Decontamination Group Meetings at Health & Safety, Fire and Security Meeting.	In progress
v) Complete the PAM gap analysis	A3, C2, C6	Director of Estates and Facilities	Dec-21	Compliance manager recruited and will prioritise this audit. PAM gap analysis is underway, supported by TIAA external PAM Audit. TIAA PAM process assurance audit is now completed. Compliance Manager has updated audit with management response/action - briefing paper has been tabled at Decembers H&S, F,S Group and Q&S Committee. Gap analysis is completed, updating action plan in progress. Note - this is significant exercise requiring trust-wide engagement to provide supporting evidence of process.	In progress COMPLETED
vi) Review mechanisms of oversight of complaince across all sites to ensure effective	C1, C3, C5, A1	Director of Estates and Facilities		Estates Compliance monthly meeting in process of being established. Estates Compliance monthly meeting now established. To inlcude over-sight of all E&N Herts sites. Agenda includes all E&Nherts sites. Included in ToR's.	COMPLETED / on-going
vi)					
Summary Narrative:					

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: **Sustainability:** To provide a portfolio of services that is financially and clinically sustainable in the long term; **Quality:** To deliver high quality, compassionate services, consistently across all our sites; **Pathways:** To develop pathways across care boundaries, where this delivers best patient care

Strategic Objective: i) Develop a future, local vision for the Trust's cancer services, and support work with partners to safely transfer MVCC to a tertiary provider	**Source of Risk:** Specialist Commissioning Review	**BAF REF No:**	011/21
Principal Risk Decription: What could prevent the objective from being achieved? 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 Finance**
	Risk Review Date: Feb-22	**Lead Committee:**	**Strategy**

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Lack of continued commitment of the preferred provider to progress service transfer ii) Failure to make decision on long term service model following public consultation iii) Inability of NHSE to reach agreement with providers, including investment required, and execute the transaction iv) Failure of service sustainability in the pre transition phase due to failture to address critical infrastructure priorities	i) Increase in uncertainty over future of MVCC and adverse impact on recruitment, retention, morale and research. ii) Potential detrimental impact on care pathways at Trust sites. Protracted strategic uncertainty impacting the abilty to deliver a sustainable service model for future services provided by MVCC iii) Protracted strategic uncertainty and increased financial pressures on the Trust iv) Potential impact on quality, safety and ability to sustain safe service	**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**
- Programme Board governance in place for Strategic Review of the MVCC - Weekly ENHT, UCLH and NHSE Director level call in place and monthly Tripartite meeting in place to monitor delivery of the Strategic Review against plan - Fortnightly Due Diligence governance meeting in place (NHSE, UCLH, ENHT, HHT) - UCLH Transition Team in place at MVCC - ENHT MVCC Transfer Programme leadership (Programme Director) and governance (Steering Committee and Task & Finish) in place - Escalation reporting to Strategy Committee and Board - Clinical policies - Monthly ENHT, UCLH, NHSE Critical Infrastructure Review in place underpinned by action plans & risk register - MVCC Service Sustainability Forum (NHSE, ENHT, ENH CCG, HHT and UCLH) established to oversee monitoring of a monthly integrated sustainability dashboard to enable early identification of increasing service fragility	- Regular reports to Strategy Committee and the Board - Status reporting through ENHT Steering Committee - July 21 - Audit Committee Deep Dive	- Strategic review and recommendations from clinical advisory panel re MVCC, July 2019 - Positive Risk Review with Specialist Commissioners, December 2019 - Jan 20 NHSE approved the recommendation that UCLH is the preferred tertiary provider for MVCC (Jan 2020) subject to due diligence outcome. - NHSI/E Risk Review - significant assurance provided and decision to step down to BAU assurance monitoring. - Dec 2020 MVCC Review Programme Board - supported recommendation for full replacement and enhancement of current MVCC services on an acute site; shortlisted Watford (meets all essential criteria) and supported full options appraisal on the Watford site. - May 2021 Submission of Due Diligence reports from UCLH to NHSE. - June 2021 - East of England Clinical Senate review of proposals; informal feedback from review team has been positive - Sept 2021 - UCLH Expression of Interest submitted to DHSC, with support from ENH Trust Board, seeking route to capital as part of new hospitals programme		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:** Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**	
	A1) Confirmation by NHSE of route to access capital for reprovision by UCH, and outcome of public consultation as required by UCH Board A2) Mitigation of financial impact of transfer on our Trust A3) Confirmation of UCH operational and corporate capacity to conclude DD to outcome and implement transition A4) Confirmation of ENHT operational and corporate capacity to implement transition	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:	Cross reference to gaps in controls and assurances (C1, C2...../ A1, A2 etc)	Lead:	Due date	Progress Update	Status: Not yet Started/In Progress/ Complete

ii) Provide input and support as relevant to NHSE activities to access capital	A1	Director of Finance	Ongoing	- Input provided to capital paper shared with NHSE Finance colleagues - Input and support provided for UCLH Expression of Interest in capital as part of DHSC new hospitals programme	In progress
iii) Chief Executive briefing of regional team to support activities in relation to access capital	A1	CEO	Ongoing	- Briefing of Ann Radmore	In progress
iv) Support public consultation process through effective development and execution of ENHT communications and engagement plan	A1	Director of Finance	TBC	- Planning to start once timing of Public Consultation is clearer, dependent on capital assurance	Not yet started
v) Finalise assessment of ENHT stranded costs	A2	Director of Finance	May-21	- Initial Financial Impact Assessment of MVCC Transfer on ENHT has been developed; detailed analysis completed. To be refreshed as required over time	Complete
vi) Negotiate settlement with NHSE to address ENHT stranded costs	A2	Director of Finance	Jul-21	- Review of stranded costs agreed with NHSE mid June 2021	Complete
vii) Lead definition and execution of plans to reshape corporate departments to deliver target reductions in corporate overheads	A2	Director of Finance	Mar-22	- Meetings held in May at which Corporate Directors shared their plans	In progress
viii) Seek assurance from UCH of commitment to resourcing and plans at programme governance forums	A3	Programme Director – MVCC Transfer	May-21 Ongoing - dates to be realigned with earliest possible transfer of October 22	- Assurance sought from UCH re resourcing and commitment to delivery Due Diligence activities to revised plan - Initital discussions underway between ENHT and UCLH to discuss transition planning principles, approach and governance	Complete In progress
ix) Lead the programme-level development of transition and decoupling plans to identify corporate and divisional resources required to implement transition	A4	Programme Director – MVCC Transfer	Ongoing - dates to be realigned with earliest possible transfer of October 22	- Prior to confirmation from NHSE supporting work at risk, initial transfer and transition/de-coupling activities underway	In progress
Summary Narrative:					

May 21 - Due Diligence is due to complete at the end of May. Overall Strategic Review Programme milestones are under review, to be presented at May Programme Board, with an expected commitment to continue to target an April 22 transfer date.

June 21 - Strategic Review Programme Board in May presented a 'Plan A' timeline with Transfer date of April 22 and 'Plan B' timeline which would move the transfer date to July 22. Both dates are at risk due to critical dependency on route to capital, which remains unclear. UCLH Due Diligence reports with revenue and capital requests were submitted at end May 21 to NHSE for assurance process.
June 21 - Strategy Board - discussed MVCC Programme transfer update and noted the completion of the UCLH due diligence. Due to the level risk of a delay to the programme increasing the Committee increase the current risk score from 12 to 16. Work being undertaken to mitigate the risk was noted.

July 21 - Strategic Review Programme Board: Confirmation that due to continued uncertainty regarding route to capital, earliest feasible transfer date is now October 2022. In light of the delays, an MVCC Service Sustainability Forum (NHSE, ENHT, ENH CCG and HHT) established to oversee monitoring of a monthly integrated sustainability dashboard to enable early identification of increasing service fragility. ENHT refresh of scenario analysis in light of the delays, for discussion at July Audit Committee. Government announcement w/c 12th July regarding DHSE competition to fund 8 new hospitals, with Expressions of Interest due early September.

Sept 21 - Expression of Interest in capital for re-provision of MVCC Services was submitted by UCLH to DHSC on 08/09. ENH Trust Board supported the submission (discussed at 01/09 Private Board).
The first MVCC Service Sustainability Group meeting took place 06/09, comprising NHSE, ENHT, UCLH, THH and ENH CCG, to review the sustainability dashboard which will be produced monthly. The Group will next meet in November unless there is an urgent requirement to meet sooner.
February 2022, Project awaits the feedback if successful with the capital funding within the national New Hospitals Programme. Risk discussed at Strategy Committee and agreed; no change.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

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

Strategic Objective:
b)Safely restore capacity, and operational and clinical performance affected by the COVID-19 pandemic, working across the system to maximise patient benefits pandemic g) Working with system partners, progress development and delivery of integrated and collaborative services, making them easier to use for patients

Source of Risk:	External/ Civil Contingencies Act	BAF REF No:	012/21
Risk Open Date:	04-Mar-20	Executive Lead/ Risk Owner	Chief Operating Officer/ Chief Nurse
Risk Review Date:	Feb-22	Lead Committee:	QSC/ Board

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

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Covid 19 outbreak/pandemic - impact of varients 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 vi) Likelihood of future surges / increase in covid numbers resulting in an increase in Covid numbers and hospitalisations, ventilated patients and a decrease in available workforce. vii)Future Covid surges combined with a decrease in available workforce could have a negative impact on staff resilience viii) Impact of winter could impact on overall capacity within the hospital	i) Risk of staff unable to attend work - due to self isolation or covid 19 positive.Risk assessments due to the changes in isolation rules to ensure vulnerable patients are not at risk. 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 v) Risk of financial impact if regulatory requirements are not achieved vi) Risk of winter demand/ illnesses on overall capacity within the hospital	**Inherent Risk** (Without controls):	5	4	**20**	
		Residual/ Current Risk:	5	3	10	
		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 Plan and Business continuity plans in place. Major Incident Command structure - Strategic, Tactical and Operational (Gold , silver, bronze) Command structures reviewed/adapted to ensure continued support to organisation / major incident Communication plan - internal and external Linked into and represented at Local and National resilience fourms/ communications/ conference calls Emergency Preparedness, Resilience and Response Committee - Chaired by Managing Director for Unplanned Care COVID Specialist Advisory Group with task and finish group structure reporting to it On call rotas - various Staff training programme - MI, loggist, Fit testing, skills refresh. Mortuary Capacity Plans IPC Policies and BAF Review and monitoring of O2 and ventialation Staff well being programme and deployment / reassignment processes - flexible (workforce triggers in place) Monitoring, review and recording of all national guidance and directives recieved re pandemic People and placed based risk assessments re COVID Social Distancing strategy Regional and Trust Local Indicators to suport decision making Flat packed pathways e.g. Ability to step up capacity esp in respiratory and critcal care pathways LFT testing and fast tracked Point of Care Tests are available for all staff who are critical for a service to continue following a rsik assessment and Executive Director sign off or available to all via the national portal. Staff vaccine hub and vaccination programme Visitors Policies - including agreed triggers if changes required.	COVID dashboard Weekly Audits on environmental, IPC, H&S and social distancing Action Log/ Minutes from Strategic (GOLD), Tactical (Silver) and COVID SAG Trust Communications	Compliant with Emergency Planning Core standards 2021/22.	Report to QSC, June 2021 and December 20	

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:** Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**	
C1.Possibility of insufficient staff available on all shifts who have passed their FFP3 Fit testing C2. Possibility of staff being exposed to Covid-19 postive people especially with the rise in asymptomatic	A1 BCP's for high risk areas / small specialitist services/ On going resilience to sustain responsiveness to national guidance which is updated daily (esp in small	Green	Effective control is in place and Board satisfied that appropriate assurances are available

cases. C3. Possibility of visitors being exposed to Covid-19 postive people especially with the rise in asymptomatic cases. ~~C4.There is a risk that patients are not screened on admission as per questions based on UK Health Secuity Agency (UKHSA) guidance about recent travel.~~ C5.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 C6. 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 C7. Business continuity plans may need to include WN-CoV. C8. Updates to national advice daily as the position changes C9. Demand for assessment and beds exceeds sideroom and bed capacity Requested regent to enable patient and staff testing internally / capacity of CUH to support increased testing Impact of COVID surges on capacity and staffing C10 – Overall hospital capacity limited by winter pressures. Winter initiatives agreed to provide additional capacity.	teams / single posts) A2 Continuity of supplies as position changes - responding to national guidance and alerts A3 Adequacy of Ventilation in clinical areas A4 Implementaion of winter initiatves Ready rooms to prevent further infection and bed closures	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

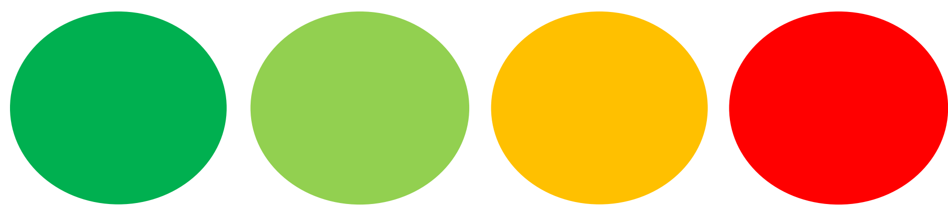
Jan-22	Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)	Lead:	Due date	Progress Update	Status: Not yet Started/In Progress/ Complete
i) COVID Specialist Advisory Group oversight and leading policy, guidance and expertise - PPE, logistics, testing, social distancing, IPC issues	A2, C1, C2, C3, C4, C5,	Chief Nurse, Medical Director	Ongoing	Currently meets fortnightly. IPC Summer BAF inder review. Ongoing audit programme. 21 July 2021: meeting weekly meetings reestablished- reporting to SILVER and GOLD. New treatment pathway under development. Test and trace self isolation risk assessment and guidance for staff undeway. Continues to meet weekly / fortnightly dependant on need.	Ongoing
ii) Review of ventilation in clinical areas and develop proposal for improvement	A3	Director of Estates and Facilities/ Ventilation AE	Q1-Q2	Engaged with external company to review the adequacy of the ventilation in the clinical areas and developing a proposal for improvement. This is being monitored through Covid SAG and Health and Safety Committee.	In progress
iii) Prepare for any future National COVID Vaccination Programme in line with National Guidance	C2, C5,	DoF/ CPO / Emergency Planning		July 2021: Awaiting national guidance Sept 21: Covid boosterand flu vaccination programme in place ready to commence in October 21. Vaccination Programmes commenced. November 21: review of mandatory vaccination programme	In progress
iv) Monitoring of triggers to enable responsivness and 'unflat packing' of COVID response if/when required.	C9	COO / Emergency Planning	On going	July 2021: Command and Control structures reviewed - GOLDnow meeting twice a week and reinstated SILVER from 21 July 2021. Workstreams, task and finish groups and surge plans - reviewed and stood up. Specialty working groups include - Critical care surge (adults/children), Paeds, Respiratory, Renal, Maternity. October 21: review of the triggers commenced to ensure they remain fit for purpose. Command structure ready to increase freqency if/when required. December 2021: Surge plans and triggers under review	In progress
iv) Implementaion of lessons learnt from previous COVID surges (internal and system)	C7, A1	COO / Emergency Planning	on going	July 2021: Command and Control structures reviewed -Workstreams, task and finish groups and surge plans - reviewed and stood up. Reviewing and preparing taskteam / deployment in readiness to respond.	In progress
v) Annual review programme and testing of the emergency planning standards	A1, C7	COO / Emergency Planning	on going	2020/21 assessment - compliant with the EPRR standards - Report to QSC June 2021. Assessment for the 2021 standards completed and compliant.	completed
vi) Monitoring implemention of winter initiatives (links to risk 1, operational delivery)	C10, A4	COO		see risk 1 performance . Mini nightigale (Additional surge capacity) programme work in line with national guidance	

Summary Narrative:

June 2021, the Committee considered the assurances received including confirmation of maintaining compliance with the EPRR standards 2020/21 and supported reduce this risk from a 15 to 10. Noted triggers and action in place to 'unflat pack' surge plans and plan in place/underdevelopment for potential increase in children young people attendances/ admissions. July 2021: Command and C|ontrol structures reviewed - GOLD now meeting twice a week and reinstated SILVER from 21 July 2021. Workstreams, task and finish groups and surge plans - reviewed and stood up. October 2021: Review of operational triggers and strucutre to support escalation commenced (taking into account the winter pressures) . December 2021 : Frequency of Gold/ Silver incident meetings reviewed and increased in frequency. Review of task and finish groups to support level 4 incident response locally and in line with national requirements. Risk assessment process introduce to support staff return to work in line with National Guidance. February 2022: Successful project to ensure the mini nightingale surge unit for general and acute beds was ready to mobilise at the beginning of February if required. This was fortunately not required and has been stood down.

Integrated Performance Report

Month 10 | 2021-22



Data correct as at 16/02/2022

NHS Oversight Framework

Quality of care

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
Overall	CQC rating	-	Dec-19	-	-	Requires improve-ment	
Caring	Written complaints - rate	Monthly	Jan-22	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)	Aug-21 - Jan-22	National	0	4	
Safe	Patient Safety Alerts not completed by deadline	Monthly	Feb-22	National	0	0	
Caring	Mixed-sex accommodation breaches	Monthly	Jan-22	National	0	0	
Caring	Inpatient scores from Friends and Family Test - % positive	Monthly	Jan-22	Local	95.0%	96.5%	
Caring	A&E scores from Friends and Family Test - % positive	Monthly	Jan-22	Local	90.0%	89.0%	
Caring	Maternity scores from Friends and Family Test - % positive - antenatal care	Monthly	Jan-22	Local	93.0%	100.0%	
Caring	Maternity scores from Friends and Family Test - % positive - birth	Monthly	Jan-22	Local	93.0%	95.6%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal ward	Monthly	Jan-22	Local	93.0%	94.2%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal community	Monthly	Jan-22	Local	93.0%	100.0%	
Safe	Emergency c-section rate	Monthly	Dec-21	Local	15%	16.5%	
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)	Apr-21 - Jan-22	NHSI	52	56	
Safe	Clostridium difficile – infection rate	Monthly (12-month rolling)	Feb-21 - Jan-22	National	21.86	35.30	
Safe	Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Monthly (12-month rolling)	Feb-21 - Jan-22	National	0.92	0.00	
Safe	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias infection rate	Monthly (12-month rolling)	Feb-21 - Jan-22	National	12.57	11.77	
Safe	Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) infection rate	Monthly (12-month rolling)	Feb-21 - Jan-22	National	27.72	28.83	
Effective	Hospital Standardised Mortality Ratio	Monthly (12-month rolling)	Dec-20 - Nov-21	National	100	88.0	
Effective	Summary Hospital-level Mortality Indicator	Monthly (12-month rolling)	Oct-20 - Sep-21	National	100	86.9	
Safe	Potential under-reporting of patient safety incidents	Monthly (six-month rolling)	Jul-21 - Dec-21	National	7.25%	5.89%	

Finance

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

Operational performance

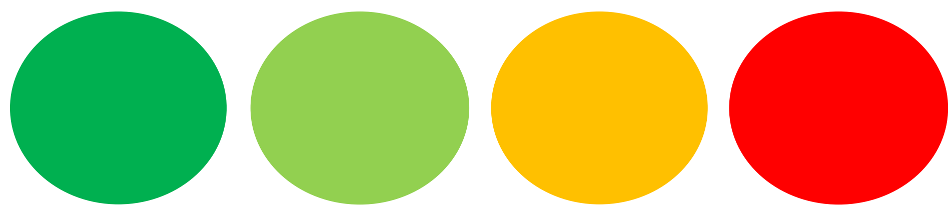
Domain	Measure	Frequency	Period	Target	Target	Score	Trend
A&E	A&E maximum waiting time of four hours from arrival to admission/transfer/discharge	Monthly	Jan-22	National	95%	69.78%	
RTT 18 weeks	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	Monthly	Jan-22	National	92%	55.87%	
Cancer Waiting Times	62-day wait for first treatment from urgent GP referral for suspected cancer	Monthly	Dec-21	National	85%	86.18%	
Cancer Waiting Times	62-day wait for first treatment from NHS cancer screening service referrals	Monthly	Dec-21	National	90%	70.00%	
Diagnostics Waiting Times	Maximum 6-week wait for diagnostic procedures	Monthly	Jan-22	National	1%	49.12%	
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

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
Organisational health	Staff sickness	Monthly	Jan-22	Local	3.8%	6.26%	
Organisational health	Staff turnover	Monthly	Jan-22	Local	12.0%	13.8%	
Organisational health	Proportion of temporary staff	Monthly	Jan-22	Local	-	13.5%	
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 & Safety

Month 10 | 2021-22



Quality and Safety

Summary

Key Issues	Executive Response

Key Issues

Incidents and Serious Incidents (SIs)

- The trust has seen an increased, sustained number of incidents reported, with a total of 1094 patient safety incidents reported in January 2022.
- 5 Serious incidents in January 2022with 1 never event was reported in January - wrong site surgery.Improving quality through the Natssip Clinical group has taken immediate actions from learning to support clinical teams adhere to their Local Safety Invasive Procedure standards.
- Outstanding Duty of candour applications reduced from 117 to 107 in January 2022.

Infection Control

- Hospital onset infections, inlcuding COVID remian a priority for overview and assurance

Deteriorating Patients

- Cardiac arrest rates were reported as 0.6 per 1,000 admissions in January continued sustained improvement below the national average.
- Hospital at Night project plans remain a work in progress.
- Reliability of observations were captured at 4-hourly 72% and 1-hourly 38.8% on Nerve Centre e-Obs.

Sepsis Screening

- Patients were audited across ED & Inpatients in January improving tarjectory picture.

Venous Thrombo-embolism and Hospital-Acquired Thrombosis (HAT)

- VTE risk assessment for stage 2, 3 remains an imporvent priorty
- 3 cases of hospital acquired thrombosis were noted to be potentially preventable in January.

Complaints

- 92% of complaints were acknowledged within 3 working days. This is above the Trust target is 75%, however the final response to complaints remains below the Trust target of 80%.
- 115 complaints open at end of January.
- 211 PALS concerns were raised in December.

Executive Response

Incidents and Serious Incidents (SIs)

- The trust continues to celebrate the increase in incident reporting as this is is important to support learning and improving care.
- 98% of all incidents reported were low or no harm, which teams a recognised and celebrated for demonstrating a healthy reporting culture.
- 27 incidents were presented to SIRP in January.
- Documentation of application of DOC remains an improvement priority
- Safety culture data analysied and supporting imporvments.
- **Infection Control**
- There were 3 COVID-19 outbreaks ongoing in January, and 3 COVID-19 outbreaks closed in January
- Ongoing support has been provided for the the Covid-19 vaccination as a condition of deployment (VCOD)
- The Hospital Charity have kindly supported the Trust by acquiring four 'Redirooms' or instant isolation units that can be installed in five minutes to create individual rooms for patients needing isolation.
- **Deteriorating Patients and Sepsis**
- A variety of digital solutions are supporting the recognition and management of the deteriorating patients, including escalations.
- A core priority is to monitor compliance with reliability of observations
- **Venous Thrombo-embolism and Hospital-Acquired Thrombosis (HAT)**
- Specific wards have seen excellent results through targeted improvement plans for VTE risk assessment through the Nursing & Midwifery Excellence Accreditation programme.
- Planning is underway to move to EPMA in March 2022, this will include VTE risk assessment.

Patient Experience

- An improvement aim has been set to reduce all overdue complains to zero by March 2022.
- Themes arising from complaints and PALS shall be reviewed and actioned through Patient and Carer Experience quality improvement ARM.

Summary

▲ (grey)	normal variation but trending up	◀▶	normal variation with no trend	▼ (grey)	normal variation but trending down
▼▲ (green)	statistically significant positive outlier	▼▲ (red)	statistically significant negative outlier		

Sub-Domain	Metric	Month	Target	Actual	Change	Long-term Trend	Comment
Incidents	Total incidents reported	Jan-22	n/a	1,094	▲ (green)		Special cause variation (11 points above the mean)
	Serious incidents	Jan-22	5	5	◀▶		Normal variation, 1 Never Event
COVID	Number of deaths from COVID-19	Jan-22	n/a	33	n/a		
	Number of deaths from hospital-acquired COVID-19	Jan-22	n/a	7	n/a		
Infection Prevention and Control	Hospital-acquired MRSA	Jan-22	0	0	◀▶		Zero hospital-acquired MRSA since Jan-20
	Hospital-acquired c.difficile	Jan-22	n/a	4	◀▶		Normal variation
	Hospital-acquired e.coli	Jan-22	n/a	5	◀▶		Normal variation
	Hospital-acquired MSSA	Jan-22	n/a	1	◀▶		Normal variation
	Hospital-acquired klebsiella	Jan-22	n/a	2	◀▶		Normal variation
	Hospital-acquired *pseudomonas aeruginosa*	Jan-22	n/a	0	◀▶		Normal variation
	Hospital-acquired Carbapenemase Producing Organisms (CPOs)	Jan-22	n/a	0	▼ (green)		Zero hospital-acquired CPOs since Jun-20
	Hand hygiene audit score	Jan-22	80%	89.6%	◀▶		Normal variation

Safe Services

Summary

Symbol	Meaning	Symbol	Meaning	Symbol	Meaning
▲ (grey)	normal variation but trending up	◀▶	normal variation with no trend	▼ (grey)	normal variation but trending down
▼▲ (green)	statistically significant positive outlier	▼▲ (red)	statistically significant negative outlier		

Sub-Domain	Metric	Month	Target	Actual	Change	Long-term Trend	Comment
Safer Staffing	Overall fill rate	Jan-22	n/a	78.5%	◀▶		Normal variation
Safer Staffing	Staff shortage incidents	Jan-22	n/a	30	◀▶		Normal variation
Cardiac Arrests	Number of Cardiac Arrest calls per 1,000 admissions	Jan-22	n/a	0.66	◀▶		Normal variation
Cardiac Arrests	Number of Deteriorting Patient calls per 1,000 admissions	Jan-22	n/a	0.53	◀▶		Normal variation
Deteriorating Patients	Reliability of observations (4-hour)	Jan-22	n/a	70.7%	◀▶		Normal variation
Deteriorating Patients	Reliability of observations (1-hour)	Jan-22	n/a	42.9%	◀▶		Normal variation
Sepsis Screening and Management	Inpatients receiving IVABs within 1-hour of red flag	Jan-22	95%	75.0%	▲ (green)		Special cause variation (10 points above the mean)
Sepsis Screening and Management	Inpatients Sepsis Six bundle compliance	Jan-22	95%	54.5%	◀▶		Normal variation
Sepsis Screening and Management	ED attendances receiving IVABs within 1-hour of red flag	Jan-22	95%	90.6%	◀▶		Normal variation
Sepsis Screening and Management	ED attendance Sepsis Six bundle compliance	Jan-22	95%	61.1%	▲ (green)		Special cause variation (3 points above upper control limit)

Safe Services

Summary

▲	normal variation but trending up	◀▶	normal variation with no trend	▼	normal variation but trending down
▼▲	statistically significant positive outlier	▼▲	statistically significant negative outlier		

Sub-Domain	Metric	Month	Target	Actual	Change	Long-term Trend	Comment
VTE	VTE risk assessment stage 1 completed	Jan-22	95%	88.8%	◀▶		Normal variation
	VTE risk assessment for stage 2, 3 and / or 4	Jan-22	95%	55.6%	◀▶		Normal variation
	Correct low molecular weight heparin prescribed and documented administration	Jan-22	95%	97.8%	◀▶		Normal variation
	TED stockings correctly prescribed and documentation of fitted	Jan-22	95%	70.6%	◀▶		Normal variation
HATs	Number of HAT RCAs in progress (rolling 24 mths)	Jan-22	n/a	58	▲		Special cause variation (2 consecutive points above upper control limit)
	Number of HAT RCAs completed	Jan-22	n/a	3	◀▶		Normal variation
	HATs confirmed potentially preventable	Jan-22	n/a	3	◀▶		Normal variation
PU	Pressure ulcers All category ≥2	Jan-22	n/a	22	◀▶		Normal variation
Patient Falls	Rate of patient falls per 1,000 overnight stays	Jan-22	n/a	4.4	◀▶		Normal variation
	Proportion of patient falls resulting in serious harm	Jan-22	n/a	1.5%	◀▶		Normal variation

Caring Services

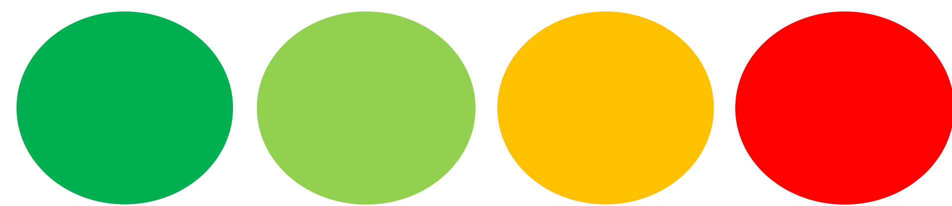
Summary

▲	normal variation but trending up	◀▶	normal variation with no trend	▼	normal variation but trending down
▼▲	statistically significant positive outlier	▼▲	statistically significant negative outlier		

Sub-Domain	Metric	Month	Target	Actual	Change	Long-term Trend	Comment
Friends and Family Test	Inpatient FFT Positive recommendations	Jan-22	93%	96.2%	◀▶		Normal variation
	A&E FFT Positive recommendations	Jan-22	93%	89.0%	▼		Special cause variation (9 consecutive points below mean)
	Maternity FFT - Antenatal Positive recommendations	Jan-22	93%	100.0%	◀▶		Normal variation
	Maternity FFT - Birth Positive recommendations	Jan-22	93%	93.5%	◀▶		Normal variation
	Maternity FFT - Postnatal Positive recommendations	Jan-22	93%	93.9%	◀▶		Normal variation
	Maternity FFT - Community Positive recommendations	Jan-22	93%	100.0%	▲		Special cause variation (7 consecutive points above mean)
	Outpatients FFT Positive recommendations	Jan-22	95%	96.0%	◀▶		Normal variation
PALS	Number of PALS referrals	Jan-22	n/a	211	◀▶		Normal variation
Complaints	Number of written complaints received in month	Jan-22	n/a	59	◀▶		Normal variation
	Proportion of complaints acknowledged within 3 working days	Jan-22	75%	92%	◀▶		Normal variation
	Proportion of complaints responded to within agreed timeframe	Jan-22	80%	47%	◀▶		Normal variation

Effective Services

Month 10 | 2021-22



Effective Services

Key Issues

Crude Mortality

- The in-month crude mortality rate remained broadly steady at 13.84 deaths per 1,000 admissions in January, compared to 13.87 in December.
- The rolling 12-months crude mortality rate improved to 12.49 deaths per 1,000 admissions in the 12 months to January and is lower than the most recently available national rate of 14.40 deaths per 1,000 admissions (Jan-21 to Dec-21).

Hospital-Standardised Mortality Ratio

- **PLEASE NOTE CHKS re-based their HSMR metric on 28/01/2022.**
- The in-month HSMR has improved from 93.36 in October to 88.02 in November.
- The rolling 12-months HSMR has increased from to 96.50 to 97.17 in the 12 months to November.
- Following the re-basing, the Trust has moved to the second quartile (26-50%) of Trusts for HSMR.
- HSMR is usually available 1-2 months in arrears.

Summary Hospital-level Mortality Indicator (SHMI)

- The latest SHMI release for the 12 months to September has increased to 86.93, from 86.31 in August.
- This Trust remains in the 'lower than expected, Band 3' category.

Re-admissions

- The re-admission rate for 12 months to November has decreased from 7.82% to 6.64%.

COVID-19

- To date CHKS analysis of our COVID-19 mortality has shown the Trust to be centrally placed in comparison to national and our PMO peer group.
- Probable/definite hospital acquired COVID-19 cases which sadly resulted in a death where COVID-19 was on part I of the death certificate have now been reviewed and passed to the SI Panel for consideration. To date a significant number have been discussed by Panel / declared SIs. An investigation report into hospital acquired COVID-19 is in its final review stages.

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.
- A number of reforms are underway regarding the Trust's learning from deaths framework. These include the adoption of a Structured Judgement Review format based on the RCP model; the incorporation of this review onto the incoming Datix DCIQ platform, together with changes to the composition of, and management of, the pool of Trust mortality reviewers.

Executive Response

Crude Mortality

- This measure is available the day after the month end. It is the factor with the most significant impact on HSMR.
- The general improvements in mortality have been as a result of a combination of corporate level initiatives such as the mortality review process and more directed areas of improvement such as the identification and early treatment of patients with Sepsis, Stroke, etc. together with a continued drive to improve the quality of our coding.
- While the COVID-19 pandemic saw peaks in April 2020 and January 2021, most of the intervening and subsequent periods have seen us positioned below or in line with the national average.

Hospital Standardised Mortality Ratio (HSMR)

- HSMR was re-based on 28/01/2022. A drift occurs to HSMR values over time which moves the norm below 100. The rebase is intended to 'reset' this back to 100. The rebase results in a general shift upwards in HSMR figures. For ENHT the re-base resulted in a shift in HSMR from 82.3 to 97.3 (15 points).
- Our current HSMR of 97.17 (rolling 12 months to November 2021) positions us in the second quartile of Trusts nationally. We remain focussed on driving further improvement.
- The NHFD advised that we are a 3SD outlier for #NOF mortality for the Jan-Dec 2020 year. Progress against the remedial action plan continues to be monitored by the Mortality Surveillance Committee with regular updates provided to the Executive.
- The significant changes in overall admissions and the change in case mix during the pandemic have made interpretation of mortality data challenging but the Trust's position will continue to be monitored.

Summary Hospital-level Mortality Indicator (SHMI)

- The latest figure of 86.93 (12 months to September 2021) sees the Trust positioned within the 'lower than expected' band 3 category. Our position relative to our national peers currently stands at 10th out of all acute non-specialist trusts (123).
- COVID-19 activity continues to be excluded from the SHMI by NHS Digital.
- The fact that SHMI includes deaths within 30 days of discharge, and the Trust has remained well placed in comparison to the national picture, provides some assurance that our response to COVID-19 has not generally resulted in a disproportionate increase in deaths within 30 days of discharge.

Re-admissions

- The Trust's re-admission rate has generally been consistent with national performance. Significant dips in readmissions were seen in March and October 2020 while July to September saw the Trust's rate rise slightly above the national picture. Recent months have seen performance improve, with the Trust tracking below the national average.

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 is scrutinised by both the Quality & Safety Committee and Trust Board.
- In tandem with the proposed move to Datix iCloud and full rollout of the Medical Examiner function a general review of our mortality review and learning from deaths processes is taking place.

Mount Vernon

- The secession of MVCC as part of the Trust, will affect both our HSMR and SHMI. In addition to reporting the current situation, in preparation for the split we will shortly begin to report these metrics showing the anticipated effect of the loss of MVCC, once work to understand the changes has been completed.

Specialist Palliative Care

- The data provided in this report only relates to information recorded on Infoflex (currently only the Cancer service uses this system) and does not reflect the Trust-wide position
- We know that nationally, Specialist Palliative Care will only see in the region of 20% of hospital palliative care patients. In January approximately 75% of deaths were referred to Palliative Care and of these 83% were seen by the team.

Effective Services

Crude mortality per 1,000 admissions In-month

Legend: Crude mortality in-month; Mean; LCL; UCL; National month

Crude mortality per 1,000 admissions Rolling 12-months

Legend: Crude mortality rolling 12-months; National rolling 12-months

HSMR In-month (re-based 28/01/2022)

Legend: HSMR in-month; Mean; LCL; UCL; Standard (100)

HSMR Rolling 12-months (re-based 28/01/2022)

Legend: HSMR rolling 12-months; Standard (100)

SHMI Rolling 12-months - published quarterly

Legend: SHMI quarterly; Standard (100)

SHMI New methodology (from Jan-19)

Legend: SHMI; Standard (100)

Effective Services

Length of Stay
Elective Length of Stay (days)

3.3 3.1 2.9 2.7 2.5 2.3 2.1 1.9 1.7 1.5

2.1 2.1 2.3 2.8 2.3 2.3 2.1 1.9 2.6 2.5 2.4 2.9 2.1 2.1 2.3 3.1 2.7 2.5 2.6 2.2 2.3 2.2 2.4 2.3

F M A M J J A S O N D J F M A M J J A S O N D J

Elective LoS — LCL — UCL — Mean

Length of Stay
Non-elective Length of Stay (days)

5.3 4.8 4.3 3.8 3.3 2.8

3.7 4.6 4.0 4.3 3.8 3.6 3.5 3.9 4.0 3.9 4.3 4.6 4.4 4.1 4.0 3.8 4.2 4.4 4.8 4.7 4.9 4.5 5.1 5.1

F M A M J J A S O N D J F M A M J J A S O N D J

Non-elective LoS — LCL — UCL — Mean

Re-admissions
Absolute number - Dec-19-Nov-21

1,100 1,000 900 800 700 600 500 400 300

989 535 866 581 375 564 697 841 863 862 798 780 753 630 638 826 788 806 766 795 683 674 645 651

D J F M A M J J A S O N D J F M A M J J A S O N

Re-admissions — Mean — UCL — LCL

Re-admissions
Rate - Dec-19-Nov-21

11% 10% 9% 8% 7% 6% 5% 4%

9.3% 4.7% 8.5% 6.5% 8.1% 10.3% 10.2% 10.5% 10.6% 9.6% 8.1% 8.6% 8.4% 8.6% 9.1% 9.1% 8.8% 8.5% 7.6% 7.7% 7.4% 7.2% 7.8% 6.6%

D J F M A M J J A S O N D J F M A M J J A S O N

Re-admission rate — Mean — UCL — LCL — National

Specialist Palliative Care
Proportion of patients with whom their preferred place of death was discussed

100% 95% 90% 85% 80% 75% 70% 65% 60%

90% 84% 86% 87% 88% 77% 79% 92% 83% 77% 84% 91% 79% 87% 79% 80% 74% 82% 86% 80% 84% 82% 82% 84.6%

F M A M J J A S O N D J F M A M J J A S O N D J

PPD recorded rate — Mean — UCL — LCL

Specialist Palliative Care
Individualised care pathways

70 60 50 40 30 20 10 0

33 34 64 45 22 23 26 36 34 23 40 57 38 33 26 33 30 31 47 35 46 39 41 39

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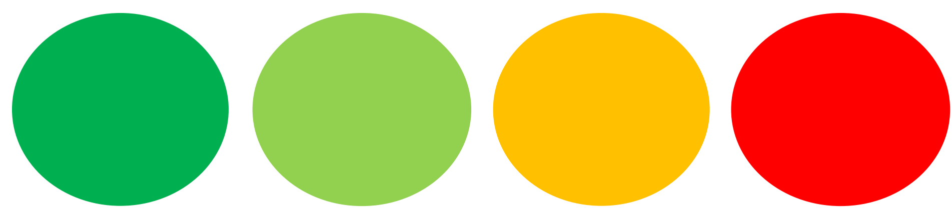
Individualised care pathways — Mean — LCL — UCL

Responsive Services

Month 10 | 2021-22



Responsive Services

Key Issues

A&E
- Performance for the month of January was 69.78%.
- There were 16 12-hour trolley waits reported in January.

Cancer Waiting Times
- The Trust achieved 6 out of the 8 national targets for Cancer performance in December.
- The Trust 62-day performance for December was 86.18%.
- There were 3.5 pathways over 104 days for the 62-day standard and 1 pathway over 104 days for 62-day screening. Longest wait is 145 days for 62-day standard.
- Good progress continues on the specialty cancer action plans, all plans being reviewed and updated weekly.
- Robust weekly cancer PTL management is in place.

RTT
- Incomplete performance for January was 55.87%. This is an increase from the 54.63% reported in December.
- The January backlog was 21,298, a decrease of 1,172 from 22,470 in December.
- There were 3739 52-week breaches reported in the January incomplete position, an decrease of 277 from the 4,016 reported in December.
- There were 159 patients waiting over 104 weeks in January. The longest week wait currently is at 204 weeks.

Diagnostics
- DM01 performance for January was 49.12%, against the national standard of 1% and the December position of 45.34%.
- Latest available National performance (December) was 29.01%.

Stroke
- 4-hour Stroke performance for January is 19.7% (based on Discharging month).
- Breach Reasons - Of the breaches (55):
  - 16% of overall breaches due to impact on demand within ED;
  - 38% of overall breaches due to Bed capacity issues - due to pressures on the Trust capacity within Opel status, impacting on Stroke bed capacity and therefore flow for admissions;
  - 33% of breaches due to Challenging/Complex Diagnosis;
  - In-hours 40% / out-of-hours 60%.
- Thrombolysis performance is at 11.4 % in January - of the 70 confirmed stroke patients 8 patients eligible, of which 5 met the target.
- Door-to-needle improvement 62.5% for January (70% Target).
- CT 1-hour to scanning 38.9%. (50% Target).
- 90% Stay on Stroke unit - decline in Performance 77.9% of the 80% Target - due to bed capacity and therefore outlie of Stroke patients.

Executive Response

A&E
- Performance against the 4-hour standard in January, despite the and increasing challenges around workforce, demand on emergency services and admitted flow, remained stable, although still significantly under par. Overcrowding in ED continued to be a significant concern with risks associated to social distancing as well as the need for regular use of surge capacity, this in turn reduces visibility and increases the risk of clinical incidents. One key area influencing the improvement during January was the improved time to initial assessment compared to previous month.
- Non-admitted demonstrated sustained improvement, despite regular use of SDEC area being used as assessment escalation capacity. It is expected that national guidelines will be published around this topic. The Unplanned Care division are currently considering solutions to this, how ever, influencing factors such as alternative spaces and ability to safely staff this and populate with appropriate patients will limit options.
- Admitted performance declined compared to the previous month with the average length of stay for admitted patients rising sli ghtly. This continues to be explained by a loss of beds due to IPC issues, continued exit blocks for patients with complex needs and continued staffing p ressures restricting the ability to open escalation areas. A review of how capacity meetings and data is used to support early identification of emerging risks are in progress and recommendations for improvements are being driven using the NEL Improvement Board and Patient Flow Steering Group. In additi on, work continues to improve inpatient flow via the Discharge Improvement Group and the virtual hospital project.
- Ambulance delays increased in January, predominately explained by the ED exit blocks. However, in February a 'Rapid Release' pilot commenced, and early data suggests some coincidental improvements to handover times with a reduction of average handover during week one of the pilot b y 14minutes. A small working group of ED, East of England and Site representatives has been established to identify learnings and embed permanent change t o how ambulance handovers and emerging risks to compliance are managed. Agreement has also been reached about how cohorting is managed and staffed going f orward, with ENHT and East of England, sharing this responsibility. In addition, although delayed due to building timelines, ED, Site and East of England are working jointly to design new robust and resilient pathways and structures to ensure sustained ambulance handover compliance when the new DARTing area is opened i n late March 2022.
- During the month of January, we declared 16 x 12 hour trolley breaches which show the continuing pressure we have encountere d over the past few months, the trend clearly shows the 24 hour period of the 11th-12th January (8 breaches) and 31st January (5 breaches) where we were under significant pressure with patient flow and available bed capacity, the department started the day with a high level of DTA patients along with the cur rent exit blocks we have been facing around MO patients within the trust. Measures across the trust were being evaluated and escalation areas were all open to su pport this including Discharge Lounge and SDEC areas.

Executive Response (continued)

Cancer Performance (December)
- In December 2021, the Trust achieved 6 of the 8 national targets and 1 out of 3 28-day FDS standards for Cancer performance: 2ww GP Referrals, 2ww Breast Symptoms, 31-day Subsequent for Radiotherapy, first treatment and Chemotherapy, and 62-day urgent referral to treatment.
- The Trust has always previously delivered against the 2ww national standard which requires 93% of patients referred on a two -week pathway by their GP to have attended the 1st Outpatient appointment within 14 days. For December 2021 the Trust performance was 97.0%.
- In December 2021, the Trust wide average days wait for first appointment is at 10 days and the majority of patients were seen between 8 and 12 days.
- The Trust has 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 December 2021, the Trust performance was 96.5%.
- The Trust has consistently delivered the 31-day second or subsequent treatment for Radiotherapy and Chemotherapy but not for the subsequent Surgery. For December 2021 the Trust Chemotherapy performance was 100%, the Trust Radiotherapy performance was 99.1% and the Trust subsequent Surge ry performance was 87.5%.
- The Trust performance for 31-day to first definitive treatment was 98.4%. The standard requires 96% of patients to receive treatment within 31 days of diagnosis.
- In December 2021, the Trust performance for the Faster Diagnosis is 75.1% for the 2ww patients, 66.7% for Breast Symptomatic and 44.1% for screening patients.
- Reported 62-day performance for December 2021 was pre-sharing 75.9% and post-sharing 86.18%.
- Cancer performance is available one month in arrears.

RTT
- The Trust continued to see more patients in clinic in December, 43,620 compared to 43,254 in 2019 -20, including an increase in OP procedures.
- Patient Tracking list:
- Overall PTL size has reduced in January to below 48,264 patients.
- The number of patients over 52 weeks and over 72 weeks has also decreased.
- The number of patients waiting over 104 weeks has increased in December to 159 from 105. This in part is due to an increase in Oral patients, who all have dates for procedures booked before end of March 2022
- 104 weeks waiters continue to increase in Trauma & Orthopaedics.
- PTL management continues, reviewing and managing patients on our treatment lists with a focus on plans for each patient.
- Investment in validation team to complete focussed work on removing DQ issues on incomplete PTL by March 2022.
- Treatment priority given to patients classified under the Royal College of Surgeons Guidelines (P1 – P6), then long waiters taking into consideration of patient's needs, such as Learning Disabilities.

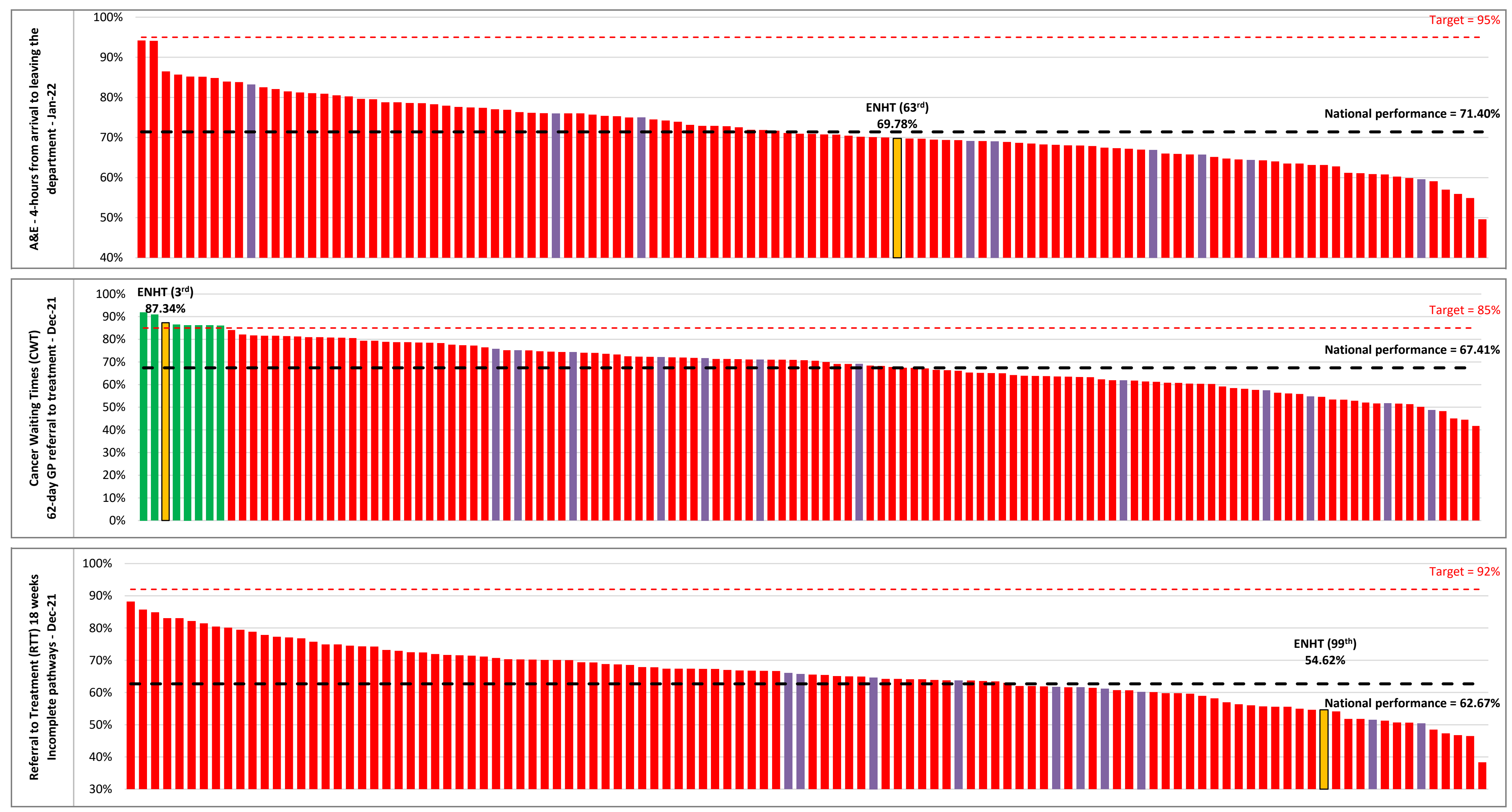
Diagnostics
- There has been an increase in PTL size by 844.
- This is due to MRI and CT and prioritising acute and cancer work.
- There was a sharp increase in acute referrals as demonstrated in the HWE elective activity pack.
- Record number of MRI and CT performed in month. Cancer turnaround performance has improved.
- There has been an increase of 396 patients waiting over 13 weeks in comparison to last month with a majority coming from the Imaging modalities.
- Neurophysiology is non-compliant this month.
- Imaging modalities continue to decline with an increase in the number of breaches.
- Overall the number of patients seen within 6 weeks continue to decline.

Stroke
- Out of hours breaches - Provision agreed for Medical on-call team to support management of Stroke patient out of hours in conjunction with the CNS. This will support the reduction in Challenging/Complex diagnosis and management of referrals and clerking.
- Bed Capacity - 38% of the overall breach reasons. Review of Stroke capacity management of Ring-Fence beds for Stroke only patients, with the view of Stroke Services management of Stroke capacity.
- 90% stay on the Stroke unit performance declined due to the number of Stroke patients outlied onto other wards due to Stroke Bed Capacity
- Thrombolysis/Door to Needle - Go Pre-Alert Trauma call for all Stroke Pre-alerts - This will ensure all resources/staff that form the Stroke Pathway to be aware of patient and enact actions as per pathway - this support the delivery of the CT 1hr performance. With the provision of Medical on -call management of Stroke patients will also support the thrombolysis pathways.
- Artificial Intelligence - implementation of AI is within the ISDN - ENHT to be part of Phase 1 roll out plan, Trust to confirm opt in or out by 28/2/22 - letter with Medical Director - potential costs to Trust TBC.
- SSNAP rating performance reduction. Main contributing factors are 4hr performance and OT/PT non -compliance of establishment in-line with National Specification. Interviews scheduled in Feb 22 - risk to Band 6 POT back out to advert and review of alternative options - once recruited staffing levels will be compliant and therefore support in recovery of the SSNAP requirement.
- Review of alternative posts within the Ward establishment to support elements of the MDT domain for SSNAP rating
- Inter-hospital Transfers - 5 patients (9% impact on breaches) transferred Thrombectomy Centres as per the agreed pathway. With the implementation of actions to support Thrombolysis pathway this will also support the early management with delays to being on a Stroke unit within 4 -hours from ENHT and arrival to Charing Cross, due to travel time and delays within Ambulances to support transfers.
- Weekly Root Cause Analysis of breaches within pathways across the SSNAP domains and identify trends and key actions to avoid future breaches.
- Digital solutions being reviewed to support the process and provide a flag to underperformance against domains - as opposed to waiting for the retrospective SSNAP report - scoping meeting commence 16.2.2022 and for escalation to Unplanned board and escalation to Execs as per weekly update if required.
- Data analysis shows that ED and Inpt demand has increased and remained above "normal" levels for CT - December was 4% higher than the previous month and jumped an additional 5% in January from December. Total 9% more in Jan
- Radiology provide capacity over 7 days and will prioritise stroke patients. However further demand and capacity modelling is to be undertaken between ops teams.
- Radiology working in collaboration with the Stroke team to review pathways and provide training/guidance where required. Regu lar meetings are being scheduled and deep dives also to be undertaken.
- Long term – once the new CT scanner is operational in August 2022 inpatients will no longer be scanned on the ED scanner, creating additional capacity.

Responsive Services

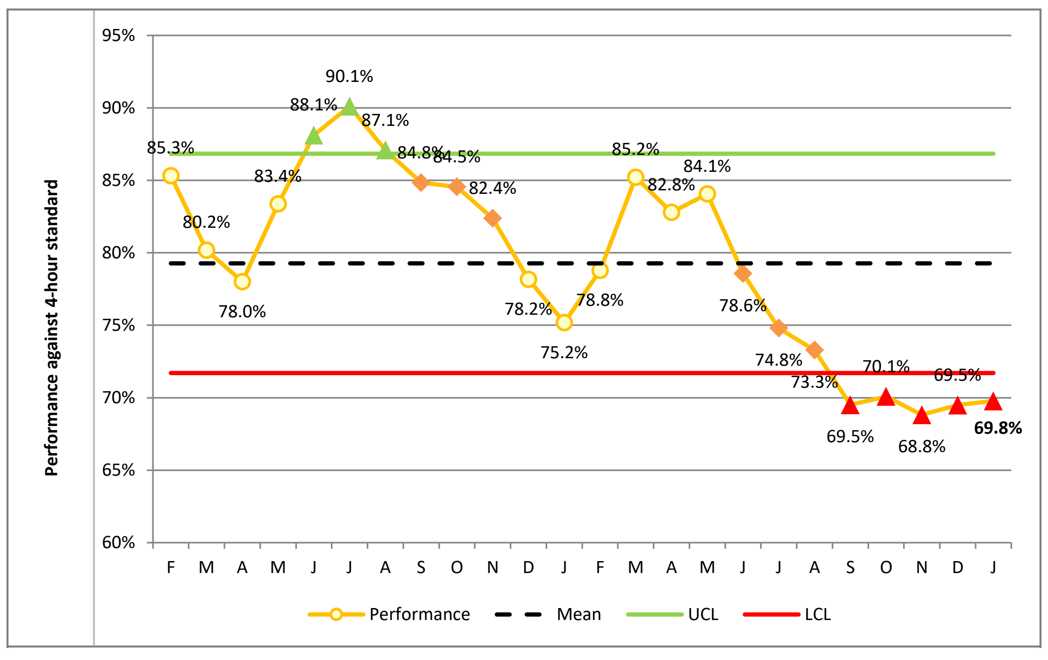
Trust performance against all Trusts nationally

East and North Hertfordshire NHS Trust

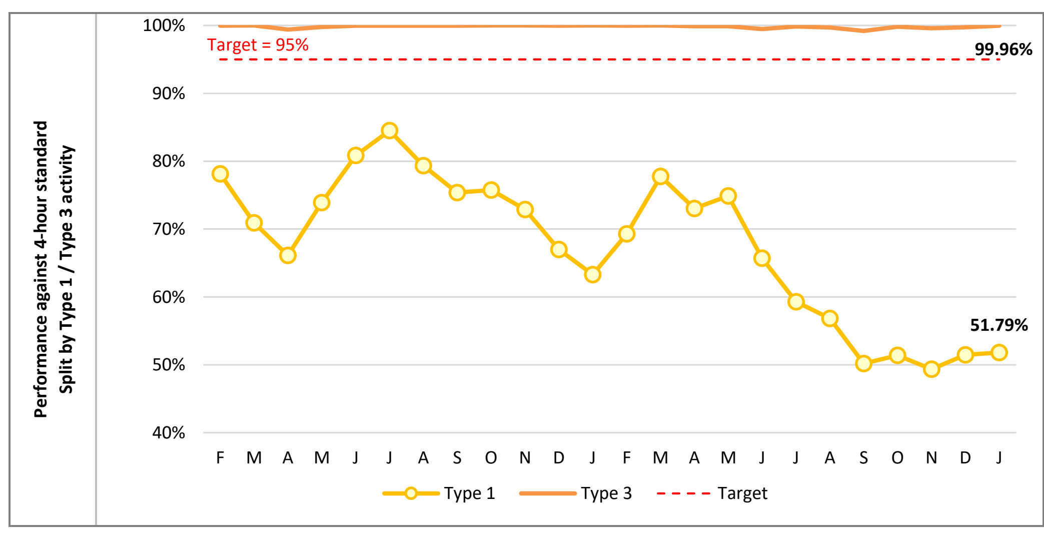


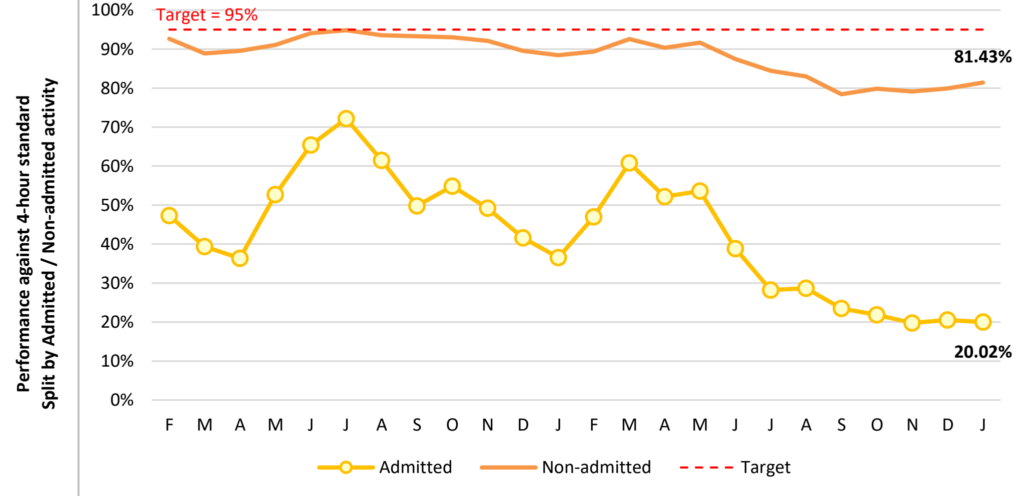
Responsive Services

Emergency Department Performance



Domain	Metric	Target	Dec-21	Jan-22	Change	Trend
Other Emergency Department measures	Ambulance handovers (Arrival to Handover) Proportion within 15 minutes	-	9.1%	8.0%	▼	
	Ambulance handover breaches 30 minutes	334	672	869	▲	
	Ambulance handover breaches 60-minutes	73	269	372	▲	
	Attendance to admission conversion rate	-	17.5%	19.9%	▲	
	Time to initial assessment Percentage within 15 minutes	-	51.7%	57.1%	▲	
	Average (mean) time in department Non-admitted patients	-	186	176	▼	
	Average (mean) time in department Admitted patients	-	581	593	▲	
	Left department before being seen for treatment	5%	2.22%	1.62%	▼	
	Unplanned re-attendance rate	5%	5.87%	5.51%	▼	





Responsive Services

New Emergency Department Standards

A&E
Percentage of ambulance handovers within 15-minutes
75%
65%
55%
45%
35%
25%
15%
5%
F M A M J J A S O N D J F M A M J J A S O N D J
Performance
Mean
UCL
LCL
Target
National

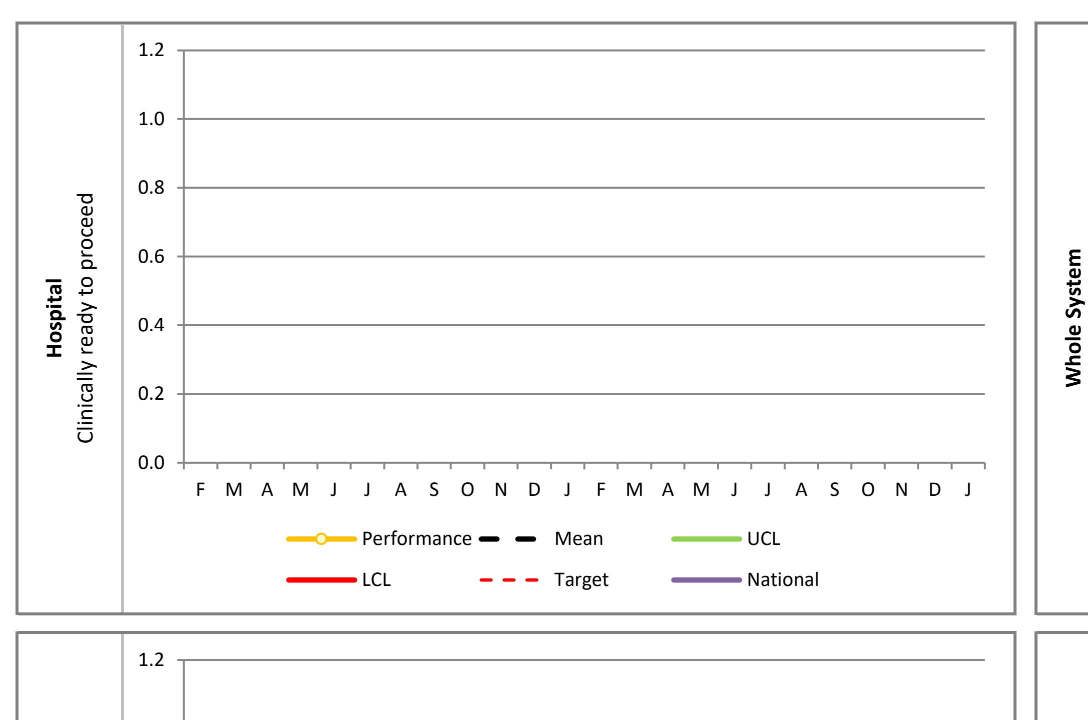
A&E
Time to initial assesment - percentage within 15-minutes
85%
80%
75%
70%
65%
60%
55%
50%
45%
40%
F M A M J J A S O N D J F M A M J J A S O N D J
Performance
Mean
UCL
LCL
Target
National

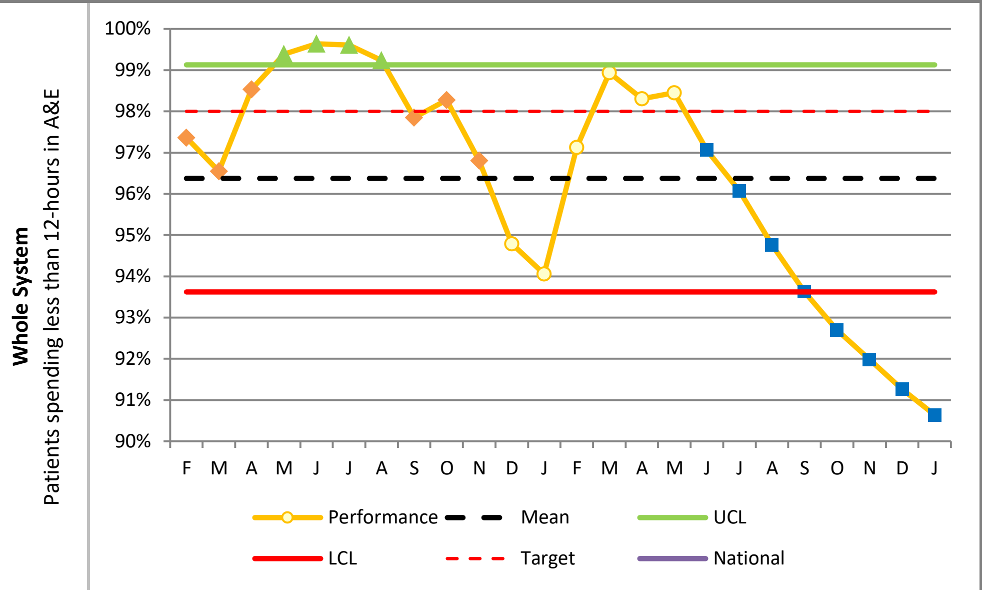
A&E
Average (mean) time in department - non-admitted patients
260
240
220
200
180
160
140
120
F M A M J J A S O N D J F M A M J J A S O N D J
Performance
Mean
UCL
LCL
Target
National

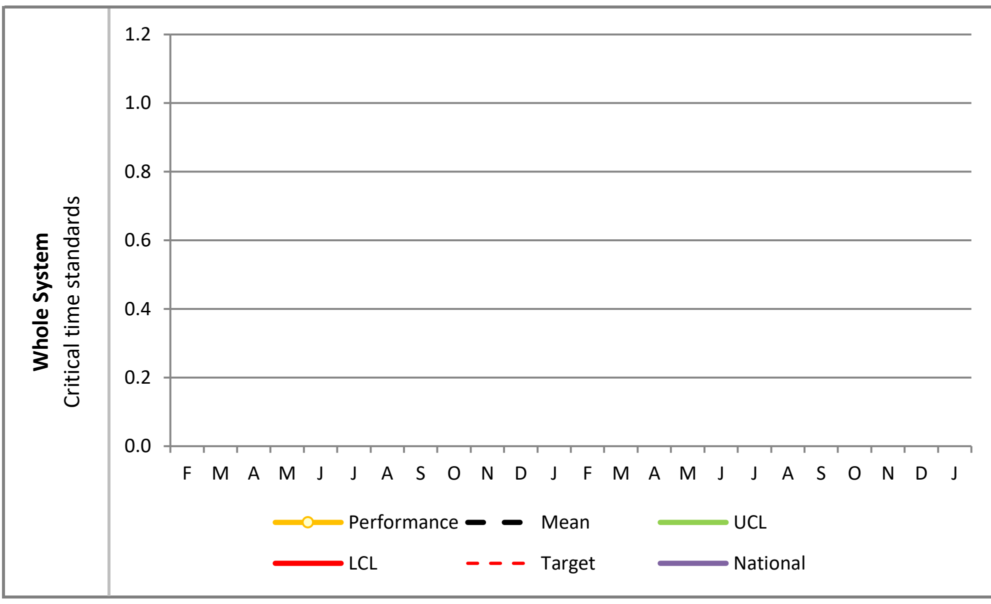
Hospital
Average (mean) time in department - admitted patients
620
570
520
470
420
370
320
270
220
170
120
F M A M J J A S O N D J F M A M J J A S O N D J
Performance
Mean
UCL
LCL
Target
National

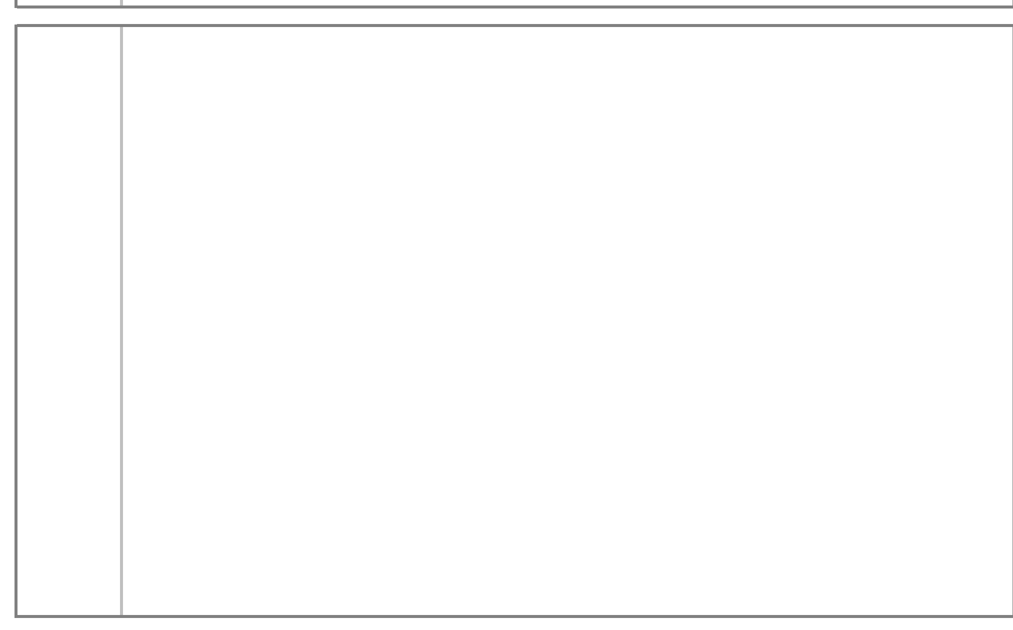
Responsive Services

New Emergency Department Standards









Responsive Services

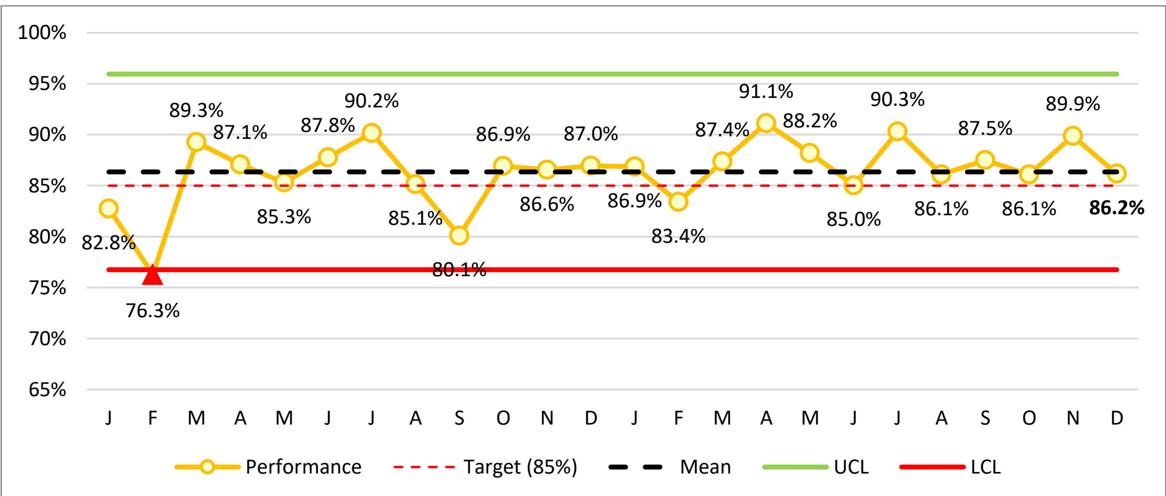
Cancer Waiting Times

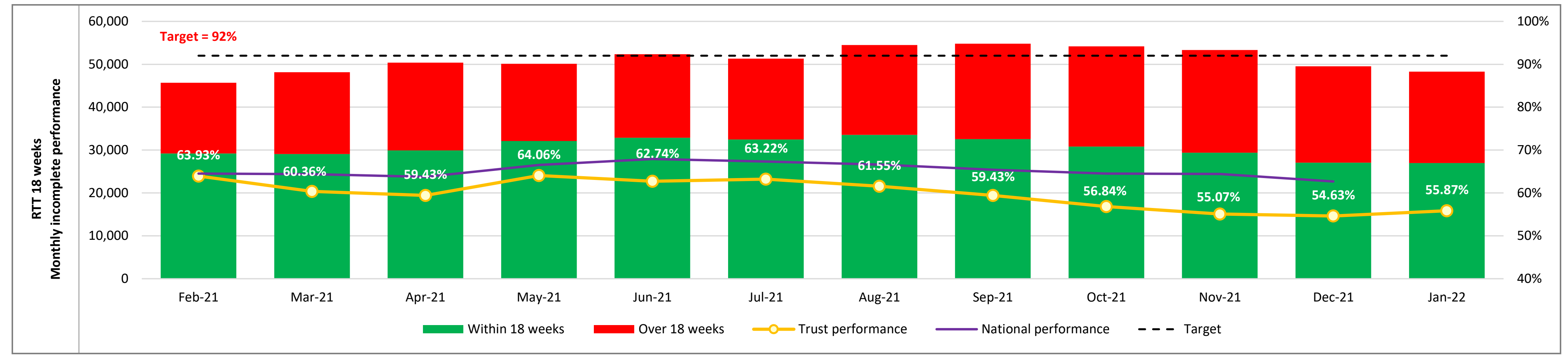
12-months' performance - all standards

Standard	Target	2020-21 Jan-21	2020-21 Feb-21	2020-21 Mar-21	2020-21 YTD	2021-22 Apr-21	2021-22 May-21	2021-22 Jun-21	2021-22 Jul-21	2021-22 Aug-21	2021-22 Sep-21	2021-22 Oct-21	2021-22 Nov-21	2021-22 Dec-21	2021-22 YTD
Two week waits Suspected cancer	93%	96.17%	98.00%	99.13%	97.26%	96.84%	97.86%	98.60%	97.62%	97.21%	97.49%	97.21%	97.74%	96.96%	97.51%
Two week waits Breast symptomatic	93%	93.40%	100.00%	100.00%	97.08%	95.10%	95.24%	96.36%	100.00%	97.83%	100.00%	100.00%	97.60%	96.51%	97.67%
31-day First definitive treatment	96%	99.05%	97.84%	96.97%	98.11%	99.51%	99.51%	96.69%	97.12%	96.93%	96.94%	94.35%	97.54%	98.37%	97.40%
31-day subsequent treatment Anti-cancer drugs	98%	100.00%	99.42%	100.00%	99.86%	100.00%	100.00%	99.10%	99.48%	99.48%	100.00%	100.00%	100.00%	100.00%	99.76%
31-day subsequent treatment Radiotherapy	94%	98.76%	98.51%	99.35%	98.87%	99.29%	98.63%	98.50%	98.94%	98.72%	99.37%	99.65%	99.42%	99.07%	99.06%
31-day subsequent treatment Surgery	94%	75.00%	92.11%	87.76%	92.68%	84.44%	92.50%	88.89%	97.14%	86.67%	78.43%	96.77%	85.00%	87.50%	87.94%
62-day GP referral to treatment	85%	86.87%	83.41%	87.36%	86.13%	91.12%	88.21%	85.04%	90.32%	86.10%	87.50%	86.09%	89.87%	86.18%	87.78%
62-day Specialist screening service	90%	80.00%	75.00%	64.29%	69.34%	81.48%	76.47%	75.00%	77.78%	85.00%	88.89%	87.50%	70.00%	70.00%	78.54%

62-day GP referral to treatment Dec-21

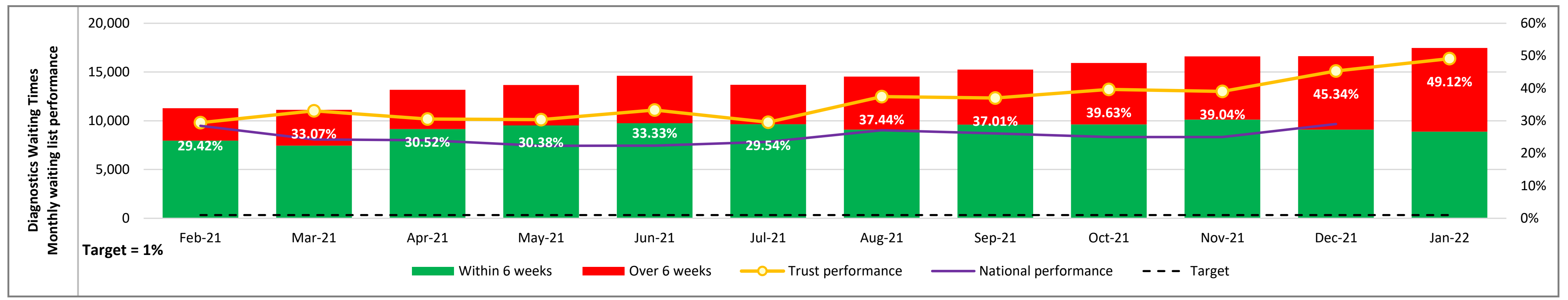
Tumour Site	OK	Breach	Total	Perf.	104+ day waits
Breast	20.5	5.0	25.5	80.39%	0.0
Gynaecology	5.5	1.5	7.0	78.57%	0.0
Haematology	2.0	2.0	4.0	50.00%	1.0
Head and Neck	7.0	2.0	9.0	77.78%	0.0
Lower GI	4.0	2.0	6.0	66.67%	1.0
Lung	5.0	1.0	6.0	83.33%	0.0
Other	0.0	0.0	0.0	-	-
Skin	22.5	1.0	23.5	95.74%	0.0
Testicular	1.0	0.0	1.0	100.00%	0.0
Upper GI	5.5	2.5	8.0	68.75%	1.5
Urology	33.0	0.0	33.0	100.00%	0.0
Total	**106.0**	**17.0**	**123.0**	**86.18%**	**3.5**





RTT 18 weeks
In-month performance by Specialty - Jan-22

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 52 weeks	Over 104 weeks	
General Surgery	216	52.78%	**30**	542	36.16%	17	1,379	872	2,251	61.26%	142	2	561
Urology	116	75.00%	**15**	630	43.33%	13	1,045	742	1,787	58.48%	165	5	441
Trauma & Orthopaedics	29	3.45%	**18**	668	22.31%	83	1,311	2,192	3,503	37.43%	838	72	333
Ear, Nose & Throat (ENT)	52	71.15%	**7**	1,282	26.29%	12	2,167	1,288	3,455	62.72%	137	1	752
Ophthalmology	91	24.18%	**24**	1,566	25.29%	192	3,195	3,454	6,649	48.05%	432	2	1,045
Oral Surgery	26	19.23%	**12**	896	17.19%	149	649	1,639	2,288	28.37%	435	54	135
Plastic Surgery	209	84.69%	**4**	412	44.66%	2	1,071	293	1,364	78.52%	9	1	578
Cardiothoracic Surgery	1	100.00%	**0**	16	50.00%	0	10	3	13	76.92%	0	0	8
General Medicine	1	100.00%	**0**	48	50.00%	0	10	1	11	90.91%	0	0	29
Gastroenterology	170	59.41%	**30**	606	22.61%	68	1,983	2,874	4,857	40.83%	742	0	641
Cardiology	27	66.67%	**1**	1,176	37.50%	5	1,882	454	2,336	80.57%	3	0	752
Dermatology	4	50.00%	**0**	404	30.69%	2	934	1,029	1,963	47.58%	1	0	329
Thoracic Medicine	29	82.76%	**0**	442	35.29%	4	820	193	1,013	80.95%	1	0	318
Neurology	0	-	**0**	402	44.03%	0	441	29	470	93.83%	0	0	217
Rheumatology	0	-	**0**	292	19.52%	4	470	360	830	56.63%	5	0	112
Geriatric Medicine	0	-	**0**	92	38.04%	1	155	32	187	82.89%	0	0	54
Gynaecology	43	48.84%	**9**	764	22.91%	12	1,785	1,041	2,826	63.16%	45	1	644
Other	150	44.67%	**39**	2,065	79.76%	95	7,659	4,802	12,461	61.46%	784	21	3,648
Total	**1,164**	**58.25%**	**189**	**7,184**	**65.01%**	**659**	**26,966**	**21,298**	**48,264**	**55.87%**	**3,739**	**159**	**10,597**



Diagnostics Waiting Times
In-month performance by Modality - Jan-22

Category	Modality	Patients still waiting at month end					Number of tests / procedures carried out during the month			
		Within 6 weeks	Over 6 weeks	Total	Performance	13+ weeks	Waiting List	Planned	Unscheduled	Total
Imaging	Magnetic Resonance Imaging	1,277	2,382	3,659	65.10%	855	1,539	168	5	**1,712**
	Computed Tomography	1,431	1,972	3,403	57.95%	696	3,231	603	0	**3,834**
	Non-obstetric ultrasound	4,078	2,271	6,349	35.77%	26	5,072	436	65	**5,573**
	DEXA Scan	483	1,035	1,518	68.18%	476	203	14	0	**217**
Physiological Measurement	Audiology - audiology assessments	46	29	75	38.67%	4	50	0	0	**50**
	Cardiology - echocardiography	761	621	1,382	44.93%	18	965	0	0	**965**
	Neurophysiology - peripheral neurophysiology	60	2	62	3.23%	0	84	0	0	**84**
	Respiratory physiology - sleep studies	112	0	112	0.00%	0	73	0	0	**73**
	Urodynamics - pressures & flows	59	111	170	65.29%	50	30	0	0	**30**
Endoscopy	Colonoscopy	285	92	377	24.40%	39	406	0	0	**406**
	Flexi sigmoidoscopy	84	27	111	24.32%	10	129	0	0	**129**
	Cystoscopy	25	0	25	0.00%	0	53	0	0	**53**
	Gastroscopy	190	41	231	17.75%	4	232	0	0	**232**
Total		**8,891**	**8,583**	**17,474**	**49.12%**	**2,178**	**12,067**	**1,221**	**70**	**13,358**

Responsive Services

Stroke Performance

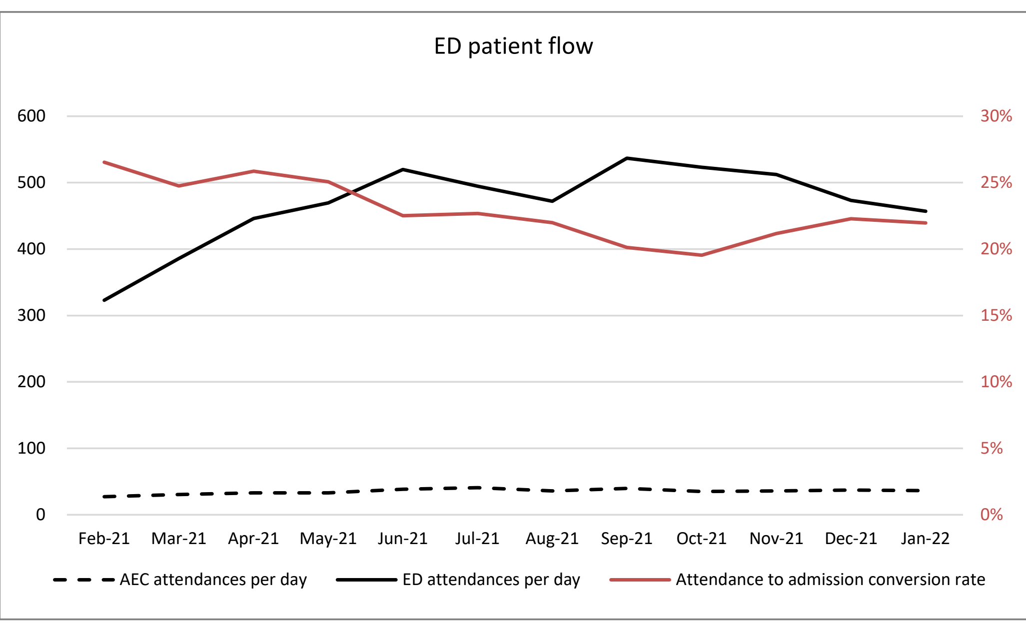
Domain	Metric	2021-22 Target	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Trend
Stroke	Trust SSNAP grade	A	C	C	C	C	C	C	D	D	D	tbc	tbc	tbc	
	% of patients discharged with a diagnosis of Atrial Fibrillation and commenced on anticoagulants	80%	100.0%	85.7%	88.9%	87.5%	66.7%	100.0%	85.7%	100.0%	91.7%	100.0%	100.0%	100.0%	
	4-hours direct to Stroke unit from ED Actual	63%	28.1%	49.3%	61.0%	43.5%	64.4%	46.4%	36.1%	29.7%	33.9%	17.1%	23.3%	19.7%	
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	63%	29.5%	48.5%	66.7%	45.0%	65.5%	47.5%	34.8%	29.5%	34.0%	17.3%	24.3%	19.0%	
	Number of confirmed Strokes in-month on SSNAP	-	66	70	63	62	59	85	72	65	57	78	74	70	
	If applicable at least 90% of patients' stay is spent on a stroke unit	80%	92.3%	97.1%	93.4%	93.5%	93.2%	83.3%	87.3%	84.6%	89.3%	84.4%	91.9%	77.9%	
	Urgent brain imaging within 60 minutes of hospital arrival for suspected acute stroke	50%	47.0%	52.9%	55.6%	58.1%	49.2%	45.9%	56.9%	49.2%	50.9%	50.0%	48.6%	38.9%	
	Scanned within 12-hours - all Strokes	100%	97.0%	95.7%	98.2%	91.9%	96.6%	94.1%	97.2%	93.8%	96.5%	98.7%	97.3%	97.2%	
	% of all stroke patients who receive thrombolysis	11%	10.6%	5.7%	11.3%	3.2%	3.4%	8.2%	4.2%	9.2%	12.5%	7.7%	4.1%	11.4%	
	% of patients eligible for thrombolysis to receive the intervention within 60 minutes of arrival at A&E (door to needle time)	70%	85.7%	25.0%	14.3%	0.0%	50.0%	57.1%	0.0%	16.7%	42.9%	33.3%	66.7%	62.5%	
	Discharged with JCP	80%	85.0%	91.3%	75.8%	91.9%	87.0%	52.6%	72.3%	81.6%	86.8%	90.7%	86.3%	72.7%	
	Discharged with ESD	40%	80.0%	62.5%	56.8%	73.0%	73.9%	60.7%	70.2%	71.7%	65.8%	60.4%	62.7%	62.2%	

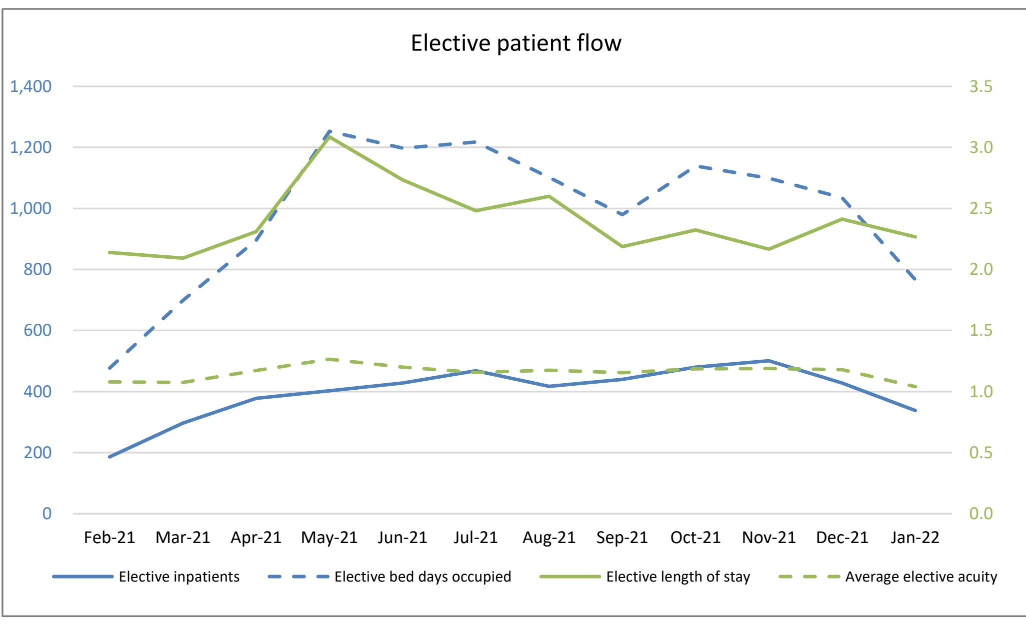
Breaches Jan-22	Breach reasons			
		• Challenging Diagnosis/Complex Patients = 18 • Late referral = 4 • Share Care Transfers = 5 • Pathway (ED delays) = 5	• Bed Capacity = 20 • Inpatient Stroke = 1 • Patient Related = 0 • COVID POC = 1 • Other = 1	**Breach reasons:** **In-hours: 22** **Out-of-hours: 33**

Responsive Services

Patient Flow

Domain	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Trend
Emergency Department Flow Indicators	A&E & UCC attendances	9,072	11,955	13,470	14,720	15,859	15,633	14,928	16,384	16,591	15,617	14,675	14,165	
	Attendance to admission conversion rate	26.5%	24.8%	25.9%	25.1%	22.5%	22.7%	22.0%	20.1%	19.5%	21.2%	22.3%	22.0%	
	ED attendances per day	323	386	446	470	520	495	472	537	523	512	473	457	
	AEC attendances per day	27	31	33	33	39	41	36	40	35	36	37	36	
	4-hour target performance %	78.8%	85.2%	82.8%	84.1%	78.6%	74.8%	73.3%	69.5%	70.1%	68.8%	69.5%	69.8%	
	Time to initial assessment Percentage within 15 minutes	71.9%	70.3%	66.3%	58.8%	50.4%	48.2%	51.7%	44.1%	48.4%	46.9%	51.7%	57.1%	
	Ambulance handover breaches 30-minutes	327	274	380	341	586	548	812	783	932	797	672	869	





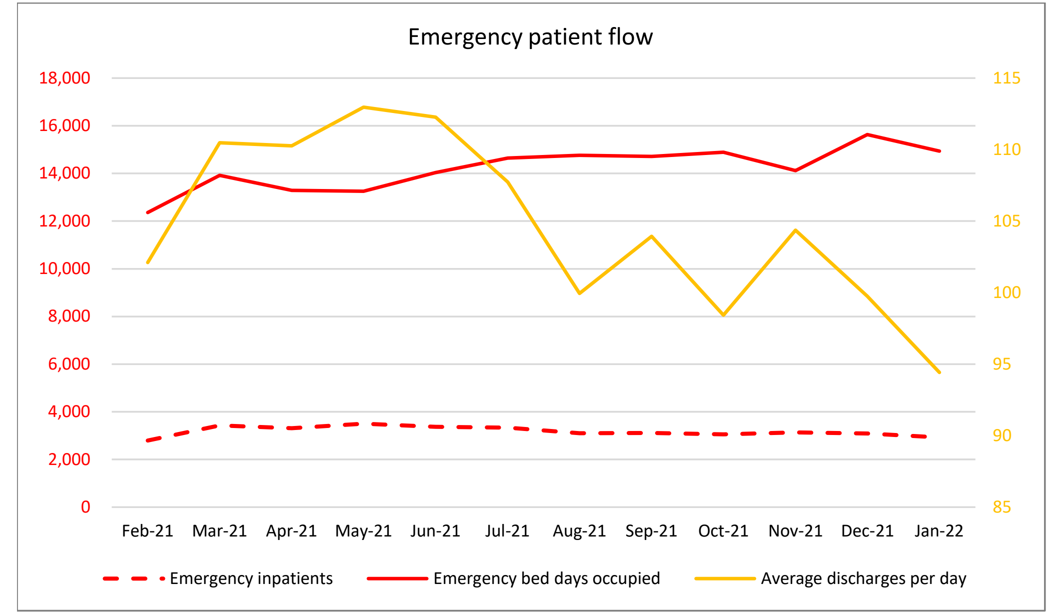
Responsive Services

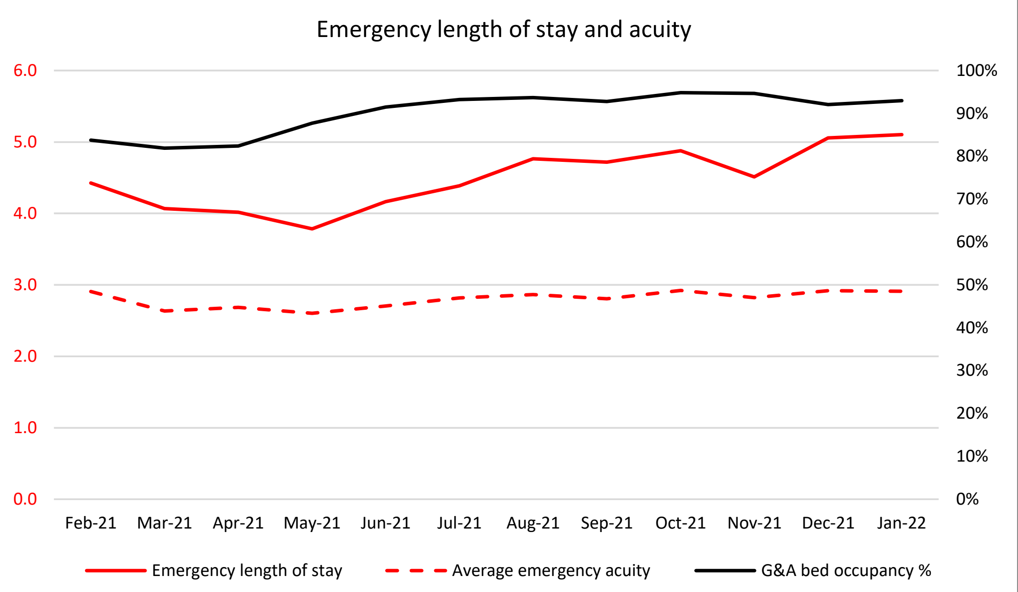
Patient Flow

Domain	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Trend
Elective Inpatient Flow Indicators	Elective inpatients	186	297	378	403	428	468	417	440	480	501	428	338	
	Elective bed days occupied	477	699	896	1,253	1,198	1,218	1,102	980	1,139	1,099	1,035	766	
	Elective length of stay	2.1	2.1	2.3	3.1	2.7	2.5	2.6	2.2	2.3	2.2	2.4	2.3	
	Daycase rate %	89.6%	89.1%	87.9%	89.0%	89.8%	89.1%	88.7%	88.3%	87.3%	87.6%	87.6%	90.1%	
	Average elective acuity	1.08	1.07	1.17	1.26	1.20	1.16	1.18	1.15	1.19	1.19	1.18	1.04	
Emergency Flow Indicators	Emergency inpatients	2,794	3,425	3,308	3,502	3,368	3,340	3,098	3,118	3,052	3,131	3,092	2,927	
	Average discharges per day	102	110	110	113	112	108	100	104	98	104	100	94	
	Emergency bed days occupied	12,361	13,926	13,290	13,253	14,033	14,650	14,758	14,714	14,892	14,122	15,631	14,937	
	Emergency length of stay	4.4	4.1	4.0	3.8	4.2	4.4	4.8	4.7	4.9	4.5	5.1	5.1	
	Average emergency acuity	2.9	2.6	2.7	2.6	2.7	2.8	2.9	2.8	2.9	2.8	2.9	2.9	
	G&A bed occupancy %	84%	82%	82%	88%	92%	93%	94%	93%	95%	95%	92%	93%	
	Patients discharged via Discharge Lounge	348	398	436	477	534	534	538	626	646	661	682	641	
	Discharges before midday	13.8%	12.8%	14.7%	14.6%	14.2%	13.3%	14.1%	15.7%	14.2%	14.7%	14.2%	13.8%	
	Weekend discharges	13.2%	13.9%	14.6%	19.0%	14.5%	16.3%	15.1%	14.6%	16.8%	13.7%	12.2%	16.4%	
	Proportion of beds occupied by patients with length of stay over 14 days	20.5%	18.4%	16.7%	16.0%	18.6%	19.6%	20.3%	20.3%	20.6%	22.6%	23.0%	22.8%	
	Proportion of beds occupied by patients with length of stay over 21 days	11.0%	9.3%	9.1%	8.3%	9.8%	10.1%	11.1%	10.0%	10.4%	13.0%	12.6%	12.8%	

Responsive Services

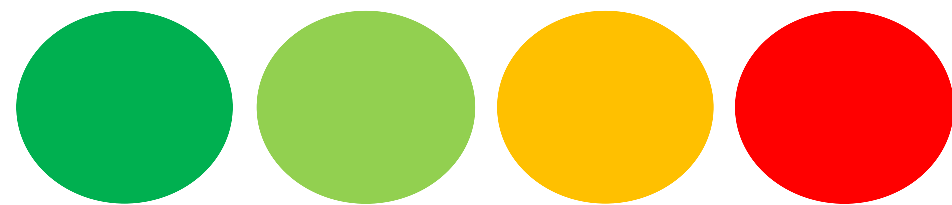
Patient Flow





People Report

Month 10 | 2021-22



Key Issues

Work

- Vacancy rate overall has increased from 6.4% to 7.6% (478 vacancies). This is largely due to an increase in recruitable establishment of 73 WTE. There are 7 WTE less people in post this month compared to last month, and 117 more people in post than there was in January 2021.
- Nursing and midwifery vacancy rate has increased from 2.6% to 4.2% (78 vacancies) – this increase is primarily due to an increase in qualified recruitable establishment of 22 WTE.
- There are 102 more nurses in post than there were 12 months ago (January 2021), there were 80 starters and 73 leavers in month, giving an in month positive outcome of +7. There were 18 new nursing and midwifery starters in month, and 23 leavers, giving an in-month deficit of - 5. International Nursing continues at pace, the Trust has just been awarded £300,000 from NHSE/I to support 100 international nurse arrivals for 22/2, we expect to recruit 9 international midwives arriving by July 2022.
- Clinical support workers are highlighted as a hotspot, with high vacancy rate and high turnover in this staff group.
- Candidate experience rating remains high at 4.7 and moving into amber for the first time since May 2021 is time to hire which is above target at 11 weeks (against a target of 10 weeks).
- There are 234 people in the recruitment pipeline, including 58 doctors, 35 clinical support workers and 55 nurses/midwives.
- Agency spend increased by 102k in month but remained 32k below ceiling rate in month, YTD the Trust remains £3.5m under 21/22 NHSE/I ceiling target. Q3 2022 showed the Trust achieved £299k in cost avoidance related to our tri party contract arrangements.
- January showed a significant improvement for Bank filled hours (over 10k), which were needed to respond to staff shortages and increased demands supporting winter resilience. This was the highest number of bank hours filled since January 2021. The filled hours also correlate with the increase in bank spend for M10.

Grow

- Statutory training compliance has shown a slight improvement this month and is currently at 86.6%. The percentage of staff with 100% compliance is at 57.13%, also an improvement on the previous month. The compliance rate is however slightly below the Aug - Nov 21 figures. Compliance rates are anticipated to improve going forward, as staff absence improves and staff are released to attend training.
- Three Statutory courses (Fire Awareness, Moving and handling and Equality & Diversity for medical staff) currently show compliance below 80%, actions are being taken to ensure staff can be released and provided with study time to complete these.
- The recorded appraisal (Grow Together review) rate is below target at 54.8 % and is marginally lower than previous months. At the end of January 2022, staff were notified that all remaining Grow Together reviews for 21/22 should be halted, as we move to the new review year from April 2022. This pause is expected to impact on compliance rates over the next two months.
- Utilisation of the Trust's CPD allocation and staff undertaking apprenticeships continues to improve, as more staff are released to undertake study days with 264 staff undertaking 30 different apprentices across the Trust, with all but £8k of the Trust's £690k CPD allocation being utilised.

Thrive

- The People Pulse quarterly survey, initial results were available 11/02/2022 and 194 people completed the survey, lower than last pulse survey by over 200 but this is not unexpected.
- Staff turnover continues to increase this month with the highest reasons for leaving include work/life balance and relocation and some contribution of fixed term funding coming to an end in the last quarter and staff seeking roles elsewhere.
- The average length of suspension for January 22 is 226.5 days which is an increase, there are two cases both of long-term nature and one outside of our internal controls.

Care

- Sickness absence rates have increased in January and is an expected increase contributed to by a combination of Covid19 positive cases, isolation, and other seasonal absences
- There continues to be a reduction in FTE days lost to mental health related absence compared to the previous month.

Executive Response

Work

- A number of workforce initiatives have commenced in January including deploying 14 team support workers to inpatient wards, 20 medical students activated as well as a new cohort of 12 CSWD (care support development programme) with a further 2 cohorts of 12 CSWD over 2022.
- Hotspots remain as midwifery and radiography. A collaborative approach to midwifery international recruitment with the ICS as well as local initiatives are underway.

Executive Response

Work (cont'd)

- A recruitment plan for radiography has just launched and an ongoing programme of international recruitment of Radiographers is underway.
- Clinical support workers are highlighted as a hotspot, with high vacancy rate and high turnover. A focus on this, covering a range of work streams, ranging from recruitment to education/support is underway.
- Inclusion Ambassador Programme continues to gain momentum, all roles above 8a now have an IA on the appointing panel.
- The Trust is now 82% compliant against NHSE/I clinical levels of attainment with a rostering system (8% off target), in addition 92% of junior doctors and 47% of consultants are live on eRoster with the remaining implementation of new areas progressing well against the action plan.
- Medical Locum spend has reduced by £970K (£242k is Agency, £728K is Bank) YoY, although the agency spend is a smaller reduction, it has almost halved from the previous year.

Grow

- Appraisal (Grow Together Reviews) have now been paused, a full launch programme for the new April to August cycle is planned in March 2022. This will ensure aligned objectives can be cascaded throughout the Trust and targeted messages sent to staff groups during the cycle. This will improve compliance and ensure the Trust has a fully embedded talent rhythm.
- A recent internal audit of Statutory and Mandatory Training and Appraisals in Q3 provided 'reasonable assurance' of the Trusts processes. Key recommendations identified are being progressed which include timely completion of appraisals and a reminder to managers regarding their responsibilities in following up and ensuring staff compliance with mandatory training.
- A working group is currently reviewing early access to the ENH academy for new joiners as part of the on-boarding process, including the automatic transfer of training records via the inter authority transfer process, which will support improving mandatory training compliance.
- A revised CPD policy is in development and will be launched in the new financial year at the same time as the Trust will be adopting an ICS CPD portal. The new portal will ensure greater transparency in relation to CPD allocations and requests for development and also allows the Trust to improve reporting across its divisions and staff groups. The annual training needs gathering has commenced as we expect the CPD allocation for 22/23 to be announced in April/May. Plans are in place to allocate the £8k underutilised by March 22.
- The number of staff offered development through apprenticeships continues to grow with plans in development to implement new Quality Improvement and NHS Leadership Apprenticeships. The Trust's levy spend is currently at £80,000 per month, with an underutilisation of £30,000. An apprenticeship and widening participation strategy in development will ensure this gap is met.
- A review of the Education board and reporting committees has taken place with the development of two new committees reporting into the board providing oversight of clinical education and the Trust's apprenticeship and widening participation strategy.

Thrive

- Initial outputs from both national and pulse staff surveys indicate focus areas include assuring staff on safe numbers of staffing, improving work life balance, involving staff in change and decisions, and creating a workplace staff thrive in.
- The first stage of reciprocal mentoring programme launched in November with selected pairing, some challenges have been raised by the National team (make-up of facilitators at some sites) and further discussions are happening on 2nd March prior to next steps happening.
- EoE has launched 2022 programme of EDI leaders development we will share and publicise availability.
- Work has commenced on data analysis relating to recognition and reward schemes to enable development of a wider, more long-term strategic approach to this area of work later in 2022, we will continue to run initiatives throughout 2022.
- In January 2022 there were 18 disciplinary cases, the maximum number of days open was 290. The minimum number was 20 days. It is likely that the new cases in December 2021 brought down the average as the new cases were closed quickly, leaving fewer cases open in January, which are more long-standing cases.

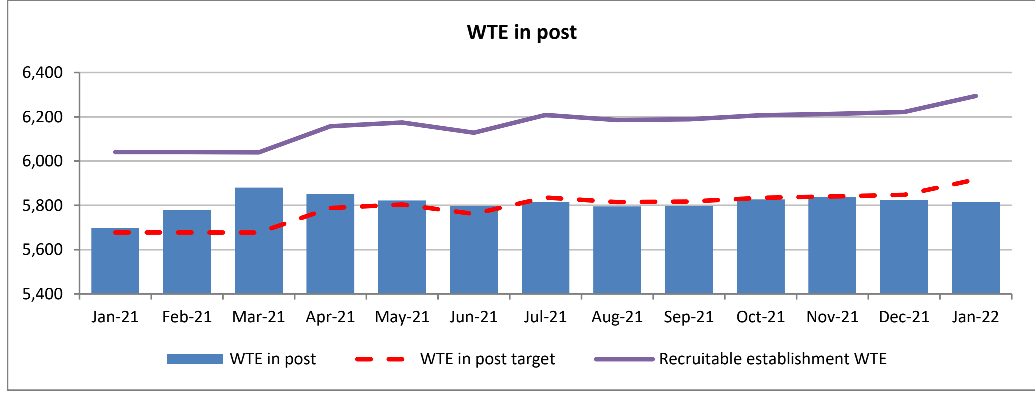
Care

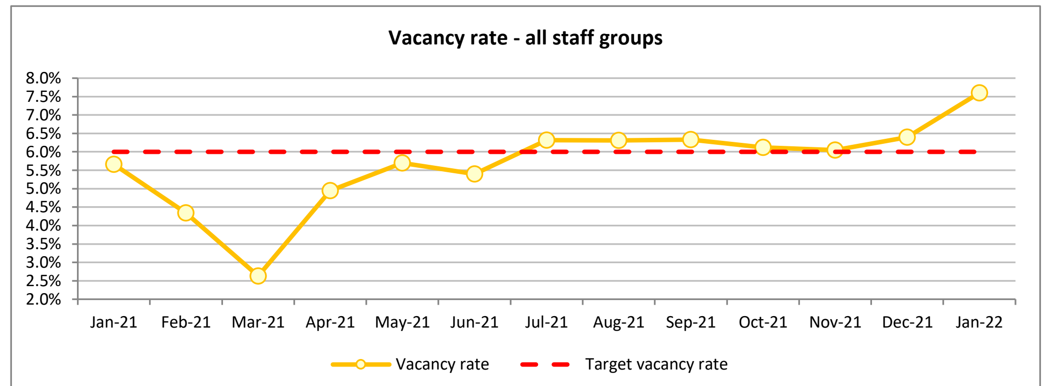
- Absence for mental health related reasons is the lowest it has been and is likely to correlate with targeted support and range of promoted wellbeing and Here For You services intervening and being contacted by staff as they need support.
- Wellbeing and sickness support Ward based interventions continue for hot spot areas of absence and are receiving targeted support including leadership coaching, support for wellbeing champions and drop-in support sessions.
- Ward based group and individual sessions from 'Here for You' continue to support staff unable to leave the clinical area to attend reflective spaces.
- Planning for a March Schwartz round is underway.
- Work continued to promote flu and booster vaccine uptake; both have plateaued, and clinic sessions will cease in late February.
- The ERAS team is working closely with Divisional leads to support with complex sickness case management. It is also important to note that there are now a few long covid long term sickness cases which have been ongoing for over 12 months. All Trusts are managing long Covid cases in line with National guidelines.

People Report

Work Together

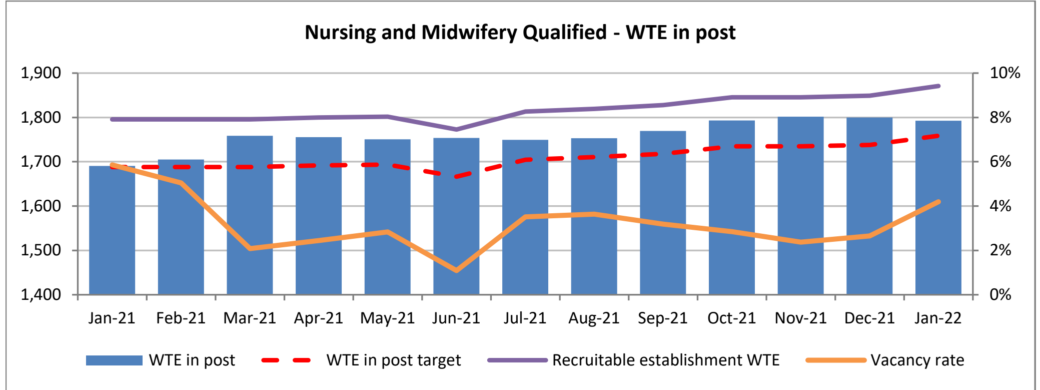
Domain	Metric	Target	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Trend
Work	Vacancy Rate	6%	5.7%	4.3%	2.6%	5.0%	5.7%	5.4%	6.3%	6.3%	6.3%	6.1%	6.1%	6.4%	7.6%	
	Time to hire (weeks)	10	11.0	10.0	10.0	11.0	11.0	10.0	9.0	9.0	9.0	10.0	10.0	10.0	11.0	
	Recruitment experience	4	4.6	4.5	4.4	4.7	4.7	4.7	4.7	4.7	4.6	4.5	4.5	4.5	4.7	
	Relative likelihood of white applicant being shortlisted and appointed over BAME applicant	1		2.00			2.00			1.43			1.53		tbc	
	Relative likelihood of non-disabled applicant being shortlisted and appointed over disabled applicant	1		0.70			1.20			1.62			3.10		tbc	
	Agency Spend (% of WTE)	4%	3.4%	3.2%	3.3%	3.5%	2.9%	3.3%	3.3%	3.6%	3.1%	3.0%	3.4%	3.1%	3.5%	
	Bank Spend (% of WTE)	10%	10.5%	11.6%	8.6%	10.4%	8.4%	8.1%	7.9%	9.2%	8.5%	9.0%	8.7%	10.7%	11.5%	
	% of Clinical Workforce (AFC) on eRoster	> 90%	80.0%	80.0%	81.0%	81.0%	82.0%	82.0%	82.0%	82.0%	82.0%	82.0%	82.0%	82.0%	82.0%	
	% of Medical & Dental on eRoster	> 60%								83.0%	83.0%	84.0%	83.0%	84.0%	84.0%	
	% of Rosters Approved more than 6 weeks in advance (NHS E/I recommended)	> 80%								62.0%	43.5%	63.5%	58.9%	61.2%	68.5%	
	% Staff on Annual Leave	13% - 17%	14.9%	13.0%	17.1%	19.1%	12.0%	12.0%	13.4%	16.7%	15.0%	11.3%	12.7%	12.4%	15.6%	
	Pulse survey Flexibility	55%		60.0%			64.3%			56.6%			tbc		tbc	

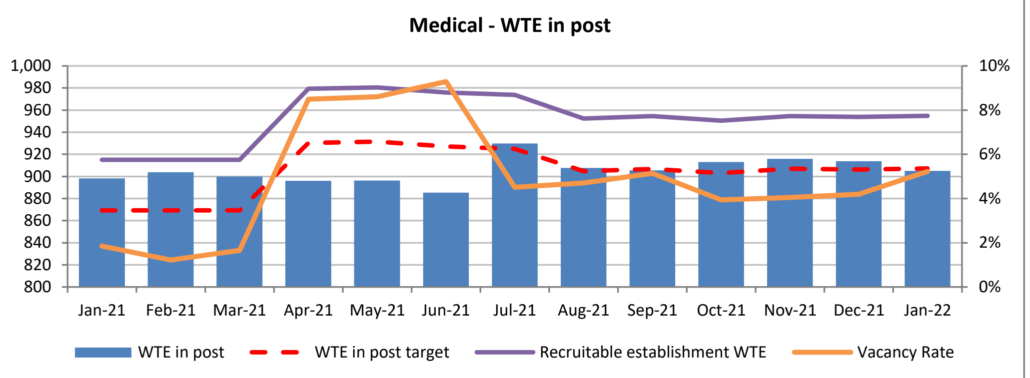


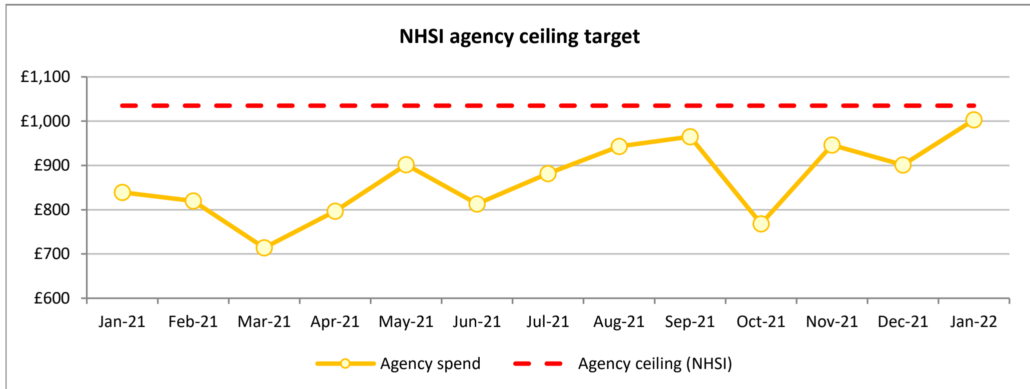


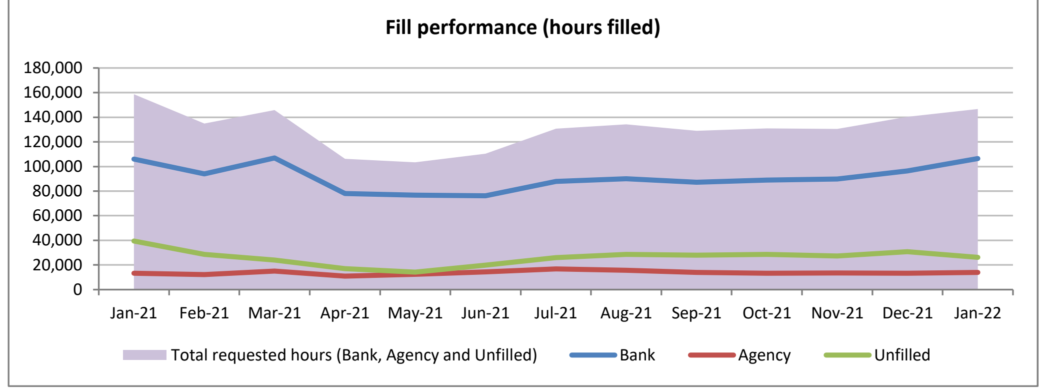
People Report

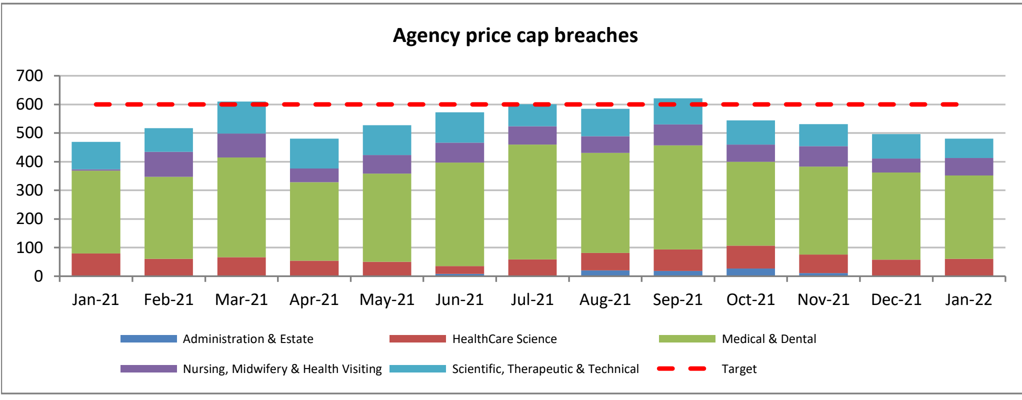
Work Together

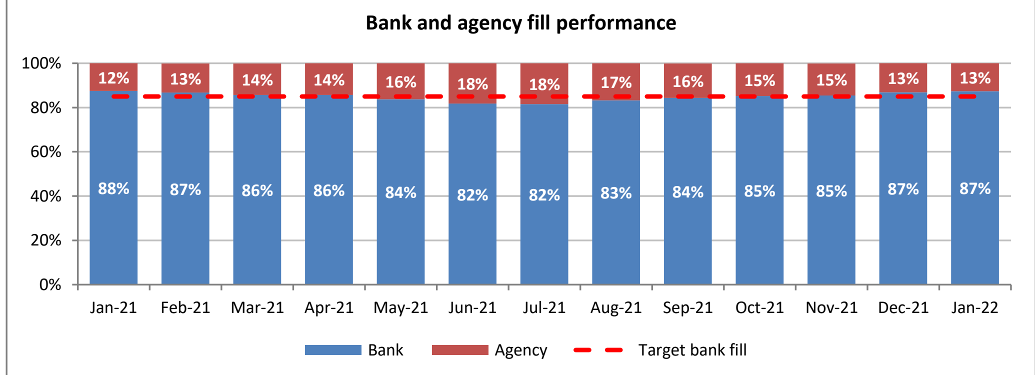






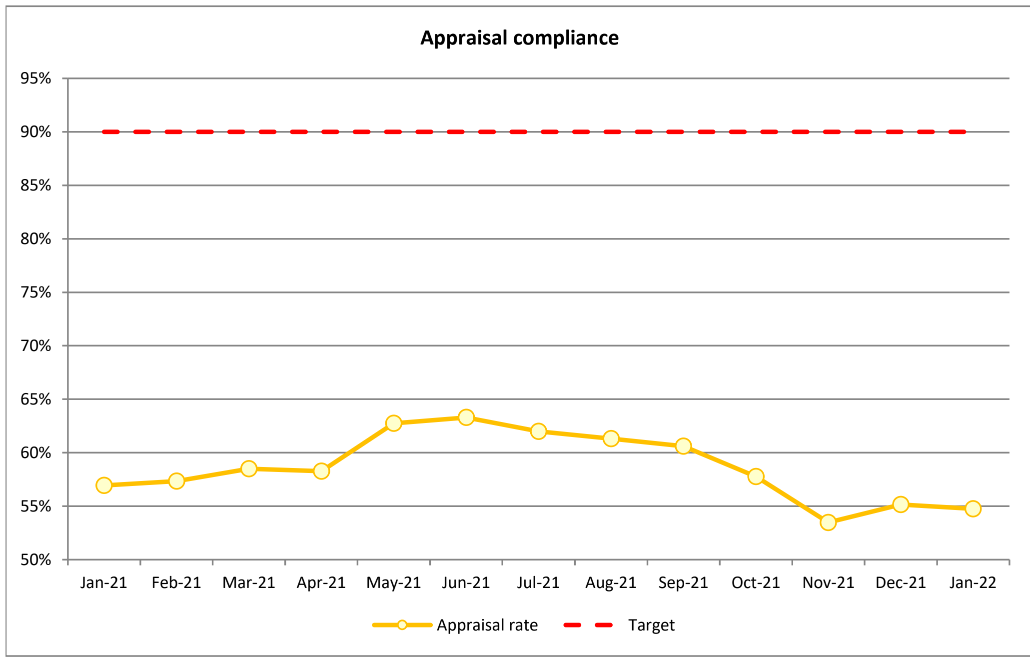


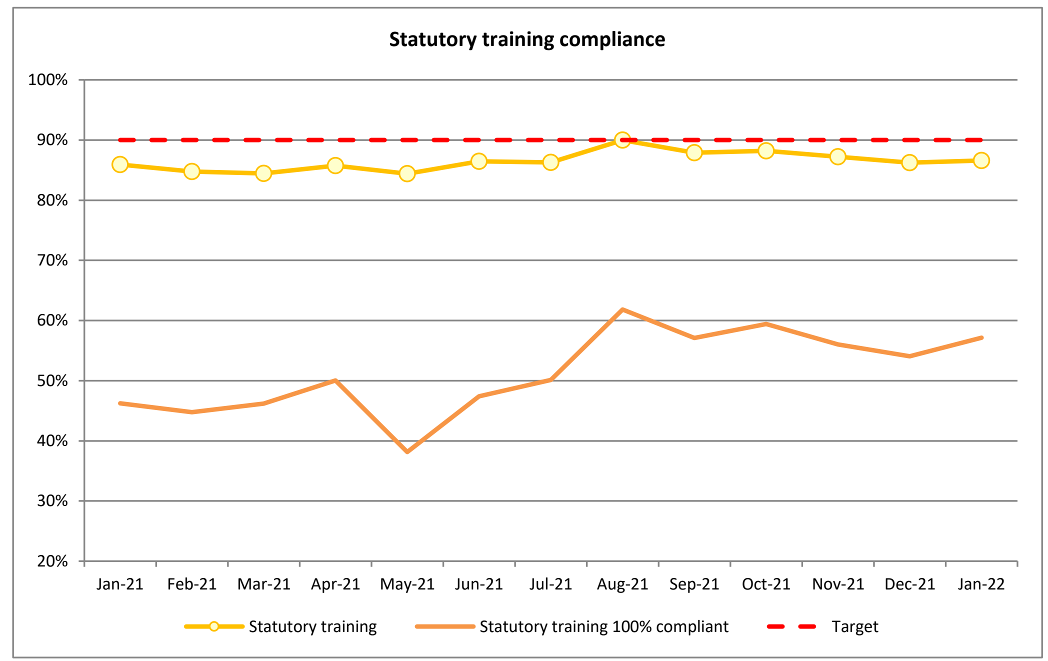




East and North Hertfordshire NHS Trust

Domain	Metric	Target	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Trend
Grow	Statutory & mandatory training compliance rate	90%	85.9%	84.8%	84.4%	85.8%	84.4%	86.5%	86.3%	90.0%	87.9%	88.2%	87.2%	86.2%	86.6%	
	Appraisal rate	90%	57.0%	57.3%	58.5%	58.3%	62.7%	63.3%	62.0%	61.3%	60.6%	57.8%	53.5%	55.2%	54.8%	
	Pulse survey Training and development opportunities	55%	52.1%			55.4%			55.1%			tbc			tbc	
	Pulse survey Talent management	55%	51.3%			61.8%			55.4%			tbc			tbc	
	Likelihood of training and development opportunities (BAME)	1	tbc			tbc			tbc			tbc			tbc	
	Likelihood of training and development opportunities (Disability)	1	tbc			tbc			tbc			tbc			tbc	



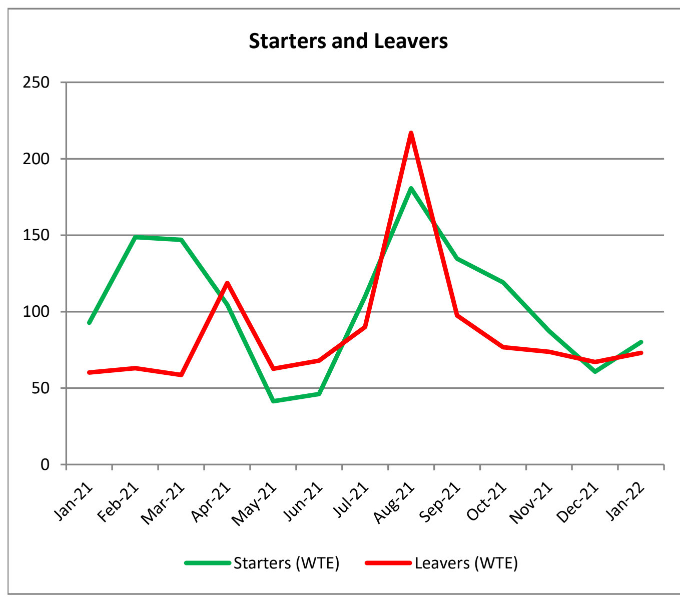


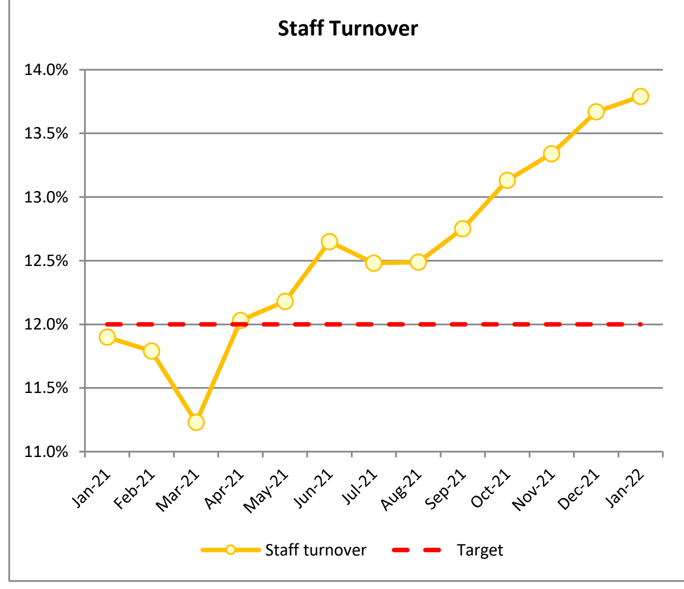
People Report

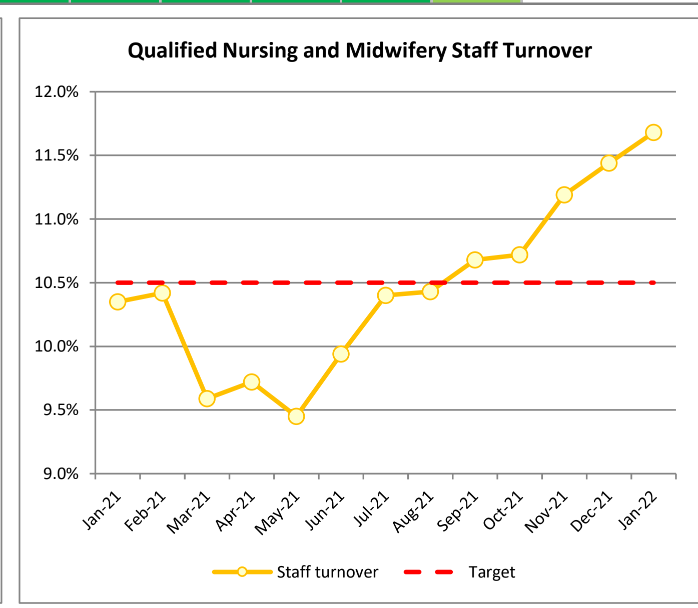
Thrive Together

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Trend
Thrive	Pulse survey My leader	75%	79.8%			85.5%			79.8%			tbc			tbc	
	Pulse survey Harnessing individuality	60%	57.7%			61.8%			52.8%			tbc			tbc	
	Pulse Survey Not experiencing discrimination	95%	68.4%			75.9%			70.8%			tbc			tbc	
	Turnover Rate	12.2%	11.9%	11.8%	11.2%	12.0%	12.2%	12.7%	12.5%	12.5%	12.8%	13.1%	13.3%	13.7%	13.8%	
	Model employer targets (% achieved)	100%	67%			50%			67%			83%			tbc	
	Average length of suspension (days)	20	33.0	43.0	37.0	59.0	57.2	76.6	105.0	96.0	142.5	140.0	177.5	86.0	226.5	
	Average length of Disciplinary (excluding suspensions) (days)	60	96.0	102.0	148.0	168.0	63.0	47.7	86.0	74.0	71.6	51.0	54.9	43.5	72.5	
	Average length of Grievance (including dignity at work) (days)	60	114.0	86.0	91.0	82.0	80.0	86.0	74.0	37.9	23.3	37.0	46.9	45.9	57.7	





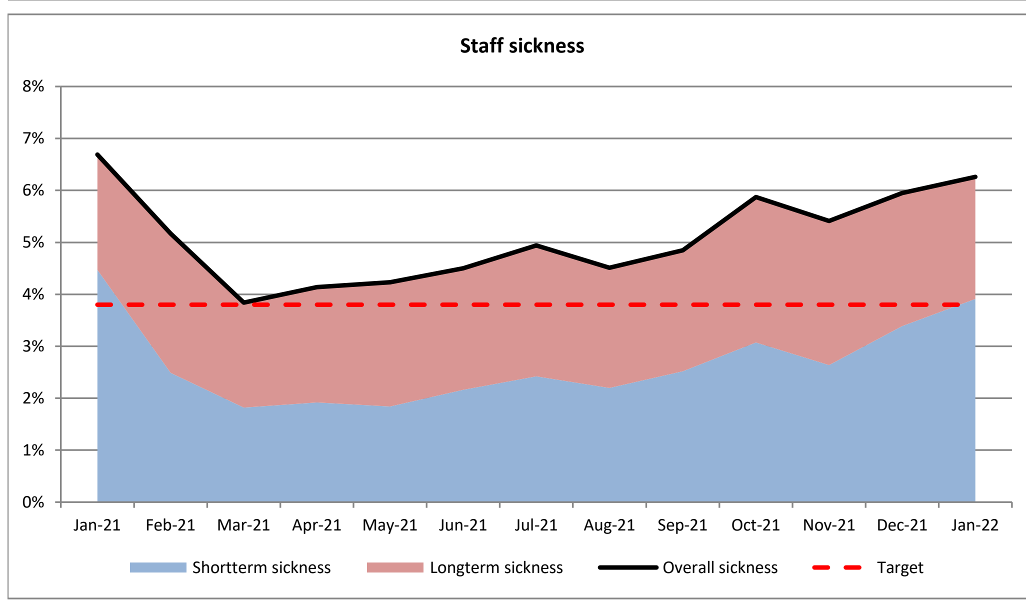


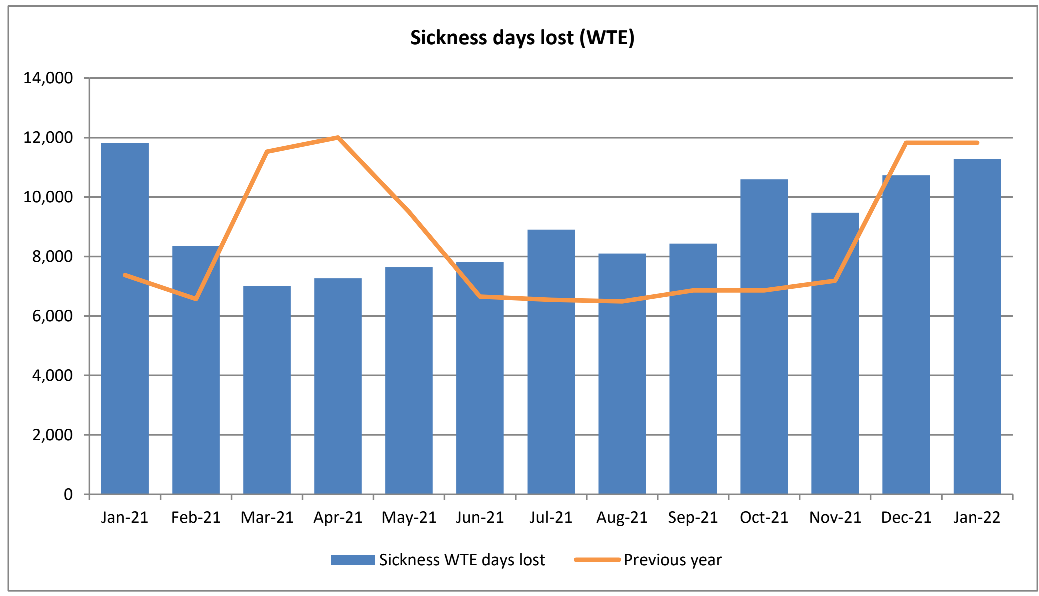
People Report

Care Together

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Trend
Care	Pulse survey Well-being	70%		68.6%			78.9%			71.5%			tbc		tbc	
	Pulse survey Reasonable adjustments	50%		60.4%			88.7%			91.4%			tbc		tbc	
	Staff FFT Recommend as a place to work	60%		47.8%			56.6%			41.7%			tbc		tbc	
	Staff FFT Recommend as a place of care	70%		70.3%			72.7%			65.9%			tbc		tbc	
	Sickness Rate	3.8%	6.69%	5.17%	3.84%	4.14%	4.23%	4.50%	4.94%	4.51%	4.85%	5.87%	5.41%	5.93%	6.26%	
	Sickness FTE Days Lost	6,777	11,825	8,357	7,005	7,265	7,633	7,818	8,905	8,102	8,437	10,599	9,474	10,735	11,278	
	Mental health related absence (days lost)	1,650	1,743	1,691	1,684	1,798	1,702	1,899	1,945	1,583	1,725	2,223	2,021	1,787	1,455	
	MSK related absence (days lost)	1,285	1,347	1,315	1,165	1,120	1,170	1,325	1,260	1,196	1,152	1,308	1,204	1,166	1,157	

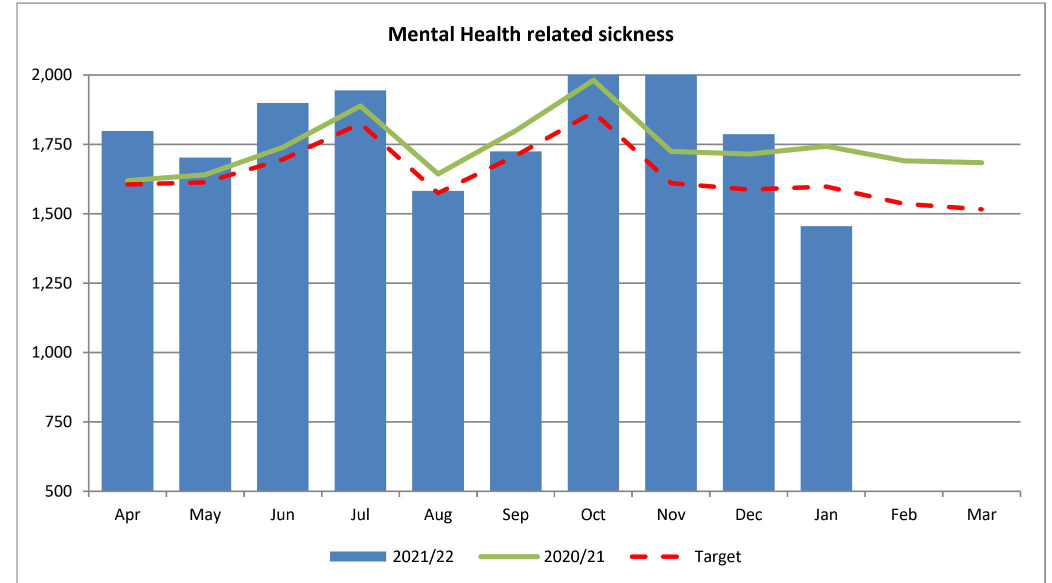


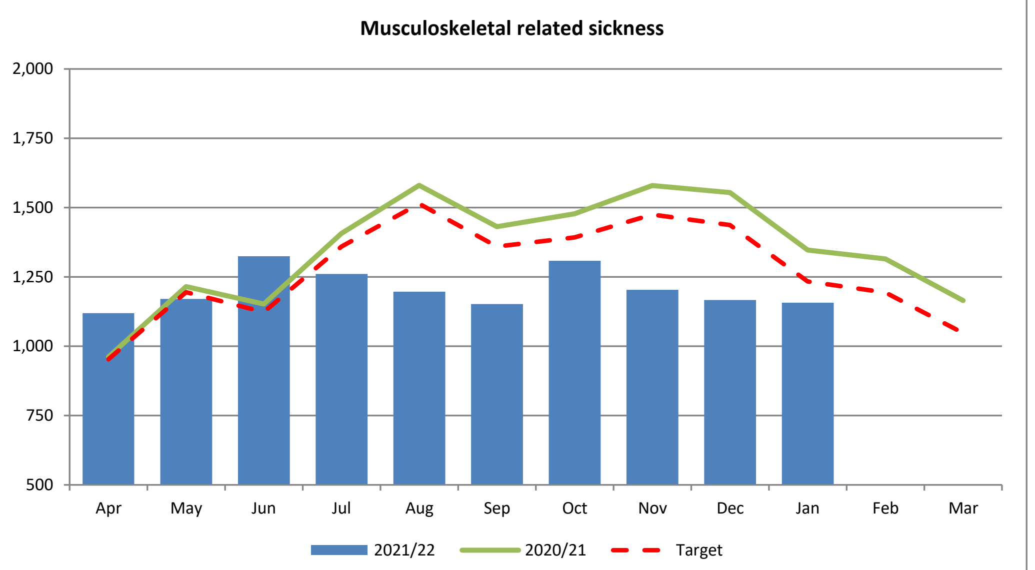


People Report

Care Together

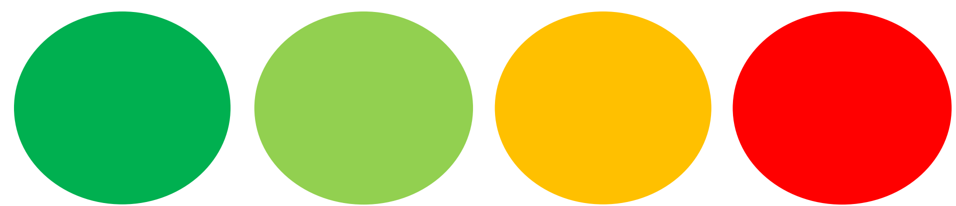
East and North Hertfordshire NHS Trust





Sustainable Services

Month 10 | 2021-22



Key Issues

- The financial funding framework for the second half of the current financial year (H2) was published by NHSIE in late September. The Trust has subsequently worked with local partner organisations to agree and confirm the distribution of the notified system envelope. The Trust financial plan for H2 was reviewed and approved by the FPPC at its October meeting. The plan includes a CIP delivery target of £5.7m.
- The funding settlements for individual NHS organisations during H2 are based upon a rollover of block, top up and other COVID monies received as key components of financial plans for the second half of 20/21. These allocations included approved distributions of System COVID and growth funds which have provided ENHT with coverage for a range of unavoidable costs resulting from the pandemic and also resources to enable the recovery of elective services. The Trust's financial plan is one component of an overarching balanced system wide financial plan that was submitted to NHSE.
- Monthly ICS Directors of Finance meetings remain in place for the system to ensure that in year delivery across partner organisations is co-ordinated to ensure that collective financial balance is achieved.
- During 21/22 the delivery of improved levels of elective activity is incentivised through the implementation of the Elective Recovery Fund (ERF). This enables providers to earn additional non recurrent funds should activity achievement exceeding specified thresholds. It is important to note that financial reimbursement through the scheme is assessed at a system level. The basis on which performance is calculated has changed during the course of the year. In July delivery thresholds were adjusted upwards and from H2 the basis of the activity counted as within the scope of the scheme also changed.
- The Trust has led work across the ICS to construct a financial and activity monitoring mechanism to allow the system to track delivery and achievement on a monthly basis. In addition, the Trust was worked with ICS colleagues to determine a framework whereby ERF funds earned by the system will be distributed
- ERF performance in Q1 was strong, although subsequent delivery has proved less fruitful.
- At Month 10 the Trust reports a small YTD surplus of £0.6m. The Trust presently reports full achievement of its H2 CIP target. The Trust continues to anticipate delivery of a breakeven position at year end and the achievement of its key financial duties.
- During Q3 the Trust reviewed and considered a range of additional winter capacity proposals to provide additional scope and space for the organisation to cope with expected seasonal pressures. Schemes with a potential value in excess of £3m were approved from recruitment and mobilisation. Progress around these schemes and their effectiveness continues to be regularly monitored.

Executive Response

- The Trust maintains robust mechanisms and systems for monitoring financial performance and maintaining good governance. In addition to its formal Committee structure, the Director of Finance also chairs monthly finance boards which each of the Divisions. Attendance and participation at each of these sessions has been high and they have proved effective in identifying and managing plan delivery and the agreement of remedial action where appropriate. In addition, monthly Delivery Oversight Group (DOG) meetings focusing upon finance and workforce issues have been helpful in promoting mature engagement and discussion of policy and planning issues.
- The Trust acknowledges H2 planning guidance that has identified the need for all providers to deliver a stepped change in efficiency levels in the second half of the year. In response the Trust has set out a CIP planning framework to deliver savings plans across divisions and corporate services to the value of £5.7m. Regular reporting arrangements through to FPPC to track delivery progress are in place.
- In order to monitor and drive the delivery of improved elective activity the Trust has set up a weekly Demand and Capacity review session. This is chaired by the Managing Director of Planned Services supported by senior corporate officers. The session reviews progress at a service line level, discussing opportunities for improvement or how obstacles to achievement can be addressed.
- As a component part of the new 'ENHT Academy' learning management system the Finance and Information team have refreshed and significantly expanded the range of business skills training materials that are available to budget holders and managers to assist in the discharge of their responsibilities. This suite of materials will continue to be monitored, expanded and enhanced to support both individual and collective training needs and also improved business decision making across the Trust.
- Finance and Corporate teams continue to work to develop and enhance business partnering models to support divisional teams.
- The availability of accurate and timely business intelligence and modelling has been key in supporting the Trusts agile and flexible response to the rapidly changing environment. 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 remain an important component in the Trust's recovery process.
- A key priority for the Trust's Finance and Information Team in 21/22 is the development of an effective suite of Population Health Management (PHM) Data products. This specific project co-ordinated by the AD for Planning will be crucial in terms of assisting the Trust and system partners in understanding the patient needs and outcome and provide a framework to set out opportunities for transformation and change. An internal steering group to co-ordinate PHM activities has been set up and project updates and briefing will be provided to Committees on a regular basis.
- The Trust continues to work with place-based partners to explore new models of service collaboration moving forward. A number of specific areas of project work have been agreed to test the effectiveness of these models.

Sustainable Services

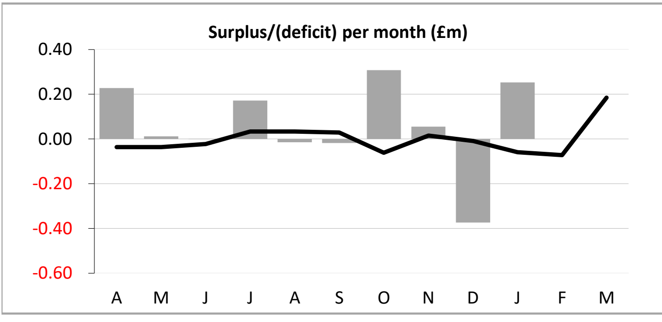
Finance Plan Performance

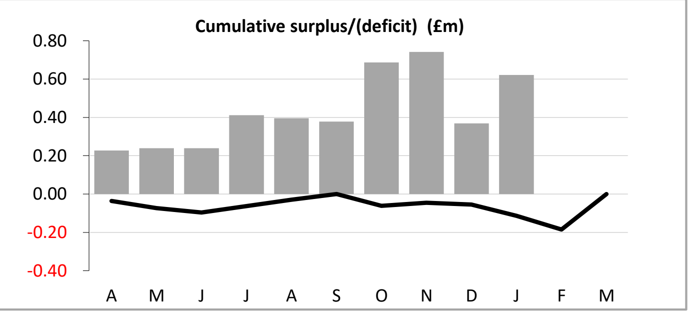
Domain	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Trend	Plan YTD	Actual YTD	Variance YTD
I&E Performance	SLA Income Earned	36.0	37.3	36.4	36.5	37.3	37.2	36.8	40.6	37.2	37.1	37.4	37.4		367.6	373.9	6.3
	Other Income Earned	2.9	10.0	2.6	7.3	5.3	6.0	4.0	5.3	3.8	3.6	1.5	3.1		34.9	42.5	7.6
	Pay Costs	26.6	31.6	26.5	26.8	26.6	26.9	27.0	31.6	27.5	28.0	28.5	28.2		278.2	277.7	-0.5
	Non Pay Costs inc Financing	16.3	17.9	16.6	21.2	20.3	20.4	18.1	19.2	17.4	16.6	15.0	18.7		167.7	183.5	15.8
	Underlying Surplus / (Deficit)	-4.0	-2.1	-4.1	-4.3	-4.3	-4.1	-4.3	-5.0	-3.9	-3.9	-4.6	-6.5		-43.4	-44.9	-1.5
	Top up payments	4.3	4.4	4.3	4.3	4.3	4.3	4.3	5.0	4.2	4.0	4.2	6.7		43.3	45.5	2.2
	Retained Surplus / Deficit	0.31	2.24	0.23	0.01	-0.00	0.17	-0.01	-0.02	0.31	0.05	-0.37	0.25		-0.11	0.62	0.7
Paybill Metrics	Substantive Pay Costs	23.4	27.8	23.4	23.5	23.4	23.0	23.2	26.8	24.0	24.3	24.2	23.9		260.0	239.7	-20.3
	Premium Pay Costs Overtime & WLI	0.1	0.0	0.2	0.2	0.3	0.3	0.4	0.3	0.3	0.4	0.4	0.3		3.1	3.0	-0.2
	Premium Pay Costs Bank Costs	2.3	3.0	2.2	2.2	2.1	2.5	2.5	3.5	2.5	2.4	2.9	3.0		11.4	26.0	14.6
	Premium Pay Costs Agency Costs	0.8	0.8	0.8	0.9	0.8	1.0	1.0	1.0	0.8	0.9	0.9	1.0		3.7	9.1	5.3
	Premium Pay Costs As % of Paybill	12.2%	11.9%	11.7%	12.4%	12.1%	14.2%	14.1%	15.2%	13.0%	13.4%	14.9%	15.3%		6.5%	13.7%	7.1%

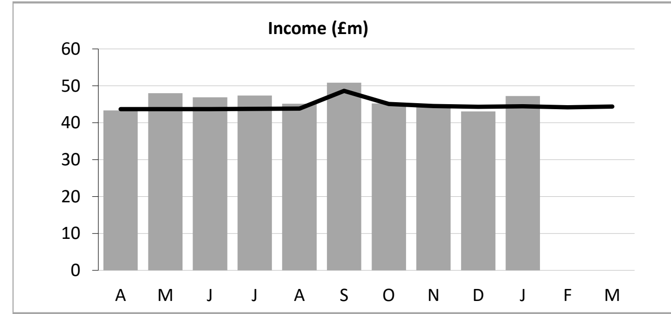
Sustainable Services

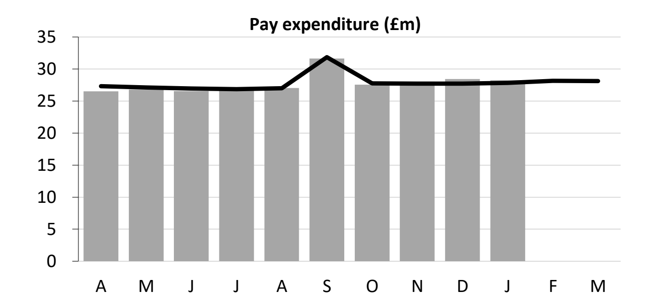
Finance Plan Performance

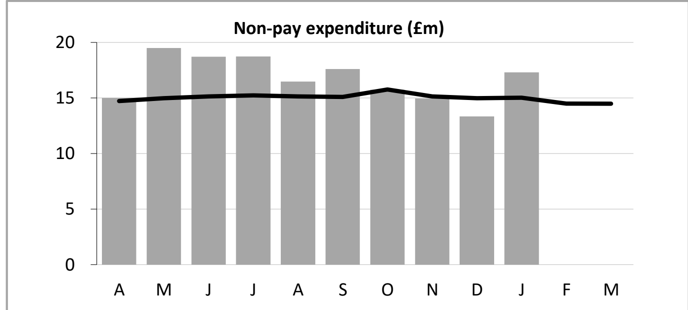
Domain	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Trend	Plan YTD	Actual YTD	Variance YTD
Single Oversight Framework	Capital Servicing Capacity	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		1	n/a	
	Liquid Ratio (Days)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		1	n/a	
	I&E Margin	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		1	n/a	
	Distance from Plan	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		1	n/a	
	Agency Spend vs. Ceiling	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		1	n/a	
	Overall Finance Metric	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		1	n/a	











Sustainable Services

SLA Contracts - Income Performance

By Point of Delivery

	In-Month			YTD		
	Planned Income	Actual Income	Income Variance	Planned Income	Actual Income	Income Variance
A&E Attendances	2,372	2,400	28	23,715	25,872	2,156
Daycases	3,121	2,379	-742	31,209	28,741	-2,468
Inpatient Elective	1,942	1,199	-744	19,423	16,132	-3,291
Inpatient Non Elective	9,813	8,287	-1,526	98,133	87,159	-10,973
Maternity	2,582	2,378	-204	25,821	25,861	40
Other	3,182	3,638	456	33,839	44,462	10,623
Outpatient First	2,188	2,257	70	21,875	20,648	-1,227
Outpatient Follow Ups	2,541	2,863	322	25,410	30,128	4,718
Outpatient Procedures	1,165	1,044	-122	11,652	12,792	1,140
NHSE Block Impact	0	2,626	2,626	0	9,806	9,806
Other SLAs	65	65	0	649	649	0
Block	847	847	0	8,469	8,469	0
Drugs & Devices	3,950	4,184	234	39,503	43,947	4,445
Chemotherapy Delivery	611	595	-16	6,107	6,628	522
Radiotherapy	1,138	1,066	-72	11,377	11,188	-189
Renal Dialysis	1,194	1,248	54	11,941	11,977	36
Total	**36,710**	**37,076**	**366**	**369,124**	**384,462**	**15,338**

By Commissioner

	In-Month			YTD		
	Planned Income	Actual Income	Income Variance	Planned Income	Actual Income	Income Variance
East & North Herts CCG	0	0	0	0	10,882	10,882
Specialist Commissioning	192	0	-192	1,916	0	-1,916
Bedfordshire CCG	-126	258	383	-503	-1,814	-1,310
Herts Valleys CCG	224	224	-0	2,246	2,246	-0
Cancer Drugs Fund	21,996	21,996	-0	220,731	220,731	-0
Luton CCG	0	0	0	0	0	0
PH - Screening	-0	0	0	-0	56	56
Other	14,425	14,599	174	144,734	152,361	7,627
Total	**36,710**	**37,076**	**366**	**369,124**	**384,462**	**15,338**

By Division

	In-Month			YTD		
	Planned Income	Actual Income	Income Variance	Planned Income	Actual Income	Income Variance
Cancer Services	6,332	6,447	115	63,318	68,476	5,158
Unplanned Care	19,077	17,896	-1,181	190,770	186,132	-4,638
Planned Care	11,431	9,800	-1,631	114,310	107,869	-6,441
Other	-130	2,933	3,062	727	21,985	21,258
Total	**36,710**	**37,076**	**366**	**369,124**	**384,462**	**15,338**

Sustainable Services

Activity and Productivity

Domain	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Trend	Plan YTD	Actual YTD	Var YTD
Patient Activity Levels	A&E & UCC	8,840	11,769	12,793	13,966	14,961	14,727	14,093	15,487	15,619	14,781	13,870	13,322		93,712	143,619	49,907
	Chemotherapy Atts	2,268	2,759	2,457	2,452	2,789	2,677	2,543	2,612	2,506	2,720	2,719	2,284		15,886	25,759	9,873
	Critical Care (Adult) - OBD's	1,117	731	574	608	650	702	635	714	666	657	831	798		4,318	6,835	2,517
	Critical Care (Paeds) - OBD's	372	492	466	709	484	451	518	433	435	452	514	518		3,885	4,980	1,095
	Daycases	1,926	2,730	2,827	3,282	3,856	4,003	3,328	3,386	3,370	3,593	3,038	3,089		27,699	33,772	6,073
	Elective Inpatients	223	334	388	406	438	491	424	448	490	507	429	338		3,932	4,359	427
	Emergency Inpatients	3,556	4,371	4,298	4,521	4,526	4,604	4,207	4,350	4,137	4,203	4,238	4,055		29,965	43,139	13,174
	Home Dialysis	139	176	154	176	156	177	202	155	196	151	153	198		1,157	1,718	561
	Hospital Dialysis	6,673	7,557	6,260	6,309	6,317	6,677	6,517	6,531	6,616	6,637	6,929	6,739		45,103	65,532	20,429
	Maternity Births	350	448	415	440	441	475	473	454	478	456	427	407		3,093	4,466	1,373
	Maternity Bookings	533	583	520	517	534	475	422	491	459	499	489	472		3,504	4,878	1,374
	Outpatient First	3,018	4,334	7,950	7,944	8,573	7,990	7,436	8,637	8,709	9,717	7,819	9,137		63,749	83,912	20,163
	Outpatient Follow Up	6,012	7,277	20,725	18,500	20,197	18,855	17,548	19,460	18,440	20,109	16,138	17,141		135,323	187,113	51,790
	Outpatient procedures	4,859	5,680	6,727	6,731	7,761	8,084	7,237	7,912	7,506	8,317	6,827	5,607		51,908	72,529	20,621
	Radiotherapy Fractions	3,585	4,233	3,771	4,071	4,704	4,184	4,037	4,195	4,016	4,746	4,805	4,072		30,144	42,601	12,457

Sustainable Services

Activity and Productivity

Domain	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Trend	Plan YTD	Actual YTD	Var YTD
Throuhput	Elective Spells per Working Day	107	133	161	194	195	204	179	174	184	186	165	171		149	180	31
	Emergency Spells per Day	96	106	106	109	108	103	95	100	95	100	95	91		98	141	43
	ED Attendances per Day	316	380	426	451	499	475	455	516	504	493	447	430		306	469	163
	Outpatient Atts per Working Day	694	752	1,007	1,147	1,136	1,137	1,135	1,193	1,217	1,276	1,076	1,137		1,184	1,621	437
	Elective Bed Days Used	477	699	896	1,253	1,198	1,218	1,102	980	1,139	1,099	1,035	766		2,779	10,686	7,907
	Emergency Bed Days Used	12,361	13,926	13,290	13,253	14,033	14,650	14,758	14,714	14,892	14,122	15,631	14,937		33,141	144,280	111,139
Efficiency	Admission Rate from A&E	27%	25%	26%	25%	23%	23%	22%	20%	20%	21%	22%	22%		23.3%	22.3%	-1.0%
	Emergency - Length of Stay	4.4	4.1	4.0	3.8	4.2	4.4	4.8	4.7	4.9	4.5	5.1	5.1		3.7	4.5	0.8
	Emergency - Casemix Value	2,907	2,635	2,687	2,602	2,704	2,819	2,864	2,805	2,922	2,821	2,917	2,911		2,321	2,805	485
	Elective - Length of Stay	2.1	2.1	2.3	3.1	2.7	2.5	2.6	2.2	2.3	2.2	2.4	2.3		2.5	2.5	-0.1
	Elective - Casemix Value	1,078	1,075	1,172	1,265	1,201	1,156	1,176	1,155	1,188	1,188	1,179	1,040		2,321	1,172	-1,149
	Elective Surgical DC Rate %	89.6%	89.1%	87.9%	89.0%	89.8%	89.1%	88.7%	88.3%	87.3%	87.6%	87.6%	90.1%		85%	89%	3.6%
	Outpatient DNA Rate % - 1st	7.1%	7.0%	7.8%	7.0%	7.1%	7.5%	8.1%	7.7%	7.7%	7.6%	8.3%	7.7%		6.4%	11.5%	5.1%
	Outpatient DNA Rate % - FUP	7.1%	7.0%	0.0%	6.0%	4.9%	5.2%	5.6%	6.4%	5.8%	6.1%	7.5%	6.7%		7.1%	5.7%	-1.4%
	Outpatient Cancel Rate % - Patient	5.1%	4.9%	5.1%	6.1%	7.0%	7.8%	8.0%	7.9%	7.9%	7.8%	8.5%	7.7%		5.6%	7.7%	2.1%

Sustainable Services

Activity and Productivity

Domain	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Trend	Plan YTD	Actual YTD	Var YTD
Efficiency	Outpatient Cancel Rate % - Hosp	11.4%	8.9%	8.7%	8.2%	7.9%	7.9%	8.1%	7.8%	7.8%	8.0%	8.5%	8.7%		11.1%	8.7%	-2.4%
	Outpatients - 1st to FUP Ratio	2.0	1.7	2.6	2.3	2.4	2.4	2.4	2.3	2.1	2.1	2.1	1.9		2.1	2.2	0.1
	Theatres - Ave Cases Per Hour	1.9	2.2	2.4	2.5	2.4	2.5	2.6	2.4	2.4	2.4	2.4	2.4		2.9	2.4	-0.4
	Theatres - Utilisation of Sessions	85%	90%	85%	84%	83%	85%	83%	80%	81%	83%	79%	80%		85%	82%	-3%
	Theatres - Ave Late Start (mins)	17	15	21	20	24	28	26	29	25	27	28	25		27	25	-1.5
	Theatres - Ave Early Finishes (mins)	27	41	33	36	32	33	31	32	37	34	44	41		39	35	-4.0

Sustainable Services

Productivity and Efficiency of Services - 2020-21 YTD vs. 2021-22 YTD

Activity Measures	2020-21 YTD	2021-22 YTD	Change
Emergency Department Attendances	103,437	143,619	40,182
Emergency Department Ave Daily Atts	338	469	131
Admission Rate from ED %	29.6%	22.3%	-7%
Non Elective Inpatient Spells	30,960	31,936	976
Ave Daily Non Elective Spells	101	104	3
Daycase Spells	22,124	33,772	11,648
Elective Inpatient Spells	3,252	4,359	1,107
Ave Daily Planned Spells	83	125	42
Day Case Rate	87%	89%	1%
Adult & Paeds Critical Care Bed Days	11,512	11,815	303
Outpatient First Attendances	77,918	83,867	5,949
Outpatient Follow Up Attendances	175,012	187,113	12,101
Outpatient First to Follow Up Ratio	2.2	2.2	-0.0
Outpatient Procedures	46,764	72,709	25,945
Ave Daily Outpatient Attendances	979	1,123	144

Workforce Measures	2020-21 YTD	2021-22 YTD	Change
Average Monthly WTE's Utilised	6,104	6,287	183
Average YTD Pay Cost per WTE	42,929	44,165	2.9%
Staff Turnover	12.6%	4.9%	-7.6%
Vacancy WTE's	785	862	77
Vacancy Rate	12.4%	12.1%	-0.4%
Sickness Days Lost	82,191	90,246	8,055
Sickness Rate	4.8%	5.1%	0.3%
Agency Spend- £m's	8.9	9.1	0.1
Temp Spend as % of Pay Costs	3.4%	3.3%	-0.1%
Ave Monthlty Consultant WTE's Worked	349.7	345.6	-4.1
Consultant : Junior Training Doctor Ratio	1 : 1.5	1 : 1.7	0.0
Ave Monthly Nursing & CSW WTE's Worked	2,528.6	2,669.0	140.4
Qual ; Unqualified Staff Ratio	25 : 10	28 : 10	0.1
Ave Monthly A&C and Senior Managers WTE's	1,338	1,358	19
A&C and Senior Managers % of Total WTE's	21.9%	21.6%	-0.3%

Sustainable Services

Productivity and Efficiency of Services - 2020-21 YTD vs. 2021-22 YTD

Capacity Measures	2020-21 YTD	2021-22 YTD	Change
Non Elective LoS	4.0	4.5	0.5
Elective LoS	2.5	2.5	-0.0
Occupied Bed Days	35,920	154,966	119,046
Adult Critical Care Bed Days	6,952	6,835	-117
Paediatric Critical Care Bed Days	4,560	4,980	420
Outpatient DNA Rate	7%	8%	0.5%
Outpatient Utilisation Rate	36%	44%	8.0%
Total Cancellations	92,097	101,970	9,873
Theatres - Ave Cases per Hour	1.8	2.4	0.6
Theatres - Ave Session Utilisation	77%	82%	4.6%
Theatres - Ave Late Start (mins)	23	25	2
Theatres - Ave Early Finishes (mins)	35.7	35.3	-0
Radiology Examinations	186,079	231,734	45,655
Drug Expenditure (excl HCD & ENH Pharma) - £000s	7,686	9,000	1,315
High Cost Drug Expenditure - £000s	38,719	43,253	4,534

Finance & Quality Measures	2020-21 YTD	2021-22 YTD	Change
Profitability - £000s	29	402	373.2
Monthly SLA Income £000s	36,333	37,386	1,052
Monthly Clinical Income per Consultant WTE	£103,889	£108,177	£4,288
High Cost Drug Spend per Consultant WTE	£110,710	£125,155	£14,445
Average Income per Elective Spell	£2,485	£1,172	-£1,313
Average Income per Non Elective Spell	£2,485	£2,805	£320
Average Income per ED attendance	£177	£180	£3
Average Income per Outpatient Attendance	£131	£142	£12
Ave NEL Coding Depth per Spell	7.4	7.6	0.2
Procedures Not Carried Out	1,998	1,806	-192
Best Practice HRGs (% of all Spells)	4.2%	3.2%	-1.0%
Ambulatory Best Practice (% of Short Stays)	n/a	n/a	n/a
Non-elective re-admissions within 30 days Rolling 12-months to Jun-21	9,368	9,120	-248
Non-elective re-admissions within 30 days % Rolling 12-months to Jun-21	8.67%	8.41%	-0.26%
SLA Contract Fines - £000's	0	0	0

East and North Hertfordshire
NHS Trust

Agenda Item:13

TRUST BOARD – PUBLIC SESSION – 2 March 2022
System Collaboration update

Purpose of report and executive summary (250 words max): This report provides updates to Board members in respect of key strands of significant collaborative system activity that the Trust is actively participating in.		
Action required: For discussion		
Previously considered by: **Strategy Committee – 16 February 2022**		
Director: **Deputy Chief Executive/Director of Finance**	**Presented by:** **Deputy Chief Executive/Director of Finance**	**Author:** **Deputy Chief Executive/Director of Finance**

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 & North Hertfordshire NHS Trust

System Collaboration Activity Report

This report provides updates to Committee members in respect of key strands of significant collaborative system activity that the Trust is actively participating in.

Provider Collaboration

NHSE expects that provider collaboratives will be key components of system working going forward, being mechanisms through which providers will work together at scale to plan, deliver and transform services. As a result all Trusts are expected to be part of more provider collaborative by April 2022.

In addition to the East & North Herfordshire place based partnership that the Trust is presently participating in, acute providers across the Integrated Care System (ICS) have also met in January and February to evaluate options to formally collaborate in respect of acute service delivery and transformation. Executive Directors from ENHT, WHHT and PAH participated in a workshop session that explored a range of collaborative considerations.

- The benefits of acute collaborative activity
- The case for change
- Criteria and scope for collaborative working
- Opportunities for transformation
- Potential governance & resourcing arrangements

Broad agreement was reached across all participants in respect of the advantages and common benefits that would be derived through the formalisation of an acute collaborative across the ICS footprint. A work programme of further activities and workshops to develop and agree the collaborative arrangements was agreed.

System Governance - Design & Reform

Recently published national planning guidance has formalised a delay in the timeframe for placing integrated care systems (ICSs) on a statutory footing. This will now be pushed back from 1 April 22 until 1 July 2022. Timelines for national and local plans will therefore be adjusted. An extended 'preparatory phase' will begin from 1 April 2022 whereby clinical commissioning groups (CCGs) remain in place as statutory organisations, and CCG leaders are expected to work closely with designate Integrated Care Board (ICB) leaders on issues likely to affect future ICBs (particularly commissioning and contracting).

Within the context of the revised timeline, it is expected that NHSE/I regional teams, designate ICB leaders, and CCG accountable officers should agree ways of working for 2022/23 by the end of March 2022. The deadline for ICB Readiness to Operate and System Development Plan submissions will be extended (with details about these plans to be set out in January 2022).

ICBs refreshed five-year plans are expected in March 2023 and ICBs are expected to undertake preparatory work throughout 2022/23 in collaboration with local authority partners.

In support of this process that Trust has during Q3 participated in local system task and finish groups to inform and shape the structure and nature of future system and place working and arrangements. These groups encompassed

1) governance arrangements,
2) target operating model (TOM) arrangements
3) provider collaborative arrangements
4) validation of system priorities and objectives and finally
5) organisational development proposals.

The Trust has been represented at the meetings of each of these groups by a variety of Executive Directors. Where relevant and appropriate specific issues of escalation and decision making have been referred to both the Executive Directors Committee and also Board Development sessions for discussion and agreement. The output from the five groups was presented at the November ICB Board meeting for review and approval.

The Governance group will continue to meet to pick up technical issues around the constitution and develop a MOU for the ICS relationship with the Region in 22/23.

A wider range of actions and issues remain to be discussed through the TOM group, with a need to set up a complimentary Finance group in the New Year given the clear linkages between financial flows and operating models

Virtual Ward / Hospital at Home Expansion
One of the key priorities for 22/23 as outlined in national planning guidance is the necessity of systems and organisations developing plans to further rollout the capacity of virtual ward arrangements that can act as credible alternatives to inpatient admission. Significant additional funding will be made available to support this objective.
Whilst the current virtual ward arrangements that are in place across the E&N place represent an encouraging but modest start to this service model during 21/22, it is clear to the Trust that the true potential of this method of care remains relatively untapped.

The Trust is keen to explore learnings from other high performing models of virtual ward delivery that exist both locally and nationally to determine how stepped changes in delivery can be achieved. With this in mind the Trust will undertake an internal diagnostic in the coming weeks blended with the experiences of other exemplar services to form a view of the optimal clinical and delivery models to maximise take up and achieve a significant expansion of sustained capacity. This diagnostic process will subsequently enable the Trust to undertake informed discussions with partner organisations across place and sectors to agree how a revised model could be implemented and that roles that organisations and teams might play.

System Oversight & Assurance Group (SOAG)
Operational planning guidance for 21/22 sets out the requirements for all ICSs to work in partnership with NHSE/I to take collective responsibility for the management of system resources and performance. The current year represents a shadow year to ensure that oversight arrangements are in place at ICS, HCP and organisation level. This includes the implementation of regular SOAG meetings. During the course of August and October this bimonthly forum has been established and its Terms of Reference agreed. The Trust has been represented by the CEO / DCEO at this forum. The third formal meeting of the group with representatives on NHSIE took place in February. The Trust continues to work alongside ICS colleagues to provide development support in the design and implementation of sustainable performance reporting mechanisms to support this new framework. Current work is focused upon waiting list management. Proposals to extend the review of appropriate performance discussions to a place level (POAG) are also being discussed.

Enhanced Services Steering Group
During the course of the COVID pandemic a number of new and innovate approaches have been developed or extended in order to help prevent unnecessary admissions into an acute setting or expedite prompt discharge, these include Prevention of Admissions (POA) schemes and Discharge to Assess (D2A)

During the course of 21/22 it has become apparent to partners across the place system that there wasn't jointly designed and aligned framework to determine the impact of these schemes in respect of activity, flow, finance and workforce. It was acknowledged that this presented an impediment to future planning, design and mobilisation arrangements unless addressed. ENHT has therefore taken a lead role in setting up the 'Enhanced Services Steering Group'. This group led by the ENHT Director of Improvement and compromised of Executive Directors across the place ecosystem meets on a bi-weekly basis to progress joint evaluation, design and implementation arrangements. Work to date has focused upon POA evaluation, and has resulted in a jointly agreed impact statement. This will be helpful in determining the scale, place and impact of this model of delivery in terms of planning for 22/23. Work is presently ongoing to develop a similar joint impact assessment for D2A.

Commissioners have been clear in recent dialogue that with the dramatic reductions in expected levels of COVID funding in 22/23 it is expected that majority of these enhanced service offerings will be expected to be resourced between existing provider baselines. This of course magnifies the importance of both impact and cost / benefit impacts being clearly understood.

ENHT / HCT partnership working projects
In April 2021 the two providers-initiated project working arrangements to explore options to maximise service effectiveness and delivery across areas where the organisations currently deliver different aspects of one overarching pathway.

The two areas that have been identified for accelerated development are Stroke / Neuro services and Community Paediatrics. To date work has concentrated upon creating revised lead provider arrangements as a mechanism to provide greater integration and thereby promoting enhanced quality and delivery outputs. It is anticipated that the work across these services areas can subsequently act as a model for lead provider delivery arrangements to a further pipeline of activity.

The group led by Directors of Finance from the two organisations and supported by contracts, operations and clinical staff was working to prioritise the mobilisation of the revised lead provider (ENHT) arrangements for Stroke / Neuro. Progress during Q3 has not proved as swift as hoped and the onset of COVID pressures has meant that this area of focus has now been deferred to the spring.

It may prove a timely opportunity for both organisations to review and reprise their investment in this process given the time that has elapsed, and the outcomes delivered. In summary HCT enthusiasm for progressing these scheme in a timely fashion or indeed at all seems extremely limited.

East of England Imaging Network

The EoE region has established 2 imaging networks. These are designed to enable clinical images from care settings close to the patient to be rapidly transferred to specialist clinicians across diverse geographical settings. ENHT is acting as the governance and leadership hub for one of these networks. To date the networks have been successful in developing bids and securing funds that support the expansion of home reporting, iRefer CDS and Imaging sharing capability and infrastructure for providers across the region.

Design and implementation meetings in support of project aims have continued in Q3 and moving forward into Q4.

Community Diagnostic Centres

The expansion of diagnostic services placed within more varied and diverse community settings is a core feature of the government's strategy to improve access to services and address the post pandemic waiting list challenge. The place-based community has responded to this challenge by designing a model for expansion and deployment. This has been achieved through diverse stakeholder design events including acute, community and commissioning colleagues.

Whilst the finalisation of the model across a five-year period and agreement of funding arrangements over this full timeframe is still pending, interim approval has already confirmed the receipt of significant capital and revenue streams to mobilise the model during 21/22. The November meeting of the FPPC approved the Final Business Case submission to NHSI

Pathology Tendering Process
The Trust remains an active partner in the process to tender ICS pathology services. The timeline for the project has slipped as a product of a number of issues and presently the earliest award of any contract is expected during Q2 of the new financial year. A full business case will be produced by the project team for consideration and approval by participant organisations prior to any contract award.

Martin Armstrong
Deputy Chief Executive
Feb 2022

Agenda Item: 14

TRUST BOARD – PUBLIC SESSION – 2 March 2022
Digital Strategy update

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

Frontline Digitisation programme – Strategy outline case

This paper outlines the current position with the development of the Digital strategy and its positioning with the NHS Frontline digitisation programme.

Context
Late December 2021 NHS X issued new guideline in terms of the submission of the Digital Strategy Outline case (SOC).

- Specific guidance in terms of the marking criteria for a successful bid
- Clarification that the UTF is a multi-year fund over the life of the project (Typically 10 years with an EPR)
- The UTF is capped at £6M for Frontline digitisation (EPR) and £6M for enabling infrastructure fund matched. (note ENH was awarded £3.6M infrastructure fund for End user devices in Q4 21/22)

In addition, the National planning guidance issues of December 2021 made reference to a Digital Minimum Viable product (MVP) that each Trust needs to deliver by 2025. In the case of ENH our Digital strategy is largely aligned with the MVP.

The Digital SOC is currently being reworked to take into account the NHS X guidance and the MVP ready for the creation of an Outline Business case and application for EPR funding.

The basis of the SOC remains the same in terms of recommending the procurement of a new Enterprise EPR. The size of the UTF fund and the current funds within the ICS and Trust help shape the ambitions of the OBC and size of likely investment

Action required: For approval

Previously considered by:
[N/A]

Director:	**Presented by:**	**Author:**
CIO	**CIO**	**CIO**

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):

Digital strategy update

March 2022

Delivering digital services for the Trust

Ease of use
Sustainability

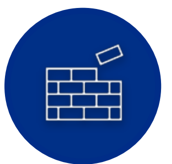
Frontline Digital Outcomes Updated Guidance 12/21

Organisations have the necessary foundational digital capabilities to deliver increased safety, efficiency and quality of care and support further innovation.

Organisations successfully implement and exploit digital capability

Supplier marketplace delivering innovate, value for money products that comply with agreed standards

Policy objectives of Long Term Plan have been achieved



#enh digital Delivering digital services for the Trust

Ease of use Sustainability

Minimal Viable Product (MVP) Business Outcomes

To deliver frontline digitisation we must enable all providers to have the digital technology to enable the following business capabilities.

MVP Business Capabilities - An abstraction of business functions

Patient, Asset & Resource Admin

Asset Administration

Bed Management, Asset Tracking

Resource Administration

Staff Rostering, Clinic and Theatre List Management, Activity Recording and Clinical Coding

Patient Digital Care Record

Patient Administration

Patient Identity Management , Patient Flow, Patient Communication Scheduling and Appointment Booking

Transfer of Care

Internal / External Digital Handover (Referrals and Discharge Summaries)

Records, Plans and Assessments

Storage and Access of Notes, Observations, Assessments, Triage and Care Plans

Diagnostic Management

Diagnostic Test Requests, Test Results, Imaging

Medicines Management and Optimisation

Prescribing, Drug Administration and Pharmacy Functions

Connected Care

Remote and Virtual Care

Virtual Consultations, Remote MDTs

Digital Insights

Decision Support

Automated Detection and Escalation, Pathways, Compliance alerts/notifications, prompts

Delivering digital services for the Trust

Ease of use Sustainability

MVP Capability Levels - Definition

NHS
East and North Hertfordshire
NHS Trust

🕐 Such technologies have yet to be proven at scale but hold promise. Theses areas should be included in future development plans of digitally mature organisations, with support from the market to develop such solutions, including future developments to support emerging national requirements.

🕐 Some example implementations are present in selected organisations, but this is not widespread. There is an emerging or scalable market offering for these functionalities and this is what all advanced Trusts should aim for;

🕐 The foundational capabilities set the bar for a minimum level of digital maturity for the levelling up agenda and there is a well-established market offering;

Innovation

Transformation

Foundation: Core Capabilities

Strategy timeline

2020-2022
Roadmap

Continue with Roadmap in leveraging value from existing systems focused on clinical pathways and digitisation of paper process and better integration to ICS partners

2022-2024
Core Capabilities

Consolidation towards a new Enterprise EPR supporting clinical process and patient access. Improved accessibility through cloud and better integration.

2024-2030
Transformation & innovation

Leverage value from new EPR with advanced IoT supporting healthcare self management, converged healthcare. Wide use of AI and advanced integration into ICS and wider.

Digital Roadmap 2022

Delivering digital services for the Trust

Ease of use Sustainability

Evolving our Technology - Roadmap

January 22

- Windows 20H2 upgrade
- Server Remediation phase 2 Remainder 100 Servers
- EPMA EUD
- Complete Office 365 second Phase + file shares into Cloud
- Additional Nursing and Doctor mobile Devices
- High Spec Screens EUD
- NHS Secure Boundary
- Sophos Replacement Proxy Server
- End of Bed Mobile Devices EUD
- Doctors WOW's EUD
- Ward PC's EUD
- Wall Mounted Bed PC's EUD

March 22

- Complete Office 365 third Phase + file shares into Cloud
- Edge Network Fibre Upgrade
- Digital Workspace (VDI) Phase 2 of a further 750 concurrent users
- High Density Wifi Upgrade
- Internet and HSCN circuit upgrades
- TANSync
- Sophos Replacement VPN
- Replacement Backup/Cloud Backup
- Cloud Disaster Recovery
- Virtual Server and Storage replacement

June 22

- Unified Comms/ Replacement Telecoms
- Corporate PC EUD replacement
- enhDgital Self Service
- Device Management and Security
- End User SSO and Tap/go
- Infrastructure Support Tools
- Backup Circuits for off site locations
- Asset Tracking RFID
- Upgrade Huawai to Cisco Edge
- Cabinet and UPS upgrade

September 22

- On Track
- At Risk
- Overdue
- Complete
- Not Started
- Not Funded

#enh digital Delivering digital services for the Trust

Quality | People | Pathways | Ease of use | Sustainability

Keeping Patients Safe – Future Roadmap

FREEZE

January 22

E-Noting Surgery

Surgical clerking, inpatient notes and theatre notes

Fluid Balance- further roll out

Ability to prevent / treat AKI. Review remotely, simple UI, Quality standards / auditable data.

Nervecentre V7 Upgrade

No user impact, new functionality enabling further roadmap development

March 22

ePMA

Electronic Prescribing and Medicines Administration

Job Lists

Transition to digital management of doctors tasks and job plans

H&N

Electronic task management for OoO.

PSAAG Refresh

Improved User interface, PSAAG set up on ward level incorporating current digital needs

Care Plans

Digital management of patient care plan replacing

Bed Management

Review of flow management, update to current ways of working, updates to application to support electronic flow management

Nursing Assessments

Support paperless journey / cost saving from paper and audit / ultimately will support views of patients at risk, falls, dementia, nutrition.

June 22

SEPSIS & AKI

Automatic detection and escalation to instigate time critical treatment.

Discharge Planning

Monitoring tools, contract changes

111

Integration with 111 system, pre-booking

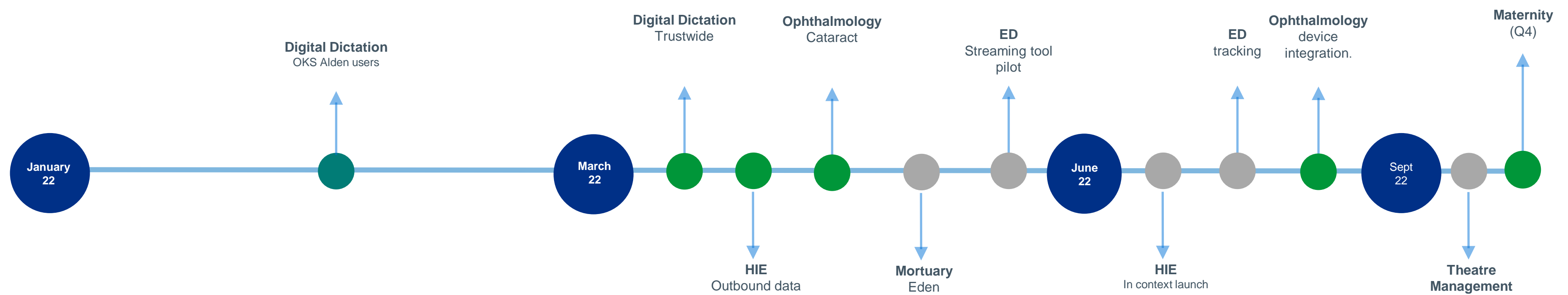
E-Consent

Patient's pre-op record and access to consent

September 22

Quality People Pathways Ease of use Sustainability

Supporting our Specialties – Roadmap



Delivering digital services for the Trust

Ease of use Sustainability

Agenda Item: 16

TRUST BOARD - PUBLIC SESSION – 22 March 2022
Ockenden Review of Maternity Services-One Year on

Purpose of report and executive summary:

In December 2020 Donna Ockenden's independent review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust was published, referred to as the Ockenden Report.

The review identified 7 Immediate and Essential Actions (IEAs) to be addressed by all Maternity Units using the Assurance Assessment Tool that all trusts were asked to take including 12 Urgent Clinical Priorities. Using the published national Assurance Assessment Tool, a review of the recommendations, and a further review of the Morecambe Bay investigation by Bill Kirkup in 2015, the Trust confirmed **compliance with 112 of the 122 requirements (92%**). All evidence was reviewed by the regional Chief Midwifery Office and feedback provided on areas for further improvement. An independent team from Midlands and Lancashire Commissioning Support Unit (MLCSU) reviewed the evidence from all 124 trusts further strengthening the process of assurance.

An improvement plan was developed to address the gaps in compliance, and this has been monitored through the maternity services divisional governance structures, the Quality and Safety Committee and the Local Maternity and Neonatal Services (LMNS) governance structures.

One year on, maternity services are being asked to discuss progress against all recommendations before the end of March 2022 highlighting:

- Progress with implementation of the seven IEAs outlined in the Ockenden report and the plan to ensure full compliance (section 2 of this report)
- Maternity Services Workforce Plan (section 3 of this report)

The Trust has demonstrated good progress against the gaps in compliance and there are clear plans in place to address the areas where there is partial compliance.

There is a robust workforce plan in place to respond to the national requirements and this will be presented to the April Quality and Safety Committee for further review and discussion.

Action required: For information

Director:	**Presented by:**	**Author:**
Chief Nurse	**Chief Nurse** **Director of Midwifery** **Clinical Director**	**Director Of Midwifery** **Clinical Director**

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) **002/21** and **008/21**
Any other risk issues (quality, safety, financial, HR, legal, equality): Risk ID 7050 - The risk to women, their babies and staff in relation to staffing levels that fall below establishment Risk ID 7161– The risk to women and babies when using midwives to staff and manage maternity theatres Risk ID 7313- The risk to the service and safety of women and their babies if unable to comply with 7 day service requirements Risk ID 2627 - Risk of inadequate nurse staffing levels in Neonatal Services Risk ID 7154 - The risk to the safety of women and their babies when unable to transfer for ongoing IOL in an appropriate time frame Risk ID 7140 - The risk to the safety of women accessing Maternity Triage Risk ID 6605 - The risk to the safety and quality of care for women and the wellbeing of staff during the Covid-19 pandemic Risk ID 6077 - Risk that the safety of women and babies will be compromised as staff may not be released for mandatory training

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Ockenden Report Update

1. *Introduction:*

The purpose of this report is to provide the Trust Board with the background and overview of the current position against the recommendations made following the publication of The Ockenden Report (December 2020).

2. *East and North Hertfordshire NHS Trust Maternity Services Assessment and Assurance:*

The Trust confirmed compliance against 112 of the 122 requirements, all detailed within the seven Immediate and Essential Actions (IEAs). The improvement plan is reviewed monthly at the Maternity and Neonatal quality and safety meeting and regularly at the Trust Quality and Safety Committee. There has been good progress against each of the ten areas where there was initially partial or non-compliance.

Evidence to demonstrate compliance against the 112 actions has been externally scrutinised and sufficient evidence was provided.

Table 1 below summarises the current position, progress and ongoing work to address the gaps in compliance and presents the work ongoing to address the gaps, all clustered into the original IEAs.

Table 1 - Areas of partial compliance:

IEA	Requirement identified as gap or partial compliance	Progress
IEA3 **Staff training and working together**	Twice daily consultant-led ward rounds on the labour ward, seven days a week.	Twice daily consultant-led ward rounds Monday to Friday. Saturday & Sunday have consultant-led ward rounds once daily with second weekend ward rounds happening where possible. To be fully compliant an additional two WTE consultant posts required.
IEA3 **Staff training and working together**	External funding allocated for the training of maternity staff is ring-fenced and used for this purpose only.	Required further evidence for allocation of monies from HEE and CPD per head. No funding has been allocated during the pandemic so evidence could not be provided. The Finance Executive confirmed ring fencing of funds allocated for training.
IEA4 **Managing Complex Pregnancy**	The organisation must support the development of maternal medicine specialist centres (MMC): • Criteria for referrals to MMC to be agreed • Pathways to be agreed	Work in progress to develop criteria and pathways. Lead maternal Obstetricians are progressing the local pathways with the regional centres. ENHT is engaged and is represented at all Regional maternal medicine network Meetings. Tertiary maternal medicine centres have been identified. Launch Event for Norfolk and Norwich is scheduled for 30/03/22. Job description for a local Maternal medicine midwife is being developed.
IEA6 **Monitoring fetal wellbeing**	Interface of fetal monitoring leads with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.	Full compliance will be demonstrated once the trust can demonstrate evidence of how the fetal monitoring leads gain their specific knowledge updates e.g. linking and attending national fetal monitoring forums in progress
IEA7 **Informed Consent**	Pathways of care highlighting choice for women is clearly described, in written information in formats consistent with NHS	Website improvement work is in progress. An improvement plan has been co-produced with Maternity Voices Partnership (MVP) and Trust Communication team. Some improvements have progressed and are in place. Future developments are planned including a new video tour of the unit.

	policy and posted on the trust website.	

3. Maternity workforce planning and investment

In support of the Ockenden Report a £95.6M investment into maternity services across England was made. This included funding for:
• Additional midwifery roles,
• Additonal consultant obstetricians,
• Backfill for MDT training
• International recruitment for midwives
• Support to the recruitment and retention of maternity support workers

As a result of this investment the trust were supported with funding to increase both midwifery and medical staffing.

A workforce gap analysis was undertaken in October 2021 utilising the Birthrate plus workforce analysis tool and their recommendations are reflected in an ambitious recruitment trajectory in year. The detailed workforce transformation plan will be presented to the Quality and Safety Committee in April 2022 outlining plans to deliver the national policy requirements set out in the Operational Planning Guidance (NHSE, 2021) and aligned to the Better Births requirement to deliver Continuity of Carer.

In addition to local workforce plans there are regional workstreams to support midwifery recruitment supported by Health Education England with oversight from the regional Chief Midwifery Officer for NHSE/I. These include:

- International Recruitment
- Return to Practice
- Advanced Clinical Practice
- Retention
- Leadership Development
- Workforce Transformation
- Increase in student midwifery university placements

This is in recognition and support of the national and regional challenge to recruit midwives into post.

4. Conclusion:

The Trust continues to progress the actions which align to the minimum evidence requirements of the Ockenden review and has demonstrated good progress against the improvement plan. Ensuring local system have oversight of maternity was a key element in the Ockenden review and therefore progress will be shared and discussed with the LMNS and ICS and to the regional maternity team by 15 April 2022.

The ongoing assurance of compliance and sustainability of improvement is supported by East of England Regional Chief Midwife. These processes may include quality assurance visits in agreement with the Maternity units.

The national team may, on occasions, periodically choose to join regional visits/engage with the assurance processes.

Reports to the national team of compliance and assurance will be agreed, this will include reports from regional teams that will be shared at Regional Perinatal Quality Oversight Meetings and if required at national quality meetings.

The second report of Donna Ockenden is anticipated in March 2022, following which the trust will respond accordingly.

Agenda Item: 17

TRUST BOARD - PUBLIC SESSION – 2 MARCH 2022

Tackling the elective care backlog: the national guidance and our local approach

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

The attached slides provide a summary of the recently published: 'delivery plan for tackling the Covid-19 backlog of elective care' setting out the timescales and requirements. The slides then describe work in progress within the Trust and our next steps to meeting to requirements of the plan.

Action required: For information

Previously considered by: N/A

Director: **Chief Operating Officer**	**Presented by:** **Chief Operating Officer**	**Author:** **Senior Operations Advisor** **Managing Director, Planned Care**

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

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

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

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Tackling the elective care backlog: the national guidance and our local approach

Julie Anne Smith

People Pathways Ease of use Sustainability

Context: recent headlines

Tories push PM to act faster on waiting lists

NHS waiting lists to keep rising despite Covid recovery plan

Numbers must fall before next election, MPs warn

Brexit Conservatives Labour Lib Dems SNP US politics

COMMENT

Tackling massive NHS waiting lists is a mission with social justice at its very heart

Prepare for tighter grip from regulators, says Mackey

The Daily Telegraph

Waiting lists will rise no matter what, says Javid

Quality | People | Pathways | Ease of use | Sustainability

Context: Jim Mackey's view (HSJ, 16 February)

"Huge investment" from government [means] increased scrutiny from both the public and ministers. "We have got to pull together and deliver this for the public and for our staff… We need to make sure that accountability is as visible with the public as is humanly possible."

"We're now going into a much more accountable, performance management-orientated world than I think most people have clocked…..we've had a couple of years where, for understandable reasons, there hasn't been quite as tight a focus on some of these things. **But there will be.**"

"**I think we should worry about it [the public's perception].** Some polling a couple of weeks ago showed the public's satisfaction with the NHS had taken a bit of a hit nationally. I think it's completely understandable, that if you've waited a long time, and then you're being told you're going to have to wait quite a long time extra, you're going to start to get grumpy about that."

Context: impact of Covid-19 on waits

There is uncertainty around the future trajectory and prevalence of Covid infections.

Six million people are now on the elective waiting list (up from 4.4 million people prior to the pandemic). There is disparity in waiting times based in regions.

Many patients' health needs were not diagnosed or treated during the pandemic. These patients may still come forward to access services and this could increase the waiting list to 14 million if no action is taken.

Around 4 in 5 are waiting not for admission to hospital but for diagnostic tests and outpatients appointments.

Summary of the guidance

Quality People Pathways Ease of use Sustainability

Tackling the backlog of elective care

- NHSE/I published a delivery plan for elective care recovery in February 2022.
- It sets out plans for the NHS to **return to pre-pandemic performance** as soon as possible.
- The intention is that around **30% more elective activity is delivered in 2024/25** than before the pandemic.

Key delivery areas

Increasing health service capacity by expanding elective and diagnostic services and by separating elective from emergency care

Prioritising diagnosis and treatment

Transforming the way the NHS provides elective care

Providing better information and support to patients

Funding commitment for elective recovery

- The government plans to spend in excess of £8 billion to support elective recovery and £5.9 billion investment in capital from 2022/23 to 2024/25.
- This is in addition to the £2 billion elective recovery fund and £700 million targeted investment fund (TIF) already made available to systems.
- The £5.9 billion capital investment includes:

£1.5 billion towards elective recovery services, to include new surgical hubs, increased bed capacity and equipment to help elective services recover.

£2.1 billion to modernise digital technology on the frontline, improve cyber security and the NHS's use of data and redesign care pathways.

£2.3 billion to help increase the volume of diagnostic activity and reduce patient waiting times with ambitions to roll out at least 100 community diagnostic centres over the next three years.

Deliverables and timescales

2022 | 2023 | 2024 | 2025

Elective Care (July 2022)

- No one to wait more than 104 weeks (except when it is the patient's choice)

Diagnostics (March 2022 - March 2023)

- Increase diagnostic activity to a minimum of 120% of pre-pandemic levels across 2022/23

Cancer (March 2023)

- 62-day cancer performance to return to 19/20 levels

Elective Care (March 2023)

- Eliminate waits of over 78 weeks
- Reduce outpatient follow-ups by a minimum of 25% against 2019/20 activity levels
- Deliver 16 specialist advice requests, including 14 advice and guidance (A&G), per 100 outpatient first attendances

Elective Care (April 2023)

- Move or discharge 5% of outpatient attendances to PIFU pathways

Cancer (March 2024)

- 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed (or cancer is ruled out) within 28 days

Elective Care (March 2024)

- Eliminate waits of over 65 weeks

Diagnostics (March 2025)

- 95% of patients needing a diagnostic test to receive it within 6 weeks

Elective Care (March 2025)

- Eliminate waits of over 52 week
- 30% more elective activity to be delivered by 2024/25 than 19/20 levels

Outpatients (ongoing/ no date specified)

- *Transform models of care, making greater use of technology*
- *Work with patients & stakeholders to monitor & improve waiting times & patients' experience of waiting for 1st outpatient appointments*
- *Reduction in follow up capacity by 24%*

Requirements

Patient and staff engagement

- Position patients at the heart of service development
- Give patients more choice around outpatient care, with options to book their follow-ups (PIFU) and attend video/phone consultations if preferred
- Address recruitment and retention through workforce strategy and transformation

Working with partners

- Determine what we can deliver more effectively at ICS level (neighbourhood, place, system)
- Consider surgical hubs, independent sector, community diagnostic hubs

Processes

- Improve discharge processes
- Review long waiters (quarterly for elective care, weekly for cancer 62+ days)
- Link into national programmes e.g. Clinical Prioritisation Programme
- Change process for prioritising patients (e.g. prioritise children and young people)

Supporting information

- Continue to validate our waiting lists to ensure accuracy
- Analyse and understand waiting list data by relevant characteristics (age, deprivation, ethnicity, and by specialty)
- Develop clinical and operational action plans based on clinical need
- Explore ICS level solutions: shared PTLs, referrals across boundaries, using available capacity

Technology

- Review use of technology to determine if we can do more and how we can work more innovatively

Quality | People | Pathways | Ease of use | Sustainability

Our response

Examples of work in progress: surgery

Theatre capacity	• 3 new procedure rooms to be operational in May 2022. • Plans in progress to open a new hybrid vascular theatre. • Subject to capital investment, access, along with system partners, to additional theatre capacity within the next 6 to 18 months. • Continued use of insourcing and work with the independent sector to increase capacity.
Intelligent scheduling	• With support from an external partner, implementation of 'intelligent theatre scheduling'. We hope to achieve a 5-10% productivity gain through this approach.
Workforce	• With support from external company Kingsgate completion of a 6-month project to look at staffing in theatres, reviewing different staffing models to ensure staff are utilised effectively.
Business intelligence support	• Refresh of our data packs to allow improved performance monitoring against KPIs. • Demand and capacity modelling in progress at specialty level - will be shared in March 2022.
Waiting well	• Clinical prioritisation process in place to make sure we treat those in need first. • Robust approach to supporting patients to stay safe while waiting for procedures. • Implementing preoperative assessment support to prepare patients for surgery. • Moving to consenting patient electronically, replacing paper systems.
Transformation programme	• Reviewing all surgical pathways through a new elective care transformation programme.
System working	• Along with system partners we are identifying opportunities to work collaboratively • Shared PTLs are already in place. • Mutual aid is requested/offered.

People Pathways Ease of use Sustainability

Examples of work in progress: outpatients

PIFU	• Patient initiated follow-up is already in place across 7 specialities. • The roll out is continuing.
Advice and Guidance	• All major specialities have the Advice and Guidance portal and as a Trust we are performing well against 48-hour turnaround time. The next step is to relook at how we promote it to GPs and to continue trialling Consultant Connect.
Referral Assessment Service	• We continue to review referrals to ensure they are appropriate.
Capacity review	• We are undertaking a capacity review across Hertford County Hospital and QEII with the aim of ensuring that outpatient capacity on these sites is used efficiently and fully.
Process automation	• The Outpatients Group are running a digital project. Included in this is a review of existing processes. We aim to automate processes where possible and beneficial.
Demand and capacity	• This is an ongoing project and we will have an agreed demand and capacity plan in place by April 2022.
Diagnostics	Our Community Diagnostic Centre at QEII will be operational in March 2022.

People Pathways Ease of use Sustainability

Our elective recovery principles

- **Release time for clinicians** to tackle the elective care backlog.
- **Increase our elective capacity** by building more theatres (subject to securing the additional capital required).
- In response to guidance **remove and reduce Covid measures** put in place to protect staff and patients during the height of the pandemic.
- **Better utilise our capacity** through increasing efficiencies through theatres, outpatients and diagnostics.
- **Deliver the transformation of our clinical pathways** through an Elective Care Recovery Programme building on ENHT's 'Here to Improve' approach.
- **Explore opportunities to utilise external support** (where this can add to existing work), e.g. Four Eyes Insight.

AIM: Deliver safe pathways of high quality and experience for patients

- Utilises workforce transformation in order to support elective recovery and sustainability
- To be clinically led and owned, and driven by specialties
- Digital first approach to delivery e.g. use of video consultations
- Maximising use of our physical capacity e.g. QEII, HCH, Independent Sector
- Changes need to be sustainable, need to address health inequalities, and utilise system-wide and integrated pathway solutions
- Reflect a movement towards being able to "live with COVID"

Quality | People | Pathways | Ease of use | Sustainability

Capacity: our planning approach

Specialities are building their capacity plans to delivery increased elective care capacity:

- 110% of 19/20 capacity 22/23
- 120% of 19/20 capacity in 23/24
- 130% of 19/20 capacity 24/25

The tools to delivering this through transformation are threefold:

- Reduction in **follow up capacity** by 24%.
- **Patient Initiated Follow Up (PIFU)** – move/ discharge 5% of outpatient attendances to PIFU pathways by April 2023
- Increased use of **advice and guidance** - 16 specialist advice requests, including 14 advice and guidance (A&G), per 100 outpatient first attendances by March 2023.

The building blocks to increasing our capacity are set out below:

Increasing risk
Decreasing value for money

1. Deliver base capacity **MARCH 2022**

2. Reduce/ remove Covid inefficiency **APRIL 2022**

3. Improve efficiency and throughput **SEPT 2022**

4. Make permanent changes i.e. 3 session days, increasing numbers of staff **NOV 2022**

5. Run additional sessions **APRIL 2022**

6. Increase provider collaboration at system/ regional level **SEPT 2022***

7. Outsourcing/ Insourcing **APRIL 2022**

The diagram shows the steps agreed to increase capacity to meet demand. The steps are listed in order of increase risk and value of money.

* Vascular already live

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High Level Transformation Structure

- This slide sets out the key high level elements of the elective pathway. The pathway crosses a range of areas. We will review and modify our processes across each area throughout 2022/23.

Elective Recovery Group

Referral Management	Outpatients	Diagnostics	Elective (Day Case/Inpatient)	Waiting List Management
RAS Lead	Deputy Divisional Director	Deputy Divisional Director	Deputy Divisional Director	Access Manager
Referral Assessment Service Advice and Guidance (16/100) General Practice Training My Planned Care Patient Communication Process Automation	Follow up (25% reduction) PIFU – 2% Virtual 25% A&G 16/100 appointments Patient Communication Process Automation	CDC Imaging Network PACS connectivity IRefer	Theatre Capacity Theatre Efficiency (82.7%, 2.5 cases/per list) COVID Inefficiency Procedure Rooms Capital Equipment	Training Validation

Clinical Pathway, Leadership, Ownership

Safe pathways, of sufficient quality and experience for the patient
Harm reviews

Elective Pathway
Standardisation
GIRFT
Digital – Theatre System, E-TCI, Ophthalmology Electronic Patient Record

People | Pathways | Ease of use | Sustainability

Governance

In order to monitor recovery:

- Services will be required to sign up to a capacity plan, demonstrating compliance to planning guidance. The Trust will consider agreeing to investment if required.
- Initially, all services will be monitored on a weekly basis.
- In time, monitoring will reduce for most services allowing the focus to be on selected specialities with greater risks of delivery.
- Monitoring will take place through the Demand and Capacity Group which meets every week. This group reports up to the Access Board.
- Escalation processes will be implemented for specialties who fail to meet their plan with support given to recover activity levels. Recovery plans will be agreed, reviewed, and reported back to the Access Board.

Weekly Review at speciality level of Activity:
Outpatient, 1st, FUP, Proc
Elective: Day case, Inpatient
Diagnostics

Green rated against, capacity plan and last years activity

No further action continue to monitor and deliver plan

Red rated against, capacity plan and last years activity

Invite to Wednesday D&C to review performance. Speciality to review performance, deep dive, and provide a recovery plan

Wednesday D&C - Exec review

Recovery plan reviewed weekly to ensure delivery

Recovery plan agreed

Risks

High level risks	Mitigations
Workforce – impacted by sickness levels and challenges recruiting theatre staff.	Measures to strengthen our workforce: • Continuous recruitment • Review of roles and staffing (supported by Kinsgate) • Creation of new rosters. • Improved efficiency
Impact of future Covid surges.	Utilise 'flatpacks' already developed
Urgent Care pressures resulting in reallocation of staff	Measures to strengthen our workforce: • Continuous recruitment • Review of roles and staffing (supported by Kinsgate) • Creation of new rosters
Emergence of unmet demand (patients coming forward who have not yet presented to their GP)	Monitor referrals use through RAS Use A&G to manage demand
Disease progression, due to late presentation, resulting in poorer outcomes and/or requirement for more complex treatment.	Waiting Well My Planned Care Enhanced recovery

Next steps

Actions	Timescale
Complete capacity and demand work	April 2022
Identify, remove or reduce Covid inefficiencies, increasing capacity	As per national guidance (expected within next quarter)
Agree efficiency gains through work with Kingsgate and intelligent theatre scheduling	June 2022
Increase base capacity where practical	Timescale to be confirmed (subject to outcome of business case)
Commence elective care recovery programme	March 2022

Appendices

Commitments to the public

The following commitments have been made to the public:

1) Increase health service capacity

- Intention is that around 30% more elective activity is delivered in 2024/25 than before the pandemic.
- NHS to return to pre-pandemic performance as soon as possible.
- Long waiting patients to be offered 'further choice' about their care

2) Prioritise your diagnosis and treatment

- Better prioritisation of treatment if you have suspected cancer or another urgent condition, thanks to enhanced national frameworks on diagnosis and treatment.
- Clinicians working with you to make sure your planned care remains the best option.
- If you are waiting a long time, offering alternative locations for treatment with shorter waiting times, and in doing so tackling the number of people waiting too long.

3) Transform the way we provide elective care, specifically

- Streamlined care and fewer cancellations, thanks to dedicated surgical hubs and other measures to separate elective care from urgent and emergency care.
- More convenient access to diagnostic procedures and more tests undertaken at the same time, thanks to new community diagnostic centres.
- The scaling up of community and NHS based sites for surgical procedures and convenient, quick diagnostic checks, towards our ambition of a network of surgical hubs and diagnostic centres covering the entire country.
- Greater flexibility in how you access advice and care, enabling more convenient and appropriate care and making the best possible use of clinical time and expertise.
- Using every pound carefully, maximising care and investing for the long term.

4) Better information and support to patients, specifically

- Better information about waiting for treatment, including greater access to personalised information.
- Greater help in deciding which treatment is most appropriate.
- Targeted, accessible support if you are waiting for treatment, and to prepare for surgery in the best way possible.
- More opportunities to provide rapid feedback to the NHS, which will be used to improve services

Impact of the pandemic

Impact on patients and staff

- Longer waits can exacerbate existing conditions, require more complicated surgery, leave patients waiting in pain, have a detrimental affect on mental health and wellbeing and worsen health outcomes.
- Waiting can also make it harder to maintain independence, work or attend school.
- A correlation with deprivation has been identified – on average, a person living in one of the most deprived areas is 1.8 times more likely to wait over a year than someone living in one of the least deprived areas.
- There is a need to address staff shortages through recruitment and retention and support for staff health and wellbeing.

Impact on urgent and emergency services

- Emergency patients need to be discharged from hospital as soon as is clinically appropriate to support the delivery of the recovery plan.

Learning from what has worked well so far

- Best practice and new ways of working from the pandemic need to be embedded including improved cross system working, use of data to inform decision making, use of innovation – including separating elective care facilities from UEC facilities.

Increasing capacity

Growing and supporting the workforce

- Further work required to train, recruit and retain staff: joined up, cross system approach to this to be taken.
- Health Education England (responsible for workforce planning, education and training) to merge with NHSE/I
- Emphasis on health and wellbeing
- Use of international recruitment
- Provision of training grants to support nurses to become cancer nurse specialists
- Emphasis on managing absence
- Increased use of e-rostering, e-job planning, digital staff passports and other workforce optimisation tools

Using digital technology and advanced data systems to free up capacity

- Capacity to be released by delivering services in new ways
- Ability to see data from home settings/ virtual ward – to enable hospital beds to be freed up ('Supporting People at Home' programme to continue).
- Increased use of technology in general including use of AI, automation, video calls
- Use of data to drive improvement
- Better access for patients to information about their care and ability to communicate with their clinicians more easily

Working with the UKHSA to safely adapt the UK's IPC measures

- Ambition is to safety return to as close of pre-pandemic conditions as possible – advice and support to be provided

Making effective use of independent sector capacity

- Systems to include independent sector provision as part of elective recovery plans
- Increased choice to be made available to patients waiting long lengths of time
- Systems to have the chance to design a joint approach with the independent sector on workforce

Prioritising treatment

Focus needs to be on clinical need, not solely on absolute numbers on the waiting list

Clinical prioritisation: ensure the order in which patients are seen reflects clinical judgement on need.

- Requires consistent approach
- Those with the most clinically urgent conditions to be diagnosed and treated most rapidly
- The 'Clinical Prioritisation Programme' has supported management of waiting lists and includes prioritisation frameworks
- A framework is due to be published in March 2022 providing guidance around reviewing patients on the waiting list for an outpatient appointment. As part of this, opportunities for prioritising access to planned care for children and young people will be explored.

Managing long waits: targeting support to reduce the number of people waiting a long time.

- Addressing long waits - central to the recovery plan.
- Advice to be offered to long waiters
- Emphasis on accuracy of waiting lists, offering alternative providers, working with GPs and other partners to support patients while they wait, reviewing people's circumstances to check surgery is the best option
- National team to be established for long waiters – systems to be given treatment alternatives (NHS or NHS-funded) for patients waiting for highly complex procedures, or where significant capacity challenges exist
- Patients taking up appointments away from their local hospital will be offered transport and accommodation where necessary
- 'Approach' to this to be launched by the end of March 2022
- Expectation to review those waiting longer than 18 months (quarterly) and those waiting more that 62 days (weekly)

Quality | People | Pathways | Ease of use | Sustainability

Prioritising treatment

Increasing the number of cancer referrals, to ensure we also prioritise those patients who have not yet presented to services

- Need to actively encourage people to come forward who have yet to do so
- Focus on cancers for which referrals have been the slowest to come forward e.g. lung cancer and prostate cancer
- New 28-Day Faster Diagnosis Standard (introduced in October) to be made possible by:
- significant planned expansion of diagnostic capacity, particularly in community diagnostic centres
- Accelerated adoption of stool testing
- Cancer patients to be prioritised within the overall planned expansion of elective capacity
- Continued focus on innovative approaches to treatment

Health inequalities

What we need to do:

- Systems will be expected to analyse their waiting list data by relevant characteristics, including age, deprivation and ethnicity, and by specialty.
- Use this data to start developing detailed clinical and operational action plans to ensure treatment is based on clinical need.
- The development of a national Health Inequalities Improvement Dashboard will support systems to pinpoint disparities in waiting times based on ethnicity and deprivation. (This has been released to the wider health and care system and continues to be developed)

Transforming elective care provision

Need to radically rethink and redesign the way that services are organised and delivered.

Investment to be made in physical separation of routine care from urgent and emergency care by:

- Expanding community diagnostic centres to enable patients to get tested faster and more conveniently. Intention is to enable us to deliver bundles of tests in a single appointment.
- Increasing surgical capacity through surgical hubs – separating out many of the low complexity surgical pathways
- Improving patient pathways (through a new pathway improvement programme) to reduce avoidable delays by ensuring we are making the best use of the latest technology, clinical time and expertise.

Reducing need for onward referral where possible by:

- Improving access to specialist advice – providing greater flexibility in how specialist advice from clinicians is accessed by patients, enabling more timely, convenient and appropriate care and avoiding the need for unnecessary appointments.
- Making outpatient care more personalised – giving patients more choice around outpatient care, with options to book their follow-ups (PIFU) and attend video/phone consultations if preferred, simultaneously freeing up capacity for the most clinically urgent. This will include digital innovation through the NHS App.

Better information and support for patients

- Providing people and their carers with information and personalised support is central to that ambition and our overall recovery plan. We aim to enable people to make informed decisions and be more in control of managing their own care, to reduce the impact of waiting for treatment and supporting recovery after treatment. That includes sharing clear information on their wait and the support available, identifying their needs early so they can best prepare, and signposting them to the most appropriate support for their needs before and after their treatment

- We plan to provide this access and support using a comprehensive approach, including:

  - **Targeted information for patients**, including through My Planned Care (an open web-based platform) to provide greater transparency for patients on waiting times and what to expect.

    – Providers will upload support information by procedural group to help patients to self-manage
    – Capturing patient feedback on waiting is crucial. The national team will work with patient charities and groups to do this.

  - **Supporting patients to prepare for surgery** – by co-developing personalised plans that provide them with the necessary information and guidance to prepare for the best possible outcomes.

  - **Emphasising the expertise of NHS staff in providing high quality personalised and tailored support to patients**, supported by the latest innovations in technology and improved data sharing

Delivering the plan

- Clear accountability for delivery
- Consistent coordinated interactions between national, regional and local teams
- Overarching support offer to rapidly share and scale best practice, with targeted support for systems and providers with significant challenges
- A focus on health inequalities will be embedded in how systems are held to account
- Cancer performance and elective performance will be managed alongside one another
- Data will be used to drive improvement and identify opportunities for transformation

Agenda Item: 18.1

TRUST BOARD - PUBLIC SESSION – 2 MARCH 2022

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE MEETING HELD ON 26 JANUARY 2022

EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present the report from the FPPC meeting on 26 January 2022.		
Action required: For information		
Previously considered by: N/A		
Director: Chair of FPPC	**Presented by:** Chair of FPPC	**Author:** Corporate Governance Officer

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
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 FPPC.
Any other risk issues (quality, safety, financial, HR, legal, equality): N/A

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FINANCE, PERFORMANCE AND PEOPLE COMMITTEE MEETING
26 JANUARY 2022

SUMMARY TO THE TRUST BOARD MEETING HELD ON 2 MARCH 2022

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

The following core attendees were present:
Adam Sewell-Jones, Thomas Pounds, Martin Armstrong, Julie Smith, Michael Chilvers and Mel Gunstone.

Finance Report Month 9

The Committee considered the key points in relation to financial performance for month 9. There was a £0.4m net deficit in the month and the Trust is reporting a £0.4m surplus in the year to date. The Trust has incurred additional costs in the month to support winter initiatives, however these have been less than forecast due to unavailability of staff. The Trust is reporting against a break-even plan for the second half of the financial year.

The Committee noted income reported to date from the Elective Recovery Fund was £10.9m. This has been partially offset by a £8.7m ERF cost provision. It also noted the reduction in Covid funding in H2.

The FPPC considered the possibility of the Trust receiving unexpected last minute funding into the system.

H2 CIP Delivery Progress Report

The Committee received a CIP delivery report for H2, highlighting performance was £2.9m in the year to date against the plan of £2.8m. The Committee noted that recurrent savings were £187k below those planned in the year to date.

Concerns were raised about the levels of private patient activity, however opportunities for improvement and increased revenue were noted.

Capital Programme Update

The Committee noted the year to date and committed spend was £25m and the plans to spend £11.8m in quarter 4. Significant additional resources were made available in November and December and the risk this presents to delivery was discussed. However, the Committee felt it was also important to highlight the benefits to our patients and staff that had been obtained from the capital spend including procedure rooms, medical equipment and digital infrastructure.

22/23 Financial Planning Guidance

The Committee received a report highlighting the ten high level priorities of the financial planning guidance and were advised that more information will follow. The mechanism for funding allocation and the systems funding envelope were discussed for capital and revenue spend. The risks and opportunities were noted.

The Committee were presented with a challenging efficiency request of £24m including a reduction in Covid funding of £15.6m . The areas to focus on, Covid costs, productivity, general efficiency and system funding, were discussed and the challenges and opportunities noted. The need for transformation and the process for developing the transformation roadmap linked to the Strategy and Business Plan was outlined.

The Committee was informed that the elective backlog will be a key focus of attention with an increase of 10% on 2019/20 levels.

IFRS 16 Implementation

IFRS 16 when implemented changes the financial reporting of leases in the Trusts accounts. The FPPC noted 58 leases within the Trust had been identified for buildings and medical equipment. The ongoing financial impact of the implementation of IFRS 16 was noted

22/23 Budget Setting Update

The Committee were advised of the process for agreement of the operational budget that will ensure the Trust will break even. An agreed budget will be presented to FPPC in March with the final budget being available on 31 March.

22/23 Divisional CIP Programme Update

The Committee received a presentation on the five CIP schemes for the three divisions with transformation being a key focus. The FPPC were advised that most areas within the divisions have been working to a CIP target of 3%. The Managing Directors for Planned and Unplanned Care explained the risks and challenges for their CIP programmes. The engagement of the Divisions and ownership of their CIPS was welcomed by the Committee and it was agreed that they would update the Committee on progress on a quarterly basis.

Performance Report Month 9

The FPPC received an update in relation to performance for month 9. ED performance improved slightly, and there was an improvement in ambulance delays. Fifteen 12 hour trolley breaches were reported in December. There were a number of challenging days in the month when the Trust was on Opel 4, with over-crowding in ED preventing patients being placed into specialty beds, causing high levels of operational pressures.

The FPPC were advised of discharges being an area of focus for patients who are medically optimised to go home. This will directly impact on the ability to improve on the four hour target. A deep dive on discharge improvement will be undertaken in February.

The Committee noted that some PET CT and MRI scanner days on the mobile vehicle had been lost due to work being carried out on the Nightingale unit.

The Committee were informed of a pre-alert commencing in January for stroke patients to ensure they are dealt with in the same way as trauma patients.

The Committee received an update on the RTT PTL position form the Managing Director Planned Care.

Workforce Report Month 9

The Committee received a workforce update and noted an increase in vacancy rates. There has been an increase in international recruitment for doctors and nurses. Recruiting of Care Support Workers has been a challenge and it was agreed that this will be discussed in detail at the February FPPC meeting.

A new appraisal timetable will be launched in April in line with organisational priorities.

The Committee were advised that the staff survey received a 42% response rate. Early indication is that cultural metrics have improved slightly, specifically environmental factors. The Trust has adopted the national people pulse survey. The national report will be published in March.

Staff members who have not been vaccinated will be contacted and asked to provide evidence of their vaccinations. It is anticipated the number will reduce once records have been updated.

Workforce Planning

The Committee were presented with a report highlighting the future of NHS human resources and organisational development. The Trust has a people plan which complements this report but any gaps will be assessed and actions agreed.

Board Assurance Framework

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

Karen McConnell
Finance, Performance and People Committee Chair
March 2022

Agenda Item: 18.2

TRUST BOARD - PUBLIC SESSION – 2 MARCH 2022
QUALITY & SAFETY COMMITTEE – MEETING HELD ON 25 JANUARY 2022
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the Quality & Safety Committee meeting of 25 January 2022 to the Board.		
Action required: For information		
Previously considered by: N/A		
Director: Chief Nurse	**Presented by:** Chair of Quality & Safety Committee	**Author:** Assistant Trust Secretary

Trust priorities to which the issue relates:		**Tick applicable**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our 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 quality & Safety Committee.
Any other risk issues (quality, safety, financial, HR, legal, equality):

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QUALITY AND SAFETY COMMITTEE MEETING – 25 JANUARY 2022

SUMMARY TO THE TRUST BOARD MEETING HELD WEDNESDAY 2 MARCH 2022

The following Non-Executive Directors were present:

Ellen Schroder, Peter Carter, David Buckle, Val Moore

The following core attendees were present:

Michael Chilvers, Rachael Corser, Thomas Pounds

Matters Considered by the Committee:

Board Assurance Framework

The Committee received and noted the latest edition of the Board Assurance Framework. The Committee was informed that early feedback from the internal audit had been positive. The Committee heard that no changes had been recommended for the month.

New and Emerging Risks

The Committee received and noted the New and Emerging Risks. They were informed that a new risk relating to Partnership working had been included and the Divisions were sighted on action plans. The Committee heard that the number of new risks had increased and a new interim risk Manager had been appointed to support the oversight and governance of risk management.

Stroke Care Update

The Committee received and noted the Stroke Care update. They were informed that the Trust's Stroke mortality compared well with the UK's top 20 Hyper-acute stroke units. The Committee heard that the HSMR index was high but the SHMI was low.

Quality Assurance Group

The Committee was informed that the Quality Assurance Group had been reinstated and would meet twice per week.

Quality and Safety Report - Month 9

The Committee received and noted the month 9 edition of the Quality and Safety Report and was informed that the work continued with the CCG to close overdue SIs.

Key points discussed included:

- There had been an increase in the number of definite and indeterminate hospital onset cases of Covid. Learning from each case continued to be shared and the Trust compared well to others in the region.
- The Keeping Our Patients Safe (KOPS) initiative was progressing well as was the implementation of the digital fluid balance recording.
- VTE remained an area of significant concern and actions and mitigations were in place. This included the appointment of a specialist pharmacist.

Maternity Reports

The Committee received and noted the Maternity Safety Highlight Report which provided the data measures for overview as per the perinatal quality surveillance model. The Committee heard that consistently demonstrating training compliance had been challenging due to the workforce having to reprioritise direct care.

The Committee was informed that there had been an increase in incidents with engagement from key regulators. They heard this was system wide and not specific to ENHT.

The Committee was informed that funding had been received to support a new digital system for Midwifery.

In regard to the Continuity of Care, the action plan was a national priority and the Trust continue to progress the building blocks towards implementation.

The Committee noted the latest maternity reports.

Clinical Harm Reviews Update

The Committee discussed the latest position in relation to clinical harms reviews and noted that there had been 300 no harm reviews completed. The Committee was informed that data quality was an issue and significant amounts of data had to be validated.

Incidents and Inquests Report

The Committee received and noted the Incidents and Inquests Report which reported that the process for incident reporting was robust, the position was improving and further improvement remained a priority.

Estates and Facilities Health and Safety Assurance Report

The Committee received and the Estates and Facilities Health and Safety Assurance report and noted the overall compliance position was limited. They were informed that this was not unusual for a Trust the size of ENHT. The Committee was informed that every area of the hospital had received some level of assurance.

Mortuary Update

The Committee received and noted the Mortuary update and was informed that all immediate improvement actions had been carried out. The Committee heard that the Trust was working with ICS colleagues to support the partial closure of the mortuary.

The Committee noted the following reports:

- Complaints, PALS and Patient Experience Quarterly Report
- Junior Doctors Contract Quarterly Update
- Integrated Performance Report
- Gastroenterology Surveillance SI Update
- Maternity Dashboard

Peter Carter
Quality and Safety Committee Chair
January 2022

Agenda Item: 18.2

TRUST BOARD - PUBLIC SESSION – 2 MARCH 2022
QUALITY & SAFETY COMMITTEE – MEETING HELD ON 22 February 2022
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the Quality & Safety Committee meeting of 22 February 2022 to the Board.		
Action required: For information		
Previously considered by: N/A		
Director: Chief Nurse	**Presented by:** Acting Chair of Quality & Safety Committee	**Author:** Assistant Trust Secretary

Trust priorities to which the issue relates:		**Tick applicable**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
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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 quality & Safety Committee.
Any other risk issues (quality, safety, financial, HR, legal, equality):

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QUALITY AND SAFETY COMMITTEE MEETING – 25 JANUARY 2022
SUMMARY TO THE TRUST BOARD MEETING HELD WEDNESDAY 2 MARCH 2022

The following Non-Executive Directors were present:

Ellen Schroder, David Buckle

The following core attendees were present:

Michael Chilvers, Rachael Corser, Adam Sewell-Jones, Julie Smith

Matters Considered by the Committee:

Board Assurance Framework

The Committee received and noted the latest edition of the Board Assurance Framework (BAF). The Committee was informed that early feedback from the internal audit had rated the BAF with reasonable assurance and three recommendations were made which had already been included within the plan.

New and Emerging Risks

The Committee received and noted the New and Emerging Risks. They were informed that six new risks had gone onto the risk register and were being discussed by the Divisional Boards. The implementation of the Electronic Prescribing and Medicines Administration system (ePMA) was highlighted as an emerging risk and the committee was informed that actions and mitigations were in place to manage the risk.

Risks 20 and Over

The Committee received and noted the Risk Profile of Risk Scores 20 and over. There were 79 risks in this category which was an increase of two since the January meeting. Each of these risks had been tested and challenged through their Specialty and Division. The Committee heard more work would be required with the Women and Children's specialty and their risk profile was indicative of the senior leadership changes.

Sepsis / Venous Thromboembolism (VTE) Deep Dives

The Committee received and noted the Sepsis and VTE Deep Dives.

Sepsis:
The Committee was informed that although there had been a decrease in compliance between December and January there was an improving trajectory. To improve the compliance specific actions including e-Learning training, Digital Fluid Balance, Sepsis alert and escalation on Nevercentre among others were being progressed. The Committee heard that staff shortages and skill mix, conflicting priorities for ward managers and Sepsis recognition were some of the challenges faced. There were also good news stories highlighted which included an increase in interest from student nurses to shadow Sepsis nurses, an invitation from nursing education to support CSW induction training and teaching, excellent training attendance as well as the increased use of Sepsis grab bags on wards.

VTE
The Committee was informed that the biggest challenge was around the documentation of VTE risk assessment and analysis of RCA particularly around the second step of the process. The committee heard that actions were in place to encourage Junior Doctors to complete VTE documentation and a Thrombosis lead had been recruited .The recruitment of a lead VTE

consultant would be required as well as VTE incorporated into the ward accreditation programme.

Stroke Deep Dive

The Committee received and noted the Stroke Deep Dive report. The Committee agreed that the deep dive would be carried out at the Finance, Performance and People Committee. The slide on mortality rate was thought to be inaccurate and further clarification requested.

Quality and Safety Report - Month 10

The Committee received and noted the month 10 edition of the Quality and Safety Report.

Key points discussed included:

- There had been an increase in the number of incidents reported however 98% were of low or no harm which highlighted a healthy reporting culture.
- There had been no IPC triggers and work was underway with the CCG to determine targets. The new cleaning standards were being rolled out and the position was encouraging.
- 92% of complaints had been acknowledged within three days which was above the Trust target however 47% had final responses which was below the Trust target. The committee recognised the importance of responding to complaints on time. An improvement aim to reduce all overdue complaints to zero by March 2022 had been set.

Clinical Harm Reviews Update

The Committee received and noted the Clinical Harm Reviews process update. They were informed that each Division had a plan and trajectory for completing the backlog. The data cleansing was almost complete and the improving data had improved the position. The Committee was informed that there had been two moderate harms identified which would be presented to the SI review panel.

Mortality Review Proposal

The Committee received and approved the Mortality Review Proposal. The Committee discussed the adoption of the SJR Plus Mortality Review Form which would be provided by FutureNHS Better tomorrow workspace and were informed that the system had been developed with dashboards to understand mortality in a wider context. The Committee heard the use of this system would be appropriate for a smooth transition to the new mortality review process.

Reducing Avoidable Variation Report and 7 Day Working

The Committee was informed there had been two virtual specialty deep dive visits which had been very successful. The Committee heard that NHSI had indicated there would be no requirement to submit a return however the Trust would undertake its own audit in Q3 of 2022/23.

Statutory / Mandatory Training and Appraisals update

The Committee received and noted the MaST and Appraisal Report. They were informed that there would be a focus on reviews commencing in April and concluding in August 2022. The Committee heard that compliance of statutory/mandatory training had declined as staff had been unable to be released from clinical duties however improvement was expected as Covid and winter pressures eased.

Ockenden – One Year On

The Committee received and noted the Ockenden update. The Committee discussed the progress of the 7 immediate and essential actions identified and the Maternity services workforce plans. The Committee was informed that the areas of non-compliance included twice daily consultant-led ward rounds only 33% compliant over weekends and a business case to address had been submitted. The Committee heard that the Unit had achieved 112 out of 122 requirements.

Maternity Safety Highlight Report

The Committee received and noted the Maternity Safety Highlight Report which provided the data measures for overview as per the perinatal quality surveillance model. The Committee heard that training was the main area of concern as staff were busy with their clinical work.

Maternity Dashboard Exceptions and Maternity Safety Concerns and Neonatal Dashboard

The Committee received and noted the update Maternity reports. The Committee recognised that any poor outcome inevitably affected staff morale which was a concern. System partners were being used to support staff and the leadership had recognised the need to work together more and support each other.

The Committee noted the following reports:

- Integrated Performance Report for Month 10
- Gastroenterology Surveillance SI Update
- Mortuary Update

David Buckle
Acting Quality and Safety Committee Chair
February 2022

Agenda Item: 18.4

TRUST BOARD - PUBLIC SESSION – 2 March 2022

AUDIT COMMITTEE – MEETING HELD ON 18 January 2022

EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the Audit Committee meeting of 18 January 2022 to the Board.		
Action required: For discussion		
Previously considered by: N/A		
Director: Director of Finance	**Presented by:** Chair of Audit Committee	**Author:** Assistant Trust Secretary

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

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

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AUDIT COMMITTEE MEETING – 18 January 2022
SUMMARY TO THE TRUST BOARD MEETING HELD ON 2 March 2022

The following Non-Executive Directors were present:
Jonathan Silver (Chair), Karen McConnell, David Buckle, Peter Carter

Internal Audit Reports:

Internal Audit Progress Report and Action Log

The Audit Committee received an update from the Internal Auditors. Four internal audit reports had been finalised since the previous meeting, as follows:

- Core Financial Systems – Substantial Assurance
- Absence Management – Reasonable Assurance
- Business Planning – Reasonable Assurance
- Capital Programme – Reasonable Assurance
- Estates & Facilities – Premises Assurance Model (PAM) Review – Limited Assurance

The Committee discussed the actions in place to address the limited assurance of the Estates & Facilities PAM review and the position would be updated at next Audit committee meeting in March.

In relation to the delay of the 7-day working audit, the committee agreed that it needed to be completed, if this would be during the next financial year it would need to be undertaken early in the schedule.

The Committee also received the latest internal audit actions tracker. It was noted that the progress had slowed in recent months.

Counter Fraud Progress Report

The Committee received the Counter Fraud Progress Report which detailed the activity carried out against the Counter Fraud work plan 2021/22 since the Audit Committee of 19 October 2021. The Committee was informed that there had been less activity in Q3 on the action plan and the red and amber actions would be completed within the current quarter.

External Audit Reports:

External Audit Plan

The Committee received and noted the External Audit Plan and received assurance with that there was a new team in place to lead the external audits. The committee were informed that the PPE evaluation would be undertaken during February and March 2022.

The committee heard that the transitional arrangements set up through Covid had been extended for the current financial year but this would be the final year of working to a different timetable.

Other Reports:

Review of Accounting Policies

The committee was informed that the IFR16 standard which had been delayed until 1st April 2022 would only have a disclosure impact on 2021/22 accounts.

Board Assurance Framework and Risk Update
The Committee was presented with the current BAF and informed that it had been through the scrutiny of each of the Board Committees and the Board. The operational risk was rated at 20 which reflected the pressures in the Trust but had strong actions in place. The number of risks rated at 20 had reduced and an updated BAF would be presented at the next Audit committee meeting in March 2022.

Significant Losses / Special Payments
The committee received and noted the significant losses / special payments report.

Cyber Security Report
The Committee received and noted the latest update regarding the Trust's cyber security position. The Committee noted the Trust remained protected as all threats were managed or mitigated.

Tenders and Waivers Report
The committee received and noted the Tenders and Waivers report. They were informed that the number of wavers approved had improved but not to pre-pandemic levels. The majority of the reported waivers were related to the procedure rooms.

Data Quality and Clinical Coding Report
The Committee received and noted the update of data quality and clinical coding activities. The Committee noted that the clinical coding team were not part of the project team for the development of new clinical data recording systems. It was agreed the project management approach would be addressed to be more inclusive of key teams.

Jonathan Silver
Audit Committee Chair
January 2022

Draft Board Annual Cycle 2021-22

Notes regarding the annual cycle:

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

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

Draft Board Annual Cycle 2021-22

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

Draft Board Annual Cycle 2021-22

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

Draft Board Annual Cycle 2021-22

Items	**April 2021**	**5 May 2021**	**June 2021**	**7 Jul 2021**	**Aug 2021**	**1 Sept 2021**	**Oct 2021**	**3 Nov 2021**	**Dec 2021**	**Jan 2022**	**Feb 2022**	**Mar 2022**
Shareholder / Formal Contracts												
ENH Pharma (Part 2)				**X** *Received and discussed at 2 June Board Development meeting*								

DATA PACK

Contents

1. Performance Data:

CQC Registration and recent Care Quality Commission Inspection

2. Friends and Family Test Report

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Dec 2019	Good ↑ Dec 2019	Good →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019

	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 was been developed against all of these and was submitted to CQC on 22 January 2020. This was monitored by the Quality Improvement Group, chaired by the Medical Director or Director of Nursing and reported to Board through the Quality and Safety Committee. Regular updates have been provided to the CQC and the action plan was formally closed in 2021. A programme of internal and external inspections remain in place to test and evidence progress and that the actions are embedded across the organisation.

During 2021 we have participated in a number of virtual assurance assessments with CQC on well led, medicine management, infection prevention and control and across our core pathways. These have all been positive but are not rated.

Site Ratings

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

Friends and Family Test - January 2022

APPENDIX 1

Inpatients & Day Case	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses	No of Patients eligible to respond
5A	100.00	0.00	2	1	0	0	0	0	3	204
5B	100.00	0.00	1	0	0	0	0	0	1	44
6A	91.30	4.35	12	9	1	1	0	0	23	63
6B	90.48	4.76	17	2	1	0	1	0	21	57
7A	88.89	5.56	11	5	1	0	1	0	18	47
7B	87.50	0.00	3	4	1	0	0	0	8	127
8A	100.00	0.00	14	13	0	0	0	0	27	62
8B	0.00	100.00	0	0	0	0	1	0	1	24
9A	NP	NP							0	31
9B	100.00	0.00	9	2	0	0	0	0	11	26
10A	93.33	6.67	8	6	0	1	0	0	15	13
10B	87.10	0.00	15	12	4	0	0	0	31	51
11A + 11B/RSU	100.00	0.00	19	2	0	0	0	0	21	76
ICU1	100.00	0.00	1	0	0	0	0	0	1	9
SSU	NP	NP							0	71
ACU	95.45	0.00	18	3	1	0	0	0	22	73
AMU2	NP	NP							0	51
Ashwell	88.00	0.00	13	9	2	0	0	1	25	28
Barley	100.00	0.00	6	0	0	0	0	0	6	42
Pirton	100.00	0.00	7	1	0	0	0	0	8	17
Swift	100.00	0.00	16	6	0	0	0	0	22	173
Day Surgery Centre, Lister	NP	NP							0	115
Day Surgery Treatment Centre	97.37	0.00	35	2	0	0	0	1	38	203
Endoscopy, Lister	100.00	0.00	76	5	0	0	0	0	81	871
Endoscopy, QEII	100.00	0.00	6	0	0	0	0	0	6	208
Cardiac Suite	100.00	0.00	40	2	0	0	0	0	42	100
MEDICINE/SURGERY TOTAL	**95.82**	**1.16**	**329**	**84**	**11**	**2**	**3**	**2**	**431**	**2786**
Bluebell ward	100.00	0.00	22	5	0	0	0	0	27	167
Bluebell day case	100.00	0.00	2	0	0	0	0	0	2	4
Neonatal Unit	100.00	0.00	1	0	0	0	0	0	1	71
WOMEN'S/CHILDREN TOTAL	**100.00**	**0.00**	**25**	**5**	**0**	**0**	**0**	**0**	**30**	**242**
MVCC 10 & 11	100.00	0.00	16	0	0	0	0	0	16	69
CANCER TOTAL	**100.00**	**0.00**	**16**	**0**	**0**	**0**	**0**	**0**	**16**	**69**
TOTAL TRUST	**96.23**	**1.05**	**370**	**89**	**11**	**2**	**3**	**2**	**477**	**3097**

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	96.04	1.10	348	89	11	2	3	2	455	2820
QEII	100.00	0.00	6	0	0	0	0	0	6	208
Mount Vernon	100.00	0.00	16	0	0	0	0	0	16	69
TOTAL TRUST	**96.23**	**1.05**	**370**	**89**	**11**	**2**	**3**	**2**	**477**	**3097**

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	89.74	5.13	51	19	3	3	1	1	78	10964
QEII UCC	87.10	0.00	18	9	3	0	0	1	31	5590
A&E TOTAL	**88.99**	**3.67**	**69**	**28**	**6**	**3**	**1**	**2**	**109**	**16554**

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	4	1	0	0	0	0	5	420
Birth	93.50	3.25	86	29	2	2	2	2	123	412
Postnatal	93.91	3.48	76	32	2	3	1	1	115	412
Community Midwifery	100.00	0.00	6	0	0	0	0	0	6	512
MATERNITY TOTAL	**93.98**	**3.21**	**172**	**62**	**4**	**5**	**3**	**3**	**249**	**1756**

Outpatients	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses
Lister	97.45	0.00	107	46	4	0	0	0	157
QEII	98.40	0.80	94	29	1	1	0	0	125
Hertford County	100.00	0.00	27	2	0	0	0	0	29
Mount Vernon CC	93.26	2.07	149	31	6	2	2	3	193
Satellite Dialysis	94.03	0.00	49	14	4	0	0	0	67
OUTPATIENTS TOTAL	**95.97**	**0.88**	**426**	**122**	**15**	**3**	**2**	**3**	**571**

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