East and North Hertfordshire NHS Trust
Trust Board - Public Meeting

Postgraduate Centre, Mount Vernon Cancer Centre

4 September 2019 11:00 - 4 September 2019 12:30

AGENDA

#	Description	Owner	Time
1	Chair's Opening Remarks	Chair	11:00
2	Apologies for Absence: VM		
3	Declaration of Interests	All	
4	Questions from the Public Members of the public are reminded that Trust Board meetings are meetings held in public, not public meetings. However, the Board provides members of the public at the start of each meeting 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 Secretary can be contacted by email (joseph.maggs@nhs.net), by telephone (01438 285454) or by post to: Trust Secretary, Lister Hospital, Coreys Mill Lane, Stevenage, Herts, SG1 4AB. Each person will be allowed to address the meeting for no more than three minutes and will be allowed to ask only one question or make one statement. However, at the discretion of the Chair of the meeting, and if time permits, a second or subsequent question may be allowed. Generally, questions and/or statements from members of the public will not be allowed during the course of the meeting. Exceptionally, however, where an issue is of particular interest to the community, the Chairman may allow members of the public to ask questions or make comments immediately before the Board begins its deliberations on that issue, provided the Chairman's consent thereto is obtained before the meeting.		
5	Minutes of Previous Meeting For approval 5. Draft Minutes of 3 July Public Trust Board Meetin... 5	Chair	
6	Patient Testimony For discussion	Director of Nursing	
7	Chief Executive's Report For discussion	Chief Executive	11:20
8	FORMULATING STRATEGY		

#	Description	Owner	Time
8.1	Quarterly Divisional Progress Report on Clinical Strategic Priorities For discussion 8.1 Quarterly Clinical Strategy progress report.pdf 17	Director of Strategy	11:25
8.2	MVCC - Strategic Review Update For information 8.2 MVCC Strategic Review Update.pdf 67	Director of Strategy	11:40
9	ENSURING ACCOUNTABILITY		
9.1	Integrated Performance Report For discussion 9.1 Integrated Performance Report M4 2019.pdf 109	All Executive Directors	11:50
9.2	Finance and Performance Committee Report to Board For discussion 9.2 FPC report to Board July 2019.pdf 161	Chair of FPC	12:10
9.3	Quality and Safety Committee Report to Board For discussion 9.3 QSC REPORT TO BOARD 30.07.2019 inc Fire... 167	Chair of QSC	12:15
9.3.1	Complaints, PALS and Patient Experience Annual Report For information 9.3.1 Patient Experience Annual Report - 2018-19 -... 179	Director of Nursing	
9.3.2	Infection Prevention and Control Annual Report For noting 9.3.2 Infection Prevention Control Annual Report 20... 213	Director of Nursing	
9.3.3	Responsible Officer Annual Report For information 9.3.3 Annual Responsible Officer Board Report 201... 231	Medical Director	

#	Description	Owner	Time
9.4	Audit Committee Report to Board For discussion [P] 9.4 22 July 2019 Audit Comm Report to Board JS.p... 249	Chair of Audit Committee	12:20
9.4.1	Annual Audit Letter For noting [P] 9.4.1 East and North Hertfordshire NHST - Annual... 253	Chair of Audit Committee	
10	Board Assurance Framework For discussion [P] 10. Board Assurance Framework September Board... 279	Associate Director of Corporate Governance	12:25
11	Annual Cycle For information [P] 11. Board Annual Cycle 2019-20.pdf 309	Associate Director of Corporate Governance	
12	Matters Arising and Actions Log For information [P] 12. Public Trust Board Actions Log.pdf 313	Chair	
13	Data Pack For information [P] 14 Data Pack.pdf 315		
14	Date of next meeting: 6 November, Hertford County Hospital (11:00 am)		12:30

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday 3 July 2019 at 11.00 am at Lister Education Centre

Present:	Mrs Ellen Schroder	Non-Executive Director (Chair)
	Dr David Buckle	Non-Executive Director – Associate
	Dr Peter Carter	Non-Executive Director
	Mrs Karen McConnell	Non-Executive Director
	Ms Val Moore	Non-Executive Director
	Mr Bob Niven	Non-Executive Director
	Mr Jonathan Silver	Non-Executive Director
	Mr Nick Carver	Chief Executive Officer
	Mr Martin Armstrong	Director of Finance
	Dr Michael Chilvers	Medical Director
	Ms Rachael Corser	Director of Nursing
	Ms Julie Smith	Chief Operating Officer
In attendance from the Trust:	Mr Duncan Forbes	Chief People Officer
	Ms Clair Hartley	Corporate Governance Officer (Minutes)
	Ms Mary Hartley	Head of Business Development (for item 8.2)
	Mr Joseph Maggs	Trust Secretary
	Mr Oliver Shoffren	East & North Hertfordshire NHS Trust (observing)
In attendance external to the Trust:	Mrs Laura Davidson-Dean	University of Hertfordshire
	Dr Linda Sheridan	Non-Executive Director, Hertfordshire Community NHS Trust
	Mr Ananth Vijendren	Cambridge University Hospital
	Ms Yolanda Rugg	Member of Public

19/059 CHAIR'S OPENING REMARKS

19/059.1 Mrs Schroder welcomed the members of the public to the meeting and thanked them for attending.

19/060 APOLOGIES FOR ABSENCE

19/060.1 Apologies for absence were received from Ms Jude Archer (Associate Director of Corporate Governance) and Ms Sarah Brierley (Director of Strategy).

19/061 DECLARATIONS OF INTEREST

19/061.1 There were no declarations of interest.

19/062 QUESTIONS FROM THE PUBLIC

19/062.1 No questions had been received from the public.

19/063 MINUTES OF PREVIOUS MEETING

19/063.1 The Board reviewed and approved the draft minutes of the previous meeting of 1 May 2019 as an accurate record of the meeting subject to a few spelling errors.

19/064 PATIENT TESTIMONY

19/064.1 Ms Yolanda Rugg provided feedback about the treatment she received from the Trust after she was diagnosed with cancer. She praised the Trust for the excellent treatment she had received. She equated her stay to being in a 5 star hotel.

19/064.2 She was grateful for the fact that after she was diagnosed, her operation could be held on the following day. She was also offered immediate reconstruction. She praised the nursing team for their caring support through her ordeal. She appreciated the effort to prevent hair loss by using a cold cap while she was undergoing chemotherapy.

19/064.3 She also thanked the surgeons who she thought were very skilled and good listeners. She appreciated the support of a young student nurse who supported her while she waited to have her operation.

A nurse who had also had cancer was empathetic and had related her cancer story. She appreciated the help from MacMillan who taught her coping skills and helped her to manage psychologically.

19/064.4 On the negative side, she felt that the wait for chemotherapy was too long. On one occasion, her blood was lost before it could be tested. She would have appreciated more advice around nutrition and diet. Parking was another issue that could have been improved.

19/064.5 She felt that the food could be improved. She advised that she would be prepared to pay more for more nutritious meals with more vegetables. She would have liked to have more advice on how to care for her scars. She also felt that continuity of consultant would help.

19/064.6 Mrs Schroder commented that she was very pleased with the positive feedback. It seemed that the processes could have been improved but the staff did not let her down and apologised when things went wrong.

Dr Carter suggested that student nurses would benefit from hearing about her experience.

19/064.7 The Board thanked her for her contribution.

19/065 CHIEF EXECUTIVE'S REPORT

19/065.1 The Chief Executive's report contained the following highlights:

1. CQC Inspection

The CQC would be inspecting the Trust on 23 – 25 July at Lister and QEII and from 30 – 31 July at MVCC.

19/065.2 **Corporate Update:**

Sarah Brierley had been appointed as the Trust's Director of Strategy.

19/065.3 **2. Our Staff**

- Consultant Urologist Tim lane represented the Royal College of Surgeons (RCS) at Buckingham Palace recently;
- Trusts respiratory team had been recognised as one of he top performing teams in the country;
- The multiple birth team had been recognised by NICE for best practice;
- Yvonne Pearse, a staff nurse in the ED had been recognised as Mentor of the Year;
- The Trust celebrated Armed Forces Day.

19/065.4 The Chief Executive added that the Chief People Officer, Duncan Forbes was attending his first Trust Board meeting and welcomed him to the Trust.

19/066 Nursing Establishment Review

19/066.1 The Director of Nursing presented the report on the bi-annual review and recommendations to ensure Nursing and midwifery staffing levels were compliant with Workforce Safeguards. The report had been considered previously at the Quality and Safety Committee (excluding the financial information which was still being finalised) and at the Executive Committee.

19/066.2 The nursing establishment review was undertaken in April 2019. Data on actual staffing, patient acuity and dependency was collected over a 20 day period on all inpatient wards. Shift plans and service requirements were reviewed. The data was then analysed using the SNCT, professional judgement, quality and safety indicators, benchmarking with other Trusts using NHSI Model Hospital and National guidance for safe staffing.

19/066.3 The Birthrate Plus® workforce analysis tool had been used for the maternity review. The tool was commissioned by the Local Maternity Systems (LMS) and undertaken in March 2019 to enable benchmarking across the three STP Maternity Services as part of the LMS wider workforce review. The full report was provided as an appendix to the Nursing and Midwifery Establishment Review. Whilst Birthrate Plus® recommended an uplift in the maternity establishment, professional judgement has been considered coupled with service and skill mix redesign the Director of Nursing confirmed that we will continue to monitor the maternity staffing levels and any potential red flags, which as yet there have been none. Reflecting the recommendations in the report, the Director of Nursing confirmed that the Head of Midwifery will develop an action plan to address the

recommendations.

19/066.4 Ms Moore noted that the report provided details of the Trust's ratio of births to midwives based on the Birthrate Plus® dataset. The overall ratio for all births for the Lister Hospital was 26 births to 1 WTE.

19/066.5 The following recommendations were made to continue to deliver safe and effective care to patients:

- Uplift 1 RN and reduce 1 CSW on an Early shift Monday-Friday on 6A;
- Ashwell: reduce band 5 RN and replace with band 2 CSW on early shifts, build in 1WTE band 3 to fund TNA;
- 10B: increase CSW at weekend and remove HK late;
- ACU: add 1 WTE B3 TNA to replace B2 CSW;
- AMUW: reduce 1 WTE B7 SV to 0.75WTE SV, increase B5 early shift on Thursdays;
- SSU: Option 1- increase B7 to WTE SV, increase B5 and reduce B2 on Thursday mornings, reduce B5 Saturday/ Sunday;

  Option 2 - increase B5 and reduce B2 on Thursday mornings, reduce B5 Saturday/ Sunday;
- AMUA: increase B5 on early shift on Thursday and reduce CSW B2;
- 8B: reduce B5 on early, B4 AP to work long days 5 days per week, add 1 WTE B3 TNA, share B6 establishment equally across level 8;
- Support the cost pressure for the Trainee Nurse Associates by building the role into the budgets for 7B, 5A, 5B;
- Uplift 1 RM in triage at night in CLU;
- Change the skill mix in MLU by changing the band 4 to a band 2 support worker, and convert 1 band 6 RM to a band 7 1 night per week;
- Convert a band 2 to band 3 in Maternity community services and utilise band 3 and 4 staff in post-natal care;
- Increase 1 RM long day and night and 1 band 4 nursery nurse long day at weekends on Gloucester ward.

19/066.6 The Board acknowledged and approved the recommendations of the report.

19/067 Strategy Highlight Report

19/067.1 The Head of Business Development presented the strategy highlights report.

19/067.2 The Board considered the Five Year Strategy Development: Programme Highlights Report. The purpose of the report was to provide monthly, high-level assurance to the Strategic Programme Board and updates to the Trust Board on the progress of the Trust's new five year strategy.

19/067.3 The strategy was launched in April 2019 and has been presented at Trust induction, all Divisional Boards and a number of team meetings. It had also been the focus of the Trust Conversation

sessions with staff.

19/067.4 The Clinical strategy was now at the implementation stage. The implementation of the communication plan was in progress. Further work was being conducted on enabling strategies.

19/067.5 Mrs Schroder noted that the Board had discussed the development of a long term financial strategy which would overlay the clinical strategy. The strategies would all need to interweave with each other.

19/068 Integrated Performance Report

19/068.1 The Integrated Performance Report was presented to the Board.

Safe

19/068.2 The Director of Nursing presented the updates on safe & caring services.

19/068.3 The National Patient Safety strategy had been launched on 2 July. Much in the strategy was already reflected in the Trust's Nursing strategy. The briefing points would be brought to the QSC, if required.

19/068.4 The Safety Thermometer showed that Harm-free care (for all and new harms) were better than the national average.

19/068.5 Areas of focus were:

- Deteriorating patient;
- Sepsis; and
- VTE.

19/068.6 There was 1 Serious Incident reported in May. There were no Never Events reported in May.

19/068.7 One Hospital Onset Healthcare Associated *c.difficile* infection had been reported for May.

19/068.8 There were 14 pressure ulcers reported in May. All were category 2 or lower.

Caring

19/068.9 There had been a continued emphasis on complaints, but the improvement target had not yet been reached. A number of clinical areas were struggling to respond to complaints within the agreed timeframe. Work continued to improve this position.

19/068.10 The Director of Nursing reported that the number of complaints was lower at this time of year. The Director of Nursing said that learning from complaints was improving. They had to address the issues behind the delays.

19/068.11 Mr Niven asked how the training on handwashing was proceeding. The Director of Nursing replied that staff had been trained on auditing and there had been an improvement but 100% was not a realistic target for any organisation.

Effective

19/068.12 Mortality rates had improved over the last 5 years as measured by

both of the major methods: HSMR and SHMI. There would be further discussion on these later in the meeting.

19/068.13 Mrs Schroder commented that due to the nature of the metrics, there had not been much variation in the figures from month to month. She asked whether there were other factors which could be measured to demonstrate an improvement in this area. The Medical Director said that he would look into this.

Responsive

19/068.14 A & E Performance

The Trust A & E performance in May was at 81.64%, an improvement on the previous month position which was 80.54%. The Trust continued to report nil 12-hour trolley breaches.

19/068.15 The Trust 4-hour performance remained a challenge. A formal action plan was being written to improve performance ahead of winter 2019/20. In addition, key actions to improve professional standards would continue.

19/068.16 A pilot on same day emergency care was being developed. Developing of ambulatory pathways, to include frailty and emergency surgery were part of the pilot study. The proposals would be taken forward through discussions with the CCG to support an ambulatory tariff to offset the potential of a reduction in inpatient income. The initiative would also free up inpatient bed capacity and reduce costs.

19/068.17 Cancer:

In April 2019, the Trust achieved 4 of the 8 national targets for cancer performance: 2ww, 31 -day subsequent for drug treatments, radiotherapy, and surgery.

19/068.18 The Trust Two Week Wait (2WW) performance for April 2019 was 95.9% which equates to 1,323 out of 1,379 pathways meeting the 2WW standard, with 56 breaches of the standard being reported.

In April 2019, the Trust-wide average days wait for a first appointment was at 10 days and the majority of patients were seen between 8 and 12 days.

In April 2019 the 31 day 1st definitive treatment was 93.5%; below the national target of 96%, which equates to 231 out of 247 pathways meeting the target, with 16 breaches. 7 out of 9 tumour sites met the target and excluding Urology the Trust would have achieved the 96% target.

In April 2019 the 28-day faster diagnosis performance was 62.30% and 58.80% for screening patients.

Reported 62-day performance for April 2019 was 79.6% pre-breach/compliance sharing and 82.3% post- (85.7% excluding all incoming referrals), which were above the revised recovery trajectory of 75.8%. In April 2019, 5 out of 9 tumour sites met the standard with 45% of avoidable breaches occurring in Urology.

19/068.19 RTT:

RTT performance remained a challenge. Performance had dropped further in May. Five 52 week breaches were reported for May. Work was taking place to address this.

19/068.20 Diagnostics:

DM01 performance for May was 1.02% against the national standard of 1% and the April position of 1.59%.

19/068.21 Stroke:

Stroke performance was disappointing at 50%. In response, immediate steps were being taken to raise the profile of ring fenced stroke beds.

19/068.22 Mrs Schroder congratulated the team and said that it seemed they were heading in the right direction in a number of areas.

Well- led

19/068.23 The Chief People Officer, who was attending his first Trust Board meeting, reported that he was very positive about future improvements. He said that excellent work had been done by the Deputy Director: Workforce and OD on staff recruitment. Having performed well in this area, it was important to consider the optimum utilisation of staff.

19/068.24 He reported that he intended to revise the reporting on his section of the IPR to focus more on outcomes.

19/068.25 He also reported that he was working on the people strategy and hoped to have it ready by September. He believed that the culture of leadership development needed to be revitalised.

19/068.26 Mrs Schroder commented about substantive pay costs. She noted that the pay costs for part time workers and agency staff were also up.

19/068.27 The Chief People Officer said that there was a need to enable divisional management to make much better decisions in terms of workforce. Mr Niven asked what form this training might take. The Chief People Officer replied that action learning was the best, where people learnt from each other as this was a more reflective way of learning.

19/068.28 Dr Carter enquired about exit interviews. He said that he believed that it was important for exit interviews to be conducted. He suggested modelling of the age of the workforce was needed. For example, they should estimate how many nurses would retire in 10 years and how the Trust would replace them. There should be contact with universities about how many nurses were being trained.

19/068.28 The Chief People Officer agreed that there should be regular dialogue. He further agreed with the need for exit interviews. He felt that it was necessary to find out what problems staff members were experiencing before they decided to leave. Exit interviews were held after the staff member had decided to leave and it was too late to address issues that could have been addressed.

Sustainable

19/068.29 The Director of Finance advised that the Trust's month 2 position was a deficit of 2.8 million. He expressed his disappointment at the failure to meet pay targets. They were not delivering on reduction of salaries. Clinical productivity was also not achieving the target. There

was a need to restore control and delivery.

19/069 Finance and Performance Committee Report to Board

19/069.1 Mrs McConnell presented the reports on the meetings of the Finance and Performance Committee which were held on 22 May 2019 and 26 June 2019. She highlighted a number of factors.

19/069.2 In May the Committee had received a report on the methodology to be used in the divisional deep dives. It was agreed that it was important to ensure enough time was set aside at the meetings to fully consider the deep dives and that the presentations should have relevant executive director input prior to the meeting.

19/069.3 The first deep dive they received was on the theatres transformation programme. The intention of the deep dive was to provide a detailed analysis of the overall performance of the theatres, its culture, effectiveness, productivity and quality. The next deep dive planned was one on outpatients.

19/069.4 The workforce team had submitted a strategy on improving staff wellbeing to the Committee for approval. The Committee had also received a number of action plans on workforce matters.

19/069.5 Mrs Schroder asked whether they had received feedback from the presenters of the theatre deep dive. It was reported that they had not found the process as helpful as had been hoped. The Chief Operating Officer and the Chief People Officer would see how they could assist.

19/070 Quality and Safety Committee Report to Board

19/070.1 The Board received the Reports on the meetings of the Quality and Safety Committee meetings held on 21 May 2019 and 26 June 2019.

19/070.2 Mrs Moore, who had deputised as chair at both of the meetings commented that the presentation to the Committee on End of Life Care in the meeting of 21 May had been very impressive, considering that this was a difficult subject.

19/070.3 Mrs Moore also reported that she had attended the Quality Improvement Day which showed an ambitious approach to improvement.

19/070.4 The Director of Nursing highlighted a report presented to the Quality and Safety Committee at the meeting of 25 June 2019 on the Clinical Negligence Schemes for Trusts (CNST) incentive scheme (reference to this report had been mistakenly omitted from the original version of the summary report). The scheme incentivises ten maternity safety actions and trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their annual contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

19/070.5 The Trust had achieved all the ten safety actions last year and had reviewed the supporting evidence and criteria and assessed that all ten maternity safety actions continued to maintain compliance.

19/070.6 The report considered at the QSC meeting outlined the current compliance assessment against the 10 maternity safety actions. The required data submissions had been met and a final review was in

progress. The Committee had received regular reports from the Women's Division during 2018/19. The internal compliance assessment for all 10 standards had been through the Divisional internal governance structures, Director of Nursing and a final scrutiny/test and challenge session had been scheduled with the CCG prior to submission to NHS Resolution by 12 noon on Thursday 15 August 2019. The Quality and Safety Committee had approved the submission subject to the final scrutiny as outlined.

19/070.7 The final submission would be considered at the next Quality and Safety Committee and signed by the Chief Executive on behalf of the Board.

19/071 Learning from Deaths Report

19/071.1 The Medical Director presented the report previously considered by the Mortality Surveillance Committee and the QSC. There were a few updates since the report was originally written.

19/071.2 The crude mortality rate had shown an improvement. It compared favourably with National figures.

19/071.3 HSMR had improved to 92.57 in March, and remained better than the standard (100). The rolling 12-months HSMR increased slightly to 93.3 in the 12 months to March, but remained in the better than expected range.

19/071.4 SHMI was now updated monthly. It had historically been higher than HSMR. In the latest update it was lower for the first time. The January figures had improved. The Trust's SHMI score was now 22nd best nationally, close to but not there yet).

19/071.5 The use of the care bundles confirmed that further work was required if the Trust was to reduce avoidable variation in the provision of patient care. This work would include a more standardised format for care bundles together with appropriate guidance regarding their creation and use.

19/071.6 The Medical Director reported that medical examiners had now been appointed.

19/071.7 Mr Buckle said it was important to learn from patient deaths. He felt that it was a useful report summarising progress.

19/071.8 Mrs Schroder suggested that this would be a useful item for the Trust AGM.

Mr Silver referred to pneumonia where the deaths were higher than expected. The Medical Director advised that this might be attributable to an incorrect diagnosis on admission. This could be addressed through better education on the matter for junior doctors,

19/072 Safeguarding and LD Annual Report

19/072.1 The Director of Nursing presented the 2018/19 Annual report on Safeguarding Children and Adults. She advised that she was the Executive Lead for Safeguarding and also a member of the Hertfordshire Children's Safeguarding Partnership and the Hertfordshire Adult Safeguarding Board.

19/072.2 She expressed her pride at the phenomenal work that had taken place over the last year. She noted the work of the carers lead and

the admiral nurse in particular.

19/072.3 She reported that statistics showed increasing activity. Despite this, the team were working to ensure that compliance with the standards was maintained.

19/072.4 She reported that it was the intention to ultimately provide a single hub for all safeguarding matters within the Trust as it was believed that a merged team working together would have a greater impact. There would also be a single point of contact.

19/072.5 Training was an essential element in safeguarding and remained a key focus. Members of the Trust Board had recently received safeguarding training.

19/073 Health & Safety Annual Report

19/073.1 The Annual report of the Health and Safety Committee was presented to provide information on activities undertaken relating to health and safety management and compliance during the period of 1st April 2018 to 31st March 2019.

19/073.2 The report detailed areas of improvement and where there had been an increase in Health and Safety incidents. Although there had been a reduction of incidents in a number of areas, there had also been increases in other areas, including a 14% increase in sharp injuries to staff.

19/073.3 The Director of Nursing noted the work that had taken place to strengthen the governance processes relating to Health and Safety.

19/073.4 Mr Niven enquired whether there were any themes from the Public Liability claims which had been received. The Director of Nursing said that she would get the details of the claims.

19/074 Audit Committee Report to Board

19/074.1 The report was taken as read.

19/075 Quality Account

19/075.1 The Board noted the report which had now been submitted.

19/076 Board Assurance Framework

19/076.1 The Board noted the latest BAF which had been considered in more detail by the sub-committees.

19/077 Annual Cycle 2019/20

19/077.1 The Board noted the Annual Cycle 2019/20.

19/078 Matters Arising and Actions Log

19/078.1 The Board reviewed and noted the Actions Log.

19/079 Data Pack

19/079.1 The Board noted the data pack.

19/080 Date of Next Meeting

19/080.1 4 September 2019, MVCC.

19/081 BOARD TO RECONVENE AS CORPORATE TRUSTEES

19/081.1 **Charity Trustee Committee Report to Board**

Mr Niven presented the summary report relating to the most recent Charity Trustee Committee meeting, highlighting the latest approvals of expenditure.

There being no further business the Chair closed the meeting at 12.45.

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Ellen Schroder

Trust Chair

September 2019

Agenda Item:8.1

TRUST BOARD - PUBLIC SESSION – 4th September 2019

DIVISIONAL REPORTING OF CLINICAL STRATEGY PRIORITIES – Q1

Purpose of report and executive summary (250 words max): Following approval of the Trust's new clinical strategy (2019 – 2024), to provide the first report to the Trust Board on progress made in Q1 of 2019/20.		
Action required: For discussion		
Previously considered by: **N/A**		
Director: **Director of Strategy**	**Presented by:** **Director of Strategy**	**Author:** **Head of Business Development**

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

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

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

DIVISIONAL REPORTING OF CLINICAL STRATEGY PRIORITIES – Q1

TRUST BOARD - PUBLIC SESSION – 4th September 2019

1) Purpose

The purpose of this paper is to update Trust Board on the progress made by Divisions against delivery of their Clinical Strategic Priorities throughout the five years of the strategy, 2019-2020. This report covers progress made in Q1 of 2019/20.

2) Background

Following approval of the Trust's Clinical Strategy (2019 – 2024) by the Trust Board in January 2019, the Board were keen to ensure that each Division quickly embedded their strategic priorities into business as usual activity and that a mechanism was put in place to ensure robust internal oversight and assurance on the progress being made, together with an understanding of particular successes and challenges.

The new strategy commenced on 1st April 2019. The Strategic Programme Board subsequently agreed an assurance reporting proposal that encompasses divisional progress reporting on a quarterly basis to the Strategic Development Committee and Trust Board, complemented by a rolling programme of divisional deep dives.

The progress report template has been designed to be simple to complete to avoid the creation of an onerous task for divisions. It gives an initial overview of progress against each clinical strategic priority and then a short update against each key action, including progress to date, any risks to delivery and issues to escalate for support.

3) Q1 Progress

Each division's report is attached in Appendix 1. Being the first quarter for reporting progress, this was the first time that divisions had completed the template. As a result of feedback, an additional column showing the timespan of the clinical priority has been added. Some priorities have commenced in year 1, with a one-year timespan, whilst others may have a 3-4 year timespan, or not commence until later years. This is now clearer on the reporting template.

The Trust's clinical strategy was informed by a comprehensive strategic case for change spanning internal and external drivers, the new strategy was then used to inform the organisation's commissioning intentions and operating plan for 2019/20. Due to the careful consideration given to their clinical priorities by divisions in the planning phase, there has generally been good initial progress.

Clinical strategy priorities align with work being undertaken externally, for example STP work streams (particularly in Women & Children's with the Local Maternity System; in Medicine with Emergency and Urgent Care; and in Surgery with Planned Care) and internally, for example PMO work streams such as workforce redesign. Others are more specific to a division, for the Cancer Division, their strategic priority *"To secure a long term, sustainable, future for the Mount Vernon*

Cancer Centre" is now being supported by the NHSE Specialised Commissioner's strategic review of the Mount Vernon Cancer Centre.

4) Key Issues

Alongside reporting progress, divisions have also identified areas to highlight for support in resolution or taking forward. Divisions are being supported to work through these with the executive team and issues are discussed as part of divisional Accountability Review Meetings. Key issues that have been identified by divisions to highlight to the Trust Board are summarised in Table 1 below.

Table 1: Issues to highlight to Trust Board

Division	Strategic Clinical Priority	Items to escalate
Cancer	To secure a long term, sustainable, future for the Mount Vernon Cancer Centre	Dedicated resource will be required to deliver Clinical Advisory Group recommendations – discussions being held with NHSI/E.
CSS	Develop a radiology strategy and enabling funding strategy to ensure appropriate capacity to sustainably meet demand, by critically assessing working arrangements, capital requirements, technological solutions, existing physical capacity and future demand drivers.	Significant dependency on access to capital Need to transform radiology workforce and service to attract and retain skills and capacity required
W&C	Achieve an outstanding CQC rating for our services by transforming services in line with National Ambitions and Drivers to improve outcomes	Non-recurrent funding from Local Maternity System (LMS) – division to put plan in place to mitigate associated risks if replacement funding streams are not identified.
W&C	Deliver consistent, high quality care and ensure patients receive the most appropriate care for their condition, from those most clinically appropriate to deliver it, and in the most appropriate setting	Non-recurrent funding from Local Maternity System (LMS) – division to put plan in place to mitigate the associated risks if replacement funding streams are not identified.
Medicine	Provide consistently high quality urgent and emergency care by : a) reviewing and revising the medical inpatient model to ensure that every patient is admitted under the care of the most clinically appropriate specialty with inter-specialty support as required; b) optimising the use of ambulatory and outpatient models of care to avoid unnecessary hospital admissions and enable patients to be cared for in their homes	a) Medical Take project proposals in development currently, PMO support identified. Risk related to recruitment to consultants in acute medicine including leadership role b) Same Day Emergency Care (SDEC) proposals supported by CCG and being implemented.
Medicine	Ensure all services are clinically and financially sustainable, working with the STP as appropriate, with rigorous focus on challenged specialties, including: • Renal • Diabetes / Endocrinology • Dermatology/Skin Health	Capacity constraint - requirement for project support to progress support

5) Recommendations

Trust Board is asked to:

- note the progress made by divisions against their strategic clinical priorities for Quarter 1 and the items highlighted.
- note that the Cancer Division will attend the private section of the Trust Board meeting for a “deep dive” into their clinical strategy and progress.
- note that Q2 progress will be reported to the Strategic Development Committee in October 2019, with Medicine and Surgery Divisions presenting their deep dives to Trust Board in November 2019.

Appendix 1: Divisions' Q1 progress on Strategic Clinical Priorities

- **Cancer**
- **Clinical Support Services**
- **Medicine**
- **Surgery**
- **Womens and Childrens**

Cancer Division's Strategic Clinical Priorities Highlight Report
Reporting Period: Quarter 1

No.	STRATEGIC CLINICAL PRIORITY	OVERALL CONFIDENCE RATING	Progress vs 2019/20 plan	Risks	Items to note / for discussion	Items to escalate? Y/N
1.	To secure a long term, sustainable, future for the Mount Vernon Cancer Centre				Specialist commissioner led MVCC review in progress – external Clinical Advisory Group report recommendation received.	Y Dedicated resource required to deliver Advisory Group recommendations
2.	Deliver sustained improvement of patients' experiences of the Trust's cancer services including improving access to radiotherapy to meet the needs of the population we serve				Radiotherapy networks established. 1st Board meeting took place in July 2019. TOR awaiting final approval. Membership agreed by ENHT	N
3.	Improve patient outcomes by facilitating earlier diagnosis and timely, effective treatment and support - own complete cancer pathways end to end for Breast, Urology, Lung and Colorectal (from diagnosis; living with and beyond cancer; supporting and managing End of Life)				Working with STP and CCG to deliver 28 day faster diagnosis standard. Capacity and demand modelling exercises completed with the support of NHSi / iMAS team. Approved cancer business, and pathway specific RAPs are in delivery	N
4.	Establish strategic partnerships to maximise commercial opportunities for long term sustainability and better patient outcomes				Continuing to develop partnerships with Baxter, BMI, UCLH.	N
5.	Become the Regional Centre for Excellence in Radiation Services (to include Immunotherapies, Nuclear Medicine, Radiation Protection and Aseptic Services)				Recognised as regional experts in a number of areas. Our ability to ensure sustainability and deliver further growth is part of the scope of the commissioner led MVCC review.	N

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
To secure a long term, sustainable, future for the Mount Vernon Cancer Centre			To develop a response to NHSE's Modernising Radiotherapy Services in England. Work with partners to develop a networked radiotherapy service that meets Commissioner's specifications.	Response developed		Divisional Chair, Cancer	RT network arrangements confirmed. Launch meeting attended by Divisional chair and Head of Business Development. TOR of working groups approved. Clinical lead for radiotherapy identified.	On-going exec attendance at oversight group meeting required. Ensure adequate engagement by the respective service leads.
			To optimise benefits for MVCC of its clinical and academic collaboration with UCLH	Project plan		Hospital Director / Divisional Chair/ clinical director /Head of Nursing	Year 1 objectives agreed. Aligned to the MVCC strategic review objectives. Medical teams to coordinate tumour specific academic meetings. Breast meeting scheduled for September 2019. Melanoma joint team approach is in delivery.	Ensure each of the 4 solid tumour teams schedule a joint academic meeting in 2019/20
			Secure the Cancer Centre's medium-term tenure of the Mount Vernon site and work with the landlord to improve the environment within which cancer services are provided	Plan in place, including estates improvement plan		ENH Exec team	Awaiting completion of actions following the presentation of the expert review panel findings to the 2nd strategic review board meeting in July.	

			Work with Michael Sobell Charity and stakeholders to agree and implement a future model of End of Life care that meets the community's needs	Plan in place and being implemented						COO / ENHCCG	Working in partnership with commissioners, landlord and hospice to support transfer of contract and associated estates to new provider.	

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Deliver sustained improvement in patients' experience of Trust cancer services including improving access to radiotherapy to meet the needs of the population we serve.			Understand key drivers of patient experience and engage patients in the development and delivery of a programme to deliver sustained improvement.	Patient Experience Surveys and feedback		Head of Engagement: Specialist commissioners Head of Engagement ENHT	4 engagement events scheduled for July as part of stakeholder involvement in shaping the future of MVCC. Patient story presented to Trust Board in July As part of the future planning of systemic therapy provision, the division has been working with BMS. 2 local patient experience sessions completed in Lung and melanoma pathways. Action plans in delivery	
			To develop a response to NHSE's Modernising Radiotherapy Services in England. Work with partners to develop networked radiotherapy services, that meets Commissioner's specifications	Response developed		Divisional Chair, Cancer	RT network arrangements confirmed. Launch meeting attended by Divisional chair and Head of Business Development. TOR of working groups approved. Clinical lead for	On-going exec attendance at oversight group meeting required. Ensure adequate engagement by the respective service leads.

											radiotherapy identified.	
			Write and implement the business case for a satellite radiotherapy unit in Stevenage.	Business plan in place							This will be taken forward as part of the specialist commissioner led review of the future service model for MVCC.	Sustainability of the existing service will take priority before an expansion of the existing service can be considered.
			Work with STP partners to develop and deliver an integrated and streamlined pathway for cancer patients from initial diagnosis through to end of life planning.	Plan in place						Head of Strategy, ENHT	Change to GI surgical pathways in progress. Implementation of 28 day faster diagnosis standard in progress.	
			Work with STP partners to develop and implement risk stratified follow up and support pathways for patients including the effective transfer of patients ongoing care into the community setting	Pathways in place						Hospital Director / Divisional Chair/ Head of Nursing	Working with STP/CCG to implement stratified pathways of care.	

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Improve patient outcomes by facilitating earlier diagnosis and timely, effective treatment and support - own complete cancer pathways end to end for Breast, Urology, Lung and Colorectal (from diagnosis; living with and beyond cancer; supporting and managing End of Life)			Work with other specialities to implement best practice, timed pathways and deliver national cancer standards	Implementation of timed pathways Achievement of national cancer standards		Hospital Director	Meeting recovery trajectory and on target to achieve full compliance by Dec 2019.	Timely Implementation of the cancer business case.
			From both a clinical and financial perspective have assessed owning the whole pathway for the four solid tumours, skin/melanoma across all sites, and rare cancer	Assessment undertaken		Hospital Director / Divisional Chair/ clinical director / Head of Nursing	Expert advisory panel findings presented to MVCC strategic development project board, defining the 2 preferred options.	
			Have a plan agreed with commissioners and partners for the identified services we do not want to own end to end	Plan agreed		Head of Strategy, ENHT		The wider MVCC strategic review recommends no changes to patient pathways during the interim phase of the project.
			Identified appropriate means to manage our chosen end to end pathways, e.g. in partnership for particular elements	Plan in place			From Year 2	
			Identified the optimal location and environment for services, e.g. co-location with surgery and anaesthetics, inpatients and specialist diagnostics to maximise quality, patient experience and access	Plan in place			From Year 4	
			Support delivery and sustainability of all eight waiting time standards for cancer, including the 62 day referral-to-treatment cancer standard.	Waiting time standards being met		Hospital Director	Meeting recovery trajectory and on target to achieve full compliance by Dec 2019.	

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Improve patient outcomes by facilitating earlier diagnosis and timely, effective treatment and support - own complete cancer pathways end to end for Breast, Urology, Lung and Colorectal (from diagnosis; living with and beyond cancer; supporting and managing End of Life) (CONT)			Make the current Mount Vernon site fit for purpose, particularly Nuclear Medicine, OPD and ward areas	Present options appraisal to include local redevelopment or alternative solutions		Hospital Director / Divisional Chair/ clinical director / Head of Nursing	Expert advisory panel findings presented to MVCC strategic development project board, defining the 2 preferred options.	Preferred provider to be identified. Access to capital to put these options into delivery
			Ensure the whole cancer centre meets all mandatory and statutory requirements for excellent cancer services to include CHKS, IRMER, ARSAC and a 'Good' CQC rating			Hospital Director / Divisional Chair/ clinical director / Head of Nursing	CHKS surveillance visit completed. Draft report suggests full compliance and accreditation of ISO 9000 standard. CQC visit scheduled for July 2019.	The uncertainty of the future of MVCC's and risks associated with sustainability may influence the findings of CQC.
			In conjunction with other providers in the STP support the rollout of FIT in the bowel cancer screening programme and the IT infrastructure to support movement of stratified pathways for breast	Roll out complete			From Year 2	
			Continue to grow ENHT rapid assessment and diagnostic pathways for lung, prostate and colorectal cancers, ensuring that patients get timely access to the latest diagnosis and treatment	Pathways reviewed and changes implemented			From Year 2	
			Strengthen the academic research portfolio for our chosen tumour pathways, including clinical trials	Research culture embedded; research and trials increased			Overall increase in patients recruited into trails, and new trials opened. Continue to strength the relationship with UCLH.	
			Introduce nurse and pharmacist led	Patient			2 ACPs and 2	

			prescribing to improve / increase capacity	satisfaction, complication management, service availability and accessibility							prescribing pharmacists. Each with	

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Establish strategic partnerships to maximise commercial opportunities for long term sustainability and better patient outcomes			Establish partnerships to provide a specialist manufacturing service from the Lister Pharmacy Aseptic Unit for specialist chemotherapy, trial drugs and novel substances to other organisations across the STP and beyond	Potential partners identified, assessment undertaken and partnership established		Head of Business Development	Plans being developed for the refit of Lister Aseptic Unit. At present will serve MVCC and Lister. Dose-banded work to be tendered at ned of July 2019.	Identifying solution within capital envelope. Timescales are tight, but currently achievable
			Work with BMI at MVCC to develop a private cancer referral pathway on site	Private cancer referral pathway established and running successfully		Hospital Director	Early discussions.	
			Explore opportunities to link with companies to commercially provide patient specific devices made in biomedical engineering	Plan in place			From Year 2	
			Establish a Clinical Trials Unit.	Plan in place; clinical trials unit established			From Year 2	
			Explore option for partnering with commercial producer of PET radiopharmaceuticals with the ability to produce PET radiopharmaceuticals using radionuclide generators on site e.g. Production and supply of Ga68 for PET cancer imaging to PSSC and other PET imaging providers within a 1 to 1.5 hour travel radius from site	Potential partners identified, assessment undertaken and partnership established			From Year 2	
			Redesign the chemotherapy authorisation and procurement pathway in order to secure a reliable, responsive and sustainable source of aseptic chemotherapy doses	Pathway redesigned and reliable source in place		Head of Nursing / Senior Site Manager and Business Management	Completed for both LMC and MVCC	

										Pharmacist		
			Develop strategic partnerships with commercial aseptic units in order to introduce a “managed inventory model” for ready to use and dose banded chemotherapy	Potential partners identified, assessment undertaken and partnership established							From Year 2	

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Become the Regional Centre for Excellence in Specialist Services (to include Immunotherapies, Nuclear Medicine, Radiation Protection and Aseptic Services)			Provision of a centralised radiopharmacy services to a larger number of customers (as per DoH /BNMS guidance) to explore opportunities to acquire services from other smaller providers e.g. Northwick Park	Plan in place			From Year 3	
			Fundraise for SPECT/CT, possibly in conjunction with charitable partners. To ensure that the cancer centre has state of the art imaging capability and can provide radiation dosimetry for all radionuclide therapies (as per new IRMER regulations)	Plan in place		Hospital Director	Awaiting confirmation from ENH charity lead to progress with fundraising appeal	
			Support and manufacture theranostics for cancer treatment	Plan in place			From Year 2	
			Engage with providers of nuclear medicine training programs / apprenticeship schemes for healthcare scientists and practitioners to ensure adequate workforce for the future	Plan in place		Hospital Director	NHSi lead identified. Awaiting approval of TOR and schedule 1:1 meetings with respective service leads.	
			Discuss with breast / plastic surgeons the introduction and repatriation of sentinel node imaging for breast and melanoma in line with NICE Guidance	Plan in place		Hospital Director	Radiology training completed. Equipment ordered. Awaiting completion of radiopharmacy upgrade; scheme can then progress to delivery	
			Obtain MHRA Manufacturers Investigational Medicinal Products (IMP) Licence to produce and supply novel diagnostic and therapeutic radiopharmaceuticals for use in research trials at MVCC and other organisations	Plan in place; licence obtained			From Year 3	

Clinical Support Services Division's Strategic Clinical Priorities Highlight Report
Reporting Period: Quarter 1

No.	STRATEGIC CLINICAL PRIORITY	OVERALL CONFIDENCE RATING	Progress vs 2019/20 plan	Risks	Items to note / for discussion	Items to escalate? Y/N
1.	Deliver a better patient experience by seeking to undertake all diagnostics only once, unless clinically indicated otherwise, working with primary care to ensure easy sharing of results across the health system.				• Phase 1 of order comms ICE upgrade completed • Outpatient Board implemented	N
2.	Develop a radiology strategy and enabling funding strategy to ensure appropriate capacity to sustainably meet demand, by critically assessing working arrangements, capital requirements, technological solutions, existing physical capacity and future demand drivers.				• HCH Plain film and MRI refurbishment delivered • Wave 5 plans being developed to support Radiology imaging bid • Capital constraints and national radiology workforce challenges remain a risk	Capital availability Radiology workforce shortages
3.	Deliver the pharmacy transformation programme, securing high quality services, to enable effective patient flow through wards and clinics.				• Roll out of Ward based Pharmacy to 9 wards with 8 NMPs now in place • Secured capital funding to refurbish Lister Aseptics, design work ongoing	N
4.	Ensure the future provision of high-quality, cost-effective pathology services, working collaboratively with STP partners to establish an STP pathology network.				• Playing key role in STP project • Ensuring implement lessons from TPP • Supporting colleagues through fortnightly comms • Working towards July 2020 contract award	N
5.	Work with STP partners to develop a sustainable model for Interventional Radiology across the STP which will meet Trust and STP expectations of future requirements.				• work ongoing with project team to support vascular hub and development of IR services	N

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Deliver a better patient experience by seeking to undertake all diagnostics only once, unless clinically indicated otherwise, working with primary care to ensure easy sharing of results across the health system.			Optimise and develop order-comms system to exploit opportunities for improving protocols, processes, reducing variation, improving functionality and productivity.	Plan in place; order-comms fully optimised; reduced variation		LC	Phase 1 software upgrade (ICE) delivered in May 2019 Phase 2 : now in project planning stages	PMO lead required
			Streamline pathways in haematology for referrals, investigations, and clinic scheduling to improve quality and ease of use for patients.	Pathway redesigned; clinic scheduling improved		NS/JH	Implemented Advice and guidance, with robust monitoring and compliance Full clinic template review now undertaken Review of cancer pathway undertaken and identified opportunities to streamline pathways	Workforce challenges-business case being developed to support new ways of working including the recruitment of CNS to undertake op activity and some procedures
			Work with primary care to ensure the easy sharing of diagnostic results	Plan in place		NS	Inputting into STP interoperability workstream to support link between ENHT and primary care systems	
			Develop a model of outpatients that allows the Trust to be in the top X% of benchmarked peers in terms of productivity, to improve quality and ease of use.	Peer review		JMc	Implementation of outpatient board Introduction of two way text reminder with positive results Suite of KPI's have been worked up and approved through OP Board, next action to develop monitoring tools for KPIs	Data quality Information/qlikview development resource
			Improve use of digital systems in line with our stabilisation programme to support service improvement and reduce wastage (for example, in bookings, records, and appointment management).	Cancelled clinics; rebooked appointments		JMc	Working with new CIO to ensure all services represented in digital strategy	Capital constraints

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Develop a radiology strategy and enabling funding strategy to ensure appropriate capacity to sustainably meet demand, by critically assessing working arrangements, capital requirements, technological solutions, existing physical capacity and future demand drivers.			Develop a radiology strategy: • Review current and predicted future demand and capacity across all services • Explore options for approach to provision • Develop preferred model for delivery and workforce • Work with STP to develop wider network elements	Assessment undertaken; preferred plans developed; strategy in place		NS/SC	D&C work undertaken with NHSI Introduction of urology one stop Carve out CT capacity provided for endoscopy to improve pathway	Need to develop STP approach to Radiology services
			Underpin service sustainability with a resourced forward plan for equipment provision and maintenance, balancing in-house (purchase or lease) with managed service options; identify capital implications to inform Trust capital programme.	Plan in place		NS/SC	2018/19 New HCH x-ray and Lister MRI refurbishment completed with charitable support Options currently being worked through to support equipment replacement plan	Availability of capital funding
			Write business cases for urgent short term capacity area: plain film X-Ray in ED	Business plan approved			To be included in Wave 5 submission	Availability of capital funding
			Extend access to services: 24/7 access to IR (including link to Vascular development) 7-day access for MRI	Access in place		KS SC	Working with Vascular hub project to secure robust workforce options to deliver 24/7 service and physical space to deliver our future IR service Scoping clinical pathway to support 7 day MRI, aim to present case	Clinical engagement across network to support rotas
			Identify opportunities for new roles / crossover roles in all specialties, under-pinned by training and development of staff, to reduce reliance on medical staffing and improve quality, e.g. reporting radiographers	Training plan in place; new roles identified; pipeline for training and recruitment understood and in place		NS	Job planned reporting radiographers in place, training budget allocation to support upskilling sonographers to complete more complex scanning and radiographers in administering injections. Review of associate mammography posts ongoing	National Shortage of radiographers/sonographers

			Introduce / extend home reporting for radiology	Home reporting in place						NS	Hardware delivered, with PACs upgrade due to take place in September, with full training programme and then a phased roll-out into consultants homes	Trust IT software issues to be resolved

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Deliver the pharmacy transformation programme, securing high quality services, to enable effective patient flow through wards and clinics.			Complete tender and out-sourcing of production functions in pharmacy to secure sustainable services.	Tender complete		AH	Capital funding received to refurbish Lister aseptics (£750K) In design phase Tender process for dose banded chemotherapy to commence from 22 July 2019	Project group including estates, finance, cancer, strategy and pharmacy meets on a weekly basis Aim the refurbished Lister aseptics unit to prepare Trust patient specific doses by 1 April 2020 Risks – affordability of design and timescale to deliver project
			Explore dispensing of outpatient prescriptions through partnerships with community pharmacies to release in-house capacity.	Plan in place			From year 2	
			Implementation of e-prescribing in pharmacy to deliver consistent quality and ease of use: • Secure funding and support • Implementation	E-prescribing in use		AH	Unsuccessful bid for NHS digital matched funding (Jan 2019) New workstream to implement e-prescribing is in the process of being developed – timescales to be confirmed Clinical Approvals Group has been set up (first meeting 24 July 2019)	
			Implement workforce redesign elements of Pharmacy Transformation Plan: • Roll out ward-based pharmacists across the Trust to reduce length of stay and improve medicines management. • Train 6 non-medical prescribers per year for 3 years to improve practice and release scarce medical time. • Develop PSW roles on wards to release pharmacist time. • Develop Advanced Practitioner roles	Ward-based pharmacists on wards; training plan in place; STP options explored		AH	Ward based pharmacy has been rolled out to 9 wards There are 8 NMP Pharmacists transcribing TTAs and on average 150 TTAs are written per week Average bed savings of	

			• Develop specialist and integrated pharmacy roles and service across the STP.								5 bed days per day A joint hospital pharmacist/PCN role is being developed	
			Improve prescribing practice with guidance and improved management of discharge medication and prescription-only medicines (POMs).	Improvement in number of discharges without medication						AH	New Lorenzo discharge Template launched across the Trust Clear process of approval by doctor and verification by pharmacist has been introduced	

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Ensure the future provision of high-quality, cost-effective pathology services, working collaboratively with STP partners to establish an STP pathology network.			Complete and implement STP review of pathology, ensuring that it is appropriately scoped and that implications for out-of-scope services are identified and addressed appropriately. (For more detail on this programme of work, refer to STP Pathology review.)	Review completed. Work commenced on procurement.		CM/TW/ SB	5 x work streams now place with ENHT well represented on all, feeding into the programme board Fortnightly staff communication process in place	Key stakeholder engagement across STP, Executive Lead
			Introduce / extend home reporting for radiology and pathology	Plan in place.		NS	Hardware delivered, with PACs upgrade due to take place in September, with full training programme and then a phased roll-out into consultants homes	Trust IT software issues to be resolved
			Develop inpatient service for haematology (links to priorities in Cancer and Medicine Divisions)	Service introduced		NS	Bed space identified and meetings scheduled to review flow and job plan changes required	Workforce not sufficient to support extended role
			Develop Advanced Practitioner roles in haematology	Plan in place; new roles in staffing mix		NS	Developed JD for CNS following review of model with nursing leadership team Business case in development to support new workforce model proposals	
			Link with West Herts and Cambridge to establish rotational training grade in haematology	Discussions held; plans in place			From year 2	

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Work with STP partners to develop a sustainable model for Interventional Radiology across the STP which will meet Trust and STP expectations of future requirements.			Extend access to services: • 24/7 access to IR (including link to Vascular development)	24/7 access in place		KS	Working with Vascular hub project to secure robust workforce options to deliver 24/7 service	Clinical engagement across network to support rotas
			Business cases for IR recovery area written and approved	Business case written and approved		KS/JC	Design options being work through to support 24/7 IR service Architect drawings complete and charitable funding committed in conjunction with committed spend from vascular hub	
			Identify opportunities for new roles / crossover roles in all specialties, under-pinned by training and development of staff, to reduce reliance on medical staffing and improve quality.	Opportunities identified; training plan in place		NS/JC	Job planned reporting radiographers in place, training budget allocation to support upskilling sonographers to complete more complex scanning and radiographers in administering injections. Review of associate mammography posts ongoing	National Shortage of radiographers/sonographers

Medicine Division's Strategic Clinical Priorities Highlight Report
Reporting Period: Quarter 1

No.	STRATEGIC CLINICAL PRIORITY	OVERALL CONFIDENCE RATING	Progress vs 2019/20 plan	Risks	Items to note / for discussion	Items to escalate? Y/N
1.	Provide consistently high quality urgent and emergency care by : a) reviewing and revising the medical inpatient model to ensure that every patient is admitted under the care of the most clinically appropriate specialty with inter-specialty support as required; b) optimising the use of ambulatory and outpatient models of care to avoid unnecessary hospital admissions and enable patients to be cared for in their homes				a) Medical take project proposals in development currently, PMO support identified. Risk related to recruitment to consultants in acute medicine including leadership role b) SDEC proposals supported by CCG, mobilisation plan currently being drafted	Y
2.	Work collaboratively with system wide partners within the STP to promote self-care and to ensure standardised pathways for the management of long term conditions to help reduce emergency attendance, with a particular focus on: • Frailty • Diabetes • Respiratory				Extension to frailty assessment to increase provision to 70 hours is in progress	N
3.	Deliver outpatient services effectively, improve ease of use and make best use of resources (e.g. maximising use of nurse-led clinics), introducing new models of delivery (such as telemedicine) and moving activity to primary care and self-management where clinically possible.				Limited progress	N
4.	Secure sustainability by working with the STP, reducing reliance on locum staffing and finding alternatives to the medical model, through innovative staffing structures, training and development, with a particular focus on: • Elderly medicine • Dermatology/Skin Health • Neurology				Limited progress	N
5.	Ensure all services are clinically and financially sustainable, working with the STP as appropriate, with rigorous focus on challenged specialties, including: • Renal • Diabetes / Endocrinology • Dermatology/Skin Health				Require PMO support	Y

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Provide consistently high quality urgent and emergency care by : **a) reviewing and revising the medical inpatient model to ensure that every patient is admitted under the care of the most clinically appropriate specialty with inter-specialty support as required;** **b) optimising the use of ambulatory and outpatient models of care to avoid unnecessary hospital admissions and enable patients to be cared for in their homes**			**Urgent care:** Establish "Emergency Village" (as per Model Hospital) to improve quality, outcomes and patient flow: • Establish effective bed bureau to ensure bed state managed in the optimal way • Ring-fence assessment capacity to eliminate unwarranted delays in assessment and direction to appropriate service. • Maximise ambulatory care, aiming to reach X % ambulatory by 2022 • Deliver "direct to specialty" care, to provide the optimum expertise for every patient, including: o Hot clinics o Review balance of inpatient capacity to match patient need • Continue to build new pathways and embed new ways of working to secure sustainability in line with STP plans and aspirations	Emergency Village established; meeting 4 hour target; bed wait from DTA reduced; use of ambulatory care increased; hot clinics established; review completed on inpatient specialty requirement and changes made to bed allocation		SM, BS, CM	a) The transformation of inpatient care requires a significant change to the way the medical take is managed and staffed and also the engagement of the site office/bed managers. This projectis being intiated in September b) The SDEC proposals have been agreed and CCG is supportive of approach and revised tariff. Mobilisation plan currently being drafted	• Clinical engagement • Site office and bed management engagement • Workforce – new ways of working and recruitment to posts, particularly consultants in acute medicine • IT to support new models
			Extend specialty support to other specialties, including: • Elderly care input (such as that offered in the ortho-geriatrics service) to a wider range of	SOP in place for management of patients; LoS reduced; number of medical		CR&JL	Discussion with planned care colleagues ongoing. POPs consultant post currently out to advert	• Surgical engagement • Workforce – recruitment to POPs consultant post

			surgical patients. • Extending Neurology support (e.g. hot clinics to reduce unnecessary admissions) • Cardiology input to non-cardiology ward extended to 6 days.	outliers reduced					PW&CS NK&CS	Neurology and cardiology new models approved and currently out to recruitment. Plan to initiate new pathways from November/December once posts recuited to	• Long term funding for POPs.

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Work collaboratively with system wide partners within the STP to promote self-care and to ensure standardised pathways for the management of long term conditions to help reduce emergency attendance, with a particular focus on: **• Frailty** **• Diabetes** **• Respiratory**			Work with STP to standardise patient pathways, removing unwarranted variation, particularly in: Frailty Diabetes Respiratory Cardiology	Pathways revised and implemented; reduced LoS; reduced admissions		CDs	Frailty proposals for 70 hour provision approved and mobilisation plan being drafted.	Workforce recruitment
			Define a Divisional priority plan for extending pathways into the community, based on an assessment of each specialty's current position and potential (to avoid risk to quality of existing services).	Divisional plan written		CDs	For discussion at Divisional board in September 19 to agree priority pathways	
			Pursue priority areas for pathway extension where pathway already established and ready to roll out: STP Frailty pathway Acute Kidney Injury (AKI) pathway	Frailty and AKI pathways rolled out; reduced LoS; reduced admissions		CB AF	AKI pathway embedded, 40 hours already provided, working on provision of 70 hours	
			Pursue other areas for pathway extension, as defined in above Divisional priority plan	Pathway plans in place; reduced LoS; reduced admissions			From Year 2	
			Work with system partners to co-design and optimise pathways for OPAT (outpatient antibiotic therapy), to reduce unnecessary admissions and improve quality and outcomes.	Pathway redesigned and in place; reduced admissions; better QoS		AG	OPAT audit currently underway to establish baseline and size of opportunity	

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Deliver outpatient services effectively, improve ease of use and make best use of resources (e.g. maximising use of nurse-led clinics), introducing new models of delivery (such as telemedicine) and moving activity to primary care and self-management where clinically possible			Actively engage in the Outpatient Transformation Project (part of Model Hospital) to co-design models and improve ease of use, resource utilisation and quality of care.	Use of Seeker embedded in Division; review of outpatient activity demand and capacity completed			Demand and capacity work yet to be completed.	Contact Centre capacity to deliver
			Contribute to Contact Centre redesign, to ensure that all clinic scheduling is optimised to match the specific clinical needs of individual specialties.	Redesign completed			Contact centre redesign requires further review	
			Identify successful examples within the Division of new models, including virtual clinics and telemedicine, and use lessons learned to extend elsewhere (for example, virtual fracture clinic in ED).	Plan in place			Diabetes proposal with execs. Cardiology have developed a proposal for virtual clinics, awaiting approval. Specialty Transformation workshops established in September for further discussion	
			Work with STP Planned Care workstream re. provision of and appropriate use of advice and guidance, both telephone and letter, and moving activity to primary care and self-management where clinically possible	Plan in place; use of advice and guidance increased with corresponding decrease in referrals				
			Extend the range of multi-disciplinary outpatient clinics, including “one-stop shops” to improve ease of use.	Number of multi-disciplinary clinics increased; reduced internal referrals			Part of workshop to identify new opportunities	

Clinical Priority	RAG Previous period	Rag This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Secure sustainability by working with the STP, reducing reliance on locum staffing and finding alternatives to the medical model, through innovative staffing structures, training and development, with a particular focus on: • Elderly medicine • Dermatology /Skin Health • Neurology			Identify new medical staffing model to deliver Emergency Village (see Objective 1); explore alternative approaches to junior and middle grade staffing (e.g. Physician Assistants in elderly medicine, training posts / MTIs in stroke services).	New staffing models identified for use in each specialty			Workforce plan for new model requires further ACPs, consultant and nursing posts.	
			Develop workforce planning tools to allow a more sensitive matching of staffing with workload	Planning tools developed			From Year 4	
			Map current non-medical workforce and identify opportunities for new roles / crossover roles, under-pinned by training and development of staff, to reduce reliance on scarce medical staffing and improve quality. Examples may include extending the use of: • Specialist Nurse roles in Neurology (MS and epilepsy) • Specialist Nurse roles in Rheumatology • Specialist Nurse roles in Elderly Medicine • ACPs in ED	Mapping completed; plans in place for recruitment of alternative staffing roles			New lead ACP post appointed to take forward development of this key workforce. Once D&C activity modelling complete, we will agree workforce required to deliver revised pathways.	

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Ensure all services are clinically and financially sustainable, working with the STP as appropriate, with rigorous focus on challenged specialties, including: • Renal • Diabetes / Endocrinology • Dermatology /Skin Health			Swift resolution of future for Dermatology / Skin Health – either STP solution or link with Plastics	Plan in place			Ongoing discussion at STP	
			Develop a sustainable model for Renal services across the main Trust sites and satellite locations.	Model in place				
			Develop strategic partnerships in order to strengthen the overall sustainability of, and local access to, cardiology services within the STP.	Improved local accessibility to cardiology service within STP			New partnership being developed with Barts	
			Address clinical sustainability issues in acute medicine through Emergency Village development (see objective 1)	Acute medicine assessed as clinically sustainable			Workforce a key enabler, particularly ACPs and acute consultants	
			Address clinical sustainability issues in Elderly care through workforce initiatives (see objective 4)	Elderly care assessed as clinically sustainable			Development of frailty workforce – ACPs and consultants	
			Address financial sustainability issues in challenged specialties – current analysis suggests these include Diabetes / Endocrinology, Elderly Medicine and Rheumatology	Contribution %				
			Review progress with delivering GIRFT recommendations. Develop, agree and deliver plan to implement remaining actions to optimise expected benefits.	Plan in place and being delivered			GIRFT action plans being developed for specialties that have had a review	

Surgical Division's Strategic Clinical Priorities Highlight Report
Reporting Period: Quarter 1

No.	STRATEGIC CLINICAL PRIORITY	OVERALL CONFIDENCE RATING	Progress vs 2019/20 plan	Risks	Items to note / for discussion	Items to escalate? Y/N
1.	Consistently deliver high quality, compassionate care across all services.	⇔	⇩	⇔	225 days since our last Never Event	N
2.	Enhance the accessibility, efficiency and capacity of planned surgical services to meet demand and facilitate repatriation of services provided for local patients in the independent sector.	⇔	⇔	⇔	Trauma & Orthopaedics Redesign paper includes VFC starting September 2019 SSDEC implementing in August/September	N
3.	Deliver the best possible care, experience and outcomes for trauma and emergency patients from their arrival to discharge by comprehensively reviewing and improving emergency surgery and trauma services. Further pathway work to support frail patients.	⇔	⇔	⇔	Trauma & Orthopaedics Service Redesign paper SSDEC paper	N
4.	Optimise theatre and bed utilisation to ensure delivery of activity is as efficient as possible; make delivery of day case surgery the norm rather than the exception.	⇔	⇔	⇔	Theatre reconfiguration IFD- A3 proposal to close half a ward (fifteen beds)	N
5.	Offer a flexible, stimulating environment to develop and work within in order to provide a sustainable, highly engaged workforce able to meet patients' needs.	⇔	⇔	⇔	New internal meeting schedule that includes two way communication Skill mx reviews	N

Clinical Priority	Previous period	This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Consistently deliver high quality, compassionate care across all services.			Develop and deliver a comprehensive quality programme which will improve quality, safety and patient experience by focussing on and embedding the basics of care.	Achieve and sustain a Good CQC rating by 2020. Quality programme in place, including patient satisfaction, complication management, mortality, length of stay and unplanned re-admissions.				
			Review progress with delivering GIRFT recommendations. Develop, agree and deliver plan to implement and embed remaining actions to optimise expected benefits.	Plan in place		Liz Ball/Luke Casey/	Divisional GIRFT delivery programme (all specialties) – discussed at Divisional Board	Priorities for funding to be identified and agreed
			Lead a review of quality and safety of PEG insertion service. Implement any recommendations.	Review concluded. Plan in place for implementation of recommendations				
			Enhance patient safety and service efficiency in Anaesthetics and ICU by developing and implementing business cases for paperless records in Anaesthetics and ICU.	Business case developed and approved. Plan in place for delivery		Liz Ball	Business Case completed, not planned for 2019	Priorities for funding to be identified and agreed IT
			Improve patient experience and prevent long term adverse health impacts by developing and implementing an ICU Survivor Programme	Plan developed and implemented			From year 3	

Clinical Priority	Previous period	This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Enhance the accessibility, efficiency and capacity of planned surgical services to meet demand and facilitate repatriation of services provided for local patients in the independent sector			Improve patient experience and reduce service costs by streamlining outpatient pathways and introducing efficient service models which will sustainably deliver all national standards and offer referral times that benchmark equitably with those offered by surrounding providers, including One Stop clinics and patient-initiated follow ups (e.g. in Ophthalmology, General Surgery (laparoscopic) & Urology)	RTT First OPA waiting times NP:Fup Service costs		Michele Murphy/ Liz Ball/Luke Casey	T & O Service Redesign paper complete Urology One Stop Clinics set up Workforce redesign signed off, currently out to advert to complete recruitment.	Priorities for funding to be identified and agreed Failure to deliver efficiencies due to lack of space Inability to recruit
			Work with STP partners to improve accessibility and sustainability of services within the STP including: •Vascular Surgery: develop and agree an OBC and FBC to develop a STP Vascular Surgery Network with hub at Lister Hospital. •Paediatric ophthalmology •Paediatric urology •Lithotripsy	Plan in place			STP Vascular Surgery Development Board in place with good pan-organisational engagement. OBC being developed with options appraisal. Capital funded allocated under STP Wave 4	Highly complex business case – challenging project timetable linked to capital availability
			Work with STP to remove variation from clinical pathways, particularly gastro and gall bladder	Plan in place; pathways redesigned and standardised		Liz Ball/Luke Casey	Straight to Test implemented Emergency gall bladder covered within SSDEC paper	Capacity shortfall (space & resource) Failure to recruit
			Develop and deliver a phased plan to repatriate planned care undertaken in the independent sector back to the Trust including: •Ophthalmology •Orthopaedics •Gastroenterology incl Endoscopy	Plan in place; work repatriated; Market share; Income		Liz Ball/Michele Murphy	Ophthalmology and T & O plan complete include repatriation element	One off costs to support redesign with different workforce models may prove prohibitive (T & O)
			Ensure the future sustainability and quality of the breast surgery service by developing a sustainable service model and pathways which provide a consistently high quality, timely experience for patients.	Service model designed and in place; quality and access time measures in place		Liz Ball/Luke Casey	Breast GIRFT visit July 2019 - recommendations to support service redesign	Not yet known

Clinical Priority	Previous period	This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Enhance the accessibility, efficiency and capacity of planned surgical services to meet demand and facilitate repatriation of services provided for local patients in the independent sector (continued)			Plastic Surgery will actively contribute to ensuring a sustainable, high quality dermatology /skin health service model for local patients by: •co-designing and supporting delivery of a high quality local dermatology service with other specialties and partners •Assessing the benefit and sustainability of offering Mohs micrographic surgery (MMS) and Sentinel Node Biopsy service within the Trust and for skin cancer	Assessment concluded and action plan in place			Division undertaking review of feasibility of Dermatology moving under the umbrella of Plastic Surgery .	Space and resource
			Enhance the financial sustainability and quality of head and neck services. Review Trust OMFS requirements, identify preferred partner and agree new service contracts/SLAs to deliver.	Review conducted; preferred partner identified; SLA				
			Ensure timely access to colonoscopy. Redesign pathways to meet demand and provide high quality patient experience including: - respond to changes in demand following the roll out of FIT - co-design and implement a Straight to Test model for colonoscopy	Access times; RTT; pathway redesign and implementation; straight to test model implementation; Market Share; Patient Experience		Luke Casey	STT has been put in place with a RAS to support this. D&C modelling and more efficient ways of using the theatre times being looked at.	D & C modelling will show a shortfall of both physical and manpower resource – solutions to address to be identified
			Improve patient care, outcomes, experience and mortality by assessing the benefits and sustainability of offering gastroenterology fibroscan as an alternative to liver biopsy.	Quality programme in place, including patient satisfaction, complication management, mortality, length of stay and unplanned re-admissions.		Luke Casey	Action plan created	

Clinical Priority	Previous period	This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Deliver the best possible care, experience and outcomes for trauma and emergency patients from their arrival to discharge by comprehensively reviewing and improving emergency surgery and trauma services. Further pathway work to support frail patients.			Provide a consistent high quality, sustainable trauma service by: •Developing and implementing a Trauma Strategy. •Reviewing and revising the Hand Trauma service and workforce model •Improve Fracture Clinic efficiency and patient experience by implementing virtual fracture clinics	Patient satisfaction, mortality, length of stay and unplanned re-admissions. National Hip Fracture Database demonstration of improvement. Fracture Clinic costs		Liz Ball/Michele Murphy	T & O Redesign paper Virtual Fracture Clinic Business case in progress for Hand Trauma Service	Priorities for funding to be identified and agreed IT support
			Agree and implement a new service model to provide sustainable 7 day eye casualty and urgent eye services to meet local needs.	Patient satisfaction, service availability and accessibility		Michele Murphy	Service redesign in progress	Recruitment
			Continuously improve the management and quality of emergency surgical care by : •Fully integrating emergency surgery into the ED, ensuring that surgical decision-making occurs promptly after arrival. •Reviewing the impact of the consultant of the week model and the potential benefits of extending the model to other surgical specialties. •Developing and implementing proposals to sustainably optimise theatre availability for emergency surgery, without adversely impacting planned care •Developing Hot Clinic and ambulatory pathways to provide sustainable alternatives to ED attendance.	Time for ED patients to be placed on emergency surgery pathway Achievement of ED standard for surgical patients Patient satisfaction, length of stay, outcomes, unplanned re-admissions LoS; Access to Surgery; Theatre utilisation ED attendances		Liz Ball	SSDEC paper complete supporting the 4th Emergency consultant enabling suitable cover on SAU supporting ED flow and emergency Surgery in a. Controlled fashion, T start date, August/September 2019	Recruitment

Clinical Priority	Previous period	This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Optimise theatre and bed utilisation to ensure delivery of activity is as efficient as possible; make delivery of day case surgery the norm rather than the exception.			Benchmark and model theatre capacity required to meet expected demand to 2024, whilst demonstrating increasing efficient utilisation.	Benchmarking and modelling completed		Liz Ball	In progress	
			Implement revised theatre session patterns and timetable in order to meet demand and optimise use of available capacity.	Demonstrable progress towards upper quartile theatre performance as measured by Model Hospital.			From year 2	
			Model longer term theatre configuration and capacity requirements to inform Estates Strategy. Assess impact of alternative options including innovative anaesthetic models on future capacity requirements.	Longer term theatre planning completed and requirements fed into Estates strategy.				
			Following modelling work for theatre configuration, agree medium to long term plan to provide theatre capacity required. Develop and submit a business case for the redevelopment of and / or increase in theatres.	Modelling work completed; business case developed and submitted, with agreed timescales for completion.		Liz Ball	From year 2 Business case complete	
			Release acute site theatre and ward space, improve patient access and strengthen community-based MDT service models by relocating and integrating pain services within locality teams.	Plan in place; patient experience			From year 2	
			Achieve and sustain a significant increase in day case rates by developing a regional (nerve block) anaesthesia service to release theatre capacity.	(BADS) day case rates; LoS Patient		Luke Casey/ Michel Murphy/	DC rates have increased in larger proportion to EL operations from 17/18 to	None identified

				Experience; Implementation and delivery of benefits for theatre availability						Liz Ball/Gavin Bacon	18/19, ongoing reviews	

Clinical Priority	Previous period	This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Optimise theatre and bed utilisation to ensure delivery of activity is as efficient as possible; make delivery of daycase surgery the norm rather than the exception (continued)			Benchmark and model bed capacity required to meet expected demand to 2024, whilst demonstrating increasing improved LoS and day case rates.	(BADS) day case rates; LoS; Patient Experience				
			Reassign inpatient bed capacity according to specialty needs to meet demand and efficiency levels.	(BADS) day case rates; LoS; Patient Experience				
			Develop, agree and implement a sustainable and appropriately staffed Enhanced Recovery Programme across all surgical specialties to reduce LoS, improve quality and enhance patient experience.	Enhanced Recovery Programme implemented; QoS; LoS; Patient Experience			Trust wide Enhanced Recovery programme. Business case for Division complete shared with Sue Wilkinson	
			Review the model and use of ITU beds. Develop, agree and implement a sustainable model going forwards which supports support optimal length of stay, flow, use of ITU beds, patient outcomes and experience.	ICNARC incl LoS, outcomes, access to ITU		Jon Bramall/ Wendy Collier	In progress	

Clinical Priority	Previous period	This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Offer a flexible, stimulating environment to develop and work within in order to provide a sustainable, highly engaged workforce able to meet patients' needs			Mitigate the potential adverse service impact on service quality and sustainability as a result of a future reduction in trainee doctors by: •Develop and deliver a plan to achieve Royal College of Anaesthetics Accreditation •Developing and implementing a business case for a Hand Fellow role and hand Therapists to clinically sustain and qualitatively enhance the hand surgery service •Deliver consistent, sustainable service quality and mitigate risks related to the availability and allocation of trainee doctors by achieving Guidelines for the Provision of Intensive Care Services (GPICS) in ICU	Impact understood and plan in place; QoS, mortality			Service Redesign takes account of potential adverse impact on reduced trainees from Deanery by use of alternative workforce models Hand Fellow mentioned earlier Accreditation review not yet started	
			Developing and implementing alternative non medical and enhanced roles.	Impact understood and plan in place; QoS, mortality			Part of service redesign and workforce models	
			Ensure service quality and sustainability by proactively developing a divisional consultant supply forecast to inform recruitment, retention and succession planning for all consultant posts. Develop divisional workforce plan and deliver.	Impact understood and plan in place; ongoing recruitment		Liz Ball/Paula Bailey/Kely Cooper	Trajectories being worked on, planned retirements etc	
			Enhance service quality and workforce recruitment & retention by developing and delivering a divisional plan to expand and increase research activity across all surgical specialties to raise skill sets, enrich job roles and benefit patients.	Plan in place				

Women & Children's Division's Strategic Clinical Priorities Highlight Report
Reporting Period: Quarter 1

No.	STRATEGIC CLINICAL PRIORITY	OVERALL CONFIDENCE RATING	Progress vs 2019/20 plan	Risks	Items to note / for discussion	Items to escalate? Y/N
1.	Achieve an outstanding CQC rating for our services by transforming services in line with National Ambitions and Drivers to improve outcomes				Investment in staff and equipment Non-recurrent funding from LMS	Y Non recurrent funding
2.	Ensure services are at a scale to deliver long-term clinical and financial sustainability				New fertility consultant appointed. Looking to widen paediatric haematology to include sickle and thalassaemia.	N
3.	Protect market share and grow birth numbers by delivering Better Births Ambition and maintaining the quality and reputation of our services				Continuity of Carer – issue finding staff wishing to work to this model. ENHT have strong participation in LMS	N
4.	Deliver consistent, high quality care and ensure patients receive the most appropriate care for their condition, from those most clinically appropriate to deliver it, and in the most appropriate setting				PNMH midwife in post but this in non-recurrent funding from LMS	Y Non-recurrent funding
5.	Develop and establish Private Patient Services, offering greater choice to our local community and improving financial sustainability				Women's services progressing well and scoping Children's. Marketing and IT support required for website to allow online bookings and payment	N
6.	Create a sustainable workforce by becoming 'Employer of Choice' for our Services, helping reduce challenges of retention and recruitment				Work commenced on exploring expanded roles / increased skillsets for nurses. Work ongoing within Division on culture	N

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Achieve an outstanding CQC rating for our services by transforming services in line with National Ambitions and Drivers to improve outcomes			Improve outcomes for women and children by implementing the national safety agenda: MatNeo/Attain/Saving Babies Lives/Each Baby Counts /PReCePT/PMRT/	Mortality		KC, MD	Making clear progress on these maternity safety drivers. LMS deliverables agreed for 19/20	
			Embed the Better Births Ambitions	Maternity survey, e-referral data, Monitoring, Local Maternity System Governance			Birthrate plus paper presented to board. Next action to be agreed. LMS to fund three midwives for 12/12 for CoC	Investment in staff and equipment required to meet this strategic aim
			Develop a safety culture across the Local Maternity Systems by imbedding the Human Factor Philosophy and multi-professional training through a safety collaborative	Training completes and embedded			MDT training across LMS to be implemented still. LMS wide safety forum in place, meets monthly	Ability to release staff for training.
			Develop a perinatal mental health service and Continuity of Carer pathway for vulnerable women	Perinatal mental health service and continuity of carer in place for 51% of women by 2021.			PNMH midwife in post for 12 months funded by LMS. To develop a case for change to be presented to board	Funding from LMS non-recurring. Additional funding required to pay for staff
			Community hubs to be established, where maternity services, particularly ante- and postnatally, alongside other family-orientated health and social services provided by statutory and voluntary agencies. Community hubs should work closely with their obstetric and neonatal unit(s)	Community hubs established			Early stages of development. For example Diamond Team have identified a Consultant lead for continuity of care. Continuity of care strategy being written for 2020 to achieve 35 % CoC	Lack of resources

			Right staff in the right place with the right skills; ensuring correct staff to birth ratios	Staff to birth ratios							Birth rate plus report done and presented to board	Funding requirement for uplift.
			Improve the appropriateness of referrals to Urogynaecology so that patients present to secondary care only after all community based interventions have failed	Number of rejected referrals						Uro gynae CD	NHSI 100 day challenge. STP/CCG meetings	

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Ensure services are at a scale to deliver long-term clinical and financial sustainability			Establish specialty clinics in both Children's and Gynae in order to protect and grow market share	Specialty clinics established and promoted; market share		Gynae CD	Endometriosis clinic set up. New fertility consultant appointed. Looking to widen paediatric haematology to include sickle and thalassaemia. Increasing allergy services.	Need additional allergy nurse and haematology nurse
			Establish endometriosis clinic and gain centre accreditation and British Society of Urogynaecology (BSUG) accreditation	Endometriosis Accreditation 2019 BSUG Accreditation 2019		C P LIm	RCOG provisional accreditation achieved. Will be applying for full accreditation by April 2020	
			Understand potential impact of CUH Children's Hospital and mitigate against potential loss of market share	CUH business case analysed and plan in place			We already refer to them and may make referrals easier. Hub working possible	Risk of staff loss.
			Develop, engage and lead the Children's STP workstream to redesign patient pathways, benchmarking services; greater co-operation across provider boundaries, creation of an adolescent unit to ensure sustainability and most efficient patient pathways	Children's STP workstream established; plan in place to review pathways				
			Provide inpatient care for our Children closer to home by ensuring estate, facilities and skills are in place to facilitate repatriation of work to ENHT (e.g. HDU; PSCU; NICU L3) once agreed with Specialised Commissioners	Plan in place to repatriate work; discussions held with Commissioners			From year 3	

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Ensure services are at a scale to deliver long-term clinical and financial sustainability (continued)			Providing outpatient care for our Children closer to home by ensuring estate, facilities and skills are in place to facilitate repatriation of work to ENHT (e.g. Cardiology; Gastro; Allergy; Haem) once agreed with Specialised Commissioners	Plan in place; discussions held with Commissioners			From year 2	
			Establish better working relationship with GPs, especially on our boundaries to develop understanding of the services we provide to protect our market share (e.g. through GP engagement events and open evenings)	GP engagement plan in place; more women choosing to give birth at the Trust, measured through market share			Have initiated working in some St Albans Surgeries. Working with new marketing team and webpage developers to improve profile of services	Withdrawing midwives out of PAH catchment. Financial risks.
			Establish shared governance across the Local Maternity System (LMS) to ensure better clinical and financial sustainability	Regular attendance at LMS meetings; engagement			From year 2 Set up safety forum to included sharing of learning and guidelines	
			Explore opportunities for improved clinical procurement efficiency and savings by working across systems	Working group in place; plan to identify potential savings in place			From year 2 We are part of the procurement working group	

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Protect market share and grow birth numbers by delivering Better Births Ambition and maintaining the quality and reputation of our services			Embed the Better Births Ambitions to introduce innovative ways of midwives providing care for women and ensure Trust has met 20% Continuity of Carer target by 2019 and then work to achieve maximum levels of Continuity of Carer	Maternity survey, e-referral data, Monitoring, Local Maternity System Governance			Early stages of development. For example Diamond Team have identified a Consultant lead for continuity of care. Continuity of care strategy being written for 2020 to achieve 35 % CoC	Lack of resources. Staff wishing to work this model.
			Improve patient outcomes by implementing the national safety agenda: MatNeo/Attain/Saving Babies Lives/ Each Baby Counts /PReCePT/PMRT/	Outcomes; Model Hospital, Reduction in stillbirths, National Measures		KC, MD, MCD, JL	Making clear progress on these maternity safety drivers. LMS deliverables agreed for 19/20	
			Develop pathways that meet woman's choice and personalised care plans to deliver better women's and families' quality and increase market share	Quality; Model Hospital; Market share		FK and RB	Choices improved and personalised care plans. Working with M Hartley. Part of LMS workstream	
			Strengthen our participation in the Maternity Voices Partnership (MVP) to better our women's experience by responding to patient feedback	Patient experience; Friends and Family		RB	Completed. Strong participation in MVP evident and demonstrable	
			Strengthen the working relationship with GPs, especially on our boundaries to develop understanding of the services we provide to protect our market share (e.g. through GP engagement events and open evenings)	Increased referrals; market share; events held			Have initiated working in some St Albans Surgeries. Working with marketing and webpage teams in the Trust to increase profile of services	Withdrawing midwives out of PAH catchment. Financial risks.

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Deliver consistent, high quality care and ensure patients receive the most appropriate care for their condition, from those most clinically appropriate to deliver it, and in the most appropriate setting			Review Paediatric Pathways with Primary Care (including Emergency Paediatric Pathways; ADHD Shared Care) to ensure best experience for patients	Pathways reviewed and changes implemented			Acute paeds CD has started this workstream	
			Create an Acute Community Children's Nursing Service (7 day service) to reduce reliance and impact on the Emergency Department	Service commenced; reduced attendances at ED				
			Develop a perinatal mental health service and Continuity of Carer pathway for vulnerable women	Service commenced			PNMH midwife in post. Pathway to be developed.	Funding from LMS non-recurring
			Develop improved patient pathways and experience for our Children and Young People with Mental Health needs	Pathways reviewed and changes implemented			From year 2 Joint meetings with HPFT and social care re regular attenders	
			All staff to have access to a Child's shared electronic health record (SystemOne) to ensure patient safety, better quality and ease of use	Access for all staff				
			Develop, engage and lead the Children's STP workstream to redesign patient pathways, benchmarking services; greater co-operation across provider boundaries, creation of an adolescent unit to ensure sustainability and most efficient patient pathways	Participation; pathways reviewed				

Clinical Priority	Rag Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Deliver consistent, high quality care and ensure patients receive the most appropriate care for their condition, from those most clinically appropriate to deliver it, and in the most appropriate setting (continued)			Expand and strengthen Transitional Pathways across Children's Services, ensuring successful handovers across providers and best patient experience Consistently and sustainably achieve the clinical effectiveness standards	Quality; successful handovers			From year 2	
			Review, promote and expand the usage of apps and social media to improve patient experience and ensure patients have tools to self manage where appropriate, e.g. paediatric asthma; paediatric diabetes	Use of apps; social media updated			From year 2	
			Review gynaecology service patient pathways to maximise efficiencies; increasing use of telephone clinics where appropriate; implementing GIRFT; benchmarking Model Hospital to reduce length of stay and improve patient outcomes	Review Gynaecology Service Pathways; Enhanced Care Pathway; Reduced Length of Stay; Model Hospital		Gynae CD & DC, Matron and GM.	Lead for enhanced recovery identified. . GIRFT action plan completed. Increased TLH. Increased out pt hysteroscopy. Telephone clinics still to be set up	Delay due to training of nurse colposcopist.
			Establish a patient and carer's group to ensure we are working collaboratively with children, young people and their carers, in line with the RCPCH framework	Group established; young person feedback incorporated into service decisions			From year 2	

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Develop and establish Private Patient Services, offering greater choice to our local community and improving financial sustainability			Identify and develop children's private services for which there is local demand	Services developed and promoted		J Biggs	Only just starting	Marketing. Consultant buy in.
			Identify and develop enhanced private maternity services for which there is local demand	Services developed and promoted		M Davis	On line booking in place. We pages to be developed. Working with marketing team	Marketing and IT support for on line booking
			Use communication platforms to promote private services with a distinct brand and develop advertising materials showcasing services, in order to grow income	Plan in place				Support for Website a

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Create a sustainable workforce by becoming 'Employer of Choice' for our Services, helping reduce challenges of retention and recruitment			Drive a positive, open and honest culture building on Trust Values, staff and cultural surveys, staff engagement	Staff survey		A Porch	Action plan for staff survey result. Regular review through SMT meetings. SCORE culture survey maternity with feedback sessions	
			Mitigate reliance on medical model and staffing by exploring expanded roles for staff through a creative career development and training environment to support retention and recruitment, supported by: •Nurse Consultant •Introducing Criteria Led Discharge •Gynae Nurse-Led Pathways •Midwifery-led Clinics for high risk women •Midwives providing specialist care within Continuity of Carer pathways •Supported and funded training and development program for all staff •Continued links with the University (research and teaching) to build reputation	Criteria Led Discharge using Enhanced Care Pathway Length of Stay Training courses		Multiple	Leads for enhanced recovery identified, agreed to feed into Trust enhanced recovery meetings. Nurse colposcopist appointed. Multiple preg continuity of carer. Scanning midwives. EPU nurses being trained in early pregnancy scanning	
			Create a flexible working environment to support our staff and services, looking at working hours, shift patterns etc to meet needs of the millennium generation	Review completed; changes implemented			Offer flexible working. Support career break. Roster requests. Details of flexible working environment needs to be agreed at Divisional level. Support secondment.	

Agenda Item: 8.2

TRUST BOARD - PUBLIC SESSION – 4 SEPTEMBER 2019

Mount Vernon Cancer Centre – Strategic Review Update

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

The purpose of this paper is to update the Trust Board on the strategic review being undertaken by NHSE Specialised Commissioners into the sustainability of oncology services provided by the Mount Vernon Cancer Centre.

The Board is asked to:

- Note the progress of the review and the report and recommendations from the Clinical Advisory Group
- Note that NHSE Specialised Commissioners are to lead on the process of identifying an existing tertiary cancer provider to take over the leadership, governance, management and strategic development of the specialised oncology service at MVCC. NHSI are to lead on the delivery of the transfer following identification of the new provider.
- An Action Plan to support delivery of the report's recommendations is in the process of being agreed with NHSE Specialised commissioners. Progress will be overseen by the existing MVCC Executive Co-ordination Group.
- Note that a new Task and Finish Group will oversee the Trust's preparations and delivery of the agreed transfer including resources required; these are in the process of being identified for discussion with NHSI/E.

Action required: For information

Previously considered by: N/A

Director:	**Presented by:**	**Author:**
Director of Strategy	**Director of Strategy**	**Head of Business Development**

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) Yes 012/19

Any other risk issues (quality, safety, financial, HR, legal, equality): Estates, workforce, quality risks all on risk register

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

TRUST BOARD 4TH SEPTEMBER 2019

Mount Vernon Cancer Centre – Strategic Review Update

1) Purpose

The purpose of this paper is to update the Trust Board on the current strategic review into the future sustainability of the Mount Vernon Cancer Centre, which is being led by NHSE East of England Specialised Commissioners and the actions that the Trust is taking to support and respond to this.

2) Background

In January 2019 NHS England agreed with East and North Hertfordshire NHS Trust (ENHT) and the East of England and London Cancer Alliances to undertake a strategic review of the oncology services provided at Mount Vernon Cancer Centre as a result of concerns raised by the Trust and other stakeholders regarding the long term sustainability of the service and the environment from which services are delivered. The review is being overseen by a Programme Board comprising key stakeholders, including the Trust, Hillingdon Hospitals NHS Foundation Trust (the landlord), Healthwatch (both Hillingdon and Hertfordshire), and Specialised Commissioners.

3) Strategic Review of Mount Vernon Services

The Strategic Review has drawn on a range of information and material to inform its development and consideration of potential solutions to support the sustainable provision of safe, high quality tertiary cancer services from the Mount Vernon site in the context of an absence of co-located acute services and significant estates and infrastructure challenges. This has involved a number of activities which led to development of an initial long list of options for the future of the MVCC. These included:

- Analysis of existing oncology activity data, such as patient access information, population health needs, travel times, service performance and patient experience
- Structured discussions with staff at the Trust and Cancer Centre, including clinical leaders and executive directors
- Feedback from patients and stakeholders, including commissioners, STP, Hillingdon Hospital NHS Foundation Trust (the landlord), other tertiary providers and Cancer Alliances

This was followed by an independent clinical advisory group review undertaken in June 2019, led by Prof. Nick Slevin, Consultant Oncologist, the Christie Hospital, and including Healthwatch Hertfordshire. This peer review encompassed a series of interviews and a two day visit to MVCC in order to reach a set of recommendations designed to support the sustainable delivery of safe, high quality care by the Mount Vernon Cancer Centre. Further details of their activities and findings are attached in the report at Appendix 1.

4) Clinical Advisory Group Recommendations

Following their review of the Mount Vernon Cancer Centre, the Clinical Advisory Group published their report (see Appendix 1) which spanned short and longer term recommendations.

The short term recommendations are:

1. A MVCC clinical consultant lead is required to help manage the transition with the existing team, to be available on a daily basis and to ensure full MVCC participation and perspective in the partnership arrangement with the tertiary provider lead from London.
2. Under either of the two supported options, the leadership, governance, management and strategic development of the specialised oncology service at MVCC should transfer as soon as possible to an existing tertiary cancer service provider.
3. Appointment of additional staff to the Acute Oncology service.
4. Robust implementation of policies concerning admission criteria to MVCC, daily consultant ward rounds and MVCC staff reviewing patients who have been transferred to other DGHs. This will require job planning and additional medical staffing.
5. Urgent backlog maintenance of existing clinical facilities.

The Trust has strongly advocated the case for local satellite radiotherapy services to improve access to radiotherapy for many patients receiving care from the Cancer Centre. In relation to their consideration of a long list of future service models for the Cancer Centre, the Clinical Advisory Group supported two for further consideration:

- Option 5 in the long list – Ambulatory Hub (modified)
- Option 3 in the long list – Full replacement on an acute site

Other recommendations included in the Clinical Advisory Report include:

- Any reconfiguration of service should not result in a significant redirection of patient pathways and patients should have local access to an integrated, networked, high quality service.
- The review identified that in order to provide modern oncology care, comprehensive medical and surgical support services, including Intensive Treatment Unit (ITU), are needed. Acutely unwell patients require inpatient, multidisciplinary management including for multisystem toxicities from increasing use of immunotherapies. These support services are no longer available on the MVCC site requiring that some oncology services, at least, should relocate to an accessible District General Hospital (DGH) with comprehensive acute services integrated with oncology expertise on site.
- Any reconfiguration should retain the co-location with the Paul Strickland imaging unit.
- Much of the existing estate used by MVCC is dilapidated and not fit for purpose. There is a need for considerable investment in buildings, equipment replacement and IT connectivity i.e. the basic physical infrastructure of the service.
- The estate used for cancer services should be owned by the service provider to strengthen their operational control.
- Aligning with an experienced tertiary cancer service provider would facilitate new opportunities to attract and retain additional expert staff, not only for the provision of the clinical service but also to exploit research opportunities. Through the experience

of the tertiary cancer centre and their critical mass of activity, robust clinical governance arrangements would be established.

- Research should be supported as a priority in order that patients have access to clinical trials that are appropriate to their condition. Research should be embedded in the clinical service to promote clinical developments and best patient outcomes.
- The transition to a reconfigured service is challenging and requires dedicated clinical leadership at MVCC as well as support and goodwill from the many stakeholders in order to provide reassurance to patients.

5) Taking Forward the Short Term Recommendations

The Trust has developed a draft Action Plan to address the recommendations which has been shared with Specialised Commissioners for their input following Executive Committee approval. Once agreed with Specialised Commissioners, the Action Plan will form part of the contract between the two organisations.

To support delivery of the action plan, the Executive Committee has delegated authority to a small executive co-ordination team to oversee and make decisions, reporting progress into Executive Committee on a regular basis. This team is meeting weekly to support resolution of a range of issues requiring executive support.

6) Taking Forward the Proposed Organisational Transfer

The Clinical Advisory Review Report recommended that the leadership, governance, management and strategic development of the specialised oncology service at MVCC should transfer as soon as possible to a tertiary cancer service provider. Specialised Commissioners for East of England and London are currently working together to confirm the process to identify the new tertiary cancer provider and proposed timetable for transfer. It has been agreed in principle that east of England NHSI will oversee the transfer process once the new provider is identified.

In preparation for this, the Executive Committee has agreed Terms of Reference for an internal Task and Finish Group to oversee the Trust's preparations and execution of the proposed transfer. This will be informed by a range of work streams covering topics including finance, workforce, clinical pathways, research and development, charitable funds and corporate services. As a first step, the resources expected to be required to deliver this, whilst maintaining business as usual, are being identified for discussion with Specialised Commissioners.

The 2018/19 income from activities carried out at MVCC has been identified as £50,164,843. However, there are significant expenses associated with the service, not least the Service Level Agreement (spanning rent, support services, depreciation etc) with Hillingdon Hospital NHS Foundation Trust for £6,513,636. The total net contribution of MVCC to ENHT will be further refined going forwards as the Trust develops its new strategy for cancer services following the transfer of the Cancer Centre. This will be a key part of the Task and Finish Group.

The potential for the outcome of the Strategic Review to provide a clear strategic direction for the Cancer Centre is to be welcomed and supported. However, this introduces or increases three particular risks which the Trust is working with commissioners to control and mitigate. These are:

- Failure to identify a new tertiary cancer provider – Specialised Commissioners in East of England and London are in discussion to agree and commence the process of identifying potential new providers. It is expected that clear leadership from both regional teams will mitigate this risk.
- Increased service fragility whilst the transfer takes place – there is a risk that the service is further put under strain by the additional capacity required to identify and transfer the cancer centre to a new provider. This will be mitigated by ensuring that resource is appropriately allocated to ensuring that the day to day work continues and that a clear and positive strategic narrative is developed between the trust and the new tertiary provider.
- Risk of unplanned service changes/fragmented repatriation of activity – Specialised Commissioners have proposed to NHSE London that, in order to support the current service and maintain the integrity of the review process, the Status Quo is maintained in terms of pathways and referrals flows into MVCC.

7) Engagement

Specialised Commissioners are leading patient and stakeholder engagement in this process with support from the Trust and other stakeholders. Healthwatch Hertfordshire and Healthwatch Hillingdon are also both closely involved. A number of engagement events have been held throughout the summer and across the geography served by MVCC. These have been supported by a number of follow up interviews with specific patient groups. Hillingdon and Hertfordshire Scrutiny Committees received an update in July and will receive a further update in September. A similar further update is to be given to Hertfordshire's Health Scrutiny Committee in October. Local MPs have also been kept abreast of the review. The Trust and Specialised Commissioners have stressed that all decisions regarding the future service model will be informed and underpinned by effective engagement and involvement and have stressed the Clinical Advisory Group's recommendation that: *"Any reconfiguration of service should not result in a significant redirection of patient pathways and patients should have local access to an integrated, networked, high quality service".*

Internally, the Cancer Division is being supported by the Head of Communications and executive team to ensure regular communications with all MVCC and divisional staff.

8) Recommendations

The Board is asked to:

- Note the report and recommendations of the Clinical Advisory Group
- Note that approval and delivery of the agreed action plan to implement the short term recommendations will be led by executive directors. Timescales for delivery are being agreed with Specialised Commissioners
- Note that an internal Task and Finish Group is being established in September to lead work to prepare for and execute the planned transfer of services from MVCC and consideration of the Trust's future cancer strategy
- Note that the final decision regarding approval to transfer MVCC out of the Trust will be brought to the Board for consideration and approval once the terms and impact of this is confirmed.

Appendix 1: MVCC Clinical Advisory Group Report

MVCC CAP Report - FINAL v1.2 08 July 2(

Mount Vernon Cancer Centre Strategic Review

Clinical Advisory Panel Review and Recommendations

July 2019

NHS England and NHS Improvement – East of England

Mount Vernon Cancer Centre Strategic Review

Clinical Advisory Panel Review and Recommendations Subtitle

Version number: 1.2

First published: July 2019

Updated: (only if this is applicable)

Prepared by: Professor Nick Slevin, Chair, MVCC Clinical Advisory Panel

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Contents

Foreword

NHS England commissioned an urgent review of Mount Vernon Cancer Centre (MVCC) in May 2019, led by the East of England Specialised Commissioning Team, due to increasing concern regarding the sustainability of a safe and high quality oncology service provided at the site.

MVCC has been subject to a long series of reviews over a period of at least 30 years. Due to the complexity of the large catchment area and patient flows, the number of organisations involved, the lack of capital funding, the continual change in oversight management, commissioning and network arrangements, these numerous reviews and recommendations have not resulted in any substantial change to the service. Moreover, the environment of oncology provision has changed enormously over this 30 year period with intensification of combined modality treatments, advent of immunotherapies with their unpredictable toxicities and increasing focus on managing comorbidities in an ageing cancer patient population. Acute support services have also been progressively depleted on the site over many years such that there is current and increasing concern regarding patient safety. All of this has inevitably led to low morale, frustration, loss of staff and difficulty in sustaining performance targets.

Services continue to be provided within very poor quality accommodation with much equipment reaching the end of its life without a replacement plan.

Undoubtedly the urgent challenges facing MVCC and those charged with their resolution are complex and will require a commitment from all the organisations involved to work collaboratively in reaching a sustainable solution for patients, their carers, the oncology staff and the oncology service. If appropriate, organisations must relinquish responsibility, and if required, associated funding in order to secure the optimal model of care.

Throughout the review, the Clinical Advisory Panel members were greatly impressed by the collegiality and determination of the MVCC team to continue to provide the best quality care they could under difficult circumstances. It should be noted that the feedback from patients has been consistently positive over a long period of time in spite of the significant challenges faced. It is a priority to maintain current patient confidence in services and to maintain local access, where appropriate.

Finally, we wanted to thank everyone we met and interviewed for their time, their candour, patience and their commitment to staying with the NHS England process. This review is focussed on expeditiously finding a practical and affordable solution for MVCC that will support their ambition to provide an integrated oncology service with the ability to deliver expert management using advanced techniques and latest treatments in a modern environment. It also aims to recommend the configuration that will continually drive improvements in clinical outcomes by significantly strengthening the focus on education, training, research and innovation.

Professor Nick Slevin
Clinical Advisory Panel Chair
July 2019

Executive Summary

1. The remit of the MVCC Clinical Advisory Panel was to undertake 3 specific actions:

   (i) Review the long list of options previously identified by key stakeholders

   (ii) Remove any non-clinically acceptable options

   (iii) Make recommendations to the MVCC Programme Board meeting held on 4th July 2019

2. The Clinical Advisory Panel undertook a series of interviews throughout June 2019 to inform their recommendations.

3. There is increasing concern as to whether high quality, safe and sustainable oncology services can continue to be delivered within the existing organisational framework and there is an urgent need to address this concern.

4. The review identified that in order to provide modern oncology care, comprehensive medical and surgical support services, including Intensive Treatment Unit (ITU), are needed. Acutely unwell patients require inpatient, multidisciplinary management including for multisystem toxicities from increasing use of immunotherapies. These support services are no longer available on the MVCC site requiring that some oncology services, at least, should relocate to an accessible District General Hospital (DGH) with comprehensive acute services integrated with oncology expertise on site.

5. Much of the existing estate used by MVCC is dilapidated and not fit for purpose. There is a need for considerable investment in buildings, equipment replacement and IT connectivity i.e. the basic physical infrastructure of the service.

6. Aligning with an experienced tertiary cancer service provider would facilitate new opportunities to attract and retain additional expert staff, not only for the provision of the clinical service but also to exploit research opportunities. Through the experience of the tertiary cancer centre and their critical mass of activity, robust clinical governance arrangements would be established.

7. The transition to a reconfigured service is challenging and requires dedicated clinical leadership at MVCC as well as support and goodwill from the many stakeholders in order to provide reassurance to patients.

8. The recommendation from the Clinical Advisory Panel review are:

   8.1 Identification of two supported options from the long list for further consideration:

      a. Option 5 in the long list – Ambulatory Hub (modified)
      b. Option 3 in the long list - Full replacement on an acute site

   8.2 Significant capital investment should be made be available to address build and equipment issues in the chosen option.

8.3 The estate used for cancer services should be owned by the service provider to strengthen their operational control.

8.4 Research should be supported as a priority in order that patients have access to clinical trials that are appropriate to their condition. Research should be embedded in the clinical service to promote clinical developments and best patient outcomes.

8.5 Any reconfiguration of service should not result in a significant redirection of patient pathways and patients should have local access to an integrated, networked, high quality service.

8.6 Any reconfiguration should retain the co-location with the Paul Strickland imaging unit.

9.0 Short Term Action Plan

The Clinical Advisory Panel identified a clear urgency for action in the short term to address the immediate concerns whilst a longer term solution is secured. The specific actions are as follows:

9.1 A MVCC clinical consultant lead is required to help manage the transition with the existing team, to be available on a daily basis and to ensure full MVCC participation and perspective in the partnership arrangement with the tertiary provider lead from London.

9.2 Under either of the two supported options, the leadership, governance, management and strategic development of the specialised oncology service at MVCC should transfer as soon as possible to an existing tertiary cancer service provider.

9.3 Appointment of additional staff to the Acute Oncology service.

9.4 Robust implementation of policies concerning admission criteria to MVCC, daily consultant ward rounds and MVCC staff reviewing patients who have been transferred to other DGHs. This will require job planning and additional medical staffing.

9.5 Urgent backlog maintenance of existing clinical facilities.

1. Introduction

The review of the Mount Vernon Cancer Centre (MVCC) has been commissioned by the East of England Specialised Commissioning Team to better understand the safety and sustainability of tertiary cancer services delivered by MVCC. MVCC is managed by East and North Hertfordshire NHS Trust (ENHT) who rent the hospital site from Hillingdon Hospital NHS Foundation Trust.

2. Scope of the Review

The review only considered oncology services provided by the MVCC team (adult oncology services and not those for paediatrics or teenage and young adults populations).

Its focus was on inpatient and outpatient services and staffing in the following service areas:

- Radiotherapy including brachytherapy and molecular radiotherapy (radioisotope treatment)
- Systemic Anti-Cancer Therapy (SACT) including cytotoxic chemotherapy, targeted therapies and immunotherapies
- Support services including imaging and inpatient care support
- Research and innovation
- Workforce

It did not include consideration of:

- Palliative care
- Oncology Surgery

It was recognised that whilst the principal focus was in the above areas, the non-surgical oncology provision at MVCC exists in a wider network of services and consideration of unintended consequences of any change with MVCC was needed.

3. Background and Key Drivers for Change

1. The particular challenges facing MVCC have been well documented and the Clinical Advisory Panel considered a comprehensive range of documentation in preparation for the review.

2. It is clear that over a period of at least 30 years, a number of different bodies have undertaken reviews of MVCC. Recommendations for action have been identified but with little evidence of the necessary investment required, resulting in no substantial change or service improvement.

3. The management of MVCC has changed several times over the years, both from a Trust perspective and also within the context of responsible cancer networks, STPs, cancer alliances and commissioning arrangements. This complexity of leadership and commissioning arrangements has contributed to the apparent lack of progress in addressing the challenges facing MVCC.

4. A consistent theme throughout the review was the value patients and carers place on the clinical team and services they experienced at MVCC. Despite the obvious issues of the capital stock, patients expressed deep appreciation regarding the care they received.

5. The ambition of the MVCC team to strengthen their focus on research and innovation in order to drive improvements in clinical outcomes is clearly evident and will be fundamental to the future success of reconfigured services.

6. The delivery model for care at MVCC has also been subject to review and the Clinical Advisory Panel considered this particular point when preparing its recommendations. The focus was on how best to consistently deliver high quality clinical care with appropriate numbers of skilled staff whilst enhancing patient experience through more local access to networked care.

7. There are a number of core clinical drivers for change in the current service configuration, recognising that standard oncological care has evolved substantially over recent years and the range of medical services required to safely deliver this has also changed. Any recommended model of care must address the following:

    - The need for onsite surgical and comprehensive medical acute support services to quickly and safely manage treatment related toxicities / complications, acute illness linked to patient comorbidities and frailty as well as disease related sequelae.
    - The need for the service to be flexible in the long term in order to cope with the different types of treatment likely to be introduced. For example, in just the next 12 months, NICE has 40 new cancer drugs being appraised, the majority of which are thought will be recommended for the Cancer Drugs Fund or routine commissioning.
    - A need for a networked service with equitable patient access to consistent management protocols and appropriate trials for their condition.
    - The recognition that research needs to be embedded with the clinical service to drive clinical developments and improved patient outcomes.
    - An appropriate infrastructure of expert workforce, IT connectivity and accommodation.
    - The need for daily consultant reviews of oncology patients acutely admitted to the oncology wards.
    - An increasing patient awareness of what constitutes an appropriate environment for their medical needs.

4. Mount Vernon Cancer Centre

1. MVCC is part of East and North Hertfordshire NHS Trust (ENHT) and provides a specialist non-surgical cancer tertiary service. It is situated in Hillingdon, Middlesex on a large site owned by Hillingdon NHS Trust and is 35 miles from East and North Hertfordshire Trust's main hospital, The Lister Hospital, in Stevenage. It serves a catchment population of 2 million people across a wide

area of Hertfordshire, Bedfordshire, Northwest London and parts of the Thames Valley (65% of its patients come from Hertfordshire and Bedfordshire, 30% from North London and 5% from East Berkshire and Buckinghamshire).

2. The MVCC clinical teams have, along with the East and North Hertfordshire NHS Trust, had concerns for some time about the clinical sustainability and longer-term future of MVCC and welcomed a commissioner review in order to create a momentum for strategic change.

3. At MVCC, there is a multi professional management team which includes a clinical director, divisional chair, a hospital director and a head of nursing.

4. The most recent CQC Inspection of the site in April 2018 rated MVCC as requiring improvement across 3 of the 5 domains, rating it Good for Effective and Caring domains (see appendix 5). Radiotherapy was rated as Good in every domain. The previous report following inspection in 2015 rated care as inadequate and raised concerns about safety and care of the acutely unwell patient. Since that report, a new management team has been in place and many of the concerns are being managed through mitigation e.g. the NEWS (National Early Warning Score) threshold for identification and subsequent escalation of a deteriorating patient is now lower than the recommended trigger point to ensure optimal management, stabilisation and transfer to the local DGH. In conjunction with this, there has been an increase in the acute oncology nursing team to proactively manage deteriorating patients and admission avoidance.

5. There is an academic and clinical collaboration in place with University College London Hospitals (UCLH) and a Memorandum of Understanding (MOU) was signed off by both Trust Boards in November 2017 to support the joint work.

6. East & North Hertfordshire NHS Trust and the Hertfordshire and West Essex STP have highlighted the poor quality of the MVCC estate within which services are provided and raised concerns about access to radiotherapy for some residents in the STP. They wish to see services re-provided in fit for purpose buildings replacing some of its oldest facilities; it is seen as an important part of delivering a healthier future for residents of Hertfordshire and West Essex.

7. Hillingdon Hospitals NHSFT as the landlord of the site has recently agreed to some estate investment. Much of the MVCC building stock is old and decrepit and recent adjustment to service provision have had to be made in some areas as a direct result of this e.g. leaking roofs.

8. The facilities at MVCC are as follows:

    - **Inpatient Facilities:** There are currently 33 medical inpatient beds (22 substantive beds and 11 beds relocated from the closure of the Michael Sobell Hospice), plus 4 escalation beds located on one ward in the oldest part of the building at MVCC. The physical structure of these facilities is poor. The ward cares for patients who require inpatient treatment because they (a) have complications of their cancers (b) are unwell during or following their

radiotherapy / chemotherapy treatment (c) are having radio-isotope treatments or brachytherapy (principally prostate and gynaecology cancers). In addition (d) some patients are admitted for their treatment if it is particularly arduous or (e) if the patient is frail. Since the relocation of the hospice inpatient service, there have been admissions for (f) symptom control and terminal care.

- There are limited support facilities onsite and, in particular, there are no onsite surgery and acute medical services and no ICU or High Dependency Unit (HDU) facilities. Patients requiring enhanced clinical support are transferred to non-specialised DGHs for acute medical care or surgery. A review of these patient transfers highlighted large numbers of patients who could not receive their inpatient care at MVCC.

- When acutely unwell patients are transferred out to local DGHs, there is a loss of line of sight to the MVCC responsible consultant, resulting in fragmentation of care. The de-skilling of inpatient staff to cope with acutely unwell patients will inevitably limit the deliverability of complex and innovative treatments and compound nursing and medical recruitment and retention issues.

- **Outpatient Facilities**: The Trust provides a chemotherapy / systemic therapy service at MVCC. Patients from all solid tumour groups, including those on clinical trials, are treated in the cancer centre's chemotherapy outpatient's suite where they receive cytotoxic drug regimens and targeted systemic therapies.

- The chemotherapy suite is open Monday to Friday, treating an average of between 50 and 70 patients per day. It has 20 treatment chairs and two beds. Side rooms are available for patients to be seen on a one-to-one basis by the unit's doctors or nurses. The current SLA with Baxter ends March 2020, and the production of long life, dose banded systemic therapy will be out to tender in the coming months. Staff raised concerns regarding the provision of short life therapies, if production could not be provided by an onsite facility.

- There are insufficient rooms for medical staff, specialist nurses, dietitians and speech and language therapists. Inadequate electronic systems and poor IT connectivity slow the clinic process. There is no direct real time connection of the x ray systems between MVCC and the hospitals in its catchment area which undermines effectiveness of clinical management.

- The 24 hour telephone service required for the MVCC chemotherapy service cannot access any more up to date information than that in the last clinic letter. Since the average time for clinic letters from MVCC clinical staff to be typed up is 2 weeks (but up to 6 weeks max), there is a risk that nurses manning the 24-hour telephone line will be acting on clinical information which has changed.

- There is an onsite MVCC acute oncology service and its main impact is on those patients who receive their treatment on the MVCC site. It works with the supportive care unit, which was opened in January 2018 to provide cancer treatments and adjuncts such as blood transfusions and any symptom management that can be managed on a day care basis in order to prevent deterioration and admission to an inpatient unit. There is also a central venous access devices (CVAD) and interventional radiology service on site.

- In addition, MVCC has a separate outpatient department with 16 clinic rooms and a small waiting room both of which are inadequate to meet current demand.

- Consultants provide a clinical outreach service for East and North Hertfordshire NHS Trust, West Hertfordshire Hospitals NHS Trust, Hillingdon Hospitals NHS Foundation Trust, Luton and Dunstable University Hospital NHS Foundation Trust, Frimley Health NHS Foundation Trust, Buckinghamshire Healthcare NHS Trust and London North West University Healthcare NHS Trust, including oversight of local delivery of chemotherapy in several of these sites.

- The radiotherapy centre has seven linear accelerators (linacs) and a cyber knife stereotactic platform covering a 5 day service 7am – 8pm. Four linacs are modern. Three of the linacs and the associated bunkers are leased. Two linacs will be over 10 years old in 2020 and in addition, one has had a temporary upgrade to prolong its useful life. There is currently a limit in treating patients with state of the art intensity modulated radiotherapy treatment (IMRT) due to a lack of treatment planning licences.

- The brachytherapy service at MVCC provides for both High Dose Rate (HDR) and Low Dose Rate (LDR) treatments but access to theatres is currently constrained. The brachytherapy service at MVCC is nationally recognised and accepts a significant number of referrals from outside its catchment area.

- Molecular radiotherapy (radioisotope therapy) includes radioiodine and radium (MVCC is one of 3 London providers of radium 223).

- MVCC has a private patient service which is currently limited but offers potential for future income generation.

5. Clinical Advisory Panel

The remit of the Clinical Advisory Panel was to undertake 3 specific actions:

- Review the long list of options previously identified by key stakeholders

- Remove any non-clinically acceptable options

- Make recommendations to the MVCC Programme Board meeting held on 4th July 2019

Panel Members:

- Professor Nick Slevin (Chair) – Former Chair of NHS England's National Radiotherapy Clinical Reference Group, The Christie NHS Foundation Trust, Manchester
- Professor Peter Clark – NHS England National Lead for the Cancer Drugs Fund and previously practiced at the Clatterbridge Cancer Centre, Merseyside
- Jenny Scott – Deputy Director of Business Development, The Christie NHS Foundation Trust, Manchester
- Julie Gray – Associate Chief Nurse and Deputy Director of Quality, The Christie NHS Foundation Trust, Manchester
- Steve Palmer – Chair, Hertfordshire Healthwatch
- Turkay Mahmoud – Interim Chief Executive Officer, Hillingdon Healthwatch

The Clinical Advisory Panel considered the current service model and its long term sustainability, referencing Key Lines of Enquiry (KLOE) with the aim of:

- ✓ Putting the needs of the patient and public first
- ✓ Developing recommendations for the MVCC Programme Board as an outcome of the clinical assessment to develop a sustainable model for the population to be served
- ✓ Providing evidence to support the outcome of the Clinical Advisory Panel assessment process.

The Clinical Advisory Panel was accountable to the Senior Responsible Officer for the Project and Chair of the Programme Board, Ruth Ashmore, Director of Specialised Commissioning and Health & Justice, NHS England and NHS Improvement, East of England.

The final Clinical Advisory Panel report outlining their assessment and recommendations will be presented to the MVCC Programme Board on 4th July 2019.

6. Key Lines of Enquiry (KLOE)

The purpose of the review was to undertake a strategic assessment of the Mount Vernon Cancer Centre with particular attention to 5 key lines of enquiry:

1. Quality of Care
2. Patient and Carer Experience
3. A Sustainable Workforce
4. Training and Education
5. Research and Innovation

KLOE	Factors under review
Quality of Care	The Clinical Advisory Panel will make an assessment and deliver a considered view regarding the Quality of Care in relation to: **Patient Safety:** reviewing safe care pathways, including patient transfer and shared care arrangements and the ability to meet the requirements for the co-location of critical services including specialist imaging. **Clinical Effectiveness**: review the ability to meet the required quality and regulatory standards, including the NHS England National Service Specifications, Cancer Waiting Time Standards and NICE guidelines. **Quality of the Patient Environment:** assess the specialist equipment required to deliver the clinical standards and patient experience. **Deliverability:** assess whether appropriate capacity is available to deliver a fast evolving service.
Patient and Carer Experience	The Clinical Advisory Panel will make an assessment and deliver a considered view of the experience of patient and carers, including access to services, taking into account: **Distance and Time to Access Services**: The Clinical Advisory Panel will review the distance and time required by patients to assess services at MVCC, including the impact on travel times (peak and off peak and non -emergency). **Patient and Carer Experience:** The Clinical Advisory Panel will establish a view on the impact on travel times on patient experience and the potential impact on patient decision making regarding treatment modality choice. **Service Availability**: The Clinical Advisory Panel will review the operating hours of the service, access to out of hours advice and care and the potential to access services to 7 days. **Continuity of Care and Survivorship**: Post treatment review arrangements and ability to address survivorship challenges
Sustainable Workforce	**Sustainability of the Workforce:** The Clinical Advisory Panel will make an assessment and deliver a considered view on the impact of the current environment in relation to the ability to recruit and retain staff across all of the multi-disciplinary team and the future sustainability of the teams to deliver the level of care required.

Training and Education	The Clinical Advisory Panel will make as assessment and deliver a considered view on the ability of MVCC to meet the training and educational requirements of the staff groups and any potential impact on opportunities for career development and progression.
Research and Innovation	The Clinical Advisory Panel will make as assessment regarding the ability of MVCC to engage in research programmes, including a broad range of research studies and the availability of academic research.

7. Activities Undertaken in the Review

A 2 day programme of meetings and interviews was held on 19th - 20th June 2019 (see appendix 2) which provided the opportunity for more detailed discussions and for triangulation of messages received from the different individuals and groups.

The Clinical Advisory Panel undertook a series of interviews, both face to face and by telephone (see appendices 3 and 4) in order to speak to as many key stakeholders as possible.

In addition to the interviews, previous review documents were referenced and 2 patient / carer listening events will be held on 3rd July.

The aim of the Clinical Advisory Panel was to be as fully informed as possible in making recommendations to the MVCC Programme Board.

A summary of the Clinical Advisory Panel's activities is outlined, with supporting evidence shown in the appendices.

7.1 Identification of Key Stakeholders

The Clinical Advisory Panel worked with East of England Specialised Commissioning Team to identify the individuals and organisations who had an interest in the future of MVCC.

These stakeholders came with a variety of perspectives and the intention was to speak to as many of them as possible in order that the review findings would have taken into account as diverse a range of comments as was possible.

Appendices 3, 4 and 7 list the stakeholders who were interviewed as part of Clinical Advisory Panel process.

7.2 Telephone Interviews

Clinical Advisory Panel members undertook a series of telephone interviews in advance of the 2 day assessment at MVCC. All interviewees were assured of the non-attributable nature of their conversation.

The Clinical Advisory Panel Chair, Professor Nick Slevin, was able to speak to almost all consultants identified on the stakeholder list and other telephone interviews included the Medical Directors at East and North Hertfordshire NHS Trust and Hillingdon Hospital NHS Trust as well as the Medical Directors at both The Royal Marsden and University College London Hospital (UCLH).

A summary of the themes to emerge from these telephone calls is shown:

Theme	Level of Support
Clinical Delivery	
Maintaining safety of patients cannot be guaranteed in the near future – status quo is not an option – there is a need for urgent action.	Consensus
To provide modern oncology care, comprehensive medical and surgical support services including ITU are needed – this is not now available at MVCC.	Consensus
Difficulty in redeveloping MVCC site to provide medical and surgical support services including ITU.	Majority
Deskilling of existing inpatient nursing staff as acutely unwell patients transferred out. Loss of ability to undertake practical interventions on site e.g. draining ascites.	Consensus
Need for an inpatient integrated service in order to manage acutely unwell patients (due to unpredictable toxicities of immunotherapies, intensive chemotherapy / radiotherapy regimens and comorbidities). Concern about the quality of integrated care for patients currently transferred out to non-specialist DGHs impacting upon patient management.	Consensus
Leadership and Oversight	
Specialist regional cancer services should not be led / provided / overseen by a DGH.	Consensus
Change of leadership for MVCC is a priority and a decision must be made urgently.	Consensus
New leadership should be an existing tertiary cancer service provider.	Majority
Service Configurations	
Radiotherapy satellite in the north of the catchment (Luton, Stevenage or St Albans) makes sense but is not the priority for now – core service must be addressed first.	Majority
Non acute sites could not provide a comprehensive acute support service.	Majority
Dividing up the existing catchment to surrounding providers would be unacceptable due to disrupted patient flows, insufficient capacity and access concerns, loss of workforce cohesion and commitment.	Consensus
Capital and Estate	
The estate should be owned by the service provider.	Consensus
Need for a robust capital replacement plan for the linacs.	Consensus
Current estate is not fit for purpose, particularly ward buildings for acutely unwell and end of life inpatients.	Consensus
Current heavy reliance on charity for capital developments.	Consensus
Poor IT / Picture Archiving and Communication System (PACS) / electronic patient record systems in place for networked activity – this is a clinical risk.	Consensus
Sustainable Workforce	
MVCC clinical staff are highly motivated, collegiate and work hard to deliver high quality clinical services.	Consensus
Urgent need for additional clinical and support staff due to the current excess workload.	Consensus
Inadequate levels of administrative support resulting in a backlog of clinical correspondence - this is a clinical risk.	Consensus
Research and Development	
Research and development is being lost as current oversight is not cancer specific, a lack of ownership of cancer trial income by cancer teams and a lack of investment in trials infrastructure.	Consensus
Development Opportunities	
Poor onsite provision for private patients which represents a missed opportunity for income generation.	Consensus

7.3 Face to Face Interviews

The Clinical Advisory Panel held a 2 day programme of interviews at MVCC on 19th / 20th June. Each group or individual were asked to outline from their perspective the key challenges facing MVCC and their views on potential solutions. The Clinical Advisory Panel also undertook a tour of the site so they could see for themselves the configuration and state of the site.

These assessment days provided the opportunity to meet with a large number of individuals and groups and to see more clearly where there was consensus in thinking and where there were divergent views on the challenges.

7.4 Patient and Carer Perspective

It was recognised that addressing issues of patient care experiences and access to service were paramount to any future service configurations. Patient safety at MVCC has been an increasing concern and the experience of patients and their carers has been undermined by basic service deficiencies and poor accommodation.

The large catchment area for MVCC and the predicted continued growth in patient numbers and treatments were clearly acknowledged.

Some geographical areas are more poorly served than others. For example, Slough and the northern parts of the catchment area suffer from poorer access to radiotherapy as a consequence of considerably longer travel times to receive treatment.

Clinical trials offer access to new treatments and should be embedded in the clinical service with equitable access for all patients – this is not currently the case at MVCC.

The impact on patients of poor IT infrastructure should not be underestimated. There are clinical risks as a consequence of duplicate paper records, lack of filing of clinical records, lack of access to complete scanning images out of hours and the inability to view a comprehensive patient record.

The Clinical Advisory Panel also reviewed previous feedback from patients and carers regarding MVCC. A set of issues of greatest importance to cancer patients had emerged from these which were used to structure the current review engagement process. Patients had identified 3 core issues:

- Assurance of quality of care
- Access to new treatments
- Ease of access to services / reduced travel time

Seeking an updated view from patients and carers at MVCC was considered fundamental to this review in order to maintain a patient focus for the recommendations. The Clinical Advisory Panel proposed holding 2 listening events to supplement the NHS England led engagement process.

These 2 events will be held on 3rd July in locations accessible to patients from either end of the MVCC catchment area.

7.5 Document Review

The Clinical Advisory Panel requested access to all previous reviews and supporting documents. They also received internal strategic documents from ENHT.

The documents reviewed by the panel can be seen in appendix 6.

8. Summary of emergent themes

From the review, the overarching theme that emerged related to the increasing concern regarding the effective clinical delivery of oncology care. For example, in relation to toxicities from systemic anti-cancer therapies, awareness of toxicities is high from traditional cytotoxic chemotherapy and these toxicities are predictable e.g. neutropenic sepsis. In contrast, there is increasing use of immunotherapies where toxicities are common (up to 90% for some therapies), awareness of toxicities is low and they are unpredictable such that there is a high potential for mismanagement. For immunotherapy toxicities, there is a need for education, awareness and expert management, supporting the requirement for comprehensive support services being readily accessible. The types of potential toxicities from immunotherapy treatment are as shown:

Organ	Examples of toxicity from immunotherapy
Heart	Myocarditis, pericarditis
Neurological	Neuropathy, Guillain Barré
Endocrine	Pituitary, thyroid, adrenal, diabetes
Kidney	Nephritis
Liver	Hepatitis
Bowel	Colitis (7% with ipilimumab)
Skin	Rashes, pemphigoid
Lung	Pneumonitis, granulomatosis
Eye	Uveitis, retinitis
Musculo skeletal	Arthritis, myositis

The Clinical Advisory Panel addressed each of the KLOE and their findings are as shown:

KLOE	Comments
Quality of care	• MVCC team to continue to provide the best quality care they can within the significant limitations of the current physical environment and clinical systems; this is not a sustainable situation.
	• There has been investment in clinical nursing leadership and this is evident in the quality of care provided to patients. However, there is still some resistance to developing nurse led services and initiatives.
	• Several elements expected within a modern healthcare system are not possible to implement due to the limitations of the environment and staff shortages e.g. daily consultant ward rounds, consultant review of patients admitted within the previous 14 hours, speedy access to simple tests and results, shortage of junior medical staff and nursing

	staff, failure to complete Do Not Attempt Resuscitation (DNAR) documentation in appropriate patients, patients self-management of medications, dementia care, non-medical prescribing and nurse and pharmacist led clinics
	• Not all patients have access to a disease specific clinical nurse specialist (CNS).
Patient and carer experience	• Feedback from patients has on the whole been positive over a long period of time in spite of the significant challenges faced.
	• Patients and carers may be unaware of the isolation of care at MVCC, the need to transfer patients if acutely unwell and the consequent dislocation of care.
Sustainable Workforce	• MVCC is still considered a good place to work. It should, however, be noted that staff stay because of their commitment to patients and the knowledge of the consequences of them leaving on patient care.
	• The team are, in the main, demoralised and frustrated with local management of the MVCC services due to an apparent lack of strategic direction over future provision.
	• Staff losses are impacting upon the service. There are additional clinical risks such as the backlog of patient letters and notes as a result of inadequate administrative support.
	• Recruitment and retention of expert staff is an increasing problem and is becoming critical.
	• Declining expertise for inpatient care – there are no onsite acute services and acutely unwell patients are transferred out, thus leading to deskilling of existing staff.
	• MVCC staff feel disempowered and disengaged from the executive management decision making.
	• MVCC is physically remote from ENHT executive team (30-35 miles away).
	• There appears to be a rapid turnover of MVCC divisional management and issues have not been resolved for many years.

Training and Education	• Poor service impacts upon training and education, measured by the following:
	  ○ Unfilled CMT posts
	  ○ Unfilled SpR posts
	  ○ Difficulty in filling consultant posts
	  ○ Difficulty in attracting nursing posts
	  ○ From August 19, unfilled General Practice support posts

	• There has been investment in clinical nursing leadership and this is evident in the quality of care provided to patients. However, there is still some resistance to developing nurse led services and initiatives.

	• Several elements expected within a modern healthcare system are not possible to implement due to the limitations of the environment and staff shortages e.g. daily consultant ward rounds, consultant review of patients admitted within the previous 14 hours, speedy access to simple tests and results, shortage of junior medical staff and nursing staff, failure to complete DNAR documentation in appropriate patients, patients self-management of medications, dementia care, non-medical prescribing and nurse and pharmacist led clinics.
Research and Innovation	• There is general acceptance that research should be embedded in the clinical service of non-surgical oncology in order to: ○ deliver clinical developments ○ ensure equitable access to appropriate clinical trials for patients according to their particular condition
	• With increasing governance required to develop investigator led trials, there is need to continually invest in cancer research and development infrastructure which in turn necessitates the ring fencing of cancer research income.
	• Other areas of cancer research which require underpinning include: ○ Sponsorship function ○ Early phase clinical trials ○ Clinical trials pharmacy ○ Research accredited pathology laboratory accreditation ○ Appropriate clinical accommodation to support toxicity management for trials patients.
	• Research activity opportunities and profile is a particularly important driver for recruitment and retention of expert staff

9. Option Appraisal

The Clinical Advisory Panel's remit was to review the long list of options that had been identified by NHS England, informed by a number of stakeholders, and to make recommendations regarding any that would not be clinically acceptable.

9.1 Long list of options for service delivery

The long list of 6 options had been identified by the E&NH Trust Executive Team, MVCC Clinical and Management Team and wider stakeholders.

Option	Description	Potential Variants
1	**Do minimum.** Minimal investment to the buildings currently on site, and no change to the clinical delivery model.	
2	**Full replacement (non-acute site)** – replacement of existing facilities (including inpatient facilities, radio pharmacy and nuclear medicine) on the current (or alternative) site. Aseptic services provided on or off site. No change to the clinical delivery model.	• New build on existing site • New build on alternative (non-acute) site
3	**Full replacement (acute site)** – replacement of existing facilities (including inpatient facilities, radio pharmacy and nuclear medicine) on an acute hospital site, co-located with ITU facilities. Aseptic services provided on or off site.	• New build (or combination of new build/absorption) on acute hospital site • New build (or combination of new build/absorption) on existing acute tertiary cancer centre hospital site
4	**Majority replacement** – all non-inpatient services provided within a new build MVCC, including radio pharmacy and nuclear medicine. Inpatient ward and brachytherapy relocated to an existing acute tertiary cancer centre site/DGH acute site. Aseptic services provided on or off site. No satellite radiotherapy.	• New build on existing site • New build on alternative (non acute site)
5	**Ambulatory Hub:** ambulatory hub at MVCC providing radiotherapy, chemotherapy and outpatients. Onsite radio pharmacy and nuclear medicine. Aseptic services provided on or off site. Inpatient ward and brachytherapy relocated to acute tertiary site/DGH acute site. Development of new satellite radiotherapy in the north of the patch (e.g. Stevenage or Luton)	• Hub at MVCC • Hub at alternative location
6	**Distributed model, with satellite radiotherapy** – split all MVCC inpatient, outpatient and ambulatory activity across neighbouring tertiary cancer providers with satellite radiotherapy in the north of the patch (e.g. Stevenage or Luton).	• Redistribute across 2 providers • Redistribute across 3 providers • Radiotherapy at MVCC/Stevenage • Radiotherapy at MVCC/Luton • Radiotherapy at other location in the north of the patch.

9.2 Short list of options

The Clinical Advisory Panel considered all the evidence gathered during the review and matched this against the long options list.

A shorter list of options was identified, with some from the long list being disregarded due to their inability to address key drivers for change or deliver an acceptable clinical model.

In all the supported options, the Clinical Advisory Panel has recommended that the accountability and ownership of the MVCC services be transferred from East and North Hertfordshire NHS Trust to a current tertiary cancer centre (see appendix 8).

Option	Long List Description	Panel View	Rationale
1	Do minimum	This option is not considered clinically acceptable	The safety and sustainability of the MVCC services could not be achieved with this option. A number of high clinical risks have been identified if services do not change in major ways.
2	Full replacement on a non-acute site	This option is not considered clinically acceptable	This option does not address the need for comprehensive acute service support in the delivery of tertiary cancer care, a clearly identified clinical risk.
3	Full replacement on an acute site	This option is considered clinically acceptable	• This option would require the build of a new integrated cancer centre on an acute DGH site. • This should preferably be close to the existing MVCC site and central to the existing catchment area to maintain patient access. • Leadership for the centre should be through an existing London based tertiary cancer centre. • Services in the new build must include: ○ Oncology inpatient beds ○ All types of radiotherapy and appropriate radiotherapy planning facilities ○ Dedicated oncology teams of nursing staff and AHPs ○ Access to anaesthetics / theatres for brachytherapy services ○ Nuclear medicine and radio pharmacy services (preferably integrated with local isotope service) ○ Chemotherapy day case unit ○ Aseptic services for oncology pharmacy capable of manufacturing licence ○ Paul Strickland imaging centre ○ Linkages to existing hospital ○ Outpatient clinics ○ Medical physics hub ○ Consultant offices ○ Office for SpRs

			○ Clinical trials offices • Additional radiotherapy satellite provision in the north of the catchment area would be preferable. • A networked chemotherapy service run from the cancer centre on acute DGH sites would be preferable.
4	Majority replacement	This option is not considered clinically acceptable	The option of building up all but inpatient services on the existing MVCC site and relocating all acute inpatient services to a DGH would largely reproduce current clinical risks and result in lack of cohesion of service delivery.
5	Ambulatory Hub	This option is considered clinically acceptable	• This would comprise a new build on an acute site with an ambulatory service for radiotherapy (4 linacs) and chemotherapy remaining on the existing MVCC site. • Leadership for the centre should be through an existing London based tertiary cancer centre. • Services in the new build on an acute DGH site must include: ○ Oncology inpatient beds ○ Some radiotherapy especially for the most complex radiotherapy e.g. chemo radiotherapy for head and neck cancer. ○ Dedicated oncology teams of nursing staff and AHPs ○ Access to anaesthetics / theatres for brachytherapy services ○ Nuclear medicine and radio pharmacy services (preferably integrated with local isotope service) ○ Chemotherapy day case unit ○ Aseptic services for oncology pharmacy capable of manufacturing licence ○ Paul Strickland imaging centre ○ Linkages to existing hospital ○ Outpatient chemotherapy suite services ○ Outpatient clinics ○ Medical physics hub ○ Consultant offices ○ Office for SpRs ○ Clinical trials offices • Additional radiotherapy satellite provision in the north of the catchment area would be preferable as would networked chemotherapy with a single governance arrangement run from the cancer

			centre on the acute DGH site linked into acute DGHs and mobile chemotherapy if possible.
6	Distributed model, with satellite radiotherapy	This option is not acceptable	Based upon the review findings, this option would result in: • The loss of expert oncology workforce due to the further demoralisation of the workforce (as there was a clear consensus that this would not be acceptable). • Patient access may also be impacted with a proportion of existing patients having to travel further • The loss of a long established service, highly valued by patients

10. Recommendations

The Clinical Advisory Panel accept the capital investment challenges of the 2 recommended options with the ambulatory hub (option 5) perhaps more pragmatic than full replacement on an acute site (option 3). Nevertheless, the cancer centre still requires a full complement of services. It must be on an acute DGH site and in order to ensure the maximum integration of care must give consultant, nursing, radiographer, physics and oncology pharmacy staff who participate in networked clinics, chemotherapy or radiotherapy as many reasons as possible to spend significant time at the cancer centre on the acute DGH site. Under either of these options, the leadership, governance, management and strategic development of the specialised oncology service at MVCC should transfer to an existing tertiary cancer service provider.

Irrespective of which model of reconfiguration is recommended, there will inevitably be a significant period of transition to full implementation. Patient safety and confidence must be maintained during this transition by bolstering acute oncology provision, consultant ward rounds, and strict admission policies to existing MVCC site, MVCC staff reviewing patients who have been transferred out to local DGHs, maintaining linac capacity, ensuring the provision of oncology pharmacy services and recruiting additional staff.

APPENDICES

Appendix 1

Clinical Advisory Panel Biographies

Prof Nick Slevin.

Professor Slevin has been a consultant Clinical Oncologist since 1988 at the Christie Hospital in Manchester specialising in the non-surgical management of head and neck cancer.

He was Chair of NHSE Radiotherapy CRG 2012-19 and remains Chair of Radiotherapy Commissioning through Evaluation. He was Senior Responsible Owner for Manchester Proton Beam Therapy until the service opened in 2018.

Professor Slevin has previously been FRCR examiner, Regional Postgraduate Advisor for Clinical Oncology. He has over 100 peer reviewed publications and initiated much original research. He has recently been visiting Professor to Philadelphia and Dublin with the award of honorary Irish Fellowship.

At the Christie Professor Slevin was Director of non-surgical oncology services for many years, overseeing the chemotherapy strategy, Project Director for new chemo treatment centre, and purchase of mobile unit.

Professor Slevin as Clinical Director of Clinical Oncology initiated the Radiotherapy Related Research strategy and expansion of consultant staff complement as well as advising on establishing Radiotherapy satellite provision.

Most recently, he has been Clinical Director of Christie International, offering consultancy advice to providers in India, Ireland and Indonesia.

Professor Peter Clark

Professor Clark is a medical oncologist and practised in Liverpool and Merseyside for over 28 years. He has a passionate belief in the equity of access for patients to high quality evidence-based cancer care and the provision of the right chemotherapy to the right patient in the right place and at the right time and in the right way.

Professor Clark's roles have included being Medical Director of his Trust (1993-2000), Director of the Mersey & Cheshire Cancer Research Network (2001-2008), leading his specialty of medical oncology nationally (2000-2006), serving on the NICE Technology Appraisal Committee (2002-2009) and then chairing it (2009-2013) and then joining NHS England Specialised Commissioning in 2013 as chair of the Chemotherapy Clinical Reference Group (2013-2019)and National Clinical lead for the Cancer Drug Fund (2013-t0 date). His enthusiasm for evidence-based care and equity of access to the right clinically and cost-effective chemotherapy remains undimmed: the need for it is ever greater in a financially challenged NHS facing both the opportunities and threats of great drug discovery in cancer and an ageing population.

Julie Gray

Associate Chief Nurse and Deputy Director of Quality, The Christie NHS Foundation Trust

Julie qualified as a Registered General Nurse in 1993 gaining experience in a range of care environments including medical, surgical and intensive care. Julie went on to become a Clinical & Professional Skills Tutor, with a special interest in medicines management, at the University Hospitals of South Manchester which led onto a role with the Greater Manchester Strategic Health Authority as a clinical placement manager supporting student nurses in practice.

Julie joined The Christie NHS Foundation Trust as a specialist nurse in 2005, moving into a governance role in 2007. During this time Julie was instrumental in the Trust's achievement of NHSLA level 3 accreditation. She also participated in the comprehensive inspection programme as a Specialist Advisor for the Care Quality Commission and in 2016 she operationally led the Trust to a CQC Outstanding rating, repeated again in 2018.

In her current role as Associate Chief Nurse and Deputy Director of Quality Julie leads the patient safety, patient experience, clinical audit and improvement and non-medical prescribing services for the Trust.

Julie has an honours degree Health Service Management & Health Promotion, a Post Graduate Certificate in Education and a Master's degree in Leadership in Health & Social Care. In 2017 she also became a scholar of the Florence Nightingale Foundation.

Jenny Scott

Deputy Director of Business Development, The Christie Hospital

Jenny Scott is Deputy Director of Business Development at The Christie in Manchester and has extensive strategic and operational management experience in the NHS having held a number of senior positions both locally and nationally. These have included leading a North West England team commissioning specialised healthcare services, managing large scale service transformation programmes and most recently being the Programme Director for both the Manchester Proton Beam Therapy initiative and the National Cancer Vanguard in Greater Manchester. Jenny is now leading on a number of commercial initiatives and is the Programme Director of Christie International offering consultancy advice to providers in India, Ireland and Indonesia.

Jenny has an honours degree in Psychology, A diploma and a Master's Degree in Healthcare Management. She has gained qualifications in programme and project management and has trained as an Action Learning set facilitator.

Steve Palmer

Steve was elected Chair in May 2018 having previously been our Treasurer. Steve worked in social housing for many years, as Finance Director and Managing Director, and subsequently worked with tenants and others looking at the future of local authority housing. Steve has also served as a Councillor in Watford and has been a Board member of Housing Associations and various Charities.

Following a number of years of ill health, Steve has extensive practical experience of the NHS, and wants to ensure that the service we all rely on is the best it can be, and that people are fully involved in the care they receive.

Turkay Mahmoud

Turkay has lived in Hillingdon for over 32 years and has significant leadership experience in education at school, local authority, regional and national level having worked in education and the public sector for over 40 years. During his early career he taught in a number of schools in London and was a head teacher of a new school. He later worked in a senior leadership capacity in several local authorities with responsibility for school development and improvement, as an Ofsted inspector and for the National College for School Leadership.

He has worked on a number of national change programmes: school workforce reform and extended services for schools. He has worked for Inspiring Futures Foundation (a charitable organisation) providing careers advice to students and acted as a senior advisor to a charitable organisation in Bangladesh which has opened a new school with the aim of providing quality education in semi-rural Sylhet.

Turkay has been with Healthwatch Hillingdon since it was established (2013) and has been Chair, Vice Chair and is currently the interim Chief Executive Officer.

Turkay has a Certificate in Education, an honours degree in Education and Human Movement Studies and a Master's degree in Education in Urban Areas.

Appendix 2 **Clinical Advisory Panel Programme**

MVCC Clinical Advisory Panel Two Day Programme

19th and 20th June 2019

Seminar Room, Post Graduate Centre, Mount Vernon Cancer Centre (WD3 1PZ)

	18th June 2019
19.00	**Welcome and outline of the programme** Ruth Ashmore, Director of Specialised Commissioning and Health and Justice, NHS England and NHS Improvement

	19th June 2019
08.30-08.45	**Meet at Post Graduate Centre to begin Tour**
08.45-10.30	**Tour of the Mount Vernon Site** Clinical Advisory Panel with Dr Paul Mulholland and Kelly McGovern
10.30 – 11.00	**Return to Meeting Room - Coffee and Discussion**
11.00-12.00	**Divisional Chair, Cancer Division, MVCC** ○ Jagdeep Kudhail **Clinical Director, MVCC** ○ Dr Paul Mulholland
12.00-12.45	**Hospital Director** ○ Sarah James **Head of Nursing, Cancer Division, Cancer Division, MVCC** ○ Kelly McGovern
12.45-13.15	**Out Patient Department** ○ Neel Bhuva, Clinical Oncologist ○ Maggie Fitzgerald, Deputy Head of Nursing ○ Trisha Webbe, Associate Director, Cancer Division ○ Sarah Morgan, Matron Out-patients
13.15 - 14.00	**Lunch and Panel Discussion**
14.00-15.00	**In-patients and Palliative Care:** ○ Dean Weston, In-patient and Palliative Care Manager ○ Claire Dua, In-patient Matron ○ Humaira Jamal, Palliative Care Consultant ○ Suprotim Basu, Consultant, In-patient Lead ○ Zandie Chakunda, Acute Oncology, Lead Nurse
15.00-16.00	**Junior Medical Staff**: ○ Laura Morrison, Jyotsna Bhudia, Mohammed Abdul-Latif
16.00 – 16.30	**Coffee – Clinical Panel Discussion**
16.30-17.30	**Chemotherapy:** ○ Dr David Miles, Clinical Lead for Chemotherapy ○ Jo Demare, Chemo, AOS, OPD and Medical Records Service Manager ○ Michelle Orsmond, Chemo matron ○ Vikash Dodhia, Lead Pharmacist ○ Andrew Hood, Chief Pharmacist
17.30-18.30	**CNSs:** ○ Amanda Webb, Palliative Care Clinical Nurse Specialist, ○ Melanie Blyth, Lung CNS, ○ Helen Johnson, Haematology CNS ○ Maggie Fitzgerald, Deputy HON
18.30	**Close**

	20th June 2019
08.30-09.15	○ Cathy Cale, Medical Director, Hillingdon Hospital
09.15-10.00	**CCG Commissioners - Teleconference** ○ Beverley Flowers, Accountable Officer, East & North Herts CCG ○ Sharn Elton, Clinical Lead, Cancer Services, East & North Herts CCG ○ Lizzy Bovill – Director of Performance & NWL SRO for Cancer
10.00 – 10.30	**Coffee**
10.30-11.45	**Radiotherapy Modelling** ○ Edward Bramley-Harker and Kim Fell
11.45-12.45	**Consultants:** ○ Roberto Alonzi, Brachytherapy Consultant ○ Pete Ostler, Breast, Urology and Brachytherapy Consultant ○ Suzy Mawdsley, Head of School for Clinical Oncology, London
12.45 – 13.30	**Lunch and discussion**
13.30-14.30	**Radiation Services**: ○ Daniel Megias, Head of Radiotherapy ○ Karen Venables, Head of Radiotherapy Physics and Bioengineering ○ Claire Strickland, CEO Paul Strickland Scanner Centre ○ Professor Padhani
14.30-15.30	**Nuclear Medicine:** ○ Suzanne Douglas, Lead Clinical Scientist, Nuclear Medicine, ○ Andrew Shah, Head of Radiation Protection
15.30 – 16.00	**Coffee with Rachael Corser**
16.00 – 16.30	**Research & Development** ○ Philip Smith, Associate Director Research and Development ○ Paul Nathan, Medical Oncologist, Melanoma lead ○ Marcia Hall, Clinical Lead Research and Development ○ Anita Holmes, Trust Lead Research Nurse
16.30 – 17.15	**Panel Discussion**
17.15	Opportunity for additional questions to Jagdeep Kudhail, Dr Paul Mulholland, Sarah James and Kelly McGovern if required
17.45	**Close**

Appendix 3

Clinical Advisory Panel Programme Participants (19/20 June)

Name	Position
Jagdeep Kudhail	Divisional Chair, Cancer Division
Dr Paul Mulholland	Clinical Director, MVCC
Sarah James	Hospital Director, MVCC
Kelly McGovern	Head of Nursing, Cancer Division, MVCC
Neel Bhuva	Clinical Oncologist
Maggie Fitzgerald	Deputy Head of Nursing
Trisha Webbe	Associate Director, Cancer Division
Sarah Morgan	Matron, Out-patients
Dean Weston	In-patient and Palliative Care Manager
Claire Dua	In-patient Matron
Humaira Jamal	Palliative Care Consultant
Suprotim Basu	Consultant, in-patient lead
Zandie Chakunda	Acute Oncology, Lead Nurse
Laura Morrison	Junior Medical Staff
Jyotsna Bhudia	Junior Medical Staff
Mohammed Abdul-Latif	Junior Medical Staff
Dr David Miles	Clinical Lead for Chemotherapy
Jo Demare	Chemo, AOS, OPD and Medical records Service Manager
Michelle Orsmond	Chemotherapy Matron
Vikash Dodhia	Lead Pharmacist
Andrew Hood	Chief Pharmacist
Amanda Webb	Palliative Care CNS
Melanie Blyth	Lung CNS
Helen Blyth	Lung CNS
Helen Johnson	Haematology CNS
Cathy Cale	Medical Director, Hillingdon Hospital
Beverley Flower	Accountable Officer, ENH CCG
Sharn Elton	Clinical Lead, Cancer services, ENH CCG
Lizzy Bovill	Director of Performance, NWL SRO for Cancer
Edward Bramley-Harker	EDGE
Kim Fell	NHS E/I
Roberto Alonzi	Brachytherapy Consultant
Pete Ostler	Breast, Urology and Brachytherapy Consultant
Suzy Mawdsley	Head of School for Clinical Oncology, London
Daniel Megias	Head of Radiotherapy
Karen Venebles	Head of Radiotherapy, Physics and Bioengineering
Claire Strickland	CEO, Paul Strickland Scanner Centre
Professor Padhani	Consultant Radiologist, Paul Strickland Cancer Centre
Suzanne Douglas	Lead Clinical Scientist, Nuclear Medicine
Andrew Shah	Head of Radiations Protection
Rachael Corser	Director of Nursing, ENHT
Philip Smith	Associate Director, research and Development
Paul Nathan	Medical Oncologist
Marcia Hall	Clinical Lead, R & D
Anita Holmes	Trust Lead Research Nurse

Appendix 4

Clinical Advisory Panel Participants – telephone call interviews

Consultants	Clinical or Medical	Speciality
Dr Roberto Alonzi	Clinical Consultant	Urology
Dr Nicola Anyamene	Clinical Consultant	Upper and Lower GI
Dr Neel Bhuva	Clinical Consultant	Upper and lower GI
Dr Kevin Chiu	Clinical Consultant	Head and Neck
Dr Shirley D'Sa	Consultant Haemato-Oncologist	Haematology
Dr Jeanette Dickson	Clinical Consultant	Lung
Dr Rob Glynne-Jones	Clinical Consultant	GI
Dr Amy Guppy	Medical Consultant	Breast
Dr Marcia Hall	Medical Consultant	Gynae
Dr Mark Harrison	Clinical Consultant	Upper and lower GI
Prof Peter Hoskin	Clinical Consultant	Urology
Dr Humaira Jamal	Palliative Care consultant	Palliative Care
Dr Jonathan Lambert	Consultant Haemato-Oncologist	Haematology
Dr Catherine Lemon	Clinical Consultant	Head and Neck
Dr Alan Makepeace	Clinical Consultant	Breast
Dr Andreas Makris	Clinical Consultant	Breast
Dr Suzi Mawdsley	Clinical Consultant	Upper and lower GI
Dr David Miles	Medical Consultant	Breast
Dr Paul Mulholland	Medical Consultant	Neuro
Dr Paul Nathan	Medical Consultant	Melanoma
Dr Peter Ostler	Clinical Consultant	Breast
Dr Andreas Polychronis	Medical Consultant	Upper and lower GI
Dr Nihal Shah	Clinical Consultant	Breast
Dr Anand Sharma	Medical Consultant	Germ cell
Dr Heather Shaw	Medical Consultant	Melanoma
Dr Narottam Thanvi	Clinical Consultant	Breast
Dr Ignacio Vazquez	Medical Consultant	Breast
Dr Anup Vinayan	Clinical Consultant	Breast
Dr Charlotte Westbury	Medical Consultant	Breast
Dr Kee Wong	Clinical Consultant	Head and Neck
Dr Hannah Tharmalingham	Clinical Consultant	Gynaecology

Appendix 5

East and North Hertfordshire NHS Trust CQC Report

The most recent CQC Inspection of the Mount Vernon Cancer Centre Site in April 2018 rated the Hospital as requiring improvement across 3 of the 5 domains:

Domain	Rating
Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Requires improvement
Well led	Requires improvement

With specific services rating:

Service	Rating
Chemotherapy	Requires improvement
End of life care	Requires improvement
Medical care	Inadequate
Outpatient and diagnostic imaging	good
Radiotherapy	Good

Appendix 6

Clinical Advisory Panel Document Review

Title	Author	Date
Clinical Strategy 2019 – 2024	ENHT	2019
NHS England Radiotherapy Specification	NHSE	2019
Documents contained within MVCC Board Papers		02.05.19 13.06.19
ENHT CQC Report	CQC	July 2018
Mount Vernon Cancer Centre Strategy 2018 -2023	ENHT	March 2018
MVCC Clinical Strategy – Phase 1 Report	ENHT	Oct 2016
ENHT Research Strategy	ENHT	2016- 2019
NHS England Chemotherapy Specification	NHSE	2013
MVCC Reviews	MVCC	2002 2009 2013

Appendix 7

Stakeholder Interviewees

Caroline Blair	NHSE
Christine Moss	West Essex & Hertfordshire STP
Jane Brown	Healthwatch Hertfordshire
Turkay Mahmoud	Healthwatch Hillingdon
Jo Murfitt	NHSE
Michael Chilvers	E&NH (Executive Team)
Laura Churchward	UCLH
Cathy Cale	Hillingdon Hospitals FT
Sarah James	E&NH (MVCC)
Claire Strickland	Paul Strickland Scanner Centre
Jagdeep Kudhail	E&NH (MVCC)
Kelly McGovern	E&NH (MVCC)
Julie Smith	E&NH (Executive Team)
Sue Douglas	E&NH (MVCC)
Dan Megias	E&NH (MVCC)
Hannah Tharmalingam	E&NH (MVCC)
Paul Mulholland	E&NH (MVCC)
Prof Hoskin	E&NH (MVCC)
Harper Brown	West Essex & Hertfordshire STP/East & North Herts CCG
Nicky Bannister	Herts Valleys CCG
Rachael Corser	E&NH (Executive Team)
Sarah Brierley	E&NH (Executive Team)
Mandy Sanderson	NHSE and I
Nicola Hunt	RM Partners West London Cancer Alliance
Naser Turabi	North Central and East London Cancer Alliance/UCLH
Maggie Fitzgerald	E&NH (MVCC)
Mohammed Abdul-Latif	E&NH (MVCC)

Appendix 8

Advantages of tertiary cancer centre leadership for MVCC services

(Majority Consultant view)

	Advantages
1.	Ownership of MVCC by experienced provider of cancer services would establish strategic and operational priorities
2.	A change of management of the MVCC services would be established and restore confidence with clinical staff
3.	Academic links to a university would be secured with links to a large academic health science centre
4.	Protection of trials base
5.	Access to high quality clinical trials unit
6.	The radiotherapy network would preferably remain the same
7.	Enable MVCC to retain their brand – highly valued by patients and the public
8.	Geographical proximity if possible
9.	A tertiary cancer centre will have experience in managing other specialist services and satellite arrangements
10.	Tertiary centres are likely to have greater flexibility in negotiating with the host of the acute services
11.	Tertiary centres may have better access to capital funding
12.	Complex and uncommon cancer patients already flow to UCLH (e.g. paediatrics, sarcoma, CNS)
13.	A tertiary cancer centre will offer greater access to laboratory facilities
14.	Haematology oncology pathway needs to be in place
15.	A tertiary cancer centre should offer SpR rotation to MVCC
16.	Shared posts would be required
17.	A partnership agreement to describe the working between a tertiary cancer centre and MVCC should be a collaborative and mutually beneficial two way partnership
18.	Complementary with regard to tumour service with MVCC focussing on the 4 most common cancers and the tertiary centre on the less common ones
19.	The tertiary centre should be able to move quickly to establish leadership arrangements
20.	A tertiary centre would ensure critical mass exists to implement effective training / education and trials infrastructure which in turn would aid recruitment and retention of expert oncology staff.

East and North Hertfordshire NHS Trust

Agenda Item: 9.1

TRUST BOARD - PUBLIC SESSION – 4 SEPTEMBER 2019

Integrated Performance Report – Month 4

Purpose of report and executive summary (250 words max): The purpose of the report is to present the Integrated Performance Report Month 4 to the Trust Board. Key challenges and mitigations under each domain are identified within the report.		
Action required: For discussion		
Previously considered by: Executive Committee 29.08.19		
Director: All Directors	**Presented by:** All Directors	**Author:** All Directors / Head of Information and Business Intelligence

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

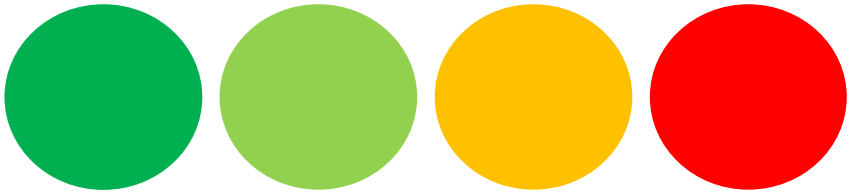
Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
Any other risk issues (quality, safety, financial, HR, legal, equality): Key challenges and mitigations under each domain are identified within the report.

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

East and North Hertfordshire NHS Trust

Integrated Performance Report

Month 04 | 2019-20



Contents

East and North Hertfordshire NHS Trust

Performance Headlines

East and North Hertfordshire NHS Trust

Domain	Positive Performance	Challenges	Lead Director
Safe & Caring Services	**Next learning event** On the 1st of October 2019 the trust shall launch the ENHT Safer Invasive procure Policy. The theatre teams have been designing and testing a 'NatSSIP complaint' audit tool, which is currently being transferred to digital format for all other invasive teams to adopt, this shall be displayed form ward to board on QlikView. Plans are also underway to deliver ENHT Winter Quality Learning event. Plans are also underway to celebrate National Patient safety day - 17th Sept, where there will be targeted focus to improve ENHT reporting Culture. **Improvement initiatives - deteriorating patients** Clinical areas have been identified and key crossing cutting themes have been analysed for improvement. The improvement group have started planning the details of ENHT Deteriorating Patient Breakthrough Series Collaborative. The current aim is to launch 1st learning set in Oct 2019. This will include improving the recognition and management of Sepsis, Aki, Hyper & Hypo glycaemia, acute laparotomy care and treatment escalation planning. **CQC preparation** Ongoing quality walk rounds continue, providing immediate feedback with clinical leaders. Specific action plans have been design where needed and agreed governance measures e.g. theatres. **Clinical Excellence framework** Designing and testing of excellence framework has been undertaken. Four wards have now undertaken their self-assessment against each framework pillar, this data is currently being analysed. Next steps include peer review of these clinical areas to ascertain potential accreditation level. This framework is supported by our 1st wave of 20 ward leader participating in a 12month RCN leadership programme, which goes live 26th Sept 2019. **Serious Incident Management** Planned Duty of Candour sessions continue to be delivered through Drs Inductions and RCA training sessions. RCA incident management has managed to improve over time, though focussed support with the surgical division and thematic grouping of key incidents into trust wide improvement work. Work is underway to move to new Datix cloud, this will enable a more supportive system for reporting and learning from incidents, complaints, mortality and claims.	**Dashboard data quality** Work continues to ensure quality control/checking of quality domains. Current dashboard on version 11. Measurement plans for End of Life metrics and cardiac arrest data are currently being agreed and have required some fine tuning to agree data sourcing. This process should become more effective with the start of Q&S Data analyst in Sept 2019. **Serious Incident Management** DOC training & compliance capture remains priority. Through deep dive to historical incidents reported, we have identified poor historical gathering of evidence to support the application of the duty. While steps in current processes are leading to current improvements, further targeted work is required to ascertain the evidence available for historical incidents. **Incident Reporting** The trust remains an outlier form an underreporting perspective. This is a concern as this could demonstrate poor learning opportunities and mitigation of against future harms. Some themes identified have included usability of Datix system and confusion of incident allocation within the system. These themes shall be focus of National Patient safety day on 17th Sept. **Supporting Staff Sustainably and Continuously Improve** While the current Quality & Safety team members within the corporate & divisional teams have work incredibly hard to drive a culture of continuous improvement with clinical teams, there remains a delay in scale and pace of building capabilities across all staff groups. This is fundamental to achieving successful shared purpose and sustainable changes. The recruitment of Quality Improvement team to co-ordinate and deliver targeted levels of learning across ENHT will contribute to the success of improving this, the team plan to be fully established by Oct 2019. **Complaints Management** Remains a priority for the trust, to both improve timeliness of response and overall reduction in open complaints.	 **Rachael Corser** **Director of Nursing**

Performance Headlines

East and North Hertfordshire NHS Trust

Domain	Positive Performance	Challenges	Lead Director
Effective Services	**Mortality** Mortality can be considered a proxy measurement of the overall care delivered to patients. Timely, high quality care, delivered by motivated, well-trained and caring staff results in better outcomes including reduced adverse events, complications and deaths. Mortality rates at the Trust have improved over the last 5 years as measured by both of the major methods: HSMR and SHMI. **Hospital Standardised Mortality ratio (HSMR)** This measure is based on a basket of 56 patient groups with relatively predictable mortality and records death in hospital. Performance has been persistently in the 'as expected range'. Refreshes since April 2019 (rolling 12 months to January-March 2019) have seen HSMR fall to within the 'Better than expected' range. The latest HSMR for the rolling 12 months to May 2019 is 93.1. HSMR is generally available 3/12 in arrears. **Summary Hospital-level Mortality Indicator (SHMI)** This is a measure of mortality for all inpatients including up to 30-days post-discharge. Historically, ENHT's SHMI has been up to 10 points higher than the HSMR, which was thought to be related to the onsite hospice at Mount Vernon. However, over the last 2 years the gap between SHMI and HSMR has steadily reduced. Since the rolling 12 months to December 2018 SHMI has now fallen to less than HSMR for the corresponding period. From January 2019 the indicator is now available monthly rather than quarterly. The latest SHMI for the rolling 12 months to March 2019 is 91.5 ('as expected' range). SHMI is now generally available 4/12 in arrears. **Crude mortality** This measure is available the day after the month end and has demonstrated a consistent decrease over the last 5 years. It is the factor with the most significant impact on HSMR. The Trust's crude mortality has continued on a downward trend. **Learning from deaths** In addition to the monitoring of mortality indicators, the Trust remains committed to reviewing and learning from the deaths of those who die while in our care, even when the death is expected. June 2019 deaths in scope = 103; Total mortality reviews undertaken = 93 Year to 30 June 2019 deaths in scope = 349; Total mortality reviews = 262.	**Mortality** Although overall Trust mortality is within the 'as expected' (SHMI) or 'better than expected' (HSMR) range, there are often still subgroups of patients where mortality is raised. Monthly Mortality Alerts meetings are held following Dr Foster refreshes to consider new and existing elevated diagnosis groups. This small group led by the Medical Director with Coding, Information, Mortality, and Quality Leads, monitors our data (HSMR, SHMI & CUSUM alerts), confirms whether the issue relates to incorrect coding and where uncertainty/concerns persist, instigates a retrospective review of a sample of the deaths underlying the mortality rate to identify learning and any changes that may be beneficial, e.g. to the patient pathway or to Trust policies and procedures. Information from the Mortality Alerts work feeds into the Mortality Surveillance Committee which has responsibility for mortality governance. Current outliers under review: HSMR - nil SHMI - Diverticulosis & Diverticulitis; Congestive heart failure CUSUM alerts - Nutritional deficiencies (1); Perio, endo; & myocarditis cardiomyopathy (2); Poisoning by psychotropic agents (1). **7-day Services** The delivery of consistently high quality care to patients across the entire week has been a challenge for the Trust. There is currently a difference (not statistically significant) in mortality between weekend/weekday emergency admissions. Recent months have seen improvements in HSMR for both weekday admissions now 'better than expected' and particularly for weekends 'as expected'. Consultant review within 14 hrs of emergency admission is lower at the weekend and an area where we need to improve our performance. While an Associate Medical Director for Reduction in Unwarranted Variation is shortly to be appointed, a new 7 Day Services Steering Group is now established with the principal aim of achieving compliance with the 4 priority Keogh standards by April 2020.	 **Michael Chilvers** **Medical Director**

Performance Headlines

East and North Hertfordshire NHS Trust

Domain	Positive Performance	Challenges	Lead Director
Responsive Services	**ED Performance** The Trust ED performance in July was at 81.47%. This is a disappointing deterioration in performance on the previous month. The deterioration has been driven by high attendances, poor flow and compounded further by IT outages for both Nerve centre and Lorenzo and a period of very high temperatures. Positively the trust continues to report 0 12-hour trolley breaches. **Cancer Performance** The trust delivered 4 compliant national cancer targets in June to include; 2ww, breast symptoms and 31-day subsequent for radiotherapy and chemotherapy. The Trust 62-day performance for June 2019 was 75.6%, NHS digital upload. This is improved on the previous month but below the revised recovery trajectory of 78.7%. In advance of the 4th urologist appointment which will deliver the additional RALP capacity, there has been a reorganisation of Consultant tasks to create some interim RALP capacity which will support short term improvements in performance, to get the trajectory back on track. It is anticipated that this will start to deliver in August. **RTT Performance** July RTT Incomplete performance was 85.38%, a slight improvement on June's performance. There were 19 x 52 week breaches reported at month end. This is the remaining impact of the cohort of patients identified with incorrect clock stops. Work is ongoing to list patients in month to avoid month end 52 week breaches. It is anticipated that there will be an improvement in the month end reportable 52 week breach position through August and September to a zero 52 week breach position in October. **Diagnostics** DM01 performance for July is 0.56% against the national standard of 1%. This is above the recovery trajectory, demonstrating great compliant performance, and has been sustained for 3 months. The key will be delivering compliance going forward. No risks to maintaining this level of performance are being flagged. **Stroke Performance** Performance for July is 63.30%. This represents deterioration on the recent June performance but still demonstrates improvement from April/May performance at 54.2% and 60% respectively. This position reflects the operational challenges felt in July on flow, beds, and the impact of business continuity incidents in support of IT outage and heat management.	**ED Performance** Positively, a significant improvement on ambulance handovers have been seen in month, with average handovers at 20 minutes. Night time breach performance remains a significant focus with plans at the 3pm bed meeting to ensure that forecast beds in assessment areas are sufficient to support the night time flow of patients coupled with expectation setting discussions at the 10.00pm huddles. There is a regular fortnightly meeting to discuss GP streaming to ensure the trust is maximising all opportunities within this patient pathway as a clear enabler for managing emergency patients. Same Day Emergency Care (SDEC), launched this week for emergency surgery patients. This initiative will be closely monitored to ensure the impact and benefits are tracked and fed back to the organisation. **Cancer Performance** The focus remains on the high impact tumour sites for recovery of urology, LGI, gynae, lung and diagnostics. Additional RALP capacity is the key to reducing urology breaches, and there is both an interim and longer term plan to deliver this. There is a meeting next week to discuss the lung pathway with the key clinicians and operational teams to ensure all the timed tool pathway analysis improvements have been implemented, and to identify if there are other improvements that can be made. This discussion will include colleagues at Papworth. Action plans are in place for the remaining tumour sites and radiology and they are scrutinised and challenged at the weekly access meeting. **Winter Planning** The winter steering group was launched this week with strong support and representation from the organisation. The teams are currently working on local initiatives to support winter flow to include Point of Care Testing (POCT) for flu in the ED; use of pharmacists within the ED to admission avoid and planning for the winter ward. These plans will be informed by the D&C modelling which will identify the number of additional beds required by the organisation to support patient flow over winter. Internal winter plans will be further enhanced by system initiatives to support early supported discharge and alternatives to patients attending the ED. **Business Continuity Incidents** There have been a number of business continuity incidents declared in month in response to IT outages and high temperature management. Positively, this has allowed the organisation to test out our incident management processes which have responded well.	 **Julie Anne Smith** **Chief Operating Officer**

Performance Headlines

East and North Hertfordshire NHS Trust

Domain	Positive Performance	Challenges	Lead Director
Well-led Services	**Recruitment** The plans for nursing recruitment for 19/20 are now complete, with all 41 of the planned international nurses already commenced. The reduction in overseas recruitment has resulted in an increased investment in domestic recruitment and retention using a variety of initiatives including interest free loans for visa renewals, a focussed and enhanced offer for current third year student nurses and a band 5 internal transfer scheme. Work is also underway to enhance the Trust's branding and image with refreshed recruitment campaigns for nurses. In addition, a refer a friend scheme was launched in month 4 for hard to recruit staff groups. **Turnover** The Trust turnover rate is down by 1.5% in July 19 (12.3%) compared to July 18 (13.8%). Over the 12 months this requested to 81 less people having left the Trust compared to the previous 12 months. Nursing and Midwifery staff have reduced most significantly down to 11.6% from an average of 12.5%. **Talent Management** The Trust has a new talent management lead and is working on some key work streams including: developing a Talent Management Strategy; replicate the work of the region within the organisation, support General Management Trainee Scheme (GMTS), Accelerated Director Development Scheme, Mary Seacole; Appraisal, feedback and Career conversations. In July, 9 members of staff were successful in starting Mary Seacole and 5 people were selected for the GMTS. **Staff Wellbeing** Sickness absence rates continue to improve with the Trust now performing better than national average. Overall sickness absence rate is 0.4% better than the previous year at 3.7%. Focus has been on reducing days lost due to mental health and muscular skeletal related issues. In July the number of full time equivalent (FTE) days lost due to sickness related to musculoskeletal issues was 27% lower than July the previous year, the days lost due to mental health was 21% lower than July 2018.	**Agency Staffing Spend** The Trust was £51k over the agency ceiling in July and is £119k over year to date. Agency medical staff are the main factor influencing overspend. However, despite the overspend in agency year to date, the Trust is confident in the recovery which will ensure that it finishes the year under the ceiling total. This is due to a strong recruitment pipeline with 19 starters in August and another 21 with confirmed start dates this year. **Appraisals** Despite a slight increase in July, appraisal rates are below target at 86.3%. A 'deep-dive' report has been provided identifying 'hot-spots' and issues. The divisions are being supported with weekly reporting and business partner support. The appraisal working group has now been set up to redesign the appraisal process to be launched in April 2020. **Culture** Work continues in response to the staff survey results. Divisional action plans have been developed supported by an over-arching action plan. Key areas of focus are on diversity and inclusion, well-being and leadership development. Women and Children division are being used as a model example for improving staff experience. The Trust People strategy will be developed throughout the summer which set out the vision for our culture.	 **Duncan Forbes** **Chief People Officer**

Performance Headlines

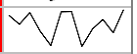
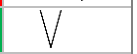
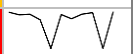
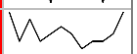
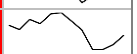
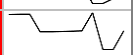
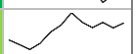
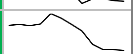
East and North Hertfordshire NHS Trust

Domain	Positive Performance	Challenges	Lead Director
Sustainable Services	The Trust has accepted its break even Control Total for 19/20. The Finance Committee and Trust Board reviewed and approved the financial and operational plan for the year ahead at meetings in March 2019. Budget plans for the new year were signed off by divisional management teams and similarly SLA activity plans for 19/20 have been reviewed and validated. In addition, the Trust has agreed SLA's with local and national commissioners for 19/20 in line with required national timelines. All contracts are signed. At M4 the Trust reports financial delivery that is in line with its agreed plan. SLA income performance reports a significant over achievement against plan, this mainly results from increased emergency admissions. In contrast the Trust reports a significant overspend against pay budgets YTD. This has been driven by pressure across medical and nursing budgets. This results in part from increased WLI spend used to deliver activity levels rather than the anticipated improvement in theatre and outpatient productivity. However, significant lapses in the control environment pertaining to the utilisation of temporary staffing across medical and nursing budgets have also characterised financial performance in the YTD. The Trust reports delivery of CIP savings of 4.2m YTD. Whilst this is slightly behind target, this level is significantly higher than historic values of achievement at this early stage in the financial year. In conjunction with other STP organisations the Trust will during Q2 initiate procurement activity to seek alternative Pathology provision arrangements from 20/21. It is expected that this will realise significant financial and service sustainability benefits. During the course of Q1 the Trust finance department has facilitated the roll out of an extensive package of financial e-learning material across 300 budget holders from the Trust. Uptake and completion rates have been excellent across this initial phase, and it is expected that the programme will be key in helping to support improved decision making and financial performance across the Trust. 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.	Elements of YTD finance performance represent a significant concern for the Trust. The significant overspent against pay budgets is largely unrelated to activity and pertains to a combination of slippage against clinical productivity targets and weaknesses in the management of medical and nursing temporary staffing costs. This underlying position is not sustainable and requires immediate redress. The Trust Executive have reintroduced weekly IFD oversight groups for both Medical Staffing and Nursing Management. These groups lapsed at the conclusion of the last financial year, there reinstatement has been identified as key in maintaining oversight and management of the temporary staffing control environment. The groups will be led by Executive Directors and will implement agreed improvement plans for these staffing areas to effect immediate reductions in run rate spend. The Trust has already implemented significant changes to its weekly Improving Financial Delivery (IFD) meetings with divisional management teams to ensure a heightened focus on establishment management, temporary staffing controls and achievement of recruitment and retention targets. A key feature of financial under delivery in previous years has been the Trust's continued reliance upon premium out of hours capacity (WLIs) and expensive locum staff in order to deliver required SLA activity throughput. The Trust needs to reduce this dependency through improvement in the productivity levels in its theatre and outpatient settings. Historically performance in these areas has been extremely poor in comparison with national benchmarks. Improvement represents a significant opportunity to make much better use of working week capacity and reduce costs. In order to support delivery of this improvement the Trust has set up a Theatre Transformation Board and an Outpatient Transformation Board. These groups are led by the COO and are designed to ensure that change plans are delivered. The success of these schemes will have a very significant impact upon the successful delivery of the overarching financial plan. The pace of progress in Q1 is significantly behind plan and this has resulted in unplanned medical spend pressures. The availability of capital resources continues to be constrained. The Trust faces significant requirements in respect of fire compliance works. The Trust is seeking emergency capital loan support from the Department of Health to help manage this requirement given their scale and the Trust extremely limited internal capital envelope.	 **Martin Armstrong** **Director of Finance**

Single Oversight Framework

East and North Hertfordshire NHS Trust

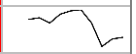
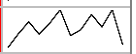
Quality of care

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
Caring	Written complaints - rate	Quarterly	Jul-19	Local	1.9	1.5	
Caring	Staff Friends and Family Test % recommended - care	Quarterly	Q1 2019-20	National	80.9%	67.8%	
Safe	Occurrence of any Never Event	Monthly (six-month rolling)	Feb-19 - Jul-19	National	0	1	
Safe	Patient Safety Alerts not completed by deadline	Monthly	Aug-19	National	0	5	
Caring	Mixed-sex accommodation breaches	Monthly	Jul-19	National	0	0	
Caring	Inpatient scores from Friends and Family Test - % positive	Monthly	Jul-19	National (excl. IS)	95.0%	97.8%	
Caring	A&E scores from Friends and Family Test - % positive	Monthly	Jul-19	National (excl. IS)	90.0%	83.8%	
Caring	Maternity scores from Friends and Family Test - % positive - antenatal care	Monthly	Jul-19	National (excl. IS)	93.0%	100.0%	
Caring	Maternity scores from Friends and Family Test - % positive - birth	Monthly	Jul-19	National (excl. IS)	93.0%	96.5%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal ward	Monthly	Jul-19	National (excl. IS)	93.0%	92.2%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal community	Monthly	Jul-19	National (excl. IS)	93.0%	100.0%	
Safe	Emergency c-section rate	Monthly	Jul-19	Local	15%	16%	
Organisational health	CQC inpatient survey	Annual	2018	National	8.0	7.8	
Safe	Venous thromboembolism (VTE) risk assessment	Quarterly	Q1 2019-20	National	95%	94.9%	
Safe	Clostridium difficile (C. difficile) plan: C.difficile actual variance from plan (actual number v plan number)	Monthly	Jul-19	National	0	1	
Safe	Clostridium difficile – infection rate	Monthly (12-month rolling)	Jul-19	National	10.20	12.45	
Safe	Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Monthly (12-month rolling)	Jul-19	National	0.61	0.96	
Safe	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	Monthly (12-month rolling)	Jul-19	National	8.14	6.70	
Safe	Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI)	Monthly (12-month rolling)	Jul-19	National	18.41	16.76	
Effective	Hospital Standardised Mortality Ratio	Monthly (12-month rolling)	Jun-18 - May-19	National	100	93.1	
Effective	Summary Hospital-level Mortality Indicator	Quarterly	Apr-18 - Mar-19	National	100	91.5	
Safe	Potential under-reporting of patient safety incidents	Monthly (six-month rolling)	Jul-18 - Jun-19	National	25.7	18.4	

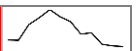
Finance

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
Financial sustainability	Capital service capacity	Monthly	Jul-19	National	1	3	
Financial sustainability	Liquidity (days)	Monthly	Jul-19	National	1	4	
Financial efficiency	Income and expenditure (I&E) margin	Monthly	Jul-19	National	1	4	
Financial controls	Distance from financial plan	Monthly	Jul-19	National	1	1	
Financial controls	Agency spend	Monthly	Jul-19	National	1	1	

Operational performance

A&E	A&E maximum waiting time of four hours from arrival to admission/transfer/discharge	Monthly	Jul-19	National	95%	81.5%	
RTT 18 weeks	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	Monthly	Jul-19	National	92%	85.4%	
Cancer Waiting Times	62-day wait for first treatment from urgent GP referral for suspected cancer	Monthly	Jun-19	National	85%	75.6%	
Cancer Waiting Times	62-day wait for first treatment from NHS cancer screening service referrals	Monthly	Jun-19	National	90%	63.6%	
Diagnostics Waiting Times	Maximum 6-week wait for diagnostic procedures	Monthly	Jul-19	National	1%	0.56%	
Dementia assessment and referral	The number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who:						
	a. have a diagnosis of dementia or delirium or to whom case finding is applied	Monthly	May-19	National	95%	-	
	b. who, if identified as potentially having dementia or delirium, are appropriately assessed	Monthly	May-19	National	95%	-	
	c. where the outcome was positive or inconclusive, are referred on to specialist services	Monthly	May-19	National	95%	-	

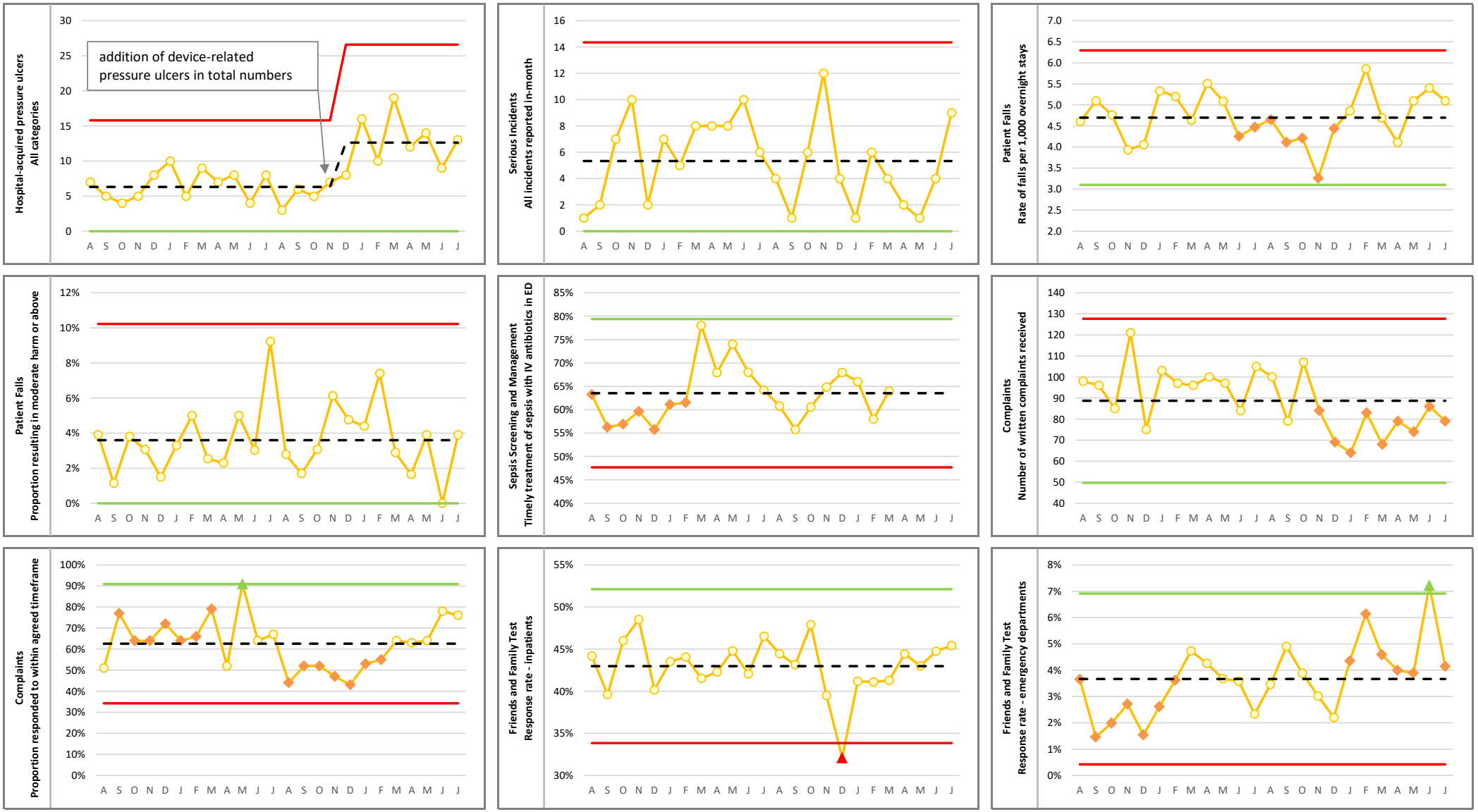
Organisational health

Organisational health	Staff sickness	Monthly	Jul-19	Local	3.4%	3.7%	
Organisational health	Staff turnover	Monthly	Jul-19	Local	12.0%	12.3%	
Organisational health	NHS Staff Survey Recommend as a place to work	Annual	2018	National	62.6%	53.9%	
Organisational health	Proportion of temporary staff	Monthly	Jul-19	Local	-	10.5%	

Quality Improvement Dashboard

Safe, Caring and Effective Services Headline Metrics

East and North Hertfordshire NHS Trust



Safe Services

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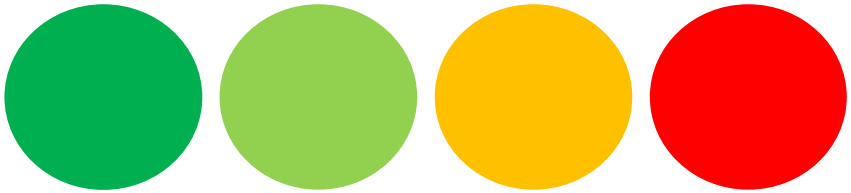


Key Issues

Safety Thermometer
- Harm-free care (for all and new harms) remain better than the national average in July. All Harms has dipped slightly in July, while the New Harms has improved.

Patient Falls
- In July 77 falls were recorded:
  - 54 resulting in no physical harm being reported to the patients involved,
  - 17 falls resulted in low levels of physical harm
  - 3 incidents resulted in moderate harm injuries such as small bone fractures along and an incident in which a patient sustained a significant laceration to their head.
  - 2 incidents resulted in severe harm injuries such as a fractured neck of femur and a neurological bleed
  - 1 patient sustained a catastrophic head injury which was linked to their cause of death
- All severe and catastrophic harm shall undergo detailed investigation.

Serious Incidents & Never Events
- There was 1 Never Event reported in July: wrong connection to air instead of oxygen, resulting in low harm.
- There was a total of 9 serious incidents reported in July:
  - 4 were related to recognition and management of the deteriorating patient
  - 1 related to harm from a fall
  - 2 related to delayed diagnosis
  - 1 related to abnormal imaging

Infection Control
- MRSA bacteraemia = 1 incidence in July
- C difficile infections = 5 incidences in July
- E.coli bacteraemia = 5 incidences in July
- MSSA bacteraemia = 1 incidence in July
- Hand hygiene compliance = 90.8%.

Hospital-acquired Pressure Ulcers
- Year-to-date we have reported 29 Cat 2 pressure ulcers
- There were the following reported for July
  - Category 4 = 0
  - Category 3 = 0
  - Category 2 = 1
  - Unstageable = 2
  - SDTI = 8

Sepsis
- New measurement of sepsis care has been undertaken this quarter Q1 2019/20.
- New threshold sample of 50 patients per quarter is now captured.
- Patients triggering 5 NEWS2 undergo surveillance via inpatient screen on Nerve Centre. The sepsis nurse then reviews the patient on the ward or in ED department and assess if red flag criteria met and if required
- Timeliness of treatment with sepsis six has commenced.
- Reviews for any evidence of clinical harm.

VTE
- Potential harm from hospital acquired thrombosis are presented to Serious Incident Review panel – there was 1 case presented in July
- There remains an on-going review of processes to improve governance and measurement of VTE risk assessments. A trust -wide action plan has been written and Trust 'Thrombosis Action group' has been established.

Executive Response

Safety Thermometer
- The Trust is in the highest (best performing) quartile for harm -free care in July.

Patient Falls
- Review of data through the harm free care collaborative has identified themes such as:
  - Harmful fall occurring at night.
  - Poor adherence to bay watch processes
  - The recognised challenge of prioritisation when all ward patient's high risk.
- These themes shall be key drivers through Harm Free Care Quality Improvement efforts.

Serious Incidents, Never Events & Safer Surgery
- Work has started to risk assess all clinical areas where potential risk of any NE may exist. This shall be completed by end of Q2
- A working group has also been stablished to review the timely management of abnormal test results.
- The safer Surgery Collaborative has now agreed launch date for ENHT NatSSIP policy 1st Oct 2019, bringing together theatre and other non-theatre clinical teams

Infection Control - High Impact Interventions (HII)
- HII audit scores in June recorded on Meridian by ward nursing teams were above 95% except Urinary Catheter Insertion, Inpatients Environment, Clinical Non-Inpatients Environment and MRSA screening.
- Enhanced peer audit processes for inpatient environment and non -inpatient clinical areas including renal environment have been introduced, resulting in lower scores which do not reflect a drop in standards.
- RAG rating based on scores exceeding 95% in 6 out of 10 categories monitored.

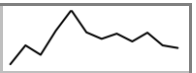
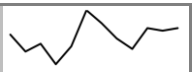
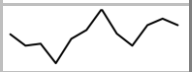
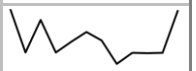
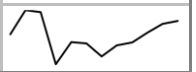
Hospital-acquired Pressure Ulcers
- The trust has joined wave 2 of NHSI stop the pressure campaign. 2 clinical areas have been identified and shall participate in this national programme, with support of QI team. Monthly monitoring of data continues.
- Plans for improvement include:
  - React to red Campaign launched
  - Tick a turn initiative re-launched
  - New documentation - launched
  - Care competencies await ratification by NMEC

Sepsis
- Work continues to review measurement tool of all sepsis six interventions.
- The sepsis team continue to clinically review all red flag sepsis patients for harm, and escalate immediate interventions and reporting to Datix as required.

VTE
- Thrombosis Action group continue to meet.
- Following changes to the national criteria an increase in 40% of cases has been seen compared to the same period 2018/19.
- Potential new structure will review pharmacy, nursing and medical leads.

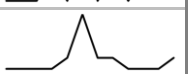
Safe Services

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Trend
Safety Thermometer	Harm-free care All harms	94.0	95.2	96.2	95.7	97.0	98.1	96.9	96.6	96.8	96.4	96.9	96.2	96.1	
	Harm-free care New harms	97.8	98.3	97.9	98.1	99.6	99.6	98.9	98.2	98.4	99.1	99.5	98.4	99.1	
Patient Falls	Number of patient falls	72	72	59	65	49	63	91	81	69	61	77	75	77	
	Rate of patient falls per 1,000 overnight stays	4.0	4.7	4.1	4.2	3.3	4.4	4.9	5.9	4.7	4.1	5.1	5.4	5.1	
	Number of patient falls resulting in serious harm	0	1	0	2	0	1	3	3	2	0	0	0	3	
Events and Incidents	Number of Never Events	0	1	0	1	1	0	0	0	0	0	0	0	1	
	Number of Serious Incidents	5	4	1	6	12	4	1	6	4	2	1	4	9	
Infection Control	Rate of MRSA incidences per 100,000 bed days	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.8	0.0	0.0	5.6	
	Rate of c.difficile incidences per 100,000 bed days	10.1	28.7	5.9	23.1	6.0	11.5	16.8	12.4	0.0	5.8	5.6	5.8	27.8	
	Rate of e.coli incidences per 100,000 bed days	18.3	5.7	17.8	11.5	11.9	11.5	16.8	37.1	5.6	17.3	27.8	11.5	27.8	
	Rate of MSSA incidences per 100,000 bed days	8.1	11.5	11.9	0.0	11.9	11.5	5.6	0.0	5.6	5.8	0.0	11.5	5.6	
	Hand hygiene audit score	95%	85.4%	95.2%	94.3%	73.1%	82.2%	81.7%	76.3%	80.9%	82.0%	86.0%	89.6%	90.8%	

Safe Services

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Trend
Hospital-acquired Pressure Ulcers	Category 4	0	0	0	1	0	0	1	0	0	1	0	0	0	
	Category 3	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Category 2	2	0	3	4	3	1	3	3	4	2	4	1	1	
	Category 2(D) Device-related	-	-	-	-	-	1	0	2	0	1	0	1	1	1	
	Mucosal membrane (D) Device-related	-	-	-	-	-	1	5	1	1	0	0	0	1	
	Unstageable	1	1	1	0	0	0	2	1	4	1	2	1	2	
	SDTI	3	2	2	0	3	6	3	5	9	8	7	6	8	
VTE	VTE risk assessment	95%	96.8%	96.4%	96.6%	95.7%	91.4%	96.5%	95.9%	96.5%	96.8%	91.4%	96.9%	tbc	
Sepsis Screening and Management	Emergency attendances with Sepsis - sample size	50	-	-	-	-	-	-	-	-	23	19	17	tbc	
	Emergency attendances receiving IVABs within 1 hour of Red Flag	90%	-	-	-	-	-	-	-	-	90.0%	84.0%	88.0%	tbc	
	Inpatients with Sepsis - sample size	50	-	-	-	-	-	-	-	-	27	21	19	tbc	
	Inpatients receiving IVABs within 1 hour of Red Flag	90%	-	-	-	-	-	-	-	-	40.0%	40.0%	0.0%	tbc	
	Sepsis six bundle complince	90%	-	-	-	-	-	-	-	-	tbc	tbc	tbc	tbc	

Caring Services

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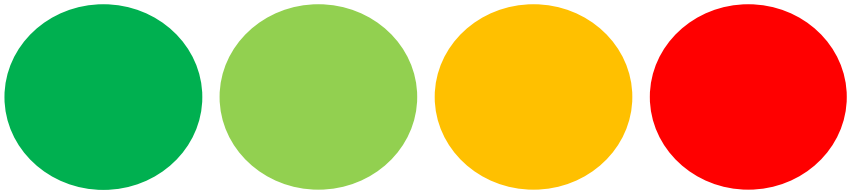


Key Issues

Friends and Family Test (FFT)

- The proportion of positive responses to the Inpatients, Outpatients, Maternity Antenatal & Birth and Community Midwifery FFT questions were better than the respective Trust targets in July.
- The proportion of positive responses to the Postnatal (wards) remains below target but has improved from 86.5% for June to 92.2% for July.
- The proportion of positive responses to the A&E FFT question has fallen below the Trust target at 83.8% for July.
- The FFT response rate for A&E has decreased from 7.2% in June to 4.1% in July, Total number of responses for A&E also decreased from 1,008 in June to 624 in July.
- The FFT response rate for Inpatients / Day Case increased to 45.4% in July and remains better than the Trust target of 40%.
- The FFT response rate for Maternity (Birth question only) increased to 24.5% in July, but remains below the Trust target of 30%.

Complaints

- Total number of complaints received since April 2019 = 318, with 79 complaints received in July. Breakdown by division:
  - Surgery 28
  - Medicine 18
  - W&C 14
  - CSS 13
  - Cancer 4
  - Operations 2
- 100% of complaints received were acknowledged within 3 working days.
- 76% were responded to within the agreed timeframe.
- Since April 2019 an average of 71% of complaints across the divisions have been responded to within the agreed timeframe.
- As at end of July 2019 we have 88 open complaints.

Executive Response

Friends and Family Test (FFT)

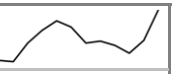
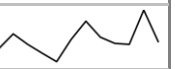
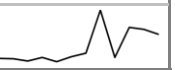
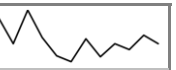
- The inpatient / day case percentage of patients who would recommend the Trust is higher than the national average and the response rate continues to exceed the latest national average response rate of 24.1%. The highest proportion of positive comments relate to staff, care and treatment.
- Negative comments from inpatient / day case patients relate to cleanliness and standard of the environment, quality of food, delays before discharge and lack of information about what is happening.
- The majority of feedback from patients in A&E is positive particularly in relation to staff being kind and caring and providing an excellent service.
- Negative feedback in A&E relates to waiting times, the cost of the car park and the need for improved seating in the waiting rooms. 9 patients out of 1008 who responded to the A&E FFT survey were unlikely or extremely unlikely to recommend the service.
- Outpatients compliment staff on their kind and caring attitude and for the care and treatment provided. There are concerns about waiting times in clinics and lack of information about reasons for the delays. Other concerns relate to administration around appointments and the cost and availability of car parking spaces.
- The majority of women compliment the staff for the support, care and attention provided to them during their birth experience. On the postnatal ward 2 out of 74 women would not recommend the service. Women would like better provision of recliner chairs and facilities for partners and an improved ward environment.

Improvement efforts - Complaints

- We are continuing to work improvement plan to achieve less than 120 open complaints across all divisions.

Caring Services

East and North Hertfordshire NHS Trust

Domain	FFT	Metric	Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Aug-18	Trend
Friends and Family Test	Inpatients	Proportion of positive responses	95%	96.2%	96.2%	96.8%	97.2%	97.5%	97.3%	96.8%	96.8%	96.7%	96.4%	96.9%	97.8%	
		Total number of responses	1,778	2,004	1,905	2,322	1,874	1,391	2,094	1,791	1,889	1,994	2,022	2,095	2,263	
		Response rate	40%	44.5%	43.1%	47.9%	39.5%	32.1%	41.2%	41.1%	41.3%	44.4%	43.0%	44.8%	45.4%	
	A&E	Proportion of positive responses	90%	88.4%	88.9%	90.5%	89.9%	85.2%	90.2%	90.9%	89.7%	92.5%	93.9%	92.7%	83.8%	
		Total number of responses	1,241	450	649	560	417	297	610	806	671	546	559	1,008	624	
		Response rate	10%	3.5%	4.9%	3.9%	3.0%	2.2%	4.4%	6.1%	4.6%	4.0%	3.9%	7.2%	4.1%	
	Maternity	Antenatal care Proportion of positive responses	93%	95.8%	90.9%	100.0%	100.0%	96.8%	92.5%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	
		Birth Proportion of positive responses	93%	98.4%	96.7%	96.5%	95.7%	94.1%	94.7%	98.1%	100.0%	96.1%	99.4%	97.3%	96.5%	
		Birth Total number of responses	137	184	150	141	139	135	132	157	71	128	159	74	115	
		Birth Response rate	30%	41.9%	34.1%	27.8%	30.3%	29.8%	30.2%	39.1%	16.3%	30.5%	34.6%	8.7%	24.5%	
		Postnatal ward Proportion of positive responses	93%	90.8%	88.6%	91.4%	86.9%	83.3%	91.6%	91.7%	83.1%	87.4%	89.7%	86.5%	92.2%	
		Postnatal community Proportion of positive responses	93%	100.0%	100.0%	100.0%	100.0%	94.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Outpatients	Proportion of positive responses	95%	94.8%	94.9%	93.9%	93.6%	95.2%	94.1%	94.4%	95.5%	94.5%	96.2%	95.8%	95.4%	
		Total number of responses	-	1,911	1,896	1,733	1,982	1,683	2,037	2,281	5,320	1,980	4,100	3,943	3,613	
Complaints		Number of written complaints received	92	100	79	107	84	69	64	83	68	79	74	86	79	
		Rate of written complaints received	1.9	2.0	1.6	1.9	1.6	1.6	1.1	1.6	1.3	1.6	1.4	1.7	1.5	
		Proportion of complaints acknowledged within 3 working days	75%	100%	100%	100%	100%	100%	95%	100%	100%	100%	100%	100%	100%	
		Proportion of complaints responded to within agreed timeframe	80%	44%	52%	52%	47%	43%	53%	55%	64%	63%	64%	78%	76%	

Effective Services

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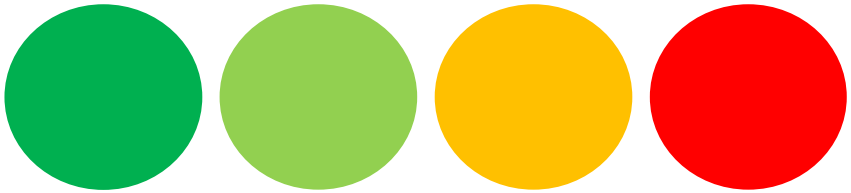


Key Issues

Crude Mortality
- The in-month crude mortality rate continues to improved to 8.9 deaths per 1,000 admissions in July.
- The rolling 12-months crude mortality rate was 11.0 deaths per 1,000 admissions in the 12 months to July, and remained better than the most recently available national rate of 13.0 deaths per 1,000 admissions.

Hospital-Standardised Mortality Ratio (HSMR)
- The in-month HSMR improved to 93.78 in May, and remained better than the standard (100).
- The rolling 12-months HSMR improved slightly to 93.1 in the 12 months to May, and remains in the better than expected range.
- HSMR is usually available 3 months in arrears.

Summary Hospital-level Mortality Indicator (SHMI)
- The latest SHMI release for the 12 months to March saw an improvement to 91.51.
- Dr Foster provides detail of which diagnosis groups have significantly elevated SHMI. The latest available information is for the rolling 12 months to February 2019. There are currently 2 significantly elevated diagnosis groups; Diverticulosis & Diverticulitis (250.0)', Congestive Heart Failure (140.0)
- SHMI is now available on a monthly basis, 4 months in arrears. This should improve the timeliness of our investigation into areas of potential concern.

Re-admissions
- The total re-admission rate increased slightly from 8.2% in January to 8.4% in February 2019.

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.

Executive Response

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

Crude mortality
- This measure is available the day after the month end and has demonstrated a consistent decrease over the last 5 years. It is the factor with the most significant impact on HSMR.
- The improvements in mortality have been as a result of a combination of corporate level initiatives such as the mortality review process and more directed areas of improvement such as the identification and early treatment of patients with sepsis, stroke, etc.
- While our crude mortality has steadily improved over recent years, up until the rolling 12 months to June 2018, the Trust's performance remained below the national average. Since this point in time our crude rate has continued to fall and our performance has been consistently better than the national average.

Hospital Standardised Mortality ratio (HSMR)
- While our current HSMR of 93.1 makes us well positioned in the 'better than expected' range, we remain focussed on driving further improvement.

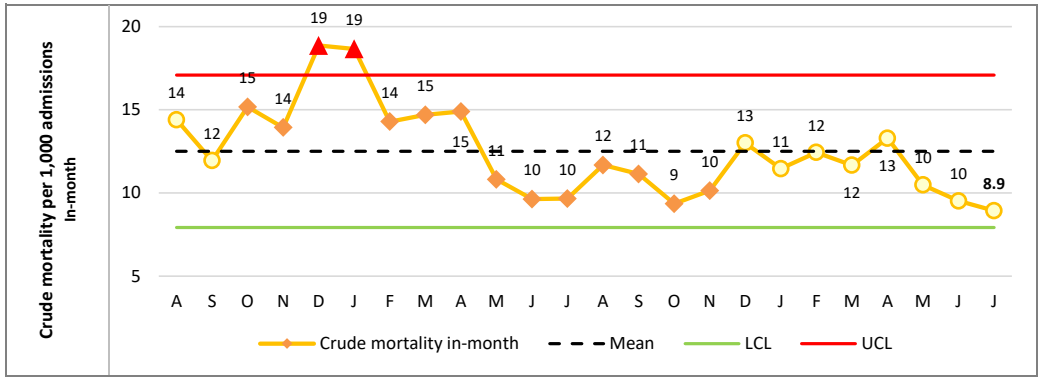
Summary Hospital-level Mortality Indicator (SHMI)
- As with HSMR, the recent significant improvements to SHMI have been welcomed. With regard to the 2 outlying diagnosis groups: reviews showed some process and coding concerns regarding Congestive Heart Failure, which are being addressed via a joint clinical/coding review initiative at weekly MDT meetings. The coding review of deaths underpinning the Diverticulosis & Diverticulitis deaths showed only a few errors and no concerns requiring clinical review. Monitoring will continue at Mortality Alerts meetings.

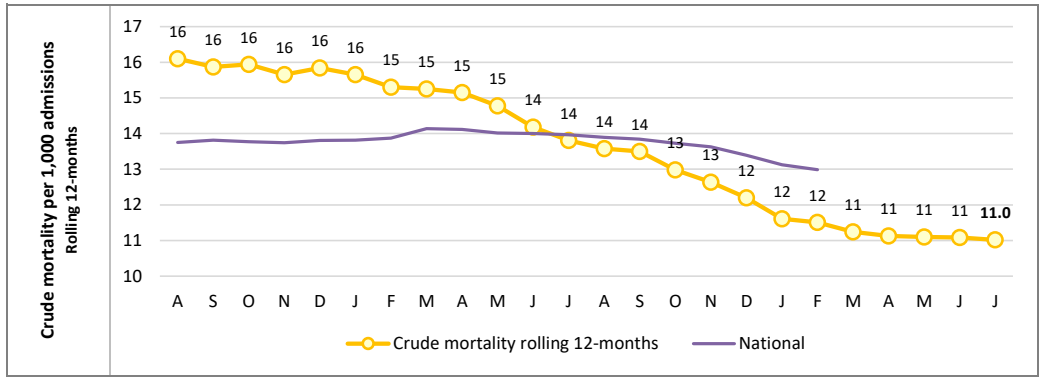
Re-admissions
- Historically the Trust reported higher than expected levels of re-admissions compared to the national average. However, the last three years have seen a consistent improving trend. The 12 months to February 2018 saw relative risk return to the 'as expected range'. The latest relative risk for the 12 months to February 2019 stands at 99.9 (Elective 91.6 , Non-Elective 103.9) and sits within the 'as expected' range.

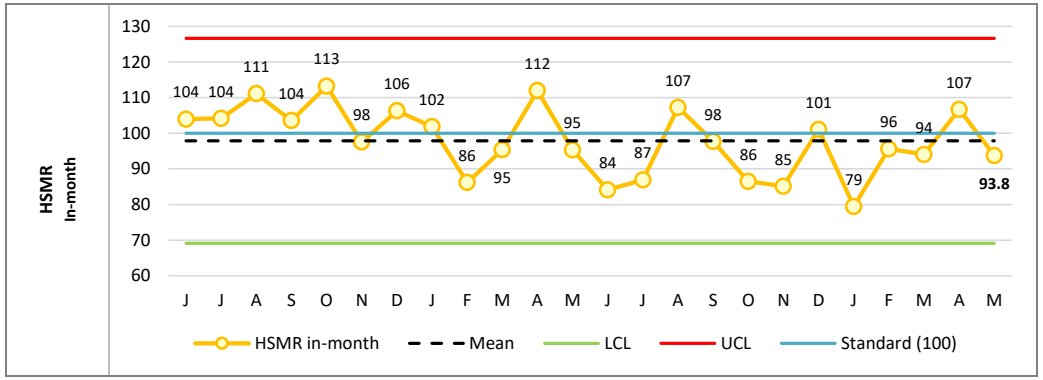
Learning from Deaths
- In addition to the outcomes of cases escalated to Specialties being considered by the Mortality Surveillance Committee (where proposed remedial/development action is approved/recommended), the quarterly Learning from Deaths report includes a summary of key themes emerging from these cases. This detail is shared with all Trust Specialties and with interested working groups such as Deteriorating Patient and End of Life.

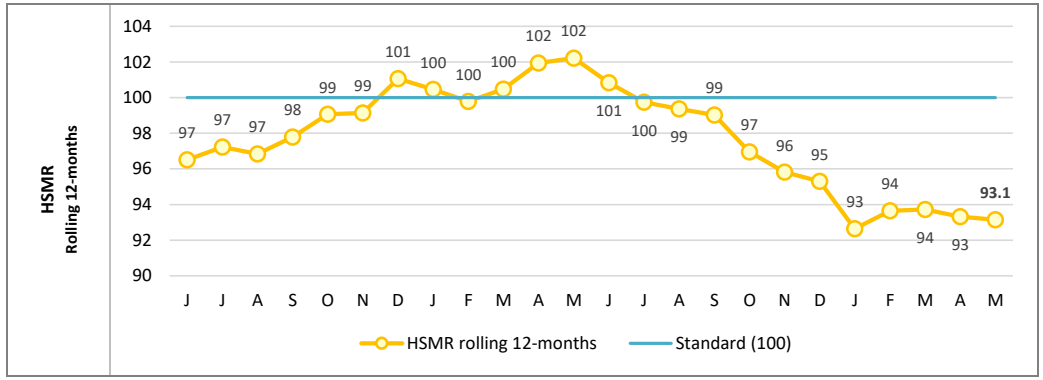
Effective Services

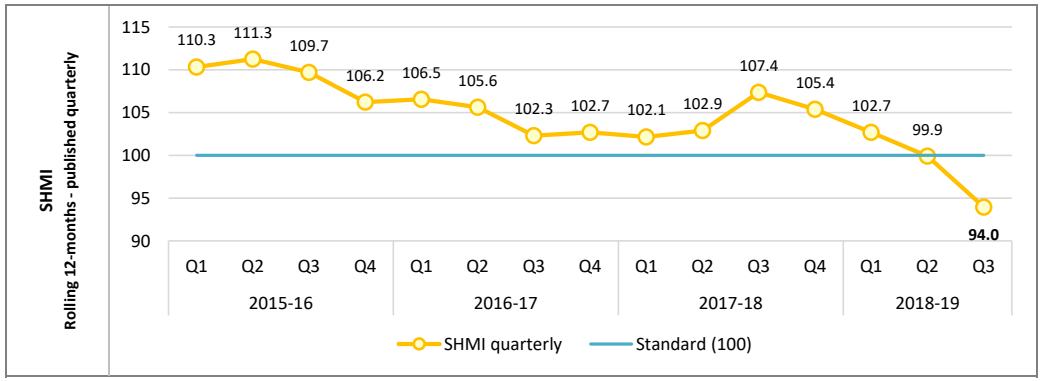
East and North Hertfordshire NHS Trust

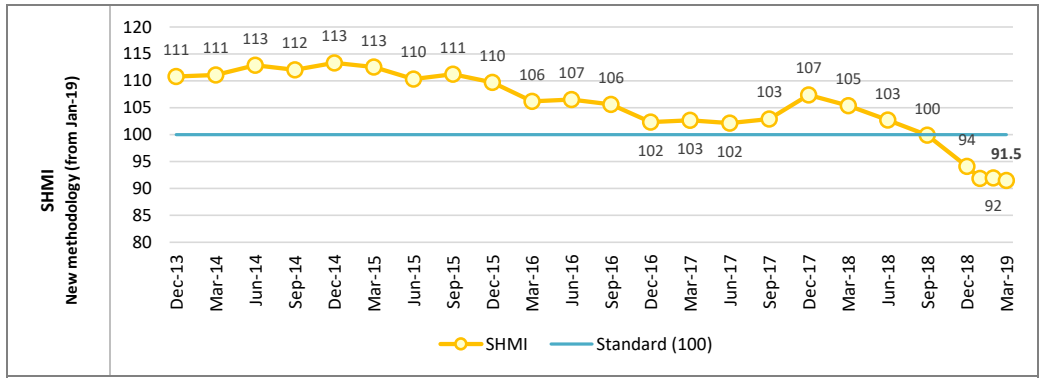








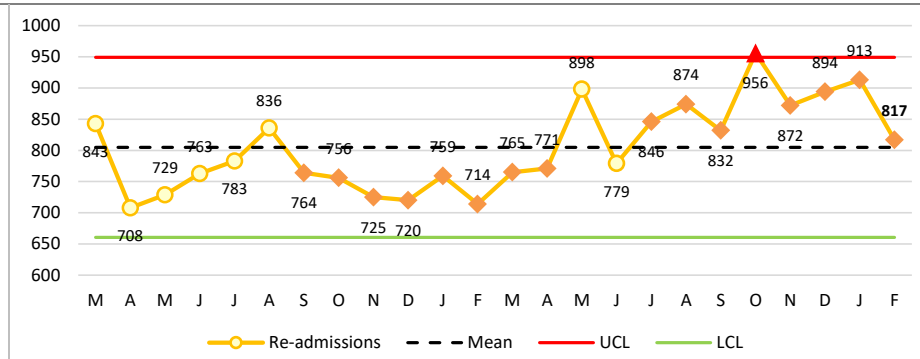




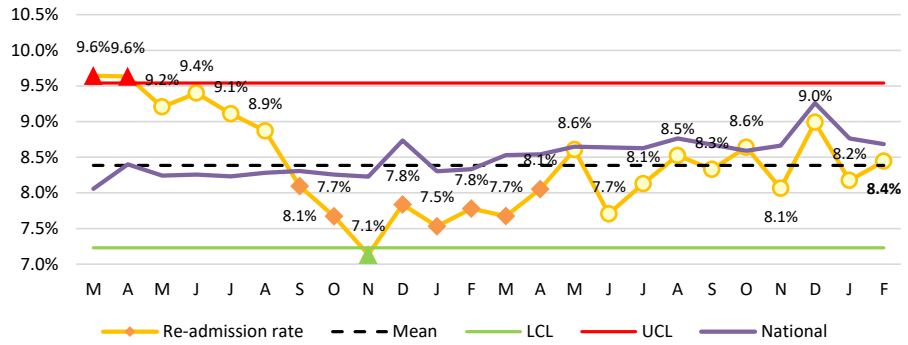
Effective Services

East and North Hertfordshire NHS Trust

Re-admissions
Absolute number - Dec-16-Nov-18



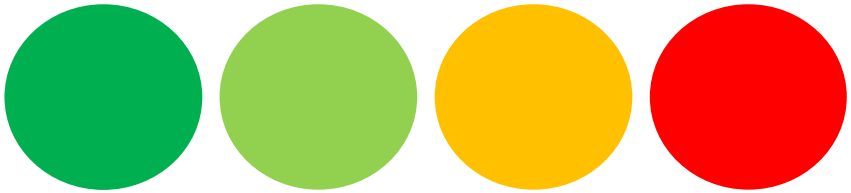
Re-admissions
Re-admission rate - Dec-16-Nov-18



End of Life Care	Proportion of patients with whom their preferred place of death was discussed	tbc	To be confirmed	
	Individualised care pathways	tbc		

Responsive Services

Month 04 | 2019-20



Key Issues

A&E
- Performance for the month of July 2019 was 81.47%.
- No 12-hour trolley waits were reported in July

Cancer Waiting Times
- In June 2019 the Trust achieved 4 of the 8 national targets for cancer performance.
- The Trust 62-day performance for June 2019 was 75.6% NHS Digital upload, which is below the revised trajectory of 78.7%.
- The cancer recovery business case is still in process to implement.
- Capacity challenges continue with specialist treatments such as RALP and Brachytherapy which is impacting on the Trust aggregate 62-day and 31-day compliance.
- There is a further risk to the sustained compliance of the 31-day subsequent Radiotherapy performance due to the need to replace LA1. To mitigate this the Trust has taken the decision to upgrade LA1 as a mitigation for a year with a longer term replacement solution to be found post April 2020.
- Commitment has been obtained from IMAS to support the Trust with ongoing work with:
  - Critical review of service specific MDT and PTL meetings with written feedback;
  - Demand & Capacity model and Pathway analysis for Histology services;
  - Continue to Work to deliver the 28-day faster diagnosis target.

RTT
- Incomplete performance for July was 85.38%, a slight improvement over the 85.08% reported in June.
- The July backlog was 6,616, an increase of 94 from June.
- There were 19 52-week breaches reported in our July incomplete position, a slight reduction from 21 in June.

Diagnostics
- DM01 performance for July is 0.56% against the national standard of 1% and the June position of 0.38%.

Stroke
- Performance for July 63.30% Improvement from April/May performance.
- 4 hr target taking into the out the exclusion of the Inter hospital transfer and inpatient stroke – July 2019 65.10%.
- Training being arranged with ED doctors, to ensure that there is early escalation and referrals are being made to the Stroke team.
- Review of Stroke pathways for A&E and Inpatient – being reviewed and review meetings taken place and review for Trust sign off to be implemented aim for Septmeber 2019– Education and Training the Ward areas underway and process for management of Inpatient strokes being updated, in-line with the Operation office processes.
- Thrombolysis rate at 13.4% continuous improvement - Stroke Nurses commenced delivery of training to the Ambulance Crew, with the aim to help with early attendance to A&E within onset time.
- Ongoing significant improvement in 60-min to scan performance. Due to the implementing of the Stroke Nurses requesting scans at time of arrival in A&E – 53.70% performance for July 2019.
- Table above now showing the 66.70% of thrombolysis received in less than 60 minutes as this is the gold standard, however up to 4.5hrs from onset time is NICE guidance approved. This has an impact on the arrival time to the Trust - as we are meeting the rate for 60mins Thrombolysis rate target of 11%.
- Maintain performance of meeting of 40% target for ESD performance at 41.30% for July 2019.
- TIA performance within 24-hrs significantly – Review of the national reporting requirements to ensure we are adhering and reporting as per national requirements. As from September we will have Project lead who will focus on the TIA element of the Stroke performance and the implementing and updating of processes in-line with NICE Guideline published in May - which is currently a Gap analysis is being undertaken.
- Charling Cross Thrombectomy pathway from 19th August will be 24/7.

Executive Response

A&E
- The trust ED performance in July was 81.47%. July was particularly challenging in terms of IT issues causing data quality issues. In addition, and the period of significant heat caused increased demand on the emergency department, impacting on to patient flow as well as resources.
- Significant improvement was made in relation to Ambulance handover times, reducing the average time from arrival to handover to 20 minutes. The percentage of handovers within 15minutes increased in July to >50% compared to June's performance of 48%. In addition, >60minute handovers reduced to less than 3% of ambulance arrivals.
- The trust 4-hour performance continues to remain a challenge with specific focus on performance out of hours. Immediate actions include improved processes to identify and plan assessment capacity between 2000 and 0800 to support efficient flow from ED as well as a pilot of overnight progress chasers. Longer term actions include training and education for key personnel in relation to identifying and managing emerging risks to performance and safety as well as Same Day Emergency Care and improved GP Streaming.

Cancer performance (June)
- In June 2019, the Trust achieved 4 of the 8 national targets for cancer performance: 2ww, breast symptoms and 31 - day subsequent for radiotherapy and Chemotherapy. Cancer performance is available one month in arrears.
- The Trust Two Week Wait (2WW) performance for June 2019 was 96.7% which equates to 1,244 out of 1,287 pathways meeting the 2WW standard, with 43 breaches of the standard being reported.
- In June 2019, the Trust-wide average days wait for a first appointment was at 10 days and the majority of patients were seen between 8 and 12 days.
- In June 2019 the 31-day first definitive treatment was 91.9%; below the national target of 96%, which equates to 193 out of 210 pathways meeting the target, with 17 breaches. 4 out of 9 tumour sites met the target, RALP and Brachytherapy capacity remains an issue and is impacting the compliance.
- In June 2019 the 28-day faster diagnosis performance was 59.0% for 2WW and 60.9% for screening patients.
- Reported 62-day performance for June 2019 was 75.6%, which is below the revised recovery trajectory of 78.7%. In June 2019, 3 out of 11 tumour sites met the standard with 45% of avoidable breaches occurring in Urology.

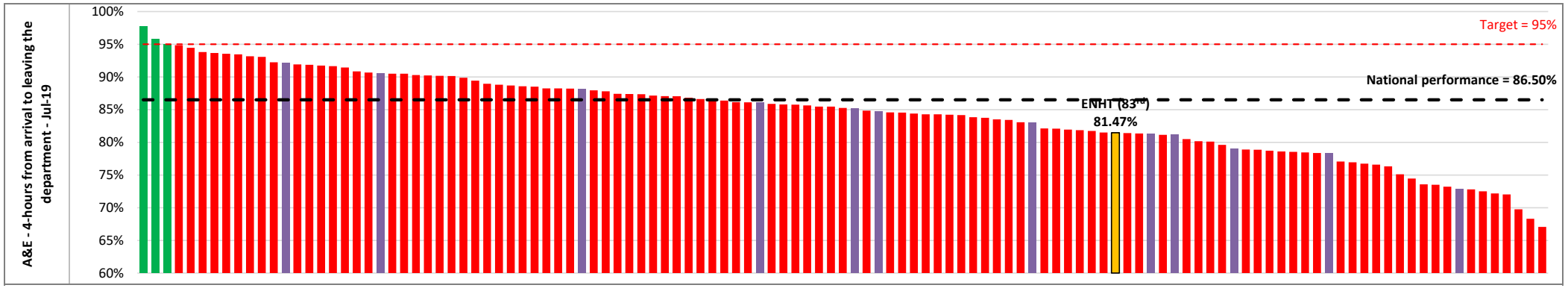
RTT
- Performance has improved slightly in July but remains below our July target of 89.3%. Validation is predominantly responsible for this improvement. The Trust reported 19 52-week breaches. The growth in 52-week breaches comes from the audit of clinic clock stops which uncovered significant numbers of patients with closed RTT clocks who still required surgery. This audit is now complete and the numbers of pts found over 52 weeks has peaked. The focus now is to reduce reportable 52-week breaches to zero by the end of October 2019.
- The Operational landscape is very challenging. Demand is rising in key areas and the commitment of clinicians to carry out additional activities has been diminished by new rules on pension contributions. This is having a significant impact particularly in surgical specialties. Divisions are currently being supported by the Intensive Support Team to develop the underlying Capacity and Demand intelligence needed to describe recovery plans.

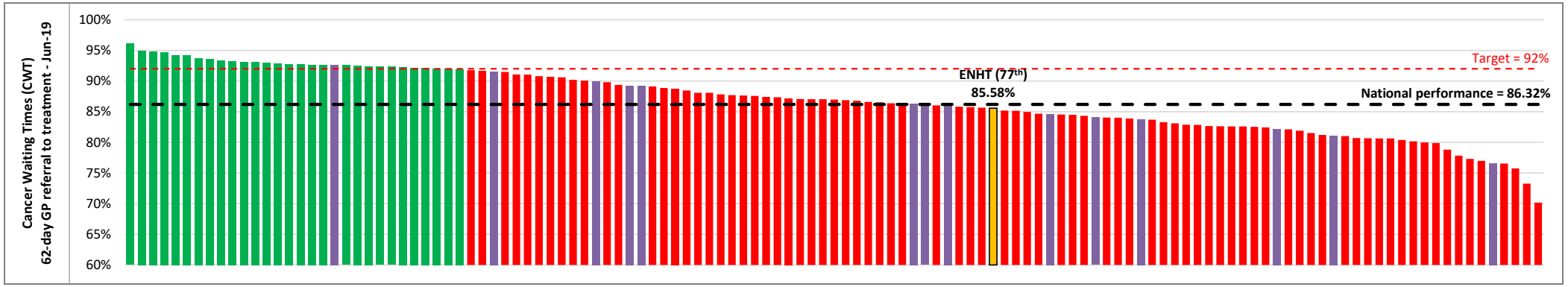
Diagnostics
- Diagnostics performance in July remains compliant at 0.56%. 6 patients waited more than 13 weeks for a diagnostic test in July. The elimination of 13-week breaches in diagnostic services is our current priority whilst maintaining the compliant position overall.

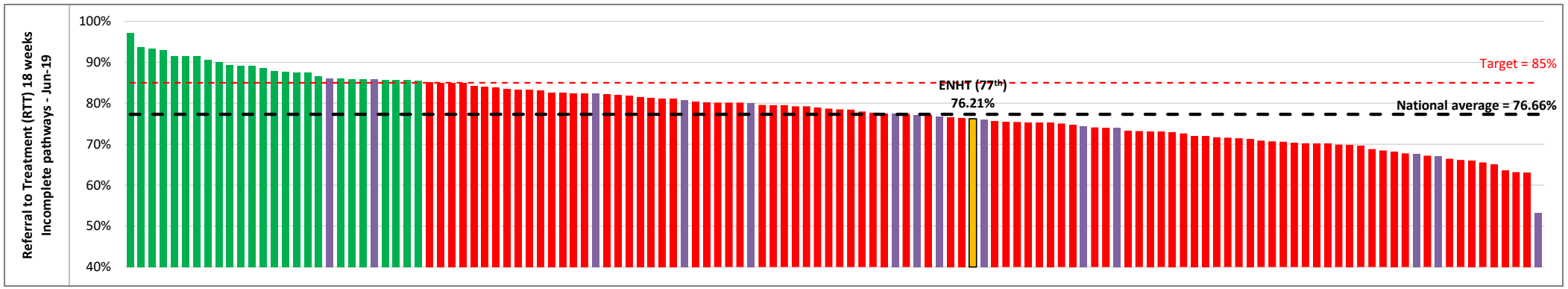
Responsive Services

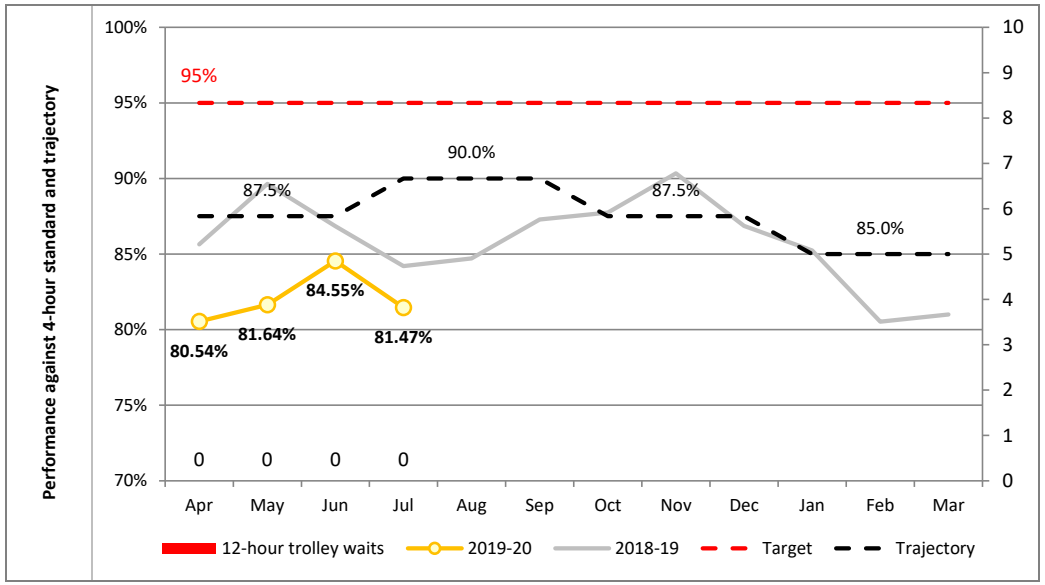
Trust performance against all Trusts nationally

East and North Hertfordshire NHS Trust

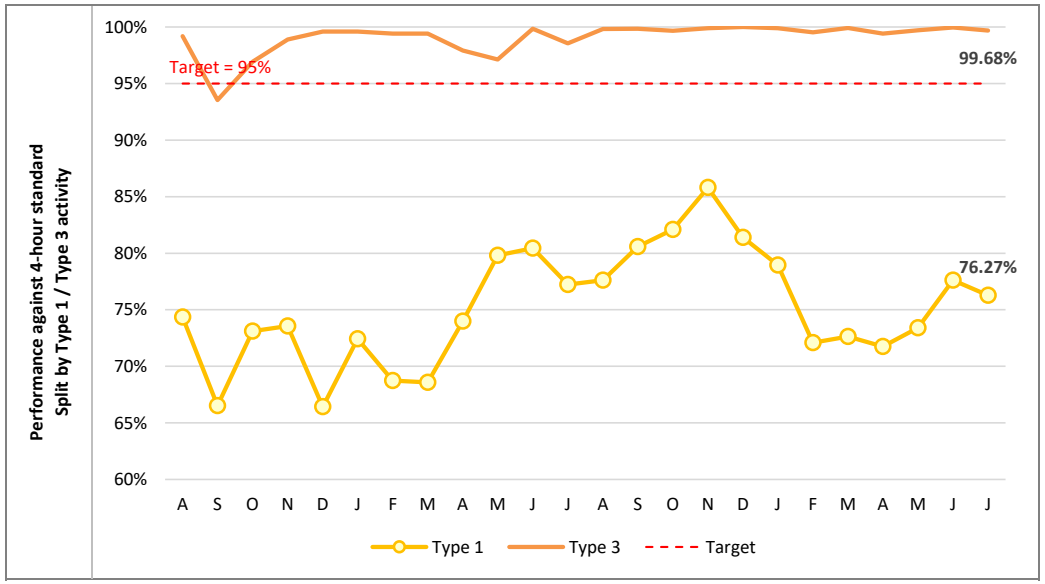


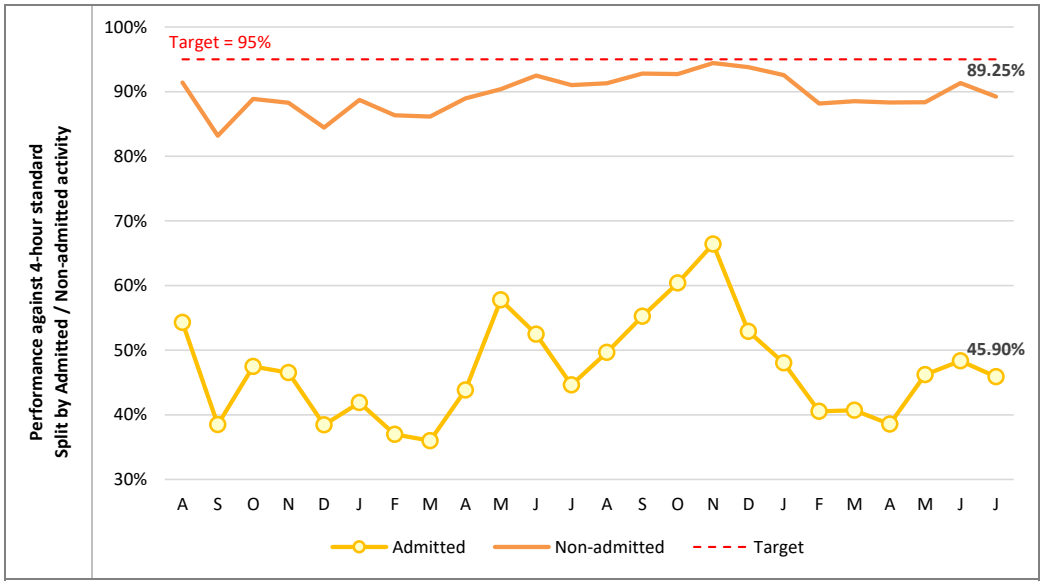






Domain	Metric	Target	Jun-19	Jul-19	Change	Trend
Other Emergency Department measures	Ambulance handovers Proportion within 15 minutes	-	52%	52%	◀▶	
	Ambulance handover breaches 30-minutes	230	262	336	▲	
	Ambulance handover breaches 60-minutes	43	54	48	▼	
	Attendance to admission conversion rate	-	33.0%	31.3%	▼	
	Time to initial assessment 95th centile	15	62	74	▲	
	Time to treatment Median	60	72	138	▲	
	Left department before being seen for treatment	5%	2.4%	1.7%	▼	
	Unplanned re-attendance rate	5%	4.5%	4.9%	▲	





Responsive Services

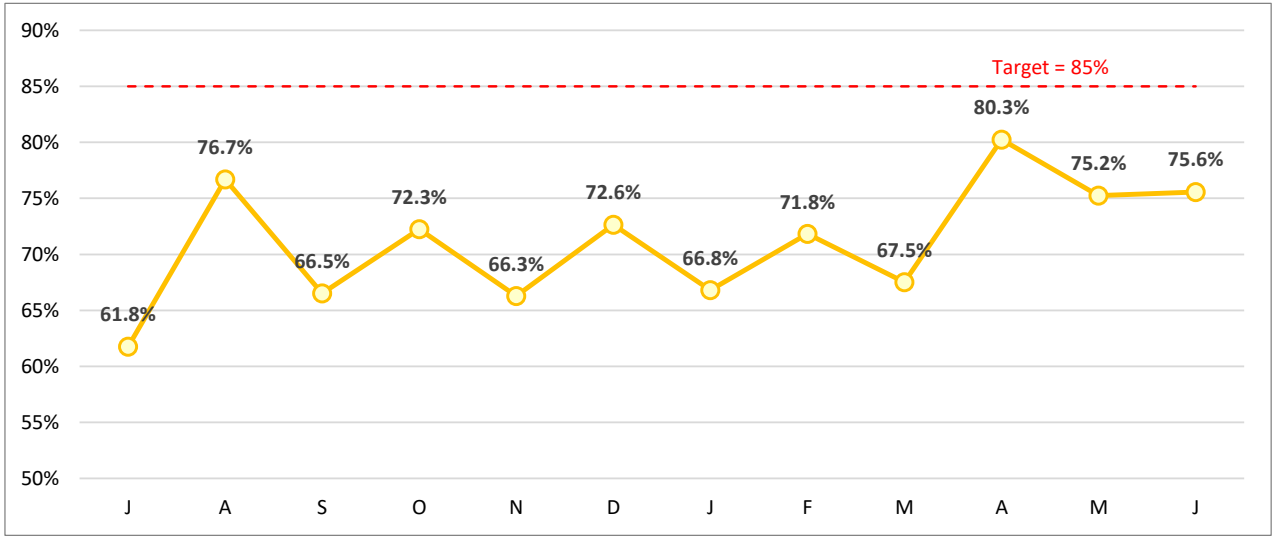
Cancer Waiting Times

12-months' performance - all standards

Standard	Target	2018-19											2019-20		
		Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	YTD	Apr-19	May-19	Jun-19
Two week waits Suspected cancer	93%	91.8%	95.5%	95.1%	92.6%	97.1%	96.7%	97.2%	95.6%	96.6%	97.0%	94.8%	95.9%	95.6%	96.7%
Two week waits Breast symptomatic	93%	83.9%	97.3%	91.2%	88.8%	94.9%	94.4%	93.4%	94.5%	94.0%	94.0%	92.6%	88.7%	92.7%	93.4%
31-day First definitive treatment	96%	96.7%	90.8%	90.3%	95.3%	93.8%	91.8%	96.3%	96.0%	95.1%	94.5%	93.9%	93.5%	94.9%	91.9%
31-day subsequent treatment Anti-cancer drugs	98%	98.3%	99.3%	98.3%	100.0%	99.4%	97.99%	100.0%	98.7%	99.4%	98.3%	99.0%	98.2%	97.8%	99.3%
31-day subsequent treatment Radiotherapy	94%	91.1%	94.1%	95.0%	97.6%	97.9%	97.3%	97.2%	95.0%	98.0%	95.7%	95.1%	96.9%	98.3%	98.9%
31-day subsequent treatment Surgery	94%	60.0%	64.0%	100.0%	57.1%	74.2%	69.4%	84.2%	63.6%	76.5%	78.8%	75.6%	96.8%	80.0%	78.9%
62-day GP referral to treatment	85%	69.4%	61.8%	76.7%	66.5%	72.3%	66.3%	72.6%	66.8%	71.8%	67.5%	69.1%	80.3%	75.2%	75.6%
62-day Specialist screening service	90%	77.8%	60.7%	75.0%	87.5%	74.2%	86.2%	100.0%	72.7%	79.2%	95.2%	79.6%	81.8%	100.0%	63.6%

62-day GP referral to treatment Jun-19

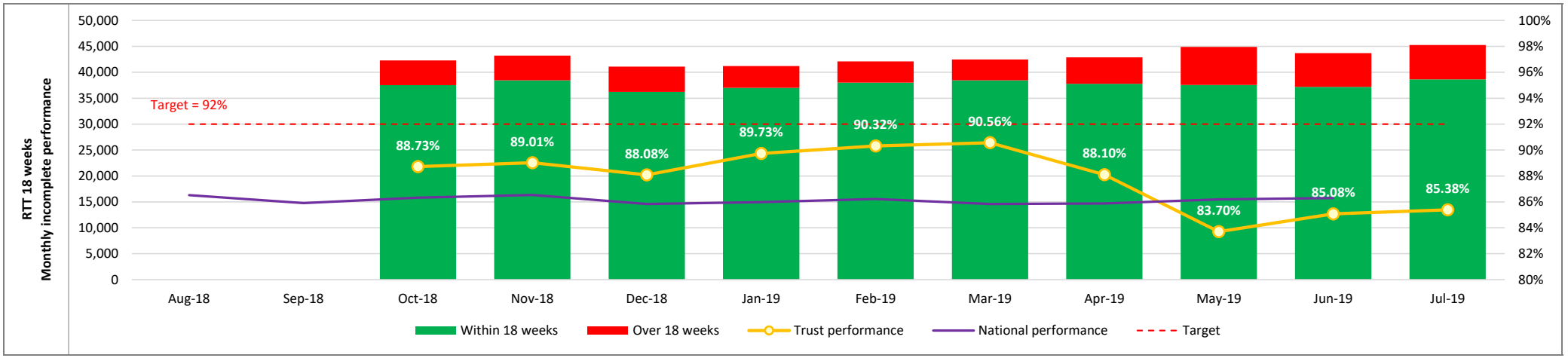
Tumour Site	OK	Breach	Total	Perf.
Breast	14.0	4.0	18.0	77.8%
Gynaecology	3.5	5.0	8.5	41.2%
Haematology	4.0	1.0	5.0	80.0%
Head and Neck	1.0	1.0	2.0	50.0%
Lower GI	6.0	1.0	7.0	85.7%
Lung	3.0	1.0	4.0	75.0%
Other	0.0	0.0	0.0	-
Sarcoma	0.0	0.0	0.0	-
Skin	25.0	2.0	27.0	92.6%
Testicular	3.0	0.0	3.0	100.0%
Upper GI	3.5	1.0	4.5	77.8%
Urology	19.0	10.5	29.5	64.4%
Total	**82.0**	**26.5**	**108.5**	75.6%



Responsive Services

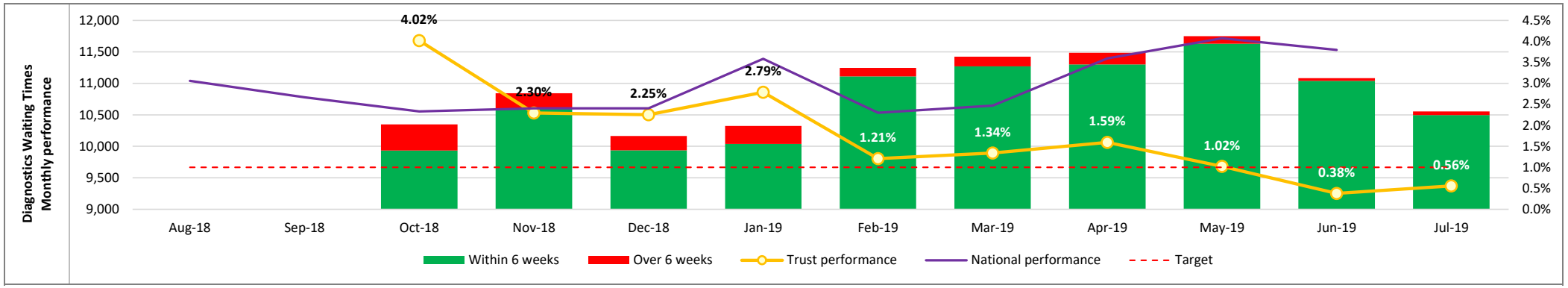
RTT 18 weeks

East and North Hertfordshire NHS Trust



RTT 18 weeks
In-month performance by Specialty - Jul-19

Specialty	Clock Stops - Admitted			Clock Stops - Non-admitted			Incomplete pathways						Clock Starts
	Total	Performance	Over 52 weeks	Total	Performance	Over 52 weeks	Within 18 weeks	Over 18 weeks	Total	Performance	Over 40 weeks	Over 52 weeks	
General Surgery	238	81.93%	0	331	90.33%	0	2,588	332	2,920	88.63%	7	0	986
Urology	186	75.81%	0	346	95.09%	0	2,127	186	2,313	91.96%	2	0	925
Trauma & Orthopaedics	84	52.38%	1	809	83.44%	0	2,979	748	3,727	79.93%	70	11	1,160
Ear, Nose & Throat (ENT)	172	70.35%	0	581	91.39%	0	2,458	214	2,672	91.99%	6	0	1,194
Ophthalmology	151	75.50%	0	584	90.41%	0	3,857	379	4,236	91.05%	10	0	1,408
Oral Surgery	80	12.50%	0	477	35.85%	0	1,848	615	2,463	75.03%	19	0	629
Plastic Surgery	105	75.24%	0	810	96.05%	0	1,699	127	1,826	93.04%	3	0	1,135
Cardiothoracic Surgery	0	-	0	10	90.00%	0	35	1	36	97.22%	0	0	24
General Medicine	1	100.00%	0	267	99.63%	0	776	1	777	99.87%	0	0	619
Gastroenterology	428	78.74%	0	259	68.34%	0	2,699	685	3,384	79.76%	13	0	966
Cardiology	66	86.36%	0	727	80.47%	0	1,977	438	2,415	81.86%	4	0	669
Dermatology	1	0.00%	0	298	87.25%	0	1,139	206	1,345	84.68%	7	0	401
Thoracic Medicine	38	97.37%	0	262	85.11%	0	1,202	224	1,426	84.29%	4	0	461
Neurology	1	100.00%	0	408	93.63%	0	1,350	75	1,425	94.74%	6	0	508
Rheumatology	2	50.00%	0	221	60.63%	0	954	189	1,143	83.46%	2	0	292
Geriatric Medicine	1	100.00%	0	84	97.62%	0	117	6	123	95.12%	0	0	95
Gynaecology	97	79.38%	0	368	86.96%	0	2,701	335	3,036	88.97%	28	3	893
Other	136	57.35%	1	2,561	81.76%	1	8,137	1,855	9,992	81.44%	96	5	4,368
Total	**1,787**	**72.41%**	**2**	**9,403**	**83.41%**	**1**	**38,643**	**6,616**	**45,259**	**85.38%**	**277**	**19**	**16,733**



Diagnostics Waiting Times In-month performance by Modality - Jul-19	Category	Modality	Within 6 weeks	Over 6 weeks	Total	Performance	13+ weeks
	Imaging	Magnetic Resonance Imaging	1,888	4	1,892	0.21%	0
		Computed Tomography	1,034	5	1,039	0.48%	0
		Non-obstetric ultrasound	4,772	6	4,778	0.13%	0
		DEXA Scan	486	0	486	0.00%	0
	Physiological Measurement	Audiology - audiology assessments	42	3	45	6.67%	0
		Cardiology - echocardiography	1,104	11	1,115	0.99%	2
		Neurophysiology - peripheral neurophysiology	118	0	118	0.00%	0
		Respiratory physiology - sleep studies	68	0	68	0.00%	0
		Urodynamics - pressures & flows	55	5	60	8.33%	4
	Endoscopy	Colonoscopy	381	2	383	0.52%	0
		Flexi sigmoidoscopy	190	4	194	2.06%	0
		Cystoscopy	91	0	91	0.00%	0
		Gastroscopy	268	19	287	6.62%	0
	Total		**10,497**	**59**	**10,556**	0.56%	6

Responsive Services

East and North Hertfordshire NHS Trust

Stroke Services

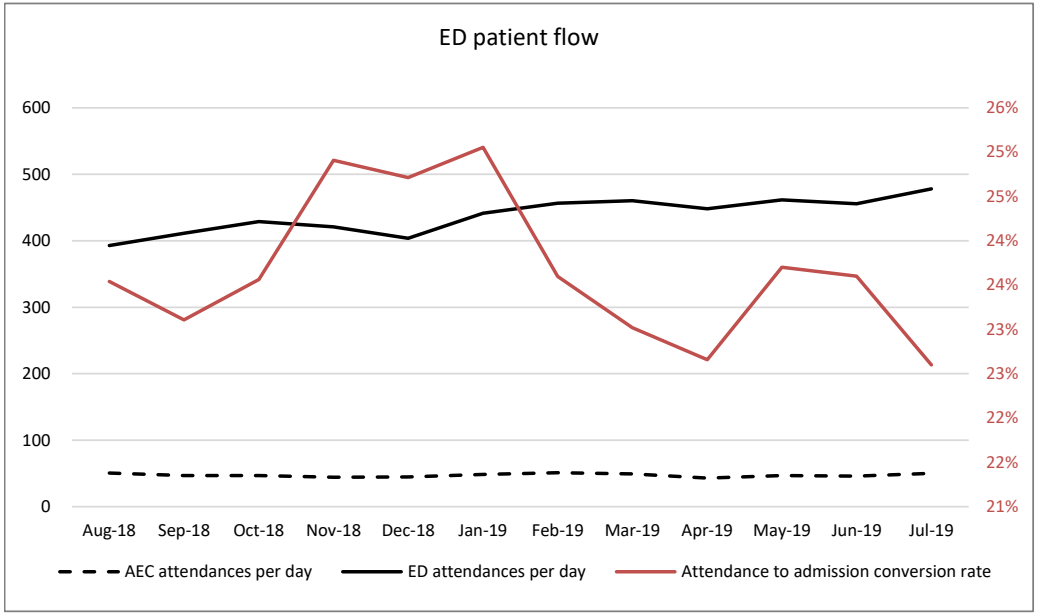
Domain	Metric	Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Trend
Stroke	Trust SSNAP grade	A	A	A	A	A	A	A	A	A	tbc	tbc	tbc	tbc	
	Discharged with AF on anticoagulants	80%	87.5%	100.0%	88.9%	80.0%	100.0%	100.0%	100.0%	88.9%	100.0%	100.0%	100.0%	77.8%	
	4-hours direct to Stroke unit from ED	90%	65.2%	72.1%	75.9%	73.0%	75.4%	69.6%	69.0%	72.1%	50.0%	59.3%	72.1%	63.3%	
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	90%	69.8%	79.2%	75.9%	72.9%	76.1%	71.0%	72.7%	75.4%	54.2%	60.0%	71.7%	65.1%	
	Number of confirmed Strokes in-month on SSNAP	-	69	63	57	64	70	70	73	71	66	86	66	67	
	Proportion of patients spending 90% of time on the Stroke unit	80%	85.3%	93.5%	92.7%	88.9%	95.7%	95.7%	93.1%	88.4%	90.8%	94.0%	92.1%	87.7%	
	60-minutes to scan from time of arrival	50%	46.4%	61.9%	57.9%	54.0%	57.1%	50.0%	61.6%	45.6%	56.1%	53.5%	53.0%	53.7%	
	Scanned within 12-hours - all Strokes	100%	97.1%	98.4%	98.2%	93.7%	97.1%	100.0%	98.6%	98.6%	97.0%	98.8%	92.4%	tbc	
	Total Thrombolysis rate for confirmed Strokes	11%	10.1%	9.5%	7.0%	14.3%	8.6%	10.0%	12.3%	8.5%	4.5%	14.3%	15.6%	13.4%	
	Thrombolysed within 60-minutes of arrival	-	42.9%	33.3%	25.0%	33.3%	n/a	42.9%	22.2%	16.7%	33.3%	50.0%	70.0%	66.7%	
	Discharged with JCP	80%	88.8%	97.8%	94.6%	97.6%	100.0%	100.0%	97.9%	100.0%	95.1%	93.7%	89.5%	95.3%	
	Discharged with ESD	40%	50.0%	54.3%	45.9%	64.4%	56.8%	48.1%	51.9%	44.4%	50.0%	50.8%	45.6%	41.3%	

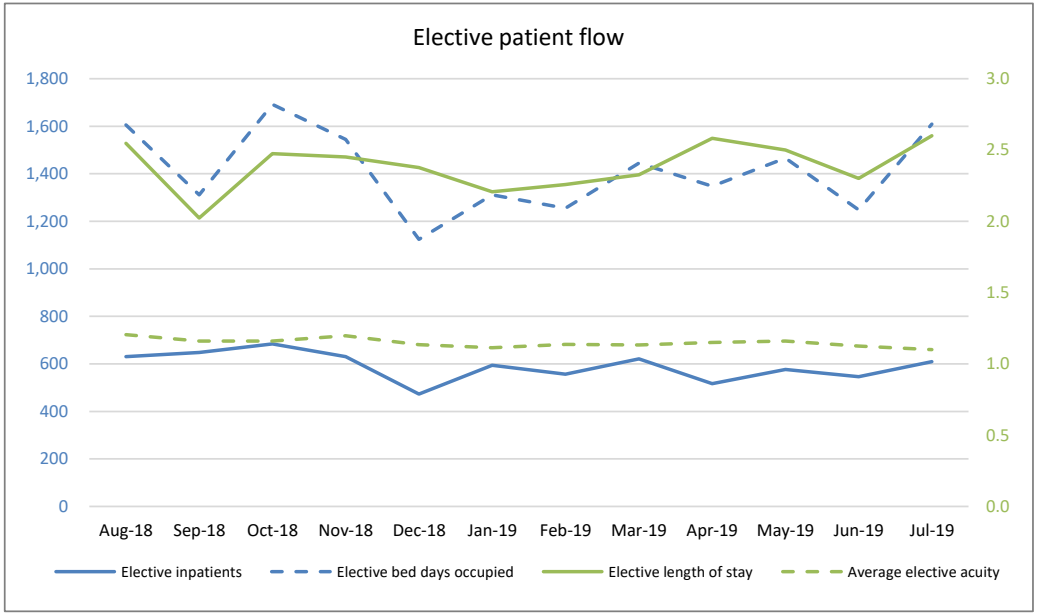
Responsive Services

East and North Hertfordshire NHS Trust

Patient Flow

Domain	Metric	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Trend
Emergency Department Flow Indicators	A&E & UCC attendances	12,178	12,333	13,297	12,627	12,517	13,690	12,788	14,266	13,440	14,306	13,675	14,821	
	Attendance to admission conversion rate	23.5%	23.1%	23.6%	24.9%	24.7%	25.1%	23.6%	23.0%	22.7%	23.7%	23.6%	22.6%	
	ED attendances per day	393	411	429	421	404	442	457	460	448	461	456	478	
	AEC attendances per day	51	47	47	44	45	49	51	49	43	47	46	50	
	4-hour target performance %	84.7%	87.3%	87.8%	90.3%	86.9%	85.2%	80.5%	81.0%	80.5%	81.6%	84.6%	81.5%	
	Time to initial assessment 95th centile	51	53	57	57	59	58	60	75	64	69	62	74	
	Ambulance handover breaches 30-minutes	457	406	491	247	373	516	597	606	480	368	262	336	

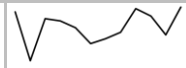
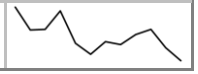
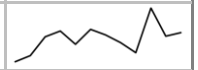




Responsive Services

Patient Flow

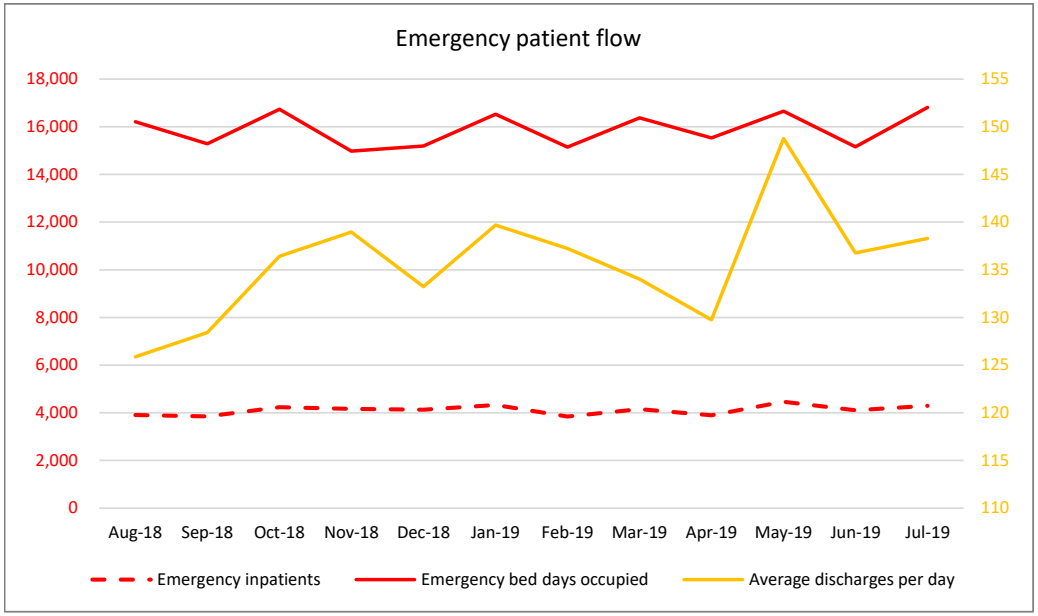
East and North Hertfordshire NHS Trust

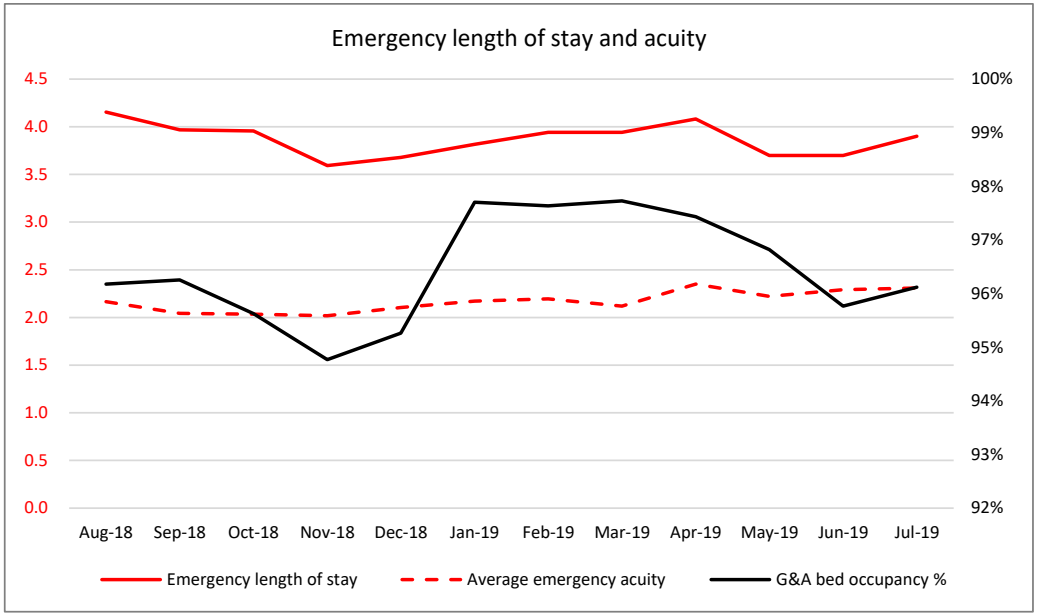
Domain	Metric	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Trend
Elective Inpatient Flow Indicators	Elective inpatients	630	648	684	630	473	594	556	621	517	577	546	609	
	Elective bed days occupied	1,605	1,311	1,692	1,544	1,124	1,311	1,255	1,445	1,348	1,466	1,248	1,609	
	Elective length of stay	2.5	2.0	2.5	2.5	2.4	2.2	2.3	2.3	2.6	2.5	2.3	2.6	
	Daycase rate %	83.1%	82.8%	84.0%	84.4%	86.0%	86.0%	84.8%	84.0%	86.8%	86.5%	87.2%	87.2%	
	Average elective acuity	1.20	1.16	1.16	1.20	1.13	1.11	1.14	1.13	1.15	1.16	1.13	1.10	
Emergency Flow Indicators	Emergency inpatients	3,902	3,852	4,229	4,169	4,130	4,330	3,843	4,155	3,893	4,463	4,103	4,287	
	Average discharges per day	126	128	136	139	133	140	137	134	130	149	137	138	
	Emergency bed days occupied	16,209	15,286	16,732	14,979	15,192	16,528	15,146	16,380	15,538	16,653	15,155	16,813	
	Emergency length of stay	4.2	4.0	4.0	3.6	3.7	3.8	3.9	3.9	4.1	3.7	3.7	3.9	
	Average emergency acuity	2.2	2.0	2.0	2.0	2.1	2.2	2.2	2.1	2.4	2.2	2.3	2.3	
	G&A bed occupancy %	96%	96%	96%	95%	95%	98%	98%	98%	97%	97%	96%	96%	
	Patients discharged via Discharge Lounge	130	156	198	195	141	180	189	186	197	225	224	303	
	Discharges before midday	15.4%	13.3%	14.7%	14.6%	14.6%	14.7%	14.4%	14.2%	13.3%	13.1%	13.8%	13.6%	
	Weekend discharges	14.6%	17.3%	13.8%	14.8%	17.2%	15.4%	15.7%	16.6%	13.6%	15.5%	16.9%	14.1%	
	Proportion of beds occupied by patients with length of stay over 14 days	20.6%	20.5%	20.1%	17.9%	18.7%	18.5%	19.6%	18.5%	17.3%	18.1%	17.6%	20.4%	
	Proportion of beds occupied by patients with length of stay over 21 days	11.1%	12.0%	10.7%	9.4%	10.0%	9.2%	10.7%	10.1%	9.2%	9.8%	8.9%	11.0%	

Responsive Services

East and North Hertfordshire NHS Trust

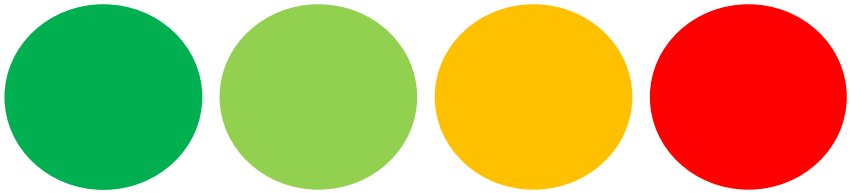
Patient Flow





Well-led Services

Month 04 | 2019-20



Key Issues

Staffing and Pay bill

- The Trust is £1.9m over the pay budget year-to-date.
- Overall staff utilised including bank and agency increased by 53 WTE
- Actual pay expenditure was £0.2m higher in M4 than the previous month caused mainly by increases in both bank and agency costs.
- Overall temporary staffing demand increased by 8% compared to month 3; bank and agency filled shifts increased by 8% and 2% respectively.
- Bank spend increased by 0.2m and agency spend increase by 0.1m. Areas with greatest increase in usage include General Surgery medical staff, Mount Vernon Cancer medical staff, Radiology medical staff, Medicine junior doctors, Neurology and Estates Management.
- In month the Trust was £51k over the agency ceiling target and £119k over year to date.
- The turnover rate continues to improve and shows a 1.5% improvement compared to the same month the previous year.

Sickness Absence

- Overall sickness absence rate remained the same but on target. The target for the year has been adjusted to 3.8% which would bring the Trust in line with the national median.

Training & Development

- Appraisal compliance increased to 86.3% against a target of 90% but has not hit the planned improvement trajectory.
- 10 out of the 15 mandatory training modules are on target and overall compliance reduced by 1%.

Executive Response

The Trust is focused on several key areas for the reduction of bank and agency spend on medical staff. Following an external review, the Trust is taking forward recommendations for establishment reviews and rota redesign for 7 specialty areas. Each area has identified opportunity for efficiency gains based on models of best practise. These will be progressed by the divisions supported by medical HR with strategic oversight from the medical workforce steering group. Work is in place to improve workforce deployment and capture productivity measures through improved use of medical e-Roster and e-Job Planning. A project lead is now in place and will lead work to optimise functionality within the e-Roster system. In addition, a work stream is in place to develop an improved approach for medical recruitment. A governance structure to monitor the progress of the work streams has been agreed.

Increasing the substantive medical workforce continues to be a priority. For the month of July, the had 9.2 WTE new starters and 9 WTE leavers to give us an increase of 0.2 WTE. Overall medical staff in post increased by 54 WTE. The unusually high number is owing to the F1 doctors who commenced with the Trust for their shadowing week on Monday 29 July, the doctors they are replacing do not leave the Trust until 06 August. The highlights for the month of July include continuing success for the recruitment of ED Middle Grades, with another doctor starting reducing to down to only 4 WTE vacancies on the rota. Also appointments to a Specialty Doctor post in Haematology, Clinical Fellows in Obs & Gynae and Trauma & Orthopaedics mean that some expensive agency locums can now be switched off.

One of the key actions to deliver the agency reduction target for nursing and midwifery include enhanced agency controls and increased efficiency through the use of e-Roster. An increased number of ward areas were identified as 'agency free' and this, along with the continued use of the 'rapid response team' to support short notice staffing requirements, resulted in a 22% reduction in agency spend. E-Roster master classes were launched in July and due to the success have been arranged periodically until the end of the year. The launch of the e-Roster QlikView app is now being used proactively to support decision making and monitor performance against KPIs.

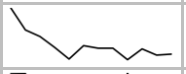
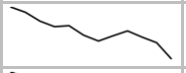
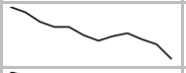
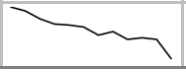
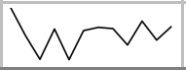
Sickness absence continues to show improved performance compared to the previous year (3.7% July 19 compared to 4.1% July 18). The absence steering group continues to ensure effective reporting and monitoring of sickness, revised policy and guides. The Trust Partnership Forum will run a workshop in August 2019 to consider the way we support staff wellbeing and attendance and will inform to policy development.

Appraisal rates are below the trajectory. New communications are being sent by divisional leads to ensure the appraisal process is complete. The appraisal working group has now been set up to redesign the appraisal process to be launched in April 2020.

Well-led Services

Workforce and Staff Development

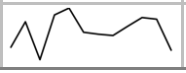
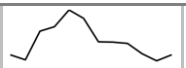
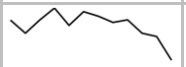
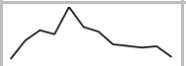
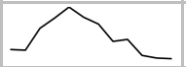
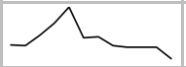
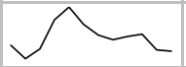
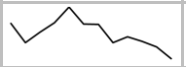
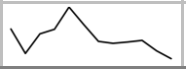
East and North Hertfordshire NHS Trust

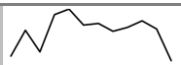
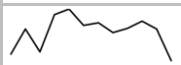
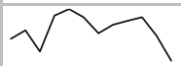
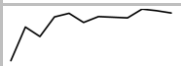
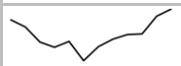
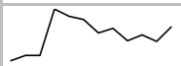
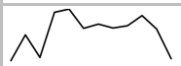
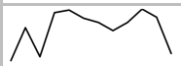
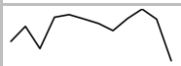
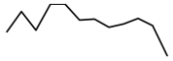
Domain	Metric	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Trend	Plan YTD	Actual YTD	Var YTD
Staffing	Approved Budget Establishment WTEs	5,916	5,905	5,915	5,912	5,912	5,923	5,927	5,927	6,089	6,074	6,083	6,100		6,100	6,100	0
	Permanent Staffing WTEs Utilised	5,011	5,002	5,052	5,084	5,084	5,077	5,114	5,123	5,185	5,245	5,248	5,276		5,779	5,276	-503
	Bank Staffing WTEs Utilised	521	463	508	473	435	485	495	566	482	510	493	516		295	516	221
	Agency Staffing WTEs Utilised	171	140	130	115	99	118	114	114	98	113	104	106		26	106	80
	Gap - Budget WTEs & Permanent WTEs	904	902	864	829	828	845	812	804	904	829	836	824		321	825	504
	Gap / Budget WTEs	15.3%	15.3%	14.6%	14.0%	14.0%	14.3%	13.7%	13.6%	14.8%	13.6%	13.7%	13.5%		6.0%	13.9%	7.9%
	Recruitable Vacant Posts	509	490	460	441	445	413	393	410	427	406	387	333		515	333	-182
	Vacancy Rate	9.0%	8.7%	8.1%	7.8%	7.8%	7.3%	6.9%	7.2%	7.4%	7.0%	6.7%	5.8%		8.9%	5.8%	-3.1%
	Turnover Rate	14.2%	14.1%	13.8%	13.6%	13.5%	13.5%	13.2%	13.3%	13.0%	13.1%	13.0%	12.3%		12.0%	12.8%	0.8%
Paybill Metrics	Total Trust Paybill - £m	23.4	22.8	23.2	23.2	22.9	23.5	23.2	23.6	24.8	24.8	24.5	24.7		96.8	98.7	1.9
	Total Permanent Staffing Costs - £m	20.1	19.5	20.0	19.8	20.0	20.3	20.0	20.1	21.6	21.3	21.2	21.1		90.7	85.2	-5.5
	Total Bank Costs - £m	2.2	2.3	2.3	2.3	2.0	2.2	2.2	2.5	2.2	2.4	2.2	2.4		4.5	9.3	4.8
	Total Agency Costs - £m	1.1	1.0	0.9	1.0	0.9	1.0	1.0	1.0	1.0	1.1	1.0	1.1		1.6	4.2	2.6
	Agency Costs as % of Paybill	4.7%	4.3%	3.8%	4.4%	3.8%	4.3%	4.4%	4.4%	4.1%	4.5%	4.2%	4.4%		1.7%	4.3%	3%

Well-led Services

Workforce and Staff Development

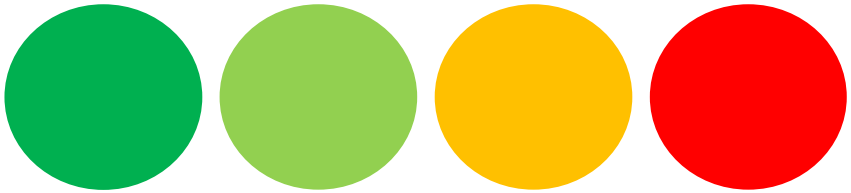
East and North Hertfordshire NHS Trust

Domain	Metric	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Trend	Plan YTD	Actual YTD	Var YTD
Training & Development	Staff Appraised	84%	83%	84%	86%	82%	83%	82%	82%	84%	84%	86%	86%		90%	86%	-4%
	Mandatory Training 100% Compliant	65%	65%	62%	62%	63%	61%	61%	62%	62%	62%	64%	66%		90%	64%	-26%
	Overall Training Compliant	88%	89%	88%	90%	90%	89%	89%	89%	89%	89%	89%	88%		90%	89%	-1%
Sickness	Sickness FTE Days Lost	6,299	6,089	7,293	7,477	8,189	7,832	6,845	6,835	6,778	6,346	6,054	6,299		25,302	25,476	174
	Short term sickness rates %	2.2%	1.8%	2.2%	2.5%	2.1%	2.4%	2.3%	2.1%	2.2%	1.8%	1.8%	1.1%		2.1%	1.7%	-0.4%
	Long term sickness rates %	1.8%	2.1%	2.3%	2.2%	2.7%	2.4%	2.3%	2.0%	2.0%	2.0%	2.0%	1.8%		2.2%	1.9%	-0.2%
	Sickness Rate	4.0%	4.0%	4.5%	4.8%	5.1%	4.8%	4.6%	4.2%	4.2%	3.8%	3.8%	3.7%		3.4%	3.9%	0.5%
	Staff on long term sick headcount	112	111	124	139	159	121	122	111	109	109	109	95		120	422	302
	Maternity % Headcount	2.2%	2.1%	2.2%	2.4%	2.4%	2.3%	2.3%	2.3%	2.3%	2.3%	2.2%	2.2%		2.2%	2.2%	0.0%
	Nursing (Q & U) sickness rate	5.3%	4.7%	5.0%	5.3%	5.8%	5.3%	5.3%	4.7%	4.9%	4.7%	4.6%	4.2%		5.2%	4.6%	-0.6%
	Nursing (Q & U) sickness days lost in month	3,471	2,989	3,376	3,461	3,900	3,559	3,226	3,190	3,216	3,244	3,040	2,890		13,619	12,391	-1,229

Domain	Metric	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Trend	Plan YTD	Actual YTD	Var YTD
Statutory and Mandatory Training	Conflict Resolution - 2 Years	91%	92%	91%	93%	93%	92%	93%	92%	92%	93%	92%	91%		90%	92%	2%
	Equality & Diversity	92%	92%	91%	91%	92%	93%	91%	91%	92%	92%	93%	93%		90%	93%	3%
	Equality, Diversity and Human Rights	73%	73%	72%	71%	70%	70%	69%	71%	72%	73%	73%	69%		90%	72%	-18%
	Fire Safety	85%	86%	84%	86%	86%	85%	85%	85%	85%	84%	84%	84%		90%	84%	-6%
	Health and Safety	91%	92%	91%	93%	93%	92%	93%	92%	92%	93%	92%	91%		90%	92%	2%
	IPC - Clinical 2 yr	91%	92%	90%	92%	93%	92%	91%	92%	92%	92%	91%	90%		90%	91%	1%
	IPC - Non-Clinical 2 yr	89%	92%	91%	93%	93%	92%	93%	93%	93%	93%	93%	93%		90%	93%	3%
	Data security awareness	75%	74%	71%	70%	71%	68%	71%	72%	73%	73%	76%	77%		90%	74%	-16%
	Moving & Handling for People Handlers	91%	91%	91%	94%	94%	94%	93%	93%	92%	92%	92%	93%		90%	92%	2%
	Moving and Handling	92%	93%	92%	94%	94%	93%	93%	93%	93%	94%	93%	92%		90%	93%	3%
	Safeguarding Adults Level 1	89%	90%	89%	91%	91%	90%	90%	90%	90%	91%	90%	89%		90%	90%	0%
	Safeguarding Adults Level 2	88%	89%	88%	90%	90%	90%	90%	89%	90%	90%	90%	87%		90%	89%	-1%
	Safeguarding Children Level 1	92%	93%	92%	94%	94%	93%	93%	92%	92%	93%	92%	90%		90%	92%	2%
	Safeguarding Children Level 2	92%	93%	92%	94%	93%	93%	92%	92%	92%	92%	92%	89%		90%	91%	1%
	Safeguarding Children Level 3	87%	89%	89%	88%	90%	88%	88%	87%	87%	88%	86%	92%		90%	88%	-2%

Sustainable Services

Month 04 | 2019-20



Key Issues

- The Trust's reported position at Month 4 is a deficit of £2.3m. Exclusive of donated asset and profit on land sale impacts the reported deficit is £3.5m. This remains in alignment with the agreed control total plan for 19/20.
- This reported M4 deficit includes the expected receipt of PSF & FRF performance incentive funds totalling £3.5m. Payment of these funds is confirmed by NHSI on a quarterly basis upon the achievement of underlying financial achievement targets. Based upon M4 results the Trust presently envisages full receipt of these funds in Q1 and across the financial year.
- At M4 the Trust reports an over achievement (£2.9m) against SLA contracts with its commissioners. The majority of the YTD income overachievement is driven by above plan volumes of emergency activity undertaken. The Trust has highlighted to Commissioners high levels of growth from areas in the local health economy where housing development expansion has accelerated over the last 12 months. The 19/20 SLA contract for emergency activity incorporates a blended payments mechanism that applies marginal rates to over performance within agreed bands. M4 performance is after the application of these rules.
- The Trust anticipates that the achievement of CQUIN target income during Q1 and across the remainder of the year will a significant challenge as a result of changes in the methodology of how these targets are derived and subsequently delivered.
- Pay budgets report a significant YTD overspend of £1.9m. Although the level of overspend and absolute pay spend has reduced compared with Q1.
- Performance against medical staffing budgets remain a key concern, reporting an overspend of £1.4m across the YTD. The bulk is driven by two separate issues (1) the use of above plan levels of WLIs in Surgery to deliver the 19/20 activity plan as opposed to planned levels of theatre and outpatient efficiency and (2) significant weaknesses in the medical workforce control environment specifically within Surgery.
- The pay position has been further compounded by significant ongoing overspends against nursing budgets, particularly in relation to increased temp staffing use across medical and surgical wards. Whilst an element of this overspend relates to escalation pressure, the majority pertains to challenges associated with weaknesses in the nursing workforce planning process.
- Staff used by the Trust to deliver services has increased significantly year on year. An additional 187 WTE's were used in July 19 compared with 12 months earlier (excluding the impact of Therapies & Pharma).
- In the YTD the Trust delivered total CIP's of £4.2m. Whilst high by historical standards this was nevertheless £0.8m less than planned. The overwhelming majority of this slippage related to the non-achievement of planned theatre and outpatient savings targets.

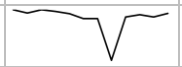
Executive Response

- Key elements of the finance performance represent a significant concern for the Trust. The income over performance YTD largely relates to emergency activity, this is neither operationally sustainable for the Trust or affordable by commissioners. The significant overspend against pay budgets is largely unrelated to activity and pertains to a combination of slippage against clinical productivity targets and weaknesses in the management of medical and nursing temporary staffing costs. This underlying position is not sustainable and requires immediate redress.
- The Trust Executive have reintroduced weekly IFD oversight groups for both Medical Staffing and Nursing Management. These groups lapsed at the conclusion of the last financial year, there reinstatement has been identified as key in maintaining oversight and management of the control environment. The groups are led by Executive Directors and will implement agreed improvement plans for these staffing areas.
- The Trust continues to maintain a weekly programme of divisional 'Improving Financial Delivery' (IFD) meetings. These meetings are chaired by either the DoF and / or PMO Director.
- The strong emphasise upon workforce issues within IFD sessions, such as the review of vacancies, the monitoring of temp staffing levels and tracking the progress made by divisions against recruitment and retention targets, represents a response to recent 'Paybill Deep Dive' analysis undertaken by the Finance Committee. This identified a need to improve control and action mechanisms in relation to the management of paybill costs. The alarming YTD pay budget performance re-emphasises the need for this focus.
- 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. Furthermore, the Trust continues to undertake monthly Accountability Review Meetings (ARM) with division to support improved performance. These meeting contain review of finance delivery and CIP achievement.
- The Trust continues to maintain 'Model Hospital' project working groups, to drive progress across a number of other key clinical processes - i.e. Theatres, Outpatients, Consultant Job Planning as well as Inpatient Flow. The success and achievements of these groups has been extremely variable.
- The Trust also continues to schedule a weekly series of Performance & Activity Meetings (PAM) meetings. Composed of key corporate and operational managers PAM meets to review and track SLA activity delivery and performance against both plan and forecast and agrees remedial action where required.
- The Trust PMO function remains embedded in terms of supporting divisional CIP projects, IFD meetings and activities as well as helping divisions to deliver improvements across key process themes.

Sustainable Services

Finance Plan Performance

East and North Hertfordshire NHS Trust

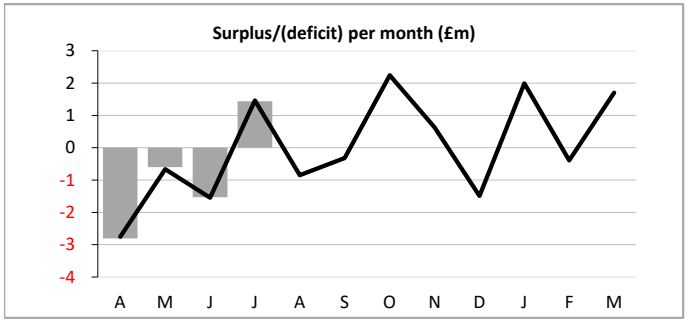
Domain	Metric	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Trend	Plan YTD	Actual YTD	Variance YTD
I&E Performance	SLA Income Earned	33.7	31.8	34.4	33.4	30.4	33.7	30.4	33.3	32.7	35.3	33.5	37.2		135.0	138.7	3.7
	Other Income Earned	5.4	4.8	5.0	5.3	5.1	5.4	4.8	-6.8	3.5	3.7	3.6	3.8		15.9	14.7	-1.3
	Pay Costs	23.4	22.8	23.2	23.2	22.9	23.5	23.2	23.6	24.8	24.8	24.5	24.7		96.8	98.7	1.9
	Non Pay Costs inc Financing	17.0	16.1	17.1	16.6	15.9	14.6	14.6	2.8	15.0	15.6	15.0	16.0		61.2	61.7	0.5
	Underlying Surplus / (Deficit)	-1.3	-2.3	-0.9	-1.1	-3.3	1.0	-2.7	0.0	-3.6	-1.4	-2.3	0.4		-7.0	-7.0	0.0
	PSF Earned	0.7	0.7	0.0	0.0	0.0	0.0	0.0	5.9	0.4	0.4	0.4	0.5		1.5	1.5	0.0
	FRF Received	-	-	-	-	-	-	-	-	0.5	0.5	0.5	0.6		2.0	2.0	0.0
	Retained Surplus / Deficit	-0.6	-1.6	-0.9	-1.1	-3.3	1.0	-2.7	6.0	-2.8	-0.6	-1.5	1.4		-3.5	-3.5	0.0
Paybill Metrics	Substantive Pay Costs	19.8	19.3	19.6	19.4	19.7	19.9	19.7	19.8	21.2	20.8	20.8	20.8		89.3	83.6	-5.7
	Premium Pay Costs Overtime & WLI	0.3	0.3	0.4	0.4	0.4	0.3	0.4	0.4	0.4	0.5	0.4	0.4		1.4	1.6	0.3
	Premium Pay Costs Bank Costs	2.2	2.3	2.3	2.3	2.0	2.2	2.2	2.5	2.2	2.4	2.2	2.4		4.5	9.3	4.8
	Premium Pay Costs Agency Costs	1.1	1.0	0.9	1.0	0.9	1.0	1.0	1.0	1.0	1.1	1.0	1.1		1.6	4.2	2.6
	Premium Pay Costs As % of Paybill	15.6%	15.3%	15.3%	16.1%	14.1%	15.3%	15.3%	16.4%	14.5%	16.2%	14.8%	15.8%		7.7%	15.3%	7.6%

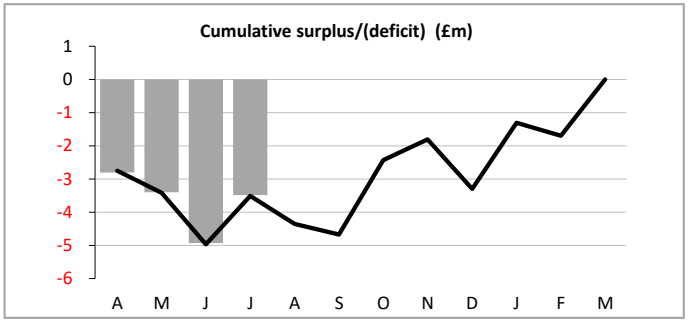
Sustainable Services

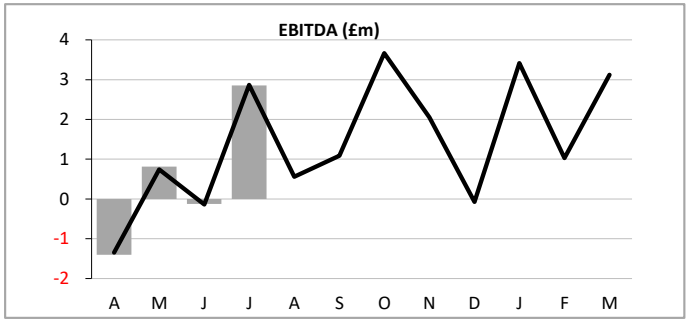
Finance Plan Performance

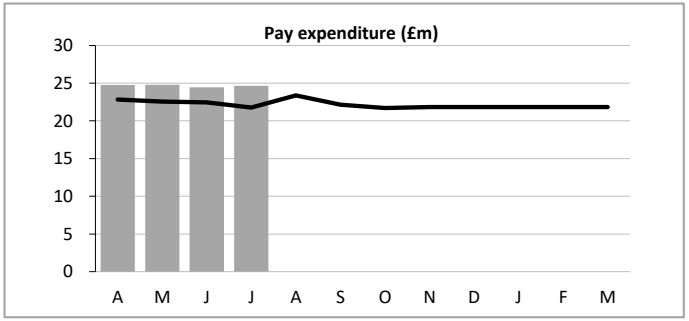
East and North Hertfordshire NHS Trust

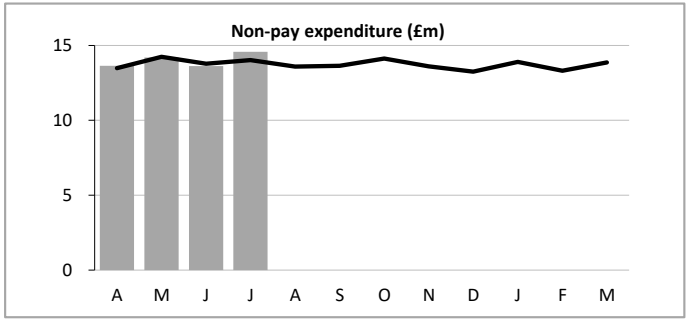
Domain	Metric	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Trend	Plan YTD	Actual YTD	Variance YTD
Single Oversight Framework	Capital Servicing Capacity	4	4	4	4	4	4	4	4	4	4	4	3		1	3	
	Liquid Ratio (Days)	4	4	4	4	4	4	4	4	4	4	4	4		1	4	
	I&E Margin	4	4	4	4	4	4	4	4	4	4	4	4		1	4	
	Distance from Plan	2	2	3	4	4	4	4	4	1	1	1	1		1	1	
	Agency Spend vs. Ceiling	2	1	1	1	1	1	1	1	1	1	1	1		1	1	
	Overall Finance Metric	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**		**1**	**3**	











Sustainable Services

SLA Contracts - Income Performance

East and North Hertfordshire NHS Trust

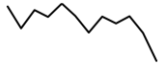
		In-Month			YTD		
		Planned Income	Actual Income	Income Variance	Planned Income	Actual Income	Income Variance
By Point of Delivery	A&E Attendances	2,161	2,443	283	8,503	9,288	786
	Daycases	3,050	3,027	-23	10,970	11,675	705
	Inpatient Elective	2,356	2,064	-292	8,456	7,682	-774
	Inpatient Non Elective	8,463	8,927	463	33,286	36,924	3,638
	Maternity	2,375	2,277	-98	9,091	9,086	-5
	Other	4,800	4,552	-248	18,656	17,866	-790
	Outpatient First	2,246	2,336	90	8,058	8,500	442
	Outpatient Follow Ups	2,490	2,307	-183	8,966	8,699	-267
	Outpatient Procedures	1,299	1,007	-292	4,668	4,417	-251
	Other SLAs	57	57	0	230	230	0
	Block	850	799	-51	3,364	3,160	-205
	Drugs & Devices	3,851	3,714	-137	14,065	14,157	92
	Chemotherapy Delivery	679	561	-118	2,480	2,298	-183
	Renal Dialysis	1,175	960	-215	4,569	4,300	-269
	Total	35,851	35,030	-821	135,363	138,282	2,919

		In-Month			YTD		
		Planned Income	Actual Income	Income Variance	Planned Income	Actual Income	Income Variance
By Commissioner	East & North Herts CCG	21,002	21,157	156	79,508	84,019	4,510
	Specialist Commissioning	8,451	8,132	-319	31,409	31,409	-0
	Bedfordshire CCG	2,443	2,407	-37	9,244	9,815	571
	Herts Valleys CCG	1,437	1,272	-165	5,447	4,986	-461
	Cancer Drugs Fund	486	364	-121	1,774	1,508	-266
	Luton CCG	319	275	-44	1,203	1,186	-17
	PH - Screening	323	365	41	1,171	1,386	215
	Other	1,391	1,058	-333	5,607	3,973	-1,634
By Division	Cancer Services	6,959	6,930	-28	25,566	25,572	6
	Medicine	11,182	11,303	121	43,184	46,069	2,885
	Women & Children	4,913	4,647	-266	18,765	18,637	-128
	Clinical Services	2,263	2,182	-81	8,312	8,703	391
	Surgery	10,840	10,701	-139	40,149	41,217	1,068
	Other	-305	-733	-428	-613	-1,916	-1,303

Sustainable Services

Activity and Productivity

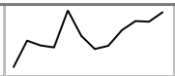
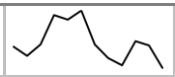
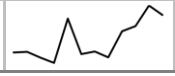
East and North Hertfordshire NHS Trust

Domain	Metric	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Trend	Plan YTD	Actual YTD	Var YTD
Patient Activity Levels	A&E & UCC	12,178	12,333	13,296	12,622	12,516	12,876	12,086	13,475	12,680	13,521	12,942	13,968		49,689	53,111	3,422
	Chemotherapy Atts	2,306	2,072	2,349	2,335	2,083	2,296	2,001	1,983	2,223	2,239	1,948	2,043		9,003	8,453	-550
	Critical Care (Adult) - OBD's	636	491	839	569	566	729	464	577	636	628	580	757		2,220	2,601	381
	Critical Care (Paeds) - OBD's	602	505	589	404	486	398	379	442	421	628	427	515		2,208	1,991	-217
	Daycases	3,106	3,130	3,581	3,415	2,896	3,638	3,102	3,269	3,410	3,683	3,704	3,994		13,396	14,791	1,395
	Elective Inpatients	630	648	684	630	473	594	556	621	517	577	546	609		2,675	2,249	-426
	Emergency Inpatients	3,902	3,852	4,229	4,169	4,130	4,330	3,843	4,155	3,893	4,463	4,103	4,287		15,264	16,746	1,482
	Home Dialysis	164	163	182	175	186	195	163	178	176	173	161	158		650	669	19
	Hospital Dialysis	6,408	5,862	6,319	6,147	6,481	6,171	5,751	6,156	5,983	6,159	5,747	5,042		24,837	22,931	-1,906
	Maternity Births	442	447	478	464	447	441	381	445	422	461	427	432		1,844	1,742	-102
	Maternity Bookings	530	466	533	532	432	541	467	469	474	551	501	504		2,068	2,030	-38
	Outpatient First	8,562	8,932	10,324	9,662	7,733	9,289	8,293	9,261	8,456	9,132	8,985	10,159		33,337	36,732	3,395
	Outpatient Follow Up	18,336	17,219	20,360	19,161	14,070	19,489	17,002	17,277	17,151	17,763	16,976	19,071		73,845	70,961	-2,884
	Outpatient procedures	6,084	6,454	6,645	7,156	6,297	8,397	7,539	7,207	7,992	7,790	6,335	6,145		26,618	28,262	1,644
	Radiotherapy Fractions	4,921	4,566	5,125	5,273	4,381	5,286	4,773	5,048	5,023	5,023	4,338	4,845		19,063	19,229	166

Sustainable Services

Activity and Productivity

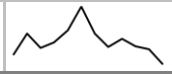
East and North Hertfordshire NHS Trust

Domain	Metric	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Trend	Plan YTD	Actual YTD	Var YTD
Throuhput	Elective Spells per Working Day	170	189	185	184	211	192	183	185	196	203	202	209		191	203	12
	Emergency Spells per Day	114	118	125	128	123	129	127	125	126	140	133	136		125	137	12
	ED Attendances per Day	393	411	429	421	404	415	432	435	423	436	431	451		407	435	28
	Outpatient Atts per Working Day	1,499	1,630	1,623	1,635	1,756	1,690	1,642	1,607	1,680	1,652	1,538	1,608		1,593	1,619	26
	Elective Bed Days Used	1,605	1,311	1,692	1,544	1,124	1,311	1,255	1,445	1,348	1,466	1,248	1,609		5,890	5,671	-219
	Emergency bed Days Used	16,209	15,286	16,732	14,979	15,192	16,528	15,146	16,380	15,538	16,653	15,155	16,813		63,842	64,159	317
Efficiency	Admission Rate from A&E	24%	23%	24%	25%	25%	25%	24%	23%	23%	24%	24%	23%		23.3%	23.1%	-0.2%
	Emergency - Length of Stay	4.2	4.0	4.0	3.6	3.7	3.8	3.9	3.9	4.0	3.7	3.7	3.9		4.1	3.8	-0.3
	Emergency - Casemix Value	2,166	2,043	2,033	2,018	2,103	2,170	2,194	2,119	2,353	2,220	2,292	2,305		2,219	2,293	74
	Elective - Length of Stay	2.5	2.0	2.5	2.5	2.4	2.2	2.3	2.3	2.6	2.5	2.3	2.6		2.4	2.5	0.2
	Elective - Casemix Value	1,205	1,160	1,161	1,197	1,134	1,113	1,137	1,132	1,148	1,156	1,128	1,102		1,202	1,134	-69
	Elective Surgical DC Rate %	83.1%	82.8%	84.0%	84.4%	86.0%	86.0%	84.8%	84.0%	86.8%	86.5%	87.2%	86.8%		85%	86.8%	1.8%
	Outpatient DNA Rate % - 1st	12.1%	12.5%	12.0%	11.9%	12.8%	12.4%	12.5%	11.6%	11.9%	12.0%	11.9%	11.6%		12.6%	12.0%	-0.6%
	Outpatient DNA Rate % - FUP	8.5%	8.6%	7.5%	7.7%	8.2%	7.6%	7.1%	7.1%	7.6%	7.9%	7.9%	7.2%		8.5%	7.9%	-0.6%
	Outpatient Cancel Rate % - Patient	9.6%	9.6%	9.4%	9.3%	10.3%	9.5%	9.6%	9.5%	10.0%	10.1%	10.6%	10.4%		9.3%	10.3%	1.0%

Sustainable Services

Activity and Productivity

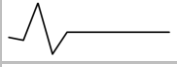
East and North Hertfordshire NHS Trust

Domain	Metric	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Trend	Plan YTD	Actual YTD	Var YTD
Efficiency	Outpatient Cancel Rate % - Hosp	5.9%	6.0%	6.6%	6.4%	6.7%	6.1%	6.3%	6.4%	6.3%	6.4%	6.2%	6.2%		6.3%	6.2%	-0.1%
	Outpatients - 1st to FUP Ratio	2.1	1.9	2.0	2.0	1.8	2.1	2.1	1.9	2.0	1.9	1.9	1.9		2.2	1.9	-0.3
	Theatres - Ave Cases Per Hour	2.8	2.9	2.8	2.6	2.9	2.7	2.7	2.8	2.7	2.6	2.8	2.8		2.9	2.7	-0.1
	Theatres - Utilisation of Sessions	80%	79%	82%	81%	78%	76%	78%	80%	78%	80%	80%	81%		85%	80%	-5%
	Theatres - Ave Late Start (mins)	27	29	28	28	26	25	23	25	23	23	25	26		27	24	-2.3
	Theatres - Ave Early Finishes (mins)	35	40	36	38	41	47	40	37	39	37	36	32		39	36	-3.3

Sustainable Services

East and North Hertfordshire NHS Trust

Cost Improvement Plan (CIP) Delivery

Domain	Metric	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Trend	Annual Plan	Plan YTD	Actual YTD	Variance YTD
CIP Delivery by Workstream	Theatre Efficiency	5	1	0	0	0	0	0	0	0	0	0	0		106	101	6	-94
	Outpatients	4	4	5	7	0	0	0	0	0	0	0	0		713	238	19	-219
	Procurement	442	231	166	226	0	0	0	0	0	0	0	0		3,109	1,171	1,065	-106
	Divisional Non Pay schemes	102	106	114	81	0	0	0	0	0	0	0	0		1,646	449	403	-46
	DQ, Coding & Income	0	0	42	41	0	0	0	0	0	0	0	0		1,656	229	83	-146
	Corporate	144	119	24	140	0	0	0	0	0	0	0	0		1,117	493	427	-66
	Demand Management	43	64	75	70	0	0	0	0	0	0	0	0		1,480	334	252	-83
	Workforce Temporary Staff reduction	83	44	63	83	0	0	0	0	0	0	0	0		1,018	322	273	-49
	Divisional Pay schemes	254	257	238	274	0	0	0	0	0	0	0	0		1,998	959	1,023	65
	Workforce transformation schemes	-10	-16	58	-43	0	0	0	0	0	0	0	0		926	-60	-11	49
	Divisional Income capture & coding	28	23	27	405	0	0	0	0	0	0	0	0		1,878	561	483	-78
	Patient Flow	0	0	0	0	0	0	0	0	0	0	0	0		463	51	0	-51
	Divisional Local Income schemes	24	51	40	18	0	0	0	0	0	0	0	0		1,324	130	134	4
	Over/Unidentified	0	0	0	0	0	0	0	0	0	0	0	0		-2,434	0	0	0
	Total CIP Delivery	**1,120**	**884**	**852**	**1,301**	0	0	0	0	0	0	0	0		**15,000**	**4,979**	**4,157**	**-822**

Sustainable Services

East and North Hertfordshire NHS Trust

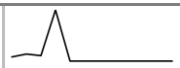
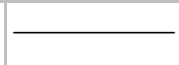
Cost Improvement Plan (CIP) Delivery

Domain	Metric	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Trend	Annual Plan	Plan YTD	Actual YTD	Variance YTD
CIP by Nature	Recurrent	467	540	571	905	0	0	0	0	0	0	0	0		14,852	3,351	2,484	-867
	Non-Recurrent	652	344	280	397	0	0	0	0	0	0	0	0		2,582	1,628	1,673	45
	Over/Unidentified	0	0	0	0	0	0	0	0	0	0	0	0		-2,434	0	0	0
	Total CIP Delivery	**1,120**	**885**	**852**	**1,301**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**15,000**	**4,979**	**4,157**	**-822**
CIP Delivery by Division	Cancer Services	164	193	177	163	0	0	0	0	0	0	0	0		1,652	706	697	-9
	Clinical Support	93	95	114	120	0	0	0	0	0	0	0	0		3,304	546	422	-123
	Corporate	582	286	222	278	0	0	0	0	0	0	0	0		3,918	1,535	1,368	-167
	Medicine	79	101	115	441	0	0	0	0	0	0	0	0		4,235	934	736	-198
	Surgery	127	141	110	166	0	0	0	0	0	0	0	0		3,134	864	544	-320
	Women's & Children's	74	69	113	133	0	0	0	0	0	0	0	0		1,190	394	389	-4
	Over/Unidentified	0	0	0	0	0	0	0	0	0	0	0	0		-2,432	0	0	0
	Total CIP Delivery	**1,120**	**884**	**852**	**1,301**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**15,001**	**4,979**	**4,157**	**-822**

Sustainable Services

East and North Hertfordshire NHS Trust

Cost Improvement Plan (CIP) Delivery

Domain	Metric	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Trend	Annual Plan	Plan YTD	Actual YTD	Variance YTD
CIP Delivery by Type	Income (other operating income)	33	55	44	396	0	0	0	0	0	0	0	0		1,960	588	529	-59
	Income (patient care activities)	23	23	70	72	0	0	0	0	0	0	0	0		3,255	349	187	-162
	Non-Pay	732	456	400	522	0	0	0	0	0	0	0	0		7,364	2,387	2,110	-277
	Pay (skillmix)	155	148	181	170	0	0	0	0	0	0	0	0		3,370	951	655	-296
	Pay (WTE reductions)	177	201	157	141	0	0	0	0	0	0	0	0		1,484	704	676	-28
	Over/Unidentified	0	0	0	0	0	0	0	0	0	0	0	0		-2,433	0	0	0
	Total CIP Delivery	**1,120**	**884**	**852**	**1,301**	0	0	0	0	0	0	0	0		**15,000**	**4,979**	**4,157**	**-822**

Sustainable Services

Productivity and Efficiency of Services - 2018-19 YTD vs. 2019-20 YTD

NHS East and North Hertfordshire NHS Trust

Activity Measures	2018-19 YTD	2019-20 YTD	Change
Emergency Department Attendances	51,610	53,111	1,501
Emergency Department Ave Daily Atts	423	435	12
Admission Rate from ED %	22.3%	23.1%	1%
Non Elective Inpatient Spells	15,516	16,746	1,230
Ave Daily Non Elective Spells	127	137	10
Daycase Spells	12,772	14,791	2,019
Elective Inpatient Spells	2,501	2,249	-252
Ave Daily Planned Spells	125	140	14
Day Case Rate	84%	87%	3%
Adult & Paeds Critical Care Bed Days	4,274	4,592	318
Outpatient First Attendances	35,153	36,732	1,579
Outpatient Follow Up Attendances	69,811	70,961	1,150
Outpatient First to Follow Up Ratio	2.0	1.9	-0.1
Outpatient Procedures	25,627	28,262	2,635
Ave Daily Outpatient Attendances	1,070	1,114	44

Workforce Measures	2018-19 YTD	2019-20 YTD	Change
Average Monthly WTE's Utilised	5,599	5,844	245
Average YTD Pay Cost per WTE	16,250	16,887	3.9%
Staff Turnover	13.6%	12.8%	-0.7%
Vacancy WTE's	914	824	-90
Vacancy Rate	15.4%	13.9%	-1.5%
Sickness Days Lost	24,417	25,476	1,059
Sickness Rate	4.0%	3.9%	-0.1%
Agency Spend- £m's	4.1	4.2	0.1
Temp Spend as % of Pay Costs	4.5%	4.3%	-0.2%
Ave Monthly Consultant WTE's Worked	304.0	324.7	20.7
Consultant : Junior Training Doctor Ratio	1 : 1.7	1 : 1.7	0.0
Ave Monthly Nursing & CSW WTE's Worked	2,402.7	2,453.9	51.2
Qual : Unqualified Staff Ratio	70 : 26	66 : 26	-0.2
Ave Monthly A&C and Senior Managers WTE's	1,220	1,294	74
A&C and Senior Managers % of Total WTE's	21.8%	22.1%	0.3%

Sustainable Services

Productivity and Efficiency of Services - 2018-19 YTD vs. 2019-20 YTD

NHS East and North Hertfordshire NHS Trust

Capacity Measures	2018-19 YTD	2019-20 YTD	Change
Non Elective LoS	4.1	3.8	-0.3
Elective LoS	2.4	2.5	0.2
Occupied Bed Days	69,732	69,830	98
Adult Critical Care Bed Days	2,183	2,601	418
Paediatric Critical Care Bed Days	2,091	1,991	-100
Outpatient DNA Rate	10%	8%	-1.8%
Outpatient Utilisation Rate	29%	27%	-1.1%
Total Cancellations	39,173	44,582	5,409
Theatres - Ave Cases per Hour	2.8	2.7	-0.1
Theatres - Ave Session Utilisation	80%	80%	-0.4%
Theatres - Ave Late Start (mins)	31	24	-7
Theatres - Ave Early Finishes (mins)	40.4	36.1	-4
Radiology Examinations	137,308	138,188	880
Drug Expenditure (excl HCD & ENH Pharma) - £000s	3,480	3,057	-422
High Cost Drug Expenditure - £000s	13,185	13,798	613

Finance & Quality Measures	2018-19 YTD	2019-20 YTD	Change
Profitability - £000s	-9,928.0	-2,282.7	7,645.3
Monthly SLA Income £000s	31,868	34,667	2,799
Monthly Clinical Income per Consultant WTE	£104,842	£106,775	£1,933
High Cost Drug Spend per Consultant WTE	£43,379	£42,498	-£880
Average Income per Elective Spell	£1,171	£1,134	-£37
Average Income per Non Elective Spell	£2,084	£2,293	£209
Average Income per ED attendance	£171	£175	£4
Average Income per Outpatient Attendance	£132	£138	£6
Ave NEL Coding Depth per Spell	n/a	n/a	n/a
Procedures Not Carried Out	694	775	81
Best Practice HRGs (% of all Spells)	9.8%	1.4%	-8.4%
Ambulatory Best Practice (% of Short Stays)	n/a	n/a	n/a
Non-elective re-admissions within 30 days Rolling 12-months to Feb-19	9,100	10,217	1,117
Non-elective re-admissions within 30 days % Rolling 12-months to Feb-19	8.30%	8.70%	0.40%
SLA Contract Fines - £000's	146	10	-136

Division	Not started	In progress	Passed	Total	%
ALL		3	2	5	40%
CANCER	9	71	32	112	29%
CAPITAL		4	1	5	20%
CSS	5	48	41	94	44%
MEDICINE	28	238	50	316	16%
SURGICAL	8	183	66	257	26%
W&C	11	81	72	164	44%
DATA QUALITY/CODING	1	5	2	8	25%
FACILITIES	2	4		6	0%
FINANCE	14	172	142	328	43%
FINANCE - INFORMATION	1	4	3	8	38%
FINANCE - IT	2		3	5	60%
NURSING PRACTICE	1	9	3	13	23%
PERF MGT			3	3	100%
PMO	1	11	56	68	82%
STRATEGY		3		3	0%
TRUST MGT		3		3	0%
WORKFORCE		12	4	16	25%
Grand Total	**83**	**851**	**480**	**1,414**	**34%**

East and North Hertfordshire NHS Trust

Agenda Item: 9.2

TRUST BOARD - PUBLIC SESSION – 4 SEPTEMBER 2019
FINANCE AND PERFORMANCE COMMITTEE –31 July 2019
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present to the Trust Board the summary report from the Finance and Performance Committee (FPC) meeting held on 31 July 2019. The report includes details of any decisions made by the FPC under delegated authority.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of FPC	**Presented by:** Chair of FPC	**Author:** Trust Secretary/ Board Committee Secretary

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

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

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

FINANCE AND PERFORMANCE COMMITTEE – 31 July 2019

EXECUTIVE SUMMARY REPORT TO TRUST BOARD – 4 September 2019

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

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

MATTERS CONSIDERED BY THE COMMITTEE:

DEEP DIVE – OUTPATIENTS EFFICIENCY PROGRAMME
The Committee was presented with a deep dive on the Outpatients Efficiency Programme. The team reported that Did Not Attend (DNA) and cancellations were a big challenge but work was ongoing and pathways were being reviewed to see what changes were needed to see improvements in this area. The Committee was informed that KPIs to monitor progress had recently been developed. The Committee also recommended that the team liaises with the communications department to help with the promotional elements. The Committee was reassured by the presentation in that it articulated the key challenges, but felt that the action plan required more focus on the outcomes to be achieved. In particular the identification of actions to secure sustainable change in the short as well as longer term. The Committee requested that further details be provided at a future FPC, including quick wins and KPIs. The Committee also agreed to nominate a Board Member to act as a critical friend in the development of these plans.

DEEP DIVE – THEATRE 100 DAY PLAN
The Committee also received an update on the Theatre 100 day Plan as requested at the previous meeting. The Committee requested greater details on deliverables and timelines be developed outside of the meeting.

BOARD ASSURANCE FRAMEWORK
The Director of Strategy updated the Committee on the Board Assurance Framework. She provided an update regarding risk 11 (Estates and facilities compliance arrangements), following a referral from Audit Committee.
She updated the committee on:

- the recruitment of a substantive Director of Estates and Facilities,
- the ongoing work towards developing a dashboard and improving reporting and governance structures
- ongoing work in relation to the Trust's preparation for a "No Deal" EU Exit; and
- discussed the possibility of reducing risk 5 regarding the Trust's IT (system not being sufficiently embedded to ensure the Hospital is run in a safe and effective way). The committee agreed that this risk should be updated for the next meeting.

INTEGRATED PERFORMANCE REPORT
The Committee received the latest Integrated Performance Report (covering month 3). The key points under each of the domains were discussed as set out below.

Responsive Services:
The Chief Operating Officer presented an update regarding the responsive services section of the IPR. She reported that:

- ED performance for June was 84.55%
- There had been increased system pressure in July due to the hot weather.
- Three national cancer Targets were delivered in May
- Improvement was noted in stroke and diagnostics performance.

Safe, Caring and Effective Services:
The Medical Director provided a brief update on these areas. This section of the report had been discussed in detail at the Quality & Safety Committee meeting.

Well-led Services:
The Chief People Officer presented an update to the Committee on the well-led services section of the report:

- Meetings to discuss and take action where necessary to address nursing and medical pay-bill issues were now established.
- Sickness absence performance was acceptable but could be improved.
- Appraisals performance was below target and work was ongoing in this area.

Sustainable Services:
The Director of Finance updated the Committee on sustainable services:

- Finance performance for M3 was in line with the plan.
- The pay-bill was showing some evidence of improvement

Other significant items were addressed in detail in the rest of the agenda.

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SAME DAY EMERGENCY CARE
The Chief Operating Officer presented a document to the Committee on Same Day Emergency Care at the Trust. She presented the proposed changes to patient pathways and advised that these would help to reduce overcrowding and waiting times in A&E. She stated the next step would be to communicate these plans with the wider organisation. It was noted that the ambulatory care tariff would have to be renegotiated with the CCG. It was agreed that performance and progress should be tracked through the IPR.

STRATEGIC PROJECT HIGHLIGHT REPORT
The Director of Strategy presented the Committee with an update report regarding the Strategic Programme Board meeting (SPB) scheduled for 16 July. The meeting was cancelled but some specific issues were reported to the FPC, including the timing of the OBC relating to Vascular Surgery. It was also noted that a review of the Trust's clinical strategy would take place through the SPB.

STRATEGY PROGRAMME BOARD
The Director of Strategy presented the Committee with updates on the progress of key strategic projects which were currently in delivery and responded to questions. The Committee noted the progress outlined against each project.

SUSTAINABILITY DEVELOPMENT BRIEIFING
The Committee noted the briefing paper regarding the Trust's sustainability agenda. The paper was provided following a referral from the Audit Committee. Work was taking place to increase oversight of this area.

M3 FINANCE REPORT
The Director of Finance presented the Committee with the Month 3 Finance Report. He reported an in month deficit which was in line with the monthly plan. He stated that the volume of staff used to deliver services in June was higher than last year by 163 WTE. The Committee also received an update on current non-elective over performance. The analysis undertaken indicated that housing developments were a key driver behind high demands on healthcare services and higher acuity.

PAY-BILL UPDATE
The Director of Finance provided an update to the Committee on the Trust pay-bill. He reported that spend across the temporary medical staff was high and work was taking place to look at long term vacancies and how these were covered. Regarding nursing staff, work was also taking place to improve staff management and understanding of nursing rosters. The Committee was pleased to hear of the progress but noted that the control issue had not yet been fully addressed.

CQUIN UPDATE
The Director of Finance reported on challenges in terms of CQUIN delivery in 2019/20. The current forecast highlighted the possibility of a significant amount of lost income against plan. The Committee requested a detailed review was undertaken to identify what could still be achieved and the challenges.

CIP PERFORMANCE ANALYSIS AND UPDATE
The PMO Director presented an update to the committee on CIP performance in the year to date. In the year to date, almost £5m had been delivered against the plan of around £15.5m for the year. He reported that work was ongoing to improve CIP delivery. The Committee commended the PMO Director for the figure achieved to date which was an improvement on previous years.

CAPITAL PLAN 2019/2020 UPDATE
The Committee received a report from the Director of Finance regarding the Capital Plan. The Trust was in a challenging position. A further update would be provided for the next meeting.

PROCUREMENT SERVICE REVIEW AND UPDATE
The Deputy Director of Finance provided an update on procurement. It was felt that this was an area where there was scope for realising greater benefits for the Trust. The Committee discussed next steps.

EQUALITY AND DIVERSITY REPORT
The Committee received an update from the workforce team on equality and diversity. The report included the draft Workforce Disability Standard (WDES) that was due to be submitted. The Committee had some comments on the WDES submission that would be provided outside of the meeting. The Chief People Officer advised that it was his intention that equality and diversity would form a key component of the new people strategy that was currently being developed.

STAFF SURVEY ACTION PLAN
The Chief People Officer also presented the staff survey action plan to the Committee. He stated that the development of the people strategy would help to deliver this work.

TALENT MANAGEMENT ACTION PLAN
The Committee received an update paper regarding talent management from the Chief People Officer. The report set out some of the broad principles around talent management

which would continue to be developed further by the Trust's new lead. The Committee noted the report.

Karen McConnell
Finance and Performance Committee Chair

July 2019

East and North Hertfordshire NHS Trust

Agenda Item:9.3

TRUST BOARD PART 1 – 4 September 2019

Quality and Safety Committee – Meeting held on 30 July 2019

EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the QSC meeting of the 30 July 2019 to the Board		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of QSC	**Presented by:** Chair of QSC	**Author:** Trust Secretary / Corporate Governance Officer

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

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

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QUALITY AND SAFETY COMMITTEE – MEETING HELD ON 25 JUNE 2019

SUMMARY REPORT TO TRUST BOARD – 4 SEPTEMBER 2019

The following Non-Executive Directors were present:

Peter Carter (Chair), David Buckle, Val Moore, Ellen Schroder.

The following core attendees were present:

Nick Carver (Chief Executive), Jude Archer, Sarah Brierley, Michael Chilvers, Rachael Corser, Julie Smith.

The following points are specifically highlighted to the Trust Board:

Maternity reports

1. Perinatal Mortality Review Group

The report of the Perinatal Mortality Review Group (PMRG) was presented to the Committee for discussion. The report provided assurance that the maternity services was monitoring the Stillbirth and Neonatal death rates by means of the Perinatal Mortality Review Tool (PMRT) and provided a summary of the outcomes and actions for the first quarter of 2019 (April-June).

The report considered:

- The number of stillbirths and neonatal deaths and their causes;
- Learning and Actions;
- Post-mortem uptake.

The Committee thanked the presenters for a very comprehensive report.

2. Each Baby Counts Review

Each Baby counts is a national quality improvement programme led by the Royal College of Obstetricians and Gynaecologists which enables national reporting of babies with severe HIE, intrapartum still birth or early neonatal death within the first week of life. The report contained information of the maternity services' analysis and actions in response to the review. The review was also part of the NHSR 10 safety actions which the Committee had to certify. The Committee discussed the findings in relation to uterine rupture rate.

The Committee thanked the presenters for attending and presenting the report.

3. NHS Resolution Maternity Incentive Scheme sign off

The Head of Midwifery presented the report on the Clinical Negligence Schemes for Trusts (CNST) Incentive Scheme. Compliance against the 10 Safety actions had been validated through a number of forums including Divisional and Trust Board and previous Quality and Safety Committee meetings.

They had assessed that the Trust was compliant against all ten actions. Three meetings have been held with the commissioners regarding the submission. The final one on the 18th July 2019 went through a process of check and challenge with review of the evidence.

The documents which were to be submitted were brought to the committee for final sign off from the committee. The Committee Chair thanked the team for their effort. The QSC approved the submission.

QTP - Clinical Excellence Accreditation Framework

The Director of Nursing reported that the Clinical Excellence Accreditation Framework is a core means of developing Nursing and Midwifery excellence across the organisation. It was the intention to ultimately expand this programme to also cover doctors and AHPs. Four wards were in the first cohort applying for accreditation. Two ward leaders who were participating in the first cohort attended to give their insight. They informed the Committee of the procedures they were following. The Director of Nursing commended the ward leaders on the excellent work they were doing and on their enthusiasm.

Other outcomes:

Patient Experience Quarterly Update

The Director of Nursing presented the Patient Experience Quarterly Update report to inform the Committee of the Trust's position with regard to the Q1 (April – June 2019) patient experience feedback, complaints and PALS activity.

As with previous reports, the majority of feedback received via the Trust's patient experience surveys, including the friends and family test question, was positive. The highest proportion of positive comments related to staff. The highest proportion of negative comments related to the environment, food, prolonged wait for medication before discharge and lack of information.

Complaints performance was below target, as discussed under the IPR.

The Committee noted the report.

Integrated Performance Report

The Integrated Performance Report - Month 3 - 2019 -2020 was presented to the Quality and Safety Committee.

Safe

- There had been 4 serious incidents reported in June.
- There was an on-going review of processes to improve governance and measurement of VTE risk assessments. A trust wide action plan had been written and Trust 'Thrombosis Action Group' had been established.

Caring

- Responses to complaints had fallen in June. The target of 80% was not achieved. Capacity modelling was taking place with the aim of improving performance.

Effective services

- SHMI had improved to 91.8 for the rolling 12 months to January 2019.
- HSMR improved to 93.6 in April 2019, and remained in the 'better than expected' range. The rolling 12-months HSMR increased slightly to 93.3 in the 12 months to March, but remained in the better than expected range.
- The total re-admission rate increased to 9.0 in December 2018 compared to the previous month. There was usually a rise in re-admissions in winter, though the exact cause was not clear at present.

Responsive Services

Performance delivery in four out of the five categories had improved. There had been an improvement in the 4 hour ED target. Performance for the month of June was 84.55%. No 12 hour trolley waits were reported in June.

Five Year Strategy Development Programme Highlights Report

The Highlights Report was presented to provide a quarterly update to the Quality and Safety Committee on the progress of the Trust's new five year strategy.

The strategy was launched in April 2019, and has been presented at Trust induction, all Divisional Boards and a number of team meetings. The draft programme plan and the draft communication plan were also presented to the committee. The Director of Strategy advised that it was the intention to review the Strategy and consider whether any updates were required.

Junior Doctors Contract Quarterly Update

The Committee noted the latest quarterly report from the Guardian of Safe Working Hours.

There were 45 exception reports submitted for the period of this report. As in previous reports, most Exception Reports were from Foundation Year Doctors, and in this period, the majority from the General Surgery rotas. All reports bar one were for extra hours worked. There were no patient safety concern reports in this period. There were no breaches of safe working hours in this period and no exceptions citing lack of support.

It was also noted that there had been a change in the level of fines.

Annual Responsible Officers' Revalidation Report

The Medical Profession (Responsible Officers) Regulations 2011 require that a Responsible officer be appointed to monitor and evaluate doctors' performance. The Report was submitted to the Committee for discussion. The report set out how the Trust had met the regulations.

The Committee discussed and approved the report.

Safer Staffing Report

The Safer Staffing Report was submitted to update the Committee on safe staffing levels for the month of June. The Overall Fill Rate had increased by 0.08% from 97.96% in May to 98.04% in June. CHPPD had increased from 7.3 to 7.5. Fourteen Nursing Associates completed their registration with the Nursing & Midwifery Council in June. This has resulted in an increase to the registered Care Hours per Patient Day. The Committee noted the report

Clinical Harm Reviews Update

The Medical Director presented an update on clinical harm to inform the Committee of developments relating to the Harm Review Process. A standard operating procedure has been produced and approved relating to cancer breaches.

Assurance processes around cancer waits and referral to treatment times have been reviewed and an improved oversight process agreed.

Patient Safety and Incident Report

The reports were presented to inform the committee of patient safety incidents data, trends and themes. The Committee discussed and noted the reports.

CQC and Compliance Quarterly Update

The inspectors from CQC have completed their core inspection at the Lister and QEII. The initial feedback had been largely positive. The CQC were presently conducting their inspection at MVCC.

Emergency Preparedness Update

The update was presented to inform the Committee on progress against the Emergency Preparedness Resilience and Response (EPRR) work programme. The Trust was fully compliant on the vast majority of the core standards. This has been achieved as a result of a wholesale review of the Trust's EPRR structures, resourcing, work programme and documentation.

The Committee also received an update on the Trust's preparations for a possible 'no deal' EU exit.

Fire Compliance Update

The Annual Statement of Fire Safety for the reporting period April 1st 2018 to March 31st 2019 was presented for approval. Fire Safety remained a priority for 2019/20 and this had been reflected in the Trust Capital plan. Compliance would continue to be monitored through the Fire Safety Committee and Health and Safety Committee reporting into the Quality and Safety Committee. The Committee approved the statement. Please see Appendix 1 (Annual Fire Statement).

BAF and Corporate Risk Register Report

The Associate Director of Corporate Governance presented the latest version of the Board Assurance Framework 2019 -2020 and risk register report to the Committee for consideration. The Director of Strategy provided an update regarding risk 11 (regarding estates and facilities compliance arrangements).

The Committee noted the report.

Annual Reports:

Patient Experience Annual Report

The Report was presented to inform the Committee of the Trust's Patient Experience Annual Report for 2018-19 including patient experience feedback, complaints and PALS activity and actions to improve patient experience. The Committee approved the report.

Infection Prevention and Control Annual Report

The Report was presented to inform the committee of infection prevention and control performance during 2018-19. The Director of Nursing reported that there had been an improvement in infection prevention and control over the period. The Committee approved the report.

The following reports were noted by the committee

Patient and Carer Experience Committee Meeting

The Committee noted the report of the key matters considered by and escalated from the Patient and Carer Experience Committee following their meeting in July.

Patient Safety Report

The Committee noted the report of the key matters considered by and escalated from the Patient Safety Committee following their meetings in June and July.

Infection Prevention and Control report

The Committee noted the report on infection prevention and control performance for the period 01-30 June 2019.

Matters referred to QSC

The Medical Director updated the Committee regarding discharge summaries following a referral from the Audit Committee. Performance across the divisions was varied and this remained an area of work in progress. A further update would be provided at the next Board meeting.

_____

Peter Carter
QSC Chair
August 2019

East and North Hertfordshire NHS Trust

Agenda Item: appendix

QUALITY AND SAFETY COMMITTEE – 30 July 2019

Annual Statement of Fire Safety 2018- 2019

Purpose of report and executive summary		
To present the Annual Statement of Fire Safety for the reporting period April 1st 2018 to March 31st 2019. This has been written taking into account the feedback received from the Trust's Authorising Engineer for Fire, progress made in enhancing the governance relating to fire safety, investments to date and utilising the standardised template. Fire Safety remains a priority for 2019/20 and this has been reflected in the Trust Capital plan. We are actively seeking to recruit into the permanent Fire Safety Officer role; cover is currently provided through an experienced interim. Compliance will continue to be monitored through the Fire Safety Committee and Health and Safety Committee reporting into Quality and Safety Committee.		
Action required: For approval		
Previously considered by: **Fire Safety Committee July 2019**		
Director: **Director of Strategy**	**Presented by:** **Associate Director of Corporate Governance / Safety & Security Manager**	**Author:** **Safety & Security Manager**

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
BAF – Risk 4 – capital; Risk 11 Estates and Facilities
Any other risk issues (quality, safety, financial, HR, legal, equality): Fire Safety

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Annual statement of fire safety 2019

NHS organisation: *East and North Hertfordshire NHS Trust*		
I confirm that for the period 1 April 2018 to 31 March 2019, all premises which the organisation owns, occupies or manages have had fire risk assessments undertaken in accordance with the Regulatory Reform (Fire Safety) Order 2005, and (please tick the appropriate boxes):		
1	There are no significant risks arising from the risk assessment	X
2	The organisation has developed a programme of work to eliminate or reduce to a reasonably practicable level the significant risks identified by the risk assessment.	✓
3	The organisation has identified significant risks but does not have a programme of work to mitigate those significant risks.	X
4	Where a programme to mitigate significant risks has not been developed, please insert the date by which such a programme will be available, taking account of the degree of risk.	N/A
5	During the period covered by this statement, the organisation has not been subject to enforcement action by the fire and rescue authority. Please outline details of enforcement action in Annex A Part 1.	✓
6	The organisation has not any ongoing enforcement action pre-dating this Statement. Please outline details of enforcement action in Annex A Part 2.	✓
7	The organisation achieves compliance with the Department of Health's fire safety policy by the application of Firecode or some other suitable method.	✓
Chief Executive:	*Nick Carver*	
Safety Manager:	*Chris Boseley, Safety and Security Manager.* *The Executive Director for Fire is Sarah Brierley, Director of Strategy.*	
Contact details:	E-mail: *chris.boseley@nhs.net*	
	Telephone: *01438 285552*	
	Mobile: *07778 435386*	
Signature of Chief Executive		
Date:		
Completed statement to be retained for future audit		

* Delete as appropriate

ANNEX A

Part 1 – Outline any enforcement action taken during the past 12 months and the action taken or intended by the organisation. Include, where possible, an indication of the cost to comply.
Not Applicable

Part 2 – Outline any enforcement action ongoing from previous years and the action the organisation has taken so far. Include an indication of the cost incurred so far and, where possible, an indication of costs to fully comply.
Not Applicable

NHS Organisation:	*East and North Hertfordshire NHS Trust*
Date:	08.07.2019

ANNEX B - Further information in support of the annual statement

Fire safety management:

Alastair Burleigh of Alfor Fire Safety Services Limited has been appointed the Trusts Authorised Engineer (Fire) and the recommendations made have been considered and progressed through a fire safety compliance group.

A monthly Fire Safety Committee was established in March 2019, replacing a weekly Fire Compliance Programme Board set up to prioritise and address the recommendations from the Authorising Engineers Review in July 2018. The Committee requires representation form each Trust site and engagement with our partners and landlords. This reports to the Health and Safety Committee and Quality and Safety Committee.

A review of the Trusts Fire Policy was completed following the review by the Authorised Engineer (Fire) this included details of the revised governance structure for Fire Safety. Corporate Governance has oversight of compliance and the environment and operational responsibility remains through Estates. The Director Lead is Director of Strategy.

The Trust made further attempts to recruit a Fire Officer, having been unable to successfully recruit an officer since the previous post holder left in May 2016. The fire safety training and operational fire safety issues have been managed by the safety and security team during this period. The Trust has an experienced interim Fire Officer whilst continuing to seek to appoint a permanent postholder.

A new fire extinguisher contractor was appointed who identified that a significant number of the fire extinguishers had reached the end of their serviceable life. These have now been replaced.

A number of fire signage issues were identified by the Interim Fire Officer; Fire extinguisher signage has been ordered and will be fitted shortly.

Monthly Fire Warden Checklists are completed by each department to ensure compliance and raise any concerns, these are sent to the Safety & Security Team who follow up with estates or the relevant landlord/ departmental manager to ensure that corrective actions are completed where required.

A multi-agency desk top exercise was completed on December 20th 2018, attended by HCC resilience planning, HFRS and Trust senior clinical staff to consider the whole hospital evacuation plan and business continuity based on a fire occurring within the Lister Tower, the exercise provided a useful opportunity to consider staff roles, information sharing and has helped inform the training, Fire Officers have attended some of the fire warden training sessions to discuss the information that officers would require in the event of ward/departmental evacuations being actioned.

Analysis of the fire alarm activations identified the following:

Year 2018-2019	Trust (Lister)	MHU	MVCC	QEII	GWP	Hertford
Dust	1					
Smoking/e-Cigarette	3					
Cooking (microwave etc.)	2	3				
Toaster	1		1			
Steam (kettle/shower etc.)	3	1				
Contractors	1	1				1
Cleaning/Aerosol	3					
Machinery (equipment)	9			1		
Human Factors (activate call point)	22				1	
System fault	15			5		4
TOTAL	60	4	1	6	1	5

Fire safety training:

The Trust delivered fire training to all staff as face to face delivery in accordance with the recommendations made by Hertfordshire Fire & Rescue Service. All staff receive fire safety awareness as part of their corporate induction when they commence their employment with the Trust and a local induction relevant to their working area by the nurse/manager in charge of their department. All staff are required to attend an annual fire safety awareness update which is also incorporated into the Trusts Statutory/Mandatory (VITAL) training every 2 years.

Following the review of the Trusts authorising Engineer (Fire) in July 2018 additional practical sessions have been introduced to ensure that ward staff are familiar with the evacuation's routes and evacuation procedures. Additional training has been provided to staff on the use of Evacuation Chairs and the Use of Albac Mats to ensure the safe and timely evacuation of patients and visitors who may require support.

The training of Fire Wardens has been taken back in house having been previously provided by a contractor, a total of 160 fire wardens have been trained during this reporting period. All fire safety training and Fire Warden training is being delivered on each of the Trust sites to ensure that the training is relevant to the site staff work on.

Practice Fire Evacuations are being carried out to ensure that all staff are familiar with the evacuation procedures and identify any concerns.

Fire risk assessment:

An interim Fire Officer was appointed in February 2019, following the completion of fire safety management review by

the Trusts Authorised Engineer (Fire) in July 2018. The interim Fire Officer has completed Fire Risk Assessments for all Trust sites including premises where the Trust rents accommodation from other NHS Trusts or private landlords. An action plan based on the significant findings has been developed and work is on-going to prioritise maintenance activities and capital expenditure required to address the issues identified.

Capital programme:

Fire Compartmentation works have been completed at Mount Vernon Cancer Centre in association with Hillingdon Hospitals NHS Foundation Trust.

On the Lister site, the capital programme for the year was a fire compartmentation scheme to fire stops the main fire compartment lines from the top floor to the 5th floor of the tower block. All the main 60 min compartment doors have been replaced on the same floors.

Strathmore 5th floor (Barley Ward) had major modifications to segregate fire compartments within the plant room and roof space.

This year's planned works is to continue main fire compartments and doors from 5th floor to lower ground floors, has been tendered following the approved of the capital funds by the executive team.

East and North Hertfordshire NHS Trust

Agenda Item: 9.3.1

TRUST BOARD - PUBLIC SESSION – 4 SEPTEMBER 2019

Patient Experience Annual Report 2018-19

Purpose of report and executive summary: To present the Trust's Patient Experience Annual Report for 2018-19 including patient experience feedback, complaints and PALS activity and actions to improve patient experience.		
Action required: For information		
Previously considered by: Patient and Carer Experience Committee - 15 July 2019 Quality and Safety Committee – 30 July 2019		
Director: Director of Nursing and Patient Experience	**Presented by:** Director of Nursing and Patient Experience	**Author:** Project Manager – Nursing and Patient Experience/ Complaints and PALS Manager

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

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

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

East and North Hertfordshire NHS Trust

Patient Experience Annual Report 2018-19

including Complaints and Patient Advice and Liaison Service (PALS)

Contents

Introduction

#hello my name is…

Rachael Corser

We aim to provide our patients and their carers with the best possible experience whilst they are using our services. This combined patient experience, complaints and Patient Advice and Liaison Service (PALS) annual report demonstrates how the Trust has collected and acted on patient feedback during 2018-19.

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

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

The Trust takes part in the national patient experience surveys co-ordinated by the Care Quality Commission and Department of Health. This feedback is valuable as it enables the Trust to compare performance with other trusts throughout the country.

In 2018-19, the Trust received feedback from the following national surveys: Cancer 2017, Maternity 2018 and Inpatients 2018. The timeframe for publication of national survey data is approximately ten months after the survey month. For example, the Inpatient survey 2018 was sent to patients who were in hospital in July 2018, the survey results were published by the Care Quality Commission in June 2019. A summary of results from these national surveys is included in Appendix 1, the 'Facts and Figures' section of this report. This section also shows the full breakdown of patient experience survey responses during 2018-19 and a breakdown of complaints and PALS enquiries. This wealth of feedback has helped the Trust prioritise areas for improvement and influenced the actions included in this report.

Rachael Corser
Director of Nursing and Patient Experience

Volunteers improving patient experience

North Herts College Beauty Therapy Students

Throughout the last 12 months, Lister Hospital has been delighted to have regular Monday visits from the beauty therapy students from North Herts College. The students have visited wards right across the hospital, offering hand massages and manicures to patients, as well as having a stall in reception catering for more mobile patients as well as visitors and staff. Many of our patients have enjoyed this opportunity for a bit of pampering, but have equally valued having a chat and a laugh with the students. Often treating more than 50 people in a day, the students have brought smiles to many patients; reminding them of life outside the hospital and helping them feel a little more like their normal selves. Feedback from patients and staff has been hugely positive, and the students themselves have enjoyed using their skills in what – for them – is an unusual setting.

Beauticians at Lister Hospital

Hygiene has been an important factor in this initiative – all the files, cotton pads etc., are single use, and washing and sanitising between patients is routine for the students. We are very grateful, not only to the college, but also for support from the Hospital Charity in funding the products and materials the students use for this very popular service.

Sew Dementia and Knit 'n' Natter

Both of these community groups continue to meet regularly in the town, producing much-needed sewn and knitted goods for hospital patients. Our knitters produce blankets, shawls, twiddle muffs, teddies and baby hats. Our sewers provide us with activity blankets, rag dolls and carry bags for syringe drivers. Both groups have also been involved in producing small items, such as Halloween and Christmas decorations, to be sold by the Hospital Charity.

Examples of knitted toys/blankets

This year we have also asked the groups to produce some goods specifically for children coming in for day surgery. These young patients can be very apprehensive, and it helps if we are able to gift them a toy to distract them on arrival, and which they can take home with them at the end of the day as a positive souvenir of the day. The stitchers and knitters have responded with enthusiasm to this new request, producing some wonderful rag dolls, knitted animals and dolls, and activity blankets with a child centred theme.

Examples of sewn activity blanket

Pets as Therapy (PAT) Dogs

The number of PAT dogs visiting the hospital has stayed around the same this last year, although some of the names and faces have changed. However, the frequency of visits has increased, with many of our dogs visiting more regularly than in previous years.

The total number of hours of 'dog time' in the hospital (between April 2018 and March 2019) was 596 hours, with an estimated 17,163 patient interactions in this period, compared to 10,382 last year. This represents an increase of around 65%, and does not include all the encounters with staff, visitors and children's outpatient clinics.

Meet Dizzy, Pets as Therapy dog

The reach of the dogs has also extended within the hospital. In 2015, we had two dogs visiting Level 9 and Bluebell ward only – this has been increased by 900% and a wide range of wards now receive regular visits. Patients love having the dogs on the wards and their visits are often eagerly anticipated. Staff acknowledge the value of these visits not just to patient welfare and wellbeing, but also their own.

Pets as Therapy dog

Butterfly Volunteers

This year marked an important milestone for the Butterfly Service. The volunteers were recognised for their dedication to supporting patients who are in the last days or hours of life, and won the 'Care and Compassion' NHS70 Parliamentary Award.

Butterfly volunteers win NHS70 Parliamentary Award

In May 2016, it was estimated that 15 patients a month were dying alone at the Lister Hospital, either waiting for relatives to arrive or because they did not have any relatives/visitors.

Voluntary services, the palliative care team and the Hospital's Charity, collectively sought to make sure that nobody had to die alone and, thanks to generous donations, were able to turn the vision of the Butterfly Project into a reality. To date the Butterfly Service have recruited 30 volunteers who have undertaken 3,000 visits and the service continues to grow.

Butterfly volunteers at Lister Hospital

Improving experience for patients with dementia

Hannah Gardner, Admiral Nurse

Hannah, our Admiral Nurse has been working to provide the specialist dementia support that families need – through psychological support, expert advice and information to help families understand and cope with their thoughts, feelings and behaviour, and to adapt to the changing situation of living with dementia. Hannah uses a range of interventions to help people live positively, develop skills to improve communication and maintain family relationships. Hannah also works with colleagues in the health and social care system to ensure that the needs of families are addressed in a co-ordinated way.

Referral pathway and criteria

- Any inpatient at East and North Hertfordshire NHS Trust (ENHT) with a diagnosis of dementia and their carer(s) with complex needs can be referred to the service. Complex needs may include things, such as carer struggling to cope; presence of complex family dynamics; high levels of distress / change in presentation of the person with dementia.
- Direct contact with the Admiral Nurse.

The model

- The Admiral Nurse works holistically, addressing both the physical and mental health needs of the carer and the person with dementia.
- The role has two strands:
  - Supporting families with complex needs. This can be at any point from time of diagnosis through to end of life care and beyond in bereavement.
  - Advising, training and being a role model for other professionals to support best practice in dementia care.
- The Admiral Nurse also works with the community Admiral Nurse team at Carers in Hertfordshire, to ensure that patients with dementia have a supported pathway from admission into hospital to when discharged.
- The service is complementary to the work of other agencies who offer support in dementia care.

Improving experience for people with a learning disability

The Acute Liaison nurses are part of the Health Liaison Team and have a specific focus on supporting adults with learning disabilities accessing the Acute Hospital Trusts across the county. On occasions the Acute Liaison Nurses work with 16-18 year olds in a hospital context as they are classed as adults in that environment but are often life limited young people who have complex health conditions and are at high risk when transferred into an unknown environment. Support is provided during normal working hours of Monday to Friday 9am-5pm.

Referrals to the Acute Liaison Nurses are made via the team contact number or email and can be made by anyone. There were 330 referrals received by the HLT during the period 2018-19 and 502 Trust staff received Learning Disability Awareness Training.

We are particularly proud of the work being done by the Trust to enable more proactive management of the risk of sepsis in learning disability patients. Resources are being developed for use nationally in conjunction with the Trust's Sepsis Team and the Health Liaison Team. This includes an easy read leaflet and a sepsis song to raise awareness.

The Purple All Stars performing the SEPSIS song
https://www.youtube.com/watch?v=FZq5sYulOB8&feature=youtu.be

Patient story

Feedback from a patent's mum about Lister Emergency Department (ED) :

Patient has learning disabilities and Autism, and doesn't use many words, went to Lister ED recently, after cutting his left little finger badly on a broken plate while at College. After an initial waiting period due to administrative issues, patient was added to the paediatric list (he is just coming into adult services). Patient and his mum were seen more promptly thereafter and the nurse who worked with them spoke directly to patient which was great. Mum explained patient's needs, and nurse showed him what she would be doing, i.e. first an injection of local anaesthetic, then wait a while for it to go numb, and then some stitches and a dressing. The nurse did the job calmly, quickly and efficiently, and mum was very impressed with her excellent manner. Nurse told mum and patient what they needed to do to make sure it healed well. Mum thought it was expedient and therefore appropriate to have Chris added to the paediatric list as a reasonable adjustment on the day to manage patient's anxieties. The approach used in communicating with the patient was also effective.

LD patient in hospital with the purple wrist band

Patient and public engagement

We continue to prioritise talking with and listening to our patients, members of the public, local communities, GPs, voluntary and charitable organisations and other partners and involving them in our strategy development and service delivery.

We have:

- Delivered a successful Annual General Meeting attended by around 300 members, partners and members of staff.
- Engaged with more GPs ensuring they get the practical information they need to resolve any issues relating to their patients' care.
- Continued to contribute to strategic partnerships' delivery projects that enhance our reputation and support our business development priorities.
- Delivered involvement opportunities for patients, public, members and communities.

The Trust continues to be showcased by NHS England as national *good practice* for our engagement work.

This year:

- The University of Hertfordshire held an engagement event with patients and carers to discuss curriculum development and gather views and feedback into making the 'Future Nurse'.

- Four patient and carer engagement events were held in partnership with Herts and West Essex Strategic Transformation Partnership to focus on responses to the national cancer patient experience survey. An example of actions taken following this event are that all patient letters have now been updated to remind patients that they can be accompanied to all appointments together with information on the benefits of having additional support, and a prompt sheet, 'questions you might want to ask'. This information was developed in conjunction with patients.

We have prioritised the involvement of patients and the public on key strategy development and service change initiatives, these include:

- Development of the Trust's Clinical Strategy for 2019-24.
- Cancer services patient and carer workshops to identify how to improve services following feedback from the national cancer patient experience survey (NCPE).
- End of life inpatient care at Mount Vernon Cancer Centre.
- Non-emergency patient transport services (in partnership with the Clinical Commissioning Group).

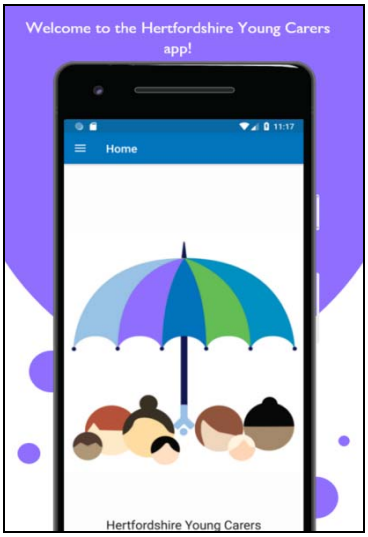
Carers

Jodie Deards, Carers Lead

Throughout the year there has been a continued emphasis to increase carer awareness within the Trust. This has been achieved through monthly carer stands, staff training days and having a visible presence on the wards. In 2018-19, 123 Carers were identified and referred to voluntary carer organisations. This number is down from the previous year as the Carers Lead role has become more strategic in ensuring carer awareness is incorporated into all divisional action plans. The aim is that this number will increase next year by at least 10%.

Young Carers App

The Young Carers App, which was co-produced with Young Carers in Hertfordshire and North Hertfordshire College, was launched during Carers Week in June 2018. It is currently available on Googleplay. The response from young carers has been very positive with 95% of those asked at the annual Young Carers Conference recommending it.



Young Carers App

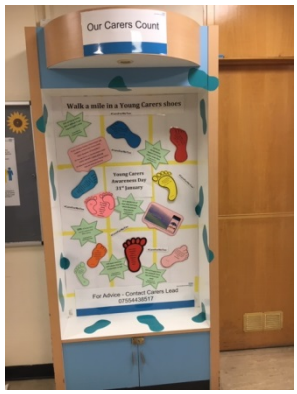
A research application to the Nursing and Midwifery Council of England in 2018 to investigate how Young Carers access information and feedback on the app was accepted. The feedback was 'I enjoyed reading this application that proposes important work to evaluate improved support for young carers, who represent complex and substantial unmet needs. The development of an app is an intelligent use of technology to improve access and service provision for this group.' Applications and ethical approval to commence the research was signed off in March 2019 and first round interviews commenced. This research is intended to last for two years with further versions of the app being developed.

This work has been recognised by Royal College of Nursing Institute Awards 2019, and by being shortlisted for the 'Commitment to Carers' category. This work has also enabled close partnership working with our local secondary school, John Henry Newman. Working together, we are highlighting young carer awareness within the school.

Raising Awareness of Young Carers

The Carers Lead, is now is a key member of the safeguarding children's weekly pyscho-social meeting. This is enabling young carer awareness and identification in a 'hard to reach' group.

Young Carer Awareness Day was held in January 2019. This year's theme was mental health. Being a young carer is a risk factor for mental ill health of children and young people. We had displays in the main hospital corridor and Bluebell children's ward.



Young Carers Awareness Day carers count

Adult Carers Handbook

The Adult Carers Handbook was launched during Carers Week in June 2018. It is now being used across NHS organisations within Hertfordshire and West Essex. The handbook was co-produced with carers, voluntary sector organisations and local NHS organisations. The handbook is being introduced by the community team as part of their stroke discharge pathway. Within this Trust, the handbook is being used for all carer identification and support across all our sites.

Adult Carers Handbook

Support for Carers

We continue to support carers within the Trust. With Hospital charity money we purchased a further 6 guest beds and now have 12 beds in use at the Lister site. Snack bags are available for carers to enable them to eat and share a meal with the person they are caring for. On average, 40 snack bags are issued each month.

The use of the carers passport is now embedded within the Trust.

Raising Awareness of Carers

Carer awareness and identification remains important within the Trust. Monthly carer awareness stands are held at the Lister site and have now been introduced at MVCC. The carer stands enable carers to receive support and information to continue their caring responsibilities. It also enables staff carers to access information about their rights and support available to enable them to continue in the workplace.

Carer Awareness Stand

Movie Afternoons

Movie afternoons were introduced in the chapel at Lister for our patients and carers. Although positively received by our patients, it was challenging to transport patients to this location. We will be re-introducing the movies into the day rooms in our wards.

Movie afternoons

Raising Awareness of Death and Dying

In partnership with Ann Robson Trust, the Trust hosted two workshops about death and dying for carers, staff and volunteers. This was positively received and very well attended. This is being offered to staff and volunteers at Mount Vernon Cancer Centre (MVCC).

Facilities

[Catering and Cleaning]

Patient Led Assessment of the Care Environment [PLACE]

PLACE is a self-assessment tool designed to give a non-technical view of the buildings and non-clinical services provided in hospital. The assessment teams include members of Trust staff and patient representatives, plus representatives from Healthwatch. The assessment falls into six categories:

- Cleanliness
- Condition
- Appearance and maintenance
- Food and hydration
- Privacy, dignity and wellbeing
- Dementia and Disability

The assessment for Mount Vernon Cancer Centre took place on 2 May 2018 and the Lister Hospital on 17 May 2018.

Lister Hospital

	2018	2017
Cleanliness	99.81	99.13
Food	94.40	93.49
Privacy, Dignity & Wellbeing	87.60	89.01
Condition, Appearance & Maintenance	96.61	95.27
Dementia	77.04	74.77
Disability	87.97	84.40

Mount Vernon Cancer Centre

	2018	2017
Cleanliness	99.87	99.29
Food	97.70	87.50
Privacy, Dignity & Wellbeing	93.49	80.83
Condition, Appearance & Maintenance	93.54	93.15
Dementia	82.30	70.56
Disability	91.82	82.69

In response to patient feedback the Catering Team have:

- Changed the patient menu to remove unpopular items and to reflect seasonal changes.
- Introduced healthier cake options in the coffee shop.
- Developed a new and improved children's menu which is proving popular with children.
- Improved the salad bar in the hospital restaurant.

- Introduced more 'special' days in the restaurant.
- Provided the Children's Emergency Department with snack boxes for children.

During my stay I was well fed and watered with excellent food provided by the housekeeping/catering staff. I was very impressed with the cleanliness of the ward, the cleaner was very efficient.

Patient on Ward 5B - Sept-18

***@enherts* is your food cooked fresh for patients? Just had the most amazing Moroccon chicken and cous cous 😋 First time I've felt like eating after my operation- well done 👌**

Examples of changes following patient survey feedback

Urgent Care Centre, QEII

Patients told us that the waiting room in the Urgent Care Centre at New QEII Hospital had no space next to the chairs for pushchairs. We moved the chairs around in the waiting room to make space for pushchairs and introduced a Crayola table and chairs equipped with toys and books to keep children occupied whilst they are waiting to be seen.

Crayola table and chairs in UCC QEII

We have also moved 'medicine management' from the triage room to the treatment room, this has stopped patients being interrupted whilst in triage, respecting and improving their privacy.

Ambulatory Care Centre, QEII

We have been working hard to improve home delivered chemotherapy and antibiotic care for patients. Staff have been teaching patients to self-administer parenteral antimicrobial therapy. We have had some fantastic feedback from patients who have been trained to administer their own intravenous antibiotics daily. This has enabled patients to have quality time at home with their loved ones and gives them back some independence. One patient told us:

"I must tell you how much my Outpatient Ambulatory IV therapy has helped me. With my Baxter Infuser connected to my PICC line I am free to live normally – and no need to stay in hospital for chemotherapy infusions which previously required a 3-day hospital stay. This avoids the need for waiting in crowded waiting rooms with patients and their relatives with coughs and colds whilst receiving a prolonged course of antibiotics. The OPAT service delivered by the New QEII Ambulatory Care Centre has enabled me to cope with my condition and reduced the impact of intensive treatment on my daily life, and the daily life of my family and friends, with relatively quick visits to the Ambulatory Care Centre for flushing and changes of dressing of my PICC line, as well as daily changes of antibiotic infusions. These two innovations, namely the Ambulatory Care Centre at the New QEII, and the Baxter Infusion systems, coupled with excellent attention from the wonderful staff in the Ambulatory Care Centre, have made my patient journey through cancer and antibiotic therapy just a little bit easier, so many thanks indeed."

Jo

For the third year running we have received our 'Purple star' award which is given to health services that work really hard to give the best help to people with learning disabilities.

Outpatients

Clinic clerks in outpatients ensure that patients are kept informed about waiting times in clinics. We continue to monitor this monthly and the front of house supervisor does regular walk-rounds to check that the 'waiting information' boards are updated.

We have improved access to one-stop breast clinics. Two new Breast Radiologists have been appointed and extra clinics set up so we now provide a one-stop service four days a week. This has improved the imaging pathway for breast patients.

We have improved turnaround times for access to and reporting of outcomes from urgent radiology diagnostics for patients attending the Emergency Department. The majority of patients are seen within one hour of referral.

Cancer Division

In response to patient feedback, all patient letters have been amended to encourage patients to bring a relative or friend to their appointment with them.

The team have introduced electronic information screens in the outpatient clinic at Mount Vernon Cancer Centre with rolling information for patients and carers, this includes information about free prescriptions.

We have re-launched the information point in the outpatients area at Mount Vernon Cancer Centre.

Women's Services

A 'Whose Shoes' maternity engagement workshop was held in 2018. This approach is designed to help staff see care through the women's eyes, using a series of thought-provoking exercises and scenarios. The workshop explored continuity of care, a requirement of the Better Births National Maternity Review.

We have established a Maternity Voices Partnership. The partnership has access to women via their jobs, i.e. Doula, baby massage. Social media is used with polls set up helping the partnership to consider ideas for improvement.

Nutrition and Hydration

We have re-launched the link nurse role on all of our wards. The link nurses have a special interest in nutrition and hydration and have taken part in a mealtime observational audit which included discussions with staff and patients about the mealtime experience.

Neonatal Big Build

Having a new baby admitted to special care is very distressing for parents and family. The Lister Neonatal Big Build project hopes to make this difficult time for parents a little more comfortable by building a special room where parents can rest, prepare a meal or see their relatives. Following many months of fundraising and welcome donations we are almost at the full amount required to start this exciting project.

Acute Paediatrics

We have raised enough money to secure the purchase of two interactive floors, one for the Children's Emergency Department and one for Bramble Day Unit. These will help to keep children occupied and lessen the stress for parents whilst waiting to be seen.

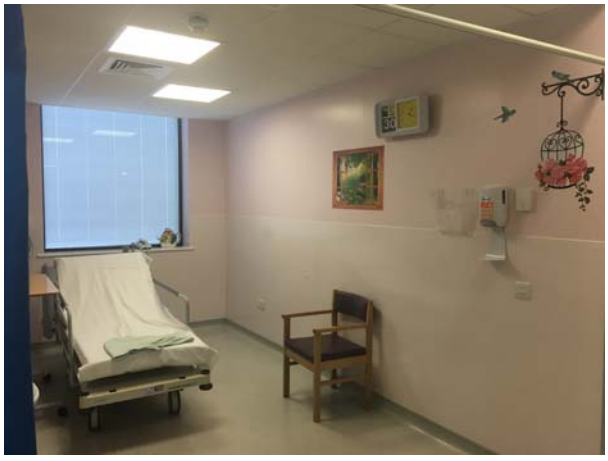
The visitors' area within Bluebell Ward has had new furniture, a sofa and dining table for parents to use whilst their children are in hospital.

We have new i-Pads across to the service for children to use whilst in inpatient and outpatient areas.

Empathy Project in Emergency Department

This project aims to support patients aged 16-24 to offer company and support to them whilst they are in the busy Emergency Department which can sometimes be a distressing time for young people. The team also look to support carers and relatives of these patients and will signpost them to other services and support networks in the community as appropriate. This initiative has received positive feedback from both the staff in the Emergency Department team and service users.

Staff in the emergency department have also worked on four of the cubicles in the department to try and make them more welcoming and less clinical to patients suffering with dementia through simple things, such as changing the colour of the walls, images on the wall which look like a window, bookshelf, birdcage, and some homely touches, such as a telephone, teapots, etc. From a patient safety aspect we have also purchased low profiling trolleys for these patients to reduce risk of falls and make transferring patients easier.



Dialysis / Diabetic Patients

91% of our diabetic patients told us that they wanted their podiatry appointments to be carried out whilst they were receiving their haemodialysis treatment. The integrated podiatry care service is now available for patients undergoing haemodialysis. This saves our service users and their families/carers an extra journey for a separate clinic appointment.

Our diabetic patients have been receiving diabetic care from the Bedfordshire community diabetic nurses for a while. The new podiatry clinics are being rolled out in parallel with the diabetic clinics to form an integrated polyclinic. This will allow patients to receive podiatry, diabetes, and haemodialysis treatments during their visit thus reducing cost, time and improving experience.

Cardiac Rehabilitation

Cardiovascular disease (CVD) is a long-term condition. Saving someone's life following a heart condition is vital, but giving them a fulfilling life that is worth living is equally important. The aims of cardiac rehabilitation and prevention is to provide the patient and their family with the skills and knowledge to self-manage, facilitate recovery both physically and psychologically and educate to reduce the risk of further CVD events, as well as achieving an absolute risk reduction in cardiovascular mortality.

Our Cardiac Rehabilitation team has been recognised by the British Association for Cardiac Rehabilitation and the National Audit for Cardiac Rehabilitation. Lister Hospital is 1 of 78 cardiac rehabilitation programmes nationally to achieve this accreditation.

Patients with heart problems are seen on the ward and are invited to attend exercise classes. The classes are designed for their individual needs and take place in our communities. Patient feedback has been really positive and the programme is showing an improvement in patient outcomes.

Cardiac Rehabilitation Team

Critical Care Team

Preventing pressure ulcers is an important part of providing high quality patient care. The Critical Care Tissue Viability Link nurse team work hard to promote the prevention and management of pressure ulcers, and provide education for the whole team to raise awareness and improve knowledge in this very important area of patient care. The team have educated staff in the use of appropriate equipment, assessment, optimum skin care and the prevention of skin damage to ensure the very best outcome and experience possible for our patients.

Critical Care Tissue Viability Link Nurses

Shared Decision Making – stable angina

Our Cardiology department is committed to involving patients in decisions about their care. We are taking part in an NHS pilot scheme called Shared Decision Making, which is being introduced for patients with angina. Patients are given an information pack if the cardiology specialist nurse or doctor believes their chest pain is likely to be angina, caused by a narrowing in one or more of the coronary arteries (the arteries supplying blood to the heart muscle).

The information pack explains how patients with stable angina due to coronary artery disease are treated and the treatment options available. It is designed to help patients make decisions about their treatment. The doctor and/or nurse will explain to the patient whether they have coronary artery disease once they have had an angiogram; having information about the treatment options in advance helps patients decide how they wish to proceed.

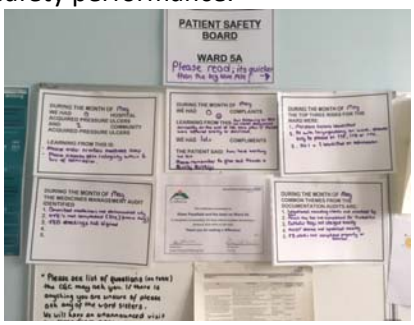
Surgical Wards

Patients tell us that they sometimes do not receive the same quality care from nursing staff who are not familiar with the patients on the ward and the ward environment. Swift ward, Ward 8B, Ward 11B and the Surgical Assessment Unit are now all 'agency nurse free'.

The nurse staffing levels in Surgery have been reviewed to ensure there is always a Band 6 nurse on duty overnight. There has also been an increase to the number of clinical support workers available both day and night.

Theatres have been commended by the Clinical Commissioning Group for their WHO surgical audit and regular safety huddles which involve all staff.

Ward 5A have developed their own patient safety board which is displayed in their staff room. This raises awareness amongst staff of the wards patient safety performance.



Accessible Services

In partnership with AccessAble the Trust offers a detailed access guide to the Lister Hospital site. Providing access information is crucial to ensuring equality of access to everyone; this guide is useful for everyone, not only people with a disability. It includes information about the multi-storey car park – photographs of the different levels, size of car parking bays, details of disabled bays etc., as well as information about accessing all hospital wards and departments – size of doorways, flooring, seating, toilet facilities etc.

Examples of changes made following feedback from complaints

Details of complaint	Outcome of investigation
Cancer Services waiting times	Service was reviewed. Patients are now seen in the Chemotherapy Suite by Specialist Nurses. This has significantly reduced the waiting times and reduced the number of patients waiting in the outpatient's clinic waiting room.
Cancer Services changed patient appointment but patient was not aware	There was a problem with the off-site printing. Safety measures were put in place to prevent a reoccurrence.
Clinical Haematology wording on letter made patient feel that a diagnosis had been made without them being informed	The wording on the letter was changed
Macmillan Centre patient with dementia attended appointment with relative. Consultant addressed relative and not patient	Apology was made and Consultant reflected on communication skills
Michael Sobel House. Patient was discharged without medication or discharge information. Sent on his own in a taxi, wearing thin pyjamas, with a syringe driver and urinary catheter bag. Medication given but not documented, observations not recorded.	An apology was made and a review of discharge. Ward Manager to be informed when any patient is discharged via taxi to ensure that this is an appropriate mode of transport and all medication has been documented
Cancer Services. Delays in Chemotherapy	An Improvement Team appointed. Additional Specialist Advanced Practitioners appointed to support the workload of Consultants.
Cancer Services Macmillan Centre. Difficulties in contacting somebody to discuss appointments. No facility to leave a voice message.	Additional Reception Staff recruited and a review to ensure service being offered is streamlined and efficient

Details of complaint	Outcome of investigation
Mount Vernon Clinical Haematology. Medication error.	An apology was given to the patient and an investigation was carried out. Measures have been put in place to prevent a recurrence and all staff have received additional training. Posters have been put up in the treatment rooms and additional information has been provided for the staff.
Bancroft Clinic. Quality of care	An apology was offered and explanation that the Phlebotomist did not follow procedures. This was discussed with the member of staff and the correct procedures were discussed. The Phlebotomist was sent for further training.
Phlebotomy delays	Recruitment of Phlebotomist's to manage the increase in patients attending the service
Contact Centre. Patient had difficulty in contacting them	An apology was offered. A review identified that additional staff were required. Staff were recruited to reduce the time taken to answer calls
Acute Medical Unit Assessment patient discharged with another patients medication	Incident discussed with nursing team and registered nurse involved. Staff reminded of their responsibilities to follow Trust and Nursing & Midwifery Council policies and of obligation to ensure patient safety is maintained at all times
Dermatology waiting times	An apology was made for delay. There has been a national shortage of trained Dermatologists. Additional weekend clinics have been added to review patients and reduce backlog
Ward 10B discharge at 1am to Essex Hospital	A proactive approach to planning discharge implemented, ensuring there is advance communication with the receiving hospital.
Dermatology Outpatients appointment seen at different locations	Dermatology Department centralised to one site to improve the service offered to patients
Cardiology. Communication regarding directions to the department	Wording on the letters reviewed and changed. New signage ordered
ENT Admissions unit 4. Surgery cancelled on the day	Patient was contacted by the Deputy General Manager. Apology offered and new date arranged
Gynaecology delay in operation	CCG had declined funding. Hospital appealed and funding approved. Surgery went ahead.

Details of complaint	Outcome of investigation
Ophthalmology Department. Problems contacting them to make or change an appointment	Given the concerns raised by patients and carers about difficulties getting through to the Ophthalmology Department, there has been a review of all the phone lines, with a view to making marked improvements to communications between the department and our patients. We have also reviewed the infrastructure surrounding the day-to-day running of the service with regards to patients being able to get through to the Trust. As a way of reducing call waiting times, the original ophthalmology contact number that was causing problems has been terminated and direct numbers to key areas are being used instead. These numbers are now listed in patient appointment letters. We have incorporated an answer-phone message stating our opening times. We have also undertaken additional training with staff and have been closely monitoring calls with the aim of making further progress. We believe that these changes will make a vast improvement to patient experience. We have implemented a phone rota in the booking office to ensure that there is a focus on answering phone calls throughout the working day. Additional staff are being recruited to monitor phone activity and workload in order to determine where more improvements can be made going forward. We are working with the Information Technology Department (IT) to analyse phone activity and what equipment can be put in place to allow us to run a more efficient service for our patients.

Patient & Carer Experience Committee

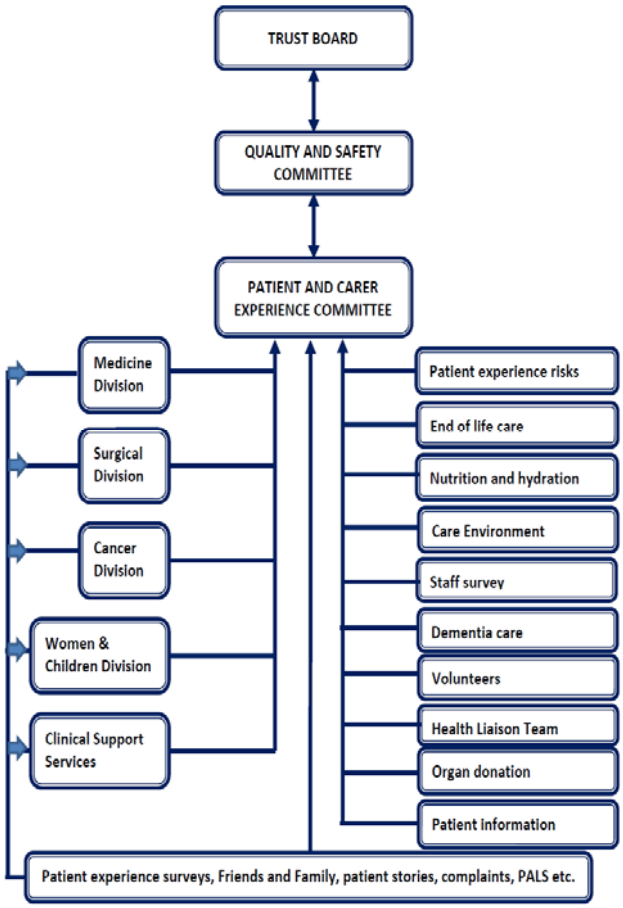
The Trust's Patient and Carer Experience Committee (PEC) is a sub-group of the Quality and Safety Committee. The role of PEC is to ensure effective communication and a co-ordinated approach to improving the experience of care for patients and their carers.

PEC is chaired by a non-Executive Director of the Trust and includes representation from the Medicine, Surgery, Cancer, Women's and Children and Clinical Support Service Divisions, Director of Nursing and Patient Experience, Project Manager – Nursing and Patient Experience, Compliance Manager, Complaints Manager, Facilities Manager, Chaplain, Head of Engagement, Organisational Development Team, Carers Lead, Nutrition and Hydration lead, Admiral Nurse, End of Life lead, Voluntary Services, Health Liaison team, a representative from Health Watch and nine patient and carer representatives. The committee met nine times during 2018-19 and received regular updates on the Trust's patient experience feedback and the Divisional patient experience action plans.

Alternate formal meetings and workshop sessions are held monthly to enable the committee to monitor progress and actions to improving patient experience. Workshop presentations have included:

- Outpatients – new appointment letters and work to reduce 'did not attend'
- AccessAble – disabled access guide
- Quality Transformation Programme
- Arts in the Hospital Project
- Pharmacy update
- Staff Survey update
- Carers Handbook and App
- Patient Experience annual report
- Lorenzo and Nervecentre (new patient administration and electronic observation systems)
- Quality Account

Reporting Structure – Patient and Carer Experience Committee



Conclusion

We aim to provide our patients and their carers with the best possible experience while they are using our services. We know that involving patients and their carers in decisions about their care and treatment leads to improved patient experience and this is why putting our patients first is one of the Trust's core values.

This patient experience annual report shows that there are many successes and areas of good practice to be celebrated but that we still have much more work to do. In particular, we need to focus on improving communication throughout the Trust, ensuring that both verbal and written communications are clear, accurate and delivered in the most appropriate way for the individual person, and ensure that there is a smooth process in place for patients being discharged from hospital.

We will continue to strive to improve the care and treatment that we provide to our patients and look forward to the challenges ahead.

Rachael Corser
Director of Nursing and Patient Experience

Sue Wilkinson
Deputy Director of Nursing

Jenny Pennell
Project Manager – Nursing and Patient Experience

Kim Clarke
Complaints/PALS Manager

I would like to thank you for the great service given to me by the Audiology team in Lister Hospital. When I arrived I was warmly welcomed by the lady at audiology reception. She was very kind and positive and I felt that she cared about helping me. Then I met the audiologist and this was much above my expectations! She provided me with new hearing aids, she asked about my use and programmed them in a way to maximize the benefits. She also equipped me with all the instructions and information on extra devices, which I can try to ask my employer to buy for me as an additional work support. She visibly enjoyed her job and helping people. She was very kind and was listening to fully understand my hearing problems. She also has a 'can do' attitude and she was quickly finding solutions. This was my first visit in this department and it is the best experience I have ever had with any of the audiology departments in the UK! This fully covers and is above the Trust values I previously read about - welcoming, kind, positive, respectful and professional.

A big thank you to every single person I've encountered so far (admissions unit, theatre, recovery and 10A where I currently am) from porters & cleaners all the way through to senior staff who have been so friendly and welcoming and using *#hellomynameis* ☺

Thanks to the @enherts A&E and radiology team at Lister today for being super good with my young son, and for all using *#hellomynameis*

Facts and Figures 2018-19

National Patient Experience Surveys

National Adult Inpatient Survey 2018

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

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

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

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

The Trust scored 'about the same' as other trusts for 52 questions in the 2018 Adult Inpatient survey and 'worse than other trusts' for the following 11 questions:-

- In your opinion, how clean was the hospital room or ward that you were in?
- Did you get enough help from staff to wash or keep yourself clean?
- In your opinion did the members of staff caring for you work well together?
- Did you have confidence in the decisions made about your condition or treatment?
- Do you feel you got enough emotional support from hospital staff during your stay?
- Did you feel you were involved in decisions about your discharge from hospital?
- Were you given enough notice about when you were going to be discharged?
- Discharge delayed due to wait for medicines/to see doctor/for ambulance
- How long was the delay?
- Did hospital staff take your family or home situation into account when planning your discharge?
- Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?

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

National Cancer Patient Experience Survey 2017

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

The survey was sent to adult patients (aged 16 and over) with a primary diagnosis of cancer discharged from an NHS Trust after an inpatient episode or day case attendance for cancer related treatment in the months of April-June 2017. In ENHT 581 patients responded to the survey – a response rate of 64% (63% nationally).

ENHT results	2017	2016	2015
Question score above expected range	0	1	0
Question score within expected range	30	42	35
Question score below expected range	22	9	15

Questions scoring <u>below</u> expected range:

No.	Question	2017 ENHT	2017 National	2016 ENHT
1	Saw GP once/twice before being told had to go to hospital.	73	77	75
2	Patient thought they were seen as soon as necessary.	81	84	81
6	The length of time waiting for the test to be done was about right.	85	88	83
11	Patient given easy to understand written information about the type of cancer they had.	69	73	69
12	Patient felt that treatment options were completely explained.	79	83	80
17	Patient given the name of the CNS who would support them through their treatment.	88	91	87
18	Patient found it easy to contact their CNS.	82	86	84
30	Patient's family or someone close definitely had opportunity to talk to doctor.	67	73	73
31	Patient had confidence and trust in all ward nurses.	69	76	74
41	Patient was able to discuss worries or fears with staff during visit.	63	71	65
42	Doctor had the right notes and other documentation with them.	93	96	94
44	Beforehand patient had all information needed about radiotherapy treatment.	79	87	82
45	Patient given understandable information about whether radiotherapy was working	49	59	47
47	Beforehand patient had all information needed about chemotherapy treatment.	79	84	81
48	Patient given understandable information about whether chemotherapy was working.	61	68	58
49	Hospital staff gave family or someone close all the information needed to help with care at home.	51	59	55

No.	Question	2017 ENHT	2017 National	2016 ENHT
50	Patient definitely given enough support from health or social services during treatment.	43	53	47
51	Patient definitely given enough support from health or social services after treatment.	32	45	44
55	Patient given a care plan.	29	35	28
57	Length of time for attending clinics and appointments was right.	56	69	49
58	Taking part in cancer research discussed with patient.	20	31	23
59	Patient's average rating of care scored from very poor to very good	8.6	8.8	8.5

Compared to the 2016 National Cancer patient experience survey

Compared to the 2016 survey, there was one question significantly lower, the remaining 51 questions showed no significant change.

Significantly lower

No.	Question
17	Patient given the name of the CNS who would support them through their treatment.

There are six questions included in phase 1 of the Cancer Dashboard developed by Public Health England and NHS England. The questions were selected in discussion with the national Cancer Patient Experience Advisory Group and reflect the key patient experience domains (provision of information, involvement in decisions, care transition, interpersonal relations, respect and dignity).

- 76% (75% in 2016) of respondents said they were definitely involved as much as they wanted to be in decisions about their care and treatment.
- 88% (87% in 2016) of respondents said that they were given the name of a Clinical Nurse Specialist who would support them through their treatment.
- 82% (85% in 2016) of respondents said that it had been 'quite easy' or 'very easy' to contact their Clinical Nurse Specialist.
- 90% (89% in 2016) of respondents said that, overall, they were always treated with dignity and respect while they were in hospital.
- 92% (91% in 2016) of respondents said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital.
- 59% (61% in 2016) of respondents said that they thought the GPs and nurses at their general practice definitely did everything they could to support them while they were having cancer treatment.

Asked to rate their care on a scale of zero (very poor) to 10 (very good) patients gave an average rating of 8.6 (8.5 in 2016), this is below the expected range for the Trust and below the national average of 8.8.

National Maternity Survey 2018

A total of 161 women who gave birth at the Trust during February 2018 responded to the maternity survey; a response rate of 43% compared to the national average response rate of 37%.

In comparison to other trusts:

ENHT was amongst the '**best** performing trusts' for 1 question:

- During your labour, were you able to move around and choose the position that made you most comfortable?

ENHT was amongst the '**worst** performing trusts' for 3 questions:

- During your pregnancy were you given a choice about where your antenatal check-ups would take place?
- Thinking about your stay in hospital, how clean was the hospital room or ward you were in?
- Did you feel that midwives and other health professionals gave you consistent advice about feeding your baby?

ENHT results were about the **same** as other trusts for 47 questions.

Compared to the 2017 Maternity Survey:

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

- Did you have confidence and trust in the midwives you saw after going home?

ENHT results show **no significant difference** between 2017 and 2018 survey results for 37 questions.

Meridian Surveys

The Trust continually monitors feedback from patients and uses this feedback to make changes and improvements to the services it provides. An electronic patient survey system is in place called 'Meridian' which enables patients to provide feedback by completing a survey on a simple electronic device (i-Pad) whilst they are in the hospital, or on a paper survey if preferred. During 2018-19, 24,628 patients completed one of our surveys (excluding the single question Friends and Family Test survey), a decrease from 25,766 surveys completed in 2017-19.

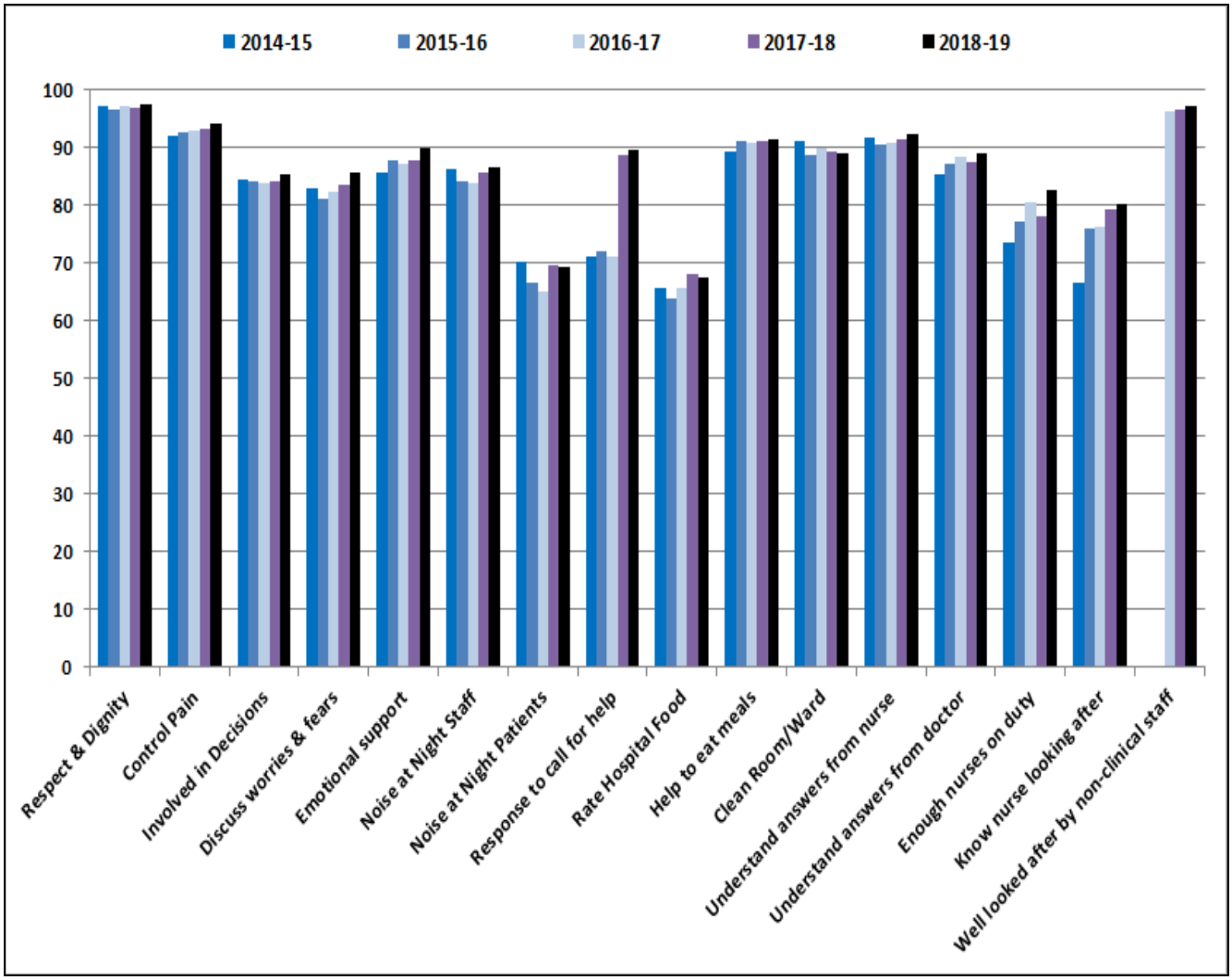
Meridian Patient Experience Surveys	No. completed 2015-16	No. completed 2016-17	No. completed 2017-18	No. completed 2018-19
Inpatient	9,685	11,954	12,239	12,311
Maternity	2,946	3,031	2,625	1,820
Day Case	2,374	3,679	2,091	760
Outpatients	1,993	2,123	5,447	5,969
Renal Dialysis Unit	1,016	1,278	1,101	1,453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

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

Respect and dignity	Did you feel you were treated with respect and dignity while you were in the hospital?
Control pain	Do you think the hospital staff did everything they could to help control your pain?
Involved in decisions	Were you involved as much as you wanted to be in decisions about your care and treatment?
Discuss worries & fears	Did you find someone on the hospital staff to talk to about your worries and fears?
Emotional support	Do you feel you got enough emotional support from hospital staff during your stay?
Noise at night - staff	Were you ever bothered by noise at night from hospital staff?
Noise at night - patients	Were you ever bothered by noise at night from other patients?
Call button response / Response to call for help	How many minutes after you used the call button did it usually take before you got the help you needed? Question changed in August 2017 to: If you needed attention, were you able to get a member of staff to help you within a reasonable time?

Rate hospital food	How would you rate the hospital food?
Help to eat meals	Did you get enough help from staff to eat your meals?
Clean room/ward	In your opinion, how clean was the hospital room or ward that you were in?
Understand answers from nurse	When you had important questions to ask a nurse, did you get answers that you could understand?
Understand answers from doctor	When you had important questions to ask a doctor, did you get answers that you could understand?
Enough nurses on duty	In your opinion, were there enough nurses on duty to care for you in hospital?
Know nurse looking after	Do you know who your named nurse is? Question changed in August 2017 to: Do you know which nurse is in charge of looking after you? (this would be a different person after each shift change)
Well looked after by non-clinical staff	During your time in hospital, did you feel well looked after by hospital staff? Question changed in August 2017 to: Did you feel well looked after by the non-clinical hospital staff (e.g. cleaners, porters, catering staff)?

The following chart shows a comparison of the inpatient survey results between 2014-15 to 2018-19:



In August 2017, the wording of three of the survey questions was changed to reflect changes to the national inpatient survey questions: get attention from staff/know nurse looking after/well looked after by hospital staff.

Friends and Family Test

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

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

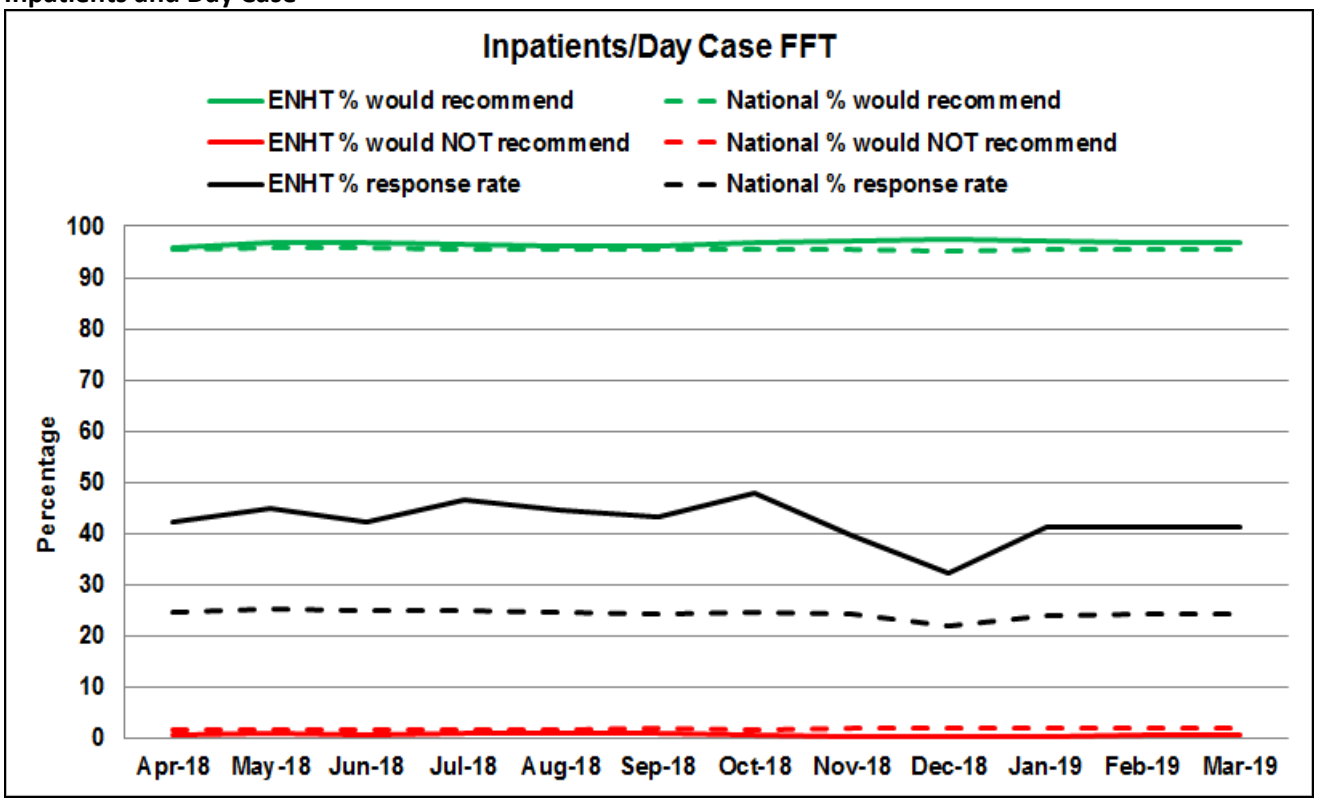
An easy read version of the FFT survey is offered to people (with appropriate support if needed) who have dementia, learning disability, are profoundly deaf, deafblind, blind/vision loss, have little or no English or low levels of literacy. Guidance is available for staff offering the FFT survey to patients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

Summary of Trust FFT results and response rates (2018-19):

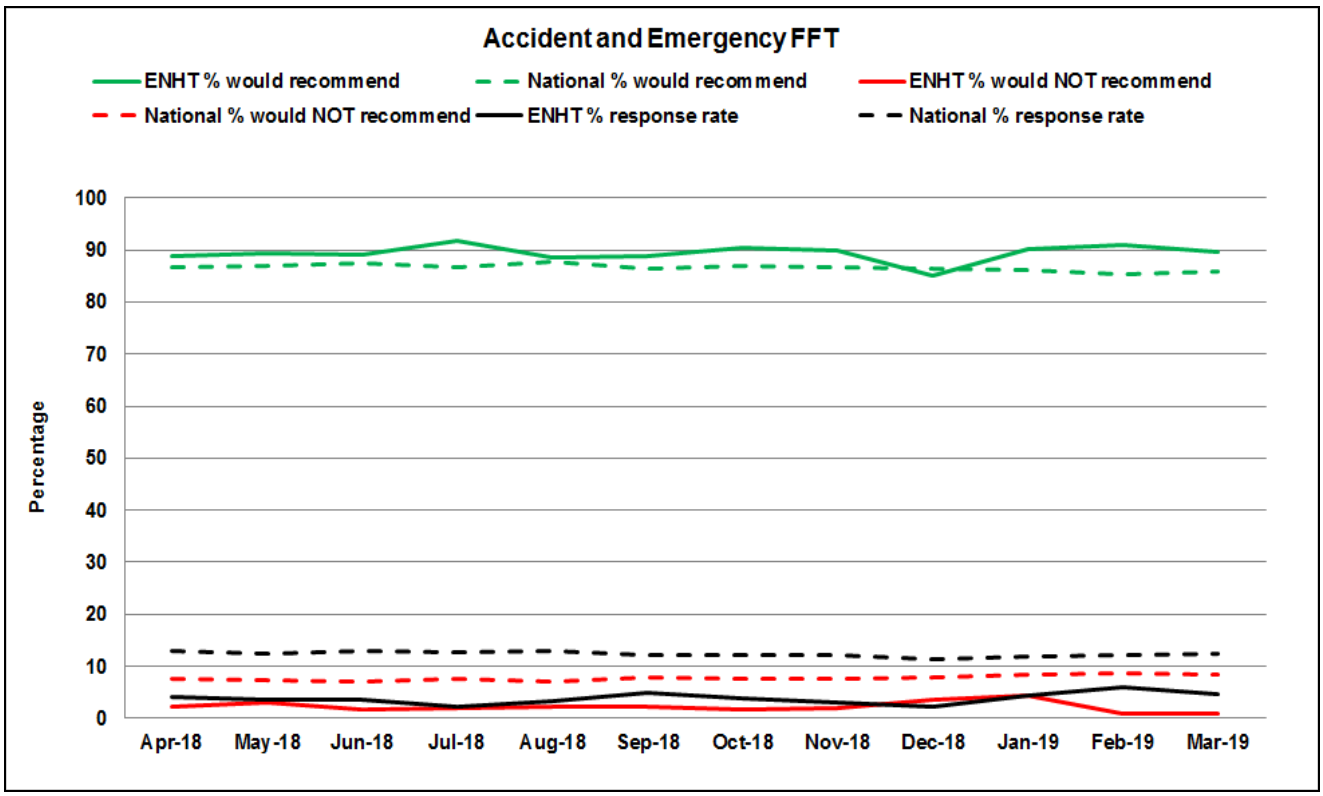
In 2018-19 55,136 patients responded to the Friends and Family Test question (compared to 57,829 in 2017-18).

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

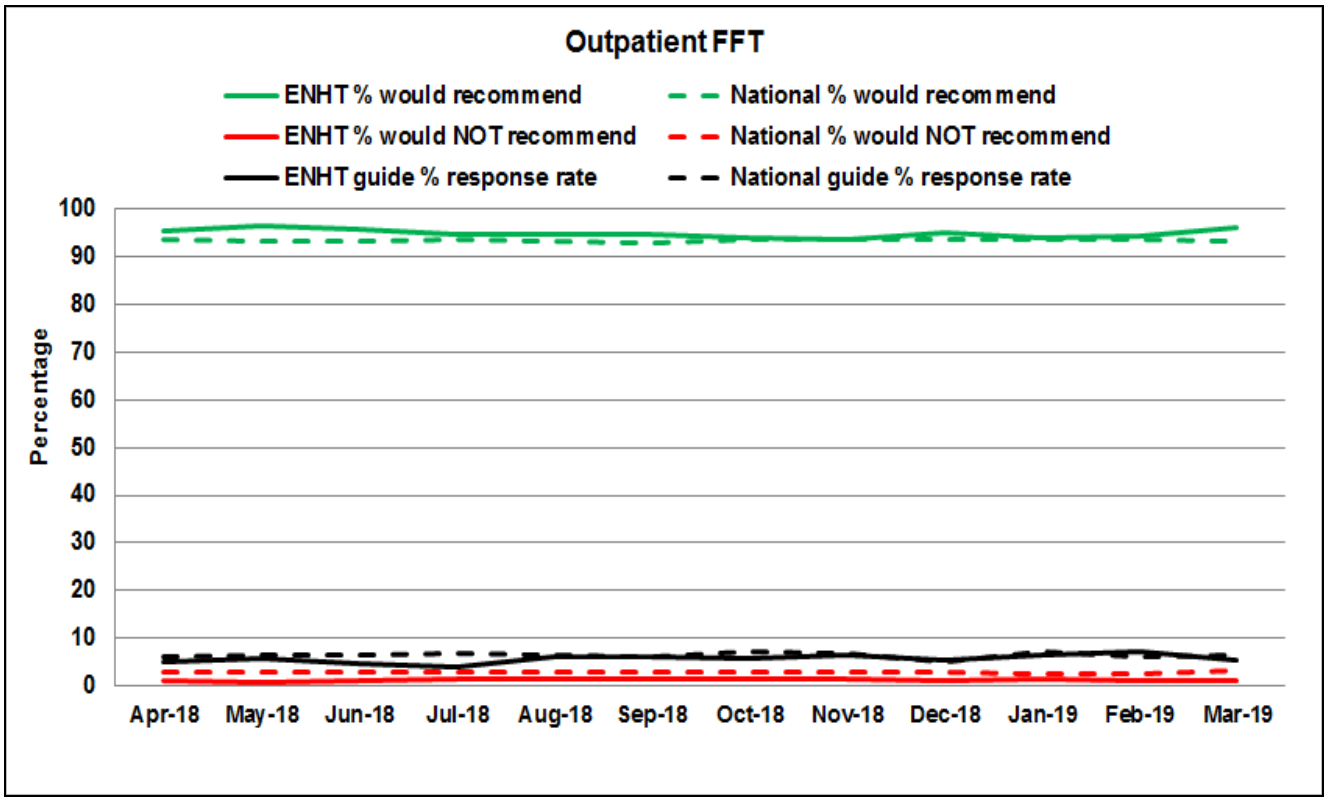
Inpatients and Day Case



Accident and Emergency



Outpatients

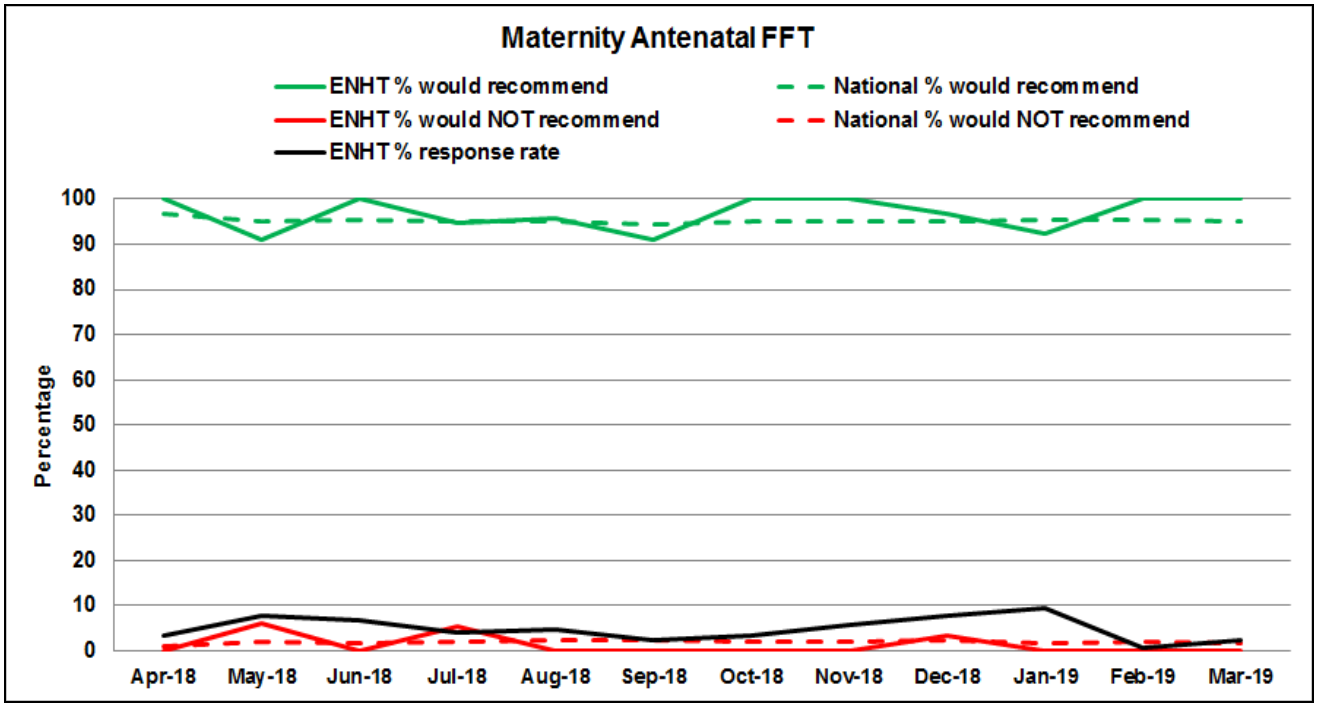


Maternity

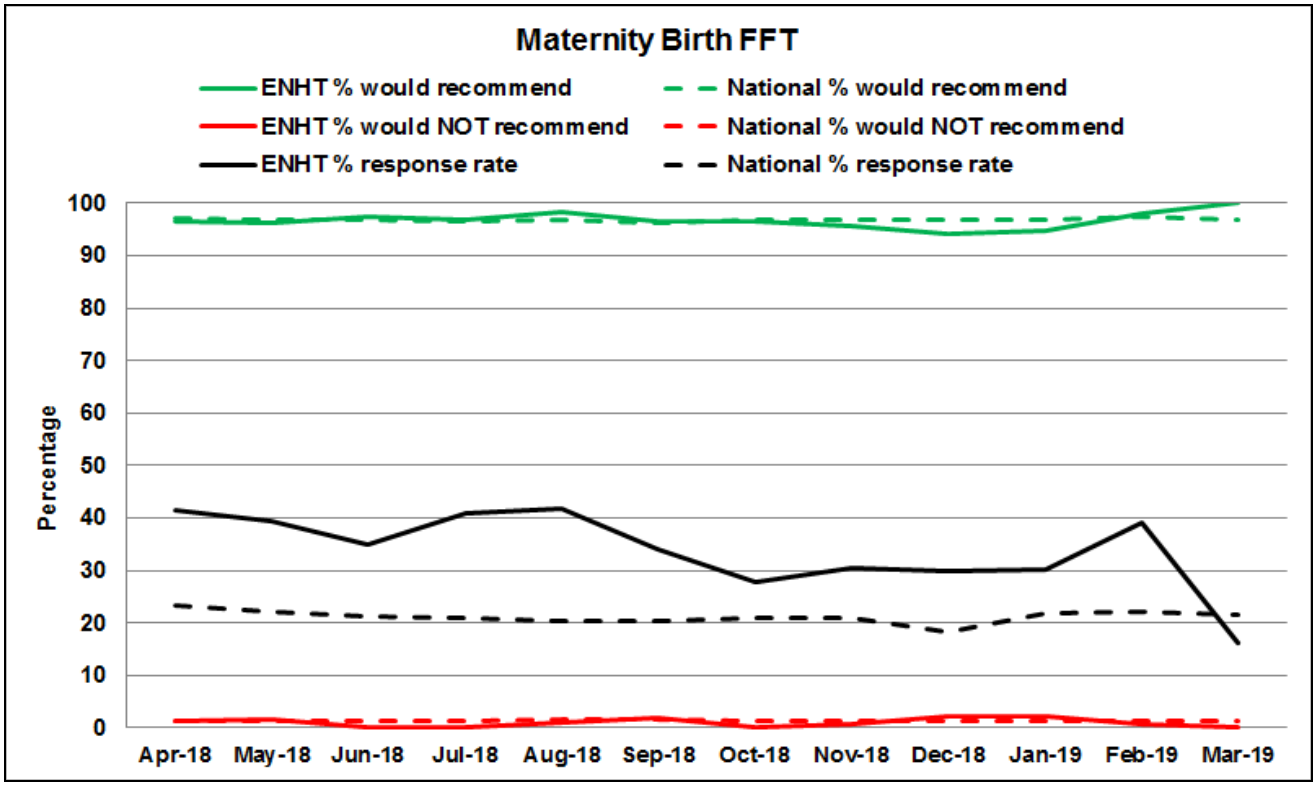
Each woman is asked the FFT question at four stages:

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

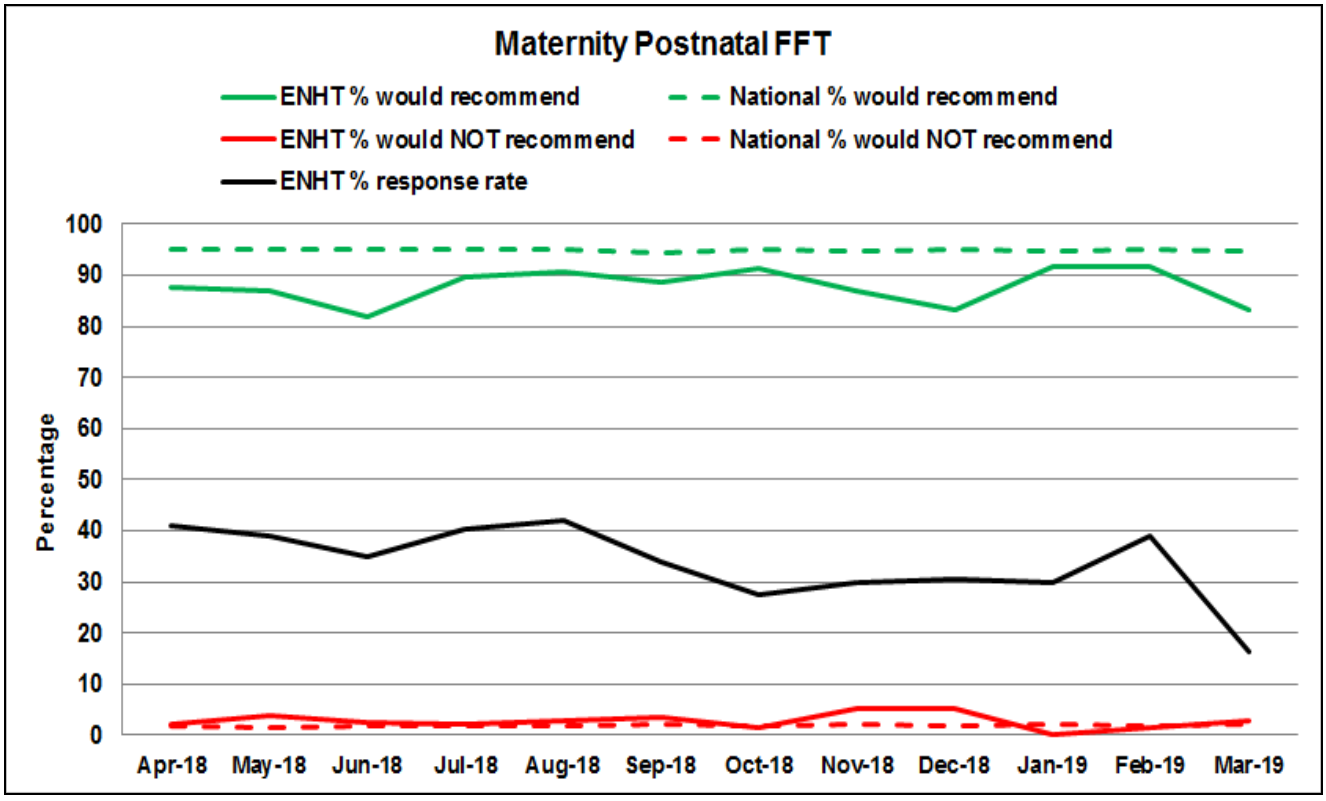
Antenatal



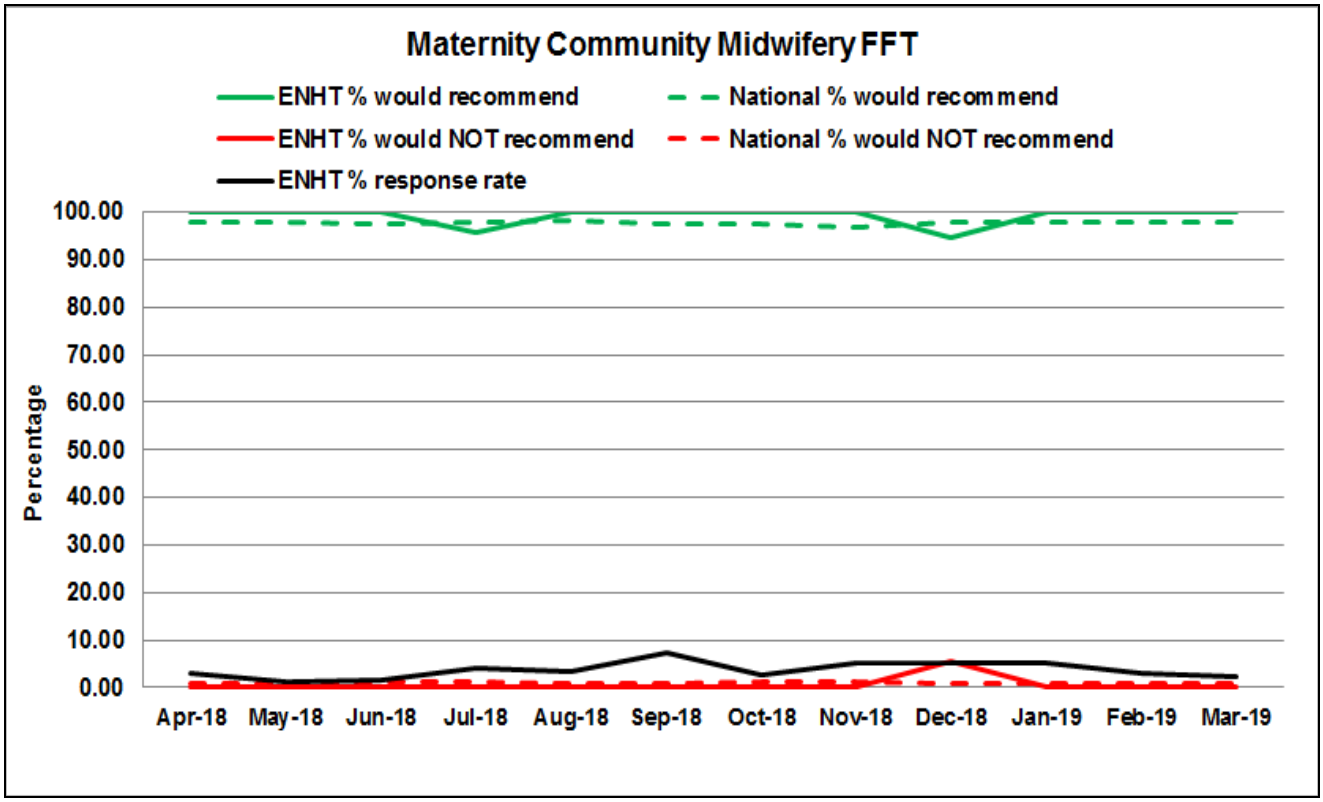
Birth



Postnatal



Community Midwifery



Complaints and Concerns

This report provides a summary of formal complaints received in 2018-19 in accordance with the NHS Complaints Regulations (2009).

The Trust is committed to improving the experience of our patients from their first contact with the Trust. Complaints and concerns provide valuable information to monitor the experience of patients, carers and relatives. Users of the service are encouraged to discuss their concerns with staff at the time the problem arises. However, it may be the case that patients feel unable to do this, or perhaps staff have tried to resolve the issue but have not achieved this. The Patient Advice and Liaison Service (PALS) provide 'on the spot advice and support' with the aim of timely resolution. In the event that this has not been achieved, PALS will give advice on the formal complaints process.

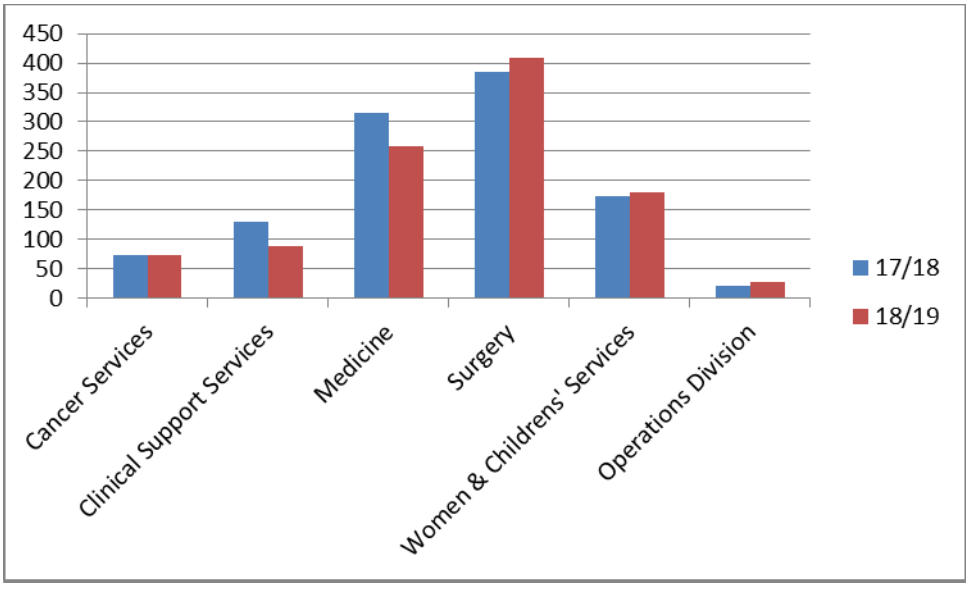
The Trust recognises the value that learning from complaints and concerns brings. It is vital to make the process simple and easily accessible, and leaflets and posters are displayed throughout the hospital to help facilitate feedback.

The following pages provide an indication of the Trust's position during 2017-18 and 2018-19 for complaints and concerns.

Complaints 2017-18 and 2018-19

In 2017-18 1,101 complaints were received. There has been an increase for 2018-19 with the organisation receiving 1,036 complaints.

Number of complaints by Division received in the last two financial years



Subject of formal complaints

Complaints data assists with measuring the success of learning and the strategy sets out targets to reduce complaints relating to delays in treatments/appointments, cancellations of surgery or clinic appointments and complaints about nursing and medical care.

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

Top six subjects of formal complaints

	2018-19
Attitude of staff	98
Communication	255
Delay in treatment/appointment/cancellations	263
Access to treatment	23
Environment	15
Quality of Care	373

Contact with complainants

There is a mandatory requirement to acknowledge all formal complaints within three working days of receipt. In 2018-19, 95% of complaints were acknowledged in three working days.

Learning from complaints and concerns

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

Parliamentary and Health Service Ombudsman (PHSO)

The bi-monthly aggregated reports to the Trust's Risk and Quality Committee (RAQC) give details of all activity and outcomes related to PHSO investigations. In 2018-19, 3 investigations were accepted by the PHSO.

The table below details the specialty and subject of complaints for 2018-2019:

Specialty	Subject	Outcome
Surgery	Delay in appointments	PHSO investigating
Medicine	Care received	PHSO investigating
Surgery	Attitude of staff and care provided	PHSO investigating

Patient Advice and Liaison Service (PALS)

The PALS service work closely with staff across the organisation to resolve concerns in a timely manner. In 2017-18, PALS supported 4,115, in 2018-19 PALS supported 4,364 patients/relatives/carers with a wide range of concerns, examples of which are detailed in the table below.

The table below provides a summary of the type of concerns that PALS received in 2017-18 and 2018-19.

	2017-18	2018-19
Attitude of staff	30	26
Cancellation	516	559
Communication with patient/relatives	1,738	1,926
Confidentiality	11	15
Consent Issues	1	0
Delay in treatment/appointment	1,489	1,592
Discharge concerns	65	47
Finance issues	3	2
Catering Issues	3	5
Estates & Facilities Issues	19	16
Hospital / Patient Information	7	6
Medical care	16	14
Nursing care	9	7
Patient's property	56	52
Medical records issues	25	22
Transport issues	15	6
Treatment received by patient	112	69

East and North Hertfordshire NHS Trust

Agenda Item: 9.3.2

TRUST BOARD - PUBLIC SESSION – 4 SEPTEMBER 2019

Infection Prevention & Control Annual Report: April 2018 - March 2019

Purpose of report and executive summary (250 words max): To present the Trust's annual report in relation to IPC.		
Action required: For information		
Previously considered by: **Quality and Safety Committee, 30 July 2019**		
Director: **Director of Nursing**	**Presented by:** **Director of Nursing**	**Author:** **Assistant Director of Infection Prevention & Control**

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

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

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

Infection Prevention & Control Annual Report 2018-19

1. Executive Summary and Headlines

The purpose of this report is to inform and provide assurance to the Trust Board, East and North Hertfordshire Clinical Commissioning Group, patients, public and staff. It provides an overview of the key work at East and North Hertfordshire NHS Trust with regard to infection prevention and control for the reporting period 1 April 2018 to 31 March 2019, and demonstrates the progress made against performance targets and compliance with the Health and Social Care Act 2008 (Reviewed 2010): *Code of Practice for the NHS on the prevention and control of infections and related guidance,* otherwise known as the *"Hygiene Code".*

The Trust has declared compliance with the Hygiene Code and continues to be registered with the CQC, without conditions, across all sites.

The Trust continues to regard patient safety in relation to the prevention of Health Care Associated Infections (HCAI) as a key priority for the organisation.

	Headlines and key achievements
1	**NHS I Trust Improvement Programme** The Trust improved the safety of our patients by raising the standards of cleaning, decontamination and associated IPC processes and practices. This improvement was reflected in the NHSI report which rated the Trust as GREEN. These improvements covered the following areas: • Providing a clean and safe environment • Robust surveillance systems to detect infections and outbreaks at an early stage • Consistent safe clinical practice • Learning from incidents and infections is identified and implemented across the Trust • Emerging risks contributing to infections are identified promptly, enabling appropriate actions and resources to be effectively targeted. • Standardised systems and processes to provide assurance Progress was monitored at a newly-formed IPC Improvement Group which met fortnightly, chaired by the Director of Nursing / DIPC
2	**Embedding IPC in the Trust structures and processes** Facilitating clinical ownership of IPC by introducing Divisional IPC committees
3	**Improving Hand Hygiene** Hand hygiene initiative rolled out to improve hand hygiene practice and assurance processes

4	**Antimicrobial Stewardship** Antibiotic stewardship by clinical teams has improved as demonstrated by the Trust meeting the Commissioning for Quality and Innovation (CQUIN) targets set by NHS England. Limiting the use of antibiotics is vital as their use may precipitate Clostridium difficile disease, and contributes to antimicrobial resistance and other healthcare associated infections. The Trust was set 2 Antimicrobial Resistance (AMR) CQUIN targets by PHE for 2018-19. The first target was to achieve 90% compliance for review of antibiotics within 72 hours for sepsis patients. The Trust achieved 91% for this element. The second target comprised three elements relating to antibiotic consumption, of which one element was achieved.
5	**Improving surveillance of infections** A successful business case for an IPC electronic management, reporting and surveillance system (ICNet). Due to be fully operational in June 2019.
6	**Control of seasonal winter outbreaks** Seasonal outbreaks of Norovirus and Influenza were identified and controlled at early stages, thus limiting the necessity to close beds to patients requiring admissions.
7	**Water Safety** The threat of Pseudomonas aeruginosa and Legionella in the water supply and other water-borne pathogens continues to be addressed by ensuring consistent monitoring of standards of water and reacting effectively to test results. There have been no water related infections reported this year.
8	**Surgical Site Infection (SSI)** The Trust continued to participate in the Surgical Site Infection Surveillance Scheme managed by Public Health England for three categories of orthopaedic surgery, namely Total Knee Replacements (TKR), Total Hip Replacements (THR), and Repair of Fractured Neck of Femurs (FNOF). The Trust remained an outlier for TKR in the first quarter of 2018-19, but the other 2 categories were in line with the national benchmark rate. SSI was suspended from July 2018 due to lack of staff but this has since been addressed and surveillance resumed in April 2019.
9	**MRSA bacteraemia** Two cases of trust allocated MRSA bacteraemia were identified, one of which was found to be a contaminant, ie not an infection. There is a national target of zero for MRSA bacteraemias.
10	***Clostridium difficile*** 27 trust allocated C. difficile cases were identified against the target of 10 cases. Five of these cases were linked to the outbreak of ribotype 027 identified in February 2018. There was no evidence of any cross-transmission in the other cases. The underlying factors that contribute to the risk of acquiring *C. difficile* infection were the focus of the IPC improvement plan agreed with NHSI and CCG following the outbreak in February 2018 (see item 1 above).

11	**Gram negative bacteraemia** The Trust has increased monitoring of gram negative bacteraemia to provide an enhanced surveillance of these organisms, namely Klebsiella sp, Pseudomonas aeruginosa and E. coli as part of the national initiative to reduce the numbers of these infections across the whole health economy. We monitor rates of trust associated bacteraemias and these are below the local and national averages. The Trust participates with other healthcare organisations across Hertfordshire and West Essex in the UTI reduction project.
12	**Protecting our patients and staff against Influenza** To help ensure protection of our patients and staff from Influenza, the Trust vaccinated 65.56% of front line staff against the target of 75%. There is a comprehensive programme for 'fit-testing' front line staff to ensure that protective masks are effective when these are required to be worn.
13	**Key Challenges for 2018-19** • Implementation of new national cleaning standards and incorporating these into the new cleaning contract which is due to be agreed in 2019. • Identifying and implementing actions to reduce Urinary Tract Infections and associated gram negative bacteraemias • Antimicrobial stewardship including achieving the 2019-20 CQUIN targets relating to diagnosis and treatment of Lower UTIs in patients >65yrs and antimicrobial prophylaxis for patients undergoing elective colorectal surgery. • Introduction of a framework to support and standardize Aseptic Non-Touch Technique (ANTT) • Continuation of the Hand Hygiene improvement programme • Incorporate the new national *C.difficile* reporting and review processes introduced in 2019-20 • Devising and implementing a review process for all hospital onset MSSA and gram negative bacteraemias to identify and disseminate learning • Working with Estates to identify and address water safety and specialized ventilation issues • Strengthening the IPC Link Practitioner role • Utilizing ICNet to provide enhanced infection data reporting • Extending SSI surveillance processes to include additional categories and embedding this within the divisions • Introducing an IPC service during weekends and public holidays during the winter season to support the Trust's operations. These challenges are included in the IPC Annual Programme 2019-20.

2. Compliance with the Health and Social Care Act 2010

The Care Quality Commission (CQC) has used the Code of Practice as a key feature of registration. Failure to observe the Code may either result in an improvement notice being issued to the Trust by the CQC following an inspection, or in it being reported for significant failings and placed on “special measures”. All NHS organisations must be able to demonstrate that they are complying with the Code. The Trust’s Risk and Quality Committee and Board have continued to receive monthly reports on Infection Control performance and compliance during the reporting year.

3. Compliance with Criterion 1: a- Systems to manage and monitor the prevention and control of infection

Infection prevention and control (IPC) is the responsibility of everyone in the organisation. Key roles and arrangements are detailed below:

3.1 Infection Prevention and Control Structure

The Chief Executive Officer has overall responsibility for the control of infection within East and North Hertfordshire NHS Trust.

3.1.1 Non-Executive Director

Bob Niven, Non-Executive Director, is an active member of the Trust Infection Prevention & Control Committee who supports and contributes to the work of the Committee and the Infection Prevention and Control agenda.

3.2 Senior IPC Management Team

The senior IPC management team, comprising the Director of Infection Prevention and Control (DIPC), the Infection Control Doctor (ICD), the Assistant DIPC (ADIPC) and the Antimicrobial Pharmacist, meets monthly to discuss activity and issues.

3.2.1 The Director of Infection Prevention and Control

The DIPC role is held by the Director of Nursing and is the Executive Lead for the IPC service, reporting directly to the Chief Executive. The role includes:

- Overseeing implementation of the IPC plan as Chair of the Trust Infection Prevention and Control Committee (TIPCC)
- Approving the Annual IPC report for public release.
- Authority to challenge inappropriate practice

3.2.2 The Infection Control Doctor (ICD)

The ICD is the Clinical Lead for the IPC service, reporting to the DIPC on IPC matters. The role includes:

- Advising and supporting the DIPC
- Overseeing local IPC policies and their implementation by ensuring that adequate laboratory support is in place
- A member of the Water Safety Group
- Supervising IPC education for doctors and delivering mandatory training lectures
- Providing expert clinical advice on infection management

- Producing, together with the assistant DIPC, the annual IPC report
- Authority to challenge inappropriate practice including inappropriate antibiotic prescribing decisions.

3.2.3 The Assistant DIPC / IPC Lead Nurse

The ADIPC / IPC Lead Nurse reports directly to the DIPC and works with the ICD. The role includes:

- Advising and supporting the DIPC and the ICD
- Chairing the TIPCC meetings in the absence of the DIPC
- Chairing the Water Safety Committee
- Deputising for the DIPC in her absence
- Advising the Divisional IPC Committees which meet monthly and report to the TIPCC and Divisional Boards
- Leading the Trust Decontamination service
- Responsible for identifying and supporting IPC training for all Trust staff
- Ensuring that all policies and guidelines related to infection prevention are valid and implemented across the service.
- Managing the infection control nurses' service level agreement with one external hospice
- Producing together with the DIPC and the ICD, the IPC Strategy, Annual Plan including the Audit Programme and the Annual IPC Report.
- Overall line management of the IPC Nursing Team

3.3 The Infection Prevention and Control Nursing Team

In 2018-19 the team consisted of:

1.0 WTE Assistant DIPC (Band 8c) (See above)
1.43 WTE IP&C Lead Nurse (Band 7)
2.0 WTE Infection Control Nurse (Band 6)
1.0 WTE Infection Control Clinical Support Worker (Band 4)
1.0 WTE IPC team and data coordinator (Band 5)

The Surgical Site Surveillance Nurse is also part of the wider team
1.0 WTE Surgical Site Surveillance Nurse (Band 6)

3.4 The Consultant Microbiologists

In addition to the Infection Control Doctor, the Trust employs two more consultant medical microbiologists (CMMs) who play an active role in IPC. There is cover 24 hours a day, 7 days a week provided by a CMM for clinical microbiology/Infection control.

3.5 The Antimicrobial Pharmacist

The Trust employs an Antimicrobial Pharmacist who works closely with the ICD and other members of the IPC team. There is robust management of antimicrobial stewardship throughout the Trust. The Antimicrobial Pharmacist is secretary of the Trust Antimicrobial Forum (TAF), a sub-committee of the New Drugs and Formulary Committee.

The role of the Antimicrobial Pharmacist also includes:

- Attending and contributing to the Trust Infection Prevention and Control Committee meetings and the Joint Infection Prevention and Control Committee meetings (with the infection control team)
- Supporting antimicrobial stewardship initiatives by working closely with the ICD and the CMMs
- Joining and contributing to Antimicrobial Ward Rounds with the CMMs
- Carrying out audits in line with national guidance
- Providing training regarding antimicrobial stewardship to clinical staff within the Trust

3.6 The Trust Infection Prevention and Control Committee (TIPCC)

The TIPCC met monthly and reports to the Trust Board via the Quality & Safety Committee. From 2019, TIPCC will meet bi-monthly. The Committee is chaired by the DIPC. Membership includes the ICD, Medical and Nursing leads from all divisions, the local Consultant for Communicable Disease Control (or representative), the Infection Prevention and Control Nurse from the CCG, a Health at Work representative, the Clinical Governance officer, Head of Estates and Facilities, Decontamination representative, education representative, and the antimicrobial pharmacist. The terms of reference and membership were reviewed in February 2019.

4. Compliance with Criterion 1: b- Monitoring the prevention and control of infection

4.1 Mandatory Surveillance

Mandatory surveillance is carried out for MRSA, MSSA and Gram negative bacteraemia cases (*E.coli*, *Pseudomonas aeruginosa* and *Klebsiella* spp), cases of *Clostridium difficile* infection and surgical site infection in elective total hip and knee replacement and fractured neck of femur surgery.

Additionally, the Critical Care unit participated in the Critical Care Unit Infection in Critical Care Quality Improvement Programme (ICCQIP) run by PHE. This programme enables participating critical care units to monitor trends and benchmark rates for central vascular catheter associated bacteraemias.

4.1.1 MRSA blood stream infections (BSI)

Isolates of MRSA (Meticillin Resistant *Staphylococcus Aureus*) from blood cultures have been reported since 2002; enhanced reporting using the Public Health England (PHE) MRSA Data Capture System began in 2006.

From April 2018, the national system changed such that only the Trusts and CCGs with the highest rates of MRSA bacteraemia were required to conduct Post Infection Reviews (PIRs). This new system maintains a zero tolerance approach to MRSA bacteraemia and the Trust continues to undertake PIRs with the CCG to ensure learning is captured to minimise risks to our patients.

The table below shows the performance of the Trust since the introduction of Mandatory Surveillance targets in 2006. Red font indicates MRSA blood stream infections (BSI) numbers exceeding yearly targets.

The table below shows the performance of the Trust since the introduction of Mandatory Surveillance targets in 2005. Red font indicates MRSA blood stream infections (BSI) numbers exceeding yearly targets.

Year	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019
Total	53	33	18	10	5	3	2	2	5	0	2	1	2
Target	31	22	21	15	3	3	3	0	0	0	0	0	0

4.1.2 *Clostridium difficile*-associated disease (CDAD)

Clostridium difficile is a type of bacterium found in the gut that can cause diarrhoea in certain circumstances. It can cause a spectrum of symptoms from mild disease to severe colitis.

The table below shows the performance of the Trust since 2006. Red font indicates CDAD numbers exceeding yearly targets.

Year	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2015-2015	2015-2016	2016-2017	2017-2018	2018-2019
Total	594	457	108	81	56	12	13	14	12	15	22 (11)*	28 (16)*	27
Target	n/a	414	183	90	63	65	14	14	15	11	11	11	10

**Figures in brackets exclude cases successfully appealed against financial sanctions.*

4.1.2.1 Actions being taken to reduce *C.difficile* infections

Following every case of Trust-associated *C.difficile* infection, a review is completed to identify any actions to reduce the likelihood of further cases. All cases are ribotyped and compared with other cases to identify any likelihood of transmission. Five of the 27 cases identified in 2018-19 were linked to the outbreak of ribotype 027 identified in February 2018. There is no evidence of any other cross-transmission during 2018-19. *C.*difficile is a spore-forming organism which contaminates the environment. Consequently, cleaning and decontamination are key to preventing the acquisition and transmission of this organism. The use of antibiotics increases the risk of developing *C.difficile* infection. Therefore, the following actions have been identified and are being implemented:

- Improve, maintain and monitor standards of cleaning
- Introduction of hydrogen peroxide vapour for effective decontamination of rooms vacated by *C.difficile* patients
- Improvement programme for hand hygiene & use of Personal Protective Equipment eg gloves & aprons
- Programme for identifying and replacing equipment to ensure it is fit for purpose and can be effectively cleaned
- Improving antibiotic stewardship
- Improving surveillance of infections by implementing an automated surveillance system (roll out of ICNet in June 2019)

4.2 Incidents related to infections (including outbreaks)

4.2.1 Carbapenemase producing organisms (CPO)

A transmission of a CPO (*Pseudomonas aeruginosa)* in an ENT clinic in October 2017 was retrospectively identified. Four patients were identified with this organism. An investigation identified the following factors which have been addressed:

- Cleaning and decontamination of equipment between patients
- Lack of assurance of hand hygiene

4.2.2 Norovirus/ Influenza Outbreaks

Seasonal outbreaks of Norovirus and Influenza were identified and controlled at early stages, thus limiting the necessity to close beds to patients requiring admissions. To support and coordinate the response to reports of symptomatic patients, the IP&C Team attended all daily site management team meetings. In addition, the IP&C Team provided daily reports to the CCG and the Department of Health for monitoring purposes.

A business case was identified for provision of an IPC service during weekends and bank holidays during the winter season to support the Trust's operations.

4.2.3 MRSA transmission on Neonatal Unit

Two babies who were in the Lister Neonatal Unit were identified with MRSA colonisation. Neither of these babies were infected with the organism. This incident was subject to a Root Cause Analysis review which identified: the need to improve hand hygiene and use of Personal Protective Equipment including gloves, cleaning of the environment and shared equipment as well as delayed reporting of results by the external pathology laboratory.

4.3 Antimicrobial stewardship

The 2018-19 Antimicrobial Resistance (AMR) CQUIN had the follow targets:

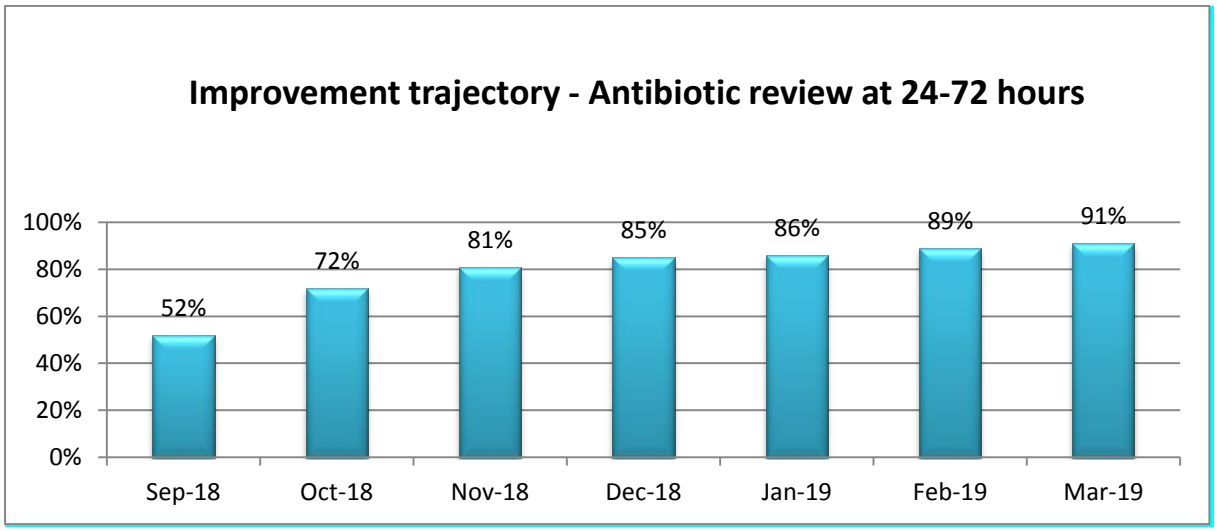
CQUIN Targets 2018-19	Trust result
Total antibiotic consumption to not exceed baseline of 4928 total Defined Daily Doses (DDD) per 1000 admissions	13.8% reduction
Carbapenem consumption not to exceed baseline of 79 DDD per 1000 admissions	8.9% increase
3% increase from baseline of 39.1% for proportion of usage of antibiotics on the 'Access' list	3.1% decrease
Increase compliance to 90% for review of antibiotics for sepsis patients at 72 hrs	91%

In addition to the CQUIN targets, an improvement trajectory was agreed with CCG to achieve 90% compliance from the baseline of 52% for review of antibiotics within 72 hrs for non-sepsis patients. To achieve this, the following steps were taken:

- Monthly antibiotic review audit was carried out on all wards. All ward pharmacists were required to audit 5 patients per ward per month and feedback results monthly to the prescribers.

- Performance for each ward was tracked to identify any lower performing wards. Further support was offered to these wards by the pharmacy team being present on the ward areas and raising awareness to all doctors, nurses, and pharmacists on appropriate antibiotic review.

The graph below shows progress to achieve the target of 90%.



4.4 Surgical site infection

It is a mandatory requirement to conduct surveillance of orthopaedic surgical site infections using the Surgical Site Infection Surveillance Service of Public Health England. The minimum requirement is for a three month module of surveillance of *one* of the following Orthopaedic options:

- Open reduction of long bone fracture
- Total Hip Replacement (THR)
- Total Knee Replacement (TKR)
- Repair Neck of Femur Fracture (RNoF)

The Trust opted to undertake surveillance for three of these categories, namely THR, TKR and RNoF for the first quarter of 2018-19 (April-June 2018).

The infection rates over the last 4 quarters for which data has been collected are considered the most useful for identifying trends, due to the comparatively small number of operations per year. Infection rates for THR and RNoF remain near or below the national benchmarks. However, the TKR infection rate showed an increase to 3.1% for April – June 2018, resulting in an increase to 1.5% over the last 4 quarters (national benchmark 0.5%) and the Trust has been identified as a high outlier.

The process to monitor and review SSIs was restructured and is led by the General Manager for Surgery and the Orthopaedic SSI Lead with support from IPC. Actions taken include reviewing cases to identify learning, re-auditing of the theatre environment and individual feedback to surgeons.

Formal surveillance was temporarily suspended from July 2018 until April 2019 due to operational issues. However, following identification of an issue with the theatre ventilation

system which may have increased the risk of infection, a retrospective surveillance exercise was undertaken to identify any deep infections in all orthopaedic patients during this period, and no cases were identified. A new process has been implemented from April 2019 to enable participation in the PHE mandatory SSI surveillance scheme.

The table below shows performance up to June 2018.

Surgical site infection rates

Category of surgery	National benchmark	ENHT Apr-Jun 2018	ENHT Jul 17-Jun 18
Total Knee Replacement (TKR)	0.5%	3.1%	1.5%
Total Hip Replacement (THR)	0.6%	1%	0.7%
Repair Neck of Femur Fracture (RNoF)	1.2%	0%	0.4%

A team from the national 'Getting it Right First Time' (GIRFT) programme visited the Trust in 2018. This programme is designed to improve the quality of care within the NHS by reducing unwarranted variations in practice as well as delivering efficiencies. The Trust will be participating in this voluntary scheme from May 2019, led by the Trust's Surgical teams, to extend surveillance to other surgical specialities.

5. Criterion 2: Clean and appropriate environment

5.1 Cleaning Services

East and North Hertfordshire NHS Trust has a responsibility to provide and maintain a clean and appropriate environment for healthcare. With a higher profile on improving cleanliness in hospitals this is now a key element of how each hospitals performance is judged and it is assessed in a number of ways which feature in the Care Quality Commission's (CQC) Essential Standards of Quality and Safety.

The majority of services are managed by external companies. G4S provides services for Lister and Hertford County Hospital. The outcomes are aligned to the National Specifications for Cleanliness in the NHS (2007). The contract with G4S is managed and monitored by the Facilities Department at Lister Hospital.

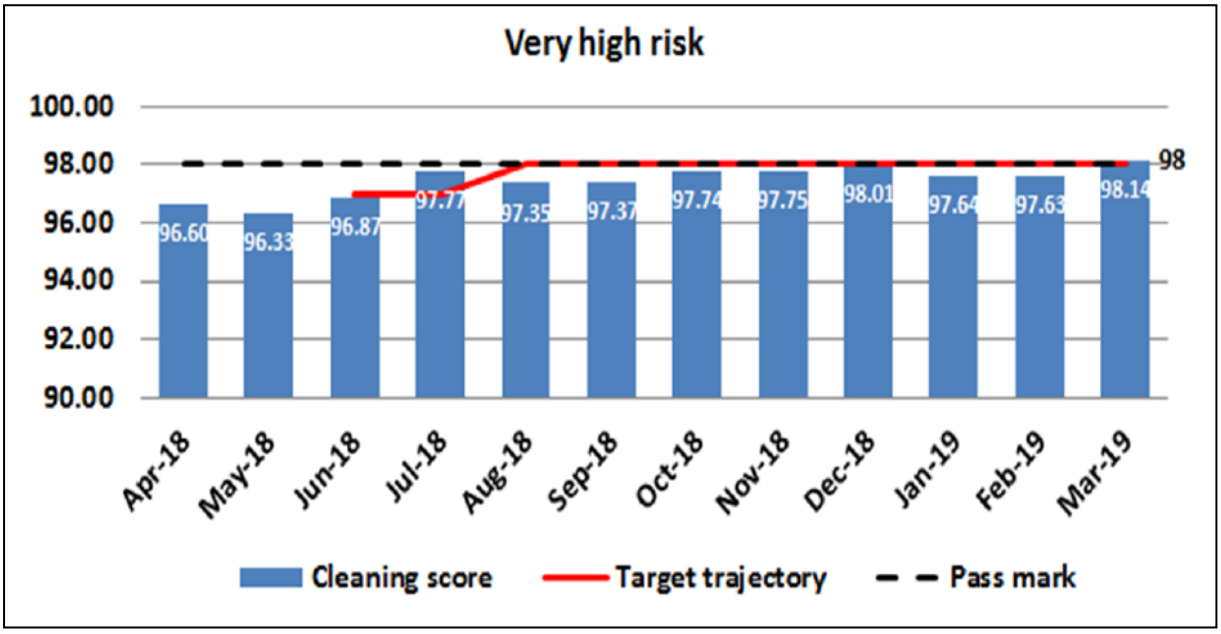
Cleaning services at the New QEII are provided by Accuro. Mount Vernon Cancer Centre services are provided in-house by the Hillingdon Hospitals NHS Foundation Trust. Services in the satellite renal dialysis units at Harlow, St Albans and Luton & Dunstable are managed through service level agreements with the respective Trusts that they are located in. Cleaning services for the Bedford Unit are managed by an external company.

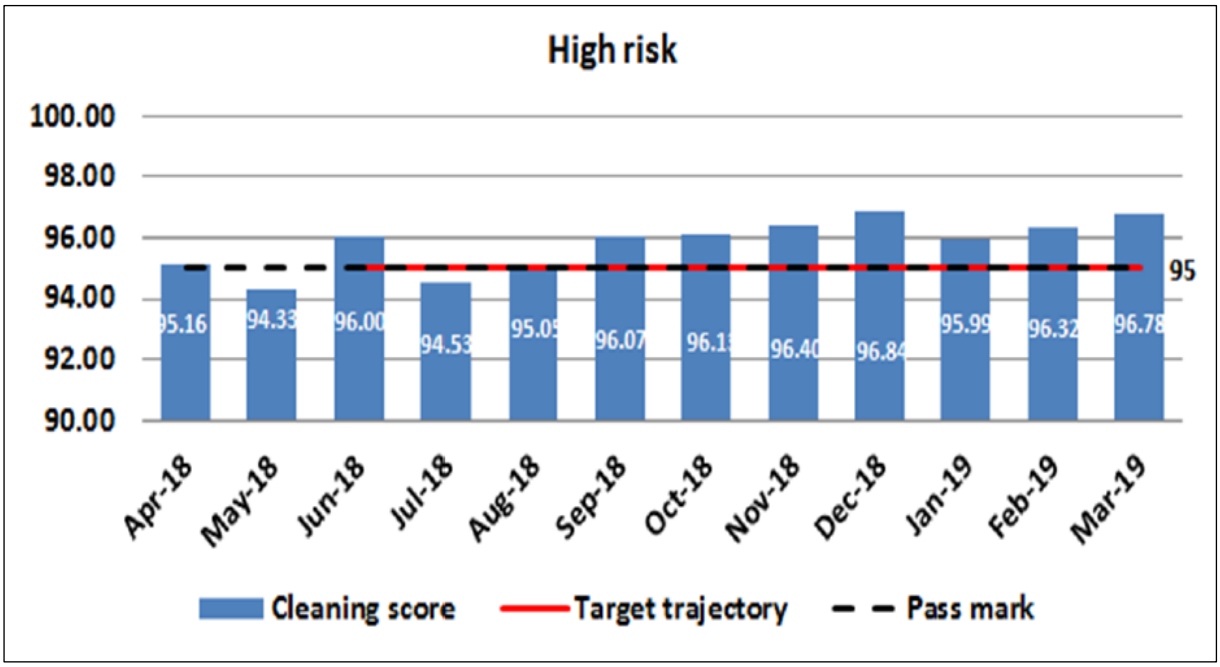
5.1.2 Monitoring arrangements

The Domestic Contractor is required to carry out technical monitoring of cleaning standards. The frequencies set out in the National Specification for Cleanliness (2007) (NSC) must be met as a minimum, as detailed below:

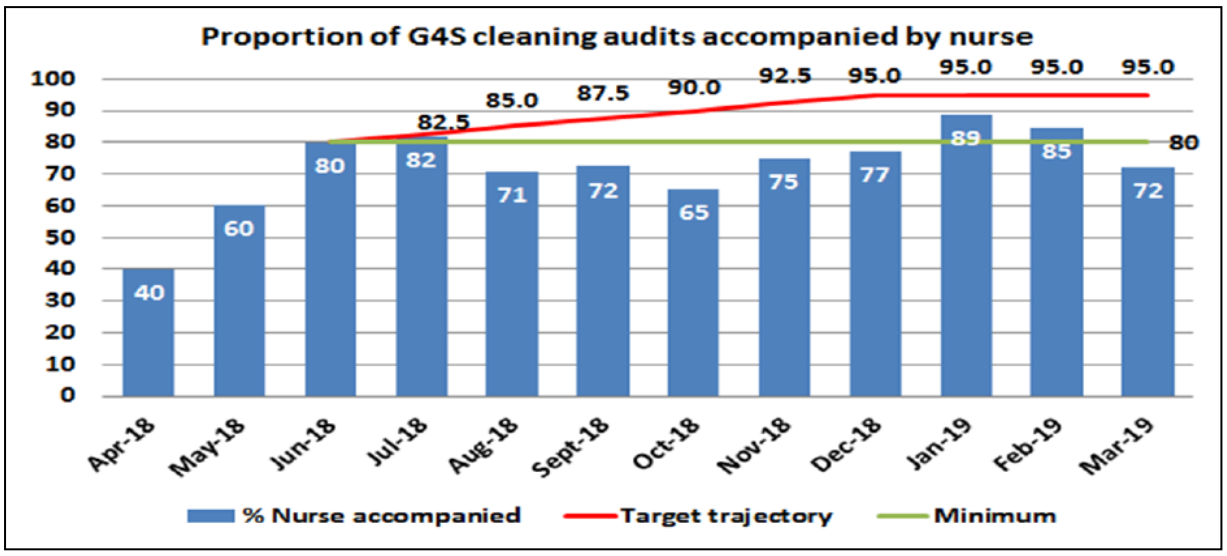
Risk	Minimum Frequency	Minimum Score
Very High Risk	Over a period of a week all areas to have been audited at least once	98%
High Risk	Over a period of a month all areas to have been audited at least once	95%
Significant Risk	Over a period of quarter of a year all areas to have been audited at least once	85%
Low Risk	Over a period of a year all areas to have been audited at least twice	75%

An improvement trajectory was agreed to meet the above target of 98% for Very High Risk areas by September 2018 and to maintain the target of 95% for High Risk areas. The graphs below show performance against these trajectories:





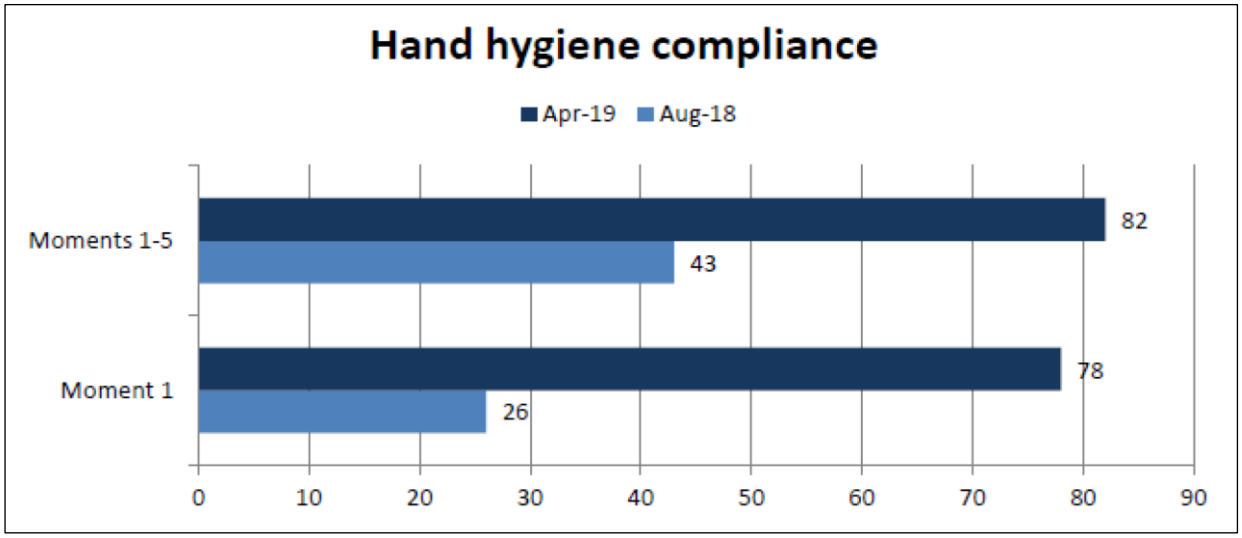
An improvement trajectory was also agreed to increase participation by nursing staff in these audits – see graph below:

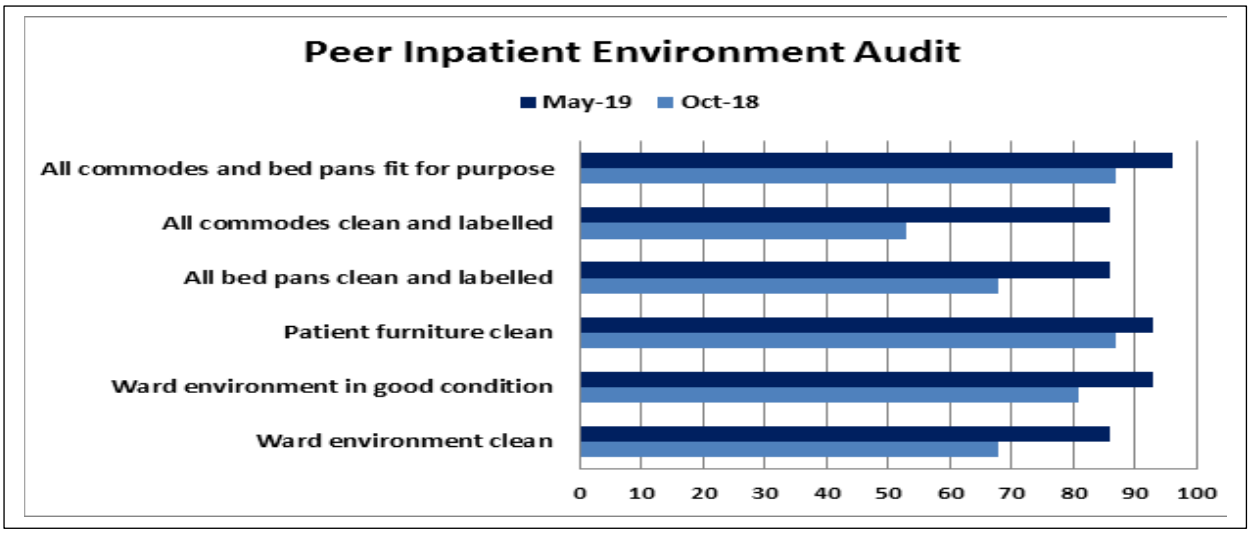


In 2018-19, the above monitoring arrangements were supplemented by weekly oversight visits by a team comprising the Executive with overall responsibility for cleaning, senior nursing representatives, IPC, Estates, Facilities and the Contractor.

The following additional improvement trajectories were also agreed and monitored by the fortnightly IP&C Improvement/Operational Delivery Group:

- Increase compliance with WHO hand hygiene Moment 1 (Before patient contact) to 90% by June 2019
- Increase compliance with WHO hand hygiene Moments 1-5 (…..) to 80% by June 2019
- Increase cleanliness of commodes to 100% by March 2019
- Increase cleanliness of patient equipment (eg dripstands) to 90% by March 2019
- Increase proportion of patient equipment in good condition to 90% by March 2019





5.2 Sharps disposal

During 2018-19, an increased number of incidents were reported by the cleaning contractors of unsafe disposal of sharps. This triggered a review of processes for the handling and disposal of sharps and a number of measures were introduced. These included provision of smaller sharps boxes and trays to facilitate disposal at the point of care, change of practice to dispose all intravenous lines with integral sharps into appropriate sharps containers, and clearer guidance and information to staff.

5.3 Water Safety

East and North Hertfordshire NHS Trust accepts its responsibility under the Health and Safety at Work etc. Act 1974 and the Control of Substances Hazardous to Health Regulation 2002 (as amended), to take all reasonable precautions to prevent or control the harmful effects of contaminated water to residents, patients, visitors, staff and other persons working at or using its premises. This is the responsibility of the Water Safety Committee.

The Water Safety Committee meets quarterly and membership comprises:

- The Assistant Director of Infection Prevention and Control (ADIPC) - Chair
- Infection Prevention and Control Nursing Representative
- Consultant Microbiologist
- Heads of Nursing or nominated representative
- Head of Estates or nominated representative
- Head of Hotel Services or nominated representative
- External Consultants
- Trust Risk Manager/Trust Health and Safety Advisor (as and when required)
- Trust Quality Control Principal Pharmacist

The above terms of reference and core membership will be reviewed in 2019.

During the year, water sampling was carried out in accordance with respective mandatory requirements for Legionella and Pseudomonas. Where positive samples were identified, action was taken and recorded in each instance to ensure that the safety of the water supply was maintained.

Estates carry out quarterly Total Viable Count (TVC) sampling on all water tanks, hot water calorifiers. Records are kept with the Estates offices and remedial actions are completed if

samples fall outside of control parameters. There is a TVC water sampling strategy covering the entire hospital site over a twelve month period which consists of 120 locations with 30 x TVC samples taken per week.

There have been no infections associated with water supply systems over the last year.

6. Criterion 3 & 4: Information on infections to service users and their visitors and information on infections to other providers

The Trust continues to use the switchboard as a mechanism for informing the public of infection outbreaks, during the Winter period. A pre-recorded message is used.

Pop up banners are used to inform the public of increased incidence of Norovirus and Influenza.

Infection Prevention and Control (IPC) information leaflets are available on the Trust website for patients and members of the public to access. Printed copies are available for patients identified with infections at ward level.

There is an IPC section on the Trust website which provides information to patients on a number of IPC issues including the numbers of Clostridium *difficile* and MRSA BSI.

7. Criterion 5: Identification and prompt management of infection

The ICD and the Consultant Microbiologists provide advice on the prompt diagnosis and treatment of infections, including appropriate use of antibiotics. Close working relationships are also in place to facilitate the reporting of infections of public health significance to the local Public Health England (PHE) Unit. In addition, the ICD works closely with PHE in the management of infection-related serious incidents in the hospital. The IPCNs also liaise with their Public Health nursing colleagues in respect of infection control incidents.

Following the transfer of pathology services to Cambridge University Hospitals NHS Foundation Trust in 2015, the identification of relevant pathology results has relied on a manual system which is resource intensive and delays identification of results required by the Infection Prevention and Control Team. An electronic surveillance management and reporting system (ICNet) has been implemented for full roll out in June 2019. This will streamline surveillance processes and will enhance patient safety through real-time identification of infectious organisms and potential outbreaks.

8. Criterion 6: Involvement of all staff

The IPCT works closely with all Trust staff to implement good practice and reduce HCAIs. The IPCT is an integral part of Trust induction for all new staff (with presentations on both Infection Prevention and Antimicrobial Stewardship) and mandatory updates on key and emerging issues.

In addition, a number of educational activities have been developed:

- There is a rolling programme of training events for IPC Link Practitioners and other clinical staff, supported by Trust staff and external partners. In December 2018, the RCN national IPC lead presented on hand hygiene and glove awareness during the IPC Annual Study Day for Trust staff.

- The IPC team participated in key national and international IPC awareness events, namely WHO Hand Hygiene day, Glove Awareness Week and IPC Week.
- The IPC team has provided information via the monthly IPC newsletter “Quick Pics” which is disseminated to Heads of Nursing, matrons, ward managers and Link practitioners and reflects themes identified from current incidents or seasonal infections.
- Collaboration with the Trust Communications Team to support awareness campaigns, eg articles in the Daily News bulletin for hand hygiene / PPE practice.
- The fortnightly IPC Improvement/Operational Delivery Group is a forum for engaging all Trust and CCG stakeholders

9. Criterion 7: Isolation facilities

The Trust has around 125 single-occupancy side rooms available across the Trust. Many of these side rooms do not have en-suite facilities which presents a challenge for meeting isolation requirements.

Demand for side rooms sometimes exceeds availability. Therefore, patients with infections are risk assessed to enable those with the highest priority requirement to be identified and isolated as required. This is reflected in the Trust Isolation Policy.

10. Criterion 8: Laboratory support

The Microbiology laboratory was re-located to the PHE Microbiology Laboratory at Addenbrooke’s Hospital in Cambridge in 2015. This is part of the Pathology partnership (tPP) process that saw the consolidation of the Pathology Departments of six Trusts in the East of England into two hub laboratories.

The Laboratory is supporting the installation of the ICNet electronic surveillance system.

11. Criterion 9: Policies

All policies required for compliance with the Health Code are in place. Most IPC policies are written by IPC team members with support from other Trust staff with expertise in the relevant areas. Some policies are written by other teams in the Trust with the relevant experience with the support of the IPC team. These policies are accessible to all staff on the Trust’s intranet system.

A programme is in place to ensure all policies are reviewed and updated where required.

12. Criterion 10: Health care workers: Infection Status, protection from infection and education in infection prevention & control

In 2017/18 the Health at Work Service (H@W) has continued to work closely with the IPC team. The service has been fully involved in IPC related incidents that affect staff health, such as Norovirus outbreaks, sharps and splash injuries and staff exposure to illness in patients such as chicken pox & measles.

12.1 Sharps/splash incidents

H@W assists the Trust in managing potential exposure to blood borne viruses. Within working hours, H@W risk assess, advise and follow up reported potential blood borne virus exposures. A monthly report is compiled of sharps injuries reported to H@W and/or recorded on the Trust's incident reporting system (Datix), devices involved in sharps injury, staff groups injured and the likely cause of injuries. In 2018-19, there were 173 injuries reported, on average 14.4 injuries a month. This is an increase on 2017-18 where there were 155 injuries, on average 13 a month

12.2 Immunisations and blood tests

Health at Work (H@W) screens all new employees to identify specific required workplace immunisations and ensure compliance with Criterion 10 of the Health and Social Care Act 2010. The service continues to work to ensure that existing staff are compliant with immunisations appropriate to their role, in line with Department of Health guidelines.

H@W requests immunisation records from all new employees before they commence work and an assessment of immunisation requirements is made in accordance with Public Health England guidelines. H@W electronically records immunisations in accordance with the Data Protection Act. H@W advises all new employees who require further evidence of immunity to book an immunisation update appointment. Additional blood tests are required for staff undertaking Exposure Prone Procedures (EPP) before these duties are commenced.

H@W recalls staff who require vaccine boosters, reviews immunisation records of existing staff and provides advice to employees on immunisation updates needed, as required.

If employees refuse vaccines or blood tests, fail to attend an appointment or to provide the required evidence of immunity, their manager is informed. Where necessary for patient and employee safety, advice may be given on adjustments to the employee's work.

In addition to routine immunisation programmes, H@W facilitates the annual frontline staff Flu Immunisation Programme. In the 2018-19 staff influenza vaccine campaign 65.56% of frontline staff were vaccinated which fell below the target of 75%.

12.3 Fit testing for FFP3 masks

The fit testing programme for staff required to wear FFP3 respirator masks is in place and is supported by the IPC Team and monitored by the Emergency Planning Resilience and Response Committee. Key areas including the Critical Care Units and the Emergency Department have access to extra equipment for staff who require rapid access to FFP3 standards of protection where fit testing cannot be completed.

13. Collaboration with external partners

The NHS Improvement IP&C Lead and Clinical Commissioning Group (CCG) IPC nursing lead made regular support and assurance visits to the Trust throughout the year, working collaboratively with the Trust IPC Team. The Trust has worked closely with NHSI & CCG to improve standards of cleaning and IP&C practices in response to the *C.difficile* outbreak in February 2018, and was given a GREEN rating for IP&C following assurance visits in December 2018 and June 2019.

The Trust participates in a Hertfordshire Infection Prevention and Control Group to coordinate actions, share best practice and devise joint strategies. The CCG IPC Lead is also a member of the Trust Infection Prevention and Control Committee.

The Trust participates with other healthcare organisations across Hertfordshire and West Essex in the UTI reduction project. There are three streams of work: 1 Improving diagnosis and treatment of UTIs; 2. UTI prevention and patient engagement, eg improved hydration to reduce UTIs; 3. Reducing catheter associated UTIs by reducing unnecessary use of catheters and improving the care and management of catheters when these are required.

14. Conclusion

Over the year 2018-19, the Trust has introduced the following measures to improve IPC practices and strengthen assurance processes:

- Providing a clean and safe environment by increased monitoring and reporting processes
- Introduction of an electronic surveillance system (ICNet) to detect infections and outbreaks at an early stage
- Consistent safe clinical practice for hand hygiene, with a plan in preparation for ANTT practice standardization
- Learning from incidents and infections is identified and implemented across the Trust, utilizing the Trust's patient safety reporting system
- No significant winter viral outbreaks which impacted on Trust operations
- No evidence of any cross-transmission of *C.difficile* or other significant infections
- Key challenges for 2019-20 are listed in the Executive Summary

East and North Hertfordshire NHS Trust

Agenda Item: 9.3.3

TRUST BOARD - PUBLIC SESSION – 4 SEPTEMBER 2019

Annual Responsible Officer's Revalidation Report

Purpose of report and executive summary (250 words max):
To support future progress and provide the required level of assurance both to the trust board and to the higher-level responsible officer: • a) help the designated body in its pursuit of quality improvement, • b) provide the necessary assurance to the higher-level responsible officer (chief executive sign off of statement of compliance), and • c) act as evidence for CQC inspections. Please note the data the personal identifiable data on pages 10 and 13 has been redacted in the version available in the Public Domain.
Action required: For information
Previously considered by: **QSC**

Director:	**Presented by:**	**Author:**
Medical Director	Medical Director	Head of Medical Workforce

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): Legal, Quality and Safety, Clinical Governance

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

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Contents

Introduction:

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

  The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

- **Statement of Compliance:**

  The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team of East & North Herts NHS Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: 6 June 2019

Action from last year:

1. Nil action recorded.

Comments:

2018-19 Annual Organisational Audit

	no. PC	% completed appraisal	% not completed (with RO approval)	% not completed (no approval)
Consultants	313	92	1	8
SASG	52	88	0	12
Fixed term doctors	77	40	3	57

2017-18 Annual Organisational Audit

	no. PC	% completed appraisal	% not completed (with RO approval)	% not completed (no approval)
Consultants	278	96	1	3
SASG	54	91	9	0
Fixed term doctors	116	72	22	6

There has been a reduction in appraisal performance, particularly in short term contract holders who are not managed through the PremierIT software. Consultant appraisal rate remains above trust target (92%).

The reduction in performance for obtaining approval for incomplete appraisal is due to a reduction in admin resource and change of team providing RO and appraisal administrative support, resulting in a loss of organisational knowledge and expertise.

The significant reduction in rates and process management for short term employees is of concern and is in part due to the change of team, but also this staff group is typically the hardest to manage in the medical appraisal process, compounded by the fact they are not processed through PremierIT nor with any other software assistance.

Action for next year:

2. In-house development of a tracking system for short term locums as an immediate interim intervention.

3. Training and support of revalidation and appraisal team by new head of medical workforce
4. Head of medical workforce and RO to conduct a wholesale review of appraisal policy and process, with a particular focus on improving the management and compliance rates for appraisals of short term employees, including a consideration of cost vs benefit of using PremierIT for *all* prescribed connections.
5. Appointment of lead appraiser to support the RO in quality assurance and improvements for medical appraisals and process

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Yes

Action from last year:

1. Appoint a lead appraiser to support the RO, by January 2019.

Comments:

The Associate Medical Director for Professional Standards has fulfilled the Responsible Officer role with East & North Herts NHS Trust since 2017. The RO attends regional RO forums and provides a bi-annual update to all appraisers. The RO is also the trust's lead appraiser and this was identified in last year's report as a risk for the organisation. The action from last year was not completed, probably due to the organisational restructure of workforce.

Action for next year:

2. Appoint a lead appraiser to support the RO. Job description to be written, funding to be identified (reattributed from current RO), and expressions of interest invited by end September 2019.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes

Action from last year:

1. Appoint a lead appraiser.

Comment:

The organisational restructure proposals were challenged as creating a risk to the detriment of performance for appraisal and revalidation, which has been borne out in the resulting reduction in performance and lack of continuous quality assurance process. However, the new head of department believes that the resourcing is sufficient to deliver a good

appraisal and revalidation service to an organisation of this size, once the staff are adequately trained.

Action for next year:

2. Head of medical workforce to streamline policy and processes so that the administrative team can work efficiently
3. Appoint appraisal lead (as per 2.2)
4. Keep resourcing and performance under review

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year:

Nil.

Comments:

There is a three-fold process to adding and removing doctors as prescribed connections, but there has not been an audit of the effectiveness of this process since the handover to the new admin team.

New starter correspondence for short term contracts from medical workforce does not include instruction on connecting to the designated body, which is a missed opportunity for communication.

Action for next year:

1. Audit prescribed connections list accuracy to evaluate effectiveness of current process.
2. Review new starter correspondence and include instruction on a doctor's obligation to connect to their designated body.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:

Nil

Comments:

The policy is reviewed per the trust's policy review schedule. It was last updated in 2017 following changes to GMC requirements for timing of appraisal. New head of medical workforce has requested an early wholesale review of the policy and procedure as it is felt the documentation could be clearer and more audience-friendly.

Action for next year:

1. A review to the current policy was in scheduled in 2020 but agreed following the change in staffing the timeline will be bought forward end to December 2019.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

No

Action from last year:

1. External review to be scheduled with a completion date of March 2019.

Comment:

External peer review not commissioned.

Action for next year:

2. External review to be commissioned via regional RO, either immediately to baseline current gaps, and/or for spring 2020 to allow for policy and procedure revisions to be embedded.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year:

Nil

Comments:

Short term employees and locums are covered by trust policy and procedure. There is a process for providing them with an appraiser and revalidation-ready appraisal documentation (MAG form)

Doctors engaged through trust bank or agency are supported with appraisal if requested, at cost to the organisation. Audit of locum (bank/agency) employees have not been completed.

Doctors working in the trust with a prescribed connection to another designated body may request supporting information (Multi Organisational Working Forms introduced in 2019) from the revalidation team to support their appraisals. This also extends to information sharing with private hospitals.

Action for next year:

1. Audit of locum (bank/agency) appraisal and revalidation processes
2. Review of processes and software for the short term employee staff group per action 1.2, 1.3, 1.4, 1.5.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:

Nil

Comments:

The trust's appraisal checklist includes supporting information and scope of practice, as above. Appraisals for those undergoing revalidation are reviewed by the RO.

Action for next year:

1. Appraisal lead and head of medical workforce to undertake appraisal quality reviews (checklists) and spot-check audit of appraisals for doctors not under notice in that year
2. Review of triangulation of supporting information from trust sources.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:

Nil

Comments:

The current appraisal policy is compliant with national policy and was approved by JLNC and trust ratified in 2017.

Action for next year:

1. Early policy review to be completed 2019, including JLNC support and approval at Trust Partnership.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:

1. Nil.

Comments:

The trust had a reduction in appraisers last year, coinciding with an increase in prescribed connections and so the RO and MAM reviewed the number of appraisers and determined that 79 was not an adequate number and aimed to increase this number to 94.

In June 2019 eight new appraisers were trained, the trust total now 85 trained appraisers which is sufficient for delivery of five to six appraisals per appaiser per annum.

Action for next year:

1. Appraisal lead to review ratio of appraisers to appraisee quarterly
2. Audit of appraiser job planned PAs and delivered appraisals 2018-19

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year:

Nil

Comments:

PremierIT automatically seeks appraisee feedback and the results from the last year are reassuringly positive. There are some exceptional appraisers at work in the trust.

Action for next year:

1. Further refresher training and calibration workshop in October 2019
2. Trust recognition and feedback for appraisers on their performance, ensure this is reviewed in their own appraisal
3. Appraisal lead to consider mentorship/buddying programme of new appraisers with high performing appraisers

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:

Nil

Comments:

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Since the restructure this has been a challenge and QAMA standard audits have not been completed for the 2019 end of year; quarterly AOA and the end of year AOA have been submitted in accordance with requirements.

However, the standard audits have also been removed from the annual report and, with other existing audits monitoring performance and compliance it may not be efficient use of resource to duplicate these.

Action for next year:

1. Head of medical workforce and appraisal lead to work in partnership to design and implement a robust quality assurance process that does not duplicate auditing or monitoring being conducted through other trust channels.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year:

Nil

Comments:

For 2018-19 there were [redacted] exclusions and [redacted] with restrictions or local supervision.

Current Process is all fitness to practice cases are discussed the Decision Making Group (DMG) and where necessary NCAS are consulted. The DMG consists of:

- Associate medical director for professional standards
- Deputy medical director
- Head of HR and ERAS
- Head of medical workforce

Action for next year:

1. Review of the current Conduct, Performance and Ill-Health Procedures for Medical and Dental Staff to ensure the trust is maintaining compliance with the national procedures and RO regulations.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year:

Nil

Comments:

Positive recommendations are confirmed to the doctor by email. Doctors are contacted if a deferral or non-engagement recommendation is going to be made. However this has not been audited for 2019.

There were three late recommendations to the GMC in 2018-19, due to insufficient information being available from the doctor's appraisal and failure to defer ahead of recommendation due date; this is a failure of process and will be addressed through senior support of the revalidation team and the review of doctors under notice by the revalidation manager lead.

Action for next year:

1. Review of policy and process (as per previous actions)
2. Significantly increase the lead time for recommendations by early review of appraisal and supporting information so that issues are highlighted in advance allowing the RO to discuss with the doctor ahead of making a recommendation and ensure no recommendations made after GMC deadline.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:

Nil

Comments:

No changes since last report; no concerns.

Action for next year:

Nil

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year:

Nil

Comments:

No changes since last report; no concerns.

Action for next year:

1. Include triangulation of supporting information in appraisal quality review process to provide assurance that reflection is taking place

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:

Nil

Comments

There are established processes, supported by a number of policies.

Action for next year:

1. Ensure revised Conduct, Performance and Ill health Procedures for M&D staff policy is ratified in September/December 19 LNC.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

Action from last year:

Nil

Comments:

The annual RO report has previously provided the board assurance on quality of the responding to concerns system.

2018-19 information

See next page

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

Concerns about a doctor's practice	High level	Medium level	Low level	Total
Number of doctors with concerns about their practice in the last 12 months *Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern*	[redacted]	[redacted]		[redacted]
Capability concerns (as the primary category) in the last 12 months	[redacted]	[redacted]		
Conduct concerns (as the primary category) in the last 12 months	[redacted]			
Health concerns (as the primary category) in the last 12 months		[redacted]		
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2018 who have undergone formal remediation between 1 April 2018 and 31 March 2019. Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice *A doctor should be included here if they were undergoing remediation at any point during the year*				0
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				0
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				0
General practitioner (for NHS England only; doctors on a medical performers list, Armed Forces)				0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				0
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)				0
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All Designated Bodies				0
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All Designated Bodies				0
Other Actions/Interventions Local Actions:				
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be inc				[redacted]
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months				[redacted]
Number of doctors who have had local restrictions placed on their practice in the last 12 months?				[redacted]
GMC Actions: Number of doctors who:				
Were referred by the designated body to the GMC between 1 April and 31 March				[redacted]
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March				[redacted]
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March				[redacted]
Had their registration/licence suspended by the GMC between 1 April and 31 March				0
Were erased from the GMC register between 1 April and 31 March				0

Action for next year:

1. Focus on addressing the disproportionate number of BAME doctors in formal processes

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Action from last year:

Nil

Comment:

MPIT or transfer of information (TOI) form is used to obtain information on doctors working between hospitals, and for providing information to other Trusts.

Action for next year:

Nil

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:

Nil

Comments:

Head of HR and ERAS, who is the trust equality lead, sits on Decision Making Group. Policies undergo EIA.

Action for next year:

1. See 4.1
2. Assessment of organisational performance using GMC governance handbook assessment tool
3. Action plan arising from any deficits discovered at 6.1

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:

Nil

Comments:

1. Medical workforce undertake appropriate pre-employment checks which include references for all permanent and fixed term contract holders and this is monitoring via TRAC.
2. Temporary staffing administer checks for the trust locum bank staff and liaise with agencies to ensure compliance for agency staff.

3. Workforce governance monitor ESR records, undertaking a gap analysis of all new starters to ensure all appropriate records are completed and compliance is monitored.

Action for next year:

1. Nil.

Section 6 – Summary of comments, and overall conclusion

General review of last year's actions

From last year's board report:

12.2 Action plan for 2017/8

Area for Development	Action required	Responsible Person	Completion by
External Quality Assurance Review	Contact with external body to investigate costs etc involved in provision of external review.	RO	March 2019
Recruitment of Deputy Lead Appraiser	Job description development, expression of interest requests sent to consultants, interview and appoint	RO	January 2019

Actions still outstanding

1. Commission external review
2. Appointment of lead appraiser

Current Issues

8. Discontinued quality assurance processes
9. Lack of depth of talent supporting revalidation and appraisal (RO and lead appraiser roles provided by single person)
10. Unmanageable process for short term employees
11. Exit of organisational knowledge and experience with move of revalidation and appraisal administrative support in workforce division restructure
12. Policy documentation is unclear in places

New Actions and Overall conclusion:

Policy and process review:
Head of medical workforce and RO to conduct a wholesale review of appraisal policy and process, by end Dec 19 with a particular focus on

- Early policy review to be completed 2019, including JLNC support and approval at Trust Partnership
- Clarity around non-engagement process

- Improving the management and compliance rates for appraisals of short term employees, including a consideration of cost vs benefit of using PremierIT for all prescribed connections.
- Streamline policy and processes so that the administrative team can work efficiently
- Significantly increase the lead time for recommendations by early review of appraisal and supporting information so that issues are highlighted in advance allowing the RO to discuss with the doctor ahead of making a recommendation and ensure no recommendations made after GMC deadline.
- Review new starter correspondence and include instruction on a doctor's obligation to connect to their designated body.
- Ensure revised Conduct, Performance and Ill health Procedures for M&D staff policy is ratified in September/December 19 LNC.
- Assessment of organisational performance using GMC governance handbook assessment tool and action plan to address gaps
- Focus on addressing the disproportionate number of BAME doctors in formal processes

Support team improvements

- Training and support of revalidation and appraisal team by new head of medical workforce
- Keep resourcing and performance under review
- In-house development of a tracking system for short term locums as an immediate interim intervention.
- Appointment of lead appraiser to support the RO in quality assurance and improvements for medical appraisals and process. Job description to be written, funding to be identified (reattributed from current RO), and expressions of interest invited by end September 2019.

Quality assurance audits

- Head of medical workforce and appraisal lead to work in partnership to design and implement a robust quality assurance process that does not duplicate auditing or monitoring being conducted through other trust channels.
- Audit prescribed connections list accuracy to evaluate effectiveness of current process.
- External review to be commissioned via regional RO, either immediately to baseline current gaps, and/or for spring 2020 to allow for policy and procedure revisions to be embedded.
- Audit of locum (bank/agency) appraisal and revalidation processes
- Appraisal lead and head of medical workforce to undertake appraisal quality reviews (checklists) and spot-check audit of appraisals for doctors not under notice in that year
- Review of triangulation of supporting information from trust sources
- Include triangulation of supporting information in appraisal quality review process to provide assurance that reflection is taking place

Appraiser resourcing

- Appraisal lead to review ratio of appraisers to appraisee quarterly
- Audit of appraiser job planned PAs and delivered appraisals 2018-19
- Further refresher training and calibration workshop in October 2019
- Trust recognition and feedback for appraisers on their performance, ensure this is reviewed in their own appraisal

- Appraisal lead to consider mentorship/buddying programme of new appraisers with high performing appraisers

Section 7 – Statement of Compliance:

The Board of East and North Hertfordshire NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Chief Executive

Official name of designated body: East and North Hertfordshire NHS Trust

Name: Nicholas Carver Signed: _ _ _ _ _ _ _ _ _ _ _ _ _ _

Role: Chief Executive

Date: _ _ _ _ _ _ _ _ _ _

East and North Hertfordshire NHS Trust

Agenda Item: 9.4

TRUST BOARD - PUBLIC SESSION – 4 September 2019

Audit Committee – Meeting held on 22 July 2019

EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present the summary report from the Audit Committee meeting of 22 July 2019 to the Trust Board. The report includes details of any decisions made by the Audit Committee under delegated authority.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of Audit Committee	**Presented by:** Chair of Audit Committee	**Author:** Trust Secretary / Board Committee Secretary

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

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

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

AUDIT COMMITTEE MEETING - 22 July 2019

SUMMARY REPORT TO TRUST BOARD MEETING HELD ON 4 SEPTEMBER 2019

The following Non-Executive Directors were present:

Jonathan Silver (Chair), Karen McConnell, Bob Niven

MATTERS REFERRED TO BOARD

Data Quality and Clinical Coding Report

The Head of Data Quality (DQ) updated the Committee on progress with data quality improvements and clinical coding activities. A Trust wide deep analysis of every service in the Trust had been embarked on. Through this work, the Data Quality Compendium (DQC) would be compiled and would be an accurate record of all types of activity taking place across all the sites of the Trust. The Consultant Master File (CMF) had a number of issues that had compromised the quality of the data on Lorenzo. The DQM team would review the data and correct the errors.

The Committee received an update in regard to the transmitting of patient discharge summaries. An improvement trajectory had been agreed with the CCG and performance had improved but the Trust was not yet meeting the national requirements. A key element was ensuring compliance with the process.

The Committee was concerned that the Trust was not meeting the national targets and referred the matter to the Quality and Safety Committee.

Sustainability Progress Report

The Committee considered the 6-monthly progress report on the delivery of the Sustainable Development Management Plan (SDMP).

The Trusts Total Carbon Footprint had increased in 17/18 and again in 18/19 was higher than target in each year and considerably higher than the 2020 target. The Committee discussed the reasons for the increase and initiatives to reduce it. To achieve the government target by 2020 would require a significant improvement.

The Committee suggested that an action plan be developed and that the matter be highlighted to the Board. The possibility of appointing a NED as a Board level lead for sustainability would also be explored.

Annual Audit Letter

The External Auditors presented the Annual Audit Letter for the year ended 31 March 2019 to the Audit Committee.

The Annual Audit Letter summarised the key issues arising from the work that the external auditors had carried out in respect of the year ended 31 March 2019 and reflected previous reports received by the Committee. The Committee discussed the process for approving the annual report and accounts and suggested that the learnings arising from the 18/19 process be shared at the next meeting.

The Committee noted the report. The report is provided on the Trust Board agenda for noting.

OTHER

Cyber Security Report

The Committee considered the latest Cyber Security Report. The report was submitted to provide awareness of the Trust's cyber security position, highlighting any risks or threats and the work done to protect and secure the Trust.

The current alert status was at 'medium'. The Committee discussed various matters raised in the report and key actions and reasons for delays. The Committee requested more detail be included on the next action tracker.

Internal Audit Progress Report

The report provided a summary update on progress against the internal audit plan for 2019/20 and summarised the results of the work to date.

Three reports had been finalised since the last meeting as follows:

- Performance Framework – Reasonable Assurance Opinion
- Stage 2 Discharge Management – Partial Assurance Opinion
- Business Case and Project Process - Reasonable Assurance Opinion

The actions related to the Stage 2 discharge management audit had already been completed.

Regarding the business case audit, the Committee asked for more detail on governance arrangements between the Business Development Committee and the FPC.

Five audits (Pseudonymisation Audit, Data Quality – Integrated Performance, Management of Sickness Absence, Permanent and Temporary Vacancy Authorisation and Consultant Job Planning) had been issued in draft and a number of audits were in various stages of completion in line with the agreed timetable.

Recommendation Tracking Status Report

The latest update in respect of recommendations made was submitted to the Commission for discussion. There had been an increase in the overall number of open actions (from 44 to 45) mainly due to the addition of the LCFS action items. 26% (16) of recommendations have been implemented, 18% (11) are overdue by 0 – 3 months, 15% (9) are overdue by 3 – 6 months, 8% (5) are overdue by 6 – 12 months and 33% (20) are not yet due. Progress had been made with 16 actions having been closed since the last Audit Committee meeting.
The Committee noted the update and would continue to monitor performance in this area.

Local counter Fraud Specialist Progress report

The report provided an update in respect of counter fraud work undertaken at the Trust since 1 April 2019 including referrals received by the LCFS. The LCFS had ensured that all deadlines for the management of reactive cases were promptly adhered to. Work undertaken with Hertfordshire NHS Procurement indicated that they had good counter-fraud measures within their processes. Areas for improvement have been highlighted and management actions have been agreed to address these areas.

Board Assurance Framework

The Committee considered the latest version of the Board Assurance Framework 2019 - 2020.

The Committee spent some time discussing risk 4 (regarding capital resources), its link with risk 11 (Estates and Facilities) and the need to develop a forward looking estates plan and strategy. The Committee discussed key issues and how the matters could be progressed.

The Committee agreed to escalate the matter to the FPC and Board.

Significant Losses and Special Payments Report

The Committee noted the report on the Trust's significant losses and special payments between October 2018 and March 2019.

The report included details of patient and staff claims, complaints, settlements and other debts and losses.

Policy for Handling Patient Claims, the Reporting of other Special Payments and the Loss of Any Trust Assets

The Trust-wide Policy and Procedures for Handling Patient Claims, the Reporting of Other Special Payments and the Loss of Any Trust Assets was presented to the Committee for approval. There were no significant changes and the policy was in line with those of other trusts.

The Committee approved the update.

Tenders and Waivers Report

The Committee noted the report on tenders and waivers. The report was intended to inform the committee of the value and volume of tender waivers and assure the committee that reducing waivers and managing non-pay spend was a key objective of procurement.

There had been a significant reduction in the volume of waivers over recent years.

Jonathan Silver
Non-Executive Director
August 2019

East and North Hertfordshire NHS Trust

Agenda Item: 9.4.1

TRUST BOARD - PUBLIC SESSION – 4 SEPTEMBER 2019

Annual Audit Letter 2018/19

Purpose of report and executive summary (250 words max): The purpose of the report is present to the Trust Board the External Auditor's Annual Audit Letter for the year ended 31 March 2019.		
Action required: For information		
Previously considered by: **Audit Committee – 22 July 2019**		
Director: **Director of Finance**	**Presented by:** **External Auditors**	**Author:** **External Auditors**

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

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

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

EAST AND NORTH HERTFORSHIRE NHS TRUST

Annual Audit Letter: Year ended 31 March 2019

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CONTENTS

WELCOME
Introduction

Purpose of the Annual Audit Letter

This Annual Audit Letter summarises the key issues arising from the work that we have carried out in respect of the year ended 31 March 2019. It is addressed to the Trust but is also intended to communicate the key findings we have identified to key external stakeholders and members of the public.

Responsibilities of auditors and the Trust

It is the responsibility of the Trust to ensure that proper arrangements are in place for the conduct of its business and that public money is safeguarded and properly accounted for.

Our responsibility is to plan and carry out an audit that meets the requirements of the National Audit Office's (NAO's) Code of Audit Practice (the Code). Under the Code, we are required to review and report on:

- The Trust's financial statements.
- The auditable parts of the Remuneration and Staff Report.
- Whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are also required to review and report on the Annual Report, Governance Statement and the Trust Accounts Consolidation schedules.

We also undertake a review of the Trust's Quality Account to confirm that it has been prepared in line with requirements, including substantive testing of two performance indicators.

We recognise the value of your co-operation and support and would like to take this opportunity to express our appreciation for the assistance and co-operation provided during the audit.

BDO LLP

22 July 2019

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Engagement lead

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AUDIT CONCLUSIONS
Executive summary

Financial statements

- We reported our detailed findings to the Audit Committee on 23 May 2019.
- We issued an unmodified true and fair opinion on the financial statements on 28 May 2019.
- Going concern disclosures were deemed sufficient.
- We referred a matter to the Secretary of State on 24 May 2018, under section 30 of the Local Audit and Accountability Act 2014, when we had reason to believe that the Trust had set a deficit budget for 2018/19, as this indicated that the Trust had begun a course of action that was unlawful.

Use of resources

- We issued a qualified 'except for' conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources on 28 May 2019.
- Although there is evidence of improvements to arrangements in 2018/19, the Trust remained in an underlying deficit position and is reliant on performance related funding to meet its challenging financial target of breakeven for 2019/20.

Other financial reporting matters

- After adjusting for issues identified by the audit, the final Remuneration and Staff Report was properly prepared.
- The Governance Statement complied with relevant guidance and was not inconsistent or misleading with other information we are aware of.
- After adjusting for issues identified by the audit, the other information in the Annual Report, which includes the Performance Report and the Accountability Report, was consistent with the financial statements and knowledge acquired in the course of the audit.
- The Trust Accounts Consolidation schedules used in the preparation of the NHS England group consolidation was consistent with the financial statements.
- We issued a modified assurance report on the Quality Account on 28 June 2019. We reported our findings within the Audit Completion Report which was presented to Audit Committee on 23 May 2019. Our Limited Assurance opinion was qualified because a mid-year change in A&E data reporting, to bring the Trust in line with applicable guidance, resulted in a truncated period of reporting, which had an unquantified impact on the completeness of data. For this reason, we were unable to conclude the indicator was reasonably stated in accordance with the dimensions of data quality.

THE NUMBERS
Executive summary

Final materiality

Group final materiality was determined based on gross expenditure.

Material misstatements

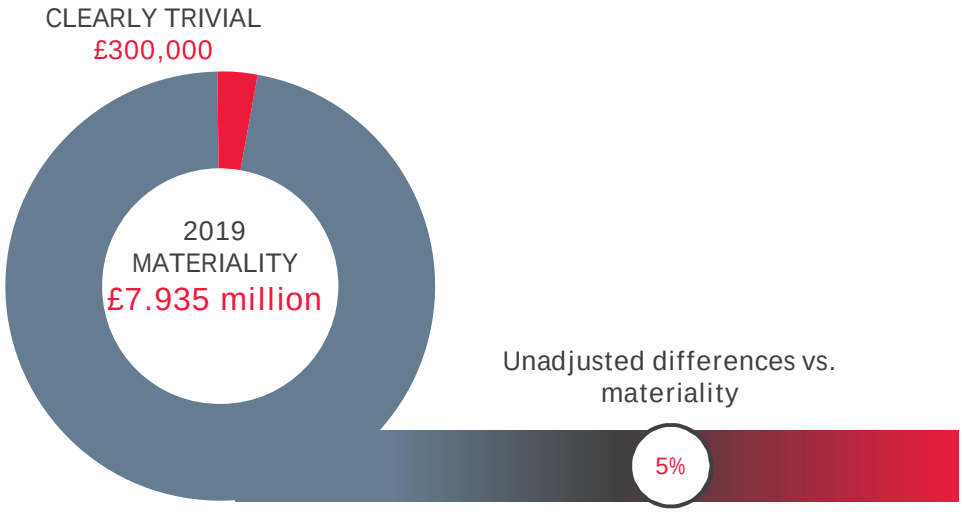
Our audit identified the following material misstatement:

Interim audit procedures identified that the Trust's single entity operating income and expenditure were both understated by £11.5m in 2017/18.

Management amended the comparatives in the financial statements for this issue, which had no impact on retained earnings.

Unadjusted audit differences

Our audit work identified adjustments that, if posted, would increase the deficit for the year by a projected £966,408.



AUDIT RISKS OVERVIEW

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that they are free from material misstatement, whether caused by fraud or error.

This includes an assessment of whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed, the reasonableness of significant accounting estimates, and the overall presentation of the financial statements.

Our assessment of risks of material misstatement

Our audit was scoped by obtaining an understanding of the Trust and its environment, including the system of internal control, and assessing the risks of material misstatement in the financial statements. We set out below the risks that had the greatest effect on our audit strategy, the allocation of resources in the audit, and the direction of the efforts of the audit team.

Audit Risk	Risk Rating	Significant Management Judgement Involved	Use of Experts Required	Error Identified	Control Findings
Management override of controls	Significant	Yes	No	No	No
Revenue recognition	Significant	Yes	No	Yes	Yes
Valuation of land and buildings	Significant	Yes	Yes	No	No
Capitalised Lorenzo expenditure	Significant	No	No	No	No
Related party transactions	Normal	No	No	No	No
Revenue from other NHS bodies	Normal	No	No	No	No
Going concern	Normal	Yes	No	No	No
Group consolidation	Normal	No	No	No	No

MANAGEMENT OVERRIDE OF CONTROLS

ISA (UK) 240 presumes that management is in a unique position to perpetrate fraud.

Significant risk	■
Normal risk	
Significant management judgement	■
Use of experts	
Unadjusted error	
Adjusted error	
Additional disclosure required	
Significant control findings	

Risk description

The primary responsibility for the detection of fraud rests with management. Their role in the detection of fraud is an extension of their role in preventing fraudulent activity. They are responsible for establishing a sound system of internal control designed to support the achievement of departmental policies, aims and objectives and to manage the risks facing the organisation; this includes the risk of fraud. Under auditing standards there is a presumed significant risk of management override of the system of internal controls.

Work performed

We carried out the following planned audit procedures:

- Tested the appropriateness of journal entries recorded in the general ledger and other adjustments made in the preparation of the financial statements.
- Reviewed accounting estimates for biases and evaluated whether the circumstances producing the bias, if any, represented a risk of material misstatement due to fraud.
- Obtained an understanding of the business rationale for significant transactions that were outside the normal course of business for the entity or that otherwise appeared to be unusual.

Results

We identified no evidence of systematic bias or management override in the processing of journals entries and other adjustments, or the making of significant accounting estimates. We did not identify any unusual transactions or transactions outside the normal course of business for the Trust.

Conclusion

No material issues identified.

REVENUE RECOGNITION

Under auditing standards there is a presumption that income recognition presents a fraud risk.

Significant risk	■
Normal risk	
Significant management judgement	
Use of experts	
Unadjusted error	
Adjusted error	■
Additional disclosure required	
Significant control findings	■

Risk description

Under auditing standards there is a presumption that income recognition presents a fraud risk. For Trusts, the risks can be identified as affecting the accuracy and existence of income.

In the public sector the risk of fraud in revenue recognition is modified by Practice Note 10 (PN10), issued by the Financial Reporting Council. PN10 states that auditors should also consider the risk that material misstatements may occur through the manipulation of expenditure recognition. We consider this risk to only be relevant to non-NHS expenditure in relation to cut-off of expenditure, where testing has been focussed.

Work performed

We carried out the following planned audit procedures:

- Updated our understanding of the Trust's internal control environment for the significant income streams, including how this operates to prevent loss of income and ensure that income is recognised in the correct accounting period
- Tested an increased sample of revenue transactions to ensure the correct value was recognised in the period and that revenue was accounted for in accordance with the applicable framework
- Tested an increased sample of non-NHS expenditure to ensure it was recorded in the correct period and was accounted for in accordance with the applicable framework.

Results

Our focused substantive testing identified three transactions for which revenue recognition criteria were satisfied in 2017/18 and so inclusion in the 2018/19 financial statements overstates the Trust's revenue to a projected value of £380,108.

Our assessment is that these errors have arisen due to a deficiency in the Trust's controls for identifying revenue that relates to the provision of goods/services in the accounting period but not invoiced before the balance sheet date. Management has confirmed that it will be reviewing the availability of information on revenue earned and not invoiced and the procedures in place for reporting this information to the Finance department at period end.

Conclusion

No material issues identified. Based on an extrapolation of errors identified, we estimate revenue to be overstated by a projected value of £380,108.

VALUATION OF LAND AND BUILDINGS

There is a risk over the valuation of land and buildings due to inherent uncertainty and judgements involved.

Significant risk	■
Normal risk	
Significant management judgement	■
Use of experts	■
Unadjusted error	
Adjusted error	
Additional disclosure required	
Significant control findings	

Risk description

The calculation of the fair value of land and buildings requires the use of judgement in determining appropriate underlying valuation assumptions and this is susceptible to bias or error. Small changes in the underlying assumptions can have a significant impact on the movements in valuation recognised in the financial statements. As a result, there is a risk of material misstatement if inappropriate or inaccurate estimates or assumptions are used in the calculation of these fair values.

Work performed

We carried out the following planned audit procedures:

• Assessed the independence, objectivity and competence of the expert engaged by management to perform the valuation of land and buildings.

• Formed our own expectations regarding the movement in property values and compared this to the valuations reflected in the Trust's financial statements.

• Reviewed the appropriateness of assumptions used in the valuation of land and buildings, including those related to the use of a Modern Equivalent Asset (MEA) methodology.

Results

The Trust obtained a desktop valuation from an independent professional valuer, Avison Young. The approach adopted for the valuation of buildings was to adjust values in line with the movement in BCIS build between the date of the last full valuation (as at 31 March 2018) and the balance sheet date (31 March 2019), and to make an adjustment to reflect a reduction in asset useful lives. The approach adopted for the valuation land was to adjust in line with market data for comparable assets.

The basis of valuation for assets valued in year was appropriate based on their usage and in line with requirements of the reporting framework. Buildings have been valued on a modern equivalent asset basis for assets valued at depreciated replacement cost. Land has been valued at its existing use value.

We are satisfied that the professional valuer used by the Trust is sufficiently independent, objective and competent, and therefore that we are able to rely upon the valuations produced for audit purposes.

Conclusion

No material issues identified.

CAPITALISED LORENZO EXPENDITURE

There is a risk that expenditure has been capitalised as intangible assets but does not meet the definition of capital.

Significant risk	■
Normal risk	
Significant management judgement	
Use of experts	
Unadjusted error	■
Adjusted error	
Additional disclosure required	
Significant control findings	

Risk description

The Trust incurred approximately £10m of expenditure in 2018/19 relating to the introduction of the patient activity system Lorenzo, despite the software being operational since 2017/18. There is a risk that this is not capital expenditure as defined by the accounting framework and should have been recognised as revenue expenditure in the period.

Work performed

We carried out the following audit procedures:

- Updated our understanding of the Trust's internal control over appropriate classification of expenditure.
- Analysed transaction data related to Lorenzo during the period, identifying transactions that are not clearly revenue or capital expenditure and sub-analysing these transaction based on their nature.
- Tested an enhanced sample of transactions to source documentation to confirm they had been correctly classified in the Trust's accounts.

Results

Our audit procedures identified that capitalised expenditure included costs related to the delivery of training activity, which does not satisfy the requirements for capital expenditure set out in the applicable accounting framework. The Trust has confirmed that the training has not been substantially delivered and is therefore not included in the capitalised costs, however it has not been possible to prove this. We have therefore reported an overstatement of intangible assets for the full value of planned training activity, which equates to £0.586m.

We are satisfied that other expenditure capitalised as intangible assets in 2018/19 has been appropriately classified.

Conclusion

No material issues identified. Based on an extrapolation of errors identified, we estimate revenue expenditure to be understated by a projected value of £586,300.

RELATED PARTY TRANSACTIONS

Transactions with related parties can be material to the users of accounts for qualitative reasons even if they do not exceed the materiality threshold applied to the financial statements as a whole.

Significant risk	
Normal risk	■
Significant management judgement	
Use of experts	
Unadjusted error	
Adjusted error	
Additional disclosure required	
Significant control findings	

Risk description

It is necessary to consider whether the disclosures in the financial statements concerning related party transactions are complete, adequate and in line with the requirements of the applicable accounting framework.

Work performed

We carried out the following planned audit procedures:

- Updated our understanding of the related party transactions identification procedures in place and reviewed relevant information concerning any such identified transactions and parties
- Reviewed Board member and senior management declarations of interest to ensure there were no potential related party transactions omitted from disclosure incorrectly.

Results

We documented the related party transactions identification procedures in place and reviewed relevant information concerning any such identified transactions. No deficiencies were identified.

We discussed with management and reviewed Board member and Senior Management declarations and obtained assurance there were no potential undisclosed related party transactions through external searches and ledger interrogation.

Conclusion

No material issues identified.

REVENUE FROM OTHER NHS BODIES

The Trust may recognise revenue from NHS bodies that differs to the corresponding expenditure recognised by those NHS bodies.

Significant risk	
Normal risk	■
Significant management judgement	
Use of experts	
Unadjusted error	
Adjusted error	
Additional disclosure required	
Significant control findings	

Risk description

The agreement of balances process is designed to ensure that NHS commissioners and providers agree the outturn expenditure (payables) and income (receivables) under the NHS contracts. However, this process often generates differences between both parties either through misallocated transactions, disputes, cash timing differences or other discrepancies. There is a risk that NHS income is not accurately recorded where there are unreconciled differences between the Trust and NHS commissioners.

Work performed

We carried out the following planned audit procedures:

- Reviewed the process for resolving discrepancies between the Trust and NHS commissioners through the agreement of balances process.
- Reviewed management's estimate of amounts receivable where there were contract disputes above the triviality threshold.

Results

We reviewed the process for resolving discrepancies between the Trust and NHS commissioners through the agreement of balances process, and management's estimate of amounts receivable where there are contract disputes. We identified no issues to report.

We also reconciled revenue from commissioners recognised in the financial statements to values per agreed contracts. We identified no issues to report

Conclusion

No material issues identified.

GOING CONCERN

The Trust faces significant financial difficulties which may cast significant doubt about the ability of the Trust to continue as a going concern.

Significant risk	
Normal risk	■
Significant management judgement	■
Use of experts	
Unadjusted error	
Adjusted error	
Additional disclosure required	■
Significant control findings	

Risk description

The Trust has incurred deficits since 2014/15 and is projecting a further deficit for the reporting period.

There is a risk that the going concern position of the Trust is not adequately reflected in the financial statement disclosures.

Work performed

We carried out the following planned audit procedures:

- Reviewed the Trust's going concern considerations and disclosure, taking account of regulator positions regarding support and continuity and disclosure requirements of relevant accounting frameworks.

Results

Management concluded that it is appropriate to prepare the accounts on a going concern basis, due to the planned continuation of service delivery, and the expectation that the Trust has adequate resources to continue to service its debts and run operational activities for the next 12 months.

Management also acknowledged that there is material uncertainty in its financial performance. This was based on a requirement for continued support funding from the Department of Health and Social Care, a deficit position in 2018/19 (£13.5m) which brought the Trust's cumulative deficit to £75.4m, and ongoing cash flow challenges which, in part, gave rise to significant new borrowing in 2018/19 (£40.3m).

We agree with management's conclusion and the material uncertainty was reflected in the audit opinion.

Conclusion

A material uncertainty was disclosed by the Trust and has been reflected in the audit opinion.

GROUP CONSOLIDATION

A prior period adjustment was identified in the Trust's prior year single entity income statement, resulting from errors in the 2017/18 consolidation process.

Significant risk	
Normal risk	■
Significant management judgement	■
Use of experts	
Unadjusted error	
Adjusted error	
Additional disclosure required	■
Significant control findings	

Risk description

The Trust consolidates subsidiary accounts within its ledger on a monthly basis for internal reporting purposes. There is a risk that this consolidation, or the year-end process of reversing consolidation when preparing Trust single entity accounts, is not executed accurately.

Work performed

We carried out the following planned audit procedures:

- Checked that consolidation adjustments were made to eliminate intra-group balances and transactions as required in preparation of group accounts.
- Checked the accuracy of calculations to reverse ledger consolidation in preparation of Trust single entity accounts.

Results

Our interim audit procedures identified that the 2017/18 statement of comprehensive income (SOCI) for the Trust as a single entity was materially misstated in both income and expenditure. This misstatement was due to errors in consolidation adjustments required to adjust the consolidated ledger position to prepare the Trust's single entity statement. The misstatement was equal for income and expenditure and therefore there was no net impact on the Trust's reported deficit. The consolidated position reported for the group was accurate.

Management reflected the required adjustment in the comparatives of the 2018/19 SOCI. A prior period adjustment note had not been prepared to reflect the adjustment made. The expenditure adjustment had all been posted against drug costs, as was the erroneous adjustment in the prior year, but should have impacted on various lines of the operating expenses note.

Management added a note for the prior period adjustment and amended the comparatives in the operating expenses note to reflect the correct 2017/18 consolidation adjustments.

Consolidation adjustments have been correctly processed in preparation of the 2018/19 statements.

Conclusion

A prior period adjustment to gross income and expenditure of £11,563,032 was disclosed by the Trust in the SOCI and related notes. This adjustment was explained in a separate note as required by the accounting framework.

MATERIALITY, ERRORS AND CONTROL DEFICIENCIES

Our application of materiality

We apply the concept of materiality both in planning and performing our audit and in evaluating the effect of misstatements.

We consider materiality to be the magnitude by which misstatements, including omissions, could influence the economic decisions of reasonably knowledgeable users that are taken on the basis of the financial statements.

Importantly, misstatements below these levels will not necessarily be evaluated as immaterial as we also take account of the nature of identified misstatements, and the particular circumstances of their occurrence, when evaluating their effect on the financial statements as a whole.

The materiality for the group financial statements as a whole was set at £7.935 million. This was determined with reference to a benchmark of gross expenditure (of which it represents 1.75 per cent) which we consider to be one of the principal considerations for the Trust in assessing its financial performance.

We agreed with the Audit Committee that we would report all individual audit differences in excess of £300,000.

Audit differences

We identified two audit differences not corrected in the final financial statements as follows:

- Revenue related to 2017/18 recognised in 2018/19, projected to total £380,108, which overstated 2018/19 revenue.
- Misclassification of expenditure as capital (intangible assets) projected to total £586,300, which understated 2018/19 expenditure.

Correcting for these misstatements would have resulted in the Trust reporting a £966,408 higher deficit for the year. These misstatements did not, therefore, have a material impact on our opinion on the financial statements.

Internal controls

We reported a significant deficiency in respect of the Trust's controls for accruing revenue in the correct period.

OTHER FINANCIAL REPORTING MATTERS

Referral to the Secretary of State

We referred a matter to the Secretary of State on 24 May 2018, under section 30 of the Local Audit and Accountability Act 2014, when we had reason to believe that the Trust had set a deficit budget for 2018/19, as this indicated that the Trust had begun a course of action that was unlawful.

Remuneration and Staff Report

We identified factual and disclosure misstatements in the auditable parts of the Remuneration and Staff Report, which were corrected in the final report.

Annual Governance Statement

The Governance Statement was found to comply with NHS England's guidance and was not inconsistent or misleading with other information we were aware of from our audit of the financial statements, the evidence provided in the Trust's review of effectiveness and our knowledge of the Trust.

Other information in the Annual Report

Our review of the Annual Report identified a number of inconsistencies with information in the quality account, which management amended. We were satisfied that the final Performance Report and Accountability Report were consistent with the financial statements and our knowledge acquired during the course of the audit.

Trust Accounts Consolidation schedules

We are required to provide an opinion to the Trust to confirm that the financial information included in the Trust Accounts Consolidation schedules (and used in the preparation of the NHS England Group consolidation) is consistent with the audited financial statements.

We reported that the CCG template was consistent with the financial statements.

OVERVIEW

Scope of the audit of use of resources

We are required to be satisfied that proper arrangements have been made to secure economy, efficiency and effectiveness in the use of resources based on the following reporting criterion:

In all significant respects, the audited body had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people.

As part of reaching our overall conclusion we consider the following sub criteria in our work: informed decision making, sustainable resource deployment, and working with partners and other third parties.

Our assessment of significant risks

Our audit was scoped by our cumulative knowledge brought forward from previous audits, review of predecessor auditor's audit file, relevant findings from work undertaken in support of the opinion on financial statements, reports from the Trust including internal audit, information disclosed or available to support the Governance Statement and Annual Report, the care Quality Commission's assessments of the Trust, and information available from the risk registers and supporting arrangements.

We set out below the risks that had the greatest effect on our audit strategy, the allocation of resources in the audit, and direction of the efforts of the audit team.

Audit Risk	Criterion	Risk Rating	Issues identified that impacted on conclusion
Sustainable resource deployment	Sustainable resource deployment	Significant	Yes, qualified 'except for' conclusion
Working with partners	Working with partners and other third parties	Significant	No

SUSTAINABLE RESOURCE DEPLOYMENT

There is a risk that there are continuing weaknesses in the Trust's arrangements for strategic financial planning, financial control and financial governance.

In particular, the Trust will need to deliver significant savings to maintain balanced budgets.

Significant risk	■
Normal risk	
Sustainable resource deployment	■
Informed decision making	
Working with partners and other third parties	
Significant control findings	

Risk description

The Trust is forecasting a shortfall against its agreed control total (for 2018/19), with a consequential impact on eligibility for provider sustainability funding (PSF).

This position suggests arrangements at the Trust relating to sustainable resource deployment are not adequate, in that a current year deficit is planned and forecast, with no medium term plan to return to breakeven (at the time of risk assessment).

Work performed

We carried out the following planned audit procedures:

- Reviewed the financial outturn, Cost Improvement Plan (CIP) performance, cash flow management and projections, and Long Term Financial Model (LTFM) assumptions.

Results

For 2018/19 the Trust had set a deficit budget of £0.28m including provider sustainability funding (PSF) and outturn for the year was £13.5m, which represents a £13.2m adverse variance to plan. The outturn deficit was considerably reduced when compared to the prior year (£25.7m), however further increases its cumulative deficit nonetheless.

The Trust has set a budget to breakeven for 2019/20, dependent on receiving £9.1m of FRF funding, £7.1m PSF funding and £4.7m MRET funding in the year (agreed to correspondence from NHS Improvement). Although a breakeven outcome in 2019/20 would be a notably positive achievement, it will not reduce the £75.4m of revenue reserves deficit accumulated to 31 March 2019. Further, as at 31 March 2019, the Trust has £189m of borrowing from DHSC, of which a net reduction of just £1.2m is planned for 2019/20.

The Trust set a CIP target of £24.1m for 2018/19 and has achieved £18m during the year. The Trust has set a CIP target of £15m for 2019/20. Whilst the Trust exceeded this target in both of the previous two years, and the full £15m of 2019/20 savings have been identified, achieving these savings will be a challenge and failing to do so would impact on eligibility for other planned funding.

Conclusion

Notwithstanding the achievements in 2018/19 and the planned breakeven for 2019/20, significant issues remain in terms of cumulative deficits, borrowing and cash flow. We concluded that these issues are evidence that the Trust's arrangements in respect of financial sustainability support are not adequate and therefore modified our opinion in respect of use of resources on an "except for" basis.

WORKING WITH PARTNERS

The Trust may not be benefitting from its participation in the Sustainability and Transformation Partnership.

Significant risk	■
Normal risk	
Sustainable resource deployment	
Informed decision making	
Working with partners and other third parties	■
Significant control findings to be reported	

Risk description

The Trust recognises that it has developed good relationships with its STP partners, but progress toward achieving its ambitions of delivering better quality and more sustainable healthcare services remains uncertain.

Work performed

We carried out the following planned audit procedures:

- Reviewed governance developments and current and expected performance against the key priorities of the Hertfordshire and West Essex STP.

Results

In return for a modest annual contribution of £0.206m the Trust has benefitted directly and indirectly from the additional revenue and capital funding made available across the STP (£6.3m and £4.2m respectively in 2018/19). The Trust anticipates calling down STP capital funding in 2019/20 to address risks faced from its aging capital infrastructure.

The STP has released a new strategy with key priorities that align with those of the Trust, signifying a consistency of direction and mutual benefit. Built-in provisions for reporting against milestones and regular programme reviews will assist with monitoring the STP's achievements and how the Trust benefits from its partnership working.

It is apparent that the new strategy brings new impetus, with more ambitious partnership working in the pipeline through Integrated Care Alliances working towards an Integrated Care System.

Plans for procurement of a joined up pathology service across the six provider and commissioner partners are anticipated to return savings of up to £22m. Partners have committed to learning lessons from the Trust's previous joint arrangement for pathology provision and lessons nation wide. Risks for the Trust's own performance are mitigated by provisions for partners to contribute costs proportionally.

Evidence suggests the Trust's exposure to risk through collaboration with partners with their own financial and clinical challenges is reasonably limited. Risk-share plans have been shelved for the time being whilst partners work to establish sustainability within their own boundaries.

Conclusion

No issues identified that impact on our conclusion regarding the Trust's arrangements to secure economy, efficiency and effectiveness.

OVERVIEW

Scope of the review of the quality account

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Account is not prepared in line with the criteria set out in the Regulations
- The Quality Account is not consistent with the sources specified in the NHS Quality Accounts Auditor Guidance
- The two performance indicators subject of limited assurance review are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the guidance.

Specified indicators for testing

The core set of indicators to be included in the 2018/19 Quality Account is set out in Regulations and the letter from NHS Improvement dated 17 December 2018. NHSI permits the Trust to follow its guidance for Foundation Trusts and in taking this option the Trust is required to select two indicators for testing from the following list (to be selected in order where applicable):

- Percentage of patients with a total time in A&E of four hours or less.
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.
- Percentage of incomplete pathways within 18 weeks.
- Emergency readmissions within 28 days of discharge from hospital.

Our work in relation to the Quality Account is in progress and a separate report will be issued in due course to report the detailed findings and conclusions from this work.

QUALITY ACCOUNT RESULTS 1

Requirements	Response	Findings
Review the content of the report and consistency with specified documents.	We reviewed the contents of the Quality Account and compared this to the guidance and Regulations issued by NHS Improvement. We read the information included in the Quality Account and considered whether it was materially inconsistent with: • Board minutes and papers relating to quality reported to the Board. • Feedback from Commissioners, Local Healthwatch and other stakeholders. • The Trust's complaints report. • Latest national patient survey and staff survey. • Head of Internal Audit's annual opinion over the Trust's control environment. • Annual Governance Statement. • Care Quality Commission's quality and risk profiles. • Results of the latest Payment by Results coding review.	The Quality Account was prepared in line with the Regulations and applicable NHSi guidance. We identified a number of inconsistencies between the Quality Account and the Annual Report. This was a result of the two documents being drafted using data prepared at different point in time. These inconsistencies were corrected by management and we subsequently concluded the Quality Account is materially consistent with our review of other information.
Testing of 62 day cancer indicator: The Trust reported performance of 66.8% in respect of the 62 day cancer indicator, against a target of 85% in the Quality Account.	We undertook testing to: • Confirm the definition and guidance used by the Trust to calculate the indicator. • Document and walk through the Trust's systems used to produce the indicator. • Undertake substantive testing on the underlying data against six specified data quality dimensions. We tested of a sample of 20 cases included in the reported performance and 20 cases which were excluded from reported performance due to not meeting the criteria for the indicator, to ensure that exclusion was appropriate.	We found no significant weaknesses in the systems used to produce the indicator. For each case tested, the information was agreed to underlying records and had been applied to the indicator in line with applicable guidance. No issues to report.

QUALITY ACCOUNT RESULTS 2

Requirements	Response	Findings
Testing of 4 hour A&E indicator: The Trust reported performance of 85.85% in respect of the 4 hour A&E indicator, against a target of 95% in the Quality Report.	We undertook testing to: • Confirm the definition and guidance used by the Trust to calculate the indicator. • Document and walk through the Trust's systems used to produce the indicator. • Undertake substantive testing on the underlying data against six specified data quality dimensions. We tested of a sample of 20 cases included in the reported performance.	We are aware that the Trust had been recording A&E attendees on the day of their admission up to 30 November 2018. Applicable guidelines require this indicator to be updated on the day A&E attendees are discharged. From 1 December 2018 the Trust began recording data against this indicator based on the day of discharge. As a result, patients admitted March 2018 and discharged April 2018 were recorded in 2017/18 and patients admitted March 2019 and discharged April 2019 were recorded in 2019/20. Hence the 2018/19 period is slightly truncated. We are not able to quantify the impact on the completeness of the 2018/19 indicator. For each case tested, the information was agreed to underlying records and had applied the appropriate guidance, with the exception of the dates of recording pre-December 2018 as detailed above. We do not have assurance over the completeness of the 4 hour A&E indicator, which means we are unable to conclude this indicator is reasonably stated in accordance with the dimensions of data quality.

REPORTS ISSUED AND FEES

Fees summary

	2018/19 Final £	2018/19 Planned £	2017/18 Final £
Audit fee			
• Consolidated Group and Trust financial statements and use of resources	52,400	52,400	52,400
We also provide audit services in respect of the ENH Pharma Limited subsidiary and the Trust's Charitable Funds, both of which have separate audit plans. Respective fees are:			
• ENH Pharma	TBC	7,200	7,200
• Charitable Funds	TBC	5,400	6,000
Non-audit assurance services			
• Fees for audit related services: Quality Account	4,880	4,880	4,880
Total fees	TBC	69,880	70,480

Reports issued

We issued the following reports in relation to the 2018/19 audit:

Report	Date
Audit Plan	January 2019
Audit Completion Report	May 2019
Limited Assurance Report on the Quality Account	June 2019
Annual Audit Letter	July 2019

FOR MORE INFORMATION:

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East and North Hertfordshire NHS Trust

Agenda Item:10

TRUST BOARD – PUBLIC – September 2019
Board Assurance Framework 2019 20 Update

Purpose of report and executive summary:
To present the latest version of the Board Assurance Framework 2019 20 (appendix 1) for consideration.

In July, risk 12 – MVCC has been reduced to 12 and the rating for risk 11 – Estates and Facilities is under review due to the permanent leadership, capacity and capability challenges and issues being identified. The Audit Committee/ FPC also discussed the risk relating to Estates and Facilities the levels of risk that are associated with the current weaknesses – specifically:

- Progress on team leadership and building capacity and resilience
- Update on Compliance issues and supporting assurance mechanisms
- The absence of E&F KPI reporting to the Trust Board or FPC *(a high level compliance paper has been to QSC)*
- Progress in respect of building a longer term capital strategy for the Trust
- How we intend to link capital and other E&F strategies (eg Sustainability) into wider discussions on Trust strategy delivery

The Audit Committee considered a deep dive of assurances particularly in regard to Risk 4 – capital. On the boarder organisational risk register there are currently 177 capital bids risks; 86 are >14 and of these 40 are >19. These are viewed with in the Divisions/ Directorates and a collated monthly report is submitted to the capital review group to inform decision making.

In July 2019 FPC requested a review of the IM&T risk and challenged the level of the risk rating. The Chief Information Officer and Associate Director of Corporate Governance have review the principle risk, content and risk rating. **The Board are asked to consider and approved the revised risk "There is a risk that the digital programme is delayed or fails to deliver the benefits, impacting on the delivery of the Clinical Strategy" . Current risk rating has been reduced fro 20 to 16.** See appendix one for details.

Please note: The BAF framework 2019/20,approved by the Board in May 2019 will enable the Board and its committees to have clearer visibility of the causes and effects of the risk and greater alignment of the controls, assurances and actions; thus supporting scrutiny and challenge and strengthening effective review and management of our risks.
A monthly review of the strategic risks is undertaken in conjunction with the lead Director. We will continue to develop assurance maps for each risk and to develop the links to the risk appetite statements approved by Board.

Action required: For discussion

Previously considered by: Audit Committee
The Board Assurance Framework is considered at each FPC,QSC & Public Board.

Director:	**Presented by:**	**Author:**
Director of Strategy	**Associate Director of Corporate Governance**	**Associate Director of Corporate Governance**

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
Yes – CQC compliance will link with all the BAF Risks.

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

Risk Scoring Guide

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

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

Trust risk scoring matrix and grading

Likelihood

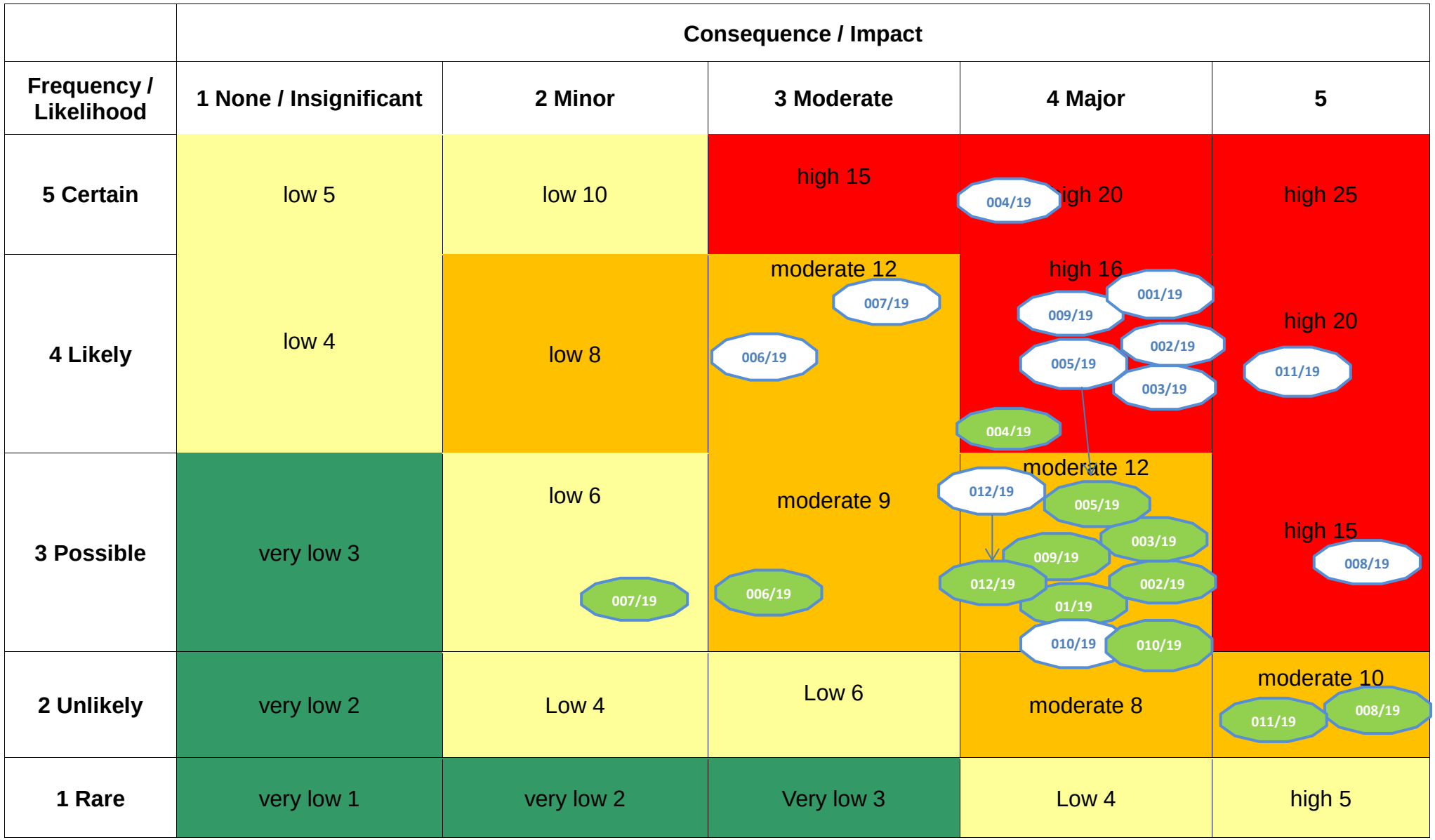
Impact	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
Death / Catastrophe 5	5	10	15	20	25
Major 4	4	8	12	16	20
Moderate 3	3	6	9	12	15
Minor 2	2	4	6	8	10
None /Insignificant 1	1	2	3	4	5

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

BOARD ASSURANCE FRAMEWORK OVERVIEW

Risk Ref	Risk Description	Lead Executive	Committee	Current Risk	Last Month	3 months ago	6 months ago	Target Score	Date added
001/19	There is a risk that within the context of the Healthcare Economy the Trust has insufficient capacity to sustain timely and effective patient flow through the system which impacts the delivery of the 62day cancer, RTT and the A&E 4-hour standards	Chief Operating Officer	FPC	16	16	20	20	12	01-03-18
002/19	There is a risk that the trust is unable to recruit and retain sufficient supply of staff with the right skills to meet the demand for services	Director of Nursing /Medical Director/CPO	FPC	16	16	16	16	12	01-03-18 reviewed 1/5/19
003/19	There is a risk that the Trust is unable to achieve financial sustainability to support the delivery of the Operational Plan and 5year clinical strategy	Director of Finance	FPC	16	25	16	20	12	01-04-19 reviewed
004/19 (was 6)	There is a risk that there is insufficient capital resources to address all high/medium estates backlog maintenance, investment medical equipment and service developments	Director of Finance	FPC	20	20	20	16	16	01-03-18
005/19	There is a risk that the Trust's IT systems are not sufficiently embedded/stabilised to ensure the hospital is run in a safe and effective way Proposed change to: "There is a risk that the digital programme is delayed or fails to deliver the benefits, impacting on the delivery of the Clinical Strategy"	Director of Finance/ COO	FPC	16	20	20	20	12	01-04-17
006/19 (was 10)	There is a risk that the STP does not work effectively to redesign and implement new models of care, which impacts on the hospital's ability to manage demand for services	Director of Strategy	FPC	12	12	12	12	9	01-03-18
007/19	There is a risk that the governance structures in the Trust do not facilitate visibility from board to ward and appropriate performance monitoring and management to achieve the Board's objectives	Chief Executive	Board of Directors	12	12	12	12	12	01-03-18
008/19 (was 11)	There is a risk that the Trust is not always able to consistently embed of a safety culture and evidence of continuous quality improvement and patient experience	Director of Nursing /Medical Director	QSC	15	20	20	20	10	01-03-18
009/19	There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered, impacting on the Trust's ability to deliver the required improvements and transformation	Chief People Officer	FPC & QSC	16	16	16	16	12	01-03-18
010/19 was 013/19	There is a risk that the Trust is adversely affected by the United Kingdom's departure from the European Union, particularly in the event of no deal being secured.	Director of Strategy	FPC	12	16	12	n/a	12	19-09-18
011/19(was 014/19	There is a risk that the Trust's Estates and Facilities compliance arrangements including fire management are inadequate leading to harm or loss of life.	Director of Strategy	QSC	20 Under review	20	20	N/A	10	22/01/19
012/19	There is a risk that the Trust is not able to secure the long-term future of the MVCC	Director of Strategy	FPC	12	16	16	12	12	01-03-18

Board Assurance Framework Heat Map –July/August 2019



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

Strategic Aim:	**Pathways: To develop pathways across care boundaries, where this delivers best patient care invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff**				**Ease of Use: To redesign and**
Strategic Objective:	**Improve and sustain delivery of operational performance**		**Source of Risk:**	Strategic Objective IPR	**BAF REF No:** 001/19
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the trust is not able to provide timely and effective patient care through the delivery of compliant and sustained performance standards, specifically in relation to the 4 hour, RTT and cancer.			**Risk Open Date:**	01/03/2018	**Executive Lead/ Risk Owner** Chief Operating Officer
			Risk Review Date:	Jul-19	**Lead Committee:** FPC

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	i) Limited ability to respond to changes in capacity and demand impacting on service delivery ii) Adverse impact on sustaining delivery of core standards iii) impact on patient safety, experience and outcomes iv) increased regulatory scrutiny v) reputation	**Inherent Risk** (Without controls):	4	5	20	⇕
		Residual/ Current Risk:	4	4	16	
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• ED Patient flow improvement steering group/ Delivery Board • Three times weekly work stream meetings including Red to Green • Weekly ED Team/COO meeting • Length of Stay consultant led reviews • Daily system telephone conference • Weekly access meeting chaired by COO • Three tier cancer tracking meeting; Divisional PRMs • Trust representation on A&E delivery Board/ Cancer Board/ STP • Integrated Care Team engagement • Additional management resource secured to support delivery of cancer timed pathway programme - CIMBIO reports and monitoring - speciality and consultant level monitoring of access plans when completed and failsafe TCI waiting list office reconciliation. Linked to training to improve compliance - Programme Boards - OPD Board, Theatre Board, Length of Stay review panel - ED breach review and vailidation and SoP - re launch of winter planning group July 2019	• A&E Delivery Board (L1) • System Resilience Group (L2) • Reports to FPC and Board of Directors (L3) • Floodlights scorecard (L1) • NHSI PRM(L3) • Cancer Board (L2) • Daily and weekly ED sit-rep reporting • Monthly breach validation audits • Monthly Performance Deep Dives considered by FPC – e.g. ED in June 2018 and rolling programme • NHSI – Deep dive – cancer recovery plan (L3) • IPR Report to Feb and March 19 FPC meeting 6 and 5 out of the 8 cancer standards, RTT performance above national average • Closure of escalation winter ward • Internal Audit – Performance Framework report - reasonable assurance March 19) Internal audits scheduled for 2019/20 include - clinical capacity and utilisation; emergency department;theatre productivity Regulator oversight - weekly detailed performace call	Internal Audit – Performance Framework report - reasonable assurance March 19) Validated demand and capacity by tumor site modelling by NHSI - led to increase investment in urology.		
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**			
Bed Occupancy and LOS reductions not being delivered consistently across specialities. Sufficient surgical capacity to deliver cancer treatments within required timeframes Demand and capacity modelling for all tumour sites not complete. Access to funding streams from the cancer alliance allocation	• Accountability Framework arrangements • Impact of local Hospitals on Trust activity • Demand and capacity profiling for TNO, Pain , oral surgery to inform future business planning Review and response to Market analysis	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		

- availabilty of capital to support developments	- Access to social care support at weekends - 7 day working linked to job planning	Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Implementation of patient flow work programme	Chief Operating Officer	on going	sameday emergency care programme in progress	In progress
ii) Implementation of agreed improvement plans for cancer, RTT and diagnostics	Chief Operating Officer	on going	Concer proformance improving. 62 day pathway in track for delivery and sustained by October 2019. RTT- focus on delivery of reductin of 52 wk breaches	In progress
iii) Review capacity and demand modelling outcomes and determine associated actions to support delivery of the clinical strategy	Chief Operating Officer	on going	TNO, Pain and oral surgery identifed as the next areas for capacity and demand modelling to inform future business planning.	In progress
iv) Continue to review and strengthen operational and governance structures	Chief Operating Officer	on going		In progress
v) To agree and develop further integrated pathways of care with our commissioners	Chief Operating Officer	on going	Postive planned care transformation day in June with CCG. Review of Same Day Emergency Care and Frality model in progress.	In progress
Summary Narrative:				

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

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

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) National shortage of nurses and doctors ii) Limited strategic workforce planning iii) Availability of training	i) Impact on staff morale ii) Impact on quality and safety iii) adverse financial impact	**Inherent Risk** (Without controls):	4	5	20	
		Residual/ Current Risk:	4	4	16	⟷
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Monthly nursing and midwifery workforce steering group • Monthly nursing look ahead – heat map / agreed agency levels • Site safety huddles to review real time staffing and capacity • Quarterly establishment reviews – skill mix, acuity and dependency • Safe care – 3 times daily staffing reviews • University of Hertfordshire recruitment • Rotation of band 5 nurses to aid retention • NHSI Wave 2 retention programme • Eroster • Scheduled regular monthly updates of staffing data to NHSP, to ensure staffing lists as accurate as they can be. • Retention Strategy • Arrangements in place to support our employees who are EU nationals re Brexit-related settled status applications.	• Report to QSC on medical staffing (L2) • Report to Board of Directors via QSC on safer staffing (L2) • Workforce report to FPC (L2) • Safer Staffing reports (L2) • NHS Professionals continuously recruiting to nursing and midwifery band 2 and band 5 roles. • Reviewing and trialling alternative shift patterns to attract staff; rapid response • Development of joint recruitment and attraction strategy with STP. • Launch of retention strategy focusing on band 5 nurses and band 2 CSWs. • Local retention targets and plans - Internal audits shceduled for 2019/20 - consultant job planning, safer staffing,			
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**			
• 40,000 nurses short across the country • Camb/London recruitment/weighting • Capacity to balance quality, money and operational pressure. • Staff leavers higher than expected in some areas • Specific targeted recruitment required for some specialities / specialists • Deanery plans reduction in rotation of medical trainees to DGHs	• Data consistency and quality • Improved retention rates • Recruitment in specialty / hard to recruit areas 5 yr Workforce strategy to support the new 5 yr clinical strategy	Green	Effective control is in place and Board satisfied that appropriate assurances are available		
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient		
		Red	Effective controls may not be in place and assurances are not available to the Board.		
Action Plan to Address Gaps					

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Develop and implement workforce strategy to support the trust new 5 yr clinical strategy	Chief People Officer	September 19 (TBC)		In progress
ii) Implement overseas recruitment plans for 2019/20	Head of Recruitment	Jun-19	international and domestic nursing and medical recruitment was agreed in May 2019. An agreed target for international recruitment was confirmed along with an increased effort to recruit domestic nurses using a variety of tools and incentives to aid recruitment and retention. This work has already commenced and a progress review is due in July 2019. 153 new starters joined the Trust in April 2019 and the vacancy rate as at end of March 2019 was 7.2%. 71 new starters joined the Trust in May 2019 and the vacancy rate as at end of May 2019 was 7%. Divisions have been set targets for their workforce per staff group and this willbe monitored at the weekly Improving Financial Delivery meetings.	In progress
iii) • Resourcing Strategy to be launched in 2019/20 setting out the Trust's approach to recruitment and retention.	Chief People Officer	TBC	Draft workforce redeployment policy by Head of HR expected June/July 2019.	In progress
iv) Review of Trusts Communication strategy to support recruitment and retention	Communication Team / Head of HR			
Summary Narrative:				

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

Strategic Aim:					
Strategic Objective:	**Meet our financial obligations** **Seek innovative STP-wide solutions to address clinically and financially unsustainable services**	**Source of Risk:**	- Operating Plan - Use of Resources	**BAF REF No:**	003/19
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the Trust is unable to achieve financial sustainability to support the devlivery of the Operational Plan and 5 year Clinical Strategy.		**Risk Open Date:**	01/04/2018	**Executive Lead/ Risk Owner**	**Director of Finance**
		Risk Review Date:	Jun-19	**Lead Committee:**	**FPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Demand and capacity planning ii) Shortfall in CIP delivery iii) Good financial management is not embedded at all levels iv) Data quailty not optimised	i) Impact on cash flow ii) CIP programme not delivered iii) Financial plan not delivered iv) unable to invest in service development v) increased CCG test and challenge and regulatory scrutiny	**Inherent Risk** (Without controls):	4	5	20	
		Residual/ Current Risk:	4	4	16	⟷
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrics aligned to IPR**
• Qlikview SLA income and activity application developed and in place (weekly and monthly) • Monthly SLA income reports to FPC / DEC and Divisions • Divisional Performance & Activity meetings (PAM) in place to review deliver • Monthly CQUIN meetings to review progress in place • Contract monitoring meetings in place with all commissioners • Key monitoring metrics reflected in new divisional PRM dashboards • CIP Work programme and workstreams - Exec review weekly • Fully established PMO function in place supporting delivery • Finance and project training programmes in place for budet holders to access • Weekly Improving Finance Delivery IFD meetings in place • £3m Contingency fund building across YTD • Coding and Data Quality Strategy reviewed at Audit Committee	• Independent reviews of coding and counting practice undertaken in 17/18 (L3) • Actions plans to address findings in place and reviewed at PAM (L1) • Regular Data quality and Clinical Coding updates to PAM and AC (L2) • Weekly OP drumbeat session re- introduced in January 2019 • CIP tracker in place to monitor delivery achievement (L1) • Monthly Finace Reports to FPC, Board and Divisions (L1) • Monthly cash reporting to FPC / Trust Board and NHSI(L2) • Monthly Accountability Framework ARMs including finance (L1) • Internal Audit – Financial Planning Process L3 +) • Monthly Financial Assurance Meetings & PRM with NHSI (L1) • FPC Deep Dives into remedial performance issues eg. Theatres	• Internal Audit - key financial control, CIP governance, performance framework 2018/19. • Summary of review of budget risks and controls into FPC May and June 2019		• Delivery of Control Total Target (Trust Level) • I&E delivery against agreed 19/20 budget plans • Agency Staffing within NHSI notified ceiling • Cash balances within agreed EFL target
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**		

• Potential challenge from commissioners in respect of volume of planned work undertaken • Comprehensive bed model and associated demand & capacity modelling • Implementation of Same Day Admission pathway change and the understanding of financial impacts • Requirement to support discharge summary remedial activity impacting upon DQ team capacity to respond to CCG challenges and queries • Pace of CIP delivery achievement • Pace of Theatre and Outpatient transformation delivery • Slippage in IFD mitigations • Temporary staffing control environment in respect of medical and nursing staffing	• Limited demand and capacity modelling • delivery of CIP schemes • delivery of activity levels • Gaps in business skill sets across divisions eg. rostering, waiting list management, budgetary management	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Monitor delivery of CIP programme and support in the development of remedial action plans where required, specifically in relation to Theatres and Temp staffing control (Medical and Nursing)	PMO Director	on going	CIP portfiolio value at 16.97M (113% of 2019/20 target. Additional improvement work continues. Significant scruitny of each scheme and monitoring of delivery.	In progress
ii) Monitor delivery of divisional operational plans through IFD meetings , PAM and Accounabilty review meetings	Director of Finance / CPO	on going	In place and IFD reviewed to support delivery and reproting to ARMs.	In progress
iii) Implementaion of the outcomes of the capacity and demand modeling	Director of Finance / COO	on going	Delivery tracked through PAM Meetings	In progress
iv) Continue to develop BI and support divisions / directorates using effectively	Director of Finance	on going	Ongoing embedding and further development of dahsboards and data sets development	In progress
v) Prepare for use of resources assessment	Executive	Aug-19		In progress
Summary Narrative:				

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

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

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Lack of available capital resources to enable investment ii) Trust in current deficit position iii) Requirement to repay capital loan debts	i) Poor patient experience ii) Patient Safety iii) limited ability to invest in IMT, equipment and services develoments iv) limited innovation	**Inherent Risk** (Without controls):	4	5	25	⇔
		Residual/ Current Risk:	4	5	20	
		Target Risk:	4	4	16	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Six Facet survey undertaken in 17/18 • Capital review Group meets monthly • Prioritising areas for limited capital spend through capital plan • Fire policy and risk assessments in place • Major incident plan • Mandatory training • Equipment Maintenance contracts • Monitoring of risks and incidents	• Report on Fire Safety to Executive Committee (L2) • Monthly Capital Review Group (CRG meetings) feeding into FPC and Exec Committe (L1) • Report on Fire and Backlog maintenance to RAQC(L2) • Reports to Health and Safety Committee (L2) • Capital plan report to FPC (L2) • Annual Fire report (L3) • PLACE reviews (L3) • Reports to Quality and Safety Committee • Deep dive review of the risks and mitigations (December 2018) • new Monthly Fire Safety Committee established March (includes other sites)			• Capital Expenditure within agreed CRL

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
• Not fully compliant with all Fire regulations and design • 1960s buildings difficult to maintain • No formalised equipment replacement plan or long term capital requirement linked through to LTFM • Estates and facilities monitoring structures and reporting	• Availability of capital	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

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

i) Estates strategy to support the five-year trust strategy	Director of Estates and Facilities	September (TBC)	Awaiting new Director to lead on this	Not yet started
ii) Develop capital equipment replacement plan	TBC	TBC		
iii) Develop programme for Charity to suppport with fundraising	Deputy Direoctr of Finance / Head of Charities	on going	ongoing	
iv) Agree capital investment for 2019/20 and monitor delivery	Executive	May 2019 and ongoing	Captial programme approved through CRG and Ececutive committee in June2019. CRG will monitor delivery	In progress
iv) Review other sources of fundung / opporunities for investment	Director of Finance / Porject leads	on going	Bid to NHSI for review including additional funding for fire.	in progress
Summary Narrative:				

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

Strategic Aim:	**Ease of Use:** To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff services that is financially and clinically sustainable in the long term **Sustainability:** To provide a portfolio of				
Strategic Objective:	**Complete stabilisation and commence optimisation of Lorenzo and make our services easier to use**	**Source of Risk:**	Project	**BAF REF No:**	005/2019
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the Trust's IT systems are not sufficiently embedded/stabilised to ensure the hospital is run in a safe and effective way **Proposed change to: "There is a risk that the digital programme is delayed or fails to deliver the benefits, impacting on the delivery of the Clinical Strategy"**		**Risk Open Date:**	Feb-18	**Executive Lead/ Risk Owner**	**Director of Finance / Chief Operating Officer**
		Risk Review Date:	Aug-19	**Lead Committee:**	**FPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Poor staff engagement in new systems and processes ii) Not all staff received the required training and support iii) Not all existing trust systems interface between systems iv) Lack of funding natioanlly or locally to complete the programme	i) Unable to deliver financial performance ii) Unable to deliver target levels of patient activity iii) Unable to meet contractual digital objectives (local, national, licience) iv) adverse impact on performance reporting	**Inherent Risk** (Without controls):	4	5	20	
		Residual/ Current Risk:	4	4	16	
		Target Risk:	4	3	12	

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

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
i)Consistancy and compliance in the application of new processes on the systems ii) Availabilty of capital to deliver priorities - year 2 and beyond.		Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

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

i) Complete rollout of the new discharge summary across all lorenzo wards	Michael Chilvers, MD / Anne Powell	End of May 2019	Wave 5 and 6 implementaiton plan for remaining areas 14.05.19-31.05.19. Completed and adherance to process being monitored. Project completed. Now being embedded into practice.	Completed.
ii) Develop Ditigal Strategy and associated Digital Programme	Mark Stanton, CIO	End o June 2019	In progress - report to FPC in June 2019. Rescheduled for September 2019	In progress,
iii) Review and implementation of revised Digital Strategy Programme Governance	Mark Stanton, CIO	End of May 2019	Proposed governance structure to be presented to FPC in May 2019 . New structures implemented in July 2019	Completed.
iv) Implement the quick wins initiative programme	Mark Stanton, CIO	Ongoing	Commencing late May as a 6 wk programmeto deliver a number of outstanding pipeline requests. Developing as a tool for new IT governance and linking to larger digital programme deliveries. Report to FPC in June 19.	Completed.
iv) Continue vaildation of records to data to ensure adhererance to the new processes	Des Lane, Associate Director of	On going	On going and deteriorating patient digital workstream commenced.	In progress
Summary Narrative:				

Risk carried forward from 2018/19. Stablisation to be completed by 31 May 2019. New digital strategy, associated digital programme and revised governance structure are in progress,

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

Strategic Aim:	**Pathways: To develop pathways across care boundaries, where this delivers best patient care and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff**				**Ease of Use: To redesign**
Strategic Objective:	**Play a leading role in the Sustainability and Transformation Partnership (STP) development of the Integrated Care System / Alliance** **Seek innovative STP-wide solutions to address clinically and financially unsustainable services**	**Source of Risk:**		**BAF REF No:**	006/19 (previously 010/18)
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the STP does not work effectively to redesign and implement new models of care, which impacts on the hospital's ability to manage demand for services		**Risk Open Date:**	01/03/2018	**Executive Lead/ Risk Owner**	**Director of Strategy**
		Risk Review Date:	Jul-19	**Lead Committee:**	**FPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Long term system leadership ii) Clinical and operational leadership and capacity iii) Capacity in primary and community services to deliver change iv) Current legal framework not designed to fully support ICS's	i) System does not deliver intergrated care pathways ii) Demand for acute services exceeds plan iii) Delay development integrated care for ENH iv) Inability to implement agreed models due to contractual, financial and legal barriers v) risk that external stakeholders are able to progress at a quicker pace than our capacity to be fully involved and contribute to the pathway design	**Inherent Risk** (Without controls):	3	5	15	⇕
		Residual/ Current Risk:	3	4	12	
		Target Risk:	3	3	9	

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**
• Participation in STP work streams including Planned care, urgent and emergency care, frailty and cancer • STP CEO bi-weekly meeting Representation at STP Chairs meeting • Vascular Hub project with West Herts and PAH • Cancer work stream of STP (chaired by Director of Strategy) and representing STP Cancer Alliance • Model Hospital redesign work • Integrated discharge team • External partner to support development of STP • New independent chair in place to drive progress. (Ten year plan published sets out expectations for ICSs)	• Reports to Board regarding progress on STP(L2) • Regular oversight by NHSI and NHSE (L2) • Monthly A&E delivery Board (L2) • Transformation Board of the CCG(L2) • Reports of Model Hospital work streams to Programme Board (L2) • NHSE Deep-dive into cancer work stream (L3) - Review of trust worksteam leads and internal governacne structure April 2019	• NHSE Deep-dive into cancer work stream (L3)		
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**		
• Scope for accelerated development of STP and its governance arrangements • Need for external resource to develop STP to ICS	Oversight of the workstreams at local 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:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete

i) Ensure effective involvement with all workstreams and monthly reporting to Strategic Programme Board and Executive Committee	Director of Strategy	on going	Monthly reportss provided to Strategic programme Board and Executive. STP Pathology Procurement in progress with the service specification. Executive and clinical engagement.	In progress
ii) Monitor and actively participate in STP programme to develop ICS	Chief Executive and Chair	on going	Consider ICS Exec/Board development session	In progress
iii) Arrange Board development session on ICS - addressing contractual and legal risks and issue	Chair, Director of Strategy, Associate Director of Corporate Governance	schedule for 2019	as above	Not yet started
iv)				
Summary Narrative:				

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

Strategic Aim:	**Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term** **Quality: To deliver high quality, compassionate services, consistently across all our sites**				
Strategic Objective:	**Improve and sustain delivery of operational performance** **Design, develop, launch and embed the Quality Strategy** **Meet our financial obligations**	**Source of Risk:**	Strategic Objectives External reviews	**BAF REF No:**	**007/19**
Principal Risk Description: What could prevent the objective from being achieved? There is a risk that the governance structures in the Trust do not facilitate visibility from board to ward and appropriate performance monitoring and management to achieve the Board's objectives		**Risk Open Date:**	01.03.2018	**Executive Lead/ Risk Owner**	**Chief Executive**
		Risk Review Date:	Jul-19	**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	i) risk to delivery of performance, finance and quailty standards ii) risk of non compliance against regulations iii) risk to patient safety and experience iv) reputational risk	**Inherent Risk** (Without controls):	4	5	**20**	
		Residual/ Current Risk:	4	3	12	
		Target Risk:	4	2	8	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Monthly Board meeting/Board Development Session/ Board Committees • Annual Internal Audit Programme/ LCFS service and annual plan • Standing Financial Instructions and Standing Financial Orders • Each NED linked to a Division (from January 2018) • Commissioned external reviews • Review of external benchmarks including model hospital , CQC Insight– reports to FPC and RAQC (QSC) • Board Assurance Framework and monthly review • Performance Management Framework/Accountability Review meetings monthly • Integrated Performance Report reviewed month at Trust Board, FPC and QSC - Quailty dashboard / compliance dashboard CQC steering group and action plan 2019/20 action plan to deliver the Trust strategy -Stretegic programme board and trsut board monitoring	• Commissioned external reviews – PwC Governance Review September 2017 NHSI review of Board and its committees 2019 • Visibility of Corporate risks and BAF as Board Committees and Board (L2) • Internal Audits delivered against plan, outcomes report to Audit Committee • Annual review of SFI/SFOs (L3) • Annual review of board committee effectiveness and terms of reference (May-July) (L3) • PwC Governance review and action plan closed (included well led assessment) (L3) • Annual governance statement (L3) • Counter fraud annual assessment and plan (L3) • Annual self-assessment on licence conditions FT4 (L3) • CQC Inspection report July 2018 –(overall requires improvement) and actions plan to address required improvements and recommendations (L3 -/+) • Use of resources report July 2018 – requires improvement (L3 _/+) • September 2018 Progress report on CQC actions and section 29a (L2 +) to CQC & Quality Improvement Board • Annual review of RAQC to Board (L2 +) • Internal Audit Report – Assurance and Risk Management (- reasonable assurance (L3) • Board development session on Risk and Risk Appetite, Feb 2019 • Internal Audit – Performance Framework report - reasonable assurance March 19) - Internal Audits 2019/20 scheduled for Data Quailty; Divisional Governance;	Internal Audit report - risk management , performance framework, IG 2019 NHSI Infection control review - green - June 2019 Review of progress with QTP workstreams with NHSI/CCG - June 2019.		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
Effectiveness of goverancne structures at ward to Divisional level • Fully embedding Performance Management Framework/Accountability Framework • Implementation of Internal Audit Recommendations • NHSI Undertaking January 2019 / CQC section 29a warning - surgery and QEII UCC	• Embedded risk management - CRR and BAF • Embedding effective use of the Integrated performance report • Evidence of timely implementation of audit actions • Consistency in the effectiveness of the governance structure's at all levels • Capacity to ensure proactive approach to compliance and assurance • Oversight of GIRFT programme and other exteranl reviews and follow up	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Monitor delivery of Risk Management implementaion plan 2019/20 including risk appetite	Associate Director of Corporate Governance / Risk Manager	ongoing	Monthly reports to Board committees	In progress
ii) Review of well led compliance and implement recommendations from NHSI Board and Committee observations to strenghten Board governance	Associate Director of Corportate Governance	Sep-19	Board development session in April commenced review of well -led. Follow up session scheduled for June 2019. Continue to review workforce matters, and reviewing DEC/Executive Committees	In progress
iii) Complete recruiment into revised corporate and quailty and safety structures and substantive Executive Director posts	Associate Director of Corportate Governance / Director of Nursing	Jul-19	One current vacancy in corporate goverance team; DPO to be advertised in July. Final QI posts in process of recruitment	In progress
iv) Review and develop a 'business as usual' programme of compliance / quality and safety reviews	Associate Director of Corportate Governance / Director of Nursing	Oct-19	Review of self assessment frameworks and mock inspeciton paperwork in progress with current programme	In progress
v) Review implementation of Trust clinical strategy and enabling strategies	Director of Strategy		Reports to the Board and Board committees scheduled	
vi) Review effectiveness of governance at a Divisional level	Associate Director of Corportate Governance	Jan-19	Internal Audit scheduled. ARM reflections.	
v) Implementation of project plan for CQC Inspection and Use of Resources Inspection	Associate Director of Corportate Governance / Director of Nursing	Aug-19	In progress with weekly reporting to Executive Committee. Inspections anticipated for July - Sept 19. CQC focus groups being promoted (3-5 July) .	In progress

Summary Narrative:				

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

Strategic Aim:	**Quality: To deliver high quality, compassionate services, consistently across all our sites**				
Strategic Objective:	**Design, develop, launch and embed the Quality Strategy**	**Source of Risk:**	Strategic Objective CQC Inspection	**BAF REF No:**	008/19 (previously 011/18)
Principal Risk Decription: What could prevent the objective from being achieved?There is a risk that the Trust is not always able to consistently embed of a safety culture and evidence of continuous quality improvement and patient experience		**Risk Open Date:**	01/03/2018	**Executive Lead/ Risk Owner**	**Director of Nursing /Medical Director**
		Risk Review Date:	Jul-19	**Lead Committee:**	**QSC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Lack of consistant approach to quality improvement ii)Limited staff engagement iii) Inconsistent ward to board governance structures and systems	i) Limited learning from incidents ii) Impact of patient safety / patient expereince iii) impact on reputation iv) increased regulatory scruitny	**Inherent Risk** (Without controls):	5	4	20	⇕ ⇔
		Residual/ Current Risk:	5	3	15	⇔
		Target Risk:	5	2	10	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Clinical effectiveness committee / Patient Safety Committee/ Patient Experience Committee • Quality Improvement Board • Accountability Framework • CQC Engagement meeting • Increased Director presence in clinical areas • SIs and Learning from death investigations • Monthly patient safety newsletter • Bi-weekly IPC improvement board • Strengthened TIPCC membership and ToRs • Quality and safety visits • Safety huddles • Policies and procedures • New Quality Manager posts in each division • Weekly review meetings of CQC improvement plans • Clinical Harm Review Panel (Weekly)	• Reports to QSC (L2) • Quality review meetings with CCG (L2) • Divisional Performance Meetings (L2) • Clinical effectiveness/ Patient Safety/Patient Experience Committee reports (L2) • Monitoring of new to follow up ratios through OPD steering group and access meetings(L2) • Peer Reviews (L3) • Audit Programme (internal and external) (L3) • Quality Transformation Programme reports and deep dives to QSC • CQC Inspection report July 2018 –(overall requires improvement) and actions plan to address required improvements and recommendations (L3) • NHSI Infection control review December 2018 - green (L3) • Quality Dashboard / Compliance dashboard Internal Audit scheduled 2019/20 - QTP, deteriorating patient, 7 day services	NHSI Infection control review June 2019 - Green		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
• National guidance and GIRFT Gap analysis identifies areas for improvement • Consistency with procurement and engagement with clinicians • Patient safety team capacity • Gaps in compliance with IPC Hygiene Code leading to C-difficile outbreak in April 2018 and MRSA bacteraemia in May 2018 • Gap in compliance with CQC standards warning notice section 29A – Surgery Lister and UCC QEII - NHSI undertaking	• Consistency in following care bundles • Implementation of action plans • Embedding of learning from SIs/Learning from Deaths • Data quality • Inconsistent audit and monitoring programme • Delivery against CQC improvement plan	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	Lead:	Due date	Progress Update	Status: Not yet Started/In Progress/ Complete
i) Delivery of the QTP implementation programme against plan	Associate Director of Quailty Improvement	ongoing	Progress / deep dive reports to QSC	In progress
ii) Delivery and monitoring of CQC improvement plans for Surgery Lister and UCC QEII and other core pathways	Associate Director of Corporate Governance / Director of Nursing	Jul-19		In progress
iii) Launch and implementation of the quailty strategy with communication plan	Director of Nursing / Medical Director	ongoing	Launched event held in May 2019, supported with the Trust conversation session in June 2019. first learning trust wide event held 21 June	In progress
iv)• Complete Gap analysis on GIRFT reports and develop and monitor action plans	Medical Director	ongoing		In progress
iv) Implement 7 day services plan	Medical Director	ongoing	Report to QSC June 2019	In progress
Summary Narrative:				

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

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

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

Principal Risk Decription: What could prevent the objective from being achieved?
There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered and motivated, impacting on the trust's ability to deliver the required improvements and transformation and to enable people to feel proud to work here.

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Poor staff engagement ii) structures, systems and processes do not support raising concerns iii) staff do not feel empowered to effect change	i) Failure to implement a learning culture ii) Opportunities for improvement missed iii) Quality and Safety Improvement culture is not achieved iv) limited engagement in service change vi) concerns are not raised	**Inherent Risk** (Without controls):	4	4	16	⇔
		Residual/ Current Risk:	4	4	16	
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• LMCDP Leadership, Management and Coaching Development Pathway • LEND Sessions • Organisational Values (PIVOT) / Leadership Behaviours (LEND) • Health and Well Being Strategy • Dedicated Associate Director of Leadership and Change • HR Policies including Raising Concerns Policy • ERAS teams and Freedom to Speak Up Guardian • People Strategy • Staff Experience Workshops were launched in April 2018 - Equailty and diversity lead and forums - Dignity at work policy Talent Management Lead in post	• Workforce reports (includes culture) to QSC, FPC, Board (L2) • LEND sessions quarterly (L1) • LMCDP evaluation • FFT (L1) – Improved position June 2018 – 49% rec place to work/ rec for care 74% • Raising Concerns report to Audit Committee and Board (L2) • Workshops – face to face and online (L1) • Review of Insight and Model Hospital • Board Development session July 2018 – (culture) • NHS Annual Staff Survey and other local monthly survey reports - FPC / Board - report on Talent Management June 2019 - Planned IA on Raising concerns in 2019/20 - Promotion of freedom to speak up guardian activites commenced			

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
• Culture change approach • • Senior leadership training • Senior leadership programme People Strategy,Talent Management Strategy and Education Strategy all under review/ development	• Review outcomes of the actions being taken • Lack of resources to respond within necessary time period • Completion of staff survey action plans	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Review of LEND and leadership behaviours in a challenging environment	Chief People Officer	on going	Summer LEND sessions commenced	In progress

ii) Increased visibility of Senior Leadership Team (Divisional, Executive and Board)	Chief People Officer	on going	Trust conversation and new Friday standup commenced	In progress
iii) Implement action plan following staff survey feedback	Chief People Officer	on going	All divisions have a local plan.	In progress
iv) Develop and implement talent management strategy	Chief People Officer		Review of talent management strategy and leadership strategy with People strategy scheduled.	In progress
v)Review of Communication strategy	Head of Communications	Jun-19		In progress
vi) Staff survey/engagement workshop and assocated actions	Chief People Officer	May-19		In progress
Summary Narrative:				

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

Strategic Aim:	**Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term which retains staff, recruits the best and develops an engaged, flexible and skilled workforce**				**People: To create an environment**
Strategic Objective:	**Improve and sustain delivery of operational performance** **Develop, support, engage and transform our workforce to provide quality services**		**Source of Risk:**		**BAF REF No:** **010/19 (previously 013/18)**
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the Trust is adversely affected by the United Kingdom's departure from the European Union, particularly in the event of no deal being secured.			**Risk Open Date:**	19.09.18	**Executive Lead/ Risk Owner** **Director of Strategy**
			Risk Review Date:	Jul-19	**Lead Committee:** **FPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) UK decision to leave the EU ii)	i) Risk to supply of goods, services, medicines to the UK from EU ii) Risk to recruitment and retention of EU Nationals	**Inherent Risk** (Without controls):	4	4	**16**	⇔
		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**
• EPRR Committee, will lead on the business continuity arrangements, reviewing existing plans to ensure they respond to the possibility of a 'no-deal' Brexit. • Reivew of national guidance - 23rd August SoS guidance and five technical notices published by UK Government and 21st December including action card for providers • Overseas recruitment mostly from outside Europe. • group in place in January to drive progress reporting to DEC/Executive Committee Communitaions to staff from European countries outside the UK. Link to STP EU Herts Strategy Control Group	• Regular reports to Executive Committee/DEC, FPC and the Board of Directors (L2) • NHSE check and challenge session on EPRR core standards including Brexit Preparedness (L3) • Paper to Board on 9th January 2019 and monthly til May 2019	• NHSE check and challenge session on EPRR core standards including Brexit Preparedness , 2018 (L3)		
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**		
Absence of clear deal in place between UK and EU post 29th march 2019 Nationally DoH unable to provide assurance from other companies in meeting their requirements.		Green	Effective control is in place and Board satisfied that appropriate assurances are available	
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient	
		Red	Effective controls may not be in place and assurances are not available to the Board.	

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Review of technical notices/ advice as it is published by the Government / NHSI/NHS Providers	Strategy Project lead	Ongoing	No outstanding guidances	In progress
ii) Continue monthly oversight group and escalation reports	Director of Strategy	Ongoing	Continue to meet monthly. Will return to weekly when required. All workstreams represented.	In progress

iii) Recruitment strategy implementation	CPO	ongoing	International and local recruitment campaigns	In progress
iv)				
Summary Narrative:				
July 2019: Workstream on hold pending further national guidance and plans.				

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

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

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) 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 assurance that routine maintainace ii) risk of regulatory intervention iii) poor patient experience iv) potiental staff and patient safety risks	**Inherent Risk** (Without controls):	5	5	25	Under review
		Residual/ Current Risk:	5	4	20	
		Target Risk:	5	2	10	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
Fire Policy and Procedures Training – mandatory awareness training and fire wardens Ward based evaluation training for Sisters completed December 2018. Communication Plan Fire Compliance meeting (monthly). Detailed Action Plan in place to address the recommendations of the 2 Fire AE reports, broken down into weekly tasks. Capital funding to make the necessary changes to the Estate to ensure compliance with guidance and fire compliance. . Capital funding to make the necessary changes to the Estate to ensure compliance with guidance and fire compliance. Revenue funding to fund improvements. Detailed Action Plan in place to address the gaps in Estates & Facilities Compliance. Interim Fire Safety Officer in post from 11 Feb 2019 Reports to Health and Safety Committee Weekly environmental audits Water safety group and action plan	Authorised Engineers report 2018. (L3 –ve) Annual fire report to Quality & Safety Committee. Papers to Executive Committee / Quality & Safety Committee. Audits of high risk areas on Lister site Works completed on wards 10/11 MVCC 2018 Desktop Fire evacuation exercise carried out December 2018.(lister) Ward evacuation plans displayed in each ward and checked. January 2019 New Monthly Fire Safety Committee established March 2019 – includes representation from other sites – reports to H&SC and QSC PLACE reviews Internal audit of estates and facilities compliance scheduled for Q3/4			

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
Ineffective estates and facilities governacne structures Estate strategy due for renewal Lack of capital funding to bring the Lister and other sites to compliance Lack of revenue funding for training Fire risk assessments and actions due for Fire Safety Officer review Actions identified from Fire desktop review Confirmation all AO's now in post and visibilty of work programme Gaps in ongoing assurance on water safety identified	Full implementation of the Fire Strategy Effective Estates and facilities governance structures Limited assurance from other sites trust operates from Visiibility of AE reports and actions	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	Lead:	Due date	Progress Update	Status: Not yet Started/In Progress/ Complete
i) Review and implement revised estates and facilities governance and reporting structure	Director of Estatesand Facilities	Sep-19	Paper presented to QSC in June 2019 outlining key workstreams.	In progress
ii) Continue to Implement fire strategy , new training plan and actions from external recommendations	Head of Safety and Securtiy / Fire Officer	monthly review	With the exeception of the renal satellites -All fire risk assessments now reviewed and actions are being taken to address /mitigate the risks and to inform future capital and maintainance works required - this will be risk assessment and prioritised. Some capital works approved for 2019/20	In progress
iii) Review of Estates Strategy	Director of Estatesand Facilities		on hold until new estates and facilities director in post	In progress
iv) review and implement mechanisms to ensure Estates, Facilities and Fire complaince assurance is received from partner organisations where trust operates from	Director of Estates and Facilities		Paper presented to QSC in June 2019 outlining key workstreams. Trust risk assessments have been shared with the relvant partners	In progress
iv) Substantive recuitment into leadership structure and other vacancies	Director of Estates and Facilities		Recuitment of new substanivve Director of Estates and Facilities in progress. Recruitment and retention rates agreed by Executive committee in line with the region.	In progress
v) Work with STP partners to ensure STP Estate Strategy reflects Trust priorities	Director of Estates and Facilities			
Summary Narrative:				
July 2019: This risk is currently under review taking into account the new emerging non compliance issues, capactiy and skills within the team and awaiting to secure the permanent Director of Estates and Facilities.				

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

Strategic Aim:	**Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term** **Quality: To deliver high quality, compassionate services, consistently across all our sites**
Strategic Objective:	**Improve and sustain delivery of operational performance** **Seek innovative STP-wide solutions to address clinically and financially unsustainable services**

Source of Risk:	Clinical Strategy, Operating Plan	**BAF REF No:**	**012/19**
Risk Open Date:	01.03.18	**Executive Lead/ Risk Owner**	**Director of Strategy**
Risk Review Date:	Jul-19	**Lead Committee:**	**FPC**

Principal Risk Decription: What could prevent the objective from being achieved?
There is a risk that the Trust is not able to secure the long-term future of the MVCC

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Trust does not own the site - owned by HHT ii) Lack of available capital resources iii) Complex model - non surgical cancer centre	i) Lack of control over strategic and specific estate decisions ii) Inability to provide level of capital investment required iii) Unable to sustain clinical model in the longer term iv) Recruitment and retention challenges v) Risks to complaince with regulatory requirements	**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 meetings between both Trust Chair's of HHT and ENHT MVCC Clinical Strategy in place with Clinical Strategy Implementation Group reporting to Strategic Board Trust Clinical Strategy Clinical and Academic Partnership in place with UCLH and MVCC - Board established. Mount Vernon Cancer Centre Review Programme Board Weekly Exec led MVCC co-ordination meeting on all workstreams. Escalation reporitng to Executive Committee and Board	• Regular reports to FPC and the Board of Directors (L2) • Regular reporting into the strategy Board (L2) • Reporting to the Board of Directors on the progress of the UCLH/MVCC partnership (L2) Capacity and demand modelling	CHKS review July 2018 Strategic review and recommendations from clinical advisory planel re MVCC, July 2019		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
i) HHT has no long term plan for the MVCC site ii) Availability of finding for capital equipment replacement and refurbishment programmes	i) Fitness for purpose of some of the accomodation in the old building ii) Specialist Commissioners Long term planning	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) SLA for Estates and Facilities at MVCC with Hillingdon	Contracting team & Divisional Director	Remains under review		In progress
ii) Development of a lease with Hillingdon for MVCC	Director of Finance	Remains under review		In progress
iii) Executive meetings with MVCC Divisional leadership on the key risk areas and linking with stakeholders and partners	Executive Lead and Divisional Director	Weekly	Weekly group established with all workstream leads, division and executve leads represented. Escalation to Executive committee.	In progress

iv) Specialist commissioners modelling activity for equipment replacement programme	Director of Strategy / COO	Review September	LA1- 12 month extension for LA1 agreed with suppliers and commissioner. Longer term review with be devlivered in Q3 as part of MVCC forward plan. Aseptic - weekly project team. Procument fir dose banded to commence. Options for non doase banded being explored by project team and continued requirement to support the services.	in progress
v) Implement joint estates forum with HHT	Director of Eastates and Facilities	Jun-19	First meeting to be held 26 June 2019	in progress
vi) MVCC strategy implementation groups	Divisional Chair	6 monthly review	Reported to Strategy Board in June - delivery of year one objectives. Continue to work with partners. Objectives for 2019/20 agreed.	In progress
v) Develop a comprehensive action plan to deliver the recommendations from the Specialist Commissioners review.	Head of Business Development / Director of Strategy	Sep-19		in progress
Summary Narrative:				

Board Annual Cycle 2019-20

A formal Trust Board meeting is held on alternate months with Board Development sessions held in the month in-between.

Items	*Apr 2019	May 2019	*Jun 2019	Jul 2019	Aug 2019	Sep 2019	*Oct 2018	Nov 2019	*Dec 2019	Jan 2020	*Feb 2020	Mar 2020
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 or Part 2 depending on the nature of the report)		x		x		x		x		x		x
Suspensions (Part 2)		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 and Performance Committee Report		x		x		x		x		x		x
Quality and Safety Committee Report		x		x		x		x		x		x
Strategic												
Annual Operating Plan and objectives *(subject to change as dependent on national timeline)*												**x (TBC)**
Strategy Highlight Report				x		x		x		x		x
Division Progress on Strategic Clinical Priorities (Part 2)		**X (2020)**				x		x				x
Strategy Deep Dives (Part 2)						**x Cancer**		**x Medicine and Surgery**		**x Women and Children's and CSS**		**TBC**

Board Annual Cycle 2019-20

Items	*Apr 2019	May 2019	*Jun 2019	Jul 2019	Aug 2019	Sep 2019	*Oct 2018	Nov 2019	*Dec 2019	Jan 2020	*Feb 2020	Mar 2020
Sustainability and Transformation Plan (STP) (Part 2)		x		x		x		x		x		x
Other Items												
Audit Committee												
Annual Report and Accounts, Annual Governance Statement and External Auditor's Report		x ***(Late May Audit Committee)***										
Annual Audit Letter						x						
Audit Committee TOR and Annual Report						**X – deferred to Nov**		X				
Raising Concerns at Work Report				x								
Review of Trust Standing Orders and Standing Financial Instructions								x				
Charity Trustee Committee												
Charity Annual Accounts and Report								x				
Charity Trust TOR and Annual Committee Review						**X – deferred to Nov**		X				
Finance and Performance Committee												
Finance Update (Part 2)		x		x		x		x		x		x
FPC TOR and Annual Report						**X – deferred to Nov**		X				
Digital Strategy Update (Part 2)		x		x		x		x		x		x
Market Strategy Review (TBC with Acting Director of Strategy)												x

Board Annual Cycle 2019-20

Items	*Apr 2019	May 2019	*Jun 2019	Jul 2019	Aug 2019	Sep 2019	*Oct 2018	Nov 2019	*Dec 2019	Jan 2020	*Feb 2020	Mar 2020
Quality and Safety Committee												
Complaints, PALS and Patient Experience Report						x						x
Safeguarding and L.D. Annual Report (Adult and Children)				x								
Detailed Analysis of Staff Survey Results												x
Equality and Diversity Annual Report and WRES						x						
Gender Pay Gap Report												x
Learning from Deaths		x		x				x		x		
Nursing Establishment Review				x						x		
Responsible Officer Annual Review						x						
Patient Safety and Incident Report (Part 2)		x				x		x		x		
University Status Annual Report												x
QSC TOR and Annual Review						**X – deferred to Nov**		x				
Shareholder / Formal Contracts												
ENH Pharma (Part 2) [i]		x						x				

[i] To include the Annual Governance Review in November

*Please note Board Development sessions will be held on the 'even' months. This will support flexibility for the Board to be able to be convened for an extraordinary meeting if an urgent decision is required. However, forward agenda planning will aim to minimise this.

The Board Annual Cycle will continue to be reviewed in-year in line with best practice and any changes to national scheduling. The annual cycle will also be updated to reflect any changes that might be agreed in relation to the QSC and FPC annual cycles which are currently under review.

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

Agenda item: 12

EAST AND NORTH HERTFORDSHIRE NHS TRUST
PUBLIC TRUST BOARD ACTIONS LOG TO 4 SEPTEMBER 2019 MEETING

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date

No outstanding actions

DATA PACK

Contents

1. Data and Exception Reports:

FFT

Friends and Family Test - July 2019

APPENDIX 2

Inpatients & Day Case	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely nor Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses	No. of Discharges	Total % response rate
5A	90.70	0.00	19	20	3	0	0	1	43	123	34.96
5B	100.00	0.00	32	7	0	0	0	0	39	65	60.00
7B	91.38	1.72	66	40	6	0	2	2	116	171	67.84
8A	94.74	1.75	33	21	1	0	1	1	57	66	86.36
8B	94.92	3.39	41	15	1	1	1	0	59	114	51.75
11B	96.00	0.00	45	27	3	0	0	0	75	157	47.77
Swift	97.73	0.00	63	23	0	0	0	2	88	206	42.72
ITU/HDU	100.00	0.00	6	0	0	0	0	0	6	8	75.00
Day Surgery Centre, Lister	98.74	1.26	183	52	0	0	3	0	238	481	49.48
Day Surgery Treatment Centre	98.58	0.94	180	29	0	0	2	1	212	542	39.11
Endoscopy, Lister	99.27	0.24	368	40	2	0	1	0	411	1061	38.74
Endoscopy, QEII	98.43	1.57	116	9	0	0	2	0	127	411	30.90
SURGERY TOTAL	97.55	0.88	**1152**	**283**	**16**	**1**	**12**	**7**	**1471**	**3405**	43.20
SSU	86.67	6.67	9	4	1	1	0	0	15	187	8.02
AMU - Blue	100.00	0.00	23	3	0	0	0	0	26	117	41.03
AMU - Green	95.45	0.00	18	3	1	0	0	0	22		
Pirton	97.87	0.00	41	5	0	0	0	1	47	47	100.00
Barley	100.00	0.00	23	4	0	0	0	0	27	71	38.03
6A	96.00	0.00	36	12	2	0	0	0	50	89	56.18
6B	95.65	4.35	18	4	0	1	0	0	23	58	39.66
11A	100.00	0.00	65	32	0	0	0	0	97	103	100.00
11A RSU	100.00	0.00	4	2	0	0	0	0	6		
ACU	100.00	0.00	33	3	0	0	0	0	36	112	32.14
10B	100.00	0.00	17	6	0	0	0	0	23	73	31.51
Ashwell	100.00	0.00	15	5	0	0	0	0	20	47	42.55
9B	100.00	0.00	43	17	0	0	0	0	60	60	100.00
9A	100.00	0.00	32	1	0	0	0	0	33	39	84.62
Cardiac Suite	100.00	0.00	89	7	0	0	0	0	96	142	67.61
MEDICINE TOTAL	98.80	0.34	**466**	**108**	**4**	**2**	**0**	**1**	**581**	**1145**	50.74
10AN Gynae	96.83	3.17	42	19	0	1	1	0	63	99	63.64
Bluebell ward	97.53	0.00	50	29	2	0	0	0	81	129	62.79
Bluebell day case	100.00	0.00	0	1	0	0	0	0	1	2	50.00
Neonatal Unit	100.00	0.00	36	1	0	0	0	0	37	95	38.95
WOMEN'S/CHILDREN TOTAL	97.80	1.10	**128**	**50**	**2**	**1**	**1**	**0**	**182**	**325**	56.00
MVCC 10 & 11	93.10	3.45	25	2	1	1	0	0	29	105	27.62
CANCER TOTAL	93.10	3.45	**25**	**2**	**1**	**1**	**0**	**0**	29	**105**	27.62
TOTAL TRUST	97.83	0.80	**1771**	**443**	**23**	**5**	**13**	**8**	**2263**	**4980**	45.44

Continued over …..

Inpatients/Day by site	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses	No. of Discharges	Total % response rate
Lister	97.86	0.71	1630	432	22	4	11	8	2107	4464	47.20
QEII	98.43	1.57	116	9	0	0	2	0	127	411	30.90
Mount Vernon	93.10	3.45	25	2	1	1	0	0	29	105	27.62
TOTAL TRUST	97.83	0.80	**1771**	**443**	**23**	**5**	**13**	**8**	**2263**	**4980**	45.44

Accident & Emergency	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses	No. of Discharges	Total % response rate
Lister A&E/Assessment	86.11	4.96	234	200	35	14	11	10	504	11200	4.50
QEII UCC	74.17	18.33	69	20	8	7	15	1	120	3856	3.11
A&E TOTAL	83.81	7.53	**303**	**220**	**43**	**21**	**26**	**11**	**624**	**15056**	4.14

Maternity	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses	No. of Discharges	Total % response rate
Antenatal	100.00	0.00	5	1	0	0	0	0	6	440	1.36
Birth	96.52	0.87	77	34	3	0	1	0	115	470	24.47
Postnatal	92.17	0.87	67	39	7	0	1	1	115	470	24.47
Community Midwifery	100.00	0.00	3	0	0	0	0	0	3	598	0.50
MATERNITY TOTAL	94.56	0.84	**152**	**74**	**10**	**0**	**2**	**1**	**239**	**1978**	12.08

Outpatients	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses
Lister	95.31	1.48	569	204	20	3	9	6	811
QEII	95.61	1.44	1141	319	36	9	13	9	1527
Hertford County	94.00	1.50	600	278	27	8	6	15	934
Mount Vernon CC	98.09	0.00	219	38	4	0	0	1	262
Satellite Dialysis	98.73	0.00	67	11	1	0	0	0	79
OUTPATIENTS TOTAL	95.38	1.33	**2596**	**850**	**88**	**20**	**28**	**31**	**3613**

Trust Targets	% Would recommend	% response rate
Inpatients/Day Case	96%>	40%>
A&E	90%>	10%>
Maternity (combined)	93%>	30%>
Outpatients	95%>	N/A

2. Performance Data:

CQC Outcomes Summary

Our CQC Registration and recent Care Quality Commission Inspection

The Care Quality Commission inspected nine of the core services provided by East and North Hertfordshire NHS trust across Lister Hospital, the Queen Elizabeth II (QEII) Hospital and Mount Vernon Cancer Centre, between 20 and 22 March 2018. The returned on 2 April 2018 for an unannounced, follow-up inspection of the surgery core service at Lister Hospital. The well led inspection took place from 23 to 25 April 2018. The Use of Resources inspection, which is led by NHS Improvement took place on 11 April 2018.

At **Lister Hospital** CQC inspected:

- Urgent and emergency care
- Surgery
- Medicine
- Maternity
- Services for children and young people at Lister Hospital.

At the **QEII Hospital** CQC inspected:
- Urgent Care Centre

At the **Mount Vernon Cancer Centre** CQC inspected:
- Medicine
- Chemotherapy
- End of Life Care

At the October 2015 inspection, these core services were rated either as inadequate or requires improvement, apart from surgery, which was rated as good overall.

Summary of the Trust's Ratings

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

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement → ← Jul 2018	Requires improvement → ← Jul 2018	Good → ← Jul 2018	Requires improvement → ← Jul 2018	Requires improvement → ← Jul 2018	Requires improvement → ← Jul 2018

	Safe	Effective	Caring	Responsive	Well-led	Overall
Lister Hospital	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Good ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018
Queen Elizabeth II Hospital	Inadequate ➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Good ➔➔ Jul 2018	Good ➔➔ Jul 2018	Inadequate ➔ Jul 2018	Inadequate ➔ Jul 2018
Mount Vernon Cancer Centre	Requires improvement ➔ Jul 2018	Good ➔➔ Jul 2018	Good ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018
Hertford County Hospital	Good Mar 2016	N/A	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Overall trust	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Good ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Good ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018
Community	Good Mar 2016	Good Mar 2016	Outstanding Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Overall trust	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Good ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018

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 2008 (Regulated Activities), Regulations 2010 Cleanliness and infection control
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing
- Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

An action plan has been developed against all of these and was submitted to CQC on 24 August 2018. This will be monitored by the Quality Improvement Board, chaired by the Medical Director or Director of Nursing and reported to Board through the Quality and Safety Committee. A programme of internal and external inspections is in place to test and evidence progress and that the actions are embedded across the organisation.

Site Ratings

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 →←	Good July 2018 ↑	Good July 2018 →←	Good July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←
Surgery	Inadequate July 2018 ↓↓	Requires Improvement July 2018 ↓	Good July 2018 →←	Inadequate July 2018 ↓↓	Inadequate July 2018 ↓↓	Inadequate July 2018 ↓↓
Critical care	Good March 2016	Good March 2016	Good March 2016	Good March 2016	Requires Improvement March 2016	Good March 2016
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 July 2018 →←	Good July 2018 ↑	Good July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←
End of life care	Good March 2016	Requires Improvement March 2016	Good March 2016	Good March 2016	Requires Improvement March 2016	Requires Improvement March 2016
Outpatients	Good March 2016	N/A	Good March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Good July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←

New QEII Hospital

Urgent and emergency services	Inadequate July 2018 ↓	Requires Improvement July 2018 →←	Good July 2018 →←	Good July 2018 →←	Inadequate July 2018 ↓	Inadequate July 2018 ↓
Outpatients and diagnostic imaging	Good March 2016	N/A	Good March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Inadequate July 2018 ↓	Requires Improvement July 2018 →←	Good July 2018 →←	Good July 2018 →←	Inadequate July 2018 ↓	Inadequate July 2018 ↓

Hertford County Hospital

Outpatients	Good March 2016	N/A	Good March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Good March 2016	N/A	Good March 2016	Good March 2016	Good March 2016	Good March 2016

Mount Vernon Cancer Centre

Medical care (including older people's care)	Requires Improvement July 2018 ↑	Good July 2018 ↑	Good July 2018 →←	Requires Improvement July 2018 ↑	Requires Improvement July 2018 →←	Requires Improvement July 2018 ↑
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 March 2016	Good March 2016	Good March 2016	Requires Improvement March 2016	Good March 2016	Good March 2016
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 March 2016	Good March 2016	Good March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Requires Improvement July 2018 ↑	Good July 2018 →←	Good July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←

Community Health Services for Children, Young People and Families

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

3. Quality and Safety Committee Reports:

Safer Staffing

1.0 Introduction

Whilst there is no single definition of 'safe staffing', NHS constitution, NHS England, CQC regulations, NICE guidelines, NQB expectations, and NHS Improvement resources all make reference to the need for NHS services to be provided with sufficient staff to provide patient care safely. NHS England cites the provision of an *"appropriate number and mix of clinical professionals"* as being vital to the delivery of quality care and in keeping patients safe from avoidable harm. (NHS England 2015)
East and North Hertfordshire NHS Trust is committed to ensuring that levels of nursing staff, which includes Registered Nurses, Midwives, Nursing Associates and Clinical Support Workers (CSWs), match the acuity and dependency needs of patients within clinical ward areas in the Trust. This includes ensuring there is an appropriate level and skill mix of nursing staff to provide safe and effective care using evidence based tools and professional judgement to support decisions. The National Quality Board (NQB 2016) recommend that on a monthly basis, actual staffing data is compared with expected staffing and reviewed alongside quality of care, patient safety, and patient and staff experience data. The trust is committed to ensuring that improvements are learned from and celebrated, and areas of emerging concern are identified and addressed promptly.

2.0 People Productivity

The following sections identify the processes in place to demonstrate that the Trust proactively manages nurse staffing to support patient safety.

2.1 Nursing Fill Rate

The Trust's safer staffing submission has been submitted to NHS Digital for June within the data submission deadline. Table 1 below shows the summary of overall fill % for this month and last month and % change. The full table of fill % can be seen in Appendix 1:

There are a number of other contributory factors which affect the fill rate for June. An exception report can be found in Appendix 2 showing those wards with a Registered Fill rate below 90% and any other points of note for the month.

Table 1

	Day		Night		Average 24 Hr		
Trust Average Fill Rates	**Registered**	**Care Staff**	**Registered**	**Care Staff**	**Registered**	**Care Staff**	**All Staff**
Trust Average (Current Month)	92.6%	98.6%	97.1%	113.2%	94.7%	104.3%	98.0%
Trust Average (Last Month)	94.0%	95.9%	97.5%	111.7%	95.6%	101.8%	98.0%
Change	↓ -1.4%	↑ 2.7%	↓ -0.4%	↑ 1.5%	↓ -0.9%	↑ 2.5%	→ 0.1%

2.2 Care Hours per Patient day (CHPPD)

CHPPD is a measure of workforce deployment and is reportable to NHS Digital as part of the monthly returns for safe staffing.

CHPPD is the total number of hours worked on the roster by both Registered Nurses & Midwives and Nursing Support Staff divided by the total number of patients on the ward at 23:59 aggregated for the month (lower CHPPD equates to lower staffing numbers available to provide clinical care).

The Trust Average CHPPD for this month and last month can be seen in the table below. A full list of CHPPD by ward can be found in Appendix 3.

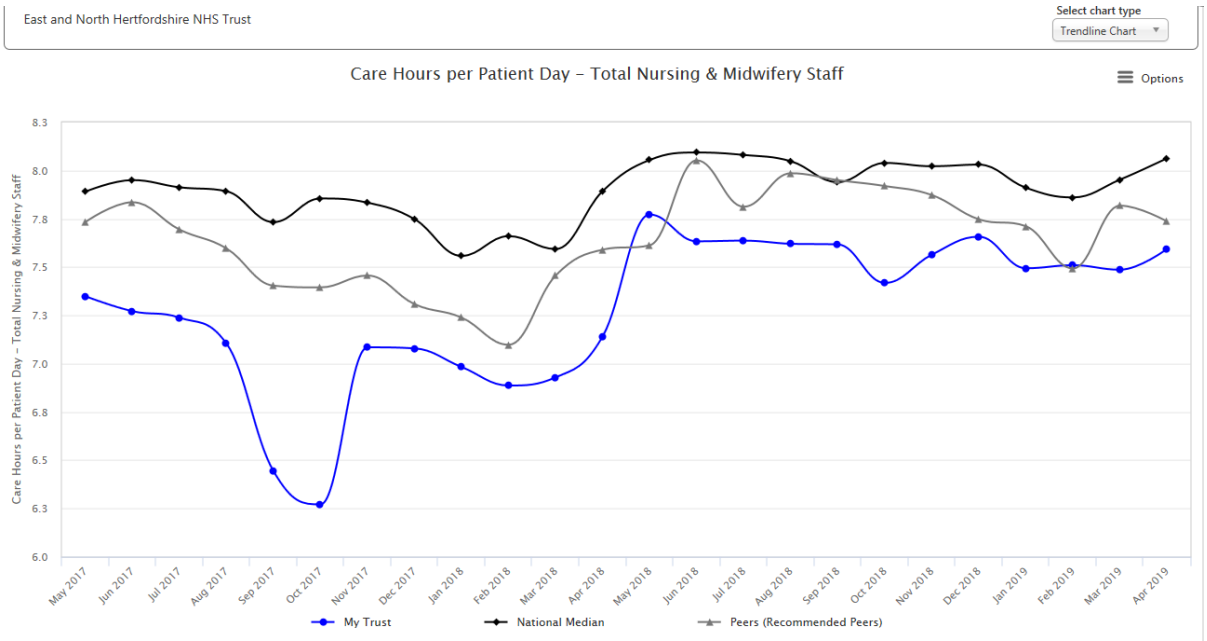
Fourteen Nursing Associates completed their registration with the Nursing & Midwifery Council in June. Thirteen ward based registered Nursing Associates have been included in the registered planned and delivered care hours in line with when they received their registrations. This has a resulted in an increase to the registered Care Hours per Patient Day.

Table 2

	Average 24 Hr		
Trust Average CHPPD	**Registered**	**Care Staff**	**All Staff**
Trust Average (Current Month)	4.7	2.8	7.5
Trust Average (Last Month)	4.4	2.8	7.3
Change	↑ 0.3	→ 0.0	↑ 0.2

The chart below shows the Trust average CHPDD alongside the National Median and our peer Trusts (as recommended by the Model Hospital dashboard). This data is reviewed at Trust and Ward level as shows that we are consistently delivering less care hours per patient day than the National Median and our Peers.

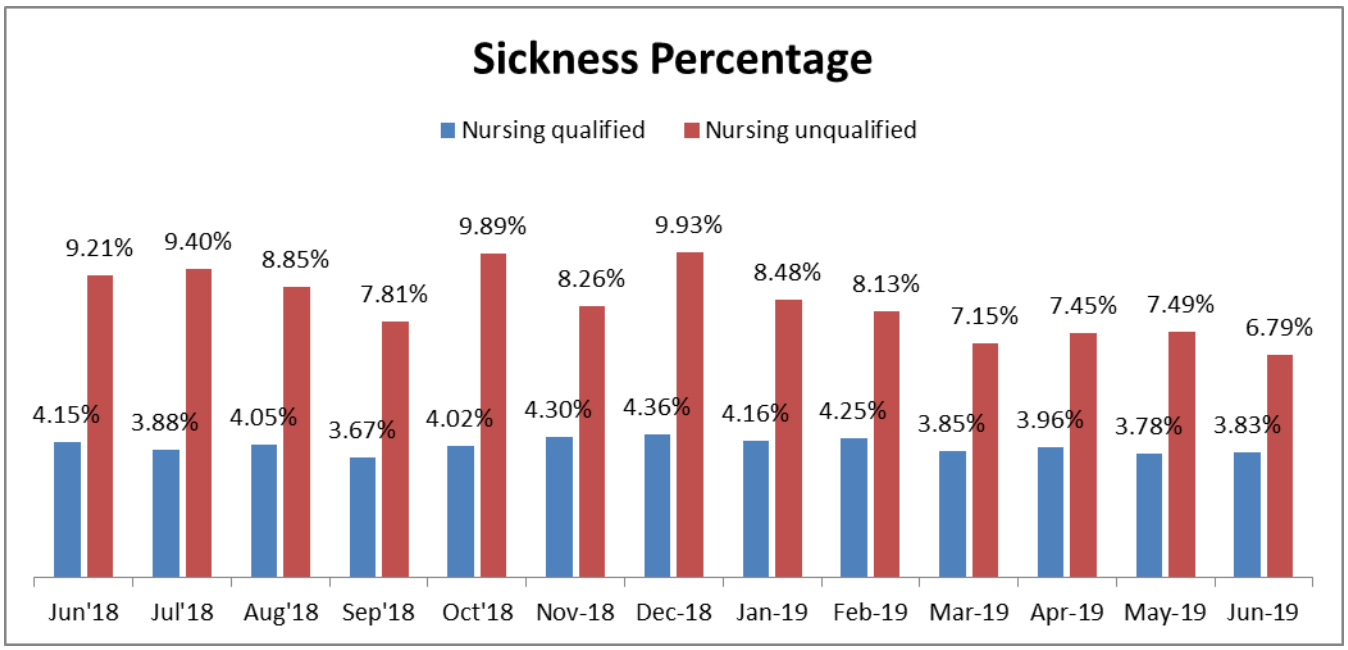
Chart 1 Care Hours per Patient Day (CHPPD): Data source Model Hospital Dashboard (latest available data).



3.3 Sickness

Chart 2 shows that sickness levels have increased for qualified and decreased for unqualified staff in June. There is ongoing work to address our above benchmark comparator sickness levels in our CSWs.

Chart 2 – Sickness Percentage by Staff Group



3.4 Enhanced Care

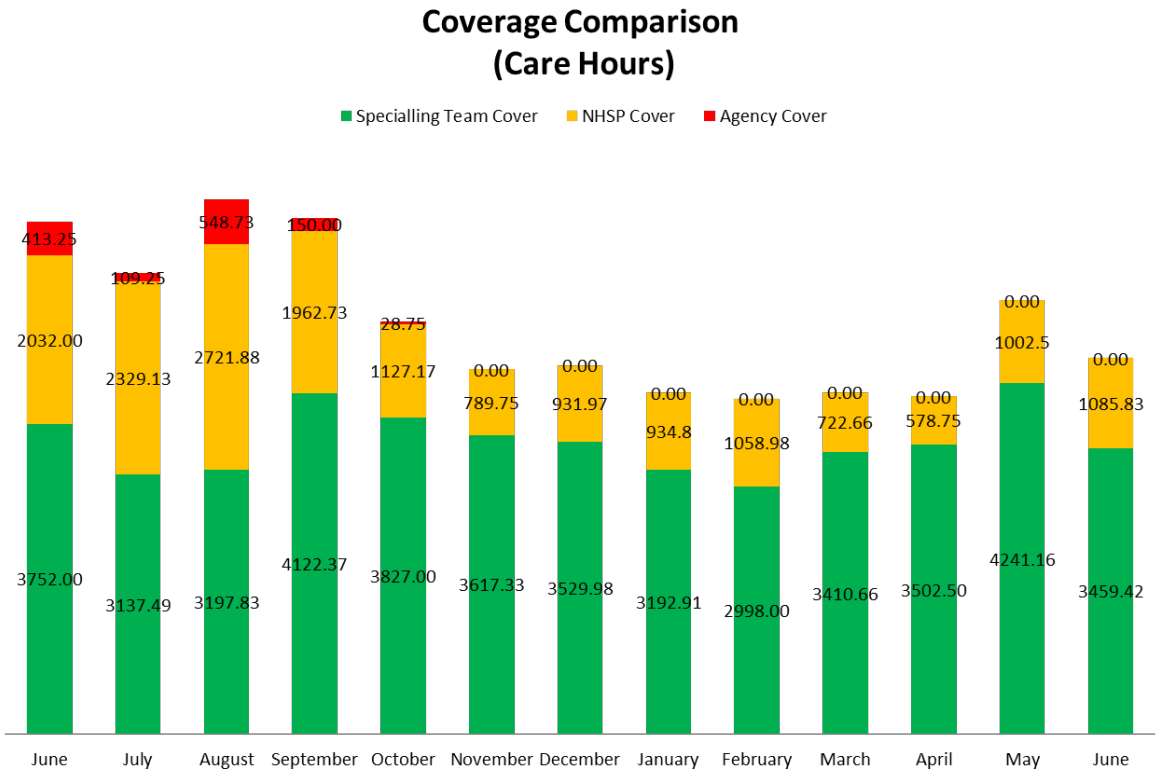
The Enhanced Nursing care team (ENCT) are a specialist substantive team who provide enhanced care, or 1-1 and are available 24 hours a day, seven days a week, ensuring that inpatients who are at risk to themselves or others are being effectively supported by specially trained staff to feel safe, secure and cared for at all times.

For the month of June 91 risk assessments were received by the team which is a decrease of 33 patients referred compared to May. Chart 3 shows that the patients referred to the team continue to remain high. The trust is seeing a higher acuity of patients and a higher number of patients requiring enhanced care support overall compared to 2017 as shown in chart 3. The team also support mental health patients who are referred by the RAID and CCAT teams that require 1-1 enhanced care. It should be noted that a number of patients requiring enhanced care are also requiring support from our security teams. For the month of June 135 additional hours have been used by the security team to manage patients displaying challenging behaviour.

The ENCT team review all risk assessed patients on a daily basis and step the level of enhanced care up or down as required to provide a streamlined flexible service. The team continue to develop the service to ensure improved patient care and outcomes. Where demand exceeds capacity the shifts will be put out to temporary staffing to cover the requirement. Chart 4 shows the breakdown of care hours provided by the ENCT, NHS Professionals. There continues to be robust check and challenge in place for all enhanced care a requirement, ensuring safe patient care is the main priority.

Chart 3

Chart 4



3.5 Recruitment and retention

The overall Trust position for qualified nursing in month 3 saw 17.4 WTE new starters and 13.6 WTE leavers, giving a positive variance of 3.8 WTE for the month. The qualified nurse trajectory currently indicates a cohort of 44.8 WTE domestic new starters in total, 17.5 of which are student midwives due to qualify and commence in month 6, and 15 student nurses who are qualifying in month 5.
In month 3 there were 16.8 WTE starters and 6.0 WTE leavers, giving a positive variance of 10.8 WTE for the month. There are a total of 35 WTE in the pipeline currently undergoing pre-employment checks, 13 with confirmed start dates in months 4 and 5.

4.0 Financial Sustainability

The Deputy Director of Nursing, all matrons, safer staffing team and heads of nursing meet monthly to prospectively review rosters to identify operational shortfalls and temporary staff requirements including agency usage/ requirements. Each ward is then RAG rated on a heat map and agency levels and restrictions agreed. Any additional ad hoc agency requirements outside of this meeting are authorised via the Director of Nursing or Deputy Director of Nursing.
Should a ward need to go above their planned agency usage a robust process is in place to be agreed by the director or deputy director of nursing.

To facilitate the reduction in agency costs, the trust have implemented a Rapid Response pool of nurses and CSWs. Bank staff get an enhanced pay rate in recognition of the workers commitment to be deployed at the time of reporting for work. The Rapid Response pool is used to mitigate daily staffing challenges such as sickness and short notice drop out to ensure wards are staffed safely.

4.1 Temporary Staffing Fill

Overall fill rate for temporary staffing increased by 0.6% from 81.3% in May to 81.9% in June. Demand hours decreased by over 5,500 hours. We continued to open additional capacity areas on the Discharge Lounge and CDU B Bay to support operational pressures daily.
Bank fill rates increased by 0.97% and Agency fill rates decreased by 0.31%. The level of unfilled shifts decreased from 18.7% in May to 18.1% in June.

Table 3 Temporary Staffing Registered and Unregistered Hours Demand and Fill Rates

Current YTD Month & Year	Net Hours Requested *	NHSP Filled Hours	% NHSP Filled Hours	Agency Filled Hours	% Agency Filled Hours	Overall Fill Rate	Unfilled Hours	% Unfilled Hours
April 2019	64,841	46,309	71.4 %	4,405	6.8 %	78.2 %	14,126	21.8 %
May 2019	67,199	49,579	73.8 %	5,036	7.5 %	81.3 %	12,584	18.7 %
June 2019	61,630	46,067	74.7 %	4,427	7.2 %	81.9 %	11,136	18.1 %
Total	**193,669**	**141,955**	**73.3 %**	**13,869**	**7.2 %**	**80.5 %**	**37,846**	**19.5 %**

Chart 5 Nursing and Midwifery Temporary Staffing Demand and Fill Rates

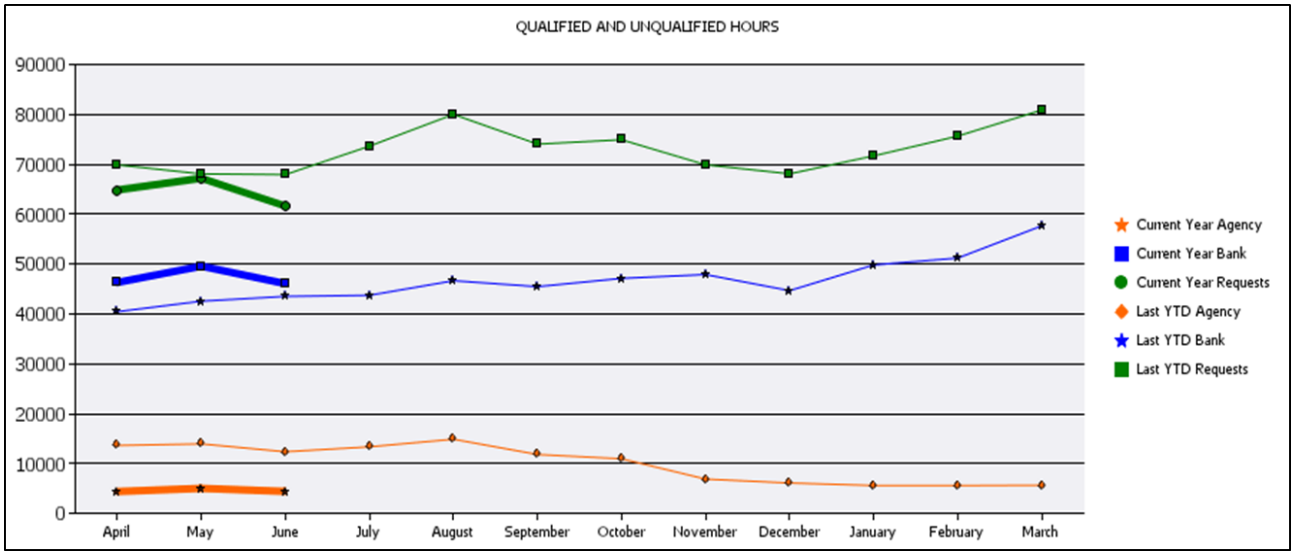


Table 4 Temporary Staffing Registered Hours Demand and Fill Rates

Current YTD Month & Year	Net Hours Requested *	NHSP Filled Hours	% NHSP Filled Hours	Agency Filled Hours	% Agency Filled Hours	Overall Fill Rate	Unfilled Hours	% Unfilled Hours
April 2019	39,531	26,870	68.0 %	4,405	11.1 %	79.1 %	8,256	20.9 %
May 2019	40,766	28,110	69.0 %	5,036	12.4 %	81.3 %	7,621	18.7 %
June 2019	38,567	26,749	69.4 %	4,427	11.5 %	80.8 %	7,390	19.2 %
Total	**118,864**	**81,729**	**68.8 %**	**13,869**	**11.7 %**	**80.4 %**	**23,267**	**19.6 %**

Table 5 Temporary Staffing Unregistered Hours Demand and Fill Rates

Current YTD Month & Year	Net Hours Requested *	NHSP Filled Hours	% NHSP Filled Hours	Agency Filled Hours	% Agency Filled Hours	Overall Fill Rate	Unfilled Hours	% Unfilled Hours
April 2019	25,309	19,439	76.8 %	0	0.0 %	76.8 %	5,871	23.2 %
May 2019	26,433	21,469	81.2 %	0	0.0 %	81.2 %	4,963	18.8 %
June 2019	23,063	19,318	83.8 %	0	0.0 %	83.8 %	3,745	16.2 %
Total	**74,805**	**60,226**	**80.5 %**	**0**	**0.0 %**	**80.5 %**	**14,579**	**19.5 %**

4.2 Roster KPIs

Table 6 shows the roster KPIs for the month of June as captured in the Nursing Quality Indicators Report. All of the division were below the recommended Annual Leave lower threshold of 13% with the exception of Women's & Children. There is ongoing work with divisions to improve their roster KPIs.

Table 6 eRostering KPIs

SUMMARY		Trust	Medicine	Surgery	Women & Children	Cancer	Assessment Wards	Emergency Department	Dialysis
e-Roastering	% E-roster Deadline Met	25.01%	11.00%	33.00%	28.29%	33.00%	0.00%	50.00%	19.80%
	Net Hours %	-0.17%	0.12%	-0.41%	0.59%	-0.30%	0.50%	-1.35%	-0.30%
	Net Hours Position	-419.05	58.08	-369.25	199.38	-16.00	48.24	-288.27	-51.23
	% of Actual Annual Leave	11.93%	12.56%	12.23%	13.07%	9.30%	11.60%	12.05%	12.72%

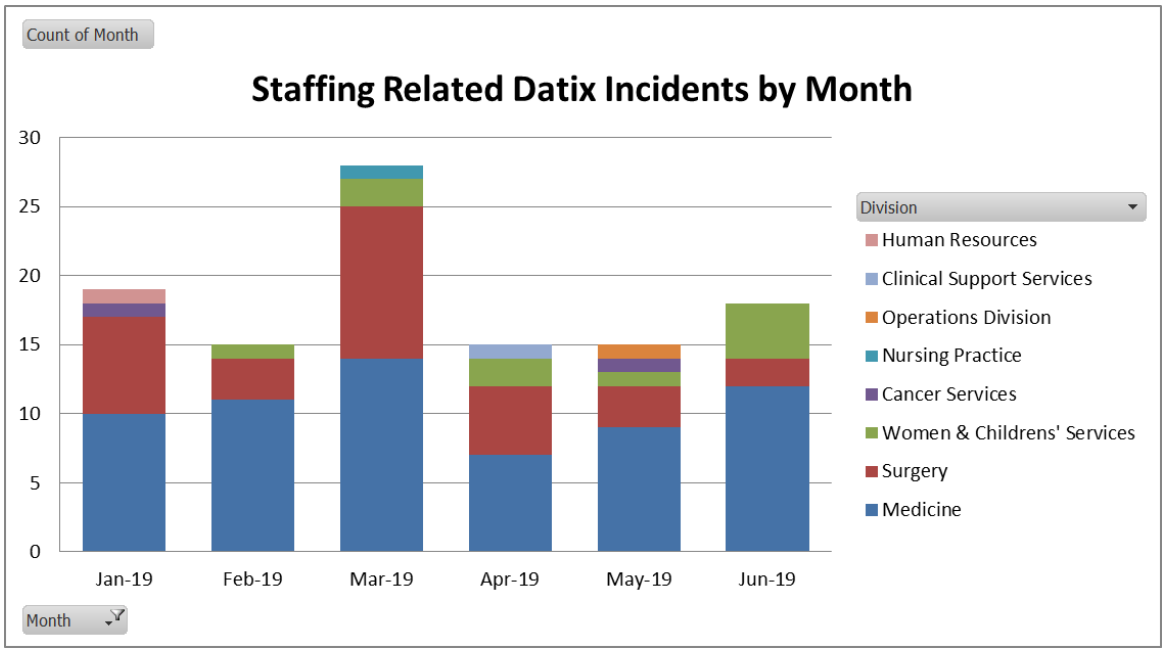
5.0 Investigations and actions on Incidents and red flag events

Shifts that fall below minimum staffing levels are escalated to the divisional staffing bleep holder who moves staff to balance risk across the division. Where the individual division is unable to mitigate independently this is escalated to the Divisional Heads of Nursing to balance risk across the organisation.

5.1 Datix Incidents

Chart 6 shows the number of staffing related Datix incidents logged in the last six month by speciality.
Eighteen staffing related Datix were raised in June. All staffing related incidents are reviewed by the Safer Staffing Matron and DoN and actioned as appropriate. All Datix for June have been reviewed and actioned by the department managers.

Chart 6



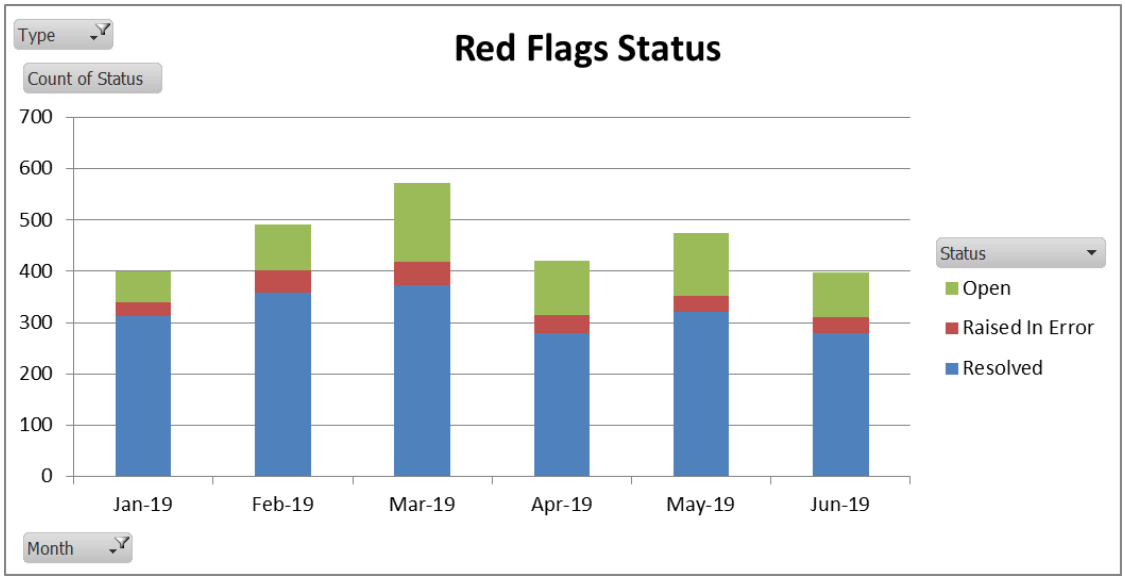
5.2 Red Flag Events

Red flags are NICE recommended nationally reportable events that require an immediate response from the Senior Nurse Team. "Red flag events" signal to the Senior Nurse Team an urgent need for review of the numbers of staff, skill mix and patient acuity and numbers. These events are considered as indicators of a ward requiring an intervention e.g. increasing staffing levels, facilitating patient discharge or closing to admissions for a temporary period following discussion and agreement with the operations centre and the executive on call.
Red flag notifications are completed in SafeCare and sent to a centralised staffing e-mail address. These notifications are then escalated at each of the three daily staffing meetings and site safety meeting, and closed once actions to mitigate are in place. The nurse in charge of the ward will try to resolve Red Flags with the help of the Divisional bleep holders who will act on escalated 'open' issues to help resolve them. Feedback from the wards has found the red flags are appropriate to the staffing challenges they need to escalate on a shift.

The Safer Staffing Team commenced work with the Maternity Services Team at the end of January and has set up Red Flag Events: signs that there may not be enough midwives available as per NICE guidance. The midwife in charge can now record red flag events and the action taken as a result using SafeCare. See **Appendix 4** for the Midwifery safe staffing update.

Chart 7 below shows the number of red flags raised each month over the last 6 months and their status excluding Maternity Red Flags.

Chart 7



6.0 Patient outcomes

The Safer Staffing Team continues to monitor staffing at the three Daily Staffing meetings and weekly staffing look ahead meetings. Daily site safety meetings give a site overview of current issues and concerns relating to capacity, quality, patient care and safety concerns. This supports multi-professional informed decision making across the day. In addition to this there is a weekly look ahead meeting to ensure early mitigation / shift changes are agreed to pro-actively cover shortfalls.

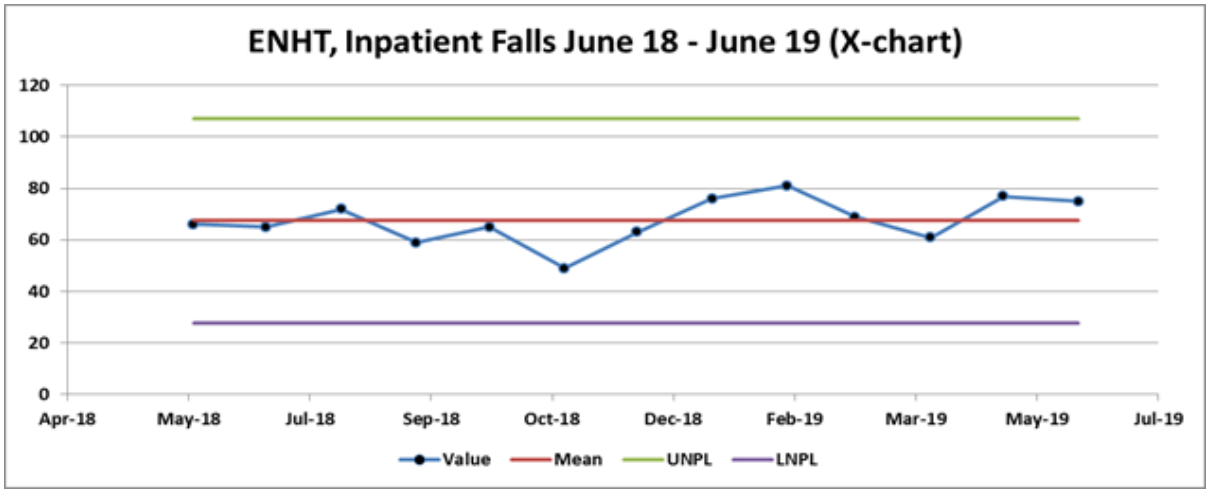
6.1 Safety Thermometer

The NHS Safety Thermometer audit provides a 'temperature check' on levels of harm and enables the measurement of 'harm free care'. Harm free care is defined by the absence of pressure ulcers, harm from a fall, urine infection (in patients with a catheter) and new VTE. This report details the number of patients 'with harm' on the specified audit date – 10 June 2019. We acknowledge that the 'harm' may not have occurred on the ward that it is captured on and therefore encourage all wards/Divisions to discuss the root cause analysis of all harms across Divisions. When looking at benchmarking data from the NHSI model hospital dashboard, as a trust we are in the top quartile for harm free care.

6.2 Falls

75 inpatient falls were recorded in the Trust during June which is a decrease of 2 incidents when compared to May. There is ongoing work to continue to improve our prevention of falls with the promotion of the Bay watch initiative and compliance with the policy. Chart 8 shows That due to a good performance in May the Trust is currently 29 incidents below the targeted reduction trajectory set for 2019/20.

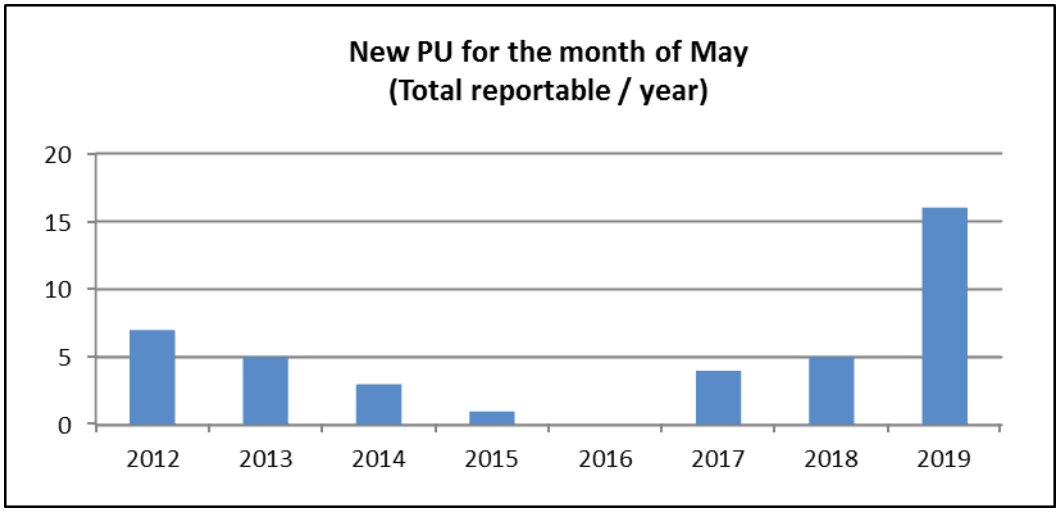
Chart 8



6.3 Pressure Ulcers

For the month of June there were 9 new pressure ulcers (all categories). In compliance with the new NHSI Pressure ulcer (PU) recommendations suspected deep tissue injury (SDTI) numbers are now incorporated into main reporting figures.
June 2019 figure incorporates all categories of damage where 2012-2017 only counts category 2-4 and unstageable ulcers shown in Chart 9. The graph depicts total number of reportable pressure ulcers per year.
2018-19 Total = 86
Current YTD = 37

Chart 9



7.0 Patient, carer and staff feedback in relation to safe staffing levels

The trust asks the question within our Inpatient survey 'In your opinion, were there enough nurses on duty to care for you in hospital?' In June 2019 there were 975 inpatient surveys completed Table 7 shows the % responses to that question: There were 7 wards in June that fell below 75% for the question relating to enough nurses to care for you in hospital. Action plans are put in place where performance is triggering red.

Table 7

		In-patient Survey										Overall
Ward	Returns	Clean ward	Rate food	Help with meals	Noise - patient	Noise - staff	Involved	Doctor question	Nurse question	Enough nurses	Total	Total
10AN	65	90	61	83	62	90	77	86	87	95	81	83.24
10B	24	82	67	97	68	95	62	82	86	79	79	80.39
11A	97	84	86	100	100	100	97	100	100	96	95	97.47
11B	49	92	62	100	65	86	79	89	88	93	83	86.70
5A	64	85	57	75	55	78	74	76	87	84	75	77.12
5B	18	96	59	100	47	100	81	75	93	67	78	85.19
6A	27	94	53	93	58	92	83	85	94	83	81	84.96
6B	22	91	36	89	55	65	61	77	90	70	69	76.33
7B	53	89	69	78	66	82	81	77	85	82	79	81.07
8A	54	77	54	94	46	91	81	84	90	65	74	80.30
8B	61	81	51	79	69	85	80	81	89	73	77	81.80
9A	43	84	78	92	77	98	93	95	92	81	88	89.57
9B	59	93	70	93	78	98	88	90	97	93	89	92.93
Acute Cardiac Unit (ACU)	35	94	61	95	74	97	79	85	86	89	83	85.02
AMU - Blue	13	100	67	100	75	92	88	100	100	79	88	90.68
AMU - Green	18	98	53	85	94	89	92	96	90	75	85	85.72
Ashwell	37	94	63	63	74	86	64	69	82	66	74	74.72
Barley	20	92	63	56	58	58	80	83	83	68	72	76.54
Bluebell	45	90	74	100	50	90	95	95	99	100	88	92.35
MVCC Ward 10/11	19	98	72	100	69	76	85	97	97	100	88	89.19
Pirton	42	91	66	94	64	83	79	92	92	94	83	87.12
SSU	33	78	65	86	50	77	83	84	88	67	74	81.51
Swift Ward	77	93	66	88	84	85	84	89	91	91	86	88.79
Total	975	88	65	88	69	88	82	87	91	85	82	86.76
Benchmark	-	* 87 ** 95 *** 100	* 54 ** 64 *** 100	* 78 ** 86 *** 100	* 65 ** 75 *** 100	* 80 ** 90 *** 100	* 74 ** 84 *** 100	* 82 ** 92 *** 100	* 84 ** 88 *** 100	* 74 ** 84 *** 100	* 75 ** 85 *** 100	* 75 ** 85 *** 100

7.1 Friends and Family

Table 8 shows the results for the friends and family test for the past 3 months. The percentage of patients that would recommend our trust for the month of June has increased from May.

Table 8
A summary of the last three months responses

Month	% Would Recommend	% Would Not Recommend	No. of patients responding	% response rate [target 40%]
April 2019	**96.69**	**0.60**	1994	**44.42**
May 2019	**96.44**	**0.79**	2022	**43.00**
June 2019	**96.85**	**0.72**	2095	**44.75**

8.0 Recommendations

- Note the information on the nurse and midwifery staffing and the impact on quality and patient safety
- Note the content of the report and that mitigation is put in place where staffing levels are below planned.
- Note the content of the report is undertaken following national guidelines using research and evidence based tools and professional judgement to ensure staffing is linked to patient safety and quality outcomes.
- Note the ongoing requirement to continue to source and recruit registered and unregistered staff to match our staffing establishments and reduce our reliance on temporary staffing.

References

Letter from Chief Nursing Officer (NHS England) to Chief Executives of Health Education England and NHS England, dated 3 June 2015
NQB (2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – Safe sustainable and productive staffing.

	Day		Night	
Ward name	Average fill rate + registered nurses/mid wives (%)	Average fill rate + care staff (%)	Average fill rate + registered nurses/mid wives (%)	Average fill rate + care staff (%)
10B	98.7%	100.4%	100.2%	129.7%
11A	95.9%	103.6%	98.7%	110.8%
11B	82.8%	128.7%	101.4%	112.6%
5A	100.4%	87.1%	100.0%	101.5%
5B	96.1%	101.5%	98.6%	129.1%
6A	96.4%	99.1%	100.5%	108.7%
6B	91.8%	107.8%	96.0%	206.1%
10A Gynae	104.7%	91.8%	100.1%	100.3%
7B	98.3%	99.6%	99.9%	108.9%
8A	97.3%	93.5%	98.2%	113.1%
8B	97.0%	97.8%	97.6%	98.5%
9A	99.1%	116.0%	99.0%	135.3%
9B	98.8%	119.3%	100.0%	148.7%
ACU	97.5%	96.7%	99.5%	102.3%
AMU-A	93.3%	89.6%	91.3%	104.4%
AMU-W	97.3%	112.9%	98.8%	116.0%
Ashwell	94.0%	117.4%	99.7%	140.7%
Barley	95.9%	107.4%	102.2%	126.6%
Bluebell	84.2%	191.1%	95.7%	112.2%
Critical Care 1	100.0%	100.0%	100.0%	100.0%
Dacre	104.7%	86.4%	87.6%	#DIV/0!
Gloucester	94.1%	75.2%	97.7%	91.8%
Mat CLU 1	98.2%	70.2%	103.6%	91.4%
Mat MLU	78.5%	87.0%	81.0%	87.1%
Pirton	78.3%	109.0%	95.1%	111.2%
SAU	95.8%	98.1%	98.4%	104.7%
SSU	90.8%	112.1%	99.9%	119.2%
Swift	90.2%	83.0%	100.4%	89.3%
Ward 11	59.1%	57.8%	73.6%	101.8%
Total	**92.6%**	**98.6%**	**97.1%**	**113.2%**

Appendix 2

Ward Staffing Exception Report

Wards with a Registered fill rate <90%, and wards where the planned staffing differs from actual.

Ward	Comment
11B	Reduced occupancy in month
Bluebell	Reduced occupancy in month
Pirton	Reduced occupancy in month
Ward 11	Reduced occupancy in month, staffing flexed across the Cancer Services Division to support safe staffing
Dacre	Low occupancy in month, staffing flexed across the Maternity Service to meet patient needs
MLU	Low occupancy in month, staffing flexed across the Maternity Service to meet patient needs

Appendix 3

Ward name	Care Hours Per Patient Day (CHPPD)		
	Registered midwives/ nurses	Care Staff	Overall
10B	3.34	2.70	6.04
11A	3.87	2.11	5.98
11B	4.11	2.99	7.10
5A	3.35	2.35	5.70
5B	3.60	2.95	6.55
6A	3.20	2.61	5.81
6B	4.17	2.81	6.98
10A Gynae	5.44	2.55	7.99
7B	3.29	2.46	5.74
8A	3.25	2.08	5.33
8B	3.37	1.99	5.36
9A	3.21	2.75	5.95
9B	3.00	2.91	5.90
ACU	4.92	2.48	7.40
AMU-A	5.90	3.47	9.37
AMU-W	4.23	3.35	7.58
Ashwell	3.33	3.44	6.77
Barley	3.57	3.19	6.76
Bluebell	7.18	2.71	9.89
Critical Care 1	18.16	1.57	19.73
Dacre	7.13	1.07	8.20
Gloucester	4.39	3.66	8.06
Mat CLU 1	23.84	6.08	29.92
Mat MLU	39.40	13.65	53.05
Pirton	4.63	3.01	7.65
SAU	7.79	3.91	11.70
SSU	3.58	3.50	7.08
Swift	4.38	2.27	6.65
Ward 11	5.67	3.24	8.92
Total	**4.7**	**2.8**	**7.5**

Appendix 4

Safer Staffing Report June 2019

Planned versus actual midwifery staffing levels

NHSR Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required Evidence:

- Details of planned versus actual midwifery staffing levels.
- The midwife: birth ratio.

Funded Clinical Establishment supports an annual ratio of 1 midwife to 29 women (includes band 3 and 4 staff that support postnatal care). Ratios will vary month on month due to variations in birth numbers however the funded establishment supports all maternity activity both hospital and community care.

	February		March		May*		June	
Midwives	175.26		175.26		178.57		178.57	
Band 3-4 Postnatal	10.52		10.52		11.53		11.53	
Total Funded Clinical	**185.78**		**185.78**		**190.1**		**190.1**	
Actual Worked	**183.29**		**189.18**		**185.26**			
	Births	**Ratios**	**Births**	**Ratios**	**Births**	**Ratios**	**Births**	**Ratios**
Predicted Births in month based on number of women EDD 4 months' time against funded* Clinical Establishment	412	**29**	428	**27**	440	**28**	460	**28**
12 Month Rolling Year to Date Against Funded Midwifery Establishment	5396	**31**	5384	**27**	5375	**30**	5353	**30**
Actual Births in Month against actual worked in month midwives	377	**28**	439	**29**	422	**30**	463	**33**

Total Clinical WTE funded	<30.5	Midwife only funded	<31.5
to a ratio of 1:29	<30.6-32	to a ratio of 1:31	<31.6-33
based on 5500 births	>32	based on 5500 births	>33

*From May 2019 included in the clinical numbers are non-recruitable 4.76 in budget to support maternity leave

Midwifery red flag events

NHSR Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required Evidence:

Number of red flag incidents (associated with midwifery staffing) reported in a consecutive six month time period within the last 12 months, how they are collected, where/how they are reported/monitored and any actions arising (Please note: it is for the trust to define what red flags they monitor.

NICE Safe midwifery staffing for maternity settings 2015 defines Red Flag events as negative events that are immediate signs that something is wrong and action is needed now to stop the situation getting worse. Action includes escalation to the senior midwife in charge of the service and the response June include allocating additional staff to the ward or unit.

Red Flags are captured as part of the role of the manager of the day and the capture of red flags by the Senior Midwife on the shift on SafeCare from January 2019 will support this process

The Red Flags recommended by NICE

Missed medication during an admission
Delay of more than 30 minutes in providing pain relief
Delay of 30 minutes or more between presentation and triage
Delay of 60 minutes or more between delivery and commencing suturing
Full clinical examination not carried out when presenting in labour
Delay of two hours or more between admission for IOL and commencing the IOL process
Delayed recognition/ action of abnormal observations as per OEWS
1:1 care in established labour not provided to a woman

Maternity Red Flags