East and North Hertfordshire NHS Trust
Trust Board - Public Meeting

Oak and Beech Rooms, Lister Education Centre, Lister Hospital
8 January 2020 11:00 - 8 January 2020 12:30

AGENDA

#	Description	Owner	Time
1	Chair's Opening Remarks	Chair	11:00
2	Apologies for absence: DB, SB		
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 6 November Public Trust Board... 5	Chair	
6	Patient Testimony For discussion	Director of Nursing	11:05
7	Chief Executive's Report For discussion 7. Chief Executive's Report.pdf 15 7. Appendix - CQC Inspection Report Staff Briefing.... 21	Chief Executive	11:15

#	Description	Owner	Time
8	Integrated Performance Report For discussion 8. Integrated Performance Report Month 8.pdf 43	All Executive Directors	11:20
9	People and Organisation Strategy For discussion 9. People and Organisation Strategy.pdf 93	Chief People Officer	11:45
10	Finance, Performance and People Committee Reports to Board For discussion 10. (a) 27 November FPPC Report to Board.pdf 135 10. (b) 18 December FPPC Report to Board.pdf 139	Chair of FPPC	12:00
11	Quality and Safety Committee Reports to Board For discussion 11. (a) 26 November 2019 QSC Report to Board.pd... 143 11. (b) 17 December 2019 QSC Report to Board.pd... 149	Chair of QSC	12:05
11.1	Nursing and Midwifery Establishment Review For approval 11.1 Nursing Establishment Review.pdf 153	Director of Nursing	
11.2	Quality Account Update For information 11.2 Quality Account Update.pdf 169	Director of Nursing and Medical Director	
12	Board Assurance Framework For discussion 12. Board Assurance Framework.pdf 263	Associate Director of Corporate Governance	12:15
13	Annual Cycle For information 13. Board Annual Cycle 2019-20.pdf 293	Associate Director of Corporate Governance	12:25

#	Description	Owner	Time
14	Matters Arising and Actions Log For information [P] 14. Public Trust Board Actions Log.pdf 297	Associate Director of Corporate Governance	
15	Data Pack For information [P] 15. Data Pack.pdf 299		
16	REPORTS FOR NOTING		
16.1	Charity Trustee Committee Report to Board For discussion [P] 16.1 CTC Report to Board.pdf 327 [P] 16.1 Appendix 1 - Charity Reforecast.pdf 331	Chair of CTC	
16.2	Learning from Deaths Report For information [P] 16.2 Learning from Death Report.pdf 341	Medical Director	
17	Date of next meeting: 4 March 2020, Mount Vernon Cancer Centre		

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday 6 November 2019 at 11.00am at Hertford County Hospital

Present:	Mrs Ellen Schroder	Non-Executive Director (Chair)
	Dr David Buckle	Non-Executive Director – Associate
	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:	Ms Jude Archer	Associate Director of Corporate Governance
	Ms Sarah Brierley	Director of Strategy
	Mr Duncan Forbes	Chief People Officer
	Mr Joseph Maggs	Trust Secretary
	Ms Eunice Olasode	Board Committee Secretary (Minutes)
Also in attendance:	Mrs Sally Knight	Member of Public (for Patient Testimony)
	Mr Neil Thomas	Member of Public

19/104 CHAIR'S OPENING REMARKS

19/104.1 Mrs Schroder welcomed the members of the public to the meeting and thanked them for attending.

19/105 APOLOGIES FOR ABSENCE

19/105.1 Apologies for absence were received from Dr Peter Carter (Non-Executive Director).

19/106 DECLARATIONS OF INTEREST

19/106.1 There were no declarations of interest.

19/107 QUESTIONS FROM THE PUBLIC

19/107.1 No questions had been received from the public.

19/108 MINUTES OF PREVIOUS MEETING

19/108.1 It was reported that Mr M Wilkinson had submitted a comment regarding paragraph 19/087.11 which referred to the team that investigate incidents being based in close proximity to the executive directors. Mr M Wilkinson had commented that this was not the same as having direct access to executive directors. The Board noted that Mr M Wilkinson's comment would be recorded in this set of minutes.

19/108.2 Additionally, the Associate Director of Corporate Governance confirmed that, whilst not explicit in the minutes of the last meeting, the patient safety team do in fact have direct access to the executives.

19/108.3 The minutes of the previous meeting were approved.

19/109 PATIENT TESTIMONY

19/109.1 The Director of Nursing introduced Mrs Sally Knight to the Board. Mrs Knight had been referred to the breast clinic two years ago. She stated that she was referred to the hospital within a fortnight of her first consultation. She stated that every patient received enough time in the consulting room and was well updated on the waiting times.

19/109.2 She stated that messages were well disseminated to her while having a CT scan as the registrar explained everything he could see on the screen in an orderly and gradual way which made it much easier to absorb.

19/109.3 She stressed the importance of seeing the consultant before and after the treatment. She reported that the consultant did a brilliant job with the surgery but felt his communication could have been better.

19/109.4 She was very impressed with another consultant who had communicated very well, displayed friendliness, expertise and care. She felt that she had given the right amount of information at the right time.

19/109.5 Mrs Knight mentioned that she checked the internet and found detailed information about one of the consultants but not the other. She suggested this would be useful for patients.

19/109.6 In regard to the one stop shop, Mrs Knight mentioned that it was valuable and of great psychological benefit. She stated that diagnoses were made within the day which relieved anxiety and it was possible to talk to someone straightaway and know that a plan of action is immediately in place.

19/109.7 Mrs Schroder thanked Mrs Knight and commented that all feedback was useful to help improve ease of use for patients. The Chief Executive also thanked Mrs Knight for her feedback, agreeing with the points she made about communication and access to information about consultants ahead of appointments.

19/110 **CHIEF EXECUTIVE'S REPORT**

19/110.1 The Chief Executive took his report as read but highlighted the following points:

19/110.2 **Pre-Election Period**

The Chief Executive reported that a briefing had been received from NHS Providers which set out considerations for NHS foundation trusts and trusts in the period of time leading up to the 2019 General Election.

19/110.3 He recommended that official candidates should be allowed to visit the Trust as long as patient care was not compromised.

19/110.4 Dr Buckle highlighted that allowing candidates to visit could create a perception of association with particular candidates even if the process was fair and open to all parties.

19/110.5 Mrs Schroder asked whether candidates would be permitted to have photographs taken at the site.

19/110.6 The Chief Executive commented the process had been well managed in the past and suggested that photographs would be allowed under the usual conditions.

19/110.7 The Board supported the approach recommended by the Chief Executive.

19/110.8 **New QEII Urgent Care Centre**

The Chief Executive reported that East and North Hertfordshire CCG had decided to delay any decision to close the New QEII urgent care centre (UCC) overnight until after the end of financial year. This would allow time for an extensive public communications campaign to raise awareness on which services were available at the UCC overnight – after which overnight usage would be measured again. The Chief Executive commented that he was supportive of this approach.

19/110.9 **Our Staff**

The Chief Executive reported that the Trust would be welcoming optometry students from the University of Hertfordshire for the first time.

19/110.10 It was also reported that the safer staffing team had won a national Allocate Award, Dr Shahid Khan had been appointed Academic Medical Lead and Visiting Professor at the University of Hertfordshire and Joyce Presland, neonatal nurse, had won a Parents' Choice Award from Bliss.

19/110.11 **Staff Awards**

The Chief Executive informed the Board that a large number of applications had been received for this year's staff awards. The awards were supported by the Trust's Charity. The shortlist had been announced and the awards ceremony would take place at Tewin Bury Farm on Friday 29 November.

19/110.12 Regarding the New QEII UCC decision, Mr Niven asked whether there was any evidence to show that overnight use of the UCC had increased. The Chief Executive responded that there was not at present, but this would continue to be monitored.

19/110.13 Ms Moore asked about the Trust's link with the University of Hertfordshire and whether the Trust would be changing its name to become a 'University Trust'. The Chief Executive advised that it was likely the Trust would have to restart the application process, but emphasised that this would not lessen the Trust's desire to continue to work collaboratively with the University.

19/111 QUARTERLY DIVISIONAL PROGRESS REPORT ON CLINICAL STRATEGIC PRIORITIES

19/111.1 The Director of Strategy provided an update to the Board on progress made against the Trust's Clinical Strategy in Q2 of 2019/20. The issues escalated by the Divisional teams included access to capital and workforce challenges.

19/111.2 The Director of Strategy added that it was the intention to undertake a refresh of the Strategy.

19/111.3 Mrs Schroder welcomed the report as a useful means of tracking progress against the Strategy.

19/111.4 Mr Niven asked for an update regarding the development of an Estates Strategy. The Director of Strategy advised that the Trust was currently looking to recruit a new Director of Estates and Facilities. If that process was not successful soon, she suggested an external company could be engaged to begin to undertake the initial aspects of that work.

19/111.5 Mr Niven sought clarification as to whether delivery of the Clinical Strategy was included as a risk on the BAF. The Director of Strategy advised that this was referred to in relevant sections of other risks but could potentially be refined.

19/111.6 Mrs Schroder suggested that delivery of the Strategy was not a risk in and of itself, but that the key risks for the Board were those that were affecting the delivery of the Strategy, such as capital and workforce.

19/111.7 In terms of the capital requirements, the Chief Executive commented that it was important for the Trust to bear in mind that phase five of the 'Our Changing Hospitals' programme was still outstanding.

19/111.8 The Director of Strategy noted that there would be an opportunity to bid for some capital funding through the STP.

19/111.9 The Board noted the report.

19/112 INTEGRATED PERFORMANCE REPORT

19/112.1 The Integrated Performance Report for Month 6 was presented to the Board.

19/112.2 <u>Safe and Caring</u>

The Director of Nursing presented the key updates regarding Safe &

Caring services. It was reported that there had been a significant improvement in terms of falls and PUs.

19/112.3 There had been a third case of MRSA reported in September and actions were being taken in response.

19/112.4 It was reported that two new Never Events relating to surgery had been reported. The total number of Never Events in the year to date was now five.

19/112.5 Regarding reporting of incidents, the Trust remained an outlier from an under-reporting perspective based on latest NRLS data.

19/112.6 It was reported that the Trust's approach to NatSSIPs was launched at a learning event on 1 October and a new NatSSIP Committee was to be launched to support this in future.

19/112.7 In terms of complaints, it was reported that 85% of complaints received had been responded to within the agreed timeframe.

19/112.8 <u>Effective</u>

The Medical Director reported in terms mortality that the Trust's mortality data provider was in the process of changing from Dr Foster to CHKS. In the short term, this could make comparison of data more difficult until the new data format was better understood. Despite these short term issues, the Trust maintained its position as the fourth best in the region in terms of mortality performance, though there had been a slight deterioration against the national picture. Additionally, crude mortality had improved.

19/112.9 The Medical Director summarised that assurance was tempered slightly whilst the new data was fully understood but on the whole the picture remained encouraging with good performance in several of areas.

19/112.10 He concluded that work continued to move towards compliance with the 7 days service requirements.

19/112.11 <u>Responsive</u>

The Chief Operating Officer presented the highlights from the Responsive services section of the report.

19/112.12 A&E performance of 85% was achieved and compared favourably against the performance of peers.

19/112.13 Cancer performance remained challenging and work was ongoing to achieve compliance. She reported that the pension tax issue was impacting service in terms of WLIs. She also reported there had been issues with the capacity of the PET-CT scanner at the Paul Strickland Scanner Centre and a recovery plan was being developed.

19/112.14 It was reported that 52 week breaches remained a priority and compliance had been achieved against the diagnostics and RTT standards.

19/112.15 The Chief Operating Officer finished by providing assurance that winter planning was underway.

19/112.16 Well – led

The Chief People Officer presented the well-led element of the report. He advised there had been an increase in sickness absence, especially due to musculoskeletal issues.

19/112.17 Appraisal compliance had dipped. It was the intention to move away from the position where a large number of appraisals were due at the same time of year.

19/112.18 The uptake of the flu vaccine by staff was better than last year but had been hampered by issues with supply.

19/112.19 He reported there had been a focus on reducing medical locum spend. The possibility of moving some locums to a direct engagement model had been explored. He commented that the IFD meetings had been useful in starting to address this issue.

19/112.20 Regarding the pensions tax issue, he advised this was still being considered but there was not a simple solution.

19/112.21 In terms of staff experience he remarked that this will be linked to People Strategy in order to be able to measure improvement.

19/112.22 Sustainable

The Director of Finance reported that at month 6 the Trust was reporting a £4.6m deficit, in line with the control total plan for 2019/20. He advised that the Trust was continuing to work with commissioners on the outturn position. He suggested that there had been some progress on the paybill issue but further work was needed.

19/112.23 Ms Moore commented on the loss of best practice tariff incentives for stroke. She enquired if the non-compliance had been due to a change to the standard.

19/112.24 The Chief Operating Officer commented that the targets had not changed but greater scrutiny of the data had highlighted that they were not being met. The Director of Finance advised that issues with reporting of data had been rectified and he was relatively confident the standard would be achieved going forward. This would continue to be monitored on a monthly basis.

19/112.25 Mr Silver queried whether WLIs could be paid through non-pensionable pay, as a means of mitigating the pension tax issues. The Chief People Officer advised that was not possible. This was a complex matter, much of which was outside of the Trust's control and area of expertise. The Director of Finance added that efficient use of theatres and outpatients services would reduce reliance on WLIs and thus help to mitigate the risk.

19/113 FINANCE AND PERFORMANCE COMMITTEE REPORT TO BOARD

19/113.1 Mrs McConnell presented the reports of the meetings of the Finance and Performance Committee which were held on 25 September and 30 October 2019.

19/113.2 She reported to the Board that the FPC had considered deep dives

on winter planning, and the theatre and outpatients programmes. The latter two deep dives had illustrated to the Committee the size of the opportunity to improve efficiency in those areas. She added that the theatres team will report back to the FPC in November with a series of key performance indicators that can be used by the FPC to monitor progress.

19/113.3 Mrs McConnell also highlighted that the FPC had reviewed the latest version of the outturn forecast. In response to a question from Mrs Schroder, Mrs McConnell advised that she believed it to be a realistic forecast with a good understanding of the risks.

19/114 FINANCE AND PERFORMANCE COMMITTEE ANNUAL REVIEW AND TERMS OF REFERENCE

19/114.1 The Board received the annual review of the Finance and Performance Committee for 2018-19 and the Committee's revised and updated terms of reference for approval. The updates to the terms of reference included the addition of workforce matters within the Committee's remit and an alteration to its name to reflect the expanded remit. The Board approved the terms of reference.

19/115 QUALITY AND SAFETY COMMITTEE REPORT TO BOARD

19/115.1 The Board received the reports of the meetings of the Quality and Safety Committee held on 24 September and 29 October 2019.

19/115.2 Ms Moore reported that the meeting on 29 October was the first of the new 'deep dive' meetings. She suggested there was room for improvement in terms of the agenda for this meeting and would provide feedback to the regular QSC Chair.

19/116 ACTIONS FROM PREVIOUS PATIENT TESTIMONY

19/116.1 The Director of Nursing presented a report had been produced in response to the actions agreed at the previous meeting (see the minutes for further details). This report would be published online with the rest of the Trust Board meeting papers. The Chief Executive and Director of Nursing advised that they would be happy to speak to the family should they have any further questions.

19/117 QUALITY AND SAFETY COMMITTEE ANNUAL REVIEW AND TERMS OF REFERENCE

19/117.1 The Board received the annual review of the Quality and Safety Committee and its terms of reference. Ms Moore reported that the QSC had posed a challenge to the secretariat to improve the response rate to the survey of the QSC members next year. The Committee approved the updated terms of reference.

19/118 AUDIT COMMITTEE REPORT TO BOARD

19/118.1 Mr Silver presented the summary report of the 28 October meeting of the Audit Committee. He highlighted the Committee's discussions regarding cyber security and data quality and clinical coding. The Committee had felt that there had been progress in both areas, with further work planned.

19/118.2 Mrs Schroder agreed that both teams did important work for the

Trust and asked that they be thanked on behalf of the Board for their hard work.

19/119 AUDIT COMMITTEE ANNUAL REVIEW AND TERMS OF REFERENCE

19/119.1 The Board received the annual review of the Audit Committee and its terms of reference. Only minor updates were proposed for the terms of reference. The Board approved the updated terms of reference.

19/120 TRUST STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

19/120.1 The Board approved the annual review of the Trust's Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions. The Audit Committee had reviewed and endorsed the changes at their last meeting.

19/121 BOARD ASSURANCE FRAMEWORK

19/121.1 The Board noted the latest version BAF which had been considered previously by the sub-committees.

19/121.2 The Associate Director of Corporate Governance reported that the FPC were due to consider the MVCC risk in the context of the strategic change at its next meeting.

19/121.3 She reported that the governance risk had been updated to reflect the recent receipt of three HSE improvement notices. An action plan was being developed to ensure that the improvement notices were adhered to. This would be monitored through the Health & Safety Committee, Quality and Safety Committee and Audit Committee.

19/121.4 Following the discussion earlier in the meeting, she also highlighted that the capital and estates and facilities compliance risks remained at 20.

19/121.5 The Director of strategy updated that the Board regarding the process for the transfer of MVCC to a tertiary provider. She advised that the invitation for expressions of interest was likely to be issued shortly. The deadline for responses to be received was likely to be the week before Christmas.

19/121.6 In response to a question from Mr Niven, it was confirmed that risk 3 had not been rated 25 last month. This was an error within the report.

19/122 ANNUAL CYCLE 2019/20

19/122.1 The Board noted the Annual Cycle 2019/20.

19/123 MATTERS ARISING AND ACTIONS LOG

19/123.1 The Board reviewed and noted the Actions Log.

19/124 DATA PACK

19/124.1 The Board noted the data pack.

19/125 REPORTS FOR NOTING

1. Charity Trustee Committee Report to Board

19/125.1 The Board noted the summary report of the Charity Trustee Committee meeting held on 9 December. This had been discussed in more detail by the Board during its private session earlier that day.

2. Charity Trustee Committee Annual Review and Terms of Reference

19/125.2 It was reported that the CTC annual review and terms of reference had been considered and approved by the Trust Board at its private session earlier that day.

3. Charity Trustee Committee Annual Report and Accounts 2018-19

19/125.3 It was reported that the Charity Annual Report and Accounts 2018-19 had been considered and approved by the Trust Board at its private session earlier that day.

4. Flu Vaccination Self-Assessment

19/125.4 The Board noted the report which provided details of the self-assessment that NHS England and NHS Improvement had asked all trusts to complete and publish relating to healthcare worker flu vaccination. Mrs Schroder noted that performance had been hampered by a lack of availability of the flu vaccine and asked whether the official target had been reduced as a result. The Chief People Officer responded that it was possible the trajectory would be revisited due to the supply issues.

5. Learning from Deaths Report

19/125.5 The Board noted the latest Learning from Deaths Report.

6. Nursing Midwifery & AHP Strategy Progress Report

19/125.6 The Board noted the progress that has been made to date in implementing Nursing, Midwifery and Allied Health Professionals Strategy for 2019-24.

19/125.7 Ms Moore asked about the impact of the discharge lounge. The Director of Nursing advised that a band 7 nurse was now in post to support this and the numbers going through the discharge lounge were increasing.

19/126 DATE OF NEXT MEETING

19/126.1 The next meeting was due to take place on 8 January 2020, Lister Education Centre, Lister Hospital.

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Ellen Schroder

Trust Chair

January 2020

East and North Hertfordshire NHS Trust

Chief Executive's Report

January 2020

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1. Corporate Update

CQC Report

Our most recent CQC report published on 18 December shows a number of improvements across the Trust. I am particularly pleased that our Good rating for caring has been maintained, and that we are now also rated Good for effectiveness.

The Care Quality Commission inspected eight 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 23 - 25 & 30 – 31 July 2019. The well led inspection took place from 10 – 11 September 2019. The Use of Resources inspection, which is led by NHS Improvement took place on 6 August 2019.

The inspectors focused on **Safety, Effectiveness, Responsiveness, Care and how Well-led services are** in eight core service lines:

At **Lister Hospital** CQC inspected:

- Surgery
- Critical Care
- Children's and young people
- End of life care
- Outpatient

At the **QEII Hospital** CQC inspected:

- Urgent Care Centre
- Outpatients

At the **Mount Vernon Cancer Centre** CQC inspected:

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

At the July 2019 inspection, these core services were rated either as requires improvement or good. Inspectors noted that we continue to deliver compassionate care and treat our patients and their loved ones with respect and dignity. Our teams should be extremely proud of this – it confirms that we put our patients at the heart of all that we do.

Summary of the Trust's Ratings

Our rating of the Trust stayed the same -**requires improvement**.
We were rated as **good** for caring and effective and **requires improvement** for and safe, responsive and well led.

We were rated as **requires improvement** for use of resources

Ratings for the whole trust

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

	Safe	Effective	Caring	Responsive	Well-led	Overall
Lister Hospital	Requires improvement →← Dec 2019	Good ↑ Dec 2019	Good →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019
Queen Elizabeth II Hospital	Requires improvement ↑ Dec 2019	Good ↑ Dec 2019	Good →← Dec 2019	Requires improvement ↓ Dec 2019	Requires improvement ↑ Dec 2019	Requires improvement ↑ Dec 2019
Mount Vernon Cancer Centre	Requires improvement →← Dec 2019	Good →← Dec 2019	Good →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019
Hertford County Hospital	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Overall trust	Requires improvement →← Dec 2019	Good ↑ Dec 2019	Good →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement →← Dec 2019	Good ↑ Dec 2019	Good →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019
Community	Good Mar 2016	Good Mar 2016	Outstanding Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016

Examples of outstanding practice were found in children and young people's services at Lister Hospital and in radiotherapy services at Mount Vernon Cancer Centre.

The New QEII and Lister Hospitals both showed improvements, with surgery at the Lister and Urgent Care Centre at the New QEII both moving from an Inadequate to requires improvement rating.

The inspectors found that:

- Staff continued to deliver compassionate care and treated patients and their loved ones with respect and dignity
- Leaders at all levels worked hard to be visible and approachable
- At the Lister the children and young people's play team delivered an outstanding service to young patients and those whose parents were acutely unwell
- At the New QEII it was easy for people to give feedback about their care, and action was taken as a result
- At Mount Vernon, the staff worked together as a team and were committed to continually learning and improving services – including pilot schemes to improve access and reducing referral time for head and neck cancer patients from 50 days to 17 days

The report also highlighted areas for the Trust to improve, particularly around medicines management, maintaining equipment and premises, and ensuring that audits are conducted across the Trust. The CQC have issued a number of requirement notices and set out a number of areas for improvement - "Must Do's" and "Should Do's".

The requirement notices are:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

Work is already underway to improve these areas as part of the Trust's quality improvement programme and an action plan is being developed that will be submitted to CQC on 22 January 2020. This will be monitored monthly reported to the Executive Committee and 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 supported by a new compliance framework.

See appendix 1 for the Staff briefing on the CQC Report which includes a breakdown of the ratings by pathway.

Our full report is published on the CQC Website - https://www.cqc.org.uk/provider/RWH

Director of Estates & Facilities

I am delighted to welcome Kevin Howell who has recently joined us as our new Director of Estates and Facilities. Kevin joins the Trust from St George's Hospital in Tooting where he has been Director of Estates since 2017. He brings over 35 years of experience within the NHS including estates and facilities roles in the London area including at the Royal Free, The Princess Royal University Hospital, Barnet & Chase Farm, North Middlesex Hospital and West Herts Trust hospitals.

New Website

I am pleased to announce the recent launch of our newly designed website. The design and navigation of the site has been simplified to make the user's experience easier, allows information to be found more quickly and is more user friendly. Information is easier to access and each of our services and locations has its own dedicated page. The site is now fully responsive and functional working on mobile phones, tablets, laptops and computers.

Plastic Surgery Department Achieves National Recognition

Congratulations to the plastic surgery department which has been highly commended in the team of the year category of the HQIP Annual Audit Heroes awards. The judging panel reported that the team work together to achieve a significant and sustainable improvement in the inpatient and outpatient pathways, patient care and outcomes for patients with lower limb skin tears across the period 2017–2019.

Judges were impressed that the experience of one patient prompted what was to become wide-ranging systemic change involving acute and community services and incorporating a vast array of specialties.

Neonatal Unit Takes First Step to Accreditation

Congratulations to the Trust's Neonatal Unit who have, following the successful completion of their first Bliss Baby Charter audit, been awarded the Bliss Baby Charter Pledge of Improvement. The certificate acknowledges that they are committed to working towards Bliss Baby Charter accreditation to deliver high-quality, family-centered care.

National Recognition for Acute Paediatrics Team

Congratulations to Dr Amitabh Gite, Clinical Director for Paediatrics, and the Acute Paediatrics Team for their success with the winter pressure initiatives. The team have gained national recognition with articles published both on the Royal College of Paediatrics and Child Health (RCPCH) website and in their magazine M*ilestones* (published this month) following a highly successful winter pressure workshop they led at the national RCPCH conference.

Breast Care Team Working with National Charity to Improve Patient Aare

The Breast Care Team at New QEII and Lister have signed up to take part in Breast Cancer Now's service pledge. This involves patients and staff coming together to improve the care being provided for breast cancer patients. Both patients and staff will be completing surveys

and taking part in focus groups about how the service can be improved.

By actively involving people with different perspectives of breast cancer, Breast Cancer Now can develop a more complete understanding of the challenges and opportunities to improve healthcare services.

2. Our Staff

Staff Awards – Proud to Make a Difference

Finally, the Trust's staff awards took place on 29 November which saw 13 awards given to amazing individuals and teams across the Trust.

The award winners were:

- Unsung Hero award – **Waste Porters (G4S supported by Trust Portering and Transport)**
- The Vicki Adkins Above and Beyond award – **Emma Fritton**
- Here to Help award – **Dawn Sheldrick**
- Charity Champion award – **Glyn Doggett**
- Bright Sparks award – **Respiratory Team - Pleural Service**
- Inspiring Leadership award – **Jennie Bloom**
- The Roche Experience Counts award – **Joyce Presland**
- Safety First award – **Resus Team**
- The G4S Patients First award – **Pharmacy team**
- Compassionate Care award – **AMU Green**
- Local Hero award – **Alice Burrows**
- Clinical Team award – **Obstetrics/Maternity**
- Pride of ENHT 2019 award – **Lizzie Bessell and Children's ED**

Congratulations to all the winners and finalists.

East and North Hertfordshire NHS Trust

CQC Inspection Result 2019

Staff Briefing

18 December 2019

Quality | People | Pathways | Ease of use | Sustainability

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

East and North Hertfordshire NHS Trust

Which core services were visited?

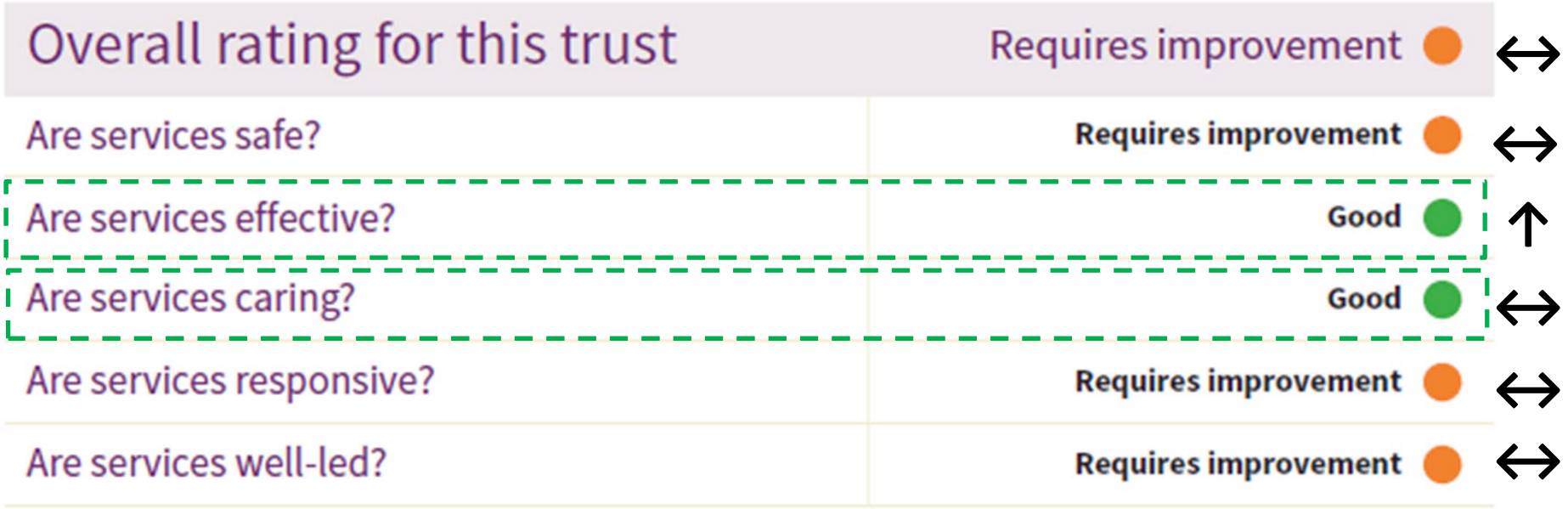
The inspectors focused on **Safety, Effectiveness, Responsiveness, Care and how well led** services are in eight core service lines:

- Surgery (Lister)
- Critical Care (Lister)
- Children's and young people (Lister)
- End of life care (Lister)
- Outpatients (The New QEII, Lister and MVCC)
- Urgent and Emergency Care (The New QEII)
- Medicine (MVCC)
- Radiotherapy (MVCC)

We had our Use of Resources Inspection, led by NHS Improvement/England on 6 August 2019 and CQC Well Led Inspection on 10/11 September 2019.

How did we do?

East and North Hertfordshire NHS Trust



Overall rating for this trust	Requires improvement ↔
Are services safe?	Requires improvement ↔
Are services effective?	Good ↑
Are services caring?	Good ↔
Are services responsive?	Requires improvement ↔
Are services well-led?	Requires improvement ↔

Ratings by site

East and North Hertfordshire NHS Trust

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Lister Hospital	Requires improvement →← Dec 2019	Good ↑ Dec 2019	Good →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019
Queen Elizabeth II Hospital	Requires improvement ↑ Dec 2019	Good ↑ Dec 2019	Good →← Dec 2019	Requires improvement ↓ Dec 2019	Requires improvement ↑ Dec 2019	Requires improvement ↑ Dec 2019
Mount Vernon Cancer Centre	Requires improvement →← Dec 2019	Good →← Dec 2019	Good →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019
Hertford County Hospital	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Overall trust	Requires improvement →← Dec 2019	Good ↑ Dec 2019	Good →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019

Quality | People | Pathways | Ease of use | Sustainability

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*↑↓↔ indicates which service as inspected this year and whether the rating has improved, remained the same or declined.

Ratings for Lister Hospital

NHS Hertfordshire NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Medical care (including older people's care)	Requires improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Surgery	Inadequate →← Dec 2019	Good ↑ Dec 2019	Good →← Dec 2019	Requires improvement ↑ Dec 2019	Requires improvement ↑ Dec 2019	Requires improvement ↑ Dec 2019
Critical care	Good →← Dec 2019	Good →← Dec 2019	Good →← Dec 2019	Good →← Dec 2019	Good ↑ Dec 2019	Good →← Dec 2019
Maternity	Requires improvement →← Jul 2018	Good →← Jul 2018	Good →← Jul 2018	Good ↑ Jul 2018	Good →← Jul 2018	Good ↑ Jul 2018
Services for children and young people	Requires improvement →← Dec 2019	Good →← Dec 2019	Good →← Dec 2019	Good ↑ Dec 2019	Good ↑ Dec 2019	Good ↑ Dec 2019
End of life care	Good →← Dec 2019	Requires improvement →← Dec 2019	Good →← Dec 2019	Requires improvement ↓ Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019
Outpatients	Good →← Dec 2019	Not rated	Good →← Dec 2019	Good →← Dec 2019	Good →← Dec 2019	Good →← Dec 2019
Overall*	Requires improvement →← Jul 2019	Good ↑ Jul 2019	Good →← Jul 2019	Good ↑ Jul 2019	Requires improvement →← Jul 2019	Requires improvement →← Jul 2019

Quality | People | Pathways | Ease of use | Sustainability

*↑↓↔ indicates which service as inspected this year and whether the rating has improved, remained the same or declined.

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

The New QEII – who was inspected and how did they do?

East and North Hertfordshire NHS Trust

Ratings for Queen Elizabeth II Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↑ Dec 2019	Good ↑ Dec 2019	Good → ← Dec 2019	Good ↑ Dec 2019	Requires improvement ↑ Dec 2019	Requires improvement ↑ Dec 2019
Outpatients	Requires improvement ↓ Dec 2019	Not rated	Good → ← Dec 2019	Requires improvement ↓ Dec 2019	Good → ← Dec 2019	Requires improvement ↓ Dec 2019
Overall*	Requires improvement ↑ Dec 2019	Good ↑ Dec 2019	Good → ← Dec 2019	Requires improvement ↓ Dec 2019	Requires improvement ↑ Dec 2019	Requires improvement ↑ Dec 2019

Mount Vernon Cancer Centre – who was inspected and how did they do?

East and North Hertfordshire NHS Trust

Ratings for Mount Vernon Cancer Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires improvement ➔➔ Dec 2019	Good ➔➔ Dec 2019	Good ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019
End of life care	Requires improvement Jul 2018	Good Jul 2018	Good Jul 2018	Inadequate Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Outpatients	Good ➔➔ Dec 2019	Not rated	Good ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Requires improvement ↓ Dec 2019	Requires improvement ↓ Dec 2019
Chemotherapy	Requires improvement Jul 2018	Good Jul 2018	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Radiotherapy	Good ➔➔ Dec 2019	Good ➔➔ Dec 2019	Good ➔➔ Dec 2019	Good ➔➔ Dec 2019	Good ➔➔ Dec 2019	Good ➔➔ Dec 2019
Overall*	Requires improvement ➔➔ Dec 2019	Good ➔➔ Dec 2019	Good ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2020

Quality | People | Pathways | Ease of use | Sustainability

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Hertford County and Community Services unchanged

East and North Hertfordshire NHS Trust

Ratings for Hertford County Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients	Good Mar 2016	N/A	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Overall*	Good Mar 2016	N/A	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for children and young people	Good Mar 2016	Good Mar 2016	Outstanding Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Overall*	Good Mar 2016	Good Mar 2016	Outstanding Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016

East and North Hertfordshire NHS Trust

Outstanding and good practice identified – Trust wide

Leaders at all levels worked hard to be visible and approachable

Patients that CQC spoke with told us that staff had been caring and treated them with kindness.

There were clear priorities for ensuring sustainable, inclusive and effective leadership capacity which included succession planning.

Patients and relatives they spoke with spoke highly of staff and the care and attention that was given to them

Staff continued to deliver compassionate care and treated patients and their loved ones with respect and dignity.

Outstanding and good practice identified – Lister

East and North Hertfordshire NHS Trust

Surgery

Surgery rating for well-led improved from inadequate to requires improvement. This was because leaders were working hard to drive necessary improvements that were sustainable.

Surgery

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Outstanding and good practice identified – Lister

East and North Hertfordshire NHS Trust

Critical Care

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Critical Care

The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Outstanding and good practice identified – Lister

East and North Hertfordshire NHS Trust

End of life

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

End of life

All staff were committed to continually learning and improving services.

Outstanding and good practice identified – Lister

East and North Hertfordshire NHS Trust

Outpatients

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care.

Outpatients

Staff gave patients practical support and advice to lead healthier lives.

Outpatients

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Outstanding and good practice identified – Lister

East and North Hertfordshire NHS Trust

Children and young people service
The play team regularly attended adult wards such as palliative care wards or the critical care unit, to assist children whose parents were acutely unwell or at the end of their lives.

Children and young people service
Transitional services were highly responsive to the individual needs of young people and had tailored their services to meet the needs of all children and especially those with protected characteristics in line with the Equality Act 2010.

Outstanding and good practice identified – New QEII

East and North Hertfordshire NHS Trust

Outpatients
Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief when needed. They supported those unable to communicate using suitable assessment tools.

Outpatients
Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Outpatients
All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

Outpatients
The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Outstanding and good practice identified – New QEII

East and North Hertfordshire NHS Trust

Urgent Care Centre

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Urgent Care Centre

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Urgent Care Centre

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Urgent Care Centre

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Outstanding and good practice identified – Mount Vernon

East and North Hertfordshire NHS Trust

Mount Vernon – Medical Care

Staff treated patients with compassion and kindness. Staff provided emotional support to patients, families and carers to minimise their distress. Staff supported and involved patients, families and carers.

Mount Vernon – Medical Care

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Outstanding and good practice identified – Mount Vernon

East and North Hertfordshire NHS Trust

Mount Vernon – Radiotherapy
All staff were committed to continually learning and improving services.

Mount Vernon – Radiotherapy
Staff gave patients practical support and advice to lead healthier lives.

Mount Vernon – Radiotherapy
It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Mount Vernon Cancer Centre
The service had pilot schemes in place to improve access. This included a head and neck rapid access pilot scheme. All patients who were deemed to be a category one patient, (most urgent) underwent a new pathway where the service had worked to ensure quicker access to CT scanning. This had reduced the referral to treatment time for this set of patients from 50 to 17 days.

Outstanding and good practice identified – Mount Vernon

East and North Hertfordshire NHS Trust

Mount Vernon – Outpatients

Patient safety incidents were managed well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Mount Vernon – Outpatients

Staff understood the service's vision and values, and how to apply them in their work. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities and all staff were committed to improving services continually.

New ‘Use of Resources’ report

East and North Hertfordshire NHS Trust

Are resources used productively?	Requires improvement

Work to do around

- Retention
- Sickness
- Financial delivery of plans
- Performance
- Non-pay costs

What's next ?

East and North Hertfordshire NHS Trust

- Report publication
- Future inspection
- Regulatory requirements
- Must and should do actions

Requirement notices received around

Safe care and treatment	Premises and equipment	Governance	Staffing

East and North Hertfordshire NHS Trust

Thank you!

Quality | People | Pathways | Ease of use | Sustainability

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

East and North Hertfordshire NHS Trust

Agenda Item: 8

TRUST BOARD - PUBLIC SESSION – 8 JANUARY 2020

Integrated Performance Report – Month 8

Purpose of report and executive summary (250 words max): The purpose of the report is to present the Integrated Performance Report Month 8 to the Trust Board. Key challenges and mitigations under each domain are identified within the report.		
Action required: For discussion		
Previously considered by: QSC – 17.12.19, FPPC – 18.12.19		
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	☒

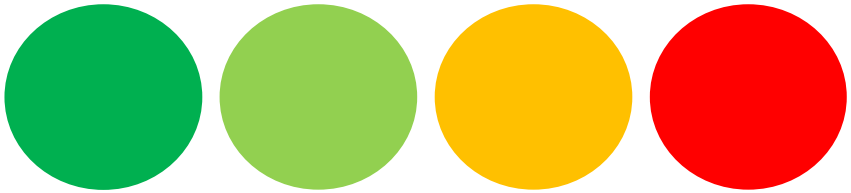
Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
Any other risk issues (quality, safety, financial, HR, legal, equality): Key challenges and mitigations under each domain are identified within the report.

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

East and North Hertfordshire NHS Trust

Integrated Performance Report

Month 08 | 2019-20



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East and North Hertfordshire NHS Trust

Performance Headlines

East and North Hertfordshire NHS Trust

Domain	Positive Performance	Challenges	Lead Director
Safe & Caring Services	**Improvement initiatives - deteriorating patients** An ENHT Patient Breakthrough Series Collaborative has confirmed launch 31st January 2020. Divisional leads have agreed wards to be included Personalised treatment plans are now in regular use. An audit of equipment to support patient monitoring has been completed and will inform the equipment allocation plan. **Safer Invasive Procedures** On the 1st of October 2019 the trust launched the ENHT Safer Invasive Procedure Policy. The launch event was well received and the endoscopy, cardiology and outpatient departments have agreed to be the next test areas for implementing their LocSSIPs. The 'Invasive procedure Clinical Group' TOR are drafted and met 5th Dec. **Clinical Excellence framework** The third session to the first wave of 20 ward leaders participating in a 12 month RCN leadership programme, has taken place. All ward leaders participating in this RCN Leadership course will have to participant in Action Learning sets and are supported locally by QI Coach. The first cohort of wards undergoing the Clinical Accreditation Excellence Framework, have had their final review and their awards have been ratified by the credentialing panel. The second cohort of wards, have been nominated and have begun to undertake their self-assessment. **Complaints Management** While complaints management remains a priority for the trust, to both improve timeliness of response and overall reduction in open complaints, improvement has been noted from Jan 2019- Aug 2019 with an overall 50% reduction in open cases. Responding to complaints within the agreed timeframe has increased to 79% year to date for this Trust. All divisions are improving on their response times, enabling the complaints team to draft responses in a timelier manner.	**Incident Reporting and Learning** The trust has seen an increase to incident reporting, we remain committed to improving this rate based on latest NRLS data. Contributing to this is delayed incident sign-off and divisions have been asked to develop incident closure trajectories. Weekly monitoring will commence 16 December 2019 Divisional learning post incident investigations and processes continue to improve with learning being shared across Divisions. While the larger quality learning events do help mitigate this, the patient safety team continue to scope a more robust business as usual approach to improve this. **Supporting staff to sustainably and continuously improve** The Quality Improvement team will be fully established when the newly appointed administrator joins the trust in January 2020. The team is coaching improvement initiatives and providing teaching in improvement methodology at the same time. This aims to build capacity whilst driving improvement. Discussions are progressing regarding the trust's QI 'way' i.e. the improvement methodologies; and the QI team is involved in the educational review around organisational capacity. **Serious Incident Management** In the recent Q3 2019 the delays in SI timeliness reporting are improving. This has been supported by additional resources. A 3rd patient safety manager will be joining the trust 6 January 2020 Work is underway to move to new Datix cloud with the implementation stage about to commence having secured the IT elements of the plan.	 **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 deaths in hospital. Performance has been consistently in the 'as expected range'. The latest HSMR for the rolling 12 months to August 2019 is 84.9. HSMR is generally available 3/12 in arrears. The significant reduction since the reported figure of 93.1 (R12M to May-19) is due to a change in data source from Dr Foster to CHKS and results from the fact that these two providers have different timeframes for re-basing their datasets. **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 June 2019 is 90.59 ('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. Deaths in scope: November 2019 = 91 2019-20 deaths reviewed: November = 29 Year to 30 November 2019 deaths in scope = 821; Related mortality reviews = 490	**Mortality** Although overall Trust mortality is within the 'as expected' (SHMI), and we are well-positioned in the second lowest quartile of Trusts for HSMR, 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. A decision has recently been made to change our provider for mortality metrics from Dr Foster to CHKS. This will involve a number of changes to the data we use for monitoring purposes. We are currently in a transition phase until the end of our Dr Foster contract at the end of March 2020. The use of CHKS data for reporting purposes will be introduced during this time. For the purpose of this IPR Crude Mortality, headline HSMR and Re-admissions has been taken from CHKS iCompare. Current outliers for review (using Dr Foster outlier definitions): HSMR - Biliary tract disease SHMI - Diverticulosis & Diverticulitis; Congestive heart failure; and Biliary tract disease. CUSUM alerts -Biliary tract disease (2), Cancer of testis (1), Nausea and vomiting (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. Consultant review within 14 hrs of emergency admission is lower at the weekend and an area where we need to improve our performance. Snapshot Specialty audits are in progress to assess our current compliance with the 14-hour review requirement. While an Associate Medical Director for Reduction in Unwarranted Variation is still 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 4-hour performance in November was at 81.43%. Demonstrating a 4% level of deterioration in month as a result of sustained ED attendances, high acuity and poor flow impacted by Norovirus and closed beds. There was one 12-hour trolley breach as a result of a complex patient who required a respiratory bed. Subsequent to the breach and RCA there has been a meeting between respiratory Consultants and ITU Consultants to agree a management plan for these patients when respiratory and ITU beds have capacity issues. **Cancer Performance** In October 2019, the Trust achieved 6 of the 8 national targets for cancer performance: 2ww and 2ww Breast Symptoms; and 31-day subsequent for Radiotherapy, Chemotherapy, 1st definitive treatment and 62-day referral to treatment from screening. The 62-day performance was 81.1%. Although this is below the forecast position for the recovery trajectory, it represents a significant improvement on the previous month's performance. This performance improvement has been delivered through a combination of increased scrutiny and tracking of patients and delivery of the actions in the RAP. Going forward monthly tumour site deep dive meetings will continue with CCG support to monitor and drive compliant levels of performance. **RTT Performance** November's RTT performance was 83.93%. A slight improvement on last month's position. 52 week breaches were 15, 1 fewer than the previous month. The focus remains on the high impact specialities with a significant backlog. **Diagnostics** The November reported position for DM01 is 0.15%. This standard remains substantively and reassuringly compliant. **Stroke Performance** Stroke performance for October is 60.3%, which is a significant deterioration from last month's position. This position is due to a number of factors: • A high number of strokes (81) in month, up 11% compared to September and up 30% compared to last October • Increased length of stay due to limited therapy resources, high vacancy rate • Increase in LoS over the weekends due to access to diagnostics – MRI and therapy at weekend services • Effective and sustainable ring fencing of stroke beds (6) – only delivered on 13 days in the month There is a stroke service/COO meeting scheduled to review these issues in detail and consider options for delivering sustained improvement and performance. Actions to address performance: • Robust adherence to ring fenced stroke beds policy • Review of business case to deliver 7-day therapy services, and an interim solution • MRI at weekends agreed as part of the winter initiatives	**ED Performance** The Trust managed to retain the above 80% performance despite a challenging environment. The Perfect week went well and initial reaction was that initiatives such as U/S in the Assessment areas; urology catheter care nurse in the ED and a cannulation team supporting the wards overnight were very well received and these initiatives supported ambulatory pathways and reduced LoS. There will be a deep dive review on 17th Dec to further evaluate the week, in particular the impact that Acute Medical colleagues had within the ED and Assessment areas. The plans for the Acute Medical model will be constructed based on the learning to prioritise areas and times to receive Acute Medical support which will deliver the biggest impact. **Cancer Performance** The 62 day performance was at 82.4% before the national upload for the Inter Trust Transfer (ITT) dates. Issues and inconsistencies with the upload, in particular with Northwick Park have been addressed through direct conversations with the COO and the Cancer Manager. Going forward there will be a weekly conference call prior to any upload to ensure both parties agree the position. Delays to PET-CT scanning and reporting TATs from the Paul Strickland Scanning Centre (PSSC) have been addressed through conversations with NHSE. An agreement has been reached that the trust can seek an alternative provider for a temporary period of time to improve waits to the expected 7 day TATs. This will improve 62 day performance further for lung, H&N and UGI tumour sites. **SDEC** Surgery - all phases of the pathway are live. Clinics built and staff recruited. Monitoring of impact to resolve issues and improve. Impact has seen a reduction of 1 day LoS since August 2019. Ambulatory medical - tested the model of Acute Medic in assessment and ambulatory emergency care 8am - 8pm for 7 days. Right patients in the right place through strengthened triage process. Improved flow through different approach to managing SSU beds, resulted in increased number of discharges. Admission avoidance was also delivered by utilising ambulatory processes.	 **Julie Anne Smith** **Chief Operating Officer**

Performance Headlines

East and North Hertfordshire NHS Trust

Domain	Positive Performance	Challenges	Lead Director
Well-led Services	**People Strategy** The Trusts new five-year people strategy has been approved. The strategy sets out the ambitions and plans to increase organisational capacity and capability to deliver high quality care to the community and make East and North Hertfordshire the best place to work. The key messages will be communicated throughout the organisation and a new governance structure is being set up to support implementation, provide oversight and assurance. **Temporary Staffing** Agency filled shift activity increased by 2% although agency expenditure reduced by £14k against the previous month, this meant that the Trust was under the agency ceiling by £140k in month. Agency price cap breaches reduced significantly against the previous month. 426 breaches across all staff-groups is the lowest recorded in 2 years. The number of Medical Locum breaches reduced significantly with 194 fewer breaches recorded since September 2019. **Sickness Absence** There has been 296 fewer days lost compared to last month. It is also a decrease on last year of 0.5% or 573 days. The number of days lost due to musculoskeletal related sickness absence is 5% lower than November 2018. Days lost due to sickness caused by stress and mental health issues is 27% lower. **Staff Survey** The staff survey results closed with a response rate of 45% which is 3% up from the previous year. The full report will be available by the end of January with the national data being published in February.	**Recruitment** The Trust is exceeding the target for increasing the number of staff in post overall and is at a vacancy rate of 6.8% (0.1% ahead of target). However, the number of substantive nurses in post reduced in month 8 and the vacancy rate increase by 0.7% to 6.5%. The issue is particularly highlighted in the medicine division who have had a greater number of staff leaving. Medicine also benefit most from international nursing cohorts for which there are fewer starting in the second part of the year. **Appraisals** Appraisal rates increased from 85% to 87%, however this is still below the target of 90%. The Trust has started to make progress following a spike in the number of appraisals due in October. The focus going forward is to improve the access and usability of the systems to record appraisal. **Flu Campaign** There is a CQUIN goal to achieve an 80% uptake of flu vaccinations in frontline staff by 28th February 2020. However, our ambition is to vaccinate all frontline staff. 2438 frontline employees have now received the flu vaccine, this represents 57.8%. This is despite the flu vaccine not being available for 2 weeks due to supply issues.	 **Duncan Forbes** **Chief People Officer**

Performance Headlines

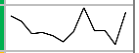
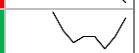
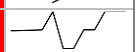
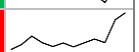
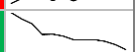
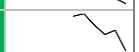
East and North Hertfordshire NHS Trust

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 M8 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. The Trust reports a significant overspend against pay budgets YTD. This has been driven by pressure across medical and nursing budgets. This results from both the impact of increased levels of emergency activity demand that the Trust has supported in the YTD, combined with the impact of lower that planned levels of theatre and outpatient productivity improvement. In addition, the Trust continues to experience challenges in the control environment pertaining to the utilisation of temporary staffing across medical and nursing budgets in the YTD. The Trust reports delivery of CIP savings of £9.9m YTD. Whilst this is 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 Q3 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 19/20 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.	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 driven by the impact of CCG QIPP scheme shortfalls and the consequent need to maintain capacity that has been expected to close. The Trust and its main commissioner have agreed a fixed share arrangement over for the 19/20 SLA contract to fairly main the risk and cost of emergency activity over performance. In addition, the Trust continues to face challenges in the delivery of clinical productivity targets and also weaknesses in the management of medical and nursing temporary staffing costs. This underlying position is not sustainable and requires redress if the Trust is to achieve financial sustainability going forward. To support the achievement of its 19/20 Control Total the Trust Executive have introduced a number of remedial forecast mitigation work streams. These include weekly IFD oversight groups for both Medical Staffing and Nursing Management which have 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. Further IFD work streams have been set up in respect of establishing a high impact focus on Pathology, Pharmacy and Procurement costs in the second half of the year. In addition, the Trust has introduced tighter controls for the review and approval of admin and senior managers temporary staffing costs. Regular reports on the effectiveness of these mitigation programmes will be provided to the Finance and Performance Committee and weekly Executive Committee meetings.	 **Martin Armstrong** **Director of Finance**

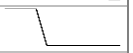
NHS Oversight Framework

East and North Hertfordshire NHS Trust

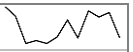
Quality of care

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
Overall	CQC rating	-	Dec-19	-	-	Requires improve-ment	
Caring	Written complaints - rate	Quarterly	Nov-19	Local	1.9	1.8	
Caring	Staff Friends and Family Test % recommended - care	Quarterly	Q2 2019-20	National	81.3%	78.9%	
Safe	Occurrence of any Never Event	Monthly (six-month rolling)	Jun-19 - Nov-19	National	0	3	
Safe	Patient Safety Alerts not completed by deadline	Monthly	Nov-19	National	0	5	
Caring	Mixed-sex accommodation breaches	Monthly	Nov-19	National	0	0	
Caring	Inpatient scores from Friends and Family Test - % positive	Monthly	Nov-19	National (excl. IS)	95.0%	97.6%	
Caring	A&E scores from Friends and Family Test - % positive	Monthly	Nov-19	National (excl. IS)	90.0%	89.3%	
Caring	Maternity scores from Friends and Family Test - % positive - antenatal care	Monthly	Nov-19	National (excl. IS)	93.0%	100.0%	
Caring	Maternity scores from Friends and Family Test - % positive - birth	Monthly	Nov-19	National (excl. IS)	93.0%	90.3%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal ward	Monthly	Nov-19	National (excl. IS)	93.0%	83.9%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal community	Monthly	Nov-19	National (excl. IS)	93.0%	100.0%	
Safe	Emergency c-section rate	Monthly	Nov-19	Local	15%	17%	
Organisational health	CQC inpatient survey	Annual	2018	National	8.0	7.8	
Safe	Venous thromboembolism (VTE) risk assessment	Quarterly	Q2 2019-20	National	95%	86.1%	
Safe	Clostridium difficile (C. difficile) plan: C.difficile actual variance from plan (actual number v plan number)	Monthly (YTD)	Apr-19 - Nov-19	National	0	-4	
Safe	Clostridium difficile – infection rate	Monthly	Nov-19	NHSI	15.5	40.39	
Safe	Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Monthly (12-month rolling)	Dec-18 - Nov-19	National	0.59	1.44	
Safe	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	Monthly (12-month rolling)	Dec-18 - Nov-19	National	8.01	6.71	
Safe	Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI)	Monthly (12-month rolling)	Dec-18 - Nov-19	National	18.49	20.62	
Effective	Hospital Standardised Mortality Ratio	Monthly (12-month rolling)	Oct-18 - Sep-19	National	100	84.9	
Effective	Summary Hospital-level Mortality Indicator	Monthly (12-month rolling)	Jul-18 - Jun-19	National	100	90.6	
Safe	Potential under-reporting of patient safety incidents	Monthly (six-month rolling)	May-19 - Oct-19	National	55.7	45.4	

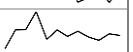
Finance

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

Operational performance

A&E	A&E maximum waiting time of four hours from arrival to admission/transfer/discharge	Monthly	Nov-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	Oct-19	National	92%	83.8%	
Cancer Waiting Times	62-day wait for first treatment from urgent GP referral for suspected cancer	Monthly	Oct-19	National	85%	81.1%	
Cancer Waiting Times	62-day wait for first treatment from NHS cancer screening service referrals	Monthly	Oct-19	National	90%	100.0%	
Diagnostics Waiting Times	Maximum 6-week wait for diagnostic procedures	Monthly	Oct-19	National	1%	0.20%	
The number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who:							
Dementia assessment and referral	a. have a diagnosis of dementia or delirium or to whom case finding is applied	Monthly	-	National	95%	-	
	b. who, if identified as potentially having dementia or delirium, are appropriately assessed	Monthly	-	National	95%	-	
	c. where the outcome was positive or inconclusive, are referred on to specialist services	Monthly	-	National	95%	-	

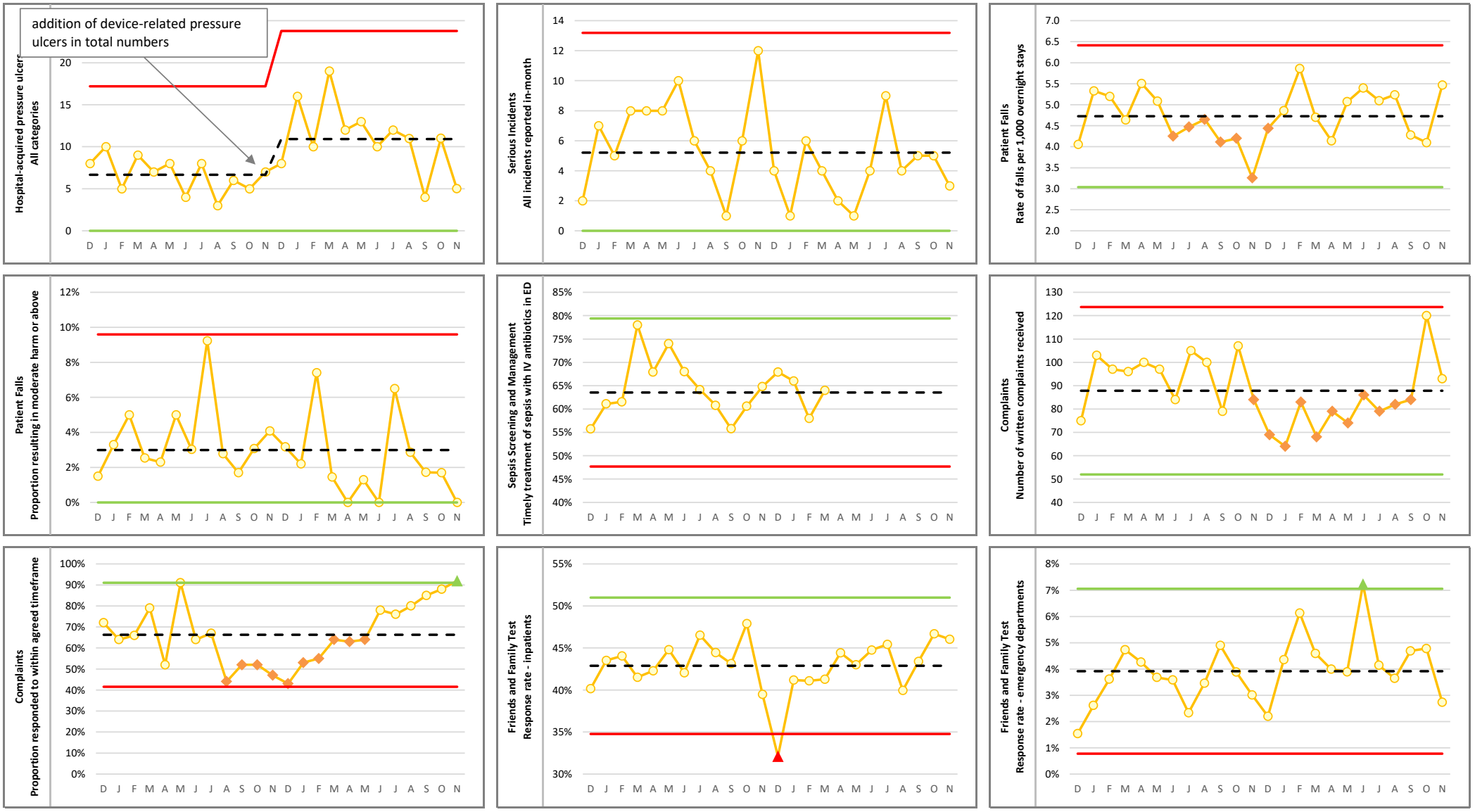
Leadership and workforce

Organisational health	Staff sickness	Monthly	Nov-19	Local	3.4%	4.2%	
Organisational health	Staff turnover	Monthly	Nov-19	Local	12.0%	12.7%	
Organisational health	Proportion of temporary staff	Monthly	Nov-19	Local	-	10.4%	
Organisational health	NHS Staff Survey Recommend as a place to work	Annual	2018	National	62.6%	53.9%	
Organisational health	NHS Staff Survey Support and compassion	Annual	2018	National	82.8%	80.0%	
Organisational health	NHS Staff Survey Teamwork	Annual	2018	National	65.4%	64.0%	
Organisational health	NHS Staff Survey Inclusion	Annual	2018	National	73.9%	71.8%	
Organisational health	BME leadership ambition (WRES) re executive appointments	Annual	2018	National	7.4%	0.0%	

Quality Improvement Dashboard

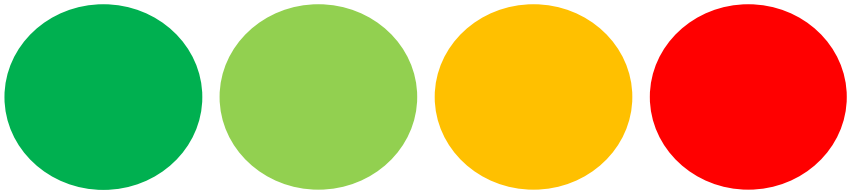
Safe, Caring and Effective Services Headline Metrics

East and North Hertfordshire NHS Trust



Safe Services

Month 08 | 2019-20



Key Issues

Safety Thermometer

- Harm-free care (for all and new harms) continue above target in November. However, All Harms 95.8% is at its lowest this financial year.

Patient Falls

- 75 inpatient falls were recorded in November this is an increase of 16 incidents when compared to October.
- Year to date the Trust is reporting a 1% increase in falls when compared to the same period in 2018.
- The Trust is 9 incidents over the target reduction trajectory set for 2019/20.

Serious Incidents & Never Events

- Zero Never Events were reported in November.
- There were 4 serious incidents reported in November:
  - 1 late treatment of diabetic keto-acidosis
  - 1 potential delay in dealing with a complication of surgery
  - 1 missed cancer diagnosis
  - 1 cannula inadequately flushed after surgery

Infection Control

- MRSA bacteraemia = 0 Hospital Onset cases and 2 Community Onset cases in November.
- C difficile infections = 7 reportable incidences in November.
- E.coli bacteraemia = 4 Hospital Onset cases in November.
- MSSA bacteraemia = 4 Hospital Onset cases in November.
- Hand hygiene compliance fell to 86.9% in November from 89.3% in October.

Hospital-acquired Pressure Ulcers

- There were the following reported for November:
  - Category 4 = 0
  - Category 3 = 1
  - Category 2 (D) = 1
  - Unstageable = 1
  - Unstageable (D) =1
  - SDTI = 6
  - MM (D) = 0

Sepsis

- ED overall sepsis 6 compliance in November was 22% which is an improvement from 17% in October
- Each intervention is now measured separately:
  - Antibiotics administration within an hour was 71% in November which is an improvement from 67% in October.

VTE

- Potential harm from hospital acquired thrombosis are presented to Serious Incident Review panel. One case was presented to panel in November with no further actions required.
- Medication chart has been revised to include time of initial VTE assessment, thereby clarifying reassessment timeframes. This will be launched in Jan 2020.

Executive Response

Safety Thermometer

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

Patient Falls

- Falls at night for the 3rd consecutive month account for less than 45% of falls incidents, studies on the epidemiology of inp atient falls highlight that falls in acute hospitals follow patterns of increased patient and staff activity in frequency and should occur at 40% (night)/ 60% (Day) split
- Year to date 552 inpatient falls have occurred in the Trust compared to 543 recorded during the same period in 2018 with incr eased focus it remains possible for the Trust to achieve an overall reduction in 2019/20 when compared to 2018/19.
- Year to date 76.3% of inpatient falls resulted in no physical harm to the patient involved, 21% resulted in a low level of ha rm such as minor cuts or bruises, 2% resulted in a moderate harm injury an example of a moderate harm injury is a small bone fracture, 0.7% of inciden ts resulted in severe harm injury to the patient involved.

Serious Incidents, Never Events & Safer Surgery

- Trust wide Never Event risk assessment plan agreed in November for phase 1 completion in December.
- Date set for 5th Dec to launch Invasive Procedure Clinical group - to support all specialities design LocSSIPs and map Human factors across invasive procure standards.

Infection Control - High Impact Interventions (HII)

- The overall hand hygiene observational audit score for October 2019 is 87% (1,200 observations).
- The Inpatient Environment peer audit scored 83% in October 2019. and 79% in November
- The Environment audit for clinical areas (non-ward areas) scored 94% in October 2019 and 92% in November.
- The Trust experienced several clusters and distinct outbreaks of viral gastroenteritis due to norovirus affecting several wards from the end of October until mid-November. A post-outbreak meeting was held to identify learning outcomes. which will be reported to the next TIPCC. T here were no further reportable incidents or outbreaks in November.
- There is an increasing incidence of C.difficile in the Trust. Ribotyping has been requested and will be analysed to identify if there may have been any potential cross-transmission. Ashwell Ward underwent a high level of decontamination using hydrogen peroxide misting ("fogging") in response to a period of increased incidence (PII) to eliminate environmental contamination as C.difficile has the ability to survive for ma ny months in the environment.
- There has been an increased incidence of patients readmitted with CPO (Carbapenemase Producing Organisms). ICNet has been co nfigured to provide alerts to the IP&C Team when known CPO-positive patients are readmitted to ensure prompt isolation. It is planned that this ale rt will be made available to site management out of hours.

Hospital-acquired Pressure Ulcers

- The tissue viability team review and validate all hospital acquired Pressure ulcers.
  Pressure ulcers remain in high focus at East and North Herts NHS trust with discussion daily at the site safety meeting, foll owing identification on ward safety huddle.
  A trust wide action plan has been implemented in response to the rise in PU numbers last year.
  The tissue viability team are leading on the clinical aspects of the new contract for beds and mattresses with specific regar d to training and use of online ordering system.
  The NHS Improvement Collaborative continues, driver diagram, aim and measures have been identified with help from a QI coach. Team meet regularly and are currently working to identify change ideas.
  Tissue viability team currently working under established by 1 WTE – due to unforeseen circumstances.
- The tissue viability team participated in the International Stop the Pressure day with an education walk around and staff mad e pledges on how they were going to improve pressure ulcer prevention for their patients.

Sepsis

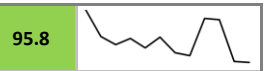
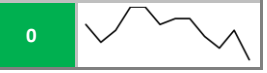
- Due to sepsis team capacity there were low numbers (4 for November) of patients with sepsis located on wards.
- Sepsis Team attending CCOT handover from beginning November & liaising with ACT to pick up more patients.
- ED patients:
  - 1 patient on immunotherapy advised not to have IVABs
  - 12 of 17 patients received IVABs within 1 hour (71%)
  - 15 of 17 patients received IVABs within 2 hours (88%)
  - 4 patients had evidence of whole sepsis six within 1 hour

VTE

- Thrombosis Action Group continue to meet bi-monthly.
- Root cause analysis from VTE cases are now presented by discharging consultant to SIRP.
- Following changes to the national criteria an increase in 23% of cases has been seen compared to the same period 2018/19, the refore a new VTE/HAT structure is under review with pharmacy, nursing and medical leads.

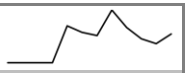
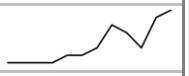
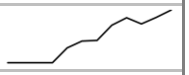
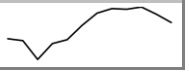
Safe Services

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Trend
Safety Thermometer	Harm-free care All harms	94.1	98.1	96.9	96.6	96.8	96.4	96.9	96.2	96.1	97.7	97.6	95.8	95.8	
	Harm-free care New harms	97.8	99.6	98.9	98.2	98.4	99.1	99.5	98.4	99.1	99.0	98.6	98.7	98.5	
Patient Falls	Number of patient falls	72	63	91	81	69	61	77	75	77	70	58	59	75	
	Rate of patient falls per 1,000 overnight stays	4.0	4.4	4.9	5.9	4.7	4.1	5.1	5.4	5.1	5.2	4.3	4.1	5.5	
	Number of patient falls resulting in serious harm	0	1	3	3	2	0	0	0	3	0	0	0	0	
Events and Incidents	Number of Never Events	0	0	0	0	0	0	0	0	1	0	1	1	0	
	Number of Serious Incidents	5	4	1	6	4	2	1	4	9	4	5	5	3	
Hospital-acquired Pressure Ulcers	Category 4	0	0	1	0	0	1	0	0	0	0	0	0	0	
	Category 3	0	0	0	0	0	0	0	0	0	0	0	0	1	
	Category 2	2	1	3	3	4	2	4	2	1	2	0	2	2	
	Category 2(D) Device-related	-	0	2	0	1	0	1	1	1	3	1	1	0	
	Mucosal membrane (D) Device-related	-	1	5	1	1	0	0	0	1	0	1	2	0	
	Unstageable	1	0	2	1	4	0	2	0	2	2	0	1	2	
	SDTI Excluding STDI (D)	3	6	3	5	9	9	6	7	7	4	2	5	0	
Sepsis Screening and Management	Inpatients with Sepsis - sample size	50	-	-	-	-	27	21	19	10	10	6	5	4	
	Inpatients receiving IVABs within 1 hour of Red Flag	90%	-	-	-	-	40%	40%	0%	40%	40%	17%	40%	50%	

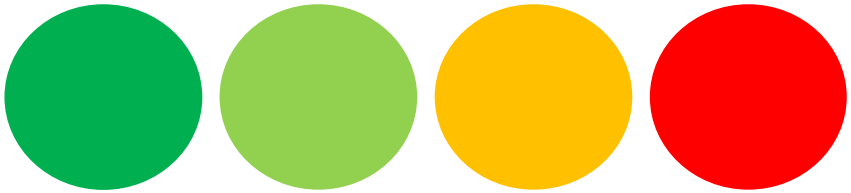
Safe Services

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Trend
Sepsis Screening and Management	Emergency attendances with Sepsis - sample size	50	-	-	-	-	23	19	17	33	22	15	12	18	
	Emergency attendances receiving IVABs within 1 hour of Red Flag	90%	-	-	-	-	90%	84%	88%	88%	86%	73%	67%	71%	
	Sepsis six bundle compliance - ED	90%	-	-	-	-	tbc	tbc	tbc	48%	68%	40%	12%	22%	
VTE	VTE risk assessment	95%	91.4%	96.5%	95.9%	96.5%	88.2%	89.8%	90.2%	87.8%	87.2%	83.5%	tbc	tbc	
Infection Control	Number of MRSA incidences	0	0	0	0	0	1	0	0	1	0	1	0	0	
	Rate of MRSA incidences per 100,000 bed days	0.6	0.0	0.0	0.0	0.0	5.7	0.0	0.0	5.7	0.0	5.9	0.0	0.0	
	Number of c.difficile incidences Healthcare-associated	4	-	-	-	-	1	1	2	5	4	2	6	7	
	Rate of c.difficile incidences per 100,000 bed days Healthcare-associated	19.0	-	-	-	-	11.4	16.6	17.1	28.7	34.4	29.7	34.6	40.4	
	Number of e.coli incidences	-	2	3	6	1	3	5	2	5	2	2	8	4	
	Rate of e.coli incidences per 100,000 bed days	18.5	11.5	16.8	37.1	5.6	17.1	27.7	11.4	28.7	11.5	11.9	46.2	23.1	
	Number of MSSA incidences	-	2	1	0	1	1	0	2	1	1	0	4	1	
	Rate of MSSA incidences per 100,000 bed days	8.0	11.5	5.6	0.0	5.6	5.7	0.0	11.4	5.7	5.7	0.0	23.1	5.8	
	Number of klebsiella incidences	-	0	2	0	1	0	0	1	3	3	3	1	2	
	Rate of klebsiella incidences per 100,000 bed days	7.6	0.0	11.2	0.0	5.6	0.0	0.0	5.7	17.2	17.2	17.8	5.8	11.5	
	Number of pseudomonas aerudinosa incidences	-	0	1	0	1	0	2	0	1	1	0	0	0	
	Rate of pseudomonas aerudinosa incidences per 100,000 bed days	3.7	0.0	5.6	0.0	5.6	0.0	11.1	0.0	5.7	5.7	0.0	0.0	0.0	
	Hand hygiene audit score	95%	82.2%	81.7%	76.3%	80.9%	82.0%	86.0%	89.6%	90.8%	90.7%	91.4%	89.3%	86.9%	

Caring Services

Month 08 | 2019-20



Key Issues

Friends and Family Test (FFT)

- The proportion of positive responses to the Inpatients, Antenatal, Postnatal Community & Outpatients are better than the respective Trust Targets in November.
- The proportion of positive responses to A&E (89.3%), Birth (90.3%) and Postnatal Ward (83.9%) are below their respective Trust Targets in November.
- Response rates fell across the board in November, although only slightly for Inpatients and Maternity Birth. A&E and Maternity Birth remain below their respective Trust Targets.
- Total responses for Inpatients (2,071), A&E (439), Maternity Birth (124) and Outpatients (2,133) all fell in November. Total responses for A&E and Maternity Birth remain below their respective Trust targets.

Complaints

- Total number of complaints received since April 2019 = 697, with 93 complaints received in November. The breakdown by division is as follows:
  - Surgery 32
  - Medicine 32
  - W&C 13
  - CSS 8
  - Cancer 5
  - Operations 3

- 100% of complaints received were acknowledged within 3 working days.
- 92% were responded to within the agreed timeframe.
- Since April 2019 an average of 79% of complaints across the divisions have been responded to within the agreed timeframe.
- As at end of November 2019 we had 74 open complaints.

Executive Response

Friends and Family Test (FFT)

- The inpatient / day case percentage of patients who would recommend the Trust remains higher than the national average. The response rate continues to exceed the latest national average response rate of 24.3% and is above the Trust's target of 40%.
- The highest proportion of positive comments from inpatient / day case patients relate to staff being kind and caring, and the care and treatment provided. Negative comments relate to communication about what is happening, noise at night and food.
- 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 including refreshments. Negative feedback relates to the length of waiting times and provision of food. 20 patients out of 439 who responded to the A&E FFT survey were unlikely or extremely unlikely to recommend the service.
- Outpatients compliment staff for being kind and helpful and for the care, treatment and information provided. There are concerns about waiting times in clinics and lack of information about reasons for the delays. Other concerns relate to appointment letters, administration of appointments and the cost and availability of car parking spaces.
- The majority of women compliment the staff for the support, care and information provided to them during their birth experience. On the postnatal ward 6 out of 124 women would not recommend the service. Women would like a quieter environment, with more space better provision of recliner chairs and more information about what's happening.

Improvement efforts - Complaints

- Case handlers are meeting regularly with divisions to support the complaints process.
- Despite an increase in the number of complaints received in the month of October 2019 compared with previous months the improvement plan to achieve less than 120 open complaints across all divisions within this Trust has still been achieved.
- The monthly open complaints have gone from 160 to 87 in October 2019 and reduced further to 74 open complaints at the end of November 2019.

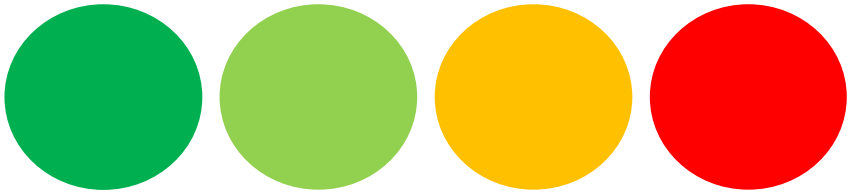
Caring Services

East and North Hertfordshire NHS Trust

Domain	FFT	Metric	Target	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Trend
Friends and Family Test	Inpatients	Proportion of positive responses	95%	97.5%	97.3%	96.8%	96.8%	96.7%	96.4%	96.9%	97.8%	96.9%	96.9%	96.3%	97.6%	
		Total number of responses	1,778	1,391	2,094	1,791	1,889	1,994	2,022	2,095	2,263	1,760	1,959	2,102	2,071	
		Response rate	40%	32.1%	41.2%	41.1%	41.3%	44.4%	43.0%	44.8%	45.4%	39.9%	43.4%	46.7%	46.0%	
	A&E	Proportion of positive responses	90%	85.2%	90.2%	90.9%	89.7%	92.5%	93.9%	92.7%	83.8%	94.0%	88.9%	90.0%	89.3%	
		Total number of responses	1,241	297	610	806	671	546	559	1,008	624	498	676	727	439	
		Response rate	10%	2.2%	4.4%	6.1%	4.6%	4.0%	3.9%	7.2%	4.1%	3.6%	4.7%	4.8%	2.7%	
	Maternity	Antenatal care Proportion of positive responses	93%	96.8%	92.5%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	
		Birth Proportion of positive responses	93%	94.1%	94.7%	98.1%	100.0%	96.1%	99.4%	97.3%	96.5%	92.9%	98.1%	95.6%	90.3%	
		Birth Total number of responses	137	135	132	157	71	128	159	74	115	98	106	135	124	
		Birth Response rate	30%	29.8%	30.2%	39.1%	16.3%	30.5%	34.6%	17.4%	24.5%	22.3%	23.7%	28.6%	27.9%	
		Postnatal ward Proportion of positive responses	93%	83.3%	91.6%	91.7%	83.1%	87.4%	89.7%	86.5%	92.2%	88.8%	94.3%	84.4%	83.9%	
		Postnatal community Proportion of positive responses	93%	94.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Outpatients	Proportion of positive responses	95%	95.2%	94.1%	94.4%	95.5%	94.5%	96.2%	95.8%	95.4%	95.4%	94.5%	94.8%	95.0%	
		Total number of responses	-	1,683	2,037	2,281	5,320	1,980	4,100	3,943	3,613	3,313	2,448	3,127	2,133	
Complaints		Number of written complaints received	92	69	64	83	68	79	74	86	79	82	84	120	93	
		Rate of written complaints received	1.9	1.6	1.1	1.6	1.3	1.6	1.4	1.7	1.5	1.8	1.7	2.2	1.8	
		Proportion of complaints acknowledged within 3 working days	75%	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
		Proportion of complaints responded to within agreed timeframe	80%	43%	53%	55%	64%	63%	64%	78%	76%	80%	85%	88%	92%	

Effective Services

Month 08 | 2019-20



Key Issues

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

Crude Mortality
- The in-month crude mortality rate increased slightly to 8.6 deaths per 1,000 admissions in November.
- The rolling 12-months crude mortality rate improved slightly to 10.7 deaths per 1,000 admissions in the 12 months to November, and remained better than the most recently available national rate of 11.5 deaths per 1,000 admissions.

Hospital-Standardised Mortality Ratio (HSMR)
- The in-month HSMR improved to 70.3 in September, and remained better than the standard (100).
- The rolling 12-months HSMR improved to 84.9 in the 12 months to September, and the Trust remains in the second-best performing quartile of Trusts for HSMR.
- HSMR is usually available 2 months in arrears.

Summary Hospital-level Mortality Indicator (SHMI)
- The latest SHMI release for the 12 months to June saw an improvement to 90.59.
- Dr Foster provides detail of which diagnosis groups have significantly elevated SHMI. The latest report provided by them indicates there are 3 significantly elevated diagnosis groups: Diverticulosis & Diverticulitis (200.0); Congestive Heart Failure (137.5); and Biliary tract disease (166.7). We have been advised that this may not be an accurate picture and that the refresh due later in December will better reflect our position. With the exception of Congestive Heart Failure there are relatively small numbers of deaths involved.
- 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 8.6% in August to 8.8% in September 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.

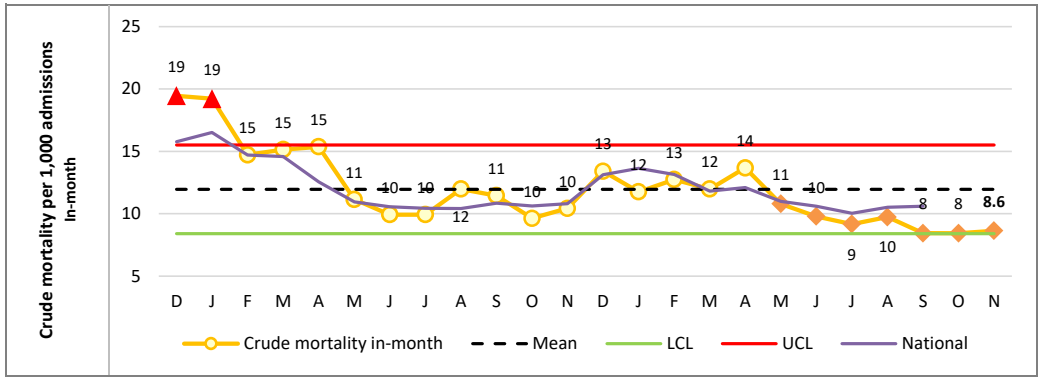
Crude mortality
- This measure is available the day after the month end and has demonstrated a consistent decrease over the last 5 years. It is the factor with the most significant impact on HSMR.
- The improvements in mortality have been as a result of a combination of corporate level initiatives such 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 May 2019, the Trust's crude mortality rate remained higher than 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.

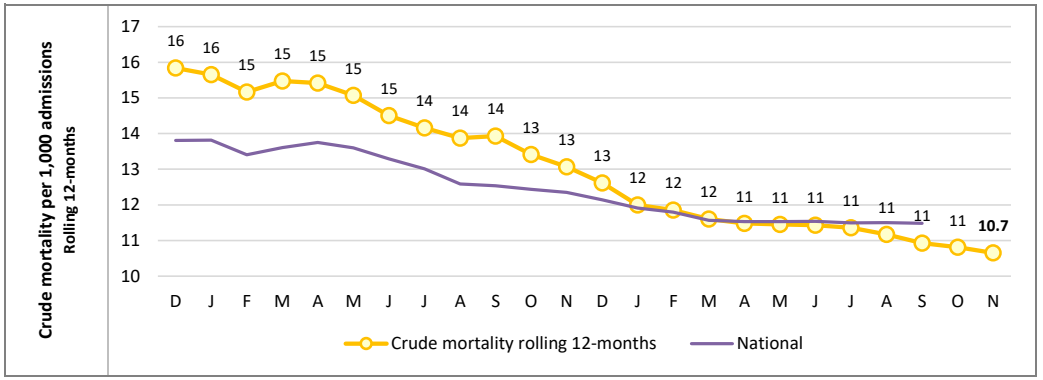
Hospital Standardised Mortality ratio (HSMR)
- While our current HSMR of 84.9 makes us well-positioned in the second lowest quartile of Trusts, we remain focussed on driving further improvement.

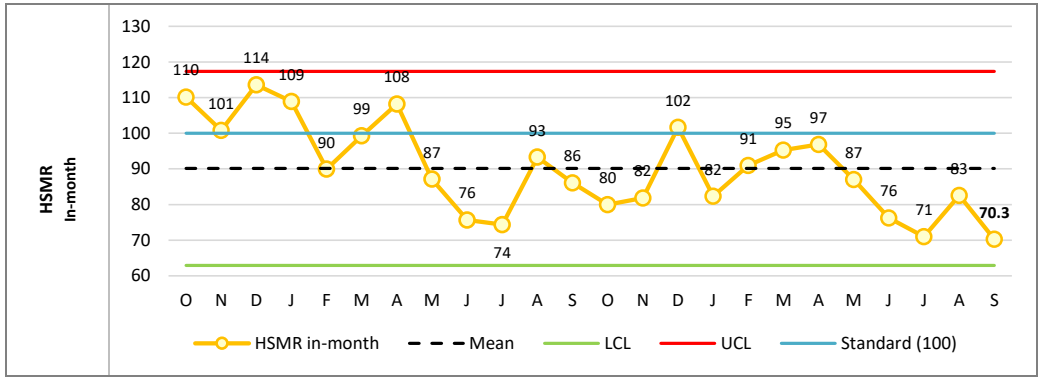
Summary Hospital-level Mortality Indicator (SHMI)
- As with HSMR, the recent significant improvements to SHMI have been welcomed. Following a recent discussion with Dr Foster we are waiting for the December SHMI refresh for an accurate indication of any alerting diagnosis groups requiring our attention.

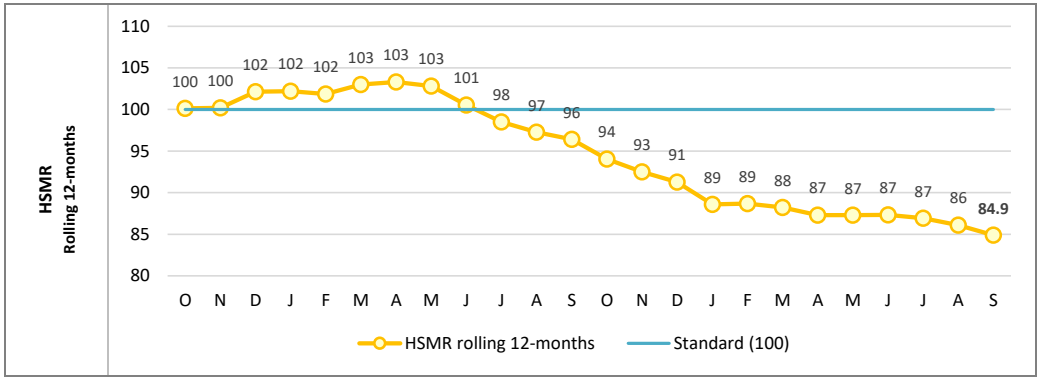
Re-admissions
- The Trust's re-admission rate has been consistent with the national performance. The most recent comparable months (June and July 2019) have been slightly higher than the national average, while the rate has increased by 0.3% from July to September.

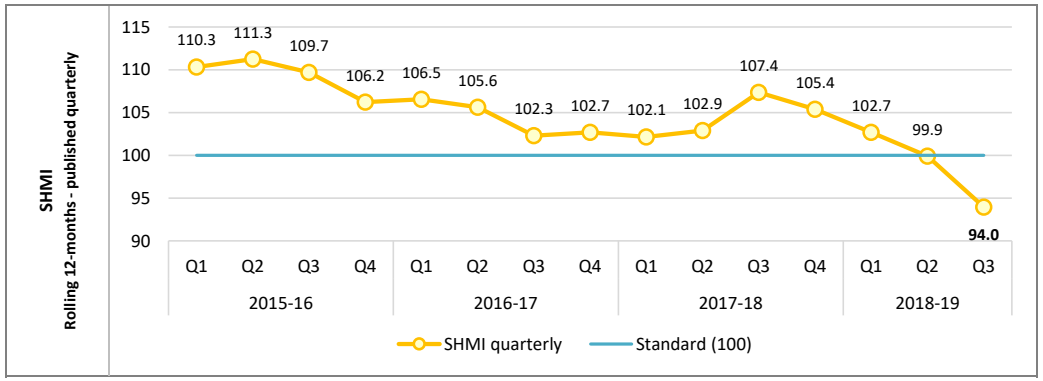
Learning from Deaths
- In addition to the outcomes of cases escalated to Specialties being considered by the Mortality Surveillance Committee (where proposed remedial/development action is approved/recommended), the quarterly Learning from Deaths report includes a summary of key themes emerging from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

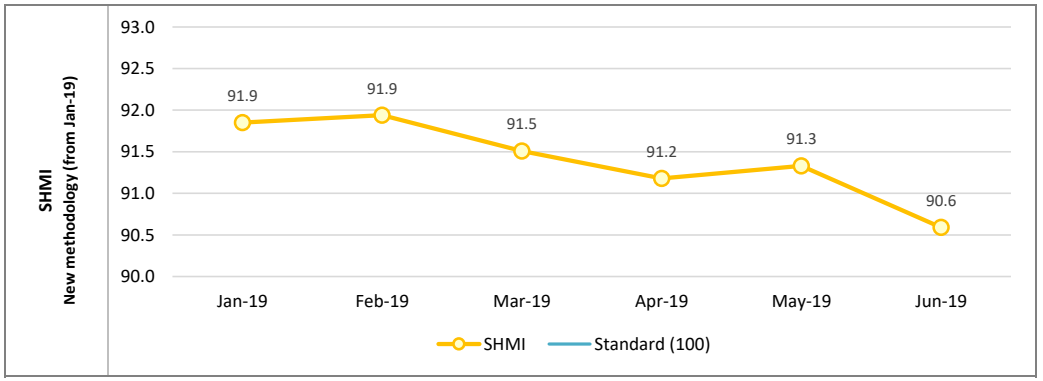

Crude mortality per 1,000 admissions
In-month
Crude mortality in-month
Mean
LCL
UCL
National


Crude mortality per 1,000 admissions
Rolling 12-months
Crude mortality rolling 12-months
National


HSMR
In-month
HSMR in-month
Mean
LCL
UCL
Standard (100)

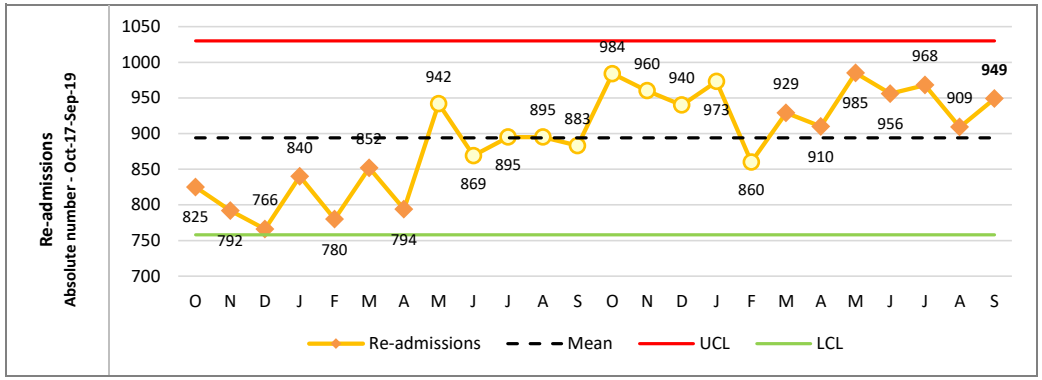

HSMR
Rolling 12-months
HSMR rolling 12-months
Standard (100)

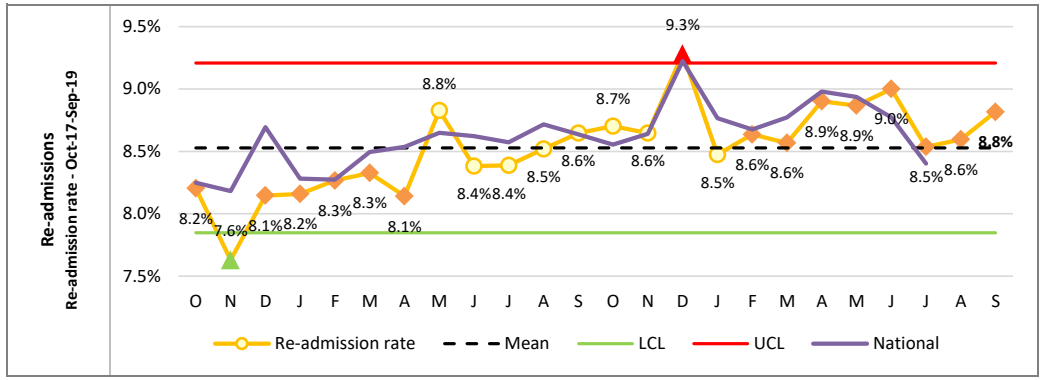

SHMI
Rolling 12-months - published quarterly
SHMI quarterly
Standard (100)


SHMI
New methodology (from Jan-19)
SHMI
Standard (100)

Effective Services

East and North Hertfordshire NHS Trust

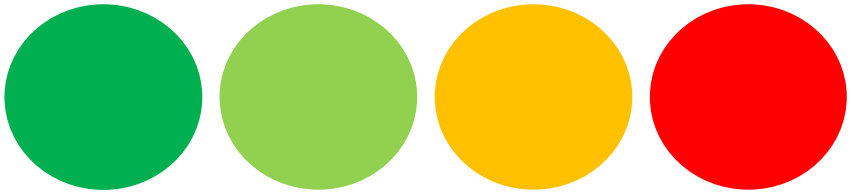




End of Life Care	Proportion of patients with whom their preferred place of death was discussed	tbc	To be confirmed	
	Individualised care pathways	tbc		

Responsive Services

Month 08 | 2019-20



Key Issues

A&E
- Performance for the month of November 2019 was 81.53%.
- There was one 12-hour trolley wait reported in November.

Cancer Waiting Times
- In October 2019 the Trust achieved 6 out of the 8 national targets for cancer performance.
- The Trust 62-day performance for October 2019 was 81.1%, which is above the previous month of 69.7%.
- The cancer recovery business case is still in process to implement.
- Good progress is being made on the speciality cancer recovery plans, all plans being reviewed and updated weekly.
- The capacity challenges with specialist treatments such as RALP, Brachytherapy, PET scans and histology, have now been addressed and plans are in place to deliver sufficient capacity to deliver Trust's 62-day performance.
- 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;
  - Histology Demand & Capacity model has been completed and awaiting final report from IST. Pathway analysis for Histology services in process to be completed by January 2020;
  - Pathway analysis for Breast, LGI and UGI in process to be completed by January 2020.
  - Continue to Work to deliver the 28-day faster diagnosis target, which is currently at 58% compliance;
  - Development of metrics to demonstrate improvements in the performance whilst working to delivery of recovery trajectory. Current analysis shows a statistically significant improvement in the Trust 62-day compliance.

RTT
- Incomplete performance for November was 83.93%, slightly better than the 83.81% reported in October.
- The November backlog was 7,034, a reduction of 237 from October.
- There were 15 52-week breaches reported in our November incomplete position, a reduction of one from the 16 reported in October.

Diagnostics
- DM01 performance for November is 0.15% against the national standard of 1% and the October position of 0.20%.

Stroke
- Performance for October 60.3% reduction in performance from September highest number of Strokes (81) since May 2019 - reduction of 19% compared to September 2019.
- Due to the change in SNNAP reporting - the impact of ENHT starting the record for all transfers to Charing Cross - this has a direct impact on the ENHT 4hr performance, as if breach at Charing Cross, the whole breach is allocated to ENHT.
- Thrombolysis rate at 12.5% improvement from August and September performance.
- Thrombolysed within 60-minutes of arrival 70% for October increase of 41% in performance from September and 45% improvement compared for October 2018.
- Ongoing significant improvement in 60-min to scan performance 65.4% performance for October 2019.
- Maintain performance of meeting of 40% target for ESD performance at 47.7% for October 2019.
- Challenging Month for Stroke performance, due to the high number of Strokes (81) and impact on LOS - this an increase of 11% compared to September 2019 and 30% Increase compared to October 2018.
- Impact on number of Medical admission within the Stroke unit for the Month of October - average of 4 per day - which has an impact on Stroke Admissions within 4hrs to Stroke unit.
- Impact on LOS due to limited resource from supporting services for delivery of therapy support - due to vacancy rate.
- Increase in LOS over the weekend due to limited access to Diagnosis services and reduced Therapy cover over the weekend - one day was at 26.00 over the weekend.
- Ring fence of Stroke beds of 6 beds per day - this was only achieved 13days within the month so therefore 58% didn't adhere to Ring fence of Stroke beds.
- Average LOS for October 8.04 which is an increase from the September LOS 7.78.

Executive Response

A&E
- The trust ED performance in November declined due to increased demand on services coupled with reduced flow which is reflecte d in the times to initial assessment and treatment.
- Demand in November was up by 7.5% compared to the same month last year.
- Although there was a continued decline in ambulance arrival to handover times, increasing to an average of 21mins, we remain above trajectory and below the regional average of 25minutes.
- The new triggers and actions were formally introduced during 'Perfect Week'. Although considered in general as a positive to ol to facilitate early identification and response to risks, there have been some suggestions for improvement to ensure responses t o identified risks are more aggressive and effective.

Cancer performance (October)
- In October 2019, the Trust achieved 6 of the 8 national targets for cancer performance: 2ww and 2ww Breast Symptoms; and 31 -day subsequent for Radiotherapy, Chemotherapy, 1st definitive treatment and 62 -day referral to treatment from screening. Cancer performance is available one month in arrears.
- The Trust has always previously delivered against the 2ww national standard which requires 93% of patients referred on a two -week pathway by their GP to have attended the 1st Outpatient appointment within 14 days. For October 2019 the Trust performance wa s 98.5% which equates to 1,443 out of 1,465 pathways meeting the two -week standard, with 22 breaches of the standard being reported.
- In October 2019, the Trust wide average days wait for first appointment is at 10 days and the majority of patients were seen between 8 and 12 days.
- The Trust has not consistently delivered against the Breast Symptomatic national standard which requires 93% of patients refe rred to have attended the 1st Outpatient appointment within 14 days. For October 2019 the Trust performance was 95.4% which equates t o 103 out of 108 pathways meeting the 2 -week standard, with 5 breaches of the standard being reported.
- The Trust has consistently delivered the 31 -day to first definitive treatment for Radiotherapy and Chemotherapy. For October 2019 the Trust Chemotherapy performance was 99.5% which equates to 192 out of 193 pathways meeting the 31 day standards, with 1 breach. For October 2019 the Trust Radiotherapy performance was 98.3% which equates to 281 out of 286 pathways meeting the 3 1 day standards, with 5 breaches of the standard reported.
- The Trust performance for 31-day to first definitive treatment was 96.9% which equates to 248 out of 256 pathways meeting the 31-day standard, with 8 breaches of the standard reported. The standard requires 96% of patients to receive treatment within 31 days of diagnosis.
- In October 2019 the Trust performance for the Faster Diagnosis is 58.1% for the 2ww patients and 32.5% for the screening pati ents. Action plans have put in place for the FDS to improve performance and meet the target by April 2020.
- Reported 62-day performance for October 2019 was 81.1%, which is 4.2% below the revised recovery trajectory of 85.3%. 5 out of 10 tumour sites met the standard.

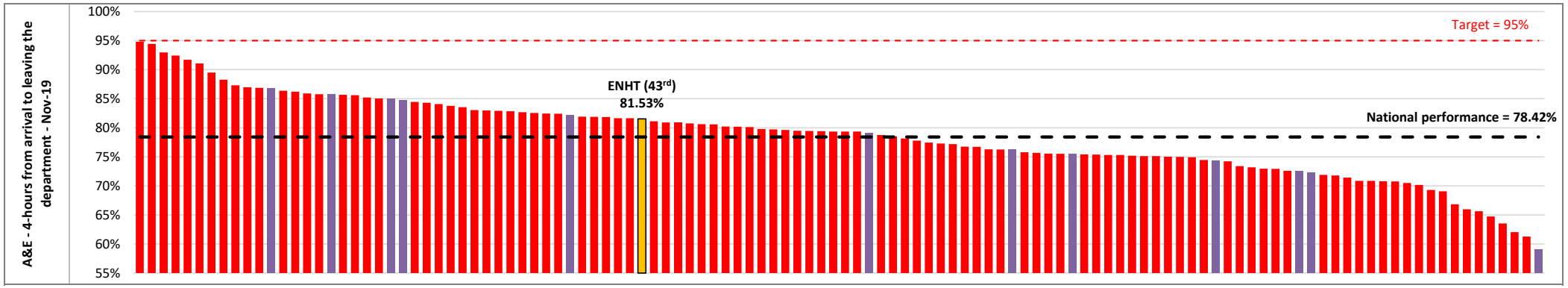
RTT
- Performance has improved very slightly in November but remains significantly below our trajectory of 89.7% Backlog pressures in the T&O, Oral and Gastroenterology continue to be the main contributors to this downturn in performance. Increasing demand and capacity constraints are the drivers. Plans to improve the position remain in development in these areas.
- The Trust reported 15 52-week breaches. All these breaches occurred in Surgical specialties. Operational grip within Surgery is improving but progress is hampered by referrals found to have been stopped incorrectly in clinic. These referrals are re -opened and added back to the incomplete PTL.

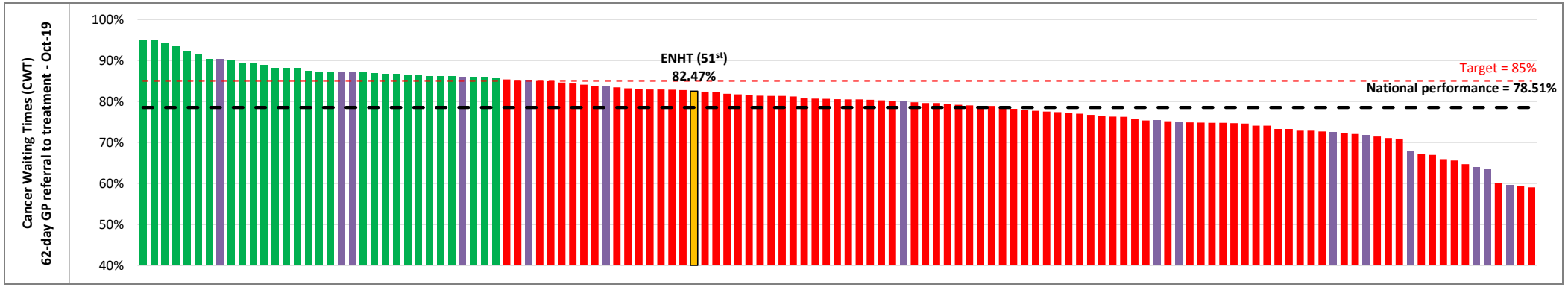
Diagnostics
- Diagnostics performance in November remains strong at 0.15%. This is very significantly better than the national aggregate p osition. The overall DM01 PTL has reduced by >20% in November. This reduction should be reviewed so the underlying drivers can be ful ly described. 8 patients waited more than 13 weeks for a diagnostic test in November. The elimination of 13 -week breaches in diagnostic services is our current priority whilst maintaining the compliant position overall.

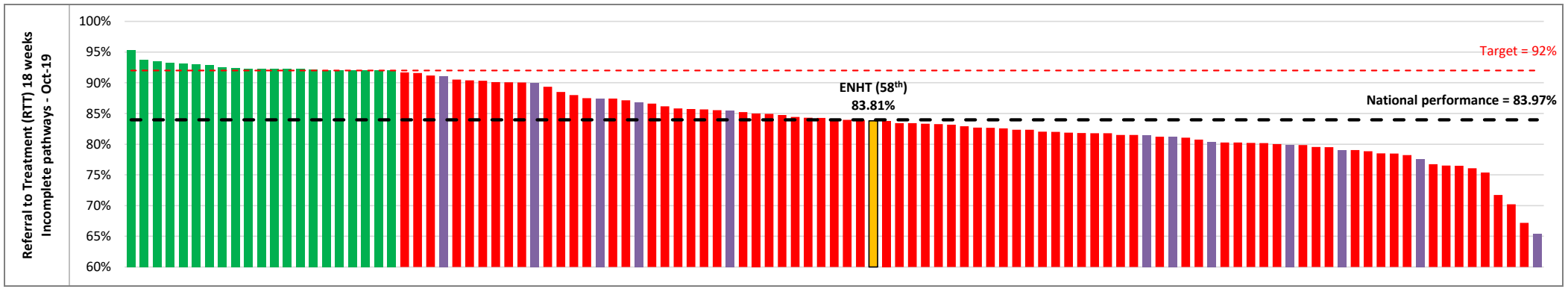
Responsive Services

Trust performance against all Trusts nationally

East and North Hertfordshire NHS Trust



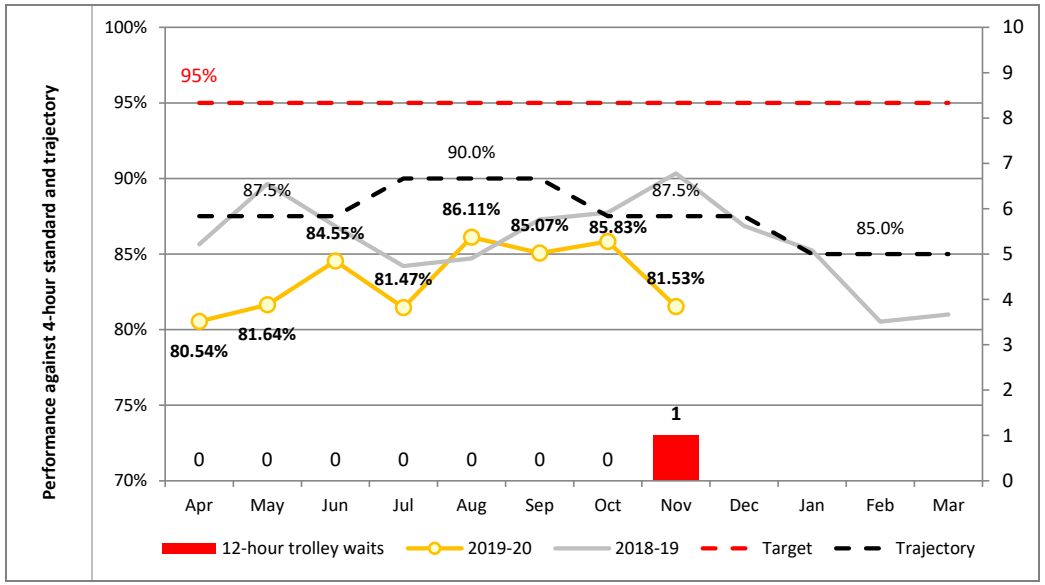




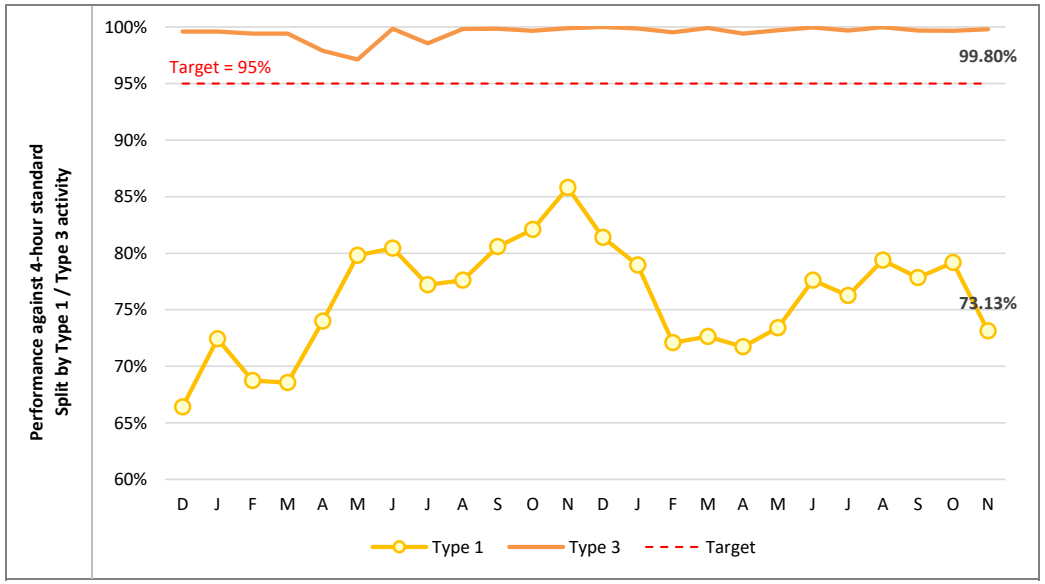
Responsive Services

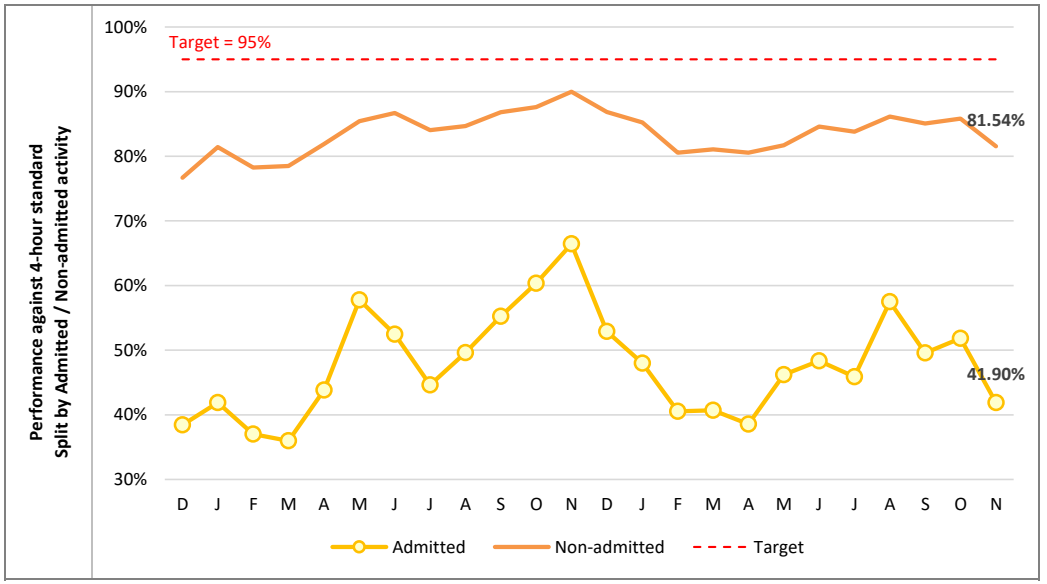
Emergency Department Performance

East and North Hertfordshire NHS Trust



Domain	Metric	Target	Oct-19	Nov-19	Change	Trend
Other Emergency Department measures	Ambulance handovers Proportion within 15 minutes	-	52%	57%	▲	
	Ambulance handover breaches 30-minutes	230	215	360	▲	
	Ambulance handover breaches 60-minutes	43	38	62	▲	
	Attendance to admission conversion rate	-	35.9%	35.4%	▼	
	Time to initial assessment 95th centile	15	51	61	▲	
	Time to treatment Median	60	64	95	▲	
	Left department before being seen for treatment	5%	1.8%	2.0%	▲	
	Unplanned re-attendance rate	5%	4.8%	tbc	▲	





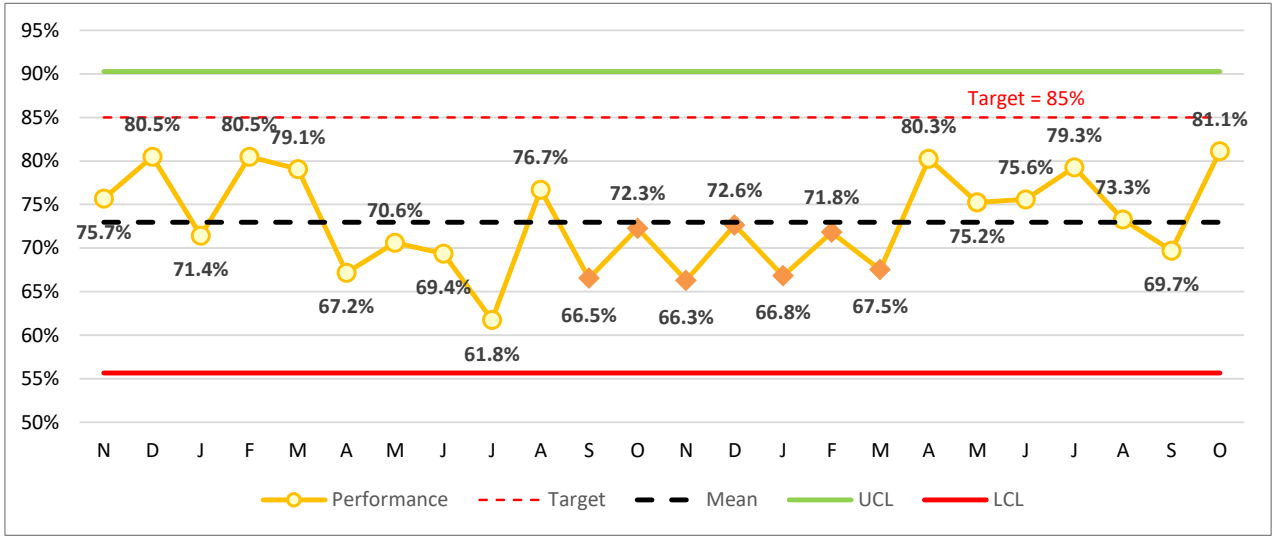
Responsive Services

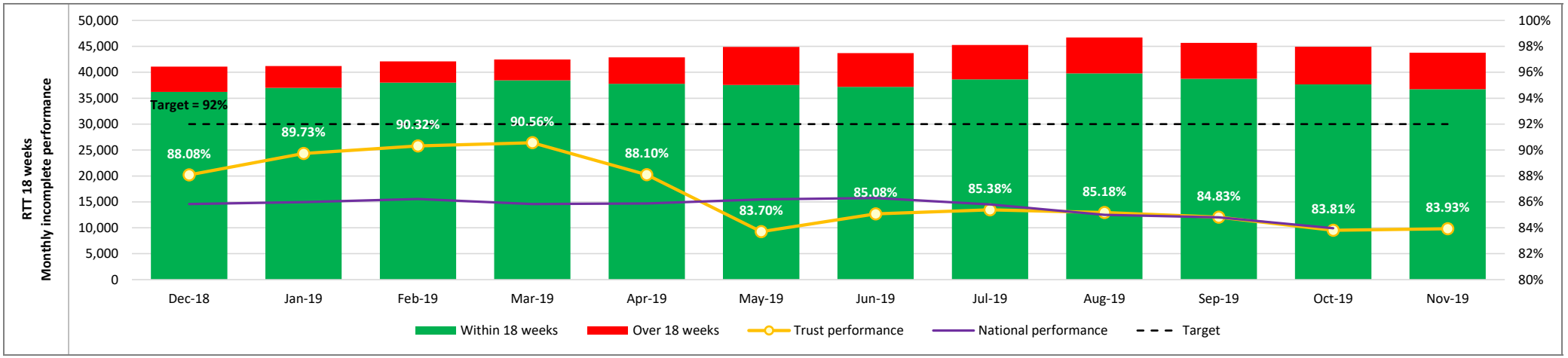
Cancer Waiting Times

East and North Hertfordshire NHS Trust

12-months' performance - all standards	Standard	Target	2018-19						2019-20							
			Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	YTD	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	YTD
	Two week waits Suspected cancer	93%	96.70%	97.24%	95.61%	96.57%	97.00%	94.77%	95.94%	95.59%	96.66%	96.15%	94.80%	97.22%	98.50%	96.42%
	Two week waits Breast symptomatic	93%	94.44%	93.38%	94.50%	94.02%	94.00%	92.56%	88.68%	92.68%	93.39%	94.78%	87.30%	95.76%	95.37%	92.30%
	31-day First definitive treatment	96%	91.84%	96.33%	96.00%	95.15%	94.47%	93.86%	93.52%	94.93%	91.90%	97.01%	96.97%	95.98%	96.88%	95.33%
	31-day subsequent treatment Anti-cancer drugs	98%	97.99%	100.00%	98.66%	99.37%	98.26%	99.00%	98.19%	97.81%	99.29%	99.07%	99.42%	99.41%	99.48%	98.95%
	31-day subsequent treatment Radiotherapy	94%	97.33%	97.20%	95.05%	97.97%	95.68%	95.11%	96.90%	98.27%	98.86%	96.32%	97.53%	97.27%	98.25%	97.60%
	31-day subsequent treatment Surgery	94%	69.39%	84.21%	63.64%	76.47%	78.79%	75.57%	96.77%	80.00%	78.95%	77.42%	83.33%	85.19%	65.52%	81.13%
	62-day GP referral to treatment	85%	66.28%	72.64%	66.80%	71.82%	67.52%	69.09%	80.25%	75.25%	75.58%	79.26%	73.28%	69.71%	81.14%	76.42%
	62-day Specialist screening service	90%	86.21%	100.00%	72.73%	79.17%	95.24%	79.61%	81.82%	100.00%	63.64%	56.00%	82.35%	73.68%	100.00%	79.87%

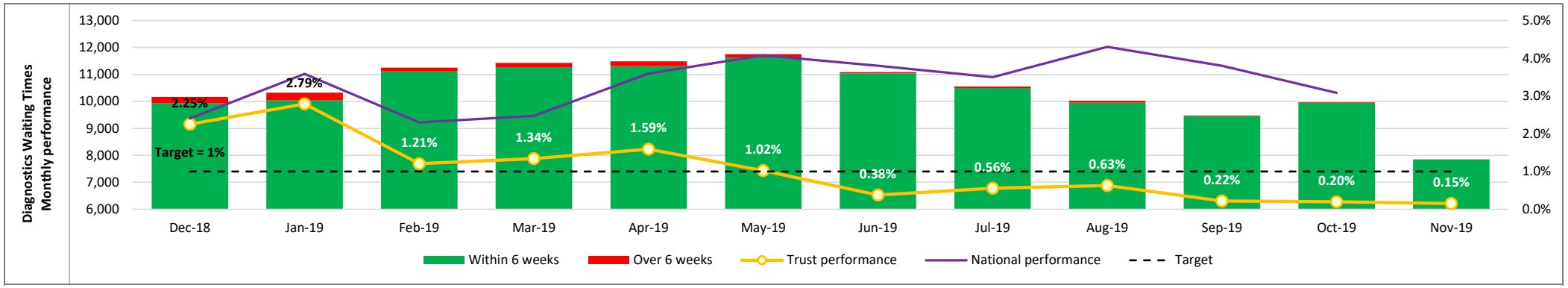
62-day GP referral to treatment Oct-19	Tumour Site	OK	Breach	Total	Perf.
	Breast	18.0	3.0	21.0	85.71%
	Gynaecology	5.5	1.0	6.5	84.62%
	Haematology	4.0	1.5	5.5	72.73%
	Head and Neck	6.0	0.5	6.5	92.31%
	Lower GI	8.0	7.0	15.0	53.33%
	Lung	6.5	3.0	9.5	68.42%
	Other	0.0	1.0	1.0	0.00%
	Sarcoma	0.0	0.0	0.0	-
	Skin	22.5	1.0	23.5	95.74%
	Testicular	1.0	0.0	1.0	100.00%
	Upper GI	7.0	2.5	9.5	73.68%
	Urology	35.5	6.0	41.5	85.54%
	Total	**114.0**	**26.5**	**140.5**	81.14%





RTT 18 weeks
In-month performance by Specialty - Nov-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	325	71.69%	0	355	87.04%	0	2,468	433	2,901	85.07%	11	0	1,009
Urology	173	65.90%	0	458	84.50%	0	1,764	191	1,955	90.23%	9	0	752
Trauma & Orthopaedics	164	48.17%	0	565	72.74%	0	2,513	658	3,171	79.25%	67	4	884
Ear, Nose & Throat (ENT)	159	66.67%	0	720	84.17%	0	2,180	377	2,557	85.26%	12	2	945
Ophthalmology	195	46.67%	0	640	82.19%	0	3,405	316	3,721	91.51%	8	0	1,065
Oral Surgery	74	10.81%	0	467	32.55%	0	1,745	671	2,416	72.23%	16	1	566
Plastic Surgery	123	78.05%	0	760	95.53%	0	1,308	87	1,395	93.76%	6	0	853
Cardiothoracic Surgery	1	100.00%	0	10	100.00%	0	27	3	30	90.00%	1	0	12
General Medicine	0	-	0	213	99.06%	0	1,308	1	1,309	99.92%	0	0	523
Gastroenterology	314	78.66%	0	332	55.12%	0	2,843	788	3,631	78.30%	34	2	1,068
Cardiology	80	93.75%	0	867	68.74%	0	2,987	505	3,492	85.54%	7	0	1,105
Dermatology	1	100.00%	0	248	85.08%	0	956	121	1,077	88.77%	1	0	355
Thoracic Medicine	24	95.83%	0	319	79.00%	0	1,067	137	1,204	88.62%	6	0	398
Neurology	0	-	0	372	86.02%	0	1,219	129	1,348	90.43%	1	0	481
Rheumatology	0	-	0	166	46.39%	0	852	279	1,131	75.33%	9	0	238
Geriatric Medicine	0	-	0	61	91.80%	0	104	1	105	99.05%	0	0	64
Gynaecology	113	60.18%	0	428	87.85%	0	2,517	301	2,818	89.32%	30	0	918
Other	151	56.95%	0	2,790	81.61%	0	7,481	2,036	9,517	78.61%	103	6	3,707
Total	**1,897**	**64.73%**	**0**	**9,771**	**78.66%**	**0**	**36,744**	**7,034**	**43,778**	**83.93%**	**321**	**15**	**14,943**



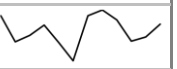
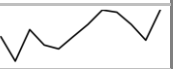
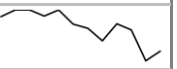
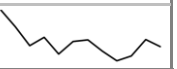
Diagnostics Waiting Times
In-month performance by Modality - Nov-19

Category	Modality	Within 6 weeks	Over 6 weeks	Total	Performance	13+ weeks
Imaging	Magnetic Resonance Imaging	1,016	0	1,016	0.00%	0
	Computed Tomography	557	3	560	0.54%	3
	Non-obstetric ultrasound	3,434	0	3,434	0.00%	0
	DEXA Scan	254	0	254	0.00%	0
Physiological Measurement	Audiology - audiology assessments	44	0	44	0.00%	0
	Cardiology - echocardiography	1,174	3	1,177	0.25%	0
	Neurophysiology - peripheral neurophysiology	136	0	136	0.00%	0
	Respiratory physiology - sleep studies	111	0	111	0.00%	0
	Urodynamics - pressures & flows	32	5	37	13.51%	4
Endoscopy	Colonoscopy	453	0	453	0.00%	0
	Flexi sigmoidoscopy	167	0	167	0.00%	0
	Cystoscopy	67	1	68	1.47%	1
	Gastroscopy	394	0	394	0.00%	0
Total		**7,839**	**12**	**7,851**	**0.15%**	**8**

Responsive Services

Stroke Services

East and North Hertfordshire NHS Trust

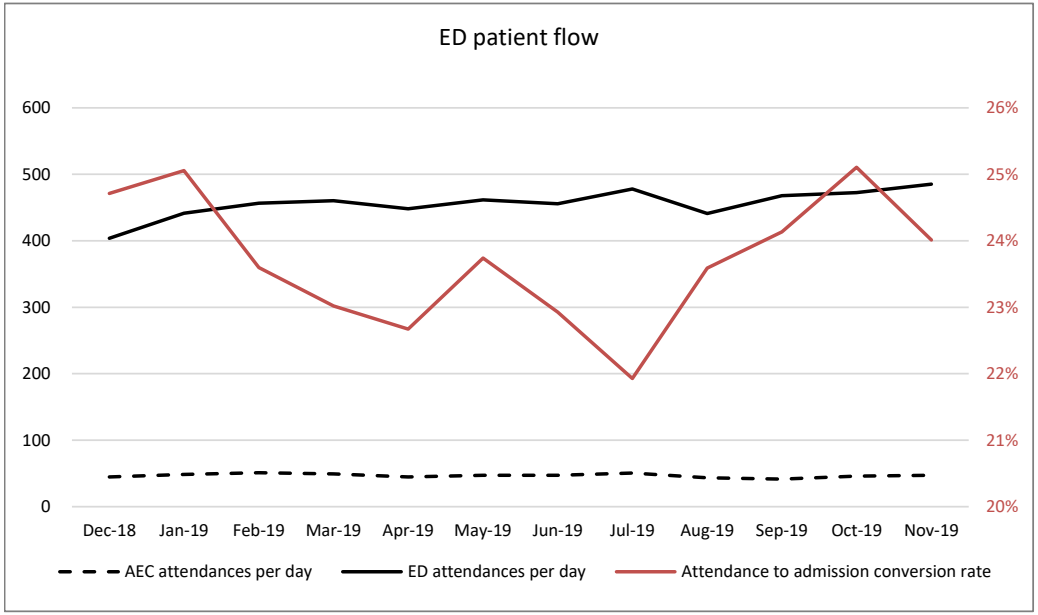
Domain	Metric	Target	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Trend
Stroke	Trust SSNAP grade	A	A	A	A	A	A	A	A	A	tbc	tbc	tbc	tbc	
	Discharged with AF on anticoagulants	80%	80.0%	100.0%	100.0%	100.0%	88.9%	100.0%	100.0%	100.0%	77.8%	100.0%	100.0%	100.0%	
	4-hours direct to Stroke unit from ED	90%	73.0%	75.4%	69.6%	69.0%	72.1%	50.0%	59.3%	72.1%	63.3%	64.5%	79.7%	60.3%	
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	90%	72.9%	76.1%	71.0%	72.7%	75.4%	54.2%	60.0%	71.7%	65.1%	64.5%	81.5%	59.5%	
	Number of confirmed Strokes in-month on SSNAP	-	64	70	70	73	71	66	86	66	67	68	72	81	
	Proportion of patients spending 90% of time on the Stroke unit	80%	88.9%	95.7%	95.7%	93.1%	88.4%	90.8%	94.0%	92.1%	87.7%	98.4%	91.4%	87.5%	
	60-minutes to scan from time of arrival	50%	54.0%	57.1%	50.0%	61.6%	45.6%	56.1%	53.5%	53.0%	53.7%	61.8%	58.3%	65.4%	
	Scanned within 12-hours - all Strokes	100%	93.7%	97.1%	100.0%	98.6%	98.6%	97.0%	98.8%	92.4%	97.0%	100.0%	95.8%	97.5%	
	Total Thrombolysis rate for confirmed Strokes	11%	14.3%	8.6%	10.0%	12.3%	8.5%	4.5%	14.3%	15.6%	13.4%	8.8%	9.7%	12.5%	
	Thrombolysed within 60-minutes of arrival	-	33.3%	n/a	42.9%	22.2%	16.7%	33.3%	50.0%	70.0%	66.7%	50.0%	28.6%	70.0%	
	Discharged with JCP	80%	97.6%	100.0%	100.0%	97.9%	100.0%	95.1%	93.7%	89.5%	95.3%	93.2%	82.7%	86.0%	
	Discharged with ESD	40%	64.4%	56.8%	48.1%	51.9%	44.4%	50.0%	50.8%	45.6%	41.3%	43.5%	50.9%	47.7%	

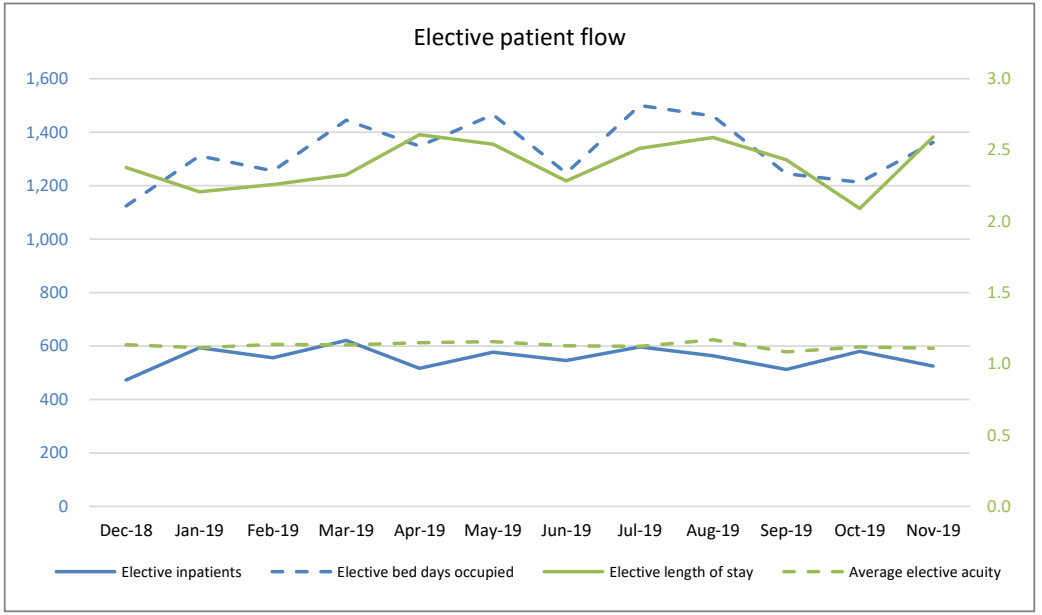
Responsive Services

East and North Hertfordshire NHS Trust

Patient Flow

Domain	Metric	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Trend
Emergency Department Flow Indicators	A&E & UCC attendances	12,517	13,690	12,788	14,266	13,440	14,306	13,675	14,821	13,676	14,041	14,649	14,556	
	Attendance to admission conversion rate	24.7%	25.1%	23.6%	23.0%	22.7%	23.7%	22.9%	21.9%	23.6%	24.1%	25.1%	24.0%	
	ED attendances per day	404	442	457	460	448	461	456	478	441	468	473	485	
	AEC attendances per day	45	49	51	49	45	47	47	51	44	42	46	47	
	4-hour target performance %	86.9%	85.2%	80.5%	81.0%	80.5%	81.6%	84.6%	81.5%	86.1%	85.1%	85.8%	81.5%	
	Time to initial assessment 95th centile	59	58	60	75	64	69	62	74	58	66	51	61	
	Ambulance handover breaches 30-minutes	373	516	597	606	480	368	262	336	180	227	215	tbc	

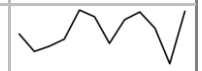
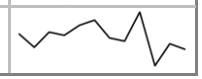
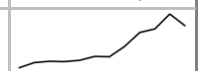
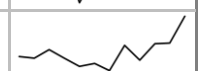




Responsive Services

Patient Flow

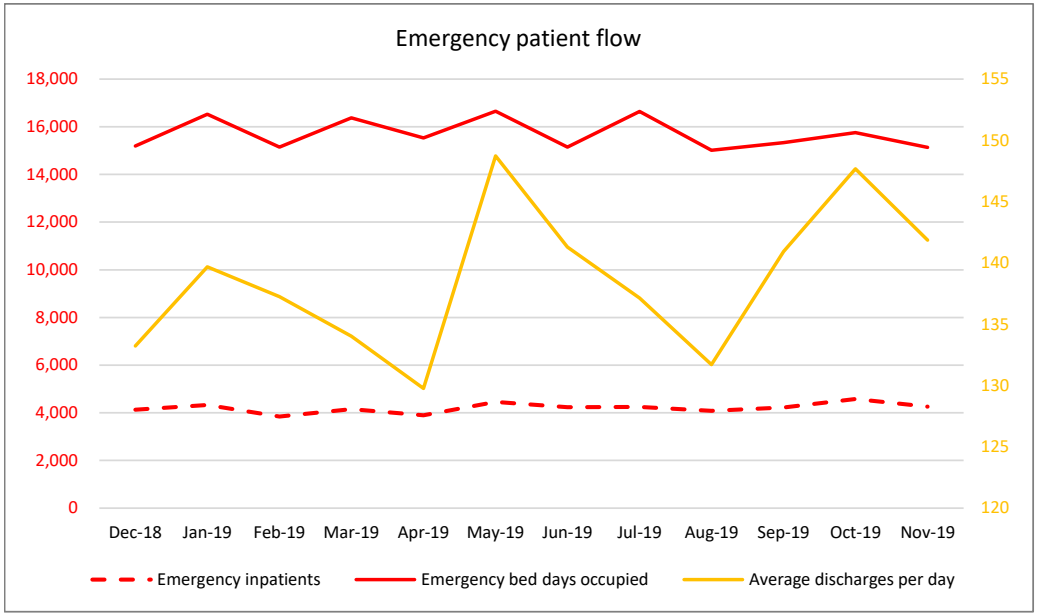
East and North Hertfordshire NHS Trust

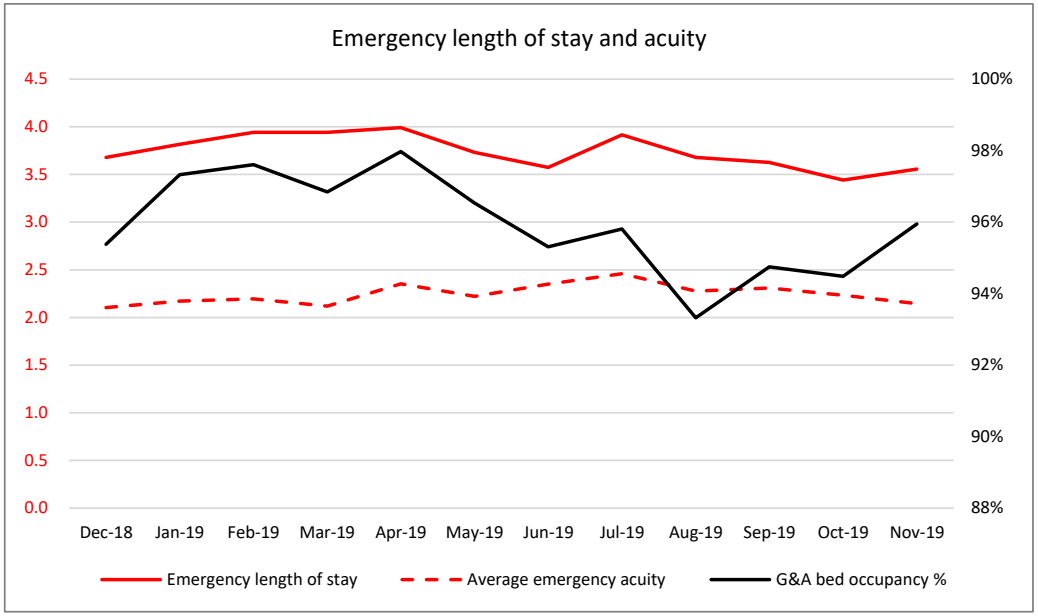
Domain	Metric	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Trend
Elective Inpatient Flow Indicators	Elective inpatients	473	594	556	621	517	577	546	597	564	512	580	525	
	Elective bed days occupied	1,124	1,311	1,255	1,445	1,348	1,466	1,247	1,500	1,460	1,245	1,212	1,361	
	Elective length of stay	2.4	2.2	2.3	2.3	2.6	2.5	2.3	2.5	2.6	2.4	2.1	2.6	
	Daycase rate %	86.0%	86.0%	84.8%	84.0%	86.8%	86.5%	87.2%	86.7%	86.2%	87.9%	87.4%	87.6%	
	Average elective acuity	1.13	1.11	1.14	1.13	1.15	1.16	1.13	1.12	1.17	1.08	1.12	1.11	
Emergency Flow Indicators	Emergency inpatients	4,130	4,330	3,843	4,155	3,893	4,462	4,239	4,251	4,083	4,228	4,578	4,256	
	Average discharges per day	133	140	137	134	130	149	141	137	132	141	148	142	
	Emergency bed days occupied	15,192	16,528	15,146	16,380	15,538	16,653	15,153	16,643	15,015	15,333	15,753	15,140	
	Emergency length of stay	3.7	3.8	3.9	3.9	4.0	3.7	3.6	3.9	3.7	3.6	3.4	3.6	
	Average emergency acuity	2.1	2.2	2.2	2.1	2.4	2.2	2.3	2.5	2.3	2.3	2.2	2.1	
	G&A bed occupancy %	95%	97%	98%	97%	98%	97%	95%	96%	93%	95%	94%	96%	
	Patients discharged via Discharge Lounge	141	180	189	186	197	225	224	302	406	432	546	457	
	Discharges before midday	14.6%	14.7%	14.4%	14.2%	13.3%	13.1%	13.8%	13.6%	12.5%	12.6%	12.8%	13.5%	
	Weekend discharges	17.2%	15.4%	15.7%	16.6%	13.6%	15.5%	17.0%	14.1%	15.7%	14.2%	15.7%	16.4%	
	Proportion of beds occupied by patients with length of stay over 14 days	18.7%	18.5%	19.6%	18.5%	17.5%	17.8%	16.9%	20.2%	18.3%	20.4%	20.5%	24.1%	
	Proportion of beds occupied by patients with length of stay over 21 days	10.0%	9.2%	10.7%	10.2%	9.3%	9.7%	8.4%	11.0%	10.3%	11.2%	12.0%	14.8%	

Responsive Services

East and North Hertfordshire NHS Trust

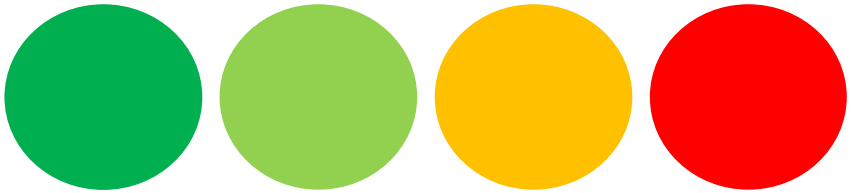
Patient Flow





Well-led Services

Month 08 | 2019-20



Key Issues

Staffing and Pay bill

- Overall staff utilised including bank and agency increased by 19 WTE
- Agency expenditure decreased by £14k, this meant that the Trust was under the agency ceiling by £140k in month.
- The Trust is under the agency ceiling target by £160k over the year to date.
- There is a 0.9% improvement on turnover compared to the same month the previous year, however month on month there has been an increase of 0.4% to 12.7%.

Sickness Absence

- Overall sickness absence rate decreased to 4.2% which is 0.5% lower than last year.

Training & Development

- Appraisal compliance increased from 85% to 87%, against a target of 90%.
- 11 out of the 15 mandatory training modules are on target and overall compliance hit the target of 90%.

Executive Response

A target of an increase of 37 WTE qualified nurses by month 12 was set at the beginning of the year and the position for month 8 is an increase of 21.2 WTE. The projected position at month 12 is an overall increase of 22.7. This shortfall has been caused by a number of factors. These include a lower than expected conversion rate of student nurses to registered nurses and the success of UK based nursing recruitment not matching the reduction in international recruitment for the year, despite focussed efforts in the UK market. In addition, Medicine are predicting significant pressures over the winter period which will result in further vacancies as well as the need to cover maternity leave and sickness absence.

Further actions have been taken to mitigate these challenges. The Trust has now completed the recruitment of a further 10 international nurses who are due to commence in months 9 and 10, assigned to Medicine to address the pressures described above. The Trust has also increased effort in engaging and attracting our student nurses to encourage them to take up employment with the Trust upon qualifying as well as launching a focussed UK social media recruitment campaign for qualified nurses in months 9 and 10.

Month 8 saw the launch of Admin Clearing House (ACH) where a more stringent challenge process was put in place weekly at Deputy Director level to challenge A&C agency activity. Whilst this has only been live for 3 weeks, agency activity for November confirms booked activity is down by 23%. The process is looking to be replicated commencing early January for our Allied Health Professionals (AHP) and Health Care Sciences (HCS) staff-groups to ensure maximum governance and compliance to demand management and agency booking activity.

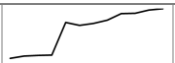
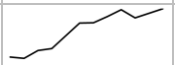
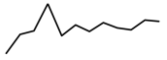
Agency usage within N&M is down by 75% for the same period compared to last year, the 'rapid response' initiative continues to support short notice redeployment and save on last minute, high cost agency usage.

Supporting staff wellbeing remains a priority with promotional events being held monthly to encourage staff to make healthier lifestyle choices and to promote sources of support available. On 6th November an event was held at Lister, supported by the Samaritans to promote strategies to reduce and manage stress. Two new support services for staff have been promoted - NHS Practitioner Health, a support service for doctors with mental health or addiction problems and 'Shout' a crisis text service for anyone seeking support in a crisis. As part of the new people strategy, the Trust are now looking to embed Schwartz rounds in key areas throughout the Trust and make the presence of a mental health first aider a mandatory requirement.

Well-led Services

Workforce and Staff Development

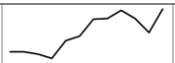
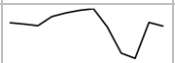
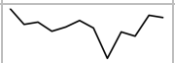
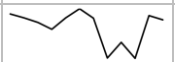
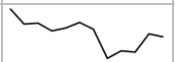
East and North Hertfordshire NHS Trust

Domain	Metric	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Trend	Plan YTD	Actual YTD	Var YTD
Staffing	Approved Budget Establishment WTEs	5,912	5,923	5,927	5,927	6,089	6,074	6,083	6,100	6,132	6,134	6,150	6,157		6,157	6,157	0
	Permanent Staffing WTEs Utilised	5,084	5,077	5,114	5,123	5,185	5,245	5,248	5,276	5,309	5,271	5,292	5,315		5,846	5,315	-531
	Bank Staffing WTEs Utilised	435	485	495	566	482	510	493	516	502	497	523	520		291	520	228
	Agency Staffing WTEs Utilised	99	118	114	114	98	113	104	106	100	87	90	90		20	90	70
	Gap - Budget WTEs & Permanent WTEs	828	845	812	804	904	829	836	824	823	863	858	842		311	842	531
	Gap Permanent Utilised / Budget WTEs	14.0%	14.3%	13.7%	13.6%	14.8%	13.6%	13.7%	13.5%	13.4%	14.1%	13.9%	13.7%		6.0%	13.9%	7.9%
	Recruitable Vacant Posts	445	413	393	410	427	403	387	333	403	443	368	394		398	394	-4
	Vacancy Rate	7.8%	7.3%	6.9%	7.2%	7.4%	7.0%	6.7%	5.8%	6.9%	7.6%	6.3%	6.8%		6.9%	6.8%	-0.1%
	Turnover Rate	13.5%	13.5%	13.2%	13.3%	13.0%	13.1%	13.0%	12.3%	12.5%	12.8%	12.3%	12.7%		12.0%	13.1%	1.1%
Sickness	Sickness FTE Days Lost	8,189	7,832	6,845	6,835	6,778	6,346	6,054	6,299	6,522	6,871	7,199	6,903		52,459	52,971	511
	Short term sickness rates %	2.1%	2.4%	2.3%	2.1%	2.2%	1.8%	1.8%	1.1%	1.7%	2.0%	1.8%	2.0%		2.1%	1.8%	-0.3%
	Long term sickness rates %	2.7%	2.4%	2.3%	2.0%	2.0%	2.0%	2.0%	1.8%	2.2%	2.3%	2.5%	2.2%		2.2%	2.1%	-0.1%
	Sickness Rate	5.1%	4.8%	4.6%	4.2%	4.2%	3.8%	3.8%	3.7%	3.9%	4.3%	4.3%	4.2%		3.4%	4.0%	0.6%
	Staff on long term sick headcount	159	121	122	111	109	109	109	95	122	110	135	124		120	124	4
	Maternity % Headcount	2.4%	2.3%	2.3%	2.3%	2.3%	2.3%	2.2%	2.2%	2.2%	2.3%	2.2%	2.1%		2.2%	2.2%	0.0%
	Nursing (Q & U) sickness rate	5.8%	5.3%	5.3%	4.7%	4.9%	4.7%	4.6%	4.2%	4.6%	5.0%	5.0%	5.4%		5.2%	4.8%	-0.4%
	Nursing (Q & U) sickness days lost in month	3,900	3,559	3,226	3,190	3,216	3,244	3,040	2,890	3,145	3,264	3,414	3,518		26,916	25,732	-1,184

Well-led Services

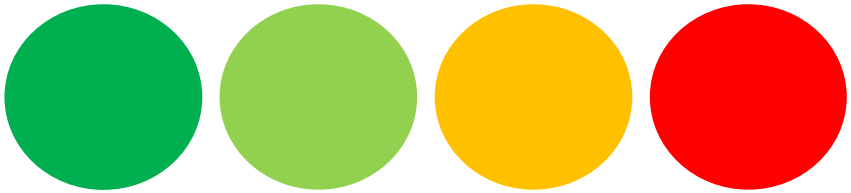
Workforce and Staff Development

East and North Hertfordshire NHS Trust

Domain	Metric	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Trend	Plan YTD	Actual YTD	Var YTD
Training & Development	Staff Appraised	82%	83%	82%	82%	84%	84%	86%	86%	87%	86%	85%	87%		90%	87%	-3%
	Mandatory Training 100% Compliant	63%	61%	61%	62%	62%	62%	64%	66%	65%	64%	65%	63%		90%	63%	-27%
	Overall Training Compliant	90%	89%	89%	89%	89%	89%	89%	88%	89%	89%	90%	90%		90%	90%	0%
Statutory and Mandatory Training	Conflict Resolution - 2 Years	93%	92%	93%	92%	92%	93%	92%	91%	92%	92%	93%	93%		90%	93%	3%
	Equality & Diversity	92%	93%	91%	91%	92%	92%	93%	93%	94%	94%	94%	94%		90%	94%	4%
	Equality, Diversity and Human Rights	70%	70%	69%	71%	72%	73%	73%	69%	63%	62%	70%	69%		90%	69%	-21%
	Fire Safety	86%	85%	85%	85%	85%	84%	84%	84%	85%	84%	85%	85%		90%	85%	-5%
	Health and Safety	93%	92%	93%	92%	92%	93%	92%	91%	92%	92%	93%	93%		90%	93%	3%
	IPC - Clinical 2 yr	93%	92%	91%	92%	92%	92%	91%	90%	91%	90%	92%	92%		90%	92%	2%
	IPC - Non-Clinical 2 yr	93%	92%	93%	93%	93%	93%	93%	93%	94%	94%	95%	94%		90%	94%	4%
	Data security awareness	71%	68%	71%	72%	73%	73%	76%	77%	76%	76%	76%	75%		90%	75%	-15%
	Moving & Handling for People Handlers	94%	94%	93%	93%	92%	92%	92%	93%	93%	92%	93%	94%		90%	94%	4%
	Moving and Handling	94%	93%	93%	93%	93%	94%	93%	92%	93%	93%	94%	94%		90%	94%	4%
	Safeguarding Adults Level 1	91%	90%	90%	90%	90%	91%	90%	89%	90%	89%	91%	91%		90%	91%	1%
	Safeguarding Adults Level 2	90%	90%	90%	89%	90%	90%	90%	87%	88%	87%	90%	90%		90%	90%	0%
	Safeguarding Children Level 1	94%	93%	93%	92%	92%	93%	92%	90%	91%	91%	92%	92%		90%	92%	2%
	Safeguarding Children Level 2	93%	93%	92%	92%	92%	92%	92%	89%	90%	89%	91%	91%		90%	91%	1%
	Safeguarding Children Level 3	90%	88%	88%	87%	87%	88%	86%	92%	93%	89%	87%	87%		90%	87%	-3%

Sustainable Services

Month 08 | 2019-20



Key Issues

- The Trust's reported position at Month 8 is a deficit of £0.6m. Exclusive of donated asset and profit on land sale impacts the deficit is £1.7m. This remains in line with the control total plan for 19/20.
- The reported M8 deficit includes the expected receipt of PSF & FRF performance incentive funds totalling £9.0m. Payment of these funds is confirmed by NHSI on a quarterly basis upon the achievement of underlying financial achievement targets. Based upon M8 results the Trust presently envisages full receipt of these funds across the financial year.
- At M8 the Trust reports an over achievement (£6.5m) against SLA contracts with its commissioners. The majority of the YTD income overachievement is driven by above plan emergency activity. Joint review and analysis of this position by the Trust and its host CCG indicates that this over performance and activity growth has been driven by a number of factors but the most significant elements are:
  - The emergency plan was not a true reflection of the 18/19 outturn run rate.
  - A very significant shortfall in the impact of CCG QIPP schemes.
  - Unprecedented levels of demand growth in areas experiencing high rates of housing growth.
  - Increasing volumes of patients directly routed to the Trust ED from primary care and NHS111. Combined with an increase in care home activity.
- The 19/20 SLA contract for emergency activity incorporates a blended payments mechanism that applies marginal rates to over performance within agreed bands. M8 performance is after the application of these rules.
- The much higher levels of emergency activity that continue to present at the Trust whilst resulting in higher levels of income have however been matched by much higher pay and cost requirements as the Trust has needed to keep open capacity that it had reasonably expected would be closed as a result of QIPP schemes and indeed has needed to incur further escalation costs beyond this level. As such Pay budgets report a significant YTD overspend of £6.4m.
- Performance against medical staffing budgets remain a key concern, reporting an overspend of £2.4m across the YTD. The bulk of this pressure 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 achieving improved levels of theatre and outpatient efficiency and (2) significant challenges in reducing reliance on high cost locum staff particularly within Surgery and Medicine.
- 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. The roll out of roster training to senior nursing managers remains a key priority.
- Staff used by the Trust to deliver services has increased significantly year on year. An additional 164.5 WTE's were used in November 19 compared with 12 months earlier (excluding the impact of Therapies & Pharma). The growth of substantive fill but the failure to commensurately reduce temp staffing spend remains a significant concern.
- In the YTD the Trust delivered total CIP's of £9.9m. Whilst high by historical standards this was nevertheless £1.3m less than planned. Key features of this slippage include the non-achievement of planned theatre and outpatient savings targets.

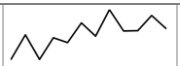
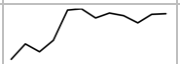
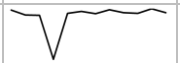
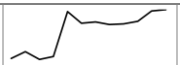
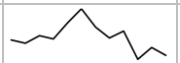
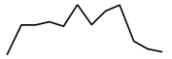
Executive Response

- 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 in large measure driven by the impact of CCG QIPP scheme shortfalls and the consequent need to maintain capacity that has been expected to close.
- The Trust has undertaken through deep dive analysis into the drivers underpinning emergency growth and shared this fully with commissioners, and remains committed to working collaboratively to manage this position.
- As at December 2019 the Trust has agreed a fixed price year end settlement with E&N CCHG in respect of the value for the 19/20 SLA. This represents a fair and balanced approach to risk share arrangements over the remainder of the financial year.
- The Trust continues to face challenges in the delivery clinical productivity targets and also weaknesses in the management of medical and nursing temporary staffing costs. This underlying position is not sustainable and requires redress.
- To support control total achievement, the Trust Executive have introduced a number of remedial forecast mitigation work streams. These include weekly IFD oversight groups for both Medical Staffing and Nursing Management which have 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.
- Further IFD work streams have been set up in respect of establishing a high impact focus on Pathology, Pharmacy and Procurement costs in the second half of the year. In addition, the Trust has introduced tighter controls for the review and approval of admin and senior managers temporary staffing costs. Regular reports on the effectiveness of these mitigation programmes will be provided to the Finance and Performance Committee and weekly Executive Committee meetings.
- 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

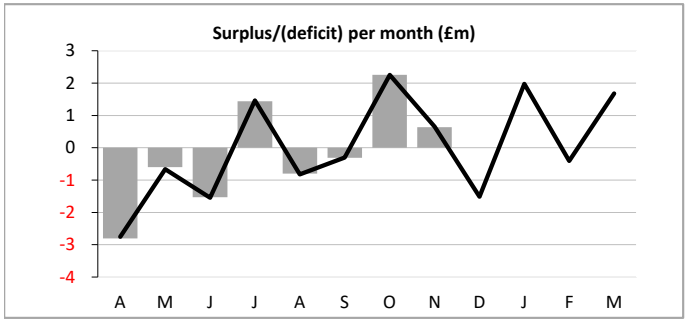
Domain	Metric	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Trend	Plan YTD	Actual YTD	Variance YTD
I&E Performance	SLA Income Earned	30.4	33.7	30.4	33.3	32.7	35.3	33.5	37.2	34.3	34.3	36.4	34.6		270.1	278.2	8.0
	Other Income Earned	5.1	5.4	4.8	-6.8	3.5	3.7	3.6	3.8	3.7	3.7	5.2	4.3		33.9	31.6	-2.3
	Pay Costs	22.9	23.5	23.2	23.6	24.8	24.8	24.5	24.7	24.5	24.3	24.6	24.6		190.4	196.7	6.4
	Non Pay Costs inc Financing	15.9	14.6	14.6	2.8	15.0	15.6	15.0	16.0	15.3	15.1	16.3	15.3		124.3	123.6	-0.7
	Underlying Surplus / (Deficit)	-3.3	1.0	-2.7	0.0	-3.6	-1.4	-2.3	0.4	-1.9	-1.4	0.6	-1.0		-10.7	-10.7	0.0
	PSF Earned	0.0	0.0	0.0	5.9	0.4	0.4	0.4	0.5	0.5	0.5	0.7	0.7		3.9	3.9	0.0
	FRF Received	-	-	-	-	0.5	0.5	0.5	0.6	0.6	0.6	0.9	0.9		5.1	5.1	0.0
	Retained Surplus / Deficit	-3.3	1.0	-2.7	6.0	-2.8	-0.6	-1.5	1.440	-0.8	-0.3	2.3	0.6		-1.7	-1.7	0.0
Paybill Metrics	Substantive Pay Costs	19.7	19.9	19.7	19.8	21.2	20.8	20.8	20.8	20.8	20.9	21.2	21.2		175.9	167.5	-8.4
	Premium Pay Costs Overtime & WLI	0.4	0.3	0.4	0.4	0.4	0.5	0.4	0.4	0.4	0.3	0.3	0.3		2.7	3.0	0.2
	Premium Pay Costs Bank Costs	2.0	2.2	2.2	2.5	2.2	2.4	2.2	2.4	2.3	2.2	2.2	2.2		8.9	18.1	9.2
	Premium Pay Costs Agency Costs	0.9	1.0	1.0	1.0	1.0	1.1	1.0	1.1	1.1	0.9	0.9	0.9		2.9	8.1	5.2
	Premium Pay Costs As % of Paybill	14.1%	15.3%	15.3%	16.4%	14.6%	16.2%	14.8%	15.8%	15.4%	14.1%	13.9%	13.8%		7.6%	14.8%	7.2%

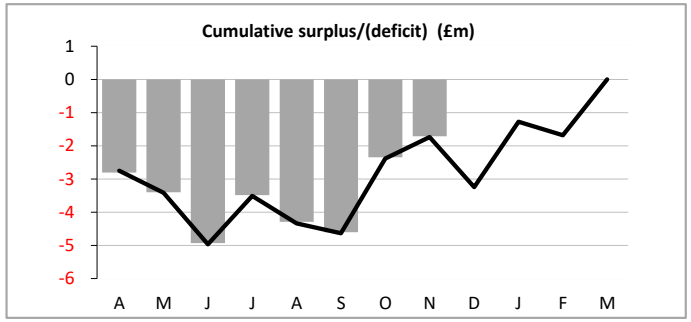
Sustainable Services

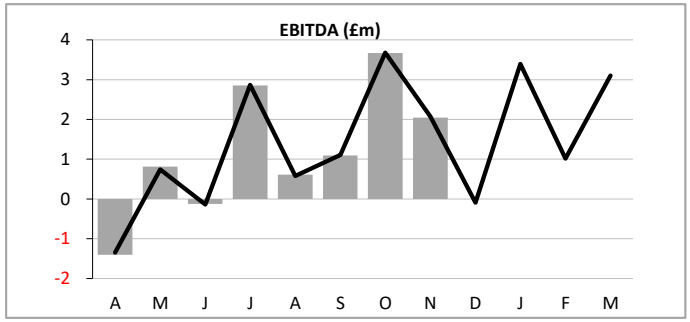
Finance Plan Performance

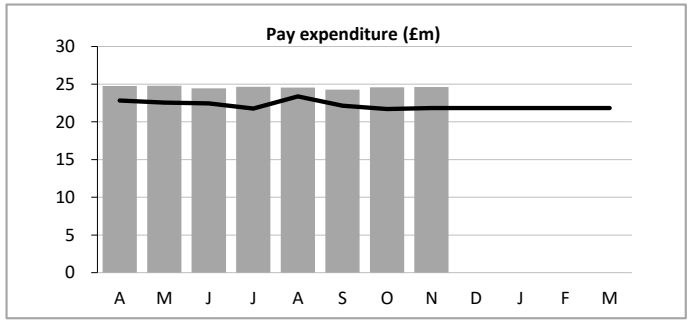
East and North Hertfordshire NHS Trust

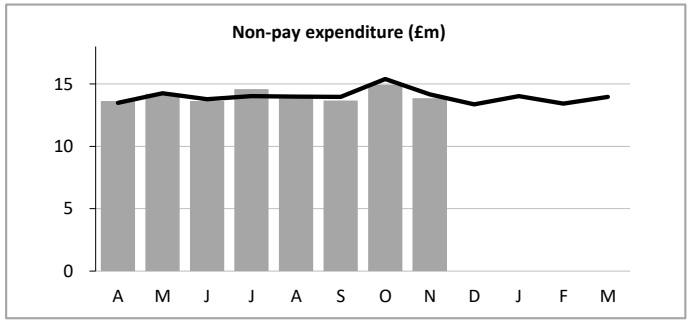
Domain	Metric	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Trend	Plan YTD	Actual YTD	Variance YTD
Single Oversight Framework	Capital Servicing Capacity	4	4	4	4	4	4	4	3	4	4	4	4		1	4	
	Liquid Ratio (Days)	4	4	4	4	4	4	4	4	4	4	4	4		1	4	
	I&E Margin	4	4	4	4	4	4	4	4	4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

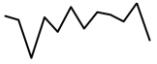
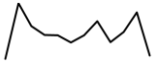
		In-Month			YTD		
		Planned Income	Actual Income	Income Variance	Planned Income	Actual Income	Income Variance
By Point of Delivery	A&E Attendances	2,154	2,441	288	17,111	18,654	1,543
	Daycases	2,719	2,871	151	21,834	23,474	1,640
	Inpatient Elective	2,096	1,842	-254	16,828	15,081	-1,747
	Inpatient Non Elective	8,438	8,810	372	67,027	75,059	8,032
	Maternity	2,250	2,190	-60	18,261	18,121	-140
	Other	3,596	3,546	-50	28,054	26,536	-1,518
	Outpatient First	2,037	2,113	77	16,183	16,646	463
	Outpatient Follow Ups	2,262	2,182	-80	17,973	17,204	-769
	Outpatient Procedures	1,169	1,026	-143	9,288	8,839	-449
	Other SLAs	57	57	0	459	459	0
	Block	842	836	-7	6,741	6,688	-53
	Drugs & Devices	3,528	3,826	298	28,557	29,097	540
	Chemotherapy Delivery	549	513	-36	4,442	4,147	-295
	Radiotherapy	1,113	1,155	42	9,000	9,246	245
	Renal Dialysis	1,131	1,121	-11	9,138	8,528	-611
	Total	33,941	34,529	588	270,897	277,777	6,880

		In-Month			YTD		
		Planned Income	Actual Income	Income Variance	Planned Income	Actual Income	Income Variance
By Commissioner	East & North Herts CCG	19,989	21,123	1,134	159,682	167,929	8,248
	Specialist Commissioning	7,782	7,882	100	62,743	62,743	-0
	Bedfordshire CCG	2,323	2,509	186	18,568	19,555	987
	Herts Valleys CCG	1,367	1,207	-160	10,940	10,074	-866
	Cancer Drugs Fund	444	404	-40	3,591	3,514	-77
	Luton CCG	302	269	-34	2,413	2,466	53
	PH - Screening	293	216	-77	2,356	2,565	209
	Other	1,441	920	-521	10,604	8,930	-1,674
By Division	Cancer Services	6,317	6,459	142	50,923	50,867	-55
	Medicine	10,989	11,375	386	87,543	93,425	5,883
	Women & Children	4,679	4,704	25	37,665	37,444	-221
	Clinical Services	2,163	2,145	-18	17,462	17,579	117
	Surgery	10,138	10,059	-79	80,606	82,158	1,552
	Other	-345	-213	132	-3,302	-3,697	-395

Sustainable Services

Activity and Productivity

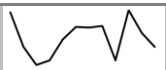
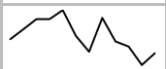
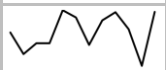
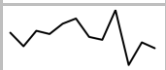
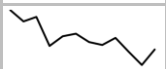
East and North Hertfordshire NHS Trust

Domain	Metric	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Trend	Plan YTD	Actual YTD	Var YTD
Patient Activity Levels	A&E & UCC	12,516	12,876	12,086	13,475	12,680	13,521	12,942	13,968	12,845	13,230	13,746	13,769		99,998	106,701	6,703
	Chemotherapy Atts	2,083	2,296	2,001	1,983	2,223	2,239	1,948	2,266	2,131	2,073	2,252	2,180		18,219	17,312	-907
	Critical Care (Adult) - OBD's	566	729	464	577	636	628	580	671	534	580	584	759		4,469	4,972	503
	Critical Care (Paeds) - OBD's	486	398	379	442	421	628	427	516	465	549	605	493		4,417	4,104	-313
	Daycases	2,896	3,638	3,102	3,269	3,410	3,683	3,708	3,879	3,512	3,722	4,013	3,709		26,664	29,636	2,972
	Elective Inpatients	473	594	556	621	517	577	546	597	564	512	580	525		5,323	4,418	-905
	Emergency Inpatients	4,130	4,330	3,843	4,155	3,893	4,462	4,239	4,251	4,083	4,228	4,578	4,256		30,719	33,990	3,271
	Home Dialysis	186	195	163	178	176	173	161	158	163	147	144	150		1,299	1,272	-27
	Hospital Dialysis	6,481	6,171	5,751	6,156	5,983	6,159	5,747	5,068	5,841	4,655	6,313	6,264		49,673	46,030	-3,643
	Maternity Births	447	441	381	445	422	461	427	453	449	438	467	409		3,688	3,526	-162
	Maternity Bookings	432	541	467	469	474	551	501	507	444	474	519	485		4,186	3,955	-231
	Outpatient First	7,733	9,289	8,293	9,261	8,456	9,132	8,996	9,845	8,262	8,708	9,866	9,381		67,059	72,646	5,587
	Outpatient Follow Up	14,070	19,489	17,002	17,277	17,151	17,763	16,959	19,196	15,895	17,009	18,724	17,705		148,507	140,402	-8,105
	Outpatient procedures	6,297	8,397	7,539	7,207	7,187	6,920	7,188	7,719	6,935	7,306	8,047	6,423		53,335	57,725	4,390
	Radiotherapy Fractions	4,381	5,286	4,773	5,048	5,023	5,023	4,338	4,884	4,775	4,480	4,755	4,735		38,580	38,013	-567

Sustainable Services

Activity and Productivity

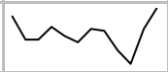
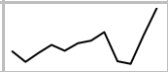
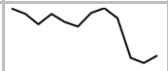
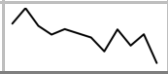
East and North Hertfordshire NHS Trust

Domain	Metric	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Trend	Plan YTD	Actual YTD	Var YTD
Throuhput	Elective Spells per Working Day	211	192	183	185	196	203	203	203	185	212	200	192		188	200	12
	Emergency Spells per Day	123	129	127	125	126	140	137	133	129	138	145	139		126	139	13
	ED Attendances per Day	404	415	432	435	423	436	431	451	414	441	443	459		410	437	27
	Outpatient Atts per Working Day	1,756	1,690	1,642	1,607	1,640	1,610	1,578	1,671	1,413	1,651	1,593	1,523		1,582	1,593	11
	Elective Bed Days Used	1,124	1,311	1,255	1,445	1,348	1,466	1,247	1,500	1,460	1,245	1,212	1,361		12,061	10,839	-1,222
	Emergency Bed Days Used	15,192	16,528	15,146	16,380	15,538	16,653	15,153	16,643	15,015	15,333	15,753	15,140		127,080	125,228	-1,852
Efficiency	Admission Rate from A&E	25%	25%	24%	23%	23%	24%	23%	22%	24%	24%	25%	24%		23.3%	23.5%	0.2%
	Emergency - Length of Stay	3.7	3.8	3.9	3.9	4.0	3.7	3.6	3.9	3.7	3.6	3.4	3.6		4.0	3.7	-0.3
	Emergency - Casemix Value	2,103	2,170	2,194	2,119	2,353	2,221	2,349	2,459	2,277	2,308	2,234	2,144		2,220	2,293	73
	Elective - Length of Stay	2.4	2.2	2.3	2.3	2.6	2.5	2.3	2.5	2.6	2.4	2.1	2.6		2.4	2.5	0.1
	Elective - Casemix Value	1,134	1,113	1,137	1,132	1,148	1,156	1,128	1,123	1,169	1,084	1,119	1,110		1,202	1,129	-73
	Elective Surgical DC Rate %	86.0%	86.0%	84.8%	84.0%	86.8%	86.5%	87.2%	86.7%	86.2%	87.9%	87.4%	87.6%		85%	87%	2.0%
	Outpatient DNA Rate % - 1st	12.8%	12.4%	12.5%	11.6%	11.9%	12.0%	11.7%	11.6%	11.9%	11.4%	11.0%	11.5%		12.6%	11.8%	-0.8%
	Outpatient DNA Rate % - FUP	8.2%	7.6%	7.1%	7.1%	7.6%	7.9%	7.9%	7.3%	7.3%	7.5%	7.3%	7.1%		8.5%	7.7%	-0.8%
	Outpatient Cancel Rate % - Patient	10.3%	9.5%	9.6%	9.5%	10.0%	10.1%	10.6%	10.3%	10.6%	10.3%	10.1%	9.7%		9.3%	10.2%	0.9%

Sustainable Services

Activity and Productivity

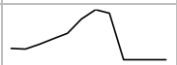
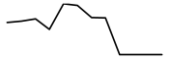
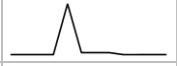
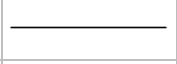
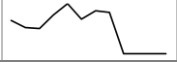
East and North Hertfordshire NHS Trust

Domain	Metric	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Trend	Plan YTD	Actual YTD	Var YTD
Efficiency	Outpatient Cancel Rate % - Hosp	6.7%	6.1%	6.3%	6.4%	6.3%	6.4%	6.2%	6.2%	6.1%	6.4%	6.3%	6.6%		6.3%	6.3%	0.0%
	Outpatients - 1st to FUP Ratio	1.8	2.1	2.1	1.9	2.0	1.9	1.9	1.9	1.9	2.0	1.9	1.9		2.2	1.9	-0.3
	Theatres - Ave Cases Per Hour	2.9	2.7	2.7	2.8	2.7	2.6	2.8	2.8	2.6	2.4	2.8	3.0		2.9	2.7	-0.2
	Theatres - Utilisation of Sessions	78%	76%	78%	80%	78%	80%	81%	82%	76%	75%	82%	88%		85%	80%	-5%
	Theatres - Ave Late Start (mins)	26	25	23	25	23	23	25	26	24	17	16	17		27	21	-5.4
	Theatres - Ave Early Finishes (mins)	41	47	40	37	39	37	36	30	39	32	37	25		39	34	-5.0

Sustainable Services

Cost Improvement Plan (CIP) Delivery

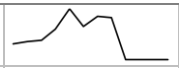
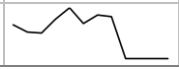
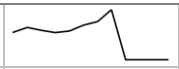
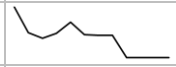
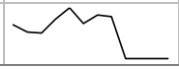
East and North Hertfordshire NHS Trust

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	63	39	103	69	0	0	0	0		106	103	280	177
	Outpatients	4	4	5	7	9	13	16	15	0	0	0	0		613	425	72	-353
	Procurement	442	231	166	226	203	216	283	222	0	0	0	0		3,597	2,343	1,990	-354
	Divisional Non Pay schemes	102	106	114	81	162	156	118	117	0	0	0	0		1,535	939	955	16
	DQ, Coding & Income	0	0	42	41	366	176	181	181	0	0	0	0		1,691	943	986	44
	Corporate	144	119	24	140	50	52	17	46	0	0	0	0		941	689	593	-96
	Demand Management	43	64	75	70	94	67	71	80	0	0	0	0		1,468	886	564	-322
	Workforce Temporary Staff reduction	83	44	63	83	40	34	35	53	0	0	0	0		1,012	545	435	-110
	Divisional Pay schemes	254	257	238	274	177	197	177	177	0	0	0	0		1,998	1,558	1,751	193
	Workforce transformation schemes	-10	-16	58	-43	17	44	96	24	0	0	0	0		984	341	170	-171
	Divisional Income capture & coding	28	23	27	405	141	120	153	155	0	0	0	0		2,012	1,226	1,053	-174
	Patient Flow	0	0	0	0	21	1	1	1	0	0	0	0		455	252	23	-229
	Divisional Local Income schemes	24	51	40	18	348	46	194	256	0	0	0	0		1,363	876	978	103
	Over/Unidentified	0	0	0	0	0	0	0	0	0	0	0	0		-2,775	0	0	0
	Total CIP Delivery	**1,120**	**884**	**852**	**1,301**	**1,690**	**1,161**	**1,446**	**1,397**	**0**	**0**	**0**	**0**		**15,000**	**11,128**	**9,851**	**-1,277**

Sustainable Services

East and North Hertfordshire NHS Trust

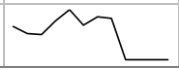
Cost Improvement Plan (CIP) Delivery

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	1,508	983	1,280	1,242	0	0	0	0		15,214	8,959	7,497	-1,461
	Non-Recurrent	652	344	280	397	182	179	165	154	0	0	0	0		2,560	2,169	2,354	185
	Over/Unidentified	0	0	0	0	0	0	0	0	0	0	0	0		-2,774	0	0	0
	Total CIP Delivery	**1,120**	**885**	**852**	**1,301**	**1,690**	**1,161**	**1,446**	**1,397**	**0**	**0**	**0**	**0**		**15,000**	**11,128**	**9,851**	**-1,277**
CIP Delivery by Division	Cancer Services	164	193	177	163	173	206	228	300	0	0	0	0		1,952	1,360	1,605	245
	Clinical Support	93	95	114	120	459	142	252	244	0	0	0	0		3,344	2,014	1,520	-494
	Corporate	582	286	222	278	406	264	255	255	0	0	0	0		3,769	2,618	2,547	-71
	Medicine	79	101	115	441	258	266	344	290	0	0	0	0		4,383	2,454	1,893	-560
	Surgery	127	141	110	166	253	183	262	204	0	0	0	0		3,152	1,900	1,446	-454
	Women's & Children's	74	69	113	133	141	100	105	104	0	0	0	0		1,173	782	840	58
	Over/Unidentified	0	0	0	0	0	0	0	0	0	0	0	0		-2,773	0	0	0
	Total CIP Delivery	**1,120**	**884**	**852**	**1,301**	**1,690**	**1,161**	**1,446**	**1,397**	**0**	**0**	**0**	**0**		**15,000**	**11,128**	**9,851**	**-1,277**

Sustainable Services

Cost Improvement Plan (CIP) Delivery

East and North Hertfordshire NHS Trust

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	118	-21	131	233	0	0	0	0		1,893	1,186	990	-195
	Income (patient care activities)	23	23	70	72	740	367	401	364	0	0	0	0		3,535	2,013	2,059	46
	Non-Pay	732	456	400	522	517	494	499	475	0	0	0	0		7,634	4,847	4,095	-751
	Pay (skillmix)	155	148	181	170	258	274	391	302	0	0	0	0		3,282	2,024	1,880	-144
	Pay (WTE reductions)	177	201	157	141	55	47	24	24	0	0	0	0		1,428	1,058	826	-232
	Over/Unidentified	0	0	0	0	0	0	0	0	0	0	0	0		-2,773	0	0	0
	Total CIP Delivery	**1,120**	**884**	**852**	**1,301**	**1,690**	**1,161**	**1,446**	**1,397**	**0**	**0**	**0**	**0**		**15,000**	**11,128**	**9,851**	**-1,277**

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	102,039	106,701	4,662
Emergency Department Ave Daily Atts	418	437	19
Admission Rate from ED %	23.0%	23.5%	1%
Non Elective Inpatient Spells	31,668	33,990	2,322
Ave Daily Non Elective Spells	130	139	10
Daycase Spells	26,004	29,636	3,632
Elective Inpatient Spells	5,093	4,418	-675
Ave Daily Planned Spells	127	140	12
Day Case Rate	84%	87%	3%
Adult & Paeds Critical Care Bed Days	8,909	9,076	167
Outpatient First Attendances	72,633	72,646	13
Outpatient Follow Up Attendances	144,887	140,402	-4,485
Outpatient First to Follow Up Ratio	2.0	1.9	-0.1
Outpatient Procedures	51,966	57,725	5,759
Ave Daily Outpatient Attendances	1,104	1,110	5

Workforce Measures	2018-19 YTD	2019-20 YTD	Change
Average Monthly WTE's Utilised	5,633	5,872	238
Average YTD Pay Cost per WTE	32,572	33,508	2.9%
Staff Turnover	13.7%	13.1%	-0.7%
Vacancy WTE's	828	842	14
Vacancy Rate	14.0%	13.9%	-0.1%
Sickness Days Lost	51,120	52,971	1,851
Sickness Rate	4.1%	4.0%	-0.1%
Agency Spend- £m's	8.1	8.1	-0.0
Temp Spend as % of Pay Costs	4.4%	4.1%	-0.3%
Ave Monthly Consultant WTE's Worked	306.8	328.9	22.1
Consultant : Junior Training Doctor Ratio	1 : 1.7	1 : 1.7	0.0
Ave Monthly Nursing & CSW WTE's Worked	2,406.3	2,452.2	45.9
Qual : Unqualified Staff Ratio	70 : 26	68 : 26	-0.1
Ave Monthly A&C and Senior Managers WTE's	1,235	1,301	66
A&C and Senior Managers % of Total WTE's	21.9%	22.2%	0.2%

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	4.0	3.7	-0.3
Elective LoS	2.4	2.5	0.1
Occupied Bed Days	139,141	136,067	-3,074
Adult Critical Care Bed Days	4,718	4,972	254
Paediatric Critical Care Bed Days	4,191	4,104	-87
Outpatient DNA Rate	9%	8%	-1.2%
Outpatient Utilisation Rate	28%	28%	-0.1%
Total Cancellations	82,004	88,089	6,085
Theatres - Ave Cases per Hour	2.8	2.7	-0.1
Theatres - Ave Session Utilisation	80%	80%	-0.1%
Theatres - Ave Late Start (mins)	30	21	-8
Theatres - Ave Early Finishes (mins)	40.4	34.4	-6
Radiology Examinations	272,675	277,517	4,842
Drug Expenditure (excl HCD & ENH Pharma) - £000s	7,178	6,122	-1,056
High Cost Drug Expenditure - £000s	26,436	28,425	1,989

Finance & Quality Measures	2018-19 YTD	2019-20 YTD	Change
Profitability - £000s	-14,114	-558	13,556.5
Monthly SLA Income £000s	32,598	34,769	2,171
Monthly Clinical Income per Consultant WTE	£106,248	£105,701	-£547
High Cost Drug Spend per Consultant WTE	£86,166	£86,415	£249
Average Income per Elective Spell	£1,176	£1,129	-£46
Average Income per Non Elective Spell	£2,074	£2,293	£219
Average Income per ED attendance	£171	£175	£4
Average Income per Outpatient Attendance	£132	£137	£5
Ave NEL Coding Depth per Spell	n/a	n/a	n/a
Procedures Not Carried Out	1,404	1,399	-5
Best Practice HRGs (% of all Spells)	9.7%	2.4%	-7.3%
Ambulatory Best Practice (% of Short Stays)	n/a	n/a	n/a
Non-elective re-admissions within 30 days Rolling 12-months to Aug-19	10,133	11,323	1,190
Non-elective re-admissions within 30 days % Rolling 12-months to Aug-19	8.3%	8.7%	0.4%
SLA Contract Fines - £000's	418	197	-221

Division	Not started	In progress	Passed	Total	%
CANCER	66	9	42	117	36%
CAPITAL	3	0	2	5	40%
CSS	39	6	49	94	52%
DATA QUALITY/CODING	2	1	5	8	63%
FACILITIES	3	2	1	6	17%
FINANCE	54	6	199	259	77%
FINANCE - INCOME	0	0	5	5	100%
FINANCE - INFORMATION	2	0	12	14	86%
FINANCE - IT	0	2	3	5	60%
MEDICINE	215	31	67	313	21%
NURSING PRACTICE	9	1	3	13	23%
PMO	5	0	66	71	93%
STRATEGY	3	0	0	3	0%
SURGICAL	160	11	86	257	33%
TRUST MGT	6	0	2	8	25%
W&C	61	9	97	167	58%
WORKFORCE	12	0	4	16	25%
Grand Total	**640**	**78**	**643**	**1,361**	47%

East and North Hertfordshire NHS Trust

Agenda Item: 9

TRUST BOARD - PUBLIC SESSION – 8 JANUARY 2020

People and Organisation Strategy

Purpose of report and executive summary (250 words max): To present the final version of the Trust's People and Organisation Strategy. The Strategy was endorsed by the FPPC at its meeting on 27 November 2019.		
Action required: For discussion		
Previously considered by: **Finance and Performance Committee – 27 November 2019**		
Director: **Chief People Officer**	**Presented by:** **Chief People Officer**	**Author:** **Chief People Officer, Deputy Director of Workforce and OD and Interim Deputy Director of Learning**

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 – Risks 2 and 9**
Any other risk issues (quality, safety, financial, HR, legal, equality):

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

Delivering productivity, quality & performance improvement by transforming our organisational

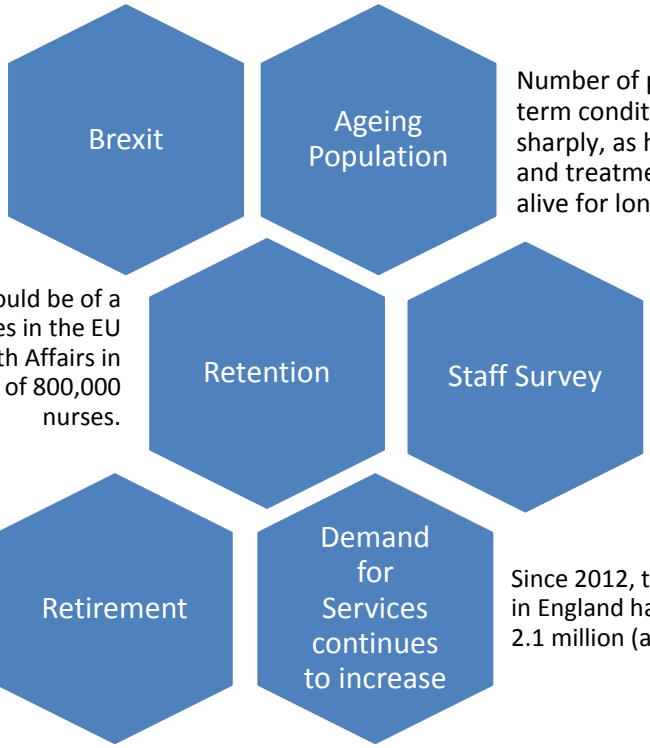
- Culture
- Capability
- Capacity

Our People & Organisation Strategy

Part 1: Our Workforce Profile Submission 2020-2024

Workforce Challenges

Brexit will have a direct effect on the availability of all staff groups. Uncertainty regarding EU citizens rights post Brexit is already affecting recruitment and retention.



Number of people with long term conditions has grown sharply, as have advances in care and treatment – keeping people alive for longer

The EU estimated that there would be of a shortfall of nearly 600,000 nurses in the EU by 2020. The Department of Health Affairs in the USA projects a shortfall of 800,000 nurses.

There are currently 4 people of working age supporting each pensioner in Britain, by 2035 this number is expected to fall to 2.5, and by 2050 to just 2.

Since 2012, the population in England has grown by 2.1 million (around 4%)

Hertfordshire Population Data

	Hertfordshire	East of England	England	% of Trust staff who live in Herts
Population All ages (2018)	1,184,400	6,201,200	55,977,200	74%

POPULATION CHANGE in HERTFORDSHIRE

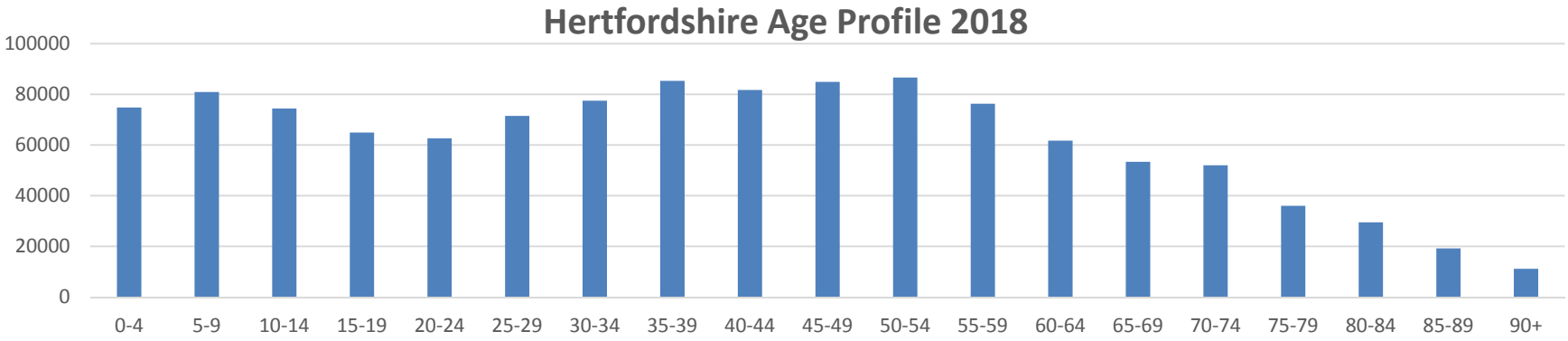
2011-18
Total Population
6% increase

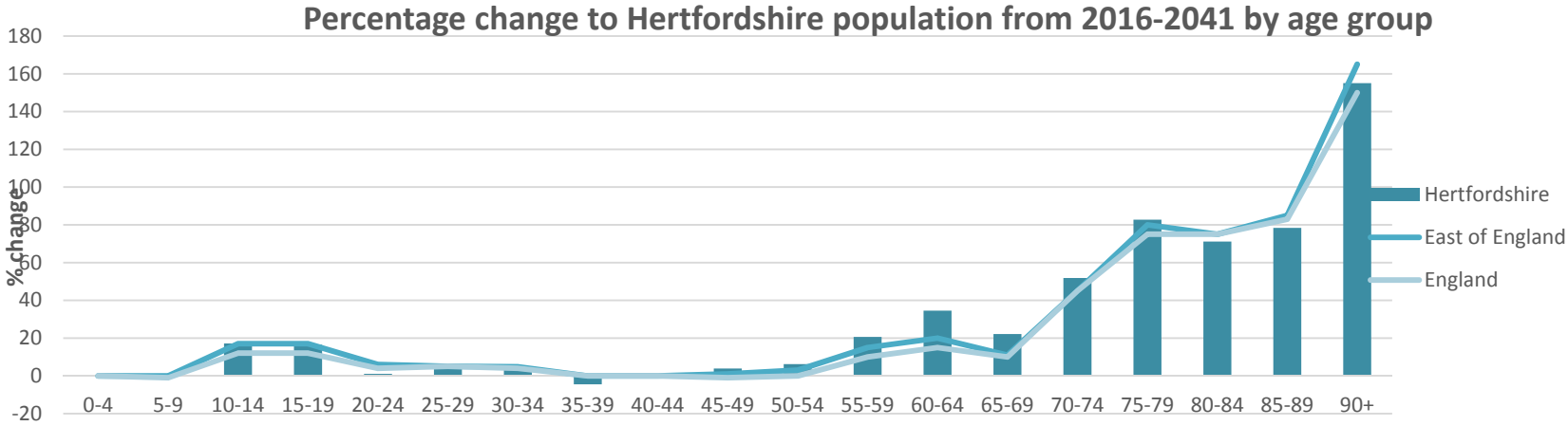
2011-18
Working Population
3% increase

2019-29
Total Population
8.3% Increase

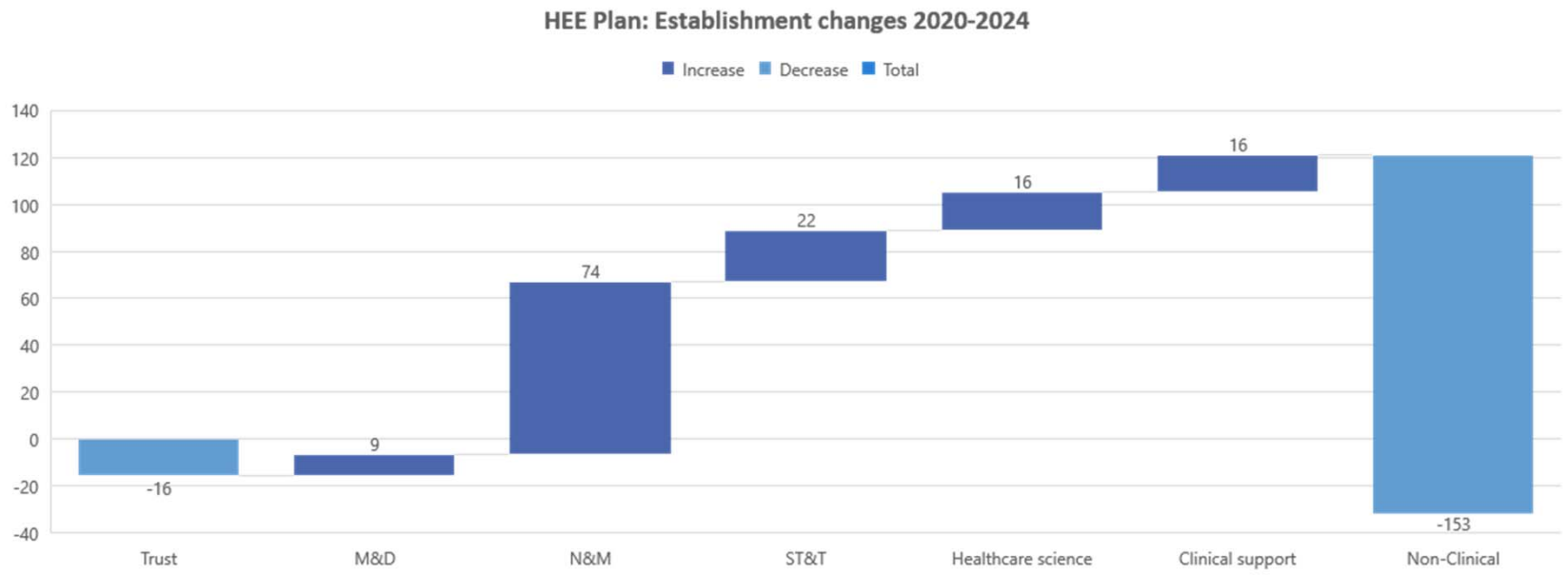
2011-18
70+ population
20% increase

2030-40
Total Population
7.7% Increase


Hertfordshire Age Profile 2018
100000
80000
60000
40000
20000
0
0-4
5-9
10-14
15-19
20-24
25-29
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65-69
70-74
75-79
80-84
85-89
90+


Percentage change to Hertfordshire population from 2016-2041 by age group
% change
180
160
140
120
100
80
60
40
20
0
-20
0-4
5-9
10-14
15-19
20-24
25-29
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65-69
70-74
75-79
80-84
85-89
90+
Hertfordshire
East of England
England

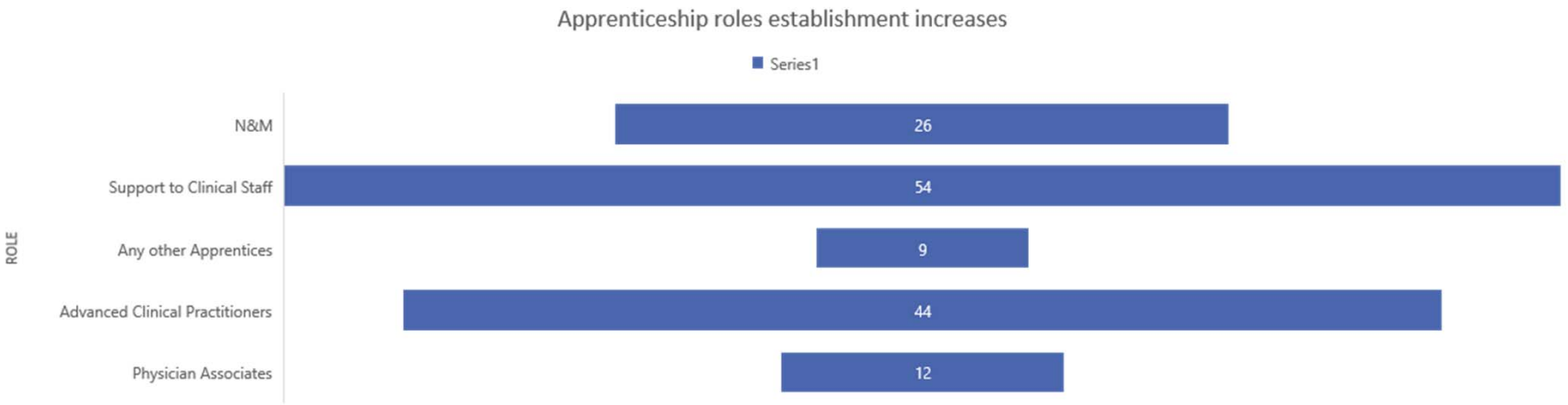
All Staffing	Nursing	Medical	Non-Clinical
There will be a modest decrease in all staffing of 16 wte	There will be a modest increase in substantive nursing staffing of 74 wte	There will be an increase in consultant staffing of 9wte	There will be a very significant decrease in non-clinical of 153 wte



APPRENTICESHIPS

As part of the HEE planning process, the Trust detailed the additional apprenticeships roles which are being or will be developed within the Trust

N&M	Clinical Support	ACPs	Physician Associates	Other Apprenticeship roles



Part 2: The problem we are facing

Time for a new strategy…

- The previous ENH people strategy ran from 2014 to 2019
- The approach it laid down drove improvements to recruitment, temporary staffing, and employee relations and supported change across the Trust at a tough time
- A number of new factors have now emerged that require a fundamental shift in emphasis for NHS workforces:
  - Changing expectations of work
  - Significant changes in the supply of workforce skills
  - Increased recognition of the efficiencies that digitisation brings to care and roles
  - Impact of the new NHS Chief People Officer and Long Term People Plan
  - Emergence of improvement approaches
  - The development of Primary Care Networks, Integrated Care Systems and Providers

What we do is not easy……

- Delivering responsive, safe and high quality care to patients relies on thousands of people collaborating across professional boundaries consistently within a supportive system
- The work is inherently demanding and the constant challenges of life and death create anxiety that drives workplace behaviour and spills over to our lives at home
- Professional boundaries become stretched and inherent gender, class, ethnicity or educational differences come to the fore, exacerbating perceived differences in salary, working conditions and status and fermenting challenging behaviours
- Facing these challenges, many staff leave before they need to and many more cite bullying, over work and stress as reasons for absence and mistakes
- In turn this adds more tension in the form of new, less-experienced or temporary agency staff all trying to fill the void, leaving the remaining staff feeling under-pressure and less safe

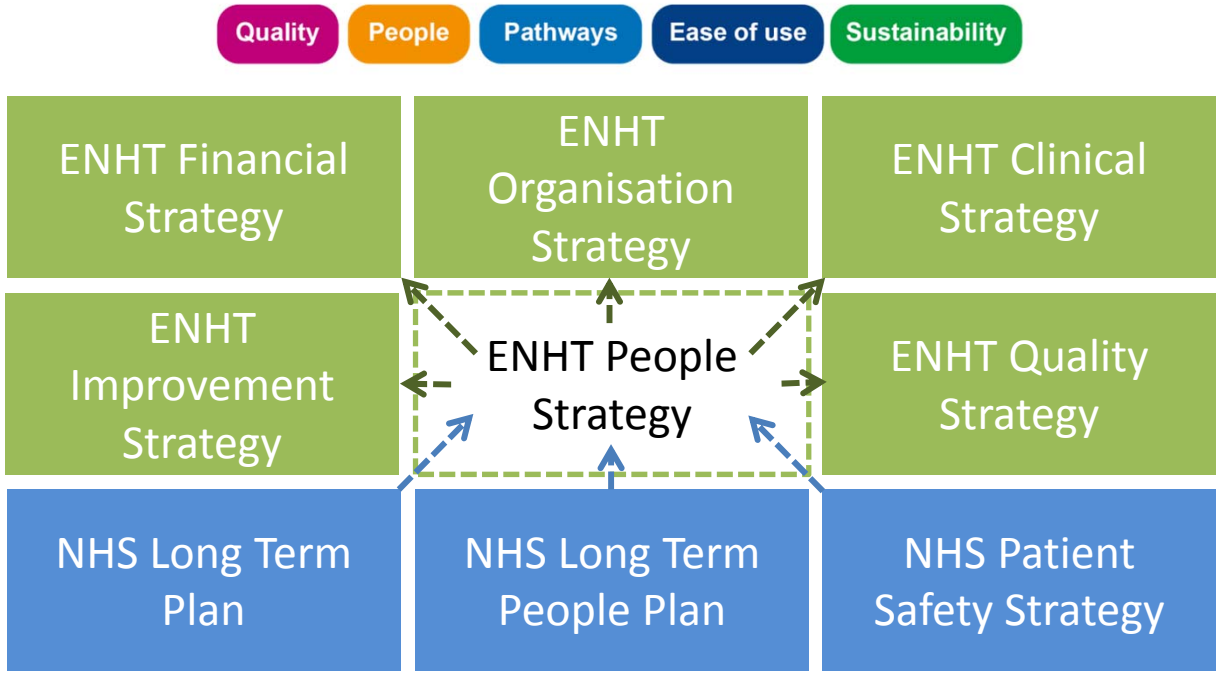
…and neither is our operating context

- Austerity has exacerbated many of the challenges we experience
- Lack of available capital has reduced vital investment in infrastructure and development and our staff often have to compensate
- The control needed to manage spend across systems had often been to the detriment of engagement, short term solutions lead to staff ‘fill the gaps’ or manage overlaps, eroding our ability to deliver change
- Leadership behaviour from the very top of the NHS, during this time of pressure has led to an increase in accusations of bullying, harassment and discrimination
- All of this, coupled with a global reduction in healthcare professionals means we cannot guarantee that our current supply of people can match the skills demanded by our current operating model

The narrative for change in ENHT

- The ENHT 5 year financial plan lays out the issues we need to address to remain sustainably viable as an organisation
- We cannot continue to operate the way we have and expect to deliver sustainable quality improvement
- We have to invest in technology, new models of working and build our capacity and capability to maximise the care, compassion and expertise of the people we employ
- Without a shift in emphasis and methodology there is a very real danger we will run out of money, our supply of people will dry up, our employment model will become too expensive and our people will become so disaffected they leave to join an organisation they perceive to be better. Ultimately, ENHT will become unsustainable.
- This is not an exaggeration, it is clearly predicted by our financial and people data projections *(trend graphs with predictions)*

Our approach enables other strategies



Part 3: Developing our Strategy

A people AND organisation strategy…

- Addressing these issues is not simply about being nice to our employees or writing better policies
- We need to invest to drive improvement and on more than workforce numbers
- Our approach has to encompass everything about our organisation
  - The way we design our organisation, roles and teams and maximise the productivity of the jobs our people do
  - The outcomes we expect from our people, the way we incentivise and what we value in terms of delivery and reward
  - The way we build organisational and individual capability, confidence and capacity
  - The experience people have at work and how this matches their expectations and our rhetoric, especially when things go wrong
  - The way we act as leaders, whether we listen and act on what we hear and how we give people space to deliver
- By influencing, designing and delivering in all of these areas, we can enable our ENHT strategy and maximise the impact of our most precious resource
- This will require a transformation of our strategic intent for people across OD, HR, Employee Relations, Leadership, Education Development & Learning, as well as our approach to managing people transition and transformation.
- It will also require a new way of thinking about people from our leaders, ensuring their needs are in our thoughts as we make decisions

A mass engagement exercise……

- It was critical to engage our staff in the development of this work as they know the REAL issues
- While the staff survey gives us snippets, it is too broad and generic to drive a new people experience or pinpiont the fundamental irritants or cultural shifts required
- To address this, over the last few months we have:
  - Run a **survey** (via Survey Monkey) to understand why our staff experience. Over **430 people** participated
  - Run two **Tweet Chats** with selected teams focusing on flexibility and care
  - Run a number of **workshops** with staff across the Trust, including consultants, nurses and operational teams
  - **Synthesised data** from Exit interviews, workshops, staff survey, Staffside meetings, 1-2-1s, Trust Conversations, Inductions
  - **Analysed** our Employee Relations **caseload** to understand root cause, failed and delivered outcomes
  - Surveyed our **key clients** to understand how they feel about our delivery
  - Looked into the People Strategies from key external businesses, the **Long Term People Plan** and **Patient strategies** currently being developed and socialised
  - Spoken to key consultancy organisations including Deloitte, PSi, Engaging Minds and OutVie to discuss the impact of **employment and social trends** on work and culture

So what did we find….?

- Our staff love working for us but are frustrated
  - They want more flexibility
  - They want to be more involved
  - They feel neglected and that they don't matter
  - They want to be heard and included
  - They want to feel safe with the people they work with and the people they work for
- They also have some amazing aspirations
  - They want more tools to help them do their jobs
  - They want more learning and development opportunities
  - They want the permission and space to improve the care they give
  - They want to be able to improve more quickly and face less bureaucracy
  - They want to see the values brought to life by everyone, all of the time

Some facts….

- 1 in 5 of our staff are carers or have caring responsibilities
- 52% of our respondents wanted us to be more flexible in the way we staff
- 2/3 of our staff told us that the way that their manager treats them is the single biggest reason that they either feel proud or not
- The biggest frustration our staff have is with poor behaviour (of each other or leaders)
- The most requested change was the ability and permission to make improvement
- The most used theme words in the free text responses were
  - Frustration
  - Flexibility
  - Permission
  - Safe
  - Patient (care)
  - Workload

What does that look like….?

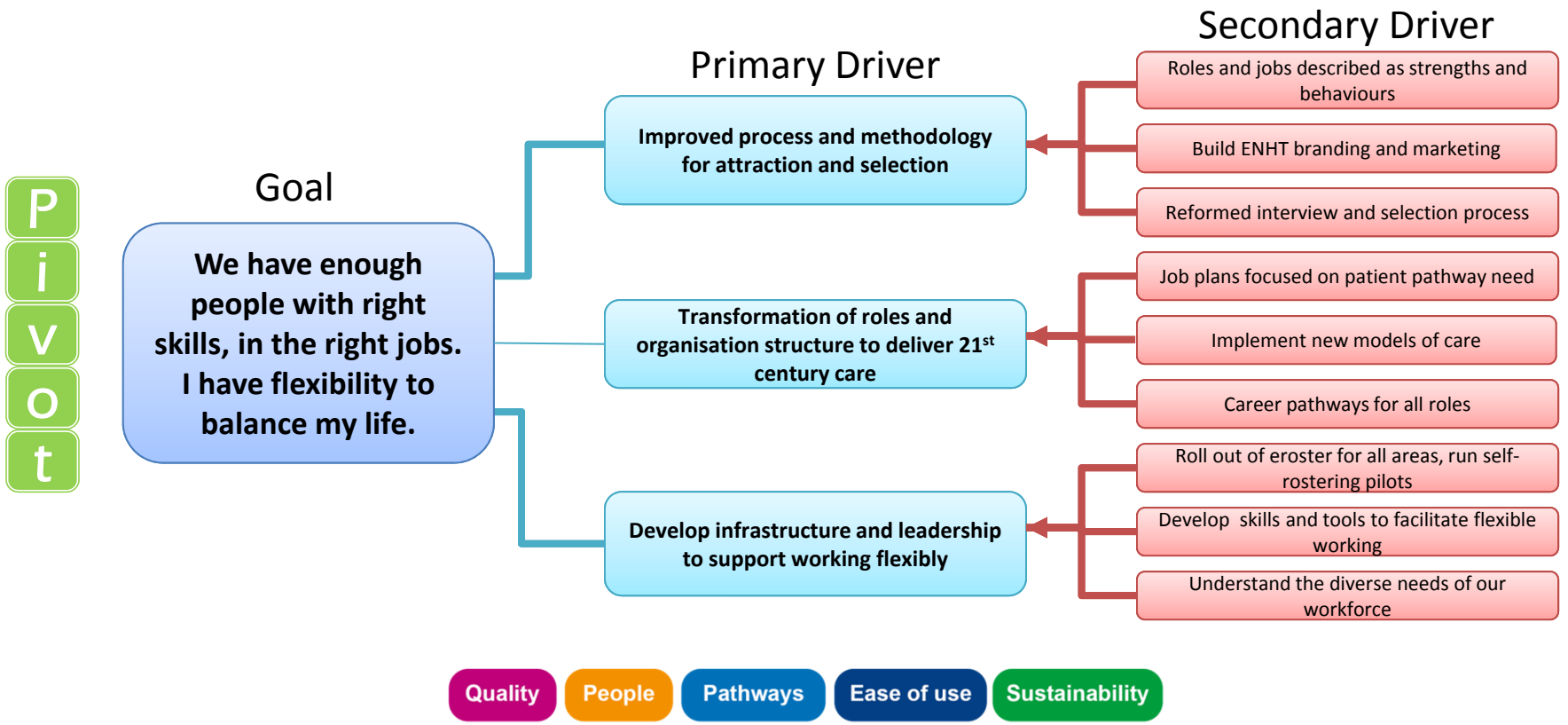
Part 4: The People & Organisation Strategy

Prioritising the impact of our investment in people

Our People & Organisation Strategy

A PLACE WHERE EVERYONE CAN WORK, GROW, THRIVE AND CARE TOGETHER, FOR OUR PATIENTS

Work Together



Work Together

Opportunity

- Efficient deployment of target operating model

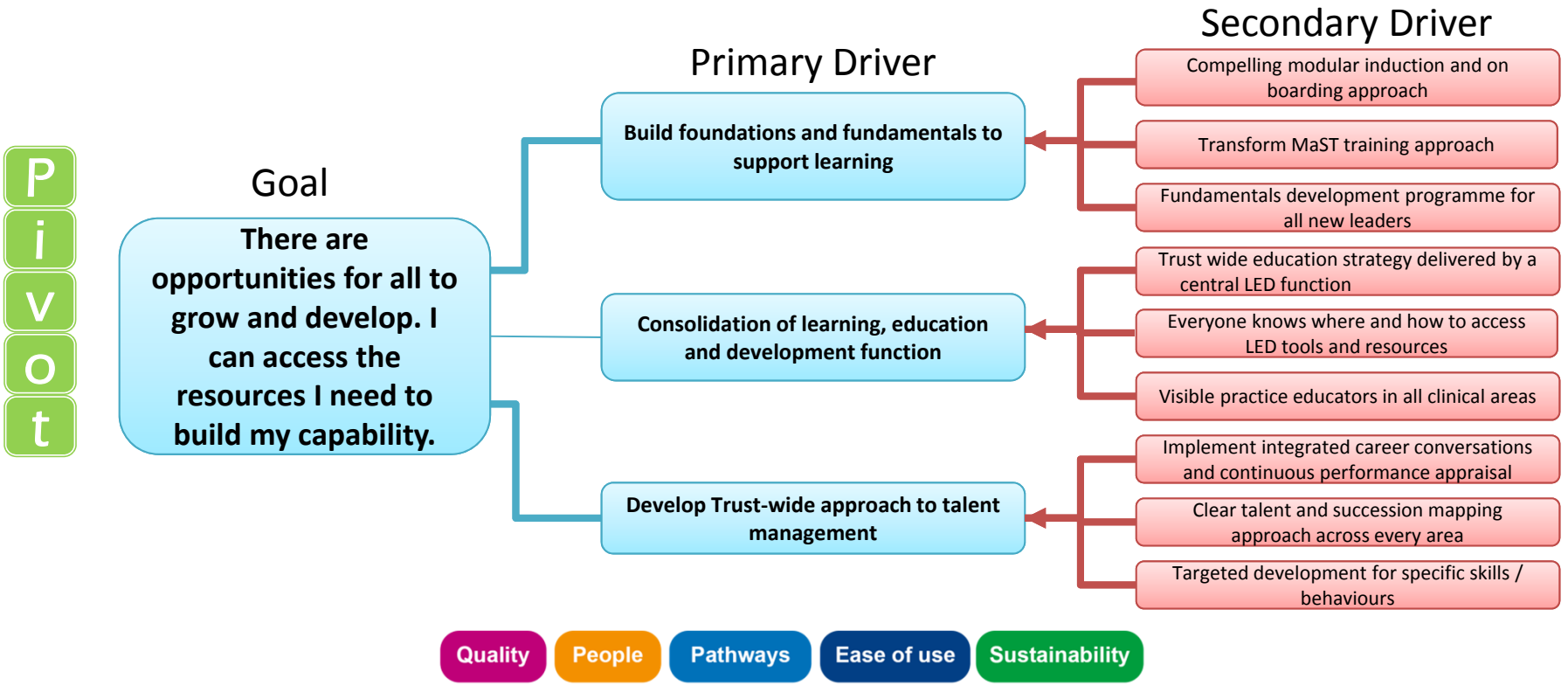
Key outcome

- More people operating at top of capability not top of capacity

Brilliant Basics

- Clear target operating model
- Workforce plan built around critical capabilities
- Implement e-roster
- Clearer roles and responsibilities
- Improve recruitment process/method
- Build employer brand
- Job plan rewrite

Grow Together



Grow Together

Opportunity

- Improve quality of care, by retaining those who want to stay whilst developing and supporting those who want to move within the system

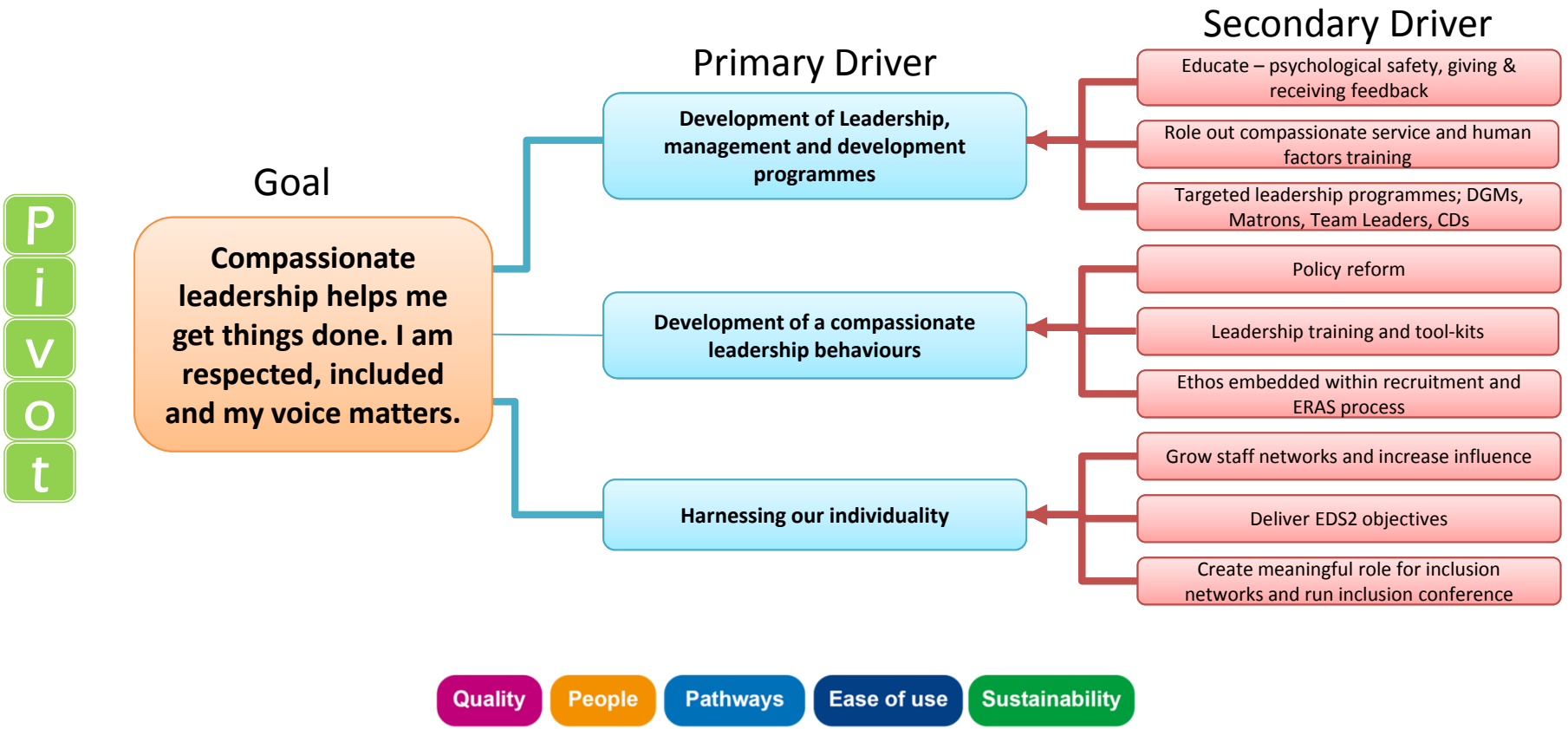
Key outcome

- Loyal, capable and engaged staff who stay longer and deliver improved care

Brilliant Basics

- E-learning implementation
- Induction and on-boarding improvement
- Increase self service/reduce administration
- Career conversations integrated to ongoing appraisal
- Talent board in every division/directorate with clear succession plan
- Clinical leadership programme
- Increased capacity for trainees

Thrive Together



Thrive Together

Opportunity

- Create improved care through collaboration ‘civility saves lives’

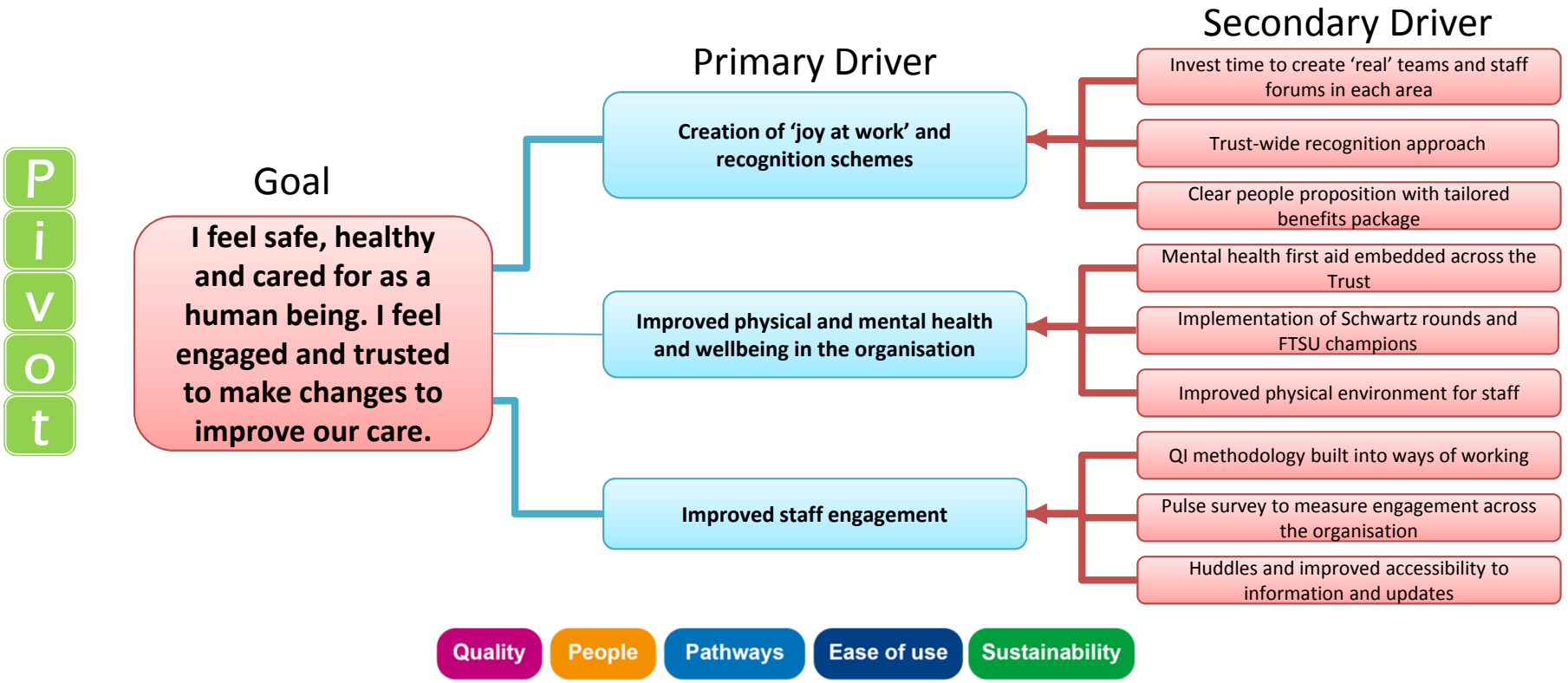
Key outcome

- Create a culture of collaboration to enable better, quicker decision making that balances money, people and quality

Brilliant Basics

- ENHT proposition
- Just and learning culture
- New suite of policies aimed at cultural alignment
- Build basic line management skills
- Compassionate service and leadership for everyone
- Include our vulnerable and underrepresented groups
- Micro-behaviour awareness

Care Together



Care Together

Opportunity

- Release the effort and passion of our people to care for their patient

Key outcome

- Great place to work where people feel engaged and able to improve what they do

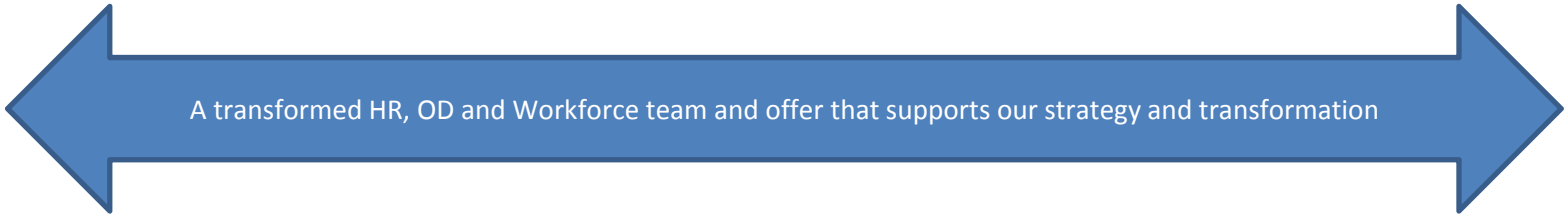
Brilliant Basics

- Package of physical and mental wellbeing interventions
- Schwarz rounds, supervision
- Clear accountabilities to enable improvement
- New communication strategy and approach
- FTSU champions across Trust

Part 5: Enabling the Strategy

3 x 3-year programmes

A PLACE WHERE EVERYONE CAN WORK, GROW, THRIVE AND CARE TOGETHER, FOR OUR PATIENTS



- Resources are not currently optimised to enable delivery of the strategy
- To deliver this we need to
  - Invest in EDI, HRBP, Resourcing and Learning
  - Digitise and automate to free up capacity
  - Drive self-service wherever possible
  - Build the capability of our People team
  - Focus on getting our basic processes right to enable scale
  - Collaborate more effectively across the people experience
  - Change the way in which we work with divisions
  - Create a skill base among managers to prevent people issues

- Teams are fragmented and opportunities to drive ‘an approach’ are limited
- To deliver change we need:
  - Develop a collaborative education function with a shared vision and centralised administrative function
  - Produce a Trust wide education strategy
  - Transform our induction and on boarding process for new staff
  - Transform our statutory and mandatory training experience
  - Create a unified work experience approach
  - Ensure that all staff are aware of the learning, education and development opportunities within the Trust
  - Develop an apprenticeship offering to new and existing staff
  - Develop leaders in the Trust with targeted leadership development opportunities

- Culture change is not just about behaviour
- Bring together improvement, quality, new models of care, values and employee experience (behavioural and physical) and communication
- Driven by existing mechanisms
  - Staff network groups
  - Employee experience group
  - Just and Learning culture group
- As well as some changes and additions
  - Education Board (new)
  - Trust partnership and LNC
  - Divisional forums (new)
  - Workforce transformation Board

Part 6: Measuring and assuring delivery

We need measures and targets

- This is a stretching agenda that requires investment of time, money and effort
- We need to know it is working and ‘paying back’ whilst also encouraging stretch
- Progress on the people agenda has been measured via traditional HR and workforce lag indicators
- These indicators have a place but only tell us a portion of the story and encourage ‘blunt’ supply interventions
- We need to broaden our view and triangulate: -
  - Clinical and operational outcomes
  - Quantitative HR data
  - Qualitative employee experience data
- This will create better assurance and more sophisticated and targeted interventions

Targets

- Trust Level
  - 5% drop in bank/agency spend over 2 years
    Vacancy rate of >5% across the Trust by April 2021
  - Attrition rate of >11.5% across the Trust by April 2021
  - Achieve Model Employer targets by end 2022
  - 75% Green on EDS2 targets by end 2022
  - Consistent <90% on MaST for each element by end April 2021
  - Avg suspension no longer than 4 weeks
  - 10% increase in FFT score
- Division/Directorate Level
  - 20% drop in agency spend over 2 years for corporate and management
  - Max vacancy rate of >8% by directorate
  - Max attrition rate of >15% by directorate
  - Consistent <90% on MaST for each directorate
  - Min 90% appraisal completion by directorate
  - Min 6 Schwarz rounds per site
  - 10% increase in staff survey score by directorate end April 2022

Measuring Engagement

- The current staff survey does not give us instant or predictive data

- We will introduce a pulse survey approach to measuring sentiment
- This will be a shared approach with the Communications team
- The exact approach and questions are to be defined by the staff experience group
- Data will be represented to leaders and staff forums to prompt immediate action and leadership
- People Team will set targets at a directorate, divisional and Trust level to drive action
- Results and narrative feedback will also drive new toolkits and approaches

Governance and reporting structure

Part 7: Our outline investment needs

Investing in People

- Hitting our workforce targets over the 2 years plus introducing new, more efficient and effective models of care represents a direct saving of over £2m
- For 2020 we need to target our investment in
  - Automation
  - Digitisation
  - Inclusion
  - Workforce capability
  - Leadership

  Plus targeting estate time and money to creating learning capacity and quality to enable us to work and deliver at scale
- Some of this can come from increased effectiveness within the People Team
- We estimate an added investment in 2020 of approximately £300k

East and North Hertfordshire NHS Trust

Agenda Item: 10(a)

TRUST BOARD - PUBLIC SESSION – 8 JANUARY 2020

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE – 27 NOVEMBER 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, Performance and People Committee (FPPC) meeting held on 27 November 2019. The report includes details of any decisions made by the FPPC under delegated authority.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of FPPC	**Presented by:** Chair of FPPC	**Author:** Trust Secretary/ Board Committee Secretary

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

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

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

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE – 27 NOVEMBER 2019

EXECUTIVE SUMMARY REPORT TO TRUST BOARD – 8 JANUARY 2020

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

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), Rachael Corser (Director of Nursing).

MATTERS CONSIDERED BY THE COMMITTEE:

BOARD ASSURANCE FRAMEWORK
The FPPC received an update on the BAF risks and actions in place to mitigate against them. It was reported that there had not been any changes to the risk ratings in month on this occasion.
The Committee discussed the "perfect week" that was taking place to improve flow within the hospital and how feedback would be provided to the Committee.

M7 FINANCE REPORT
The Committee was presented with the Month 7 Finance Report. Month 7 year to date position was a £1.2m deficit against a planned deficit of £2.5m. The key trends for M7 were similar to previous months, with over performance on SLA income but some challenges in terms of pay and some of the CIP schemes.

OUTTURN UPDATE
The FPPC received an update on the 2019/20 forecast outturn review. It was reported that an agreement was being discussed with the Commissioners regarding payment for the extra activity the Trust had undertaken. The Committee noted the update.

BUSINESS PLANNING 2020-2021 – GENERAL PRINCIPLES
The FPPC was presented with a report on the general principles of business planning for 2020/2021.The need for the planning to integrate with other plans and priorities was noted. It was reported that it was the intention to hold workshops in Q4 to establish these priorities.

BUSINESS PLANNING 2020/2021 - FUTURE MECHANISMS
The FPPC received an update on the future principles of business planning. The report presented an update on changes in payment systems and its relevance to the Trust as an organisation. The committee discussed some of the possible payment arrangements.

B**USINESS PLANNING 2020/2021 – APPROACH TO TRANSFORMATION AND SAVINGS**
The Committee was provided with a report that set out the intended approach to savings and transformation aspect of business planning for 2020/2021. The report set out the proposed approach on the CIP and transformation portfolio and future plans to move from a transactional to transformational CIP model. The Committee noted the report.

BUSINESS PLANNING 2020/2021 – TARIFF ENGAGEMENT
The Committee received an update on changes in national tariffs on health services for the coming year. It was reported that key changes to payment systems are under consideration for next year. The Committee noted the report.

COSTING ASSURANCE REPORT
The FPPC received a report which provided an update on the Trust's reference cost submission. The Committee noted the update.

LONG TERM PLAN UPDATE
The FPPC was provided with a report on the Trust's Long Term Plan. The report provided an update on the development of the Trust's 5 year financial plan that accompanies the Herts and West Essex STP's

Strategic Delivery Plan. This was a high level plan for which further detail would need to be developed in time. The plan had been submitted on 15 November. The Committee noted the report.

INTEGRATED PERFORMANCE REPORT
The FPPC was presented with the latest Integrated Performance Report. The safe, caring and effective elements were also discussed at the Quality and Safety Committee meeting on 26 November 2019.

Safe & Caring Services
The FPPC received a brief update regarding the safe and caring services. The key points highlighted included the sustained good performance in terms of the safety thermometer and an improvement in complaints timeliness. (Though it was noted there had been an increased number of complaints lately as winter pressure increased).

Effective Services
The FPPC received an update on effective services. It was reported that SHMI performance continued to improve and HSMR was lower than at the same point in 2018. Readmissions were slightly higher than the average but continued to improve.

Responsive Services:
Key points regarding responsive services included:

- 4-hour ED target – Performance remains steady at 85%. Perfect week should help support this target (and as the national average has reduced, the Trust was now performing comparatively better).
- 62 Day Cancer performance was at 69.71%, below the previous month's performance (73.28%)
- Diagnostics – performance remained compliant.
- Stroke - Performance for October was 60.3%, an almost 20% reduction from the September performance. Factors behind low performance had been identified and addressed.
- RTT – Performance was at 83.81%. Work was ongoing to gain an improved understanding of the level of capacity needed to deliver this target.

Well-led Services:
The key points reported regarding well-led services included:

- There had been an improvement noted in demand for temporary staff.
- Sickness absence had increased but was better than at the same point in 2018.
- The number of flu vaccinations had been affected by lack of available vaccine
- The Trust was in a relatively strong position in terms of medical recruitment.

Sustainable Services:
The Sustainable services section of the IPR was covered through other reports on the agenda.

THEATRE TRANSFORMATION UPDATES
The FPPC received an update on the progress of the theatre transformation programme following discussion at previous FPPC meetings. It was reported that there had been good progress made in terms of utilisation and cancellation rates. The Committee also received the KPIs that had been developed to enable the FPPC to keep track of performance. The Committee discussed with the programme leads how the improvements could be sustained and congratulated the team on the progress.

PTL MANANGEMENT
The FPPC considered the findings of a deep dive into PTL management. The report presented the FPPC with updates on systems in place to ensure validation, compliance and sustainability. The Committee recommended that KPIs should be developed to enable the FPPC to maintain an oversight of performance.

PEOPLE STRATEGY
The FPPC was provided with a final view of the People Strategy for discussion. The document set out the background and the process of the development of the strategy. The People Strategy is a key enabling strategy for the Trust. The Chief People Officer explained that quantifying the value of the strategy would be difficult but areas of focus for investment would need to be identified. Subject to some minor changes, the Committee endorsed the strategy.

MANAGED SERVICE PROVISION
The FPPC received a report on managed service provision. It was reported that the current contract for a fully outsourced managed bank staff service provision was due to expire in March 2020 and approval was needed to award a contract to the winning bidder. The Committee approved the recommendation of the paper (final approval by Board would be required due to the value of the contract).

FLU UPDATE
The FPPC received an update on the staff flu vaccination programme. The Committee noted the update.

MVCC UPDATE
The FPPC was updated on progress on the actions arising from the strategic review undertaken by Specialist Commissioners regarding Mount Vernon Cancer Centre (MVCC) and the steps that the Trust was undertaking to support these. The Committee recommended that consideration should be given to rephrasing the BAF risk relating to MVCC.

ESTATES COMPLIANCE REPORT
The FPPC was provided with a report on Estates Compliance as requested at the last FPPC meeting. It was reported that a more robust system of reporting through estates and facilities governance structures is now in place. The Committee agreed that this was an area that they should continue to focus on over coming months.

CLINICAL WASTE
The FPPC was provided with a report to provide assurance regarding clinical waste processes. The report outlined the duty of care responsibilities with regards to clinical waste disposal, both nationally and locally. The Committee noted the report.

DIGITAL STRATEGY
This item was deferred to the next meeting.

Karen McConnell
Finance and Performance Committee Chair

November 2019

East and North Hertfordshire NHS Trust

Agenda Item: 10(b)

TRUST BOARD - PUBLIC SESSION – 8 JANUARY 2020

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE – 18 DECEMBER 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, Performance and People Committee (FPPC) meeting held on 18 December 2019. The report includes details of any decisions made by the FPPC under delegated authority.		
Action required: For discussion		
Previously considered by: Due to be considered by Corporate Trustee prior to public meeting of Trust Board on 8 January 2020.		
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, PERFORMANCE AND PEOPLE COMMITTEE – 18 DECEMBER 2019

EXECUTIVE SUMMARY REPORT TO TRUST BOARD – 8 JANUARY 2020

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

The following core attendees were present:
Martin Armstrong (Director of Finance), Duncan Forbes* (Chief People Officer), Julie Smith* (Chief Operating Officer)
** Present for part of meeting only.*

MATTERS CONSIDERED BY THE COMMITTEE:

BOARD ASSURANCE FRAMEWORK AND RISK REPORT
The FPPC received an update on the BAF risks. It was reported that there were no significant changes to the risk ratings in month. The FPPC were updated on the risk relating to the transfer of MVCC and continuity of service.

RISK REPORT
The FPPC received an update on the latest risk report. The report highlighted the good processes and improvements in risks areas, achievements in KPIs and new risks. The Committee discussed some specific risks and noted the update. It was suggested that the report should be considered in more detail by the Audit Committee.

DIGITALISATION STRATEGY
The FPPC was presented with an update on the Digitalisation Strategy. This covered progress made in the roll out of the electronic prescribing medicines and administration (ePMA) system with the first ward due to go live in February 2020. It was reported that hardware and infrastructure upgrades were also taking place. The FPPC discussed the timelines for the projects and noted the impact of the 'quick wins' on staff morale. Further details of ongoing/new projects and timescales were requested.

ESTATES COMPLIANCE REPORT
The Committee discussed the estates compliance report following initial discussion at the previous meeting. There had been delays with some of the projects. The Committee considered some of the reasons for this. A high level project plan and associated risks was requested. The Committee also requested clarification of the basis of the risk scoring.

STRATEGIC PROJECTS UPDATE
The FPPC received a report on key strategic projects. Updates were provided regarding the vascular, renal, STP pathology and PET CT projects. The Committee discussed next steps including the development of STP funding bids. It was agreed that the FPPC would receive an update on these including the associated risks at its January meeting.

MONTH 8 FINANCE REPORTS
The Committee was presented with the Month 8 Finance Report. The Month 8 position was a £0.6m surplus in month, which is in line with the plan submitted to NHSI. SLA income continued to show a strong over performance in line with forecast.

OUTTURN FORECAST SUMMARY
The FPPC was provided with an update on the outturn forecast. It was reported that a deal had been agreed with the Commissioner reflecting the risk and cost of the Trust's emergency activity over performance. The Trust continued to envisage delivery of its control total in 2019/20 based on M8 financial performance, supported by a number of remedial forecast mitigation workstreams.

INTEGRATED PERFORMACE REPORTS
The FPPC was presented with the latest Integrated Performance Report.

Responsive Services

The key points regarding responsive services included:

- ED 4-hour Target - Performance had improved in November to 81.43%. There was some discussion on how the winter planning would continue to support this level of performance
- Cancer performance - 6 National Cancer Targets were delivered for October. This was welcomed by the committee.
- The 62-day performance was 81.1%.
- RTT performance was 83.81%.
- Stroke performance had deteriorated and actions taken to improve this performance were highlighted.

The Committee commended the Chief Operating Officer on the relatively strong 4 hour ED performance. It was recommended that a report be produced on stroke performance if not improved by next month. A report on learning from the Perfect week was requested for the January FPPC.

Well-led Services

The Deputy Director of Workforce and OD presented an update to the FPPC on the well-led element of the IPR. He reported that;

- The recruitment of nurses has become more challenging. The Committee discussed the need for comprehensive and crosscutting retention plans.
- Flu vaccine uptake had improved to 60.5% and the Trust now compared better nationally than it did last year. The campaign was continuing to ensure as much uptake as possible by front-line staff.
- The Committee discussed the impact of International recruitment and the possible future approach

Sustainable Services

The Sustainable services section of the IPR was covered through other reports on the agenda.

DEEP DIVE – OUTPATIENTS

The FPPC received an update on the progress of the Outpatients programme following discussion at previous FPPC meetings. The positive progress was welcomed. The Committee agreed the KPIs that had been developed but suggested the inclusion of a metric regarding utilisation of virtual clinics. FPPC also requested sight of the 5 year Strategy which was being developed.

EMPLOYEE RELATIONS UPDATE

The Committee was provided with an update on Employee Relations matters. A reduction was reported in sickness absence and better reporting of medical staff sickness was welcomed. The Committee recommended comparing data with other Trusts where possible.

WORKFORCE AND OD RISK REGISTER REPORT

The Committee received an update on workforce and organisational development risks. The Committee discussed the latest staff survey, the results of which related to some of the risks. The survey findings were due to be published in February.

INDEPENDENT CONTRACTOR AND HIGH VALUE AGENCY UPDATE

The FPPC received an update on independent contractors and high value agency staff. The Committee requested that some more details are presented at future meetings.

Karen McConnell
Finance, Performance and People Committee Chair

December 2019

East and North Hertfordshire NHS Trust

Agenda Item: 11 (a)

TRUST BOARD - PUBLIC SESSION – 8 JANUARY 2020

QUALITY AND SAFETY COMMITTEE – MEETING HELD ON 26 NOVEMBER 2019

EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the QSC meeting of the 26 November 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	☒
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Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

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

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

QUALITY AND SAFETY COMMITTEE – MEETING HELD ON 26 NOVEMBER 2019

SUMMARY REPORT TO TRUST BOARD – 8 JANUARY 2020

The following Non-Executive Directors were present:

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

The following core attendees were present:

Nick Carver (Chief Executive), Jude Archer (Associate Director of Corporate Governance), Michael Chilvers (Medical Director), Rachael Corser (Director of Nursing), Duncan Forbes (Chief People Officer), Julie Smith (Chief Operating Officer).

The following points are specifically highlighted to the Trust Board:

1. Medical Staff Establishment Report

The medical establishment and recruitment update was presented to provide the board with

- an update on work completed to review the medical establishment; and
- an update on progress with medical resourcing for both permanent and temporary staffing.

The Deputy Director Workforce and OD reported the steps that were taken in restructuring the medical workforce team. The Medical Director added that they had been targeting high cost locums and had been successful because the number of high cost locums had decreased.

2. 7 Day Working Report

The 7 day Hospital Services Programme supports providers of acute services to tackle variation in outcomes for patients admitted to hospitals in an emergency, at the weekend across the NHS in England. The measurement system requires board assurance of four clinical standards that were made priorities for delivery to ensure patients admitted in an emergency receive the same high quality initial consultant review, access to diagnostics and interventions and ongoing consultant-directed review at any time on any day of the week.

A number of audits had been conducted and re-auditing was in progress on four wards during the perfect week to demonstrate where shortfalls were and how they could improve their performance by recording their interaction with patients.

The Committee approved the self-assessment template for submission to NHSI.

3. Emergency Preparedness

The Chief Operating Officer delivered an update on progress against the Emergency Preparedness Resilience and Response (EPRR) work programme. She reported that over the last year, the readiness of the Trust for business continuity events and major incidents continued to develop, and the Trust had a compliance rating of Fully Compliant against NHS England's EPRR Core Standards Assurance Rating. This had been achieved as a result of the continuing wholesale review of the Trust's EPRR structures, resourcing, work programme, and documentation. Work was ongoing on development of the business continuity plans, major incident planning and training for key staff and the planning for the EU exit.

Other outcomes:

Integrated Performance Report

The Integrated Performance Report - Month 7 was presented to the Committee.

Safe and caring

The Deputy Director of Nursing reported that according to the Safety Thermometer. The Trust was in the highest (best performing) quartile for harm-free care in October. A 3rd Never event was declared in October. A throat pack was unintentionally retained. This caused minimum harm. A root cause analysis was underway to prevent re-occurrence.

Management of complaints remained a priority. The Trust aimed to improve timeliness of responses and reduce open complaints. There had been an improvement in response rates.

Effective services

The Medical Director reported that the rolling 12-months crude mortality had improved slightly and remained better than the most recently available national rate. The in-month HSMR increased to 80.6 in August but remained better than the standard (100). The rolling 12-months HSMR remained in the better than expected range. The latest SHMI release for the 12 months to June saw an improvement to 90.59.

Responsive Services

The Chief Operating Officer reported that A & E performance for the month of October was 85.83%. There was a high attendance rate and this remained extremely challenging. Stroke performance had dropped due to capacity issues. The norovirus outbreak resulted in some wards being closed in November, impacting on availability of stroke beds. In September the Trust achieved 4 out of the 8 national targets for cancer performance.

Well led

The Chief People Officer said that there had been some positive developments in recruitment. Agency price cap breaches had reduced significantly. Medical temporary staffing remained the priority for opportunities to reduce agency spend. Sickness was a challenge. An additional 328 days were lost due to sickness absence in October. The response to the flu campaign had been positive.

BAF and Corporate Risk Register Report

The Associate Director of Corporate Governance presented the latest version of the Board Assurance Framework 2019 -2020 to the Committee for consideration.

The Committee were asked to note that there have not been any changes to the risk rating in the month. Two risks, Estates and Facilities and Capital remained at 20 and would be discussed at the FPC meeting.

Complaints, PALS and Patient Experience Report

The report was submitted to inform the Committee of the Trust's position with regard to the Q2 (July - September 2019) patient experience feedback, complaints and PALS activity.

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 and care/treatment and the highest proportion of negative comments related to the environment. The Patient Advice Liaison Service (PALS) received several contacts in

relation to cancellation of appointments and patients seeking assistance in obtaining access to treatment.

Patient Safety Incidents Report and Serious Incidents and Never Event Report

The report was submitted to inform the committee of patient safety incidents data, trends and themes. This report provided an update on serious incidents and never events. The Medical Director reported that there were three Never Events this year, 1 in regard to an oxygen switch, I wrong tooth extraction and the leaving in of a throat pack. No patients came to harm as a result of these events. There had been an average of 5 serious incidents per month. There was an improvement in the duty of candour performance.

Clinical Audit & Effectiveness Report 2018 -2019

This report summarises the half yearly 2019\2020 Clinical Audit and Effectiveness (CAE) performance on, developments and current risks. The Medical Director reported that there had been an increase in the number of mandatory audits that were required and it was difficult to keep up. There was some good work done and the Trust was recognised for excellent work in National audits. The Committee noted the work planned to improve engagement and compliance with audits and implementation of outcomes.

Reducing Avoidable Variation

The Medical Director reported that he planned to produce a report on the issue for the January meeting. He asked the committee what they would like him to report on. The report would focus around GIRFT. The GIRFT team had visited the Trust 11 times in the last three months, eight reports had been completed with recommendations and action plans. In two or 3 matters they were waiting for the action plans to come back.

Learning from Death

The Medical Director presented the quarterly report which summarised the results of mortality improvement work, including the regular monitoring of mortality rates, together with outputs from learning from death work that was a continual on-going process throughout the Trust. It also incorporated information and data mandated under the National Learning from Deaths Programme.

Infection report

The Director of Nursing presented the Infection control report to inform the committee of infection prevention and control performance for October 2019. She reported that for the first year for a long time they had had a winter outbreak of norovirus. Because of good communication, only 3 wards had been closed and affected although it did impact a large number of beds and capacity. There had been no incidents of hospital acquired flu.

Safer Staffing

The Director of Nursing reported that the overall picture was positive. There had been an increase in numbers of whole time substantive staff and a reduction in the number of demand shifts that temporary workers were required for.

Clinical Harm Reviews Update

The Medical Director presented the report to inform the Committee of developments relating to the Harm Review Process. The clinical harm review process provides assurance that there is Divisional and Executive oversight of potential or actual harm as an unintended

consequence of delayed cancer treatment, delayed cancer treatment and breaches of referral. The report detailed some of the processes and the numbers behind the three areas.

Briefing Paper and letter JH

The Director of Nursing asked the committee to note the briefing paper and letter. JH died in 2011. She had been treated at both Lister Hospital and Great Ormond Street Hospital. After her death her care was reviewed. The Medical Director and Director of Nursing had reviewed the case again recently and discussed it with the CCG, CQC and NHSI and it was agreed that no further actions would be taken, lessons had been learnt and processes changed. Two non-executive directors agreed to take a final review of the records from a Board Assurance perspective.

CQC and Compliance report

The Associate Director of Corporate Governance presented an update on CQC compliance including a summary of the enquiries received. The Trust had received four enquiries from the CQC in October. Four of these were closed and one remained. The outstanding enquiry concerned safeguarding. They were presently looking into it.

Litigation Annual report

The Associate Director of Quality and Safety presented a summary of clinical claims and inquests to the Committee. Trust data and comparisons nationally were reflected. The report highlighted notable developments and key themes. She reported that there had been a downward trend in new claims in the last five years.

MVCC Risk review presentation

The Director of Nursing informed the Committee of the meeting held to discuss the review that was conducted around MVCC. The present position and what the Trust was doing to support the local team was explained. A new clinical director had been appointed with a supportive clinical leadership team under her. The ongoing focus was on management of the transition.

Organisational Culture

The Chief People Officer updated the Committee on the People Strategy due for consideration. They were looking at strategies to improve recruitment, training and induction while embedding values and behaviours across the organisation as well. They were also looking at methods to improve the experience of staff through their managers.

Quality Account

The Associate Director of Quality and Safety presented the quality account to provide an updated view of progress against ENHT Quality Account milestones. Performance in terms of the Quality Priorities 2019/20 was reviewed. Four key quality pillars have been identified to provide a structure in which to focus our efforts of continuous improvement. Each pillar had an annual quality plan which it would be measured against. See agenda item 11.2 for a copy of the report.

University Status Annual Report Update

The University Trust Partnership Annual report was presented to detail the progress made by the Trust partnership with the University of Hertfordshire. KPIs had been updated to reflect the progress made since the signing of the Memorandum of Understanding in March

2017over the past 2½ years. The progress that had been made in these indicators was set out in the report. Tangible benefits of the partnership were being seen and were collated in the form of case studies.

Medical Devices

The annual report was presented by the Director of Nursing. The purpose was to assure the Committee that the Trust had systems in place to ensure safe, effective management and operation of medical devices within the organisation. The Director of Nursing said that medical devices were currently high on the corporate risk register. She said she would provide an update by January 2020 and report to the committee with a plan by the end of the financial year.

The following reports were noted by the Committee

Maternity Dashboard Exceptions and Maternity Safety Concerns

The report was presented to provide the Committee with information on the Maternity Dashboard exceptions for October 2019. The Director of Nursing reported that there were ongoing concerns about increasing patient safety and indirect correlation with funding to support increasing demands. In line with the national picture it was likely that Maternity services would remain an area of increased scrutiny.

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Peter Carter

QSC Chair

November 2019

East and North Hertfordshire NHS Trust

Agenda Item: 11 (b)

TRUST BOARD - PUBLIC SESSION – 8 JANUARY 2020

QUALITY AND SAFETY COMMITTEE – MEETING HELD ON 17 DECEMBER 2019

EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the QSC meeting of the 17 December 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	☒
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Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

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

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

QUALITY AND SAFETY COMMITTEE – MEETING HELD ON 17 DECEMBER 2019

SUMMARY REPORT TO TRUST BOARD – 8 JANUARY 2020

The following Non-Executive Directors were present:

Peter Carter (Committee Chair), Ellen Schroder (Trust Chair), David Buckle.

The following core attendees were present:

Jude Archer (Associate Director of Corporate Governance), Michael Chilvers (Medical Director).

The following points are specifically highlighted to the Trust Board:

1. Women's Services Presentation

The Women's Services team delivered a presentation to the Committee on the progress they had made regarding quality and safety over the year. They gave an overview of the services delivered. They reported that their multiple pregnancy case loading model and service was recognised as outstanding. Continuity of Carer team models had been introduced. A Quality and Safety Improvement Programme Manager had been recruited to support the continued delivery of NHS resolutions ten steps to safety. The Maternity and Neonatal Safety Improvement Programme had been completed. They reported that there had been a significant decrease in the number on complaints since last year.

The team informed the Committee of the challenges they were facing in implementing Continuity of Carer and in meeting the core 7 day service standards for both Obstetrics and Gynaecology. They informed the Committee of future developments in obstetrics and maternity for example the development of a local maternity system wide safety dashboard and redesigning obstetric pathways. Some of the future developments planned in gynaecology were the improvement of Gynaecology Emergency Pathways and the development of fertility services. The Committee congratulated the team.

2. Quality Improvement Team Update

The Quality Improvement Team (QIT) introduced themselves to the Committee. They explained the methods they were employing to improve quality throughout the Trust. They were encouraging patient involvement in all projects. They had recruited 3 patients to be on the QI steering group. They were following the STEEEP principles to ensure that care was Safe, Timely, Efficient, Effective, Equitable and Patient centred. In conversations with patients and staff, they asked what mattered to them. They were presently involved in 31 projects. They reiterated the expectations regarding the time it would take for QI to work. The Committee welcomed the oversight of the QI programme and requested a further update in 6 months and future Board discussion.

3. Deteriorating Patients Presentation

The Deteriorating patient Improvement Collaborative was formed as a result of a number of serious incidents that occurred with a theme of a deterioration in patients. The progress by date was outlined including the CCOT and resus team had been collocated; Equipment for identification and treatment of the deteriorating patient was sourced and treatment escalation plans launched. A Driver Diagram which aimed to improve reliability of recognition and escalation of the deteriorating patient had been developed.

The Committee was assured of the actions being taken for improvements and noted the programme had been audited by external auditors. The team reported that a launch day would be held on 30 January 2020 and invited the Committee members to attend.

4. Laparotomy Audit Presentation

The National Emergency Laparotomy Audit (NELA) Surgical Lead delivered a presentation on the laparotomy audit results. He explained that NELA aims to enable the improvement of the quality of care for patients undergoing emergency laparotomy, through the provision of high quality comparative data from all providers of emergency laparotomy. He also explained the criteria for inclusion or exclusion. He gave the Committee details of the National principle performance statistics and outlined the improvements over the last few years and areas of continued focus including the need to recruit into 3rd Geriatric consultants or specialist nurse for Emergency Laparotomy. The Committee supported the efforts being taken to increase engagement.

5. Equality, Diversity and Inclusion Deep Dive

The Head of HR delivered a paper on Equality, Diversity and Inclusion. She set out the current position, areas for improvement, aspirations and planned actions. The statistics showed that there was more work to do on Workforce Race Equality Standard (WRES) regarding BAME staff at Band 8 and above. 30% of disabled staff reported experiencing bullying, harassment and abuse. There was also a large Gender Pay Gap (GPG). The Equality delivery Service (EDS) showed that the better health and inclusive leadership standards needed improvement whilst the Trust was doing well on Improved Patient Access and Experience and Representative and Supported Workforce.

Aspirational targets and planned actions to reach the targets were set out in the paper.

Other outcomes:

Nursing Establishment Review

A report was delivered to provide the Committee with the bi-annual review of the nursing establishment and recommendations to ensure Nurse staffing and Midwifery levels are compliant with Workforce Safeguards. The nursing and midwifery establishment review was undertaken in October 2019. Actual staffing, along with patient acuity and dependency data, was collected over a 20 day period on all inpatient wards. The data was then analysed using validated frameworks, professional judgement, quality and safety indicators, benchmarking with other Trusts using NHSI Model Hospital Appendix 1 and National guidance for safe staffing.

Individual ward recommendations from the nursing and midwifery establishment review were submitted. Options A and B were submitted for the Committee's decision.

The Committee supported the recommendations for Board approval.

The following reports were noted by the Committee:

- **Integrated Performance Report**

The Integrated Performance Report - Month 8 was presented to the Committee. Reports were presented on performance, key challenges and mitigations in the domains of:

  - Safe and Caring services;
  - Effective services;
  - Responsive Services; and
  - Well led services.

- **Board Assurance Framework**
- **Safer Staffing Report - November 2019**
- **Infection Control and Prevention Report - November 2019**
- **Maternity Dashboard and Exception Report - October 2019**
- **Women's and Neonatal Q&S Committee Escalation – October 2019**
- **Patient Safety Committee Escalation – October 2019**

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Peter Carter

QSC Chair

December 2019

East and North Hertfordshire NHS Trust

Agenda Item: 11.1

TRUST BOARD - PUBLIC SESSION – 8 JANUARY 2020

Nursing and Midwifery Establishment Review

Purpose and executive summary:

To provide the Board with the bi-annual review and recommendations to ensure Nurse staffing and Midwifery levels are compliant with Workforce Safeguards (NHSI October 2018).

The nursing and midwifery establishment review was undertaken in October 2019. Actual staffing, along with patient acuity and dependency data, was collected over a 20 day period on all inpatient wards. The data was then analysed using validated frameworks, professional judgement, quality and safety indicators, benchmarking with other Trusts using NHSI Model Hospital Appendix 1 and National guidance for safe staffing.

The Board are asked to note:

- This review incorporates inpatient wards only
- Individual ward recommendations from the nursing and midwifery establishment review can be seen in Appendix 2
- Option A Summary Request: +4.5 WTE RN, -1.21 WTE RNA, +2.42 WTE TNA, +1.39 WTE CSW.
- Option B Summary Request: +4.89 WTE RN, -1.21 WTE RNA, +2.42 WTE TNA, +0.03 WTE CSW
- Shift plans are calculated to provide a 7% Recruitable headroom uplift, which has reduced from 17% in April thus reducing WTE posts
- Non ward based departments are currently under review and recommendations will be presented in March 2020

Action required: For approval

Previously considered by: Elements of content previously considered by the Nursing and Midwifery Executive Committee (NMEC) and Ward Sisters and Matrons Committee and the Quality and Safety Committee (QSC)

Director: Director of Nursing and Infection Control	**Presented by: Director of Nursing and Infection Control**	**Author: Deputy Director of Nursing, Safer Staffing matron and E Roster Manager.**

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

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

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

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

1. Introduction

Trust Boards have a duty to ensure safe staffing levels are in place and patients have a right to be cared for by appropriately qualified and experienced staff in a safe environment. These rights are set out within the National Health Service (NHS) Constitution, and the Health and Social Care Act (2012) which make explicit the Board's corporate accountability for quality and safety.
The Nursing and Midwifery Council (NMC) sets out nurses responsibilities in relation to safe staffing levels. Demonstrating safe staffing is one of the six essential standards that all healthcare providers must meet to comply with the Care Quality Commission (CQC) regulation. This is also incorporated within the NICE guidelines 'Safe Staffing for nursing in adult inpatient wards in acute hospitals' (2014). The Carter report (2015) recommends the implementation of care hours per patient day (CHPPD) as the preferred metric to provide NHS trusts with a single consistent way of recording and reporting deployment of staff working on inpatient wards.
The Royal College of Nursing (RCN) 'Mandatory Nurse Staffing Levels' (2012) and NICE 'Safe staffing for nursing in adult inpatient wards in acute hospitals' (2014), suggest wards have a planned registered nurse to patient ratio of no more than 8 patients to one registered nurse on day shifts.
Nationally the NHS is facing huge challenges such as an ageing population, increased acuity and dependency of patients, increased demand for services, financial constraints, shortages to workforce supply and challenges with recruitment and retention. There is a large body of evidence that hospital wards should have sufficient nurses with adequate skills on duty to meet patient needs and deliver the nursing care required, safely and to a high standard. Too few staff may lead to care being compromised, work pressures becoming intensified leading to burnout, more staff going off sick, and costly recruitment and retention challenges. The nursing team recognise that the ongoing challenges will require a whole system approach using innovative workforce models to ensure safe staffing levels and strategic planning are in place such as overseas recruitment initiatives to ensure a robust and sustainable workforce for the future. This year we have seen our first registered nurse associates (RNAs) qualify and we have included these new roles within our review.

2. Establishment review methodology

A full review of the data, collection processes and methodologies can be found in Appendix 3
To note for this review we undertook to engage and involve all ward managers, matrons and heads of nursing and financial colleagues, to ensure robust clinical discussions and context were captured.

3. Current assumptions – Skill Mix and Registered Nurse to bed ratio

The nurse to patient ratio describes the number of patients allocated to each registered nurse. Nurse patient allocations are based on the acuity or needs of the patients on the ward. In critical care the ratio may be 1:1 for the sickest patients or 1:2 or 1:3 for patients who are acutely ill but stable. On general wards the nurse to patient ratio is higher, for example 1:6 or 1:8 depending on the type of service delivered and the needs of the patients. This type of nurse patient ratio is based on guidelines from professional organisations and accreditation bodies, but also reflects the needs of the individual patients at a given point in time.

A full ward breakdown of the service model skill mix and the actual worked skill mix for the reference period can be found in Appendix 4

Table 1
Registered Nurse to Patient ratio per division

Division	RN to Bed Ratio		
	Early	Late	Night
Medicine	1/6	1/6	1/6
Surgery (Excluding Critical Care)	1/6	1/6	1/7
Women's and Children's	2/9	2/9	2/9
Cancer	1/5	1/5	1/7

4. Data Triangulation (Methodology Appendix 3)

4.1 Care Hours per Patient Day (CHPPD)

At ENHT care hours per patient day (CHPPD) is a productivity model that has been used, in triangulation with other methods, to set the nursing and midwifery establishments.
The review of NHS productivity, chaired by Lord Carter, highlighted CHPPD as the preferred metric to provide NHS trusts with a single consistent way of recording and reporting deployment of staff working on inpatient wards. The methodology for calculating CHPPD used in this review can be found in Appendix 3.

CHPPD is used prospectively to identify the likely care time required for expected patient type for a service; this can then be compared to the required CHPPD for actual patients using the service. This can then be compared to the actual CHPPD provided by staff on the ward to assess if wards were appropriately staffed for actual patients.
Table 2 below shows the summary of the three dynamics of the continuous linear CHPPD cycle per Division. A full breakdown per ward can be seen in Appendix 5.

Table 2
Care Hours per Patient Day service model, required, and actual worked per division during the 20 day data collection period.

Division	Service Model CHPPD	Required CHPPD	Actual worked CHPPD
Medicine	6.05	7.60	6.99
Surgery (Excluding Critical Care)	5.47	5.79	6.23
Women's and Children's	6.85	6.74	10.08
Cancer	7.01	5.90	11.55

4.2 Safer Nursing Care Tool (SNCT)

The SNCT is an evidence-based tool developed to help NHS hospitals measure patient acuity and dependency to inform decision making on staffing and workforce.
SafeCare has been used since October 2015 to provide the safer nursing care data for the establishment review. Acuity/dependency is measured on all inpatient wards three times a day and recorded on SafeCare. SafeCare allows nursing staff to capture actual patient numbers by acuity and dependency using the SNCT and assess if staffing levels are appropriate. SafeCare provides visibility across wards and areas transforming rostering into acuity based daily staffing process that unlocks productivity and safeguards safety. SafeCare has been awarded an endorsement statement by NICE as an effective tool to support Safe Staffing.

Table 3 below shows the occupancy information for each division for the sample period; the SNCT recommended establishment (whole time equivalent - WTE) adjusted to include 7% headroom, current Recruitable establishment and the variance between the two metrics. The table shows the cumulative divisional position.

Table 3

Divisional bed occupancy, SNCT, recruitable establishment based on current headroom modelling at the time of this review and variance

Division	Bed Occupancy %	CHPPD Bench Marking Data			SNCT Recommended Data		
		Recommended CHPPD recruitable WTE based on occupancy	Recruitable Establishment Oct 2017	Variance form actual funded WTE	SNCT recommended WTE	Recruitable Establishment Apr 2018	Variance of operation establishment to SNCT recommended
Medicine	92%	28.43	30.74	2.31	34.52	30.74	-3.78
Surgery (Excluding Critical Care)	88%	26.03	29.43	3.41	27.91	29.43	1.52
Women's and Children's	81%	16.29	23.47	7.19	13.52	23.47	9.95
Cancer	46%	21.21	54.88	33.67	20.55	54.88	34.33

When using this tool, other variables should also be taken into consideration:

- Clinical speciality
- Ward size and layout
- Staff capacity, skill mix, competence and leadership
- Organisational support and support roles
- Ward manager supervisory time

The outlying variances are discussed per individual unit further in Appendix 2.

The combined data demonstrating CHPPD Benchmark Recommended WTE compared to the SNCT Recommended WTE can be found in Appendix 6

4.2.1 Data Validation

To validate data collection for the SNCT specifically for the establishment review, the following actions were taken:

- Inter-rater reliability training - To ensure that the SNCT data is validated and consistent, inter-rater reliability exercises have been undertaken with the nursing teams to ensure consistent application of the acuity multipliers.
- Comparing recommended establishment for both CHPPD and SNCT
- Matron Acuity Audits - Throughout the data collection period Matrons audited their wards on a weekly basis to validate data inputs. Any discrepancies in the acuity data scoring were corrected and Matrons worked with nurses to ensure consistent application of the tool.
- External benchmarking with other organisations using the NHS Improvement (NHSI) Model Hospital Dashboard.
- Professional Judgement.
- Review and discussion at ward board rounds and quality huddles.

4.2.2 Nursing and Midwifery Quality Indicators

The Trust uses information and statistical tools to examine indicators of care. These indicators include; pressure ulcer prevalence, complaints, patient falls, drug administration errors, Clostridium-difficile rates, MRSA rates. Standardising these metrics by occupancy and length of stay creates a statistical tool that highlights outlying areas whose indicators are higher than anticipated.

Any indicator triggering above established threshold is subject to detailed root cause analysis and an action plan developed where appropriate to improve patient safety and experience. A summary of the nursing and midwifery quality indicators for October 2019 can be seen in Appendix 7.

4.2.3 Red Triggered Shifts

The Trust monitors shifts that fall below minimum staffing levels (red triggered shifts) on an on-going basis. Appendix 8 shows the percentage of shifts that fell below minimum levels during the establishment review period. Proactive mitigating action is taken by nursing team to balance risk across the organisation.

Factors affecting red triggering shifts include:

- Patient numbers, dependency and acuity
- Staffing number and skill mix
- Temporary Staffing fill rate
- Vacancy Rate
- Sickness
- Enhanced Nursing Care requirements (Specialling)

5. Registered and Trainee Nursing Associates (RNA, TNA)

The Trust has supported 17 student Nursing Associates (SNA) through the two year programme. This cohort qualified in April 2019. Financial considerations are being put together to support the funding to further develop the career pathway for RNAs to undertake a Top-up programme to enable them to achieve a BSC in Nursing and become a registered nurse.
Since May 2018, we have been supporting 27 student Nursing Associates throughout the Trust compromising of 4 cohorts. Scoping work will be undertaken by Health roster and Nurse Education to look at wards and clinical areas to project numbers of potential SNAs in each area to enhance capacity and capability within the multi professional workforce.
Currently funding a SNA is a cost pressure to the wards supporting these staff due to an upgrade to band 3 and study leave..In order to support growth within this valuable workforce further funding needs to be identified.
Reconciliation is underway of the funding streams for the STP Nursing associated activities, including HEE funding and NHS organisation pooled funding, for current resources supporting Student Nursing Associates in practice. Work is also being undertaken by the STP to develop a Nursing Associate toolkit to standardise approaches for the development of this role and benchmark the level of practice and application across clinical practice, leadership and management. This will be shared with organizations when completed.

6. Hospital Out of Hours

The trust recognises that out of hours, during weekends and nights there is a significantly reduced skill mix and support to staff and patients across the Trust. There is a large body of evidence that suggests patients are at higher risk of harm during these times. As part of the hospital at night work, it is proposed that there is a review of the current structure and resources. As part of this review it is planned that there will be 3 supernumerary Band 6 RNs during the weekend days and all night shifts to support the patients in Medicine tower block, Surgery tower block and Medicine Strathmore wing. These shifts will be staffed by current ward band 6s and these shifts will be back filled with a band 5 RN. It is anticipated that all inpatient wards in the tower block and Strathmore wing will participate in this rota. The bleep holders for the shift will be responsible for ensuring that each area is safely staffed, monitoring quality and safety out of hours, support with patient flow and support with any issues or emergencies. They will report into the site manager and ensure the site is safe. The cost of backfilling to release the band 6s will be £ 396,048.73 per annum. However further review of costings need to be aligned with other proposed changes in the out of hours senior cover.

7. Inpatient Wards

See Appendix 2 for the review of all inpatient wards and midwifery services.

8. Considerations that are facing the Nursing and Midwifery Workforce are as follows;

- The increasing complexity of the patient population and being able to meet this need with a skilled, stable workforce
- The continued growth in services, requiring a constant focus on finding creative ways to recruit and retain
- Safely staffing across a 24 hour period 7 days a week in a fair way to all, whilst also trying to meet the flexibility staff now require
- The impact of reduction in numbers of Junior Doctors and the increasing requirement for Nurses to take on extended roles
- Development of Advanced Practice in Nursing and Midwifery – standardising and ensuring rigor around practice in these roles across the Directorates, ensuring equity of role requirements and banding and effective succession planning
- Responding to the different entry routes to professional registration when there is no salary support
- Loss/ reduction of CPD funding which continues to inhibit the ability to support staff with their ongoing professional development requirements and also developments which will enhance service provision.
- Increase in mental health patients which requires a different skill set

9. Summary and Recommendations for Executive Approval

This establishment review has considered and analysed the data relating to shift plans and actual staffing requirements to continue to deliver safe and effective care to our patients. A full narrative of the recommendations made can be seen in Appendix 2.

- Uplift 5A 1 CSW on the late shift 7 days per week
- Uplift 7B 1 CSW on the early shift 7 days per week
- Uplift 8A 1 CSW on the long day Monday-Friday and 1 CSW on the late Saturday and Sunday
- Replace an RN with a CSW on Swift ward at night 7 days per week
- 10B RNA has left the trust, replace with Band 2 CSW
- 9A Backfill the RNA with CSW whilst on maternity leave
- AMU-W to have an additional RN on the late shift Monday-Friday and the long day Saturday and Sunday. Band 7 to be supervisory 5 days per week.
- 3 Supernumerary band 6s across Lister out of hours to support quality and safety, backfilled by band 5 from inpatient wards.

Table 4 – Costings for Shift Plan Changes

Unit	Change Request Total Funded WTE (inclusive of 21% Headroom)	Option A	Option B
10B Endocrinology/Gen Med	Band 4 RNA - 1.21 WTE Band 2 CSW + 0.96 WTE	£12,308	£12,308
Pirton Hyper Acute Stroke	Band 3 TNA + 1.21 WTE Band 2 CSW - 0.77 WTE	-£17,713	-£17,713
Acute Medical Ward (AMU-W)	Band 6 + 0.39 WTE Band 5 + 1.57 WTE	-£76,426	-£76,426
Division General and Speciality Medicine		**-£81,831**	**-£81,831**
8A	Band 2 CSW + 2.16 WTE	-£26,688	-£26,688
7B	**Option A**: Band 2 CSW +1.36 WTE **Option B**: Band 5 + 0.39 WTE	-£34,430	-£10,960
5A	Band 3 TNA + 1.21 WTE Band 2 CSW + 0.22 WTE	-£29,204	-£29,204
Swift	Band 6 - 2.54 WTE Band 5 + 5.08 WTE Band 2 CSW -2.54 WTE	-£15,409	-£15,409
Division Surgery		**-£105,731**	**-£82,261**
		-£187,562	**-£164,092**

10. Next Steps

- Continue to work collaboratively across the system to maximise domestic recruits and increase students entering training
- Continue to scope and support flexible routes into nursing
- Continue with overseas recruitment to ensure a consistent pipeline for registered nurses
- To continue to monitor and review establishments and continue with the integration of the Nurse Associate within the nursing workforce.
- Continue to monitor key performance indicators and incidents to ensure pro-active staffing reviews are carried out in a timely fashion.
- Progress work on clinical pathways and multi-professional delivery review
- Continued investment in recruitment and retention initiatives

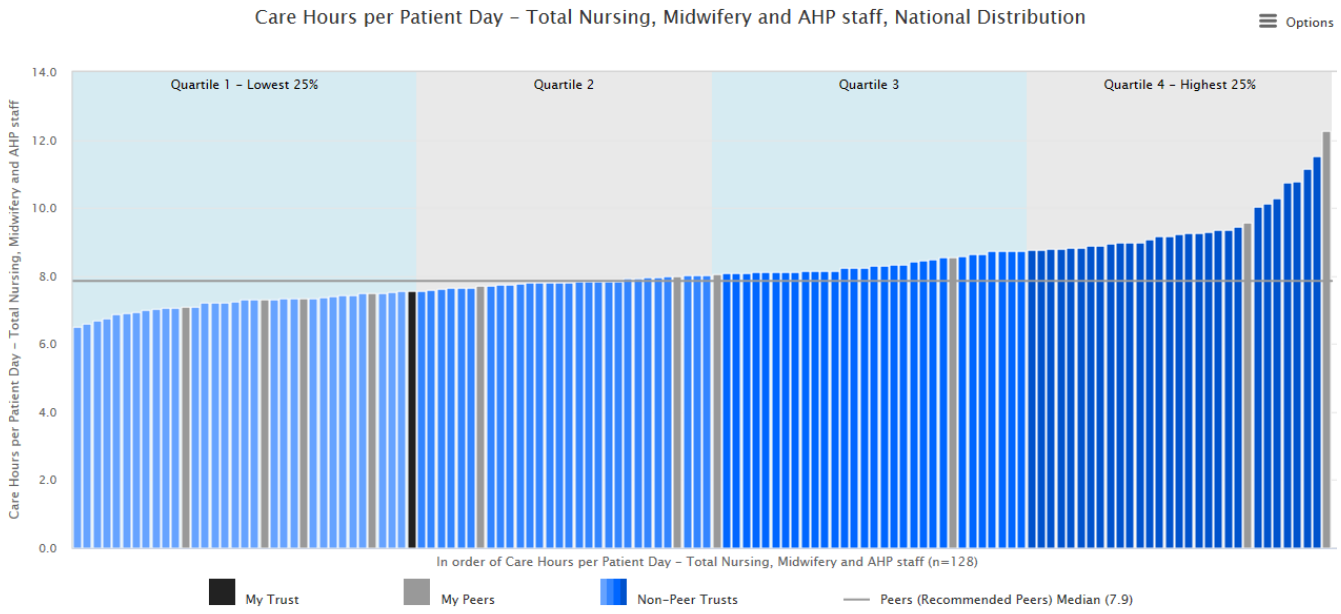
References:

- Carter (2015). Productivity in NHS Hospitals. London: Department of Health.
- Developing workforce safeguards Supporting providers to deliver high quality care through safe and effective staffing (2018) NHS Improvement
- Francis R (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: Stationery Office
- NHS England (2016). Leading Change and Adding Value: A framework for nursing, midwifery and care staff. London: NHS England
- NICE (2013) Safe Staffing for nursing in adult inpatient wards in acute hospitals.
- National Quality Board safe, sustainable and productive staffing (2018)

Benchmarking data comparing local peers From the NHSI Model Hospital Dashboard – latest data available September 2019

East and North Hertfordshire NHS Trust

Select chart type: Variation Chart



East and North Hertfordshire NHS Trust

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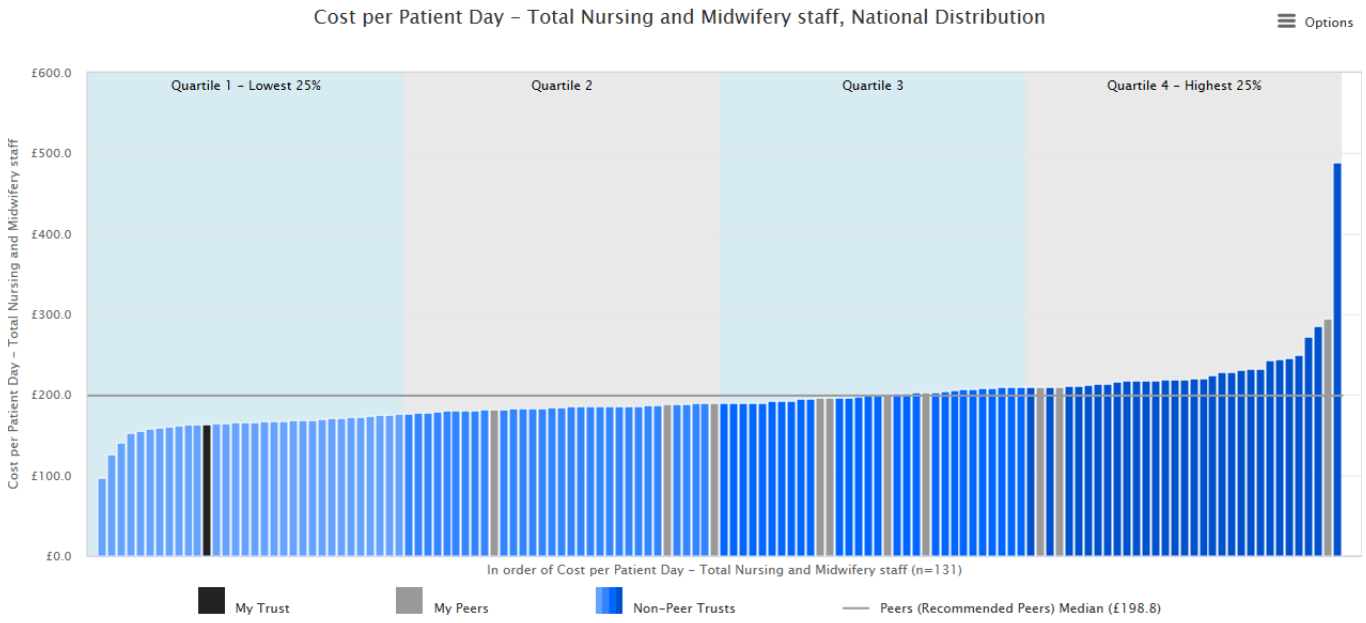


Summary Change Request Table

Unit	Narrative	Change Request Total Funded WTE (inclusive of 21% Headroom)
Division General and Speciality Medicine		
9B Elderly Care	Charity funded Activity Support Worker from 15 Dec for one year not incl in nos but will help to alleviate nursing workload	
Ashwell Frailty	Bed closures during data collection period. High red-triggered stats due to vacancies rather than shift plan - no change to establishment	
9A Elderly care	Charity funded Activity Support Worker from 15 Dec for one year not incl in nos but will help to alleviate nursing workload. RNA on mat leave so replaced with a CSW during this period - no change to shift plan.	
6A Medical/Renal	No change	
10B Endocrinology/Gen Med	RNA left Trust shift plan and roster template updated. RNA will be replaced with a CSW. In place from Dec 19	Band 4 RNA - 1.21 WTE Band 2 CSW + 0.96 WTE
11A Respiratory	No change. Concerned about protecting staffing on RSU separately to 11A. Need to capture in daily staffing meetings	
Acute Cardiac Unit (ACU)	No change	
6B Renal	No change	
Division Emergency and Acute Medicine		
Pirton Hyper Acute Stroke	TNA to be added into shift plan - due to qualify May 2021	Band 3 TNA + 1.21 WTE Band 2 CSW - 0.77 WTE
Barley Stroke Rehab	No change currently, but review budget for TNA	
Acute Medical Ward (AMU-W)	Large gap in recruitable WTE as per SNCT, consistent gap as per previous establishment review Check acuity/red flags over the next 6 months and whether RNA role is appropriate for acute ward. Propose SV moves to 5 days and backfill 2 Early shifts with Band 6. Increase to 4-2 RN Late. Weekends increased to 4-2 for LD. Nights to remain on 3-2	Band 6 + 0.39 WTE Band 5 + 1.57 WTE
Short Stay Unit (SSU)	Workload increased with high number of discharges not reflected on reporting stats. To capture this data over the next 6 months to demonstrate increased activity. No change at present	
Acute Medical Assessment unit (AMU-A)	Separate Assessment from AMU-B to ensure correct numbers of B6s on shift. Also, review TW shift times to 1400-2200 as acuity is higher then. TW staff often moved to other areas and/or no fill. No change required to establishment	
Division Surgery		
8A	Increase by X1 CSW LD Mon-Fri and X1 CSW Late Weekend	Band 2 CSW + 2.16 WTE
8B	No change. TNA has left - backfill TNA shifts with CSW	
11B	No change	
7B	**Option A:** increase by X1 CSW on Early 7 days a week. **Option B:** SV Mon-Fri	Option A: Band 2 CSW +1.36 WTE Option B: Band 5 + 0.39 WTE
5A	Increase by X1 CSW on the Late 7 days a week (4:4). Amend Band 6 on Nights to 3.5 on the shift plan (Band 6 shared across 5A and 5B)	Band 3 TNA + 1.21 WTE Band 2 CSW + 0.22 WTE
Swift	Swap X1 Band 6 with Band 5/RNA on the LD and change to 4:1 on the Night (4th registered either an RNA/RN). Isolated ward, high number of side room, increased risk at night due to location. Changes will support the private patient initiative.	Band 6 - 2.54 WTE Band 5 + 5.08 WTE Band 2 CSW -2.54 WTE
5B	No change	
SAU	No change - to be reviewed through SDEC project	
Division Women's & Children's		
Bluebell	Working to winter shift plan - no change	
10A Gynae	No change due to size of ward	
Division Cancer		
Ward 10	Review TBC	

Methodology

The following information was also collected and reviewed; a review of all relevant literature and guidelines was undertaken prior to commencement of this review, these included:

NICE Guidance on Safer Staffing for nursing in adult inpatient wards in acute hospitals (2012)
Compassion in Practice, NHS England (2012)
Safer Nursing Care Tool
Nurse sensitive quality indicators
Safer Staffing Guidance, Trust Development Authority (2015)
Leading Change Adding Value (2016)
Lord Carter Report (2016)
Lord Willis Report (2015)

As part of this review all calculations utilising validated tools were in line with the national guidance associated with these tools. This document details the assumptions, methods of data collection, calculation and evaluation as applied in the establishment review. These are set out for each information process below:

Skill Mix:

Data for this metric is collected from the approved shift plans defining each service model and actual hours worked on the roster system. It is assumed that the roster template is an accurate representation of the shift plan, that the shift plan is an accurate representation of the service model and that the hours worked on the roster are true reflection of what was worked. The calculations for this metric are:

Service model skills mix:

Total number of clinical hours available on shift plan for registered/unregistered staff
/
Total number of clinical hours available on shift plan

Actual skills mix:

Total number of clinical hours worked for registered/unregistered staff for the reference period
/
Total number of clinical hours worked for the reference period

Registered nurse to bed ratio:

The data for this metric is collected from the daily staff sheet and the shift plan, it is assumed that the number of available beds on the daily staffing return is correct and the number of registered nurses on shift on the shift plan is an accurate representation of what could be rostered to work. The calculations for this metric are:

Number of registered nurse on shift
/
Number of available beds for reference period

Care Hours per patient day (CHPPD)

The data for this metric is collected from the service model shift plans, the Trusts e-roster system and SafeCare. It is assumed that the service model shift plan is an accurate representation of the service, the roster is an accurate reflection of the hours worked and SafeCare has accurate patient acuity and dependency scores input for each patient. As SafeCare uses an external formula to calculate the required and actual CHPPD values, it is assumed that this formula is correct and the Shelford Acuity and Dependency model is appropriate for the service. The calculations for this metric are:

Service Model CHPPD:

Total service model care hours (clinical care hours for registered and unregistered staff)
/
Total beds

Required CHPPD:

Required hours of work based on standardised SNCT model
/
Average patients per 24 hours in reference period (Patient days)

Actual CHPPD:

Actual Hours Worked
/
Average patients per 24 hours in reference period (Patient days)

Safer Nursing Care Tool:

Calculations for this metric follow the SNCT national guidelines; data collection for this metric is taken from the roster and SafeCare systems. It is assumed that the roster is an accurate reflection of the work carried out and that SafeCare has accurate patient acuity and dependency scores input for each patient. Calculations for this metric are:

Bed Occupancy:

Total bed days in reference period
/
Total available beds in reference period

SNCT WTE required:

Sum of { Total number of patient of a specific acuity X SNCT specific multiplier

Required SNCT is then adjusted to include 17% headroom

Variance from actual funded WTE:

Funded WTE – Adjusted SNCT Recommended WTE

Professional Judgement:

All ward managers, matrons, heads of nursing, finance, Human resources and the e-roster team met with the deputy director of nursing to review all the above data and triangulate associated quality indicators, incidents and red triggered shifts. The recommended adjustments to shift plans are based on the data review and robust discussions with all present. This process added specific clinical context to the discussions and provided an evidence based approach ensuring ward managers, matrons and heads of nursing were engaged and took ownership of their clinical areas.

Table 1

The table below shows the registered and unregistered nurse % for each ward:

Div	Speciality	Ward	Service model registered nurse %	Service model unregistered nurse %	Actual registered nurse %	Actual unregistered nurse %
Medicine	Care of the Elderly	9B	57.00	43.00	53.17	46.83
		Ashwell	56.00	44.00	55.70	44.30
		9A	60.00	40.00	56.91	43.09
	Stroke	Pirton	67.00	33.00	60.96	39.04
	Stroke	Barley	57.00	43.00	49.32	50.68
	General	6A	58.00	42.00	57.98	42.02
	General	10B	58.00	42.00	55.94	44.06
	Respiratory	11A	67.00	33.00	66.22	33.78
	Cardiology	ACU	67.00	33.00	62.93	37.07
	Acute	AMU Assessment	65.00	35.00	66.86	33.14
		AMU Ward	60.00	40.00	52.98	47.02
		SSU	52.00	48.00	52.22	47.78
	Renal	6B	67.00	33.00	65.72	34.28
Surgery	General	8A	62.00	38.00	62.97	37.03
		8B	59.00	41.00	57.83	42.17
	Surgical Spec	11B *	63.00	37.00	62.21	37.79
		7B	62.00	38.00	65.45	34.55
	T&O	5A	60.00	40.00	58.43	41.57
		Swift	65.00	35.00	64.87	35.13
		5B	58.00	42.00	57.84	42.16
	ATCC	Critical Care	89.00	11.00	91.29	8.71
W&C	Gynae	10A Gynae*	67.00	33.00	66.66	33.34
	Paeds	Bluebell	57.00	43.00	69.97	30.03
Cancer	Inpatient	Ward 10	65.00	35.00	67.60	32.40

** Clinics removed*

Table 2

The table below shows the available staff on shift as per the agreed shift plan and the Registered Nurse to bed ratio

Div	Speciality	Ward	RN to Bed Ratio Early	Late	Night
Medicine	Care of the Elderly	9B	1/7	1/7	1/7
		Ashwell	1/6	1/6	1/8
		9A	1/6	1/7	1/7
	Stroke	Pirton	2/9	2/9	1/7
	Stroke	Barley	1/6	1/6	1/8
	General	6A	1/6	1/7	1/7
	General	10B	1/6	1/7	1/7
	Respiratory	11A	1/6	1/6	1/6
	Cardiology	ACU	1/5	1/5	1/5
	Acute	AMU Assessment	2/9	2/9	2/9
		AMU Ward	1/5	1/5	1/5
		SSU	1/6	1/6	1/8
	Renal	6B	1/5	1/5	1/6
Surgery	General	8A	1/6	1/7	1/7
		8B	1/7	1/7	1/7
	Surgical Spec	11B *	1/5	1/5	1/7
		7B	1/6	1/7	1/7
	T&O	5A	1/6	1/7	1/7
		Swift	1/5	1/6	1/9
		5B	1/6	1/7	1/7
	ATCC	Critical Care**	4/5	4/5	4/5
W&C	Gynae	10A Gynae*	1/5	1/5	1/5
	Paeds	Bluebell	1/4	1/4	1/4
Cancer	Inpatient	Ward 10	1/5	1/5	1/7

* Denotes the number of staff allocated to the inpatient ward areas

** Critical Care staffing is dependant on the patient number and acuity and therefore the available shifts is not representative of required staff

Appendix 5

Care Hours per Patient Day service model, required, and actual worked

The table below shows Care Hours per Patient Day service model, required and actual worked

Div	Speciality	Ward	Service Model CHPPD	Required CHPPD	Actual worked CHPPD
Medicine	Care of the Elderly	**Ward 9B Elderly Care**	5.26	7.12	5.85
		Ashwell ward	5.92	7.55	6.61
		Ward 9A Elderly Care	5.35	6.97	5.95
	Stroke	**Pirton HASU**	6.18	7.36	7.69
	Stroke	**New Barley**	5.8	9.18	7.41
	General	**Ward 6A**	5.5	6.85	6.12
	General	**Ward 10B**	5.46	6.47	6.02
	Respiratory	**Ward 11A Respiratory**	5.83	6.42	6.23
	Cardiology	**Acute Cardiac Unit**	6.17	7.99	7.99
	Acute	**AMU Assessment**	7.39	9.25	9.11
		AMU Ward	7.08	10.4	8.53
		SSU	6.3	6.57	6.57
	Renal	**Ward 6B**	6.43	6.61	6.79
Surgery	General	**Gen Surgery Ward 8A**	5.1	5.55	5.08
		Gen Surgery Ward 8B	5.12	5.57	5.84
	Surgical Spec	**Ward 11B Plastics & ENT**	6.1	5.17	7.34
		Urology Ward 7BN	5.19	5.26	5.75
	T&O	**T&O Ward 5A**	5.43	6.7	5.93
		Swift Ward	5.83	4.93	6.42
		T&O Ward 5B	5.53	7.36	7.25
	ATCC	**Critical Care Unit**	23	19.57	19.79
W&C	Gynae	**Gynaecology Ward 10A**	6.79	4.8	9.05
	Paeds	**Children Bluebell Ward**	6.9	8.68	11.11
Cancer	Inpatient	**MV Ward 10**	7.01	5.9	11.55

Appendix 6

The table below shows the CHPPD Benchmark Recommended WTE compared to the SNCT Recommended WTE.

				CHPPD Bench Marking Data			SNCT Recommended Data		
Div	Speciality	Ward	Bed Occupancy %	Recommended CHPPD recruitable WTE based on occupancy	Recruitable Establishment Oct 2019	Variance form actual funded WTE	SNCT recommended WTE	Recruitable Establishment Oct 2019	Variance of operation establishment to SNCT recommended
Medicine	Care of the Elderly	**9B**	99.50%	31.36	32.12	0.76	42.36	32.12	-10.24
		Ashwell	87.71%	24.89	28.88	3.99	32.04	28.88	-3.16
		9A	99.67%	31.95	32.56	0.61	41.85	32.56	-9.29
	Stroke	**Pirton**	82.95%	22.53	27.71	5.18	26.59	27.71	1.12
	Stroke	**Barley**	87.71%	24.39	28.82	4.43	39.10	28.82	-10.28
	General	**6A**	87.67%	28.89	33.46	4.57	35.74	33.46	-2.28
	General	**10B**	97.50%	31.90	33.31	1.41	37.65	33.31	-4.34
	Respiratory	**11A**	97.24%	32.84	34.36	1.52	35.95	34.36	-1.59
	Cardiology	**ACU**	82.05%	22.24	27.66	5.42	27.29	27.66	0.37
	Acute	**AMU Assessment**	78.28%	36.97	35.45	-1.52	35.94	35.45	-0.49
		AMU Ward	98.75%	22.34	23.14	0.80	33.69	23.14	-10.55
		SSU	97.71%	29.51	30.77	1.26	30.79	30.77	-0.02
	Renal	**6B**	96.46%	29.73	31.37	1.64	29.73	31.37	1.64
Surgery	**General**	**8A**	98.30%	30.05	31.08	1.03	32.69	31.08	-1.61
		8B	92.30%	28.33	31.24	2.91	30.22	31.24	1.02
	Surgical Spec	**11B ***	78.30%	14.32	18.78	4.46	12.20	18.78	6.58
		7B	90.50%	28.14	31.62	3.48	28.66	31.62	2.96
	T&O	**5A**	95.30%	31.02	33.01	1.99	37.52	33.01	-4.51
		Swift	82.10%	24.86	26.67	1.81	21.23	26.67	5.44
		5B	76.80%	25.46	33.63	8.17	32.85	33.63	0.78
	ATCC	**Critical Care****	76.00%	69.83	104.22	34.39	57.57	104.22	46.65
W&C	**Gynae**	**10A Gynae ***	86.50%	11.73	15.8	4.07	18.91	15.8	-3.11
	Paeds	**Bluebell**	75.60%	20.84	31.14	10.30	8.12	31.14	23.02
Cancer	**Inpatient**	**Ward 10**	45.90%	21.21	54.88	33.67	20.55	54.88	34.33

* Denotes the number of staff allocated to the inpatient ward areas

NURSING & MIDWIFERY QUALITY INDICATORS: October 2019

East and North Hertfordshire NHS Trust

*** Bed Totals & Occupancy figures taken from SafeCare data*
*** Aggregated to Trust and Division from the ward unit(s) of analysis only*

SUMMARY		Trust	Medicine	Surgery	Women & Children	Cancer
Beds	Total Beds (based on Wards within this report)	656	336	187	100	33
	Bed occupancy % (at Midnight)	82.11	92.48	77.74	56.03	39.30
E-Rostering	% Roster Deadline Met	42.9	38.2	49.5	28.3	33.0
	Net Hours %	-0.4	0.3	-0.3	0.1	0.4
	Net Hours Position	-693.2	15.1	-26.1	-9.1	23.8
	% of Actual Annual Leave	10.7	10.3	12.7	11.6	3.1
Staffing	Funded WTE	1528.7	620.9	357.2	331.2	65.9
	Actual WTE	1311.0	517.7	316.8	300.5	45.6
	Vacancy rate %	14.0	16.6	11.3	9.3	30.8
	RN FR Rate (day shifts)	94.8	94.8	94.8	91.1	25.3
	Sickness %	4.6	4.2	4.6	5.2	7.3
	Agency usage %	1.1	2.4	1.4	0.0	0.2
	Bank usage %	18.1	20.1	17.0	15.4	7.5
	Staff Appraised % (rolling 12 months)	88.2	87.2	91.6	84.7	87.5
	Nursing Overtime	0.5	0.0	0.0	0.5	0.0
	Statutory Mandatory Training Overall Coverage %	92.9	91.5	94.0	93.0	95.3
	% Shifts Triggered Red in Month - Initial	13.3	18.9	15.8	1.1	0.0
	% Shifts Triggered Red in Month - Final	0.0	0.0	0.1	0.0	0.0
Patient Safety	Inpatient falls (rate per 1000 bed days)	2.90	3.74	2.98	0.65	0.98
	Inpatient falls resulting in harm (rate per 1000 bed days)	0.05	0.10	0.00	0.00	0.00
	Hospital Acquired Pressure Ulcers (rate per 1000 bed days)	0.84	1.04	1.21	0.00	0.00
	% Observations completed within timeframe	72.81	72.28	72.42	82.51	59.18
	% Observations completed up to 15 mins after timeframe	10.32	10.39	10.75	8.24	6.33
	% Observations completed more than 15 mins after timeframe	17.08	17.33	16.83	9.25	34.49
	% of Delay and/or Omission of Critical Medicine	3.80	4.10	2.10	5.60	4.70
	No. Medication Reportable errors	99	56	29	11	3
	% Medication administered as prescribed	97.0	96.2	95.1	100.0	100.0
	% Analgesia administered as prescribed	97.0	100.0	99.1	100.0	100.0
	Intentional rounding completed	96.0	100.0	87.0	100.0	100.0
	Patient Identification	93.0	94.0	87.0	100.0	82.0
	Safety Thermometer Patients with harm	23	16	7	0	0
	% of Compliance with Hand Hygiene	90.0	86.3	73.7	89.6	100.0
Patient Experience	% Response to Inpatient Survey	39.7	45.0	58.2	22.9	50.0
	Help to eat meals/Infant Feeding	89	92.2	86.9	89.5	83.0
	Enough nurses on duty	86	84.5	80.3	94.3	89.0
	Staff provide help	90	89.5	85.9	91.5	93.0
	Pain Control	92	92.3	89.0	89.3	97.0
	Understand answers from nurses	91	89.8	87.8	92.8	99.0
	Someone to talk to about worries and fears	84	84.9	77.9	79.3	92.0
	Enough emotional support from staff	88	89.2	83.4	88.8	92.0
	Know named nurse	79	76.3	77.6	86.3	80.0
	Inpatient FFT - % of patients would recommend	96.3	96.5	96.6	94.1	98.1
	Inpatient FFT - % of patients would not recommend	1.0	1.0	0.9	0.9	1.9
	FFT Response Rate %	46.7	47.4	45.1	57.0	50.0
	No.of Complaints	33	14	8	4	7

Nursing Quality Indicators (NQI) 2019-20 (MAT) October 2019_v2.xlsx

Red Triggering Shifts October 2019

Month	Oct-19	Days in Month	31

Division	Speciality	Ward	Total no. of shifts available	INITIAL REDS					FINAL REDS				
				Early	Late	Night	Number of shifts where staffing initially fell below agreed levels	% of shifts where staffing fell below agreed levels and triggered a Red rating	Early	Late	Night	Number of shifts where staffing initially fell below agreed levels	% of shifts where staffing fell below agreed levels and triggered a Red rating
Medicine	Care of the Elderly	9A	93	6	6	6	18	19.35	0	0	0	0	0.00
		9B	93	11	9	8	28	30.11	0	0	0	0	0.00
	Stroke	Barley	93	13	13	3	29	31.18	0	0	0	0	0.00
		Pirton	93	1	4	6	11	11.83	0	0	0	0	0.00
	General	6A	93	13	9	4	26	27.96	0	0	0	0	0.00
		10B	93	14	9	6	29	31.18	0	0	0	0	0.00
	Respiratory	11A	93	2	6	8	16	17.20	0	0	0	0	0.00
	Cardiology	ACU	93	5	10	13	28	30.11	0	0	0	0	0.00
	Acute	AMU-A	93	0	7	0	7	7.53	0	0	0	0	0.00
		SSU	93	8	7	6	21	22.58	0	0	0	0	0.00
		AMU-W	93	6	10	3	19	20.43	0	0	0	0	0.00
	Renal	6B	93	1	4	2	7	7.53	0	0	0	0	0.00
		Ashwell	93	15	15	7	37	39.78	0	0	0	0	0.00
	ED	A&E	93	1	3	1	5	5.38	0	0	0	0	0.00
		CDU	93	0	0	0	0	0.00	0	0	0	0	0.00
		UCC	93	0	0	0	0	0.00	0	0	0	0	0.00
Total			**1488**	**96**	**112**	**73**	**281**	**18.88**	**0**	**0**	**0**	**0**	**0.00**
Surgery		8A	93	10	10	13	33	35.48	0	0	0	0	0.00
		8B	93	4	10	3	17	18.28	0	0	0	0	0.00
		SAU	93	1	5	2	8	8.60	0	0	0	0	0.00
	Surgical Spec	11B	93	1	3	3	7	7.53	0	0	0	0	0.00
		7B	93	4	9	8	21	22.58	0	0	0	0	0.00
	T&O	5A	93	4	7	4	15	16.13	0	0	0	0	0.00
		5B	93	8	11	6	25	26.88	0	0	0	0	0.00
		Swift	93	1	1	3	5	5.38	0	0	0	0	0.00
	ATCC	Critical Care 1	93	0	0	1	1	1.08	0	0	1	1	1.08
Total			**837**	**33**	**56**	**43**	**132**	**15.77**	**0**	**0**	**1**	**1**	**0.12**
Women's & Children	Gynae	10A Gynae	93	0	0	1	1	1.08	0	0	0	0	0.00
	Paeds	Bluebell	93	0	0	0	0	0.00	0	0	0	0	0.00
		Child A&E	93	1	1	2	4	4.30	0	0	0	0	0.00
		NICU	93	0	0	0	0	0.00	0	0	0	0	0.00
	Maternity	Dacre	93	0	0	0	0	0.00	0	0	0	0	0.00
		Gloucester	93	0	0	0	0	0.00	0	0	0	0	0.00
		Mat MLU	93	0	1	1	2	2.15	0	0	0	0	0.00
		Mat CLU 1	93	0	0	1	1	1.08	0	0	0	0	0.00
Total			**744**	**1**	**2**	**5**	**8**	**1.08**	**0**	**0**	**0**	**0**	**0.00**
C a n	Inpatient	Ward 10	93	0	0	0	0	0.00	0	0	0	0	0.00
Total			**93**	**0**	**0**	**0**	**0**	**0.00**	**0**	**0**	**0**	**0**	**0.00**
		TRUST TOTAL	**3162**	**130**	**170**	**121**	**421**	**13.31**	**0**	**0**	**1**	**1**	**0.03**

East and North Hertfordshire NHS Trust

Agenda Item: 11.2

TRUST BOARD – PUBLIC SESSION – 8 JANUARY 2020

Quality Account Update

Purpose of report and executive summary: This report provides an update view of progress against the Trust's Quality Account milestones.		
Action required: For information		
Previously considered by: QSC – 26 November 2019		
Director: Director of Nursing & Medical Director	**Presented by:** Director of Nursing & Medical Director	**Author:** Associate Director of Quality & Safety

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

Quality Account

2019-20

6 monthly update

Appendices

Introduction

How we're accountable for quality

From September 2018, East and North Hertfordshire NHS Trust have transitioned from the Improving Patient Outcomes and Patient & Carers Experience Strategies towards a more holistic approach to align quality across our clinical and non-clinical services. This transformational design phase of our quality management has seen agreement and prioritisation of key pillars that will underpin the foundation of this 5 year strategy.

Clinical strategy (2019-24)
A five year strategy, developed through clinical, staff and public engagement during 2018 defines the organisation's vision to be *"Proud to deliver high quality, compassionate care to our community".*

Quality is one of the five key strategic priorities of the strategy as outlined in the picture below.

The priority and guiding principles are shown in the two boxes below. Details of how the priority will be delivered are outlined within a new Quality Strategy.

Strategic Priority: Deliver high quality care consistently across all of our services in terms of clinical quality, safety and compassion.

Therefore, guiding principles for the clinical strategy have included:

- We will deliver consistently high quality, safe, patient-centered care across all our services, 7 days a week
- Our services will be underpinned by a culture of continuous quality improvement and learning
- We will standardise clinical pathways and eliminate unwarranted clinical variation, ensuring that every patient receives the most appropriate care for their condition

Simultaneously, during 2018/19 the Board has agreed a cultural commitment which clarifies the desired leadership behaviours to support the delivery of the clinical strategy.

Cultural commitment
Quality and compassion are at the centre of how we behave and act
Staff are proud of the care they deliver
Our roles and purpose are clear
Feedback to staff and services is a continuous process
Our Trust and leadership values are visible through our choices, actions & behaviours
Staff are empowered to deliver and improve performance in all areas
The development of staff is the responsibility of us all as we work to nurture talent
Challenge and speaking up are welcomed in a safe and supportive climate

Quality Strategy (2019-2014)

This supporting strategy aims to improve our quality management systems by approaching quality with a more holistic view that includes: quality planning, quality assurance and quality improvement.

Through 2018 transformation phase of managing quality we have:

- Defined a ‘model of quality improvement’ that can be adopted by all, from ‘ward to board’
- We have undertaken gap analysis of Training and development need for all staff to contribute to the delivery continuous improvement.
- Prioritised the need to improve data and measurement capability.
- We have designed the plans for our ‘Clinical Excellence Framework’
- We have improved the delivery and oversight of our Compliance Framework

This supporting strategy shall enable all our staff to work safely, by giving them the skills and authority to make changes that drive continuous improvement for our patients. Demonstrating adherence to our Trust values by:

- Putting **p**atients first, through patient co-design and innovation of quality improvements plans.
- Striving for continuous **i**mprovement and continually learning that becomes integral in everything we do.
- **V**aluing everybody through providing robust governance and improvement frameworks that celebrate excellence.
- Being **o**pen and honest with candid, supportive skills that ensure fair balance of accountability and kindness.
- Recognising the importance of **t**eamwork is the core fundamental ingredient to any efforts of improving quality of what we do.

Key objectives of the Quality Strategy include:

To understand where variation exists and uses data to proactively drive improvement by reducing the 'unwarranted variation '. Aiming to enable staff, to develop anlaytical capabilites, and access to real-time data from ward to board.

To foster a culture where staff can generate ideas, lead improvement efforts, feel valued and confident to influence the care they deliver; continuously striving to understand the experiences, wisdom, ideas and creativity of others.

To enable our people with skills and knowledge that strengthens their craftsmanship and expertise to execute their work well; supporting the practical application of quality improvement theory.

To prioritise and understand what matters to staff, patients and carers who experience our organisation. Supporting staff to move focus with patients and carers from 'what is the matter' towards understanding 'what matters to you'?

Through 2018 **4 key quality pillars** have been identified to provide a structure in which to focus our efforts of continuous improvement. These are:

1. Valuing the Basics
2. Patient & Carer Experience
3. Keeping our Patient Safe
4. Quality Governance

Each pillar shall have an annual quality plan to measure ourselves against.

Quality Pillars	
Pillar	**Workstream**
Valuing the basics	• Harm Free Care Collaborative – venous thrombo-embolism, pressure ulcer reduction, catheter associated urinary tract infections, falls, medicines management • Infection Prevention and Control • Documentation and communication – assessment and plans of care • Medicines management • Safeguarding our most vulnerable patients • Medical devices and use of equipment • Handovers – between services – internal / external
Quality governance and risks	• Structure & reporting – team and infrastructure • Audit and effectiveness – NICE, annual audit programme • Management of incidents and learning from them • Duty of Candour • Risk management process • Data and reporting – key performance indicators • Learning from incidents to be shared across all areas of the Trust and not restricted to divisional boundaries
Keeping our patients safe	• Caring for our most unwell patients – reducing, and learning from, avoidable deaths • Sepsis compliance • Safer Surgery • End of Life Care – DNACPR, Treatment Escalation Plans • Maternity Better Births and Maternity Transformation Plan
Patient experience	• Improving experience at beginning, middle and end of stay • Learning from complaints and patient feedback • Carers • Volunteers

Part 1 Review of Performance 2019/20

Priority One: Build ENHT Quality Improvement Capability & Capacity

Reason: Adoption of quality improvement to become an integral part of everything we do -requires an infrastructure that supports all staff.

Monitoring: Quality & Safety Committee

Reporting: Monthly update to Quality & Safety Committee

Responsible Directors: Director of Nursing and Patient Experience

Theme	Measure		18/19	19/20
Clinical and non-Clinical staff are offered opportunity to gain knowledge on Quality Improvement theory.	Quality Improvement for all Theory & Practitioner level	New	N/A	Ascertain organisational readiness and set trajectory
	Quality Improvement for Leaders	Ongoing	Approx. 60	Ascertain organisational spread and set trajectory.
	Organisational wide Quality learning Events	New	N/A	Minimum one summer and one winter event.
	Measurement masterclass sessions	New	N/A	Deliver approx. 1 per quarter
Staff are supported to practically apply Quality Improvement knowledge through QI coaching.	Establish 'quality clinics' that will empower all staff to discuss quality, scope new ideas and think how they could work differently.	New	N/A	Deliver approx. 1 per month
	Agree and delver curriculum for Quality Improvement coaches	New	N/A	Ascertain organisational readiness and set trajectory
	Recruit to Quality Improvement Team	New	N/A	AIM: 4 WTE posts dedicated to QI capability Building
Deliver organisational wide Structured Quality Improvement continuous Learning	Adopt 'Patient Safety Breakthrough Series Collaborative'	New	N/A	Successfully recruit approx. 10-15 improvement teams who contributing over 18

programme				month programme.
Clinical Excellence Framework	Design and imbed ENHT Exemplar ward programme	New	N/A	Following published accreditation criteria, all adult in patient areas shall have undertaken accreditation assessment.

From September 2019 the Quality Improvement team have now successfully been recruited and started. This consists of:

- Head of Quality Improvement: Tracey van Wyk
- Quality Improvement Coach: Ruth Bradford
- Quality Improvement Coach: Bianca Viegas
- Quality Improvement data analyst (supported through HEE): Karan Jhajj

The team objectives are to help ascertain organisational readiness for system wide quality improvement, which will include working with wider ENHT key stakeholders such as Educational & Development teams, Patient Safety, Clinical Audit team, Divisional Quality teams, Information's team, Business & strategy teams, HR Business partners, Project Management teams as well as engage clinical and non-clinical workforce groups.

1.1 **Clinical and non-Clinical staff are offered opportunities to gain knowledge on Quality Improvement theory.**

Early information gathering has been undertaken by the QI team to understand how we can enable clinical and non-clinical staff with the right skills, at the right time to help drive continuous quality improvement. Historically there has been structured

training delivered to staff by Patient Safety and OD leadership team, this has also incorporated project management tools and skills.

In alignment with wider Trust education review, the objective is to seek an understanding of current approaches and content to mandates session e.g. inductions, and offer a 'QI theory 'approach to training starting at this level.

A recent analysis has been undertaken to review this QI training and feedback from staff who have attended. Staff who attended the latest 3 cohorts of training have been contacted and asked some key questions:

Question	Answer
To rate the 2 day QI training between 1-10 (least to very effective)	Scored between 8-9 mostly
1How useful was the training?	Inspiring, useful, too long, unclear about day 2, would be useful to have more skills in *how* to run the project
Have you applied the skills in practice i.e. started a QI Project	37% said 'Yes', 63% said 'No' . For those who said no time/resources constraints or unable to engage stakeholders cited as most common reason
How far have you come along with the project?	For those who said yes it is unclear and lacked details of how skills had been applied successfully
Did you get any help after attending the course or how could we help further?	All said 'No'. Request for adhoc and ongoing support and feedback were made from 50% of respondents.

A general raising awareness of adopting a quality improvement approach has been started through Trust quality huddles, Friday at 8, visiting wards, visiting key stakeholders, joining existing team and committee meetings. Current plans include:

- Ongoing collaborative working with OD and QI team to review training plans and appropriate 'QI offer' alongside what is offered by the project management office, human factors training in the trust and leadership training and consider a tiered approach to all. This will result in a new suite of training packages, to be developed by April 2020, including ongoing support in the form of clinics or a hub for staff to access ongoing support.

- Design a Quality Improvement Science in depth session for key leaders of Quality across ENHT. These targeted sessions will be to help build theory and QI coaching capability as a priority with key stakeholders such as quality managers, senior nurses, and medical clinical leads involved in current quality improvement work. This work is currently under design and a date is being sought for Dec 2019.

- Support the design of our 'ENH Improvement Task & Finish group', which is now in progress to explore what key principles and skills are needed for sustainable model of improvement, across the wider Health Care systems, going forward.

1.2 Staff are supported to practically apply Quality Improvement knowledge through QI coaching.

Current steps to supporting staff practically apply Quality Improvement knowledge are applied through 'QI coaching' model. In essence this means:

- Staff engagement starts with a 'with what matters to you' conversation and helping staff look at variation in their data
- Agree consensus that QI approach is appropriate and progress to set up a coaching contract with identified the project leads
- Assess the teams likelihood of success for QI or the project leads self-assessment of their current QI abilities (MUSIQ Scores) (see appendix)
- Set ground rules and check in to build team cohesion, ensuring MDT approach
- Help teams understand their aim, measures and tests of change they plan to carry out. Helping them track their progress over time through a validated QI project scoring tool.

Identified Enablers:

- Good sources of data to help understand problems
- Enthusiastic and motivated leads who are keen to see change

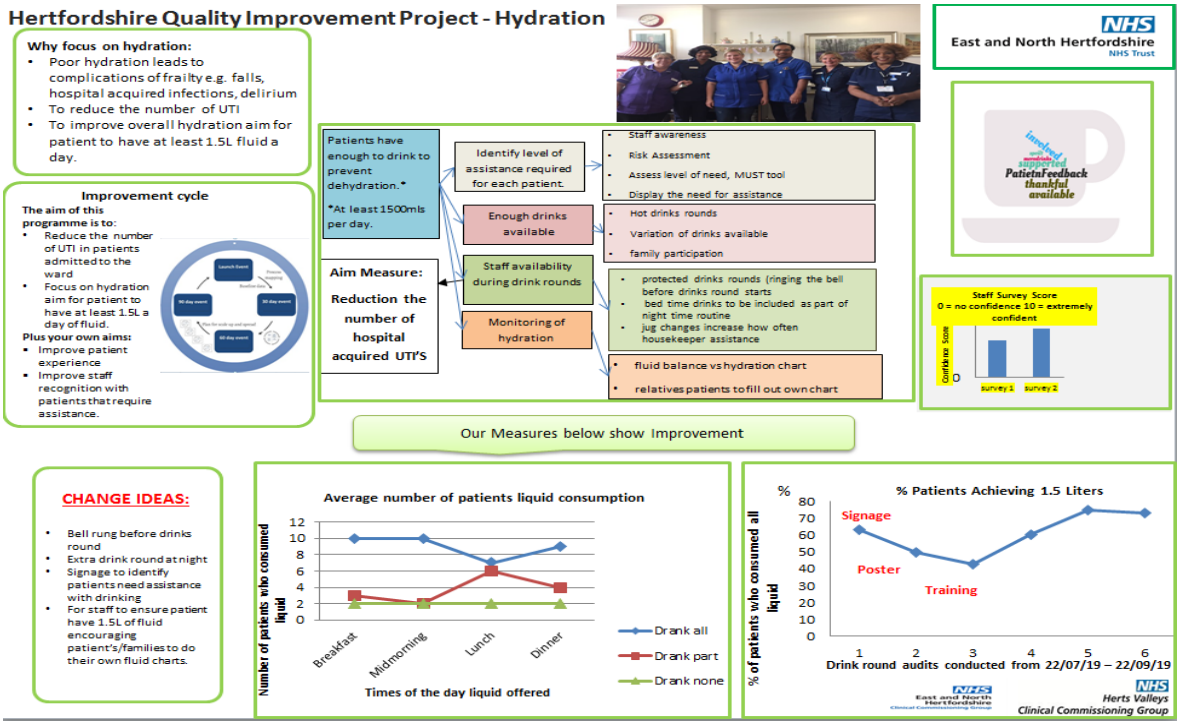
Identified Barriers:

- Staff finding time/ capacity a challenge
- There is evidence of cultural norms of 'uni-disciplinary' thinking rather than MDT involvement, therefore missing engagement with the right people
- Teams often focus on the problems with process, however the issues often appear to be human factors and the 'non-technical' skills required to deliver high quality care.

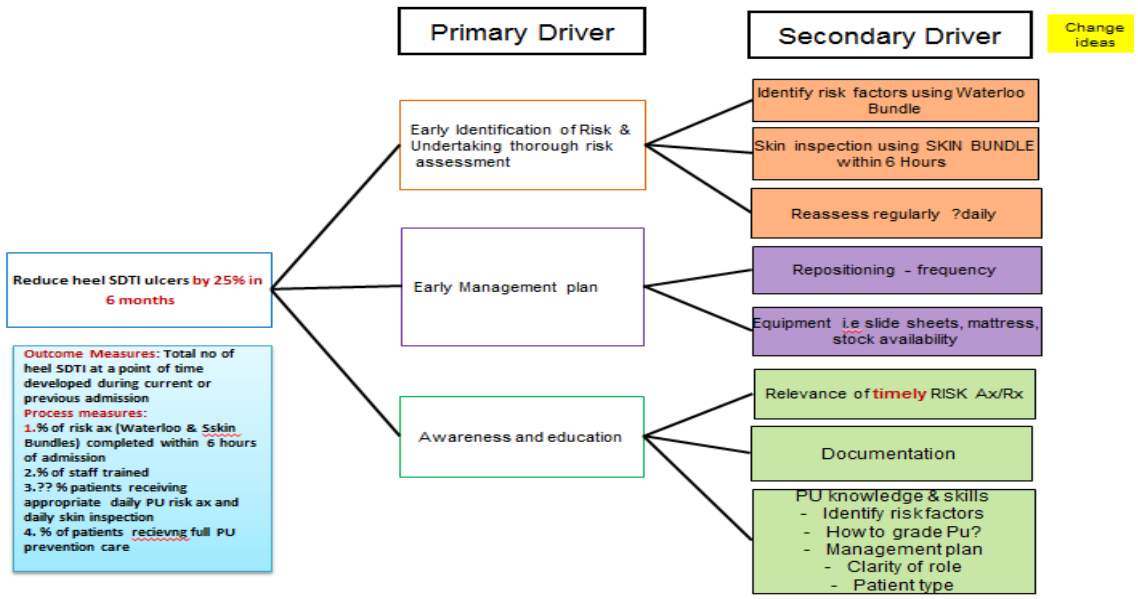
NHS Improvement

Some clinical team are participating in nation improvement collaborative. These teams are supported locally through quality improvement coaching on weekly basis.

Hertfordshire Hydration collaborative



National Pressure Ulcer quality improvement collaborative



1.3 Deliver organisational wide Structured Quality Improvement continuous Learning programme

- Plans have been agreed with Executives and Divisional leads to embark on an ENHT Deteriorating Patient Breakthrough series collaborative. This is an 18 month programme of a structured approach to improve the recognition and management of deteriorating patients. This programme will enable multiple clinical teams with the skills, knowledge and supported ward based coaching to drive continuous improvements. The first learning event has been arranged for 31st Jan 2020.
- In August 2019 ENHT partnered with the Royal College of Nursing to deliver a 12 month Clinical leadership programme, to support our 1st cohort of 20 ward leaders develop leadership and quality improvement skills through delivery of QI project over the 12 month period. .
- Develop an individual's clinical leadership skills through coaching and leading change.
- To manage the process of change in the clinical environment impacting on patient safety, practice, compassion or care.
- Ensure the clinical leader is seen as working within a team, in an organisation, influenced by and influencing local and national policy.
- There are 6 in-depth classroom sessions throughout the 12 months with a focus on patient experience, capturing data, theories of leadership, financial value to quality, staff experience, compassionate leadership, understanding team and individual behaviours. These ward leaders are also supported through structured group 'action learning sets' and practical 'QI coaching' in the clinical areas.

ALS Group	Ward	GROUP ALS Facilitators	Quality Improvement coach
1	7B Surgical AMU Green 6B Renal medical 9B Care of Elderly OPD MVCC Dacre Ward Antenatal 8B Surgical	Steve Andrews & Fiona Culley	Tracey Van Wyk
2	Children's Day services LMCC (Cancer Care) 10B Diabetes and Endocrine Gloucester Ward Ashwell Medical 5B Surgical Emergency Dept	Carrie Kirby & Connie Chambers	Ruth Bradford
3	10/11 MVCC (Cancer Care) Swift Surgical Surgical Assessment Unit 10A Gynaecology 5A Surgical Ambulatory Care Centre	Margaret Mary Devaney & Tracey Van Wyk	Bianca Viegas

LEARNING EVENTS

- **Quality learning event (June 2019)**

In June 2019 a Quality Learning programme was attended by >200 staff through a 1 day event. Multiple topics including how to adopt quality improvement were covered.

Topics throughout the day included:

Enjoying work…..Quality Improvement for all
Patient safety Incident reporting
'Proud to improve our environment'
Improving quality through human factors in health care
Quality & Safety Dashboard
Equality and Diversity
Clinical Audit to Quality improvement
Safer Medication
Learning form deaths & introduction of the Medical Examiner
Litigation overview and Duty of Candour
National Safety Standard for invasive Procedures (NatSSIP) – what is the ask?
Celebrating Excellence – ENHT Framework
Key Note: Working safely ….what do we mean? Suzette Woodward, National Director Sign up to Safety

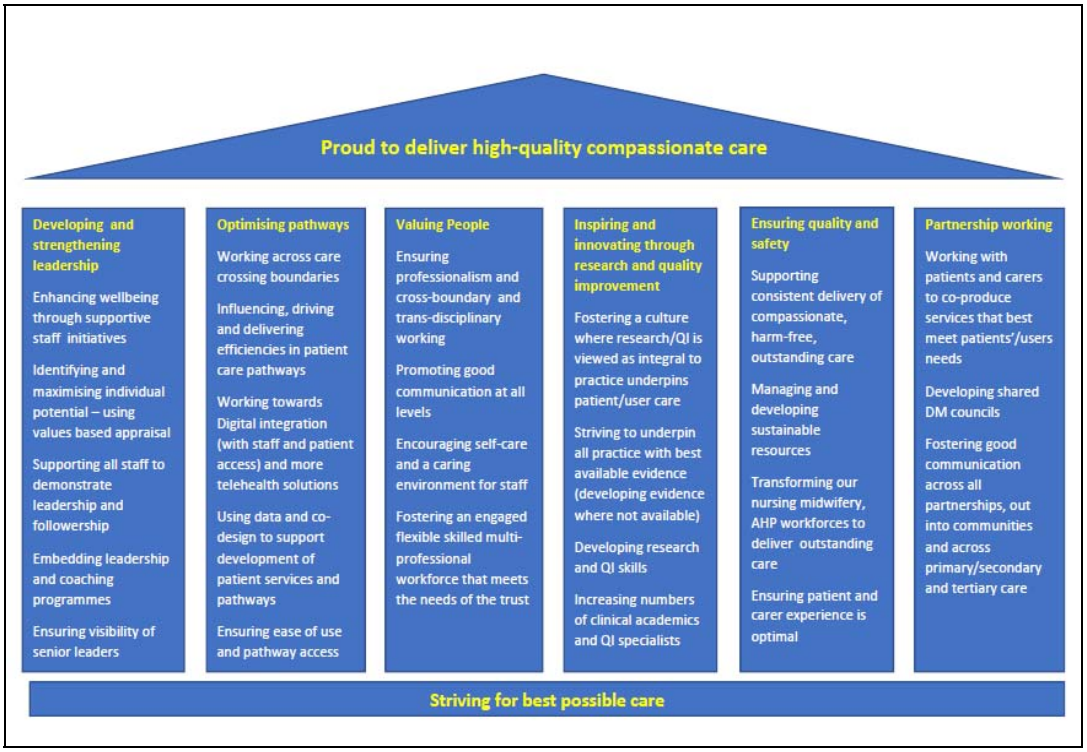
Safer Invasive Procedures Launch (October 2019)

- October 2019 over 30 people covering 15 specialties attended the ENHT launch to Safer Invasive Procedures.
- Staff shared data and learning form national and local never events
- Heard inspirational story from a consutant invloved in a never event
- Explored how quality improvements tools will enable changes
- Heard how human factors such as situaiton awareness and teamwork are key to working safely
- Introduced a new audit tool draft- and explores adopting data for improvement.

This event was attended by many specialities such as theatres, Cardiology, respiratory, Plastics, Dermatology, Endoscopy, Radiology, Critical Care and Renal services.

1.4 Clinical Excellence Framework

The Trust's Clinical Excellence Accreditation Framework (CEAF) brings together key measures of nursing and clinical care to enable a comprehensive assessment of the quality of patient safety and patient experience to be undertaken at ward/unit level. The CEAF supports delivery of the Trust's Nursing, Midwifery and Allied Health Professionals Strategy 2019-24 and focuses on 6 pillars:



Teams are supported by our Quality Improvement Matron to undertake a comprehensive self-assessment and are then reviewed by a core assessment team comprising of senior leaders. Teams strive for improvement through four levels of accreditation – bronze, silver, gold and platinum.

The CEAF supports a culture which develops and strengthens leadership, recognises and rewards success and strives for continuous improvement. Staff engagement is critical to the success of the CEAF, including investment in shared decision making councils.

Progress with CEAF:	
June 2019	Development of Trust guidelines for ENHT Clinical Excellence Accreditation Framework
June/July 2019	Development and testing of CEAF metrics
July 2019	Presentation to Quality and Safety Committee with ward managers
July 2019	Development of self-assessment reporting template
August/September 2019	Cohort 1 (Swift Ward, 6B, 8B, 10B) undertake self-assessment
October 2019	Review of Cohort 1 wards by core assessment team
Next Steps:	
October/November 2019	'Time to Shine' leadership discussions for Cohort 1 followed by final review and decision by credentialing panel.
October 2019	Cohort 2 (AMU Green, 5B, Gloucester, NICU) to commence self-assessment
October 2019	Develop plan for Trust-wide roll-out

Priority two: Keeping our patients safe

Reason: These are quality Goals within Quality Strategy (2019-2024). Further progress is required for the majority of the 2018/19 indicators, with the aim to adopt quality improvement methodology and drive more sustainable changes in 19/20.

Monitoring: Medication Forum, Harm Free Care Group, Deteriorating Patient Group, Safer Surgery Collaborative, Patient Safety Committee and Safeguarding Board.

Reporting: Rotational monthly updates to the Quality & Safety Committee

Responsible Directors: Director of Nursing & Medical Director

	Theme	Measure	19/20
2.1	Medication management	Omissions of critical medications	<5%
		Medicines optimisation framework score (max 168)	135
		Antimicrobial stewardship	>90%
2.2	Sepsis pathway compliance	Screening for sepsis in ED	> 97%
		Neutropenic sepsis door to needle time	>80%
		Antibiotics in ED within an hour	>90%
		Antibiotics on the ward within an hour	>90%
2.3	Safer Invasive Procedure Standards	Phased approach to developing and imbedding Local Standards for Invasive Procedures	>95%
2.4	Deteriorating patient	Reduce rate of cardiac arrests	<0.8%
		Audit of compliance with timely observations	> 95% reliability all observations
		Launch escalation module and develop a means of monitoring the escalations	Launch
2.5	Safeguarding Adult and Children	Ensuring reduction all patients with known learning disability	Ascertain baseline data and set trajectory
2.6	VTE Risk Assessment	Improved compliance with VTE risk assessment part 1 and part 2	>95% compliance with part 1 and part 2

*Baseline will be the 2018/19 data once measurement ability becomes available

2.1 Medication management	AIM
Omissions of critical medications	<5%
Medicines optimisation framework score (max 168)	135
Antimicrobial stewardship	>90%

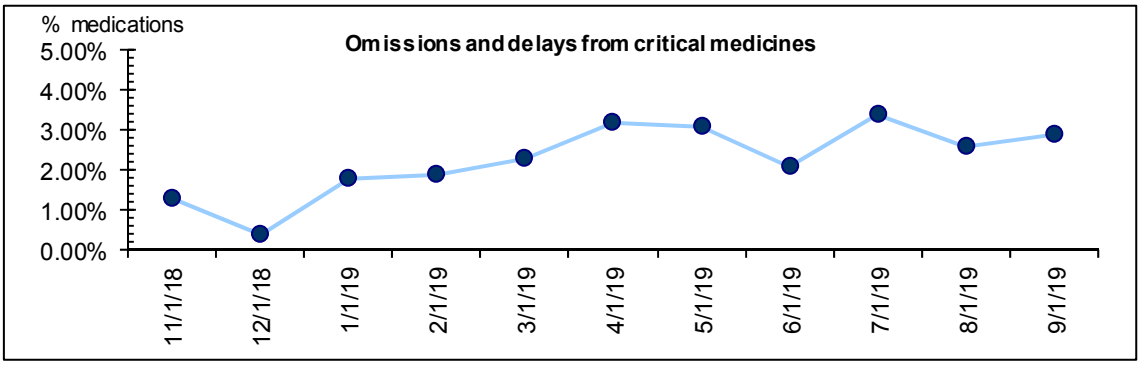
The data below are captured through monthly observation audits by the pharmacy team. There is a monthly audit of 10 patients' charts on every ward.

Omissions of critical medications

The critical medication omission numerator is the number of doses of critical medicines that have been delayed (>2h) or omitted in the previous 24h.

The denominator is the total number of doses of critical meds off regular medications prescribed in previous 24h.

The aim for the trust is to achieve < 5% omissions of critical medications that should not be missed or given late.



Reducing the incidences of critical meds remains priority for continuous improvement through the Trust's Harm Free Care Collaborative.

The Trust's Medicines Optimisation Strategy for 2019 – 2022 has been developed using the NHS Improvement, Hospital Pharmacy and Medicines Optimisation Assessment Framework.

The purpose of the Medicines Optimisation Framework is to help NHS Trusts review their approach to medicines optimisation and pharmaceutical services. In addition, the outcome will be used by NHS Improvement to provide an assessment of the extent and quality of services provided by NHS Trusts as a focus for developmental support.

- The framework establishes a baseline assessment of current approach and practices; identifies areas of existing good practice but also areas for development and provides assurance on medicines optimisation and pharmaceutical services.
- The core domains and criteria used in the framework draw on a wide variety of sources. These include standards and guidance published by the Department of Health and Social Care, National Patient Safety Agency (now part of NHS Improvement), Care Quality Commission, NHS Litigation Authority, the Audit commission and the Royal Pharmaceutical Society (RPS).
- The framework content has been devised in consultation with NHS Chief Pharmacists, as well as peers and other clinical colleagues. It is intended to meet the specific needs of NHS Improvement. However, it may be of interest to other healthcare providers.
- The Medicines Optimisation Framework was completed by the Chief Pharmacist, Medical Director and the Director of Nursing and the Medicines

Optimisation Strategy was approved at the Quality and Safety Committee in May 2019.

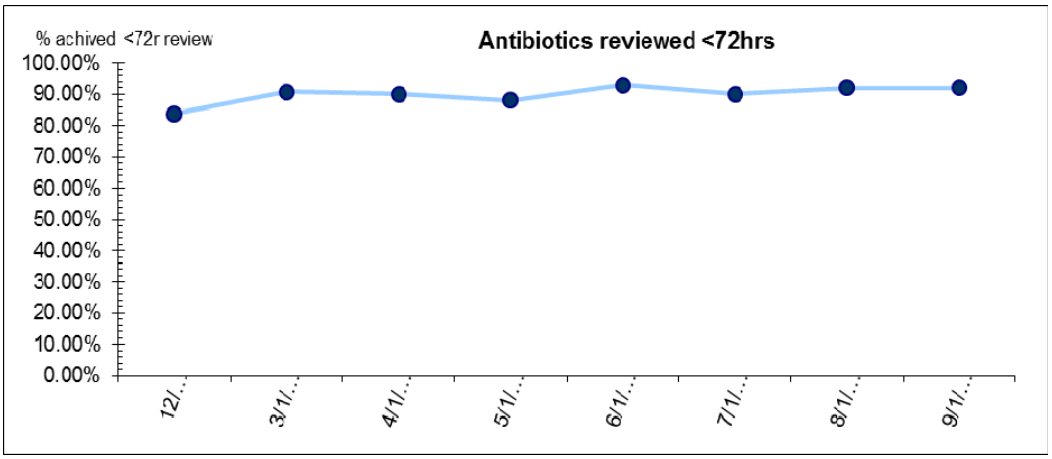
- The outcome of the baseline assessment was an achievement score of **115** out of a maximum score of **168**. The Trust strategy is to improve our score over the next three years to be comparable with the highest achieving Trusts. This has informed the strategy and key priorities moving forward.
- The Medicines Optimisation Framework has been reviewed in November 2019 and the achievement score has increased from 115 to **123.**

Progress has been made in the following areas to drive continuous improvement towards achieving this score:

- The Hospital Pharmacy Transformation Plan (Ward Based Pharmacy) has demonstrated increases in the number of medicines reconciliation completed at ward level and the number of TTOs prescribed by pharmacists.
- A Therapeutics Policy Committee biannual report was presented to the Clinical Effectiveness Committee in September 2019.
- A Medication Forum biannual report was presented to the Quality and Safety Committee in July 2019
- The Medicines Optimisation KPIs on Qlikview have been presented at Divisional Accountability Review Meetings, the Nursing Quality Huddle, Medication Forum and Pharmacy Rolling Half Day.
- The Medical Director and the Director of Nursing receive a biweekly report on Medication Safety and Security from the Pharmacy and Senior Nurse Executive Walk Around.
- Pharmacy reports quarterly to Medicine and Surgery on their drug spend and top 50 drugs.
- The Trust has a register of Patient Group Directions and all the PGDs are in date.
- EPMA - the Lorenzo Investment Case (LIC) and Benefits case has been approved by NHSD. Timescale is for EPMA to be piloted on one ward by February 2020 and then to be rolled out during 2020/21 – Project timetable to be finalised.

Antimicrobial stewardship

The aim is to achieve >90% compliance with good governance of antibiotic stewardship, the data below shows reliability of a clinical review of 72h antibiotic collected by pharmacy every month.



An annual antimicrobial stewardship point prevalence audit is taking place this week during Antimicrobial Awareness Week (November 2019). This shall incorporate a deep dive into other good governance's processes such as prescribing with indication, duration, as per guidelines/ discussed with micro, etc.

2.2 Sepsis pathway compliance	AIM
Screening for sepsis in ED	> 97%
Neutropenic sepsis door to needle time	>80%
Antibiotics in ED within an hour	>90%
Antibiotics on the ward within an hour	>90%

ED Sepsis Care

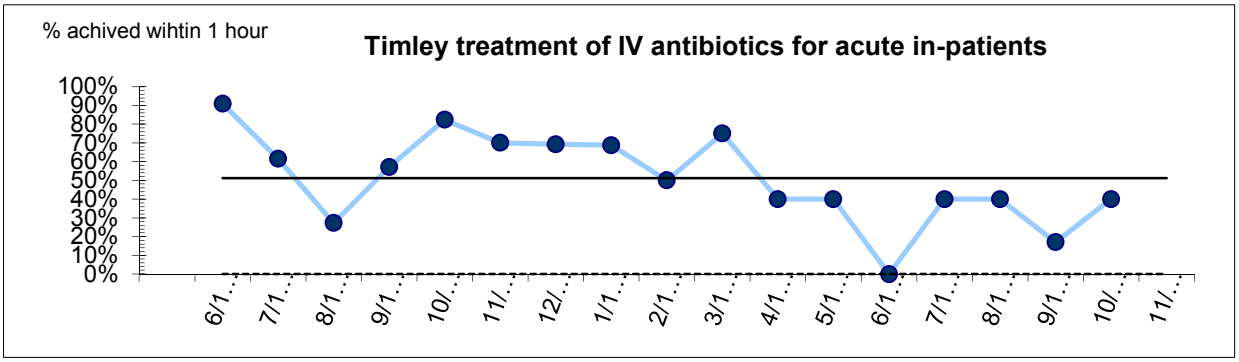
The data below shows improving trend of timely antibiotic administration within 1 hr; achieving an average of 70% compliance.

Themes identified for areas of continuous improvement include:

- Improving recognition and awareness to clinical signs of new confusion / change in mental state through use of NEWS2 score.
- Improving urine output / fluid balance at time of admission/deterioration
- Delayed decisions to administer IVABs for patients with suspected neutropenic sepsis

In patient sepsis care

The data below shows an average compliance of 50% timely administration of IV antibiotics in in-patient settings.



Themes identified for areas for continuous improvement include:

- Time to escalation by ward team after first red flag
- Time to doctor review after trigger
- New antibiotics being written on regular side of drug chart rather than stat
- 50% Sepsis triggered by Pneumonia; some readmissions with sepsis after treatment for pneumonia some work is under way adopting Quality Improvement tools to collaborate with sepsis team and with Acute Chest Team
  - Aim to of this new piece of work is to improve survival from pneumonia and sepsis by
  - improving sepsis screening & treatment (if appropriate) for patients with pneumonia
  - improving time to pneumonia treatment according to guidelines
  - giving consistent verbal and written safety netting advice to all patients before discharge

These themes are priority for drivers for improvement within the planned Trust Wide Deteriorating Patient Collaborative.

Sepsis measurement plan 2019/20:

New measurement plan has been agreed to measure and monitor the timely recognition and management of sepsis, this will include the timely administration of the nationally recognised sepsis bundle.

1. Administration of IV antibiotics
2. Serum lactate measurement
3. Accurate Fluid Balance chart
4. Sample for blood culture
5. Administration of IV fluid challenge
6. Administration of 02 therapy

This approach shall be reflected in our annual 2019/20 quality account update.

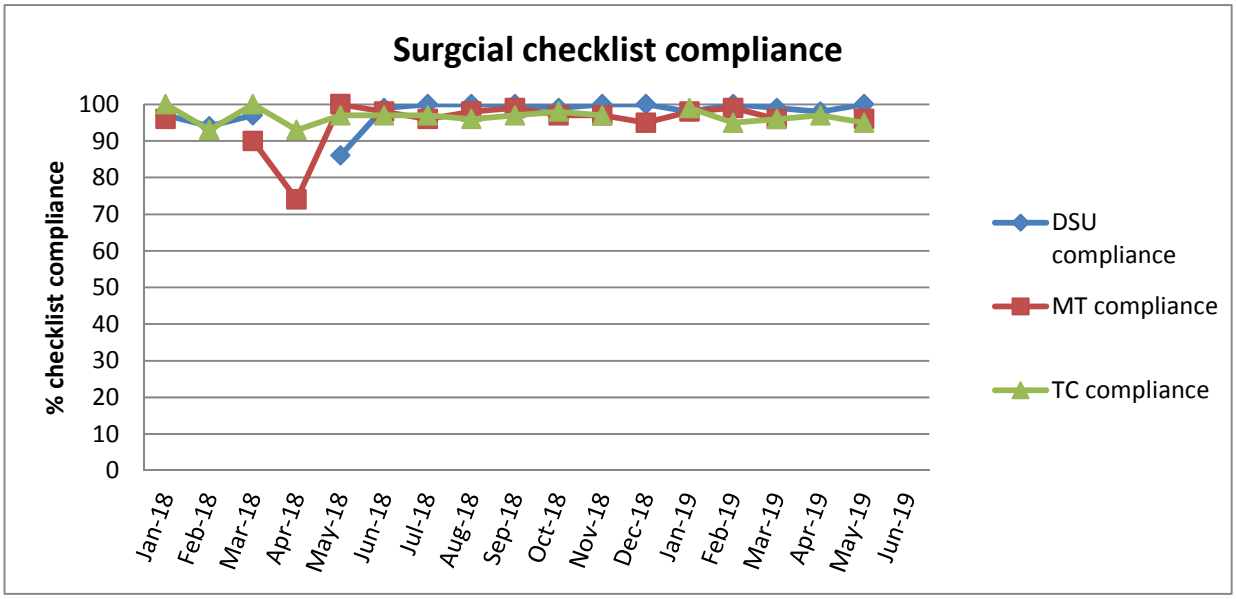
2.3 Safer Invasive Procedure Standards	AIM
Phased approach to developing and imbedding Local Standards for Invasive Procedures	>95%

The Safer Surgery Collaborative continues to drive process and systems changes through better understanding of human factors associated with the reliably deliver safer invasive procedure standards.

To support the delivery of safer invasive procedures across the Trust, the Quality team have successfully delivered a Trust wide learning event in October 2019.

Surgical checklist audits have focused on documented completion of safety critical moments, but despite evidence of good documentation we have recognised many other contributing factors towards surgical errors, hence our quality priority 'safer surgery work stream'. This has been established to look at ways of improving surgical safety checks through a more structured approach to audit the National Safety Standard of Invasive Procedure standards through peer observational data collection.

AIM: 95% compliance with surgical safety checks



Data collection methods

- Observational and paper audits against surgical checklist standards are undertaken in key areas such as Day Surgery Unit, Treatment Centre and the Main Theatres.

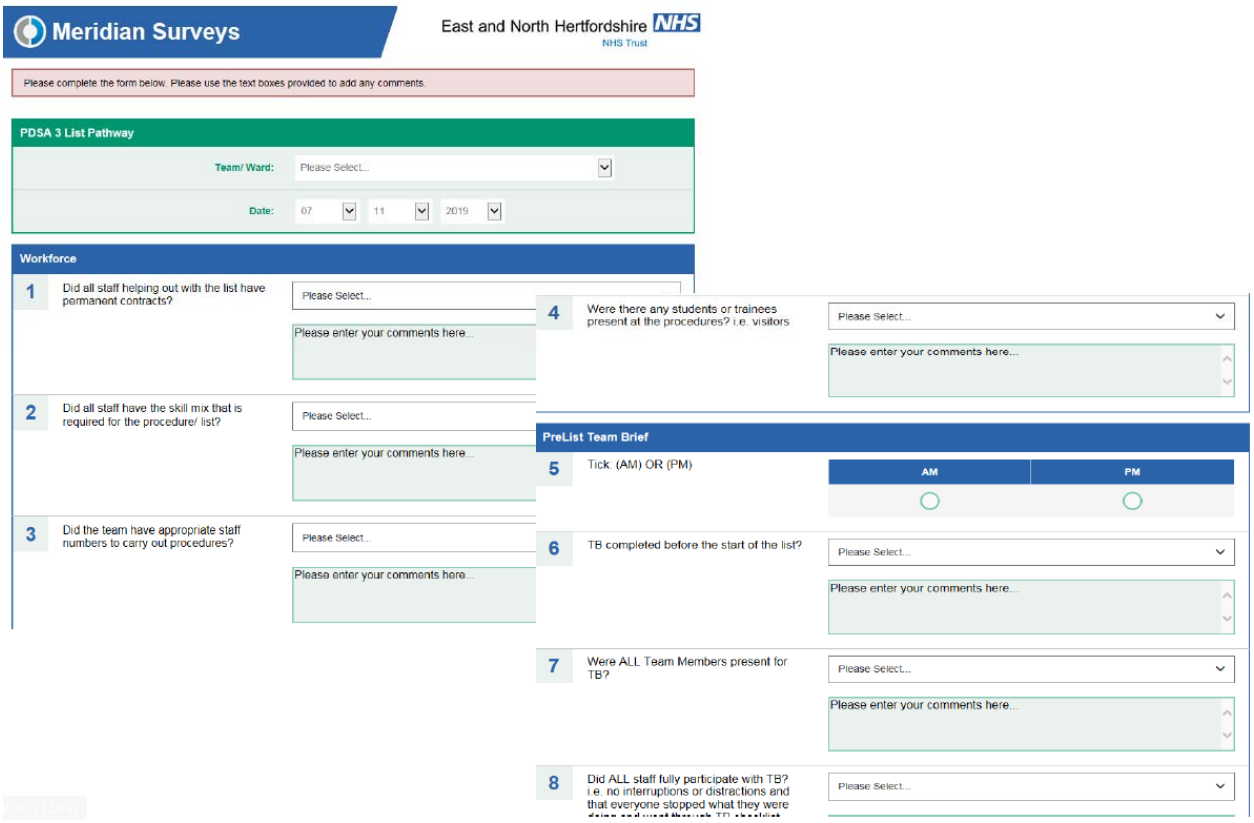
- A random sample (10%) is audited per area, looking at key surgical safety checks: 'Team Brief, Sign In, Time Out, Sign Out and Team de-brief' are each observed.

Safer surgery continuous improvements:

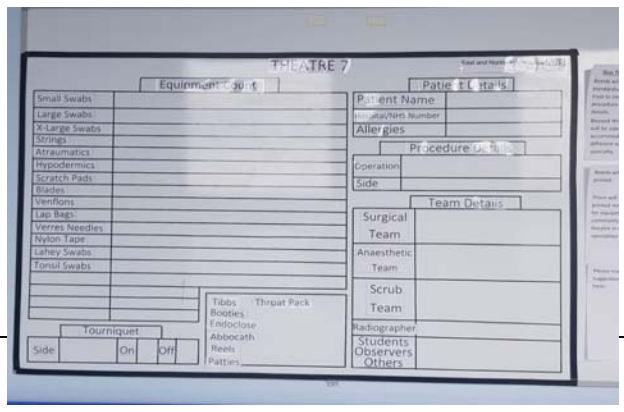
- Theatres final version of newly designed paperwork ready for launch and further local system testing
- Non- theatres specialities now undertaking a gap analysis- Currently working with theatres (all); ENT, plastics, cardiology, ED, radiology
- Human Factors video for use on departmental induction with new staff in the use of the new pathway
- Planned work with treatment centre band 7's for wellbeing and joy in work projects
- New pathway nationally- NATSSIP audit has been adapted for local use and is on Meridian for testing by all specialties. This audit tool has been tested and re-designed with theatre staff and shall be reflected in next quality account update. (see example below).

Digitalised NatSSIP tool on intranet

East and North Hertfordshire NHS Trust



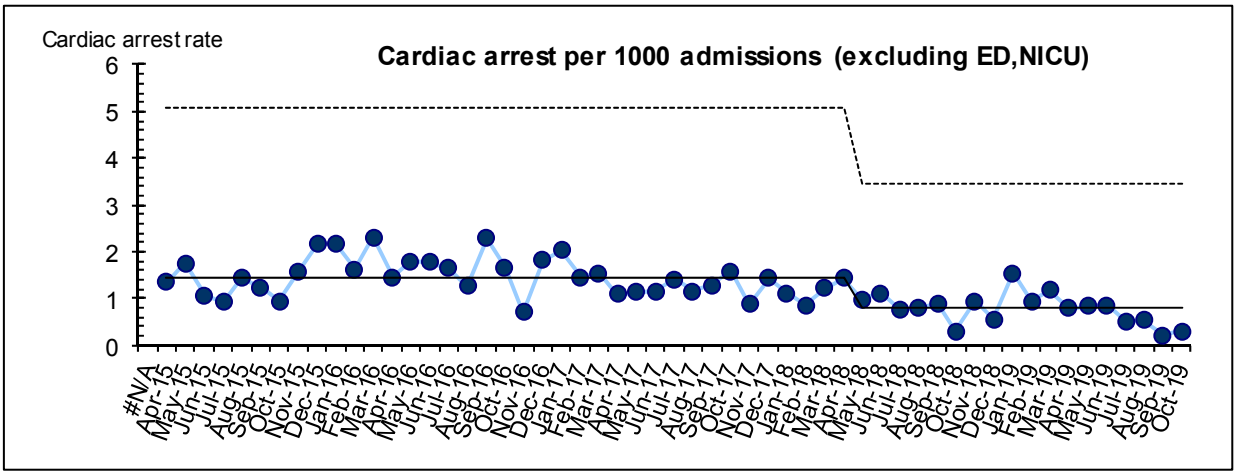
All theatres have tested, redesigned and now have new 'Procedural boards', with a key purpose to improve team communication before and during invasive procures.



2.4 Deteriorating patient	AIM
Reduce rate of cardiac arrests	<0.8%
Audit of compliance with timely observations	> 95% reliability all observations
Launch escalation module and develop a means of monitoring the escalations	Launch

Cardiac arrest data is routinely submitted to the National Cardiac Arrest Audit (NCAA) database. Trust data has historically included cardiac arrests that have occurred within the Emergency Department. However, other Trusts do not include Emergency Department data so our benchmark data, although improving, is not directly comparable to other trusts.

The chart below shows our ENHT Cardiac arrest data has sustained a reduction in in-hospital cardiac arrests, with an average rate of 0.8 per 1000 admissions.



DNACPR and Treatment Escalation Plans (TEP)

Previous audits undertaken have demonstrated that 40% of resuscitation events were not in the patient best interests i.e. intervention to support a comfortable end of life care plan may have been more appropriate.

Pilots have been undertaken to test tools that support clinical staff discuss and communicate clinical treatment options in the event of deterioration. These will aim to improve:

- Better documentation of discussions regarding resuscitation decisions
- Clarification about the need to record DNACPR status
- A more robust process for the handover of patients not appropriate for CPR and decision of appropriate treatment options.

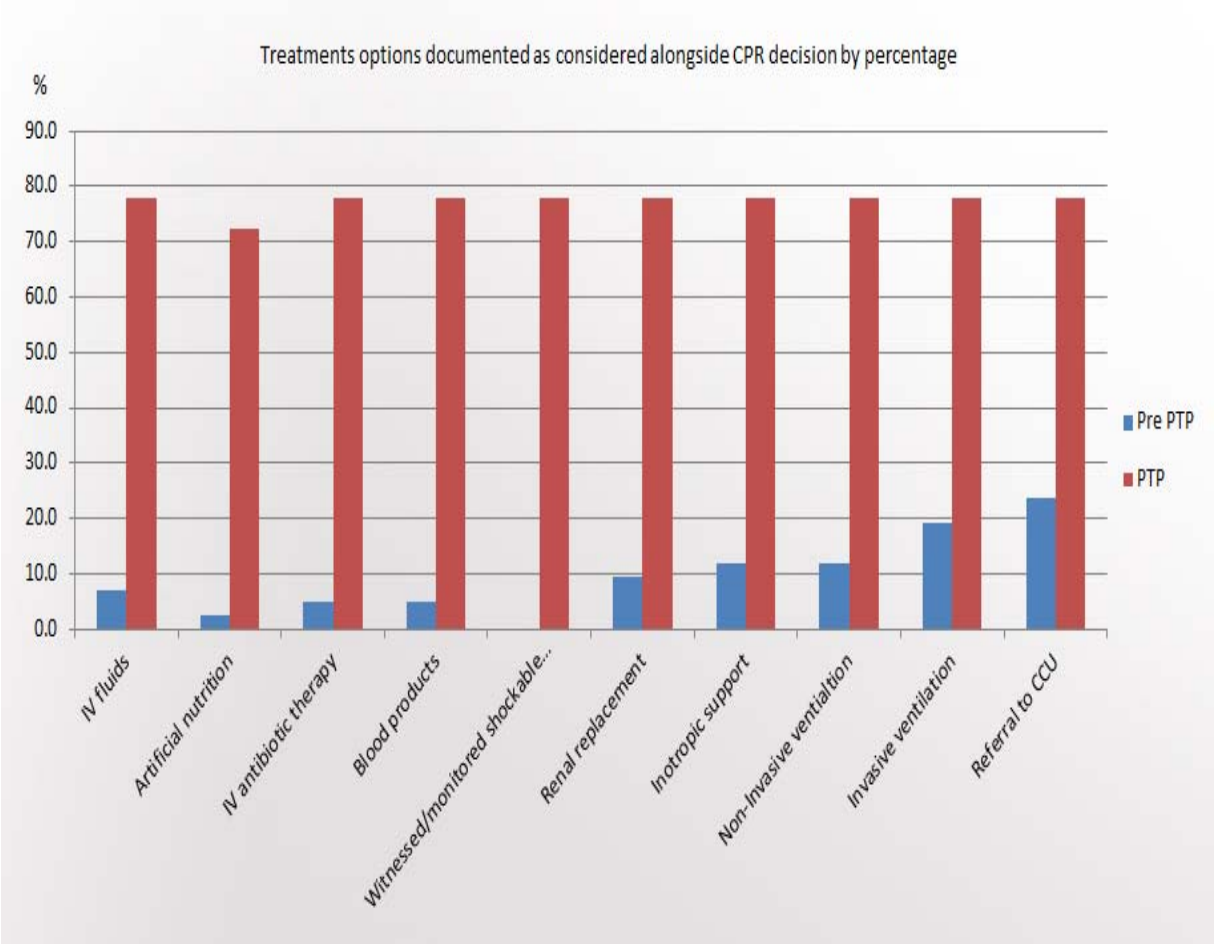
Supported through the governance of the End of Life Board, the Deteriorating patient Collaborative and Patient safety Committee the learning from the pilot phase has resulted in final version of our ENHT Personalised treatment plan (PTP). A

personalised treatment plan has been created, tested and re-designed following a 3 month pilot.

In December 2019 these Treatment Escalation pans shall be officially launched and live in all in patient areas. (see appendix 2)

Learning demonstrated there was poor documentation of discussions or planning for interventions in the event of deterioration; and only 5% of patient where a DNACPR decision had been made also had details of what interventions should be considered. Through iterative testing within the pilot areas, there has been a witnessed an increase in documented decision making appropriate treatment interventions and it was noted to that 80% of patients had a documented DNACPR decision.

Categories of treatment options noted pre and post pilot phase of personalised treatment Plans are noted on graph below.

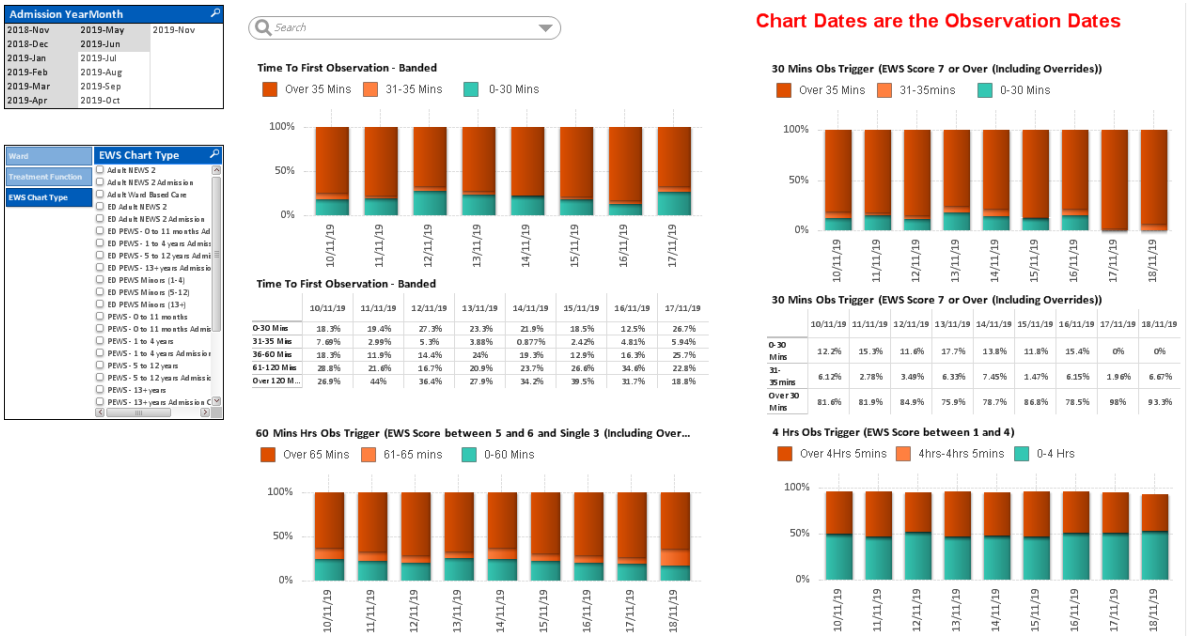


Timeliness of observations

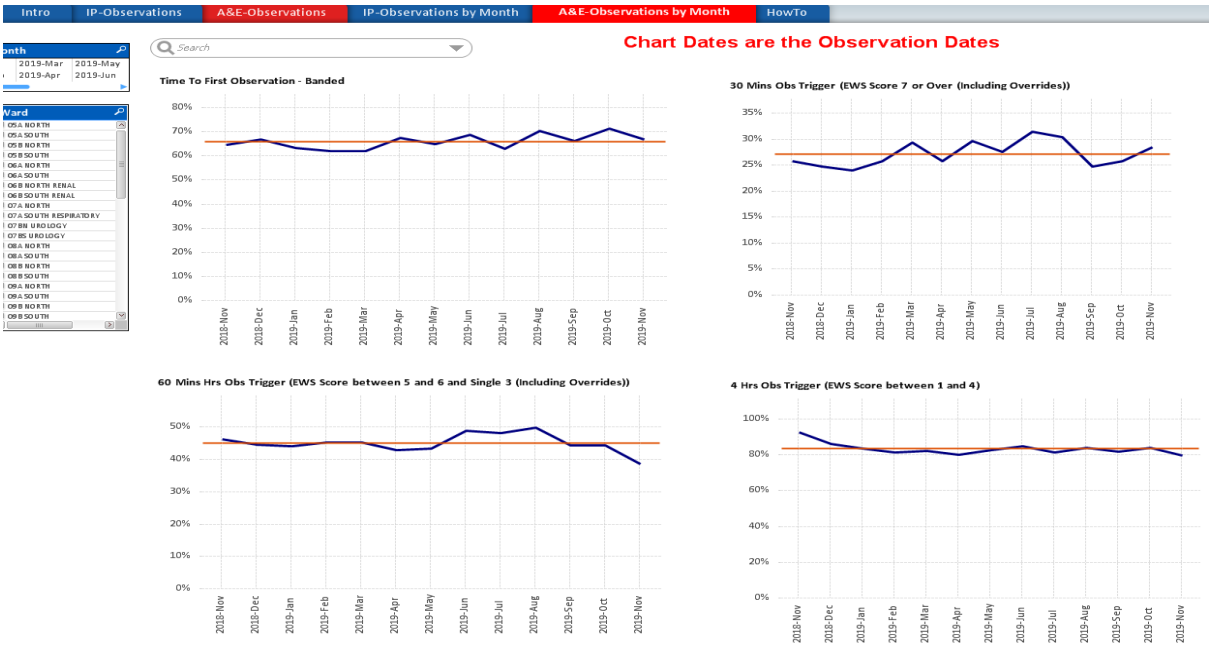
The ENHT deteriorating patient collaborative consists of a group of subject matter experts including critical care, outreach, resuscitation, sepsis, AKI and learning disabilities. An identified key process measure to improve the recognition and management of the deteriorating patient has been identified as reliability of recording observations.

There is now improved transparency and visibility of daily observations reliability against set timeframe (i.e. on admission, 30min, 1 hrly, 4 hrly etc.).

The charts below are live on intranet Qlickview dashboards.



This data can also be mapped for each month and show trends across time for each clinical area, this is displayed on Qlickview and stratifies in-patient form ED observations.



- A current audit is underway to review equipment required to reliably carry out observations, including equipment needed, equipment availability and equipment location.
- Review of the digital Escalation module within nerve centre is underway, at present all cardiac arrests are undertaken by the

Resuscitation team and any areas of escalation concerns are raised and if required discussed through our serious incident review panel.

Deteriorating Patient continuous improvement plan:

- Dates booked for next year's learning events for the breakthrough series 30/1/20; 22/04/20; 29/07/20; 22/10/20
- Participating teams are being be named by divisions
- Ongoing macro level improvements with digital team around the collection of data from nervecentre and data analytics to enhance accuracy and ensure data is valid
- Work is underway to track handheld devices to ensure access for all staff as and when the devices are needed
- Assisting audit of equipment by ward managers for treatment of deteriorating patients

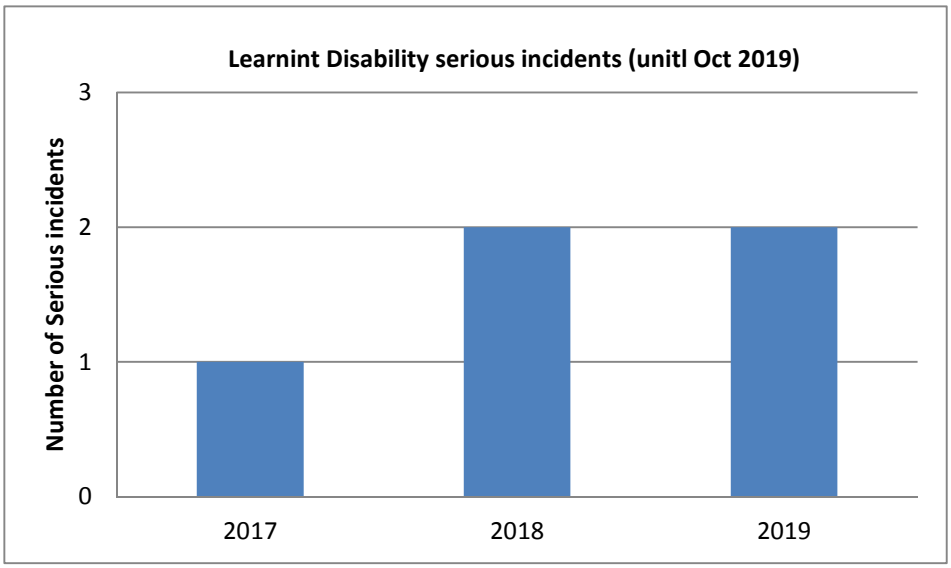
Patient safety Recognition

National recognition was given to the contribution of the work undertaken by the resuscitation team to review and learn from cardiac arrests, helping staff in clinical areas use RCA tool to reflect on events pre-arrest occurring.

2.5 Safeguarding Adult and Children	AIM
Ensuring reduction all patients with harm who have known learning disability	Ascertain baseline data and set trajectory

The trust is committed to providing high quality services for people with learning disabilities.

The table below demonstrated the baseline data for incidents of serious incidents within our learning disability patient population.



Learning and monitoring of improvement actions post incidents are monitored through the trust Learning Disability Steering Group, chaired by the Director of Nursing. This group also oversees the implementation of the NHS Improvement Learning Disability improvement standards that were published in July 2018. The three standards of which apply to acute NHS trusts, cover:

(1) Respecting and protecting rights
(2) Inclusion and engagement
(3) Workforce

2.6 VTE Risk Assessment	AIM
Improved compliance with VTE risk assessment part 1 and part 2	>95% compliance with part 1 and part 2

VTE Risk assessment is measured in several ways within the trust.

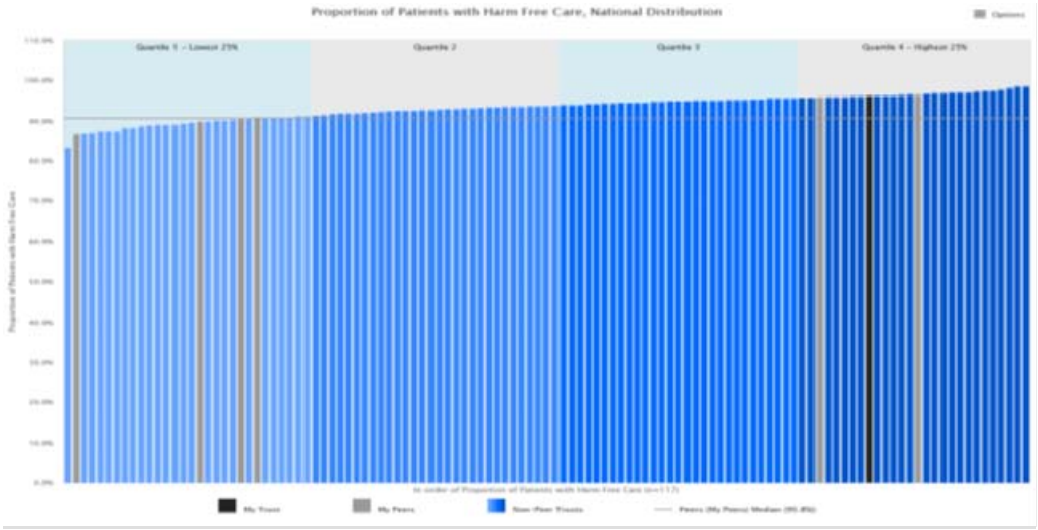
- National Safety thermometer- a point prevalence on one day
- Medical records – all in-patients after discharge of 24hrs, this is shown in the trust Integrated performance report
- Pharmacy- random sampling in real time in patient setting

Safety thermometer:

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.

The Trust (black line) is in the highest (best performing) quartile for harm free care.

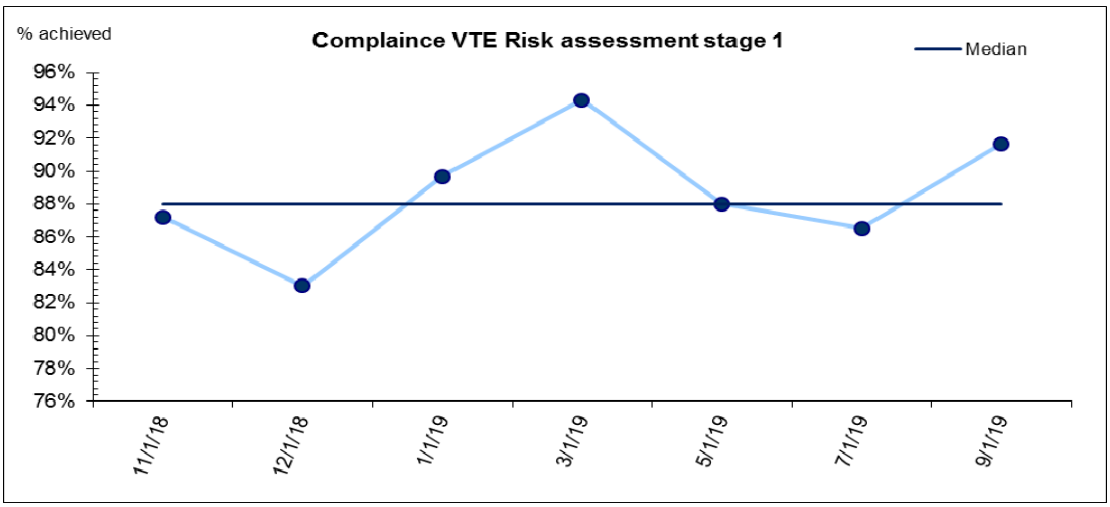
The chart below demonstrates the breakdown of patient harms over the past 6 months, with the Trust position shown as the black line (September 2019 data).



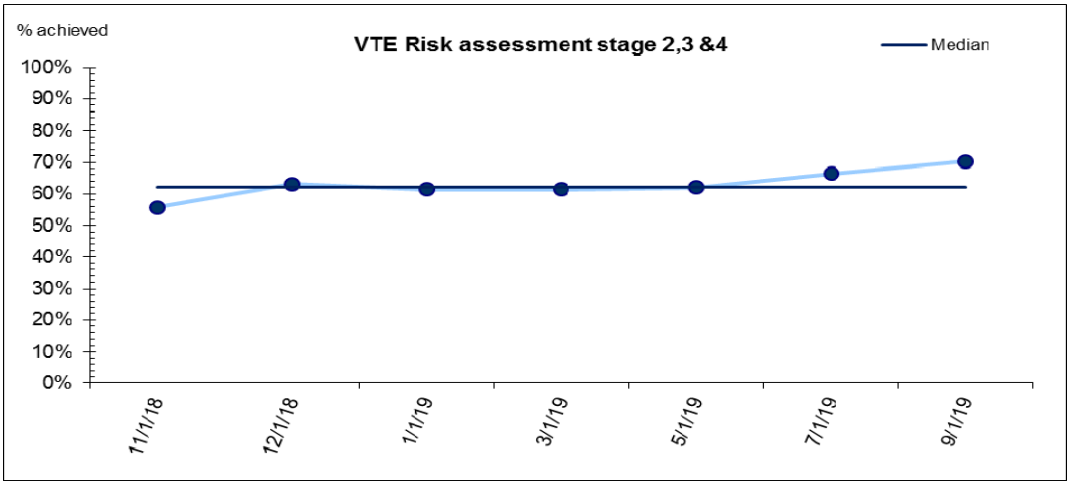
In patient sampling:

The data bellow shows real-time data collected by pharmacy who review 10 samples each month, looking at stage 1 and stage 2-4 VTE risk assessments. This data is now accessible through Qlikview and demonstrates less reliable completion of VTE risk re-assessments

Stage 1 Risk assessment data shows an average of 90% compliance.



Stage 2 Risk assessment shows an average of 61% compliance.



- **Themes for continuous improvement:**

Regular root cause analysis learning is undertaken when potential hospital acquired thrombosis cases are identified. Areas for improvement include:

- Reliability of providing patient prevention information on discharge (and on admission), variation exists where elective surgical patients receive this information reliably, however emergency medical or emergency surgical patients yet to be measured.
- Adjusting current drug charts to provide allocated space for 'time' of VTE review. This is currently missing and therefore not allowing accurate documentation of timely risk assessments.
- The second changes currently being undertaken include whole system review to establish a more co-ordinated, sustainable core HAT Prevention team. This work is led by divisional chair for CSS and currently includes establishing a new structure where pharmacy, medical, nursing and medical records roles are re-defined with clear expectations to manage HAT prevention and treatment processes. External organisations have been contacted to learn how other structures work and job descriptions for relevant roles have been gained for review. Current mapping of WTE needed to undertake all aspects of VTE risk assessment, HAT identification, Learning from RCA's, provide patient and staff education has been gathered and shall be included in a business case for presentation internally, by October 2019.

There are examples of excellence on surgical areas e.g. Trauma and Orthopaedics where the team have implemented ward round stickers as prompts for VTE risk assessment to be carried out. Learning from this approach shall be included through next steps of improvement work.

Through the harm free care collaborative data analysis has been undertaken and some medical clinical areas have been identified as priority to adopt quality improvement approach to understand where systems and team work can be strengthened to improve risk assessments and sharing of preventative patient information.

Priority three: Respect our patient's time through improving the flow through inpatient and outpatient services

Reason: Further progress is required for the majority of the 2018/19 indicators; to monitor the effectiveness of the improvements made with the IT systems

Monitoring: Quality & Safety Committee, Finance & Performance Committee

Reporting: Quarterly update to the Quality & Safety Committee

Responsible Directors: Chief Operating Officer

	Theme	Measure	19/20
3.1	Improving discharge processes	Reduce number of discharge summaries not sent to GP within 24 hours of discharge	90% reduction
		Patients discharged by midday	>15%
		Reduce proportion of beds occupied with length of stay > 14 days	<19%
3.2	Improve access	Improve cancer waits from 2019/20 position	National standard
		Improve delivery of 7 days services Alison report	Ascertain baseline and agree Trajectory
		Reduce delays in ED 4 hour waiting time	National standard

3.1 Safe and timely discharge processes

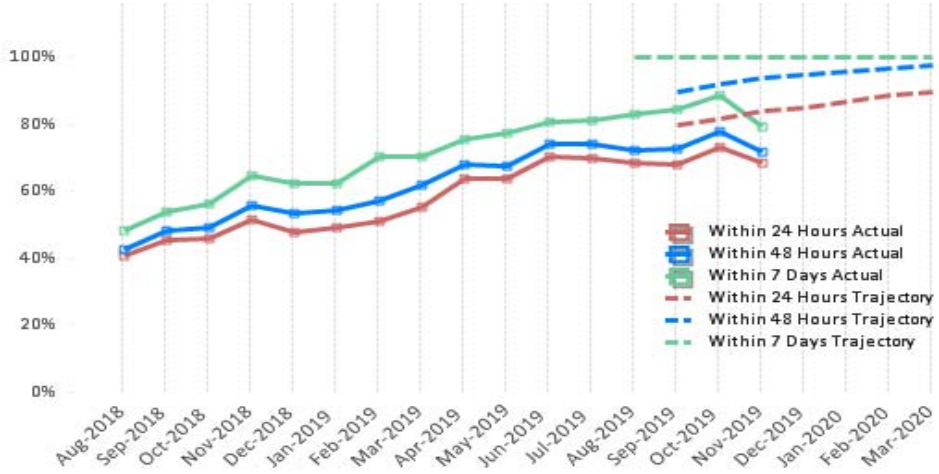
- **Discharge summaries** remain priority for the trust and a more sustainable approach has been undertaken to continuously improve the number of discharge summaries being sent to GPs within 24hrs of discharge.

Continuous improvement interventions have included:

1. Engagement with staff involved in the discharge process
2. Training and education for the creation and distribution of the discharge summary
3. Review of templates standardising format
4. Daily monitoring through improved data
5. Improvement to process, removing unnecessary steps in the discharge process
6. Ongoing review developing an improvement culture to test ideas

The back log has been reduction from 2900 (April 2019) to 300 (November 2019).

The data below shows a 30% increase of reliably sending summaries within 24hrs and 40% increase in sending within 7 days.



- Reduce proportion of beds occupied with length of stay > 14 days

Length of stay reviews occur weekly within divisions, measurement throughout the year has shown normal variation.

Metric	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Proportion of beds occupied by patients with length of stay over 14 days	20.5%	20.1%	17.9%	18.7%	18.5%	19.6%	18.5%	17.3%	18.1%	17.6%	20.4%	18.2%

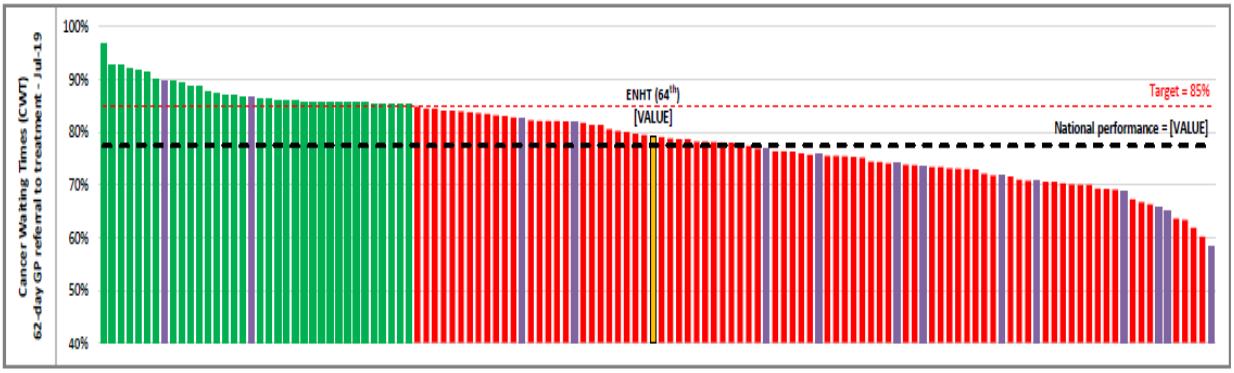
3.2 Improved access

- Improve cancer waits from 2019/20 position

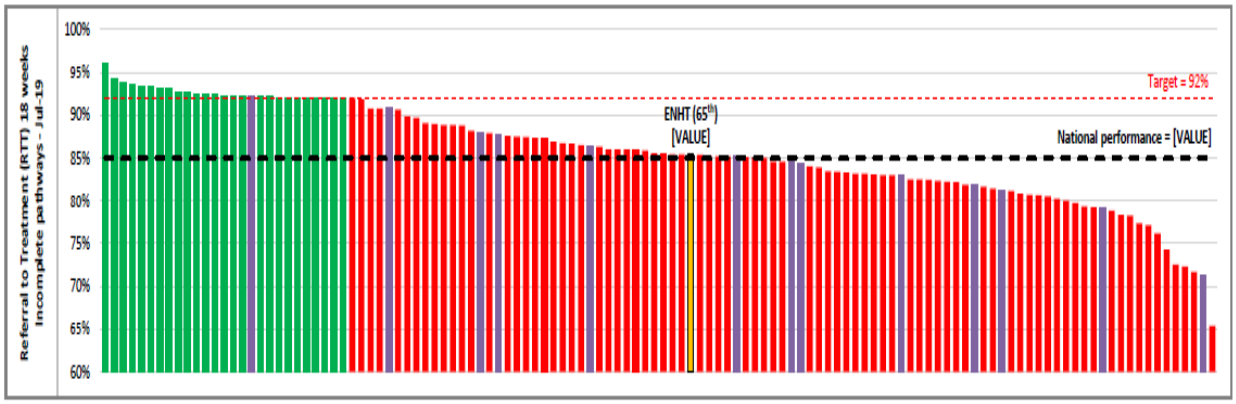
The delivery of the national cancer performance standards continues to be priority for the Trust in 2019/20. The Trust has worked with NHS Improvement during 2018/19the year to develop a cancer recovery business case for 2019/20.

Referral to treatment time (RTT) data became available in October 2018.

The 62 day referral to treatment standard for August (89.4 %) places the Trust (yellow bar in the chart below) above the 79.78% national average.



The 18 week RTT standard for August (85%) places the Trust (yellow bar in the chart above) same as the national average.



- Improve delivery of 7 days

Whilst hospitals function for 24 hours every day the level of services offered maybe different during the weekend. The NHS is moving towards offering the same level of service every day of the week. An assessment of current provision towards meeting the 7 day objectives using the Seven Day Hospital Services Board Assurance Framework has been undertaken. The results of the assessment against four standards are shown below.

Standard	Requirement	Outcome	2019/20
2	All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant within 14 hours of admission	44% for weekday admissions; 33% for weekend admissions	Not met
5	Inpatients must have scheduled 7 day access to diagnostic services	All diagnostic requirements have been met but with limited provision of MRI scanning which is restricted at the weekend to the diagnosis of spinal cord compression only	Met
6	Inpatients must have timely 24 hour access to key consultant-directed interventions	Interventions available, although interventional radiology is available on an ad hoc basis	Met
8	Patients with high dependency needs should be seen by a consultant twice daily; then daily once a clear plan of care is in place	100% compliance with twice daily review 89% compliance with daily consultant review (May 2019 data)	Not Met

The delivery of consistently high quality care to patients across the entire week has been a challenge for the Trust. Although there is no significant difference in mortality between those patients admitted at the weekend and during the week there is an observable trend.

Consultant review within 14 hrs of emergency admission is lower at the weekend and an area where we need to improve our performance. A new post of Associate Medical Director for
Reduction in Unwarranted Variation has been advertised with a portfolio to include consistent provision of services across the whole week.

Further details of compliance with the standards for specific services are shown below and more detail can be found on trust NHS 7 day services self-assessment.

7DS and Urgent Network Clinical Services

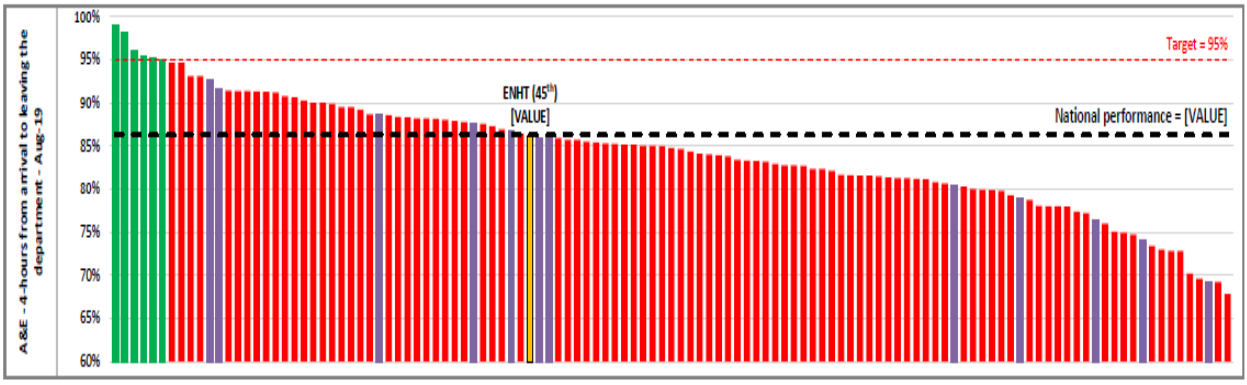
	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency

- Reduce delays in ED 4 hour waiting time

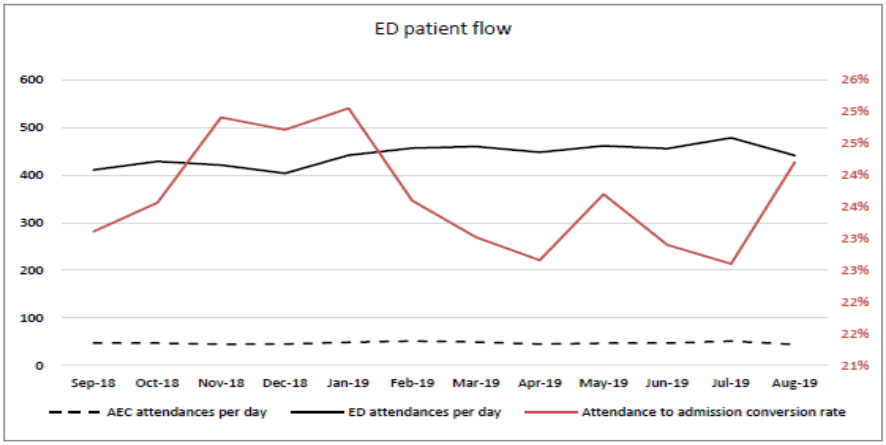
The trust ED performance in August was 86.11%. Improvement was achieved in both admitted and non-admitted performance. Admitted performance improved by > 13%. Improvement in the admitted performance was largely due to the level of flow.

2019/20	Performance
Q1	82%
Q2	85%

The achievement of the 4 hour wait has been variable throughout the year and the Trust delivered a 6 month performance of 85.0%, matching national average.



Approximately 400 patients attend the ED each day with 24% of them requiring in patient admission.



Priority four: Patient & Carer Experience

Reason: Quality goal within ENHT Quality Strategy is to improve the opportunities for our patient's voice to contribute to quality improvements.

We believe our patients and carers should have opportunities to provide real time feedback during their care. We shall support all staff to prioritise local goals in alignment with real time patient carer feedback.

The full measurement plan associated with the Quality Strategy is being finalised at the time of writing.

Monitoring: Patient Experience Committee

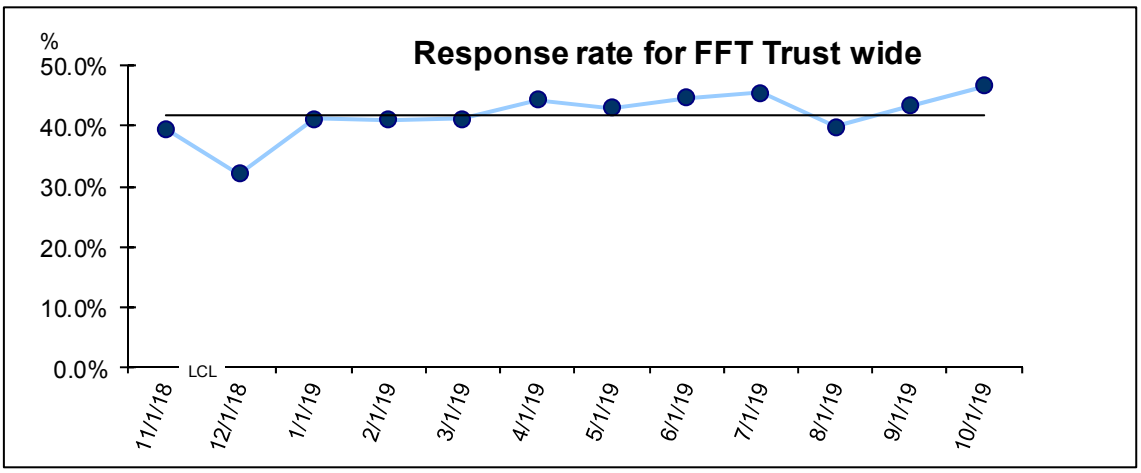
Reporting: Quarterly update to the Quality & Safety Committee

Responsible Director: Director of Nursing

	Theme	Measure	19/20
4.1	Patient feedback	Maintain Friends & Family Test scores (average) for in-patients, out-patients, maternity (birth) and emergency department	Maintain Aim 40%
4.2	'Always events'	Evaluate cancer team project	Capture lesson learnt
4.3	Improve partnership working with patients and carers within key Quality Strategy goals	Design and support patient co-design within planning, design and testing phases of quality improvement initiatives.	Ascertain organisational readiness and agree Trajectory

4.1The inpatient / day case percentage of patients who would recommend the Trust remains higher than the national average. The Trust's target is to maintain a response rate > or equal to 40%.

The chart below shows an average in patient repose rate is 41% over the past 12 months.



On 10 July 2019, NHS England formally announced that, following extensive consultation and research, there will be changes to the way that the Friends and Family Test (FFT) is carried out. These changes are expected to take effect from 1 April 2020.

A new universal mandatory question will be introduced, that has been tested with a broad range of people including children. The question will ask, in the context of each service,
'Overall, how was your experience of our service?' There will be six response options:

- Very good
- Good
- Neither good nor poor
- Poor
- Very poor
- Don't know

Revised guidance will be issued to trusts around September 2019. The requirement to ask at least one free text question, alongside the mandatory question, will not change. ENHT asks these two free text questions after the FFT:
 What was good about your stay/visit?
 What would have made your experience better?
Responses to these questions enable teams to focus on what they are doing well and areas where improvements can be made.

Regular updates will be provided to the Patient and Carer Experience Committee on implementation of the new patient feedback guidance.

The chart below demonstrates key divisional break down of FFT response rates.

FFT	Metric	Target	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Inpatients	Proportion of positive responses	95%	97.2%	97.5%	97.3%	96.8%	96.8%	96.7%	96.4%	96.9%	97.8%	96.9%	96.9%	96.3%
	Total number of responses	1,778	1,874	1,391	2,094	1,791	1,889	1,994	2,022	2,095	2,263	1,760	1,959	2,102
	Response rate	40%	39.5%	32.1%	41.2%	41.1%	41.3%	44.4%	43.0%	44.8%	45.4%	39.9%	43.4%	46.7%
A&E	Proportion of positive responses	90%	89.9%	85.2%	90.2%	90.9%	89.7%	92.5%	93.9%	92.7%	83.8%	94.0%	88.9%	90.0%
	Total number of responses	1,241	417	297	610	806	671	546	559	1,008	624	498	676	727
	Response rate	10%	3.0%	2.2%	4.4%	6.1%	4.6%	4.0%	3.9%	7.2%	4.1%	3.6%	4.7%	4.8%
Maternity	Antenatal care Proportion of positive responses	93%	100.0%	96.8%	92.5%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	92.3%	100.0%
	Birth Proportion of positive responses	93%	95.7%	94.1%	94.7%	98.1%	100.0%	96.1%	99.4%	97.3%	96.5%	92.9%	98.1%	95.6%
	Birth Total number of responses	137	139	135	132	157	71	128	159	74	115	98	106	135
	Birth Response rate	30%	30.3%	29.8%	30.2%	39.1%	16.3%	30.5%	34.6%	17.4%	24.5%	22.3%	23.7%	28.6%
	Postnatal ward Proportion of positive responses	93%	86.9%	83.3%	91.6%	91.7%	83.1%	87.4%	89.7%	86.5%	92.2%	88.8%	94.3%	84.4%
	Postnatal community Proportion of positive responses	93%	100.0%	94.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Outpatients	Proportion of positive responses	95%	93.6%	95.2%	94.1%	94.4%	95.5%	94.5%	96.2%	95.8%	95.4%	95.4%	94.5%	94.8%
	Total number of responses	-	1,982	1,683	2,037	2,281	5,320	1,980	4,100	3,943	3,613	3,313	2,448	3,127

Patient feedback

• The highest proportion of positive comments from inpatient / day case patients relate to staff, and the care and treatment provided. Negative comments relate to food, cleanliness, and delays before discharge and communication.

• 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 relates to waiting times, provision of food and temperature in waiting areas.

• Outpatients compliment staff for being kind and helpful 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 appointment letters, administration of 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 3 out of 98 women would not recommend the service. Women would like a quieter environment, better provision of recliner chairs and facilities for partners and an improved ward environment.

4.3 **Improve partnership working with patients and carers within key Quality Strategy goals**

There is an objective within the RCL Clinical leadership programme to actively gain patient involvement within approach to quality improvement projects. The quality improvement team are working closely with patient engagement to explore infrastructure to proactively involve patient e.g. consent form, role and responsibilities documents etc.

Learning From Your Experience - Examples of 'You Said – We Did' Actions

April – June 2019

Ward/Dept.	You Said	We Did
Pre-operative Assessment (POA)	Not having swabs.	Certain tests, e.g. swabs, ECG's, blood tests and BMI are necessary at pre-op assessment to prevent the patient from being cancelled prior to, or on the day of procedure.
Cardiac Suite	To have clear instructions on what can be eaten and drank prior to the procedure.	We try to provide patients with as much information as possible before their procedure so they are fully informed and know what to expect. We do this through information leaflets that are sent out in the post before the procedure and we also pre-assess patients in person or on the telephone before they come in.
Acute Cardiac Unit (ACU)	Better information on my health welfare, i.e. better updates on the condition of my health.	The nurses are always available to answer any queries you may have, and we also have a specialist cardiac rehab team who are available to give advice.
AMU Assessment	My room never got cleaned. A hot drink first thing in the morning.	The team has been reminded to be vigilant in keeping an eye on the cleanliness of patients' environment. The night team have been reminded to offer hot drinks to patients before their shift ends.
Consultant Led Unit	My elective caesarean section could have been improved regarding: Length of wait; processing of bloods; moving the date.	We have been working to improve the efficiency of our elective theatre list. The elective list has been adversely impacted by the number of bank holidays during April and May and this has meant that the same number of elective procedures have been performed in fewer days. As part of this work we have been improving the process for the pre-assessment clinic to reduce the chance of bloods not being ready. Unfortunately we do have to reschedule some electives; this is often because we are trying to fit in a woman with higher priority needs.
10AN	Unable to sleep well at night due to noise.	Earplugs are provided to all patients that require them to minimise the noises they hear at night. Please ask a member of staff if you need them.
10B	Staff are nice and caring but can take a little time to answer call bells at times.	We monitor our staffing levels continuously to make sure there are enough staff to care for the patients on the ward. Please talk to a member of staff if you have any concerns.

Ward/Dept.	You Said	We Did
9A	You wanted smaller meal portions. More staff to provide care on the ward.	Nutrition is a very important aspect of your care. It is hopeful that in the near future the ward will be moving over to a family style meal service, which will give us more control over portion size. The ward staff use the escalation processes in place if there are any pressures on staffing levels. The ward staff work to ensure that staffing pressures do not have any impact on patient safety or the care you receive. If you have any questions or concerns about your care, please talk to a member of our nursing team.
9B	More information from medical staff about what to expect.	This has been discussed in our clinical governance meeting. During ward rounds, doctors will be communicating with patients or their next of kin (NOK) regarding the plan of care and what to expect. Any change in patient's condition or plans must be communicated as soon as possible to the patient or their NOK.
8A	Cleaner bathrooms and shower.	An environmental audit, Matron's audit and weekly cleaning schedule are all in place to monitor the cleanliness on the ward.
6A	Long wait for prescriptions on discharge. Stuffy room, could have used a fan.	Potential discharges are identified the day before to facilitate early dispensing of medications. If a fan is not available, families are allowed to bring their own in for use, subject to PAT testing.
6B	Better support is needed for staff in terms of workload.	The ward staffing is reviewed three times daily. The senior nursing team also plan ahead to identify any shortfalls in staffing so that this can be addressed where possible. The Trust has introduced a "Rapid Response" system which enables additional staff support to be obtained at short notice.
Antenatal Clinic, Bancroft	Better seating layout.	For safety we cannot add any more seating to the waiting room. However, we now have two benches outside in our garden which can be utilised, weather permitting.
5B	You would like more food available and not someone else's choice from the previous day.	We have spoken to the catering department and the menu is to be updated soon. Housekeepers are reminded to ask patients that are newly admitted what they would like to eat, not to just give them someone else's choice of food.

PART 2.0 Quality Assurance

2.1 Participation in clinical audits 2019/20 6 month summary

Clinical Audit (CA) forms part of our NHS Standard Contract requirements as well as being part of the Care Quality Commission (CQC) Key Lines of Enquiry (KLOE). It is also one of the areas included within the Quality Account (QA) which, the Trust has a legislative requirement to submit annually, summarising the quality of their services, to the Secretary of State via publication on the NHS Choices Website. A robust CA programme is vital to ensure we continually strive to provide safer, more clinically effective and reliable care.

Year to date ENHT is participating in 64 (98%) of the 65 eligible QA national clinical audits and 8 (100%) of the 8 eligible QA national confidential enquiries. For a fourth year the trust was not able to participate in the National Ophthalmology Audit due to the lack of funds available to purchase & install the audit software.

A copy of the full report with a more in depth study of the clinical audit programme follows in Appendices 1 – 6.

KEY PERFORMANCE INDICATORS (KPI)

The Divisional Clinical Audit KPI Compliance is shown in the table below.

Division	KPI 1	KPI 2	KPI 3
Cancer Services	37%	-	66%
Clinical Support	50%	-	86%
Medicine	84%	100%	76%
Surgery	75%	100%	56%
Women's & Children's	88%	100%	83%
Trust & Nursing	97%	-	45%
TOTAL	**80%**	**100%**	**73%**

DEVELOPMENTS

- The number of clinical audits continues to rise with an 8 percentage increase on the previous half year.
- KPI 1 fell to 80% this half year which is 13 percentage points less than last half years 93%
- KPI 2 improved to 100% which is a 29 percentage point increase compared with last half year.
- KPI 3 showed a similar performance of 73% compared to the previous half year of 74%
- The number of completed audits year to date shows a similar performance compared with last year.
- 21% of outstanding audit actions have a risk rating as 'unknown'
- Clinical audits evidencing quality/improvement examples – appendix 6

CURRENT RISKS AND MITIGATION

Risk	Mitigation
Failure to participate in Mandatory audits may result in the Trust's failure to comply with legislative requirements	Improved monitoring and escalation process for the withdrawal/abandoning of mandatory audits
Delayed implementation of identified areas for improvement poses clinical risk	Improved monitoring of action plans and outcomes

CLINICAL AUDIT (CA) HALF YEAR SUMMARY REPORT

1. INTRODUCTION

This report gives the half year position regarding all registered Clinical Audit (CA) activity in 2019/20, with a comparison against the half year position in 2018/19 where appropriate.

All figures included in this report are based on specialty feedback received in the Clinical Audit & Effectiveness (CAE) Office, either direct from Audit Leads/Auditors, or via updated CA Status Reports and CA Forward Plans.

1. 2019/20 AUDIT ACTIVITY

This includes all audits contained in the 2019/20 Clinical Audit Forward Plan (CAFP), plus any extra 'In-year' projects that have been registered with the Clinical Audit and Effectiveness (CAE) Team during the year.

- **Total Forward Plan and 'In-year' Audits**

2019/20 - Forward Plan audits 360 (90%) 'In-year' audits 21 (10%) Total 381

2018/19 – Forward Plan audits 332 (94%) 'In-year' audits 22 (6%) Total 354

This year has seen an 8 percentage increase in the total number of registered audits compared to last year's half yearly report.

- **Audits included in the Clinical Audit Forward Plan**

- Of the 360 audits contained in the 2019/20 CAFP, 358 (99%) are Mandatory topics – either National/External or Trust and 2 (1%) are Specialty Interest topics.
- This shows a 4 percentage uplift in mandatory audits compared to the previous half year's report, where 314 (95%) of the total 332 audits were on National/External or Trust Mandatory topics and the remaining 18 (5%) audits were Specialty Interest.
- Year to date ENHT is participating in 68 (99%) of the 69 eligible QA national clinical audits and 8 (100%) of the 8 eligible QA national confidential enquiries. For a fourth year the trust was not able to participate in the National Ophthalmology Audit due to the lack of funds available to purchase & install the audit software. It is important to note that as the Quality Accounts forms part of our NHS Standard Contract, failure to participate could result in us incurring financial penalties imposed by our commissioners. A local audit using the national audit datasets could mitigate this risk.

- **'In year' Audits** (i.e. not included in the CAFP)

- Of the 21 'in-year' audits registered to date, 4 (19%) were on Mandatory topics and 17 (81%) were on Specialty Interest topics.
- This shows a 17 percentage point decrease in the number of Mandatory audits compared to last year's report 8 (36%) and a 17 percentage point increase in the number of Specialty Interest topics 14 (64%).

- **Audits Carried Forward from Previous Year**

6 (2%) audits were carried forward from the previous year, of which 4 (67%) have been completed. This shows a 4 percentage improvement in the number of audits brought forward compared to last half year's 19 (6%) with a similar percentage completed 13 (68%).

1 (17%) audit has been delayed whilst funding to purchase the equipment required for the Interventional Procedure was sourced. The monies have now been awarded from the charitable funds resulting in the audit being withdrawn and deferred until 2020/2021.

HALF YEAR POSITION FOR ALL 2019/20 AUDITS

Of the 381 audits registered 2 (1%) were withdrawn.

Of the remaining 379 registered audits there are:

- 46 (12%) continuous nursing audits, compared to 45 (12%) last half year. Nursing audits are not included in the remaining analysis in section 3 below as these audits progress are reported separately by the Nursing Directorate.

- To date 20 (5%) audits are completed* out of the total 333 audits with fixed completion dates. Although this is an increase of 1 audit on the previous half years 19 (12%) completed audits out of a total 156 audits. The 7 percentage point decrease is due to all annual/continuous audits now being included within these totals (with the exception of nursing audits) as some have completion due dates within the reporting period which has inflated the denominator.

  - National/External Priority Audits – 9/212 (4%) [0/37 (0%)]
  - Trust Priority Audits (inc NICE) – 0/102 (0%) [1/82 (1%)]
  - Specialty Interest Audits – 11/19 (58%) [18/32 (56%)]

  **It is important to note that audits are only recorded as completed once an Outcome Form and Audit Report/Presentation have been received.*

- 167 (50%) audits with fixed completion date are currently in progress, of which 156 (93%) are on schedule. Last half year 43 (28%) were in progress of which 31 (79%) were on schedule. The increase in the number of audits showing as 'in progress' is due to audits which are continuous/annual audits (with the exception of nursing audits) are now recorded as 'in progress' to enable closer monitoring of their progress.

- 1 (1%) in progress Mandatory audit is scheduled for completion after 31 March 2020.

- 146 (44%) audits with fixed completion dates are not started, of which 67 (46%) are behind schedule (past audit start date).

Abandoned Audits

0 (0%) audits have been abandoned this half year which is the same as last half year.

Withdrawn Audits

2 audits (0.5%) have been withdrawn for legitimate reasons compared to 1 (0.1%) in the previous half year. Full details are provided in Appendix 2.

Divisional Audit Activity and Progress for 2019/20

Priority Level/ Category	Total number of audits				Completed audits	Audits in progress	Audits not started	Abandoned audits	Continuous audits
	Total	*FP*[1]	*In-year*[2]	Final Total (i.e. excluding withdrawn audits)					
MANDATORY									
CORP[3]	8	8	-	**8**	3	5	-	-	-
CQUIN	14	14	-	**14**	-	14	-	-	-
National inc. QA[4]	88	87	1	**87**	3	41	43	-	-
NICE	1	1	-	**-**	-	-	-	-	-
Other National[5]	116	114	2	**116**	3	87	26	-	-
Trust	89	88	1	**89**	-	12	77	-	-
Nursing	46	46	-	**46**	-	-	-	-	46
Subtotal	***362***	***358***	***4***	***360***	***9***	***159***	***146***	-	***46***
NON-MANDATORY (Specialty Interest)									
Specialty	19	2	17	**19**	***11***	***8***	-	-	-
TOTALS	**381**	**360**	**21**	**379**	**20 (5%)**	**167 (44%)**	**146 (39%)**	**0 (0%)**	**46 (12%)**

Key
[1]FP = audits listed in 2019/20 Forward Plan (includes audits in progress carried forward from previous year);
[2]In-year = audits that emerge after publication of the 2019/20 Clinical Audit Forward Plan (CAFP)
[3]CORP = Confidential Outcome Review Programme
[4]QA = Quality Account,
[5]Other National - include audits commissioned by NHS England, CCG and other national bodies

MANDATORY AUDITS BY DIVISIONS

The ('n' =) figures quoted are the numbers of audits included in the Division's CA programme minus, where applicable, any that were withdrawn during the year. Last year's end of year combined figures are shown alongside in the blue boxes.

Cancer Services (n =19) *No withdrawn audits*

Completed	0	3 (16%)	19 (83%)
In progress	3 (16%)		
Not started	16 (84%)		
Abandoned	0		

Clinical Support Services (n=11) *No withdrawn audits*

Completed	0	6 (55%)	15 (94%)
In progress	6 (55%)		
Not started	5 (45%)		
Abandoned	0		

Medicine (n=107) *No withdrawn audits*

Completed	5 (4%)	56 (52%)	47 (52%)
In progress	51 (48%)		
Not started	51 (48%)		
Abandoned	0		

Surgery (n= 136) *2 audits withdrawn*

Completed	6 (5%)	81 (60%)	82 (70%)
In progress	75 (55%)		
Not started	55 (40%)		
Abandoned	0		

Women's and Children's Services (n=38) *No withdrawn audits*

Completed	8 (21%)	24 (63%)	16 (64%)
In progress	16 (42%)		
Not started	14 (37%)		
Abandoned	0		

Nursing & Trust (n=68) *No audits withdrawn*

Completed/Continuous	47 (69%)	63 (93%)	48 (94%)
In progress	16 (24%)		
Not started	5 (7%)		
Abandoned	0		

COMPLIANCE WITH CA KEY PERFORMANCE INDICATORS (KPIs)

Specialty	KPI 1 % of Mandatory Audits 'on schedule' (excluding withdrawn).		KPI 2 % of Outcome Forms and reports/ presentations returned to the CAE team, within 2 months of audit completion			KPI 3 % of audit actions completed or on schedule for any completed audits in 2016/17, 2017/18, 2018/19 & 2019/20	
	No of Mand audits	On schedule	No of eligible audits	Excl not yet due	No of docs received ≤2 months	No of Actions	No of Actions on schedule
Cancer Services	19	**7 (37%)**	-	-	-	41	**27 (66%)**
CSS	10	**5 (50%)**	1	-	-	93	**80 (86%)**
Medicine	106	**89 (84%)**	1	**1**	**1 (100%)**	59	**45 (76%)**
Surgery	127	**95 (75%)**	4	**3**	**3 (100%)**	172	**97 (56%)**
Women's & Children's	30	**26 (88%)**	3	**2**	**2 (100%)**	212	**175 (83%)**
Trust & Nursing	68	**66 (97%)**	-	-	-	11	**5 (45%)**
TOTALS	360	**288 (80%)**	9	**6**	**6 (100%)**	588	**429 (73%)**

Divisional KPI Compliance for 2019/20 compared to 2018/19

Division	2019/20			2018/19		
	KPI 1	KPI 2	KPI 3	KPI 1*	KPI 2⁞	KPI 3≈
Cancer Services	37%	-	66%	95%	0%	73%
Clinical Support	50%	-	86%	88%	0%	90%
Medicine	84%	100%	76%	89%	40%	62%
Surgery	75%	100%	56%	94%	76%	54%
Women's & Children's	88%	100%	83%	92%	87%	86%
Trust & Nursing	97%	-	45%	100%	33%	0%
TOTAL	**80%**	**100%**	**73%**	**93%**	**71%**	**74%**

*KPI 1 in 19/20 was KPI 2 in 18/19
⁞KPI 2 in 19/20 was KPI 3 in 18/19
≈KPI 3 in 19/20 was KPI 4 in 18/19

Clinical Audit actions 2019 - 2020

Specialty	Total actions	Actions Completed	Actions In Progress (on schedule)	Actions Not Started (on schedule)	Actions In Progress (behind schedule)	Actions Not Started (behind schedule)	Status Unknown
Cancer Services	-	-	-	-	-	-	-
Clinical Support Services	-	-	-	-	-	-	-
Medicine	1	1	-	-	-	-	-
Surgery	9	8	1	-	-	-	-
Women's & Children's	11	5	3	-	3	-	-
Trust & Nursing	6	-	5	-	1	-	-
TOTAL Division)	**27**	**14 (52%)**	**9 (33%)**	**-**	**4 (15%)**	**-**	**-**

Clinical Audit actions 2018 - 2019

Specialty	Total actions	Actions Completed	Actions In Progress (on schedule)	Actions Not Started (on schedule)	Actions In Progress (behind schedule)	Actions Not Started (behind schedule)	Status Unknown
Cancer Services	-	-	-	-	-	-	-
Clinical Support Services	5	-	-	-	5	-	-
Medicine	6	3	-	-	1	-	2
Surgery	34	8	3	-	16	6	1
Women's & Children's	51	27	4	-	20	-	-
Trust & Nursing	6	-	-	-	-	-	6
TOTAL Division)	**102**	**38 (37%)**	**7 (7%)**	**-**	**42 (41%)**	**6 (6%)**	**9 (9%)**

Clinical Audit actions 2017 - 2018

Specialty	Total actions	Actions Completed	Actions In Progress (on schedule)	Actions Not Started (on schedule)	Actions In Progress (behind schedule)	Actions Not Started (behind schedule)	Status Unknown
Cancer Services	22	7	1	-	8	5	1
Clinical Support Services	41	34	-	-	4	3	-
Medicine	13	5	-	-	6	2	-
Surgery	61	27	-	-	24	10	-
Women's & Children's	56	48	-	-	7	1	-
Trust & Nursing	-	-	-	-	-	-	-
TOTAL (Division)	**193**	**121 (63%)**	**1 (0.5%)**	**-**	**49 (25%)**	**21 (11%)**	**1 (0.5%)**

Clinical Audit actions 2016 – 2017

Specialty	Total actions	Actions Completed	Actions In Progress (on schedule)	Actions Not Started (on schedule)	Actions In Progress (behind schedule)	Actions Not Started (behind schedule)	Status Unknown
Cancer Services	19	19	-	-	-	-	-
Clinical Support Services	47	46	-	-	1	-	-
Medicine	39	36	-	-	3	-	-
Surgery	68	50	-	-	13	1	4
Women's & Children's	94	88	-	-	4	2	-
Trust & Nursing	-	-	-	-	-	-	-
TOTAL (Division)	**267**	**239 (90%)**	**-**	**-**	**21 (8%)**	**3 (1%)**	**4 (1%)**

CA PRIORITY GUIDANCE FOR 2019/20

In January 2019 the Healthcare Quality Improvement Partnership (HQIP) published their annual list of NCAPOP\QA audits. This list was used by the Clinical Audit and Effectiveness Team to produce the annual Trust CA Priority Guidance 2019/2020 which was agreed by specialties at their February RHD.

CAE TEAM ACHIEVEMENTS AND FUTURE PLANS

Achievements

- **Action Plans**

  The CAE team continues to monitor audit action plans and are reminding Specialties of the importance of adding audits to the Risk Register where the standards have not been met to ensure the risk is sighted and managed appropriately.

- **Audit Database**

  The Clinical Audit & Effectiveness Manager is working with the IT Team to identify a new method for automating the extraction of data from the Audit database to simplify and streamline the reporting of audit information and progress.

- **Monitoring of Quality Account (QA) audits**

  The CAE team has increased the monitoring and reporting of data submissions to the national QA audits. The Clinical Audit half year report included the QA progress summary.

- **CAE Team**
  This year has seen some significant changes within the CAE Team as a result of 1 secondment to the QI Team and 2 staff leaving to take up new roles within other Trusts. This has had a significant impact on the workload of the remaining team members whilst the recruitment and induction of new staff is underway. The Team should be back up to full complement by mid-November.
- **Clinical Audit Awareness Week (CAAW)**

  The CAE will be running 3 sessions in the Lister HUB during the November national CAAW, to help promote and advertise clinical audit within the Trust.

- **Quality Improvement (QI)**

  The CAE Manager continues to work with the Associate Director of Quality & Safety, Associate Director Leadership & Change, Head of Quality & Patient Safety and the Head of Quality Improvement to develop and implement the Trust's Quality Strategy which is designed to move towards a more holistic approach to prioritise quality across our clinical and non-clinical services.

Future Plans

The CAE team have some key objectives they want to achieve in the next year as follows;

- To work with the IT Team to design a method for automating the extraction of data from the Audit database to simplify and streamline the reporting of audit information and progress.
- To increase the understanding of the new staffs QI techniques/knowledge by attending a QI training session run by the new QI Team.

- To promote the purpose and benefits of Clinical Audit within the Trust in November's 2019 Clinical Audit Awareness Week (CAAW) with a presence in the Trust Hub over 3 sessions combined with articles in the daily news.

- Continue to raise importance of adding clinical audit related risks onto the DATIX Risk register.

- Continue to make use of the common themes from SI's, Risks, ACON's, claims and complaints to help inform the CAEQGG when agreeing Trust Mandatory Audits for the Clinical Audit Forward Plan.

ENHT NHS England Quality Accounts 2019/20 Participation as at September 2019

Year to date ENHT is participating in 64 (98%) of the 65 eligible QA national clinical audits and 8 (100%) of the 8 eligible QA national confidential enquiries. For a fourth year the trust was not able to participate in the National Ophthalmology Audit due to the lack of funds available to purchase & install the audit software.

National Clinical Audits	Eligible	Participating	Submissions to date (Sept 19)
Antibiotic Consumption - Reducing the impact of serious infections (anti-microbial resistance and sepsis)	Yes	Yes	TBC
Antimicrobial Stewardship - Reducing the impact of serious infections (anti-microbial resistance and sepsis)	Yes	Yes	TBC
Assessing Cognitive Impairment in Older People/Care in Emergency Departments	Yes	Yes	Not started yet, Cost to participate charged by RCEM
BAUS Urology Audits - Cystectomy BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	Yes	Yes	8 cases submitted
BAUS Urology Audits - Female Stress Urinary Incontinence Audit Female Stress Urinary Incontinence Audit BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	Yes	Yes	5 cases submitted
BAUS Urology Audits - Nephrectomy audit BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	Yes	Yes	20 cases submitted
BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL) BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	Yes	Yes	2 cases submitted
BAUS Urology Audits - Radical Prostatectomy Radical Prostatectomy Audit BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	Yes	Yes	38 cases submitted
Care of Children in Emergency Departments	Yes	Yes	Not started yet, Cost to participate charged by RCEM
Case Mix Programe (CMP)	Yes	Yes	0 cases submitted so far
Elective Surgery (National PROMs Programme) PROMs operates a continuous collection model	Yes	Yes	TBC
Endocrine and Thyroid National Audit BAETS operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	Yes	Yes	TBC
Falls and Fragility Fractures Audit programme (FFFAP) - National Audit of Inpatient Falls	Yes	Yes	2 records submitted
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database	Yes	Yes	36 cases submitted for August
Inflammatory Bowel Disease (IBD) Registry Biological Therapies Audit	Yes	Yes	180 cases submitted
Major Trauma Audit	Yes	Yes	Data submitted to TARN on 29/08/19
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	Yes	Yes	Not collected data
Mental Health - Care in Emergency Departments	Yes	Yes	Not started yet, Cost to participate charged by RCEM

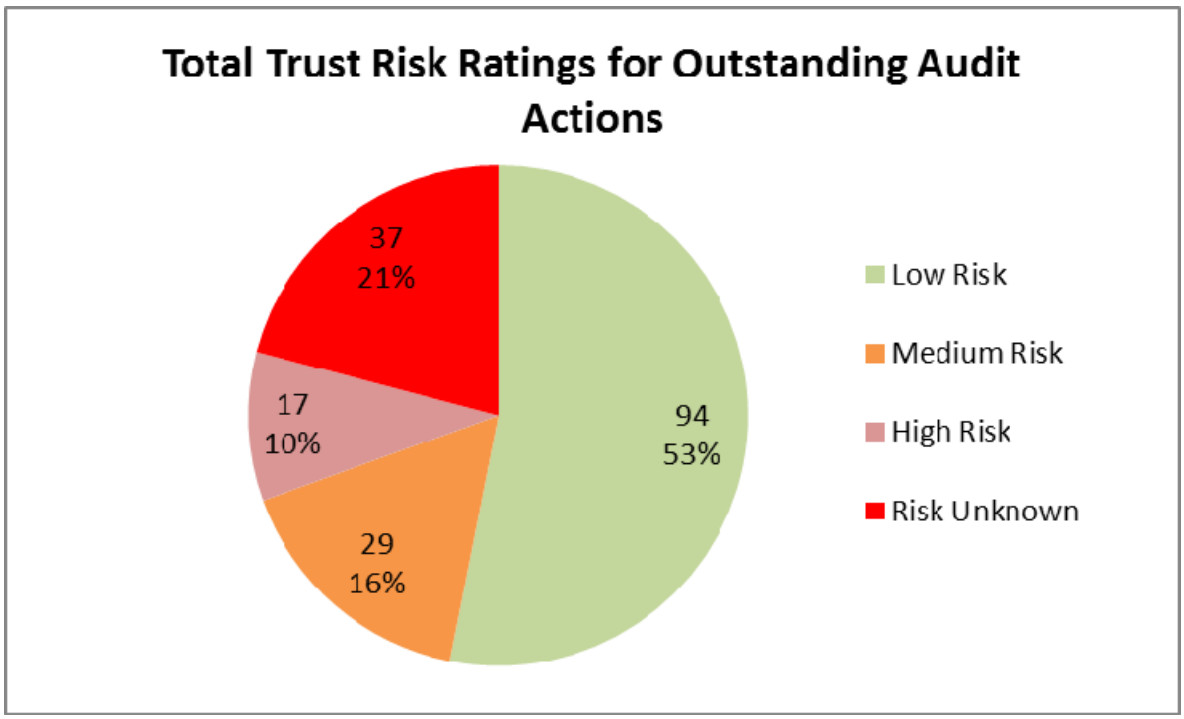
National Clinical Audits	Eligible	Participating	Submissions to date (August 19)
Mental Health care Pathway – CYP Urgent & Emergency Care and Intensive Community Support	No	No	NA
Mental Health Clinical Outcome Review Programme	No	No	NA
National Adult Community Acquired Pneumonia (BTS)	Yes	Yes	60 cases submitted (1 organisational)
National Asthma and COPD Audit Programme (NACAP) - COPD Secondary Care	Yes	Yes	52 cases submitted
National Asthma and COPD Audit Programme (NACAP) - Asthma adult in secondary care	Yes	Yes	0 cases submitted
National Asthma and COPD Audit Programme (NACAP) - Paediatric asthma in secondary care	Yes	Yes	TBC
National Audit of Breast Cancer in Older People (NABCOP)	Yes	Yes	TBC
National Audit of Cardiac Rehabilitation	Yes	Yes	TBC
National Audit of Care at the End of Life (NACEL)	Yes	Yes	TBC
National Audit of Dementia (in General Hospitals)	Yes	No	Not participating as only for Trusts with e- prescribing
National Audit of Pulmonary Hypertension (NAPH)	No	No	NA
National Audit of Seizure Management in Hospitals (NASH 3)	Yes	Yes	30 cases submitted
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	Yes	TBC
National Bariatric Surgery Registry (NBSR)	No	No	NA
National Cardiac Arrest Audit (NCAA)	Yes	Yes	TBC
National Cardiac Audit Programme (NCAP) Cardiac Rhythm Management (CRM)	Yes	Yes	TBC
National Cardiac Audit Programme (NCAP) Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	TBC
National Cardiac Audit Programme (NCAP) National Heart Failure Audit	Yes	Yes	76.50%
National Cardiac Audit Programme Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	Yes	TBC
National Clinical Audit of Anxiety and Depression	No	No	NA
National Clinical Audit of Psychosis	No	No	NA
National Diabetes Audit - Adults - National Core Diabetes Audit	Yes	Yes	TBC
National Diabetes Audit - Adults - National Diabetes Inpatient Audit (NaDia)	Yes	Yes	0 cases submitted
National Diabetes Audit - Adults - National Pregnancy in Diabetes Audit	Yes	Yes	TBC
National Diabetes Audit - Adults -National Diabetes Foot Care Audit	Yes	Yes	9 cases submitted
National Diabetes Audit - Adults - NaDIA-Harms - reporting on diabetic inpatient harms in England	Yes	Yes	TBC
National Early Inflammatory Arthritis (NEIAA)	Yes	Yes	37% cases submitted
National Emergency Laparotomy Audit (NELA)	Yes	Yes	93 cases submitted
National Gastro-intestinal Cancer Programme (NGCAP) National Bowel Cancer (NBOCA)	Yes	Yes	TBC
National Gastro-Intestinal Cancer Programme (NGCAP) National Oesophago-gastric Cancer (NAOGC)	Yes	Yes	TBC
National Joint Registry (NJR) - Ankles	Yes	Yes	2 cases submitted

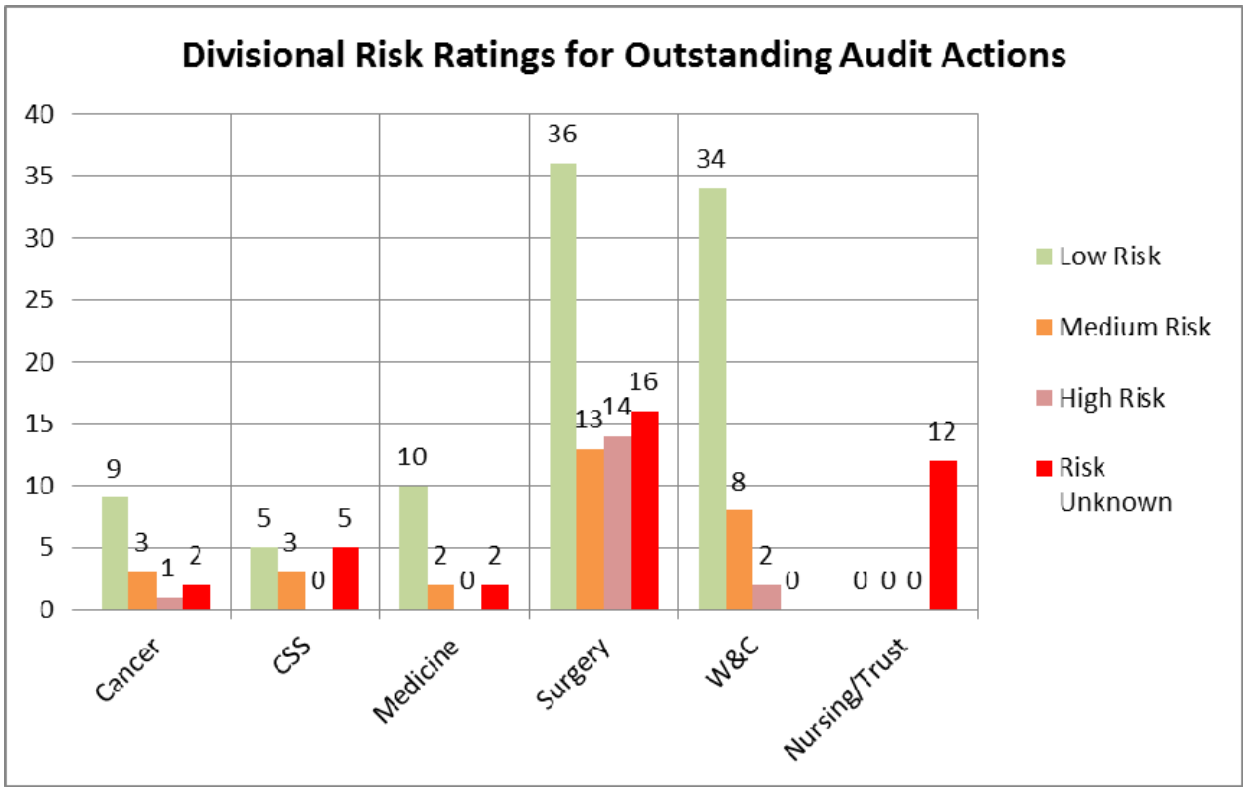
National Clinical Audits	Eligible	Participating	Submissions to date (August 19)
National Joint Registry (NJR) - Elbows	Yes	Yes	7 cases submitted
National Joint Registry (NJR) - Hips	Yes	Yes	270 cases submitted
National Joint Registry (NJR) - Knees	Yes	Yes	218 cases submitted
National Joint Registry (NJR) - Shoulders	Yes	Yes	39 cases submitted
National Lung Cancer Audit (NLCA)	Yes	Yes	TBC
National Maternity and Perinatal Audit (NMPA)	Yes	Yes	TBC
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	Yes	TBC
National Ophthalmology Audit - Adult Cataract surgery	Yes	**No**	Audit withdrawn, to carry out their own internal audit
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	TBC
National Prostate Cancer Audit	Yes	Yes	TBC
National Smoking Cessation Audit	Yes	Yes	0 Data submitted
National Vascular Registry - Carotid endarterectomy	Yes	Yes	12 cases submitted
National Vascular Registry - Lower limb angioplasty/stenting	Yes	Yes	8 cases submitted
National Vascular Registry - Lower limb bypass	Yes	Yes	3 cases submitted
National Vascular Registry - Major lower limb amputation	Yes	Yes	5 cases submitted
National Vascular Registry - Repair of abdominal aortic aneurysm (both elective and emergency)	Yes	Yes	4 cases submitted
Neurosurgical National Audit Programme	No	No	NA
Paediatric Intensive Care Audit Network (PICANet)	No	No	NA
Perioperative Quality Improvement Programme (PQIP)	Yes	Yes	179 patients
Prescribing Observatory for Mental Health (POMH-UK)	No	No	NA
Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	0 cases submitted
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	Yes	0 cases submitted
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes	Yes	0 cases submitted
Surgical Site Infection Surveillance Service	Yes	Yes	Not collected data
UK Cystic Fibrosis Registry	No	No	NA
UK Parkinson's Audit	Yes	Yes	8 cases submitted to date

National Confidential Enquiries	Eligible	Participating	% Cases submitted
Child Health Clinical Outcome Review Programme - Long-term ventilation in children, young people and young adults	Yes	Yes	7 (100%)
Clinical Outcome Review Programme - Out of Hospital Cardiac Arrest	Yes	Yes	5 (83%)
Clinical Outcome Review Programme - Dysphagia in Parkinson's Disease	Yes	Yes	2 (50%)
Clinical Outcome Review Programme - Acute Bowel Obstruction Audit	Yes	Yes	6 (100%)
Child Health Clinical Outcome Review Programme – Long Term Ventilation	Yes	Yes	TBC
Maternal, New-born and Infant Clinical Outcome Review Programme – Perinatal Mortality and Morbidity	Yes	Yes	1 case
Maternal, New-born and Infant Clinical Outcome Review Programme – Maternal morbidity confidential enquiries	Yes	No cases to submit this year	
Maternal, New-born and Infant Clinical Outcome Review Programme – Maternal Mortality surveillance and mortality confidential enquiries	Yes	No cases to submit this year	
Maternal, New-born and Infant Clinical Outcome Review Programme – Perinatal Mortality Surveillance	Yes	Yes	13 cases

Completed Clinical Audit's and Relevant Risks Identified

The chart below shows the current risk ratings for all uncompleted audit actions for 16/17, 17/18, 18/19 & 19/20. Specialties should add a DATIX risk register entry for all audits that are either partially/non-compliant. The risk should be rated at the level carried by the highest rated outstanding action.

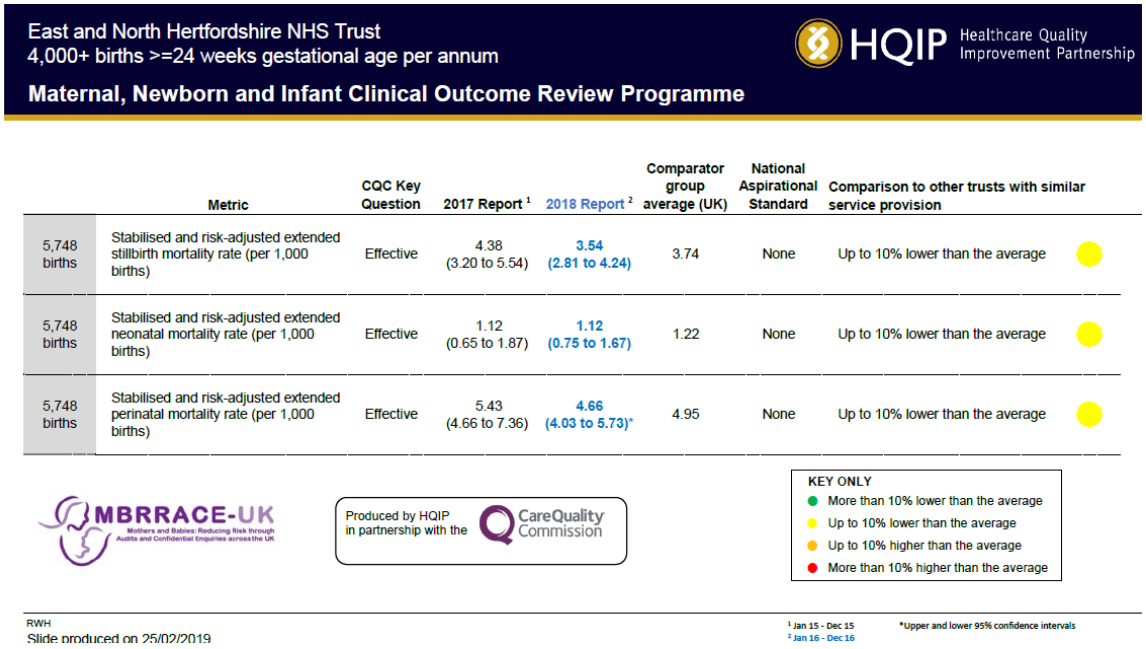




HQIP Clinical Audit Benchmarking Tool

National Clinical Audit Benchmarking Results (NCAB)

NCAB is an initiative originally created in collaboration between HQIP and CQC, with a vision to enhance the way medical directors, local clinical audit teams and others engage, interact with and share clinical audit data. NCAB provides a visual snapshot of individual Trust audit data set against individual national benchmarks.



East and North Hertfordshire NHS Trust
4,000+ births >=24 weeks gestational age per annum
Maternal, Newborn and Infant Clinical Outcome Review Programme

HQIP Healthcare Quality Improvement Partnership

	Metric	CQC Key Question	2017 Report [1]	2018 Report [2]	Comparator group average (UK)	National Aspirational Standard	Comparison to other trusts with similar service provision
5,748 births	Stabilised and risk-adjusted extended stillbirth mortality rate (per 1,000 births)	Effective	4.38 (3.20 to 5.54)	3.54 (2.81 to 4.24)	3.74	None	Up to 10% lower than the average
5,748 births	Stabilised and risk-adjusted extended neonatal mortality rate (per 1,000 births)	Effective	1.12 (0.65 to 1.87)	1.12 (0.75 to 1.67)	1.22	None	Up to 10% lower than the average
5,748 births	Stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births)	Effective	5.43 (4.66 to 7.36)	4.66 (4.03 to 5.73)*	4.95	None	Up to 10% lower than the average

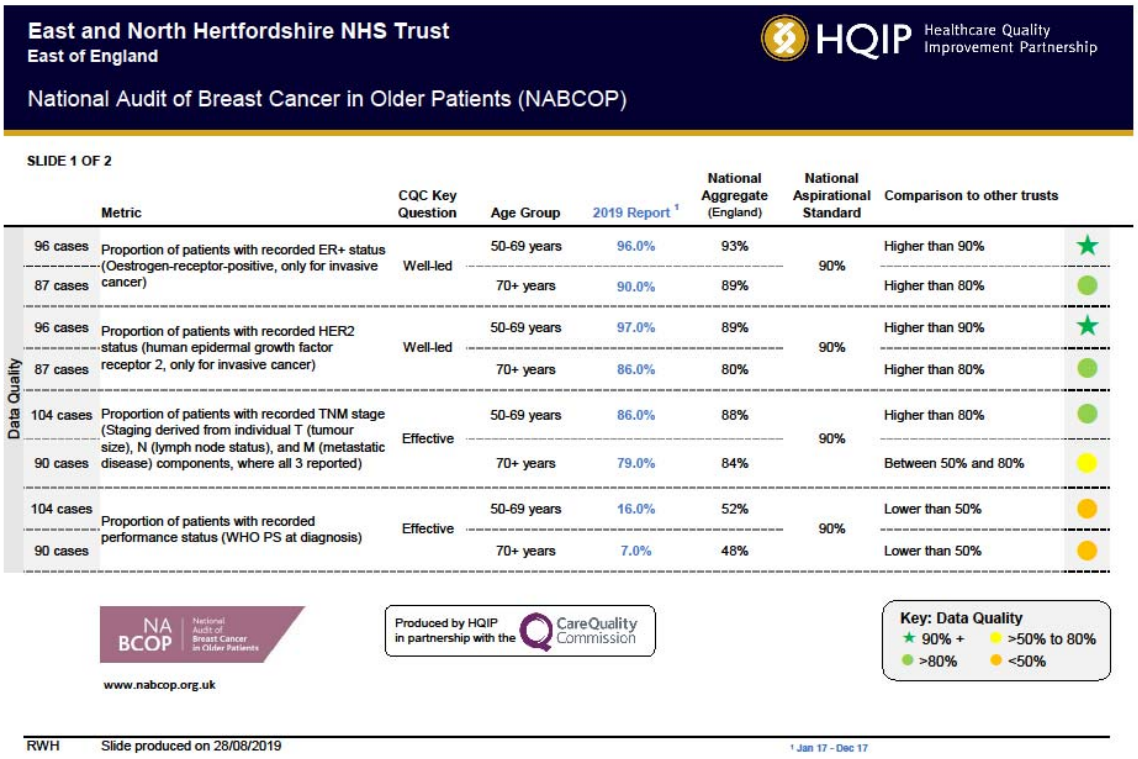
MBRRACE-UK Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

Produced by HQIP in partnership with the CareQuality Commission

KEY ONLY
- More than 10% lower than the average
- Up to 10% lower than the average
- Up to 10% higher than the average
- More than 10% higher than the average

RWH
Slide produced on 25/02/2019

[1] Jan 15 - Dec 15
[2] Jan 16 - Dec 16
*Upper and lower 95% confidence intervals



East and North Hertfordshire NHS Trust
East of England
National Audit of Breast Cancer in Older Patients (NABCOP)

HQIP Healthcare Quality Improvement Partnership

SLIDE 1 OF 2

		Metric	CQC Key Question	Age Group	2019 Report [1]	National Aggregate (England)	National Aspirational Standard	Comparison to other trusts
Data Quality	96 cases	Proportion of patients with recorded ER+ status (Oestrogen-receptor-positive, only for invasive cancer)	Well-led	50-69 years	96.0%	93%	90%	Higher than 90%
	87 cases			70+ years	90.0%	89%		Higher than 80%
	96 cases	Proportion of patients with recorded HER2 status (human epidermal growth factor receptor 2, only for invasive cancer)	Well-led	50-69 years	97.0%	89%	90%	Higher than 90%
	87 cases			70+ years	86.0%	80%		Higher than 80%
	104 cases	Proportion of patients with recorded TNM stage (Staging derived from individual T (tumour size), N (lymph node status), and M (metastatic disease) components, where all 3 reported)	Effective	50-69 years	86.0%	88%	90%	Higher than 80%
	90 cases			70+ years	79.0%	84%		Between 50% and 80%
	104 cases	Proportion of patients with recorded performance status (WHO PS at diagnosis)	Effective	50-69 years	16.0%	52%	90%	Lower than 50%
	90 cases			70+ years	7.0%	48%		Lower than 50%

NABCOP National Audit of Breast Cancer in Older Patients
www.nabcop.org.uk

Produced by HQIP in partnership with the CareQuality Commission

Key: Data Quality
★ 90% + ● >80% ● >50% to 80% ● <50%

RWH Slide produced on 28/08/2019

[1] Jan 17 - Dec 17

EAST AND NORTH HERTFORDSHIRE NHS TRUST
Bowel Cancer Audit

HQIP Healthcare Quality Improvement Partnership

	Metric	CQC Key Question	2016 Report	2017 Report	National Aggregate (England & Wales)	National Aspirational Standard	Comparison to other hospitals
254 admissions	Case Ascertainment	Well Led	80% [1]	106% [1]	95%	None	Good (over 80%)
N/A	Risk-adjusted post-operative length of stay after major resection >5days	Responsive	83.1% [1]	N/A [1]	69.5%	None	N/A
86 admissions	Risk-adjusted 90-day post-operative mortality rate	Effective	3.0% [1]	0.0% [1]	3.2%	None	0 — 20 Within expected range
110 admissions	Risk-adjusted 2-year post-operative mortality rate	Effective	17.9% [2]	20.5% [2]	19.5%	None	0 — 55 Within expected range
N/A	Risk-adjusted 30-day unplanned readmission rate	Effective	10.9% [1]	N/A [1]	9.9%*	None	0 — 30
70 admissions	Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection	Effective	59% [3]	60% [3]	52%*	None	0 — 90 Within expected range

National Bowel Cancer Audit

Produced by HQIP in partnership with the CareQuality Commission

http://content.digital.nhs.uk/bowel

KEY ONLY

Positive outlier (below 99.8% Control Limit) | Within expected range | Negative outlier Trust (above 99.8% CL)

Better than expected (Below 95% CL) | Worse than expected (above 95% CL)

Display of performance boundaries does vary depending on volume of activity. See FAQs for further information.

NOTES: No 30d readmission or LOS risk adjusted analysis because >80% of patients are missing ASA grade and/or TNM stage and/or overall data completeness was <80%

East and North Hertfordshire NHS Trust
Lung Cancer Audit

HQIP Healthcare Quality Improvement Partnership

	Metric	CQC Key Question	2017 Report [1]	2018 Report [2]	National Aggregate (England & Wales)	National Aspirational Standard	Comparison to other trusts
All patients 246 cases	Crude proportion of patients seen by a Cancer Nurse Specialist	Responsive	63.80%	64.6%	TBC	90%*	Does not meet the national minimum standard of 90%
	Case mix adjusted one year relative survival rate	Effective	39.10% Within the expected range	36.6%	36.7%	None	Within the expected range
NSCLC 246 cases	Case mix adjusted percentage of patients with Non Small Cell Lung Cancer (NSCLC) receiving surgery	Effective	15.3% Within the expected range	17.5%	18.4%	17%*	Within the expected range
NSCLC 246 cases	Case mix adjusted percentage of fit patients with advanced Non Small Cell Lung Cancer (NSCLC) receiving Systemic Anti-Cancer Treatment	Effective	55.1% Within the expected range	67.4%	65.1%	65%*	Within the expected range
SCLC 23 cases	Case mix adjusted percentage of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy	Effective	69.2% Within the expected range	67.9%	70.7%	70%*	Within the expected range

Royal College of Physicians | National Lung Cancer Audit

www.rcplondon.ac.uk/NLCA

Produced by HQIP in partnership with the CareQuality Commission

All trusts in England participate in the audit, and data is submitted for approximately 100% of patients. Case ascertainment is therefore not presented separately.

Absolute values will not always be directly comparable due to differences in confidence intervals.

RWH

Slide produced on 09/07/2019

[1] Jan 16 - Dec 16
[2] Jan 17 - Dec 17

*Audit standard based on NICE guidance. General expectation of performance rather than aspirational standard.

East and North Hertfordshire NHS Trust
East of England
Oesophago-gastric Cancer Audit

HQIP Healthcare Quality Improvement Partnership

		Metric	CQC Key Question	2017 Report [1]	2018 Report [2]	National Aggregate (England & Wales)	National Aspirational Standard	Comparative performance
Trust-level metrics	135 cases	Case Ascertainment All eligible patients	Well led	81 to 90	81 to 90	79.1%*	None	Green - greater than 80%
	135 cases	Age and sex adjusted proportion of patients diagnosed after an emergency admission	Effective	14.2%	12.4%	13.3%	None	Less than 15%
	Not eligible	Risk-adjusted 90-day post-operative mortality rate	Effective	Not reported	Not reported	3.2%	None	0 Not applicable 15
Strategic Clinical Network-level metrics	2224 cases	Crude proportion of patients treated with curative intent in the **Strategic Clinical Network**	Effective	33.8%	37.7%	38.6%	None	Lower than 95%

National Oesophago-Gastric Cancer Audit

Produced by HQIP in partnership with the CareQuality Commission

KEY ONLY:

Display of performance boundaries does vary depending on volume of activity. See FAQs for further information.

Adjusted emergency
- Less than 15%
- Between 15% and 20%
- Higher than 20%

RWH
Slide produced on 05/04/2019

[1] Apr 13- Mar 15
[2] Apr 15- Mar 17
* England only

East and North Hertfordshire NHS Trust
National Ophthalmology Database Audit

HQIP Healthcare Quality Improvement Partnership

Metric	CQC Key Question	2018 Report[2]	2019 Report[1]	National Aggregate (England & Wales)	National Aspirational Standard	Comparison to other units
Case ascertainment	Well Led	Insufficient data supplied	Insufficient data supplied	N/A	None	
Risk-adjusted posterior capsule rupture rate	Effective	Insufficient data supplied	Insufficient data supplied	1.1%[3]	None	0% 2.1% Insufficient data supplied
Risk-adjusted Visual Acuity Loss	Effective	Insufficient data supplied	Insufficient data supplied	0.9%[3]	None	0% 1.5% Insufficient data supplied

NOTES:
Not Signed up or declined to participate in the audit.

The ROYAL COLLEGE of OPHTHALMOLOGISTS | NOD NATIONAL OPHTHALMOLOGY DATABASE AUDIT

www.nodaudit.org.uk

Produced by HQIP in partnership with CareQuality Commission

KEY ONLY

Display of performance boundaries does vary depending on volume of activity. See FAQs for further information.

RWH Slide produced on 26/09/2019

1 Sep 17 - Aug 18
2 Sep 16 - Aug 17
3 Based on operations at 34 centres between April 2011 and March 2015

East and North Hertfordshire NHS Trust

Trust-wide audit

Paediatric Diabetes Audit

HQIP Healthcare Quality Improvement Partnership

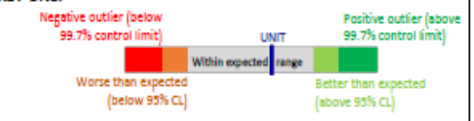
		Metric	CQC Key Question	2015/16 Report[1]	2016/17 Report[2]	National Aggregate (England & Wales)	National Aspirational Standard	Comparison to other units
	N/A	Case ascertainment	Well Led	Not reported for this audit			N/A	N/A
Process measures	125 cases	Crude proportion of patients 12+ receiving all key care processes annually	Effective	Not reported	82.97%	84.01%	N/A	47.5% – 99.6% Within Expected Range
Blood glucose diabetes control (HbA1c)	249 cases	**Organisation compared with nationally:** Case-mix adjusted mean HbA1c (mmol/mol)	Effective	Not outlier	65.16	67.30	N/A	54.0 – 75.6 Better Than Expected
	252 cases	**Organisational performance compared between years:** Median HbA1c (mmol/mol)	Effective	62.30	61.48	64.00	N/A	This metric is provided to compare year on year changes within the unit rather than comparison with national figures.
			A change of more than 1 mmol/mol is deemed by the audit body to be indicative of a clinically significant change.					No Significant Change

NPDA National Paediatric Diabetes Audit

HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time. Higher values indicate poorer control.

Produced by HQIP in partnership with the Care Quality Commission

KEY ONLY



Display of performance boundaries does vary depending on volume of activity. See FAQs for further information.

RWHX Slide produced on 24/10/2018

1 Apr 15 - Mar 16
2 Apr 16 - Mar 17

East and North Hertfordshire NHS Trust

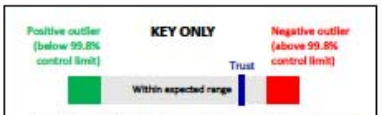
National Prostate Cancer Audit

HQIP Healthcare Quality Improvement Partnership

		Metric	CQC Key Question	2017 Report*	2018 Report*	National Aggregate (UK)	National Aspirational Standard	Comparison to other hospitals
Part of specialist MDT	902 cases	Men with complete information to determine disease status	Well Led	89.9% [3]	94.9% [1]	93.5%	93%	
Centre-level	154 cases	Percentage of patients who had an emergency readmission within 90 days of radical prostatectomy	Effective	1.73% [3]	12.2% [1]	13.2%	N/A	4.8 – 29.8 Within expected range
	86 cases	Percentage of patients experiencing a severe urinary complication requiring intervention following radical prostatectomy	Effective	8.0% [4]	12.5% [2]	11.4%	N/A	0 – 28.1 Within expected range
	382 cases	Percentage of patients experiencing a severe gastrointestinal complication requiring an intervention following external beam radiotherapy	Effective	10.9% [4]	8.3% [2]	9.9%	N/A	0 – 25.1 Within expected range

NOTES: Data is submitted for approximately 100% of patients. Case ascertainment is therefore not presented separately.

KEY ONLY



Display of performance boundaries does vary depending on volume of activity. See FAQs for further information.

NPCA National Prostate Cancer Audit
www.npca.org.uk

Produced by HQIP in partnership with the Care Quality Commission

RWH
Slide produced on 20/03/2019

* Please note figures published in the annual report are rounded to nearest whole number and so may not match exactly

[1] Apr 16 - Mar 17
[2] Jan 15 - Dec 16
[3] Apr 15 - Mar 16
[4] Apr 14 - Mar 15

East and North Hertfordshire NHS Trust
National Vascular Registry

HQIP Healthcare Quality Improvement Partnership

		Metric	CQC Key Question	2017 Report	2018 Report	National Aggregate (UK)	National Aspirational Standard	Comparison to other hospitals
Abdominal Aortic Aneurysm	26 cases	Case Ascertainment	Well Led	112% [1]	90% [3]	90%	90%	Better than audit standard
		Risk-adjusted post-operative in-hospital mortality rate	Effective	0.0% [2]	0.0% [4]	1.3%	None	0 — 14.8 Within expected range
Carotid Endarterectomy	44 cases	Case Ascertainment All eligible patients	Well Led	85% [1]	85% [3]	90%	90%	Worse than audit standard
		Crude median time from symptom to surgery	Responsive	5 days [1]	5 days [3]	14 days	14 days*	Better than the national aspirational standard
		Risk-adjusted 30-day mortality and stroke rate	Effective	2.2% [2]	3.3% [4]	2.1%	None	0 — 19.8 Within expected range

VSQIP Vascular Services Quality Improvement Programme
www.vsqip.org.uk

Produced by HQIP in partnership with the Care Quality Commission

KEY ONLY
Positive outlier (below 99.8% control limit) | Trust | Negative outlier (above 99.8% control limit)
Within expected range
Display of performance boundaries does vary depending on volume of activity. See FAQs for further information.

RWH
Slide produced on 14/01/2019

[1] Jan 16 - Dec 16 [3] Jan 17 - Dec 17 * NICE guideline
[2] Jan 14 - Dec 16 [4] Jan 15 - Dec 17

Lister Hospital
East and North Hertfordshire NHS Trust
Chronic Obstructive Pulmonary Disease Audit

HQIP Healthcare Quality Improvement Partnership

	Metric	CQC Key Question	Oct 2018 and Mar 2019	National Aggregate (England & Wales)	National Aspirational Standard	Comparison to other hospitals	
441 Cases	Case ascertainment	Well-led	Not yet available	Not yet available			
441 Cases	Percentage of patients seen by a member of the respiratory team within 24hrs of admission	Responsive	83.70%	59.5%	60.0%*	Better than national aggregate	▲
384 Cases	Percentage of patients receiving oxygen in which this was prescribed to a stipulated target oxygen saturation (SpO2) range (of 88-92% or 94-98%)	Effective	100.00%	99.3%	100.0%†	Better than national aggregate	▲
30 Cases	Percentage of patients receiving non invasive ventilation (NIV) within the first 24 hours of arrival who do so within 3 hours of arrival	Effective	36.70%	23.1%	31.9%†	Better than national aggregate	▲
113 Cases	Percentage of documented current smokers prescribed smoking-cessation pharmacotherapy	Responsive	60.20%	50.0%	63.6%†	Better than national aggregate	▲
441 Cases	Percentage of patients for whom a British Thoracic Society, or equivalent, discharge bundle was completed for the admission	Responsive	94.60%	77.1%	60.0%*	Better than national aggregate	▲
441 Cases	Percentage of patients with spirometry confirming FEV1/FVC ratio <0.7 recorded in case file	Effective	46.50%	44.4%	60.3%†	Better than national aggregate	▲

Royal College of Physicians
www.rcplondon.ac.uk/projects/national-copd-audit-programme-2013-18

Produced by HQIP in partnership with the Care Quality Commission

RWH01 Slide produced on 10/06/2019

* Best Practice Tariff; † Upper quartile

Lister Hospital
Emergency Laparotomy Audit

HQIP Healthcare Quality Improvement Partnership

		Metric	CQC Key Question	Year 3[1]	Year 4[2]	National Aggregate (England & Wales)	National Standard	Comparison to other hospitals
Proportion of patients for which each process of care was met	165 cases	Case Ascertainment	Well Led	70%	100.0%	82.7%	85%	Higher than 85% ▲
	165 cases	Crude proportion of cases with pre-operative documentation of risk of death	Effective	93%	33.9%	74.6%	85%	Less than 55% ●
	28 cases	Crude proportion of cases with access to theatres within clinically appropriate time frames	Effective	83%	96.4%	82.0%	85%	Higher than 85% ▲
	67 cases	Crude proportion of high-risk cases (≥5% predicted mortality) with consultant surgeon and anaesthetist present in theatre	Effective	63%	73.1%	82.5%	85%	Between 55% and 85% ■
	34 cases	Crude proportion of highest-risk cases (>10% predicted mortality) admitted to critical care post-operatively	Responsive	67%	82.4%	86.8%	85%	Between 55% and 85% ■
	165 cases	Risk adjusted 30-day mortality	Effective	14.5%	13.2%	9.5%	None	Within Expected Range

NELA www.nela.org.uk

Produced by HQIP in partnership with the CareQuality Commission

KEY ONLY

Positive outlier (below 99.8% Control Limit) | Unit | Negative outlier (above 99.8% CL)

Within expected range

Better than expected (Below 95% CL) | Worse than expected (above 95% CL)

Display of performance boundaries does vary depending on volume of activity. See FAQs for further information.

RWH01
Slide produced on 25/01/2019

[1] Dec 15 - Nov 16
[2] Dec 16 - Nov 17

* England only

NELA produces quarterly reports to give the most up to date data
https://data.nela.org.uk/Reports/Hospital-reports.aspx

Lister Hospital
East and North Hertfordshire NHS Trust

Heart Failure Audit

HQIP Healthcare Quality Improvement Partnership

	Metric	CQC Key Question	2018 Report[1]	2019 Report[2]	National Aggregate (England & Wales)	National Standard	Comparison to other hospitals
612 Cases	Case ascertainment	Well-led	84.9%	80.0%	76.0%*	N/A	Better than national aggregate
455 Cases	Crude proportion of inpatients admitted with Heart Failure (HF) who receive input from the specialist team	Effective	82.7%	88.9%	82.0%	100%**	Better than national aggregate
455 Cases	Crude proportion of inpatients admitted with HF who receive cardiology follow up	Effective	42.5%	53.7%	56.7%	90%***	Worse than national aggregate
455 Cases	Crude proportion of patients with HF with reduced fraction who are discharged from hospital on: an ACEI/ARB	Effective	96.4%	87.6%	83.8%	80%***	Better than national aggregate
455 Cases	Crude proportion of patients with HF with reduced fraction who are discharged from hospital on: Beta-blocker	Effective	95.6%	94.7%	89.3%	80%***	Better than national aggregate
455 Cases	Crude proportion of patients with HF with reduced fraction who are discharged from hospital on: Mineralocorticoid receptor antagonist (MRA)	Effective	38.3%	30.7%	54.7%	80%***	Worse than national aggregate

NICOR

Produced by HQIP in partnership with the CareQuality Commission

RWH01 Slide produced on 22/07/2019

[1] Apr 16 – Mar 17
[2] Apr 17 – Mar 18

* England only ** NICE Quality statement *** Audit recommendation

Lister Hospital
East and North Hertfordshire NHS Trust

Myocardial Ischaemia National Audit Project

HQIP Healthcare Quality Improvement Partnership

	Metric	CQC Key Question	2015/16 Report[1]	2016/17 Report[2]	National Aggregate (England & Wales)	National Standard	Comparison to other hospitals
703 Cases	Case ascertainment	Well-led	118.0%	108.3%	102.2%	N/A	N/A
617 Cases	Proportion of patients receiving all appropriate secondary prevention medications	Effective	95.7%	82.2%	90.4%	80%*	Better than national standard
607 Cases	Rate of referral to a cardiac rehabilitation programme following discharge	Effective	N/A	95.9%	81.0%	85%*	Better than national standard

MINAP

Produced by HQIP in partnership with the CareQuality Commission

MINAP website

RWH01 Slide produced on 09/07/2019

1 Apr 15- Mar 16
2 Apr 16– Mar 17

* National Framework Service

Lister Hospital
East and North Hertfordshire NHS Trust

National Audit of Dementia

HQIP Healthcare Quality Improvement Partnership

	Metric	CQC Key Question	2017 Report[1]	National Aggregate (England)	National Standard	Comparison to other sites
16 carers	Percentage of carers rating overall care received by the person cared for in hospital as Excellent or Very Good	Caring	66.70%	68.90%	N/A	8.7 60.0 76.7 100
55 staff	Percentage of staff responding "always" or "most of the time" to the question "Is your ward/ service able to respond to the needs of people with dementia as they arise?"	Responsive	92.30%	77.70%	N/A	30.8 71.4 84.6 100
42 casenotes	Mental state assessment carried out upon or during admission for recent changes or fluctuation in behaviour that may indicate the presence of delirium	Effective	26.20%	44.90%	N/A	0 27.8 61.4 98.0
31 casenotes	Multi-disciplinary team involvement in discussion of discharge	Effective	87.10%	81.90%	N/A	21.2 75.9 92.5 100

DEMENTIA CCQI

www.rcpsych.ac.uk/dementiareport2017

Produced by HQIP in partnership with the CareQuality Commission

KEY ONLY
BOTTOM 25% HOSPITAL TOP 25%

RWH01 Slide produced on 22/08/2018

[1] April - November 2016

*Insufficient questionnaires distributed or returned

Lister Hospital
East and North Hertfordshire NHS Trust

National Audit of Inpatient Falls

HQIP Healthcare Quality Improvement Partnership

	Metric	CQC Key Question	2015 Report [1]	2017 Report [2]	National Aggregate (England & Wales)	National Standard	Audit's rating	
	Does the trust have a multi-disciplinary working group for falls prevention where data on falls are discussed at most or all the meetings?	Effective	Yes	Yes	87.0%	Yes	N/A	
31 Cases	Crude proportion of patients who had a vision assessment (if applicable)	Safe	33.3%	76.9%	46.2%	100%*	Between 50 and 79%	■
31 Cases	Crude proportion of patients who had a lying and standing blood pressure assessment (if applicable)	Safe	33.3%	40.9%	19.1%	100%*	Less than 50%	●
31 Cases	Crude proportion of patients assessed for the presence or absence of delirium (if applicable)	Safe	37.5%	100.0%	39.7%	100%*	More than 80%	▲
31 Cases	Crude proportion of patients with a call bell in reach (if applicable)	Responsive	Not reported	100.0%	81.3%	100%*	More than 80%	▲

Royal College of Physicians | FFFAP

www.fffap.org.uk

Produced by HQIP in partnership with the CareQuality Commission

KEY ONLY
- ▲ Green - More than 80%
- ■ Amber - Between 50 and 79%
- ● Red - Less than 50%

RWH01 Slide produced on 12/03/2019

[1] May 15
[2] May 17

*NICE Clinical Guideline

East and North Herts Hospital
East and North Hertfordshire NHS Trust

Hip Fracture Audit

HQIP Healthcare Quality Improvement Partnership

	Metric	CQC Key Question	2017 Report [1]	2018 Report [2]	National Aggregate (England, Wales, NI & IOM)	National Aspirational Standard	Comparison to other hospitals
443 cases	Case ascertainment	Well Led	100.9%	102.3%	100.7%	100%	65.30 95.30 106.60 416.00
443 cases	Crude proportion of patients having surgery on the day or day after admission	Responsive	77.4%	81.5%	69.5%†	85%*	23.20 64.90 80.30 94.50
443 cases	Crude perioperative medical assessment rate	Effective	94.9%	98.0%	88.6%	100%*	0.00 88.45 97.28 100.00
443 cases	Crude proportion of patients documented as not developing a pressure ulcer	Safe	94.5%	97.5%	95.6%	100%	54.50 93.83 98.50 100.00
443 cases	Crude overall hospital length of stay	Responsive	20 days	15.1 days	20 days	none	12.20 16.23 22.00 36.60
443 cases	Risk-adjusted 30-day mortality rate	Effective	6.8%	7.7%	6.9%	none	Within expected range

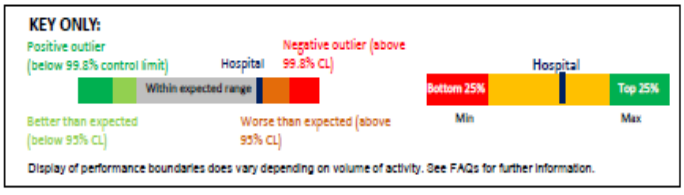
Values displayed on NHFD website may differ as a result of updates to the supplied data made by providers.

Royal College of Physicians | Falls and Fragility Fracture Audit Programme

www.nhfd.co.uk

Produced by HQIP in partnership with the CareQuality Commission

KEY ONLY:



Display of performance boundaries does vary depending on volume of activity. See FAQs for further information.

RWH01
Slide produced on 25/01/2019

[1] Jan 16 - Dec 16
[2] Jan 17 - Dec 17

*Audit recommendation based on NICE guideline
**England only

†This figure differs from the annual report figure (70.2%) which is taken from the best practice tariff data set

Lister Hospital

East And North Hertfordshire NHS Trust

HQIP Healthcare Quality Improvement Partnership

National Joint Registry: Hip and Knee operations

		Metric	CQC Key Question	2017 Report [1]	2018 Report [2]	National Aggregate	National Audit Standard	Comparison to other trusts
Trust-level	876 Cases	Case ascertainment (hips, knees, ankles and elbows)	Well-led	No data available	100.00%	N/A	>95%	95% and above ▲
Hospital-level	881 Cases	Proportion of patients consented to have personal details included (hips, knees, ankles and elbows)	Well-led	91.08%	95.57%	85%	100%	95% and above ▲
	1563 Cases	Risk adjusted 5 year revision ratio (for hips excluding tumours and NOF#)	Effective	1.21	1.21	1.0	1.0	Within expected range
	1315 Cases	Risk adjusted 90 day mortality ratio (for hips excluding tumours and NOF#)	Effective	1.33	1.57	1.0	1.0	Within expected range
	1255 Cases	Risk adjusted 5 year revision ratio (for knees excluding tumours)	Effective	1.00	1.33	1.0	1.0	Within expected range
	1229 Cases	Risk adjusted 90 day mortality ratio) (for knees excluding tumours	Effective	1.00	1.00	1.0	1.0	Within expected range

National Joint Registry

www.njrcentre.org.uk

Produced by HQIP in partnership with the CareQuality Commission

KEY ONLY

Outlier Status Bands:
- Positive Outlier
- Better than Expected
- Within Expected Range
- Worse than Expected
- Negative Outlier

▲ Green - 95% and above
● Amber - 80% to less than 95%
● Red - Less than 80%

RWH01 Slide produced on 06/03/2019

[1] Aug 12 – Aug 17
[2] Aug 13 – Aug 18

NOF#: Neck of femur fracture

Lister Hospital

East and North Hertfordshire NHS Trust

HQIP Healthcare Quality Improvement Partnership

Trauma Audit

	Metric	CQC Key Question	April 2016 - Mar 2018	April 2016 - July 2018	TARN Aggregate	National Audit Standard	Comparison to other hospitals
229 cases	Case ascertainment	Well-led	43.5 - 51.2%	62.4%	N/A	80%	N/A
15 cases	Crude median time from arrival to CT scan of the head for patients with traumatic brain injury	Effective	51 mins (48.0 - 76.0)	70 mins (53.0 - 308.0)	31 min	60 min*	Longer than the TARN aggregate
Insufficient data supplied	Crude proportion of eligible patients receiving Tranexamic Acid within 3 hours of injury	Effective	40%	Insufficient data supplied	79%	N/A	Insufficient data supplied
4 cases	Crude proportion of patients with severe open lower limb fracture receiving appropriately timed surgery	Effective	0.0%	0.0%	31%	100%	Lower than the TARN aggregate
417 cases	Risk-adjusted in-hospital survival following injury	Effective	1 (-3.1 - 1.1) Additional Deaths per 100 Cases†	1 (-3.1 - 1.1) Additional Deaths per 100 Cases†	0 Additional deaths	0 Additional deaths	Within Expected Range

TARN THE TRAUMA AUDIT & RESEARCH NETWORK

www.tarn.ac.uk

Produced by HQIP in partnership with the CareQuality Commission

KEY ONLY:

Risk-adjusted in-hospital survival following injury
- Positive outlier
- Within expected range
- Negative outlier

Survival rate value range can include '-' values representing negative survival

Aggregate value displayed as additional survivors or deaths to aid interpretation.

RWH01 Slide produced on 13/03/2019

* NICE guideline

† January 2016 - December 2018

Diamond Jubilee Maternity Unit, Lister Hospital

East and North Hertfordshire NHS Trust

National Maternity and Perinatal Audit

HQIP Healthcare Quality Improvement Partnership

Slide 1 of 2

		Metric	CQC Key Question	2017 Report[1]	National Aggregate (England only)	National Standard	Comparison to other sites
Trust-level	5780 cases	Case ascertainment	Well-Led	103.57%*	92.00%	>95%	Meets the national standard
Ante-natal	211 cases	Case-mix adjusted proportion of small-for-gestational-age babies (birthweight below 10th centile) who are not delivered before their due date	Effective	61.46%	55.30%	N/A	38.7 – 74.9 Within expected range
Intra-partum	514 cases	Case-mix adjusted proportion of elective deliveries (caesarean or induction) between 37 and 39 weeks with no documented clinical indication for early delivery	Effective	32.91%	26.00%	N/A	3.6 – 55.6 Within expected range
	5120 cases	Case-mix adjusted overall caesarean section rate for single, term babies	Effective	25.61%	24.50%	N/A	20.2 – 32.4 Within expected range

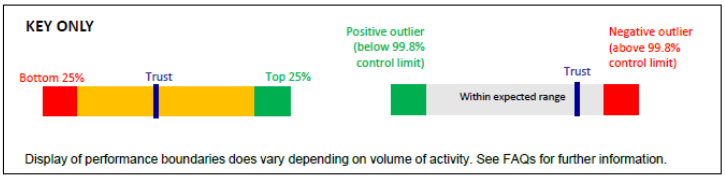
Slide 2 of 2

		Metric	CQC Key Question	2017 Report[1]	National Aggregate (England only)	National Aspirational Standard	Comparison to other sites
Intra-partum	5072 cases	Case-mix adjusted proportion of single, term infants with a 5-minute Apgar score of less than 7	Effective	1.45%*	1.20%	N/A	0.5 – 3.5 Within expected range
	3840 cases	Case-mix adjusted proportion of vaginal births with a 3rd/4th degree perineal tear	Safe	2.23%*	3.60%	N/A	1.4 – 6.5 Better than expected
	5120 cases	Case-mix adjusted proportion of women with severe post partum haemorrhage of greater than or equal to 1500 ml	Safe	1.69%*	2.70%	N/A	1.3 – 5.5 Better than expected
Post-partum	4907 cases	Proportion of live born babies who received breast milk for the first feed	Effective	81.58%	74.10%	N/A	45.8 – 64.5 – 81.6 – 96.0

NMPA National Maternity & Perinatal Audit

www.maternityaudit.org.uk

Produced by HQIP in partnership with the Care Quality Commission



RWH01 Slide produced on 28/06/2018

[1] Apr 15 - Mar 16

*Particularly low rates may reflect poor detection/measurement

LISTER HOSPITAL

East and North Hertfordshire NHS Trust

Neonatal Audit

HQIP Healthcare Quality Improvement Partnership

Slide 1 of 2

		Metric	Core Service	CQC Key Question	2017 Report[1]	2018 Report[2]	National Aggregate (England & Wales)	National Standard	Comparison to other sites
Trust- level	123 cases	Mothers who deliver babies between 24 and 34 weeks gestation and were given any dose of antenatal steroids	Maternity	Safe	88.90%	89.70%*	89.07%	85%*	Within Expected Range
Ante-natal	21 cases	Mothers who deliver babies below 30 weeks gestation given Magnesium Sulphate in the 24 hours prior to delivery	Maternity	Safe	48.2%	62.90%	65.07%	None	Within Expected Range
Intra-partum	50 cases	Babies <32 weeks gestation who had temperature taken within an hour of admission that was 36.5°c-37.5°c	Children and young people	Safe	66.00%	59.60%	64.47%	90%*	Within Expected Range
	749 cases	Documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of admission	Children and young people	Caring	92.10%	92.40%	94.73%	100%*	Better than Expected

Slide 2 of 2

		Metric	Core Service	CQC Key Question	2017 Report[1]	2018 Report[2]	National Aggregate (England only)	National Aspirational Standard	Comparison to other sites
Intra-partum	60 cases	Babies of very low birthweight or <32 weeks gestation who receive appropriate screening for retinopathy of prematurity	Children and young people	Effective	97.40%	98.00%	94.43%	100%†	Within Expected Range
	37 cases	Babies with gestation at birth <30 weeks who had received documented follow-up at 2 years gestationally corrected age	Children and young people	Effective	80.00%	66.40%	62.33%	100%*	Within Expected Range
	110 cases	Babies born at less than 27 weeks who were born in a hospital with a Neonatal Intensive Care Unit onsite	Children and young people	Effective	Not available	46.40%	73.15%	85%‡	Negative Outlier

The values shown are taken from the outlier analysis data set which means they may vary slightly from the values shown on the NNAP online platform which display the raw values.

www.maternityaudit.org.uk

Produced by HQIP in partnership with the Care Quality Commission

KEY ONLY

Negative outlier (below 99.8% control limit) | Positive outlier (above 99.8% control limit)

NNU

Worse than expected (below 97.5% CL) | within expected range | Better than expected (above 97.5% CL)

Display of performance boundaries does vary depending on volume of

RWH01 Slide produced on 24/01/2019

[1] Jan 16- Dec 16
[2] Jan 17- Dec 17

*Audit recommendation
†Audit recommendation based on specialist guideline

‡ The standard for outlier analysis is the national rate. The aspirational standard is currently 85%, but this is recognised to be aspirational

Lister Hospital, Intensive Care Unit
East and North Hertfordshire NHS Trust

HQIP Healthcare Quality Improvement Partnership

Intensive Care Audit

	Metric	CQC Key Question	2016/17 Report	2017/18 Report	National Aggregate (England, Wales & N. Ireland)	National Aspirational Standard	Comparison to other hospitals
	Case ascertainment	Well Led	Not reported for this audit			None	N/A
1090 admissions	Crude non-clinical transfers	Responsive	0.2%	0.2%	0.3%	0%*	0 Within Expected Range 5.0
616 admissions	Crude, non-delayed, out-of-hours discharge to ward proportion	Responsive	0.6%	0.8%	2.0%	0%*	0 Within Expected Range 25.0
7300 available critical care bed days	Crude delayed discharge (% bed-days occupied by patients with discharge delayed >8 hours)	Responsive	10.9%	12.2%	4.6%	0%*	In the Worst 5% of Units
1045 admissions	Risk-adjusted hospital mortality ratio (all patients)	Effective	1.02	1.07	1.0	None	0.18 Within Expected Range 2.0
655 admissions	Risk-adjusted hospital mortality ratio for patients with predicted risk of death <20% (lower risk)	Effective	1.03	0.93	1.0	None	0.10 Within Expected Range 3.16

icnarc intensive care national audit & research centre
https://onlinereports.icnarc.org/

Produced by HQIP in partnership with the CareQuality Commission

KEY ONLY:
Positive outlier (below 99.8% control limit)
Negative outlier (above 99.8% CL)
Trust
Within expected range
Better than expected (below 95% CL)
Worse than expected (above 95% CL)
Display of performance boundaries does vary depending on volume of activity. See FAQs for further information.

RWH01A Slide produced on 10/02/2019

1 Apr 16- Mar 17
2 Apr 17- Mar 18

* FICM/ICS guideline

Lister Hospital, Respiratory High Dependency Unit

East and North Hertfordshire NHS Trust

HQIP Healthcare Quality Improvement Partnership

Intensive Care Audit

	Metric	CQC Key Question	2016/17 Report	2017/18 Report	National Aggregate (England, Wales & N. Ireland)	National Aspirational Standard	Comparison to other hospitals
	Case ascertainment	Well Led	Not reported for this audit			None	N/A
261 admissions	Crude non-clinical transfers	Responsive	0.0%	0.4%	0.3%	0%*	0 Within Expected Range 5.0
135 admissions	Crude, non-delayed, out-of-hours discharge to ward proportion	Responsive	14.6%	7.4%	2.0%	0%*	0 Within Expected Range 25.0
1460 available critical care bed days	Crude delayed discharge (% bed-days occupied by patients with discharge delayed >8 hours)	Responsive	0.0%	3.7%	4.6%	0%*	Not in the Worst 5% of Units
226 admissions	Risk-adjusted hospital mortality ratio (all patients)	Effective	1.12	1.76	1.0	None	0.18 Negative Outlier 2.0
180 admissions	Risk-adjusted hospital mortality ratio for patients with predicted risk of death <20% (lower risk)	Effective	2.10	2.74	1.0	None	0.10 Worse Than Expected 3.16

icnarc intensive care national audit & research centre

https://onlinereports.icnarc.org/

Produced by HQIP in partnership with the CareQuality Commission

KEY ONLY:

Positive outlier (below 99.8% control limit) | Negative outlier (above 99.8% CL) | Trust | Within expected range | Better than expected (below 95% CL) | Worse than expected (above 95% CL)

Display of performance boundaries does vary depending on volume of activity. See FAQs for further information.

RWH01B Slide produced on 10/02/2019

1 Apr 16- Mar 17
2 Apr 17- Mar 18

* FICM/ICS guideline

Lister Treatment Centre

East And North Hertfordshire NHS Trust

HQIP Healthcare Quality Improvement Partnership

National Joint Registry: Hip and Knee operations

		Metric	CQC Key Question	2017 Report [1]	2018 Report [2]	National Aggregate	National Audit Standard	Comparison to other trusts
Trust-level	N/A	Case ascertainment (hips, knees, ankles and elbows)	Well-led	No data available	N/A	N/A	>95%	N/A
Hospital-level	N/A	Proportion of patients consented to have personal details included (hips, knees, ankles and elbows)	Well-led	N/A	N/A	85%	100%	N/A
	N/A	Risk adjusted 5 year revision ratio (for hips excluding tumours and NOF#)	Effective	N/A	N/A	1.0	1.0	N/A
	N/A	Risk adjusted 90 day mortality ratio (for hips excluding tumours and NOF#)	Effective	N/A	N/A	1.0	1.0	N/A
	NULL	Risk adjusted 5 year revision ratio (for knees excluding tumours)	Effective	Not eligible	NULL	1.0	1.0	N/A
	NULL	Risk adjusted 90 day mortality ratio) (for knees excluding tumours	Effective	Not eligible	NULL	1.0	1.0	N/A

National Joint Registry www.njrcentre.org.uk Working for patients, driving forward quality

www.njrcentre.org.uk

Produced by HQIP in partnership with the CareQuality Commission

KEY ONLY

Outlier Status Bands:
- Positive Outlier
- Better than Expected
- Within Expected Range
- Worse than Expected
- Negative Outlier

Green - 95% and above
Amber - 80% to less than 95%
Red - Less than 80%

RWHTC Slide produced on 06/03/2019

[1] Aug 12 – Aug 17
[2] Aug 13 – Aug 18

NOF#: Neck of femur fracture

Queen Elizabeth II Hospital
East And North Hertfordshire NHS Trust
National Joint Registry: Hip and Knee operations

HQIP Healthcare Quality Improvement Partnership

		Metric	CQC Key Question	2017 Report [1]	2018 Report [2]	National Aggregate	National Audit Standard	Comparison to other trusts
Trust-level	N/A	Case ascertainment (hips, knees, ankles and elbows)	Well-led	No data available	N/A	N/A	>95%	N/A
Hospital-level	N/A	Proportion of patients consented to have personal details included (hips, knees, ankles and elbows)	Well-led	N/A	N/A	85%	100%	N/A
	N/A	Risk adjusted 5 year revision ratio (for hips excluding tumours and NOF#)	Effective	N/A	N/A	1.0	1.0	N/A
	N/A	Risk adjusted 90 day mortality ratio (for hips excluding tumours and NOF#)	Effective	N/A	N/A	1.0	1.0	N/A
	59 Cases	Risk adjusted 5 year revision ratio (for knees excluding tumours)	Effective	1.00	0.50	1.0	1.0	Within expected range
	58 Cases	Risk adjusted 90 day mortality ratio) (for knees excluding tumours	Effective	1.00	1.00	1.0	1.0	Within expected range

National Joint Registry www.njrcentre.org.uk Working for patients, driving forward quality
www.njrcentre.org.uk

Produced by HQIP in partnership with the CareQuality Commission

KEY ONLY
Outlier Status Bands:
- Positive Outlier
- Better than Expected
- Within Expected Range
- Worse than Expected
- Negative Outlier

▲ Green - 95% and above
● Amber - 80% to less than 95%
● Red - Less than 80%

RWH20 Slide produced on 06/03/2019

[1] Aug 12 – Aug 17
[2] Aug 13 – Aug 18

NOF#: Neck of femur fracture

CLINICAL AUDIT DRIVING QUALITY IMPROVEMENT

The following are clinical audits that have received external and internal recognition for the Division's quality and commitment as evidenced by their participation in clinical audit;

National Early Inflammatory Arthritis Audit
The Rheumatology team have been recognised by the British Society got Rheumatology as being in in 7th place across the country for their use of the National Early Inflammatory Arthritis Audit.

National Audit for Cardiac Rehabilitation
Our Cardiac Rehabilitation team has been recognised by the British Association for Cardiac Rehabilitation and the National Audit for Cardiac Rehabilitation.

Patients with heart problems are seen on the ward and are invited 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**.**

National Asthma & COPD Audit
Our respiratory team has been recognised as one of the top performing sites in the country by the National Asthma and COPD Audit Programme (NACAP) for the number of records they have entered in the NACAP good practice repository web tool. The team has been invited to share the work they are doing in the first edition of the adult asthma good practice repository.

BLISS Audit
The trust's neonatal unit have successfully completed their first Bliss Baby Charter audit and have been awarded the Bliss Baby Charter Pledge of Improvement.

The certificate acknowledges that they are committed to working towards Bliss Baby Charter accreditation to deliver high-quality, family-centred care.

2.2 Research and development

The number of patients receiving relevant health services, provided or sub-contracted by the ENHT in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 1,183.

Further details of research activity are given in Appendix 1.

2.3 Goals agreed with commissioners CQUIN

A proportion of the ENHT's income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between the ENHT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2018/19 and for the following 12 month period are available electronically at www.enht-tr.nhs.uk

2019/20 income identified is dependent upon achieving CQUIN targets set out by NHS England and the Clinical Commissioning Group.

The CQUINs for 2019/20 agreed with the Clinical Commissioning Group are set out in the table below.

Domain	CQUIN Indicator	Progress
CCG1: Antimicrobial Resistance (AMR)*	CCG1a: Antimicrobial Resistance Lower Urinary Tract Infections in Older People	In progress
	CCG1b: Antimicrobial Resistance Antibiotic Prophylaxis in colorectal surgery	
CCG2: Staff Flu Vaccinations	CCG2: Staff Flu Vaccinations	In progress
CCG3: Alcohol and Tobacco (A&T)	CCG3a: Alcohol and Tobacco Screening (18-19 performance 75%)	In progress
	CCG3b: Alcohol and Tobacco Tobacco Brief Advice	
	CCG3c: Alcohol and Tobacco Alcohol Brief Advice	

CCG7: Three high impact actions to prevent Hospital Falls	CCG7: Three high impact actions to prevent Hospital Falls	In progress
CCG11: Same Day Emergency Care (SDEC)	CCG11a: SDEC Pulmonary Embolus	In progress
	CCG11b: SDEC Tachycardia with Atrial Fibrillation	
	CCG11c: SDEC Community Acquired Pneumonia	

The final data shall be confirmed in the annual account and this will include indications of anticipated secured % payment.

2.4 Statements from the Care Quality Commission

Following the inspection during July 2019 and initial report factual accuracy steps are currently being undertaken. The findings and subsequent rating across cores services shall be available for annual account reporting.

2.5 Data quality

Data Quality Steering Group continue to meet regularly within new agreed governance structures and drive continuous improvement efforts to Implement a data quality improvement plan by service/division. Key performance indicators shall be shared in annual report.

2.6 Learning from deaths

The content and format of the learning from deaths statutory requirements ('The National Health Service (Quality Accounts) (Amendment) Regulations 2017) shall be summarised and presented in the annual report.

Mortality review process

I. Stage 1 is undertaken by designated, trained mortality reviewers using the Trust's bespoke case record review methodology which was developed by a multi-professional team. It is a structured, evidence based review format comprised of a core section of questions relating to care that are relevant to all specialties, with additional Medicine/Surgery specific sections.
II. Potential areas of concern (ACON's) found by reviewers trigger a Stage 2 review by the relevant Specialty with discussion and identification of learning/actions points at their Clinical Governance Forum.
III. Outputs feed into Stage 3 where the case is considered by the Mortality Surveillance Group, a subset of the Trust's Quality and Safety Committee. Here the adequacy/appropriateness of actions/learning points suggested by Specialties is considered and an avoidability of death score is agreed (using the scoring criteria adopted from the RCP methodology). Scores of ≤3 have been used to answer this question. Quality of Care rating is now also agreed using the scale adopted from the PRISM methodology.

Learning from Deaths

Reducing mortality is one of the Trust's key objectives for 2017 to 2019. This quarterly report summarises the results of mortality improvement work, including the regular monitoring of mortality rates, together with outputs from our learning from deaths work that are continual on-going processes throughout the Trust. It also incorporates information and data mandated under the National Learning from Deaths Programme.

As part of the mortality review process where areas of concerns are identified these are themed to provide an at-a-glance summary. These themes are reviewed against incident themes etc to identify learning and to plan improvements.

2.7 Performance against national core indicators

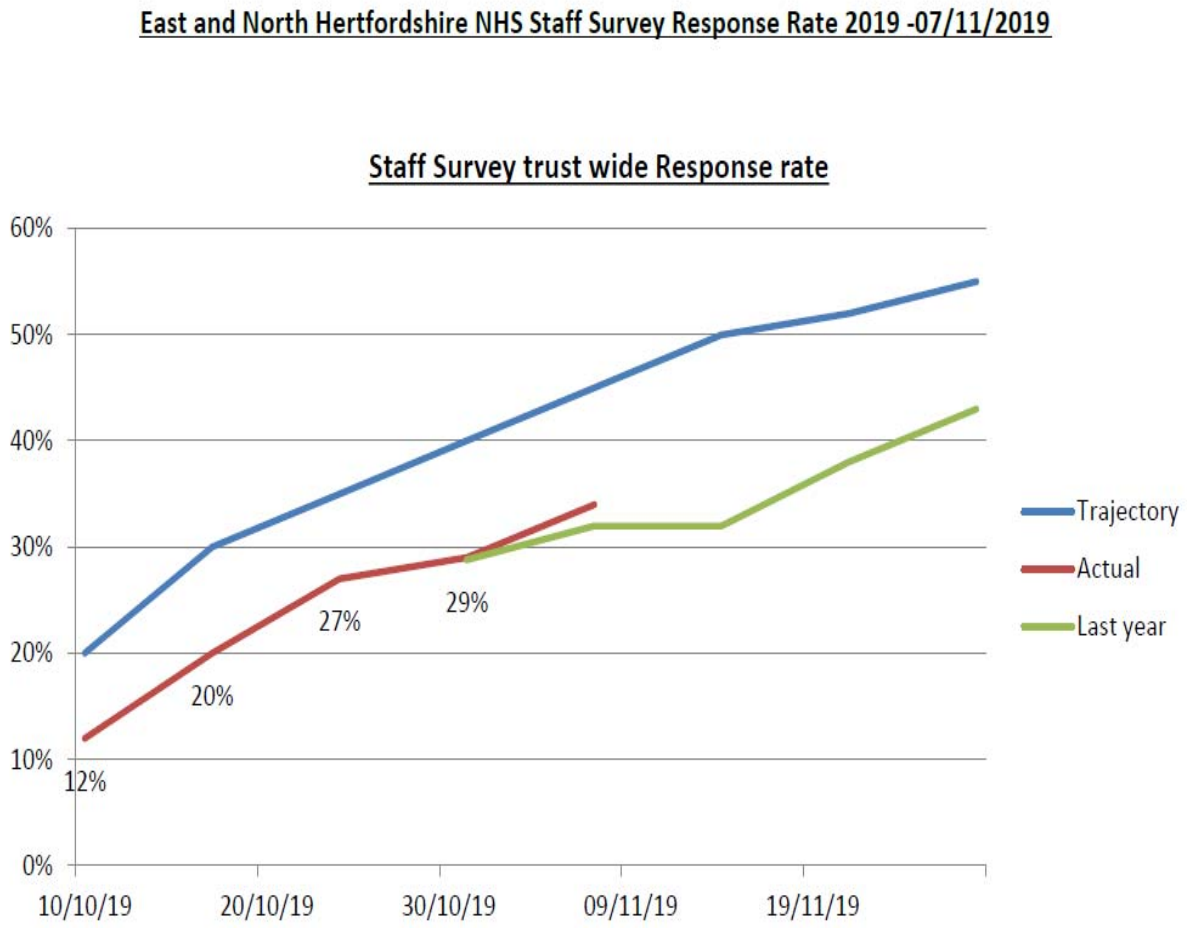
In this section the outcomes of a set of mandatory indicators are shown. This benchmarked data, provided in the tables, is the latest published on the NHS Digital website and is not necessarily the most recent data available. More up to date information, where relevant, is given.

For each indicator the Trusts performance is reported together with the national average and the performance of the best and worst performing Trusts, where applicable.

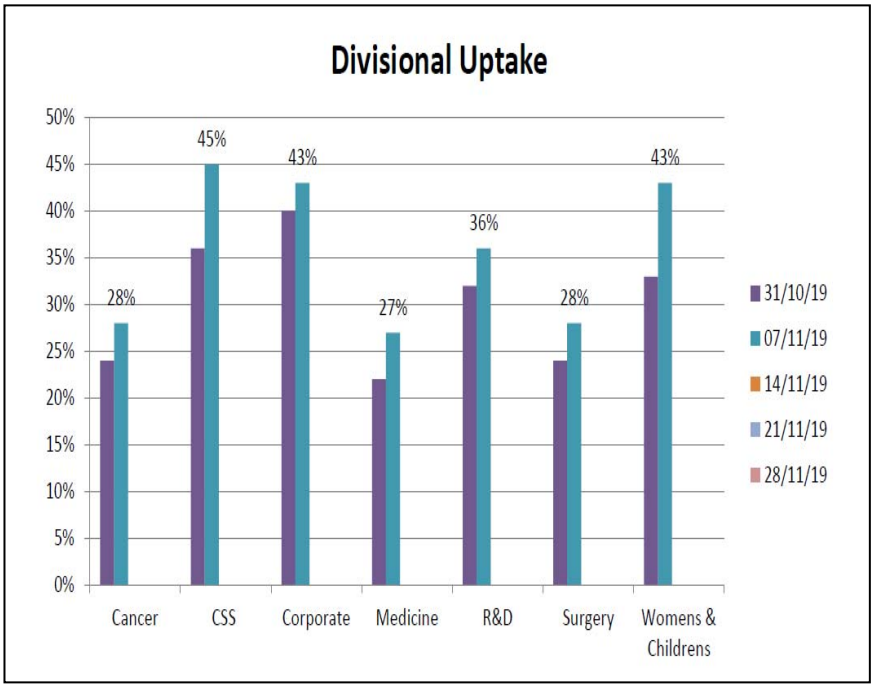
- **Recommending the Trust**

- Staff

The current national NHS national staff survey 2019 is actively being undertaken. ENH teams have welcomed the opportunity to encourage staff to share their experiences and complete the survey. The trust Executive led 'Friday a 08:00' huddles has provided opportunity for staff to suggest ideas on how to improve survey response rates.



Teams who have successfully improved their response rate have been recognised and rewarded.



Patients

Patients are asked, as part of the FFT measurement framework, if they would participate in a survey to provide feedback after their visit to the hospital either as an in-patient, out-patient, emergency department attender or maternity attender. They are asked whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.

Indicator	Measure	Trust result	Time period	Trust previous result	Best performing trust	Worst performing trust	National average
Recommending the Trust	Staff	In progress					
	Patients	IP 97% A/E 90% Mat 96%** OP 94%	Jan 2019	IP 97% A/E 90% Mat 96% OP 94%	-	-	TBC

* Acute trusts only
**Maternity indicator is a measure relating to birth experiences only

The ENHT considers that this data is as described, as it is based on data submitted directly by patients and staff to the national surveys. The ENHT has taken the following actions to improve this score, and so the quality of its services, by reviewing the staff survey responses and producing initiatives to improve staff engagement; and by reviewing patient survey responses alongside other sources of patient feedback to determine improvements.

Mortality

Mortality rates have improved over the last 5 years as measured by both of the major methods: HSMR and SHMI.
The table below provides a summary of key mortality indicators

Metric	Result
Crude mortality	Crude mortality is 1.09% for the 12 month period to August 2019 compared to 1.33% for the latest 3 years.
HSMR: (data period Jun18 – May19)	HSMR for the 12 month period is **93.15** and is statistically **'better than expected'.**
SHMI: (data period May18 – Apr19)	Headline SHMI for the 12 month period is **91.18**: **'as expected band 2'.**
HSMR – Peer comparison	E&NH is ranked 4th (out of 15) in the East of England Peer group.

The Summary Hospital Mortality Index (SHMI) measures hospital mortality outcomes for all diagnosis groups along with deaths in the community up to 30 days after discharge. SHMI data is not adjusted for palliative (end of life) care.

Indicator	Measure	Trust result	Time period	Trust previous result	Best performing trust	Worst performing trust	National average
SHMI	Value	0.912	Oct 17 – March 19	0.999			1
	Banding	As expected		As expected	-	-	N/A
% deaths with palliative care code	N/A	TBC		37.6%	TBC	TBC	TBC

The national average is always reported as '1' with a smaller number representing a better outcome. The SHMI for the twelve months to December 2018 is **0.912**, slightly better than the national average and within the 'as expected' range. This is the first time that SHMI has been below 1 since its inception in 2010. SHMI is generally available 6/12 in arrears.

The Trust's SHMI currently stands at 91.18 for the rolling 12 months to April 2019 (NHS Digital September 2019 release). This remains in the 'as expected' range. This is a marginal improvement on the 91.94 quoted in my last report for the twelve months to February 2019 and compares favourably to the 99.90 for rolling 12 months to September 2018, which itself was the first time that the Trust's SHMI had fallen below 100 since the inception of this metric in 2010.

A different measure of mortality is the Hospital Standardised Mortality Ratio (HSMR) which measures the actual number of patients who die in hospital against the number that would be expected to die given certain characteristics eg. demographics.

The England average is always 100 (black dashed line in the graph below) and a lower number indicates better than average. Performance has remained in the 'as expected range' and there was a predictable, unsustained increase in HSMR following the introduction of the Lorenzo system as described earlier. HSMR is generally available 3 months in arrears and the latest HSMR for the rolling 12 months to March 2019 is 93.01 and within the 'Better than expected' range.

The ENHT considers that this data is as described, as it is based on data submitted by the Trust to a national data collection, and reviewed as part of the routine performance monitoring. The ENHT has taken the following actions to improve these scores, and so the quality of its services, by presenting and tracking monthly data to identify and investigate changes. The mortality data is also captured by diagnosis so any deviation can be investigated at the case by case level.

Patient Reported Outcome Measures (PROMs)

Patient reported outcomes for surgical specialties shall be reflected in annual report.

Emergency readmissions

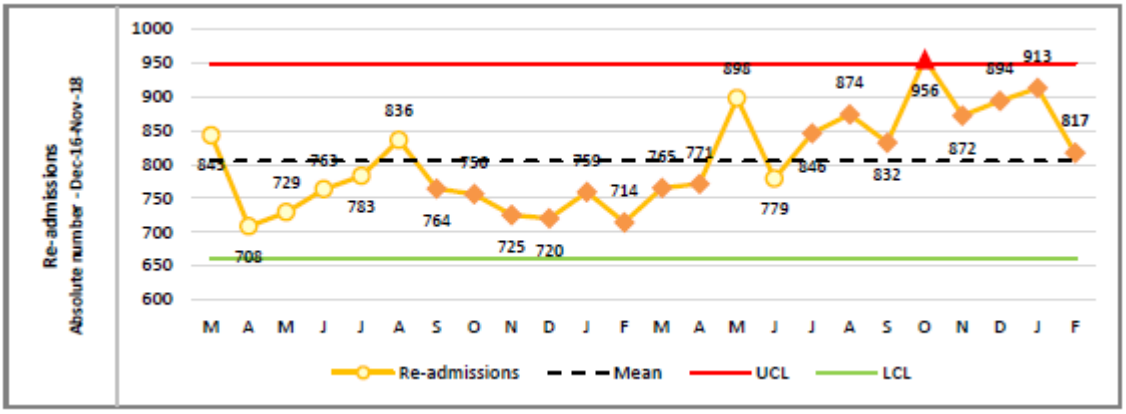
This indicator measures the percentage of patients readmitted to hospital within 28 days of being discharged from hospital after an emergency admission.

Indicator	Measure	Trust result	Time period	Trust previous result	Best performing trust	Worst performing trust	National average
28 day emergency readmission rate	Age 0-15	TBC					
	Age 16 and over	TBC					

*Large acute trusts

Nationally there is an ongoing review by NHS Digital of emergency readmissions indicators and it is intended that new indicators, aligned with other frameworks, this will be reflected in annual report.

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.



Responsiveness to personal needs

The indicator is shall be updated for the annual report.

Recruitment and retention

This indicator shall be updated for the annual report.

Appraisal and Statutory and Mandatory Training

These are key factors in supporting and enabling good staff performance. Since November 2015, incremental pay awards have been dependent on the completion of an annual appraisal, along with statutory and mandatory training compliance (for nine statutory competencies)

- Appraisal rates at the end of September 2019 are at 86.28%.
- 88.7% staff are compliant with all mandatory competencies

Venous Thromboembolism (VTE)

A blood clot in the leg (deep vein thrombosis) or lung (pulmonary embolism) may develop for a number of reasons eg. reduced mobility. Patients in hospital tend to be less mobile than at home and therefore may be at a greater risk developing a clot. As part of the admission process patients should be assessed as to their risk of developing a clot, and be prescribed anti-coagulant (blood thinning) medication if required.

Indicator	Measure	Trust result	Time period	Trust previous result	Best performing trust	Worst performing trust	National average
VTE assessments	N/A	87.8%	2018/19 Q3	94.68%	100%	54.86%	95.65%

*When Lorenzo was introduced it was not possible to validate the data so Trust information was not submitted to the national system.

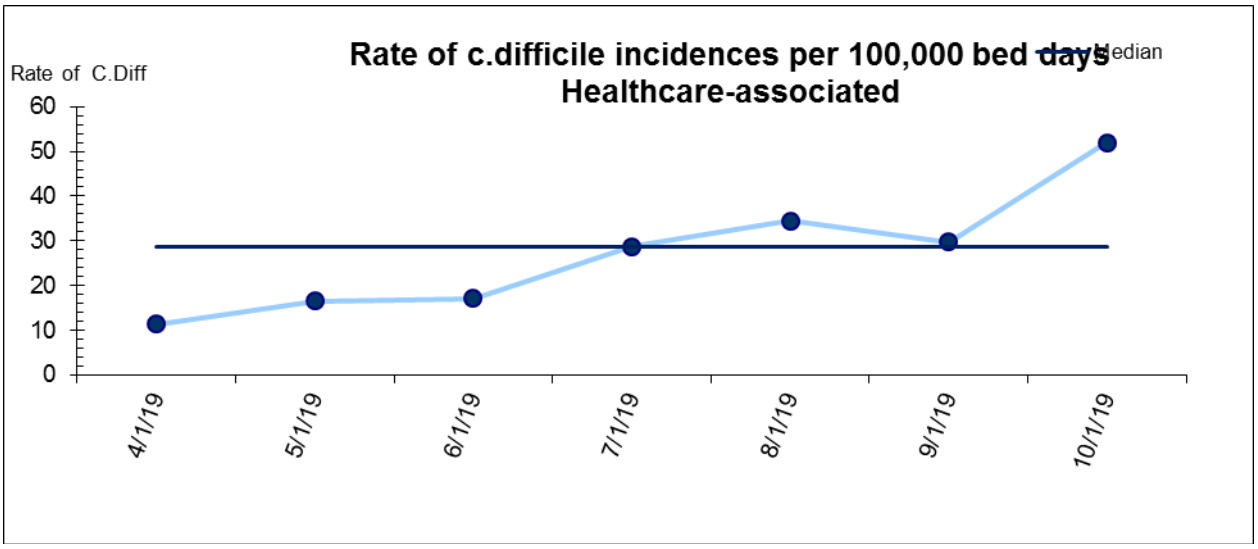
	metric	AIM	Nov 18	Dec 18	Jan 19	Feb 19	Marc h 19	April 19	May 19	June 19	July 19	Aug 19	Sept 19
VTE	VTE risk assessme nt	95%	95.7 %	91.4 %	96.5 %	95.9 %	96.5 %	88.2 %	89.8%	90.2 %	87.8 %	87.2 %	83.5 %

Clostridium difficile

This indicator measures the number of hospital acquired Clostridium difficile infections per 100,000 bed days.

Indicator	Measure	Trust result 2018/19	Trust result (average)	Time period
Clostridium Difficile infection rate	Trust apportioned cases	70	28	2019/20 (until September 2019)

As per Public Health England recommendations this data reflects all reported cases' refers to all C. difficile-positive patients reported by the trust whose laboratory processes the specimen. It is important to note that this does not necessarily imply that the infection was acquired there.



Patient safety incidents

Incidents are reported on the electronic reporting system, Datix. The data is uploaded into a national system where incident reporting patterns, types of incidents etc can be analysed. The rate of incidents is the number reported by 1,000 bed days.

Indicator	Measure	Trust result	Time period	Trust previous result	Best performing trust	Worst performing trust	National average
Patient safety incidents	Number of incidents	3940	Oct 18 – Mar 9	2798	-	-	-
	Rate	38.1		25	95.4	16.9	
	Number of severe harm / death	30		27	0	TBC	-
	% of severe harm / death	0.7		0.24	0	TBC	TBC

*Acute non-specialist trusts

More recent data for April - Sept 2019 shows the number of incidents reported at 3940 giving a rate of 38.1 incidents per 1000 bed days.

The ENHT has taken the following actions to improve this score, and so the quality of its services - implementing a range of initiatives to continuously improve incident management, promoting a safety culture and improving feedback to staff on learning.

Part 3 Review against selected metrics

3.1 Review against selected metrics

- **Patient safety**
  - Never events
  - MRSA Bacteraemia (post 48 hours
  - Number of inpatient falls
  - Number of inpatient falls resulting in serious harm
  - Number of preventable hospital acquired pressure ulcers
- **Clinical effectiveness**
  - LOS
  - Stroke thrombolysis
  - Crude mortality
- **Patient experiences**
  - **Complaints & learning from feedback**

3b Performance against national requirements

3.1 Patient safety

Data below refer to May 2019-September 2019

Indicator	16/17	17/18	18/19	19/20 (Sept)	Aim
Never events	2	6	**6**	3	0
MRSA Bacteraemia (post 48 hours)	2	1	**2**	3	0
Number of inpatient falls	867	859	**845**	418	<845
Number of inpatient falls resulting in serious harm	15	12	**12**	3	≤15
Number of preventable hospital acquired pressure ulcers	27	33	**N/A**	TBC	≤25 **Zero Cat 4**

Never events

A never event is an incident that should never happen if the correct procedures are in place and being followed to prevent an occurrence.

During 2019/20 May – October 2019:

	2017/18	2018/19	2019/20
Wrong site surgery	1	4	1
Retained object	3	0	1
NG Feeding	1	1	0
Blood transfusion	1	0	0
Oxygen tubing to air	0	1	1

A trust Never Event oversight group is now active and oversees risks associated with NHSI Never Event Serious Incidents framework. Risk assessments are currently under way in clinical areas and this will produce a heat map gaps analysis and action plan. The finding form this shall be available in end of year report.

MRSA Bacteraemia (post 48 hours)

The incidences of MRSA bacteraemia have undergone local root cause analysis investigation and action plans are monitored through the Trust Infection and prevention Control Committee, Chaired by Director of Nursing.

metric	AIM	Nov 18	Dec 18	Jan 19	Feb 19	March 19	April 19	May 19	June 19	July 19	Aug 19	Sept 19
Number of MRSA incidences	0	0	0	0	0	0	1	0	0	1	0	1
Rate of MRSA incidences per 100,000 bed days	0.6	0.0	0.0	0.0	0.0	0.0	5.7	0.0	0.0	5.7	0.0	5.9

Number of inpatient falls

Number of inpatient falls resulting in serious harm

Year to date the Trust is reporting a 3.4% decrease in falls when compared to the same period in 2018. The Trust is 17 incidents below the target reduction trajectory set for 2019/20 (October data).
These for continuous improvement include

- Improving processes to support safe care at night
- Review and test changes to falls risk assessment tools.

	metric	AIM	Nov 18	Dec 18	Jan 19	Feb 19	March 19	April 19	May 19	June 19	July 19	Aug 19	Sept 19
Patient Falls	Number of patient falls	72	49	63	91	81	69	61	77	75	77	70	58
	Rate of patient falls per 1,000 overnight stays	4.0	3.3	4.4	4.9	5.9	4.7	4.1	5.1	5.4	5.1	5.2	4.3
	Number of patient falls resulting in serious harm	0	0	1	3	3	2	0	0	0	3	0	0

Number of preventable hospital acquired pressure ulcers

In June 2018 measurement and categorising of pressure damage has changed following new NHSi guidance. This has progressed to new reporting for all trusts using revised framework. And review of data at a national level to understand impact all pressure skin damage is captured and measured and irrelevant if hospital acquired or community acquired.

The tissue viability team review and validate all hospital acquired Pressure ulcers. Pressure ulcers remain in high focus at East and North Herts NHS trust with discussion daily at the site safety meeting, following identification on ward safety huddle.

A trust wide improvement plan in collaboration with the National ' NHS Improvement Collaborative' continues, driver diagram, aim and measures have been identified with help from a QI coach. Team meet regularly and are currently working to identify change ideas. The programme sits within the wider National wound care Strategy, National Patient safety strategy, which is also linked to the NHS Long Term Plan published in January 2019.

	metric	AIM	Nov 18	Dec 18	Jan 19	Feb 19	March 19	April 19	May 19	June 19	July 19	Aug 19	Sept 19
Hospital-acquired Pressure Ulcers	Category 4	0	0	0	1	0	0	1	0	0	0	0	0
	Category 3	0	0	0	0	0	0	0	0	0	0	0	0
	Category 2	2	3	1	3	3	4	2	4	2	1	2	0
	Category 2(D) Device-related	-	1	0	2	0	1	0	1	1	1	3	1
	Mucosal membrane (D) Device-related	-	-	1	5	1	1	0	0	0	1	0	1
	Unstageable	1	0	0	2	1	4	0	2	0	2	2	0
	SDTI Excluding STDI (D)	3	3	6	3	5	9	9	6	7	7	4	2

Serious incidents

The trust has reported 26 serious incidents since April 2019.- September 2019. Key themes are associated with

- Falls
- Deteriorating patient
- Medication errors
- Delayed treatment

The number of reported serious incidents per month is collected as per graph below showing on average 5.1 serious incidents per month.

	metric	AIM	Nov 18	Dec 18	Jan 19	Feb 19	March 19	April 19	May 19	June 19	July 19	Aug 19	Sept 19
Events and Incidents	Number of Never Events	0	1	0	0	0	0	0	0	0	1	0	1
	Number of Serious Incidents	5	12	4	1	6	4	2	1	4	9	4	5

3.2 Clinical effectiveness

Indicator	17/18	18/19	19/20	Aim
Length of stay (non-elective / emergency)	3.5	4 (To Feb)	**3.78 (Aug)**	≤4.3
Stroke – thrombolysis rate	7.2%	12.3% (Feb)	**11.2% (April-Aug)**	≥11%
Crude mortality – rolling 12 month rate	15 (Mar)	11.5 (Feb)	**10.8 (Aug)**	Reduce

Length of stay

Minimising the time that a person is in hospital is better for them and better for the efficiency of the organisation. A range of length of stay indicators are monitored as part of the integrated performance report with the emergency length of stay demonstrating since April 2019 an average of 3.8 days. This is better than last year of an average 4 days.

Metric	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Emergency length of stay	4.0	4.0	3.6	3.7	3.8	3.9	3.9	4.0	3.7	3.6	3.9	3.7

Stroke – thrombolysis rate

The Trust measures a range of stroke indicators. Providing thrombolysis (anti-clot treatment) for patients consistently when their stroke has been confirmed has been variable during the year.

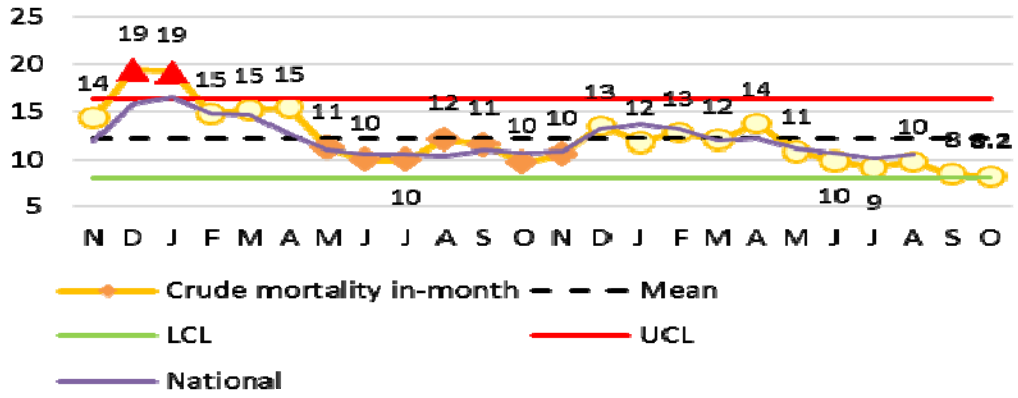
		Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Total Thrombolysis rate for confirmed Strokes	11%	9.5%	7.0%	14.3%	8.6%	10.0%	12.3%	8.5%	4.5%	14.3%	15.6%	13.4%	8.8%

Factors that are helping to support earlier treatment are delivering training to ED doctors to ensure early escalation and referrals to the Stroke team; review of stroke pathways for emergency and inpatients and improvement in scanning performance as a result of the stroke nurses requesting scans at time of arrival in ED. Currently plans are being arranged for the stroke nurses to work with the ambulance crew to help with early attendance to ED.

Crude mortality

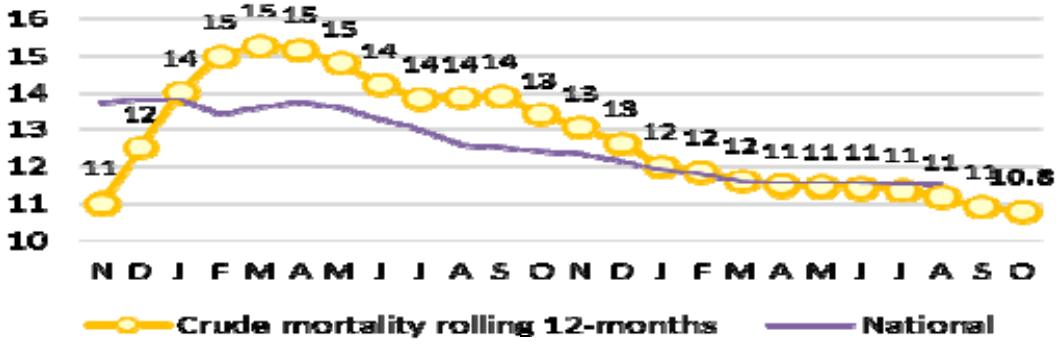
Crude mortality is based upon the number of patients who die in the Trust whilst an in-patient.

- 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.
- The Trust's performance has remained below the national average.
- The graphs below show the crude mortality rate per month (measured per 1,000 admissions) and the rolling 12-month average rate during the last two years. The Trust's crude mortality has continued on a general downward trend.



The in-month crude mortality rate improved slightly to 8.2 deaths per 1,000 admissions in October.

The rolling 12-months crude mortality rate improved slightly to 10.8 deaths per 1,000 admissions in the 12 months to October, and remained better than the most recently available national rate of 11.5 deaths per 1,000 admissions.



3.3 Patient experiences

Indicator	17/18	18/19	19/20 (October 2019)	Aim
Number of written complaints	1106	**1068 (to Feb)**	609	<previous year
Number of PALS concerns	4151	**4502**	1924	N/A

Complaints per level of activity - per 100 bed days	0.52*	**1.2-2.2**	TBC	<1.9**
Complaints – response within agreed timeframe	67%	**47-91%**	75%	≥80%***

Source: Datix internal system & information held by local teams

*Bed day data for quarter 4 not published so quarter 3 bed day data used for quarter 4

**Aim has been revised in light of changing methodology (2017/18 quality account stated <0.5)

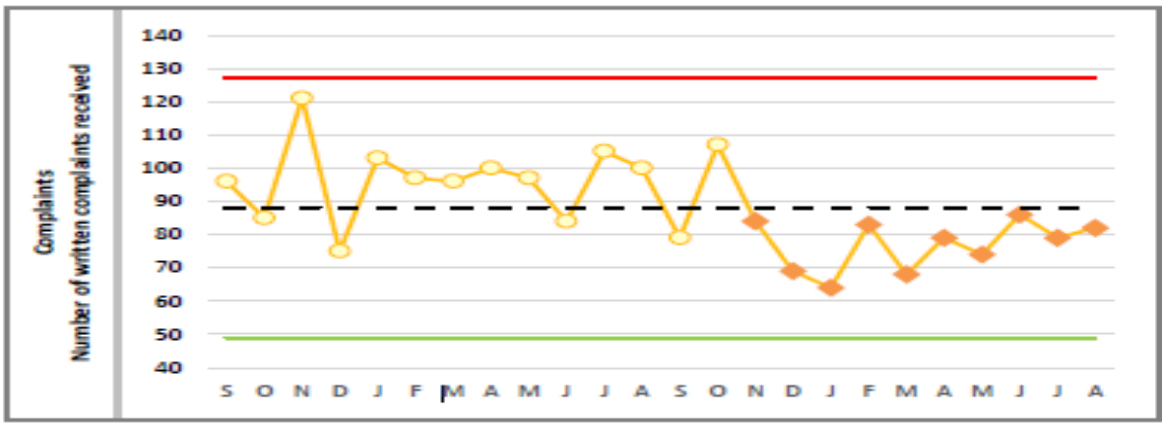
***Aim has been revised (2017/18 quality account stated ≥75%)

Data relating to complaints is captured on the integrated performance report as below.

Metric	Target	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Number of written complaints received	92	84	69	64	83	68	79	74	86	79	82	84	125
Rate of written complaints received	1.9	1.6	1.6	1.1	1.6		1.6	1.4	1.7	1.5	1.8	1.7	2.3
Proportion of complaints acknowledged within 3 working days	75%	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Proportion of complaints responded to within agreed timeframe	80%	47%	43%	53%	55%	64%	63%	64%	78%	76%	80%	85%	80%

Number of complaints and PALS concerns and activity

The number of written complaints has overall remained comparable to the previous year, but has reduced per month during the last few months. Activity overall during the last two years is seen in the chart below demonstrating an improved average of 90 average to an average 80 written complaints per month.



Complaints response times

The Trust continues to acknowledge complaints within 3 working days on all occasions. However the proportion of letters responded to within the agreed timeframe has been a cause of concern as shown in the graph below with only one month in the year achieving our target.

The Trust has consistently monitored, and reported to Board, complaints handling performance. However the Trust has experienced challenges in ensuring that complaints are thoroughly investigated and responded to in a timely way.
The monthly open complaints has gone from 160in early 2019 to 87 in October 2019.

3.4 Performance against national requirements

National standards

The indicators in this section form part of the NHS Improvement Single Oversight Framework.

	17/18	18/19	19/20	Aim
Max 18 weeks from referral in aggregate – patients on incomplete pathways	**Not given**[a]	**90.3%** **(To Feb)**	92% (to Sept)	≥92%
Four hour maximum wait in A&E	**83.6%**	**80.5%** **(To Feb)**	86.1% (to sept)	≥95%
62-day urgent referral to treatment of all cancers	**75.7%** **(to Jan)**	**66.8%** **(To Jan)**	79.3% (to sept)	≥85%
Maximum 6 week wait for diagnostic procedures	**Not given**[a]	**98.79%** **(Feb)**	93% (to sept)	<99%

[a] A problem with the reporting function of a new administration system meant this data was not available

National Speaking up legislation

Our current framework and governance to support this legislation is actively under review, as part of our future planning People Strategy. Findings, actions and plans shall be shared in annual account report.

Rota gaps

Gaps to rotas of doctors and dentists in training are monitored on a monthly basis. This review allows for identification of clinical teams that are short of staff.

The table below shows the average number of rota gaps in each of the quarters.

Jul-Sept 2018	Oct-Dec 2018	Jan-Mar 2019	April-June 19	July-Sept 2019
35	38	36	39	33

Recruitment initiatives to fill these posts continue. The position in Q2 shows an improvement in position and is also reflected in the fill rate of the Emergency Department posts such that their vacancies now only account for one sixth of the total compared to approximately half of the vacancies in Q3 of the previous year.

Appendix 1 Research and development

During the first 6 months of 2019/20 the Trust so far has entered 1,183 participants to research which has received ethical approval from the Health Research Authority.

Background

The Trust is part of the National Institute for Health Research (NIHR) which has a national vision"***to improve the health and wealth of the nation through research***". The Trust has a long history of being research-active with particular strengths in cancer, renal, cardiovascular disease and new areas are emerging.

Our research is led by 60 lead Investigators and our research activity includes participants across 18 specialty areas. We fund 120 people (70 whole time equivalent) including consultants, doctors, research nurses, non-clinical support and management staff. Our research is well managed and leads to improved patient care.

Research supports the Trust vision in the following ways:

- **Trust Vision**: Proud to deliver high-quality, compassionate care to our community.
- **Research Vision:** To support high-quality, compassionate care to our community through research and innovation.
- **Public & Patients:** To ensure that the public and patients have the opportunity to contribute to
  a) the setting of the Trust's research priorities,
  b) the design of research studies, and
  c) to take part in wide range of research.
- **Culture:** Well trained and professional staff working within in an environment that is safe, well governed and fit for purpose.
- **Principal drivers:** Public and patient engagement, patient benefit, interested lead researchers, income generation, research metrics

Our research is led by **60 lead Investigators** and our research activity includes participants across **18 specialty areas**.

We fund **120 people** (70 whole time equivalent) including consultants, doctors, research nurses, non-clinical support and management staff. Our strategy has seen the **number of patients involved in research double** in the past five years.

The Trust has robust structures and processes to:

- develop and support an environment where patients, service users and the public have the opportunity to participate in health and social care research
- this means new treatments, care and other services can be developed through ethical and scientifically sound research for the benefit of patients, service users and the public.
- Research is now embedded in the Trust's clinical strategy.

This June we launched our **Patient and Public Involvement in Research panel**; many patients and public members attended and we have a fantastic resource now in place to ensure the research we support is patient-drive and patient-centred, contact: involvementinresearch.en-tr@nhs.net

Some research highlights, with numbers of participants April – Aug 2019, are shown below:

Psychological risk factors for fatigue in in patients with long-term conditions (125 participants, Mental Health). We are investigating a number of factors which may influence levels of fatigue, distress and disability in patients with long-term conditions. We are specifically focusing on behavioural and psychological factors including quality of sleep, anxiety and depression, beliefs about fatigue and coping strategies.

Inflammatory Bowel Disease (IBD) Bioresource (104 participants **,** Gastroenterology). Working with the NIHR Bioresource, we are developing a centralised national recallable bioresource of 25,000 patients with Crohn's disease or ulcerative colitis (collectively inflammatory bowel disease / IBD) to support scientific and clinical IBD research.

Perioperative Quality Improvement Programme: Patient Study (197 participants, Anaesthesia, Perioperative Medicine and Pain Management). This study is to gather and analyse patient data using the PQIP Database. PQIP will measure complications after major planned surgery and seek to improve these outcomes through feedback of data to clinicians. This analysis will answer important research questions about variation in quality of care in major surgery.

UroX Biomarker Bladder Cancer Study (59 participants, Cancer). This is a prospective observational study looking at urine samples from participants under referral for a standard of care investigative cystoscopy and biopsy. The study aims to test if the UroX™ biomarker (a measurable indicator of a biological condition) can be detected in urine samples from participants who may later test positive following a biopsy for bladder cancer. The study aims to assess the value of the biomarker as a

screening tool for bladder cancer. This national study has been locally developed under the leadership of Mr Nikhil Vasdev.

OPHELIA study - Causes of Gestational Diabetes (40 participants, Reproductive Health and Childbirth). Gestational diabetes (GDM) affects approximately 35,000 pregnancies in the UK every year and is associated with adverse pregnancy outcomes affecting both mother and child. Although most cases of GDM are thought to occur due to pregnancy-hormone-induced insulin resistance, there is likely to be some variation in the contribution of autoimmunity, insulin resistance, insulin insufficiency and pregnancy hormone concentrations to the disease process. The aim of this study is to identify pathophysiological differences in women with GDM by measuring autoantibodies, insulin and hormone concentrations, and to assess how these differences might affect pregnancy outcomes.

Investigating lifestyle determinants of muscle and physical function, and the impact on patient experience and support needs in kidney disease (18 participants, Renal Disorders). People with kidney disease (KD) have a loss of kidney function. Poor kidney function is related to other health problems such as diabetes and high blood pressure. Patients also suffer from poor physical functioning, low levels of physical activity, and increased levels of disability. This makes doing everyday activities difficult and reduced their quality of life. Patients have many symptoms such as muscle wasting, severe tiredness, and pain. KD patients are required to make self-imposed changes to their lifestyle to accommodate their diagnosis. This included changing their diet and taking medication. This study aims to investigate the role and differing impact of KD and basic lifestyle factors on patient's physical function, symptoms, healthcare usage, and muscle function.

VaLiDate-R - Can Very Low Dose Rivaroxaban in addition to dual antiplatelet therapy improve thrombotic status in acute coronary syndrome (25 participants, Cardiovascular Disease). Heart attacks are caused by a blood clot occurring in a blood vessel (artery) which supplies blood to the heart. The standard treatment for a heart attack is two blood thinning medications combined, every day, to reduce the risk of further blood clots forming and to prevent another heart attack. Our earlier research has shown that through a blood test, we can identify patients who remain at increased risk of further clots and who may benefit from further blood thinners to reduce the risk of further heart attack, stroke and death in the next 30 days. The aim of this study is to test which of 3 blood thinning treatment options (all already in widespread clinical use) is best for patients to reduce further blood clots, in particular the addition of low dose rivaroxaban. This is a locally developed study being led by Prof Diana Gorog and is in partnership with the University of Hertfordshire.

A study to co-produce a Young Carers App (20 participants, Children). We have co-produced and are testing a mobile phone App and a booklet, with input from local secondary schools and carer support groups to develop and pilot-test the App, in in order to ensure it is designed to meet young people's needs. Young carers have been involved since the outset and drove this planned study. This is a locally developed and externally funded study being led by Prof Natalie Pattison and Jodie Deards and is in partnership with the University.

Circulating cells in advanced cancer (51 participants, Cancer). Patients are always inquiring why we are unable to tell them about their cancer from a simple blood test. There is increasing evidence that cancer cells travel in the circulatory system but to date efforts to securely identify these have predominantly relied on certain surface markers that are not regularly present on the circulating tumour cells (CTCs) (but are present when the cells settle to grow). This study is requesting blood samples from patients with advanced cancer in order to determine how best to use the new technology to give us a better understanding about their cancer from a simple blood test.

Appendix 2

Patient Addressograph

East and North Hertfordshire NHS Trust

Personalised Treatment Plan (PTP)
Must be completed by ST3 or above

ALL TREATMENTS WILL BE ASSUMED APPROPRIATE (YES) UNLESS INDICATED BY TICKING NO	YES	NO
Would intravenous fluid resuscitation be an appropriate treatment?		
Would artificial nutrition be an appropriate treatment?		
Would intravenous antibiotic therapy be an appropriate treatment?		
Would transfusion of blood products be an appropriate treatment?		
Would defibrillation of a witnessed/monitored VF/pulseless VT be an appropriate treatment?		
Would cardio-pulmonary resuscitation (CPR) be an appropriate treatment?		
If not appropriate for CPR has a DNACPR form completed and filed in front of patients notes?		
Treatments requiring level 2 or 3 care:		
Would renal replacement therapy (dialysis) be an appropriate treatment?		
Would cardiovascular support with inotropes and vasopressors be an appropriate treatment?		
Would **non-invasive** ventilation of the lungs be an appropriate treatment?		
Would **invasive** ventilation of the lungs be an appropriate treatment?		
Would Critical Care referral be appropriate?		
Clinical treatment recommendations: (additional information relating to clinical treatments)		

RECORD OF DISCUSSION

Has the patient got mental capacity to understand and/or be involved in decisions treatment options and CPR? If no: Patient must have a mental capacity assessm

Has this treatment plan been discussed with the patient or where the patient lack relative/next of kin(NOK)/close friend/Lasting Power of Attorney, in line with MCA

(discussion to be documented overleaf)

If No, document reason overleaf i.e:

- Patient declined
- Patient incapacitated-as defined by Trusts mental capacity policy
- No family/NOK/LPA available (update and document discussion as soo

TREATMENT DECISIONS	Indefinite	Review date	Pl
As the clinician responsible for this plan, I have indicated the next review date as:			
Consultant decision: (or ratification within 24 hours)			

If decisions relating to treatment plan change ple file in patient's notes and complete a new for

DOCUMENTED RECORD OF DISCUSSION	
DATE	

CONSULTANT REVIEW AS APPROPRIATE:	Indefinite	Review date	PRINT & GRADE	SIGN	DATE
I have reviewed the above plan and agree with decisions. I have indicated the next review as:					
I have reviewed the above plan and agree with					

East and North Hertfordshire NHS Trust

Agenda Item: 12

TRUST BOARD – PUBLIC SESSION – 8 JANUARY 2020

Board Assurance Framework Update

Purpose of report and executive summary:

To present the latest version of the Board Assurance Framework 2019/20 for information.

The Board are asked to note:

- There have not been any changes to the risk ratings in month.
- Two risks remain at 20 and were discussed at FPPC:
  - **Risk 11** – Estates and Facilities remains a 20 due to the permanent leadership, capacity and capability challenges and risk to compliance issues being identified. A review of compliance levels has commenced and an update presented to FPPC in November and for further discussion in December. The Audit Committee also reviewed this risk at their last meeting in October. The new Director of Estates and Facilities is due to commence in January 2020.
  - **Risk 4** – capital remains a risk of 20 and is monitored through the capital review group and Executive Committee.
- **Risk 7** (governance). The outcome of the CQC and use of resources reports have now been received for factual accuracy. A compliance framework has been developed to strengthen ward to board governance and a proactive approach.
- **Risk 12** (MVCC) – Risk remains at 16 and a focused discussion was held at FPPC November 2019
- FPPC and QSC agendas are focused on the key risks.

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: The Board Assurance Framework is considered at each FPPC,QSC & Public Board meeting.

Director: Director of Strategy	**Presented by:** Associate Director of Corporate Governance	**Author:** 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	☒

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

Yes – all BAF risks

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

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

Risk Scoring Guide

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

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

Trust risk scoring matrix and grading

Likelihood

Impact	1 Rare	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 (Dec)	Last Month	3 months ago (Sept)	6 months ago (June)	Target Score	Date added (all reviewed in October 19)
001/19	There is a risk that within the context of the Healthcare Economy the Trust has insufficient capacity to sustain timely and effective patient flow through the system which impacts the delivery of the 62day cancer, RTT and the A&E 4-hour standards	Chief Operating Officer	FPC	16	16	16	16	12	01-03-18
002/19	There is a risk that the trust is unable to recruit and retain sufficient supply of staff with the right skills to meet the demand for services	Director of Nursing /Medical Director/CPO	FPC	16	16	16	16	12	01-03-18
003/19	There is a risk that the Trust is unable to achieve financial sustainability to support the delivery of the Operational Plan and 5year clinical strategy	Director of Finance	FPC	16	16	16	16	12	01-04-19
004/19 (was 6)	There is a risk that there is insufficient capital resources to address all high/medium estates backlog maintenance, investment medical equipment and service developments	Director of Finance	FPC	20	20	20	20	16	01-03-18
005/19	There is a risk that the digital programme is delayed or fails to deliver the benefits, impacting on the delivery of the Clinical Strategy	Director of Finance/ COO	FPC	16	16	16	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	15	15	15	10	01-03-18
009/19	There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered, impacting on the Trust's ability to deliver the required improvements and transformation	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	16	16	12	12	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	20	20	20	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	16	16	12	16	12	01-03-18

Board Assurance Framework Heat Map –November 2019 (no changes to risks scores)

Frequency / Likelihood	Consequence / Impact				
	1 None / Insignificant	2 Minor	3 Moderate	4 Major	5
5 Certain	low 5	low 10	high 15	high 20 004/19	high 25
4 Likely	low 4	low 8	moderate 12 007/19 006/19	high 16 001/19 009/19 002/19 005/19 004/19 003/19 012/19 010/19	high 20 011/19
3 Possible	very low 3	low 6 007/19	moderate 9 006/19	moderate 12 005/19 003/19 009/19 008/19 012/19 002/19 01/19 010/19	high 15
2 Unlikely	very low 2	Low 4	Low 6	moderate 8	moderate 10 011/19 008/19
1 Rare	very low 1	very low 2	Very low 3	Low 4	high 5

008/18 Existing risk score

011/18 Target risk score

Movement from previous month

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

Strategic Aim:	**Pathways: To develop pathways across care boundaries, where this delivers best patient care redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff**				**Ease of Use: To**
Strategic Objective:	**Improve and sustain delivery of operational performance**	**Source of Risk:**	Strategic Objective IPR	**BAF REF No:**	001/19
Principal Risk Decription: What could prevent the objective from being achieved? **There is a risk that 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:	Dec-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 iv) Impact of tax issue on Consultants willingness to undertake WLIs. v) Impact of specialist commissioning review and resultant outcome for MVCC on staff retension and recruitment, impacting on effectiveness of the cancer team.	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 Comprehensive D&C work undertaken by speciality teams supported by in house D&C team and external IST team. Aim is to identify capacity gaps which will be addressed through a series of actions to include job plan review, efficiecy improvement e.g. reduction in DNA rate; increase utilisation in theatres and where required funding for substantive resources.	• A&E Delivery Board (L1) • System Resilience Group (L2) • Reports to FPC and Board of Directors (L3) • NHSI PRM(L3) • Cancer Board (L2) • Daily and weekly ED sit-rep reporting • Monthly breach validation audits • 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 - Audit Committee deep dive review - October 2019	Internal Audit – Performance Framework report - reasonable assurance March 19) Validated demand and capacity by tumor site modelling by NHSI - led to increase investment in urology.		
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 high impact tumour sites complete.	• Accountability Framework arrangements • Impact of local Hospitals on Trust activity • Demand and capacity profiling for T&O, 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		

Access to funding streams from the cancer alliance allocation - 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	T&O, 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	Perfect week 25.11.2019 . Review of learning and outcomes of perfect week in progress to inform future work streams	In progress
v) To agree and develop further integrated pathways of care with our commissioners	Chief Operating Officer	on going	Postive planned careand urgent/emergency care transformation day in November 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:	Dec-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. • Arrangements in place to support our employees who are EU nationals re Brexit-related settled status applications. Strategic intent defined through work on new People Strategy	• 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. • Divisional increased headcount targets for 2019/20, which are reviewed regularly at Improving Financial Delivery meetings. - 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 Ability to staff the winter ward	Green	Effective control is in place and Board satisfied that appropriate assurances are available		
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient		
		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 will be monitored at the weekly Improving Financial Delivery meetings. A formal progress review was taken to Executives in September 2019 with a prediction that, based on known activity and trajectories, the Trust is likely to meet its recruitment targets for 2019/2020. 113 new starters joined the Trust in October 2019 and the vacancy rate at the end of October reduced to 6.3%.	In progress
iii) • People Strategy to be launched in 2019/20 setting out the Trust's approach to recruitment and retention.	Chief People Officer	Feb-20	Draft workforce redeployment policy by Head of HR expected by February 2020.	In progress
iv) Review of Trusts Communication strategy to support recruitment and retention	Communication Team / Head of HR	Nov-19	The Head of Communications is developing a new Communication Strategy and she is aiming for this to be completed by end November 2019.	In progress
v) Review supporting interventions re mediicine division staff ing due to Winter Pressures and longer term recruitment strategy	Chief People Officer	Dec-19	Short term initiatives and incentives considered and approved through Executive Committee 12 Dec 19 for implementation.	
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:	Dec-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	Awaiting outcome of assessment - anticipated November 2019	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:	Dec-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 v) impact on delivery of clinical strategy	**Inherent Risk** (Without controls):	4	5	25	⇔
		Residual/ Current Risk:	4	5	20	
		Target Risk:	4	4	16	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Six Facet survey undertaken in 17/18 • Capital review Group meets monthly • Prioritising areas for limited capital spend through capital plan • Fire policy and risk assessments in place • Major incident plan • Mandatory training • Equipment Maintenance contracts • Monitoring of risks and incidents	• 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 / opportunities for investment	Director of Finance / Project leads	on going	Bid to NHSI for review including additional funding for fire. Wave 5 bids in process of being developed.	in progress
Summary Narrative:				

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

Strategic Aim:	**Ease of Use:** To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff services that is financially and clinically sustainable in the long term **Sustainability:** To provide a portfolio of				
Strategic Objective:	**Complete stabilisation and commence optimisation of Lorenzo and make our services easier to use**	**Source of Risk:**	Project	**BAF REF No:**	005/2019
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the digital programme is delayed or fails to deliver the benefits, impacting on the delivery of the Clinical Strategy		**Risk Open Date:**	Feb-18	**Executive Lead/ Risk Owner**	**Director of Finance / Chief Operating Officer**
		Risk Review Date:	Dec-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 of June 2019	In progress - report to FPC in June 2019. Rescheduled for September 2019 Discussed and endoresed by FPC	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 Information /Richard Hammond Deputy COO	On going	On going and deteriorating patient digital workstream commenced. Discharge Summary Task and finish group chaired by Richard Hammand is now monitoring complaince and looking at medium to long term improvments. Daily reporting to Exec's in place	In progress
Summary Narrative:				
Risk carried forward from 2018/19. Stablisation to be completed by 31 May 2019. New digital strategy, associated digital programme and revised governance structure are in progress. Funding for EPMA confirmed from NHS Digital for implemetation by February 2020.				

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:	Dec-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 ICP/S's v) Limited internal capacity and capability to engage	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) System Transformation days and Transformation Group in place. STP identified as Accelerator site for national support. ENH Chief Executives' Oversight Meeting in place. Agreement to joint QIPP planning or 20/21	• 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 Regular updates considered at Executive Committee Executive Director ICP Transition Group set up representing all 5 core ICP partners - reporting into CEO Oversight Group	• NHSE Deep-dive into cancer work stream (L3) Executive Team and Trust Board consideration of ICP development (Sept 2019). Agreement to joint ICP winter planning for 2019 and QIPP planning for 20/21.		
	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 and at sub Board level. ICP governance in design stageto be agred by CEOs.	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. Strategic Programme Board to be replaced by Strategy Committee from Nov 2019 with remit including ICP and ICS development. Terms of Reference Agreed and meetings being scheduled.	In progress
ii) Monitor and actively participate in STP programme to develop ICS	Chief Executive and Chair	on going	Executive dsiucssion and Board update and dsicussion took place Sept 2019. Director of Strategy one of two ENH ICP representatives on the STP ICS/ICP Architecture Committee. Director of Strategy represting ICS on STP Task & Finish ICS architcture Group.	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	Ongoing	In addition to above, the STP has arranged for workshops on ICS and ICP development with STP Board members in Nov and December 2019. Trust representatives have been identified for these.	In progress
iv) Actively support and provide collaborative leadership to support the development of the ENH ICP	Chief Executive and Director of Strategy	on going	CEO joint lead with HCT CEO for the ENH ICP. Draft clinical priorities identified in discucssion with ICP partners and reflected in draftLong Term Plan. Executive Ttransition Group established to devise and support the transition to shadow ICP from April 2020. Trust has worked collabortively with ENHCCG, HPFT, HCC and HCT to develop the first draft narrative of the ICP submission for the long term plan. Further work to do to develop ICP development programme and future governance.	In progress
Summary Narrative:				

Sept 19: The Trust is actively working with emerging ICP partners to identify clinical priorities for pathway transformation and develop governance for the future ICP which will support a QI approach to transformation. There is a need to review and align current ENH system transformtion work and the organisational restructure to the emerging ICP clinical priororities in order to align resources to support optimal impact on population health management. This work is ongoing and progress is being overseen by the ENH CEOs' Group. This work is forwards facing and includes joint planning for winter with HCT. Emergency activity is currently above plan ehich suggests that the ICP needs to continue to identify and deliver more effective ways of effectivly mnaging emergency growth - this will be a priority area for collaborative working. October 2019: CEOs' Group has agreed tp identify additional capacity to help drive the development of the ICP transition programme. Executive Directors' Group has been tasked with supporting development of the shadow ICP. Trust to review and refresh Year 2 of the clinical strategy in the contxt of emerging ICP vision and priorities. Nov 19: Positive system engagement in Transformation Days - future governance of clinical tansformation workstreams drafted and to be agreed. Further work to be undertaken on remaining aspects of ICP governance. External support engaged to further strengthen ENHT internal thinking , preparation and readiness to optimise our role and support for the ICP.

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:	Dec-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. Internal Audit - Surgical division governance - reasonable assurnance - 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**	
Effectiveness of goverancne structures at ward to Divisional level • Fully embedding Performance Management Framework/Accountability Framework • Implementation of Internal Audit Recommendations • NHSI Undertaking January 2019 / CQC section 29a warning - surgery and QEII UCC - HSE Improvement notices received on V&A, MSD and sharps in October 2019	• Embedded risk management - CRR and BAF • Embedding effective use of the Integrated performance report • Evidence of timely implementation of audit actions • Consistency in the effectiveness of the governance structure's at all levels • Capacity to ensure proactive approach to compliance and assurance • Oversight of GIRFT programme and other exteranl reviews and follow up - follow up investigations on V&A and Sharps incidents - MH equipment - review and replacement programme - specialist training	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Monitor delivery of Risk Management implementaion plan 2019/20 including risk appetite	Associate Director of Corporate Governance / Risk Manager	ongoing	Monthly reports to Board committees	In progress
ii) Review of well led compliance and implement recommendations from NHSI Board and Committee observations to strenghten Board governance	Associate Director of Corporate Governance	Sep-19	Board development session in April commenced review of well -led. Follow up session scheduled for June 2019. Continue to review workforce matters, and reviewing DEC/Executive Committees	In progress
iii) Complete recruiment into revised corporate and quailty and safety structures and substantive Executive Director posts	Associate Director of Corporate Governance / Director of Nursing	Jul-19	One current vacancy in corporate goverance team; DPO to be advertised in July. Final QI posts in process of recruitment . Compliance facilitator post under recruitment	In progress
iv) Review and develop a 'business as usual' programme of compliance / quality and safety reviews	Associate Director of Corporate Governance / Director of Nursing	Oct-19	Review of self assessment frameworks and mock inspeciton paperwork in progress with current programme - draft compliance framework to QSC in November	In progress
v) Review implementation of Trust clinical strategy and enabling strategies	Director of Strategy		action plan under development. Scheduled to present draft action plan to Executive Committee through to QSC in November/December. Trust partnership engaged. Action taken 23.10.19 to have a security officer in the ED 24/7 with immediate effect. Reviewing security provision	In progress
vi) Review effectiveness of governance at a Divisional level	Associate Director of Corporate Governance	Jan-19	Internal Audit scheduled. ARM reflections. Internal audit of surgical division - reasonable assurance.	In progress
v) Implementation of project plan for CQC Inspection and Use of Resources Inspection	Associate Director of Corporate Governance / Director of Nursing	Aug-19	In progress with weekly reporting to Executive Committee. Inspections anticipated for July - Sept 19. CQC focus groups being promoted (3-5 July) . Inspections completed and awaiting draft reports and outcome	In progress
v) develop and implement action plan to address HSE findings and improvement notices	Associate Director of Corporate Governance	January 2020 - action plan to HSE	Action plan under development. Scheduled to present draft action plan to Executive Committee through to QSC in November/December. Trust partnership engaged. Action taken 23.10.19 to have a security officer in the ED 24/7 with immediate effect. Reviewing H&S structure to support a more proactive service across the Trust.	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:	Dec-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	Complete May 2019	Quality transformation phase now complete. Objectives and quality priorities now imbedded with ENHT Quality Strategy	Complete- milestones and aciton now wihtin Quality Stratgey
ii) Delivery and monitoring of CQC improvement plans for Surgery Lister and UCC QEII and other core pathways	Associate Director of Corporate Governance / Director of Nursing	Ongoin	Internal monitoring and review continues each month. CQC action plan monitored through theatre improvement group and Theatre Board. Awaiting formal outcome and re-design of action plan from CQC inspection. Current factual accuray stage in progress of rpeort - new action plan to be finalised by Dec 2019.	In progress
iii) Launch and implementation of the quailty strategy with communication plan	Director of Nursing / Medical Director	ongoing	Launch event held in May 2019, supported with the Trust conversation session in June 2019. First learning trust wide event held 21 June . Invasive Procdure learning event held in October 2019. Reporting cycle to QSC reviewed with scheduled deep dives. Quality Improvement team now fully established. Regular tracking of QI and QS priorties undertaken through QSC. Offcial communication launch of QI planned for November, communication strategy in progress.	In progress
iv)• Complete Gap analysis on GIRFT reports and develop and monitor action plans	Medical Director	ongoing	GIRFT visits continue and accumulation of actions currently being undertaken. Non-Exectutive has been identified to chair GIRFT oversight committee.	Started
iv) Implement 7 day services plan	Medical Director	ongoing	Report to QSC June 2019. Steering group established. Information gathering started against each 7 day standard and current baseline of PA allocation.	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
Principal Risk Decription: What could prevent the objective from being achieved? **There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered and motivated, impacting on the trust's ability to deliver the required improvements and transformation and to enable people to feel proud to work here.**		**Risk Open Date:**	01.03.18	**Executive Lead/ Risk Owner**	**Chief People Officer**
		Risk Review Date:	Dec-19	**Lead Committee:**	**FPC & QSC**

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	Autumn LEND sessions are now taking place and include the theme of 'psychological safety / fear in the workplace'.	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 and is currently being reviewed, so as to roll out to consultants and wider teams.	In progress
iii) Implement action plan following staff survey feedback	Chief People Officer	on going	All divisions have a local plan; these are monitored at Trust Board and at staff partnership meetings.	In progress
iv) Develop and implement talent management strategy	Chief People Officer	Feb-20	Progress update on Talent Management Strategy is planned for the February 2020 meeting of the Finance, Performance and Workforce Committee.	In progress
v)Review of Communication strategy	Head of Communications	Nov-19	The Head of Communications is developing a new Communication Strategy and she is aiming for this to be completed by end November 2019.	In progress
vi) Staff survey/engagement workshop and assocated actions	Chief People Officer	ongoing	The Trust 'Just and Learning Culture' approach to be defined and rolled out in January 2020, supported by a Culture Steering Group (currently being recruited).	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:	01/122019	**Lead Committee:** **FPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) UK decision to leave the EU ii) Potential for UK to leave the EU with No Deal in place	i) Risk to supply of goods, services, medicines and vaccines to the UK from EU ii) Risk to recruitment and retention of EU Nationals iii) Risk to transport infrastructre and ability of staff to get to and from work iv) risk to flows of data due to information governance regulations	**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**
• EPRR Committee, will lead on the business continuity arrangements, reviewing existing plans to ensure they respond to the possibility of a 'no-deal' Brexit. • Review 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 from January 2019 to drive progress reporting to Executive Committee Communitaions to staff from European countries outside the UK. Link to STP EU Herts Strategy Control Group Information Governance EU Exit Surveys being undertaken . Trust participation in Hertfordshire Strategic Resilience 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 . Papers to Executive Committee recommenced in August 2019 and to Board reccomenced in September 2019. Results of EU Data Surveys.	• 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 UK parliament approved deal in place between UK and EU post 31 January 2020. Nationally DH undertaking contingency planning and guidance is being issued to the NHS to support planning. DH is centrally seeking assurance from a core list of national suppliers on behalf of the NHS. Hertfordshire Procurement seeking assurance from all other suppliers and identifyng any produce lines for which alternative suppliers may not be available in order to agree alterative supply in the event that it is required in recognition of reliance on third parties.		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	Meetings paused in November in line with UK paliament developments and guidance from DHSC. To reccomence in Dec 19 to support preparation for potentail no deal EU Exit on 31 January 2020	In progress
iii) Recruitment strategy implementation	CPO	ongoing	International and local recruitment campaigns. Information available to support recruiting managers respond to queries from potential new staff.	In progress
iv)				
Summary Narrative:				
September 2019: Workstream meetings increased to weekly from August 2019, incorporating all guidance issued by the government. All areas reviewing business continuity plans to support service continuity. Particpation in Regional DH EU Exit workshops in September. October 2019: EU Exit preparation group continued to meet weekly. Additional Command and Control arrangements in place to support management of any EU related issues. Nov 19:Preparation planning paused for November following approval of extension to end January. In line with DHSC guidance regarding preparation planning. Preparation Group to recommence meetings in December to support preparation in the event of a No Deal EU Exit in January.				

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:	Nov-19	**Lead Committee:**	**QSC**

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

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
Fire Policy and Procedures Training – mandatory awareness training and fire wardens Ward based evaluation training for Sisters completed December 2018. Communication Plan Fire Compliance meeting (monthly). Detailed Action Plan in place to address the recommendations of the 2 Fire AE reports, broken down into weekly tasks. Capital funding to make the necessary changes to the Estate to ensure compliance with guidance and fire compliance. . Capital funding to make the necessary changes to the Estate to ensure compliance with guidance and fire compliance. Revenue funding to fund improvements. Detailed Action Plan in place to address the gaps in Estates & Facilities Compliance. Interim Fire Safety Officer in post from 11 Feb 2019 Reports to Health and Safety Committee Weekly environmental audits Water safety group and action plan Revised governance structure adopted within Estates & Facilities, along with a new Estates & Facilities Management Assurance Group (EFMAG), to receive reports and monitor progress. EFMAG report sto H&S Committee, within its revised governance arrangements. Revised governanec structure adopted within Estates & Facilities, along with a new Estates & Facilities Management Assurance Group (EFMAG), to receive reports and monitor progress. EFMAG report sto H&S Committee, within its revised governance arrangements.	Authorised Engineers report 2018. (L3 –ve) Annual fire report to Quality & Safety Committee. Papers to Executive Committee / Quality & Safety Committee. Audits of high risk areas on Lister site Works completed on wards 10/11 MVCC 2018 Desktop Fire evacuation exercise carried out December 2018.(lister) Ward evacuation plans displayed in each ward and checked. January 2019 New Monthly Fire Safety Committee established March 2019 – includes representation from other sites – reports to H&SC and QSC PLACE reviews Internal audit of estates and facilities compliance scheduled for Q3/4 E&F escalation reporting to both TIPCC and H&S Committees from EFMAG, adopting araes to celebrate and areas of concern. Trusts Water Safety Group is receiving trend analysis data on laboratory testt results, and the situation is stable, although continues to be significant. Final independent compliance audit report received October 19.	AE Water Safety Report to Water Safety Group (Nov 19) confirmed positive progress in relation to water safety		

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	Full implementation of the Fire Strategy Effective Estates and facilities governance structures	Green	Effective control is in place and Board satisfied that appropriate assurances are available

Lack of capital funding to bring the Lister and other sites to compliance Lack of revenue funding for training Fire risk assessments and actions due for Fire Safety Officer review Actions identified from Fire desktop review Confirmation all AO's now in post and visibilty of work programme Gaps in ongoing assurance on water safety identified Limited visibility on the compliance status for the Trusts satellites locations.	Limited assurance from other sites trust operates from Visiibility of AE reports and actions	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. Implemention of the supporting committees commences with water safety, ventilation and electrical safety. E&F Governance structure and reporting arrangements were revised in August 2019, and to be reviewed 4th Qtr 2019/20.	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 Estates and Facilities	Mar-20	on hold until new estates and facilities director in post from January 2020.	To commence
iv) review and implement mechanisms to ensure Estates, Facilities and Fire compliance assurance is received from partner organisations where trust operates from	Director of Estates and Facilities	Dec-19	Paper presented to QSC in June 2019 outlining key workstreams. Trust risk assessments have been shared with the relevant partners. Correspondence issued to all satellites CEO's requesting assurance on their water compliance and all areas of the HTM's and health & safety, for completeness. External review of compliance completed.	In progress
iv) Substantive recuitment into leadership structure and other vacancies	Director of Estates and Facilities	Mar-20	Recuitment of new substantive Director of Estates and Facilities in progress. Recruitment and retention rates agreed by Executive committee in line with the region. Some successful recruitment - position being monitored.	In progress
v) Work with STP partners to ensure STP Estate Strategy reflects Trust priorities	Director of Estates and Facilities	Dec-20	ENH was represented at a meeting in September 2019, with the regional Estates & Facilities Directors. STP Estates Strategy completed and rated as Good by NHSI/E,	Ongoing
Summary Narrative:				

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

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**
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**		**Risk Open Date:**	01.03.18	**Executive Lead/ Risk Owner**	**Director of Strategy**
		Risk Review Date:	Dec-19	**Lead Committee:**	**FPC**

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 compliance with regulatory requirements vi) Potential impact on patient safety during period of change	**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**
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 . Internal MVCC Task & Finish Group established, linking into NHSI/E fortnightly confernance calls on topic. Policies Clinical Advisory Group	• 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 Monitoring of Quailty Indicators and audit of admissions policy	CHKS review July 2018 Strategic review and recommendations from clinical advisory planel re MVCC, July 2019 Positive Risk Review with Specialist Commissioners, December 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 funding 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 - process to identify new tertiary cancer provider to assume responsibility for the leadership, governance and development of MVCC commenced in Nov 19.	Green	Effective control is in place and Board satisfied that appropriate assurances are available	
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient	
		Red	Effective controls may not be in place and assurances are not available to the Board.	

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) 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) Planned equipment replacement programme	Director of Strategy / COO	Dec-19	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 - building works commenced and contract for external supply confimed . Business case to replace LA1 drafted. 20/21 equipment requirements to be considered in Trust 20/21 capital planning process .	in progress
v) Implement joint estates forum with HHT	Director of Estates and Facilities	Jun-19	Terms of Reference in place.	Complete
vi) MVCC strategy implementation group	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. Q1 progress in delivering clinical strategy reported to Trust Board in September. Q2 progress reported to Trust Board in November. Refresh of Year 2 clinical strategy to be undertaken during Q3. Positive clincal engagement	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	Action plan to implement short term reccomendations from Clinical Advisory Group developed and agreed with NHSE. Progress monitored at weekly Executive Co-ordination Group and issues escalated to Executive ommittee if required. All actions on track.	Complete
Summary Narrative:				

The Trust has been actively working with the MVCC leadership team, NHSE Specialised Commissioners and Hillingdon Hospital NHSFT to take forward the reccomendations from the Clinical Advisory Report. Regular forums are now in place to support delivery of this, with reporting into the Executive Co-ordination Group and the MVCC Strategic Review Programme Board. Discussions are ongoing between NHSI/E in both East of England and London to take forward the reccomendation regarding the transfer of leadership of MVCC to a tertiary cancer provider and identifiation of intensive support for MVCC from a tertiary cancercentrein the medium term - the Trust is supportive of this and looks forward to working with the new organisation, commissioners and staff to take forward this reccomendation. An internal Task & Finish Group, chaired by the Director of Finance is in place to oversee the Trust's preparation for and delivery of the organisation transfer once the new provider is identified.

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 where possible)		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)**
Clinical Strategy Quarterly Update (Part 1)		**X (2020)**				x		x				x
Strategy Deep Dives (Part 2)		**X (2020) CSS**				**x Cancer**		**x Medicine**		**X Women and Children's**		**X Surgery**

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)												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 - deferred to Mar**				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.

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

Agenda item: 14

EAST AND NORTH HERTFORDSHIRE NHS TRUST
PUBLIC TRUST BOARD ACTIONS LOG TO 8 JANUARY 2020

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date

No actions outstanding

DATA PACK

Contents

1. Data and Exception Reports:

FFT

Friends and Family Test - November 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	80.95	2.38	22	12	5	1	0	2	42	72	58.33
5B	100.00	0.00	11	7	0	0	0	0	18	46	39.13
7B	95.06	0.00	50	27	1	0	0	3	81	157	51.59
8A	100.00	0.00	17	23	0	0	0	0	40	58	68.97
8B	94.74	0.00	45	27	4	0	0	0	76	113	67.26
11B	95.51	1.12	64	21	2	1	0	1	89	123	72.36
Swift	98.89	0.00	80	9	1	0	0	0	90	210	42.86
ITU/HDU	100.00	0.00	3	1	0	0	0	0	4	4	100.00
Day Surgery Centre, Lister	99.45	0.00	148	34	1	0	0	0	183	424	43.16
Day Surgery Treatment Centre	98.47	0.38	215	42	3	0	1	0	261	538	48.51
Endoscopy, Lister	99.72	0.28	324	28	0	0	1	0	353	958	36.85
Endoscopy, QEII	99.20	0.00	112	12	0	0	0	1	125	357	35.01
SURGERY TOTAL	97.94	0.29	**1091**	**243**	**17**	**2**	**2**	**7**	**1362**	**3060**	44.51
SSU	96.15	0.00	16	9	1	0	0	0	26	175	14.86
AMU - Blue	100.00	0.00	6	7	0	0	0	0	13	115	33.04
AMU - Green	100.00	0.00	19	6	0	0	0	0	25		
Pirton	100.00	0.00	28	10	0	0	0	0	38	66	57.58
Barley	100.00	0.00	8	0	0	0	0	0	8	26	30.77
6A	96.72	1.64	39	20	1	1	0	0	61	61	100.00
6B	92.31	7.69	12	0	0	1	0	0	13	48	27.08
11A	100.00	0.00	57	31	0	0	0	0	88	88	100.00
ACU	97.30	2.70	28	8	0	1	0	0	37	75	49.33
10B	100.00	0.00	16	6	0	0	0	0	22	61	36.07
Ashwell	84.21	5.26	10	6	1	1	0	1	19	42	45.24
9B	98.04	0.00	29	21	1	0	0	0	51	51	100.00
9A	100.00	0.00	57	0	0	0	0	0	57	57	100.00
Cardiac Suite	100.00	0.00	45	4	0	0	0	0	49	124	39.52
MEDICINE TOTAL	98.22	0.79	**370**	**128**	**4**	**4**	**0**	**1**	**507**	**989**	51.26
10AN Gynae	93.75	2.50	46	29	2	2	0	1	80	92	86.96
Bluebell ward	89.83	1.69	35	18	2	0	1	3	59	207	28.50
Bluebell day case	100.00	0.00	3	3	0	0	0	0	6	6	100.00
Neonatal Unit	97.14	0.00	31	3	1	0	0	0	35	63	55.56
WOMEN'S/CHILDREN TOTAL	93.33	1.67	**115**	**53**	**5**	**2**	**1**	**4**	**180**	**368**	48.91
MVCC 10 & 11	100.00	0.00	21	1	0	0	0	0	22	82	26.83
CANCER TOTAL	100.00	0.00	**21**	**1**	**0**	**0**	**0**	**0**	22	**82**	26.83
TOTAL TRUST	97.63	0.53	**1597**	**425**	**26**	**8**	**3**	**12**	**2071**	**4499**	46.03

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	97.51	0.57	1464	412	26	8	3	11	1924	4060	47.39
QEII	99.20	0.00	112	12	0	0	0	1	125	357	35.01
Mount Vernon	100.00	0.00	21	1	0	0	0	0	22	82	26.83
TOTAL TRUST	**97.63**	**0.53**	**1597**	**425**	**26**	**8**	**3**	**12**	**2071**	**4499**	**46.03**

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	89.02	4.67	223	158	25	10	10	2	428	12287	3.48
QEII UCC	100.00	0.00	10	1	0	0	0	0	11	3778	0.29
A&E TOTAL	**89.29**	**4.56**	**233**	**159**	**25**	**10**	**10**	**2**	**439**	**16065**	**2.73**

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	10	4	0	0	0	0	14	416	3.37
Birth	90.32	2.42	75	37	8	2	1	1	124	444	27.93
Postnatal	83.87	4.84	57	47	12	4	2	2	124	444	27.93
Community Midwifery	100.00	0.00	3	1	0	0	0	0	4	563	0.71
MATERNITY TOTAL	**87.97**	**3.38**	**145**	**89**	**20**	**6**	**3**	**3**	**266**	**1867**	**14.25**

Outpatients	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses
Lister	94.68	2.55	333	112	11	6	6	2	470
QEII	96.75	0.91	568	177	15	1	6	3	770
Hertford County	91.98	1.60	357	159	21	2	7	15	561
Mount Vernon CC	96.17	0.85	186	40	5	1	1	2	235
Satellite Dialysis	97.94	0.00	75	20	2	0	0	0	97
OUTPATIENTS TOTAL	**95.03**	**1.41**	**1519**	**508**	**54**	**10**	**20**	**22**	**2133**

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 eight 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 23 - 25 & 30 – 31 July 2019. The well led inspection took place from 10 – 11 September 2019. The Use of Resources inspection, which is led by NHS Improvement took place on 6 August 2019.

The inspectors focused on **Safety, Effectiveness, Responsiveness, Care and how well led services are** in eight core service lines:

At **Lister Hospital** CQC inspected:

- Surgery
- Critical Care
- Children's and young people
- End of life care
- Outpatient

At the **QEII Hospital** CQC inspected:

- Urgent Care Centre
- Outpatients

At the **Mount Vernon Cancer Centre** CQC inspected:

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

At the July 2019 inspection, these core services were rated either as requires improvement or good.

Summary of the Trust's Ratings

Our rating of the Trust stayed the same -**requires improvement**.
We were rated as **good** for caring and effective and **requires improvement** for and safe, responsive and well led.

We were rated as **requires improvement** for use of resources

	Safe	Effective	Caring	Responsive	Well-led	Overall
Lister Hospital	Requires improvement →← Dec 2019	Good ↑ Dec 2019	Good →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019
Queen Elizabeth II Hospital	Requires improvement ↑ Dec 2019	Good ↑ Dec 2019	Good →← Dec 2019	Requires improvement ↓ Dec 2019	Requires improvement ↑ Dec 2019	Requires improvement ↑ Dec 2019
Mount Vernon Cancer Centre	Requires improvement →← Dec 2019	Good →← Dec 2019	Good →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019
Hertford County Hospital	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Overall trust	Requires improvement →← Dec 2019	Good ↑ Dec 2019	Good →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement →← Dec 2019	Good ↑ Dec 2019	Good →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019
Community	Good Mar 2016	Good Mar 2016	Outstanding Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016

The CQC have issued a number of requirement notices and set out a number of areas for improvement - “Must Do’s” and “Should Do’s”.

The requirement notices are:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

An action plan has been developed against all of these and was submitted to CQC on 22 January 2020. This will be monitored by the Quality Improvement Board, chaired by the Medical Director or Director of Nursing and reported to Board through the Quality and Safety Committee. A programme of internal and external inspections is in place to test and evidence progress and that the actions are embedded across the organisation.

Site Ratings

East and North Hertfordshire NHS Trust

Lister Hospital

	Safe	Effective	Caring	Responsive	Well-Led		Overall
Urgent and emergency services	Good July 2018	Good July 2018	Good July 2018	Good July 2018	Good July 2018		Good July 2018
Medical care (including older people's care)	Requires Improvement July 2018	Requires Improvement July 2018	Requires Improvement July 2018	Requires Improvement July 2018	Requires Improvement July 2018		Requires Improvement July 2018
Surgery	Inadequate December 2019	Good December 2019	Good December 2019	Requires Improvement December 2019	Requires Improvement December 2019		Requires Improvement December 2019
Critical care	Good December 2019	Good December 2019	Good December 2019	Good December 2019	Good December 2019		Good December 2019
Maternity	Requires Improvement July 2018	Good July 2018	Good July 2018	Good July 2018	Good July 2018		Good July 2018
Services for children and young people	Requires Improvement December 2019	Good December 2019	Good December 2019	Good December 2019	Good December 2019		Good December 2019
End of life care	Good December 2019	Requires Improvement December 2019	Good December 2019	Requires Improvement December 2019	Requires Improvement December 2019		Requires Improvement December 2019
Outpatients	Good December 2019	Good December 2019	Good December 2019	Good December 2019	Good December 2019		Good December 2019
Overall	Requires Improvement December 2019	Good December 2019	Good December 2019	Good December 2019	Requires Improvement December 2019		Requires Improvement December 2019

New QEII

	Safe	Effective	Caring	Responsive	Well-Led		Overall
Urgent and emergency services	Requires Improvement December 2019	Good December 2019	Good December 2019	Good December 2019	Requires Improvement December 2019		Requires Improvement December 2019
Outpatients and diagnostic imaging	Requires Improvement December 2019	N/A	Good December 2019	Requires Improvement December 2019	Good December 2019		Requires Improvement July 2018
Overall	Requires Improvement December 2019	Good December 2019	Good December 2019	Requires Improvement December 2019	Requires Improvement December 2019		Requires Improvement December 2019

Hertford County Hospital

	Safe	Effective	Caring	Responsive	Well-Led		Overall
Outpatients	Good March 2016	Good March 2016	Good March 2016	Good March 2016	Good March 2016		Good March 2016
Overall	Good March 2016	Good March 2016	Good March 2016	Good March 2016	Good March 2016		Good March 2016

Mount Vernon Cancer Centre

	Safe	Effective	Caring	Responsive	Well-Led		Overall
Medical care (including older people's care)	Requires Improvement December 2019	Good December 2019	Good December 2019	Requires Improvement December 2019	Requires Improvement December 2019		Requires Improvement December 2019
End of life care	Requires Improvement July 2018	Good July 2018	Good July 2018	Inadequate July 2018	Requires Improvement July 2018		Requires Improvement July 2018
Outpatients	Good December 2019	N/A	Good December 2019	Requires Improvement December 2019	Requires Improvement December 2019		Requires Improvement December 2019
Chemotherapy	Requires Improvement July 2018	Good July 2018	Good July 2018	Requires Improvement July 2018	Requires Improvement July 2018		Requires Improvement July 2018
Radiotherapy	Good December 2019	Good December 2019	Good December 2019	Good December 2019	Good December 2019		Good December 2019
Overall	Requires Improvement December 2019	Good December 2019	Good December 2019	Requires Improvement December 2019	Requires Improvement December 2019		Requires Improvement December 2019

Community Health Services for Children, Young People and Families

	Safe	Effective	Caring	Responsive	Well-Led		Overall
Community health services for children and young people	Good March 2016	Good March 2016	Outstanding March 2016	Good March 2016	Good March 2016		Good March 2016
Overall	Good March 2016	Good March 2016	Outstanding March 2016	Good March 2016	Good March 2016		Good March 2016

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 November 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 November. 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**	**Non-Registered**	**Registered**	**Non-Registered**	**Registered**	**Non-Registered**	**All Staff**
Trust Average (Current Month)	93.4%	91.2%	96.6%	112.0%	94.9%	99.3%	96.4%
Trust Average (Last Month)	94.6%	92.4%	97.5%	115.2%	95.9%	101.3%	97.8%
Change	⇩ -1.2%	⇩ -1.2%	⇩ -0.9%	⇩ -3.2%	⇩ -1.0%	⇩ -2.0%	⇩ -1.4%

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).

Registered Nursing Associates and Non-Registered Nursing Associates are now identified in separate fields within the NHS England & Improvement fill rate template. The planned care hours have been adjusted to reflect the actual care hours as the nursing associate workforce is a limited pool and the hours worked are variable each month. The total planned care

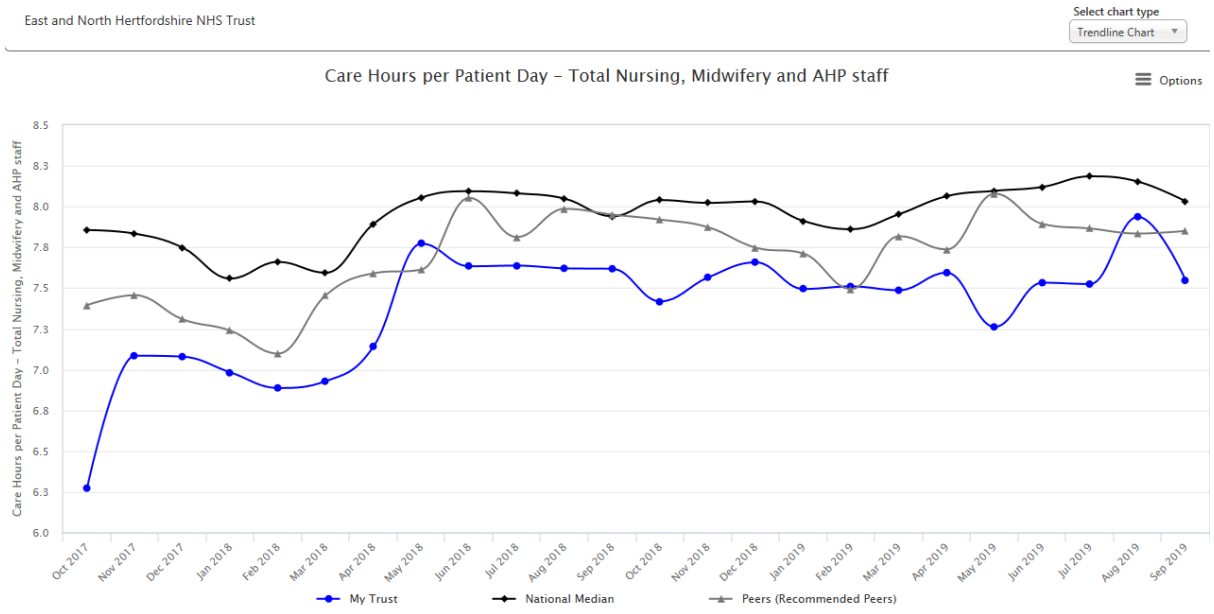
hours for each ward is fixed as per the agreed establishment settings therefore the planned hours will be flexed across Registered Nurses and Registered Nursing Associates each month.
The Trust Average CHPPD for this month and last month can be seen in the table below. A full list of CHPPD by ward can be found in Appendix 3.

Table 2

	Average 24 Hr				
Trust Average CHPPD	**Registered Nurses / Midwives**	**Non-registered Nurses / Midwives (Care Staff)**	**Registered Nursing Associates**	**Non-registered Nursing Associates**	**All Staff**
Trust Average (Current Month)	4.7	2.7	0.1	0.1	7.5
Trust Average (Last Month)	4.8	2.7	0.1	0.1	7.7
Change	↓ -0.1	→ 0.0	→ 0.0	→ 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.

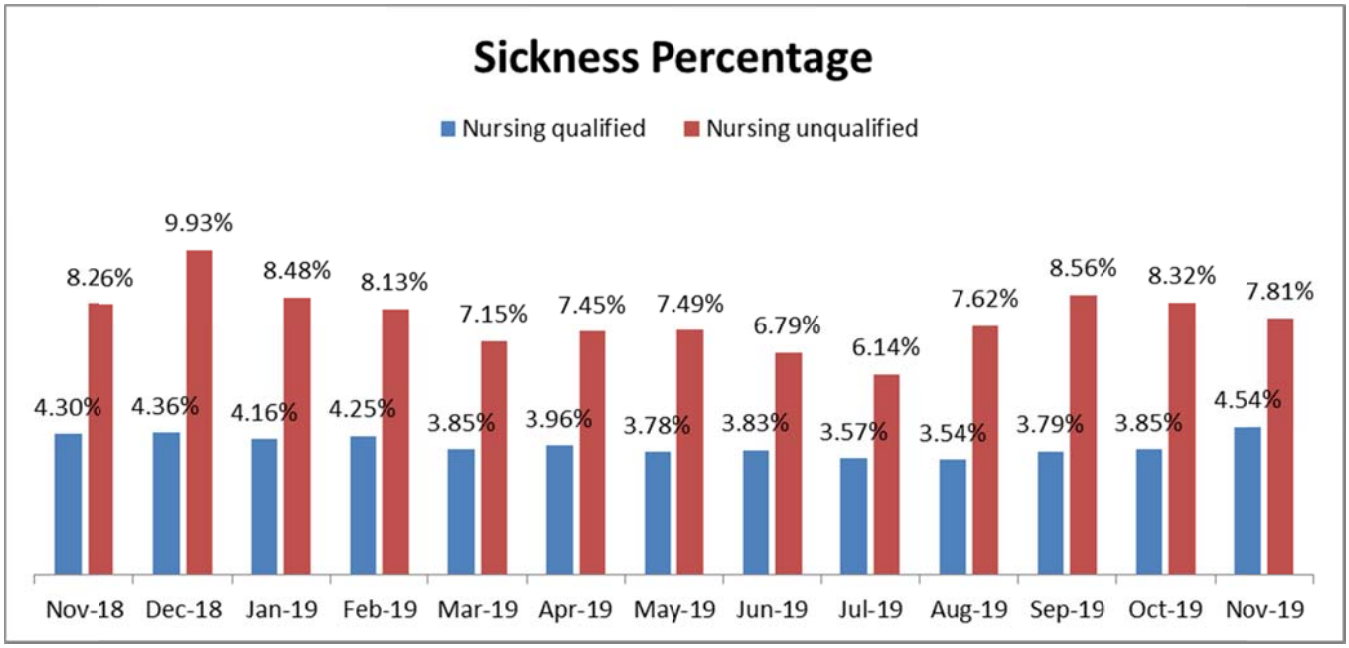
Chart 1 Care Hours per Patient Day (CHPPD): Data source Model Hospital Dashboard (latest available data).



3.3 Sickness

Chart 2 shows that sickness levels have increased for qualified nursing staff the highest level since January 2018 and decreased for unqualified nursing staff in November. There is ongoing work to address our above benchmark comparator sickness levels in our CSWs.

Chart 2 – Sickness Percentage by Staff Group



3.4 Patient Flow and Escalation

Good patient flow is central to patient experience, clinical safety and reducing the pressure on staff. It is also essential to the delivery of national emergency care access standards. (NHSI 2017)
Chart 3 shows for the month of November the Opel status of the trust each day, linked with the number of Learning disability patients in acute beds and the number of enhanced care patients requiring a higher level of care per day. These factors all have an impact to staff experience, patient safety, quality and outcomes on our wards.
Where patient numbers and acuity demands on the trust increase, an informed decision to open escalation beds is made to cope with the pressures on the system. Additional staff is requested to support this requirement.
For the month of November escalation shifts were requested on 17 occasions to support the site safety and flow.

Chart 3

Nov-19		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Opel Status		OPEL 2	OPEL 2	OPEL 2	OPEL 3	OPEL 3	OPEL 3	OPEL 2	OPEL 2	OPEL 2	OPEL 2	OPEL 3	OPEL 3	OPEL 3	OPEL 3	OPEL 3	OPEL 2	OPEL 2	OPEL 2	OPEL 2	OPEL 2	OPEL 2	OPEL 2	OPEL 3	OPEL 3	OPEL 3	OPEL 3	OPEL 3	OPEL 3	OPEL 3	OPEL 3
Number of LD Patients		6	6	6	4	6	9	6	9	9	9	8	9	5	7	6	6	4	6	6	4	6	7	7	7	6	6	5	7	9	9
Number of Enhanced Care		33	33	33	40	39	35	35	39	39	39	27	33	45	45	41	41	42	44	39	37	37	29	29	29	34	34	32	36	35	35
Escalation	Discharge Lounge	NO	NO	NO	NO	YES	YES	YES	NO	NO	NO	YES	NO	YES	YES	NO	NO	NO	YES	YES	YES	YES	NO	YES	YES	YES	YES	YES	YES	YES	NO
Shifts	CDU	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	YES	NO	NO	NO	YES	YES	YES	YES	NO	NO	NO	NO	YES	YES	YES	NO	NO	NO	NO	NO

3.5 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 November 119 risk assessments were received by the team which is an increase of 10 patients referred compared to October. Chart 4 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 November, 67 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 5 shows the breakdown of care hours provided by the ENCT and 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 4

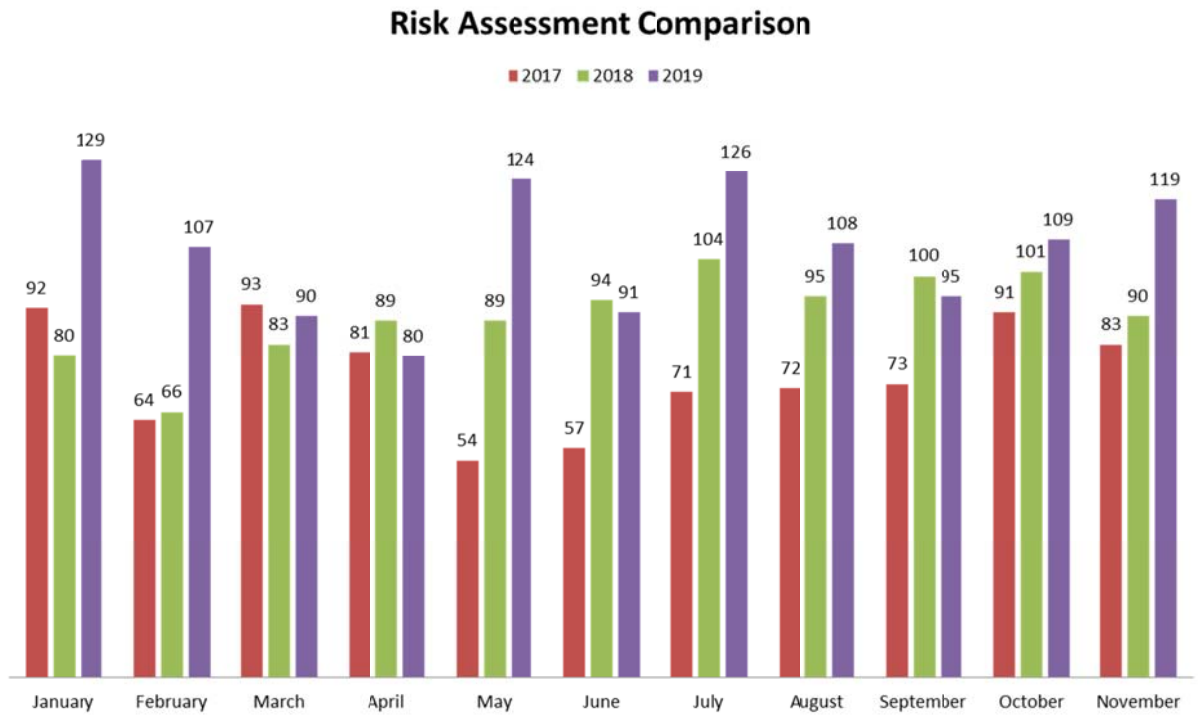
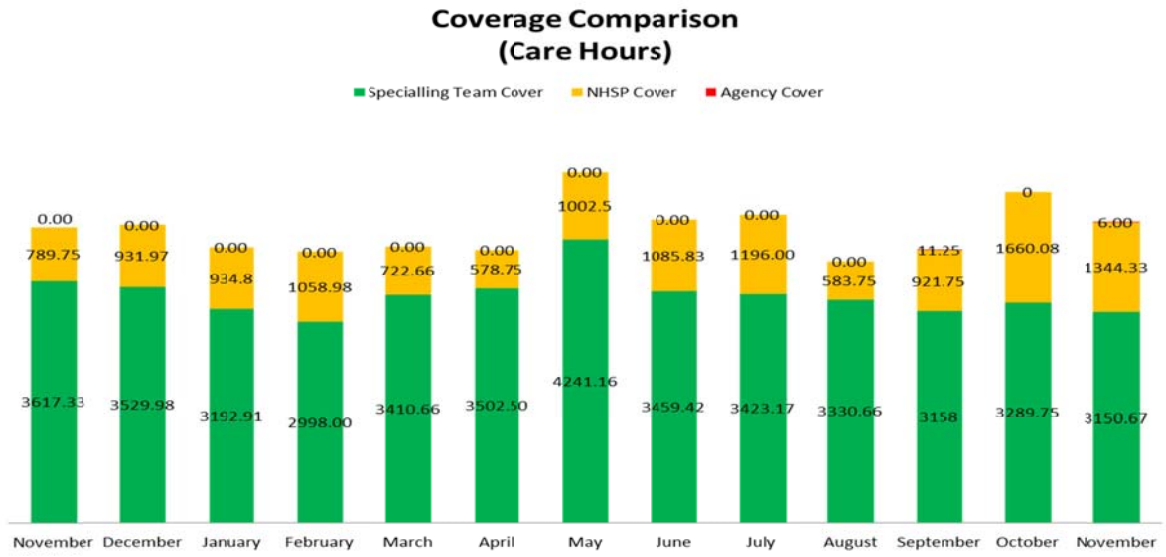


Chart 5



3.6 Recruitment and retention

The overall Trust position for qualified nursing in month 8 saw 9.2 WTE new starters and 23.5 WTE leavers, giving a negative variance of 14.3 WTE for the month. This, combined with an increase in Recruitable establishment of 5.8 WTE, has resulted in a vacancy rate of 6.5%, an increase of 0.7% from month 6. The qualified UK nurse pipeline currently indicates a total of 31.3 WTE future new starters, and a further 14 student nurses not yet showing on the pipeline but who qualify in month 11 and have applied for positions.
The vacancy rate for Clinical Support Workers increased by 2.1% in month 8 to 13.7%, equating to 87 vacancies. This was due to only 2 WTE starting in month against 11.07 WTE leaving. There are a total of 14 WTE in the pipeline currently undergoing pre-employment checks, starting in month 10. Regular recruitment events are held for Clinical Support Workers and an increase focus will be made to recruit given the increase in vacancy rate.

4.0 Financial Sustainability

The Deputy Director of Nursing, all matrons, safer staffing team and heads of nursing continue to 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 continue to use a Rapid Response pool of nurses and CSWs. These bank staffs get an enhanced pay rate and flexible hours in recognition of the workers commitment to be deployed to any clinical area 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. The number of shifts made available are flexed up or down as the need arises.

4.1 Temporary Staffing Fill

Overall fill rate for temporary staffing decreased by 2.6% from 82.2% in October to 79.6% in November. Demand hours increased by over 3,100 hours.

Bank fill rates decreased by 2.8% and Agency fill rates increased by 0.2%. The level of unfilled shifts increased from 17.8% in October to 20.4% in November.

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	64,834	46,309	71.4 %	4,405	6.8 %	78.2 %	14,120	21.8 %
May 2019	67,192	49,578	73.8 %	5,049	7.5 %	81.3 %	12,566	18.7 %
June 2019	61,630	46,262	75.1 %	4,434	7.2 %	82.3 %	10,934	17.7 %
July 2019	55,419	49,281	88.9 %	3,502	6.3 %	95.2 %	2,637	4.8 %
August 2019	63,729	48,400	75.9 %	2,571	4.0 %	80.0 %	12,759	20.0 %
September 2019	65,165	49,709	76.3 %	2,349	3.6 %	79.9 %	13,107	20.1 %
October 2019	68,676	53,768	78.3 %	2,670	3.9 %	82.2 %	12,237	17.8 %
November 2019	71,868	54,284	75.5 %	2,925	4.1 %	79.6 %	14,658	20.4 %
Total	**518,513**	**397,591**	**76.7 %**	**27,905**	**5.4 %**	**82.1 %**	**93,017**	**17.9 %**

Chart 5 Nursing and Midwifery Temporary Staffing Demand and Fill Rates

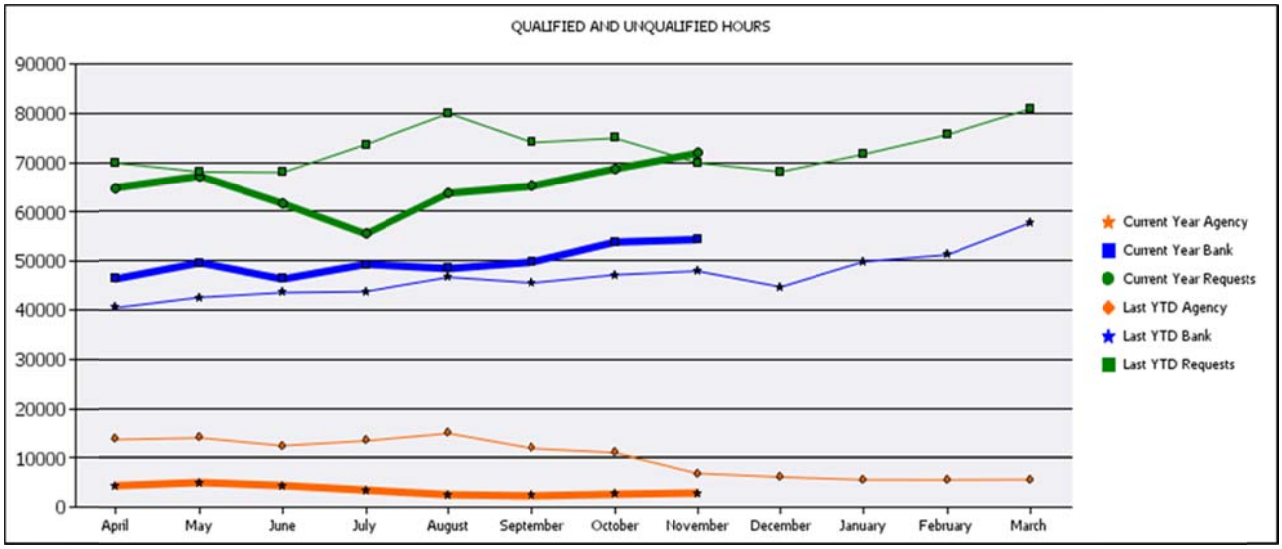


Table 4 Temporary Staffing Registered Hours Demand and Fill Rates

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	39,525	26,870	68.0 %	4,405	11.1 %	79.1 %	8,250	20.9 %
May 2019	40,785	28,116	68.9 %	5,049	12.4 %	81.3 %	7,621	18.7 %
June 2019	38,575	26,915	69.8 %	4,434	11.5 %	81.3 %	7,226	18.7 %
July 2019	33,442	27,978	83.7 %	3,502	10.5 %	94.1 %	1,963	5.9 %
August 2019	39,049	28,380	72.7 %	2,571	6.6 %	79.3 %	8,099	20.7 %
September 2019	40,708	29,779	73.2 %	2,349	5.8 %	78.9 %	8,579	21.1 %
October 2019	41,315	32,063	77.6 %	2,668	6.5 %	84.1 %	6,584	15.9 %
November 2019	44,364	32,851	74.0 %	2,925	6.6 %	80.6 %	8,588	19.4 %
Total	**317,763**	**232,951**	**73.3 %**	**27,903**	**8.8 %**	**82.1 %**	**56,909**	**17.9 %**

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	26,408	21,463	81.3 %	0	0.0 %	81.3 %	4,945	18.7 %
June 2019	23,055	19,346	83.9 %	0	0.0 %	83.9 %	3,709	16.1 %
July 2019	21,977	21,303	96.9 %	0	0.0 %	96.9 %	674	3.1 %
August 2019	24,680	20,020	81.1 %	0	0.0 %	81.1 %	4,660	18.9 %
September 2019	24,457	19,930	81.5 %	0	0.0 %	81.5 %	4,527	18.5 %
October 2019	27,361	21,705	79.3 %	2	0.0 %	79.3 %	5,653	20.7 %
November 2019	27,503	21,434	77.9 %	0	0.0 %	77.9 %	6,069	22.1 %
Total	**200,750**	**164,640**	**82.0 %**	**2**	**0.0 %**	**82.0 %**	**36,108**	**18.0 %**

4.2 Roster KPIs

Table 6 shows the roster KPIs for the month of November as captured in the Nursing Quality Indicators Report. There is ongoing work with divisions to improve their roster KPIs through the eRoster and Finance Master Classes currently being rolled out to Ward Managers and Matrons.

SUMMARY		Trust	Medicine	Surgery	Women & Children	Cancer	Assessment Wards	Emergency Department	Dialysis
e-Roastering	% E-roster Deadline Met	52.61%	44.08%	78.88%	33.00%	33.00%	33.00%	66.50%	79.80%
	Net Hours %	-0.34%	-0.22%	0.45%	-0.64%	-0.90%	-0.40%	-0.05%	-0.64%
	Net Hours Position	-216.60	-135.41	395.33	-267.44	-54.11	-24.09	23.29	-154.17
	% of Actual Annual Leave	13.48%	13.11%	13.60%	11.86%	17.50%	11.85%	14.20%	12.24%

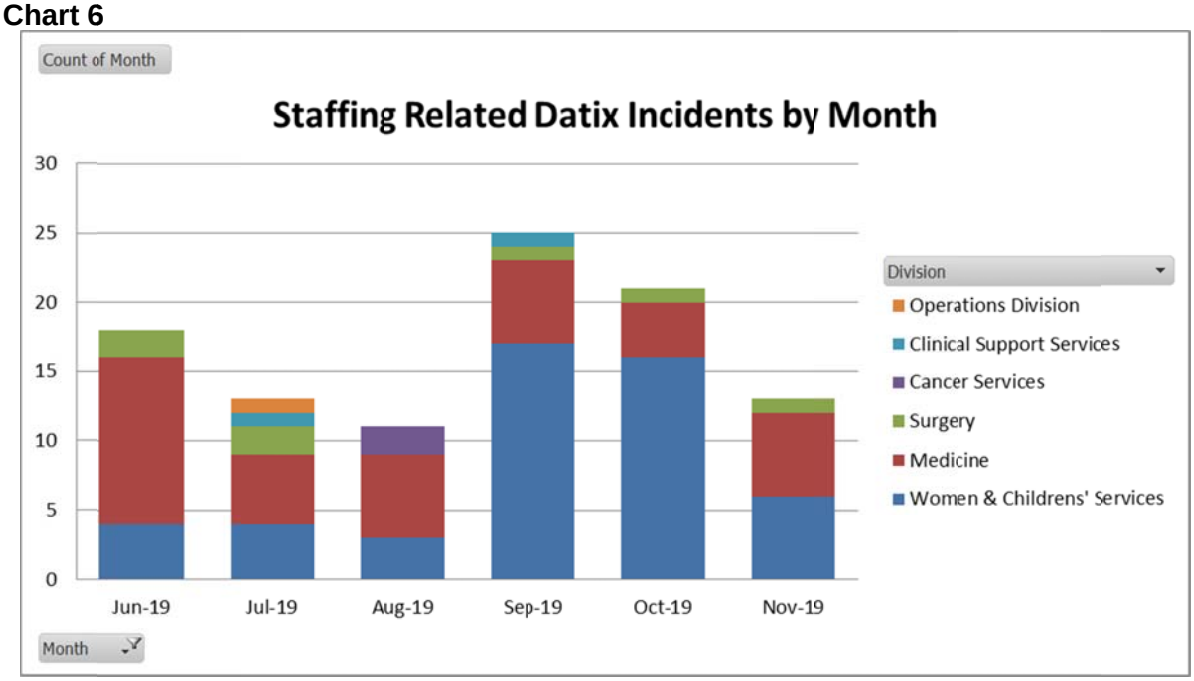
5.0 Investigations and actions on Incidents and red flag events

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 months by speciality.
Thirteen staffing related Datix were raised in November. All staffing related incidents are reviewed by the Safer Staffing Matron and DoN and actioned as appropriate. All Datix for November have been reviewed and actioned by the department managers.

Chart 6

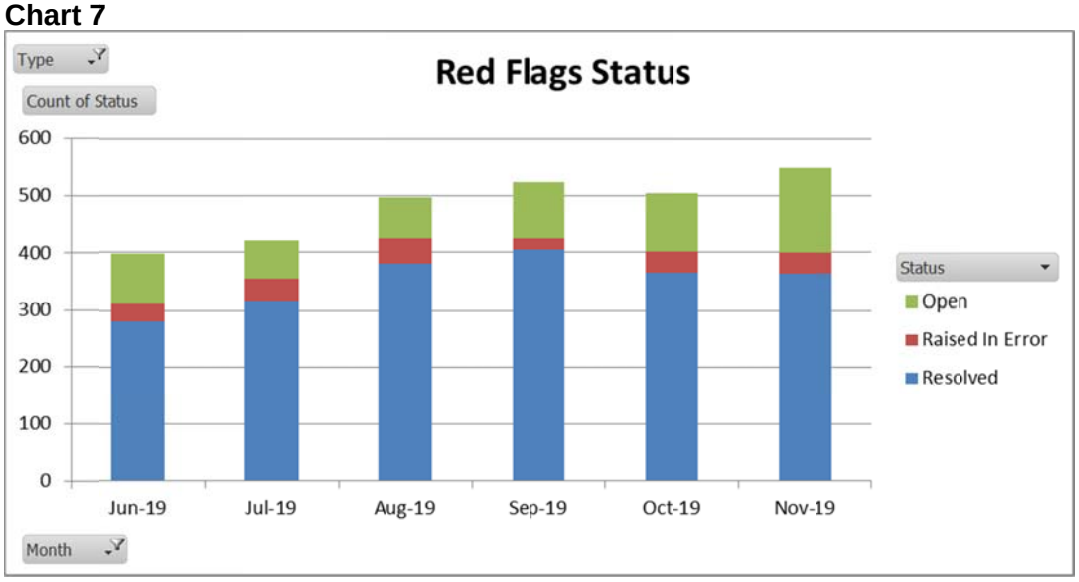


5.2 Red Flag Events

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.

Chart 7 shows the number of red flags raised each month over the last 6 months and their status excluding Maternity Red Flags. See **Appendix 4** for the Midwifery safe staffing update.

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.

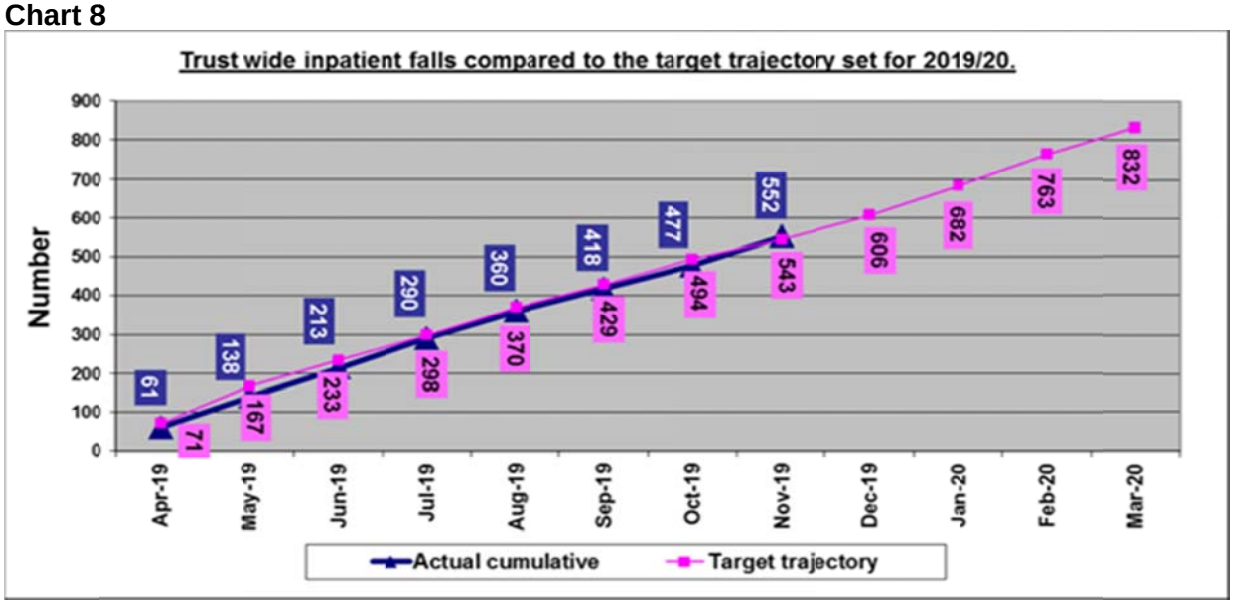
6.1 Safety Thermometer

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 – 13th November 2019. We acknowledge that the 'harm' in November 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 November this is an increase of 16 incidents when compared to October. The Trust is 9 incidents below the target reduction trajectory set for 2019/20.as shown in chart 8. 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.

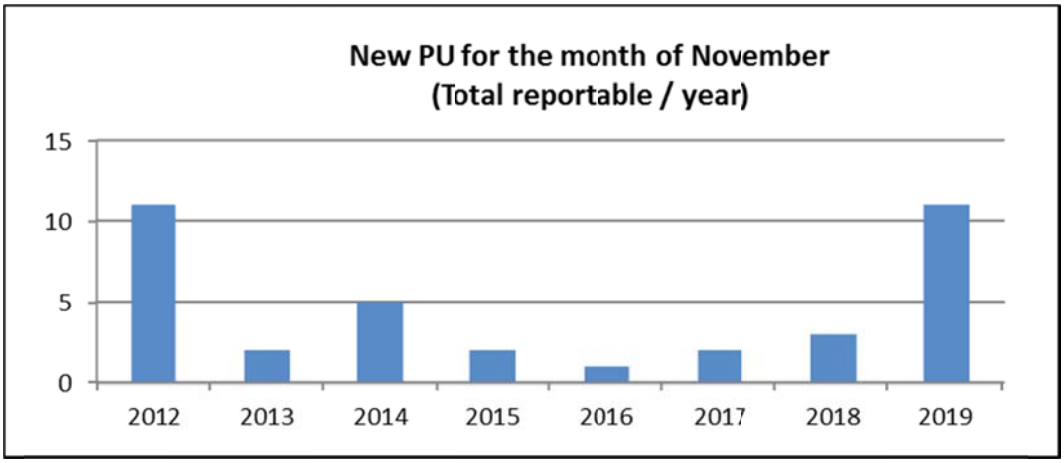
Chart 8



6.3 Pressure Ulcers

For the month of November there were 11 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.
November 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 = 92

Chart 9

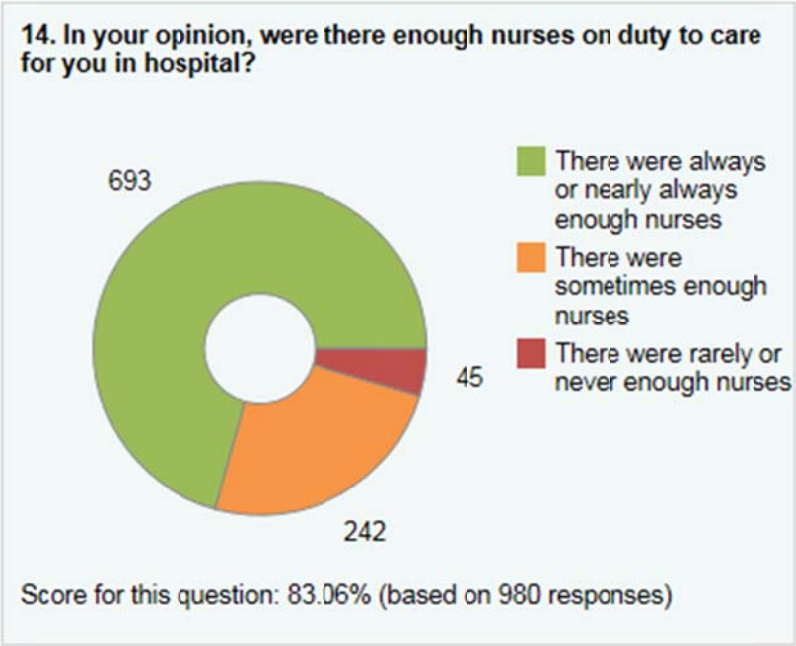


7.0 Patient, carer and staff feedback in relation to safe staffing levels

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 November 2019, 4.59% of 980 responses felt there were not enough nurses on duty. This is an increase in patients / carers feeling there were not enough nurses on duty from 4.09% in October.
Chart 10 shows the breakdown of responses for November 2019. Action plans are put in place where performance is triggering red.

Chart 10

November 2019



7.1 Friends and Family

Table 7 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 November has increased slightly from October.

Table 7

A Summary of the last 3 months responses

Month	% Would Recommend	% Would Not Recommend	No. of patients responding	% response rate [target 40%]
September 2019	96.94	0.56	1959	43.38
October 2019	96.33	0.96	2182	46.69
November 2019	97.63	0.53	2071	46.36

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 November 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.
Good practice guide: Focus on improving patient flow NHSI October (2017)

Appendix 1

	Day				Night			
Ward name	Average fill rate + registered nurses/ midwives (%)	Average fill rate + care staff (%)	Average fill rate - Registered Nursing Associates	Average fill rate - Non - Registered Nursing Associates	Average fill rate + registered nurses/ midwives (%)	Average fill rate + care staff (%)	Average fill rate - Registered Nursing Associates	Average fill rate - Non - Registered Nursing Associates
10B	97.5%	87.4%	#DIV/0!	#DIV/0!	98.7%	130.7%	#DIV/0!	#DIV/0!
11A	99.8%	96.2%	#DIV/0!	100.0%	97.8%	114.9%	#DIV/0!	#DIV/0!
11B	84.8%	102.1%	100.0%	100.0%	101.8%	102.7%	100.0%	#DIV/0!
5A	95.3%	91.1%	100.0%	100.0%	98.9%	124.9%	100.0%	#DIV/0!
5B	92.0%	90.2%	100.0%	#DIV/0!	98.1%	115.1%	#DIV/0!	#DIV/0!
6A	96.7%	93.9%	#DIV/0!	100.0%	96.4%	113.3%	#DIV/0!	#DIV/0!
6B	95.3%	92.9%	#DIV/0!	#DIV/0!	99.0%	148.6%	#DIV/0!	#DIV/0!
10A Gynae	102.3%	84.3%	#DIV/0!	#DIV/0!	101.1%	96.7%	#DIV/0!	#DIV/0!
7B	97.0%	89.3%	100.0%	100.0%	100.3%	99.3%	#DIV/0!	100.0%
8A	95.4%	101.6%	100.0%	#DIV/0!	95.6%	126.9%	#DIV/0!	#DIV/0!
8B	99.4%	91.9%	#DIV/0!	#DIV/0!	98.2%	112.6%	#DIV/0!	#DIV/0!
9A	94.3%	109.5%	#DIV/0!	#DIV/0!	98.8%	129.9%	#DIV/0!	#DIV/0!
9B	100.2%	101.9%	100.0%	100.0%	99.8%	137.0%	#DIV/0!	#DIV/0!
ACU	96.5%	81.3%	#DIV/0!	100.0%	100.3%	105.1%	#DIV/0!	#DIV/0!
AMU-A	94.8%	95.1%	100.0%	100.0%	97.4%	103.0%	100.0%	#DIV/0!
AMU-W	98.6%	133.0%	#DIV/0!	#DIV/0!	99.8%	130.6%	#DIV/0!	#DIV/0!
Ashwell	94.0%	100.5%	100.0%	100.0%	102.2%	128.3%	100.0%	#DIV/0!
Barley	97.5%	92.6%	#DIV/0!	#DIV/0!	101.5%	142.7%	#DIV/0!	#DIV/0!
Bluebell	109.8%	69.3%	100.0%	100.0%	92.3%	112.2%	#DIV/0!	#DIV/0!
Critical Care 1	100.0%	100.0%	#DIV/0!	#DIV/0!	100.0%	100.0%	#DIV/0!	#DIV/0!
Dacre	89.1%	97.8%	#DIV/0!	#DIV/0!	88.2%	#DIV/0!	#DIV/0!	#DIV/0!
Gloucester	91.3%	81.3%	#DIV/0!	#DIV/0!	96.5%	95.1%	#DIV/0!	#DIV/0!
Mat CLU 1	93.9%	87.2%	#DIV/0!	#DIV/0!	96.0%	97.0%	#DIV/0!	#DIV/0!
Mat MLU	79.3%	93.6%	#DIV/0!	#DIV/0!	76.0%	95.1%	#DIV/0!	#DIV/0!
Pirton	84.9%	91.7%	#DIV/0!	100.0%	97.8%	110.8%	#DIV/0!	100.0%
SAU	93.9%	93.6%	#DIV/0!	100.0%	98.6%	103.2%	#DIV/0!	100.0%
SSU	95.2%	108.2%	#DIV/0!	100.0%	99.6%	109.3%	#DIV/0!	#DIV/0!
Swift	86.5%	84.0%	100.0%	#DIV/0!	99.9%	98.2%	#DIV/0!	#DIV/0!
Ward 11	62.6%	45.3%	100.0%	#DIV/0!	73.4%	63.9%	#DIV/0!	#DIV/0!
Total	**93.2%**	**91.0%**	**100.0%**	**100.0%**	**96.6%**	**112.0%**	**100.0%**	**100.0%**

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
Pirton	Reduced occupancy in month
Swift	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

Ward name	Care Hours Per Patient Day (CHPPD)				
	Registered midwives/ nurses	Care Staff	Registered Nursing Associates	Non-Registered Nursing Associates	Overall
10B	3.37	2.55	0.00	0.00	5.93
11A	3.87	1.98	0.00	0.04	5.89
11B	4.31	2.85	0.23	0.10	7.49
5A	3.22	2.34	0.17	0.07	5.80
5B	3.56	2.72	0.14	0.00	6.42
6A	3.58	2.55	0.00	0.10	6.23
6B	4.38	2.31	0.00	0.00	6.68
10A Gynae	5.56	2.47	0.00	0.00	8.03
7B	3.28	1.87	0.15	0.17	5.48
8A	3.03	2.27	0.16	0.00	5.46
8B	3.34	2.33	0.00	0.00	5.67
9A	3.19	2.61	0.00	0.00	5.80
9B	3.03	2.43	0.01	0.14	5.60
ACU	4.77	2.14	0.00	0.14	7.06
AMU-A	5.86	3.36	0.20	0.09	9.51
AMU-W	4.27	3.74	0.00	0.00	8.01
Ashwell	3.40	3.13	0.23	0.11	6.86
Barley	3.64	3.14	0.00	0.00	6.78
Bluebell	6.59	2.62	0.35	0.20	9.76
Critical Care 1	15.96	2.08	0.00	0.00	18.04
Dacre	6.53	1.18	0.00	0.00	7.72
Gloucester	4.25	3.84	0.00	0.00	8.09
Mat CLU 1	21.50	6.74	0.00	0.00	28.24
Mat MLU	35.23	13.56	0.00	0.00	48.79
Pirton	4.37	2.22	0.00	0.23	6.83
SAU	7.55	3.58	0.00	0.15	11.28
SSU	3.40	3.38	0.00	0.08	6.86
Swift	3.98	2.26	0.20	0.00	6.45
Ward 11	7.04	3.13	0.24	0.00	10.40
Total	**4.7**	**2.7**	**0.1**	**0.1**	**7.5**

Appendix 4

Safer Staffing Report November 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 including band 3 and 4 staff that support postnatal care against BR+ recommendation of a ratio of 1:26. 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. In addition, a review of staff skill mix was carried out to bring the staffing in line with the recommended ratios. Band 3 and 4 support workers currently supporting inpatients antenatal care have been transferred to the community to provide postnatal care. The result is an improvement in the right skills, providing the right care, in the right place, improving midwife to birth ratio overall.

2019	Aug		Sept		Oct		Nov	
Midwives	178.57		178.57		178.57		178.57	
Band 3-4 Postnatal	11.53		11.53		11.53		11.53	
Total Funded Clinical	**190.1**		**190.1**		**190.1**		**190.1**	
Actual Worked	**175.89**		**176.79**		**184.2**		**185.2**	
	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	454	**28**	440	**28**	445	**27.5**	**453**	**29**
12 Month Rolling Year to Date Against Funded Midwifery Establishment	5318	**30**	5327	**28**	5301	**30**	**5286**	**30**
Actual Births in Month against actual worked in month midwives	5228	**32**	5487	**33**	5475	**32**	**5414**	**31**

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 April 2019 included in the clinical numbers are non-recruitable 4.76 in budget to support maternity leave
Also included 4% non recruitable headroom

Actions

- Birthrate Plus (BR+) Workforce Analysis based on QTR 3 18/19 activity recommended an uplift in establishment (not including requirements to support national maternity transformation ambitions)
- Presented to Trust Board in July 2019 as part of the Trust Bi-annual Establishment Review reflecting professional judgment to inform recommended uplift
- Local Maternity System funds utilised to support maternity transformation workforce ambitions and increase establishment
- BR+ recommendations shared across the LMS
- Draft LMS 5 Year Workforce Strategy to be shared with the STP
- A maternity staffing paper to be presented to execs in October 2019

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).

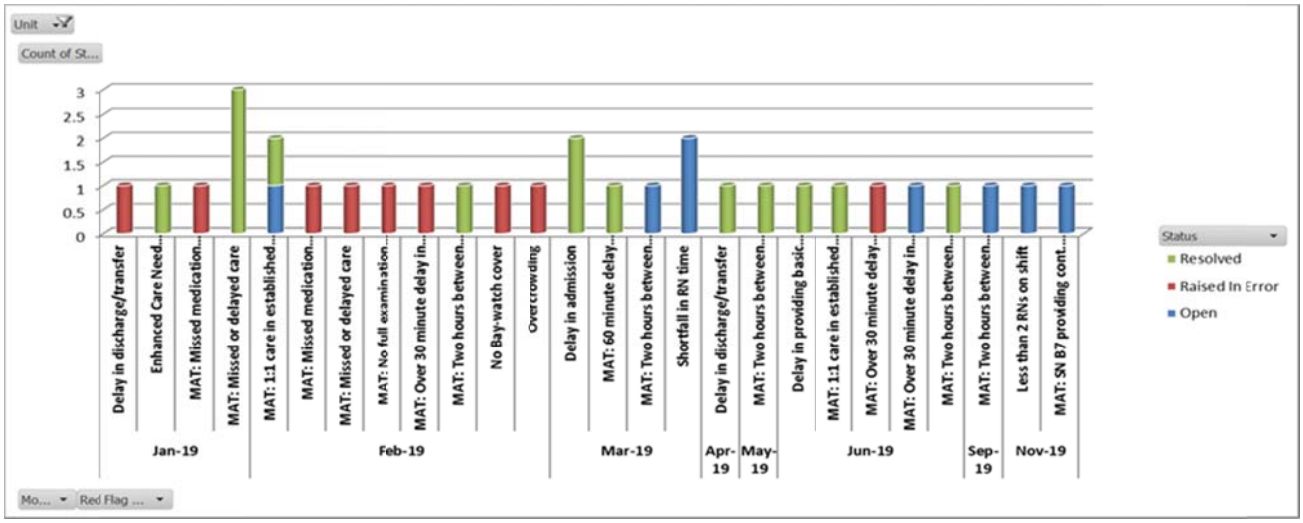
NICE Safe midwifery staffing for maternity settings 2015 defines Red Flag events as negative events that are immediate signs that something is wrong and action is needed now to stop the situation getting worse. Action includes escalation to the senior midwife in charge of the service and the response may 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



East and North Hertfordshire NHS Trust

Agenda Item: 16.1

TRUST BOARD - PUBLIC SESSION – 8 JANUARY 2020
CHARITY TRUSTEE COMMITTEE – 9 DECEMBER 2019
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present to the Trust Board the summary report from the Charity Trustee Committee (CTC) meeting of 9 December 2019. The report includes details of any decisions made by the CTC under delegated authority.		
Action required: For information		
Previously considered by: Due to be considered by the Board as Corporate Trustee immediately prior to public meeting of Trust Board on 8 January 2020.		
Director: Chair of CTC	**Presented by:** Chair of CTC	**Author:** Board Committee Secretary / Trust Secretary

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

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

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CHARITY TRUSTEE COMMITTEE MEETING HELD 9 DECEMBER 2019

SUMMARY REPORT TO BOARD

The following members were present: Bob Niven (CTC Chair), Val Moore (Non-Executive Director), David Buckle (Non–Executive Director) and Jude Archer (Associate Director of Corporate Governance).

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

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

Proposal	Cost	Outcome
Admiral Nurse management and development annual fees	£6,000 for three years	Approved
Create a Patient/Relatives Room for renal ward 6b	£12,000	Approved
2.3 WTE Activity Coordinator (Medicine)	£53,000	Not approved – The CTC requested further details regarding the roles.
Redecorating theatre recovery area - recovery level 4	TBC	Approved in principle and subject to donor's agreement.
Patient Experience Project Coordinator role 1 years backfill April 2019 – March 2020	£9,406.50 pa (18.75 hrs p/w).	Approved Q4 (the CTC was opposed to the idea of approving an application retrospectively).
To continue to fund Volunteering Service at MVCC	£105,640	Approved.
Infection Prevention and Control MSc	£6,500	The CTC approved funding for 75% of the remaining course fees.

Other outcomes:

Investment Portfolio Update
The Committee was presented with an update on the investment portfolio. The update included analysis of various factors that could affect the value of the investments. It was reported that the charity's portfolio has outperformed the ARC Charity steady growth index. The CTC updated Rathbones on the situation regarding the transfer of MVCC to a tertiary provider and the potential future impact on the Charity's income.

Divisional Fund Management Reports:
1. Surgery
The Committee considered a report regarding the deployment of the Surgery funds. The report summarised the current position and future plans regarding the charitable funds within the surgery division. It was reported that the total number of funds have reduced to 12 from 28. The Committee discussed the benefit of consolidating funds. The Committee also noted the strong relationship the division had developed with the Charity over the last couple of years.

2. Cancer

The CTC also received an update on charitable funds management in the Cancer Division and discussed key priorities. The Committee noted the application for funding relating to the Community engagement team at MVCC (this would be considered under the approvals of expenditure over £5k agenda item).

Charity Strategy Update

The Committee considered an update on the Charity Strategy. There was generally good performance against the KPIs though some had not been achieved, such as the cost ratio. The Head of Charity proposed developing a new three year strategy for the Charity based in part of the outcome of the discussion regarding the forecast. The CTC supported this proposal.

Charity Finance Report

The CTC considered the report which provided an update on the financial performance of the Charity. The report provided an update on the closing finance position of the Charity for Month 7.

As at 31 October 2019, Year to date Income was £620k against plan of £858k, expenditure was £939k against plan of £1.078k resulting in an adverse position of £322k. Lower than expected legacy income was a particularly significant factor. The Committee noted the report.

Charity Reforecast

The Committee considered a paper requesting approval of a reforecast in income for 2019/20. The report explained that the income target of £3m in 3 years had been unrealistic and did not take account of the nuances between different income sources, particularly legacy income. Furthermore, the strategy underestimated the groundwork required to recruit and deploy the expanded charity team in order to build donations. The proposal was for an income reforecast from £2.2m to £1.3m, made of £1.05m fundraised income and legacy income of £250k. The impact of the reforecast would result in the cost of raising funds ratio increasing to either 30% or 35% depending on which one of the two options regarding recruitment to two posts that were due to become vacant. The CTC endorsed the Charity reforecast.

Option 1 was holding these posts vacant.

Note - this would halt income growth and result in a reforecast of £200k less income in 20/21 due to the rest of the staff being at capacity and not having the skillset or time to deliver the major donor or trust activity. This would lessen the Charity's ability to support the Trust to fund additional capital costs in the future, reducing patient benefit.

Option 2 was to staff to a structure (which saves £30,294 against the current approved staff budget) and would forecast 1.5m income including 250k legacy income in 20/21. NB Part of the new structure includes a role (which replaces one of the replacement roles) being recruited on a 1 year fixed term contract, recognising the risk of and safeguarding against a loss in income due to losing Mount Vernon.

The Committee noted that the impact of organising the staff awards contributed 1% to the cost of raising funds ratio.

The Committee discussed the two options. The implications of the MVCC transfer were considered. It was believed that these had been mitigated as far as possible at this stage.

The Committee supported the proposal for a reforecast and endorsed option two regarding the recruitment to vacant posts.

The report is attached as Appendix 1 for information.

Trust Overhead Charges

The CTC was presented with a report which set out to review the overhead cost recharged to the Charity by the Trust. This was provided in response to the issues raised by the external auditor at the last audit. The Committee recommended further minor changes. The charges would be reviewed annually. The Committee approved the updated charges subject to the minor changes.

Charity Annual Report and External Auditor's Update

The CTC was informed that the Charity's annual report and accounts for 2018/19 had now been submitted to the Charity Commission.

Bob Niven
Chairman of the Charity Trustee Committee

December 201

East and North Hertfordshire NHS Trust

Agenda Item: 16.1 Appendix 1

TRUST BOARD - PUBLIC SESSION – 8 JANUARY 2020

CHARITY REFORECAST

Purpose of report and executive summary (250 words max): This report was considered by the CTC at the meeting held on 9 December 2019. The paper requested approval for a reforecast in income for 2019/20. Please see the CTC summary report for details of the discussion and decision made by the CTC in relation to this report.		
Action required: For information		
Previously considered by: **CTC – 09.12.19**		
Director: Director of Strategy	**Presented by:** Chair of CTC	**Author:** Head of Charity

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): As detailed within the paper.

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1. Executive Summary

This paper requests approval for a reforecast in income for 19/20. As a result of this the *percentage ratio of the cost of fundraising as compared to funds raised will* exceed the 25% as outlined as a KPI in the approved charity strategy. The implications of this and an explanation is provided in context of the fundraising ratios achieved by the charity in past years and the fundraising ratios achieved by other NHS hospital charities. CTC are asked to approve the reforecast and decide whether they want to accept the ratio increase and continue to invest to grow or take advantage of opportunities to reduce costs for Q4 and 20/21.

2. History

CTC approved a charity growth strategy in 2016/17 with a target of £3m to be raised by 20/20 (extended to 20/21 in March 2019). This target figure may not have taken into account the spike in legacy income seen in 16/17 and 17/18 and the fact the charity was at the time actually raising only 700k from donations and activities to raise funds.

In order to meet the ambitious targets the charity team has been staffed so it is able to deliver income of 2.2m and as such, be on track to raise 3m, however to achieve this there was an expectation of 500k p/a in legacy income, an ability to react to opportunity in a timely manner and a warm donor database which in practise has been shown not to be realistic.

The Charity has increased fundraised income from £700k in 16/17 to £1,03m in 18/19; a 47% increase. The Charity is now forecasting £1,05m for 19/20 and anticipates income will continue to increase each year whilst staff cost remain. During this time legacy income, over which the charity has no in year control, has reduced dramatically.

The Charity strategy included a KPI stating the cost of fundraising should be below or equal to 25% of income raised.

3. Reforecast

The Charity proposes a realistic income reforecast from £2,2m to £1.3m; made of £1,05m fundraised income plus legacy income of £250k.

Income	Original Budget	YTD Actual @ 31/10/2019	YTD Forecast @ 31/03/2020	Variance
	£		£	£
Income - legacies	555,000	12,102	250,000	-305,000
Income - Individuals Giving	250,174	36,375	58,400	-191,774
Income - In Memory	185,172	51,538	59,172	-126,000
Income - Bank interest	600	401	624	24
Income - Dividend Income	79,400	38,689	78,987	-413
Income - Chart lodge	0	182,374	182,374	182,374
Income - Community	344,175	153,239	363,335	19,161
Income - Tin Collections	50,000	16,525	28,865	-21,135
Income - lottery	55,000	17,214	30,360	-24,640
Income - Corporate	118,422	4,816	28,121	-90,301
Income - Major Donors £1k+	112,057	71,493	76,083	-35,974
Income - Trusts and Foundations	350,000	17,373	103,700	-246,300
Income - Gift Aid	100,000	18,223	41,728	-58,272
	2,200,000	**620,361**	**1,301,750**	**-898,250**

4. CTC are asked to approve the reforecast

5. Explanation as to why the income target has been reduced

The income target was set against a strategy to raise 3m in 3 years. In order to get to 3m, the charity would have first needed to get to 2.2m - in hindsight this strategy was unachievable and did not take into account he nuances between different income sources, particularly legacy income. It was also based on an unrealistic account of the work the charity was undertaking before the new team was in place and the length of time it would take to recruit a team able to meet these targets.

Prior to strategy implementation the team would primarily thank (higher amounts only) and bank; with little resource to identify, cultivate and steward donors. There will always be baseline of income for the charity thanks to grateful patients, which accounted for some of their successes, plus some solid trust and foundation work, however increasing giving levels required significant ground work which had not been included in the strategy.

In order to meet the strategy a team with the ability to raise 2.2m in year has been recruited and they have shown steady growth. We now have a compliant and sound charity operating in line with best practise and have shown a significant increase in engagement and donors over the last year. It is anticipated this will result in steady income growth over the next 5 years, if the team remain.

6. Effect on cost of raising funds ratio

The proposed reforecast results in an increase in the cost of raising funds to either 30% or 35%, depending on whether vacant posts are recruited into.

	Original Budget	YTD Actual @ 31/10/2019*	Option 1	Option 2
Cost of Raising Funds ratio	21%	36%	30%	35%
Cost of Governance ratio	6%	13%	11%	11%
Full Running Costs ratio	**28%**	**50%***	41%	**46%**

It is important to note that the charity reports £120,000 in pledged income – yet to be received. If this income is added to the above the YTD cost of raising funds actuals is 30%.

7. Options for reducing the ratio

Due to two leavers in the charity there is currently the opportunity to reduce costs and as such the ratio, for this year and future years. Two options are presented:

Option 1 - holding these posts vacant.

Note - this would halt income growth and result in a reforecast of £200k less income in 20/21 due to the rest of the staff being at capacity and not having the skillset or time to deliver the major donor or trust activity. This would lessen the Charity's ability to support the Trust to fund additional capital costs in the future, reducing patient benefit.

Option 2 staff to a structure (which saves £30,294 against the current approved staff budget) and would forecast 1.5m income including 250k legacy income in 20/21. NB *Part of the new structure includes a role (which replaces one of the replacement roles) being recruited on a 1 year fixed term contract, recognising the risk of and safeguarding against a loss in income due to losing Mount Vernon.*

8. Comparative data

Comparative data can be viewed in Appendix one. Legacy income has been removed as this income skews the data and does not accurately show the performance of the fundraising team and its associated costs.

The figures show that when comparing the reforecast to past charity performance with similar costs of fundraising (13/14) there is currently much better performance (cost of fundraising ratio was 58% and full running cost ratio 62%).Bar 17/18 and 18/19 the ratios are the lowest seen in the past 7 years.

It is concerning that the ratio for 19/20 is higher than both 17/18 and 18/20. This can be explained by new staff in post since Nov 2017 who have implemented quick wins to raise funds, which have been sustained. **It is anticipated that now the team is in place and embedded, income will raise gradually** year on year, whilst the cost of fundraising will not increase, meaning the ratio will decrease annually from 20/21 if the model is kept the same. This is in line with the charities growth strategy and speculating to accumulate.

9. Activity that delivers added value

It must be noted the charity team also deliver more than just income, there has also been a significant shift in culture, and attitude and willingness towards the charity in the past 2 years which is hoped to continue to increase. The charity has spent more funds that ever before, delivering added value to the Trust. Indeed fundraisers time is taken up significantly with supporting the procurement and purchase process to the benefit of our colleagues. This year charity has delivered six fundraising events, with two more planned which are used as team building events for staff, the charity has also supported 85 staff to deliver fundraising events since January.

In addition the Charity has delivered the staff awards for the past two years. This takes a significant amount of time and planning. Staff awards are seen as a valuable asset to the charity as they provide the opportunity to build relationships with sponsors (we have 10 this year) and enhance our reputation with staff; however the sponsorship achieved currently only covers the actual costs of running the event, they do not deliver the 1:4 ratio needed to deliver the 25% ratio. **If the staff awards were not delivered the cost of raising funds ratio would decrease by 1%.**

10. Special circumstances for 20/21

There is an additional opportunity to temporarily reduce the ratios further for 20/21 as the Head of Charity (HoC) will be taking maternity leave and has proposed current resource is used to provide 1 years cover. This would enable the charity to embed the successful development delivered in the past 2 years, deliver a tested activity plan and develop relationships to increase income, with little risk. **Regardless of option chosen this would see the cost of fundraising ratio decrease by 7% and the cost of governance decrease by 2% in 19/20.**

The HoC post being vacant for a year is a recognised risk, however due to the ground work completed over the past 2 years, the relationships the charity is cultivating and the resources now in place income is still forecasted to increase in 20/21. There will be a loss to some of the proactive development work and a full plan for supporting a cover post and risk assesment has been created.

11. Conclusion

If the growth strategy continues to be supported the cost of fundraising will not increase, yet, as we have seen in practise, income is projected to increase year on year. Due to the maternity leave of Head of Charity and reduced costs that brings there is also a little flex in 20/21. If a strategy to reduce risk is supported then income may not increase as quickly, however the ratios will be in line with those approved in the current strategy.

12. For discussion

CTC are asked to discuss the information presented, approve the reforecast and provide strategic direction regarding either continuing to invest, to gain in the future, or to reduce costs. Once a decision has been made finance will circulate a revised forecast outturn.

Appendix 2

Comparison to past performance

Year	Total cost of fundraising	Raised (k)	*Legacy (k)*	Performance (k) (Raised – Legacy)	Cost of fundraising % of funds raised ex legacies	inc legacies	Full running costs ex legacies	inc legacies
2012/13	341	916	376	540	**63%**	**37%**	**67%**	**40%**
13/14	371	758	113	645	**58%**	**49%**	**62%**	**52%**
14/15	493	710	81	629	**78%**	**69%**	**83%**	**73%**
15/16	484	939	236	703	**69%**	**52%**	**73%**	**54%**
16/17	307	1,877	*1177*	700	**44%**	**16%**	**61%**	**23%**
17/18	223	1,631	891	740	**30%**	**14%**	**45%**	**20%**
18/19	296	1,203	173	1,030	**29%**	**25%**	**42%**	**36%**
19/20 m7	*226*	*620*	*12*	*608*	***37%***	***36%***	***51%***	***50%***
19/20 m7 inc pledged income	*226*	*740*	*12*	*728*	***31%***	***31%***	***42%***	***42%***

Comparison to other NHS Charities

Red indicates ENHH Charity at 18/19 and at 19/20 reforecast. Yellow indicates charities with similar fundraised income. Legacies have been removed to give a more accurate indication of fundraising performance. It must be noted that staff costs are not expected to increase, whilst income is; this is the highest the ratio is expected to be.

2018	Donations	Fundraising activities	Trading activities	Fundraising activities	Total income exc legacies	Raising funds *Fundraising costs*	Other expenditure on raising funds	Fundraising staff costs	Total income exc legacies divided by cost of raising funds
Milton Keynes Hospital Charity	206	0	0	0	206	128	0	110	**62%**
Kingston Hospital NHS Trust General Charitable Fund	276	0	28	28	332	194	0	128	**58%**
Avon & Wiltshire Mental Health Partnership NHS Trust Charitable Fund	65	0	0	0	65	35	0	0	**54%**
King George & Queen's Hospital Charity	259	220	0	0	479	374	47	0	**54%**
Above and Beyond	982	0	122	122	1,226	631	0	400	**51%**
Barts Charity	2,245	0	0	0	2,245	1,011	0	531	**45%**
Central London Community Healthcare NHS Trust Charity	95	0	0	0	95	42	0	42	**44%**
Birmingham Children's Hospital Charities	4,166	0	718	0	4,884	2,881	0	1,264	**42%**
University College London Hospitals Charity	8,052	0	4,629	93	12,774	5,815	0	198	**41%**
Nottingham University Hospitals Charity	1,334	0	84	0	1,418	565	0	393	**40%**
Royal Orthopaedic Hospital NHS FT Charity	53	0	0	0	53	20	0	20	**38%**
East and North Hertfordshire NHS Trust Charitable Fund projection	*550*			*500*	*1,050*	*391*		*243,250*	**37%**
Countess Of Chester Hospital NHS Charitable Funds	440	0	227	0	667	241	0	173	**36%**
Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust CF	257	492	0	0	749	446	20	446	**36%**
Royal Free Charity,The	4,852	202	527	0	5,581	2,025	0	642	**35%**
Heads On, Sussex Partnership NHS Foundation Trust's Charity	234	0	0	0	234	81	0	0	**35%**
Sheffield Hospitals Charity	1,017	101	828	828	2,774	971	0	401	**34%**

The Walton Centre Charity	277	0	158	158	593	199	0	147	34%
East Kent Hospitals Charity	212	20	0	0	232	84	0	58	33%
Northern Lincolnshire and Goole NHS Foundation Trust Charitable Fund	332	0	0	0	332	168	0	142	31%
Moorfields Eye Charity	2,452	0	366	366	3,184	985	0	578	31%
London North West Healthcare Trust Charity	370	0	0	0	370	187	0	125	31%
Yeovil Hospital Charity	397	0	0	0	397	119	0	94	30%
Clatterbridge Cancer Charity, The	821	0	1,121	0	1,942	649	0	497	30%
Royal Surrey County Hospital's Charitable Fund	296	0	26	26	348	93	0	79	27%
Manchester University NHS Foundation Trust Charity (MFT Charity)	3,371	844	0	0	4,215	1,346	0	700	27%
Kings College Hospital Charity	2,234	0	0	0	2,234	588	0	118	26%
St George's Hospital Charity	755	280	45	45	1,125	354	0	226	25%
Guy's and St Thomas' Charity	7,573	0	0	0	7,573	1,842	0	0	24%
Great Ormond Street Hospital Children's Charity	67,632	0	5,468	2,404	75,504	18,833	0	4,266	24%
Royal National Orthopaedic Hospital Charity	979	25	0	0	1,004	234	0	184	23%
Portsmouth Hospitals NHS Trust General Charitable Fund	428	40	326	250	1,044	245	0	193	23%
County Durham & Darlington NHS Foundation Trust Charity	277	0	0	0	277	61	0	64	22%
Liverpool Heart and Chest Hospital Charity, The	837	0	41	41	919	202	0	82	20%
Colchester & Ipswich Hospitals Charity	962	0	0	0	962	190	0	139	20%
East and North Hertfordshire NHS Trust Charitable Fund	421	0	245	245	911	179	5	123	20%
North Bristol NHS Trust Charitable Funds	1,324	0	25	0	1,349	264	0	73	20%
Sandwell & West Birmingham Hospitals NHS Trust	277	56	10	0	343	112	51	0	19%
Hywel Dda Health Charities	787	0	0	0	787	148	0	134	19%
Royal United Hospital Bath NHS Trust Charitable Funds	2,076	57	543	543	3,219	613	106	465	19%

Derby Hospitals Charitable Trust	1,352	0	94	0	1,446	259	0	175	**17%**
Western Sussex Hospitals Charities	267	0	128	128	523	85	0	53	**16%**
Darent Valley Hospital Charity Fund	231	0	95	95	421	67	0	5	**16%**
West Hertfordshire Hospitals NHS Trust Charity	218	22	0	0	240	41	0	0	**16%**
Luton and Dunstable Hospital Charitable Fund	1,013	0	0	6	1,019	154	0	154	**15%**
Poole Hospital Charity	712	141	11	0	864	149	0	107	**14%**
Awyr Las Gogledd Cymru/Blue Sky North Wales	1,170	0	403	403	1,976	280	0	195	**14%**
Royal Brompton and Harefield Hospitals Charity	3,453	1,585	0	0	5,038	706	0	0	**14%**
Plymouth Hospitals General Charity	545	74	0	0	619	91	0	55	**13%**
Gloucestershire Hospitals NHS Foundation Trust Charity	1,694	0	0	0	1,694	213	0	117	**13%**
Velindre NHS Trust Charitable Fund	2,681	0	646	646	3,973	484	0	196	**12%**
Royal Berkshire NHS Foundation Trust Charity	2,388	8	8	8	2,412	288	0	0	**12%**
Bradford Teaching Hospitals NHS Foundation Trust	103	0	111	35	249	26	0	66	**10%**
Royal Papworth Hospital Charity	776	45	47	47	915	99	0	168	**10%**
Northamptonshire Health Charitable Fund	501	0	96	96	693	62	0	37	**9%**
Royal Marsden Cancer Charity, The	18,486	0	191	191	18,868	1,645	45	0	**9%**
CW+ (Chelsea and Westminster Health Charity)	7,081	0	1	0	7,082	614	0	412	**9%**
Norfolk & Norwich University NHS Foundation Trust	632	2	2	0	636	56	0	51	**9%**
Salisbury District Hospital Charitable Fund	1,097	73	829	829	2,828	240	0	115	**8%**
Taunton and Somerset NHS Foundation Trust General Charitable Funds	843	0	60	0	903	69	0	0	**8%**
Addenbrooke´s Charitable Trust	1,364	0	722	722	2,808	369	397	760	**7%**
Imperial Health Charity	2,392	0	78	0	2,470	160	659	216	**6%**
Newcastle upon Tyne Hospitals NHS Charity	812	1,460	63	0	2,335	245	0	77	**6%**

Tayside Health Fund	846	170	61	0	1,077	64	1	64	**6%**
Royal Wolverhampton Hospitals NHS Trust Charity, The	596	91	91	0	778	43	4	37	**6%**
Southend University Hospital NHS Foundation Trust Charity	854	0	151	72	1,077	58	0	211	**5%**
University Hospitals Birmingham Charity	10,785	857	0	0	11,642	669	0	389	**5%**
James Paget University Hospitals NHS Foundation Trust	465	33	0	0	498	27	0	41	**5%**
Borders Health Board Endowment Fund	361	455	0	0	816	64	0	59	**5%**
Frimley Health Charity	575	0	55	0	630	29	0	85	**4%**
Southampton Hospital Charity	3,348	818	79	79	4,324	184	0	365	**4%**

East and North Hertfordshire NHS Trust

Agenda Item: 16.2

TRUST BOARD - PUBLIC SESSION – 8 JANUARY 2020

Learning from Deaths Report

Purpose of report and executive summary (250 words max):		
Reducing mortality is one of the Trust's key objectives. This quarterly report summarises the results of mortality improvement work, including the regular monitoring of mortality rates, together with outputs from our learning from deaths work that are continual on-going processes throughout the Trust. It also incorporates information and data mandated under the National Learning from Deaths Programme.		
Action required: For information		
Previously considered by: **Mortality Surveillance Committee, 16 October 2019** **Quality and Safety Committee, 26 November 2019**		
Director: **Medical Director**	**Presented by:** **Medical Director**	**Author:** **Mortality Improvement Lead**

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) **No**
Any other risk issues (quality, safety, financial, HR, legal, equality): **Detailed on page 1 of report**

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

SECTION 1: LEARNING FROM DEATHS REPORT SUMMARY

1.1 Introduction

Reducing mortality is one of the Trust's key objectives for 2017 to 2019. This quarterly report summarises the results of mortality improvement work, including the regular monitoring of mortality rates, together with outputs from our learning from deaths work that are continual on-going processes throughout the Trust. It also incorporates information and data mandated under the National Learning from Deaths Programme.

The time intervals between quarterly reports have been flexed to allow prior approval by the Mortality Surveillance Committee. In view of the irregular time intervals it was proposed that alternate reports follow a reduced format focusing on refreshed data and headline information. As the first shortened version was well received and the length and content more appropriate to the time available to Committee/Board members, while still providing the key information required for assurance purposes, it is proposed that all future reports follow this format.

Further information on the key metrics, developments and current risks summarised on this page can be found in Sections 2 and 3, together with Appendix 1.

1.2 Key metrics

Table 1 below provides headline information on the Trust's current mortality performance.

Metric	Result
Crude mortality	Crude mortality is 1.09% for the 12 month period to August 2019 compared to 1.33% for the latest 3 years.
HSMR: (data period Jun18 – May19)	HSMR for the 12 month period is **93.15** and is statistically **'better than expected'.**
SHMI: (data period May18 – Apr19)	Headline SHMI for the 12 month period is **91.18**: **'as expected band 2'.**
HSMR – Peer comparison	E&NH is ranked 4th (out of 15) in the East of England Peer group.

1.3 Headlines

- HSMR has remained stable in the 'better than expected' range
- SHMI has remained stable in the 'as expected band' following significant reduction
- Mortality Review Tool development to commence following purchase of DatixIQ
- Medical Examiners appointed and implementation plans in progress
- Regular on-going mortality monitoring via Mortality Surveillance Committee, Quality and Safety Committee, Board and joint meetings with ENHCCG.

1.4 Current tasks

Table 2 below summaries key risks identified:

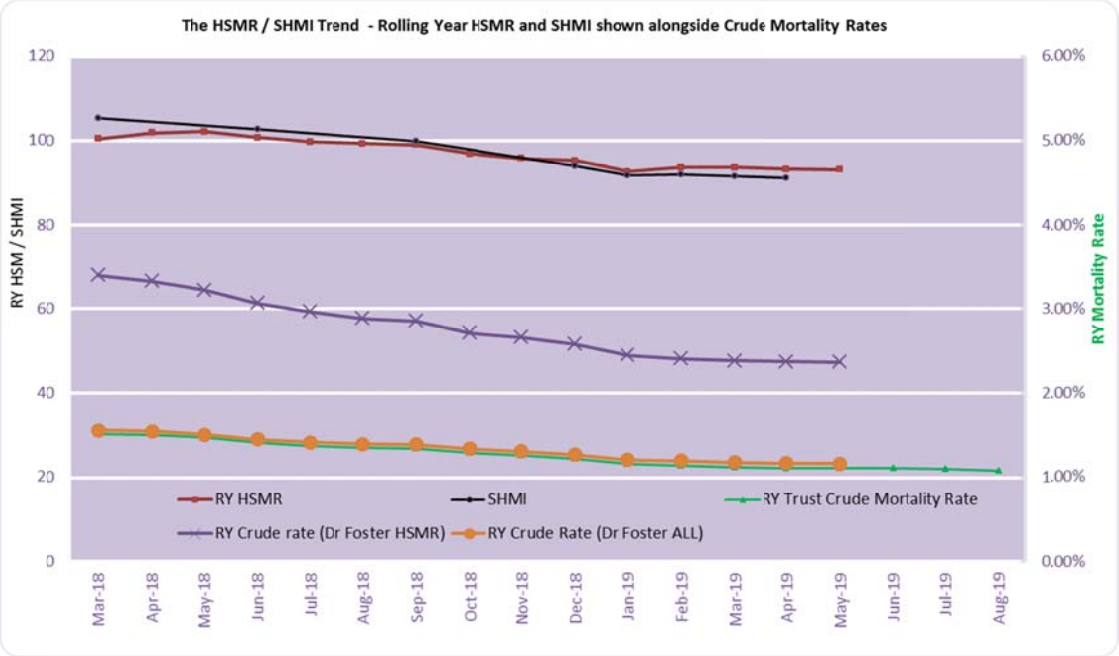
Risks	Report ref (Mitigation)
7 day service	2.5.1
Care bundles/lack of Lead	2.5.2
Medical Examiner Introduction	2.5.3
Mortality management - capacity	3.1
Mortality Review Process – need for significant development of IT tool	3.1
Severe Mental Illness – Identification/flagging of patients	3.2.3

SECTION 2: MORTALITY PERFORMANCE

2.1 Key metrics

2.1.1 Trust rolling 12 month overview

Figure 1: Trust Key Mortality Metrics: Latest Rolling 12 Month Position



The chart above shows the Trust's latest Rolling 12 month trend for the three key mortality metrics: Crude mortality, HSMR and SHMI. This shows that these three metrics have been fairly flat for the last 4 data points. Note: data source for SHMI data is Dr Foster for the quarterly figures and NHS Digital for Feb18-Jan19 onwards.

Crude mortality: Dr Foster compares performance of crude mortality and reports that the average national crude in-patient mortality (for Acute, non-specialist trusts, for ordinary admissions excluding day cases) is 1.3% and 1.4% within the region for the twelve months to May 2019. This compares to 1.2% within ENHT. The Trust's locally recorded crude mortality rate, stands at 1.09% for the latest twelve months to August 2019.

HSMR: The past 12 months has seen a downward direction of travel in our rolling 12 month HSMR from 100.83 (Jul17-Jun18) to 93.15 for the latest rolling 12 months (Jun18-May19), with the last five periods all sitting within the 'better than expected' range. The Trust's position relative to its East of England peers has improved to 4th (out of 15).

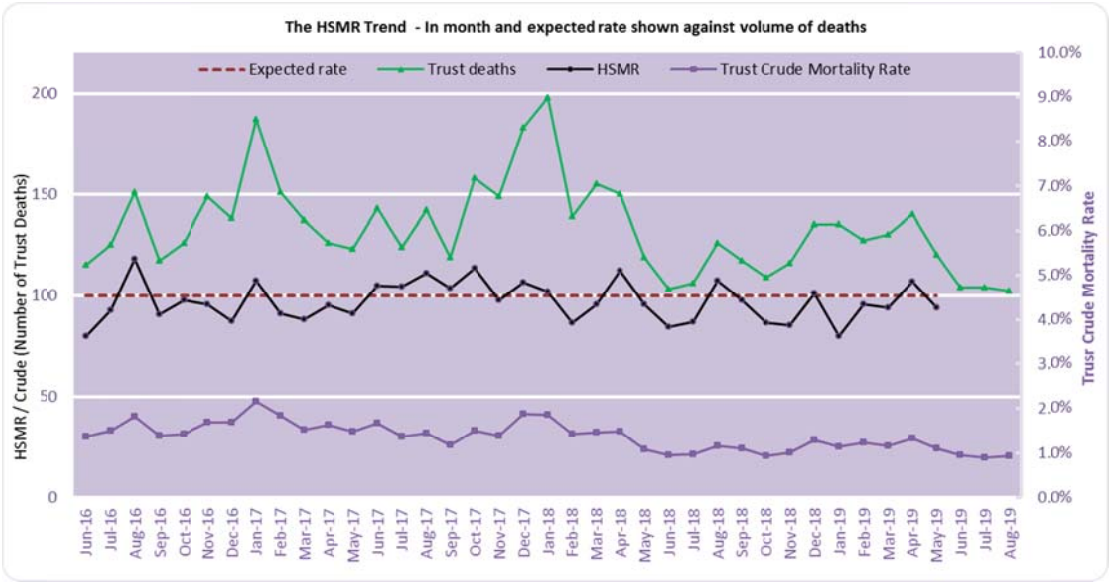
SHMI: The Trust's SHMI currently stands at 91.18 for the rolling 12 months to April 2019 (NHS Digital September 2019 release). This remains in the 'as expected' range. This is a marginal improvement on the 91.94 quoted in my last report for the twelve months to February 2019 and compares favourably to the 99.90 for rolling 12 months to September 2018, which itself was the first time that the Trust's SHMI had fallen below 100 since the inception of this metric in 2010.

As previously reported NHS Digital is currently leading a review of SHMI to evaluate potential short and long term changes to improve the indicator. An early change has been the introduction of monthly reporting which was introduced in June 2019.

2.1.2 Trust In-month trend (crude/HSMR)

Figure 2 below provides the latest available in-month position for crude and HSMR mortality rates together with volume of deaths. This shows that while there was some increase in deaths over the winter months, this did not equate to the pronounced spike seen in previous years. June to August 2019 has seen a significant reduction in in-month deaths.

Figure 2: Trust Crude Mortality/HSMR latest in-month trend



The observed number of deaths within the risk model for HSMR is the greatest factor determining the overall score for an organisation which means that crude mortality can be used as a useful predictor of coming HSMR performance.

2.1.3 Trust HSMR peer comparison

Figure 3: Trust Peer comparison

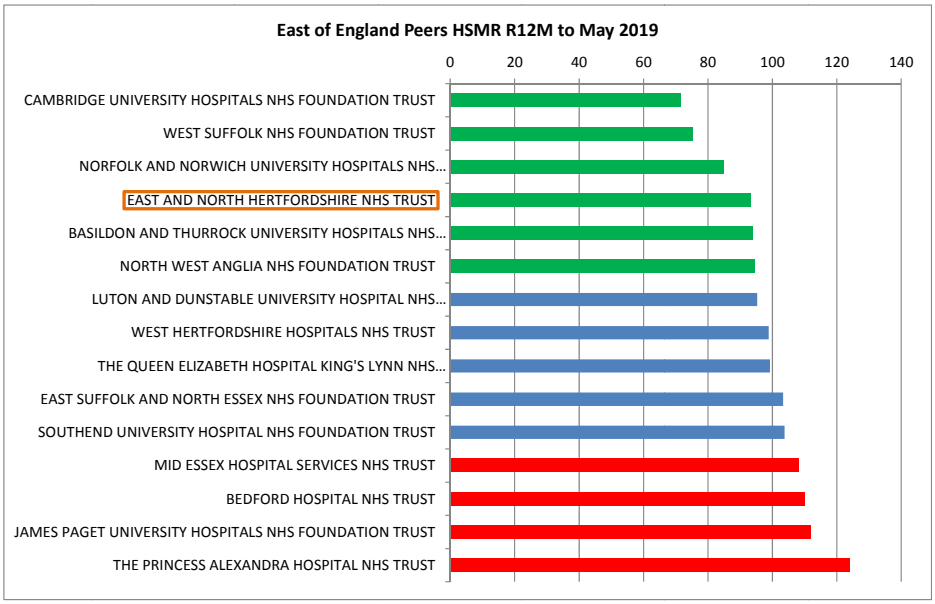


Figure 3 above shows how well placed the Trust is among its East of England peers.

2.1.4 Divisional HSMR performance

Table 3: Monthly Trust and Divisional HSMR May 2018 to May 2019

	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Rolling 12M
Cancer	122.9	32.3	102.6	48.4	62.6	79.4	71.9	83.1	49.8	39.2	60.2	73.6	67.8	62.8
CSS	0.0	0.0	0.0	0.0	448.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	64.4
Medicine	95.9	95.5	86.3	113.6	96.1	87.0	91.8	105.5	81.1	99.9	100.5	106.9	96.0	96.6
Surgery	89.8	83.0	86.9	104.3	123.3	90.5	58.8	85.0	92.6	96.4	71.6	135.1	105.0	93.3
Women & Children	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	109.0	0.0	0.0	0.0	9.3
Trust	**96.2**	**85.7**	**86.6**	**107.3**	**97.7**	**86.5**	**85.2**	**101.1**	**79.5**	**95.7**	**94.0**	**106.7**	**93.8**	**93.2**

Source: Dr Foster Healthcare Intelligence Portal

Table 3 shows Trust and Divisional monthly HSMR performance RAG rated against internal targets for the latest rolling 12 month period to May 2019. The Rolling 12 month position for Medicine shows an amber rating with an HSMR of 96.6. This represents a marginal decrease from the last reported HSMR for the twelve months to March 2019 of 96.9.

2.2 Key quality measures

It is important to triangulate mortality data with other quality measures to give a balanced perspective on quality of care provided by the Trust.

Table 4 below compares HSMR/SMR with Length of Stay and Readmissions within 28 days. Since Readmissions data is available 3 months in arrears of HSMR, all metrics have been provided up to that date for comparative purposes.

HSMR and SMR mortality for the period is within the 'better than expected' band for the trust. Length of stay has also remained consistently below the expected levels, meaning that overall we discharge patients sooner than expected for our case mix. In this reporting period while the overall Trust figure for readmissions is in the 'as expected' band, Elective is within the better than expected and the Non-Elective rate has remained in the significantly elevated band.

Table 4: Key Quality Measures March 2018 – February 2019

	Trust Total	Elective	Non-Elective
HSMR	93.7	103.7	93.5
SMR	91.6	102.4	91.4
Length of Stay	87.3	86.5	87.4
Readmissions within 28 days	99.9	91.6	103.9

Source: Dr Foster Healthcare Intelligence Portal

2.3 Mortality alerts

2.3.1 CQC CUSUM alerts

As previously reported, in March 2018 the Dr Foster Unit at Imperial College alerted the CQC to the Trust's CUSUM alerts for Septicaemia. In November 2018, following a request for further information, we provided a report to the CQC detailing the findings of our internal investigation. One focus of the investigation was an in-depth review of sepsis coding following the changes to national protocols. This resulted in significant changes being made to realign our coding with our new understanding of the requirements, with supporting training given to ensure a standardised approach moving forward. The anticipated significant reduction in our sepsis HSMR occurred in

the January Dr Foster release which saw sepsis HSMR fall to 81.06 (better than expected range).

It is now over a year since our HSMR was significantly elevated, with the last eight HSMR refreshes all falling within the 'better than expected' range. The latest rolling 12 months to May 2019 currently stands at 69.48, latest SHMI to April 2019 stands at 74.72 and is also within the 'better than expected' range. The CQC has continued to monitor the situation via its regular Engagement meetings with the Trust.

2.3.2 HSMR outliers

With regard to HSMR for the latest rolling year to May 2019, there are currently no diagnostic groups attracting significantly higher than expected deaths at the 95% confidence level for relative risk where 6 or more deaths are observed. Detail of the action taken regarding the previously alerting biliary tract disease diagnosis group is included in table 5, in 2.41 below.

The Dr Foster data refresh due to take place on 19 September (rolling 12 months to June 2019) was postponed due to data quality concerns. Dr Foster has since advised that the September refresh will not take place. This means that the latest available HSMR data is for the rolling 12 months to May 2019.

2.3.3 SHMI outliers

With regard to SHMI for the latest rolling year to April 2019, while NHS Digital provides the relevant data, Dr Foster indicates which diagnosis groups are significantly elevated via their Mortality Comparator. While they are not currently updating this report, they are providing a brief summary which indicates outlier groups.

According to their latest report, covering the April 2019 SHMI release, the two diagnosis groups previously reported as outliers, have continued to alert, these being diverticulosis & diverticulitis and congestive heart failure. Detail of action taken regarding these diagnosis groups is included in table 5, in 2.41 below.

2.4 Specific actions to address high mortality conditions

Mortality Alerts meetings, chaired by the Medical Director, are now held following Dr Foster monthly refreshes to review new CUSUM alerts and HSMR/SHMI diagnosis group outliers. Agreed actions then feed into the Mortality Surveillance Committee.

The HSMR/SHMI trends of alerting groups are tracked. Investigation usually starts with coding reviews. Where concerns or uncertainty persist Specialty clinical reviews are requested. A watching brief is maintained until there is assurance regarding performance. When the number of deaths is very small, or the diagnosis group consists of a number of sub categories, the situation may be monitored before action is taken.

2.4.1 Summary report of current/recent outliers

Table 5 below provides a summary of action taken regarding current/recent HSMR and/or SHMI outliers.

Table 5: Recently elevated diagnosis groups update

Diagnosis group	HSMR R12m-May19	SHMI R12m-Apr19	Investigation summary
Diverticulosis & Diverticulitis *(Not in HSMR basket)*	119.11 *(SMR)*	*200	SHMI remains elevated. A joint clinical/coding review showed minor coding discrepancies and no clinical concerns. Monitoring continues via the Mortality Alerts meeting.
Congestive Heart Failure	117.18	146.67	SHMI remains elevated. A clinical review of a sample of deaths underpinning the deaths was undertaken. Due to the fact that in 50% of the reviewed deaths heart failure was not an appropriate diagnosis, and may not have been in a significant number of the remaining deaths, together with some concerns regarding appropriate specialist nurse care, it was decided that further monitoring to be undertaken. All new deaths with a primary diagnosis of heart failure are currently being subject to a joint coding/clinician discussion/review at the relevant weekly MDT meetings. Findings not yet reported.
Sepsis	69.58	74.72	Investigation following CQC alert led to changes in the interpretation of coding protocols which have been reflected in significant reductions to both HSMR/SHMI.
Pneumonia	104.94	105.38	Joint coding/clinical review of 36 cases. 20 were found to have been coded incorrectly. The poor clinical awareness was discussed with the Respiratory Lead and a Coding presentation to the respiratory physicians was agreed. Significant improvements have since been seen in mortality rates. Neither HSMR nor SHMI are currently alerting.
Coronary atherosclerosis	124.91	**Not available	The clinical review concluded that of the sample of 12 deaths reviewed all had been managed appropriately; 7 were OOHCA; 2 were incorrectly coded.
Stroke	100.95	106.45	As SHMI had alerted, a sample of 20 deaths of patients who had died within 30 days of discharge were considered. Coding errors were discovered in 4 cases. The review did not highlight clinical concerns relating to the deaths that occurred in the Community following discharge from hospital.
Chronic renal failure	66.0	**Not available	A joint coding/clinical review was undertaken of 13 deaths. 12 of the deaths were shown to be incorrectly coded. The findings were presented back to the Renal team and it was agreed that moving forward simultaneous mortality/coding reviews should commence. The review highlighted that junior doctors were not liaising sufficiently with consultants regarding the COD for death certificate and while there was strict oversight of these patients in Renal, this cohort were often not on Renal wards. It is anticipated that the introduction of the Medical Examiner role should deal with such issues.
Fractured neck of femur	89.38	97.08	Following a predominantly downward trend in deaths over recent years, there was a spike in deaths in 2018. This was sufficient for the Trust to receive notification from the National Hip Fracture Database (NHFD) regarding mortality, although the Trust was not an official outlier. While neither HSMR nor SHMI has been significantly elevated, the Mortality Surveillance Committee asked that the diagnosis group be monitored until it was clear that the situation had stabilised. On 7 September 2019 we received notification from the CQC that they had been notified of the alert and requesting detail of our response to the findings, with discussion of these at the next scheduled Engagement meeting with the CQC.
Biliary Tract Disease	163.0	133.33	A coding review found only one error and did not highlight concerns warranting a clinical review. The results were discussed at August Mortality Surveillance where it was agreed that there should be ongoing monitoring via mortality alerts meeting, until assurance was gained that the situation had fully stabilised. HSMR returned to the as expected range for the rolling 12 months to April 2019.

* SHMI provided for the group Digestive, Anal and Rectal conditions. Diverticulosis and Diverticulitis is a subset of this. There is no direct comparative HSMR/SHMI group.
** NHS Digital does not report on groups where there are five or less deaths for the purpose of disclosure control.

2.5 Associated trust initiatives

2.5.1 Seven day services

The Trust continues to work towards 7 day working and fully achieving the Keogh standards set out in the report NHS Services, Seven Days A Week. Originally ENHT was confirmed as being in the tranche of trusts tasked with achieving compliance against the four prioritised standards by the end of March 2018. Nationally it has now been indicated that all Trusts must be compliant with these standards by 2020. The four prioritised standards are:

- Standard 2: Time to Consultant Review
- Standard 5: Access to Diagnostics
- Standard 6: Access to Consultant-directed Interventions
- Standard 8: On-going Review.

To date the Trust has not achieved compliance with the four prioritised standards. Previously focus on this work has been hampered by the absence of a 7 Day Services Lead. To address this issue a Steering Group has now been created with responsibility for oversight of this important work. Additionally the PMO team will be involved in shaping developments, and requirements are being taken into account in this year's winter planning.

2.5.2 Care bundles

While our work to improve the use of available care bundles is strongly supported by the CCG via the Mortality Review Group, as previously reported, progress has been hampered by resource constraints. It is intended that focus on care bundles will be strengthened by incorporation of the work into wider quality improvement initiatives together with the anticipated appointment of an Associate Medical Director with responsibility for reducing avoidable variation. To date as it has proved challenging to attract appropriate candidates for the role, the scope is being reconsidered.

2.5.3 Medical Examiner

A team of Medical Examiners has now been recruited from within the Trust's existing consultant body and includes a Lead and Deputy, and multi-disciplinary representation. The Medical Examiner function will sit within Clinical Support Services. The Division is continuing to work closely with the newly appointed Lead Medical Examiner to scope the requirements for implementation which is intended to take place over Q3/4 2019-20 during the non-statutory implementation phase. Progress towards implementation is currently being hampered by the lack of appropriate office space to accommodate this critical new service. If this situation continues it will represent a significant risk to our ability to comply with national guidance which requires the service to be fully operational within the non-statutory phase which is due to end on 31 March 2020.

As previously reported the update from NHS Improvement in June 2019 highlighted the need for close collaboration between the Medical Examiner function and Learning from Deaths programme, with Medical Examiners being responsible for flagging cases warranting further review. As plans progress for the migration of the Trust's mortality review process to the Datix iCloud platform it will be imperative that the required interaction between the processes in taken into account.

2.5.4 Coding/data quality

The heads of both Coding and Data Quality continue to drive forward quality improvement initiatives. These are not only of direct significance regarding the provision of better quality information, but are also resulting in greater engagement by Clinicians as confidence in data provided to them increases. The seeds of this cultural shift should support future improvements.

SECTION 3: LEARNING FROM DEATHS

3.1 Mortality case record review process and methodology

The decision to adopt the Datix iCloud platform to support our Clinical Governance framework has now been signed off and the start of implementation development work with Datix is anticipated to commence shortly. This work will include change to both our mortality review content and process.

Although a manager to support our Mortality Improvement Lead was recently recruited, unfortunately the candidate withdrew. The position has been immediately re-advertised. Once in place the manager's core responsibility will be the day to day management of the mortality review process including administration of ACONs (Areas of Concern).

3.2 Mandated mortality information

The Learning from Deaths framework states that trusts must collect and publish certain key data and information regarding deaths in their care via a quarterly public board paper. This mandated information is provided below.

3.2.1 Learning from deaths dashboard

The National Quality Board provided a suggested dashboard for the reporting of core mandated information. This is currently being used and is attached at Appendix 1. It should be noted that for cases where Areas of Concern are raised, the current lapse in time between the death and completion of Stages 1, 2 and 3 of the review process, means that the avoidability of death score is often not decided in the same review year. This should be borne in mind when viewing the data contained in the dashboard at Appendix 1, which only details the conclusion details for 2019-20 deaths which can appear to skew the data. In this regard, of particular note, in Q1 three ACONs were concluded relating to deaths in 2017/18 where an avoidability of death score of less than 3 was decided, as detailed below.

Table 6: 2017-18 Deaths: Avoidability Score ≤3

ID	Serious Incident	Avoidability score	Avoidability definition
ACON 325	Yes	1	Definitely avoidable
ACON 286	Yes	2	Strong evidence of avoidability
ACON 290	No (IRI)	3	Probably avoidable, more than 50-50

All three cases have been investigated by the Patient Safety team, two as Serious Incidents and one as an internal IRI review. Remedial action plans have been put in place commensurate with the severity of the incidents and detailed information provided in the Serious Incident report submitted to the Quality and Safety Committee.

It is intended that the creation of a more useful dashboard will form part of the process developments alluded to in 3.1 above.

As the current dashboard does not cover all the data that the national guidance requires, the additionally mandated detail is provided below.

3.2.2 Learning disability deaths

Table 7: Q1 Learning Disability Deaths

	Apr-19	May-19	Jun-19
Learning Disability deaths	2	0	0

In Q1 two deaths occurred of patients with a learning disability. Both deaths have been reported to the national LeDeR programme. The internal mortality review of one case did not give rise to concerns, although safeguarding concerns were raised by the Ambulance crew regarding care in the nursing home. Concerns have been raised regarding the second case and are currently under review by the patient safety team.

3.2.3 Severe mental illness deaths

The learning from deaths guidance stipulates that Trusts must have systems in place to flag patients with severe mental health needs so that if they die in an Acute Trust setting their care can be reviewed and reported on. No clear indication was given in the national guidance regarding what definition should be attached to the term 'severe mental illness'.

As previously reported, discussion at the March East of England Learning from Deaths Forum, revealed the general uncertainty among acute trusts as to how best to interpret and comply with this requirement. Following discussions with our expert mental health colleagues at Hertfordshire Partnership University NHS Foundation Trust, we decided to base our criteria for mortality review on the 'red flags' detailed in the national guidance for NHS mental health trusts, which was drawn up by the Royal College of Psychiatrists (RCPsych) in November 2018.

On 24 September the Clinical Approval Group approved our request to include a supporting alert on Lorenzo. Further work will be required prior to the alert being activated, including creation of a supporting SOP to ensure there is clarity regarding identification of relevant patients and use of the alert. This is due to be taken forward via the Treat as One Task and Finish Group.

Additionally, now that clarity has been gained as to which diagnoses should be considered for this cohort of patients, a regular report of deceased patients revealing relevant ICD10 codes has been requested to ensure that the deaths of this vulnerable cohort of patients are reviewed in line with the Learning from Deaths guidance.

3.2.4 Stillbirth, children and maternity deaths

Q1 statistics are provided below:

Table 8: Q1 Stillbirth, Children and Maternity Deaths

	Apr-19	May-19	Jun-19
Stillbirth	1	0	0
Children	0	0	0
Maternity	0	0	0

3.2.5 Serious Incidents involving deaths

Table 9: Q1 Serious Incidents Involving a Patient Death

Serious Incidents involving the death of a patient	Apr-19	May-19	Jun-19
Serious Incidents reported	1	0	2
Serious Incidents – final report approved*	0	1	1

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

Key issues highlighted in the Serious Incidents approved in Q1 included:

- The spontaneous rupture of membranes checklist which provides information in order to support informed decision making and management of care was not completed
- Obstetric review requested but not obtained for urinary retention in the latent phase of labour
- Situational awareness was compromised as a result of a breakdown in effective communication between the woman and the midwife
- Sub-optimal follow-up as an out-patient
- Failure to completely follow management plans including nutrition, capacity assessments.

3.2.6 Learning from complaints

Table 10 below provides detail of the number of complaints received in Q1 that relate to a patient who has died.

Table 10: Q1 Complaints Involving a Patient Death

	Apr-19	May-19	Jun-19
Complaints received relating to an in-hospital death	0	0	4

3.2.7 Learning from inquests

Table 11: Q1 Inquests into a Patient Death

	Apr-19	May-19	Jun-19
Requests for a Report to the Coroner	4	6	5
Regulation 28: Report to Prevent Future Deaths	0	0	0

3.2.8 Learning from mortality reviews

Central to the topics covered at clinical governance Rolling Half Days are cases raised as Areas of Concern (ACONs) as a consequence of mortality case record reviews. The RHD meetings provide a forum for discussion, learning and the creation of appropriate Specialty-specific action plans and represent a key element of the Trust's learning from deaths framework.

In order to ensure all important themes and learning are made available to the Board, the detail provided below in Figure 4 relates to all ACONs concluded in Q1, whether the patient's death occurred in the current or previous year.

Throughout the year emerging themes are shared across the Trust via RHDs and other interested specialist groups including the Deteriorating Patient Committee, End of Life Committee and Seven Day Services Steering Group. The information will also be used to inform broad quality improvement initiatives.

Key themes arising from the ACONs which were concluded in Q1 are detailed in Figure 4 below.

Fig 4: ACON Themes: Q1 2019-20

4.0 Options/recommendations

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

Appendix 1: ENHT Learning from deaths dashboard June 2019

East and North Hertfordshire NHS Trust: Learning from Deaths Dashboard: December 2018

Department of Health

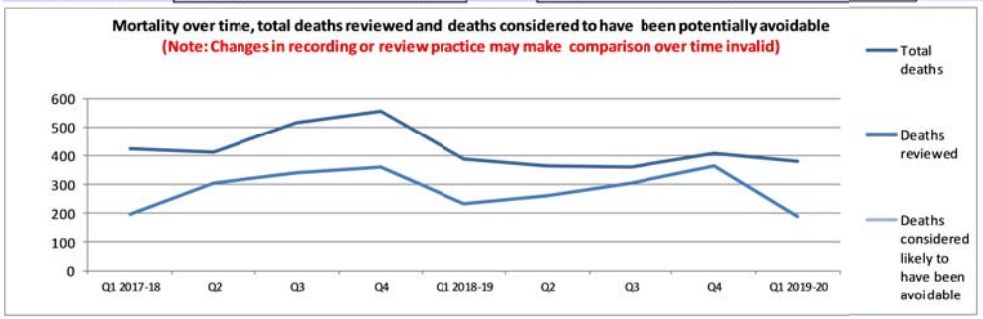
Description:
This dashboard is a tool to aid the systematic recording of deaths and learning from the care provided by East and North Hertfordshire NHS Trust and is based on the dashboard suggested by the National Quality Board in its Learning from Deaths Guidance published in March 2017. Its purpose is to record relevant incidents of mortality, deaths reviewed and lessons learnt to encourage future learning and the improvement of care.

Summary of total number of deaths and total number of cases reviewed under ENHT Structured Mortality Case Record Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
379	1518	190	1161	0	0

Time Series: Start date 2017-18 Q1 End date 2019-20 Q1



Total Deaths Reviewed by RCP Methodology Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-
This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD	0	-
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	192	100.0%

Summary of total number of learning disability deaths and total number reviewed under ENHT Structured Mortality Case Record Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
2	11	2	12	0	0

Time Series: Start date 2017-18 Q1 End date 2019-20 Q1