East and North Hertfordshire NHS Trust
Trust Board - Public Meeting

Lister Education Centre

3 July 2019 10:45 - 3 July 2019 12:30

AGENDA

#	Description	Owner	Time
1	Chair's Opening Remarks	Chair	10:45
2	Apologies for Absence: 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 1 May Public Trust Board Meetin... 7	Chair	
6	Patient Testimony For discussion	Director of Nursing	
7	Chief Executive's Report For discussion 7. Chief Executive's Report.pdf 19	Chief Executive	
8	FORMULATING STRATEGY		

#	Description	Owner	Time
8.1	Nursing Establishment Review For approval 8.1 Nursing and Midwifery Establishment Review.p... 23	Director of Nursing	
8.2	Strategy Highlight Report For information 8.2 Strategy Development Programme Highlights R... 59 8.2 Appendix 1 - 5Y Strategy Programme Plan as a... 61 8.2 Appendix 2 - 5Y Strategy Comms Plan as at 12... 63	Associate Director of Corporate Governance	
9	ENSURING ACCOUNTABILITY		
9.1	Integrated Performance Report For discussion 9.1 IPR Month 2.pdf 65	All Executive Directors	
9.2	Finance and Performance Committee Report to Board For discussion 9.2 (a) FPC Report to Board - 22.05.19.pdf 117 9.2 (b) FPC Report to Board - 26.06.19.pdf 121	Chair of FPC	
9.3	Quality and Safety Committee Report to Board For discussion 9.3 (a) QSC Report to Board - 21.05.19.pdf 125 9.3 (b) QSC Report to Board - 25.06.19.pdf 129	Chair of QSC	
9.3.1	Learning from Deaths Report For information 9.3.1 Learning from Deaths Report.pdf 135	Medical Director	
9.3.2	Safeguarding and LD Annual Report For approval 9.3.2 Safeguarding Annual Report.pdf -	Director of Nursing	

#	Description	Owner	Time
9.3.3	Health and Safety Annual Report For approval 9.3.3 Health and Safety Annual Report.pdf 151	Associate Director of Corporate Governance	
9.4	Audit Committee Report to Board For discussion 9.4 Audit Committee Report to Board - 23.05.19.pdf 169	Chair of Audit Committee	
9.4.1	Quality Account For information 9.4.1 Quality Account.pdf 173	Director of Nursing	
10	Board Assurance Framework For discussion 10. BAF Report.pdf 255 10. Appendix 1 - BAF 2019-20.pdf 257	Associate Director of Corporate Governance	
11	Annual Cycle For information 11. Board Annual Cycle 2019-20.pdf 285	Associate Director of Corporate Governance	
12	Matters Arising and Actions Log For information 12. Public Trust Board Actions Log.pdf 289	Chair	
13	Data Pack For information 13. Data Pack.pdf 291		
14	Date of next meeting: 4 September, Mount Vernon Cancer Centre (11:00 am)		
15	BOARD TO RECONVENE AS CORPORATE TRUSTEES		

#	Description	Owner	Time
15.1	CTC Report to Board For discussion [P] 15.1 CTC Report to Board - 20.05.19.pdf 317 [P] 15.1 CTC Report to Board - Appendix 1.pdf 321	Chair of CTC	

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday 1 May 2019 at 11.00am at Lister Education Centre

Present:	Mrs Ellen Schroder	Non-Executive Director (Chair)
	Dr David Buckle	Non-Executive Director – Associate
	Dr Peter Carter	Non-Executive Director
	Mrs Karen McConnell	Non-Executive Director
	Ms Val Moore	Non-Executive Director
	Mr Nick Carver	Chief Executive Officer
	Mr Martin Armstrong	Director of Finance
	Ms Rachael Corser	Director of Nursing
	Ms Julie Smith	Chief Operating Officer
	Dr Tim Walker	Deputy Medical Director
In attendance from the Trust:	Ms Jude Archer	Associate Director of Corporate Governance
	Ms Sarah Brierley	Acting Director of Strategy
	Ms Clair Hartley	Corporate Governance Officer (Minutes)
	Mr Joseph Maggs	Trust Secretary
	Ms Susan Young	Interim Chief People Officer
In attendance external to the Trust:	Ms Hannah Cattell	CQC
	Ms Vanessa Wort	CQC
	Ms Maria Rushton	For item 19/043

19/038 CHAIR'S OPENING REMARKS

19/038.1 Mrs Schroder welcomed the members of the public to the meeting.

19/039 APOLOGIES FOR ABSENCE

19/039.1 Apologies for absence were received from Jonathan Silver (Non-Executive Director), Bob Niven (Non-Executive Director) and Michael Chilvers (Medical Director). Tim Walker (Deputy Medical Director) was in attendance to deputise for the Medical Director.

19/040 DECLARATIONS OF INTEREST

19/040.1 There were no declarations that were relevant to the agenda items. It was noted that the annual update of the Board members' declarations of interest would be taking place imminently and would capture any recent changes.

19/041 QUESTIONS FROM THE PUBLIC

19/041.1 No questions had been received from the public.

19/042 MINUTES OF THE PREVIOUS MEETING

19/042.1 The Board reviewed and approved the draft minutes of the previous meeting on 6 March 2019 as an accurate record of the meeting.

19/043 PATIENT TESTIMONY

19/043.1 Ms Rushton joined the meeting to give a report on the care father received at Lister Hospital. She informed the Board that she worked for the Trust's patient experience team, having started in the role 4 and a half years ago.

19/043.2 Her father had been admitted when he was 80 years old. Ms Rushton and her mother accompanied him. She related that there were many positive aspects of his stay. However, there were a number of members of staff who did not deliver the quality of care that was expected, especially during the night shift.

19/043.3 Mrs Schroder thanked Ms Rushton for telling the Board about her experience.

19/043.4 The Director of Nursing said that she had been struck by the experience and there was a lot to be learnt from it. The impact of the feedback Ms Rushton gave had been far reaching and she was grateful to her for sharing her experience.

19/043.5 Dr Carter said that it was painful to hear about her father's experience and the matter should be followed up. The report should be brought to the attention of staff so that they are aware of the consequences of their actions. The Director of Nursing advised that this learning had already been shared.

19/043.6 The Chief Executive thanked her for sharing the feedback. Her report had highlighted the good work and also where she had been let down. Nursing staff very often provided quality care but this was not always as consistent as it should be, as this case highlighted.

19/043.7 Mrs Moore thanked Ms Rushton for sharing her experiences. She said that it was useful to hear of cases where a formal complaint had not been raised.

19/043.8 Mrs Schroder said that it was difficult to hear Ms Rushton's story

because she had been let down by a number of people. The Director of Nursing reported that the issues had now been addressed.

19/043.9 Dr Carter congratulated the Director of Nursing for bringing to the Board a patient testimony which was not wholly positive. The Director of Nursing advised that she would send a letter to Ms Rushton's father, thanking him for allowing her to tell his story.

19/044 CHIEF EXECUTIVE'S REPORT

19/044.1 The Chief Executive delivered his report highlighting the following items:

1. Corporate Update:

- *Executive Director Update* – The Chief Executive announced that Mark Stanton had been appointed and commenced in post as Chief Information Officer. Duncan Forbes had been appointed as Chief People Officer and would commence work at the Trust on 3 June 2019. Susan Young would stay on in a temporary position initially. The appointment of a new Director of Estates and Facilities would be announced soon.
- *Stabilisation Programme* - The Stabilisation programme managed by Channel 3 completed on 18th April 2019 and delivered the majority of the 90 identified actions relating to Lorenzo.
- *Acute Therapy Services* – On Monday, 1st April, colleagues from Acute Therapy Services, which includes inpatient and outpatient physiotherapy and occupational therapy, joined the Trust from Hertfordshire Community NHS Trust (HCT). The Chief Executive expressed his delight at welcoming them to the team.
- *Flu Vaccinations* – The Chief Executive thanked the 3,594 members of staff who received the vaccination this year.
- *Hospital Charity Funds Lifesaving Liver Scanner* - The Chief Executive announced that the East and North Herts NHS Trust charity had funded a Fibroscan machine with support from local Rotary Groups and a grant from the Rotary Foundation. The scanner would be used by the Gastroenterology and Hepatology teams to detect early liver scarring and damage.

19/044.2 **2. Our Staff**

- *Rheumatology Team in Nationwide Top 10 for Audit* - The Chief Executive congratulated the Rheumatology Team who had been recognised by the British Society for Rheumatology as being in in 7th place across the country for their use of the National Early Inflammatory Arthritis Audit.
- *Finalist in RCNi Awards* - The Chief Executive congratulated Carers Lead, Jodie Deards, who had been shortlisted for the Commitment to Carers award in the prestigious RCNi Nurse Awards. Her nomination focused on her involvement in developing the Young Carers in Herts app.
- *Research Nurse Accepted for Prestigious Programme* - The

Chief Executive congratulated Carina Cruz who was successful in her application for the National Institute for Health Research 70@70 Senior Nurse Research Leader programme.

- *Congratulations to Jeanette Dickson* - The Chief Executive congratulated Jeanette Dickson, consultant clinical oncologist at the Mount Vernon Cancer Centre who had been elected to the role of President of the Royal College of Radiologists (RCR).

19/044.3 Dr Buckle commented that the Trust's performance needed to improve in terms of flu vaccinations.

FORMULATING STRATEGY

19/045 Nursing and midwifery strategy

19/045.1 The Director of Nursing presented the draft Nursing, Midwifery and Allied Health Professionals Strategy 2019-24 to the Board for approval. She reported that she had engaged with the Trust's nursing, midwifery and AHP workforce in developing the strategy. The strategy was aligned with the NHSE long term plan and with new nursing standards and training.

19/045.2 National Nurses' Week was celebrated from 6th to 12th May and it was the intention that the strategy would be launched during this week. Some of the Non-Executive Directors, including Dr Carter would attend the celebration on 7th May. Nurses would also be showcasing their work at the event.

19/045.3 The strategy would be shared with all students. It was hoped that the strategy would set the Trust apart for newly qualified nurses.

19/045.4 Mrs Schroder expressed the opinion that it was a very well-prepared document. The Director of Nursing added that there had been minor updates to the document and formatting changes.

19/045.5 The Board approved the strategy, subject to final formatting and minor wording updates.

19/046 Quality Strategy

19/046.1 The Director of Nursing presented the ENHT Quality Strategy 2019-2024. The Strategy had been discussed previously and approved at the Board Development meeting in April. The report included the current approach to quality, the background to the Quality Transformation Programme (QTP) and the assessment of key drivers and quality priorities.

19/046.2 The Director of Nursing said that performance in terms of the strategy would be continually measured.

19/046.3 The Acting Director of Strategy commented that this was a key supporting strategy to the clinical strategy that had been launched earlier in the year. Other supporting strategies would be developed over the next few months.

SHAPING CULTURE

19/047 Talent Management Report

19/047.1 The Interim Chief People Officer presented a paper on talent management which outlined work taking place and opportunities available for Trust staff in relation to talent management. There were a number of local, regional and national schemes in place. She also reported that a new appraisal system was being developed that was linked to talent management.

19/047.2 The Committee was asked to note and endorse the current programme of work and to agree the additional new priorities for 19/20 as follows:

- Completion of a Talent Management Diagnostic in advance of the national launch;
- Development of a more structured approach to Talent Management through a new Talent Management Strategy;
- Development of an implementation plan to build diversity and inclusion into talent management;
- Clinical leadership development programme to be designed and to start in October 2019;
- ADDS – the Executive team to complete a talent mapping exercise to identify nominees for the regional assessment exercise by May 2019;
- To scope the transformation of a new appraisal system to link with talent mapping, development plans and to be available digitally for completion by managers by October 2019.

Subject to Board agreement of these priorities, a plan would be developed.

19/047.3 Retention of staff was high on the Trust's workforce agenda. The Trust was well known for its action on talent development. The Chief Executive said that there was a lot on offer on a regional and national level but he wanted to look at the local programme again and to extend it further.

19/047.4 The Chief Executive said that the initiatives proposed were important in getting the right people to come into the Trust and stay and develop their talents. It was important to attract people for deputy roles and work with them to develop potential future directors.

19/047.5 The Interim Director of Strategy commented that there was an improved focus on development of clinical leaders. Dr Buckle agreed but felt that there were benefits to these development programmes being for multi-disciplinary groups, as opposed to having clinicians attending separate programmes. He urged the Board to work with other NHS programmes.

19/047.6 The Board noted the paper and supported the proposals.

ENSURING ACCOUNTABILITY

19/048 Integrated Performance Report

19/048.1 Safe and Caring Domains

19/048.1.1 The Director of Nursing provided the following updates regarding the Safe and Caring Services section of the IPR:

19/048.1.2 • Sepsis screening and management

This was an area of focus nationally and work continued to take place within the Trust. NEWS 2.0 was designed to detect warning signs. The delay in implementation of NEWS 2.0 had contributed to the current backlog.

19/048.1.3 • Infection control

It was noted that the method of measuring *C.difficile* infections was changing and could markedly affect the numbers reported by the Trust.

19/048.1.4 • Pressure ulcers

19 pressure ulcers were reported in March. The increase had been in part due to a change in how they were recorded.

19/048.1.5 • Friends and Family Test

Responses to the friends and family test were discussed. The inpatient / day case percentage of patients who would recommend the Trust was higher than the national average and the response rate continued to exceed the latest national average response rate of 24.24%. The highest proportion of positive comments related to staff. Negative comments related to the cleaning, particularly in toilets and bathrooms, temperature on the ward and noise at night from other patients.

The majority of feedback from patients was positive, particularly in relation to staff. Negative feedback related to waiting times and the need for more staff.

19/048.1.6 • Complaints

The 90-day improvement plan was ongoing. 100% of complaints received were acknowledged within 3 working days. 64% were responded to within the agreed timeframe, which is a 9% increase from last month. The Chief Executive was impressed by the reduction in the number of complaints. Mrs Schroder said that she was pleased that the backlog was being reduced.

19/048.2 Effective Services

The Deputy Medical Director presented the Effective Services section highlights:

19/048.2.1 • The rolling 12-month HSMR improved to 93.00 in the 12 months to December, remaining in the 'as expected' range. The quarterly SHMI figure improved to 102.7 for Q1 2018-19

and then improved further to 99.9 in Q2 2018-19 (SHMI was provided quarterly in arrears). This was the first the Trust's time SHMI had been below 100 since its inception in 2010.

19/048.2.2

- 7 Day Delivery - There is currently a difference in mortality between weekend/weekday emergency admissions. Recent months have seen improvements in both with HSMR for weekday admission now 'better than expected' and for weekends 'as expected'. Consultant review within 14 hrs of emergency admission is lower at the weekend and needs improvement. It was thought that under-reporting of consultant visits was also a factor.

19/048.2.3 Dr Buckle noted the impressive performance regarding the mortality metrics.

19/048.3 Responsive Services

The Chief Operating Officer presented the responsive Services update:

19/048.3.1

- ED Performance
  - The Trust ED performance in March was at 81%. This was a slight improvement on the March 2018 position which was at 80%. Positively, the Trust continued to report zero 12-hour trolley breaches.
  - Work was taking place on minimising ambulance handover delays. The Chief Operating Officer reported that she had met with the ambulance service and the CCG to review ambulance arrivals. An audit would be undertaken to provide ambulance arrival and handover details to inform actions for improvement.
  - The regional regulators had expressed some concerns about the ED performance within the Herts and West Essex STP and a joint STP response had been provided. An improvement plan had been agreed with NHSI.
  - The Trust performance had been particularly challenged over the Easter weekend. It was explained that the numbers attending ED on the Easter weekend were not much higher than previous holidays but patient acuity had been higher. The Chief Operating Officer expressed the belief that the situation would be improved with the actions being taken. It was essential that the ED performance be brought back to 90%.

19/048.3.2

- Cancer Performance
  - The Trust achieved 4 of the 8 national targets for cancer performance including; 2ww and 2ww breast, 31-day subsequent treatments – cancer drugs and 31-day subsequent treatments – radiotherapy. The Chief Operating Officer considered that cancer performance remained in a steadily improving position.

19/048.3.3

- RTT performance
  - Incomplete performance for March was 90.56% with a reported backlog of 4,005. This was an improvement on the February position.
  - There were two 52-week breaches reported in the March incomplete position against three reported in February.

19/048.3.4 • Diagnostics performance

- DM01 performance for March is 1.34% against the national standard of 1% and the February position of 1.21%. The Chief Operating Officer advised that compliance was being targeted by the end of Q1.

19/048.3.5 • Stroke performance

- There was an improvement in performance for March 72.1% compared to 69.0% in February 2019. Performance in March 2018 was 60%. This was an improvement of 12.1 % compared to last year's performance. The Chief Operating Officer reported that work to reduce the number of outliers would improve stroke performance.

19/048.4 Well-Led Services

The Interim Chief People Officer presented an update relating to the Well-Led Services section of the report:

19/048.4.1
- The vacancy and turnover rates both increased slightly in March. However both showed an improvement from the start of the year.
- Agency spend remained on target, however bank and permanent spend combined took the pay-bill above plan.
- The Trust was therefore overspent by £10.7m YTD in terms of the pay bill.
- The Trust continued to focus on nursing and medical recruitment to drive down agency expenditure. It was also reported that the Trust had not exceeded the agency ceiling target in 2018/19.

19/048.4.2
- The overall sickness rate reduced in March although remained above the Trust target. Sickness absence was above plan at 4.2% in month and 4.3 year to date average.

19/048.4.3
- Appraisal compliance remained at 82% in March, against a target of 90%. Mandatory training was under target by 1% in March.

19/048.4.4
- It was reported that a workforce plan 2019/20 was currently being developed and would be presented to FPC.

19/048.5 Sustainable Services

19/048.5.1 The Director of Finance presented a report on sustainable services.

19/048.5.2
- The Director of Finance informed the Board of the 2018/19 outturn position. The Trust's reported position at Month 12 was a deficit of £13.2m against a deficit plan of £0.3m, thus an adverse variance to plan of £12.9m at the year end. The position excluding the impact of the provider sustainability funding (PSF) was an adverse variance to plan of £8.0m.

19/048.5.3
- Income showed a £9.1m favourable variance (excl. PSF and ENH Pharma), of which £7.3m related to over performance on SLA income. The Trust had however incurred significant

corresponding marginal and step change costs.

19/048.5.4
- The overall pay position showed £10.7m adverse to plan. Overspends against Medical staff budgets accounted for £7.4m of this variance, and £2.8m related to overspends against nursing staff budgets. The majority of this variance related to shortfalls against workforce CIP schemes, and marginal costs associated with activity over performance.

19/048.5.5 The Director of Finance advised that the theatres transformation would remain a key focus for 2019/20.

19/048.5.6 Dr Buckle asked about the current pathology costs. The Director of Finance advised that the next step would be procurement of a service with the STP partners. The costs of the current system were already priced into the budget.

19/049 Finance and Performance Committee Report to Board

19/049.1 Mrs McConnell presented the Finance and Performance Committee Summary Reports to the Board.

19/049.2 The FPC had considered two papers which set out a proposed methodology and reporting cycle for a programme of deep dives to be provided by divisional teams in 2019/20. This was in order to ensure that the deep dives were productive and useful for both the FPC and the teams attending to present them at the FPC meetings. The Committee welcomed the review and supported the proposals.

19/049.3 A pay-bill deep dive had been conducted and a report produced and presented to the Committee. An action plan which was based on the findings of the report was being drafted.

19/049.4 Other points from the reports highlighted by Mrs McConnell included:
- The FPC had been considering the lessons learnt from 2018/19 in relation to several areas.
- The FPC continued to maintain a focus on CIPs and the development of the programme for 2019/20.
- For a trial period, the FPC had been receiving all workforce papers since April. Following the conclusion of the trial period, a review of the FPC / QSC meeting structures would take place.

19/049.5 The Board noted the Finance and Performance Committee Summary Reports.

19/050 Revised FPC Terms of Reference

19/050.1 It was agreed that the remit of the FPC would be extended to include all workforce matters for a trial period of three months. Amendments to the Committee's Terms of Reference which reflected the expanded remit had been drafted by the Interim Chief People Officer. The Board approved the amended Terms of Reference for the duration of the trial period.

19/051 **Quality and Safety Committee Report to Board**

19/051.1 Mr Carter presented the key points from the Quality and Safety Committee summary reports. He reported that there had been a request at the meeting for a review of the meeting / agenda structure with a view to making the meetings more efficient and effective. He asked that the draft report on the meeting of 23 April 2019 be amended to include reference to that discussion.

19/052 **Audit Committee Report to Board**

19/052.1 Mrs McConnell presented the Audit Committee Report to Board in the absence of Mr Silver (Audit Committee Chair). She informed the Board of the latest internal audit reports received by the Committee and noted that the external auditors had commenced their audit of the Trust's 2018/19 accounts.

19/053 **Board Assurance Framework and Risk Management Strategy**

19/053.1 The Associate Director of Corporate Governance presented the latest version of the Board Assurance Framework for discussion and the revised BAF strategic risks for 2019/20 for consideration.

19/053.2 The revised BAF strategic risks for 2019/20 had been considered previously at the QSC and FPC meetings. Based on the output for 2018/19, the new framework for 2019/20 had been developed to help in the better handling of risks.

19/053.3 Mrs Schroder said that the rewording of the risks should be considered carefully. She commented that the revised document was the result of much work over a long period of time. After some discussion of the proposed amendments to the risks, the Board approved the revised risks.

19/053.4 The Board also considered the Risk Management Strategy and Procedure for approval. This included the Trust's first risk management capability assessment, risk appetite statements and updates to reflect current developments and Internal Audit recommendations. The Associate Director of Corporate Governance advised that the strategy had been reviewed last year and had been reviewed and refreshed for 2019/20. The next step would be looking at how to operationalise the implementation of the plan. The Board approved the Risk Management Strategy.

19/054 **ANNUAL CYCLE 2019/20**

19/054.1 The Board noted the Annual Cycle 2019/20. It was noted that this would be updated if changes were made to the QSC/FPC meetings and agenda structures.

19/055 **MATTERS ARISING AND ACTIONS LOG**

19/055.1 The Board reviewed and noted the Actions Log.

19/056 **DATA PACK**

19/056.1 The Board noted the data pack.

19/057 **DATE OF NEXT MEETING**

19/057.1 3 July, Lister Education Centre, Lister Hospital

BOARD TO RECONVENE AS CORPORATE TRUSTEES

19/058 **Charity Trustee Committee Report to Board**

19/058.1 In Mr Niven's absence, Ms Moore presented the summary report relating to the most recent Charity Trustee Committee meeting. Ms Moore highlighted:

- Details of the expenditure and proposed fundraising projects considered by the CTC.
- The Investment Policy and Management of Charitable Funds Policy that had been considered by the CTC.
- The update received by the CTC on the Charity finances and 2019/20 budget forecast.

19/058.2 Mrs Schroder said that it was essential that concerted fundraising strategies be employed. She considered that fundraising should be conducted in a wider geographical area than before.

19/058.3 The following reports that were endorsed by the CTC were approved by the Board:

- Investment of Charitable Funds Policy;
- Charities income and expenditure plan for 2019/20;
- Management of Charitable Funds Policy.

There being no further business the Chair closed the meeting at 12.50.

Ellen Schroder
Trust Chair

July 2019

East and North Hertfordshire NHS
NHS Trust

Chief Executive's Report

July 2019

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1. CQC Inspection

The CQC have now confirmed that they will be visiting us to undertake their routine inspection of our services on the:

23 – 25 July 2019 – Lister and QEII
30 -31 July 2019 – MVCC
Unannounced visits will also take place

We will also have a Use of Resources Inspection on 6 August 2019 and a Well Led inspection on 10, 11 September 2019

In preparation for these visits, the CQC would like to hear the views of patient, carers, staff and stakeholders to help them gain a broad perspective of our services from a diverse range of people. One way they do this is through focus groups**,** these will be taking place in July for our staff across the Trust.

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

- Surgery
- Critical Care
- Children's and young people
- End of life care
- Outpatients
- Urgent and Emergency Care
- Medicine
- Radiotherapy

Although they are focusing on the above eight core services this does not mean that other services will not be visited. The CQC can still undertake visits to other core services and undertake night and weekend visits. The Compliance and Quality and Safety Teams are supporting our teams being prepared.

We will provide feedback to the Board during and after the inspection.

2. Corporate Update

I am delighted to announce that Sarah Brierley has been appointed as the Trust's Director of Strategy, with responsibility for strategy development and delivery, communications and engagement, corporate governance and estates and facilities. Sarah has extensive local experience, gained both within the Trust and through working with our health and social care partners. I look forward to her continuing the excellent work she began as our Interim Director Strategy.

Our Hospital Charity has funded a new x-ray machine at Hertford County, costing £200,000. The new machine will improve patient experience by ensuring a fast and accurate diagnosis, reducing waiting times and offering greater convenience and choice for patients.

We have successfully delivered our three-year research strategy, helping to improve patient care and experience. Beginning in 2016, the strategy promoted a research-active culture at our hospitals. In 2018/19, over 3,000 people took part in national health research at the Trust – a 91% increase from before the introduction of the strategy. This is a great achievement made possible only through the hard work and dedication of our staff and the support from our patients.

3. Our Staff

Trust consultant represents Royal College at Buckingham Palace

Consultant urologist Tim Lane represented the Royal College of Surgeons (RCS) at Buckingham Palace recently at an event hosted by Her Majesty the Queen. Tim is chairman of the Court of Examiners and Member of Council at the RCS of England, as well as editor-in-chief of the Annals, clinical lead for the international surgical training programme and the national curriculum lead for urology.

Respiratory team recognised as top performer in national audit

Our respiratory team has been recognised as one of the top performing teams 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.

Multiple Birth Team Recognised by NICE for Best Practice

An article by our multiple birth team was published by NICE as an example of best practice. Following recommendations from the Better Births National Maternity Review and the Twins and Multiple Births Association (TAMBA), our team introduced a new pilot for all women who have a multiple pregnancy that focused on the continuity of carer. This created a new model of care within their service, called the multiple pregnancy continuity of carer pathway.

As a result, the team has been recognised as an outstanding service by TAMBA and they are 100% compliant with NICE guidance for multiple pregnancy, significantly improving patient experience and care.

ED Nurse Awarded Mentor of the Year

Congratulations to Yvonne Pearse, staff nurse in the Emergency Department who has been recognised for her work to support and mentor dozens of student nurses from the University of Hertfordshire. She was nominated for the award by one of her students and was chosen as a winner from 33 nominations across ten NHS organisations.

Armed Forces Day

Armed Forces Day takes place on Saturday 29 June, with the celebrations starting at the Trust last week as the Armed Forces Day flag was raised at the Lister Hospital. We are very proud to show our support for the people who serve our country. The Trust has a long history of supporting the Armed Forces, and we benefit enormously from the scores of

people working across our hospitals who are reservists, veterans or military spouses, partners and family members.

The Trust already holds a silver award in the Armed Forces Covenant's Employer Recognition Scheme and this year an application for a gold award was submitted, with the outcome expected in late July 2019. Much has been done with our armed forces community this year, including the Trust signing its own Covenant, establishing an internal armed forces network, celebrating armed forces week and advertising suitable roles on the Career Transitions Partnership job site to attract leavers from the forces. Additionally, the Trust supports recruitment into local reservists and sea cadets groups by providing them with a prominent position in the Lister site on a regular basis, as well as having the Royal British Legion on site to raise awareness and support staff, patients and relatives.

East and North Hertfordshire NHS Trust

Agenda Item: 8.1

TRUST BOARD - PUBLIC SESSION – 3 JULY 2019
Nursing and Midwifery Establishment Review

Purpose
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).

Executive Summary
The nursing and midwifery establishment review was undertaken in April 2019. Actual staffing, along with patient acuity and dependency data, was collected over a 20 day period on all inpatient wards. For non-ward based departments, shift plans and service requirements were reviewed. 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 and departments
- Birth Rate Plus has been used for the Maternity review
- Individual ward recommendations from the nurse and midwifery establishment review can be seen in Appendix 2
- Shift plans are calculated to provide operational requirements

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	**Presented by:** Director of Nursing	**Author:** Deputy Director of Nursing, Safer Staffing matron, 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	1/7
Surgery (Excluding Critical Care)	1/7	1/6	1/7
Women's and Children's	2/9	2/9	2/9
Cancer	1/6	1/6	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	5.97	6.97	6.49
Surgery (Excluding Critical Care)	5.43	5.83	5.91
Women's and Children's	6.85	6.96	9.40
Cancer	7.01	5.45	8.87

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 17% 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 %	Recommended SNCT recruitable WTE based on occupancy (headroom adjusted to 17%)	Recruitable Establishment (17% headroom)	Variance from actual funded WTE
Medicine	96%	440.90	411.11	-29.79
Surgery (Excluding Critical Care)	93%	227.18	231.82	4.64
Women's and Children's	74%	32.84	47.84	15.00
Cancer	58%	21.91	54.88	32.97

A full breakdown of the data for each ward can be found in Appendix 6.

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 7

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 April 2019 can be seen in Appendix 8.

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 9 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. Departmental Reviews

5.1 Theatres

Theatres is currently undergoing a transformation programme so has not been included in this review.

5.2 Outpatients

The Outpatients department covers three sites. Lister, QE2, and Hertford county hospital (HCH)

Lister

This department runs numerous clinics which also support the Dental department. Nursing staff in the dental department manage their leave by working with OPD Lister to cover any shortage. In addition annual leave is managed by allocating Dental Nurses annual leave in line with Consultants leave. Clinics are usually planned 6 weeks in advance in line with Consultants leave. Nursing coverage is aligned to the service demand. Work is ongoing with the new Head of Nursing to look at new roles and skill mix in this department.

Hertford County

A registered Nurse is required at HCH to staff Gastro/Colorectal clinics. This is because In the absence of Pharmacy on site, the nurses are required to dispense Bowel Preparation requiring two trained nurses to check. Dermatology moved to the site in November 2018 and have now centralised their activities at HCH. This has resulted in increased activity in Minor operations which is mainly assisted by registered nurses.
Phototherapy is run daily which is being staffed by a registered nurse who has completed the Phototherapy Course - this is a nurse led clinic.
The Hertford county hospital does not have an A & E at this site, often people will attend with an emergency as they can see that this is a hospital, therefore it is necessary that there are registered nurses on site to support walk-ins.

QE2

Due to the geographical layout - there needs to be a trained nurse in each of the 4 areas. The Surgical division have now started a pathway for two week wait patients for Trained Nurses to dispense Bowel Preparation for CT Colonography.
With both QE2 and HCH there have been challenges with Delayed Transport and Collection of patients which is on the Risk register. Often the clinics do not close until 6 pm, when other clinical staff have left the building, therefore there needs to be two staff members on site every day to ensure that patients are looked after whilst waiting for transport. Both sites work together to cover shortage.

The shift plans have been updated to support the current activity. Skill mix has been reviewed with the possibility of introducing band 3 and 4 roles to be utilised in this area in the future. The division has

just introduced a new Head of Nursing who is working with the leads to introduce this plan. The cost pressure to meet the updated shift plans will be £23K.

5.3 Paediatrics

Paediatrics manages staffing across three areas; children's emergency department (ED) & children's assessment unit (CAU), Bluebell ward and Children's day services which includes day surgery, ambulatory care and outpatients. The team review each area daily as well as looking ahead and redeploy staff throughout the department as required.
The department have introduced a paediatric decision unit (PDU) within the minors area of children's ED. The aim of this is to provide additional assessment capacity; all children who go to PDU have been seen by a doctor and have a plan of care. For example they are children who have been seen by a GP in the community and referred to our paediatric team. They can also be children who have been seen within children's ED and are awaiting review by a speciality team or for further assessment following treatment. All children who are within PDU are clinically stable, and have a clear plan of care and responsible clinician / medical team.
Bluebell ward has a summer shift plan for 16 beds starting from June moving to a winter shift plan for 20 beds from November, due to higher acuity over the winter months.

5.4 Neonatal Intensive Care Unit (NICU)

NICU runs the unit using the British Association of Perinatal Medicine (BAPM) standards. The levels include;
Intensive care 1:1 ratio is provided for babies who have serious life threatening problems, who are very premature (those born more than 3 months early) and or has an extremely low birth weight (birth weight less than 1000 grams).
High dependency care: 1:2 ratio is provided for babies without life threatening problems but who still need a great deal of observation and support and for those who are recovering from critical illness.
Special care: 1:4 ratio is provided for babies who have less serious problems, who do not require continuous observation and or who are stable and growing.
Transitional care: 1:4 is provided for babies who need some medical treatment but who do not need to be separated from their mothers. It is also suitable for parents and babies being prepared for discharge home.
The unit is part of the Operational Delivery Network (ODN) for the east of England, and uses Badger net to input and monitor staffing levels and to continuously benchmark with the 17 units in the East of England ODN to ensure staff are flexed according to the service requirements.

5.6 Maternity

Birthrate Plus workforce analysis tool was commissioned by the Local Maternity Systems (LMS) and undertaken in March 2019 to enable benchmarking across the three STP Maternity Services as part of the LMS wider workforce review.
The full report can be seen in Appendix 9. Whilst Birth rate plus recommends a significant uplift in the maternity services, professional judgement has been applied and service and skill mix redesign have been looked at. The full recommendations can be seen in Appendix 2. However the key findings of the review were

- The recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of 21% for annual, sick & study leave allowance and 12.5% for travel in community.
- The overall clinical establishment for 5469 births is a total of 225WTE total Clinical & Non-Clinical staff against a budget of 199.93 WTE a variance of 25.07 WTE.

*There has been an increase in funded establishment from 195.72 to 199.93 since the review due to 3 posts externally funded for 12 months added to the budget.

Summary of BR+ Recommendations

BR+ Total Clinical Roles	206.42 WTE	The total WTE bands 3 - 8 for hospital & community services 20.64 WTE can be suitably qualified support staff replacing midwifery hours in postnatal care only and 185.78 clinical midwives
Additional non-clinical midwifery 9%	18.58 WTE	Currently 11.9WTE in post inc 3 WTE externally funded posts for 12 months
Variance	-25.07 WTE	Variance between BR+ Total WTE & Current Funded WTE – Bands 3 – 8 covering the skill mix for postnatal care

Midwife Ratios based on the data and results

The ratios below are based on the BR+® dataset, national standards with the BR+ methodology and local factors, such as % uplift for annual, sick & study leave, case mix of women birthing in hospital, provision of outpatient/day unit services and total number of women having community care irrespective of place of birth.

Recommends an overall Midwife to birth ratio of 26 births to 1 WTE midwife

Recommendations

To review shift plans to apply clinical judgement in the uplift required to support the current clinical activity, acuity and workforce model. To further review BR+ recommendations in line with the staffing requirements to support the national requirement to implement the Continuity of Carer Model for 35% of women by March 2020 and 51% by March 2021.

Current Ratios

Month 18/19	Oct	Nov	Dec	Jan	Feb	March	April	May
Births YTD	5454	5450	5460	5444	5396	5384	5375	5353
Funded Clinical WTE	190.23	190.23	190.23	190.23	190.23	190.23	190.23	190.23
Ratios	28	28	28	28	28	28	28	28

5.7 Cancer Services

Cancer services consist of Ward 10, a 33 bedded inpatient ward, John Bush ward a 12 bedded supportive day care unit, Outpatients department, Chemotherapy suite and Lister Macmillan Cancer centre day unit. For the past year Mount Vernon have on patient safety grounds relocated the inpatient Hospice Palliative care beds into the cancer centre on ward 10/11. There has been a variable level of referrals during this period which has reflected in the bed occupancy. However, they have staffed these beds flexibly according to the occupancy and dependency appropriately. A long term solution is on the horizon and they will be able to complete a full review of establishment at that point in time. Until then they will need to maintain the present staffing level and will be looking at Benchmarking with other Cancer centres and reviewing skill mixes in the outpatient areas.

5.8 Enhanced Nursing Care Team

The Enhanced care team have embedded an award winning best practice service model for patients in our trust that require enhanced care (specialling).
The trust continues to see an increase in patients that require enhanced care year on year. The team cannot always cover this demand without using temporary staffing however the team has now achieved zero agency usage for enhanced care by the implementation of a robust process and policy.
The team won the national Skills for health, Health Heroes workforce planning team of the year in November 2018 which was presented by NHS England.
Appendix 11 shows the data relating to the increased demand of specialling requirements across the trust. The team continue to streamline the service and provide a higher level of quality care to our most vulnerable patients. It is recommended to continue the requirements for this service and to flex the team using temporary staffing where demand exceeds capacity. The team will continue to look at new ways of working and new models of care to support the increase in mental health patients in the acute trust.

5.9 Emergency Department (ED)

The ED is currently undergoing two reviews around workforce planning. Kendall Bluck is an external consulting agency who has been looking at activity and skill mix. The CLeAR (Clinically Led workforce and Redesign) project commenced in May 2019. This is a Health Education England funded project which is also looking at workforce/staffing/skill mix from a clinical point of view. The team are delivering training to a small group of Lister clinicians who can then review and assess other areas within the Trust in terms of workforce planning.
Staff from both Kendall Bluck and CLeAR have spent time in ED and with staff, discussing current staffing, ways of working and demand.
The senior nursing team have also completed two sets of data collected for The RCN Best Tool and a partial set collected in January 2019. This data supports an uplift of RN's but it is recognised that the data sets are incomplete and further evidence and professional judgement will be required prior to decisions being made to change the establishment and skill mix.
The Urgent Care Centre (UCC) at QE2 changes to an Urgent Treatment Centre as 1/11/19 following national guidance. This brings with it a new staffing model to include Advanced Clinical practitioners (ACP) which has been costed separately from the ED roster. The current UCC establishment sits within the ED establishment, further consideration is required as to the best way to move forward with this ie: continue to combine roster and rotate fully or have separate establishments with some rotation through both areas. Significant concerns were raised by the Care Quality Commission (CQC) due to a lack of leadership/oversight/ownership. By moving to a separate establishment at UTC this will support a more cohesive team with full ownership.
The ED team acknowledge the difficulties in recruiting and retaining RN's in the department. The senior nursing team have worked on a new shift plan and adjusted the skill mix to include two band 7 sisters per day and night. One will be a quality supervisor and remain supervisory monitoring and supporting the department, the second band 7 will lead the front end of the department, managing the triage and assessment teams and monitoring attendance.
The team have also added in Progress Chaser's 24/7 in order to manage the flow which will free up the band 7 s so they can concentrate on clinical and quality issues.
The team have also considered paramedics, these will come at a cost as they are band 6's, however they have several band 6 vacancies and will open these to paramedics to keep within the current establishment. The department will await both external reviews before full recommendations are proposed.

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

The first cohort of nursing associates has now qualified and has been integrated into the ward skill mix. Work was undertaken 2 years ago when they were introduced into the workforce, an RN post was reduced to incorporate the TNA. It should be noted that whilst in training a TNA is rostered as a band 3 care support worker. Their role is to support but not substitute registered nurses. All wards that support a nurse associate maintain a 1 RN to 8 patient ratio. The trust has gone through a robust process looking at the skill mix to ensure delivery of high quality, safe care for each service using a triangulated approach and professional judgement.
A full quality impact assessment has been undertaken following NQB guidance to ensure effective governance for the trust to introduce this new role into the workforce. The role continues to be monitored to ensure continuous improvement and effective deployment of the role.

The RNA competencies specific for ENHT have been agreed by the Clinical Skills Steering Group and Nursing Associate steering group. These competencies have been incorporated into the Nursing Associate preceptorship workbook and preceptorship programme. Funding received from Health Education England has enabled the Trust to recruit a band 6 Educational Facilitator to support training and development for the TNAs and RNAs.
The Trust has commissioned a new group of TNAs who commenced on 28th May 2019 who are supported by the University of Hertfordshire. The Trust has eight candidates in this cohort. The Trust is preparing for the next cohort of TNAs commencing in September 2019. With the introduction of this TNA role and the national requirement for them to be band 3 equivalent there will be a financial impact for wards and departments supporting this role, to cover study leave and back filling when on placement.
The NMC has summarised its standards of proficiency for both the RN role and NA role as shown in Table 4. The highlighted areas are where the roles differ.

Table 4

Platform	Nursing associate	Platform	Registered nurse
1	Be an accountable professional	1	Be an accountable professional
2	Promoting health and preventing ill health	2	Promoting health and preventing ill health
3	Provide and monitor care	3	Assessing needs and planning care
		4	Providing and evaluating care
4	Working in teams	5	Leading and managing nursing care and working in team
5	Improving safety	6	Improving safety
6	Contributing to integrated care	7	Co-ordinating care

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
- Preparing the Workforce for the NMC changes to the pre-registration curriculum planned for commencement in September 2019
- 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 1 RN and reduce 1 CSW on an Early shift Monday-Friday on 6A
- Ashwell: reduce band 5 RN and replace with band 2 CSW on early shifts, build in 1WTE band 3 to fund TNA
- 10B: increase CSW at weekend and remove HK late
- ACU: add 1 WTE B3 TNA to replace B2 CSW
- AMUW: reduce 1 WTE B7 SV to 0.75WTE SV, increase B5 early shift on Thursdays
- SSU: option 1- increase B7 to WTE SV, increase B5 and reduce B2 on Thursday mornings, reduce B5 Saturday/ Sunday. Option 2 - increase B5 and reduce B2 on Thursday mornings, reduce B5 Saturday/ Sunday
- AMUA: increase B5 on early shift on Thursday and reduce CSW B2
- 8B: reduce B5 on early, B4 AP to work long days 5 days per week, add 1 WTE B3 TNA, share B6 establishment equally across level 8.
- Support the cost pressure for the Trainee Nurse Associates by building the role into the budgets for 7B, 5A, 5B.
- Uplift 1 RM in triage at night in CLU
- Change the skill mix in MLU by changing the band 4 to a band 2 support worker, and convert 1 band 6 RM to a band 7 1 night per week.
- Convert a band 2 to band 3 in Maternity community services and utilise band 3 and 4 staff in post-natal care.
- Increase 1 RM long day and night and 1 band 4 nursery nurse long day at weekends on Gloucester ward.

Table 5 – Costings for Shift Plan Changes

		OPTION 1 Change to budget		OPTION 2 Change to budget	
Division	**Ward/Dept**	**WTE**	**£000's**	**WTE**	**£000's**
Surgery	8A	0.00	0	0.00	0
Surgery	8B	-0.68	-17	-0.68	-17
Surgery	11B	0.00	0	0.00	0
Surgery	7B	0.34	12	0.34	12
Surgery	5A	0.78	40	0.78	40
Surgery	Swift	0.00	0	0.00	0
Surgery	5B	-1.13	-44	-1.13	-44
Surgery	SAU	0.00	0	0.00	0
Medicine	Ward 6A	0.15	17	0.15	17
Medicine	Ward 9B	0.00	0	0.00	0
Medicine	Ashwell	-0.06	-13	-0.06	-13
Medicine	Ward 9A	0.00	0	0.00	0
Medicine	Ward 10B	0.39	11	0.39	11
Medicine	Ward 11A	0.00	0	0.00	0
Medicine	ACU	0.33	4	0.33	4
Medicine	Ward 6B	0.00	0	0.00	0
Medicine	Pirton & Barley	0.00	0	0.00	0
Medicine	AMU-W (Green)	-0.40	-16	-0.40	-16
Medicine	SSU option 1	0.94	19		
Medicine	SSU Option 2			0.44	3
Medicine	AMU-A (Blue)	-0.10	-2	-0.10	-2
TOTAL		**0.56**	**11**	**0.06**	**-5**

Notes:

Two options due to different options for SSU.

Option 1 is £11k additional cost for full year

Option 2 is £5k surplus for full year

10. Next Steps

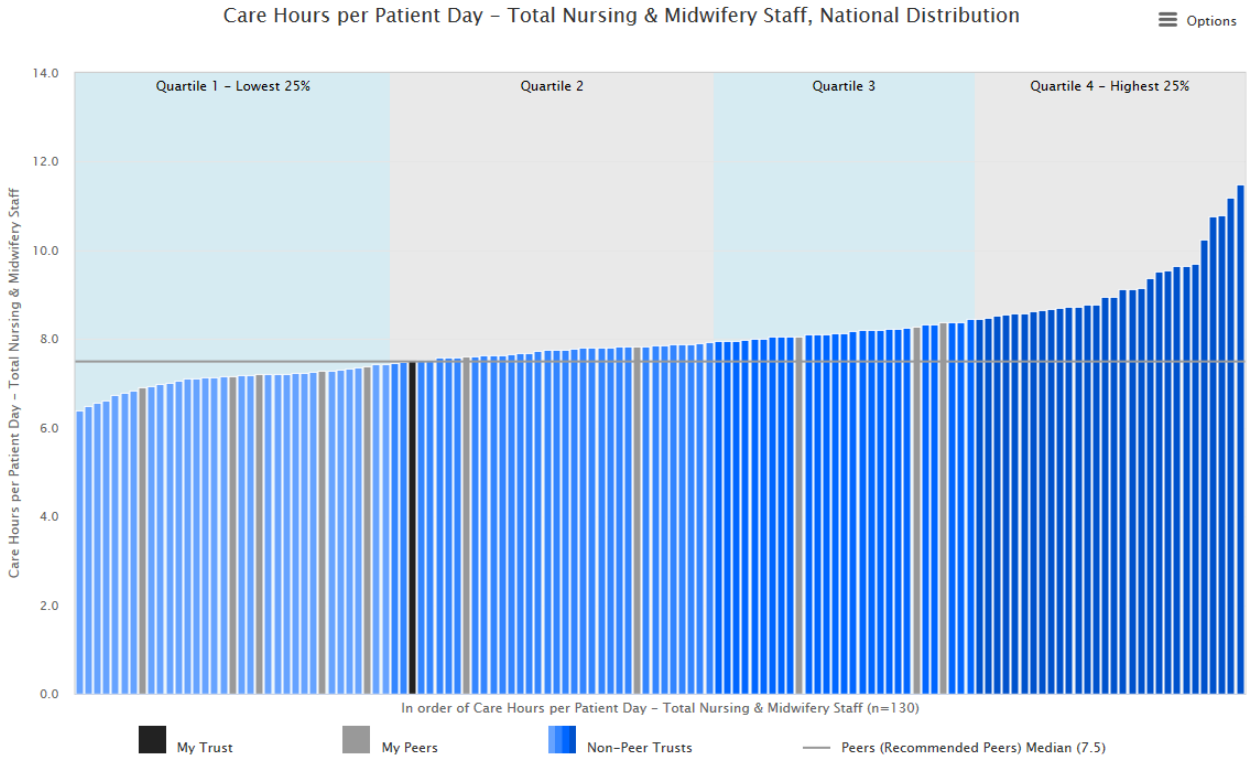
- Continue to work collaboratively across the system to maximise domestic recruits and increase students entering training
- Continue to scope and support flexible routes into nursing
- Continue with overseas recruitment to ensure a consistent pipeline for registered nurses
- To continue to monitor and 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

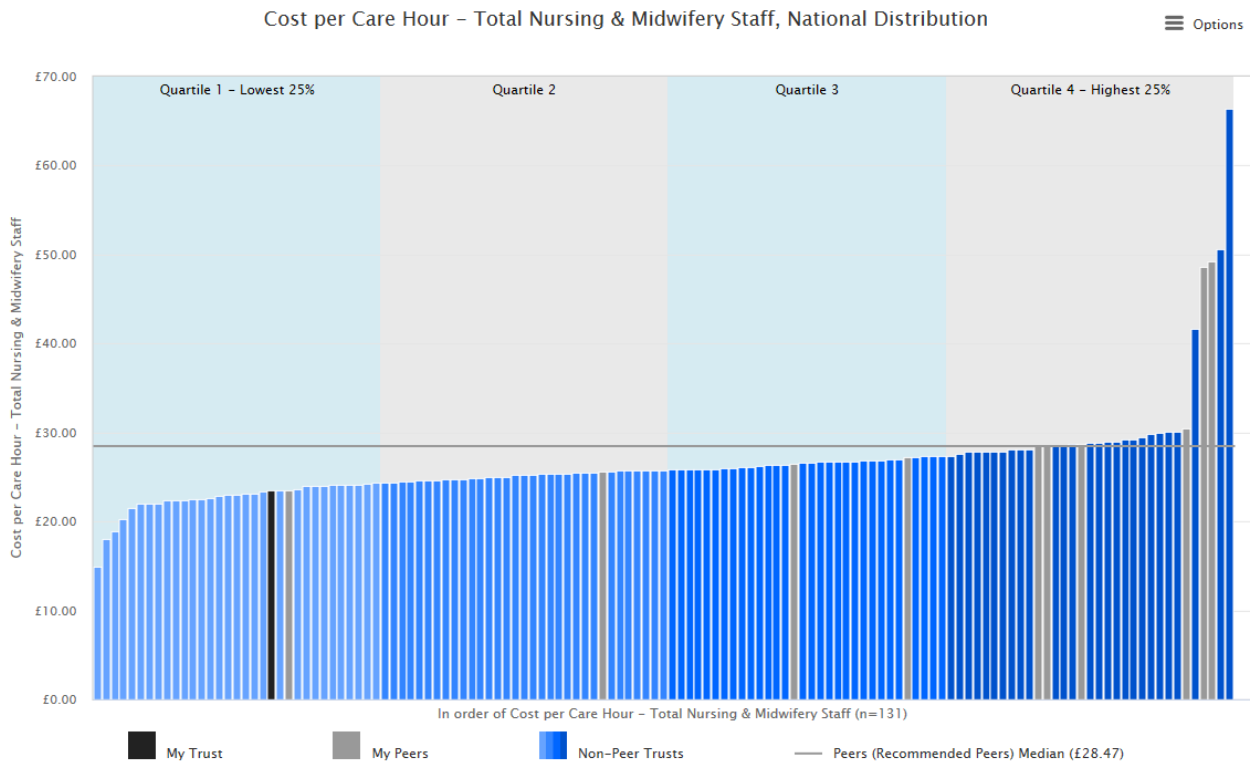
References:

- 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)

Appendix 1

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





Summary Change Request Tables

Unit	RNA	TNA	Narrative	Change Request
Division General and Speciality Medicine				
9B Elderly Care		1	During the data collection period 9B had a high level of patients requiring enhanced care. 9B is a 30 bedded elderly care ward. The ward have recently been changed to the Adult Safer nursing care tool and had challenges with acuity scoring. The SNCT results do not reflect the patient acuity and further training and support has been put in place for this. The ward manager feels that staffing levels are appropriate for patient acuity at present. With support from the Enhanced Care team.	No Change
Ashwell Frailty	Y		Ashwell is a 24 bedded Frailty ward, which also supports the frailty assessment unit(FAU) in ED which Ashwell ward cover this 09:00-17:00 and rotate their staff to support this unit. It is proposed that Ashwell reduce a band 5 on the early shift to incorporate their new nurse associate. The SNCT data was not reflective due to Ashwell ward being moved to 7A during the data collection period and running on reduced occupancy.	Reduce band 5 early replace with band 2 CSW, build in 1 WTE band 3 to fund TNA Staffing Matrix: Early 4-4 Late 4-3 Night 3-2 RNA to be 4th trained on the Long Day and utilised as the 3rd trained at night once preceptorship completed
9A Elderly care	Y		During the data collection period 9A had a high level of patients requiring enhanced care. 9A is a 30 bedded elderly care ward. The ward have recently been changed to the Adult Safer nursing care tool and had challenges with acuity scoring. The SNCT results do not reflect the patient acuity and further training and support has been put in place for this. The ward manager feels that staffing levels are appropriate for patient acuity at present with support from the Enhanced Care team.	No Change
6A Medical/Renal		1	6A has been monitored since the previous establishment review, and coninues to have high acuity patients, The ward manager and matron are concerned that the staff are not coping with the current workload on the ward and have had 9 registered nurses hand their notice in to work in other areas in the trust. The SNCT and CHPPD and professional judgement suggest 6A has a skill mix change to support the complexity of patients and junior staff on this ward. It is proposed that 6A have replace a band 2 CSW with a band 5 RN on an early shift Monday-Friday. And the band 6 is uplifted to 3 WTE in line with other 30 bedded wards to ensure senior cover to support junior staff.The division have put an action plan in place to support this ward.	Increase 1x band 5 on early Mon-Fri , reduce band 2 on early Mon-Friday Staffing Matrix Weekday: Early 5-4 (including TNA in unregistered numbers) Late 4-4 Night 4-2 Increase Band 6 Establishment to 3 WTE to bring in line with other 30 Bed Wards
10B Endocrinology/Gen Med	Y		10B is a 30 bedded ward that has many patients with chronic, complex and complicated needs. SNCT and CHPPD required have shown consistently over the past 3 reviews that this ward may require an uplift to manage the acuity and dependency on this ward. It is proposed that 10B have an additional CSW on an Early at the weekends and remove the additional housekeeper late to have 7 day a week even coverage.	Increase CSW at weekend and remove HK Late Matrix Weekend: Early 4-5 Late 4-4 Night 4-2
11A Respiratory			11B is a 29 bedded respiratory ward that has a 4 bedded respiratory support unit. No change to establishment. The ward have introduced a band 4 assistant practioner role to enrich the skill mix.	No Change
Acute Cardiac Unit (ACU)		1	ACU has completed a risk assessment to protect staff being moved off the unit. ACU has a large ward footprint , they also support the primary percutaneous coronary intervention (PPCI) out of hours and often have level 2 cardiac patients. The current establishment of 4 + 2 is appropriate. It has been agreed that if staff are moved from ACU this must be agreed by the executive nurse team following an assessment of acuity and dependency.	Add 1 WTE B3 TNA (replacing B2 CSW)
6B Renal		1	6B is a 24 bedded renal ward and runs ward clinics and a treatment room that is built into the ward establishment but not rostered. However this workload is not captured in the SNCT data or the CHPPD data so professional judgement must be used. The ward is vulnerable overnight due to the ward layout. At the south end there are 10 beds which is managed with 1 RN. The ward also has high acuity patients that require specialist skills in renal management. The ward had an uplift of 1 RN at night at the previous reveiw. The establishment is now appropriate for the ward acuity and dependancy. No change	No Change

Unit	RNA	TNA	Narrative	Change Request
Division Emergency and Acute Medicine				
Pirton Hyper Acute Stroke			Pirton is a 22 bedded Hyper Acute Stroke ward. The shift plan remains appropriate for the service.	No Change
Barley Stroke Rehab		1	Barley is a 24 bedded Stroke Rehabilitation Ward. The majority of patients have high care needs and need a high level of support with activities of daily living. The establishment on this ward is appropriate following uplift at the last establishment reveiw. No change required.	No Change
Acute Medical Ward (AMUW)	Y		AMUW is a 16 bedded acute medical ward. All beds are single side rooms. A large number of patients tend to be frail elderly/being barrier nursed. The acuity on this ward is high and SNCT shows they may require an uplift, following the RNA qulifying the ward will now revert back to the ward manager being supervisory 3 days a week and the 3rd registered RNA or RN will be put back on the early shift.	Reduce 1WTE Band 7 SV to 3 days a week increase RN band 5 early Thursday for consistent staffing Staffing Matrix Early 3-2 Late 3-2 Night 3-2
Short Stay Unit (SSU)	Y	1	SSU is a 24 bedded short stay medical unit. It has a high turnover of patients. It is proposed to introduce the RNA that	Option 1. increase to 5 Days band 7 SV. Increase x1 band 5 on early Thursday, reduce 1x CSW B2 on Thursday early to balance skill mix. Reduce B5 early shift Sat/Sun Option 2. Increase x1 band 5 on early Thursday, reduce 1x CSW B2 on Thursday early to balance skill mix. Reduce B5 early shift Sat/Sun
Acute medical assessment unit (AMU-A)	Y	1	AMUA is a 25 bedded Acute medical assessment unit, it has a large geographical footprint and has a high turnover of beds. The SNCT does not truly reflect the acuity in this unit. There is no proposed change to shift plan,	Increase RN B5 Early Thursday and Reduce CSW B2. RNA now 37.5 clinical (was 30 hours)

Unit	RNA	TNA	Narrative	Change Request
Division Surgery				
8A	Y		8A is a 30 bedded Gastroenterology ward. The shift plan remains appropriate for the service. Band 6 budget to be shared across the floor.	Share band 6 establishment across Level 8
8B		1	8B is a 30 bedded general surgical and vascular ward. The ward has 2 band 4 assistant practioners. It is proposed that the band 5 is reduced on the early shift and replaced with a band 4 assistant practioner 5 days a week.	Reduce B5 early, B4 AP Long Day 5 days a week Share Band 6 establishment across Level 8 Add 1 WTE Band 3 TNA (reduce band 2 CSW)
11B *	Y		11B is a 15 bedded plastics and ear, nose and throat ward. This ward use 1 CSW for their plastics dressing clinic and minor ops room on the early shift. These clinics are not captured in the SNCT and CHPPD. The ward also requires specialist skills to manage airway patients and breast reconstructions. Shift plan remains appropriate for the service.	No change
7B	Y	1	7B is a 30 bedded Urology and Colorectal ward. The shift plan is now in line with the needs of the service.	1 xWTE TNA to be included in budget as B3
5A	Y	1	5A is a 30 bedded Trauma and orthopaedic ward. The shift plan is now appropriate for the service.	1xWTE TNA to be included in budget as B3 Share band 6 establishment across Level 5
Swift	Y		Due to the large number of side rooms, footprint and isolation of the unit, a risk assessment has been completed to protect staff from being moved at night. This must go through a risk assessed process if considering to move staff. Ops matron to visit at least x2 overnight	No Change
5B	Y	1	5B is a 30 bedded Fracture Neck of Femur ward. The shift plan is appropriate for the service.	1xWTE TNA to be included in budget as B3 Share Band 6 establishment across Level 5
SAU		1	SAU is a 12 bedded surgical assessment unit that had an uplift at the previous review. The shift plan is now appropriate for the service.	No Change

Unit	RNA	TNA	Narrative	Change Request
Division Women's & Children's				
Bluebell	Y		Bluebell reduces its beds from 20 to 16 on a seasonal basis and staffing reduced to accommodate this for the summer. Due to increased demands on the service in winter Bluebell cannot manage with 16 beds. From November the ward will increase capacity to 20 beds. The ward works closely with children's ED and flexes staff across children's services.	Summer shift plan agreed
10A Gynae*			Establishment to remain 2+1 due to small ward phenomenon and isolation of the ward. No emergency call system in place.	No change
CLU			To increase staffing cover for triage from 1 to 2 midwives on the nightshift, Reduction in delays in assessment of fetal heart for women who present for reduced fetal movements, Achieve Triage on arrival within guidelines reduce waiting times for care provision ,Reduce complaints During the day there are two midwives and one maternity support worker from 09.30 to 6pm Monday to Friday. At night there is one midwife only. The Triage on CLU is a high risk assessment area for unplanned emergency admissions. The activity in triage has increased significantly in both number and complexity of the women presenting since it opened in 2011 from number to currently 900 to over 1000 women monthly with no staffing uplift. Increasing the staffing will enable women to be seen and managed in appropriate time scales and improve patient experience	Uplift 1 RM in triage at Night
MLU			During the day there are two midwives and one maternity support worker from 09.30 to 6pm Monday to Friday. At night there is one midwife only.	Remove band 4 LD at replace to band 2 MSW, Convert 1 B6 Night per week to B7
Dacre			No Change	No change
Gloucester (Postnatal Ward)			Increase Nursery Nurse cover to include the weekend. To have a 7 day equitable service for Nursery Nurse support -Monday-Sunday early shift Improve Breast feeding support and care of Transitional Care (TC) babies. Sustainable TC weekends as part of TC action plan for NHSR 10 steps to safety. Improve ability to readmit babies on w/e reduce admissions to Bluebell ward. Increase midwifery cover from three to four 24/7 to reduce complaints, decrease delay's, improve FFT scores and additionally enable midwives to undertake the newborn physical examinations previously performed by the neonatal team	Uplift 1 Band 6 RM at Night and B4 NN at weekends
Community			Birthrate plus (BR+) Workforce analysis for ENHT 2014 and 2019 identified a shortfall in community based on 5469 births (QTR 3 19/20) with the total number of women seen in the community just fewer than 7000 women this is driven by: • The large geographical area covered by the ENHT community midwives • The number of women seen in the community additional to the number of births • Reduced antenatal admissions and length of stay increasing care in the community. • Midwives undertaking the Newborn Physical Examination instead of paediatricians. • Cross border activity different processes, documentation, referral pathways • All women booked by 10 weeks gestation, women are meeting their midwife earlier. • Change in the national screening program increasing booking time • Meeting the public health agenda, obesity, smoking, mental health, wellbeing	Covert band 2 to band 3 post and utilise band 4s in postnatal care
Antenatal Clinic			No Change	No change

Unit	RNA	TNA	Narrative	Change Request
Division Cancer				
Ward 10	Y		Ward 10 has 33 beds . Michael Sobel is currently closed whilst the service is being reviewed. Ward 10 takes these patients and can flexes beds . The ward also run an acute oncology service out of hours which is not captured in the SNCT. No changes will be made to the current shift plan until the service has had a full review.	No Change

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.

Baseline Emergency Staffing Tool (BEST)

The original tool was developed by the RCN Emergency Care Association (ECA) and Faculty of Emergency Nursing (FEN) in 2013.
The tool makes reference to the new RCN National Curriculum and Career Framework for Emergency Nursing rather than the Faculty of Emergency Nursing Framework.
BEST is a workforce planning tool for use at local level in the Emergency Department (ED) to allow any disparity between nursing workload and staffing to be highlighted. The tool allows you to:

- Analyse the volume and pattern of nursing workload in your ED
- Track this against your rostered staffing level
- Calculate the whole time equivalent workforce and skill mix which would be required to provide the nursing care needed in the department during the audit period.

The tool will highlight disparity between nursing workload and actual staffing. Any disparity can then be addressed either by measures to reduce nursing workload, such as improving patient pathways or departmental processes, or by increasing nursing availability; or a combination of the two.
The tool should be used in conjunction with local professional judgement and benchmarking with organisations with similar patient profiles. Every ED is different and it is important that the results are interpreted by people who are familiar with it.
Geography and layout of a department, including the need to staff different work streams, will also have an impact on nursing numbers needed. Therefore local intelligence should always be considered when planning workforce reviews.
BEST is used to calculate the nursing workload and makes no recommendations for other professional groups needed in the workforce, such as doctors.
The BEST calculation requires data to be collected and entered for a seven-day period on an hour-by-hour basis.
The calculations work by using nurse-to-patient ratios in the various dependency categories.
The ratios used by BEST are:
- Total dependency - 2 nurses to 1 patient (e.g. Cardiac Arrest patient)
- High dependency – 1 nurse to 1 patient (e.g. Patient undergoing procedural sedation for joint manipulation)
- Moderate dependency - 1 nurse to 2 patients (e.g. Patient with high level of care needs due to incontinence and dementia, combined with an acute illness). This ratio reflects the nursing workload for initial assessment and on-going patient monitoring and care
- Low dependency - 1 nurse to 3.5 patients (e.g. Isolated limb fracture patient). This ratio includes nursing time to triage or make an initial assessment and also to complete treatments.

The hourly data sets used by BEST are:
- Patient dependency volume in the department using the validated Jones Dependency Tool (JDT)
- The total number of staff rostered to be clinical on shift in the department.

An indication of the skill mix breakdown required of the whole time equivalent (WTE) workforce in the ED will be provided. This is based on the RCN National Curriculum and Competency Framework.

Methodology for current establishment review Birthrate Plus

Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in use in UK maternity units since 1988. The Royal College of Midwives and Royal College of Obstetricians and Gynaecologists recommend the use of Birthrate Plus® There is no other research-based methodology for workforce planning in maternity services and traditional methods are of little value in today's health service.
The recommendations of the report were based on Q4 2018/2019 activity and include all antenatal, intrapartum and postnatal care provided by East and North Herts Trust (ENHT) Midwives. The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the non-clinical midwifery roles to manage maternity services.

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	53.08	46.92
		Ashwell	57.00	43.00	55.71	44.29
		9A	56.00	44.00	50.97	49.03
	Stroke	**Pirton**	67.00	33.00	65.24	34.76
	Stroke	**Barley**	57.00	43.00	56.46	43.54
	General	**6A**	56.00	44.00	56.09	43.91
	General	**10B**	58.00	42.00	56.78	43.22
	Respiratory	**11A**	67.00	33.00	65.93	34.07
	Cardiology	**ACU**	67.00	33.00	67.91	32.09
	Acute	**AMU Ward**	56.00	44.00	55.15	44.85
		SSU	53.00	47.00	51.96	48.04
	Renal	**6B**	67.00	33.00	62.67	37.33
Surgery	**General**	**8A**	59.00	41.00	57.77	42.23
		8B	63.00	37.00	61.43	38.57
	Surgical Spec	**11B ***	57.00	43.00	54.20	45.80
		7B	58.00	42.00	54.96	45.04
	T&O	**5A**	57.00	43.00	54.88	45.12
		Swift	61.00	39.00	57.00	43.00
		5B	56.00	44.00	50.83	49.17
	ATCC	**Critical Care**	90.00	10.00	87.43	12.57
W&C	**Gynae**	**10A Gynae***	67.00	33.00	67.79	32.21
	Paeds	**Bluebell**	61.00	39.00	67.65	32.35
Cancer	**Inpatient**	**Ward 10**	65.00	35.00	61.57	38.43
		Michael Sobell House				

** 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	**1/7**	**1/7**	**1/7**
	Stroke	**Pirton**	**2/9**	**2/9**	**1/7**
	Stroke	**Barley**	**1/6**	**1/6**	**1/8**
	General	**6A**	**1/7**	**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 Ward**	**1/8**	**1/5**	**1/5**
		SSU	**1/6**	**1/6**	**1/8**
	Renal	**6B**	**1/5**	**1/5**	**1/6**
Surgery	General	**8A**	**1/7**	**1/7**	**1/7**
		8B	**1/6**	**1/7**	**1/7**
	Surgical Spec	**11B ***	**1/7**	**1/5**	**1/7**
		7B	**1/7**	**1/7**	**1/7**
	T&O	**5A**	**1/7**	**1/7**	**1/7**
		Swift	**1/6**	**1/6**	**1/9**
		5B	**1/7**	**1/7**	**1/7**
	ATCC	**Critical Care****	**6/7**	**6/7**	**8/9**
W&C	Gynae	**10A Gynae***	**1/5**	**1/5**	**1/5**
	Paeds	**Bluebell**	**1/4**	**1/4**	**1/4**
Cancer	Inpatient	**Ward 10**	**1/6**	**1/6**	**1/7**
		Michael Sobell House			

* 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	7.26	5.63
		Ashwell ward	5.93	7.65	8.11
		Ward 9A Elderly Care	5.34	7.41	6.1
	Stroke	**Pirton HASU**	6.18	6.7	6.86
	Stroke	**New Barley**	5.8	6.74	6.01
	General	**Ward 6A**	5.51	6.5	5.82
	General	**Ward 10B**	5.44	7.22	5.8
	Respiratory	**Ward 11A Respiratory**	6.04	6.74	5.91
	Cardiology	**Acute Cardiac Unit**	6.19	6.66	6.79
	Acute	**Acute Medical Unit**	7.08	7	6.89
		Short Stay Unit - SSU	6.42	6.92	7.01
	Renal	**Ward 6B**	6.43	6.78	6.94
Surgery	General	**Gen Surgery Ward 8A**	5.12	5.46	5.39
		Gen Surgery Ward 8B	5.12	5.17	5.15
	Surgical Spec	**Ward 11B Plastics & ENT**	5.8	5.67	6.41
		Urology Ward 7BN	5.19	5.8	5.69
	T&O	**T&O Ward 5A**	5.43	6.36	5.86
		Swift Ward	5.79	5.06	6.39
		T&O Ward 5B	5.56	7.3	6.49
	ATCC	**Critical Care Unit**	23	19.27	18.2
W&C	Gynae	**Gynaecology Ward 10A**	6.79	5.36	7.78
	Paeds	**Children Bluebell Ward**	6.9	8.56	11.01
Cancer	Inpatient	**MV Ward 10**	7.01	5.45	8.87
		MV M.S.H Inpatient Unit			

Appendix 6

The table below shows the recommended recruitable WTE based on the benchmark for the service and the average occupancy for the reference period compared to the actual funded recruitable WTE for the period

Div	Speciality	Ward	Bed Occupancy %	Recommended SNCT recruitable WTE based on occupancy (headroom adjusted to 17%)	Recruitable Establishment (17% headroom)	Variance from actual funded WTE
Medicine	Care of the Elderly	**9B**	99.3%	47.57	36.04	-11.53
		Ashwell	95.3%	31.76	33.72	1.96
		9A	99.3%	47.95	36.57	-11.38
	Stroke	**Pirton**	87.0%	27.60	31.07	3.47
	Stroke	**Barley**	95.6%	33.63	32.33	-1.30
	General	**6A**	98.8%	41.52	37.67	-3.85
	General	**10B**	99.2%	46.97	37.19	-9.78
	Respiratory	**11A**	99.7%	41.97	38.57	-3.40
	Cardiology	**ACU**	88.6%	28.14	31.12	2.98
	Acute	**AMU Ward**	99.4%	24.22	26.49	2.27
		SSU	96.5%	35.26	35.14	-0.12
	Renal	**6B**	98.3%	34.31	35.20	0.89
Surgery	**General**	**8A**	98.2%	34.87	35.05	0.18
		8B	98.5%	33.39	35.05	1.66
	Surgical Spec	**11B ***	92.7%	16.82	21.05	4.23
		7B	96.5%	36.84	35.51	-1.33
	T&O	**5A**	97.8%	40.00	37.12	-2.88
		Swift	77.3%	22.38	29.94	7.56
		5B	90.8%	42.88	38.1	-4.78
	ATCC	**Critical Care****	75.8%	63.59	87.78	24.19
W&C	**Gynae**	**10A Gynae ***	92.5%	12.06	15.8	3.74
	Paeds	**Bluebell**	56.3%	20.78	32.04	11.26
Cancer	**Inpatient**	**Ward 10**	57.5%	21.91	54.88	32.97
		Michael Sobell House		0.00	0	0.00

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

**Recruitable data as per QlikView 19/20 Month 1

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

Div	Speciality	Ward	CHPPD Bench Marking Data			SNCT Recommended Data		
			Recommended CHPPD recruitable WTE based on occupancy	Recruitable Establishment Oct 2018	Variance form actual funded WTE	SNCT recommended WTE	Recruitable Establishment Oct 2018	Variance of operation establishment to SNCT recommended
Medicine	Care of the Elderly	9B	34.22	36.04	1.82	47.57	36.04	-11.53
		Ashwell	20.57	33.72	13.15	31.76	33.72	1.96
		9A	34.74	36.57	1.83	47.95	36.57	-11.38
	Stroke	Pirton	25.83	31.07	5.24	27.60	31.07	3.47
	Stroke	Barley	29.06	32.33	3.27	33.63	32.33	-1.30
	General	6A	35.67	37.67	2.00	41.52	37.67	-3.85
	General	10B	35.36	37.19	1.83	46.97	37.19	-9.78
	Respiratory	11A	38.14	38.57	0.43	41.97	38.57	-3.40
	Cardiology	ACU	26.35	31.12	4.77	28.14	31.12	2.98
	Acute	AMU Ward	24.59	26.49	1.90	24.22	26.49	2.27
		SSU	32.47	35.14	2.67	35.26	35.14	-0.12
	Renal	6B	33.13	35.2	2.07	34.31	35.2	0.89
Surgery	General	8A	32.94	35.05	2.11	34.87	35.05	0.18
		8B	33.04	35.05	2.01	33.39	35.05	1.66
	Surgical Spec	11B *	17.61	21.05	3.44	16.82	21.05	4.23
		7B	32.81	35.51	2.70	36.84	35.51	-1.33
	T&O	5A	34.79	37.12	2.33	40.00	37.12	-2.88
		Swift	25.41	29.94	4.53	22.38	29.94	7.56
		5B	33.08	38.1	5.02	42.88	38.1	-4.78
	ATCC	Critical Care**	76.15	87.78	11.63	63.59	87.78	24.19
W&C	Gynae	10A Gynae *	13.72	15.8	2.08	12.06	15.8	3.74
	Paeds	Bluebell	16.97	32.04	15.07	20.78	32.04	11.26
Cancer	Inpatient	Ward 10	29.05	54.88	25.83	21.91	54.88	32.97
		Michael Sobell House	0.00	0	0.00	0.00	0	0.00

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

**Recruitable data as per QlikView 19/20 Month 1

Division	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	30.84	34.26	3.42	36.74	34.26	-2.48
Surgery (Excluding Critical Care)	29.96	33.12	3.16	32.45	33.12	0.66
Women's and Children's	15.34	23.92	8.58	16.42	23.92	7.50
Cancer	14.53	27.44	12.91	10.96	27.44	16.49

NURSING & MIDWIFERY QUALITY INDICATORS: April 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)	668	338	187	100	33
	Bed occupancy % (at Midnight)	83.46	92.01	88.87	54.68	52.83
e-Rostering	% E-roster Deadline Met	36.6	22.8	41.3	42.6	33.0
	Net Hours %	-0.3	-0.1	0.3	-0.2	-0.6
	Net Hours Position	-27.7	-2.2	9.4	-7.4	-28.2
	% of Actual Annual Leave	15.3	13.2	16.2	14.9	6.3
Staffing	Funded WTE	1322.4	530.5	308.2	298.9	42.3
	Actual WTE	1328.4	531.8	310.1	312.3	41.6
	Vacancy rate %	-4.5	-0.2	-0.6	-0.5	1.6
	RN Fill Rate (day shifts)	94.2	95.5	95.5	95.0	19.2
	Sickness %	5.4	5.4	4.2	6.8	5.0
	Agency usage %	2.0	2.6	5.3	0.0	0.0
	Bank usage %	16.3	17.3	17.3	10.8	10.7
	Staff Appraised % (rolling 12 months)	87.3	85.3	83.1	88.9	92.9
	Nursing Overtime	0.4	0.0	0.0	0.4	0.0
	Statutory Mandatory Training Overall Coverage %	90.1	89.3	87.5	92.4	95.4
	% Shifts Triggered Red in Month - Initial	11.2	15.4	14.0	1.1	0.0
	% Shifts Triggered Red in Month - Final	0.6	1.0	0.3	0.0	0.0
Patient Safety	Inpatient falls (rate per 1000 bed days)	3.10	4.07	2.85	0.00	4.04
	Inpatient falls resulting in harm (rate per 1000 bed days)	0.00	0.00	0.00	0.00	0.00
	Hospital Acquired Pressure Ulcers (rate per 1000 bed days)	0.61	1.78	0.36	0.00	0.00
	% Eobservations completed within timeframe	66.96	68.23	63.69	82.42	50.42
	% Eobservations completed up to 15 mins after timeframe	9.89	10.07	10.24	7.13	6.53
	% Eobservations completed more than 15 mins after timeframe	23.15	21.70	26.08	10.45	43.05
	% of Delay and/or Omission of Critical Medicine	1.55	2.05	1.26	0.85	Not Provided
	No. Medication Reported errors	61	27	25	6	3
	% Medication administered as prescribed	96.0	94.3	93.8	100.0	100.0
	% Analgesia administered as prescribed	94.0	92.6	100.0	87.5	100.0
	Intentional rounding completed	95.0	98.1	89.8	100.0	100.0
	Patient Identification	87.0	89.1	93.0	89.6	78.0
	Safety Thermometer Patients with harm	19	14	5	0	0
	% of Compliance with Hand Hygiene	82.1	73.8	76.9	95.6	100.0
Patient Experience	% Response to Inpatient Survey	39.5	57.7	49.9	17.3	28.7
	Help to eat meals/Infant Feeding	92	92.7	91.1	90.0	83.0
	Enough nurses on duty	80	77.8	78.3	94.3	96.0
	Staff provide help	89	92.2	83.4	85.0	86.0
	Pain Control	94	95.6	92.4	92.3	95.0
	Understand answers from nurses	92	92.7	89.0	94.8	100.0
	Someone to talk to about worries and fears	84	85.2	76.0	79.0	91.0
	Enough emotional support from staff	89	90.2	85.4	91.8	87.0
	Know named nurse	80	81.9	76.4	85.7	60.0
	Inpatient FFT - % of patients would recommend	96.7	96.6	96.6	97.4	100.0
	Inpatient FFT - % of patients would not recommend	0.6	0.3	0.8	0.9	0.0
	FFT Response Rate %	44.4	60.8	39.9	0.0	27.7
	No.of Complaints	22	8	9	5	0

Nursing Quality Indicators (NQI) 2019-20 (M01) April 2019_v2.xlsx

Period	01/04/2019-20/04/2019	Days in Month	20

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	60	5	0	7	12	20.00	0	0	1	1	1.67
		9B	60	9	8	2	19	31.67	0	0	1	1	1.67
	Stroke	Barley	60	2	3	6	11	18.33	0	0	0	0	0.00
		Pirton	60	1	0	2	3	5.00	0	0	0	0	0.00
	General	6A	60	12	8	3	23	38.33	0	0	1	1	1.67
		10B	60	7	6	3	16	26.67	0	0	1	1	1.67
	Respiratory	11A	60	2	3	1	6	10.00	0	0	0	0	0.00
	Cardiology	ACU	60	1	9	3	13	21.67	0	0	0	0	0.00
	Acute	AMU-A	60	1	3	2	6	10.00	0	0	0	0	0.00
		SSU	60	0	1	2	3	5.00	0	0	0	0	0.00
		AMU-W	60	4	1	3	8	13.33	0	0	0	0	0.00
	Renal	6B	60	3	3	1	7	11.67	0	0	0	0	0.00
		Ashwell	60	2	3	2	7	11.67	0	0	0	0	0.00
	ED	A&E	60	3	4	5	12	20.00	1	1	3	5	8.33
		CDU	60	1	3	1	5	8.33	0	1	1	2	3.33
		UCC	60	1	1	0	2	3.33	0	0	0	0	0.00
Total			**960**	**54**	**56**	**43**	**153**	**15.94**	**1**	**2**	**8**	**11**	**1.15**
Surgery		8A	60	2	2	10	14	23.33	0	0	0	0	0.00
		8B	60	1	1	4	6	10.00	0	0	1	1	1.67
		SAU	60	2	5	2	9	15.00	0	0	0	0	0.00
	Surgical Spec	11B	60	1	2	2	5	8.33	0	0	0	0	0.00
		7B	60	2	3	6	11	18.33	0	0	0	0	0.00
	T&O	5A	60	3	2	4	9	15.00	0	0	0	0	0.00
		5B	60	7	6	5	18	30.00	0	0	0	0	0.00
		Swift	60	2	0	2	4	6.67	0	0	0	0	0.00
	ATCC	Critical Care 1	60	2	1	1	4	6.67	0	0	0	0	0.00
Total			**540**	**22**	**22**	**36**	**80**	**14.81**	**0**	**0**	**1**	**1**	**0.19**
Women's & Children	Gynae	10A Gynae	60	2	1	0	3	5.00	0	0	0	0	0.00
	Paeds	Bluebell	60	0	0	0	0	0.00	0	0	0	0	0.00
		Child A&E	60	0	0	0	0	0.00	0	0	0	0	0.00
		NICU	60	0	0	0	0	0.00	0	0	0	0	0.00
	Maternity	Dacre	60	0	0	0	0	0.00	0	0	0	0	0.00
		Gloucester	60	0	0	0	0	0.00	0	0	0	0	0.00
		Mat MLU	60	0	0	0	0	0.00	0	0	0	0	0.00
		Mat CLU 1	60	0	0	1	1	1.67	0	0	0	0	0.00
Total			**480**	**2**	**1**	**1**	**4**	**0.83**	**0**	**0**	**0**	**0**	**0.00**
C a n	Inpatient	Ward 10	60	0	0	0	0	0.00	0	0	0	0	0.00
Total			**60**	**0**	**0**	**0**	**0**	**0.00**	**0**	**0**	**0**	**0**	**0.00**
		TRUST TOTAL	**2040**	**78**	**79**	**80**	**237**	**11.62**	**1**	**2**	**9**	**12**	**0.59**

BIRTHRATE PLUS®

MIDWIFERY SERVICES WORKFORCE PLANNING & DECISION MAKING

The Lister Hospital, East and North Hertfordshire NHS Trust

FINAL REPORT – May 2019

Birthrate Plus ®: THE SYSTEM

Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units for a significant number of years.

It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings, and have been endorsed by the RCM and RCOG.

The RCM strongly recommends using Birthrate Plus® (BR+) to undertake a systematic assessment of workforce requirements, since BR+ is the only recognised national tool for calculating midwifery staffing levels. Of course birth outcomes are not influenced by staff numbers alone. Nevertheless a recognised and well-used tool like BR+ is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour (as per recommendation 1.1.3).

Birthrate Plus® has been used in maternity units ranging from stand-alone community/midwife units through to regional referral centres, and from units that undertake 10 births p.a. through to those that have in excess of 8000 births. In addition BR+ caters for the various models of providing care, such as traditional, community based teams and caseload working. It is sensitive to local factors such as demographics of the population; socio-economic needs; rurality issues; complexity of associated neo-natal services, etc. The methodology remains responsive to changes in government policies on maternity services and clinical practices. Any maternity unit and service must be able to assess its staffing needs using a tried and tested system of workforce planning. Birthrate Plus® is the most widely used system for classifying women and babies according to their needs, and using clinical outcome data to calculate the numbers of midwives required to provide intrapartum and postpartum care.

An individual service will produce a casemix based on clinical indicators of the wellbeing of the mother and infant throughout labour and delivery. Each of the indicators has a weighted score designed to reflect the different processes of labour and delivery and the degree to which these deviate from obstetric normality. Five different categories are created - the lower the score the more normal are the processes of labour and delivery. Other categories classify women admitted to the delivery suite for other reasons than for labour and delivery.

Together with the casemix, the number of midwife hours per patient/client category based upon the well-established standard of one midwife to one woman throughout labour, plus extra midwife time needed for complicated Categories III, IV & V, calculates the clinical staffing for the annual number of women delivered.

In addition BR+ determines the staffing required for antenatal inpatient and outpatient services, postnatal care of women and babies in hospital and community care of the local population birthing in either the local hospital or neighbouring ones.

The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the non-clinical midwifery roles to manage maternity services. Skill mix adjustment of the clinical staffing between midwives and competent & qualified support staff have been applied.

Factors affecting Maternity Services for inclusion within the Birthrate Plus® Study

The Governance agenda, which includes evidence based guidelines, on-going monitoring and audit of clinical practices and clinical training programmes, will have an impact upon the required midwifery input; plus other key health policies. Birthrate Plus® allows for inclusion of the requisite resources to undertake such activities.

Wards provide care to 'normal' uncomplicated postnatal women needing basic midwifery care, which is often over-shadowed by other women who are more complex cases. This results in insufficient time being spent with such women who may require considerable assistance with breast feeding and general care of their baby.

The encouragement of early transfer home does mean that the level of midwifery input during their hospital stay is considerable, in order to ensure that the mothers are prepared for coping at home. It is a known fact that if adequate skilled resources are provided during this postnatal period, then such problems as postnatal depression or inability to breast-feed can be reduced or avoided.

Community based care is expanding with the emphasis being placed on 'normal/low risk/need care being provided in community by midwives, midwifery support roles and GPs. Women and babies are often being seen more in a clinic environment with less contacts at home. However reduced antenatal admissions and shorter postnatal stays result in an increase in community care. Midwives are undertaking the Newborn and Physical Examination (NIPE) instead of paediatricians, either in hospital or at home.

Cross border activity can have significant impact on community resources in two ways. Some women receive ante and postnatal care from their "home" maternity service, but give birth in another. Because these count as extra to the workload related to that recorded in relation to the annual births of a unit they have been termed as "imported" cross border" cases. The Lister Hospital provides intrapartum care to 1199 women and some degree of immediate postnatal to women from another maternity service, but "export" their community care. Adjustments to midwifery establishments have been made to accommodate the community flows.

The NICE guideline on Antenatal Care recommends that all women be 'booked' by 10 weeks gestation, consequently more women are meeting their midwife earlier than previously happened. This early visit requires midwifery assessment/advice, but the pregnancy may end as a fetal loss so the total number of postnatal women is less than antenatal. The Lister Hospital similar to most maternity services book approximately 546 women and then have no further contact with the midwife.

SUMMARY: RESULTS/FINDINGS

The Lister Hospital & Local Community

The recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of 21% for annual, sick & study leave allowance and 12.5% for travel in community. *A detailed summary is included on page 8.*

The overall clinical establishment for total of 5469 births at The Lister Hospital is summarised as follows:

[a] Hospital Services	147.44 WTE
[b] Community Services	58.98 WTE
TOTAL CLINICAL WTE	**206.42 WTE**
[c] Additional non-clinical midwifery 9%	18.58 WTE

Discussion of Findings

1. The main factor in the results is the casemix based on 3 months' data from October – December 2018 collected using the BR+ scoring system and validated by the Birthrate Plus Team to ensure data quality was 100%.

2. Within the methodology are national standards which include the minimum standard of 1 midwife to 1 woman for care in the labour, delivery and an additional % m/w increase is applied to Categories III (20%); IV (30% & V (40%). Community antenatal care is based on NICE guidance, as is postnatal care with allocation of average midwife hours for the women to cover their standards a/n & p/n assessments, Parent Education, socio-economic issues and all clinical needs.

3. The annual births are based on 5469 as below:
    - 4193 in Delivery Suite and Obstetric Theatres
    - 1112 in the Birth Centre
    - 164 at Home or BBAs in community

4. The casemix is unique to each individual unit and reflects the health and social needs of the local population, as well as clinical practices and decision-making (*see appendix 1 for Birthrate scoresheet)*.

5. The casemix is analysed in 3 ways, namely, generic for all births taking place; those in the Delivery Suite and births in the co-located Birth Centre. This is to provide a comparative casemix with similar maternity services and also to enable calculation of midwifery staffing based on the models of care for respective place of birth.

The Lister Hospital	**Cat I**	**Cat II**	**Cat III**	**Cat IV**	**Cat V**
D/S Casemix	0.8%	4.0%	22.2%	37.9%	35.1%
Generic Casemix	6.2%	17.9%	17.7%	30.2%	28.0%

6 The Generic Casemix indicates that 24.1% of births are in the lower categories I & II with 75.9% in the moderate to high categories, of which 58.2% are in IV & V. Key contributory factors include obesity, Postpartum Haemorrhage, Massive Obstetric Haemorrhage, Prelabour Rupture of membranes (requiring augmentation and IV antibiotics) method of delivery and vulnerability with specific reference to mental health issues. Of the 55 maternity units in England who have undertaken a BR+ assessment from 2015 to 2017, the average % of women in Categories IV & V is 56% ranging from 41 to 69%. The Lister Hospital at 58.2% is just above the average, indicating that a higher % of the population require more clinical input.

7 Category V at 28% includes emergency CS, and women with obstetric/medical problems, such as increased diabetes, obesity related problems, mental health and high incidence of complex safeguarding issues

8 The women in Category IV at 30.2% are those having an elective CS or epidural for pain relief with a normal birth. Women with low birth weight/preterm babies; high-risk inductions of labour and PPH fall into this group.

9 Category III women (17.7%) have moderate risk/need such as Induction of Labour with syntocinon, instrumental deliveries as well as normal births with continuous fetal monitoring fall into this group.

10 The D/S Casemix will predominantly be those women in categories III to V thus impacting on the workload for this service and also for postnatal care on the ward. Thus, this Casemix was used to calculate the staffing for Delivery Suite and the postnatal ward.

11 The assessment of midwives for the Birth Centre activity is based on a 'package of care' that includes intra-partum care with 2 midwives for the birth, postnatal care until transfer home and examination of the new-born. Time for Parent Education is factored in within all clinical hours allocated. There are a number of women, who commence labour in the Birth Centre but are transferred to Delivery Suite prior to or at delivery due to maternal or fetal complications. The care given to the women is included in the Birth Centre staffing whilst the actual birth and post-delivery care is within the D/S establishment.

12 Often the antenatal activity taking place in hospital is reflective of the higher % in Categories IV & V, as women with medical/obstetric problems, low birth weight &/or preterm infants require more frequent hospital based care. Category A2 women (n=242) are high risk-antenatal cases that would usually be 'admitted' to a ward for on-going care following a stay on delivery suite having one to one midwifery care.

13 Some additional non-birth activity is caring for women who have a fetal loss prior to 24 weeks gestation (n = 18). On average, there are 16 escorted transfers from The Lister Hospital to another obstetric unit usually for neonatal reasons.

14 All maternity units have significant antenatal activity that is both planned and unplanned cases and often the latter equate to the actual number of women delivering in the service. Maternity units deal with this activity in a variety of ways, such as via DAU, the antenatal ward and through a dedicated Triage/Assessment area. The staffing for the annual episodes of 11392 is based on having a 24/7 Triage that sees women with labour queries and many more presenting reasons as well as planned antenatal cases, so acts like a day unit.

15 The casemix is an indicator of the needs of women and their babies for the postnatal stay in hospital and used to calculate the staffing. It is often where the significant safeguarding/social issues have an impact on midwifery staffing to ensure systems are in place to deal with such matters. Many babies require additional observation and monitoring in postnatal wards (n=156). There were 160 PN re-admissions which create additional workload and this is factored into the staffing requirements.

16 Midwives now carry out more of the NIPE checks on the postnatal ward which was previously performed by the paediatric team requiring additional resources from the Midwifery team.

17 The inpatient antenatal annual episodes of (n=630) exclude elective cases, namely Inductions and Elective Caesarean Sections. It is not feasible to produce comparative data for antenatal admissions in similar sized units as practices depend on bed capacity, geography, clinical decision-making, clinical risk factors and availability of outpatient services.

18 The majority of Inductions of labour take place on the ward with some outpatient inductions, high-risk women are induced on the labour ward. The annual total of 2497 will be fewer women as some may receive more than one dose of prostin/propess. As with many maternity units there has been a significant increase in the number of women requiring induction of labour as part of the 'Each Baby Counts' safety agenda.

19 Outpatient Clinic services are based on session times and numbers of staff to cover these, rather than on a dependency classification and average hours. Professional judgement is used to assess the numbers of midwives and support staff required to 'staff' the clinics/sessions. The outpatients' profile is unique to each maternity service and will heavily depend on the obstetric specialities provided, complexity of women, etc.

20 The community cases are based on those women birthing in The Lister Hospital and having all ante & postnatal community care locally plus any women, who may birth in neighbouring units, but belong to the local CCG area. The total number of community cases is 6937, excluding home births, whilst 1199 women are transferred to neighbouring Trusts for their community care, there are an additional 1945 women who receive ante and postnatal care having birthed in neighbouring hospitals and another 722 who receive post natal care only.

21 There are approximately 546 women who will see a midwife in early pregnancy as per NICE Antenatal Guidelines and the 'Early Contact' recommendation, but do not progress further with their pregnancy. An average 2 hours of midwifery time is allocated to these women.

22 A skill mix adjustment of 90/10% can be applied to the clinical total of 206.42 WTE and local community where an average of 10% of the total clinical WTE can be competent and qualified support staff usually being Bands 3 & 4 [See Appendix 2]. This equates to 20.64 WTE support staff split between postnatal care in hospital and community.

23 The skill mix % is not a recommendation of Birthrate Plus®, but a rationale for having a sensible skill mix that does not reduce the midwifery establishment to an unsafe level and prevents flexibility of deployment to areas of high risk and needs.

24 The total clinical establishment of 206.42WTE does not include the following roles:

- Head of Midwifery & Matrons with additional hours for team leaders to participate in strategic planning & wider Trust business.
- Clinical Governance role
- Time for Baby Friendly Initiative, which is not to assist women with breast feeding, but to produce & monitor guidelines & undertake audits
- Additional hours for antenatal screening over & above the time provided in actual clinics
- Coordination for such work as Safeguarding Children
- The research & training aspect of the Consultant Midwife

25 The above additional roles can be included based on adding in % of the total clinical establishment, as suggested by Birthrate Plus® and cited in the RCM Staffing Guidance 2016. It is a local decision as to the % increase, for e.g. addition of 9% equates to 18.58 WTE. Applying an agreed % avoids duplication of roles irrespective of which midwives undertake the non-clinical duties.

26 **The Total Clinical & Non-Clinical WTE is 225WTE. Of this total, 20.64WTE can be suitably qualified support staff replacing midwifery hours in postnatal care only and 204.36WTE midwives proving clinical care and management roles.**

Comparison of Birthrate Plus® staffing totals with Current Funded Establishment based on above dataset

The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the non-clinical midwifery roles and skill mix adjustment of the clinical staffing between midwives and competent & qualified support staff can be applied.

The table below outlines the comparison of Birthrate Plus® results with current funded establishments based on above data and results;

Comparison of Maternity Staffing

BR+ Total Clinical & Non-Clinical WTE	225 WTE	The total WTE bands 3 - 8 for hospital & community services and including all non-clinical roles
Comparative Current Funded establishment	195.72 WTE	The total WTE bands 3 - 8 for hospital & community services and including all non-clinical roles
Variance	**-29.28 WTE**	**Variance between BR+ Total WTE & Current Funded WTE – Bands 3 – 8 covering the skill mix for p/n care**

SUMMARY of DATA & REQUIRED WTE for

East and North Hertfordshire

Second draft 19/03/2019

Data collected Oct to Dec 2018

Total births in service **5469**

CASEMIX	Cat I	Cat II	Cat III	Cat IV	Cat V
D/S %Casemix	0.8	4.0	22.2	37.9	35.1
Generic %Casemix	6.2	17.9	17.7	30.2	28.0

			Annual No.	Required WTE	
Consultant Led Unit					
Delivery Suite Births			4193	53.02	**53.02**
Other DS Activity					
	Category X		*via Triage*		**8.23**
	Category A1		*180*	0.64	
	Category A2		*242*	2.59	
	Category R		*68*	0.24	
	Inductions		*2497*	4.45	
	Escorted Transfers OUT		*16*	0.08	
	Non-viables		*18*	0.22	
Triage			*11392*	8.02	**8.02**
Birth Centre			***Annual No.***		
Births only			*1112*	12.88	**20.60**
Transfers to DS			*567*	4.64	
Ward Attenders/Cat X			***370***	0.34	
PN Care of women & Parent Education			***890***	2.74	
			Annual No.		
Antenatal Care	Antenatal admissions		*630*	4.06	**4.06**
Postnatal Care	Postnatal women		*4415*	39.80	**42.54**
	Postnatal Ward Attenders		*440*	0.29	
	Postnatal Re-admissions		*160*	0.83	
	NIPE Clinics			0.81	
	Extra Care Babies		156	0.81	
OUTPATIENT SERVICES					
Antenatal Clinics	Booking Clinics			4.46	**8.38**
	Midwife Led Specialist Clinics			1.95	
	Fetal Medicine			0.41	
	BCGs			0.13	
	Obstetric Clinics			1.43	
Day Unit				2.60	**2.60**
			Annual No.		
COMMUNITY SERVICES	Home Births		*164*	4.62	**58.98**
	Community Cases		*6773*	53.49	
	Community Bookings ONLY		*546*	0.71	
	NIPE		*325*	0.16	
CLINICAL MIDWIFERY WTE REQUIRED					**206.42**
	Additional non-clinical midwifery wte @ 9%			18.58	

Using ratios of births/cases to midwife WTE for projecting staffing establishments

To calculate for staffing based on increase in activity, it is advisable to apply ratios of births/cases to midwife WTE, as this will take into account an increase or decrease in all areas and not just the intrapartum care of women. There will be changes in community, hospital outpatient and inpatient services if the annual number of women giving birth alters.

Once the clinical 'midwifery' establishment has been calculated using the ratios, a skill mix % can be applied to the total clinical WTE to work out what of the total clinical 'midwifery' WTE can be suitably qualified support staff, namely MSWs Band 3. Nursery Nurses and RGNs working in postnatal services only.

In addition, a % is added (8/10%) to include the non-clinical roles as these are outside of the skill mix adjustment as above. However, the addition of other support staff (usually Band 2s MCAs) that do not contribute to the clinical establishment will be necessary.

Calculating staffing changes using a ratio to meet increase in births assumes that there will be an increase in activity across ALL models of care and areas including homebirths.

If there is an increase or decrease in activity, then the appropriate ratio can be applied depending on the level of care provided to the women. For example, if the women just have community care as birth in a neighbouring unit, it is only necessary to estimate the increase in community staffing so the ratio of 127 cases to 1 WTE is the correct ratio to apply. To use the 1:26 ratio will overestimate the staffing as this covers all ante, intra and postnatal care.

Example; A woman who births in the Delivery Suite but is 'exported' to another community, then the ratio of 26 births to 1 WTE should be applied. The main factor in using ratios is to know if having total care for the 'Trust' midwives or only hospital or community.

Midwife Ratios based on above data and results
The ratios below are based on the BR+® dataset, national standards with the BR+ methodology and local factors, such as % uplift for annual, sick & study leave, case mix of women birthing in hospital, provision of outpatient/day unit services and total number of women having community care irrespective of place of birth.

Ratios:

- Home births — 35 births to 1 WTE
- Delivery Suite births (all hospital care) — 36 births to 1 WTE
- Birth Centre Births — 54 births to 1 WTE
- Ante & Postnatal Community care only — 127 cases to 1 WTE

  Community imports only receive postnatal care so affects ratio
- Overall ratio for **all** births — 26 births to 1 WTE

Note: The overall ratio for The Lister Hospital of 26 births to 1WTE equates to the often-cited ratio of 28 or 29.5 births to 1 WTE, but they are not directly comparable for the above local factors. The latter ratios are based on extensive data from Birthrate Plus studies and whilst published so seen as 'up to date', more recent studies in the past 3 years are indicating that these ratios may not be appropriate to use for comparison, mainly due to increase in acuity of mothers and babies and subsequent care required. These factors have changed the overall and, indeed, individual ratios. Therefore, it is advisable to use own ratios calculated from a detailed assessment for workforce planning purposes.

Method for Classifying Birthrate Plus® Categories by Scoring Clinical Factors in the Process and Outcome of Labour and Delivery

There are five [5] categories for mothers who have given birth during their time in the delivery suite [Categories I – V)

CATEGORY I **Score = 6**

This is the most normal and healthy outcome possible. A woman is defined as Category I [*lowest level of dependency*] if:
The woman's pregnancy is of 37 weeks gestation or more, she is in labour for 8 hours or less; she achieves a normal delivery with an intact perineum; her baby has an Apgar score of 8+; and weighs more than 2.5kg; and she does not require or receive any further treatment and/or monitoring

CATEGORY II **Score = 7 – 9**

This is also a normal outcome, very similar to Category I, but usually with the perineal tear [score 2], or a length of labour of more than 8 hours [score 2]. IV Infusion [score 2] may also fall into this category if no other intervention. However, if more than one of these events happens, then the mother and baby outcome would be in Category III.

CATEGORY III **Score = 10 – 13**

Moderate risk/need such as Induction of Labour with syntocinon, instrumental deliveries will fall into this category, as may continuous fetal monitoring. Women having an instrumental delivery with an epidural, and/or syntocinon may become a Category IV.

CATEGORY IV **Score = 14 –18**

More complicated cases affecting mother and/or baby will be in this category, such as elective caesarean section; pre-term births; low Apgar and birth weight. Women having epidural for pain relief and a normal delivery will also be Category IV, as will those having a straightforward instrumental delivery.

CATEGORY V **Score = 19 *or more***

This score is reached when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth or multiple pregnancy, as well as unexpected intensive care needs post-delivery. Some women who require emergency anaesthetic for retained placenta or suture of third degree tear may be in this category.

Category X women are those who are admitted to the delivery suite, but after assessment/monitoring are found not to be in labour or to need any intervention. These women are either sent home or transferred to the antenatal ward for observation.

Categories A1 & A2 women are those who require some intervention such as intravenous infusion and/or monitoring, e.g. antepartum haemorrhage, pre-eclampsia or premature labour. Such women often spend considerable time on delivery suite before being transferred to the antenatal ward or to another maternity unit with neonatal facilities. However, some women with moderate risk/needs will go home following assessment and treatment.

Category R women are re-admitted after delivery as postnatal cases, often requiring medical care.
Inductions of labour with prostins are recorded, as are escorted transfers to another maternity unit and the non-viable pregnancies.

Due to changes in skill mix with the increasing use of support staff with a formal qualification in maternity services, there is a need to distinguish between those that can replace midwife hours, and other staff that support the midwife in care of women and their babies. Maternity Support Workers (MSW) refers to those support workers with a formal qualification such as Level 3 NVQ or Nursery Nurse, and who can replace midwife hours. The Maternity Care Assistant (MCA) is used to denote the more basic grade of support worker who supports the midwife. In all clinical areas the use of Care Assistants greatly aids the provision of maternity care, by releasing midwifery staff to be client, rather than ward centered.

Skill Mix Rationale

It is important to distinguish between the situations where support staff assist the midwife and where he/she replaces the midwife.

Birthrate Plus® (1996) makes it clear the ward and clinic staffing levels for midwives are based upon the premise that they are supported by MCA and clerical staff and these staff needs are assessed on a shift by shift basis.

The decision about the percentage of midwife time, which might be replaced, by MSW time must be that of the local service managers.

Antenatal care: As this calls for midwife skills so it is not recommended to replace the midwives with an MSW, but units should ensure that midwives are well supported by clerical and MCA staff.

Intrapartum care: Birthrate Plus® does not recommend any replacement of midwife time by MSW time. To do so would undermine the basic quality standard of one to one care throughout labour plus the increased % of midwife time required for high needs categories.

Postnatal care in Hospital: Many services now suggest 20 - 25% of midwife time can be replaced by MSW input. Once a local decision has been made, the calculations of WTE staff for each ward can readily be adjusted.

Postnatal Care in Community: Many services now suggest that 25% of midwife time can be replaced by MSW time. This would allow for full assessment and planning of care by the midwife, with a minimum of three visits and additional visits being undertaken by the MSW working under the direction of the midwife in charge of each woman's care.

Based on adjustments made by other maternity units, an average of 10% of the clinical total WTE can be competent and qualified support staff usually being Bands 3 & 4.

The skill mix % is not a recommendation of Birthrate Plus®, but a rationale for having a sensible skill mix that does not reduce the midwifery establishment to an unsafe level and prevents flexibility of deployment to areas of high risk and needs. Some services are moving towards an 85/15% split with more MSWs working in community and increasing support staff on the p/n ward to work with transitional care babies.

Note: In addition, there is a need for Maternity Care Assistants in the Delivery Suite, Outpatient Services and Wards to provide support to women and their babies, but are in addition to the calculated clinical establishments. To assess the requirement of Band 2 support staff is on the numbers per shift in the various areas based on professional judgment and management decision. For example, 2 per shift on D/S at all times inclusive of the leave allowance.

References:

Ante Natal Care for Uncomplicated Pregnancies NICE 2017 CG62 https://www.nice.org.uk/Guidance/CG62

Better Births a five year forward view for Maternity care https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing midwifery and care staffing capacity and capability (National Quality Board 2013)

Kings Fund 2011 Staffing in Maternity Units: getting the right people in the right place at the right time (King's Fund 2011)

RCOG 2007 Safer Childbirth – Minimum standards for the organisation and delivery of care in Labour (RCOG 2007)

RCOG 2015 'Each Baby Counts' https://www.rcog.org.uk/en/guidelines-research-services/audit-quality-improvement/each-baby-counts/ebc-2015-report/

Royal College of Midwives 2015 State of Maternity Services https://www.rcm.org.uk/briefings-and-reports

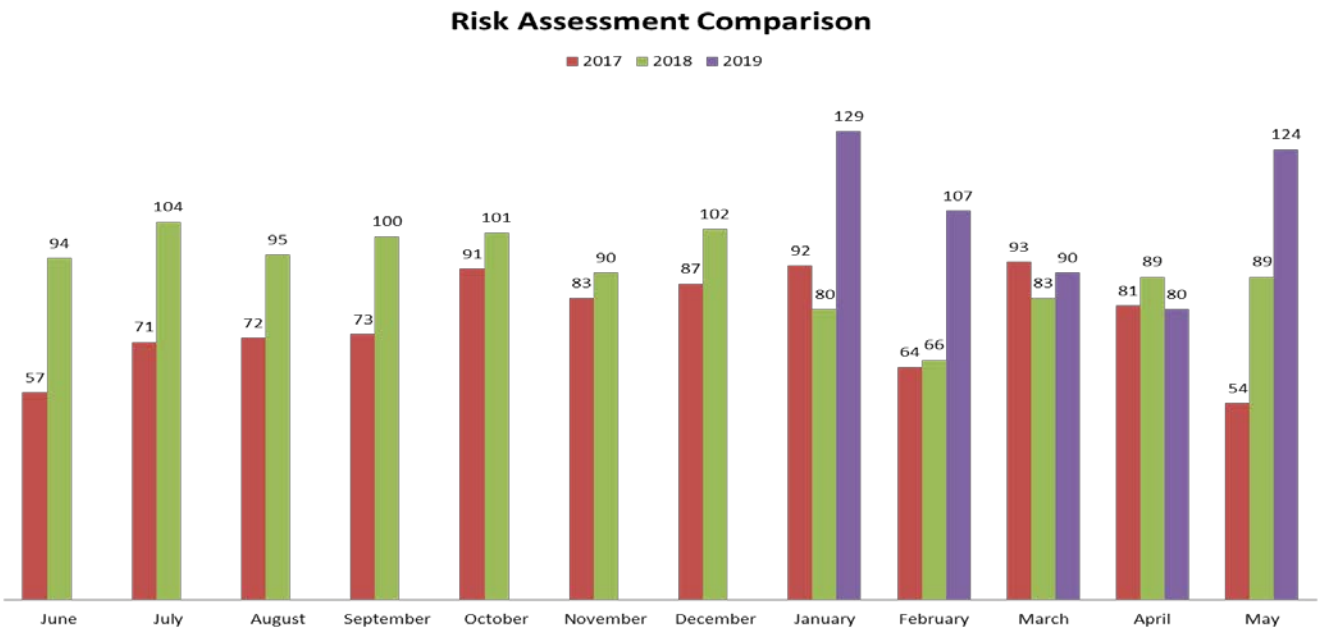
Royal College of Midwives 2016 Guidance on implementing the NICE safe staffing guideline on midwifery staffing in maternity settings

Royal College of Midwives 2016 'Getting the Midwifery Workforce Right' https://www.rcm.org.uk/sites/default/files/Getting%20the%20Midwifery%20Workforce%20Right%20A5%2024pp_2_1.pdf

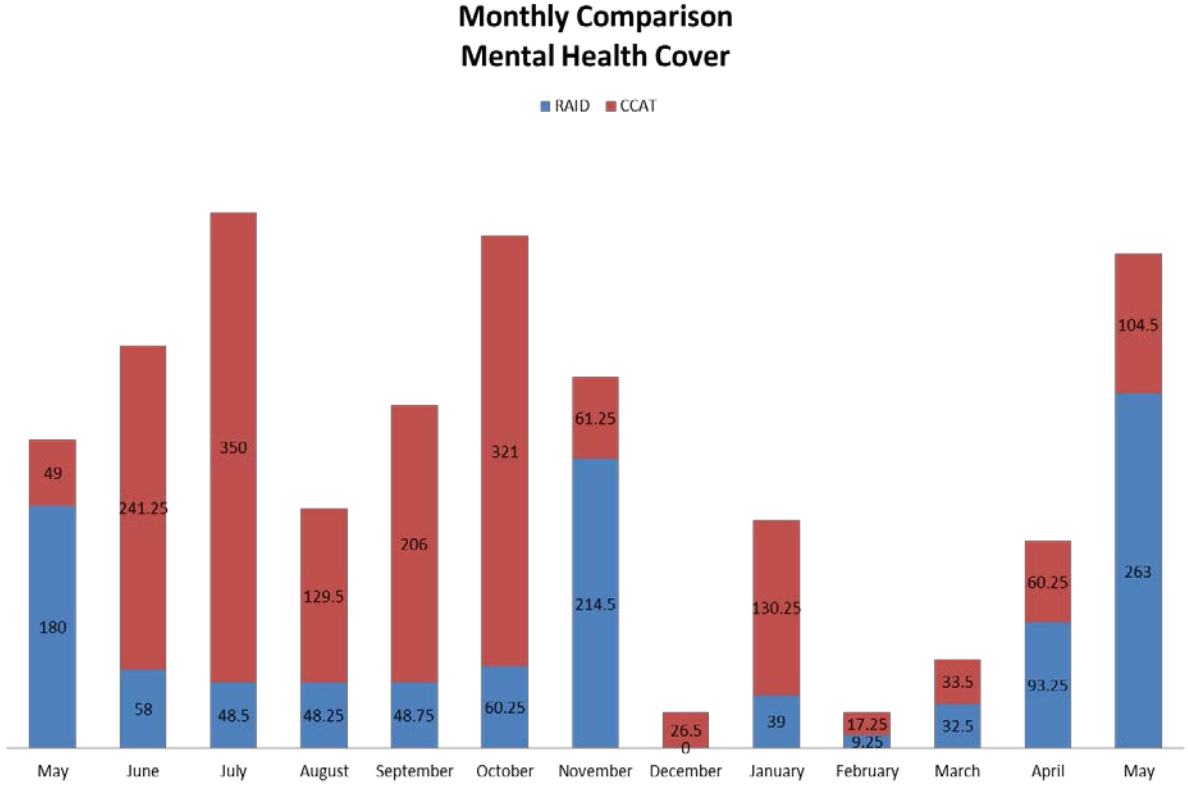
Safe Midwifery Staffing for Maternity Settings NICE 2015 NG4 www.nice.org.uk/guidance/ng4

Appendix 11

Number of patients referred to the Enhanced Care team per month and year



Number of hours the Enhanced care team have covered mental health patients



East and North Hertfordshire NHS Trust

Agenda Item: 8.2

TRUST BOARD - PUBLIC SESSION – 3 JULY 2019

FIVE YEAR STRATEGY DEVELOPMENT: PROGRAMME HIGHLIGHTS REPORT

Purpose of report and executive summary (250 words max): The purpose of the Five Year Strategy Development: Programme Highlights Report is to provide monthly, high-level assurance to the Strategic Programme Board and updates to the Trust Board on the progress of the Trust's new five year strategy. The strategy launched in April 2019, and has been presented at Trust induction, all Divisional Boards and a number of team meetings. It has also been the focus of Trust Conversations. Additional posters have arrived and these will replace all old strategy posters and used to actively engage teams throughout the Trust on how they can help live the new vision.		
Action required: For information		
Previously considered by: N/A		
Director: **Director of Strategy**	**Presented by:** **Associate Director of Corporate Governance**	**Author:** **Head of Business Development**

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

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

FIVE YEAR STRATEGY DEVELOPMENT: PROGRAMME HIGHLIGHTS REPORT

PERIOD: 17 MAY – 14 JUNE 2019

Executive Sponsor: Sarah Brierley **Programme Director / Lead: Sarah Brierley**

OVERALL CONFIDENCE RATING	Progress vs workstream plan	Actions delivered vs agreed (previous reporting period)	Resolving risks and issues	Expenditure v Budget	Escalated items to note / for discussion
					Yes

Scope	To develop and implement a new five year strategy for the Trust spanning 2019/20 – 2023/24.	
Progress vs work stream plan and agreed milestones **(Programme and Communications Plans attached)**	**Key milestones / deliverables**	**Key milestones/ deliverables current position**
	Clinical Strategy development	Complete, The Clinical Strategy is now in the Implementation phase.
	Programme Plan	In Progress. On plan.
	Communications Plan	In progress. On plan
Key actions delivered in this reporting period	• Rolled out divisional reporting mechanism to give oversight of strategy implementation at committees and Board • Further work on enabling strategies • Continued roll out of Communications plan • Attended various team meetings to explain new vision and strategy, including PMO, HR Business Partners, Mount Vernon volunteers • Work is continuing on Finance and IM&T enabling strategies • New Vision and Strategy has been presented at all Divisional Boards • New presentation template developed • Desk top message and screen savers ongoing • Contacted Trust leads on hybrid mail project to check templates for old vision	
Key actions outstanding from this reporting period	• None	
Key actions planned for the next reporting period	• Trust Conversation to call in at specific areas e.g. pathology, radiology • Poster blitz across sites to replace strategy and divisional team posters • Issue press release re new strategy	
Expenditure v budget	• Within budget	
New / escalating risks and mitigations	• None	
Key Issues	• Development of the Estates Strategy is awaiting start of a new Director of Estates & Facilities	
Items for consideration/ discussion/ Action	• None	

Appendix 1: Programme Plan

5Y Strategy Programme Plan as at

Appendix 2: Communications Plan

5Y Strategy Comms Plan as at 12 June.xls

Five Year Strategy Development: Draft Programme Plan

CQC Inspections

Director input required

	Lead(s)	Status	Jan				Feb				Mar				Apr				May				June				July				Aug				Sep				
			31/12/2018	07/01/2019	14/01/2019	21/01/2019	28/01/2019	04/02/2019	11/02/2019	18/02/2019	25/02/2019	04/03/2019	11/03/2019	18/03/2019	25/03/2019	01/04/2019	08/04/2019	15/04/2019	22/04/2019	29/04/2019	06/05/2019	13/05/2019	20/05/2019	27/05/2019	03/06/2019	010/06/2019	17/06/2019	24/06/2019	01/07/2019	08/07/2019	15/07/2019	22/07/2019	29/07/2019	05/08/2019	12/08/2019	19/08/2019	26/08/2019	02/09/2019	09/09/2019	16/09/2019	23/09/2019	30/09/2019
Divisional Executive Committee meeting																																							
Strategic Programme Board meetings																																							
Internal and external comms re clinical strategy approval and next steps			9	9																																			
Send cross cutting clinical themes slide to East and North Hertfordshire Delivery Board as evidence of change their input has made	Head of Engagement / Head of Business Development	Completed																																					
Write letter from Chair & Chief Executive to be sent to key external stakeholders confirming new clinical strategy and thanking for their input (exec 1:1s; external test & confirm attendees)	Head of Engagement / Head of Business Development	Completed																																					
Communicate to external stakeholders re approval of Clinical Strategy (stakeholder communications group; round 1 and 2 workshop attendees; external test and confirm attendees; East and North Hertfordshire Delivery Board; staff)	Head of Engagement	Completed																																					
Create a short, external-friendly version without acronyms to share with patients, members and non-NHS organisations	Head of Engagement	To commence																																					
Internal communications to Divisional Directors, Divisional Chairs, Heads of Nursing - Director of Strategy to send final clinical strategy and confirm integration into Year 1 objectives	Head of Business Development	Completed																																					
Medical Director to send final Clinical Strategy to Clinical Directors, explaining next steps in terms of Directions of Travel	Head of Engagement / Head of Business Development	Completed																																					
Devise a communications plan for dissemination of the clinical strategy across the Trust - to include web, posters, Knowledge Centre, Daily News, table talkers	Head of Engagement / Head of Business Development / Communications team	Completed																																					
Implementation of Communications plan	Head of Engagement / Head of Business Development / Communications team	In progress																																					
IMPLEMENTATION AND OPERATIONALISATION OF THE CLINICAL STRATEGY - ASSURANCE																																							
Quantification and alignment of Clinical Strategy with financial and operational planning																																							
Confirmation of operating plan process and inputs required	Interim Director of Strategy / Deputy Director of Finance (Financial Planning)	Completed																																					
Build year 1 divisional objectives into Operating plan and Divisional plans	Divisions/Finance/Strategy/Workforce/PMO	Completed																																					
Development and alignment of Enabling Strategies with Clinical Strategy																																							
Confirm schedule for refresh / redevelopment of enabling strategies with lead Execs	Stategy with Exec leads	Completed																																					
Refresh / development of enabling strategies:	Execs	In progress																																					
Finance Strategy	Finance/PMO/Divisions	In progress																				21		6																
Workforce Strategy	Workforce/PMO/Divisions	In progress																												16										
Culture Strategy	Workforce	In progress												19			3																							
Quality Strategy	Med Dir/ Director of Nursing /Divisions	Completed												19			3																							
Estates Strategy	Estates	To commence																												16						4			
IM&T Strategy	IM&T	In progress																												16						4			
Research & Development Strategy	Research & Development	Completed								19																													
Embedding Clinical Strategy																																							
Draft Trust Clinical Strategy Plan on a Page for 2019/20	Strategy	Completed																																					
Update Board and Committee Cover Sheets with new vision and strategic priorities	Trust Secretary	Completed																																					
Strategy to work with Divisions to develop reporting format to monitor progress to committees and Accountability Review Meetings (ARM)	Strategy	Completed																																					
Plan in Divisional deep dives and updates to Trust Board	Strategy	Completed																																					

	Who	Status	Jan				Feb				Mar				Apr				May				June				July				Aug				Sep				
			31/12/2018	07/01/2019	14/01/2019	21/01/2019	28/01/2019	04/02/2019	11/02/2019	18/02/2019	25/02/2019	04/03/2019	11/03/2019	18/03/2019	25/03/2019	01/04/2019	08/04/2019	15/04/2019	22/04/2019	29/04/2019	06/05/2019	13/05/2019	20/05/2019	27/05/2019	03/06/2019	010/06/2019	17/06/2019	24/06/2019	01/07/2019	08/07/2019	15/07/2019	22/07/2019	29/07/2019	05/08/2019	12/08/2019	19/08/2019	26/08/2019	02/09/2019	09/09/2019	16/09/2019	23/09/2019	30/09/2019
Strategic Programme Board Meetings																																							
Trust Board workshops																																							
Divisional Executive Committee meeting																																							

Five Year Strategy Development: Draft Programme Plan

CQC Inspections

	Lead(s)	Status
DEC meeting		
SPB meetings		
Internal Meetings		
Design presentation for use at all internal meetings	David	Completed
Induction - discuss with Jacqui Attrill how we can access and plan into diaries	Associate Director Leadership & Change	Completed
Statuatory Mandatory Training - discuss with Nurse Education how we can access and plan into diaries	Head of Business Development	Completed
LEND - plan into sessions	Associate Director Leadership & Change	Completed
Divisional Boards - discuss at each Divisional Board (CSS 21st May; all others complete)	Head of Business Development	In progress
Link with Jude Archer re Nick carver roadshows	Head of Business Development	Completed
Matrons meeting - discuss and plan in team visits / discssions with teams and wards	Head of Business Development	Completed
Rolling Half days - plan in dissemination to teams (talk to Jackie Evans)	Head of Business Development	In progress
Ward / Team / Secretarial meetings - can contact via Strategy email address. Steve, David, Mary happy to go to meet and discuss	Associate Director Leadership & Change / Head of Engagement / Head of Business Development	In progress
Internal training	Associate Director Leadership & Change	In progress
Consultant Committee	Medical Director	To commence
Finance team	Damien O'Brien	In progress
Payroll team		In progress
PMO team		Completed
IT team		In progress
HR team		In progress
Estates team		In progress
Patient Experience team		Completed
Pharmacy team		In progress
Pathology team		In progress
Health records team		Complated
Complaints and PALs team		In progress
Bed managers team		In progress
Spiritual and Pastoral team		In progress
Charity		Completed
Audit team		In progress
Coding team		In progress
Health@Work team		In progress
Library team		Completed
Nurse Education and Training		In progress
Volunteers team		Completed
Jude's team		Completed
G4S		In progress
Sonographers		Completed
Patient Experience MVCC		Completed
Gastro team		Completed
MVCC volunteers		Completed
Reasearch & development		
Collateral		
Design posters, postcards, banners, table tops, email sign-off, desktop, screen savers	Comms team / strategy	Completed
Get quote for postcards, posters, table tops	Strategy	Completed
Print postcards, posters, table tops	Strategy	Completed
Retrieve old strategy banners from front entrances of all sites (ED, Lister, New QEII, HCH, MVCC, Wiltron)	Comms team / strategy	In progress
Overprint banners with new strategy and put back into entrances of all sites (ED, Lister, New QEII, HCH, MVCC)	Clinical Photography	In progress
AMNESTY APRIL Encourage all staff to help us identify where the old visision and strategy are being used - e.g. appraisals, posters, letter heads. Then replace with new designs	All	In progress
AMNESTY APRIL Sweep up across sites retrieving & replacing strategy posters	David, Mary, Steve, Sue T, Alex	In progress
Visit all sites to handout postcards	Associate Director Leadership & Change / Head of Engagement / Head of Business Development	Completed
Encourage Execs to discuss at drop in and all other sessions	Strategy	In progress
Electronic messages		
New vision to appear on desktop backgrounds	Comms team / strategy	Completed
Vision, strategic priorities and values to appear as screensaver	Comms team / strategy	Completed
Press release re new strategy	Comms team / strategy	To commence
Daily News articles re new strategy	Comms team / strategy	Completed
Update Knowledge Centre	Strategy	Completed
Update external web	Comms team	Completed
Add to Steve Andrew's weekly bulletin	Strategy	Completed
Trust Staff Awards		
Discuss staff awards at Senior Team Meeting	Mary / David	To commence
Discuss Awards with Duncan Forbes	Mary / David/Steve	To commence
Commission charity to deliver event with awards that reflect new Vision	Strategy/Steve	To commence

Jan: 31/12/2018, 07/01/2019, 14/01/2019, 21/01/2019
Feb: 28/01/2019, 04/02/2019, 11/02/2019, 18/02/2019
Mar: 25/02/2019, 04/03/2019, 11/03/2019, 18/03/2019, 25/03/2019
Apr: 01/04/2019, 08/04/2019, 15/04/2019, 22/04/2019
May: 29/04/2019, 06/05/2019, 13/05/2019, 20/05/2019, 27/05/2019
June: 03/06/2019, 010/06/2019, 17/06/2019, 24/06/2019
July: 01/07/2019, 08/07/2019, 15/07/2019, 22/07/2019 (Potential?)
Aug: 29/07/2019, 05/08/2019, 12/08/2019, 19/08/2019, 26/08/2019
Sep: 02/09/2019, 09/09/2019, 16/09/2019, 23/09/2019, 30/09/2019

Status
SPB meetings
Board workshops
DEC meeting

East and North Hertfordshire NHS Trust

Agenda Item: 9.1

TRUST BOARD - PUBLIC SESSION – 3 JULY 2019
Integrated Performance Report – Month 2

Purpose of report and executive summary (250 words max): The purpose of the report is to present the Integrated Performance Report Month 2 to the Trust Board. Key challenges and mitigations under each domain are identified within the report.		
Action required: For discussion		
Previously considered by: Quality and Safety Committee – 25 June, Finance and Performance Committee – 26 June		
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	☒

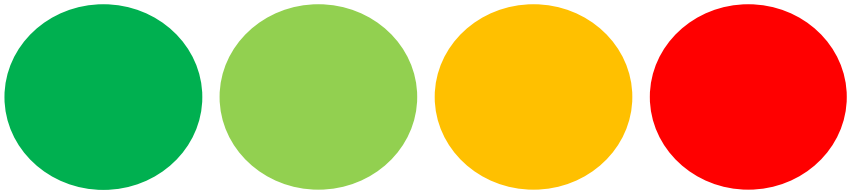
Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
Any other risk issues (quality, safety, financial, HR, legal, equality): Key challenges and mitigations under each domain are identified within the report.

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

East and North Hertfordshire NHS Trust

Integrated Performance Report

Month 02 | 2019-20



Contents

East and North Hertfordshire NHS Trust

Performance Headlines

East and North Hertfordshire NHS Trust

Domain	Positive Performance	Challenges	Lead Director
Safe & Caring Services	**Quality learning event** 21st June 2019; all-day event - LEC, RHD slots, external speakers Suzette Woodward has confirmed attendance (National Director for NHSE Sign up to Safety campaign). Plans and communications are underway to encourage all clinical and non-clinical staff attendance. **Serious Incident Management** Planned Duty of Candour awareness sessions currently have been designed and management of RCA processes remains priority **Improvement initiatives** Harm Free Care panel continue to measure baseline data and prioritise clinical areas for including Break through Series, and QI team recruitment now live. **CQC preparation** Following the submission of IPR scheduled of commination and Quality walk rounds are currently being planned **'Safer Surgery Collaborative'** 'Surgical Team' training plans have started and the team have recorded human factors Video. The team plan to share NatSSIP Policy across department in June rolling half Day. Human Factors session planned for July RHD. **Clinical Excellence framework** Designing and testing of excellence framework has been undertaken and final version of frame work (standards and measures) for 1st cohort of assessment has been agreed. **Improving IPC** Baseline data is being collected for CAUTI improvement work, and ongoing handwashing & environmental audits continue. Recent positive review from multi-agency visit.	**Dashboard data quality** Work continues to ensure quality control/checking. Current dashboard on version 9 with patient safety data, Falls, pressure ulcer and Risk management data now populated. Measurement plans ready for t Nursing Indicators, End of Life metrics **Nerve Centre** The deteriorating patient work continues to focus on reliability of observations, a gap in some NC functionalities have been identified e.g. alerts to doctors, and central oversight at ward level. **Incident Management** Grouping of divisional RCA investigations and action plans continues.DOC training & compliance capture remains priority. DOC sessions included in site Quality Huddles and Trust-wide Quality Event. Face to face sessions planned within divisions. **Improving the Quality of Response to Complaints** Ongoing engagement with surgical division good and starting to see improved timeliness of responses.	 **Rachael Corser** **Director of Nursing**

Performance Headlines

East and North Hertfordshire NHS Trust

Domain	Positive Performance	Challenges	Lead Director
Effective Services	**Mortality** Mortality rates have improved over the last 5 years as measured by both of the major methods: HSMR and SHMI **Hospital Standardised Mortality ratio (HSMR)** This measure is based on a basket of 56 patient groups with relatively predictable mortality and records death in hospital. Performance has been persistently in the 'as expected range'. There was a predictable, unsustained increase in HSMR following the introduction of the Lorenzo system in September 2017. This is a pattern commonly seen after the introduction of any PAS and is thought to be related to changes in depth of coding and, hence, predicted mortality. HSMR remained in the 'as expected' range during this period. The latest HSMR for the rolling 12 months to February 2019 is 92.1. 'Better than expected'. HSMR is generally available 3/12 in arrears. **Summary Hospital-level Mortality Indicator (SHMI)** This is a measure of mortality for all inpatients including up to 30-days post-discharge. Historically, ENHT's SHMI has been up to 10 points higher than the HSMR, which is thought to be related to the onsite hospice at Mount Vernon (a relatively unusual arrangement nationally). However, over the last 2 years the gap between SHMI and HSMR has reduced to less than 0.5 points. Although a similar (to HSMR) increase in SHMI was seen post-Lorenzo launch, it too remained in the 'as expected' range. The latest SHMI for the rolling 12-months to December 2018 is 94.1. 'As expected'. SHMI is generally available 6/12 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 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.	**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. Although overall Trust mortality is within the 'as expected (SHMI) or better than expected' (HSMR) range, there are subgroups of patients where mortality is raised. A recent example of this would be in patients with sepsis, where high HSMR/SHMI resulted in a CQC alert in the Spring of 2018 as the Trust was a marked outlier for sepsis mortality. Continued, targeted work by the sepsis team as well as staff from ED and other areas of the Trust including Coding has resulted in a marked improvement back to an HSMR of 65.1 'better than expected'. There will always be groups of patients with higher mortality levels and the Mortality Surveillance Group monitors our data and after confirming whether the issue is real (via coding review) instigates a review of the patient pathway and a retrospective review of a sample of the affected patients to identify where changes to the pathway may be beneficial. We also work closely with Dr Foster to identify areas with a true rise in mortality where concentration of resources in reviewing coding and clinical pathways is likely to benefit future patients. **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 in mortality between weekend/weekday emergency admissions. Recent months have seen improvements in both with HSMR for weekday admission now 'better than expected' and for weekends 'as expected'. Consultant review within 14 hrs of emergency admission is lower at the weekend and an area where we need to improve our performance. 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. This new role is a result of the Trust's decision in 2018 to invest in an expanded Quality & Safety Team.	 **Michael Chilvers** **Medical Director**

Performance Headlines

East and North Hertfordshire NHS Trust

Domain	Positive Performance	Challenges	Lead Director
Responsive Services	**ED Performance** The Trust ED performance in May was at 81.64%, an improvement on the previous month position which was 80.54%. Positively the trust continues to report 0 12-hour trolley breaches. **Cancer Performance** The trust delivered 4 compliant national cancer targets in April, to include; 2ww, 31-day subsequent for drug treatments radiotherapy and surgery. The Trust 62-day performance for April 2019 was 79.6 % pre-breach sharing and 82.3% post breach sharing, which is above the revised trajectory of 75.8%. In April 2019, 5 out of 9 tumour sites met the standard with 45% of avoidable breaches occurring in Urology. That said, urology had only 9 breaches in month with is a significant reduction on the usual monthly position of around 16 breaches. This improvement is due, in the main, to the introduction of the one stop clinic and is in line with the expected forecast recovery and above the recovery trajectory. **RTT Performance** May RTT performance was 83.7% with 5 x 52 week breaches. The deterioration in performance is due to a number of factors to include an increase in demand, a change in strategy around validation and a number of patient clocks stops that have been reopened and added to the active incomplete PTL. The rise in backlog has now stabilised and work is ongoing regarding listing additional capacity to treat patients. Regarding the 52 week position – the focus remains on close scrutiny of all long waiters to minimise the month end 52 week breach position. Going forward 'tip ins' will be significantly reduced as a result of an improved eoutcome process for the next steps for patients on an 18 week pathway. **Diagnostics** The May position for DM01 is 1.02%. This compliant position is above the recovery trajectory which was forecast to be compliant in June. Work is ongoing on the foreword view with actions taken to minimise breaches and maintain compliance. **Stroke Performance** April total stroke performance was disappointing at 50%, with direct from the ED stroke performance at 54.2%. Deterioration in performance is rarely as a result of a single issue but high bed occupancy and lack of flow within the organisation is plainly a major factor. This has resulted in stroke patients competing for priority beds within the environment when acutely unwell patients in the ED with long waits need to be admitted into IP beds; ITU wardable patients need to be stepped down and elective cancer and urgent patients require a bed post–op. In response to this position, immediate steps have been taken to raise the profile of 'ring fenced' stroke beds at the three times day bed meetings with the requirement to maintain stroke bed capacity at all times.	**ED Performance** ED performance is in line with the recent trends seen in the regional and national position. The ED improvement plan has been updated in response to a challenge from the regional Director regarding ED recovery plans. ED performance remains a priority concern for the regional and national performance teams. There is an emphasis on taking forward the Same Day Emergency Care (SDEC) pathway work and ongoing reviews of stranded patients and long LoS within the acute setting. A new GM has started in the ED, Andrea Holloway. She has a strong track record on emergency pathway and will bring energy and a fresh pair of eyes to the service. Alison Gibson, another senior operational manager, who is on secondment from Papworth, is taking the ENHT lead on the UCC to UTC consultation at QEII. **Cancer Performance** Work continues with IMAS support to further improve the high impact tumour site recovery plans, scrutinise MDT process and undertake demand and capacity modelling for histopathology. Through key forums such as cancer board, cancer steering group and access board, governance, oversight and escalation is in place to maintain grip and control to deliver 62 day compliance in October 2019. The same forums will be used to monitor and deliver compliance going forward. **Same Day Emergency Care** Work is ongoing developing ambulatory pathways within medicine, to include frailty and emergency surgery. The proposals will be taken forward through discussions with the CCG to support an ambulatory tariff to offset the potential of a reduction in inpatient income. There will also be associated benefits freeing up IP bed capacity which can be closed to reduce costs or used to support repatriated work from the private sector. This initiative will be a key enabler in managing bed occupancy levels during winter and maintain capacity and flow.	 **Julie Anne Smith** **Chief Operating Officer**

Performance Headlines

East and North Hertfordshire NHS Trust

Domain	Positive Performance	Challenges	Lead Director
Well-led Services	**Recruitment** Vacancy rate for all staff groups reduced by 0.4% from 7.4% to 7.0% in month 2. There was 71.5 WTE new starter and 52.6 WTE leavers in month 2 resulting in a positive variance for month 2 of 18.8 WTE. Divisional recruitment targets and trajectories for all staff groups are now finalised for 19/20 and progress will be monitored through the weekly Improving Financial Delivery meetings. **Talent Management** A lead for Talent Management will start in July. Where possible they will align the TM process of ENHT with that of the region and national activity. Five places have been agreed as part of the General Manager Trainee Scheme which the Trust is participating in with Princess Alexandra Hospital. In addition, 9 members of staff were successful in the Mary Seacole Programme and begin in July. This is an STP wide programme and the Trust has the largest number of staff on the programme and are supporting the facilitation of the events. **Staff Wellbeing** In May the number of WTE days lost due to sickness related to musculoskeletal issues was 12.4% lower than April the previous year, the days lost due to mental health is 6.2% lower than May 2018. Staff wellbeing promotion events are held monthly to encourage staff to make healthier lifestyle choices and to promote sources of support available. May 13th to 17th was mental health awareness week, the Health at Work Service had a health promotion stand in the coffee lounge all week promoting strategies to prevent and manage stress, the staff support & counselling service Workplace Options was promoted and a healthy mind toolkit online seminar and an anxiety & depression management app were promoted. **Absence Management** Sickness absence rates dropped by 0.4% down to 3.8% and was 0.2% better than the same month last year. Coaching and support clinics have been held in most Divisions on a monthly basis to ensure that managers are supporting staff who are off work to return at the earliest opportunity. The Trust needs to maintain rates consistently below 3.8% for the first 6 months of the year to be able to achieve the target by the end of the year. **Turnover** The Trust turnover rate has dropped from a peak in August 18 of 14.2% down to 13.1% and is lower than the turnover rates at the same point in 2018 (13.5%).	**Demand Management** Overall temporary staffing demand increased by 6% and flexible workforce fill rate increased by 8% in month 2. This increase occurred despite the number of vacancies reducing. **Agency Spend** Agency hours increased by 7% and agency expenditure increased by £113k. This meant that the Trust was over the agency ceiling by £91k in month. **Appraisals** Despite an increase in May, appraisal rates are significant below target at 84.3%. A 'deep-dive' report has been provided identifying 'hot-spots' and issues. A full action plan has been developed to bring the Trust back up to target by August. The divisions are being supported with weekly reporting and business partner support. **Culture** Work continues in response to the staff survey results. Divisional action plans have been developed supported by an over-arching action plan. Key areas of focus are on diversity and inclusion, well-being and leadership development. The Trust People strategy will be developed throughout the summer which set out the vision for our culture.	 **Duncan Forbes** **Chief People Officer**

Performance Headlines

East and North Hertfordshire NHS Trust

Domain	Positive Performance	Challenges	Lead Director
Sustainable Services	The Trust has accepted its break even Control Total for 19/20. The Finance Committee and Trust Board reviewed and approved the financial and operational plan for the year ahead at meetings in March 2019. Budget plans for the new year have been 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 Month 2 the Trust reports financial delivery that is in line with its agreed plan. SLA income performance reports a significant over achievement against plan, this mainly results from increased emergency admissions. In contrast the Trust reports a significant overspend against pay budgets in M2. This has been driven by pressure across medical and nursing budgets. This results in part from increased WLI spend used to deliver activity levels rather than the anticipated improvement in theatre and outpatient productivity. However, significant lapses in the control environment pertaining to the utilisation of temporary staffing across medical and nursing budgets have also characterised financial performance in the YTD. The Trust reports delivery of CIP savings of £2.0m YTD. Whilst this is slightly behind target, this level is significantly higher than historic values of achievement at this early stage in the financial year. In conjunction with other STP organisations the Trust will during Q1 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 April and May 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. Undertake 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.	The Month 2 finance performance represents a significant concern for the Trust. The significant overspent against pay budgets at M2 is largely unrelated to activity and pertains to a combination of slippage against clinical productivity targets and weaknesses in the management of medical and nursing temporary staffing costs. This underlying position is not sustainable and requires immediate redress. The Trust Executive have reintroduced weekly IFD oversight groups for both Medical Staffing and Nursing Management. These groups lapsed at the conclusion of the last financial year, there reinstatement has been identified as key in maintaining oversight and management of the temporary staffing control environment. The groups will be led by Executive Directors and will implement agreed improvement plans for these staffing areas to effect immediate reductions in run rate spend. The Trust has already implemented significant changes to its weekly Improving Financial Delivery (IFD) meetings with divisional management teams to ensure a heightened focus on establishment management, temporary staffing controls and achievement of recruitment and retention targets. A key feature of financial under delivery in previous years has been the Trust's continued reliance upon premium out of hours' capacity (WLI's) and expensive locum staff in order to deliver required SLA activity throughput. The Trust needs to reduce this dependency through improvement in the productivity levels in its theatre and outpatient settings. Historically performance in these areas has been extremely poor in comparison with national benchmarks. Improvement represents a significant opportunity to make much better use of working week capacity and reduce costs. In order to support delivery of this improvement the Trust has set up a Theatre Transformation Board and an Outpatient Transformation Board. These groups are led by the COO and are designed to ensure that change plans are delivered. The success of these schemes will have a very significant impact upon the successful delivery of the overarching financial plan. The pace of progress in Q1 is significantly behind plan and this has resulted in unplanned medical spend pressures. The availability of capital resources continues to be constrained. The Trust faces significant requirements in respect of fire compliance works. The Trust is seeking emergency capital loan support from the Department of Health to help manage this requirement given their scale and the Trust extremely limited internal capital envelope. However, national capital constraints make this extremely challenging.	 **Martin Armstrong** **Director of Finance**

Single Oversight Framework

East and North Hertfordshire NHS Trust

Quality of care

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
Caring	Written complaints - rate	Quarterly	May-19	Local	1.9	1.4	
Caring	Staff Friends and Family Test % recommended - care	Quarterly	Q2 2018-19	National	80.9%	74.8%	
Safe	Occurrence of any Never Event	Monthly (six-month rolling)	May-19	National	0	0	
Safe	Patient Safety Alerts not completed by deadline	Monthly	Jun-19	National	0	3	
Caring	Mixed-sex accommodation breaches	Monthly	May-19	National	0	0	
Caring	Inpatient scores from Friends and Family Test - % positive	Monthly	May-19	National (excl. IS)	95.0%	96.4%	
Caring	A&E scores from Friends and Family Test - % positive	Monthly	May-19	National (excl. IS)	90.0%	93.9%	
Caring	Maternity scores from Friends and Family Test - % positive - antenatal care	Monthly	May-19	National (excl. IS)	93.0%	92.3%	
Caring	Maternity scores from Friends and Family Test - % positive - birth	Monthly	May-19	National (excl. IS)	93.0%	99.4%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal ward	Monthly	May-19	National (excl. IS)	93.0%	89.7%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal community	Monthly	May-19	National (excl. IS)	93.0%	100.0%	
Safe	Emergency c-section rate	Monthly	May-19	Local	15%	15%	
Organisational health	CQC inpatient survey	Annual	2018	National	8.0	7.8	
Safe	Venous thromboembolism (VTE) risk assessment	Quarterly	Q4 2018-19	National	95%	96.3%	
Safe	Clostridium difficile (C. difficile) plan: C.difficile actual variance from plan (actual number v plan number)	Monthly	May-19	National	0	-3	
Safe	Clostridium difficile – infection rate	Monthly (12-month rolling)	May-19	National	10.10	11.07	
Safe	Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Monthly (12-month rolling)	May-19	National	0.63	0.48	
Safe	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	Monthly (12-month rolling)	May-19	National	8.10	5.77	
Safe	Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI)	Monthly (12-month rolling)	May-19	National	18.56	16.84	
Effective	Hospital Standardised Mortality Ratio	Monthly (12-month rolling)	Feb-19	National	100	92.1	
Effective	Summary Hospital-level Mortality Indicator	Quarterly	Q3 2018-19	National	100	94.1	
Safe	Potential under-reporting of patient safety incidents	Monthly (six-month rolling)	May-19	National	47.9	37.54	

Finance

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

Operational performance

A&E	A&E maximum waiting time of four hours from arrival to admission/transfer/discharge	Monthly	May-19	National	95%	81.6%	
RTT 18 weeks	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	Monthly	May-19	National	92%	83.7%	
Cancer Waiting Times	62-day wait for first treatment from urgent GP referral for suspected cancer	Monthly	Apr-19	National	85%	80.3%	
Cancer Waiting Times	62-day wait for first treatment from NHS cancer screening service referrals	Monthly	Apr-19	National	90%	81.8%	
Diagnostics Waiting Times	Maximum 6-week wait for diagnostic procedures	Monthly	May-19	National	1%	1.02%	
Dementia assessment and referral	The number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who:						
	a. have a diagnosis of dementia or delirium or to whom case finding is applied	Monthly	May-19	National	95%	-	
	b. who, if identified as potentially having dementia or delirium, are appropriately assessed	Monthly	May-19	National	95%	-	
	c. where the outcome was positive or inconclusive, are referred on to specialist services	Monthly	May-19	National	95%	-	

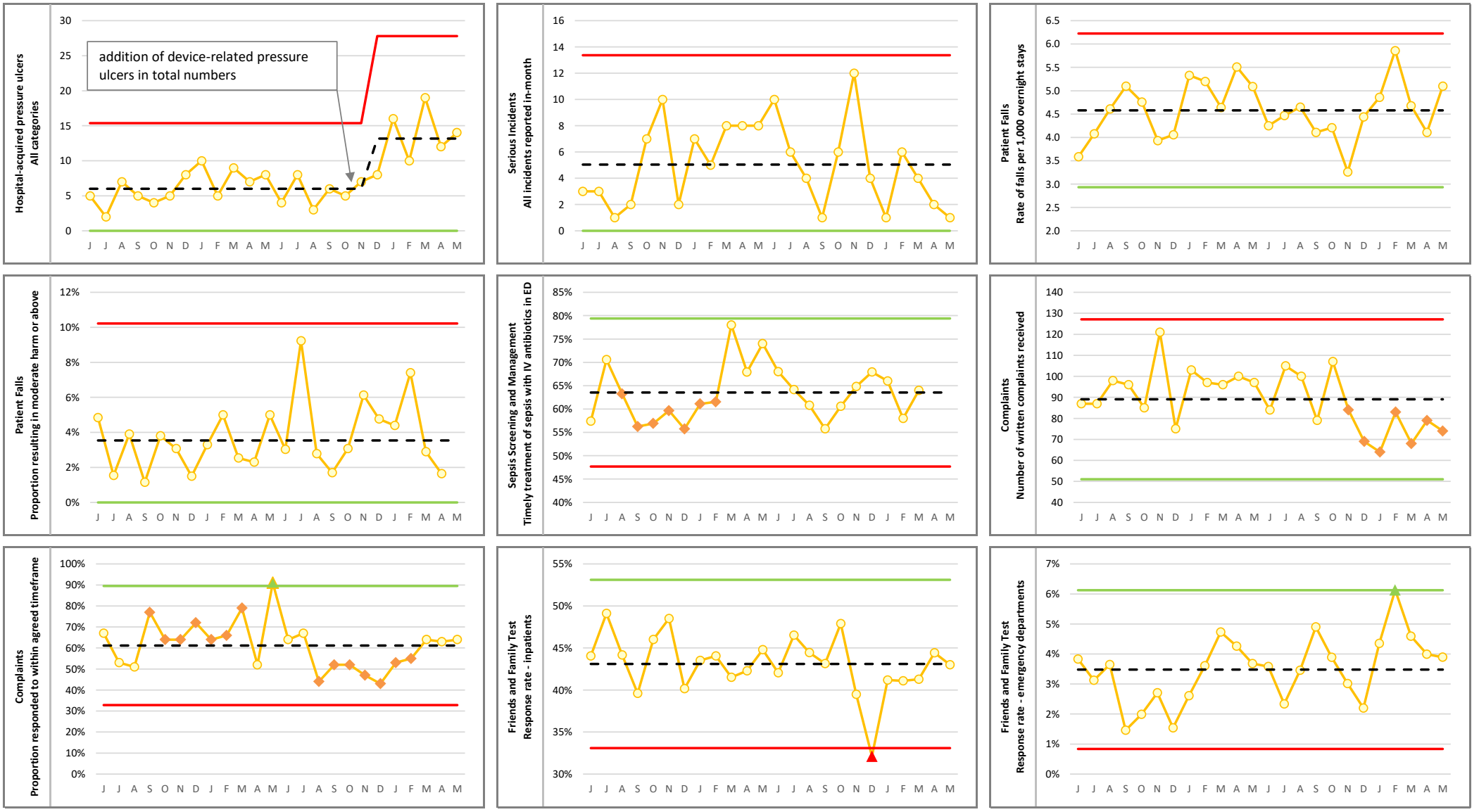
Organisational health

Organisational health	Staff sickness	Monthly	May-19	Local	3.4%	3.8%	
Organisational health	Staff turnover	Monthly	May-19	Local	12.0%	13.1%	
Organisational health	NHS Staff Survey Recommend as a place to work	Annual	2018	National	62.6%	53.9%	
Organisational health	Proportion of temporary staff	Monthly	May-19	Local	-	12.9%	

Quality Improvement Dashboard

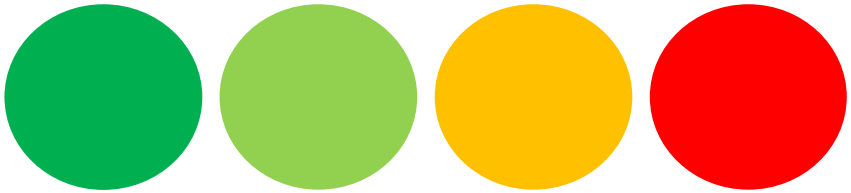
Safe, Caring and Effective Services Headline Metrics

East and North Hertfordshire NHS Trust



Safe Services

Month 02 | 2019-20



Key Issues

Safety Thermometer
- Harm-free care (for all and new harms) were the better than the national average in May.

Patient Falls
- In 2018/19 our annual reduction slowed to 3.14% when compared to the previous year which is not a cause for concern and is indicative of overall improvements in reducing preventable falls.
- Our aim for 2019/20 is to achieve a 2.5% reduction in inpatient falls.
- 62 falls occurring in May resulted in no physical harm reported to the patients who fell, 13 incidents resulted in patients sustaining low harm injuries such as minor lacerations and bruising, there were no severe harm falls recorded during the month.

Serious Incidents & Never Events
- There have been 1 serious incident reported in May:
    1. Delayed radiology review in diagnosis of lodged foreign body.
- There were no Never Events reported in May.

Infection Control
- MRSA bacteraemia = 0 MRSA BC allocated to the Trust for May.
- C difficile infections = 1 incidence
- E.coli bacteraemia = 5 incidences in May
- MSSA bacteraemia = 0 incidence in May
- Hand hygiene compliance = 86%

Hospital-acquired Pressure Ulcers
- Year to date we have reported 28 pressure ulcers
- There were 14 reported in May:
    - Category 4 = 0
    - Category 3 = 0
    - Category 2 = 3
    - Unstageable = 2
    - SDTI = 7

Sepsis
- NEWS 2.0 now in place to improve screening sensitivity. Improvement work shall monitor timely sepsis bundle compliance - which shall include: o2 therapy, fluid balance charts; lactate measurement; blood culture sampling; and fluid resuscitation - as well as antibiotic administration. Q4 sepsis data collection in progress.

VTE
- There remains an on-going review of processes to improve governance and measurement of VTE risk assessments. A trust-wide action plan has been written and Trust 'Thrombosis Action group' as been established.

Executive Response

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

Patient Falls
- Inpatient fall improvement work shall include focussed target work on lying and standing BP management, this shall be done through harm free care collaborative.

Serious Incidents and Never Events
- As at 21/05/2019, it has been 226 days since our last Never Event.

Never Events / Safer Surgery
- Our Safer surgery improvement work continues and NatSSIP policy shall be launched in Quality Learning event 21/6/19
- Theatre team have continued to video NatSSIP / surgical checklist video
- WHO audit data was shared verbally at theatre board.

Harm-free Care Collaborative
- Collaborative now reviewing themes and trends in medication errors and urinary catheter associated infections (CQUIN)
- Pressure Ulcer prevalence data shall be reviewed
- Falls data shall include CQUIN requirements
- Medication error data has been analysed

Infection Control
- Glove awareness week (raised the profile of appropriate glove sue in May.
- Execs and clinical directors undergone hand hygiene competency in May
- Training to clean equipment was rolled out May in Lister and Mount Vernon

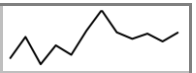
Hospital-acquired Pressure Ulcers
- ***In the May time period unfortunately previous Unstageable skin damage deteriorated to category 4 skin damage following debridement***
- The tissue viability team review and validate all hospital acquired Pressure ulcers and the data within Datix is cleansed.
- The tissue viability team continue to follow the NHS I recommendations for reporting of PU and MASD.
- Pressure ulcers remain in high focus at east and North Herts NHS trust with discussion daily at the site safety meeting and on each ward safety huddle.
- The PU collaborative meet regularly to continue the drive toward improvement with tick a turn and react to red initiatives happening on wards.
- PU Messages of the week have been written and will be circulated to the wards.
- A trust wide action plan is focuses on education, staff competency and regular audit of practice and documentation – progress on the action plan will be fed through the Harm free care group.
- The tissue viability team are working with estates and facilities to inform the new contract for beds and mattresses.

Sepsis
- Sepsis data collection shall now reflect National requirements for NHSE contract standards i.e. sample 50 patient s per quarter that were successfully screened and treated in ED and also inpatient sample.
- Next month reporting shall also reflect sepsis 6 bundle compliance
- Over all trust wide compliance of 95% through delivery of Quality Strategy (2019 -2024)

VTE
- Hospital-acquired thrombosis risk assessment remains priority for Quality Improvement, work is underway to review a service re-design and WTE needed to adequately meet the contractual requirement of new national criteria.

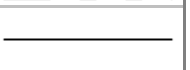
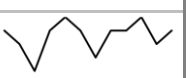
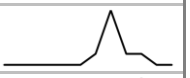
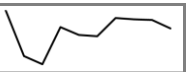
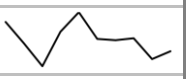
Safe Services

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Trend
Safety Thermometer	Harm-free care All harms	93.8	95.5	96.7	95.2	96.2	95.7	97.0	98.1	96.9	96.6	96.8	96.4	96.9	
	Harm-free care New harms	97.8	98.5	99.1	98.3	97.9	98.1	99.6	99.6	98.9	98.2	98.4	99.1	99.5	
Patient Falls	Number of patient falls	72	66	65	72	59	65	49	63	91	81	69	61	77	
	Rate of patient falls per 1,000 overnight stays	4.0	4.3	4.5	4.7	4.1	4.2	3.3	4.4	4.9	5.9	4.7	4.1	5.1	
	Number of patient falls resulting in serious harm	0	2	4	1	0	2	0	1	3	3	2	0	0	
Events and Incidents	Number of Never Events	0	0	1	1	0	1	1	0	0	0	0	0	0	
	Number of Serious Incidents	5	10	6	4	1	6	12	4	1	6	4	2	1	
Infection Control	Rate of MRSA incidences per 100,000 bed days	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.8	0.0	
	Rate of c.difficile incidences per 100,000 bed days	10.1	0.0	17.2	28.7	5.9	23.1	6.0	11.5	16.8	12.4	0.0	5.8	5.6	
	Rate of e.coli incidences per 100,000 bed days	18.6	17.3	23.0	5.7	17.8	11.5	11.9	11.5	16.8	37.1	5.6	17.3	27.8	
	Rate of MSSA incidences per 100,000 bed days	8.1	0.0	5.7	11.5	11.9	0.0	11.9	11.5	5.6	0.0	5.6	5.8	0.0	
	Hand hygiene audit score	95%	94.2%	93.0%	85.4%	95.2%	94.3%	73.1%	82.2%	81.7%	76.3%	80.9%	82.0%	86.0%	

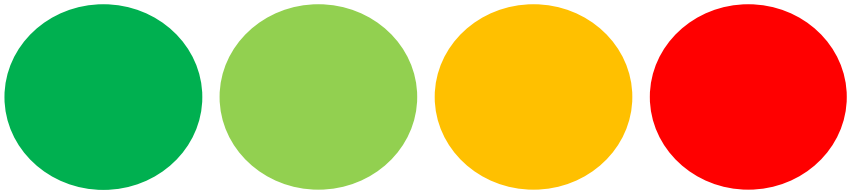
Safe Services

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Trend
Hospital-acquired Pressure Ulcers	Category 4	0	0	0	0	0	1	0	0	1	0	0	1	0	
	Category 3	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Category 2	2	3	2	0	3	4	3	1	3	3	4	2	3	
	Category 2(D) Device-related	-	-	-	-	-	-	1	0	2	0	1	0	2	
	Mucosal membrane (D) Device-related	-	-	-	-	-	-	-	1	5	1	1	0	0	
	Unstageable	1	1	3	1	1	0	0	0	2	1	4	1	2	
	SDTI	3	0	3	2	2	0	3	6	3	5	9	9	7	
VTE	VTE risk assessment	95%	96.9%	96.6%	96.8%	96.4%	96.6%	95.7%	91.4%	96.5%	95.9%	96.5%	tbc	tbc	
Sepsis Screening and Management	Indicator 2a: Sepsis screening Emergency department	90%	100.0%	91.5%	90.0%	96.9%	95.5%	95.2%	98.6%	98.3%	98.2%	96.6%	tbc	tbc	
	Indicator 2a: Sepsis screening Acute inpatient departments	90%	91.7%	73.3%	53.8%	83.3%	100.0%	77.3%	76.2%	77.8%	60.0%	66.7%	tbc	tbc	
	Indicator 2b: Timely treatment of sepsis with IV antibiotics Emergency department	90%	68.0%	64.2%	60.8%	55.8%	60.6%	64.8%	67.9%	66.0%	58.0%	64.0%	tbc	tbc	
	Indicator 2b: Timely treatment of sepsis with IV antibiotics Acute inpatient departments	90%	90.9%	61.5%	27.3%	57.1%	82.4%	70.0%	69.2%	68.8%	50.0%	75.0%	tbc	tbc	

Caring Services

Month 02 | 2019-20



Key Issues

Friends and Family Test (FFT)

- The proportion of positive responses to the Inpatients, A&E, Outpatients, Maternity birth and Community Midwifery FFT questions were better than the respective Trust targets in May.
- The proportion of positive responses to the Inpatient, A&E, Outpatients Antenatal, Birth and Community FFT questions were better than the respective Trust targets in May.
- The proportion of positive responses to the Outpatient FFT question improved to 96.2% in May better than the Trust target of 95%.
- Positive responses to the Maternity Antenatal Ward FFT question fell to 92.3%; below the Trust target of 93%.
- The FFT response rate for A&E continues to fall to 3.9% in May and continues to be well below the Trust target of 10%.
- The FFT response rate for Inpatients / Day Case fell to 43.0% in May, but remains better than the Trust target of 40%.
- The FFT response rate for Maternity (Birth question only) continues to improve at 34.6% in May, remaining above the Trust target of 30%.

Complaints

- Total number of complaints received YTD = 153 There were 74 complaints received in May. Breakdown by division:
  - Surgery - 34 (28 closed)
  - Medicine - 22 (29closed)
  - W&C - 9 (15 closed)
  - CSS - 6 (5 closed)
  - Cancer - 3 (4 closed)
  - Operations - 0 (1 closed)
- 100% of complaints received were acknowledged within 3 working days.
- 64% were responded to within the agreed timeframe.

Executive Response

Friends and Family Test (FFT)

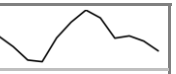
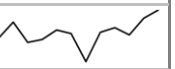
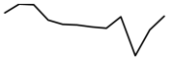
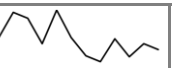
- The inpatient / day case percentage of patients who would recommend the Trust is higher than the national average and the response rate continues to exceed the latest national average response rate of 24.06%. The highest proportion of positive comments relate to staff. and care and treatment.
- Negative comments from inpatient/day case patients related to the environment, food, wait for medication before discharge, and information about what is happening.
- 5 patients out of 559 who responded to the A&E FFT survey were unlikely or extremely unlikely to recommend the service.
- The majority of feedback from patients in A&E is positive particularly in relation to staff. being compassionate, kind and caring. Negative feedback relates to waiting times, access to refreshments at night at Lister and QEII.
- Outpatients compliment staff on their kind and caring attitude and for the care and treatment provided. There are concerns about waiting times in clinics and lack of information about reasons for the delays. Other concerns relate to administration around appointments, car parking and access to refreshments.
- On the postnatal ward 5 out of 156 women would not recommend the service. Women would like better provision of recliner chairs and facilities for partners and an improved ward environment.

Improvement efforts - Complaints

- We are continuing to work on our 90-day improvement plan. An aim of the project is to achieve less than 120 open complaints across all divisions. At the end of April, the total number of complaints open was 99.
- We have identified the surgical division as priority, and work continues with the divisional team and we have started to see a significant reduction in the number of complaints open, with 34 open complaints at the end of May.

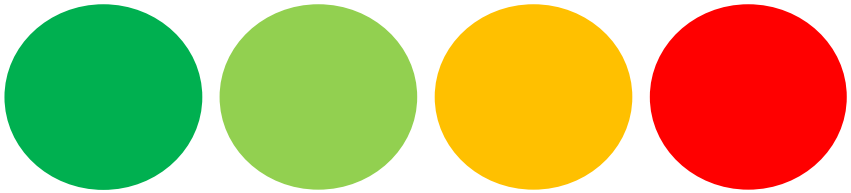
Caring Services

East and North Hertfordshire NHS Trust

Domain	FFT	Metric	Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Trend
Friends and Family Test	Inpatients	Proportion of positive responses	95%	96.8%	96.6%	96.2%	96.2%	96.8%	97.2%	97.5%	97.3%	96.8%	96.8%	96.7%	96.4%	
		Total number of responses	1,778	1,979	2,146	2,004	1,905	2,322	1,874	1,391	2,094	1,791	1,889	1,994	2,022	
		Response rate	40%	42.0%	46.5%	44.5%	43.1%	47.9%	39.5%	32.1%	41.2%	41.1%	41.3%	44.4%	43.0%	
	A&E	Proportion of positive responses	90%	89.2%	91.9%	88.4%	88.9%	90.5%	89.9%	85.2%	90.2%	90.9%	89.7%	92.5%	93.9%	
		Total number of responses	1,241	490	332	450	649	560	417	297	610	806	671	546	559	
		Response rate	10%	3.6%	2.3%	3.5%	4.9%	3.9%	3.0%	2.2%	4.4%	6.1%	4.6%	4.0%	3.9%	
	Maternity	Antenatal care Proportion of positive responses	93%	100.0%	94.7%	95.8%	90.9%	100.0%	100.0%	96.8%	92.5%	100.0%	100.0%	100.0%	92.3%	
		Birth Proportion of positive responses	93%	97.6%	96.8%	98.4%	96.7%	96.5%	95.7%	94.1%	94.7%	98.1%	100.0%	96.1%	99.4%	
		Birth Total number of responses	137	166	186	184	150	141	139	135	132	157	71	128	159	
		Birth Response rate	30%	34.9%	40.8%	41.9%	34.1%	27.8%	30.3%	29.8%	30.2%	39.1%	16.3%	30.5%	34.6%	
		Postnatal ward Proportion of positive responses	93%	81.9%	89.7%	90.8%	88.6%	91.4%	86.9%	83.3%	91.6%	91.7%	83.1%	87.4%	89.7%	
		Postnatal community Proportion of positive responses	93%	100.0%	95.8%	100.0%	100.0%	100.0%	100.0%	94.6%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Outpatients	Proportion of positive responses	95%	95.7%	94.7%	94.8%	94.9%	93.9%	93.6%	95.2%	94.1%	94.4%	95.5%	94.5%	96.2%	
		Total number of responses	-	1,431	1,175	1,911	1,896	1,733	1,982	1,683	2,037	2,281	5,320	1,980	4,100	
Complaints		Number of written complaints received	92	84	105	100	79	107	84	69	64	83	68	79	74	
		Rate of written complaints received	1.9	1.7	2.0	2.0	1.6	1.9	1.6	1.6	1.1	1.6	1.3	1.6	1.4	
		Proportion of complaints acknowledged within 3 working days	75%	100%	100%	100%	100%	100%	100%	100%	95%	100%	100%	100%	100%	
		Proportion of complaints responded to within agreed timeframe	80%	64%	67%	44%	52%	52%	47%	43%	53%	55%	64%	63%	64%	

Effective Services

Month 02 | 2019-20



Key Issues

Crude Mortality
- The in-month crude mortality rate increased to 10.5 deaths per 1,000 admissions.
- The rolling 12-months crude mortality rate remained at 11.1 deaths per 1,000 admissions in the 12 months to May, which remained better than the most recently available national rate of 13.4.

Hospital-Standardised Mortality Ratio (HSMR)
- The in-month HSMR improved to 92.57 in March, and remained better than the standard (100).
- The rolling 12-months HSMR increased slightly to 93.3 in the 12 months to March, but remains in the better than expected ranged.
- HSMR is available several months in arrears.

Summary Hospital-level Mortality Indicator (SHMI)
- The quarterly SHMI figure improved to 99.9 in Q2 2018-19 and then improved further to 93.96 in Q3 2018-19.
- SHMI is available quarterly in arrears.

Re-admissions
- The total re-admission rate decreased by 0.6% to 8.0% in November 2018 compared to the previous month. This corresponds to 869 re-admissions out of 10,814 spells.

Executive Response

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

Hospital Standardised Mortality ratio (HSMR)
- This measure is based on a basket of 56 patient groups with relatively predictable mortality and records death in hospital. Performance has been persistently in the 'as expected range'. There was a predictable, unsustained increase in HSMR following the introduction of the Lorenzo system in September 2017. This is a pattern commonly seen after the introduction of any PAS and is thought to be related to changes in depth of coding and, hence, predicted mortality. HSMR remained in the 'as expected' range during this period. The latest HSMR for the rolling 12 months to March 2019 is 93.3. 'Better than expected'. HSMR is generally available 3/12 in arrears.

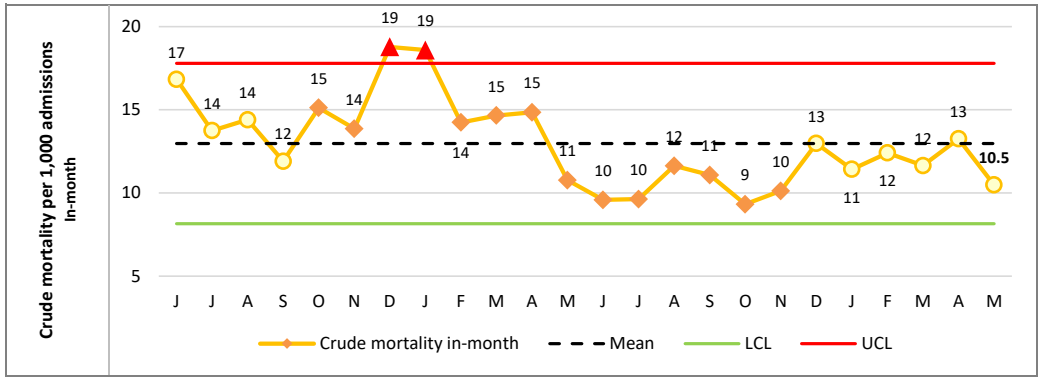
Summary Hospital-level Mortality Indicator (SHMI)
- This is a measure of mortality for all inpatients including up to 30-days post-discharge. Historically, ENHT's SHMI has been up to 10 points higher than the HSMR, which is thought to be related to the onsite hospice at Mount Vernon (a relatively unusual arrangement nationally). However, over the last 2 years the gap between SHMI and HSMR has reduced to approximately 1 point. Although a similar (to HSMR) increase in SHMI was seen post-Lorenzo launch, it too remained in the 'as expected' range. The latest SHMI for the rolling 12-months to December 2018 is 93.96. 'As expected'. SHMI is generally available 6/12 in arrears.

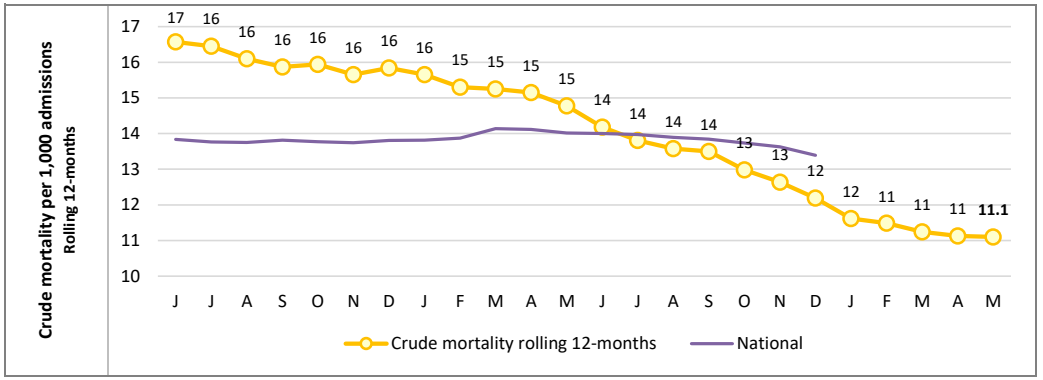
Crude mortality
- This measure is available the day after the month end and has demonstrated a consistent decrease over the last 5 years. It is the factor with the most significant impact on HSMR.
- The improvements in mortality have been as a result of a combination of corporate level initiatives such as the mortality review process and more directed areas of improvement such as the identification and early treatment of patients with sepsis, stroke, etc.

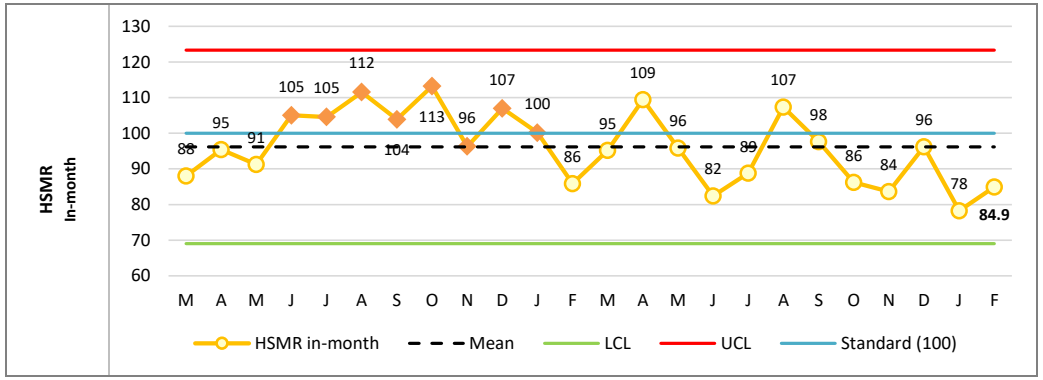
Re-admissions
- Historically the Trust reported higher than expected levels of re-admissions compared to the national average. However, the last three years have seen a consistent improving trend. The 12 months to February 2018 saw relative risk return to the 'as expected range'. The latest relative risk for the 12 months to December 2018 stands at 99 (Elective 91.8, Non-Elective 102.6) and sits within the 'as expected' range.

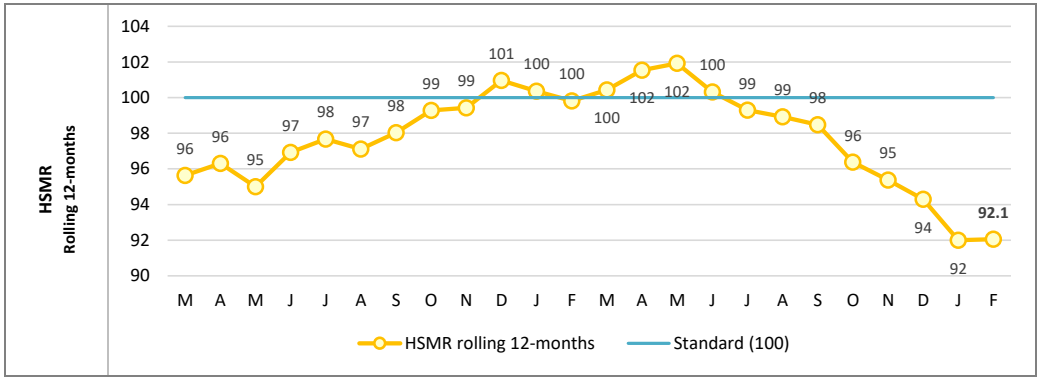
Effective Services

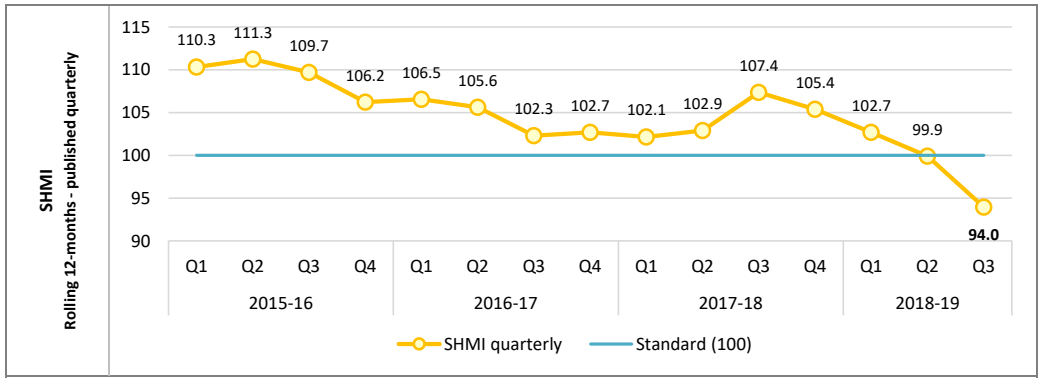
East and North Hertfordshire NHS Trust



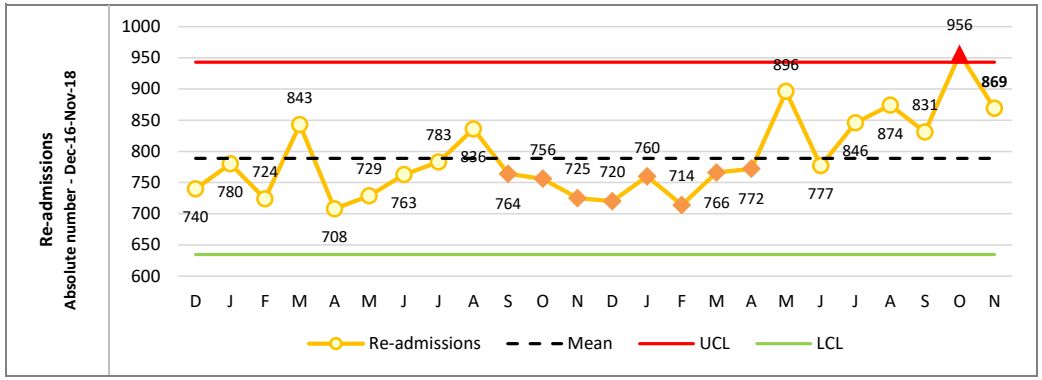


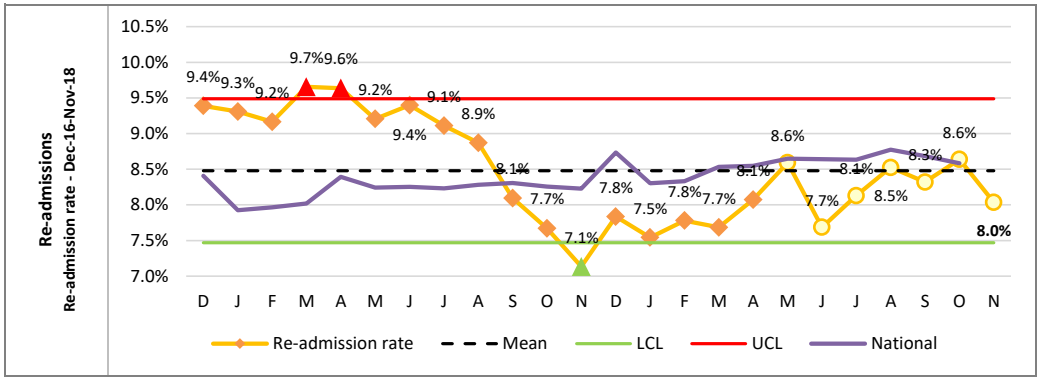






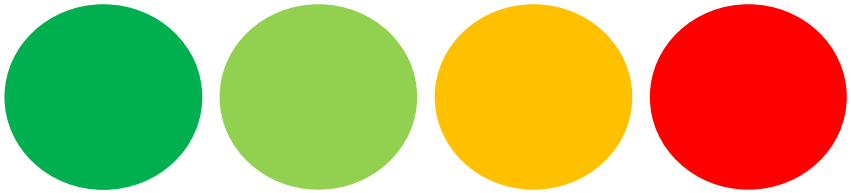
Effective Services





Responsive Services

Month 02 | 2019-20



Key Issues

A&E
- Performance for the month of May 2019 was 81.64%.
- No 12-hour trolley waits were reported in May.

Cancer Waiting Times
- In April 2019 the Trust achieved 4 of the 8 national targets for cancer performance.
- The Trust 62-day performance for April 2019 was 79.6% pre-breach sharing and 82.3% post breach sharing, which is above the revised trajectory of 75.8%.
- The cancer recovery business case has now been signed off and in process to implement.
- Capacity challenges continue with specialist treatments such as RALP and Brachytherapy which is impacting on the Trust aggregate 62-day compliance.
- There is a further risk to the sustained compliance of the 31-day subsequent Radiotherapy performance due to the need to replace LA1. To mitigate this the Trust has taken the decision to upgrade LA1 as a mitigation for a year with a longer term replacement solution to be found post April 2020.
- Commitment has been obtained from IMAS to support the Trust with ongoing work with:
  - Completed External validation of the Trust 62-day recovery RAPs;
  - Critical review of service specific MDT and PTL meetings with written feedback
  - Demand & Capacity model and Pathway analysis for Histology services
  - Continue to Work to deliver the 28-day faster diagnosis target;
  - Cancer Support Unit has now completed the deep dive analysis for all breaches

RTT
- Incomplete performance for May was 83.70% with a reported backlog of 7,314. This is a deterioration on the April position.
- There were five 52-week breaches reported in our May incomplete position against four reported in April.

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

Stroke
- Performance for April 50%
- 4 hr target taking into the out the exclusion of the Inter hospital transfer and inpatient stroke – April 2019 54.2%
- Training being arranged with ED doctors, to ensure that there is early escalation and referrals are being made to the Stroke team.
- Review of Stroke pathways for A&E and Inpatient – being reviewed and review meetings due to take place in March – Education and Training the Ward areas underway and process for management of Inpatient strokes being updated, in line with the Operation office processes.
- Thrombolysis rate at 4.5%. Stroke Nurses commenced delivery of training to the Ambulance Crew, with the aim to help with early attendance to A&E within onset time.
- Ongoing significant improvement in 60-min to scan and 12-hrs to scan performance. Due to the implementing of the Stroke Nurses requesting scans at time of arrival in A&E – 56.1% performance for April 2019 improvement from March performance.
- Table above now showing the 33.3 % of thrombolysis received in less than 60 minutes as this is the gold standard, however up to 4.5hrs from onset time is NICE guidance approved. This has an impact on the arrival time to the Trust - as we are meeting the rate for 60mins Thrombolysis rate target of 11%
- Maintain performance of meeting of 40% target for ESD performance at 50% for April 2019.
- TIA performance within 24-hrs significantly – Data currently not available for April – details of actions to be undertaken with the RAP. Review of the national reporting requirements to ensure we are adhering and reporting as per national requirements.

Executive Response

A&E
- The trust ED performance in May was 81.64% which was an improvement compared to April, with notable improvement in admitted performance. Improvement in admitted performance is largely due to the continued work around professional standards.
- Improvement has continued further with MTD June validated at 85.78%.
- The trust 4-hour performance remains a challenge. A formal action plan is being written to improve performance ahead of winter 2019/20. This includes a focus on reducing; waits to triage, time to be seen by clinical decision makers and ambulance handov ers as well as improved pathways for mental health patients to reduce delays in psych assessments and improve patient experience. In addition, key actions to improve professional standards will continue.

Cancer performance (April)
- In April 2019, the Trust achieved 4 of the 8 national targets for cancer performance: 2ww, 31 -day subsequent for drug treatments, radiotherapy, and surgery. Cancer performance is available one month in arrears.
- The Trust Two Week Wait (2WW) performance for April 2019 was 95.9% which equates to 1,323 out of 1,379 pathways meeting the 2WW standard, with 56 breaches of the standard being reported.
- In April 2019, the Trust-wide average days wait for a first appointment was at 10 days and the majority of patients were seen between 8 and 12 days.
- In April 2019 the 31 day 1st definitive treatment was 93.5%; below the national target of 96%, which equates to 231 out of 24 7 pathways meeting the target, with 16 breaches. 7 out of 9 tumour sites met the target and excluding Urology the Trust would have achieved the 96% target.
- In April 2019 the 28-day faster diagnosis performance was 62.30% and 58.80% for screening patients.
- Reported 62-day performance for April 2019 was 79.6% pre-breach/compliance sharing and 82.3% post- (85.7% excluding all incoming referrals), which is above the revised recovery trajectory of 75.8%. In April 2019, 5 out of 9 tumour sites met the standard with 45% of avoidable breaches occurring in Urology.

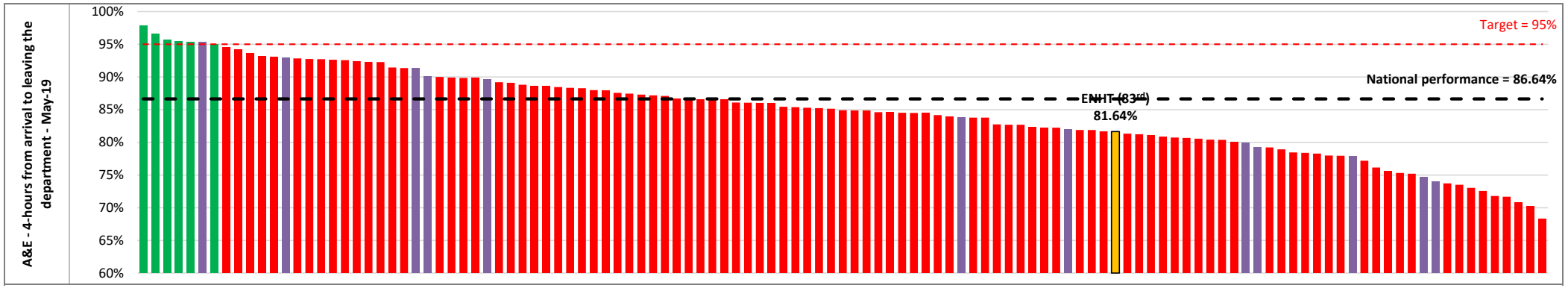
RTT
- Performance has dropped further in May. Five 52-week breaches were reported for May.

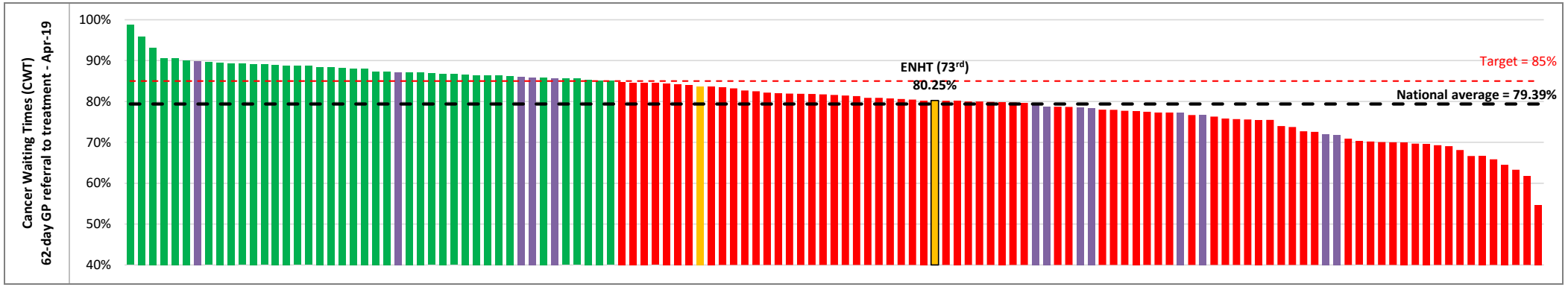
Diagnostics
- Diagnostics performance in May has improved over April, narrowly missing the 1% target with final performance at 1.02%. This is well within our recovery trajectory for May (1.50%).

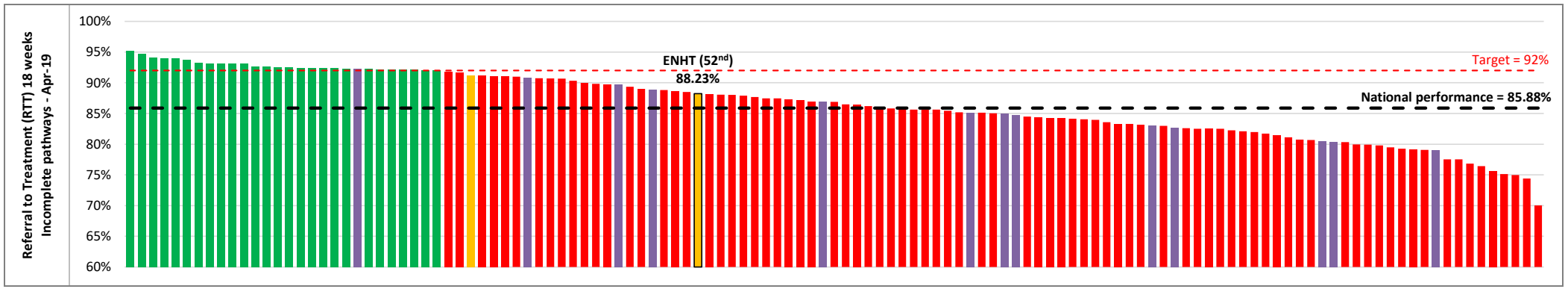
Responsive Services

Trust performance against all Trusts nationally

East and North Hertfordshire NHS Trust



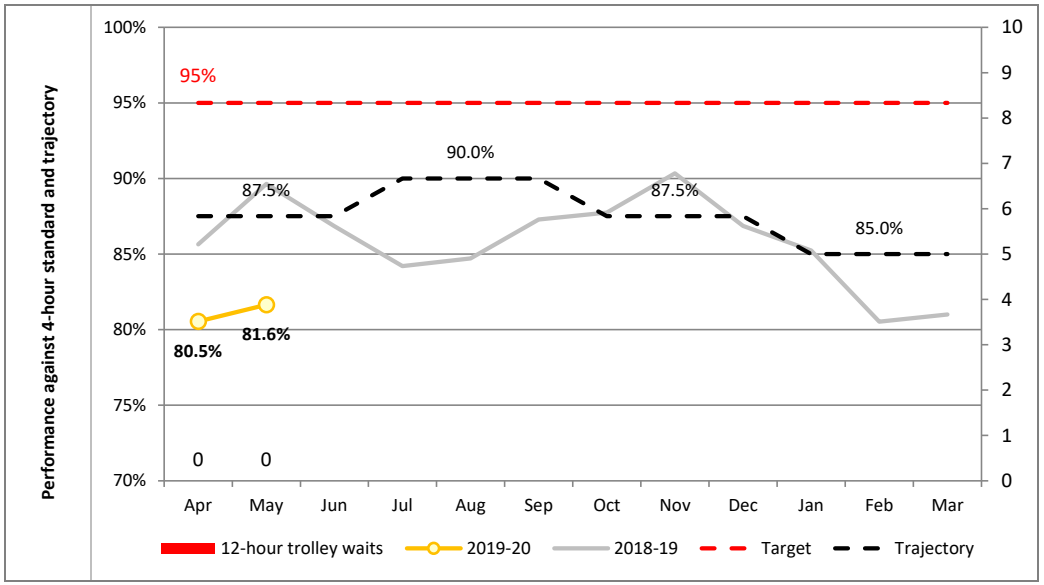




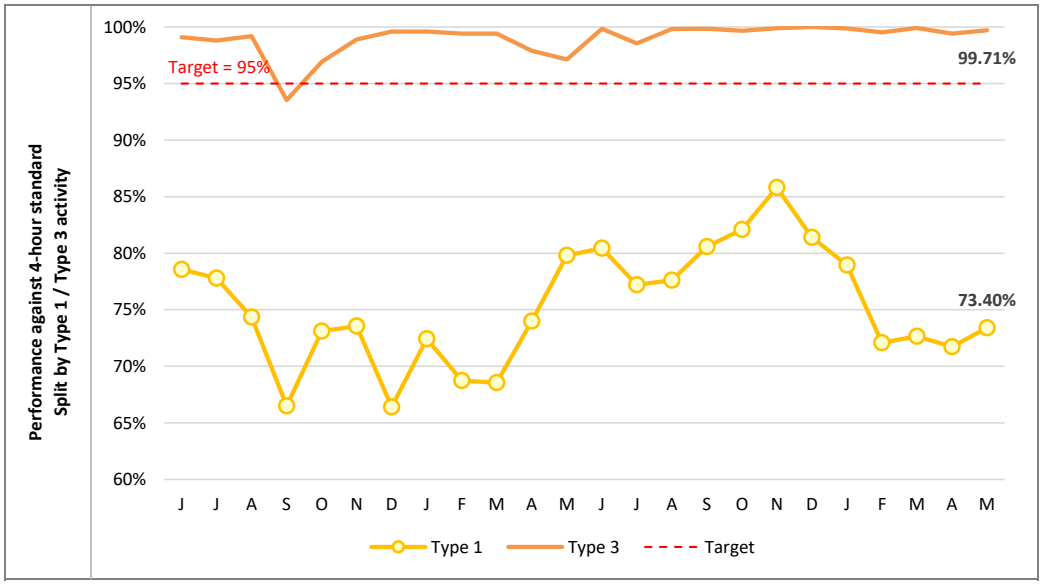
Responsive Services

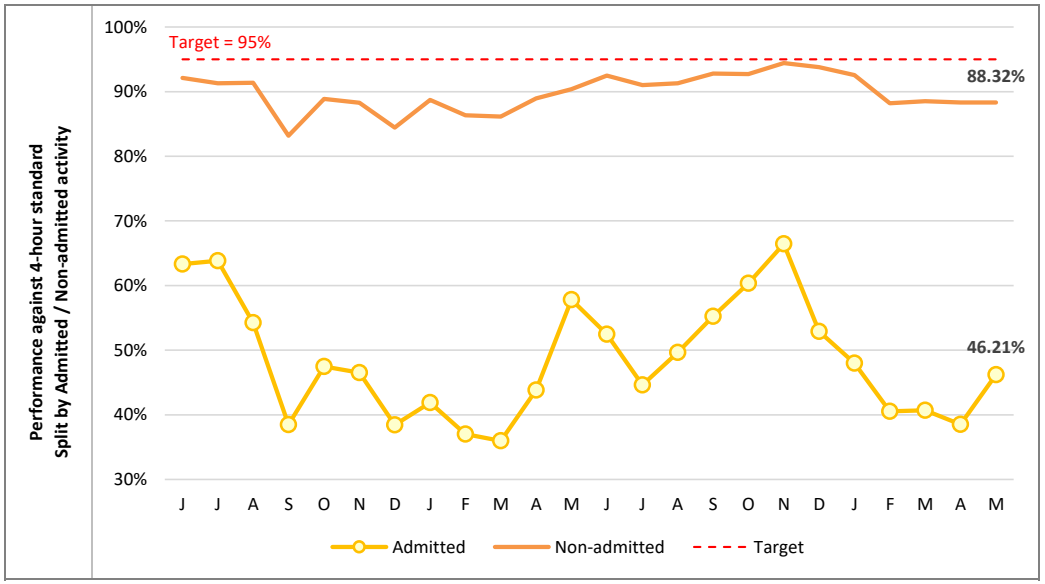
Emergency Department Performance

East and North Hertfordshire NHS Trust



Domain	Metric	Target	Apr-19	May-19	Change	Trend
Other Emergency Department measures	Ambulance handovers Proportion within 15 minutes	-	60%	tbc	▲	
	Ambulance handover breaches 30-minutes	230	480	tbc	▲	
	Ambulance handover breaches 60-minutes	43	141	tbc	▲	
	Attendance to admission conversion rate	-	31.9%	33.7%	▲	
	Time to initial assessment 95th centile	15	64	69	▲	
	Time to treatment Median	60	75	78	▲	
	Left department before being seen for treatment	5%	2.0%	2.1%	▲	
	Unplanned re-attendance rate	5%	4.6%	5.0%	▲	





Responsive Services

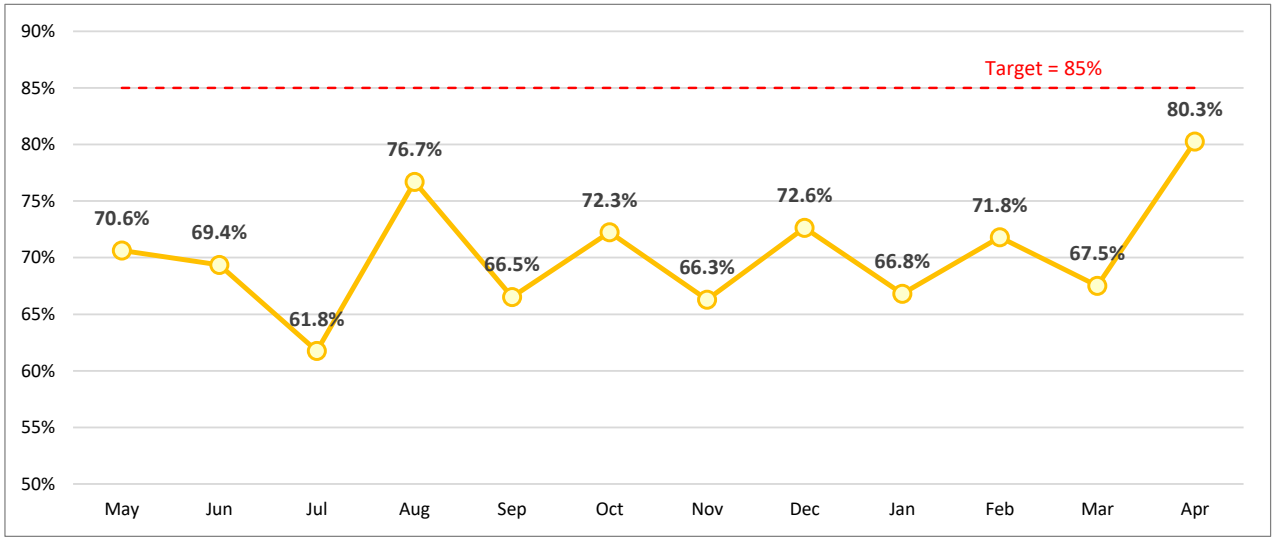
Cancer Waiting Times

12-months' performance - all standards

Standard	Target	2018-19												2019-20
		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	YTD	Apr-19
Two week waits Suspected cancer	93%	89.3%	92.1%	91.8%	95.5%	95.1%	92.6%	97.1%	96.7%	97.2%	95.6%	96.6%	97.0%	94.8%	95.9%
Two week waits Breast symptomatic	93%	93.7%	91.8%	83.9%	97.3%	91.2%	88.8%	94.9%	94.4%	93.4%	94.5%	94.0%	94.0%	92.6%	88.7%
31-day First definitive treatment	96%	95.0%	92.4%	96.7%	90.8%	90.3%	95.3%	93.8%	91.8%	96.3%	96.0%	95.1%	94.5%	93.9%	93.5%
31-day subsequent treatment Anti-cancer drugs	98%	99.4%	99.3%	98.3%	99.3%	98.3%	100.0%	99.4%	97.99%	100.0%	98.7%	99.4%	98.3%	99.0%	98.2%
31-day subsequent treatment Radiotherapy	94%	91.7%	90.6%	91.1%	94.1%	95.0%	97.6%	97.9%	97.3%	97.2%	95.0%	98.0%	95.7%	95.1%	96.9%
31-day subsequent treatment Surgery	94%	88.5%	95.8%	60.0%	64.0%	100.0%	57.1%	74.2%	69.4%	84.2%	63.6%	76.5%	78.8%	75.6%	96.8%
62-day GP referral to treatment	85%	67.2%	70.6%	69.4%	61.8%	76.7%	66.5%	72.3%	66.3%	72.6%	66.8%	71.8%	67.5%	69.1%	80.3%
62-day Specialist screening service	90%	86.7%	75.0%	77.8%	60.7%	75.0%	87.5%	74.2%	86.2%	100.0%	72.7%	79.2%	95.2%	79.6%	81.8%

62-day GP referral to treatment Apr-19

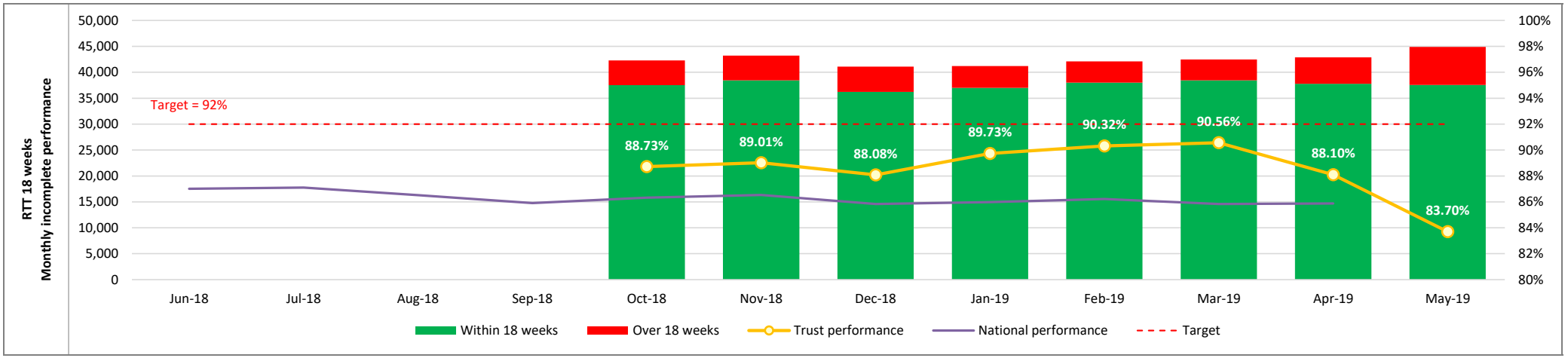
Tumour Site	OK	Breach	Total	Perf.
Breast	18.0	2.0	20.0	90.0%
Gynaecology	4.5	2.0	6.5	69.2%
Haematology	4.0	0.0	4.0	100.0%
Head and Neck	5.5	2.0	7.5	73.3%
Lower GI	13.0	3.0	16.0	81.3%
Lung	4.0	3.5	7.5	53.3%
Other	0.0	0.0	0.0	-
Sarcoma	0.0	0.0	0.0	-
Skin	16.5	1.5	18.0	91.7%
Testicular	1.0	0.0	1.0	100.0%
Upper GI	6.5	0.5	7.0	92.9%
Urology	22.5	9.0	31.5	71.4%
Total	**95.5**	**23.5**	**119.0**	80.3%



Responsive Services

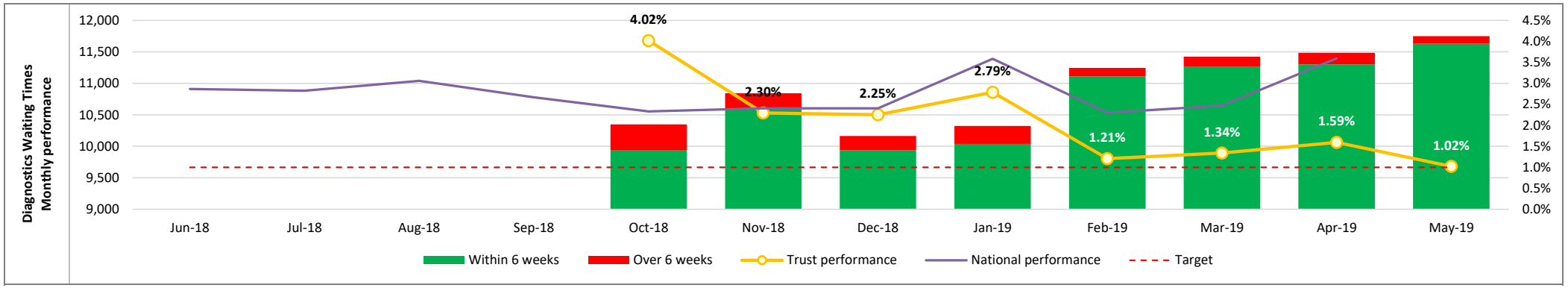
RTT 18 weeks

East and North Hertfordshire NHS Trust



RTT 18 weeks
In-month performance by Specialty - May-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	218	85.78%	0	503	94.43%	0	2,580	364	2,944	87.64%	4	0	1,004
Urology	91	87.91%	0	461	93.49%	1	1,900	131	2,031	93.55%	1	0	687
Trauma & Orthopaedics	89	51.69%	1	738	83.47%	2	2,732	720	3,452	79.14%	40	3	1,056
Ear, Nose & Throat (ENT)	158	75.32%	0	940	86.17%	0	2,266	207	2,473	91.63%	3	0	1,217
Ophthalmology	150	67.33%	0	584	86.99%	0	4,022	364	4,386	91.70%	2	0	1,060
Oral Surgery	28	21.43%	3	281	41.99%	0	1,732	529	2,261	76.60%	39	0	371
Plastic Surgery	102	71.57%	0	818	96.94%	0	1,728	101	1,829	94.48%	1	0	962
Cardiothoracic Surgery	1	100.00%	0	12	75.00%	0	19	0	19	100.00%	0	0	19
General Medicine	5	100.00%	0	187	100.00%	0	1,434	24	1,458	98.35%	1	0	645
Gastroenterology	185	73.51%	0	346	70.81%	1	2,607	807	3,414	76.36%	15	0	692
Cardiology	40	95.00%	0	710	69.01%	0	1,977	565	2,542	77.77%	14	0	589
Dermatology	1	100.00%	0	306	81.37%	1	1,291	255	1,546	83.51%	11	0	445
Thoracic Medicine	16	81.25%	0	254	87.80%	0	1,273	287	1,560	81.60%	8	0	391
Neurology	0	-	0	311	92.28%	0	1,277	96	1,373	93.01%	2	0	524
Rheumatology	2	100.00%	0	154	66.23%	0	861	291	1,152	74.74%	1	0	253
Geriatric Medicine	0	-	0	69	98.55%	0	143	3	146	97.95%	0	0	80
Gynaecology	56	76.79%	1	429	89.51%	0	2,862	604	3,466	82.57%	18	0	940
Other	96	64.58%	0	2,628	89.04%	1	6,860	1,966	8,826	77.72%	177	2	3,426
Total	**1,238**	**73.75%**	**5**	**9,731**	**85.65%**	**6**	**37,564**	**7,314**	**44,878**	**83.70%**	**337**	**5**	**14,361**



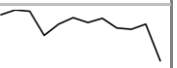
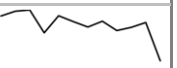
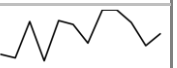
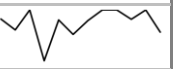
Diagnostics Waiting Times
In-month performance by Specialty - May-19

Category	Modality	Within 6 weeks	Over 6 weeks	Total	Performance	13+ weeks
Imaging	Magnetic Resonance Imaging	2,093	7	2,100	0.33%	0
	Computed Tomography	1,300	4	1,304	0.31%	0
	Non-obstetric ultrasound	5,063	1	5,064	0.02%	0
	DEXA Scan	444	0	444	0.00%	0
Physiological Measurement	Audiology - audiology assessments	45	1	46	2.17%	0
	Cardiology - echocardiography	1,163	85	1,248	6.81%	2
	Neurophysiology - peripheral neurophysiology	99	1	100	1.00%	0
	Respiratory physiology - sleep studies	55	0	55	0.00%	0
	Urodynamics - pressures & flows	91	0	91	0.00%	0
Endoscopy	Colonoscopy	510	10	520	1.92%	0
	Flexi sigmoidoscopy	212	3	215	1.40%	0
	Cystoscopy	83	2	85	2.35%	0
	Gastroscopy	471	6	477	1.26%	0
Total		**11,629**	**120**	**11,749**	**1.02%**	**2**

Responsive Services

Stroke Services

East and North Hertfordshire NHS Trust

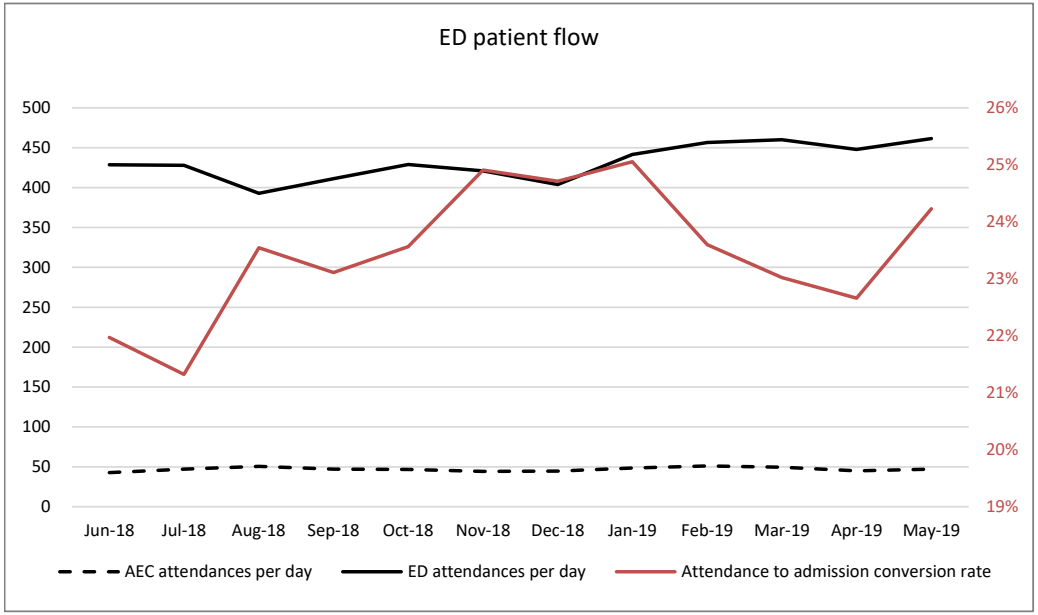
Domain	Metric	Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Trend
Stroke	Trust SSNAP grade	A	A	A	A	A	A	A	A	A	tbc	tbc	tbc	tbc	
	Discharged with AF on anticoagulants	80%	91.7%	92.9%	100.0%	87.5%	100.0%	88.9%	80.0%	100.0%	100.0%	100.0%	88.9%	100.0%	
	4-hours direct to Stroke unit from ED	90%	77.6%	80.6%	79.7%	65.2%	72.1%	75.9%	73.0%	75.4%	69.6%	69.0%	72.1%	50.0%	
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	90%	79.0%	81.7%	82.5%	69.8%	79.2%	75.9%	72.9%	76.1%	71.0%	72.7%	75.4%	54.2%	
	Number of confirmed Strokes in-month on SSNAP	-	69	66	60	69	63	57	64	70	70	73	71	66	
	Proportion of patients spending 90% of time on the Stroke unit	80%	86.6%	85.9%	93.3%	85.3%	93.5%	92.7%	88.9%	95.7%	95.7%	93.1%	88.4%	90.8%	
	60-minutes to scan from time of arrival	50%	56.5%	57.1%	56.7%	46.4%	61.9%	57.9%	54.0%	57.1%	50.0%	61.6%	45.6%	56.1%	
	Scanned within 12-hours - all Strokes	100%	95.7%	94.8%	100.0%	97.1%	98.4%	98.2%	93.7%	97.1%	100.0%	98.6%	98.6%	97.0%	
	Total Thrombolysis rate for confirmed Strokes	11%	7.2%	4.8%	16.7%	10.1%	9.5%	7.0%	14.3%	8.6%	10.0%	12.3%	8.5%	4.5%	
	Thrombolysed within 60-minutes of arrival	-	60.0%	66.7%	60.0%	42.9%	33.3%	25.0%	33.3%	n/a	42.9%	22.2%	16.7%	33.3%	
	Discharged with JCP	80%	98.0%	95.6%	100.0%	88.8%	97.8%	94.6%	97.6%	100.0%	100.0%	97.9%	100.0%	95.1%	
	Discharged with ESD	40%	46.9%	45.7%	59.2%	50.0%	54.3%	45.9%	64.4%	56.8%	48.1%	51.9%	44.4%	50.0%	

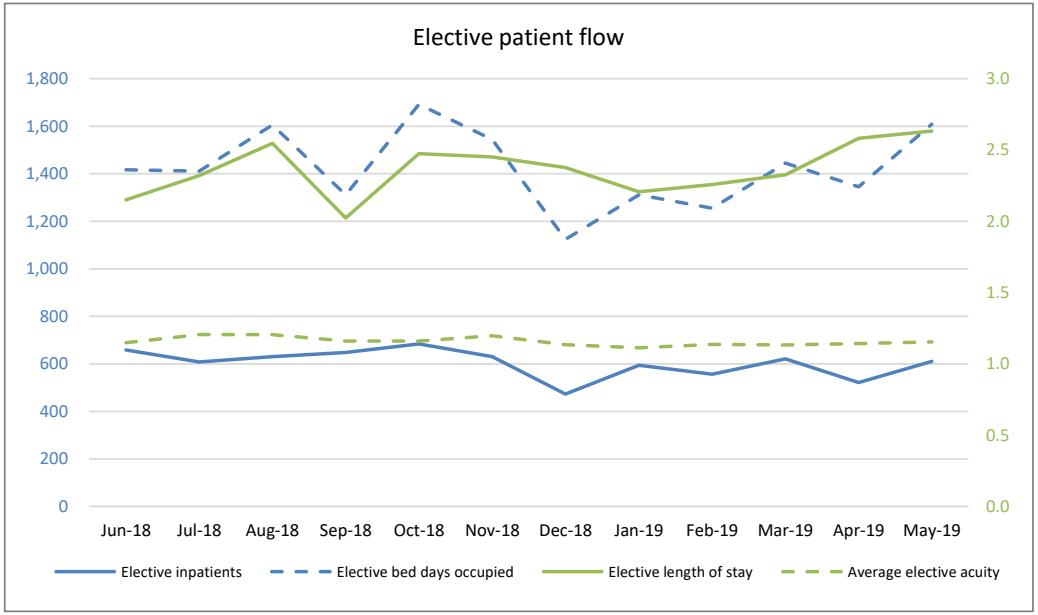
Responsive Services

East and North Hertfordshire NHS Trust

Patient Flow

Domain	Metric	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Trend
ED Flow Indicators	A&E & UCC attendances	12,854	13,268	12,178	12,333	13,297	12,627	12,517	13,690	12,788	14,266	13,440	14,306	
	Attendance to admission conversion rate	22.0%	21.3%	23.5%	23.1%	23.6%	24.9%	24.7%	25.1%	23.6%	23.0%	22.7%	24.2%	
	ED attendances per day	428	428	393	411	429	421	404	442	457	460	448	461	
	AEC attendances per day	43	47	51	47	47	44	45	49	51	49	45	47	
	4-hour target performance %	86.9%	84.2%	84.7%	87.3%	87.8%	90.3%	86.9%	85.2%	80.5%	81.0%	80.5%	81.6%	
	Time to initial assessment 95th centile	54	58	51	53	57	57	59	58	60	75	64	69	
	Ambulance handover breaches 30-minutes	248	511	457	406	491	247	373	516	597	606	480	tbc	

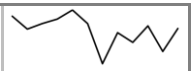
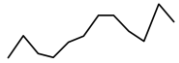
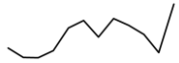
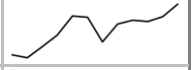




Responsive Services

Patient Flow

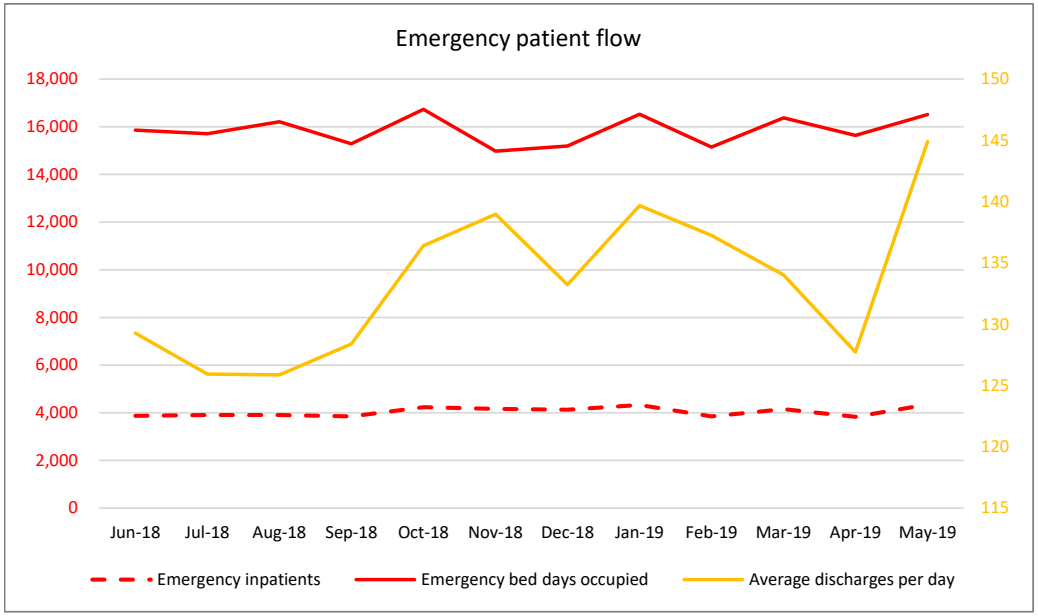
East and North Hertfordshire NHS Trust

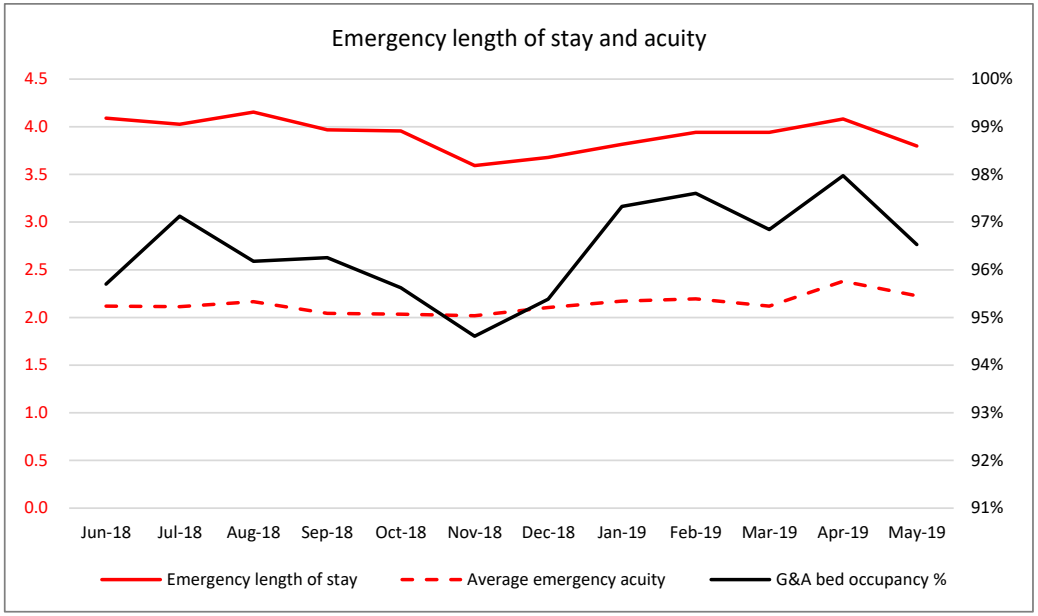
Domain	Metric	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Trend
Elective Inpatient Flow Indicators	Elective inpatients	659	608	630	648	684	630	473	594	556	621	521	611	
	Elective bed days occupied	1,417	1,411	1,605	1,311	1,692	1,544	1,124	1,311	1,255	1,445	1,345	1,609	
	Elective length of stay	2.2	2.3	2.5	2.0	2.5	2.5	2.4	2.2	2.3	2.3	2.6	2.6	
	Daycase rate %	82.8%	84.5%	83.1%	82.8%	84.0%	84.4%	86.0%	86.0%	84.8%	84.0%	86.8%	85.5%	
	Average elective acuity	1.15	1.21	1.20	1.16	1.16	1.20	1.13	1.11	1.14	1.13	1.14	1.15	
Emergency Flow Indicators	Emergency inpatients	3,878	3,904	3,902	3,852	4,229	4,169	4,130	4,330	3,843	4,155	3,832	4,347	
	Average discharges per day	129	126	126	128	136	139	133	140	137	134	128	145	
	Emergency bed days occupied	15,860	15,714	16,209	15,286	16,732	14,979	15,192	16,528	15,146	16,380	15,642	16,517	
	Emergency length of stay	4.1	4.0	4.2	4.0	4.0	3.6	3.7	3.8	3.9	3.9	4.1	3.8	
	Average emergency acuity	2.1	2.1	2.2	2.0	2.0	2.0	2.1	2.2	2.2	2.1	2.4	2.2	
	G&A bed occupancy %	96%	97%	96%	96%	96%	95%	95%	97%	98%	97%	98%	97%	
	Patients discharged via Discharge Lounge	112	106	130	156	198	195	141	180	189	186	197	225	
	Discharges before midday	16.4%	16.2%	15.4%	13.3%	14.7%	14.6%	14.6%	14.7%	14.4%	14.2%	13.5%	13.4%	
	Weekend discharges	16.8%	14.1%	14.6%	17.3%	13.8%	14.8%	17.2%	15.4%	15.7%	16.6%	13.6%	15.5%	
	Proportion of beds occupied by patients with length of stay over 14 days	21.1%	19.9%	20.6%	20.5%	20.1%	17.9%	18.7%	18.5%	19.6%	18.5%	17.3%	18.1%	
	Proportion of beds occupied by patients with length of stay over 21 days	12.3%	11.3%	11.1%	12.0%	10.7%	9.4%	10.0%	9.2%	10.7%	10.1%	9.2%	9.8%	

Responsive Services

East and North Hertfordshire NHS Trust

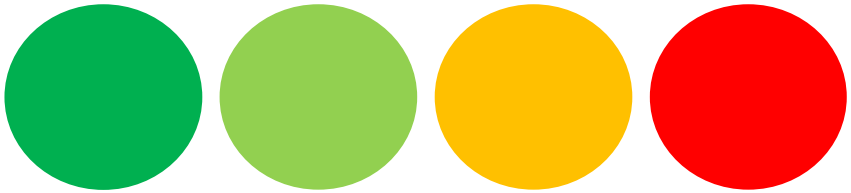
Patient Flow





Well-led Services

Month 02 | 2019-20



Key Issues

Staffing and Pay bill

- The Trust is £1m over the pay budget year to date
- The permanent staff utilised has increased which is a combination of new services (therapies) and improved recruitment and retention.
- Overall staff utilised including bank and agency increase by 104 WTE
- The turnover rate continues to improve and shows a 0.4% improvement compared to the same month the previous year.

Sickness Absence

- Overall sickness absence rate reduced by 0.4% to 3.8%. The target for the year has been adjusted to 3.8% which would bring the Trust in line with the national median.

Training & Development

- Appraisal compliance increased to 84% against a target of 90%.
- 11 out of the 15 mandatory training modules are on target.

Executive Response

Overall temporary staffing demand increased by 6% and flexible workforce fill rate increased by 8% in month 2. This increase occurred despite the number of vacancies reducing. One of the main factors identified is continued requirement for flexible staff while new starters are in their supervisory period. A significant proportion of the new starters were from overseas therefore require an extended training and induction period. Other factors include additional shifts added to drive activity and income, improved fill rates and areas of poor roster management. Weekly meetings are being held with divisions to monitor the staff being utilised against the budget and provide support for mitigating actions. A new application is being developed in QlikView to highlight roster information to support managers recognised outliers and take corrective action. Plans are also in place to run workforce planning master classes to support managers with improved roster management and use of pay budget.

Agency hours increased by 7% and agency expenditure increased by £113k. This meant that the Trust was over the agency ceiling by £91k in month. A significant proportion of the increase in agency (£118k) was in the corporate division for admin roles including operations, PMO and communications. Clinical Support Services also increased (£13k) with the main area being radiology and Surgery increased (£11k) due to operational management. A review of all admin agency will be conducted to ensure plans are in place for substantive appointments.

Medical recruitment is key to reducing the overall pay spend and contributes to a significant proportion of the pay CIPs. The vacancy rate for medical staff in month 2 was 8.8% (77 WTE vacancies), a reduction of 0.4% from month 1. There were 9.8 WTE new starters and 1.0 WTE leavers, giving a positive variance of 8.8 WTE for the month. 2 new Consultants commenced employment in month 1 meaning that 2 expensive agency Consultants have been released, which will positively impact the pay position in month 3.

There are a total of 55 WTE doctors in the pipeline, 29 with confirmed start dates. The focus for medical recruitment includes continuing with the successful recruitment of ED Middle Grades with 2 doctors starting in month 2 and 3 due to start in month 3. Anaesthetics and Stroke Medicine also had starters at middle grade level in their respective areas.

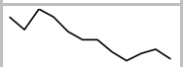
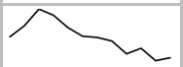
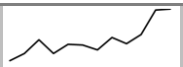
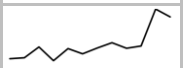
The Finance and Performance Committee (April 2019) approved the strategic priority above to effectively manage sickness absence within the Trust. The Trust is now working to a target of 3.8% over the 12 months which is in line with the national median. The newly formed absence steering group has met and is working through the action plan to ensure effective reporting and monitoring of sickness, revised policy and practical guides and effective transition from absence assist.

Following a deep-dive into appraisal rates and statutory and mandatory training rates which was presented to the FPC in May, the trust has developed a detailed recovery plan to retrieve the position by August. The plan is already underway and has identified the high impact actions required to achieve the target. There is a longer term piece of work commencing to reform the entire system and approach for training and appraisal in the organisation.

Well-led Services

Workforce and Staff Development

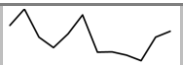
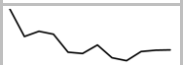
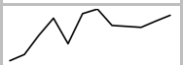
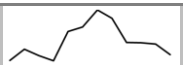
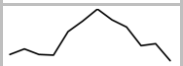
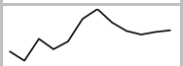
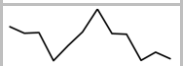
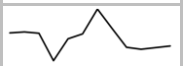
East and North Hertfordshire NHS Trust

Domain	Metric	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Trend	Plan YTD	Actual YTD	Var YTD
Staffing	Approved Budget Establishment WTEs	5,919	5,930	5,916	5,905	5,915	5,912	5,912	5,923	5,927	5,927	6,089	6,074		6,074	6,074	0
	Permanent Staffing WTEs Utilised	5,011	5,016	5,011	5,002	5,052	5,084	5,084	5,077	5,114	5,123	5,185	5,245		5,773	5,245	-528
	Bank Staffing WTEs Utilised	429	467	521	463	508	473	435	485	495	566	482	510		293	510	217
	Agency Staffing WTEs Utilised	137	136	171	140	130	115	99	118	114	114	98	113		8	113	105
	Gap - Budget WTEs & Permanent WTEs	908	914	904	902	864	829	828	845	812	804	904	829		301	830	529
	Gap / Budget WTEs	15.3%	15.4%	15.3%	15.3%	14.6%	14.0%	14.0%	14.3%	13.7%	13.6%	14.8%	13.6%		6.0%	14.2%	8.2%
	Recruitable Vacant Posts	489	461	509	490	460	441	445	413	393	410	427	406		455	406	-49
	Vacancy Rate	8.7%	8.2%	9.0%	8.7%	8.1%	7.8%	7.8%	7.3%	6.9%	7.2%	7.4%	7.0%		7.9%	7.0%	-0.9%
	Turnover Rate	13.6%	13.8%	14.2%	14.1%	13.8%	13.6%	13.5%	13.5%	13.2%	13.3%	13.0%	13.1%		12.0%	13.0%	1.0%
Paybill Metrics	Total Trust Paybill - £m	22.4	22.8	23.4	22.8	23.2	23.2	22.9	23.5	23.2	23.6	24.8	24.8		48.6	49.6	1.0
	Total Permanent Staffing Costs - £m	19.6	19.7	20.1	19.5	20.0	19.8	20.0	20.3	20.0	20.1	21.6	21.3		45.6	42.8	-2.8
	Total Bank Costs - £m	1.9	2.1	2.2	2.3	2.3	2.3	2.0	2.2	2.2	2.5	2.2	2.4		2.2	4.6	2.4
	Total Agency Costs - £m	0.9	1.0	1.1	1.0	0.9	1.0	0.9	1.0	1.0	1.0	1.0	1.1		0.8	2.1	1.3
	Agency Costs as % of Paybill	4.0%	4.6%	4.7%	4.3%	3.8%	4.4%	3.8%	4.3%	4.4%	4.4%	4.1%	4.5%		1.7%	4.3%	3%

Well-led Services

Workforce and Staff Development

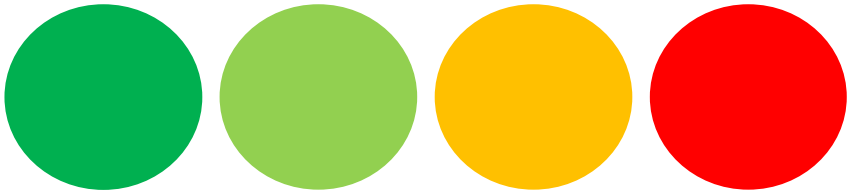
East and North Hertfordshire NHS Trust

Domain	Metric	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Trend	Plan YTD	Actual YTD	Var YTD
Training & Development	Staff Appraised	85%	86%	84%	83%	84%	86%	82%	83%	82%	82%	84%	84%		90%	84%	-6%
	Mandatory Training 100% Compliant	68%	64%	65%	65%	62%	62%	63%	61%	61%	62%	62%	62%		90%	62%	-28%
	Overall Training Compliant	87%	88%	88%	89%	88%	90%	90%	89%	89%	89%	89%	89%		90%	89%	-1%
Sickness	Sickness FTE Days Lost	6,105	6,561	6,299	6,089	7,293	7,477	8,189	7,832	6,845	6,835	6,778	6,346		12,635	13,124	488
	Short term sickness rates %	1.9%	2.1%	2.2%	1.8%	2.2%	2.5%	2.1%	2.4%	2.3%	2.1%	2.2%	1.8%		2.1%	2.0%	-0.1%
	Long term sickness rates %	2.1%	2.0%	1.8%	2.1%	2.3%	2.2%	2.7%	2.4%	2.3%	2.0%	2.0%	2.0%		2.2%	2.0%	-0.2%
	Sickness Rate	4.0%	4.1%	4.0%	4.0%	4.5%	4.8%	5.1%	4.8%	4.6%	4.2%	4.2%	3.8%		3.8%	4.0%	0.2%
	Staff on long term sick headcount	113	119	112	111	124	139	159	121	122	111	109	109		120	218	98
	Maternity % Headcount	2.1%	2.1%	2.2%	2.1%	2.2%	2.4%	2.4%	2.3%	2.3%	2.3%	2.3%	2.3%		2.2%	2.3%	0.1%
	Nursing (Q & U) sickness rate	5.4%	5.3%	5.3%	4.7%	5.0%	5.3%	5.8%	5.3%	5.3%	4.7%	4.9%	4.7%		5.2%	4.8%	-0.4%
	Nursing (Q & U) sickness days lost in month	3,477	3,494	3,471	2,989	3,376	3,461	3,900	3,559	3,226	3,190	3,216	3,244		6,648	6,460	-188

Domain	Metric	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Trend	Plan YTD	Actual YTD	Var YTD
Statutory and Mandatory Training	Conflict Resolution - 2 Years	89%	91%	91%	92%	91%	93%	93%	92%	93%	92%	92%	93%		90%	93%	3%
	Equality & Diversity	91%	91%	92%	92%	91%	91%	92%	93%	91%	91%	92%	92%		90%	92%	2%
	Equality, Diversity and Human Rights	68%	65%	73%	73%	72%	71%	70%	70%	69%	71%	72%	73%		90%	72%	-18%
	Fire Safety	85%	85%	85%	86%	84%	86%	86%	85%	85%	85%	85%	84%		90%	85%	-5%
	Health and Safety	89%	91%	91%	92%	91%	93%	93%	92%	93%	92%	92%	93%		90%	93%	3%
	IPC - Clinical 2 yr	89%	90%	91%	92%	90%	92%	93%	92%	91%	92%	92%	92%		90%	92%	2%
	IPC - Non-Clinical 2 yr	87%	91%	89%	92%	91%	93%	93%	92%	93%	93%	93%	93%		90%	93%	3%
	Data security awareness	78%	74%	75%	74%	71%	70%	71%	68%	71%	72%	73%	73%		90%	73%	-17%
	Moving & Handling for People Handlers	90%	89%	91%	91%	91%	94%	94%	94%	93%	93%	92%	92%		90%	92%	2%
	Moving and Handling	90%	91%	92%	93%	92%	94%	94%	93%	93%	93%	93%	94%		90%	94%	4%
	Safeguarding Adults Level 1	88%	88%	89%	90%	89%	91%	91%	90%	90%	90%	90%	91%		90%	90%	0%
	Safeguarding Adults Level 2	87%	86%	88%	89%	88%	90%	90%	90%	90%	89%	90%	90%		90%	90%	0%
	Safeguarding Children Level 1	89%	90%	92%	93%	92%	94%	94%	93%	93%	92%	92%	93%		90%	93%	3%
	Safeguarding Children Level 2	89%	89%	92%	93%	92%	94%	93%	93%	92%	92%	92%	92%		90%	92%	2%
	Safeguarding Children Level 3	88%	85%	87%	89%	89%	88%	90%	88%	88%	87%	87%	88%		90%	88%	-2%

Sustainable Services

Month 02 | 2019-20



Key Issues

- The Trust's reported position at Month 2 is a deficit of £2.8m. Exclusive of donated asset and profit on land sale impacts the reported deficit is £3.4m. This remains in alignment with the agreed control total plan for 19/20.
- This reported M2 deficit includes the expected receipt of PSF & FRF performance incentive funds totalling £1.6m. Payment of these funds is confirmed by NHSI on a quarterly basis upon the achievement of underlying financial achievement targets. Based upon M2 results the Trust presently envisages full receipt of these funds in Q1 and across the financial year.
- At M2 the Trust reports an over achievement (£1.4m) against SLA contracts with its commissioners. This represents an in month over achievement of £1.0m. However, of this monthly position £0.7m pertains to the refresh of the M1 period, reflecting relatively high levels of uncoded activity at the April reporting point.
- The majority of the YTD income overachievement is driven by above plan volumes of emergency activity undertaken, particularly in May. The 19/20 SLA contract for emergency activity incorporates a blended payments mechanism that applies marginal rates to over or under performance within agreed bands. Reported M2 performance is after the application of these rules.
- Maternity and Paediatric Critical Care activity levels improved in May and matched plan. This represents a reversal of consistent downward trends over extended periods, as such performance will be closely monitored over coming months to determine the sustainability of this improvement.
- Pay budgets at M2 report a significant overspend of £0.9m. The key component pertains to medical staffing budgets which are overspent by £0.5m. Whilst an element of this (£0.15m) relates to recently confirmed backdated national pay awards, the bulk is driven by two separate issues (1) the use of above plan levels of WLIs in Surgery to deliver the 19/20 activity plan as opposed to planned levels of theatre and outpatient efficiency and (2) significant breakdowns in the medical workforce control environment specifically within Surgery.
- The pay position has been further compounded by significant in month overspends against nursing budgets, particularly in relation to increased temp staffing use across medical and surgical wards. This is unrelated to activity levels, as increased M2 emergency admissions were accommodated within the same bed day base as April. Whilst increased sickness absence in May partially contributed to the position, it is acknowledged that the majority of the overspend was driven by significant lapses in nursing workforce planning and control.
- Staff used by the Trust to deliver services has increased significantly year on year. An additional 166 WTE's were used in May 19 compared with 12 months earlier (excluding the impact of Therapies).
- In the YTD the Trust delivered total CIP's of £2.0m. Whilst high by historical standards this was nevertheless £526k less than planned. The overwhelming majority of this slippage related to the non-achievement of planned theatre and outpatient savings targets.

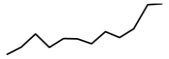
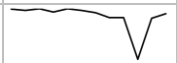
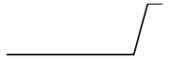
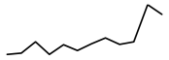
Executive Response

- The Month 2 finance performance represents a significant concern for the Trust. The income over performance in M2 largely relates to a refresh of the M1 period. The significant overspent against pay budgets is largely unrelated to activity and pertains to a combination of slippage against clinical productivity targets and weaknesses in the management of medical and nursing temporary staffing costs. This underlying position is not sustainable and requires immediate redress.
- The Trust Executive have reintroduced weekly IFD oversight groups for both Medical Staffing and Nursing Management. These groups lapsed at the conclusion of the last financial year, there reinstatement has been identified as key in maintaining oversight and management of the control environment. The groups will be led by Executive Directors and will implement agreed improvement plans for these staffing areas.
- The Trust continues to maintain a weekly programme of 'Improving Financial Delivery' (IFD) meetings with each division. These meetings are chaired by either the DoF and / or PMO Director.
- The emphasis of these meetings has been refreshed as we enter into a new financial year. These sessions with focus upon (1) improvement of workforce productivity metrics, (2) monitoring of CIP delivery and also the identification of (3) other remedial financial issues.
- The strong emphasise upon workforce issues within IFD sessions, such as the review of vacancies, the monitoring of temp staffing levels and tracking the progress made by divisions against recruitment and retention targets, represents a response to recent 'Paybill Deep Dive' analysis undertaken by the Finance Committee. This identified a need to improve control and action mechanisms in relation to the management of paybill costs. The alarming M2 pay budget performance re-emphasises the need for this focus.
- The Trust continues to expand the scope and sophistication of its BI universe at pace to support the need to supply relevant, timely and accurate data to clinicians and managers to enable more effective decision making and plan delivery. Furthermore, the Trust continues to undertake monthly Accountability Review Meetings (ARM) with division to support improved performance. These meeting contain review of finance delivery and CIP achievement.
- The Trust continues to maintain 'Model Hospital' project working groups, to drive progress across a number of other key clinical processes - i.e. Theatres, Outpatients, Consultant Job Planning as well as Inpatient Flow. The success and achievements of these groups has been extremely variable.
- The Trust also continues to schedule a weekly series of Performance & Activity Meetings (PAM) meetings. Composed of key corporate and operational managers PAM meets to review and track SLA activity delivery and performance against both plan and forecast and agrees remedial action where required.
- The Trust PMO function remains embedded in terms of supporting divisional CIP projects, IFD meetings and activities as well as helping divisions to deliver improvements across key process themes.

Sustainable Services

Finance Plan Performance

East and North Hertfordshire NHS Trust

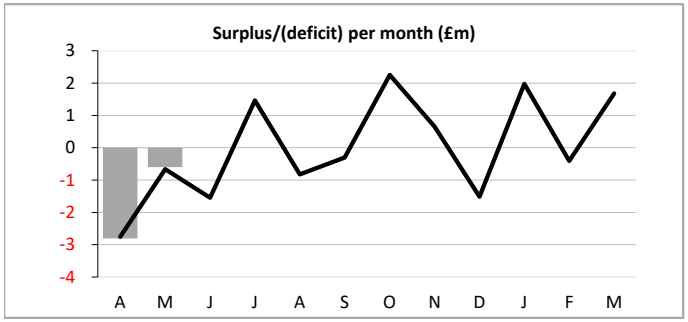
Domain	Metric	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Trend	Plan YTD	Actual YTD	Variance YTD
I&E Performance	SLA Income Earned	32.6	32.4	33.7	31.8	34.4	33.4	30.4	33.7	30.4	33.3	32.7	35.3		66.3	68.0	1.7
	Other Income Earned	4.3	4.8	5.4	4.8	5.0	5.3	5.1	5.4	4.8	-6.8	3.5	3.7		7.8	7.2	-0.6
	Pay Costs	22.4	22.8	23.4	22.8	23.2	23.2	22.9	23.5	23.2	23.6	24.8	24.8		48.6	49.6	1.0
	Non Pay Costs inc Financing	17.0	16.5	17.0	16.1	17.1	16.6	15.9	14.6	14.6	2.8	14.4	15.7		30.6	30.1	-0.5
	Underlying Surplus / (Deficit)	-2.5	-2.1	-1.3	-2.3	-0.9	-1.1	-3.3	1.0	-2.7	0.0	-3.0	-1.5		-5.1	-4.5	0.6
	PSF Earned	0.1	0.7	0.7	0.7	0.0	0.0	0.0	0.0	0.0	5.9	0.4	0.4		0.7	0.7	0.0
	FRF Received	-	-	-	-	-	-	-	-	-	-	0.5	0.5		0.9	0.9	0.0
	Retained Surplus / Deficit	-2.5	-1.4	-0.6	-1.6	-0.9	-1.1	-3.3	1.0	-2.7	6.0	-2.2	-0.6		-3.5	-2.8	0.6
Paybill Metrics	Substantive Pay Costs	19.3	19.3	19.8	19.3	19.6	19.4	19.7	19.9	19.7	19.8	21.2	20.8		45.2	42.0	-3.2
	Premium Pay Costs Overtime & WLI	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.3	0.4	0.4	0.4	0.5		0.5	0.9	0.4
	Premium Pay Costs Bank Costs	1.9	2.1	2.2	2.3	2.3	2.3	2.0	2.2	2.2	2.5	2.2	2.4		2.2	4.6	2.4
	Premium Pay Costs Agency Costs	0.9	1.0	1.1	1.0	0.9	1.0	0.9	1.0	1.0	1.0	1.0	1.1		0.8	2.1	1.3
	Premium Pay Costs As % of Paybill	14.1%	15.1%	15.6%	15.3%	15.3%	16.1%	14.1%	15.3%	15.3%	16.4%	14.5%	16.2%		7.1%	15.4%	8.3%

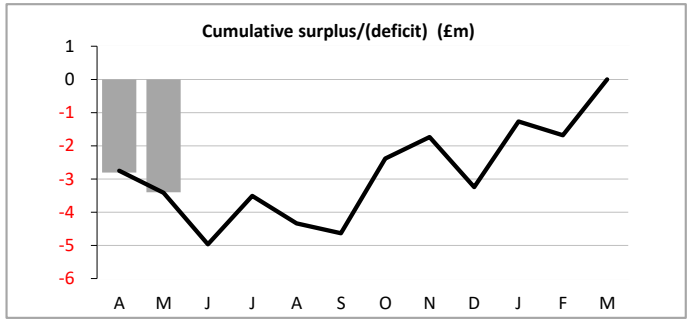
Sustainable Services

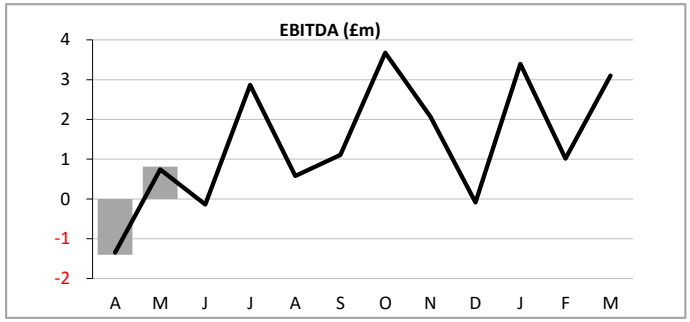
Finance Plan Performance

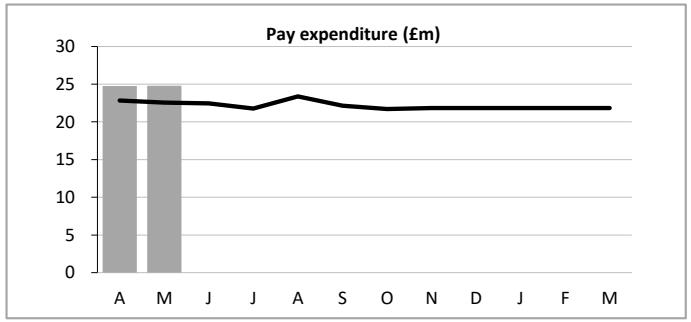
East and North Hertfordshire NHS Trust

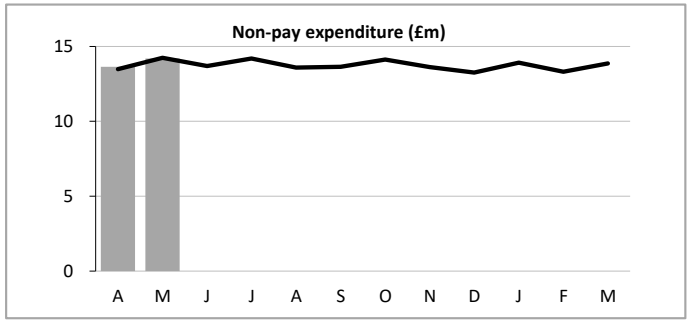
Domain	Metric	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Trend	Plan YTD	Actual YTD	Variance YTD
Single Oversight Framework	Capital Servicing Capacity	4	4	4	4	4	4	4	4	4	4	4	4		1	4	
	Liquid Ratio (Days)	4	4	4	4	4	4	4	4	4	4	4	4		1	4	
	I&E Margin	4	4	4	4	4	4	4	4	4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











Sustainable Services

SLA Contracts - Income Performance

East and North Hertfordshire NHS Trust

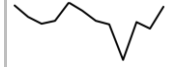
		In-Month			YTD		
		Planned Income	Actual Income	Income Variance	Planned Income	Actual Income	Income Variance
By Point of Delivery	A&E Attendances	2,161	2,351	190	4,251	4,556	305
	Daycases	2,798	2,861	63	5,256	5,626	370
	Inpatient Elective	2,158	2,025	-133	4,054	3,792	-262
	Inpatient Non Elective	8,469	9,154	685	16,654	18,087	1,433
	Maternity	2,296	2,546	250	4,512	4,837	326
	Other	4,702	4,207	-496	9,228	8,393	-835
	Outpatient First	2,038	2,144	106	3,882	4,136	254
	Outpatient Follow Ups	2,272	2,137	-135	4,328	4,180	-148
	Outpatient Procedures	1,181	1,029	-152	2,249	2,237	-12
	Other SLAs	57	57	0	115	115	0
	Block	845	838	-7	1,686	1,672	-13
	Drugs & Devices	3,516	3,633	117	6,865	6,968	103
	Chemotherapy Delivery	549	518	-31	1,071	1,055	-16
	Renal Dialysis	1,175	1,109	-66	2,306	2,187	-119
	Total	34,216	34,608	391	66,456	67,842	1,386

		In-Month			YTD		
		Planned Income	Actual Income	Income Variance	Planned Income	Actual Income	Income Variance
By Commissioner	East & North Herts CCG	20,328	21,124	796	39,453	41,622	2,170
	Specialist Commissioning	7,821	7,823	2	15,239	15,243	5
	Bedfordshire CCG	2,346	2,482	136	4,551	4,811	259
	Herts Valleys CCG	1,381	1,270	-111	2,683	2,419	-264
	Cancer Drugs Fund	444	409	-35	866	784	-83
	Luton CCG	306	307	2	591	582	-9
	PH - Screening	295	355	60	566	674	108
	Other	1,296	838	-426	2,507	1,707	-2,651
By Division	Cancer Services	6,322	6,004	-317	12,306	12,021	-285
	Medicine	10,987	11,106	119	21,484	22,370	886
	Women & Children	4,745	4,965	220	9,283	9,408	125
	Clinical Services	2,046	2,102	57	3,991	4,110	119
	Surgery	10,228	10,138	-90	19,615	20,065	449
	Other	-111	292	402	-224	-132	91

Sustainable Services

Activity and Productivity

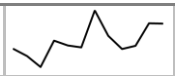
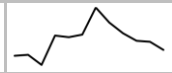
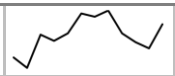
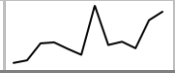
East and North Hertfordshire NHS Trust

Domain	Metric	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Trend	Plan YTD	Actual YTD	Var YTD
Patient Activity Levels	A&E & UCC	12,854	13,268	12,178	12,333	13,296	12,622	12,516	12,876	12,086	13,475	12,681	13,521		24,845	26,201	1,356
	Chemotherapy Atts	2,103	2,279	2,306	2,072	2,349	2,335	2,083	2,296	2,001	1,983	1,918	2,183		4,394	4,416	22
	Critical Care (Adult) - OBD's	665	554	636	491	839	569	566	729	464	577	729	586		1,110	1,127	17
	Critical Care (Paeds) - OBD's	511	531	602	505	589	404	486	398	379	442	418	622		1,104	1,042	-62
	Daycases	3,178	3,302	3,106	3,130	3,581	3,415	2,896	3,638	3,102	3,269	3,466	3,600		6,422	7,032	610
	Elective Inpatients	659	608	630	648	684	630	473	594	556	621	559	611		1,281	1,132	-149
	Emergency Inpatients	3,878	3,904	3,902	3,852	4,229	4,169	4,130	4,330	3,843	4,155	3,733	4,347		7,632	8,179	547
	Home Dialysis	146	172	164	163	182	175	186	195	163	178	176	173		328	350	22
	Hospital Dialysis	5,926	5,943	6,408	5,862	6,319	6,147	6,481	6,171	5,751	6,156	5,984	6,159		12,537	12,142	-395
	Maternity Births	473	454	442	447	478	464	447	441	381	445	434	471		922	905	-17
	Maternity Bookings	533	497	530	466	533	532	432	541	467	469	466	537		1,010	1,008	-2
	Outpatient First	8,640	9,342	8,562	8,932	10,324	9,662	7,733	9,289	8,293	9,261	9,128	9,184		16,057	17,713	1,656
	Outpatient Follow Up	17,155	18,311	18,336	17,219	20,360	19,161	14,070	19,489	17,002	17,277	17,335	17,164		35,581	33,563	-2,018
	Outpatient procedures	6,549	6,323	6,084	6,454	6,645	7,156	6,297	8,397	7,539	7,207	5,598	6,568		12,824	14,299	1,475
	Radiotherapy Fractions	4,802	4,833	4,921	4,566	5,125	5,273	4,381	5,286	4,773	5,048	5,023	4,902		9,305	9,925	620

Sustainable Services

Activity and Productivity

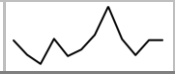
East and North Hertfordshire NHS Trust

Domain	Metric	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Trend	Plan YTD	Actual YTD	Var YTD
Throuhput	Elective Spells per Working Day	183	178	170	189	185	184	211	192	183	185	201	201		188	199	11
	Emergency Spells per Day	117	115	114	118	125	128	123	129	127	125	122	136		125	134	9
	ED Attendances per Day	428	428	393	411	429	421	404	415	432	435	423	436		407	430	22
	Outpatient Atts per Working Day	1,540	1,544	1,499	1,630	1,623	1,635	1,756	1,690	1,642	1,607	1,603	1,567		1,572	1,599	27
	Elective Bed Days Used	1,417	1,411	1,605	1,311	1,692	1,544	1,124	1,311	1,255	1,445	1,470	1,609		3,062	2,954	-108
	Emergency bed Days Used	15,860	15,714	16,209	15,286	16,732	14,979	15,192	16,528	15,146	16,380	15,871	16,517		32,268	32,159	-109
Efficiency	Admission Rate from A&E	22%	21%	24%	23%	24%	25%	25%	25%	24%	23%	23%	24%		23.3%	23.5%	0.1%
	Emergency - Length of Stay	4.1	4.0	4.2	4.0	4.0	3.6	3.7	3.8	3.9	3.9	4.3	3.8		4.2	4.0	-0.3
	Emergency - Casemix Value	2,119	2,114	2,166	2,043	2,033	2,018	2,103	2,170	2,194	2,119	2,252	2,227		2,221	2,304	83
	Elective - Length of Stay	2.2	2.3	2.5	2.0	2.5	2.5	2.4	2.2	2.3	2.3	2.6	2.6		2.5	2.6	0.2
	Elective - Casemix Value	1,148	1,205	1,205	1,160	1,161	1,197	1,134	1,113	1,137	1,132	1,132	1,154		1,202	1,148	-54
	Elective Surgical DC Rate %	82.8%	84.5%	83.1%	82.8%	84.0%	84.4%	86.0%	86.0%	84.8%	84.0%	86.1%	85.5%		85%	86.2%	1.2%
	Outpatient DNA Rate % - 1st	12.4%	12.2%	12.1%	12.5%	12.0%	11.9%	12.8%	12.4%	12.5%	11.6%	11.8%	11.8%		12.6%	12.0%	-0.6%
	Outpatient DNA Rate % - FUP	9.0%	8.9%	8.5%	8.6%	7.5%	7.7%	8.2%	7.6%	7.1%	7.1%	7.4%	7.8%		8.5%	7.9%	-0.6%
	Outpatient Cancel Rate % - Patient	9.2%	9.2%	9.6%	9.6%	9.4%	9.3%	10.3%	9.5%	9.6%	9.5%	10.0%	10.2%		9.3%	10.2%	0.9%

Sustainable Services

Activity and Productivity

East and North Hertfordshire NHS Trust

Domain	Metric	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Trend	Plan YTD	Actual YTD	Var YTD
Efficiency	Outpatient Cancel Rate % - Hosp	6.6%	5.8%	5.9%	6.0%	6.6%	6.4%	6.7%	6.1%	6.3%	6.4%	6.2%	6.3%		6.3%	6.4%	0.1%
	Outpatients - 1st to FUP Ratio	2.0	2.0	2.1	1.9	2.0	2.0	1.8	2.1	2.1	1.9	1.9	1.9		2.2	1.9	-0.3
	Theatres - Ave Cases Per Hour	2.8	2.7	2.8	2.9	2.8	2.6	2.9	2.7	2.7	2.8	2.7	2.7		2.9	2.7	-0.2
	Theatres - Utilisation of Sessions	78%	81%	80%	79%	82%	81%	78%	76%	78%	80%	78%	78%		85%	78%	-7%
	Theatres - Ave Late Start (mins)	30	30	27	29	28	28	26	25	23	25	23	23		27	23	-3.7
	Theatres - Ave Early Finishes (mins)	40	37	35	40	36	38	41	47	40	37	40	40		39	40	0.1

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	0	0	0	0	0	0	0	0		1,627	220	6	-214
	Outpatients	4	4	0	0	0	0	0	0	0	0	0	0		863	144	7	-137
	Procurement	442	231	0	0	0	0	0	0	0	0	0	0		3,120	737	673	-64
	Divisional Non Pay schemes	102	106	0	0	0	0	0	0	0	0	0	0		1,616	216	208	-7
	DQ, Coding & Income	0	0	0	0	0	0	0	0	0	0	0	0		1,656	28	0	-28
	Corporate	144	119	0	0	0	0	0	0	0	0	0	0		1,139	281	263	-17
	Demand Management	43	64	0	0	0	0	0	0	0	0	0	0		1,410	117	107	-10
	Workforce Temporary Staff reduction	83	44	0	0	0	0	0	0	0	0	0	0		1,099	161	127	-34
	Divisional Pay schemes	254	257	0	0	0	0	0	0	0	0	0	0		1,952	507	511	4
	Workforce transformation schemes	-10	-16	0	0	0	0	0	0	0	0	0	0		1,015	3	-26	-29
	Divisional Income capture & coding	28	23	0	0	0	0	0	0	0	0	0	0		566	63	51	-12
	Patient Flow	0	0	0	0	0	0	0	0	0	0	0	0		463	0	0	0
	Divisional Local Income schemes	24	51	0	0	0	0	0	0	0	0	0	0		461	55	76	20
	Over/Unidentified	0	0	0	0	0	0	0	0	0	0	0	0		-1,987	0	0	0
	Total CIP Delivery	**1,120**	**884**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**15,000**	**2,530**	**2,004**	**-526**

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	0	0	0	0	0	0	0	0	0	0		14,726	1,518	1,008	-511
	Non-Recurrent	652	344	0	0	0	0	0	0	0	0	0	0		2,261	1,012	997	-16
	Over/Unidentified	0	0	0	0	0	0	0	0	0	0	0	0		-1,987	0	0	0
	Total CIP Delivery	**1,120**	**885**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**15,000**	**2,530**	**2,004**	**-526**
CIP Delivery by Division	Cancer Services	164	193	0	0	0	0	0	0	0	0	0	0		1,652	355	358	3
	Clinical Support	93	95	0	0	0	0	0	0	0	0	0	0		2,606	269	188	-81
	Corporate	582	286	0	0	0	0	0	0	0	0	0	0		3,872	895	868	-27
	Medicine	79	101	0	0	0	0	0	0	0	0	0	0		3,043	194	180	-14
	Surgery	127	141	0	0	0	0	0	0	0	0	0	0		4,649	620	268	-352
	Women's & Children's	74	69	0	0	0	0	0	0	0	0	0	0		1,164	197	143	-54
	Over/Unidentified	0	0	0	0	0	0	0	0	0	0	0	0		-1,986	0	0	0
	Total CIP Delivery	**1,120**	**884**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**15,000**	**2,530**	**2,004**	**-526**

Sustainable Services

East and North Hertfordshire NHS Trust

Cost Improvement Plan (CIP) Delivery

Domain	Metric	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Trend	Annual Plan	Plan YTD	Actual YTD	Variance YTD
CIP Delivery by Type	Income (other operating income)	33	55	0	0	0	0	0	0	0	0	0	0		701	76	88	13
	Income (patient care activities)	23	23	0	0	0	0	0	0	0	0	0	0		2,338	78	46	-32
	Non-Pay	732	456	0	0	0	0	0	0	0	0	0	0		7,003	1,288	1,188	-99
	Pay (skillmix)	155	148	0	0	0	0	0	0	0	0	0	0		5,352	674	303	-371
	Pay (WTE reductions)	177	201	0	0	0	0	0	0	0	0	0	0		1,592	415	379	-36
	Over/Unidentified	0	0	0	0	0	0	0	0	0	0	0	0		-1,985	0	0	0
	Total CIP Delivery	**1,120**	**884**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**15,000**	**2,530**	**2,004**	**-539**

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	25,488	26,201	713
Emergency Department Ave Daily Atts	418	430	12
Admission Rate from ED %	22.9%	23.5%	1%
Non Elective Inpatient Spells	7,734	8,179	445
Ave Daily Non Elective Spells	127	134	7
Daycase Spells	6,292	7,032	740
Elective Inpatient Spells	1,234	1,132	-102
Ave Daily Planned Spells	123	134	10
Day Case Rate	84%	86%	3%
Adult & Paeds Critical Care Bed Days	2,013	2,169	156
Outpatient First Attendances	17,171	17,713	542
Outpatient Follow Up Attendances	34,345	33,563	-782
Outpatient First to Follow Up Ratio	2.0	1.9	-0.1
Outpatient Procedures	12,755	14,299	1,544
Ave Daily Outpatient Attendances	1,054	1,075	21

Workforce Measures	2018-19 YTD	2019-20 YTD	Change
Average Monthly WTE's Utilised	5,600	5,817	217
Average YTD Pay Cost per WTE	8,173	8,523	4.3%
Staff Turnover	13.5%	13.0%	-0.4%
Vacancy WTE's	864	829	-34
Vacancy Rate	14.7%	14.2%	-0.4%
Sickness Days Lost	12,183	13,124	940
Sickness Rate	4.0%	4.0%	0.0%
Agency Spend- £m's	2.2	2.1	-0.1
Temp Spend as % of Pay Costs	4.8%	4.3%	-0.5%
Ave Monthly Consultant WTE's Worked	301.4	324.0	22.6
Consultant : Junior Training Doctor Ratio	1 : 1.7	1 : 1.7	0.0
Ave Monthly Nursing & CSW WTE's Worked	2,404.3	2,453.6	49.3
Qual : Unqualified Staff Ratio	68 : 25	64 : 25	-0.2
Ave Monthly A&C and Senior Managers WTE's	1,218	1,279	61
A&C and Senior Managers % of Total WTE's	21.7%	22.0%	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	4.2	4.0	-0.3
Elective LoS	2.5	2.6	0.2
Occupied Bed Days	35,330	35,113	-217
Adult Critical Care Bed Days	964	1,127	163
Paediatric Critical Care Bed Days	1,049	1,042	-7
Outpatient DNA Rate	11%	8%	-2.6%
Outpatient Utilisation Rate	28%	27%	-1.2%
Total Cancellations	18,750	21,731	2,981
Theatres - Ave Cases per Hour	2.8	2.7	-0.1
Theatres - Ave Session Utilisation	81%	78%	-3.0%
Theatres - Ave Late Start (mins)	32	23	-9
Theatres - Ave Early Finishes (mins)	40.4	39.5	-1
Radiology Examinations	69,312	68,176	-1,136
Drug Expenditure (excl HCD & ENH Pharma) - £000s	1,823	1,641	-182
High Cost Drug Expenditure - £000s	6,222	6,458	236

Finance & Quality Measures	2018-19 YTD	2018-19 YTD	Change
Profitability - £000s	-6.0	-2.8	3.2
Monthly SLA Income £000s	31,258	33,997	2,739
Monthly Clinical Income per Consultant WTE	£103,697	£104,931	£1,234
High Cost Drug Spend per Consultant WTE	£20,640	£19,931	-£709
Average Income per Elective Spell	£1,165	£1,148	-£17
Average Income per Non Elective Spell	£2,051	£2,304	£253
Average Income per ED attendance	£171	£174	£3
Average Income per Outpatient Attendance	£132	£139	£6
Ave NEL Coding Depth per Spell	n/a	n/a	n/a
Procedures Not Carried Out	322	359	37
Best Practice HRGs (% of all Spells)	9.8%	1.2%	-8.6%
Ambulatory Best Practice (% of Short Stays)	n/a	n/a	n/a
Non-elective re-admissions within 30 days Rolling 12-months to Nov-18	6,064	6,821	757
Non-elective re-admissions within 30 days % Rolling 12-months to Nov-18	7.14%	8.04%	0.90%
SLA Contract Fines - £000's	100	10	-90

Division	Not started	In progress	Passed	Total	%
ALL	3	1	1	5	20%
CANCER	77	5	22	104	21%
CSS	56	5	43	104	41%
MEDICINE	253	24	37	314	12%
SURGICAL	171	8	45	224	20%
W&C	117	6	50	173	29%
DATA QUALITY/CODING	5	1	2	8	25%
PMO	20	2	26	48	54%
WORKFORCE	15		6	21	29%
PERF MGT	1		2	3	67%
NURSING PRACTICE	10	1	2	13	15%
FACILITIES	10	2	4	16	25%
TRUST MGT	3			3	0%
FINANCE	209	18	97	324	30%
FINANCE - INFORMATION	2		3	5	60%
FINANCE - IT		2	3	5	60%
Total	**952**	**75**	**343**	**1,370**	**25%**

East and North Hertfordshire NHS Trust

Agenda Item: 9.2 (a)

TRUST BOARD - PUBLIC SESSION – 3 JULY 2019
FINANCE AND PERFORMANCE COMMITTEE – 22 MAY 2019
EXECUTIVE SUMMARY REPORT

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

To present to the Trust Board the summary report from the Finance and Performance Committee (FPC) meeting of 22 May 2019.

The report includes details of any decisions made by the FPC under delegated authority.

Action required: For discussion

Previously considered by:
N/A

Director:	**Presented by:**	**Author:**
Chair of FPC	Chair of FPC	Trust Secretary

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
The discussions at the meetings reflect the BAF risks assigned to the FPC.

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

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

FINANCE AND PERFORMANCE COMMITTEE – 22 MAY 2019

EXECUTIVE SUMMARY REPORT TO TRUST BOARD – 3 JULY 2019

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

The following core attendees were present:
Nick Carver (Chief Executive), Jude Archer (Associate Director of Corporate Governance), Martin Armstrong (Director of Finance), Julie Smith (Chief Operating Officer) and Susan Young (Interim Chief People Officer)

DECISIONS MADE UNDER DELEGATED AUTHORITY:

No decisions were made under delegated authority.

OTHER MATTERS CONSIDERED BY THE COMMITTEE:

BOARD ASSURANCE FRAMEWORK
The Committee was presented with the latest Board Assurance Framework. The Committee noted the strategic risks presented on the new framework for 2019/20 with the revised strategic risks, as approved by the Board in May 2019.

DEEP DIVE METHODOLOGY REVIEW
The FPC discussed a review of the methodology for the Divisional deep dives. It was agreed that it was important to ensure enough time was set aside at the meetings to fully consider the deep dives and that the presentations should have relevant executive director input prior to the meeting.

INTEGRATED PERFORMANCE REPORT
The Committee received the latest Integrated Performance Report, covering Month 1. The Committee received the following updates:

Responsive Services:

- The 4-hour Emergency Department target remains a challenge due to attendance at Emergency Department remaining high at the moment.
- The year-end position was 85.85%, an increase of 2.2% compared to last year.
- Referral to treatment (RTT) performance remains in a strong position.
- Diagnostics performance saw a slight deterioration last month but was still performing well against the national average.
- Cancer - The Trust delivered 5 out of the 8 compliance standards.
- Radiotherapy – The Chief Operating Officer had met with the Linac manufacturer and had agreed a technical upgrade for 12 months pending final decision by the Trust.

Well-led Services:

- It was reported that the vacancy rate had increased slightly.
- The sickness absence rate was at 4.2%
- The turnover continues to improve and showed a 0.5% improvement compared to Month 1 of 2018.

Sustainable Services:

- The financial performance was broadly on plan at Month 1.
- It was noted that delivering theatre efficiency will be key over the year.

- Activity was slightly over plan in Month 1.

WINTER INITIATIVE ASSESSMENT
The Committee received a report on the initiatives that were put in place in the winter of 2018/19 to ensure that flow was maintained during the winter. The paper highlighted the schemes that required a funding solution to enable capacity benefits for the Trust to continue. The paper had been considered by the Executive Committee and a way forward agreed.

CIP PERFORMANCE ANALYSIS AND UPDATE
The Committee received a report on CIP performance. The PMO Director updated the committee on progress in terms of CIP developments in general and in relation to a number of initiatives the team was working on currently. Theatre initiatives were still a challenge in part due to the scale of the work. It was noted that there would be a presentation on the theatres programme at the next meeting . The FPC concluded that this could be an area where regular updates would be beneficial.

COSTING SUBMISSION.
The Committee also reviewed the costing plan and supporting information provided to ensure that the Trust meets the expected requirements as per National Cost Collection Guidance and Healthcare Costing Standards for England. The Committee approved the costing plan and processes.

PAYBILL DEEP DIVE UPDATE
The Director of Finance updated the Committee on actions taking place regarding the pay – bill. It was noted that a workforce plan for 2019/20 was due to be considered at the next meeting. The Committee asked to be kept updated on the work taking place regarding medical staffing.

DIGITAL PROGRAMME UPDATE
The Committee received an update on the Trust's digital programme. The Chief information Officer updated the Committee on the Lorenzo stabilisation process that was now coming to an end and moving to the next stage. The FPC endorsed the completion of the stabilisation process post 31 May 2019.

The Chief Information Officer also presented a paper regarding a proposed governance system for the digital programme. He proposed a three tier system reporting into the QSC and FPC meetings. Subject to some minor amendments to the terms of reference, the Committee approved the proposal.

IMPROVING WELL BEING STRATEGY
The Committee considered a strategy for approval from the workforce team on improving staff wellbeing. The paper proposed an in-house mental health support system to improve staff mental wellbeing. It also proposed access to physiotherapy treatment within their locality to help reduce sickness absence. The Committee requested that a robust communication and engagement strategy be put in place and milestones developed. Subject to these amendments, the FPC approved the strategy.

INFLUENZA VACCINE UPDATE
The Committee considered a report on the lessons learnt from the staff influenza vaccine campaign 2018-19. Performance in 2018-19 had been disappointing. The Committee discussed how performance could be improved for the next campaign and the key role communication would play. The Committee endorsed the paper subject to strengthening the recommendations in particular those relating to communications.

STAFF APPRAISAL UPDATE
The Committee was presented with an update on staff appraisal performance. The Deputy Director of Workforce and OD reported that appraisal rate had been below target, but there were improvement plans in place to improve compliance. The Committee requested further updates on current and future plans regarding appraisals.

STATUTORY AND MANDATORY TRAINNING UPDATE
The Director of Nursing provided a report regarding statutory and mandatory training. Overall compliance as of March 2019 was 88.9%. She highlighted some of the challenges regarding training and the key priorities for the team. It was agreed that a proposal regarding actions to improve compliance would be provided for the next meeting.

EQUALITY, DIVERSITY AND INCLUSION ACTION PLAN
The Committee considered an action plan regarding equality, diversity and inclusion. The Committee approved the action plan.

EMPLOYEE RELATIONS STRATEGY
The Committee considered and welcomed the action plan requested at the previous meeting relating to the employee relations strategy.

STAFF SURVEY
The Committee considered and noted an action plan regarding the staff survey results. The team reported that work is ongoing across divisions in response to the feedback from the staff survey.

OD TEAM ANNUAL REPORT
The Committee received an update regarding operational development. It was reported that the team had a successful year with an increase in coaching and mentoring and programmes being well evaluated. The Committee requested a more forward looking report regarding organisational development for a future meeting.

INTERNATIONAL RECRUITMENT
The Committee received a paper regarding the Trust's plan relating to international staff recruitment. The Executive Committee had agreed some international recruitment would be needed but it was also the intention to improve home recruitment and retention rates. The FPC noted the report and that it would be helpful to set this paper in the context of a Workforce Plan at a future meeting.

Karen McConnell
Finance and Performance Committee Chair

May 2019

East and North Hertfordshire NHS Trust

Agenda Item: 9.2 (b)

TRUST BOARD - PUBLIC SESSION – 3 JULY 2019
FINANCE AND PERFORMANCE COMMITTEE – 26 JUNE 2019
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present to the Trust Board the summary report from the Finance and Performance Committee (FPC) meeting of 26 June 2019. The report includes details of any decisions made by the FPC under delegated authority.		
Action required: For discussion		
Previously considered by: N/A		
Director: Director of Finance / Chief Operating Officer / Chief People Officer	**Presented by:** Chair of FPC	**Author:** Board Committee Secretary / Trust Secretary

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

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

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

FINANCE AND PERFORMANCE COMMITTEE – 26 JUNE 2019

EXECUTIVE SUMMARY REPORT TO TRUST BOARD – 3 JULY 2019

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

The following core attendees were present:
Nick Carver (Chief Executive), Martin Armstrong (Director of Finance), Michael Chilvers (Medical Director), Rachael Corser (Director of Nursing), Chin Okunuga (Deputy Chief Operating Officer), Tom Pounds (Deputy Director of Workforce and OD).

OTHER MATTERS CONSIDERED BY THE COMMITTEE:

DEEP DIVE – THEATRES TRANSFORMATION PROGRAMME
The FPC received a deep dive presentation on the theatres transformation programme. The intention of the deep dive was to provide a detailed analysis of the overall performance of the theatres, its culture, effectiveness, productivity and quality. The Committee discussed performance targets and the work plans that were in place to deliver the improvements. Key areas of focus for the team were avoiding Never Events and reducing late starts and DNAs. The Committee also noted the importance of staff culture in delivering the improvements that were required. The FPC requested to see a 100-day plan relating to the programme, including quick wins and intended outcomes. The Committee thanked the presenters for attending the meeting.

BOARD ASSURANCE FRAMEWORK
The Committee noted the latest Board Assurance Framework and the risks assigned to the Committee. A workforce risk update was provided separately on the agenda. It was noted that the finance risks were to be updated for the Board meeting.

INTEGRATED PERFORMANCE REPORT
The Committee received the latest Integrated Performance Report, covering Month 2. The following updates were provided:

Responsive Services:

- 4-hour ED Target – Performance had improved to 81.64%. It was anticipated that the June position would show further improvement.
- 62 Day Standard - Performance against the 62 day standard was 79.6% (pre-breach sharing). Urology, which is responsible for a significant proportion of breaches, had improved from 16 breaches previously to 9.
- Diagnostics – The May position was 1.02% against the national target of 1%.
- Stroke - Six beds had been ring-fenced for stroke patients to help support improvements to stroke performance.
- RTT – Performance had deteriorated to 83.7%. There would be a report provided for the next meeting regarding this performance standard.

Well-led Services:

- Temporary staffing demand increased in May.
- An improvement in the sickness rate was noted.
- Recruitment was on track in terms of recruitment delivery plans.
- The Committee noted there had been an increase in WTE staff employed by the Trust from April to May which had increased the pay-bill.

Sustainable Services:

- The key points relating to the sustainable services section of the IPR were addressed through other papers on the agenda.

FINANCE REPORT MONTH 2

The Committee noted the Month 2 Finance Report. The financial position was broadly on plan at Month 2 but there had been significant adverse variance to the plan in terms of the pay position. Positive variance, including in terms of the Month 1 refresh, brought the position for the month in line with the plan. The Committee was informed that the majority of the overspend on pay was unrelated to activity. Plans to address the issues relating to the pay spend were discussed. The Committee would receive an update and further assurance on pay controls at the next meeting.

CIP PERFORMANCE ANALYSIS AND UPDATE

The PMO Director updated the Committee on progress in terms of CIP performance. He reported that CIP delivery for month 2 was higher than at the same point last year, though the overall plan was behind target. The theatre and outpatient programmes were proving challenging but it was considered that overall the target for the year remained achievable.

BUDGET RISK ANALYSIS

The Committee received an update on the risks and opportunities relating to the 2019-20 budget. Regarding capital availability, the Committee was informed that there was now a system in place whereby capital funding bids were being considered within the STP.

Long Term Financial Strategy

The Committee received a presentation from the Director of Finance regarding the long term financial strategy. The presentation outlined the approach that had been followed to undertake the financial modelling, detailed the key base case assumptions used and provided a range of scenario outputs. The Committee noted the key role financial sustainability provided in enabling the Trust to achieve its quality and operational aims. It was agreed that sessions would be held with the Committee Chair and other members to better understand the model and output scenarios. It was also noted other strategies and plans (such as workforce) would need to be developed to input into the model. The presentation would also be discussed at the next Board meeting.

DIGITAL PROGRAMME UPDATE

The Committee received an update on the Trust's digital programme. The Chief Information Officer updated the Committee on the high level plans for the new digital strategy. He also reported on a programme of work to update/replace some computers within the Trust. Additionally, the Committee received an update on the 'quick win' opportunities identified from the stabilisation programme.

STATUTORY AND MANDATORY TRAINNING AND APPRAISALS UPDATE

The Committee was presented with an update on current statutory and mandatory training and appraisals compliance. The Committee discussed the current position and that there were plans to review the current systems over the coming months.

WORKFORCE 2019/20 PLAN

The Deputy Director of Workforce and OD presented the workforce plan for 2019/20 based on Whole Time Equivalent staff. The Committee discussed how this would need to link with the finance plan. They discussed ownership of the plan and the need to extrapolate it beyond 2019/20.

EQUALITY DELIVERY SYSTEM 2
The Committee received an update from the workforce team on the Equality Delivery System. The team reported that they had self-assessed against the requirements and currently considered the Trust rated ‘green’ in two areas and ‘amber’ in the remainder and had developed the action plan with a view to being rated ‘green’ in all areas next year. It was agreed that the FPC should receive a regular update on equality and diversity performance metrics.

HEALTH AND WELLBING ACTION PLAN
The Committee reviewed the action plan that was provided relating to staff health and wellbeing.

INFLUENZA VACCINE ACTION PLAN
The Committee noted an action plan regarding the influenza vaccination. The Committee discussed communications plans relating to the programme.

WORKFORCE RISKS REPORT
The Committee was presented with a report about the current workforce risks as recorded on the risk register. The Committee discussed the risk relating to the lifetime pension allowance rules and agreed that further work to review the risk and possible mitigations would be beneficial.

Karen McConnell
Finance and Performance Committee Chair

June 2019

East and North Hertfordshire NHS Trust

Agenda Item: 9.3 (a)

TRUST BOARD PART 1 – 3 JULY 2019

QUALITY AND SAFETY COMMITTEE – MEETING HELD ON 21 MAY 2019
EXECUTIVE SUMMARY REPORT

PURPOSE	To present to the Board the report from the QSC meeting of 21 May 2019.
PREVIOUSLY CONSIDERED BY	
Objective(s) to which issue relates *	☑ **1. Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ☐ **2. Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Key assurance committee reporting to the Board
Healthcare/National Policy (includes CQC/Monitor)	Potential risk to CQC outcomes Key statutory requirement under SFIs, SOs. Healthcare regulation, DH Operating Framework and other national performance standards
CRR/Board Assurance Framework *	☐ **Corporate Risk Register** ☑ **BAF**

ACTION REQUIRED *

For approval		For decision	
For discussion	☑	For information	

DIRECTOR:	Chairman of QSC
PRESENTED BY:	Chairman of QSC
AUTHOR:	Corporate Governance Officer/ Trust Secretary
DATE:	May 2019

We put our patients first We work as a team We value everybody We are open and honest We strive for excellence and continuous improvement

QUALITY AND SAFETY COMMITTEE – MEETING HELD ON 21 MAY 2019

SUMMARY REPORT TO TRUST BOARD – 3 JULY 2019

The following Non-Executive Directors were present:

Val Moore (deputising as QSC Chair), Ellen Schroder

The following core attendees were present:

Jude Archer, Rachael Corser, Julie Smith, Tim Walker, Susan Young

The following points are specifically highlighted to the Trust Board:

End of Life Care Presentation

The EOLC nursing leads made a presentation regarding EOLC at the Trust. A key message from the presentation was that the Trust believed that when a patient is dying, caring for them and those important to them is everyone's responsibility.

The Cancer division had taken on the management of EOLC/Palliative care for the whole of the Trust over the past 8 months. The Trust had a rapid discharge team in place to audit all rapid discharges and to provide that patients were discharged to their preferred place of death. The Butterfly Volunteer Service comforted patients in their last hours of life. They also provided information and respite to families at a difficult time.

A number of challenges were articulated. Staff members at every level were to be trained, supported and valued for their contribution to end of life care. It was the intention to develop a new strategy for EOLC.

The members discussed the method of measuring success, and whether a numerical aim should be set to show improvement.

The Committee thanked the presenters for attending the meeting.

Quality Transformation Programme Deep Dive - Harm-Free Care Collaborative

A report about the activities of the Harm Free Care Collaborative was presented. The meetings were chaired by the Deputy Director of Nursing and the Associate Director of Nursing for Quality and Safety. The committee had been meeting monthly. The incident management team consisted of representatives from a number of divisions. Their improvement aims included timely reporting and management of incidents and reducing avoidable harms from pressure ulcers, VTE, catheters, etc.

Medicines Optimisation Strategy

The Chief Pharmacist presented the Medicines Optimisation Strategy 2019 – 2022 to the Committee. The NHSI Hospital, Pharmacy and Medicines Optimisation Framework was devised to help NHS Trusts review their approach to medicines optimisation and pharmaceutical services. In addition, the outcome would 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 established a baseline assessment of current approach and practices; identified areas of existing good practice and areas for development and provided assurance on medicines optimisation and pharmaceutical services. A Medicines Optimisation Framework (MOF) was drafted for the Trust based on the NHSI Hospital, Pharmacy and Medicines Optimisation Framework and provided the structure to the Trusts' strategy.

The Committee discussed the electronic prescriptions system, the formulary and self-administration of medication. Recruitment and retention of pharmacy staff was a high priority for the Trust.

The Committee asked the Chief Pharmacist to review the staff survey findings relating to raising concerns and also add reference to the link with the STP work. The Chief Pharmacist agreed to do so and to make changes to the strategy accordingly. The strategy was approved subject to these changes.

Other outcomes:

Integrated Performance Report

The Integrated Performance Report Month 1 /2019 -2020 was presented to the Quality and Safety Committee.

Safe

- One MRSA bacteraemia had been allocated to the Trust for April. Due to the change in the method of reporting *c.difficile* infections, a potential increase in numbers was expected.
- There were no Never Events reported in April. It had been more than 200 days since the last Never Event.
- Hospital-acquired thrombosis risk assessment remained a priority for Quality Improvement. An improvement plan had been written to review processes and improve governance and measurement of VTE risk assessments.

Caring

- In regard to complaints, work was continuing on the 90-day improvement plan. There was a slight increase in the number of complaints but this was normal to see in the April period.

Effective services

- There were a number of positive aspects that were highlighted. The SHMI had dropped even lower to 94.1. Re-admissions had also decreased.

Learning from Deaths Report

The Deputy Medical Director presented the quarterly report which summarised the results of mortality improvement work conducted, including the regular monitoring of mortality rates, together with outputs from the learning from deaths initiative which were continual on-going processes throughout the Trust. The report also incorporated information and data mandated under the National Learning from Deaths programme and regarding 7 day services. Trust performance regarding mortality remained positive.

Safer Staffing Report

The Safer Staffing Report was submitted to update the Quality and Safety committee on safe staffing levels for the month of March. The Committee noted the latest position and briefly discussed nursing recruitment and retention.

Infection Prevention and Control Report

The Director of Nursing presented a report to inform the Committee of infection prevention and control performance for April 2019. It was noted that NHSI colleagues would be returning to undertake a follow-up visit in the next few weeks.

The Committee discussed cleaning and long term options regarding cleaning services.

Risk Register Report

The Associate Director of Corporate Governance presented the Risk Update Report to the Committee. An analysis of the Corporate Risk Register (CRR) showed risks by theme and strategic priority.

The emphasis continued to be getting all parts of the Trust to identify and review risks systematically. Training had been arranged for all divisions. Risk clinics were being held in all the divisions. The Risk Manager was monitoring the risk clinics to ensure that they were held regularly and had adequate support. The escalation of risks process within divisions was also being closely monitored and facilitated. There had been a consistent improvement in the review of risks.

Engagement Annual Report

The acting Director of Strategy presented a report summarising work on the Trust's external engagement for the year 2018/19 and highlighting emerging priorities, risks and opportunities for 2019/20.

Much of the engagement activity in 2018/19 was designed to support the development of the Trust's new Clinical Strategy. Patients and public, staff and partners were involved in the development of the new vision, strategic priorities and clinical strategy. It was the intention to increase focus on designing effective public / patient involvement, building and sustaining effective relationships and securing improved and sustained engagement with GPs in 2019/20.

The following reports were noted by the committee

CQC and Compliance update

The Trust's Provider Information Request had been submitted to the CQC. Weekly CQC Steering Group meetings had been stepped up to lead and support the organisation and preparedness for the forthcoming CQC inspection.

Maternity Report and Dashboard; QSC Subcommittee Escalation Reports

The Committee noted the Maternity Report and Dashboard and the QSC Subcommittee Escalation Reports.

Val Moore (deputising as QSC Chair)

June 2019

East and North Hertfordshire NHS Trust

Agenda Item: 9.3 (b)

TRUST BOARD PART 1 – 3 JULY 2019

QUALITY AND SAFETY COMMITTEE – MEETING HELD ON 25 JUNE 2019
EXECUTIVE SUMMARY REPORT

PURPOSE	To present to the Board the report from the QSC meeting of 25 June 2019.
PREVIOUSLY CONSIDERED BY	
Objective(s) to which issue relates *	☑ **1. Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ☐ **2. Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Key assurance committee reporting to the Board
Healthcare/National Policy (includes CQC/Monitor)	Potential risk to CQC outcomes Key statutory requirement under SFIs, SOs. Healthcare regulation, DH Operating Framework and other national performance standards
CRR/Board Assurance Framework *	☐ **Corporate Risk Register** ☑ **BAF**

ACTION REQUIRED *

For approval		For decision	
For discussion	☑	For information	

DIRECTOR:	Chairman of QSC
PRESENTED BY:	Chairman of QSC
AUTHOR:	Corporate Governance Officer/ Trust Secretary
DATE:	June 2019

We put our patients first We work as a team We value everybody We are open and honest We strive for excellence and continuous improvement

QUALITY AND SAFETY COMMITTEE – MEETING HELD ON 25 JUNE 2019

SUMMARY REPORT TO TRUST BOARD – 3 JULY 2019

The following Non-Executive Directors were present:
Val Moore (deputising as QSC Chair), Ellen Schroder.

The following core attendees were present:
Jude Archer, Rachael Corser, Michael Chilvers, Tom Pounds.

The following points are specifically highlighted to the Trust Board:

Medicine and ED Presentation

The Divisional Director for Medicine and the Head of Nursing – Medical Division delivered a presentation on the medicine division's achievements, risks and challenges. They reported that they were focusing on a reduction in MSRI and serious incidents. They listed 20 of the highest risks and discussed mitigations. Recognition and escalation of deteriorating patients was one of the essential activities planned to reduce serious incidents. A quality improvement action plan was drawn up using the five key lines of the CQC enquiry and included plans to improve management and prevention of 'harms', pressure injuries and VTE.

There were a number of good news stories. Introducing the divisional quality manager post had made a significant positive impact to the Division. There had been an improvement in safety and leadership. The work-plan for 2019/20 included:

- electronic handovers;
- Excellence Accreditation Pathways for wards;
- 90 day improvement programme to improve hydration and reduce UTI in patients;
- RCN ward leaders programme; and
- Developing the future of informatics on the wards.

The Committee noted the update and thanked the presenters for attending the meeting.

Quality Transformation Programme Deep Dive – Deteriorating patient

The Deteriorating Patient Collaborative (DPC) is made up of a team incorporating a wide variety of staff from across the Trust, including, Critical Care Outreach Team lead, Resuscitation service, Sepsis Leads, LD adult lead, AKI lead nurse, Diabetes lead nurse, Quality & safety managers and Divisional staff.

They aim to gather and share information amongst those who work with deteriorating patients and had set a target of reducing avoidable serious harm by 50%. A list of drivers to achieve this target had been compiled.

The Committee discussed e-observations and how to improve use amongst staff. One option being considered was ward based screens of digital observations. Timely detection of deteriorating patients would need to be the key focus for the Trust for the next 3 to 6 months. It was noted that there had been a successful Quality day held within the Trust on Friday 21 June. The Deteriorating Patient Collaborative had also presented at that event.

Estates and Facilities Compliance Report
The Interim Director of Estates and Facilities presented the report which set out the current position in relation to Estates and Facilities compliance and recommended actions to ensure that the Trust fulfils its statutory and non-statutory duties to comply with legislation and guidance. He expressed his concern that there was currently limited compliance in some areas. He informed the Committee of a number of problem areas, including difficulty in filling vacancies within the department. An external review of the current position in terms of compliance was being commissioned. This would enable a thorough prioritisation of actions required.

The Committee noted the update and expressed concern about the current position and the possible consequences.

Other outcomes:

Integrated Performance Report
The Integrated Performance Report for Month 2 of 2019 -2020 was presented to the Quality and Safety Committee.
Safe

- One serious incident relating to radiology was reported in May. There were no Never Events reported in May.
- One Hospital Onset Healthcare Associated *c.difficile* infection had been reported for May.
- There were 14 pressure ulcers reported in May. All were category 2 or lower.

Caring

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

Effective services

- The rolling 12-months crude mortality rate remained at 11.1 deaths per 1000 admissions in the 12 months to May, which remained better than the most recently available national rate of 13.4.
- SHMI had improved further from 93.96 in December to 91.85 in the latest release.

R & D Annual report and Strategy
The Medical Director presented a report on the implementation of the Trust's three year research strategy which had concluded in 2018/19. One of the strategy's aims was to make the Trust an internationally recognised centre of excellence for research and patient outcome. There had been a dramatic and sustained increase in annual research participation. Results of a CGC inspection found that Mount Vernon Cancer Centre (MVCC) was regarded as outstanding practice. The Trust was ranked in the top 50 acute trusts for research. The Trust continued to support academic partnership, working with the University of Hertfordshire, UCLH and other Universities including Brunel University, London.

A one year transition period was proposed for 2019/20 to enable the development of the next research strategy which would act as an 'enabling strategy' to support the delivery of the Trust 5 year strategy.

R & D finances were discussed. A new international financial regulation which the Trust has to comply with had resulted in a change in the management of research finances. This would require a different approach that the finance team were supporting R & D colleagues with.

Nurse Establishment review

The Director of Nursing presented the draft report of the bi-annual review and recommendations to ensure Nurse staffing and Midwifery levels were compliant with Workforce Safeguards. The nursing and midwifery establishment review was undertaken in April 2019. Data on actual staffing, patient acuity and dependency was collected over a 20 day period on all inpatient wards. The Committee noted the draft recommendations which would be presented to the next Trust Board meeting once finalised.

Safer staffing report

The Director of Nursing presented the Safer staffing Report to update the Committee on safe staffing levels for the month of May. She reported that:

- The Overall Fill Rate increased by 1.6% from 96.4% in April to 98.0% in May;
- Sickness Levels deceased for Registered Nursing and increased for unregistered staff;
- Overall fill rate for temporary staffing increased by 2.7% from 78.2% in April to 80.9% in May.

7 Days services Self- Assessment

The Medical Director presented a report on 7 day Services which required approval prior to submission to NHSI for the 28th June deadline. The 7 day Hospitals Services programme was designed to support 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.

A new measurement system was introduced in autumn 2018. Ten clinical standards were introduced. Board assurance is required in four clinical standards that were prioritised by NHSI to ensure patients admitted in an emergency received 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. The Committee discussed compliance with the priority standards and endorsed the submission.

Clinical Harm Reviews Update

The Medical Director presented an update on clinical harm reviews. 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 >100 days
• Breaches of referral >52 weeks

Delayed cancer treatment

The delay in cancer treatment had improved. There was a robust process in place for the oversight of harm reviews relating to cancer waits.

52 week breaches of referrals

Work was taking place to enable improvements in the division where the majority of breaches currently took place. It was also the intention to work with the divisions to develop consistency in how the reviews were handled.

BAF Report

The Associate Director of Corporate Governance presented the latest version of the Board Assurance Framework 2019/20 for consideration. A couple of key issues relating to the QSC agenda were highlighted. It was suggested that there would be an in-depth review of the risk relating to Estates and Facilities in September.

Medication forum 6 monthly Report

The Medication Forum is a sub-group of the Patient Safety Committee. It provides assurance that medicines are used safely within the Trust. Meetings are held every 2 months and the contents of the December 2018, February 2019 and April 2019 meetings were detailed in the report. The report provided an update and assurance to the Committee on medication safety and highlights medication safety issues and progress. The Committee noted the report.

Annual Reports:

Health and Safety Annual Report

The Associate Director of Corporate Governance presented the Health and Safety Annual report to inform the Committee on activities undertaken relating to health and safety management and compliance during the period of 1st April 2018 to 31st March 2019. The Committee was informed that the Trust's Health and Safety Strategy was due for review in 2019. An initial workshop session to inform the review took place in May 2019 with key stakeholders.

It was reported that 2018-2019 had seen a significant improvement in the approach to health and safety. The Trust aimed to make further sustainable improvements in 2019-2020. Raising the profile of Health and Safety and improving the safety culture would mitigate the risks associated with health and safety, ensure statutory compliance and ensure the health, safety and welfare of staff, patients and visitors.

The Committee endorsed the report for approval by the Trust Board.

Safeguarding Adults and Children Annual report

The Director of Nursing presented the 2018/19 Annual report on Safeguarding Children and Adults. Key developments in 2018/19 included:

- The appointment of a perinatal mental health midwife;
- The development and ongoing training of safeguarding champions in Children and Maternity;

- Purple Star accreditation for 4 clinical areas with 2 more in progress.
-

It was reported that it was the intention to ultimately provide a single hub for all safeguarding matters within the Trust.

The Committee endorsed the report for approval by the Trust Board.

The following reports were noted by the committee

CQC and Compliance update
The CQC Steering Group continued to meet weekly to lead and support the organisation and ensure that action was taken on identified areas in preparation for the forthcoming CQC inspection.

Maternity Report and Dashboard
The report informed the Committee about the Maternity Dashboard exceptions for May 2019, the analysis and actions in response to the exceptions and safety concerns raised within maternity services.

Health and Safety Committee Report to QSC
The report informed the Committee of key matters considered by and escalated from the Health, Safety, Security and Fire Committee.

Val Moore (deputising as QSC Chair)
June 2019

East and North Hertfordshire NHS Trust

Agenda Item: 9.3.1

TRUST BOARD - PUBLIC SESSION – 3 JULY 2019
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 discussion

Previously considered by:
Mortality Surveillance Committee - 17 April 2019, Quality and Safety Committee – 21 May 2019

Director:	**Presented by:**	**Author:**
Medical Director	**Medical Director**	**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.

While quarterly reports will continue to be provided, the time intervals between these have been flexed to allow prior approval by the Mortality Surveillance Committee. In view of the irregular time intervals it is proposed that alternate reports follow a reduced format focusing on refreshed data and headline information. This is the first such report for consideration.

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 1.15% for the 12 month period to February 2019 compared to 1.43% for the latest 3 years.
HSMR (data period Jan18 – Dec18)	HSMR for the 12 month period is **93.01** and is statistically **'better than expected'.**
SHMI (data period Oct17 – Sep18)	SHMI for the 12 month period is **99.90**: **'as expected band 2'.**
HSMR – Peer comparison	E&NH is ranked 5th (out of 15) in the East of England Peer group compared to 6th in the previous report.

1.3 HEADLINES

- HSMR has reduced and is now in the 'better than expected' range
- SHMI has remained within the 'as expected band'
- Sustained improvement in Sepsis HSMR following in-depth Coding review work
- Mortality Review Tool – consideration of DatixIQ
- Medical Examiner Introduction – ongoing preparation
- Regular mortality monitoring via Mortality Surveillance Committee, Quality and Safety Committee, Board and joint meetings with ENHCCG
- Participation in Regional Learning from Death Forum.

1.4 CURRENT RISKS

Table 2 below summaries key risks identified:

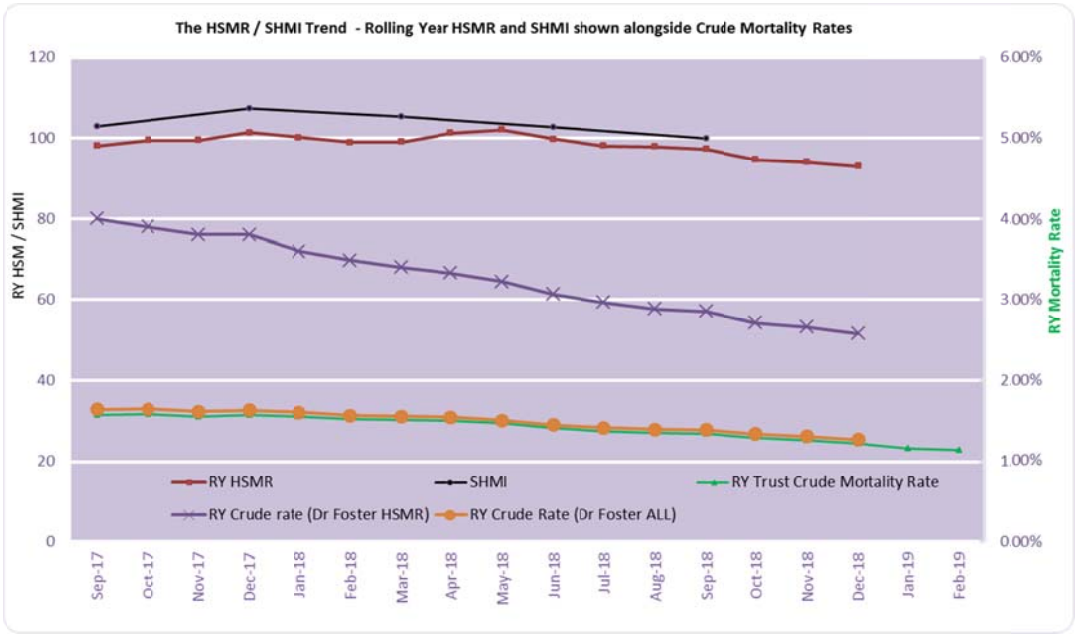
Risks	Report ref (Mitigation)
Sepsis CQUIN performance	2.4.1.1
7 day service/current lack of 7DS Lead	2.5.1
Care bundles/lack of Lead	2.5.2
Medical Examiner Introduction	2.5.3
Coding capability	2.5.4
Data Quality issues	2.5.4
Mortality management - capacity	3.1
Mortality Review Process – need for significant 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 all these metrics remain on a downward trajectory.

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 1.4% and 1.4% within the region for the twelve months to December 2018. This compares to 1.3% within ENHT. The Trust's locally recorded crude mortality rate, stands at 1.15% for the latest twelve months to February 2019 and has continued on a general downward trend.

HSMR: The latest data release in March saw a modest reduction in the Trust's HSMR for the last twelve months to December 2018 to **93.01.** This means that our HSMR is continuing to sit within the better than expected range. The Trust's position relative to its East of England peers has improved to 5th (out of 15).

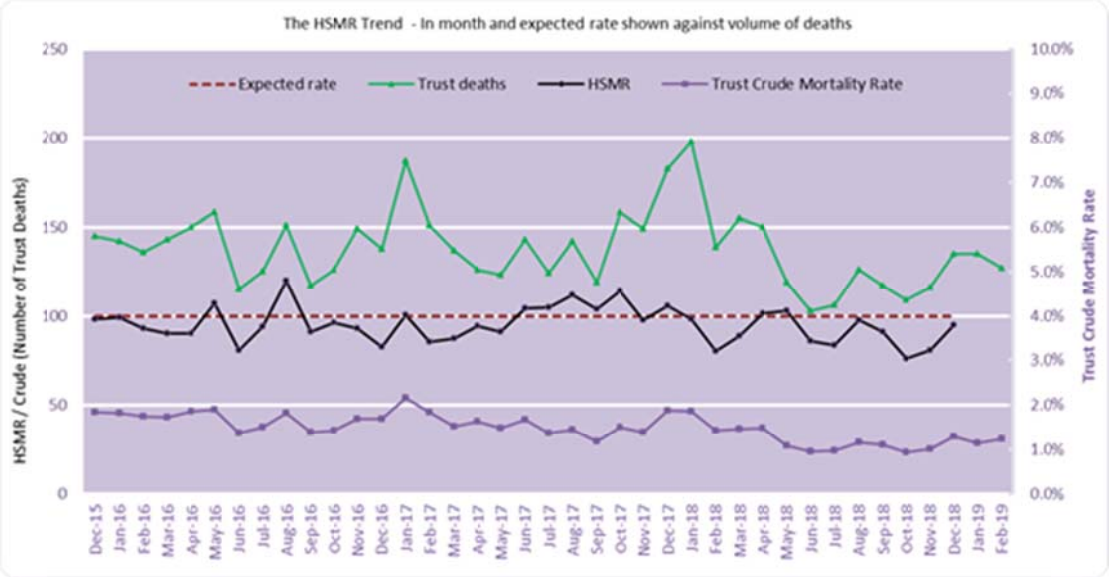
SHMI: The latest release covering deaths up to September 2018 has seen a further reduction to 99.90. This remains in the 'as expected' range. This is the first time that the Trust's SHMI has been below 100 since the inception of this metric in 2010.

NHS Digital is currently leading a review of SHMI to evaluate potential short and long term changes to improve the indicator. The impact of this is as yet unclear and will be reported on as developments unfound.

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 to date the usual winter spike in deaths has been far less pronounced than in previous years.

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 Divisional HSMR performance

Table 3: Monthly Trust and Divisional HSMR December 2017 to December 2018

	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Rolling 12M
Cancer	64.0	75.2	88.4	104.3	88.3	123.6	32.2	103.7	48.4	61.5	72.7	66.6	78.2	80.3
CSS	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	444.4	0.0	0.0	0.0	33.3
Medicine	114.6	106.1	87.1	100.7	110.4	95.3	92.0	88.8	113.0	92.9	80.5	83.9	98.4	96.2
Surgery	68.5	86.8	82.3	49.0	119.1	89.0	76.8	86.7	103.1	118.8	90.0	54.2	87.3	86.6
Women & Children	0.0	0.0	0.0	0.0	129.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	10.1
Trust	**106.3**	**100.5**	**85.9**	**95.1**	**109.6**	**95.7**	**82.2**	**88.6**	**106.7**	**94.5**	**80.8**	**78.0**	**95.6**	**93.0**

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 December 2018. The Rolling 12 month position for Medicine shows an amber rating, with an HSMR of 96.2. This is an improvement on the last reported HSMR of 98.4 for the twelve months to October 2018.

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/SMR mortality were both within the 'better than expected' band for the stated date range. Length of stay has remained consistently below the expected levels, meaning that overall we discharge patients sooner than expected for our case mix. The recent downward trend in readmissions has been maintained. In this reporting period the overall Trust figure for readmissions has reduced further and is now better than the national average.

Table 4: Key Quality Measures October 2017 – September 2018

	Trust Total	Elective	Non-Elective
HSMR	98.0	89.7	98.2
SMR	95.7	94.4	95.7
Length of Stay	90.3	88.3	90.6
Readmissions within 28 days	97.2	91.2	100.1

Source: Dr Foster Healthcare Intelligence Portal

2.3 Mortality Alerts

2.3.1 CQC CUSUM Alerts

In March the Dr Foster Unit at Imperial College alerted the CQC to the Trust's recent CUSUM alerts for Septicaemia. As previously reported, in October we received a request for further information from the CQC. A full response was provided in November, 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). Further reductions were seen in February and March with HSMR now standing at 67.22.

In March we received a brief request for additional information from the CQC regarding three cases whose outcomes had been pending at the time of our initial response. A formal response was submitted on 25 March 2019.

2.3.2 HSMR outliers

With regard to HSMR for the latest rolling year to December 2018, there are two diagnostic groups attracting significantly higher than expected deaths at the 95% confidence level for relative risk where 6 or more deaths are observed.

Table 5: HSMR Negative Outliers January 2018 to December 2018

	Relative Risk	Observed Deaths	Expected Deaths	"Excess" Deaths
Coronary atherosclerosis and other heart disease	211.62	14	6	8
Pneumonia	116.97	295	252	43

Source: Dr Foster Healthcare Intelligence Portal

2.3.3 SHMI outliers

With regard to SHMI for the latest rolling year to September 2018, there are six diagnostic groups reporting significantly higher numbers of observed than expected deaths where the calculated numbers of expected deaths is 5 or more.

Table 6: SHMI Negative Outliers October 2017 to September 2018

CCS Group	SHMI	Observed Deaths	Expected Deaths	"Excess" Deaths
Diverticulosis and diverticulitis	270.12	17	6.29	10.71
Coronary atherosclerosis and other heart disease	228.25	15	6.57	8.43
Coma, stupour, and brain damage	217.00	22	10.14	11.86
Infective arthritis and osteomyelitis	211.77	11	5.19	5.81
Congestive heart failure, nonhypertensive	144.84	120	82.85	37.15
Pneumonia	121.49	409	336.65	72.35

Source: Dr Foster Healthcare Intelligence Portal

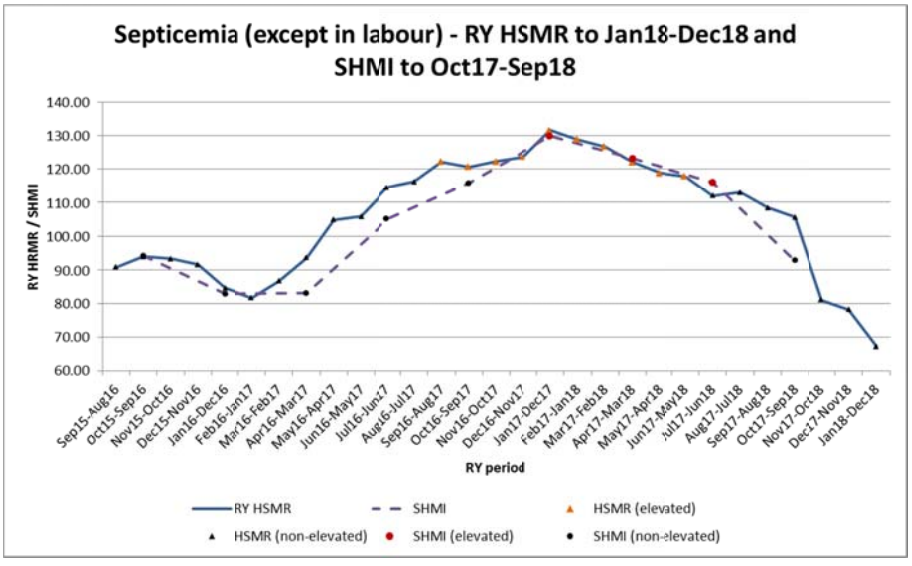
2.4 Specific Actions to Address High Mortality Conditions

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 being taken.

2.4.1 Sepsis

Figure 3: Sepsis HSMR/SHMI latest rolling 12 month trend



Following changes to Sepsis Coding guidelines which came into effect on 1 April 2017, HSMR for Septicaemia had been consistently elevated. HSMR for Septicaemia for the latest 12 month period to December 2018, now stands at 67.27 which is again

in the better than expected range. SHMI is 92.73 for October 2017-September 2018 and is now in the as expected range. Performance will continue to be monitored pending the outcome of the CQC's outlier review.

2.4.1.1 CQUIN

Sepsis continued as a national CQUIN for 2018-19. The final end of year results are detailed below.

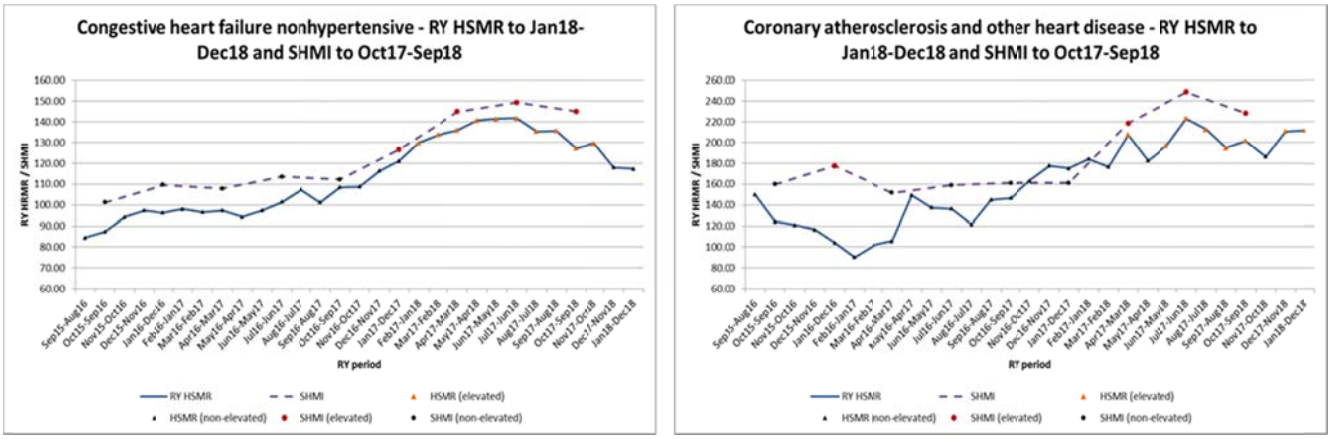
Table 7: Sepsis CQUIN Data 2018-2019

Indicator	Q1	Q2	Q3	Q4
2a Screening Adult ED	93%	95%	97%	98%
2a Screening CED	100%	86%	96%	95%
2a Screening Inpatient	81%	68%	82%	70%
2b Treatment Adult ED	70%	61%	66%	63%
2b Treatment CED	N/A	33%	33%	N/A
2b Treatment Inpatient adult	62%	45%	74%	63%

The results remain mixed and evidence the continuing risks and challenges faced. The service remains committed to achieving further improvements.

2.4.2 Cardiology

Figure 4: Congestive Heart Failure/Coronary Atherosclerosis HSMR/SHMI latest rolling 12 month trend



One of the Trust's current HSMR outliers sits within the Cardiology basket; Coronary atherosclerosis and other heart disease. At the time of my last report HSMR for this diagnosis group was in the 'as expected' range at 186.09, it has now returned to significantly elevated range standing at 211.62. Congestive heart failure non-hypertensive was last reported with an HSMR of 129.41, improvement has been seen in the HSMR falling to 117.27, in the 'as expected' range.

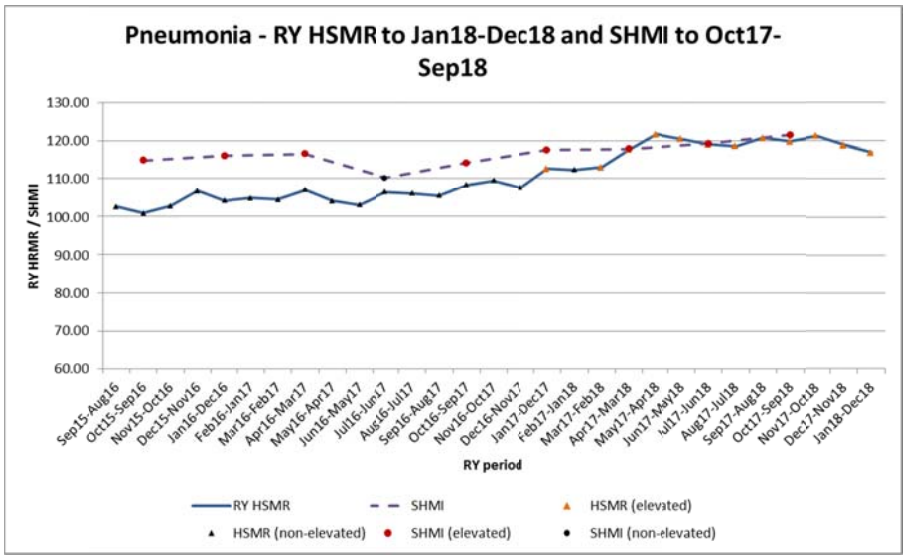
As coding reviews showed few errors further clinical reviews of deaths underpinning both diagnosis groups are in progress. Unfortunately the pace of these has been hindered by resource constraints and the final outputs are still awaited.

2.4.3 Respiratory

Figure 5 below shows the recent trend for HSMR/SHMI for pneumonia. A combined Coding/Clinical review of deaths was undertaken. This showed that a significant number of deaths are being incorrectly attributed to pneumonia. While a relatively small proportion of these related to incorrect coding, most were the result of incorrect diagnosis of the patient's condition by the team on admission. These included

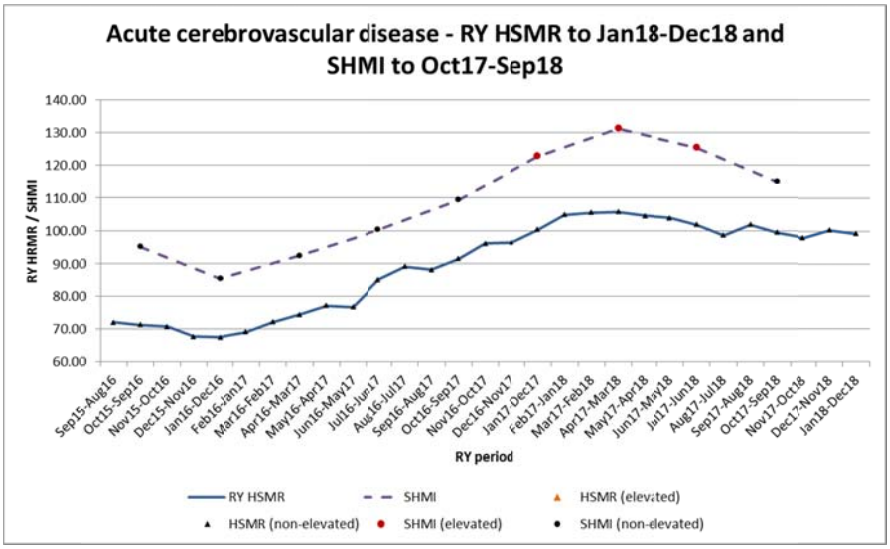
patients who would more appropriately have been described as chest infections (no radiological signs of pneumonia), while others should have been badged as heart failure, UTI or general frailty (whether due to old age or other conditions such as cancer).

Figure 5: Pneumonia HSMR/SHMI latest rolling 12 month trend



2.4.4 Acute Cerebrovascular Disease (Stroke)

Figure 6: Acute cerebrovascular disease HSMR/SHMI latest rolling 12 month trend

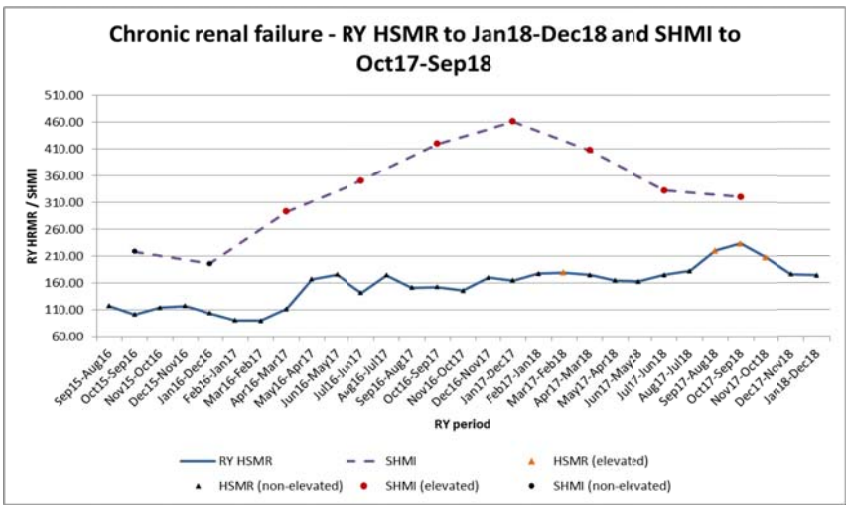


In 2015 there had been concerns when Stroke SHMI for the rolling 12 months to December 2015 rose to 124.08. Subsequent SHMI releases saw significant reductions, with the rolling 12 month period to December 2016 falling to 85.3. However, recent releases have seen an upward trend.

The latest SHMI release saw a reduction from 125.5 to 115.0, with a return to the 'as expected' range. As SHMI and not HSMR had been alerting a sample of cases where patients had died within 30 days of discharge was reviewed. These were considered to be expected deaths and did not give rise to clinical concerns.

2.4.5 Chronic Renal Failure

Figure 7: Chronic renal failure HSMR/SHMI latest rolling 12 month trend

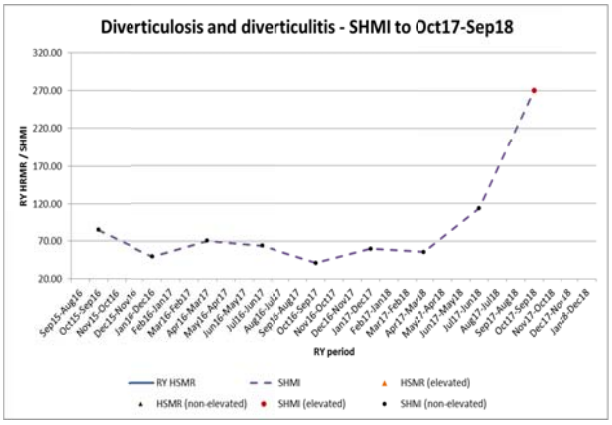


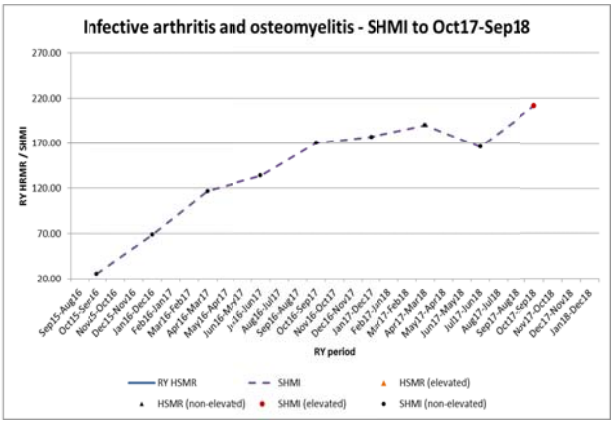
Note: All the Chronic renal failure SHMI CCS group values have number of expected deaths less than 5

While the numbers involved are quite small a joint coding/clinical review has taken place. A sample of 6 cases was considered and all were shown to be incorrectly coded. As a result all deaths for the current year are in the process of being reviewed. A trial of joint coding/mortality reviews is also to be undertaken to assess if this model could be adopted. It has always been accepted that such an approach would be ideal, but logistically challenging.

2.4.6 Diverticulosis & Diverticulitis/Infective Arthritis & osteomyelitis

Figure 8: Diverticulosis and diverticulitis/Infective Arthritis HSMR/SHMI latest rolling 12 month trend





Both these new SHMI alerts show significant, sharp increases (relatively small numbers of deaths are involved). At the latest Mortality Alerts meeting it was agreed that both should be subject to joint Coding/Clinician reviews.

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. 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. These 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.

The target of compliance with the four prioritised standards by the end of March 2018 was not achieved. Focus on this work has been hampered by the absence of a 7 Day Services Lead. Responsibility for oversight of this important work has recently passed to the Deputy Operating Officer. Further updates will be provided as appropriate plans are developed.

2.5.2 Care Bundles

Recent audits completed to gain baseline information regarding awareness and use of the care bundles confirmed that further work is required if the Trust is to reduce avoidable variation in the provision of patient care. This work would include a more standardised format for care bundles together with appropriate guidance regarding their creation and use together with a Trust-wide awareness campaign, and ultimately a transfer to an electronic format.

While this work 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. This post will also involve clinical leadership regarding the provision of 7 Day Services.

2.5.3 Medical Examiner

The appointment of the National Medical Examiner has recently been confirmed. This is to be Dr Alan Fletcher, who has led the principal pilot scheme over recent years. Speaking at the East of England Learning from Deaths Forum, he acknowledged that there was little infrastructure yet in place and that it was accepted that the April 2019 deadline for implementation would be a soft one. He indicated that Trusts would be expected to develop their internal systems over the next 12 months so that they were fully functioning and robust by April 2020.

The Medical Examiner function will sit within Clinical Support Services. The Division is currently scoping the requirements for implementation, supported by the Working Group set up to oversee the introduction of the role. Expressions of interest have now been received from a number of consultants and an appointment panel is in the process of being arranged. The Medical Examiners will be supported by Medical Examiner Officers. As there was a clear overlap with this role and our existing Bereavement Officers, our current team will be expanded and undertake additional training to enable them to take on new duties.

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

While it has been agreed that the Trust will consider adoption of the Datix iCloud platform to support our Clinical Governance framework, progress towards making a decision has so far been hampered by competing commitments and resource constraints. Only when this decision has been made can the required developments to the mortality review process be started in earnest. Plans to expand the mortality management team are still in progress.

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 2018-19 deaths which can appear to skew the data. In this regard, of particular note, in Q3 1 ACON was concluded relating to a death in 2017/18 where an avoidability of death score of less than 3 was decided as detailed below.

Table 8: 2017-18 Death: Avoidability Score ≤3

Year of death	Serious Incident	Avoidability score	Avoidability definition
2017-18	Yes	2	Strong evidence of avoidability

This case has been investigated as a Serious Incident and a remedial action plan has been put in place.

It is intended that the creation of a more useful dashboard will form part of the process developments alluded to 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 9: Q3 Learning Disability Deaths

	Oct-18	Nov-18	Dec-18
Learning Disability deaths	0	0	1

In Q3 1 death occurred of a patient with a learning disability. This death has been reported to the national LeDeR programme. It has also received an internal mortality review, which did not give rise to concerns regarding the avoidability of death or clinical care.

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'.

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. We are reaching out to our expert mental health colleagues at Hertfordshire Partnership University NHS Foundation Trust for guidance as to the best way of ensuring we have appropriate processes in place to safeguard this vulnerable cohort of patients and to ensure we can comply with the Learning from Deaths guidance.

3.2.4 Stillbirth, Children and Maternity Deaths

Q3 statistics are provided below:

Table 10: Q3 Stillbirth, Children and Maternity Deaths

	Oct-18	Nov-18	Dec-18
Stillbirth	2	0	3
Children	1	1 *	0
Maternity	0	0	0

* Sadly in November a deceased young lady was brought into CED following a suicide. As the patient was dead on arrival at the hospital this death has not been included in these figures.

3.2.5 Serious Incidents involving Deaths

Table 11: Q3 Serious Incidents Involving a Patient Death

Serious Incidents involving the death of a patient	Oct-18	Nov-18	Dec-18
Serious Incidents reported	4	2	0
Serious Incidents – final report approved*	3	3	5

** the reports approved do not necessarily relate to the incidents reported*

Key issues highlighted in the Serious Incidents approved in Q3 included:

- Inability to confirm complete aseptic technique during the line insertion procedure
- Lack of a standardised pathway for patients requiring a laparotomy
- Sub-optimal management of warfarin reversal through late consideration of its requirement then delay in administering Octaplex
- Failure to assess neurological status appropriately
- Poor compliance with following the observations policy

- Transfer to an outlier ward led to delays to haemodialysis
- Sub-optimal management of nutrition and hydration needs due to being NBM
- Frequent interruptions during radiology reporting sessions
- Lack of microbiology opinion sought or given
- Sub-optimal admission to Swift Ward of a patient with significant medical co-morbidities
- Failure to perform VTE risk assessment and reassessment; on admission; failure to prescribe and commence VTE prophylaxis
- Lack of an appropriate treatment plan with regards to a life limiting disease
- Incorrect documented & communication of resuscitation status
- Discharges should not be made until patient is deemed medically fit once test results have been reviewed
- No recording of the Grace score in the ICP which meant that the risk score for ACS was not determined and Clopidogrel rather than Ticagrelor prescribed
- Breakdown in the referral process between specialties
- Placement on sub-optimal ward
- Care pathway not optimally followed.

3.2.6 Learning from Complaints

Table 15 below provides detail of the number of complaints received in Q3 that relate to a patient who has died.

Table 12: Q3 Complaints Involving a Patient Death

	Oct-18	Nov-18	Dec-18
Complaints received relating to an in-hospital death	0	0	1

3.2.7 Learning from Inquests

Table 13: Q3 Inquests into a Patient Death

	Oct-18	Nov-18	Dec-18
Requests for a Report to the Coroner	8	9	10
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 above in Figure 9 relates to all ACONs concluded in Q3, whether the patient's death occurred in the current or previous year. Throughout the year emerging themes are shared across the Trust via the Patient Safety Newsletter and RHDs. They will also be used to inform quality improvement initiatives.

Key themes arising from the ACONs which were concluded in Q3 are detailed in Figure 9 below.

Fig 9: ACON Themes: Q3 2018-19

4.0 OPTIONS/RECOMMENDATIONS

The Committee is invited to note the contents of this Report.

Appendix 1: ENHT Learning from Deaths Dashboard December 2018

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	361	0	304	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1112	1904	798	1199	0	2

Time Series: Start date 2017-18 Q1 End date 2018-19 Q3

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)	1	0.1%	This Year (YTD)	8	0.8%	This Year (YTD)	950	99.1%

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	1	0	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
5	10	6	8	0	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q3

East and North Hertfordshire NHS Trust

Agenda Item: 9.3.3

TRUST BOARD – PUBLIC MEETING – 3 JULY 2019

Annual Report of the Health & Safety Committee

Purpose and executive summary:
To inform the Health and Safety Committee, Trust Board and sub committees of the Trust Board on activities undertaken relating to health and safety management and compliance during the period of 1st April 2018 to 31st March 2019.

The Board is asked to note that the Trust's Health and Safety Strategy is due for review in 2019 and an initial workshop session to inform the review took place in May 2019 with key stakeholders.

The Trust Board is asked to approve the report.

Action required: For approval

Previously considered by:
Health & Safety Committee - 21 June 2019, Quality and Safety Committee – 25 June 2019

Director:	Presented by:	Author:
Associate Director of Corporate Governance	**Associate Director of Corporate Governance**	**Safety & Security Manager**

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
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
009/19 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
010/19 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.

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

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

Health and Safety Annual Report – 2018 to 2019

1. Aim of Report

To inform the Health and Safety Committee, Trust Board and sub committees of the Trust Board on activities undertaken relating to health and safety management and compliance during the period of 1st April 2018 to 31st March 2019.

2. Performance over the reporting period

2018-19 targets aimed to achieve a reduction of incidents compared to last year. The following were achieved:

- Slips, trips and falls by patients: (not including mechanical or medical falls) 100% reduction. (Decrease from 2 to 0)
- Musculoskeletal Injuries: 17% reduction (Decrease from 59 to 49)
- Slips, trips and falls by visitors: 65% reduction (Decrease from 23 to 8)
- Slips, trips and falls by staff: 15% reduction (Decrease 66 to 56)
- RIDDOR reportable incidents:38% reduction (Decrease from 39 to 24)

However, increases were reported in the following incidents:

- Public liability claims by visitors: 100% increase (Increase from 4 to 8)
- Referrals for work related stress: 40% increase (Increase from 45 to 63)
- Employer liability claims by staff: 20% increase (Increase from 10 to 12)
- Sharps injuries to staff: 14% increase(increase from 149 to 169)
- Physical assaults of staff: 28% increase (increase from 94 to 120)

Fire Incidents: There were no significant fires reported during this reporting period

3. Actions and Learning:

- Investigation of all incidents to ensure that lessons are learnt, and appropriate control measures put in place to prevent a reoccurrence.
- Liaison with the Health@work teams to reduce the number of sharps injuries
- Analysis of sharp and splash injuries to identify trends by device type, procedure and staff group. This has led to a reduction of sharps injuries during quarter 1 2019/2020.
- Areas of weakness identified by audits and incidents will be incorporated into the departments work plan to ensure on-going monitoring and improvement

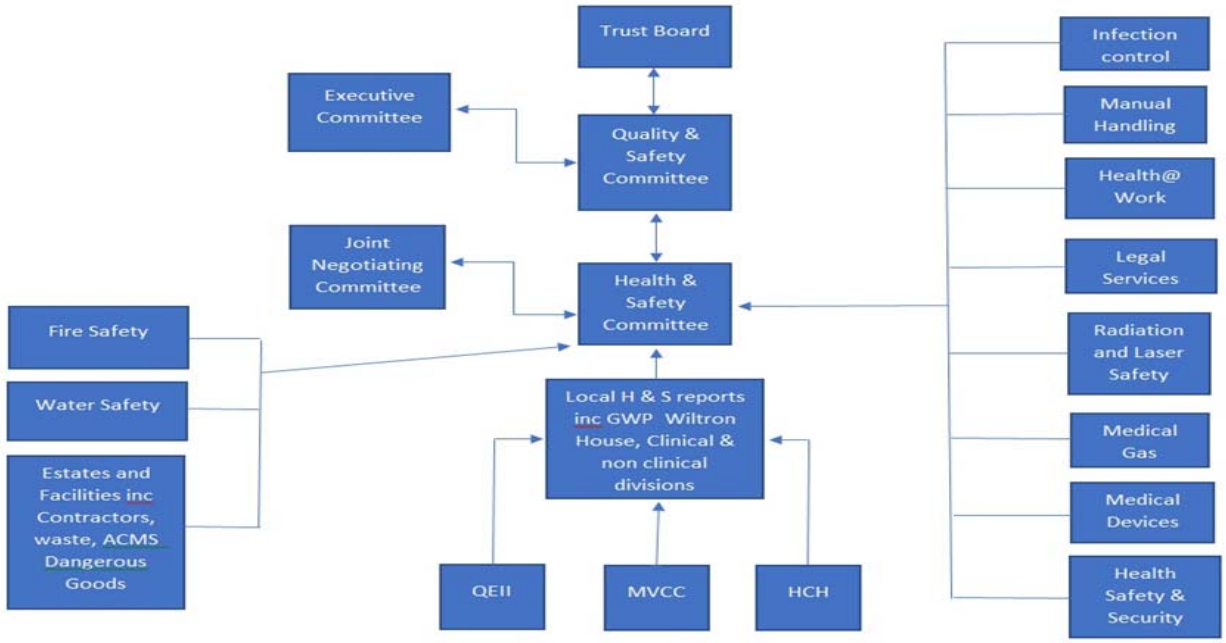
4. Strategic Context

This report details Trust-wide health and safety performance throughout 2018- 2019 in order to comply with the Health and Safety at Work Act 1974 and associated statutory regulations, with particular reference to Health and Safety, Fire Safety, Moving and Handling and Health@Work

The Safety and Security team reported to the Director of Estates and Facilities during part of this reporting period and transferred to Corporate Governance in November 2018 reporting to the Associate Director of Corporate Governance. The Health@Work team are accountable to the Director of Workforce and Organisational Development and liaise with the Safety and Security team regarding the management of health risks that affect Trust employees and contractors. The Trust has a Health and Safety Strategy (launched in May 2012), which includes specific improvement targets for Health and Safety, Fire Safety, Health@work and public and employer liability claims. Since May 2017 the department also has responsibility for fire safety management.

The Trusts Security Management is managed by the same team. Since October 2017 the Health & Safety Committee and Security Committee amalgamated.

Table 1 Committee Reporting Structure



5. Committees/groups

- The Health and Safety Committee met bi- monthly and was chaired by the Director of Strategy from April 2018 until November 2018 and then by the Associate Director of Corporate Governance from December 2018 onwards. Both reported to the Quality and Safety Committee and Trust Board.
- A Fire Safety Committee was established in March 2018 which meets monthly and includes representation from estates, partner organisations, safety team, representatives from other Trust sites
- Health and Safety is a regular agenda item at the Joint Negotiation Committee (formally Trust partnership) which meets monthly.
- The Safety and Security Manager attends the Patient Safety Committee and Emergency Response and Resilience Committee.
- Health and safety performance data is reviewed at Divisional Performance Review meetings
- Formal reporting regarding radiation and laser safety was re-established in January 2019 and representatives attend the Health and Safety Committee.
- Areas identified to strengthen reporting and regular attendance in 2019/20 are Estates and Facilities and Medical Devices.

6. Monitoring compliance and effectiveness

A monthly set of performance indicators are used to measure health and safety performance, which also includes a number of Health@work outcomes including skin surveillance and new referrals for work related stress. These metrics are discussed at the Health & Safety Committee and Quality and Safety Committee

Key health and safety metrics are included in the Trust Floodlight Scorecard and reported to the Trust Board and Trust Partnership. The metrics and dashboard will be reviewed in 2019 in line with the review of the Health and Safety Strategy.

7. RIDDOR Analysis

In the 2018-2019 reporting period there were 24 RIDDOR reportable incidents; this represents a decrease of 16 incidents compared to 2017-2018. 23 were injuries to staff and 1 to a visitor knocked over by a wooden seat which moved during high winds.

Of the 23 staff RIDDOR reportable incidents 9 were manual handling injuries, 8 slips, trips or falls and 1 assault. 5 were associated with knocks and bumps and 1 from contact with moving equipment; 20 were injuries to workers which resulted in their incapacitation for more than seven days.

Table 2 RIDDOR reportable incidents 2018-2019 by incident type

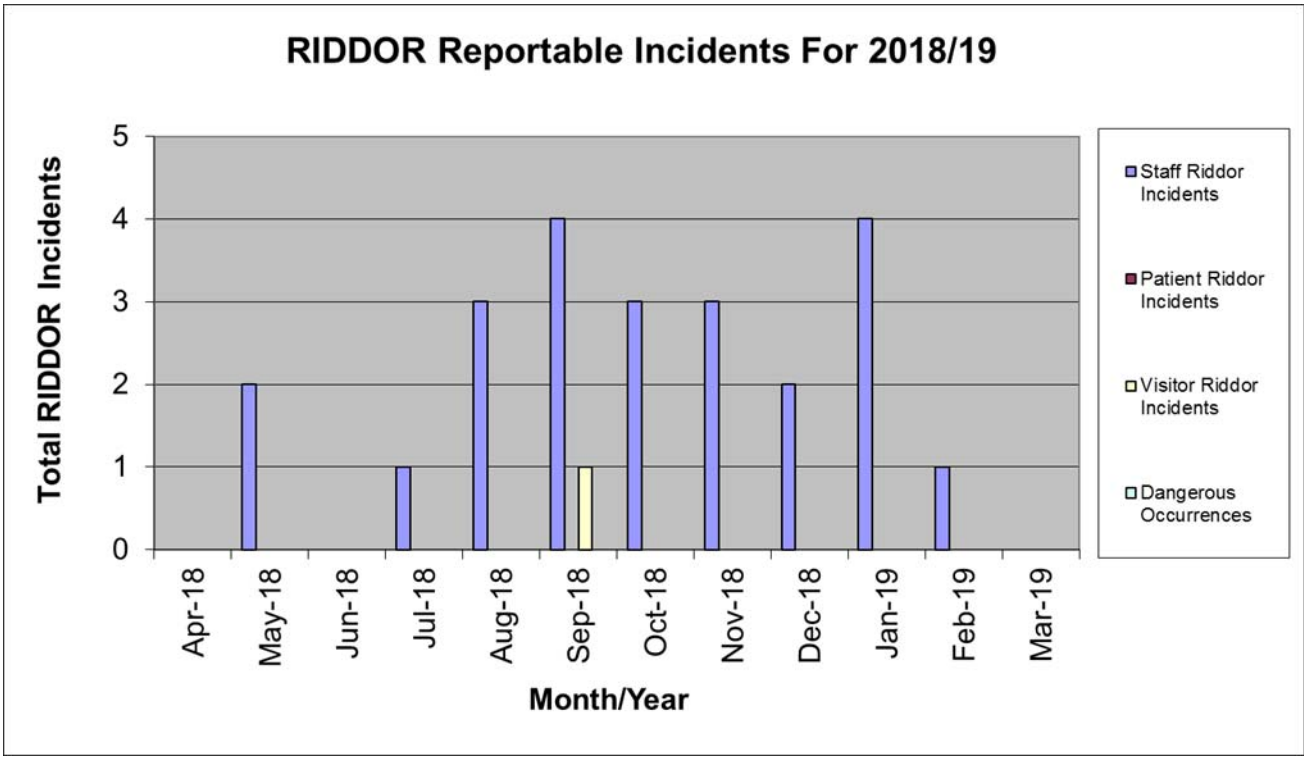
F2508 Incidents April 2018 - March 2019

Cause of Injury	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Moving & Handling		1			2	1			1	3	1	
Exposure to a Harmful Substance												
Slip/Trip/Fall				1		3	1	1	1	1		
Fall from Height												
Assault		1										
Hit Something fixed or stationary												
Contact with Moving Machinery							1					
Another Kind of Accident					1	1	1	2				
Unknown												
Stress												

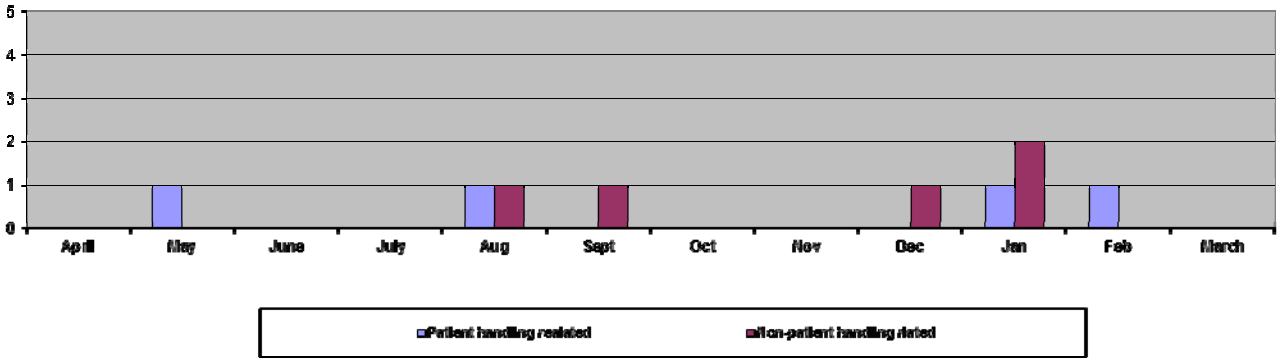
Outcome of Incidents	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Specific Injury				1		2						
>7 Day Injury		2			2	3	3	3	2	4	1	0
Dangerous Occurrence					1							

Outcome of Incidents	2014	2015	2016	2017	2018
Specific Injury	9	6	8	5	3
>7 Day Injury	34	31	17	28	21
Dangerous Occurrence	0	3	2	3	1

Graph 1 RIDDOR reportable incidents by month



Graph 2 Manual Handling related reportable Injuries by month incident occurred & sub-category



- A total of **9** RIDDOR reportable injuries to staff related to moving & handling incidents; 4 patient handling related & 5 non-patient handling related.

- (For comparison with the previous year with **15** RIDDOR reportable injuries to staff related to moving & handling incidents; 10 patient handling related & 5 non-patient handling related.)

- There has been a decrease in RIDDOR reportable injuries to staff from patient handling related incidents with 4 reported this year in comparison to 10 last year. The previous four-year average has been 7.2 per year.

- There has been no change in RIDDOR reportable injuries to staff involved in object / inanimate load handling incidents with 5 reported this year in comparison to 3 last year, this is however less the previous four-year average of just under 6 per year.

  All injured staff have their training records checked for compliance with statutory/mandatory training and followed up as necessary.

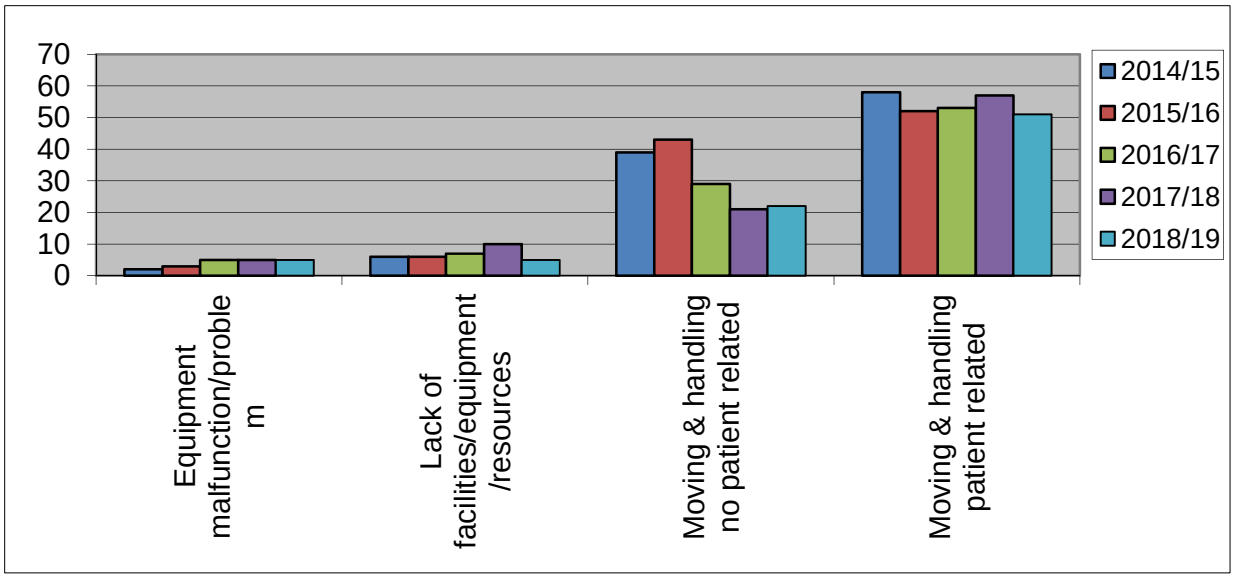
8. Incident Analysis

- Sharps/splash injuries are the most common injury to staff.
- Physical assaults are the second highest cause of injuries to staff; however, the majority have been associated with confused patients and the level of harm caused has been minor.
- Slips trips and falls are also a main cause of injury to both staff and visitors
- Incident rates and trends from DATIX have been reviewed bi-monthly, and findings submitted to the Health and Safety Committee

Manual Handling related Incidents

- Incident rates and trends from DATIX have been reviewed bi-monthly, and findings submitted to the Health & Safety Committee.

Graph 3 Incidents by category for the financial year 2018-19 & previous 4-year comparison 2014/15 – 2017/18

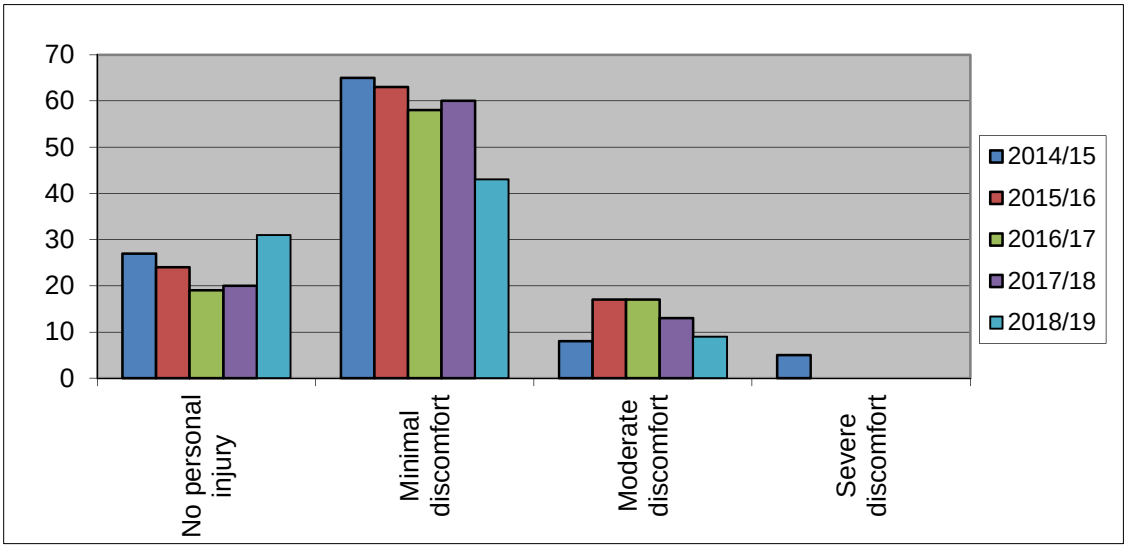


In Summary

Total incidents for this financial year = **83**
51 Patient Handling related
22 Non-Patient handling related
5 lack of equipment / resources
5 equipment malfunction / failure)

The year showed a total of **83** incidents reported with a similar number of non-patient related / object handling incidents and a slight decrease the number of patient handling related incidents in comparison to last year.

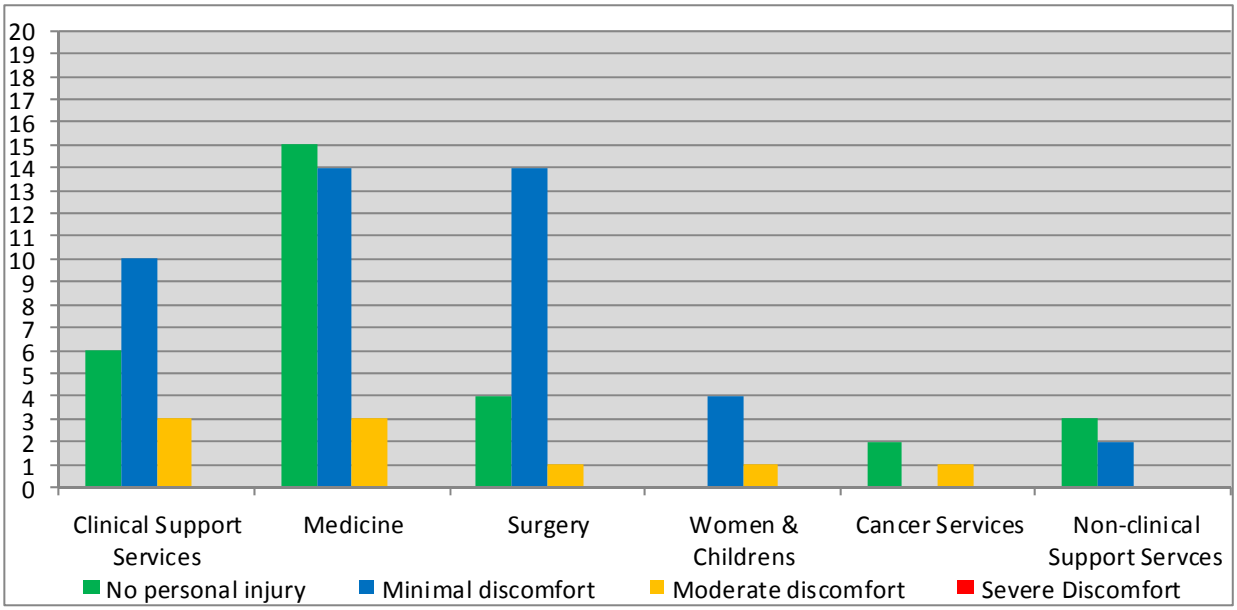
Graph 4 Manual handling incidents by severity for this financial year 2018-19 & previous 4-year comparison 2014/15 – 2017/18



In Summary

The year showed a decreased number in the both the minimal and moderate categories (total of 9 moderate), with no reported incidents in the severe discomfort category. For the fourth straight year no incidents have been reported with a category of severe discomfort at the time of reporting.
There were 6 less RIDDOR reportable injuries than last year.

Graph 5 Manual handling incidents by division & severity for this financial year 2018-19



9. Training

Health and Safety Training

The Health and Safety team delivers health and safety awareness training at Induction and Vital mandatory training days. Safety, security and conflict resolution training continue to be delivered as part of the VITAL training for all staff; this ensures that staff receive refresher training every two years. Training metrics indicate that 92% of staff are compliant with their Health and Safety and conflict resolution competencies

Table 3; Staff Health & Safety Training

Course	Number of courses run	Number Attended	DNA	Withdrew	Cancelled courses
Competent person	10	50	6	6	0
Competent persons update	4	35	5	3	0
COSHH	7	24	3	1	0
Managers	3	10	0	0	0
Display Screen Equipment	9	47	3	1	0

Medical Gas Training (HTM02 compliance)

The medical gas training is now delivered by staff reading a handout and completing eight questions which are submitted to the Health & Safety Department for checking and if a pass is achieved the member of staff's competency is updated. There is still an expectation that staff receive local training within their individual departments.

Table 4 Training Compliance for Moving & Handling training 2018-19 averages from ESR figures

Staff Group	Course	Competency / frequency	Compliant	Non - Compliant
All Trust staff: **Average 5657**	Manual Handling - underpinning knowledge	Moving & Handling / 2 years	**Average for the year =** **92.88%**	**Average for the year =** **7.12%**
All Clinical staff: **Average 2450**	Patient Handling - Induction or update	Moving & Handling for People Handlers / 2 years	**Average =** **91.61%**	**Average =** **8.39%**

In Summary

Compliance rates for manual handling training have remained relatively stable showing a compliance rate above 91% for each month.

Compliance rates for practical patient handling training have remained stable showing a compliance rate above 90% for each month.

10. Health and Safety Executive Visits

The Health and Safety Executive conducted an inspection in relation to compliance with the ionising Radiation Regulations 2017 and visited the Lister Hospital and Mount Vernon Cancer Centre sites in October 2018. The Trust was issued with a Notification of Contravention which identified a number of actions required to achieve compliance. These were completed and the case closed.

11. Policies

All health, safety and security policies have been reviewed and made available for staff to access via the Safety and Security pages of the Knowledge Centre. Master copies have been retained on each of the Trust sites to ensure access can be maintained in the event of any Information Technology or electrical interruptions.

12. Health & Safety Red File Audit

During 2018- 2019 the audit process was based on the completion of a short, simple audit with four questions emailed to departmental/ ward managers on a monthly basis using the Median survey tool. Managers open the link to the Trusts Health & Safety audit tool page and submit the answers to the questions asked. There is one action per question. The website provides an up to date dashboard so that at any time the safety team can view who has started the audit, who has completed it and who has not done anything at all.

Audit questions are based on the Trusts Health & Safety Strategy and additional questions focus on emerging issues and incidents as they arise. The intention is to provide a quick and simple check of compliance that staff find easy to complete and also incorporates some questions in relation to Fire Safety.

13 Non – Clinical Claims

East & North Hertfordshire NHS Trust is a member of the NHS Resolution Risk Pooling Scheme for Trusts (RPST), which, subject to the membership rules, indemnifies the Trust for non-clinical claims. These claims fall into two categories.

Employer Liability (EL) claims are those made by Trust employees who have injured themselves during the course of their employment. **Public Liability (PL)** claims are those made by visitors whilst on Trust premises and have to be considered in view of the Trust's responsibility to provide a safe place for the public.

In addition, the Trust has indemnity under the **Property Expenses Scheme (PES)** for damage to its buildings and other related expenses such as business interruption.

There are, however, excess levels for all categories of these claims as detailed below:

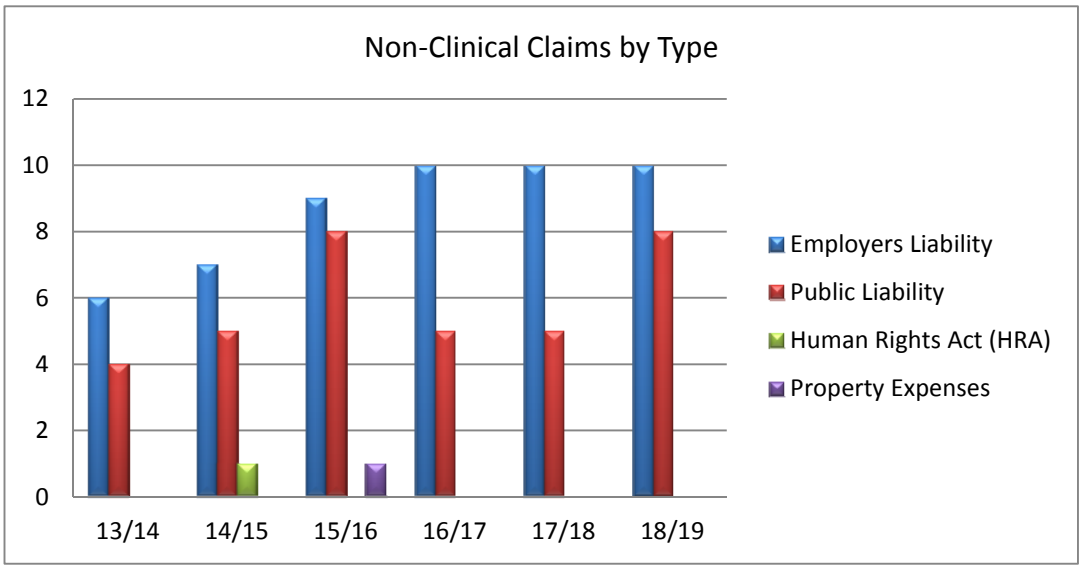
Scheme	Excess level
Employers Liability (EL)	£10,000
Public Liability (PL)	£3,000
Property Expenses (PES)	£20,000

Financial Contributions

The table below sets out our contributions to these schemes and it is pleasing to note the further fall in our contributions for the coming year.

Scheme	2015/16	2016/17	2017/18	2018/19	2019/20
EL & PL	£222,689	£213,048	£189,683	£188,730	£158,142
PES	£18,549	£16,906	£15,829	£47,349	£24,737

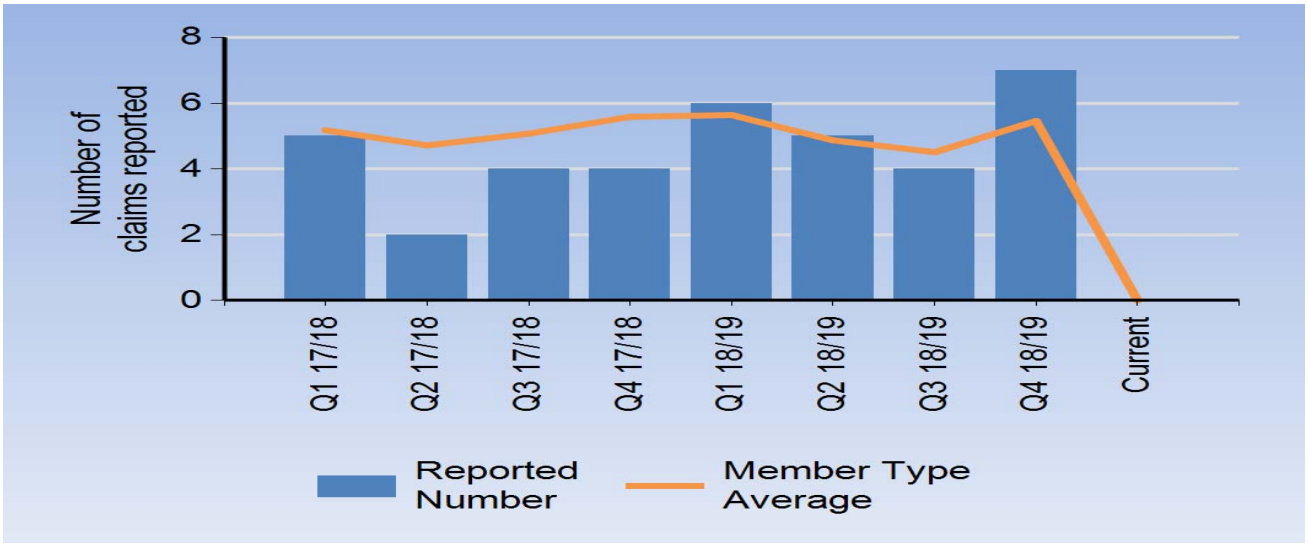
Graph 6: The number of new non-clinical claims received by type over the last six financial years.



It is interesting to note that the number of claims made by members of the public rose in the last financial year for the first time in three years.

Comparative data

Number of Claims



Graph 7 above is taken from the NHS Resolution (NHSR) extranet and allows us to benchmark ourselves against Trusts of a similar type (large, acute) with respect to the number of new employer and public claims reported. The graph shows that whilst we generally mirror the national pattern, we had, until quarter four of 2018/2019, fewer claims than other large acute Trusts. The quarter 4 increase is two above the member type average and can in part be explained by two separate claims that relate to the same incident. However, the increase will be monitored.

All new claims are reported to the bi-monthly Health and Safety Committee along with any themes and trends. In addition, any learning/notable points identified from investigations is shared.

Details of new and closed claims in 2018/19 are included within the appendices that were provided to the Quality and Safety Committee.

Closed Claims

In 2018/19 a total of 10 Employer and Public liability claims were closed; 5 were repudiated/defended (50%) and 5 were settled (50%). During the previous financial year, the Trust repudiated/defended 63% of the claims closed.

Summary

Although the investigations carried out into new claims made, seek to identify any learning or risk reduction measures, it should be noted that where the date of the incident predates the claim by a significant time, working methods and environmental factors might well have changed in the interim. The successful defence of these claims is reliant upon good documentation – incident forms, risk assessments, maintenance records etc. The centralisation of training records on ESR has been helpful.

15. Estates and Facilities

Fire Safety Please refer to the Annual Fire Safety report for more detailed information.

Management of Contractors

The electronic logging system remains in use for contractors attending site to be checked and signed in, thereby authoring access and works programmed through the site. This controls he access given to contractors ensuring that they have submitted and had approval on works RAMS for each visit. The Control of Contractors Policy is to be rewritten to add further controls on the contractors visiting and undertaking works on Trust sites

Water Safety

The Water Safety Group continues to meet quarterly and is focusing on the current issues being experienced within the Trust. The focus has remained on the control Legionella and Pseudomonas within the supplies and this focus is proving to be well founded and bearing results. The testing for both has been identified as an area in which the Trust require to be more active and this has also now been actioned giving greater visibility on our high risk and augmented care areas. The group is currently looking to have both the Water Safety Policy and Terms of Reference documents updated and re-issued, with this expected in the near future. The works identified within the Water Risk Assessment, compiled by the independent Authorising Engineer are being carried out and are to be completed prior to the resurvey of the full system, due next year.

Flushing infrequently used outlets

The issues at Lister hospital with local ownership on the flushing of these outlets has improved with the reporting of these events having increased, there are still some locations where forms are being returned spasmodically by a combination of ward staff, G4S & housekeeping staff. It can be seen from the reduction in water sample positives found for Legionella and Pseudomonas that staff awareness and the increased flushing of water outlets is having a direct effect. These improvements can be, in part, directly attributed to the IP&C team involvement when carrying out their ward audits; however there is still room for improvement in the continuing identification of outlets which become infrequently used which will help maintain the improvement found in our water quality. The WSG reiterates that it is the responsibility of the ‘user’ of the water system to flush any infrequently used outlets within their area of responsibility and that Estates only pick up the outlets in areas not occupied or that become temporarily unoccupied for any reason.

Waste

The early part of 2018/2019 year was spent working on increased opportunities to provide waste training to different audiences in addition to the sessions already supported such as, Clinical Support Workers Preparation to Practice; Preceptorship; Patient Safety Days. Waste quizzes and new promotional material developed to increase understanding of waste segregation. This work has continued throughout the year.

The Trust's clinical waste contractor ceased providing service to the NHS in early December, resulting in contingency arrangements being implemented, supported by NHSI, NHS England and the Environment Agency. Storage containers and a chilled container were placed on site in order to store waste prior to collection. A national emergency supplier was engaged, who undertook collections from main hospital sites.

Clinical waste was decanted from 770 litre bins into the relevant storage container and bins washed and disinfected on site in order to maintain continuity of service. Whilst not considered good practice, this system was permitted via the Environment Agency issuing Regulatory Position Statements allowing affected Trusts to operate outside of normal practice whilst the contingency situation existed.

Clinical waste from QEII and Hertford County Hospitals was transferred to Lister for disposal, using as regulations permit the transfer of clinical waste under 333kg between sites without the need for ADR qualified drivers and specialised vehicles.

There were a number of service issues with the national contract, meaning that the Trust took the decision to move away from this contract and engage another contractor, more able to provide the level of service needed. The Novus contract started on 1st April 2019.

Delivery of additional 770 litre clinical waste carts is expected at the end of July, at which time, an empty for full bin exchange system will resume

Dangerous Goods Nothing to report.

Asbestos monitoring and management

No incidents have been reported in relation to accidental disturbance of Asbestos Containing Materials (ACM) throughout the course of the year at the Lister Hospital site**.**

Removals/Encapsulation work;

- L4 Main Theatres – Removal under controlled conditions of High Level AIB window soffit panels from within the Theatres Dirty Corridor - 4F200.
- L4 Main Theatres – Removal under controlled conditions of High Level AIB window soffit panels from Storage Area - 4F68.
- L4 Theatre Block - Recovery - Removal under controlled conditions of High Level AIB window soffit panels from Recovery - 4F50.
- L4 CCU North – Removal under controlled conditions of High Level AIB window soffit panels from Corridor - 4F207 + Adjacent Office - 4F66.
- L2/3 OPD Staircase – Removal under controlled conditions of High Level AIB suspended ceiling bulkhead and Mid-level landing AIB Staircase panelling.
- L1 D1Plant Area - Removal under controlled conditions of 2 x over door AIB firebreak headers and 2x AIB containing plant room doors from Electrical Substation No 5.
- L12 Plant Room Staircase Entrance Doors - Removal under controlled conditions of over door AIB firebreak header and riser panels + Double set of AIB containing plant room doors.

Details from asbestos survey reports, removals/encapsulations are currently being entered into an electronic database to bring the information up to date; this is expected to be completed by end of June thereby providing an accurate reference source.

All planned and reactive asbestos removal together with Management and Refurbishment/ Demolition surveys have been undertaken successfully with all works managed by Estates and/or Capital Projects.

16 Health at Work activity report April 2018 to March 2019

Skin surveillance programme

Skin Health Surveillance	Apr-18	May-18	Jun-18	Jul 18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Questionnaires received	70	67	87	84	70	93	85	70	47	64	40	63
Initial face to face assessments	2	3	1	4	2	3	4	6	2	1	5	3
Review face to face assessments	3	6	3	3	1	1	0	8	3	2	1	5
Telephone assessments	2	2	0	3	0	0	0	2	0	0	1	1
Manager referrals due to contact dermatitis	0	0	0	0	0	0	0	0	1	0	0	0
Self-referrals due to contact dermatitis	0	0	0	0	0	0	0	0	0	4	0	1
New diagnosed cases of contact dermatitis	0	0	0	0	0	0	0	0	0	0	0	0
New diagnosed cases of latex allergy	0	0	0	0	0	0	0	0	0	0	0	0
Number of referrals to dermatology	0	0	0	0	0	0	0	0	1	0	0	0

Stress

Manger referrals due to work related stress	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Total Trust	3	4	9	5	4	8	6	6	5	4	6	5
Medicine	1	1	3	0	0	0	0	0	2	2	1	1
Surgical	0	1	0	0	1	2	2	2	1	0	1	1
Women's & Children's	1	0	1	0	1	1	0	0	0	0	2	0
Cancer	1	0	3	1	0	3	0	0	1	1	1	1
Clinical Support Services	0	0	1	1	1	1	2	2	1	0	1	1
Corporate	0	0	1	3	1	1	1	1	0	1	0	1
Research & Development	0	0	0	0	0	0	1	1	0	0	0	0

Health & Wellbeing

Wellbeing promotion	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Employee Assistance Programme - Telephone contacts	25	31	44	12	23	17	34	25	26	36	24	23
- Web contacts	69	68	21	12	28	15	48	5	13	27	13	15
Physiotherapy referrals	11	17	25	9	6	15	20	13	10	8	8	10

Wellbeing initiatives & Services

Promotion of musculoskeletal (MSK) health and reduction of MSK injuries at work

- Access to a fast track physiotherapy service for staff with musculoskeletal issues affecting them at work.
- Early assessment and advice for staff unable to work due to an MSK issue. Advisors from the Health at Work Service telephone staff on day one of their sickness absence (or the next working day if at a weekend) to undertake an early assessment, offer advice, support, and where appropriate refer to fast track physiotherapy.
- Collaborative approach in supporting managers with complex moving and handling and ergonomic risk assessments. Assessments are undertaken in partnership with colleagues in Health and Safety and Moving and Handling teams.

- Post injury early advice service. Advisors from the Health at Work Service telephone all staff who report a workplace injury on Datix to undertake an early assessment, offer advice, support, and where appropriate refer to fast track physiotherapy.

Promotion of mental health and wellbeing

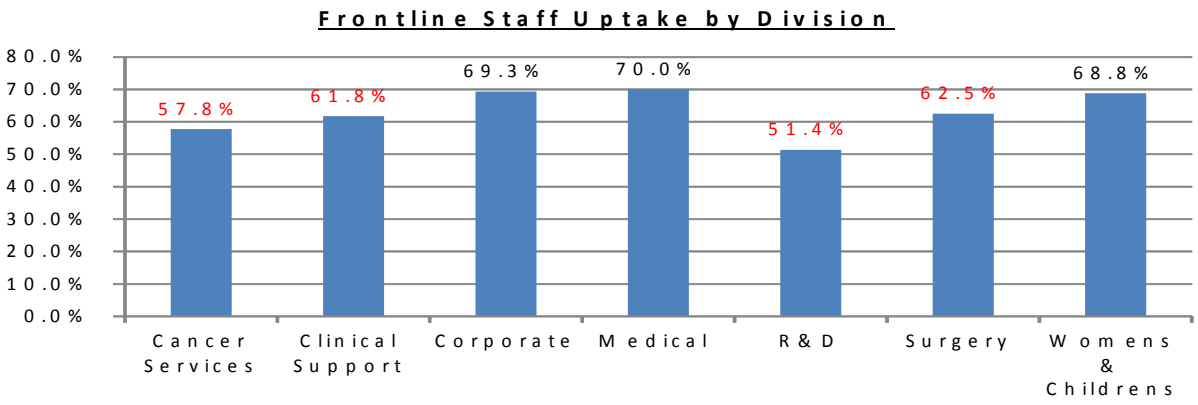
- Early assessment and advice for staff unable to work due to a stress related or mental health issue. Advisors from the Health at Work Service telephone staff on day one of their sickness absence (or the next working day if at a weekend) to undertake an early assessment, offer advice and support, signpost staff to appropriate sources on ongoing support and where appropriate refer to counselling and / or online CBT.
- Guidance and support for staff and managers in managing work-related stress.
- Weekly Mindfulness drop in sessions delivered by the hospital chaplains.
- Employee Assistance Programme, which provides free access to confidential advice and counselling.

Promotion of general health and wellbeing

- A minor ailments service provided in partnership with 'Your Health Pharmacy'.
- A range of initiatives to promote walking such as lunchtime walking groups, walk buddy schemes, active travel plans, cycle to work scheme and step challenges.
- Promotion of physical fitness with onsite exercise classes, reduced gym membership, promotion of local exercise classes/groups.
- Referrals for 12 weeks free at Weight Watchers and Slimming World.
- Promotion of and referrals to stop smoking service.
- A Health at Work advice line, for employees and managers to request confidential advice on any health at work issue.
- Health at Work advice to managers on adjustments to prevent sickness absence and promote health improvement and return to work plans to support safe and sustained early return to work.
- Pre-placement health assessment and advice on any adjustments to ensure that new employees with health issues or disabilities can work safely and effectively.
- Health surveillance programmes for employees exposed to potential hazards in the workplace such as annual skin health assessments.
- Occupational immunisation programmes to protect employees and patients form vaccine preventable infections.
- 21 staff wellbeing events held (17 at Lister Community hub, 4 at Mount Vernon) on a range of health and wellbeing issues such as: Mental health awareness, healthy eating, alcohol, and skin health, free health checks such as cholesterol monitoring, blood pressure, height, weight and body fat measurements.

Improving the uptake of Flu vaccinations for frontline staff

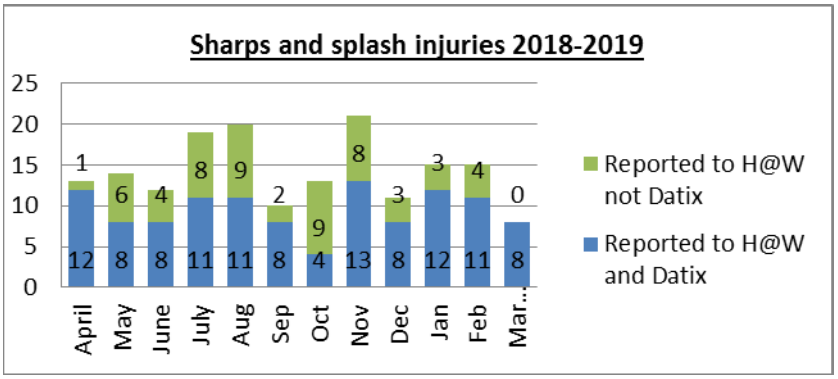
- The staff flu vaccine target for 2018-19 was to achieve a flu vaccine uptake in current frontline employees of over 75% by 28th February 2019.
- In total 4358 flu vaccines have been received, in addition to 2772 current frontline staff 822 non-frontline staff have received their vaccine. 764 flu vaccines have been given to staff on site who are not directly employed by the trust, including Medical and Nursing students, G4S facilities and NHS Professionals staff.
- Some people chose not to receive the flu vaccine, in total 746 (17.6%) of frontline staff have informed us that they wish to decline.
- The frontline staff flu vaccine uptake achieved was 65.56%.
- The CQUIN goal has been partially achieved, the frontline staff flu vaccine uptake is within the 65-75 % uptake so will qualify for 75% of the payment.



Sharps injuries April 2018-March 2019

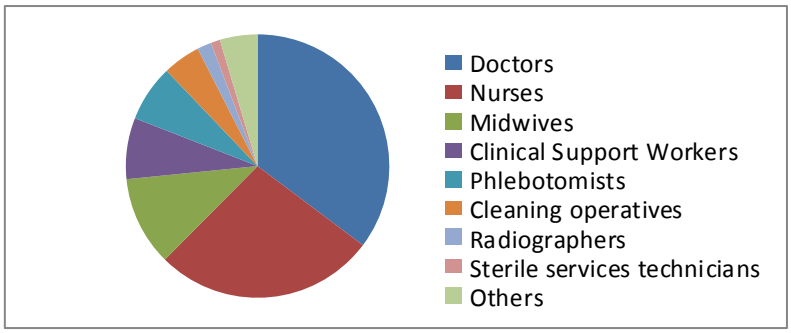
This report details the total sharps and splash injuries reported to the Health at Work Service and Datix between April 2018 and March 2019.

In total there have been 173 injuries reported, on average 14.4 injuries a month.
This is an increase on 2017-18 where there were 155 injuries, on average 13 a month.



Job titles of staff reporting injuries

154 of the reported incidents involved East and North Hertfordshire NHS Trust employees, 4 students, 1 volunteer, 6 agency/bank staff and 8 G4S staff also reported sharps/splash injuries.



61 doctors
47 nurses
19 midwives
13 CSW
12 phlebotomists
8 cleaners
3 Radiographers
2 Sterile services technicians

Injuries have occurred in 62 locations, the most common locations where injuries occur are:

Main theatre Lister - 27
Maternity consultant led unit - 10
Midwifery led unit - 9
Emergency Department -8
Acute Medical Unit - 8
Treatment Centre theatre - 8
Renal unit Lister - 5

Types of injury
There were 24 splash incidents where blood stained body fluids splashed non-intact skin, eyes or mouth and 149 sharps injuries.

The sharps injuries involved 35 different devises, the most common are:

Suture needle - 34
Phlebotomy safety needle – 17
Green needle - 13
Cannula - 12
Butterfly needle for phlebotomy - 9
Patient's lancet - 7
Patient's insulin needle - 5

Cause of injury

39 different causes were identified, the most common easily preventable causes were:

Sharps bin not taken to point of use – 15
Incorrect closure of 'safety' cover – 13
Device placed on tray before disposal in sharps bin – 9
Sharp item disposed of in clinical waste bin - 5

17. Infection Prevention & Control

The Infection Prevention and Control Team provide updates to the Health and Safety Committee and produce their own annual report for The Infection Prevention and Control Committee. Please refer to the Infection Prevention and Control annual report for further information.

18. Conclusion

2018-2019 has seen a significant improvement in the approach to health and safety. The Trust aims to make further sustainable improvements in 2019-2020. Raising the profile of Health and Safety and improving the safety culture will mitigate the risks associated with health and safety, ensure statutory compliance and ensure the health, safety and welfare of our staff, patients and visitors. To support this, the Health and Safety Strategy will be reviewed in 2019.

19. Recommendation

The Trust Board are asked to note the contents of this report and note the performance of the Health and Safety Department and Specialist Advisors in delivering its Statutory Health and Safety responsibly.

East and North Hertfordshire NHS Trust

Agenda Item: 9.4

TRUST BOARD - PUBLIC SESSION – 3 JULY 2019
AUDIT COMMITTEE – 23 MAY 2019
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present to the Trust Board the summary report from the Audit Committee meeting of 23 May 2019. The report includes details of any decisions made by the Audit Committee under delegated authority.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of Audit Committee	**Presented by:** Chair of Audit Committee	**Author:** Trust Secretary

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

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

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

AUDIT COMMITTEE – MEETING HELD ON 23 MAY 2019

SUMMARY REPORT TO BOARD – 3 JULY 2019

The following members were present: Jonathan Silver (Chair) and Karen McConnell

MATTERS REFERRED TO BOARD

Annual Report and Annual Governance Statement
The Committee reviewed the Annual Report 2018-19 and AGS. The Committee members advised that they had no material comments regarding the reports, but some suggestions regarding minor wording changes. The Audit Committee recommended the Annual Report and AGS for approval by the Trust Board subject to those changes.

Final Accounts 2018-19
The Audit Committee received the final accounts for 2018-19. The Director of Finance advised that minor changes were possible once the external audit was completed but the substance and materiality would not be changed. The Committee advised that the briefing sessions that had been held with the finance team prior to the meeting had been beneficial. The Audit Committee recommended the final accounts for 2018-19 for approval by the Trust Board.

Quality Account
The Committee considered the draft Quality Account. The report assessed progress against the priorities identified in the previous year and included details of the priorities for the forthcoming year. The report had been circulated to external stakeholders for comments and amended based on the feedback received to date.

The External Auditors' work in relation to the Quality Account remained in progress and a separate report would be issued in due course to report the detailed findings and conclusions of the work. They advised that their work included a check of the content of the report against the annual report and testing of two indicators. One of the indicators that had been tested was the 4 hour Emergency Department target and due to a change in the way that the data was recorded by the Trust over the period they were testing, the External Auditors advised that they would be unable to conclude that the indicator was reasonably stated in accordance with the dimensions of data quality.

The Audit Committee recommended the Quality Account for approval by the Trust Board.

OTHER

Internal Audit Annual Report and Head of Internal Audit Opinion
The Head of Internal Audit's opinion was unchanged from the draft provided at the previous meeting. The opinion was:

'The organisation has an adequate and effective framework for risk management, governance and internal control.

However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure it remains adequate and effective.'

The opinion was included within the AGS. The Head of Internal Audit advised that this was a positive opinion whilst acknowledging that there were areas for enhancement. He advised that this was the most common opinion provided to NHS clients.

External Audit ISA 260 Report
The Committee considered the ISA 260 report provided by the External Auditors. They advised that there were some outstanding matters that would be completed following the meeting. The most significant matter still to be finalised was in relation to the treatment of capital expenditure relating to the Lorenzo stabilisation work. The External Auditors were confident at this stage that this would not be a material issue and the accounts would not lead to a change to the ISA 260 report, but a statement regarding the matter would be provided to be appended to the letter of representation.

The External Auditors' anticipated issuing an unmodified audit opinion on the consolidated Group financial statement and the Trust's individual financial statements. They were proposing to qualify the opinion on an 'except for' basis in respect of use of resources. This position was consistent with the majority of other trusts.

Letter of Representation
The Committee noted the letter of representation and acknowledged that it was subject to change, dependent on the outcome of the final external audit work (as referred to above).

Internal Audit Tracking Report
The Audit Committee considered the latest Internal Audit Tracking Report. The Committee discussed that whilst there had been some improvement in terms of ensuring actions were completed on time, the position was still not ideal. The Committee discussed steps to ensure performance improved further. It was agreed that the report would be expanded to include external audit and counter fraud actions in future.

Local Counter Fraud Specialist Annual Report
The Committee received the LCFS Annual Report which provided an overview of the key pieces of work undertaken as part of the counter fraud work plan in 2018/19, a summary of the reactive referrals reviewed and investigations pursued and outlined the ratings awarded during the Counter Fraud Authority's Self Review Assessment.

Regarding the self-assessment, the overall rating was amber (as had been the case in 2017/18). Action points had been developed to address the actions that were rated as red or amber.

Clinical Audit Assurance
The Medical Director attended the meeting to present the Clinical Audit Assurance Report. The Audit Committee was required to assure itself on the questions relating to clinical audit set out in the Audit Committee Handbook. To provide the necessary assurance, the Clinical Audit and Effectiveness Manager undertook an annual review of all clinical audit processes and systems and completed an evidence-based assessment table which was provided within the report.

The Medical Director suggested that whilst the undertaking of audits in the Trust was generally good, he considered that bringing action plans to fruition was an area that could be improved. He advised that the clinical audit policy was due for review by the end of the year and work was taking place to review the clinical audit function. The Committee noted the report.

Board Assurance Framework and Risk Update
The Audit Committee received the latest BAF and Risk Register Reports. Regarding the BAF, this had now been updated with the new framework that was agreed at the previous meeting. The next step would be to update individual risks following consultation with the relevant director owners. The Committee discussed the progress in terms of risk management over the last year and noted some of the developments.

The Committee discussed the role of the Audit Committee in terms of risk management. It was agreed that they did not want to duplicate the work that was taking place at the FPC and QSC where the risks were covered by the reports considered at each meeting. It was agreed that the Audit Committee should maintain an oversight of the areas where risks had not progressed and would receive detailed reviews on some of the BAF risks throughout the year.

NHSI Governance Self-Certification
The annual self-certification provides assurance that NHS providers are compliant with the conditions of their NHS provider licence. Compliance with the licence is routinely monitored through the Single Oversight Framework but, on an annual basis, the licence requires NHS providers to self-certify as to whether they have:

- Effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution (condition G6)
- Complied with governance arrangements (condition FT4).

The Audit Committee approved both statements as 'confirmed'.

Jonathan Silver
Non-Executive Director

July 2019

East and North Hertfordshire NHS Trust

Agenda Item: 9.4.1

TRUST BOARD - PUBLIC SESSION – 3 JULY 2019
Quality Account

Purpose of report and executive summary (250 words max): To present the final version of the Trust's Quality Account 2018-19, as submitted to NHS Choices.		
Action required: For information		
Previously considered by: **The QA was approved (subject to final completion of the external audit) by the Trust Board on 23 May 2019.**		
Director: **Director of Nursing**	**Presented by:** **Director of Nursing**	**Author:** **Head of Quality and Patient 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

East and North Hertfordshire NHS Trust

Quality Account

2018-19

Contents


https://www.facebook.com/enherts/


http://twitter.com/enherts


https://www.youtube.com/user/Enherts

We always appreciate feedback from members of the public. If you'd like to tell us your thoughts on the Quality Account or suggest ideas for items to focus on in the future please let us know. We can be contacted by email ftmembership.enh-tr@nhs.net

Part 1

1a Statement on quality from the Chief Executive

2018/19 has been a year of transformation, setting the foundations from which to base further improvements. The quality transformation plan outlined a series of objectives to improve care through better understanding and monitoring of important matters such as falls and infection control; to ensure structures are in place to optimise accountability and oversight; to introduce new ways of working to improve safety and patient experiences; and to further develop ways of sharing learning. We've also invested in the quality and safety team to support frontline staff in delivering the transformation. Examples of how the plan is being implemented are given throughout the report.

Our patients continue to rate highly the care given with around 97% of in-patients recommending the Trust. Feedback from patients and their carers is generally that the Trust offers friendly staff, and good care; but poor administration, communications and waiting times. We are also aware that the Trust's appointment systems are complex and not easy to use. Efforts are underway to make improvements with 2018/19 focusing on a number of information technology projects in particular redesigning the processes and communication of discharge summaries. I am pleased that a new process has been established and is being rolled out. Staff are reporting the benefits but there remain some concerns by GPs regarding missing or delayed summaries. This situation will improve during 2019/20.

We welcomed the Care Quality Commission (CQC) who undertook a review of our services at the Lister Hospital, QEII Hospital and Mount Vernon Cancer Centre. Whilst a number of improvements were seen the inspection highlighted that the Trust is not yet consistently delivering high quality care across all of its services or sustaining performance of key national standards.

I'm grateful for the time spent by staff working with partners and members of the public throughout the year to produce the Clinical Strategy which outlines how we will drive high quality, compassionate care in the future.

The Trust Board has made a fundamental commitment to improving quality and we look forward to building on the good work and successes of 2018/19.

To the best of my knowledge the information in this document is accurate.

Nick Carver, Chief Executive

1b About us

East and North Hertfordshire NHS Trust (ENHT) provide:

- Secondary acute services to a population of approximately 600,000 people across east and north Hertfordshire, and south Bedfordshire
- Tertiary cancer services to a population of over 2 million from London, Hertfordshire and Bedfordshire, from the Mount Vernon Cancer Centre (MVCC)
- Community children's services to the population of East and North Hertfordshire
- Satellite renal dialysis units in Luton, Bedford, St Albans and Harlow

The Trust offers 23 specialities across four sites (including MVCC). It has a turnover of £417m and employs 5,000 staff.

During 2018/19:

152,080 attendances to the Emergency Department

63,379 day case admissions
48,272 emergency admissions

172,213 first out-patient appointments attended

Our hospitals

Lister Hospital	District general hospital in Stevenage providing medical and surgical specialties together with maternity and children's services. General wards are supported by critical care and coronary care units, as well as pathology, radiology and other diagnostic services. There are specialist sub-regional services in urology and renal dialysis; and chemotherapy services are delivered via the Lister Macmillan Cancer Centre
Hertford County Hospital	Based in Hertford the hospital provides outpatient and diagnostic services including: • Radiology and Pathology • A range of outpatients clinics • GP out-of-hours service • Specialist children's centre • Physiotherapy and other therapies
Mount Vernon Cancer Centre	The Cancer Centre, based in Northwood in Middlesex, offers comprehensive chemotherapy and radiotherapy services; with many patients involved in clinical trials. There are two inpatient wards and a range of day-case services are offered. Other services include: • The Paul Strickland Scanner Centre providing comprehensive scanning services for the diagnosis, treatment, monitoring and research of cancer and other

	serious diseases • The Lynda Jackson Macmillan Centre providing support, information and therapies (eg massage) to people affected by cancer
Queen Elizabeth II (QEII) Hospital	The new QEII in Welwyn Garden City is owned by a partnership arrangement, although clinical services are managed by the East and North Hertfordshire NHS Trust. The hospital offers a full range of outpatient, diagnostic (radiology, pathology and endoscopy), therapy and ante/post-natal services. It has a 24/7 urgent care centre for adults and children with minor injuries and illnesses and carries out some day case procedures. Pre-operative assessments are undertaken as well as care and treatment offered within the Breast Unit.

Satellite and Community Services

The Trust provides services in renal medicine and has satellite dialysis units at St Albans, the Luton & Dunstable Hospital, Bedford Hospital and the Princess Alexandra Hospital in Harlow.

The Trust offers community services for children and young people. Services include provision, by the continuing care team, of respite care in the home for children with complex health needs; specialist school nursing for children with learning disabilities and other medical impairments; and diagnosis and management of a range of conditions through the teamwork of doctors, nurses, therapists and special health visitors.

1c 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 the 5 year clinical strategy.

Services 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 the 2018 transformation phase of managing quality we have:

- Defined a 'model of quality improvement' that can be adopted by all, from 'ward to board'
- Undertaken a 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
- Designed the plans for our 'Clinical Excellence Framework'
- 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 improvement 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 use 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 understanding 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'?

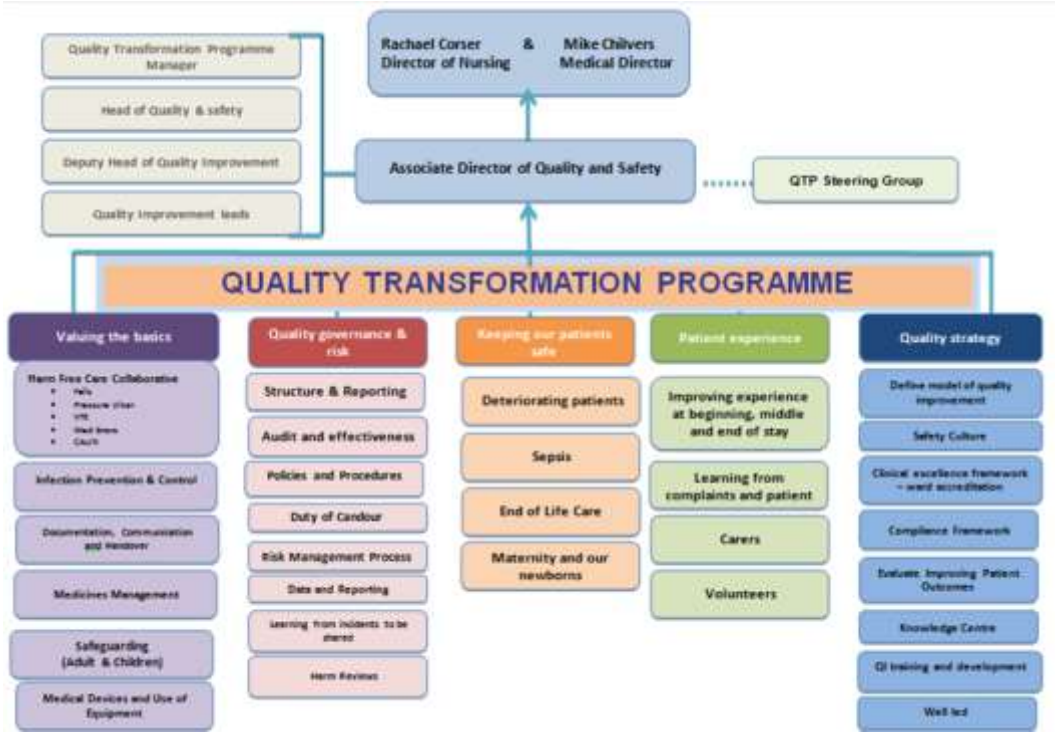
Through 2018 **4 key quality pillars** have been identified to provide a structure in which to focus our efforts of continuous improvement. These are:

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.

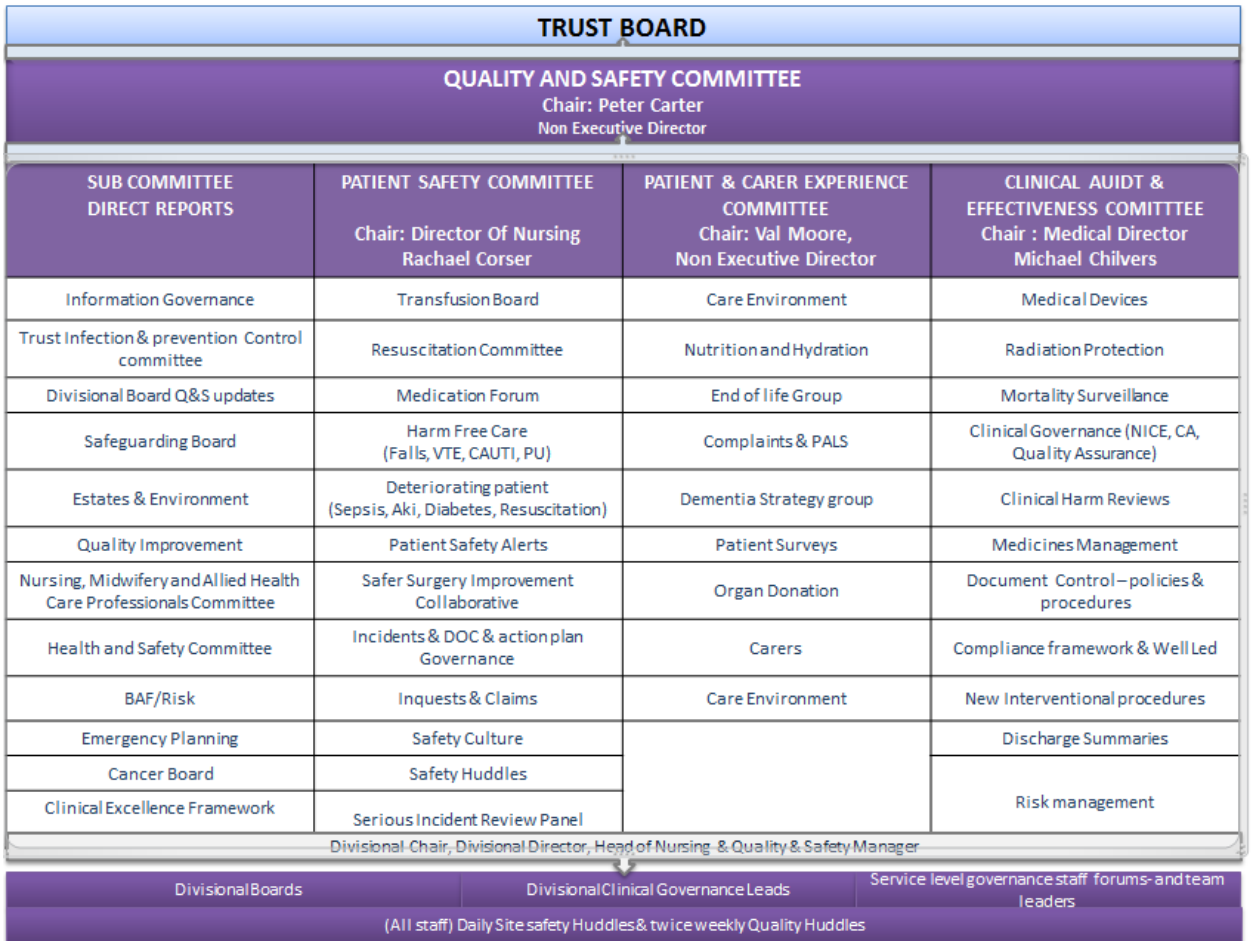
Quality Pillars	
Pillar	**Workstream**
Valuing the basics	• Harm Free Care Collaborative – venous thrombo-embolism, pressure ulcer reduction, catheter associated urinary tract infections, falls, medicines management • Infection Prevention and Control • Documentation and communication – assessment and 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

Governance of Quality Transformation in 2018



Committee structure

The Trust Board has overall responsibility for the delivery of quality with the support of sub-committees who evaluate progress and monitor assurance. During 2018/19 the Board sub-committee structure and terms of reference were revised to strengthen accountabilities and oversight. The framework is shown in the diagram below.



Divisional structure

The Trust has five clinical divisions: Medical, Surgical, Cancer, Women's and Children's and Clinical Support Services. Each is led by a Divisional Director, Divisional Chair and a Head of Nursing. The divisions are separated into a number of clinical specialties each headed by a Clinical Director supported by senior nurses and managers. Roles and structures within each division support the monitoring of quality.

The clinical divisions are supported by staff from departments such as education, patient safety and organisation development. These provide advice and information to support evaluation and learning.

Rolling half days (RHD)

Each month (except January and August) all non-emergency activity is suspended for half a day to allow a significant proportion of team members to meet and to review their practices. This dedicated time offers an opportunity to review outcomes such as audit findings, care reviews and incident investigations, and where necessary to make plans for improvement.

RHD 'learning points' and divisional reports providing tailored feedback are prepared by the governance teams and are circulated prior to the meetings for discussion. These highlight

recent matters of concern or interest for sharing; and examples of learning from incidents, claims etc.

Site safety huddles

Occurring daily these huddles describe key matters of concern on that particular day such as staffing levels, or demand for services.

Quality and Service Improvement for Leaders

These multidisciplinary sessions occur throughout the year and provide staff with 2 days to learn quality improvement methodology and tools, applying them to an identified aspect of quality within their services.

LEND sessions (Listen, Empower, Nurture and Develop)

These leadership development sessions have covered a vast array of topics and issues from interpersonal communication, coaching as an approach to leadership, complexity, organisational habits, resilience, resistance, followership, value of values, the importance of WHY, culture, teamwork, quality, unconscious cognitive bias, compassion and 'Why Patients Need Leaders'.

Quality huddles

Started in early 2018 the Quality Huddles occur each Tuesday and Friday morning the quality huddles are a gathering of senior nursing staff (sisters, matrons) to discuss recent quality achievements, matters of concern or points for sharing.

Part 2

2a Review of quality performance in 2018/19

Data is given for the full year 2018/19 unless specifically specified and 2018/19 priorities included:

1. Reduction in avoidable harm to our patients:

- 1.1 Improving medication errors and antibiotic stewardship
- 1.2 Improving sepsis pathway management
- 1.3 Improving Surgical Safety Checklist (WHO/ NatSSIPs)
- 1.4 Improve the management of the deteriorating patient
- 1.5 Safeguarding adults & children

2. Use of digital technology

- 2.1 Electronic vital signs observations
- 2.2 Electronic medication-prescribing
- 2.3 Electronic discharge summaries

3. Respect our patients time through improving the flow through our in and outpatient services by:

- 3.1 Improve discharge process
- 3.2 Improving experience and access to our outpatients department
- 3.3 Reduce the number of patients who are delayed in the care they receive through the Emergency Department

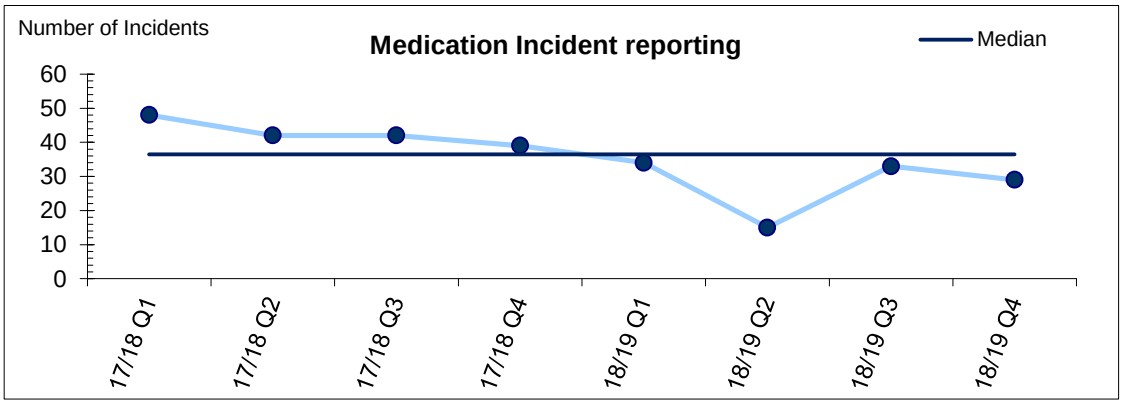
4. To be amongst the best in the experience our patients have through:

- 4.1 Implementing always events
- 4.2 Improving our friends and family response rate in all our services

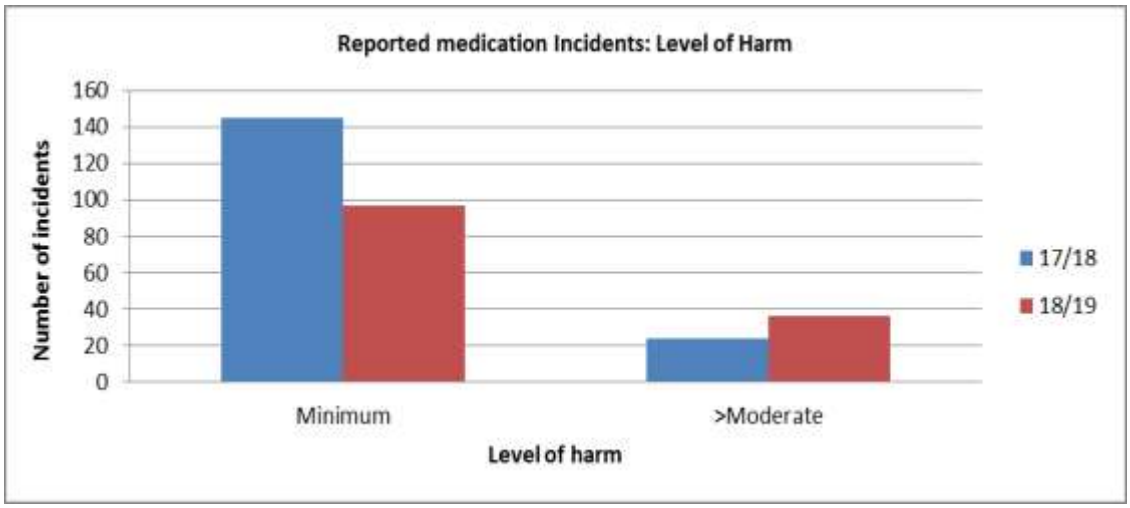
Priority One: Reduction in avoidable harm to our patients

Priority 1.1 Focus on reducing medication errors, timely delivery of critical medications and management of antibiotics

- The number of medication errors reported on the trust safety incident management system continues to show a downward trajectory. Quarterly data trends can be seen in chart below.



- Overall harm associated with medication errors has reduced. All incidents where potential moderate harm or above may have occurred are reviewed by the Trust Serious Incident Review Panel.



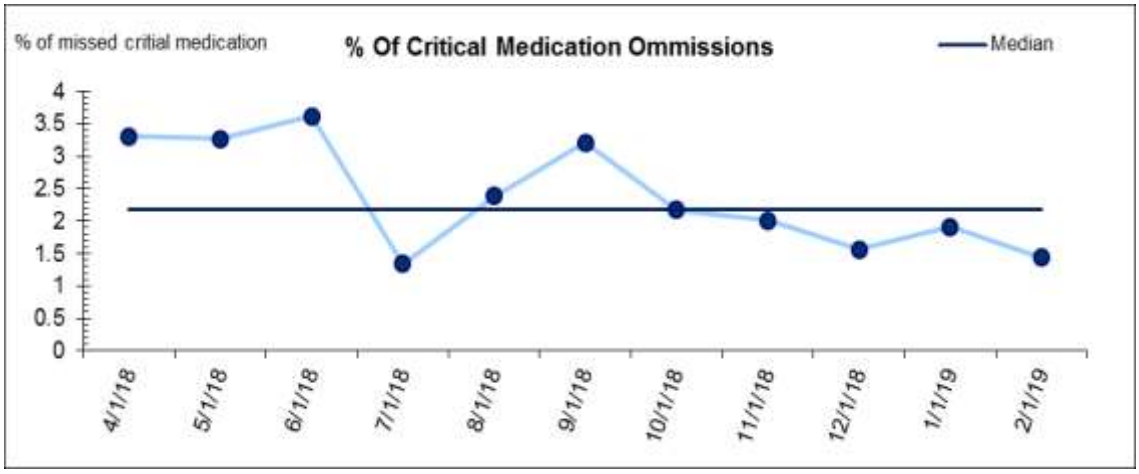
- Critical drugs are those where a delay or omission could have a serious detrimental effect to the patient eg. medicines used for managing Parkinson's disease, diabetes or sepsis. Monthly spot-check audits are undertaken to establish the percentage of omitted and delayed (more than 2 hours) doses.

  The audit reviews 10 drug charts on each ward and provides real time feedback to ward teams where information about the delays and omissions are acted upon quickly.

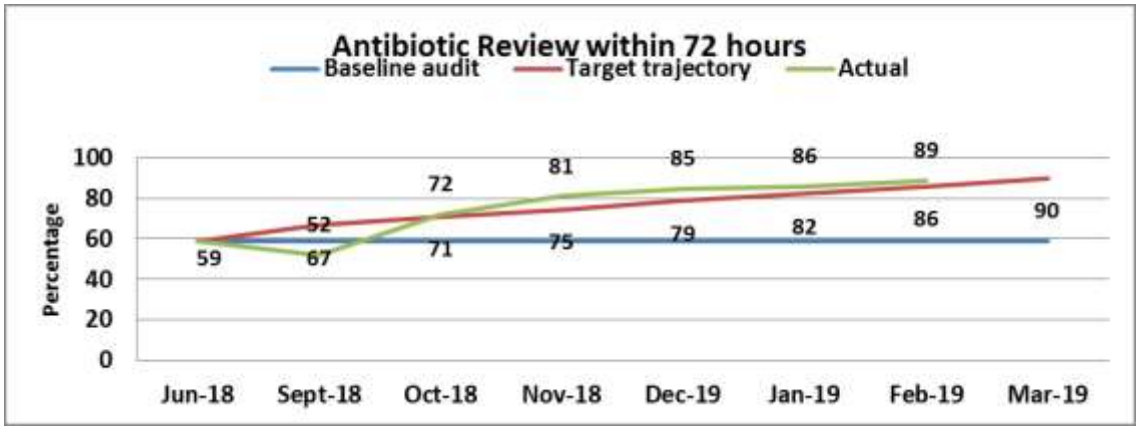
Improvement since 2016/17 can be seen in the table below.

		16/17	17/18	18/19	Aim
1.1	% critical medication doses omitted	8.38%	<6.15% (Since Dec 17)	**2.46%**	<5%

- The % of critical medication omission continues on a downward trajectory, as seen below.



- Antimicrobial stewardship ensures that antibiotic usage is monitored carefully so that people who need them receive them for the correct amount of time. Inpatients on antibiotics should have their medicines reviewed every 72 hours. The graph below shows the improvement in compliance towards the aim of 90% by March 2019 from a 59% baseline in June 2018.



This improvement has been achieved by:

- Ward pharmacists providing audit feedback to staff to reinforce reassessment within 24-72 hours of initiation of antibiotics
- Doctors using the ward round safety checklist prompt which includes review of antibiotics
- The requirement for written rationale where a patient requires extended use of intravenous antibiotics
- The development of an antimicrobial stewardship prompt card

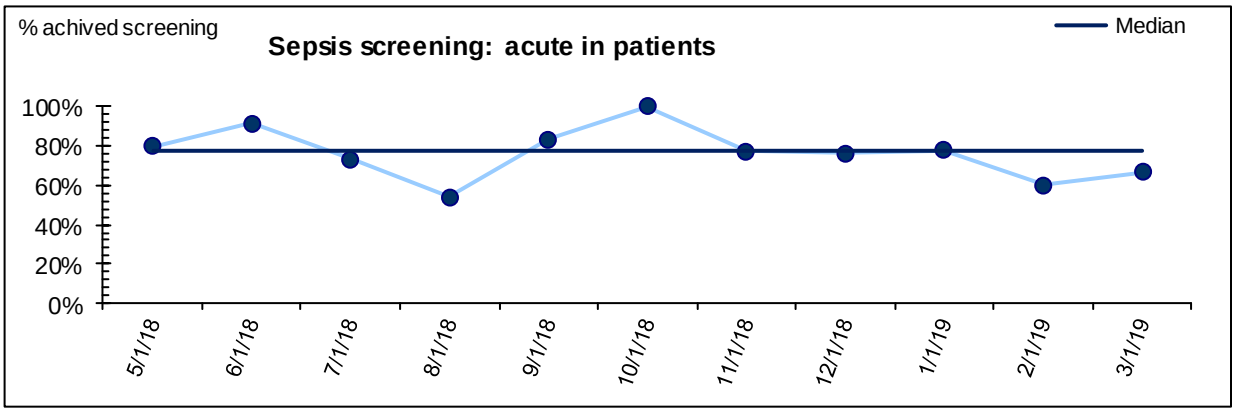
Priority 1.2 Increase compliance with sepsis pathway

Compliance information is recorded on the monthly integrated performance report produced by the information department. Tabular and graphical information is shown as per tables below, showing the month position overtime.

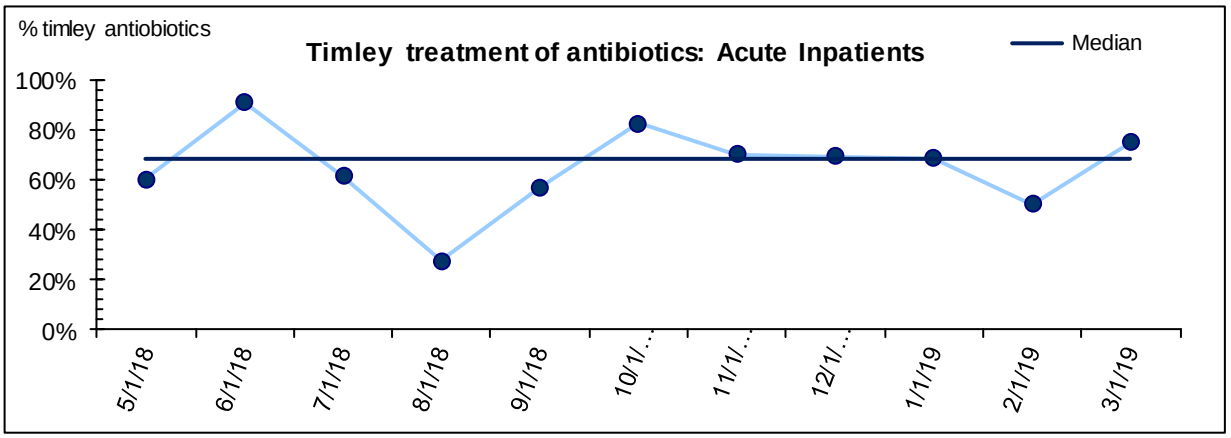
		17/18	18/19	Aim
1.2a	Screening for sepsis in the Emergency Department	92.75%	**>90%**	>90%
1.2b	Neutropenic sepsis door to needle time		**49%** **(Feb 2019)**	>80%
1.2c	Antibiotics in ED within an hour	61.5%	**72.35%** **(Apr-Jan)**	>90%
1.2d	Antibiotics on the ward within an hour		**60.4%**	>90%
1.2e	Introduce sepsis module on Nerve Centre	N/A	**x**	Implement

Compliance information is recorded on the monthly integrated performance report and trend information is shown as per table below, showing the month by month position.

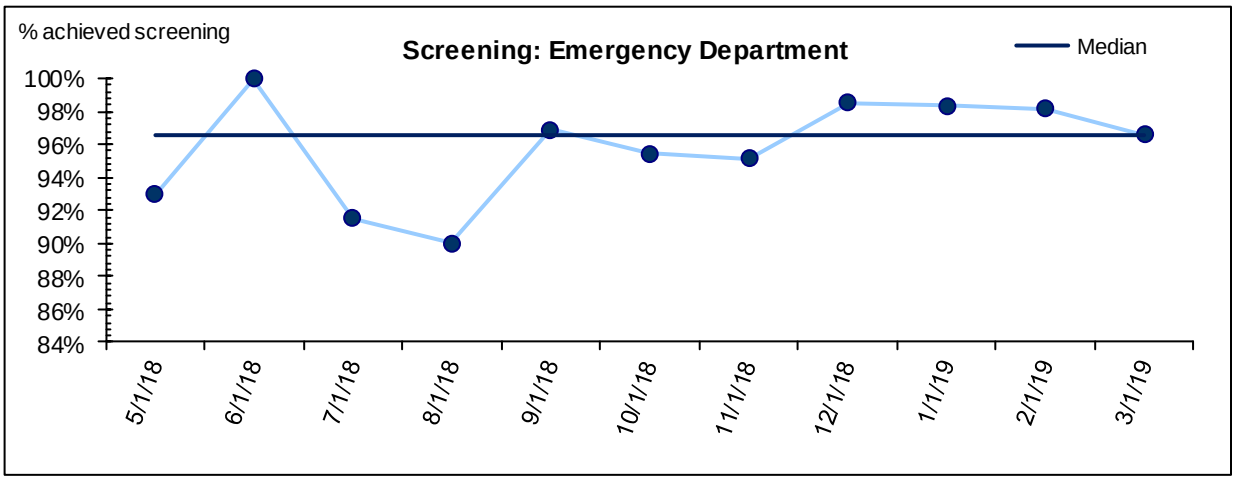
- Sepsis Screening: Acute in-patient
  AIM: 90%; current average compliance 80%



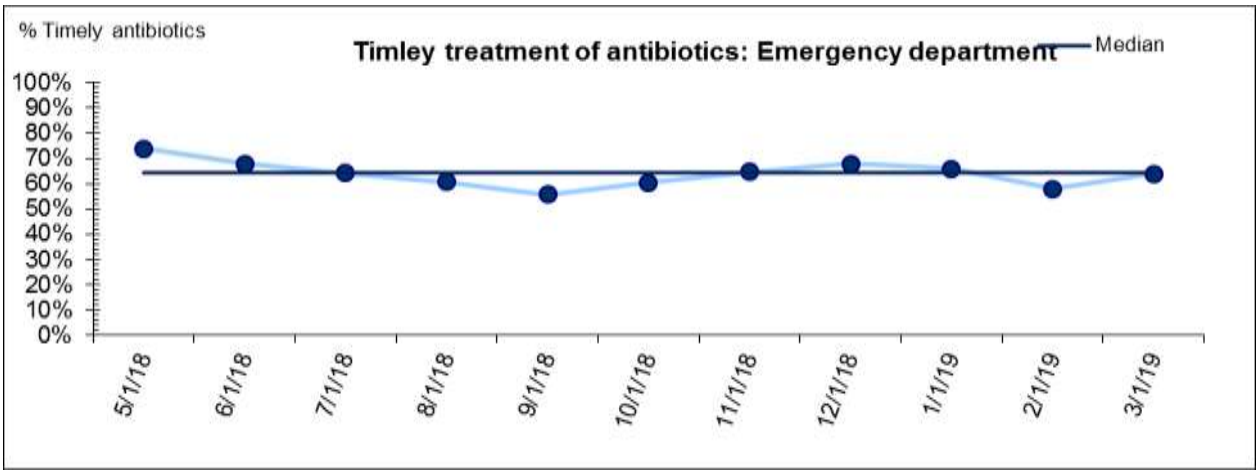
- Timely treatment of sepsis with IV antibiotics: Acute inpatient departments
  AIM: 90%; current average compliance 70%



- Screening within the Emergency Department
  AIM: 90%; current average compliance is 96%



- Timely treatment of sepsis with IV antibiotics: Emergency department
  AIM: 90%:, current compliance 64%.



- Patients with a low white blood cell count, known as neutropenia, have a reduced ability to fight infections, and are therefore at greater risk of developing sepsis. Chemotherapy treatment lowers the number of white blood cells so it's important that patients with cancer, who have recently received chemotherapy treatment and are showing signs of infection, are treated quickly. Audits are undertaken each month to measure whether the patients with suspected sepsis receive antibiotics within an hour of arrival to the hospital.

  The results of the door-to-needle time audits are as follows, demonstrating that the aim has not yet been achieved:

  - January 2019: 50%
  - February 2019: 49%

  At the time of writing the full year evaluation is underway.

Sepsis Improvement:

- Our electronic vital signs system (Electronic Observations on Nerve Centre) can be developed to deliver sensitive sepsis awareness capabilities. Prior to implementing this

capability a software update was required to enable Nerve Centre to become compliant with the new national early warning score (NEWS2) requirements. This upgrade was tested in March 2019 and implemented in May 2019. Progress on further adaptation and implementation of 'sepsis alerts' will be reported within the 2019/20 report as part of the sepsis pathway compliance update.

- Mortality (HSMR) for Septicaemia covering 12 months to October 2018 is at 81.06 and in the 'better than expected' range. This is better than the England average of 100.

  The improvements have been achieved by:

  - Sepsis nurse role modelling in the Emergency Department by facilitating assessment and treatment; highlighting patients on chemotherapy who are at greater risk of sepsis
  - Locality teaching sessions and ongoing promotion and education, eg. Maternal Sepsis Week
  - Review of patients within 24 hours of admission with intervention if required
  - Monitoring the in-patent list on Nervecentre to proactively identify patients whose observation scores are >5 or 3 in one parameter, indicating potential infection
  - Surveillance of patients with a learning disability for early signs of sepsis
  - Introduction of a 'sepsis grab-bag' which is being piloted at the time of writing

Priority 1.3 Improving Surgical safety checklists (National Safety Standards for Invasive Procedures 'NatSSIP')

The World Health Organisation (WHO) Guidelines for Safe Surgery (2009) has been combined to widen the lens of expectations during invasive procedures through publication of NHS England's National Safety Standards for Invasive Procedures (NatSSIPs) Framework (September 2015).

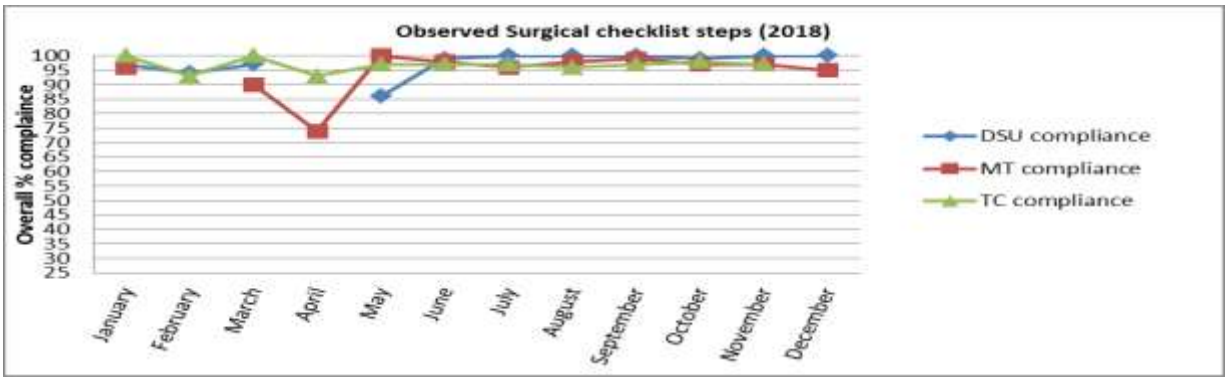
The NatSSIPs have been created to bring together national and local learning from the analysis of patient safety incidents such as Never Events, Serious Incidents and near misses in a set of recommendations that will help NHS organisations to provide safer care to their patients. The aim is for the trust to review local standards and ensure that these are harmonised with the national standards.

		17/18	18/19	Aim
1.3a	Redesign WHO checklist compliance audit	N/A	✓	Complete
1.3b	Compliance (phased approach)	100%	Variable	>99%

- Previous audits have focused on document completion but despite evidence of good documentation there have still been incidents relating to surgical error. A 'safer surgery' workstream has been established to look at ways of improving surgical safety with one action focused on the NatSSIP standards.

- Observational 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. Over 2018 a total of 265 observations were recorded, each area total compliance is seen on chart below.



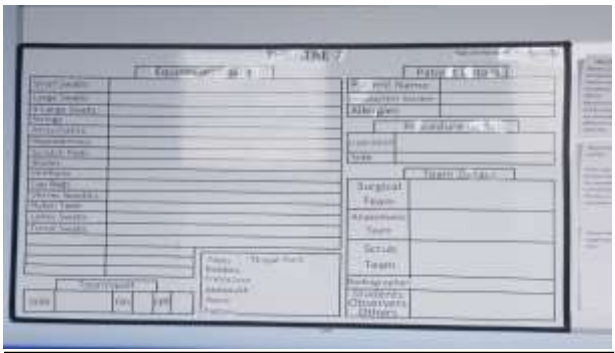
At the time of writing it has been 193 days since our last reported surgical never event. There were 6 never events reported this year, 4 related to invasive procedures.

Themes for Never Events have included human fcators such as distractions and interruptions, reduced team situation awareness and communcation. Clinical teams have started designing training to improve these surgcial team communication skills and have developed tools such as 'Video ENHT Surgcial Team Working' for dissemnaiton to all teams invloved in invasive procedures and on induciton to the Trust.

Ongoing improvements include:

- Refinement of the NatSSIP standards – with a focus on anaesthetic block administration
- Re-design communication tools e.g. team boards in theatres to give at a glance assurance about the patient, team, equipment etc
- Develop plan to improve staff knowledge and skills of human factors associated with incidents occurring e.g. team situation awarenss and distractions and interruptions
- Strengthen the governance of more trust wide invasive procedure standards (ie non-theatre areas)

Surgical Team Video



Team communication board

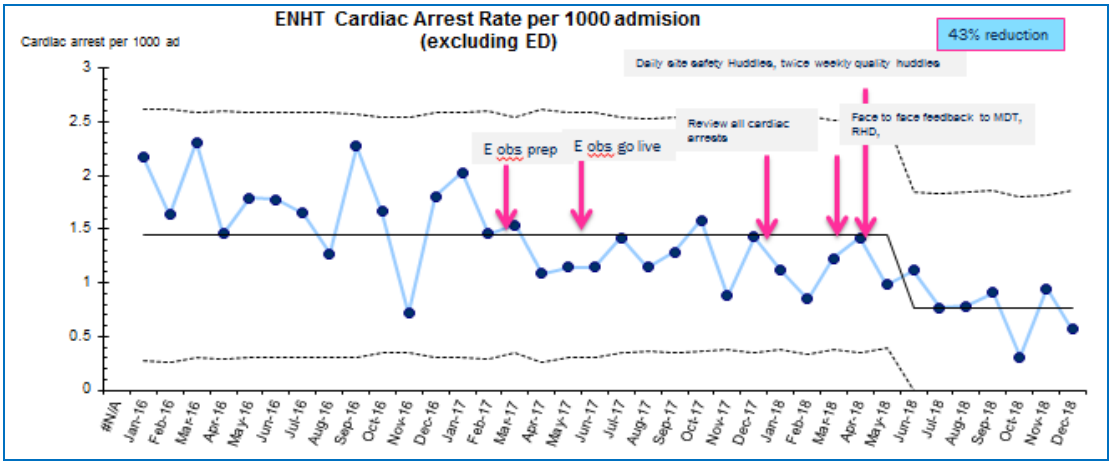
Priority 1.4 Improve the management of the deteriorating patient

		17/18	18/19	Aim
1.4a	Reduce rate of cardiac arrests (per 1000 patients)	2.25	0.8	<2
1.4b	Introduce revised DNACPR* form with launch	N/A	✓	Complete
1.4c	Root cause analysis completed for all cardiac arrests with learning captured and shared	N/A	✓	Complete

*DNACPR – Do not attempt cardio-pulmonary resuscitation

- 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.

  Trust data has been interrogated using statistical process control chart methods, and has demonstrated a **43% reduction in in-hospital** cardiac arrests rate per 1000 admissions. This is demonstrated in the chart below with the improvement resulting from multiple actions as highlighted.



- An audit of 97 DNACPR forms conducted during January 2019 across the Lister site identified the need for:

  - Better documentation of discussions regarding resuscitation decisions
  - Clarification about the need to record DNACPR status on the nerve centre electronic system for more timely access in an emergency
  - A more robust process for the handover of patients not appropriate for CPR

  From the audits undertaken we know that 40% of resuscitation events were not in the patient best interests ie intervention to support a comfortable end of life care plan may have been more appropriate. To this end a personalised treatment plan has been created and a three month pilot commenced in February 2019.

- Root cause analysis is undertaken routinely following all cardiac arrests to identify whether there were any omissions in care in the 24-48 hours before the arrest which may account for the deterioration.

- An analysis of 82 cardiac arrests from January to December 2018 was undertaken and is routinely reported back to clinical teams. These audit analysis show:

  - 10% had received optimal care
  - 35% were identified for further review, in particular infrequent monitoring of observations or failure to escalate concerns
  - 55% showed the need for some local improvement, mainly around escalation of deterioration and documentation.

Patient Safety achievements in 2018/19

- Through collaborative working of our Sepsis, Acute Kidney Injury, Critical Care Outreach Team (CCOT) and resuscitation teams the organisation has seen the introduction of face to face root cause analysis with local teams post cardiac arrests. The Deteriorating Patient Collaborative have currently analysed data to identify where 80% of cardiac arrests have occurred and escalation could have been strengthened. This improvement work and pilot areas is underway. The Trust has presented this at local and national patient safety events and has submitted this for consideration for a number of national awards

- As part of Doctoral Studies, our sepsis lead nurse has presented her research and shared experiences on improving the care of patients with learning disabilities who develop sepsis in the Houses of Parliament, resulting in the development of, and influence over, the national sepsis agenda

- Our learning disabilities team have been recognised nationally for their work in implementing the national standards published in 2018

- Our safeguarding team have established closer collaborative working across children and adults services, reviewed and delivered new adult safeguarding training, designed and implemented Learning Disability action plans

- Recognised nationally by the Twins and Multiple Births Association (TAMBA) for the outstanding work we do for our multiple birth pregnancies.

Priority 1.5 Adult and children's safeguarding services

Adult safeguarding is an important part of patient care within the Trust, reflecting the statutory framework for adult safeguarding under the Care Act 2014.

The Trust's director of nursing is the executive lead for safeguarding in the Trust, with the day-to-day work of adult safeguarding undertaken by all Trust staff with support from the adult safeguarding nurses and adult safeguarding doctor. All staff receive training and regular updates, guided by the Trust, local and national policies. The Trust is an active partner in the activities of the Hertfordshire Safeguarding Adults Board.

The Trust continues to support the adult safeguarding systems and processes in Hertfordshire by raising concerns, or supporting families to raise concerns, about neglect or abuse and to work with adults at risk to provide personalised protection plans.

During 2018/19 the Trust has continued to work closely with the Herts IDVA (independent domestic violence advisor) to support victims of domestic abuse. Through raising awareness of domestic abuse an increase in the number of cases being referred to the IDVA has been seen. More victims are therefore being offered practical support to escape abusive relationships.

- Work has also been undertaken in partnership with other health organisations and the Modern Slavery partnership to raise awareness of modern slavery and victims.

- Providing support to at risk adults is an important part of health care and the Trust has developed services to support adults with particular needs. For example, adults with learning disability are supported by the learning disability acute liaison nurses and patients with dementia are supported by the Trust's Admiral Nurse and the enhanced care team.

- During 2018/19 the Trust's ophthalmology service at the Lister Treatment centre was successful in being awarded Purple Star accreditation by Hertfordshire County Council in recognition of the work the team has done to develop learning disability-friendly services. This was the fourth service to receive the accreditation. The Emergency Departments and Endoscopy services also began the work to achieve accreditation.

- The Trust has also developed action plans to improve the care for adults with Learning Disability (LD) following concerns about the care of patients with LD. The Trust has taken part in the NHSI LD standards benchmarking exercise, established the LD working group and committed to ensuring staff have the skills and knowledge to provide appropriate care for patients with LD.

- Our learning disability population are also a priority in the Harm Free Care Collaborative, where we have focused improvements on key topics e.g. recognition and management of the deteriorating patient with Learning Disability.

- The Trust has an Enhanced Care Team that provides enhanced support on the Lister's wards for patients who need extra supervision or assistance whilst they are in hospital; this can include patients with confusion, delirium, dementia, learning disability or physical disability. The team works with patients to reduce agitation or distress and help to keep patients safe from harm.

- During 2018/19 emphasis has been given to patient safety, including actions to promote and use safety huddles on wards and whole site, the aim of which is to make sure that the whole team is cited on risks or actions that need to be taken to promote safety and reduce the risk of harm to patients. This has included highlighting at a senior level any situations where delays or blockages have occurred in delivering patient care so that actions can be taken to resolve issues or concerns.

- The Butterfly volunteers, who provide support to patients and their families at the end of life, particularly where an individual may not have anyone who can stay with them, were winners of the NHS70 Care and Compassion award in 2018. This recognised the commitment these volunteers have given to patients when they are at a particularly vulnerable stage in their life's journey.

- The work of the adult safeguarding team continues to include awareness training for staff around the statutory duty for Prevent (the Government's anti-radicalisation strategy), as well as increasing knowledge and skills in relation to use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The Trust continues to see a year-on-year increase in the number of urgent authorisations for Deprivation of Liberty Safeguards (DoLS) since the changes made by the Supreme Court in 2014.

Children's Safeguarding services promote the welfare of children and prevent them from harm. It is a core part of the Trust's business and recently has had a very positive review to ensure compliance against Section 11 of The Children's Act.

- The Trust works closely with partner organisations and services; it has executive representation at the Hertfordshire Safeguarding Children's Partnership through the Trust's director of nursing and executive safeguarding lead attending these meetings. The children's safeguarding team attend a number of working groups to ensure representation in yearly work plans and objectives.

- During 2018/19 the Children's safeguarding service has continued to manage a continued increase in workload including referrals to children's services and information requests.
- The service has developed and piloted a workbook for staff in adult areas caring for young people aged 16 and 17years. This was successful and is now being launched across the organisation.
- The children's safeguarding team continue to carry out safeguarding supervision and peer review sessions for all staff within the service and these have also been audited for quality and changes made as appropriate and feedback to participants.
- The service has also been actively involved within the organisations emphasis on patient safety including the site safety meetings which a member of team attends to ensure representation and promote safeguarding of our younger patients across the organisation and escalating areas of concern and helping mitigate issues and concerns that are highlighted.
- The service is actively involved in developing a joint safeguarding quality dashboard across the whole organisation for children and adults, measuring key performance indicators.

The Trust is committed to providing high quality services for people with learning disabilities. The Trust has established a learning disability steering group, chaired by the Director of Nursing, to oversee the implementation of the NHS Improvement Learning Disability improvement standards that were published in July 2018. The Trust is partially complaint with each of the three standards and will be fully compliant by the end of October 2019.

Priority Two: Use of digital technology

Priority 2.1 Further embed the way we use technology to improve the care we provide to our patients through e-observations and live bed state

		17/18	18/19	Aim
2.1a	Complete roll-out of Nerve Centre across all areas	**N/A**	✓	As plan
2.1b	Launch escalation module	**N/A**	**x**	Complete
2.1c	Audit of compliance with timely observations	**Improved**	**x**	Complete
2.1d	Audit of compliance with response to escalations	**N/A**	**x**	Complete

a) Nerve Centre is an electronic system for recording clinical observations eg blood pressure. The system was implemented in September 2017 and has been rolled out to all Trust sites. Handheld devices are assigned to staff each shift and are used for recording the observations. The data is held centrally and is accessible from remote computers allowing doctors to view information from any computer to support early decision making.

b) Alerts can be sent to staff directly from Nerve Centre when observations indicate that further medical or senior review is required. However the full escalation module has not yet been launched. Through preparations for the initiation of the new mandatory National System (NEWS 2.0) our improvement plans have identified a sense of urgency to plan and adopt this important escalation module, and work has started for implementation in 2019/20.

c) Trust-wide oversight of timeliness of e.observations has been a challenge, and this has been escalated through senior executive leads. Discussions are now underway with the manufacturers of the software to facilitate real time oversight and audit of timeliness of e. observations.

d) As above, discussions are now underway with the senior leaders and manufacturers of the software to facilitate real time oversight and audit of timely response to escalations of e. observations.

Priority 2.2 Electronic-prescribing

		18/19	Aim
2.2	Progress with plan towards implementation of electronic prescribing system	**x**	Progress

- Electronic prescribing and medicines administration (ePMA) systems replace paper medication charts by having an electronic solution with recognised medication doses, easy identification of medications that might conflict and bar codes to help ensure that patients receive the right medications at the right time. Using such a system should reduce medication errors and improve efficiency.

  An opportunity for funding for ePMA arose from central government. The Trust applied for this funding but was informed in March that the application was unsuccessful. Further opportunities will be explored during 2019/20.

Priority 2.3 Electronic discharge summaries

		17/18	18/19 (Aug-Mar)	Aim
2.3	Reduce number of discharge summaries not sent to GP within 24 hours of discharge	-	**7157**	Reduction

- Discharge summaries should be completed within 24 hours of discharge. This allows GPs to manage care effectively following departure from in hospital. A backlog of summaries not sent to GPs became apparent in early 2018 but the scale of the problem could not be confirmed due to problems in producing some reports from the new patient administration system introduced in the previous September.

- Since August 2018 we have been focused on improving the reporting of outstanding discharge summaries. At the time of writing the report a significant amount (7157) discharge summaries remain outstanding and improvement efforts continue to reduce this number as soon as possible.

- We recognise the serious potential for harm when discharge summaries are not sent to the GP as instructions for future care or treatment plans are not shared. During this improvement process clinical reviews have also been undertaken to proactively look for potential harm. A sample of 1595 patient notes discharged before July 2018 has been reviewed both internally and from external peers and no harm being identified.

- In January 2019 a revised discharge summary process was piloted with the intention to significantly reduce the time taken for the summary to be completed and sent on to the GP. The new form roll-out started in March with a significant number being completed in 'real time'. Doctors report that completion takes 5-11 minutes, instead of previous 45 minutes, enabling summaries to be provided to patients and their GPs more or less immediately after discharge.

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

Priority 3.1 Reducing delays in the discharge process

		17/18	18/19	Aim
3.1a	Delayed transfers of care	96	**Improved**	<96
3.1b	Patients discharged by midday	156	**Improved***	>156

*The rate of discharges has been measured during 18/19, rather than the number of patients

- Where discharges are complex, for example when a patient requires a care package or admission to a care home, the discharge planning may be time consuming. Consequently a proportion of beds may be occupied longer than anticipated. We have changed how we measure delayed transfers in 2018/19. A more meaningful measure through a proportion of length of stay days was introduced.

  During 2018/19 the proportion of beds occupied by someone over 14 days has reduced steadily from 24% in April to 19% in February. Similarly the proportion of beds occupied by someone over 21 days has reduced steadily from 13.6% in April to 9.5% in February.

Metric	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Proportion of beds occupied by patients with length of stay over 14 days	24.0%	23.2%	22.9%	21.4%	20.5%	20.9%	21.1%	20.8%	18.7%	19.4%	19.1%	20.1%
Proportion of beds occupied by patients with length of stay over 21 days	13.6%	12.7%	13.5%	12.4%	11.7%	11.1%	12.2%	11.1%	9.8%	10.3%	9.5%	10.9%

These improvement efforts have included:

- Considering alternative treatment options instead of in-patient stay
- Better working with community partners to maximise complex discharges eg. the Integrated Community Respiratory Service
- Enhancing weekend and out of hours working has supported more timely management of patient flow. This benefits both the current in-patient patient's experience; but also the overall efficiency of the organisation to respond to the needs of emergency admissions in ED.
- Expedition of discharges, through improved identification of patients who can safely transfer to the discharge lounge whilst waiting for transportation home. The number of patients being sent home via the discharge lounge has doubled since the start of 2018/19.

Metric	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Patients discharged via discharge Lounge	63	88	112	106	130	156	198	195	141	180	188	186
Discharge before midday	15.9%	16.4%	16.4%	16.2%	15.4%	13.3%	14.7%	14.6%	14.6%	14.8%	14.6%	14.3%

- On average we achieve discharging patients before midday 15% of the time, to increase this improvement efforts have been undertaken by the Trust through:
  - Prompt prescribing and dispensing of medications to take home
  - Prompt writing of discharge summaries (see priority 2.3)
  - Reduction in the number of medical patients admitted to surgical wards
  - Identification of patients suitable to use the discharge lounge during the preceding evening

Priority 3.2 Improving experience and access to our outpatient's department

The Friends and Family Test (FFT) is a question asked of people who have recently used the service whether they would recommend the service they have received to friends and family who need similar treatment or care.

		17/18	18/19	Aim
3.2a	Friends & Family Test (FFT) improved scores	>94.3%	**>93.6%**	>95%
3.2b	Improve cancer waits from 2017/18 position	Variable	**Variable**	Variable
3.2c	Report referral to treatment time data	N/A	✓	By Nov 2018

- The outpatient FFT score has been variable with 5 of 10 months above the target of 95%. The minimum score was 93.6%. In January 2019 the Trust score was 94.4% against an England average of 94%.

FFT	Metric	Target	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Trend
Outpatients	Proportion of positive responses	95%	95.2%	95.5%	96.6%	95.7%	94.7%	94.8%	94.9%	93.9%	93.6%	95.2%	94.1%	94.4%	
	Total number of responses		1,532	1,561	1,755	1,431	1,175	1,911	1,896	1,710	1,982	1,683	2,037	2,281	

- Cancer waits show a variable position compared with the previous year as shown in the table below.

12-months' performance - all standards	Standard	Target	2017-18 YTD	2018-19 Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	YTD
	Two week waits Suspected cancer	93%	97.7%	89.3%	92.1%	91.8%	95.5%	95.1%	92.6%	97.1%	96.7%	97.2%	95.6%	96.6%	97.0%	94.8%
	Two week waits Breast symptomatic	93%	94.0%	93.7%	91.8%	83.9%	97.3%	91.2%	88.8%	94.9%	94.4%	93.4%	94.5%	94.0%	94.0%	92.6%
	31-day First definitive treatment	96%	93.6%	95.0%	92.4%	96.7%	90.8%	90.3%	95.3%	93.8%	91.8%	96.3%	96.0%	95.1%	94.5%	93.9%
	31-day subsequent treatment Anti-cancer drugs	98%	95.8%	99.4%	99.3%	98.3%	99.3%	98.3%	100.0%	99.4%	97.99%	100.0%	98.7%	99.4%	98.3%	99.0%
	31-day subsequent treatment Radiotherapy	94%	98.1%	91.7%	90.6%	91.1%	94.1%	95.0%	97.6%	97.9%	97.8%	97.2%	95.0%	98.0%	95.2%	95.1%
	31-day subsequent treatment Surgery	94%	86.4%	88.5%	95.8%	60.0%	64.0%	100.0%	57.1%	74.2%	69.4%	84.2%	63.6%	76.5%	78.8%	75.6%
	62-day GP referral to treatment	85%	73.8%	67.2%	70.6%	69.4%	61.8%	76.7%	66.5%	72.3%	66.3%	72.6%	66.8%	71.8%	67.5%	69.1%
	62-day Specialist screening service	90%	72.0%	86.7%	75.0%	77.8%	60.7%	75.0%	87.5%	74.2%	86.2%	100.0%	72.7%	79.2%	95.2%	79.6%

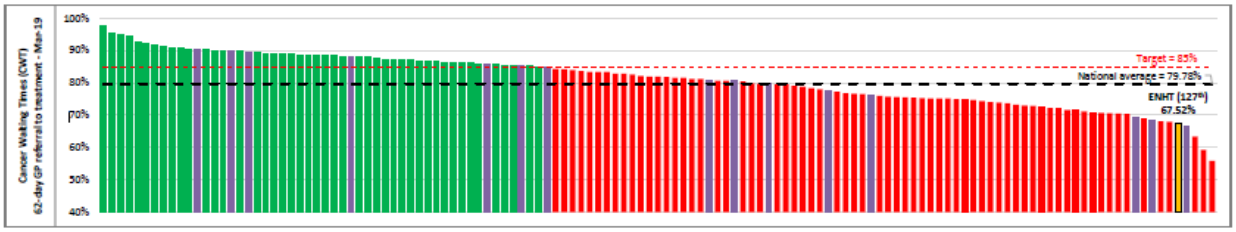
Of the eight standards measured:

- Five of the eight standards were achieved in March 2019
- Three surpass the target for the year 2018/19
- Four show an improved position compared with 2017/18; three of which relate to the 31 day standards
- Four show a worsening position compared with 2017/18; two of which relate to the 2 week and 62 day standards

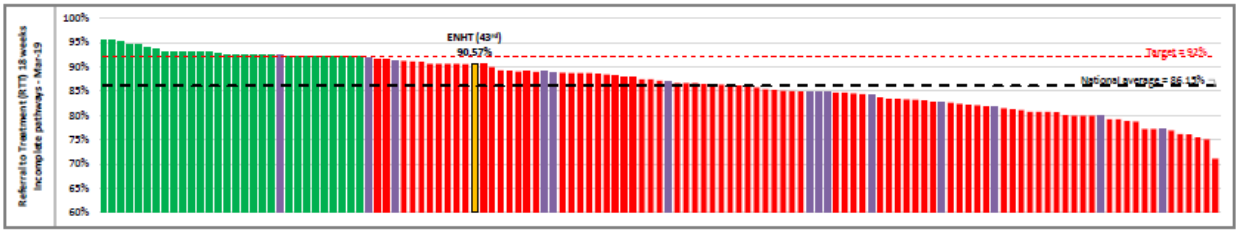
The delivery of the national cancer performance standards continues to be a challenge for the Trust in 2018/19. The Trust has worked with NHS Improvement during the year to develop a cancer recovery business case for 2019/20.

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

The 62 day referral to treatment standard for March (67.52%) places the Trust (yellow bar in the chart below) below the 79.78% national average.



The 18 week RTT standard for March (90.57%) places the Trust (yellow bar in the chart above) above the 86.15 % national average.

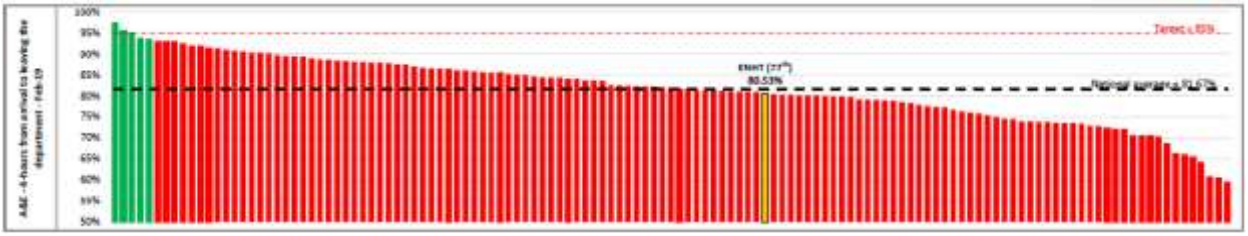


Priority 3.3 Reduce the number of patients who are delayed in the care they receive through the Emergency Department

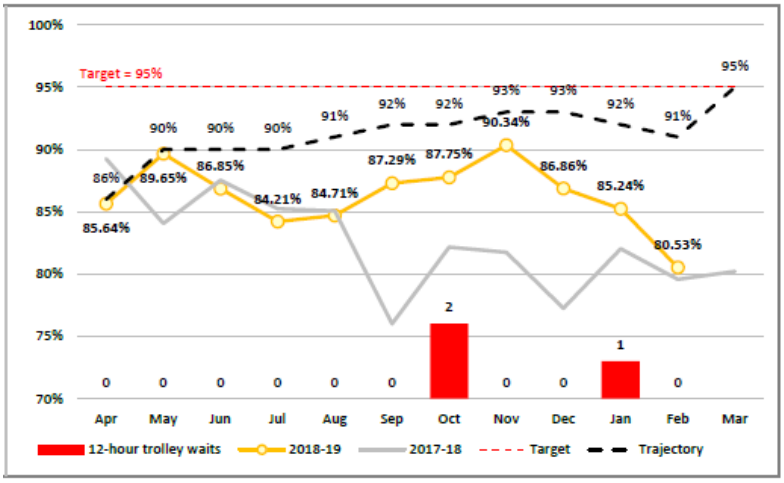
		17/18	18/19	Aim
3.3a	4 hour waiting time	83.6%	**85.85%**	>=95%
3.3b	Reduce average waiting time	-	**Not avail**	Reduction

- The achievement of the 4 hour wait has been variable throughout the year and the Trust delivered an end of year performance of 85.85%.

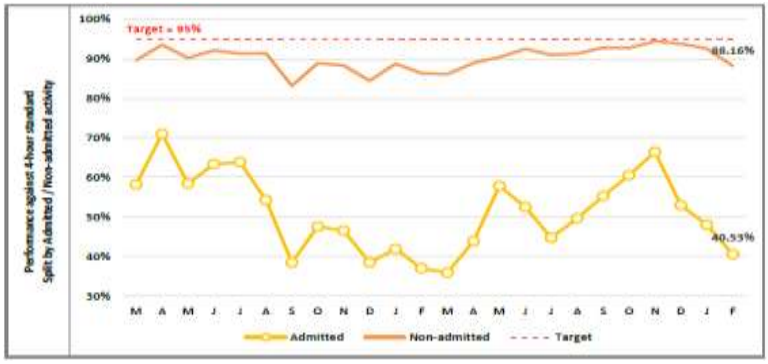
Metric	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
4 hour Target performance	85.6%	89.7%	86.9%	84.2%	84.7%	87.3%	87.8%	90.3%	86.9%	85.2%	80.5%	81.0%



- The performance chart below for 2018/19 (yellow line) shows an improvement against the 2017/18 data (grey line).



- Approximately 400 patients attend the ED each day with 23% of them requiring in patient admission. The graph below shows how the 4-hour standard performance varies depending upon whether the patient is admitted or not.



Over 88% of those not admitted are seen and treated within 4 hours; however it is now more likely that patients presenting are acutely unwell and require beds in critical care and specialist areas. This can result in a longer length of stay in the resuscitation area of the ED whilst awaiting the specialist bed to become available.

Improvements to patient flow 2018/19

- The Trust is proud of the outstanding practice across our cancer pathway, through the implementation of one stop urology clinics and straight to test in gastroenterology services. These innovative pathways have resulted in improved service to our patients and resultant improved performance.

- Children's ED performance has achieved 12 months >95% target. This is as a result of increased Paediatric Registrar support and additional capacity within the Paediatric Day Unit.

- Through the winter planning process additional beds were identified in support of forecast bed capacity of additional 29-55 beds every day. The additional beds were delivered through a combination of:

  - Admission avoidance
  - Increased bed capacity through 14 beds on the winter ward
  - Reduction on Length of Stay

- As a result of this planning the winter was better managed, resulting in improved safety, care and experience for our patients.

- Frailty patients are now managed through an exemplar pathway through our Clinical Decisions Unit b – bay which is a purpose built designated area for frailty with associated support of a designated frailty Consultant and therapist support.

- An Out Patient improvement process - key enabler to reduce Did Not Attend rates in outpatients was the implementation of a two-way text reminder service. Supplementary initiatives also launched included the review of all outpatient letter templates and utilising volunteers in more hard-to-reach specialties.

- A new text reminder service started in May 2018 in Outpatients and has delivered a significant reduction in DNA rates from 11% April 2018 to 8% in April 2019. The service has also been rolled out to endoscopy, in-patients, and cancer services.

- Multiple standard outpatient letter templates have been changed and tailored to each speciality, with new allocation of volunteers into care of the elderly medicine and paediatrics clinics to improve patient flow and experience.

Priority Four: To be amongst the best in the experience our patients have

		17/18	18/19	Aim
4.1	Implementing 'Always events'	N/A	**x**	Agree pilot area
4.2a	Improving the friends and family response rate - maternity	24%	**27.8-41.9%**	>30%
4.2b	Improving the friends and family response rate – emergency department	4.7%	**2.2-6.1%**	>10%

Priority 4.1 Implementing 'Always events'

- Always Events® are defined as "those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the health care delivery system". It's a way of working to promote optimum experience. The Always Event planned within the stroke ward started in April 2018. It aimed to improve the experience of carers, in particular the difficulties they reported relating to communication and feeling informed and involved with discharges. The plans to adopt this initiative were challenging due to many other commitments within the stroke department.

  In March an Always Events project started within Cancer Services to support carers; and from April – June 2019 the cancer services team are participating in an Always Event pilot around 'What matters most for our staff', especially those who have caring responsibilities.

Priority 4.2a Improving the friends and family response rate - maternity

- The FFT response rate for Maternity (relating to birth only) improved to 39.1% in February with nine of eleven months in 2018/19 surpassing the desired response rate of 30%.

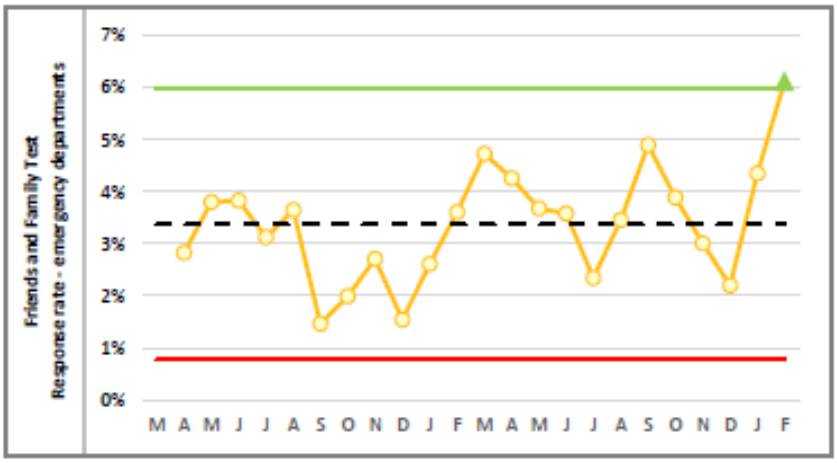
Metric	Target	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Trend
Birth Response rate	30%	46.1%	41.5%	39.4%	34.9%	40.8%	41.9%	34.1%	27.8%	30.3%	29.8%	30.2%	39.1%	

Women who responded to the February survey said they would like better provision of recliner chairs and facilities for partners and an improved ward environment.

Priority 4.2b Improving the friends and family response rate - emergency department

The chart below show the Trust FFT response rate for ED improved to 6.1% in February; however we recognise there are ongoing challenges to achieve the Trust aim of 10% response rate.

Metric	Target	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Trend
Response rate	10%	4.7%	4.3%	3.7%	3.6%	2.3%	3.5%	4.9%	3.9%	3.0%	2.2%	4.4%	6.1%	



Improving this response rate shall remain a priority for 2019/20; however we do recognise that feedback from 806 patients who attended the service in February has been positive, particularly in relation to staff interactions.

Negative feedback relates to waiting times and requiring more staff and children attending the department would like charging points for phones/USB devices, more toys, and seating in the waiting area.

FFT survey with patients currently relies on a patient completing and returning a paper based survey. During ED treatment episode this has proven to be a continual challenge. In an effort to improve, the team have introduced a credit card-sized FFT survey card to enable patients to provide their feedback quickly. This is offered alongside the standard FFT survey and easy-read survey forms.

2b Priorities for improvement for 2019/20

The Quality Strategy (2019-24) has identified priority 'Quality Goals' by triangulating information:

- Existing priorities and indicators from 2018/19 were reviewed to consider their ongoing relevance and progress made
- Current performance was considered to identify emerging concerns eg. Patient safety Incidents (including never events); Patient Experience (including complaints), Clinical Effectives outcomes, GP concerns raised through hotline enquiries and staff feedback (some feedback form staff below),

1. 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 deliver 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 programme	Adopt 'Patient Safety Breakthrough Series Collaborative'	New	N/a	Successfully recruit approx. 10-15 improvement teams who contributing over 18 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.

2. Priority two: **Keeping our patients safe**

Reason: These are quality goals within the 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		18/19	19/20
Medication management	Omissions of critical medications	Continue	2.46%	<5%
	Medicines optimisation framework score (max 168)	New	115	135
	Antimicrobial stewardship	New	89%	>90%
Sepsis pathway compliance	Screening for sepsis in ED	Continue	90%	> 97%
	Neutropenic sepsis door to needle time	Continue	49% (Feb)	>80%
	Antibiotics in ED within an hour	Continue	61.5%	>90%
	Antibiotics on the ward within an hour	Continue	60.4%	>90%
Safer Invasive Procedure Standards	Phased approach to developing and imbedding Local Standards for Invasive Procedures	Continue	-	>95%
Deteriorating patient	Reduce rate of cardiac arrests	Continue	0.8%	<0.8%
	Audit of compliance with timely observations	Continue	Not available	> 95% reliability all observations
	Launch escalation module and develop a means of monitoring the escalations	Continue	-	Launch
Safeguarding Adult and Children	Ensuring reduction all patients with known learning disability	New	N/A	Ascertain baseline data and set trajectory
VTE Risk Assessment	Improved compliance with VTE risk assessment part 1 and part 2	Continue	Variation	>95% compliance with part 1 and part 2

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

3. 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		18/19	19/20
Improving discharge processes	Reduce number of discharge summaries not sent to GP within 24 hours of discharge	Continue	7157 (At time of writing)	90% reduction
	Patients discharged by midday	Continue	14.6% (Feb)	>15%
	Reduce proportion of beds occupied with length of stay > 14 days	New	19.1% (Feb)	<19%
Improve access	Improve cancer waits from 2019/20 position	Continue	Variable	National standard
	Improve delivery of 7 days services	New	N/A	Ascertain baseline and agree trajectory
	Reduce delays in ED 4 hour waiting time	Continue	85.85%	National standard

4. 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		18/19	19/20
Patient feedback	Maintain Friends & Family Test scores (average) for in-patients, out-patients, maternity (birth) and emergency department	Continue	96.7% 94.8% 93% 89.6%	Maintain
'Always events'	Evaluate cancer team project	Continue	N/A	Capture lesson learnt
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.	New	N/A	Ascertain organisational readiness and agree trajectory

2c Statements of assurance from the Board

This section contains the statutory statements concerning the quality of services provided by the Trust.

Review of services

During 2018/19, the East and North Hertfordshire NHS Trust (ENHT) provided and/or sub-contracted 23 relevant health services. The ENHT has reviewed all the data available to them on the quality of care in 23 of these relevant health services. The income generated by the relevant health services reviewed in 2018/19 represents 100% of the total income generated from the provision of relevant services by the ENHT for 2018/19.

Participation in clinical audits

During 2018/19 59 national clinical audits and 7 national confidential enquiries covered relevant health services that ENHT provides.

During that period ENHT participated in 58 (98%) national clinical audits and 7 (100%) national confidential enquiries of the clinical audits and national confidential enquiries which it was eligible to participate in.

The two tables below show:

- The National Clinical Audits and National Confidential Enquiries that ENHT was eligible to participate in during 2018/19
- The National Clinical Audits and National Confidential Enquiries that ENHT participated in during 2018/19, and for which data collection was completed during 2018/19, alongside percentage compliance or, where possible, the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry

National Clinical Audits	**Eligible**	**Participated**	**Numbers submitted** (by % or total number)
Adult Cardiac Surgery	No	No	N/A
Adult Community Acquired Pneumonia	Yes	In Progress (data submission until 31st May 2019)	
BAUS Urology Audit - Cystectomy	Yes	Yes	100%
BAUS Urology Audit – Female Stress Urinary Incontinence (SUI)	Yes	Yes	100%
BAUS Urology Audit - Nephrectomy	Yes	Yes	52 cases
BAUS Urology Audit - Percutaneous Nephrolithotomy (PCNL)	Yes	Yes	100%
BAUS Urology Audit – Radical Prostatectomy	Yes	Yes	225 cases
Cardiac Rhythm Management (CRM)	Yes	Yes	Pending Data[1]
Case Mix Programme (CMP)	Yes	Yes	294 cases: July - Sep 18 336 cases: Oct - Dec 18
Elective Surgery (National PROMs Programme)	Yes	Yes	1036 cases
Falls and Fragility Fractures Audit Programme (FFFAP) - Fracture Liaison Service Database	No	No	N/A
Falls and Fragility Fractures Audit Programme (FFFAP) - Hip Fracture	Yes	Yes	100%

National Clinical Audits	Eligible	Participated	Numbers submitted (by % or total number)
Database			
Feverish Children (care in emergency departments)	Yes	Yes	124 cases (100%)
Inflammatory Bowel Disease programme / IBD Registry	Yes	Yes	179 cases
Learning Disability Mortality Review Programme (LeDeR)	Yes	Yes	100%
Major Trauma Audit	Yes	Yes	199 cases (100%)
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Yes	Yes	100%
Mental Health Clinical Outcome Review Programme	No	No	N/A
Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	191 cases
National Asthma and COPD Audit Programme (NACAP)	Yes	Yes	100%
National Audit of Anxiety and Depression	No	No	N/A
National Audit of Breast Cancer in Older People	Yes	Yes	100%
National Audit of Cardiac Rehabilitation	Yes	Yes	Pending Data[2]
National Audit of Care at the End of Life (NACEL)	Yes	Yes	78 (100%)
National Audit of Dementia	Yes	Yes	46 cases (100%)[3]
National Audit of Intermediate Care	No	No	N/A
National Audit of Percutaneous Coronary Interventions (PCI)	Yes	Yes	217 cases
National Audit of Pulmonary Hypertension	No	No	N/A
National Audit of Seizures and Epilepsies in Children and Young People	Yes	Yes	37 cases
National Bariatric Surgery Registry (NBSR)	No	No	N/A
National Bowel Cancer Audit (NBOCA)	Yes	Yes	600 cases
National Cardiac Arrest Audit (NCAA)	Yes	Yes	100%
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	Yes	Yes	64 cases
National Clinical Audit of Psychosis	No	No	N/A
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	No	No	N/A
National Comparative Audit of Blood Transfusion^ programme – Management of massive haemorrhage	Yes	Yes	1 case
National Comparative Audit of Blood Transfusion programme – Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children	No[4]	No	N/A
National Congenital Heart Disease	No	No	N/A

National Clinical Audits	Eligible	Participated	Numbers submitted (by % or total number)
(CHD)			
National Diabetes Audit – Foot Care Audit	Yes	Yes	Data Pending[5]
National Diabetes Inpatient Audit (NaDia)	Yes	Yes	Data Pending[5]
National Core Diabetes Audit	Yes	Yes	Data Pending[5]
National Pregnancy in Diabetes Audit	Yes	Yes	Data Pending[5]
National Emergency Laparotomy Audit (NELA)	Yes	Yes	67.4%
National Heart Failure Audit	Yes	Yes	70%
National Joint Registry (NJR) – Knees	Yes	Yes	391 - 2018 68 - 2019
National Joint Registry (NJR) – Hips	Yes	Yes	454 - 2018 72 - 2019
National Joint Registry (NJR) – Ankles	Yes	No	0 - 2018 1 - 2019
National Joint Registry (NJR) – Elbows	Yes	Yes	21 - 2018 2 - 2019
National Joint Registry (NJR) – Shoulder	Yes	Yes	60 - 2018 10 - 2019
National Lung Cancer Audit (NLCA)	Yes	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	Yes	100% (organisational questionnaire only)
National Mortality Case Record Review Programme	Yes	Yes	100%
National Neonatal Audit Programme (NNAP)	Yes	Yes	Pending Data[6]
National Oesophago-gastric Cancer (NAOGC)	Yes	Yes	100%
National Ophthalmology Audit	Yes	No	No data submitted[7]
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	284 cases
National Prostate Cancer Audit	Yes	Yes	479 cases (100%)[8]
National Vascular Registry – Carotid Interventions	Yes	Yes	29 cases
National Vascular Registry – Lower Limb Amputation	Yes	Yes	12 cases
National Vascular Registry – Lower Limb Angioplasty	Yes	Yes	16 cases
National Vascular Registry – Lower Limb Bypass	Yes	Yes	10 cases
National Vascular Registry – Repair and abdominal aortic aneurysm	Yes	Yes	24 cases
Neurosurgical National Audit Programme	No	No	N/A
Non-Invasive Ventilation - Adults	Yes	In progress until the 30/06/2019	
Paediatric Intensive Care (PICANet)	No	No	N/A
Prescribing Observatory for Mental Health (POMH-UK)*	No	No	N/A
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)*	Yes	Yes	100%

National Clinical Audits	Eligible	Participated	Numbers submitted (by % or total number)
Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	508 cases
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes	Yes	32 cases
Seven Day Hospital Services	Yes	Yes	100%
Surgical Site Infection Surveillance Service	Yes	Yes	100%
UK Cystic Fibrosis Registry	No	No	N/A
Vital Signs in Adults (care in emergency departments)	Yes	Yes	100%
VTE risk in lower limb immobilisation (care in emergency departments)	Yes	Yes	100%

[1] Data has been moved to a different server, hence no figure is available at present.
[2] Data pending from NICOR, Cardiology Data Coordinator is awaiting file
[3] Although the target was 50 cases due to the smaller number of eligible cases in the ENHT the Royal College of Psychiatrists accepted our submission of 46.
[4] A decision was made not to participate in the audit as no meaningful data contribution was possible. Throughout the year only 1 patient meeting eligibility criteria was transfused.
[5] Data pending from NHS Digital for all 4 Diabetes audits
[6] HQIP is unable to give the exact figure. In September 2018 the trust was 100% compliance with its submissions.
[7] Due to a lack of financial resources required for the installation of the necessary software.
[8] Although 100% data compliance has been secured due to a lack of administrative support the data submitted is not 100% complete.

National Confidential Enquiries	Eligible	Participated	% Cases submitted
Medical and Surgical Clinical Outcome Review Programme NCEPOD Acute Small Bowel Obstruction	Yes	Yes	7 (100%)
Medical and Surgical Clinical Outcome Review Programme NCEPOD Pulmonary Embolism	Yes	Yes	4 (100%)
Child Health Clinical Outcome Review Programme – Long Term Ventilation	Yes	1 case selected for the study withdrawn as not eligible	
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

National Audits

The reports of 15 national clinical audits were reviewed by the provider in 2018/19 and ENHT intends to take the following actions to improve the quality of healthcare provided.

National audit	Action
National Percutaneous Coronary Intervention	• To reach agreement for time allocation in job plans • To train database manger
NNAP 2017 (2016 Data)	• Ongoing auditing of delivery rooms temperature. • Appropriate use of aids eg. plastic bags and hats. • Monitoring of babies temperature in the delivery rooms /

National audit	Action
	theatre prior to transfer to NNU • Transfer of babies from delivery rooms and theatre using the transport incubators • Ongoing audit on accuracy in recording admission temperature on Badgernet data system & feedback to the team on compliance at NNU meetings • Continued education on thermoregulation neonatal and maternity staff
National diabetes Inpatient Audit (NaDIA) 2017	• Recruit to vacancies • Forward plan for staff returning from secondments • Increase consultant body to allow requisite amounts of sessions to be delivered • Need to upgrade report produced by nervecentre • Trust IT strategy to be implemented
National Pregnancy in Diabetes (NPID) Audit	• Cover for consultants and DSM when on leave is on risk register • Pump support, CGMS, Libre, diasend availability
National Audit of Dementia Delirium Spotlight Audit Report 2018	• Update to Nervcentre and Lorenzo IT systems for recording of assessment • Trust wide education • Education and use of specific discharge summary. Updates to IT system to ensure discharge summary is fit for purpose
Recovering after a hip fracture: helping people understand physiotherapy in the NHS	• The physio team will look at possible equipment to be used at the bed side to try and maximise rehab potential in addition to physio time • Awaiting business case from trust
National Lung Cancer Audit 2017 Key findings for patients and carers March 2018	• Need FEV1 check quarterly to ensure capture • Need more CNS to meet 1.8 CNS per 250 patients diagnosed
National Review of Asthma Deaths (NRAD) "Why asthma still kills" Report	• To highlight and inform respiratory colleges and respiratory department of the guidelines • To introduce standard measure of compliance
Oesophago-Gastric Cancer (NOGCA)	• Data needs to be uploaded to NOGCA • Ongoing review
Adult and Paediatric Bronchectasis Audit	• Need to encourage consultant colleagues to complete these tests and make these referrals
MBRRACE-UK Perinatal Mortality 2016 - Intrapartum stillbirths and Intrapartum related Neonatal Deaths (up to 28 days after birth)	• Auditing delays in transfer for transfer and impact of care. Staffing is being addressed
National Maternity & Perinatal Audit (Clinical report)	• Audit to be conducted in rolling audit plan for 18/19 • Discussed and included in budget settings
MBRRACE-UK Maternal Mortality surveillance and mortality confidential enquiry	• Antenatal guidance to be amended especially for high risk clinic • MDT discussion with microbiologist
MBRRACE UK Perinatal Mortality for Births	• NHS England & HQIP to work on establishing a National forum to agree an appropriate benchmark against which stillbirth and neonatal mortality rates should be monitored across the UK

National audit	Action
National Diabetes Foot Care Audit Third Annual Report England & Wales	• No actions required as fully compliant

Local audits

The reports of 52 local clinical audits were reviewed by the provider in 2018/19 and ENHT intends to take the following actions to improve the quality of healthcare provided.

Local clinical audit	Actions to be taken
Antibiotic Point Prevalence	• Feedback results to divisions and Trust
Quality improvement project to improve geriatric care including early assessment and management of delirium and risk of falls.	• Audit to look for significant rise in delirium and falls assessment after introduction of the forms • Roll out the proforma to ward 9B, our sister ward • Involve the Acute Medical Unit to initiate cognitive assessment using these forms for all patients > 75 years
Post Take Ward Round Documentation QIP	• All medical clerking doctors is trained how to do document but using an aid memoire has failed therefore better strategy will be considered by the Acute Medical team for future that is inline with the trusts on-going development plans
Stent on a String for Stone Surgery	• Ensure all patients have stent removed within 2 weeks
Periorbital Cellulitis	• Emphasise importance of documentation, teaching • Agreemennt with Radiology department to add CT scans to out of hours protocol • Agreement with Ophthalmology on solution for out of hours reviews
Audit of Enhanced Recovery following elective caesarean section	• Teaching and training at rolling half day, through message of week, through safety huddles, emails, newsletters and ward based • Stickers already on c/section leaflet, information leaflets in the clinics
Audit of Paediatric Emergency Transfers to Tertiary Units Over One Year	• Development and implementation of a 'Safer Transfer of the Paediatric Patient' tool. This will accompany the child on transfer, is photocopied at the tertiary centre and is bought back for filing by the accompanying nurse/doctor. • The use of this tool will be re-audited

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 3,336. Further details are given in Annex 1.

Goals agreed with commissioners

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

In 2018/19 £7.8 million of income was dependent upon achieving CQUIN targets set out by NHS England and the Clinical Commissioning Group.

The CQUINs for 2018/19 agreed with the Clinical Commissioning Group are set out in the table below.

	CQUIN Indicator
	CCG Indicator
1	Staff health & wellbeing
2	Reducing the impact of serious infections (including sepsis)
3	Improving the services for people with mental health needs who present to A&E
4	Offering advice and guidance
5	Preventing ill health by risky behaviours (alcohol & tobacco)
6	Supporting local areas
	NHS England Indicators
10	Dental
11	Public health
12	SACT dose banding
13	Medicines optimisation
14	Enhanced support
15	Palliative chemotherapy decision making
16	Shared decision making

The final data is yet to be confirmed but indications suggest that during the year we secured a part payment of 97% in quarter 1 (April – June) and 81% in quarter 2 (July – September).

Statements from the Care Quality Commission

The ENHT is required to register with the Care Quality Commission (CQC) and its current registration status is 'requires improvement'.

Lister Hospital's registration includes the registrations for renal satellite units in St Albans Hospital and Luton and Dunstable Hospital. The Renal Satellite Units at Harlow and Bedford were inspected but not rated in 2015.

The ENHT has not participated in any special reviews or investigations by the CQC during 2018/19.

The Care Quality Commission inspected nine of the core services provided by the Trust across Lister Hospital, the New Queen Elizabeth II (QEII) Hospital and Mount Vernon Cancer Centre in March 2018 and returned in April 2018 to undertake an unannounced, follow-up inspection of the surgery core service at Lister Hospital.

The Trust maintained it's 'requires improvement' rating overall; including 'good' for caring.

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018	Good ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018

The two tables below show the changes since the previous inspection in October 2015. Specific site ratings are given in Annex 2.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Lister Hospital	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018	Good ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018
Queen Elizabeth II Hospital	Inadequate ↓ Jul 2018	Requires improvement ↔ Jul 2018	Good ↔ Jul 2018	Good ↔ Jul 2018	Inadequate ↓ Jul 2018	Inadequate ↓ Jul 2018
Mount Vernon Cancer Centre	Requires improvement ↑ Jul 2018	Good ↔ Jul 2018	Good ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018
Hertford County Hospital	Good Mar 2016	N/A	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Overall trust	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018	Good ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018	Good ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018
Community	Good Mar 2016	Good Mar 2016	Outstanding Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Overall trust	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018	Good ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018

The CQC have issued a number of requirement notices and set out a number of areas for improvement including in a section 29a warning notice to ensure improvements in the New QEII Urgent Care Centre and Surgery at the Lister Hospital site. The requirement notices are:

- Regulation 12 Cleanliness and infection control
- Regulation 12 Safe care and Treatment
- Regulation 17 Good governance
- Regulation 18 Staffing
- Regulation 19 Fit and proper persons employed

An action plan was developed with the teams against all of these requirements and was submitted to CQC in August 2018. In addition each pathway inspected has an improvement plan and learning is shared across the organisation. Progress is reported to Board through the Quality and Safety Committee and reported to CQC through regular engagement visits. A programme of internal and external inspections is in place to test and evidence progress and that the actions are embedded and sustained across the organisation.

Improvements have been made across all of the requirements and across the organisation including:

- We implemented an infection control improvement programme which resulted in the Trust achieving a Green rating by NHSI in terms of infection prevention and control in December 2018. This was the result of a significant investment in equipment replacement, further training and development of our clinical staff, improved audit programmes and a commitment from all care givers to keep our patients free from harm in relation to reducing healthcare acquired infection. The trust is achieving its trajectories for improvement against key measures including hand hygiene and this continues to be an area of focus.

- We have developed and are in the process of implementing a quality transformation programme to ensure we continue to improve. The work streams also take into account the key findings from the CQC Inspection

- We have implemented new ways to ensure we learn from our serious incidents and never events in a timely way and can take early action to learn from these, encourage reporting and support staff

- We have invested and strengthened in our quality and safety and corporate governance teams

- We have reviewed and strengthened our governance structures

- We have reviewed the staff on the surgical wards as part of the regular nursing establishment review and funded additional staff on a night shift

- We undertake an annual review to ensure the requirements of the fit and proper persons are met and have reviewed our induction programme for our new Executive Directors

To support this, the Quality Governance structures have been reviewed and streamlined and significant investment has been made in strengthening the teams to support quality improvement and corporate governance.

A number of outstanding practices were observed:

- In the Emergency Department - alert flags indicating vulnerabilities; the use of a validated streaming process to determine the most appropriate route for treating patients; enabling junior sisters to prescribe and administer early sepsis treatment as part of a patient group direction. The mental health team, known as RAID (rapid assessment, intervention and discharge team) are available 24 hours a day and responded to referrals within an hour.

- The twins and multiple births association rated the multiple pregnancy service as outstanding.

- Mount Vernon Cancer Centre had a research and clinical trials department and was in the top 100 trusts for research. Patients attending MVCC had access to clinical trials and were able to participate in research.

Data quality

The ENHT submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number and the patient's valid General Medical Practice Code is given in the table below.

	Included valid NHS Number	Included valid General Medical Practice Code
Admitted patient care	99.8%	100%
Out-patient care	99.9%	100%
Accident & Emergency care	98.8%	100%

Information Governance

The ENHT's Information Governance Assessment Report overall score for 2018/19 demonstrates 39 out of 40 assertions were confirmed and graded under the new Data Security and Protection Toolkit as 'Standards Not Fully Met (Plan Agreed)'.

Clinical coding error rate

The ENHT was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission. However the Trust undertook a General Data Protection Regulation Standard 1 audit with results at Level 3 (highest level) as follows:

Primary diagnoses correct	95%
Secondary diagnoses correct	97.55%
Primary procedures correct	96.86%
Secondary procedures correct	98.77%

The results should not be extrapolated further than the actual sample audited.

There are a number of on-going data quality improvement related programmes underway across ENHT to progress and improve patient experience, service delivery and patient flow which include accuracy of data recording. ENHT will be taking the following actions to improve data quality:

- Implement a Trust Wide Data Quality (DQ) strategy
- Introduce a frame work and systematic approach to assessing quality of data across all services with overall ratings, define areas for improvement, indicating short term and long term issues
- Promote awareness of the importance of DQ and set out expectations of staff responsibility, provide training and support
- Identify divisional champions
- Set up bi-monthly Data Quality Steering Group and weekly divisional data quality meetings
- Implement a data quality improvement plan by service/division
- Provide exception reports for staff to manage improvements
- Agree and set up Trust wide data quality key performance indicators and governance structures
- Trust wide cleansing and review of legacy data.

Learning from deaths

The content and format of the learning from deaths information below has been provided in accordance with the statutory instrument 2017 No 744 'The National Health Service (Quality Accounts) (Amendment) Regulations 2017.

Statutory ref.	**Response** (using prescribed wording)
27.1	During 2018/19 1472 of ENHT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: • 371 in the first quarter • 349 in the second quarter • 361 in the third quarter • 391 in the fourth quarter
27.2	By 31 March 2019, 1107 case record reviews and 94 investigations have been carried out in relation to 1472 of the deaths included in item 27.1. In 94 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: • 202 in the first quarter • 238 in the second quarter • 305 in the third quarter • 362 in the fourth quarter
27.3	0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: • 0 representing 0% for the first quarter • 0 representing 0% for the second quarter • 0 representing 0% for the third quarter • 0 representing 0% for the fourth quarter *[Note: this does not mean that no 2018-19 deaths will be identified within the item 27.3 definition, but that by 31 March 2019 no concluded investigations had fallen within this definition. As detailed in 27.8 below, investigations concluded after the end of the current reporting period will be reported in next year's Quality Account].* These numbers have been estimated using the Trust's Mortality Review process (see process over the page).
27.4 - 6	0 2018-19 deaths have yet been identified within the item 27.3 definition. This information is based on concluded investigations considered by the Mortality Surveillance Committee by 31 March 2019. *[Refer to note in 27.3]*
27.7	139 case record reviews and 51 investigations completed after 1 April 2018 which related to deaths which took place before the start of the reporting period.
27.8	7 *[of the 138 cases reported in 27.7 above]* representing 0.4% of the patient deaths before the reporting period *[ie 2017/18]* are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the mortality review process methods detailed above in 27.3.
27.9	7 representing 0.4% of the patient deaths during 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient *[this represents a revised total figure incorporating the sum of 27.3 from last year's report and 27.8 above]*.

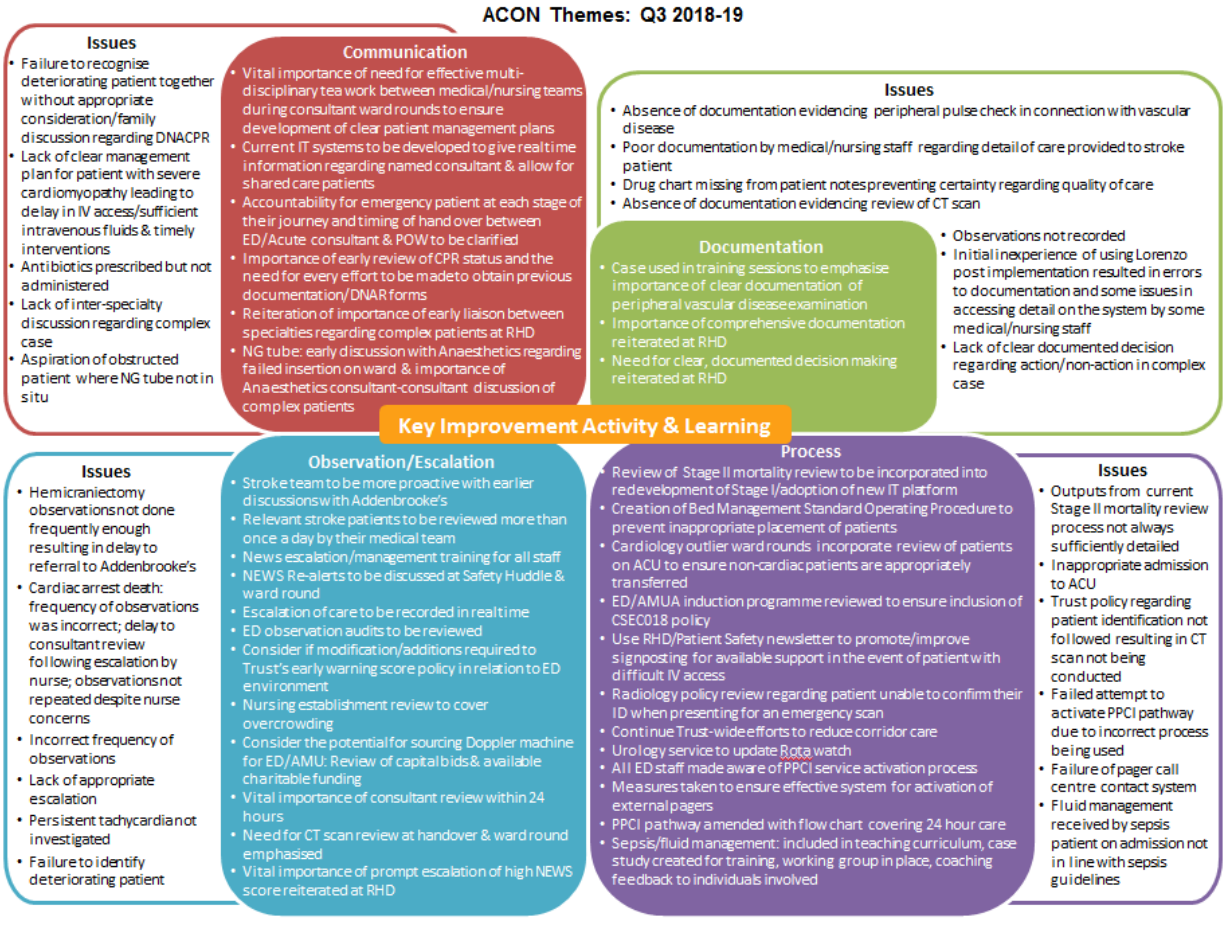
Mortality review process

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.

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.



Learning themes are shared into wider Quality Improvement initiatives such as Deteriorating Patient Collaborative and End of Life Board; where they are captured as key drivers for change ideas.

2d 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.

Mortality

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	0.999	Oct 17 – Sept 18	1.029			1
	Banding	As expected		As expected	-	-	N/A
% deaths with palliative care code	N/A	37.6%		42.55%	14.3%	59.5%	33.6%

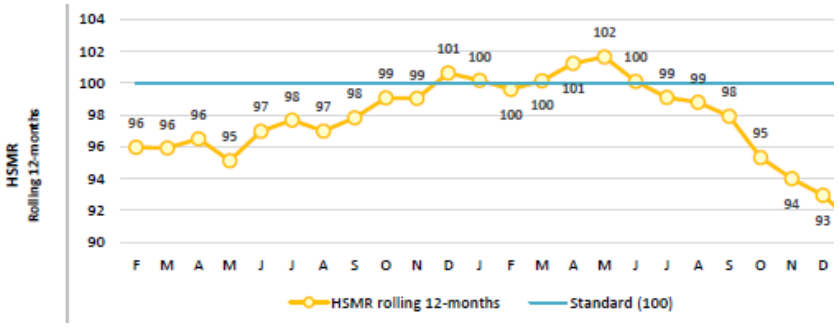
The national average is always reported as '1' with a smaller number representing a better outcome. The SHMI for the twelve months to December 2018 is **0.941**, slightly better than the national average and within the 'as expected' range. This is the first time that SHMI has been below 1 since its inception in 2010. SHMI is generally available 6/12 in arrears.

Over the last three years the SHMI has reduced by 10 points with a temporary rise, as expected, following the introduction of Lorenzo in September 2017 when mortality rates were affected by changes to the depth of coding. This phenomenon is commonly seen following the introduction of a new patient administration system, but is temporary.

In this chart the average is '100' and is comparable to the '1' as described above

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 (blue 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 December 2018 is 93.01 and within the 'Better than expected' range.



The 2017/18 palliative care code accounted for patients admitted to the trusts hospice. The reduction in 2018/19 is linked with the closure of the hospice.

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.

PROMs

Patient Reported Outcome Measures (PROMs) measure health gain in patients undergoing hip replacement, knee replacement and up to September 2017, varicose vein and groin hernia surgery in England.

Indicator	Measure	Trust result	Time period	Trust previous result	Best performing trust	Worst performing trust	National average
Groin hernia	EQ-5D	Data no longer collected		0.09	Data no longer collected		
	EQ-VAS			0.94			
Varicose vein surgery	EQ-5D			0.12			
	EQ-VAS			3.05			
	Aberdeen			-11.11			
Hip replacement surgery	EQ-5D	0.46	2017/18	0.41	0.55	0.36	0.46
	EQ-VAS	15.22		12.27	18.51	7.99	13.9
	Oxford	21.99		20.75	25.04	18	22.2
Knee replacement surgery	EQ-5D	0.35		0.35	0.4	0.25	0.377
	EQ-VAS	9.61		5.75	13.98	1.73	8.2
	Oxford	17.62		17.29	20.39	12.89	17.1

Patients are given questionnaires to complete before and after surgery, from which the improvement is measured. Three methods of data collection are used:

EQ-5D: The score comprises five dimensions: mobility, self-care, usual activities, pain/discomfort and anxiety/depression. The score ranges from -0.594 (worst possible health) to 1.0 (full health).

EQ-VAS: The score records the patient's self-rated health on one scale ranging from 0 (worst) to 100 (best).

Oxford Score: The score records the views of patients on 12 aspects of their daily living with the total score ranging from 0 (worst) to 48 (best).

In October 2017 the collection of groin hernia and varicose vein patient reported outcome measures ceased, hence data is not provided.

The Trust outcomes are the same or better than national averages.

The ENHT considers that this data is as described, as it is based on data submitted by users of the service to the national data collection team. The ENHT has taken the following actions to improve this score, and so the quality of its services, by monitoring data to confirm the data is correct.

Emergency readmissions

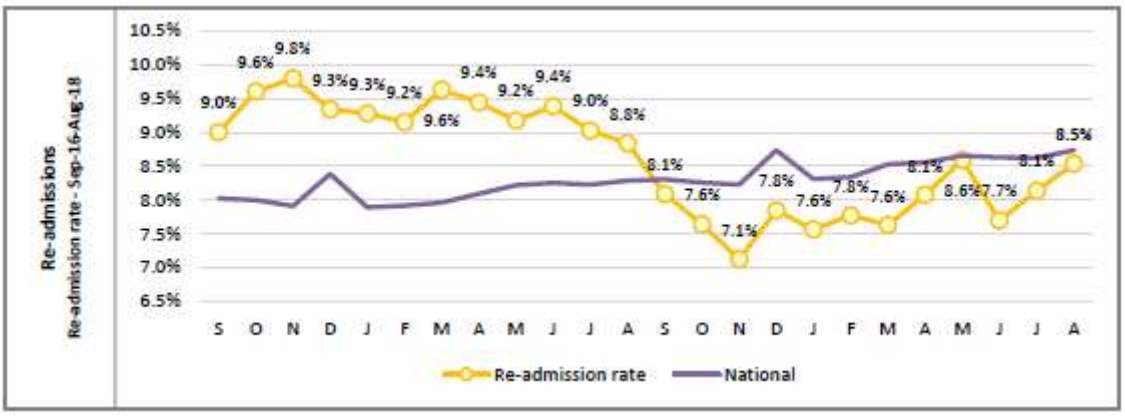
This indicator measures the percentage of patients readmitted to hospital within 28 days of being discharged from hospital after an emergency admission.

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	13.65%	2011/12	13.52%	6.4%*	14.94%*	Not given
	Age 16 and over	11.11%		10.56%	9.34%*	13.8%*	11.45%

*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, will be updated and published in April/May 2019.

The chart below shows Trust published data for the two years to August 2018, based on readmissions within 30 days shows an improving rate with the most recent data showing a readmission rate of 8.5%, just better than the national average.



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 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 this score, and so the quality of its services, by tracking data and undertaking reviews of readmissions to identify underlying data.

Responsiveness to personal needs

The indicator is based on the average score of five questions from the National Inpatient Survey, which measures the experiences of people admitted to hospital.

Indicator	Measure	Trust result	Time period	Trust previous result	Best performing trust	Worst performing trust	National average
Responsiveness to personal needs	N/A	64.2	2017/18	64.5	85	60.5	68.6

The questions together with their scores (scale 0-10) from the 2017/18 survey are given in the table below. Results of the 2018/19 survey are not due until later in the year.

Question	Trust Score	Compared with others
Were you involved as much as you wanted to be in decisions about your care and treatment?	6.9	Same
Did you find someone on the hospital staff to talk to about your worries and fears?	5	Same
Were you given enough privacy when discussing your condition or treatment?	8.6	Same
Did a member of staff tell you about medication side effects to watch for when you went home?	4.4	Same
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	7.2	Same

The ENHT considers that this data is as described, as it is based on data submitted directly by patients to the national survey. The ENHT has taken the following actions to improve this score, and so the quality of its services, by scrutinising the detail within the national survey and developing divisional action plans for improvement. These are monitored at the Patient Experience Committee.

Recommending the Trust

Staff

NHS national staff survey 2018

The national staff survey is an indicator measure of the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the trust as a provider of care to their family or friends.

The Trust's response rate to the staff survey was 42.8%, a little below the national average of 44%, and a significant improvement on 2017 when the trust's response rate was 29%.

2389 staff completed the questionnaire which means that the results were more representative of their views.

The results compare the Trust's position with other trusts in the benchmark group of acute trusts in England. In relation to the ten indicators, the Trust scored better than average in two areas: Quality of Appraisals and Violence, but worse than average in the following areas (which represent the results for groups of questions):

- Staff engagement
- Health and Wellbeing
- Equality Diversity and Inclusion
- Morale
- Immediate Managers
- Bullying and Harassment

- Quality of Care
- Safety Culture

It is encouraging that in areas where the Trust has had some focus over the past year, the results have improved compared with the previous position. For example, for some of the questions on safety culture which cover the way the trust treats staff who are involved in an error, near miss or incident, the action taken in such cases and the feedback given, the Trust's scores have improved since the previous year.

Many of the results are not where the Trust would want them to be, with 5 out of the 9 indicators which are comparable with last year having fallen. Some of these deteriorations are in line with national trends, for example on staff health and wellbeing which is declining on most measures.

Recruitment and retention

The Trust has continued to work to reduce vacancy rates during 2018/2019, and works within a robust approvals process where vacancies are only filled where there is a demonstrable need and are within budget. In addition, the time taken to recruit to vacancies has been a key focus to ensure that positions are filled as quickly as possible and without delays.

One of the key areas of work has been to continue the work in reducing the number of band two clinical support worker (CSW) vacancies as well as band five staff nurses vacancies. The clinical support worker vacancy rate has seen a significant reduction over the year to 12% through targeted local and social media campaigns, the introduction of different career pathways and regular recruitment open days. The Trust's approach to nursing recruitment has been a blend of UK recruitment to hold staffing levels against turnover, and international recruitment to fill vacant posts. Recruitment improvements has seen the Trust adopt a variety of methods to aid international and UK recruitment such as regular recruitment open days, an improved streamlined recruitment process for student nurses guaranteeing them a post and attendance at national jobs fairs.

Whilst the Trust's turnover rate remains the lowest locally, there continues to be a focus on retention during 2018/2019, with a multi-disciplinary steering group regularly meeting to review turnover trends and reasons, as well as making a variety of improvements through a number of sub groups.

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 March 2019 are at 81.8%.
- 88.90% staff are compliant with all nine competencies

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	64%	2018	62%	87%*	41%*	71%
	Patients	IP 97% A/E 90% Mat 96%** OP 94%	Jan 2019	IP 97% A/E 92% Mat 97% OP 96%	-	-	IP 95% A/E 86% Mat 97% OP 94%

* Acute trusts only
**Maternity indicator is a measure relating to birth experiences only

FFT	Metric	Target	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Trend
Inpatients	Proportion of positive responses	95%	96.7%	96.0%	96.8%	96.8%	96.6%	96.2%	96.3%	96.8%	97.2%	97.5%	97.3%	96.8%	
	Total number of responses	1,778	1,919	1,881	2,170	1,979	2,146	2,004	1,905	2,122	1,824	1,991	2,094	1,791	
	Response rate	40%	41.5%	42.3%	44.8%	43.0%	46.5%	44.5%	43.1%	47.9%	38.5%	42.1%	43.2%	41.1%	
A&E	Proportion of positive responses	90%	88.8%	88.8%	89.4%	89.2%	91.9%	88.4%	88.9%	90.5%	89.9%	89.2%	90.2%	90.9%	
	Total number of responses	1,241	640	527	545	490	552	450	649	560	417	297	610	806	
	Response rate	10%	4.7%	4.3%	3.7%	3.6%	2.9%	3.5%	4.9%	3.9%	3.0%	2.2%	4.4%	6.1%	
Maternity	Antenatal care Proportion of positive responses	93%	95.7%	100.0%	91.2%	100.0%	94.7%	95.8%	90.9%	100.0%	100.0%	96.8%	92.5%	100.0%	
	Birth Proportion of positive responses	93%	95.0%	96.6%	96.4%	97.6%	96.8%	98.8%	96.7%	96.5%	95.7%	94.1%	96.7%	98.2%	
	Birth Total number of responses	157	196	179	192	166	186	184	150	141	139	135	132	157	
	Birth Response rate	30%	46.1%	41.5%	39.4%	34.9%	40.8%	41.9%	34.1%	27.8%	30.3%	29.8%	30.2%	35.1%	
	Postnatal ward Proportion of positive responses	93%	92.7%	87.6%	86.8%	81.9%	89.7%	90.8%	88.6%	91.4%	86.9%	81.3%	91.6%	91.7%	
	Postnatal community Proportion of positive responses	93%	100.0%	100.0%	100.0%	100.0%	95.2%	100.0%	100.0%	100.0%	100.0%	94.6%	100.0%	100.0%	
Outpatients	Proportion of positive responses	95%	95.2%	95.5%	96.6%	95.7%	94.7%	94.8%	94.9%	93.9%	93.6%	95.2%	94.1%	94.4%	
	Total number of responses		1,532	1,561	1,755	1,431	1,175	1,911	1,896	1,733	1,982	1,683	2,037	2,281	

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.

2018/19 improving patient experience.

- Introduced empathy project with Youth Connect, young volunteers providing peer support in Children's Emergency Department
- 'Whose Shoes' maternity engagement workshop to explore continuity of carer
- Establishment of the Maternity Voices Partnership providing a forum to promote collaborative working
- Development of a young carers App including useful information to support young carers
- Development of a carer's handbook including information to support carers whilst the person they care for is in hospital and signpost them to organisations providing help for carers
- We have 135 carers referred to Carers in Hertfordshire/Bedfordshire
- Launch of the enhanced recovery pathway and outpatient induction of labour which has helped to reduce delays in discharge and length of stay
- Refurbishment of the bereavement room on the Consultant Led Unit and transformed the Bancroft garden into a children's play area
- Introduction of screen with information for cancer outpatients at Mount Vernon Cancer Centre
- Increased the number of patient information leaflets available on the Trust website to 445.

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	94.68%	2018/19 Q3	No data*	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.

NICE QUALITY STANDARD 3: describes quality statements below:

Statement 1 Medical, surgical or trauma patients have their risk of VTE and bleeding assessed using a national tool as soon as possible after admission to hospital.

Statement 2 Patients, who are at increased risk of VTE, are given information about VTE prevention on admission to hospital.

Statement 3 Patients provided with anti-embolism stockings have them fitted and monitored in accordance with NICE guidance.

Statement 4 Medical, surgical or trauma patients have their risk of VTE reassessed at consultant review or if their clinical condition changes.

Statement 5 Patients assessed to be at risk of VTE are offered VTE prophylaxis in accordance with NICE guidance.

Statement 6 Patients/carers are offered verbal and written information on VTE prevention as part of the discharge process.

Statement 7 Patients are offered extended (post hospital) VTE prophylaxis in accordance with NICE guidance.

The Trust had previously monitored, and reported to Board, in relation to hospital acquired thrombosis through the function of the Thrombosis Committee. Historically it has also formed an important part of the 'Improving Patient Outcomes Strategy 2015-2018' and to ensure we continually strive to provide safer, more clinically effective and reliable care. As part of the Trust's Quality Schedule it has been agreed to carry out a Root Cause Analysis (RCA), following all episodes of a Hospital Associated Thrombosis (HAT), which is defined as: "Any VTE (ie deep vein thrombosis, above or below the knee, or pulmonary embolus) occurring during a hospital admission OR within 90 days of discharge."

The initial RCA shall be completed by the Consultant in charge of the patient at time of discharge; and further independent RCA review completed by the lead Haematology Consultant.

When a Hospital Acquired Thrombosis has been confirmed (by +ve scan or post mortem), we know by definition that moderate harm has occurred to the patient. When our RCA learning demonstrates care and services delivery issues, this will trigger a report to Datix and a review by the Serious Incident Review Panel.

RCA Learning has identified:

- Poor documented timeliness of patient risk assessment
- Poor drug prophylaxis prescribing
- Poor documentation of capacity assessments
- Poor drug prescribing stewardship
- Poor past medical history assessment

This learning shall be incorporated in the trust quality improvement priorities in 2019/20.

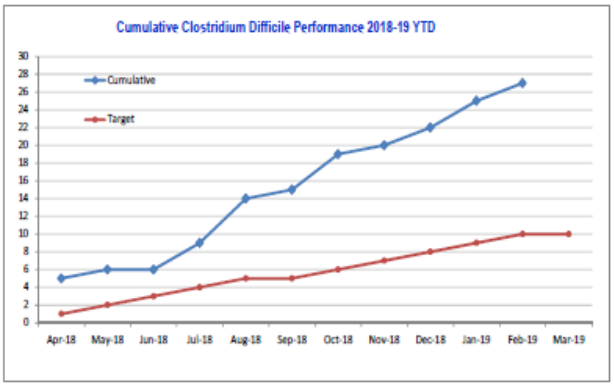
Clostridium difficile

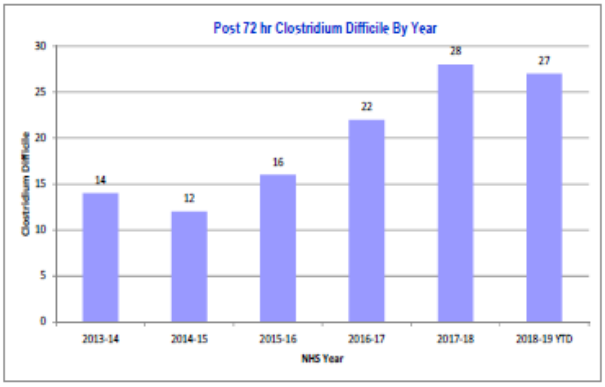
This indicator measures the number of hospital acquired Clostridium difficile infections per 100,000 bed days.

Indicator	Measure	Trust result	Time period	Trust previous result	Best performing trust	Worst performing trust	National average
Clostridium Difficile infection rates	Trust apportioned cases	12.3	2017/18	10.1	0	29.5	13.7

*The 2017/18 report indicated this value to be 10.1

The Trust reported 27 clostridium difficile infections during 2018/19.





Available benchmark data from Public Health England (April 2018 – February 2019) shows the Trust has reported 13.48 c. difficile infections per 100,000 bed days. This is slightly higher than the 12.02 average across the East of England.

The ENHT considers that this data is as described, as it is based on data submitted by the Trust to a national data collection. The ENHT has taken the following actions to improve this score, and so the quality of its services, by auditing infection prevention and control practices; delivering the infection control improvement plan and undertaking post infection reviews to identify gaps in care and potential learning.

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	2798	Oct 17 – Mar 18	3582	-	-	-
	Rate	25		35.3	124	0	
	Number of severe harm / death	27		20	0	99	-
	% of severe harm / death	0.24		0.5	0	0.55	0.37

*Acute non-specialist trusts

More recent data for April - Sept 2018 shows the number of incidents reported at 3929 giving a rate of 37.6 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 improve incident management, promoting a safety culture and improving feedback to staff on learning.

Part 3

3a Review against selected metrics
- Patient safety
- Clinical effectiveness
- Patient experiences

3b Performance against national requirements

3a Review against selected metrics

Patient safety

Indicator	16/17	17/18	18/19	Aim
Never events	2	6	**6**	0
MRSA Bacteraemia (post 48 hours)	2	1	**2**	0
Number of inpatient falls	867	859	**845**	<845
Number of inpatient falls resulting in serious harm	15	12	**12**	≤15
Number of preventable hospital acquired pressure ulcers	27	33	**N/A**	≤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 2018/19 there were 6 never events:

	2017/18	2018/19
Wrong site surgery	1	4
Retained object	3	
NG Feeding	1	1
Blood transfusion	1	
Oxygen tubing to air		1

- A patient requiring oxygen was given air as the equipment was connected to an airflow outlet
- A patient was commenced on fluids via a feeding tube that was inadvertently placed in the lung instead of the stomach
- A wrong lesion was removed from a patient's arm
- A biopsy was taken from the wrong lung

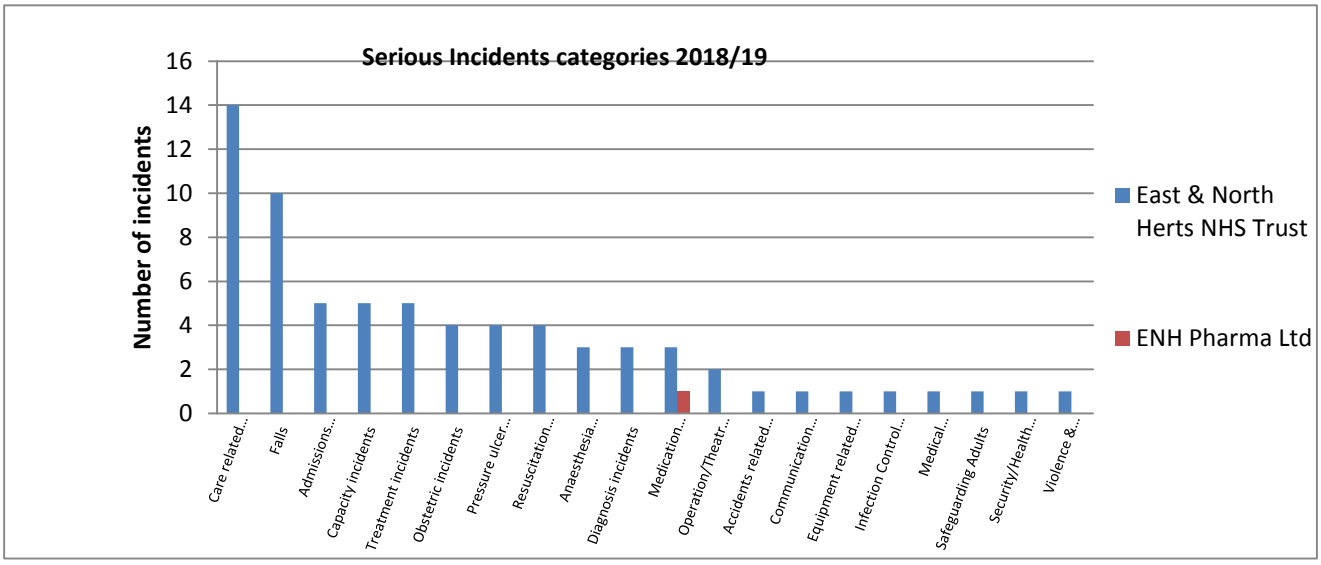
- Wrong side surgery
- A nerve block was given on the wrong side

Each of these incidents has been investigated fully to understand how they happened and to apply methods to prevent a re-occurrence. As a result of these incidents the following changes have been made / are underway:

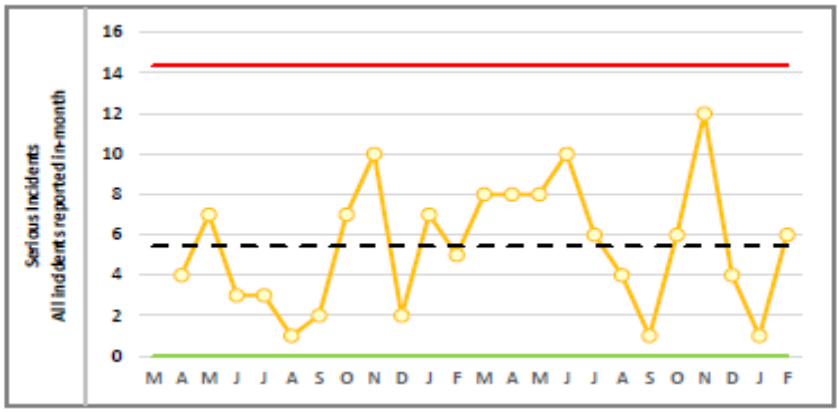
- Flaps have been placed over airflow outlets to act as a barrier to accidental use. They have to be purposely removed for use
- Development of a nasogastric feed pathway with clarity over assessments and ongoing checks
- Register of nursing staff with naso-gastric tube competencies to ensure appropriate expertise is available
- Revision of lung biopsy consent form
- Instigation of a 'safer surgery' collaborative to redesign checklists; standardise communication boards and introduce human factors training

Serious incidents

In 2018/19 the Trust reported 71 serious incidents. The themes are given below with the majority due to care related incidents and falls.



The number of reported serious incidents per month is collected as per graph below showing on average 5.5 serious incidents per month.



Learning from Series incidents remains priority for 2019/20. A vehicle to improve this locally shall include the planned collaborative working within quality goals of the Quality Strategy.

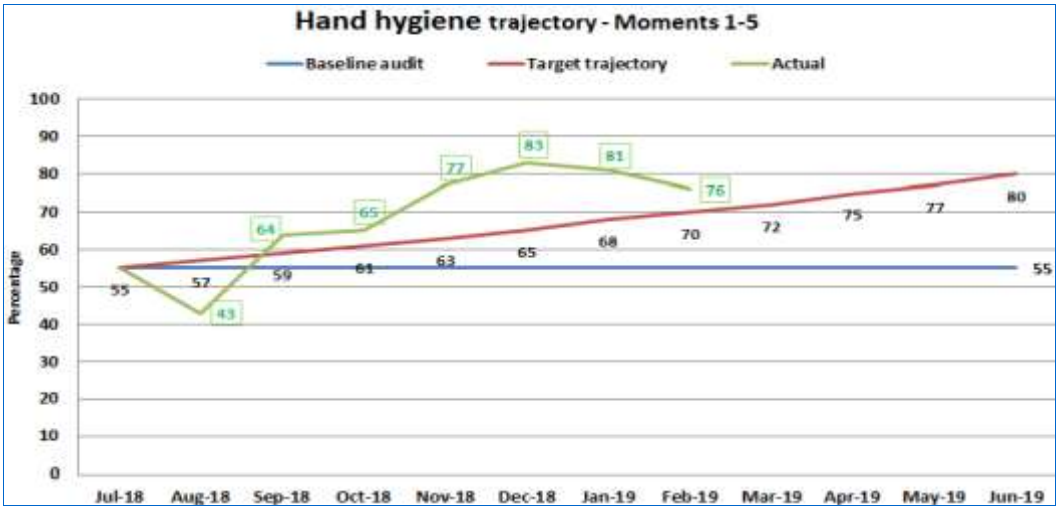
MRSA

MRSA bacteraemias are bloodstream infections. During 2018/19 two of such infections were reported.

Metric	Target	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Trend
Rate of MRSA incidences per 100,000 bed days	0.6	0.0	0.0	11.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	

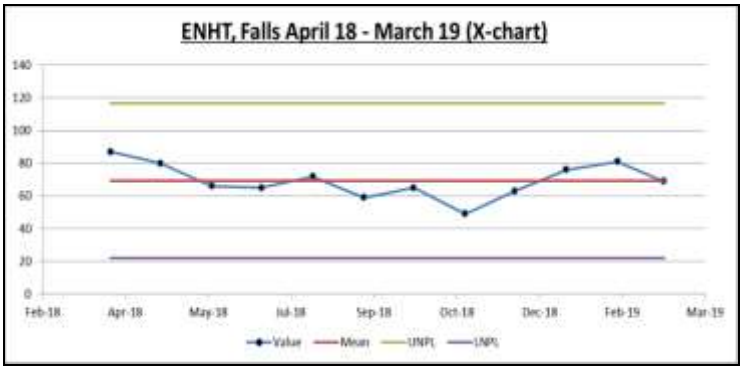
A range of initiatives are in place to further improve infection prevention and control:

- Improving cleanliness of commodes and equipment
- Ensuring equipment is in good condition
- Increasing cleanliness within high risk areas through joint working with the cleaning contractors
- Promoting antimicrobial stewardship as described in section 2a, priority 1
- Minimising surgical site infections
- Promoting hand hygiene, with results shown in the graph below

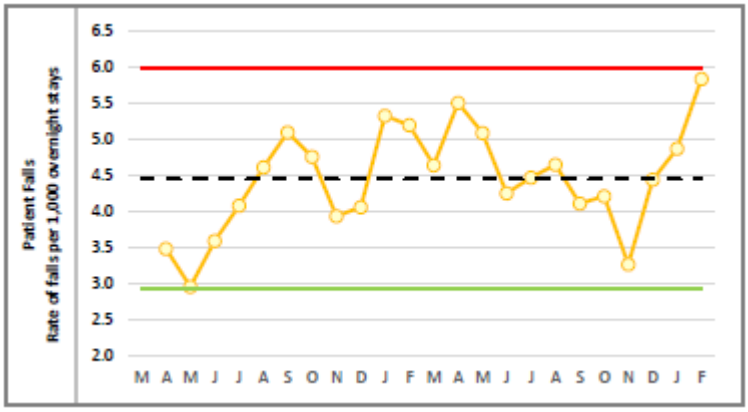


Falls

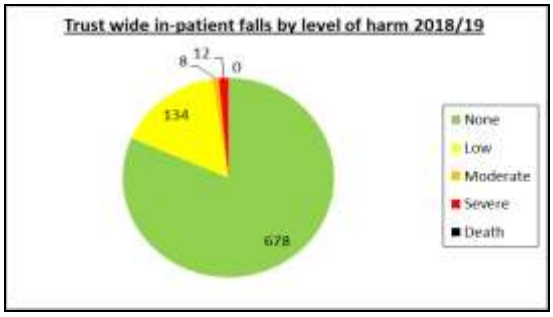
During 2018/19, 845 inpatient falls were recorded in the Trust - 27 fewer than reported in 2017/18. This equates to a 3.14% decrease in falls surpassing our target to achieve a 2.5% annual decrease.

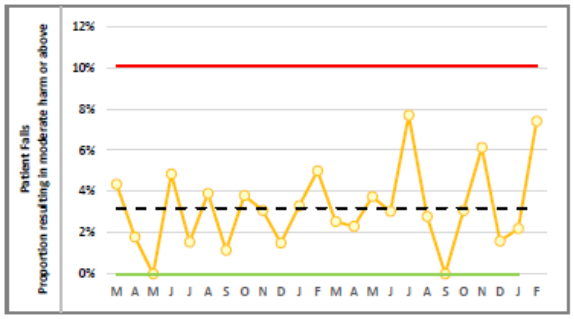


The rate of falls per 1,000 overnight stays during the last two years is shown in the chart below.



In 2018/19 81.5% of the falls resulted in no harm with a further 16% resulting in low harm injuries such as minor cuts and bruises.





8 falls resulted in moderate harm injuries and 12 falls resulted in patients sustaining severe harm injuries. The graph on the right shows the rate of falls leading to moderate or more severe harm during the last two years.

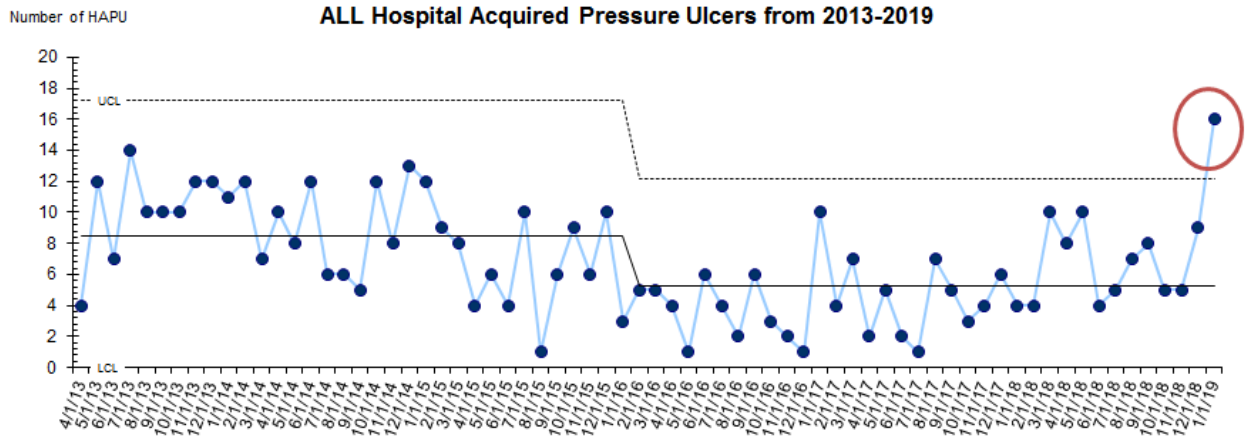
All moderate and severe harm falls are routinely subject to an investigation with findings shared with teams to improve organisational learning. This year a Harm Free Care Panel was established as part of the quality transformation work. The panel monitors falls trends and outcomes to make recommendations for future developments, such as the requirement for registered nurses to support clinical support workers more closely in undertaking and signing off risk assessments; and for nurses to undertake lying and standing blood pressure checks to monitor for 'postural hypotension' (blood pressure reduction when standing up) which is associated with an increased risk of falling.

Pressure Ulcers

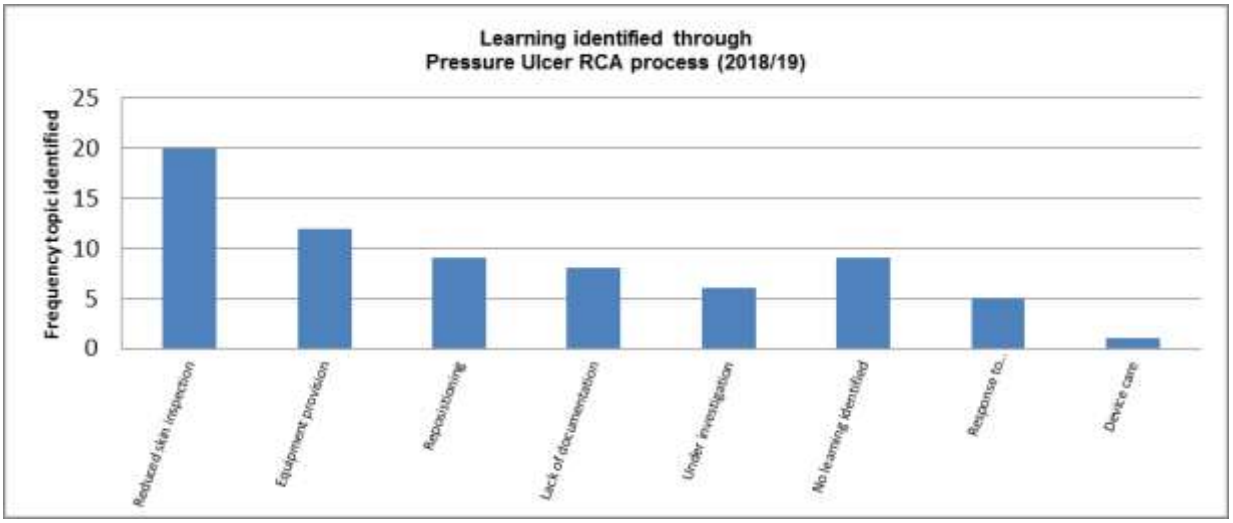
Prior to 2017/18 the Trust gathered data as to whether pressure ulcers were avoidable or not, ie. whether better pressure area care management would have prevented the ulcer forming. This data is no longer collated due to changes in the national definition introduced in December 2018. Since this change in definition the number of pressure ulcers now reportable has increased.

During 2018/19 the Trust declared a total of 101 pressure ulcers including 3 grade 4 pressure ulcers. Data is also gathered on ulcers resulting from device use, such as naso-gastric tubes; and deep tissue injuries.

The graph showing all categories of pressure ulcers is given below with the sharp rise seen during 2019 as a result in the change of the national definitions.



Data is analysed through root-cause analysis learning for each reported pressure ulcer is shown in table below. These themes shall influence quality improvement efforts in 2019/20.



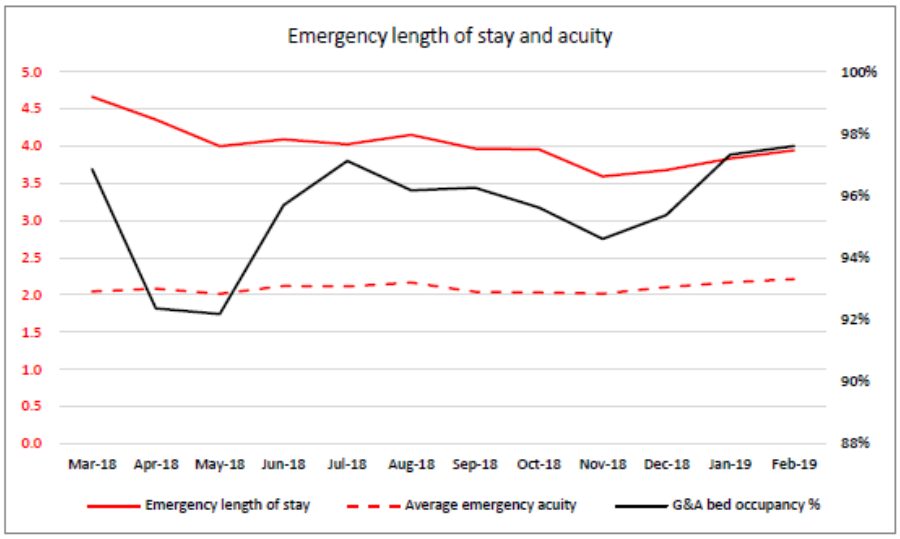
Clinical effectiveness

Indicator	16/17	17/18	18/19	Aim
Length of stay (non-elective / emergency)	3.9	3.5	**4 (To Feb)**	≤4.3
Stroke – thrombolysis rate	6.1%	7.2%	**12.3% (Feb)**	≥11%
Crude mortality – rolling 12 month rate	17 (Mar)	15 (Mar)	**11.5 (Feb)**	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 a year to date figure of an average of 4 days. This is better than the plan of 4.3 days.

Metric	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Trend	Plan YTD	Actual YTD	Var YTD
Emergency - Length of Stay	4.7	4.4	4.0	4.1	4.0	4.2	4.0	4.0	3.6	3.7	3.8	3.9		4.3	4.0	-0.4



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 with the February data surpassing national requirements.

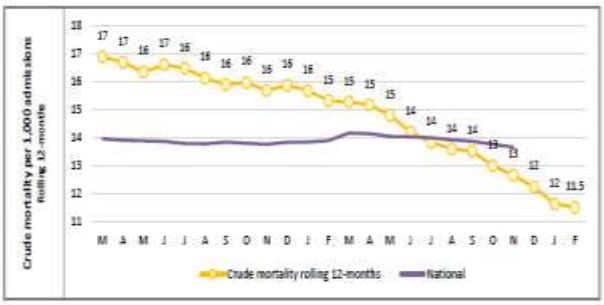
Metric	Target	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Trend
Total Thrombolysis rate for confirmed Strokes	11%	8.3%	12.5%	7.2%	4.8%	16.7%	10.1%	9.5%	7.0%	14.3%	8.6%	10.0%	12.3%	

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.

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 change from July 2017 onwards in reporting chemotherapy treatments as day cases has contributed to the downward direction of travel.



The average national crude inpatient mortality (for ordinary admissions excluding day cases) is 1.4% and 1.5% within the region. This compares to 1.15% within ENHT.

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.

Patient experiences

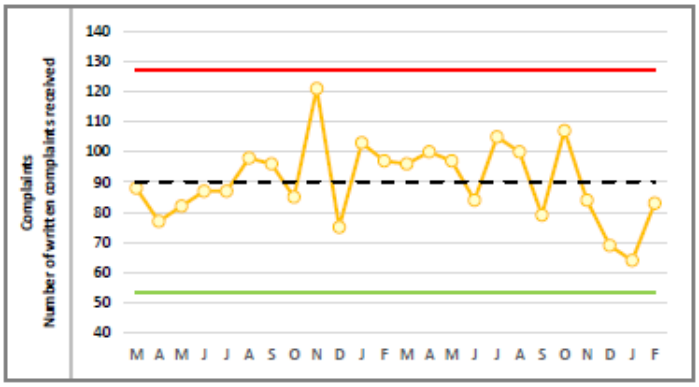
Indicator	16/17	17/18	18/19	Aim
Number of written complaints	924	1106	**1068 (to Feb)**	<previous year
Number of PALS concerns	3195	4151	**4502**	N/A
Complaints per level of activity - per 100 bed days	0.42	0.52*	**1.2-2.2**	<1.9**
Complaints – response within agreed timeframe	48%	67%	**47-91%**	≥80%***

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.

Number of complaints and PALS concerns and activity

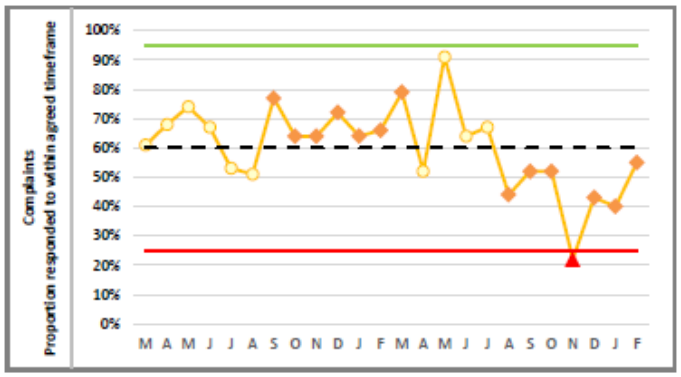
The number of written complaints has overall remained comparable to the previous year, but has reduced per month during the last few months. Activity overall during the last two years is seen in the chart below demonstrating an average of approximately 90 written complaints per month.



The number of PALS concerns has increased, but this is encouraged to resolve concerns at an early stage.

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. Current challenges are evident, particularly in relation to capacity and competing priorities. The number of open complaints gradually increased, with the Trust having approximately 200 open complaints in January when a manageable level is approximately 120.

A 90 day quality improvement project to help understand and improve the position commenced in January. The complaints handling process has been reviewed and quality improvement methodology applied to make small changes and test them. At the time of writing improvements are starting to be seen.

Learning outcomes

Below are some examples from October – December 2018 of what has happened as a result of patient feedback.

Ward/Dept.	You Said	We Did
Pre-operative Assessment, Lister	Better signs	Laminated signs have been put up to direct people where to go. Please ask at reception if you are unsure.
Pirton	Less people crowding at visiting times and also those outside of visiting times – limit to just two per bed space, we require our rest.	All staff, including doctors, are reminded to monitor the number of visitors to a bed space and to ask visitors to rotate if necessary. Protected mealtimes are in place and are upheld.
Short Stay Unit (SSU)	SSU is an extremely busy department both during the day and night. At night the staff can sometimes be a little noisy. We feel a little more consideration should be given to patients who are trying to sleep.	You are right that the SSU is a busy department and at times can be noisy. The ward manager has spoken to the night staff to ensure they try to keep the noise level to a minimum.
11A	I didn't get enough help from the staff with eating meals.	We are working closely with the kitchen and food service to ensure we have enough red trays on the ward when meals are served as these help staff identify those who need assistance with eating their meals.
10AN	I would have liked a TV to distract myself from other noises on the ward and to take my mind off things.	Patients are able to hire a bedside TV. Please ask a member of staff if you would like more information about this.
10B	The temperature on the ward was too hot.	Please let a member of staff know if you are too hot, we may be able to provide a fan for your bedside.
9A	You enjoyed watching sport on TV.	Our Trust Charity department will be happy to hear that. They do their best to help provide equipment to make our patients' stay in hospital more enjoyable.
	That you would have liked more variety with the food.	Our catering department have worked hard to produce a wide range of different meal options and an 'á la carte' style menu. Please talk to our housekeeper if you need help selecting your meal or would prefer another option.
8A	Not having to wait too long for medication to take home.	We are encouraging the medical team to complete the TTOs a day before the discharge date to avoid delays in dispensing patients take home medications.

3b Performance against national requirements

National standards

The indicators in this section form part of the NHS Improvement Single Oversight Framework.

	16/17	17/18	18/19	Aim
Max 18 weeks from referral in aggregate – patients on incomplete pathways	92.2%	**Not given**[a]	**90.3%** (To Feb)	≥92%
Four hour maximum wait in A&E	84.6%	**83.6%**	**80.5%** (To Feb)	≥95%
62-day urgent referral to treatment of all cancers	73.6%	**75.7%** (To Jan)	**66.8%** (To Jan)	≥85%
Maximum 6 week wait for diagnostic procedures	99.7%	**Not given**[a]	**98.79%** (Feb)	<99%

[a] A problem with the reporting function of a new administration system meant this data was not available

7 day services

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	2018/19
2	All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant within 14 hours of admission	71% for weekday admissions; 60% 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 96% compliance with daily consultant review (April 2018 data)	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.

	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

National Speaking up legislation

Freedom to Speak Up / Raising Concerns

The Trust is committed to achieving the highest possible standards of quality, openness and accountability in all its practices. To achieve these, the Trust is committed to supporting any members of staff who are worried about any areas of poor practice, attitudes or inappropriate behaviour within our organisation. We believe in promoting a departmental culture which encourages open communication between staff and managers to ensure that questions and concerns can be raised and resolved quickly.

The Trust positivity encourages its staff to report any concerns they may have as well as provide advice and guidance. We have several ways in which our staff can raise a concern:

- Via our Freedom to Speak Up Guardian
- Via our Non-Executive Director Whistleblowing Guardian
- Via the Speak in Confidence Service
- Through the Employee Relations Advisory Service.
- The Chief Executive or any Executive Director
- The Deputy Director for Nursing or Workforce and Organisation Development
- Raising a concern on datix incident reporting system

Concerns can be raised in person, by telephone or in writing (Including by email).

Our Commitment to our staff is:

- ‘Speak up and we will listen’. We will agree any next steps together
- To fully explore concerns in a timely, impartial and confidential manner
- To listen, investigate and feedback
- To take action to address any concerns upheld
- To ensure that there is no detriment or repercussions as a result of raising concerns

The focus of any investigation is on improving the service we provide for our patients and the working environment for our staff. Where improvements can be made, we track them to ensure necessary changes are made, and are working effectively. Feedback is given to the individual raising the concern; although this is not always possible when the concern is raised anonymously.

During 2018/19, 28 cases have been raised via our Freedom to Speak Up Guardian/ Associate Director of Corporate Governance

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. Approximately a quarter of the gaps are in the Emergency Department.

Apr-Jun 2018	Jul-Sept 2018	Oct-Dec 2018	Jan-Mar 2019
33	35	38	36

The gaps are currently being filled by temporary staff, often regular staff well known to the organisation. Recruitment initiatives to fill these posts continue. It is to be noted that there is a worldwide shortage of middle grade Emergency Department doctors and recruitment activities are at the international level. The Trust continues to liaise with the East of England Deanery to maximise the number of junior doctor posts assigned to us.

Annex 1 Research and development

During 2018/9 the Trust entered 3,336 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.

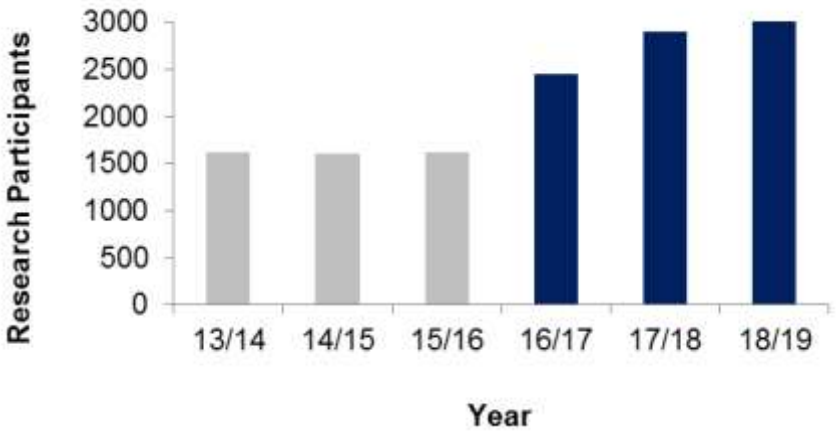
The Trust's Research Strategy

The Trust has an ambitious research strategy which has a vision to "***enhance patient experience and outcomes through research opportunity and innovation for all patients and all staff***".

The Trust has put in place a structure and processes to:

- develop and support an environment where patients, service users and the public are given, and take, the opportunity to participate in health and social care research, and are confident about doing so; and so
- new treatments, care and other services are developed through ethical and scientifically sound research for the benefit of patients, service users and the public.

Since the introduction of the Trust's research strategy in 2016/7 there has been a dramatic and sustained increase (92% increase from pre-strategy baseline of 1,612 to 3,079 in 2018/9) in the number of people participating in research studies adopted to the National Institute for Health Research (NIHR) portfolio (see below).



Our success in delivering our research strategy can be attributed to the following:

1) We have a really dedicated, hard-working and wonderful research team at the Trust who always put our patients first.
2) We had high level Board engagement from the outset; this ensured that research could support the wider needs of the Trust.
3) We developed annual business plans so that we could focus on what we wanted to achieve.
4) We aligned our thinking and we introduced effective decision-making to ensure we optimized use of resources to deliver our strategy. We developed lean processes and reduced waste.
5) We developed a sense of community within the Trust, and wider, to ensure that we could all contribute and feel valued. We grew our community to include more and more people from an increasingly wide geographical area. We established numerous partnerships.
6) We maintained momentum because we could see the progress we made, we could hear our patients telling us how research has given them hope and changed their lives.
7) We have seen national and local practice change through our actions for the benefit of patients.

Research has been identified as an 'enabler' to deliver the Trust's new 5 year Clinical Strategy. Research is now embedded into every Divisional Board meeting so that it is considered alongside all other operational issues.

The national Patient Research Experience Survey

A small sample (n=9) of our research participants provided the following qualitative feedback:

- *"Really happy to be able to take part, and my weight loss is a bonus"*
- *"I am always happy to participate in research that may be helpful to others"*
- *"Made to feel comfortable and at ease about taking part"*

Some of the 2018/9 research highlights

- **CQCInspection -** From a research perspective it was great to see that research at the Mount Vernon Cancer Centre (MVCC) was regarded as ***outstanding practice.***
- The Trust has been ranked again in the **top 50 acute trusts for research**, this time for both the number of research studies and the number of participants taking part.
- The Trust continues to support **academic partnership working** with the University of Hertfordshire, with UCLH and other Universities including Brunel University London.
- In 2018, members of the Trust co-authored wrote **154 research publications** in peer-reviewed journals.
- The Trust was a finalist in the **2018 Nursing Times Awards** for 'Clinical Research Nursing dramatically increases research to support the needs of patients and the public'.
- **MVCC recruits first national patient to a landmark study into brain cancer** - Dr Paul Mulholland is the Chief Investigator for a study called "*A Phase II, Open Label, Randomised Study of Ipilimumab with Temozolomide versus Temozolomide alone after surgery and chemoradiotherapy in patients with recently diagnosed glioblastoma*". Glioblastoma is the most aggressive cancer that begins within the brain and we have had no new treatment options for patients with glioblastoma for well over a decade. Mount Vernon has recruited the first patient to this trial and six other NHS hospitals will help reach the overall target of 120.

- **Renal peer support service now up and running as a result of local research with benefits for patients** The SELFMADE research study, with Prof Ken Farrington as Chief Investigator, led to the development of shared care in our Renal Units. Patients are encouraged and trained to put themselves on and take themselves off dialysis.
- **Supportive Oncology Research Team highest UK recruiters to international trial** The team at the Mount Vernon Cancer Centre has recruited the most patients in the UK to an international study looking at monitoring side-effects of chemotherapy remotely.
- Jodie Deards (Carers Lead for Patient and Carer Experience) and Prof Natalie Pattison (Florence Nightingale Foundation Clinical Professor of Nursing) secured £20k external funding from General Nursing Council for England & Wales to run a study to **co-produce, and explore the impact of, an app-based support intervention on young carers.**
- The Trust's has recruited the highest number of patients in England to a national study (ELATION) looking at whether a **new ultrasound method will help reduce the number of patients needing a diagnostic operation**. The study was led by consultant head and neck surgeon Mr George Mochloulis and consultant radiologist Dr Kanchana Rajaguru.
- Prof Diana Gorog gained external funding for a research project that seeks to answer "**can very low dose rivaroxaban (VLDR) in addition to Dual Antiplatelet Therapy (DAPT) improve thrombotic status in Acute Coronary Syndrome (ACS)?"**
- Mount Vernon Cancer Team are leading the way in **international testicular cancer research** and **Dr Anand Sharma and Dr Marcia Hall** were invited to present a poster at the 2018 Genitourinary Cancers Symposium in San Francisco.
- STAMPEDE: Systemic Therapy for Advanced or Metastatic Prostate cancer: Evaluation of Drug Efficacy (STAMPEDE) This study is being run by our Urology Cancer Research Team and the Trust has recruited 36 patients to the study. This research has found that **additional radiotherapy can improve survival for some patient groups**.
- As part of gaining ethical approval all research projects have to be submitted to the Health Research Authority. Our Research Office supports research teams to make these applications and we got some great feedback recently ***"the Committee recorded an outright favourable opinion of your study – congratulations, this does not happen often! Once again, the Committee would like to extend its thanks to you for an exceptionally well-written application and an excellent presentation at the meeting itself".***
- Members of the Trust's gastroenterology team have been major contributors to the national AspECT study, the results of which have just been published in the prestigious Lancet Journal. The AspECT trial aimed to evaluate the efficacy of high-dose esomeprazole proton-pump inhibitor (PPI) and aspirin for **improving outcomes in patients with Barrett's oesophagus**.
- Mr Nikhil Vasdev, consultant urological surgeon **leads an international collaboration between 19 centres across Europe, America and Canada** looking at the impact of initial pathology and response rates following chemotherapy and surgery.
- **Research was recognised at the Trust's staff awards** and Ana Gaspar was the winner of the Ryalto innovation and research award. Ana is a respiratory and sleep physiologist who is looking to improve the lives of patients and staff by looking for better ways of working. The winner of the quality and safety award at our staff awards was Anne Hunt, our sepsis lead nurse. Going above and beyond in her role, Anne has delivered important work to improve understanding of sepsis for people with learning disabilities.

Annex 2 CQC inspection site ratings

Lister Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good July 2018 ↑↑	Good July 2018 ↑	Good July 2018 ↑	Good July 2018 ↑	Good July 2018 ↑↑	Good July 2018 ↑↑
Medical care (including older people's care)	Requires Improvement July 2018 →←	Good July 2018 ↑	Good July 2018 →←	Good July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←
Surgery	Inadequate July 2018 ↓↓	Requires Improvement July 2018 ↓	Good July 2018 →←	Inadequate July 2018 ↓↓	Inadequate July 2018 ↓↓	Inadequate July 2018 ↓↓
Critical care	Good March 2016	Good March 2016	Good March 2016	Good March 2016	Requires Improvement March 2016	Good March 2016
Maternity	Requires Improvement July 2018 →←	Good July 2018 →←	Good July 2018 →←	Good July 2018 ↑	Good July 2018 →←	Good July 2018 ↑
Services for children and young people	Requires Improvement July 2018 →←	Good July 2018 ↑	Good July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←
End of life care	Good March 2016	Requires Improvement March 2016	Good March 2016	Good March 2016	Requires Improvement March 2016	Requires Improvement March 2016
Outpatients	Good March 2016	N/A	Good March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Good July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←

New QEII Hospital

Urgent and emergency services	Inadequate July 2018 ↓	Requires Improvement July 2018 →←	Good July 2018 →←	Good July 2018 →←	Inadequate July 2018 ↓	Inadequate July 2018 ↓
Outpatients and diagnostic imaging	Good March 2016	N/A	Good March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Inadequate July 2018 ↓	Requires Improvement July 2018 →←	Good July 2018 →←	Good July 2018 →←	Inadequate July 2018 ↓	Inadequate July 2018 ↓

Mount Vernon Cancer Centre

Medical care (including older people's care)	Requires Improvement July 2018 ↑	Good July 2018 ↑	Good July 2018 →←	Requires Improvement July 2018 ↑	Requires Improvement July 2018 →←	Requires Improvement July 2018 ↑
End of life care	Requires Improvement July 2018 ↑	Good July 2018 →←	Good July 2018 →←	Inadequate July 2018 ↓	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←
Outpatients	Good March 2016	Good March 2016	Good March 2016	Requires Improvement March 2016	Good March 2016	Good March 2016
Chemotherapy	Requires Improvement July 2018 ↓	Good July 2018 →←	Good July 2018 ↓	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←
Radiotherapy	Good March 2016	Good March 2016	Good March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Requires Improvement July 2018 ↑	Good July 2018 →←	Good July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←

Community Health Services for Children, Young People and Families

Community health services for children and young people	Good March 2016	Good March 2016	Outstanding March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Good March 2016	Good March 2016	Outstanding March 2016	Good March 2016	Good March 2016	Good March 2016

Hertford County Hospital

Outpatients	Good March 2016	N/A	Good March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Good March 2016	N/A	Good March 2016	Good March 2016	Good March 2016	Good March 2016

Annex 3 Statements from stakeholders

East and North Hertfordshire Clinical Commissioning Group

NHS
East and North Hertfordshire
Clinical Commissioning Group

East and North Herts Clinical Commissioning Group's Response to the Quality Account provided by East and North Hertfordshire Hospitals NHS Trust

East and North Herts CCG (ENHCCG) has reviewed the information provided by East and North Hertfordshire Hospitals NHS Trust (ENHT) and checked the accuracy of the data within it. We believe the information is a true reflection of the Trust's performance during 2018/19, based on the data submitted during the year as part of the on-going quality monitoring process.

The Trust has clearly identified within its Quality Account where progress has been made and where further improvements are still needed.

During 2018/19 ENHCCG has worked closely with ENHT, meeting regularly to review progress in relation to quality improvement initiatives as well as undertaking Quality Assurance Visits.

The Quality Transformation Programme has been a key area of focus for the Trust during 2018/19. The CCG has been pleased to see that the Trust has been working hard to strengthen systems and processes as well as establishing key work streams such as harm free care, safer surgery, and documentation and communication. We look forward to the launch of the Quality Strategy, and to following the Trust's progress in relation to quality improvement over the coming year, including seeing improved patient outcomes.

Following the Care Quality Commission's (CQC) inspection in March and April 2018 the findings were published in July 2018. Positive improvements were identified in a number of areas, particularly urgent and emergency services at the Lister Hospital, and the Trust was rated as 'good' for the domain of caring across all sites. However the CQC also found areas where significant improvement was required, with the Surgical Division at the Lister Hospital and the urgent and emergency services at the QEII hospital rated as 'inadequate'.

As described in the Trust's Quality Account, the Trust has developed an action plan in response to the CQC's findings and work is ongoing to ensure the required improvements are made and sustained. The CCG will continue to monitor progress carefully and seek assurance during Quality Assurance Visits.

During 2018/19 ENHT has seen mixed results in relation to achievement of their quality priorities. The CCG is pleased to see the ongoing improvements in mortality rates with the latest SHMI data in the 'as expected' range, and the latest HSMR in the 'better than expected' range. The improvements relating to the reduced rate of avoidable cardiac arrests as well as medication incidents are also positive. However the CCG remains concerned regarding the limited progress in relation to the timely administration of antibiotics for patients with sepsis.

Whilst the CCG understands that since the implementation of the new Patient Administration System there has needed to be focus on IT stabilisation, it is disappointing that other areas of digitalisation are behind schedule such as progress towards e-prescribing, and launch of the escalation module on the electronic

observation system. ENHCCG looks forward to seeing progress in this area during 2019/20.

Following the identification of a significant backlog of discharge summaries that had not been sent to primary care and the reviews undertaken, ENHCCG is pleased to note that no harm has been identified either through the Independent Review or the Primary Care audit. Whilst some progress has been made to strengthen processes, the CCG expects to see further improvements in the timeliness and quality of discharge summaries during 2019/20. The current Contract Performance Notice will remain in place until the CCG is assured that these improvements have been made.

A Contract Performance Notice was also issued by the CCG in June 2018 in relation to infection prevention and control. Improvements have since been made in some areas including hand hygiene and timely antibiotic review, however further improvement is required in relation to cleanliness of equipment. Again, the CCG will continue to monitor progress closely.

During 2018/19 the Trust reported 6 Never Events which is equal to the number reported the previous year; this is disappointing as the Trust had a new quality priority regarding surgical safety last year. We are pleased to note the ongoing focus in this area and would expect to see a reduction in Never Events occurring in 2018/19. ENHCCG will continue to seek assurance that relevant actions and improvements are being implemented to prevent reoccurrence, and we will continue to undertake Quality Assurance Visits to review progress and ensure the improvements have been sustained in relation to Never Events and Serious Incidents.

The Trust has demonstrated positive improvements in Serious Incident management over the last 12 months, and ENHCCG wishes to see the improved position sustained over the coming year.

The 2018 annual staff survey results were disappointing. Whilst the Trust's results were better than average for two indicators, they were worse than average for the other 8 indicators including staff engagement and bullying and harassment. The CCG expects this to be a key area of focus for the coming year.

The CCG supports the Trust's 2019/20 quality priorities and is pleased to see that improving care of deteriorating patients, compliance with the sepsis pathway and improvements in the timeliness of discharge summaries are priority areas for the Trust.

Additionally ENHCCG wishes to see significant improvement in compliance with venous thromboembolism (VTE) assessment and re-assessment, and improving the timeliness of complaint responses during 2019/20.

Whilst cancer performance in relation to two week wait from GP referral has been good throughout the year, performance regarding the 62 day standard has remained an area of continual challenge and has been slow to show improvement during the

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Clinical Commissioning Group

year. The CCG would like to see sustained improvement in 62 day cancer performance as well as A&E performance regarding the 4 hour standard.

We look forward to working with and supporting ENHT in further developing and monitoring the quality of services it provides for patients. We hope the Trust finds these comments helpful and we look forward to continuous improvement in 2019/20.

Beverley Flowers
Chief Executive Officer
May 2019

Healthwatch Hertfordshire's response to East and North Hertfordshire NHS Trust (ENHT) Quality Account 2019

Healthwatch Hertfordshire welcomes the opportunity to comment on ENHT's Quality Account. We would like to make the following comments:

- The Quality Account provides a clear assessment of progress against the 2018/19 priorities and there is a clear rationale for the focus of the priorities for 2019/20 which are underpinned by the new Clinical Strategy. We therefore support the priorities and look forward to seeing the improvements for patients in the coming year.

- We have been pleased to have been welcomed at the Lister Hospital to have a stall there on a regular basis so that patients can come and talk to us about their experience on the day. Patients regularly praise the level of care they have received and the friendliness of staff but have sometimes been frustrated by communication and administrative processes. This is acknowledged in the CEO's statement.

- Complaints handling is recognised by the Trust as an important element of quality improvement and ENHT is committed to learning from all aspects of the patient experience through the Quality Transformation Programme. The Trust has been responsive to our suggestions about improving their complaints policy, particularly in relation to patient support and accessibility of the policy. As part of this work we have met with the complaints manager and are providing comments on the revised policy.

- Implementation of the electronic systems has been challenging and has impacted on patients with delayed discharge summaries and difficulties with the appointment system. We feel confident that the Trust is sighted on these issues and is focusing on implementing processes that will lead to sustained improvement for patients going forward.

- It is very pleasing to see the continued improvement in the Trust's hospital mortality rates which the Trust is rightly proud of.

We look forward to working with ENHT in the coming year to continue to improve patient experience and outcomes.

Steve Palmer, Chair Healthwatch Hertfordshire, May 2019

Quality Account 2019/20 – Response to East and North Herts NHS Trust
Response prepared by Cllr Peter Hollick, Chairman, Social Care Health and Housing Overview and Scrutiny Committee, Central Bedfordshire Council.

One recognises that there are many pressures on the Health Service generally. I note that in the introduction it is reported that there are friendly staff and good care but poor administration, communications and waiting times. I therefore sought any clear references particularly to communication. While there is no specific section for 'communication' there are references which may be said to come under communication. I would have liked to see specific references since this is an area which is so important to the patient, relatives, carers etc. The appointments system needs some reform to be more easily understood and 'used'.

Certain 'headings' are more easily written down - 'cultural commitment' - but more difficult to turn them into practice. However, this is a report which is generally well set out and can be read with some ease.

- Improving carers experience 'Always event'. A certain irony that this was not progressed given concerns about communication and carers wanting to feel informed and involved with discharges.

- QA priorities for 19/20 largely the same as for 18/19 so looking for further improvements. Need to monitor effectiveness of improvements made with IT systems and relates to administration. Reinforce that communication is so important as is conscientious record keeping.

- The current registration status requires improvement. QEII Hospital received three inadequate ratings and need to step up. Regulation 19 - fit and proper persons employed - on the face of it, this is worrying and look here for improvement in recruitment/training. In contrast the areas of outstanding practices on page 34 are recognised.

- Page 39 Emergency readmissions - near bottom of table and more than twice below that of the best performing trusts, albeit a reported and consistent improving trend. Look for further improvement which brings performance nearer the top.

- While the number of falls has decreased and surpassed target to achieve an annual decrease, the number of falls still seem high.

- Pressure ulcers, with a change in definition presumably to better reflect the patient's care, has increased and the number of incidents reported has caused a sharp rise. The question for the Trust is; are patients being as well looked after as they should be?

- The number of complaints (page 49) looks to reduce the number received by the Trust last year. Why not aim to have less than those in 16/17 being the least number over that past few years. How many statements of appreciation did the Trust receive?
- Annex 1 the need to eliminate inadequate ratings, especially at the QEII.
- Congratulations are extended to the Community Health Services for Children, Young People and Families and the Hertford Hospital.

Annex 4 Statement of the directors' responsibilities

Statement of directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011, 2012 and 2017).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the Quality Accounts presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

27 JUNE 2018 Date..... Chair

27 JUNE 2018 Date..... Chief Executive

Annex 5 Statement from auditors

INDEPENDENT AUDITOR'S LIMITED ASSURANCE REPORT TO THE DIRECTORS OF EAST AND NORTH HERTFORDSHIRE NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We have been engaged by East and North Hertfordshire NHS Trust to perform an independent assurance engagement in respect of East and North Hertfordshire NHS Trust's Quality Account for the year ended 31 March 2019 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011, the National Health Service (Quality Account) Amendment Regulations 2012 and the National Health Service (Quality Account) Amendment Regulations 2017 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following indicators:

- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge;
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

We refer to these two indicators collectively as "the indicators".

Directors' responsibilities

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibilities

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by the Department of Health in March 2015 as supplemented by the Quality Accounts: Reporting Arrangements 2018/19 letter dated 17 December 2018 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2018 to May 2019;
- papers relating to quality reported to the Board over the period April 2018 to May 2019;
- feedback from Healthwatch Hertfordshire issued May 2019;
- the Trust's complaints reports published during 2018/19 under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009;
- feedback from other named stakeholders involved in the sign off of the Quality Account;
- the latest national patient survey, related to 2017;
- the latest national staff survey, related to 2018;
- the Head of Internal Audit's annual opinion over the trust's control environment in respect if 2018/19;
- the annual governance statement in respect of 2018/19;
- the Care Quality Commission's quality and risk profiles published 17 July 2018; and
- local patient experience surveys conducted throughout 2018/19.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of East and North Hertfordshire NHS Trust as a body in accordance with the terms of our engagement letter dated 8 May 2019. Our work has been undertaken so that we might state to the Directors those matters we have agreed with them in our engagement letter and for no other purpose.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and East and North Hertfordshire NHS Trust for our work or this report or for the conclusions we have formed save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by East and North Hertfordshire NHS Trust.

Basis for qualified conclusion

Our testing completed over the "percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge" indicator identified a weakness in relation to the completeness of the data recorded.

During the year the Trust updated its processes for reporting A&E admissions data in respect of this indicator to bring the Trust in line with national guidelines. This change involved the Trust moving to reporting wait times on dates of discharge rather than on dates of admission. As the change in process took place mid-year, reporting of patients at the start and end of the reporting period was inconsistent. This shortened the period for which A&E admissions were reported in 2018/19 because the information will have excluded patients admitted but not yet discharged as at 31 March 2018, whilst also (correctly) excluding patients admitted but not yet discharged as at

31 March 2019. The impact on the number of A&E patients reported in 2018/19 has not been quantified.

This issue prevents us from concluding that the indicator has been reasonably stated in all material respects in accordance with the Regulations.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter reported in the *Basis for qualified conclusion* paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

BDO LLP

BDO LLP
Chartered Accountants
Ipswich, UK

28 June 2019

East and North Hertfordshire NHS Trust

Agenda Item: 10

TRUST BOARD – PUBLIC SESSION – 3 JULY 2019
Board Assurance Framework 2019 20 Update

Purpose of report and executive summary (250 words max):
To present the latest version of the Board Assurance Framework 2019 20 (appendix 1) for consideration. Latest updates are in green text.

The Board are asked to note

- The strategic risks presented on the new framework for 2019/20 with the revised strategic risks as approved by the Board in May 2019. It is hoped that this 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. This will continue to evolve. Alignment with the internal audit programme is included in this iteration.
- Consider any further recommendations and required assurances. There are no changes to the risk scores this month.
- Over the next month the risks will be further reviewed with each lead Directors, which will include a Q1 summary and then as an Executive team. The purpose of this review will be to test the controls, assurances, KPIs and actions are all identified and documented and to agree the target risks associated timeline. A cross reference exercise of all the annual operational objectives to the BAF will be undertaken in conjunction with this.
- The Risk manager and Associate Director of Corporate Governance will undertake a review of the BAF against the recently approved risk appetite statements and develop a short 'risk appetite at a glance' reference guide to support future BAF reviews; this will be undertaken in Q2.
- FPC focused on the IM&T risk (risk 5), finance (risk 3) and the workforce risk (risk 2) in June 2019
- QSC focused on Estates and Facilities (risk 11) and Quality and safety (risk 8) in June 2019.

Action required: For discussion

Previously considered by:
The Board Assurance Framework is considered at each FPC,QSC & Public Board.

Director:	**Presented by:**	**Author:**
Director of Strategy	**Associate Director of Corporate Governance**	**Associate Director of Corporate Governance**

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
Yes – CQC compliance will link with all the BAF Risks

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

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	Short disruption to services affecting patient care or intermittent breach of key target	Local media coverage	Loss of between £10,000 and £100,000
		<3 days off work, if staff			
3	**Moderate**	Moderate injury requiring professional intervention	Sustained period of disruption to services / sustained breach key target	Local media coverage with reduction of public confidence	Loss of between £101,000 and £500,000
		RIDDOR reportable incident			
4	**Major**	Major injury leading to long term incapacity requiring significant increased length of stay	Intermittent failures in a critical service	National media coverage and increased level of political / public scrutiny. Total loss of public confidence	Loss of between £501,000 and £5m
			Significant underperformance of a range of key targets		
5	**Extreme**	Incident leading to death	Permanent closure / loss of a service	Long term or repeated adverse national publicity	Loss of >£5m
		Serious incident involving a large number of patients			

Trust risk scoring matrix and grading

Likelihood

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

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

BOARD ASSURANCE FRAMEWORK OVERVIEW

Risk Ref	Risk Description	Lead Executive	Committee	Current Risk	Last Month	3 months ago	6 months ago	Target Score	Date added
001/19	There is a risk that within the context of the Healthcare Economy the Trust has insufficient capacity to sustain timely and effective patient flow through the system which impacts the delivery of the 62day cancer, RTT and the A&E 4-hour standards	Chief Operating Officer	FPC	16	16	20	20	12	01-03-18
002/19	There is a risk that the trust is unable to recruit and retain sufficient supply of staff with the right skills to meet the demand for services	Director of Nursing /Medical Director/CPO	FPC	16	16	16	16	12	01-03-18 reviewed 1/5/19
003/19	There is a risk that the Trust is unable to achieve financial sustainability to support the delivery of the Operational Plan and 5year clinical strategy	Director of Finance	FPC	16	25	16	20	12	01-04-19 reviewed
004/19 (was 6)	There is a risk that there is insufficient capital resources to address all high/medium estates backlog maintenance, investment medical equipment and service developments	Director of Finance	FPC	20	20	20	16	16	01-03-18
005/19	There is a risk that the Trust's IT systems are not sufficiently embedded/stabilised to ensure the hospital is run in a safe and effective way	Director of Finance/ COO	FPC	20	20	20	20	15	01-04-17
006/19 (was 10)	There is a risk that the STP does not work effectively to redesign and implement new models of care, which impacts on the hospital's ability to manage demand for services	Director of Strategy	FPC	12	12	12	12	9	01-03-18
007/19	There is a risk that the governance structures in the Trust do not facilitate visibility from board to ward and appropriate performance monitoring and management to achieve the Board's objectives	Chief Executive	Board of Directors	12	12	12	12	12	01-03-18
008/19 (was 11)	There is a risk that the Trust is not always able to consistently embed of a safety culture and evidence of continuous quality improvement and patient experience	Director of Nursing /Medical Director	QSC	15	20	20	20	10	01-03-18
009/19	There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered, impacting on the Trust's ability to deliver the required improvements and transformation	Chief People Officer	FPC & QSC	16	16	16	16	12	01-03-18
010/19 was 013/19	There is a risk that the Trust is adversely affected by the United Kingdom's departure from the European Union, particularly in the event of no deal being secured.	Director of Strategy	FPC	12	16	12	n/a	12	19-09-18
011/19(was 014/19	There is a risk that the Trust's Estates and Facilities compliance arrangements including fire management are inadequate leading to harm or loss of life.	Director of Strategy	QSC	20	20	20	N/A	10	22/01/19
012/19	There is a risk that the Trust is not able to secure the long-term future of the MVCC	Director of Strategy	FPC	16	16	16	12	12	01-03-18

Board Assurance Framework Heat Map – May 2019 – For review with Executive Committee

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 16 001/19 009/19 002/19 012/19 003/19 004/19	high 20 011/19 005/19
3 Possible	very low 3	low 6 007/19	moderate 9 006/19	moderate 12 010/19 010/19 009/19 003/19 012/19 01/19 002/19	high 15 008/19 005/19
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 invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff**				**Ease of Use: To redesign and**
Strategic Objective:	**Improve and sustain delivery of operational performance**		**Source of Risk:**	Strategic Objective IPR	**BAF REF No:** 001/19
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the trust is not able to provide timely and effective patient care through the delivery of compliant and sustained performance standards, specifically in relation to the 4 hour, RTT and cancer.			**Risk Open Date:**	01/03/2018	**Executive Lead/ Risk Owner** Chief Operating Officer
			Risk Review Date:	Jun-19	**Lead Committee:** FPC

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Increases / changes to capacity and demand ii) leadership and capacity challenges iii) conflicting priorities iv) Inconsistency in application of pathways/ processes	i) Limited ability to respond to changes in capacity and demand impacting on service delivery ii) Adverse impact on sustaining delivery of core standards iii) impact on patient safety, experience and outcomes iv) increased regulattory scruitiny 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	• A&E Delivery Board (L1) • System Resilience Group (L2) • Reports to FPC and Board of Directors (L3) • Floodlights scorecard (L1) • NHSI PRM(L3) • Cancer Board (L2) • Daily and weekly ED sit-rep reporting • Monthly breach validation audits • Monthly Performance Deep Dives considered by FPC – e.g. ED in June 2018 and rolling programme • NHSI – Deep dive – cancer recovery plan (L3) • IPR Report to Feb and March 19 FPC meeting 6 and 5 out of the 8 cancer standards, RTT performance above national average • Closure of escalation winter ward • Internal Audit – Performance Framework report - reasonable assurance March 19) Internal audits scheduled for 2019/20 include - clinical capacity and utilisation; emergency department;threatre productivity	Internal Audit – Performance Framework report - reasonable assurance March 19)		
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**		
Bed Occupancy and LOS reductions not being delivered consistently across specialities. Sufficient surgical capacity to deliver cancer treatments within required timeframes Demand and capacity modelling for all tumour sites not complete. Access to funding streams from the cancer alliance allocation	• Accountability Framework arrangements • Impact of local Hospitals on Trust activity • Demand and capacity profiling by tumour site not available 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	

		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		In progress
iv) Continue to review and strengthen operational and goverancne structures	Chief Operating Officer	on going		In progress
v) To agree and develop further integrated pathways of care with our commissioners	Chief Operating Officer	on going	Postive planned care transformation day in June with CCG	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:	Jun-19	**Lead Committee:**	**FPC**

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) National shortage of nurses and doctors ii) Limited strategic workforce planning iii) Availability of training	i) Impact on staff morale ii) Impact on quality and safety iii) adverse financial impact	**Inherent Risk** (Without controls):	4	5	20	⇔
		Residual/ Current Risk:	4	4	16	
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Monthly nursing and midwifery workforce steering group • Monthly nursing look ahead – heat map / agreed agency levels • Site safety huddles to review real time staffing and capacity • Quarterly establishment reviews – skill mix, acuity and dependency • Safe care – 3 times daily staffing reviews • University of Hertfordshire recruitment • Rotation of band 5 nurses to aid retention • NHSI Wave 2 retention programme • Eroster • Scheduled regular monthly updates of staffing data to NHSP, to ensure staffing lists as accurate as they can be. • Retention Strategy • Arrangements in place to support our employees who are EU nationals re Brexit-related settled status applications.	• Report to QSC on medical staffing (L2) • Report to Board of Directors via QSC on safer staffing (L2) • Workforce report to FPC (L2) • Safer Staffing reports (L2) • NHS Professionals continuously recruiting to nursing and midwifery band 2 and band 5 roles. • Reviewing and trialling alternative shift patterns to attract staff; rapid response • Development of joint recruitment and attraction strategy with STP. • Launch of retention strategy focusing on band 5 nurses and band 2 CSWs. • Local retention targets and plans - Internal audits shceduled for 2019/20 - consultant job planning, safer staffing,			
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**			
• 40,000 nurses short across the country • Camb/London recruitment/weighting • Capacity to balance quality, money and operational pressure. • Staff leavers higher than expected in some areas • Specific targeted recruitment required for some specialities / specialists • Deanery plans reduction in rotation of medical trainees to DGHs	• Data consistency and quality • Improved retention rates • Recruitment in specialty / hard to recruit areas 5 yr Workforce strategy to support the new 5 yr clinical strategy	Green	Effective control is in place and Board satisfied that appropriate assurances are available		
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient		
		Red	Effective controls may not be in place and assurances are not available to the Board.		

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Develop and implement workforce strategy to support the trust new 5 yr clinical strategy	Chief People Officer	September 19 (TBC)		In progress
ii) Implement overseas recruitment plans for 2019/20	Head of Recruitment	Jun-19	international and domestic nursing and medical recruitment was agreed in May 2019. An agreed target for international recruitment was confirmed along with an increased effort to recruit domestic nurses using a variety of tools and incentives to aid recruitment and retention. This work has already commenced and a progress review is due in July 2019. 153 new starters joined the Trust in April 2019 and the vacancy rate as at end of March 2019 was 7.2%.	In progress
iii) • Resourcing Strategy to be launched in 2019/20 setting out the Trust's approach to recruitment and retention.	Chief People Officer	TBC	Draft workforce redeployment policy by Head of HR expected June/July 2019.	In progress
iv) Review of Trusts Communication strategy to support recruitment and retention	Communication Team / Head of HR			
Summary Narrative:				

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

Strategic Aim:					
Strategic Objective:	**Meet our financial obligations** **Seek innovative STP-wide solutions to address clinically and financially unsustainable services**	**Source of Risk:**	- Operating Plan - Use of Resources	**BAF REF No:**	003/19
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the Trust is unable to achieve financial sustainability to support the devlivery of the Operational Plan and 5 year Clinical Strategy.		**Risk Open Date:**	01/04/2018	**Executive Lead/ Risk Owner**	**Director of Finance**
		Risk Review Date:	Jun-19	**Lead Committee:**	**FPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Demand and capacity planning ii) Shortfall in CIP delivery iii) Good financial management is not embedded at all levels iv) Data quailty not optimised	i) Impact on cash flow ii) CIP programme not delivered iii) Financial plan not delivered iv) unable to invest in service development v) increased CCG test and challenge and regulatory scrutiny	**Inherent Risk** (Without controls):	4	5	20	
		Residual/ Current Risk:	4	4	16	⟷
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrics aligned to IPR**
• Qlikview SLA income and activity application developed and in place (weekly and monthly) • Monthly SLA income reports to FPC / DEC and Divisions • Divisional Performance & Activity meetings (PAM) in place to review deliver • Monthly CQUIN meetings to review progress in place • Contract monitoring meetings in place with all commissioners • Key monitoring metrics reflected in new divisional PRM dashboards • CIP Work programme and workstreams - Exec review weekly • Fully established PMO function in place supporting delivery • Finance and project training programmes in place for budet holders to access • Weekly Improving Finance Delivery IFD meetings in place • £3m Contingency fund building across YTD • Coding and Data Quality Strategy reviewed at Audit Committee	• Independent reviews of coding and counting practice undertaken in 17/18 (L3) • Actions plans to address findings in place and reviewed at PAM (L1) • Regular Data quality and Clinical Coding updates to PAM and AC (L2) • Weekly OP drumbeat session re- introduced in January 2019 • CIP tracker in place to monitor delivery achievement (L1) • Monthly Finace Reports to FPC, Board and Divisions (L1) • Monthly cash reporting to FPC / Trust Board and NHSI(L2) • Monthly Accountability Framework ARMs including finance (L1) • Internal Audit – Financial Planning Process L3 +) • Monthly Financial Assurance Meetings & PRM with NHSI (L1) • FPC Deep Dives into remedial performance issues eg. Theatres	• Internal Audit - key financial control, CIP governance, performance framework 2018/19. • Summary of review of budget risks and controls into FPC May and June 2019		• Delivery of Control Total Target (Trust Level) • I&E delivery against agreed 19/20 budget plans • Agency Staffing within NHSI notified ceiling • Cash balances within agreed EFL target
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**		

• Potential challenge from commissioners in respect of volume of planned work undertaken • Comprehensive bed model and associated demand & capacity modelling • Implementation of Same Day Admission pathway change and the understanding of financial impacts • Requirement to support discharge summary remedial activity impacting upon DQ team capacity to respond to CCG challenges and queries • Pace of CIP delivery achievement • Pace of Theatre and Outpatient transformation delivery • Slippage in IFD mitigations • Temporary staffing control environment in respect of medical and nursing staffing	• Limited demand and capacity modelling • delivery of CIP schemes • delivery of activity levels • Gaps in business skill sets across divisions eg. rostering, waiting list management, budgetary management	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Monitor delivery of CIP programme and support in the development of remedial action plans where required, specifically in relation to Theatres and Temp staffing control (Medical and Nursing)	PMO Director	on going	CIP portfiolio value at 16.97M (113% of 2019/20 target. Additional improvement work continues. Significant scruitny of each scheme and monitoring of delivery.	In progress
ii) Monitor delivery of divisional operational plans through IFD meetings , PAM and Accounabilty review meetings	Director of Finance / CPO	on going	In place and IFD reviewed to support delivery and reproting to ARMs.	In progress
iii) Implementaion of the outcomes of the capacity and demand modeling	Director of Finance / COO	on going	Delivery tracked through PAM Meetings	In progress
iv) Continue to develop BI and support divisions / directorates using effectively	Director of Finance	on going	Ongoing embedding and further development of dahsboards and data sets development	In progress
v) Prepare for use of resources assessment	Executive	Aug-19		In progress
Summary Narrative:				

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

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

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Lack of available capital resources to enable investment ii) Trust in current deficit position iii) Requirement to repay capital loan debts	i) Poor patient experience ii) Patient Safety iii) limited ability to invest in IMT, equipment and services develoments iv) limited innovation	**Inherent Risk** (Without controls):	4	5	25	⇔
		Residual/ Current Risk:	4	5	20	
		Target Risk:	4	4	16	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Six Facet survey undertaken in 17/18 • Capital review Group meets monthly • Prioritising areas for limited capital spend through capital plan • Fire policy and risk assessments in place • Major incident plan • Mandatory training • Equipment Maintenance contracts • Monitoring of risks and incidents	• Report on Fire Safety to Executive Committee (L2) • Monthly Capital Review Group (CRG meetings) feeding into FPC and Exec Committe (L1) • Report on Fire and Backlog maintenance to RAQC(L2) • Reports to Health and Safety Committee (L2) • Capital plan report to FPC (L2) • Annual Fire report (L3) • PLACE reviews (L3) • Reports to Quality and Safety Committee • Deep dive review of the risks and mitigations (December 2018) • new Monthly Fire Safety Committee established March (includes other sites)			• Capital Expenditure within agreed CRL

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
• Not fully compliant with all Fire regulations and design • 1960s buildings difficult to maintain • No formalised equipment replacement plan or long term capital requirement linked through to LTFM • Estates and facilities monitoring structures and reporting	• Availability of capital	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete

i) Estates strategy to support the five-year trust strategy	Director of Estates and Facilities	September (TBC)	Awaiting new Director to lead on this	Not yet started
ii) Develop capital equipment replacement plan	TBC	TBC		
iii) Develop programme for Charity to suppport with fundraising	Deputy Direoctr of Finance / Head of Charities	on going	ongoing	
iv) Agree capital investment for 2019/20 and monitor delivery	Executive	May 2019 and ongoing	Captial programme approved through CRG and Ececutive committee in June2019. CRG will monitor delivery	In progress
iv) Review other sources of fundung / opporunities for investment	Director of Finance / Porject leads	on going	Bid to NHSI for review including additional funding for fire.	in progress
Summary Narrative:				

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

Strategic Aim:	**Ease of Use:** To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff services that is financially and clinically sustainable in the long term **Sustainability:** To provide a portfolio of				
Strategic Objective:	**Complete stabilisation and commence optimisation of Lorenzo and make our services easier to use**	**Source of Risk:**	Project	**BAF REF No:**	005/2019
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the Trust's IT systems are not sufficiently embedded/stabilised to ensure the hospital is run in a safe and effective way		**Risk Open Date:**	Feb-18	**Executive Lead/ Risk Owner**	**Director of Finance / Chief Operating Officer**
		Risk Review Date:	Jun-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 with Lorenzo iii) Programme is not fully aligned to the Trust's operational plan and Clinical Strategy	i) Unable to deliver financial performance ii) Unable to deliver target levels of patient activity iii) continuing failure to send discharge summaries electronically to the GP for every patient discharged iv) adverse impact on performance reporting	**Inherent Risk** (Without controls):	5	5	25	
		Residual/ Current Risk:	5	4	20	
		Target Risk:	5	3	15	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
i) Digital programme 2019 ii) Floor walkers to support implementation of new systems processes iii) Internal monitoring of programme implementation through - FPC and Board , Stablisation Board Staff training and communication	• The Trust was reviewed its Stabilisation plan with regulators (inc NHSI, NHSD)(L3) • Monitoring of key safety and quality indicators through PRM's (L2) • Reports to Executive Committee, FPC and Board (L2) • RTT oversight group reports into stabilisation board • NHSI consultancy approval given in respect of C3 support spend • Weekly Executive monitoring of implementation plans data quality internal audit scheduled for 2019/20			

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
i) Optimising discharge summary processes New Discharge summary process and training - not yet completed ii)Consistancy and compliance in the application of new processes on the systems iii)	i)New Discharge summary process and training - not yet completed ii) Staff able to access previous access 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) 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.	In progress

ii) Develop Ditigal Strategy and associated Digital Programme	Mark Stanton, CIO	End o June 2019	In progress - report to FPC in June 2019.	In progress
iii) Review and implementation of revised Digital Strategy Programme Governance	Mark Stanton, CIO	End of May 2019	Proposed governance structure to be presented to FPC in May 2019	In progress
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.	In progress
iv) Continue vaildation of records to data to ensure adhererance to the new processes	Mark Stanton, CIO	On going	On going and deteriorating patient digital workstream commenced.	In progress
Summary Narrative:				
Risk carried forward from 2018/19. Stablisation to be completed by 31 May 2019. New digital strategy, associated digital programme and revised governance structure are in progress,				

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

Strategic Aim:	**Pathways: To develop pathways across care boundaries, where this delivers best patient care and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff**				**Ease of Use: To redesign**
Strategic Objective:	**Play a leading role in the Sustainability and Transformation Partnership (STP) development of the Integrated Care System / Alliance** **Seek innovative STP-wide solutions to address clinically and financially unsustainable services**	**Source of Risk:**		**BAF REF No:**	006/19 (previously 010/18)
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the STP does not work effectively to redesign and implement new models of care, which impacts on the hospital's ability to manage demand for services		**Risk Open Date:**	01/03/2018	**Executive Lead/ Risk Owner**	**Director of Strategy**
		Risk Review Date:	Jun-19	**Lead Committee:**	**FPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Long term system leadership ii) Clinical and operational leadership and capacity iii) Capacity in primary and community services to deliver change iv) Current legal framework not designed to fully support ICS's	i) System does not deliver intergrated care pathways ii) Demand for acute services exceeds plan iii) Delay development integrated care for ENH iv) Inability to implement agreed models due to contractual, financial and legal barriers v) risk that external stakeholders are able to progress at a quicker pace than our capacity to be fully involved and contribute to the pathway design	**Inherent Risk** (Without controls):	3	5	15	⇔
		Residual/ Current Risk:	3	4	12	
		Target Risk:	3	3	9	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Participation in STP work streams including Planned care, urgent and emergency care, frailty and cancer • STP CEO bi-weekly meeting Representation at STP Chairs meeting • Vascular Hub project with West Herts and PAH • Cancer work stream of STP (chaired by Director of Strategy) and representing STP Cancer Alliance • Model Hospital redesign work • Integrated discharge team • External partner to support development of STP • New independent chair in place to drive progress. (Ten year plan published sets out expectations for ICSs)	• Reports to Board regarding progress on STP(L2) • Regular oversight by NHSI and NHSE (L2) • Monthly A&E delivery Board (L2) • Transformation Board of the CCG(L2) • Reports of Model Hospital work streams to Programme Board (L2) • NHSE Deep-dive into cancer work stream (L3) - Review of trust worksteam leads and internal governacne structure April 2019	• NHSE Deep-dive into cancer work stream (L3)		
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**		
• Scope for accelerated development of STP and its governance arrangements • Need for external resource to develop STP to ICS	Oversight of the workstreams at local level			

Green	Effective control is in place and Board satisfied that appropriate assurances are available
Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete

i) Ensure effective involvement with all workstreams and monthly reporting to Strategic Programme Board and Executive Committee	Director of Strategy	on going	Monthly reportss provided to Strategic programme Board and Executive. STP Pathology Procurement in progress with the service specification. Executive and clinical engagement.	In progress
ii) Monitor and actively participate in STP programme to develop ICS	Chief Executive and Chair	on going	Consider ICS Exec/Board development session	In progress
iii) Arrange Board development session on ICS - addressing contractual and legal risks and issue	Chair, Director of Strategy, Associate Director of Corporate Governance	schedule for 2019	as above	Not yet started
iv)				
Summary Narrative:				

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

Strategic Aim:	**Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term** **Quality: To deliver high quality, compassionate services, consistently across all our sites**				
Strategic Objective:	**Improve and sustain delivery of operational performance** **Design, develop, launch and embed the Quality Strategy** **Meet our financial obligations**	**Source of Risk:**	Strategic Objectives External reviews	**BAF REF No:**	**007/19**
Principal Risk Description: What could prevent the objective from being achieved? There is a risk that the governance structures in the Trust do not facilitate visibility from board to ward and appropriate performance monitoring and management to achieve the Board's objectives		**Risk Open Date:**	01.03.2018	**Executive Lead/ Risk Owner**	**Chief Executive**
		Risk Review Date:	Jun-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 monlth at Trust Board, FPC and QSC - Quailty dashboard / compliance dashboard	• Commissioned external reviews – PwC Governance Review September 2017 NHSI review of Board and its committees 2019 • Visibility of Corporate risks and BAF as Board Committees and Board (L2) • Internal Audits delivered against plan, outcomes report to Audit Committee • Annual review of SFI/SFOs (L3) • Annual review of board committee effectiveness and terms of reference (May-July) (L3) • PwC Governance review and action plan closed (included well led assessment) (L3) • Annual governance statement (L3) • Counter fraud annual assessment and plan (L3) • Annual self-assessment on licence conditions FT4 (L3) • CQC Inspection report July 2018 –(overall requires improvement) and actions plan to address required improvements and recommendations (L3 -/+) • Use of resources report July 2018 – requires improvement (L3 _/+) • September 2018 Progress report on CQC actions and section 29a (L2 +) to CQC & Quality Improvement Board • Annual review of RAQC to Board (L2 +) • Internal Audit Report – Assurance and Risk Management (- reasonable assurance (L3) • Board development session on Risk and Risk Appetite, Feb 2019 • Internal Audit – Performance Framework report - reasonable assurance March 19) - Internal Audits 2019/20 scheduled for Data Quailty; Divisional Governance;	Internal Audit report - risk management , performance framework, IG 2019 NHSI Infection control review - green - June 2019 Review of progress with QTP workstreams with NHSI/CCG - June 2019.		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
Effectiveness of goverancne structures at ward to Divisional level • Fully embedding Performance Management Framework/Accountability Framework • Implementation of Internal Audit Recommendations • NHSI Undertaking January 2019 / CQC section 29a warning - surgery and QEII UCC	• Embedded risk management - CRR and BAF • Embedding effective use of the Integrated performance report • Evidence of timely implementation of audit actions • Consistency in the effectiveness of the governance structure's at all levels • Capacity to ensure proactive approach to compliance and assurance •	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Monitor delivery of Risk Management implementaion plan 2019/20 including risk appetite	Associate Director of Corporate Governance / Risk Manager	ongoing	Monthly reports to Board committees	In progress
ii) Review of well led compliance and implement recommendations from NHSI Board and Committee observations to strenghten Board governance	Associate Director of Corportate Governance	Sep-19	Board development session in April commenced review of well -led. Follow up session scheduled for June 2019. Continue to review workforce matters, and reviewing DEC/Executive Committees	In progress
iii) Complete recruiment into revised corporate and quailty and safety structures and substantive Executive Director posts	Associate Director of Corportate Governance / Director of Nursing	Jul-19	One current vacancy in corporate goverance team; DPO to be advertised in July. Final QI posts in process of recruitment	In progress
iv) Review and develop a 'business as usual' programme of compliance / quality and safety reviews	Associate Director of Corportate Governance / Director of Nursing	Oct-19	Review of self assessment frameworks and mock inspeciton paperwork in progress with current programme	In progress
v) Review implementation of Trust clinical strategy and enabling strategies	Director of Strategy		Reports to the Board and Board committees scheduled	
vi) Review effectiveness of governance at a Divisional level	Associate Director of Corportate Governance	Jan-19	Internal Audit scheduled. ARM reflections.	
v) Implementation of project plan for CQC Inspection and Use of Resources Inspection	Associate Director of Corportate Governance / Director of Nursing	Aug-19	In progress with weekly reporting to Executive Committee. Inspections anticipated for July - Sept 19. CQC focus groups being promoted (3-5 July) .	In progress

Summary Narrative:				

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

Strategic Aim:	**Quality: To deliver high quality, compassionate services, consistently across all our sites**				
Strategic Objective:	**Design, develop, launch and embed the Quality Strategy**	**Source of Risk:**	Strategic Objective CQC Inspection	**BAF REF No:**	008/19 (previously 011/18)
Principal Risk Decription: What could prevent the objective from being achieved?There is a risk that the Trust is not always able to consistently embed of a safety culture and evidence of continuous quality improvement and patient experience		**Risk Open Date:**	01/03/2018	**Executive Lead/ Risk Owner**	**Director of Nursing /Medical Director**
		Risk Review Date:	Jun-19	**Lead Committee:**	**QSC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Lack of consistant approach to quality improvement ii)Limited staff engagement iii) Inconsistent ward to board governance structures and systems	i) Limited learning from incidents ii) Impact of patient safety / patient expereince iii) impact on reputation iv) increased regulatory scruitny	**Inherent Risk** (Without controls):	5	4	20	⇕ ⇔
		Residual/ Current Risk:	5	3	15	
		Target Risk:	5	2	10	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Clinical effectiveness committee / Patient Safety Committee/ Patient Experience Committee • Quality Improvement Board • Accountability Framework • CQC Engagement meeting • Increased Director presence in clinical areas • SIs and Learning from death investigations • Monthly patient safety newsletter • Bi-weekly IPC improvement board • Strengthened TIPCC membership and ToRs • Quality and safety visits • Safety huddles • Policies and procedures • New Quality Manager posts in each division • Weekly review meetings of CQC improvement plans • Clinical Harm Review Panel (Weekly)	• Reports to QSC (L2) • Quality review meetings with CCG (L2) • Divisional Performance Meetings (L2) • Clinical effectiveness/ Patient Safety/Patient Experience Committee reports (L2) • Monitoring of new to follow up ratios through OPD steering group and access meetings(L2) • Peer Reviews (L3) • Audit Programme (internal and external) (L3) • Quality Transformation Programme reports and deep dives to QSC • CQC Inspection report July 2018 –(overall requires improvement) and actions plan to address required improvements and recommendations (L3) • NHSI Infection control review December 2018 - green (L3) • Quality Dashboard / Compliance dashboard Internal Audit scheduled 2019/20 - QTP, deteriorating patient, 7 day services	NHSI Infection control review June 2019 - Green		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
• National guidance and GIRFT Gap analysis identifies areas for improvement • Consistency with procurement and engagement with clinicians • Patient safety team capacity • Gaps in compliance with IPC Hygiene Code leading to C-difficile outbreak in April 2018 and MRSA bacteraemia in May 2018 • Gap in compliance with CQC standards warning notice section 29A – Surgery Lister and UCC QEII - NHSI undertaking	• Consistency in following care bundles • Implementation of action plans • Embedding of learning from SIs/Learning from Deaths • Data quality • Inconsistent audit and monitoring programme • Delivery against CQC improvement plan	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Delivery of the QTP implementation programme against plan	Associate Director of Quailty Improvement	ongoing	Progress / deep dive reports to QSC	In progress
ii) Delivery and monitoring of CQC improvement plans for Surgery Lister and UCC QEII and other core pathways	Associate Director of Corporate Governance / Director of Nursing	Jul-19		In progress
iii) Launch and implementation of the quailty strategy with communication plan	Director of Nursing / Medical Director	ongoing	Launched event held in May 2019, supported with the Trust conversation session in June 2019. first learning trust wide event held 21 June	In progress
iv)• Complete Gap analysis on GIRFT reports and develop and monitor action plans	Medical Director	ongoing		In progress
iv) Implement 7 day services plan	Medical Director	ongoing	Report to QSC June 2019	In progress
Summary Narrative:				

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

Strategic Aim:	**People: To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce**				
Strategic Objective:	**Develop, support, engage and transform our workforce to provide quality services**	**Source of Risk:**	Strategic Objective Staff Survey	**BAF REF No:**	009/19
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:	Jun-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 • Update May 2018 – A series of indicators will be agreed by CPO senior workforce and OD team members and the Board on how we should measure and assess our culture. • Staff Experience Workshops were launched in April 2018 - Equailty and diversity lead and forums - Dignity at work policy	• 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 • Talent management post/lead • Senior leadership training • Senior leadership programme	• Review outcomes of the actions being taken • Lack of resources to respond within necessary time period • Completion of staff survey action plans	Green	Effective control is in place and Board satisfied that appropriate assurances are available	
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient	
		Red	Effective controls may not be in place and assurances are not available to the Board.	

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Review of LEND and leadership behaviours in a challenging environment	Chief People Officer	on going	Summer LEND sessions commenced	In progress

ii) Increased visibility of Senior Leadership Team (Divisional, Executive and Board)	Chief People Officer	on going	Trust conversation and new Friday standup commenced	In progress
iii) Implement action plan following staff survey feedback	Chief People Officer	on going	All divisions have a local plan.	In progress
iv) Develop and implement talent management strategy	Chief People Officer		Review of talent management strategy and leadership strategy with People strategy scheduled.	In progress
v)Review of Communication strategy	Head of Communications	Jun-19		In progress
vi) Staff survey/engagement workshop and assocated actions	Chief People Officer	May-19		In progress
Summary Narrative:				

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

Strategic Aim:	**Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term which retains staff, recruits the best and develops an engaged, flexible and skilled workforce**				**People: To create an environment**
Strategic Objective:	**Improve and sustain delivery of operational performance** **Develop, support, engage and transform our workforce to provide quality services**		**Source of Risk:**		**BAF REF No:** **010/19 (previously 013/18)**
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the Trust is adversely affected by the United Kingdom's departure from the European Union, particularly in the event of no deal being secured.			**Risk Open Date:**	19.09.18	**Executive Lead/ Risk Owner** **Director of Strategy**
			Risk Review Date:	Jun-19	**Lead Committee:** **FPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) UK decision to leave the EU ii)	i) Risk to supply of goods, services, medicines to the UK from EU ii) Risk to recruitment and retention of EU Nationals	**Inherent Risk** (Without controls):	4	4	**16**	
		Residual/ Current Risk:	4	3	12	⟷
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• EPRR Committee, will lead on the business continuity arrangements, reviewing existing plans to ensure they respond to the possibility of a 'no-deal' Brexit. • Reivew of national guidance - 23rd August SoS guidance and five technical notices published by UK Government and 21st December including action card for providers • Overseas recruitment mostly from outside Europe. • group in place in January to drive progress reporting to DEC/Executive Committee Communitaions to staff from European countries outside the UK. Link to STP EU Herts Strategy Control Group	• Regular reports to Executive Committee/DEC, FPC and the Board of Directors (L2) • NHSE check and challenge session on EPRR core standards including Brexit Preparedness (L3) • Paper to Board on 9th January 2019 and monthly	• NHSE check and challenge session on EPRR core standards including Brexit Preparedness , 2018 (L3)		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
Absence of clear deal in place between UK and EU post 29th march 2019		Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Review of technical notices/ advice as it is published by the Government / NHSI/NHS Providers	Strategy Project lead	Ongoing	No outstanding guidances	In progress
ii) Continue monthly oversight group and escalation reports	Director of Strategy	Ongoing	Continue to meet monthly. Will return to weekly when required. All workstreams represented.	In progress

iii) Recruitment strategy implementation	CPO	ongoing	International and local recruitment campaigns	In progress
iv)				
Summary Narrative:				

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:	Jun-19	**Lead Committee:**	**QSC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Lack of available resources to enable investment ii) Ineffective governance processes iii) Reactive not responsive estates maintainance iv) skill mix, expertise and capacity	i) lack of assurance that routine maintainace ii) risk of regulatory intervention iii) poor patient experience iv) potiental staff and patient safety risks	**Inherent Risk** (Without controls):	5	5	25	⇕ ⇔
		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	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			

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
Ineffective estates and facilities governacne structures Estate strategy due for renewal Lack of capital funding to bring the Lister and other sites to compliance Lack of revenue funding for training Fire risk assessments and actions due for Fire Safety Officer review Actions identified from Fire desktop review Confirmation all AO's now in post and visibilty of work programme	Full implementation of the Fire Strategy Effective Estates and facilities governance structures Limited assurance from other sites trust operates from	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Review and implement revised estates and facilities governance and reporting structure	Director of Estatesand Facilities	Sep-19	Paper presented to QSC in June 2019 outlining key workstreams.	In progress
ii) Continue to Implement fire strategy , new training plan and actions from external recommendations	Head of Safety and Securtiy / Fire Officer	monthly review	With the exeception of the renal satellites -All fire risk assessments now reviewed and actions are being taken to address /mitigate the risks and to inform future capital and maintainance works required - this will be risk assessment and prioritised. Some capital works approved for 2019/20	In progress
iii) Review of Estates Strategy	Director of Estatesand Facilities		on hold until new estates and facilities director in post	In progress
iv) review and implement mechanisms to ensure Estates, Facilities and Fire complaince assurance is received from partner organisations where trust operates from	Director of Estatesand Facilities		Paper presented to QSC in June 2019 outlining key workstreams. Trsut risk assessments have been shared with the relvant partners	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** **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:	Jun-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 complaince with regulatory requirements	**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**
Regular meetings between both Trust Chair's of HHT and ENHT MVCC Clinical Strategy in place with Clinical Strategy Implementation Group Trust Clinical Strategy Clinical and Academic Partnership in place with UCLH and MVCC - Board established. Mount Vernon Cancer Centre Review Programme Board	• Regular reports to FPC and the Board of Directors (L2) • Regular reporting into the strategy Board (L2) • Reporting to the Board of Directors on the progress of the UCLH/MVCC partnership (L2) Capacity and demand modelling	CHKS review July 2018		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
i) HHT has no long term plan for the MVCC site ii) Availability of finding for capital equipment replacement and refurbishment programmes	i) Fitness for purpose of some of the accomodation in the old building ii) Specialist Commissioners Long term planning	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) SLA for Estates and Facilities at MVCC with Hillingdon	Contracting team & Divisional Director	Remains under review		In progress
ii) Development of a lease with Hillingdon for MVCC	Director of Finance	Remains under review		In progress
iii) Executive meetings with MVCC Divisional leadership on the key risk areas and linking with stakeholders and partners	Excutive Lead and Divisional Director	Weekly	Weekly group established with all workstream leads, division and executve leads represented. Escalation to Executive committee.	In progress

iv) Specialist commissioners modelling activity for equipment replacement programme	Director of Strategy	Review September		in progress
v) Implement joint estates forum with HHT	Director of Eastates and Facilities	Jun-19	First meeting to be held 26 June 2019	in progress
vi) MVCC strategy implementation groups	Divisional Chair	6 monthly review	Reported to Strategy Board in June - delivery of year one objectives. Continue to work with partners. Objectives for 2019/20 agreed.	In progress
Summary Narrative:				

Board Annual Cycle 2019-20

A formal Trust Board meeting is held on alternate months with Board Development sessions held in the month in-between.

Items	*Apr 2019	May 2019	*Jun 2019	Jul 2019	Aug 2019	Sep 2019	*Oct 2018	Nov 2019	*Dec 2019	Jan 2020	*Feb 2020	Mar 2020
Standing Items												
Chief Executive's Report		x		x		x		x		x		x
Integrated Performance Report		x		x		x		x		x		x
Board Assurance Framework		x		x		x		x		x		x
Data Pack		x		x		x		x		x		x
Patient Testimony (Part 1 or Part 2 depending on the nature of the report)		x		x		x		x		x		x
Suspensions (Part 2)		x		x		x		x		x		x
Board Committee Summary Reports												
Audit Committee Report				x		x		x				x
Charity Trustee Committee Report		x		x				x		x		
Finance and Performance Committee Report		x		x		x		x		x		x
Quality and Safety Committee Report		x		x		x		x		x		x
Strategic												
Annual Operating Plan and objectives *(subject to change as dependent on national timeline)*												**x (TBC)**
Strategy Highlight Report				x		x		x		x		x
Division Progress on Strategic Clinical Priorities (Part 2)		**X (2020)**				x		x		x		
Strategy Deep Dives (Part 2)						**x Cancer and CSS**		**x Medicine and Surgery**		**x Women and Children's**		**TBC**

Board Annual Cycle 2019-20

Items	*Apr 2019	May 2019	*Jun 2019	Jul 2019	Aug 2019	Sep 2019	*Oct 2018	Nov 2019	*Dec 2019	Jan 2020	*Feb 2020	Mar 2020
Sustainability and Transformation Plan (STP) (Part 2)		x		x		x		x		x		x
Other Items												
Audit Committee												
Annual Report and Accounts, Annual Governance Statement and External Auditor's Report		x ***(Late May Audit Committee)***										
Annual Audit Letter						x						
Audit Committee TOR and Annual Report						x						
Raising Concerns at Work Report				x								
Review of Trust Standing Orders and Standing Financial Instructions								x				
Charity Trustee Committee												
Charity Annual Accounts and Report								x				
Charity Trust TOR and Annual Committee Review						x						
Finance and Performance Committee												
Finance Update (Part 2)		x		x		x		x		x		x
FPC TOR and Annual Report						x						
Digital Strategy Update (Part 2)		x		x		x		x		x		x
Market Strategy Review (TBC with Acting Director of Strategy)												x
Quality and Safety Committee												
Complains, PALS and Patient Experience Report						x						x
Safeguarding and L.D. Annual Report (Adult and Children)				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
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						
Shareholder / Formal Contracts												
ENH Pharma (Part 2) [i]		x						x				

[i] To include the Annual Governance Review in November

*Please note Board Development sessions will be held on the 'even' months. This will support flexibility for the Board to be able to be convened for an extraordinary meeting if an urgent decision is required. However, forward agenda planning will aim to minimise this.

The Board Annual Cycle will continue to be reviewed in-year in line with best practice and any changes to national scheduling. The annual cycle will also be updated to reflect any changes that might be agreed in relation to the QSC and FPC annual cycles which are currently under review.

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

Agenda item: 12

EAST AND NORTH HERTFORDSHIRE NHS TRUST
PUBLIC TRUST BOARD ACTIONS LOG TO 3 JULY 2019 MEETING

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date

No outstanding actions

DATA PACK

Contents

1. Data and Exception Reports:

FFT

Friends and Family Test - May 2019

APPENDIX 2

Inpatients & Day Case	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely nor Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses	No. of Discharges	Total % response rate
5A	90.14	1.41	33	31	4	1	0	2	71	71	100.00
5B	100.00	0.00	26	11	0	0	0	0	37	63	58.73
7B	89.16	1.20	28	46	8	0	1	0	83	183	45.36
8A	92.45	0.00	31	18	4	0	0	0	53	77	68.83
8B	95.92	0.00	65	29	3	0	0	1	98	146	67.12
11B	93.55	0.00	44	14	4	0	0	0	62	144	43.06
Swift	89.66	3.45	63	15	5	0	3	1	87	201	43.28
ITU/HDU	100.00	0.00	4	0	0	0	0	0	4	8	50.00
Day Surgery Centre, Lister	98.26	0.87	87	26	1	1	0	0	115	410	28.05
Day Surgery Treatment Centre	99.12	0.00	198	28	2	0	0	0	228	457	49.89
Endoscopy, Lister	98.44	0.62	290	26	2	1	1	1	321	951	33.75
Endoscopy, QEII	100.00	0.00	65	5	0	0	0	0	70	362	19.34
SURGERY TOTAL	96.26	0.65	**934**	**249**	**33**	**3**	**5**	**5**	**1229**	**3073**	39.99
SSU	95.35	2.33	27	14	1	0	1	0	43	160	26.88
AMU - Blue	90.00	0.00	15	3	2	0	0	0	20	162	30.86
AMU - Green	93.33	6.67	23	5	0	2	0	0	30		
Pirton	100.00	0.00	44	13	0	0	0	0	57	84	67.86
Barley	90.91	0.00	17	3	2	0	0	0	22	34	64.71
6A	90.91	1.82	31	19	4	1	0	0	55	96	57.29
6B	100.00	0.00	6	2	0	0	0	0	8	63	12.70
11A	100.00	0.00	54	26	0	0	0	0	80	91	87.91
ACU	96.08	0.00	45	4	2	0	0	0	51	112	45.54
10B	92.59	0.00	16	9	2	0	0	0	27	78	34.62
Ashwell	100.00	0.00	13	3	0	0	0	0	16	46	34.78
9B	96.97	0.00	33	31	2	0	0	0	66	66	100.00
9A	100.00	0.00	32	29	0	0	0	0	61	68	89.71
Cardiac Suite	97.06	2.94	59	7	0	0	2	0	68	124	54.84
MEDICINE TOTAL	96.52	0.99	**415**	**168**	**15**	**3**	**3**	**0**	**604**	**1184**	51.01
10AN Gynae	98.39	1.61	36	25	0	0	1	0	62	117	52.99
Bluebell ward	93.44	1.64	44	13	2	0	1	1	61	135	45.19
Bluebell day case	100.00	0.00	3	4	0	0	0	0	7	7	100.00
Neonatal Unit	100.00	0.00	39	5	0	0	0	0	44	84	52.38
WOMEN'S/CHILDREN TOTAL	97.13	1.15	**122**	**47**	**2**	**0**	**2**	**1**	**174**	**343**	50.73
MVCC 10 & 11	100.00	0.00	13	2	0	0	0	0	15	102	14.71
CANCER TOTAL	100.00	0.00	**13**	**2**	**0**	**0**	**0**	**0**	15	**102**	14.71
TOTAL TRUST	96.44	0.79	**1484**	**466**	**50**	**6**	**10**	**6**	**2022**	**4702**	43.00

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	96.28	0.83	1406	459	50	6	10	6	1937	4238	45.71
QEII	100.00	0.00	65	5	0	0	0	0	70	362	19.34
Mount Vernon	100.00	0.00	13	2	0	0	0	0	15	102	14.71
TOTAL TRUST	96.44	0.79	**1484**	**466**	**50**	**6**	**10**	**6**	**2022**	**4702**	43.00

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	93.03	1.02	300	154	28	2	3	1	488	10683	4.57
QEII UCC	100.00	0.00	57	14	0	0	0	0	71	3675	1.93
A&E TOTAL	93.92	0.89	**357**	**168**	**28**	**2**	**3**	**1**	**559**	**14358**	3.89

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	92.31	0.00	7	5	0	0	0	1	13	460	2.83
Birth	99.37	0.63	122	36	0	1	0	0	159	460	34.57
Postnatal	89.74	3.21	86	54	8	4	1	3	156	460	33.91
Community Midwifery	100.00	0.00	11	2	0	0	0	0	13	554	2.35
MATERNITY TOTAL	94.72	1.76	**226**	**97**	**8**	**5**	**1**	**4**	**341**	**1934**	17.63

Outpatients	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses
Lister	94.72	1.22	481	219	28	3	6	2	739
QEII	96.83	0.84	1617	463	38	5	13	12	2148
Hertford County	95.41	0.69	589	242	21	2	4	13	871
Mount Vernon CC	96.79	0.46	174	37	3	1	0	3	218
Satellite Dialysis	98.94	1.06	81	12	0	1	0	0	94
OUTPATIENTS TOTAL	96.19	0.86	**2942**	**973**	**90**	**12**	**23**	**30**	**4070**

Trust Targets	% Would recommend	% response rate
Inpatients/Day Case	96%>	40%>
A&E	90%>	10%>
Maternity (combined)	93%>	30%>
Outpatients	95%>	N/A

2. Performance Data:

CQC Outcomes Summary

Our CQC Registration and recent Care Quality Commission Inspection

The Care Quality Commission inspected nine of the core services provided by East and North Hertfordshire NHS trust across Lister Hospital, the Queen Elizabeth II (QEII) Hospital and Mount Vernon Cancer Centre, between 20 and 22 March 2018. The returned on 2 April 2018 for an unannounced, follow-up inspection of the surgery core service at Lister Hospital. The well led inspection took place from 23 to 25 April 2018. The Use of Resources inspection, which is led by NHS Improvement took place on 11 April 2018.

At **Lister Hospital** CQC inspected:

- Urgent and emergency care
- Surgery
- Medicine
- Maternity
- Services for children and young people at Lister Hospital.

At the **QEII Hospital** CQC inspected:
- Urgent Care Centre

At the **Mount Vernon Cancer Centre** CQC inspected:
- Medicine
- Chemotherapy
- End of Life Care

At the October 2015 inspection, these core services were rated either as inadequate or requires improvement, apart from surgery, which was rated as good overall.

Summary of the Trust's Ratings

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

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement → ← Jul 2018	Requires improvement → ← Jul 2018	Good → ← Jul 2018	Requires improvement → ← Jul 2018	Requires improvement → ← Jul 2018	Requires improvement → ← Jul 2018

	Safe	Effective	Caring	Responsive	Well-led	Overall
Lister Hospital	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018	Good ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018
Queen Elizabeth II Hospital	Inadequate ↓ Jul 2018	Requires improvement ↔ Jul 2018	Good ↔ Jul 2018	Good ↔ Jul 2018	Inadequate ↓ Jul 2018	Inadequate ↓ Jul 2018
Mount Vernon Cancer Centre	Requires improvement ↑ Jul 2018	Good ↔ Jul 2018	Good ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018
Hertford County Hospital	Good Mar 2016	N/A	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Overall trust	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018	Good ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018	Good ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018
Community	Good Mar 2016	Good Mar 2016	Outstanding Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Overall trust	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018	Good ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018

The CQC have issued a number of requirement notices and set out a number of areas for improvement - “Must Do’s” and “Should Do’s”.

The requirement notices are:

- Regulation 12 HSCA 2008 (Regulated Activities), Regulations 2010 Cleanliness and infection control
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing
- Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

An action plan has been developed against all of these and was submitted to CQC on 24 August 2018. This will be monitored by the Quality Improvement Board, chaired by the Medical Director or Director of Nursing and reported to Board through the Quality and Safety Committee. A programme of internal and external inspections is in place to test and evidence progress and that the actions are embedded across the organisation.

Site Ratings

Lister Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good July 2018 ↑↑	Good July 2018 ↑	Good July 2018 ↑	Good July 2018 ↑	Good July 2018 ↑↑	Good July 2018 ↑↑
Medical care (including older people's care)	Requires Improvement July 2018 →←	Good July 2018 ↑	Good July 2018 →←	Good July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←
Surgery	Inadequate July 2018 ↓↓	Requires Improvement July 2018 ↓	Good July 2018 →←	Inadequate July 2018 ↓↓	Inadequate July 2018 ↓↓	Inadequate July 2018 ↓↓
Critical care	Good March 2016	Good March 2016	Good March 2016	Good March 2016	Requires Improvement March 2016	Good March 2016
Maternity	Requires Improvement July 2018 →←	Good July 2018 →←	Good July 2018 →←	Good July 2018 ↑	Good July 2018 →←	Good July 2018 ↑
Services for children and young people	Requires Improvement July 2018 →←	Good July 2018 ↑	Good July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←
End of life care	Good March 2016	Requires Improvement March 2016	Good March 2016	Good March 2016	Requires Improvement March 2016	Requires Improvement March 2016
Outpatients	Good March 2016	N/A	Good March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Good July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←

New QEII Hospital

Urgent and emergency services	Inadequate July 2018 ↓	Requires Improvement July 2018 →←	Good July 2018 →←	Good July 2018 →←	Inadequate July 2018 ↓	Inadequate July 2018 ↓
Outpatients and diagnostic imaging	Good March 2016	N/A	Good March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Inadequate July 2018 ↓	Requires Improvement July 2018 →←	Good July 2018 →←	Good July 2018 →←	Inadequate July 2018 ↓	Inadequate July 2018 ↓

Hertford County Hospital

Outpatients	Good March 2016	N/A	Good March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Good March 2016	N/A	Good March 2016	Good March 2016	Good March 2016	Good March 2016

Mount Vernon Cancer Centre

Medical care (including older people's care)	Requires Improvement July 2018 ↑	Good July 2018 ↑	Good July 2018 →←	Requires Improvement July 2018 ↑	Requires Improvement July 2018 →←	Requires Improvement July 2018 ↑
End of life care	Requires Improvement July 2018 ↑	Good July 2018 →←	Good July 2018 →←	Inadequate July 2018 ↓	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←
Outpatients	Good March 2016	Good March 2016	Good March 2016	Requires Improvement March 2016	Good March 2016	Good March 2016
Chemotherapy	Requires Improvement July 2018 ↓	Good July 2018 →←	Good July 2018 ↓	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←
Radiotherapy	Good March 2016	Good March 2016	Good March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Requires Improvement July 2018 ↑	Good July 2018 →←	Good July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←

Community Health Services for Children, Young People and Families

Community health services for children and young people	Good March 2016	Good March 2016	Outstanding March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Good March 2016	Good March 2016	Outstanding March 2016	Good March 2016	Good March 2016	Good March 2016

3. Quality and Safety Committee Reports:

Safer Staffing

1.0 Introduction

Whilst there is no single definition of 'safe staffing', NHS constitution, NHS England, CQC regulations, NICE guidelines, NQB expectations, and NHS Improvement resources all make reference to the need for NHS services to be provided with sufficient staff to provide patient care safely. NHS England cites the provision of an *"appropriate number and mix of clinical professionals"* as being vital to the delivery of quality care and in keeping patients safe from avoidable harm. (NHS England 2015)
East and North Hertfordshire NHS Trust is committed to ensuring that levels of nursing staff, which includes Registered Nurses, Midwives, Nursing Associates and Clinical Support Workers (CSWs), match the acuity and dependency needs of patients within clinical ward areas in the Trust. This includes ensuring there is an appropriate level and skill mix of nursing staff to provide safe and effective care using evidence based tools and professional judgement to support decisions. The National Quality Board (NQB 2016) recommend that on a monthly basis, actual staffing data is compared with expected staffing and reviewed alongside quality of care, patient safety, and patient and staff experience data. The trust is committed to ensuring that improvements are learned from and celebrated, and areas of emerging concern are identified and addressed promptly.

2.0 People Productivity

The following sections identify the processes in place to demonstrate that the Trust proactively manages nurse staffing to support patient safety.

2.1 Nursing Fill Rate

The Trust's safer staffing submission has been submitted to NHS Digital for May 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 May. An exception report can be found in Appendix 2 showing those wards with a Registered Fill rate below 90% and any other points of note for the month.

Table 1

	Day		Night		Average 24 Hr		
Trust Average Fill Rates	**Registered**	**Care Staff**	**Registered**	**Care Staff**	**Registered**	**Care Staff**	**All Staff**
Trust Average (Current Month)	94.0%	95.9%	97.5%	111.7%	95.6%	101.8%	98.0%
Trust Average (Last Month)	94.2%	92.6%	96.1%	109.0%	95.1%	98.8%	96.4%
Change	⇩ -0.2%	⇧ 3.3%	⇧ 1.4%	⇧ 2.7%	⇧ 0.5%	⇧ 3.0%	⇧ 1.6%

2.2 Care Hours per Patient day (CHPPD)

CHPPD is a measure of workforce deployment and is reportable to NHS Digital as part of the monthly returns for safe staffing.

CHPPD is the total number of hours worked on the roster by both Registered Nurses & Midwives and Nursing Support Staff divided by the total number of patients on the ward at 23:59 aggregated for the month (lower CHPPD equates to lower staffing numbers available to provide clinical care).

The Trust Average CHPPD for this month and last month can be seen in the table below. A full list of CHPPD by ward can be found in Appendix 3.

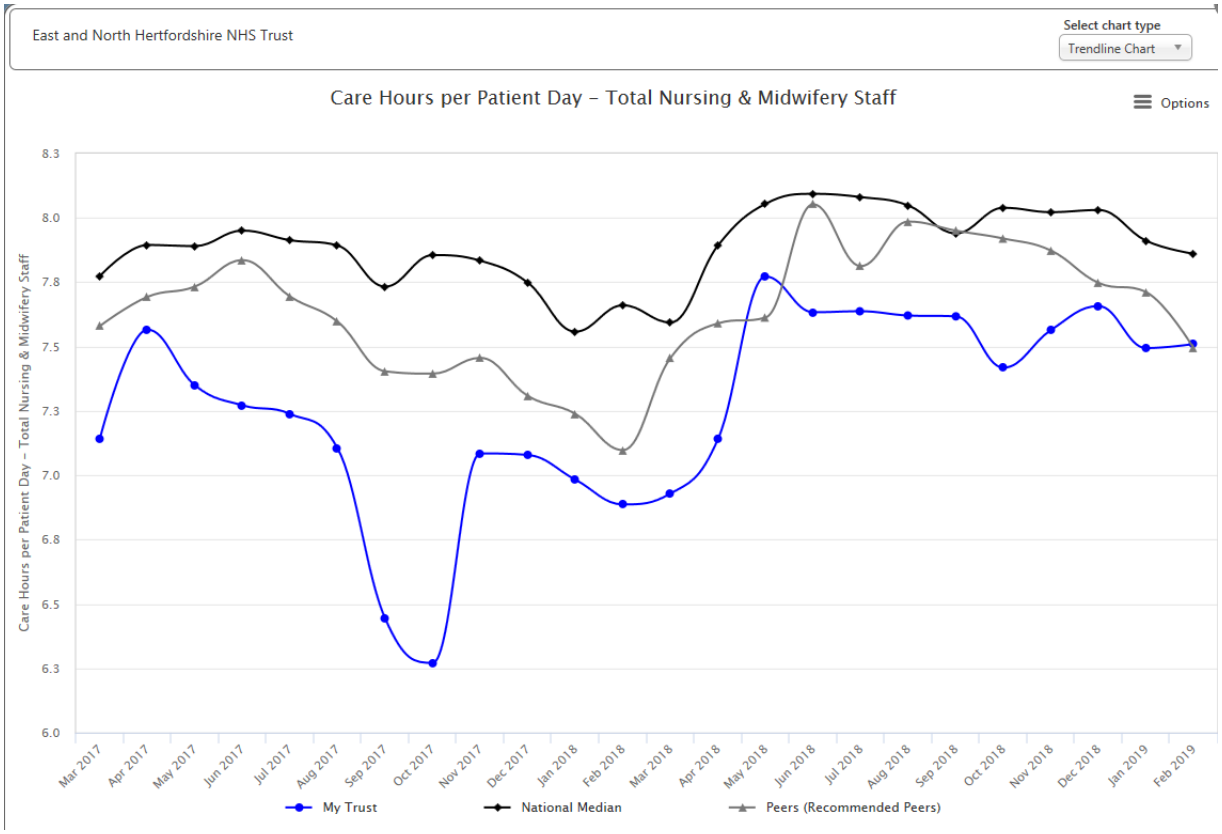
Further to the recent Establishment Review and conversations with a Peer Trust, it was noted that the Theatre, Recovery and Triage Midwives working in the CLU should not be included within the planned and actual care hours delivered to the inpatients on the CLU. The hours have therefore been removed from the Nursing Fill rate return to NHS Digital this month which has reduced the Trust Registered and All Staff CHPPD for May.

Table 2

	Average 24 Hr		
Trust Average CHPPD	**Registered**	**Care Staff**	**All Staff**
Trust Average (Current Month)	4.4	2.8	7.3
Trust Average (Last Month)	4.8	2.8	7.6
Change	↓ -0.4	→ 0.0	↓ -0.3

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.

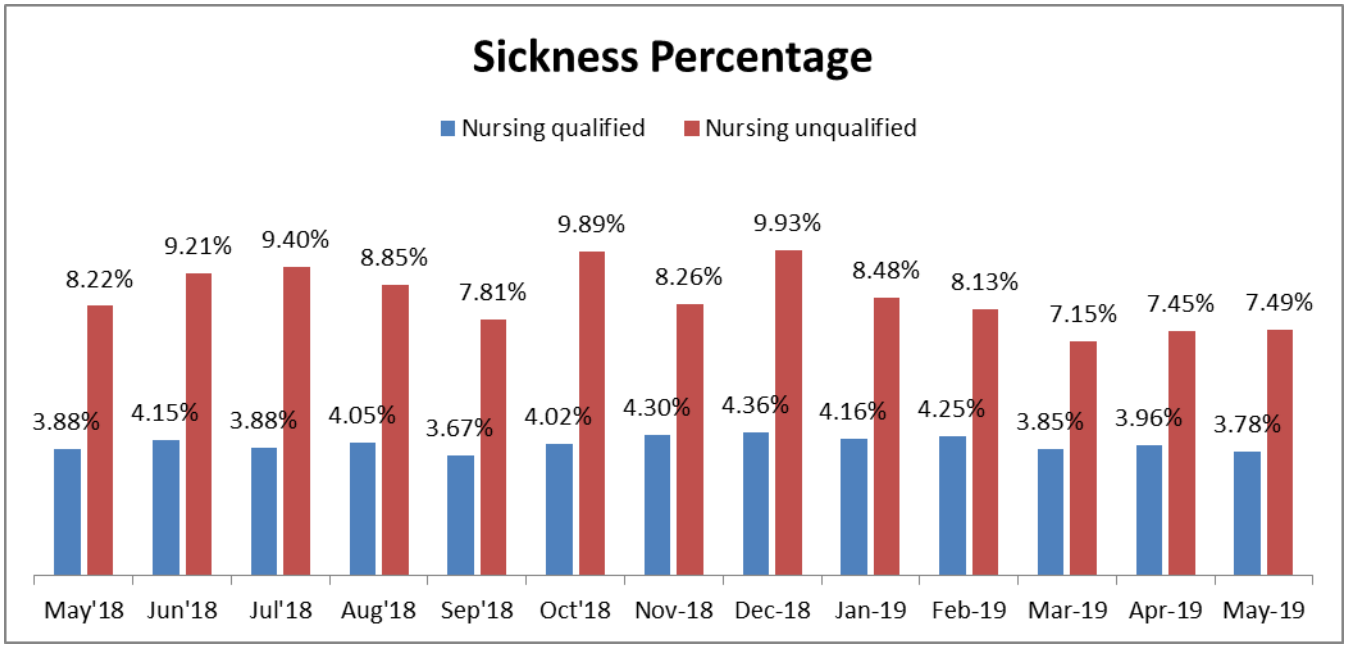
Chart 1 Care Hours per Patient Day (CHPPD): Data source Model Hospital Dashboard (latest available data).



3.3 Sickness

Chart 2 shows that sickness levels have decreased for qualified and increased for unqualified staff in May. There is ongoing work to address our above benchmark comparator sickness levels in our CSWs.

Chart 2 – Sickness Percentage by Staff Group



3.4 Enhanced Care

The Enhanced Nursing care team (ENCT) are a specialist substantive team who provide enhanced care, or 1-1 and are available 24 hours a day, seven days a week, ensuring that inpatients who are at risk to themselves or others are being effectively supported by specially trained staff to feel safe, secure and cared for at all times.

For the month of May 124 risk assessments were received by the team which is a large increase of 44 patients referred compared to April. Chart 3 shows that the patients referred to the team continue to remain high. The trust is seeing a higher acuity of patients and a higher number of patients requiring enhanced care support overall compared to 2017 as shown in chart 3. The team also support mental health patients who are referred by the RAID and CCAT teams that require 1-1 enhanced care. It should be noted that a number of patients requiring enhanced care are also requiring support from our security teams. Chart 3 shows the amount of additional hours used by the security team to manage patients displaying challenging behaviour.

The ENCT team review all risk assessed patients on a daily basis and step the level of enhanced care up or down as required to provide a streamlined flexible service. The team continue to develop the service to ensure improved patient care and outcomes. Where demand exceeds capacity the shifts will be put out to temporary staffing to cover the requirement. Chart 4 shows the breakdown of care hours provided by the ENCT, NHS Professionals. There continues to be robust check and challenge in place for all enhanced care a requirement, ensuring safe patient care is the main priority.

Chart 3

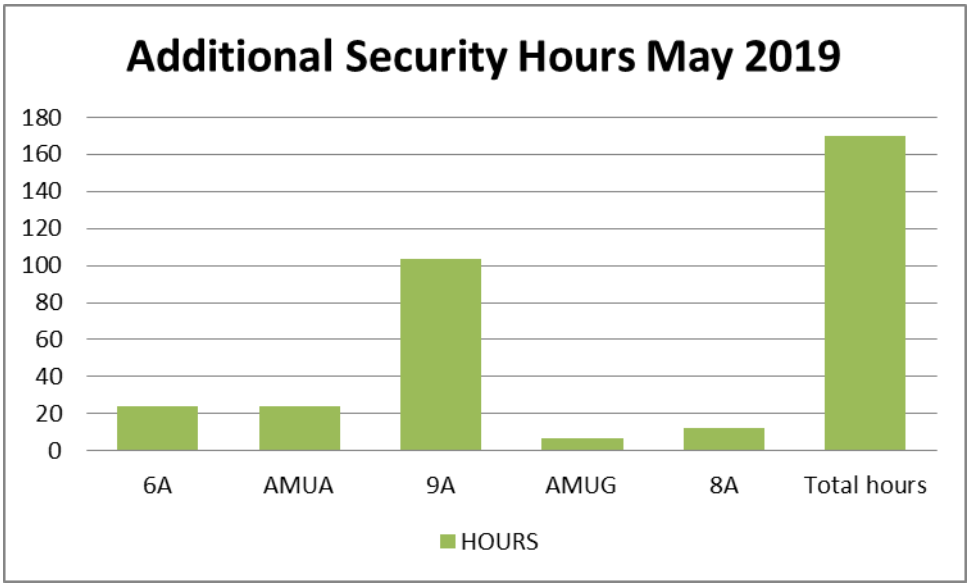


Chart 4

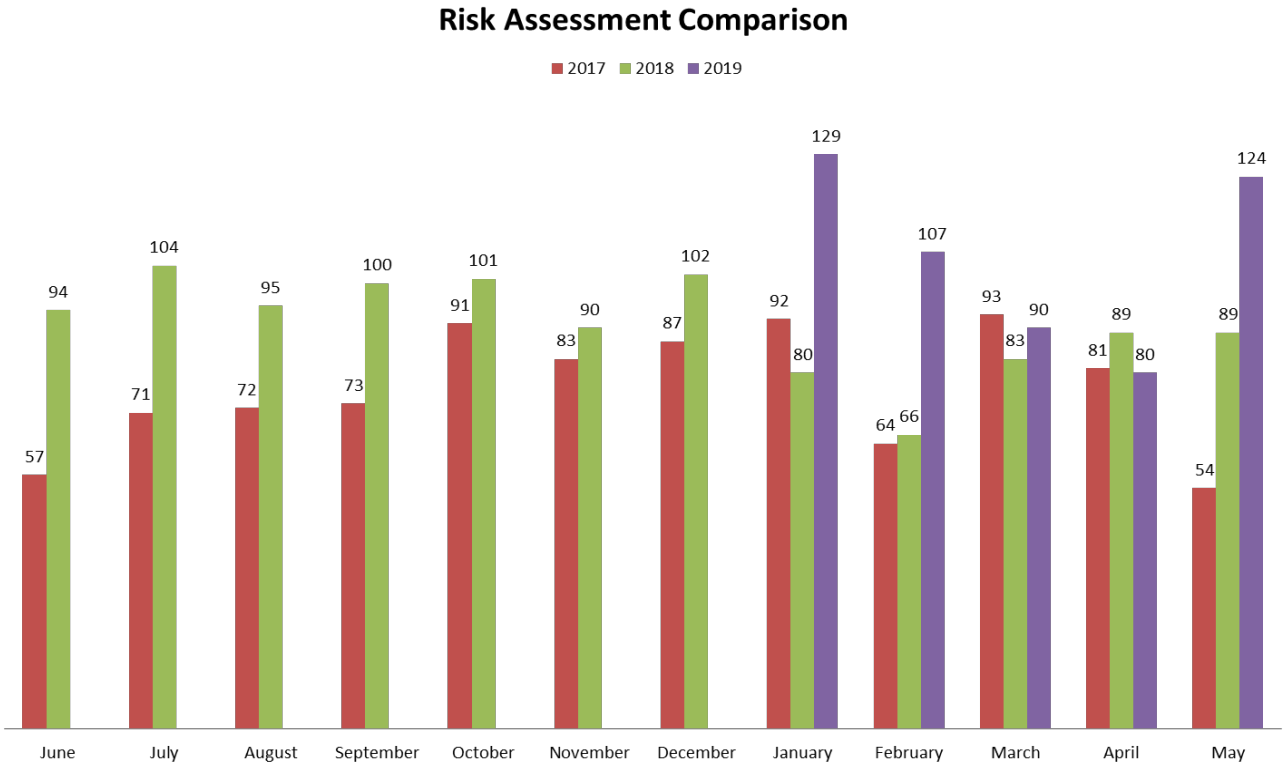
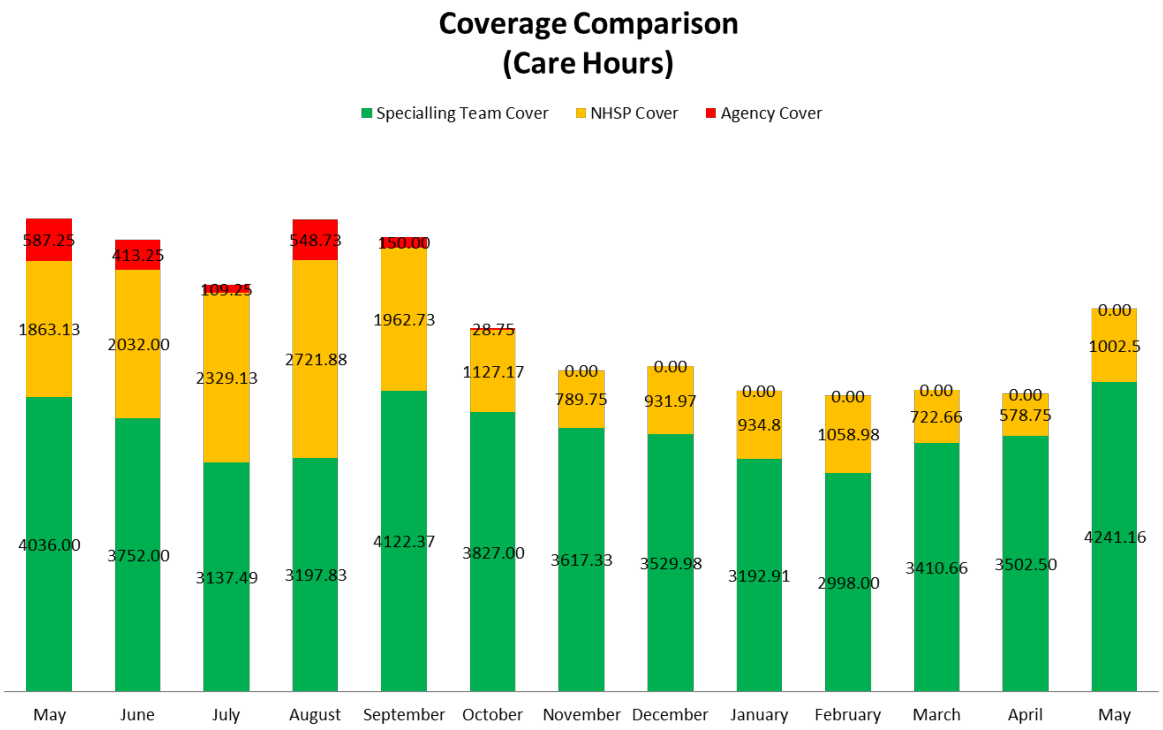


Chart 5



3.5 Recruitment and retention

The overall Trust position for qualified nursing in month 2 saw 18.2 WTE new starters and 12.2 WTE leavers, giving a positive variance of 6 WTE for the month. The qualified nurse trajectory currently indicates a cohort of 16.6 WTE domestic new starters in total, plus 18 student nurses who are qualifying in month 5 and are in the process of being assigned wards/departments and undergoing pre-employment checks.
The plans for nursing recruitment for 19/20 are underway as scheduled, with 29 out of the planned 41 international nurses already commenced in months 1 to 3, with a further 9 arriving later in month 3 and the remainder arriving in month 4.

4.0 Financial Sustainability

The Deputy Director of Nursing, all matrons, safer staffing team and heads of nursing meet monthly to prospectively review rosters to identify operational shortfalls and temporary staff requirements including agency usage/ requirements. Each ward is then RAG rated on a heat map and agency levels and restrictions agreed. Any additional ad hoc agency requirements outside of this meeting are authorised via the Director of Nursing or Deputy Director of Nursing.
Should a ward need to go above their planned agency usage a robust process is in place to be agreed by the director or deputy director of nursing.

To facilitate the reduction in agency costs, the trust have implemented a Rapid Response pool of nurses and CSWs. Bank staff get an enhanced pay rate in recognition of the workers commitment to be deployed at the time of reporting for work. The Rapid Response pool is used to mitigate daily staffing challenges such as sickness and short notice drop out to ensure wards are staffed safely.

4.1 Temporary Staffing Fill

Overall fill rate for temporary staffing increased by 2.7% from 78.2% in April to 80.9% in May. Demand hours increased slightly by 2,534 hours largely which is an equitable increase for a 31 day month. The Trust's Winter Pressures Ward 7A closed on the 7th April, however we continued to open additional capacity areas on the Discharge Lounge and CDU B Bay to support operational pressures daily.
Bank fill rates increased by 2.1% and Agency fill rates decreased by 0.7%. The level of unfilled shifts decreased from 21.8% in April to 19.1% in May.

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	64,872	46,320	71.4 %	4,405	6.8 %	78.2 %	14,147	21.8 %
May 2019	67,405	49,521	73.5 %	5,024	7.5 %	80.9 %	12,860	19.1 %
Total	**132,277**	**95,841**	**72.5 %**	**9,429**	**7.1 %**	**79.6 %**	**27,006**	**20.4 %**

Chart 5 Nursing and Midwifery Temporary Staffing Demand and Fill Rates

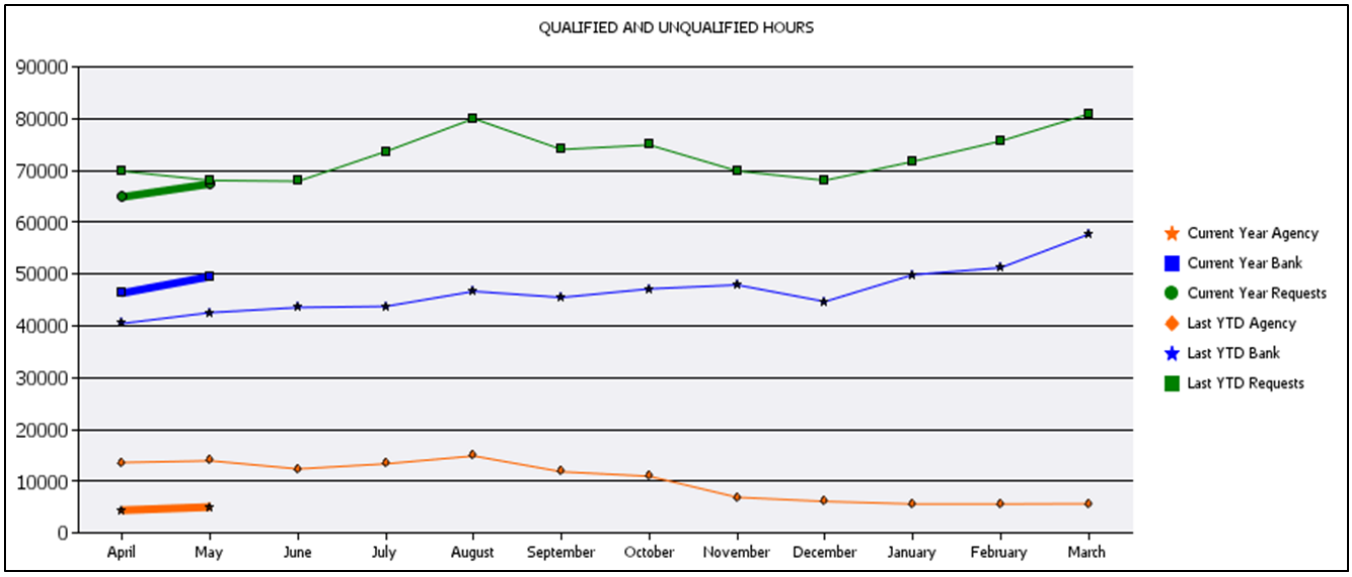


Table 4 Temporary Staffing Registered Hours Demand and Fill Rates

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	39,558	26,881	68.0 %	4,405	11.1 %	79.1 %	8,272	20.9 %
May 2019	40,842	28,077	68.7 %	5,024	12.3 %	81.0 %	7,741	19.0 %
Total	**80,400**	**54,958**	**68.4 %**	**9,429**	**11.7 %**	**80.1 %**	**16,013**	**19.9 %**

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	25,313	19,439	76.8 %	0	0.0 %	76.8 %	5,875	23.2 %
May 2019	26,563	21,445	80.7 %	0	0.0 %	80.7 %	5,119	19.3 %
Total	**51,877**	**40,884**	**78.8 %**	**0**	**0.0 %**	**78.8 %**	**10,993**	**21.2 %**

4.2 Roster KPIs

Table 6 shows the roster KPIs for the month of May as captured in the Nursing Quality Indicators Report. All of the division were below the recommended Annual Leave lower threshold of 13%. There is ongoing work with divisions to improve their roster KPIs. The Safer Staffing Matron and eRoster Systems Manager delivered training at Mount in the first week of June with a focus on Safer Staffing and Roster Performance Metrics. The Director of Nursing is meeting with ward managers on a 1:1 basis to review their rostering and budgets.

Table 6 eRostering KPIs

SUMMARY		Trust	Medicine	Surgery	Women & Children	Cancer	Assessment Wards	Emergency Department	Dialysis
e-Roastering	% E-roster Deadline Met	47.09%	33.00%	62.13%	42.43%	33.00%	33.00%	66.50%	59.60%
	Net Hours %	-0.47%	-0.38%	-1.31%	-0.60%	1.30%	-1.15%	-0.50%	-0.68%
	Net Hours Position	-1505.21	-185.52	-757.51	-126.94	69.87	-117.64	-247.36	-140.11
	% of Actual Annual Leave	11.79%	11.47%	11.49%	12.54%	10.40%	11.65%	12.65%	12.32%

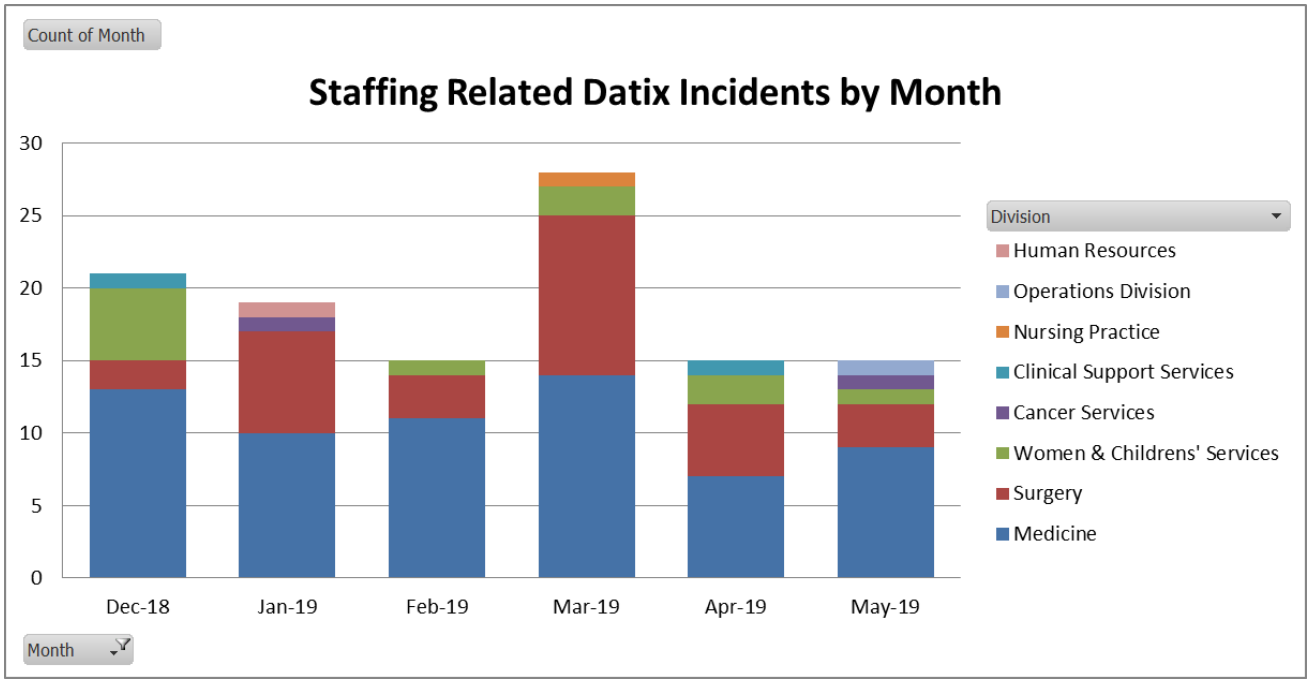
5.0 Investigations and actions on Incidents and red flag events

Shifts that fall below minimum staffing levels are escalated to the divisional staffing bleep holder who moves staff to balance risk across the division. Where the individual division is unable to mitigate independently this is escalated to the Divisional Heads of Nursing to balance risk across the organisation.

5.1 Datix Incidents

Chart 6 shows the number of staffing related Datix incidents logged in the last six month by speciality.
Fifteen staffing related Datix were raised in May. All staffing related incidents are reviewed by the Safer Staffing Matron and DoN and actioned as appropriate. All Datix for May have been reviewed and actioned by the department managers.

Chart 6



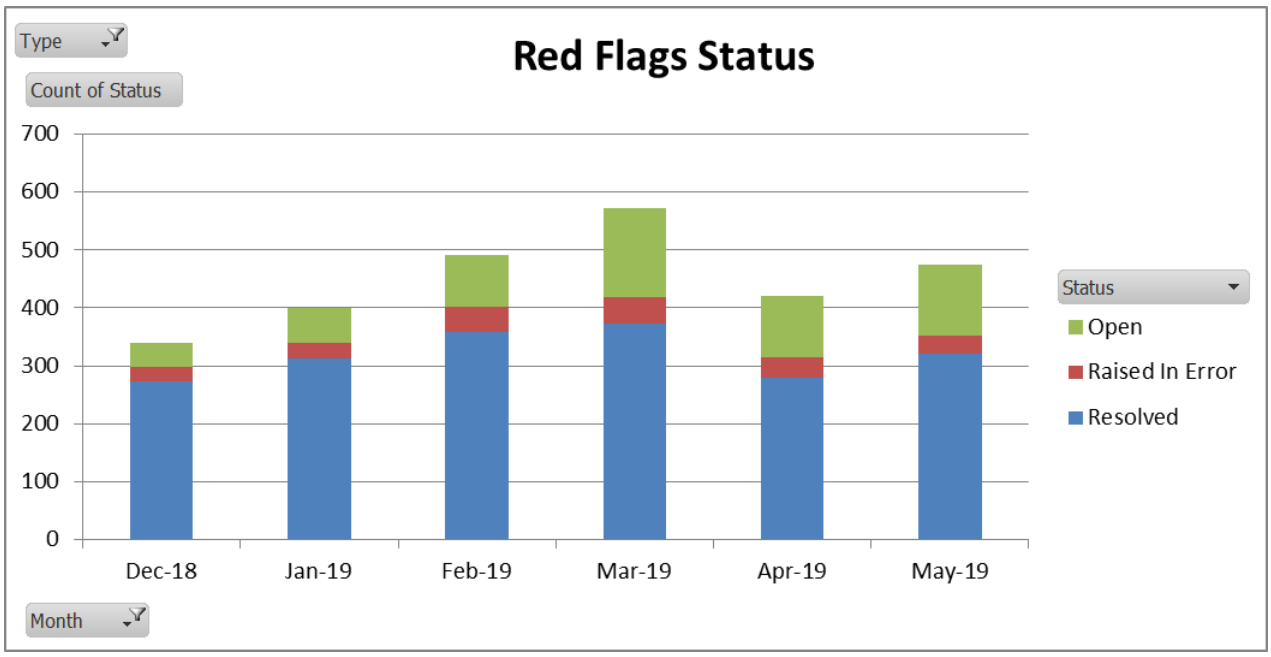
5.2 Red Flag Events

Red flags are NICE recommended nationally reportable events that require an immediate response from the Senior Nurse Team. "Red flag events" signal to the Senior Nurse Team an urgent need for review of the numbers of staff, skill mix and patient acuity and numbers. These events are considered as indicators of a ward requiring an intervention e.g. increasing staffing levels, facilitating patient discharge or closing to admissions for a temporary period following discussion and agreement with the operations centre and the executive on call.
Red flag notifications are completed in SafeCare and sent to a centralised staffing e-mail address. These notifications are then escalated at each of the three daily staffing meetings and site safety meeting, and closed once actions to mitigate are in place. The nurse in charge of the ward will try to resolve Red Flags with the help of the Divisional bleep holders who will act on escalated 'open' issues to help resolve them. Feedback from the wards has found the red flags are appropriate to the staffing challenges they need to escalate on a shift.

The Safer Staffing Team commenced work with the Maternity Services Team at the end of January and has set up Red Flag Events: signs that there may not be enough midwives available as per NICE guidance. The midwife in charge can now record red flag events and the action taken as a result using SafeCare. See **Appendix 4** for the Midwifery safe staffing update.

Chart 7 below shows the number of red flags raised each month over the last 6 months and their status excluding Maternity Red Flags. .

Chart 7



6.0 Patient outcomes

The Safer Staffing Team continues to monitor staffing at the three Daily Staffing meetings and weekly staffing look ahead meetings. Daily site safety meetings give a site overview of current issues and concerns relating to capacity, quality, patient care and safety concerns. This supports multi-professional informed decision making across the day. In addition to this there is a weekly look ahead meeting to ensure early mitigation / shift changes are agreed to pro-actively cover shortfalls.

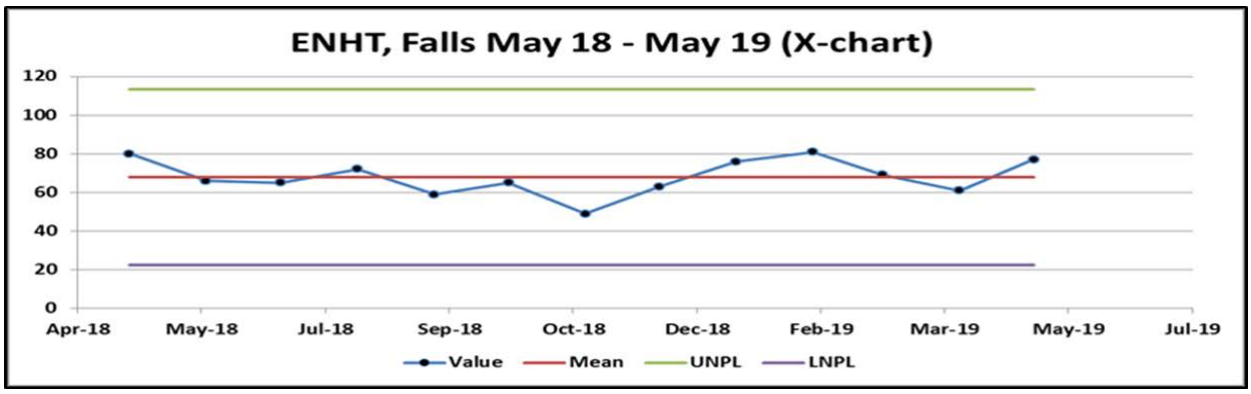
6.1 Safety Thermometer

The NHS Safety Thermometer audit provides a 'temperature check' on levels of harm and enables the measurement of 'harm free care'. Harm free care is defined by the absence of pressure ulcers, harm from a fall, urine infection (in patients with a catheter) and new VTE. This report details the number of patients 'with harm' on the specified audit date – 10 May 2019. We acknowledge that the 'harm' may not have occurred on the ward that it is captured on and therefore encourage all wards/Divisions to discuss the root cause analysis of all harms across Divisions. When looking at benchmarking data from the NHSI model hospital dashboard, as a trust we are in the top quartile for harm free care.

6.2 Falls

77 inpatient falls were recorded in the Trust during May which is a increase of 16 incidents when compared to April. There is ongoing work to continue to improve our prevention of falls with the promotion of the Bay watch initiative and compliance with the policy. Chart 8 shows That due to a good performance in April the Trust is currently 29 incidents below the targeted reduction trajectory set for 2019/20. The total number of falls reported in May was one incident above the pre-set monthly target trajectory.

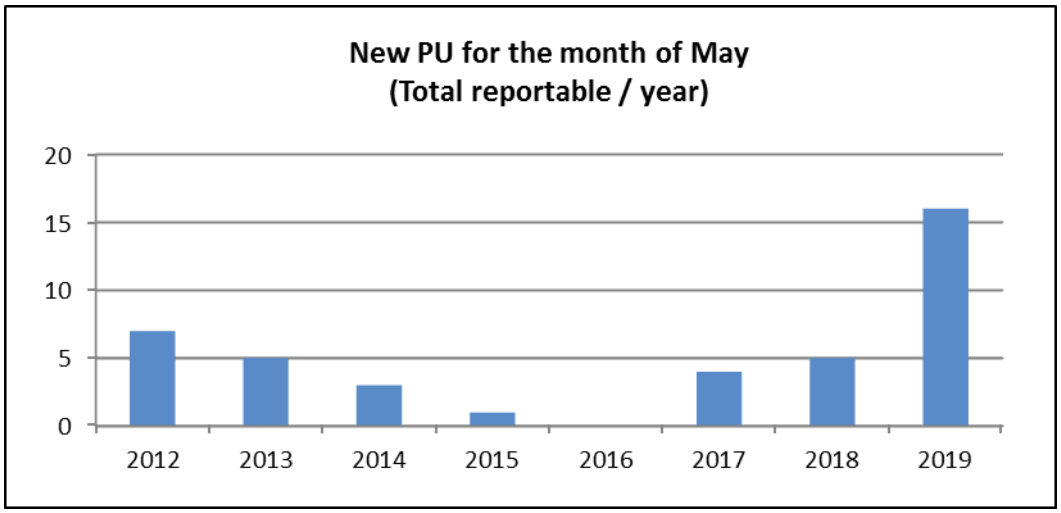
Chart 8



6.3 Pressure Ulcers

For the month of May there were 16 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.
May 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 = 12

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 May 2019 there were 1,058 inpatient surveys completed Table 7 shows the % responses to that question:

Table 7

Ward	Enough nurses
10AN	97
10B	73
11A	96
11B	93
5A	63
5B	72
6A	73
6B	69
7B	73
8A	60
8B	69
9A	83
9B	90
Acute Cardiac Unit (ACU)	88
AMU - Blue	64
AMU - Green	66
Ashwell	78
Barley	77
Bluebell	95
MVCC Ward 10/11	87
Pirton	87
SSU	68
Swift Ward	91
Total	81

7.1 Friends and Family

Table 8 shows the results for the friends and family test for the past 3 months. The percentage of patients that would recommend our trust for the month of May has decreased slightly from April.

Table 8

Month	% Would Recommend	% Would Not Recommend	No. of patients responding	% response rate [target 40%]
March 2019	96.82	0.69	1889	41.29
April 2019	96.69	0.60	1994	44.42
May 2019	96.44	0.79	2022	43.00

8.0 Recommendations

- Note the information on the nurse and midwifery staffing and the impact on quality and patient safety
- Note the content of the report and that mitigation is put in place where staffing levels are below planned.
- Note the content of the report is undertaken following national guidelines using research and evidence based tools and professional judgement to ensure staffing is linked to patient safety and quality outcomes.
- Note the ongoing requirement to continue to source and recruit registered and unregistered staff to match our staffing establishments and reduce our reliance on temporary staffing.

References

Letter from Chief Nursing Officer (NHS England) to Chief Executives of Health Education England and NHS England, dated 3 June 2015

NQB (2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – Safe sustainable and productive staffing.

Appendix 1

	Day		Night	
Ward name	Average fill rate + registered nurses/midwives (%)	Average fill rate + care staff (%)	Average fill rate + registered nurses/midwives (%)	Average fill rate + care staff (%)
10B	98.8%	96.4%	100.9%	132.1%
11A	99.3%	87.9%	100.0%	94.0%
11B	87.5%	89.7%	98.7%	100.3%
5A	97.6%	96.6%	97.2%	115.0%
5B	93.3%	95.5%	97.8%	107.1%
6A	101.1%	102.0%	99.1%	127.4%
6B	90.7%	109.4%	97.8%	170.9%
10A Gynae	101.4%	71.9%	100.3%	100.0%
7B	97.9%	100.0%	98.5%	106.7%
8A	100.3%	106.9%	101.1%	129.0%
8B	97.3%	112.2%	94.5%	125.4%
9A	102.0%	109.9%	98.8%	128.7%
9B	100.1%	107.6%	99.3%	137.5%
ACU	99.6%	89.7%	98.0%	99.0%
AMU-A	95.8%	89.8%	96.1%	104.0%
AMU-W	100.5%	101.9%	96.9%	117.0%
Ashwell	95.1%	104.3%	99.2%	121.5%
Barley	101.6%	110.5%	100.7%	123.6%
Bluebell	96.5%	83.5%	92.8%	114.9%
Critical Care 1	100.0%	100.0%	100.0%	100.0%
Dacre	85.8%	95.1%	100.0%	#DIV/0!
Gloucester	98.7%	74.7%	98.6%	94.5%
Mat CLU 1	92.9%	88.0%	105.1%	82.2%
Mat MLU	77.6%	87.9%	82.2%	80.5%
Pirton	88.3%	99.8%	98.4%	113.3%
SAU	95.5%	104.7%	101.1%	98.9%
SSU	101.8%	114.8%	100.1%	118.1%
Swift	96.1%	84.4%	99.1%	93.0%
Ward 11	62.9%	63.3%	75.7%	101.5%
Total	**94.0%**	**95.9%**	**97.5%**	**111.7%**

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.
Ward 11	Reduced occupancy in month, staffing flexed across the Cancer Services Division to support safe staffing.
Dacre	Low occupancy in month, staffing flexed across the Maternity Service to meet patient needs.
MLU	Low occupancy in month, staffing flexed across the Maternity Service to meet patient needs.

Appendix 3

Ward name	Care Hours Per Patient Day (CHPPD)		
	Registered midwives/ nurses	Care Staff	Overall
10B	3.24	2.54	5.78
11A	3.91	1.77	5.68
11B	3.91	2.91	6.82
5A	3.41	2.75	6.15
5B	3.56	2.96	6.52
6A	3.21	2.76	5.97
6B	4.19	2.67	6.85
10A Gynae	5.23	2.23	7.46
7B	3.16	2.37	5.53
8A	3.27	2.60	5.87
8B	3.30	2.37	5.66
9A	3.13	2.80	5.93
9B	3.01	2.65	5.66
ACU	5.24	2.50	7.74
AMU-A	6.03	3.68	9.71
AMU-W	4.05	3.52	7.57
Ashwell	3.40	3.09	6.48
Barley	3.50	3.07	6.58
Bluebell	7.22	3.48	10.70
Critical Care 1	6.12	0.44	6.56
Dacre	7.97	1.31	9.28
Gloucester	4.66	3.89	8.54
Mat CLU 1	25.47	7.23	32.69
Mat MLU	33.20	11.12	44.31
Pirton	4.52	2.62	7.14
SAU	7.73	3.81	11.54
SSU	3.56	3.66	7.22
Swift	4.36	2.58	6.94
Ward 11	5.35	3.35	8.70
Total	**4.4**	**2.8**	**7.3**

Appendix 4

Safer Staffing Report May 2019

Planned versus actual midwifery staffing levels

NHSR Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required Evidence:

- Details of planned versus actual midwifery staffing levels.
- The midwife: birth ratio.

Funded Clinical Establishment supports an annual ratio of 1 midwife to 29 women (includes band 3 and 4 staff that support postnatal care). Ratios will vary month on month due to variations in birth numbers however the funded establishment supports all maternity activity both hospital and community care.

	February		March		April*		May	
Midwives	175.26		175.26		178.57		178.57	
Band 3-4 Postnatal	10.52		10.52		11.53		11.53	
Total Funded Clinical	**185.78**		**185.78**		**190.1**		**190.1**	
Actual Worked	**183.29**		**189.18**		**185.26**			
	Births	**Ratios**	**Births**	**Ratios**	**Births**	**Ratios**	**Births**	**Ratios**
Predicted Births in month based on number of women EDD 4 months' time against funded* Clinical Establishment	412	**29**	428	**27**	440	**28**	460	**28**
12 Month Rolling Year to Date Against Funded Midwifery Establishment	5396	**31**	5384	**27**	5375	**30**	5353	**30**
Actual Births in Month against actual worked in month midwives	377	**28**	439	**29**	422	**30**	463	**33**

Total Clinical WTE funded	<30.5	Midwife only funded	<31.5
to a ratio of 1:29	<30.6-32	to a ratio of 1:31	<31.6-33
based on 5500 births	>32	based on 5500 births	>33

*From April 2019 included in the clinical numbers are non-recruitable 4.76 in budget to support maternity leave

Midwifery red flag events

NHSR Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required Evidence:

Number of red flag incidents (associated with midwifery staffing) reported in a consecutive six month time period within the last 12 months, how they are collected, where/how they are reported/monitored and any actions arising (Please note: it is for the trust to define what red flags they monitor.

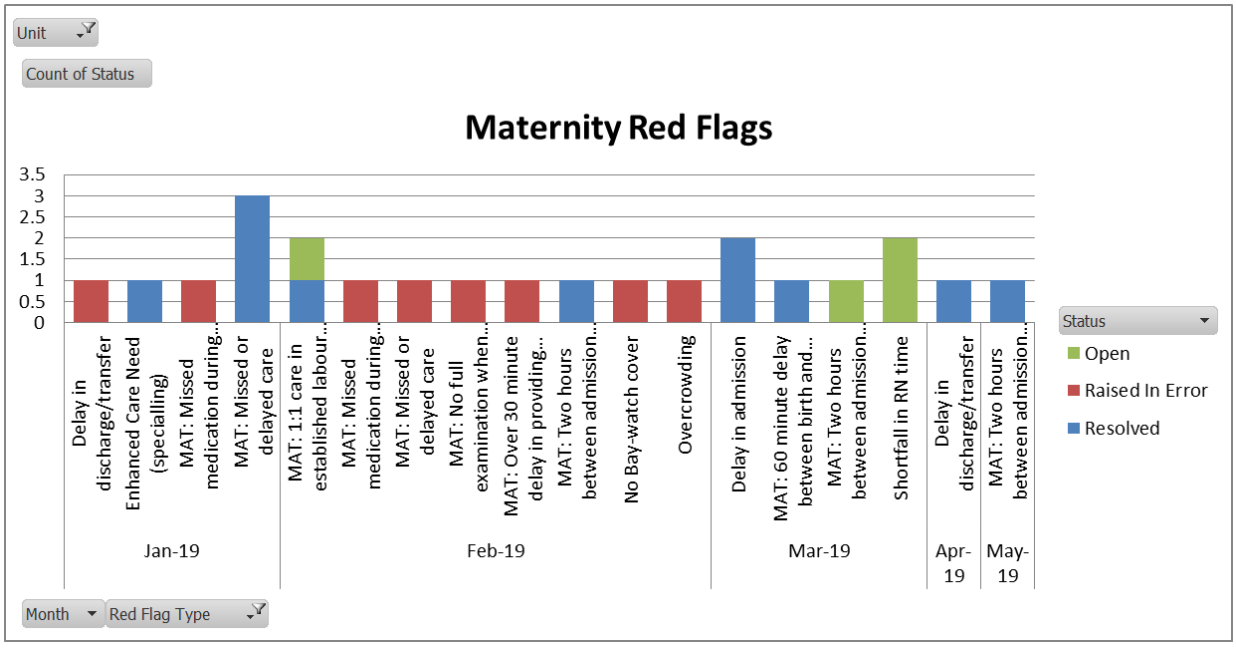
NICE Safe midwifery staffing for maternity settings 2015 defines Red Flag events as negative events that are immediate signs that something is wrong and action is needed now to stop the situation getting worse. Action includes escalation to the senior midwife in charge of the service and the response 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: 15.1

TRUST BOARD - PUBLIC SESSION – 3 JULY 2019
CHARITY TRUSTEE COMMITTEE – 20 MAY 2019
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present to the Trust Board the summary report from Charity Trustee Committee (CTC) meeting of 20 May 2019. The report includes details of any decisions made by the CTC under delegated authority.		
Action required: For discussion		
Previously considered by: N/A		
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:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☐
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

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

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

CHARITY TRUSTEE COMMITTEE MEETING HELD 20 MAY 2019

SUMMARY REPORT TO BOARD

The following members were present: Bob Niven (Committee Chairman), Eloise Huddleston (Head of Charity), Val Moore (Non-Executive Director) and Rachael Corser (Director of Nursing)

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:

Applications for expenditure over £5,000
The Committee discussed the following applications for expenditure over £5,000.

Proposal	Cost	Outcome
Nursing and Midwifery Excellence Framework (Nursing)	£40,000	Approved
Purchase new equipment to deliver physiology Testing at Lister (Surgery)	£30,000	It was agreed that this should first be explored as a CIP. If this was not possible, the Charity was open to reconsidering the proposal.
Creation of an Interventional Radiology Day Unit (CSS)	Full cost TBC	The CTC approved the expenditure above the £100k that would need to be provided by the Trust.
Renal Doppler x 5 (Medicine)	£15,000	Approved
Patient Wi-Fi (Corporate)	£4,590 - plus a monthly cost of £2,190	The CTC approved the application but noted that the process had not been correctly followed and would need to be in future.

The CTC also approved the opening of a new bank account that was needed to install two contactless payment boxes costing £1,248.80 each plus a monthly fee of £19.95. The finance department would follow Trust due diligence and SFI's prior to opening the account.

The CTC also noted the details of the charitable expenditure approved and submitted to Discretionary Review Panel by the Head of Charity since 2 March 2019. Please see Appendix 1 for details.

Other outcomes:

Divisional Fund Management Reports – CSS
The Committee considered a report regarding the deployment of CSS charitable funds. Since May 2018, CSS had delivered charitable projects relating to the Hertford X-ray room and MRI scanner at Lister.

The division had worked with the Head of Charity to identify seven funds to close with its remaining balances merged into 'staff training' and 'general patient benefit' funds. It was reported that the division were engaged with the Charity and were planning a number of fundraising activities for the year.

Review of Charity Strategy Progress
The Head of Charity provided an update report which included charity performance, key achievements and progress against the KPI's for 2018/19. She reported that it has been a strong year for community event fundraising and the events programme could now be viewed on the Charity website. The KPI's were all rated as either 'green' (achieved) or 'amber' (in progress). It was reported that there had been a marked increase in staff engagement and further activities are planned to build enthusiasm among staff.

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 financial position for 2018/19 as well as the financial performance Month 1 2019/20.

As at 31 March 2019 the Charity reported a year-to-date deficit of £548k (favourable variance of £107k against the original plan of £655k). The Charity submitted a reforecast of £1,01k deficit in December 2018 following the review of its performance during the first half of 2018/19. As a result, the Charity is reporting a favourable variance of£464k against its revised budget. Capital performance was below plan due to x-ray invoice coming in after close of last financial year. The running costs for the year were 21%.

Regarding Month 1 performance, there had been an adverse variance against plan in terms of income. The team were confident that income would improve to the planned level.

Annual Review of Risk Register
The CTC considered the report which provided details of the Charity's risk register. Three top level risks were identified and the controls that were in place were discussed.

Acceptance and Refusal of Donations
The CTC considered proposed guidelines for accepting donations from the pharmaceutical industry. The guidelines were developed to be used alongside the Management of Charitable Funds Policy and followed a similar approach to the guidelines of other charities. It was agreed that implementing guidelines relating to food, alcohol and tobacco donations would also be considered by the CTC in the future. The Committee supported the guidelines that had been drafted.

Investment Portfolio Update
The Committee noted the investment portfolio update.

Bob Niven
Chairman of the Charity Trustee Committee

May 2019

Appendix 1 Charitable expenditure approved and submitted to Discretionary Review Panel by the Head of Charity since 2nd March 2019. This includes items under £500 and items previously approved by CMT and CTC.

Number	Division	Project	Cost
296	Women's & Childrens	Architect costs - extending the parents area to include washing facilities, kitchen, dining area play space for older siblings and a larger seating area to allow parents & relatives to relax. We will be doing specific fundraising and receiving sponsorship towards this	£19,152
297	Women's & Childrens	Cost Consultants extending the parents area to include washing facilities, kitchen, dining area play space for older siblings and a larger seating area to allow parents & relatives to relax. We will be doing specific fundraising and receiving sponsorship towards this	£10,750
298	Medical	Interactive table projection, sensory interaction and stimulation	£6,177
299	Womens & Childrens	Interactive table projection, sensory interaction and stimulation	£15,123
300	Medical	Emergency hardship payment to a patient to help relieve a dire situation	£160
303	Medical	POC machine To enable patients to have testing on the same day as a scan instead of booking a separate appointment. This is in addition to £4330 which was approved on DRP 2364 but all the funds were from a single donation into LMCC.	£770
305	Cancer	Bandanas, Headware for patients	£76
306	Cancer	Headscarves	£72
308	Corporate	4 x Scalp Coolers. To provide MVCC patients with the option of trying to keep their hair when having chemo	£28,000
309	Corporate	New chairs for patients	£3,000
310	Medical	Benefit Advisor Role, previously funded by LAKPA	£6,200
311	Medical	Rheumatology probe- to better manage patients with giant cell arthritis by reducing the need for invasive biopsy and unnecessary steroid use	£15,446
312	Cancer	Schwartz Rounds including admin support, training and subscription.	£14,480
313	Womens & Childrens	Children's Christmas party	£230
314	Corporate	Charity Recruitment cost	£699
315	Cancer	Water Cooler	£244
320	Corporate	Expenditure incurred in the running of the children's patch party	£68
321	Surgical	Expenditure incurred in the running and preparation of Anaesthesia Study day. Company sponsorship has been received to help with the costs of the course	£1,343
322	Medical	Christmas gifts for Critical care patients	£28
323	Corporate	Volunteer supplies for providing support to patients	£500
326	Women & Childrens	Install tanoy system for outside maternity unit to try & prevent smoking outside the area	£1,000
327	Corporate	Community Fundraising workshops, training staff in the best way of fundraising	£1,250
328	Cancer Services	League of Jewish Women Headwear for patients	£69
329	Corporate	Big Build MES Consultant	£9,150
335	Cancer	Mount Vernon Volunteering expenditure	£300
331	Cancer services	Volunteer Thank you event	£850