East and North Hertfordshire NHS Trust
Trust Board - Public Meeting

Postgraduate Centre, Mount Vernon Cancer Centre, Northwood

4 March 2020 11:00 - 4 March 2020 12:30

AGENDA

#	Description	Owner	Time
1	Chair's Opening Remarks	Chair	11:00
2	Apologies for absence		
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 8 January 2020 Public Trust Boa... 5	Chair	
6	Staff Story For discussion	Director of Nursing	11:05
7	Chief Executive's Report For discussion 7. CE Board Report - March 2020.pdf 13	Chief Executive	11:20

#	Description	Owner	Time
8	**Integrated Performance Report** For discussion 8. Integrated Performance Report - Month 10.pdf 15	All Executive Directors	11:25
9	**Clinical Strategy Q3 Update** For discussion 9. Clinical Strategy - Q3 Board Update.pdf 61 9. Appendix 1 - Q3 Clinical Strategy Highlights.pdf 65	Director of Strategy	11:50
10	**Staff Survey Results** For discussion 10. Staff Survey Key Findings.pdf 67	Chief People Officer	12:00
11	**Finance, Performance and People Committee Reports to Board** For discussion 11. (a) FPPC January 2020 Report to Board.pdf 85 11. (b) FPPC February 2020 Report to Board.pdf 89	Chair of FPPC	12:10
11.1	**Gender Pay Gap Report** For approval 11.1 Gender Pay Gap Report.pdf 93	Chief People Officer	12:15
12	**Quality and Safety Committee Reports to Board** For discussion 12. (a) QSC January 2020 Report to Board.pdf 101 12. (b) QSC February 2020 Report to Board.pdf 107	Chair of QSC	12:20
12.1	**Complaints, PALS and Patient Experience Report** For information 12.1 Patient Experience Quarterly Update.pdf 113	Director of Nursing	12:25
12.2	**University Status Annual Report** For information 12.2 University Hospital Partnership - Draft Annual... 137	Medical Director	12:30

#	Description	Owner	Time
13	Audit Committee Report to Board For discussion [P] 13. Audit Committee January 2020 Report to Board... 155	Chair of Audit Committee	12:35
14	Board Assurance Framework For discussion [P] 14. Board Assurance Framework Report.pdf 159 [P] 14. BAF - Appendix 1.pdf 163	Associate Director of Corporate Governance	12:40
15	Actions Log For information [P] 15. Public Trust Board Actions Log.pdf 191	Associate Director of Corporate Governance	
16	Annual Cycle For information [P] 16. Board Annual Cycle 2019-20.pdf 193	Associate Director of Corporate Governance	
17	Data Pack For information [P] 17. Data Pack.pdf 197		
18	Date of next meeting: 6 May 2020, Lister Education Centre		

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday, 8 January 2020 at 11.00 am at the Lister Education Centre, Lister Hospital, Stevenage

Present:	Mrs Ellen Schroder	Non-Executive Director (Chair)
	Dr Peter Carter	Non-Executive Director
	Mrs Karen McConnell	Non-Executive Director
	Ms Val Moore	Non-Executive Director
	Mr Bob Niven	Non-Executive Director
	Mr Jonathan Silver	Non-Executive Director
	Mr Nick Carver	Chief Executive Officer
	Mr Martin Armstrong	Director of Finance
	Dr Michael Chilvers	Medical Director
	Ms Rachael Corser	Director of Nursing
	Ms Julie Smith	Chief Operating Officer
In attendance from the Trust:	Mr Duncan Forbes	Chief People Officer
	Ms Eunice Olasode	Board Committee Secretary (Minutes)
	Mr Joseph Maggs	Trust Secretary
	Ms Jude Archer	Associate Director of Corporate Governance
Also in attendance:	R. Macow	Hertfordshire Partnership University NHS Foundation Trust
	Sarah Nardone	Nuance Communications Limited
	James Newton	NHS Professionals
	Neil Thomas	Member of the public

20/001 CHAIR'S OPENING REMARKS

20/001.1 Mrs Schroder welcomed the members of the public to the meeting and thanked them for attending.

20/002 APOLOGIES FOR ABSENCE

20/002.1 Apologies were received from Dr David Buckle (Non-Executive Director, Associate) and the Director of Strategy.

20/003 DECLARATIONS OF INTEREST

20/003.1 There were no declarations of interest

20/004 QUESTIONS FROM THE PUBLIC

20/004.1 No questions had been received from the public.

20/005 MINUTES OF PREVIOUS MEETING

20/005.1 The minutes of the previous meeting were approved as an accurate record of the meeting.

20/005.2 Mrs Schroder commented on minute item 19/109.5 in relation to a comment Mrs Knight had made about some consultants' details not being available on the website. She reported that the Trust now has a new website with updated information about consultants on it and suggested it would be useful to also encourage them to provide photographs.

20/006 PATIENT TESTIMONY

20/006.1 The Director of Nursing provided examples of recent feedback received from patients and details of actions that had been taken in response.

20/006.2 She reminded the Board that 2020 is the International Year of the Nurse and Midwife and this was an opportunity for these staff to be recognised nationally and internationally for the work they do.

20/006.3 She updated the Board on the treatment received by an elderly lady known to have dementia who did not receive care in the optimum way partly due to the failure of the care home in updating the ambulance service about her health when she was picked up. She was initially seen in an environment that was not ideal for dementia patients. Despites this, It was reported that excellent personal care was received. The Director of Nursing advised that investment in dementia friendly environments was being explored.

20/006.4 Other updates provided included that excellent feedback was received in terms of communication, meeting patients' personal needs, dealing with questions in a professional and timely manner, especially during the summer period when the hospital was particularly busy. She also reported that there had been recent investment in pillows for patients in ED.

20/006.5 The Chief Operating Officer commented that the Executives are passionate about supporting the staff to ensure that a safe service is delivered at all times, even in the most challenging circumstances. She remarked that the winter ward was now opened as planned.

20/006.6 Mrs Moore asked about plans to make the environment more dementia friendly. The Director of Nursing commented that this was an aspiration for the Trust as dementia friendly environments were good for all patients. The Chief Operating Officer added that some funding had become available to refresh Ashwell ward.

20/006.7 Dr Carter commented that little things like provision of pillows can transform a patient's experience. He spoke of his visit to Lister hospital on Christmas Day, when he had spoken with lots of patients and their relatives. He remarked that the feedback was mostly very positive.

20/007 CHIEF EXECUTIVE'S REPORT

20/007.1 The Chief Executive started by thanking his executive colleagues for their support whilst he was recovering from surgery over the Christmas period.

20/007.2 He referred to recent correspondence from the CQC which indicated that there was a presentational error within the recently issued CQC report; however the overall and individual pathway ratings were unaffected. This would be followed up with the CQC.

20/007.3 He took his report as read but highlighted the following points:

- The Chief Executive updated the Board on the appointment of a New Director of Estates and Facilities. He had started in the role last week and brought a wealth of experience with him.
- The Trust's new website had now been launched. It was redesigned to be more user-friendly.
- He mentioned that the Trust's CQC report had been published and the Trust was moving towards achieving a 'Good' overall rating.
- He also highlighted recent staff awards and achievements.

20/007.4 The Associate Director of Corporate Governance clarified that achievement of a 'Good' overall CQC rating depended on the CQC's re-inspection programme and which services were inspected in the next inspection.

20/008 INTEGRATED PERFORMANCE REPORT

20/008.1 The Integrated Performance Report for Month 8 was presented to the Board.

20/008.2 Safe and Caring
The Director of Nursing presented the key updates regarding Safe & Caring services.

20/008.3 It was reported that there were no new Never Events since the last report, with the total for the year remaining at 3.

20/008.4 It was reported that the Trust's safety thermometer benchmarking had improved further and the Trust now benchmarked in the upper quartile.

20/008.5 There were no new incidences of MRSA recorded since the previous report. She also reported that there was now a new IPC lead nurse in post.

20/008.6 Regarding complaints management, she reported that improvement was noted from January to August last year with an overall 50% reduction in open cases. Since April 2019 79% of complaints across the Divisions had been responded to within the agreed timeframe, which represented an improved position. She advised that there would continue to be a focus on checking that learning from the complaints is reflected in the way patients are treated.

20/008.7 Mrs Schroder commended the team for good work in improving complaints turnaround times.

20/008.8 Mr Niven asked about hand hygiene. He asked if the focus had dropped following the CQC inspection. The Director of Nursing agreed that this was a possibility, but it was the intention to work to ensure good IPC practices were embedded within the Trust and work would take place with newly qualified staff to help with this.

20/008.9 Effective
The Medical Director presented the key updates regarding Effective services.

20/008.10 It was reported that a slight increase was recorded in crude mortality in month but the rolling 12 month position remained better than the most recently available national rate.

20/008.11 The rolling 12-months HSMR improved to 84.9%. The latest reported SHMI figure was 90.9. The Medical Director summarised that generally the Trust's mortality figures compared favourably.

20/008.12 The Medical Director also noted that there was a slight increase in re-admissions in the most recent dataset.

20/008.13 The Learning from Deaths report was also provided with the Board papers.

20/008.14 It was reported that the medical examiner service would be launched in March, initially with cardiology and critical care. It was believed that documentation around cause of death would be improved and communication would be better with the introduction of the service.

20/008.15 Regarding 7 days services, it was reported that some consideration of resource required for patients admitted out of hours to get an equivalent service to those admitted in-hours was likely to be needed as part of budget setting.

20/008.16 Mrs Moore enquired about progress with recruiting into some of the Associate Medical Director posts. The Medical Director advised that the Medical Director's office was being redesigned to strengthen the capacity and resource available.

20/008.17 Mr Niven commented on figures reported on sepsis rate and the number of sepsis incidents. The Medical Director reported there were signs of a negative trend and additional scrutiny would be targeted in this area.

20/008.18 <u>Responsive</u>
The Chief Operating Officer presented the highlights from the Responsive Services section of the report.

20/008.19 It was reported that ED 4 hour performance remained a challenge with a slight slip recorded in December. Additional incentives had been identified to support flow and it was believed that improvement would be noticed in January.

20/008.20 Regarding Patient flow, the Trust was pushing forward its ambulatory care pathways prior to admission in order to ensure that beds were used for the seriously ill patients and, wherever possible, patients who are not seriously ill are supported through ambulatory care to leave the hospital and receive their care through ambulatory pathways.

20/008.21 Significant improvement was recorded in terms of the 62 days cancer standard, with the Trust achieving a compliant position for the first time since 2014.

20/008.22 It was reported that the Trust remained compliant with the diagnostics target and it was the intention to undertake a concerted effort to achieve the RTT target over 2020.

20/008.23 A certain level of non-compliance was recorded in 52 weeks breaches and a recovery action plan was being developed.

20/008.24 Stroke performance for October had deteriorated to 60.3%. There were a number of factors related to the performance issues and improving stroke performance would remain a key focus.

20/008.25 Mr Niven asked when improvements in stroke performance could be expected. The Chief Operating Officer advised that a recovery action plan had been requested but in the short term performance was likely to remain challenging.

20/008.26 Mrs Schroder commended the team for the great work done in achieving the 62 day cancer target. She remarked that some of the lessons learned from the work to achieve that target could be reengineered into a plan to achieve RTT compliance.

20/008.27 Well – led
The Chief People Officer presented the Well-led element of the report.

20/008.28 It was reported that there remained good progress in terms of achieving the agency cap.

20/008.29 Whilst sickness absence had improved compared to the same point last year, it was felt that further work was needed to improve sickness absence across the year as a whole.

20/008.30 Appraisal performance was below target but plans were in place in terms of introducing a new system for learning and development. It was expected that this would reduce some of the administrative burden around appraisals.

20/008.31 In terms of workforce numbers, it was reported that the target for a 37 WTE increase in the number of nurses would not be met, though the next wave of international nurse recruits were due to commence next month.

20/008.32 The Chief People Officer remarked that it has been a challenging period in terms of staffing and lessons around the theme of better planning and deployment would be taken forward.

20/008.33 Regarding flu vaccinations, it was reported that the Trust's performance was now at 65%.

20/008.34 Mrs Moore asked if the staff flu vaccination target was achievable. The Chief People Officer believed that, in part due to the supply issues, achieving 80% would be a challenge, but work was ongoing to achieve as many vaccinations as possible. He advised that some organisations were also considering the possibility of making the vaccinations compulsory.

20/008.35 Dr Carter asked if there were any specific staff groups where vaccination rates were particularly low. The Chief People Officer advised that the breakdown was fairly evenly split.

20/008.36 Mr Niven asked about the planned changes to appraisals and suggested it could be useful for the quality of appraisals to also be measured.

20/008.37 Sustainable
The Director of Finance reported that at Month 8 the Trust performed well against the financial plan. The Trust remained on track to meet the control total and an agreement had now been reached with East and North Hertfordshire CCG for an over-performance overpayment of approximately £12.9m.

20/008.38 The Director of Finance also noted that whilst there had been some progress in terms of paybill, the challenge had not been resolved yet.

20/008.39 Mr Niven asked how achievement of CIPs IN 2019/20 compared to previous years. The Director of Finance advised the position was better than at this point in previous years, though noted that a large element of the plan was back loaded to the end of the year.

20/009 PEOPLE AND ORGANISATIONAL STRATEGY

20/009.1 The Board received the final draft of People and Organisational Strategy. The report outlined current workforce challenges and the high level proposals to address these challenges.

20/009.2 This would be a key enabling strategy for other strategies within the Trust and the workforce team would work with other departments with planning and modelling to ensure a consistent approach across strategies.

20/009.3 The draft strategy had been considered at FPPC previously and plans for its rollout were being developed.

20/009.4 Mrs Schroder suggested that actual figures would be useful as the strategy is implemented for the Board to monitor ongoing performance.

20/009.5 The Chief People Officer added that he expected the strategy to evolve further in the context of STP developments.

20/009.6 Mrs McConnell asked how the success of the strategy would be measured. The Chief People Officer advised that the employee experience group would help with feedback on implementation, as would other forms of staff feedback and surveys.

20/009.7 The Board approved the strategy subject to final internal checks.

20/010 FINANCE, PERFORMANCE AND PEOPLE COMMITTEE REPORTS TO BOARD

20/010.1 Mrs McConnell presented the reports of the meetings of the Finance, Performance and People Committee which were held on 27 November and 18 December 2019.

20/010.2 She reported that the FPPC had been updated on the development of the People Strategy, progress with the Digital Strategy and had received deep dives regarding theatres and outpatients. She added that the FPPC had requested and agreed on a number of KPIs to enable it to monitor progress in terms of theatres and outpatients on a monthly basis.

20/010.3 Mrs McConnell also informed the Board that she expected the FPPC meetings to include a significant focus on estates issues over the coming months now that the new Director of Estates and Facilities was in post.

20/011 QUALITY AND SAFETY COMMITTEE REPORTS TO BOARD

20/011.1 Dr Carter provided a brief introduction to the reports of the two most recent QSC meetings. He commented that they had both been good meetings and in particular he had found some of the deep dive sessions particularly interesting. He commented that the length of

the agenda had been a little challenging and was something that he would like to address.

20/012 NURSING AND MIDWIFERY ESTABLISHMENT REVIEW

20/012.1 The Board received the Nursing and Midwifery Establishment Review.

20/012.2 The Director of Nursing reported that the recommendations were supported by the Executive Committee, and an earlier draft had also been considered by the QSC.

20/012.3 The Director of Finance reminded the Board of the financial and quality commitments the Board were making in accepting the recommendations.

20/012.4 Mr Niven asked about issues with provision of training for nursing staff. The Director of Nursing advised a number of initiatives were being explored.

20/012.5 The Board approved the recommendation of the Nursing and Midwifery Establishment Review.

20/013 QUALITY ACCOUNT UPDATE

20/013.1 The Board received an update on progress against the Trust's Quality Account milestones. The report had also been presented to the Quality and Safety Committee.

20/013.2 The Director of Nursing highlighted significant areas of progress, including the development of the deteriorating patients collaborative, the strengthening of the quality improvement resource and the launch of the Trust's ward accreditation programme.

20/013.3 Mrs Schroder welcomed the update but suggested that the next edition could be more succinct and include an overview of the current position in terms of work to achieve each priority.

20/013.4 Ms Moore enquired about progress in terms of adopting and implementing a quality improvement initiative. It was reported that this would be discussed at the Board Development session in February.

20/014 BOARD ASSURANCE FRAMEWORK

20/014.1 The Board noted the latest version of the BAF which had been considered in more detail by the sub-committees.

20/014.2 It was reported that the risk around MVCC remained at 16 at present but would be reviewed with the Director of Strategy following discussion at the last FPPC meeting.

20/014.3 It was also reported in terms of the governance risk that the Trust's previous section 29A notice had now been lifted. The Associate Director of Corporate Governance proposed that the Audit Committee undertake a deep dive in relation to this risk at their next meeting.

20/015 ANNUAL CYCLE 2019/20

20/015.1 The Board noted the Annual Cycle 2019/20.

20/016 **MATTERS ARISING AND ACTIONS LOG**

20/016.1 The Board reviewed and noted the Actions Log.

20/017 **DATA PACK**

20/017.1 The Board noted the data pack.

20/018 **REPORTS FOR NOTING**

20/018.1 CTC Report to Board

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

20/018.1 Learning from Deaths

The Board noted the latest Learning from Deaths Report.

20/019 **DATE OF NEXT MEETING**

20/019.1 4 March 2020, Mount Vernon Cancer Centre.

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Ellen Schroder

Trust Chair

March 2020

East and North Hertfordshire NHS
NHS Trust

Chief Executive's Report

March 2020

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1. Corporate Update

COVID-19

The NHS in Hertfordshire and Public Health England (PHE) are extremely well prepared for outbreaks of new infectious diseases. The NHS has put in place measures to ensure the safety of all patients and NHS staff while also ensuring services are available to the public as normal.

There has been a lot of media speculation and at present, we are not treating any patients with coronavirus. There are plans in place for how we handle the testing of possible cases. Anyone being tested is kept in isolation and away from public areas. Public Health England has advised us on the appropriate safety measures including when and how to decontaminate testing areas.

Staff Survey

The 2019 NHS Staff Survey has recently been published. We had a 45% response rate which represents 2,605 completed questionnaires – a rise on the previous year. The results show that we are on track in many areas with signs of positive improvement; including an improvement in morale, staff engagement and team working.

62-day Cancer Standard Achieved

The Trust has been successful in improving our cancer pathway. In November, we achieved the 62-day standard for the first time since March 2015. This meant that 85.3% of our patients started their first cancer treatment within 62 days following an urgent GP referral.

2. Our Staff

Diabetic Eye Screening Team Achieve Highest Uptake in England

Congratulations to our diabetic eye screening team who have once again been rated as one of the best performing services in England, according to the screening key performance indicators published by PHE for the year 1 April 2018 to 31 March 2019.

The service was rated the best in England for the uptake of screening, with 91.8% of patients offered an appointment attending. They also reported that 99% of patients received their screening results within three weeks of their appointment and 90.1% of patients with referable proliferative diabetic retinopathy were seen in the ophthalmology department within six weeks of their screening appointment.

Congratulations to Ashwin Tamhankar, Senior Robotic Fellow at Lister Hospital, on being awarded first national prize at USICON 2020 – the 53rd annual Urological Society of India (USI) conference. The event in Kochi in India is attended by over 3,000 delegates from around the world and explores scientific and technological aspects of urology. Ashwin presented three papers and won first prize in the conference's 'USI got Talent' showcase for the fourth consecutive year for urology cancer research undertaken at the trust.

Well done to Lizzie Bessell, who gave a passionate and inspiring speech at the launch of the International Year of the Nurse and Midwife, held at the House of Lords. The event saw the launch of the new Florence Nightingale Foundation Academy, which develops nursing and midwifery leaders at all levels. It was attended by some of the most senior and influential people in NHS, including Secretary of State for Health and Social Care Matt Hancock and Simon Stevens, Chief Executive of NHS England.

East and North Hertfordshire NHS Trust

Agenda Item: 8

TRUST BOARD - PUBLIC SESSION – 4 MARCH 2020
Integrated Performance Report – Month 10

Purpose of report and executive summary (250 words max): The purpose of the report is to present the Integrated Performance Report Month 10 to the Trust Board. Key challenges and mitigations under each domain are identified within the report.		
Action required: For discussion		
Previously considered by: QSC – 25.02.20, FPPC – 24.02.20		
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	☒

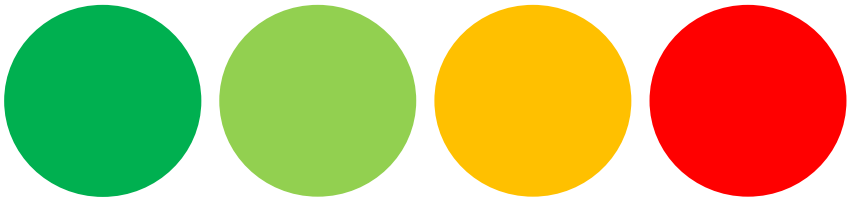
Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
Any other risk issues (quality, safety, financial, HR, legal, equality): Key challenges and mitigations under each domain are identified within the report.

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

East and North Hertfordshire NHS Trust

Integrated Performance Report

Month 10 | 2019-20



Data correct as at 21/02/2020

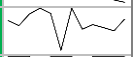
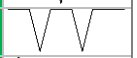
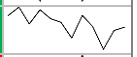
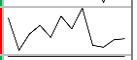
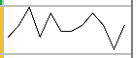
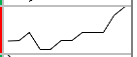
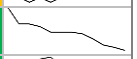
Contents

East and North Hertfordshire NHS Trust

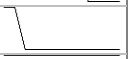
NHS Oversight Framework

East and North Hertfordshire NHS Trust

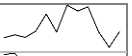
Quality of care

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
Overall	CQC rating	-	Dec-19	-	-	Requires improve-ment	
Caring	Written complaints - rate	Quarterly	Jan-20	Local	1.9	1.8	
Caring	Staff Friends and Family Test % recommended - care	Quarterly	Q2 2019-20	National	81.3%	78.9%	
Safe	Occurrence of any Never Event	Monthly (six-month rolling)	Aug-19 - Jan-20	National	0	2	
Safe	Patient Safety Alerts not completed by deadline	Monthly	Feb-20	National	0	6	
Caring	Mixed-sex accommodation breaches	Monthly	Jan-20	National	0	0	
Caring	Inpatient scores from Friends and Family Test - % positive	Monthly	Jan-20	National (excl. IS)	95.0%	96.2%	
Caring	A&E scores from Friends and Family Test - % positive	Monthly	Jan-20	National (excl. IS)	90.0%	91.3%	
Caring	Maternity scores from Friends and Family Test - % positive - antenatal care	Monthly	Jan-20	National (excl. IS)	93.0%	100.0%	
Caring	Maternity scores from Friends and Family Test - % positive - birth	Monthly	Jan-20	National (excl. IS)	93.0%	95.4%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal ward	Monthly	Jan-20	National (excl. IS)	93.0%	86.2%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal community	Monthly	Jan-20	National (excl. IS)	93.0%	100.0%	
Safe	Emergency c-section rate	Monthly	Jan-20	Local	15%	17%	
Organisational health	CQC inpatient survey	Annual	2018	National	8.0	7.8	
Safe	Venous thromboembolism (VTE) risk assessment	Quarterly	Q3 2019-20	National	95%	88.1%	
Safe	Clostridium difficile (C. difficile) plan: C.difficile actual variance from plan (actual number v plan number)	Monthly (YTD)	Apr-19 - Jan-20	National	0	6	
Safe	Clostridium difficile – infection rate	Monthly	Jan-20	NHSI	25.3	16.74	
Safe	Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Monthly (12-month rolling)	Feb-19 - Jan-20	National	0.60	2.88	
Safe	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	Monthly (12-month rolling)	Feb-19 - Jan-20	National	8.08	5.77	
Safe	Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI)	Monthly (12-month rolling)	Feb-19 - Jan-20	National	18.78	20.67	
Effective	Hospital Standardised Mortality Ratio	Monthly (12-month rolling)	Dec-18 - Nov-19	National	100	84.1	
Effective	Summary Hospital-level Mortality Indicator	Monthly (12-month rolling)	Oct-18 - Sep-19	National	100	90.1	
Safe	Potential under-reporting of patient safety incidents	Monthly (six-month rolling)	Aug-19 - Jan-20	National	58.2	46.0	

Finance

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
Financial sustainability	Capital service capacity	Monthly	Jan-20	National	1	4	
Financial sustainability	Liquidity (days)	Monthly	Jan-20	National	1	4	
Financial efficiency	Income and expenditure (I&E) margin	Monthly	Jan-20	National	1	3	
Financial controls	Distance from financial plan	Monthly	Jan-20	National	1	1	
Financial controls	Agency spend	Monthly	Jan-20	National	1	1	

Operational performance

A&E	A&E maximum waiting time of four hours from arrival to admission/transfer/discharge	Monthly	Jan-20	National	95%	81.5%	
RTT 18 weeks	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	Monthly	Jan-20	National	92%	83.3%	
Cancer Waiting Times	62-day wait for first treatment from urgent GP referral for suspected cancer	Monthly	Dec-19	National	85%	87.6%	
Cancer Waiting Times	62-day wait for first treatment from NHS cancer screening service referrals	Monthly	Dec-19	National	90%	100.0%	
Diagnostics Waiting Times	Maximum 6-week wait for diagnostic procedures	Monthly	Jan-20	National	1%	0.28%	
The number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who:							
Dementia assessment and referral	a. have a diagnosis of dementia or delirium or to whom case finding is applied	Monthly	-	National	95%	-	
	b. who, if identified as potentially having dementia or delirium, are appropriately assessed	Monthly	-	National	95%	-	
	c. where the outcome was positive or inconclusive, are referred on to specialist services	Monthly	-	National	95%	-	

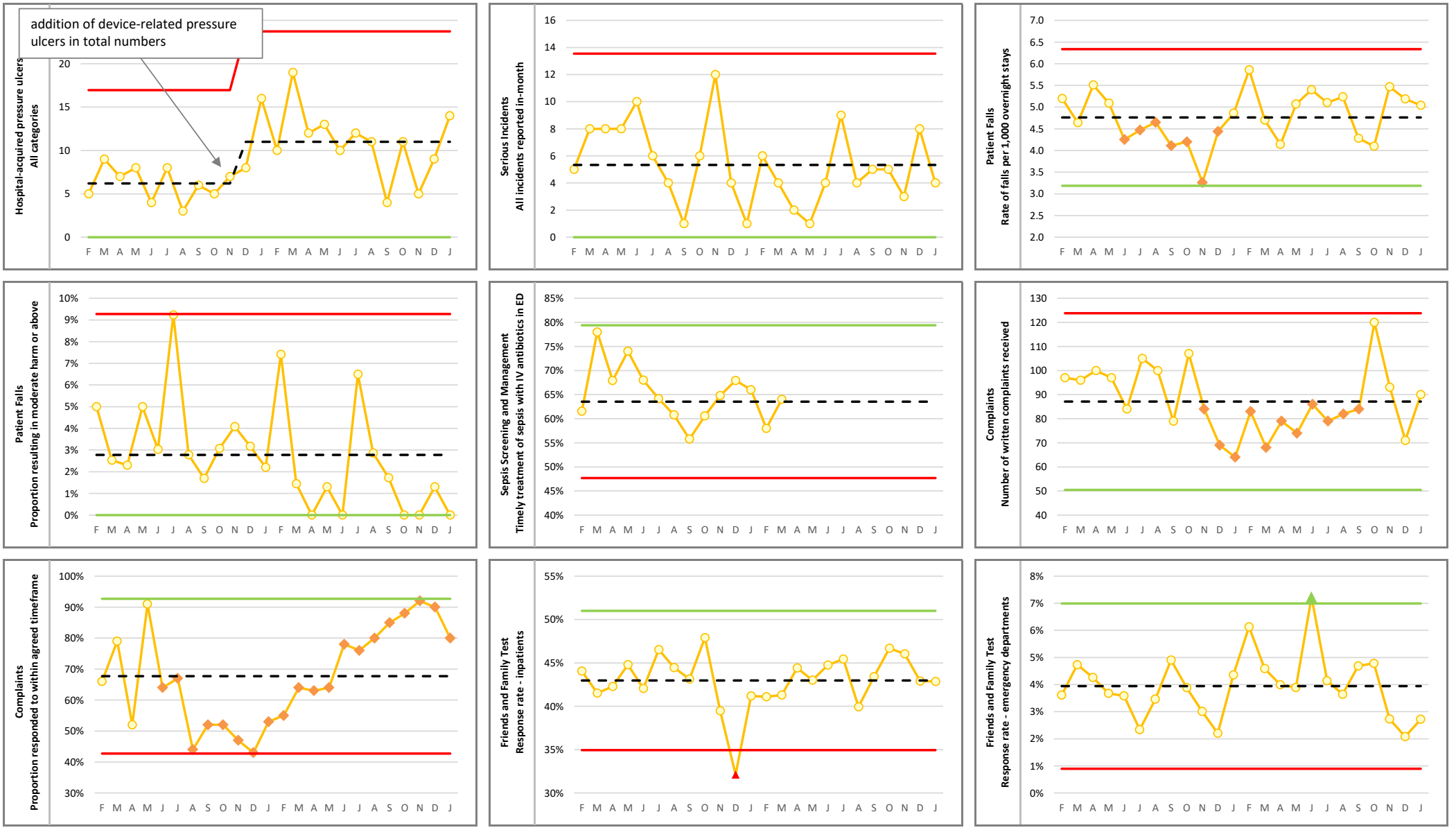
Leadership and workforce

Organisational health	Staff sickness	Monthly	Jan-20	Local	3.4%	4.4%	
Organisational health	Staff turnover	Monthly	Jan-20	Local	12.0%	12.8%	
Organisational health	Proportion of temporary staff	Monthly	Jan-20	Local	-	10.8%	
Organisational health	NHS Staff Survey Recommend as a place to work	Annual	2018	National	62.6%	53.9%	
Organisational health	NHS Staff Survey Support and compassion	Annual	2018	National	82.8%	80.0%	
Organisational health	NHS Staff Survey Teamwork	Annual	2018	National	65.4%	64.0%	
Organisational health	NHS Staff Survey Inclusion	Annual	2018	National	73.9%	71.8%	
Organisational health	BME leadership ambition (WRES) re executive appointments	Annual	2018	National	7.4%	0.0%	

Quality Improvement Dashboard

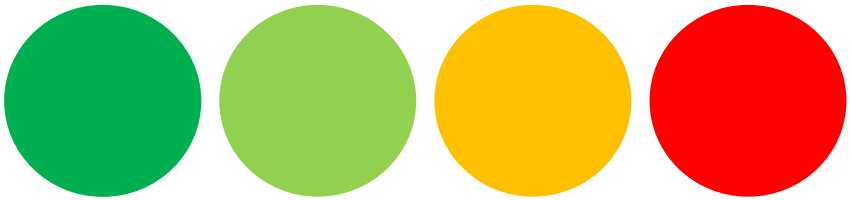
Safe, Caring and Effective Services Headline Metrics

East and North Hertfordshire NHS Trust



Safe Services

Month 10 | 2019-20



Key Issues

Safety Thermometer
- Harm-free care (for all and new harms) remain above target in January. All Harms (97.0%) continues to improve, while New Harms (98.5%) has dropped slightly from December (99.4%).

Patient Falls
- 70 inpatient falls were recorded in January
- There was 1 Serious Incident related to fall, sustaining a fracture in January.
- Our current rate of falls with moderate harm or above is 0.1/1000 bed days.

Serious Incidents & Never Events
- Zero Never Events were reported in January.
- There were 5 serious incidents reported in January:
  - Sharps contamination
  - Pressure ulcer
  - Deteriorating patient
  - Admissions related incidents (12 hr breach)
  - Fall, fracture sustained

Infection Control
- MRSA bacteraemia = 1 Hospital Onset cases and 0 Community Onset cases in January.
- C difficile infections = 3 reportable incidences in January.
- E.coli bacteraemia = 3 Hospital Onset cases in January.
- MSSA bacteraemia = 0 Hospital Onset cases in January.
- Klebsiella incidences = 0 Hospital Onset cases in January.
- Pseudomonas aerudinosa incidences = 0 Hospital-onset cases in January
- Hand hygiene compliance dropped slightly to 92.2% in January from 92.3% in December.

Hospital-acquired Pressure Ulcers
- There were the following reported for January:
  - Category 4 = 1
  - Category 3 = 0
  - Category 2 (D) = 9
  - MM (D) = 0
  - Unstageable = 1
  - Unstageable (D) = 2
  - SDTI excl. STDI (D) = 9
  - SDTI D (D) = 3

Sepsis
- ED overall 'sepsis 6' bundle compliance in January was 14%, decreasing from 73% in December.
- Each intervention is now measured separately:
  - Antibiotics administration within an hour IP (28%) and ED (68%) have both decreased for January compared to December IP (38%) and ED (79%).

VTE
- Potential harm from hospital acquired thrombosis is presented to Serious Incident Review panel. There were no HATs presented in Jan 2020.
- Plans are currently underway to report HAT numbers through IPR processes.

Executive Response

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

Patient Falls
- Through the falls CQUIN work we have continued to improve our prescribing stewardship of hypnotic and anti-psychotic drug administration.
- There continues to be efforts to improve the monitoring lying and standing BP in the prevention of falls.
- Early learning from our serious incident reported suggests inaccurate handover and subsequent mitigation of identified high r isk of falls.

Serious Incidents
- 24 cases were presented to SIRP in January.
- 3 cases led to root cause analysis reports, and others formed local learning.

Infection Control - High Impact Interventions (HII) with Lorraine
- It has been acknowledged the number of hospital acquired MRSA bacteraemia cases. Themes identified include IV access and poor risk assessment associate with VIP assessments. This has been identified as a Quality Improvement priority. An in-depth thematic analysis is currently under way and a 90-day QI programmes has commenced. Immediate clinical harm reviews have been undertaken and hot safety briefings have been held at trust Quality huddles and within clinical areas.
- While winter operational pressures due to Influenza and Norovirus have occurred within the hospital, this has been very well mitigated to minimise disruption to overall patient flow and safety.

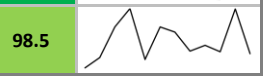
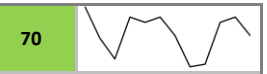
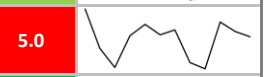
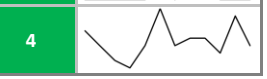
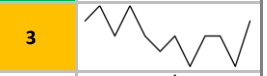
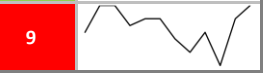
Hospital-acquired Pressure Ulcers
- Current YTD pressure ulcer reported = 124
- Unfortunately, we have reported a cat 4 skin damage in January. Early learning has identified inappropriate skin cleaning eq uipment in use to sacrum, and poor documentation of re-positioning and frequent non-compliance with re-positioning. Procurement work is underway to introduce stock and equipment more appropriate for skin cleansing in high risk patients.
- Every hospital acquired Pressure Ulcer is investigated by a Tissue Viability Nurse. This is to enable identification of gaps in care so that learning can be identified and delivered.
- 2019 saw a rise is secondary to adding in a new category of damage not previously reported following the new NHSI Recommendat ions.
- The trust improvement aims are: Zero tolerance for Category 3 and 4 Pressure Ulcers and a 20% reduction on All Other Categori es (n=69 for year 2019-20).
- 24% of wards are one year or more pressure ulcer free.

Sepsis
- Collaborative targeted work continues with AKI team, CCOT, 6a and 6b on fluid balance monitoring and how identifying areas fo r improvement.
- Future ePMA trial on Barley ward will facilitate more accurate measurement of stat doses of IVAB and IV fluid therapies admin istered.
- Common non-compliance themes (Emergency Department) include:
  - Urine output / fluid balance not measured from time of admission/deterioration - ED Team commenced improvement sessions focusing on Fluid Balance Monitoring and documenting urine output.
  - Some discrepancy with not all patients getting blood cultures or no times of BC taken in notes or sepsis proforma.
  - ABG machine not printing out lactate either due to machine being broken or clotted samples blocking the machine (POC) - ongoing issues.
- Common non-compliance themes (Inpatients) include:
  - Time to escalation by ward team after first red flag - recognition of sepsis, Drs still not wanting to take blood cultures unless there has been a temperature spike

VTE
- Thrombosis Action Group continues to meet bi-monthly.
- VTE improvement group meeting fortnightly to progress VTE/HAT restructure is led by Divisional Chair for CSS, current work in cludes cleansing of data provided by Lorenzo.
- Electronic prescribing work includes review and testing of digital medication chart and VTE risk assessments.

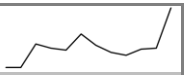
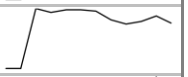
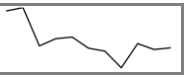
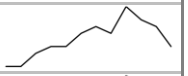
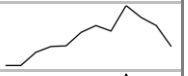
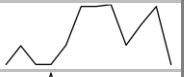
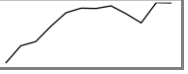
Safe Services

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Trend
Safety Thermometer	Harm-free care All harms	93.9	96.6	96.8	96.4	96.9	96.2	96.1	97.7	97.6	95.8	95.8	96.6	97.0	
	Harm-free care New harms	97.7	98.2	98.4	99.1	99.5	98.4	99.1	99.0	98.6	98.7	98.5	99.4	98.5	
Patient Falls	Number of patient falls	72	81	69	61	77	75	77	70	58	59	75	77	70	
	Rate of patient falls per 1,000 overnight stays	4.0	5.9	4.7	4.1	5.1	5.4	5.1	5.2	4.3	4.1	5.5	5.2	5.0	
	Number of patient falls resulting in serious harm	0	3	2	0	0	0	3	0	0	0	0	0	0	
Events and Incidents	Number of Never Events	0	0	0	0	0	0	1	0	1	1	0	0	0	
	Number of Serious Incidents	5	6	4	2	1	4	9	4	5	5	3	8	4	
Hospital-acquired Pressure Ulcers	Category 4	0	0	0	1	0	0	0	0	0	0	0	0	0	
	Category 3	0	0	0	0	0	0	0	0	0	0	1	0	0	
	Category 2	2	3	4	2	4	2	1	2	0	2	2	0	3	
	Category 2(D) Device-related	-	0	1	0	1	1	1	3	1	1	0	1	1	
	Mucosal membrane (D) Device-related	-	1	1	0	0	0	1	0	1	2	0	0	0	
	Unstageable	1	1	4	0	2	0	2	2	0	1	2	1	1	
	SDTI Excluding STDI (D)	3	5	9	9	6	7	7	4	2	5	0	7	9	
Sepsis Screening and Management	Inpatients with Sepsis - sample size	50	-	-	27	21	19	10	10	6	5	4	10	12	
	Inpatients receiving IVABs within 1 hour of Red Flag	90%	-	-	40%	40%	0%	40%	40%	17%	40%	50%	38%	28%	

Safe Services

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Trend
Sepsis Screening and Management	Emergency attendances with Sepsis - sample size	50	-	-	23	19	17	33	22	15	12	18	19	59	
	Emergency attendances receiving IVABs within 1 hour of Red Flag	90%	-	-	90%	84%	88%	88%	86%	73%	67%	71%	79%	68%	
	Sepsis six bundle compliance - ED	90%	-	-	tbc	tbc	tbc	48%	68%	40%	12%	22%	73%	14%	
VTE	VTE risk assessment	95%	95.9%	96.5%	88.2%	89.8%	90.2%	87.8%	87.2%	83.5%	88.8%	87.5%	87.9%	tbc	
Infection Control	Number of MRSA incidences	0	0	0	1	0	0	1	0	1	0	0	2	1	
	Rate of MRSA incidences per 100,000 bed days	0.6	0.0	0.0	5.7	0.0	0.0	5.8	0.0	6.0	0.0	0.0	11.5	5.6	
	Number of c.difficile incidences Healthcare-associated	4	-	-	2	3	3	5	6	5	9	7	6	3	
	Rate of c.difficile incidences per 100,000 bed days Healthcare-associated	19.0	-	-	11.4	16.6	17.1	28.8	34.6	29.8	51.9	41.7	34.6	16.7	
	Number of e.coli incidences	-	6	1	3	5	2	5	2	2	8	4	2	3	
	Rate of e.coli incidences per 100,000 bed days	18.5	37.1	5.6	17.1	27.7	11.4	28.8	11.5	11.9	46.2	23.9	11.5	16.7	
	Number of MSSA incidences	-	0	1	1	0	2	1	1	0	4	1	1	0	
	Rate of MSSA incidences per 100,000 bed days	8.0	0.0	5.6	5.7	0.0	11.4	5.8	5.8	0.0	23.1	6.0	5.8	0.0	
	Number of klebsiella incidences	-	0	1	0	0	1	3	3	3	1	2	3	0	
	Rate of klebsiella incidences per 100,000 bed days	7.6	0.0	5.6	0.0	0.0	5.7	17.3	17.3	17.9	5.8	11.9	17.3	0.0	
	Number of pseudomonas aerudinosa incidences	-	0	1	0	2	0	1	1	0	0	0	1	1	
	Rate of pseudomonas aerudinosa incidences per 100,000 bed days	3.7	0.0	5.6	0.0	11.1	0.0	5.8	5.8	0.0	0.0	0.0	5.8	5.6	
	Hand hygiene audit score	95%	76.3%	80.9%	82.0%	86.0%	89.6%	90.8%	90.7%	91.4%	89.3%	86.9%	92.3%	92.2%	

Caring Services

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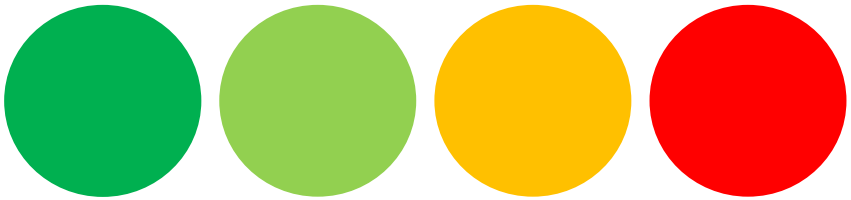


Key Issues

Friends and Family Test (FFT)

- The proportion of positive responses to the Inpatients, A&E, Antenatal, Birth, Community & Outpatients are better than the respective Trust Targets in January.
- The proportion of positive responses to Maternity - Postnatal (86.2%) is below the Trust Target in January.
- Response rates for Inpatients remains (42.9%) which is above the Trust target for January. A&E response rate has improved (2.7%) but remains below target. Maternity Birth has decreased (15.9%) from December (21.2%) and continues below Trust target.
- Total responses for Inpatients (1,975) & Outpatients (2,429) have both improved in January and are above their respective Trust targets.

Complaints

- Total number of complaints received since April 2019 = 858, with 90 complaints received in January 2020. The breakdown by division is as follows:
  - Surgery 41
  - Medicine 26
  - W&C 10
  - CSS 7
  - Cancer 4
  - Operations 2
- 100% of complaints received were acknowledged within 3 working days in January. 85% were responded to within the agreed timeframe in January 2020.
- Since April 2019 an average of 80% of complaints across the divisions have been responded to and closed within the agreed timeframe.

Executive Response

Friends and Family Test (FFT)

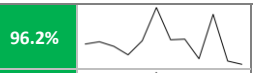
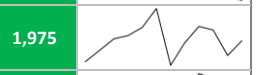
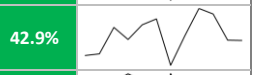
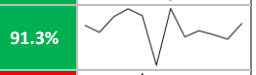
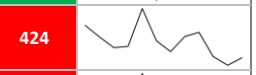
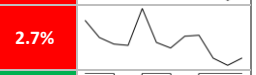
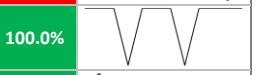
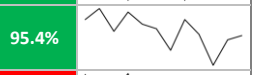
- The inpatient / day case percentage of patients who would recommend the Trust remains higher than the national average. The response rate continues to exceed the latest national average response rate of 21.8% and is above the Trust's target of 40%.
- The highest proportion of positive comments from inpatient / day case patients relate to staff being friendly, helpful and kind, and the care and treatment provided. Negative comments relate to the environment, communication about what is happening, noise at night and food.
- The majority of feedback from patients in A&E is positive particularly in relation to staff being kind and caring and providing an excellent service and good explanation about what is happening. Negative feedback mainly relates to the length of waiting times. 8 patients out of 424 who responded to the A&E FFT survey were unlikely or extremely unlikely to recommend the service.
- Outpatients compliment staff for being kind and helpful and for the care, treatment and information provided. There are concerns about waiting times in clinics directions to the clinics. Other concerns relate to appointment letters, administration of appointments and the cost of the car park.
- The majority of women compliment the staff for the support, care and information provided to them during their birth experience. On the postnatal ward 5 out of 65 women would not recommend the service. Women would like a quieter environment, more space, better provision of recliner chairs and more information about what's happening.

Improvement efforts - Complaints

- An improvement plan was to initially reduce the number of open complaints to less than 120 across all divisions within this Trust.
- This has been achieved and we have successfully maintained an average of 100 open complaints per month.

Caring Services

East and North Hertfordshire NHS Trust

Domain	FFT	Metric	Target	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Trend
Friends and Family Test	Inpatients	Proportion of positive responses	95%	96.8%	96.8%	96.7%	96.4%	96.9%	97.8%	96.9%	96.9%	96.3%	97.6%	96.3%	96.2%	
		Total number of responses	1,778	1,791	1,889	1,994	2,022	2,095	2,263	1,760	1,959	2,102	2,071	1,847	1,975	
		Response rate	40%	41.1%	41.3%	44.4%	43.0%	44.8%	45.4%	39.9%	43.4%	46.7%	46.0%	42.9%	42.9%	
	A&E	Proportion of positive responses	90%	90.9%	89.7%	92.5%	93.9%	92.7%	83.8%	94.0%	88.9%	90.0%	89.3%	88.5%	91.3%	
		Total number of responses	1,241	806	671	546	559	1,008	624	498	676	727	439	338	424	
		Response rate	10%	6.1%	4.6%	4.0%	3.9%	7.2%	4.1%	3.6%	4.7%	4.8%	2.7%	2.1%	2.7%	
	Maternity	Antenatal care Proportion of positive responses	93%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	100.0%	
		Birth Proportion of positive responses	93%	98.1%	100.0%	96.1%	99.4%	97.3%	96.5%	92.9%	98.1%	95.6%	90.3%	94.6%	95.4%	
		Birth Total number of responses	137	157	71	128	159	74	115	98	106	135	124	93	95	
		Birth Response rate	30%	39.1%	16.3%	30.5%	34.6%	17.4%	24.5%	22.3%	23.7%	28.6%	27.9%	21.2%	15.9%	
		Postnatal ward Proportion of positive responses	93%	91.7%	83.1%	87.4%	89.7%	86.5%	92.2%	88.8%	94.3%	84.4%	83.9%	85.9%	86.2%	
		Postnatal community Proportion of positive responses	93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Outpatients	Proportion of positive responses	95%	94.4%	95.5%	94.5%	96.2%	95.8%	95.4%	95.4%	94.5%	94.8%	95.0%	95.8%	96.8%	
		Total number of responses	-	2,281	5,320	1,980	4,100	3,943	3,613	3,313	2,448	3,127	2,133	1,777	2,429	
Complaints		Number of written complaints received	92	83	68	79	74	86	79	82	84	120	93	71	90	
		Rate of written complaints received	1.9	1.6	1.3	1.6	1.4	1.7	1.5	1.8	1.7	2.2	1.8	1.6	1.8	
		Proportion of complaints acknowledged within 3 working days	75%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
		Proportion of complaints responded to within agreed timeframe	80%	55%	64%	63%	64%	78%	76%	80%	85%	88%	92%	90%	80%	

Effective Services

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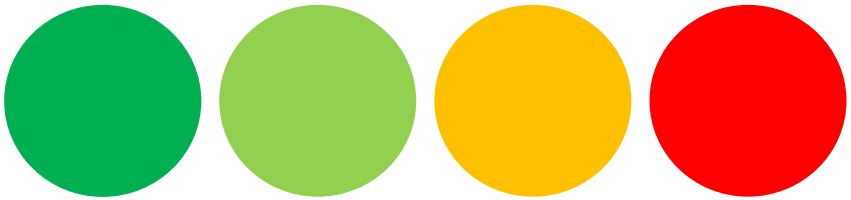


Key Issues

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

Crude Mortality
- The in-month crude mortality rate increased to 14.2 deaths per 1,000 admissions in January.
- The rolling 12-months crude mortality rate is at 10.9 deaths per 1,000 admissions in the 12 months to January, and was lower than the most recently available national rate of 11.5 deaths per 1,000 admissions (Dec-18-Nov-19).

Hospital-Standardised Mortality Ratio (HSMR)
- The in-month HSMR improved to 74.9 in November, and remained better than the standard (100).
- The rolling 12-months HSMR improved to 84.1 in the 12 months to November, and the Trust remains in the second-best performing quartile of Trusts for HSMR.
- Dr Foster showed no outlying diagnosis groups in the latest data refresh.
- HSMR is usually available 2 months in arrears.

Summary Hospital-level Mortality Indicator (SHMI)
- The latest SHMI release for the 12 months to September saw a slight improvement to 90.06.
- Dr Foster currently shows 2 diagnosis groups with significantly elevated SHMI: Congestive Heart Failure and Biliary tract disease.
- SHMI is now available on a monthly basis, 4-5 months in arrears. This should improve the timeliness of our investigation into areas of potential concern.

Re-admissions
- The total re-admission rate increased from 8.8% in October to 9.2% in November 2019.

Learning from Deaths
- Where mortality reviews give rise to significant concern regarding the quality of care or the avoidability of the death, the case is subject to further scrutiny and discussion at the relevant Specialty clinical governance forum. The outcomes of these reviews are then considered by the Mortality Surveillance Committee.

Executive Response

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

Crude mortality
- This measure is available the day after the month end and has demonstrated a consistent decrease over the last 5 years. It is the factor with the most significant impact on HSMR.
- The improvements in mortality have been as a result of a combination of corporate level initiatives such as the mortality review process and more directed areas of improvement such as the identification and early treatment of patients with sepsis, stroke, etc.
- While our crude mortality has steadily improved over recent years, up until the rolling 12 months to May 2019, the Trust's crude mortality rate remained higher than the national average. Since this point in time our crude rate has continued to fall and our performance has been consistently better than the national average, although the last two months have seen an increase in crude mortality that needs to be monitored.

Hospital Standardised Mortality ratio (HSMR)
- While our current HSMR of 84.1 makes us well-positioned in the second lowest quartile of Trusts, we remain focussed on driving further improvement.

Summary Hospital-level Mortality Indicator (SHMI)
- Following significant improvements to SHMI, there has now been a sustained period of stability, within the lower end of the 'as expected' band 2. The latest figure of 90.06 sees the Trust best placed in the 'as expected' band. This places us 16th nationally out of all acute non-specialist trusts, with the 15 trusts above us sitting in the 'better than expected' band 3.

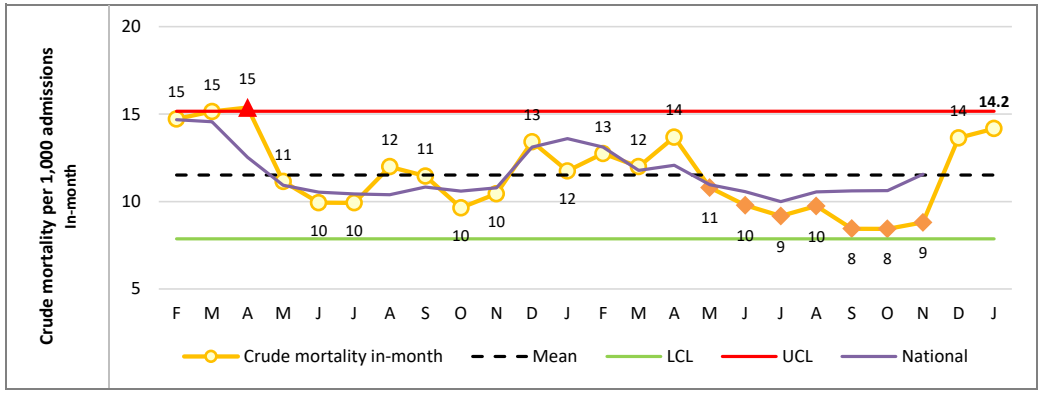
Re-admissions
- The Trust's re-admission rate has generally been consistent with the national performance. The most recent comparable month (8.8%, Oct-19) was higher than the national average (8.5%), and the Trust rate increased by 0.4% from October to November.

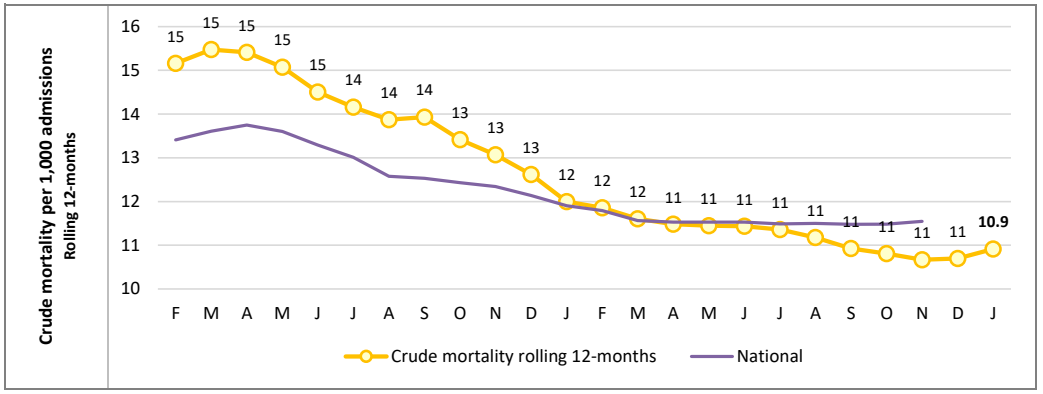
Learning from Deaths
- In addition to the outcomes of cases escalated to Specialties being considered by the Mortality Surveillance Committee (where proposed remedial/development action is approved/recommended), the quarterly Learning from Deaths report includes a summary of key themes emerging from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

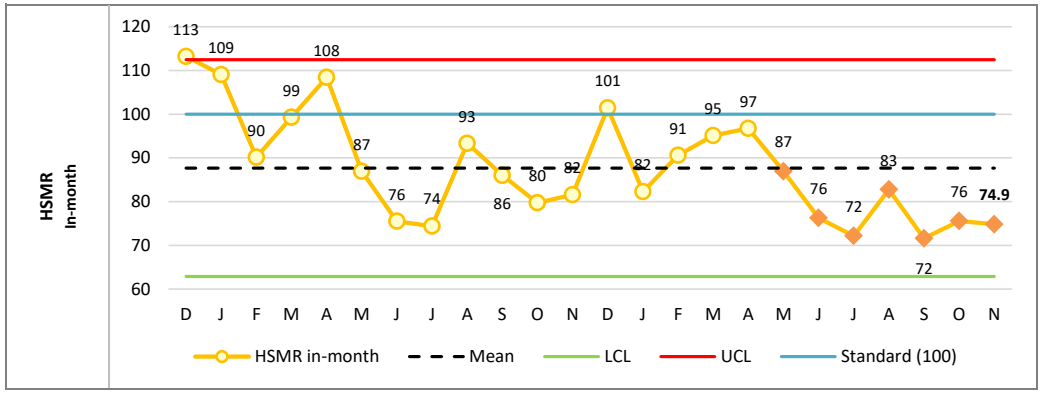
Specialist Palliative Care
- This data refers solely to patients under the care/review of the Palliative Care Team. Other data is available for deaths that are not known to the PCT. However, it resides in an access database and we are currently

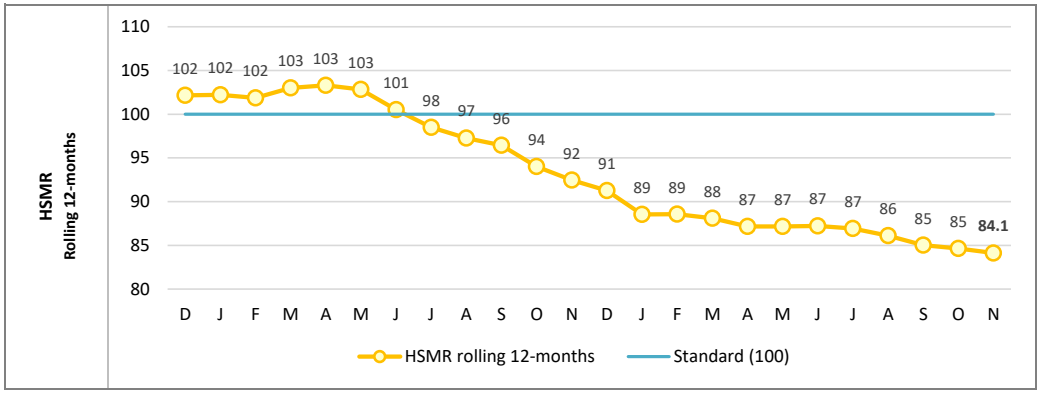
Effective Services

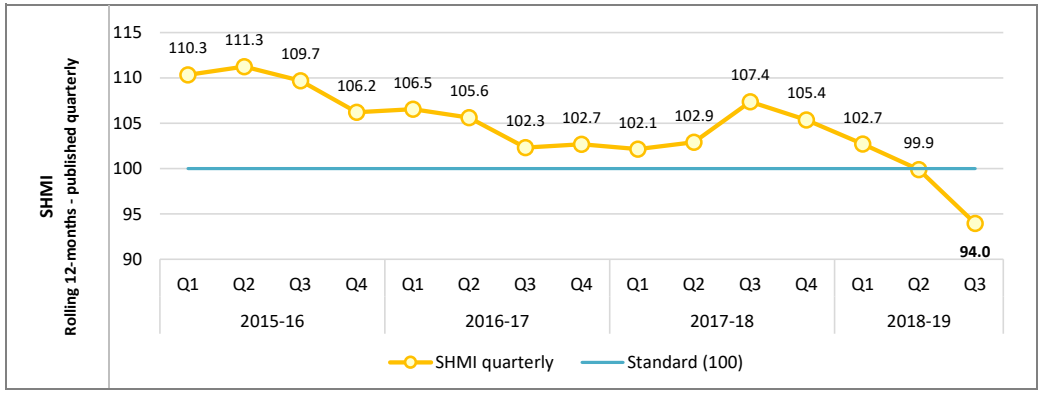
East and North Hertfordshire NHS Trust

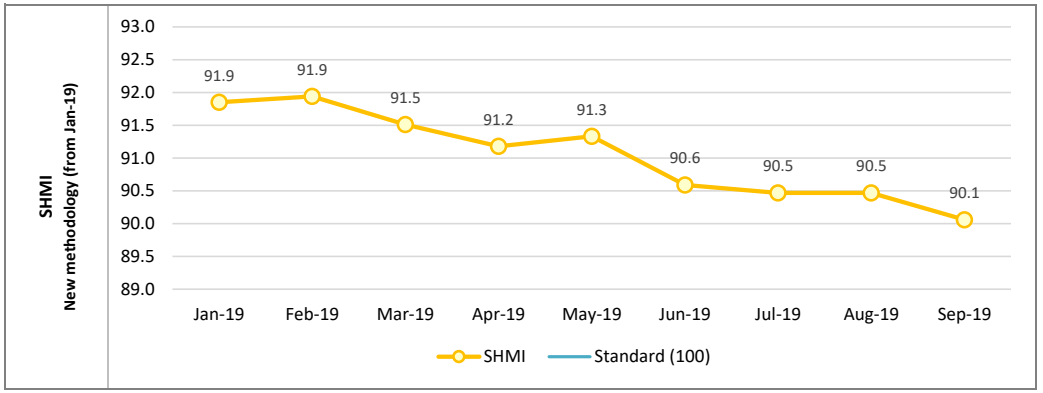






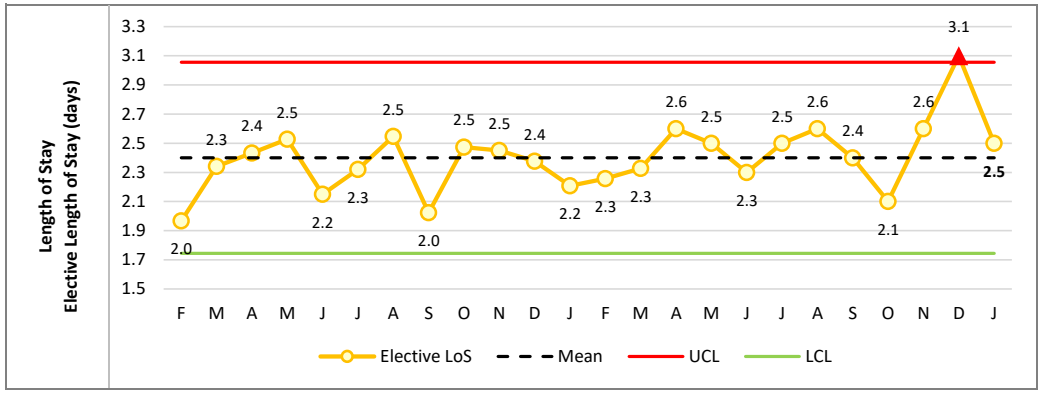


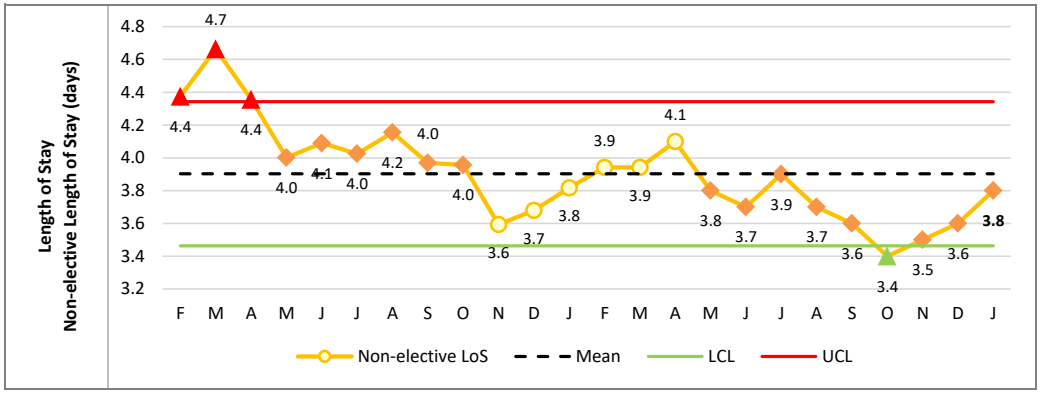


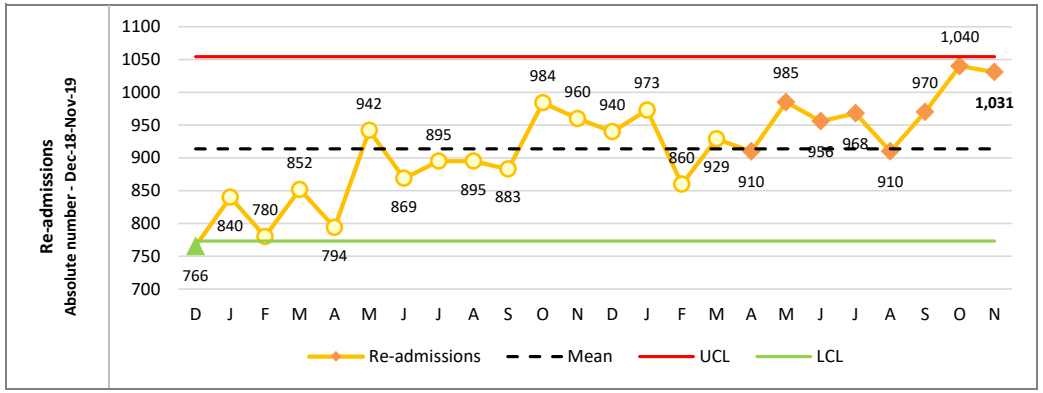


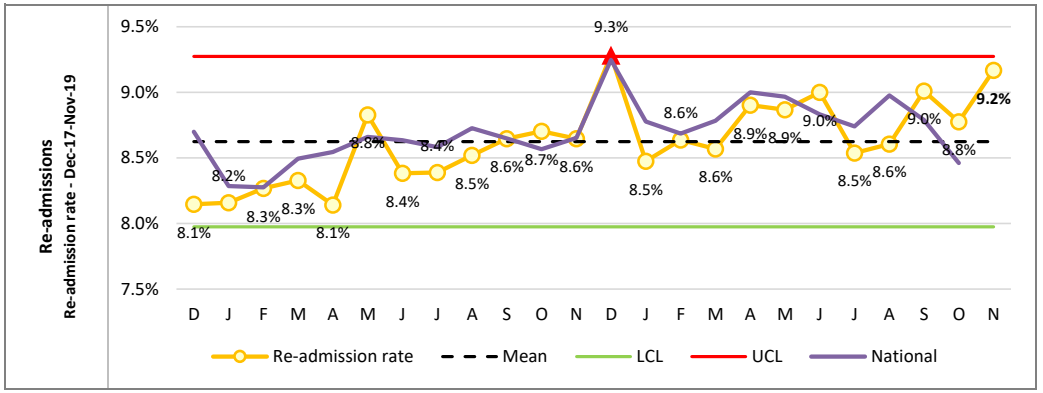
Effective Services

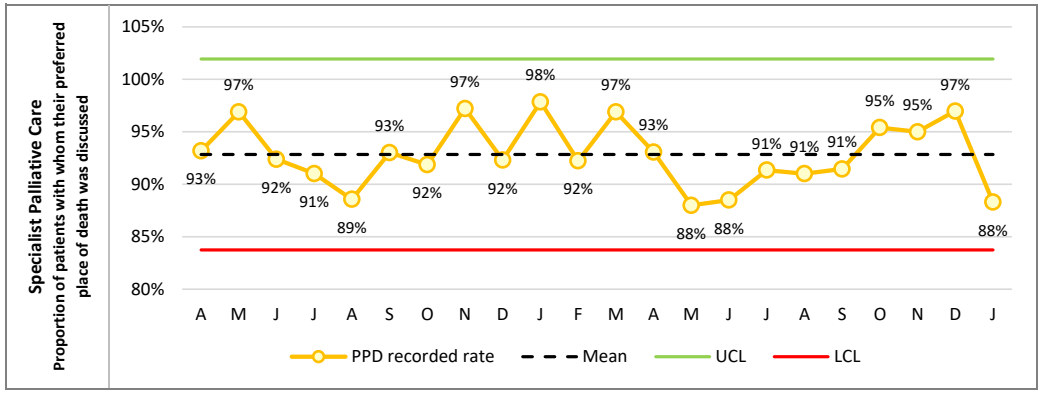
East and North Hertfordshire NHS Trust

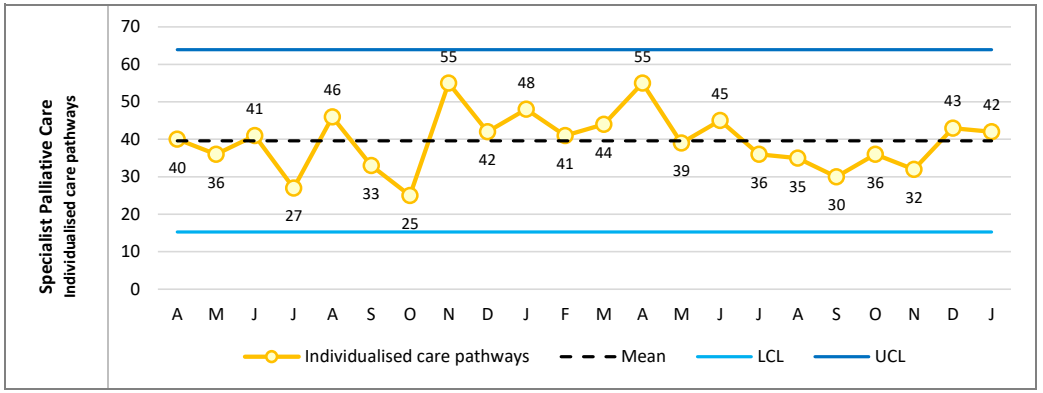






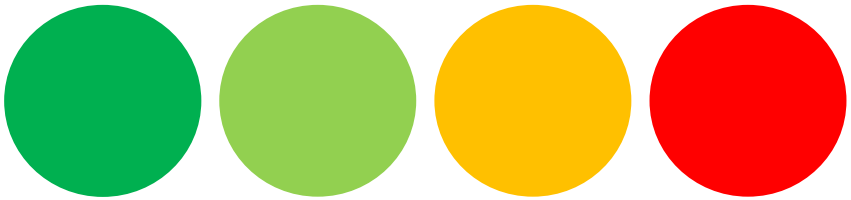






Responsive Services

Month 10 | 2019-20



Key Issues

A&E
- Performance for the month of January 2020 was 81.54%.
- There was one 12-hour trolley wait reported in January.

Cancer Waiting Times
- In December 2019 the Trust achieved 7 out of the 8 national targets for cancer performance.
- The Trust 62-day performance for December 2019 was 87.6%, which is above the trajectory of 85.4% and the November position of 85.3%. The Trust has achieved this standard after a period of 4 years and 8 months.
- Good progress is being made on the speciality cancer action plans, all plans being reviewed and updated weekly.
- The capacity challenges with specialist treatments such as RALP, Brachytherapy, PET scans and histology, have now been addressed and plans are in place to deliver sufficient capacity to deliver and maintain Trust's 62-day performance.
- Commitment has been obtained from IMAS to support the Trust with ongoing work with:
  - Critical review of service specific MDT and PTL meetings with written feedback;
  - Histology Demand & Capacity model has been completed and awaiting final report from IST. Pathway analysis for Histology services in process to be completed by February 2020;
  - Pathway analysis for Breast, LGI and UGI in process to be completed by February 2020.
  - Continue to Work to deliver the 28-day faster diagnosis target, which is currently at 65.2% compliance;
  - Development of metrics to demonstrate improvements in the performance whilst working to delivery of recovery trajectory.

RTT
- Incomplete performance for January was 83.27%, an improvement from the 83.05% reported in December.
- The January backlog was 7,402, an increase of 207 from December.
- There were 22 52-week breaches reported in the January incomplete position, a reduction of three from the 25 reported in December.
- The focus in 2020 is on RTT with a recovery action plan supported by D&C modelling and a PTL strategy to minimise 52 week breaches.

Diagnostics
- DM01 performance for January was 0.28% against the national standard of 1% and the November position of 0.46%. This standard has remained compliant since June 2019.

Stroke
- Performance for January 40.6% - impact is partly due to the impact on the Bed capacity for the prior months- as the data is taken from Discharge data - so therefore patient admissions' from November/December that breach due to Bed capacity are counted against the discharged month performance.
- Direct impact mainly due to bed flow within the HASU and Acute Stroke unit to manage demand– this therefore results in the patient being outlied into other Ward areas - which is a direct breach for the 4hr target. With Opel 3 status recorded within the month of January
- High demand on Rehab beds within the Community and due to the wait for Rehab beds - escalated daily via the Con Call and up to date list provided - this has had a direct impact on the flow to Rehab beds, since the introduction of in-reach service - ongoing review with HCT to review the pathway.
- Thrombolysis rate at January 5.4% Performance decline is as a direct result of the demand on the Ambulance service and ED dept. Patients would have arrived at the Hospital outside the Thrombolysis window
- Thrombolyised within 60-minutes of arrival January 25% - performance is a direct result of the demand within the ED and impact on Ambulance service to support adherence to the 60min arrival target - this has been highlighted with EEAST and is being reviewed internally - regarding the achievement of the Target - whist managing high demand.
- Impact on LoS due to limited resource from supporting services for delivery of therapy review to support discharge planning - due to vacancy rate.
- Increase in LoS over the weekend due to limited access to Diagnosis services and reduced Therapy cover over the weekend.
- Ring fence of Stroke beds of 6 beds per day - based on review of Jan - Dec 19 data on admission vs discharges - on average 4 admission to 4 discharges per day - this pattern doesn't support the surplus of bed requirement to manage the variance of demand.
- Combined Average LoS for January 9.90 for both Pirton and Barley - compared to Jan to Sept Cumulative average of 8.30 LoS.

Executive Response

A&E
- The trust ED performance in January 2020 showed improvement compared to December 2019. In January 2020 ENHT was 7th highest performance regionally. Work streams continue into February to improve performance, one example being a pilot to relocate minors into CDU BBay. This will release some much needed assessment and treatment cubicles in Majors Sub-Wait for improved flow of ambulant majors patients.
- The 12-hour trolley breach was associated to a resus patient allocated the only available ITU bed at the time. However, a patient in higher need of the bed was admitted instead. The patient that breached was eventually admitted to an RSU bed once it became available. A full RIR was completed.
- Positively, ambulance handovers completed within 15 minutes continued to improve in January. ENHT achieved 58%. Also average handover times remained above regional average.

Cancer performance (December)
- In December 2019, the Trust achieved 7 of the 8 national targets for cancer performance: 2ww and 2ww Breast Symptoms; and 31-day subsequent for Radiotherapy, Chemotherapy, 1st definitive treatment, 62-day referral to treatment from screening and 62-day referral to treatment for all cancers. Cancer performance is available one month in arrears.
- The Trust has always previously delivered against the 2ww national standard which requires 93% of patients referred on a two-week pathway by their GP to have attended the 1st Outpatient appointment within 14 days. For December 2019 the Trust performance was 97.9 % which equates to 1,334 out of 1,363 pathways meeting the two-week standard, with 29 breaches of the standard being reported.
- In December 2019, the Trust wide average days wait for first appointment is at 10 days and the majority of patients were seen between 8 and 12 days.
- The Trust has not consistently delivered against the Breast Symptomatic national standard which requires 93% of patients referred to have attended the 1st Outpatient appointment within 14 days. For December 2019 the Trust performance was 95.5% which equates to 128 out of 134 pathways meeting the 2-week standard, with 6 breaches of the standard being reported and all were patient choice.
- The Trust has consistently delivered the 31-day second or subsequent treatment for Radiotherapy and Chemotherapy. For December 2019 the Trust Chemotherapy performance was 99.5% which equates to 182 out of 183 pathways meeting the 31 day standards, with 1 breach. For December 2019 the Trust Radiotherapy performance was 99.3% which equates to 269 out of 271 pathways meeting the 31 day standards, with 2 breaches of the standard reported.
- The Trust performance for 31-day to first definitive treatment was 98.3% which equates to 230 out of 234 pathways meeting the 31-day standard, with 4 breaches of the standard reported. The standard requires 96% of patients to receive treatment within 31 days of diagnosis.
- In December 2019 the Trust performance for the Faster Diagnosis is 65.2% for the 2ww patients and 54.3% for the screening patients. Action plans have been put in place for the FDS to improve performance and meet the target by April 2020.
- Reported 62-day performance for December 2019 was 87.6%, which equates to 113.5 out of 129.5 pathways meeting the 62-day standard, with 16.0 breaches of the standard reported. The trust post sharing performance is above the revised recovery trajectory of 85.4%.

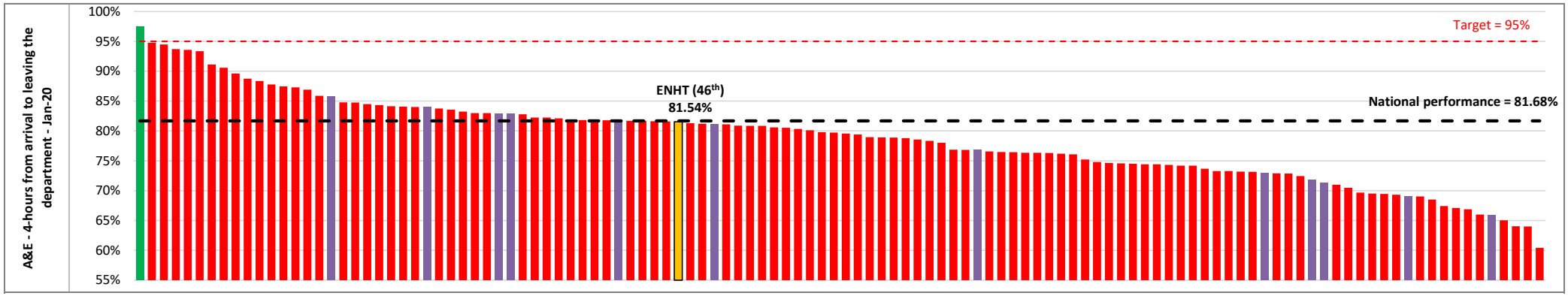
RTT
- Performance improved very slightly in January but remains significantly below our trajectory. Backlog pressures in the T&O, Oral, Pain and Gastroenterology continue to be the main contributors to this performance. Increasing demand and capacity constraints are the drivers. Plans to improve the position remain in development in these areas.
- The Trust reported 22 52-week breaches. All these breaches occurred in Surgical specialties, with the largest proportion occurring in Pain.
- Operational grip is improving and more robust PTL management is in place.
- Additionally:
  - training has been undertaken with the operational managers in both RTT and PTL management,
  - support has been given by NHSI and the NECSU which includes RTT validators,
  - analysis of the incomplete PTL has been completed and report issued to the Trust on the opportunities.

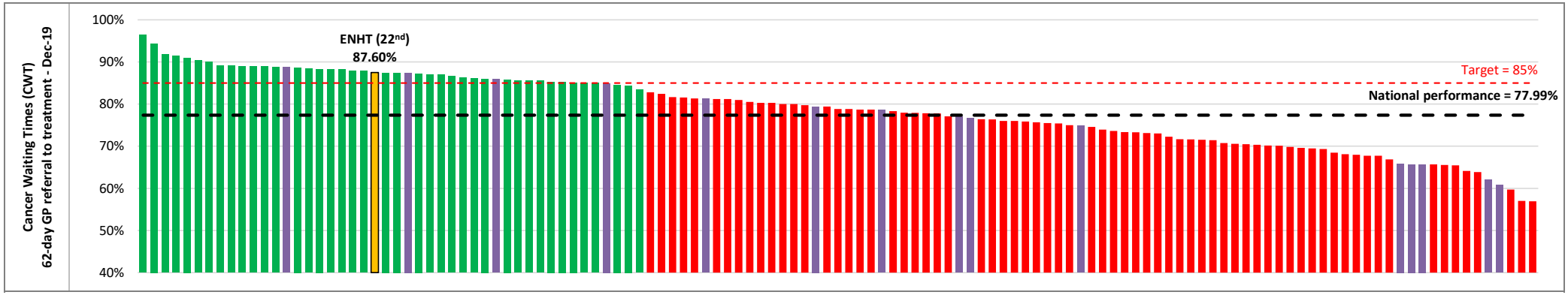
Diagnostics
- Diagnostics performance in January remains strong at 0.28%. Only 3 patients waited longer than 13 weeks which is a significant improvement on previous months. The elimination of 13-week breaches in diagnostic services is our current priority whilst maintaining the compliant position overall.

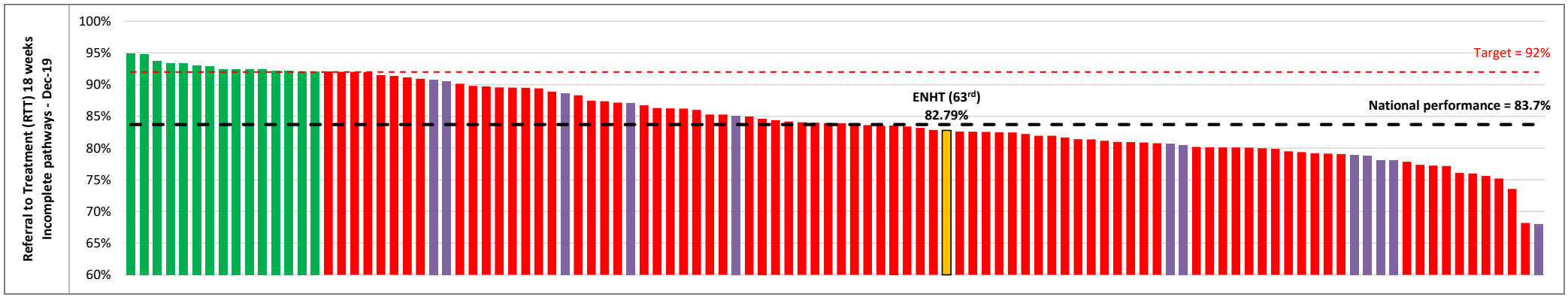
Responsive Services

Trust performance against all Trusts nationally

East and North Hertfordshire NHS Trust



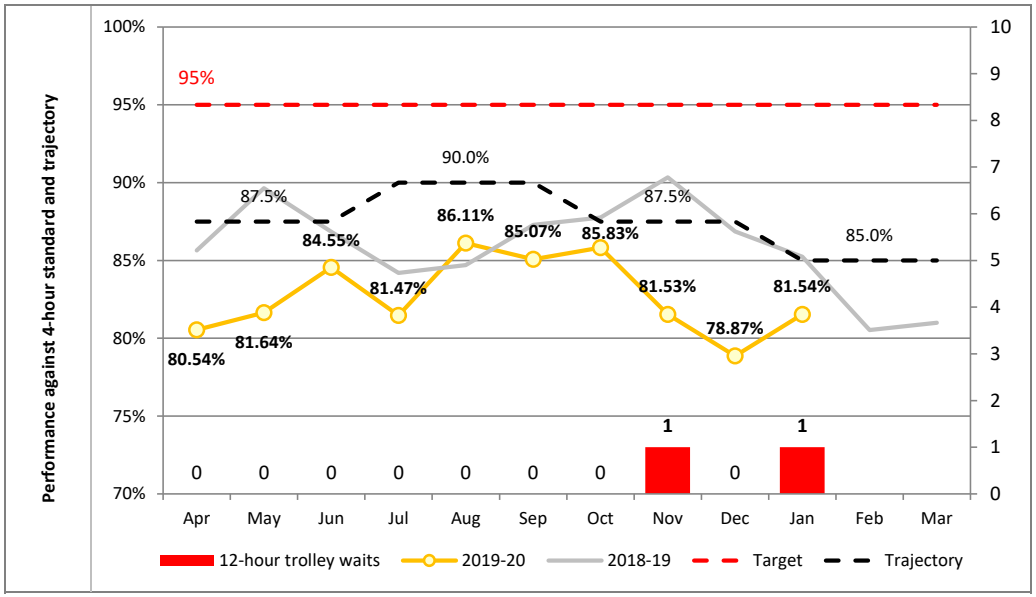




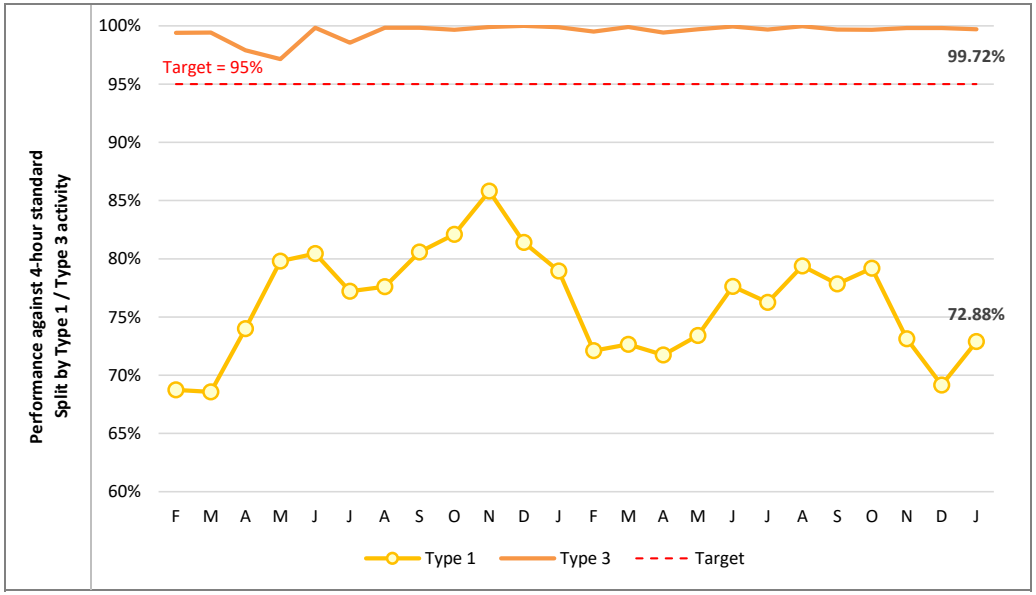
Responsive Services

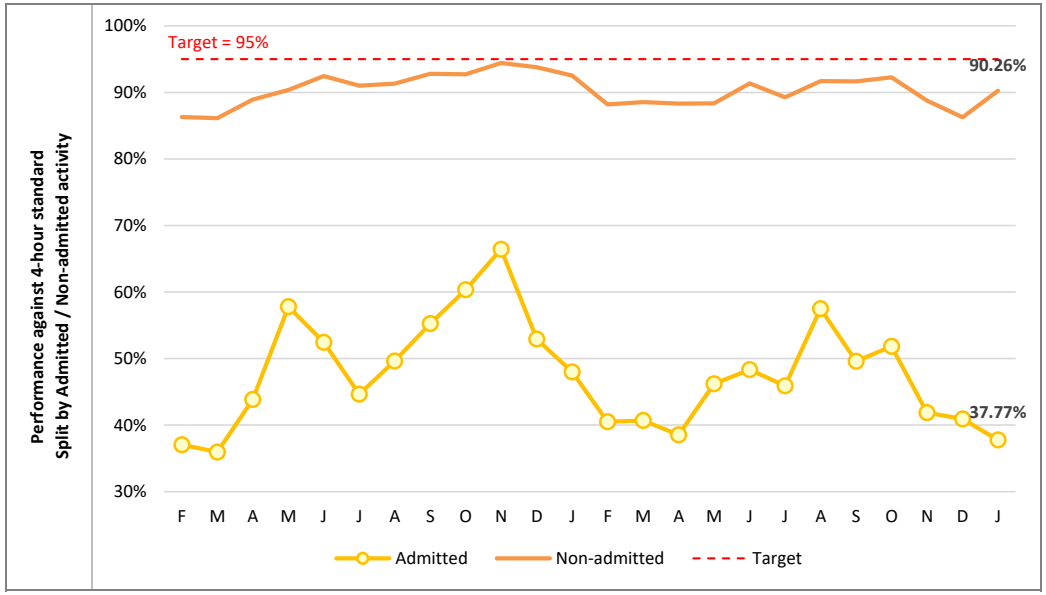
Emergency Department Performance

East and North Hertfordshire NHS Trust



Domain	Metric	Target	Dec-19	Jan-20	Change	Trend
Other Emergency Department measures	Ambulance handovers Proportion within 15 minutes	-	58%	tbc	◀▶	
	Ambulance handover breaches 30-minutes	230	453	tbc	◀▶	
	Ambulance handover breaches 60-minutes	43	119	tbc	◀▶	
	Attendance to admission conversion rate	-	35.4%	35.8%	▲	
	Time to initial assessment 95th centile	15	62	64	▲	
	Time to treatment Median	60	102	89	▼	
	Left department before being seen for treatment	5%	2.3%	1.0%	▼	
	Unplanned re-attendance rate	5%	5.28	4.83	▼	





Responsive Services

Cancer Waiting Times

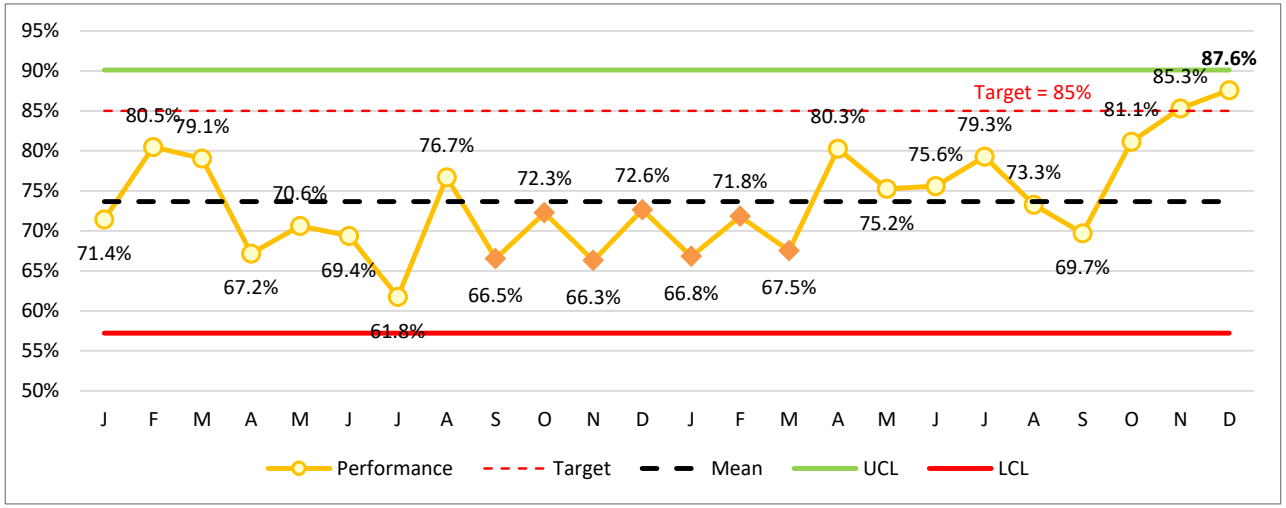
East and North Hertfordshire NHS Trust

12-months' performance - all standards

Standard	Target	2018-19				2019-20									
		Jan-19	Feb-19	Mar-19	YTD	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	YTD
Two week waits Suspected cancer	93%	95.61%	96.57%	97.00%	94.77%	95.94%	95.59%	96.66%	96.15%	94.80%	97.22%	98.50%	97.43%	97.87%	96.69%
Two week waits Breast symptomatic	93%	94.50%	94.02%	94.00%	92.56%	88.68%	92.68%	93.39%	94.78%	87.30%	95.76%	95.37%	98.39%	95.52%	93.35%
31-day First definitive treatment	96%	96.00%	95.15%	94.47%	93.86%	93.52%	94.93%	91.90%	97.01%	96.97%	95.98%	96.88%	99.00%	98.29%	96.04%
31-day subsequent treatment Anti-cancer drugs	98%	98.66%	99.37%	98.26%	99.00%	98.19%	97.81%	99.29%	99.07%	99.42%	99.41%	99.48%	100.00%	99.45%	99.13%
31-day subsequent treatment Radiotherapy	94%	95.05%	97.97%	95.68%	95.11%	96.90%	98.27%	98.86%	96.32%	97.53%	97.27%	98.25%	96.54%	99.26%	97.66%
31-day subsequent treatment Surgery	94%	63.64%	76.47%	78.79%	75.57%	96.77%	80.00%	78.95%	77.42%	83.33%	85.19%	65.52%	84.21%	93.55%	82.92%
62-day GP referral to treatment	85%	66.80%	71.82%	67.52%	69.09%	80.25%	75.25%	75.58%	79.26%	73.28%	69.71%	81.14%	85.31%	87.60%	78.66%
62-day Specialist screening service	90%	72.73%	79.17%	95.24%	79.61%	81.82%	100.00%	63.64%	56.00%	82.35%	73.68%	100.00%	69.23%	100.00%	79.77%

62-day GP referral to treatment Dec-19

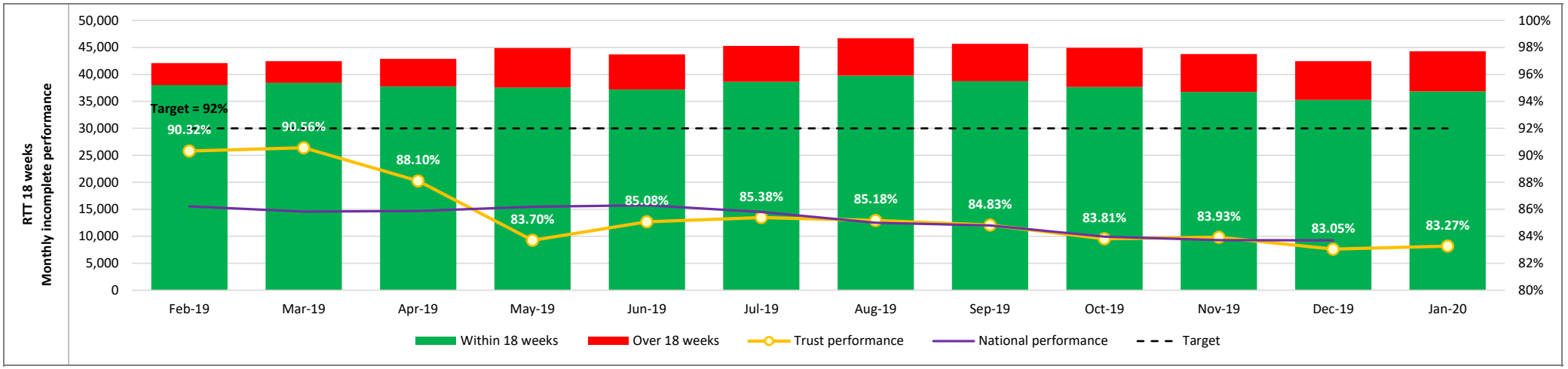
Tumour Site	OK	Breach	Total	Perf.
Breast	14.0	1.0	15.0	93.33%
Gynaecology	8.0	2.5	10.5	76.19%
Haematology	5.0	1.0	6.0	83.33%
Head and Neck	4.0	2.0	6.0	66.67%
Lower GI	15.0	3.5	18.5	81.08%
Lung	4.5	3.5	8.0	56.25%
Other	0.0	0.0	0.0	-
Skin	22.0	0.0	22.0	100.00%
Testicular	1.0	0.0	1.0	100.00%
Upper GI	8.0	2.5	10.5	76.19%
Urology	31.5	0.0	31.5	100.00%
Total	**113.0**	**16.0**	**129.0**	**87.60%**



Responsive Services

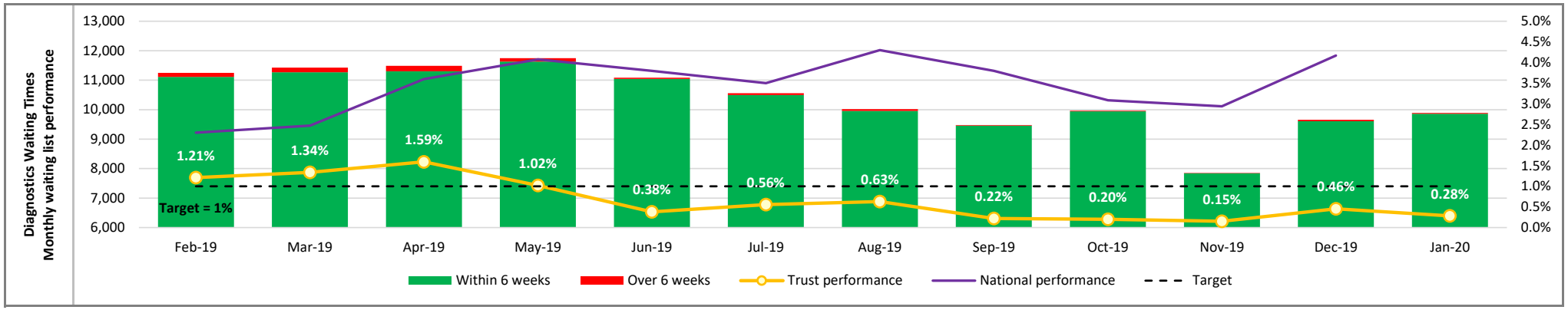
RTT 18 weeks

East and North Hertfordshire NHS Trust



RTT 18 weeks
In-month performance by Specialty - Jan-20

Specialty	Clock Stops - Admitted			Clock Stops - Non-admitted			Incomplete pathways						Clock Starts
	Total	Performance	Over 52 weeks	Total	Performance	Over 52 weeks	Within 18 weeks	Over 18 weeks	Total	Performance	Over 40 weeks	Over 52 weeks	
General Surgery	230	56.09%	0	317	84.54%	0	2,411	409	2,820	85.50%	14	0	1,012
Urology	160	68.75%	0	378	93.12%	0	1,730	179	1,909	90.62%	7	0	861
Trauma & Orthopaedics	97	44.33%	0	515	71.26%	1	2,757	743	3,500	78.77%	83	8	935
Ear, Nose & Throat (ENT)	166	55.42%	0	734	83.51%	0	2,433	289	2,722	89.38%	17	1	1,145
Ophthalmology	125	22.40%	0	674	80.56%	0	3,282	406	3,688	88.99%	15	0	1,090
Oral Surgery	88	6.82%	0	415	43.86%	0	1,877	637	2,514	74.66%	26	1	638
Plastic Surgery	114	71.93%	0	575	95.48%	0	1,029	79	1,108	92.87%	5	0	780
Cardiothoracic Surgery	2	0.00%	0	17	76.47%	0	14	3	17	82.35%	0	0	11
General Medicine	1	100.00%	0	189	100.00%	0	1,018	2	1,020	99.80%	0	0	584
Gastroenterology	194	57.22%	0	311	55.95%	0	3,016	946	3,962	76.12%	32	1	1,135
Cardiology	64	85.94%	0	1,066	65.57%	0	2,991	450	3,441	86.92%	7	0	1,171
Dermatology	0	-	0	296	83.45%	0	892	117	1,009	88.40%	3	0	364
Thoracic Medicine	18	77.78%	0	300	78.67%	0	1,130	166	1,296	87.19%	10	0	487
Neurology	1	0.00%	0	450	89.11%	0	1,262	57	1,319	95.68%	2	0	510
Rheumatology	2	100.00%	0	179	40.78%	0	831	329	1,160	71.64%	6	0	221
Geriatric Medicine	0	-	0	58	91.38%	0	116	9	125	92.80%	0	0	61
Gynaecology	90	61.11%	0	416	84.86%	0	2,408	359	2,767	87.03%	35	3	1,050
Other	122	53.28%	0	2,747	82.05%	1	7,658	2,222	9,880	77.51%	191	8	3,862
Total	**1,474**	**53.80%**	**0**	**9,637**	**78.51%**	**2**	**36,855**	**7,402**	**44,257**	**83.27%**	**453**	**22**	**15,917**



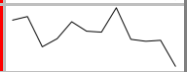
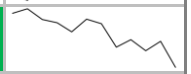
Diagnostics Waiting Times
In-month performance by Modality - Jan-20

Category	Modality	Patients still waiting at month end					Number of tests / procedures carried out during the month			
		Within 6 weeks	Over 6 weeks	Total	Performance	13+ weeks	Waiting List	Planned	Unscheduled	Total
Imaging	Magnetic Resonance Imaging	1,484	1	1,485	0.07%	0	2,343	172	2	**2,517**
	Computed Tomography	1,090	5	1,095	0.46%	0	2,877	547	1,643	**5,067**
	Non-obstetric ultrasound	4,507	0	4,507	0.00%	0	5,823	475	62	**6,360**
	DEXA Scan	317	0	317	0.00%	0	296	31	0	**327**
Physiological Measurement	Audiology - audiology assessments	30	0	30	0.00%	0	51	0	0	**51**
	Cardiology - echocardiography	1,124	12	1,136	1.06%	0	906	0	0	**906**
	Neurophysiology - peripheral neurophysiology	150	4	154	2.60%	0	116	0	0	**116**
	Respiratory physiology - sleep studies	83	0	83	0.00%	0	149	0	0	**149**
	Urodynamics - pressures & flows	27	5	32	15.63%	3	36	0	0	**36**
Endoscopy	Colonoscopy	393	0	393	0.00%	0	371	0	0	**371**
	Flexi sigmoidoscopy	181	0	181	0.00%	0	127	0	0	**127**
	Cystoscopy	64	1	65	1.54%	0	105	0	0	**105**
	Gastroscopy	410	0	410	0.00%	0	307	0	0	**307**
Total		**9,860**	**28**	**9,888**	**0.28%**	**3**	**13,507**	**1,225**	**1,707**	**16,439**

Responsive Services

Stroke Services

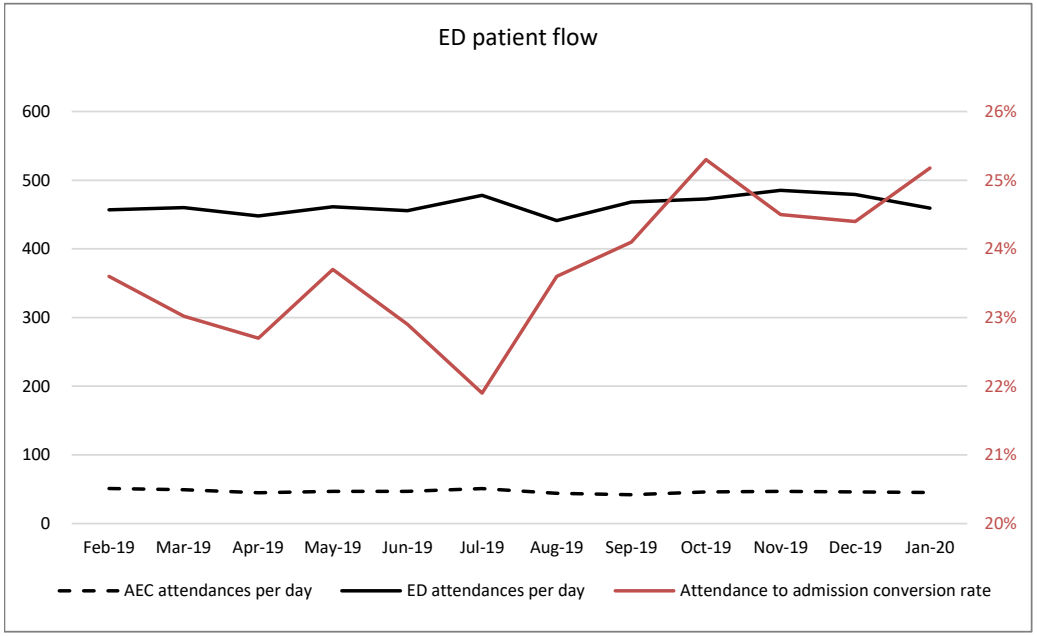
East and North Hertfordshire NHS Trust

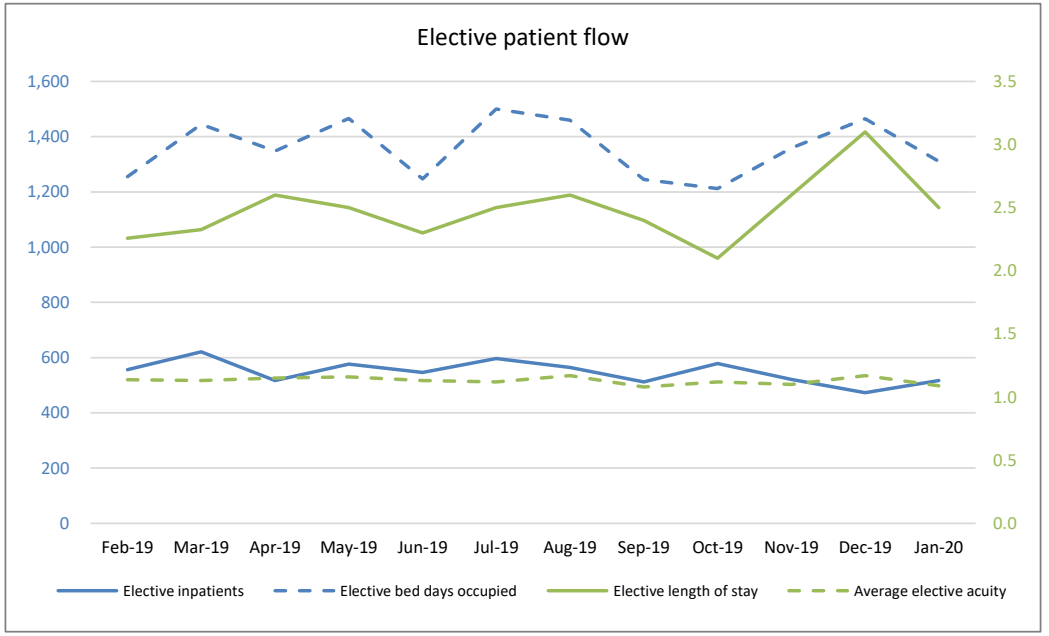
Domain	Metric	Target	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Trend
Stroke	Trust SSNAP grade	A	A	A	A	A	A	tbc	tbc	tbc	tbc	tbc	tbc	tbc	
	Discharged with AF on anticoagulants	80%	100.0%	88.9%	100.0%	100.0%	100.0%	77.8%	100.0%	100.0%	100.0%	88.9%	85.7%	75.0%	
	4-hours direct to Stroke unit from ED	90%	69.0%	72.1%	50.0%	59.3%	72.1%	63.3%	64.5%	79.7%	60.3%	57.1%	54.0%	40.6%	
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	90%	72.7%	75.4%	54.2%	60.0%	71.7%	65.1%	64.5%	81.5%	59.5%	58.2%	58.7%	40.8%	
	Number of confirmed Strokes in-month on SSNAP	-	73	71	66	86	66	67	68	72	81	71	53	74	
	Proportion of patients spending 90% of time on the Stroke unit	80%	93.1%	88.4%	90.8%	94.0%	92.1%	87.7%	98.4%	91.4%	87.5%	88.7%	90.2%	84.9%	
	60-minutes to scan from time of arrival	50%	61.6%	45.6%	56.1%	53.5%	53.0%	53.7%	61.8%	58.3%	65.4%	45.1%	67.9%	52.7%	
	Scanned within 12-hours - all Strokes	100%	98.6%	98.6%	97.0%	98.8%	92.4%	97.0%	100.0%	95.8%	97.5%	95.8%	94.4%	94.6%	
	Total Thrombolysis rate for confirmed Strokes	11%	12.3%	8.5%	4.5%	14.3%	15.6%	13.4%	8.8%	9.7%	12.5%	11.3%	7.7%	5.4%	
	Thrombolysed within 60-minutes of arrival	-	22.2%	16.7%	33.3%	50.0%	70.0%	66.7%	50.0%	28.6%	70.0%	50.0%	25.0%	25.0%	
	Discharged with JCP	80%	97.9%	100.0%	95.1%	93.7%	89.5%	95.3%	93.2%	82.7%	86.0%	81.1%	85.3%	73.6%	
	Discharged with ESD	40%	51.9%	44.4%	50.0%	50.8%	45.6%	41.3%	43.5%	50.9%	47.7%	61.4%	48.6%	54.2%	

Responsive Services

Patient Flow

Domain	Metric	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Trend
Emergency Department Flow Indicators	A&E & UCC attendances	12,788	14,266	13,440	14,306	13,675	14,821	13,676	14,041	14,649	14,556	14,848	14,243	
	Attendance to admission conversion rate	23.6%	23.0%	22.7%	23.7%	22.9%	21.9%	23.6%	24.1%	25.3%	24.5%	24.4%	25.2%	
	ED attendances per day	457	460	448	461	456	478	441	468	473	485	479	459	
	AEC attendances per day	51	49	45	47	47	51	44	42	46	47	46	45	
	4-hour target performance %	80.5%	81.0%	80.5%	81.6%	84.6%	81.5%	86.1%	85.1%	85.8%	81.5%	78.9%	81.5%	
	Time to initial assessment 95th centile	60	75	64	69	62	74	58	66	51	61	62	64	
	Ambulance handover breaches 30-minutes	597	606	480	368	262	336	180	227	215	360	453	tbc	

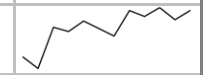
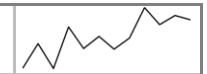
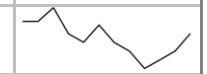




Responsive Services

Patient Flow

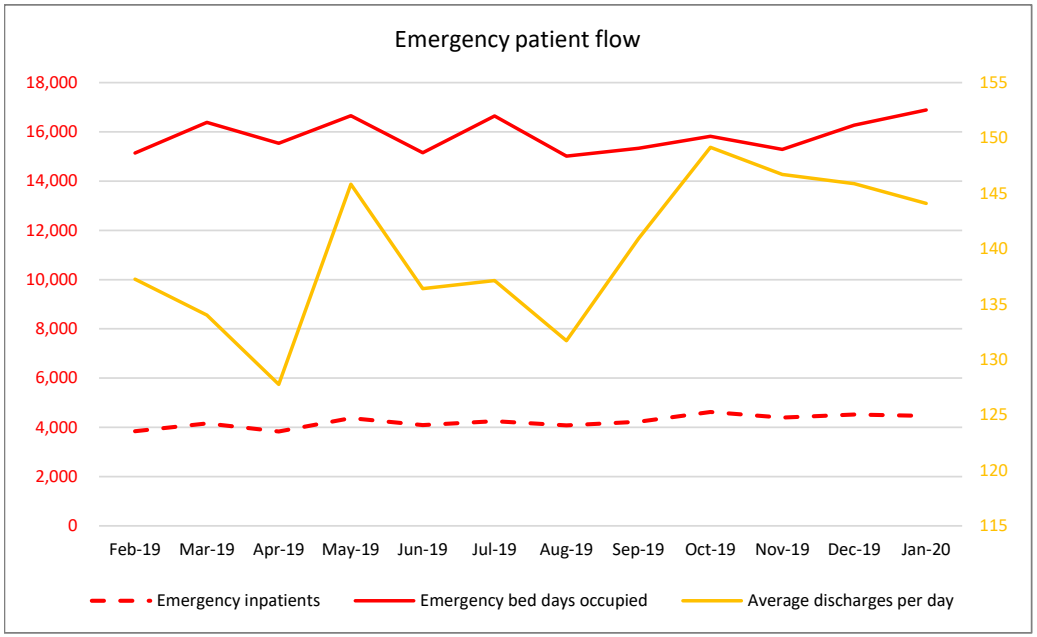
East and North Hertfordshire NHS Trust

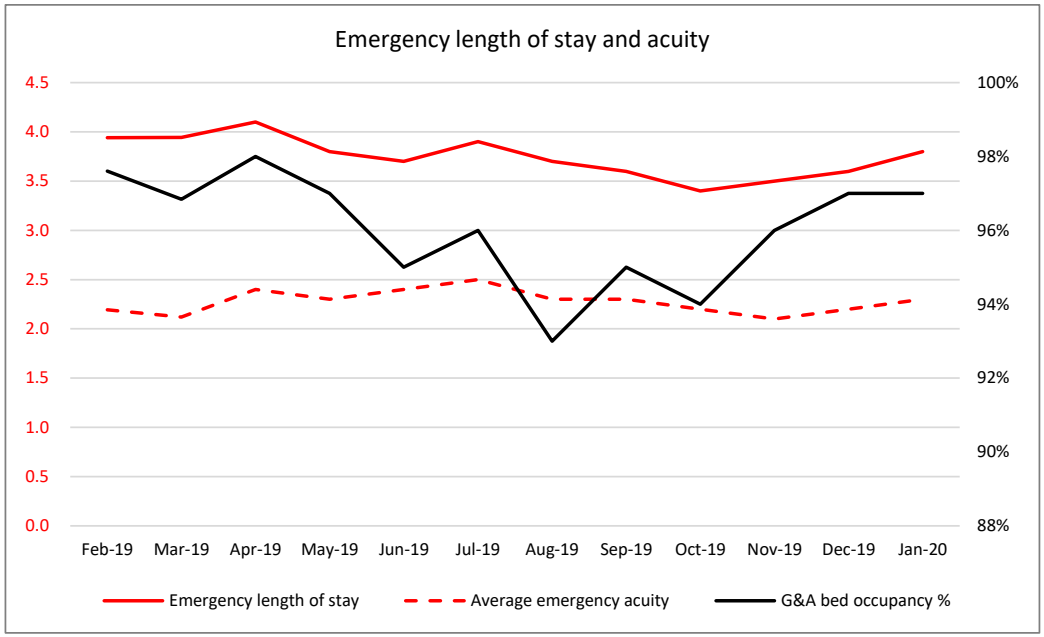
Domain	Metric	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Trend
Elective Inpatient Flow Indicators	Elective inpatients	556	621	517	577	546	597	564	512	579	521	473	517	
	Elective bed days occupied	1,255	1,445	1,348	1,466	1,247	1,500	1,460	1,245	1,212	1,359	1,465	1,311	
	Elective length of stay	2.3	2.3	2.6	2.5	2.3	2.5	2.6	2.4	2.1	2.6	3.1	2.5	
	Daycase rate %	84.8%	84.0%	86.8%	86.5%	87.2%	86.7%	86.2%	87.9%	87.5%	88.1%	87.3%	87.9%	
	Average elective acuity	1.14	1.13	1.15	1.16	1.13	1.12	1.17	1.08	1.12	1.10	1.17	1.09	
Emergency Flow Indicators	Emergency inpatients	3,843	4,155	3,833	4,375	4,092	4,251	4,083	4,228	4,624	4,401	4,522	4,467	
	Average discharges per day	137	134	128	146	136	137	132	141	149	147	146	144	
	Emergency bed days occupied	15,146	16,380	15,538	16,653	15,153	16,643	15,015	15,333	15,821	15,290	16,268	16,889	
	Emergency length of stay	3.9	3.9	4.1	3.8	3.7	3.9	3.7	3.6	3.4	3.5	3.6	3.8	
	Average emergency acuity	2.2	2.1	2.4	2.3	2.4	2.5	2.3	2.3	2.2	2.1	2.2	2.3	
	G&A bed occupancy %	98%	97%	98%	97%	95%	96%	93%	95%	94%	96%	97%	97%	
	Patients discharged via Discharge Lounge	189	186	197	225	224	302	406	432	546	457	383	433	
	Discharges before midday	14.4%	14.2%	13.0%	13.0%	14.0%	14.0%	13.0%	13.0%	13.0%	13.0%	15.0%	14.0%	
	Weekend discharges	15.7%	16.6%	14.0%	16.0%	17.0%	14.0%	16.0%	16.0%	14.0%	16.0%	16.0%	15.0%	
	Proportion of beds occupied by patients with length of stay over 14 days	19.6%	18.5%	17.5%	17.8%	16.9%	20.1%	18.0%	20.1%	20.2%	23.8%	19.2%	21.7%	
	Proportion of beds occupied by patients with length of stay over 21 days	10.7%	10.2%	9.3%	9.7%	8.4%	11.0%	10.0%	10.9%	11.7%	14.5%	10.5%	11.6%	

Responsive Services

East and North Hertfordshire NHS Trust

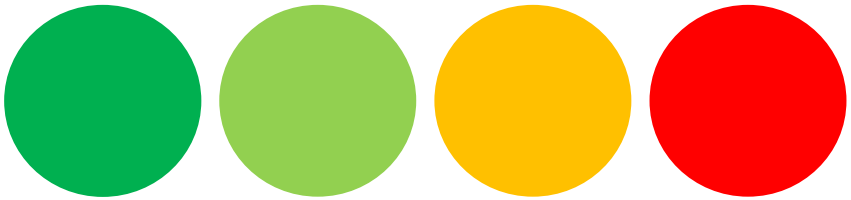
Patient Flow





Well-led Services

Month 10 | 2019-20



Key Issues

Staffing and Pay bill

- Overall staff utilised including bank and agency increase by 84 WTE.
- Agency expenditure increased by £44k, however the Trust was under the agency ceiling by £74k in month.
- The Trust is under the agency ceiling target by £352k over the year to date.
- There is a 0.7% improvement on turnover compared to the same month the previous year, while the monthly rate remains at 12.8%.

Sickness Absence

- Overall sickness absence rate remained at 4.4% which is 0.4% lower than last year.

Training & Development

- Appraisal compliance decreased from 84% to 83%, against a target of 90%.
- 11 out of the 15 mandatory training modules are on target and overall compliance hit the target of 90%.

Executive Response

The Trust is performing well against the recruitment plan. However, recruitment for qualified nursing remains a challenge and is some way off the planned target. The overall Trust position for qualified nursing in month 10 saw 19.8 WTE new starters and 18.5 WTE leavers, giving a positive variance of 1.3 WTE for the month. This has resulted in a vacancy rate of 7.4%, which is unchanged from month 9. This equates to 129 vacancies.

The Trust started the 19/20 year with a qualified nursing vacancy rate of 8.4%, with a target to reduce the vacancy rate to 6% by the end of the year. In order to achieve this target, the Trust needed to increase its qualified nurses in post by 37 WTE. Since April 2019, 171.4 qualified nurses have commenced employment with the Trust; however, this has only resulted in an overall increase of 6.6 WTE as at month 10. The qualified UK nurse pipeline currently indicates a total of 52.5 WTE future new starters, which includes 7.2 WTE student nurses who are due to qualify in month 11. In addition, there are 12 overseas nurses in the pipeline, of which 7 are due to commence in months 11 and 12.

Actions to mitigate these challenges include the recruitment of further international nurses, and a further focussed UK social media recruitment campaign for qualified nurses in months 9 and 10, as well as a revised approach to engaging and attracting our student nurses to take up employment with the Trust upon qualifying. Additionally, a focussed nursing recruitment and retention action plan for Medicine is place, with some specific initiatives underway, such as a retention payment scheme due to be implemented shortly.

The shortfall in nursing staff has created pressures on staffing levels and medicine division have been most impacted due to increase vacancy, maternity leave and sickness absence. Shift fill initiatives have been put in place including 'Flexi Pool' – offering a range of flexible working hours and 'Lister Pool' – to enables targeted, proactive placements for agency staff. There is also a specific incentive for Registered Nurses to encourage fill on difficult to fill late shifts as well as increasing specific Rapid Response shifts to minimise use of agencies at short notice.

Medical recruitment continues to perform well and remains ahead of trajectory. The overall Trust position for medical recruitment for month 10 is a vacancy rate of 5.6%, an increase of 1.6% from month 9. This equates to 48.9 WTE vacancies. There are a total of 43.6 WTE doctors in the pipeline, 6 of whom have confirmed start dates in months 11 and 12.

Medical Temporary Staffing remains the priority for opportunities to reduce agency spend. Temporary Staffing are working closely with NHS Professionals on a dedicated locum action plan to improve system efficiencies, improved rate card challenge and improve the Bank composition vs agency. Recommendations and progress are being reported into the Medical Working Group. Temporary Staffing are linking closely with Procurement and other Trusts within the STP on 'sharing best practice' around Medical utilisation.

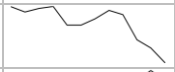
Agency fill overall increased by 11%, which is consistent with agency expenditure increasing by 44k against the previous month, however the Trust was under the agency ceiling by £74k. The Trust remains on course to achieve the 19-20 NHSI agency ceiling target.

There has been a 0.03% increase or 77 additional days lost compared to last month, however, it has improved considerably on the same period last year which was 0.42% higher with an additional 452 days lost in January 2019. Two significant areas of improvement are musculoskeletal related sickness absence (8.8% lower than January 2019) and sickness caused by stress and mental health (26% lower than January 19). The target to reduce the length of sickness absence due to Musculoskeletal issues, stress and mental health issues by 10% compared to the previous year has been consistently achieved over the past 4 months.

Well-led Services

Workforce and Staff Development

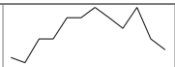
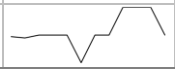
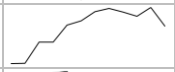
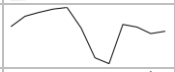
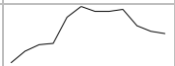
East and North Hertfordshire NHS Trust

Domain	Metric	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Trend	Plan YTD	Actual YTD	Var YTD
Staffing	Approved Budget Establishment WTEs	5,927	5,927	6,089	6,074	6,083	6,100	6,132	6,134	6,150	6,157	6,167	6,168		6,168	6,168	0
	Permanent Staffing WTEs Utilised	5,114	5,123	5,185	5,245	5,248	5,276	5,309	5,271	5,292	5,315	5,311	5,314		5,857	5,314	-543
	Bank Staffing WTEs Utilised	495	566	482	510	493	516	502	497	523	520	476	545		291	545	254
	Agency Staffing WTEs Utilised	114	114	98	113	104	106	100	87	90	90	87	99		20	99	79
	Gap - Budget WTEs & Permanent WTEs	812	804	904	829	836	824	823	863	858	842	856	854		311	854	543
	Gap Permanent Utilised / Budget WTEs	13.7%	13.6%	14.8%	13.6%	13.7%	13.5%	13.4%	14.1%	13.9%	13.7%	13.9%	13.8%		6.0%	13.9%	7.9%
	Recruitable Vacant Posts	393	410	427	403	387	333	403	443	368	394	427	407		478	427	-51
	Vacancy Rate	6.9%	7.2%	7.4%	7.0%	6.7%	5.8%	6.9%	7.6%	6.3%	6.8%	7.3%	6.9%		8.0%	6.9%	-1.1%
	Turnover Rate	13.2%	13.3%	13.0%	13.1%	13.0%	12.3%	12.5%	12.8%	15.1%	12.7%	12.8%	12.8%		12.0%	13.0%	1.0%
Sickness	Sickness FTE Days Lost	6,845	6,835	6,778	6,346	6,054	6,299	6,522	6,871	7,199	6,903	7,304	7,380		68,480	67,654	-826
	Short term sickness rates %	2.3%	2.1%	2.2%	1.9%	1.8%	1.1%	1.7%	2.0%	1.8%	2.0%	1.9%	2.4%		2.1%	1.9%	-0.2%
	Long term sickness rates %	2.3%	2.0%	2.0%	2.0%	2.0%	1.8%	2.2%	2.3%	2.5%	2.2%	2.4%	2.0%		2.2%	2.1%	-0.1%
	Sickness Rate	4.6%	4.2%	4.2%	3.8%	3.8%	3.7%	3.9%	4.3%	4.3%	4.2%	4.4%	4.4%		3.4%	4.1%	0.7%
	Staff on long term sick headcount	122	111	109	109	109	95	122	110	135	124	143	106		120	116	-4
	Maternity % Headcount	2.3%	2.3%	2.3%	2.3%	2.2%	2.2%	2.2%	2.3%	2.2%	2.1%	2.1%	2.0%		2.2%	2.2%	0.0%
	Nursing (Q & U) sickness rate	5.3%	4.7%	4.9%	4.7%	4.6%	4.2%	4.6%	5.0%	5.0%	5.4%	5.6%	5.4%		5.2%	4.2%	-1.0%
	Nursing (Q & U) sickness days lost in month	3,226	3,190	3,216	3,244	3,040	2,890	3,145	3,264	3,414	3,518	3,774	3,620		34,374	33,126	-1,248

Well-led Services

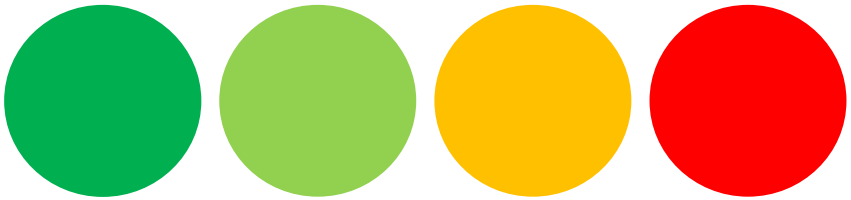
Workforce and Staff Development

East and North Hertfordshire NHS Trust

Domain	Metric	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Trend	Plan YTD	Actual YTD	Var YTD
Training & Development	Staff Appraised	82%	82%	84%	84%	86%	86%	87%	86%	85%	87%	84%	83%		90%	85%	-5%
	Mandatory Training 100% Compliant	61%	62%	62%	62%	64%	66%	65%	64%	65%	63%	64%	61%		90%	64%	-26%
	Overall Training Compliant	89%	89%	89%	89%	89%	88%	89%	89%	90%	90%	90%	89%		90%	89%	-1%
Statutory and Mandatory Training	Conflict Resolution - 2 Years	93%	92%	92%	93%	92%	91%	92%	92%	93%	93%	93%	92%		90%	92%	2%
	Equality & Diversity	91%	91%	92%	92%	93%	93%	94%	94%	94%	94%	94%	93%		90%	93%	3%
	Equality, Diversity and Human Rights	69%	71%	72%	73%	73%	69%	63%	62%	70%	69%	68%	68%		90%	68%	-22%
	Fire Safety	85%	85%	85%	84%	84%	84%	85%	84%	85%	85%	86%	84%		90%	84%	-6%
	Health and Safety	93%	92%	92%	93%	92%	91%	92%	92%	93%	93%	93%	92%		90%	92%	2%
	IPC - Clinical 2 yr	91%	92%	92%	92%	91%	90%	91%	90%	92%	92%	93%	90%		90%	90%	0%
	IPC - Non-Clinical 2 yr	93%	93%	93%	93%	93%	93%	94%	94%	95%	94%	95%	93%		90%	93%	3%
	Data security awareness	71%	72%	73%	73%	76%	77%	76%	76%	76%	75%	74%	74%		90%	74%	-16%
	Moving & Handling for People Handlers	93%	93%	92%	92%	92%	93%	93%	92%	93%	94%	95%	93%		90%	93%	3%
	Moving and Handling	93%	93%	93%	94%	93%	92%	93%	93%	94%	94%	94%	93%		90%	93%	3%
	Safeguarding Adults Level 1	90%	90%	90%	91%	90%	89%	90%	89%	91%	91%	91%	90%		90%	90%	0%
	Safeguarding Adults Level 2	90%	89%	90%	90%	90%	87%	88%	87%	90%	90%	90%	89%		90%	89%	-1%
	Safeguarding Children Level 1	93%	92%	92%	93%	92%	90%	91%	91%	92%	92%	92%	91%		90%	91%	1%
	Safeguarding Children Level 2	92%	92%	92%	92%	92%	89%	90%	89%	91%	91%	92%	90%		90%	90%	0%
	Safeguarding Children Level 3	88%	87%	87%	88%	86%	92%	93%	89%	87%	87%	90%	90%		90%	90%	0%

Sustainable Services

Month 10 | 2019-20



Key Issues

- The Trust's reported cumulative position at Month 10 is a deficit of £0.1m. Exclusive of donated asset and profit on land sale impacts the deficit is £1.2m. This remains in line with the control total plan for 19/20.
- The reported M10 deficit includes the expected receipt of PSF & FRF performance incentive funds totalling £12.5m. Payment of these funds is confirmed by NHSI on a quarterly basis upon the achievement of underlying financial achievement targets. Based upon M10 results the Trust presently envisages full receipt of these funds across the financial year.
- At M10 the Trust reports an over achievement (£9.6m) against SLA contracts with its commissioners. The majority of the YTD income overachievement is driven by above plan emergency activity. Joint review and analysis of this position by the Trust and its host CCG indicates that this over performance and activity growth has been driven by a number of factors but the most significant elements are:
  - The emergency plan was not a true reflection of the 18/19 outturn run rate.
  - A very significant shortfall in the impact of CCG QIPP schemes.
  - Unprecedented levels of demand growth in areas experiencing high rates of housing growth.
  - Increasing volumes of patients directly routed to the Trust ED from primary care and NHS111.
- The 19/20 SLA contract for emergency activity incorporates blended payments mechanisms that applies marginal rates to over performance within agreed bands. M10 performance is after the application of these rules.
- As at December 2019 the Trust has agreed a fixed price year end settlement with E&N CCHG in respect of the value for the 19/20 SLA. This represents a fair and balanced approach to risk share arrangements over the remainder of the financial year. The impact of this settlement is reflected in the M10 reported position.
- The much higher levels of emergency activity that continue to present at the Trust whilst resulting in higher levels of income have however been matched by much higher pay and cost requirements as the Trust has needed to keep open capacity that it had reasonably expected would be closed as a result of QIPP schemes and indeed has needed to incur further escalation costs beyond this level. As such Pay budgets report a significant YTD overspend of £8.0m.
- Performance against medical staffing budgets remain a key concern, reporting an overspend of £3.2m across the YTD. The bulk of this pressure is driven by two separate issues (1) the use of above plan levels of WLIs in Surgery to deliver the 19/20 activity plan as opposed to achieving improved levels of theatre and outpatient efficiency and (2) significant challenges in reducing reliance on high cost locum staff
- The pay position has been further compounded by significant overspends against nursing budgets, particularly in relation to increased temp staffing use across medical and surgical wards.
- Staff used by the Trust to deliver services has increased significantly year on year. An additional 190 WTE's were used in January 20 compared with 12 months earlier (excluding the impact of Therapies & Pharma). The growth of substantive fill but the failure to reduce temp staffing spend remains a significant concern.
- In the YTD the Trust delivered total CIP's of £12.5m. Whilst high by historical standards this was nevertheless £2.0m less than planned. Key features of this slippage include the non-achievement of planned theatre and outpatient savings targets.

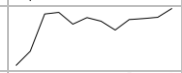
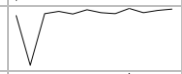
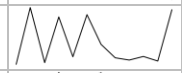
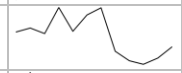
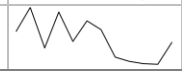
Executive Response

- Key elements of the finance performance represent a significant issue. The income over performance YTD largely relates to emergency activity, this is neither operationally sustainable for the Trust or affordable by commissioners. The significant overspend against pay budgets is in large measure driven by the impact of CCG QIPP scheme shortfalls and the consequent need to maintain capacity that has been expected to close.
- The Trust has undertaken through deep dive analysis into the drivers underpinning emergency growth and shared this fully with commissioners, and remains committed to working collaboratively to manage this position.
- The Trust continues to face challenges in the delivery clinical productivity targets and also weaknesses in the management of medical and nursing temporary staffing costs. This underlying position is not sustainable and requires redress.
- To support control total achievement, the Trust Executive have introduced a number of remedial forecast mitigation work streams. These include weekly IFD oversight groups for both Medical Staffing and Nursing Management which have been identified as key in maintaining oversight and management of the control environment. The groups are led by Executive Directors and will implement agreed improvement plans for these staffing areas.
- Further IFD work streams have been set up in respect of establishing a high impact focus on Pathology, Pharmacy and Procurement costs in the second half of the year. In addition, the Trust has introduced tighter controls for the review and approval of admin and senior managers temporary staffing costs. Regular reports on the effectiveness of these mitigation programmes will be provided to the Finance and Performance Committee and weekly Executive Committee meetings.
- The Trust continues to expand the scope and sophistication of its BI universe at pace to support the need to supply relevant, timely and accurate data to clinicians and managers to enable more effective decision making and plan delivery.
- Furthermore, the Trust continues to undertake monthly Accountability Review Meetings (ARM) with division to support improved performance. These meeting contain review of finance delivery and CIP achievement.
- The Trust continues to maintain 'Model Hospital' project working groups, to drive progress across a number of other key clinical processes - i.e. Theatres, Outpatients, Consultant Job Planning as well as Inpatient Flow. The success and achievements of these groups has been extremely variable.
- The Trust also continues to schedule a 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.
- 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.

Sustainable Services

Finance Plan Performance

East and North Hertfordshire NHS Trust

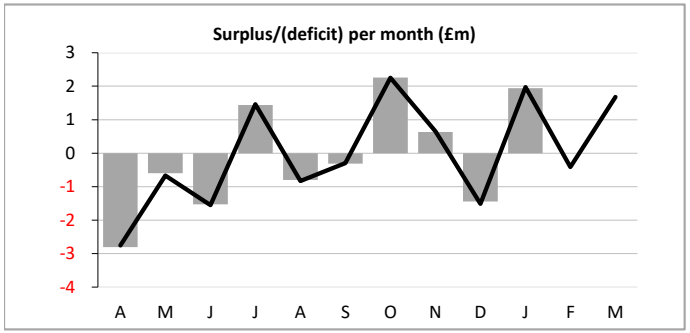
Domain	Metric	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Trend	Plan YTD	Actual YTD	Variance YTD
I&E Performance	SLA Income Earned	30.4	33.3	32.7	35.3	33.5	37.2	34.3	34.3	36.4	34.6	33.8	36.6		337.1	348.6	11.4
	Other Income Earned	4.8	-6.8	3.5	3.7	3.6	3.8	3.7	3.7	5.2	4.3	3.6	4.5		42.0	39.7	-2.4
	Pay Costs	23.2	23.6	24.8	24.8	24.5	24.7	24.5	24.3	24.6	24.6	24.7	24.9		238.3	246.3	8.0
	Non Pay Costs inc Financing	14.6	2.8	15.0	15.6	15.0	16.0	15.3	15.1	16.3	15.3	15.8	16.1		154.6	155.6	1.0
	Underlying Surplus / (Deficit)	-2.7	0.0	-3.6	-1.4	-2.3	0.4	-1.9	-1.4	0.6	-1.0	-3.1	0.0		-13.8	-13.7	0.1
	PSF Earned	0.0	5.9	0.4	0.4	0.4	0.5	0.5	0.5	0.7	0.7	0.7	0.8		5.5	5.5	0.0
	FRF Received	-	-	0.5	0.5	0.5	0.6	0.6	0.6	0.9	0.9	0.9	1.1		7.0	7.0	0.0
	Retained Surplus / Deficit	-2.7	6.0	-2.8	-0.6	-1.526	1.4	-0.8	-0.3	2.3	0.6	-1.4	1.9		-1.3	-1.2	0.1
Paybill Metrics	Substantive Pay Costs	19.7	19.8	21.2	20.8	20.8	20.8	20.8	20.9	21.2	21.2	21.3	21.2		220.6	210.0	-10.6
	Premium Pay Costs Overtime & WLI	0.4	0.4	0.4	0.5	0.4	0.4	0.4	0.3	0.3	0.3	0.3	0.3		3.4	3.5	0.1
	Premium Pay Costs Bank Costs	2.2	2.5	2.2	2.4	2.2	2.4	2.3	2.2	2.2	2.2	2.2	2.5		11.1	22.8	11.7
	Premium Pay Costs Agency Costs	1.0	1.0	1.0	1.1	1.0	1.1	1.1	0.9	0.9	0.9	0.9	1.0		3.2	10.0	6.8
	Premium Pay Costs As % of Paybill	15.3%	16.4%	14.6%	16.2%	14.8%	15.8%	15.4%	14.1%	13.9%	13.8%	13.8%	14.8%		7.4%	14.7%	7.3%

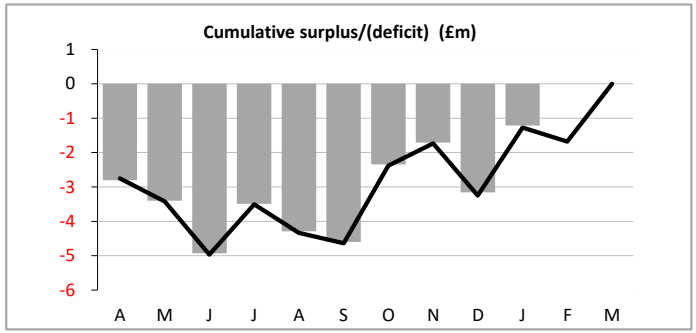
Sustainable Services

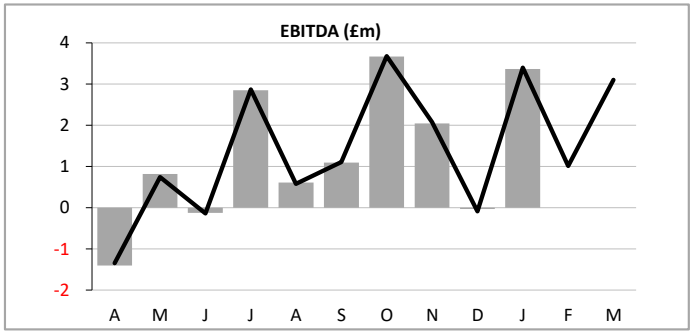
Finance Plan Performance

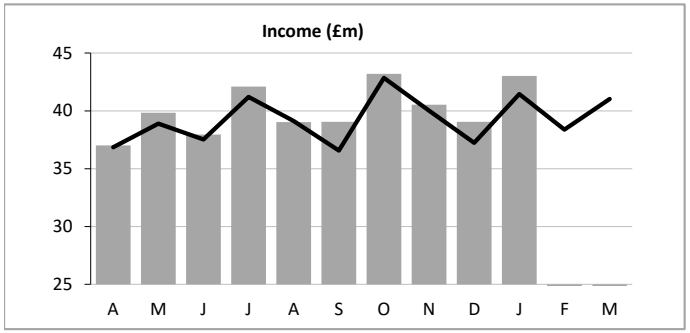
East and North Hertfordshire NHS Trust

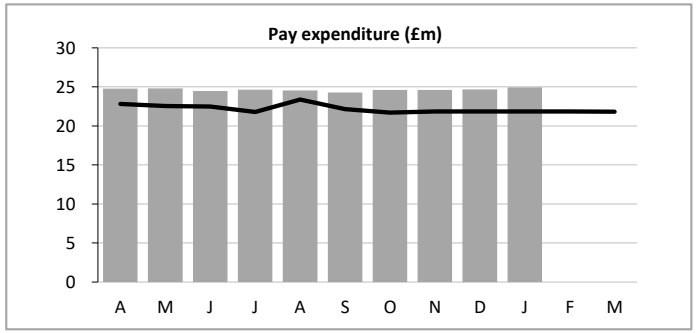
Domain	Metric	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Trend	Plan YTD	Actual YTD	Variance YTD
Single Oversight Framework	Capital Servicing Capacity	4	4	4	4	4	3	4	4	4	4	4	4		1	4	
	Liquid Ratio (Days)	4	4	4	4	4	4	4	4	4	4	4	4		1	4	
	I&E Margin	4	4	4	4	4	4	4	4	3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

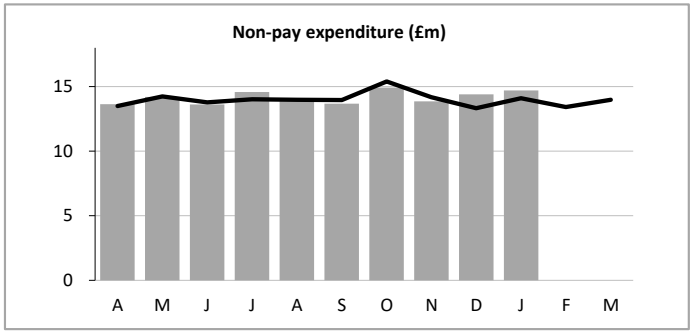












Sustainable Services

SLA Contracts - Income Performance

East and North Hertfordshire NHS Trust

		In-Month			YTD		
		Planned Income	Actual Income	Income Variance	Planned Income	Actual Income	Income Variance
By Point of Delivery	A&E Attendances	2,269	2,344	75	21,627	23,421	1,794
	Daycases	2,854	2,928	74	26,736	29,199	2,463
	Inpatient Elective	2,201	1,748	-453	20,597	18,627	-1,970
	Inpatient Non Elective	8,907	10,011	1,104	84,753	94,812	10,059
	Maternity	2,335	2,199	-136	22,852	22,679	-173
	Other	3,708	3,403	-305	35,411	31,791	-3,620
	Outpatient First	2,140	2,197	57	19,846	20,586	740
	Outpatient Follow Ups	2,372	2,236	-136	22,056	21,264	-792
	Outpatient Procedures	1,227	1,052	-175	11,393	11,044	-349
	Other SLAs	57	57	0	574	574	0
	Block	846	839	-7	8,426	8,359	-67
	Drugs & Devices	3,695	4,099	404	35,613	37,029	1,416
	Chemotherapy Delivery	575	568	-7	5,539	5,298	-241
	Radiotherapy	1,160	1,279	119	11,227	11,639	412
	Renal Dialysis	1,175	1,156	-19	11,445	11,384	-61
	Total	35,520	36,117	597	338,094	347,706	9,612

		In-Month			YTD		
		Planned Income	Actual Income	Income Variance	Planned Income	Actual Income	Income Variance
By Commissioner	East & North Herts CCG	20,942	20,865	-77	199,263	209,912	10,649
	Specialist Commissioning	8,121	8,753	632	78,165	78,165	0
	Bedfordshire CCG	2,436	2,585	149	23,177	24,407	1,230
	Herts Valleys CCG	1,431	1,538	107	13,657	12,948	-709
	Cancer Drugs Fund	465	597	132	4,478	4,862	384
	Luton CCG	317	337	20	3,008	3,042	34
	PH - Screening	307	269	-38	2,916	3,179	263
	Other	1,502	1,173	-329	13,431	11,191	-2,240
By Division	Cancer Services	6,599	6,965	366	63,366	64,081	715
	Medicine	11,527	12,301	774	109,873	118,261	8,388
	Women & Children	4,865	4,871	6	47,042	47,363	321
	Clinical Services	2,254	2,304	50	21,752	22,136	384
	Surgery	10,647	10,338	-309	99,969	102,190	2,221
	Other	-371	-663	-292	-3,907	-6,325	-2,418

Sustainable Services

Activity and Productivity

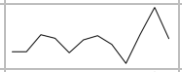
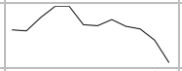
East and North Hertfordshire NHS Trust

Domain	Metric	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Trend	Plan YTD	Actual YTD	Var YTD
Patient Activity Levels	A&E & UCC	12,086	13,475	12,680	13,521	12,942	13,968	12,845	13,230	13,745	13,769	14,127	13,469		126,386	134,296	7,910
	Chemotherapy Atts	2,001	1,983	2,223	2,239	1,948	2,266	2,131	2,073	2,348	2,261	2,246	2,330		22,721	22,065	-656
	Critical Care (Adult) - OBD's	464	577	636	628	580	671	534	580	584	668	632	706		5,648	6,219	571
	Critical Care (Paeds) - OBD's	379	442	421	628	427	516	465	549	605	498	583	510		5,539	5,202	-337
	Daycases	3,102	3,269	3,410	3,683	3,708	3,879	3,512	3,722	4,070	3,841	3,260	3,752		32,652	36,837	4,185
	Elective Inpatients	556	621	517	577	546	597	564	512	579	521	473	517		6,514	5,403	-1,111
	Emergency Inpatients	3,843	4,155	3,833	4,375	4,092	4,251	4,083	4,228	4,624	4,401	4,522	4,467		38,825	42,876	4,051
	Home Dialysis	163	178	176	173	161	158	163	147	144	150	164	160		1,627	1,596	-31
	Hospital Dialysis	5,751	6,156	6,062	6,236	5,813	6,281	6,306	5,963	6,313	6,264	6,627	6,440		62,210	62,305	95
	Maternity Births	381	445	422	461	427	453	449	438	467	440	436	414		4,625	4,407	-218
	Maternity Bookings	467	469	474	551	501	507	444	474	518	507	481	515		5,220	4,972	-248
	Outpatient First	8,293	9,261	8,403	9,081	8,944	9,845	8,244	8,675	9,788	9,312	8,355	9,656		82,227	90,303	8,076
	Outpatient Follow Up	17,002	17,277	16,993	17,594	16,734	19,196	15,893	17,009	18,795	17,931	15,518	18,432		182,248	174,095	-8,153
	Outpatient procedures	7,539	7,207	8,185	7,984	7,429	7,719	6,935	7,306	8,029	6,750	5,888	6,698		65,431	72,923	7,492
	Radiotherapy Fractions	4,773	5,048	5,023	5,023	4,338	4,884	4,775	4,480	4,764	4,800	4,828	5,227		48,112	48,142	30

Sustainable Services

Activity and Productivity

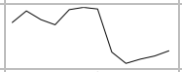
East and North Hertfordshire NHS Trust

Domain	Metric	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Trend	Plan YTD	Actual YTD	Var YTD
Throuhput	Elective Spells per Working Day	183	185	196	203	203	203	185	212	202	198	233	194		185	199	14
	Emergency Spells per Day	127	125	124	137	132	133	129	138	145	143	142	140		127	140	13
	ED Attendances per Day	432	435	423	436	431	451	414	441	443	459	456	434		413	439	26
	Outpatient Atts per Working Day	1,642	1,607	1,679	1,650	1,577	1,671	1,412	1,650	1,592	1,545	1,860	1,581		1,556	1,591	35
	Elective Bed Days Used	1,255	1,445	1,348	1,466	1,247	1,500	1,460	1,245	1,212	1,359	1,465	1,311		14,501	13,613	-888
	Emergency Bed Days Used	15,146	16,380	15,538	16,653	15,153	16,643	15,015	15,333	15,821	15,290	16,268	16,889		158,808	158,603	-205
Efficiency	Admission Rate from A&E	24%	23%	23%	24%	23%	22%	24%	24%	25%	24%	24%	25%		23.3%	23.8%	0.5%
	Emergency - Length of Stay	3.9	3.9	4.1	3.8	3.7	3.9	3.7	3.6	3.4	3.5	3.6	3.8		4.0	3.7	-0.3
	Emergency - Casemix Value	2,194	2,119	2,390	2,265	2,434	2,459	2,277	2,308	2,222	2,116	2,211	2,329		2,220	2,301	81
	Elective - Length of Stay	2.3	2.3	2.6	2.5	2.3	2.5	2.6	2.4	2.1	2.6	3.1	2.5		2.4	2.5	0.2
	Elective - Casemix Value	1,137	1,132	1,148	1,156	1,128	1,123	1,169	1,084	1,121	1,104	1,172	1,091		1,202	1,130	-72
	Elective Surgical DC Rate %	84.8%	84.0%	86.8%	86.5%	87.2%	86.7%	86.2%	87.9%	87.5%	88.1%	87.3%	87.9%		85%	87%	2.2%
	Outpatient DNA Rate % - 1st	12.5%	11.6%	11.9%	12.0%	11.7%	11.6%	11.9%	11.4%	11.0%	11.6%	12.1%	11.7%		12.6%	11.8%	-0.8%
	Outpatient DNA Rate % - FUP	7.1%	7.1%	7.6%	7.9%	7.9%	7.3%	7.3%	7.5%	7.3%	7.2%	6.8%	6.0%		8.5%	7.5%	-1.0%
	Outpatient Cancel Rate % - Patient	9.6%	9.5%	10.0%	10.2%	10.6%	10.3%	10.6%	10.3%	10.1%	9.6%	10.9%	9.9%		9.3%	10.2%	1.0%

Sustainable Services

Activity and Productivity

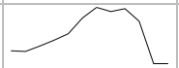
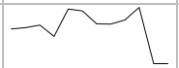
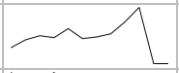
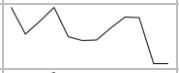
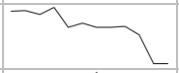
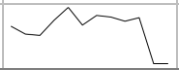
East and North Hertfordshire NHS Trust

Domain	Metric	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Trend	Plan YTD	Actual YTD	Var YTD
Efficiency	Outpatient Cancel Rate % - Hosp	6.3%	6.4%	6.3%	6.4%	6.2%	6.2%	6.1%	6.4%	6.3%	6.6%	6.7%	6.6%		6.3%	6.4%	0.1%
	Outpatients - 1st to FUP Ratio	2.1	1.9	2.0	1.9	1.9	1.9	1.9	2.0	1.9	1.9	1.9	1.9		2.2	1.9	-0.3
	Theatres - Ave Cases Per Hour	2.7	2.8	2.7	2.6	2.8	2.8	2.7	2.6	2.8	3.0	2.7	2.8		2.9	2.7	-0.1
	Theatres - Utilisation of Sessions	78%	80%	78%	80%	81%	83%	79%	80%	83%	88%	84%	86%		85%	82%	-3%
	Theatres - Ave Late Start (mins)	23	25	23	23	25	26	25	18	16	17	17	18		27	21	-5.9
	Theatres - Ave Early Finishes (mins)	40	37	39	37	36	30	41	35	38	25	36	31		39	35	-4.7

Sustainable Services

East and North Hertfordshire NHS Trust

Cost Improvement Plan (CIP) Delivery

Domain	Metric	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Trend	Annual Plan	Plan YTD	Actual YTD	Variance YTD
CIP Delivery by Workstream	Theatre Efficiency	5	1	0	0	63	39	103	69	33	29	0	0		106	104	342	237
	Outpatients	4	4	5	7	9	13	16	15	16	12	0	0		613	519	100	-419
	Procurement	442	231	166	226	203	216	283	222	242	276	0	0		3,597	2,967	2,507	-460
	Divisional Non Pay schemes	102	106	114	81	162	156	118	117	129	166	0	0		1,576	1,264	1,251	-13
	DQ, Coding & Income	0	0	42	41	366	176	181	181	181	206	0	0		1,691	1,299	1,373	74
	Corporate	144	119	24	140	50	52	17	46	74	53	0	0		941	813	720	-93
	Demand Management	43	64	75	70	94	67	71	80	112	151	0	0		1,468	1,177	826	-351
	Workforce Temporary Staff reduction	83	44	63	83	40	34	35	53	69	68	0	0		1,072	790	571	-220
	Divisional Pay schemes	254	257	238	274	177	197	177	177	182	142	0	0		1,998	1,778	2,075	297
	Workforce transformation schemes	-10	-16	58	-43	17	44	96	24	24	24	0	0		984	657	219	-438
	Divisional Income capture & coding	28	23	27	405	141	120	153	155	136	123	0	0		2,012	1,615	1,312	-304
	Patient Flow	0	0	0	0	21	1	1	1	1	1	0	0		455	354	25	-329
	Divisional Local Income schemes	24	51	40	18	348	46	194	256	75	130	0	0		1,363	1,123	1,183	60
	Over/Unidentified	0	0	0	0	0	0	0	0	0	0	0	0		-2,876	0	0	0
	Total CIP Delivery	**1,120**	**884**	**852**	**1,301**	**1,690**	**1,161**	**1,446**	**1,397**	**1,273**	**1,380**	**0**	**0**		**15,000**	**14,461**	**12,503**	**-1,958**

Sustainable Services

East and North Hertfordshire NHS Trust

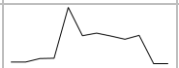
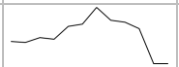
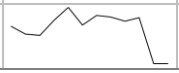
Cost Improvement Plan (CIP) Delivery

Domain	Metric	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Trend	Annual Plan	Plan YTD	Actual YTD	Variance YTD
CIP by Nature	Recurrent	467	540	571	905	1,508	983	1,280	1,242	1,074	1,225	0	0		15,314	12,100	9,797	-2,304
	Non-Recurrent	652	344	280	397	182	179	165	154	199	154	0	0		2,560	2,361	2,707	345
	Over/Unidentified	0	0	0	0	0	0	0	0	0	0	0	0		-2,874	0	0	0
	Total CIP Delivery	**1,120**	**885**	**852**	**1,301**	**1,690**	**1,161**	**1,446**	**1,397**	**1,273**	**1,380**	**0**	**0**		**15,000**	**14,461**	**12,503**	**-1,958**
CIP Delivery by Division	Cancer Services	164	193	177	163	173	206	228	300	169	209	0	0		1,952	1,654	1,983	330
	Clinical Support	93	95	114	120	459	142	252	244	269	312	0	0		3,385	2,705	2,101	-605
	Corporate	582	286	222	278	406	264	255	255	286	260	0	0		3,769	3,188	3,093	-95
	Medicine	79	101	115	441	258	266	344	290	248	247	0	0		4,383	3,392	2,388	-1,004
	Surgery	127	141	110	166	253	183	262	204	186	218	0	0		3,212	2,545	1,851	-694
	Women's & Children's	74	69	113	133	141	100	105	104	115	133	0	0		1,173	977	1,088	110
	Over/Unidentified	0	0	0	0	0	0	0	0	0	0	0	0		-2,874	0	0	0
	Total CIP Delivery	**1,120**	**884**	**852**	**1,301**	**1,690**	**1,161**	**1,446**	**1,397**	**1,273**	**1,380**	**0**	**0**		**15,000**	**14,461**	**12,503**	**-1,958**

Sustainable Services

East and North Hertfordshire NHS Trust

Cost Improvement Plan (CIP) Delivery

Domain	Metric	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Trend	Annual Plan	Plan YTD	Actual YTD	Variance YTD
CIP Delivery by Type	Income (other operating income)	33	55	44	396	118	-21	131	233	73	88	0	0		1,893	1,356	1,063	-292
	Income (patient care activities)	23	23	70	72	740	367	401	364	324	374	0	0		3,535	2,392	2,382	-10
	Non-Pay	732	456	400	522	517	494	499	475	538	648	0	0		7,634	5,527	4,633	-894
	Pay (skillmix)	155	148	181	170	258	274	391	302	288	243	0	0		3,282	2,319	2,168	-151
	Pay (WTE reductions)	177	201	157	141	55	47	24	24	51	26	0	0		1,428	1,149	877	-272
	Over/Unidentified	0	0	0	0	0	0	0	0	0	0	0	0		-2,773	0	0	0
	Total CIP Delivery	**1,120**	**884**	**852**	**1,301**	**1,690**	**1,161**	**1,446**	**1,397**	**1,273**	**1,380**	**0**	**0**		**15,000**	**12,744**	**11,124**	**-1,620**

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	127,431	134,296	6,865
Emergency Department Ave Daily Atts	416	439	22
Admission Rate from ED %	23.4%	23.8%	0%
Non Elective Inpatient Spells	40,128	42,876	2,748
Ave Daily Non Elective Spells	131	140	9
Daycase Spells	32,538	36,837	4,299
Elective Inpatient Spells	6,160	5,403	-757
Ave Daily Planned Spells	126	138	12
Day Case Rate	84%	87%	3%
Adult & Paeds Critical Care Bed Days	11,088	11,421	333
Outpatient First Attendances	89,655	90,303	648
Outpatient Follow Up Attendances	178,446	174,095	-4,351
Outpatient First to Follow Up Ratio	2.0	1.9	-0.1
Outpatient Procedures	66,660	72,923	6,263
Ave Daily Outpatient Attendances	1,094	1,102	8

Workforce Measures	2018-19 YTD	2019-20 YTD	Change
Average Monthly WTE's Utilised	5,637	5,881	244
Average YTD Pay Cost per WTE	40,793	41,891	2.7%
Staff Turnover	13.7%	13.0%	-0.7%
Vacancy WTE's	844	854	9
Vacancy Rate	14.3%	13.9%	-0.4%
Sickness Days Lost	67,006	67,654	649
Sickness Rate	4.3%	4.1%	-0.2%
Agency Spend- £m's	10.0	10.0	-0.0
Temp Spend as % of Pay Costs	4.4%	4.1%	-0.3%
Ave Monthly Consultant WTE's Worked	308.4	331.0	22.6
Consultant : Junior Training Doctor Ratio	1 : 1.7	1 : 1.7	0.0
Ave Monthly Nursing & CSW WTE's Worked	2,407.2	2,451.4	44.2
Qual : Unqualified Staff Ratio	69 : 26	68 : 26	-0.0
Ave Monthly A&C and Senior Managers WTE's	1,237	1,303	66
A&C and Senior Managers % of Total WTE's	21.9%	22.2%	0.2%

Sustainable Services

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

East and North Hertfordshire NHS Trust

Capacity Measures	2018-19 YTD	2019-20 YTD	Change
Non Elective LoS	4.0	3.7	-0.3
Elective LoS	2.4	2.5	0.2
Occupied Bed Days	173,308	172,216	-1,092
Adult Critical Care Bed Days	6,013	6,219	206
Paediatric Critical Care Bed Days	5,075	5,202	127
Outpatient DNA Rate	9%	8%	-1.1%
Outpatient Utilisation Rate	28%	28%	0.3%
Total Cancellations	102,978	109,711	6,733
Theatres - Ave Cases per Hour	2.8	2.7	-0.0
Theatres - Ave Session Utilisation	80%	82%	2.5%
Theatres - Ave Late Start (mins)	29	21	-8
Theatres - Ave Early Finishes (mins)	40.4	34.6	-6
Radiology Examinations	340,089	346,315	6,226
Drug Expenditure (excl HCD & ENH Pharma) - £000s	9,108	7,731	-1,377
High Cost Drug Expenditure - £000s	32,699	36,202	3,503

Finance & Quality Measures	2018-19 YTD	2019-20 YTD	Change
Profitability - £000s	-16,470	-120	16,350.4
Monthly SLA Income £000s	32,487	34,855	2,368
Monthly Clinical Income per Consultant WTE	£105,340	£105,299	-£41
High Cost Drug Spend per Consultant WTE	£106,025	£109,368	£3,343
Average Income per Elective Spell	£1,165	£1,130	-£36
Average Income per Non Elective Spell	£2,087	£2,301	£214
Average Income per ED attendance	£171	£174	£3
Average Income per Outpatient Attendance	£133	£137	£4
Ave NEL Coding Depth per Spell	n/a	n/a	n/a
Procedures Not Carried Out	1,803	1,992	189
Best Practice HRGs (% of all Spells)	9.8%	2.7%	-7.1%
Ambulatory Best Practice (% of Short Stays)	n/a	n/a	n/a
Non-elective re-admissions within 30 days Rolling 12-months to Nov-19	10,460	11,472	1,012
Non-elective re-admissions within 30 days % Rolling 12-months to Nov-19	8.44%	8.82%	0.4%
SLA Contract Fines - £000's	252	278	26

Division	Not started	In progress	Passed	Total	%
CANCER	62	8	59	129	46%
CAPITAL	3		2	5	40%
CSS	30	3	61	94	65%
DATA QUALITY/CODING		1	7	8	88%
FACILITIES	3	2	1	6	17%
FINANCE	6	3	200	209	96%
FINANCE - INFORMATION	2		12	14	86%
FINANCE - IT		2	3	5	60%
MEDICINE	204	30	82	316	26%
NURSING PRACTICE	9	1	3	13	23%
PMO	4		66	70	94%
STRATEGY	3			3	0%
SURGICAL	130	10	90	230	39%
TRUST MGT	6		2	8	25%
W&C	51	8	100	159	63%
WORKFORCE	12		4	16	25%
FINANCE - INCOME			5	5	100%
Grand Total	**525**	**68**	**697**	**1,290**	54%

East and North Hertfordshire NHS Trust

Agenda Item: 9

TRUST BOARD - PUBLIC SESSION – 4th MARCH 2020

DIVISIONAL REPORTING OF CLINICAL STRATEGY PRIORITIES – Q3

Purpose of report and executive summary (250 words max): Following approval of the Trust's clinical strategy (2019 – 2024), to provide a report to the Trust Board on progress made in Q3 of 2019/20 and preparations for the second year of the strategy.		
Action required: For discussion		
Previously considered by: **N/A**		
Director: **Director of Strategy**	**Presented by:** **Director of Strategy**	**Author:** **Head of Business Development**

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

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

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DIVISIONAL REPORTING OF CLINICAL STRATEGY PRIORITIES – Q3

TRUST BOARD - PUBLIC SESSION – 4th March 2020

1) Purpose

The purpose of this paper is to update Trust Board on the progress made by Divisions against delivery of their Clinical Strategic Priorities throughout the five years of the strategy, 2019-2020. This report covers progress made in Q3 of 2019/20.

2) Background

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

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

3) Q3 Progress and Key Issues

Each Division has identified progress made against their clinical strategic priorities. Key themes are:

- Good progress has been made on the majority of key actions and priorities. In general, progress has been best on actions that are solely within the gift of the Division and Trust. Progress has been slower on actions requiring partnership working with others. There are lessons around setting realistic timescales for such work and an expectation that this will be aided by greater inter-organisational collaboration through the East and North Hertfordshire ICP.
- Many Divisions report successes in work on culture and staff engagement, which is having an impact on retention and turnover. All report a genuine shift in culture and engagement, although it is recognised that such changes take time to embed. Lessons and experiences can be shared across Divisions.
- Several actions are now awaiting decisions on business cases / investment proposals. In some cases these are sitting within the Trust's internal governance processes and progress cannot be made until decisions are forthcoming (whether for approval or not). An internal review of business case governance is being undertaken during March in order to clarify and refine processes to support decision making.
- There are some intransigent issues that are not resolved, despite actions being pursued and progressed. The Executive team are considering new approaches or additional executive input that may be needed to resolved. These include the implementation of a number of transformation / pathway proposals requiring system funding flows and tariff to

be reshaped to support them. These objectives will be picked up and considered in relation to ICP clinical priorities for the coming year.

- In common with the rest of the NHS, there is a common concern on the need for capital investment and anxiety about the capital constraints, although these are understood by the Divisions. The Trust is developing proposals for STP Wave 5 funding to address specific environmental and equipment issues and will develop business cases for required investments.

Clinical strategy highlights for Q3 are in Appendix 1.

Divisions have also been reviewing their Year 2 clinical strategy milestones in the light of Year 1 learning and progress and material changes to the strategic environment. All divisions have been presenting their conclusions from this to the Strategic Development Committee. This work will then be further refined following agreement of ICP clinical priorities for 2020/21in the coming weeks.

4) Recommendations

Trust Board is asked to:

- note the progress made by divisions against their strategic clinical priorities for Quarter 3 and the themes highlighted

Quarter 3 progress on clinical strategy

East and North Hertfordshire NHS Trust

Quality

- Sustained delivery of 7 cancer standards
- CHKS accreditation of ISO 9000 standard
- Radiotherapy rated as good by CQC
- Making clear progress on these maternity safety drivers. LMS deliverables agreed for 19/20. Children's Network Excellence Group now in place
- Endometriosis – Royal College of Gynaecologists provisional accreditation achieved. Will be applying for full accreditation by April 2020

Sustainability

- Work undertaken focused on efficiency and effective use of capacity and facilities, stabilisation of services and securing operational sustainability, particularly in Surgery
- On going development of plans preparing for the transfer of ownership of MVCC to UCLH - due diligence now in progress
- Refurbishment of Lister Aseptic Unit on target - will strengthen sustainability of the service and also enable greater control over patient experience
- Delivery of the Hospital Pharmacy Transformation Plan (HPTP) is on track and progressing well

People

- Roll-out of new clinical roles, including the introduction of ACPs and ESPs (Extended Scope Practitioners) has been effective – but more work still to be done
- Marked shift in culture and governance resulting in improvements in turnover and vacancy rates
- Close collaborative working with key stakeholders re. future of MVCC
- GAP analysis on personalised care underway to identify staff training and woman's needs
- Action plans developed for staff survey results, with regular reviews through SMT meetings; PULSE surveys ongoing at MVCC

Our vision:
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Ease of Use

- Introduction of new processes and protocols to drive ease of use, utilisation and efficiencies in theatres
- Children's STP workstream established to review pathways and processes to make our services easier to use for GPs, patients and their families
- Criteria led discharge being implemented in key areas
- Roll out of IT upgrade is increasing efficiency on wards and reducing frustration
- Electronic Prescribing and Medicines Administration (EPMA) Project Board set up – on target for pilot on one ward by February 2020, and then to be rolled out during 2020/21

Pathways

- Virtual fracture clinic introduced, with considerable positive impact on patient experience and new to follow up ratios
- Project lead appointed to support delivery of stratified pathways in breast and urology follow up care
- Perinatal Mental Health Pathway developed - PNMH midwife in post
- Pilot for Continuity of Career is in progress in North Herts community team
- Endometriosis clinic providing specialised care for this cohort of patients
- Paediatricians meeting with primary care to review an d improve specific pathways, with view to move activity as much into the community as possible

East and North Hertfordshire NHS Trust

Agenda Item: 10

TRUST BOARD - PUBLIC SESSION – 4 MARCH 2020

Staff Survey Key Findings

Purpose of report and executive summary: To present a summary of the Trust's Staff Survey results.		
Action required: For discussion		
Previously considered by: **Quality and Safety Committee, 25 February 2020**		
Director: Chief People Officer	**Presented by:** Chief People Officer	**Author:** Deputy Director of Workforce and OD

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) Risks 002/19 and 009/19
Any other risk issues (quality, safety, financial, HR, legal, equality):

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East and North Hertfordshire NHS Trust

Staff Survey Key Findings

February 2020

Quality | People | Pathways | Ease of use | Sustainability

East and North Hertfordshire NHS Trust

Staff Survey Structure

Staff Engagement score

- **Overall Trust Staff Engagement Score 2019: 6.94 (+0.13 from 2018)**
- Staff Engagement is measured across three sub-sections of Theme 10 (Staff engagement) and measured on a scale of 0 to 10
- Used in CQC insight reporting and NHSI regulation

Themes

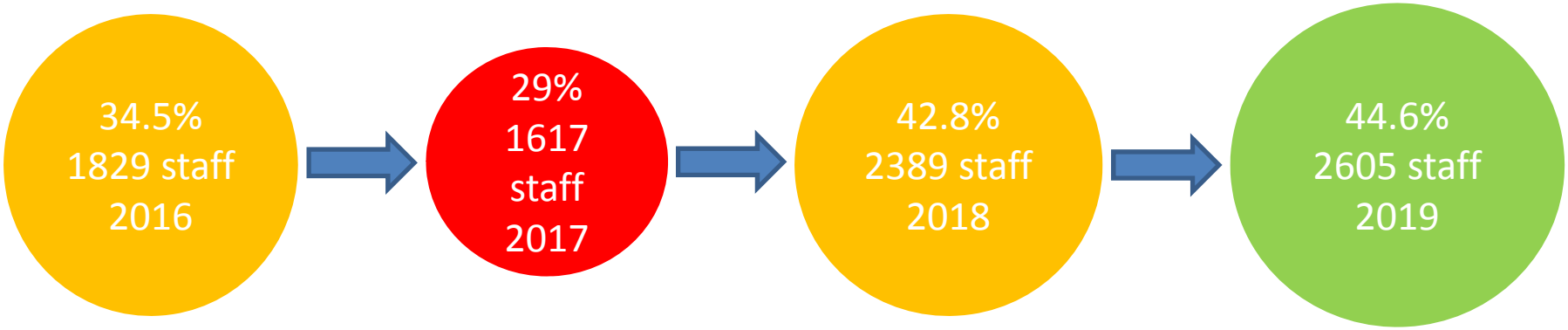
- Increase to 11 themes from 10 with the inclusion on team working
- New sections for workforce equality standards covering Race and Disability

Quality | People | Pathways | Ease of use | Sustainability

East and North Hertfordshire NHS Trust

Participation and Approach

- **Trust response rate 2019: 45% (2,605 out of 5,845)**
- Provided by Quality Health
- Used mixed-mode – paper and electronic
- All staff census
- Division led
- Benchmarked against acute Trusts (85 in group)



Quality | People | Pathways | Ease of use | Sustainability

East and North Hertfordshire NHS Trust

Comparison to 2018 performance

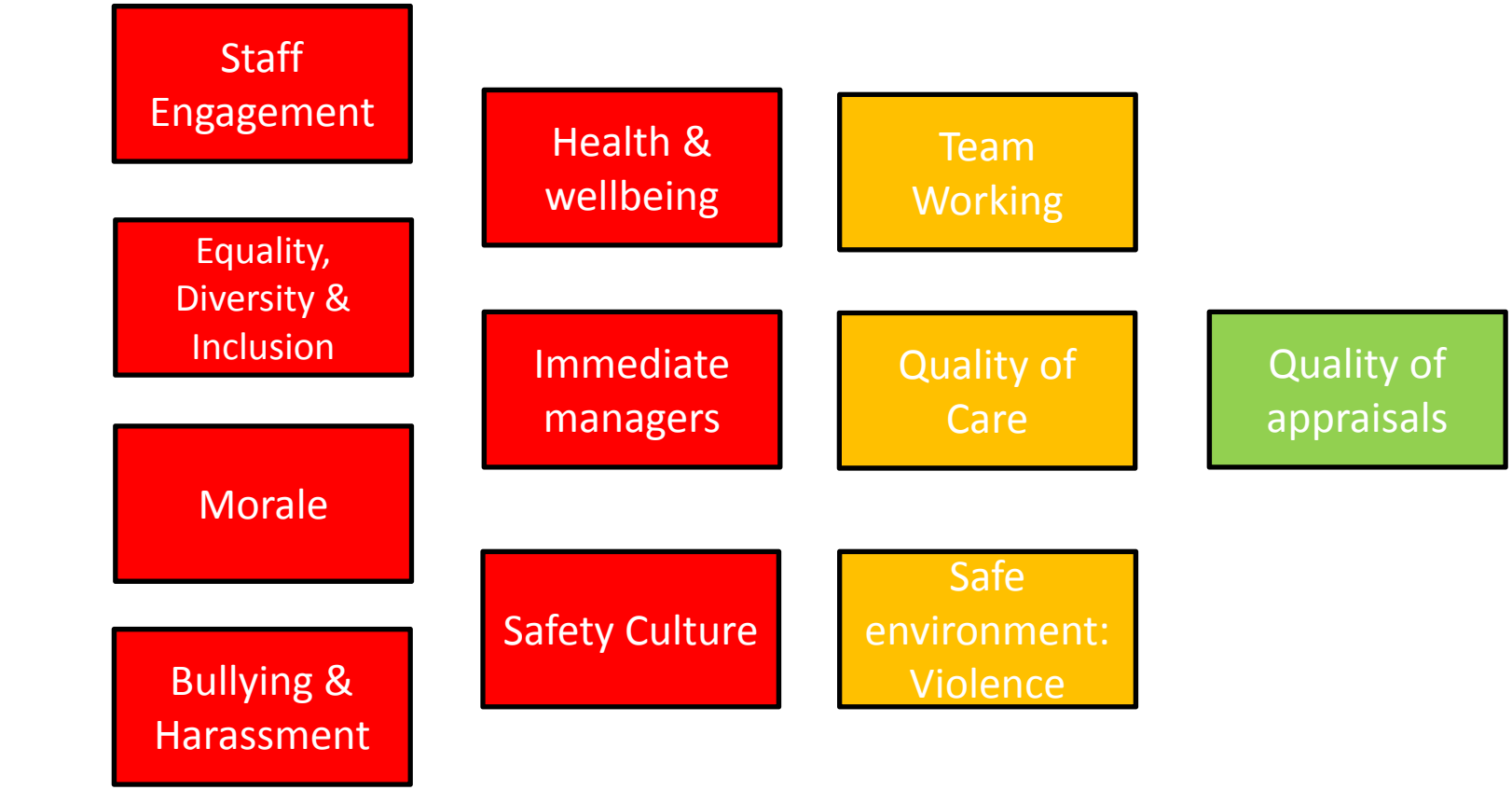
- Improvement in 9 out of the 11 themes – 5 of which have statistical significance
- Decline in 1 theme although this remains in line with national average

Theme	2018 score	2018 respondents	2019 score	2019 respondents	Statistically significant change?
Equality, diversity & inclusion	**8.9**	2331	**8.9**	2544	Not significant
Health & wellbeing	**5.7**	2349	**5.8**	2573	Not significant
Immediate managers	**6.5**	2361	**6.7**	2586	↑
Morale	**5.8**	2319	**6.0**	2550	↑
Quality of appraisals	**5.6**	1960	**5.7**	2130	Not significant
Quality of care	**7.4**	2129	**7.5**	2278	Not significant
Safe environment - Bullying & harassment	**7.6**	2330	**7.7**	2554	Not significant
Safe environment - Violence	**9.5**	2332	**9.4**	2550	Not significant
Safety culture	**6.3**	2332	**6.5**	2559	↑
Staff engagement	**6.8**	2373	**6.9**	2600	↑
Team working	**6.4**	2348	**6.6**	2561	↑

Quality | People | Pathways | Ease of use | Sustainability

East and North Hertfordshire NHS Trust

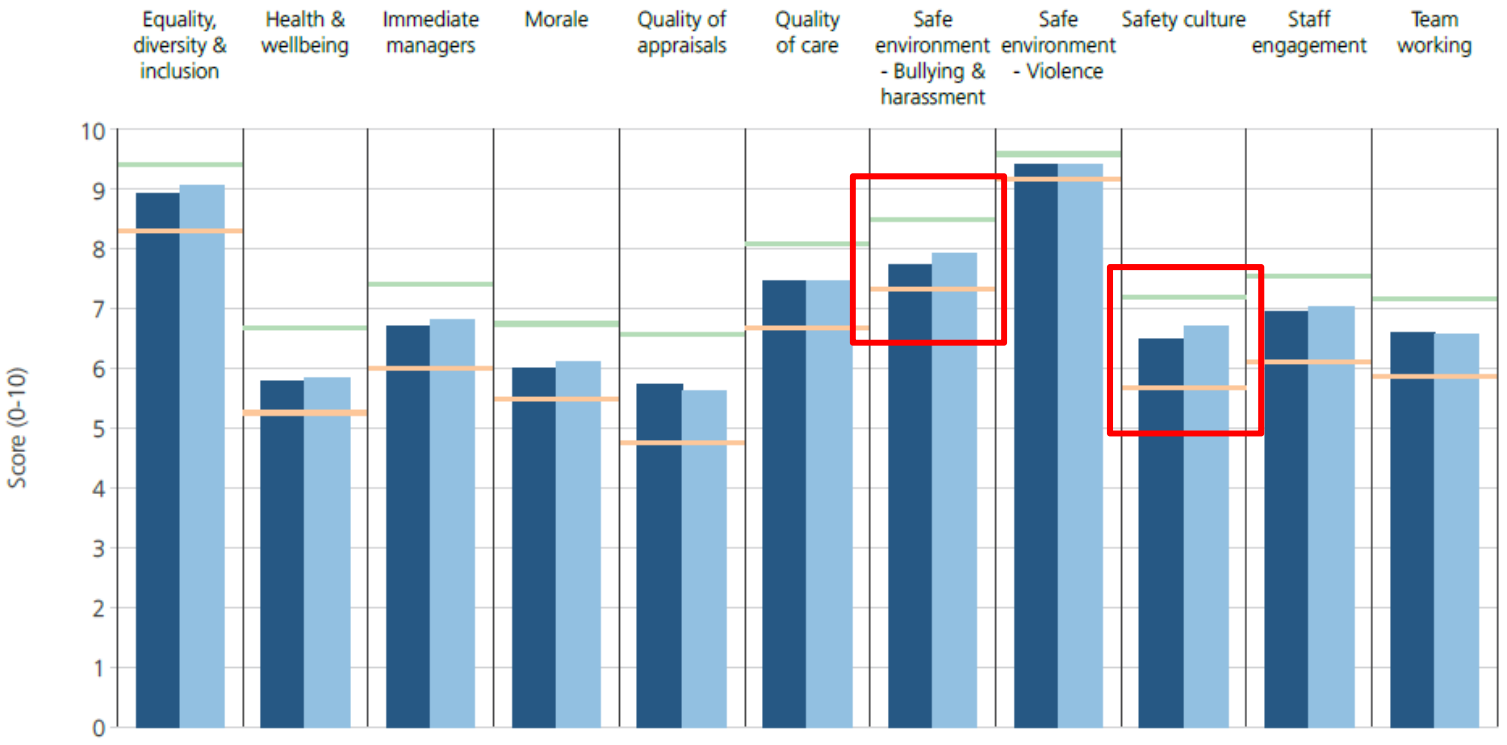
Comparison to benchmark group



Quality | People | Pathways | Ease of use | Sustainability

East and North Hertfordshire NHS Trust

Theme Results



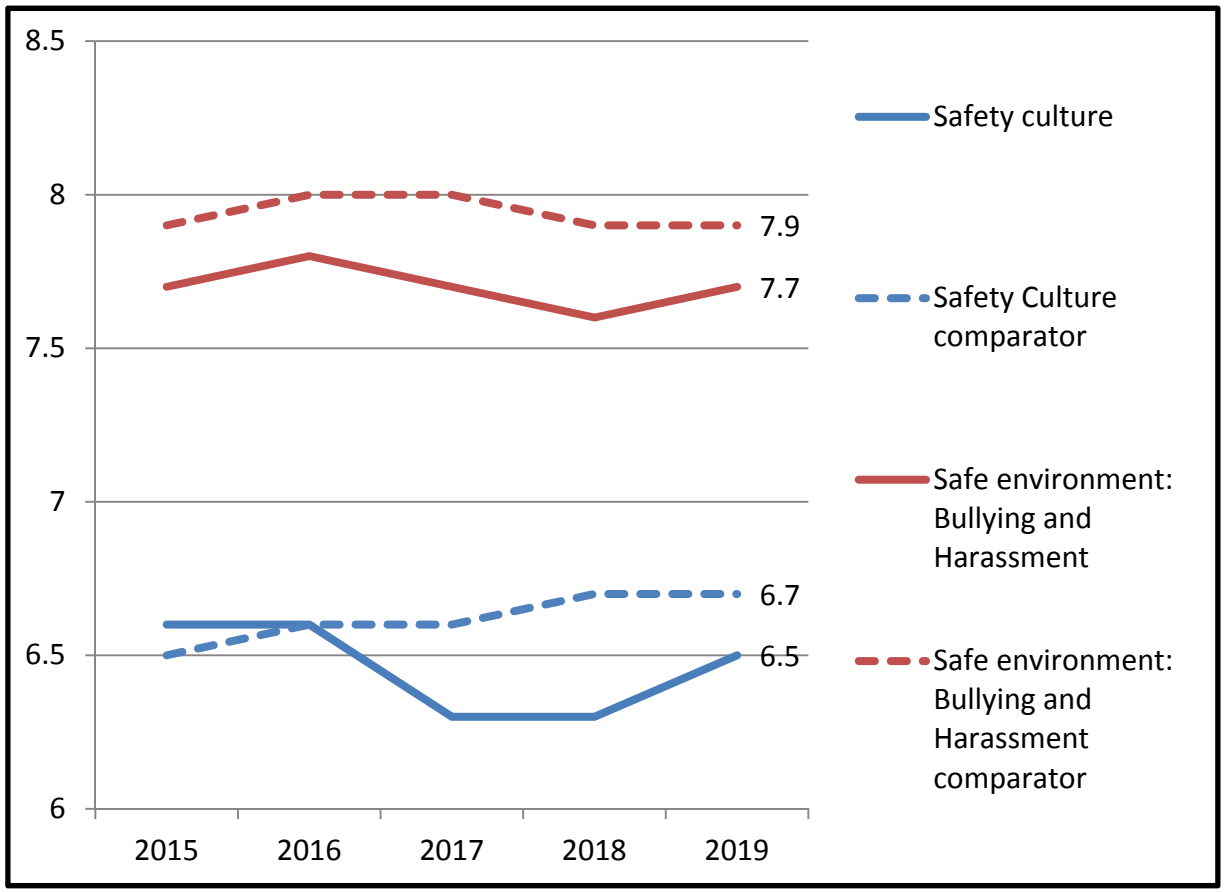
	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.4	6.7	7.4	6.7	6.6	8.1	8.5	9.6	7.2	7.5	7.2
Your org	8.9	5.8	6.7	6.0	5.7	7.5	7.7	9.4	6.5	6.9	6.6
Average	9.0	5.9	6.8	6.1	5.6	7.5	7.9	9.4	6.7	7.0	6.6
Worst	8.3	5.3	6.0	5.5	4.8	6.7	7.3	9.2	5.7	6.1	5.9
Responses	2,544	2,573	2,586	2,550	2,130	2,278	2,554	2,550	2,559	2,600	2,561

Themes furthest from average and best

Quality | People | Pathways | Ease of use | Sustainability

East and North Hertfordshire NHS Trust

Trend on key themes



- Safety culture has improved by 0.2 points but remains significantly different from average – this is an area where the Trust has performed better than average previously but it has not recovered since the drop in 2017
- B&H has been consistently below average – the gap reduced in 2019 but there remains a significant difference

Quality | People | Pathways | Ease of use | Sustainability

East and North Hertfordshire NHS Trust

Safe Environment – Bullying & Harassment

- The table below demonstrates that the key area differentiating the Trust from the sector is harassment, bullying and abuse (HBA) from managers
- It is also highlighted in another section of the survey that our staff are far less likely to report it (our Trust 42% vs sector at 47%)
- Black and Minority Ethnic (BAME) staff are more likely to experience HBA than white staff (31.2% vs 28.4%) and a greater proportion of BAME staff in our organisation report experiencing HBA compared to sector (31.2% vs 28.8%)
- Disabled staff are also more likely to experience HBA than non-disabled staff (23.7% vs 14.7%) and a greater proportion of disabled staff in our organisation report experiencing HBA compared to sector (14.7% vs 11%)

Theme/Question	Score 2018	Score 2019	Sector score
Theme 7 – Safe Environment – Bullying & Harassment	**7.64**	**7.75**	**7.90**
Experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public in the last 12 months	30%	30%	29%
Experienced harassment, bullying or abuse at work from managers in the last 12 months.	18%	16%	13%
Experienced harassment, bullying or abuse at work from other colleagues in the last 12 months.	22%	21%	20%

East and North Hertfordshire NHS Trust

Safety Culture

- While across the majority of indicators demonstrate 'significant' improvement all show a 'significant' differential from the sector score
- Key questions for the Trust to consider in relation to these indicators are:
  - Do our people feel the Trust put safety at the heart of what we do?
  - Do people feel that they work in a psychological safe environment?

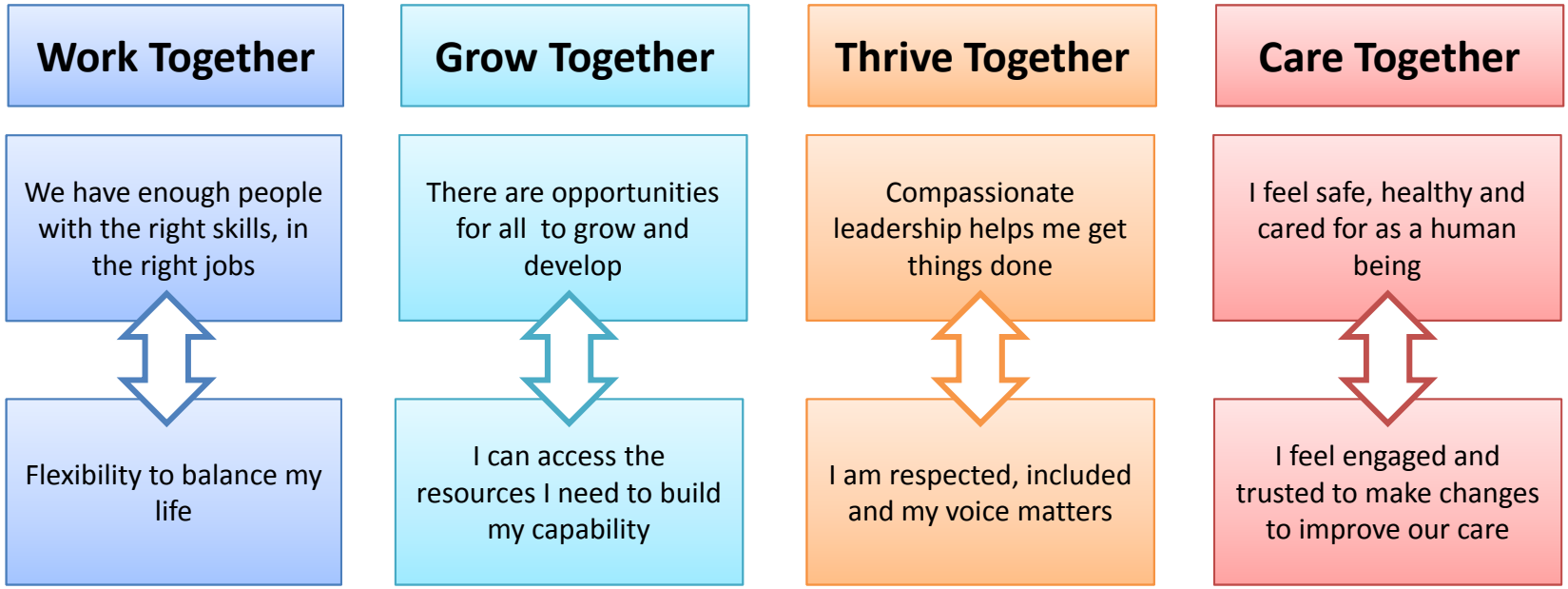
Theme/Question	Score 2018	Score 2019	Sector score
Theme 9 – Safety Culture	**6.28**	**6.49**	**6.65**
My organisation treats staff who are involved in an error, near miss or incident fairly.	53%	↑ 57%	↓ 59%
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	63%	↑ 67%	↓ 69%
We are given feedback about changes made in response to reported errors, near misses and incidents.	52%	↑ 57%	↓ 59%
I would feel secure raising concerns about unsafe clinical practice.	64%	66%	↓ 70%
I am confident that my organisation would address my concerns	49%	↑ 53%	↓ 57%
My organisation acts on concerns raised by patients / service users	66%	↑ 69%	↓ 72%

Quality | People | Pathways | Ease of use | Sustainability

East and North Hertfordshire NHS Trust

How do we respond

- The People Strategy is set out to respond to the issue that we are aware of and that are demonstrated within the staff survey results
- Safety culture and Safe Environment are specifically address within the Thrive Together and Care Together elements of the plan



Quality | People | Pathways | Ease of use | Sustainability

Key Programmes of work to deliver People Strategy

East and North Hertfordshire NHS Trust

Work

- Roles and jobs described as strengths and behaviours
- Reformed interview and selection process
- Job plans focused on patient pathway need
- Roll out of eroster for all areas, run self-rostering pilots
- Develop skills and tools to facilitate flexible working

Thrive

- Educate – psychological safety, giving & receiving feedback
- Targeted leadership programmes; DGMs, Matrons, Team Leaders, CDs
- Ensure all people policies are person centred and easy to use
- Develop leadership training and tool-kits to enable compassionate management
- Promote inclusion through influential staff networks

Grow

- Compelling modular induction and on boarding approach
- Transform MaST training approach
- Implement integrated career conversations and continuous performance appraisal
- Clear talent and succession mapping approach across every area
- Trust wide education strategy delivered by a central LED function

Care

- Clear people proposition with tailored benefits package
- Mental health first aid embedded across the Trust
- Implementation of Schwartz rounds and FTSU champions
- Pulse survey to measure engagement across the organisation
- Huddles and improved accessibility to information and updates

Quality | **People** | **Pathways** | **Ease of use** | **Sustainability**

East and North Hertfordshire NHS Trust

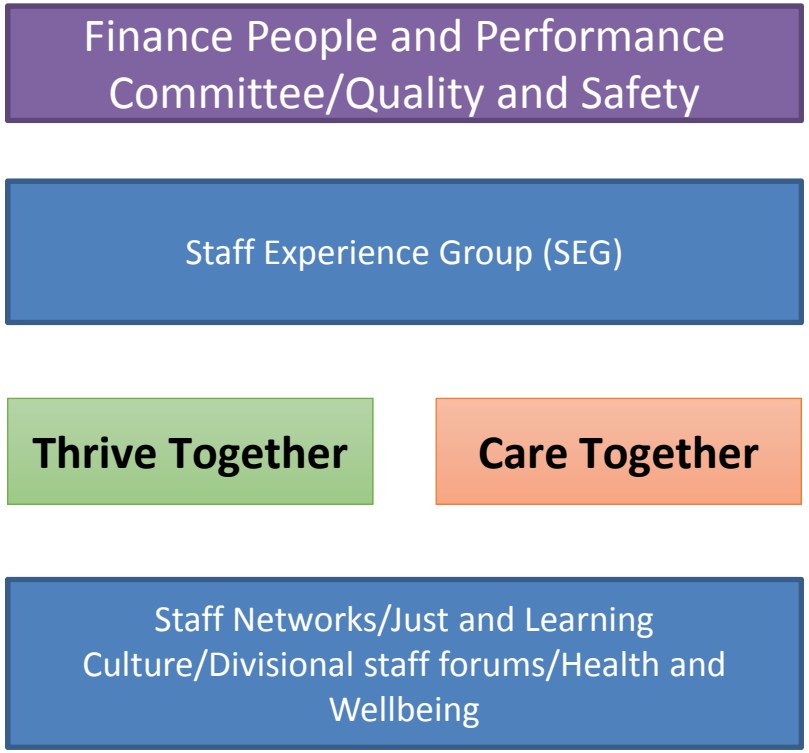
In addition…

- Immediate actions identified within Quality Health report (appendix 1) to be delivered within divisional staff forums
- Detailed analytics to take place to identify themes and hotspot areas within divisions
- Communication plan to be developed to ensure on-going communication throughout the year outlining what the feedback is telling us and all the ways that the organisation is responding
- Continuation of feedback through regular pulse surveys focusing on key themes
- Revised people metrics dashboard and measure which represent staff experience
- Key themes taken into board development sessions
- Investment in EDI and staff engagement resource through reorganisation of people team to deliver improvements

East and North Hertfordshire NHS Trust

Governance and oversight

- The Staff Experience Group (SEG) provides the reporting framework, its key responsibilities are:
- ensure the delivery of the People Strategy
- ensuring the actions are responding to the issues outline in the staff survey and will deliver improvements
- receive reports from the working groups and deal with matter for escalation
- review data to inform decision making including risks, workforce metric, staff feedback (staff survey, pulse surveys, leavers information)
- Updates on staff experience will be reported to FPPC and Q&SC as required



Quality | People | Pathways | Ease of use | Sustainability

East and North Hertfordshire NHS Trust

Appendix 1 – Quality Health Recommendations

Recommendations 1/3

- Identify any concentrations of staff who feel they have been discriminated against - in particular by managers
- Prioritise the issue of reported physical deterioration and stress at work. Make it clear that work should not come at a cost to their own health and wellbeing
- Work with immediate managers to ensure they are able to support their staff effectively and demonstrate to their staff that their work is valued
- Explore issues around morale – drill down into your data to better understand these scores
- Seek to improve the coverage of appraisals – the quality of appraisals is good

East and North Hertfordshire NHS Trust

Recommendations 2/3

- Investigate issues of HBA in particular from Managers
- Improve awareness of the need to report incidents of HBA and ensure that staff are aware of the process around this
- Investigate issues of violence in particular from Managers
- Improve awareness of the need to report incidents of violence and ensure that staff are aware of the process around this
- Ensure that the organisation's policies on handling errors, near misses and incidents are transparent and effectively communicated to all staff. Investigate the high number of errors and near misses witnessed by staff.
- Investigate why many staff don't feel they have adequate materials, supplies and equipment

Recommendations 2/3

- **Investigate issues around pay. This is directly linked to staff engagement and staff feeling valued.**
- **Look to develop communication channels between senior management and staff so that staff feel they have access to up to date information from senior staff.**
- **Ensure that staff are aware that the organisation seeks feedback from staff on a regular and ongoing basis; and that action is taken as a result of this. This could be in a 'you said, we did' model. Ensure that all staff know how to give feedback, and publicise the results.**
- **Investigate why so many staff are working additional UNPAID hours and are feeling pressured by managers to do this.**

East and North Hertfordshire NHS Trust

Agenda Item: 11 (a)

TRUST BOARD - PUBLIC SESSION – 4 MARCH 2020

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE – 29 JANUARY 2020
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present to the Trust Board the summary report from the Finance, Performance and People Committee (FPPC) meeting held on 29 January 2020 The report includes details of any decisions made by the FPPC under delegated authority.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of FPPC	**Presented by:** Chair of FPPC	**Author:** Trust Secretary/ Board Committee Secretary

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

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

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FINANCE, PERFORMANCE AND PEOPLE COMMITTEE – 29 JANUARY 2020

EXECUTIVE SUMMARY REPORT TO TRUST BOARD

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

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

OTHER MATTERS CONSIDERED BY THE COMMITTEE:

BOARD ASSURANCE FRAMEWORK

The Committee noted the latest Board Assurance Framework and risks assigned to the committee. It was reported that the risk regarding financial performance will be reviewed as year-end approaches. A summary of the deep dive regarding the governance risk that was undertaken by the Audit Committee was presented to the FPPC. The FPPC recommended that consideration should be given to raising the governance risk score in relation to recent correspondence with HSE.

DIGITAL PROGRAMME REPORT

The Committee received an update on the Trust's digital programme. A proposed road map detailing timeframes and funding secured to date was presented ahead of consideration by the Clinical Advisory Group. The Committee reviewed an update regarding the implementation of windows 10. The Committee also discussed the importance of the implementation, adoption and effective use of new systems including Nervecentre.

FINANCE REPORT M9

The Committee was presented with Month 9 Finance report. The report showed an in month deficit of £1.4m which was £69k favourable to the plan submitted to NHSI. The Trust remained on track to deliver the control total.

OUTTURN FORECAST

The Committee received a report from the Director of Finance regarding the Outturn Forecast. The report provided an updated position in terms of the expected outturn forecast. The Director of Finance emphasised that achieving the control total was not a given and would require focus and discipline through to the year end.

BUDGET SETTING UPDATES

The FPPC received an update on the Budget setting process including operational and system expectations and requirements to be considered in 20/21 financial planning. The FPPC noted the update.

CIP PERFORMANCE ANALYSIS AND UPDATE

The Committee received a report on CIP performance. The PMO Director updated the committee on the current position and expected performance by year end. He also reported on work underway to identify CIP schemes for 20/21 and work taking place with the CCG on the development of QIPPS. The FPPC requested a short report on key reflections from 2019/20 and how the learning would be built into the 2020/21 CIP.

PROCUREMENT UPDATES
The FPPC received an update on procurement. The report provided an update on next steps to improve the Trust's procurement function, and the progress with the previously reported business case proposal that had been agreed by all partner STP Trusts. The FPPC noted the update.

INTEGRATED PERFORMANCE REPORT
The Committee received the latest Integrated Performance Report, covering Month 9. The Committee received the following updates:

Safe and Caring
The safe and caring and effective aspects of the integrated performance report were covered at the Quality and Safety meeting held on 28 January 2020.

Responsive Services:

- ED performance was 78.87% for December. The year-end position was 82.69% which was slightly above the National average.
- FPPC welcomed the ongoing improvement to cancer waiting times with the 62 day performance target being met. Mechanisms to ensure improvements were maintained were discussed.
- Diagnostics –Six months of sustained delivery had now been recorded.
- Stroke – Performance had not improved since the previous meeting; a separate stroke performance update was also provided.
  RTT – Performance had deteriorated from November to December. It was the intention to put a significant focus on improving RTT in 2020.

Well-led Services:
The report was covered at the Quality and safety meeting held on 28 January 2020, and through other reports on the agenda.

Sustainable Services:
The key points under sustainable Services were addressed through other papers on the agenda.

STROKE PERFORMANCE UPDATES
The Committee received an actions log detailing steps being taken to improve stroke performance. The Committee discussed some of the key elements and requested a follow-up in a few months' time.

PERFECT WEEK AND WINTER PLANNING
The FPPC received an update on Perfect week and winter planning. It was reported that 21 initiatives were supported and invested in to improve performance over winter and work was taking place to identify the schemes with the biggest impact. It was reported that regular scheduled perfect weeks would be planned for Easter, summer break and before winter to assist ongoing improvement to services.

PLANNED PATIENTSMANAGEMENT
The Committee received a report on Planned Patient Management. The report outlined issues, actions taken to date and risks relating to managing patients on the patient tracking lists (PTL).The Committee requested that KPI metrics should be presented at the next meeting and sight of the action plan at a future meeting.

RESOURCING UPDATE
The Committee was presented with an update on resourcing performance over the last year. It was reported that there had been a net increase in terms of WTE staff within the Trust. The Committee discussed the impact of different staffing models and noted current plans and expected timeframes for delivery.

APPRAISAL AND STATUTORY AND MANDATORY TRAINING UPDATE
The Committee received a report on Appraisals and Mandatory and Statutory Training. It was reported that the Trust was considering options for a digitally oriented approach in terms of staff training. The Committee supported the report and direction of travel.

WAVE 5 BID UPDATE
The Committee was presented with an update on STP wave 5 bids. A total of 4 bids was planned to be submitted to the STP; it was reported that work had taken place to ensure the alignment of those bids to the Trust's strategy. The committee noted the latest updates regarding each bid and discussed how business case development might be strengthened in future.

Karen McConnell
Finance, Performance and People Committee Chair

January 2020

East and North Hertfordshire NHS Trust

Agenda Item: 11 (b)

TRUST BOARD - PUBLIC SESSION – 4 MARCH 2020

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE – 24 FEBRUARY 2020
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present to the Trust Board the summary report from the Finance, Performance and People Committee (FPPC) meeting held on 24 February 2020. The report includes details of any decisions made by the FPC under delegated authority.		
Action required: For discussion		
Previously considered by: Due to be considered by Corporate Trustee prior to public meeting of Trust Board on 24 February 2020.		
Director: Chair of FPC	**Presented by:** Chair of FPC	**Author:** Trust Secretary/ Board Committee Secretary

Trust priorities to which the issue relates:	**Tick applicable boxes**
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Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term.	☒

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

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FINANCE, PERFORMANCE AND PEOPLE COMMITTEE – 24 FEBRUARY 2020

EXECUTIVE SUMMARY REPORT TO TRUST BOARD

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

The following core attendees were present:
Martin Armstrong (Director of Finance), Rachael Corser (Director of Nursing), Julie Smith (Chief Operating Officer), Jude Archer (Associate Director of Corporate Governance)

OTHER MATTERS CONSIDERED BY THE COMMITTEE:

BOARD ASSURANCE FRAMEWORK
The Committee noted the latest Board Assurance Framework and risks assigned to the Committee. The risks around IT, finance and performance were reviewed and risk ratings were unchanged. The Committee supported that the risk relating to EU Exit should be de-escalated from the BAF. Any new risk rising from EU exit would be included in the relevant governance area eg staffing in the BAF. The Committee requested an update on any procurement risks arising from Coronavirus. It was reported that additional controls are in place regarding purchases and no supply chain issues had been identified. On the Corporate Risk Register the new IT risks were noted and it was acknowledged that there has been an improved performance on all corporate risks and work is ongoing towards closing all historical risks that were no longer relevant.

ESTATES AND FACILITIES DEEP DIVE
The Committee received an update on estates and facilities. The report provided an overview of the Trust's estates and facilities and key priorities. It was reported that work is currently ongoing on strengthening the governance structure, premises assurance model, better document management procedures, strategies, risks and external services. The Committee commended the report and recommended a risk review which would also help prioritise areas for investment. The draft strategy will be discussed at the Committee in September 2020.

RENAL BUSINESS CASE
The FPPC received an update on the Renal Business case. The report presented the current position and identified issues and risks, including those relating to the future operation of the Renal Unit. It was reported that there was no delivery timeline at present as the structure and governance arrangements need to be improved. An expert opinion will be sought. The FPPC requested a 'lessons learnt' report on business case development and implementation at a future meeting. In the meantime work will continue on the Renal Business Case.

INTEGRATED PERFORMANCE REPORT
The Committee was presented with the latest Integrated Performance Report, covering Month 10. The Committee received the following updates:

Safe and Caring Services
The safe and caring and effective aspects of the integrated performance report would be covered at the Quality and Safety meeting on 25 February 2020.

Responsive Services

The Chief Operating Officer updated the Committee on the Responsive aspect of the IPR. It was reported that;

- ED performance was 85% for January. This meant that the Trust is ranked 7th in terms of highest performance regionally.
- Cancer continues to improve at 87.6%. This puts the Trust in 22nd position nationwide.
- Stroke – Performance had not improved since the previous meeting. Improvement is envisaged in the February report. It was agreed that this should be reflected on the BAF and will be considered as a future topic for a deep dive.
- Diagnostics –remained compliant to Trust and National target.
- RTT – Performance had improved compared to last month but the backlog had increased.

The FPPC enquired about stroke metrics and challenges around compliance. They referred to the data presented on bed occupancy and discussed bed utilisation.

Well- led

The Deputy Director of Workforce and OD presented the well led aspect of the IPR to the FPPC. It was reported that;

- 11 out of 15 mandatory models were compliant with a target of 90%
- Newly recruited international nurses were due to commence in the next couple of months
- 70% performance recorded in terms of the staff flu vaccination rate.
- The Committee suggested doing more work on retention. It was reported that a deep dive into nursing and midwifery recruitment would provide assurance that steps were being taken to improve the retention rate.

Sustainable Service

The key points under sustainable Services were addressed through other papers on the agenda.

MONTH 10 FINANCE REPORT

The Committee received a report from the Director of Finance regarding the Month 10 finance report. The Trust is on Plan at month 10. However, it remains important that cost control is maintained as the majority of SLA income is now fixed. The FPPC noted the report.

OUTTURN FORECAST

The FPPC received an update on the Outturn Forecast. It was reported that Month 10 and Year to Date performance remains in line with the financial operating plan and is consistent with achievement of the 19/20 control total. The FPPC noted the report.

BUDGET SETTING UPDATE

The FPPC received an update on budget setting. It was reported that the Project Management Office is working collaboratively with the CCG on the QIPP portfolio with joint PMO review of the proposed schemes. Work is ongoing to identify which schemes to prioritise. It was believed that collaborative working would help to achieve successful delivery of QIPP.

CIP PERFORMANCE ANALYSIS AND UPDATE

The Committee received a report on CIP performance. The CIP portfolio is forecast to deliver against both the forecast and original financial plan CIP target of £15m. An update was provided on CIP development for 2020/21. Progress to date has been slower than anticipated because of Winter Pressures but steps are being taken to ensure the Trust will have schemes in place within the required timeframes.

IFRS 16
The FPPC received a report on the implementation of IFRS 16 accounting standard and the estimated impact on the Trust financial position and the effect on the future Capital Departmental Expenditure Limit (CDEL) of the Trust. It was agreed that the Finance Department should have oversight of contractual agreements before they are signed to assess the impact of the new standard. The Committee noted a potential risk arising from IFRS 16 relating to the Mount Vernon transfer.

STRATEGY PROGRAMME BOARD REPORT
The FPPC received a report from the Strategic Development Committee following its first meeting on 6 February 2020. It was reported that clinical strategies and strategic priorities in terms of ICP/ICS were discussed. The future work of the Committee was highlighted. The FPPC recommended that a 5 year workforce and finance plan should be considered by the Committee.

STAFF EXPERIENCE GROUP UPDATE
The FPPC received an update on the development of and progress made by the Staff Experience Group for consideration. It was reported that the purpose of the group was to focus on continuous improvement and help to deliver the People Strategy along with requirements of the NHS People Plan. Progress against the Strategy will be incorporated into the IPR. Future plans and recommendations were noted and approved by the Committee

INCLUSION / EDI REPORT
The Committee received an update on equality, diversity and inclusion. The report provided detailed initiatives and updates from staff networks, high level indicators from the staff survey, employee relations information and how this supports the Trust's People Strategy. It was noted that representatives from the staff networks will be attending Board development days throughout the year. The next steps and recommendations in the report were agreed by the Committee

GENDER PAY GAP REPORT
The FPPC received and discussed a report on the gender pay gap. The report contained analysis and findings based on data as at March 2019. It was reported that a review of the entire workforce identified areas with the highest percentage pay gaps. The report and its recommendations were approved.

Karen McConnell
Finance, Performance and People Committee Chair

February 2020

East and North Hertfordshire NHS Trust

Agenda Item: 11.1

TRUST BOARD - PUBLIC SESSION – 4 MARCH 2020

Gender Pay Gap Report February 2020

Purpose of report and executive summary (250 words max): This paper outlines the Gender Pay Gap analysis and findings based on data as at March 2019. The Board is asked to consider and note the content and approve the publication of the same on the Trust and national websites.		
Action required: For approval		
Previously considered by: HR senior team		
Director: Chief People Officer	**Presented by:** Chief People Officer	**Author:** Head of HR

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

Does the issue relate to a risk recorded on the Board Assurance Framework? YES

1. There is a risk that the trust is unable to recruit and retain sufficient supply of staff with the right skills to meet the demand for services
2. There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered and motivated, impacting on the trust's ability to deliver the required improvements and transformation and to enable people to feel proud to work here

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

Ineffective or inefficient staff management is likely to increase negative staff survey results, turnover, sickness absence and replacement costs.

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

TRUST BOARD – PUBLIC MEETING

Gender Pay Gap Report 2020
(data as at 31 March 2019)

1. ORGANISATIONAL BACKGROUND

East and North Hertfordshire NHS Trust provides secondary care services for a population of around 600,000 in East and North Hertfordshire as well as parts of South Bedfordshire and tertiary cancer services for a population of approximately 2,000,000 people in Hertfordshire, Bedfordshire, north-west London and parts of the Thames Valley.

We are committed to Equality, Diversity and Inclusion (EDI) being at the heart of everything we do and deliver for service users and their relatives, as well as our 6,000 plus staff.

The composition of our workforce presented in the table below is based on the staff list report from the Electronic Staff Record (ESR) as of 31st March 2019. It represents the ratio of females to males in each staff group; and females and males in relation to all staff in each staff group.

Main Staff Group	Males to females	Females to males	Males to all staff	Females to all staff
Add Prof Scientific and Technic (e.g Pharmacists Technicians)	20.50%	79.50%	0.68%	2.65%
Additional Clinical Services (e.g HCA's, health support workers)	16.07%	83.93%	2.40%	12.55%
Administrative and Clerical	15.24%	84.76%	3.54%	19.67%
Allied Health Professionals (e.g Occ Therapists, Physio's)	17.76%	82.24%	0.77%	3.55%
Estates and Ancillary	57.02%	42.98%	3.25%	2.45%
Healthcare Scientists (e.g Pathology staff)	36.68%	63.32%	1.22%	2.10%
Medical and Dental	55.04%	44.96%	7.66%	6.26%
Nursing and Midwifery Registered	8.92%	91.08%	2.79%	28.31%
Overall	22.31%	77.69%	22.31%	77.69%

2. CONTEXT AND REPORTING REQUIREMENTS

Gender pay gap reporting is a mandatory reporting requirement for public sector organisations employing in excess of 250 staff. The gender pay gap is the difference between average (mean and median) earnings of men and women, expressed relative to men's earnings. It should not be confused with unequal pay, which is the unlawful practice of paying men and women differently for performing the same or similar work or work of equal value.

The East and North Hertfordshire NHS Trust ("Trust") is therefore required to publish its gender pay gap data and any supportive narrative on its public facing website and submit its gender pay gap report/data to the government online reporting service.

The Trust is reporting the following information, as per these requirements:

1. The difference between the mean hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees

2. The difference between the median hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees
3. The difference between the mean bonus pay paid to male relevant employees and that paid to female relevant employees
4. The difference between the median bonus pay paid to male relevant employees and that paid to female relevant employees
5. The proportions of male and female relevant employees who were paid bonus pay
6. The proportions of male and female full-pay relevant employees in the lower, lower middle, upper middle and upper quartile pay bands

The Trust will update our action plan to respond to these findings. Progress will be monitored and reported quarterly to the Finance, Performance and People Committee.

All information captured in this report is based on the calculations made relating to the pay period in which the snapshot day falls. For the purpose of the 2018/19 analysis, this has been set as 31st March 2019. (N.B. any enhancements for unsocial hours for staff on agenda for change and medical and dental contracts are paid a month in arrears). A detail of how the calculations are conducted is available at appendix 1.

3. DATA ANALYSIS

1. **Mean gender pay gap** – the data suggests that the gender pay gap for mean average ordinary earnings for women is **23%** less than for men an improvement of 4% compared to 2018.

2. **Median gender pay gap** – the data suggests that the gender pay gap for median average ordinary earnings for women is **12.4%** less than for men, which is 1.2% worse than in 2018.

Gender	Mean hourly rate 2018	Mean hourly rate 2019	Median hourly rate 2018	Median hourly rate 2019
Male	£21.95	£21.56	£16.23	£16.64
Female	£15.91	£16.61	£14.40	£14.57
Difference	£6.04	£4.95	£1.83	£2.07
Pay Gap %	**27.53%**	**22.97%**	**11.27%**	**12.44%**

3. **Mean bonus pay gap** – the data suggest that the gender pay gap for mean average bonus earnings for women is **5.4**% less than for men, a marked improvement of 21.43% compared to 2018.

4. **Median bonus pay gap** – the data suggests that the gender pay gap for median average bonus earnings for women is **7.6%** less than for men, a marked improvement of 25.73% compared to 2018.

Gender	Mean average bonus 2018	Mean average bonus 2019	Median average bonus 2018	Median average bonus 2019
Male	£14,668.64	£9383.32	£9,040.50	£9227.42
Female	£10,732.85	£8880.49	£6.027.04	£8524.57
Difference	£3,975.79	£502.38	£3,013.46	£702.85
Pay Gap %	**26.83%**	**5.4%**	**33.33%**	**7.6%**

As this represents a significant improvement, further analysis will be completed to understand if this relates to actions the Trust has taken to influence the change or whether this was an exception. This is essential to understand so that the improvement can be sustained.

5. **Gender composition of bonuses** – the data shows that the proportion of males receiving a bonus was **6.43**%, whilst **0.83**% of female employees were in receipt of a bonus payment. This is comparable with last year with only a 0.03% reduction for females receiving bonuses.

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	39	4657	0.83%
Male	86	1337	6.43%

Staff receiving bonus will only apply to medical consultants due to the merit awards, therefore when this is represented as a proportion of the entire Trust, which has a majority female workforce, it will show a far higher proportion in favour of males. However, of our total staff, only 317 employees (medical consultants) were eligible for bonus payments in 2019. The table below represents the consultant body with gender composition and bonus payments distribution. Out of 317 eligible staff, 125 were in receipt of clinical merit award, which equated to **39.43**% in total distributed by **36.11**% of female compared to **41.15**% of male medical consultants were paid the award. While additional people have received bonuses in both groups the percentage of males in receipt has increased this year compared to the previous.

Gender	2018 headcount Consultants	2018 % of consultants with bonus	2019 headcount Consultants	2019 % of consultants with bonus
Female	104	33.65%	108	36.11%
Male	210	39.05%	209	41.15%
Grand Total	314	37.26%	317	39.43%

6. **Gender composition in each quartile pay band** – the tables below represents the proportion of male and female employees in each quartile pay band:

Quartile (2018)	Female	Male	Female %	Male %
1 (lowest pay)	1071	299	78.18	21.82
2	1116	252	81.58	18.42
3	1158	211	84.59	15.41
4 (highest pay)	866	502	63.30	36.70
Overall gender split	4211	1264	76.91%	23.09%

Quartile (2019)	Female	Male	Female %	Male %
1 (lowest pay)	1116	288	79.49%	20.51%
2	1126	277	80.26%	16.74%
3	1191	222	84.29%	15.71%
4 (highest pay)	900	512	63.74%	36.26%
Overall gender split	4333	1299	76.94%	23.06%

The above tables highlight that although the representation at each quartile remains largely consistent. This demonstrates the disparity in tier 4 (highest pay) which is influenced mostly by admin staff, mostly in corporate areas where there are more males in senior positions.

7. **Additional reporting** – In looking to give greater detail around the mean difference, additional reports were taken from ESR – the following highlights the differences by staff group. Negative

figures in AHP and Nursing and Midwifery staff groups indicate a gender pay gap in favour of females. The most significant gender pay gap in favour of males are admin and clerical, healthcare scientists and, medical staff with a pay gap of **21.76%, 12.9**% and **14.19**% respectively.

Main Staff Group	Male Avg. Hourly Rate	Female Avg. Hourly rate	Difference	Pay gap 2019	Pay gap 2018
Add Prof Scientific and Technic (e.g Pharmacists Technicians)	£19.33	£17.90	£1.43	7.38%	-0.13%
Additional Clinical Services (HCA's, health support workers)	£11.00	£10.98	£0.02	0.20%	3.41%
Administrative and Clerical	£17.40	£13.61	£3.79	21.76%	20.90%
Allied Health Professionals (Occ Therapists, Physio's)	£19.11	£20.12	-£1.02	-5.33%	-5.00%
Estates and Ancillary	£11.59	£10.81	£0.78	6.74%	7.58%
Healthcare Scientists (Pathology staff)	£20.46	£17.82	£2.64	12.90%	15.21%
Medical and Dental	£38.05	£32.65	£5.40	14.19%	15.40%
Nursing and Midwifery Registered	£16.68	£18.00	-£1.32	-7.91%	-9.35%

The RAG rating above is classified as follows compared to 2018:

- green highlights a positive change for female workers,
- amber shows a positive change towards female favour however remains a significantly in favour of males
- red shows a significant change / or significant level in favour of male workers.

Agenda for change vs. medical and dental – the trust has also undertaken analysis of staff pay in order to identify potential gender pay gap separating Agenda for Change and Medical and Dental terms and conditions of pay. The data suggests that gender pay gap for agenda for change employees is in favour of females, whilst the medical and dental staff group's gender pay gap is in favour of males.

	Mean average hourly rate	Mean average hourly rate
	Non Medical (AfC, Trust Pay & Tupe)	Medical and Dental staff
All (hourly rate)	£15.65	£35.80
Female	£15.72	£32.65
Male	£15.30	£38.05
Difference	£0.42	£5.40
Pay Gap %	2.67% in females favour	14.19% in males favour

4. ENHT PAY ARRANGEMENTS

Gender Pay Gap is different to Equal Pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman. The trust delivers equal pay through a number of means but primarily through adopting nationally agreed terms and conditions for our workforce:

5. RECOMMENDATIONS

The trust is committed to addressing issues identified within this Gender Pay Gap report. A number of actions are suggested to ensure that the trust continues to follow best practice in this area:

1. All female employees continue to be encouraged to submit applications for Clinical Excellence Awards.
2. Ensure the trust's recruitment and selection policy and process for internal and external candidates avoids potential bias against women.
3. Explore whether there are any genuine occupational requirements which may enable recruitment to post that are underrepresented by female employees.
4. Consider occupational stereotypes and create staff stories and share role models to reduce these.
5. To ensure that flexible arrangements apply equally to all posts irrespective of seniority which may assist female under representation at higher bandings.
6. Ensure that the Trusts talent conversations identify and remove barriers for all staff who would otherwise be dissuaded from exploring promotion.

Appendix 1 Details on how calculations are completed.

For the calculation of **ordinary pay** the following has been taken into consideration:

- Basic pay
- Paid leave, including annual, sick, maternity, paternity, adoption or parental leave (except where an employee is paid less than usual or nothing because of being on leave)
- Area and other allowances (N.B. the Trust, due to its sites geographical location, awards outer, fringe and no High Cost Area Supplement, depending on employees' main base of work)
- Shift premium pay, defined as the difference between basic pay and any higher rate paid for work during different times of the day or night
- Pay for piecework

The calculation of an ordinary pay does not include any of the following:

- Remuneration referable to overtime.
- Remuneration referable to redundancy or termination of employment
- Remuneration in lieu of leave
- Remuneration provided otherwise than in money.

For the calculation of **bonus pay** the following has been taken into consideration:

- Any remuneration that is in the form of money, vouchers, securities, securities options, or interests in securities, and
- Relating to profit sharing, productivity, performance, incentive or commission.

The calculation of a bonus pay does not include any of the following:

- Ordinary pay
- Remuneration referable to overtime
- Remuneration referable to redundancy or termination of employment
- Remuneration in lieu of leave

NB – Bonus payments in the Trust are exclusively made up from Medical Consultants' merit awards (i.e. Clinical Excellence Awards)

East and North Hertfordshire NHS Trust

Agenda Item: 12 (a)

TRUST BOARD PART 1 – 4 MARCH 2020

QUALITY AND SAFETY COMMITTEE – MEETING HELD ON 28 JANUARY 2020

EXECUTIVE SUMMARY REPORT

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

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

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

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

QUALITY AND SAFETY COMMITTEE MEETING HELD ON 28 JANUARY 2020

SUMMARY REPORT TO TRUST BOARD MEETING ON 4 MARCH 2020

The following Non-Executive Directors were present:

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

The following core attendees were present:

Jude Archer (Associate Director of Corporate Governance), Rachel Corser (Director of Nursing), Duncan Forbes (Chief People Officer), Julie Smith (Chief Operating Officer).

The following points are specifically highlighted to the Trust Board:

1. Perinatal Mortality Review Report

The report was submitted to provide the assurance that the maternity services are contemporaneously and continuously monitoring the Stillbirth and Neonatal death rates, by means of the PMRT (perinatal mortality review tool).

The report provided a summary of the outcomes and actions for the third quarter of 2019/2020 (Oct-Dec) and considered the number of stillbirths and neonatal deaths and their causes and learning and actions from the deaths. In the time period, there were 1347 babies born and one case where care issues may have made a difference. This was being investigated as a SI.

2. Health and Safety Executive Update

Following an inspection in September 2019, the HSE found the Trust in breach of the Health and Safety Regulations and issued three improvement notices in regard to Moving and Handling, Violence and Aggression and Sharps. An action plan was developed and submitted to the HSE on 10 January 2020.

The Associate Director of Corporate Governance reported that the HSE had responded that they were not content with the progress of the actions so they were not able to discharge on the improvement notices as yet. The CEO, Director of Strategy and Associate Director of Corporate Governance met the HSE representatives on 23 January 2020 and revised actions and timescales were agreed. The issues of Sharps and Violence and Aggression were to be addressed by 28 April 2020. A deadline of 31 July had been set for Moving and Handling actions.
The Associate Director of Corporate Governance would submit bi-monthly updates to the Committee.

Other outcomes:

NHS Resolution Update

The Divisional Chair, Women & Children gave an update on the third year of NHS Resolutions 10 steps to safety. He reported that the Trust had been compliant with the standards for the past two years. He said that complying with the 10 steps was getting more challenging as the requirements became more stretching and highlighted current areas of concern in complying with the standards.

The QSC noted the update.

Integrated Performance Review

The Integrated Performance Report Month 9 was presented to the Committee. Key challenges and mitigations under each domain were identified within the report.

Safe and Caring services

The Director of Nursing reported;

- Infection control was an ongoing challenge. There had been 2 MRSA cases in December.
- Sir Robert Francis would attend the formal launch of the Deteriorating Patient breakthrough series in April.
- Complaints and Patient Experience - for four months consecutively the response rate had been above 85%.

Effective Services

The Associate Medical Director: Clinical Effectiveness reported that

- The in-month crude mortality rate increased to 13.3 deaths per 1,000 admissions in December.
- The rolling 12-months crude mortality rate remained at 10.7 deaths per 1,000 admissions in the 12 months to December;
- The in-month HSMR increased to 75.4 in October, but remained better than the standard (100).
- The latest SHMI release for the 12 months to July saw a slight improvement to 90.47.
- The Mortality Surveillance Committee would keep a watching brief for any outliers.

Responsive Services

The Chief Operating Officer reported that December had been a very challenging month in A&E. Performance was at 78.87%. The calendar year end position was 82.69%, compared to a national position of 82.19%.

There were no 12-hour trolley waits reported in December. There was an average of 495 patient attendances every day in December which was the highest for the 12 month period.

- Cancer Waiting Times - The Trust 62-day performance for November 2019 was 85.3%, which was above the trajectory of 85.1%.
- RTT - Incomplete performance for December was 83.05%, deterioration from the 83.93% reported in November.
- Stroke - Performance for November was 57.1% and had deteriorated to 54%.

Well Led Services

- Overall staff utilised including bank and agency had reduced by 50 WTE. Agency expenditure increased by £22k, however the Trust was under the agency ceiling by £118k in month.
- There was a 0.9% improvement on turnover compared to the same month the previous year, however month on month there has been an increase of 0.1% to 12.8%.
- Overall sickness absence rate increased by 0.1% to 4.3% which was 0.7% lower than last year.

- Appraisal compliance decreased from 87% to 84%, against a target of 90%.
- 12 out of the 15 mandatory training modules were on target and overall compliance hit the target of 90%.

Board Assurance Framework

Updates in terms of BAF risks were:

- Risk 4, Capital Resources and Risk 11, Estates and Facilities which remained at 20. The new Director of Estates and Facilities commenced in January 2020 and would develop an Estates Strategy.
- Risk 12, MVCC - A preferred provider for the services at MVCC was been agreed by Specialist Commissioners in January 2020.
- Risk 10, EU Exit - The risk has been reduced to 12, in line with the national position reducing the risk of a no deal scenario.
- Risk 7, Governance - The outcome of the CQC and use of resources reports in December 2019, the HSE Inspection in October 2019 and NHSI and Internal Audit reviews were now reflected in the risk.

Risk Update Report

The Committee received the latest version of the risk report and noted the updates and latest thematic analysis. The Trust's mean figure for compliance with the timely review of risks KPI is 72.5%. Compliance with the timely implementation of risk actions KPI is 72.9%. This is an improving position.

Patient Experience Quarterly Update

The update was submitted to inform the QASC of the Trust's position with regard to the quarter 3 (October – December 2019) patient experience feedback, complaints and PALS activity.

The majority of feedback received via the Trust's patient experience surveys, including the friends and family test question, was positive. The highest number of positive comments related to staff and care/treatment and the highest number of negative comments related to the environment. The report is attached as item 12.1.

Patient Safety Incidents Report

A report was submitted to inform the committee of patient safety incidents data, trends and themes. Key areas covered in this report included the following:

- Key Trust changes that may affect incident reporting;
- Total incidents reported;
- Approval status;
- The safety thermometer; and
- GP liaison hotline queries.

The Committee discussed the possibility of changing the focus of future reports to learning from SIs and NEs.

Infection Prevention and Control Report

A report was submitted to inform the Committee of infection prevention and control performance for December 2019. The Committee noted the latest performance, having discussed IPC already under the IPR.

Safer Staffing Report

The major findings from the report on safe staffing levels were:

- The Overall Fill Rate decreased by 0.2 from 96.4% in November to 96.2% in December.
- CHPPD remained static at 7.5 CHPPD in November and December as a result of decreased fill rates and decreased occupancy.
- The overall fill rate for temporary staffing decreased by 3.6% from 80.0% in November to 76.4% in December. Demand hours decreased by 941 hours.
- The overall Trust position for qualified nursing in month 9 saw 11.4 WTE new starters and 23.1 WTE leavers, giving a negative variance of 11.7 WTE for the month. This has resulted in a vacancy rate of 7.4%, an increase of 0.8% from month 8.
- The vacancy rate for unqualified nursing increased by 0.7% in month 9 to 14.4%, equating to 92 vacancies.

The Committee noted the latest update.

Clinical Harm Reviews Update

An update was provided regarding the Clinical harm review process. The report outlined the number of 52 week breaches and the process in place for their review.

The Committee noted the update.

GIRFT Report

The Committee received a report regarding the Trust's engagement with the GIRFT programme. Getting It Right First Time (GIRFT) is a programme designed to improve clinical quality and efficiency within the NHS by reducing unwarranted variations. The programme identifies differences in the way services are delivered. In addition GIRFT also encourages the sharing of best practice between trusts and proposes improvements within specialties to help improve patient outcomes and bring about efficiencies.

The Associate Medical Director: Clinical Effectiveness reported that the Trust has participated in 12 GIRFT Speciality programme Deep Dives and 1 Operational Patient Flow review. Visits are prepared through survey questionnaire data collection. A provider specific speciality pack is then populated. After the visit a Rapid review report is published. This informs local actions plans. She reported that clinical engagement was strong and learning had been substantive.

Compliance Update

A compliance update was presented to the Committee. The CQC Inspection report was published in December 2019. An action plan was submitted to the CQC on 22 January 2020 and a comprehensive engagement process was agreed with the CQC. The S29a warning notices for surgery and QEII UCC were lifted.

The Committee noted the report.

Emergency Preparedness Report

The Chief Operating Officer advised the Committee of progress against the Emergency Preparedness Resilience and Response (EPRR) work programme. She reported that over the last year, the readiness of the Trust for business continuity events and major incidents continued to develop, and the Trust had a compliance rating of Fully Compliant against NHS England's EPRR Core Standards. This had been achieved as a result of the continuing wholesale review of the Trust's EPRR structures, resourcing, work programme, and documentation.

The Committee also noted the actions being taken regarding coronavirus.

Learning, Education and Talent Management Report

The Chief People Officer briefed the Committee on plans for Learning and Education Development within the Trust. A review into education development had been initiated. It was reported that an Education Board would be forming and options for greater use of digital systems for learning were being explored.

In response to questions from Committee members, it was reported that firmer plans were expected by March 2020.

Junior Doctors Contract Quarterly Update

The Associate Medical Director presented the latest quarterly report from the Trust's Guardian of Safe Working Hours. For the period of this report there were 95 Exception Reports submitted (95 episodes). The majority of reports (79) were for overtime hours.

There were 2 patient safety concern reports of which only 1 represented a true safety concern. Understaffing of Junior Dr rotas was documented as an issue in 44 Exception Reports from this quarter.

The Committee noted the update.

The following reports were noted by the Committee:

- Maternity Dashboard Exceptions
- Clinical Effectiveness Committee Escalation Report

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Peter Carter

QSC Chair

January 2020

East and North Hertfordshire NHS Trust

Agenda Item: 12 (b)

TRUST BOARD - PUBLIC SESSION – 4 MARCH 2020

QUALITY AND SAFETY COMMITTEE – MEETING HELD ON 25 FEBRUARY 2020

EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the QSC meeting of the 25 February 2020 to the Board.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of QSC	**Presented by:** Chair of QSC	**Author:** Trust Secretary / Corporate Governance Officer

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

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

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

QUALITY AND SAFETY COMMITTEE MEETING HELD ON 25 FEBRUARY 2020
SUMMARY REPORT TO TRUST BOARD MEETING of 4 MARCH 2020

The following Non-Executive Directors were present:
Peter Carter (Committee Chair), Ellen Schroder (Trust Chair), David Buckle (Associate).

The following core attendees were present:
Michael Chilvers (Medical Director), Rachel Corser (Director of Nursing), Julie Smith (Chief Operating Officer).

The following Deep Dives were considered by the Committee:

1. Cancer Services Presentation

The Committee received a presentation from representatives of the Cancer Division. The presentation covered the Division's top risks, an update on the MVCC clinical advisory panel review action plan and an update on the CQC action plan.

The Committee discussed that, despite challenges in terms of the environment, the feedback from patients regarding the care received was generally positive.

Regarding the clinical advisory panel review recommendation to transfer the specialised oncology service at MVCC to an existing tertiary cancer service provider, it was reported that UCLH had been identified as the preferred provider and the due-diligence process was currently underway.

The Committee discussed workforce challenges and was pleased to hear of recent successes in terms of recruitment at MVCC.

The Committee took assurance from the presentation and thanked the presenters and their Divisional colleagues for the work they are undertaking.

2. National Safety Standards for Invasive Procedures (NatSSIP) Presentation

The Committee received a presentation regarding the work taking place in the Trust in terms of NatSSIPs, following a dedicated launch in October 2019. NatSSIPs are intended to provide a skeleton for the production of Local Safety Standards for Invasive Procedures (LocSSIPs). They standardise key elements of procedural care, ensure that care is harmonised and reinforce the importance of education to patient safety. It was noted that it had been more than 120 days since the last surgical Never Event. LocSSIPs and NatSSIPs would help to prevent the occurrence of such incidents in future.

The presentation set out the governance process for the work and the aim of having 80% of invasive procedures undertaken at the Trust with published Local Safety Standards by March 2021. The Committee noted that this was an ambitious target.

The Committee discussed the application of LocSIPPS across departments and how these initiatives are communicated with staff.

The Committee discussed and agreed that a means for the Committee to monitor progress against the 80% target would be developed.

3. Harm Free Care Collaborative Presentation

The Committee received a presentation regarding the Harm Free Care Collaborative. The presentation provided an update on the work that had taken place to date through the collaborative. The presentation set out plans to broaden the scope of the work of the collaborative, to place greater emphasis on celebrating success as well as learning from failures. They also discussed how changing some of the language used in terms of patient safety could help to create the right mind set for staff.

The Committee also noted the intention to expand the current use of Schwartz rounds within the Trust. The Committee discussed the purpose and benefits of the Shwartz rounds for staff. There was also some discussion regarding the best means of utilising safety huddles.
The Committee noted the update.

4. Staff Survey

The Committee received a presentation regarding the staff survey results. It was reported that the overall Trust staff engagement score had increased slightly from 2018, but not by a material amount.

The Trust's response rate had increased over the last two years though the Committee considered an even greater response rate could be achieved and would help to provide a more accurate insight of staff satisfaction overall.

The results were grouped under 11 themes and the Trust's 2019 scores had improved on the 2018 scores in all but one theme, though in the majority of cases the change was not by a statistically significant amount. The comparison to the benchmark group indicated that the Trust's scores were worse than average in 7 of the 11 themes.

The Committee were informed that the People Strategy would be the main mechanism for addressing the areas of concern raised by the survey results. It was also the intention to undertake regular 'pulse' surveys throughout the year to provide in-year evidence of staff satisfaction.

The Committee noted that there had been a small improvement on the previous year's results, but recognised that there was further work to be done. The Chair also suggested that a more rigorous action plan was needed to be discussed in preparation for the next staff survey.

<u>Other outcomes</u>:

University Status Annual Report

The Committee considered the draft University Status Annual Report. The report outlined key achievements and progress made over the year. The Committee discussed the link between the University and the Trust's internal education services and opportunities for greater alignment. The Committee endorsed the annual report.

Integrated Performance Report
The Committee considered the latest edition of the IPR. Key points raised under each of the domains were as follows:

Safe and Caring:

- IPC performance remained an area of focus.
- Sepsis six bundle compliance was disappointing and work was ongoing to improve performance in this area.
- Performance in terms of complaints response times had been sustained.

The Committee also received an update regarding the Trust's preparations in relation to coronavirus.

Effective:

- The mortality metrics remain in a good position on the whole.
- The Committee was pleased to note the inclusion of data regarding palliative care for the first time.

Responsive

- The 4 hour ED performance was 81.54% for January but had improved in February to date.
- The Trust had continued to achieve the 62 day cancer target and was now compliant with 7 of the 8 national standards for cancer services.
- Stroke performance had continued to deteriorate. This performance was impacted by challenges with patient flow within the organisation. There would be continued focus on improving this performance and a deep dive had been requested by FPPC.

Well-led

- The vacancy rate remained a challenge and work was taking place to address this.
- The next cohort of international nurses was due to join the Trust over the next couple of months.

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

Safer Staffing Report
The Committee received the latest Safer Staffing Report, covering January 2020. The report therefore covered the period in which the winter ward had been opened. The fill rate was up slightly and it was noted that there had been 46 unmitigated red shifts across inpatient areas in January, which equated to 1.42%. The Committee also discussed the impact of sickness rates and noted that the unqualified nursing sickness rate was much greater than that for qualified nurses.

Infection Prevention and Control Report
The Committee noted the IPC report, having discussed performance already under the IPR.

Maternity Dashboard
The Committee noted the latest version of the Maternity Dashboard and the matters escalated through the report.

Clinical Effectiveness Committee Escalation Report
The Committee noted the Clinical Effectiveness Committee Escalation Report

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Peter Carter
QSC Chair
February 2020

Agenda Item: 12.1

TRUST BOARD - PUBLIC SESSION – 4 MARCH 2020

Patient Experience Quarterly Update

Purpose of report and executive summary:

Purpose:

To inform the Board of the Trust's position with regard to the Q3 (October – December 2019) patient experience feedback, complaints and PALS activity.

Executive Summary:

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

The Patient Advice Liaison Service (PALS) received several contacts in relation to cancellation of appointments and patients seeking assistance in obtaining access to treatment. Patients advised PALS that they remain on hold for long periods of time when trying to contact the Ophthalmology Service via the telephone.

Formal complaints were raised by patients in relation to appointments being cancelled, sometimes at short notice and difficulties in contacting the Trust by telephone to rebook. Concerns were raised that some patients did not receive an appointment letter by post in a timely manner.

Action required: For discussion

Previously considered by:
Patient and Carer Experience Committee, 20 January 2020,
Quality and Safety Committee, 28 January 2020

Director:	**Presented by:**	**Author:**
Director of Nursing and Patient Experience	Director of Nursing and Patient Experience	Project Manager – Nursing and Patient Experience/ Deputy Complaints and PALS Manager

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☐
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):

East and North Hertfordshire NHS Trust

DIRECTOR OF NURSING AND PATIENT EXPERIENCE REPORT – JANUARY 2020

COMMENTS, COMPLIMENTS, CONCERNS, COMPLAINTS

Introduction

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

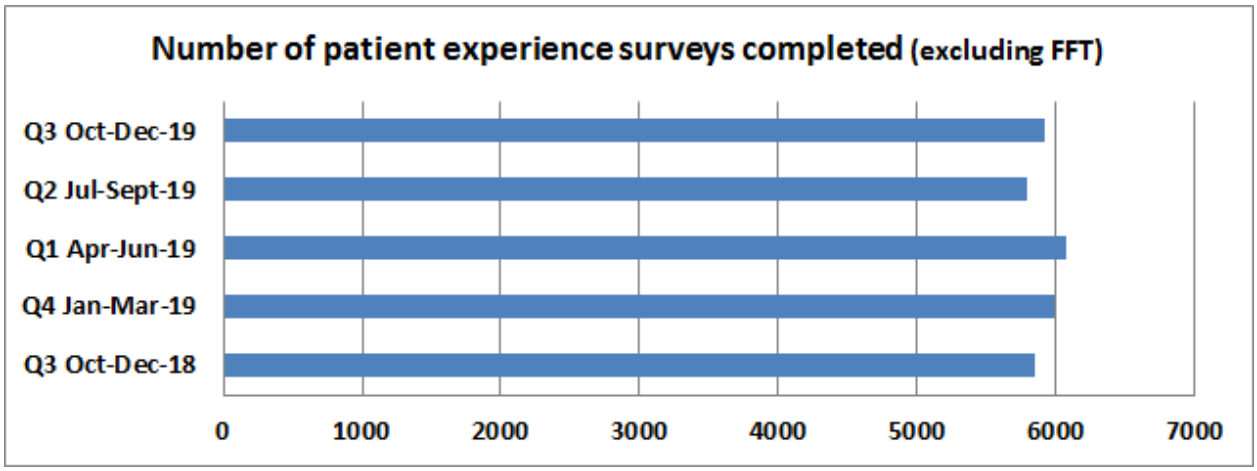
Patients and carers are able to provide feedback and raise questions or concerns about their hospital experiences in a variety of ways. All feedback is shared with the relevant ward or department to enable teams to share positive feedback and consider suggestions for improvements made by patients and carers. Each ward/department has a 'learning from your experience' poster which is updated monthly to share the actions that have been taken as a result of patient feedback. The responses to key questions from the inpatient experience survey is monitored and reported monthly by ward/department in the Nursing and Midwifery Quality Indicators. Each Division has a patient experience action plan which is reviewed and monitored by the Trust's Patient and Carer Experience Committee.

Rachael Corser
Director of Nursing and Patient Experience

Patient Experience Headlines	Page No	RAG
CQC Children's and Young People's 2018 survey Compared to other Trusts, ENHT is better than most trusts on 5 questions, worse than most trusts on 2 questions and about the same on the remaining 57 questions. Compared to the 2016 Children and Young People's survey, ENHT results were significantly higher on 5 questions, significantly lower on 1 question and there was no significant difference for the remaining 51 questions.	**15**	
Patient Advice and Liaison Service (PALS) In Q3 2019-20 932 PALS concerns were received, compared to 962 in Q2 2019-20.	**16-19**	
Formal Complaints In Q3 2019-20 282 formal complaints were received, compared to 242 in Q2 2019-20.	**19-23**	
Acknowledgement rate and telephone contact The NHS Complaints Regulations (2009) stipulate that formal complaints must be acknowledged within three working days. In Q3 2019-20, 100% of all formal complaints received across the Trust were acknowledged in writing or via telephone within three working days.		
Timeframe for response The Trust KPI is for 80% of complaints to be responded to within the agreed timeframe. Year to date 80% of complaints have been responded to within the agreed timeframe agreed with the complainant.		
PHSO In Q3 2019-20 the Parliamentary Health Service Ombudsman made requests for two papers for review.	**23**	
PHSO report on Complaints about the NHS in England – Quarter 1 2019-20 The PHSO have committed within their strategy 2018-2021 to publish more information about their casework than in previous reports. For the first time they have published data and information on complaints that they have assessed and investigated, as well as the recommendations they have made. ENHT does not feature in the PHSO Q1 report.	**23**	
Healthwatch England 'Shifting the Mindset' – a closer look at hospital complaints Healthwatch England have published a report 'Shifting the Mindset' – a closer look at hospital complaints. The publication follows research undertaken by Healthwatch which has concluded that trusts are publishing information on the number of complaints they receive but are not communicating learning and recommendations to the public.	**23**	

Patient Experience Surveys

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



There has been a slight increase in the total number of patient experience surveys completed – 5,927 in Q3, compared to 5,794 in Q2 2019-20.

Word clouds generated from Inpatient and Day Case comments received between October-December 2019

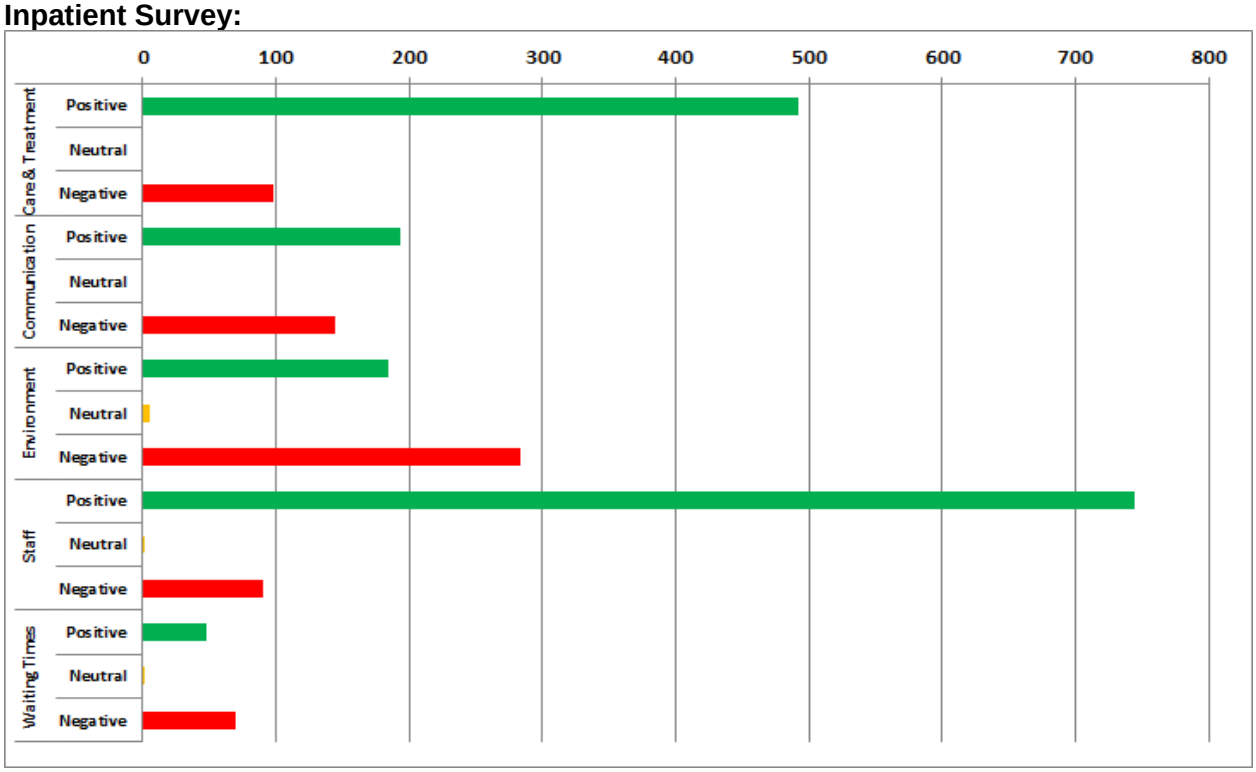
What was good about your stay/visit?

What would have made your experience better?

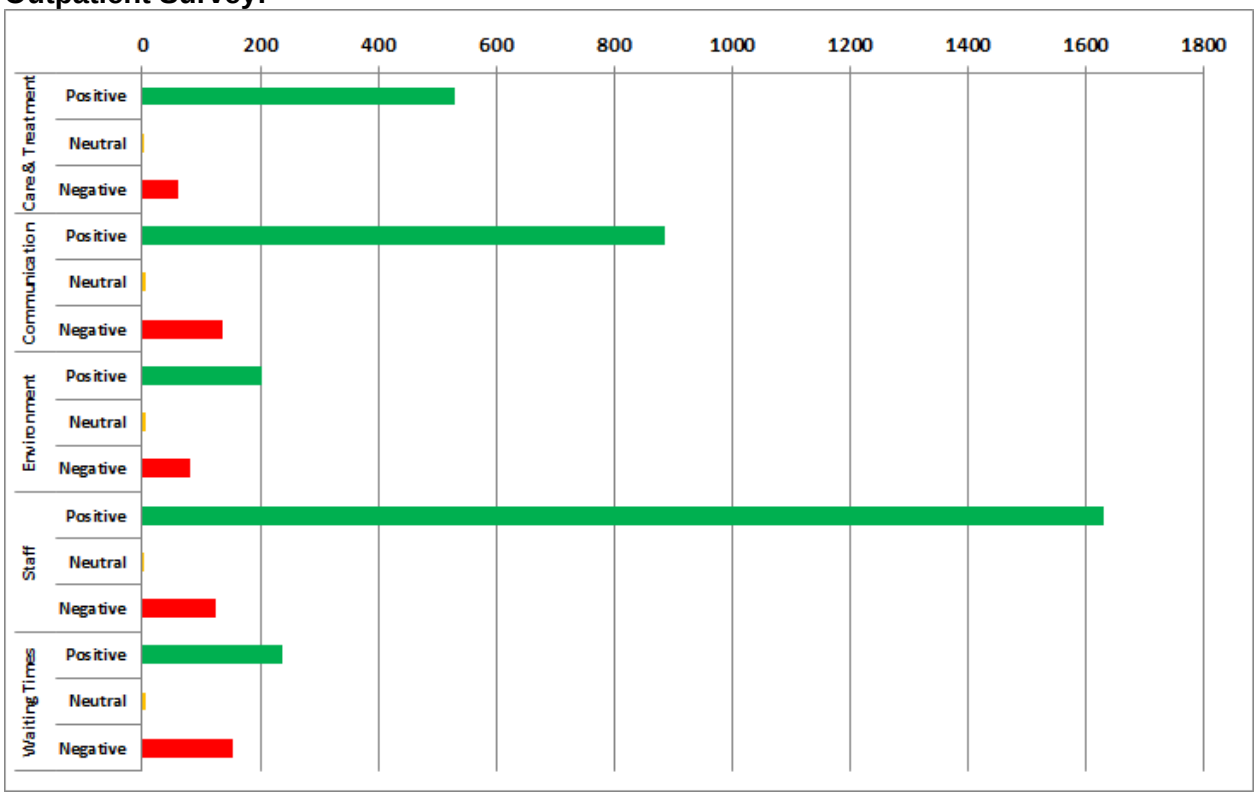
The IQVIA (previously called Meridian) patient experience survey system automatically allocates a positive, neutral or negative rating to patient comments, theming them against the following five categories: Care and treatment, Communication, Environment, Staff, Waiting. This system has been set up using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

The graphs below summarise the number of positive, negative and neutral comments against each category for Q3 for the Inpatient survey and Outpatient survey:

Inpatient Survey:

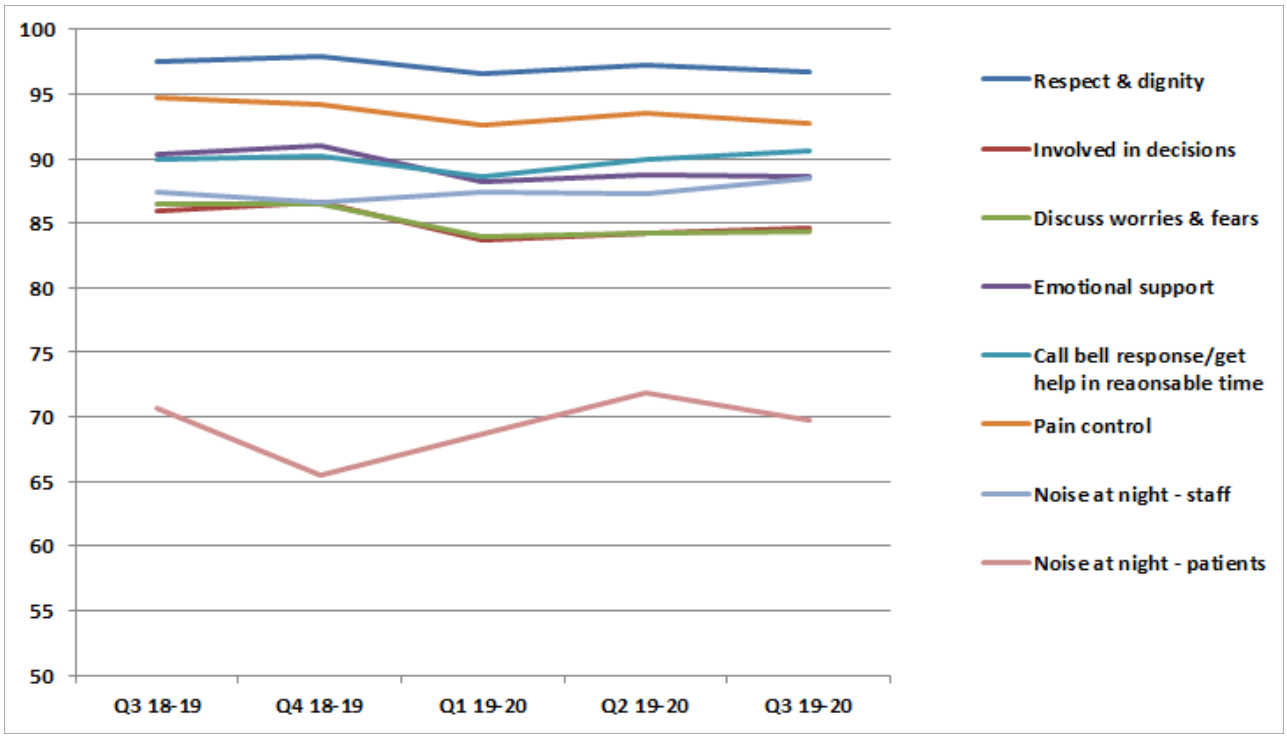


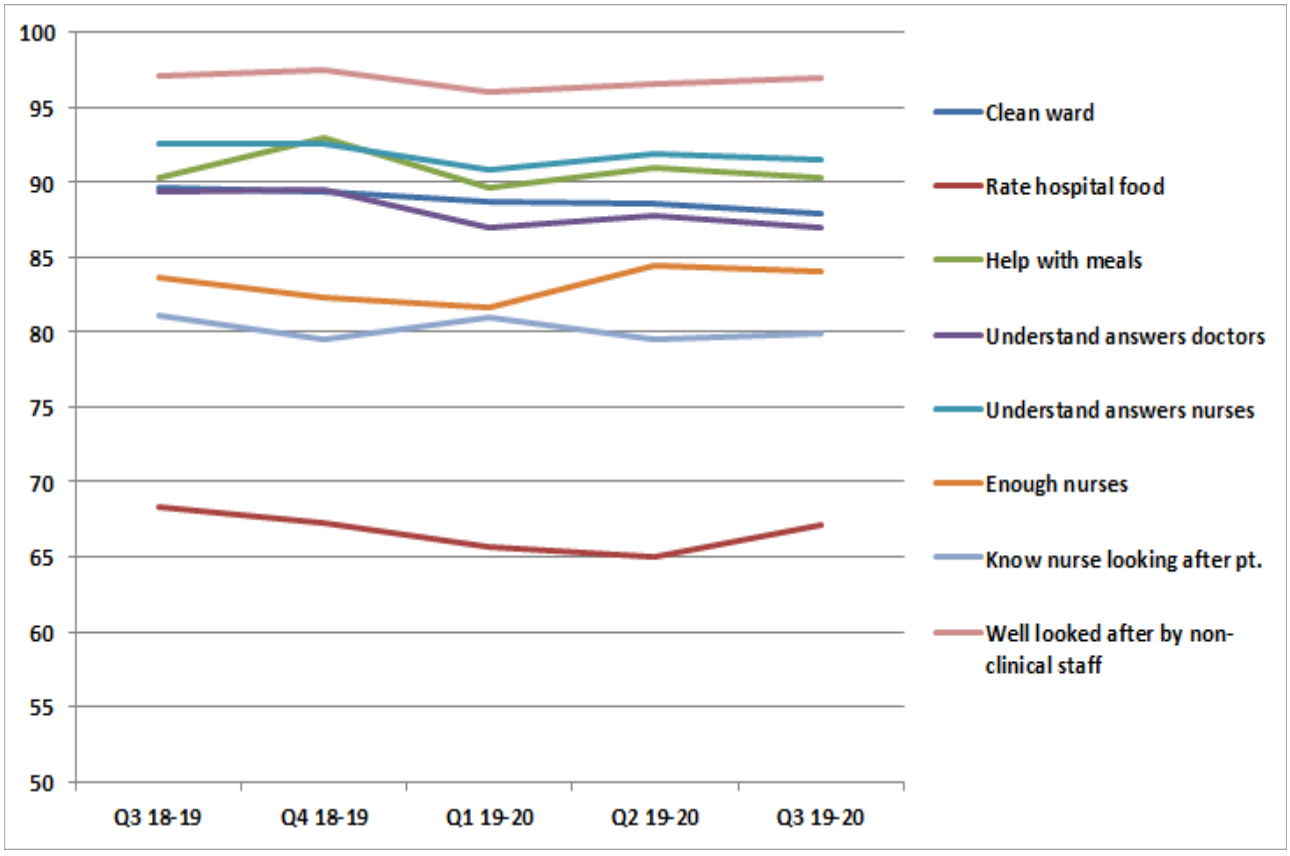
Outpatient Survey:



Inpatient Survey

Comparison of responses to questions in the Inpatient survey: Q3 2018-19 to Q3 2019-20





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

Hospital Food:

- The Catering Team have reviewed the patient dining menus incorporating seasonal changes, and at this time of year will be adding fresh cabbage and Brussel sprouts to the menus. Going forward into Spring the team will look at adding kale, broccoli tops and swede.
- The new Texture Modified Meals have been a hit with those patients that have some form of dysphasia. By the end of February we will also have a new range of cultural, religious and allergen meals available.
- The patient dining experience over the Christmas period was a great success with every patient being offered a special Christmas, Boxing and New Year's Day lunch and supper. The feedback has been positive with many comments on how nice the turkey was and how patients enjoyed their party sandwiches over the three days.
- Around the Christmas period the Restaurant hosted Christmas dinner over three days which culminated with many members of the executive team serving customers their Christmas lunch. The event was a great success and the catering team were grateful of the support at this busy time.

Noise at night from other patients:

- The Enhanced Nursing Care Team (ENCT) provide additional support for vulnerable patients who may disturb other patients on the wards. Staff within the team have the training and skills to meet the specific care needs of patients requiring specialling. Patient care can be planned according to individual patient care needs with the involvement of relatives and carers. The Trust's Dementia and Delirium Policies include care pathways, which include referral of patients to the ENCT as indicated.

The Friends and Family Test (FFT)

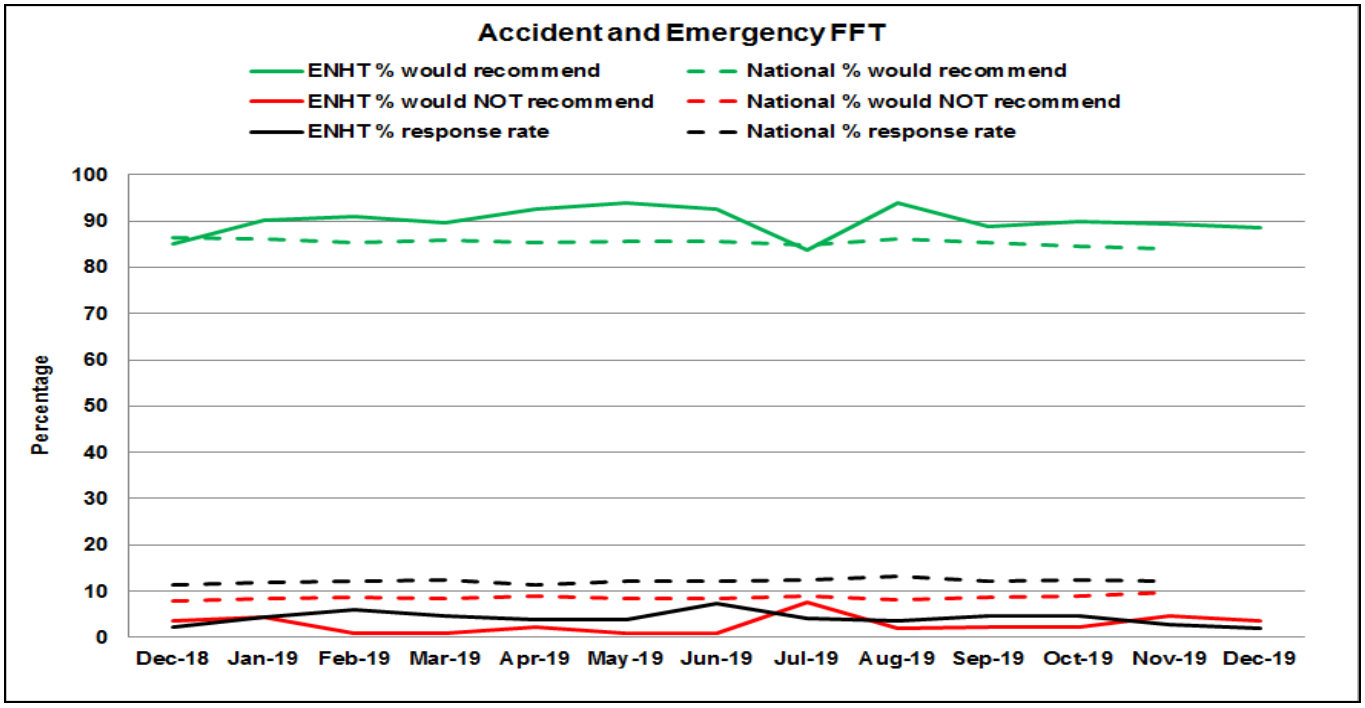
Number of patients responding to Friends and Family Test

Breakdown of FFT responses for Q3 2018-19 – Q3 2019-20:

	Inpatients/ Day Case	A&E	Outpatients	Maternity				TOTAL
				Antenatal	Birth	Postnatal	Community	
Q3 2018-19	5587	1274	5398	71	415	415	82	**13242**
Q4 2018-19	5774	2087	6055	53	360	358	55	**14742**
Q1 2019-20	6111	2113	9993	28	361	357	30	**18993**
Q2 2019-20	5982	1798	9374	29	319	319	13	**17834**
Q3 2019-20	6100	1504	7037	29	352	351	24	**15397**
Total	**18193**	**5415**	**26404**	**86**	**1032**	**1027**	**67**	**52224**

Inpatients & Day Case FFT

	Would recommend		Would not recommend		Response rate	
	%	Compared to last quarter	%	Compared to last quarter	%	Compared to last quarter
Trust target	96% 2019-20				40% 2019-20	
Q3 Oct-Dec-18	97.08	↑	0.36	↓	40.12	↓
Q4 Jan-Mar-19	96.97	↓	0.47	↑	41.19	↑
Q1 Apr-Jun-19	96.66	↓	0.70	↑	44.05	↑
Q2 Jul-Sept-19	97.26	↑	0.77	↑	43.03	↓
Q3 Oct-Dec-19	96.75	↓	0.80	↑	45.26	↑



Staff were welcoming, friendly and compassionate to all family, not just patient. Play specialist Stacey was fantastic with our baby's older brother and built a teddy with him that had a nasal tube like his sibling so he didn't find it frightening. Nursing staff really helped advocate for our son's case and what was right/best for him as an individual and our family. Nurses don't get enough credit for the thankless job they do.

Bluebell Ward Oct-19

Staff were very swift when asked for pain relief and other medications. They answered all questions I had, gave me emotional support when I found things hard. Staff and volunteers are very friendly. Porters were very hard working and always chatted to cheer me up.

Ward 7B *Oct-19*

Need better communication between doctors/consultants and patient. They all said different things.

Ward 8B Nov-19

Recovery nurse was amazing - very caring and looked after me well. Treatment Centre staff were lovely, I didn't feel rushed out of the door. Thorough post-op advice and checked if I had any questions.

Treatment Centre Day Surgery Nov-19

It's way too noisy at night. I knew staff need to do their things but other patients are inconsiderate when it comes to late night noise and light.

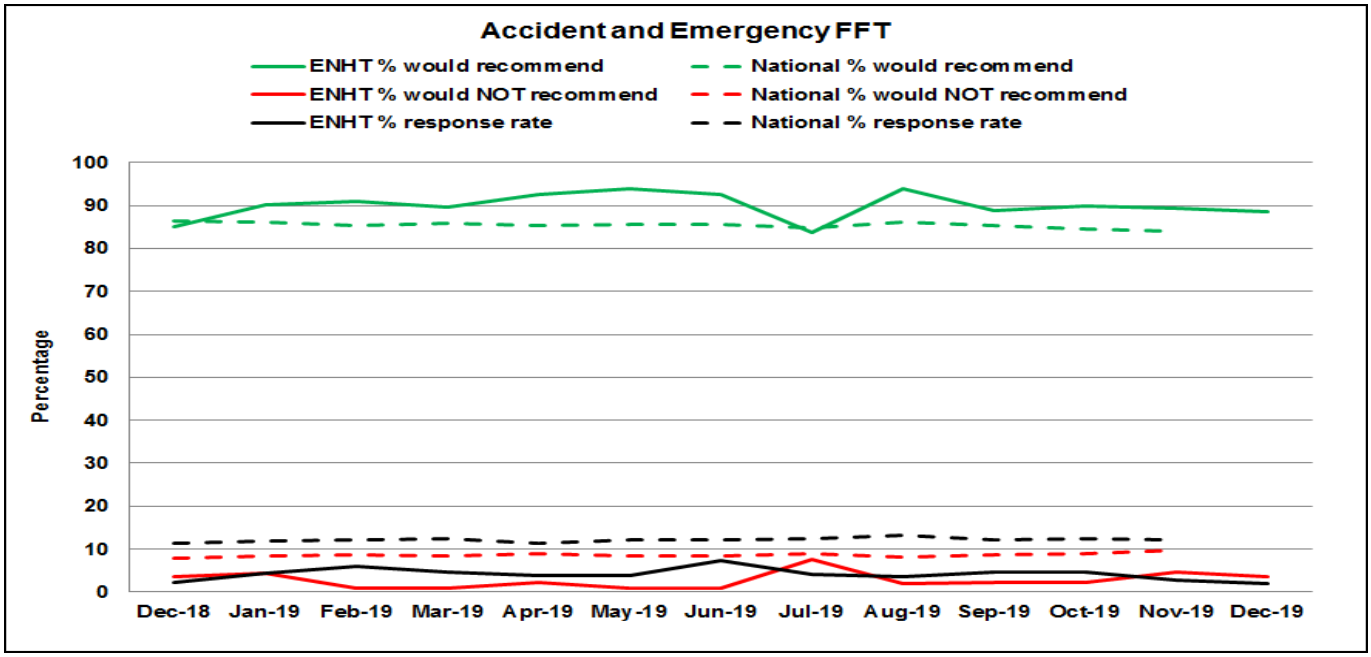
Ward 11B Dec-19

Lovely nurses. Everyone kind. Quiet ward at night. I felt safe and secure and well looked after.

Ward 10AN Dec-19

Accident and Emergency FFT

	Would recommend		Would not recommend		Response rate	
	%	Compared to last quarter	%	Compared to last quarter	%	Compared to last quarter
Trust target	90% 2019-20				10% 2019-20	
Q3 Oct-Dec-18	89.09	↓	2.20	↓	3.05	↓
Q4 Jan-Mar-19	90.32	↑	1.96	↓	5.00	↑
Q1 Apr-Jun-19	92.95	↑	1.28	↓	5.03	↑
Q2 Jul-Sept-19	88.54	↓	4.06	↑	4.17	↓
Q3 Oct-Dec-19	89.43	↑	3.19	↓	3.16	↓



Very friendly nurse, very effective no nonsense triage. Little one liked her so much that he (a) instantly talked to her while he is normally very shy towards strangers, (b) invented another injury so he could stay longer :)

Children's ED, Lister Nov-19

Pleasant, calm, friendly staff who kept me informed as to what was happening. Had seen staff at QEII Urgent Care who were excellent and referred me here. Nice to have café in emergency waiting room - friendly person there too, always treated with courtesy.

ED Lister (adults) Dec-19

Frequently checked on by staff. Asked by nurse if there was anything I needed and if I understood what the plan was - this was fantastic as I did need little things but didn't want to bother busy staff. Staff all very clear with explanations about plan of care, their clinical reasoning and checked I was in agreement.

Children's AU, Lister Oct-19

Far too busy with no areas to go to if you need somewhere quiet. Sharing one doctor with the whole of children's A&E is disgusting. No clear information on who you hand folder to on arrival and information about wait time only given if asked. TVs were turned off far too early; calm programme and dimmed lights would've calmed down overtired children.

Children's ED, Lister Nov-19

Given an urgent appointment for 30 minutes after phone call. Seen promptly within 10 minutes of appointment time. Impressed by thoroughness of examination and very pleased to have surgery same day.

Urgent Eye, Treatment Centre Oct-19

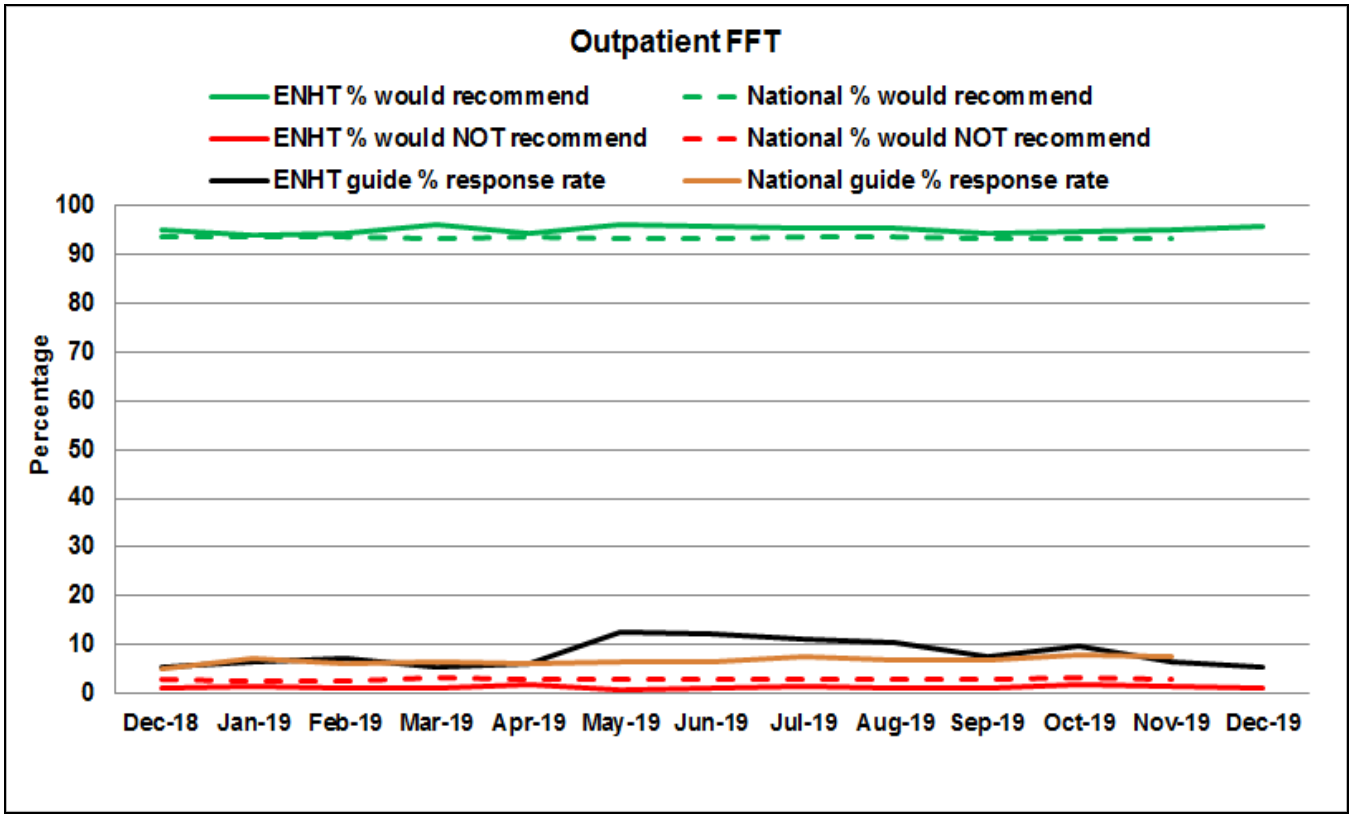
Waiting time was too long. Maybe have better chairs and TV.

SAU Oct-19

Outpatient FFT

	Would recommend		Would not recommend		Response rate	
	%	Compared to last quarter	%	Compared to last quarter	%	Compared to last quarter
Trust target	95% 2019-20					
Q3 Oct-Dec-18	94.22	↓	1.26	↓	5.82	↑
Q4 Jan-Mar-19	94.78	↑	1.22	↓	6.35	↑
Q1 Apr-Jun-19	95.72	↑	1.20	↓	10.47	↑
Q2 Jul-Sept-19	95.15	↓	1.22	↑	9.69	↓
Q3 Oct-Dec-19	95.13	↓	1.48	↑	7.25	↓

Note: Outpatient attendance data is taken from the NHS England Quarterly Activity Return and presented as monthly average. This data is intended as a guide to the response rate.



The nurses and doctors were very kind and gentle when handling my daughter's injuries. Free Lego and juice! Nurses and doctor explained how they want to proceed with further treatment. No long waiting times. Overall this was one of the best experiences I have had from being greeted by the reception staff right the way through to speaking to the doctors. Their interaction with me and my daughter was fantastic - very happy all round.

Bramble (Plastics), Lister Dec-19

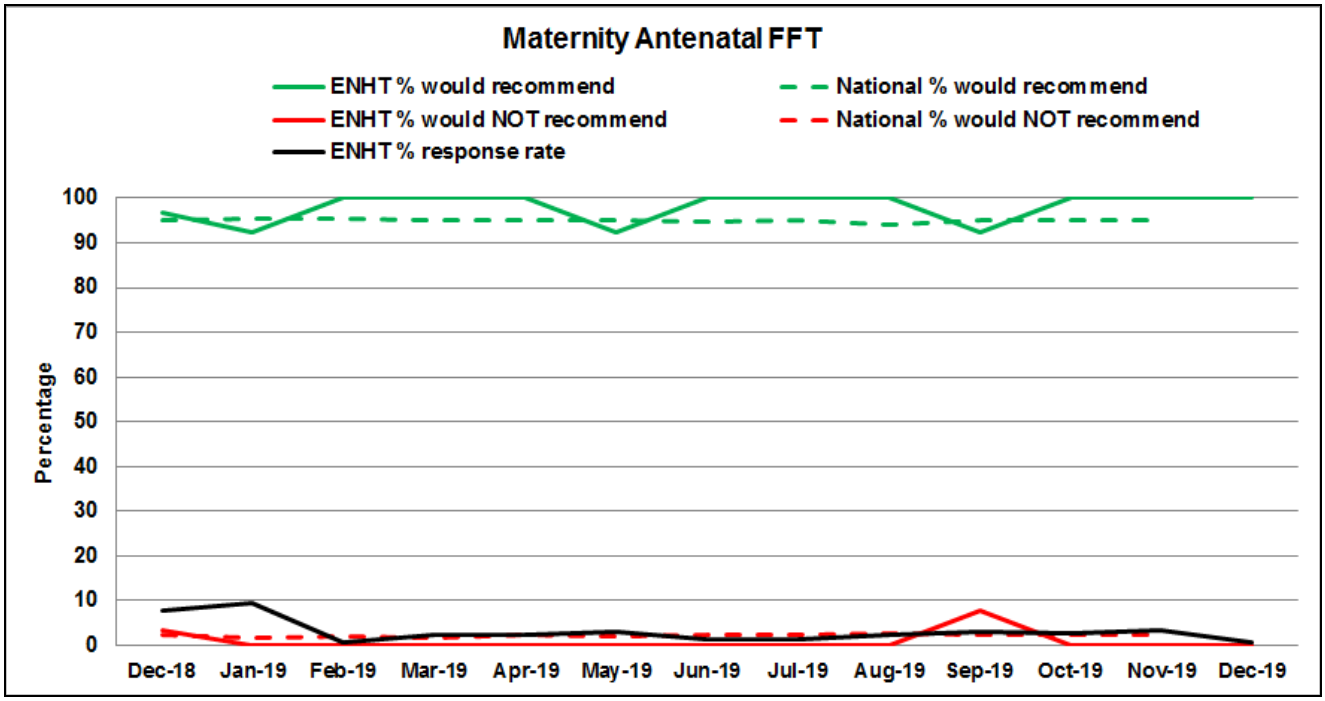
My previous appointment was cancelled without any notification and reception staff said there had been printer problems so letter was not despatched and next appointment letter never received. We had a wasted journey (2 hours) and a long gap between appointments.

Rheumatology, New QEII Dec-19

Maternity : Antenatal, Birth, Postnatal and Community Midwifery FFT

Antenatal FFT

	Would recommend		Would not recommend	
	%	Compared to last quarter	%	Compared to last quarter
Trust target	93%			
Q3 Oct-Dec-18	98.59	↑	1.41	↓
Q4 Jan-Mar-19	94.34	↓	0	↓
Q1 Apr-Jun-19	96.43	↑	0	↔
Q2 Jul-Sept-19	96.55	↑	3.45	↑
Q3 Oct-Dec-19	100	↑	0	↓



Midwife was reassuring, gave me lots of information and answered any questions I had in detail.
Community Nov-19

Waiting room was very crowded and it was very warm even with doors open.
Nov-19

I had regular friendly check-ups. Any concerns would be answered by midwife.
Community Dec-19

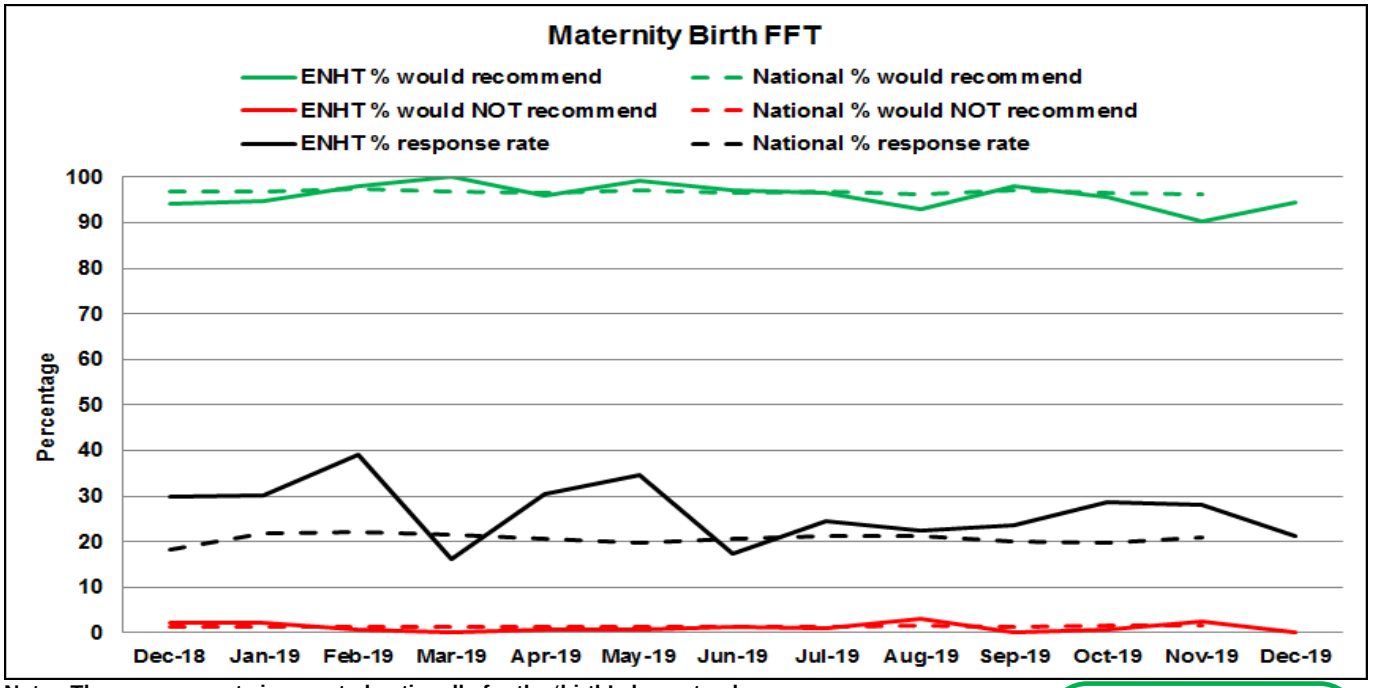
Friendly, reassuring and caring staff. Lots of helpful information
Oct-19

Knowledgeable, friendly, approachable midwives. Personalised care, cautious and took action when appropriate to send for scans or to Day Assessment Unit etc.
Community Oct -19

Could do with more seating, I had to stand last time while waiting. It would be better if there was less waiting for the doctors.
Nov-19

Birth FFT

	Would recommend		Would not recommend		Response rate	
	%	Compared to last quarter	%	Compared to last quarter	%	Compared to last quarter
Trust target	93%				30% combined 4 elements	
Q3 Oct-Dec-18	95.42	↓	0.96	↔	29.27	↓
Q4 Jan-Mar-19	97.22	↑	1.11	↑	28.24	↓
Q1 Apr-Jun-19	97.78	↑	0.83	↑	27.66	↓
Q2 Jul-Sept-19	95.92	↓	1.25	↑	23.49	↓
Q3 Oct-Dec-19	93.47	↓	1.14	↓	25.98	↑



Note: The response rate is reported nationally for the 'birth' element only.

Just want to say a huge thank you to everyone that has helped us from start to end and still now. I highly recommend Lister and always will. It's been nearly five years since I was last here having my son and it's improved so much since then. So much more support, guidance and generally amazing! Thank you everyone.

Consultant Led Unit Oct-19

I called my midwife who was able to come round for the home birth, this meant I knew her and I found this very reassuring. Both midwives came to my home soon after I called for them and they were really professional and respectful of my chosen place of birth. They helped where needed and gave strong support that I feel made my home birth experience a very positive one.

Homebirth Dec-19

Every member of staff I have come across at Lister has been friendly and professional. The anaesthetists were absolutely fantastic during my C-section. All doctors and midwives have been really supportive and informative. It was a really positive birth experience without any unnecessary discomfort. I have given birth in three different hospitals and Lister has been the best by far.

CLU Nov-19

Horrible experience in Triage: in active labour and not getting pain relief. Asked four times (doctor and 3x midwives) whilst waiting, nothing for three hours which was when we moved in labour room and got gas and air. Shouldn't have to chase and chase.

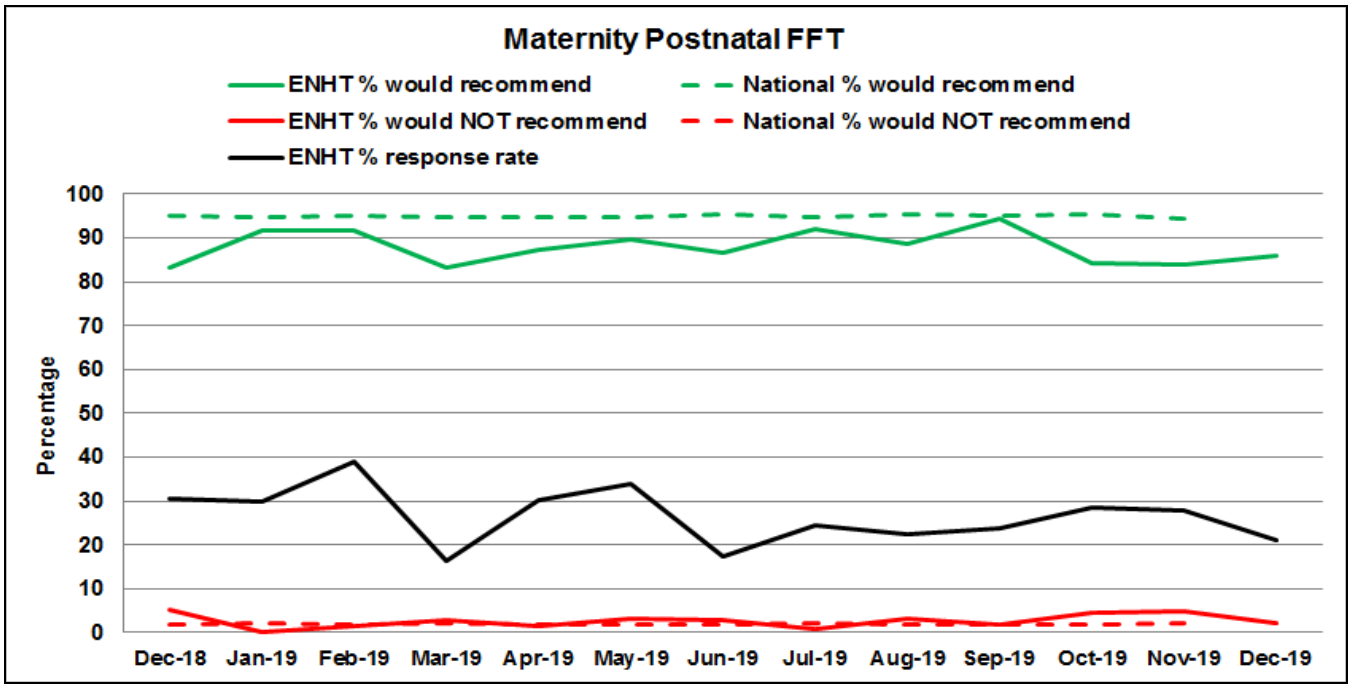
Triage to CLU Dec-19

The midwife and student midwife were fantastic and I got to have the water birth I had wanted. The staff also did their best to stick to my birth plan which was really appreciated.

Midwife Led Unit Nov-19

Postnatal FFT

	Would recommend		Would not recommend	
	%	Compared to last quarter	%	Compared to last quarter
Trust target	93%			
Q3 Oct-Dec-18	87.23	↓	3.86	↑
Q4 Jan-Mar-19	89.94	↑	1.12	↓
Q1 Apr-Jun-19	88.24	↓	2.52	↑
Q2 Jul-Sept-19	91.85	↑	1.88	↓
Q3 Oct-Dec-19	84.62	↓	3.99	↑



Being first time young parents we were very anxious. We were made to feel very comfortable throughout the whole experience, everything was explained in detail, we were given options and always able to make our own decisions. All the staff involved were very helpful, always making sure we were okay and asking if we needed anything. After baby was born, we really appreciated all of the help and were shown how to breastfeed, get her dressed, change her nappy etc., this was very useful as we had no experience in these areas.

CLU to Gloucester Dec-19

More updates on our progress towards going home. Extra paediatricians at the weekend to check over the Gloucester ward as we could have gone home a lot earlier.

Gloucester Ward Nov-19

All staff were attentive and gently encouraging (as opposed to pushy) about breastfeeding and making sure I was up and mobile.

Gloucester Oct-19

I was left to get on with my baby but always knew support from midwives was there when I needed it. It made me feel very good and confident in myself.

Midwife Led Unit Dec-19

The staff are all attentive and listen to any concerns, they are knowledgeable and always offer their advice. The staff have been great and when feeling down they talk to you in a way that makes you feel better.

Gloucester Nov-19

More comfortable chairs for partners staying overnight needed, at least ones with reclining backs. That would have greatly reduced the anxiety and improved my sleep.

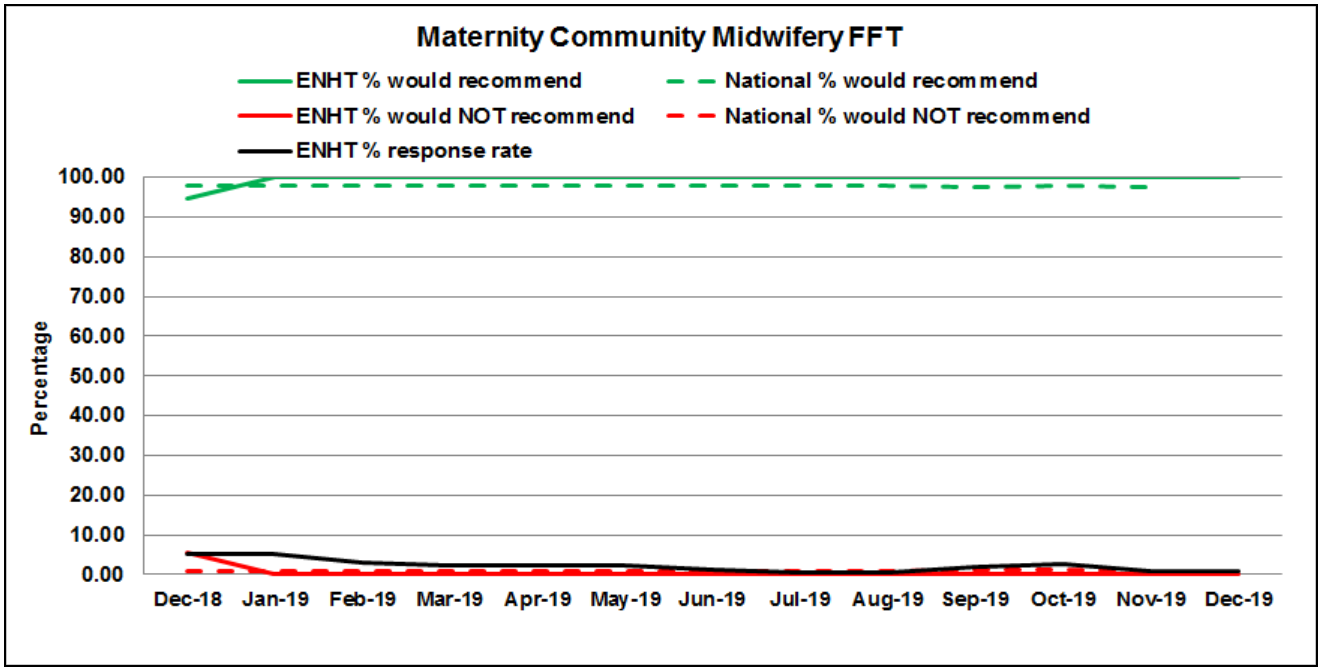
Midwife Led Unit Dec-19

Community Midwifery FFT

	Would recommend		Would not recommend	
	%	Compared to last quarter	%	Compared to last quarter
Trust target	93%			
Q3 Oct-Dec-18	97.56	↓	2.44	↑
Q4 Jan-Mar-19	100	↑	0	↓
Q1 Apr-Jun-19	100	↔	0	↔
Q2 Jul-Sept-19	100	↔	0	↔
Q3 Oct-Dec-19	100	↔	0	↔

The FFT responses for Community Midwifery often fluctuate due to the varying number of responses received from women:

82 responses Oct-Dec-18
55 responses Jan-Mar-19
30 responses Apr-Jun-19
13 responses Jul-Sept-19
24 responses Oct-Dec-19



	Combined response rate for antenatal, birth, postnatal, community midwifery FFT	
	%	Compared to last quarter
Trust target	30%	
Q3 Oct-Dec-18	16.57	↓
Q4 Jan-Mar-19	15.17	↓
Q1 Apr-Jun-19	13.94	↓
Q2 Jul-Sept-19	12.08	↓
Q3 Oct-Dec-19	13.35	↑

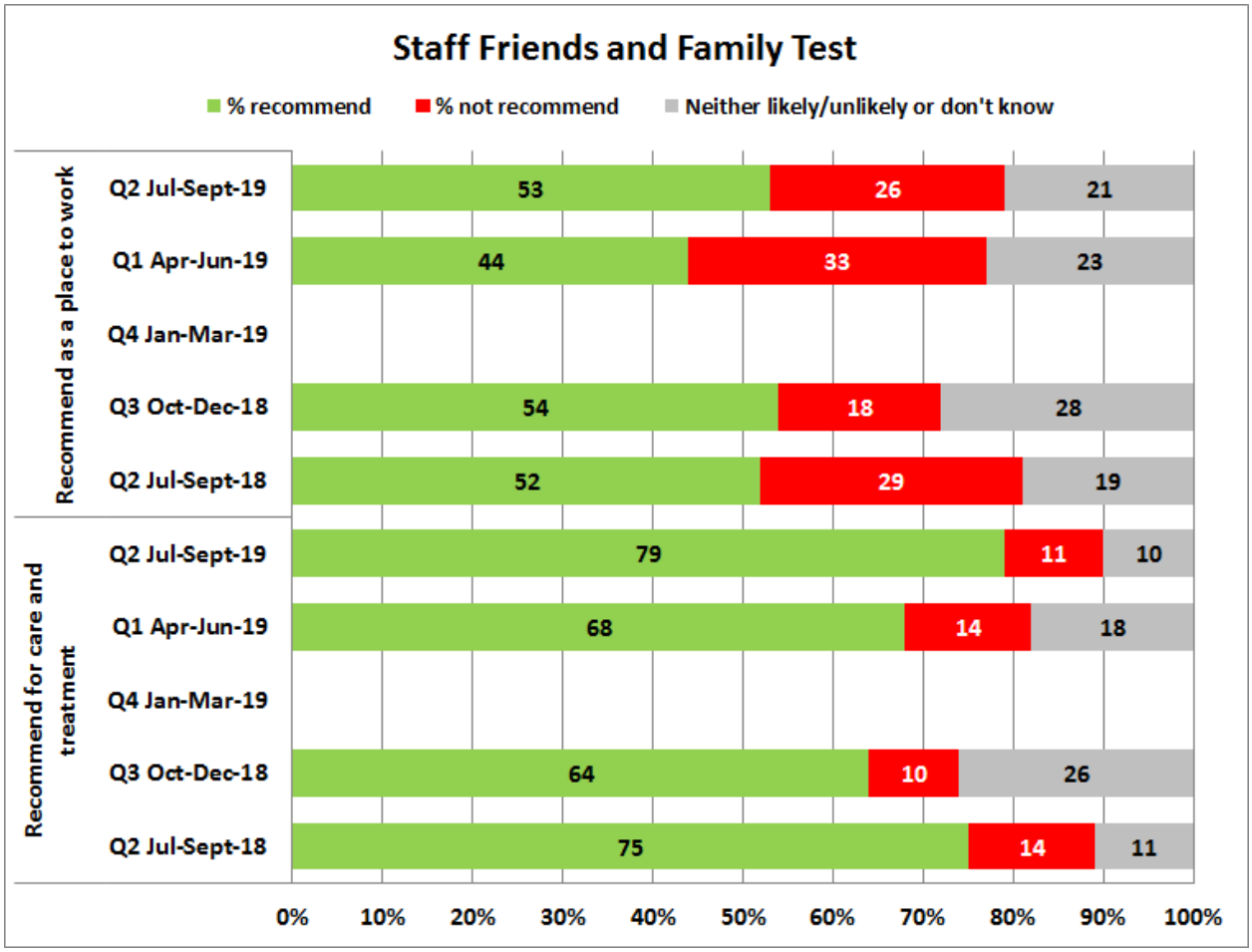
Excellent midwife services at hospital post birth and when visiting at home after discharge. They are caring and you really feel they want the best for you and baby. Midwife was excellent and helped me feel confident with everything I was doing.
Dec-19

The community experience would be better if maybe given a time slot of arrival for example, between 2-4, so you can go for a walk or something whilst waiting.
Dec-19

I knew my midwife really well and she always has time for me. It was easy to contact her direct.
Nov-19

Very detailed and thorough care, questions always answered and felt very aware of schedule of care.
Oct-19

Staff Friends and Family Test



Number of staff responding:

Q2 2018-19	413/5,696 (7.3%)
Q3 2018-19	2,389 (43%)
Q4 2018-19	0 (0%)
Q1 2019-20	177/5,803 (3.27%)
Q2 2019-20	76/5,926 (1.28%)

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

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

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

National CQC Children and Young People's Patient Experience Survey

The results of the 2018 national children's and young people's patient experience survey were published by the Care Quality Commission on the 19 November 2019. Patients (and parents of young children)who were admitted to hospital in November-December 2018 and aged between 15 days and 15 years old were invited to complete the survey.

129 acute and specialist NHS Trusts participated in the survey. 302 people responded to the ENHT survey, a response rate of 24.43%. Three questionnaires were used to target different age groups: a parent/carer version for 0-7 year olds and versions for 8-11 year olds and 12-15 year olds which had a section for the young person to complete and a separate section for their parent/carer to complete.

Young people and their parent/carer were asked what they thought about different aspects of the care and treatment they received.

Compared to other trusts

ENHT results were **better** than most trusts for 5 questions:

Q49 Was the ward suitable for someone of your age?
Q54 Did hospital staff talk with you about how they were going to care for you?
Q55 When the hospital staff spoke with you, did you understand what they said?
Q57 Did the hospital staff answer your questions?
Q65 Afterwards, did staff explain to you how the operations or procedures had gone?

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

Q9 Were there enough things for your child to do in the hospital?
Q44 Do you feel that your child was well looked after by the hospital staff?

ENHT results were about the same as other trusts for the remaining 57 questions.

Compared to 2016 survey:

ENHT results were **significantly higher** for 5 questions:

Q22 Were the different members of staff caring for and treating your child aware of their medical history?
Q38 Did a staff member give you advice about caring for your child after you went home?
Q53 Was it quiet enough for you to sleep when needed in the hospital?
Q55 When the hospital staff spoke with you, did you understand what they said?
Q67 When you left hospital, did you know what was going to happen next with your care?

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

Q36 During any operations or procedures, did staff play with your child or do anything to distract them?

There were no significant differences for the remaining 51 questions.

The Divisional patient experience action plans will be reviewed in light of these results and presented to the Patient and Carer Experience Committee meeting in January 2020.

Patient Advice and Liaison Service (PALS) Concerns

PALS received 932 concerns in Q3 2019-20 compared to 962 in Q2 2019-20. The table below details the number of PALS concerns by division in Q3:

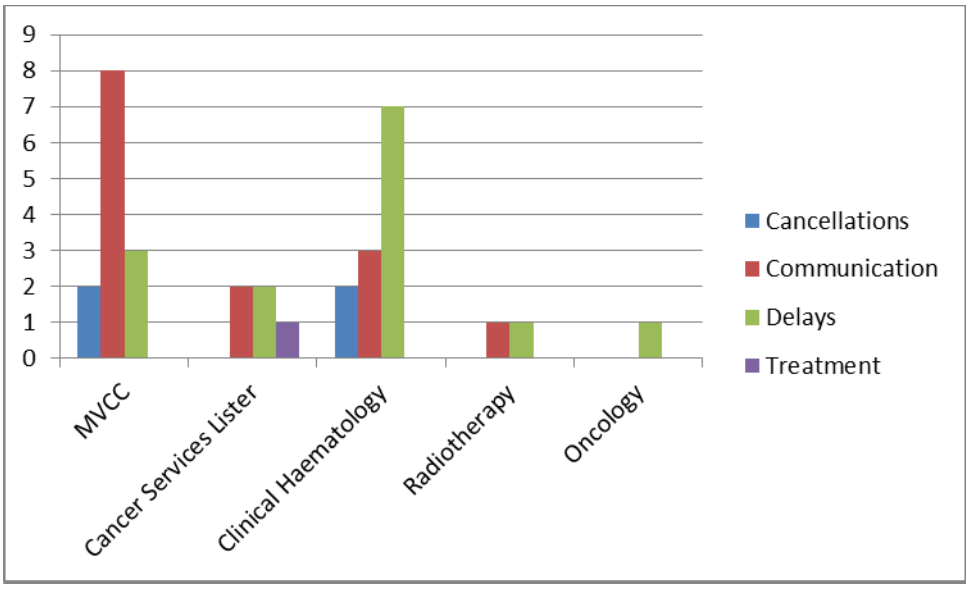
	October 2019	November 2019	December 2019	Total
Cancer Services	12	14	7	33
Clinical Support	27	23	23	73
Medicine	98	75	47	220
Surgery	209	158	123	490
Women & Children's	46	38	24	108
Operations	1	4	3	8
Totals:	**393**	**312**	**227**	**932**

The graphs below detail the number of PALS concerns received per division by specialty and subject for Q3:

Cancer Services

Cancer services received 33 concerns in Q3 compared to 48 in Q2.

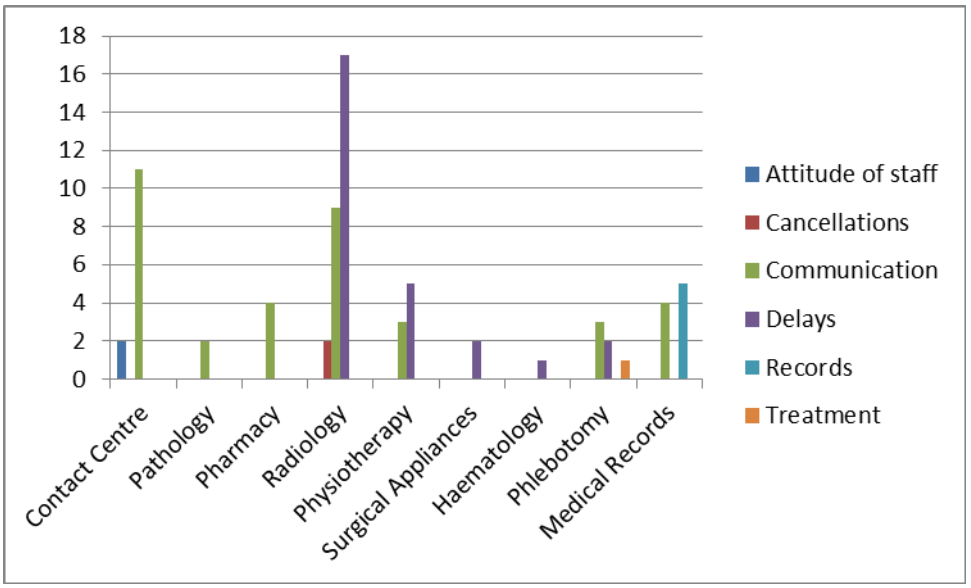
Concerns by specialty and subject – Q3



Clinical Support

Clinical Support received 73 concerns in Q3 compared with 71 in Q2.

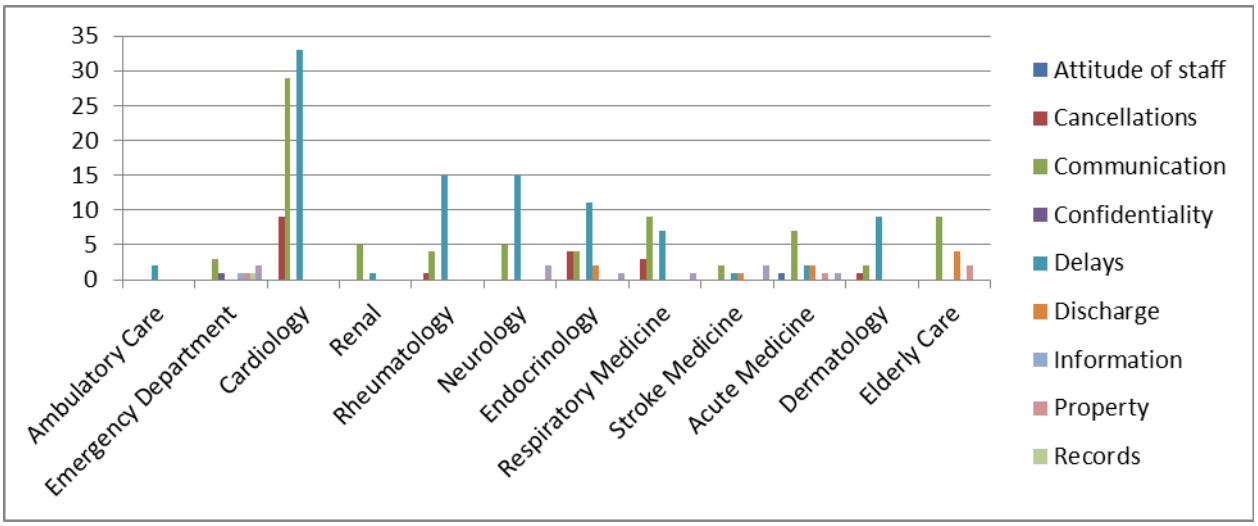
Concerns by specialty and subject – Q3



Medicine Division

In Q3 220 concerns were received for compared to 232 concerns received in Q2.

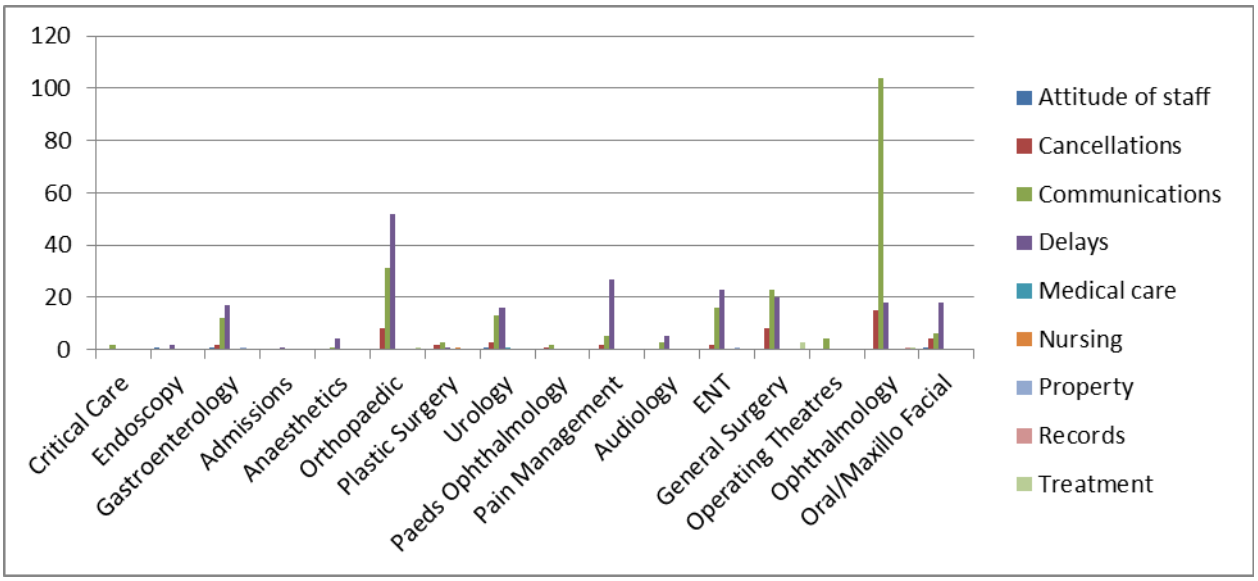
Concerns by specialty and subject for Q3



Surgery Division

The Surgery Division received 490 concerns in Q3 compared to 511 concerns in Q2.

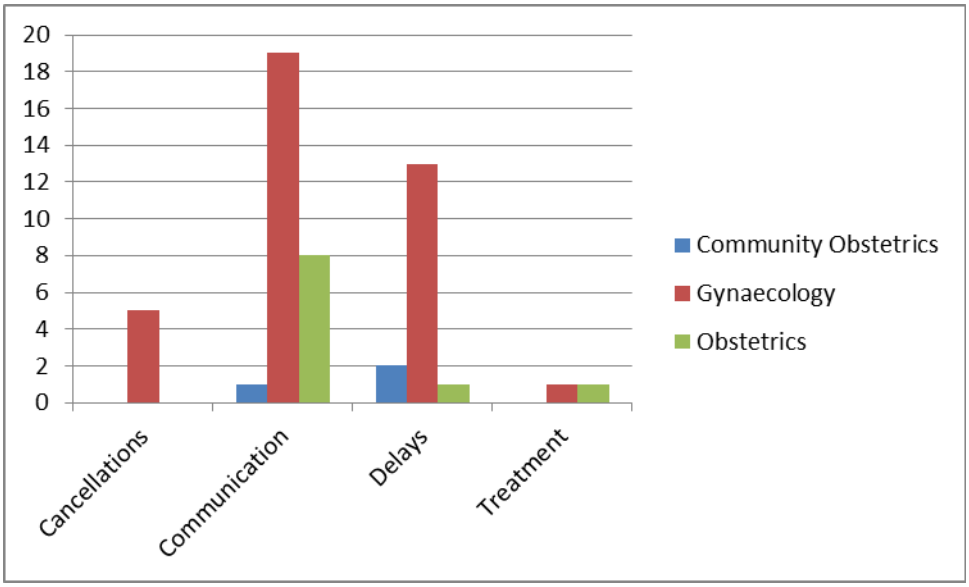
Concerns by specialty and subject – Q3



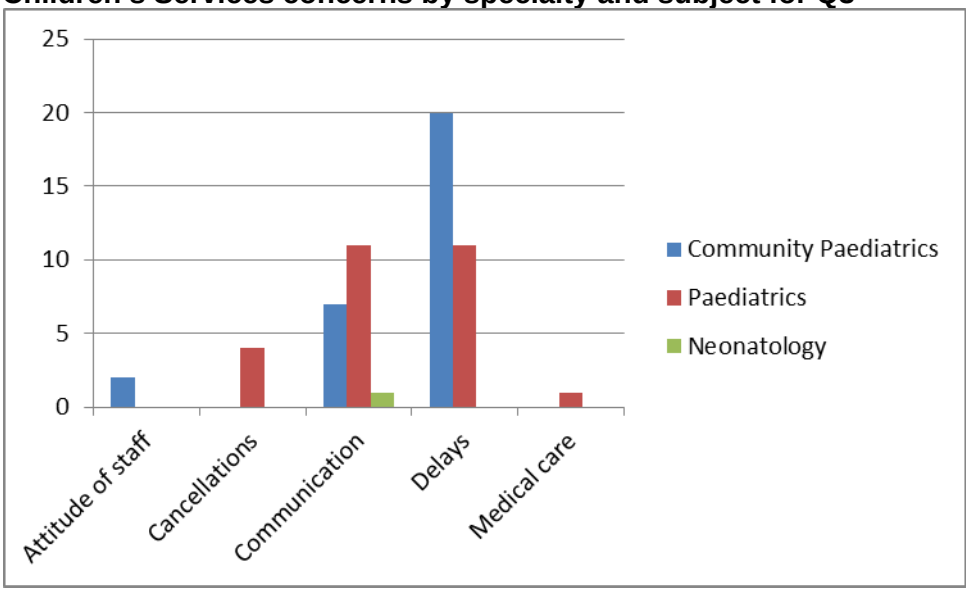
Women's and Children's Services

In Q3 108 concerns were received compared to 92 received in Q2.

Women's Services concerns by specialty and subject for Q3



Children's Services concerns by specialty and subject for Q3



Formal Complaints

The Trust received 282 formal complaints in Q3. Further detail with regard to the speciality and subject of complaints for all divisions is provided later in the report. The table below shows the number of complaints by division in Q3:

	October 2019	November 2019	December 2019	Total
Cancer	6	4	4	14
Clinical Support	11	8	9	28
Medicine	34	32	17	83
Surgery	48	32	26	106
Women & Children	14	13	10	37
Operations	6	3	5	14
Totals:	119	92	71	282

Timeframe for acknowledgement of formal complaints

The complaints team are achieving the national mandatory timeframe of acknowledging and contacting all complainants within three working days, either in writing, email or via telephone.

Timeframe for response

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

The Trust recognised that there were challenges in ensuring that comprehensive investigations continued to be conducted and responded to in a timely manner. Challenges were evident in both the Complaints team and the divisions and particularly in relation to capacity and competing priorities. A Quality Improvement Project commenced in January 2019, with the aim of improving key areas of patient experience across the Trust. This has resulted in stronger relationships within the Trust and staff supporting the process which has enabled the Complaints team to draft letters and forward the signed response to the complainant within the agreed timeframe.

	October 2019	November 2019	December 2019	YTD
Cancer	86%	100%	100%	89%
Clinical Support	83%	90%	100%	85%
Medicine	92%	100%	100%	85%
Surgery	85%	83%	79%	73%
Women's & Children's	100%	95%	89%	77%

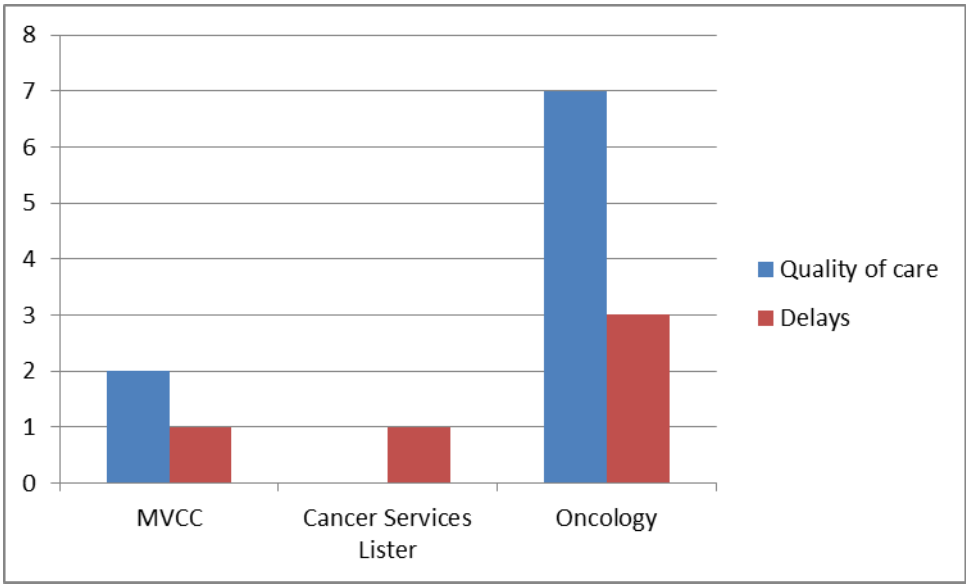
Patients and carers are encouraged to raise questions or concerns about their hospital experiences. The outcome of complaint investigations are shared with the relevant ward, department and divisions so that staff understand what they are doing well and where they need to make improvements.

The following graphs detail the number of complaints per division by specialty and subject for Q3. Examples of investigation outcomes are provided for each division.

Cancer Services

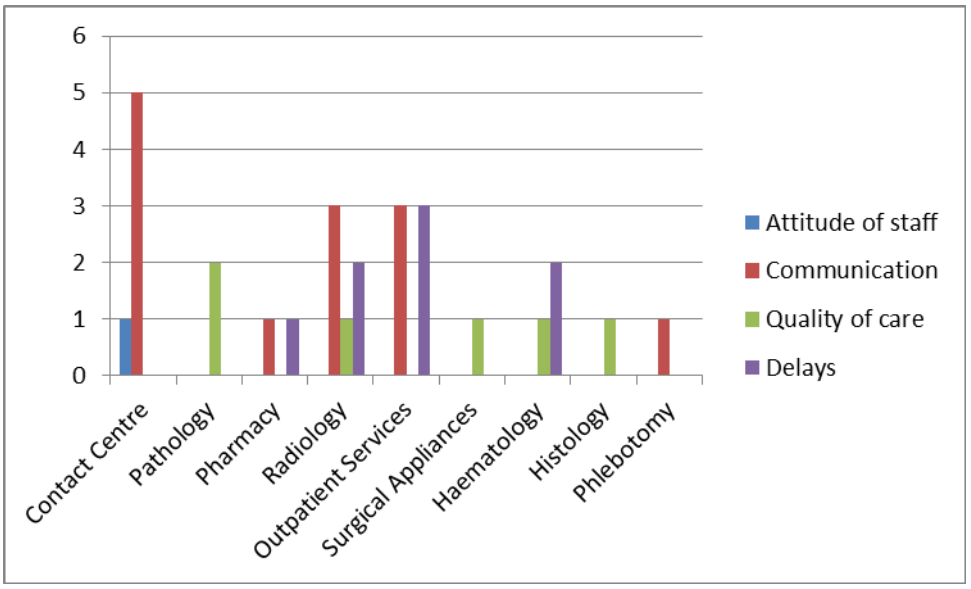
In Q3 Cancer Services received 14 complaints compared to 9 in Q2. The graphs below detail the number of cancer complaints by specialty and subject for Q3.

Cancer Services complaints by specialty and subject – Q3



Clinical Support Services complaints by speciality and subject – Q3

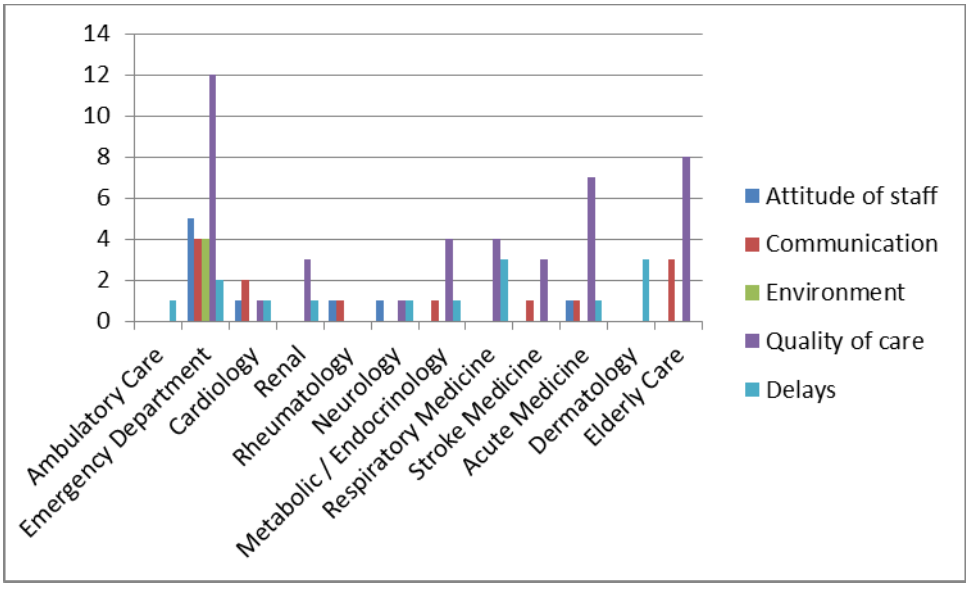
In Q3 Clinical Support Services received 28 complaints, 28 complaints were also received in Q2. The graphs below detail the number of complaints received by specialty and subject for Q3.



Medicine Division

In Q3 the Medicine Division received 83 formal complaints compared to 70 in Q2. The graphs below shows the speciality and subject of complaints for Medicine in Q3.

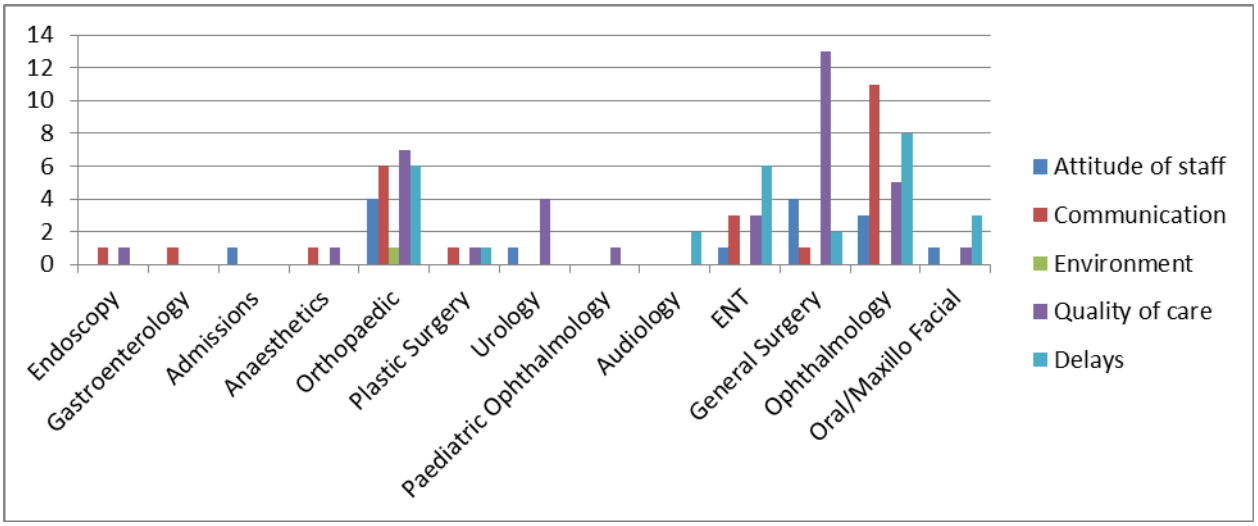
Medicine complaints by specialty and subject – Q3



Surgery Division

In Q3 Surgery Division received 106 complaints, compared to 95 in Q2.The graph below details the number of complaints by specialty and subject for Q3.

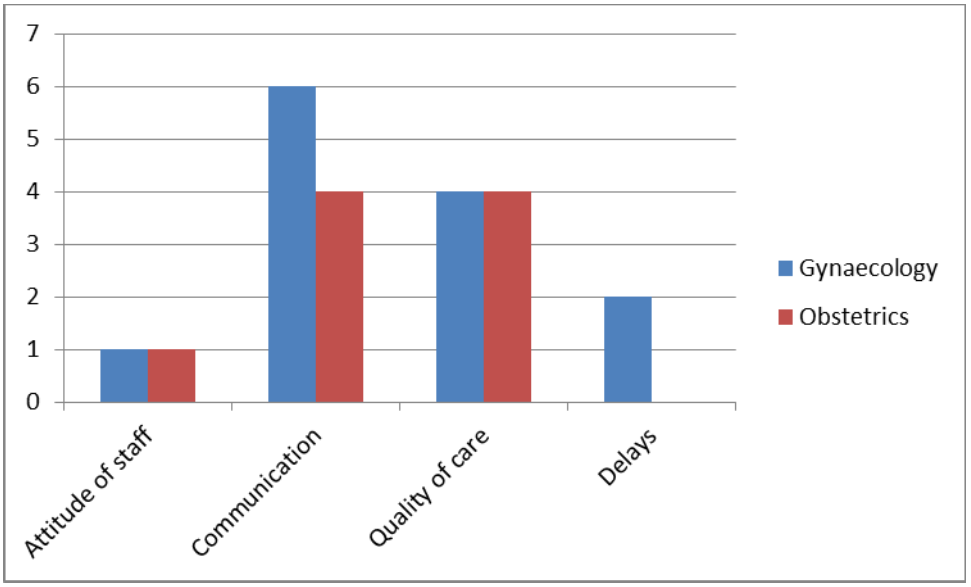
Surgery division complaints by specialty and subject – Q3



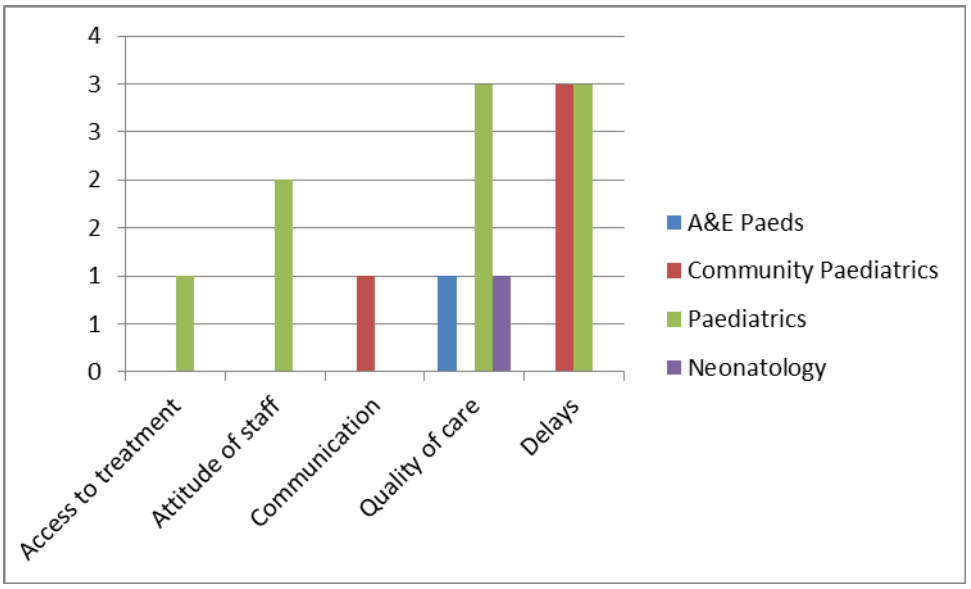
Women's and Children's Services

In Q3 Women's and Children's Services received 37 complaints (22 in Women's and 15 in Children's) compared to 34 in Q2. The graphs below detail the number of complaints by specialty and subject for Q3.

Women's Services complaints by specialty and subject – Q3



Children's Services complaints by speciality and subject – Q3



Parliamentary & Health Service Ombudsman (PHSO)

In Q3 there were two requests for papers from the PHSO. At present a decision has not been made as to whether they will be commencing a review of these complaints**.**

PHSO report on Complaints about the NHS in England – Quarter 1 2019-20

The PHSO have published a report providing information on complaints they received, assessed and investigated between April-June 2019. Publication of the report has been introduced following the launch of the PHSO Strategy for 2018-2021. Every quarter the PHSO will publish data and information on complaints and the recommendations they have made to organisations. The quarter 1 report includes case studies demonstrating how things can go wrong when the NHS fails to meet the needs of people with a learning disability or autism when providing treatment. ENHT does not feature in the PHSO quarter 1 report.

Healthwatch England 'Shifting the Mindset' – a closer look at hospital complaints

Sir Robert Francis QC, Chair of Healthwatch England has written to all Chief Executives following the publication of Healthwatch England's report 'Shifting the Mindset – A closer look at NHS complaints'.

The report follows on from the Mid Staffordshire public enquiry and the recommendations that he made. A fundamental part of the report was the expectation that Trusts would use complaints to learn from mistakes and take actions to make improvements. An important part of this was to communicate these changes to the public. Research has identified that four in five people have said that seeing the positive impact that other people's complaints have would encourage them to speak up. Currently, there is inconsistency across the NHS in the reporting of complaints.

The Trust publishes several internal reports that provide learning outcomes but other than the individuals who write to us with their concerns there is no process to ensure that the general public have access to the complaints we have investigated. In order to rectify this the complaints lead will be working with the communications team to publicise anonymous case studies from complaints on the public website.

East and North Hertfordshire NHS Trust

Agenda Item: 12.2

TRUST BOARD - PUBLIC SESSION – 4 MARCH 2020
University Hospital Partnership – Draft Annual Report

Purpose of report and executive summary (250 words max): To present the draft University Partnership – Joint Management Committee Annual Report 2019-2020 (v4).		
Action required: For approval		
Previously considered by: **Quality and Safety Committee, 25 February 2020**		
Director: **Medical Director**	**Presented by:** **Medical Director**	**Author:** **Partnership 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) **Not directly**
Any other risk issues (quality, safety, financial, HR, legal, equality): **As set out in the report**

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

University Partnership - Joint Management Committee

Annual Report 2019-2020 v0.4

Report prepared by Jennifer Godwin

Partnership Manager

January 2020

1. Executive Summary

KPI	Deliverable for Year 3 onwards	Progress at 31st December 2019
KPI-1. Innovative Workforce Development and Transformation	Embed newly developed roles into Trust workforce including Physician Associate, Nursing Associate, expansion of Non-Medical Prescribing and Advanced Clinical Practitioners. - Collaborative workforce planning to inform requirements for future training demands. - Increase uptake of other transformational workforce roles such as Advanced Clinical Practitioners. Increase collaboration between Trust Faculty of Leadership and the Business School to support staff development and talent management. - Career conversations underpinned by coaching and talent management. - IT solutions for recording of continuous feedback. - Explore further the support for a joint leadership lab.	Trust has established an Education Board to examine these opportunities in a strategic way. Trust is undertaking a major education and training review set to report later in the year. Career conversations with leaders and managers set to start by the end of the year.
KPI-2. Enhanced Student Experience	Evidence of enhanced student experience will be assessed through the University's Annual Monitoring and Evaluation Report and reviewed by Joint Management Committee Development of clinical educators including Ward Managers and Ward Leaders in line with the requirements from the NMC and other relevant professional bodies. Work towards a more integrated and collaborative approach to location of training and sharing of physical, clinical and teaching resources. This may include UH endorsement of Trust in-house courses. Recognition of clinical experts and trainers including honorary contracts and time in job plan. Increase the numbers of clinical subject experts and the percentage of courses delivered by them. Renewal and revision of the Practice Placement Agreement between the Trust and UH which expires in March 2020. Sustainable access to non-medical prescribing course for Pharmacists and other staff groups to support Trust objectives. Increase the range of students on placement within the Trust for example: - Ensure Trust placement opportunities reflect the full range of fields of study on offer at UH. - Placement of 'sandwich' students e.g. Biosciences students currently employed as Clinical Trials Assistants at Mount Vernon. - Joint PhD students.	Alternative mechanisms more fit for purpose to be explored for assessing student experience. Exploring Knowledge Transfer Partnership joint PhD in I.T. to enhance the digital agenda. First cohort of 30 optometry undergraduate students on clinical placement in the Trust Oct-Dec 2019. Research sandwich student placements at Mount Vernon were open to UH students for the first time this summer (traditionally all have come from Brunel University).
KPI-3. Research, Innovation and Service Improvement	Increase the number of collaborative research projects, joint publications and an assessment of their contribution to UH and ENHT objectives and strategic drivers. Include an assessment of the impact of joint research on patients and patient care. - Monitor breadth of projects across disease areas and academic schools. - Optimisation of Trust IM&T services and further digitisation of Trust systems will give rise to additional opportunities for collaboration.	Establishing a register of research active and research interested staff including their area of interest / expertise.
KPI-4. Strategic Planning	A strategic plan will be in place covering the first 6 years of the partnership until the planned revalidation in 2023. This will encompass establishing project themes, facilitation of wider engagement between the Trust and Schools across the whole University, risk management and the sustainability of the partnership.	ENHT launched new 5 year strategy in April 2019 and UH is in the process renewing their 5 year strategy.

2. Partnership Management

To be effective, the University Status partnership between East & North Hertfordshire NHS Trust (ENHT) and University of Hertfordshire (UH) requires a robust system for leadership, oversight and management.

The purpose of the Joint Management Committee is to support the delivery of the commitments made by both the Trust and University under the memorandum of understanding. It will ensure effective inter-professional collaboration in the areas of research, education and practice across both organisations.

2.1. Status and Authority

The Committee has no executive powers other than those derived from its membership, or those if specifically delegated in these terms of reference.

The Committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any officers of the Trust or University and all officers and staff are directed to co-operate with any request made by the Committee.

The Committee may obtain professional advice as required, and may require directors or other officers to attend meetings.

2.2. Membership

The membership of the Joint Management Committee comprises:

From the Trust	**From the University**
• Medical Director (Co- chair) • Director of Nursing and Patient Experience • Director of Workforce & Organisational Development • Director of Medical Education • Associate Director of Research and Development	• Dean of LMS (Co- chair) • Dean of HSK • Associate Dean for Academic Quality from either LMS or HSK • Head of Centre for Health Services and Clinical Research • Associate Dean for Community, International and Partnership LMS
External Scrutiny	**In attendance**
• Service User • External Advisor (from Hertfordshire Partnership University NHS Foundation Trust who have a similar partnership with UH)	• Partnership Manager.

In addition to the above list of attendees the committee will co-opt attendance as required from either the Trust or University

If a conflict of interests is established, the above member / attendee concerned should declare this and withdraw from the meeting and play no part in the relevant discussion or decision.

2.3. Quorum

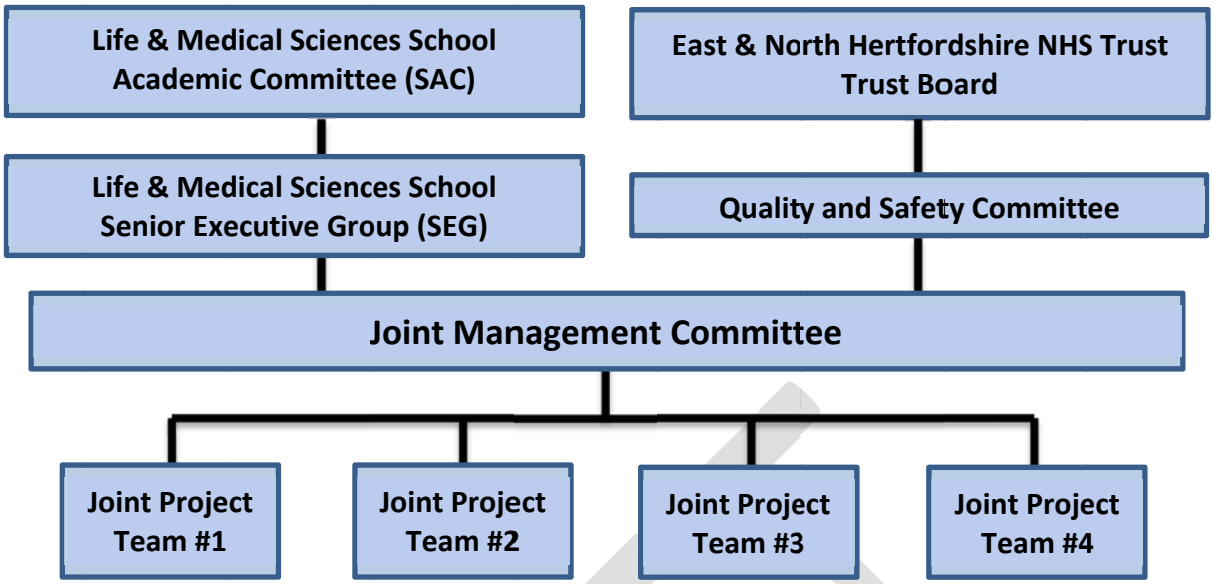
The Committee will be quorate if there are two members present from each of the Trust and University. See Appendix B for summary of attendees.

2.4. Frequency of Meetings

The committee will normally meet quarterly. The Chair(s) of the Committee may convene additional meetings if required to consider business that requires urgent attention.

In 2019-20 the Joint Management Committee met on 10th April 2019, 17th July 2019, 23rd October 2019 and 8th January 2020.

2.5. Structure of Partnership



2.6. Monitoring and review

The committee will monitor and review its compliance through the following:

- Annual report to the Trust Board and University Senior Executive Group (detailed 2019-20 reporting timetable can be found in the table below).
- Annual review of the action plan for each of the work stream objectives will be completed and submitted to the Trust Quality and Safety Committee, Trust Board and the University Senior Executive Group.
- Annual evaluation and review of its terms of reference.
- Re-approval of the University Status in 2023 (with planning to begin in year 5).

2019-20 Timetable for Submission of the Annual Report			
Meeting	**Version of annual report**	**Date of submission of document**	**Date of meeting**
UH LMS Senior Executive Meeting	V0.2 (draft)	19th November 2019	26th November 2019
ENHT Quality and Safety Committee	V0.2 (draft)	20th November 2019	27th November 2019
Joint Management Committee	V0.3 (draft)	1st January 2020	8th January 2020
UH LMS School Academic Committee	V0.4 (final draft)	28th January 2020	11th February 2020
ENHT Quality and Safety Committee	V0.4 (final draft)	14st March 2020	21st March 2020
ENHT Board	V0.4 (final draft)	25th March 2020	1st April 2020
Joint Management Committee	V1 (final report)	23rd April 2020	30th April 2020

3. Success Measures

3.1. Progress towards Key Performance Indicators

Following a period of consultation during 2018-19, the key performance indicators have been updated to reflect both the successes in achievement of previous KPIs and the current challenges and opportunities afforded to this partnership.

KPIs will be updated as required on publication of the UH 5 year strategy in 2020 to ensure that the aims of the partnership are fully aligned to the strategic priorities of both organisations.

KPI	Deliverable for Year 3 onwards	Progress at 31st December 2019
KPI-1. Innovative Workforce Development and Transformation	Embed newly developed workforce roles into Trust workforce including Physician Associate, Nursing Associate, expansion of Non-Medical Prescribing and Advanced Clinical Practitioners. - Collaborative workforce planning to inform requirements for future training demands. - Increase uptake of other transformational workforce roles such as advanced clinical practitioners. Increase collaboration between Trust Faculty of Leadership and the Business School to support staff development and talent management. - Career Conversations underpinned by coaching and talent management - IT solutions for recording of continuous feedback - Explore further the support for a joint leadership lab	Trust has established an Education Board to examine these opportunities in a strategic way. Trust is undertaking a major education and training review set to report later in the year. Career conversations with leaders and managers set to start by the end of the year.
KPI-2. Enhanced Student Experience	Evidence of enhanced student experience will be assessed through the University's Annual Monitoring and Evaluation Report and reviewed by Joint Management Committee Development of clinical educators including ward managers and ward leaders in line with the requirements from the NMC and other relevant professional bodies. Work towards a more integrated and collaborative approach to location of training and sharing of physical, clinical and teaching resources. This may include UH endorsement of Trust in-house courses Recognition of clinical experts and trainers including honorary contracts and time in job plan. Increase the numbers of clinical subject experts and percentage of courses delivered by them. Renewal and revision of the Practice Placement Agreement between the Trust and UH which expires in March 2020. Sustainable access to non-medical prescribing course for Pharmacists and other staff groups to support Trust objectives. Increase the range of students on placement within the Trust for example: - Ensure Trust placement opportunities reflect the full range of fields of study on offer at UH	Alternative mechanisms more fit for purpose to be explored for assessing student experience. Exploring Knowledge Transfer Partnership joint PhD in I.T. to enhance the digital agenda. First cohort of 30 optometry undergraduate students on clinical placement in the Trust Oct-Dec 2019. Research sandwich student placements at Mount Vernon were open to UH students for the first time this

KPI	Deliverable for Year 3 onwards	Progress at 31st December 2019
	- Placement of 'sandwich' students e.g. Biosciences students currently employed as Clinical Trials Assistants at Mount Vernon. - Joint PhD students	summer (traditionally all have come from Brunel University)
KPI-3. Research, innovation and Service Improvement	Increase the number of collaborative research projects, joint publications and an assessment of their contribution to UH and ENHT objectives and strategic drivers. Including an assessment of the impact of joint research on patients and patient care. - Monitor breadth of projects across disease areas and academic schools. - Optimisation of Trust IM&T services and further digitisation of Trust systems will give rise to additional opportunities for collaboration.	Establishing a register of research active and research interested staff including their area of interest / expertise.
KPI-4 Strategic Planning	A strategic plan will be in place covering the first 6 years of the partnership until the planned revalidation in 2023. This will encompass establishing project themes, facilitation of wider engagement between the Trust and Schools across the whole University, risk management and the sustainability of the partnership.	ENHT launched new 5 year strategy in April 2019 and UH is in the process renewing their 5 year strategy.

3.2. Workstream Updates

3.2.1. Nursing

- **The Nursing Associate Apprenticeship (TNA)** – This is a 2 year, level 5 apprenticeship with students attending UH on a day release basis. First cohort started training April 2017, second cohort started May 2018 third cohort December 2019. In-house steering group in the Trust has convened to support implementation of the new role.

  Two paediatric Nursing Associates qualified in March 2019, and 15 adult Nursing Associates qualified in April 2019.

  In training: 10 May 2018, 7 December 2018, 8 May 2019, 8 September 2019 cohorts.

  OSCE training to support their development.

  The steering group have developed a job description which is currently being job matched against agenda for change role profiles. Preceptorship programme and associated workbook is in development. Competencies to support service delivery have been agreed.

  Trust looking at the APEL route for supporting our Registered Nursing Associates to convert to Registered Nurses from September 2019.

- **Nursing Degree Apprenticeship** – This is a 4 year, level 6 apprenticeship with students attending UH on a day release basis. ENHT has not yet enrolled any students on this course; Directors of Nursing from across the STP area have met to map the requirements for this course.

- **Undergraduate Nursing** - Changes to the requirement for mentors / coaching skills for Clinical Supervisors. Trust preparing for new Nursing and Midwifery Council standards. Coaching skills to be included into preceptorship and also proposing standalone coaching sessions

- On line package available for Mentorship course and updates, programme has commenced within the Trust and is registered with the electronic staff record to update automatically.

- Training needs analysis completed and commissioning in progress with Health Education England (HEE) Learning Beyond Registration funds. Advanced Clinical Practitioner separate funding stream.
- Apprenticeship opportunities being explored to support Continuous Professional Development (CPD) – ongoing. Additional funding received from HEE for qualifications in specialisms.
- Partnership between UH and ENHT was cited as exemplary during validation of the BSc, MSC and Apel programme for registered nursing by the Nursing and Midwifery Council.

3.2.2. Medical

Physician Associates - The first cohort of students have completed their studies and took the final national exam in October. Results may only be disclosed to the training organisations with consent from the student. As of January 2020 we are aware of the results of 9 students in the cohort, 4 of whom passed. Of those 9, 6 were on placement at ENHT and 2 passed. These results appear to be consistent with the results of first cohorts at other organisations but there will be lessons to learn in order to improve these statistics for future cohorts. Students can retake the national exam an additional two times and UH are supporting those students approaching resits.

The second cohort have completed their first year and begun their second year; the third cohort has started successfully. Trust remains committed to training Physician Associates.

3.2.3. Education & Training

Development of training to ensure the Trust can utilise the Apprenticeship Levy in the most efficient and productive manner is ongoing. The Trust has continued to fund apprenticeships as in previous years and has also expanded to increase the breadth of opportunities for staff training and development including apprenticeships with UH - Nursing Degree Apprenticeship, Nursing Associate Apprenticeship and Leadership Apprenticeships Masters in Business Administration (MBA), Masters in Business and Organisational Strategy (MBOS) and Advanced Clinical Practice course.

In 2019, 200 ENHT staff enrolled on apprenticeships including 19 at UH; 16 Nursing Associate, 2 MBOS and 1 MBA. Of the remaining apprenticeships at other providers; 134 are at level 2, 43 at level 3, 1 at level 4 and 3 at level 5 therefore the majority are below the level of provision at UH.

3.2.4. Pharmacy

- Implementation of Non-Medical Prescribing (NMP) strategy – Access to the NMP course at UH has been challenging in the past but the decision taken in Spring 2019 to enrol 8 cohorts of 45 students per year going forward was welcomed – 3 in Semester A (September); 3 cohorts in Semester B (January); and 2 in Semester C (April). ENHT (and other HEE funded applicants) will have preferential access to places provided that applications are received a month prior to the course start date. 3 pharmacists have enrolled in each of the most recent cohorts; May 2019, September 2019 and January 2020.

  Funding secured via Trust CPD and HEE for 2019/20 cohort. Uncertainty over future funding and difficulty in securing training places may impact the Trust's ability to meet clinical pharmacy Carter report targets. Trust Medicines Optimisation Strategy 2019-2022 includes KPI 2 - Number of TTOs completed at ward level should be ≥75%. This is a significant increase from a baseline in 2017-2018 of 54% and requires the expertise of ward based prescribing pharmacists.

  The impact of pharmacist NMPs is already being seen within the Trust. Ward based pharmacists are attending ward rounds and once the decision to discharge a patient is made, the pharmacist is able to prescribe and dispense medications patients need to take out (TTO) on discharge. This can reduce time to write up prescriptions by up to 3-4 hours and as most medications can be dispensed from ward stocks, time to fill prescriptions can be reduced by over an hour and without impacting on central pharmacy in line with KPI 3 above.

- Training of Junior Pharmacists Postgraduate Diploma in Pharmacy Practice (PGDipPP) - 5 junior pharmacists successfully completed the Postgraduate Diploma in July 2018. Currently 11 junior pharmacists from across the Trust are taking course at UH, 6 of which enrolled September 2019 and 5

in year 2 who are due to complete in July 2020. In addition, there are also 7 pharmacists enrolled onto distance learning diploma courses at other universities. This is because the Trust cannot release more staff to attend study days at the same time. Extra cohorts at UH on different days of the week would be welcome.

- Extended Placement of Masters in Advanced Clinical Pharmacy Practice (EP ACPP) - Three cohorts completed. No students commenced in September 2019 due to UH recruitment issues. Next cohort expected September 2020.
- PhD students - Currently supporting one PhD student who is in the process of writing up their thesis.
- The Trust continues to support undergraduate MPharm students on placement in each of their 4 years of study.
- The commitment of UH in funding a joint Academic/Clinical Link Tutor with the pharmacy department started in 2014 is ongoing.

3.2.5. Research

- Alignment of legal processes has been completed as far as practicable. Focus for the research work stream has moved on to outputs and will include future assessments of the impact of joint research on patients and patient care.
- ENHT fully supports UH's ambition to develop the existing Clinical Trials Support Network into a fully functioning Clinical Trials Unit.
- Both organisations remain committed to submitting joint research funding bids and to conducting joint research for the benefit of patients and the wider community of Hertfordshire. Listings of joint projects, posts and publications are detailed below.
- Details of research grant applications and other metrics can be found below in 3.3.2.

3.2.6. Placements

3.2.6.1. Optometry – ENHT welcomed optometry students from the UH for the first time between October and December 2019. 30 third-year undergraduate students rotated through various eye clinics at the Lister and New QEII to gain a better understanding of abnormal eye conditions.

Lister Treatment Centre placements include;
- Ophthalmology clinics - Medical Retina and Glaucoma.
- The Urgent Eye Clinic.
- Specialist Imaging.
- Adult Ocular motility.

The QE2 Clinics placements include;
- Paediatric Ophthalmology.
- Diabetic Eye Screening/Grading clinics.

- Student Experience – Students were asked to provide feedback on their experience within the Trust; this was overwhelmingly positive; copes of the correspondence can be found in Appendix D.

3.2.6.2. Practice Placement Agreement – This agreement forms the basis of the relationship by which UH students can attend placements at ENHT without the need for individual contracts. The agreement also allows for input from the Trust into course design to help ensure that the future workforce are trained to carry out the skills they will need to perform on the job.

UH have developed a generic agreement that is in use with other placement providers and takes into account the needs of courses developed in recent times including physician associate. ENHT signed this new agreement in December 2019

3.2.7. Information Technology

- Following the appointment of Mark Stanton, Chief Information Officer the Trust are developing a new three-year digital programme which focuses on our clinical systems, aligned with the Trust strategy to make things easier, improve quality and improve our patient services.
- Supported by a three-five year capital plan we will move to electronic records that support clinical staff to deliver safe patient care, developed with doctors, nursing staff and allied health professionals involved in the digital decision-making process.
- Currently working towards Knowledge Transfer Partnership (KTP) to employ a joint PhD student to investigate digital integration and use of data for generating research questions.

3.2.8. Leadership & Management

- Access to UH Business School MBA, MSc Business and Organisational Strategy and BA Chartered Manager programmes through the Apprentice Levy. Our first candidate successfully completed year 1. Others have now joined the programme and access to higher level course via apprentice levy is now a proven process.
- Facilitators from ENHT and from UH to jointly deliver programmes. Verbal agreement has been reached but the harder elements of 'what we do' and 'what we pay' needs work in 2020 on strategy – action in financial year 2020/2021.
- UH accreditation for LMCDP - The LMCDP (Leadership, Management and Coaching Development Pathway) at ENHT continues to evaluate well and is now open to all across our STP. Accreditation by the UH would be hugely supportive. The challenge will come in 'how we assess' as much of the LMCDP is experiential and practical with 'actions taken at work' the output over 'academic delivery'. The new ENHT education strategy will give this new momentum – unlikely to see any concrete programmes until 2020/2021 financial year but planning is underway.
- New model for delivery of leadership, management and coaching - The ENHT leadership model believes that 'a leader's role is to develop leaders' and there are now several programmes, coaching interventions and design groups populated with facilitators who are organisational leaders. Further expansion and development would be in collaboration with UH Business School. Bringing together the educational functions of ENHT in 2019/2020 will be significant in providing access and uniformity to this approach.
- An aspiration for the future is to establish a Joint ENHT and UH leadership lab at ENHT - an idea in name and consideration only at present; it does seem to catch the imagination but practical next steps require hard resources. The idea of a joint ENHT/UH facility on site is appealing – this might also support the STP role of a single Leadership approach. The STP work is vital in this. Meetings with an emerging STP committee began in Autumn 2019.
- The Trust appointed a Talent Management Lead in August 2019. As part of this role Career Conversations will be launched soon; these include coaching mentoring and talent management as well as IT solutions to record real-time continuous feedback.

3.2.9. Student Experience

During the application and validation process that took place prior to both organisations signing the memorandum of understanding in March 2017 it was stated that '*Evidence of enhanced student experience will be assessed through the University's Annual Monitoring and Evaluation Report (AMER) and this information will be utilised by the Joint Management Group to ensure that the partnership enhances student experience'.*

This statement does not seem to deliver a practicable solution to monitoring student experience. The AMERs are presented to School Academic Committees from each programme of study within each school; there is no separate University AMER overall and these are not written from the perspective of one placement provider.

Current measures of student experience received by the Trust are predominantly from pre-registration nursing students and can be found in appendix C. These quantitative data start from a high baseline and ask a series of YES / NO questions which make it difficult to see a meaningful enhancement of student experience.

There is also an element of qualitative data recorded in the form of comments which can be addressed individually or grouped into themes as appropriate. Whilst the feedback received is overwhelmingly positive, the Trust is keen to learn from any negative comments and ensure students have the best experience possible.

The Trust responds on a regular basis to the pre-registration nursing student feedback provided by UH; a flow chart of this process can also be found in Appendix C.

A copy of the correspondence outlining feedback on student experience from the recent first cohort of Optometry students can also be found in Appendix C.

There is still more work to be done to develop a robust mechanism for collecting feedback from all student placements in a format that is useful to both organisations and that can demonstrate the impact of actions taken. This may also combine with feedback from staff supervising and mentoring students.

3.2.10. Florence Nightingale Foundation Chair in Clinical Nursing Practice

This post is a joint appointment between UH and the Trust designed to prioritise building research capacity for nurses across the trust and university underpinned by strengthening links between the two organisations. Natalie Pattison took up the post on 1st October 2017.

As a clinical academic post, the goal is to develop and consolidate strong links to ensure research is driven by best practice and best practice is underpinned by research. The vision is:

- To create a culture where research is embedded in all clinical practice.
- To facilitate access to, and support, clinical academic career pathways for those committed to research in practice.
- To foster a culture of collaborative working.
- To develop research skills and knowledge for clinical staff ensuring that clinically relevant knowledge translation occurs.

Report on current projects from Natalie Pattison October 2019:

- Strategic - I've worked closely with the nursing executive team (Director of Nursing, Deputy Director of Nursing, Assistant Director of Nursing) and the Heads of Nursing to develop a nursing strategy (launched on 7.5.19), as well as develop a Ward Accreditation Framework with the Assistant Director of Nursing, as a basis for the nursing excellence framework. I also successfully wrote an application to HEE for a quality improvement Matron and data analyst on behalf of the Director of Nursing, to support these activities. We have recently appointed to this position.
- Critical Care Outreach Team (CCOT) / Resus / HERRTS Hub - I've worked with our two deteriorating patient/CCOT and resuscitation leads, alongside the quality improvement methods, to support them in the roll-out of a HERRTS hub, drawing together acute care services to support deteriorating patients and my work has centred on helping these leads to provide evidence through service evaluation and interpreting quality improvement results. I'm also formal mentor for the CCOT lead in an HEE/NIHR mentoring programme.
- Research Nursing - I've also worked with our research nursing team (I am the professional lead for the lead research nurse, who has a team of 40 nurses, and for the new 70@70 nurse whom I supported, on behalf tof the Director of Nursing, to successfully apply) on professional issues and on a project to explore how shared decision-making relates to informed consent (as part of an HEE fellowship I'm acting as mentor for).
- Applied Research Collaboration (ARC) fellowships - Supported two nurses in the trust to apply for the new ARC fellowships – one achieved this (awarded 15 days to write a systematic review on acute kidney injury), the other person we are awaiting to hear.

- Completed HEE Fellowships - Two nurses completed HEE research fellowships in 2019. This includes one on shared decision-making (see above) and another on the use of bioimpedance to manage fluid status in acute kidney injury (AKI). We have worked closely with the renal team, including the AKI medical lead/nursing lead, in this service evaluation project, with the expectation this will lead to the broader adoption of this adjunct method of fluid management in renal/AKI patients.
- Research grants - Another project involves development of an app for young people who are carers, I'm the CI of this project supporting a novice researcher Jodie Deards, the trust Carers Lead, to undertake this General Nursing Council sponsored project. We have worked with young people from the local school adjacent to ENHT, as well as young carers to refine an app, to be further tested in the summer.

  We are rolling out another App based project for families of intensive care patients, funded by the European Society of Intensive Care Medicine.

  I led submission of 3 grants, including one to Burdett Trust (unsuccessful), and one to NIHR Research for Patient Benefit (RfPB) (unsuccessful) and an NIHR Health Services and Delivery Research stage 2 submission on Bereavement following death in the ICU. I am co-CI, with a colleague from Edinburgh. Overall bid: £907,000 (741,000 FEC). We will hear if we are successful in this final stage in Jan. I also collaborated on another grant led from ENHT for RfPB (unsuccessful).
- Research internships - With a UH colleague, last year we created a bespoke research internship for undergraduate elective placements, with positive feedback and one student publishing a reflective account in Nursing Standard about the experience (an expected output was a publication and poster presentation). We have repeated this with another student on the elective in summer 2019, who has since attended the trust Critical Appraisal Course, and whom we hope will apply for the Chief Nurse Fellow posts.
- Chief Nurse Fellows - We have created these fellow positions, aimed at newly qualified/band 5 nurses (one in medicine, and one in surgical division) to spend 50% of their time working on research/QI/chief nurse projects. We have written the JDs and about to send these for banding.
- Doctoral research fund - We opened this in January 2019, with a successful applicant (Anne Hunt) having her fees paid at UH for her doctorate. We are awaiting ENHT charity decision to see if we can run this again for 2019/2020.
- Critical Appraisal Course - I created and ran a Masters-level Critical appraisal course (2 days) went well and well evaluated/attended (all professions up to consultants), we are still waiting to see if we can have formal accreditation via UH. Content includes: critical appraisal of RCTs/qualitative research/epidemiology/systematic reviewing and statistics refresher for critical appraisal. UH staff are also invited to attend.
- Service evaluations - We have three service evaluations underway, and several more planned.
- Other fellowships - Supported other fellowship applications (e.g. CLARHC), including a successful application for the Safe Care Fellowship for Emily Watts, working with her on a service evaluation.
- Research champions/research coaching - We have a rolling education programme for research, and have developed research champions (which the 70@70 nurse, who works alongside me, is leading).

3.3. Other performance metrics

In addition to the key metrics above; a number other metrics will be collected and used to support the development of the partnership. Whilst no formal targets have been set for these metrics, work is underway to establish sustainable and reliable methods for recording and updating this information.

- Number of joint appointments, visiting lecturers and professors.
- Number of joint research bids.
- Income from joint research bids.

- Number of joint publications.
- Number of placements.

3.3.1. Number of joint appointments and number of Visiting Lecturers / Professors.

Baseline 2016-17 for joint appointments is 10 – 2 substantive, 6 honorary & 2 advisory including 2 Professors and 5 Visiting Lecturers.

2019-20 the number of substantive joint appointments has increased to 11 with a number of additional joint research posts in various stages of development as described above in 3.2.10. The number of honorary posts has increased to 7 & 2 advisory; this is net of any posts that were made substantive during the year.

The Trust does not currently keep a central record of individuals with an honorary contract with UH so these figures may be an underrepresentation. The Trust is currently reviewing the information held on the Electronic Staff Record and will endeavour to include more information on staff participation in education, training and research subject to software constraints.

3.3.2. Number of joint research bids & income received

Summary of grant applications for 2019.

2019	ENHT Total	Joint with UH
Grant Applications Submitted	23	11 (details below)
Awarded	10	4
Submitted	4	3
Unsuccessful	8	4
In Preparation	1	1

Joint research bids submitted in 2019

Status	Short Title	Applicant	Specialty / Department	Funding Body	Primary Recipient	Amount requested	Date submitted	Amount awarded	Date of Outcome
Awarded	CRN: Eastern 2018/9 CI support scheme	Ken Farrington	Urology	CRN: Eastern CI Support	ENHT	£15,447	14 January 2019	£11,594	26 January 2019
Awarded	CRN: Eastern 2018/9 CI support scheme	Diana Gorog	Cardiology	CRN: Eastern CI Support	ENHT	£6,250	14 January 2019	£6,250	26 January 2019
Awarded	Supporting person-centred care for people with dementia in hospital settings	Melanie Handley	Mental Health	Alzheimers society	UH	£316,381	28 March 2019	£316,381	
In prep	Video Games develop transferrable skills that benefit the learning process and practicalities of robotic surgery	Nikhill Vasdev	Urology	Intuitive Foundation	ENHT	£32,182	N/A		
Submitted	Evaluation of gastrointestinal permeability as a source of unexplained inflammation in end stage renal failure	Oscar Swift	Renal	NIHR Doctoral Fellowship	ENHT	£194,128	18 June 2019		
Submitted	AV fistula maturation: effect of Remote Ischaemic pre-conditioning and hand exercise (AV MARIE)	Dr Enric Vilar	Renal	NIHR EME Researcher Led 19/24	ENHT	£1,176,329	28 August 2019		
Submitted	The enhanced fluid assessment study: Developing a fluid assessment tool for patients with acute kidney injury	Karen Nagalingam	Renal	Kidney Research UK	UH	£135,158	02 December 2019		23 March 2020
Unsuccessful	AV fistula maturation: effect of Remote Ischaemic pre-conditioning and hand exercise (AV MARIE)	Dr Enric Vilar	Renal	NIHR EME Researcher Led 18/125	ENHT	£1,067,195	19 March 2019	n/a	30 June 2019
Unsuccessful	Family and Friends Toolkit - Kidney Disease	Julia Jones	Renal	NIHR RFPB	UH	£149,618	20 March 2019	n/a	19 June 2019
Unsuccessful	Comprehensive Geriatric Assessment for CKD	Maria Da Silva-Gane	Renal	NIHR HS&DR	ENHT	£1,418,440	25 April 2019	n/a	01 August 2019
Unsuccessful	Glycaemic parameters, endogenous fibrinolysis and reduction of cardiovascular events in high risk individuals with diabetes	Diana Gorog	Cardiology	MRC Newton Fund	UH	£350,000	29 May 2019		31 August 2019

3.3.3. Number of joint publications: 2018 = 17; 2017 = 14; 2016 = 11; 2015 = 9; 2015 = 6

3.3.4. Number of placement places

In 2019 ENHT hosted Optometry undergraduate students for the first time with 30 students spending 2 days in the Trust to gain exposure to abnormal eye conditions in line with the requirements laid down by the Royal College of Optometry.

3.4. Case Studies

Jennifer Godwin, Partnership Manager has begun to highlight the achievements of the partnership with a series of Partnership Working Case Studies.

Case studies can be found in Appendix D and include so far:

- Florence Nightingale Foundation Clinical Professor of Nursing.
- Research and Innovation.
- Degree Apprenticeships – MBOS.
- Degree Apprenticeships – MBA.
- Degree Apprenticeships – The Nursing Associate.
- Library Services.
- Physicians Associate.
- Developing the Physician Associate Programme.

4. Strategic Planning

Strategic direction of both organisations	
Trust Vision	**University Vision**
To be 'Proud to deliver high-quality, compassionate care to our community'	To be '*internationally renowned as the UK's leading business-facing University*'.
Trust Strategic Priorities 2019-24	**University Strategic Priorities 2015-20**
• Sustainability: Develop a portfolio of services that is financially and clinically sustainable in the long term. • People: Create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce able to meet the needs of our patients. • Pathways: Pursue actively the development of pathways across care boundaries, where this is in the best interests of patients and adds value. • Ease of Use: Redesign and invest in our systems and processes to ensure that they provide a consistently simple and quick experience for our patients, their referrers, and our staff, minimising frustration and maximising efficiency.	• Providing expert teaching informed by research, business and the professions. • Offering workplace engagement and overseas learning opportunities. • Creating and developing innovative ideas, products and processes. • Fostering and strengthening research with global partners. • Developing international partnerships. • Strengthening the global perspective in the curriculum. • Developing students with the knowledge, skills and attributes to succeed in business and the professions. • Enhancing relationships with business and industry.

Trust Strategic Priorities 2019-24	University Strategic Priorities 2015-20
• Quality: Deliver high quality care consistently across all of our services in terms of clinical quality, safety and compassion.	• Demonstrating and promoting our positive social, cultural and economic impact. • Attracting and developing outstanding people. • Strengthening the diversity of our community. • Consolidating financial sustainability.

ENHT launched its new five year strategy in April 2019; UH is in the process renewing its 5 year strategy to be launched in 2020. The partnership strategy is in development and will reflect the strategic priorities of both organisations.

5. External Advisor and Stakeholder Involvement

The post of External Advisor for the Joint Management Committee has been filled by the Deputy Director of Nursing from Hertfordshire Partnership University NHS Trust who have been in a similar partnership with UH for some time and have recently had their partnership revalidated.

Elizabeth Hesketh attended her first meeting of the Joint Management Committee on 16th January 2019 having been appointed as lay member for a period of 2 years.

6. Resources to Support Partnership

The Trust and the University have a wealth of existing infrastructure to support this joint venture. The main resource is the knowledge, skills and experience of the staff of both organisations. Learning resources include the Learning Resource Centre, libraries, specialist training facilities, simulation provision and IT infrastructure.

The Trust's Board has agreed to support this venture and to fund the costs of new signs, stationary and other information such as the website. The University has agreed to provide resources to support this joint venture from within existing staffing, equipment and learning resources.

6.1. Partnership Manager

Both the Trust and the University have committed to contribute equally to the post of Partnership Manager. This post has been revised since the original submission to reflect the greater level of leadership and responsibility envisage to support the partnership.

The post was offered at 0.6 WTE (22.5 hrs per week) on a fixed term contract for 2 years. The post has been graded at grade 8b (NHS) and 9 (university) with a total combined cost of circa £40k per annum. Interviews took place on 3rd October 2017 and Jennifer Godwin started in post on 1st November 2017. No decision has yet been made whether to extend this post.

7. Relationship between the University and the NHS Organisation

The Trust and UH have a longstanding history of collaboration. Prior to the formal partnership this collaboration had centred on the school of Health and Social Work and the school of Life and Medical Sciences however over the past few months we have begun to expand the scope of these collaborations including with Hertfordshire Business School and drawing on the data science / big data expertise across schools including Physics, Astronomy and Mathematics & Engineering and Technology.

The Trust has agreed to sponsor undergraduate student awards in Summer 2020; specifics are yet to be agreed.

Appendices available on request.

East and North Hertfordshire NHS Trust

Agenda Item: 13

TRUST BOARD - PUBLIC SESSION – 4 MARCH 2020

AUDIT COMMITTEE – MEETING HELD ON 20 JANUARY 2020
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present the summary report from the Audit Committee meeting of 20 January 2020 to the Trust Board. The report includes details of decisions made by the Audit Committee under delegated authority.		
Action required: For discussion		
Previously considered by: **N/A**		
Director: Chair of Audit Committee	**Presented by:** Chair of Audit Committee	**Author:** Trust Secretary / Corporate Governance Officer

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

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

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

AUDIT COMMITTEE MEETING – 20 JANUARY 2020

SUMMARY REPORT TO TRUST BOARD MEETING HELD ON 4 MARCH 2020

The following Non-Executive Directors were present:

Jonathan Silver (Chair), Bob Niven, Karen McConnell

MATTERS REFERRED TO BOARD:

Auditor Panel

The Committee reconvened as the Auditor Panel following the conclusion of the other agenda items (without any external representatives present) to consider an application for the provision of external audit services from April 2020. The Auditor Panel has made a recommendation to the Trust Board in this regard.

OTHER:

Cyber Security Update

The Cyber Security update was presented to provide an update on developments in the Trusts Cyber Security position in the period October to January 2020, highlighting any risks or threats and the work done to protect and secure the Trust.

The Data Security Officer reported that there had been no notable cyber security threats. The Trust had also recently implemented Microsoft Advanced Threat Protection (ATP) which had already proved useful in alerting the IT Department to issues and identifying workstations that could be compromised. The Committee also noted progress in terms of the implementation of Windows 10 across the Trust.

Board Assurance Framework and Risk Deep Dive

The latest version of the Board Assurance Framework 2019/20 was presented to the Committee for consideration and discussion.

Key areas of the risks to note for January 2020 were the two risks which remained at 20. These were risk 4, capital resources and Risk 11, Estates and Facilities.

The new Director of Estates and Facilities commenced in January 2020 and would be expected to provide effective leadership and structure in the development of an Estates Strategy and an action plan to address the issues.

In regard to risk 12, MVCC, a preferred provider for the services at MVCC had been agreed by Specialist Commissioners. The due diligence work to support this had commenced. Risk 10, EU Exit had been reduced to 12, in line with the national position. Risk 7, Governance had been presented to the Committee as the focus for the deep dive discussion.

Regarding risk 7, the outcome of the CQC and use of resources reports were received in November 2019. The risk had been updated to reflect the receipt of three HSE improvement notices – Violence and aggression, Moving and Handling and sharps. It was also reported that a follow-up meeting with HSE was scheduled for later in the week, following submission of the Trust's action plan.

The Risk Update Report was presented to show progress in improving risk management. The Trust's mean figure for compliance with the timely review of risks was 72.5%. The Risk

manager referred to 3 risks scored at 25. There was some discussion as to the extent that these risks were already mitigated. The Committee suggested that the Quality and Safety Committee should be asked to monitor those risks.

Internal Audit Progress Report

An update on progress against the internal audit plan for 2019/20 was presented. Six reports had been finalised since the last meeting as follows:

- Deterioration of Patients – Use of Nerve Centre – Partial Assurance Opinion;
- Data Security and Protection Toolkit – Advisory;
- Theatre Productivity Governance Arrangements - Partial Assurance Opinion;
- Safer Staffing – Reasonable Assurance Opinion;
- Radiology Utilisation - Reasonable Assurance Opinion;
- Management of Sickness Absence including the Local Proactive Counter Fraud Exercise - Reasonable Assurance Opinion.

One audit (Pay Budget Setting) had been issued in draft but was yet to be finalised. The Associate Director, Quality and Safety and the Clinical Director, Surgery, reported on deterioration of patients.

Proposed Areas for Internal Audit Coverage 20/21

The Internal Auditors provided an outline of their approach to planning to date for 2020/21 and outlined potential areas for coverage for discussion. They reported that the strategy for 2020/21 to 2021/22 was subject to feedback from the Executive Team. The Committee made some suggestions for consideration and noted the report.

Local Counter Fraud Specialist Progress Report

The Counter Fraud progress report was presented to provide an overview of the key pieces of work undertaken as part of the counter fraud work plan since the last Audit Committee meeting; to provide a summary of the reactive referrals received and investigations pursued and to outline the progress against management actions.

The Committee noted the report.

Recommendation Tracking Report

The report showed the latest updates in respect of recommendations made. At the time of reporting, 45% (28) of recommendations had been implemented, 26% (16) were overdue by 0 – 3 months, 11% (7) were overdue by 3 – 6 months, 15% (9) were overdue by 6 + months and 3% (2) were not yet due.

The Audit Committee was disappointed to find that only limited progress had been made. It was agreed that RSM would provide an overview for the Board Development meeting on 4 February and the issue would be escalated to the Board for discussion at that meeting.

Plan for 19/20 External Audit

The report summarised the planned audit strategy for the year ending 31 March 2020 in respect of the External Auditor's Audit of the financial statements and consolidated entities, use of resources and Quality Account; comprising materiality, key audit risks and the planned approach to these together with a timetable.

It was also confirmed that the finance team would look to hold another session with the

NEDs regarding the draft accounts prior to the Audit Committee taking place in May. An increase in fees was proposed. The Committee supported the increase.

Data Quality and Clinical Coding Report

The report was presented to inform the Committee of progress on data quality improvements and clinical coding activities.

The data Quality team had been involved in the following projects:

- Data Quality Compendium (DQC) – The review and recording of all services was complete.
- Access Plan Project - During December, the Data Quality team was tasked with closing down the old legacy access plan profiles, mapping the old DNU profile to the new existing profile and transferring patients across.
- Consultant Master File – The Team was currently overseeing the amendment and update of the current master file with Division sign off.

The Audit Committee noted the report.

Review of Accounting Policies

A report was submitted on changes in accounting standards and the impact on the Trust accounts for 2019/20. IFRS 16 (Leases) would be adopted on 1 April 2020 and would have an impact on 2019-20 accounts. The Audit Committee noted the report.

Significant Losses / Special Payments

The Losses and Special Payments Committee submitted a report on the Trust's significant losses and special payments between April and September 2019. The Audit Committee was asked to note the reported Trust losses and special payments.

Tenders and Waivers Report

The report was submitted to inform the audit committee of the value and volume of tender waivers and assure the committee that reducing waivers and managing non-pay spend was a key objective of Procurement. The Audit Committee noted the report.

Jonathan Silver
Non-Executive Director
February 2020

East and North Hertfordshire NHS Trust

Agenda Item: 14

TRUST BOARD – PUBLIC SESSION – 4 MARCH 2020
Board Assurance Framework 2019 20

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.

Key areas of the risks to note for February 2020:

- Two risks remain at 20. Risk 4 – Capital resources and Risk 11 – Estates and Facilities
- One risk has increased in rating Risk 7 – Governance.
- One risk for consideration for de -escalation from the BAF. Risk 10 – EU Exit. The risk has been reduced to 8, below the target mitigated risk of 12.

  Please note the FPPC endorsed this recommendation 24 February 2020.
- The strategic risks will be reviewed in quarter 4 to ensure they reflect the strategic risks for 2020/21. This will be informed by the new Operating Plan, strategic priorities and review of the clinical strategies.
- The annual Risk Management and Assurance review by the Internal Auditors is in progress and will inform the review of the Risk Management Strategy, BAF and identification priorities for continuing to strengthen our Board assurance in 2020/21.
- Each risk continues to be reviewed monthly with each lead director.

Action required: For discussion

Previously considered by: The Board Assurance Framework is considered at each FPC,QSC & Board. Executive Committee 20.2.20 – Changes endorsed with additional recommendation to reflect the preparedness re CoronaVirus and challenges in Medical Division regarding nurse recruitment. Endorsed de-escalation of Risk 10 – EU Exit from the BAF.

Director:	**Presented by:**	**Author:**
Director of Strategy	**Associate Director of Corporate Governance**	**Associate Director of Corporate Governance**

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) Yes – CQC compliance will link with all the BAF Risks

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

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

Board Assurance Framework 2019 20 – February 2020

Executive Summary

- Key areas of the risks to note for February 2020:

  - Two risks remain at 20

    Risk 4 – Capital resources and Risk 11 – Estates and Facilities.
    Additional capital funding to support fire compliance has been approved from NHSE for 2019/20 (£1M) and 2020/21 (£1.5M); the work programme is currently being finalised. FPPC received a report on currently Estate and Facilities compliance in November and December 2019. The new Director of Estates and Facilities commenced in January 2020 and will provide clear leadership and structure to progress developing an Estates Strategy and a prioritised plan to address the issues. These are reviewed monthly by the Finance, People and Performance Committee and a deep dive on Estates and Facilities was discussed at FPPC in February 2020.

  - One risk has increased in rating

    Risk 7 - Governance. Risk increased from 12 to 16. This is reflective of the deep dive presentation at the Audit Committee and Board Committee discussions in January 2020 regarding the three HSE improvement notices – Violence and aggression, Moving and Handling and sharps. Action plan is place to deliver compliance by end of April for two of the notices and end of July for Moving and Handling. On track for delivery.

    The action plan and updates will be presented through the new Compliance Group, Quality and Safety Committee to Board and monitored through the Health and safety committee and Executive Committee.

    New compliance framework for implementation in February. The draft dashboard and programme of activities will be presented to the Executive Committee and QSC in March 2020.

  - One risk for consideration for de -escalation from the BAF

    Risk 10 – EU Exit. The risk has been reduced to 8, below the target mitigated risk of 12.

    February 2020: internal EU preparation stood down following issuing of Brexit Operational Readiness Guidance (December 2019) and the approval of the EU Withdrawal Agreement. There is now a transition period until the end of 2020 while the UK and EU negotiate additional arrangements. The current rules on trade, travel, and business for the UK and EU will continue to apply during the transition period. New rules will take effect on 1 January 2021. It is recommended that this risk is reduced and monitored going forwards in order to respond to any development regarding arrangements following the end of the Transition Period.

    Monitoring government advice regarding arrangements from the end of the Transition Period (January 2021), identify and work to mitigate any risks to the organisation will be undertaken as business as usual and any specific risks identified will be fed to the risk register and other relevant BAF risks e.g. business continuity under Governance and Staffing.

In view of above and as the risk has met and been reduced beyond its target risk rating it is recommended it is de-escalated from the BAF. This will be considered by the FPPC.

- Other points to note from the reviews

  Risk 1 – Performance
  The improved performance for the cancer standards has been reflected. The RTT and ED/4 hours remain under performing currently.

  Will reconsider the risk rating if we can land RTT this year with the demand and capacity modelling and agree with commissioners to commission reasonable levels of activity to reduce the backlog and deliver 18 week pathways.

  Agreed at February 2020 FPPC to include Stroke performance within the scope of the risk and a deep dive on performance has been requested.

  Risk 12 – MVCC. A preferred provider for the services at MVCC was agreed by Specialist Commissioners in January 2020. The due diligence work to support this has commenced. The risk was been reduced to its target risk '12.' The scope of the risk to reflect the Trusts residual position is currently under review with the Director of Strategy and will be revised for the 2020/21 BAF.

  Risk 3 – Finance. Risk currently rated 16. The month 10 position shows the Trust is on track to deliver against its 2019/20 financial plan. The potential to reduce the risk rating will be considered at Month 11.

- The strategic risks will be reviewed in quarter 4 to ensure they reflect the strategic risks for 2020/21. This will be informed by the new Operating Plan, strategic priorities and review of the clinical strategies.

- The annual Risk Management and Assurance review by the Internal Auditors is in progress and will inform the review of the Risk Management Strategy, BAF and identification priorities for continuing to strengthen our Board assurance in 2020/21.

Board Assurance Framework: 2019/20.

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

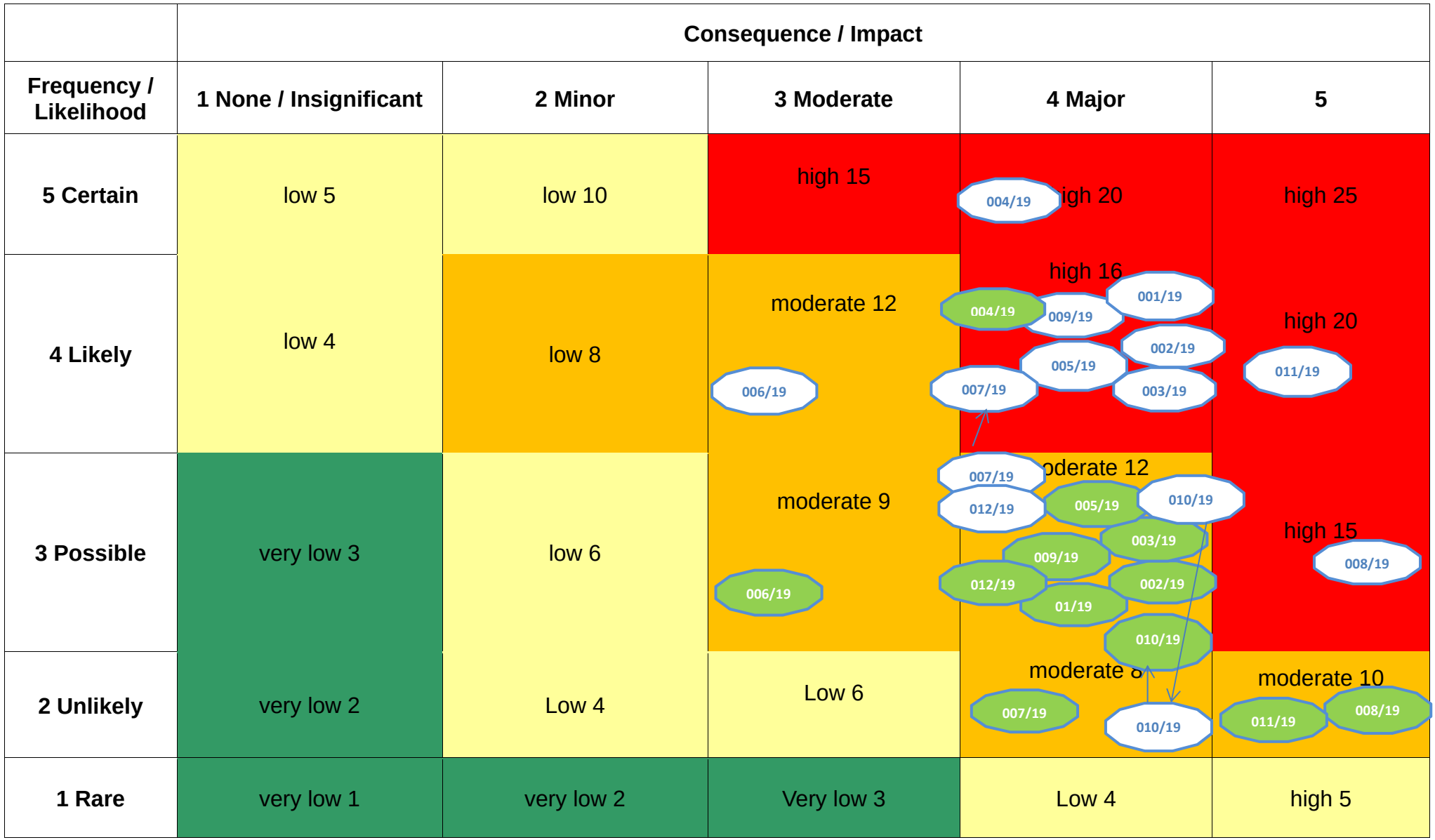
Impact	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
Death / Catastrophe 5	5	10	15	20	25
Major 4	4	8	12	16	20
Moderate 3	3	6	9	12	15
Minor 2	2	4	6	8	10
None /Insignificant 1	1	2	3	4	5

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 (Feb)	Last Month (Jan)	3 months ago (Nov)	6 months ago (Aug)	Target Score	Date added (all reviewed in October 19)
001/19	There is a risk that within the context of the Healthcare Economy the Trust has insufficient capacity to sustain timely and effective patient flow through the system which impacts the delivery of the 62day cancer, RTT, the A&E 4-hour standard and Stroke performance	Chief Operating Officer	FPC	16	16	16	16	12	01-03-18
002/19	There is a risk that the trust is unable to recruit and retain sufficient supply of staff with the right skills to meet the demand for services	Director of Nursing /Medical Director/CPO	FPC	16	16	16	16	12	01-03-18
003/19	There is a risk that the Trust is unable to achieve financial sustainability to support the delivery of the Operational Plan and 5year clinical strategy	Director of Finance	FPC	16	16	16	16	12	01-04-19
004/19 (was 6)	There is a risk that there is insufficient capital resources to address all high/medium estates backlog maintenance, investment medical equipment and service developments	Director of Finance	FPC	20	20	20	20	16	01-03-18
005/19	There is a risk that the digital programme is delayed or fails to deliver the benefits, impacting on the delivery of the Clinical Strategy	Director of Finance/ COO	FPC	16	16	16	↓16	12	01-04-17
006/19 (was 10)	There is a risk that the STP does not work effectively to redesign and implement new models of care, which impacts on the hospital's ability to manage demand for services. (scope of risk under review for consideration on the BAF for April 2020)	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	↑16	12	12	12	12	01-03-18
008/19 (was 11)	There is a risk that the Trust is not always able to consistently embed of a safety culture and evidence of continuous quality improvement and patient experience	Director of Nursing /Medical Director	QSC	15	15	15	15	10	01-03-18
009/19	There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered, impacting on the Trust's ability to deliver the required improvements and transformation	Chief People Officer	FPC & QSC	16	16	16	16	12	01-03-18
010/19 was 013/19	There is a risk that the Trust is adversely affected by the United Kingdom's departure from the European Union, particularly in the event of no deal being secured. Suggested risk de-escalated from BAF.	Director of Strategy	FPC	↓8	↓12	↑16	12	12	19-09-18
011/19(was 014/19	There is a risk that the Trust's Estates and Facilities compliance arrangements including fire management are inadequate leading to harm or loss of life.	Director of Strategy	QSC	20	20	20	20	10	22/01/19
012/19	There is a risk that the Trust is not able to secure the long-term future of the MVCC (scope of risk under review for consideration on the BAF for April 2020)	Director of Strategy	FPC	12	↓12	↑16	12	12	01-03-18

Board Assurance Framework Heat Map – February 2020



EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2019-20

Strategic Aim:	**Pathways: To develop pathways across care boundaries, where this delivers best patient care redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff**				**Ease of Use: To**
Strategic Objective:	**Improve and sustain delivery of operational performance**	**Source of Risk:**	Strategic Objective IPR	**BAF REF No:**	001/19
Principal Risk Decription: What could prevent the objective from being achieved? **There is a risk that 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, the A&E 4-hour standard and Stroke performance**		**Risk Open Date:**	01/03/2018	**Executive Lead/ Risk Owner**	**Chief Operating Officer**
		Risk Review Date:	Feb-20	**Lead Committee:**	**FPC**

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Increases / changes to capacity and demand . ii) leadership and capacity challenges iii) conflicting priorities iv) Inconsistency in application of pathways/ processes iv) Impact of tax issue on Consultants willingness to undertake WLIs. v) Impact of specialist commissioning review and resultant outcome for MVCC on staff retension and recruitment, impacting on effectiveness of the cancer team.	i) Limited ability to respond to changes in capacity and demand impacting on service delivery ii) Adverse impact on sustaining delivery of core standards iii) impact on patient safety, experience and outcomes iv) increased regulatory scrutiny v) reputation	**Inherent Risk** (Without controls):	4	5	20	⇕
		Residual/ Current Risk:	4	4	16	⇔
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• ED Patient flow improvement steering group/ Delivery Board • Three times weekly work stream meetings including Red to Green • Weekly ED Team/COO meeting • Length of Stay consultant led reviews • Daily system telephone conference • Refresh of access board structure and governance led by the Deputy Coo with oversight by the COO • Monthly deep dive cancer meetings with CCG support, to challenge and review tumour site performance, quality and safety • Trust representation on A&E delivery Board/ Cancer Board/ STP • Integrated Care Team engagement • Additional management resource secured to support delivery of cancer timed pathway programme - CIMBIO reports and monitoring - speciality and consultant level monitoring of access plans when completed and failsafe TCI waiting list office reconciliation. Linked to training to improve compliance - Programme Boards - OPD Board, Theatre Board, Length of Stay review panel - ED breach review and vailidation and SoP - re launch of winter planning group July 2019 Comprehensive D&C work undertaken by speciality teams supported by in house D&C team and external IST team. Aim is to identify capacity gaps which will be addressed through a series of actions to include job plan review, efficiecy improvement e.g. reduction in DNA rate; increase utilisation in theatres and where required funding for substantive resources.	• A&E Delivery Board (L1) • System Resilience Group (L2) • Reports to FPC and Board of Directors (L3) • NHSI PRM(L3) • Cancer Board (L2) • Daily and weekly ED sit-rep reporting • Monthly breach validation audits • Internal Audit – Performance Framework report - reasonable assurance March 19) Internal audits scheduled for 2020/21 include the ED triage, SDEC and ambulance handover process and deep dives into several aspects of patient flow Regulator oversight - weekly detailed performance call - Audit Committee deep dive review - October 2019	Internal Audit – Performance Framework report - reasonable assurance March 19) Validated demand and capacity by tumor site modelling by NHSI - led to increase investment in urology. Internal Audit Radiology Utilisation - reasonable assurance Clinical Capacity and Utilisation Governance - partial assurance 2019 Audit Committee deep dive review October 2019 • The trust has been formally stepped down from IST cancer support due to the improvement in cancer performance. • IPR Report to Nov and Dec 2019 FPC/Board demonstrated 6 and 7 compliant cancer standards respectively, with 62 days above compliant levels of 85%+ performance.		Cancer performance ED Performance RTT performance

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
Bed Occupancy and LOS reductions not being delivered consistently across specialities. Sufficient surgical capacity to deliver cancer treatments within required timeframes Demand and capacity modelling for all high impact tumour sites complete.	• Accountability Framework arrangements • Impact of local Hospitals on Trust activity • Demand and capacity profiling for T&O, Pain , oral surgery to inform future business planning Review and response to Market analysis	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient

Access to funding streams from the cancer alliance allocation - availabilty of capital to support developments Capacity to support the Stroke Care Pathway and KPI	- Access to social care support at weekends - 7 day working linked to job planning	Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Implementation of patient flow work programme	Chief Operating Officer	on going	sameday emergency care programme in progress, reporting to the Patient Flow Board	In progress
ii) Implementation of agreed improvement plans for cancer, RTT and diagnostics	Chief Operating Officer	on going	Cancer performance improving. 62 day pathway in track for delivery and sustained by October 2019. RTT- focus on delivery of reductin of 52 wk breaches. Trajectory agreed to be at 0 52 week breaches in July 2020. Funding requesting to deliver insourcing solution for endoscopy which would bring 0 position forward to April 2020.	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	All specilaities currently undergoing D&C modelling to determine the resourcing and efficiency gaps required to deliver the 18 week pathway. This work will be aligned with the contract discussions regarding the level of RTT activity agreed and commissioned with our commissioners. The desire is to deliver compliant RTT pathway treatments for our patients through substantive teams paid at plain time rather than adhoc and WLI sessions.	In progress
iv) Continue to review and strengthen operational and governance structures	Chief Operating Officer	on going	Perfect week delivered improved performance. 21 initiatives were commissioned post perfect week to support flow, to include U/S in the assessment areas; catheter nurse in ED; 7 day access to MRI. There are planned 3 times a year Perfect weeks in the diary, before Easter, before the summer holidays and prior to the next winter, to facilitate advance preparation and ensure the weeks' are as impactful as possible.	In progress
v) To agree and develop further integrated pathways of care with our commissioners	Chief Operating Officer	on going	Next transformation day is 6th March to further develop integrated pathways in support of patient care, access and improved use of capacity and flow.	In progress

Summary Narrative:
20/21 system operating plan - bed occupancy plan to delver 92% occupancy. System bed solutions and bed alternative solutions have been drafted and agreed by providers and commissioners in support of delivering 92 % bed occupancy at the trust. These in clude increasing ambulatory pathway solutions within the trust; working with HCT colleagues on access to rehabilitation beds in the community and HCC colleagues on improving the use of discharge home to assess initiatives (DH2A).

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:	Feb-20	**Lead Committee:**	**FPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) National shortage of nurses and doctors ii) Limited strategic workforce planning iii) Availability of training	i) Impact on staff morale ii) Impact on quality and safety iii) adverse financial impact	**Inherent Risk** (Without controls):	4	5	20	⇕ ⇔
		Residual/ Current Risk:	4	4	16	⇔
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Monthly nursing and midwifery workforce steering group • Monthly nursing look ahead – heat map / agreed agency levels • Site safety huddles to review real time staffing and capacity • Quarterly establishment reviews – skill mix, acuity and dependency • Safe care – 3 times daily staffing reviews • University of Hertfordshire recruitment • Rotation of band 5 nurses to aid retention • NHSI Wave 2 retention programme • Eroster • Scheduled regular monthly updates of staffing data to NHSP, to ensure staffing lists as accurate as they can be. • Arrangements in place to support our employees who are EU nationals re Brexit-related settled status applications. Strategic intent defined through work on new People Strategy	• Report to QSC on medical staffing (L2) • Report to Board of Directors via QSC on safer staffing (L2) • Workforce report to FPC (L2) • Safer Staffing reports (L2) • NHS Professionals continuously recruiting to nursing and midwifery band 2 and band 5 roles. • Reviewing and trialling alternative shift patterns to attract staff; rapid response • Development of joint recruitment and attraction strategy with STP. • Divisional increased headcount targets for 2019/20, which are reviewed regularly at Improving Financial Delivery meetings. - Internal audits scheduled 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 - effective nursing recuitment strategy for the Medical Division	• Data consistency and quality • Improved retention rates • Recruitment in specialty / hard to recruit areas 5 yr Workforce strategy to support the new 5 yr clinical strategy Ability to staff the winter ward Recruitment into Nursing Vacancies in Medical Divisional	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. A formal progress review was taken to Executives in September 2019 with a prediction that, based on known activity and trajectories, the Trust is likely to meet its recruitment targets for 2019/2020. 66 new starters joined the Trust in December 2019 and the vacancy rate at the end of December 2019 was 7% against a target of 6% overall. A paper proposing overseas nursing recruitment activity for 20/21 was tabled to Executives in January 2020 setting out recommended plans for overseas recruitment in 20/21. Whilst there are some aspects that require further discussion, work is now underway to commence international recruitment of nurses for 20/21.	In progress
iii) • People Strategy to be launched in 2019/20 setting out the Trust's approach to recruitment and retention.	Chief People Officer	Feb-20	Draft workforce redeployment policy by Head of HR expected by end February 2020.	In progress
iv) Review of Trusts Communication strategy to support recruitment and retention	Communication Team / Head of HR	Nov-19	The Head of Communications has developed a new Communication Strategy , which has been approved.	Complete
v) Review supporting interventions re mediicine division staff ing due to Winter Pressures and longer term recruitment strategy	Chief People Officer	Dec-19	Short term initiatives and incentives considered and approved through Executive Committee 12 Dec 19 for implementation. Some immediate additional efforts to increase nursing recruitment in Medicine have been undertaken with an increased number of overseas nurses due to be deployed between January and March 2020.	In progress
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:	Feb-20	**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 Performance Framework - reasonable assurance 2019 Month 10 delivery on track for delivery of financial trajectory/ control total.		• 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 - major year-end settlements agreed. • 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	outcome of assessment - - Requires improvement , December 2019	completed
Summary Narrative:				

Month 10 delivery on track for delivery of financial - risk score for review post Month 11

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:	Feb-20	**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 iv) Volume of leased equipment not generating capital	i) Poor patient experience ii) Patient Safety iii) limited ability to invest in IMT, equipment and services develoments iv) limited innovation v) impact on delivery of clinical strategy	**Inherent Risk** (Without controls):	4	5	25	⇔
		Residual/ Current Risk:	4	5	20	
		Target Risk:	4	4	16	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Six Facet survey undertaken in 17/18 • Capital review Group meets monthly • Prioritising areas for limited capital spend through capital plan • Fire policy and risk assessments in place • Major incident plan • Mandatory training • Equipment Maintenance contracts • Monitoring of risks and incidents	• Report on Fire Safety to Executive Committee (L2) • Monthly Capital Review Group (CRG meetings) feeding into FPC and Exec Committe (L1) • Report on Fire and Backlog maintenance to RAQC(L2) • Reports to Health and Safety Committee (L2) • Capital plan report to FPC (L2) • Annual Fire report (L3) • PLACE reviews (L3) • Reports to Quality and Safety Committee • Deep dive review of the risks and mitigations (December 2018) • new Monthly Fire Safety Committee established March (includes other sites)			• Capital Expenditure within agreed CRL

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
• Not fully compliant with all Fire regulations and design • 1960s buildings difficult to maintain • No formalised equipment replacement plan or long term capital requirement linked through to LTFM • Estates and facilities monitoring structures and reporting	• Availability of capital	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete

i) Estates strategy to support the five-year trust strategy	Director of Estates and Facilities	September (TBC)	Awaiting new Director to lead on this	Not yet started
ii) Develop capital equipment replacement plan	TBC	TBC		
iii) Develop programme for Charity to suppport with fundraising	Deputy Direoctr of Finance / Head of Charities	on going	ongoing	
iv) Agree capital investment for 2019/20 and monitor delivery	Executive	May 2019 and ongoing	Captial programme approved through CRG and Ececutive committee in June2019. CRG will monitor delivery	In progress
iv) Review other sources of fundung / opportunities for investment	Director of Finance / Project leads	on going	Bid to NHSI for review including additional funding for fire. Wave 5 bids in process of being developed. NHSI/E capital funding - 1M for 2019/20 ans 1.5M for 2021 approved in January 20.	in progress
Summary Narrative:				

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2019-20

Strategic Aim:	**Ease of Use:** To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff services that is financially and clinically sustainable in the long term **Sustainability:** To provide a portfolio of				
Strategic Objective:	**Complete stabilisation and commence optimisation of Lorenzo and make our services easier to use**	**Source of Risk:**	Project	**BAF REF No:**	005/2019
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the digital programme is delayed or fails to deliver the benefits, impacting on the delivery of the Clinical Strategy		**Risk Open Date:**	Feb-18	**Executive Lead/ Risk Owner**	**Director of Finance / Chief Operating Officer**
		Risk Review Date:	Feb-20	**Lead Committee:**	**FPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Poor staff engagement in new systems and processes ii) Not all staff received the required training and support iii) Not all existing trust systems interface between systems iv) Lack of funding natioanlly or locally to complete the programme	i) Unable to deliver financial performance ii) Unable to deliver target levels of patient activity iii) Unable to meet contractual digital objectives (local, national, licience) iv) adverse impact on performance reporting	**Inherent Risk** (Without controls):	4	5	20	
		Residual/ Current Risk:	4	4	16	
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**iii)**	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
i) Digital programme 2019 iii) Internal monitoring of programme implementation through - FPC and Board , Staff training and communication - generic and targeted Clinical review group, operational and governance oversight group/clinical approval group reporting into Digital Programme Board	• Monitoring of key safety and quality indicators through PRM's (L2) • Reports to Executive Committee, FPC and Board (L2) • Weekly Executive monitoring of implementation plans . data quality internal audit scheduled for 2019/20 - CIMBIO reporting and monitoring linking to training and support plans . First clinical approval group (CAG) July 2019	Closed post stabilisation workstreams - access plans, ereferals, hardware - supported by external review group with NHSI/D		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
i)Consistancy and compliance in the application of new processes on the systems ii) Availabilty of capital to deliver priorities - year 2 and beyond.		Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete

i) Complete rollout of the new discharge summary across all lorenzo wards	Michael Chilvers, MD / Anne Powell	End of May 2019	Wave 5 and 6 implementaiton plan for remaining areas 14.05.19-31.05.19. Completed and adherance to process being monitored. Project completed. Now being embedded into practice.	Completed.
ii) Develop Ditigal Strategy and associated Digital Programme	Mark Stanton, CIO	End of June 2019	In progress - report to FPC in June 2019. Rescheduled for September 2019 Discussed and endorsed by FPC. Programme for the next 3 years agreed by FPC with 20/21 Capital funding agreed	In progress, Complete
iii) Review and implementation of revised Digital Strategy Programme Governance	Mark Stanton, CIO	End of May 2019	Proposed governance structure to be presented to FPC in May 2019 . New structures implemented in July 2019	Completed.
iv) Implement the quick wins initiative programme	Mark Stanton, CIO	Ongoing	Commencing late May as a 6 wk programmeto deliver a number of outstanding pipeline requests. Developing as a tool for new IT governance and linking to larger digital programme deliveries. Report to FPC in June 19.	Completed.
Enabler greater CCIO engagement through more available CCIO PA's and clearer remit	Michael Chilvers /Mark Stanton	Apr-20		
iv) Continue vaildation of records to data to ensure adhererance to the new processes	Des Lane, Associate Director of Information /Richard Hammond Deputy COO	On going	On going and deteriorating patient digital workstream commenced. Discharge Summary Task and finish group chaired by Richard Hammand is now monitoring complaince and looking at medium to long term improvments. Daily reporting to Exec's in place	In progress
Summary Narrative:				

Risk carried forward from 2018/19. Stablisation to be completed by 31 May 2019. New digital strategy, associated digital programme and revised governance structure are in progress. Funding for EPMA confirmed from NHS Digital for implemetation by February 2020.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2019-20

Strategic Aim:	**Pathways: To develop pathways across care boundaries, where this delivers best patient care and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff**				**Ease of Use: To redesign**
Strategic Objective:	**Play a leading role in the Sustainability and Transformation Partnership (STP) development of the Integrated Care System / Alliance Seek innovative STP-wide solutions to address clinically and financially unsustainable services**	**Source of Risk:**		**BAF REF No:**	006/19 (previously 010/18)
Principal Risk Decription: What could prevent the objective from being achieved? **There is a risk that the STP does not work effectively to redesign and implement new models of care, which impacts on the hospital's ability to manage demand for services**		**Risk Open Date:**	01/03/2018	**Executive Lead/ Risk Owner**	**Director of Strategy**
		Risk Review Date:	Feb-20	**Lead Committee:**	**FPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Long term system leadership ii) Clinical and operational leadership and capacity iii) Capacity in primary and community services to deliver change iv) Current legal framework not designed to fully support ICP/S's v) Limited internal capacity and capability to engage	i) System does not deliver intergrated care pathways ii) Demand for acute services exceeds plan iii) Delay development integrated care for ENH iv) Inability to implement agreed models due to contractual, financial and legal barriers v) risk that external stakeholders are able to progress at a quicker pace than our capacity to be fully involved and contribute to the pathway design	**Inherent Risk** (Without controls):	3	5	15	
		Residual/ Current Risk:	3	4	12	
		Target Risk:	3	3	9	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Participation in STP work streams including Planned care, urgent and emergency care, frailty and cancer • STP CEO bi-weekly meeting Representation at STP Chairs meeting • Vascular Hub project with West Herts and PAH • Model Hospital redesign work • Integrated discharge team • External partner to support development of STP • New independent chair in place to drive progress. (Ten year plan published sets out expectations for ICSs) System Transformation days and Transformation Group in place. STP identified as Accelerator site for national support. ENH Chief Executives' Oversight Meeting in place. Agreement to joint QIPP planning or 20/21	• Reports to Board regarding progress on STP(L2) • Regular oversight by NHSI and NHSE (L2) • Monthly A&E delivery Board (L2) • Transformation Board of the CCG(L2) • Reports of Model Hospital work streams to Programme Board (L2) • NHSE Deep-dive into cancer work stream (L3) - Review of trust worksteam leads and internal governacne structure April 2019 Regular updates considered at Executive Committee Executive Director ICP Transition Group set up representing all 5 core ICP partners - reporting into CEO Oversight Group - CEOs' have approved the establishment of an ICP Partnership Board wef April 2020. Executive Committee weekly ICP update item to support awareness and co-ordination of partnership development	• NHSE Deep-dive into cancer work stream (L3) Executive Team and Trust Board consideration of ICP development (Sept 2019). Agreement to joint ICP winter planning for 2019 and QIPP planning for 20/21.		
	Gaps in Assurance: Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**		
• Scope for accelerated development of STP and its governance arrangements • Need for external resource to develop STP to ICS ICP governance in design stageto be agred by CEOs.	Oversight of the workstreams at local level and at sub Board level. Need for dedicated programme director capacity to support development of the ICP on behalf of all partners Need to review and streamline internal and ICP transformation work to align shared resources to best effect within the ICP.	Green	Effective control is in place and Board satisfied that appropriate assurances are available	
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient	
		Red	Effective controls may not be in place and assurances are not available to the Board.	

Action Plan to Address Gaps

Action:	Lead:	Due date	Progress Update	Status: Not yet Started/In Progress/ Complete
i) Ensure effective involvement with all workstreams and monthly reporting to Strategic Programme Board and Executive Committee	Director of Strategy	on going	Monthly reportss provided to Strategic programme Board and Executive. STP Pathology Procurement in progress with the service specification. Executive and clinical engagement. Strategic Programme Board to be replaced by Strategy Committee from Nov 2019 with remit including ICP and ICS development. Terms of Reference Agreed and meetings being scheduled. ICS/ICP standing item at Executive Committee to support shared understanding of issues and responses. Executive Committee 2nd ICP workshop scheduled 21/1/20 to support joint consideration of key issues. Ongoing weekly ICP item at Executive Committee. New Strategic Development Cttee includes ICP development within its Terms of Reference.	In progress
ii) Monitor and actively participate in STP programme to develop ICS		on going	Executive dsiucssion and Board update and dsicussion took place Sept 2019. Director of Strategy one of two ENH ICP representatives on the STP ICS/ICP Architecture Committee. Director of Strategy represting ICS on STP Task & Finish ICS architcture Group. ICS/ICP standing item at Executive Committee to support shared underdstanding of issues and responses.	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	on going	In addition to above, the STP has arranged for workshops on ICS and ICP development with STP Board members in Nov and December 2019. Trust representatives have been identified for these. Internal ICP session held in Dec 2019.	Completed
iv) Actively support and provide collaborative leadership to support the development of the ENH ICP	Chief Executive and Director of Strategy	on going	CEO joint lead with HCT CEO for the ENH ICP. Draft clinical priorities identified in discucssion with ICP partners and reflected in draftLong Term Plan. Executive Ttransition Group established to devise and support the transition to shadow ICP from April 2020. Trust has worked collabortively with ENHCCG, HPFT, HCC and HCT to develop the first draft narrative of the ICP submission for the long term plan. Further work to do to develop ICP development programme and future governance. Director of Strategy plays active role in ICP Transition Director's Group and other executive directors are increasingly engaged in system leadership eg OD and transformation.	In progress
Summary Narrative:				
Sept 19: The Trust is actively working with emerging ICP partners to identify clinical priorities for pathway transformation and develop governance for the future ICP which will support a QI approach to transformation. There is a need to review and align current ENH system transformtion work and the organisational restructure to the emerging ICP clinical priororities in order to align resources to support optimal impact on population health management. This work is ongoing and progress is being overseen by the ENH CEOs' Group. This work is forwards facing and includes joint planning for winter with HCT. Emergency activity is currently above plan ehich suggests that the ICP needs to continue to identify and deliver more effective ways of effectivly mnaging emergency growth - this will be a priority area for collaborative working. October 2019: CEOs' Group has agreed tp identify additional capacity to help drive the development of the ICP transition programme. Executive Directors' Group has been tasked with supporting development of the shadow ICP. Trust to review and refresh Year 2 of the clinical strategy in the contxt of emerging ICP vision and priorities. Nov 19: Positive system engagement in Transformation Days - future governance of clinical tansformation workstreams drafted and to be agreed. Further work to be undertaken on remaining aspects of ICP governance. External support engaged to further strengthen ENHT internal thinking , preparation and readiness to optimise our role and support for the ICP. Jan 20 : Internal consideration and readiness for ICP/ICS is developing with external support and increasing system focussed discussion eg QIPP, service transformation, ICP milestones etc. It will be important to align the development of 20/21 operational plans with emerging ICP governance for shadow status. Feb 20: Increasing pace of ICP development across director portfolios. ICP Partnership Board to commence from April 2021. 20/21 Operating Plan for the ICP being co-ordinated by the Director of Finance.				

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:	Feb-20	**Lead Committee:**	**Board**

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) In effective governance structures and systems - ward to board ii) Ineffective performance management iii) ineffective staff engagement	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	4	16	
		Target Risk:	4	2	8	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Monthly Board meeting/Board Development Session/ Board Committees • Annual Internal Audit Programme/ LCFS service and annual plan • Standing Financial Instructions and Standing Financial Orders • Each NED linked to a Division (from January 2018) • Commissioned external reviews • Review of external benchmarks including model hospital , CQC Insight– reports to FPC and RAQC (QSC) • Board Assurance Framework and monthly review • Performance Management Framework/Accountability Review meetings monthly • Integrated Performance Report reviewed month at Trust Board, FPC and QSC - Quailty dashboard / compliance dashboard CQC steering group and action plan 2019/20 action plan to deliver the Trust strategy -Stretegic programme board and trsut board monitoring - Safer sharps group - Daily Corona virus group, policies, pods in situ on Lister and QEII sites.	• 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; HSE improvement notices on Sharps, Violence and aggression and moving and handling (-ve) Action plan in progress of delivery - Desktop reivew of Pandemic Flu plan scheduled for February 20	Internal Audit report - risk management , performance framework, IG 2019 NHSI Infection control review - green - June 2019 Review of progress with QTP workstreams with NHSI/CCG - June 2019. Internal Audit - Surgical division governance - reasonable assurnance - July 2019. CQC Inspection report 2019 - Requires Improvement overall - UCC and surgery improved to requires mprovement. CYP achieved good. MVCC retained requires improvement. 6 monthly Quailty Account progress reported to QSC November and Board in January. Deep dive reviews on QI areas to QSC in December. Business continuity - compliant assessment validated 2019		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
Effectiveness of goverancne structures at ward to Divisional level • Fully embedding Performance Management Framework/Accountability Framework • Implementation of Internal Audit Recommendations • NHSI Undertaking January 2019 / CQC section 29a warning - surgery and QEII UCC - HSE Improvement notices received on V&A, MSD and sharps in October 2019	• Embedded risk management - CRR and BAF • Embedding effective use of the Integrated performance report • Evidence of timely implementation of audit actions • Consistency in the effectiveness of the governance structure's at all levels • Capacity to ensure proactive approach to compliance and assurance • Oversight of GIRFT programme and other exteranl reviews and follow up - follow up investigations on V&A and Sharps incidents - MH equipment - review and replacement programme - specialist training	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Monitor delivery of Risk Management implementaion plan 2019/20 including risk appetite	Associate Director of Corporate Governance / Risk Manager	ongoing	Monthly reports to Board committees	In progress
ii) Review of well led compliance and implement recommendations from NHSI Board and Committee observations to strenghten Board governance	Associate Director of Corporate Governance	Sep-19	Board development session in April commenced review of well -led. Follow up session scheduled for June 2019. Continue to review workforce matters, and reviewing DEC/Executive Committees	In progress
iii) Complete recruiment into revised corporate and quailty and safety structures and substantive Executive Director posts	Associate Director of Corporate Governance / Director of Nursing	Jul-19	One current vacancy in corporate goverance team; DPO now absorbed . Final QI posts in process of recruitment- completed . Compliance facilitator commenced.	
iv) Review and develop a 'business as usual' programme of compliance / quality and safety reviews	Associate Director of Corporate Governance / Director of Nursing	Oct-19	Review of self assessment frameworks and mock inspeciton paperwork in progress with current programme - draft compliance framework to QSC in November. Compliance revised for implementation in February 2020.	In progress
v) Review implementation of Trust clinical strategy and enabling strategies	Director of Strategy		action plan under development. Scheduled to present draft action plan to Executive Committee through to QSC in November/December. Trust partnership engaged. Action taken 23.10.19 to have a security officer in the ED 24/7 with immediate effect. Reviewing security provision	In progress
vi) Review effectiveness of governance at a Divisional level	Associate Director of Corporate Governance	Jan-19	Internal Audit scheduled. ARM reflections. Internal audit of surgical division - reasonable assurance.	In progress
v) Implementation of project plan for CQC Inspection and Use of Resources Inspection	Associate Director of Corporate Governance / Director of Nursing	Aug-19	In progress with weekly reporting to Executive Committee. Inspections anticipated for July - Sept 19. CQC focus groups being promoted (3-5 July) . Inspections completed and awaiting draft reports and outcome . Action plan submitted to CQC in January 2020 - feedback stated comprehensive. engagement progamme agreed with CQC. Monitoring delivery	In progress
v) develop and implement action plan to address HSE findings and improvement notices	Associate Director of Corporate Governance	January 2020 - action plan to HSE	Action plan under development. Scheduled to present draft action plan to Executive Committee through to QSC in November/December. Trust partnership engaged. Action taken 23.10.19 to have a security officer in the ED 24/7 with immediate effect. Reviewing H&S structure to support a more proactive service across the Trust. Meeting with HSE January 2020 and updated action plan submitted, revised compliance timelines agreed. Monitoring delivery	In progress
Summary Narrative:				
Deep dive of this risk was presented to Audit Committee in January 2020. Discussed with QSC and FPPC. Agreed to increase the risk rating to take into account the current HSE Improvement notices. Actions in place to deliver a compliant position by end of April 2020 for Violence and Agression and Sharps; end of July 2020 for Moving and Handling. Action plans in place for CQC must dos and should do's supported by test and challenge and implementaion of the complaince framework and monitoing of other 3rd party assessments. Reivew of Internal and External Auditor. Internal audit on Risk and Assurrance in progress.				

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:	Feb-20	**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**
• Reports to QSC (L2) • Quality review meetings with CCG (L2) • Divisional Performance Meetings (L2) • Clinical effectiveness/ Patient Safety/Patient Experience Committee/ Health and Safety Committee reports (L2) • Nursing and Midwifery Executive Committee • Invasive procedure Clinical Group • Monitoring of new to follow up ratios through OPD steering group and access meetings(L2) • Peer Reviews (L3) • Audit Programme (internal and external) (L3) • Quality Strategy reports and Quality Improvement deep dives to QSC • CQC Inspection report July 2019 –(overall requires improvement) and actions plan to address required improvements and recommendations (L3) • NHSI Infection control review June 2019 - green (L3) is this the latest? • Quality Dashboard / Compliance dashboard • Internal Audit scheduled , Clinical audit and effectiveness procsses, Patietn safety incndent management. • RCN Clinical Leadership Programme • Pathways to Excellence committee • Harm Free Care Collaborative • Deteriorating Patient Collaborative (Quality Improvement Break through Series Learning Collaborative)	• Clinical effectiveness committee / Patient Safety Committee/ Patient Experience Committee • Accountability Framework • CQC Engagement meeting • Increased Director presence in clinical areas • SIs and Learning from death investigations • Serious Incident Review Panel • Strengthened TIPCC membership and ToRs • Quality and safety visits • Medication safety quality peer reviews • Safety huddles • Quality Huddles (bi-weekly) • Policies and procedures • Quality Strategy updates • Divisional Quality Manager posts in each division • Weekly review meetings of CQC improvement plans • Clinical Harm Review Panel (Weekly) • Invasive Procedure Clinical group (safer Surgery Collaborative) • Recruitment and deployment of Quality Improvement team • Deteriorating Patient Quality Improvement Collaborative • Harm Free Care Collaborative • Thrombosis committee • Safer Sharps Committee • Appointment of Associate Medical Director for Quality Improvement & Safety • Recruitment of Improvement Director	• NHSI Infection control review June 2019 - Green • CQC Inspection report 2019 - Requires Improvement overall - UCC and surgery improved to requires improvement. • CYP achieved good. • MVCC retained requires improvement. • 6 monthly Quality Account progress reported to QSC November and Board in January. • Deep dive reviews on QI areas to QSC in December. • Quality Improving team KPis • Areas achieving pathways accreditation • Sustain reduction cardiac arrest rates	

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	• 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

• Gap in compliance with CQC standards warning notice section 29A – Surgery Lister and UCC QEII - NHSI undertaking		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Delivery of the QTP implementation programme against plan	Associate Director of Quailty Improvement	Complete May 2019	Quality transformation phase now complete. Objectives and quality priorities now imbedded with ENHT Quality Strategy	Complete- milestones and aciton now wihtin Quality Stratgey
ii) Delivery and monitoring of CQC improvement plans for Surgery Lister and UCC QEII and other core pathways	Associate Director of Corporate Governance / Director of Nursing	Ongoin	Internal monitoring and review continues each month. CQC action plan monitored through theatre improvement group and Theatre Board. Awaiting formal outcome and re-design of action plan from CQC inspection. Current factual accuray stage in progress of rpeort - new action plan to be finalised by Dec 2019.	In progress
iii) Launch and implementation of the quailty strategy with communication plan	Director of Nursing / Medical Director	ongoing	Launch event held in May 2019, supported with the Trust conversation session in June 2019. First learning trust wide event held 21 June . Invasive Procdure learning event held in October 2019. Reporting cycle to QSC reviewed with scheduled deep dives. Quality Improvement team now fully established. Regular tracking of QI and QS priorties undertaken through QSC. Offcial communication launch of QI planned for November, communication strategy in progress.	In progress
iv)• Complete Gap analysis on GIRFT reports and develop and monitor action plans	Medical Director	ongoing	GIRFT visits continue and accumulation of actions currently being undertaken. Non-Exectutive has been identified to chair GIRFT oversight committee.	Started
iv) Implement 7 day services plan	Medical Director	ongoing	Report to QSC June 2019. Steering group established. Information gathering started against each 7 day standard and current baseline of PA allocation.	In progress
Summary Narrative:				

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2019-20

Strategic Aim:	**People: To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce**				
Strategic Objective:	**Develop, support, engage and transform our workforce to provide quality services**	**Source of Risk:**	Strategic Objective Staff Survey	**BAF REF No:**	009/19
Principal Risk Decription: What could prevent the objective from being achieved? **There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered and motivated, impacting on the trust's ability to deliver the required improvements and transformation and to enable people to feel proud to work here.**		**Risk Open Date:**	01.03.18	**Executive Lead/ Risk Owner**	**Chief People Officer**
		Risk Review Date:	Feb-20	**Lead Committee:**	**FPC & QSC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Poor staff engagement ii) structures, systems and processes do not support raising concerns iii) staff do not feel empowered to effect change	i) Failure to implement a learning culture ii) Opportunities for improvement missed iii) Quality and Safety Improvement culture is not achieved iv) limited engagement in service change vi) concerns are not raised	**Inherent Risk** (Without controls):	4	4	16	⇕ ⇔
		Residual/ Current Risk:	4	4	16	⇔
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• LMCDP Leadership, Management and Coaching Development Pathway • LEND Sessions • Organisational Values (PIVOT) / Leadership Behaviours (LEND) • Health and Well Being Strategy • Dedicated Associate Director of Leadership and Change • HR Policies including Raising Concerns Policy • ERAS teams and Freedom to Speak Up Guardian • People Strategy • Staff Experience Workshops were launched in April 2018 - Equailty and diversity lead and forums - Dignity at work policy • Talent Management Lead in post • Interim Education Lead in post • Just and Learning Culture Steering Group	• 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 • Just and Learning Culture Steering Group creating action plan			
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**			
• Culture change approach • • Senior leadership training • Senior leadership programme • Talent Management Strategy and Education Strategy under review/ development	• Review outcomes of the actions being taken • Lack of resources to respond within necessary time period • Completion of staff survey action plans • No Education Board currently in place	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	2020 approach to leadership and management development being consulted with business leaders to define appropriate approach for coming year.	In progress
ii) Increased visibility of Senior Leadership Team (Divisional, Executive and Board)	Chief People Officer	on going	Next round of Trust conversations being planned, to commence March 2020. Friday stand-up event to be continued and extended.	In progress
iii) Implement action plan following staff survey feedback	Chief People Officer	on going	All divisions have a local plan; these are monitored at Trust Board and at staff partnership meetings.	In progress
iv) Develop and implement talent management strategy	Chief People Officer	Feb-20	Progress update on Talent Management Strategy is planned for the February 2020 meeting of the Finance, Performance and Workforce Committee.	In progress
v)Review of Communication strategy	Head of Communications	Nov-19	The Head of Communications has developed a new Communication Strategy, which has now been approved.	Complete
vi) Staff survey/engagement workshop and assocated actions	Chief People Officer	ongoing	Just and Learning Culture Steering Group meets regularly and will roll out schedule of activities over course of 2020.	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:	Feb-20	**Lead Committee:** **FPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) UK decision to leave the EU ii) Potential for UK to leave the EU with No Deal in place	i) Risk to supply of goods, services, medicines and vaccines to the UK from EU ii) Risk to recruitment and retention of EU Nationals iii) Risk to transport infrastructre and ability of staff to get to and from work iv) risk to flows of data due to information governance regulations	**Inherent Risk** (Without controls):	4	4	**16**	
		Residual/ Current Risk:	4	2	8	
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• EPRR Committee, will lead on the business continuity arrangements, reviewing existing plans to ensure they respond to the possibility of a 'no-deal' Brexit. • Review of national guidance - 23rd August SoS guidance and five technical notices published by UK Government and 21st December including action card for providers • Overseas recruitment mostly from outside Europe. • group in place from January 2019 to drive progress reporting to Executive Committee Communitaions to staff from European countries outside the UK. Link to STP EU Herts Strategy Control Group Information Governance EU Exit Surveys being undertaken . Trust participation in Hertfordshire Strategic Resilience Group.	• Regular reports to Executive Committee/DEC, FPC and the Board of Directors (L2) • NHSE check and challenge session on EPRR core standards including Brexit Preparedness (L3) • Paper to Board on 9th January 2019 and monthly til May 2019 . Papers to Executive Committee recommenced in August 2019 and to Board reccomenced in September 2019. Results of EU Data Surveys.	• NHSE check and challenge session on EPRR core standards including Brexit Preparedness , 2018 (L3)		
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**			
Absence of UK parliament approved deal in place between UK and EU post 31 January 2020. Nationally DH undertaking contingency planning and guidance is being issued to the NHS to support planning. DH is centrally seeking assurance from a core list of national suppliers on behalf of the NHS. Hertfordshire Procurement seeking assurance from all other suppliers and identifyng any produce lines for which alternative suppliers may not be available in order to agree alterative supply in the event that it is required in recognition of reliance on third parties.		Green	Effective control is in place and Board satisfied that appropriate assurances are available			
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient			
		Red	Effective controls may not be in place and assurances are not available to the Board.			

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Review of technical notices/ advice as it is published by the Government / NHSI/NHS Providers	Strategy Project lead	Ongoing	No outstanding guidances	In progress

ii) Continue monthly oversight group and escalation reports	Director of Strategy	Ongoing	Meetings paused in November in line with UK paliament developments and guidance from DHSC. To reccomence in Dec 19 to support preparation for potentail no deal EU Exit on 31 January 2020. Preparation stood down following UK Parliament and EU agreement of Withdrawal Agreement wef 31/1/20.	In progress
iii) Recruitment strategy implementation	CPO	ongoing	International and local recruitment campaigns. Information available to support recruiting managers respond to queries from potential new staff.	In progress
iv) Monitor government advice regarding arrangements frommowing the end of the Transition Period (January 2021) , identify and work to mitigate any risks to the organisation	Director of Strategy	Ongoing	February 2020: new action.	To commence
Summary Narrative:				
September 2019: Workstream meetings increased to weekly from August 2019, incorporating all guidance issued by the government. All areas reviewing business continuity plans to support service continuity. Particpation in Regional DH EU Exit workshops in September. October 2019: EU Exit preparation group continued to meet weekly. Additional Command and Control arrangements in place to support management of any EU related issues. Nov 19:Preparation planning paused for November following approval of extension to end January. In line with DHSC guidance regarding preparation planning. Preparation Group to recommence meetings in December to support preparation in the event of a No Deal EU Exit in January. February 2020: internal EU preparation stood down following issuing of Brexit Operational Readiness Guidance (December 2019) and the approval of the EU Withdrawal Agreement. There is now a transition period until the end of 2020 while the UK and EU negotiate additional arrangements. The current rules on trade, travel, and business for the UK and EU will continue to apply during the transition period. New rules will take effect on 1 January 2021. It is reccomended that this risk is reduced and monitored going forwards in order to respond to any development regarding arrangements following the end of the Transition Period. As the risk has met and been reduced beyond its target risk rating it is recommended it is de-escalated from the BAF. Monitoring government advice regarding arrangements from the end of the Transition Period (January 2021) , identify and work to mitigate any risks to the organisation will beundertaken as business as usual and any specific risks identifed will be fed to the risk register and other relevant BAF risks e.g business continuity under Governance and Staffing.				

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2019-20

Strategic Aim:	**Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long termQuality: To deliver high quality, compassionate services, consistently across all our sites**				
Strategic Objective:	**Design, develop, launch and embed the Quality Strategy Develop, support, engage and transform our workforce to provide quality services Meet our financial obligations**	**Source of Risk:**	Risk register	**BAF REF No:**	011/19 (previously 014/18)
Principal Risk Decription: What could prevent the objective from being achieved? **There is a risk that the Trust's Estates and Facilities compliance arrangements including fire management are inadequate leading to harm or loss of life.**		**Risk Open Date:**	22/01/2019	**Executive Lead/ Risk Owner**	**Direcotr of Strategy/ Director of Estates and Facilities**
		Risk Review Date:	Nov-19	**Lead Committee:**	**QSC**

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

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
Fire Policy and Procedures Training – mandatory awareness training and fire wardens Ward based evaluation training for Sisters completed December 2018. Communication Plan Fire Compliance meeting (monthly). Detailed Action Plan in place to address the recommendations of the 2 Fire AE reports, broken down into weekly tasks. Capital funding to make the necessary changes to the Estate to ensure compliance with guidance and fire compliance. . Capital funding to make the necessary changes to the Estate to ensure compliance with guidance and fire compliance. Revenue funding to fund improvements. Detailed Action Plan in place to address the gaps in Estates & Facilities Compliance. Interim Fire Safety Officer in post from 11 Feb 2019 Reports to Health and Safety Committee Weekly environmental audits Water safety group and action plan Revised governance structure adopted within Estates & Facilities, along with a new Estates & Facilities Management Assurance Group (EFMAG), to receive reports and monitor progress. EFMAG report sto H&S Committee, within its revised governance arrangements. Revised governanec structure adopted within Estates & Facilities, along with a new Estates & Facilities Management Assurance Group (EFMAG), to receive reports and monitor progress. EFMAG report sto H&S Committee, within its revised governance arrangements.	Authorised Engineers report 2018. (L3 –ve) Annual fire report to Quality & Safety Committee. Papers to Executive Committee / Quality & Safety Committee. Audits of high risk areas on Lister site Works completed on wards 10/11 MVCC 2018 Desktop Fire evacuation exercise carried out December 2018.(lister) Ward evacuation plans displayed in each ward and checked. January 2019 New Monthly Fire Safety Committee established March 2019 – includes representation from other sites – reports to H&SC and QSC PLACE reviews Internal audit of estates and facilities compliance scheduled for Q3/4 E&F escalation reporting to both TIPCC and H&S Committees from EFMAG, adopting araes to celebrate and areas of concern. Trusts Water Safety Group is receiving trend analysis data on laboratory testt results, and the situation is stable, although continues to be significant. Final independent compliance audit report received October 19.	AE Water Safety Report to Water Safety Group (Nov 19) confirmed positive progress in relation to water safety		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
Ineffective estates and facilities governacne structures Estate strategy due for renewal Lack of capital funding to bring the Lister and other sites to	Full implementation of the Fire Strategy Effective Estates and facilities governance structures	Green	Effective control is in place and Board satisfied that appropriate assurances are available

Lack of capital funding to bring the Lister and other sites to compliance Lack of revenue funding for training Fire risk assessments and actions due for Fire Safety Officer review Actions identified from Fire desktop review Confirmation all AO's now in post and visibilty of work programme Gaps in ongoing assurance on water safety identified Limited visibility on the compliance status for the Trusts satellites locations.	Limited assurance from other sites trust operates from Visiibility of AE reports and actions	Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Review and implement revised estates and facilities governance and reporting structure	Director of Estatesand Facilities	01/09/2019 revised date with Director April 2020	Paper presented to QSC in June 2019 outlining key workstreams. Implemention of the supporting committees commences with water safety, ventilation and electrical safety. E&F Governance structure and reporting arrangements were revised in August 2019, and to be reviewed 4th Qtr 2019/20. February - E&F structure and governance structure under review with new Director of Estates and Facilities.	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. New Fire Officer in post since November. Annual AE report report in progress to inform work programme for 2020/21. Fire Safety Committee Continues to meet alternate months.	In progress
iii) Review of Estates Strategy	Director of Estates and Facilities	Mar-20	on hold until new estates and facilities director in post from January 2020. New Estates and Facilities Director commenced January 2020. Review of Estates Strategy Commenced	To commence
iv) review and implement mechanisms to ensure Estates, Facilities and Fire compliance assurance is received from partner organisations where trust operates from	Director of Estates and Facilities	Dec-19	Paper presented to QSC in June 2019 outlining key workstreams. Trust risk assessments have been shared with the relevant partners. Correspondence issued to all satellites CEO's requesting assurance on their water compliance and all areas of the HTM's and health & safety, for completeness. External review of compliance completed.	In progress
iv) Substantive recuitment into leadership structure and other vacancies	Director of Estates and Facilities	Mar-20	Recuitment of new substantive Director of Estates and Facilities in progress. Recruitment and retention rates agreed by Executive committee in line with the region. Some successful recruitment - position being monitored. New Estates and Facilities Director commenced January 2020.	In progress
v) Work with STP partners to ensure STP Estate Strategy reflects Trust priorities	Director of Estates and Facilities	Dec-20	ENH was represented at a meeting in September 2019, with the regional Estates & Facilities Directors. STP Estates Strategy completed and rated as Good by NHSI/E,	Ongoing
Summary Narrative:				

July 2019: This risk is currently under review taking into account the new emerging non compliance issues, capactiy and skills within the team and awaiting to secure the permanent Director of Estates and Facilities.
Oct 2019: Whilst the status of compliance continues to be a significant concern, there is increasing visibility on the issues, based on external surveys, and the appointment of a panel of 'subject matter expert's, to help inform, support and challenge the Trust position. Similarly the mobilisation of the new governance structure and compliance monitoring within the E&F Division, including the adoption of a new compliance reporting format, has provided the foundations to move forward. Access to sufficient investment and the real estate strategy will be seminal to reducing the back log liabilities and and improving compliance, going forward. Reporting on compliance into the Health and Safety Committee will be strenghened. Nov 2019:
Position strengthed by completion of external audit which is now being used to develop a risk based mitigation programme -monitor by EFMAG.
February 2020: E&F structure and governance structure under review with new Director of Estates and Facilities. Recruitment into substantive structure commencing. Annual reviews by AE are underway. Priorities for the E&F based on the external review.

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** ***(N.B. Scope of the risk under current review with the Director of Strategy)***		**Risk Open Date:**	01.03.18	**Executive Lead/ Risk Owner**	**Director of Strategy**
		Risk Review Date:	Feb-20	**Lead Committee:**	**FPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Trust does not own the site - owned by HHT ii) Lack of available capital resources iii) Complex model - non surgical cancer centre	i) Lack of control over strategic and specific estate decisions ii) Inability to provide level of capital investment required iii) Unable to sustain clinical model in the longer term iv) Recruitment and retention challenges v) Risks to compliance with regulatory requirements vi) Potential impact on patient safety during period of change	**Inherent Risk** (Without controls):	4	5	20	⇕
		Residual/ Current Risk:	4	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**
MVCC Clinical Strategy in place with Clinical Strategy Implementation Group reporting to Strategic Board Trust Clinical Strategy Clinical and Academic Partnership in place with UCLH and MVCC - Board established. Mount Vernon Cancer Centre Review Programme Board Weekly Exec led MVCC co-ordination meeting on all workstreams. Escalation reporitng to Executive Committee and Board . Internal MVCC Task & Finish Group established, linking into NHSI/E fortnightly confernance calls on topic. Policies Clinical Advisory Group	• Regular reports to FPC and the Board of Directors (L2) • Regular reporting into the strategy Board (L2) • Reporting to the Board of Directors on the progress of the UCLH/MVCC partnership (L2) Capacity and demand modelling Monitoring of Quailty Indicators and audit of admissions policy Director of Finance in dsicussion with UCLH and NHSI/E regarding resources requyired for due diligenve and transition.	CHKS review July 2018 Strategic review and recommendations from clinical advisory planel re MVCC, July 2019 Positive Risk Review with Specialist Commissioners, December 2019 Jan 20 - NHSE approved the reccomendation that UCLH is the preferred tertiary provider for MVCC from April 2021 subject to the outcome of due diligence. NHSI/E Risk Review - singificant assurance provided and decision to step down to BAU assurance monitoring.		
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**			
i) HHT has no long term plan for the MVCC site ii) Availability of funding for capital equipment replacement and refurbishment programmes iii) Availability of funding for costs of due diligence and transition	i) Fitness for purpose of some of the accomodation in the old building ii) Specialist Commissioners Long term planning - process to identify new tertiary cancer provider to assume responsibility for the leadership, governance and development of MVCC commenced in Nov 19.	Green	Effective control is in place and Board satisfied that appropriate assurances are available		
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient		
		Red	Effective controls may not be in place and assurances are not available to the Board.		

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) SLA for Estates and Facilities at MVCC with Hillingdon	Contracting team & Divisional Director	Remains under review		In progress

ii) Development of a lease with Hillingdon for MVCC	Director of Finance	Remains under review		In progress
iii) Executive meetings with MVCC Divisional leadership on the key risk areas and linking with stakeholders and partners	Executive Lead and Divisional Director	Weekly	Weekly group established with all workstream leads, division and executve leads represented. Escalation to Executive committee.	In progress
iv) Planned equipment replacement programme	Director of Strategy / COO	Dec-19	LA1- 12 month extension for LA1 agreed with suppliers and commissioner. Longer term review with be devlivered in Q3 as part of MVCC forward plan. Aseptic - building works commenced and contract for external supply confimed . Business case to replace LA1 drafted. 20/21 equipment requirements to be considered in Trust 20/21 capital planning process . Gamma camera - dsicussions ongoing with NHSE. To be considered in capital planning 20/21. LA1 replacement to be considered in capital planning 20/21.	in progress
v) Implement joint estates forum with HHT	Director of Estates and Facilities	Jun-19	Terms of Reference in place. Monthly Forum commenced , chaired by HHT but requires embedding. Director of Estates & Facilities also establishing bimonthly meeting with the HHT Director of Estates .	Complete
vi) MVCC strategy implementation group	Divisional Chair	6 monthly review	Reported to Strategy Board in June - delivery of year one objectives. Continue to work with partners. Objectives for 2019/20 agreed. Q1 progress in delivering clinical strategy reported to Trust Board in September. Q2 progress reported to Trust Board in November. Refresh of Year 2 clinical strategy to be undertaken during Q3. Positive clincal engagement . Progress to be monitored by newly constitued Strategic Development Committee.	In progress
v) Develop a comprehensive action plan to deliver the recommendations from the Specialist Commissioners review.	Head of Business Development / Director of Strategy	Sep-19	Action plan to implement short term reccomendations from Clinical Advisory Group developed and agreed with NHSE. Progress monitored at weekly Executive Co-ordination Group and issues escalated to Executive ommittee if required. All actions on track and some completed.	Complete
Summary Narrative:				
The Trust has been actively working with the MVCC leadership team, NHSE Specialised Commissioners and Hillingdon Hospital NHSFT to take forward the reccomendations from the Clinical Advisory Report. Regular forums are now in place to support delivery of this, with reporting into the Executive Co-ordination Group and the MVCC Strategic Review Programme Board. Discussions are ongoing between NHSI/E in both East of England and London to take forward the reccomendation regarding the transfer of leadership of MVCC to a tertiary cancer provider and identifiation of intensive support for MVCC from a tertiary cancercentrein the medium term - the Trust is supportive of this and looks forward to working with the new organisation, commissioners and staff to take forward this reccomendation. An internal Task & Finish Group, chaired by the Director of Finance is in place to oversee the Trust's preparation for and delivery of the organisation transfer once the new provider is identified. Jan 20: NHSE has concluded the process of inviting and evaluating expressions of interest from tertiary cancer centres for the future leadership, governance and management of MVCC . A reccomendation has been made for approval by NHSI/E and ENHCCG by the end of January 2020. Feb 20: NHSE has approved the reccomendation of UCLH as the new prrovider for MVCC from Apr 21 subject to the outcome of due diligence. Director of Finance leading the dur diligence process for the Trust. Director of Strategy leading Phase 2 of the Strategic Review for ENHT - identification of future service model and location options. Process being designed and led overall by NHSE.				

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

Agenda item: 15

EAST AND NORTH HERTFORDSHIRE NHS TRUST
PUBLIC TRUST BOARD ACTIONS LOG TO 4 MARCH 2020

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date

No actions outstanding

Board Annual Cycle 2019-20

A formal Trust Board meeting is held on alternate months with Board Development sessions held in the month in-between.

Items	*Apr 2019	May 2019	*Jun 2019	Jul 2019	Aug 2019	Sep 2019	*Oct 2018	Nov 2019	*Dec 2019	Jan 2020	*Feb 2020	Mar 2020
Standing Items												
Chief Executive's Report		x		x		x		x		X		x
Integrated Performance Report		x		x		x		x		X		x
Board Assurance Framework		x		x		x		x		X		x
Data Pack		x		x		x		x		X		x
Patient Testimony (Part 1 where possible)		x		x		x		x		X		x
Suspensions (Part 2)		x		x		x		x		X		x
Board Committee Summary Reports												
Audit Committee Report				x		x		x				x
Charity Trustee Committee Report		x		x				x		X		
Finance and Performance Committee Report		x		x		x		x		X		x
Quality and Safety Committee Report		x		x		x		x		X		x
Strategic												
Annual Operating Plan and objectives *(subject to change as dependent on national timeline)*												x (TBC)
Clinical Strategy Quarterly Update (Part 1)		X (2020)				x		x				x
Strategy Deep Dives (Part 2)		X (2020) CSS				x Cancer		x Medicine		X Women and Children's		X Surgery

Board Annual Cycle 2019-20

Items	*Apr 2019	May 2019	*Jun 2019	Jul 2019	Aug 2019	Sep 2019	*Oct 2018	Nov 2019	*Dec 2019	Jan 2020	*Feb 2020	Mar 2020
Sustainability and Transformation Plan (STP) (Part 2)		x		x		x		x		x		x
Other Items												
Audit Committee												
Annual Report and Accounts, Annual Governance Statement and External Auditor's Report		x ***(Late May Audit Committee)***										
Annual Audit Letter						x						
Audit Committee TOR and Annual Report						**X – deferred to Nov**		**X**				
Raising Concerns at Work Report				x								
Review of Trust Standing Orders and Standing Financial Instructions								x				
Charity Trustee Committee												
Charity Annual Accounts and Report								x				
Charity Trust TOR and Annual Committee Review						**X – deferred to Nov**		**X**				
Finance and Performance Committee												
Finance Update (Part 2)		x		x		x		x		x		x
FPC TOR and Annual Report						**x – deferred to Nov**		x				
Digital Strategy Update (Part 2)		x		x		x		x		x		x
Market Strategy Review (TBC)												x

Board Annual Cycle 2019-20

Items	*Apr 2019	May 2019	*Jun 2019	Jul 2019	Aug 2019	Sep 2019	*Oct 2018	Nov 2019	*Dec 2019	Jan 2020	*Feb 2020	Mar 2020
Quality and Safety Committee												
Complaints, PALS and Patient Experience Report						x						x
Safeguarding and L.D. Annual Report (Adult and Children)				x								
Detailed Analysis of Staff Survey Results												x
Equality and Diversity Annual Report and WRES						x						
Gender Pay Gap Report												x
Learning from Deaths		x		x				x		x		
Nursing Establishment Review				x						x		
Responsible Officer Annual Review						x						
Patient Safety and Incident Report (Part 2)		x				x		x		x		
University Status Annual Report												x
QSC TOR and Annual Review						**X – deferred to Nov**		x				
Shareholder / Formal Contracts												
ENH Pharma (Part 2) [i]		x						**X - deferred to Mar**				X

[i] To include the Annual Governance Review in November

*Please note Board Development sessions will be held on the 'even' months. This will support flexibility for the Board to be able to be convened for an extraordinary meeting if an urgent decision is required. However, forward agenda planning will aim to minimise this.

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

DATA PACK

Contents

1. Data and Exception Reports:

FFT

Friends and Family Test - January 2020

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	87.50	6.25	18	24	2	1	2	1	48	88	54.55
5B	100.00	0.00	16	4	0	0	0	0	20	37	54.05
7B	87.67	1.37	41	23	7	0	1	1	73	175	41.71
8A	90.48	0.00	20	18	4	0	0	0	42	76	55.26
8B	94.32	1.14	56	27	4	1	0	0	88	118	74.58
11B	95.74	0.00	28	17	1	0	0	1	47	118	39.83
Swift	98.89	1.11	76	13	0	1	0	0	90	209	43.06
ITU/HDU	100.00	0.00	8	1	0	0	0	0	9	9	100.00
Day Surgery Centre, Lister	97.13	0.57	128	41	3	0	1	1	174	436	39.91
Day Surgery Treatment Centre	99.20	0.40	215	32	1	0	1	0	249	483	51.55
Endoscopy, Lister	98.24	0.88	307	27	3	1	2	0	340	960	35.42
Endoscopy, QEII	100.00	0.00	142	7	0	0	0	0	149	347	42.94
SURGERY TOTAL	96.99	0.83	**1055**	**234**	**25**	**4**	**7**	**4**	**1329**	**3056**	43.49
SSU	92.31	0.00	8	4	0	0	0	1	13	207	6.28
AMU - Blue	100.00	0.00	11	3	0	0	0	0	14	122	38.52
AMU - Green	96.97	0.00	23	9	0	0	0	1	33		
Pirton	96.08	0.00	40	9	2	0	0	0	51	51	100.00
Barley	100.00	0.00	15	1	0	0	0	0	16	21	76.19
6A	96.00	0.00	18	6	0	0	0	1	25	68	36.76
6B	88.46	3.85	13	10	0	1	0	2	26	68	38.24
11A	100.00	0.00	56	30	0	0	0	0	86	86	100.00
ACU	NP	NP	0	0	0	0	0	0	0	96	0.00
10B	100.00	0.00	10	12	0	0	0	0	22	51	43.14
Ashwell	100.00	0.00	10	12	0	0	0	0	22	55	40.00
9B	93.06	2.78	28	39	3	1	1	0	72	72	100.00
9A	100.00	0.00	35	1	0	0	0	0	36	45	80.00
Cardiac Suite	100.00	0.00	37	1	0	0	0	0	38	129	29.46
7A	100.00	0.00	13	10	0	0	0	0	23	23	100.00
MEDICINE TOTAL	97.27	0.63	**317**	**147**	**5**	**2**	**1**	**5**	**477**	**1094**	43.60
10AN Gynae	88.14	1.69	35	17	3	1	0	3	59	96	61.46
Bluebell ward	95.38	1.54	45	17	2	0	1	0	65	187	34.76
Bluebell day case	60.00	20.00	2	1	1	1	0	0	5	5	100.00
Neonatal Unit	100.00	0.00	23	4	0	0	0	0	27	95	28.42
WOMEN'S/CHILDREN TOTAL	92.31	1.92	**105**	**39**	**6**	**2**	**1**	**3**	**156**	**383**	40.73
MVCC 10 & 11	100.00	0.00	13	0	0	0	0	0	13	75	17.33
CANCER TOTAL	100.00	0.00	**13**	**0**	**0**	**0**	**0**	**0**	13	**75**	17.33
TOTAL TRUST	96.71	0.86	**1490**	**420**	**36**	**8**	**9**	**12**	**1975**	**4608**	42.86

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	96.41	0.94	1335	413	36	8	9	12	1813	4186	43.31
QEII	100.00	0.00	142	7	0	0	0	0	149	347	42.94
Mount Vernon	100.00	0.00	13	0	0	0	0	0	13	75	17.33
TOTAL TRUST	**96.71**	**0.86**	**1490**	**420**	**36**	**8**	**9**	**12**	**1975**	**4608**	**42.86**

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	91.19	1.90	245	138	26	4	4	3	420	11781	3.57
QEII UCC	100.00	0.00	4	0	0	0	0	0	4	3806	0.11
A&E TOTAL	**91.27**	**1.89**	**249**	**138**	**26**	**4**	**4**	**3**	**424**	**15587**	**2.72**

NP = Not provided

Maternity	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses	No. of Discharges	Total % response rate
Antenatal	100.00	0.00	12	6	0	0	0	0	18	445	4.04
Birth	95.38	1.54	45	17	1	1	0	1	65	408	15.93
Postnatal	86.15	7.69	35	21	3	5	0	1	65	408	15.93
Community Midwifery	100.00	0.00	2	1	0	0	0	0	3	513	0.58
MATERNITY TOTAL	**92.05**	**3.97**	**94**	**45**	**4**	**6**	**0**	**2**	**151**	**1774**	**8.51**

Outpatients	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses
Lister	96.06	1.42	457	152	14	2	7	2	634
QEII	97.25	0.92	790	166	12	1	8	6	983
Hertford County	96.39	0.85	316	138	11	0	4	2	471
Mount Vernon CC	98.43	0.78	203	48	1	2	0	1	255
Satellite Dialysis	95.35	1.16	75	7	3	0	1	0	86
OUTPATIENTS TOTAL	**96.83**	**1.03**	**1841**	**511**	**41**	**5**	**20**	**11**	**2429**

Trust Targets	% Would recommend	% response rate
Inpatients/Day Case	96%>	40%>
A&E	90%>	10%>
Maternity (combined)	93%>	30%>
Outpatients	95%>	N/A

2. Performance Data:

CQC Outcomes Summary

Our CQC Registration and recent Care Quality Commission Inspection

The Care Quality Commission inspected eight of the core services provided by East and North Hertfordshire NHS trust across Lister Hospital, the Queen Elizabeth II (QEII) Hospital and Mount Vernon Cancer Centre, between 23 - 25 & 30 – 31 July 2019. The well led inspection took place from 10 – 11 September 2019. The Use of Resources inspection, which is led by NHS Improvement took place on 6 August 2019.

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

At **Lister Hospital** CQC inspected:

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

At the **QEII Hospital** CQC inspected:

- Urgent Care Centre
- Outpatients

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

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

At the July 2019 inspection, these core services were rated either as requires improvement or good.

Summary of the Trust's Ratings

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

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

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

Ratings for a combined trust

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

The CQC have issued a number of requirement notices and set out a number of areas for improvement - “Must Do’s” and “Should Do’s”.

The requirement notices are:

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

An action plan has been developed against all of these and was submitted to CQC on 22 January 2020. This will be monitored by the Quality Improvement Board, chaired by the Medical Director or Director of Nursing and reported to Board through the Quality and Safety Committee. A programme of internal and external inspections is in place to test and evidence progress and that the actions are embedded across the organisation.

Site Ratings

East and North Hertfordshire NHS Trust

Lister Hospital

	Safe	Effective	Caring	Responsive	Well-Led		Overall
Urgent and emergency services	Good July 2018	Good July 2018	Good July 2018	Good July 2018	Good July 2018		Good July 2018
Medical care (including older people's care)	Requires Improvement July 2018	Requires Improvement July 2018	Requires Improvement July 2018	Requires Improvement July 2018	Requires Improvement July 2018		Requires Improvement July 2018
Surgery	Inadequate December 2019	Good December 2019	Good December 2019	Requires Improvement December 2019	Requires Improvement December 2019		Requires Improvement December 2019
Critical care	Good December 2019	Good December 2019	Good December 2019	Good December 2019	Good December 2019		Good December 2019
Maternity	Requires Improvement July 2018	Good July 2018	Good July 2018	Good July 2018	Good July 2018		Good July 2018
Services for children and young people	Requires Improvement December 2019	Good December 2019	Good December 2019	Good December 2019	Good December 2019		Good December 2019
End of life care	Good December 2019	Requires Improvement December 2019	Good December 2019	Requires Improvement December 2019	Requires Improvement December 2019		Requires Improvement December 2019
Outpatients	Good December 2019	Good December 2019	Good December 2019	Good December 2019	Good December 2019		Good December 2019
Overall	Requires Improvement December 2019	Good December 2019	Good December 2019	Good December 2019	Requires Improvement December 2019		Requires Improvement December 2019

New QEII

	Safe	Effective	Caring	Responsive	Well-Led		Overall
Urgent and emergency services	Requires Improvement December 2019	Good December 2019	Good December 2019	Good December 2019	Requires Improvement December 2019		Requires Improvement December 2019
Outpatients and diagnostic imaging	Requires Improvement December 2019	N/A	Good December 2019	Requires Improvement December 2019	Good December 2019		Requires Improvement July 2018
Overall	Requires Improvement December 2019	Good December 2019	Good December 2019	Requires Improvement December 2019	Requires Improvement December 2019		Requires Improvement December 2019

Hertford County Hospital

	Safe	Effective	Caring	Responsive	Well-Led		Overall
Outpatients	Good March 2016	Good March 2016	Good March 2016	Good March 2016	Good March 2016		Good March 2016
Overall	Good March 2016	Good March 2016	Good March 2016	Good March 2016	Good March 2016		Good March 2016

Mount Vernon Cancer Centre

	Safe	Effective	Caring	Responsive	Well-Led		Overall
Medical care (including older people's care)	Requires Improvement December 2019 → ←	Good December 2019 → ←	Good December 2019 → ←	Requires Improvement December 2019 → ←	Requires Improvement December 2019 → ←		Requires Improvement December 2019 → ←
End of life care	Requires Improvement July 2018	Good July 2018	Good July 2018	Inadequate July 2018	Requires Improvement July 2018		Requires Improvement July 2018
Outpatients	Good December 2019 → ←	N/A	Good December 2019 → ←	Requires Improvement December 2019 → ←	Requires Improvement December 2019 ↓		Requires Improvement December 2019 ↓
Chemotherapy	Requires Improvement July 2018	Good July 2018	Good July 2018	Requires Improvement July 2018	Requires Improvement July 2018		Requires Improvement July 2018
Radiotherapy	Good December 2019 → ←	Good December 2019 → ←	Good December 2019 → ←	Good December 2019 → ←	Good December 2019 → ←		Good December 2019 → ←
Overall	Requires Improvement December 2019 → ←	Good December 2019 → ←	Good December 2019 → ←	Requires Improvement December 2019 → ←	Requires Improvement December 2019 → ←		Requires Improvement December 2019 → ←

Community Health Services for Children, Young People and Families

	Safe	Effective	Caring	Responsive	Well-Led		Overall
Community health services for children and young people	Good March 2016	Good March 2016	Outstanding March 2016	Good March 2016	Good March 2016		Good March 2016
Overall	Good March 2016	Good March 2016	Outstanding March 2016	Good March 2016	Good March 2016		Good March 2016

3. Quality and Safety Committee Reports:

Safer Staffing

1.0 Introduction

Whilst there is no single definition of 'safe staffing', NHS constitution, NHS England, CQC regulations, NICE guidelines, NQB expectations, and NHS Improvement resources all make reference to the need for NHS services to be provided with sufficient staff to provide patient care safely. NHS England cites the provision of an *"appropriate number and mix of clinical professionals"* as being vital to the delivery of quality care and in keeping patients safe from avoidable harm. (NHS England 2015)
East and North Hertfordshire NHS Trust is committed to ensuring that levels of nursing staff, which includes Registered Nurses, Midwives, Nursing Associates and Clinical Support Workers (CSWs), match the acuity and dependency needs of patients within clinical ward areas in the Trust. This includes ensuring there is an appropriate level and skill mix of nursing staff to provide safe and effective care using evidence based tools and professional judgement to support decisions. The National Quality Board (NQB 2016) recommend that on a monthly basis, actual staffing data is compared with expected staffing and reviewed alongside quality of care, patient safety, and patient and staff experience data. The trust is committed to ensuring that improvements are learned from and celebrated, and areas of emerging concern are identified and addressed promptly.

2.0 People Productivity

The following sections identify the processes in place to demonstrate that the Trust proactively manages nurse staffing to support patient safety.

2.1 Nursing Fill Rate

The Trust's safer staffing submission has been submitted to NHS Digital for January 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 January. An exception report can be found in Appendix 2 showing those wards with a Registered Fill rate below 90% and any other points of note for the month.

Table 1

	Day		Night		Average 24 Hr		
Trust Average Fill Rates	**Registered**	**Non-Registered**	**Registered**	**Non-Registered**	**Registered**	**Non-Registered**	**All Staff**
Trust Average (Current Month)	91.8%	91.9%	97.4%	119.0%	94.4%	102.3%	97.2%
Trust Average (Last Month)	92.1%	93.1%	96.2%	112.0%	93.9%	100.4%	96.2%
Change	⇩ -0.3%	⇩ -1.2%	⇧ 1.2%	⇧ 7.0%	⇧ 0.5%	⇧ 1.9%	⇧ 1.0%

2.2 Care Hours per Patient day (CHPPD)

CHPPD is a measure of workforce deployment and is reportable to NHS Digital as part of the monthly returns for safe staffing.

CHPPD is the total number of hours worked on the roster by both Registered Nurses & Midwives and Nursing Support Staff divided by the total number of patients on the ward at 23:59 aggregated for the month (lower CHPPD equates to lower staffing numbers available to provide clinical care).

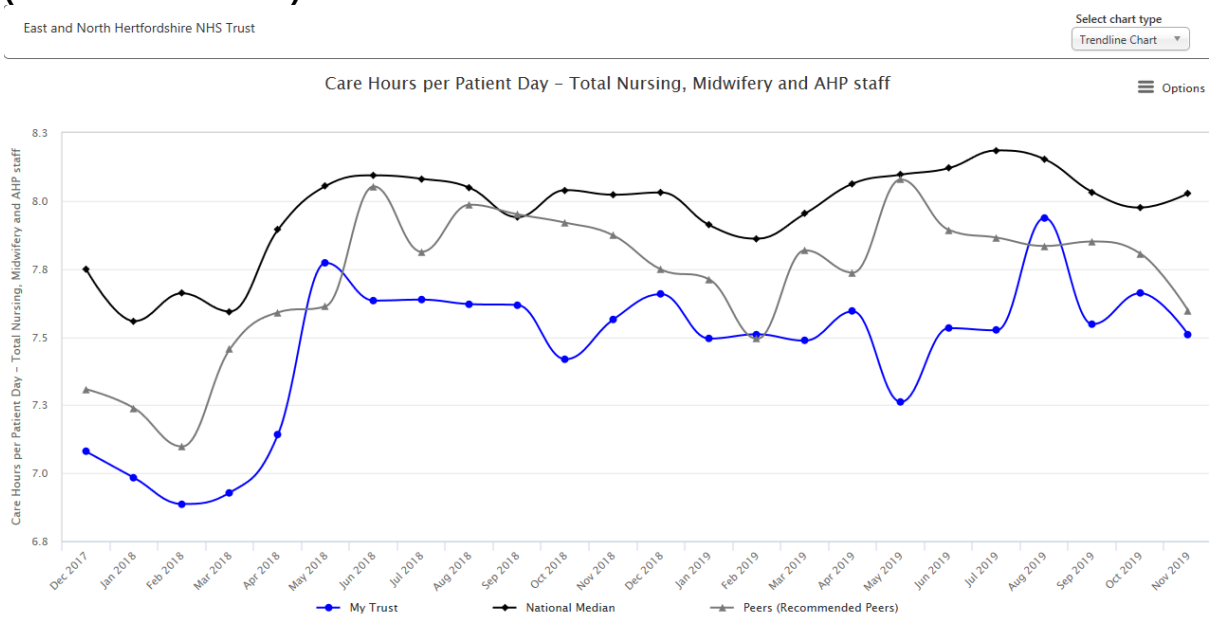
Registered Nursing Associates and Non-Registered Nursing Associates are now identified in separate fields within the NHS England & Improvement fill rate template. The planned care hours have been adjusted to reflect the actual care hours as the nursing associate workforce is a limited pool and the hours worked are variable each month. The total planned care hours for each ward is fixed as per the agreed establishment settings therefore the planned hours will be flexed across Registered Nurses and Registered Nursing Associates each month.
The Trust Average CHPPD for this month and last month can be seen in the table below. A full list of CHPPD by ward can be found in Appendix 3.

Table 2

	Average 24 Hr				
Trust Average CHPPD	**Registered Nurses / Midwives**	**Non-registered Nurses / Midwives (Care Staff)**	**Registered Nursing Associates**	**Non-registered Nursing Associates**	**All Staff**
Trust Average (Current Month)	4.6	2.7	0.1	0.1	7.5
Trust Average (Last Month)	4.7	2.7	0.1	0.1	7.5
Change	-0.1	0.0	0.0	0.0	0.0

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.

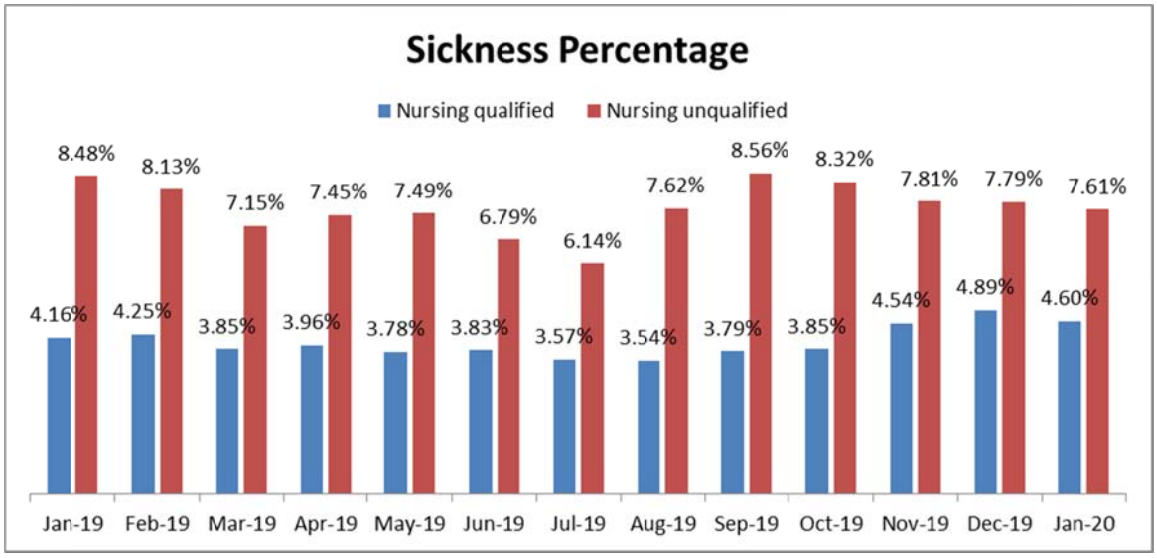
Chart 1 Care Hours per Patient Day (CHPPD): Data source Model Hospital Dashboard (latest available data).



3.3 Sickness

Chart 2 shows that sickness levels have decreased for both qualified and unqualified nursing staff in January. There is ongoing work to address our above benchmark comparator sickness levels in our CSWs.

Chart 2 – Sickness Percentage by Staff Group



3.4 Patient Flow and Escalation

Good patient flow is central to patient experience, clinical safety and reducing the pressure on staff. It is also essential to the delivery of national emergency care access standards. (NHSI 2017)

Chart 3 shows for the month of January the Opel status of the trust each day, linked with the number of Learning disability patients in acute beds and the number of enhanced care patients requiring a higher level of care per day. These factors all have an impact to staff experience, patient safety, quality and outcomes on our wards.

Where patient numbers and acuity demands on the trust increase, an informed decision to open escalation beds is made to cope with the pressures on the system. Additional staff is requested to support this requirement.

For the month of January escalation shifts were requested on 22 occasions to support the site safety and flow.

Chart 3

Jan-20		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Opel Status		OPEL 3	OPEL 3	OPEL 3	OPEL 3	OPEL 3	OPEL 3	OPEL 3	OPEL 3	OPEL 4	OPEL 3	OPEL 3	OPEL 3	OPEL 3	OPEL 2	OPEL 3	OPEL 3	OPEL 3	OPEL 3	OPEL 2	OPEL 2	OPEL 3	OPEL 3	OPEL 2	OPEL 2	OPEL 2	OPEL 2	OPEL 2	OPEL 2	OPEL 2	OPEL 2	OPEL 2
Number of LD Patients		4	4	2	4	3	2	5	3	5	2	3	3	4	5	7	9	10	10	9	7	6	6	4	5	5	5	6	6	6	6	4
Number of Enhanced Care Patients		35	44	44	44	44	46	46	45	40	44	44	38	38	32	36	31	34	34	34	45	43	36	33	33	33	33	42	42	40	40	39
Escalation Shifts	Discharge lounge	NO	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	NO	NO	NO	NO	NO	NO	NO	NO
	CDU	NO	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	NO	NO	NO	NO	NO	NO	NO	NO

3.5 Enhanced Care

The Enhanced Nursing care team (ENCT) are a specialist substantive team who provide enhanced care, or 1-1 and are available 24 hours a day, seven days a week, ensuring that inpatients who are at risk to themselves or others are being effectively supported by specially trained staff to feel safe, secure and cared for at all times.

For the month of January 131 risk assessments were received by the team which is an increase of 5 patients referred compared to December. Chart 4 shows that the patients referred to the team continue to remain high. The trust is seeing a higher acuity of patients and a higher number of patients requiring enhanced care support overall compared to 2018 as shown in chart 3. The team also support mental health patients who are referred by the

RAID and CCAT teams that require 1-1 enhanced care. It should be noted that a number of patients requiring enhanced care are also requiring support from our security teams. For the month of January, 62.25 additional hours have been used by the security team to manage patients displaying challenging behaviour. The ENCT team review all risk assessed patients on a daily basis and step the level of enhanced care up or down as required to provide a streamlined flexible service. The team continue to develop the service to ensure improved patient care and outcomes. Where demand exceeds capacity the shifts will be put out to temporary staffing to cover the requirement. For the month of January there were 1131.5 unfilled hours where the shifts were not filled for the increased enhanced care demand.
We continue to pro-actively recruit to the team to ensure sufficient substantive fill.

Chart 5 shows the breakdown of care hours provided by the ENCT and NHS Professionals. There continues to be robust check and challenge in place for all enhanced care a requirement, ensuring safe patient care is the main priority.

Chart 4

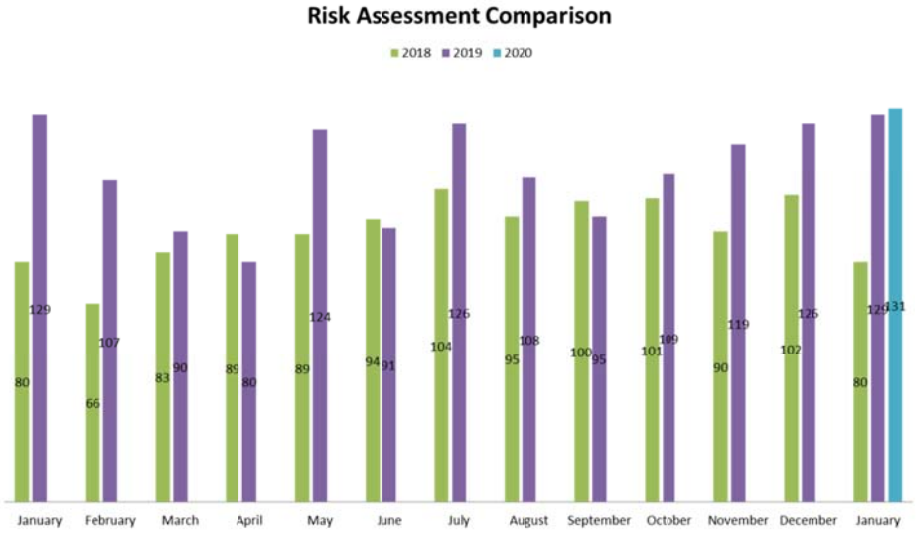
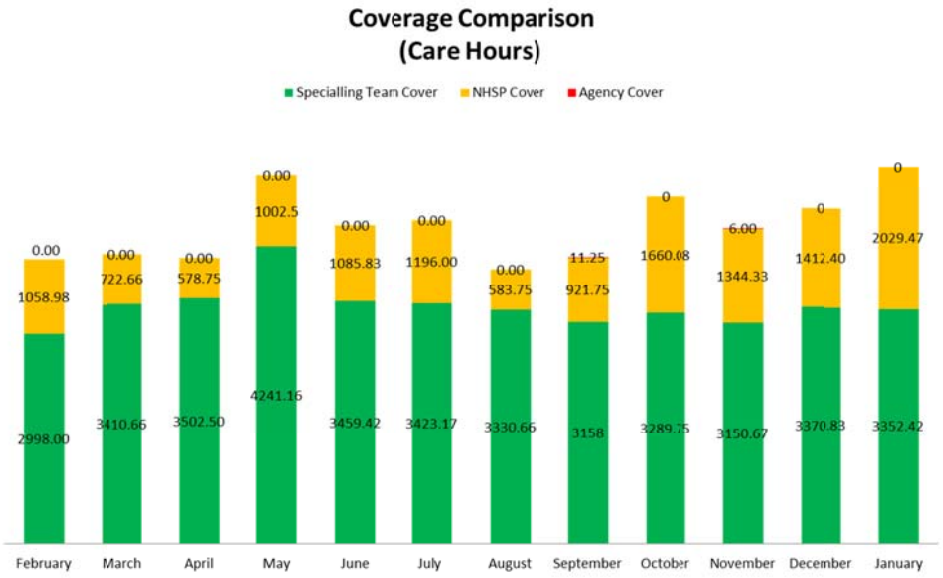


Chart 5



3.6 Recruitment and retention

The overall Trust position for qualified nursing in month 10 saw 19.8 WTE new starters and 18.5 WTE leavers, giving a positive variance of 1.3 WTE for the month. This has resulted in a vacancy rate of 7.4%, which is unchanged from month 9. This equates to 129 vacancies. Funding for 41 overseas nurses has been confirmed so far, with a request for a further 39 being considered at a later point. Work has already commenced to recruit from overseas, with the first group aiming to arrive in month 1.
The vacancy rate for unqualified nursing decreased by 1.45% in month 10 to 12.9%, equating to 82 vacancies. This was due to 15 WTE starting in month 10 against 5 WTE leaving, giving a positive variance in month of 10 WTE.

4.0 Financial Sustainability

The Deputy Director of Nursing, all matrons, safer staffing team and heads of nursing continue to meet monthly to prospectively review rosters to identify operational shortfalls and temporary staff requirements including agency usage/ requirements. Each ward is then RAG rated on a heat map and agency levels and restrictions agreed. Any additional ad hoc agency requirements outside of this meeting are authorised via the Director of Nursing or Deputy Director of Nursing.

Should a ward need to go above their planned agency usage a robust process is in place to be agreed by the director or deputy director of nursing.

To facilitate the reduction in agency costs, the trust continue to use a Rapid Response pool of nurses and CSWs. These bank staffs get an enhanced pay rate and flexible hours in recognition of the workers commitment to be deployed to any clinical area at the time of reporting for work. The Rapid Response pool is used to mitigate daily staffing challenges such as sickness and short notice drop out to ensure wards are staffed safely. The numbers of shifts made available are flexed up or down as the need arises.
The staffing team have also introduced a flexible pool to offer bank staff more flexible hours encouraging more shifts to be worked and supporting flexible working, and the Lister pool a controlled amount of shifts sent out to bank and agency to support escalation.

4.1 Temporary Staffing Fill

Overall fill rate for temporary staffing increased by 3.3% from 76.8% in December to 80.0% in January. Demand hours increased by 8120 hours.

Bank fill rates increased by 2.9% and Agency fill rates increased by 0.4 %. The level of unfilled shifts decreased from 23.2% in December to 20.0% in January.

Table 3 Temporary Staffing Registered and Unregistered Hours Demand and Fill Rates

Current YTD Month & Year	Net Hours Requested *	NHSP Filled Hours	% NHSP Filled Hours	Agency Filled Hours	% Agency Filled Hours	Overall Fill Rate	Unfilled Hours	% Unfilled Hours
April 2019	64,834	46,309	71.4 %	4,405	6.8 %	78.2 %	14,120	21.8 %
May 2019	67,172	49,558	73.8 %	5,049	7.5 %	81.3 %	12,566	18.7 %
June 2019	61,620	46,252	75.1 %	4,434	7.2 %	82.3 %	10,934	17.7 %
July 2019	55,419	49,281	88.9 %	3,502	6.3 %	95.2 %	2,637	4.8 %
August 2019	63,712	48,399	76.0 %	2,571	4.0 %	80.0 %	12,743	20.0 %
September 2019	65,138	49,690	76.3 %	2,349	3.6 %	79.9 %	13,098	20.1 %
October 2019	68,651	53,780	78.3 %	2,670	3.9 %	82.2 %	12,201	17.8 %
November 2019	71,638	54,404	75.9 %	2,903	4.1 %	80.0 %	14,330	20.0 %
December 2019	70,596	50,704	71.8 %	3,482	4.9 %	76.8 %	16,410	23.2 %
January 2020	78,716	58,788	74.7 %	4,211	5.3 %	80.0 %	15,718	20.0 %
Total	**667,497**	**507,164**	**76.0 %**	**35,576**	**5.3 %**	**81.3 %**	**124,757**	**18.7 %**

Chart 5 Nursing and Midwifery Temporary Staffing Demand and Fill Rates

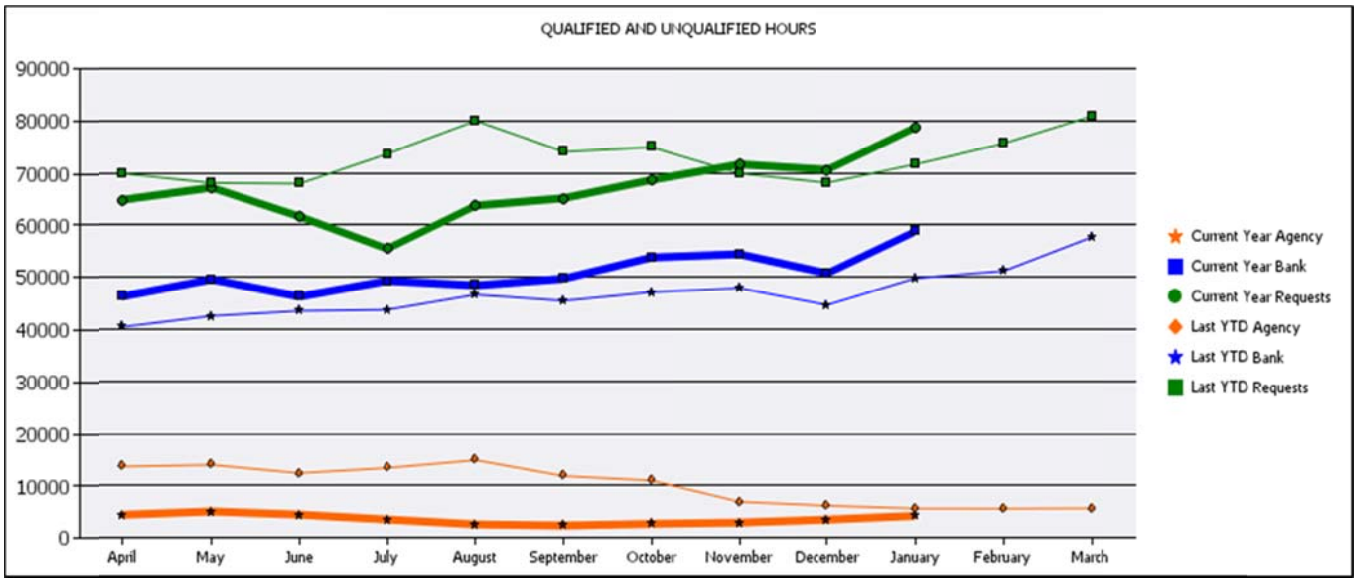


Table 4 Temporary Staffing Registered Hours Demand and Fill Rates

Current YTD Month & Year	Net Hours Requested *	NHSP Filled Hours	% NHSP Filled Hours	Agency Filled Hours	% Agency Filled Hours	Overall Fill Rate	Unfilled Hours	% Unfilled Hours
April 2019	39,525	26,870	68.0 %	4,405	11.1 %	79.1 %	8,250	20.9 %
May 2019	40,775	28,106	68.9 %	5,049	12.4 %	81.3 %	7,621	18.7 %
June 2019	38,565	26,905	69.8 %	4,434	11.5 %	81.3 %	7,226	18.7 %
July 2019	33,442	27,978	83.7 %	3,502	10.5 %	94.1 %	1,963	5.9 %
August 2019	39,026	28,367	72.7 %	2,571	6.6 %	79.3 %	8,089	20.7 %
September 2019	40,680	29,760	73.2 %	2,349	5.8 %	78.9 %	8,571	21.1 %
October 2019	41,306	32,076	77.7 %	2,668	6.5 %	84.1 %	6,562	15.9 %
November 2019	44,174	32,898	74.5 %	2,903	6.6 %	81.0 %	8,373	19.0 %
December 2019	42,925	29,778	69.4 %	3,482	8.1 %	77.5 %	9,666	22.5 %
January 2020	48,288	35,065	72.6 %	4,211	8.7 %	81.3 %	9,012	18.7 %
Total	**408,707**	**297,803**	**72.9 %**	**35,574**	**8.7 %**	**81.6 %**	**75,331**	**18.4 %**

Table 5 Temporary Staffing Unregistered Hours Demand and Fill Rates

Current YTD Month & Year	Net Hours Requested *	NHSP Filled Hours	% NHSP Filled Hours	Agency Filled Hours	% Agency Filled Hours	Overall Fill Rate	Unfilled Hours	% Unfilled Hours
April 2019	25,309	19,439	76.8 %	0	0.0 %	76.8 %	5,871	23.2 %
May 2019	26,398	21,453	81.3 %	0	0.0 %	81.3 %	4,945	18.7 %
June 2019	23,055	19,346	83.9 %	0	0.0 %	83.9 %	3,709	16.1 %
July 2019	21,977	21,303	96.9 %	0	0.0 %	96.9 %	674	3.1 %
August 2019	24,686	20,032	81.1 %	0	0.0 %	81.1 %	4,654	18.9 %
September 2019	24,457	19,930	81.5 %	0	0.0 %	81.5 %	4,527	18.5 %
October 2019	27,344	21,704	79.4 %	2	0.0 %	79.4 %	5,639	20.6 %
November 2019	27,463	21,506	78.3 %	0	0.0 %	78.3 %	5,957	21.7 %
December 2019	27,671	20,926	75.6 %	0	0.0 %	75.6 %	6,745	24.4 %
January 2020	30,428	23,722	78.0 %	0	0.0 %	78.0 %	6,706	22.0 %
Total	**258,789**	**209,361**	**80.9 %**	**2**	**0.0 %**	**80.9 %**	**49,426**	**19.1 %**

4.2 Roster KPIs

Table 6 shows the roster KPIs for the month of January as captured in the Nursing Quality Indicators Report. There is ongoing work with divisions to improve their roster KPIs through the eRoster and Finance Master Classes currently being rolled out to Ward Managers and Matrons.

Table 6 Nursing & Midwifery NQIs

SUMMARY		Trust	Medicine	Surgery	Women & Children	Cancer	Assessment Wards	Emergency Department	Dialysis
e-Rostering	% E-roster Deadline Met	65.52%	69.25%	66.25%	47.43%	33.00%	66.50%	83.00%	93.20%
	Net Hours %	-1.35%	-0.81%	-1.23%	-0.20%	-3.00%	-0.75%	-2.55%	-0.94%
	Net Hours Position	-1638.82	-384.67	-367.93	-78.53	-148.72	-96.34	-384.96	-177.67
	% of Actual Annual Leave	12.68%	11.78%	11.85%	13.63%	14.80%	14.35%	7.80%	14.56%

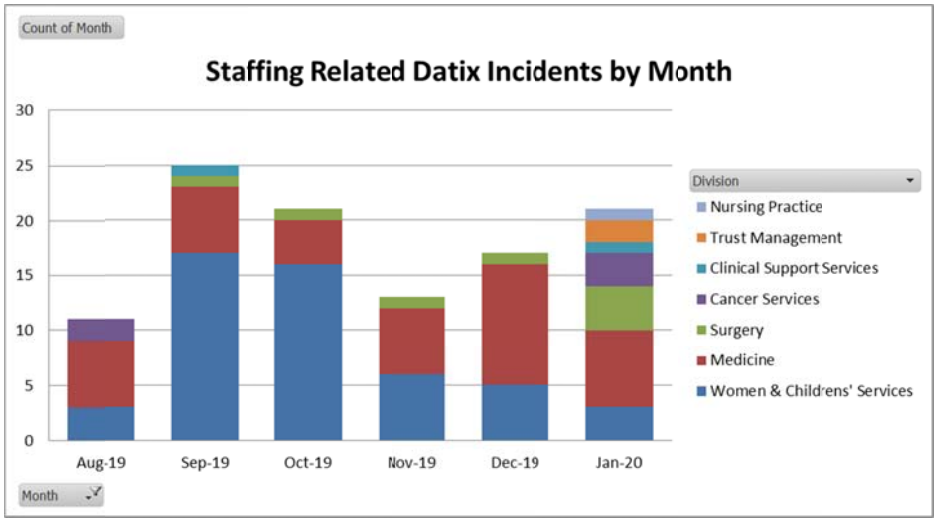
5.0 Investigations and actions on Incidents and red flag events

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. There were 756 shifts across our inpatient areas that triggered red across the month (23.33%) of which 46 were not fully mitigated and remained red (1.42%). All the wards were supported and visited by senior nursing staff during the shift.

5.1 Datix Incidents

Chart 6 shows the number of staffing related Datix incidents logged in the last six months by speciality.
Twenty-one staffing related Datix were raised in January. All staffing related incidents are reviewed by the Safer Staffing Matron and DoN and actioned as appropriate. All Datix for January have been reviewed and actioned by the department managers.

Chart 6

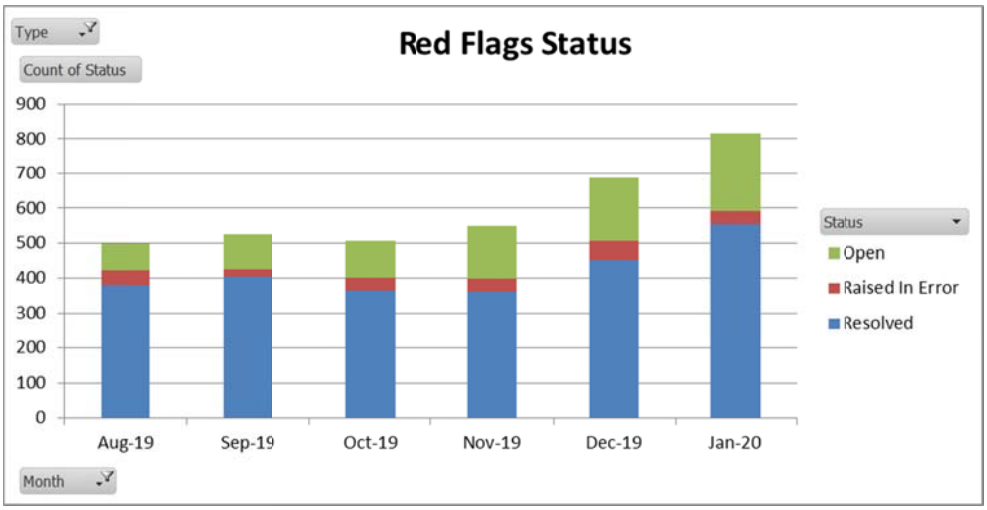


5.2 Red Flag Events

Red flags are NICE recommended nationally reportable events that require an immediate response from the Senior Nurse Team. "Red flag events" signal to the Senior Nurse Team an urgent need for review of the numbers of staff, skill mix and patient acuity and numbers. These events are considered as indicators of a ward requiring an intervention e.g. increasing staffing levels, facilitating patient discharge or closing to admissions for a temporary period following discussion and agreement with the operations centre and the executive on call.
Red flag notifications are completed in SafeCare and sent to a centralised staffing e-mail address. These notifications are then escalated at each of the three daily staffing meetings and site safety meeting, and closed once actions to mitigate are in place. The nurse in charge of the ward will try to resolve Red Flags with the help of the Divisional bleep holders who will act on escalated 'open' issues to help resolve them. Feedback from the wards has found the red flags are appropriate to the staffing challenges they need to escalate on a shift.

Chart 7 shows the number of red flags raised each month over the last 6 months and their status excluding Maternity Red Flags. See **Appendix 4** for the Midwifery safe staffing update.

Chart 7



6.0 Patient outcomes

The Safer Staffing Team continues to monitor staffing at the three Daily Staffing meetings and weekly staffing look ahead meetings. Daily site safety meetings give a site overview of current issues and concerns relating to capacity, quality, patient care and safety concerns. This supports multi-professional informed decision making across the day. In addition to this there is a weekly look ahead meeting to ensure early mitigation / shift changes are agreed to pro-actively cover shortfalls.

6.1 Safety Thermometer

The NHS Safety Thermometer audit provides a 'temperature check' on levels of harm and enables the measurement of 'harm free care'. Harm free care is defined by the absence of pressure ulcers, harm from a fall, urine infection (in patients with a catheter) and new VTE. This report details the number of patients 'with harm' on the specified Audit date – 15th January 2019. We acknowledge that the 'harm' in January 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.

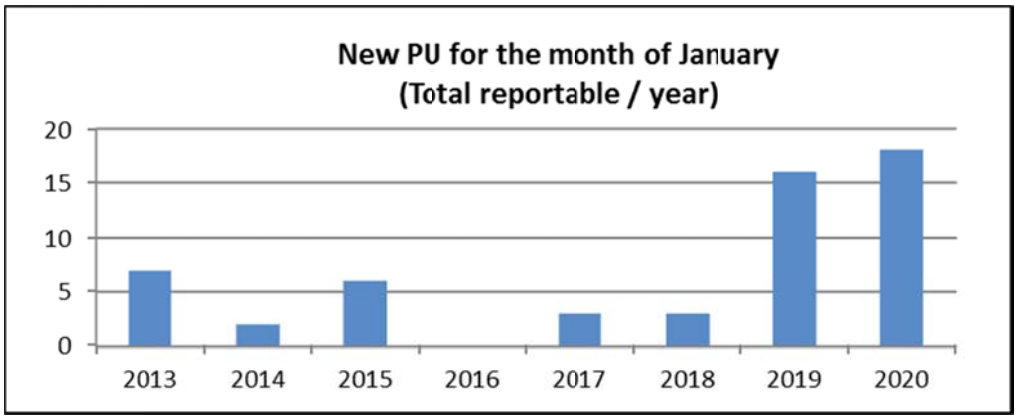
6.2 Falls

70 inpatient falls were recorded in January this is an decrease of 8 incidents when compared to December. 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.

6.3 Pressure Ulcers

For the month of January there were 18 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.
January 2019 figure incorporates all categories of damage where 2012-2017 only counts category 2-4 and unstageable ulcers shown in Chart 8.
The graph depicts total number of reportable pressure ulcers per year.
2018-19 Total = 86, Current YTD = 126

Chart 8

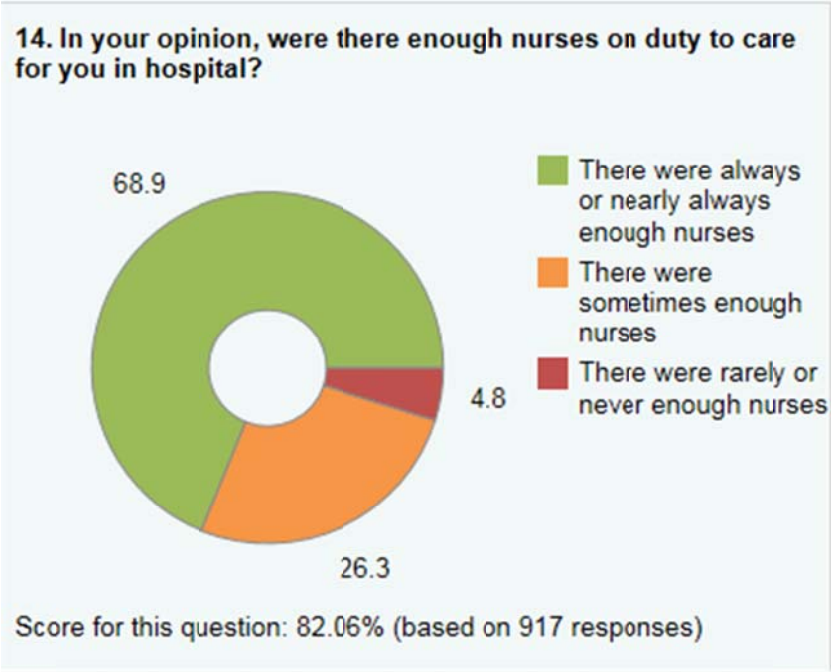


7.0 Patient, carer and staff feedback in relation to safe staffing levels

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 January 2019, 41 of 934 responses felt there were not enough nurses on duty.
Chart 9 shows the breakdown of responses for January 2019. Action plans are put in place where performance is triggering red.

Chart 9

January 2020



7.1 Friends and Family

Table 7 shows the results for the friends and family test for the past 3 months. The percentage of patients that would recommend our trust for the month of January has increased slightly from December.

Table 7

A Summary of the last 3 months responses

A summary of the last three months responses is shown below	% Would Recommend	% Would Not Recommend	No. of patients responding	% response rate [target 40%]
November 2019	97.63	0.53	2071	46.36
December 2019	96.26	0.92	1847	41.55
January 2020	96.71	0.86	1975	42.86

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 January 2015
NQB (2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – Safe sustainable and productive staffing.
Good practice guide: Focus on improving patient flow NHSI December (2017)

Appendix 1

	Day				Night			
Ward name	Average fill rate + registered nurses/ midwives (%)	Average fill rate + care staff (%)	Average fill rate - Registered Nursing Associates	Average fill rate - Non - Registered Nursing Associates	Average fill rate + registered nurses/ midwives (%)	Average fill rate + care staff (%)	Average fill rate - Registered Nursing Associates	Average fill rate - Non - Registered Nursing Associates
10B	95.5%	99.4%	100.0%	100.0%	97.3%	134.2%	#DIV/0!	#DIV/0!
11A	98.1%	106.5%	#DIV/0!	#DIV/0!	98.7%	156.3%	#DIV/0!	#DIV/0!
11B	77.6%	95.2%	100.0%	#DIV/0!	104.1%	123.4%	#DIV/0!	#DIV/0!
5A	95.2%	89.7%	100.0%	100.0%	99.0%	119.7%	100.0%	#DIV/0!
5B	91.0%	85.3%	100.0%	100.0%	99.4%	116.1%	#DIV/0!	#DIV/0!
6A	94.7%	93.5%	#DIV/0!	100.0%	99.7%	137.9%	#DIV/0!	#DIV/0!
6B	92.0%	95.1%	#DIV/0!	100.0%	100.0%	150.1%	#DIV/0!	#DIV/0!
10A Gynae	102.2%	89.3%	#DIV/0!	#DIV/0!	99.4%	107.2%	#DIV/0!	#DIV/0!
7A	94.8%	83.8%	#DIV/0!	#DIV/0!	106.4%	104.4%	#DIV/0!	#DIV/0!
7B	95.6%	92.9%	100.0%	100.0%	98.1%	118.7%	#DIV/0!	#DIV/0!
8A	96.0%	93.1%	100.0%	#DIV/0!	98.7%	127.6%	#DIV/0!	#DIV/0!
8B	98.4%	91.5%	100.0%	#DIV/0!	96.1%	113.7%	#DIV/0!	#DIV/0!
9A	93.2%	118.5%	#DIV/0!	#DIV/0!	101.4%	181.2%	#DIV/0!	#DIV/0!
9B	98.3%	112.2%	#DIV/0!	100.0%	99.3%	160.7%	#DIV/0!	#DIV/0!
ACU	94.8%	95.2%	#DIV/0!	100.0%	98.8%	105.8%	#DIV/0!	#DIV/0!
AMU-A	93.2%	102.1%	100.0%	100.0%	98.2%	108.8%	100.0%	#DIV/0!
AMU-W	92.9%	124.7%	#DIV/0!	#DIV/0!	101.1%	142.2%	#DIV/0!	#DIV/0!
Ashwell	88.4%	110.0%	100.0%	100.0%	101.6%	125.6%	100.0%	#DIV/0!
Barley	96.8%	98.0%	#DIV/0!	100.0%	100.3%	123.5%	#DIV/0!	#DIV/0!
Bluebell	104.9%	65.2%	100.0%	100.0%	95.7%	106.4%	#DIV/0!	#DIV/0!
Critical Care 1	100.0%	100.0%	#DIV/0!	#DIV/0!	100.0%	100.0%	#DIV/0!	#DIV/0!
Dacre	92.1%	90.7%	#DIV/0!	#DIV/0!	79.5%	#DIV/0!	#DIV/0!	#DIV/0!
Gloucester	93.3%	66.9%	#DIV/0!	#DIV/0!	99.0%	95.2%	#DIV/0!	#DIV/0!
Mat CLU 1	96.1%	82.0%	#DIV/0!	#DIV/0!	99.9%	89.0%	#DIV/0!	#DIV/0!
Mat MLU	75.0%	83.9%	#DIV/0!	#DIV/0!	81.9%	84.6%	#DIV/0!	#DIV/0!
Pirton	84.9%	88.6%	#DIV/0!	#DIV/0!	100.3%	110.5%	#DIV/0!	#DIV/0!
SAU	88.8%	107.4%	100.0%	100.0%	100.6%	102.4%	#DIV/0!	100.0%
SSU	93.6%	92.7%	#DIV/0!	100.0%	100.7%	111.6%	#DIV/0!	#DIV/0!
Swift	81.8%	84.0%	100.0%	#DIV/0!	100.1%	96.2%	#DIV/0!	#DIV/0!
Ward 11	56.2%	47.1%	100.0%	#DIV/0!	71.1%	94.4%	#DIV/0!	#DIV/0!
Total	**91.6%**	**91.5%**	**100.0%**	**100.0%**	**97.4%**	**119.0%**	**100.0%**	**100.0%**

Appendix 2

Ward Staffing Exception Report

Wards with a Registered fill rate <90%, and wards where the planned staffing differs from actual.

Ward	Comment
11B	Reduced occupancy in month
Ashwell	Reduced occupancy in month and staffing levels impacted by vacancies and sickness
Pirton	Reduced occupancy in month
SAU	Staffing levels impacted by vacancies
Swift	Reduced occupancy in month
Ward 11	Reduced occupancy in month, staffing flexed across the Cancer Services Division to support safe staffing
MLU	Low occupancy in month, staffing flexed across the Maternity Service to meet patient needs

Ward name	Care Hours Per Patient Day (CHPPD)				
	Registered midwives/ nurses	Care Staff	Registered Nursing Associates	Non-Registered Nursing Associates	Overall
10B	**3.22**	**2.47**	**0.00**	**0.24**	**5.93**
11A	**3.89**	**2.49**	**0.00**	**0.00**	**6.38**
11B	**3.93**	**2.83**	**0.18**	**0.00**	**6.93**
5A	**3.35**	**2.30**	**0.14**	**0.12**	**5.92**
5B	**3.38**	**2.44**	**0.15**	**0.09**	**6.07**
6A	**3.25**	**2.46**	**0.00**	**0.12**	**5.84**
6B	**4.26**	**2.20**	**0.00**	**0.14**	**6.60**
10A Gynae	**5.76**	**2.81**	**0.00**	**0.00**	**8.57**
7A	**3.27**	**2.21**	**0.00**	**0.00**	**5.48**
7B	**3.17**	**2.20**	**0.19**	**0.03**	**5.59**
8A	**3.18**	**2.20**	**0.12**	**0.00**	**5.49**
8B	**3.24**	**2.30**	**0.01**	**0.00**	**5.54**
9A	**3.14**	**3.07**	**0.00**	**0.00**	**6.21**
9B	**2.98**	**2.87**	**0.00**	**0.02**	**5.87**
ACU	**4.55**	**2.20**	**0.00**	**0.17**	**6.92**
AMU-A	**6.02**	**3.79**	**0.26**	**0.02**	**10.10**
AMU-W	**4.25**	**3.85**	**0.00**	**0.00**	**8.11**
Ashwell	**3.05**	**2.95**	**0.17**	**0.14**	**6.32**
Barley	**3.31**	**2.64**	**0.00**	**0.14**	**6.10**
Bluebell	**6.25**	**2.32**	**0.37**	**0.27**	**9.21**
Critical Care 1	**18.95**	**2.06**	**0.00**	**0.00**	**21.02**
Dacre	**6.80**	**1.18**	**0.00**	**0.00**	**7.98**
Gloucester	**4.70**	**3.75**	**0.00**	**0.00**	**8.45**
Mat CLU 1	**22.61**	**6.40**	**0.00**	**0.00**	**29.01**
Mat MLU	**33.82**	**11.55**	**0.00**	**0.00**	**45.37**
Pirton	**4.18**	**2.28**	**0.00**	**0.00**	**6.46**
SAU	**7.38**	**3.59**	**0.01**	**0.31**	**11.29**
SSU	**3.54**	**3.26**	**0.00**	**0.13**	**6.92**
Swift	**3.78**	**2.25**	**0.32**	**0.00**	**6.35**
Ward 11	**5.62**	**3.20**	**0.23**	**0.00**	**9.05**
Total	**4.6**	**2.7**	**0.1**	**0.1**	**7.5**

Safer Staffing Report January 2020

Planned versus actual midwifery staffing levels

NHSR Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required Evidence:

- Details of planned versus actual midwifery staffing levels
- The midwife: birth ratio

Funded Clinical Establishment supports an annual ratio of 1 midwife to 29 women including band 3 and 4 staff that support postnatal care against BR+ recommendation of a ratio of 1:26. Ratios will vary month on month due to variations in birth numbers however the funded establishment supports all maternity activity both hospital and community care. In addition, a review of staff skill mix was carried out to bring the staffing in line with the recommended ratios. Band 3 and 4 support workers currently supporting inpatients antenatal care have been transferred to the community to provide postnatal care. The result is an improvement in the right skills, providing the right care, in the right place, improving midwife to birth ratio overall.

2019-20	Oct		Nov		Dec		Jan	
Midwives	178.57		178.57		178.57		178.57	
Band 3-4 Postnatal	11.53		11.53		11.53		11.53	
Total Funded Clinical	**190.1**		**190.1**		**190.1**		**190.1**	
Actual Worked	**184.2**		**185.2**		**178.7**		**186.4**	
	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	445	**27.5**	**453**	**29**	**444**	**27**	**416**	**26**
12 Month Rolling Year to Date Against Funded Midwifery Establishment	5301	**30**	**5286**	**30**	**5272**	**30**	**5247**	**30**
Actual Births in Month against actual worked in month midwives	5475	**32**	**5414**	**31**	**5134**	**30**	**4839**	**28**

Total Clinical WTE funded	
to a ratio of 1:29	30.6-32
based on 5500 births	>32

Midwife only funded	
to a ratio of 1:31	31.6-33
based on 5500 births	>33

*From April 2019 included in the clinical numbers are non-recruitable 4.76 in budget to support maternity leave

Also included 4% non recruitable headroom

Actions

- Birthrate Plus (BR+) Workforce Analysis based on QTR 3 18/19 activity recommended an uplift in establishment (not including requirements to support national maternity transformation ambitions)
- Presented to Trust Board in July 2019 as part of the Trust Bi-annual Establishment Review reflecting professional judgment to inform recommended uplift
- Local Maternity System funds utilised to support maternity transformation workforce ambitions and increase establishment
- BR+ recommendations shared across the LMS
- Draft LMS 5 Year Workforce Strategy to be shared with the STP
- A maternity staffing paper to be presented to Board

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